Australian Government
Australian Institute of Health and Welfare

Alcohol, tobacco & other drugs in Australia

Web report | Last updated: **28 Apr 2026** | Topic: Alcohol

About

Alcohol, tobacco and other drug use is a major cause of preventable disease, illness and death in Australia. This report consolidates recent information on the availability and consumption of alcohol, tobacco and other drugs in Australia, and related impacts, harms and treatment.

This report is regularly updated with data from a range of sources. There are differences in the source year and frequency of publication. Content is correct as at 24 February 2026. Reports released after this date will be included in the next scheduled release.

Cat. no: PHE 221

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Key findings

- There were around 177,000 alcohol and other drug-related ambulance attendances in 2024
- Almost 1 in 2 people who died due to drugs (excluding alcohol) in 2024 recorded at least one psychosocial risk factor
- Most drug-induced deaths (excluding alcohol) in 2024 were due to the acute effects of drugs (97% or around 1,900 deaths)
- Over 127,800 clients received specialist alcohol and other drug treatment across Australia in 2024–25

Explore report and related articles

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- Older people's experiences of alcohol and other drugs

Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Policy context

In this section

Introduction

This page provides a broad overview of national policies and laws relating to alcohol and other drugs in Australia. For information on drug-related law enforcement activities and wastewater drug monitoring, see Illicit drug markets and drug-related law enforcement activities.

What are the laws on alcohol and other drugs in Australia?

Australia has a range of laws in place to regulate the use of alcohol and other drugs. These laws are complex and include federal laws as well as state and territory-based laws (Department of Health, Disability and Ageing 2025).

Legal drugs

Legal drugs include alcohol, caffeine, nicotine, and over-the-counter and prescription drugs (such as paracetamol and codeine)

Some legal drugs have regulations that restrict their advertising and sale, who is able to use them and where or in what contexts they can be used (for example, driving) (Department of Health, Disability and Ageing 2025). For example, alcohol and tobacco products are available for purchase but there are a number of strict regulations that control their supply. Specific supply reduction interventions include:

- controls prohibiting or restricting drugs at the border (such as illicit tobacco or nicotine e-cigarettes that are not supplied with a prescription)
- the enforcement of a minimum purchasing age
- restriction of operating hours for venues supplying alcohol
- restrictions on the size and strength of beverages or the number of drinks that can be purchased at one time, and the size (minimum number of cigarettes) of cigarette packets.

Pharmaceutical drugs, including over-the-counter and prescription drugs, are used to treat illness and injury and can be purchased legally from pharmacies. Certain controls govern the marketing and availability of these drugs due to the potential increased risk of harm associated with their use, particularly non-medical use. To help ensure safe use, the Therapeutic Goods Administration (TGA) decides how drugs are controlled and classified in Australia, through a process called Scheduling. The TGA also assesses the evidence of the risks and benefits of drugs before they can be sold in Australia (such as paracetamol). Some drugs used to treat illness and injury have not been assessed by TGA but can be sold legally under access schemes (such as medicinal cannabis).

Certain higher risk pharmaceutical drugs may only be lawfully supplied on prescription from a registered health practitioner, including medicinal cannabis, psilocybin and MDMA. Depending on the risk of the drug, there may be certain controls applied to the quantity of the drug that can be supplied and directions for use. This may include the provision of advice to the consumer on restricting the use of pharmaceutical drugs in combination with alcohol and other licit and illicit drugs (TGA 2023b).

Policies aimed at reducing the supply of pharmaceutical drugs for non-medical use in Australia include:

- border controls limiting the entry of nicotine containing e-cigarettes and e-liquids that are not supplied with a prescription or other appropriate exemption
- agreement to develop a national real-time prescription monitoring system
- the up-scheduling of codeine (1 February 2018) to a prescription-only medication
- the up-scheduling of alprazolam (1 February 2014) from prescription-only to a controlled medication.

What are the rules about medicinal cannabis?

In 2016, cannabis became available medicinally in Australia for specific patient groups under strict medical supervision. Other than in these limited circumstances, the cultivation, possession, and supply of cannabis remains prohibited in most of Australia (ODC 2017).

Illegal drugs

Illegal drugs include amphetamines, ecstasy, cocaine, heroin and cannabis (excluding medicinal cannabis)

The possession and supply of illegal drugs such as cannabis, amphetamines (including methamphetamine), heroin and cocaine are prohibited in Australia. However, research with people who use drugs suggest illicit drugs are readily available in Australia. Illicit drugs are commonly sourced for use from friends and relatives, dealers and online (AIHW 2024, Sutherland et al. 2025a, Sutherland et al. 2025b).

For related content on illicit drug use in this report, see Drug types.

What specific laws and regulations are in place?

As outlined above, the laws and regulations governing alcohol and other drugs are complex and vary by drug type and jurisdiction. Key federal laws for tobacco, e-cigarettes, alcohol, pharmaceutical drugs and illegal drugs are outlined below.

Tobacco and smoking laws

Tobacco use in Australia is legal, however, its supply and consumption are subject to strict regulations. There are a range of restrictions related to tobacco in Australia, such as limiting the sale, advertising and packaging of tobacco products (including smokeless tobacco products), banning the sale of menthol cigarettes, and taxation of tobacco products (including duty-free tobacco). In recent years, existing restrictions have expanded to include additional restrictions such as health warnings on individual cigarettes. States and territories have laws which regulate the retail sale of tobacco, including point-of-sale requirements, age restrictions and smoke-free areas.

Smoke-free laws exist in Australia to protect people from harmful second-hand tobacco smoke. This includes banning smoking in all enclosed public spaces and certain outdoor public areas, including inside restaurants, bars and clubs, in cars with children and around many public places such as near children's play equipment, swimming pools, public transport, and around public buildings.

Tobacco products where no taxation has been paid are illicit, including both unbranded tobacco and branded tobacco products. Unbranded tobacco includes finely cut, unprocessed loose tobacco that has been grown, distributed, and sold without taxation (AIHW 2024). Branded illicit tobacco includes tobacco products that are sold in Australia without the plain packaging/graphic health warnings that are required by law. Tobacco that complies with all plain packaging and graphic health warning requirements may still be illicit.

For detailed information on tobacco and smoking laws, see Smoking and tobacco laws in Australia.

E-cigarette and vaping laws

In Australia, e-cigarettes and vaping products are primarily regulated by the Commonwealth and states and territories as therapeutic goods. However, certain other laws and regulations also apply, including those which prohibit the use of vaping products in smoke-free areas.

The Australian Government and state and territory governments are continuing to take action to reduce e-cigarette use through strengthened legislation, enforcement, education and support. These reforms aim to protect young people and the broader community from the harms of vaping, while ensuring appropriate access to therapeutic vapes for smoking cessation and nicotine dependence. As of 2025, the importation, manufacture, supply, commercial possession and advertising of disposable single-use and non-therapeutic e-cigarettes is prohibited.

From 1 October 2024, individuals aged 18 and over can buy therapeutic vapes with a nicotine concentration of 20mg/mL or less from a participating pharmacy without a prescription, to support smoking cessation and the management of nicotine dependence, subject to certain conditions and where state and territory laws allow. For a pharmacist to supply a vape without a prescription, a consultation must be conducted with the patient to ensure that a vaping good is the appropriate treatment option. A prescription is required to dispense a therapeutic vape in some instances, including for people under 18 or for vapes with nicotine concentrations above 20 mg/mL. In some jurisdictions, all therapeutic vapes remain prescription-only. Only mint, menthol and tobacco flavours are permitted in therapeutic vapes.

Strengthened product standards are being introduced, including lower nicotine concentrations, smaller volumes for vaping substance containers, only permitted ingredients in vaping substances and plain packaging and pharmaceutical labelling. From 1 July 2025, only products that meet updated standards can be lawfully supplied in Australia.

It is illegal for all other retailers such as tobacconists, vape shops and convenience stores to sell any kind of vape, regardless of whether they contain nicotine. The domestic manufacture, commercial possession and sale of non-therapeutic vapes and disposable vapes is banned, regardless of whether they include nicotine or other controlled substances. Vapes cannot be purchased from overseas retailers or websites for personal use, even with a prescription.

For detailed information about the range of reforms being implemented, see Changes to the regulation of vapes, Product standards: unapproved therapeutic vapes, and About vaping and e-cigarettes.

Alcohol laws

There are a range of laws restricting the labelling and supply of alcohol in Australia, as well as laws governing drink driving, restrictions on place and legal drinking age.

Drink driving laws are enforced across Australia to deter people from operating a vehicle under the influence of alcohol and prevent deaths and significant injuries on the road. It is a criminal offence for drivers with a learner or probationary licence to have a blood alcohol concentration above zero and for full licence holders to have a blood alcohol concentration above 0.05 grams of alcohol per 100 millilitres of blood.

For detailed information on alcohol laws in Australia, see Alcohol laws in Australia.

Illicit drug laws

Drug driving laws are enforced across Australia to deter people from operating a vehicle under the influence of drugs. All Australian states and territories have roadside drug testing laws requiring drivers to provide a roadside saliva sample or a blood or urine sample in other specified circumstances. These samples are then tested for the presence of illicit substances. All jurisdictions penalise the presence of drugs and do not test for impairment. Any presence of an illicit substance is a criminal offence for drivers, regardless of the type of licence held.

For detailed information on Australia's drug laws, see Drug laws in Australia.

Medicinal cannabis laws

Prior to 2016, cannabis was classified as an illegal narcotic under Australian law. In February 2016, this legislation was amended to allow access to medicinal cannabis for specific patients under strict medical supervision. 'Medicinal cannabis' is generally used to refer to cannabis that is obtained via a prescription from a health care provider, but some people use cannabis without a prescription for self-determined medicinal purposes. Data sources on both kinds of medicinal cannabis use in Australia are relatively limited, and some methodologies (for example, wastewater analysis, urinalysis) are not able to distinguish between medicinal and non-medicinal use. However, available data on medicinal cannabis indicate a growing number of Australians are accessing medicinal cannabis via a prescription.

For detailed information on medicinal cannabis laws in Australia, see Medicinal cannabis.

Other pharmaceutical drug regulations

There are a range of restrictions regulating the supply of pharmaceutical drugs in Australia, particularly for drugs with a higher risk of harm (such as opioids and benzodiazepines).

In July 2017, the Australian Government announced $16 million in funding to implement a national real-time monitoring system of prescription drugs. The system will provide an instant alert to pharmacists and doctors if patients are receiving multiple supplies of prescription only medicines (also referred to as 'doctor or pharmacy shopping'). The program will initially include the monitoring of controlled medicines that are particularly susceptible to non-medical use including morphine, oxycodone, dexamphetamine, and alprazolam. The system aims to assist doctors and pharmacists to identify patients who are at risk of harm due to dependency or non-medical use of pharmaceutical drugs and patients that are diverting these medicines.

There are also a number of restrictions relating to the supply of specific drugs:

- From 1 July 2023, the TGA approved the prescribing of medicines containing psilocybin and MDMA by specifically authorised psychiatrists for the treatment of treatment-resistant depression (psilocybin) and post-traumatic stress disorder (MDMA). Psilocybin and MDMA prescribed for these specific purposes were reclassified as Schedule 8 (Controlled Drugs) medicines. For all other uses, these drugs remain Schedule 9 (Prohibited Substances) (TGA 2023a).
- Regulatory changes are being implemented to reduce harm from prescription opioid medicines. These include smaller pack sizes for immediate-release prescription opioid products, the inclusion of boxed warnings and class statements in the Product Information documents regarding their potential for harmful and hazardous use, and reinforcing the indications for immediate release and modified release products and for fentanyl patches. Smaller pack sizes and fentanyl indication changes came into effect in the first half of 2020. Other changes will be phased in subsequently (TGA 2021).
- From 1 February 2025, the Australian Government introduced new restrictions on paracetamol to reduce the risk of overdose. These restrictions included reducing the maximum pack size available for general sale from 20 to 16 tablets or capsules, reducing the maximum pack size available in pharmacies from 100 to 50 tablets or capsules (in most jurisdictions), and restricting the availability of other pack sizes of up to 100 tablets or capsules such that these are only available under the supervision of a pharmacist (TGA 2024).
- From 1 February 2018, medicines containing codeine were reclassified to schedule 4 drugs, meaning they could no longer be sold over-the-counter in pharmacies and were available by prescription only. This decision was made by the Therapeutic Goods Administration (TGA) following substantial evidence of harm from the use of low dose codeine-containing medicines including analgesic preparations combined with other pain relief medicines such as aspirin, paracetamol, and ibuprofen (TGA 2016).
- From February 2017, higher-strength alprazolam products and larger alprazolam pack sizes were delisted from the PBS and are not captured in the data reported here.
- From 1 February 2014, alprazolam was rescheduled from schedule 4 to schedule 8 (a controlled medication). This decision was made by the Therapeutics Goods of Administration (TGA) on the basis that substantial evidence demonstrated alprazolam has increased morbidity and mortality in overdose with the possibility of increased toxicity with no additional therapeutic benefits in comparison to other drugs classed as benzodiazepines (TGA 2013).

What is Australia's policy response to alcohol and other drugs?

The National Drug Strategy 2017–2026 ('the Strategy') is the overarching framework which identifies national priorities relating to alcohol, tobacco and other drugs, and guides action by governments in partnership with service providers and the community. The Strategy outlines a national commitment to harm minimisation through adoption of effective demand, supply and harm reduction strategies (Department of Health 2017).

What specific policies are in place?

More information about the National Drug Strategy and other relevant policies is outlined below.

National Drug Strategy 2017–2026

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

The NDS has an overarching approach of harm minimisation and encompasses 3 pillars:

- demand reduction, which aims to prevent the uptake and/or delay the onset of alcohol and other drug use, reduce alcohol and other drug use and associated harms in the community, and provision of evidence-informed treatment
- supply reduction, which aims to prevent or otherwise reduce the production and supply of illegal drugs, and control, manage, and/or regulate the availability of illegal drugs
- harm reduction, which aims to reduce the adverse health, social and economic consequences of drug use for people who use drugs, their families, and the wider community (Department of Health 2017).

National Preventive Health Strategy 2021–2030

Tobacco control is a key component of the Australian Government's 10-year National Preventive Health Strategy and includes a range of policy achievements that aim to reduce tobacco use and nicotine addiction. The 4 overarching aims of the National Preventive Health Strategy are:

- All Australians have the best start in life.
- All Australians live in good health and wellbeing for as long as possible.
- Health equity is achieved for priority populations.
- Investment in prevention is increased (Department of Health 2021).

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

The National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029 ('the Framework') aims to ensure that all Australians seeking alcohol and other drug treatment have access to high-quality treatment appropriate to their needs, when and where they need it (Department of Health 2019a).

The Framework complements the National Drug Strategy 2017–2026. It aims to provide a nationally endorsed shared understanding and common reference point for funders, treatment providers and practitioners, and people who use drugs and their families and friends. The Framework facilitates strategic planning for the Australian treatment service system and provides the context for national and state treatment processes, programs and policies.

National Tobacco Strategy 2023–2030

The National Tobacco Strategy 2023–2030 is a sub-strategy of the National Drug Strategy 2017–2026 and aims to improve the health of all Australians by reducing tobacco use and the associated health, social, environmental and economic costs. The objectives of the strategy are to:

- prevent uptake of tobacco use
- prevent uptake of e-cigarettes by young people and those who have never smoked
- prevent and reduce nicotine addiction
- denormalise and limit the marketing and use of e-cigarettes
- encourage and assist as many people as possible who use tobacco and e-cigarettes to quit as soon as possible, and prevent relapse
- prevent and reduce prevalence of tobacco use among First Nations people
- prevent and reduce tobacco use among groups at higher risk from tobacco use, and other populations with a high prevalence of tobacco use
- eliminate harmful exposure to second-hand tobacco smoke
- prevent and reduce the marketing and harms associated with use of novel and emerging products
- ensure tobacco control in Australia is guided by focused research, monitoring and evaluation
- protect tobacco control policy from all commercial and other vested interests
- ensure all the above contribute to the continued denormalisation of the tobacco industry and tobacco use (Department of Health and Aged Care 2023).

The targets of the strategy are to:

- Reduce the national daily smoking prevalence to less than 10% by 2025 and 5% or less by 2030.
- Reduce the daily smoking rate among First Nations people to 27% or less by 2030 (Department of Health and Aged Care 2023).

National Alcohol Strategy 2019–2028

The National Alcohol Strategy 2019–2028 is a sub-strategy of the National Drug Strategy 2017–2026 and aims to prevent and reduce alcohol-related harms in Australia by:

- identifying national priority areas and policy options
- promoting and facilitating collaboration, partnership and commitment from the government and non-government sectors
- targeting a 10% reduction in harmful alcohol consumption, including alcohol consumption at levels that puts individuals at risk of injury from a single occasion of drinking, at least monthly; and - alcohol consumption at levels that puts individuals at risk of disease or injury over a lifetime (Department of Health 2019b).

National Ice Action Strategy 2015

In April 2015, the Australian Government established a National Ice Taskforce, to provide advice on the development of a National Ice Action Strategy (NIAS). The objectives of the NIAS are to ensure that:

- families and communities have better access to information, support and tools to help them to respond to ice (methamphetamine)
- prevention messages are targeted at high-risk populations and accurate information about ice is more accessible
- early intervention and treatment services are better tailored to respond to ice and meet the needs of the populations they serve
- law enforcement efforts are better targeted to disrupt the supply of ice
- better evidence is available to drive responses to the effects of ice in our community (Department of Health 2015).

Aboriginal and Torres Strait Islander Health Performance Framework

The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) monitors progress in health outcomes for First Nations people, health system performance and the broader determinants of health. The HPF consists of 68 performance measures across 3 tiers:

- Tier 1: Health status and outcomes
- Tier 2: Determinants of health
- Tier 3: Health system performance

For detailed information on alcohol and other drugs under the HPF, see Access to alcohol and drug services.

National FASD Strategic Action Plan 2018–2028

The National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018–2028 ('the Plan') provides an overview of strategies to improve the prevention, diagnosis, support and management of FASD in Australia. It builds on foundational work by governments, non-government organisations, family advocates, researchers and clinicians, as well as individual champions and communities.

The Plan aims to:

- reduce the prevalence of FASD
- reduce the impact of FASD on individuals and communities
- improve quality of life for people living with FASD (Department of Health 2018).

What does the public think about alcohol and other drug-related policies and laws?

There is a high degree of support for measures aimed at reducing harms associated with tobacco and e-cigarettes

Almost 1 in 2 (46%) people in Australia aged 14 years and over approve of regular adult consumption of alcohol and 15.5% approve of regular tobacco use (AIHW 2024).

There is a high level of support among the general population in Australia for measures aimed at reducing tobacco-related harm. According to the 2022–2023 NDSHS, of people aged 14 and over:

- 81% supported banning the advertising of tobacco products on social media.
- 78% supported banning additives (flavouring) in cigarettes and other tobacco products to make them less attractive to young people (AIHW 2024, Table 2.46).

Support for measures to reduce the problems associated with e-cigarettes and vaping was also high, specifically:

- 86% of people supported prohibiting the sale of e-cigarettes or vapes, including those without nicotine, to people under 18.
- 80% of people supported restricting the use of e-cigarettes in public places (AIHW 2024, Table 3.44).

For information on public support for measures to reduce the harm related to alcohol and other drug use in this report, see also Harm reduction measures related to alcohol and other drugs.

Where do I go for more information?

- Alcohol laws in Australia
- Drug laws in Australia
- Smoking and tobacco laws in Australia
- Support for alcohol and other drug-related policies

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Viewing this data

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Health and harms

Health and harms
Explore content on health and harms related to alcohol and other drugs, including injuries, ambulance attendances, hospitalisations, deaths and harms to the community.

- Alcohol and other drug-related ambulance attendances
- Alcohol and other drug-related hospitalisations
- Burden of disease and injuries related to alcohol and other drugs
- Community harms related to alcohol and other drugs
- Deaths involving alcohol and other drugs

Key findings

Tobacco and alcohol use are among the leading risk factors for the disease burden in Australia, contributing to a range of health conditions including cancers

Source: Australian Burden of Disease Study

The number of alcohol and other drug-related ambulance attendances has overall risen between 2021 and 2024 in most jurisdictions

Source: AIHW analysis of the National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose

Updated

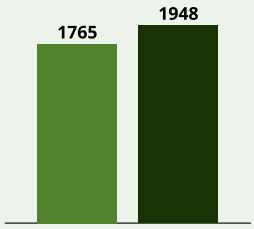
Alcohol intoxication contributed to around 3 in 5 alcohol and other drug-related ambulance attendances every year between 2021 and 2024

Source: AIHW analysis of the National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose

There were around 146,000 hospitalisations due to alcohol and other drugs in 2023–24, representing 1.2% of all hospitalisations

Source: AIHW National Hospital Morbidity Database

Updated



Alcohol-induced and drug-induced deaths in 2024

There are more deaths involving alcohol than any other drug

Source: AIHW National Mortality Database; Causes of Death, Australia

In 2022–2023, almost 1 in 7 people who had recently consumed alcohol took part in at least one risky activity while under the influence of alcohol

Source: National Drug Strategy Household Survey

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Treatment

Treatment
Explore content on specialist alcohol and other drug treatment, opioid pharmacotherapy, and smoking and alcohol cessation medicines.

- Alcohol and other drug treatment services
- Availability of smoking and alcohol cessation medicines in Australia

Key findings

Rates of dispensing for smoking cessation medicines have fluctuated over time, with an overall decline since 2012–13

Source: AIHW analysis of the Pharmaceutical Benefits Scheme data collection

Males and people in their 50s and 60s typically have the highest dispensing rates for smoking cessation medicines

Source: AIHW analysis of the Pharmaceutical Benefits Scheme data collection

The number of patients who were dispensed a script for an alcohol cessation medicine more than doubled between 2012–13 and 2024–25

Source: AIHW analysis of the Pharmaceutical Benefits Scheme data collection

Males and people in their 40s and 50s typically have the highest dispensing rates for alcohol cessation medicines

Source: AIHW analysis of the Pharmaceutical Benefits Scheme data collection

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Alcohol and other drug treatment services

Alcohol and other drug treatment services is an Australia's health topic

In this section

Introduction

Alcohol and other drug (AOD) treatment agencies across Australia provide a range of services and support to people who received treatment for their own drug use, as well as their families and friends.

There are many types of treatment available to assist people with drug and alcohol use, most treatments aim to minimise harm, often by stopping or reducing a person's drug use, or changing their drug use patterns to be less harmful (Department of Health 2019). Treatments can include:

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

For information on the use of alcohol and other drugs, see Alcohol and Illicit use of drugs.

What data sources are available?

Data sources for alcohol and other drug treatment

- Alcohol and other drug treatment services in Australia
- Alcohol treatment in Australia: Client characteristics and patterns of service use, 2013–14 to 2022–23
- National Opioid Pharmacotherapy Statistics Annual Data collection
- Pharmaceutical Benefits Scheme data collection

There are several health administrative data sources that contain information about alcohol and other drug treatment. Each data set uses a different methodology, and the types of treatment also differ across sources. These include:

- **Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS)** provides information about publicly funded alcohol and other drug treatment services in Australia, the people that receive treatment, and the treatment provided.
- **National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection** provides information about people receiving opioid pharmacotherapy for their opioid dependence in Australia, as well as health professionals who prescribe opioid pharmacotherapy and dosing points (such as pharmacies) where clients receive treatment. Services whose sole function is to prescribe or provide dosing services for opioid pharmacotherapy are excluded from the AODTS NMDS, as data from these services are captured in the NOPSAD collection (AIHW 2026a, 2026b).
- **Pharmaceutical Benefits Scheme Opioid Dependence Treatment Program**:
  - Data from the Pharmaceutical Benefits Scheme (PBS) provides information on the number of prescriptions and the number of patients dispensed at least one opioid dependence medicine prescription within a given financial year.
  - The Australian Government supports access to opioid pharmacotherapy through the PBS Opioid Dependence Treatment (ODT) Program.
  - On 1 July 2023, ODT medicines became part of the Section 100 Highly Specialised Drugs (HSD) Program (Community Access) arrangements enabling eligible patients to access up to 28 days' supply of ODT medicines from approved dispensers. AIHW analysis of the ODT program on the Pharmaceutical Benefits Scheme data collection provides financial year information about patients:
    - with a current Medicare card
    - dispensed opioid dependence medicines through the PBS at a PBS approved pharmacy between 1 July 2023 and 30 June 2025.
- **Alcohol treatment in Australia: Client characteristics and patterns of service use, 2013–14 to 2022–23**. Clients accessing alcohol and other drug treatment services often receive multiple episodes of treatment over a number of years. This report describes the characteristics and patterns of service use for 3 client cohorts between 2013–14 and 2022–23 where alcohol was a principal drug of concern (either alcohol only or alcohol and another principal drug of concern).

For more information about each data source, see Technical notes.

Who uses alcohol and other drug treatment services?

The AODTS NMDS report shows that 127,804 clients aged 10 and over received AOD treatment in 2024–25. These clients received 244,411 treatment episodes from 1,316 publicly funded AOD treatment agencies.

In 2024–25:

- 3 in 5 (62%) clients were male and half (49%) were aged 20–39.
- 1 in 5 (19%) clients were Aboriginal and Torres Strait Islander (First Nations) people.
- Most (92%) clients received treatment for their own alcohol or drug use.
- The number of clients decreased by 3.1% from the previous year (from 131,892 clients in 2023–24 to 127,804 in 2024–25). Overall, there were fewer clients, but some clients received 2 or more treatment episodes leading to a rise in treatment episodes.
- The number of people who received treatment increased by 12% over the last decade, rising from around 114,400 to 127,800 clients, between 2013–14 and 2024–25. However, when considering population growth over this period, the rate of clients has dropped slightly from 556 to 527 people per 100,000, respectively.

Who receives opioid pharmacotherapy treatment?

The NOPSAD report shows that 57,740 clients received opioid pharmacotherapy treatment from 3,241 dosing point sites on a snapshot day in 2025.

People receiving opioid pharmacotherapy treatment had similar characteristics to clients of publicly funded AOD treatment, but there was a higher proportion of people in older age groups. On a snapshot day in 2025:

- 7 in 10 (70%) opioid pharmacotherapy clients were male, and 3 in 5 (57%) were aged 40–59.
- 1 in 10 clients (12%) were First Nations people.

Between 2011 and 2025:

- The number of clients receiving opioid pharmacotherapy treatment increased by 24% (from 46,450 clients to 57,740).
- After adjusting for population growth, the rate of clients accessing opioid pharmacotherapy treatment remained stable at around 21 clients per 10,000 population.

In 2024–25, opioid dependence medicines available through the PBS, indicated a total of 728,400 PBS prescriptions were dispensed to patients for opioid dependence medicines.

Around 65,400 patients were dispensed at least one prescription for an opioid dependence medicine, this is a rate of 24 patients per 10,000 people.

For patients dispensed an opioid dependence medicine through the PBS:

- More than 7 in 10 (71%) patients were male.
- 1 in 3 patients (33%) were aged 40–49.

What drugs do people receive treatment for?

The AODTS NMDS shows that for clients receiving treatment for their own alcohol or drug use, alcohol continued to be the most common principal drug of concern (PDOC) in 2024–25.

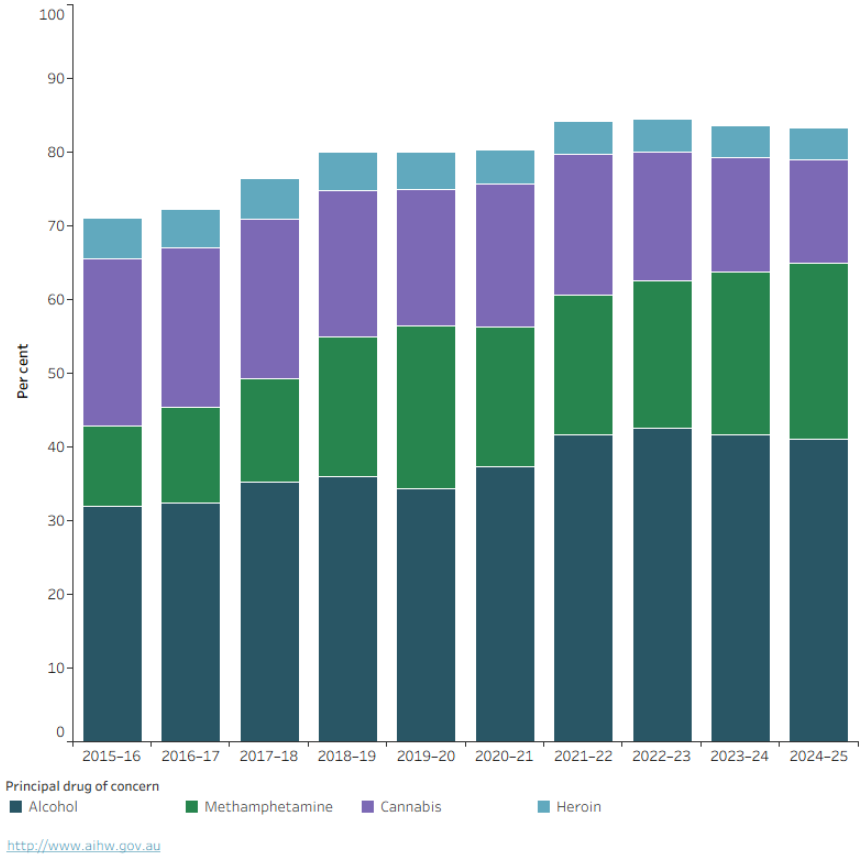
Between 2015–16 and 2024–25:

- Treatment episodes provided for alcohol as a PDOC rose from 32% in 2015–16 to 42% in 2021–22 and this has remained stable in 2024–25 (41%) (in relation to all PDOCs).
- Methamphetamine was the second most common PDOC in 2024–25. Treatment for methamphetamine has been growing, reaching 24% in 2024–25 (Figure 1).

Recent analysis of a cohort of almost 179,488 clients who received treatment for their own use of alcohol at any point between 2013–14 and 2022–23 showed that:

- Most clients (73%) received treatment for use of alcohol only, and most of these clients (84%) received treatment in fewer than 3 years.
- Clients treated for alcohol and another PDOC (27% of the total cohort) received about half of all treatment episodes, and most of these clients received treatment in 3 or more years (AIHW 2025a).

Figure 1: Closed treatment episodes for clients' own drug use, by most common principal drugs of concern, 2015–16 to 2024–25



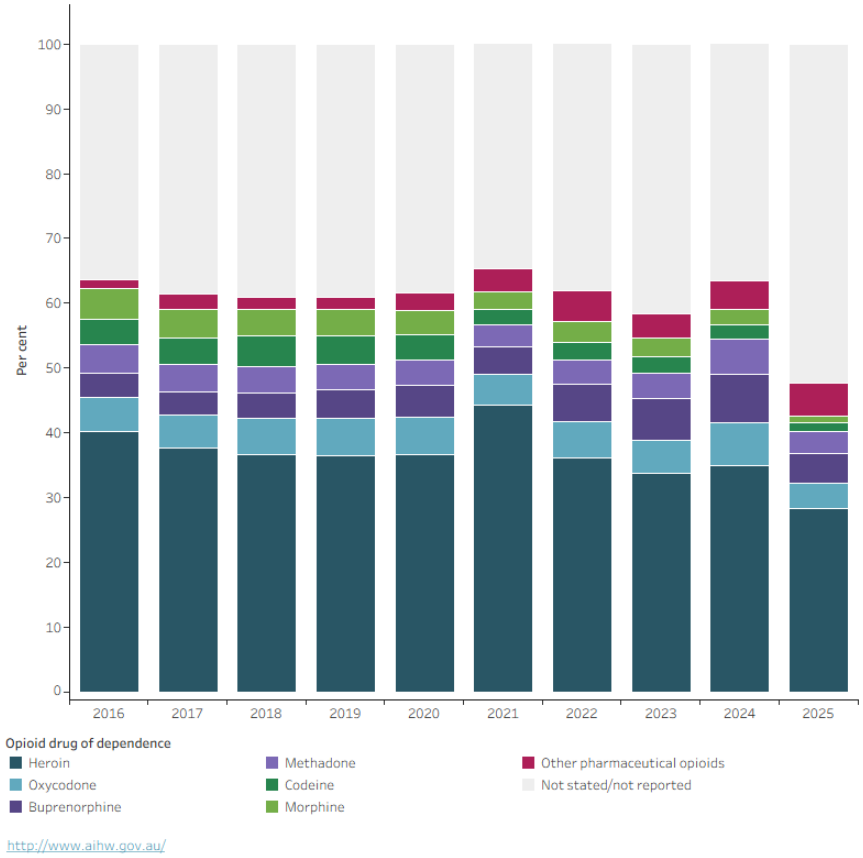
From 2015–16 to 2024–25, the proportion of closed treatment episodes for alcohol and methamphetamine have increased, while cannabis and heroin have decreased.

Data from the AODTS NMDS indicate that the main principal drug of concern (PDOC) that clients were treated for in 2024–25 was different across the age groups:

- Younger people were more likely to get treatment for cannabis, with over half (53%) of episodes for those aged 10–19 and a quarter (24%) for those aged 20–29.
- People aged 30–39 (32%) were more likely to receive treatment for methamphetamine.
- Older people were more likely to get treatment for alcohol, with 45% of treatment episodes for those aged 40–49, 60% for those aged 50–59, and 75% for those aged 60 and over.

Data from the NOPSAD report shows that in 2025, heroin remained the most common opioid drug of dependence among opioid pharmacotherapy clients (28%). These data should be interpreted with caution as there was a high proportion of clients with 'Not stated/Not reported' as the opioid drug of dependence (52%), an increase over previous years (Figure 2).

Figure 2: Clients receiving opioid pharmacotherapy treatment on a snapshot day, by opioid drug of dependence, 2016 to 2025

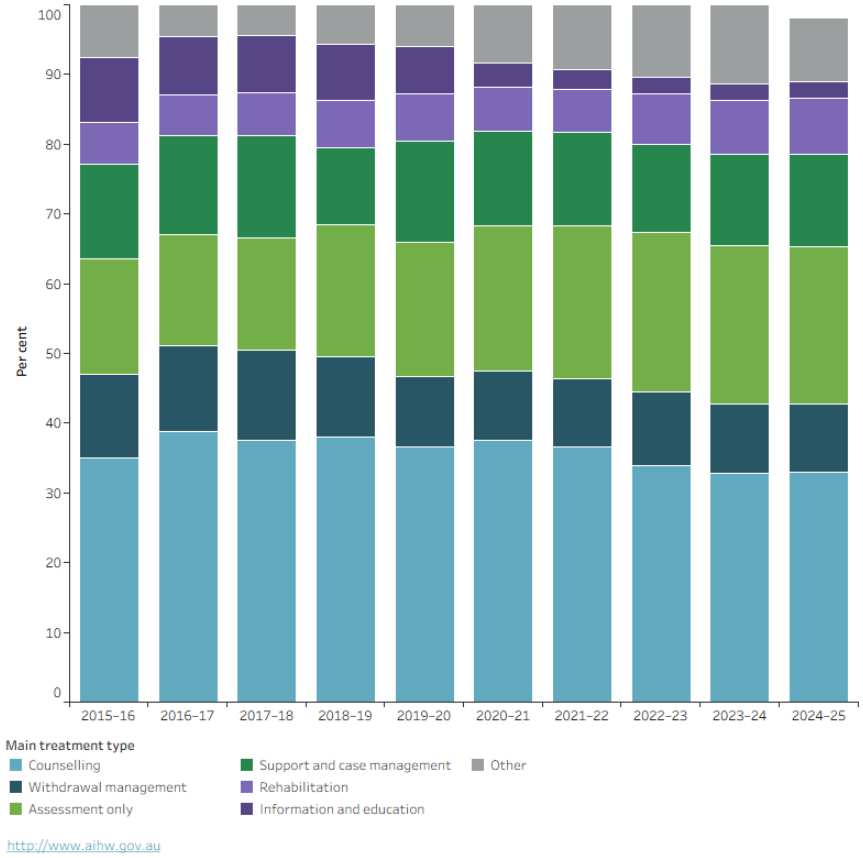


From 2016 to 2025, heroin continued to be the most common opioid drug of dependence, all other drug of dependence reported by clients were less than 10% (such as, buprenorphine).

What types of treatment do people receive?

The AODTS NMDS shows that counselling continues to be the most common treatment provided to clients accessing AOD treatment each year. In 2024–25, among clients who received treatment for their own alcohol or drug use, 33% of episodes involved counselling and 23% involved an assessment only (Figure 3).

Figure 3: Closed episodes for clients' own drug use, by main treatment type, 2015–16 to 2024–25



Between 2015–16 and 2024–25, counselling was the most common main treatment type, assessment only increased over this period while other types of treatments (such as rehabilitation) remained stable.

The NOPSAD report shows that buprenorphine opioid drug formulations have now overtaken methadone as the most common opioid pharmacotherapy treatment provided to clients in 2025:

- 60% of clients received a buprenorphine formulation.
- 40% received methadone.

From 2016 to 2025, the proportion of clients receiving methadone has fallen from 65% to 40% and the proportion receiving a buprenorphine formulation has risen from 35% to 60%. This in part reflects the availability of new buprenorphine formulations such as buprenorphine long-acting injections.

Mortality among specialist alcohol and other drug treatment services clients

Alcohol and other drug (AOD) use is associated with a higher risk of dying and premature death compared with the general population (Abdul-Rahman et al. 2018; Havard et al. 2023). Data from the AODTS NMDS linked with national deaths data over an 11 year study period has examined mortality among this population to inform the National Drug Strategy and identify targeted prevention activities.

There were 15,400 people who died and received publicly funded, specialist AOD treatment services in their last year of life, over the 11-year study period (1 July 2012 to 30 June 2023) (AIHW 2025b). Among these clients who died:

- The majority received treatment for their own drug use (99%) and most were male (72%).
- The death rate was 3.3 times higher than the general population (that is, the non-AODTS population).
- The median age at death was 48 years.
- Accidental poisoning (20%), suicide (15%) and liver disease (15%) were the most common causes of death, accounting for nearly half of all deaths.
- 1 in every 5 accidental poisoning deaths in Australia were people who received specialist AOD treatment in their last year of life.

Where do I go for more information?

- Alcohol and other drug treatment services in Australia: early insights
- National Opioid Pharmacotherapy Statistics Annual Data collection
- Alcohol and other drug use: feature analysis
- Alcohol, tobacco & other drugs in Australia
- Alcohol treatment in Australia: Client characteristics and patterns of service use, 2013–14 to 2022–23

For more on this topic, visit Alcohol & other drug treatment services.

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Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Harm reduction

Harm reduction

Explore content on harm reduction initiatives related to alcohol and other drugs, including specific harm reduction measures and monitoring of illicit drug markets, law enforcement activities and wastewater.

- Availability of prescription opioids, benzodiazepines and gabapentinoids in Australia
- Harm reduction measures related to alcohol and other drugs
- Illicit drug markets and drug-related law enforcement activities
- Wastewater drug monitoring

Rates of dispensing for opioids, benzodiazepines and gabapentinoids have been declining since around 2017–18

Source: AIHW analysis of the Pharmaceutical Benefits Scheme data collection

329,000 patients who were dispensed opioids in 2024–25 had also received benzodiazepines in the previous 30 days

Source: AIHW analysis of the Pharmaceutical Benefits Scheme data collection

Almost 2 in 3 people in Australia supported allowing people to test their drugs at designated sites in 2022–2023

Source: National Drug Strategy Household Survey

The price, purity and availability of drugs including cannabis and methamphetamine have remained relatively stable in recent years

Source: Ecstasy and Related Drugs Reporting System; Illicit Drug Reporting System

Over 2 in 3 illicit drug offences related to the possession or use of drugs in 2023–24

Source: Recorded Crime - Offenders

Alcohol and nicotine continue to be the highest consumed drugs across Australia as measured in wastewater, followed by cannabis and methylamphetamine

Source: National Wastewater Drug Monitoring Program

Viewing this data

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Harm reduction measures related to alcohol and other drugs

In this section

Introduction

Australia has adopted a harm minimisation approach for addressing a range of issues associated with the use of tobacco, alcohol, and other drugs since 1985. This is reflected in the National Drug Strategy 2017–2026, the national policy for alcohol and other drug use. Harm reduction measures that aim to reduce the harm associated with drug use among people who use drugs, their family and friends, and the broader community, include:

- reducing risks associated with alcohol and other drug use in particular contexts, including creating safer settings
- safe transport and sobering up services
- protecting children from other people's drug use
- protecting the community from infectious disease, including blood borne viruses
- reducing driving while under the influence of alcohol or other drugs
- ensuring the availability of opioid treatment programs (Department of Health 2017).

This page provides an overview of harm reduction programs and initiatives in Australia, use of harm reduction services among people who use drugs, and community support for these measures. For related content on alcohol and other drug treatment in this report, see Treatment.

Key findings

- Most people in Australia are supportive of harm reduction measures such as drug checking, needle and syringe programs, and take-home naloxone
- Support for harm reduction measures has generally been rising since 2019
- People who use drugs, younger people, people living in major cities, and people living in the least disadvantaged areas of Australia are generally more supportive of drug checking and supervised drug consumption rooms than other groups

What data sources are available?

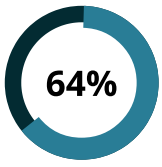
Data sources for harm reduction measures and public support

- Ecstasy and Related Drugs Reporting System
- Illicit Drug Reporting System
- National Drug Strategy Household Survey
- Needle Syringe Program National Minimum Data Collection

There are a limited number of data sources that contain information about measures to reduce harms from alcohol and other drugs in Australia. The data sources that do exist include administrative data from health services and self-report surveys that ask people what they think about harm reduction measures. Each data set uses a different methodology, and the language used to describe harm reduction measures varies.

For more information about each data source, see Technical notes.

Drug checking services



Almost 2 in 3 people in Australia supported allowing people to test their drugs at designated sites in 2022–2023

Source: National Drug Strategy Household Survey

Drug checking, also known as pill testing, is a harm reduction service that allows people who are thinking about using drugs to submit their drugs for testing by a chemist at designated sites. These sites can be either mobile (for example, at a music festival) or at a fixed site (for example, a health service). Drug checking services also provide an opportunity for service users to discuss drug use and harm reduction strategies with a health professional or peer worker (ADF 2025). Some drug checking services also release public drug alerts based on drug checking results.

Drug checking services vary by state and territory:

- Australia's first fixed-site health and drug checking service, CanTEST, has been operating in the Australian Capital Territory since July 2022. Drug notifications and reports about the services provided are available on the CanTEST website.
- Queensland piloted a drug checking service, CheQpoint, from April 2024–April 2025. The service included two fixed-site locations and mobile services at festivals (QuIHN 2024).
- Drug checking trials have been under way in New South Wales from early 2025 and Victoria from late 2024:
  - The New South Wales trial is a 12-month pilot involving mobile sites at selected music festivals (NSW Health 2025).
  - The Victorian trial involves a combination of mobile services at festivals and events combined with a fixed-site service that is expected to open in mid-2025 (YSAS 2025).

Almost 2 in 3 (64%) people in Australia aged 14 and over supported drug checking in 2022–2023, an increase from 57% in 2019 (AIHW 2024, Table 11.13). Over 4 in 5 (83%) people who had recently used drugs supported drug checking, compared with 55% of those who had never used drugs. Support was highest among people:

- aged 18–24 (74%), and decreased to 55% in those aged 70+
- in *Major cities* (66%) and decreased with increased remoteness (54% in *Remote and very remote* areas)
- in the most advantaged socioeconomic areas (73%) and lowest in the most disadvantaged areas (59%) (AIHW 2024, Table 11.12).

Data from the Ecstasy and Related Drugs Reporting System (EDRS) show that nearly 2 in 5 (39%) people who regularly use stimulants reported that they or someone else had tested their illicit drugs in the past year in 2025. Over 2 in 5 (43%) of these people reported that they had submitted drugs for testing at a drug checking service, most often a fixed-site service (Sutherland et al. 2025a).

Drug alerts

Most drug alerts were for detections of unexpected substances, detections of new psychoactive substances and high-dose MDMA

Source: Prompt Response Network Drug Alerts Report

Drug alerts or warnings are public notices issued by state and territory government agencies, community, and harm reduction agencies to notify the community of substances of public health concern detected in the illicit drug supply (Kypri et al. 2025). Drug alerts aim to provide accurate and timely risk information and encourage people who use drugs to engage in a range of harm reduction behaviours.

As of August 2025, six of the eight Australian states and territories have established processes for issuing public drug alerts or warnings, excluding Western Australia and Tasmania (Kypri et al. 2025). Drug alerts issued are monitored and shared via the Prompt Response Network (PRN), which aims to enhance public health decision-making and responses to emerging drugs across Australia (Kypri et al. 2025). The PRN re-publishes all public drug alerts released across Australia via The Know.

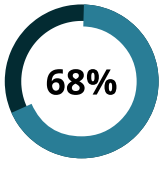
Between July and September 2025, 13 unique drug alerts were republished via The Know website. All of these alerts included information about detections of unexpected substances, with nine alerts relating to detections of novel psychoactive substances (Kypri et al. 2025). No alerts were issued for high-dose MDMA/ecstasy tablets, unlike previous reports (Kypri et al. 2025).

For detailed and timely information on drug alerts across Australia, see The Know.

For related content on ecstasy, nitazenes and new psychoactive substances in this report, see also:

- Amphetamines and other stimulants
- New psychoactive substances
- Other drugs

Needle and syringe programs



Over 2 in 3 people in Australia supported needle and syringe programs as a policy measure in 2022–2023

Source: National Drug Strategy Household Survey

Needle and syringe programs (NSPs) are designed to reduce the sharing of injecting equipment through the provision of sterile needles and syringes to people who inject drugs. NSPs are a cost-effective measure that have successfully prevented the spread of blood-borne viruses such as human immunodeficiency virus (HIV) and Hepatitis C infection. NSPs also provide counselling services and actively encourage clients into drug treatment programs (Wodak and Cooney 2004).

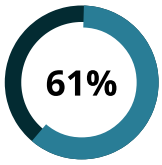
There were 4,708 NSPs operating across Australia in June 2024, including 3,220 NSPs in pharmacies and 458 syringe dispensing machines (Heard et al. 2024). The number of NSPs (excluding syringe dispensing machines) across Australia has increased by around 10% since 2020, while the number of syringe dispensing machines has risen by 24%. Around 54.6 million needles and syringes were distributed to 72,984 people in 2023–24, or 749 needles per person (Heard et al. 2024).

In 2025, over half (55%) of the Illicit Drug Reporting System (IDRS) participants were recruited via NSPs. The IDRS also showed that NSPs were by far the most common source of needles and syringes used by people who regularly inject drugs in the past month (used by 84% of participants), followed by NSP vending machines (22%) (Sutherland et al. 2025b). This is supported by the findings of the 2022–2023 NDSHS that NSPs were the most reported source of needles and syringes (45%), followed by chemists (31%) (AIHW 2024b, Table 5.110). This is likely to reflect the different sampling of the two surveys whereby the NDSHS is targeted at the general population, while the IDRS specifically recruits people who inject drugs and are mostly recruited through NSPs.

Over 2 in 3 (68%) people in Australia supported needle and syringe programs in 2022–2023, up from 64% in 2019 (AIHW 2024, Table 11.19). Support was highest among people who had recently injected drugs (83%, compared with 68% of people who had never injected drugs) (AIHW 2024, Table 11.21).

For related content on people who inject drugs in this report, see Experiences of alcohol and other drugs among people who inject drugs.

Take-home naloxone



Around 3 in 5 (61%) people in Australia supported the availability of take-home naloxone in 2022–2023, up from 56% in 2019

Source: National Drug Strategy Household Survey

Opioid overdose represents a significant and ongoing problem for Australia's public health. Naloxone is a medication that reverses the effects of opioids and is an important means of responding to the harms associated with opioid overdose (including death) (Penington Institute 2018). Take-home naloxone programs enable those people at risk of opioid overdose or adverse reaction, and their friends and family members to access naloxone at community and hospital-based pharmacies, alcohol and drug treatment centres and NSPs. Given in a timely manner, naloxone can reverse the effects of opioid overdose (Department of Health 2021).

Around 3 in 5 (61%) people in Australia supported take-home naloxone in 2022–2023, up from 56% in 2019 (AIHW 2024, Table 11.19). Support was highest among people who had recently injected drugs (88%, compared with 61% of people who had never injected drugs) (AIHW 2024, Table 11.21).

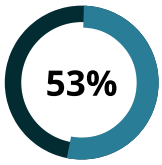
Awareness of take-home naloxone is increasing among people who regularly inject drugs interviewed via the IDRS. In 2025:

- Over 4 in 5 (86%) participants had heard of naloxone (up from 80% in 2024), and 4 in 5 (80%) had heard of take-home naloxone programs (up from 73% in 2024).
- Almost 2 in 3 (65%) people had obtained naloxone in their lifetime, up from 54% in 2024. Around 3 in 5 (60%) of these people said they last accessed naloxone from an NSP.
- Over half (55%) of people had accessed naloxone in the past year, up from 46% in 2024.
- 1 in 3 (32%) people reported using naloxone to resuscitate someone at least once in their lifetime and 18% had done so in the past year (Sutherland et al. 2025b).

Data from the EDRS indicate that naloxone awareness and access among people who regularly use stimulants is also rising. In 2025, almost 3 in 4 (73%) participants had ever heard of naloxone and over 1 in 4 (27%) had obtained it in the past year (up from 63% and 10%, respectively, in 2024) (Sutherland et al. 2025a).

For related content on people who inject drugs in this report, see Experiences of alcohol and other drugs among people who inject drugs.

Supervised drug consumption rooms



Over half of people (53%) in Australia supported supervised drug consumption rooms in 2022–2023, up from 47% in 2019

Source: AIHW National Hospital Morbidity Database

Supervised drug consumption rooms and medically supervised injecting centres (MSIC) are places where people can use and inject drugs under the supervision of registered nurses, counsellors, and health education professionals. These services aim to prevent injury and death by being present when someone injects in order to provide immediate medical assistance as required. Kings Cross in Sydney has been home to a MSIC since 2001 (Uniting 2017) and a second opened in Richmond, Victoria, in July 2018. In 2025, 11% of IDRS participants in Melbourne and 6% of those in Sydney reported that they last injected at a supervised injecting facility (Sutherland et al. 2025b, Table 22).

Just over half (53%) of people in Australia supported supervised drug consumption rooms in 2022–2023, up from 47% in 2019 (AIHW 2024, Table 11.13). Nearly three-quarters (72%) of people who had recently used drugs supported this measure, compared with 45% of people who had never used drugs. Additionally, support was highest:

- among people aged 18–24 (64%) compared with those aged 70 and over (44%)
- in *Major cities* (56%) and decreased with increased remoteness (38% in *Remote and very remote* areas)
- among people in the most advantaged socioeconomic areas (63%) and lowest among people in the 2nd most disadvantaged areas (47%)
- among people with a bachelor degree or higher (72%) and lowest among people who had completed year 11 or less (55%) (AIHW 2024, Table 11.12).

For related content on people who inject drugs in this report, see Experiences of alcohol and other drugs among people who inject drugs.

Where do I go for more information?

- Pill testing in Australia
- Support for alcohol and other drug-related policies
- Take Home Naloxone program
- The Know

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Viewing this data

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Illicit drug markets and drug-related law enforcement activities

In this section

Introduction

Monitoring and law enforcement activities form part of Australia's broader harm minimisation approach to alcohol and other drugs under the National Drug Strategy 2017–2026 (Department of Health 2017). This approach includes supply reduction as one of three 'pillars' of harm minimisation, which aims to reduce the risk of harm by preventing or reducing illegal drug production and supply and regulating the availability of legal drugs such as pharmaceuticals (Department of Health 2017).

Examples of supply reduction initiatives to limit the availability of illegal drugs include:

- law enforcement operations involving drug seizures and arrests
- disrupting the diversion of precursor chemicals that are used in the manufacture of illicit drugs (Department of Health 2017).

This page contains information on illicit drug markets and drug-related law enforcement activities in Australia. For related content on Australia's drug laws, see Policy context.

Key findings

- The price, purity and availability of drugs including cannabis and methamphetamine have remained relatively stable in recent years
- Most illicit drug detections at the Australian border in 2020–21 were for cannabis
- Drug seizures and arrests have risen over the past 10 years, with cannabis and amphetamine-type stimulants accounting for the highest numbers of both seizures and arrests
- Police and court illicit drug offences have fallen in recent years, driven largely by declines in possession and use offences

What data sources are available?

Data sources for illicit drug markets and drug-related law enforcement activities

- Criminal Courts, Australia
- Ecstasy and Related Drugs Reporting System
- Illicit Drug Reporting System
- Illicit Drug Data Report
- National Drug Strategy Household Survey
- Prisoners in Australia
- Recorded Crime – Offenders

Information on monitoring and law enforcement activities related to alcohol, tobacco and other drugs in Australia comes from a range of data sources including research with people who use drugs and data from law enforcement agencies (such as police). Each data source uses a different methodology and are therefore not comparable.

For more information about each data source, see Technical notes.

What do people who use drugs say about illicit drug markets?

The price, purity and availability of drugs including cannabis and methamphetamine have remained relatively stable in recent years

Source: Ecstasy and Related Drugs Reporting System; Illicit Drug Reporting System

Most people who use illicit drugs report that they source them from a friend or dealer

Source: Ecstasy and Related Drugs Reporting System; Illicit Drug Reporting System; National Drug Strategy Household Survey

Surveys of people who regularly use illicit stimulants or inject drugs have shown that many people who regularly use illicit drugs report it is 'easy' or 'very easy' to obtain drugs including cannabis and cannabinoid-related products, methamphetamine, cocaine, ecstasy and heroin (Sutherland et al. 2025a, Sutherland et al. 2025b). The perceived price and purity of most of these drugs also remained relatively stable in 2025 compared to the previous year, with a significant reduction in the price of heroin (from $80 per point in 2024 to $50 in 2025) (Sutherland et al. 2025b).

Illicit drug markets have remained relatively consistent over time, with some fluctuations for specific drug types potentially due to market disruptions. For example, in the early 2000s there was a widespread heroin shortage in Australia, which followed a period of unprecedented heroin availability in Australia in the late 1990s. The heroin shortage was attributed to a range of factors, including high purity and low profit margins for dealers, along with several law enforcement seizures (Degenhardt et al. 2004).

People who use drugs most often obtain them from a friend or dealer:

- According to the 2022–2023 National Drug Strategy Household Survey (NDSHS), almost 2 in 3 (61%) people aged 14 years and over who had recently used cannabis reported their usual source as friends, while 1 in 5 (21%) usually sourced cannabis from a dealer (AIHW 2024, Table 5.35).
- Around 4 in 5 (79%) people who regularly use stimulant drugs reported obtaining drugs from a friend, partner, colleague or relative in the last 12 months in 2025, and 66% had obtained drugs from a known dealer (Sutherland et al. 2025a).

Among people who regularly inject drugs or regularly use stimulants, the most common modes for arranging the purchase of illicit or non-prescribed drugs include face-to-face, via social networking or messaging applications (such as WhatsApp or Telegram), via text message or by phone call (Sutherland et al. 2025a, Sutherland et al. 2025b).

For related content on people who regularly use stimulants and people who inject drugs in this report, see also:

- Amphetamines and other stimulants
- Experiences of alcohol and other drugs among people who inject drugs

What do we know about illicit drug detections at the Australian border?

Most illicit drug detections at the Australian border in 2020–21 were for cannabis

Source: Illicit Drug Data Report

National illicit drug border detection data, including the number and weight of border detections, are collected annually from federal, state and territory police services and reported via the IDDR. In 2020–21, there were:

- 24,255 cannabis detections, weighing 819 kilograms in total (ACIC 2023, Figure 10)
- 2,169 cocaine detections, weighing 2,576 kilograms, the highest amount detected since reporting began (ACIC 2023a, Figure 22)
- 1,753 amphetamine-type stimulant (excluding MDMA) detections at the Australian border, weighing 5,290 kilograms (ACIC 2023a, Figure 1)
- 1,773 MDMA (ecstasy) detections, weighing 106 kilograms (ACIC 2023a, Figure 2).
- 1,415 pharmaceutical detections (including benzodiazepines, morphine, buprenorphine, methadone and oxycodone only). Most (64%) of these detections were for benzodiazepines (902 in 2020–21).

Between 2011–12 and 2020–21:

- The number of heroin detections at the Australian border rose from 179 to 622 detections in 2020–21, and the weight of heroin detected rose from 256 to 1,247 kilograms.
- The number of pharmaceutical detections (including benzodiazepines, morphine, buprenorphine, methadone and oxycodone only) increased by 6% (from 1,337 to 1,415 detections).
- There was a 1,215% increase in the number of pharmaceutical opioid detections (39 In 2011–12), increasing to the highest number recorded of 513 in 2020–21 (ACIC 2023).

What do we know about drug seizures?

The number of drug seizures has risen over the past 10 years

Source: Illicit Drug Data Report

Cannabis and amphetamine-type stimulants continue to account for the highest numbers of seizures

Source: Illicit Drug Data Report

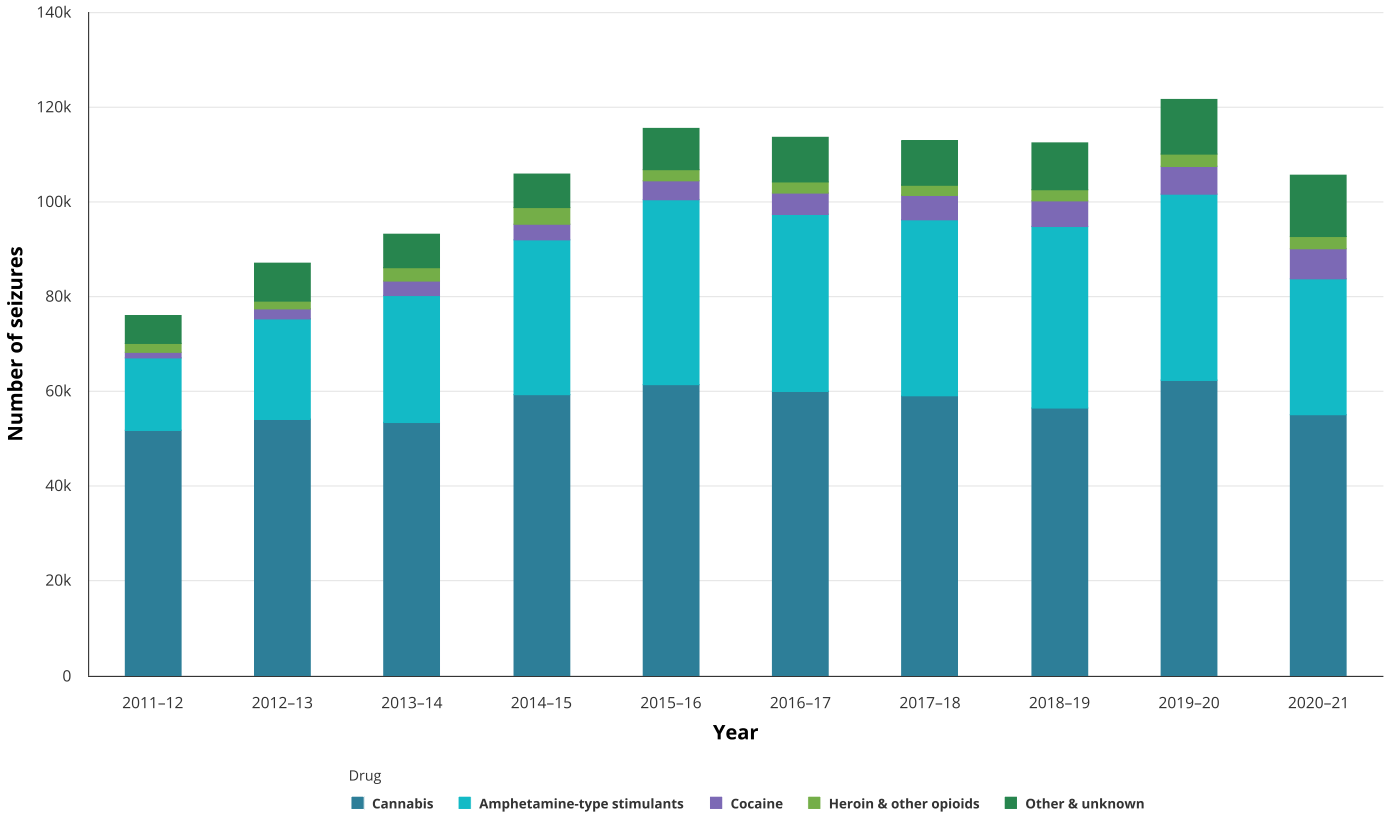
National illicit drug seizure data, including the number and weight of seizures, are collected annually from federal, state and territory police services and reported via the IDDR. According to the most recent report:

- There were 105,694 national illicit drug seizures in 2020–21, equivalent to around one seizure every 5 minutes.
- There has been an increase in the number of seizures over the last decade from 76,083 in 2011–12, but a 13% decrease compared with the previous year.

- Cannabis (52%) and amphetamine-type stimulants (ATS; 27%) accounted for the greatest proportion of national illicit drug seizures in 2020–21. Amphetamines (including amphetamine, methylamphetamine, dexamphetamine and amphetamines not elsewhere classified) accounted for 90% of the total number of ATS seizures (24,745 seizures).
- The number of cannabis seizures decreased 12% in 2020–21 and ATS seizures decreased 27% compared with 2019–20 (ACIC 2023).
- The number of heroin seizures increased from 1,758 in 2011–12 to 2,130 in 2020–21 (Table IDDR1, Figure 1).

Figure 1: National illicit drug seizures, by drug type, 2011–12 to 2020–21

Number



Notes:

1. Includes only those seizures for which a drug weight was recorded. No adjustment has been made to account for double counting data from joint operations between the Australian Federal Police and state/territory police.
2. 'Other and unknown' includes the categories Steroids, Hallucinogens and Other and unknown drugs.

Chart: AIHW. Source: ACIC 2013, ACIC 2018, ACIC 2019, ACIC 2020, ACIC 2021, ACIC 2022 and ACIC 2023.

The weight of illicit drugs seized nationally was 41.4 tonnes in 2020–21, an increase from 38.5 tonnes in 2019–20 (8%). Illicit drugs classified as other and unknown accounted for the greatest proportion of the weight of illicit drugs seized in 2020–21 (45%) followed by cannabis (26%), ATS (15%), cocaine (11%) and heroin (3%) (Table IDDR2, Figure 1).

The weight of illicit drugs seized in 2020–21 increased from the previous year across all drug types except ATS, which decreased by 51%. There has been a 74% increase in the weight of illicit drugs seized over the last decade (23.8 tonnes in 2011–12) (Table IDDR2, Figure 1).

What do we know about drug-related arrests?

The number of illicit drug arrests has risen over the past 10 years

Source: Illicit Drug Data Report

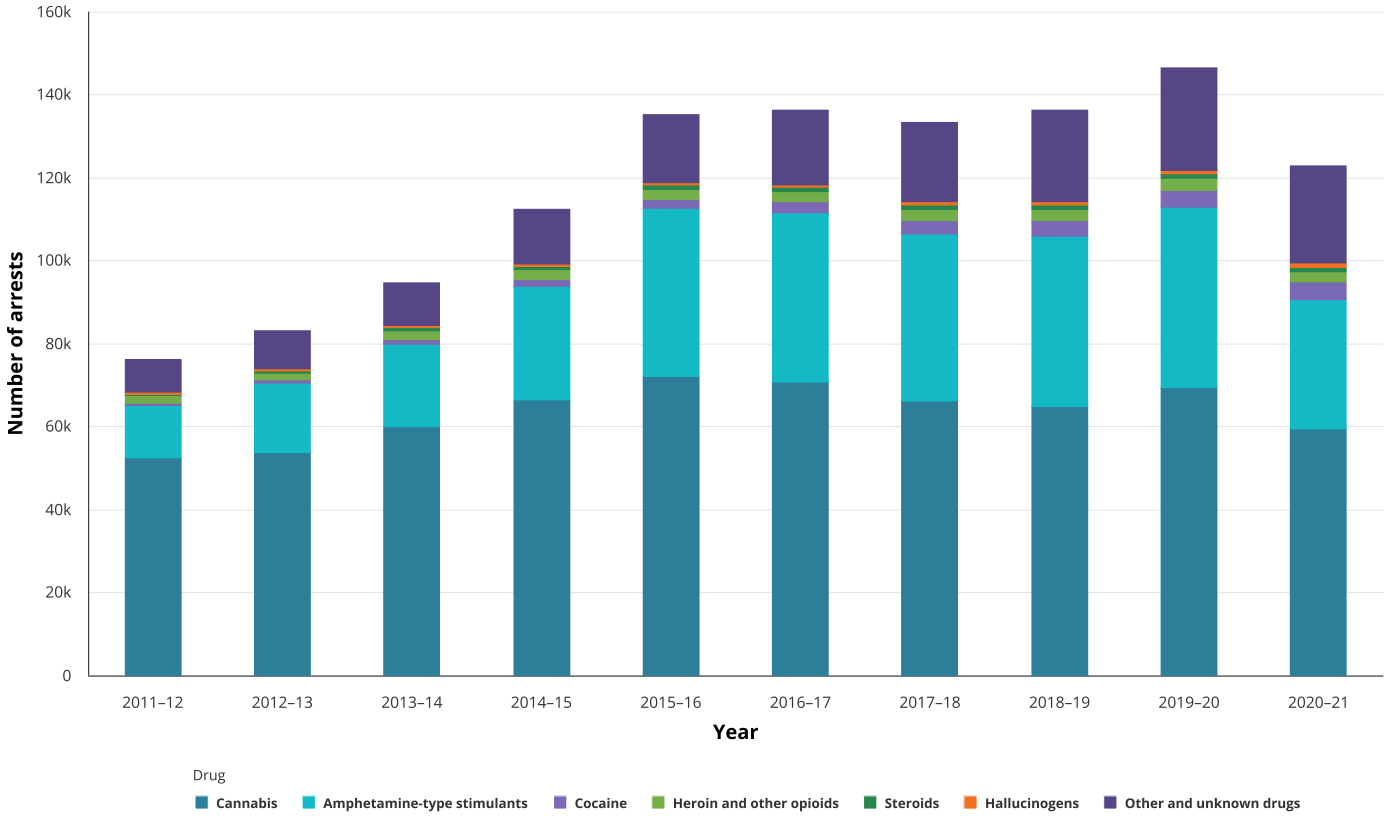
Cannabis and amphetamine-type stimulants continue to account for the highest numbers of arrests

Source: Illicit Drug Data Report

In addition to data on drug seizures, the IDDR includes information on national illicit drug arrest data as collected annually from federal, state and territory police services. According to the IDDR, the number of national illicit drug arrests rose by 51% over the decade to 2020–21 (from 93,148 arrests in 2011–12 to 140,624 in 2020–21) (ACIC 2023). However, the number of arrests has fallen since 2019–20 (166,321 arrests). Most (87%) illicit drug arrests in 2020–21 were for consumer related offences (Table IDDR3, Figure 2).

Figure 2: Consumer, provider, and total national illicit drug arrests, 2011–12 to 2020–21

Arrest type: Consumer



Note: Includes those offenders for whom consumer/provider status was not stated. Total may exceed the sum of the table components.
Source: ACC 2013, ACIC 2018, ACIC 2019, ACIC 2020, ACIC 2021, ACIC 2022 and ACIC 2023.

Data from the 2020–21 IDDR found that:

- There were 66,285 national cannabis arrests in 2020–21, with the number of arrests increasing 9% over the last decade (61,011 in 2011–12). Cannabis (47%) accounted for the greatest proportion of national illicit drug arrests in 2020–21, but this proportion has declined since 2011–12 (65% of arrests) (ACIC 2023).
- Amphetamine-type stimulants (ATS) accounted for the second largest proportion (26%) of national illicit drug arrests in 2020–21, up from 18% in 2011–12.
- The number of national cocaine arrests has increased 499% over the last decade, from 995 in 2011–12 to 5,958 in 2020–21, the highest number recorded in the IDDR (ACIC 2023).
- Heroin and other opioids accounted for 2.0% of national illicit drug arrests in 2020–21, down from 2.9% in 2011–12 (ACIC 2023).

What do we know about police and court illicit drug offences?

Police and court illicit drug offences have fallen across Australia in recent years

Source: Criminal Courts, Australia; Recorded Crime - Offenders

Over 2 in 3 illicit drug offences related to the possession or use of drugs in 2023–24

Source: Recorded Crime - Offenders

The number of illicit drug offences has declined in recent years, both for offenders proceeded against by police and defendants finalised in court (ABS 2025a, ABS 2025c). Possession and use offences continue to account for the highest proportion of all illicit drug offences across available data sources.

Data from Recorded Crime – Offenders found that 14% of offenders aged 10 and over had a principal offence that was illicit drug related in 2023–24.

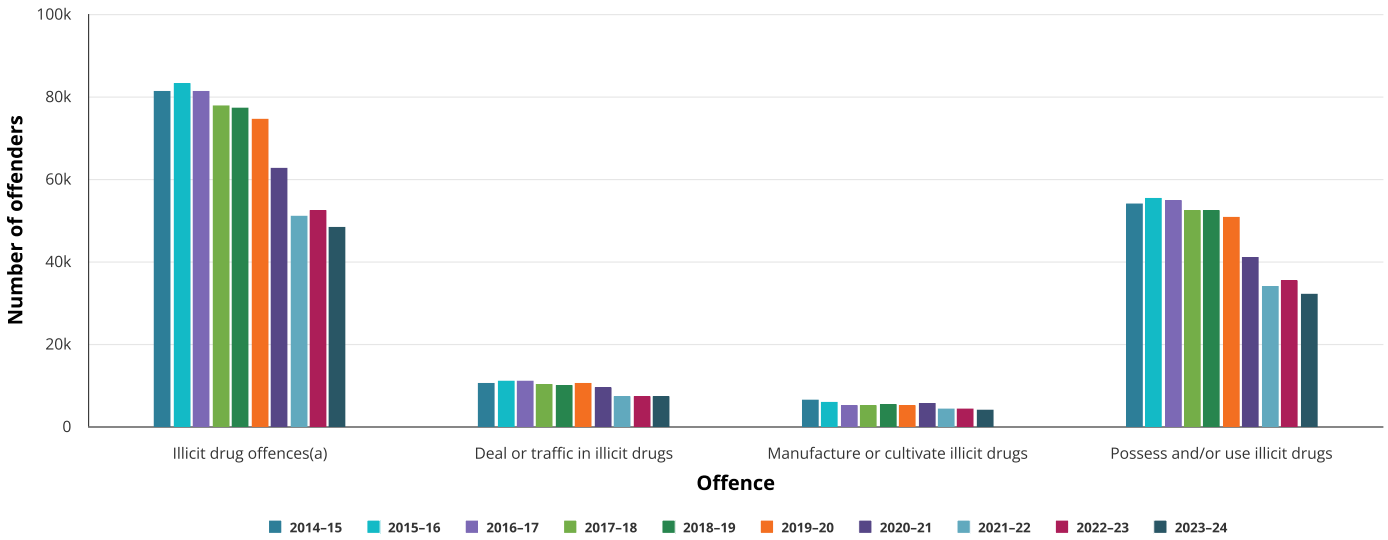
- Illicit drug offences (48,213 offenders) were the second most common principal offence nationally, behind acts intended to cause injury (92,259 offenders).
- The number of illicit drug offences decreased by 8% (down 4,102 offenders) between 2022–23 and 2023–24 (ABS 2025c, Table 1). The number of illicit drug offenders is now at the lowest point since peaking at 83,204 in 2015–16.
- 2 in 3 (67%) illicit drug offences were related to possession and/or use of drugs – 32,135 out of 48,213 offences (ABS 2025c).

Among those aged 18 and over, the offender rate decreased between 2022–23 (238.0 per 100,000 persons) and 2023–24 (214.5 per 100,000 persons) (ABS 2025c, Table 4).

Between 2022–23 and 2023–24, the number of principal illicit drug offences among young people aged 10–17 decreased by 17% from 3,380 to 2,791 offences (ABS 2025c). Most (76%) of the offences were related to possession and/or use of drugs – 2,134 out of 2,791 offences (ABS 2025c).

Figure 3: Offenders proceeded against by police and defendants finalised in court for illicit drug offences, by principal offence, 2014–15 to 2023–24

Offenders



a. Includes 101 import or export illicit drugs, 109 other illicit drug offences and 1000 illicit drug offences n.f.d.
b. The 2018–19 reference period is the first full year in which 17 year old defendants in Queensland are considered to be a child/juvenile. Users should therefore use caution when making comparisons with data from previous years.

Notes:

1. 'Offenders' are people proceeded against by police for one or more criminal offences.
2. 'Defendants finalised in court' excludes defendants transferred to other court levels.

Source: ABS 2025a, ABS 2025c

Data from Criminal Courts, Australia showed that illicit drug offences accounted for 7% (38,039) of defendants finalised across all Criminal Courts in Australia in 2023–24 (ABS 2025a). The number of illicit drug offences has overall declined since 2018–19 (58,883 defendants), driven largely by a fall in the number of possession or use offences (from 37,701 in 2018–19 to 24,837 in 2023–24) (ABS 2025a).

In 2023–24, consistent with previous years:

- Almost 2 in 3 (65%, or 24,837 defendants) illicit drug offences were possession or use offences (ABS 2025a, Table 1).
- Almost 3 in 4 (74% or 28,328) defendants with an illicit drug offence were male and almost 1 in 3 (31% or 11,640) were aged in their 30s (ABS 2025a, Table 3).
- Most illicit drug offences were finalised in the Magistrates' Courts (34,257 defendants), as opposed to the Higher Courts (3,078) or Children's Courts (706) (ABS 2025a, Table 1).
- Of those defendants who were found guilty of an illicit drug offence (35,048 defendants), around half (55% or 19,407 defendants) received a fine, 12% (4,246) received a good behaviour order and 10% (3,632) received 'nominal and other' penalties (ABS 2025a, Table 10).

The Prisoners in Australia report showed that illicit drug offences were the most serious offence for just over 1 in 10 (11% or around 5,200) people in custody on 30 June 2025, down from almost 6,600 in 2019 (ABS 2025b). Among people in custody for an illicit drug offence on 30 June 2025:

- almost 9 in 10 (89%) were male
- the median age was 38 years
- almost 1 in 2 (48%) had previously been imprisoned (ABS 2025b, Table 1).

For related content on alcohol and other drug use among people in contact with the criminal justice system in this report, see Experiences of alcohol and other drugs among people in contact with the criminal justice system.

Where do I go for more information?

- Criminal Courts, Australia
- Illicit Drug Data Report
- Prisoners in Australia
- Recorded Crime – Offenders

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ABS (2025b) *Prisoners in Australia, 2025*, ABS, Australian Government, accessed 11 February 2026.

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Viewing this data

Caution: This content contains information and data on alcohol or other drugs

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The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Wastewater drug monitoring

In this section

Introduction

What is wastewater drug monitoring?

Wastewater analysis provides estimates of drug usage in a population by measuring concentrations of drug metabolites (excreted into the sewer system after consumption) in wastewater samples. Wastewater data provides information about drug consumption at the population level but cannot show how often or how much people are using, or who is using drugs. Wastewater analysis cannot differentiate between prescribed and illicit use for drugs including cannabis, oxycodone and fentanyl (ACIC 2025). For more information, see Technical notes.

Monitoring and law enforcement activities form part of Australia's broader harm minimisation approach to alcohol and other drugs under the National Drug Strategy 2017–2026 (Department of Health 2017). Wastewater drug monitoring is used to measure the presence of drugs and their metabolites in wastewater, providing information about trends in drug consumption at the population level (ACIC 2025).

This page contains information on population-level wastewater drug monitoring. For related content on Australia's drug laws, see also Policy context.

Key findings

- Alcohol and nicotine continue to be the highest consumed drugs across Australia as measured in wastewater, followed by cannabis and methylamphetamine
- Between 2022–23 and 2023–24, the estimated consumption of methylamphetamine, cocaine, MDMA and heroin increased across Australia

What data sources are available?

Data sources for wastewater drug monitoring

- National Wastewater Drug Monitoring Program

Information on wastewater drug monitoring in Australia comes from the National Wastewater Drug Monitoring Program (NWDMP), which has been operating since 2016. The NWDMP measures the presence of alcohol and other drugs in wastewater in regional and capital city sites across Australia. The study focuses on 12 licit and illicit drugs, including nicotine from tobacco, ethanol from alcohol intake, pharmaceutical opioids, and illicit substances such as methylamphetamine, MDMA and cocaine.

For more information about the NWDMP, see Technical notes.

What does wastewater drug monitoring data tell us?

Alcohol and nicotine continue to be the highest consumed drugs across Australia as measured in wastewater, followed by cannabis and methylamphetamine

Source: National Wastewater Drug Monitoring Program

The most recent wastewater report covers the period from April to August 2024 for both capital cities and regional sites, with additional information up to October 2024 for capital cities (ACIC 2025). Sixty-one wastewater treatment sites participated nationally in the August 2024 collection, covering 57% of the Australian population or about 14.5 million people (ACIC 2025).

Alcohol and nicotine have remained the highest consumed substances recorded in wastewater analysis across Australia since monitoring began, followed by cannabis and methylamphetamine (ACIC 2025).

Nationally, between 2022–23 and 2023–24, the estimated consumption of:

- methylamphetamine increased by 21% (from 10,585 to 12,815 kilograms per annum)
- cocaine increased by 69% (from 4,037 to 6,835 kilograms per annum)
- MDMA increased by 49% (from 962 to 1,430 kilograms per annum)
- heroin increased by 14% (from 999 to 1,137 kilograms per annum) (ACIC 2025).

Wastewater monitoring can also be used to assess the relationship between supply and demand within illicit drug markets. For example, the Australian Criminal Intelligence Commission examined supply and demand in the Australian methylamphetamine market by overlaying NWDMP data with illicit drug seizures data. The key findings indicated that large seizures had an impact on consumption, particularly in capital cities. The impact was not

immediate and usually lasted 2–4 months (ACIC 2019).

For related content on wastewater drug monitoring in this report, see also:

- Remoteness areas
- State and territory data

Where do I go for more information?

- National Wastewater Drug Monitoring Program reports

References

ACIC (Australian Criminal Intelligence Commission) (2019) *Methylamphetamine supply reduction: measures of effectiveness*, ACIC, Australian Government, accessed 14 October 2019.

ACIC (2025) *Report 24 of the National Wastewater Drug Monitoring Program*, ACIC, Australian Government, accessed 29 September 2025.

Department of Health (2017) *National Drug Strategy 2017–2026*, Department of Health, Australian Government, accessed 15 July 2025.

Viewing this data

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The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Drug types

Drug types
Explore content on the use, treatment and health and harms of different drug types in Australia, including alcohol, tobacco and cannabis.

- Alcohol
- Amphetamines and other stimulants
- Cannabis
- Heroin
- New psychoactive substances
- Other drugs
- Pharmaceutical drugs
- Tobacco
- Vaping and e-cigarettes

Key findings

There have been long-term declines in tobacco smoking in Australia since the 1990s

Source: National Drug Strategy Household Survey

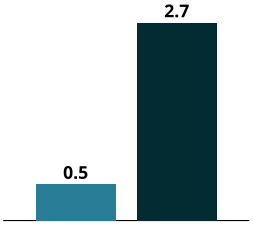
Alcohol use was responsible for 4.1% of the total burden of disease and injury in Australia in 2024

Source: Australian Burden of Disease Study

11.5% of the general population in Australia had recently used cannabis in 2022–2023

Source: National Drug Strategy Household Survey

Updated



The rate of deaths involving all psychostimulants has risen 5-fold between 2000 and 2024 (from 0.5 to 2.7 deaths per 100,000 population)

Source: National Mortality Database

Updated

In 2024, there were over 31,000 ambulance attendances involving any pharmaceutical drug among people aged 15 and over (171 per 100,000 population)

Source: National Ambulance Surveillance System

There were 3,674 hospitalisations with a principal diagnosis of GHB in 2023–24, up from 569 in 2015–16

Source: National Hospital Morbidity Database

Viewing this data

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Tobacco

Tobacco is an Australia's health topic

In this section

Introduction

What is tobacco?

Tobacco is made from the dried leaves of the tobacco plant. It is usually smoked in a cigarette, cigar, or pipe, but it might also be snorted or chewed. Nicotine, the active ingredient responsible for tobacco's addictive properties, which can be tobacco-derived or synthetic, can also be consumed in a range of other ways, including through electronic cigarettes (also known as e-cigarettes or vapes).

The use of tobacco in Australia, while gradually declining, continues to be a leading risk factor for disease burden (AIHW 2024a). Tobacco use contributes to a range of health-related harms in Australia, including cancer and chronic lung conditions (AIHW 2024a). Tobacco use also incurs significant social costs. The estimated social cost of tobacco was $155.4 billion in 2020–21, projected to rise to $159.7 billion in 2022–23 (Gadsden et al. 2024, Table 1). The most significant projected costs for 2022–23 were related to premature mortality ($107.5 billion), smoking attributable ill–health ($29.8 billion), and health care ($7.9 billion) (Gadsden et al. 2024, Figure 3).

There has been a long-term commitment to addressing the harms associated with tobacco smoking in Australia through a range of measures such as taxation on tobacco products, restrictions on advertising, and the prohibition of smoking in certain locations. This has contributed to the rate of smoking among the general population declining over time (Figure 1).

Figure 1: People aged 14 and over who smoke daily[ab] and key tobacco control measures in Australia, 1990 to 2024

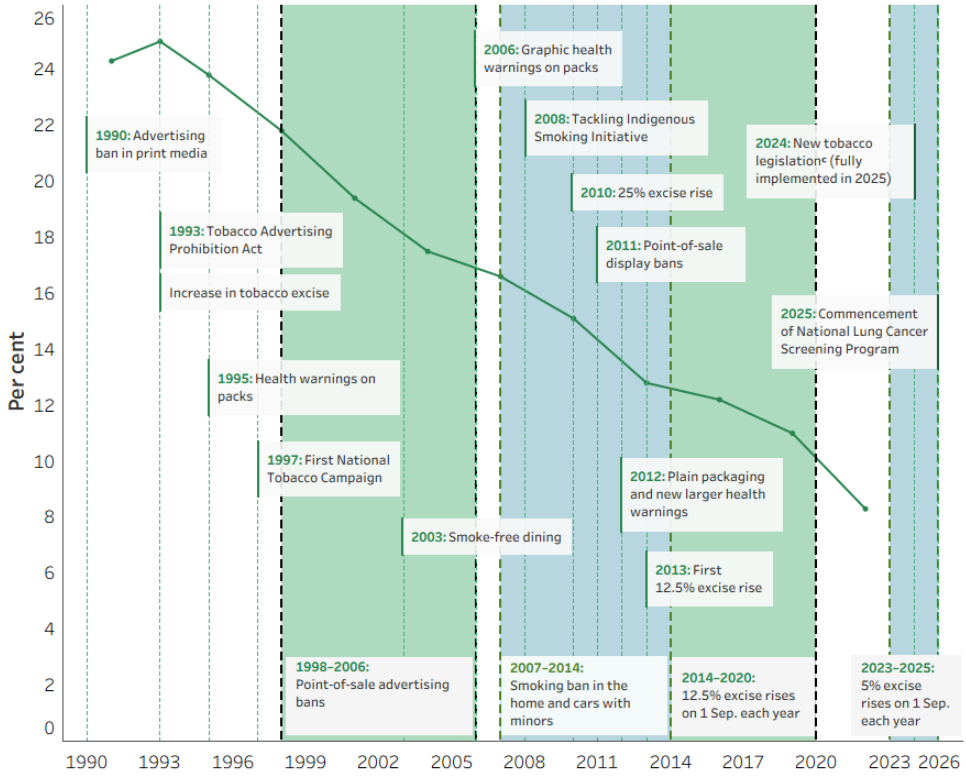


Chart: Alcohol, tobacco and other drugs in Australia, AIHW 2026.
http://www.aihw.gov.au

This figure shows the daily smoking proportion for people aged 14 and over and key national tobacco policy implementation points (such as tobacco tax increases and health campaigns) over time. The proportion of people who smoke daily declined from 24% in 1991 to 8% in 2022–23.

This page focuses on tobacco availability, use, treatment and harms in Australia, including both legal tobacco products and illicit tobacco. The reporting uses data from a range of sources, mostly national administrative and survey data. For related content on laws and policies about tobacco, see Policy context.

Key findings

- Daily tobacco smoking has been falling since the early 2000s, decreasing from 19% to 8.3% of people in Australia between 2001 and 2022–2023
- Tobacco smoking has declined among both men and women, but men continue to be more likely than women to smoke daily
- There has been an increase in the number of people choosing to never take up smoking (65% in 2022–2023, up from 49% in 1991)
- Tobacco use is the second leading risk factor for the burden of disease in Australia, contributing to 7.6% of disease burden in 2024

What data sources are available?

Data sources for tobacco availability, use, harms and treatment

- Alcohol and Other Drug Treatment Services National Minimum Data Set
- Australian Burden of Disease Study
- Australian Taxation Office
- Household, Income and Labour Dynamics in Australia survey
- National Drug Strategy Household Survey
- National Health Survey
- National Perinatal Data Collection
- Pharmaceutical Benefits Scheme data collection
- Tobacco in Australia: Facts and Issues

There are a range of data sources that contain information about tobacco use, harms and treatment. These include self-report surveys that ask people about their use of tobacco, health administrative data sets (such as administrative data routinely collected by hospitals), and burden of disease analysis. Each data set uses a different methodology, and the language used to describe tobacco use may also differ across sources.

In particular, the National Drug Strategy Household Survey (NDSHS) and the National Health Survey (NHS) have large sample sizes and collect self-reported data on tobacco smoking and alcohol consumption. Data from the NDSHS and NHS show variations in estimates, yet comparison of trends over time are consistent between the 2 surveys. Differences in scope, collection methodology and design may account for this variation and comparisons between collections should be made with caution. For example:

- Data are collected for people aged 14 and over for the NDSHS and people aged 15 and over for the NHS. Estimates are provided for people aged 18 and over for both surveys.

- NDSHS respondents could choose to complete the survey via a self-complete drop and collect questionnaire, online survey, or computer-assisted telephone interview (CATI).
- The questions asked in the surveys also differ and therefore results from the surveys are not directly comparable (ABS 2023, AIHW 2024b).

For more information about each data source, see Technical notes.

What do we know about tobacco availability in Australia?

Australian households spent an average of $919 on tobacco products in 2023, down from $1,079 in 2019

Source: Household, Income and Labour Dynamics in Australia Survey

Data on tobacco expenditure in Australia indicate a decline in the estimated amounts spent by consumers on cigarettes and tobacco (Bayly and Scollo 2025). Adjusting for seasonality and increasing prices of tobacco products (so that all prices are expressed in current-day terms), the estimated amount that Australians spent on tobacco declined from $77 billion in 1990 to $55 billion in 2000 and $15 billion in 2024 (Bayly and Scollo 2025). This corresponds with declines in the prevalence of smoking among the general population (AIHW 2024b).

Latest available industry sales data indicate that the number of ready-made (manufactured) cigarettes sold in Australia has declined from 15.7 billion sticks in 2016 to 5.0 billion in 2024 (Scollo and Bayly 2025). This represents a decline from 800 to 223 cigarettes per capita, noting that stock shipments in the year to December 2024 would be artificially low due to the introduction of new restrictions on packaging, product names and contents from 1 April 2025 (Scollo and Bayly 2025).

Household spending on tobacco products has also declined, when adjusting for inflation. Across all Australian households (including households with people who use tobacco, and households with no people who use tobacco):

- Households spent an average of $919 on tobacco products in 2023, equating to $17.6 per week.
- The average household spending on tobacco products decreased by 14.8% between 2019 and 2023, from $1,079 to $919 (expressed in December 2023 prices) (Laß et al. 2025).

Among households with any tobacco expenditure in a given year, after adjusting for inflation, expenditure on tobacco increased by 28% between 2006 and 2022 (from $3,840 to $4,932, expressed in 2022 prices) (Bayly and Scollo, 2025).

Data on the availability of illicit tobacco in Australia have previously been limited. The Australian Government established the role of Illicit Tobacco and E-cigarette (ITEC) Commissioner in July 2024, with related ITEC reporting requirements. The first ITEC report was released in 2025, providing insights into Australia's illicit tobacco and e-cigarette market in 2024–25 (ITEC 2025).

Industry-funded reports have historically been vastly different when compared against illicit tobacco consumption estimates provided by the ATO Tobacco Tax Gap and the NDSHS.

- Industry estimates indicate that illicit tobacco consumption accounted for 28.6% of the total tobacco market in Australia in 2023, up from 11.8% in 2012 (Cho et al. 2025).
- Estimates from the NDSHS indicate that less than 1 in 10 (9.0%) people who currently smoke reported currently smoking unbranded tobacco in 2022–2023, the highest proportion recorded in the NDSHS. Around 1 in 10 (10.2%) people reported purchasing packs without plain packaging in 2022–2023 (AIHW 2024b, tables 2.30 and 2.31).
- The Australian Taxation Office estimated that around 25% (1,741 tonnes) of all tobacco for sale in Australia in 2023–24 was illicit. The amount of lost customs and excise duty from illicit tobacco ($3.2 billion) accounted for an estimated net gap of 19.6% between the expected and actual customs and excise duty collected from all tobacco consumed within Australia (ATO 2025a). However, the ATO advises using caution for these data (ATO 2025b).
- The ITEC report estimates that the illicit tobacco market accounted for 50–60% of the total tobacco market in 2024–25, with a value of $4.1–$6.9 billion. This estimate is based on modelling of 2022–2023 consumption data (ITEC 2025).

For more information on illicit tobacco use and markets in Australia, see Tobacco in Australia: Facts and issues.

What do we know about people who use tobacco?

How many people use tobacco and has it changed over time?

There have been long-term declines in tobacco smoking in Australia since the 1990s

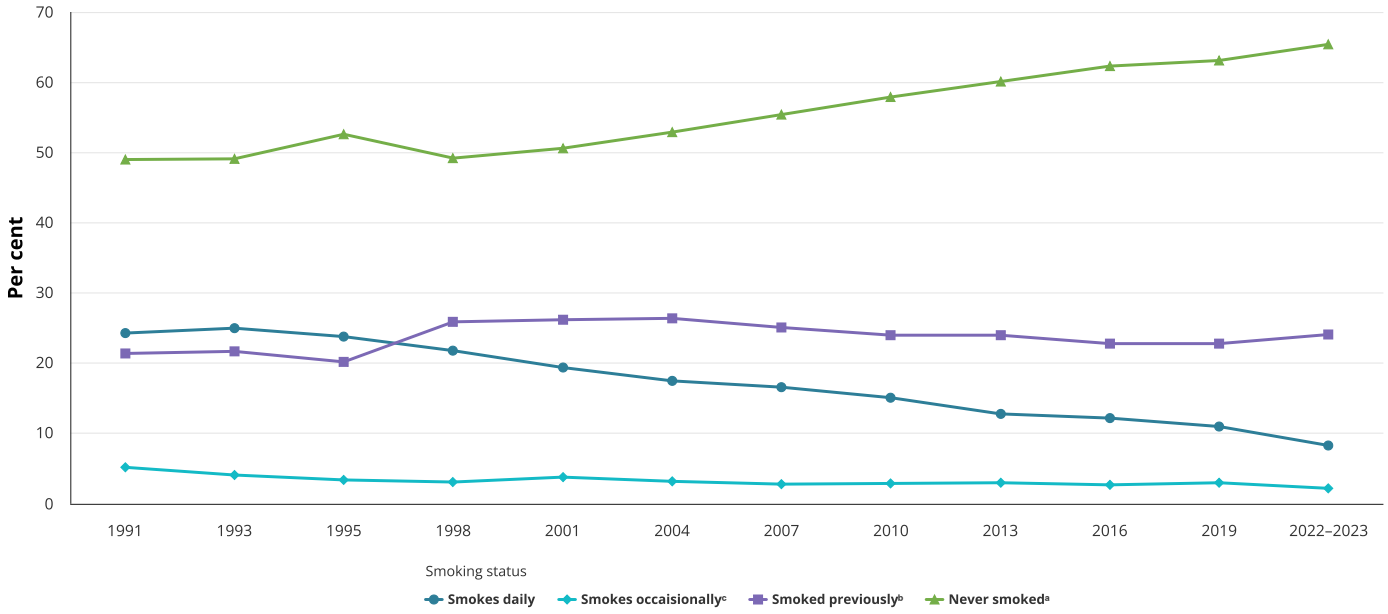
Source: National Drug Strategy Household Survey

The most recent NDSHS found that, among people aged 14 and over:

- the proportion who smoked daily more than halved from 24% in 1991 to 8.3% in 2022–2023
- the proportion who have never smoked has increased to the highest levels since the survey began (from 49% in 1991 to 65% in 2022–2023) (AIHW 2024b, Table 2.1; Figure 2).

The long-term decline in daily smoking has largely been driven by people never taking up smoking, alongside the proportion of people quitting smoking also rising over time (AIHW 2024b, Greenhalgh et al. 2025).

Figure 2: Tobacco smoking status, people aged 14 and over, 1991 to 2022–2023



a. Never smoked 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco.
b. Smoked at least 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco in their life, and reported no longer smoking.
c. Includes weekly and less than weekly smoking.

Statistically significant change between 2019 and 2022–2023

Notes:

1. In 1991, daily smoking included people who reported smoking daily, or most days.
2. In 1993, smoking status was only asked to people aged 20 years or over.

Source: AIHW 2024 (Supplementary table 2.1)

Data from the 2022 National Health Survey (NHS) showed a similar pattern to the NDSHS data over time. The proportion of adults who smoke daily declined steadily over the 2 decades to 2022, and, after adjusting for age, has halved from 22.4% in 2001 to 10.6% in 2022 (ABS 2023).

What types of tobacco products do people use?

Most people who smoke report exclusively smoking manufactured cigarettes, but the proportion of people who smoke roll-your-own cigarettes is rising

Source: National Drug Strategy Household Survey

Trends in the type of tobacco product consumed by people who smoke has changed over the past decades, with a shift towards use of roll-your-own cigarettes and a higher awareness of illicit tobacco.

Data from the 2022–2023 NDSHS found that, of people who currently smoke:

- The proportion of people who smoked manufactured cigarettes exclusively declined from a peak of 74% in 2004 to 56% in 2022–2023 (AIHW 2024b, Table 2.24).
- The proportion who smoked roll-your-own cigarettes exclusively increased from 5.7% in 2001 to 16% in 2022–2023 (AIHW 2024b, Table 2.24). Over 1 in 5 (22%) people aged 18–24 smoked roll-your-own cigarettes exclusively, the highest of any age group (AIHW 2024b, Table 2.25).

Over 2 in 5 (43%) people who currently smoked in 2022–2023 were aware of unbranded tobacco, up from 34% in 2019.

- Almost one quarter (23%) had smoked unbranded tobacco in their lifetime (AIHW 2024b, Table 2.30).
- More had seen tobacco products without plain packaging or graphic health warnings in the previous 3 months (20% compared with 15.2% in 2019). Of the 10% who purchased these products, 40% said they purchased them from a tobacconist and 26% said they bought them from a supermarket, convenience or grocery store (AIHW 2024b, Table 2.31).

Does tobacco use differ by age and gender?

Tobacco smoking has declined among both men and women, but men continue to be more likely than women to smoke daily

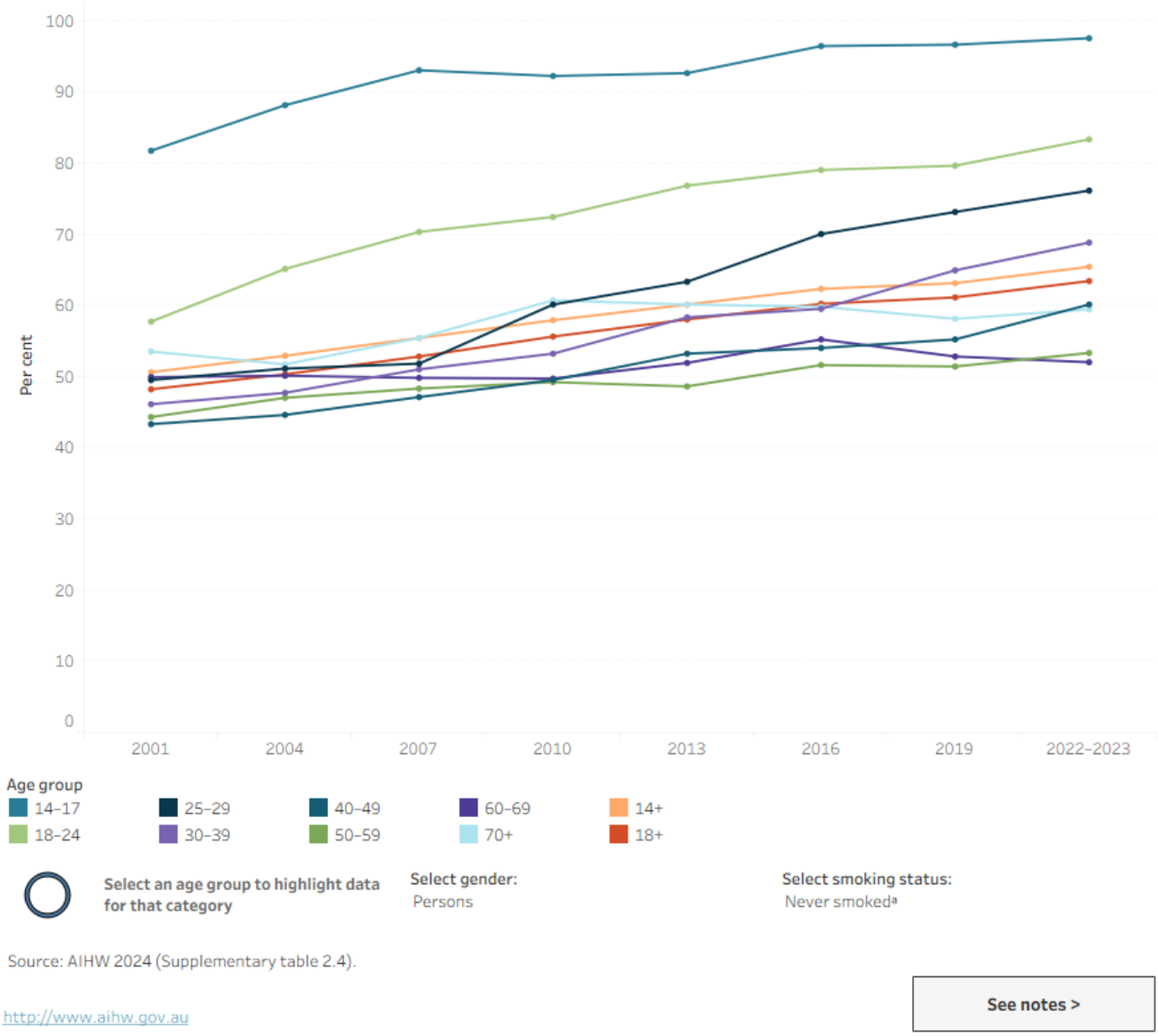
Source: National Drug Strategy Household Survey

Daily use of tobacco is typically higher among people in older age groups than younger people (Figure 3). Findings from the 2022–2023 NDSHS showed that:

- People aged 50–59 (12.1%) were the most likely age group to smoke tobacco daily.
- In people aged 14 and over, males (9.0%) were more likely to smoke daily than females (7.7%).
- Young adults aged 18–24 were more likely to have never smoked than any other adult age group (AIHW 2024b, Table 2.4; Figure 3).

The average age at which younger people (aged 14–24) had their first full cigarette decreased from 16.6 years in 2019 to 16.3 years in 2022–2023 (AIHW 2024b, Table 2.18).

Figure 3: Tobacco smoking status, people aged 14 and over, by age and gender, 2001 to 2022–2023



Data from the 2022 NHS showed that:

- People aged 55–64 (14.9%) had the highest proportion for daily tobacco smoking (ABS 2023, Table 14.3).
- Of people aged 18 and over, a higher proportion of men (12.6%) than women (8.7%) currently smoked daily (ABS 2023, Table 14.3).
- 79% of 18–24-year-olds reported never smoking in 2022, up from 75% in 2017–18 (ABS 2019, 2023).
- The number of cigarettes smoked per day increased with age – 8.2% of people who smoked aged 18–24 smoked more than 20 cigarettes per day, compared with 26.5% of those aged 65 and over (ABS 2023, Table 14.3).

How many women smoke during pregnancy?

Tobacco smoking during pregnancy is a preventable risk factor for pregnancy complications, and support to stop smoking is widely available through antenatal clinics.

Data from the National Perinatal Data Collection indicates that tobacco smoking during pregnancy has been declining over time in Australia. In 2023, 7.8% (or 21,450) of all mothers who gave birth reported smoking at any time during pregnancy, down from 13% in 2011 (AIHW 2025b).

There have been notable improvements over time in smoking rates at any time during pregnancy for some population groups including:

- First Nations mothers (from 49% in 2011 to 38% in 2023)

- mothers aged under 20 (from 36% in 2011 to 29% in 2023) (AIHW 2025b).

Does tobacco use differ by geographic area?

Since 2001, the proportion of people aged 14 and over who smoke tobacco daily has declined across all states and territories and socioeconomic areas, and most remoteness areas (AIHW 2024b). Detailed information on tobacco use by geographic area within Australia is available in the National Drug Strategy Household Survey.

Detailed information on tobacco use by geographic area, including state and territory data, is available in Geographic areas.

For related content on tobacco use among specific population groups in this report, see Population groups.

What are the harms associated with tobacco use?

Tobacco use continues to be one of the leading risk factors contributing to the burden of disease in Australia

Source: Australian Burden of Disease Study

Over the past thirty years, there has been a decrease in the proportion of children aged under 14 who are exposed to tobacco smoke in the home

Source: National Drug Strategy Household Survey

Burden of disease and injury

In 2024, tobacco was the second highest risk factor contributing to the burden of disease in Australia and was responsible for 7.6% of the total burden of disease and injury (AIHW 2024a). The age-standardised rate of total attributable burden due to tobacco use was 12.7 Disability-Adjusted Life Years (DALY) per 1,000 population in 2024, a decrease from 21.6 DALY per 1,000 population in 2003.

Tobacco use contributed to a number of diseases and injuries including:

- 73% of the burden due to lung cancer
- 71% of the burden due to chronic obstructive pulmonary disorder
- 69% of the burden due to laryngeal cancer
- 47% of the burden due to lip and oral cavity cancer
- 46% of the burden due to oesophageal cancer (AIHW 2024a, Table S8).

For related content on the burden of disease due to tobacco, alcohol and other drugs in this report, see Burden of disease and injuries related to alcohol and other drugs.

Harms from second-hand smoke

The inhalation of other people's tobacco smoke can be harmful to health. Second-hand smoke can cause coronary heart disease and lung cancer in non-smoking adults and is known to induce and exacerbate a range of mild to severe respiratory effects in infants, children and adults. Second-hand smoke is also a cause of sudden infant death syndrome (SIDS) and a range of other serious health outcomes in young children. There is increasing evidence that second-hand smoke exposure is associated with psychological distress (Campbell et al. 2017).

Results from the 2022–2023 NDSHS showed that parents and guardians are choosing to reduce their children's exposure to tobacco smoke at home. The proportion of households with children aged under 14 where someone smoked inside the home on a daily basis has fallen substantially from 31% in 1995 to 2.1% in 2022–2023 (AIHW 2024b, Table 2.14). In 2022–2023, 2.6% of adults who did not smoke were exposed to tobacco inside the home on a daily basis (AIHW 2024b, Table 2.16).

Harms related to smoking during pregnancy

Compared with babies born to mothers who did not smoke at any time during pregnancy, babies born to mothers who smoked tobacco at any time during pregnancy were more likely to:

- be low birth weight, 13.7% compared with 5.9%, in 2023 (among liveborn babies)
- be born pre-term, 13.7% compared with 7.8%, in 2023 (among all babies)
- be admitted to a special care nursery or neonatal intensive care unit, 27.3% compared with 17.3%, in 2023 (among liveborn babies)
- have a higher perinatal mortality rate, 17.5 per 1,000 births compared with 9.3 per 1,000, in 2022 (among all babies) (AIHW 2025b).

Results for 2023 were based on data from the National Perinatal Data Collection, while 2022 results were based on data from the National Perinatal Mortality Data Collection.

How many people quit smoking or receive treatment for tobacco use?

Intentions to quit

Over 3 in 5

people who smoked in 2022–2023 had future intentions to quit

Source: National Drug Strategy Household Survey

Data from the 2022–2023 NDSHS showed that 62% of people who currently smoked had future intentions to quit (AIHW 2024b, Table 2.39).

Of those who had changed their smoking behaviour:

- 53% did so because it was costing too much
- 45% did so because it was affecting their health or fitness (AIHW 2024b, Table 2.35).

Successful smoking cessation may take many attempts over several years. Data from the HILDA survey indicate that between 2.1% and 3.5% of people quit smoking in any given year between 2003 and 2021. However, 3 in 5 (61.5%) people who quit smoking between 2003 and 2018 started again within 3 years (Wilkins et al. 2024). These data are likely an underestimate as people who quit and start smoking again between annual survey waves will not be counted in these estimates (Wilkins et al. 2024).

Smoking cessation medicines

Data from Australia's Pharmaceutical Benefits Scheme (PBS) provide information about prescription medicines that are used to help people stop their smoking (smoking cessation medicines). Data from the PBS show that rates of dispensing for smoking cessation medicines fluctuated between 2012–13 and 2024–25, potentially influenced by factors including shortages of Varenicline in 2021–22 (tables PBS62 and PBS64). For detailed information on prescription smoking cessation medicines in this report, see Smoking and alcohol cessation medicines.

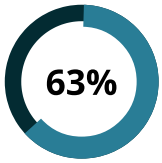
Specialist treatment for nicotine use

Nicotine treatment provided in alcohol and other drug treatment services

When considering nicotine treatment in Australia, consultation between a client and a service provider/clinician is an important step in determining a client's treatment plan. Clients may actively seek treatment for nicotine dependence or be offered treatment for nicotine dependence by the service provider/clinician as a parallel treatment with other drugs of concern. Nicotine may be reported as a principal or additional drug of concern. Following consultation, a service provider/clinician will determine a treatment plan with the client.

Clients do not regularly seek (or are referred to) AOD treatment services for nicotine addiction treatment. Clients are more often referred to other avenues of treatment. This is due to the prevalence of other resources for the management of nicotine dependence and smoking cessation support, including helplines and access to nicotine replacement therapy (NRT) via general practitioners.

For more information, see Alcohol and other drug treatment services in Australia.



Almost 2 in 3 treatment episodes provided to clients for their own use of nicotine in 2023–24 were for people who had not previously received treatment

Source: Alcohol and other drug treatment services in Australia report

Nicotine (including both tobacco and e-cigarette use) accounts for a small proportion of specialist alcohol and other drug treatment episodes provided to clients each year (AIHW 2026). Nicotine was the principal drug of concern in just 1.0% (around 2,100) of treatment episodes in 2024–25, relatively stable since 2015–16 (2.4% or around 4,700 episodes).

Data collected for the Alcohol and Other Drug Treatment Services National Minimum Data Set are released twice each year, via an early insights report in April and a detailed annual report mid-year. The section below will be updated with information from the annual report once these data become available.
Of the 1,440 clients who received treatment for nicotine as their principal drug of concern in 2023–24:

- half (50%) were male (AIHW 2025a, Table SC.9)
- 7 in 10 (70%) were aged under 40, including those aged 10–19 (38%), 20–29 (17%), or 30–39 (15%) (AIHW 2025a, Table SC.10)
- around 1 in 5 (19%) were First Nations people (AIHW 2025a, Table SC.11).

For related content on nicotine treatment in this report, see Alcohol and other drug treatment services.

Where do I go for more information?

- Did people who smoke try to quit or reduce their smoking?
- How many people were exposed to tobacco smoke at home?
- Tobacco in Australia: Facts and issues
- Tobacco smoking in the NDSHS

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Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Vaping and e-cigarettes

Vaping and e-cigarettes is an Australia's health topic

In this section

Introduction

What are e-cigarettes?

Electronic cigarettes or vapes, collectively referred to as 'e-cigarettes', are personal vaping devices designed to deliver nicotine and/or other chemicals via inhalation of an aerosol vapour (Department of Health, Disability and Ageing 2025). The solution used in e-cigarettes varies. Common e-liquids include propylene glycol, vegetable glycerol, and flavourings, and may contain nicotine in freebase or salt form (Banks et al. 2022).

The use of e-cigarettes ('vaping') has risen sharply over the last decade, including among people who also use regular cigarettes (AIHW 2024). The long-term harms of e-cigarettes are not fully known, but people who use e-cigarettes are exposed to toxic chemicals that can cause adverse health effects (NHMRC 2022). Ongoing monitoring of e-cigarette use and harms is important to identify groups of people at increased risk of harm and potential areas for intervention.

This page focuses on e-cigarette use, treatment and harms in Australia. The reporting uses data from a range of sources, mostly survey data. For information on laws and policies related to e-cigarettes in this report, see Policy context.

Key findings

- The number of people who use e-cigarettes has been rising in recent years
- Daily use of e-cigarettes is generally more common among younger people than people in older age groups
- E-cigarette use has been linked to numerous short- and medium-term health risks, but evidence for longer-term health effects is currently limited

What data sources are available?

Data sources for e-cigarette use, treatment and harms

- Household, Income and Labour Dynamics in Australia Survey
- National Drug Strategy Household Survey
- National Health Survey

There are a limited number of data sources that contain information about e-cigarette use, harms and treatment. These are mostly self-report surveys that ask people about their use of e-cigarettes, with limited information available in health administrative data sets. Each data set uses a different methodology, and the language used to describe e-cigarette use may also differ across sources.

For more information on each data source, see Technical notes.

What do we know about e-cigarette availability in Australia?

The sale of e-cigarettes in Australia is regulated by Commonwealth and jurisdictional laws. On 1 July 2024, the law changed so that all vapes and vaping products, regardless of whether they contain nicotine or not, can only be sold in a pharmacy for the purpose of helping people quit smoking or manage nicotine dependence. (Department of Health, Disability and Ageing 2025). From 1 October 2024, people aged 18 and over can buy vapes from participating pharmacies with a nicotine concentration of 20mg/mL or less subject to state and territory arrangements. People (regardless of their age) who require vapes with a higher nicotine concentration, and people under 18 years, need a prescription to access vapes, subject to state and territory arrangements (Department of Health, Disability and Ageing, 2024).

Prior to the introduction of these laws, data from the National Drug Strategy Household Survey (NDSHS) showed that, among people who currently use e-cigarettes in 2022–2023:

- 40% of people sourced e-cigarettes from a tobacco retail outlet, up from 20% in 2019

- 23% of people sourced e-cigarettes from a friend or family member, up from 14% in 2019
- 8.5% of people sourced e-cigarettes online from an overseas retailer and 8.3% sourced them online from an Australian retailer, down from 22% and 24% in 2019, respectively (AIHW 2024, Table 3.38).

For related content on e-cigarette policy in this report, see Policy context.

What do we know about people who use e-cigarettes?

How many people use e-cigarettes and has it changed over time?

The number of people who use e-cigarettes has been rising in recent years

Source: National Drug Strategy Household Survey

of people in Australia currently used e-cigarettes in 2022–2023

Source: National Drug Strategy Household Survey

The 2022–2023 NDSHS showed both lifetime and current use of e-cigarettes increased between 2016 and 2019, and again to 2022–2023. Between 2019 and 2022–2023, lifetime use of e-cigarettes increased from 11.3% to 19.8% and current use increased from 2.5% to 7.0% (AIHW 2024, tables 3.1 and 3.3).

Among people who currently used e-cigarettes in 2022–2023:

- around 1 in 2 (49%) used them daily, an increase from 2019 (42%) (AIHW 2024, Table 3.8)
- almost 3 in 4 (73%) reported the last e-cigarette they used contained nicotine (AIHW 2024, Table 3.16).

The 2022 National Health Survey (NHS) reported that about 1 in 7 (14%) people aged 18 and over had used an e-cigarette or vaping device at least once, and 4.0% reported currently using a device (ABS 2023).

Does e-cigarette use differ by age and gender?

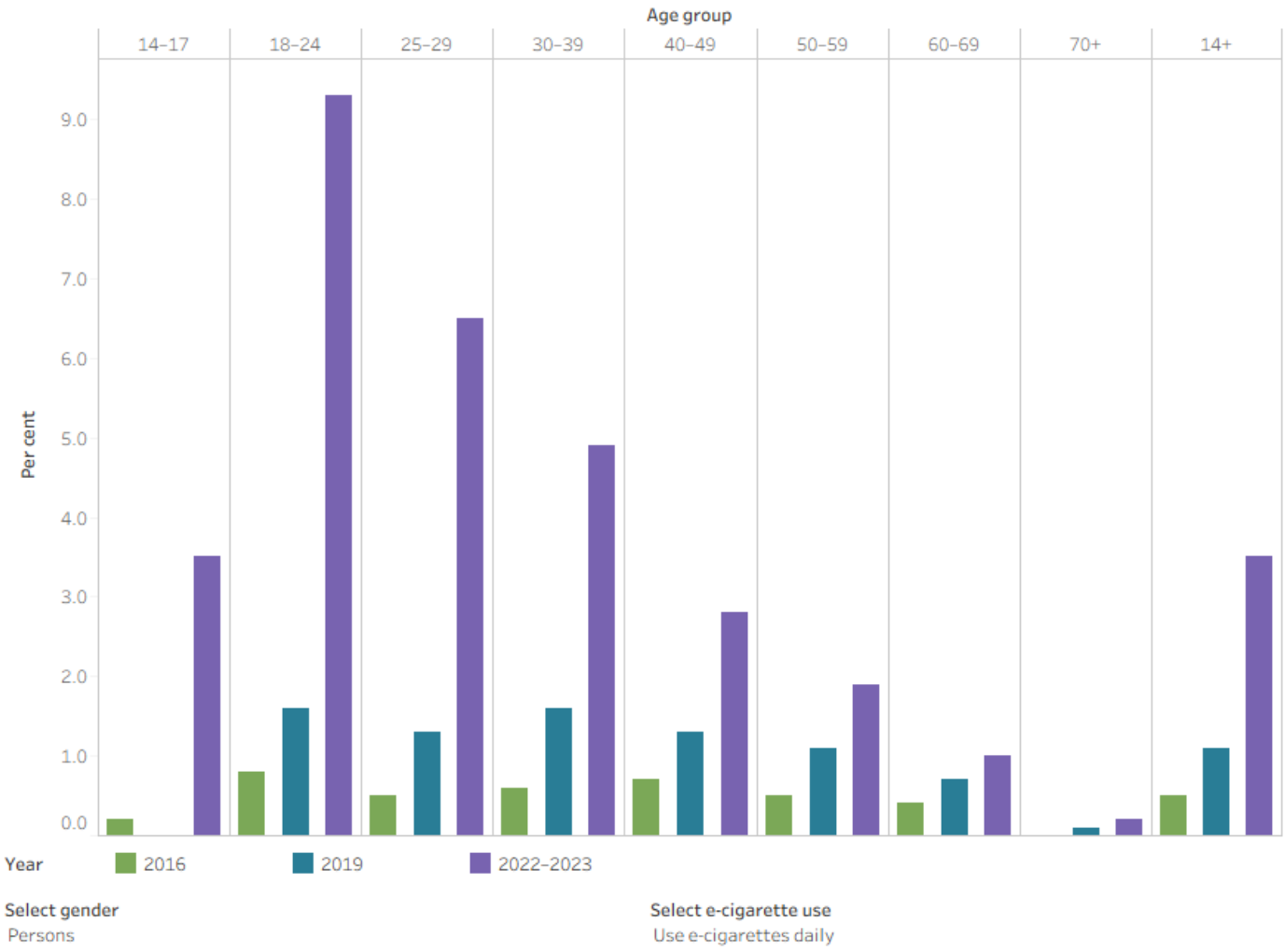
People aged 18–24 have the highest rates of e-cigarette use

Source: National Drug Strategy Household Survey

Daily use of e-cigarettes is generally more common among younger people than people in older age groups (Figure 1). Data from the 2022–2023 NDSHS showed that:

- People aged 18–24 had the highest rate of daily e-cigarette use (9.3%). Daily use of e-cigarettes was more common among females in this age group (10.3%) than males (8.5%).
- People aged 25–34 were the most likely to report they used to use e-cigarettes but no longer use them (6.0%) (AIHW 2024, Table 3.9).

Figure 1: Use of e-cigarettes, by age and gender, 2016 to 2022–2023



(a) Includes people who reported using electronic cigarettes/vapes at least weekly (but not daily), at least monthly (but not weekly) or less than monthly.
AIHW 2024 (Supplementary table 3.9).

In 2022–2023, the average age of initiation for e-cigarette use among people who currently use e-cigarettes was:

- 19.4 years for those who had never smoked tobacco when they first tried an e-cigarette, a decrease from 20.2 years in 2019
- 25.8 years for people who smoked tobacco socially when they first tried an e-cigarette
- 33.0 years for people who smoked regularly when they first tried an e-cigarette, a decrease from 38.1 years in 2019 (AIHW 2024, Table 3.33).

The 2022 NHS reported:

- Almost 1 in 5 (18%) young people aged between 15 and 17 had used an e-cigarette or vaping device at least once.
- Men were more likely than women to have used an e-cigarette or vaping device at least once (17% compared with 11%) (ABS 2023).

Why do people use e-cigarettes?

Younger people are more likely to try e-cigarettes out of curiosity, while people in their 60s and over are more likely to try e-cigarettes to help them quit smoking

Source: National Drug Strategy Household Survey

Use of e-cigarettes is more common among younger age groups in Australia, and their reasons for using e-cigarettes are different to that of older people. According to the 2022–2023 NDSHS, the most common reason for trying e-cigarettes was curiosity (57%), but this varied by age. Specifically:

- Curiosity was the most common reason for e-cigarette use among people aged 14–17 (74%) and 18–24 (68%).
- To help them quit smoking was the most common reason for e-cigarette use among people aged 60–69 (53%) and 70 and over (49%) (AIHW 2024, Table 3.34; Figure 2).

Figure 2: Reasons for using e-cigarettes, by people who had ever used electronic cigarettes, by age, 2022–2023

Note: Base is people who had used electronic cigarettes/vapes in their lifetime.
AIHW 2024 (Supplementary table 3.34).

Does e-cigarette use differ by geographic area?

Since 2016, current e-cigarette use has risen across all Australian states and territories, remoteness areas, and socioeconomic areas (AIHW 2024, tables 9b.8, 9a.12 and 9a.14). Detailed information on e-cigarette use by geographic area within Australia is available in the National Drug Strategy Household Survey.

Detailed information on e-cigarette use by geographic area in this report is available in Geographic areas.

For related content on e-cigarette use among specific population groups in this report, see Population groups.

What are the harms associated with e-cigarette use?

As e-cigarettes are relatively new, only becoming popular in the last 10–15 years, evidence for the longer-term health effects of their use is limited. However, e-cigarette use is associated with a range of health risks including nausea and vomiting, persistent coughing, nicotine dependence, respiratory problems and lung damage, and poisoning and seizures from excessive nicotine inhalation or ingestion of e-liquid (Department of Health, Disability and Ageing 2025). Illegal e-cigarettes can contain chemicals that are known to cause cancer, including formaldehyde and heavy metals like lead (Department of Health, Disability and Ageing 2025, Winnall et al. 2023).

For the latest available information on harms related to e-cigarettes, see Tobacco in Australia: Facts and issues.

How many people receive treatment for e-cigarette use?

Specialist treatment for nicotine use

Nicotine treatment provided in alcohol and other drug treatment services

Clients do not regularly seek (or are referred to) AOD treatment services for nicotine addiction treatment. Clients are more often referred to other avenues of treatment. This is due to the prevalence of other resources for the management of nicotine dependence and smoking cessation support, including helplines and access to nicotine replacement therapy (NRT) via general practitioners.

For more information, see Alcohol and other drug treatment services in Australia.

Nicotine (including both tobacco and e-cigarette use) accounts for a small proportion of specialist alcohol and other drug treatment episodes provided to clients each year (AIHW 2026). Nicotine was the principal drug of concern in just 1.0% (around 2,100) of treatment episodes in 2024–25, relatively stable since 2015–16 (2.4% or around 4,700 episodes) (AIHW 2026).

For related content on nicotine treatment in this report, see also:

- Alcohol and other drug treatment services
- Availability of smoking and alcohol cessation medicines in Australia

Where do I go for more information?

- Tobacco in Australia: Facts and issues
- Vaping and e-cigarette use in the NDSHS

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Viewing this data

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Alcohol

Alcohol is an Australia's health topic

In this section

Introduction

What is alcohol?

Alcohol is a depressant drug made from ethanol, typically consumed in the form of beer, wine, cider or spirits (ADF 2025). Alcohol concentration varies considerably with the type of drink. In Australia, beer contains 0.9–6% alcohol, wine contains 12–14%, fortified wines such as sherry and port contain around 18–20%, and spirits such as scotch, rum, bourbon and vodka contain 40–50% (NDARC 2017).

The consumption of alcohol is widespread within Australia and associated with many social and cultural activities. However, alcohol use is a leading risk factor for the burden of disease in Australia and is associated with a range of health and social harms including hospitalisation and death. The estimated social cost of alcohol use in Australia was $72.9 billion in 2020–21, projected to rise to $75.0 billion in 2022–23 (Gadsden et al. 2023, Table 1). The most significant projected costs in 2022–23 were related to premature mortality ($29.1 billion) and morbidity ($23.3 billion), and workplace-related costs ($4.5 billion) (Gadsden et al. 2024, Figure 2).

This page focuses on alcohol use, treatment and harms in Australia. The reporting uses data from a range of sources, mostly national administrative and survey data. For related content on policies and laws related to alcohol (including policies related to fetal alcohol spectrum disorder), see Policy context.

Key findings

- There were 217.1 million litres of pure alcohol available for consumption in Australia in 2023–24, down from 227.3 million litres in 2020–21
- Over two-thirds of people in Australia had consumed alcohol in the previous 12 months in 2022–2023, and 1 in 3 did so in ways that put their health at risk
- Alcohol has consistently accounted for a higher number of ambulance attendances, hospitalisations and deaths than any other drug over time
- More people receive specialist treatment for their use of alcohol than for other drugs including cannabis, methamphetamine and heroin

What data sources are available?

Data sources for alcohol use, treatment and harms

- Alcohol and other drug treatment services in Australia
- Alcohol available for consumption in Australia
- Australian Burden of Disease Study
- Australia's mothers and babies
- Causes of Death, Australia
- Household Income and Labour Dynamics in Australia (HILDA) survey
- Pharmaceutical Benefits Scheme data collection
- National Ambulance Surveillance System
- National Drug Strategy Household Survey
- National Health Survey
- National Hospital Morbidity Database

There are a range of data sources that contain information about alcohol use, treatment and harms. These include self-report surveys of people who use alcohol, health administrative data (such as hospitalisations data), burden of disease analysis, and economic data (such as taxation data). Each data set uses a different methodology, and the language used to describe alcohol may also differ across sources.

For more information about each data source, see Technical notes.

What do we know about alcohol availability in Australia?

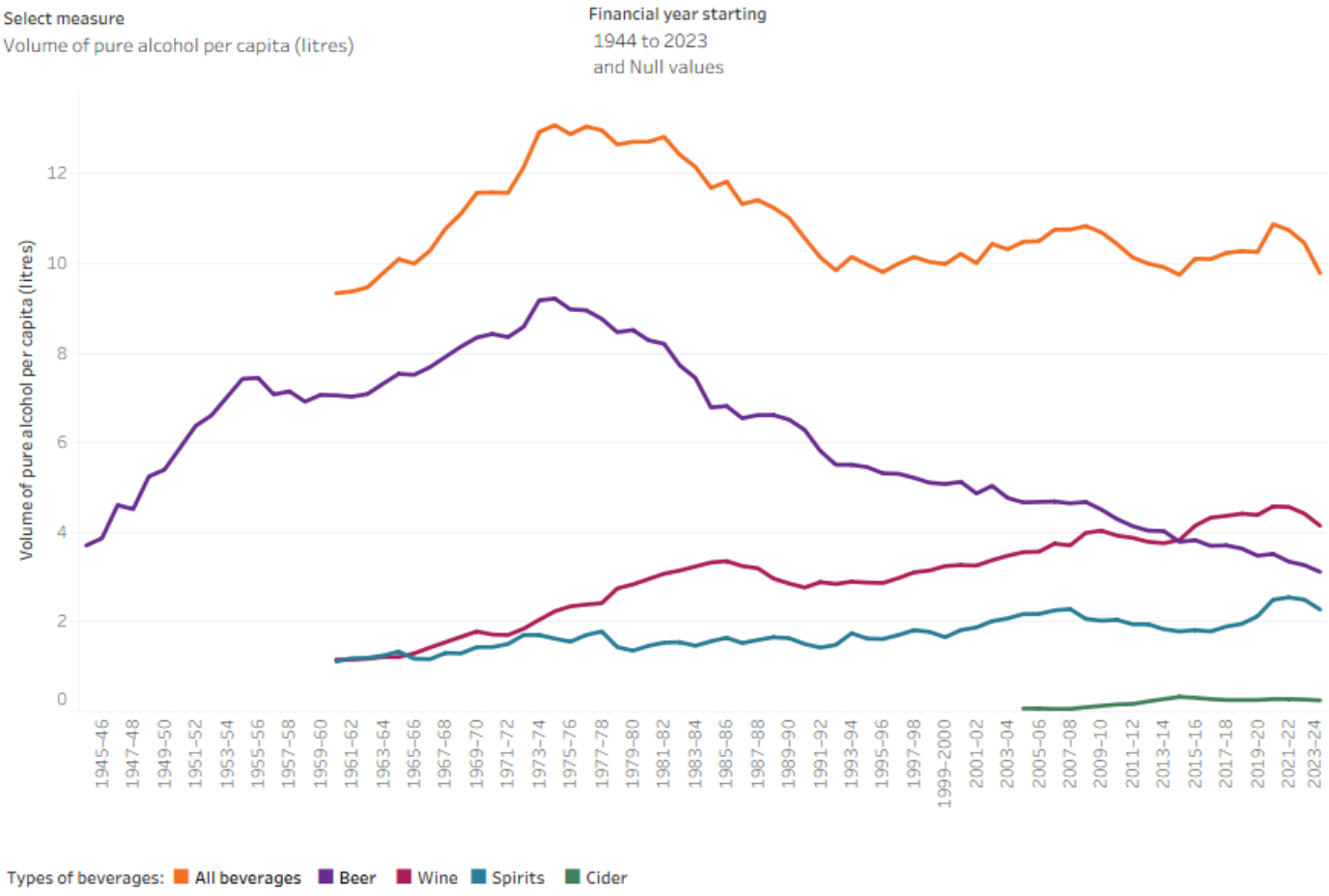
There were 9.8 litres of alcohol available for consumption per capita in 2023–24

Source: Alcohol available for consumption in Australia

In 2023, the mean annual spend on alcohol across Australian households was $1,770, or $34 per household per week on average. Household spending on alcohol has fluctuated over time but has declined since 2021 when the household average was $1,929 (Laß et al. 2025).

Long term data from the Alcohol available for consumption in Australia report show that the volume of alcohol available per capita has gradually decreased since the mid-1970s (AIHW 2025b). In 2023–24, there were 217.1 million litres of pure alcohol available for consumption in Australia, down from 227.3 million litres in 2020–21 (AIHW 2025b). The amount of alcohol available for consumption per capita has also fallen in recent years, from 10.9 litres in 2020–21 to 9.8 litres in 2023–24. Wine accounted for the largest proportion of pure alcohol available for consumption in 2023–24 (42%), followed by beer (32%) and spirits (23%) (AIHW 2025b; Figure 1).

Figure 1: Alcohol available for consumption in Australia by beverage type, 1944–45 to 2023–24



Notes
1. Data represents the annual calculation of the quantity of alcohol being made available for consumption to people living in Australia rather than quantifying individual drinking habits.
2. Reference period: Financial year.
3.Denominator for per capita consumption is persons aged 15 and over (ABS 2025).
Source: AIHW 2025

Of all pure alcohol in wine available for consumption in 2023–24, white and red wine made up a similar proportion (43% and 41% of total alcohol in wine, respectively). Full-strength beer was the most widely available form of beer in 2023–24, but the availability of mid-strength beer has risen and the availability of full- and low-strength beer has declined since 2008–09 (AIHW 2025b).

What do we know about people who consume alcohol?

How many people consume alcohol and has it changed over time?

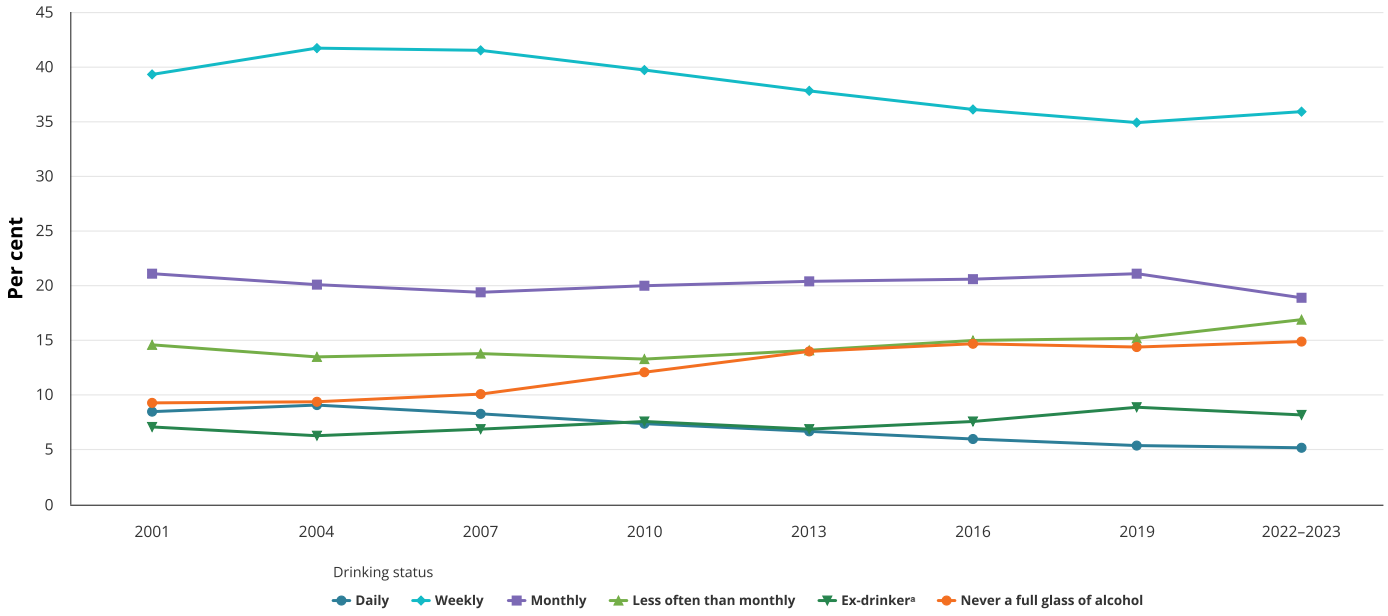
Over 2 in 3 people in Australia had consumed alcohol in the previous 12 months in 2022–2023

Source: National Drug Strategy Household Survey

Most people in Australia aged 14 and older have consumed alcohol in their lifetime. The 2022–2023 National Drug Strategy Household Survey (NDSHS) found that of the population aged 14 and over:

- Over two-thirds (69%) had consumed alcohol in the previous 12 months (AIHW 2024b, Table 4.6).
- 14.9% had never consumed a full serve of alcohol (AIHW 2024b, Table 4.1).
- The proportion who consumed alcohol daily remained stable between 2019 (5.4%) and 2022–2023 (5.2%) (AIHW 2024b, Table 4.1; Figure 2).

Figure 2: Alcohol drinking status, people aged 14 and over, 2001 to 2022–2023



(a) Consumed at least a full serve of alcohol, but has not had an alcoholic drink in the previous 12 months.

Statistically significant change between 2019 and 2022–2023.

Note: The calculation of drinking status and alcohol risk variables was updated for all years in 2019. Trend data may not match previously published results.
Source: AIHW 2024 (Supplementary table 4.1)

How many people consume alcohol at risky levels, and does this differ by age and gender?

What is risky alcohol consumption?

In the 2022–2023 NDSHS, "drinking at risky levels" or "risky drinking" is defined according to Guideline 1 of the Australian guidelines to reduce health risks from drinking alcohol (NHMRC 2020). In the NDSHS, a person doing either or both of the following is classified as having consumed alcohol in ways that increased their risk of harm:

1. Having more than 10 standard drinks per week on average in the previous 12 months.
2. Having more than 4 standard drinks in a single day at least once a month over the previous 12 months.

The full guidelines state:

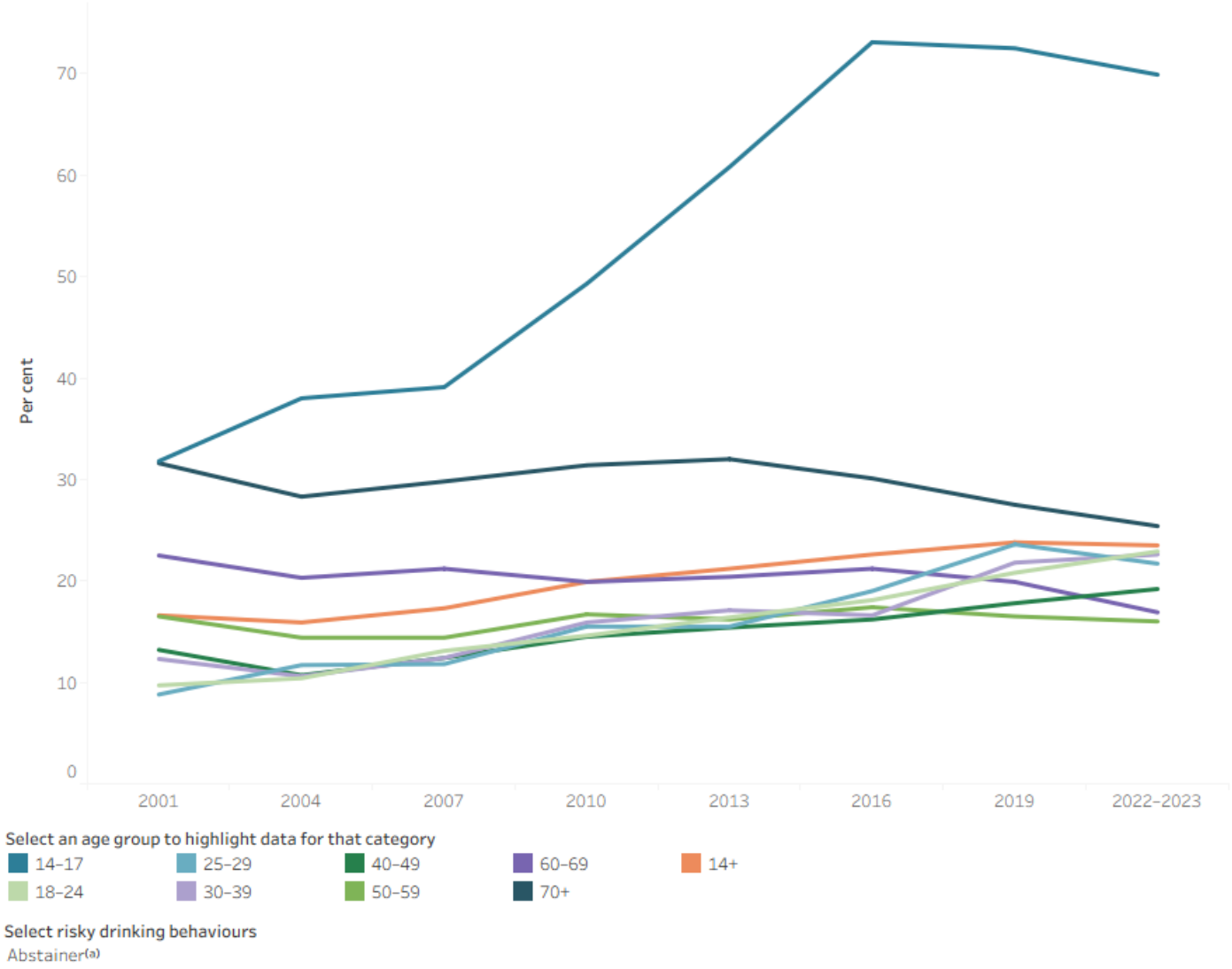
- Guideline 1: To reduce the risk of harm from alcohol-related disease or injury, healthy men and women should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day.
- Guideline 2: To reduce the risk of injury and other harms to health, children and people under 18 years of age should not drink alcohol.
- Guideline 3: To prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol. For women who are breastfeeding, not drinking alcohol is safest for their baby (NHMRC 2020).

Around 1 in 3 people aged 14 and over consumed alcohol at risky levels in 2022–2023

Source: National Drug Strategy Household Survey

The National Health and Medical Research Council (NHMRC) has released risk guidelines to reduce the risk of alcohol-related harm. The NDSHS found around 1 in 3 people (31% or 6.6 million people) aged 14 and over consumed alcohol at risky levels (per the adult risk guidelines) in 2022–2023. This is a similar level to 2019, when 32% of the population (around 6.7 million people) reported drinking at risky levels (AIHW 2024b, tables 4.25 and 4.26; Figure 3).

Figure 3: Alcohol consumption and risk, people aged 14 and over, by age, 2001 to 2022–2023



Source: AIHW 2024 (Supplementary table 4.28).

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See notes >

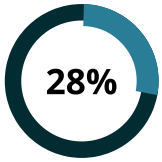
The 2022–2023 NDSHS found that:

- Males continued to be more likely than females to exceed adult risk guidelines for alcohol (39% of males aged 14 and over and 23% of females aged 14 and over).
- Fewer younger people (those aged 14-17) exceeded adult risk guidelines (5.5% in 2022–2023, compared with 9.5% in 2019) (AIHW 2024b, Table 4.28).

Data from the 2022 National Health Survey (NHS) were collected against the 2020 Australian guidelines to reduce health risks from drinking alcohol. Estimates using self-reported data showed that in 2022:

- More than 1 in 4 (26.8%) Australians aged 18 and over exceeded Guideline 1 of the Australian Alcohol Guidelines. This includes people who consumed more than 10 drinks in the last week and/or consumed 5 or more drinks in any day at least monthly in the last 12 months.
- Men were more likely than women to exceed the guideline (35.8% compared with 18.1%).
- People born in Australia were more than twice as likely as those born overseas to exceed the guideline (33.0% compared with 16.0%) (ABS 2023).

How many women consume alcohol during pregnancy?



Over 1 in 4 pregnant women consumed alcohol at some point during their pregnancy in 2022–2023, most often before they knew they were pregnant

Source: National Drug Strategy Household Survey

Alcohol consumption during pregnancy can lead to poorer perinatal outcomes including low birthweight, pre-term birth and fetal alcohol spectrum disorder (FASD). People with FASD are affected for life and can experience challenges with learning, communication, memory and regulating behaviour and emotions (NOFASD 2026).

An estimated 1 in 28 or 3.6% (95% confidence interval 2.9%, 4.4%) people in Australia have FASD, based on the best available data on prenatal alcohol exposure from a recent systematic review with meta-analysis (Tsang et al. 2025). This is similar to other high-income countries such as Canada and the United States (Tsang et al. 2025).

The NHMRC advises that women who are planning a pregnancy, or are pregnant, should not drink alcohol. Support to address alcohol consumption is available through antenatal clinics (AIHW 2024c).

Data on maternal consumption of alcohol during pregnancy were available in the National Perinatal Data Collection for 6 of 8 jurisdictions in 2023 (excluding New South Wales and the Australian Capital Territory). In 2023, most women who gave birth reported they did not consume alcohol during their pregnancy: 2.4% of women reported consuming alcohol in the first 20 weeks of pregnancy, decreasing to 0.5% of women after 20 weeks of pregnancy (AIHW 2025c). In 2023, reported consumption of alcohol in the first 20 weeks of pregnancy was more common among women who:

- lived in *Remote* (4.0%) or *Very remote* (7.6%) areas
- were aged under 20 (5.5%) (AIHW 2025c).

However, women from these population groups showed a decrease in reported alcohol consumption after 20 weeks of pregnancy to:

- 1.5% in *Remote* areas and 3.6% in *Very remote* areas
- 1.3% of women aged under 20 (AIHW 2025c).

Some women may consume alcohol before they know they are pregnant and stop once they find out they are pregnant. Data from the 2022–2023 NDSHS showed that:

- Over 1 in 4 (28%) women who had been pregnant in the past 12 months consumed alcohol at some stage during their pregnancy, similar to 29% in 2019.
- Of pregnant women who reported a period of time they were unaware of their pregnancy, 64% had consumed alcohol before knowing they were pregnant.
- After they became aware of their pregnancy, women were much less likely to consume alcohol (AIHW 2024b, Table 10.21).

Does alcohol use differ by geographic area?

Since 2010, the proportion of people aged 14 and over consuming alcohol at risky levels has declined across all states and territories, socioeconomic areas and remoteness areas (AIHW 2024b).

Detailed information on alcohol and other drug use by geographic areas, including state and territory data, is available in Geographic areas.

For related content on alcohol use among specific population groups in this report, see Population groups.

What are the harms associated with alcohol use?

Alcohol is absorbed rapidly in the bloodstream and affects the brain within about 5 minutes, though this may vary from person to person depending on body mass and general state of health (NDARC 2017). Short-term effects of alcohol such as a sense of relaxation and reduced inhibitions, may add to the appeal of its consumption. However, when consumed in excess, alcohol can also produce unpleasant effects such as nausea and vomiting and may influence people to engage in harmful behaviour (Table 1).

Table 1: Effects of alcohol consumption

Short-term effects	Long-term effects
• Reduced inhibitions • A sense of relaxation • Loss of alertness or coordination, and slower reaction times • Impaired memory and judgement • Nausea, shakiness, and vomiting • Blurred or double vision • Disturbed sleep patterns • Disturbed sexual functioning	• Oral, throat, and breast cancers • Liver cirrhosis • Brain damage and dementia • Some forms of heart disease and stroke

Source: NDARC (2017).

How does alcohol use contribute to the burden of disease and injury?

Alcohol use was responsible for 4.1% of the total burden of disease and injury in Australia in 2024

Source: Australian Burden of Disease Study

The Australian Burden of Disease Study 2024 found that alcohol use was the sixth highest risk factor contributing to the burden of disease in Australia and was responsible for 4.1% of the total burden of disease and injury (Table ABDS1). The age-standardised rate of total attributable burden due to alcohol use was 8.3 Disability-Adjusted Life Years (DALY) per 1,000 population in 2024, a 13.5% decline from 9.6 DALY per 1,000 population in 2003.

Alcohol use contributed to a number of diseases and injuries including:

- 100% of the burden due to alcohol use disorders
- 39% of the burden due to liver cancer
- 26% of the burden due to road traffic injuries involving motor vehicle occupants
- 20% of the burden due to chronic liver disease
- 13% of the burden due to suicide and self-inflicted injuries
- 11% of the burden due to breast cancer (AIHW 2024a, Table S6).

For related content on the burden of disease in this report, see Burden of disease and injuries related to alcohol and other drugs.

Alcohol-related injuries

The definitions of alcohol-related conditions in the following injury statistics are different to those reported elsewhere. For more information, see Alcohol-related injury: hospitalisations and deaths, 2019–20.

In 2019–20, alcohol-related injuries accounted for 5.7% of all injury hospitalisations and 14% of all injury deaths (AIHW 2023). For more information, see Alcohol-related injury: hospitalisations and deaths, 2019–20.

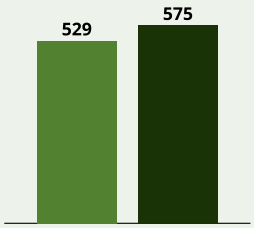
The 2022–2023 NDSHS reported those who consumed alcohol at risky levels were:

- 14 times as likely to experience an injury requiring medical attention while under the influence of alcohol (4.2% compared with *0.3%) as those who did not drink at risky levels
- 10.5 times as likely to have experienced an injury requiring admission to hospital while under the influence of alcohol (2.1% compared with *0.2%) (*Estimate has a relative standard error between 25% and 50% and should be used with caution) (AIHW 2024b, Table 4.52).

For related content on injuries in this report, see Burden of disease and injuries related to alcohol and other drugs.

Alcohol-related ambulance attendances

The rate of alcohol intoxication-related ambulance attendances increased from 529 to 575 per 100,000 population between 2022 and 2023



Source: National Ambulance Surveillance System

Data on alcohol and other drug-related ambulance attendances are sourced from the National Ambulance Surveillance System (NASS) and are currently available for six of the eight Australian states and territories (excluding Western Australia and South Australia).

Alcohol intoxication accounts for the highest number and rate of alcohol and other drug-related ambulance attendances. There were over 99,200 ambulance attendances for alcohol intoxication among people aged 15 and over in 2024, or 540 per 100,000 population (Table NASS3).

Among these attendances:

- almost 3 in 5 (59%) were for males
- the highest rate of attendances was for people aged 45–54 (740 per 100,000 population) (Table NASS3).

Between 2021 and 2023, the number and rate of alcohol intoxication-related ambulance attendances overall increased from around 97,300 (565 per 100,000 population) to around 103,400 (575 per 100,000 population). The number and rate of attendances overall decreased between 2023 and 2024, largely due to a decrease in attendances in Victoria (from around 27,900 attendances (498 per 100,000 population) to around 17,300 (302 per 100,000 population). This is explained by industrial action by paramedics in Victoria between March and September 2024, which resulted in fewer ambulance attendances being captured over that period. 2024 data should be interpreted with caution (Table NASS3).

For related content on ambulance attendances in this report, see Alcohol and other drug-related ambulance attendances.

Alcohol-related hospitalisations

Alcohol accounted for almost 3 in 5 of all drug-related hospitalisations in 2023–24

Source: National Hospital Morbidity Database

Alcohol has continued to account for a higher rate of hospitalisations than any other drug over the past decade, though alcohol-related hospitalisations have remained stable in recent years (see Figure 1). Alcohol accounted for almost 3 in 5 drug-related hospitalisations in 2023–24 (58% or 84,318 hospitalisations), a rate of 312.8 hospitalisations per 100,000 people (tables NHMD2 and NHMD3) (see Figure 1).

Among alcohol-related hospitalisations in 2023–24:

- Over half (52% or 44,234 alcohol-related hospitalisations) involved an overnight stay, while the remainder ended with a same-day discharge.
- Almost 3 in 5 (59% or 49,354) were for males.
- 3 in 5 (60% or 50,306) were for people aged 45 years and over (tables NHMD1–NHMD3).

Alcohol-induced deaths

9 in 10 alcohol-induced deaths in 2024 were related to chronic conditions like liver cirrhosis

Source: Causes of Death, Australia

Release of preliminary deaths data for 2024

Preliminary causes of death data for deaths registered in 2024 were made available on the ABS website in mid-November 2025, including updated data tables for both alcohol- and drug-induced deaths. Estimates for 2022, 2023 and 2024 are expected to rise with standard revision processes.

Preliminary estimates from Causes of Death, Australia indicate there were 1,765 alcohol-induced deaths in 2024, higher than for any other drug. This represents an age-standardised rate of 5.9 deaths per 100,000 people (ABS 2025, Table 13.11). The number and rate of alcohol-induced deaths has risen over the past decade, from 1,362 deaths in 2015 (5.2 per 100,000 people) (ABS 2025, Table 13.11).

Among all alcohol-induced deaths in 2024:

- 9 in 10 (90%, or 1,585) deaths were related to chronic conditions such as liver cirrhosis, while the remainder were due to acute conditions such as alcohol poisoning (10% or 180 deaths).
- The death rate was higher for males than females (8.9 compared with 3.0 deaths per 100,000 population, respectively).
- The median age at death was 58.4 years (ABS 2025, tables 13.11, 13.15 and 13.16).

AIHW analysis of the National Mortality Database showed that of the 1,765 alcohol-induced deaths registered in 2024:

- The highest age-specific rates were for older people – 16 per 100,000 population for those aged 55–64 and 13 for those aged 45–54 (Table NMD6).
- The majority (74% or 1,311 deaths) were recorded for males (Table NMD5).
- Almost half (47% or 837 deaths) recorded mental and behavioural disorders due to psychoactive substance use as an associated cause of death (that is, a factor that contributed to the death but was not the underlying cause of death) (Table NMD8).

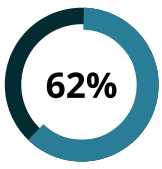
For related content on deaths in this report, see Deaths involving alcohol and other drugs.

How many people receive treatment for alcohol use?

Alcohol cessation medicines

Data from Australia's Pharmaceutical Benefits Scheme (PBS) provide information about prescription medicines that are used to help people stop or reduce their alcohol consumption (alcohol cessation medicines), including the number of prescriptions dispensed and the number of patients dispensed a script. Data from the PBS show that rates of dispensing for alcohol cessation medicines have risen between 2012–13 and 2024–25 (tables PBS78 and PBS80).

Specialist treatment for alcohol use



of treatment episodes provided to clients for their own use of alcohol in 2023–24 were for people who had previously received AOD treatment

Source: Alcohol and other drug treatment services in Australia report

Data from the Alcohol and other drug treatment services in Australia: early insights report show that alcohol continues to be the most common principal drug of concern (AIHW 2026). Alcohol was the principal drug of concern in more than 2 in 5 (41%, around 87,600) treatment episodes provided to people for their own drug use in 2024–25, stable from 42% (around 91,400 episodes) in 2023–24 and up from 32% (around 63,200) in 2015–16 (AIHW 2026).

Data collected for the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) are released twice each year, via an early insights report in April and a detailed annual report mid-year. The section below will be updated with information from the annual report once these data become available.
Of the 49,552 clients who received treatment for alcohol as their principal drug of concern in 2023–24:

- 3 in 5 (60%) were male (AIHW 2025a, Table SC.9).
- 1 in 4 (26%) clients were aged 40–49 and a further 1 in 4 (25%) were aged 30–39 (AIHW 2025a, Table SC.10).
- 1 in 6 (17%) were First Nations people (AIHW 2025a, Table SC.11).

Additionally, 62% (56,679) of treatment episodes provided to clients for their own use of alcohol in 2023–24 were for people who had previously received AOD treatment since 2013–14 (AIHW 2025a, Table SCR.28a).

For detailed information on alcohol cessation medicines and alcohol and other drug treatment in this report, see:

- Alcohol and other drug treatment services
- Availability of smoking and alcohol cessation medicines in Australia

Where do I go for more information?

- Risky alcohol consumption in the NDSHS
- Support for alcohol and other drug-related policies

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Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Cannabis

In this section

Introduction

What is cannabis?

The 2 most common subspecies within the cannabis genus from which cannabis is harvested are Cannabis sativa and Cannabis indica. Cannabis comes in 3 main forms:

- herbal cannabis (also referred to as marijuana) – the dried leaves and flowers of the cannabis plant (the weakest form)
- cannabis resin (hashish) – the dried resin from the cannabis plant
- cannabis oil (hashish oil) – the oil extracted from the resin (the strongest form) (ACIC 2021; NDARC 2017).

Cannabis is most commonly smoked in a rolled cigarette (joint) or water pipe, often in combination with tobacco, but it may also be added to food and eaten. Cannabis oil is generally applied to cannabis herb or tobacco and smoked or heated and the vapours inhaled (ACIC 2021).

The main psychoactive component of the cannabis plant is delta-9-tetrahydrocannabinol (THC). THC is highest in the flowering tops and leaves of the plant. Other than THC, cannabis has more than 70 unique chemicals that are collectively referred to as cannabinoids (ACIC 2018). Cannabis is a central nervous system depressant, but also alters sensory perceptions and may produce hallucinogenic effects when large quantities are used (ACIC 2018; NDARC 2017). The use of cannabis for medicinal purposes was legislated by the Australian parliament in 2016.

Synthetic cannabinoids are a new psychoactive substance that was originally designed to mimic or produce similar effects to cannabis (Alcohol and Drug Foundation 2017). The availability, consumption and harms associated with synthetic cannabis are discussed further in the section on new psychoactive substances (NPS).

Cannabis continues to be the most widely used illicit drug in Australia and one of the most commonly used drugs internationally, noting that the legal status of cannabis differs across countries. Globally in 2024, around 224 million people aged 15–64 reported using cannabis in the past year (UNODC 2025). This represents around 4.6% of adults worldwide (UNODC 2024).

While most people who use cannabis do not experience adverse effects, cannabis use is associated with a range of harms including morbidity and mortality. The social cost of cannabis use was estimated to be $5.1 billion in 2020–21, projected to rise to $5.2 billion in 2022–23 (Gadsden et al. 2023, Table 1). More than half ($2.8 billion) of the projected costs for 2022–23 were related to the criminal justice system, including imprisonment, administering community supervision orders and the impact on victims of crime (Gadsden et al. 2024, Table 3).

This page focuses on cannabis use, treatment and harms in Australia. The reporting uses data from a range of sources, mostly national administrative and survey data. For related content on cannabis policies and laws, see Policy context.

Key findings

- Cannabis continues to be the most widely used illicit drug in Australia
- The number of people who report using cannabis for medical purposes remained stable between 2019 and 2022–2023, but more people are accessing it with a prescription
- Ambulance attendances and hospitalisations for cannabinoids most often involve males and people in their 30s and under
- Cannabis is among the most common drugs for which people seek treatment, accounting for 16% of alcohol and other drug treatment service episodes in 2023–24

What data sources are available?

Data sources for cannabis use, treatment and harms

- Alcohol and other drug treatment services in Australia
- Australian Burden of Disease Study
- Causes of Death, Australia

- Ecstasy and Related Drugs Reporting System
- Household, Income and Labour Dynamics in Australia (HILDA) survey
- Illicit Drug Reporting System
- National Ambulance Surveillance System
- National Drug Strategy Household Survey
- National Hospital Morbidity Database
- National Mortality Database
- World Drug Report

There are a range of data sources available examining cannabis use, harms and treatment in Australia, including surveys, administrative data and burden of disease analysis.

For more information about each data source, see Technical notes.

What do we know about cannabis availability in Australia?

Surveys of people who regularly use illicit drugs indicate that cannabis is readily available in Australia. Cannabis also accounts for a high proportion of illicit drug seizures, arrests and border detections each year.

For detailed information on cannabis availability, see Illicit drug markets and drug-related law enforcement activities.

What do we know about people who use cannabis?

How many people use cannabis and has it changed over time?

11.5% of the general population in Australia had recently used cannabis in 2022–2023

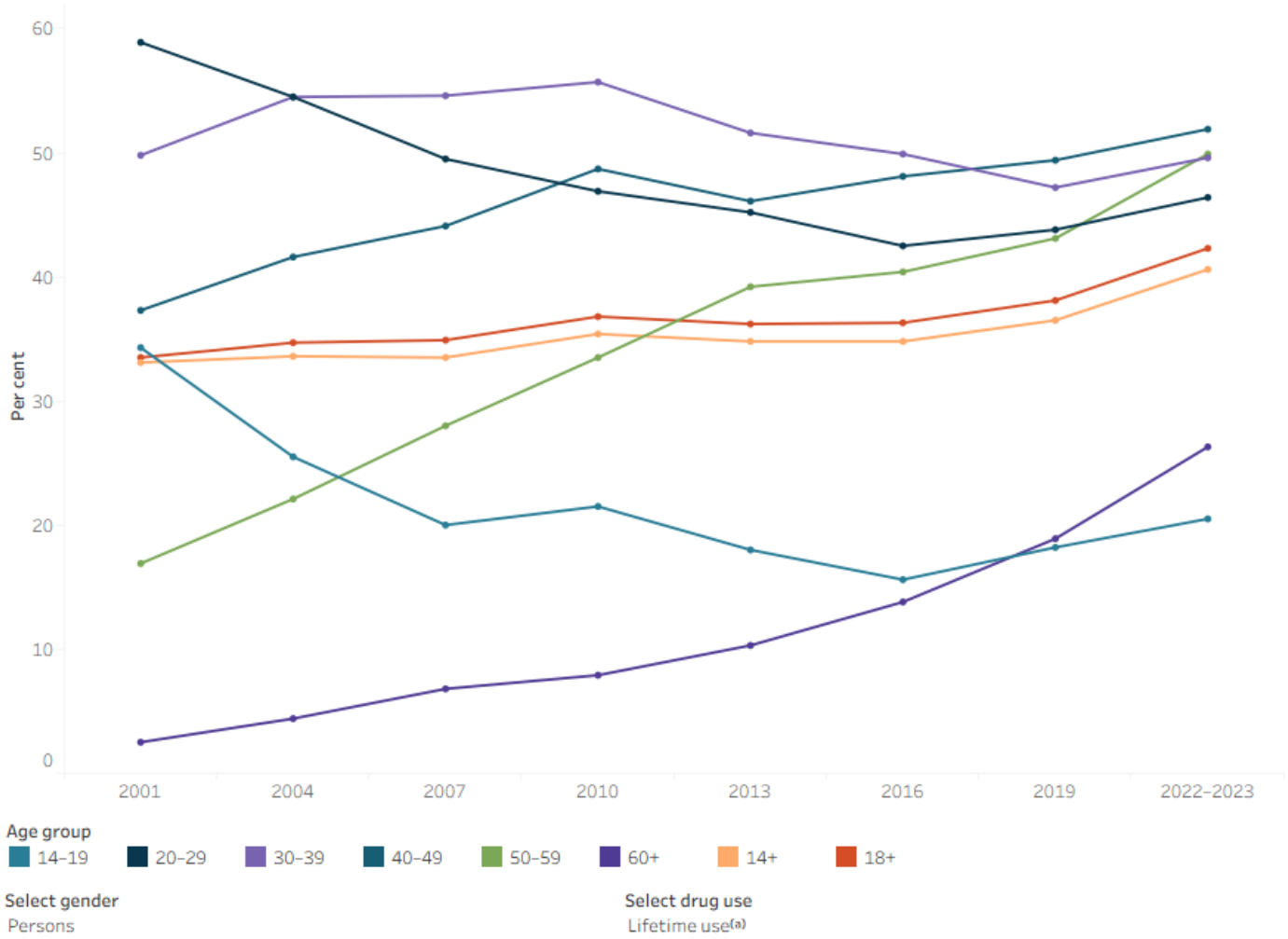
Source: National Drug Strategy Household Survey

The 2022–2023 National Drug Strategy Household Survey (NDSHS) showed that cannabis continues to have the highest reported prevalence of lifetime and recent consumption among the general population in Australia, compared with other illicit drugs (AIHW 2024b, tables 5.2 & 5.6). For people aged 14 and over in 2022–2023:

- 41% had used cannabis in their lifetime and 11.5% had used cannabis in the previous 12 months (Figure 1).
- The lifetime use of cannabis has increased from 33% in 2001 while recent use of cannabis has decreased from 12.9%.
- Daily cannabis use among people who had recently used it has increased from 14% in 2019 to 18% in 2022–2023 (AIHW 2024b, tables 5.2, 5.6 & 5.33).

Wastewater monitoring also shows that cannabis is one of the most consumed drugs in Australia, though this analysis cannot distinguish medicinal and illicit cannabis use (ACIC 2025). For more information on wastewater monitoring, see Remoteness areas – What does Wastewater monitoring tell us?.

Figure 1: Lifetime[a] or recent[b] use of cannabis, people aged 14 and over, by age and gender, 2001 to 2022–2023



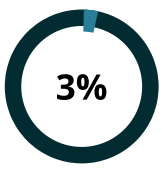
(a) Used at least once in lifetime.
(b) Used in the previous 12 months.
Note: Excludes people that only used marijuana/cannabis that was pescribed by a doctor, and only used it for medical purposes.
Source: AIHW 2024. Supplementary tables 5.48 and 5.50.

http://www.aihw.gov.au

How many people use cannabis for medicinal purposes?

What is medicinal cannabis?

Medicinal cannabis generally refers to medicinal products that contain Tetrahydrocannabinol (THC) or Cannabidiol (CBD) (Healthdirect 2022). Access to medicinal cannabis was legalised in Australia in 2016 and went through substantial changes in 2021. These changes were designed to improve accessibility, by making it easier for prescribers to be authorised to prescribe medicinal cannabis and making it easier for patients to change to different medicinal cannabis products (NPS MedicineWise 2022). Medicinal cannabis typically refers to use of cannabis that is prescribed by a health care professional. However, in the 2022–2023 National Drug Strategy Household Survey, use includes that where a respondent received a diagnosis and prescription from a medical professional, as well as cases where the respondent has used cannabis for self-determined medical purposes.



of people aged 14 and over in Australia reported using cannabis for medical purposes in the previous 12 months in 2022–2023, a small increase from 2019

Source: National Drug Strategy Household Survey

The NDSHS captures information on people who reported using any form of cannabis for self-described medicinal purposes, including people who had cannabis prescribed to them by a medical professional and those who may have obtained it illicitly (AIHW 2024b). NDSHS estimates on the prevalence of medicinal cannabis use may differ from other data sources, such as data from the Therapeutic Goods Administration (TGA) on use of medicinal cannabis products.

In 2022–2023, the NDSHS found 3.0% of people aged 14 and over in Australia reported using cannabis for medical purposes in the previous 12 months. This was a small increase from 2019, but the total number of people in Australia who reported using cannabis for medical purposes in the NDSHS did not change substantially (AIHW 2024b). One in 3 (or 1.0% nationally) reported that they had used cannabis exclusively for medical purposes, an increase from 0.8% in 2019 (AIHW 2024b, Table 8.1). Additionally, of people aged 14 and over who had used cannabis in the previous 12 months:

- 22% were always prescribed by a doctor, an increase from 1.8% in 2019 (AIHW 2024b, Table 8.3), potentially reflecting better accessibility to medicinal cannabis prescriptions.
- 48% reported being diagnosed or treated for chronic pain (AIHW 2024b, Table 8.7).
- Of those who used cannabis only for medical purposes, and were prescribed by a doctor, 64% used medicinal cannabis products (for example, pharmaceutical CBD/THC oil) (AIHW 2024b, Table 8.9).

Compared with people who did not use cannabis for medical purposes, people who had recently used cannabis for medical purposes only (and were prescribed by a doctor) were:

- typically, older (39% aged 50 and over) than people who used cannabis non-medically (18%)
- more likely to live in *Major city* areas (63%) than *Outer regional* (15.3%) or *Remote and very remote* areas (*2.4%) (AIHW 2024b, Table 8.6).

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

For related content on regulations on medicinal cannabis in this report, see Policy context.

Does cannabis use differ by age and gender?

Almost 1 in 4

people aged 20–29 had used cannabis in the previous 12 months in 2022–2023

Source: National Drug Strategy Household Survey

Recent cannabis use has declined among people in younger age groups and increased among those in their 40s and over in recent years (AIHW 2024b). However, people in their 20s continue to be the most likely to use cannabis. The most recent NDSHS showed that:

- Recent cannabis use among those aged 20–29 fell from 29% in 2001 to 23% in 2022–2023.
- Males aged 14 and over were more likely to have recently used cannabis (13.1%) than females (9.8%) in 2022–2023 (AIHW 2024b, Table 5.50).

Cannabis is used more frequently than other drugs such as ecstasy and cocaine. Specifically, 21% of people who used cannabis did so as often as weekly or more, compared with only 2.2%* and 3.2% of people who use ecstasy and cocaine, respectively. Males were more likely than females to use cannabis weekly (22% compared with 19%) (AIHW 2024b, Table 5.33).

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

Are people using cannabis with other drugs?

Around 3 in 4

people who had recently used cannabis in 2022–2023 reported using it with alcohol

Source: National Drug Strategy Household Survey

Polydrug use is defined as mixing or taking another illicit or licit drug whilst under the influence of another drug. Cannabis use is also highly correlated with the use of tobacco, alcohol, and other drugs. This makes measuring the effects of cannabis alone difficult and potentially increases risks for people who use cannabis.

Data from the NDSHS showed that the use of other drugs with cannabis increased between 2016 and 2019 but subsequently declined across all reported drug types to 2022–2023 (AIHW 2024b, Table 5.61). The most common other drugs concurrently used by people who had recently used cannabis were:

- alcohol (74% of people aged 14 and over who had recently used cannabis)
- tobacco (41%)
- cocaine (11.4%)
- ecstasy (10.5%)
- hallucinogens (9.9%) (AIHW 2024b, Table 5.61).

Analysis of NDSHS data indicated that poly drug use varied among different population groups:

- Males were more likely than females to have used alcohol, tobacco, or any illicit drug at the same time as cannabis in 2022–23.
- People in their 50s were more likely than those in other age groups to have used cannabis at the same time as alcohol or tobacco, while those in their 20s were the most likely to have used it with an illicit drug (AIHW 2024b).

Data on alcohol and other drug-related ambulance attendances are sourced from the National Ambulance Surveillance System (NASS), including six Australian states and territories (excludes Western Australia and South Australia). In 2024, the proportion of cannabis-related ambulance attendances where multiple drugs were involved was 45% (Table NASS5).

Data is available for the most common drug combinations resulting in ambulance attendances. For such data relating to cannabis, see Data tables: National Ambulance Surveillance System.

Does cannabis use differ by geographic area?

Since 2010, there have been slight increases in the proportion of recent cannabis use across most states and territories, remoteness areas and socioeconomic areas (AIHW 2024b).

Detailed information on cannabis by geographic areas within Australia, including state and territory data, is available in Geographic areas.

For related content on cannabis use among specific population groups in this report, see Population groups.

What are the harms associated with cannabis use?

The effects of cannabis (like all drugs) vary from one person to another including, but not limited to, the amount consumed, the mode of administration, previous experience, mental health and mood, and body weight (NDARC 2017). The active drug in cannabis makes its way into the bloodstream more quickly when cannabis is smoked, compared to when it is orally ingested. Ongoing and regular use of cannabis is associated with a number of negative long-term effects. People who use cannabis regularly can become dependent and commonly reported symptoms of withdrawal include anxiety, sleep difficulties, appetite disturbance and depression (Hall and Degenhardt 2009; Nielsen and Gisev 2017).

An overview of some of the short and long-term effects of cannabis are provided in Table 1.

Table 1: Effects of cannabis

Short-term effects	Long-term effects
• Mild euphoria, relaxation and reduced inhibitions • Perceptual alterations, including time distortion and intensification of ordinary experiences • Feelings of hunger • Panic reactions, confusion and feelings of paranoia • Nausea, headache and reddened eyes • Increased heart rate for up to 3 hours after smoking • Dizziness, with impaired balance and coordination	• Physical dependence • Upper respiratory tract cancers, chronic bronchitis and permanent damage to the airways when smoked • Cardiovascular system damage • Mental health conditions including depression and schizophrenia • Poor adolescent psychosocial development

Source: Adapted from (Hall and Degenhardt 2009; Nielsen and Gisev 2017; NDARC 2017).

How does cannabis use contribute to the burden of disease and injury?

The Australian Burden of Disease Study 2024 found that cannabis use contributed to 0.2% of the total burden of disease and injuries in 2024 and 6.9% of the total burden due to illicit drugs (AIHW 2024a, Table S6). Cannabis use contributed 11.6% of the total burden due to drug use disorders (excluding alcohol), 2.6% of the burden due to schizophrenia and 2.5% of the burden due to poisoning (AIHW 2024a, Table S6).

For related content on the burden of disease due to alcohol and other drugs in this report, see Burden of disease and injuries related to alcohol and other drugs.

Cannabis-related ambulance attendances

Updated

In 2024, people aged 15–24 had the highest rate of cannabis-related ambulance attendances

Source: National Ambulance Surveillance System

There were nearly 20,600 cannabis-related ambulance attendances among people aged 15 and over in 2024, or 112 per 100,000 population (Table NASS3). Among these attendances:

- almost 3 in 5 (59%) were for males
- attendances were typically for a younger cohort of people, with the highest rate of attendances for people aged 15–24 (230 per 100,000 population) (Table NASS3).

Between 2021 and 2023, the rate of cannabis-related ambulance attendances overall increased from 96 to 104 per 100,000 population. The rate further rose between 2023 and 2024, to 112 per 100,000 population, with increases in attendances across all states and territories with available data, except Victoria.

In Victoria, attendances decreased from around 4,700 (84 per 100,000 population) in 2023 to around 3,100 (54 per 100,000 population) in 2024. This is explained by industrial action by paramedics in Victoria between March and September 2024, which resulted in fewer ambulance attendances being captured over that period. Therefore, the national data for 2024 is also lower than expected and should be interpreted with caution (Table NASS3).

For related content on alcohol and other drug-related ambulance attendances in this report, see Alcohol and other drug-related ambulance attendances.

Cannabis-related hospitalisations

There were 6,878 cannabinoid-related hospitalisations in 2023–24

Source: National Hospital Morbidity Database

Cannabinoids accounted for around 1 in 20 drug-related hospitalisations in 2023–24 (4.7% or 6,878 hospitalisations), a rate of 25.5 hospitalisations per 100,000 people (tables NHMD3 and NHMD4) (see Figure 3). This represents an overall decrease from 2020–21 (7,488 hospitalisations, or 29.2 per 100,000), following previous increases from 2015–16 (Table NHMD4).

Among cannabis-related hospitalisations in 2023–24:

- 2 in 3 (66% or 4,561 cannabis-related hospitalisations) involved an overnight stay, while the remainder ended with a same-day discharge.
- Almost 3 in 5 (59% or 4,066 hospitalisations) were for males.
- Around 3 in 5 (61% or 4,167) were for people aged 15–34, including 1 in 3 (33% or 2,284) among people aged 25–34 (tables NHMD1–NHMD3).

For related content on alcohol and drug-related hospitalisations in this report, see Alcohol and other drug-related hospitalisations.

Deaths involving cannabinoids

Updated

There were 43 cannabinoid-induced deaths in 2024

Source: National Mortality Database

AIHW analysis of the National Mortality Database showed that in 2024, cannabinoids were directly involved in 2.2% (or 43) of all drug-induced deaths, a decrease from 16.4% (325 deaths) in 2018 (Table NMD2). These numbers should be interpreted with caution due to a recent coding change surrounding the determination of the involvement of cannabis in drug-induced deaths. Prior to 2020, cannabis detected in the blood of a person who died from a multi-drug toxicity was assigned to T40.7 '*Poisoning by cannabis (derivatives)*'. Since 2020, T40.7 is assigned to drug-induced deaths only when cannabis is determined by the pathologist as contributing to the toxicity. Where cannabis is detected in the blood, but is not specified as contributing to the toxicity, it is coded as R78.3 '*Finding of hallucinogen in blood*'. For more information, see Technical notes.

The short-term effects of cannabis can increase the risk of road traffic crashes, largely due to diminished driving performance in response to emergencies (Hall and Degenhardt 2009). In 2016, cannabis was the second most common drug identified as contributing to deaths from transport accidents (among transport accident deaths involving drugs excluding alcohol) (ABS 2017).

For related content on deaths involving alcohol and other drugs in this report, see Deaths involving alcohol and other drugs.

How many people receive specialist treatment for cannabis use?

of cannabis-related treatment episodes in 2023–24 were referred via diversion from the criminal justice system

Source: Alcohol and other drug treatment services in Australia report

Data from the Alcohol and other drug treatment services in Australia: early insights report show that cannabis was the third most common principal drug of concern in 2024–25, representing 14% (around 30,300) of treatment episodes provided to clients for their own drug use. Over the 10 years to 2024–25, this proportion decreased from 23% (around 45,000 episodes) in 2015–16 (AIHW 2026).

Data collected for the Alcohol and Other Drug Treatment Services National Minimum Data Set are released twice each year, via an early insights report in April and a detailed annual report mid-year. The section below will be updated with information from the annual report once these data become available.
Of the 21,028 clients who received treatment for cannabis as their principal drug of concern in 2023–24:

- Around 3 in 5 (58%) were male (AIHW 2025, table SC.9).
- Almost two-thirds were aged either 10–19 (30% of clients) or 20–29 (34%) (AIHW 2025, Table SC.10).
- Over 1 in 5 (23%) were Aboriginal and Torres Strait Islander (First Nations) people (AIHW 2025, Table SC.11).

Additionally, of all treatment episodes provided to clients for their own use of cannabis in 2023–24:

- Around half (51% or 17,265) were for people who had previously received AOD treatment since 2013–14 (AIHW 2025, Table SCR.28a).
- 1 in 6 (17% or 5,968) were provided to clients who had been referred via a drug diversion program, down from 38% (14,919) in 2014–15 (AIHW 2025, Table Drg.13).

For more information on alcohol and other drug treatment in this report, see Alcohol and other drug treatment services.

Where do I go for more information?

- Cannabis in the NDSHS
- Medicinal cannabis hub

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Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Amphetamines and other stimulants

In this section

Introduction

What are stimulants?

Stimulants are a group of drugs that produce stimulatory effects by increasing nerve transmission in the brain and body (Nielsen and Gisev 2017). These drugs are sometimes referred to as amphetamine-type stimulants (ATS), which covers a large range of drugs including:

- methamphetamine (also referred to as methylamphetamine), a potent derivative of amphetamine that is commonly found in 3 forms: powder (speed), base and its most potent form, crystalline (ice or crystal)
- other amphetamines, which may be used for therapeutic purposes (for example, to treat attention deficit-hyperactivity disorder), but may also be used non-medically.
- 3, 4-methylenedioxymethamphetamine (MDMA), an amphetamine derivative that is commonly referred to as 'ecstasy'. MDMA/ecstasy is often consumed in the form of a tablet or capsules but can also be in powder or crystal form, and may contain a range of other substances or no MDMA/ecstasy at all
- cocaine, which is produced from a naturally occurring alkaloid found in the coca plant. Cocaine is commonly found in powder form.

The focus in this section is on the illicit use of amphetamines and other stimulants. Information on non-medical use of amphetamines is included in Pharmaceutical drugs.

Stimulant use contributes to a range of harms in Australia, including health and social impacts. The estimated social cost of methamphetamine use in 2020–21 was $5.9 billion, projected to rise to $6.1 billion in 2022–23 (Gadsden et al. 2024, Table 1). Most of the projected costs in 2022–23 were related to crime and criminal justice expenditure ($3.9 billion) (Gadsden et al. 2024, Table 3).

This page focuses on amphetamine and other stimulant use, treatment and harms in Australia. The reporting uses data from a range of sources, mostly national administrative and survey data. For related content on laws and policies related to amphetamines and other stimulants and law enforcement activities including seizures and arrests, see Policy context.

Key findings

- In 2022–2023, 1% of people in Australia aged 14 and over had recently consumed methamphetamine and amphetamine
- Recent cocaine use was similar between 2019 (4.2%) and 2022–2023 (4.5%)
- Amphetamines and other stimulants (including methamphetamine) accounted for 12% of drug-related hospitalisations in 2023–24, while cocaine accounted for an additional 0.9%
- Amphetamines continue to be among the most common drugs of concern for which people receive publicly funded treatment (26% of treatment episodes in 2023–24)

What data sources are available?

Data sources for amphetamine and other stimulant use, treatment and harms

- Alcohol and other drug treatment services in Australia
- Australian Burden of Disease Study
- Ecstasy and Related Drugs Reporting System
- Household, Income and Labour Dynamics in Australia (HILDA) survey
- Illicit Drug Data Report
- Illicit Drug Reporting System
- National Ambulance Surveillance System
- National Drug Strategy Household Survey
- National Hospital Morbidity Database
- National Mortality Database

There are a range of data sources that contain information about amphetamine and other stimulant use, treatment and harms. These include self-report surveys that ask people about their use of amphetamines and other stimulants, health administrative data sets (such as administrative data routinely collected by hospitals), and burden of disease analysis. Each data set uses a different methodology, and the language used to describe amphetamines and other stimulants may also differ across sources.

Data sources on methamphetamine, amphetamine and other psychostimulants contain a variety of terms. In some instances, these terms cover similar but not the same range of drugs.

For more information about each data source, see Technical notes.

What do we know about amphetamine and other stimulant availability in Australia?

Surveys of people who regularly use illicit drugs indicate that amphetamines and other stimulants are readily available in Australia. Amphetamines and other stimulants also account for a high proportion of illicit drug seizures, arrests and border detections each year.

For detailed information on the availability of amphetamines and other stimulants, see Illicit drug markets and drug-related law enforcement activities.

What do we know about people who use amphetamines and other stimulants?

How many people use amphetamines and other stimulants and has it changed over time?

of people aged 14 and over in Australia had recently used methamphetamine and amphetamine in 2022–2023

Source: National Drug Strategy Household Survey

In 2022–2023, 59% of people who had recently used MDMA/ecstasy and 58% of people who had recently used cocaine reported doing so once or twice a year

Source: National Drug Strategy Household Survey

There are differences in trends and patterns of consumption in Australia according to the type of stimulant used. General population survey data from the National Drug Strategy Household Survey (NDSHS) indicate that more people in Australia report recent use of cocaine and MDMA/ecstasy than methamphetamine and amphetamine (AIHW 2024b). However, data from the National Wastewater Drug Monitoring Program (NWDMP) show that methylamphetamine is consistently the second most consumed illicit drug (behind cannabis) measured in wastewater, with higher levels of use than either cocaine or MDMA/ecstasy. In 2023–24, the estimated methylamphetamine consumption across Australia was 12,815 kilograms, compared with 6,835 kilograms for cocaine and 1,430 kilograms for MDMA (ACIC 2025).

These differences may indicate that while fewer people use methamphetamine than cocaine or MDMA/ecstasy, those who do may use it more frequently or in higher quantities. This is supported by data from the NDSHS showing that almost 1 in 4 people (23%) who used methamphetamine and amphetamine recently did so at least once a week or more, compared with 3.2% for cocaine and 2.2%* for MDMA/ecstasy (*estimate has a relative standard error of 25–50% and should be used with caution) (AIHW 2024b, Table 5.33).

The difference may also be due to differences in methodologies between the NDSHS and NWDMP collections, including that NWDMP data cannot distinguish between use of illicit consumption and consumption of prescribed stimulants (for example, ADHD medications such as lisdexamfetamine and dexamfetamine) (ACIC 2025).

For related content on wastewater monitoring in this report, see Wastewater drug monitoring.

Methamphetamine and amphetamine

The National Drug Strategy Household Survey (NDSHS) uses the term “methamphetamine and amphetamine”, which includes methamphetamine and amphetamine. Prior to 2022–2023, the NDSHS used the term “meth/amphetamines”, which also included the non-medical use of pharmaceutical amphetamines such as Ritalin (methylphenidate) and pseudoephedrine-based cold and flu tablets. The change in terminology was implemented to improve national estimates for use of methamphetamine and amphetamine and improve the understanding of the questions among people who had used methamphetamine and amphetamine.

The 2022–2023 NDSHS reported 1.0% of people aged 14 and over in Australia had used methamphetamine and amphetamine in the last 12 months, whereas 7.5% had used methamphetamine and amphetamine in their lifetime (AIHW 2024b, tables 5.2 and 5.6). Most people who had used methamphetamine and amphetamine recently had used powder/speed at some point in their lifetime (67%), followed by crystal/ice (55%) (AIHW 2024b, Table 5.85).

Data from the 2025 Ecstasy and Related Drugs Reporting System (EDRS) and Illicit Drug Reporting System (IDRS) indicate that use of methamphetamine is relatively common among people who regularly use illicit drugs:

- 29% of participants in the EDRS reported use of any form of methamphetamine in the previous 6 months in 2025, stable from 25% in 2024. Methamphetamine use has steadily declined since monitoring began (84% in 2003) (Sutherland et al. 2025a).
- 82% of participants in the IDRS reported use of any form of methamphetamine in the previous 6 months, stable relative to 2024 (82%). Methamphetamine use previously declined from 89% in 2003 to 60% in 2010, before rising and then stabilising in recent years (Sutherland et al. 2025b).

Methamphetamine powder was the most reported form used among EDRS participants from 2003 until 2021, when use of crystal became more common. Use of crystal methamphetamine in the preceding 6 months has remained stable over the last 10 years (19% in 2015 compared with 20% in 2025) (Sutherland et al. 2025a, Figure 16).

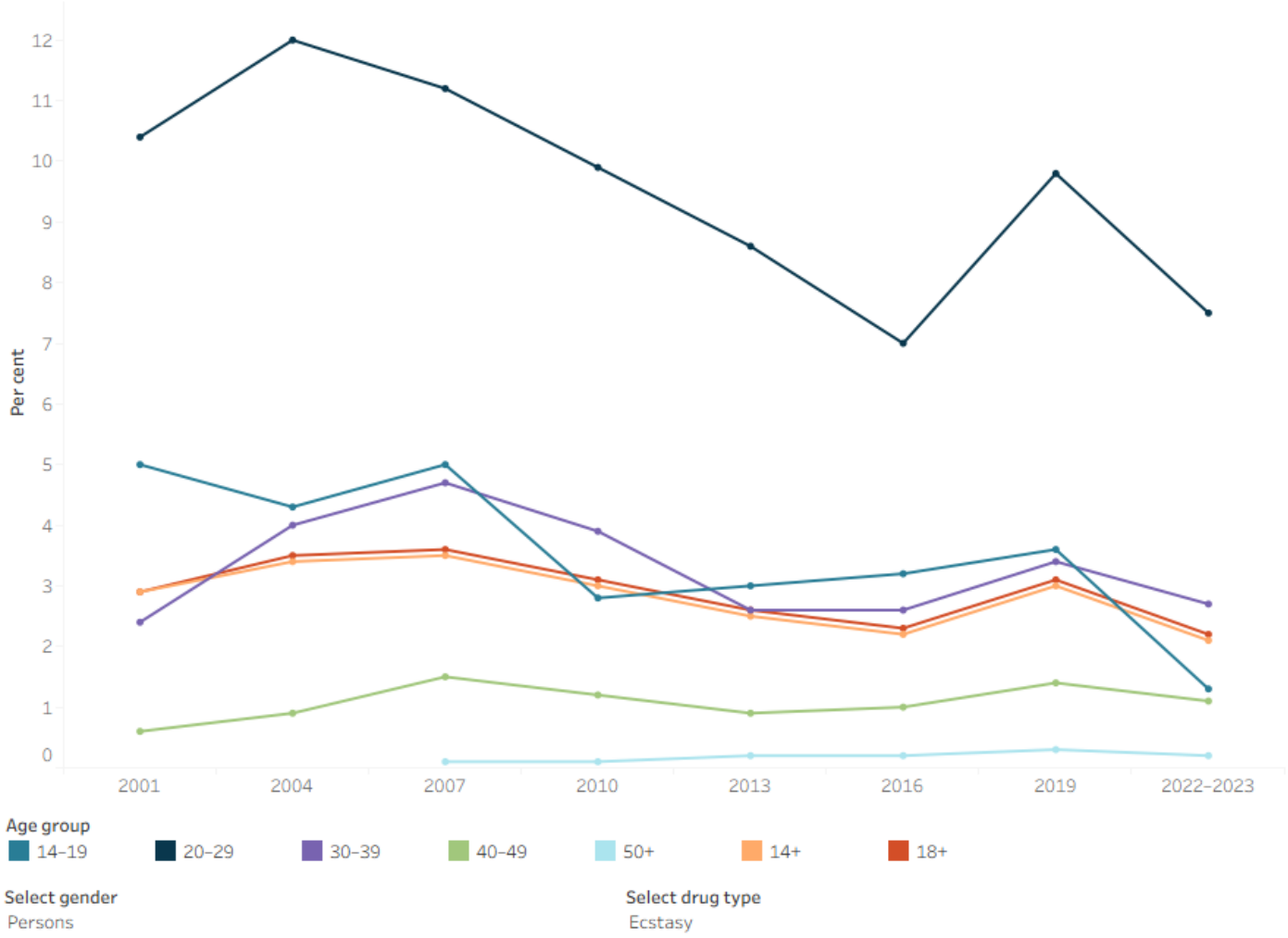
For related content on use of alcohol and other drugs among people who inject drugs in this report, see Experiences of alcohol and other drugs among people who inject drugs.

Ecstasy

The 2022–2023 NDSHS found:

- 2.1% of people aged 14 and over in Australia used ecstasy in the previous 12 months, a decrease since 2019 (3.0%) (Figure 1). This may be due to disruptions in the ecstasy market between 2019 and 2022–2023 due to seizures of ecstasy and detections of ecstasy laboratories and COVID-19 disruptions to festivals, raves/dance parties (AIHW 2024b). Early evidence from 2023 suggests that use may already be increasing again.
- Most people (59%) who had recently used ecstasy reported using it once or twice a year, while almost 1 in 3 (31%) reported using it every few months (AIHW 2024b, Table 5.33).

Figure 1: Recent[a] use of cocaine or ecstasy, people aged 14 and over, by age and gender, 2001 to 2022–2023



(a) Used in the last 12 months.
(b) Included 'designer drugs' before 2004.
Source: AIHW 2024. Supplementary tables 5.65 and 5.73.

http://www.aihw.gov.au

Cocaine

The 2022–2023 NDSHS found:

- 4.5% of people aged 14 and over in Australia used cocaine in the last 12 months, similar to 2019 (4.2%) (Figure 1).
- Most people (58%) who used cocaine recently reported doing so once or twice a year, and over 1 in 4 (27%) used it every few months (AIHW 2024b, Table 5.33).
- Cocaine was the second most used illicit drug, after marijuana/cannabis.
- The proportion of people who reported recent use of cocaine was 3.5 times higher than the level reported in 2001 (1.3% in 2001 compared with 4.5% in 2022–2023 (AIHW 2024b, Table 5.65).

For participants of the EDRS, cocaine was the second most commonly used stimulant drug (after MDMA/ecstasy), with 79% reporting use in the past 6 months in 2025. More than 9 in 10 (96%) of these participants reported using cocaine in powder form. Recent cocaine use has remained stable from 2021 following previous rises (Sutherland et al. 2025a).

Does amphetamine and other stimulant use differ by age?

People aged 20–29

were the most likely age group to have recently used ecstasy (7.5%) and cocaine (11.8%) in 2022–2023

Source: National Drug Strategy Household Survey

The 2022–2023 NDSHS found:

- People aged 20–29 (1.7%), 30–39 (1.5%) and 40–49 (1.7%) had the highest proportions of recent methamphetamine and amphetamine use in 2022–2023.
- In 2022–2023, people aged 20–29 were more likely to have recently used MDMA/ecstasy (7.5%) and cocaine (11.8%) than those in other age groups (AIHW 2024b, Tables 5.65 and 5.73).
- Recent cocaine use remained stable between 2019 and 2022–2023 across all age groups, except those in their 30s where use increased from 6.5% in 2019 to 8.1% in 2022–2023 (AIHW 2024b, Table 5.65).

Does amphetamine and other stimulant use differ by gender?

Recent methamphetamine and amphetamine use was similar between males (1.1%) and females (0.9%) in 2022–2023

Source: National Drug Strategy Household Survey

The 2022–2023 NDSHS found:

- A similar proportion of males (1.1%) and females (0.9%) aged 14 and over reported recent methamphetamine and amphetamine use in 2022–2023 (AIHW 2024b, Table 5.83).
- A higher proportion of males than females reported recent MDMA/ecstasy use in 2022–2023 (2.5% compared with 1.6%) (AIHW 2024b, Table 5.73).
- The proportion of females who had recently used cocaine increased in 2022–2023 (3.7%), while recent use of cocaine remained stable among males (5.3%), narrowing the gap between males' and females' use (AIHW 2024b, Table 5.65) (Figure 1).

Are people using amphetamines and other stimulants with other drugs?

Polydrug use is defined as the use of mixing or taking another illicit or licit drug whilst under the influence of another drug. In 2022–2023, the NDSHS showed that among people who had used methamphetamine or amphetamine in the previous 12 months:

- Alcohol (71%) and tobacco (56%) were the most common other drugs used at the same time.
- Cannabis (48%) and MDMA/ecstasy (31%) were the most common illicit drugs used at the same time.
- *11.1% said they did not use any other illicit drug (AIHW 2024b, Table 5.96).

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

People who reported recent use of MDMA/ecstasy and cocaine also reported concurrent use of cannabis (38% and 26%, respectively) (AIHW 2024b, tables 5.69 and 5.79).

Data on alcohol and other drug-related ambulance attendances are sourced from the National Ambulance Surveillance System (NASS), including six Australian states and territories (excludes Western Australia and South Australia). In 2024, multiple drugs were involved in around:

- 2 in 5 (39%) amphetamine-related ambulance attendances
- 7 in 10 (69%) of cocaine-related attendances
- 3 in 4 (76%) of ecstasy-related attendances (Table NASS5).

Data is available for the most common drug combinations resulting in ambulance attendances. For such data relating to amphetamines and cocaine, see Data tables: National Ambulance Surveillance System.

Does amphetamine and other stimulant use differ by geographic area?

A higher proportion of people living in remote areas of Australia reported recent use of methamphetamine and amphetamine than people living in urban and regional areas. However, there was little variation in the recent use of methamphetamine and amphetamine across socioeconomic areas (AIHW 2024b, tables 9a.12 and 9a.14). Cocaine and MDMA/ecstasy use were higher among those who lived in cities or the highest socioeconomic areas.

Detailed information on amphetamines and other stimulants by geographic area is available in State and territory data, Remoteness areas, and Socioeconomic areas.

For related content on amphetamine and other stimulant use among specific population groups in this report, see Population groups.

What are the harms associated with amphetamine and other stimulant use?

The short and long-term effects associated with the use of methamphetamine and other stimulants are provided in Table 1.

Table 1: Short and long-term effects associated with the use of methamphetamine and other stimulants

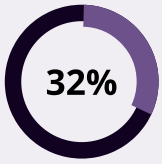
Drug type	Short-term effects	Long-term effects

Methamphetamine (includes powder, base and crystal/ice)	• Increased energy • Sense of euphoria and wellbeing • Increased attention and alertness • Increased talkativeness • Increased heart rate, breathing and body temperature • Decreased appetite • Jaw clenching and teeth grinding • Nausea and vomiting • A dry mouth • Changes in libido • Nervousness, anxiety and paranoia • Aggression and violence	• Mood and anxiety disorders • Cardiovascular problems • Haemorrhagic stroke • Poor concentration and memory • Psychotic symptoms such as paranoia and hallucinations • Weight loss • Chest pains
Ecstasy/MDMA	• Sense of euphoria and wellbeing • Feelings of intimacy with others • Confidence • Lack of inhibitions • Nausea • Sweating • Increased blood pressure and pulse rate • Jaw clenching and teeth grinding	• Depression • Anxiety • Memory and cognitive impairment
Cocaine	• Sense of euphoria and wellbeing • Increased blood pressure, heart rate and body temperature • Increased alertness and energy • Sexual arousal • Loss of appetite	• Sleep disorders • Sexual problems such as impotence • Nose bleeds, sinusitis and damage to the nasal wall from snorting • Cardiovascular problems • Stroke • Paranoia, depression and anxiety • Cocaine-induced psychosis

Source Adapted from ACIC 2019; Darke et al. 2017; NDARC 2017.

Data from the EDRS indicate that almost 1 in 5 (18%) EDRS participants reported experiencing a non-fatal stimulant overdose in the last 12 months in 2025 (Sutherland et al. 2025a).

How does amphetamine and other stimulant use contribute to the burden of disease and injury?



Amphetamine use was responsible for 32% of the disease burden of drug use disorder (excluding alcohol) in 2024

Source: Australian Burden of Disease Study

The Australian Burden of Disease Study 2024 found that amphetamine use was responsible for 0.7% of the total burden of disease and injuries in Australia in 2024 and 25% of the total burden due to illicit drug use (AIHW 2024a, Table S6). Amphetamine use was responsible for 32% of the disease burden of drug use disorder (excluding alcohol) and 22% of the burden due to poisoning (AIHW 2024a, Table S8).

Cocaine use contributed 0.3% of the total burden of disease and injuries in 2024 and 11% of the total burden due to illicit drug use (Table S6). Cocaine use contributed 11% to the burden due to drug use disorders (excluding alcohol) and 3.2% of the burden due to poisoning (AIHW 2024a, Table S8).

For related content on the burden of disease due to alcohol and other drugs in this report, see Burden of disease and injuries due to alcohol and other drugs.

Amphetamine and other stimulant-related ambulance attendances

Updated

The rate of amphetamine-related ambulance attendances overall rose from 74 to 90 per 100,000 population between 2021 and 2023, and continued to rise in 2024

Source: National Ambulance Surveillance System

In 2024, among people aged 15 and over, there were over 18,200 ambulance attendances involving amphetamines (99 per 100,000 population), 4,200 involving cocaine (23 per 100,000) and 2,300 involving ecstasy (13 per 100,000) (Table NASS3).

Among attendances for amphetamines, cocaine and ecstasy in 2024:

- more than half were for males (ranging from 59% for ecstasy to 68% for cocaine)

- the highest rate of attendances involving amphetamines was for people aged 25–34 (184 per 100,000 population), while for cocaine and ecstasy the highest rates were for those aged 15–24 (53 and 49 per 100,000, respectively) (Table NASS3).

Between 2021 and 2023, rates of ambulance attendances for amphetamines and cocaine overall rose, while for ecstasy, they remained stable. The rates further rose for all three drugs between 2023 and 2024, with increases in attendances across most states and territories with available data.

In Victoria, attendances decreased for all three drugs in 2024. This is explained by industrial action by paramedics in Victoria between March and September 2024, which resulted in fewer ambulance attendances being captured over that period. Therefore, the jurisdictional total data for 2024 is lower than expected and should be interpreted with caution (Table NASS3).

For related content on alcohol and other drug-related ambulance attendances in this report, see Alcohol and other drug-related ambulance attendances.

Amphetamine and other stimulant-related hospitalisations

Around 1 in 8 drug-related hospitalisations in 2023–24 had a principal diagnosis related to amphetamines and other stimulants

Source: National Hospital Morbidity Database

In this section, the term “amphetamines and other stimulants” refers to methamphetamine, MDMA/ecstasy and other amphetamine-type stimulants, while cocaine is reported separately.

Amphetamines and other stimulants (including methamphetamine) are among the most common illicit drugs involved in drug-related hospitalisations, with cocaine accounting for a lower rate of hospitalisations each year (Table NHMD4).

Around 1 in 8 (12% or 18,141) drug-related hospitalisations had a principal diagnosis related to amphetamines and other stimulants in 2023–24, of which 83% (15,067 hospitalisations) were for methamphetamine and 2.7% (493) were for MDMA/ecstasy. By comparison, 0.9% of all drug-related hospitalisations in the same year were for cocaine (1,322 hospitalisations) (tables NHMD3 and NHMD4).

In 2023–24, among all drug-related hospitalisations:

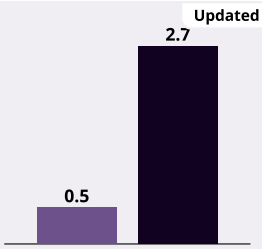
- Most (69% or 12,542) hospitalisations for amphetamines and other stimulants (including methamphetamine and MDMA/ecstasy) involved an overnight stay, compared with just over 2 in 5 (42% or 561) for cocaine-related hospitalisations.
- Males accounted for over 3 in 5 (62% or 11,273) hospitalisations for amphetamines and other stimulants, and over 4 in 5 (81% or 1,077) cocaine-related hospitalisations.
- People aged 25–44 accounted for around 2 in 3 hospitalisations amphetamines and other stimulants (67% or 12,137), while people aged 15–34 accounted for around 2 in 3 hospitalisations for cocaine (65% or 857), and rates of hospitalisation were also highest among these age groups (tables NHMD1–NHMD3).

There was a large increase in hospitalisations for methamphetamine between 2022–23 (11,300 or 42.9 per 100,000 population) and 2023–24 (15,067 or 55.9 per 100,000 population). There were slight increases in hospitalisations for cocaine and MDMA/ecstasy over the same period. This followed previous declines in hospitalisations for all three drugs from 2019–20 (Table NHMD4) (Figure 3, Alcohol and other drug-related hospitalisations).

For related content on alcohol and other drug-related hospitalisations in this report, see Alcohol and other drug-related hospitalisations.

Deaths involving amphetamines and other stimulants

The rate of deaths involving all psychostimulants has risen 5-fold between 2000 and 2024 (from 0.5 to 2.7 deaths per 100,000 population)



Source: National Mortality Database

The rate of drug-induced deaths related to methamphetamine and other stimulants has increased rapidly in recent years.

AIHW analysis of the National Mortality Database shows that the preliminary death rate for all psychostimulants (including amphetamines, methamphetamine, MDMA/ecstasy and caffeine) in 2024 was 2.7 per 100,000 population (714 deaths), 5 times as high as that in 2000 (0.5 per 100,000 population or 104 deaths) (Table NMD2). Over the same period, the rate of drug-induced deaths involving cocaine increased from 0.1 (27 deaths) to 0.5 (135 deaths) per 100,000 population (Table NMD2). Estimates for 2024 are expected to rise with standard revision processes.

Research examining methamphetamine-related deaths in isolation from other stimulants found that mortality rates almost doubled during a period of 7 years between 2009 and 2015. The most common manner of methamphetamine-related death was accidental drug toxicity, but natural disease (for example, coronary disease, stroke, kidney disease, and liver disease), suicide and accidents comprised more than half of the deaths (Darke et al. 2017).

For related content on deaths involving alcohol and other drugs in this report, see Deaths involving alcohol and other drugs.

Other harms

Mental health conditions are common among people who regularly use stimulants. Data from the EDRS show that nearly 3 in 5 (57%) people who regularly use illicit stimulants reported experiencing a mental health condition in the past 6 months in 2025 (Sutherland et al. 2025a). Among these people:

- depression (61%), anxiety (60%) and Attention-Deficit Hyperactivity Disorder (ADHD; 32%) were the most commonly reported conditions
- 57% had seen a mental health professional in the past 6 months (Sutherland et al. 2025a).

For related content on mental health conditions in this report, see Experiences of alcohol and other drugs among people with mental health conditions.

How many people receive treatment for amphetamine and other stimulant use?

of treatment episodes provided to clients for their own use of amphetamines in 2023–24 were for people who had previously received AOD treatment

Source: Alcohol and other drug treatment services in Australia report

29% of MDMA/ecstasy-related treatment episodes

21% of cocaine-related treatment episodes

were referred via diversion from the criminal justice system in 2023–24

Source: Alcohol and other drug treatment services in Australia report

Data from the Alcohol and other drug treatment services in Australia: early insights report show that in 2024–25:

Methamphetamine was the second most common principal drug of concern, accounting for 24% (around 50,900) of treatment episodes provided to people for their own drug use.

MDMA/ecstasy was the principal drug of concern in less than 1% (0.3%, or around 560) of episodes provided for clients' own drug use, down from 0.6% (or around 1,200 episodes) in 2015–16.

Cocaine was the principal drug of concern in 1.3% (around 2,800) of treatment episodes provided for clients' own drug use. The proportion of treatment episodes for cocaine has remained low over the 10-year period to 2024–25 but has increased from 0.3% (around 670) of episodes in 2015–16 (AIHW 2026).

Data collected for the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) are released twice each year, via an early insights report in April and a detailed annual report mid-year. The section below will be updated with information from the annual report once these data become available.

Amphetamines

The Alcohol and Other Drug Treatment Services National Minimum Data Set defines amphetamines according to the Australian Standard Classification of Drugs of Concern (ASCDC) (ABS 2011). Under this classification, "amphetamines" includes amphetamine, methamphetamine, dexamphetamine, amphetamine analogues and amphetamines not elsewhere classified. Information on methamphetamine as a principal drug of concern was reported for the first time in 2019–20 (AIHW 2025).

Of the 30,540 clients who received treatment for amphetamines as their principal drug of concern in 2023–24:

- around 3 in 5 (61%) were male
- almost 2 in 3 were aged either 30–39 (39% of clients) or 40–49 (25%)
- around 1 in 5 (21%) were Aboriginal and Torres Strait Islander (First Nations) people (AIHW 2025, tables SC.9–SC.11).

Additionally, of treatment episodes provided to clients for their own use of amphetamines as principal drug of concern in 2023–24:

- Almost 3 in 4 (74% or 42,596) were for people who had previously received AOD treatment since 2013–14 (AIHW 2025, Table SCR.28a).
- 1 in 4 (25% or 14,310) ended with an unplanned completion, the highest proportion out of all principal drug of concern categories (AIHW 2025, Table Drg.14).

MDMA/ecstasy

Of the 356 clients who received treatment for MDMA/ecstasy as their principal drug of concern in 2023–24:

- almost 3 in 4 (73%) were male
- 4 in 5 were aged either 10–19 (29% of clients) or 20–29 (51%)
- 7.0% were First Nations people (AIHW 2025, tables SC.9–SC.11).

The most common sources of referral for treatment episodes with MDMA/ecstasy as the principal drug of concern were diversion from the criminal justice system and self/family (29% of episodes each) (AIHW 2025, Table Drg.73).

Cocaine

Of the 1,858 clients who received treatment for cocaine as their principal drug of concern in 2023–24:

- over 4 in 5 (82%) were male
- almost half (47%) were aged 20–29, and 31% were aged 30–39
- 6.8% were First Nations people (AIHW 2025, tables SC.9–SC.11).

The most common sources of referral for treatment episodes with cocaine as the principal drug of concern were self/family (37% of episodes) and diversion from the criminal justice system (21%) (AIHW 2025, Table Drg.82).

For related content on alcohol and other drug treatment in this report, see Alcohol and other drug treatment services.

Where do I go for more information?

- Ecstasy and Related Drugs Reporting System
- Methamphetamine and amphetamine in the NDSHS

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Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Heroin

In this section

Introduction

What is heroin?

Heroin, also known as diacetylmorphine, is derived from the opium poppy (ACIC 2019; NDARC 2025). Heroin belongs to the same group of drugs as pharmaceutical opioids such as morphine and has similar effects in the body. Unlike pharmaceutical opioids, heroin is illegal and is not regulated in the same way as pharmaceutical opioids in Australia (Department of Health, Disability and Ageing 2024). Heroin may be snorted, swallowed, or smoked, but is usually melted from a powder or rock form and injected.

The availability of heroin in illicit drug markets in Australia has fluctuated over time. In the early 2000s, there was a rapid and considerable reduction in the availability of heroin (commonly referred to as the heroin shortage or drought) and this was associated with dramatic reductions in heroin-related overdoses (Degenhardt et al. 2004). Since then, the availability of heroin rose and later stabilised.

This page focuses on the harms, availability, consumption of and treatment for heroin, as distinct from pharmaceutical opioids. Pharmaceutical opioids (including morphine, methadone and oxycodone) have been regulated by health professionals and used as pharmaceuticals for medical purposes, including pain management and treatment for opioid dependence (NDARC 2016). The reporting uses data from a range of sources, mostly national administrative and survey data. For related content on use of pharmaceutical opioids in this report, see Pharmaceutical drugs.

Key findings

- Heroin use among the general population in Australia is low, with *0.1% reporting consumption in the last 12 months in 2022–2023
- Males and people aged in their 30s, 40s and 50s have the highest rates of ambulance attendances, hospitalisations and deaths involving heroin
- Of the 1,948 drug-induced deaths in Australia in 2024, 501 or 26% were due to heroin
- Heroin is one of the most common drugs for which people receive treatment, accounting for 4.3% of treatment episodes provided to people for their own drug use in 2023–24

What data sources are available?

Data sources for heroin use, treatment and harms

- Alcohol and other drug treatment services in Australia
- National Ambulance Surveillance System
- National Drug Strategy Household Survey
- National Hospital Morbidity Database
- National Mortality Database
- Trends in drug-related hospitalisations in Australia

Data on heroin use is predominantly sourced from surveys while harms data such as ambulance attendances, hospitalisations and deaths are sourced from administrative or computer systems.

For more information about each data source, see Technical notes.

What do we know about the availability of heroin in Australia?

Surveys of people who regularly inject drugs indicate that heroin is generally easy to obtain among people who regularly use it. Heroin accounts for a relatively small but rising proportion of the total illicit drug border detections, seizures and arrests in Australia each year.

For detailed information on heroin availability, see Illicit drug markets and drug-related law enforcement activities.

What do we know about people who use heroin?

How many people use heroin and has it changed over time?

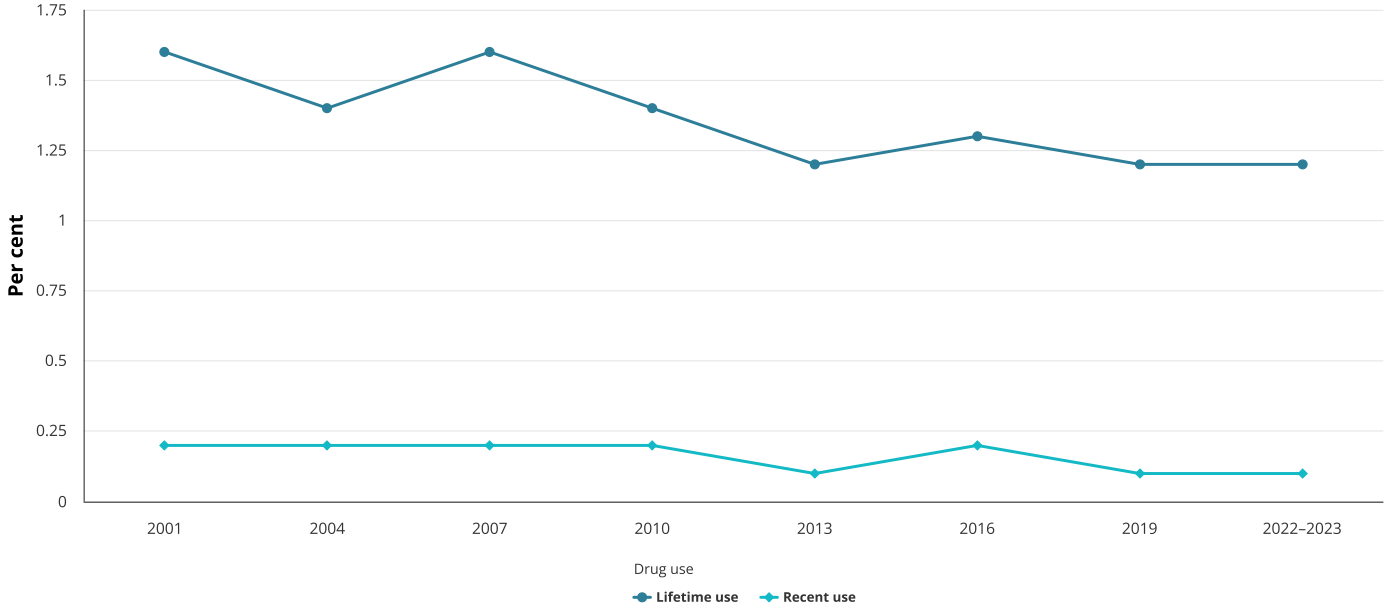
Lifetime heroin use

among the general population **remained low and stable** between 2001 (1.6%) and 2022–2023 (1.2%)

Source: National Drug Strategy Household Survey

The National Drug Strategy Household Survey (NDSHS) shows that past year heroin use among the general population has remained low in Australia between 2001 (0.2%) and 2022–2023 (0.1%; estimate has a relative standard error of 25% to 50% and should be used with caution) (AIHW 2024, Table 5.6; Figure 1). Lifetime use has also remained low over the same period (1.6% in 2001 and 1.2% in 2022–2023) (AIHW 2024, Table 5.6).

Figure 1: Lifetime (a) and recent (b) use of heroin, people aged 14 and over, 2001 to 2022–2023



a. Used at least once in lifetime.
b. Used in the previous 12 months.

* Estimate has a relative standard error of 25% to 50% and should be used with caution.
Source: AIHW 2024 (Supplementary tables 5.2 and 5.6)

Does heroin use differ by age and gender?

In 2022–2023, lifetime use of heroin was similar among males (1.4%) and females (0.9%)

Source: National Drug Strategy Household Survey

The use of heroin is similar among males and females. In 2022–2023, 1.4% of males and 0.9% of females reported using heroin at least once in their lifetime (AIHW 2024, table 5.106). Data on heroin use by age is not available in the NDSHS due to the small number of people reporting use.

Are people using heroin with other drugs?

Data from the NDSHS does not include estimates for the proportion of people who used heroin with other drugs. However, data from the National Ambulance Surveillance System showed that in 2024, 39% of all ambulance attendances involving heroin involved multiple drugs.

Data is available for the most common drug combinations resulting in ambulance attendances. For such data relating to heroin, see Data tables: National Ambulance Surveillance System.

Does heroin use differ by geographic area?

Data on heroin use by state and territory, remoteness area and socioeconomic areas is not available in the NDSHS due to the small number of people reporting use and a high margin of error in the results.

Detailed information on heroin use by geographic area within Australia is available in State and territory data, Remoteness areas, and Socioeconomic areas.

For related content on heroin use among specific population groups in this report, see Population groups.

What are the harms associated with heroin use?

Heroin is a central nervous system depressant. Like other opioids, it binds to receptors in the brain, sending signals to block pain and slow breathing (Table 1). Heroin can also trigger a range of negative short- and long-term effects, including drowsiness, constipation, and dry mouth resulting in tooth decay. Injection comes with a range of additional harms associated with the unsanitary sharing of injecting equipment, such as the transmission of blood borne viruses like Hepatitis C and HIV (Table 1).

Table 1: Short and long-term effects of heroin use

Short-term effects	Long-term effects
• Analgesia • Cough suppressant • Euphoria • Dry mouth • Heavy feeling in hands and feet • Nausea and vomiting • Severe itch • Drowsiness • Respiratory depression resulting in fatal and non-fatal overdose, especially when used in conjunction with other sedative substances including benzodiazepines and alcohol	• Severe constipation • Tooth decay (from lack of saliva) • Irregular menstrual periods in females • Impotence in males • Loss of appetite and weight • Neurochemical changes in the brain • Memory impairment • Mental health issues including depression • Physical dependence and associated withdrawal, which manifest as flu-like symptoms

Source: Adapted from ACIC 2019; Nielsen and Gisev 2017; NDARC 2017.

Heroin-related ambulance attendances

Updated

Between 2021 and 2023, the rate of heroin-related ambulance attendances remained relatively stable overall (ranging from 22 to 25 per 100,000 population), before increasing in most states and territories with available data in 2024

Source: National Ambulance Surveillance System

Data on alcohol and other drug-related ambulance attendances are sourced from the National Ambulance Surveillance System (NASS) and are currently available for six of the eight Australian states and territories (excluding Western Australia and South Australia).

There were almost 4,100 heroin-related attendances among people aged 15 and over in 2024, a rate of 22 per 100,000 population. Among these attendances:

- over 7 in 10 (71%) were for males
- the highest rates of attendances were in people aged 35–44 (38 per 100,000 population) and 45–54 (40 per 100,000) (Table NASS3).

Between 2021 and 2023, the rate of heroin-related ambulance attendances remained relatively stable overall, ranging from 22 to 25 per 100,000 population. While the national number and rate of attendances remained stable between 2023 and 2024 (around 4,000 and 4,100 attendances, respectively, or 22 per 100,000 population in both years), there were increases in attendances across all individual states and territories with available data, except Victoria.

In Victoria, attendances decreased from around 2,100 (38 per 100,000 population) in 2023 to around 1,300 (23 per 100,000 population) in 2024. This is explained by industrial action by paramedics in Victoria between March and September 2024, which resulted in fewer ambulance attendances being captured over that period. Therefore, the national data for 2024 is lower than expected and should be interpreted with caution (Table NASS3).

For related content on alcohol and other drug-related ambulance attendances in this report, see Alcohol and other drug-related ambulance attendances.

Heroin-related hospitalisations

In the National Hospital Morbidity Database, opioids are not coded separately by type, except where the principal diagnosis is related to opioid poisoning. This section relates to hospitalisations where the principal diagnosis related to opioid poisoning and does not include hospitalisations for other principal diagnoses (for example, substance use disorders).

Opioid-related poisoning hospitalisations are generally more likely to involve pharmaceutical opioids than heroin. The number and rate of heroin-related poisoning hospitalisations has fluctuated over time, with an overall decrease from 994 hospitalisations (3.9 per 100,000 population) in 2018–19 to 494 (1.9 per 100,000 population) in 2022–23 following previous rises (Chrzanowska et al. 2025a). Additionally, in 2022–23:

- Males had a higher number and rate of hospitalisations (359 hospitalisations; 2.7 per 100,000 population) than females (134 hospitalisations; 1.0 per 100,000). This has remained consistent over time.
- People aged 40–49 had the highest number of hospitalisations (158; 4.7 per 100,000) out of all age groups (Chrzanowska et al. 2025a).

For related content on alcohol and drug-related hospitalisations in this report, see Alcohol and other drug-related hospitalisations.

Heroin-induced deaths

Updated

In 2024, there were 501 heroin-induced deaths (a rate of 1.9 per 100,000 population)

Source: National Mortality Database

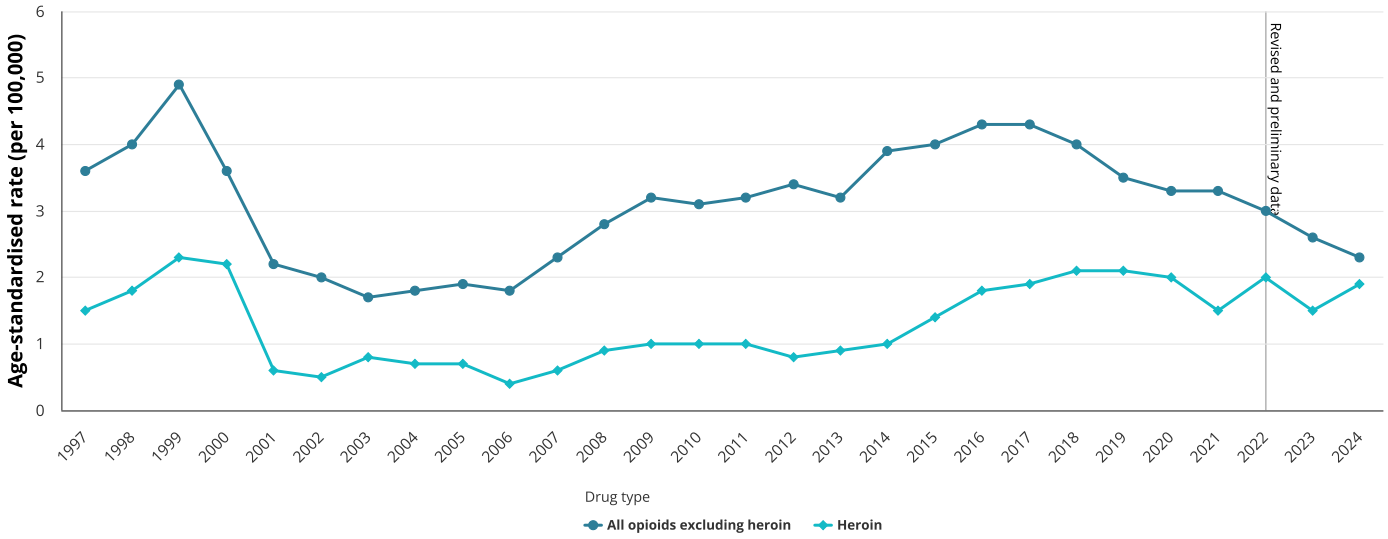
Opioids, including both licit and illicit substances, have been the leading class of drug present in drug-induced deaths in Australia for the last 2 decades. Of the 1,948 drug-induced deaths in Australia in 2024, 501 or 26% involved heroin (Table NMD2).

People who use heroin have a particularly high risk of overdose, especially when heroin is used in conjunction with other drugs like benzodiazepines (for example, alprazolam, diazepam) and alcohol. However, there are some challenges in interpreting the numbers of heroin deaths. Heroin can be difficult to identify at toxicology because it is rapidly metabolised to morphine by the body and these metabolites cannot be distinguished from other morphine sources (for example, codeine).

The rate of deaths involving heroin has overall declined since the late 1990s, when heroin consumption was at its peak in Australia (Degenhardt et al. 2004). Following declines in the 2000s, deaths involving heroin have shown an increase over the last decade, from 1.0 per 100,000 people in 2014 to 2.1 in 2018 and 2019. The rate has since decreased slightly to 1.9 in 2024, though this is a preliminary estimate and may increase with further revisions (Table NMD2, Figure 2).

Figure 2: Drug-induced deaths for all opioids excluding heroin and heroin only, 1997 to 2024

Measure: Rate



a. Drug-induced deaths are defined as those that can be directly attributable to drug use, as determined by toxicology and pathology reports. Drug-induced deaths capture the underlying causes of death (and includes any associated causes), that align with the definition of drug-induced deaths used by the ABS reporting on drug-induced deaths in *Causes of Death, Australia*. This classification excludes deaths solely attributable to alcohol and tobacco.

Source: AIHW analysis of the National Mortality Database (Table NMD2)

There has also been a shift in the profile of opioid-induced deaths in Australia over time, away from pharmaceutical opioids and towards heroin (Table NMD2, Figure 2). In 2024, all opioids excluding heroin were involved in 62% (635 deaths) of opioid-induced deaths, down from 83% (917 deaths) in 2014. Heroin was involved in 49% of opioid-induced deaths in 2024 (501 deaths), up from 22% (237 deaths) in 2014 (Table NMD2).

In 2023, the rate of heroin-induced deaths was higher for:

- males than females (2.2 compared with 0.6 deaths per 100,000 population, respectively)
- people aged 35–44 (2.8 per 100,000 people) or 45–54 (3.6 per 100,000) (Chrzanowska et al. 2025b).

For related content on alcohol and other drug-induced deaths in this report, see Deaths involving alcohol and other drugs.

How many people receive specialist treatment for heroin use?

Updated

Heroin was the fourth most common principal drug of concern in 2024–25, accounting for 4.3% of treatment episodes provided to people for their own drug use

Source: Alcohol and other drug treatment services in Australia report

Data from the Alcohol and other drug treatment services in Australia: early insights report show that heroin was the fourth most common principal drug of concern in 2024–25, accounting for 4.3% (around 9,200) of treatment episodes provided to people for their own drug use. This is a decrease from 5.5% (almost 11,000 episodes) in 2015–16 (AIHW 2026a).

Data collected for the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) are released twice each year, via an early insights report in April and a detailed annual report mid-year. The section below will be updated with information from the annual report once these data become available.
Of the 5,462 clients who received treatment for heroin as their principal drug of concern in 2023–24:

- over 2 in 3 (68%) were male
- about two-thirds were aged either 30–39 (32% of clients) or 40–49 (33%)
- over 1 in 5 (22%) were Aboriginal and Torres Strait Islander (First Nations) people (AIHW 2025, tables SC.9–SC.11).

Additionally, of all treatment episodes provided to clients for their own use of heroin as their principal drug of concern in 2023–24:

- Around 4 in 5 (81% or 7,532) were for people who had previously received AOD treatment since 2013–14 (AIHW 2025, Table SCR.28a).
- Assessment only was the most common main treatment type (22% of episodes, or 2,028), followed by pharmacotherapy (20% or 1,835) and counselling (19% or 1,815) (AIHW 2025, Table Drg.54).

Treatment agencies with a sole function of prescribing or providing dosing services for opioid pharmacotherapy are excluded from the AODTS NMDS. Due to the multi-faceted nature of service delivery in this sector, these data are captured in the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection.

NOPSAD data showed that, on a snapshot day in 2025, 28% of clients across Australia reported heroin as their opioid drug of dependence. However, these data should be interpreted with caution due to the high proportion of clients whose drug of dependence was 'Not stated/not reported' (52% of clients overall in 2025) (AIHW 2026b, Table S10).

For related content on alcohol and other drug treatment in this report, see Alcohol and other drug treatment services.

Where do I go for more information?

- Low-prevalence illicit drugs in the NDSHS
- National Opioid Pharmacotherapy Statistics Annual Data collection

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Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Pharmaceutical drugs

In this section

Introduction

What is non-medical use of pharmaceutical drugs?

In Australia, pharmaceutical drugs are available via a prescription from a registered health-care professional or over-the-counter (OTC) from pharmacies and other retail outlets, and are widely used to prevent, treat and cure injury and illness. When used appropriately, pharmaceutical drugs are associated with considerable reductions in morbidity and mortality and are an important pillar of public health. However, pharmaceutical drugs are subject to use other than prescribed use. Throughout this page, use of pharmaceuticals is reported in terms of non-medical use.

Pharmaceutical non-medical use refers to the consumption of a prescription or over-the-counter drug for non-therapeutic purposes or other than directed by a registered health-care professional (Larance et al. 2011). Pharmaceutical drugs may be consumed for non-medical use for a range of reasons including to induce euphoria, to enhance the effects of alcohol and other drugs, to self-medicate illness or injury, to mitigate the symptoms of withdrawal from alcohol and other drugs, or to improve performance.

Pharmaceutical drugs, including over-the-counter and prescription medicines, have a legitimate purpose in the treatment of illness and injury. However, their use can be associated with increased risk of harm, particularly when used for non-medical purposes. In Australia, pharmaceutical drugs that are most often used for non-medical purposes include opioids (such as oxycodone and morphine), steroids, pharmaceutical stimulants, and sedatives (such as benzodiazepines) (AIHW 2024b). In recent years, there has also been rising concern about the non-medical use of gabapentinoids (particularly pregabalin).

This page focuses on pharmaceutical drug use, treatment and harms in Australia. The reporting uses data from a range of sources, mostly national administrative and survey data. For related content on laws and policies related to pharmaceutical drugs in Australia, see Policy context.

Key findings

- In 2022–2023, around 1 in 20 people in Australia aged 14 and over reported using a pharmaceutical for non-medical purposes in the past 12 months
- Pharmaceutical pain-relievers/pain-killers and opioids and pharmaceutical stimulants were the most common pharmaceuticals used for non-medical purposes in 2022–2023
- Pharmaceuticals are among the most common substances involved in drug-related hospitalisations and drug-induced deaths, including benzodiazepines and opioids
- Women have higher rates of ambulance attendances and hospitalisations for pharmaceutical drugs than men, and rates are particularly high among young women
- Deaths involving pharmaceutical drugs are more common among men than women

What data sources are available?

Data sources for use, treatment and harms related to pharmaceutical drugs

- Alcohol and other drug treatment services in Australia
- Australian Burden of Disease Study
- Household, Income and Labour Dynamics in Australia (HILDA) survey
- National Ambulance Surveillance System
- National Drug Strategy Household Survey
- National Hospital Morbidity Database
- National Mortality Database
- Pharmaceutical Benefits Scheme data collection
- Trends in drug-related hospitalisations in Australia

There are a range of data sources that contain information about pharmaceutical availability, use, treatment and harms. These include self-report surveys that ask people about their use of pharmaceuticals, health administrative data sets (such as administrative data routinely collected by hospitals) and burden of disease analysis. Each data set uses a different methodology, and the language used to describe pharmaceuticals may also differ across sources.

For more information about each data source, see Technical notes.

What do we know about the availability of pharmaceuticals in Australia?

Illicit pharmaceuticals

Detections of pharmaceutical drugs, including benzodiazepines and opioids, at the Australian border have risen over the past decade.

For detailed information on the availability of illicit pharmaceuticals in Australia, see Illicit drug markets and drug-related law enforcement activities.

Pharmaceutical prescriptions

In 2024–25, there were around 12.6 million PBS-subsidised opioid prescriptions dispensed to around 2.9 million patients in Australia

Source: Pharmaceutical Benefits Scheme data collection

Data from Australia's Pharmaceutical Benefits Scheme (PBS) provide information about the availability of prescription opioids, benzodiazepines and gabapentinoids in Australia, including the number of prescriptions dispensed and the number of patients dispensed a script each year. Data from the PBS show that rates of dispensing for benzodiazepines, opioids and gabapentinoids have been generally declining since around 2017–18 (Tables PBS2, PBS4, PBS22, PBS24, PBS46 and PBS48; see Figure 1).

These numbers largely represent medicines being prescribed for and used for their intended purposes. However, as drug-related harms are often associated with drug prescribing rates (Roxburgh et al. 2017), it is important to monitor prescription rates in the context of harm reduction.

Detailed information on dispensing of these drugs is available in Availability of prescription opioids, benzodiazepines and gabapentinoids in Australia.

What do we know about people who use pharmaceuticals for non-medical purposes?

How many people use pharmaceuticals for non-medical purposes and has it changed over time?

1 in 20 people

aged 14 and over in Australia reported using a pharmaceutical for non-medical purposes in the previous 12 months in 2022–2023

Source: National Drug Strategy Household Survey

Data from the 2022–2023 National Drug Strategy Household Survey (NDSHS) showed that:

- 1 in 20 (5.3%) people in Australia aged 14 and over had used a pharmaceutical for non-medical purposes in the previous 12 months (AIHW 2024b, Table 6.3).
- About 1 in 9 (11.9%) people in Australia aged 14 and over had used a pharmaceutical for non-medical purposes in their lifetime (AIHW 2024b, Table 6.1).
- Pharmaceutical pain-killers/pain-relievers and opioids (excluding over-the-counter medications such as paracetamol) are the most common pharmaceuticals used for non-medical purposes (2.2%), followed by pharmaceutical stimulants (2.1%) and tranquilisers/sleeping pills (1.6%) (AIHW 2024b, Table 6.2).

Between 2019 and 2022–2023, there was a decrease in the use of pain-relievers for non-medical purposes in the previous 12 months (from 2.7% to 2.2%) (AIHW 2024b, Table 6.2).

Changes to pharmaceutical questions in the 2022–2023 NDSHS

In 2022–2023, the way the NDSHS captured illicit amphetamine use changed to better reflect how these substances are used and understood in the community. Two separate categories were created, specifically:

- methamphetamine and amphetamine, including illicit methamphetamine and amphetamine (colloquially known as ice, speed and crystal). This category is not included as part of the pharmaceuticals category
- non-medical use of pharmaceutical stimulants, including any medications that are usually prescribed to treat ADHD or narcolepsy and require a prescription from a medical professional to obtain legally, such as methylphenidate (Ritalin, Concerta) and modafinil (Modavigil).

These changes to the 2022–2023 survey resulted in a break in the time-series for the overall non-medical use of pharmaceuticals. There were no changes to the pain-killers/pain-relievers and opioids, tranquillisers/sleeping pills, steroids, or methadone/buprenorphine sections of the questionnaire.

Does non-medical pharmaceutical use differ by age and gender?

Non-medical use of pharmaceuticals was highest among people aged 20–29 in 2022–2023, with 8.3% reporting use in the previous 12 months

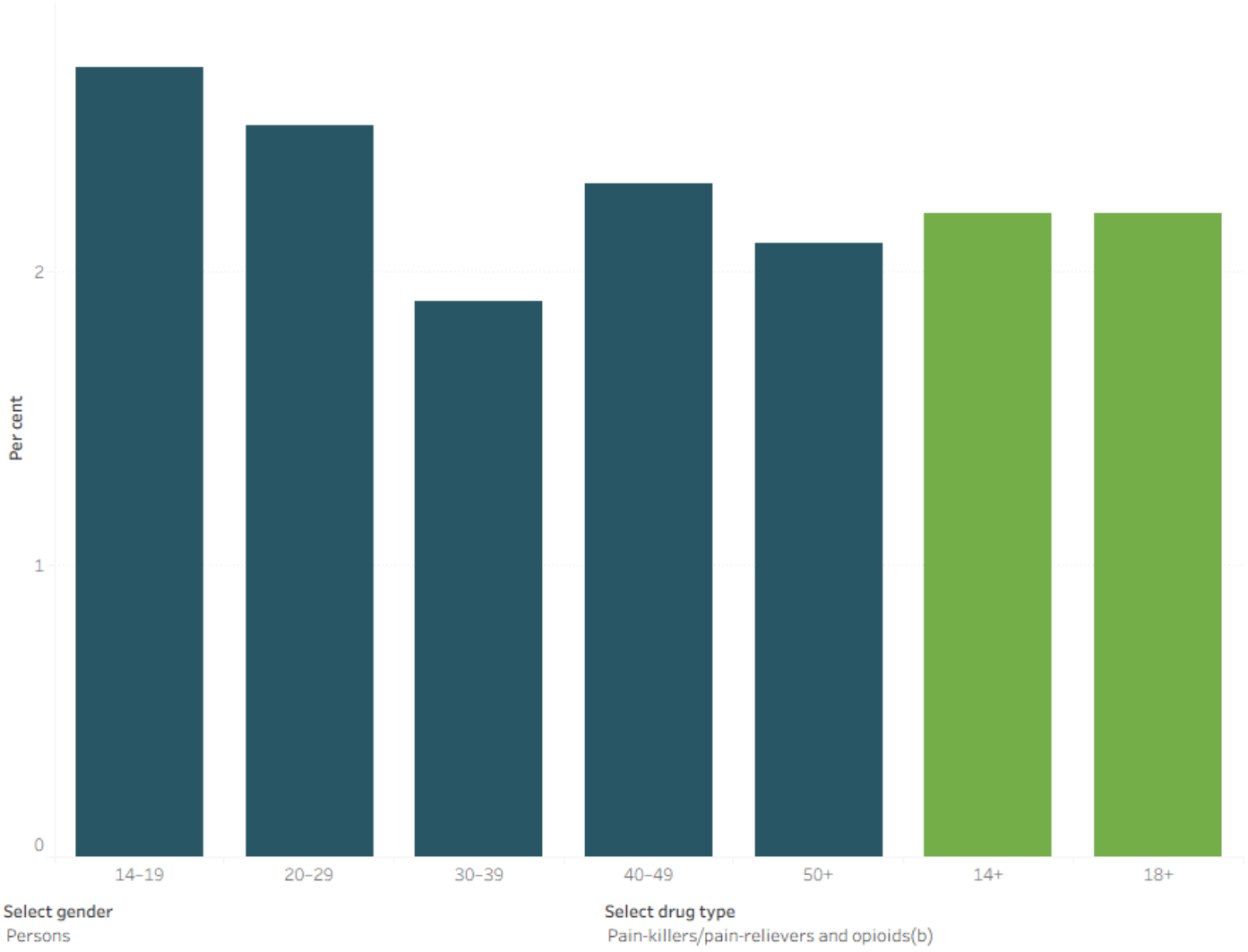
Source: National Drug Strategy Household Survey

In 2022–2023, similar proportions of males and females had recently used pharmaceuticals for non-medical purposes

Source: National Drug Strategy Household Survey

Data from the 2022–2023 NDSHS showed that males and females aged 14 and over were similarly as likely to have used a pharmaceutical for non-medical purposes in the previous 12 months (5.7% and 4.8% respectively) (AIHW 2024b, Table 6.3) (Figure 1).

Figure 1: Recent use of pharmaceuticals, by age, gender and drug used, 2022–2023



(a) Used in the previous 12 months for non-medical purposes.
(b) Excludes over-the-counter medications such as paracetamol and aspirin.
Source: AIHW 2024. Supplementary table 6.4.

http://www.aihw.gov.au

The types of pharmaceuticals used for non-medical purposes differed slightly by gender:

- Among males aged 14 and over, the most common types of pharmaceuticals used for non-medical purposes were pharmaceutical stimulants (2.5%) followed by pain-killers/pain-relievers and opioids (2.1%)
- Among females aged 14 and over, the most common types of pharmaceuticals used for non-medical purposes were pain-killers/pain-relievers and opioids (2.2%) followed by pharmaceutical stimulants (1.5%) (AIHW 2024b, Table 6.4).

Non-medical use of pharmaceuticals was highest among people aged 20–29 (8.3%) in 2022–2023, with pharmaceutical stimulants (4.8%) being the most common pharmaceutical used for non-medical purposes among this age group (AIHW 2024b). While people in their 60s and older were less likely to have used pain relievers and opioids for non-medical purposes in the previous 12 months than those in their 20s, they were more likely to have used them in the last month and were much more likely to have used them in the previous week (AIHW 2024b, tables 6.4 and 6.6).

Are people using pharmaceuticals with other drugs?

In 2022–2023, the NDSHS showed that just over half (54%) of people who reported the non-medical use of pain-relievers and opioids in the last 12 months said they had used another drug at the same time. The most common other drugs concurrently used were alcohol (40%), tobacco (24%) and cannabis (19.5%) (AIHW 2024b, Table 6.14).

Data on alcohol and other drug-related ambulance attendances are sourced from the National Ambulance Surveillance System (NASS), including six Australian states and territories (excludes Western Australia and South Australia). In 2024, multiple drugs were involved in most ambulance attendances related to benzodiazepines (72% of attendances) and pharmaceutical opioids (71% of attendances) (Table NASS5).

Data is available for the most common drug combinations resulting in ambulance attendances. For such data relating to pharmaceutical drugs, see Data tables: National Ambulance Surveillance System.

Does pharmaceutical use differ by geographic area?

In 2022–2023, the proportion of people aged 14 and over who reported non-medical use of pharmaceuticals in the previous 12 months varied across states and territories and was typically higher for people in regional and remote areas of Australia (AIHW 2024b, tables 9a.12 and 9b.46). There was no pattern of non-medical use of pharmaceuticals by socioeconomic area.

Detailed information on pharmaceutical drug use by geographic area in this report is available in State and territory data, Remoteness areas, and Socioeconomic areas.

For more information on non-medical use of pharmaceuticals among specific population groups in this report, see Population groups.

What are the harms associated with pharmaceutical drug use?

There are a range of short and long-term health, social and economic harms associated with the non-medical use of pharmaceutical drugs (Table 1). People who use opioids for chronic pain are more likely than the general population to use pharmaceutical drugs for non-medical purposes (Currow et al. 2016; Vowels et al. 2015). Iatrogenic dependence occurs when patients become dependent on medications that they were medically prescribed for legitimate purposes. Iatrogenic dependence is an increasing concern among people living with chronic non-cancer pain.

Table 1: Short- and long-term effects associated with use of pharmaceuticals

Drug type	Short-term effects	Longer-term effects
Opioids	• Constipation • Nausea • Sedation • Vomiting • Respiratory depression • Dizziness • Itching • Dry mouth • Overdose (fatal and non-fatal)	• Dependence • Decreased cognitive function • Psychiatric co-morbidity • Occlusion of blood vessels • Gastrointestinal bleeding • Mental health conditions including depression
Benzodiazepines	• Relaxation, sedation, and lack of energy • Ataxia and slowed reaction times • Respiratory depression • Dizziness • Euphoria • Confusion • Visual distortions • Moodiness • Short-term memory loss	• Dependence • Anxiety, irritability, paranoia, aggression and depression • Muscle weakness, rashes, nausea and weight gain • Sexual problems • Menstrual irregularities • Memory loss, cognitive impairment, dementia and falls • Confusion, lethargy and sleep problems
Stimulants	• Euphoria • Heightened feelings of wellbeing • Chest pain • Headaches • Sweating and increased body temperature • Heart palpitations • Decreased appetite • Anxiety and paranoia • Nausea • Seizures • Overdose	• Tolerance and dependence • Weight loss • Insomnia • Psychosis • Increased risk of stroke and myocardial infarction

Source: Adapted from Currow et al. 2016; DCPC 2007; Farzam et al. 2023; Nicholas et al. 2011; NSW Ministry of Health 2017.

Opioid-related burden of disease and injury

Opioid use contributed 0.8% of the total Australian burden of disease in 2024

Source: Australian Burden of Disease Study

The Australian Burden of Disease Study 2024 found that opioid use (including pharmaceutical opioids and heroin) was responsible for 0.8% of the total burden of disease and injuries in Australia in 2024 and 28% of the total burden due to illicit drug use (AIHW 2024a, Table S6).

Most of the burden due to opioid use was due to poisoning and drug use disorders (excluding alcohol). Opioid use contributed to 46% of the burden due to poisoning and 22% of the burden due to drug use disorders. A further 2.3% of the burden due to suicide and self-inflicted injuries was attributed to opioid use (AIHW 2024a).

Pharmaceutical-related ambulance attendances

Updated

In 2024, there were over 31,000 ambulance attendances involving any pharmaceutical drug among people aged 15 and over (171 per 100,000 population)

Source: National Ambulance Surveillance System

In 2024, there were around 31,500 ambulance attendances involving any pharmaceutical drug among people aged 15 and over, or 171 per 100,000 population (Table NASS3). This included:

- around 9,200 attendances involving benzodiazepines (50 per 100,000 population)
- over 4,300 attendances involving pharmaceutical opioids (24 per 100,000), noting that multiple drug types may be recorded in the same ambulance attendance.

Unlike most other drugs, ambulance attendances involving pharmaceuticals are more likely to involve females than males. In 2024, almost 3 in 5 attendances involving pharmaceutical drugs were for females (57% of total attendances). This was consistent for both benzodiazepines (53% of attendances) and pharmaceutical opioids (54%).

The highest rates of attendances for any pharmaceutical were among people aged 15–24 (295 per 100,000), followed by people aged 25–34 (201 per 100,000) (Table NASS3). This age profile differed by drug type:

- The highest rates of benzodiazepine-related attendances were for people aged 25–34 (65.5 per 100,000) and 15–24 (65.1 per 100,000).
- The highest rates of pharmaceutical opioid-related attendances were for people aged 45–54 (28 per 100,000) (Table NASS3).

Between 2021 and 2023, the number of pharmaceutical-related ambulance attendances fell from around 37,900 (220 per 100,000 population) to 34,700 (193 per 100,000 population). Over this period:

- rates of benzodiazepine-related ambulance attendances fell by 20%, from 12,700 (74 per 100,000 population) to 10,200 (57 per 100,000 population)
- rates of opioid analgesic-related ambulance attendances fell by 9%, from 5,400 attendances (31 per 100,000 population) to 4,900 (27 per 100,000 population).
- females aged 15–24 consistently had the highest rates of attendances for any pharmaceuticals, though rates have declined over time (Table NASS3).

These declines were largely driven by people aged 15–24, with a 20% decrease in attendances for any pharmaceutical across the period (from 12,100 or 473 attendances per 100,000 population to 10,000 or 346 per 100,000). This was consistent across drug types, with a 31% decrease in benzodiazepine-related attendances and a 24% decrease in opioid-related attendances for this age group (Table NASS3).

There were further declines in pharmaceutical-related ambulance attendances between 2023 and 2024, largely due to a decrease in attendances in Victoria (from around 1,300 or 24 attendances per 100,000 population to around 850 or 15 per 100,000 population). This is due to industrial action by paramedics in Victoria between March and September 2024, which resulted in fewer ambulance attendances being captured over that period. 2024 data should be interpreted with caution (Table NASS3).

For related content on alcohol and other drug-related ambulance attendances in this report, see Alcohol and other drug-related ambulance attendances.

Pharmaceutical-related hospitalisations

How are pharmaceutical drugs classified in hospitalisations data?

In this section, the term “pharmaceuticals” includes the following drugs:

- benzodiazepines
- antidepressants
- antipsychotics and neuroleptics
- non-opioid analgesics, including paracetamol.

The AIHW’s reporting also includes information on pharmaceutical opioids (such as morphine, codeine and oxycodone), but these drugs are reported together with illegal opioids such as heroin. Opioids are not coded separately by type in hospitalisations data, except where the principal diagnosis is related to opioid poisoning. Data on hospitalisations due to pharmaceutical opioid poisoning are available in reporting by the National Drug and Alcohol Research Centre.

Data on hospitalisations related to pharmaceutical drugs cannot distinguish between non-medical use and use as prescribed.

There were 6,091 hospitalisations that involved non-opioid analgesics in 2023–24, representing 4.2% of all alcohol and other drug-related hospitalisations

Source: National Hospital Morbidity Database

Benzodiazepines and other sedative-hypnotics (excluding alcohol and GHB) accounted for 4.4% of alcohol and other drug-related hospitalisations in 2023–24

Source: National Hospital Morbidity Database

Pharmaceuticals are among the most common substances involved in alcohol and other drug-related hospitalisations. In 2023–24, non-opioid analgesics accounted for 4.2% (6,091) of all alcohol and other drug-related hospitalisations, and benzodiazepines and other sedative-hypnotics (excluding alcohol and GHB) accounted for 4.4% (6,416). Smaller numbers were reported for other pharmaceuticals such as antidepressants (2.1% or 3,032) and antipsychotics and neuroleptics (2.1% or 3,040) (Tables NHMD3 and NHMD4; see Figure 3).

In 2023–24, among hospitalisations related to benzodiazepines and other sedative-hypnotics, antidepressants, antipsychotics and neuroleptics, and non-opioid analgesics:

- Around 2 in 3 involved an overnight stay (72% or 4,380 for non-opioid analgesics, 68% or 4,348 for benzodiazepines and other sedative-hypnotics, 66% or 1,994 for antidepressants and 73% or 2,230 for antipsychotics and neuroleptics), while the remainder ended in same-day discharge.
- Over half were for females (74% or 4,524 for non-opioid analgesics, 54% or 3,442 for benzodiazepines and other sedative-hypnotics, 70% or 2,127 for antidepressants, 67% or 2,034 for antipsychotics and neuroleptics).
- People aged 15–34 accounted for around half of hospitalisations for non-opioid analgesics (53% or 3,236), antidepressants (50% or 1,531), and antipsychotics and neuroleptics (50% or 1,505), and almost 2 in 5 hospitalisations for benzodiazepines and other sedative-hypnotics (37% or 2,404).
- Females aged 15–24 had substantially higher rates of hospitalisation for non-opioid analgesics (115.6 per 100,000 population), than any other age and sex group for any pharmaceutical drug (Tables NHMD1–NHMD3).

Pharmaceutical opioids and illegal opioids such as heroin together accounted for 4.2% (5,614) of all drug-related hospitalisations in 2022–23 (Table NHMD3).

Analysis by the National Drug and Alcohol Research Centre indicates that most opioid poisoning hospitalisations are for pharmaceuticals, largely natural and semi-synthetic opioids (such as oxycodone and morphine). These drugs accounted for over half (55%) of all opioid poisoning hospitalisations in 2022–23, compared with 20% for heroin, 14% for synthetic opioids (such as tramadol and fentanyl), 6.6% for methadone and 4.9% for other opioids (Chrzanowska et al. 2025).

For related content on alcohol and other drug-related hospitalisations in this report, see Alcohol and other drug-related hospitalisations.

Deaths involving pharmaceutical drugs

Updated

In 2024, the rate of benzodiazepine-induced deaths was 2.4 per 100,000 population (654 deaths)

Source: National Mortality Database

Data from AIHW analysis of the National Mortality Database shows that benzodiazepines were the single most common drug type in drug-induced deaths (654 deaths) in Australia in 2024. Furthermore, in 2024 there were:

- 635 deaths (2.3 per 100,000 population) induced by all opioids (excluding heroin)
- 295 deaths (1.1 per 100,000 population) induced by antipsychotics
- 119 deaths (0.4 per 100,000 population) induced by non-opioid analgesics (Table NMD2, Figure 2).

Males had higher numbers of deaths than females for benzodiazepines, opioids excluding heroin, antipsychotics and non-opioid analgesics in 2024 (Table NMD13).

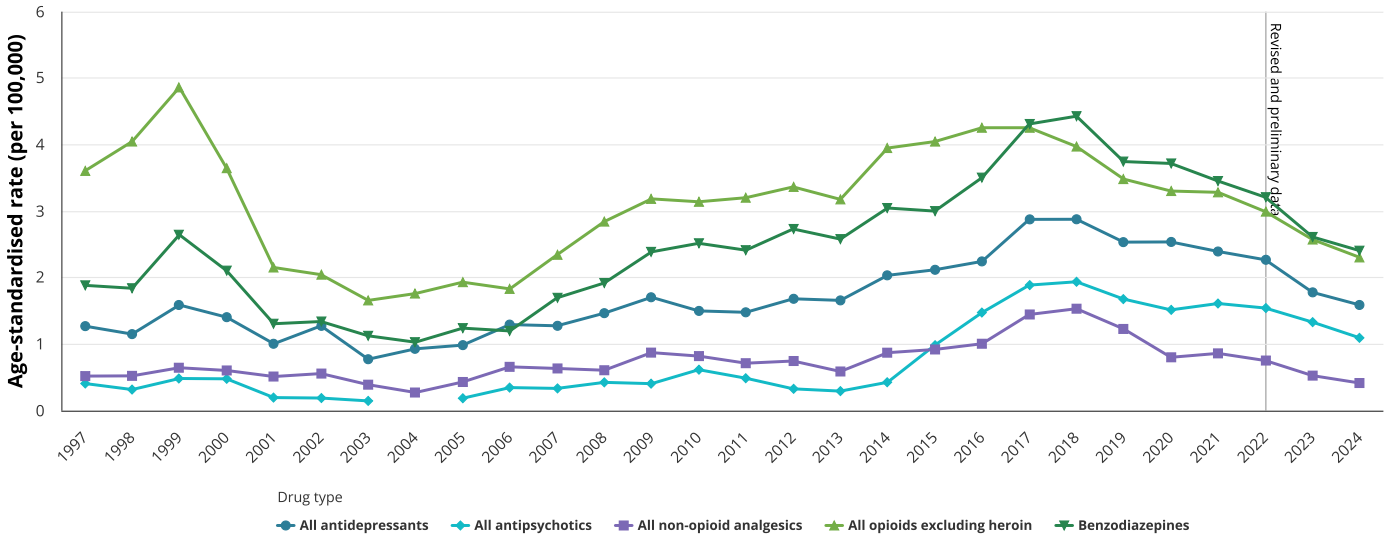
Deaths related to pharmaceutical drugs have broadly declined over the past decade:

- The rate of benzodiazepine-induced deaths rose from 1.9 per 100,000 population in 1997 to 4.4 per 100,000 in 2018 before declining to 2.4 deaths per 100,000 in 2024.
- The rate of opioid-induced deaths (excluding heroin) has declined from a high of 4.3 per 100,000 in 2016 and 2017 to 2.3 per 100,000 in 2024.
- The rate of all antidepressant-induced deaths has declined from a high of 2.9 per 100,000 in 2017 and 2018 to 1.6 in 2024.
- The rate of non-opioid analgesic-induced deaths has declined from a high of 1.5 per 100,000 in 2018 to 0.4 in 2024 (Table NMD2, Figure 2).

These estimates are expected to rise with standard revision processes.

Figure 2: Drug-induced deaths for pharmaceutical drugs, 1997 to 2024

Measure: Rate



(a) Drug-induced deaths are defined as those that can be directly attributable to drug use, as determined by toxicology and pathology reports. Drug-induced deaths capture the underlying causes of death (and includes any associated causes), that align with the definition of drug-induced deaths used by the ABS reporting on drug-induced deaths in *Causes of Death, Australia*. This classification excludes deaths solely attributable to alcohol and tobacco.

n.p. Not published. Calculating age-standardised rates is not recommended when there are fewer than 20 events in the numerator, as the calculated rate is unstable.
Source: AIHW analysis of the National Mortality Database (Table NMD2)

In recent years, there have been rapid and dramatic increases in opioid-related deaths associated with rising use in North America (CDC 2024). Similar increases in harm have not been observed in Australia, with declines in the rate of deaths involving pharmaceutical opioids since around 2017 (Table NMD2, Figure 2). While Australia and the US previously had similar rates of non-medical opioid use, this has declined in Australia in recent years (UNODC 2021). In addition, rates of dispensing of prescription opioids have been declining following the introduction of several policies that aim to reduce harm from prescription opioid medicines. For more information on these policies, see Policy context.

For related content on deaths involving alcohol and other drugs in this report, see Deaths involving alcohol and other drugs.

How many people receive treatment for pharmaceutical use?

Updated

Pharmaceuticals were the principal drug of concern in 6.1% (around 13,100) of treatment episodes provided to people for their own drug use in 2024–25

Source: Alcohol and other drug treatment services in Australia report

In treatment services data from the Alcohol and Other Drug Treatment Services National Minimum Data Set, the classification of 'pharmaceuticals' includes 10 drug types: codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics (AIHW 2025).

Data from the Alcohol and other drug treatment services in Australia: early insights report show that pharmaceuticals were the principal drug of concern in 6.1% (around 13,100) of treatment episodes provided to people for their own drug use in 2024–25. This proportion has been relatively stable since 2015–16 (5.2% or around 10,300 episodes) (AIHW 2026).

Data collected for the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) are released twice each year, via an early insights report in April and a detailed annual report mid-year. The section below will be updated with information from the annual report once these data become available.
Of treatment episodes for pharmaceuticals in 2023–24, nearly 2 in 3 (63% or 8,144 episodes) involved either opioids (40% of episodes, or 5,265) or benzodiazepines (22% or 2,879) as the principal drug of concern (AIHW 2025, Table Drg.87).

Of the 7,344 clients who received treatment for pharmaceuticals as their principal drug of concern in 2023–24:

- Around 3 in 5 (61% of clients) were male (AIHW 2025, Table SC.30).
- Nearly 3 in 5 were aged either 20–29 (26% of clients) or 30–39 (32%), but this varied by drug type (AIHW 2025, Table SC.31).
- Around 1 in 7 (16%) were Aboriginal and Torres Strait Islander (First Nations) people (AIHW 2025, Table SC.32).

For more information on alcohol and other drug treatment in this report, see Alcohol and other drug treatment services.

Where do I go for more information?

- Non-medical use of pain-relievers and opioids in the NDSHS
- Non-medical use of pharmaceutical stimulants in the NDSHS

- Pharmaceuticals: client demographics and treatment
- Pharmaceutical Benefits Scheme prescriptions: monthly data

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Viewing this data

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New psychoactive substances

In this section

Introduction

What are new psychoactive substances?

New psychoactive substances (NPS) are substances that are not controlled by international drug control conventions (UNODC 2024). NPS often mimic the effects of existing drugs, but with the chemical structure modified to avoid drug control laws (UNODC 2024). There are several main types of NPS, including synthetic cannabinoid receptor agonists, novel benzodiazepines, synthetic opioids (for example, nitazenes), phenethylamines, tryptamines, piperazines and synthetic cathinones.

As at October 2025, 1,396 individual NPS have been reported to the United Nations Office on Drugs and Crime Early Warning Advisory (EWA) worldwide (UNODC 2025). The annual number of individual NPS reported to the EWA each year has risen over time, from 460 NPS in 2014 to a record high 688 in 2024 (UNODC 2025).

There are several types of NPS, including:

- synthetic cannabinoid receptor agonists (SCRAs), which are designed to mimic or produce similar effects to cannabis
- phenethylamines, a class of drugs with psychoactive and stimulant effects and includes amphetamine, methamphetamine and MDMA (ecstasy). NPS phenethylamines include the '2C series', the NBOMe series, PMMA and benzodifurans
- tryptamines, which are psychoactive hallucinogens found in plants, fungi and animals
- piperazines, which are typically described as 'failed pharmaceuticals' and are frequently sold as ecstasy due to their central nervous system stimulant properties
- synthetic cathinones, which have an amphetamine-type analogue including mephedrone ('meow meow') and methylone
- synthetic opioids, including fentanyl analogues, nitazenes (including protonitazene and metonitazene), and newly emerging substances such as brorphine analogues
- novel benzodiazepines, which often do not belong to a precise category and are grouped into "other substances". They have sedative and hypnotic effects, varying dosages of active ingredients and contain contaminants, including highly potent synthetic opioids. Other names given to this group of drugs include research chemicals, analogues, legal highs, herbal highs, bath salts, novel psychoactive substances, and synthetic drugs (NDARC 2016, UNODC 2025).

This page focuses on NPS use, treatment and harms in Australia. The reporting uses data from a range of sources, mostly national administrative and survey data. For related content on NPS in this report, see Illicit drug markets and drug-related law enforcement activities.

Key findings

- A low proportion of people in Australia report recent use of new psychoactive substances, including synthetic cannabinoids and other synthetic drugs
- The proportion of people reporting recent use of synthetic cannabinoids has decreased over time
- New psychoactive substances can cause health problems including cardiovascular problems, breathing difficulty and dependence

What data sources are available?

Data sources for new and emerging psychoactive substances

- Ecstasy and Related Drugs Reporting System
- National Drug Strategy Household Survey
- Prompt Response Network Drug Alert Reports

Data on NPS availability, use and harms are sourced from both survey and administrative sources. However, the available data is limited due to the absence of NPS classifications in reporting and coding systems (Smith et al. 2022). Available data on NPS may evolve as new substances emerge in drug markets.

For detailed information about each data source, see Technical notes.

What do we know about new psychoactive substance availability in Australia?

In Australia, the NPS market is highly dynamic with fluctuations in the types of NPS available (Sutherland et al. 2020). NPS account for a small proportion of illicit drug detections at the Australian border each year, but the number of NPS detections has risen over time.

For detailed information on the availability of NPS, see Illicit drug markets and drug-related law enforcement activities.

What do we know about people who use new psychoactive substances?

Between 2013 and 2022–2023, the proportion of people who reported recent use of synthetic cannabinoids fell from 1.2% to *0.1%

Source: National Drug Strategy Household Survey

Both the National Drug Strategy Household Survey (NDSHS) and the Ecstasy and Related Drugs Reporting System (EDRS) indicate that the use of NPS in Australia is low.

The 2022–2023 NDSHS showed that:

- Lifetime use of synthetic cannabinoids doubled between 2013 and 2022–2023 (from 1.3% to 2.6%), but recent use dropped from 1.2% to *0.1% (AIHW 2024, tables 5.2 and 5.6).
- Lifetime use of other psychoactive substances remained stable between 2019 and 2022–2023 (from 0.7% to 0.8%) (AIHW 2024, Table 5.104). In 2022–2023, less than *0.1% of people aged over 14 had used other psychoactive substances in the last 12 months (*estimate has a relative standard error of 25% to 50% and should be used with caution).

In 2025, 13% of EDRS participants reported known use of any NPS in the past 6 months (excluding plant-based NPS). This is stable from 2024 (14%), and down from a peak of 42% in 2013 (Sutherland et al. 2025, Table 17). Use of synthetic cannabinoids was low in 2024, with less than 1% reporting use in the past 6 months (Sutherland et al. 2025). The most common types of NPS used by EDRS participants were drugs that mimic the effects of psychedelic drugs (6%) and ecstasy (3%) (Sutherland et al. 2025).

Some people may consume NPS unknowingly when these substances are present in other drugs such as methamphetamine, MDMA and cocaine (Peck et al. 2019). In Australia, NPS such as nitazenes have been detected at drug checking services in Canberra and Queensland, and numerous drug alerts have been released related to unexpected detections of NPS in other drugs (CanTEST 2026; CheQpoint 2025). Between July and September 2025 across Australia there were 5 reports for nitazenes across multiple drug alerts reported by The Know (Kypri et al. 2025).

For related content on drug checking services and drug alerts in this report, see Harm reduction measures related to alcohol and other drugs.

What do we know about the harms associated with new psychoactive substance use?

New psychoactive substances can cause health problems including cardiovascular problems, breathing difficulty and dependence

ACIC 2019; NDARC 2017; UNODC 2024b

The use of NPS has been linked to a range of health problems, including (but not limited to):

- cardiovascular problems
- memory and cognitive impairment
- psychiatric problems
- aggression and acute psychosis
- breathing difficulties
- fatigue
- headaches
- nausea and persistent vomiting
- abnormally fast heartbeat (tachycardia)
- seizures
- tolerance and dependence (ACIC 2019; NDARC 2017; UNODC 2024).

There is limited available data on other NPS-related harms including ambulance attendances, hospitalisations and deaths. This is partially due to reporting and coding systems lacking NPS-specific classifications (Smith et al. 2022).

Recent research on coronial data identified 17 deaths attributed to nitazene toxicity in Australia, with the first occurring in 2021 (Darke et al. 2024).

For related content on health and harms related to alcohol and other drug use in this report, see Health and harms.

Where do I go for more information?

- CanTEST
- Ecstasy and Related Drugs Reporting System
- UNODC Early Warning Advisory on New Psychoactive Substances
- The Know

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Viewing this data

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Other drugs

In this section

Introduction

Some drugs are not commonly used in Australia but warrant ongoing monitoring due to rising trends in use or risk of harm attributed to their use, including GHB (gamma-hydroxybutyrate), ketamine and hallucinogens.

This page focuses on GHB, ketamine and hallucinogen use and harms in Australia. There is currently no available data on treatment for these drugs. The reporting uses data from a range of sources, mostly national administrative and survey data. For related information on wastewater drug monitoring (including ketamine), illicit drug seizures and arrests, see Illicit drug markets and drug-related law enforcement activities.

Key findings

- 0.2% of people aged 14 and over had used GHB in the past 12 months in 2022–2023, stable from 2019
- The number of GHB-related ambulance attendances and hospitalisations has increased substantially in recent years
- Both lifetime and recent use of ketamine have risen since 2019, with 1.4% of people aged 14 and over reporting recent use in 2022–2023
- 2.4% of people aged 14 and over reported using hallucinogens in the last 12 months in 2022–2023, up from 1.6% in 2019

What data sources are available?

Data sources for other drugs

- Ecstasy and Related Drugs Reporting System
- Illicit Drug Reporting System
- National Drug Strategy Household Survey
- National Hospital Morbidity Database

There are a range of data sources that contain information about GHB, ketamine and hallucinogen availability, use, treatment and harms. These include self-report surveys that ask people about their use of pharmaceuticals and health administrative data sets (such as administrative data routinely collected by hospitals). Each data set uses a different methodology, and the language used to describe these drugs may also differ across sources.

For more information about each data source, see Technical notes.

What do we know about GHB use and harms?

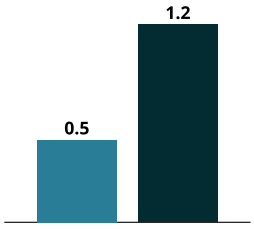
GHB is a central nervous system depressant that is produced naturally in the body but is also produced synthetically for anaesthetic and therapeutic purposes (NDARC 2016). GBL (Gamma-butyrolactone) and 1,4-BD (1,4-Butanediol) are closely related to GHB and metabolise as GHB in the body (ADF 2025). GHB, GBL and 1,4-BD use among the general population in Australia is low but rising, with rapid increases in serious harms including ambulance attendances, hospitalisations and mortality in recent years (Darke et al. 2024).

There are currently limited data on GHB, GBL and 1,4-BD availability and treatment. Data on use and harms is outlined below.

How many people use GHB?

In 2022–2023, 0.2% of people aged 14 and over had used GHB in the past 12 months

Source: National Drug Strategy Household Survey



The proportion of people reporting lifetime GHB use has risen from 0.5% in 2004 to 1.2% in 2022–2023

Source: National Drug Strategy Household Survey

The proportion of people who report using GHB in Australia is low and relatively stable, though lifetime use has risen over the past two decades. Findings from the National Drug Strategy Household Survey (NDSHS) show that, in 2022–2023:

- 0.2% of people aged 14 and over had used GHB in the previous 12 months, stable from 0.1% each collection between 2004 and 2019 (AIHW 2024, Table 5.2).
- 1.2% of people aged 14 and over had used GHB in their lifetime, up from 0.5% in 2004 (AIHW 2024, Table 5.6).

The average age of initiation of GHB use was 27.2 years – the highest among all illicit drugs reported (AIHW 2024, Table 5.17).

People who use stimulants or inject drugs report higher rates of GHB use than the general population:

- Of the 1.0% of people aged over 14 who reported recent use of methamphetamine and amphetamine in the NDSHS in 2022–2023, 11.5% reported using GHB, GBL or 1,4-BD at the same time as methamphetamine and amphetamine (AIHW 2024, tables 5.6 and 5.96).
- Nearly 1 in 10 (9%) Ecstasy and Related Drugs Reporting System (EDRS) participants reported use of GHB/GBL/1,4-BD in the past 6 months in 2025, stable from 2024 (12%). Among people who reported recent use, GHB/GBL/1,4-BD was used on a median of four days in 2025, stable from 2024 (Sutherland et al. 2025a).
- Of those surveyed in the Illicit Drugs Reporting System (IDRS) in 2025, 17% reported using GHB/GBL/1,4-BD in the previous 6 months, stable from 15% in 2024. Among those who reported recent use, GHB/GBL/1,4-BD was used on a median of 5 days, stable from 2024 (Sutherland et al. 2025b).

What are the harms related to GHB use?

GHB-related ambulance attendances

The number of ambulance attendances involving GHB more than doubled between 2021 and 2023 (from around 3,200 attendances to around 6,800)

Source: National Ambulance Surveillance System

Updated

The highest rates of GHB-related ambulance attendances in 2024 were for people aged 25–34

Source: National Ambulance Surveillance System

Data on alcohol and other drug-related ambulance attendances are sourced from the National Ambulance Surveillance System (NASS) and are currently available for six of the eight Australian states and territories (excluding Western Australia and South Australia).

There were around 6,000 GHB-related attendances among people aged 15 and over in 2024, a rate of 33 per 100,000 population. Among these attendances:

- just over half (52%) were for males
- the highest rates of attendances were in people aged 25–34 (around 2,500 attendances, 75 per 100,000 population) and 35–44 (around 1,800, 57 per 100,000) (Table NASS3).

Between 2021 and 2023, GHB-related ambulance attendances increased substantially from around 3,200 (19 per 100,000 population) to 6,800 (38 per 100,000). The largest increase was among people aged 25–34 (from 1,600 to 3,000 attendances). Attendances decreased between 2023 and 2024, largely due to a decrease in attendances in Victoria (from around 3,700 attendances to around 2,500). This is explained by industrial action by paramedics in Victoria between March and September 2024, which resulted in fewer ambulance attendances being captured over that period. 2024 data should be interpreted with caution (Table NASS3).

For related content on alcohol and other drug-related ambulance attendances in this report, see Alcohol and other drug-related ambulance attendances.

GHB-related hospitalisations

There were 3,674 hospitalisations with a principal diagnosis of GHB in 2023–24, up from 569 in 2015–16

Source: National Hospital Morbidity Database

Almost half of all GHB-related hospitalisations in 2023–24 were for people aged 25–34

Source: National Hospital Morbidity Database

Drug-related hospitalisations involving GHB have also risen in recent years. AIHW analysis of the National Hospital Morbidity Database (NHMD) showed that in 2023–24, there were 3,674 hospitalisations with a principal diagnosis relating to GHB use, up from 569 in 2015–16 and increasing by 67% from the previous year (2,200 in 2022–23) (tables NHMD3 and NHMD4). Of these 3,674 GHB-related hospitalisations:

- 1,671 (45%) were among people aged 25–34 and 1,031 (28%) were among people aged 35–44.
- There were slightly more hospitalisations among males (54% or 1,974) than females (46% or 1,699 hospitalisations) (Table NHMD3).

For related content on alcohol and other drug-related hospitalisations in this report, see Alcohol and other drug-related hospitalisations.

What do we know about ketamine use?

Ketamine is a dissociative drug originally used as an anaesthetic for medical purposes (NDARC 2021). Ketamine use has been rising among the general population in Australia, but there is currently limited or no available evidence on ketamine treatment and harms at the national level.

How many people use ketamine?

Both lifetime and recent use of ketamine have risen since 2019

Source: National Drug Strategy Household Survey

In 2022–2023, ketamine use was highest among people aged 20–29 years

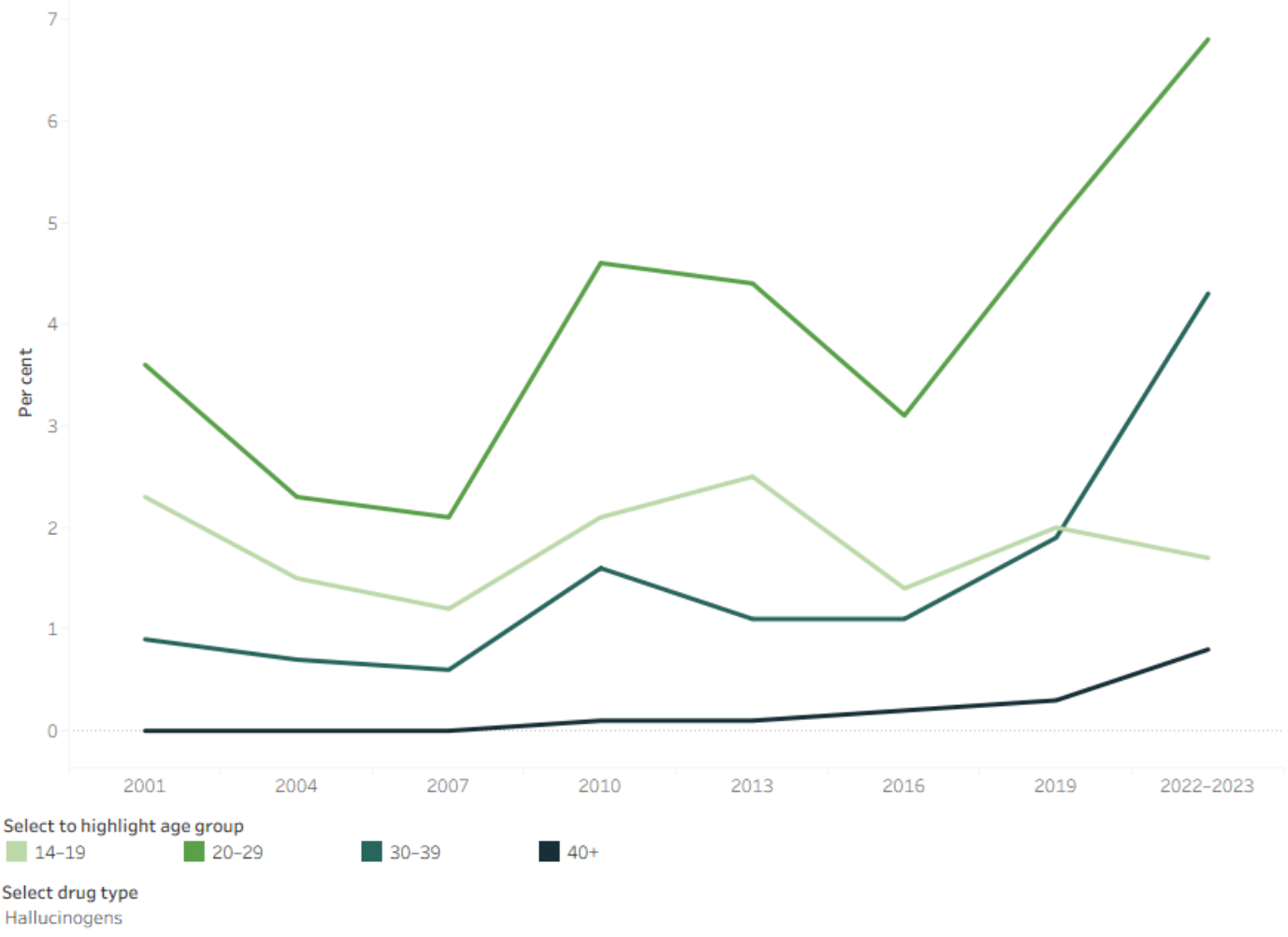
Source: National Drug Strategy Household Survey

In recent years, use of ketamine has increased among the general population though rates of use remain low (AIHW 2024). Data from the 2022–2023 NDSHS showed that:

- 1.4% of people aged 14 and over had used ketamine in the last 12 months, up from 0.9% in 2019 and 0.4% in 2016 (AIHW 2024, Table 5.6).
- 4.3% of people aged 14 and over had used ketamine in their lifetime, up from 3.1% in 2019 (Figure 1; AIHW 2024, Table 5.2).
- Ketamine use was highest among people aged 20–29 years (4.2%) (AIHW 2024, Table 5.109) (Figure 1).

Use of ketamine is far more common among people who regularly use illicit stimulants than among the general population. The 2025 EDRS showed that, of people who regularly use ecstasy or illicit stimulants, 52% had used ketamine in the previous 6 months. This remained stable from 2024 (53%), following previous increases from 2009 to 2021 (Sutherland et al. 2025a).

Figure 1: Recent[a] use of ketamine or hallucinogens, people aged 14 and over, by age 2004 to 2022–2023



(a) Used in the previous 12 months.
Note:
1. The NDSHS offers introductory text for each class of drug, including examples of the drugs included. Examples for several drug types have varied over time.
2. Data <0.1 were not presented in the visualisation.
AIHW 2024. Supplementary tables 5.97 and 5.109.

What do we know about hallucinogen use and harms?

Hallucinogens are a group of psychedelic drugs that cause the user to hallucinate (Black and Bruno 2018). Common hallucinogens include LSD (lysergic acid diethylamide), mushrooms, mescaline, salvia and DMT (dimethyltryptamine) (Black and Bruno 2018).

How many people use hallucinogens?

In 2022–2023, 2.4% of people aged 14 and over reported using hallucinogens in the previous 12 months

Source: National Drug Strategy Household Survey

Recent hallucinogen use was most common among people aged 20–29

Source: National Drug Strategy Household Survey

Recent use of hallucinogens among people aged 14 and over has gradually increased since 2007 (AIHW 2024). According to the 2022–2023 NDSHS:

- 2.4% of people aged 14 and over had used hallucinogens in the last 12 months, up from 1.6% in 2019.
- 12.2% reported lifetime use, up from 10.4% in 2019.
- Recent hallucinogen use was most common among people aged 20–29 (6.8%).
- For people who had recently used hallucinogens, 77% had used mushrooms/psilocybin (1.8% of the total population aged 14 and over) and 62% had used LSD/acid/tabs (1.5%) (AIHW 2024, tables 5.97, 5.98 and 5.99).

The 2025 EDRS showed that, of people who regularly use ecstasy or illicit stimulants, 41% had used non-prescribed hallucinogenic mushrooms/psilocybin, 35% had used LSD and 11% had used DMT in the previous 6 months. These numbers remained stable from 2024 (Sutherland et al. 2025a). The proportion of EDRS participants reporting use of hallucinogenic mushrooms/psilocybin in the previous 6 months almost doubled between 2016 (22%) and 2025 (41%) but has remained stable since around 2021 (Sutherland et al. 2025a).

What are the harms related to hallucinogen use?

Hallucinogen-related hospitalisations

There were 392 hallucinogen-related hospitalisations in 2023–24, up from 255 in 2022–23

Source: National Hospital Morbidity Database

Most hallucinogen-related hospitalisations in 2023–24 were for people aged 15–34

Source: National Hospital Morbidity Database

AIHW analysis of the NHMD showed that in 2023–24 there were 392 hospitalisations that involved a principal diagnosis relating to hallucinogens, up from 255 in 2022–23, following a peak of 471 in 2020–21 (Table NHMD4). Of these 392 hospitalisations:

- over 2 in 5 (42% or 165 hospitalisations) were among people aged 15–24, and a further 36% (or 142 hospitalisations) were among people aged 25–34
- almost 3 in 4 (74% or 292 hospitalisations) were among males
- over half (54% or 210 hospitalisations) involved an overnight stay (tables NHMD2 and NHMD3).

For related content on alcohol and other drug-related hospitalisations in this report, see Alcohol and other drug-related hospitalisations.

Where do I go for more information?

- Ecstasy and Related Drugs Reporting System
- Low-prevalence illicit drugs in the NDSHS

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Viewing this data

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Geographic areas

Geographic areas

- International data
- Remoteness areas
- Socioeconomic areas
- State and territory data

Wastewater analysis shows that consumption of nicotine, alcohol, cannabis and methylamphetamine are typically higher in regional areas than major cities

Source: National Wastewater Drug Monitoring Program

In 2023–24, *Remote and very remote* areas had the highest rate of drug and alcohol-related hospitalisations (852.7 per 100,000 population)

Source: National Hospital Morbidity Database

The highest proportion of drug-related hospitalisations (23%) in 2022–23 was for people living in the most disadvantaged areas

Source: Trends in drug-related hospitalisations in Australia

In 2022–2023, people living in the most disadvantaged areas of Australia were more likely than people living in the least disadvantaged areas to smoke daily, but less likely to drink at risky levels

Source: National Drug Strategy Household Survey

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State and territory data

In this section

Key findings

New South Wales

- In 2022–2023, 31% of people aged 14 and over had consumed alcohol at risky levels in the previous year
- Rates of daily tobacco smoking and risky alcohol consumption have fallen in New South Wales since 2007, while rates of e-cigarette and illicit drug use have been rising since 2016 and 2007, respectively
- In 2022–2023, 7.9% of people reported they currently used e-cigarettes, the highest rate of any state or territory
- Between 2022–23 and 2023–24, wastewater analysis showed rises in average consumption of heroin, methamphetamine, MDMA (ecstasy) and cocaine in New South Wales
- Alcohol continues to have the highest rate of alcohol and other drug-related ambulance attendances in New South Wales (505 attendances per 100,000 people in 2024)
- Rates of hospitalisations and deaths involving drugs (excluding alcohol) have declined in New South Wales since around 2017, with 5.0 deaths and 192 hospitalisations per 100,000 people in 2023 and 2022–23, respectively
- Alcohol was the most common drug for which people sought treatment in New South Wales in 2023–24

Victoria

- In 2022–2023, 26% of people aged 14 and over had consumed alcohol at risky levels in the previous year
- In 2022–2023, 5.3% of people reported they used cocaine in the previous 12 months
- In 2022–2023, 3.2% of people reported they used hallucinogens in the previous 12 months
- Between 2022–23 and 2023–24, methylamphetamine consumption increased from 2,798.6 kg to 3,455.2 kg per annum
- In 2024, the rate of alcohol-involved ambulance attendances among people aged 15 and over was 302 per 100,000 population, higher than for any other drug
- Of all people who received alcohol and other drug treatment services in Victoria in 2023–24, 30% were aged 30–39

Queensland

- In 2022–2023, 33% of people aged 14 and over had consumed alcohol at risky levels in the previous year
- The crude rate of patients dispensed alcohol cessation medicines in 2024–25 was 205 per 100,000 population – higher than any other state or territory
- In 2024, the rate of alcohol-involved ambulance attendances among people aged 15 and over was 780 per 100,000 population, higher than any other drug
- In 2024, among people aged 45–54, rates of alcohol-related ambulance attendances were 1,080 per 100,000 population, the highest of any age group
- In 2024, rates of amphetamine-related ambulance attendances were 148 per 100,000 population

Western Australia

- In 2022–2023, 33% of people aged 14 and over had consumed alcohol at risky levels in the previous year
- 7.2% of people aged 14 and over reported using pharmaceuticals for non-medical purposes in the previous 12 months
- Between 2022–23 and 2023–24, heroin consumption increased by 46%, from 40.0 kg to 58.4 kg per annum
- Amphetamine-type stimulants were associated with the highest rates of drug-related hospitalisation
- In 2023, rates of opioid-induced deaths were 5.3 per 100,000 population (153 deaths)

South Australia

- In 2022–2023, 32% of people aged 14 and over had consumed alcohol at risky levels in the previous year
- Daily tobacco smoking was higher among males than females (12% and 7.6% respectively; people aged 18 and over)
- The rate of hospitalisations with a principal diagnosis involving amphetamine-type stimulants was 72 per 100,000 population
- The rate of drug-induced deaths among people aged 55–64 was 12 per 100,000 population, the highest of any age group
- Alcohol was the principal drug of concern for 37% of clients receiving specialist alcohol and other drug treatment services

Tasmania

- In 2022–2023, 34% of people aged 14 and over had consumed alcohol at risky levels in the previous year

- In 2022–2023, 85% of people aged 14 and over consumed alcohol in the previous 12 months
- In 2022–2023, 1 in 5 (19%) people aged 25–34 reported smoking daily, the highest of any age group
- In 2024, the rate of alcohol-involved ambulance attendances among people aged 15 and over was 609 per 100,000 population, higher than for any other drug
- In 2024, rates of alcohol-related ambulance attendances were highest among people aged 15–24 (882 per 100,000 population)
- In 2023, the rate of drug-induced deaths among females was 5.7 deaths per 100,000 population

Australian Capital Territory

- In 2022–2023, 27% of people aged 14 and over had consumed alcohol at risky levels in the previous year
- In 2022–2023, 5.1% of people aged 18 and over reported daily smoking, the lowest of any state or territory
- In 2022–2023, 43% of people aged 18–24 reported using illicit drugs in the previous 12 months
- In 2024, the rate of alcohol-involved ambulance attendances among people aged 15 and over was 524 per 100,000 population, higher than for any other drug
- In 2024, rates of alcohol-related ambulance attendances were highest among people aged 45–54 (639 per 100,000 population)
- In 2022–23, drug-related hospitalisations were highest among people aged 10–19 (304 per 100,000 population)

Northern Territory

- In 2022–2023, 40% of people aged 14 and over had consumed alcohol at risky levels in the previous year
- In 2022–2023, 7.2% of people aged 14 and over reported daily alcohol consumption
- In 2022–2023, 14% of people aged 18 and over reported daily smoking
- In 2024, the rate of alcohol-involved ambulance attendances among people aged 15 and over was 2,827 per 100,000 population, higher than for any other drug
- In 2023, the rate of cannabinoid-related hospitalisations was 324 per 100,000 population

Introduction

In each state and territory in Australia, the experiences people have with alcohol, tobacco and other drugs differ, and therefore the health and service needs of each jurisdiction will vary.

This page focuses on alcohol and other drug use and harms across states and territories in Australia. The reporting uses data from a range of sources, mostly national administrative and survey data.

What data sources are available?

Data sources for alcohol and other drugs by state and territory

- Alcohol and other drug treatment services in Australia
- National Ambulance Surveillance System
- National Drug Strategy Household Survey
- National Wastewater Drug Monitoring Program
- Pharmaceutical Benefits Scheme data collection
- Trends in drug-related hospitalisations in Australia
- Trends in overdose and other drug-induced deaths in Australia

There are a range of data sources that contain information about alcohol and other drug use, harms and treatment across states and territories. These include self-report surveys that ask people about their use of alcohol and other drugs, wastewater analysis and health administrative data sets (such as administrative data routinely collected by hospitals). Each data set uses a different methodology, and the language used to describe alcohol and other drugs may also differ across sources.

For more information about each data source, see Technical notes.

How does alcohol, tobacco and other drug use vary across states and territories?

Data on alcohol, tobacco and other drug use across all eight Australian states and territories is available in the National Drug Strategy Household Survey (NDSHS).

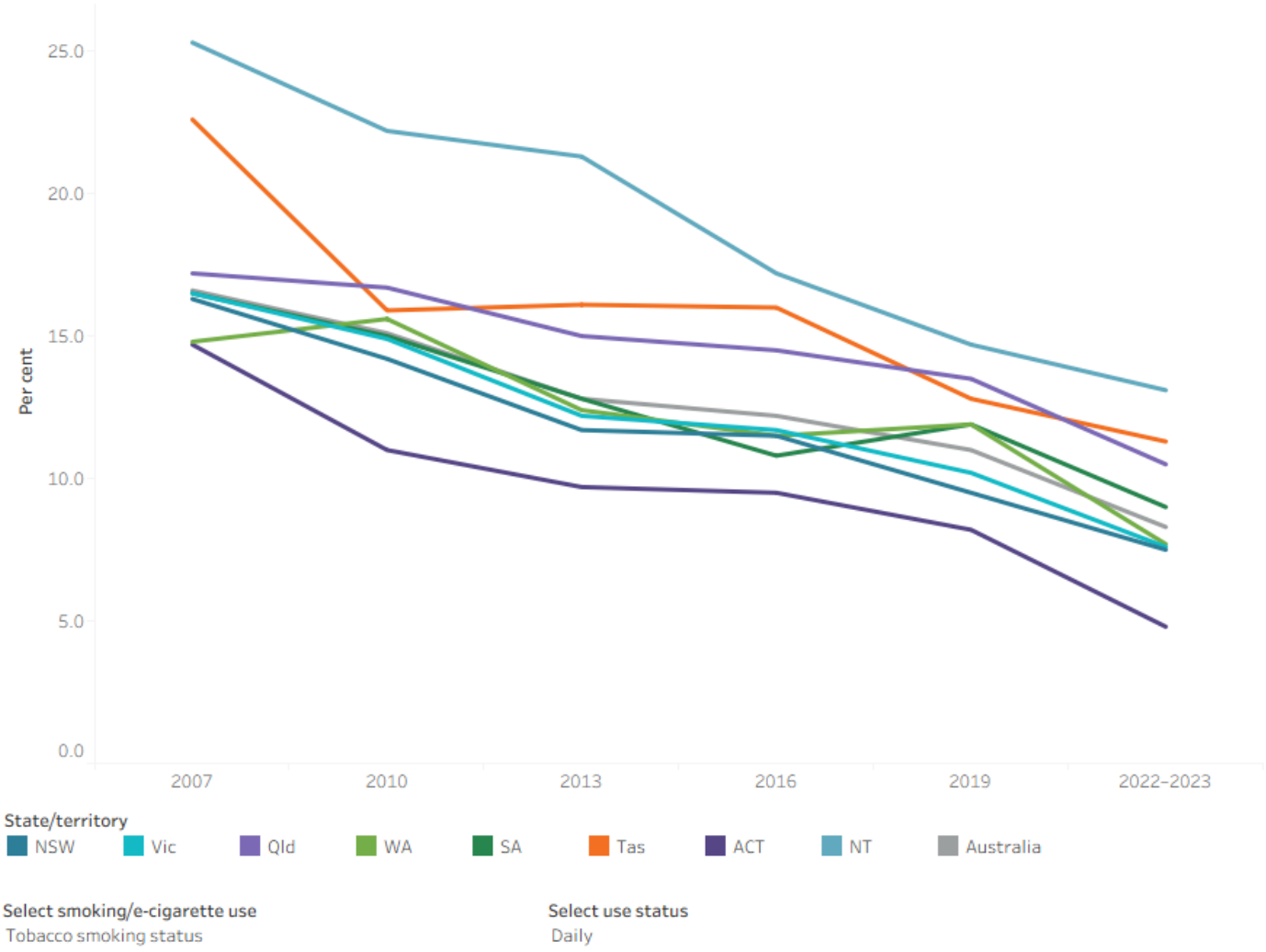
For detailed findings, see National Drug Strategy Household Survey 2022–2023: State and Territory summaries of alcohol, tobacco, e-cigarette and other drug use.

Tobacco

The proportion of people who reported daily smoking in the 2022–2023 NDSHS varied slightly, but daily smoking has declined across all states and territories since 2007. Findings showed that daily smoking was most common among adults aged 14 and over in the Northern Territory (13%) and Tasmania (11%), and least common among adults in the Australian Capital Territory (4.8%) and New South Wales (7.5%) (AIHW 2024, Table 9b.5; Figure 1).

In most states and territories, rates of daily smoking were similar among males and females, except for the Northern Territory and South Australia where rates of smoking were higher among males than females (AIHW 2024, Table 9b.2).

Figure 1: Tobacco smoking status and e-cigarette use, people aged 14 and over in Australia, 2007 to 2022–2023



Source: AIHW 2024 (Supplementary table 9b.5 and 9b.9).

See notes >

People in the 35–44, 45–54 or 55–64 age groups had the highest rate of daily smoking in all states and territories except for Tasmania and the Australian Capital Territory:

- In Tasmania, 1 in 5 (19%) people in the 25–34 age group reported daily smoking – the highest of any age group.
- In the Australian Capital Territory, *8.6% of people in the 65–74 age group reported daily smoking – the highest of any age group (*estimate has a relative standard error between 25% and 50% and should be used with caution) (AIHW 2024, Table 9b.7).

For related content on tobacco use, harms and treatment in this report, see Tobacco.

Vaping and e-cigarettes

E-cigarette use among states and territories is relatively similar and has been increasing since 2016. Findings from the 2022–2023 NDSHS showed that among people aged 14 and over:

- The proportion of people who reported current use of e-cigarettes ranged from 3.7% in Tasmania to 7.9% in New South Wales.
- The largest difference between male and female e-cigarette use was in the Australian Capital Territory, where 8.6% of males and *3.2% of females reported currently using e-cigarettes (*estimate has a relative standard error between 25% and 50% and should be used with caution).
- Across most states and territories, e-cigarette use was most common among people aged 18–24, except for the Northern Territory where e-cigarette use was most common among the 25–34 age group (AIHW 2024, tables 9b.10 and 9b.12).

For related content on vaping and e-cigarette use, harms and treatment in this report, see Vaping and e-cigarettes.

Alcohol

Alcohol consumption across states and territories is relatively similar. Most people who drink alcohol do so weekly or less often (as opposed to daily), and daily and weekly drinking have declined across most states and territories since 2007 (AIHW 2024).

Among people aged 14 and over in 2022–2023:

- Consumption of alcohol in the previous 12 months ranged from 75% in New South Wales to 85% in Tasmania, and was similar between males and females in all states and territories. The greatest gender difference was in the Australian Capital Territory (85% of males compared with 77% of females).
- Daily alcohol consumption ranged from 4.0% in Victoria to 7.2% in the Northern Territory and Tasmania (AIHW 2024, Table 9b.13; Figure 2).

Figure 2: Alcohol drinking status, people aged 14 and over in Australia, 2007 to 2022–2023

The proportion of people at risk of alcohol-related harm varied among states and territories but has declined across all states and territories since 2007. Findings from the NDSHS showed that among people aged 14 and over, in 2022–2023, the proportion of people who consumed alcohol at risky levels ranged from 26% in Victoria to 40% in the Northern Territory.

Additionally, across all jurisdictions, males were more likely than females to consume alcohol at risky levels:

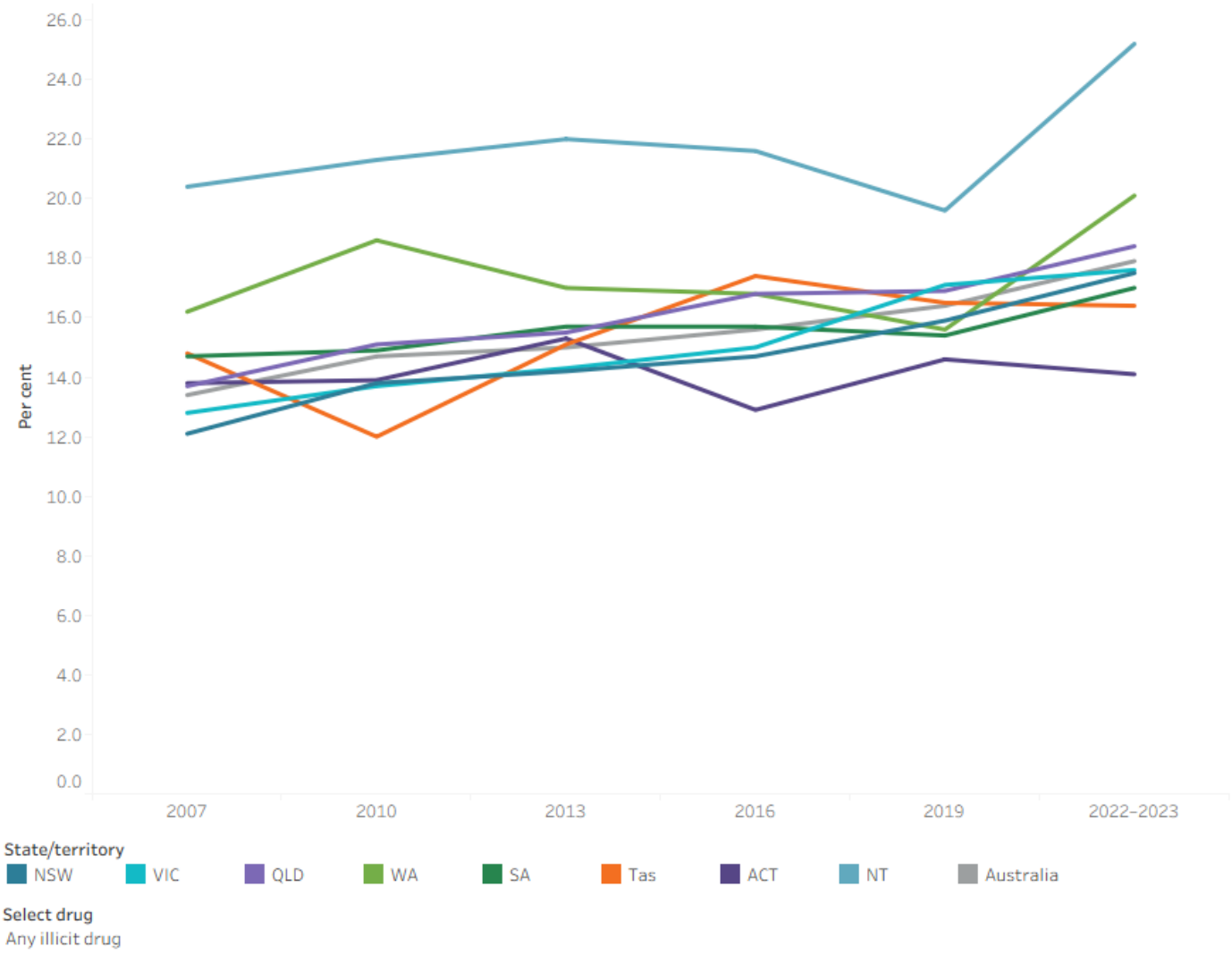
- The proportion of females who consumed alcohol at risky levels ranged from 20% in Victoria to 36% in the Northern Territory.
- The proportion of males who consumed alcohol at risky levels ranged from 33% in the Australian Capital Territory to 45% in Tasmania (AIHW 2024, Table 9b.16).

For related content on alcohol use, harms and treatment in this report, see Alcohol.

Illicit drugs

The NDSHS showed that use of any illicit drug varied among states and territories but has risen across most states and territories since 2007. In 2022–2023, the proportion of people aged 14 and over reporting recent illicit drug use ranged from 14% in the Australian Capital Territory to 25% in the Northern Territory (AIHW 2024, Table 9b.27; Figure 3).

Figure 3: Recent use of illicit drugs, people aged 14 and over in Australia, 2007 to 2022–2023



* Estimate has a relative standard error of 25% to 50% and should be used with caution.
(a) Drug category was changed in 2022–2023. Results for 2019 and earlier years are not comparable.
Note: Recent use of drugs indicates use at least once in the previous 12 months.
Source: AIHW 2024 (Supplementary table 9b.32).

Cannabis had the highest rates of recent use of any illicit drug across all states and territories in 2022–2023, ranging from 8.7% in the Australian Capital Territory to 19% in the Northern Territory (AIHW 2024, Table 9b.32; Figure 3). Rates of recent cannabis use were highest among people aged 18–24 in all states and territories except for the Northern Territory, ranging from 21% of people in this age group in New South Wales to 37% of people in this age group in Tasmania. In the Northern Territory, recent cannabis use was highest among people aged 25–29. (AIHW 2024, Table 9b.36). Use of other drugs varied across the states and territories.

The characteristics of people who reported recent illicit drug use in 2022–2023 were broadly similar across states and territories:

- Among people aged 14 and over, the proportion of males who reported recent illicit drug use was higher than females in every state and territory except for the Northern Territory where it was similar for males and females (AIHW 2024, Table 9b.29).
- Across most states and territories, people aged 18–24 had the highest rates of recent illicit drug use (ranging from 31% in New South Wales to 43% in the Australian Capital Territory). In the Northern Territory, recent illicit drug use was most common among people aged 25–29 (AIHW 2024, Table 9b.31).

The National Wastewater Drug Monitoring Program (NWDMP) monitors the presence of drugs (including illicit drugs) and their metabolites in wastewater sites across Australia, providing information about trends in drug consumption at the population level (ACIC 2025).

Findings from Report 24 of the NWDMP found that between 2022–23 and 2023–24:

- Estimated methylamphetamine consumption increased across all states and territories, with the largest proportionate increases in the Northern Territory (up 53% from 52.8 kilograms (kg) to 80.6 kg per annum) and Tasmania (up 38% from 134.7 kg to 185.9 kg per annum). The largest crude increase was in Victoria – methylamphetamine consumption increased from 2,798.6 kg to 3,455.2 kg per annum.
- Estimated cocaine consumption increased across all states and territories, with the largest proportionate increases in the Northern Territory (up 222% from 9.7 kg to 31.2 kg per annum) and Tasmania (up 107% from 24.5 kg to 50.7 kg per annum). The largest crude increase was in Victoria – cocaine consumption increased from 974.4 kg to 1,846.5 kg per annum.

- Estimated MDMA consumption increased across all jurisdictions, with the largest proportionate increases in the Northern Territory (up 92% from 8.5 kg to 16.3 kg per annum) and Western Australia (up 65% from 66.9 kg to 110.3 kg per annum). The largest crude increase was in New South Wales – MDMA consumption increased from 334.0 kg to 511.8 kg per annum.
- Estimated heroin consumption increased across all jurisdictions, with the largest proportionate increases in Tasmania (up 65% from 3.1 kg to 5.1 kg per annum) and Western Australia (up 46% from 40.0 kg to 58.4 kg per annum). The largest crude increase was in New South Wales – heroin consumption increased from 366.4 kg to 444.4 kg per annum (ACIC 2025).

Detailed information on wastewater drug monitoring (including alcohol, nicotine and cannabis) is available in Remoteness areas.

For related content on alcohol and other drug use in this report, see Drug types.

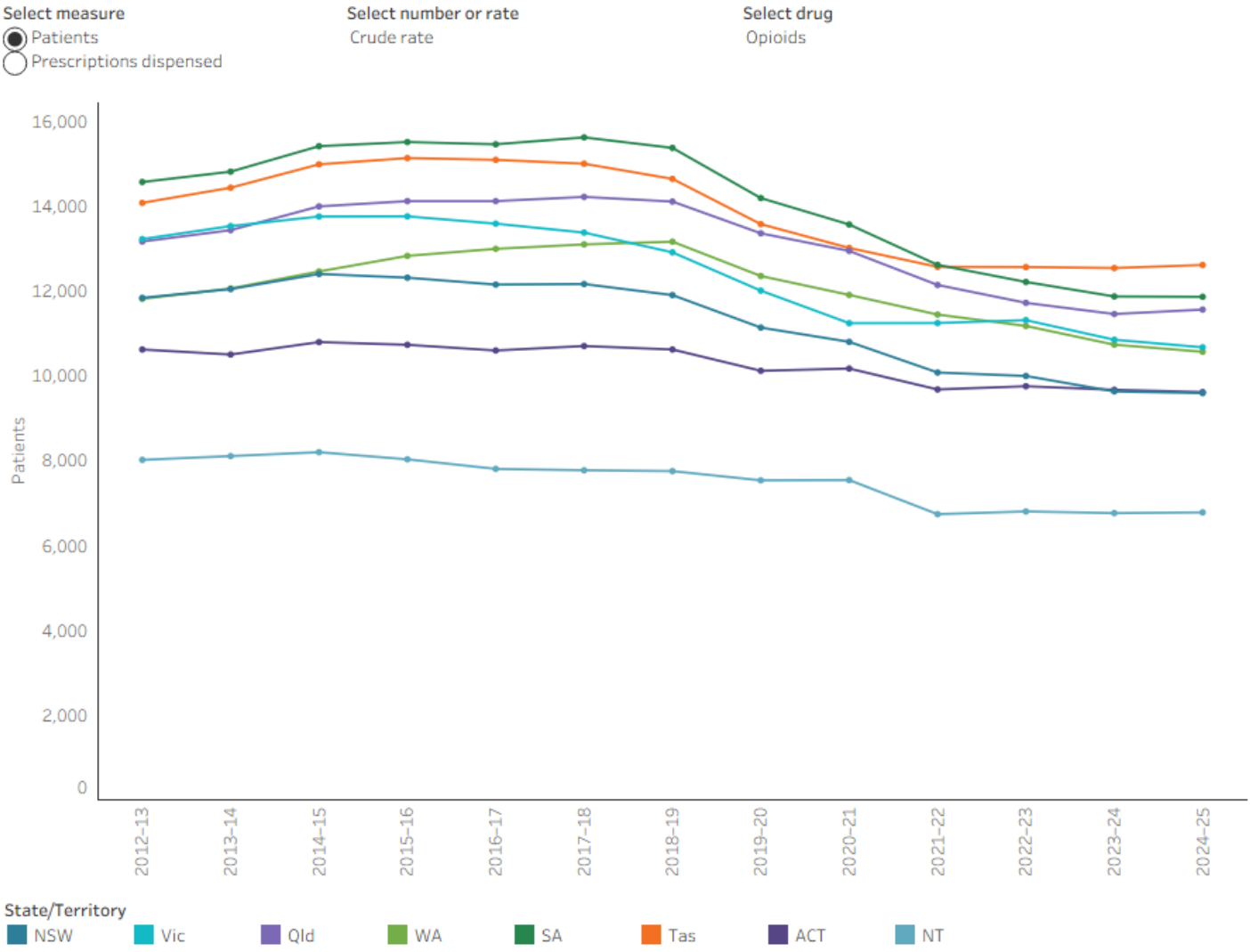
How does prescription drug dispensing vary across states and territories?

Data on prescription medicine dispensing in this report are sourced from the Pharmaceutical Benefits Scheme (PBS). Data from the PBS provide information on the number of prescriptions dispensed and the number of patients supplied at least one script within a given financial year. The PBS database includes information on medicines that may be used for non-medical purposes (including opioids, benzodiazepines and gabapentinoids) and medicines that are used to help people stop their smoking or alcohol consumption (smoking cessation medicines and alcohol cessation medicines).

AIHW analysis of the PBS showed that among all states and territories, in 2024–25:

- The crude rates of patients who were dispensed opioids, benzodiazepines, gabapentinoids and smoking cessation medicines were highest in Tasmania.
- The crude rate of patients who were dispensed alcohol cessation medicines was highest in Queensland (205 per 100,000 population).
- The Northern Territory had the lowest rate of patients dispensed alcohol cessation medicines (120 per 100,000 population), despite having the highest rates of risky alcohol consumption, alcohol-related ambulance attendances and specialist alcohol and other drug treatment services of any state or territory (AIHW 2024, AIHW 2025; Figure 4).

Figure 4: PBS prescriptions dispensed or patients who were dispensed selected medicines, by drug class and state/territory, 2012–13 to 2024–25



AIHW analysis of PBS data maintained by the Department of Health, Disability and Ageing and sourced from Services Australia and the Australian Bureau of Statistics. Supplementary tables PBS9–12, PBS29–32, PBS53–56, PBS69–72 and PBS85–88.

http://www.aihw.gov.au

See notes >

For related content on prescription drug dispensing in this report, see also:

- Availability of prescription opioids, benzodiazepines and gabapentinoids in Australia
- Availability of smoking and alcohol cessation medicines in Australia

How do alcohol and other drug-related harms vary across states and territories?

Alcohol and other drug-related ambulance attendances

Fewer ambulance attendances were captured in Victoria between March and September 2024 due to industrial action by paramedics. Victorian data for 2024 should be interpreted with caution.
Data on alcohol and other drug-related ambulance attendances are sourced from the National Ambulance Surveillance System (NASS) and are currently available for six of the eight Australian states and territories (excluding Western Australia and South Australia).

AIHW analysis of NASS data showed that among included jurisdictions in 2024:

- Excluding Victoria, rates of total alcohol and other drug-related ambulance attendances ranged from 745 per 100,000 population (around 63,300 attendances) in New South Wales to 2,960 per 100,000 population (around 7,700 attendances) in the Northern Territory.
- In Victoria, the rate of attendances was around 465 per 100,000 population (around 32,400 attendances), a decrease from around 756 per 100,000 population (around 51,400 attendances) in 2023. This is mainly due to industrial action by paramedics in Victoria in 2024, which resulted in fewer ambulance attendances being captured (Table NASS3).

Monthly data indicate that alcohol and other drug-related ambulance attendances fluctuate throughout the year but tend to be highest around December to January. This pattern is consistent across most states and territories, and appears largely driven by increases in alcohol-related attendances in these months (Table NASS1, Figure 5).

Figure 5: All alcohol and other drug ambulance attendances, by month, sex and selected states and territories, 2021 to 2024

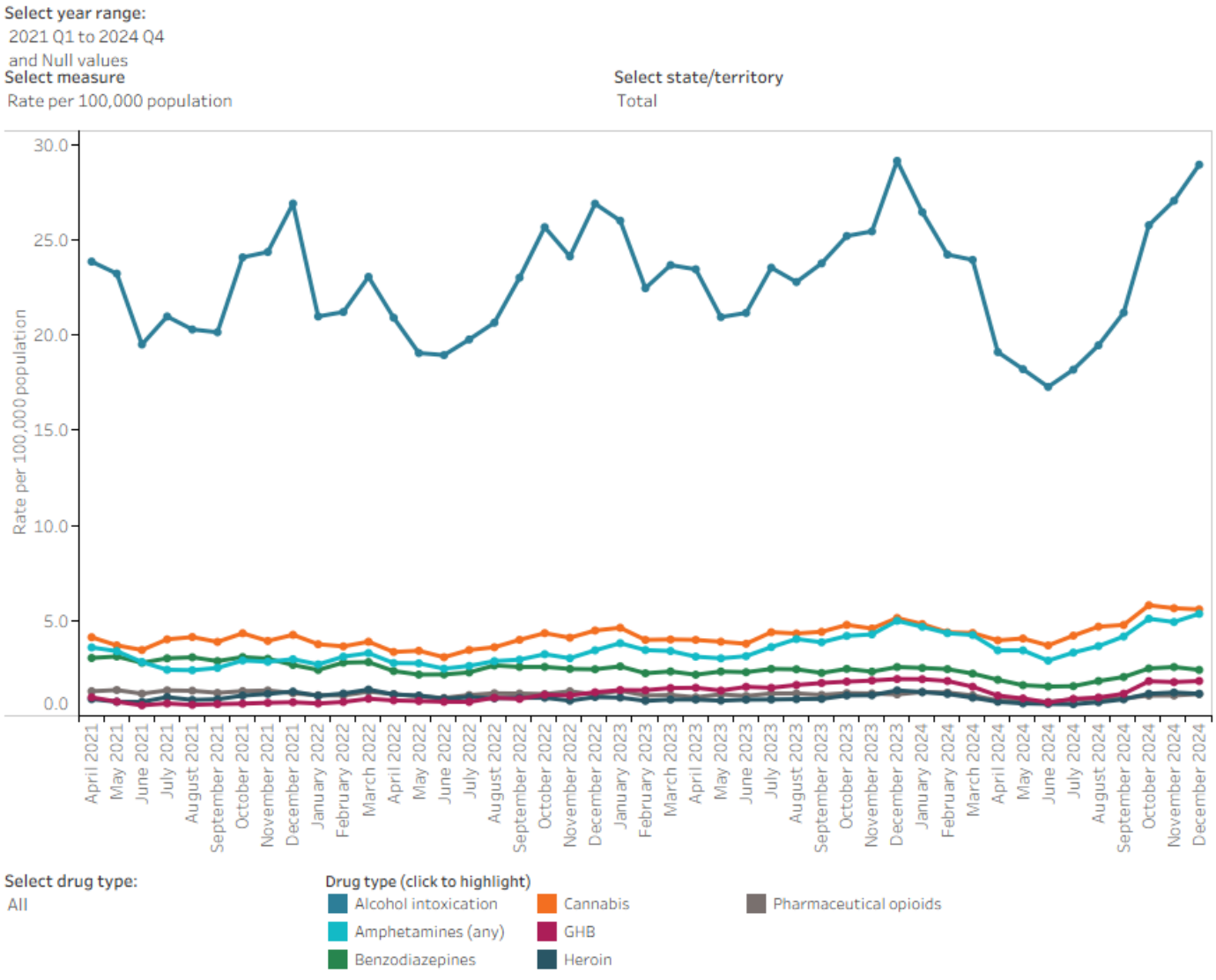


Chart: AIHW (Supplementary table NASS1). Source: National Ambulance Surveillance System, Monash University, Turning Point.

See notes >

Annual data (excluding Victorian data) indicate that in 2024, among all alcohol and other drug-related ambulance attendances:

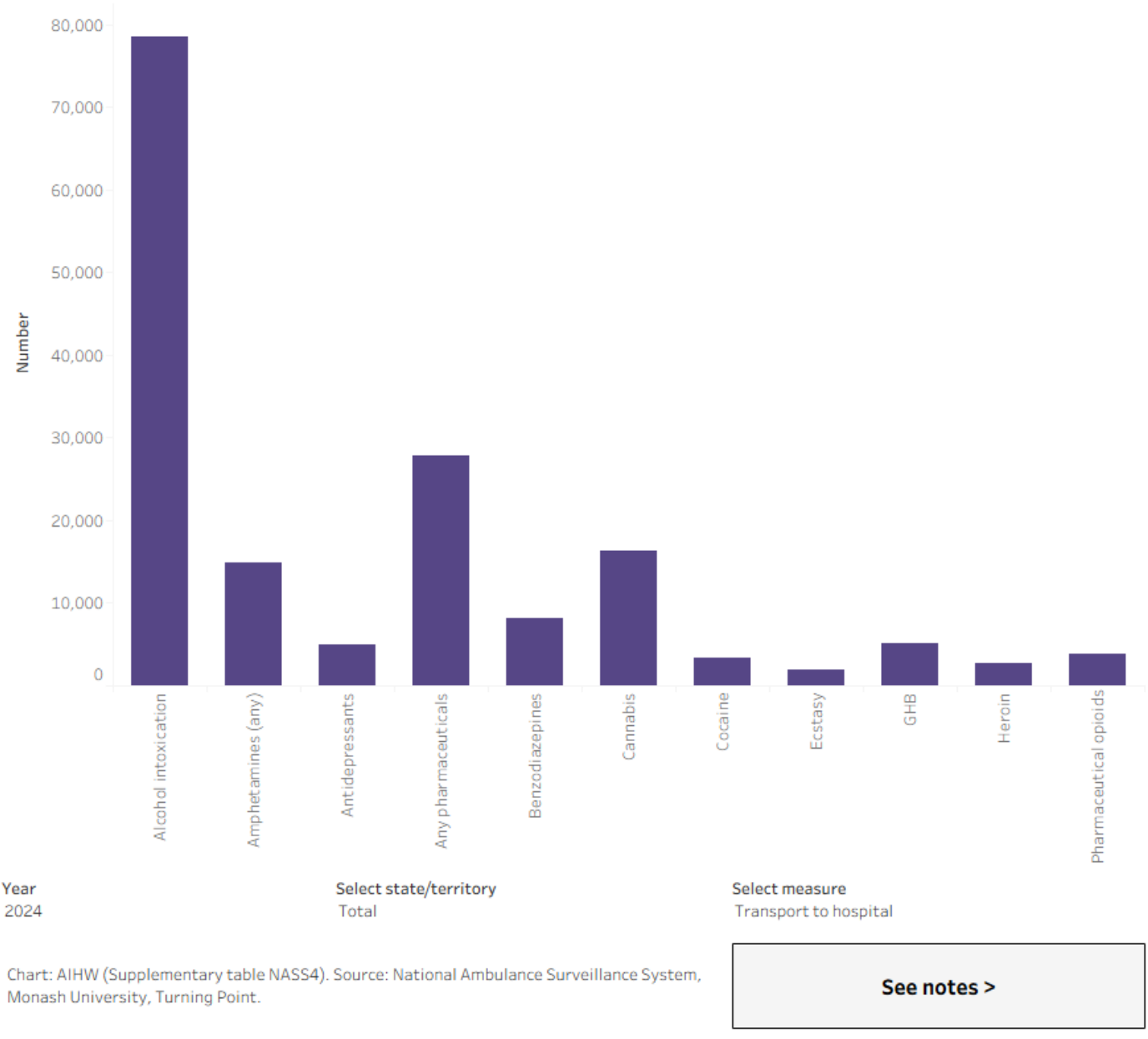
- Males had a higher number of ambulance attendances than females across all states and territories except for the Northern Territory where it was higher for females.

- Alcohol was involved in more ambulance attendances than any other drug across all states and territories, ranging from 505 per 100,000 population (around 35,400 attendances) in New South Wales to 2,827 per 100,000 (around 5,900) in the Northern Territory.
  - People aged 45–54 had the highest rates of ambulance attendances for alcohol intoxication in all included states and territories except Tasmania, ranging from 639 per 100,000 population in the Australian Capital Territory to 4,674 per 100,000 in the Northern Territory. In Tasmania, rates were highest among people aged 15–24 (882 per 100,000).
- Cannabis and amphetamines were in the top three most common drug types involved in ambulance attendances across all states and territories.
  - Rates of cannabis-related ambulance attendances ranged from 107 per 100,000 population (around 7,500 attendances) in New South Wales to 459 per 100,000 population (around 950 attendances) in the Northern Territory.
  - Rates of amphetamine-related ambulance attendances ranged from 84 per 100,000 population (around 335 attendances) in the Australian Capital Territory to 148 per 100,000 population (around 6,700 attendances) in Queensland (Table NASS3).

Other characteristics of alcohol and other drug-related ambulance attendances also varied by state and territory, including transport to hospital, police co-attendance and use of multiple drugs.

Most ambulance attendances in 2024 involved the person being transported to hospital, ranging from 74% in Tasmania and the Australian Capital Territory to 83% in Queensland. In every jurisdiction, attendances involving antidepressants had the highest rates of transport to hospital, ranging from 91% in Victoria to 98% in the Northern Territory (tables NASS3 and NASS4, Figure 6).

Figure 6: Ambulance attendances involving transport to hospital, police co-attendance and multiple drug use, by year, selected states and territories, 2021 to 2024



In 2024, among all alcohol and other drug-related ambulance attendances:

- The proportion of attendances where multiple drugs were present ranged from 8% in the Northern Territory to 22% in Tasmania and the Australian Capital Territory.
  - In New South Wales (75% attendances), Queensland (76%) and the Australian Capital Territory (79%), ambulance attendances were most likely to involve multiple drugs when ecstasy was present.
  - In Tasmania (80% attendances) and the Northern Territory (76%), among drug types with available data, ambulance attendances were most likely to involve multiple drugs when opioid analgesics were present.
  - In Victoria (79% attendances), ambulance attendances were most likely to involve multiple drugs when antidepressants were present.

- The proportion of attendances where police co-attended ranged from 23% in the Australian Capital Territory to 34% in New South Wales (Table NASS4, Figure 6).

For related content on alcohol and other drug-related ambulance attendances in this report, see Alcohol and other drug-related ambulance attendances.

Drug-related hospitalisations (excluding alcohol)

Information on drug-related hospitalisations (excluding alcohol) by state and territory is available in analysis of the National Hospital Morbidity Database by the National Drug and Alcohol Research Centre (NDARC).

In 2022–23, the rate of drug-related hospitalisations ranged from 161 per 100,000 population in the Australian Capital Territory to 324 per 100,000 population in the Northern Territory (Chrzanowska et al. 2025a).

Among all drug-related hospitalisations:

- Amphetamine-type stimulants were associated with the highest rates of hospitalisation in New South Wales, Victoria, Queensland, Western Australia, South Australia and Tasmania (ranging from 38 per 100,000 population in Tasmania to 72 per 100,000 population in South Australia).
  - In the Australian Capital Territory, the highest rates of hospitalisation involved a principal diagnosis of non-opioid analgesics (39 per 100,000 population).
  - In the Northern Territory, the highest rates of hospitalisation involved a principal diagnosis of cannabinoids (134 per 100,000 population).
- Females had higher rates of hospitalisations in all states and territories except for New South Wales. Of these jurisdictions, rates of drug-related hospitalisations involving females ranged from 183 per 100,000 population in Western Australia to 329 per 100,000 population in the Northern Territory.
  - In New South Wales, rates of drug-related hospitalisations were 218 per 100,000 population for males compared with 166 per 100,000 population for females.
- People aged 20–29 had the highest rates of hospitalisations in most jurisdictions, except for the Australian Capital Territory where rates were highest among those aged 10–19 (304 per 100,000 population).
  - Of other jurisdictions, rates of drug-related hospitalisations among people aged 20–29 ranged from 313 per 100,000 population in Western Australia to 724 per 100,000 population in the Northern Territory (Chrzanowska et al. 2025a).

For detailed findings, see Trends in drug-related hospitalisations in Australia, 2003-2023.

For related content on alcohol and other drug-related hospitalisations in this report, see Alcohol and other drug-related hospitalisations.

Drug-induced deaths (excluding alcohol)

Information on drug-induced deaths (excluding alcohol) by state and territory is available in NDARC's annual analysis of data from the National Mortality Database.

In 2023, the rate of drug-induced deaths ranged from 5.0 per 100,000 population (421 deaths) in New South Wales to 9.5 per 100,000 population (278 deaths) in Western Australia (excluding the Northern Territory) (Chrzanowska et al. 2025b).

Among all drug-induced deaths in 2023 (excluding the Northern Territory):

- Opioids were associated with the highest rates of deaths in all states and territories except Queensland, ranging from 2.7 per 100,000 population (223 deaths) in New South Wales to 5.3 per 100,000 population (153 deaths) in Western Australia.
  - In Queensland, the highest rates of drug-induced deaths were attributed to antiepileptic, sedative-hypnotic and anti-parkinsonism drugs (3.0 deaths per 100,000 population, or 165 deaths).
- Most deaths were among males across all states and territories, ranging from 59% of deaths in South Australia to 71% of deaths in New South Wales.
  - The jurisdiction with the highest rates of drug-induced deaths among females was Western Australia (7.1 deaths per 100,000 population) (excluding the Australian Capital Territory where the rate was unavailable).
- People aged 45–54 had the highest rates of deaths in most jurisdictions with available data (Chrzanowska et al. 2025b).

For detailed findings, see Trends in overdose and other drug-induced deaths in Australia, 2004-2023.

For related content on deaths involving alcohol and other drugs in this report, see Deaths involving alcohol and other drugs.

How does specialist treatment for alcohol and other drug use vary across states and territories?

Data from the Alcohol and other drug treatment services in Australia report showed that the rate of clients receiving treatment varied among each state and territory. In 2023–24, the rate of clients receiving treatment ranged from 370 per 100,000 population in New South Wales to 1,560 per 100,000 population in the Northern Territory (AIHW.

In all states and territories:

- Males were more likely to receive treatment than females, ranging from 55% of clients in Victoria to 71% of clients in the Northern Territory.
- Alcohol was the most common drug for which clients received treatment, ranging from 37% of clients in South Australia to 63% of clients in the Northern Territory.
- People aged 30–39 had the highest rates of treatment, ranging from 26% in Queensland to 30% in Victoria (AIHW 2025).

For detailed findings, see Alcohol and other drug treatment services in Australia annual report, State and territory summaries.

For related content on specialist alcohol and other drug treatment in this report, see Alcohol and other drug treatment services.

Where do I go for more information?

- Alcohol and other drug treatment services in Australia annual report
- State and Territory summaries of alcohol, tobacco, e-cigarette and other drug use
- Trends in drug-related hospitalisations in Australia
- Trends in overdose and other drug-induced deaths in Australia

References

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AIHW (2025) *Alcohol and other drug treatment services in Australia annual report*, AIHW, Australian Government, accessed 12 September 2025.

Chrzanowska A, Man N, Sutherland R, Degenhardt L and Peacock A (2025a) *Trends in drug-related hospitalisations in Australia, 2003–2023*, National Drug and Alcohol Research Centre, UNSW Sydney, accessed 26 September 2025.

Chrzanowska A, Man N, Sutherland R, Degenhardt L and Peacock A (2025b) *Trends in overdose and other drug-induced deaths in Australia, 2004–2023*, National Drug and Alcohol Research Centre, UNSW Sydney, accessed 26 September 2025.

Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Remoteness areas

In this section

Introduction

How do we define remoteness areas?

Most data sources in this report classify remoteness areas according to the Australian Statistical Geography Standard (ASGS) Remoteness Area. This remoteness classification is based on the road distances from goods and services (ABS 2023b). The ASGS Remoteness Area classification reflects the population at the time of the 2021 Census.

The ASGS Remoteness Structure describes five levels of remoteness:

- Major cities
- Inner regional areas
- Outer regional areas
- Remote areas
- Very remote areas (ABS 2023b).

In the National Drug Strategy Household Survey, remote and very remote areas are grouped together.

Around 7 million people live in rural and remote areas of Australia, accounting for 28% of the total population (AIHW 2024b). People living in the most remote areas generally have poorer health outcomes than those living in more urban areas, including higher rates of hospitalisation, death and injury. Those in remote areas also have poorer access to primary health care services (AIHW 2024b).

This page focuses on alcohol and other drug use and harms across remoteness areas in Australia. The reporting uses data from a range of sources, mostly national administrative and survey data.

Key findings

- 1 in 5 (20%) people who lived in *Remote and very remote areas* of Australia in 2022–2023 smoked daily
- Wastewater drug monitoring shows that consumption of cannabis and methylamphetamine is typically higher in regional areas than capital cities
- The rate of drug-induced deaths was slightly higher in *Regional and remote* areas than *Major cities* in 2023

What data sources are available?

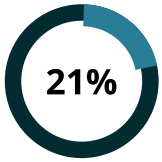
Data sources for alcohol and other drugs by remoteness area

- National Drug Strategy Household Survey
- National Health Survey
- National Hospital Morbidity Database
- National Mortality Database
- National Wastewater Drug Monitoring Program
- Pharmaceutical Benefits Scheme data collection
- Trends in overdose and other drug-induced deaths in Australia

There are a range of data sources that contain information about alcohol and other drug use across remoteness areas. These include self-report surveys that ask people about their use of alcohol and other drugs, wastewater analysis and health administrative data sets (such as administrative data routinely collected by hospitals). Each data set uses a different methodology, and the language used to describe alcohol and other drugs or remoteness areas may also differ across sources.

For more information about each data source, see Technical notes.

How does alcohol and other drug use vary across remoteness areas?



In 2022–2023, people living in *Remote and very remote* areas were the most likely out of all remoteness areas to have recently used any illicit drug

Source: National Drug Strategy Household Survey

Tobacco smoking

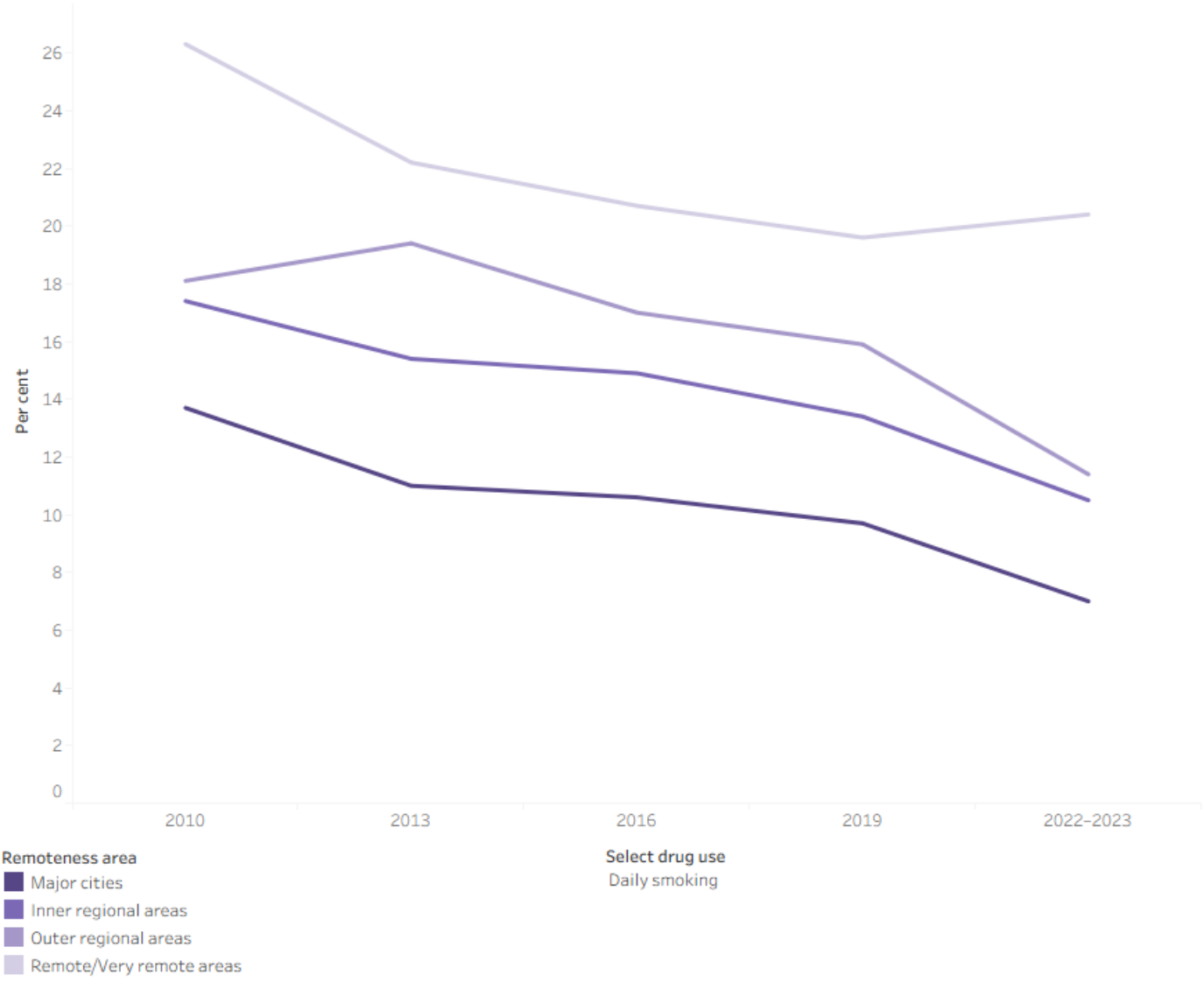
Data from both the National Drug Strategy Household Survey (NDSHS) and the National Health Survey (NHS) show that people in more remote areas of Australia are more likely to smoke than those in major cities.

Results from the 2022 NHS found that people aged 18 and over living in *Outer regional and remote* areas were around 1.5 times as likely to smoke daily as those in *Major cities* (16.7% compared with 9.4%) (ABS 2023a, Table 6.3).

The proportion of people aged 14 and over who smoke daily has decreased over time in most remoteness areas, except for *Remote and very remote* areas where daily smoking rates have remained stable since 2016 (AIHW 2024a; Figure 1). In 2022–2023, the proportion of people who smoked daily in:

- *Major cities* decreased (from 9.7% in 2019 to 7.0% in 2022–2023)
- *Inner regional* areas decreased (13.4% to 10.5% in 2022–2023)
- *Remote and very remote* areas (20%) was higher than the proportion in *Major cities* (7%) (AIHW 2024a, Table 9a.12; Figure 1).

Figure 1: Daily smoking, alcohol consumption risk or recent use of illicit drugs, by remoteness area, people aged 14 and over, 2010 to 2022–2023



Source: AIHW 2024 (Supplementary table 9a.12)
http://www.aihw.gov.au

See notes >

Vaping and e-cigarette use

In 2022–2023, people living in *Major cities* (3.9%) and *Remote and very remote* areas (*3.7%) were more likely than people living in *Inner regional* (2.2%) and *Outer regional* (2.5%) areas to use e-cigarettes/vapes daily (AIHW 2024a). Between 2019 and 2022–2023, daily use of e-cigarettes increased in all remoteness areas except for *Remote and very remote* areas where it remained stable (AIHW 2024a, Table 3.11).

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

Risky drinking

In general, people living in more remote areas of Australia are more likely than people in *Major cities* to exceed the alcohol risk guidelines.

- The 2022–2023 NDSHS showed that people aged 14 and over living in *Remote and very remote (*40%) and *Outer regional* areas (39%) were about 1.4 times as likely as those living in *Major cities* (29%) to consume alcohol at risky levels (AIHW 2024a, Table 4.34; Figure 1).
- Similarly, the 2022 NHS showed that adults (aged 18 and over) in *Outer regional and remote* areas (30.9%) were more likely to drink at risky levels than those in *Major cities* (25.6%) (ABS 2023a, Table 6.3).

Illicit drug use

Data from the 2022–2023 NDSHS showed that people living in *Remote and very remote areas* (21%) were more likely to have recently used any illicit drug than those living in *Major cities* (18.4%), *Inner regional* (15.2%) and *Outer regional* (18.7%) areas (AIHW 2024a, Table 9a.12). This varied by drug type:

- People living in *Remote and very remote areas* were more likely than those living in *Major cities* to have used cannabis in the previous 12 months (13.2% and 11.7% respectively).
- Similar proportions of people living in *Major cities, Inner regional* and *Outer regional* areas recently used methamphetamine and amphetamine (1.1%, 0.9% and *0.7%, respectively). A higher proportion (*2.1%) of people living in *Remote and very remote areas* reported recent use of methamphetamine and amphetamine.
- People living in *Remote and very remote* areas were about 1.2 times as likely as those from *Major cities* to have recently used pain-killers/pain-relievers and opioids for non-medical purposes in 2022–2023 (*2.7% compared with 2.2%). This is a reduction from 2019 when they were 1.5 times as likely to have done so.
- Cocaine and ecstasy use were higher among those who lived in *Major cities* (AIHW 2024a, Table 9a.12; Figure 1).

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

Between 2019 and 2022–2023:

- Recent use of cannabis decreased remained largely stable across all remoteness areas.
- Use of pain-killers/pain-relievers and opioids for non-medical purposes in remained stable across all remoteness areas except *Outer regional areas*, where it significantly decreased (from 3.5% to 2.2%) (AIHW 2024a, Table 9a.12; Figure 1).

Polydrug use

Analysis of NDSHS data indicated that polydrug use varied across remoteness areas. People in *Remote and very remote* areas were the most likely to use alcohol (79%) or tobacco (51%) at the same time as cannabis, while those in *Major cities* were the most likely to report using illicit drugs (24%) or not using other drugs (20%) with cannabis (AIHW 2024a).

For related content on alcohol and other drug use in this report, see Drug types.

What does wastewater drug monitoring tell us about alcohol and other drug use across capital cities and regional areas?

Wastewater analysis shows that consumption of nicotine, alcohol, cannabis and methylamphetamine are typically higher in regional areas than major cities

Source: National Wastewater Drug Monitoring Program

The National Wastewater Drug Monitoring Program (NWDMP) monitors selected substances of concern in most populated regions of Australia (ACIC 2025). The most recent wastewater report covers the period from April to August 2024 for both capital cities and regional sites, with additional information up to October 2024 for capital cities (ACIC 2025).

Data from the NWDMP show that consumption of nicotine, alcohol, cannabis and methylamphetamine is generally higher in regional areas, while consumption of other drugs varies between capital cities and regional areas (Table 1).

Table 1: Drug consumption in capital cities and regional areas, estimated from wastewater, 2024

Drug type	**Consumption higher in (August 2024)**		**Change in consumption (April–August 2024)**	
	Capital cities	Regional areas	Capital cities	Regional areas
Nicotine		X	↓	↓
Alcohol		X	↑	↓
Cannabis		X	↑	↓

Methylamphetamine		X	↑	↑
MDMA	X		↑	↑
Cocaine	X		↑	↑
Oxycodone		X	↓	↑
Fentanyl		X	↓	↑
Heroin	X		↑	↑
Ketamine	X		↓	↓

Note: The amount of ketamine consumed cannot be determined based on excreted concentrations in wastewater, therefore ketamine is reported as the amount excreted (in milligrams) into the sewer network per 1,000 people per day.

This report showed that:

- In capital cities, average consumption of methylamphetamine reached record high levels in August 2024, while consumption of MDMA and excretion of ketamine reached record highs in October 2024.
- In regional areas, average heroin consumption reached a record high in August 2024 and methylamphetamine reached its highest level since April 2020 (ACIC 2025).

More information on wastewater drug monitoring is available in the National Wastewater Drug Monitoring Program reports.

For related content on wastewater drug monitoring in this report, see also:

- Wastewater drug monitoring
- State and territory data

How does prescription drug dispensing vary across remoteness areas?

In 2024–25, *Inner regional* areas had the highest rate of patients who were dispensed benzodiazepines

Source: AIHW analysis of the Pharmaceutical Benefits Scheme data collection

Data on prescription medicine dispensing in this report are sourced from the Pharmaceutical Benefits Scheme (PBS). Data from the PBS provide information on the number of prescriptions dispensed and the number of patients supplied at least one script within a given financial year. The PBS database includes information on medicines that may be used for non-medical purposes (including opioids, benzodiazepines and gabapentinoids) and medicines that are used to help people stop their smoking or alcohol consumption (smoking and alcohol cessation medicines).

AIHW analysis of the PBS showed that in 2024–25:

- The highest crude rates of patients who were dispensed opioids were in *Outer regional* (around 13,600 per 100,000 population) and *Inner regional* (around 13,300 per 100,000 population) areas.
- The highest crude rate of patients who were dispensed benzodiazepines was in *Inner regional* areas (around 5,800 per 100,000 population).
- The highest crude rate of patients who were dispensed gabapentinoids was in *Inner regional* (around 3,100 per 100,000 population) and *Outer regional* (around 3,100 per 100,000 population) areas.
- The highest crude rate of patients who were dispensed smoking cessation medicines was in *Outer regional* areas (1,100 per 100,000 population).
- The highest crude rate of patients who were dispensed alcohol cessation medicines was in *Inner regional* areas (210 per 100,000 population) (tables PBS16, PBS36, PBS60, PBS76 and PBS92, Figure 2).

Figure 2: PBS prescriptions dispensed or patients who were dispensed selected medicines, by drug class and remoteness area, 2012–13 to 2024–25

AIHW analysis of PBS data maintained by the Department of Health, Disability and Ageing and sourced from Services Australia and the Australian Bureau of Statistics. Supplementary tables PBS13–16, PBS33–36, PBS 57–60, PBS73–76, PBS 89–92.

http://www.aihw.gov.au

See notes >

For related content on prescription drug dispensing in this report, see also:

- Availability of prescription opioids, benzodiazepines and gabapentinoids in Australia
- Availability of smoking and alcohol cessation medicines in Australia

How do alcohol and other drug-related harms vary across remoteness areas?

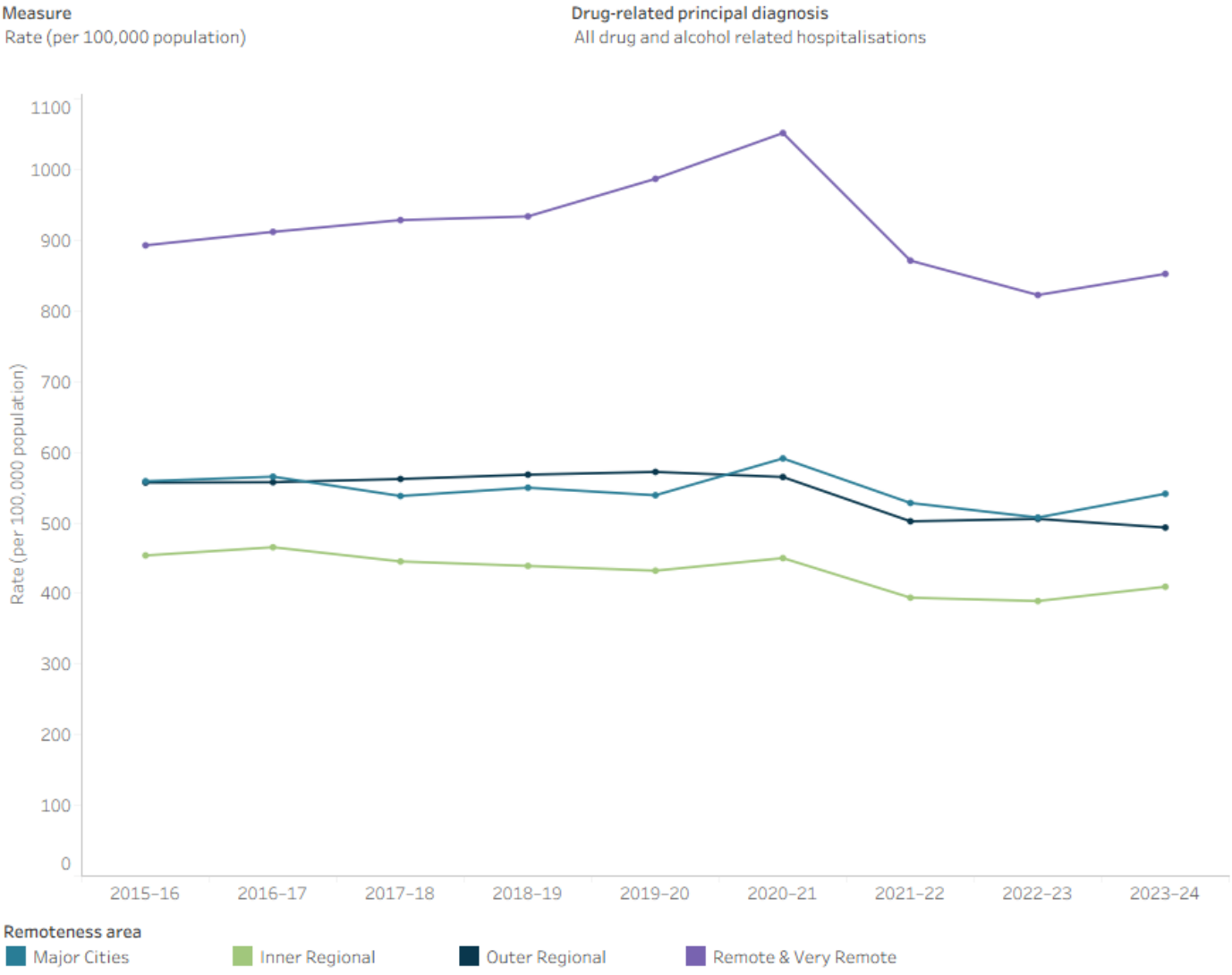
In 2023–24, *Remote and very remote* areas had the highest rate of drug and alcohol-related hospitalisations (852.7 per 100,000 population)

Source: National Hospital Morbidity Database

Alcohol and other drug-related hospitalisations

Among all alcohol and other drug-related hospitalisations in 2023–24, most (72% or 104,716 hospitalisations) occurred in *Major cities*, but the highest rate of hospitalisations was in *Remote and very remote* areas (852.7 per 100,000 people, or 4,281 hospitalisations) (Table S1.14). Among alcohol-related hospitalisations in 2023–24, almost 3 in 4 (73% or 61,655) occurred in *Major cities*, but the rate of alcohol-related hospitalisations was highest in *Remote and very remote* areas (577.8 per 100,000 population, or 2,901 hospitalisations) (Table NHMD5, Figure 3).

Figure 3: Hospitalisations with a drug-related principal diagnosis, by remoteness area and drug type, 2015–16 to 2023–24 (number or crude rate per 100,000 population)



Source: AIHW National Hospital Morbidity Database 2023–24 (Supplementary Table NHMD5)
http://www.aihw.gov.au

See notes >

Among other drug-related hospitalisations in 2023–24:

- Around 2 in 3 (67% or 4,599) cannabis-related hospitalisations occurred in *Major cities*, but the rate was highest in *Remote and very remote* areas (70.7 per 100,000 people, or 355 hospitalisations).
- Most hospitalisations for both amphetamines and other stimulants (68% or 12,264 hospitalisations) and cocaine (87% or 1,153) occurred in *Major cities*, but rates of hospitalisation for amphetamines and other stimulants were highest *Remote and very remote* areas (88.2 per 100,000 people or 443 hospitalisations, compared with 63.4 per 100,000 in *Major cities*).
- Most hospitalisations occurred in *Major cities* (65% or 3,973 for non-opioid analgesics, 74% or 4,733 for benzodiazepines and other sedative-hypnotics, 65% or 1,966 for antidepressants, and 66% or 1,996 for antipsychotics and neuroleptics.
- Although the number of pharmaceutical-related hospitalisations was higher in *Major cities* than *Regional and remote* areas, the rate was slightly higher in *Regional and remote* areas than *Major cities* across all pharmaceutical types except benzodiazepines and other sedative-hypnotics (Table NHMD5, Figure 3).

For related content on alcohol and other drug-related hospitalisations in this report, see Alcohol and other drug-related hospitalisations.

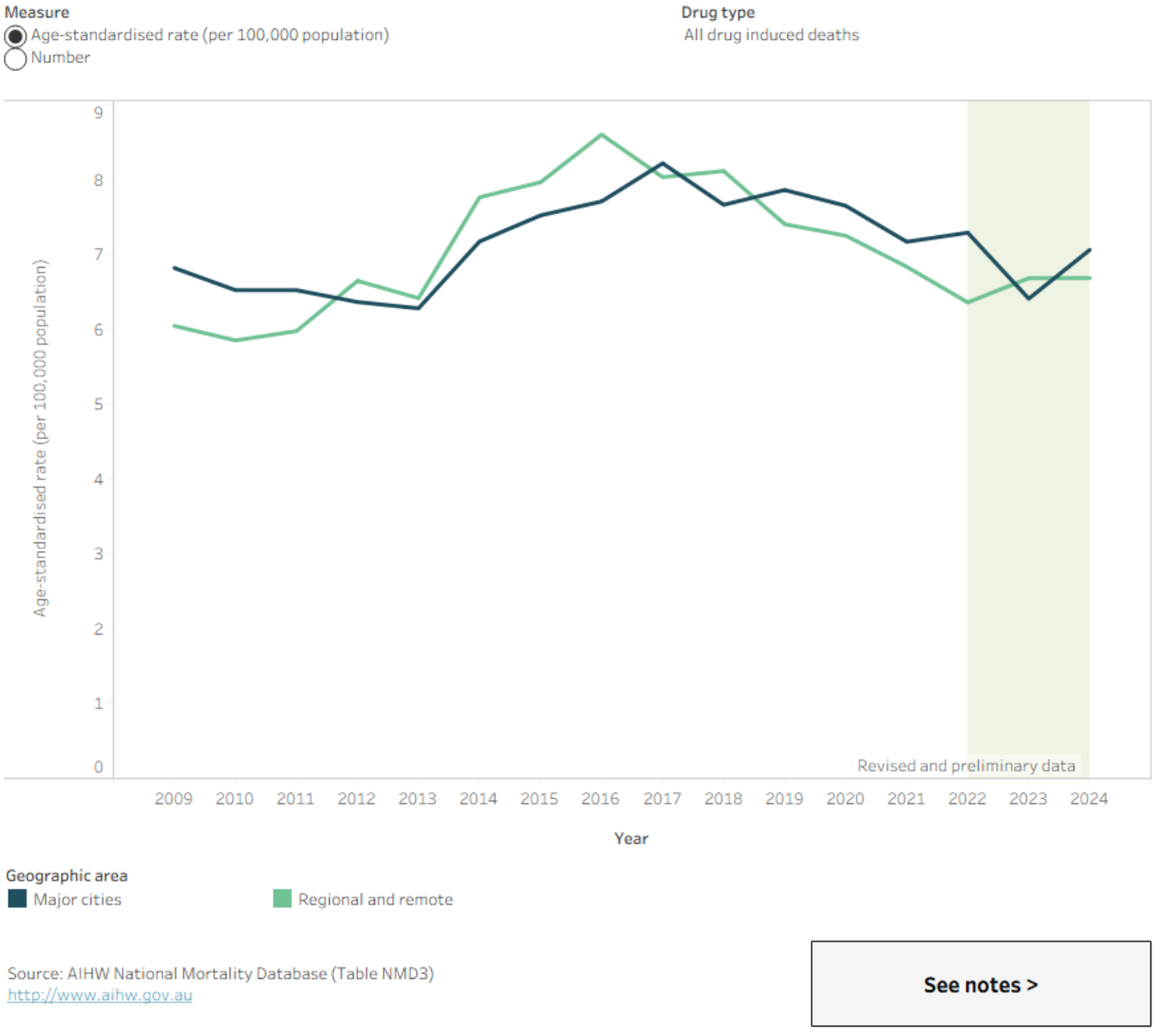
Drug-induced deaths (excluding alcohol)

AIHW analysis of preliminary data from the National Mortality Database showed that in Australia:

- In 2024, rates of drug-induced deaths were slightly higher in *Major cities* (age-standardised rate of 7.1 per 100,000 population; 1,424 deaths) than *Regional and remote* areas (6.7 per 100,000 population; 481 deaths).
- The rate of drug-induced deaths has fluctuated since 2009 in both *Major cities* and *Regional and remote* areas, reaching a peak of 8.2 per 100,000 people in 2017 in *Major cities* and 8.6 per 100,000 people in *Regional and remote* areas in 2016.
- Rates of drug-induced deaths have varied over time by drug type (Table NMD3, Figure 4).

Estimates for 2023 and 2024 are expected to rise following standard revision processes.

Figure 4: Number or age-standardised rate (per 100,000 population) of drug-induced deaths[a], by remoteness area and drug type or drug class, 2009 to 2024



Source: AIHW National Mortality Database (Table NMD3)
http://www.aihw.gov.au

See notes >

Recent NDARC analysis of preliminary revised data showed that the highest proportion of drug-induced deaths in 2023 occurred among people aged 45–54 for both *Major cities* (27% or 333 deaths) and *Regional and remote* areas (27% or 127 deaths) (Chrzanowska et al. 2025).

For related content on deaths involving alcohol and other drugs in this report, see also Deaths involving alcohol and other drugs.

Where do I go for more information?

- National Drug and Alcohol Research Centre reports
- National Wastewater Drug Monitoring Program

References

ABS (Australian Bureau of Statistics) (2023a) *National Health Survey*, ABS, Australian Government, accessed 3 January 2024.

ABS (2023b), *Remoteness Areas*, ABS Website, accessed 4 September 2025.

ACIC (Australian Criminal Intelligence Commission) (2025) *Report 24 of the National Wastewater Drug Monitoring Program*, ACIC, Australian Government, accessed 17 September 2025.

AIHW (Australian Institute of Health and Welfare) (2024a) *National Drug Strategy Household Survey 2022–2023*, AIHW, Australian Government, accessed 4 March 2024.

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Viewing this data

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Socioeconomic areas

In this section

Introduction

How do we define socioeconomic areas?

The different data sources in this report each use one of two different indexes to classify socioeconomic areas:

- Index of Relative Socio-economic Advantage and Disadvantage (IRSAD), which includes measures of both relative advantage and disadvantage.
- Index of Relative Socio-economic Disadvantage (IRSD), which includes measures of relative disadvantage only.

Both indexes are part of the Socio-Economic Indexes for Areas (SEIFA) collection of four indexes, compiled by the Australian Bureau of Statistics. Each index uses different data from the Census of population and housing, so the same area may receive different scores on the different indexes.

Scores for each SEIFA index can be divided into quintiles. The 20% of areas with the lowest scores are in the quintile 1, while the 20% of areas with the highest scores are in the quintile 5. Areas in quintile 1 on IRSAD have the greatest relative disadvantage and least advantage in general, while areas in quintile 5 have the least relative disadvantage and greatest advantage in general. Areas in quintile 1 on IRSD have the greatest relative disadvantage, while areas in quintile 5 have the least relative disadvantage (ABS 2023b).

Socioeconomic area is a key determinant of health and influences people's health and wellbeing (AIHW 2024b). Both in Australia and internationally, people living in lower socioeconomic areas are at greater risk of poor health (WHO 2024). For example, people living in the lowest socioeconomic areas have had the highest crude death rate and the highest rates of public hospitalisation (AIHW 2025a; AIHW 2025b). This is also true in the context of alcohol and other drugs, where both use and harms vary by socioeconomic area.

This page focuses on alcohol and other drug use and harms by socioeconomic area across Australia.

Key findings

- People living in the lowest socioeconomic areas had higher rates of daily smoking than people living in the highest socioeconomic areas
- People living in the lowest socioeconomic areas were the least likely to drink at risky levels in 2022–2023
- People living in areas of the highest socioeconomic advantage were more likely than those living in the most disadvantaged areas to have recently used cannabis, ecstasy and cocaine in 2022–2023
- People in the most disadvantaged socio-economic areas had the highest rates of alcohol-induced death

What data sources are available?

There are a limited number of data sources that contain information about alcohol and other drug use and harms across socioeconomic areas. These include self-report surveys that ask people about their use of alcohol and other drugs and reports that analyse health administrative data sets (such as administrative data routinely collected by hospitals). Each data set uses a different methodology, and the language used to describe alcohol and other drugs or socioeconomic areas may also differ across sources.

For more information about each data source, see Technical notes.

Data sources for alcohol and other drug use by socioeconomic area

- Causes of Death, Australia
- National Drug Strategy Household Survey
- National Health Survey
- Trends in drug-related hospitalisations in Australia
- Trends in overdose and other drug-induced deaths in Australia

How does alcohol and other drug use vary across socioeconomic areas?

In 2022–2023, people living in the most disadvantaged areas of Australia were more likely than people living in the least disadvantaged areas to smoke daily, but less likely to drink at risky levels

Source: National Drug Strategy Household Survey

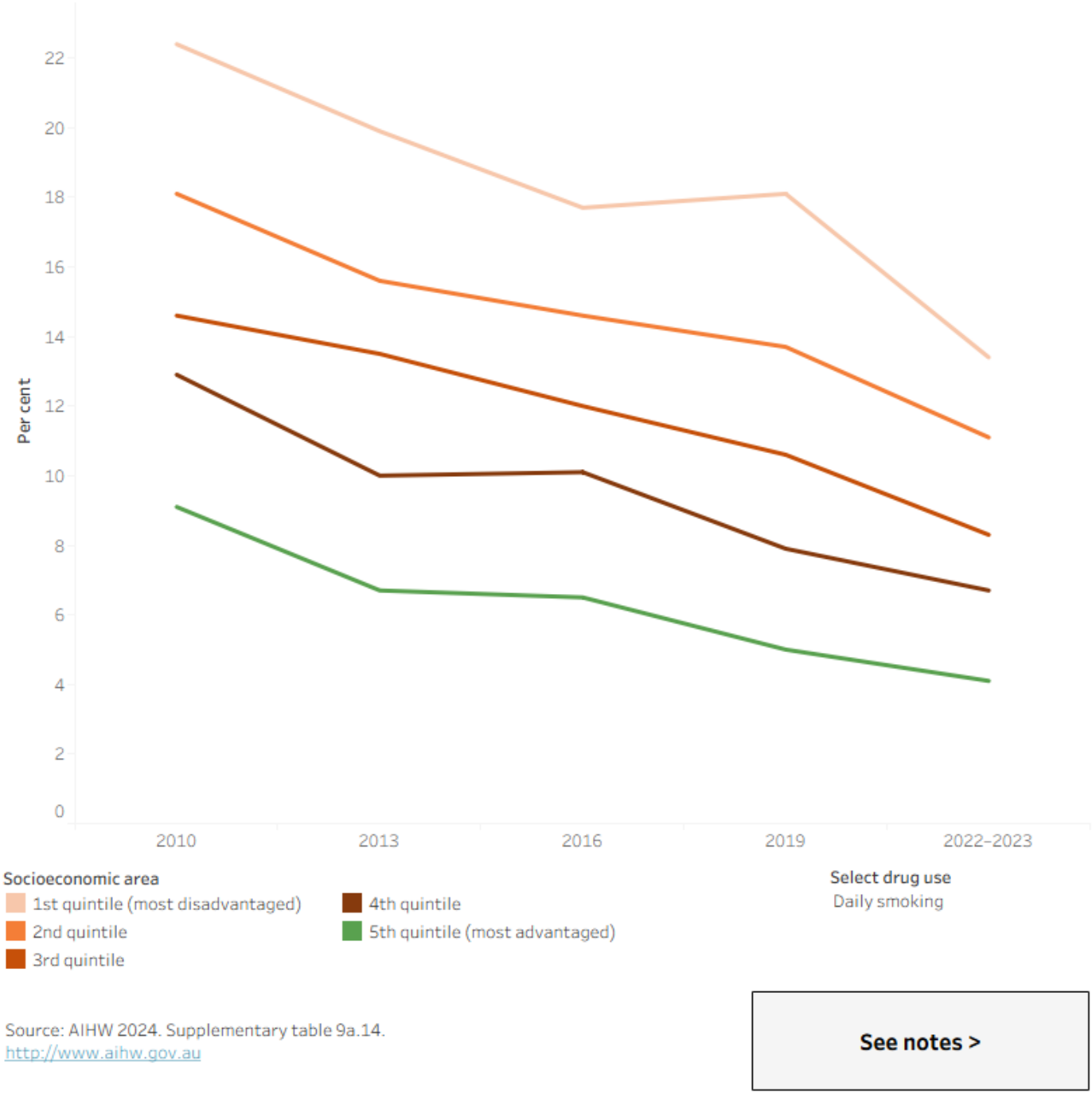
Tobacco and e-cigarette use

Social and economic factors shape people's behaviours of vaping or smoking. In general, people who live in the most disadvantaged areas of Australia are far more likely to smoke daily than those living in the least disadvantaged areas. Specifically:

- The 2022–2023 NDSHS found 13.4% of people aged 14 and over living in the most disadvantaged areas smoked daily, compared with 4.1% of people living in the least disadvantaged areas (AIHW 2024a, Table 9a.14).
- Similar results were reported in the 2022 NHS, where 18.1% of adults aged 18 and over living in the most disadvantaged area smoked daily, compared with 5.4% of those living in the least disadvantaged area (ABS 2023a, Table 6.3).

Rates of current smoking have fallen across most socioeconomic areas between 2019 and 2022–2023, with the steepest decline occurring among people living in the most disadvantaged areas (AIHW 2024a; Figure 1).

Figure 1: Daily smoking, alcohol consumption risk or recent use of illicit drugs, by socioeconomic area, people aged 14 and over, 2010 to 2022–2023



Source: AIHW 2024. Supplementary table 9a.14.
http://www.aihw.gov.au

See notes >

Generally, people living in the lowest socio-economic areas were the most likely to currently smoke but not vape (13.2% in 2022–2023). By contrast, people living in the highest socio-economic areas were the most likely to vape but not smoke (6.6%) (AIHW 2024a, Table 3.43).

Risky drinking

The 2022–2023 NDSHS found that people living in the lowest socioeconomic areas were the least likely to drink at risky levels (27% of people in the lowest quintile) and most likely to have abstained from drinking alcohol in the previous 12 months (30.5% of people in the lowest quintile) (AIHW 2024a, Table 4.34).

Illicit drug use

The 2022–2023 NDSHS found that people living in areas of the most socioeconomic advantage were more likely than those living in the most disadvantaged areas to have recently used:

- cannabis (13.1% compared with 11.6%)
- ecstasy (3.6% compared with 0.7%)
- cocaine (7.4% compared with 1.9%)
- pharmaceutical stimulants for non-medical purposes (3.5% compared with 1.3%) (AIHW 2024a, Table 9a.14) (Figure 1).

Conversely, people living in the most disadvantaged socioeconomic areas were 1.6 times as likely as those from the most advantaged socioeconomic areas to have used pain-relievers/opioids for non-medical purposes (2.8% compared with 1.7%). There was little variation in the recent use of methamphetamine and amphetamine for those living in the lowest socioeconomic areas compared with those living in the highest socioeconomic areas (1.1% and 1.3%, respectively) (AIHW 2024a, Table 9a.14).

For related content on alcohol and other drug use in this report, see Drug types.

How do alcohol and other drug-related harms vary across socioeconomic areas?

The highest proportion of drug-related hospitalisations (23%) in 2022–23 was for people living in the most disadvantaged areas

Source: Trends in drug-related hospitalisations in Australia

Alcohol and other drug-related hospitalisations

Analysis by the National Drug and Alcohol Research Centre (NDARC) showed that people living in the most disadvantaged areas made up 23% of drug-related hospitalisations in 2022–23. This was largely consistent between males and females and across most age groups. People living in the four other socioeconomic areas made up 18–19% each (Chrzanowska et al. 2025a).

Deaths involving alcohol and other drugs

Release of preliminary deaths data for 2024

Preliminary causes of death data for deaths registered in 2024 were made available on the ABS website in mid-November 2025, including updated data tables for both alcohol- and drug-induced deaths. These data were not available at the time of the analyses by the AIHW and NDARC, and the latest year of data differs between these sources. Estimates for 2022, 2023 and 2024 are expected to rise with standard revision processes.

Despite slightly lower rates of risky drinking, the rate of alcohol-induced deaths is higher among people from the most disadvantaged areas than people from the most advantaged areas (AIHW 2024a, ABS 2025). Similarly, rates of drug-induced deaths are generally higher among those living in the most disadvantaged areas.

- Preliminary estimates from the ABS indicate that people in the most disadvantaged socio-economic areas had the highest rates of alcohol-induced deaths in 2024 (10.7 deaths per 100,000 people for Quintile 1 (most disadvantaged areas) compared with 2.8 per 100,000 for Quintile 5 (least disadvantaged area)) (ABS 2025, Table 13.14).
- NDARC analysis of preliminary revised death rates showed that almost 1 in 3 drug-induced deaths (32% or 575 deaths) occurred among people living in Quintile 1. This has remained relatively stable since 2018, and was consistent by sex and across most age groups and all drug types except for cocaine (Chrzanowska et al. 2025b).

For related content on alcohol and other drug-related harms in this report, see Health and harms.

Where do I go for more information?

- National Drug and Alcohol Research Centre Reports
- National Drug Strategy Household Survey

References

ABS (Australian Bureau of Statistics) (2023a) *National Health Survey*, ABS, Australian Government, accessed 3 January 2024.

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Chrzanowska A, Man N, Sutherland R, Degenhardt L and Peacock A (2025b) *Trends in overdose and other drug-induced deaths in Australia, 2004–2023*, National Drug and Alcohol Research Centre, UNSW Sydney, accessed 1 October 2025.

WHO (World Health Organization) (2024) *Determinants of health*, WHO website, accessed 1 October 2025.

Viewing this data

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International data

In this section

Introduction

Comparing Australian data on alcohol and other drugs with other countries supports planning and policy making. This page describes the use of alcohol and other drugs in Australia compared to other countries, focusing on widely-used drugs such as alcohol, tobacco and e-cigarettes, cannabis and amphetamines. For related information on Australia's drug laws, see Policy context.

What data sources are available?

Data sources for international alcohol and other drug data

- National Wastewater Drug Monitoring Program
- OECD Health Statistics
- World Drug Report

International data on indicators including alcohol consumption, smoking and use of vaping products are available from the Organisation for Economic Cooperation and Development (OECD). The OECD reports data from its 38 Member countries. Indicator methodology may vary between countries, which should be considered when interpreting the data.

Information on stimulant consumption across different countries comes from Report 19 of the National Wastewater Drug Monitoring Program. This report compared wastewater monitoring data collected in Australia with international data collected by members of the Sewage Core Group Europe (SCORE) network.

For more information, see Technical notes.

How do daily smoking rates vary across different countries?

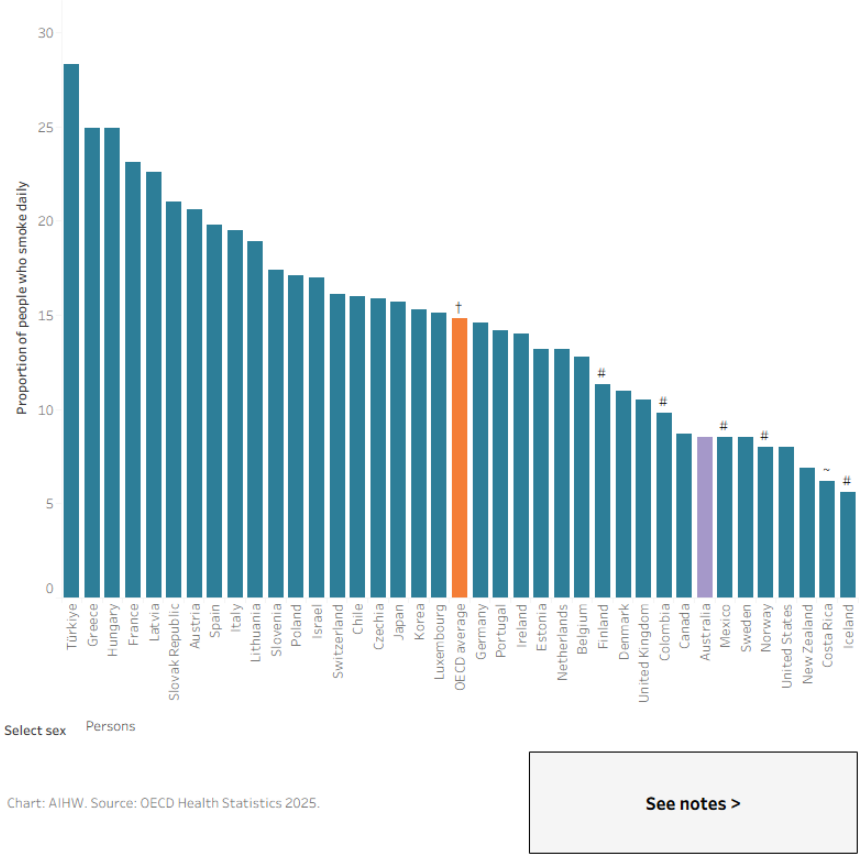
Proportion of people who smoke daily

In 2024 or the nearest year of available data, Australia had the fifth lowest proportion of daily tobacco smoking among people aged 15 and over (8.5% in 2022–2023). This was lower than the OECD average of 14.8% (OECD 2025) (Table OECD1, Figure 1). The proportions of both females and males who smoke daily were also below the OECD average.

Number of cigarettes smoked per person per day

In 2024 or the nearest year of available data, Australia was slightly higher than the OECD average for number of cigarettes smoked per day. In Australia, people aged 15 and over who smoked tobacco smoked an average of 13.1 cigarettes per day, while the OECD average was 12.7 cigarettes per day (OECD 2025) (Table OECD2, Figure 1).

Figure 1: Proportion of population smoking daily and number of cigarettes smoked, OECD countries, 2024 or nearest year



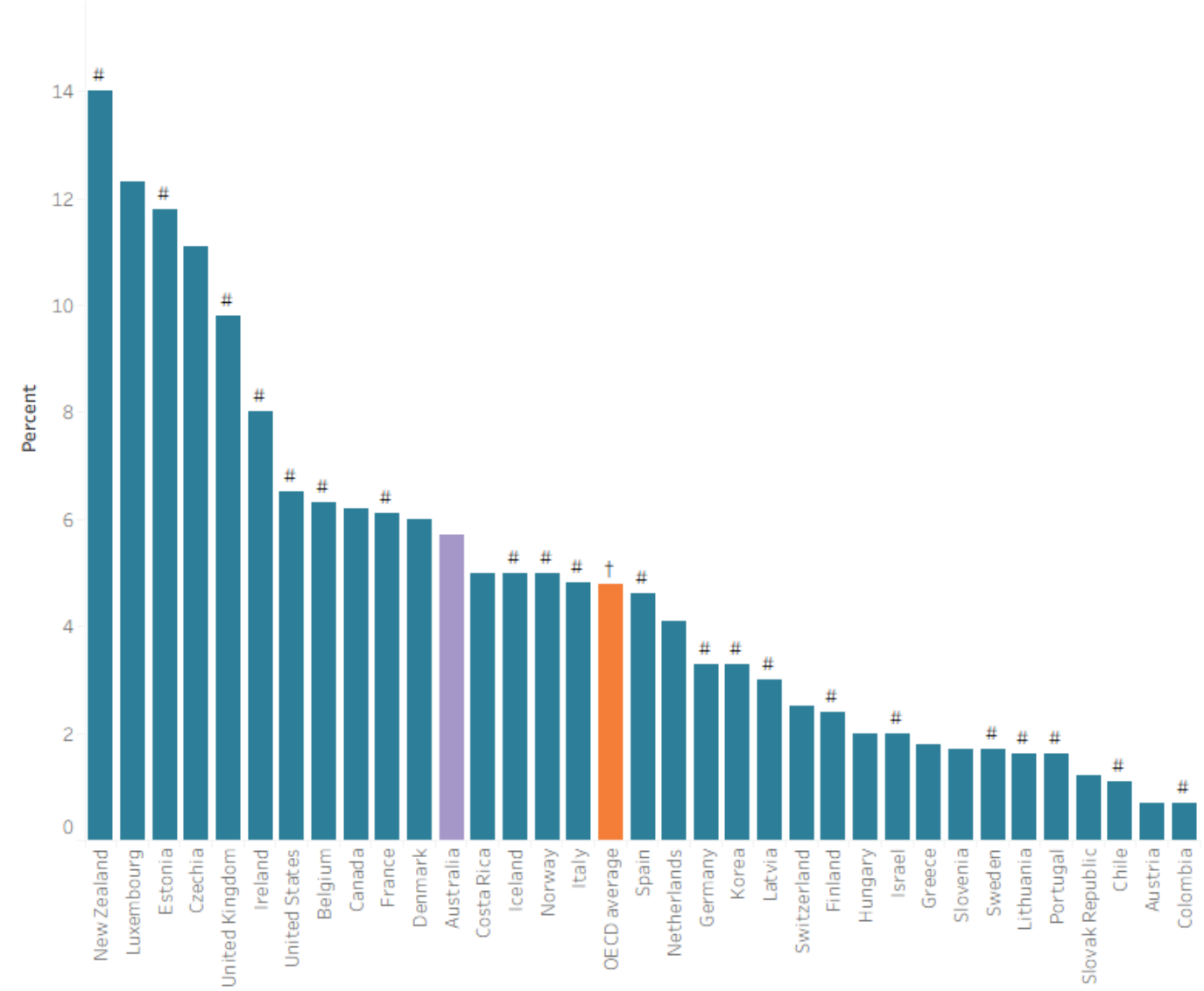
This bar charts show that Australia has the eighth lowest rate of daily smoking of all OECD countries

For related content on tobacco use within Australia in this report, see Tobacco.

How common is the use of vaping products in different countries?

The regular use of e-cigarettes in Australia is higher than the OECD average. In 2022–2023, 5.7% of people aged 15 and over in Australia used e-cigarettes regularly. The OECD average for regular use of vaping products was 4.8% for 2024 or the nearest year of available data (OECD 2025) (Table OECD3, Figure 2).

Figure 2: Population percentage reporting regular use of vaping products, total population aged 15 and over, OECD countries, 2024 or nearest year

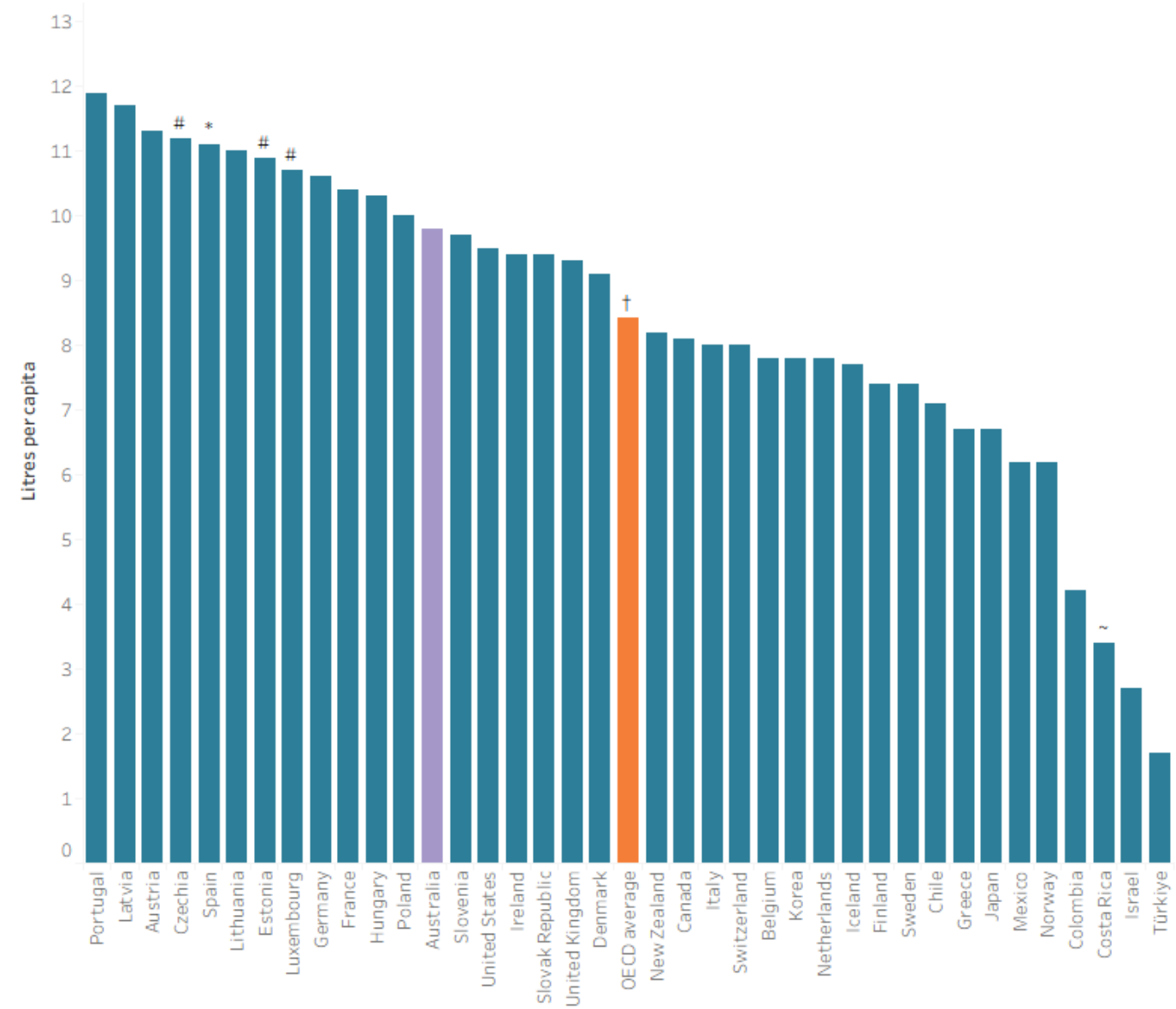


For related content on vaping and e-cigarette use within Australia in this report, see Vaping and e-cigarettes.

How much alcohol is available for consumption in different countries?

In 2023–24, there were 9.8 litres of pure alcohol available for consumption per person aged 15 years and over in Australia (AIHW 2025). This was higher than the OECD average (8.4 litres) (OECD 2025; Table OECD4, Figure 3). The most recent year of available data varies among countries. This should be considered when interpreting the data. The OECD report has not yet been updated with the latest available Australian data.

Figure 3: Alcohol consumption in litres of pure alcohol per capita, total population aged 15 and over, OECD countries, 2024 or nearest year



For related content on alcohol availability and use within Australia in this report, see Alcohol.

How common is the use of cannabis globally and across different countries?

Cannabis is the most commonly used illicit drug in Australia (AIHW 2024, Table 5.2), which is consistent with international data. The latest World Drug Report indicates that in 2023:

- Globally, cannabis was used in the past year by 4.6% of (or 244 million) people aged 15–64. According to qualitative assessments, cannabis cultivation trended upward between 2010 and 2021 but has recently been trending down.
- About 1 in 10 people who used cannabis, an estimated 22.6 million people globally, developed a cannabis use disorder (UNODC 2025).

For related content on cannabis use within Australia in this report, see Cannabis.

How does stimulant consumption vary across different countries?

The National Wastewater Drug Monitoring Program (NWDMP) recently examined average stimulant consumption (amphetamine, methylamphetamine, cocaine, and MDMA) in Australia compared with 24 countries across Europe, Oceania and Asia; also included was one city in the United States of America. From March–May 2022:

- Australia had the 6th highest average total stimulant consumption of all included countries at 44 doses per 1,000 people per day, lower than the USA (110 doses per day), Czechia (73 doses), Sweden (68 doses), Belgium (54 doses) and the Netherlands (50 doses).
- Australia had the 3rd highest average consumption of methylamphetamine (42 doses per 1,000 people per day), lower than the USA (85 doses per day) and Czechia (57 doses).

- Cocaine consumption in Australia ranked 18th of 27 countries at 4.0 doses, compared with 35 doses for the highest-ranked country (Belgium) and 0.43 doses for the lowest-ranked countries (New Zealand; 0.43 doses and South Korea; 0.01 doses).
- Australia ranked 21st of 27 reporting countries in MDMA consumption at 1.5 doses per 1,000 people per day, compared with the Netherlands (6.1 doses), New Zealand (4.3 doses) and Portugal (3.6 doses).
- Australia ranked 6th of 16 reporting countries in cannabis consumption at 120 doses per 1,000 people per day, behind the USA (790 doses), Switzerland (160 doses) and the Netherlands (150 doses).

When examining each drug type as a proportion of total combined stimulant consumption:

- Most stimulant consumption in Australia related to methylamphetamine use, which is similar to New Zealand, Czechia, the USA, South Korea, Latvia, Cyprus and Turkey. Finland, Sweden, Poland and the United Kingdom had higher use of amphetamine and the remaining locations predominantly featured cocaine consumption.
- Average consumption in Australia was proportionally higher for methamphetamine than MDMA, which is consistent with most other countries.
- Cocaine consumption in Australia was proportionally higher than the use of MDMA. This was consistent with most participating countries but was the opposite of New Zealand (where MDMA consumption was higher than cocaine) (ACIC 2023).

For related content on stimulant use within Australia in this report, see Amphetamines and other stimulants.

Where do I go for more information?

- Health at a glance 2023, OECD
- World Drug report 2025, UNODC

References

ACIC (Australian Criminal Intelligence Commission) (2023) *National Wastewater Drug Monitoring Program report 19*, ACIC, Australian Government, accessed 12 March 2025.

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OECD (Organisation for Economic Cooperation and Development) (2025) *OECD Health Statistics 2025*, OECD, accessed 03 September 2025.

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Population groups

Population groups
Explore content on alcohol and other drug use, treatment and health and harms among specific population groups, including children and young people, older people, and First Nations people.

- Children and young people's experiences of alcohol and other drugs
- Experiences of alcohol and other drugs among culturally and linguistically diverse Australians
- Experiences of alcohol and other drugs among First Nations people
- Experiences of alcohol and other drugs among lesbian, gay, bisexual, transgender, intersex or queer people
- Experiences of alcohol and other drugs among people experiencing homelessness
- Experiences of alcohol and other drugs among people in contact with the criminal justice system
- Experiences of alcohol and other drugs among people who inject drugs
- Experiences of alcohol and other drugs among people with mental health conditions
- Older people's experiences of alcohol and other drugs

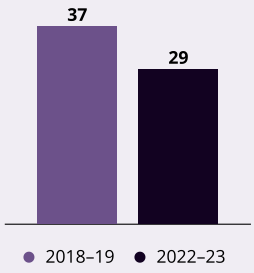
Key findings

Alcohol and illicit drug use are among the leading risk factors for the total burden of disease among young men and women

Source: Australian Burden of Disease Study

People who mainly speak a language other than English at home are more likely than primary English speakers to have never smoked

Source: National Drug Strategy Household Survey



%
The proportion of First Nations people who smoke tobacco has declined

Source: National Aboriginal and Torres Strait Islander Health Survey

Updated

Most alcohol-related deaths in 2024 occurred among people aged 50 and over

Source: Causes of Death, Australia

Almost 2 in 5

people with mental health conditions reported drinking alcohol at risky levels in 2022–2023

Source: National Drug Strategy Household Survey

Illicit drug use has risen among lesbian, gay and bisexual people since 2010

Source: National Drug Strategy Household Survey

Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Technical notes

In this section

Introduction

The data presented in this report are sourced from a range of different data collections from several agencies and organisations, including the:

- Australian Institute of Health and Welfare (AIHW)
- Australian Bureau of Statistics (ABS)
- Australian Criminal Intelligence Commission (ACIC)
- Australian Institute of Criminology (AIC)
- National Drug and Alcohol Research Centre (NDARC).

Each of the data sources provide part of the story of alcohol, tobacco and drug use. Data sources include a range of methodologies such as:

- general population surveys (for example, the National Drug Strategy Household Survey)
- surveys of sentinel populations (for example, the Illicit Drug Reporting System, the Drug Use Monitoring in Australia program and the National Needle Syringe Program)
- population consumption data (for example, the National Wastewater Drug Monitoring Program and Alcohol available for consumption in Australia report)
- administrative data (for example, Criminal Courts data).

Consolidating these data sources across multiple collections into one place provides a more complete story of current and emerging trends. However, it is also important to note methodological differences that can influence the comparability of results across data sources.

List of data sources and data quality

Australian Bureau of Statistics data sources

The ABS publishes a range of data examining different aspects of alcohol and other drugs, including:

- surveys on alcohol and other drug use among the general population and among specific population groups (including First Nations people)
- administrative and survey data on alcohol and other drug-related harms, including victimisation and mortality
- administrative data on drug-related offences finalised in criminal courts across Australia.

Australian Aboriginal and Torres Strait Islander Health Survey 2012–13

National survey data on alcohol and other drug use among First Nations people.
The Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) includes a range of health data including behavioural health risk factors such as smoking, alcohol consumption and illicit drug use for Aboriginal and Torres Strait Islanders. It combines the ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) with a National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey (NATSINPAS) and a National Aboriginal and Torres Strait Islander Health Measures Survey (NATSIHMS).

The 2012–13 AATSIHS was conducted throughout Australia in *Remote* and *Non-remote areas* from April 2012 to February 2013. The 2012–13 AATSIHS collected information on a range of demographics from over 9,000 Aboriginal and Torres Strait Islander people of all ages. The scope of the survey was all Aboriginal and Torres Strait Islander people who were usual residents of private dwellings in Australia. Private dwellings are houses, flats, home units and any other structures used as private places of residence at the time of the survey. People usually resident in non-private dwellings, such as hotels, motels, hostels, hospitals, nursing homes, and short-stay caravan parks were not in scope. Usual residents are those who usually live in a particular dwelling and regard it as their own or main home.

The 2012–13 AATSIHS was designed to produce reliable estimates at the national level and for each state and territory. For selected states and territories, that is New South Wales, Queensland, Western Australia and the Northern Territory, the sample for children aged 0–14 years and people aged 15 years and over was allocated to produce estimates that have a relative standard error (RSE) of no greater than 25% for characteristics that at least 5% of these populations would possess.

The 2012–13 AATSIHS contains information from the Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) core sample of around 12,900 people (a combined data file of both the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and the National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey (NATSINPAS) for people aged 2 years and over).

For more information about the AATSIHS, see Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012–13.

Causes of Death, Australia

National administrative data on causes of death in Australia and demographics for all deaths registered in Australia, released annually.
Statistics presented in Causes of Death, Australia are sourced from death registrations administered by the various state and territory Registrars of Births, Deaths and Marriages. It is a legal requirement of each state and territory that all deaths are registered. In addition, the ABS supplements this data with information from the National Coronal Information System (NCIS) for those deaths certified by a coroner.

Deaths are considered “drug-induced” if directly attributable to drug use (for example, drug overdose or due to chronic use such as drug-induced cardiac conditions), and “drug related” where drugs played a contributory factor (for example, traffic accidents).

In Australia, acute drug overdose deaths are referred to a coroner and subject to forensic pathology and toxicology. Autopsy and toxicology reports provide detailed drug information including the identification of specific drugs in the system, approximate levels of drugs in the system and the relatedness of drugs to the death. The ABS accesses this information via the NCIS and applies codes from the International Classification of Diseases, 10th Revision, to the medical text for tabulation into statistical output.

For more information about the report, see Cause of Deaths, Australia.

Crime Victimisation

National survey data on experiences of a selected range of personal and household crimes in Australia, released annually.
Data on crime victimisation are collected via the Crime Victimisation Survey (CVS), a topic on the Multipurpose Household Survey (MPHS). The MPHS is a self-report household survey conducted each financial year by the ABS as a supplement to the Labour Force Survey (LFS). The 2023–24 survey was conducted from July 2023 to June 2024 and includes information collected from 26,176 respondents, including 543 proxy interviews for people aged 15–17 and 1,958 proxy interviews for people aged 18 and over.

The survey collects details on the prevalence of selected personal and household crimes that occurred in the 12 months prior to interview, including demographic information about the person who experienced the crimes and characteristics of the most recent incident of each crime type experienced. Data are available for Australia and by state and territory.

The MPHS includes coverage of people aged 15 and over who are usual residents of private dwellings, excluding:

- members of the Australian permanent defence forces
- certain diplomatic personnel of overseas governments
- overseas residents in Australia
- members of non-Australian defence forces (and their dependants)
- persons living in non-private dwellings such as hotels, university residences, boarding schools, hospitals, nursing homes, homes for people with disabilities, and prisons
- residents of the Indigenous Community Strata (ICS).

For more information about the survey, see Crime Victimisation methodology.

Criminal Courts, Australia

National administrative data on defendants finalised by principal offences (including illicit drug offences) in Australia, released annually.
Criminal Courts, Australia contains data on defendants whose case was finalised in the Higher (Supreme and District/County Courts), Magistrates’ and Children’s Courts across Australian states and territories during the relevant financial year. The report includes information about the offences, outcomes and sentences for each defendant.

Information presented in the report are compiled from administrative data supplied to the ABS from each state and territory. All data provided to the ABS are coded to national classifications and standards. Principal offences are coded according to the Australian and New Zealand Standard Offence Classification 2011 as the most serious offence associated with a finalised defendant; for defendants finalised with a single offence type, this offence is recorded as their principal offence.

From 2019–20 onwards, transfers to other court levels are excluded from defendant counts in most tables to avoid double-counting of defendants who were transferred and subsequently adjudicated in a different court level.

For more information about the report, see Criminal Courts, Australia methodology.

Personal Safety, Australia

National survey data on experiences of violence among men and women aged 18 years and over in Australia.
Personal Safety, Australia contains results from the Personal Safety Survey (PSS), conducted by the ABS throughout Australia. The survey collects information about violence experienced since the age of 15 among men and women aged 18 and over, and experiences of:

- violence, emotional abuse, and economic abuse by a cohabiting partner
- sexual harassment in the last 12 months
- stalking
- abuse and witnessing parental violence during childhood
- feelings of general safety.

The most recent PSS was conducted from March 2021 to May 2022, with previous surveys conducted in 2016, 2012 and 2005. The 2021–22 survey topics are largely consistent with earlier survey waves, but the design and data collection was adapted in response to the COVID-19 pandemic. Key changes included:

- reduced sample size
- the introduction of Computer-Assisted Telephone Interviews (CATI), providing the option for respondents to complete the survey over the phone.

For more information about the PSS, see Personal safety survey: User guide.

Prisoners in Australia

National administrative data on people remanded or sentenced to adult custodial corrective services agencies in Australia, released annually.

Prisoners in Australia contains information on people remanded or sentenced to adult custodial corrective services agencies in each state and territory in Australia on June 30 of the reference year. Information presented in the report is derived from administrative systems maintained by corrective services agencies in each state and territory, collected annually via the National Prisoner Census (NPC).

The NPC includes all people in the legal custody of the corrective services who, as at midnight on 30 June of the reference year, were:

- absent on an authorised temporary leave permit (except for Victoria and the Australian Capital Territory)
- absent from the correctional facility on a work release permit or program
- located in secure wards in a hospital or mental health institution outside the correctional facility administered under Corrective Services departments
- periodic detainees until 2016
- serving post-sentence detention orders.

Data from the NPC are coded according to national standards for corrective services statistics. All offences are coded to the Australian and New Zealand Standard Offence Classification 2011.

For more information about the report, see Prisoners in Australia methodology.

Record Crime—Offenders

National administrative data on alleged offenders who have been proceeded against by police in Australia, released annually.
Recorded Crime – Offenders contains data on alleged offenders who were proceeded against by police across all Australian states and territories during the 12-month reference period. The report includes information about the most serious offence ('principal offence') associated with an alleged offender.

The collection includes all offenders above the minimum age of criminal responsibility who have been proceeded against by police, including all criminal offences where police agencies have the authority to take legal action against an individual, excluding:

- persons less than the minimum age of criminal responsibility
- organisations
- offences that come under the authority of agencies other than state and territory police, such as Environmental Protection Authorities
- proceedings initiated by the Australian Federal Police.

Information presented in the report is obtained from administrative records held by state and territory police agencies that is provided to the ABS. Data are coded according to national standards for corrective services statistics. All offences are coded to the Australian and New Zealand Standard Offence Classification 2011 and the National Offence Index, 2018.

For more information about the report, see Recorded Crime - Offenders methodology.

National Aboriginal and Torres Strait Islander Health Survey 2022–23

National survey data on health, language, cultural identification, education, labour force status, income and discrimination among First Nations people in Australia.
The 2022–23 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) is a component of the broader Intergenerational Health and Mental Health Study (IHMHS). The 2022–23 survey was conducted between August 2022 and March 2024, covering approximately 4,900 households across *Non-remote* and *Remote* areas of Australia, including discrete Indigenous communities. The overall coverage of the NATSIHS was approximately 25% of Aboriginal and Torres Strait Islander persons in Australia, or 7,768 fully responding persons.

The NATSIHS includes data on a broad range of health-related topics, language, cultural identification, education, labour force status, income and discrimination. This includes questions on tobacco smoking and vaping, alcohol consumption and substance use.

The scope of the survey was all Aboriginal and Torres Strait Islander people living in private dwellings. The following people were not included in the survey:

- non-Indigenous people
- visitors to private dwellings staying for less than 6 months
- people in households where all usual residents were less than 18 years of age
- people who usually lived in non-private dwellings, such as hotels, motels, hostels, hospitals, nursing homes and short-stay caravan parks
- students at boarding school
- non-Australian diplomats, diplomatic staff and members of their household
- members of non-Australian defence forces stationed in Australia and their dependents
- overseas visitors.

For more information about the NATSIHS, see National Aboriginal and Torres Strait Islander Health Survey.

National Aboriginal and Torres Strait Islander Social Survey 2014–15

National data including information on alcohol and other drug use among First Nations people in Australia.
The 2014–15 NATSISS was conducted throughout Australia, including *Remote* areas, from September 2014 to June 2015.

The scope of the survey is all Aboriginal and Torres Strait Islander people who were usual residents of private dwellings in Australia. Private dwellings are houses, flats, home units and any other structures used as private places of residence at the time of the survey. People usually resident in non-private dwellings, such as hotels, motels, hostels, hospitals, nursing homes, and short-stay caravan parks were not in scope. Usual residents are those who usually live in a particular dwelling and regard it as their own or main home.

After screening and sample loss (due to households with no residents in scope for the survey or where dwellings proved to be vacant, under construction or derelict) 8,235 dwellings were approached for an interview. Of these eligible dwellings, 80% responded fully (or adequately) which yielded a total sample from the survey of 6,611 dwellings. An adequately responding household was defined as a household where at least one of the people selected for the survey completed their interview.

For more information about the 2014–15 NATSISS, see 2014–15 NATSISS.

National Health Survey

National survey data on tobacco, alcohol and other drug use and related health issues, released every 3 years.
The 2022 National Health Survey (NHS) is the most recent in a series of Australia-wide health surveys conducted by the ABS, collected between January 2022 and April 2023. It was designed to collect a range of information about the health of Australians, including:

- prevalence of long-term health conditions
- health risk factors such as smoking, overweight and obesity, alcohol consumption and exercise
- use of health services such as consultations with health practitioners and actions people have recently taken for their health
- demographic and socioeconomic characteristics.

The 2022 NHS collected data on children and adults living in private dwellings but excluded people living in non-private dwellings, *Very remote* areas and discrete Aboriginal and Torres Strait Islander communities.

The 2022 NHS is considered to be comparable to the 2017-18 NHS and previous cycles. The 2020–21 NHS data should be considered a break in time series from previous NHS collections and used for point-in-time national analysis only. The survey was collected during the COVID-19 pandemic which significantly changed the data collection.

Alcohol consumption risk levels have been assessed using the 2020 guidelines from the National Health and Medical Research Council (NHMRC). The 2022 NHS survey measured monthly consumption as consuming 5 or more drinks at least 12 or more times in the last 12 months.

For more information about the 2022 NHS, see National Health Survey.

Australian Criminal Intelligence Commission data sources

The ACIC publishes several reports examining alcohol and other drugs, including:

- data on illicit drug markets, including arrests, seizures, and detections of illicit drugs at the Australian border
- population consumption data for a range of drugs as measured via wastewater.

Illicit Drug Data Report

National data on the illicit drug market (including seizures, detections and arrests) in Australia.
The Illicit Drug Data Report (IDDR) brings together illicit drug data from a variety of sources including law enforcement, forensic services, health and academia. Data used to inform the IDDR is provided by all Australian state and territory police agencies, the Australian Federal Police, the Department of Home Affairs, Australian Border Force, the Australian Institute of Criminology and forensic laboratories. Data collected and presented in the report includes arrest, detection seizure, purity, profiling and price data. The statistics and analysis in the report are primarily used in to inform understanding of the Australian illicit drug market and the development of drug supply and harm reduction strategies.

For more information about the 2020–21 IDDR, see Illicit Drug Data Report 2020–21.

National Wastewater Drug Monitoring Program

National data measuring the presence of licit and illicit drugs in samples obtained from wastewater treatment plants in capital city and regional sites across Australia.
The National Wastewater Drug Monitoring Program (NWDMP) measures the presence of alcohol and other drugs in wastewater in regional and capital city sites across Australia. The study focuses on 12 licit and illicit drugs, including nicotine from tobacco (including cigarettes, e-cigarettes, gum and patches), ethanol from alcohol intake, pharmaceutical opioids, and illicit substances such as methylamphetamine, MDMA and cocaine. The August 2025 collection covered 57% of the Australian population, which equates to about 14.5 million people (ACIC 2025).

The method underlying wastewater-based monitoring of drug use in a given population is based on the principle that any given compound that is consumed will be excreted (either in the chemical form it is consumed and/or in a chemically modified form that is referred to as a metabolite). The excreted compound or metabolite will eventually arrive in the sewer system.

Collectively, waste products in the sewer system arrive at a wastewater treatment plant (WWTP) where wastewater samples are collected over a defined sampling period. Measuring the amount of target compound in the wastewater stream allows for a back-calculation factor to be applied to determine the amount of drug that was used over the collection period. The method is non-invasive and is done on a population-scale level, so individuals are not targeted, and privacy is respected. Wastewater consists of highly complex mixtures that derive from toilets, bathrooms, kitchen, and laundry appliances, as well as all other domestic, industrial or commercial plumbed structures. To obtain an estimate of drug use, representative samples are collected over a given period (typically 24 hours) using autosamplers that collect time or flow proportional samples.

A number of factors may influence interpretations of the results, including uncertainties in population estimates in an area over a 24-hour period due to work movements and the variation in excretion rates (that is, some people may metabolise a drug faster than others). There are also a number of considerations relating to specific drugs:

- Tobacco is measured using two nicotine metabolites. Wastewater analysis cannot distinguish between nicotine intake from tobacco or e-cigarettes and nicotine replacement products (such as gums and patches).
- Pharmaceutical drugs such as oxycodone, fentanyl and ketamine are included in the collection, but it is not possible to distinguish between medical and non-medical use of these drugs in wastewater data.

- Cannabis was included for the first time in the August 2018 collection. Cannabis results are expressed as daily doses of the ingested active ingredient (tetrahydrocannabinol; THC) consumed per 1,000 people. THC is excreted in extremely small amounts and detection is affected by surface adsorption. Sewer design and collection method may influence the levels detected and samples must be preserved to avoid degradation, without using acidification. This is one reason why cannabis consumption is not reported on a regular basis in other countries where wastewater analysis is routinely conducted (as acidification is a common preservation technique). For the NWDMP, separate samples are collected each day and preserved specifically for analysis.
- Ketamine was included in monitoring from December 2020. The amount of ketamine excreted following consumption is not known. Therefore, results for ketamine are reported as the amount (mg) of drug excreted per day per 1,000 people.

Given these limitations, it is important that other data sources such as general population and sentinel surveys are also used to estimate the consumption of licit and illicit drugs. As a collective, these data inform our understanding of drug markets and how we can best respond to reduce supply, demand and harm.

For more information about the NWDMP, see National Wastewater Drug Monitoring Program reports.

Australian Institute of Criminology data sources

The AIC produces several reports examining alcohol and other drugs and related harms in Australia, including:

- ongoing monitoring of illicit drug use among people in police detention
- reporting on the involvement of alcohol and other drugs in homicides.

Drug Use Monitoring in Australia

National data on licit and illicit drug use among people in police detention in Australia, released on an ad hoc basis.
The Drug Use Monitoring in Australia (DUMA) program is an ongoing illicit drug use monitoring program that captures information on people in police detention across 5 locations throughout Australia annually. In 2021, 2,223 people in police detention participated in the DUMA program. There are 2 core components involved in the DUMA program:

- A self-report survey, which captures a range of criminal justice, demographic, drug use, drug market participation and offending information.
- Voluntary provision of a urine sample, tested via urinalysis at an independent laboratory to detect the presence of licit and illicit drugs. Urinalysis serves as an important objective method for corroborating self-reported drug use. Not all detainees who respond to the self-report survey agree to provide a urine sample when requested, although the compliance rate is high (75% of detainees in 2021).

For more information about the 2021 DUMA program, see Drug use monitoring in Australia: Drug use among police detainees, 2021.

Homicide in Australia

National administrative data on homicide incidents, victims and offenders in Australia, released annually.
The Homicide in Australia report uses data from the National Homicide Monitoring Program (NHMP) to provide information on homicide incidents, victims and offenders in Australia, including incidents where alcohol and other drugs were involved.

The NHMP contains unit record data on homicide incidents, victims and offenders as recorded by state and territory police across Australia since 1989–90. NHMP data are drawn from offence records from state and territory police services and state and territory coronial records from the National Coronial Information System (NCIS). Offence data are cross-referenced with coronial records from the NCIS, including finalised cases and cases where the coronial investigation has not yet been finalised (open cases).

Homicide in Australia defines 'homicide' as the unlawful killing of a person, including:

- all cases resulting in a person or persons being charged with murder or manslaughter
- all murder–suicides classed as murder by police
- all driving causing death offences where the offender was charged with murder, manslaughter or equivalent offences
- all other deaths classed as homicides by police, including infanticides, whether or not an offender was apprehended.

It excludes attempts to unlawfully kill and conspiracy to kill.

In recent years, there have been larger amounts of missing data on a number of variables including victim and offender use of alcohol, illicit drugs and prescription drugs at non-therapeutic levels. This is due to the revised publication timeframe for the report, which has affected the availability of coronial and court documents used to cross-reference police data on homicide offences.

For more information about the 2023–24 report, see Homicide in Australia 2023–24.

Australian Institute of Health and Welfare data sources

The AIHW publishes a range of administrative and survey data examining different aspects of alcohol and other drugs, including:

- availability of alcohol and prescription medicines
- use of alcohol, tobacco, e-cigarettes and other drugs
- treatment for alcohol and other drug use, including opioid pharmacotherapy
- analysis of the burden of disease and injury related to alcohol and other drugs
- alcohol and other drug-related harms, including hospitalisations and deaths.

Alcohol and other drug treatment services in Australia

National administrative data on alcohol and other drug treatment services in Australia, released annually.

The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) contains data on closed episodes of treatment provided to clients of alcohol and other drug treatment agencies, including data on drugs of concern and the types of treatment received.

All in-scope service agencies are publicly funded through state, territory or Australian government programs. The collection is a service-based administrative data set, and does not reflect demand for AOD services. Changes in client numbers over time may reflect access to treatment, treatment availability, differences in counting methodologies and available funding for treatment services. Data for each reporting period are first released as a brief early insights report. This is followed by the detailed findings report. As such, not all data on alcohol and other drug treatment services will be updated at the same time.

Key quality issues to consider for the collection include:

- Funding programs cannot be differentiated. That is, services are categorised according to sector and service outlet location, with government-funded and operated services reported as public services and those operated by non-government organisations reported as private agencies.
- National data are affected by variations in service structures and collection practices between states and territories; these should be considered when making comparisons between jurisdictions.
- The AODTS NMDS reports both main and additional treatment types. However, Victoria's and Western Australia's state AOD collections do not differentiate between main and other treatment types.

For more information about the AODTS NMDS, see Data quality statement for the AODTS NMDS 2024–25.

Alcohol available for consumption in Australia

National data containing estimates of pure alcohol available for consumption in Australia, released annually.
The Alcohol available for consumption in Australia report (previously called 'apparent consumption of alcohol') quantifies the amount of alcohol available to people living in Australia by combining data from various sources (for example, alcohol sales and taxation data). The collection examines long-term trends in the total amount of beer, wine, cider and spirits entering the Australian community each year, but does not allow for examination of trends below the national level or by priority population groups.

The total amount of alcohol available each year does not directly translate to individual consumption patterns, but changes in availability are likely to reflect broad changes in consumption patterns. Alcohol availability trends are a useful indicator of whether the Australian community is drinking more or less alcohol on average than previously, and how different beverage types contribute to the total amount of alcohol available.

Results should be interpreted in relation to the time-series rather than used for absolute values of the amount of alcohol that was consumed each year, due to limitations in the data sources and assumptions made:

- The collection assumes that all alcohol that was produced or imported in a given financial year was consumed in the same financial year.
- No data is available to account for beverages that may have been wasted, used in cooking, cellared, or otherwise not consumed.
- The collection does not account for beverages that were purchased overseas and brought into the country duty-free.

This publication is a continuation of the long-running Apparent Consumption of Alcohol, Australia series previously managed by the ABS.

For information on previous methods, see Apparent Consumption of Alcohol, Australia methodology. For more information on changes to calculation methods and data sources used for each beverage type, see Alcohol available for consumption in Australia.

Alcohol-related injury: hospitalisations and deaths

National administrative data on alcohol-related hospitalisations and deaths due to injury in Australia, released on an ad hoc basis.
This report aims to count the number of hospitalisations and deaths due to alcohol-related and alcohol-induced injuries from 1 July 2019 to 30 June 2020. It includes patients who had both an injury condition and an alcohol-related condition recorded in their hospital record, or an injury-related and an alcohol-related cause of death recorded.

The report uses data from the National Hospital Morbidity Database (NHMD). However, this data does not contain text fields, therefore diagnosis and external-cause-of-injury information is restricted to International Statistical Classification of Diseases and Related Health Problems Tenth Revision Australian Modification (ICD-10-AM) codes. The data quality therefore depends on the extent to which hospital staff record the involvement of alcohol and the completeness with which those notes are coded by hospital coders.

The deaths data used in this report comes from the National Mortality Database (NMD), which contains information on all deaths certified by a doctor or coroner. The NMD, like the hospitalisations data, contains coded fields, meaning the cause of death and external cause of injury information is restricted to the ICD-10 classification system coding (ABS 2020).

The report does not include information on cases that did not result in hospitalisation or death. For each hospitalisation or death there are many more cases that are treated by emergency departments, general practitioners, allied health professionals or outpatient clinics.

For more information on the report, see Alcohol-related injury: hospitalisations and deaths, 2019–20.

Australian Burden of Disease Study

National data on the fatal and non-fatal burden of tobacco, alcohol and other drug use in Australia, released every 3 years.
Burden of disease analysis measures the impact of diseases and injuries on the population of Australia. It looks at the fatal and non-fatal burden, both premature deaths and living with health impacts from disease or injury. These measures combined are referred to as 'total burden'. Burden of disease measures the difference between a population's actual health and its ideal health (that is, if everyone lived as long as possible and no one lived with illness or injury). The 2024 Study was the 6th Australian study, with previous studies being undertaken in 1996, 2003, 2011, 2015 and 2018.

Disease burden is measured using the summary metric of disability-adjusted life years (DALY). One DALY is one year of healthy life lost to disease and injury. DALY caused by living in poor health (non-fatal burden) are known as 'years lived with disability' (or YLD). DALY caused by premature death (fatal burden) are known as 'years of life lost' (YLL) and are measured against an ideal life expectancy.

For more information about the 2024 ABDS, see Australian Burden of Disease Study 2024.

Australian Burden of Disease Study, Aboriginal and Torres Strait Islander people

National data on the fatal and non-fatal burden of tobacco, alcohol and other drug use in Australia among First Nations people, released on an ad hoc basis.
Burden of disease estimates for the Aboriginal and Torres Strait Islander population provide evidence on the diseases and injuries currently contributing most to Indigenous mortality and ill health, and on the largest gaps in disease burden between Indigenous and non-Indigenous Australians. This information will be important in assisting governments and service providers to develop interventions that can reduce the incidence of risk factors and other main contributors to the burden of disease and injury in the Indigenous population.

The Australian Burden of Disease Study 2018: key findings for Aboriginal and Torres Strait Islander people report contains key findings for Aboriginal and Torres Strait Islander people from the forthcoming Australian Burden of Disease Study (ABDS) 2018. Full results, including detailed reports and interactive data visualisations, were released in 2022.

The ABDS 2018 Aboriginal and Torres Strait Islander study includes 219 diseases, as well as estimates of the burden attributable to 39 individual risk factors, such as alcohol use and smoking. The study includes results for 2003 and 2011 for comparison, as well as estimates for selected states and territories, by remoteness area and socioeconomic groups.

For more information about the 2018 study, see Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018.

Australia's mothers and babies

National administrative data on pregnancy, birth experiences and outcomes of mothers and babies in Australia, released several times a year.
Data presented in Australia's mothers and babies are largely drawn from the National Perinatal Data Collection (NPDC), the National Maternal Mortality Data Collection (NMMDC), the National Perinatal Mortality Data Collection (NPMDC) and the Maternity Models of Care Data Set (MoC DS).

A standardised extract of electronic data from each state and territory collection is provided to the AIHW annually. Records received from states and territories are anonymous: that is, they do not include any names or addresses, but do include a unique set of identification numbers so that the source record can be identified. Data are checked for completeness, validity and logical errors before inclusion in the national collection.

Some topics in this report may exclude data for selected states and territories for reasons including:

- changes in definitions or data collection methods in a state and territory that mean the data item is not considered to be of sufficient quality to release
- data are not currently collected by a state and territory, or are not collected in a format that is comparable with the specifications for the NPDC, NPMDC or the NMMDC
- data are not currently supplied by a state and territory for the NPDC, NPMDC or NMMDC. Data items that are not part of the Perinatal NMDS are not mandatory for provision to the NPDC, and there are currently no Perinatal NMDS items in the NPMDC.

For more information about the collections, Australia's mothers and babies, Collation of national perinatal data.

National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose, Monash University

National administrative data on ambulance attendances involving alcohol and other drugs in Australia, released several times a year by the AIHW.
The National Ambulance Surveillance System (NASS) is a surveillance system derived from ambulance service records. The NASS is a partnership between Monash University, Turning Point, and state and territory ambulance services across Australia.

The NASS data are coded specifically for alcohol and other drugs, mental health, and suicide and self-harm, and capture more detail than the ICD-10-AM coding system used in the National Hospital Morbidity Database and National Mortality Database. The NASS also includes data on incident location and on people who may be missing or underrepresented in national surveys, such as people who are homeless.

Data are published for each jurisdiction when that data has been made available. Currently data has not been available for South Australia and Western Australia due to system constraints. The data utilised for this project are extracted from electronic data collection systems used by paramedics to record the details of all emergency cases they attend. Trained clinical coders manually examine each record to identify the substance involved and to determine alcohol and drug misuse based on paramedic observation, patient self-report, information provided by third parties, and other evidence on the scene.

- Historically, data were reported on snapshot months, specifically the third month of each fiscal quarter, commencing with March. Since 2021, data have been reported monthly.
- From time to time, there may be reporting issues within a jurisdiction, as footnoted within the data.
  - Fewer ambulance attendances were captured in New South Wales in June 2021, January 2023 and February 2023, which may be related to industrial action by paramedics. These data should be interpreted with caution.
  - Significantly fewer ambulance attendances were captured in Victoria between March and September 2024, due to industrial action by paramedics. These data should be interpreted with caution.
- Gender is reported as a binary variable with values 'male' and 'female'. In the initial documentation of ambulance attendances, paramedics use a dropdown box to select male or female. While notes can be added to indicate if a patient is trans, transitioning or non-binary, this is likely to be underreported.

For more information about the NASS, see:

- The National Ambulance Surveillance System: A novel method for monitoring acute alcohol, illicit and pharmaceutical drug related-harms using coded Australian ambulance clinical records
- Data sources - Suicide & self-harm monitoring.

National Drug Strategy Household Survey

National survey data on use and opinions of alcohol, tobacco and other drugs in Australia, released every 3 years.
The National Drug Strategy Household Survey (NDSHS) collects information on alcohol and tobacco consumption, and illicit drug use among the general population in Australia. It also surveys people's attitudes and perceptions relating to tobacco, alcohol, and other drug use. The 2022–2023 NDSHS survey was the 14th conducted under the National Drug Strategy. The survey was first undertaken in 1985 and has been undertaken every 3 years since 1995.
Key quality issues to consider for the collection include:

- Reported findings are based on self-reported data and are not empirically verified by blood tests or other screening measures.
- It is known from past studies of alcohol and tobacco consumption that respondents tend to underestimate actual consumption levels.
- Estimates of illicit drug use and related behaviours are also likely to be underestimates of actual use.
- The exclusion of people from non-private dwellings, institutional settings, homeless people, and the difficulty in reaching marginalised people are likely to have affected estimates.
- The response rate for the 2022–2023 survey was 44%. Given the nature of the topics in this survey, some non-response bias is expected, but this bias has not been measured.
- Both sampling and non-sampling errors should be considered when interpreting results.
- The 2022–2023 survey used a multi-mode completion methodology – respondents could choose to complete the survey via a paper form, an online form or via a telephone interview. This was the third time an online form has been used in the survey series. Changes in mode may have some impact on responses, and users should exercise some degree of caution when comparing data over time.
- Data from the questions on 'activities undertaken while under the influence of alcohol or illicit drugs' are not considered comparable to previous data collections, due to questionnaire changes.

For more information about the 2022–2023 NDSHS, see National Drug Strategy Household Survey 2022–2023; Data Quality Statement.

National Hospital Morbidity Database

National administrative data on drug-related hospitalisations from admitted patient morbidity data collection systems in Australian hospitals, released annually.
The 2023–24 National Hospital Morbidity Database (NHMD) includes data from all public hospitals and all private hospitals. The data set for the reference period 2023–24 includes records for admitted patient hospitalisations between 1 July 2023 and 30 June 2024.

Coding of drug-related hospitalisations

For the purposes of this report, drug-related hospitalisations are defined as hospitalisations with a principal diagnosis relating to a substance use disorder or direct harm relating to use of selected substances. This includes legal, accessible drugs such as alcohol and tobacco, drugs that are available by prescription or over-the-counter (for example, analgesics and antidepressants), and drugs that are generally not obtained through legal means (for example, heroin and cocaine). A proportion of the hospitalisations reported here may result from harm arising from the therapeutic use of drugs, and this inclusion may mean the burden on the hospital system appears larger than expected. Supplementary analysis of hospitalisations with a drug-related diagnosis in the first 20 diagnosis fields is also included. In this analysis, all hospitalisations with a principal or additional diagnosis (across the first 20 diagnosis fields) are included.

The hospitalisation data in this report were extracted from the NHMD using a selection of codes from the International statistical classification of diseases and related health problems, 10th revision, Australian modification 12th edition (ICD-10-AM) (Table 1).

Table 1: List of ICD-10-AM codes used to identify drug-related hospitalisations

Drug identified in principal diagnosis	**ICD-10-AM codes**
Alcohol (including ethanol)	E24.4, E52, F10.0–10.9, G31.2, G62.1, G72.1, I42.6, K29.2, K70.0–70.9, K85.2, K86.0, R78.0, T51.0–T51.3, T51.8, T51.9, Z71.4
Opioids (including heroin, opium, morphine and methadone)	F11.0–11.9, T40.0–40.4, T40.6
Non-opioid analgesics (including paracetamol)	F55.2, N14.0, T39.0–39.4, T39.8, T39.9
Antiepileptic, sedative-hypnotic and antiparkinsonism drugs (excluding alcohol)	F13.0–13.9, F13.*1, F13.00, F13.09, F13.10, F13.19, F13.20, F13.29, F13.30, F13.39, F13.40, F13.49, F13.50, F13.59, F13.60, F13.69, F13.70, F13.79, F13.80, F13.89, F13.90, F13.99, T41.2, T41.20, T41.21, T41.22, T41.29, T42.0–42.3, T42.4, T42.5–42.8
Benzodiazepines	*T42.4*
Gamma-hydroxybutyrate (GHB)	*F13.01, F13.11, F13.21, F13.31, F13.41, F13.51, F13.61, F13.71, F13.81, F13.91, T41.21*
Other sedatives and hypnotics (including barbiturates; excludes alcohol)	*F13.0–13.9, F13.00, F13.09, F13.10, F13.19, F13.20, F13.29, F13.30, F13.39, F13.40, F13.49, F13.50, F13.59, F13.60, F13.69, F13.70, F13.79, F13.80, F13.89, F13.90, F13.99, T41.2, T41.20, T41.22, T41.29, T42.0–42.3, T42.5–42.8*
Cannabinoids (including cannabis)	F12.0–12.9, T40.7
Hallucinogens (including LSD)	F16.0–16.9, F16.0*–16.9*, T40.8, T40.9
Cocaine	F14.0–14.9, T40.5
Nicotine	F17.0–17.9, T65.2, Z58.7, Z71.6

Amphetamines and other stimulants	F15.01–15.02, F15.11–15.12, F15.21–15.22, F15.31–15.32, F15.41–15.42, F15.51–15.52, F15.61–15.62, F15.71–15.72, F15.81–15.82, F15.91–15.92, T43.61–43.62, F15.0–15.9, F15.00, F15.09, F15.10, F15.19, F15.20, F15.29, F15.30, F15.39, F15.40, F15.49, F15.50, F15.59, F15.60, F15.69, F15.70, F15.79, F15.80, F15.89, F15.90, F15.99, T43.6, T43.60, T43.69
Methamphetamine	*F15.01, F15.11, F15.21, F15.31, F15.41, F15.51, F15.61, F15.71, F15.81, F15.91, T43.61*
Methylenedioxy methamphetamine (MDMA)	*F15.02, F15.12, F15.22, F15.32, F15.42, F15.52, F15.62, F15.72, F15.82, F15.92, T43.62*
Other amphetamines and stimulants (includes caffeine)	*F15.0–15.9, F15.00, F15.09, F15.10, F15.19, F15.20, F15.29, F15.30, F15.39, F15.40, F15.49, F15.50, F15.59, F15.60, F15.69, F15.70, F15.79, F15.80, F15.89, F15.90, F15.99, T43.6, T43.60, T43.69*
Antidepressants	F55.0, T43.0–43.2
Antipsychotics and neuroleptics	T43.3–43.5
Volatile solvents	F18.0–18.9, T52.0–52.9, T53.0–53.7, T53.9, T59.0, T59.8
Multiple drug use	F19.0–19.9
Unspecified drug use and other drugs not elsewhere classified (including psychotropic drugs not elsewhere classified; diuretics; laxatives; anabolic and androgenic steroids and opioid receptor antagonists)	F55.1, F55.3–6, F55.8, F55.9, K85.3, N14.1–3, T38.7, T43.8–43.9, T47.2–47.4, T50.1–50.3, T50.7, Z71.5
Fetal and perinatal related conditions (including conditions caused by the mother's alcohol, tobacco or other drug addiction)	Q86.0

Notes

1. Data for 2018–19 were reported to the NHMD using the ICD-10-AM (10th edition). Revision of ICD-10-AM (10th edition) mapping to drugs of concern was applied in 2017–18. The mapping has been applied to the time series.
2. Code E52 includes non-alcohol niacin deficiencies.

In 2022–23, the AIHW undertook a review of the codes used for some drug types, resulting in changes for the following groupings:

- Codes for "GHB" are reported separately for the first time (these codes were previously reported under "Other sedatives and hypnotics").
- Codes for "MDMA" were reported separately for the first time (these codes were previously reported under "Methamphetamine").
- Codes for alcohol were revised to include E24.4, G62.1, G72.1 and R78.0.

These changes have been applied to the time series, however data may not match previously published tables.

Calculation of population rates

Crude rates reported in time series analysis of NHMD data were calculated using the Australian Bureau of Statistics estimated resident population (ERP) as at 31 December of the reference year. For example, rates for the 2020–21 collection period were calculated using the ERP as at 31 December 2020.

In the year ending 30 June 2021, the estimated residential population in Victoria decreased. This decline was driven by a relatively large net negative overseas migration, likely due to the closure of Australia's international border in March 2020 in response to the COVID-19 pandemic. This may result in increased rates even if the number of clients did not increase. Other states and territories were also impacted by border closures; caution should be taken when comparing population data for 2021 with previous years.

This does not impact rates by remoteness area, which were calculated using the ERP as at 30 June 2020.

For more information about the NHMD, see NHMD Data Quality statement.

National Mortality Database

National administrative data on records for deaths in Australia from 1964, released annually.

The AIHW National Mortality Database (NMD) contains information supplied by the registrars of Births, Deaths and Marriages and the National Coronial Information System – and coded by the ABS – for deaths from 1964 to 2024. Registration of deaths is the responsibility of each state and territory Registry of Births, Deaths and Marriages. These data are then collated and coded by the ABS and are maintained at the AIHW in the NMD.

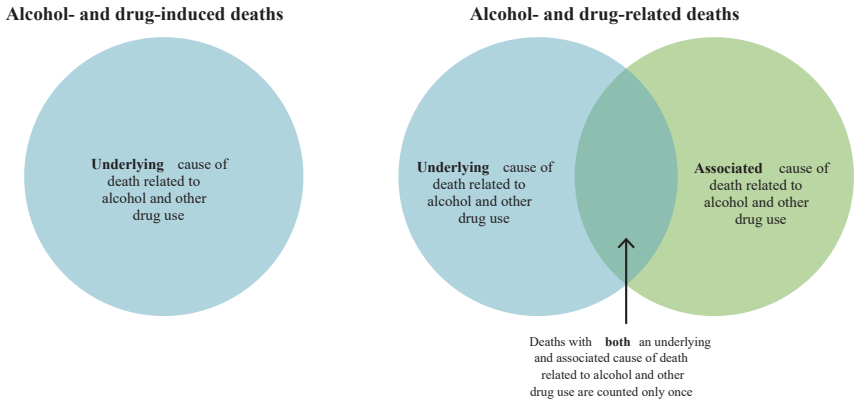
- The Medical Certificate of Cause of Death includes all diseases, morbid conditions or injuries that either resulted in or contributed to death and the circumstances of the accident or violence that produced any such injuries. The underlying cause of death is the disease or injury that initiated the train of morbid events (deaths are referred to as being directly attributable to the disease or injury). Associated causes of death are other causes listed on a death certificate, other than the underlying cause.
- Causes of death are coded by the ABS to the International Statistical Classification of Diseases and Related Health Problems (ICD). Deaths in this report are counted according to year of registration of death, which is not necessarily the year in which the death occurred. Further, mortality data by geographical regions were derived using the place of a person's usual residence at the time of death. The ICD is revised periodically to incorporate changes in the medical field. In 2020, the definition for alcohol-induced deaths was revised to include ICD-10 code *K85.2 alcohol-induced acute pancreatitis*. See Post release changes in Causes of Death, Australia.

Deaths registered in 2021 and earlier are based on the final version of cause of death data; deaths registered in 2022 are based on revised data; deaths registered in 2023 and 2024 are based on preliminary data. Revised and preliminary data are subject to further revision by the ABS.

Estimates of deaths directly attributable to alcohol and illicit drug will vary from other sources. For example, the Australian Burden of Disease Study estimates the proportion of deaths attributable to alcohol use and illicit drug use using a comparative risk assessment methodology. In 2024, it was found that 2.4% of male deaths and 1.2% of female deaths were estimated to be attributable to illicit drug use. Further, 4.6% of male deaths and 2.9% of female deaths were estimated to be attributable to alcohol use in 2024. For more information, see Australian Burden of Disease Study 2024.

In this report, "deaths involving alcohol and other drugs" includes data on drug-induced, drug-related, alcohol-induced and alcohol-related deaths (Figure 1).

Figure 1: Deaths involving alcohol and other drugs



Note: Alcohol-induced and -related deaths include ICD-10 codes outlined in Table 6.

Drug-induced and drug-related deaths

Drug-induced deaths include deaths that were identified as being directly **due to** drug use (that is, where a drug-related condition is recorded as the underlying cause of death). These can include both those due to acute toxicity (for example, drug overdose) and consequences of chronic use (for example, drug-induced cardiac conditions), as determined by toxicology and pathology reports. The underlying causes of deaths align with the definition of drug-induced deaths used by the ABS reporting on drug-induced deaths as defined in Causes of Death, Australia. Deaths solely attributable to alcohol and tobacco are excluded.

Drug-related deaths include deaths where the person died either **from *or* with** drug use related conditions. This includes death directly due to drug use (as defined above) and deaths where a drug contributed to, but did not directly cause, the death (for example, a motor vehicle accident where heroin was detected in the person's blood or chronic drug use in someone who died from coronary heart disease).

For a full list of ICD-10 codes used to identify drug-induced deaths, see the "ICD-10 codes" tabulation in the NMD data tables. Information on the specific drug type involved in drug-induced and drug-related deaths is obtained using ICD-10 T codes (acute poisoning) (Table 2).

Table 2: List of ICD-10 codes used to identify specific drug types in deaths

Drug type	ICD-10 codes
Heroin	T40.1
Natural and semi-synthetic opioids (for example, oxycodone, codeine, morphine)	T40.2
Methadone	T40.3
Synthetic opioids (for example, fentanyl, tramadol, pethidine)	T40.4
All opioids	T40.0, T40.1, T40.2, T40.3, T40.4, T40.6
All opioids excluding heroin	T40.0, T40.2, T40.3, T40.4, T40.6
Cocaine	T40.5
Cannabinoids	T40.7
Benzodiazepines	T42.4
All depressants	T42.0–T42.8
All psychostimulants	T43.6
All antidepressants	T43.0, T43.1, T43.2
All antipsychotics	T43.3, T43.4, T43.5
Paracetamol	T39.1

Ibuprofen and aspirin	T39.3
All non-opioid analgesics	T39.0–T39.9
Alcohol	T51.0, T51.1, T51.2, T51.3, T51.8, T51.9

Note: The underlying causes of deaths align with the definition of drug-induced deaths used by the ABS reporting on drug-induced deaths as defined in Causes of Death, Australia. This classification excludes deaths solely attributable to alcohol and tobacco.

Drug-induced deaths are classified according to their intent as accidental, intentional (including assault and suicide) or undetermined intent (Table 3). They include deaths from illicit drugs (for example, heroin, amphetamines and cocaine) and licit drugs (for example, benzodiazepines and anti-depressants). Drug-induced causes exclude accidents, homicides, and other causes indirectly related to drug use. Also excluded are newborn deaths associated with mother's drug use.

Table 3: List of ICD-10 codes used for intent in drug-induced deaths

Intent	**ICD-10 codes**
Accidents	X40–X44
Intentional (suicide and assault)	X60–X64
Undetermined intent	Y10–Y14

Note: Deaths from external causes are assessed to determine intent. This may also determine how a death is investigated and influence the type of information that can be included on the death record (ABS 2020).

As part of the National Suicide and Self-harm Monitoring Project, the AIHW funded the Australian Bureau of Statistics (ABS) to identify and code (using ICD-10) psychosocial risk factors for deaths referred to a coroner, including drug-induced deaths. Following on from a pilot study (ABS 2019), the ABS reviewed and coded psychosocial risk factors through a review of police, toxicology and pathology reports and coronial findings held by the National Coronial Information System. Psychosocial risk factors, now included in the NMD, are defined as social processes and social structures which can have an interaction with individual thought, behaviour and/or health outcomes (ABS 2019; Table 4).

Table 4: List of most common psychosocial risk factors identified in drug-induced deaths (excluding alcohol), 2019 to 2024

Psychosocial risk factor	**ICD-10 codes**
Unemployment, unspecified	Z560
Other problems related to housing and economic circumstances	Z598
Problems in relationship with spouse or partner	Z630
Absence of family member	Z633
Disappearance and death of family member	Z634
Disruption of family by separation and divorce	Z635
Other specified problems related to primary support group	Z638
Conviction in civil and criminal proceedings without imprisonment	Z650
Release from prison	Z652
Problems related to other legal circumstances	Z653
Limitation of activities due to disability	Z736
Family history of other mental and behavioural disorders	Z818
Personal history of other specified conditions	Z878
Personal history of noncompliance with medical treatment and regimen	Z911
Personal history of self-harm	Z915

Alcohol-induced and alcohol-related deaths

Alcohol-induced deaths include deaths that were identified as being directly **due to** alcohol use (that is, where an alcohol-related condition is recorded as the underlying cause of death). These can include both those due to acute toxicity (for example, alcohol poisoning) and consequences of chronic use (for example, alcoholic liver cirrhosis), as determined by toxicology and pathology reports.

The underlying causes of deaths align with the definition of alcohol-induced deaths used by the ABS as defined in Causes of Death, Australia.

- Alcohol-induced causes exclude accidents, homicides, and other causes indirectly related to alcohol use. This category also excludes newborn deaths associated with maternal alcohol use.

- Alcohol-induced deaths may be due to a chronic condition which is directly related to alcohol use (for example, alcoholic liver cirrhosis) or from an acute condition directly related to harmful consumption (for example, alcohol poisoning which led to respiratory depression).

Alcohol-related deaths include deaths where the person died either **from *or* with** alcohol use related conditions. This includes death directly due to alcohol use (as defined above) and deaths where alcohol use contributed to, but did not directly cause, the death (for example, a motor vehicle accident where a person recorded a high blood alcohol concentration or chronic alcohol use in someone who died from cancer).

The ICD-10 codes used to identify alcohol-induced and alcohol-related deaths are the same (Table 5).

Table 5: List of ICD-10 codes used for alcohol-induced and alcohol-related deaths

Description	ICD-10 code
Alcohol-induced pseudo-Cushing's syndrome	E24.4
Mental and behavioural disorders due to alcohol use	F10
Degeneration of nervous system due to alcohol	G31.2
Alcoholic polyneuropathy	G62.1
Alcoholic myopathy	G72.1
Alcoholic cardiomyopathy	I42.6
Alcoholic gastritis	K29.2
Alcoholic liver disease	K70
Alcohol-induced acute pancreatitis	K85.2
Alcohol-induced chronic pancreatitis	K86.0
Finding of alcohol in blood	R78.0
Accidental poisoning by and exposure to alcohol	X45
Intentional self-poisoning by and exposure to alcohol	X65
Poisoning by and exposure to alcohol, undetermined intent	Y15

Note: ICD-10 code R78 is an invalid underlying cause of death and is included as an associate cause of death for alcohol-related deaths.

Associated causes of death

This report also presents information on the most common associated causes recorded in drug-induced and alcohol-induced deaths, including chronic conditions, injuries and other associated causes (Table 6).

Table 6: List of most common associated causes identified in drug-induced and alcohol-induced deaths, 2019–2024

Associated cause of death	ICD-10 codes
Septicaemia	A40–A41
Viral hepatitis excl. vaccine-preventable diseases	B15–B19 excl. B15, B16, B17.0, B18.0, B18.1, B18.9, B19
Diabetes	E10–E14
Obesity and other hyperalimentation	E65–E68
Mental and behavioural disorders due to psychoactive substance use	F10–F19
Schizophrenia, schizotypal and delusional disorders	F20–F29
Mood (affective) disorders	F30–F39
Neurotic, stress-related and somatoform disorders	F40–F48
Hypertensive disease	I10–I15
Coronary heart disease	I20–I25
Heart failure and complications and ill-defined heart disease	I50–I51
Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified	I80–I89
Chronic obstructive pulmonary disease (COPD)	J40–J44
Liver disease	K70–K76
Other diseases of the digestive system	K90–K93
Diseases of the musculoskeletal system and connective tissue	M00–M99

Kidney failure	N17–N19
Accidental poisoning	X40–X49
Injuries to multiple body regions, crushing, asphyxiation, poisoning by drugs, other	T00–T98
Factors influencing health status and contact with health services	Z00–Z99
Other ill-defined causes	R00–R94, R96–R99, I46.9, I95.9, I99, J96.0, J96.9, P28.5

For more information about the NMD, see National Mortality Database.

National Opioid Pharmacotherapy Statistics Annual Data Collection

National administrative data on clients receiving opioid pharmacotherapy treatment, the doctors prescribing opioid pharmacotherapy drugs, and the dosing points where clients receive treatment, released annually.
The main purpose of the NOPSAD collection is to aggregate standardised jurisdictional data on the number of clients accessing pharmacotherapy for the treatment of opioid dependence, the number of prescribers participating in the delivery of pharmacotherapy treatment, and quantitative information about the prescribing sector. Unit record data are provided by all jurisdictions except Victoria and Queensland.

Key quality issues to consider for the collection include:

- Each state and territory use different methods to collect data about the pharmacotherapy used to treat those with opioid dependence. These methods are driven by the jurisdiction's particular legislation, information technology systems and resources.
- Data were not available for Western Australia in 2023, and for Queensland in 2021. Data for these years may not be comparable to other years.
- Prior to 2023, New South Wales was unable to differentiate between clients prescribed buprenorphine, buprenorphine-naloxone or buprenorphine long acting injections (LAI) in its reporting. These formulations were reported for the first time in 2023.
- Indigenous status of client is reported as a total by Victoria, that is, a breakdown of Indigenous status by individual pharmacotherapy drug type is not available.
- In Western Australia, the number of clients receiving pharmacotherapy treatment is usually reported through the month of June (rather than on a snapshot day), likely resulting in an over-reporting of clients in Western Australia.
- In Tasmania, the number of clients receiving treatment in June is counted. If a client changes dosing point sites during the month, they are only counted once and the activity is attributed to the dosing point that administered the greater number of doses.
- In the Australian Capital Territory, there is some undercounting of the total number of clients receiving treatment in 2024 due to collection systems not capturing buprenorphine long-acting injections administered in primary care settings.

For more information about the NOPSAD collection, see National Opioid Pharmacotherapy Statistics Annual Data collection, 2025; Quality Statement.

People who received specialist Alcohol and Other Drug Treatment Services in their last year of life

National administrative data on people who received specialist alcohol and other drug treatment services in their last year of life, released on an ad hoc basis.
This report uses data from the NACS linked dataset, which was created by the AIHW's Data Linkage Unit by linking health and welfare data sets held by the AIHW. Approval for this project was provided by the AIHW ethics committee under project number EO2023/2/1413.

The final linked data asset is referred to as the NACS dataset and contains the following source datasets:

- **N**ational Death Index (NDI) January 2011 to May 2024
- **A**lcohol and Other Drug Treatment Services (AODTS) July 2012 to June 2023
- **C**ommonwealth primary health datasets
  - Medicare Benefits Schedule (MBS) January 2007 to February 2023
  - Pharmaceutical Benefits Scheme (PBS) January 2007 to February 2023
- **S**pecialist Homelessness Services Collection (SHSC) July 2011 to June 2023.

For this analysis, data from the NACS linked dataset have been restricted to the study period 1 July 2012 to 30 June 2023. Data have been presented for annual financial year periods, and in some instances as a unique count of people across the entire study period.

For more information about this report, see Alcohol and other drug use - feature analysis: People who received specialist Alcohol and Other Drug Treatment Services in their last year of life.

Pharmaceutical Benefits Scheme data collection, Department of Health, Disability and Ageing

National administrative data on dispensing of selected prescription drugs under the Pharmaceutical Benefits Scheme in Australia, updated annually by the AIHW.
The Pharmaceutical Benefits Scheme (PBS) data collection contains information on prescription medicines that qualify for a benefit under the *National Health Act 1953*, and for which a claim has been processed. PBS administrative data are managed and maintained by the Department of Health, Disability and Ageing and contain information on subsidised PBS prescriptions and under co-payment data. Data include all claims processed by Services Australia up to 29 September 2025 for prescriptions dispensed up to 30 June 2025.

PBS data are sufficiently large and captures a significant proportion of the population, however, may underestimate total dispensing. Key limitations to consider for the collection include:

- Data do not capture medicines bought over-the-counter, such as from pharmacies and supermarkets.
- Data do not capture private prescriptions (that is, prescriptions for medicines that are not subsidised by the PBS).

- Medicines dispensed to public hospital inpatients are not captured, nor are PBS- subsidised medicines dispensed to day-admitted patients and patients upon discharge from public hospitals in New South Wales and the Australian Capital Territory.
- Some medicines supplied under section 100 of the *National Health Act 1953*, including those supplied directly for Remote Area Aboriginal Health Services and for the Opioid Dependence Treatment Program, are not included in the PBS data collection.
- PBS medicines and PBS items are listed on or deleted from the PBS regularly. These changes may cause the apparent dispensing of drugs to change over time, and trends should be interpreted in this context.
- Some PBS dispensing records do not include patient information and are not included in tables which examine patients or combinations of prescribed drugs.

The medicines reported from PBS data are classified based on the ATC (Anatomical Therapeutic Chemical) classification system, defined by the World Health Organisation Collaborating Centre for Drug Statistics Methodology. For more information on the structure of the ATC classification system and specific ATC codes, see WHOCC - ATC/DDD Index.

Data contained in this report include prescriptions for the following patient entitlements:

- General
- Concessional
- Repatriation.

Medicines supplied under prescriber bag orders were removed from the dataset prior to analysis. Analysis includes under-co-payment data which include information on prescriptions priced below the co-payment as defined in the *National Health Act 1953*.

Drugs selected for this report were extracted from the PBS data using the ATC codes outlined below (Table 6).

Table 6: List of ATC codes used for each drug classification

Drug classification	**ATC codes**
Opioids	N02A
Codeine as cough suppressant (excluding combinations with expectorants)	R05DA04
Benzodiazepines	N03AE, N05BA, N05CD
Gabapentinoids	N02BF
Gabapentin	*N02BF01*
Pregabalin	*N02BF02*
Smoking cessation medicines	N07BA
Alcohol cessation medicines	N07BB
Cancer treatment medicines	L01AA01–L01AX04, L01BA01, L01BA03–L01XX53, L02AE02, L02AE03, L02BA01, L02BG03, L02BG04, L02BG06, L02BB01–L02BB04, L02BX01–L02BX03, L04AX02, L04AX04, L04AX06

Notes

1. Pregabalin and gabapentin are classified as N02BG when listed to manage pain.

2. ATC codes for some cancer treatment medicines (L01BA01, L02AE02, L02AE03 and L02BA01) have multiple indications in the PBS. Data for these codes were extracted using PBS item codes for medicines that were specifically indicated for cancer treatment. This methodology is consistent with that used by Lalic et al. 2019.

3. The data also included drugs that were incorrectly classified as drugs used in opioid dependence (N07BC).

Calculations of Defined Daily Doses for Statistical purposes (S-DDDs)

S-DDDs were calculated as follows for each opioid prescription:

> Number of S-DDDs = (Number of units × Amount of specified opioid in each unit) / (DDD amount for the specified opioid)

- Units are the individual forms of the opioids, such as tablets or patches.
- DDD amounts match WHO DDD definitions, except for codeine. The WHO DDD amount for codeine (100mg) is for the indication of cough suppression. These results use the International Narcotics Control Board definition of 240mg as the DDD for codeine used for pain relief (INCB 2021).

Opioid dispensing related to palliative care and cancer treatment

Data for opioids were further disaggregated by dispensing that was in relation to palliative care or cancer treatment.

- Opioid dispensing was classified as being related to palliative care where a patient received a PBS supply of any drug under the Palliative Care Section in the previous 365 days. For more information on palliative care items in the PBS, see Pharmaceutical Benefits Scheme (PBS) | Palliative Care Items.
- Opioid dispensing was classified as being related to cancer treatment where a patient received a supply of a medicine used to treat cancer within the previous 365 days. Drugs related to cancer treatment were extracted using the ATC codes in the table above.

Patients using opioids and benzodiazepines at the same time

The PBS does not contain information related to how dispensed prescriptions are intended to be used, in terms of quantity or frequency. As such, it is not possible to derive how long any given prescription is likely to last.

As a result, after consulting with researchers with experience in prescription drug research, this report uses a fixed window of 30 days from the point of prescription as the time in which a prescription of another drug type is considered to be "at the same time" as the first drug.

This may count some people who were dispensed one drug for a short time (for example, two weeks) and then dispensed a prescription for the other drug type. Conversely, it may not count some patients who are dispensed long-term courses of one drug (over many months) and were then dispensed a prescription of the other drug type. As a result, numbers should be considered indicative only.

For more information about the PBS data collection, see Pharmaceutical Benefits Scheme data collection.

Specialist Homelessness Services annual report

National administrative data on characteristics of clients receiving support from specialist homelessness services in Australia, released annually.
The Specialist Homelessness Services annual report uses data from the Specialist Homelessness Services Collection (SHSC) to describe services and support provided to people experiencing, or at risk of, homelessness. Each month, data from around 1,800 SHS agencies across Australia are provided directly to the AIHW. State and territory governments determine the services delivered through the SHS-funded agencies, so models of support differ between jurisdictions.

All SHSC agencies report standardised data about the clients they support each month to the AIHW, as specified by the SHS National Minimum Dataset. Information is collected about clients' characteristics and circumstances when they first present to an agency. Additional data on the assistance provided and changes in clients' circumstances are collected at the end of the month in which services are received, and again when contact with the client has ceased.

The SHSC provides a comprehensive picture of the specialist homelessness services clients receive and the outcomes achieved. The SHSC data describes the service response to people experiencing housing insecurity. While the data do not capture the full extent of homelessness in the community, SHSC data on emergency and supported accommodation contribute to Australia's broader homelessness profile.

The data collected by agencies are based on periods of support provided to clients. Data related to support periods vary in terms of their duration, the number of times a client and an SHS agency or worker have contact within that period, and the reasons that support ends. Some support periods are relatively short and are likely to have begun and ended in the reference period. Others are much longer and may have been ongoing from the previous year and/or were still ongoing at the end of the reference period.

For more information about the 2024–25 SHSC, see Specialist homelessness services annual report 2024–25, SHS system overview.

The health of people in Australia's prisons

National survey data on the health and wellbeing of people entering or being discharged from prison in Australia, released every 3 years.
The health of people in Australia's prisons contains data from the 2022 National Prisoner Health Data Collection (NPHDC), based on information obtained from people aged 18 and over from participating prisons across all states and territories (except Victoria).

The NPHDC collects self-reported data on alcohol consumption, smoking and the use of drugs for non-medical purposes in people entering and leaving prison. The term 'illicit drugs' in this report includes the following:

- illegal drugs (such as cocaine, heroin, and amphetamine type stimulants)
- pharmaceutical drugs (such as opioid-based pain relief medications, benzodiazepines and steroids) when used for non-medical purposes
- other substances, legal or illegal, used inappropriately, such as inhalants from petrol, paint or glue.

For more information about the 2022 NPHDC, see The health of people in Australia's prisons 2022.

Australian Research Centre in Sex, Health and Society data sources

The Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University manages several national surveys examining health and wellbeing of lesbian, gay, bisexual, transgender, intersex and queer people in Australia, including use of alcohol and other drugs among these cohorts.

Private Lives 3

National survey data on the health and wellbeing of lesbian, gay, bisexual, transgender, intersex and queer people in Australia.
Private Lives is a national survey series on the health and wellbeing of lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people. Private Lives 3 (PL3) is the third iteration of The Private Lives survey series with previous releases in 2005 and 2011. The survey was conducted by the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University.

In 2020, 6,835 participants were recruited to the survey through paid Facebook advertising and via LGBTIQ community organisations and their networks. The survey was completed online, with paper copies of the survey available on request. The survey was provided in English and was restricted to participants who resided in Australia at the time of the survey who were aged 18 years and above. Questions in the PL3 survey were not compulsory and the total sample size for questions therefore varies slightly.

For more information about the survey, see Private Lives 3.

Writing Themselves In 4

National survey data on the health and wellbeing of lesbian, gay, bisexual, transgender, intersex and queer young people in Australia.

Writing Themselves In is a national survey series on the health and wellbeing among LGBTQA+ young people in Australia. This is the fourth iteration in the Writing Themselves In survey series with previous releases in 1998, 2004 and 2010. The survey was conducted by the Australian Research Centre in Sex, Health and Society at La Trobe University.

In 2019, 6,418 participants were recruited to the survey, through promotion of still images and a short video distributed via paid advertising on Facebook and Instagram, online networks of community organisations working with and for LGBTIQA+ young people and promotional posters provided to community organisations. The survey was designed for online completion and was provided in English and restricted to participants who resided in Australia at the time of the survey, who were 14 to 21 years of age, and identified as LGBTIQA+ (or used a synonymous term).

For more information about the survey, see Writing Themselves In 4.

Cancer Council Victoria data sources

Cancer Council Victoria produces several reports that include information about tobacco, alcohol and other drugs in Australia, including:

- use of tobacco, e-cigarettes, alcohol and other substances among secondary school students
- comprehensive information on tobacco in Australia.

Australian Secondary School Students' Alcohol and Drug Survey

National survey data on use of tobacco, e-cigarettes, alcohol and other substances among 12–17-year-old secondary school students in Australia, released every 3 years.
The Australian Secondary School Students' Alcohol and Drug Survey (ASSAD) survey is a triennial survey that was first conducted in 1984. The survey assesses secondary students' use of tobacco, e-cigarettes, alcohol, over-the-counter drugs (for non-medicinal purposes) and other substances in Australia.

The 2022/2023 ASSAD was completed by secondary students across 83 schools from March 2022 to July 2023, using an online self-report questionnaire. The survey uses a standard sampling procedure and core questionnaire throughout all states and territories in Australia, drawing on a national sample of schools across Australia.

The 2022/23 survey was postponed from 2020 due to the COVID-19 pandemic's consequent restrictions on school survey involvement. In 2022/2023, the survey was completed via an online questionnaire for the first time. Schools in most jurisdictions were also given the option of having classroom teachers administer the survey in place of research staff.

For more information about the 2022/2023 ASSAD, see Australian Secondary School Students Alcohol and Drug Survey.

Tobacco in Australia: Facts & Issues

Compilation of data on tobacco use and policy from Australian and international sources, released on an ad hoc basis.
Tobacco in Australia: Facts & Issues provides a comprehensive overview of research on tobacco use and policy from Australia and globally. The report primarily uses information from other published sources.

The following report sections are included in this report:

- Chapter 2: Trends in tobacco consumption – 2.5 Industry sales figures as estimates for consumption
- Chapter 4: The health effects of secondhand smoke – 4.0 Background
- Chapter 7: Smoking cessation – 7.2 Quitting activity
- Chapter 12: Tobacco products – 12.7 Menthol
- Chapter 13: The pricing and taxation of tobacco products in Australia – 13.A3 Industry estimates of the extent of illicit trade in tobacco.

For more information about the report, see Tobacco in Australia: Facts & Issues.

Kirby Institute data sources

The Kirby Institute at the University of New South Wales releases several reports on Needle Syringe Programs (NSPs) across Australia, including information about services provided by NSPs and the people who access them.

Australian Needle Syringe Program Survey

National survey data on the prevalence of human immunodeficiency virus (HIV), hepatitis C virus (HCV), and sexual and injecting risk behaviour among people who inject drugs attending needle syringe programs in Australia, released annually.
The Australian Needle Syringe Program Survey (ANSPS) is a national survey of people who inject drugs who attend participating needle syringe programs (NSPs) across Australia. The ANSPS aims to provide serial point prevalence estimates of HIV antibody, HCV antibody and RNA (active infection), and sexual and injecting risk behaviours among people who inject drugs. The ANSPS consists of annual interviews with clients attending participant NSPs across Australia and blood tests to confirm HIV and HCV status.

The ANSPS has been conducted every year since 1995, consisting of annual interviews with clients attending participant NSPs across Australia and blood tests to confirm HIV and HCV status. Annual response rates have ranged from 34% to 60%, with 1,760 participants recruited via 54 participating NSPs in 2024.

Due to a range of public health measures implemented to reduce community transmission during ANSPS data collection periods since COVID-19, the number of respondents for 2020 and 2021 was lower than in previous years. Additionally, changes to the assays used for HCV antibody testing may have resulted in an increase in HCV antibody prevalence in 2023 and 2024 relative to 2022. This should be considered when comparing data with previous years.

For more information about the 2024 ANSPS, see Australian NSP Survey 30 year National Data Report 1995–2024.

Needle Syringe Program National Minimum Data Collection

National administrative data on Needle Syringe Programs (NSPs) and NSP clients across Australia, released annually.
The Needle Syringe Program National Minimum Data Collection (NSP NMDC) provides information on NSP service provision, enabling the ongoing monitoring of Australia's National Strategies for reducing blood-borne viral infections as part of the National Surveillance and Monitoring Plan. The NSP NMDC includes data from three areas of NSP operations:

- agency-level administrative data
- client-level data (including demographic characteristics of NSP attendees and drugs injected by NSP attendees)
- national needle and syringe distribution.

For more information about the NSP NMDC, see Needle Syringe Program National Minimum Data Collection (NSP NMDC).

National Drug and Alcohol Research Centre data sources

The National Drug and Alcohol Research Centre at the University of New South Wales manages the Drug Trends program of work, which releases reports related to the following research activities:

- ongoing monitoring of illicit drug markets across Australia
- surveys of alcohol and other drug use among people who regularly use stimulant drugs or regularly inject drugs
- monitoring of epidemiological data on drug-related harms, including drug-related hospitalisations and drug-induced deaths.

Ecstasy and Related Drugs Reporting System

National survey data on illicit drug markets and alcohol and other drug use among people who regularly use ecstasy and related drugs across capital cities in Australia, released annually.
The Ecstasy and Related Drugs Reporting System (EDRS) is a national monitoring system for ecstasy and related drugs that is intended to identify emerging trends of local and national interest in the markets for these drugs. The EDRS is based on the IDRS methodology and includes data obtained from interviews with people who regularly use ecstasy and/or other illicit stimulant drugs. The EDRS monitors the price, purity, availability, and patterns of use and harms of ecstasy and other drugs such as methamphetamine, cocaine, gamma-hydroxybutyrate (GHB), d-lysergic acid (LSD), 3,4-methylendioxyamphetamine (MDA) and ketamine.

The EDRS sample is a sentinel group that provides information on patterns of drug use and market trends and is not representative of all people who use illicit drugs nor the general population. The 2025 EDRS survey recruited 690 participants between April and July 2025. The sample size reflects predetermined quotas.

Interviews from 2020 onwards were delivered face-to-face or via telephone or videoconference, to reduce the risk of COVID-19 transmission. Interviews prior to 2020 were conducted face-to-face only. This change in methodology should be considered when comparing data from 2020 onwards with previous years.

For more information about the EDRS, see The Ecstasy and Related Drugs Reporting System (EDRS).

Illicit Drug Reporting System

National survey data on illicit drug markets and alcohol and other drug use among people who regularly inject drugs across capital cities in Australia, released annually.
The Illicit Drug Reporting System (IDRS) is a national illicit drug monitoring system intended to identify emerging trends of local and national concern in illicit drug markets. The IDRS consists of annual interviews with people who regularly inject drugs, conducted in all capital cities across Australia. The monitoring system is intended to provide trends and identify emerging issues in illicit drug markets.

The IDRS sample is a sentinel group that provides information on patterns of drug use and market trends and is not representative of all people who use illicit drugs nor the general population. 865 participants were recruited to the 2025 IDRS survey between May and July 2025. The sample size reflects predetermined quotas.

Interviews from 2020 onwards were delivered face-to-face or via telephone or videoconference, to reduce the risk of COVID-19 transmission. Interviews prior to 2020 were conducted face-to-face only. This change in methodology should be considered when comparing data from the 2020–2025 samples with previous years.

For more information about the IDRS, see The Illicit Drug Reporting System (IDRS).

Trends in drug-related hospitalisations in Australia

National administrative data on hospitalisations with a drug-related principal diagnosis across Australia, released annually.
This report presents data on drug-related hospitalisations in Australia, focusing on hospitalisations related to opioids, amphetamine-type stimulants, cannabinoids, cocaine and other drugs. Data are extracted from the AIHW's National Hospital Morbidity Database.

Data are coded according to the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM). The main data describe drug-related hospitalisations where the principal diagnosis was directly attributable to the use of illicit drugs, prescription medicines, or over-the-counter medicines. Alcohol and tobacco are excluded from the analysis. For information about the differences between NDARC's reporting compared with the AIHW, see Data on alcohol and other drug-related hospitalisations.

For more information about the report, see Trends in drug-related hospitalisations in Australia, 2003–2023.

Trends in overdose and other drug-induced deaths in Australia

National administrative data on drug-induced deaths in Australia, released annually.

This report presents data on overdose and drug-induced deaths in Australia, using data from the Australian Bureau of Statistics' Causes of Death Unit Record File (COD URF) through the Australian Coordinating Registry. The most recent report covers the period 2004–2023, including final data for 2004–2021, revised data for 2022, and preliminary revised data for 2023. Data for 2022 and 2023 are subject to further revision.

NDARC's reporting includes drug-induced deaths directly attributable to illicit drugs, certain prescription medicines, and medicines available over-the-counter. The report includes only overdose and drug-induced deaths where drugs were deemed the underlying cause of death. This excludes deaths due to accidents caused by being under the influence of a drug, such as motor vehicle accidents. Deaths where conditions related to alcohol or tobacco use fall outside the scope of NDARC's monitoring, however rates of alcohol involvement in drug-induced deaths are reported. For information about the differences between NDARC's reporting compared with the ABS and the AIHW, see Data on deaths involving alcohol and other drugs.

For more information about the report, see Trends in overdose and other drug-induced deaths in Australia, 2004–2023.

Other data sources

Several other agencies release data that are included in this report, including:

- Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts
- Organization for Economic Cooperation and Development (OECD)
- United Nations Office on Drugs and Crime (UNODC).

OECD Health Statistics

International data on a range of health-related topics, including alcohol and other drug use, in Australia and internationally, released annually by the OECD.
The OECD releases updated data on the prevalence of smoking, e-cigarette use and alcohol consumption across OECD and partner countries. Data are supplied from a range of data sources, and the most recent year of available data is used for each country. The years of data and methodologies may differ across countries and over time. Australian data come from numerous sources including the National Drug Strategy Household Survey and the Alcohol available for consumption in Australia report.

For more information on the OECD Health Statistics report, see OECD Data Explorer.

Road Trauma Australia

National administrative data on fatalities and hospitalised injuries from road crashes in Australia, released by the Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts.
Road Trauma Australia provides annual data on road fatalities in Australia, including information on road trauma incidents involving alcohol. In this report, road crashes are any apparently unpremeditated event reported to police or another relevant authority, where the movement of a road vehicle on a public road has resulted in death, injury or property damage. Alcohol involvement refers to road crashes where at least one vehicle operator was recorded as having tested with an illegal concentration of alcohol (that is, higher than the legal limit for driving).

For more information about the report, see Road Trauma Australia—Annual Summaries.

World Drug Report

International data on a range of topics related to alcohol and other drugs, including supply, prevalence of use, price and treatment, released annually by the UNODC.
The World Drug Report presents global, regional and sub-regional data on drug markets, trends and policy developments. Data are submitted to the UNODC by Member States via an annual report questionnaire, unless specific otherwise in the report.

For more information about the 2024 report, see World Drug Report 2024.

Comparison of national data sources on alcohol and other drug use and harms

Surveys on alcohol and other drug use

Several nationally representative data sources are available to analyse recent trends in alcohol and other drug consumption. This includes the National Drug Strategy Household Survey (NDSHS) and the National Health Survey (NHS), which examine a range of factors including alcohol and other drug use among the general population. In addition, the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) are designed to obtain a representative sample of First Nations people across Australia.

Differences in scope, collection methodology and design may account for variation in estimates reported and comparisons between collections should be made with caution. For a summary of the methodological differences, see Table T1: Methodological differences between surveys [XLSX 20kB].

Data on alcohol and other drug-related hospitalisations

Information about drug-related hospitalisations comes from the National Hospital Morbidity Database (NHMD), an administrative data set containing data from hospitals across Australia and coded to the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM).

Data on drug-related hospitalisations are routinely reported by the Australian Institute of Health and Welfare (AIHW) and the National Drug and Alcohol Research Centre (NDARC). NDARC reports a lower number of drug-related hospitalisations than the AIHW due to a number of methodological differences, including:

- NDARC does not include hospitalisations where the principal diagnosis is related to tobacco or alcohol use, other unspecified drug use and fetal and perinatal conditions. The AIHW includes these principal diagnoses in totals (although fetal and perinatal numbers are not reported separately).

- NDARC includes hospitalisations by the state or territory of a patient's usual residence and do not include cross-border hospitalisations. The AIHW does not provide state/territory disaggregation and includes cross-border hospitalisations.
- NDARC calculate age-standardised rates in some areas, along with a crude rate as of 30 June of the reference year. The AIHW calculates crude rates only, as of 31 December of the reference year.
- Both NDARC and the AIHW exclude hospitalisations for which the care type was reported as 'Newborn without qualified days', and records for 'Posthumous organ procurement' and 'Hospital boarders'.

For detailed information about the AIHW and NDARC analyses of hospitalisations data, see Australian Institute of Health and Welfare data sources and National Drug and Alcohol Research Centre data sources.

Data on deaths involving alcohol and other drugs

Data on drug-induced deaths are released by the Australian Bureau of Statistics (ABS) annually, using information from the Registrar of Births, Deaths and Marriages in each state and territory, and the National Coronial Information System for deaths certified by a coroner. Causes of death are coded by the ABS to the International Statistical Classification of Diseases and Related Health Problems (ICD).

Data on deaths involving alcohol and other drugs are released by the ABS within 10 months of the year end (for example, 2023 data were released in October 2024). Additional analysis is undertaken by the National Drug and Alcohol Research Centre (NDARC) and Australian Institute of Health and Welfare (AIHW) and released the following year. For this reason, the latest year of data reported here will sometimes vary. The number of deaths reported across each data source may differ due to variations in data collection purpose, scope, and terminology:

- The ABS, AIHW and NDARC all use the term "drug-induced deaths" to refer to deaths that are directly attributable to drug use (for example, where drug overdose is the underlying cause of death). Drug-related deaths, where a drug has played a contributory role (for example, a traffic accident), are excluded.
- The ABS, AIHW and NDARC report drug-induced deaths (excluding deaths solely attributable to alcohol and tobacco) using the drug-induced death tabulation. This tabulation outlines the ICD-10 codes for causes of death attributable to drug-induced mortality. Drug-induced deaths data are reported for the whole of the population across all data sources.
- The AIHW also reports separately on alcohol-induced and alcohol-related deaths, using the same tabulation for alcohol-induced deaths.
- Since 2022, the ABS Causes of Death report has referred to mortality data by year of registration (based on the date when the death was registered). In previous years, data was presented by reference year. This change has been applied across the time series in the Causes of Death report. For more information, see Causes of Death, Australia.

For detailed information about the ABS, AIHW and NDARC analyses of mortality data, see Australian Bureau of Statistics data sources, Australian Institute of Health and Welfare data sources and National Drug and Alcohol Research Centre data sources.

Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Fact sheets

These fact sheets consolidate key information of *Alcohol, tobacco & other drugs in Australia*. They highlight insights into selected drug types and priority populations.

Fact sheet: Tobacco
Educational resource | *11 Dec 2025*
PDF 335kB

Fact sheet: Vaping and e-cigarettes
Educational resource | *11 Dec 2025*
PDF 152kB

Fact sheet: Alcohol
Educational resource | *11 Dec 2025*
PDF 276kB

Fact sheet: Cannabis
Educational resource | *28 Apr 2026*
PDF 1.3MB

Fact sheet: Amphetamines and other stimulants
Educational resource | *28 Apr 2026*
PDF 345kB

Fact sheet: Heroin
Educational resource | *28 Apr 2026*
PDF 1.2MB

Fact sheet: Pharmaceutical drugs
Educational resource | *28 Apr 2026*
PDF 993kB

Fact sheet: Other drugs and new psychoactive substances
Educational resource | *28 Apr 2026*
PDF 951kB

Fact sheet: Experiences of alcohol and other drugs among First Nations people
Educational resource | *28 Apr 2026*
PDF 945kB

Fact sheet: Children and young people's experiences of alcohol and other drugs
Educational resource | *11 Dec 2025*
PDF 353kB

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Notes

What's been updated?

28 April 2026

Chapter updated	Page updated	Data sources
Health and harms	Alcohol and other drug-related ambulance attendances	AIHW analysis of the National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose
Health and harms	Deaths involving alcohol and other drugs	AIHW analysis of the National Mortality Database Deaths from external causes, 2024
Treatment	Alcohol and other drug treatment services	Alcohol and other drug treatment services in Australia: early insights National Opioid Pharmacotherapy Statistics Annual Data collection
Harm reduction	Illicit drug markets and drug-related law enforcement activities	Prisoners in Australia, 2025
Drug types	Tobacco	Alcohol and other drug treatment services in Australia: early insights
Drug types	Alcohol	AIHW analysis of the National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose AIHW analysis of the National Mortality Database Alcohol and other drug treatment services in Australia: early insights
Drug types	Cannabis	AIHW analysis of the National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose AIHW analysis of the National Mortality Database Alcohol and other drug treatment services in Australia: early insights
Drug types	Amphetamines and other stimulants	AIHW analysis of the National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose AIHW analysis of the National Mortality Database Alcohol and other drug treatment services in Australia: early insights
Drug types	Heroin	AIHW analysis of the National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose AIHW analysis of the National Mortality Database Alcohol and other drug treatment services in Australia: early insights National Opioid Pharmacotherapy Statistics Annual Data collection
Drug types	Pharmaceuticals	AIHW analysis of the National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose AIHW analysis of the National Mortality Database Alcohol and other drug treatment services in Australia: early insights
Drug types	New psychoactive substances	Current NPS Threats
Drug types	Other drugs	AIHW analysis of the National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose
Geographic areas	State and territory data	AIHW analysis of the National Ambulance Surveillance System for Alcohol and Other Drug Misuse and Overdose

Geographic areas	Remoteness areas	AIHW analysis of the National Mortality Database
Population groups	Experiences of alcohol and other drugs among First Nations people	Alcohol and other drug treatment services in Australia: early insights National Opioid Pharmacotherapy Statistics Annual Data collection
Population groups	Children and young people's experiences of alcohol and other drugs	AIHW analysis of the National Mortality Database Alcohol and other drug treatment services in Australia: early insights
Population groups	Older people's experiences of alcohol and other drugs	AIHW analysis of the National Mortality Database Alcohol and other drug treatment services in Australia: early insights National Opioid Pharmacotherapy Statistics Annual Data collection
Population groups	Experiences of alcohol and other drugs among people in contact with the criminal justice system	Prisoners in Australia, 2025
Population groups	Experiences of alcohol and other drugs among people with mental health conditions	AIHW analysis of the National Mortality Database

Amendments

17 December 2025

- In the "Alcohol, tobacco and other drugs in Australia – National Ambulance Surveillance System" set of data tables, additional rows of duplicate data were present in table NASS4 (in rows 243 to 604). These rows of data were removed from the table.
- In the "Alcohol, tobacco and other drugs in Australia – Organization for Economic Co-operation and Development" set of data tables, there was data in table OECD3 that was incorrect (the Belgium values for males and females, and the OECD average for males and females). This data was corrected.
- In Figure 2 of the "International data" page, there was data that was incorrect (the Belgium values for males and females, and the OECD average for males and females). This data was corrected.
- In Figure 1 and Figure 3 of the "International data" page, the Notes views were displaying as blank. The notes have been added to the figure.
- On the "Community harms" page, there was an incorrectly placed link saying "Crime Victimisation" next to the "Family, domestic and sexual violence" heading. The link was removed.

14 August 2025

- On Alcohol and other drug-related ambulance attendances, *Figure REGION 5* was re-loaded as some numbers were incorrect.
- On Health impacts, *Figures IMPACT 2*, *IMPACT 3*, *IMPACT 4* and *IMPACT 5* were re-loaded as some numbers were incorrect.
- On Alcohol, under the heading **Ambulance attendances**, the rate of ambulance attendances for Queensland in 2022 was amended. This rate was previously incorrect.
- On Amphetamines and other stimulants, *Figure STIM 3* was re-loaded as some numbers were incorrect.
- On Pharmaceuticals, under the heading **Ambulance attendances**, the rates of ambulance attendances for 'any pharmaceuticals' in Tasmania and New South Wales were amended. These rates were previously incorrect.
- On Illicit opioids, including heroin, under the heading **Ambulance attendances**, the rate of ambulance attendances for Tasmania was removed and replaced with a statistic for Queensland due to concerns about the quality or confidentiality of the data.
- On New (and emerging) psychoactive substances, under the heading **GHB (Gamma-hydroxybutyrate) – Harms**, numbers and rates of GHB-related attendances for Tasmania in 2022 and 2023 were removed due to concerns about the quality or confidentiality of the data.
- On Lesbian, gay, bisexual, transgender, intersex or queer people, under the heading **Illicit drugs**, the percentages for recent cannabis use were amended. These percentages were previously incorrect.

9 July 2025: On the Illicit opioids, including heroin page, under the heading **Consumption**, the first sentence was changed. The term 'lifetime' was updated to 'recent' as the data described recent heroin use.

17 March 2025: On New (and emerging) psychoactive substances page, under GHB (Gamma-hydroxybutyrate) – Harms heading, data describes ambulance attendances where GHB was present. One sentence was removed from this section as the data pertained to cannabis not GHB attendances.

13 December 2024: On Alcohol and other drug-related ambulance attendances, Figure REGION 5 has been updated to include monthly data (where available). In previous reporting this figure included data from select months (March, June, September and December). The surrounding text that describes the figure has now been updated to align with this change and exclude references to select months.

28 May 2024

- The data in Figure INDIGENOUS 2 was amended to correctly reference tables 3.5 and 3.6. This data pertains to single-occasion and lifetime alcohol risk. This change was made on Aboriginal and Torres Strait Islander (First Nations) people.
- The numbering of Supplementary tables 'Data by region' was be amended from '1-12' to '1-5'. This change was made on Data.

18 January 2023: Revised data in Health impacts – Burden of disease

16 December 2022: Updated data in fact sheets with 2021-2022 data from Specialist Homelessness Services.

Viewing this data

Caution: This content contains information and data on alcohol or other drugs

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The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.

Data

Data tables: Alcohol, tobacco and other drugs in Australia - Australian Burden of Disease Study

Data

Tables ABDS1–ABDS2.
XLSX 125kB

Data tables: Alcohol, tobacco and other drug use in Australia - Illicit Drug Data Report

Data

Tables IDDR1–IDDR3.
XLSX 127kB

Data tables: Alcohol, tobacco and other drugs in Australia - LGBTIQ+ data

Data

Tables LGBTIQ1–LGBTIQ2.
XLSX 134kB

Data tables: Alcohol, tobacco and other drugs in Australia - National Ambulance Surveillance System

Data

Tables NASS1–NASS14.
XLSX 1MB

Data tables: Alcohol, tobacco and other drugs in Australia - National Hospital Morbidity Database

Data

Tables NHMD1–NHMD5.
XLSX 284kB

Data tables: Alcohol, tobacco and other drugs in Australia - National Mortality Database

Data

Tables NMD1–NMD14.
XLSX 304kB

Data tables: Alcohol, tobacco and other drugs in Australia - OECD comparisons

Data

Tables OECD1–OECD4.
XLSX 1.2MB

Data tables: Alcohol, tobacco and other drugs in Australia - Pharmaceutical Benefits Scheme data collection

Data

Tables PBS1–PBS92.
XLSX 456kB

Viewing this data

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Related material

Resources

Alcohol and other drug treatment services in Australia

Resource

National Drug Strategy Household Survey 2022–2023

Resource

National Opioid Pharmacotherapy Statistics Annual Data collection

Resource

Alcohol, tobacco and other drugs in Australia - COVID-19

Resource
PDF 3.8MB

National Surveillance System for Alcohol and Other Drug Misuse and Overdose January to December 2019

Resource
PDF 4.7MB

National Surveillance System for Alcohol and Other Drug Misuse and Overdose January to December 2018

Resource
PDF 5MB

National Surveillance System for Alcohol and Other Drug Misuse and Overdose January to December 2017

Resource
PDF 5MB

National Surveillance System for Alcohol and Other Drug Misuse and Overdose January to December 2016

Resource
PDF 5.1MB

National Surveillance System for Alcohol and Other Drug Misuse and Overdose January to December 2015

Resource
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- Experiences of alcohol and other drugs among people who inject drugs |
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- Experiences of alcohol and other drugs among lesbian, gay, bisexual, transgender, intersex or queer people |
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Related topics

- Alcohol
- Alcohol & other drug treatment services
- Illicit use of drugs
- Smoking and e-cigarettes

Viewing this data

Caution: This content contains information and data on alcohol or other drugs

If you have concerns about your own or someone else's alcohol or other drug use, contact the National Alcohol and Other Drug Hotline on 1800 250 015. Go to the support services page for a list of support services.

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe reporting on alcohol and other drug use. Please consider these guidelines when reporting on these topics.