

Alcohol and other drug treatment services in Australia annual report 2024–25

Web report | Last updated: 25 Jun 2026 | Topic: [Alcohol & other drug treatment services](#)

About

The *Alcohol and other drug treatment services in Australia* report presents detailed statistics about Australia's publicly funded alcohol and other drug (AOD) treatment services. Information is presented about services provided to people who are receiving treatment for their own drug use and those receiving assistance for someone else's drug use, including the treatment provided, and the drug of concern.

This report has been updated with financial year data for 2024–25 and is updated on an annual basis.

Cat. no: HSE 258

- [State and territory summaries](#)
- [Geography data for Primary Health Networks](#)
- [Interactive data cubes](#)
- [Data](#)

Key findings

- [Treatment agencies provided around 244,400 treatment episodes to an estimated 127,800 people aged 10 and over](#)
- [3 in 5 people who received treatment were male \(62%\) and half \(51%\) were aged 30–49](#)
- [Counselling remains the most common treatment \(32%\), followed by assessment only \(21%\)](#)
- [Alcohol remains the most common principal drug of concern for which clients received treatment](#)

Related reports

Insights

Clients



Around 127,800 people aged 10 and over received 244,400 alcohol or other drug (AOD) treatment episodes in 2024–25

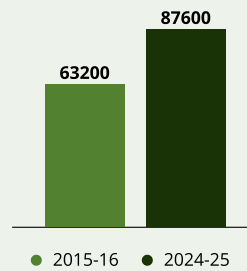


Since 2019–20, the number of clients in AOD services has dropped by 8.2%, falling from 139,295 to 127,804, while rates have fallen from 623 to 527 per 100,000 people

Principal drugs of concern



The most common principal drug of concern was alcohol (41%, 87,600 episodes), followed by methamphetamine (24%), cannabis (14%) and heroin (4.3%)



Alcohol has remained the most common principal drug of concern, increasing since 2015-16

AOD treatment



88% of all AOD treatment episodes were provided to people receiving treatment for their own drug use while a further 12% were for someone else's AOD use



From 2015–16, the number of AOD treatment episodes rose by 18% from 206,395 in 2015–16 to 244,411 in 2024–25



In 2024–25, 3 in 5 (59%, 143,496) treatment episodes ended as an expected or planned completion and has remained similar since 2015–16



The median length of AOD treatment was four weeks for clients' own AOD use and two weeks for clients who received support for someone else's AOD use

AOD agencies



Nationally, over the 10-year period to 2024–25, the total number of publicly funded agencies providing AOD treatment increased by 66% from 791 in 2015–16 to 1,316 in 2024–25



Over half of all AOD agencies (55%) were located in *Major cities*

Clients

Clients who received alcohol and other drug treatment

Insights



Around 127,800 people aged 10 and over received 244,400 alcohol or other drug treatment (AOD) treatment episodes in 2024–25



Since 2019–20, the number of clients in AOD services has dropped by 8.2%, falling from 139,295 to 127,804, while rates have fallen from 623 to 527 per 100,000 people



In 2024–25, fewer clients received treatment, however, on average clients received more than one treatment episode. This has been steadily rising, indicating while fewer people are accessing services, those who do receive multiple episodes of care.



Clients who received treatment for their own AOD use tended to be younger than those who received treatment for someone else's AOD use



3 in 5 people who received AOD treatment were male (62%)



3 in 5 (60%) clients returned to AOD treatment in 2024–25



Aboriginal and Torres Strait Islander (First Nations) people accounted for 1 in 5 (19%) clients aged 10 and over who received AOD treatment



Clients receiving AOD treatment for someone else's AOD use almost doubled from 2015–16 to 2024–25 (5,575 to 10,672)

Client profile

In this section

- Overview
- Client trends
- Treatment episodes per client
- Characteristics of clients
- Client profile
- Age and sex
- New and returning clients
- Principal drug of concern
- Clients and drugs of concern
- Usual accommodation type for clients
- Clients by socioeconomic area

People may receive alcohol and other drug (AOD) treatment for their own alcohol or drug use or seek support for someone else's alcohol or drug use. AOD services ensure that people who may be experiencing harm from alcohol, prescribed medicines or other substances are provided with information, support and the opportunity to seek further assistance if appropriate, for themselves or for someone else (Department of Health and Aged Care 2019).

Clients in the AODTS NMDS

People may receive treatment for their own or someone else's alcohol or drug use. Characteristics of all clients aged 10 and over are described below, including clients' principal drugs of concern by age group, and new and returning clients in the current collection year.

The [Alcohol and Other Drug Treatment Services \(AODTS\) collection](#) captures information on treatment services clients received. It does not measure the underlying need for treatment or level of alcohol or drug use in the community. Changes in client numbers over time may be due to clients' access to treatment, treatment availability, differences in counting methodologies, and/or funding available for alcohol and other drug treatment services.

Client trends

In 2024–25:

- Around 127,800 people received 244,400 treatment episodes for their own or someone else's alcohol or drug use from publicly funded alcohol and other drug (AOD) treatment services (Table SCR.21).
- 120,148 people received treatment for their own alcohol or drug use and 14,581 received treatment in relation to someone else's alcohol or drug use.
- 1 in 20 (5.4%, 6,925) clients received treatment for their own in addition to support for someone else's alcohol or drug use (Table SCR.27).

Between 2023–24 and 2024–25:

- The number of clients fell by 3.1%, from 131,892 in 2023–24 to 127,804 in 2024–25.
- The rate of clients fell from 553 per 100,000 people in 2023–24 to 527 in 2024–25, when considering population growth (Figure 1).

Between 2015–16 and 2024–25:

- Since 2019–20, there has been an 8.2% decline in overall client numbers from 139,295 to 127,804, with rates declining from 623 to 527 per 100,000 people.
- The number of clients receiving AOD treatment for their own use fell by 7% between 2015–16 (125,655) to 2024–25 (117,132).
- Whereas, client numbers for people receiving AOD treatment for someone else's AOD use almost doubled between 2015–16 (5,575) to 2024–25 (10,672).

Decreases in the number of clients receiving AOD treatment may also be due to changes in funding for services, agencies reporting for only part of the financial year, and system issues resulting in problems collecting or extracting AODTS NMDS data. Clients are also receiving more treatment episodes within a year (see [treatment episodes per client](#)).

Figure 1: AODTS clients and treatment episodes, by state and territory, 2013–14 to 2024–25



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Treatment episodes per client

In 2024–25:

- There were fewer clients overall, but on average, clients received more than one treatment episode within a year. This has been steadily rising, indicating that although fewer people are accessing services, those who do are receiving multiple episodes of care, especially in Victoria, Queensland and the Northern Territory.
 - Between 2020–21 and 2024–25, nationally, the number of people receiving 1 treatment episode has been dropping while the number of people receiving more episodes has been rising (Figure 2).

Figure 2: Clients who received one or more treatment episodes by state and territory, 2020–21 to 2024–25



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Characteristics of clients

Client profile

In 2024–25:

- Most people (92%, 117,132) received treatment for their own alcohol or drug use.
 - These clients were more likely to be male (63%, 73,670).
- Of the 9.3% (10,672) of people who received treatment for someone else's alcohol or drug use, 48% (5,129) were male.
- the rates of clients using an AOD service use were highest in *Very remote* areas (1,343 people per 100,000) and lowest in *Major cities* (441 per 100,000; Table SCR.29).
- 77% (98,314) of people received treatment at a single agency:
 - 15% (19,693) attended 2 agencies, and 7.7% (9,797) clients received treatment at 3 or more agencies (Table SCR.23).

See [key terminology](#) for further information on how clients are counted in this report.

Age and sex

In 2024–25:

- 62% (78,799) of all people were male
- 51% (65,065) of all people were aged 30–49
- Less than one percent (0.5%, 643) of all people reported a sex of 'Another term'.

Clients who received treatment for their own alcohol or drug use tended to be younger than those who received treatment for someone else's alcohol or drug use.

- Of the people who received treatment for their own alcohol or drug use (117,132):
 - 57% (66,612) of people were aged under 40
 - 7.7% (9,009) of people were 10–19 years of age
 - 20% (23,119) of people were aged 50 and over.
- Of the people who received treatment for someone else's alcohol or drug use (10,672):
 - 53% (5,645) of people were aged under 40
 - 25% (2,660) of people were aged 50 and over (Figure 3, tables SC.2-4).

Figure 3: Proportion of clients by client type, sex, and age group, 2013–14 to 2024–25



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New and returning clients

In 2024–25:

- For clients who received treatment for the first time, 40% (51,512) were new clients (Table SCR.28).
 - 59% (30,403) were male.
 - 59% (30,370) were aged under 40, with 14% (6,989) aged 10–19.
 - Most (90%, 46,418) clients received treatment for their own alcohol or drug use and these clients received an average of 1.4 treatment episodes.
- For clients who had previously received AOD treatment, 60% (76,292) were returning clients:
 - 63% (48,396) were male.
 - 56% (42,864) were aged 30–49.
 - Most (93%, 70,714) received treatment for their own alcohol or drug use and these clients received an average of 1.9 treatment episodes (Figure 4, Table SCR.28).

Figure 4: New and returning clients by sex, client type and age group, 2022-23 to 2024-25



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Principal drug of concern

In 2024-25, among clients who received treatment for their own alcohol or drug use:

- 2 in 3 of all alcohol treatment episodes (65%, 56,347) were provided to returning clients, compared with 35% (30,160) new clients.
- Over half 54% (16,024) of all cannabis treatment episodes were provided to returning clients compared with new clients (46%, 13,510).
- Most (76%, 38,178) of all methamphetamine treatment episodes were for returning clients, compared with new clients (24%, 12,020).
- Most (84%, 7,647) of all heroin treatment episodes were for returning clients, compared with new clients (16%, 1,492) (Figure 5, Table SCR.28a).

Figure 5: Treatment episodes by principal drug of concern and new client indicator, 2021–22 to 2024–25



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Further information on client pathways through specialist AOD treatment services

- [Patterns of intensive alcohol and other drug treatment service use in Australia, 1 July 2014 to 30 June 2019](#)
- [Patterns of alcohol and other drug treatment service use in Australia, 1 July 2014 to 30 June 2018](#)

Clients and drugs of concern

AOD treatment services provide treatment for the drug that is of most concern to the client, which is referred to as their principal drug of concern.

The most common principal drugs of concern that clients were treated for in 2024–25 were different across age groups:

- Younger people were more likely to receive treatment for cannabis, with over half (53%) of episodes for those aged 10–19 and a quarter of episodes (24%) for those aged 20–29 related to cannabis use.
- 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 related to alcohol (Figure 6, Table SC.10).

Figure 6: Clients who received treatment for their own drug use, by age group and principal drug of concern, 2013–14 to 2024–25



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The age and sex profiles of clients varied by principal drug of concern. For people who received treatment for their own alcohol or drug use in 2024–25 (117,132):

- Where heroin (5,365) was the principal drug of concern, the majority (85%) of people were aged 30 and over (31% were aged 30–39, 34% were aged 40–49 and 20% aged 50 and over) (Table SC.10).
- Where cocaine (1,886) was the principal drug of concern, males were nearly 6 times (84%) more likely to receive treatment than females (13%).
- Where GHB (1,242) was the principal drug of concern, half (50%) of clients were female (noting 9.3% of client sex was reported as not stated) (Table SC.9).

Usual accommodation type for clients

In 2024–25, treatment episodes reporting the usual accommodation type for clients receiving AOD treatment from selected states and territories revealed (144,086):

- The most common accommodation prior to the start of treatment was independent residential accommodation (for example, private residence, boarding house, private hotel, or informal housing) which ranged from 50% in the Northern Territory to 90% in Western Australia.
- The Northern Territory reported the highest proportion of episodes with usual accommodation types as custodial (prison/remand centre/youth training centre) (20%) and supported independent living (21%).
- South Australia reported the highest proportion of episodes with usual accommodation types as none/homeless/public place (10%) (Figure 7, Table OV.13).



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Clients by socioeconomic area

Socio-economic areas

Socioeconomic indexes have been developed to help understand differences between relative socioeconomic disadvantage (ABS, 2023). The analysis in this report uses population data to group people by socioeconomic disadvantage. There are 5 groups (quintiles) which each contain 20% of the population, based on the socioeconomic ranking of the area they live in. This means that the people living in the 20% of areas with:

- the greatest level of socioeconomic disadvantage are described as living in the *lowest socioeconomic* areas.
- the least level of socioeconomic disadvantage are described as living in the *highest socioeconomic* areas.

In 2024–25, people living in the most socioeconomically disadvantaged areas were the most likely to access publicly funded AOD treatment services.

Among clients who received AOD treatment:

- Most were living in the two lowest socioeconomic areas – 53% of males and 52% of females.
- Far fewer were living in the highest socioeconomic area (socioeconomic area 5) – 10% of males and 11% of females.
- Clients aged 20–49 living in the lowest socioeconomic area were about 3 times as likely to access publicly funded AOD treatment services as those living in the highest socioeconomic area (Figure 8, tables SCR.32–33).

For further information on socioeconomic area in the AODTS NMDS see [technical notes – data and methods](#).

Figure 8: Clients by sex, age group and socioeconomic area, 2024-25



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References

ABS 2023. *Socio-Economic Indexes for Areas (SEIFA), Australia*. Canberra: ABS, accessed 30 March 2026.

Australian Government Department of Health and Aged Care 2019. [National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-29](#), Department of Health and Aged Care, Australian Government, accessed 6 March 2024.

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Aboriginal and Torres Strait Islander (First Nations) people

In this section

- Overview
- Client profile
- Profile of new and returning clients
- Principal drug of concern
- Main treatment
- Australian Government-funded Aboriginal and Torres Strait Islander (First Nations) people AOD reporting

In 2024–25, Aboriginal and Torres Strait Islander (First Nations) people accounted for 19% (24,629) of people aged 10 and over who received treatment or support for their own or someone else's alcohol or drug use (45,158 treatment episodes) (Table SCR.26). There has been a 1.6% increase in First Nations people receiving AOD treatment services compared with the previous year.

Nationally, the rate of First Nations people who received treatment remains high:

- In 2024–25, 3,064 per 100,000 people received treatment for alcohol or drug use (crude rate).
- Crude rates have risen for First Nations people from 2,800 per 100,000 people in 2016–17 to 3,064 in 2024–25.
- In 2024–25, First Nations people were 7 times as likely as non-Indigenous Australians to receive treatment (3,125 per 100,000 people compared with 457 per 100,000, age standardised rates) (Figure 1, Table SCR.26).

Figure 1: Estimated number and rate of clients, by Indigenous status, 2016–17 to 2024–25



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Client profile

In 2024–25:

- 1 in 5 people who received treatment for their own alcohol or drug use were First Nations people (20%).
- 1 in 10 people who received treatment for someone else's alcohol or drug use were First Nations people (12%).
- 3 in 5 (60%) First Nations clients were male and 2 in 5 (39%) were female.
- 3 in 4 (78%) First Nations clients were aged 20 to 49 years.
- Indigenous status was not reported for 3.5% (4,504) of clients (Figure 2, tables SC.5–SC.8).

Figure 2: Proportion of First Nations clients by Indigenous status, sex and age group (10 years and over), 2024–25



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Profile of new and returning First Nations clients

In 2024–25:

- 35% (8,535) of First Nations clients received treatment for the first time (new clients), (had not previously received treatment since 2013–14).
- 65% (16,094) of First Nations clients had previously received AOD treatment from a service at some point since 2013–14 (returning clients), when client reporting was enabled (Table SCR.28).

Principal drug of concern

The most common drugs of concern that First Nations people received treatment for were:

- Alcohol (32% of clients), methamphetamine (27%), cannabis (20%), and heroin (5.3%).
- 3 in 5 (58%, 111) clients who received treatment for volatile solvents were First Nations people (Figure 3, Table SC.11).

National trends in principal drugs of concern have changed over time. The crude rate of First Nations people who received treatment for:

- Alcohol rose from 1,026 per 100,000 people in 2016–17 to 1,043 in 2024–25 (after peaking in 2022–23 at 1,176).
- Methamphetamine rose from 806 per 100,000 people in 2019–20 to 902 in 2024–25 (Table SCR.26). Note that in 2019–20 improvements in data reliability for methamphetamine as a principal drug of concern led to greater consistency in reporting.

In 2024–25, after adjusting for differences in age-structure, First Nations people were:

- Ten times as likely to receive treatment for heroin (age standardised rate ratio) as non-Indigenous Australians (202 per 100,000 compared with 21 per 100,000).
- Six times as likely to receive treatment for alcohol as non-Indigenous Australians (1,132 per 100,000 compared with 196 per 100,000).
- Nine times as likely to receive treatment for methamphetamine as non-Indigenous Australians (931 per 100,000 compared with 109 per 100,000).
- Eight times as likely to receive treatment for cannabis as non-Indigenous Australians (583 per 100,000 compared with 72 per 100,000) (Figure 3, Table SCR.26).

Figure 3: Proportion and rate of First Nations AODTS clients, by Indigenous status and principal drug of concern, 2016–17 to 2024–25



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Main treatment

In 2024–25:

- For First Nations people who received treatment for their own alcohol or drug use (23,352):
 - Counselling was the most common main treatment type (36% of clients), followed by assessment only (26%).
- For First Nations people who received treatment for another person's alcohol or drug use (1,277):
 - Support and case management (42%) was the most common, followed by counselling (32%, Table SC.20).

Clients can receive one or more treatment episodes within the reference year.

Referral into treatment and the setting for treatment varied by treatment type for First Nations clients:

- 34% of referrals into treatment were from a family member or a self-referral, followed by health services (27%) and correctional services (17%).
- Clients who received withdrawal management (56%) or pharmacotherapy (50%) for their own alcohol or drug use, were most likely to be referred by a family member or a self-referral.
- Clients who received information and education were most likely referred by a health service (46%).
- In non-residential settings, the most common treatments were counselling (86%) and pharmacotherapy (96%).
- In residential treatment settings, the most common treatments were rehabilitation (64%) and withdrawal management (74%) (Figure 4 and 5, tables SC.21 and SC.22).

Figure 4: Proportion of First Nations AODTS clients, by Indigenous status, main treatment type and referral source for all clients, 2024-25



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Figure 5: Proportion of First Nations AODTS clients, by Indigenous status, main treatment type and delivery setting for all clients, 2024-25



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Australian Government-funded First Nations AOD reporting

The Australian Government funds primary health care services and substance use services specifically for First Nations people. These services may be in scope for the AODTS NMDS, but the majority of the services currently do not report to the NMDS. As a result, the number of First Nations clients and treatment episodes will be under-estimated. Refer to the [technical notes](#) for further details on data collection and funding of First Nations AOD services.

Drugs of concern

Insights

In 2024-25:

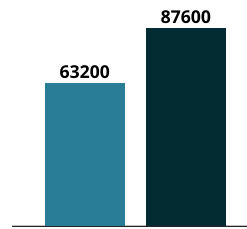


The most common principal drug of concern was alcohol (41%, 87,600 episodes), followed by methamphetamine (24%), cannabis (14%) and heroin (4.3%).

Between 2015-16 and 2024-25:

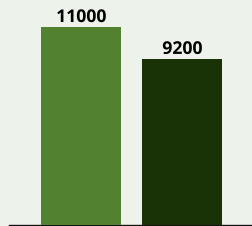


The top 4 drugs of concern have remained consistent since 2015-16 when amphetamines, including methamphetamine, replaced cannabis as the second most common principal drug of concern.



● 2015-16 ● 2024-25

Alcohol has remained the most common principal drug of concern, increasing from 63,200 (32%) to 87,600 (41%) episodes over this period.



● 2015-16 ● 2024-25

AOD treatment episodes for **heroin** as a principal drug of concern fell from 5.5% to 4.3% over this period (11,000 to 9,200).

Trends in drugs of concern

In this section

- Overview
- Treatment episodes and drugs of concern

People enter alcohol and other drug (AOD) treatment to identify and assess harmful use of one or more substances. The principal drug of concern (PDOC) is the main substance that led the person to seek support. AOD services can facilitate referral into intensive interventions if required, also providing coordinated care and case management services, with an aim to match the person's needs and the interventions being offered.

Reporting Drugs of Concern in the AODTS NMDS

This section presents information on treatment episodes provided to clients for their own AOD use only. The principal drug of concern (PDOC) is the main substance that the client stated led them to receive treatment. It is assumed that only the person using a substance themselves can accurately report their principal drug of concern. Clients can also nominate up to 5 additional drugs of concern, though these are not necessarily the subject of any treatment within the episode.

These data are not collected for people who received treatment for someone else's drug use.

This section focuses on treatment episodes provided for alcohol, methamphetamine, cannabis and heroin as the PDOC. These 4 drugs were consistently the most common principal drugs of concern across Australia in the 10-year period up to 2024–25. For detailed information on each drug of concern, refer to the [technical notes](#).

Treatment episodes and drugs of concern

In 2024–25, 214,662 (88%) treatment episodes were provided to 117,132 clients for their own AOD use (Table OV.1).

Of these episodes:

- The most common principal drugs of concern were alcohol (41% of episodes), followed by methamphetamine (24%), cannabis (14%) and heroin (4.3%) (Table Drg.1).
- 30% of treatment episodes reported at least 1 additional drug of concern. The most common additional drugs of concern were cannabis (12%), followed by nicotine (10%) and alcohol (7.1%) (tables Drg.1, Drg.2, Drg.3).
- The number of additional drugs reported was most commonly one drug (19%) or 2 drugs (7.2%).
- For the 4 most common principal drugs of concern, the most common treatment setting was non-residential treatment settings ranging from:
 - 75% of episodes for heroin.
 - 69% of episodes for alcohol.
 - 67% of episodes for cannabis.
 - 65% of episodes for methamphetamine (Table Drg.8).

Between 2015–16 to 2024–25, of the clients who received treatment for their own AOD use:

- Client numbers decreased by 9.1%, from a peak in 2019–20 (128,860) to 117,132 in 2024–25.
- The number of treatment episodes also decreased by 4.2%, from a peak in 2020–21 (224,135) to 214,662 in 2024–25 (Table OV.1).
 - The drop in the number of clients receiving AOD treatment may also be due to changes in funding for services, agencies reporting for only part of the financial year, and system issues resulting in problems collecting or extracting AODTS NMDS data.
 - There were fewer clients receiving treatment for their own AOD use, but on average clients received more than one treatment episode within a year. Indicating that although fewer people are accessing services, those who do receive treatment are receiving multiple episodes of care (Table SCR.27).

Between 2015–16 to 2024–25, for the 4 most common principal drugs of concern:

- Alcohol remained the most common principal drug of concern each year.
 - Alcohol treatment episodes showed some variation in treatment activity over this period, with the number of episodes falling since 2022–23 (from 92,417 to 87,632).
- Methamphetamine episodes as a principal drug of concern rose from 22% in 2019–20 (47,599) to 24% (50,863) in 2024–25. In 2019–20 improvements in data reliability for methamphetamine treatment episodes led to greater consistency in reporting.
- Treatment episodes for cannabis as the principal drug of concern fell from 23% to 14% (45,043 to 30,287).
- The number of treatment episodes for heroin as the principal drug of concern peaked in 2019–20 (11,133 or 5.1%) falling to 9,204 (4.3%) in 2024–25 (Table Drg.5).

Changes in Principal Drugs of Concern

Changes in certain principal drug treatment episodes in particular years may be due to administrative anomalies in the data. For example, the drop in all treatment episodes in the 2016–17 collection year may be partly related to state and territory policy changes, state system changes resulting in under-reporting or partial reporting of the number of episodes in some jurisdictions (See the [Data quality statement](#) for further details).



Alcohol

Alcohol: client demographics and treatment

In this section

- Introduction
- Client demographics
- Treatment

What is alcohol?

Alcohol is a depressant drug which means it slows down messages travelling between the brain and body. The most common type of alcohol is ethanol, typically consumed in the form of beer, wine, cider or spirits. Alcohol concentration varies considerably with the type of drink (ADF 2025).

Alcohol has remained the most common principal drug of concern (PDOC) since the beginning of reporting for the [Alcohol and Other Drug Treatment Services National Minimum Data Set \(AODTS NMDS\)](#) in 2002-03.

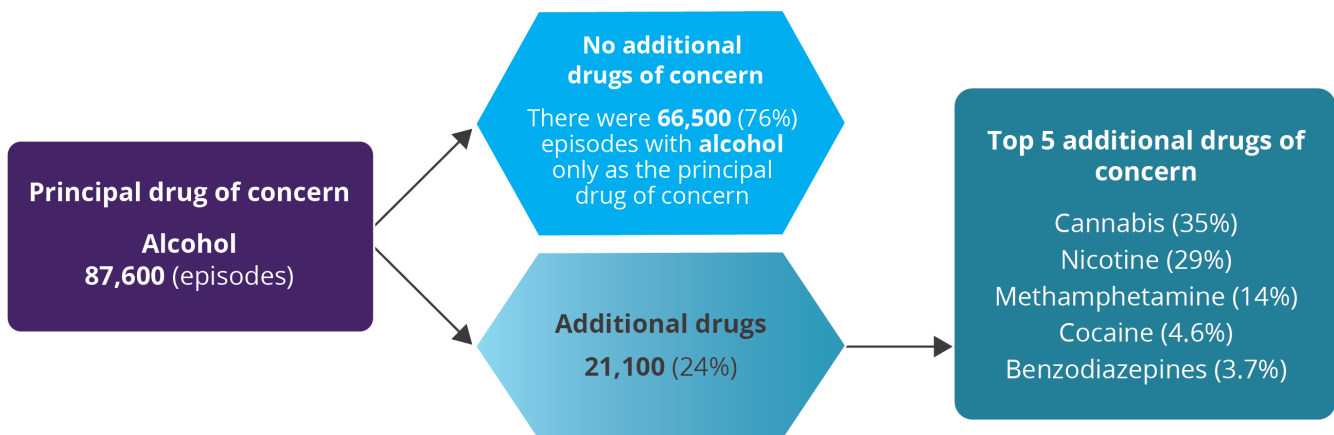
In 2024-25, of the 214,662 treatment episodes provided for a client's own drug use, alcohol was reported as a drug of concern (either principal or additional) in half of all treatment episodes (48% or 102,923) (Table Drg.5).

In 2024-25:

- Alcohol remained the most common principal drug of concern (41%, 87,632 episodes) (Table Drg.5).
- 24% (21,160) of alcohol-related treatment episodes reported at least one additional drug of concern (Table Drg.2). The most common additional drugs of concern were:
 - cannabis (35%, 10,706)
 - nicotine (29%, 8,744) (Table Drg.3).
- The proportion of treatment episodes for alcohol in relation to all other drugs of concern rose from 32% in 2015-16 to 41% in 2024-25 (Table Drg.1).

Clients can nominate up to 5 additional drugs of concern, these drugs may not have been the subject of any treatment in the episode.

Figure ALCOHOL: Closed treatment episodes for own alcohol or drug use by alcohol as a principal drug of concern and top 5 additional drugs of concern, 2024-25



Note: Diagram presents the top 5 additional drugs of concern for a principal drug of concern by closed treatment episodes. Totals do not add to 100%.

For information on alcohol use and harms, see:

- [Tobacco, alcohol and other drugs in Australia: Alcohol](#)
- [National Drug Strategy Household Survey 2022-2023: Alcohol consumption](#)
- [Alcohol treatment in Australia: Client characteristics and patterns of service use, 2013-14 to 2022-23](#)
- [Trends in alcohol availability, use and treatment 2003-04 to 2014-15](#)

Client demographics

In 2024-25, 46,836 clients received treatment for alcohol as a principal drug of concern. Of these clients:

- 3 in 5 were male (62%) (Table SC.9).
- 1 in 2 people were aged either 30-39 (24%) or 40-49 (26%) (Table SC.10).
 - This was consistent for both males and females (Figure 1).
- 1 in 6 (16%) people were Aboriginal and Torres Strait Islander (First Nations) people (Table SC.11).
 - This represents a rate of 1,043 First Nations clients per 100,000 people (crude rate for clients aged 10 and over) (Table SCR.26).

Figure 1: Clients with alcohol as the principal drug of concern, by sex and age group, 2024–25



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Treatment

In 2024–25, 87,632 treatment episodes were provided to clients for alcohol as their principal drug of concern (Table Drg.5).

Of these episodes:

- The most common referrals into treatment were from self or family (41%, 35,701) or health services (38%, 33,357).
 - Between 2015–16 and 2024–25, health service referrals increased from 36% to 38% while referral from the criminal justice system (diversion) fell from 8.3% to 2.6% (Figure 2, Table Drg.13).
- The most common main treatment type was counselling (34%, 29,425), followed by assessment only (22%, 19,428) and withdrawal management (13%, 11,701) (Figure 2, Table Drg.18).
 - Counselling, withdrawal management, and assessment only remained the most common treatment types between 2015–16 and 2024–25, although the proportion of episodes for each treatment type has varied over time.
- 7 in 10 (69%) episodes were provided in a non-residential treatment settings. A further 19% were provided in residential treatment settings and outreach settings (5.1%) (Table Drg.20).
- The median duration of treatment episodes was around 4 weeks (27 days) (Table Drg.21).
 - 1 in 3 (36%) treatment episodes lasted 2–29 days, and 26% lasted 1–3 months (Table OV.12).
- The most common reasons treatment ended were planned completion (62%) and unplanned completion (19%) (Figure 2, Table Drg.19).



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References

ADF (Alcohol and Drug Foundation) (2025) *Alcohol*, ADF, accessed 20 August 2025.

NDARC (National Drug and Alcohol Research Centre) (2017) *A quick guide to drugs & alcohol*, 3rd edn, Drug Info, State Library of NSW.

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Methamphetamine

Methamphetamine: client demographics and treatment

In this section

- Introduction
- Client demographics
- Treatment
- Method of use

What is methamphetamine?

Methamphetamine is a stimulant, that is part of a group of drugs that produce stimulatory effects by increasing nerve transmission in the brain and body (Nielsen and Gisev 2017). Methamphetamine (also referred to as methylamphetamine), is a potent derivative of amphetamine that is commonly found in 3 forms: powder (speed), base and its most potent form, crystalline (ice or crystal) which can cause more serious harms.

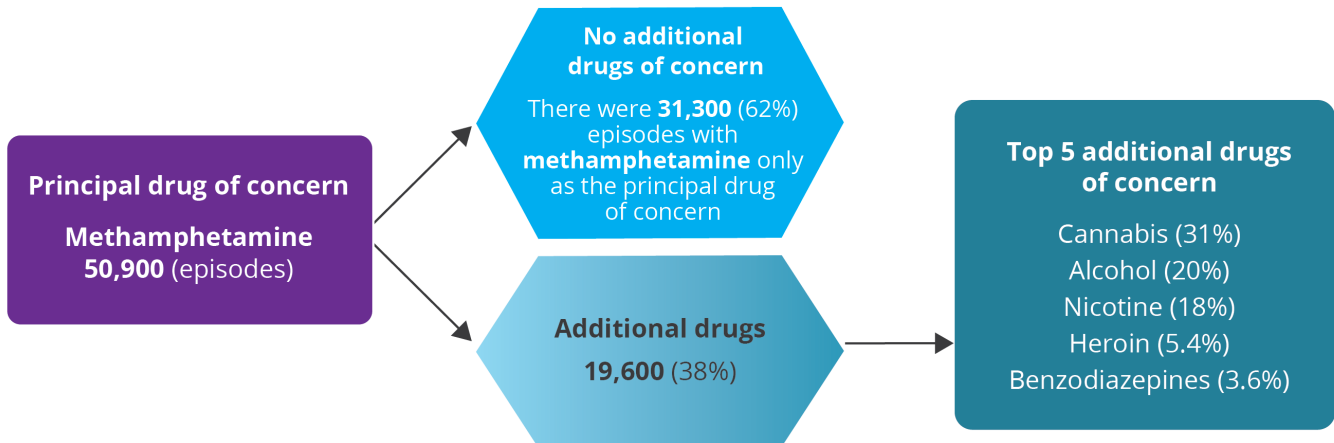
In 2024–25, of the 214,662 treatment episodes provided for a client's own drug use, methamphetamine was reported as a drug of concern (either principal or additional) in 3 in 10 treatment episodes (29%, 62,549) (Table Drg.5).

In 2024–25:

- Methamphetamine was the second most common principal drug of concern (24%, 50,863 episodes) (Table Drg.4).
 - This has been the case since 2022–23, when methamphetamine surpassed cannabis as the second most common principal drug of concern (Table Drg.5).
- Methamphetamine treatment episode increases since 2019–20 (from 47,599 to 50,863 in 2024–25), are due to improvements in methamphetamine data reliability and greater consistency in reporting (Figure 3).
- 4 in 10 (38%, 19,551) methamphetamine treatment episodes reported at least one additional drug of concern (Table Drg.2). For methamphetamine, the most common additional drugs of concern were:
 - Cannabis (31%, 10,443)
 - Alcohol (20%, 6,711)
 - Nicotine (18%, 5,953) (Table Drg.3).

Clients can nominate up to 5 additional drugs of concern: these drugs may not have been the subject of any treatment in the episode.

Figure METHAMPHETAMINE: Closed treatment episodes for own alcohol or drug use by amphetamines as a principal drug of concern and top 5 additional drugs of concern, 2024–25



Note: Diagram presents the top 5 additional drugs of concern for a principal drug of concern by closed treatment episodes. Totals do not add to 100%.

For information on methamphetamine use and harms, see:

- [Tobacco, alcohol and other drugs in Australia: Meth/amphetamine and other stimulants](#)
- [National Drug Strategy Household Survey 2022–2023: Methamphetamine and amphetamine in the NDSHS](#)
- [Trends in methylamphetamine availability, use and treatment, 2003–04 to 2013–14](#)

Client demographics

In 2024–25, 26,831 clients received treatment for methamphetamine as the principal drug of concern.

Of these clients:

- 3 in 5 were male (63%) (Table SC.9).

- 2 in 3 people were aged either 30–39 years (38%) or 40–49 years (27%) (Table SC.10).
 - This was consistent for both males and females (Figure 2).
- 1 in 5 people were Aboriginal and Torres Strait Islander (First Nations) people (23%) (Table SC.11).
 - This represents a rate of 902 First Nations clients per 100,000 people (crude rate for clients aged 10 and over) (Table SCR.26).

Figure 1: Clients with methamphetamine as the principal drug of concern, by sex and age group, 2024–25



Problem creating image.

Treatment

In 2024–25, 50,863 treatment episodes were provided to clients for methamphetamine as the principal drug of concern (Table Drg.4).

Among these episodes:

- The most common referrals into treatment were from self or family (36%, 18,271), and health services (28%, 14,235) (Table Drg.37) (Figure 2, Table Drg.13).
- The most common main treatment types were counselling (35%, 17,911) and assessment only (23%, 11,654) (Figure 2, Table Drg.36).
 - This is consistent with previous years, although the proportion of counselling episodes has fluctuated in the 10 years to 2024–25.
- The most common treatment settings were non-residential treatment settings (65%) and residential treatment settings (17%) (Table Drg.38).
- The median duration of methamphetamine treatment episodes was around four weeks (29 days) (Table Drg.39).
 - Episode duration varied by main treatment type, with the longest median duration being around 9 weeks (64 days) for counselling (Table Drg.41).
 - 1 in 3 (30%) treatment episodes lasted 2–29 days, and a further 1 in 4 (27%) lasted 1 to 3 months (Table OV.12).
- The most common reasons methamphetamine-related AOD treatment ended were planned completion (51%) and unplanned completion (25%) (Figure 3, Table Drg.38).

Figure 2: Treatment episodes with amphetamine-related drugs as the principal drug of concern, by main treatment type, reason for cessation or source of referral, 2015–16 to 2024–25



Problem creating image.

Method of use

In 2024–25, among methamphetamine treatment episodes (50,863), the most common methods of use were:

- Smoking/inhaling (51%)
- Injecting (32%) (Figure 4, Table Drg.6).

Between 2019–20 and 2024–25, as data reliability improved:

- Among methamphetamine treatment episodes, where the method of use was smoking/inhaling rose from 24,809 in 2019–20 to 27,324 in 2024–25.
- Among amphetamine-related episodes, where the method of use was smoking/inhaling dropped in 2019–20 (4,699 episodes) to 2,194 in 2024–25 (Figure 4, Table Drg.6).
- Among methamphetamine episodes, with injecting as a method of use peaked in 2019–20 (18,497), fluctuating until 2024–25 (16,298).
- Among amphetamine-related episodes with injecting as a method of use fell in 2019–20 (6,357 episodes) to 3,838 episodes in 2024–25 (Figure 4, Table Drg.6).

Method of use for methamphetamine from 2015–16 to 2019–20

From 2015–16 to 2019–20, the *method of use* (injecting or smoking) for the principal drug of concern was used to identify methamphetamine-related treatment episodes, this was due to data quality issues and limited coding options within some states and territories impacting reporting over this period. Increases in treatment episodes for smoking or injecting amphetamines overtime are associated with increases in harms associated with purity and availability in the form of crystalline methamphetamines (McKetin et al. 2021). For more background information on method of use for methamphetamine as a principal drug of concern, refer to the [technical notes](#).



Problem creating image.

References

Nielsen S and Gisev N (2017) 'Drug pharmacology and pharmacotherapy treatments', in Ritter, King and Lee (eds) *Drug use in Australian society*, 2nd edn, Oxford University Press, South Melbourne.

McKetin R, Chrzanowska A, Man N, Peacock A, Sutherland R & Degenhardt L. 2021. Trends in treatment episodes for methamphetamine smoking and injecting in Australia, 2003-2019. *Drug and Alcohol Review*.

Cannabis

Cannabis: client demographics and treatment

In this section

- Client demographics
- Treatment
- Clients referred via diversion programs

What is cannabis?

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). 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 use of cannabis for medicinal purposes was legislated by the Australian parliament in 2016.

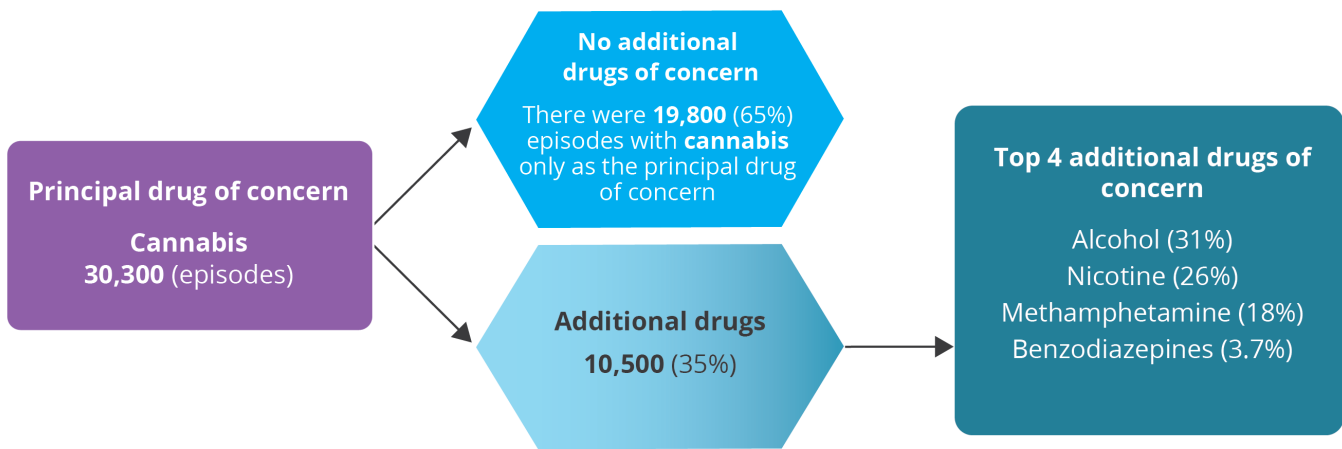
In 2024–25, of the 214,662 treatment episodes provided for a client's own drug use, cannabis was reported as a drug of concern (either principal or additional) in 1 in 4 treatment episodes (26%, 56,503) (Table Drg.5).

In 2024–25:

- Cannabis was the third most common principal drug of concern (14%, 30,287 episodes) (Drg.4).
- 1 in 3 (35%, 10,519) cannabis-related treatment episodes reported at least 1 additional drug of concern (Table Drg.2). The most common additional drugs of concern were:
 - Alcohol (31%, 4,823 episodes)
 - Nicotine (26%, 4,010)
 - Methamphetamine (18%, 2,798) (Table Drg.3).

Clients can nominate up to 5 additional drugs of concern, these drugs may not have been the subject of any treatment within the episode.

Figure CANNABIS: Closed treatment episodes for own alcohol or drug use by cannabis as a principal drug of concern and top 5 additional drugs of concern, 2024–25



Note: Diagram presents the top 5 additional drugs of concern for a principal drug of concern by closed treatment episodes. Totals do not add to 100%.

For information on cannabis use and harms, please see:

- [Tobacco, alcohol and other drugs in Australia: Cannabis](#)
- [National Drug Strategy Household Survey 2022–2023: Cannabis in the NDSHS](#)
- [Trends in cannabis availability, use, and treatment in Australia, 2013–14 to 2021–22](#)

Client demographics

In 2024–25, 17,863 clients received treatment for cannabis as the principal drug of concern.

Of these clients:

- 3 in 5 were male (59%) (Table SC.9).
- 3 in 5 people were aged either 10–19 (27%) or 20–29 years (34%) (Table SC.10).
 - This was consistent for both males and females (Figure 1).
- 1 in 4 people were Aboriginal and Torres Strait Islander (First Nations) people (26%) (Table SC.11).
 - This represents a rate of 657 First Nations clients per 100,000 people (crude rate for clients aged 10 and over) (Table SCR.26).

Figure 1: Clients with cannabis as the principal drug of concern, by sex and age group, 2024–25



Problem creating image.

Treatment

In 2024–25, 30,287 treatment episodes were provided to clients for cannabis as the principal drug of concern (Table Drg.4).

Of these episodes:

- The most common referrals were from self or family (31%) followed by health services (31%) and diversion referrals from the criminal justice system (12%) (Figure 2, Table Drg.13).
- The most common main treatment types were counselling (39%) and assessment only(18%) (Figure 2, Table Drg.27).
 - Counselling remained the most common main treatment type between 2015–16 and 2024–25.
- The most common treatment settings were non-residential treatment settings (67%) and outreach settings (13%) (Table Drg.29).
- The median duration of treatment episodes was over 4 weeks (30 days) (Table Drg.30).
- The most common reasons treatment ended were planned completion (63%) and unplanned completion (20%) (Table Drg.29).



Problem creating image.

Clients referred via diversion programs

Diversion treatment programs

Throughout Australia, diversion programs have been developed to divert people who were apprehended or sentenced for minor drug offences away from the criminal justice system into drug treatment. Treatment services range from short-term assessment, information or education sessions to longer-term treatments such as counselling and withdrawal management. For more information, refer to the [Key terminology - diversion client type](#).

Most treatment episodes provided to clients diverted from the criminal justice system are for cannabis, followed by methamphetamine. Clients who are referred via diversion may also receive other treatment episodes with a source of referral other than diversion.

In 2024–25, 1 in 10 clients receiving treatment for their own drug use were referred into treatment via police or court diversion programs (9.7%, 11,401 clients) (Table SC.13).

Of these clients:

- 1 in 4 reported cannabis as the principal drug of concern (24%) (SC.13).
 - 1 in 6 treatment episodes for cannabis as the principal drug of concern were provided to clients who had been referred via diversion programs (12%, 3,586) (Table Drg.13).

Of the clients referred to AOD treatment via diversion episodes, 25% received further treatment through other sources of referral, such as from a health service, self or family (Table OV.14).

Diversion clients by selected principal drug of concern

In 2024–25, treatment referrals via drug diversion programs accounted for a substantial proportion of treatment episodes for clients with a principal drug of concern of cannabis.

Diversion in the AODTS NMDS collection

Clients who are referred into AOD treatment via diversion may receive multiple treatment episodes during a collection period, including treatment:

- for diversion-related episodes only (diversion episodes)
- for episodes with a non-diversion source of referral (such as a health service), in addition to episodes where they were referred via diversion (combinations of diversion and non-diversion treatment episodes).

For more information see:

In 2024–25, of the total 23,379 diversion-related treatment episodes:

- Cannabis (24%) was the most common principal drug of concern for diversion referral episodes into treatment, followed by methamphetamine (22%).
 - Since 2023–24, the proportion of diversion referral episodes into treatment for cannabis fell from 40%.
 - Due to the Cannabis Expiation Notice legislation in South Australia, adult simple cannabis offences are not diverted to treatment and so are not included in the data (see the [Data Quality Statement](#) for further information).
- Methamphetamine (29%) was the most common principal drug of concern for diversion clients who also received non-diversion treatment episodes (Figure 3, Table OV.14).
 - For clients with no diversion-related referrals, alcohol was the principal drug of concern for nearly half (44%) of the episodes.

Figure 3: Client diversion referrals for own drug use by selected principal drug of concern and client diversion episode type, 2024–25



Problem creating image.

References

ACIC (Australian Criminal Intelligence Commission) (2018) *Illicit Drug Data Report 2016–17*, ACIC, Australian Government, accessed 21 September 2018.

Alcohol and Drug Foundation (2017) *Synthetic cannabinoids*, Alcohol and Drug Foundation website, accessed 30 November 2017.

NDARC (National Drug and Alcohol Research Centre) (2017) *A quick guide to drugs & alcohol*, 3rd edn, Drug Info, State Library of NSW.

Heroin

Heroin: client demographics and treatment

In this section

- Client demographics
- Treatment

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).

People who receive treatment for heroin use have several options for treatment, including withdrawal programs (called detoxification) and abstinence-based treatment (for example, residential rehabilitation in a therapeutic community) (O'Brien 2004).

Pharmacotherapy treatment for heroin use

In Australia, one of the most common treatments for heroin use is opioid pharmacotherapy treatment (also known as opioid agonist therapy). Opioid pharmacotherapy involves replacing opioid drugs, including heroin, with a longer-lasting, medically prescribed opioid.

Agencies whose sole function is to prescribe or provide dosing services for opioid pharmacotherapy are excluded from the AODTS NMDS. Data from these agencies are captured in the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection (AIHW 2026). For more information, please see the [2025 NOPSAD report](#).

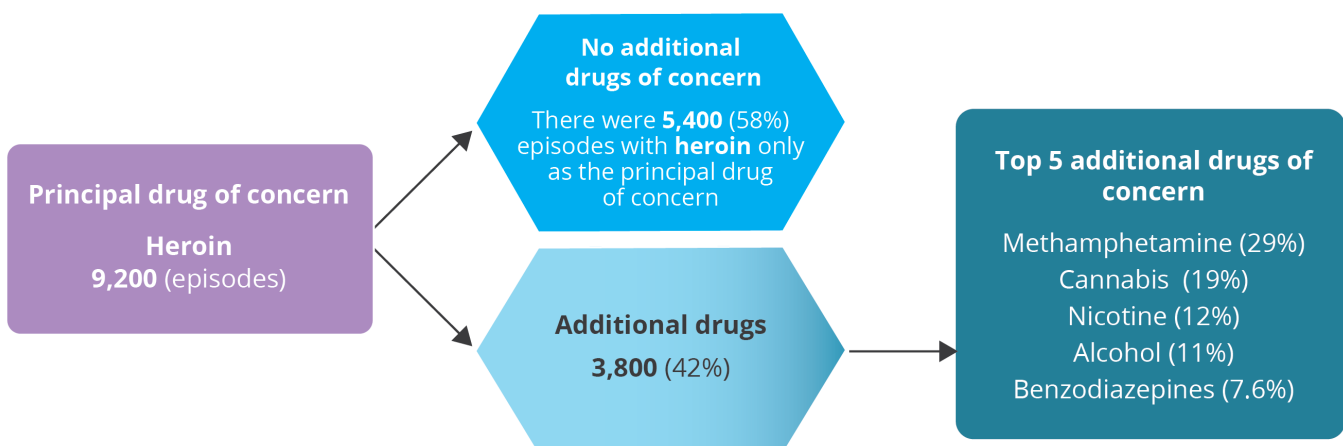
In 2024–25, of the 214,662 treatment episodes provided for a client's own drug use, heroin was reported as a drug of concern (either principal or additional) in 5.8% (12,406) of all treatment episodes (Table Drg.4).

In 2024–25:

- Heroin was the fourth most common principal drug of concern (4.3%, 9,204 episodes) (Table Drg.4).
 - This has remained consistent between 2015–16 and 2024–25, although the proportion of heroin-related episodes has declined from a peak of 5.5% (10,999) in 2015–16 (Table Drg.5).
- 4 in 10 (42%, 3,849) heroin-related treatment episodes reported at least 1 additional drug of concern (Table Drg.2). The most common additional drugs of concern were:
 - Methamphetamine (29%, 1,910)
 - Cannabis (19%, 1,249)
 - Nicotine (12%, 804) (Table Drg.3).

Clients can nominate up to 5 additional drugs of concern, these drugs may not have been the subject of any treatment within the episode.

Figure HEROIN: Closed treatment episodes for own alcohol or drug use by heroin as a principal drug of concern and top 5 additional drugs of concern, 2024–25



Note: Diagram presents the top 5 additional drugs of concern for a principal drug of concern by closed treatment episodes. Totals do not add to 100%.

For information on heroin use and harms, please see:

- [Tobacco, alcohol and other drugs in Australia: Illicit opioids, including heroin](#)
- [National Drug Strategy Household Survey 2022–2023: Low prevalence illicit drugs in the NDSHS](#)

Client demographics

In 2024–25, 5,365 clients received treatment for heroin as the principal drug of concern. Of these clients:

- 7 in 10 were male (71%) (Table SC.9).
- 2 in 3 people were aged either 30–39 (31%) or 40–49 (34%) (Table SC.10).
 - This was consistent for both males and females (Figure 1).
- 1 in 4 people were Aboriginal and Torres Strait Islander (First Nations) people (23%) (Table SC.11).
 - This represents a rate of 181 First Nations clients per 100,000 people (crude rate for clients 10 and over) (Table SCR.26).

Figure 1: Clients with heroin as the principal drug of concern, by sex and age group, 2024–25



Problem creating image.

Treatment

In 2024–25, 9,204 treatment episodes were provided to clients for heroin as the principal drug of concern (Table Drg.4).

Of these episodes:

- The most common referrals were from self or family (41%) and health services (29%) (Figure 2, Table Drg.55).
- The most common main treatment types were pharmacotherapy (22%) followed by assessment only (21%) and counselling (18%) (Figure 2, Table Drg.54).
- The most common treatment settings were non-residential treatment facilities (75%) and residential treatment settings (14%) (Table Drg.56).
- The median duration of treatment episodes was 4 weeks (28 days) (Table Drg.58).
- The most common reasons treatment ended were planned completion (57%) and unplanned completion (20%) (Figure 3, Table Drg.56).

Between 2015–16 and 2024–25, main treatment types for heroin have fluctuated:

- Treatment episodes for withdrawal management decreased from 14% to 8.1% (or from 1,505 to 745).
- Episodes for pharmacotherapy decreased from 23% in 2015–16 to 12% in 2018–19 (from 2,478 to 1,261) and increased to 22% in 2024–25 (2,064).
 - Fluctuations in pharmacotherapy treatment episodes over time can be attributed to changes to jurisdictional coding practices and systems, resulting in under-reporting of pharmacotherapy at the national level (Table Drg.54).



Problem creating image.

In 2024–25, among the 9,204 treatment episodes for heroin-related treatment episodes:

- Injecting remained the most common method of use (70%) (Table Drg.6) and injecting drug use was reported:
 - Within the past 3 months (47%).
 - Within 3–12 months (9.8%).
 - More than 12 months prior (11%)
 - Never (20%) (Table Drg.52).

Between 2015–16 and 2024–25, the proportion of treatment episodes where clients receiving treatment for heroin as a principal drug of concern reported that they had never injected drugs increased 3-fold, rising from 6.5% (717) to 20% (1,818) (Table Drg.52).

References

-
- ACIC (Australian Criminal Intelligence Commission) (2019) *Illicit Drug Data Report 2017–18*, ACIC, Australian Government, accessed 7 August 2019.
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- Department of Health, Disability and Ageing (2024) *Drug laws in Australia*, Department of Health, Disability and Ageing, Australian Government, accessed 30 September 2025.
- NDARC (National Drug and Alcohol Research Centre) (2025) *Heroin fact sheet*, NDARC, accessed 1 October 2025.
- O'Brien S 2004. Treatment options for heroin and other opioid dependence: a guide for families and carers. Canberra: Department of Health and Ageing.
-

Pharmaceuticals

Pharmaceuticals: client demographics and treatment

In this section

- Pharmaceuticals by drug type
- Client demographics
- Treatment

What are 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.

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 healthcare 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.

In this section of the report, the 'pharmaceuticals' drug classification includes the following 10 drug types: codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics.

In 2024–25:

- Of the 214,662 treatment episodes provided for a client's own drug use, pharmaceuticals were reported as a drug of concern (either principal or additional) in 12% (26,444) of all treatment episodes (Table Drg.87).
- Pharmaceuticals were the principal drug of concern (PDOC) in 6.1% of treatment episodes (13,128) (Table Drg.87).

Between 2015–16 and 2024–25, pharmaceuticals transitioned from being reported as an additional drug of concern to being reported as a principal drug of concern:

- The proportion of episodes with pharmaceuticals as a principal drug of concern increased from 5.2% in 2015–16 to 6.1% in 2024–25.
- The proportion of episodes with pharmaceuticals as an additional drug of concern decreased from 9.1% in 2015–16 to 6.2% in 2024–25 (Table Drg.87).
- The most common additional drugs of concern reported with pharmaceutical treatment episodes were:
 - Methamphetamine (25%, 2,165)
 - Cannabis (17%, 1,492)
 - Nicotine (14%, 1,198) (Table Drg.88).

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

For information on pharmaceutical drug use and harms, see:

- [Tobacco, alcohol and other drugs in Australia: Pharmaceuticals](#)
- [Non-medical use of pharmaceuticals: trends, harms and treatment 2006–07 to 2015–16](#)

National Drug Strategy Household Survey 2022–2023:

- [Non-medical use of pain-relievers and opioids in the NDSHS](#)
- [Non-medical use of pharmaceutical stimulants in the NDSHS](#)
- [NDSHS data tables 6. Non-medical pharmaceuticals](#)

Pharmaceuticals by drug type

In 2024–25, 57% (7,455) of pharmaceutical drug-related treatment episodes were for opioids or benzodiazepines as the principal drug of concern (Table Drg.87). 'Opioids' includes codeine, morphine, buprenorphine, oxycodone, methadone, and other opioids.

In 2024–25:

- Opioids were a principal drug of concern in 2.4% (5,222 of all treatment episodes and an additional drug of concern in 1.1% (2,392).
- The most common principal drug types recorded in opioid-related treatment episodes were buprenorphine (2,164) followed by oxycodone (795) and methadone (702).
- Benzodiazepine was a principal drug of concern in 1.0% (2,233) of treatment episodes and listed as an additional drug of concern in 2.1% (4,428).

Between 2015–16 and 2024–25:

- The number of treatment episodes for opioids fell from 7,486 in 2015–16 to 4,722 in 2021–22 and rose to 5,222 in 2024–25.
- The number of treatment episodes for benzodiazepines as a principal drug of concern rose from 1,727 in 2015–16 to its highest level in 2022–23 (3,354), falling to 2,233 in 2024–25 (Figure 1, Table Drg.87).



Problem creating image.

Client demographics

In 2024–25, 7,220 clients received treatment for any pharmaceutical drug as the principal drug of concern (Table SC.30).

Of these clients:

- 3 in 5 were male (62%).
 - The proportion of male clients receiving treatment for a pharmaceutical principal drug of concern ranged from 42% for other sedatives and hypnotics to 82% for buprenorphine (Table SC.30).
- 1 in 2 clients were aged either 20–29 (25%) or 30–39 (32%). The proportion of clients in each age group varied by PDOC:
 - Clients receiving treatment for benzodiazepines had the highest proportion of people aged 10–19 (9.8%).
 - Most clients receiving treatment for opioids were aged either 30–39 or 40–49, ranging from 51% for oxycodone to 64% for buprenorphine (Table SC.31).
- 1 in 5 people were Aboriginal and Torres Strait Islander (First Nations) people (17% of clients).
 - The proportion of First Nations clients was highest for buprenorphine (29% of clients) (Table SC.32).

Treatment

In 2024–25, around 13,128 treatment episodes were provided to clients for pharmaceuticals as the principal drug of concern (Table Drg.87).

For these episodes:

- The most common sources of referral into treatment were health services (40% of episodes) and self or family (36%).
 - This was relatively consistent across drug types, but diversion was the most common referral into treatment for steroid-related treatment episodes (39%) (Table Drg.90).
- The most common main treatment types were assessment only (32% of episodes) and counselling (18%) (Figure 2, Table Drg.89).
- Most took place in non-residential treatment settings (71%) which was the most common treatment setting across pharmaceutical drug types (Figure 2, Table Drg.92).
- 3 in 5 ended with a planned completion (56%), ranging from codeine (542%) to other analgesics (67%).
- 1 in 6 ended unplanned (18%) (Figure 2, Table Drg.91).

Figure 2: Treatment episodes with selected pharmaceutical drugs as the principal drug of concern, by main treatment type, treatment delivery setting or reason for cessation, 2024–25



Problem creating image.

References

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Larance B, Degenhardt L, Lintzeris N, Winstock A and Mattick R (2011) '[Definitions related to the use of pharmaceutical opioids: extramedical use, diversion, non-adherence and aberrant medication-related behaviours](#)', *Drug and Alcohol Review*, 30(3):236–245, doi:10.1111/j.1465-3362.2010.00283.x.

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Selected other drugs

Selected other drugs: client demographics and treatment

In this section

- Nicotine
- Ecstasy
- Cocaine
- GHB (Gamma-Hydroxybutyrate)

Reporting Nicotine, Ecstasy, Cocaine and Gamma-Hydroxybutyrate (GHB) in the AODTS NMDS

In addition to the most common principal drugs of concern, the [Alcohol and Other Drug Treatment Services National Minimum Data Set \(AODTS NMDS\)](#) report includes information on selected other drug types: nicotine, ecstasy, cocaine and GHB (Gamma-Hydroxybutyrate). These drugs may be commonly used in the community or linked to increased risk of harm. Treatment captured through the AODTS NMDS for these drugs may be less prominent than for other drugs as they are relatively uncommon, or people who use them are less likely to receive treatment than people who use other drugs.

Nicotine, ecstasy, cocaine and GHB have contributed around 1–2% of all treatment episodes each year since 2015–16 (tables Drg.1, Drg.5). Individually, the proportion of treatment episodes for each of these drugs has remained at less than 2% per year between 2015–16 and 2024–25 (Table SD.9).

Nicotine, ecstasy and cocaine are more likely to be reported as an additional drug of concern rather than principal drug of concern. For example, nicotine was reported as a principal drug of concern in only 1.0% of treatment episodes in 2024–25 but was an additional drug of concern in 10% of episodes (Table Drg.5).

For information on selected other drug use and harms, see:

- [Tobacco, alcohol and other drugs in Australia: Tobacco](#)
- [Tobacco, alcohol and other drugs in Australia: Meth/amphetamine and other stimulants](#)

National Drug Strategy Household Survey 2022–2023:

- [Tobacco and e-cigarettes/vapes](#)
- [Ecstasy in the NDSHS](#)
- [Cocaine in the NDSHS](#)

Nicotine

In 2024–25, nicotine was reported as a drug of concern (either principal or additional) in 11% (23,845) of all treatment episodes (Table Drg.5).

In 2024–25:

- Nicotine was the principal drug of concern in just 1.0% of treatment episodes (2,095) (tables Drg.1, Drg.5). This proportion has remained relatively stable since 2016–17 (1.3%, 2,584) (Table Drg.5).
- Nicotine was an additional drug of concern in 1 in 10 treatment episodes (10%, 21,750) (Table Drg.4).
- Most treatment episodes with nicotine as an additional drug of concern were for alcohol (40%) followed by methamphetamine (27%) and cannabis (18%) (Table Drg.3).

Nicotine Treatment provided in AOD 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.

Reporting Nicotine in the AODTS NMDS

The low proportion of episodes for nicotine as the principal drug of concern in the AODTS NMDS collection may be due to the existence of numerous alternative support options within the community (for example, general practitioners, pharmacies, helplines, and web services). Additionally, people may view alcohol and other drug (AOD) treatment services as being most appropriate for drug use that is beyond the expertise of general practitioners. However, therapy to quit smoking is becoming an integral part of some AOD services as a parallel treatment with other drugs of concern.

Client demographics

In 2024–25, 1,442 clients received treatment for nicotine as the principal drug of concern (Table SC.9).

Of these clients:

- Half were male (54%) (Table SC.9).

- 7 in 10 (71%) people were aged either 10–19 (36%), 20–29 (18%), or 30–39 (17%) years (Table SC.10).
- 1 in 4 people were Aboriginal and Torres Strait Islander (First Nations) people (23%) (Table SC.11).

Treatment

In 2024–25, 2,095 treatment episodes were provided to clients for nicotine as the principal drug of concern.

Among these episodes:

- The most common sources of referral into treatment were health services (29%) and self or family (25%) (Table Drg.46).
- The most common main treatment types were assessment only and counselling (both 30%), followed by support and case management (28%) (Table Drg.45).
- The median duration of these treatment episodes was 31 days (Table Drg.48). Of these episodes, 6 in 10 (57%) lasted between 2 days and 3 months and 1 in 5 (21%) lasted less than 1 day (Table OV.12).
- The most common reasons treatment ended were planned completion (71%) and unplanned completion (15%) (Table Drg.47).

Ecstasy

In 2024–25, ecstasy was reported as a drug of concern (either principal or additional) in 1.3% (2,827) of all treatment episodes (Table Drg.4).

In 2024–25:

- Ecstasy was the principal drug of concern in 0.3% (558) of treatment episodes (Table Drg.5).
- This proportion has remained relatively stable since 2015–16 (0.6%, 1,249) (Table Drg.5).
- Ecstasy was an additional drug of concern in 1.1% (2,269) of treatment episodes, this has fallen since 2015–16 (1.8%, 3,545) (tables Drg.4 and Drg.5).
- Most treatment episodes with ecstasy as an additional drug of concern were for methamphetamine (34%) followed by cannabis (25%) and alcohol (22%) (Table Drg.3).

Client demographics

In 2024–25, 371 clients received treatment for ecstasy as the principal drug of concern. Of these clients:

- 7 in 10 were male (70%) (Table SC.9)
- 4 in 5 people were aged either 10–19 (33%) or 20–29 (43%) (Table SC.10)
- More than 1 in 10 were First Nations people (13%) (Table SC.11).

Treatment

In 2024–25, 558 treatment episodes were provided to clients for ecstasy as the principal drug of concern (Table Drg.4).

Among these episodes:

- The most common sources of referral into treatment were from self or family (31%) and diversions (25%) (via the criminal justice system) (Table Drg.73).
- The most common main treatment types were counselling (37%) and support and case management (24%) (Table Drg.72).
- 2 in 3 treatment episodes took place in a non-residential treatment setting (66%) (Table Drg.74).
- The median duration of these treatment episodes was 3 weeks (20 days), almost tripling since 2022–23 (8 days) (Table Drg.75).
- The most common reasons treatment ended were planned completion (70%) and unplanned completion (15%) (Figure 3).
- The proportion of episodes with a planned completion ranged from 64% for support and case management to 85% for information and education (Table Drg.74).

Cocaine

In 2024–25, cocaine was reported as a drug of concern (either principal or additional) in 2.9% of all closed treatment episodes (6,178) (Table Drg.4).

In 2024–25:

- Cocaine was the principal drug of concern in 1.3% of treatment episodes (2,827), rising from 0.3% in 2015–16 (668) (Table Drg.5).
- Cocaine was an additional drug of concern in 1.6% of treatment episodes (3,351).
 - This has remained relatively stable since 2015–16 (1.1%), with an increase in episode numbers from 2,259 to 3,351 across the period (Table Drg.5).
- Most treatment episodes with cocaine as an additional drug of concern were for alcohol (42%) followed by methamphetamine (28%) and cannabis (15%) (Table Drg.3).

Client demographics

In 2024–25, 1,886 clients received treatment for cocaine as the principal drug of concern (Table SC.12).

Of these clients:

- 4 in 5 were male (84%) (Table SC.9).
- Half of the people were aged 20–29 years (45%) and a further 30% were aged 30–39 (Table SC.10).
- Under 1 in 10 (8.7%) were First Nations people (Table SC.11).

Treatment

In 2024–25, 2,827 treatment episodes were provided to clients for cocaine as the principal drug of concern (Table Drg.4):

Among these episodes:

- The most common sources of referral into treatment were self or family (37%) followed by health services (23%) and diversion (15%) (Table Drg.82).
- The most common main treatment types were counselling (40%) and assessment only (25%) (Table Drg.81).
- The most common treatment settings were non-residential treatment settings (74%) and residential treatment settings (11%) (Table Drg.83).

- The median duration of these treatment episodes was just over 4 weeks (29 days) (Table Drg.84).
- The most common reasons treatment ended were planned completion (61%) and unplanned completion (20%) (that is, the client ceased to participate against advice, without notice or due to non-compliance).
 - Planned completions were most likely where the main treatment type was information and education (85%) (Table Drg.82).

GHB (Gamma-Hydroxybutyrate)

In 2024–25, GHB was reported as a drug of concern (either principal or additional) in 3.9% of all closed treatment episodes (8,575) (Table Drg.4).

In 2024–25:

- GHB was the principal drug of concern in 1.8% (3,757) of treatment episodes, rising from less than 1% (46) in 2015–16 (Table Drg.5).
- GHB was an additional drug of concern in 2.2% (4,818) of treatment episodes. This has increased since 2015–16 (0.1%, 180 episodes).

Client demographics

In 2024–25, 1,242 clients received treatment for GHB as the principal drug of concern (Table SC.12). Among these clients:

- Half (50%) were female (Table SC.9) (noting 9.3% of client sex was reported as not stated).
- 1 in 3 people were aged 20–29 years (34%) and a further 45% were aged 30–39 (Table SC.10).
- 1 in 10 (12%) people were First Nations people (Table SC.11).

Treatment

In 2024–25, 3,757 treatment episodes were provided to clients for GHB as the principal drug of concern (Table Drg.4).

Among GHB-related treatment episodes in 2024–25:

- The most common main treatment types were ‘other’ main treatment types (24%), withdrawal management (23%) and assessment only (20%) (Table Drg.11).
- The most common source of referral into treatment was a health service (37%), followed self or family (31%) (Table Drg.9).
- Half of treatment episodes took place in non-residential treatment facilities (47%) (Table Drg.8).

Treatment provided

Insights



244,411 treatment episodes were provided to 127,804 people for their own or someone else's AOD use.



88% of all AOD treatment episodes were provided to people receiving treatment for their own drug use while a further 12% were for someone else's AOD use.



From 2015-16, the number of AOD treatment episodes rose by 18% from 206,395 in 2015-16 to 244,411 in 2024-25.



For clients receiving treatment for their own AOD use, the most common treatment type was counselling (33%), followed by assessment only (23%).



For someone else's AOD use, the most common treatment was support and case management (50% of episodes), followed by counselling (24%).



Counselling remains the most common AOD treatment provided to all clients, but this has dropped by 4.5% since 2016-17



Support and case management increased from 13% of all episodes in 2015-16 to 18% in 2024-25.



Treatment episodes for withdrawal management for a client's own drug use fell from 12% in 2015-16 to 8.6% in 2024-25.

Trends in treatment provided

In this section

- Overview
- Treatment episodes for clients who received treatment for their own alcohol or drug use
- Treatment episodes for clients who received treatment for someone else's alcohol or drug use
- Trends in main treatment types

Treatment in Australia

Many types of treatment are available in Australia, aiming to reduce the risk of harm associated with drug use through services such as counselling, withdrawal management, rehabilitation, support and case management or information and education. Some people may require ongoing support to achieve long-term change. For other people, early support and treatment will be sufficient to reduce harms and prevent the need for further treatment or they may access treatment intermittently as required (Australian Government Department of Health and Aged Care 2019).

People can receive treatment for their own or someone else's alcohol or drug use. Rehabilitation, withdrawal management (detoxification) and pharmacotherapy are only available for people who received treatment for their own alcohol or drug use.

In 2024–25:

- 244,411 treatment episodes were provided to 127,804 clients for their own or someone else's alcohol or drug (AOD) use.
- Clients received 1.9 treatment episodes per person nationally, meaning almost 2 treatment episodes were provided to each client (Table SCR.21).

Between 2015–16 and 2024–25:

- Treatment episodes overall rose to a high of 242,980 in 2020–21, before falling in 2021–22 (228,451), rising in 2024–25 (244,411). Treatment episodes rose by 18% from 2015–16 (206,395).
 - Episodes for clients receiving treatment for their own AOD use increased by 8% from 2015–16 (198,507) to 2024–25 (214,662).
 - Episodes for clients who received treatment for someone else's AOD use were nearly 4 times higher, rising from 7,888 in 2015–16 to 29,749 in 2024–25.

On average clients received more than one treatment episode within a year. Indicating, those who do receive treatment are receiving multiple episodes of care.

- Client numbers overall declined by 8.2% from a peak of 139,295 in 2019–20 dropping to 127,804 in 2024–25.
- Between 2015–16 (131,230) and 2024–25 client numbers fell by 3%.
 - Client numbers for people receiving AOD treatment for their own use fell by 7% between 2015–16 (125,655) to 2024–25 (117,132).
 - Whereas, client numbers for people receiving AOD treatment for someone else's AOD use almost doubled between 2015–16 (5,575) to 2024–25 (10,672).

Treatment episodes for clients who received treatment for their own alcohol or drug use

In 2024–25:

- 214,662 (88%) of treatment episodes were provided to 117,132 clients for their own alcohol or drug use (tables Trt.2, SC.1).
- Among these clients:
 - Counselling was the most common treatment across most age groups followed by an assessment only, except for:
 - Clients aged 10–19, where it was counselling (42%) followed by support and case management (29%).
 - Clients aged over 60, where it was assessment only (35%) followed by counselling (33%).
- Older Clients (aged 40 and over) were more likely to receive withdrawal management as a main treatment type (7.8–9.8%) than younger clients (aged 10–19) (3.5%) (Figure 1, Table SC.19).

Treatment episodes for clients who received treatment for someone else's alcohol or drug use

In 2024–25:

- 29,749 (12%) of treatment episodes were provided to 10,672 clients for someone else's own alcohol or drug use (tables Trt.2, SC.19).
 - The age of these clients varied by main treatment type. Counselling was the most common treatment provided to:
 - 40% of clients aged 40–49.
 - 50% of clients aged 50–59.
 - 62% of clients aged over 60.
 - 2 in 5 clients aged 10–19 (41%), 20–29 (45%) or 30–39 (43%), received support and case management (Figure 1, Table SC.19).

Figure 1: Clients, by client type, main treatment type and age group, 2024-25



Problem creating image.

Trends in main treatment types

The types of treatments clients received have changed over time, reflecting expansion and changes to service delivery practices, changes in coding practices/methodology, state and territory policies and the clients' needs at the time of an assessment.

In 2024-25, counselling continued to be the most common main treatment type, making up almost one third (32%) of all treatment episodes, followed by assessment only (21%) and support and case management (18%).

Trends for all clients who received treatment

Between 2015-16 and 2024-25:

- Counselling was the most common treatment type. Episodes rose from 36% (75,184), and peaked at 40% in 2016-17, before declining to 32% (77,976) in 2024-25. Changes in trends maybe related to:
 - AOD services adapted to other ways of delivering AOD treatment, such as, telehealth models during the COVID-19 pandemic.
 - Changes to coding practices: from 2020-21, diversion programs were reported as counselling in a few states (previously recorded as information and education). Caution should be used when comparing these data over time.
- Assessment only episodes rose from 33,168 (16%) in 2015-16 to 51,075 (21%) in 2024-25.
 - This increase may be due in part to recording a separate assessment only episode, prior to commencement of treatment in some states and territories.
- Support and case management episodes increased from 27,798 (13%) in 2015-16 to 43,594 (18%) in 2024-25.
- Information education episodes remained relatively steady up to 2018-19 (18,039, 8.2%) before falling in 2024-25 (5,903, 2.4%) (Figure 2, Table Trt.3). This was due to:
 - Changes to coding practices: from 2020-21, police and court diversion programs were reported as counselling (previously coded as Information and Education). Caution should be used when comparing these data over time.
- 'Other' main treatment type increased from 9,593 (4.7%) in 2015-16 to 23,616 (9.7%) in 2024-25 (Figure 2, Table Trt.3). This increase is noticeable from 2019-20 and likely relates to:
 - Agencies adapted to telephone/video conference consultations (during COVID-19).

Treatment episodes for clients who received treatment for their own alcohol or drug use

Between 2015-16 and 2024-25:

- Counselling remained the most common treatment, but dropped from 39% (74,753) of episodes in 2016-17 to 33% (70,732) in 2024-25.
- Withdrawal management episodes fell from 12% (23,853) in 2015-16 to 9.8% (20,929) in 2024-25.
- Assessment only (from 16% to 23%) and 'other' treatment rose (from 4.7% to 9.0%) over this period.

Treatment episodes for clients who received treatment for someone else's alcohol or drug use

Between 2015–16 and 2024–25:

- Until 2020–21, counselling was the most common treatment type, peaking at 73% (5,637) of episodes in 2016–17 before falling to 25% (7,244) in 2024–25.
- Support and case management became the most common main treatment, increasing over 8-fold in the 10 years to 2021–22. It rose from 9% in 2017–18 to 50% in 2024–25 (Table Trt.3).
 - This increase may be due in part to changes in coding practices for support and case management in 2019–20. The word 'only' was removed (support and case management only) allowing agencies to more accurately capture this treatment type in conjunction with other treatment types.

For further information on changes in the AODTS NMDS collection see [2024–25 AODTS NMDS Data Quality Statement](#).

Figure 2: Treatment episodes, by client type and main treatment type, 2015–16 to 2024–25



Problem creating image.

References

Australian Government Department of Health and Aged Care 2019. [National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29](#), Department of Health and Aged Care, Australian Government, accessed 6 March 2024.

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Assessment only

What is assessment in the AODTS NMDS?

Assessment is often a crucial first step in alcohol and other drug (AOD) treatment, helping treatment providers identify clients' needs and goals, develop treatment plans and match clients to appropriate support services (Department of Health and Aged Care 2019). It can also occur at other times during a client's treatment journey as an early intervention, to help identify and target emerging or risky AOD use. Australia's National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029 states that assessment should be ongoing, as it helps to ensure that treatment aligns with people's needs and goals throughout their treatment journey.

In 2024–25:

- 1 in 5 (21%, 51,075) of all treatment episodes were for an assessment only:
 - 23% of episodes were for people who received an assessment only for their own alcohol or drug use.
 - 8.7% of episodes were for people who received an assessment only for someone else's alcohol or drug use.
 - Assessment only treatment episodes most commonly involved alcohol (40%) or methamphetamine (24%) as the principal drug of concern (tables Trt.3, Trt.32).
-

Client profile

In 2024–25, 30,921 clients received an assessment only:

- Of the people who received an assessment for their own alcohol or drug use:
 - 66% were male.
 - 20% were Aboriginal and Torres Strait Islander (First Nations) people.
- Of the people who received an assessment for someone else's alcohol or drug use:
 - 55% were male.
 - 9.6% were First Nations people (tables SC.18, SC.20).

For more information see:

[Accessing alcohol and drug treatment services after an assessment](#)

References

Department of Health and Aged Care (2019b). [National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029](#). Canberra: Commonwealth of Australia.

Counselling

What is counselling in the AODTS NMDS?

Counselling is the most common treatment type for clients' who received treatment for alcohol or other drug use. Psycho-social counselling refers to evidence-informed talking therapies, aimed at helping the person develop skills (whether that be psychological skills, and/or practical skills) to reduce alcohol or other drug consumption and/or harms, in line with the person's own goals.

Counselling is provided for a client's own alcohol or drug use, as well as those who received support for someone else's alcohol or drug use.

In 2024–25:

- Counselling was provided in 32% (77,976) of all treatment episodes:
 - 1 in 3 (33%) episodes were for people who received counselling for their own alcohol or drug use, similar to 2023–24 (33%).
 - 1 in 4 (24%) episodes were for people who received counselling for someone else's alcohol or drug use, a decrease from 2023–24 (35%).
 - Counselling episodes most commonly involved alcohol (42%) or methamphetamine (25%) as the principal drug of concern.
 - The median length of counselling episodes was 68 days (over 9 weeks) (tables Trt.3, Trt.16, OV.11).
-

Client profile

In 2024–25, 50,339 clients received counselling:

- Of the people who received counselling for their own alcohol or drug use:
 - 3 in 5 (62%) people were male.
 - Half (52%) were aged 30–49.
 - 1 in 5 (18%) people were Aboriginal and Torres Strait Islander (First Nations) people.
 - Of the people who received counselling for someone else's alcohol or drug use:
 - 53% were female (13% did not state their sex).
 - 3 in 5 (59%) were aged 40 and over.
 - 10% were First Nations people (tables SC.18–20).
-

Treatment profile

Between 2015–16 and 2024–25:

- Treatment episodes for counselling were longer than all other treatment types, ranging between a median length of 54 and 71 days (Table OV.11).
 - For a client's own alcohol or drug use, the proportion of counselling episodes that ended within 1 month fell from 34% in 2016–17 to 27% in 2024–25.
 - For someone else's alcohol or drug use, the proportion of counselling episodes ending within 1 month fell from 42% in 2015–16 to 22% in 2024–25.
 - In contrast, the proportion lasting 1 to 6 months increased from 50% in 2015–16 to 59% in 2024–25 (Table Trt.21).
-

Information and education

What is information and education in the AODTS NMDS?

Information and education can be provided to clients as written information or a psycho-educational intervention program.

It is important to note that information and education treatment trends are influenced by differences in jurisdictional program practices over time.

In 2024–25:

- Information and education was provided in 2.4% (5,903) of all treatment episodes.
 - Information and education episodes most commonly involved alcohol (42%) or methamphetamine (19%).
 - 2 in 5 (38%) of information and education episodes lasted 1 day for clients receiving treatment for their own alcohol or drug use.
 - 46% of information and education episodes lasted 1 day for clients who received treatment for someone else's use (tables Trt.3, Trt.42, Trt.44).
-

Client profile

In 2024–25, 3,370 clients received information and education:

- Of the people who received information and education for their own alcohol or drug use:
 - 2 in 3 (66%) were male.
 - 62% of people were aged 10–39 (14% aged 10–19, 22% aged 20–29 and 25% aged 30–39).
 - 3 in 10 (30%) were Aboriginal and Torres Strait Islander (First Nations) people.
 - Of the people who received information and education for someone else's alcohol or drug use:
 - 2 in 3 (65%) were female.
 - Half (54%) were aged 40 or over.
 - 1 in 10 (11%) were First Nations people (tables SC.18–20).
-

Treatment profile

Between 2015–16 and 2024–25:

- For own alcohol or drug use, the proportion of information and education episodes that lasted 1 day fell from 79% in 2015–16 to 38% in 2024–25. These decreases were likely due to:
 - Coding changes: from 2020–21, police and court diversion programs were reported as counselling (previously recorded as information and education). Caution should be used when comparing these data over time.
 - Reductions in service delivery from 2019–20 onwards (such as COVID-19 impacts).
- For someone else's alcohol or drug use, the proportion of information and education episodes that lasted one day rose from 38% in 2015–16 to 46% in 2024–25.
- For all clients, the proportion of information and education episodes for lasting from 2 days to 3 months rose from 19% in 2015–16 to 52% in 2024–25 (Table Trt.44).

In 2019–20, changes were made to categories under Main Treatment; the word 'only' was removed from information and education. The removal of the word 'only' from information and education, changed reporting rules for agencies; allowing agencies to be able to report and more accurately capture these items as an additional treatment in conjunction with a main treatment type.

Pharmacotherapy

What is pharmacotherapy in the AODTS NMDS?

There are several medications (pharmacotherapies) used to treat dependence on alcohol, tobacco and other drugs. These pharmacotherapies can be prescribed for a short, medium or long-term duration, depending on the person's goals.

In the [Alcohol and Other Drug Treatment Services National Minimum Data Set](#) (AODTS NMDS), only episodes where pharmacotherapy was either an additional treatment, or where it was the main treatment with an additional treatment provided, are included. Episodes where pharmacotherapy was the main treatment only and no additional treatment was provided are excluded. Pharmacotherapy is only available to people receiving treatment for their own drug use. As most pharmacotherapy services are outside the scope of the AODTS NMDS, the data presented here are a substantial under-representation.

More information on opioid pharmacotherapy treatment provided in Australia is presented in the [National Opioid Pharmacotherapy Statistics](#) Annual Data report (NOPSAD). The latest data from the [National Opioid Pharmacotherapy Statistics](#) indicate that on a snapshot day in 2025, around 57,740 people received pharmacotherapy for opioid dependence (AIHW 2026).

For services in scope of the AODTS NMDS in 2024–25:

- Pharmacotherapy accounted for 1.7% (4,222) of episodes for a client's own alcohol or drug use.
 - Of these episodes, 43% (1,799) reported pharmacotherapy as an additional treatment (tables Trt.3, Trt.54).
-

Client profile

In 2024–25, 2,962 clients received pharmacotherapy for their own alcohol or drug use:

- 7 in 10 (70%) were male.
 - 2 in 3 (64%) were aged 30–49 and 15% were aged 50 and over.
 - 1 in 5 (18%) were Aboriginal and Torres Strait Islander (First Nations) people (tables SC.18–20).
-

Treatment profile

In 2024–25, for pharmacotherapy episodes for a client's own alcohol or drug use:

- Half (53%) of episodes lasted over 3 months, of which 1 in 4 (25%) lasted over 12 months.
 - 1 in 5 (19%) of episodes lasted 2–29 days.
- Pharmacotherapy episodes most commonly involved heroin (49%) or alcohol (14%) as the principal drug of concern (tables Trt.55, Trt.59).

References

AIHW (2026) [National Opioid Pharmacotherapy Statistics Annual Data collection](#), AIHW, Australian Government, accessed 27 May 2026.

Rehabilitation

What is rehabilitation in the AODTS NMDS?

Rehabilitation is an intensive treatment program that integrates a range of services and therapeutic activities, including counselling, behavioural treatment, social and community living skills, relapse prevention and recreational activities. This type of treatment is not available for people who received treatment for someone else's alcohol or drug use.

In 2024–25, for a client's own alcohol or drug use:

- Rehabilitation accounted for 1 in 14 (8.0%, 17,096) treatment episodes.
 - Rehabilitation treatment most commonly involved alcohol (39%) or methamphetamine (34%) as the principal drug of concern (tables Trt.3, Trt.47).
-

Client profile

In 2024–25, 7,303 clients received rehabilitation treatment for their own alcohol or drug use:

- 3 in 5 (63%) were male.
 - 3 in 5 (58%) were aged 30–49.
 - 3 in 10 (32%) were Aboriginal and Torres Strait Islander (First Nations) people (tables SC.18–20).
-

Treatment profile

In 2024–25, for rehabilitation episodes for a client's own alcohol or drug use:

- 38% of episodes lasted 1–3 months and 37% lasted between 2–29 days.

Between 2015–16 and 2024–25:

- The duration of rehabilitation treatment remained relatively stable, which may be related to rehabilitation programs lasting a set period of time (Table Trt.52).
 - The median duration for rehabilitation treatment was highest in 2016–17 at 53 days and dropped to 40 days in 2024–25 (Table OV.11).
-

Support and case management

What is support and case management in the AODTS NMDS?

Support includes activities such as providing information and support to family members/friends/children, delivering peer-based support services, cultural support, and ongoing contact/regular communication between client/provider. Care co-ordination and case management involves ongoing treatment planning, goal setting and review and facilitation for client to achieve their goals. This includes supported referral and system navigation support to other services, if needed, such as health or social welfare services (Department of Health and Aged Care 2019).

In 2024–25:

- Support and case management accounted for 18% (43,594) of all treatment episodes:
 - 13% (28,604) of episodes were for clients' who received support and case management for their own alcohol or drug use.
 - 50% (14,990) of episodes were for clients who received support and case management for someone else's alcohol or drug use.
 - Support and case managed episodes most commonly involved alcohol (35%), cannabis (22%) and methamphetamine (21%) (tables Trt.3, Trt.37).
-

Client profile

In 2024–25, 17,649 clients received support and case management:

- Of the people who received support and case management for their own alcohol or drug use:
 - 60% were male
 - 67% were aged 10–39
 - 23% were Aboriginal and Torres Strait Islander (First Nations) people.
 - Of the people who received support and case management for someone else's alcohol or drug use:
 - 60% were aged 10–39
 - 13% were First Nations people (tables SC.18–20).
-

Treatment profile

In 2024–25:

- Support and case management episodes lasting 1 day were more common for treatment related to someone else's alcohol or drug use (53%) than for clients' own use (12%).
- Most (83%) treatment episodes for all clients lasted from one day to 3 months.

Between 2015–16 and 2024–25:

- Among support and case management treatment episodes for own alcohol or drug use:
 - Episodes lasting 1 day fell from 43% in 2015–16 to 12% in 2024–25.
 - Episodes lasting one to 3 months rose from 23% in 2015–16 to 32% in 2024–25.
 - The median treatment duration rose from 17 days to 35 days.
- Among support and case management episodes for someone else's alcohol or drug use:
 - Episodes lasting 1 day rose substantially from 2015–16 (7.6%) to 2018–19 (87%) before falling in 2024–25 (53%).
 - The median treatment duration dropped from 36 days to 1 day (tables Ov.11, Trt.39).

In 2019–20, changes were made to categories under Main Treatment; the word 'only' was removed from support and case management. The removal of the word 'only' from support and case management, changed reporting rules for agencies; allowing agencies to be able to report and more accurately capture these items as an additional treatment in conjunction with a main treatment type.

References

Department of Health and Aged Care 2019. [National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29](#), Department of Health and Aged Care, Australian Government, accessed 6 March 2024.

Withdrawal management

What is withdrawal management in the AODTS NMDS?

Withdrawal management (detoxification) includes medicated and non-medicated treatment in a residential or non-residential setting, to help manage, reduce or stop the use of a drug of concern. This type of treatment is not available for people who received treatment for someone else's alcohol or drug use.

In 2024–25, for a client's own alcohol or drug use:

- Withdrawal management accounted for nearly 1 in 10 (8.6%, 20,929) of all treatment episodes.
 - Most episodes were for alcohol (56%) or methamphetamine (17%) (tables Trt.3, Trt.24).
-

Client profile

In 2024–25, 7,981 clients received withdrawal management treatment for their own alcohol or drug use:

- 3 in 5 (57%) were male
 - Half (52%) were aged 30–49
 - 1 in 8 (14%) were Aboriginal and Torres Strait Islander (First Nations) people (tables SC.18–20).
-

Treatment profile

Among withdrawal management episodes for a client's own alcohol or drug use:

- 81% of treatment episodes lasted 2–29 days, followed by 9.7% episodes lasting 30–90 days in 2024–25.
 - Between 2015–16 and 2024–25, median treatment duration has remained stable at 8 days (tables Ov.11, Trt.29).
-

Other main treatment

What is other main treatment in the AODTS NMDS?

Other main treatment types are modes of treatment that do not fit the descriptions of the main treatment types. Examples of other main treatment types may be living skills classes, outdoor therapy, relapse prevention and safe using or drug use reduction education and support.

In 2024–25, other treatment:

- Accounted for 9.7% (23,616) of all treatment episodes and was reported as an additional treatment in 47% (11,199) of episodes.
- Most episodes were for alcohol (39%), methamphetamines (24%) or cannabis (11%) (tables Trt.4, Trt.61, Trt.63).

Between 2015–16 and 2024–25:

- Among other treatment episodes for own alcohol or drug use:
 - Most episodes lasted less than one month, falling from 73% in 2015–16 to 49% in 2024–25.
 - Episodes lasting one to 3 months rose from 12% in 2015–16 to 29% in 2024–25.
 - Episodes lasting one day fell from 40% in 2015–16 to 27% in 2024–25.
 - Among other treatment episodes for someone else's alcohol or drug use:
 - Episodes that lasted 2–29 days peaked at 76% in 2015–16, before dropping to 39% in 2024–25.
 - Episodes lasting one to 3 months increased from 10% in 2015–16 to 36% in 2024–25.
 - Median treatment duration for other treatment ranged from 37 days to 47 days for all clients for most years between 2015–16 and 2024–25, except for 2015–16 (19 days) (tables Ov.11, Trt.68).
-

Treatment referral and completion

Insights



The most common referral into treatment was self or family (37%, 91,419 episodes) in 2024-25



Self or family referrals into treatment remained fairly stable between 2015-16 and 2024-25 (both 37%).



The median length of treatment was 4 weeks for clients' own AOD use and two weeks for clients who received support for someone else's AOD use



In 2024-25, 3 in 5 (59%, 143,496) treatment episodes ended as an expected or planned completion and this has been stable since 2015-16.

Trends in treatment referral and completion

In 2024–25:

- For all treatment episodes (244,411), the most common referral into treatment was self or family (37%, 91,419 episodes) followed by referral by health services (33%, 80,384 episodes):
 - This referral pattern into treatment was consistent for all treatment types except for information and education (57%), assessment only (33%) and other treatment types (49%) where health services was the most common referrals.
- Referrals into treatment for a client's own alcohol or drug use (214,662 episodes) and someone else's alcohol or drug use (29,749 episodes) were similar:
 - Self or family (37%) was most common for a client's own alcohol or drug use, followed by health service (32%).
 - Self or family (42%) was the most common referral for clients who received treatment for someone else's alcohol or drug use, followed by health service (36%).
- Diversion (8.0%, 17,184 episodes) referrals into treatment were most common for a client's own alcohol or drug use.
 - Treatment episodes referred via diversion were most common for ecstasy (25%) and cocaine (15%) (tables Trt.10, Trt.11, Drg.13).

Between 2015–16 and 2024–25:

- Diversion referrals fell from 17% (34,620) in 2015–16 to 7.2% (17,696) in 2024–25.
- Where a referral came from an 'other' referral source, treatment episodes rose from 7.8% (16,096) in 2015–16, peaking at 17% (40,474) in 2019–20, before falling to 13% (31,552) in 2024–25.
 - Other source of referral includes persons referred through community services, government departments, remand or prison, education (through teachers and schools).
- Self or family referrals remained stable (37% or 76,725 in 2015–16 and 37% or 91,419 in 2024–25).
- Health service referrals rose from 28% (56,962) to 33% (80,384) (tables Trt.10, Trt.11).
- Referrals into treatment varied according to clients' principal drug of concern. Among episodes (214,662) for a client's own alcohol or drug use (Figure 1, Table Drg.13):
 - Where alcohol was the principal drug of concern, referrals from self or family (41%, 26,224 in 2015–16 and 41%, 35,701 in 2024–25) or a health service (36%, 22,987 in 2015–16 and 38%, 33,357 in 2024–25) remained stable.
 - Where methamphetamines were the principal drug of concern:
 - Referrals rose for health services (22%, 4,689 in 2015–16 to 28%, 14,235 in 2024–25) and corrections (9.8%, 2,074 in 2015–16 to 16%, 8,299 in 2024–25).
 - Self or family referrals proportionally fell, from 44% (9,242) in 2015–16 to 36% (18,271) in 2024–25.
 - Where cannabis was the principal drug of concern:
 - Diversion referrals fell, from 36% (16,152) in 2015–16 to 12% (3,586) in 2024–25.
 - The proportion of referrals rose for self or family (from 28%, 12,419 in 2015–16 to 31%, 9,527 in 2024–25) and health services (from 23%, 10,476 in 2015–16 to 31%, 9,442 in 2024–25).

Figure 1: Treatment episodes for own drug use, by principal drug of concern and referral source, 2015–16 to 2024–25



Problem creating image.

Duration of treatment

In 2024–25:

- For a client's own alcohol or drug use:
 - 3 in 4 treatment episodes ended within 3 months (78%, 167,772).
 - The median duration of treatment episodes was 4 weeks (27 days).
 - Counselling had the longest median duration (67 days), while assessment only had the shortest (3 days) (Figure 1).
- For someone else's alcohol or drug use:
 - 4 in 5 treatment episodes ended within 3 months (83%, 24,801).
 - The median duration of treatment was two weeks (16 days) (tables Ov.9, Ov.10, Ov.11).

Between 2015–16 and 2024–25:

- For client's own alcohol or drug use:
 - Treatment episodes ending within 3 months remained the most common duration.
 - The median duration of treatment episodes fluctuated, from 16 days in 2015–16, falling to 27 days in 2024–25.
 - These trends were driven primarily by changes in the duration of support and case management and other treatment episodes.
 - The median duration of counselling increased from 58 days to 67 days (Figure 1, tables Trt.12, Ov.11).
- For clients who received support for someone else's alcohol or drug use:
 - The median duration fluctuated more widely, rising from 14 days in 2018–19, peaking at 37 days in 2020–21, then falling to 16 days in 2024–25 (tables Trt.12, Ov.11).
 - This fluctuation was driven primarily by decreases in support and case management treatment duration and increases in counselling duration.

Figure 1: Median duration of treatment episodes, by client type and main treatment type, 2015–16 to 2024–25



Problem creating image.

Completion of treatment

Reason for cessation in the AODTS NMDS

Reasons for clients who no longer received treatment from an alcohol and other drug (AOD) treatment service include:

- expected completions (for example, the treatment program was completed)
- unplanned completions (for example, the client ceased to participate in the treatment program without notice or advice)
- administrative completion (for example, the client transferred to another service provider or their treatment changed) (see [Key terminology](#)).

In 2024–25:

- Among treatment episodes for a client's own alcohol or drug use (214,662 episodes):
 - 3 in 5 (59%, 126,384) episodes ended as expected (planned) completions.
 - 1 in 5 (21%, 45,428) of treatment episodes ended due to an unplanned completion.
- The pattern of reasons for ceasing treatment differed for clients who received treatment for someone else's alcohol or drug use (29,749 episodes):
 - The proportion of episodes that ended due to an unplanned completion was lower (6.9%, 2,044) than for a client's own alcohol or drug use (Figure 1, Table Trt.8).

For more information see:

[Completion of alcohol and drug treatment in Australia, 2011–12 to 2020–21: differences by drugs of concern and treatment characteristics](#)

Figure 1: Treatment episodes, by client type and reason for completion, 2015–16 to 2024–25



Problem creating image.

In 2024–25, completion of treatment varied by principal drug of concern, for a client's own alcohol or drug use (214,662 episodes):

- Ecstasy had the highest proportion of episodes with expected completions (70%, 392), followed by cannabis (63%, 19,080), alcohol and benzodiazepines (both 62%, 54,638 and 1,389 respectively).
- Methamphetamines had the highest proportion of episodes for unplanned end to treatment (25%, 12,829), followed by codeine and cannabis (21%, 68 and 20%, 6,175 respectively) (Table Drg.14, Figure 2).

Figure 2: Treatment episodes for selected drugs, by principal drug of concern and reason for completion, 2015–16 to 2024–25



Problem creating image.

Between 2015–16 and 2024–25, for a client's own alcohol or drug use (214,662 episodes):

- The proportion of treatment episodes that ended in an expected completion remained stable (61%, 121,632 in 2015–16 and 59%, 126,384 in 2024–25) (Table Ov.7):
- Where alcohol was the principal drug of concern, episodes with an expected completion ranged from 65% (41,216) in 2015–16 to 62% (54,638) in 2025–26.
- Where methamphetamine was the principal drug of concern, episodes with an expected completion remained stable between 2019–20 (50%, 23,315) and 2024–25 (51%, 25,965).
- Where cannabis was the principal drug of concern, episodes with an expected completion fell from a peak of 73% (30,521) in 2016–17 to 63% (19,080) in 2024–25.
- Where heroin was the principal drug of concern, the proportion of treatment episodes with an expected completion ranged between 54% and 61% between 2015–16 and 2024–25 (Table Drg.12).

Between 2015–16 to 2024–25 for someone else's alcohol or drug use (29,749 episodes):

- Episodes with an expected completion fell from 70% (5,520) in 2015–16 to 58% (17,112) in 2024–25.
- 'Other' as a reason for ending treatment rose from 14% (1,114) in 2015–16 to 31% (9,241) in 2024–25 (Table Ov.7).

Agencies

Insights

In 2024-25:



1,316 publicly funded agencies provided data about their AOD treatment services to the AODTS NMDS.



7 in 10 (69%) AOD agencies were non-government.



Over half of all AOD agencies (55%) were located in *Major cities*.



The most common treatment provided by non-government AOD services included counselling (32%), support and case management (22%) and assessment only (15%).



The most common AOD treatment provided by government services included assessment only (36%), counselling (31%) and withdrawal management (13%).



Nationally, over the 10-year period to 2024-25, the total number of publicly funded agencies providing AOD treatment increased by 66% from 791 in 2015-16 to 1,316 in 2024-25.

Trends in agencies

The Australian Government and state and territory governments fund non-government and government agencies to provide a range of alcohol and other drug (AOD) treatment services. Treatment services are delivered in both residential and non-residential settings, and often include treatments such as detoxification, rehabilitation, counselling and pharmacotherapy.

In 2024–25:

- 1,316 publicly funded AOD treatment agencies reported to the AODTS NMDS.
- The number of agencies in each jurisdiction ranged from 16 in the Australian Capital Territory to 513 in New South Wales.

Between 2015–16 and 2024–25:

- The total number of AOD treatment agencies rose by 66% (from 791 to 1,316).
- The number of non-government AOD treatment services has grown from 462 in 2015–16 to 906 in 2024–25 due to increases in funding and expansion in the sector.

Reasons for expansion in the sector include:

- New funding arrangements for existing AOD programs to increase service capacity.
- Expanded collaboration across agencies to deliver new treatment services.
- Some jurisdictions may change data collection approaches, for example, by moving from collecting data at an administrative or management level to a service outlet level, an agency can have more than one service outlet operating in different locations.

See the [Alcohol and other drug treatment services NMDS Data Quality Statement, 2024–25](#) for further information.

Figure 1: Treatment agencies, by state and territory, 2015–16 to 2024–25



Problem creating image.

Service sector

In 2024–25, 244,411 treatment episodes were provided by a mix of government and non-government agencies who deliver publicly funded alcohol and other drug (AOD) treatment services.

In 2024–25:

- 7 in 10 (69%) of AOD treatment agencies (service outlets) were non-government.
 - Non-government agencies provided 72% of all treatment episodes.
- Across states and territories, the proportion of non-government services ranged from 62% in South Australia to 99% in Victoria.
 - The exception was New South Wales, where 3 in 5 (58%) of AOD treatment agencies were government services (Figure 1).
- Over half (55%) of all agencies were located in *Major cities*.
 - 7 in 10 (70%) of agencies located in *Major cities* were non-government agencies (tables Agcy.1–3).

Between 2015–16 and 2024–25, the proportion of non-government services increased from 58% to 69% nationally.

Figure 1: Treatment agencies, by service sector and state or territory, 2015–16 to 2024–25



Problem creating image.

The main treatment type and treatment delivery setting where AOD treatment was provided varied depending on the agency sector (government or non-government agency).

In 2024–25:

- The most common AOD treatment provided by government services (67,235 episodes) included:
 - assessment only (36%)
 - counselling (31%)
 - withdrawal management (13%) (Figure agencies sector 2, Table Agcy.7).
- The most common delivery settings where AOD treatment was provided by government services included:
 - non-residential treatment settings (83%)
 - residential treatment settings (11%) (Figure 2, Table Agcy.8).

- The most common AOD treatment provided by non-government services (177,176 episodes) included:
 - counselling (32%)
 - support and case management (22%)
 - assessment only (15%) (Figure 2, Table Agcy.7).
- The most common delivery settings where treatment was provided was by non-government services included:
 - non-residential treatment settings (63%)
 - residential treatment settings (17%) (Figure 2, Table Agcy.8).
- Within each service sector in 2024–25:
 - 1 in 10 treatment episodes provided by non-government services were for rehabilitation as the main treatment (9.4%) compared to 0.7% of treatment episodes provided by government services.
 - 1 in 8 treatment episodes provided by government services were for withdrawal management as the main treatment (13%) compared to 6.7% of treatment episodes provided by non-government services (Figure 2, Table Agcy.7).

Figure 2: Treatment episodes, by service sector, main treatment type, and treatment delivery setting, state or territory, 2024–25



Problem creating image.

Location of agencies

Alcohol and other drug (AOD) treatment agencies (service outlets) can be explored by the state location or remoteness area in which the agencies are located, noting that an agency can have more than one service delivery outlet, located in different areas.

In 2024–25, of the 1,316 treatment agencies who reported to the AODTS NMDS:

- The most common locations for treatment agencies were:
 - *Major cities* (55%, 727 agencies)
 - *Inner regional areas* (26%, 337)
 - Agencies in these two areas provided 90% of all treatment episodes (Figure 1, tables Agcy.3–Agcy.4).
 - *Remote areas* (2.7%, 36)
 - *Very remote areas* (2.7%, 35).
 - Agencies in these two areas provided 2.3% of all treatment episodes.

This pattern was similar across most states and territories, except for the Northern Territory due to having no *Major cities* or *Inner regional areas*.

- In the Northern Territory, 3 in 5 (52%) of all agencies were in either:
 - *Remote areas* (39%)
 - *Very remote areas* (13%).
 - The other half were located in *Outer regional* (48%) areas (Figure 1, Table Agcy.3).

Between 2015–16 and 2024–25:

- The total number of agencies delivering AOD services increased from 791 agencies in 2015–16 to 1,316 agencies in 2024–25.

Remoteness structures differ by state and territory. For further information on reporting remoteness area, [see technical notes](#).

Figure 1: Treatment agencies, by remoteness area and state or territory, 2022–23 to 2024–25



Problem creating image.

In 2024–25, counselling was the most common main treatment type provided by AOD agencies across all remoteness areas:

- The proportion of treatment episodes provided by agencies for counselling ranged from 31% in *Major cities* to 54% in *Very remote areas* (Figure 2, Table Agcy.6).

In 2024–25, main treatment types varied by AOD agency location by remoteness areas across jurisdictions:

- In New South Wales, counselling was the main treatment across all areas, ranging from 34% of episodes in major cities to 100% in very remote areas.
- In Victoria, support and case management and counselling were most common across all areas:
 - *Major cities* (28% and 20% of episodes, respectively)
 - *Inner regional* (23% for both)
 - *Outer regional* (25% and 23% respectively).
- In Queensland, assessment only was the most common treatment in all areas, ranging from 37% of episodes in inner regional to 55% in remote areas.
- In Western Australia, counselling was most common across all areas, ranging from 56% of episodes in major cities to 91% in very remote areas.
- In South Australia, withdrawal management was highest in major cities (17% of episodes), while support and case management was higher in very remote areas (43%).
- In Tasmania, rehabilitation was most common in remote areas (100% of episodes), while counselling was most common in inner (63%) and outer regional (46%) areas.
- In Northern Territory, assessment only was most common across all areas, ranging from 30% of episodes in remote areas to 59% in outer regional areas.

See [technical notes](#) for information on reporting of the number of agencies in a particular remoteness category.

Figure 2: Treatment episodes, by service sector, main treatment type, and treatment delivery setting, state or territory, 2024–25



Problem creating image.

State and territory summaries

Insights



Publicly funded AOD agencies ranged from 16 in the Australian Capital Territory to 513 in New South Wales



In all states and territories, most clients were treated for alcohol as their principal drug of concern



There were fewer clients overall, but on average people were receiving more treatment episodes, especially in Victoria, Queensland and the Northern Territory.



Methamphetamine was the second most common principal drug of concern in most states and territories



Counselling was the most common treatment provided in most states and territories including, New South Wales, Western Australia, South Australia and Tasmania.



The number of publicly funded agencies rose from 791 in 2015–16 to 1,316 in 2024–25, a change largely driven by increases in New South Wales and Victoria

Trends in clients in states and territories

In this section

- State and territory client rates
- Characteristics of clients

This section presents key state and territory findings on specialist alcohol and other drug (AOD) treatment services, the people they treat, and the treatment they provided in 2024–25.

The [technical notes](#) page provides details on the data, with further information available in the [Alcohol and other drug treatment services NMDS 2024–25 Quality Statement](#). In addition, a series of state and territory [supplementary tables](#) accompanying the annual report are also available.

State and territory client rates

Across states and territories:

- The rate of clients who received specialist AOD treatment ranged from 1,381 per 100,000 people in the Northern Territory to 369 in New South Wales in 2024–25 (Table SCR.21).
- The rate of clients treated by publicly funded AOD treatment agencies in each state and territory varied over time, most notably with recent decreases in New South Wales, Queensland, Western Australia, the Australian Capital Territory and Northern Territory (Figure 1).

Figure AODTS 1: AODTS clients and treatment episodes, by state and territory, 2013–14 to 2024–25



Problem creating image.

Over the period from 2013–14 to 2024–25, in 4 of 8 states and territories, the rate of clients remained consistently higher than the rate of clients nationally:

- In Victoria, Queensland and Tasmania, the rates of clients fluctuated but with no substantial or prolonged changes over this period.
- In Western Australia and the Australian Capital Territory there have been steady declines in the rates of clients since 2018–19 and in New South Wales and the Northern Territory since 2020–21.

For more information see the [Data quality statement](#).

State and territory AOD treatment episodes

In Victoria, Queensland and the Northern Territory, since 2019–20, on average clients received more than one treatment episode within a year. This has been steadily rising, indicating that although fewer people are accessing services, those who do are receiving multiple episodes of care.

Characteristics of clients

The following data visualisations show:

- Number of clients by state/territory and client type, 2013–14 to 2024–25
- Number of clients by state/territory and sex, 2013–14 to 2024–25
- Number of clients by state/territory and age group, 2013–14 to 2024–25
- Number of clients by state/territory and Indigenous status, 2013–14 to 2024–25

Figure AODTS 2: Clients, by client type, sex, age group and Indigenous status, state and territory, 2013–14 to 2024–25



Problem creating image.

The following data visualisations show:

- Number of clients by state/territory and principal drug of concern, 2013–14 to 2024–25
- Number of clients by state/territory and main treatment type, 2013–14 to 2024–25
- Number of clients by state/territory and source of referral, 2013–14 to 2024–25
- Number of clients by state/territory and reason for cessation, 2013–14 to 2024–25



Problem creating image.

New South Wales

In this section

- Overview
- Client demographics
- Drugs of concern
- Treatment
- Agencies

In 2024–25, 513 publicly funded alcohol and other drug (AOD) treatment agencies in New South Wales provided 47,437 treatment episodes to 27,928 clients (tables ST NSW.1, Agcy.1, SCR.21).

New South Wales reported:

- Client numbers were similar between 2023–24 and 2024–25 (27,536 to 27,928).
- The number of clients receiving AOD services between 2013–14 and 2024–25 remained stable, after adjusting for population growth (372 clients per 100,000 people compared with 369 per 100,000, respectively).
- The number of treatment episodes was similar between 2013–14 and 2024–25 (42,406 and 47,437, respectively), peaking in 2018–19 (52,563) (tables ST NSW.2, SCR.21).

New South Wales, 2024–25



Problem creating image.

In 2024–25:

- Most clients in New South Wales attended 1 agency for treatment (79%).
- Clients received an average of 1.7 treatment episodes, lower than the national average (1.9) (tables SCR.2, SCR.23).

Client demographics

In 2024–25:

- Nearly all (98%) clients received treatment for their own alcohol or drug use, of which 2 in 3 people were male (64%) (Figure NSW 1).
- Half (51%) of all clients were aged 30–49 years.
- 1 in 5 (22%) of all clients were Aboriginal and Torres Strait Islander (First Nations) people, consistent with the national proportion (19%).
- The majority (87%) of all clients were born in Australia and nearly all (98%) reported English as their preferred language (tables SCR NSW.1-4, SCR NSW.9-10, SC.5).

Figure NSW 1: AODTS clients by client type and selected demographics, New South Wales, 2024–25



Problem creating image.

New and returning clients

In 2024–25 in New South Wales:

- 2 in 5 (41%, 11,135) of all clients were a new client, who had not previously received AOD treatment since 2013–14, when client reporting was enabled.
- 3 in 5 (59%, 16,297) of all clients were returning clients, who have previously received AOD treatment from a service at some point since 2013–14 (Table SCR.28).

Drugs of concern

In 2024–25:

- Among clients who received treatment episodes for their own alcohol or drug use (46,197 episodes):
 - Alcohol was the most common principal drug of concern (42%, 19,324 episodes).
 - Methamphetamine accounted for 1 in 4 episodes (23%, 10,579), followed by cannabis (13%, 6,207) (Figure NSW 2, Tables ST NSW.6).
- Where additional drugs of concern were reported, cannabis (13%) and nicotine (11%) were the most common additional drugs of concern (Figure NSW.2, Table ST NSW.7).

Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see [technical notes](#)).



Problem creating image.

In 2024–25, for clients who received treatment for their own use of methamphetamine (10,579 episodes), the most common method of use was smoking (53%), followed by injecting (36%) (Figure NSW 3, Table ST NSW.10).

From 2015–16 to 2019–20, the method of use (injecting or smoking) for the principal drug of concern was used to identify methamphetamine-related treatment episodes, this was due to data quality issues and limited coding options within some states and territories impacting reporting over this period.



Problem creating image.

Between 2015–16 and 2024–25:

- Alcohol remained the most common drug of concern, although there was variation in treatment episode numbers during this time, fluctuating from 17,174 to 19,324 over this period.
 - Alcohol treatment episodes increased from 37% of all treatment episodes in 2015–16 to 42% in 2024–25 (Figure NSW 2, Table ST NSW.6).
- Methamphetamine was the second most common principal drug of concern in 2024–25 (23%, 10,579 episodes). Numbers have been relatively stable since 2019–20, when reporting of methamphetamine became more consistent.
 - Methamphetamine treatment episodes ranged between 21% and 24% of all episodes since 2019–20.
- Cannabis was the third most common principal drug of concern, decreasing from 17% (7,951 episodes) to 13% (6,207) in 2024–25 (Figure NSW 2, Table ST NSW.6).

Treatment

In 2024–25, for treatment episodes in New South Wales (47,437):

- Counselling was the most common main treatment provided (35%), followed by support and case management (18%) and withdrawal management (14%).
- Where an additional treatment was provided, supplementary to the main treatment, 'other' treatment (17%) was the most common (Table ST NSW.13). See [technical notes](#) for further information on calculating proportions for additional treatment type.

Between 2015–16 to 2024–25:

- Counselling remained the most common treatment relative to other treatment types, rising from 31% (14,746) in 2015–16 to 42% (16,090) in 2016–17, before dropping to 35% (16,814) in 2024–25.
- The proportion of withdrawal management episodes has remained consistent between 2015–16 and 2024–25 from 14% (6,727) to 14% (6,604) (tables ST NSW.13, NSW.15).



Problem creating image.

Agencies

In 2024–25, in New South Wales:

- 3 in 5 (58%, 295) AOD agencies were government funded treatment agencies.
- 3 in 5 (60%) of the 513 publicly funded treatment services were located in *Major cities*, followed by *Inner regional* areas (32%).
- Agencies located in *Major cities* provided 70% of all treatment episodes.
- One treatment agency was located in *Very remote* areas. Less than 1% (14) of treatment episodes were provided in *Remote and very remote* areas (Figure NSW 5, tables Agcy.1, Agcy.3–4).

Between 2015–16 to 2024–25, the number of publicly funded treatment agencies in New South Wales rose from 286 to 513 (Table Agcy.1).



Problem creating image.

Victoria

In this section

- Overview
- Client demographics
- Drugs of concern
- Treatment
- Agencies

In 2024–25, 337 publicly funded alcohol and other drug (AOD) treatment agencies in Victoria provided 96,640 treatment episodes to 35,492 people (tables Agcy.1, SCR.21).

Victoria reported:

- An 8.3% decrease in client numbers in 2024–25 (35,492) compared with the previous year (38,700).
- Client numbers increased gradually from 2013–14 (29,548), with the largest increase in clients from 2017–18 (33,006) to 2019–20 (37,391).
- Fewer clients are receiving AOD services in 2024–25 than 2013–14, after adjusting for population growth (572 clients per 100,000 people, compared with 580, respectively).
- Clients received an average of 2.7 treatment episodes, which is higher than the national average of 1.9 treatment episodes (tables SCR.21, SCR.23). This is due to:
 - The number of clients receiving two or more treatment episodes is rising and those receiving 1 treatment episode dropping (Table SCR.22). Note: due to the different way Victorian data systems count episodes they are not comparable with other states and territories, as episode counts will be higher (see Data Quality Statement for further information).
- There was a similar number in treatment episodes in 2024–25 (96,640) compared with the previous year (97,509) (Table SCR.21).
- The number of treatment episodes increased by 71% since 2013–14 (56,392) to 2024–25 (96,640) (Table SCR.21).
- 7 in 10 (68%) clients in Victoria attended 1 agency in 2024–25.

Victoria, 2024–25



Problem creating image.

Client demographics

In 2024–25:

- 8 in 10 (77%) clients in Victoria received treatment for their own alcohol or drug use, of which 3 in 5 (61%) people were male (Figure VIC 1, tables SCR VIC.1-2).
- 6.2% of all clients reported sex as 'another term', the highest proportion reported across all states and territories in the collection period. 'Another term' replaced the category 'other' in 2022–23 (Table SCR VIC.2).
- Half (52%) of all people were aged 20–39 years.
- 1 in 10 (11%) of all clients were Aboriginal and Torres Strait Islander (First Nations) people, which is lower than the national proportion (19%).
- The majority (82%) of all clients were born in Australia and most (93%) reported English as their preferred language (tables SCR VIC.1–4, SCR VIC.9–10, SC.5).

Figure VIC 1: AODTS clients by client type and selected demographics, Victoria, 2024–25



Problem creating image.

New and returning clients

In 2024–25:

- 2 in 5 (38%, 13,559) of all clients were a new client, who had not previously received treatment since 2013–14, when client reporting was enabled.
- 3 in 5 (62%, 21,841) of all clients were returning clients, who have previously received AOD treatment from a service at some point since 2013–14 (Table SCR.28).

Drugs of concern

In 2024–25 in Victoria:

- Among clients receiving treatment for their own alcohol or drug use (70,639 episodes)
 - Alcohol was the most common principal drug of concern, accounting for 38% (27,053) of treatment episodes.
 - Methamphetamine (24%, 16,740) was the second most common principal drug of concern, followed by cannabis (16%, 11,019) (Figure VIC 2, Table ST VIC.6).
- Where additional drugs of concern were reported, cannabis was the most common (11% of episodes), followed by nicotine and alcohol (9.2% and 7.6%, respectively) (Figure VIC 2, Table ST VIC.7). Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see [technical notes](#)).

Figure VIC 2: Treatment episodes for own drug use, by drug of concern, Victoria, 2015–16 to 2024–25 (per cent)



Problem creating image.

In 2024–25, for clients who received treatment for their own use of methamphetamine (16,740 episodes), the most common method of use was smoking (58%) (Figure VIC 3, tables ST VIC.6 and ST VIC.10).

From 2015–16 to 2019–20, the method of use (injecting or smoking) for the principal drug of concern was used to identify methamphetamine-related treatment episodes, due to data quality issues and limited coding options within some states and territories over this period.



Problem creating image.

Between 2015–16 and 2024–25:

- Alcohol was the most common principal drug of concern, increasing from 30% of all treatment episodes in 2015–16, rising to 38% in 2024–25. The number of episodes rose from 18,396 in 2015–16 to 27,053 in 2024–25 (Figure VIC 2, Table ST VIC.7).
- The number of treatment episodes for methamphetamine has risen over this period and appears to be still rising from 2019–20, when improvements in reporting reliability is evident, increasing from 12,472 to 16,740 in 2024–25.
 - Methamphetamine has risen from 17% of all treatment episodes to 24% over this period to become the second most common (Figure VIC 2, Table ST VIC.7)

Treatment

In 2024–25, for treatment episodes in Victoria (96,640):

- Support and case management (27%) was the most common treatment type, followed by counselling (21%) (Figure VIC 4, Table ST VIC.13).

Between 2015–16 to 2024–25:

- Support and case management is the most common treatment type in 2024–25 overtaking counselling. It has dropped from 30% of all treatment episodes in 2015–16 to 27% in 2024–25.
- Counselling was one of the most common treatments provided until 2023–24 (23%) falling to 21% in 2024–25, this proportion has nearly halved since 2015–16 (37%).
- Assessment only as a main treatment rose from 13% in 2015–16 to 20% in 2024–25.
- Withdrawal management dropped from 14% to 8.8% and 'other' treatment rose from 1.1% to 19% over the same period (Figure VIC 4, Table ST VIC.13).

Increases in 'other' treatment in Victoria relate to additional funding for programs where the main treatment type was categorised as 'other'. This includes other types of services coded within the Victorian Alcohol and Drug Collection (VADC) (which started in 2018), these may not align with standard main treatment types. See [technical notes](#) for further information on how the VADC counts treatment episodes.



Problem creating image.

Agencies

In 2024–25, in Victoria:

- Only 3 of the 337 AOD agencies were government treatment agencies .
- 3 in 5 (58%) treatment services were located in *Major cities*, followed by *Inner regional* areas (30%) (Figure VIC 5, Table Agcy.3)
- Victoria does not have any areas classified as *Remote* or *Very remote*.

Between 2015–16 to 2024–25:

- The number of publicly funded treatment agencies in Victoria increased from 129 in 2015–16 to 404 in 2018–19, dropping to 337 in 2024–25 (Figure VIC 5, Table Agcy.1).
- The increase in agency numbers over time in Victoria is attributed to counting each location of a service delivery outlet, which may be located in different areas for a single agency.



Problem creating image.

Queensland

In this section

- Overview
- Client demographics
- Drugs of concern
- Treatment
- Agencies

In 2024–25, 196 publicly funded alcohol and other drug (AOD) treatment agencies in Queensland provided 51,868 treatments to 32,112 clients (tables Agcy.1, SCR.21).

Queensland reported:

- There was a 6.4% decrease in clients between 2023–24 and 2024–25 from 34,302 to 32,112.
- Client numbers dropped from 28,960 in 2013–14 to 32,112 in 2024–25.
- Fewer clients are receiving AOD services in 2024–25 than 2013–14, after adjusting for population growth (645 clients per 100,000 people compared with 714, respectively) (Table SCR.21). This is due to:
 - The number of clients receiving two or more treatment episodes is rising while clients receiving 1 treatment episode is dropping (Table SCR.22).
- There was a similar number of treatment episodes in 2024–25 compared with the previous year (51,868 and 51,979, respectively), and a 44% increase since 2013–14 (36,093) (Table SCR.21).

Queensland, 2024–25



Problem creating image.

In 2024–25, most (82%) clients in Queensland attended 1 agency, and received an average of 1.6 treatment episodes, which is lower than the national average of 1.9 treatment episodes (tables SCR.21, SCR.23).

Client demographics

In 2024–25:

- Nearly all (98%) clients received treatment for their own alcohol or drug use, of which 3 in 5 (63%) people were male (Figure QLD 1).
- Clients who received treatment for someone else's alcohol or drug use were more likely to be female (67%).
- Half (50%) of all clients were aged 30–49 years, and 7.7% were aged 10–19 years which was similar to the national proportion for clients aged 10–19 years (7.7%).
- 1 in 5 (21%) of all clients were Aboriginal and Torres Strait Islander (First Nations) people, which is higher than the national proportion (19%).
- The majority (89%) of all clients were born in Australia and nearly all (99%) reported English as their preferred language (tables SCR QLD.1–4, SCR QLD.9–10, SC.5, SC.3).

Figure QLD 1: AODTS clients by client type and selected demographics, Queensland, 2024–25



Problem creating image.

New and returning clients

In 2024–25:

- 2 in 5 (39%, 12,587) of all clients were a new client, who had not previously received treatment since 2013–14.
- 3 in 5 (61%, 19,317) of all clients were returning clients, who have previously received AOD treatment from a service at some point since 2013–14 (Table SCR 28).

Drugs of concern

In 2024–25 in Queensland:

- Among clients receiving treatment episodes for their own alcohol or drug use (51,237):
 - Alcohol was the most common principal drug of concern (40%, 20,652 episodes) (Figure QLD 2, Table ST QLD.6).
 - Methamphetamine was the second most common principal drug of concern in Queensland (25%, 12,790), followed by cannabis (13%, 6,471).
 - In Queensland, the level of cannabis reported as the principal drug of concern is a result of the police and illicit drug court diversion programs operating in the state (Table ST QLD.12).
- Where additional drugs of concern were reported, cannabis was the most common additional drug (7.9% of episodes), followed by nicotine (5.0%) (Figure QLD 2, Table ST QLD.7).

Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see [Technical notes](#)).

Figure QLD 2: Treatment episodes for own drug use, by drug of concern, Queensland, 2015–16 to 2024–25 (per cent)



Problem creating image.

In 2024–25, for clients who received treatment for their own use of methamphetamine (12,790 episodes), the most common method of use was injecting (44%), followed by smoking (40%) (Figure QLD 3, Table ST QLD.10).



Problem creating image.

Between 2015–16 and 2024–25:

- Alcohol was the most common principal drug of concern from 2018–19 onwards, overtaking cannabis.
 - Alcohol as a principal drug of concern increased from 27% of all treatment episodes in 2015–16 to 40% in 2024–25. The number of treatment episodes over this period almost doubled from 11,734 to 20,652 (Table ST QLD.7).
- Cannabis was the second most common principal drug of concern, with episodes decreasing from 39% of all treatment episodes in 2014–15 to 13% in 2024–25. Over this period the number of treatment episodes decreased from 16,929 to 6,471.
- The number of episodes for methamphetamine has been rising over this period and appears to be still rising from 2019–20 when improvements in the reliability of methamphetamine reporting is evident, increasing from 10,448 to 12,790 over this period.
 - Methamphetamine as a principal drug of concern increased from 23% of all treatment episodes in 2019–20 to 25% in 2024–25.
- The proportion of treatment episodes in Queensland where cannabis was the principal drug of concern was lower than the national proportion in 2024–25 (13% compared with 14%) (Table Drg.1). This has broken the 10-year trend where it has been consistently higher than the national proportion.

Treatment

Changes to AOD reporting in Queensland

Changes in assessment-only episodes in Queensland should be interpreted with caution. From 2020–21, changes to Queensland's public alcohol and other drug reporting arrangements improved the capture of referral-stage and early service activity that resulted in increases in treatment episodes with assessment only as the main treatment type.

Assessment-only episodes should also be interpreted in the context of how AODTS NMDS activity is reported. Closed treatment episode counts measure the number of episodes provided, but do not reflect the relative duration or intensity of treatment. Assessment-only episodes in Qld are generally higher-volume and shorter-duration than other treatment types such as counselling, support and case management, rehabilitation or withdrawal management. See [Data Quality Statement](#) for further information.

In 2024–25, for treatment episodes in Queensland (51,868):

- Assessment only was the most common main treatment (41%), followed by counselling (35%) (Figure QLD 4).
- The proportion of episodes for information and education as a main treatment dropped 19 percentage points from 2019–20 (21%) to 2024–25 (2.2%). This was due to a review of coding practices which resulted a large proportion of episodes previously coded as information and education being coded as counselling (Table ST QLD.13).

- Where an additional treatment was provided as supplementary to the main treatment, information and education (1.7%) was also the most common type of additional treatment. See [technical notes](#) for further information on calculating proportions for additional treatment type.

Between 2015–16 to 2024–25:

- Assessment only replaced counselling as the most common main treatment type from 2023–24.
 - The proportion of main treatment episodes where assessment only was the main treatment type increased from 17% in 2015–16 to 41% in 2024–25.
- Counselling as the main treatment type increased from 32% in 2015–16 to 35% in 2024–25 and was surpassed as the most common main treatment in 2023–24.
- The proportion of withdrawal management as a main treatment type decreased from 8.4% to 3.1% in 2024–25.
- The proportion of information and education as a main treatment decreased from 33% in 2015–16 to 2.3% in 2024–25.

Figure QLD 4: Treatment episodes, by treatment type, Queensland, 2015–16 to 2024–25 (per cent)



Problem creating image.

Agencies

In 2024–25, in Queensland:

- 7 in 10 (71%) AOD agencies were non-government treatment agencies (Table Agcy.1).
- Almost half (45%) of the 196 treatment agencies were located in *Major cities*, followed by *Outer regional* (24%) and *Inner regional* (19%) areas.
- 1 in 10 (12%) of all government treatment agencies were located in *Remote and very remote* areas (Figure QLD 5, Table Agcy.3).

In the 10 years to 2024–25, the number of publicly funded treatment agencies in Queensland steadily increased from 158 in 2015–16 to 194 in 2019–20, falling to 196 in 2024–25 (Table Agcy.1).



Problem creating image.

Western Australia

In this section

- Overview
- Client demographics
- Drugs of concern
- Treatment
- Agencies

In 2024–25, 127 publicly funded alcohol and other drug (AOD) treatment agencies in Western Australia provided 20,327 treatment episodes to 14,773 clients (tables Agcy.1, SCR.21).

Western Australia reported:

- Client numbers increased from 2013–14 (15,146) to 2018–19 (19,348), before decreasing steadily to 14,773 in 2024–25.
- Fewer clients are receiving AOD services in 2024–25 than 2013–14, after adjusting for population growth (556 compared with 697 per 100,000 people, respectively) (Table SCR.21). This is due to:
 - Clients receiving two or more treatment episodes is rising while clients receiving 1 treatment episode is dropping (Table SCR.22).
- There was a similar number of treatment episodes in 2024–25 compared with the previous year (20,327 and 19,639, respectively), while over a longer period there has been a 2.6% decrease since 2013–14 (20,867) (Table SCR.21).

Western Australia, 2024–25



Problem creating image.

In 2024–25, most (82%) clients in Western Australia attended 1 treatment agency, and received an average of 1.4 treatment episodes, which is lower than the national average of 1.9 treatment episodes (tables SCR.21, SCR. 23).

Client demographics

In 2024–25 in Western Australia:

- Most (95%) clients received treatment for their own alcohol or drug use, of which 2 in 3 (63%) people were male (Figure WA 1).

- 3 in 4 people who received treatment for someone else's alcohol or drug use were female (77%).
- Half (54%) of the people who received treatment for their own alcohol or drug use were aged 30–49 years. In contrast, people who received treatment for someone else's alcohol or drug use were more likely to be aged 50 and over (52%).
- 1 in 5 (21%) of all clients were Aboriginal and Torres Strait Islander (First Nations) people, which is higher than the national proportion (19%).
- The majority (81%) of all clients were born in Australia and nearly all (98%) reported English as their preferred language (tables SCR WA.1–4, SCR WA.9-10, SC.5).

Figure WA 1: AODTS clients by client type and selected demographics, Western Australia, 2024–25



Problem creating image.

New and returning clients

In 2024–25:

- 2 in 5 (43%, 6,312) of all clients were a new client, who had not previously received treatment since 2013–14.
- 3 in 5 (57%, 8,419) of all clients were returning clients, who have previously received AOD treatment from a service at some point since 2013–14 (Table SCR.28).

Drugs of concern

In 2024–25 in Western Australia:

- Among clients receiving treatment episodes for their own alcohol or drug use (19,412):
 - Alcohol was the most common principal drug of concern (46%, 8,827).
 - Methamphetamine was the second most common principal drug of concern (26%, 4,952) (Figure WA 2, tables ST WA.2 and ST WA.6).
- Where additional drugs of concern were reported, cannabis was the most common additional drug (18% of episodes), followed by alcohol (11%) (Figure WA 2, Table ST WA.7).
 - Clients can nominate up to 5 additional drugs of concern; however, these drugs are not necessarily the subject of any treatment within the episode (see [technical notes](#)).



Problem creating image.

In 2024-25, for clients who received treatment for their own use of methamphetamine (4,952 episodes), the most common method of use was injecting (49%), followed by smoking (46%) (Figure WA 3, Table ST WA.10).



Problem creating image.

Between 2015–16 to 2024–25:

- Alcohol as a principal drug of concern rose from 30% (6,739) of all treatment episodes in 2015–16 to 46% (8,827 episodes) in 2024–25. Alcohol replaced amphetamine-related episodes as the most common principal drug of concern from 2020–21 (40%, 8,548).
- Amphetamines were the most common principal drug of concern between 2016–17 (36%) and 2019–20 (34%), with methamphetamine in over 4 in 5 of all amphetamine-related episodes over this period.
 - Methamphetamine has remained the second most common principal drug of concern since 2020–21 (25%) to 2024–25 (26%) (Table ST WA.6).
- The proportion of treatment for cannabis decreased from 23% in 2015–16 to 15% in 2024–25.

Treatment

In 2024–25, for treatment episodes in Western Australia (20,327), counselling was the most common treatment provided (61%), followed by support and case management 12% (Figure WA 4, Table ST WA.13).

Between 2015–16 to 2024–25:

- Counselling remained the most common main treatment for all episodes.
- The proportion of episodes where counselling was a main treatment type remained substantially higher in Western Australia than nationally over the period, ranging from 61% to 71% in Western Australia compared with 32% to 40% nationally (tables ST WA.13, Trt.3).
- The next most common main treatment types were support and case management (6.4% to 12%) and withdrawal management (7.7% to 7.7%).



Problem creating image.

Agencies

In 2024–25, in Western Australia:

- 9 in 10 (90%) AOD agencies were non-government treatment agencies (Table Agcy.1).
- 3 in 5 (58%) of the 127 treatment agencies were located in *Major cities* (Figure WA 5, Table Agcy.3).
- *Very remote* areas were the only areas where there were more government than non-government agencies (8 and 5, respectively).

In the 10 years from 2015–16 to 2024–25, the number of publicly funded treatment agencies in Western Australia rose from 79 to 127 (Table Agcy.1).



Problem creating image.

South Australia

In this section

- Overview
- Client demographics
- Drugs of concern
- Treatment
- Agencies

In 2024–25, 84 publicly funded alcohol and other drug (AOD) treatment agencies in South Australia provided 12,706 treatment episodes to 8,721 clients (tables Agcy.1, SCR.21).

South Australia reported:

- Client numbers decreased steadily from 9,215 in 2013–14 to 7,989 in 2023–24, before increasing to 8,721 in 2024–25.
- Fewer clients are receiving AOD services in 2024–25 than 2013–14, after adjusting for population growth (516 clients per 100,000 people compared with 624, respectively) (Table SCR.21).
- Treatment episodes have fluctuated since 2015–14, falling from 13,155 to 9,689 in 2021–22, then rising to 12,706 in 2024–25 (Table SCR.21).

South Australia, 2024–25



Problem creating image.

In 2024–25, most (82%) clients in South Australia attended 1 agency, and received an average of 1.5 treatment episodes, which is lower than the national average of 1.9 treatment episodes (tables SCR.21, SCR.23).

Client demographics

In 2024–25 in South Australia:

- Nearly all (98%) clients received treatment for their own alcohol or drug use, of which 3 in 5 (63%) people were male (Figure SA 1).
- 7 in 10 people who received treatment for someone else's alcohol or drug use were female (68%).
- Half (54%) of all people were aged 30–49 years.

- 1 in 6 (18%) people were Aboriginal and Torres Strait Islander (First Nations) people, which is less than the national proportion (19%).
- The majority (85%) of clients were born in Australia and nearly all (92%) reported English as their preferred language (tables SCR SA.1–4, SCR SA.9–10, SC.5).

Figure SA 1: AODTS clients by client type and selected demographics, South Australia, 2024–25



Problem creating image.

New and returning clients

In 2024–25:

- 2 in 5 (44%, 3,800) of all clients were a new client, who had not previously received treatment since 2013–14.
- More than half (56%, 4,874) of all clients were returning clients, who have previously received AOD treatment from a service at some point since 2013–14 (Table SCR 28).

Drugs of concern

In 2024–25 in South Australia:

- Among clients receiving treatment episodes for their own alcohol or drug use (12,539):
 - Alcohol was the most common principal drug of concern (35%, 4,408 episodes).
 - Methamphetamine accounted for one-quarter of treatment episodes (25%, 3,141), followed by cannabis (13%, 1,570) (Figure SA 2, Table ST SA.6).
- Where additional drugs of concern were reported, nicotine was the most common (24% of episodes), followed by cannabis (18%) (Figure SA 2, Table ST SA.7). Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see [technical notes](#)).

Figure SA 2: Treatment episodes for own drug use, by drug of concern, South Australia, 2015-16 to 2024-25 (per cent)



Problem creating image.

In 2024-25, for clients who received treatment for their own use of methamphetamine (3,141 episodes), the most common method of use was smoking (62%), followed by injecting (28%) (Figure SA 3, Table ST SA.10).



Problem creating image.

Between 2015–16 and 2024–25:

- Alcohol remains the most common principal drug of concern since 2020–21, increasing from 3,971 episodes to 4,408 in 2024–25. Alcohol replaced amphetamines as the most common principal drug of concern from 2020–21.
 - Alcohol rose from 29% of all treatment episodes in 2015–16, peaking at 41% in 2021–22, before falling to 35% in 2024–25 (Table ST SA.7).
- In South Australia, amphetamines were the most common principal drug of concern between 2015–16 (36%) and 2019–20 (35%). Methamphetamine was reported as a principal drug of concern in 7 in 10 of amphetamine-related episodes, when improvements in reporting reliability is evident, from 2018–19 onwards.
 - Methamphetamine has remained the second most common principal drug of concern since 2020–21 (25%) to 2024–25 (25%).

The proportion of treatment episodes for amphetamines/methamphetamine as a principal drug of concern has been consistently higher in South Australia than the national proportion overtime. This is related to a state government legislated program regarding assessments provided under a Police Drug Diversion initiative. The program results in comparatively high proportions of engagement with methamphetamine users.

In addition, due to the Cannabis Expiation Notice legislation in South Australia, adult simple cannabis offences are not diverted to treatment and so are not included in the data (see the [Data Quality Statement](#)).

Treatment

In 2024–25, for treatment episodes in South Australia (12,706):

- Counselling was the most common main treatment (42% of episodes), followed by assessment only (20%) and withdrawal management (13%) (Figure SA 4, Table ST SA.13).
- Where an additional treatment was provided as a supplementary to the main treatment, support and case management (15%) was the most common additional treatment. See [technical notes](#) for further information on calculating proportions for additional treatment type.

Between 2015–16 to 2024–25:

- Counselling as a main treatment rose from 2,684 to 5,384 episodes over this period, increasing from 24% of all episodes in 2015–16 to 42% in 2024–25.
- The number of episodes with rehabilitation as a main treatment fell from 5.5% (618) of all treatment episodes to 1.2%, with 153 treatment episodes provided in 2024–25.
- Assessment only as the main treatment decreased from 4,656 episodes to 2,604 over this period, falling from 42% of all episodes to 20% in 2024–25 (tables ST SA.13, Trt.3).

The high proportion of assessment only treatment episodes relates, in part, to the SA Police Drug Diversion Initiative (PDDI).

Figure SA 4: Treatment episodes, by treatment type, South Australia, 2015–16 to 2024–25 (per cent)



Problem creating image.

Agencies

In 2024–25, in South Australia:

- 3 in 5 (62%) AOD treatment agencies were non-government agencies (Table Agcy.1).
- Nearly 3 in 5 (56%) of all treatment agencies were located in *Major cities*, followed by *Outer regional areas* (24%) and *Inner regional areas* (14%) (Figure SA 5, Table Agcy.3).
- In *Very remote* areas all agencies (2) were government organisations.

Between 2015–16 and 2024–25, the number of publicly funded treatment agencies in South Australia increased from 78 to 84 (Table Agcy.1).



Problem creating image.

Tasmania

In this section

- Overview
- Client demographics
- Drugs of concern
- Treatment
- Agencies

In 2024–25, 20 publicly funded alcohol and other drug (AOD) treatment agencies in Tasmania provided 3,685 treatment episodes to 2,804 clients (tables Agcy.1, SCR.21).

Tasmania reported:

- Client numbers increased from 2,432 in 2013–14 to 2,804 in 2024–25.
- Client numbers between 2013–14 and 2024–25 remained stable, after adjusting for population growth (543 clients per 100,000 people compared with 540, respectively) (Table SCR.21).
- There was a similar number of treatment episodes in 2024–25 compared with the previous year (3,685 and 3,703, respectively), and a 30% increase since 2013–14 (2,841) (Table SCR.21).

Tasmania, 2024–25



Problem creating image.

In 2024–25, most (88%) clients in Tasmania attended 1 treatment agency, and received an average of 1.3 treatment episodes, which is lower than national average of 1.9 treatment episodes (tables SCR.21, SCR.23).

Client demographics

In 2024–25 in Tasmania:

- Most (94%) clients received treatment for their own alcohol or drug use, of which 3 in 5 (61%) people were male (Figure TAS 1).
- People who received treatment for someone else's alcohol or drug use were most likely to be female (71%).

- Half (48%) of all clients were aged 30–49 years.
- 1 in 7 (15%) of all clients were Aboriginal and Torres Strait Islander (First Nations) people, which is lower than the national proportion (19%).
- The majority (93%) of all clients were born in Australia and nearly all (96%) reported English as their preferred language (tables SCR TAS.1–4, SCR TAS.9–10, SC.5).

Figure TAS 1: AODTS clients by client type and selected demographics, Tasmania, 2024–25



Problem creating image.

New and returning clients

In 2024–25:

- Half (47%, 1,295) of all clients were a new client, who had not previously received treatment since 2013–14.
- Half (53%, 1,481) of all clients were returning clients, who have previously received AOD treatment from a service at some point since 2013–14 (Table SCR 28).

Drugs of concern

In 2024–25 in Tasmania:

- Among clients receiving treatment episodes for their own alcohol or drug use (3,473):
 - Alcohol was the most common principal drug of concern (48%, 1,658 episodes) (Figure TAS 2, Table ST TAS.7)
 - Methamphetamine was the second most common, accounting for 1 in 5 treatment episodes (21%, 718).

Figure TAS 2: Treatment episodes for own drug use, by drug of concern, Tasmania, 2015-16 to 2024-25 (per cent)



Problem creating image.

In 2024-25, for clients who received treatment for their own use of methamphetamine (718 episodes), the most common method of use was injecting (41%), followed by smoking (39%) (Figure TAS 3, Table ST TAS.10).



Problem creating image.

Between 2015–16 to 2024–25:

- Alcohol was the most common principal drug of concern, increasing from 39% of all episodes in 2015–16 (1,379) to 48% (1,658) in 2024–25 (Table ST TAS.7).
- Treatment episodes for methamphetamine increased when improvements in reporting reliability was evident from 2019–20 (971), falling in 2024–25 (718 episodes).
- Treatment episodes for cannabis decreased from 26% (918) of all treatment episodes to 14% (498).

Treatment

In 2024–25, for treatment episodes in Tasmania (3,685):

- Counselling was the most common main treatment (58% of episodes), followed by Assessment only (18%) (Figure TAS 4, Table ST TAS.13).
- Where an additional treatment was provided as a supplementary to the main treatment, support and case management (5.4%) was the most common type of additional treatment. See [technical notes](#) for further information on calculating proportions for additional treatment type.

Between 2015–16 to 2024–25:

- Counselling remained the most common main treatment, with episodes rising from 1,645 (43%) in 2015–16 to 2,143 (58%) in 2024–25.
- Assessment only decreased from 1,102 (29%) episodes to 647 (18%) in 2024–25.
- The number of episodes with rehabilitation rose from 568 (15%) in 2015–16 peaking at 882 (24%) in 2023–24, before dropping by half to 401 (11%) in 2024–25.
- The proportion of episodes for rehabilitation in Tasmania is higher than the national proportion over this period (ranging from 6–8%) (tables ST TAS.13, Trt.1).



Problem creating image.

Agencies

In 2024–25, in Tasmania:

- 8 in 10 (80%) AOD treatment agencies were non-government agencies.
- 55% of agencies were located in *Inner regional* areas, followed by *Outer regional* (45%) (Figure TAS 5, Table Agcy.3).
- Agencies located in *Inner regional* and *Outer regional* areas were more likely to be non-government organisations.

Between 2015–16 and 2024–25, the number of publicly funded treatment agencies in Tasmania increased from 23 in 2015–16 to 27 in 2017–18, before decreasing to 20 in 2024–25 (Table Agcy.1). For further information on remoteness areas see [technical notes](#) for further details.



Problem creating image.

Australian Capital Territory

In this section

- Overview
- Client demographics
- Drugs of concern
- Treatment
- Agencies

In 2024–25, 16 publicly funded alcohol and other drug (AOD) treatment agencies in the Australian Capital Territory provided 6,686 treatment episodes to 3,921 clients (tables Agcy.1, SCR.21).

The Australian Capital Territory reported:

- Client numbers increased from 2,949 in 2013–14 to 4,109 in 2017–18, then fell to 3,921 in 2024–25.
- More clients were receiving AOD services in 2024–25 than 2013–14, after adjusting for population growth (918 clients per 100,000 people compared with 877, respectively) (Table SCR.21).
- There was a 44% increase in treatment episodes between 2013–14 and 2024–25, from 4,652 to 6,684 (Table SCR.21).

Australian Capital Territory, 2024–25



Problem creating image.

In 2024–25, most (82%) clients in the Australian Capital Territory attended 1 agency, and received an average of 1.7 treatment episodes (tables SCR.21, SCR.23).

Client demographics

In 2024–25 in the Australian Capital Territory:

- Nearly all (92%) clients received treatment for their own alcohol or drug use, of which 2 in 3 (66%) people were male (Figure ACT 1).
- People who received treatment for someone else's alcohol or drug use were more likely to be female (65%).
- Half (48%) of all clients were aged 30–49 years.

- 1 in 7 (16%) of all clients were Aboriginal and Torres Strait Islander (First Nations) people, which is lower than the national proportion (19%).
- The majority (85%) of all clients were born in Australia and nearly all (98%) reported English as their preferred language (tables SCR ACT.1-4, SCR ACT.9-10, SC.5).

Figure ACT 1: AODTS clients by client type and selected demographics, Australian Capital Territory, 2024-25



Problem creating image.

New and returning clients

In 2024-25:

- 2 in 5 (42%, 1,577) of all clients were a new client, who had not previously received treatment since 2013-14.
- 3 in 5 (58%, 2,196) of all clients were returning clients, who have previously received AOD treatment from a service at some point since 2013-14 (Table SCR 28).

Drugs of concern

In 2024-25 in the Australian Capital Territory:

- Among clients receiving treatment episodes for their own alcohol or drug use (6,334):
 - Alcohol was the most common principal drug of concern (45%, 2,816 episodes) (Figure ACT 2, Table ST ACT.7).
 - Methamphetamine was the second most common, accounting for 1 in 5 (22%, 1,380) treatment episodes.
- Where additional drugs of concern were reported, nicotine was the most common additional drug (21% of episodes), followed by cannabis (16%) (Figure ACT 2, Table ST ACT.7). Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see [technical notes](#)).



Problem creating image.

In 2024-25, for clients who received treatment for their own use of methamphetamines (1,184 episodes), the most common method of use was smoking (39%), followed by injecting (34%) (Figure ACT 3, Table ST ACT.10).



Problem creating image.

Between 2015–16 to 2024–25:

- Alcohol was the most common principal drug of concern accounting for 42% (2,450) of all treatment episodes in 2015–16, increasing to 45% (2,816) in 2024–25.
- Methamphetamine numbers fluctuated over this period, increasing from 2020–21 when improvements in reporting reliability were evident, from 1,009 treatment episodes to 1,380 in 2024–25.
 - Methamphetamine increased from 17% to 22% of all treatment episodes over this period to 2024–25.
- The proportion of episodes for heroin as a principal drug of concern over the period in the ACT, was higher than the national rate, peaking in 2021–22 (14%) compared with 4.5% nationally, falling to 5% in 2024–25 compared with 4% nationally (Table Drg.5).
- Cannabis as the principal drug of concern steadily declined from 2015–16 (15% of all treatment episodes to 11% in 2024–25) (Table ST ACT.7).

Treatment

In 2024–25, for treatment episodes in the Australian Capital Territory (6,686):

- Information and education was the most common main treatment type (33% of episodes) (Figure ACT 4, Table ST ACT.13).
- Counselling was the second most common treatment (24%), followed by withdrawal management (11%).
- Where an additional treatment was provided as a supplementary to the main treatment, information and education (4.1%) was the most common additional treatment. See [technical notes](#) for further information on calculating proportions for additional treatment type.

Between 2015–16 to 2024–25:

- Information and education as a main treatment rose from 1,424 (24%) episodes in 2015–16 to 2,227 (33%) in 2024–25
- The number of episodes with counselling as a main treatment rose from 1,272 (22%) in 2015–16, to 1,877 (28%) in 2018–19, fluctuating until 2024–25 (1,619, 24%).
- The ACT had more information and education as main treatment compared to nationally (ranging from 24% to 33% in the ACT compared with 2.0% to 9.0% nationally) (tables ST ACT.13, Trt.3). Note that in the ACT counselling and information and education episodes are defined and counted differently, with counselling requiring minimum qualifications and structured delivery. Differences in classification practices may affect comparability across jurisdictions. See [technical notes](#) for further information.

Figure ACT 4: Treatment episodes, by treatment type, Australian Capital Territory, 2015-16 to 2024-25 (per cent)



Problem creating image.

Agencies

In 2024-25 in the Australian Capital Territory, the majority of treatment agencies are non-government organisations (94%) (Figure ACT 5, Table Agcy.3). Between 2015-16 to 2024-25, the number of publicly funded treatment agencies rose from 15 to 16 agencies (Table Agcy.1).



Problem creating image.

Northern Territory

In this section

- Overview
- Client demographics
- Drugs of concern
- Treatment
- Agencies

In 2024–25, 23 publicly funded alcohol and other drug (AOD) treatment agencies in the Northern Territory provided 5,062 treatment episodes to 3,136 clients (tables Agcy.1–2, SCR.21).

The Northern Territory reported:

- A decrease in client numbers in 2024–25 compared with the previous year (3,136 and 3,429, respectively). Over a longer period, client numbers have been decreasing since a peak in 2019–20.
- Fewer clients are receiving AOD services in 2024–25 than 2013–14, after adjusting for population growth (1,381 clients per 100,000 people compared with 1,397 per 100,000, respectively) (Table SCR.21).
- There was a 11% drop in treatment episodes in 2024–25 (5,062) compared with the previous year (5,678), while over a longer period episodes continued to decrease since a peak in 2019–20 (8,565) (Table ST NT.2).

Northern Territory, 2024–25



Problem creating image.

In 2024–25, most (82%) clients in the Northern Territory attended 1 treatment agency, and received an average of 1.6 treatment episodes, which is lower than the national average of 1.9 treatment episodes (tables SCR.21, SCR.23).

Client demographics

In 2024–25 in the Northern Territory:

- Most (94%) clients received treatment for their own alcohol or drug use, of which 7 in 10 (72%) people were male (Figure NT 1)

- People who received treatment for someone else's alcohol or drug use were more likely to be female (65%).
- Over half (56%) of all people were aged 20–39 years, and 11% of people were aged 10–19 years which is higher than national proportion (7.7%).
- 7 in 10 (73%) of all clients were Aboriginal and Torres Strait Islander (First Nations) people, 4 times higher than the national proportion (19%).
- Nearly all (95%) people were born in Australia and 3 in 5 (63%) reported English as their preferred language, with 1 in 3 (33%) reporting Indigenous languages as their preferred language (tables SCR NT.1–4, SC.3–5).

Figure NT 1: AODTS clients by client type and selected demographics, Northern Territory, 2024–25



Problem creating image.

New and returning clients

In 2024–25:

- 2 in 5 (40%, 1,247) of all clients were a new client, who had not previously received treatment since 2013–14.
- 3 in 5 (60%, 1,867) of all clients were returning clients, who have previously received AOD treatment from a service at some point since 2013–14 (Table SCR.28).

Drugs of concern

In 2024–25 in the Northern Territory:

- Among clients receiving treatment episodes for their own alcohol or drug use (4,831):
 - Alcohol was the most common principal drug of concern for clients (60%, 2,894 episodes) (Figure NT 2, Table ST NT.7).
 - Cannabis (18%, 846) and methamphetamine (12%, 563) were the second and third most common principal drugs of concern.
 - Volatile solvents (1.8%, 87) were the next most common principal drug of concern, with proportions higher than the national level (less than 1%) (Table Drg.1).
- Where additional drugs of concern were reported, cannabis was the most common additional drug of concern (26% of episodes), followed by cocaine (24%) (Figure NT 2, Table ST NT.7). Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see [technical notes](#)).



Problem creating image.

In 2024-25, for clients who received treatment for their own use of methamphetamine (563 episodes), the most common method of use was injecting (49%), followed by smoking (43%) (Figure NT 3; Table ST NT.10).



Problem creating image.

Between 2015–16 to 2024–25:

- Alcohol remained the most common principal drug of concern, with the number of treatment episodes peaking in 2020–21 (5,531) before declining to 2,894 in 2024–25.
 - Alcohol rose from 48% of all treatment episodes in 2015–16 to peak at 72% in 2020–21, falling to 60% in 2024–25.
 - More treatment episodes are provided for alcohol relative to other principal drugs of concern in the NT than any other jurisdiction (for example, 60% compared with 41% nationally in 2024–25) (tables ST NT.7, Drg.1).
- Methamphetamine numbers fluctuated over this period alongside similar variability in all other amphetamines, making reporting of trends unreliable.
 - Methamphetamine numbers varied between 649 and 392 from 2020–21, with 563 treatment episodes reported in 2024–25, ranging from 8% to 12% of all treatment episodes over this period (tables ST NT.7, Drg.1).
- The proportion of treatment episodes for volatile solvents as a principal drug of concern decreased from 12% in 2015–16 to 1.8% in 2024–25 (Table Drg.1).

Treatment

In 2024–25, for treatment episodes in the Northern Territory (5,062):

- Assessment only was the most common main treatment (46% of episodes), followed by counselling (20%) and rehabilitation (16%) (Figure NT 4, Table ST NT.13).
- Where an additional treatment was provided as a supplementary to the main treatment, 'other' main treatment was the most common additional treatment (22%), (Table ST NT.13). See [technical notes](#) for further information on calculating proportions for additional treatment type.

Assessment only in the Northern Territory

All agencies in the Northern Territory are required to undertake a separate assessment only episode prior to the commencement of treatment. This supports consistent recording of assessment activity, including instances where treatment does not proceed, and enables analysis of client flow and subsequent treatment pathways.

Between 2015–16 and 2024–25:

- Assessment only remained the most common main treatment type over this period, rising from 1,930 (37%) episodes in 2015–16 to a peak in 2020–21 (3,569), then falling in 2024–25 (2,316, 46%).

- The number of episodes with counselling as the main treatment fluctuated between 1,155 (22%) in 2015–16, to 932 in 2022–23 increasing to 1,021 (20%) in 2024–25.
- The number of episodes with rehabilitation as a main treatment peaked in 2016–17 (1,343), then fluctuated until 2024–25 (816) (Table ST NT.13).

Figure NT 4: Treatment episodes, by treatment type, Northern Territory, 2015–16 to 2024–25 (per cent)



Problem creating image.

Agencies

In 2024–25:

- The majority of the 23 treatment agencies were in non-government services (78%).
- *Outer regional* areas contained the most treatment agencies (48%), followed by *Remote* areas (39%) (Figure NT 5, Table Agcy.3).

Between 2015–16 and 2024–25, the number of publicly funded treatment agencies has remained consistent (23 and 23 respectively) (Table Agcy.1).



Problem creating image.

Technical notes - state and territory summaries

In this section

- General notes
- Client demographics
- Drugs of concern
- Treatment
- Agencies
- Data quality statement
- Data

General notes

1. Data are subject to minor revisions over time.
2. Components of figures may not sum to totals due to rounding.

Client demographics

1. Data are based on client records with a valid Statistical Linkage Key (SLK-581).
2. Client data exists from the 2013–14 collection onwards.
3. The client data used in these visualisations is not imputed. Therefore, these numbers may differ from what have been previously published.
4. Rates are crude rates based on the Australian estimated resident population as at 31 December of the reference year. Rates for previous years may differ to those previously reported due to updated estimated resident populations.
5. Proportions are calculated based on overlapping unit record data sorted by state/territory. As clients can receive treatment in multiple states/territories within the same collection period, the total number of clients is less than the summed number of clients for each state/territory. Therefore, the proportions by each state/territory may differ from those reported elsewhere as they are calculated from the summed number of clients in each state/territory.
6. The COVID-19 pandemic and the resulting Australian Government closure of the international border from 20 March 2020, caused significant disruptions to the usual Australian population trends. This report uses Australian Estimated Resident Population (ERP) estimates that reflect these disruptions.

In the year July 2020 to June 2021, the overall population growth was much smaller than the years prior and in particular, there was a relatively large decline in the population of Victoria. ABS reporting indicates these were primarily due to net-negative international migration ([National, state and territory population, June 2021](#)).

Please be aware that this change in the usual population trends may complicate interpretation of statistics calculated from these ERPs. For example, rates and proportions may be greater than in previous years due to decreases in the denominator (population size) of some sub-populations.

Drugs of concern

1. Unlike the principal drug of concern, additional drug/s of concern is not necessarily the subject of any treatment within the episode.
2. The proportion of episodes for an additional drug of concern is calculated by the number of treatment episodes for that particular additional drug (up to 5 drug types can be reported) divided by the total number of treatment episodes for clients who received treatment for their own alcohol or drug use in the collection year.
3. From 2015–16 to 2019–20, the *method of use* (injecting or smoking) for the principal drug of concern was used to identify methamphetamine-related treatment episodes, due to data quality issues and limited coding options within some states and territories over this period.
4. The AODTS NMDS contains data on drugs of concern that are coded using the ABS's Australian Standard Classification of Drugs of Concern (ASCDC) ([ABS 2011](#)). Pharmaceuticals were grouped using the following 10 drug categories and ASCDC codes:

Table 1: Pharmaceutical drugs of concern, ASCDC codes and classifications

Drug category	ASCDC code
Codeine	1101
Morphine	1102
Buprenorphine	1201
Oxycodone	1203
Methadone	1305
Benzodiazepines	2400–2499
Steroids	4000–4999
Other opioids	1100, 1199, 1200, 1299, 1300–1304, 1306–1399

Other analgesics	0005, 1000, 1400–1499
Other sedatives and hypnotics	2000, 2200–2299, 2300–2399, 2500–2599, 2900–2999

Jurisdictional notes regarding principal drug of concern

In 2019–20, Victoria reported comparatively high incidences of 'Not stated drugs' (15%) as the drug of concern. This proportion decreased in 2020–21 (2.1%), due to work with service providers by the Victorian Agency for Health Information to encourage more specific reporting of drug of concern. In 2024–25, this remains low, 2.5% of treatment episodes. For more information see the [Data quality statement](#).

In Queensland, the level of cannabis reported as the principal drug of concern is a result of the Police Drug Diversion Program, Illicit Drugs Court Diversion Program and Drug and Alcohol Assessment Referral Program (DAAR) operating in the state.

South Australia reports a high proportion of treatment episodes where amphetamines are the principal drug of concern due to the SA Police Drug Diversion Initiative (PDDI). In addition, adult cannabis offences are not included in the PDDI due to the SA Cannabis Expiation Notice legislation.

In the Australian Capital Territory, removal of criminal penalties for possession of small quantities of cannabis in the ACT at the end of January 2020 reduced the number of cannabis-related diversions recorded as treatment episodes to low levels (mainly under-18s). Data collection improvements at government-operated services resulted in fewer 'not stated' responses in the 2022–23 collection.

Treatment

1. The proportion of episodes for an additional treatment type is calculated by the number of treatment episodes for that particular additional treatment type divided by the total number of treatment episodes for main treatment type in the collection year.
2. Rehabilitation, withdrawal management (detoxification), and pharmacotherapy are not available for clients who received treatment for someone else's alcohol or other drug use.
3. The main treatment type of 'other' includes pharmacotherapy. In 2019–20, changes were made to categories under Main Treatment; the word 'only' was removed from code 5 (support and case management) and code 6 (information and education). The removal of the word 'only' from support and case management and information and education, changed reporting rules for agencies; allowing agencies to be able to report and more accurately capture these items as an additional treatment in conjunction with a main treatment type. Main treatment code for 'Other' changed from 8 to 88.
4. Changes were also made to Other Treatment type (or additional treatment) categories, which added the codes 5 (Support and case management) and code 6 (Information and education) as categories to allow agencies to better reflect and record the current use of these treatment types in services. Other treatment type coding for the category 'Other' changed from 5 to 88.
5. In 2019–20, 2020–21 and 2021–22, unprecedented restrictions related to the COVID-19 pandemic impacted delivery of some AOD services including withdrawal management, residential rehabilitation, counselling and face-to-face outreach services, which moved to providing telehealth services to ensure social distancing guidelines were met. Withdrawal and rehabilitation bed-based occupancy decreased compared to pre-COVID occupancy in most states. See [State and Territory Data Quality](#) for further information.
6. In Victoria, the majority of services that submit AODTS NMDS data use the Victorian Alcohol and Drug Collection (VADC), which does not differentiate between main and other treatment types. The small proportion of services that submit data directly to the AIHW do not need to comply to VADC collection requirements and thus will apply different counting methods to that used by the VADC.
7. In the Australian Capital Territory, an episode of 'constructive talking about AOD issues' is counted as information and education, unless the AOD worker has a recognised counselling qualification and the session is structured as a counselling session then the episode is counted counselling. Differences in classification practices may affect comparability across jurisdictions.

Agencies

1. An agency's remoteness area is derived by applying an ABS Australian Statistical Geography Standard (ASGS) Edition 3 Remoteness Structure 2021 and 2021 to Statistical Area Level 2 code (SA2) correspondence. Some SA2s are split between multiple remoteness areas. Where this is the case, the data are weighted according to the proportion of the population of the SA2 in each remoteness area. As a result, it is possible that the number of agencies in a particular remoteness area is not a whole number. After rounding, this can result in there being '<0.5' or '<0.5%' of agencies in a remoteness area due to the agency's SA2 partially crossing into the remoteness area.
2. The number of agencies by remoteness or sector may not sum to the total number of agencies due to rounding.
3. The number of agencies is not an accurate reflection of all in-scope AOD specialist treatment services in Australia, as some agencies fail to report data during a collection for various reasons. See the [Alcohol and other drug treatment services NMDS 2024–25 data quality statement](#) for further details.
4. In 2018–19, the AOD treatment agency counting methodology was revised to better reflect the number of unique AOD treatment service outlets. There is a level of agency duplication, due to agencies splitting out episode data related to the funding source for that program/service. A small number of agencies split their data submission according to state funded service episodes, which are reported to relevant state or territory departments; and Commonwealth funded service episodes are reported to a peak body or directly to the AIHW. This has resulted in the double counting of some services over time. This revision has been applied to all time-series; the main changes in data related to AOD service counts are from 2014–15 to 2017–18.
5. Data for SA2 only available for 2014–15 collection onwards.

For further technical information regarding the AODTS NMDS see [Annual report technical notes](#).

Data quality statement

[AODTS NMDS 2024–25 data quality statement](#)

Data

[2024-25 States and territories \(episodes\) data tables](#)

[2024-25 Clients \(states and territories\) data tables](#)

References

ABS 2011. [Australian Standard Classification of Drugs of Concern, 2011](#). ABS cat. no. 1248.0. Canberra: ABS.

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Data – pharmacotherapy in Australia

Opioid pharmacotherapy is one of the main treatment options for dependence on opioid drugs, such as heroin and morphine. Treatment involves replacing the opioid drug of dependence with a legally obtained, longer-lasting opioid. In Australia, clients attend dosing point sites (for example, pharmacies) regularly to take the dose of their prescribed medication under the supervision of a pharmacist or other health professional.

Clients who receive pharmacotherapy treatment can be captured in various data sources. The two national sources presented in this report are:

- [Alcohol and Other Drug Treatment Services National Minimum Data Set \(AODTS NMDS\)](#).
- [National Opioid Pharmacotherapy Statistics Annual Data \(NOPSAD\) Collection](#).

Due to the specifications of these collections, it is not possible to directly compare or identify people who received pharmacotherapy treatment via dosing point site as well as treatment from a publicly funded alcohol and other drug (AOD) service (see [technical notes](#) for more details). However, exploring this information in parallel can provide a more detailed picture about pharmacotherapy treatment in Australia.

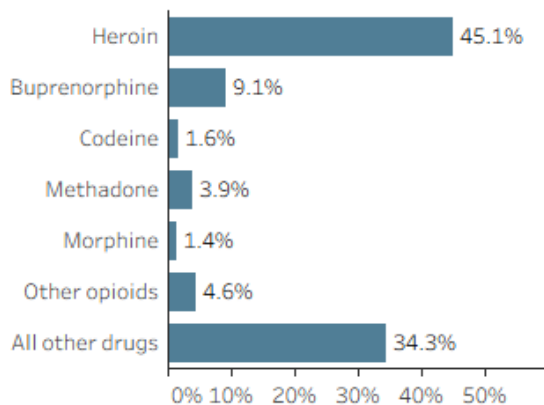
Pharmacotherapy in Australia: Overview

AODTS NMDS

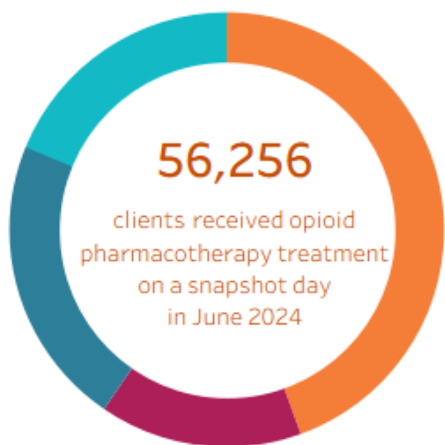


Main treatment type:
■ Pharmacotherapy ■ All other treatment types

Among pharmacotherapy treatment episodes provided to **AODTS NMDS** clients for their own drug use, the most common principal drug of concern was **heroin**:

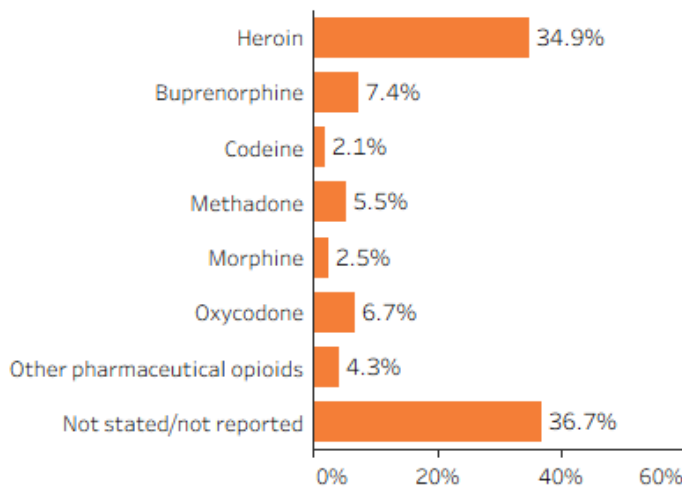


NOPSAD collection



Pharmacotherapy treatment type:
■ Methadone ■ Buprenorphine LAI
■ Buprenorphine ■ Buprenorphine-naloxone

Among all **NOPSAD** clients, the most common opioid drug of concern was **heroin**:



Sources: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set (Tables Trt.2 and Trt.55), AIHW National Opioid Pharmacotherapy Statistics Annual Data Collection (Tables S4 and S10).
<http://www.aihw.gov.au>

Data tables

[Data tables \(AODTS NMDS\)](#)

[Data tables \(NOPSAD collection\)](#)

Geography data for Primary Health Networks (PHNs)

In this section

- Alcohol and other drug treatment services dashboards
- Alcohol and other drug treatment
- Client demographics
- Principal drug of concern
- Data tables

Information on Public Health Networks and funding

In December 2015, the Australian Government announced the release of the *Australian Government Response to the National Ice Taskforce Final Report* (the Response). The Response underpinned the National Ice Action Strategy (NIAS), which was endorsed by the Council of Australian Governments (COAG) on 11 December 2016.

The Australian Government invested approximately \$561 million over four years from 1 July 2016 in drug and alcohol treatment services, as part of a \$713 million investment in reducing the impact of drug and alcohol misuse on individuals, families and communities under the *Drug and Alcohol Program*.

Approximately \$412.1 million of this investment was provided to Primary Health Networks (PHNs) to commission locally based treatment in line with community need. This included the \$241.5 million committed under the NIAS. This funding was delivered through the Australian Government's *Drug and Alcohol Program* and aims to improve the access to, and effectiveness of drug and alcohol treatment services in the community.

In April 2020, the Australian Government announced an additional \$6 million would be invested in online and phone support services for people experiencing substance issues during the COVID-19 pandemic.

The main source of data about specialist drug and alcohol treatment services in Australia is the Alcohol and Other Drug Treatment Services National Minimum Data Set (the AODTS NMDS), compiled on an annual basis from administrative data by the Australian Institute of Health and Welfare (AIHW).

PHN-commissioned specialist alcohol and other drug treatment providers collect data, in accordance with the AODTS NMDS, on in-scope specialist treatment services and provide it to the AIHW. Alcohol and other drug treatment agencies funded by PHN organisations under the *Drug and Alcohol Program* submitted data to the AODTS NMDS for the first time in 2016–17.

The following set of data visualisations present information at PHN geographic areas. The data presented are from all publicly funded AOD treatment services (which includes PHN-commissioned services) that have reported to the AODTS NMDS (see [technical notes](#) for more details).

PHNs are organisations that connect health services across a specific geographic area (PHN areas). There are 31 PHN areas that cover the whole of Australia with the [boundaries defined by the Australian Government Department of Health, Disability and Ageing](#). Some states/territories consist of a single PHN area, while others are made up of multiple PHN areas.

Alcohol and other drug treatment services dashboards

Click on the icon maps to explore the dashboards

- For the best experience use Chrome, Edge or Firefox browsers. For more information on browser compatibility, see [Supported browsers](#)
- Best viewed on a desktop, laptop or tablet.

Alcohol and other drug treatment agencies map, 2022–23 to 2024–25

Primary Health Network
(opens in new window)

Alcohol and other drug treatment map, 2020–21 to 2024–25

Primary Health Network
(opens in new window)

Principal drug of concern map, 2020–21 to 2024–25

Primary Health Network
(opens in new window)



Problem creating image.

Client demographics

The following data visualisation shows:

- Clients by PHN area of client, client type and sex, 2024-25.
- Clients by PHN area of client, client type and age group, 2024-25.
- Clients by PHN area of client, client type and Indigenous status, 2024-25.



Problem creating image.

Principal drug of concern

The following data visualisation shows:

- Treatment episodes for clients who received treatment for their own drug use by PHN area of client and principal drug of concern, 2020-21 to 2024-25.
- Treatment episodes for clients who received treatment for their own drug use by PHN area of client and main treatment type, 2024-25.
- Treatment episodes for clients who received treatment for their own drug use by PHN area of client and source of referral, 2024-25.



Problem creating image.

Data tables

[PHN AODTS NMDS data tables](#)



Data – diversion programs in Australia

In this section

- What are drug diversion programs?
- About the diversion client data visualisation
- How do we count treatment episodes provided to diversion clients?

What are drug diversion programs?

In Australia, drug diversion treatment programs (diversion programs) divert people who have been apprehended or sentenced for a minor drugs offence from the criminal justice system. Diversions often result in clients being referred to drug treatment agencies, including publicly funded alcohol and other drug (AOD) treatment agencies captured in [Alcohol and Other Drug Treatment Services National Minimum Data Set \(AODTS NMDS\)](#) data. Treatment services for clients referred via diversion programs range from short-term assessment (such as information or education sessions) to longer-term treatments (such as counselling or withdrawal management).

There are 2 key types of diversion programs in Australia that are captured in AODTS NMDS data:

- **Police diversion** occurs when an offence is first detected by a law enforcement officer. This typically applies for minor drug offences (for example, drug possession or use), often relating to cannabis. The offender may receive a caution or fine and will sometimes be required to attend mandatory drug assessment or education sessions.
- **Court diversion** occurs after a charge has been laid. It is usually applied for offences where criminal behaviour was related to drug use (for example, burglary or public order offence). Bail-based programs generally involve drug assessment and treatment, while pre- and post-sentence programs (such as drug courts) are aimed at repeat offenders and may involve more intensive treatment.

For more information on diversion programs, refer to the [Key terminology and glossary](#).

Diversion has several objectives, including:

- avoiding the negative labelling and stigma associated with criminal conduct and contact with the criminal justice system
- preventing further offending by minimising a person's contact with, and progression through, the criminal justice system
- reducing the number of people reaching the courts and prisons, thereby lightening the heavy caseload of courts and reducing delays as well as costs of court processes and incarceration
- reducing unnecessary social controls
- providing appropriate interventions to those offenders who are in need of treatment or other services.

About the diversion client data visualisation

This interactive data visualisation is based on AODTS NMDS data on clients who are referred to treatment via police or court diversion programs. It includes all clients who received at least 1 treatment episode for their own drug use with diversion as the referral source in a given collection period (that is, financial year). In this visualisation:

- **Diversion clients** include all clients who were referred to treatment via a diversion program (police or court) in at least 1 treatment episode in the collection period. For example, where clients received more than 1 treatment episode in the same collection period, if at least 1 had a diversion referral source, then they are counted in 'Diversion clients' for the purpose of this analysis.
- **Non-diversion clients** include all clients who did not receive any episodes with a diversion referral source in the collection period.

Police and court diversion client counts are reported both separately and combined in this visualisation. The sum of clients for police and court diversion exceeds the total number of diversion clients reported due to overlap where, for example, clients received at least 2 treatment episodes with referrals from police and court diversion in the same collection period.

How do we count treatment episodes provided to diversion clients?

Standard AODTS NMDS reporting counts diversion treatment episodes as the total number of episodes in which the source of referral was listed as 'diversion'. For this feature diversion visualisation, treatment episodes are counted as follows:

- **Treatment episodes provided to non-diversion clients** include all treatment episodes provided to non-diversion clients in the collection period.
- **Treatment episodes provided to diversion clients** include all treatment episodes provided to diversion clients (police or court). Where diversion clients received multiple treatment episodes in the collection period, all episodes related to these clients are counted as 'diversion treatment episodes' regardless of the referral source. For example, if a client received 2 treatment episodes in 2023–24 and 1 of these listed 'diversion' as the referral source, both episodes are counted as treatment episodes for a diversion client even if the second episode did not list diversion as the referral source.

Treatment episodes in this visualisation are only included for clients with a valid SLK. The total number of treatment episodes reported is lower here than in the standard AODTS NMDS report, where all treatment episodes are counted regardless of client SLK.

Diversion clients in Australia: Overview

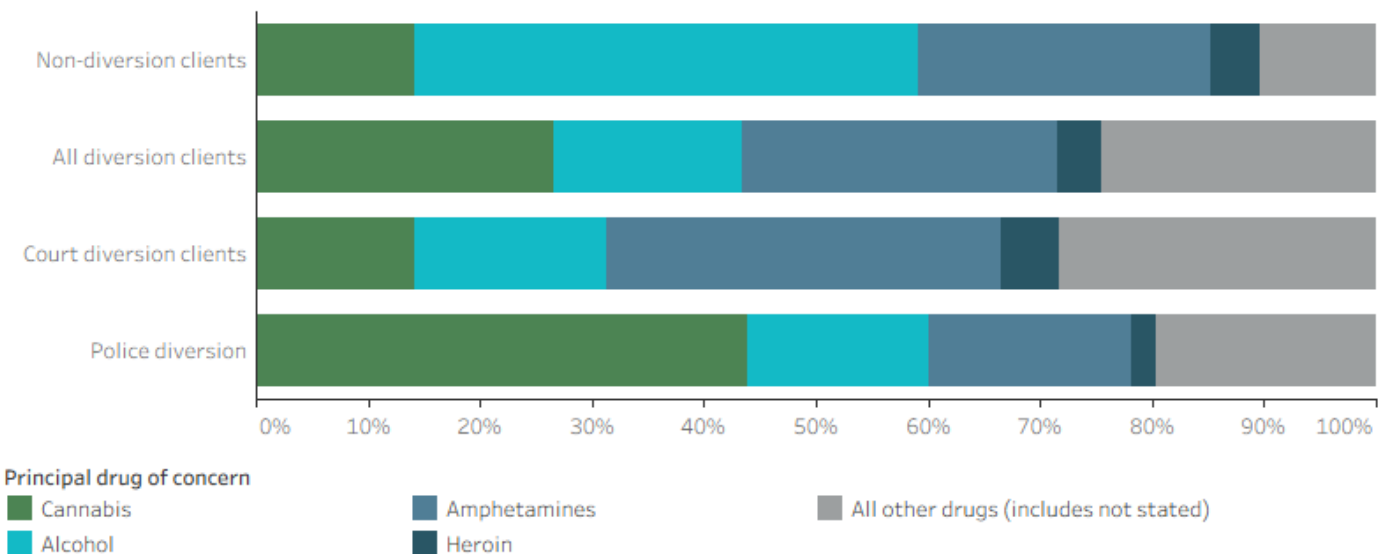
Select year:
2023-24

Select state/territory:
Australia



Nationally in 2023-24, the most common principal drug of concern among treatment episodes provided to diversion clients was amphetamines (28%), followed by cannabis (28%) (compared with alcohol for non-diversion clients, 45%).

Proportion of episodes provided to clients in Australia, 2023-24



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
<http://www.aihw.gov.au>



Technical notes



Policy framework

In this section

- Drug use in Australia
- The National Drug Strategy
- Alcohol and other drug treatment services
- The Alcohol and Other Drug Treatment Services National Minimum Data Set
- Aboriginal and Torres Strait Islander (First Nations) people

Drug use in Australia

Alcohol and tobacco are 2 of the most widely used drugs in Australia. The most recent [2022–2023 National Drug Strategy Household Survey](#) reported that of people aged 14 and over in Australia:

- 8.3% smoked tobacco daily.
- 77% consumed an alcoholic drink in the previous 12 months.

About 1 in 3 (31% or 6.6 million) people aged 14 and over consumed alcohol in ways that put their health at risk according to the [Australian Alcohol Guidelines](#) (drinking more than 10 standard drinks per week on average or more than four standard drinks in a single day at least once a month; NHMRC 2020). This was similar to 2019, when 32% of the population (around 6.7 million people) reported drinking at risky levels (AIHW 2024a).

In 2022–2023, illicit drug use was relatively common among people aged 14 and over in Australia:

- 47% self-reported they had illicitly used a drug at some point in their life (including pharmaceuticals used for non-medical purposes) and 17.9% had done so in the last 12 months.
- Cannabis continued to be the most commonly used illicit drug with more than 2 in 5 (41%) having used it in their lifetime and 11.5% using it in the previous 12 months.
- Ecstasy and cocaine were the second and third most common illicit drugs used in a lifetime (13.6% and 13.5%, respectively) and in the last 12 months (2.1% and 4.5%, respectively) (AIHW 2024a).

Health impacts

Tobacco, alcohol, and illicit drug use contribute to increased chronic disease, injury, poisoning and premature death and are among the leading risk factors contributing to the total disease burden in Australia. Together tobacco, alcohol and illicit drug use accounted for 14% of the total burden of disease in Australia in 2024 (AIHW 2024c).

Social impacts

The social impacts of AOD use in Australia include involvement in criminal activity, engagement in risky behaviours, victimisation and road trauma. In 2022–2023, 1 in 5 people (21%) aged 14 and over were victims of alcohol-related incidents and 1 in 10 people (10.1%) were victims of illicit drug-related incidents. Alcohol and illicit drug related incidents include verbal abuse, physical abuse, or being put in fear by someone under the influence of a substance in the previous 12 months (AIHW 2024). This trend was similar in 2019, where 1 in 5 (21%) people in Australia aged 14 and over were victims of an alcohol-related incident and 10.5% were victims of an illicit drug-related incident (AIHW 2020).

Economic impacts

The use and non-prescribed use of licit and illicit drugs imposes a heavy financial cost on the Australian community. In 2022–23, the projected separate costs of tobacco (\$159.7 billion), opioid (\$18.4 billion), methamphetamine (over \$6 billion) and alcohol use (\$74.9 billion) in Australia have been estimated, utilising different methodologies (Gadsden et al. 2023).

The National Drug Strategy

Australia has had a coordinated approach to dealing with alcohol and other drugs since 1985. The [National Drug Strategy \(NDS\) 2017–2026](#) is the 7th and latest iteration of the cooperative strategy between the Australian Government, state and territory governments, and the non-government sector. 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 balanced adoption of effective demand, supply, and harm reduction strategies.

The objective of the National Drug Strategy

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



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

The collection of treatment services data, for example in the [Alcohol and Other Drug Treatment Services National Minimum Data Set \(AODTS NMDS\)](#), forms part of the evidence base reinforcing harm reduction actions in the strategy, which include (NDSC 2017):

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

Alcohol and other drug treatment services

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

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

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

- the [National Opioid Pharmacotherapy Statistics Annual Data collection](#)
- the [National Hospital Morbidity Database](#)
- the [Specialist Homelessness Services collection](#)
- the [National Prisoner Health Data collection](#).

The Alcohol and Other Drug Treatment Services National Minimum Data Set

The [Alcohol and Other Drug Treatment Services National Minimum Data Set \(AODTS NMDS\)](#) is a service based collection. It contains information on treatment provided to clients by publicly funded alcohol and other drug (AOD) treatment services, including government and non-government organisations. Information on clients and treatment services are included in the AODTS NMDS when a treatment episode provided to a client is closed (see [Key terminology](#)). This is a service-based collection and not a demand-based collection. This is a service-based collection and not a demand-based collection, noting that services are limited by the number of clients they are able to provide treatment to, and that this may not be reflective of the demand for services by the broader community.

Information on the following types of treatment are reported:

- assessment only
- counselling
- information and education
- pharmacotherapy
- rehabilitation
- support and case management
- withdrawal management
- other (see [Key terminology](#)).

The AODTS NMDS collects data about services provided to people who received treatment for their own alcohol or drug use and those who received support for someone else's alcohol or drug use.

Client information is collected at the episode level in the AODTS NMDS. Further details on the estimation of client numbers and the imputation methodology can be found in [data and methods](#).

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

Coverage and data quality

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

The current scope of the collection, includes:

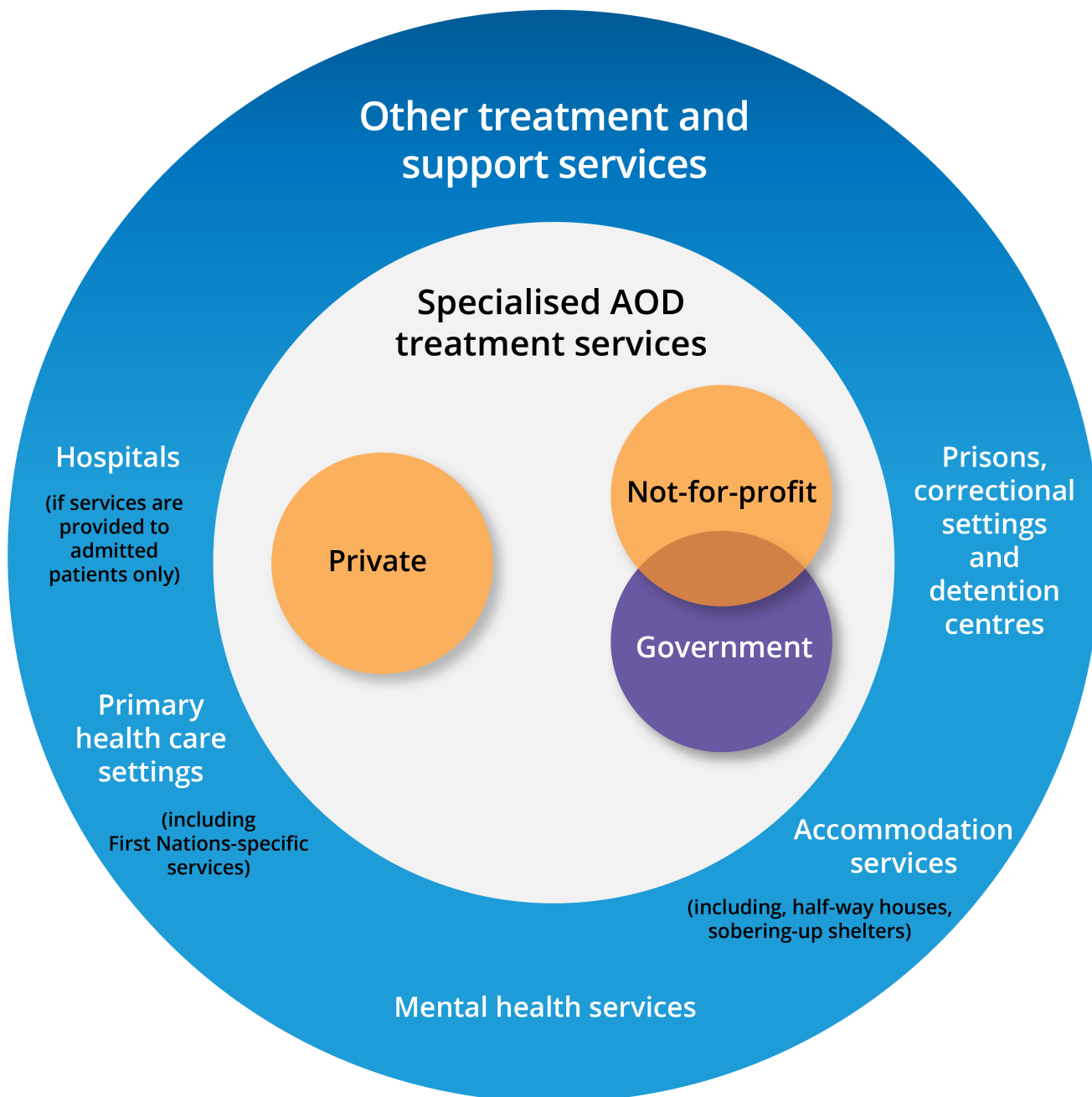
- All publicly funded (state, territory or Australian Government level) government and non-government agencies that provide one or more specialist alcohol and other drug treatment services, whether residential or non-residential.
- Acute care hospitals or psychiatric hospitals if they have specialist alcohol and other drug units that provide treatment to non-admitted patients (for example, outpatient services).
- Aboriginal or mental health services if they provide specialist alcohol and other drug treatment.

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

- services provided by other not-for-profit organisations and private treatment agencies that do not receive public funding
- alcohol and other drug treatment units in acute care or psychiatric hospitals that provide treatment only to admitted patients
- prisons, correctional facilities and detention centres
- primary health-care services, including general practitioner settings, community-based care, First Nation-specific primary health-care services and dedicated substance use services
- health promotion services (for example, needle and syringe programs)
- accommodation services (for example, halfway houses and sobering-up shelters) (Figure AODTS 1).

In addition, agencies whose sole function is prescribing or providing dosing services for opioid pharmacotherapy are excluded from the AODTS NMDS. These data are captured in the AIHW's [National Opioid Pharmacotherapy Statistics Annual Data collection](#).

Figure AODTS 1: Alcohol and other drug treatment and support services in Australia



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

Text description of Figure AODTS1: Alcohol and other drug treatment and support services in Australia

The Venn diagram shows the scope of alcohol and other drug treatment and support services in Australia. They include specialised services (private, government, and non-government), and other services (hospitals, prisons, primary health care services, accommodation and mental health services). The purple-coloured shape represents the services that are in scope to report to the AODTS NMDS and orange are out of scope.

Aboriginal and Torres Strait Islander (First Nations) people

The Australian Government funds primary health care services and substance use services specifically for First Nations people. These services may be in scope for the AODTS NMDS, but not all of the services currently report to the NMDS. As a result, the number of First Nations clients and treatment episodes may be under-estimated.

These services previously reported via the Australian Government-funded First Nations substance use services, via the Online Services Report (OSR) data collection up to 2017–18 (AIHW 2024b). However, the substance use services program was transferred to the Indigenous Affairs Group within the Department of Prime Minister and Cabinet in September 2013 and then to the National Indigenous Australians Agency in July 2019 (Australian National Audit Office 2017, National Indigenous Australians Agency 2024). Since the cessation of substance use services data being collected by the OSR, the number of substance use services for First Nations people that are considered in-scope and reporting to the AODTS NMDS has gradually increased.

The [National Agreement on Closing the Gap](#) noted that funding for First Nations Alcohol and Other Drugs (AOD) services and support will increase by up to \$66 million to 2024–25, in addition to current funding. First Nations' AOD Treatment Services funded under the Indigenous Advancement Strategy (IAS) currently assists more than 65 providers to deliver AOD activities (Department of Prime Minister and Cabinet 2024). The Commonwealth also provides AOD treatment services and prevention, research and communication activities through the Drug and Alcohol Program (DAP) and funding to Primary Health Networks (PHNs), with nearly 30% of PHN funding allocated for First Nations specific treatment services (National Indigenous Australians Agency 2022).

In 2023–24, the Government committed an additional \$10 million over 4 years to support place-based justice reinvestment partnerships located in the Central Australia region of the Northern Territory, under the \$250 million Central Australia Plan. This includes funding for justice reinvestment initiatives aimed at crime prevention, or providing community led treatments for drug and alcohol addiction, or diversionary supports for illegal drug use (National Indigenous Australians Agency 2025).

AOD services in scope to report

In 2024–25, 98.3% (1,316) of in-scope agencies submitted data to the AODTS NMDS. Overall, from 2023–24 to 2024–25, there was an increase of 4.9% in the proportion of in-scope agencies that reported to the collection. For the 2014–15 and 2015–16 reporting periods, sector reforms and system issues in some jurisdictions affected the number of in-scope agencies that reported. This led to an under-count of the number of closed treatment episodes reported for these years, so results, especially across reporting years, should be interpreted with caution.

Further details on scope, coverage and data quality are available from the [AODTS NMDS 2023–24 Data Quality Statement](#).

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Data and methods

In this section

- Age
- Counting clients
- Counting agencies
- Data collection process
- Drugs of concern
- Drugs of concern supplementary tables
- Methamphetamine coding
- Method of use of amphetamines as a principal drug of concern
- Duration
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- Imputation methodology for clients receiving AOD services
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For technical notes on the state and territory summaries refer to [Technical notes - state and territory summaries](#).

Age

Age is calculated as at the start of the episode.

Counting clients

Every client in the [Alcohol and Other Drug Treatment Services National Minimum Data Set \(AODTS NMDS\)](#) is assigned a statistical linkage key (SLK-581).

Client counts are based on the number of SLK-581s in the AODTS NMDS.

National client counts are based on the first time a client's SLK-581 appears in the AODTS NMDS in the financial year. All clients are counted once in national totals irrespective of the number of times they receive treatment (distinct count).

Treatment and demographic characteristics of clients counted at the national level are based on the first treatment episode for the client within the financial year the data was collected.

State and territory client counts are based on counting the first occurrence of an SLK-581s in the AODTS NMDS in each jurisdiction in that financial year. Clients who receive treatment in more than one jurisdiction will therefore be counted in each of these jurisdictions (overlap count). This is most common among clients who reside close to interstate borders and travel interstate for treatment. For example, clients who reside in Queanbeyan, NSW and travel to Canberra, ACT for treatment. This means that the sum of clients at the state and territory level can be greater than the national total.

Treatment and demographic characteristics of clients are based on the first treatment episode for the client within the state/territory and within the financial year the data was collected.

This report uses both national and state and territory counts to describe trends at both national and jurisdictional levels, as well as movements between jurisdictions. For more information, refer to the supplementary table footnotes and the [PDF SLK-581 guide for use \[PDF 96kB\]](#).

Counting treatment services

The [Alcohol and Other Drug Treatment Services National Minimum Data Set \(AODTS NMDS\)](#) contains information from publicly funded AOD treatment agencies and their service delivery outlets. An agency can have more than one service delivery outlet, located in different areas.

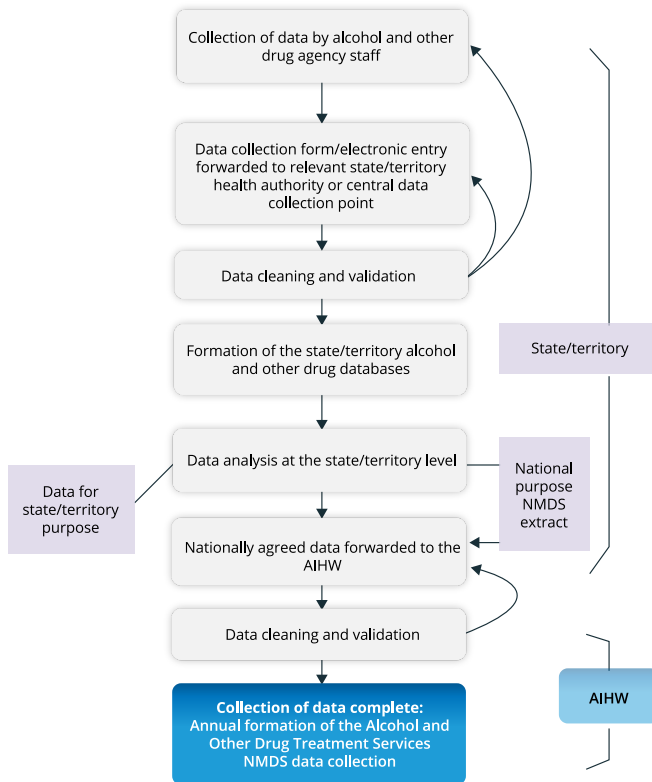
This is a service provision-based collection and not demand-based, noting that services are limited by the number of clients they are able to provide treatment to, and that this is not reflective of the demand for services by the broader community.

In 2018–19, the AOD treatment agency counting methodology was revised to better reflect the number of unique AOD treatment service outlets. There is a level of agency duplication, due to agencies splitting out episode data that is related to the funding source for that program/service. Some agencies chose to split their data according to the funding source. For example, state funded service episodes are reported to the relevant state or territory department and the Commonwealth funded service episodes are separated and reported to a peak body or directly to the Australian Institute of Health and Welfare (AIHW). This has resulted in some services being counted as 2 separate agencies over time. The revision was applied to all time-series, with AOD service counts from 2014–15 to 2017–18 affected.

Data collection process

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

Figure A1: Alcohol and other drug treatment data collection flowchart



Text description of Figure A1: Alcohol and other drug treatment data collection flowchart

The flowchart depicts the collection process of the Alcohol and Other Drug Treatment National Minimum Data Set. The boxes show the steps involved to submit, clean and validate data at the state and territory level. First, starting with the collection of data by AOD agency staff, data collected via collection form/electronic entry is forwarded to relevant state/territory health authority or central data collection point. Data is cleaned, validated and used in the formation of the state/territory AOD databases. Data extracts from state/territories and from services solely funded under the Drug and Alcohol Program at the Department of Health, Disability and Ageing is forwarded to the AIHW. At the AIHW, the data is cleaned, validated and compiled into the national data set for use in the annual formation of the AODTS NMDS.

Drugs of concern

The [Alcohol and Other Drug Treatment Services National Minimum Data Set](#) (AODTS NMDS) contains data on drugs of concern that are coded using the [ABS's Australian Standard Classification of Drugs of Concern \(ASCDC\)](#) (ABS 2011). In this report, these drugs are grouped (Table A1).

Table A1: Groupings of drugs of concern

Group	ASCDC codes	Category	Includes
Analgesics	1000–1999	Codeine	
		Morphine	
		Buprenorphine	
		Heroin	
		Methadone	
		Other opioids	Oxycodone, fentanyl, pethidine
		Other analgesics	Paracetamol
Sedatives and hypnotics	2000–2999	Alcohol	Ethanol, methanol and other alcohols
		Benzodiazepines	Clonazepam, diazepam and temazepam
		Other sedatives and hypnotics	Ketamine, nitrous oxide, barbiturates and kava
Stimulants and hallucinogens	3000–3999	Amphetamines	Amphetamine, dexamphetamine and methamphetamine

		Ecstasy (MDMA)	
		Cocaine	
		Nicotine	
		Other stimulants and hallucinogens	Volatile nitrates, ephedra alkaloids, phenethylamines, tryptamines and caffeine
Cannabinoids	7000-7199	Cannabis	
Other	4000-6999 9000-9999	Other	Anabolic agents and selected hormones, antidepressants and antipsychotics, volatile solvents, diuretics and opioid antagonists
Not stated	0000-0002	Not stated	

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

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

Drug category	ASCDC code	ASCDC classification (broad group and narrow group/s)	Drug description (ASCDC base level unit/s)
Codeine	1101	Analgesics Organic opiate analgesics	Codeine
Morphine	1102	Analgesics Organic opiate analgesics	Morphine
Buprenorphine	1201	Analgesics Semisynthetic opioid analgesics	Buprenorphine
Oxycodone	1203	Analgesics Semisynthetic opioid analgesics	Oxycodone
Methadone	1305	Analgesics Synthetic opioid analgesics	Methadone
Benzodiazepines	2400-2499	Sedatives and hypnotics Benzodiazepines	Benzodiazepines n.f.d., alprazolam, clonazepam, diazepam, flunitrazepam, lorazepam, nitrazepam, oxazepam, temazepam, benzodiazepines n.e.c.
Steroids	4000-4999	Anabolic agents and selected hormones Anabolic androgenic steroids Beta2 agonists Peptide hormones, mimetics and analogues Other anabolic agents and selected hormones Not further defined	Anabolic agents and selected hormones n.f.d., anabolic androgenic steroids n.f.d., boldenone, dehydroepiandrosterone, fluoxymesterone, mesterolone, methandriol, methenolone, nandrolone, oxandrolone, stanozolol, testosterone, anabolic androgenic steroids n.e.c., beta2 agonists n.f.d., eformoterol, fenoterol, salbutamol, beta2 agonists n.e.c., peptide hormones, mimetics and analogues n.f.d., chorionic gonadotrophin, corticotrophin, erythropoietin, growth hormone, insulin, peptide hormones, mimetics and analogues n.e.c., other anabolic agents and selected hormones n.f.d., sulfonylurea hypoglycaemic agents, tamoxifen, thyroxine, other anabolic agents and selected hormones n.e.c.

Other opioids	1100, 1199, 1200, 1299, 1300– 1304, 1306– 1399	Analgesics Organic opiate analgesics Semisynthetic opioid analgesics Synthetic opioid analgesics Not further defined	Organic opiate analgesics n.f.d., organic opiate analgesics n.e.c., semisynthetic opioid analgesics n.f.d., semisynthetic opioid analgesics n.e.c., synthetic opioid analgesics n.f.d., fentanyl, fentanyl analogues, levomethadyl acetate hydrochloride, meperidine analogues, pethidine, tramadol, synthetic opioid analgesics n.e.c.
Other analgesics	0005, 1000, 1400– 1499	Analgesics Non-opioid analgesics Not further defined	Analgesics n.f.d., non-opioid analgesics n.f.d., acetylsalicylic acid, paracetamol, ibuprofen, non-opioid analgesics n.e.c.
Other sedatives and hypnotics	2000, 2200– 2299, 2300– 2399, 2500– 2599, 2900– 2999	Sedatives and hypnotics Anaesthetics Barbiturates Gamma-hydroxybutyrate (GHB) type drugs and analogues Other sedatives and hypnotics	Sedatives and hypnotics n.f.d., anaesthetics n.f.d., ketamine, nitrous oxide, phencyclidine, propofol, anaesthetics n.e.c., barbiturates n.f.d., amylobarbitone, methylphenobarbitone, phenobarbitone, barbiturates n.e.c., GHB-type drugs and analogues n.f.d., GHB, gamma-butyrolactone, 1,4-butanediol, GHB-type drugs and analogues n.e.c., other sedatives and hypnotics n.f.d., chlormethiazole, kava lactones, zopiclone, doxylamine, promethazine, zolpidem, other sedatives and hypnotics n.e.c.

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

Jurisdictional notes regarding principal drug of concern

- In 2019–20, Victoria reported comparatively high incidences of 'Not stated drugs' (15%) as the drug of concern. This proportion decreased in 2020–21 (2.1%), due to work with service providers by the Victorian Agency for Health Information to encourage more specific reporting of drug of concern. In 2024–25, this remains low, 2.5% of treatment episodes. For more information see the [Data quality statement](#).
- In Queensland, the proportion of cannabis episodes reported as the principal drug of concern is a result of the Police Drug Diversion Program, Illicit Drugs Court Diversion Program and Drug and Alcohol Assessment Referral Program (DAAR) operating in the state.
- South Australia reports a high proportion of treatment episodes where amphetamines are the principal drug of concern due to the SA Police Drug Diversion Initiative (PDDI). In addition, adult cannabis offences are not included in the PDDI due to the SA Cannabis Expiation Notice legislation.
- In the Australian Capital Territory, removal of criminal penalties for possession of small quantities of cannabis in the ACT at the end of January 2020 reduced the number of cannabis-related diversions recorded as treatment episodes to low levels (mainly under-18s). Data collection improvements at government-operated services resulted in fewer 'not stated' responses in the 2022–23 collection.

Drugs of concern supplementary tables

Data for drugs of concern published in the supplementary tables may differ from results published within other tables, due to different counting methodology. Tables have been footnoted where there is different counting methodology. For example, where the principal drug of concern is coded as fentanyl (1301) and other drug of concern is coded as tramadol (1307), these drugs are within the same drug grouping (synthetic opioid analgesics) and counted only once.

Methamphetamine coding

The rise in reported episodes for methamphetamine is likely to be due to a combination of factors, including improvements in agency coding practices for methamphetamine, treatment system updates and increases in funded treatment services.

Method of use of amphetamines as a principal drug of concern

A client's usual method of administering their principal drug of concern may indicate the form of drug used, particularly for amphetamines. For example:

- Clients who report smoking or inhaling amphetamines are most likely to be using amphetamines in crystal form.
- Clients who report ingesting or snorting are most likely to be using a powder form.
- Clients who report injecting amphetamines may be using any form of amphetamines, as each form (base, crystal and powder) can be injected. However, recent data from the Illicit Drug Reporting System (an annual survey of people who inject drugs) indicate that crystal and powder are the most common forms used among people who inject methamphetamine (Sutherland et al. 2022).

Increases in treatment episodes for smoking methamphetamine from 2010 onwards are associated with increased importation of high purity crystalline methamphetamine into Australia (Degenhardt et al. 2017). National Drug and Alcohol Research Centre (NDARC) analysis of AODTS NMDS data indicates this greater availability of crystalline methamphetamines is reflected in the increased number of episodes identifying smoking as a method of use. Treatment episodes for methamphetamines where smoking was the method of use were primarily provided to younger clients (median age 30 years). These clients were more likely to receive main treatment types of assessment only or support and case management (McKetin et al. 2021).

From 2015–16 to 2019–20, the *method of use* (injecting or smoking) for the principal drug of concern was used to identify methamphetamine-related treatment episodes, due to data quality issues and limited coding options within some states and territories over this period.

Duration

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

Population rates

In this publication, crude rates were calculated using the ABS's estimated resident population at the midpoint of the data range: that is, rates for 2024–25 data were calculated using the estimated resident population at 31 December 2024.

Rates may differ from previously published data based on revised Australian population estimates. Due to non-demographic changes in the 2021 Census-based Aboriginal and Torres Strait Islander population estimates, rates for 'Aboriginal and Torres Strait Islander (First Nations) people', rates are only available for 2016–17 onwards.

The COVID-19 pandemic and the resulting Australian Government closure of the international border from 20 March 2020 caused significant disruptions to the usual Australian population trends. This report uses Australian Estimated Resident Population (ERP) estimates that reflect these disruptions.

In the year July 2020 to June 2021, the overall population growth was much smaller than the years prior and, in particular, there was a relatively large decline in the population of Victoria. ABS reporting indicates these were primarily due to net-negative international migration; for further information, refer to [National, state and territory population, June 2021](#).

Note that this change in the usual population trends may affect interpretation of statistics calculated from these ERPs. For example, rates and proportions may be greater than in previous years due to decreases in the denominator (population size) of some sub-populations.

Reason for cessation

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

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

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

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

Remoteness area

This report uses the ABS's Australian Statistical Geography Standard (ASGS) Edition 3 (ABS 2023a) to analyse the proportion of AOD treatment agencies by remoteness area. This structure allows areas that share common characteristics of remoteness to be classified into broad geographic regions of Australia. These areas are:

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

The remoteness structure divides each state and territory into several regions based on road distance to population centres of various sizes. This allows a proxy to be created for relative access to services.

Examples of urban centres in each remoteness area are:

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

For this report, the remoteness area of the agency was determined using the Statistical Area Level 2 (SA2) of the agency. Not all SA2 codes fit neatly within a single remoteness category, and a ratio is applied to reapportion each SA2 to the applicable remoteness categories. As a result, it is possible that the number of agencies in a particular remoteness category is not a whole number. After rounding, this can result in there being '<0.5%' agencies in a remoteness area, due to the agency's SA2 partially crossing into the remoteness area. It should be noted that some states and territories do not contain all remoteness areas, for example:

- Australian Capital Territory only has one geographical classification of *Major cities*.
- Northern Territory does not contain the geographical classifications of *Major cities* or *Inner regional* areas.
- Tasmania does not contain the geographical classification of *Major cities*.

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

Socioeconomic area

This report uses the ABS's Socio-Economic Indexes for Areas (SEIFA), 2021 standard, to analyse the proportion of people who received AOD treatment by Index of Relative Socio-economic Disadvantage (IRSD).

The IRSD classifies people based on the economic and social conditions of an area in which they live. It scores each area based on income, education/qualifications and jobs in skilled or unskilled occupations.

The areas are grouped into 5 quintiles indicating overall or average disadvantage or lack of disadvantage. Each quintile contains 20% of the population, based on the socioeconomic ranking of the area they live in. This means that the people living in the 20% of areas with:

- the greatest level of socioeconomic disadvantage are described as living in the lowest socioeconomic areas.
 - An area could have a score for the lowest socioeconomic area if there are many households with low income, or many people without qualifications, and many people in low skilled occupations
- the least level of socioeconomic disadvantage are described as living in the highest socioeconomic areas.
 - An area could have a score for the least level of socioeconomic disadvantage if there are few households with low incomes, few people without qualifications, few people in low skilled occupations (ABS 2023b).

Note that the IRSD reflects the overall or average disadvantage or lack of disadvantage of the population of an area, it does not show how individuals living in the same area differ from each other in their socioeconomic position.

In this report, socioeconomic indexes have been derived from Statistical Area Level 2 (SA2) of client's last known home address before commencing treatment. In 2024-25, 6,017 clients did not map to socioeconomic indexes. SA2s may not be assigned to a SEIFA area due to low population counts (a meaningful index score cannot be assigned). For example,

- the SA2 has no usual addresses
- the usual resident population is less than or equal to Ten
- there are fewer than six employed people
- the proportion of people in private dwellings is less than or equal to 20 per cent. Further information on areas without SEIFA scores is available [here](#).

Service sectors

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

Source of referral – diversion

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

In Australia, drug diversion programs come in 2 main forms:

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

Treatment

The number of closed treatment episodes for counselling as a main treatment type has remained the most common treatment type for all clients over all collection years. All information included in the AODTS NMDS regarding clients and treatment services are based on a closed treatment episode (there is an end date which falls within the reporting period). Fluctuations over time in closed treatment episodes for particular treatment types may be influenced by coding practices, increased funding or changes in treatment policies or capacity to provide specialised alcohol and other drug treatment services, which may contribute to variation in treatment types over time.

Trends

Trend data may differ from data published in previous versions of [Alcohol and other drug treatment services in Australia](#), due to data revisions.

Imputation methodology for clients receiving AOD services

A Statistical Linkage Key-581 (SLK) was introduced into the AODTS NMDS for the 2012–13 collection to enable the number of clients receiving treatment to be counted, while continuing to ensure the privacy of these individuals receiving treatment.

An imputation strategy for the collection was implemented in 2012–13, 2013–14 and 2015–16. It was developed to correct for the impact of invalid or missing SLKs on the total number of clients. This strategy took into account several factors relating to the number of episodes per client and makes assumptions relating to spread across agencies. It also took into consideration the likelihood that an episode with a missing SLK relates to a client that has already been counted through other episodes with a valid SLK.

To ensure an accurate representation of the AODTS client population, imputation was applied to the 2012–13, 2013–14 and 2015–16 AODTS NMDS to account for the proportion of valid SLKs being less than 95% for these years. The national rate of valid SLKs for these years was largely affected by low proportions of valid SLKs in New South Wales. Further information about the imputation methodology applied to historical data can be found the report [Alcohol and other drug treatment services in Australia 2015–16, Appendix B: Imputation methodology for clients receiving AOD services](#).

Historical data element changes

Details on historical data element changes are found in Appendix A of the [PDF](#) [AODTS NMDS Data Collection Manual 2024–25 \[PDF 747kB\]](#).

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State and territory data quality

Principal drug of concern

From 2015–16 to 2019–20, the *method of use* (injecting or smoking) for the principal drug of concern was used to identify methamphetamine-related treatment episodes, due to data quality issues and limited coding options within some states and territories over this period.

COVID-19

From 2019–20 to 2021–22, restrictions related to the COVID-19 pandemic impacted delivery of AOD services in Australia.

Many AOD services, especially withdrawal management and residential rehabilitation, experienced reduced occupancy and, in some cases, temporary closures. Counselling and outreach services largely transitioned to telehealth to comply with public health measures. As a result, there were fewer AOD referrals and more cancellations for residential admissions, with most providers limiting face-to-face contact except where it was essential for withdrawal or rehabilitation treatment. For further information on the impacts to AOD service delivery during COVID see, [COVID-19 impact \[PDF 12.7MB\]](#).

Policy, legislation and environmental changes

New South Wales

In 2019–20, a number of natural disasters impacted the 2019–20 NSW reporting period, including large areas of NSW experiencing unprecedented bushfires between October 2019 and March 2020, and in February 2020 some areas of NSW experienced flooding.

During 2023, there was a transition between data warehouses, this may have impacted the data for the 2022-23 period.

Victoria

In February 2021, the Victorian Department of Health and Human Services was separated into two new departments: the Department of Health (DH) and the Department of Families, Fairness and Housing (DFFH) to better prepare for the state's public health response to the COVID-19 pandemic. The DH is responsible for the state's health system, including mental health and AOD treatment services.

Victorian AOD services operate under a mixed-funding model.

- The majority of adult residential and non-residential services have been funded through Activity-Based Funding (ABF), Drug Treatment Activity Unit (DTAU) based on the number of closed courses, since September 2014.
- Aboriginal and youth-specific services are funded on the basis of an episode of care (EOC).
- Other AOD treatment grants such as research, local initiatives and pharmacotherapy programs are block funded.
- Funding for AOD prevention and control activities is based on block grants and submissions.

Adult community alcohol and other drug treatment services were re-commissioned in late 2014 and are now delivered through several treatment streams within catchment areas. These treatment streams include intake, brief intervention, counselling, care and recovery co-ordination, withdrawal, rehabilitation and pharmacotherapy.

Funded services are accountable for the appropriate use of funding and for the delivery of services specified in the service agreement. To ensure accountability, services are required to report monthly on the services they are funded to deliver through the Victorian Alcohol and Drug Collection (VADC) and other reporting. This allows both the DH and AOD funded services to monitor their progress towards agreed targets and performance measures, respond to demand for services and ensure funding accountability is met.

Queensland

Assessment-only episodes should also be interpreted in the context of how AODTS NMDS activity is reported. Closed treatment episode counts measure the number of episodes provided, but do not reflect the relative duration or intensity of treatment. Assessment-only episodes in Qld are generally higher-volume and shorter-duration than other treatment types such as counselling, support and case management, rehabilitation or withdrawal management.

South Australia

South Australia reported a high proportion of episodes of treatment where amphetamines are the principal drug of concern and assessment only is the main treatment type. This is related to assessments provided under the Police Drug Diversion Initiative. This program is legislated in South Australia, unlike other jurisdictions, and therefore results in a higher percentage of assessment only services with high rates of engagement with methamphetamine users. In addition, due to the Cannabis Expiation Notice legislation in South Australia, adult simple cannabis offences are not diverted to treatment and so are excluded from the data.

The South Australian Police Drug Diversion initiative also saw a change in legislation from April 2019 [Statutes Amendment (Drug Offences) Bill 2018], where youth are no longer diverted immediately for an Assessment. Adults who have been apprehended twice in four years are no longer eligible for an Assessment.

Australian Capital Territory

ACT non-government-operated alcohol and other drug services were (re) commissioned in 2024. New deeds of grant come into effect in September 2024, and run until 30 June 2031. ACT government-operated services were not in-scope for commissioning and were unaffected.

There were only limited changes to the existing AOD treatment sector resulting from commissioning, and therefore interpretation of trends ACT AODTS MDS data is unlikely to be significantly affected by the commissioning process.

One new ACT service began reporting to the AODTS MDS in 2024–25. This service's focus is on providing support to families and friends of people who use drugs, increasing the number of ACT treatment episodes for 'someone else's drug use'.

Northern Territory

All agencies in the Northern Territory are required to undertake a separate assessment only episode prior to the commencement of treatment. This supports consistent recording of assessment activity, including instances where treatment does not proceed, and enables analysis of client flow and subsequent treatment pathways.

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Key terminology

In this section

- Closed treatment episodes
- Drugs of concern
- Reasons for cessation
- Treatment types
- Client counts
- Diversion client type
- Median

Closed treatment episode

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

A treatment episode is considered **closed** where any of the following occurs:

- treatment is completed or has ceased (see [reasons for cessation](#))
- there has been no contact between the client and treatment provider for 3 months, or
- there is a change in the main treatment type, principal drug of concern or delivery setting.

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

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

All information included in the AODTS NMDS regarding clients and treatment services are based on a closed treatment episode (there is an end date which falls within the reporting period). Each treatment episode has 1 principal drug of concern and 1 main treatment type. If the principal drug or main treatment changes, then a new episode is recorded.

The [Alcohol and Other Drug Treatment Services National Minimum Data](#) set is a service-based collection and not a demand-based collection, noting that services are limited by the number of clients they are able to provide treatment to, and that this may not be reflective of the demand for services by the broader community.

Drugs of concern

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

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

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

Reasons for cessation

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

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

- completed treatment – where the treatment was completed as planned
- a change in the main treatment type
- a change in the delivery setting
- a change in the principal drug of concern
- been transferred to another service provider – including where the service provider is no longer the most appropriate, and the client is transferred or referred to another service. For example, transfers could occur for clients between non-residential and residential services, or between residential services and a hospital – excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment
- ceased to participate against advice – here the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest
- ceased to participate without notice
- ceased to participate involuntarily – where the service provider stops the treatment due to non-compliance with the rules or conditions of the program

- ceased to participate at expiration – where the client has fulfilled their obligation to satisfy expiration requirements (for example, participation in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with further treatment
- ceased to participate by mutual agreement – where the client ceases participation by mutual agreement with the service provider, even though the treatment plan has not been completed. This may include situations where the client has moved out of the area
- been to a drug court or sanctioned by court diversion service – where the client is returned to court or jail due to non-compliance with the program
- been imprisoned (other than sanctioned by a drug court or diversion service)
- died.

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

- **expected/planned completion**: episodes where the treatment was completed, or where the client ceased to participate at expiration or by mutual agreement.
- **ended due to unplanned completion**: episodes where the client ceased to participate against advice, without notice or due to non-compliance.
- **referred to another service/change in treatment mode**: episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.
- **other**: episodes that ended due to the client returning to court or jail due to non-compliance with a drug court program or sanctioned by court diversion service, imprisoned (other than drug court sanctioned), died, or reasons not elsewhere classified.

Treatment types

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

- assessment only – where only assessment is provided to the client (service providers would normally include an assessment component in all treatment types)
- counselling – can include cognitive behaviour therapy, brief intervention, relapse intervention [WB1] and motivational interviewing
- information and education – where information and education is provided to the client (service providers would normally include an information and education component in all treatment types)
- pharmacotherapy – where the client receives another type of treatment in the same treatment episode and includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who experience dependence on certain types of opioids. Where a pharmacotherapy is used for withdrawal, it is included in the withdrawal category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy
- rehabilitation – focuses on supporting clients in stopping their drug use, and to prevent psychological, legal, financial, social and physical consequences of drug use. Rehabilitation can be delivered in several ways, including residential treatment services, therapeutic communities and community-based rehabilitation services
- support and case management – support includes helping a client who occasionally calls an agency worker for emotional support, while case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs (including general welfare needs) and it includes assessment, planning, linking, monitoring and advocacy
- withdrawal management (detoxification) – includes medicated and non-medicated treatment to help manage, reduce or stop the use of a drug of concern.

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

In 2019–20, changes were made to categories under Main Treatment; the word 'only' was removed from support and case management and information and education. The removal of the word 'only' from support and case management and information and education, changed reporting rules for agencies; allowing agencies to be able to report and more accurately capture these items as an additional treatment in conjunction with a main treatment type.

Additional treatment types refer to other treatment types provided to the client, in addition to their main treatment type. Up to 4 additional treatment types can be reported. For example, a client may receive counselling as their main treatment and support and case management as an additional treatment. Up to four additional treatment types can be recorded for each client.

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

Client counts

Every client in the [Alcohol and Other Drug Treatment Services National Minimum Data Set](#) (AODTS NMDS) is assigned a statistical linkage key (SLK-581).

Client counts are based on the number of valid SLK-581s in the AODTS NMDS.

National client counts are based on the first time a client's SLK-581 appears in the AODTS NMDS in the financial year. All clients are counted once in national totals irrespective of the number [WB1] of times they receive treatment (distinct count).

Treatment and demographic characteristics of clients counted at the national level are based on the first treatment episode for the client within the financial year the data was collected.

State and territory client counts are based on counting the first occurrence of an SLK-581 in the AODTS NMDS in each jurisdiction in that financial year. Clients who receive treatment in more than one jurisdiction will therefore be counted in each of these jurisdictions (overlap count). This is most common among clients who reside close to interstate borders and travel interstate for treatment. For example, clients who reside in Queanbeyan, NSW and travel to Canberra, ACT for treatment. This means that the sum of clients at the state and territory level can be greater than the national total.

This report uses both national and state and territory counts to describe trends at both national and jurisdictional levels, as well as movements between jurisdictions. For more information, refer to the [supplementary table footnotes](#) and the [SLK-581 guide for use \[PDF 96kB\]](#).

New client

Clients who have received treatment from a publicly funded AOD agency in the financial year for the first time, having never received treatment in any previous year. This is based on if a client's Statistical Linkage Key-581 has not appeared previously in the data collection since 2013-14. This does not account for miscoding of, or changes to, client name, date of birth or sex.

Returning client

Clients who have received treatment from a publicly funded AOD agency in the financial year plus at least 1 previous year since 2013-14. This is based on if a client's Statistical Linkage Key-581 has appeared previously in the data collection since 2013-14. This does not account for miscoding of, or changes to, client name, date of birth or sex.

Diversion client type

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

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

Median

The midpoint of a list of observations ranked from the smallest to the largest.  [SLK-581 guide for use \[PDF 96kB\]](#)

Acronyms

Table 1: List of acronyms used in report

Acronym	Full name
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASCDC	Australian Standard Classification of Drugs of Concern
ASGC	Australian Standard Geographical Classification
ASGS	Australian Statistical Geography Standard
GHB	gamma hydroxybutyrate
MDMA	3, 4-methylenedioxyamphetamine
NA	Not applicable
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NGOs	Non-Government Organisations
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
SLK	statistical linkage key
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Geography data for Primary Health Networks (PHN)

General notes:

- The Australian Government commissioned Primary Health Networks (PHNs) from 1 July 2015, to provide funding for locally based AOD treatment services in line with community need. This funding is delivered through the Australian Government's *Drug and Alcohol Program*, and aims to improve the access to, and effectiveness of drug and alcohol treatment services in the community.
- Data presented in the dashboards are from all publicly funded alcohol and other drug (AOD) treatment services (which include PHN-commissioned services) that have reported to the [Alcohol and Other Drug Treatment Services National Minimum Data Set](#) (AODTS NMDS).
- AOD treatment agencies funded by their PHN under the Australian Government Department of Health, Disability and Ageing's Drug and Alcohol Program (DAP) submitted data to the AODTS NMDS for the first time in 2016–17.
- In these [dashboards](#), data are presented from the 2020–21 collection year to show the trends in each PHN prior to the establishment of the boundaries.
- Financial year data from agencies include treatment episodes that ended within the period (closed treatment episodes) and excludes those that were ongoing or new (not closed) within the reporting year.

Agencies dashboard:

- The PHN of the agency was assigned based on the Statistical Area Level 2 (SA2) of the treatment agency using the Australian Bureau of Statistics' (ABS) SA2 2021 to Primary Health Network 2023 concordance file.
- As SA2 2021 boundaries may not correspond to PHN 2023 boundaries, some agencies may be captured in a neighbouring PHN including those in a neighbouring jurisdiction.

Main treatment for client dashboards:

- The PHN of the client was based on the postcode of the client using the Australian Bureau of Statistics' (ABS) Postal Area 2021 to Primary Health Network 2023 concordance file. Clients reporting an invalid postcode were assigned: 'PHN Unallocated' and removed from analysis. In 2024–25, 12,152 records contained invalid postcodes. Correspondence mappings may change over time and data may differ from what was previously published. The numbers presented here may also not correspond to those presented elsewhere based on this correspondence.
- Results with cell sizes less than 5 have been presented as '<5' (in some cases the value is null), due to this adjustment some values may not sum to the total or 100%.
- Data collection and reporting practices in Western Australia and Victoria are not directly comparable with data for other jurisdictions because every treatment type provided is reported as a separate episode.

Client demographics dashboard:

- Client numbers are based on records with a valid statistical linkage key (SLK-581).
- Client numbers are not comparable to client data published in the [AODTS in Australia 2024–25](#) report. These dashboards include clients who attended treatment in multiple PHN locations in the collection year. The sum of clients across the 31 PHN levels is greater than the state/territory results due to finer geographic granularity of PHNs compared to the state/territory level. The sum of clients across PHNs is also greater than the national distinct client total for 2023–24, which reflects the number of clients treated, irrespective of whether they received treatment in multiple locations.

Principal drug of concern dashboards:

- The PHN of the client was based on the postcode of the client using the Australian Bureau of Statistics' (ABS) Postal Area 2021 to Primary Health Network 2023 concordance file. Clients reporting an invalid postcode were assigned: 'PHN Unallocated' and removed from analysis. In 2024–25, 10,411 records contained invalid postcodes. Correspondence mappings may change over time and data may differ from what was previously published. The numbers presented here may also not correspond to those presented elsewhere based on this correspondence.
- Results with cell sizes less than 5 have been presented as '<5' (in some cases the value is null), due to this adjustment some values may not sum to the total or 100%.

Jurisdiction-specific notes:

- In 2019–20, Victoria reported comparatively high incidences of 'Not stated drugs' (15%) as the drug of concern. This proportion decreased in 2020–21 (2.1%), due to work with service providers by the Victorian Agency for Health Information to encourage more specific reporting of drug of concern. In 2024–25, this remains low, 2.5% of treatment episodes. For more information see the [Data quality statement](#).
- In Queensland, the proportion of cannabis episodes reported as the principal drug of concern is a result of the Police Drug Diversion Program, Illicit Drugs Court Diversion Program and Drug and Alcohol Assessment Referral Program (DAAR) operating in the state.
- South Australia reports a high proportion of treatment episodes where amphetamines are the principal drug of concern due to the SA Police Drug Diversion Initiative (PDDI). In addition, adult cannabis offences are not included in the PDDI due to the SA Cannabis Expiation Notice legislation.
- In the Australian Capital Territory, removal of criminal penalties for possession of small quantities of cannabis in the ACT at the end of January 2020 reduced the number of cannabis-related diversions recorded as treatment episodes to low levels (mainly under-18s). Data collection improvements at government-operated services resulted in fewer 'not stated' responses in the 2022–23 collection.

Pharmacotherapy in Australia

Technical notes

AODTS NMDS

The [Alcohol and Other Drug Treatment Services National Minimum Data Set](#) (AODTS NMDS) visualisations are based on episode data reported during the 2023–24 collection cycle and contains information on treatment provided to clients by publicly funded alcohol and other drug (AOD) treatment services. Only episodes where pharmacotherapy was an additional treatment, or a main treatment with an additional treatment provided are included in the AODTS NMDS. Episodes where pharmacotherapy and no additional treatment was provided are excluded.

NOPSAD collection

The [National Opioid Pharmacotherapy Statistics Annual Data](#) (NOPSAD) Collection visualisations are based on client data reported on a snapshot day in June 2024. This collection contains information on clients receiving opioid pharmacotherapy treatment, prescribers of opioid drugs and the dosing points that clients attend to receive their medication.

Notes

Data quality statement

[AODTS NMDS 2024-25 Data quality Statement](#)

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- Department of Health, Tasmania
- Health Directorate, Australian Capital Territory
- NT Health, Northern Territory

Data

Data cubes (*Alcohol and other drug treatment services in Australia: early insights*)

Data tables: 2024–25 Agcy.Agency (episodes)

Data
XLSX 256kB

Data tables: 2024–25 SC.Clients (national)

Data
XLSX 1.1MB

Data tables: 2024–25 SC.Clients (state and territories)

Data
XLSX 661kB

Data tables: 2024–25 SCR.Clients rates and multiple years

Data
XLSX 37.7MB

Data tables: 2024–25 Drg.Drugs (episodes)

Data
XLSX 2.9MB

Data tables: 2024–25 OV.Overview (episodes)

Data
XLSX 504kB

Data tables: 2024–25 ST.State and territories (episodes)

Data
XLSX 4.8MB

Data tables: 2024–25 Trt.Treatment (episodes)

Data
XLSX 2.2MB

Data tables: 2024–25 Primary Health Network (PHN) geography (episodes)

Data
XLSX 525kB

Data tables: 2024–25 SCR.Clients (state and territories numbers)

Data
XLSX 2.4MB

Report editions

- Alcohol and other drug treatment services in Australia annual report 2024–25 |

Web report | 25 Jun 2026

This release



Archived content

Alcohol and other drug treatment services in Australia annual report 2022-23

Resource | 14 Jun 2024

In 2022-23, around 131,500 people aged 10 and over received treatment from alcohol and other drug treatment services. The 4 most common drugs that led clients to seek treatment were alcohol (43% of episodes), amphetamines (24%), cannabis (17%) and heroin (4.5%). The median age of all clients was 36 years. This report has been updated with financial year data for 2022-23 and is updated on an annual basis.

PDF 10.9MB

Alcohol and other drug treatment services in Australia annual report 2021-22

Resource | 21 Jun 2023

In 2021-22, around 131,000 people aged 10 and over received treatment from alcohol and other drug treatment services. The four most common drugs that led clients to seek treatment were alcohol (42% of episodes), amphetamines (24%), cannabis (19%) and heroin (4.5%). The median age of clients was 37 years.

PDF 12.7MB

Alcohol and other drug treatment services in Australia annual report 2020-21

Resource | 27 Jul 2022

In 2020-21, around 139,300 clients aged 10 and over received AOD treatment. The four most common drugs that led clients to seek treatment were alcohol (37%), amphetamines (24%), cannabis (19%) and heroin (4.6%). The median age of clients was 35 years.

PDF 10MB

Alcohol and other drug treatment services in Australia annual report 2019-20

Resource | 16 Jul 2021

In 2019-20, around 139,300 clients aged 10 and over received AOD treatment. The four most common drugs that led clients to seek treatment were alcohol (34%), amphetamines (28%), cannabis (18%) and heroin (5.1%). The median age of clients was 35 years. Early responses of AOD services to the COVID-19 pandemic are seen in the last quarter of 2019-20, impacting some treatment types and service delivery settings.

PDF 3.9MB

Related material

Resources

Alcohol and other drug treatment services in Australia: early insights

Resource

High-level information for 2022–23 about publicly funded AOD treatment services, the people they treated, and the treatment provided. This report includes data cubes.

Alcohol, tobacco & other drugs in Australia

Resource

Key trends in availability, consumption, harms and treatment of alcohol, tobacco and other drug use for vulnerable populations.

National Opioid Pharmacotherapy Statistics Annual Data collection

Resource

Information about the clients who access opioid pharmacotherapy, the health professionals who provide pharmacotherapy, and dosing points.

National Drug Strategy Household Survey 2022–2023

Resource

Information about drug use trends over time, how these patterns have changed over time and opinions on a range of initiatives designed to reduce the harm caused by tobacco, alcohol and illicit drug use.

Alcohol and other drug use - feature analysis

Resource

Articles in this report examine the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) data in novel ways to draw insights about the characteristics and experiences of AODTS clients, not available through the individual data set. Reporting draws on AODTS NMDS data linked with other data sets, providing valuable insights into the treatment provided, the drugs that led clients to receive treatment, and the health and welfare outcomes of people receiving specialist AOD treatment services.

Accessing aod treatment services after assessment

Resource

Assessment is often the first step for people accessing treatment for alcohol or drug (AOD) use. It helps identify immediate risks, set goals and plan next steps. While assessments are usually followed by further treatment such as counselling, some people receive only an assessment, with no further treatment recorded. Understanding how people move from assessment to treatment, can improve continuity of care and support better service planning.

Alcohol treatment in Australia: Client characteristics and patterns of service use, 2013–14 to 2022–23

Resource

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 (PDOC)).

Trends in cannabis availability, use, and treatment in Australia, 2013–14 to 2021–22

Resource

Cannabis is the most widely used illegal drug in Australia, with 2.5 million people in 2022–2023 having used it in the previous 12 months. Between 2013–14 and 2021–22, 221,000 clients received treatment for their cannabis use from publicly-funded drug treatment agencies. This report draws together data from multiple sources to describe trends in cannabis availability, use and treatment in Australia, including the characteristics of people who use or receive treatment for cannabis.

Completion of alcohol and drug treatment in Australia, 2011–12 to 2020–21: differences by drugs of concern and treatment characteristics

Resource

Understanding how clients leave specialist alcohol and other drug (AOD) treatment provides insights into how clients and AOD services engage with each other. Between 1 July 2013 and 30 June 2021, 228,500 people sought specialist AOD treatment for either alcohol or amphetamines. Of the 648,400 treatment episodes provided to these clients across this 8 year period, 1 in 4 episodes did not end as planned. This report examines how the likelihood of planned completion varies by treatment characteristics such as drug type (alcohol compared to amphetamines), main treatment and client remoteness.

Patterns of intensive alcohol and other drug treatment service use in Australia, 1 July 2014 to 30 June 2019

Resource

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

Related topics

- [Alcohol & other drug treatment services](#)
 - [Men's health](#)
-

