AOD Sector Insights

Report

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Acknowledgement of Country

VAADA acknowledges the Traditional Owners of the land on which our work is undertaken. Our office stands on the country of the Wurundjeri people of the Kulin Nation. We pay our respects to all Elders past and present and acknowledge their continuing and ongoing connection to land, waters and sky.

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About VAADA

The Victorian Alcohol & Drug Association (VAADA) is a member-based peak body and health promotion charity representing organisations and individuals involved in prevention, treatment, rehabilitation, harm reduction or research related to alcohol or drugs. VAADA aims to support and promote strategies that prevent and reduce the harms associated with alcohol and other drug (AOD) use across the Victorian community. Our vision is a Victorian community in which AOD-related harms are reduced and well-being is promoted to support people to reach their potential.

About Latitude Network

Latitude Network is a data analytics and social impact consultancy based in Melbourne, Australia, that specialises in helping nonprofit organisations and social service providers make better use of their data. Latitude Network acts as the secure data custodian for our Victorian AOD sector collaboration, VAADABase.

VAADA acknowledges and celebrates people and their families and supporters who have a lived and living experience of alcohol, medication and other drug use. We value your courage, wisdom and experience, and recognise the important contribution that you make to the AOD sector in Victoria.

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Executive Summary

This AOD Sector Insights report presents aggregated insights from the VAADABase pilot project, which has compiled data from 15 Victorian Alcohol and Other Drug (AOD) agencies over the period of 1 July 2024 to 30 June 2025. The dataset has been drawn from Victorian Alcohol and Drug Collection (VADC) and includes information on 25,258 clients and 60,788 closed service events delivered across 126 service outlets. While not encompassing all funded AOD providers across the state, this sample offers high-value insights into our sector.

The AOD Sector Insights 24-25 report shows that over the period:

- The primary (most common) client demographic group accessing AOD services were individuals aged 30–39, who identified as male, with Alcohol as the presenting drug of concern, living in a private residence with a mental health diagnosis of a mood (affective) disorder.
- On average, 68% of clients reported a mental health diagnosis (excluding 'unknowns').
- 11% of clients were born outside Australia.
- Metropolitan services supported a more culturally diverse client group, with nearly three times as many refugees/asylum seekers and almost triple the proportion of clients born outside Australia compared with regional services.
- 9% of individuals identified as Aboriginal and/or Torres Strait Islander.
- 23% of clients had a recorded forensic status, with the majority linked to community-based orders, with Community Correction Orders making up just under half of all forensic clients, followed by other diversion referrals, bail, and court diversion.
- Alcohol was the primary presenting drug of concern, followed by stimulants and cannabinoids in both metropolitan and regional service settings.
- Geographic analysis revealed that metro services manage more diverse substance presentations, while regional areas showed particularly elevated methamphetamine treatment relative to other substances.

The VAADABase project highlights the value of collective data sharing in building a clearer picture of sector trends and client needs. While this report provides an important early snapshot, expanding the number of organisations participating in the project and strengthening data consistency will be key to developing more robust and representative insights.

VAADABase supports the sector to better understand demand, client complexity, and service patterns—informing planning, advocacy, and policy development to improve outcomes for people accessing AOD treatment in Victoria.

Introduction

This report presents findings from the VAADABase pilot project, a collaborative initiative involving AOD agencies across Victoria. VAADABase is an online data platform that compiles de-identified client and service information from agency client management systems (CMS), aligned with the VADC specification.

Participating Agencies

- Access Health & Community
- Ballarat Community Health
- Bendigo Community Health Services
- Caraniche
- Dhelkaya Health
- Each
- Odyssey Victoria
- Primary Care Connect
- Salvation Army Victoria
- Uniting Victoria & Tasmania
- Windana
- WRAD Health
- Youth Support + Advocacy Service (YSAS)
- Better Health Network
- Latrobe Community Health Service
- Anglicare Victoria*
- Sunraysia Community Health Services*

**These agencies participated in VAADABase across 2023 to 2024 and were instrumental in developing the project structure and governance framework, though they are not contributing data to this current report.*

VAADABase operates under a governance structure comprising two key groups:

Project Executive Group (PEG): Provides strategic oversight and direction for the project, ensuring alignment with sector needs and strategic objectives. PEG members have shared data, contributed dashboard enhancement ideas, and provided expert guidance on the development of dashboards and this sector insights report.

Data Working Group: Comprises individuals who support data sharing processes, provide data guidance, and contribute technical expertise to ensure data quality and integrity

VAADA coordinates VAADABase, while The Latitude Network serves as the trusted third-party data custodian, responsible for developing data dashboards and processing the data securely.

All participating agencies have invested their own funding and time to support this project, demonstrating their dedication to sector-wide data collaboration and evidence-based practice improvement without external government or grant funding.

Data Scope and Coverage

The data analysed in this report covers the period 1 July 2024 – 30 June 2025 and includes information on 25,258 clients and 60,788 closed service events across 126 service outlets. While this does not represent all Victorian AOD services, the report provides an early view of service utilisation, drug trends and client demographics across a diverse sample of agencies and regions.

It is important to note that not all Victorian AOD agencies are currently participating in VAADABase. Expanding the project will help build a more comprehensive picture of drug treatment trends, client demographics and service utilisation across the Victorian AOD sector.

Purpose of this Report

The purpose of this AOD Sector Insights report is to:

- Provide a high-level overview of who is accessing AOD treatment services within VAADABase participating agencies.
- Highlight patterns in service utilisation, presenting issues, and co-occurring needs such as mental health and family violence.
- Support sector agencies, policy makers, and the workforce with emerging insights that can inform planning and service development.

Methodology

The data in this report is drawn from participating agencies' respective client management systems which report to the Victorian Department of Health via the VADC specification. De-identified VADC data is shared monthly with The Latitude Network, the project's trusted third-party data custodian. Aggregated data is then shared by The Latitude Network with the VAADA, which maintains a comprehensive, de-identified State of the Sector dashboard, comprising data from all contributing agencies.

This report draws on data from 15 participating agencies, encompassing 25,258 clients and 60,788 closed service events across 126 service outlets. While this does not capture all AOD service activity in Victoria, the sample offers a strong representation of service utilisation across the sector.

The report includes information on:

- Client demographics
- Family violence prevalence
- Drugs of concern

- Service events
- Mental health diagnosis prevalence
- Health assessments

This report was prepared by Esther Toomey, Project Coordinator at VAADA, with support from Palermo Moyo, Data & Analytics Manager and Dale Renner, Chief Executive Officer from The Latitude Network. Findings have been drawn from data processed by The Latitude Network.

Interpreting the Data

The interpretation of the data requires consideration of several factors. The geographical distribution of client numbers primarily reflects the service capacity of participating agencies rather than actual demand for services. Further, the analysis draws from a subset of Victorian AOD treatment agencies. While it represents a significant sample of service types and service locations, caution should be exercised in generalising the findings.

In analysing these statistics, it's important to recognise that the dataset counts clients in each organisational program and client episodes rather than unique individuals by Statistical Linkages Key (SLK). In other words, the data shows the number of service contacts, rather than the number of unique individuals accessing services.

Service delivery patterns are significantly shaped by funding allocations and service agreements. Individual agencies are funded to provide specific service types. For example, some agencies may be funded to provide counselling, while others may focus exclusively on residential withdrawal treatment. This targeted funding model means that service utilisation data cannot be interpreted as a direct indicator of service type demand. Rather, it reflects the predetermined service capacity and contractual obligations of each agency.

These factors mean the current dataset cannot yet provide a complete picture of AOD service demand and delivery across Victoria. Ongoing expansion of agency participation, along with continued improvements to data quality and consistency, will strengthen future reporting and sector insights

Key Findings

Clients

Between 1 July 2024 and 30 June 2025, a total of 25,258 clients accessed AOD services, contributing to 60,788 closed treatment events across 126 service outlets.

Metropolitan services supported a more culturally diverse client group, with nearly three times as many refugees/asylum seekers and almost triple the proportion of clients born outside Australia compared with regional services.

Regional services recorded proportionally more Aboriginal and Torres Strait Islander clients. Despite these differences, both service types share a similar overall client profile:

- Predominantly male clients aged 30–39
- Most live in private accommodation
- Alcohol is the leading presenting drug of concern
- Mood disorders is the most common co-occurring mental health condition

Metropolitan Providers

The image (1) below shows the most frequent client responses and percentage proportions for key demographic indicators within metropolitan AOD services
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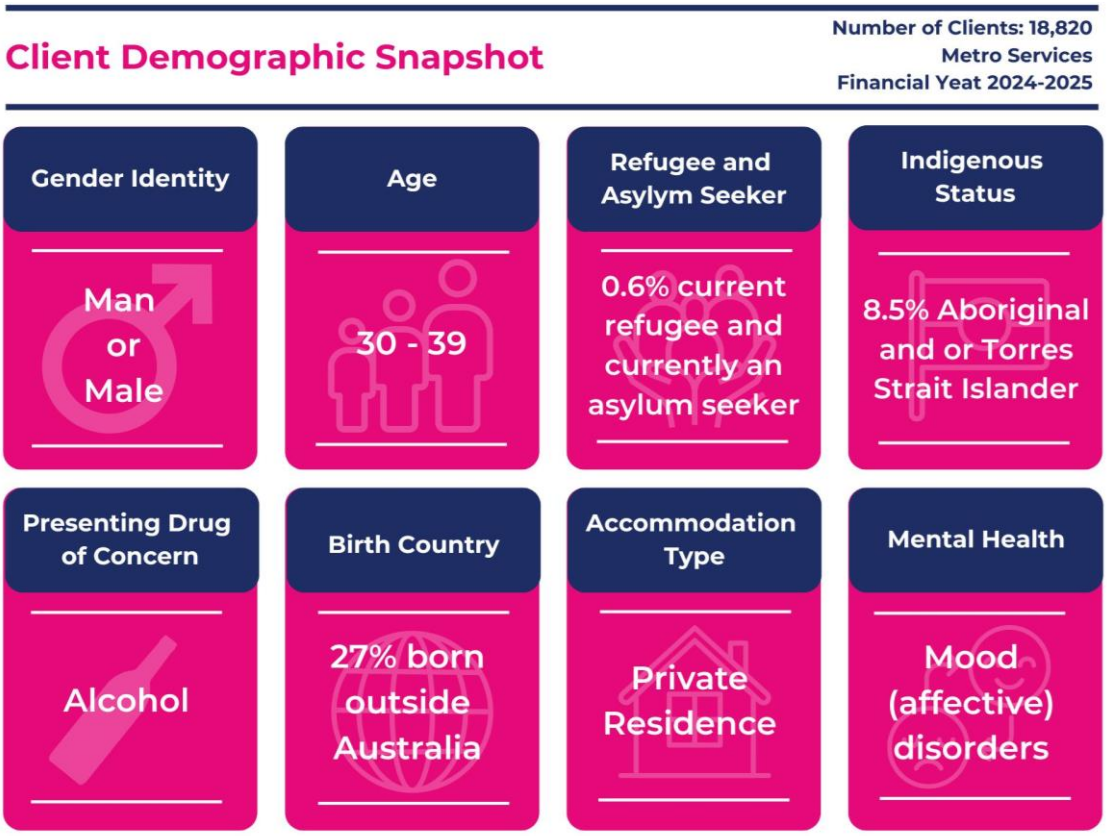


Image 1. Client demographic snapshot across metropolitan services

Regional Providers

The image (2) below shows the most frequent client responses and percentage proportions for key demographic indicators within regional AOD services.

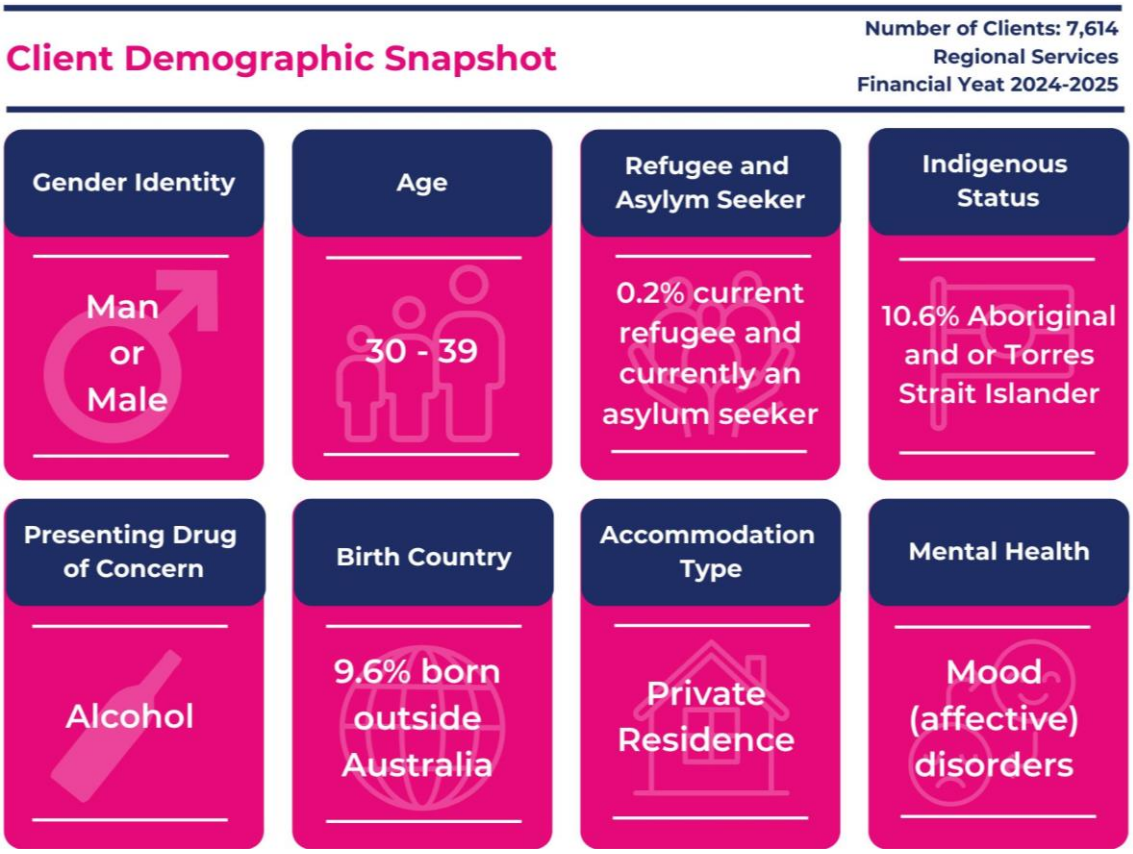


Image 2. Client demographic snapshot across regional services.

Age and Gender

AOD treatment services are primarily accessed by people aged 20-49, particularly those aged 30-39, who appear overrepresented compared to the general population. While 30-39 year-olds make up 15.5% of Victoria's population, they represent 31% of all clients in the dataset-twice their population proportion. Similarly, 40-49 year-olds (24% of clients vs 12.9% of the population) and 20-29 year-olds (22% vs 14.4%) are overrepresented by age in the demographics (Table 3).

Young people (10-19) comprise 5% of clients despite making up 12% of the Victorian population. However, this disparity can be explained by our sample predominantly servicing adults and limited youth-specific services making up the sample.

Those aged 60+ collectively represent 23.4% of Victoria's population, but this is 5% for AOD clients in our sample.

It should be noted that the current dataset obtained through VADC has limitations in capturing comprehensive gender identity information. While VADC collects both sex assigned at birth and gender identity fields, the current data collection does not include specific categories for transgender, cisgender, or gender fluid identities. This limits our ability to understand the experiences and service utilisation patterns of gender diverse clients within participating agencies.

Gender Identity \ Age	10-19	20-29	30-39	40-49	50-59	60-59	70-79	80-89
Woman or Female	2%	7%	8%	6%	3%	1%	0%	0%
Man or Male	2%	9%	13%	10%	6%	2%	0%	0%
Other			0%					
Non-binary	0%	0%	0%	0%	0%			
Different Term	0%	0%		0%	0%			
Prefer Not To Answer		0%						
Not Stated / Inadequately Described	1%	6%	10%	8%	5%	2%	0%	0%

Table 3. Client Gender Identity and Age

Sexuality

A total of 7.8% of clients identified as Lesbian, Gay, or Bisexual (LGB), excluding unknown data.

It should be noted that the current dataset obtained through VADC has limitations in capturing comprehensive sexuality information. The available categories are limited to Lesbian, Gay, and Bisexual, which does not fully represent the diversity of sexual orientations. Other sexual orientations such as pansexual, asexual, queer, or other identities are not currently captured in the data collection.

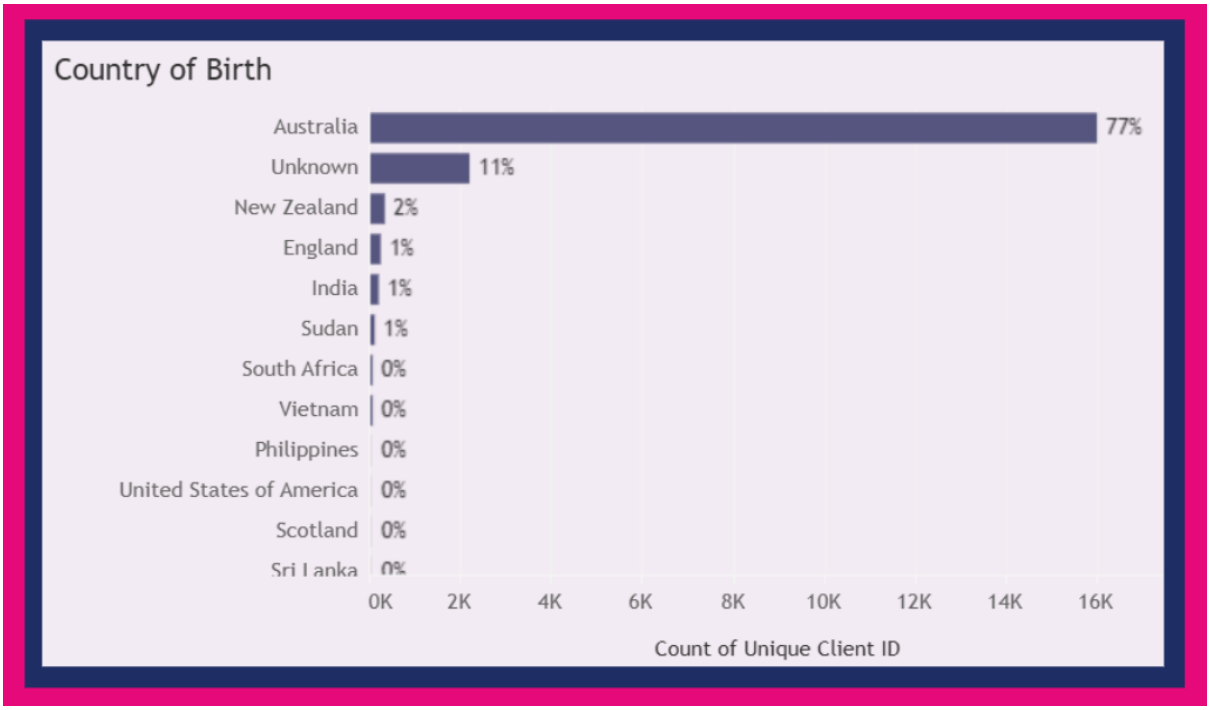
Future enhancements to data collection may include expanding sexual orientations and gender identities to better capture the diversity of clients accessing AOD services and ensure more inclusive reporting.

Country of Birth

The dataset indicates that the majority of clients (78%) were born in Australia and 11% were born outside of Australia, with 11% unknown (Graph 4). The most common country of birth outside Australia is New Zealand (2%). Smaller proportions of clients originated from England, India and Sudan. In comparison, as of June 2024, Victoria's estimated resident population was approximately 7 million, with about 72% born in Australia and 28% born overseas. The most common countries of birth for overseas-born Victorians include England, India, China, and New Zealand (ABS). This indicates that overseas-born communities are accessing AOD services at less than half the rate of their population.

Country of birth serves however as a limited proxy for cultural background and may not accurately reflect the cultural diversity of clients accessing AOD services. Many people born within Australia identify as being culturally diverse, including second or third-generation migrants, or those from multicultural families. Conversely, some people born overseas (such as in England or New Zealand) may not identify as being culturally diverse due to shared language and similar cultural contexts.

The underrepresentation of overseas-born clients may suggest potential barriers to service access for some culturally and linguistically diverse communities, such as language barriers, cultural stigma around substance use, lack of culturally appropriate services, or limited awareness of available supports. However, the true extent of cultural diversity among clients remains unclear due to the limitations of using country of birth as the primary indicator of cultural background.



Graph 4. Country of Birth

Demographics

In terms of First Nations background, 8.9% of individuals identified as Aboriginal (but not Torres Strait Islander), 0.2% as Torres Strait Islander (but not Aboriginal), and 0.4% identified as both Aboriginal and Torres Strait Islander. The majority, 90.5%, identified as neither Aboriginal nor Torres Strait Islander.

According to ABS census data from 2021, 1% of Victoria's population identified as Aboriginal and Torres Strait Islander. The VAADABase data shows that First Nations people comprise 9.5% of service users compared to 1% of the general population—nearly ten times their population representation. This higher representation reflects the ongoing impacts of colonisation and systemic racism on First Nations communities. Historical and continuing trauma, dispossession, discrimination, and barriers to accessing culturally safe healthcare have contributed to complex health challenges, including substance use and mental health issues in Aboriginal and Torres Strait Islander communities.

These same systemic factors mean that First Nations people are also overrepresented in other service systems including forensic and justice systems, reflecting the compounding effects of intergenerational trauma and ongoing structural inequities.

It should be noted that there are currently no Aboriginal Community Controlled Health Organisations (ACCHOs) participating in the VAADABase project. This means that First Nations people accessing culturally appropriate services through Aboriginal-controlled organisations are not captured in this data. The inclusion of

ACCHOs in future phases of the project would provide a more complete picture of First Nations service utilisation patterns and may reveal even higher rates of service access than currently represented.

Family Violence

Family violence data within the Victorian Alcohol and Drug Assessment Tools (VAOD-Ax Tools) is substantially shaped by the design of the current system. While MARAM screening has been embedded into assessments for people who experience family violence (recorded as victim survivors), ensuring this cohort is consistently screened, the VAOD-Ax Tools have not yet been reformed to include systematic screening questions for people who use substances who also use family violence (recorded as perpetrators of family violence). This means the sector is not resourced to consistently identify family violence in this cohort, and current data underrepresents actual prevalence.

Most service events have not recorded family violence data. However, when 'Unknowns' are excluded, 28.6% of service events identify people as victim survivors of family violence, 14.3% as people who use violence, and 57.1% as neither. MARAM has been applied in 65.2% of service events (excluding 'Unknowns').

The relatively high proportion of victim survivors is particularly significant given the gendered demographics of AOD services. While our services predominantly work with community members who identify as male, the substantial representation of victim survivors reflects the experiences of the smaller cohort of women who access AOD services. This pattern—where a comparatively smaller number of women access AOD services but a significant proportion of these have experienced family violence—mirrors data from other settings such as correctional facilities, highlighting the strong intersection between substance use and experiences of family violence among women.

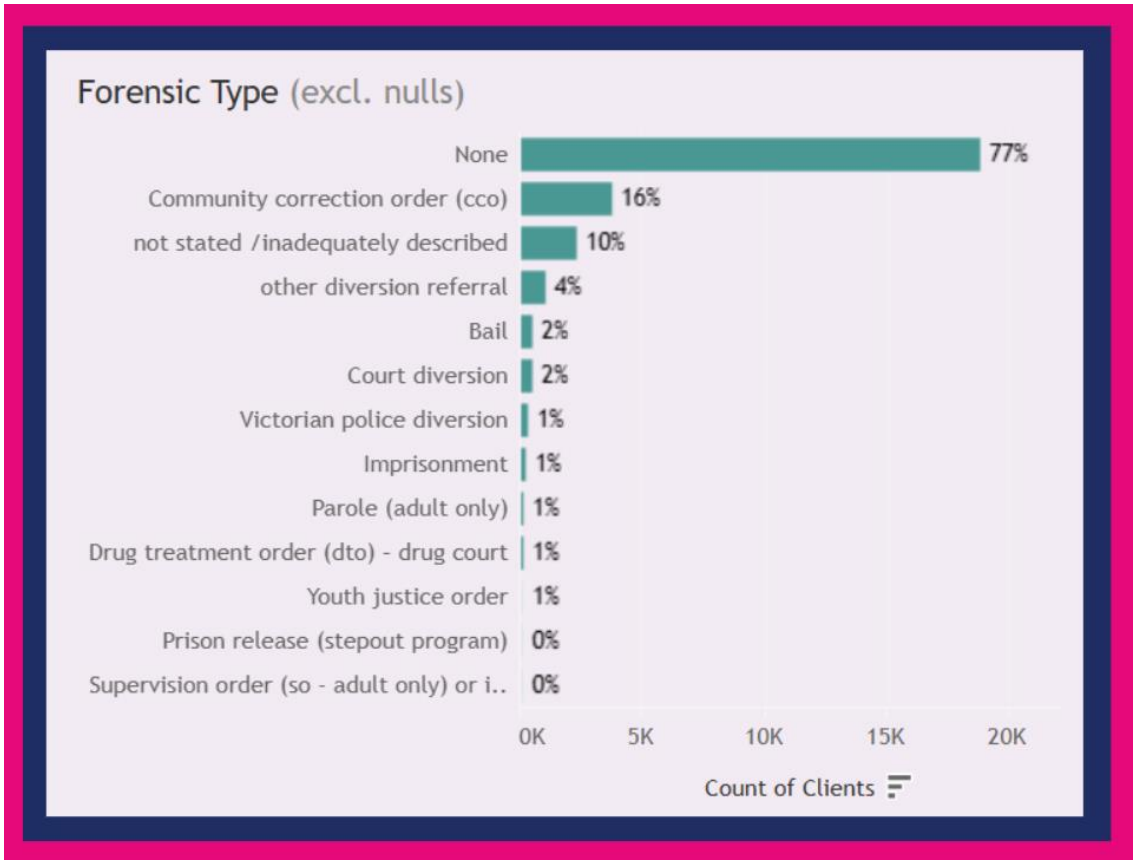
These figures align with sector expectations, reflecting both the gendered nature of family violence and the complex pathways between trauma, family violence, and substance use that particularly affect women entering AOD treatment.

The figures also highlight that the data is shaped more by systemic recording practices than by actual prevalence. The high rate of 'Unknown' recordings reflects both the absence of screening tools for people who perpetrate family violence and broader complexities in how family violence is recorded across the sector. Specialist Family Violence Advisors are working to support services in addressing these gaps, but until reform occurs, family violence prevalence data will remain a conservative estimate

Forensic Type

Excluding unknowns and "not stated/inadequately described" responses, 23% of clients had a recorded forensic status (Graph 5). Among clients with a recorded forensic status, Community Correction Orders (CCO) represented the largest single category at 16% of all clients, making up approximately 70% of clients with known forensic involvement.

Other community-based orders and diversions included other diversion referrals (4%), bail (2%), court diversion (2%), and Victorian police diversion (1%). Custodial and post-release pathways represented smaller proportions: imprisonment (1%), parole (1%), drug treatment orders (1%), youth justice orders (1%), prison release programs (0.2%), and supervision orders (0.1%).



Graph 5. Forensic Type

Client Residence Catchment

The maps below provide a visual representation of client postcodes alongside whether clients accessed metro or regional services. When examining the Metro vs Regional segments—categorised by each organisation's catchment area—a pattern emerges: many clients residing in regional areas are accessing services from metro-based organisations, while some metro residents access regional services. This cross-catchment service utilisation suggests that people aren't

always accessing services close to home and may indicate gaps in regional service provision.

These maps represent data from participating VAADABase pilot agencies only and do not include all AOD services across Victoria.

Metro Services (Map 2 - Blue): Metro services show highly concentrated client activity within Melbourne and surrounding metropolitan areas, with the largest service clusters located in central Melbourne. However, blue dots are clearly visible throughout regional Victoria—including areas around Mildura, Wodonga, Ballarat, Bendigo, and other regional centres—indicating that regional residents are travelling significant distances to access metropolitan AOD services.

Regional Services (Map 3 - Orange): Regional services demonstrate strong local catchments in their immediate geographical areas, with concentrated client activity around major regional centres like Ballarat, Bendigo, Mildura, and along the Murray River region. Notably, orange dots are visible within the Melbourne metropolitan area, suggesting that some metro residents travel to access regional services. This may be to access specialised programs or specific treatment modalities not available closer to home.

It should be noted that regional clients often travel considerable distances to access treatment, which may reflect limited service availability in their local areas. The reduced availability of outreach services means that clients often need to travel for treatment, which can be challenging for clients without reliable transport, those with caring responsibilities, or those whose circumstances affect their ability to travel.

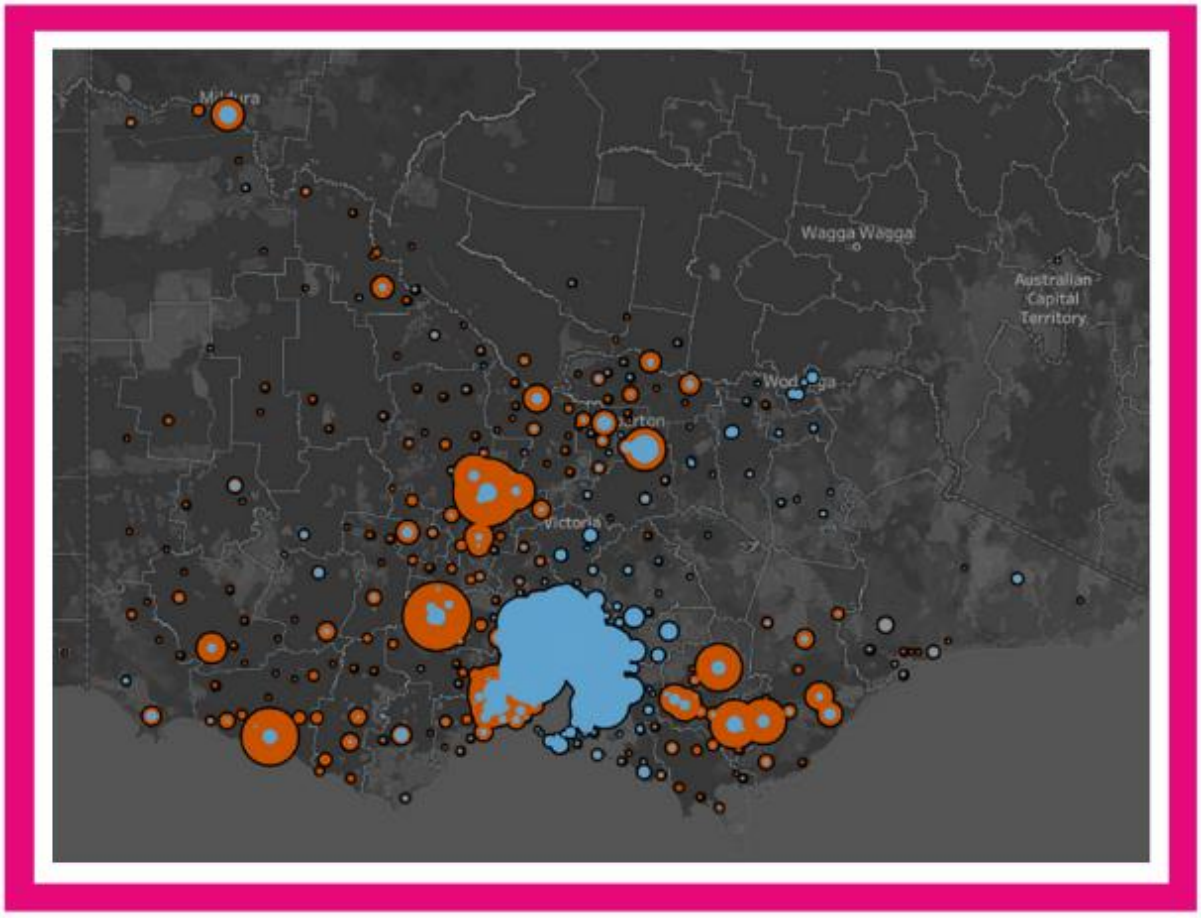
Regional areas often have fewer AOD service options compared to metropolitan areas. Clients may access metro services for specialised interventions such as residential rehabilitation, medically supervised withdrawal, or specific therapeutic programs not available locally.

The limited availability of regional Aboriginal-led services and culturally appropriate options means that First Nations clients in regional areas may seek services in metropolitan areas to find culturally suitable care. This can create additional barriers for Aboriginal and Torres Strait Islander communities and may affect help-seeking patterns or treatment engagement.

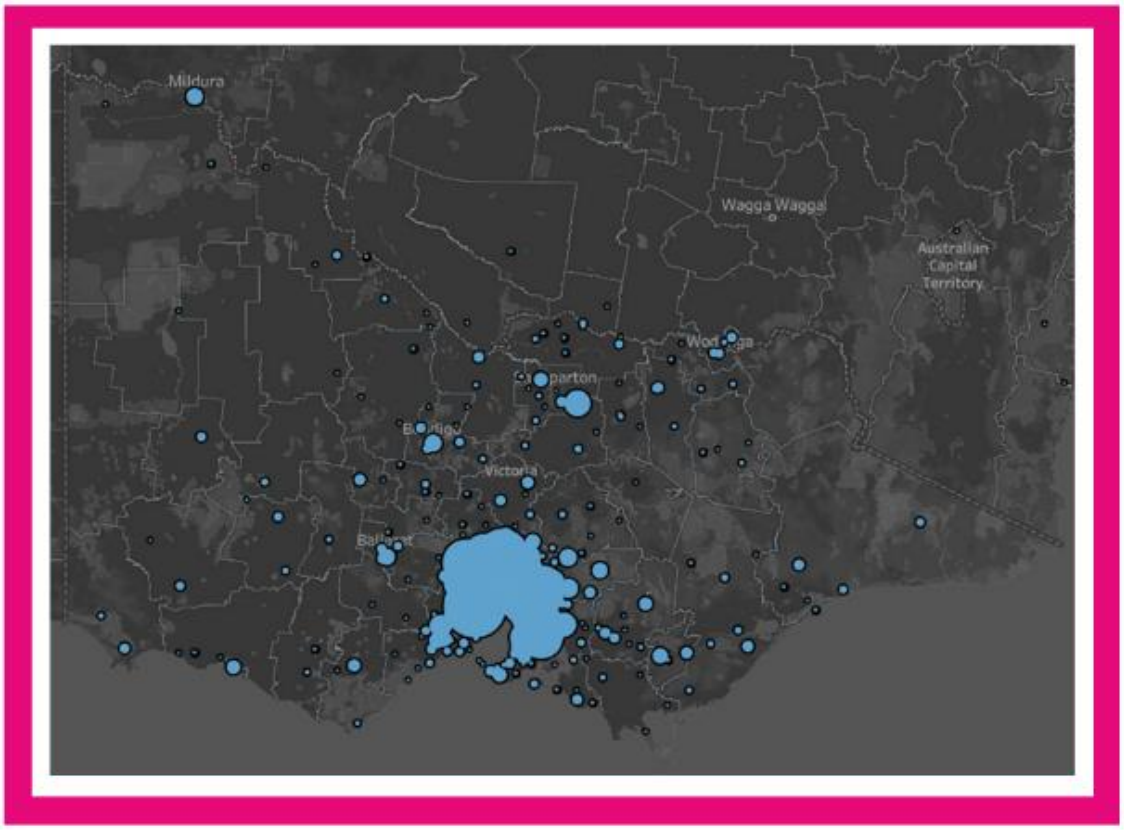
Regional service capacity may be affected by infrastructure limitations including fewer withdrawal management beds, residential rehabilitation facilities, and specialist medical support. These factors can lead regional clients to access metropolitan services for treatments that might ideally be available closer to home, which can impact support networks and create additional considerations for sustained recovery.

This cross-catchment utilisation pattern highlights opportunities for investment in regionally-based infrastructure, culturally appropriate service models, and rural workforce development. The current pattern creates additional considerations for both metropolitan services (which accommodate out-of-area clients) and regional clients (who may face geographic, financial, and social considerations in accessing care).

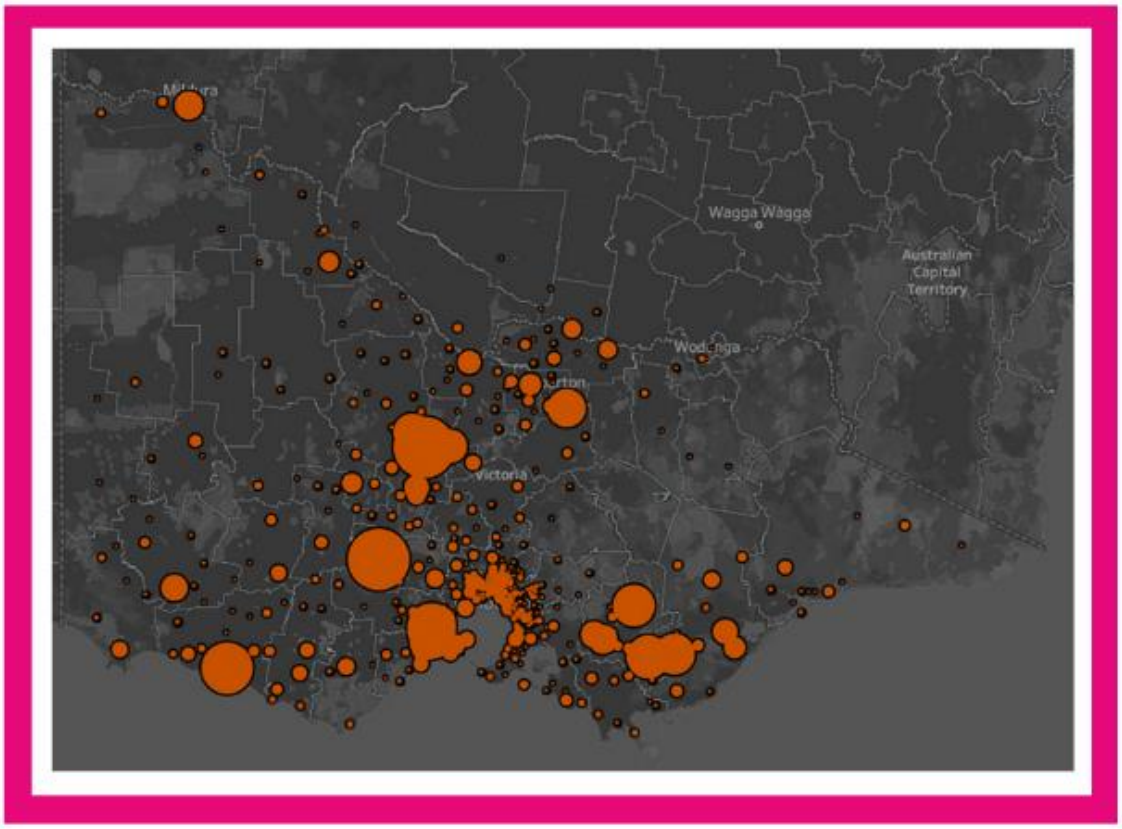
Blue dot: Metro Service + Client Postcode
Orange dot: Regional Service + Client Postcode



Map 1. Metro and Regional Services + Client Location



Map 2. Metro Services + Client Location



Map 3. Regional Services + Client Location

Drug of Concern

Over the 2024–25 period, alcohol consistently accounted for the largest presenting drug of concern across Victorian alcohol and drug services. Stimulants, including amphetamines and methamphetamine, were the second most common presenting substance, followed by cannabinoids. Other substances such as heroin, cocaine, and GHB remained steady but at lower levels. Overall, alcohol and stimulants appear to drive primary treatment demand (Chart 1).

Across all services, some substance categories show a decline in presentations from mid-2024 to mid-2025; however, this likely reflects incomplete data sharing rather than actual decreases in use patterns.

Regional services (Chart 2) exhibit distinct substance use patterns compared to metropolitan areas. Alcohol remains the primary drug of concern, followed by methamphetamine and cannabis. Presentations for heroin, cocaine, and GHB are notably lower than in metropolitan areas, while methamphetamine is particularly prominent, indicating different substance use patterns and availability in regional communities.

Metro services (Chart 3) mirror overall state patterns, with alcohol presenting as the highest concern, followed by stimulants. Presentations for heroin, GHB, cocaine, and cannabis remain consistent, suggesting more diverse substance use patterns in metropolitan settings. Many substance categories show declining numbers from mid-2024 to mid-2025, again likely due to incomplete data sharing rather than reduced use.

All charts display monthly service events by the presenting drug of concern. This refers to the substance identified by the client at presentation, which is a mandatory data item in the VADC. While secondary or additional drugs may emerge during treatment, this extract captures only the primary drug reported at presentation. Data are classified using the Australian Standard Classification of Drugs of Concern (ABS) and exclude Null or Unknown entries.

While the VADC system can capture secondary and multiple drugs of concern (up to six substances), this information is not included in the current report. This represents a limitation, as clients often present with complex polydrug use patterns that are not reflected in primary substance reporting alone.

Future reporting would benefit from analysis of secondary and tertiary drug concerns, including examination of "unknown" entries in these categories, to better understand the full scope of substance use presentations and improve service responses to address complex client needs.

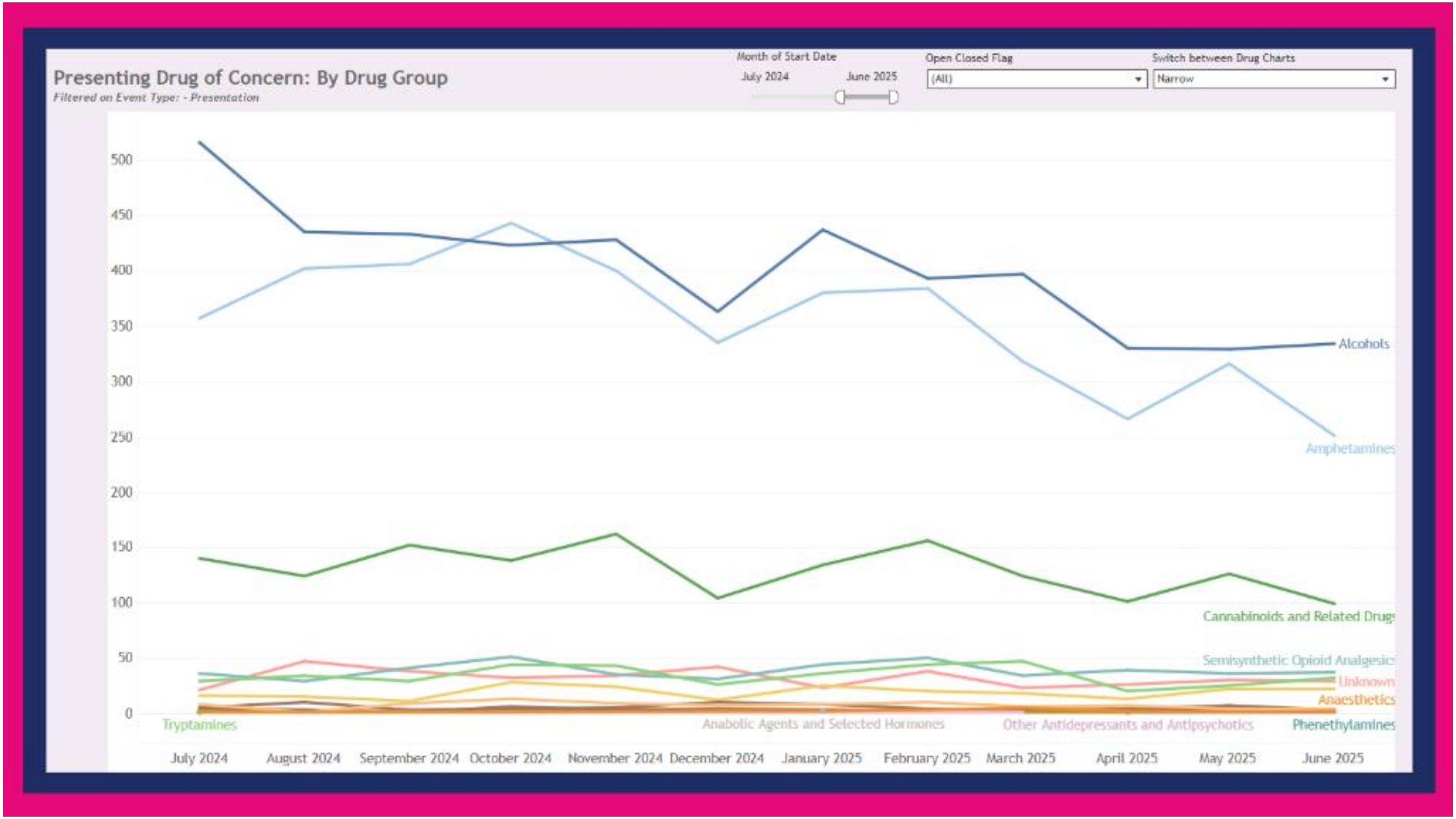


Chart 1. Presenting Drug of Concern – Metro and regional services 2024-2025

Chart 2. Presenting Drug of Concern – Regional services 2024-2025

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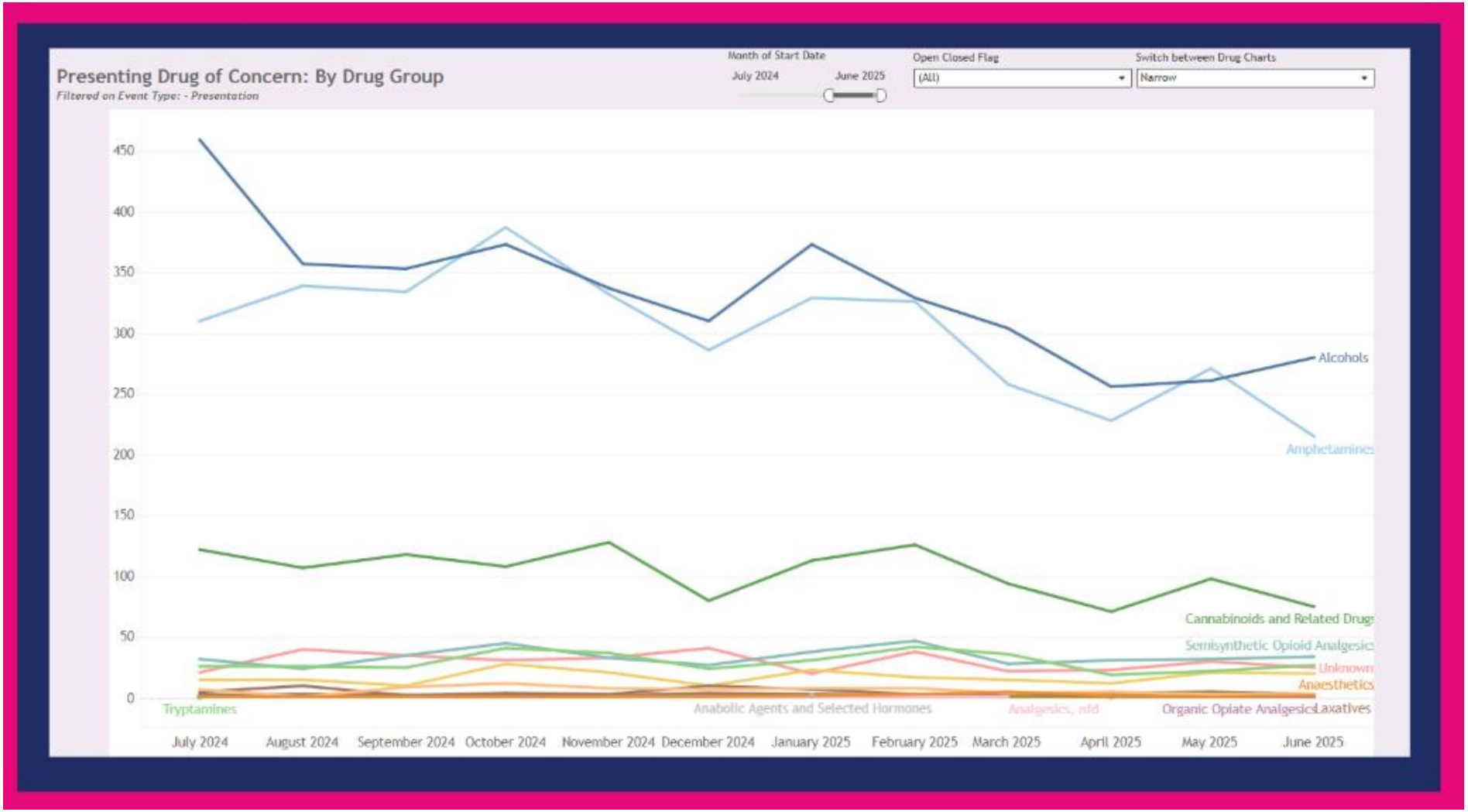

Chart 3. Presenting Drug of Concern – Metro services 2024-2025

Drug Use Patterns by Victorian Region

When examining drug use patterns by Victorian regions (Chart 4) based on participating services in the project, Sedatives and Hypnotics represent the largest treatment demand across most regions, typically accounting for 35-60% of presentations and Stimulants and Hallucinogens form the second major category, generally comprising 25-50% of regional presentations. For broad drug groupings, refer to the Australian Standard Classification of Drugs of Concern.

Metro areas show relatively consistent patterns with sedatives dominating (36-59%), while regional areas display more variation. Notably, Goulburn Valley shows a high proportion of cannabinoid presentations (43%), and some regions like Hume and Metro-South show a higher proportion of stimulant presentations (52% and 45% respectively).

Cannabinoid presentations vary significantly by region (7-43%), suggesting different local substance use patterns or service specialisation. Analgesics remain a minor but consistent category across most areas (2-8%), while other drug categories represent a minimal proportion of treatment demand.

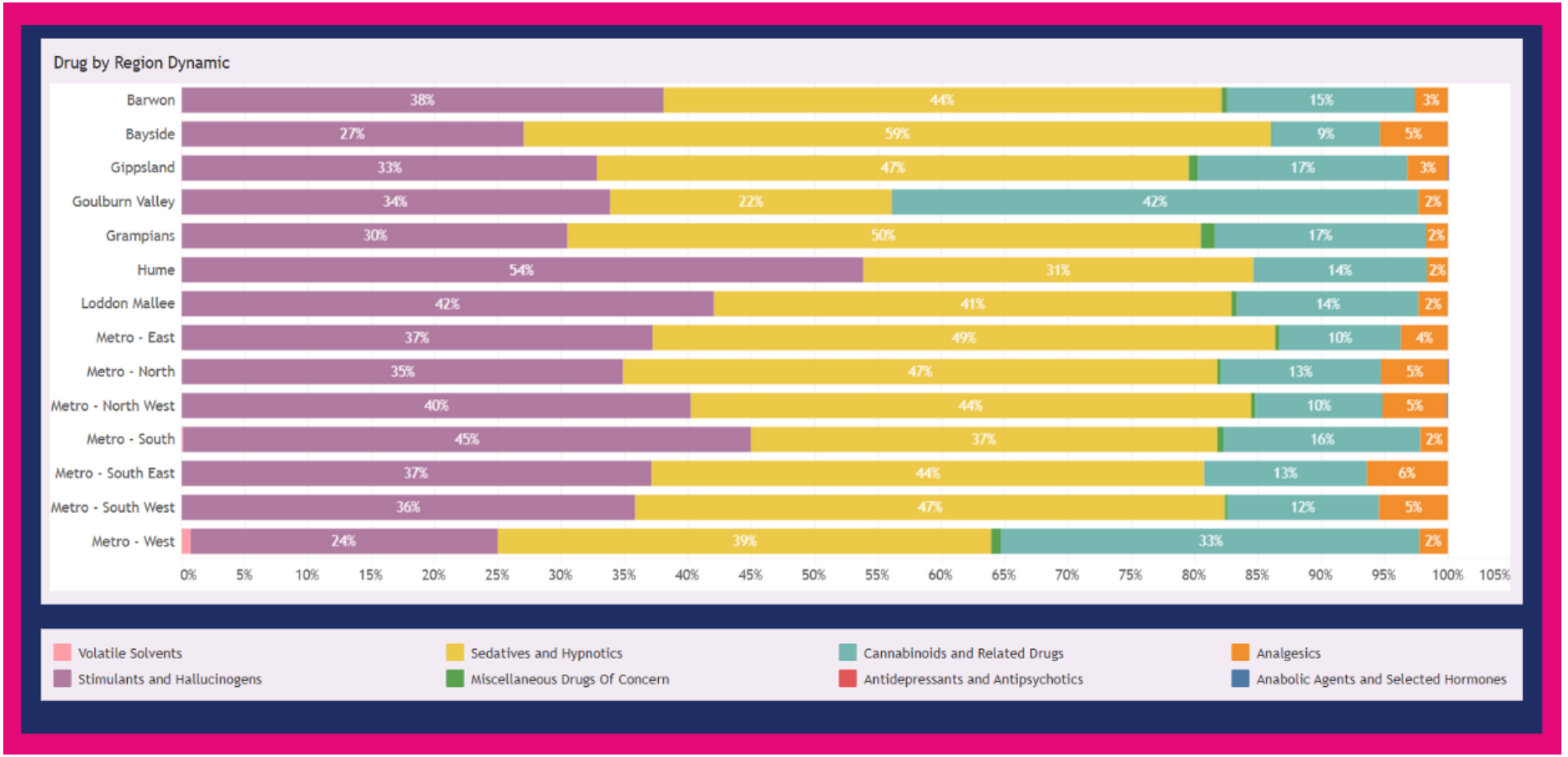

Chart 4. Drug of Concern by Victorian Region

Mental Health

Analysis of data (Chart 5) over the period (FY24-25) showed that 68% of clients reported a mental health diagnosis (excluding 'nulls').

These findings align with recent research in the VAADA Mental Health Presentations report (March 2025), which found even higher rates of mental health presentations among AOD clients when including both diagnosed conditions and those presenting with symptoms of psychological distress. According to that report, 83% of clients accessing AOD treatment services had either a diagnosed mental health disorder or displayed symptoms of a mental health condition.

Among diagnosed conditions in the VAADABase data, mood (affective) disorders were predominant.

It's worth emphasising that the data focuses specifically on mental health diagnoses as documented in the VADC data, rather than self-reported symptoms without diagnosis (which were included in the Mental Health Presentations report's broader assessment).

Despite these methodological differences, both offer a similar picture: mental health conditions represent the norm rather than the exception among clients seeking AOD treatment services.

Chart 5. Mental Health Trends

Health Assessments

The Health Assessments data (Chart 6) indicates AOD clients typically present with co-occurring needs across physical health, psychological wellbeing, and substance use domains. The patterns suggest most clients fall in the moderate to higher concern ranges across these assessment tools (some of which are self-assessed), reflecting the complex needs of clients who seek AOD treatment services.

Physical health scores displayed a bell curve distribution with peaks at scores 5-6, out of 10 (24% and 22%), indicating most clients rated their physical health in the moderate range, with fewer reporting very poor (5%) or excellent (4%) physical health.

Psychological health showed concentration in the lower-middle range, with the highest percentage at score 5 (25%) and substantial representation across scores 4-7. Quality of life followed a similar distribution, peaking at score 5 (23%) with gradual decline toward higher scores.

AUDIT scores indicated significant alcohol-related issues, with the largest concentrations in the 25-35 range, out of 40, (20-21% each), reflecting severe alcohol use patterns. DUDIT scores showed 44% were classified as "Likely Severe" for drug-related problems, with notable numbers in the 35-40 score ranges (19-20%).

The K10 psychological distress measure showed 44% were experiencing likely severe distress levels, with an additional 17% having moderate concerns and 15% with mild issues. 22% were classified as "Likely Well."

Chart 6. Assessments of physical, mental health and AUDIT / DUDIT

Limitations

The findings presented in this report should be interpreted as indicative rather than comprehensive, offering a snapshot of AOD service utilisation across participating agencies. Several limitations shape the interpretation of these results and highlight opportunities for future development.

VAADABase currently represents a meaningful but incomplete view of Victoria's AOD service landscape, with gaps in geographic coverage and some service types not yet represented. Notably, Aboriginal Community Controlled Health Organisations (ACCHOs) are absent, limiting insights into how First Nations clients access culturally appropriate care contribute to the overall treatment system.

The data collection, while aligned with VADC specifications, provides a limited view of the full diversity of client identities and experiences. Using country of birth as a proxy for cultural background does not fully capture the complex realities of cultural identity in contemporary Australia, where Australian-born individuals may identify strongly with diverse heritage, and some overseas-born clients may not identify as culturally diverse. Similarly, gender and sexuality fields, while improved, do not encompass the full spectrum of identities, potentially rendering invisible clients who are transgender, intersex, pansexual, asexual, or otherwise not captured in standard categories.

Importantly, the current data infrastructure captures service provision from an administrative perspective but does not systematically incorporate the voices of clients and their families. Understanding barriers to engagement, experiences of treatment, and service improvement priorities requires going beyond administrative data to include client perspectives.

Collectively, these limitations indicate that while the VAADABase project is already providing valuable early insights, it represents a foundation for understanding rather than a complete picture. The data likely underrepresents the experiences of certain communities, service pathways, and aspects of care, particularly for underrepresented groups or non-participating services. As the project evolves, addressing these gaps will be essential for building a more comprehensive, representative understanding of AOD service provision and improving outcomes for all Victorians who need support.

Conclusion

The 2024–25 AOD Sector Insights report provides a preliminary overview of client demographics, service utilisation, and presenting drug of concern trends across 15 participating Victorian AOD agencies part of the VAADABase data collaboration project. The data reveals that clients accessing services often present with complex needs, including high rates of mental health diagnoses, family violence involvement, and justice system contact. Alcohol was the most common presenting drug of concern, followed by stimulants and cannabinoids, with regional areas showing elevated methamphetamine use and metropolitan services demonstrating more diverse substance presentations. The findings highlight the critical role of AOD services in addressing substance use needs and co-occurring health and social issues.

Looking ahead, the VAADABase project highlights the value of collective data sharing in building a clearer picture of sector trends and client needs. While the current findings provide an important early snapshot, expanding participation and strengthening data consistency will be key to developing more robust and representative insights. This work supports the sector to better understand demand, client complexity, and service patterns—informing planning, advocacy, and policy development to improve outcomes for people accessing AOD treatment in Victoria.

Glossary of Terms

AOD (Alcohol and Other Drugs) – Refers to substances including alcohol and other drugs.

AUDIT (Alcohol Use Disorders Identification Test, 0–40) – A 10-item WHO screening tool measuring alcohol use frequency, dependence signs, and alcohol-related harm. Higher scores indicate greater alcohol-related risk. Data is presented in 5-point groupings.

Australian Standard Classification of Drugs of Concern – The Australian statistical standard for classifying data relating to drugs which are considered to be of concern in Australian society. Refer to the index here.

CALD (Culturally and Linguistically Diverse) – This term refers to people from diverse cultural backgrounds who speak languages other than English, including first- and second-generation Australians born overseas. This term is used in Australian health and social services to ensure equitable access to culturally appropriate care and services.

Client – In this report, the number of clients reflects the total count of individuals who consented to receive a funded service within a participating organisation during the reporting period. This includes people accessing AOD services and family members, carers, or significant others receiving support services. Counts are based on service start dates and may include multiple service episodes for the same individual.

Community Correction Order (CCO) – A court-issued order allowing a person to serve a sentence in the community under supervision, rather than in custody.

Co-occurring / Complex Needs – Refers to clients experiencing multiple needs simultaneously, such as mental health conditions, substance use, family violence involvement, or justice system contact.

CMS (Client Management System) – Software used by agencies to manage client information, record service events, and report data to funders.

DUDIT (Drug Use Disorders Identification Test, 0–44) – An 11-item questionnaire assessing drug intake, harmful use, and dependence according to ICD-10 and DSM-IV criteria. Higher scores indicate greater drug-related risk. Scores ≥25 suggest likely dependence; lower cut-offs indicate potential drug-use problems.

Family Violence: Victim Survivors and Perpetrators – Victim survivors are individuals experiencing family violence, whereas perpetrators are individuals using violence within the family context. Screening may identify either or both.

Forensic Client / Forensic Status – Refers to clients who are involved with the criminal justice system, including those subject to community correction orders, bail, court diversion, drug treatment orders, parole, or youth justice orders.

Health Assessments – Assessments capturing client wellbeing across physical health, psychological health, and substance use domains. Often self-reported.

K10 (Kessler Psychological Distress Scale, 10–50) – A 10-item self-administered measure of non-specific psychological distress over the past four weeks. Higher scores indicate greater distress, with scores ≥30 typically classified as severe. Categories include Likely Well, Mild, Moderate, and Likely Severe distress.

Metro / Regional – Classification of service location or client residence based on geographic area. Metro refers to metropolitan areas, while regional refers to non-metropolitan areas of Victoria

Mood (Affective) Disorders – Mental Health conditions that are marked by disturbances in mood and activity, ranging from depression to mania. They include manic episodes, bipolar disorder, depressive episodes, recurrent depressive disorder, and persistent forms such as cyclothymia and dysthymia. Other or unspecified mood disorders cover mixed or less clearly defined presentations.

MARAM (Multi-Agency Risk Assessment and Management Framework) – A framework for identifying and responding to family violence risk in Victoria, used across multiple service sectors.

Quality of Life Measures (0–10 scale) – Clients rate aspects of their wellbeing over the past four weeks. Higher scores indicate better outcomes.

- **Physical Health:** Self-rated physical health.
- **Psychological Health:** Self-assessed mental wellbeing.
- **Overall Quality of Life:** Ratings of life satisfaction, connection, and enjoyment.

Service Event – An instance of service provision to a client or potential client. Each event is assigned a service type and stream (e.g., Treatment + Counselling) and may be episodic (multiple contacts) or non-episodic (single contact). Events are marked as open (no end date) or closed (with end date).

Service Outlet – A physical or virtual site where services are delivered. Each provider has at least one outlet per funded service area.

SFVA (Specialist Family Violence Advisor) – Staff role providing guidance and support to AOD services on family violence screening and practice.

Statistical Linkage Key (SLK) – A method for linking client records across services in a de-identified way to track individuals while maintaining privacy.

Unknowns / Nulls – Data that is 'Not stated' or 'Inadequately described' in agency reporting. Null values refer to missing data in a database.

VAADABase – An online data platform compiling de-identified client and service information from participating AOD agencies in Victoria, used for analysis, reporting, and sector planning.

VAADA (Victorian Alcohol and Drug Association) – The peak body representing AOD services in Victoria and coordinating the VAADABase project.

Victorian Alcohol and Drug Collection (VADC) – The data collection specification for all Victorian funded AOD treatment providers. VADC lists the data elements that agencies must report from their CMS to the Department of Health.

Drug Categories / Drugs of Concern – Substances classified under the Australian Standard Classification of Drugs of Concern. Common examples include:

- **Alcohol** – Including sedatives and hypnotics.
- **Stimulants** – Amphetamines, methamphetamines, etc.
- **Cannabinoids** – Cannabis and related products.
- **Analgesics** – Pain-relief medications.
- **GHB (Gamma-Hydroxybutyrate)** – Central nervous system depressant.
- **Hallucinogens** – LSD, psilocybin, etc.