Alcohol and other drug outcome measure (ADOM)

Report 20: Summary of ADOM collection data for period July 2024 to June 2025

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Acknowledgements

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Glossary

Term	Definition
AOD	Alcohol and other drug (services).
Matched pairs	Two collections, in this case treatment start and routine treatment end collections.
Episode of care	Where multiple referrals for a person are overlapping or within 14 days they have been condensed to one episode of care using the first referral and last discharge.
PRIMHD	Programme for the Integration of Mental Health Data.
Tangata whai ora, Tāngata whai ora	Person or people seeking wellness; refers to people accessing AOD services.

Executive summary

This 20th national Alcohol and other drug outcome measure (ADOM) report provides an overview of tāngata whai ora accessing community alcohol and drug (AOD) community services and their outcomes. This report builds on previous reports by Te Pou.[1]

This report analyses PRIMHD data supplied by Health New Zealand | Te Whatu Ora (extracted on 26 October 2025) for the period July 2024 to June 2025. The data includes Health New Zealand and non-government organisation (NGO) services mandated to offer the ADOM to tāngata whai ora; and people with valid ADOM collections at treatment start and matched pairs (both treatment start and end).[2]

Appendix A summarises the method. Note, some Health New Zealand districts are not yet submitting ADOM collections to PRIMHD, so results do not represent all people attending community AOD services.

This report has three parts.

- Part one provides an overview of ADOM collections for the analysis period.
- Part two summarises ADOM data at treatment start.
- Part three presents outcomes at treatment end for tāngata whai ora in substance use, lifestyle and wellbeing, and recovery progress.

Key findings

Between July 2024 and June 2025, Health New Zealand district addiction services collected ADOM data for 37 percent of episodes of care at treatment start or assessment only; and 39 percent among NGOs.

Among ADOM treatment start collections for this period:

- 3 in 5 (57 percent) were at NGOs
- over one-third identify as Māori (36 percent)[3]
- 3 in 5 report alcohol (59 percent) as the main substance of concern; this was higher among older age groups, particularly those aged 65 and over (89 percent), and 45 to 64 (72 percent)
- 1 in 4 people (25 percent) who report a different main substance of concern say alcohol is a secondary concern.

ADOM data collected at both treatment start and end shows:

- medium-to-large decreases in the use of substances
- improvements in most lifestyle and wellbeing domains
- improvements in people's perceptions of their recovery progress.

Findings highlight positive outcomes for people accessing community AOD services and align with previous ADOM reports.

[1] ADOM reports are published on the Te Pou website, https://www.tepou.co.nz/initiatives/alcohol-and-drug-outcome-measure

[2] Tāngata whai ora could potentially have multiple treatment starts. ADOM treatment end is within July 2023 to June 2024.

[3] Māori reflect 16.8% of the general population aged 18 to 64 years, see https://www.stats.govt.nz

Introduction

This report provides an overview of ADOM data for tāngata whai ora who accessed community AOD services between July 2024 and June 2025. Findings are reported for services mandated to offer ADOM collections, tāngata whai ora with ADOM collections at treatment start, and matched pairs (people with valid ADOM collections at both treatment start and end).[4][5]

This report presents findings in three main parts.

- Part one: overview of ADOM collections for July 2024 to June 2025.
- Part two: overview of ADOM data at treatment start.
- Part three: changes during treatment (matched pairs).

It is important to consider the following when interpreting report findings.

- Findings may not be generalisable to all people accessing AOD services as ADOM data has not been collected for all people accessing these services.
- Findings in part three reflect outcomes for people who have had ADOM collected at both treatment start and end. Findings may not apply to others with different ADOM collections.
- Data cannot be used to estimate levels of problematic substance use in the general population.

This report uses PRIMHD data supplied by Health New Zealand | Te Whatu Ora extracted on 26 October 2025. Appendix A provides full details of the method.

[4] ADOM treatment end is within the July 2024 to June 2025 period.

[5] Valid collections are defined as ADOM collections with four or fewer missing items (excluding questions 7, 9, and 11).

Part one: ADOM collections within PRIMHD

This section describes ADOM collections between July 2024 and June 2025 by service type, region, and reasons for collection. Figure 1 shows the ADOM collections included in this report.

Figure 1. AOD episodes of care, ADOM treatment start collections, and matched pairs (July 2024 to June 2025)

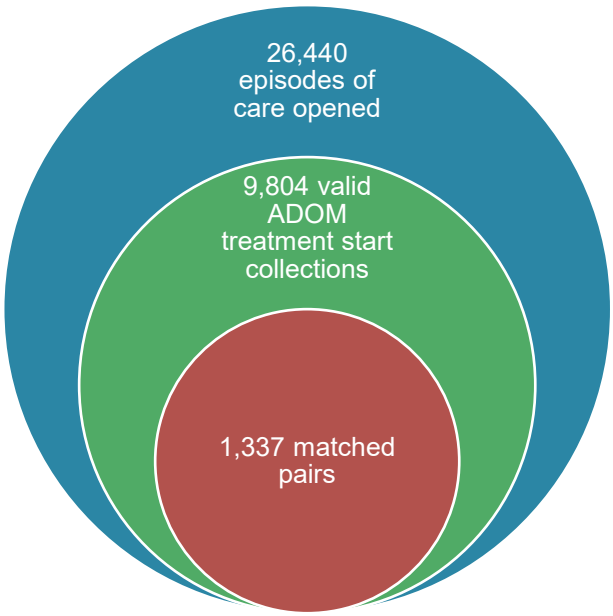


Figure 2 shows that more than half of episodes of care in ADOM data started in NGOs.

Figure 2. AOD episodes of care in ADOM mandated services by organisation type (July 2024 to June 2025)

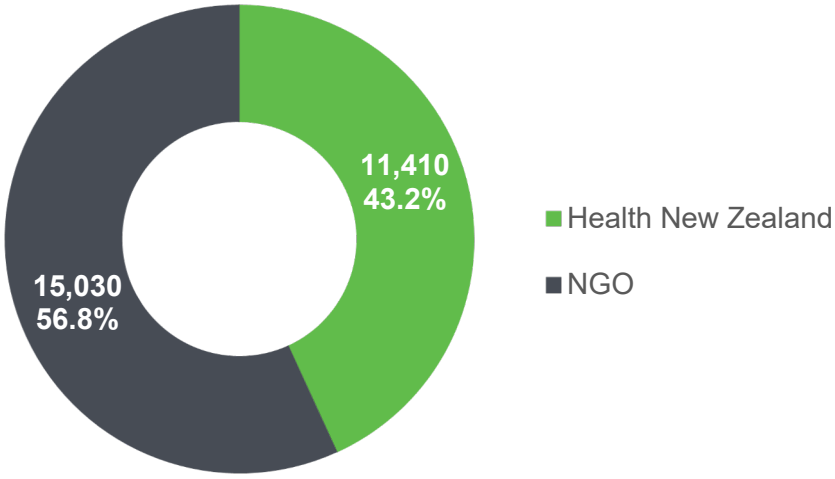


Figure 3 shows how many episodes of care within NGO and Health New Zealand services have at least one ADOM collection (treatment start or assessment only). Overall, over one-third (38.1 percent) of episodes in PRIMHD have ADOM data collected. NGOs are more likely to collect ADOM data for episodes of care than Health New Zealand services. Therefore, findings presented in Parts 2 and 3 of this report are slightly more reflective of NGOs.[6]

Figure 3. AOD episodes of care with ADOM collections (treatment start or assessment only) by organisation type (July 2024 to June 2025)

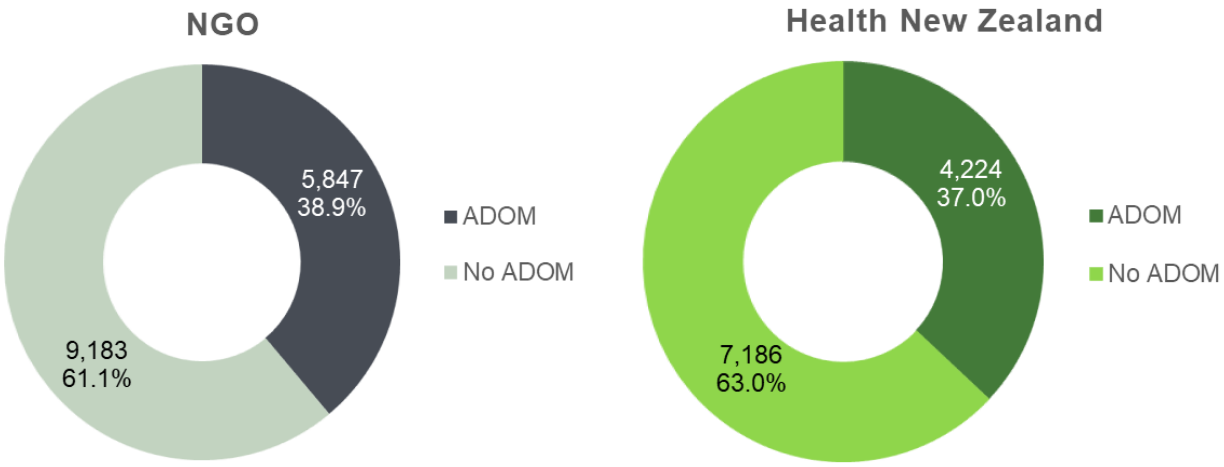


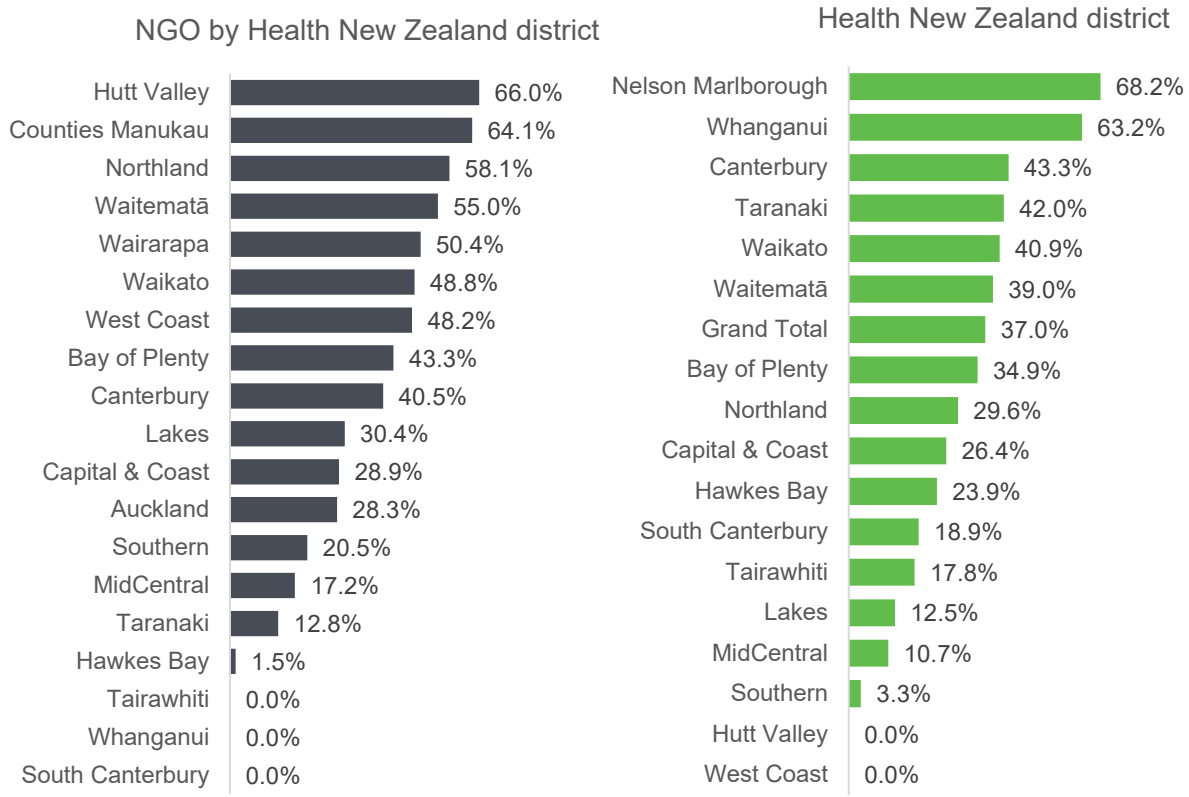
Figure 4 shows level of ADOM data collection for each Health New Zealand district (at treatment start or assessment only) in relation to episodes of care.[7] For example, on average NGOs in the Hutt Valley region collect ADOM data for two-thirds of episodes of care.

The level of ADOM collection reported here is influenced by a range of factors. For example, ADOM data is collected in some community mental health teams by addiction kaimahi are not included in ADOM completions. In addition, some Health New Zealand districts who collect ADOM do not report this to PRIMHD. This may be due to issues such as IT systems. Therefore, findings do not fully reflect the level of ADOM use within each region.

[6] Table 5 in Appendix B presents sensitivity analyses on the demographic profile of tāngata whai ora who did and did not have ADOM collections. Overall there are no large differences that would have affected data presented in this report.

[7] There are currently no eligible or very few NGOs in Nelson Marlborough district areas. It is not possible to disaggregate AOD tāngata whai ora in Health New Zealand integrated mental health teams for Hutt Valley and Wairarapa.

Figure 4. Episodes of care with ADOM collections (treatment start or assessment only) by organisation type and Health New Zealand district area (July 2024 to June 2025)



Reason for ADOM collection

Figure 5 shows reasons for ADOM collections by organisation type. Health New Zealand services had more treatment review collections. NGOs are more likely to undertake assessment only, start and end collections.

Figure 5. Reasons for ADOM collections by organisation type (July 2024 to June 2025)

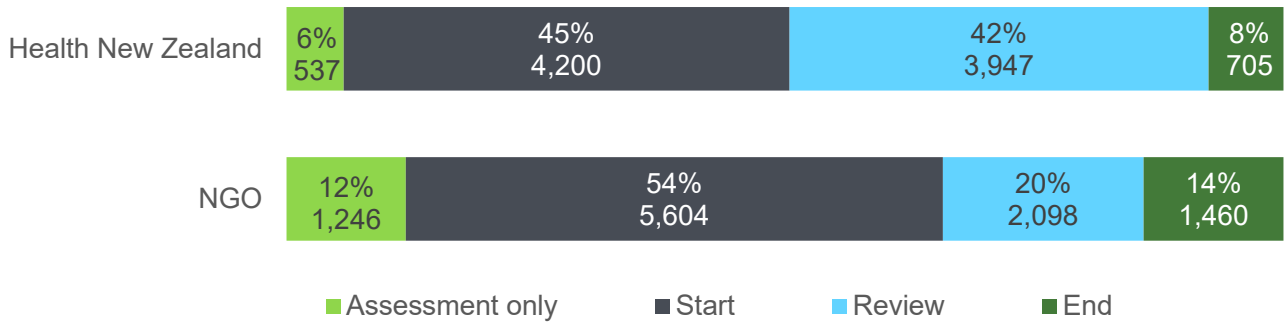


Table 1 shows the percentage of valid ADOM collections by reasons for collection. There are fewer valid collections at treatment end overall.

Table 1. Valid ADOM collections by reason for collection (July 2024 to June 2025)

Reason for collection	Valid	Not valid	Total	% valid
Assessment only	1,783	125	1,908	93%
Start	9,804	526	10,330	95%
Review	6,045	594	6,639	91%
End	2,165	417	2,582	84%

Part two: ADOM treatment start

This section describes ADOM data at treatment start including tāngata whai ora demographics, frequency of substance use, and lifestyle and wellbeing.

Figure 6 shows NGOs comprise 57 percent of ADOM collections at treatment start.

Figure 6. ADOM treatment start collections by organisation type (July 2024 to June 2025)

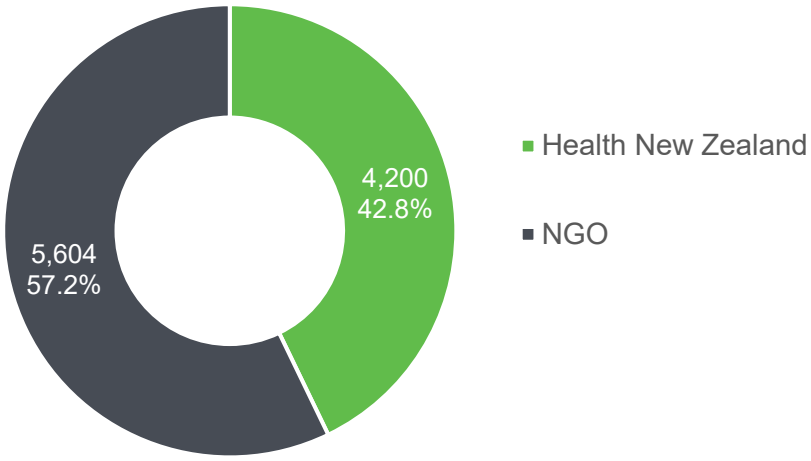


Table 2 shows the demographic profile of tāngata whai ora seen overall and those with ADOM treatment start collections. The distribution of treatment start collections is similar to the profile of tāngata whai ora accessing services, with ADOM data containing slightly higher proportions of men and Pacific peoples, and slightly lower proportions of women, Māori, and people aged between 18 and 24.

Table 2. Profile of ADOM treatment start collections and tāngata whai ora seen by gender, ethnicity, and age group (July 2024 to June 2025)

Demographic	Number ADOM	Percentage ADOM	Tāngata whai ora seen[8]
Gender			
Female	3,065	31.3%	33.7%
Male	6,726	68.6%	66.2%
Total	9,804	100.0%	100.0%
Ethnicity[9]			
Māori	3,542	36.1%	40.9%
Pacific	1,124	11.5%	9.3%
Other	5,138	52.4%	49.8%
Total	**9,804**	**100.0%**	**100.0%**
Age group			
18 to 24 years	1,257	12.8%	14.3%
25 to 44 years	5,777	58.9%	58.1%
45 to 64 years	2,484	25.3%	24.7%
65 years and over	286	2.9%	2.9%
Total	**9,804**	**100.0%**	**100.0%**

Table 3 shows average substance use in the last 28 days at treatment start. Substances with the highest reported frequency of recent use include cannabis and opioids.

Table 3. Substance use in the last 28 days at ADOM treatment start (July 2024 to June 2025)

Substance	Average use	Number	Percentage
Alcohol (frequency)	12.0 days	5,880	60.1%
Alcohol (quantity)[10]	11.6 (standard drinks)	5,785	60.0%
Cannabis	16.8 days	3,580	36.7%
Amphetamine - type stimulants	10.6 days	1,943	20.0%
Opioids	13.2 days	400	4.2%
Sedatives/tranquilisers	11.5 days	433	4.5%
Cigarette/tobacco	10.3 cigarettes	3,516	38.7%
Injected drug	11.3 days	296	3.2%

[8] Distribution of tāngata whai ora seen in community addiction services for July 2024 to June 2025.

[9] Ethnicity is prioritised in order of: Māori, Pacific, Other.

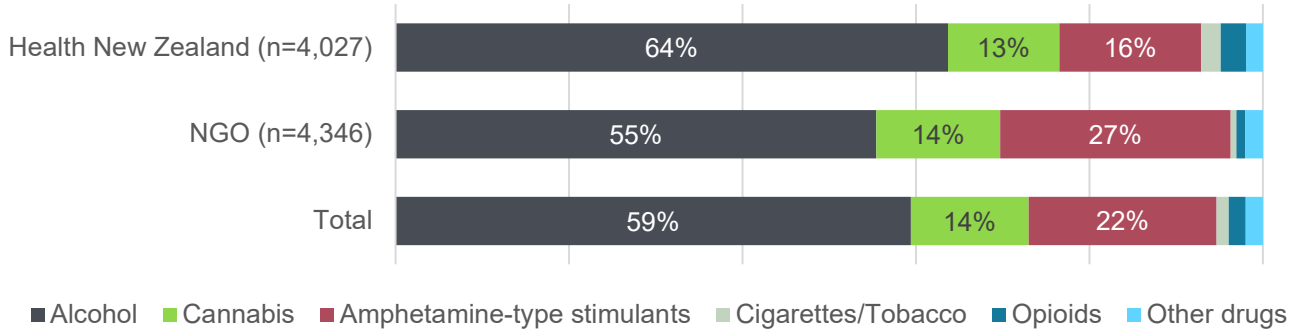
[10] Average number of standard drinks consumed on a typical drinking day.

Main substance of concern at treatment start

When tāngata whai ora access services and complete their first ADOM collection, they are asked to report their main substance of concern – this may differ from the substance they use most frequently. A main substance of concern reflects the substance people think is having the most impact on their lives. A total of 8,373 people reported a main substance of concern at start of treatment.[11]

Figure 7 shows the main substance of concern reported at treatment start in relation to organisation type. Alcohol is most commonly the main substance of concern, particularly in Health New Zealand services. Markedly more tāngata whai ora accessing NGOs report amphetamine-type stimulants as their main substance of concern compared to Health New Zealand services.[12,13]

Figure 7. Main substance of concern at treatment start by organisation type (July 2024 to June 2025)



Note. Proportions of 5 percent or less not labelled.

[11] Not all of the 9,804 people with valid ADOM treatment start collections reported a substance of concern.

[12] Figures are not indicative of substances of concern for people not accessing services or accessing different types of AOD services (eg residential).

[13] There are some differences between Health New Zealand and NGOs. Compared to NGOs, more people in Health New Zealand services report alcohol (64 percent vs 55 percent) and opioids (3 percent vs 1 percent) as their main substance of concern; and fewer people specify amphetamine-type substances (16 percent vs 27 percent).

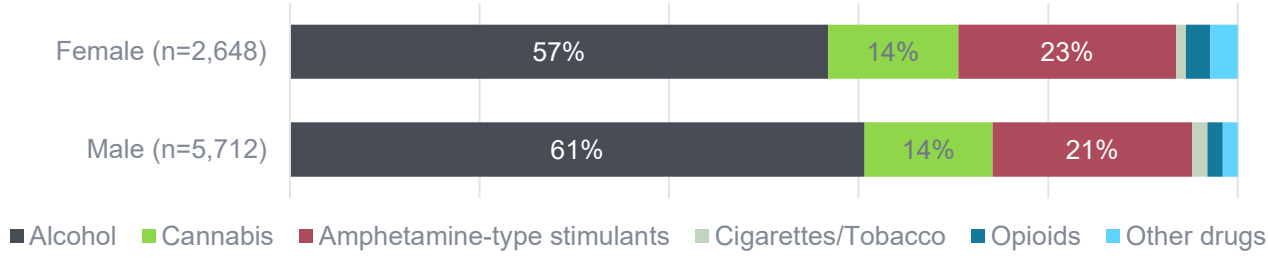
Among people who reported at least one substance of concern, around half (46 percent) reported two or more.[14] Table 4 summarises secondary substance(s) of concern. Alcohol and cannabis are common secondary concerns among people who report a different main substance of concern. Cigarettes/tobacco are secondary concerns for many tāngata whai ora regardless of their main substances of concern.

Table 4. Secondary substances of concern by main substance of concern (July 2024 to June 2025)

Main substance of concern	Total	Second substance of concern	Number	Percentage
Alcohol	4,974	Cannabis	889	17.9%
		Cigarettes/Tobacco	502	10.1%
		Amphetamine-type stimulants	273	5.5%
Cannabis	1,139	Alcohol	287	25.2%
		Amphetamine-type stimulants	175	15.4%
		Cigarettes/Tobacco	122	10.7%
Amphetamine-type stimulants	1,812	Cannabis	548	30.2%
		Alcohol	388	21.4%
		Cigarettes/Tobacco	89	4.9%

Figure 8 shows that alcohol is the main substance of concern for both men and women at treatment start. A higher proportion of women report amphetamine-type substances as their main substance of concern compared to men.

Figure 8. Main substance of concern at ADOM treatment start by gender (July 2024 to June 2025)

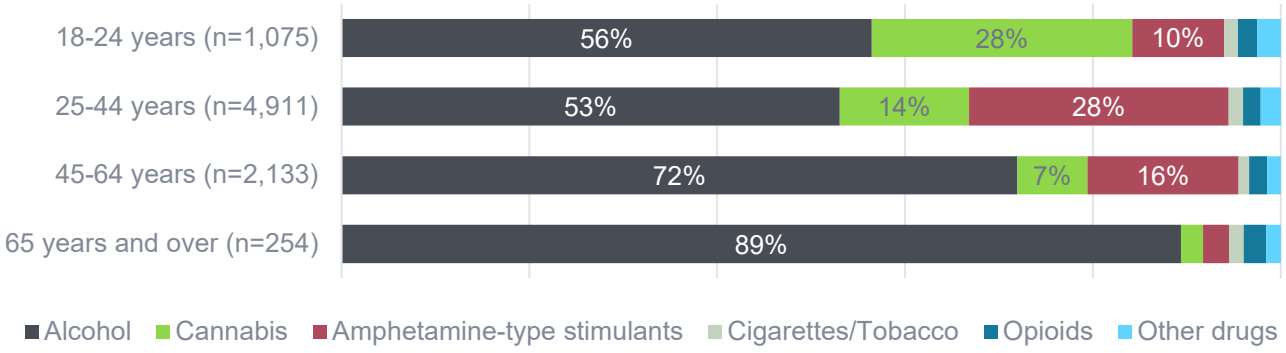


Note. Proportions of 5 percent or less not labelled.

[14] Fifteen percent of people in both Health New Zealand and NGO services did not report a substance of concern. Among those who did, slightly more people in NGOs reported more than one substance of concern (49 percent) than in Health New Zealand services (42 percent).

Figure 9 shows alcohol is the most common main substance of concern across all age groups, particularly for people aged 45 and over. After alcohol, young people aged 18 to 24 commonly report cannabis as their main substance of concern, while people aged 25 to 44 years more frequently report amphetamine type stimulants.

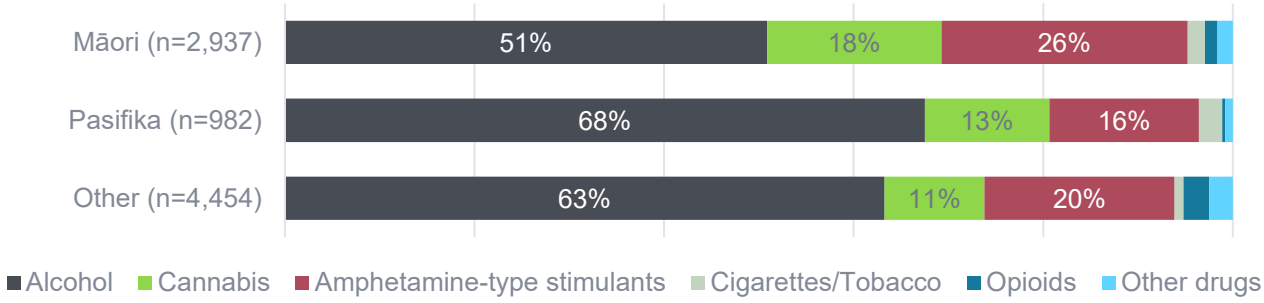
Figure 9. Main substance of concern at ADOM treatment start by age group (July 2024 to June 2025)



Note. Proportions of 5 percent or less not labelled.

Figure 10 shows alcohol is the most common main substance of concern across ethnic groups, followed by amphetamine-type stimulants and cannabis. Māori are more likely to report cannabis and amphetamine-type stimulants as a main substance of concern.

Figure 10. Main substance of concern at ADOM treatment start by ethnicity (July 2024 to June 2025)



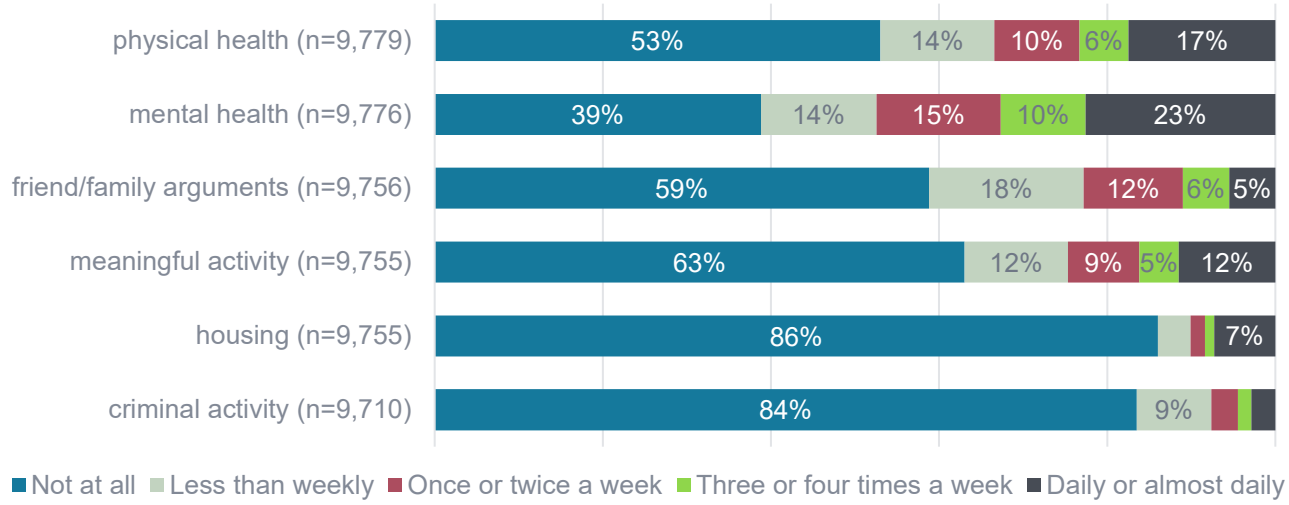
Note. Proportions of 5 percent or less not labelled.

Lifestyle and wellbeing at treatment start

This section describes lifestyle and wellbeing domains for tāngata whai ora at treatment start based on ADOM section two questions.[15]

Figure 11 illustrates the proportion of tāngata whai ora who experienced problems with lifestyle and wellbeing domains at treatment start. Almost half (47 percent) of tāngata whai ora reported mental health problems at least weekly. People also commonly reported problems with their physical health, arguments with friends/family, and engagement with meaningful activities. Around 1 in 12 (8 percent) say they are engaged in criminal activity at least once a week.

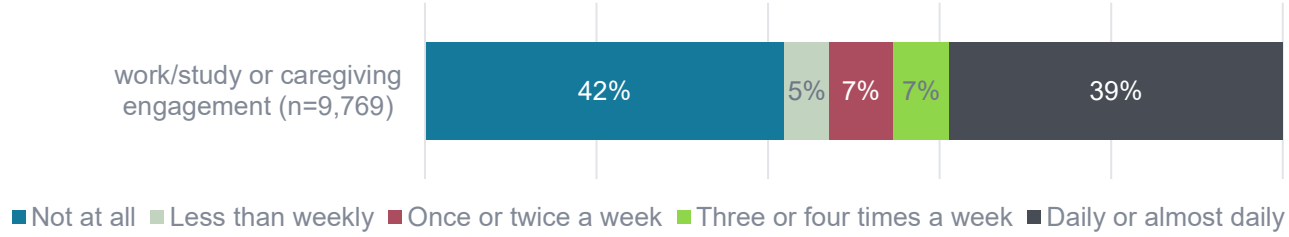
Figure 11. Lifestyle and wellbeing domains at ADOM treatment start (July 2024 to June 2025)



Note. Proportions of 5 percent or less not labelled.

Figure 12 shows over half (53 percent) of tāngata whai ora at treatment start are engaged in work, study, or caregiving each week.

Figure 12. Engagement with work, study, or caregiving at ADOM treatment start (July 2024 to June 2025)

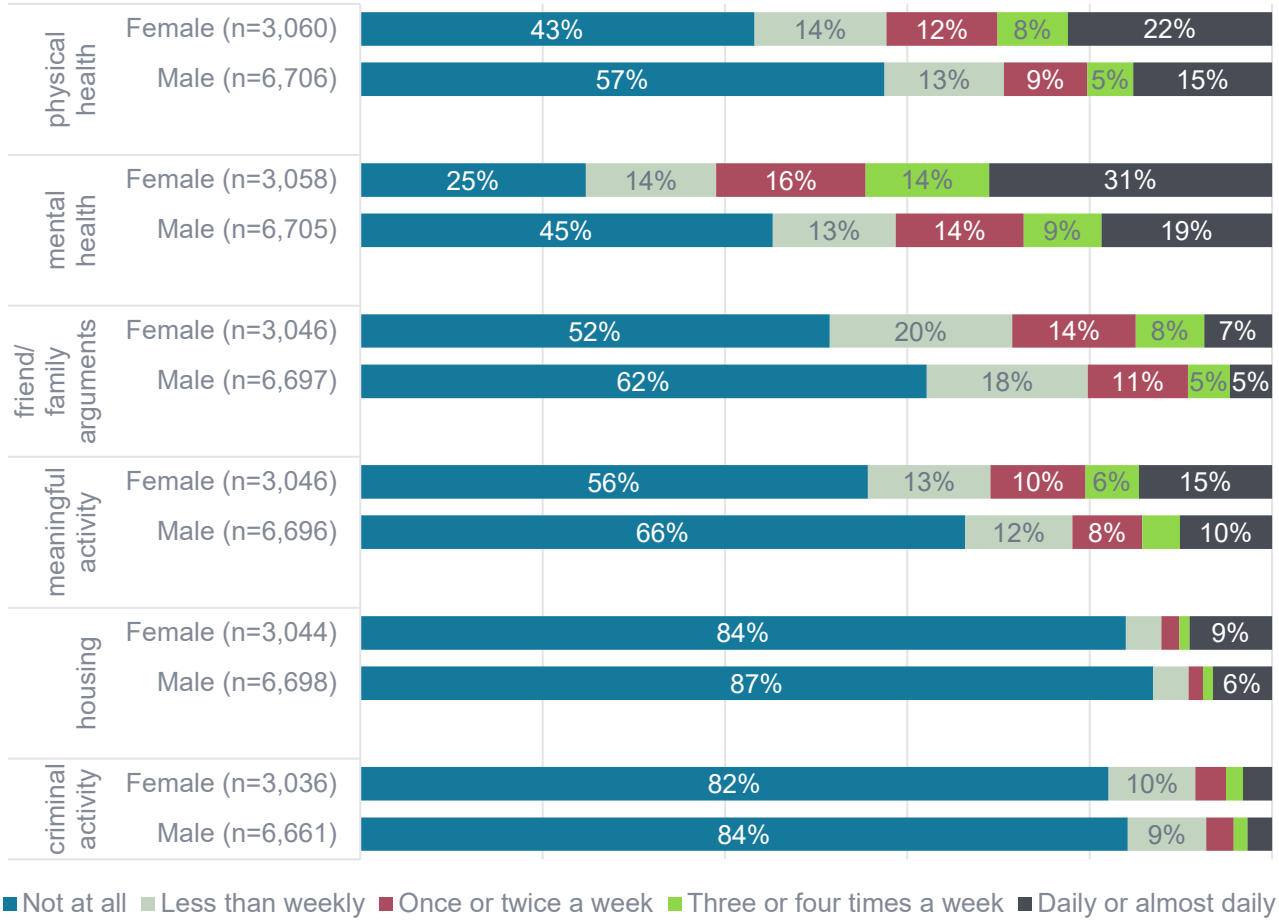


Lifestyle and wellbeing by gender

Figure 13 indicates that women are more likely to report lifestyle and wellbeing concerns than men in most areas, particularly mental and physical health.

[15] Table 7 in Appendix C provides the section two questions in full.

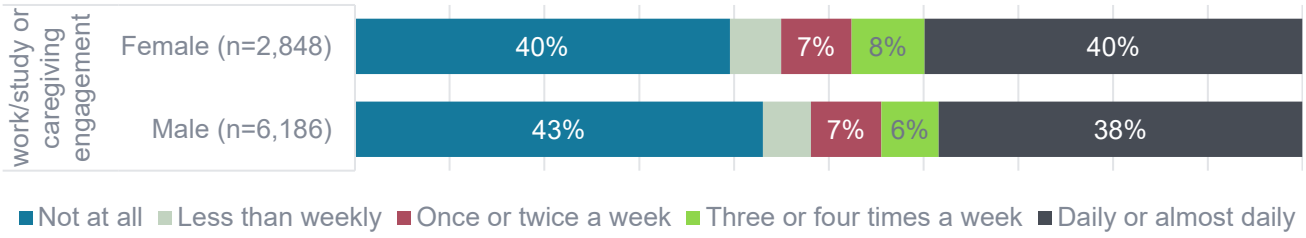
Figure 13. Lifestyle and wellbeing domains at ADOM treatment start by gender (July 2024 to June 2023)



Note. Proportions of 5 percent or less not labelled.

Figure 14 shows men and women are engaged with work, study, or caregiving activities at similar rates at treatment start.

Figure 14. Engagement with work, study, or caregiving at ADOM treatment start by gender (July 2024 to June 2025)

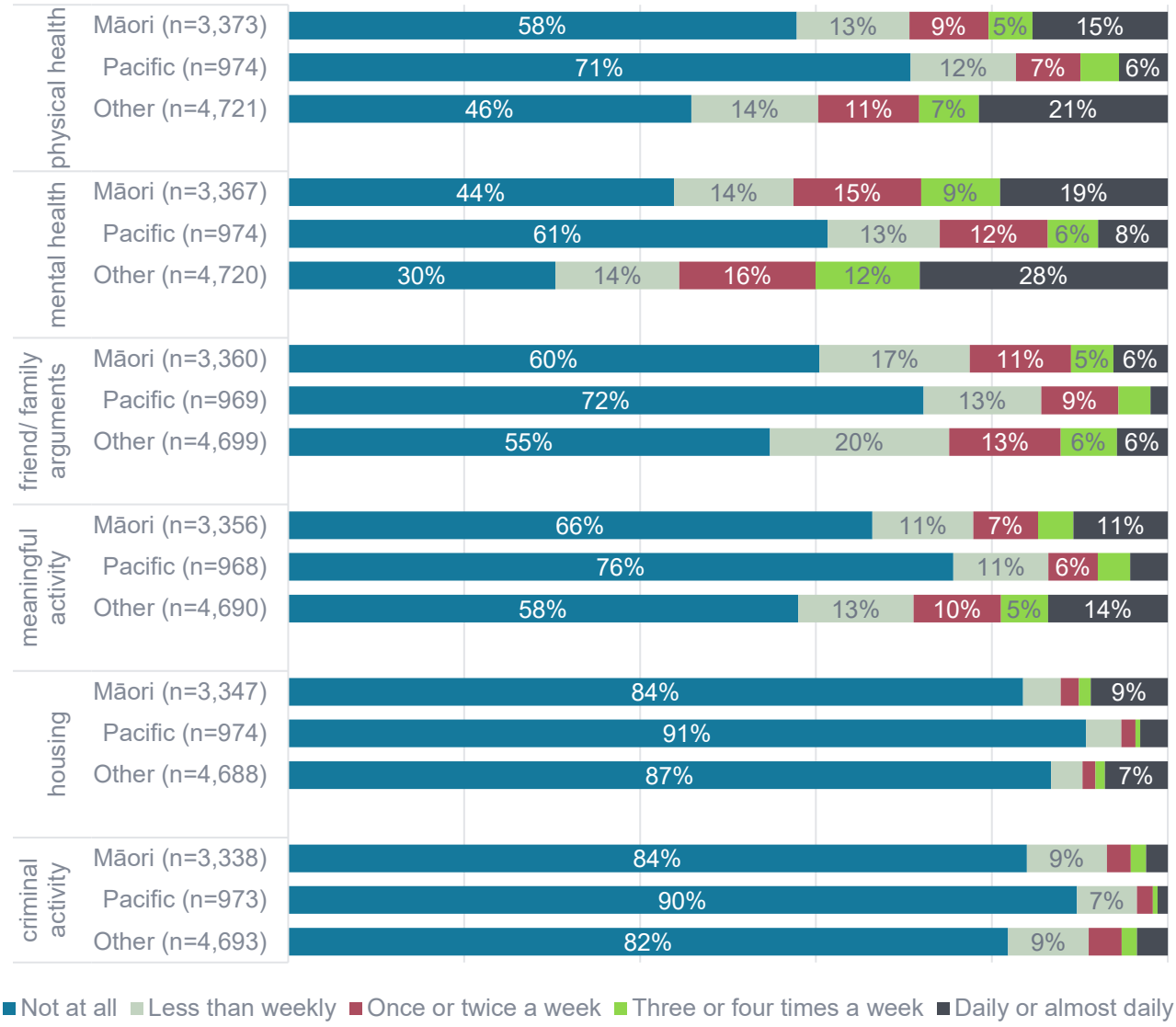


Lifestyle and wellbeing by ethnicity

Figure 15 shows how lifestyle and wellbeing problems vary for different ethnic groups. Issues more common among people of 'other' ethnicities (predominantly New Zealand European) include mental health and physical health problems. These ratings may be influenced by various factors that impact on wellbeing for people in different ethnic groups including different cultural worldviews and health

beliefs, experiences of trauma, including intergenerational trauma, discrimination, service access, and other social determinants.

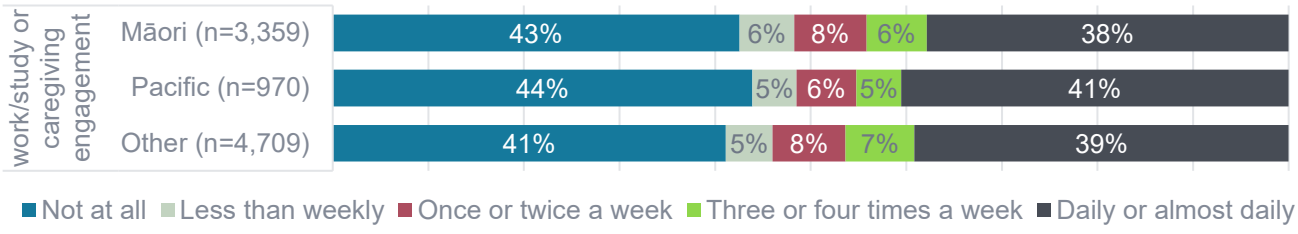
Figure 15. Lifestyle and wellbeing domains at ADOM treatment start by ethnicity (July 2024 to June 2025)



Note. Proportions of 5 percent or less not labelled.

Figure 16 indicates slight differences in levels of engagement with work, study, or caregiving across ethnic groups.

Figure 16. Engagement with work/study or caregiving at ADOM treatment start by ethnicity (July 2024 to June 2025)



Note. Proportions of 5 percent or less not labelled.

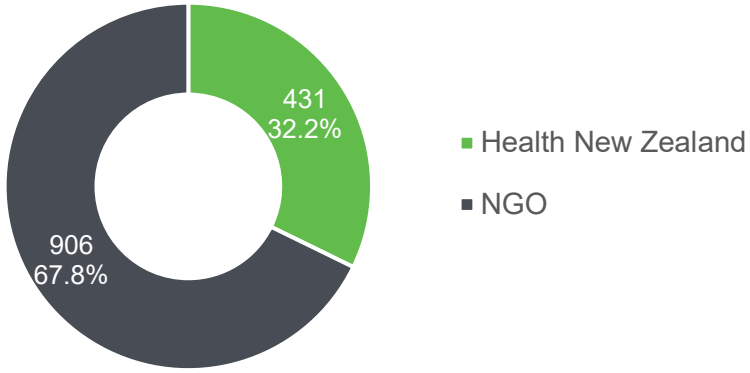
Part three: Outcomes (matched pairs)

This section describes outcomes for people accessing community AOD services where ADOM has been collected at both treatment start and treatment end (1,337 matched pairs).[16]

People who have completed treatment after this period are not included in the following analyses.[17] There is a large drop off in ADOM collections between treatment start and treatment end. A significant number of tāngata whai ora are missing ADOM treatment end collections and are therefore not included (see Appendix A for inclusion criteria).

Figure 17 shows Health New Zealand make up one third of matched pairs and two-thirds NGOs.

Figure 17. ADOM matched pairs by organisation type (July 2024 to June 2025)



Changes in substance use

This section presents changes in people's substance use between treatment start and end. Analyses by main substance of concern are not undertaken due to the amount of data available.

Figure 18 shows a decrease in the frequency of substance use for tāngata whai ora across all substances between treatment start and treatment end.

[16] The main substance of concern for people with matched pairs data is similar to that of all people who had ADOM collected at treatment start.

[17] It is noted that treatment for some substances (eg opioid substitution treatment) occurs over a long duration and are therefore less likely to be captured in matched pair analyses covering a short time period.

Figure 18. Change in average days of substance use in the past 28 days between treatment start and end for matched pairs (July 2024 to June 2025)[18]

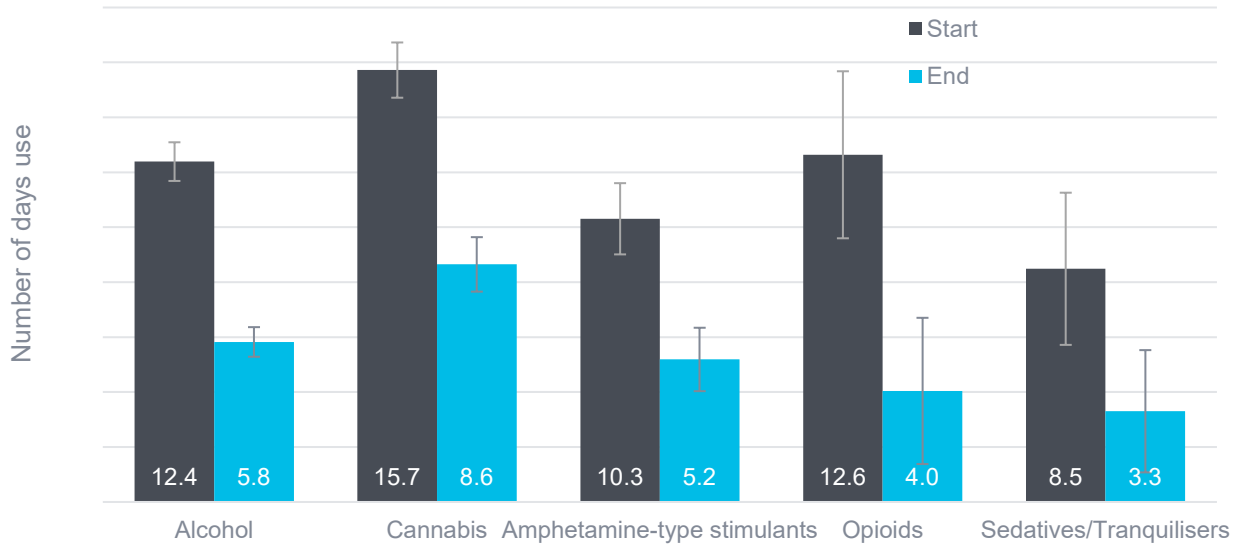


Figure 19 shows a reduction in the average number of standard drinks tāngata whai ora consume on a typical drinking day between the start and end of treatment (from 12.8 to 6.4).

Figure 19. Change in average standard drinks consumed in a typical drinking day between treatment start and end for matched pairs (July 2024 to June 2025)

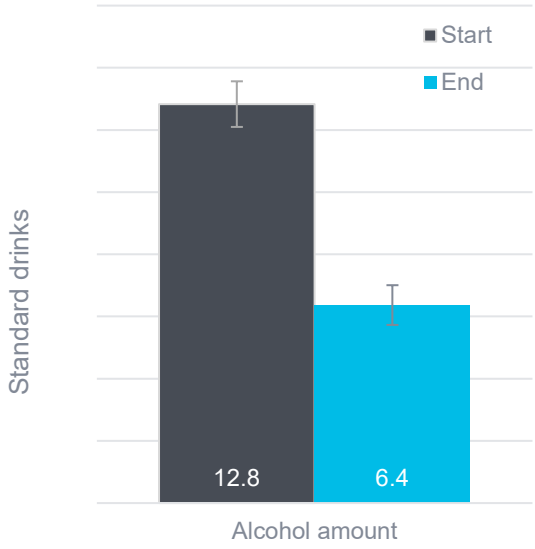


Table 5 summarises the effect size of changes in substance use between treatment start and end for different substances. Results show large reductions in days of use for opioids. All other substances, except cigarettes/tobacco, had a medium reduction.

[18] Matched pairs with reported substance use frequency at treatment start.

Table 5. Effect sizes of changes in substance use between treatment start and end for matched pairs (July 2024 to June 2025)

Question	Start mean	End mean	Outcome (Start minus end mean)	Cohen's *d* (effect size with 95% CI)	Effect size
Q1: Alcohol days of use	12.4 *(n=813)*	5.8 *(n=812)*	6.6	0.72 (0.62-0.82)	Medium
Q2: Alcohol number of standard drinks consumed in a typical days use	12.8 *(n=806)*	6.4 (n=*801)*	6.5	0.65 (0.55-0.75)	Medium
Q3: Cannabis days of use	15.7 *(n=456)*	8.6 *(n=452)*	7.1	0.65 (0.52-0.79)	Medium
Q4: Amphetamine-type stimulant days of use	10.3 *(n=191)*	5.2 *(n=186)*	5.1	0.60 (0.39-0.80)	Medium
Q5: Opioids days of use	12.6 *(n=47)*	4.0 *(n=47)*	8.6	0.88 (0.45-1.30)	Large
Q6: Sedatives/tranquilisers days of use	8.5 *(n=43)*	3.3 *(n=43)*	5.2	0.63 (0.20-1.06)	Medium
Q8: Cigarettes/tobacco amount used	10.5 *(n=472)*	6.4 *(n=453)*	4.2	0.48 (0.35-0.61)	Small

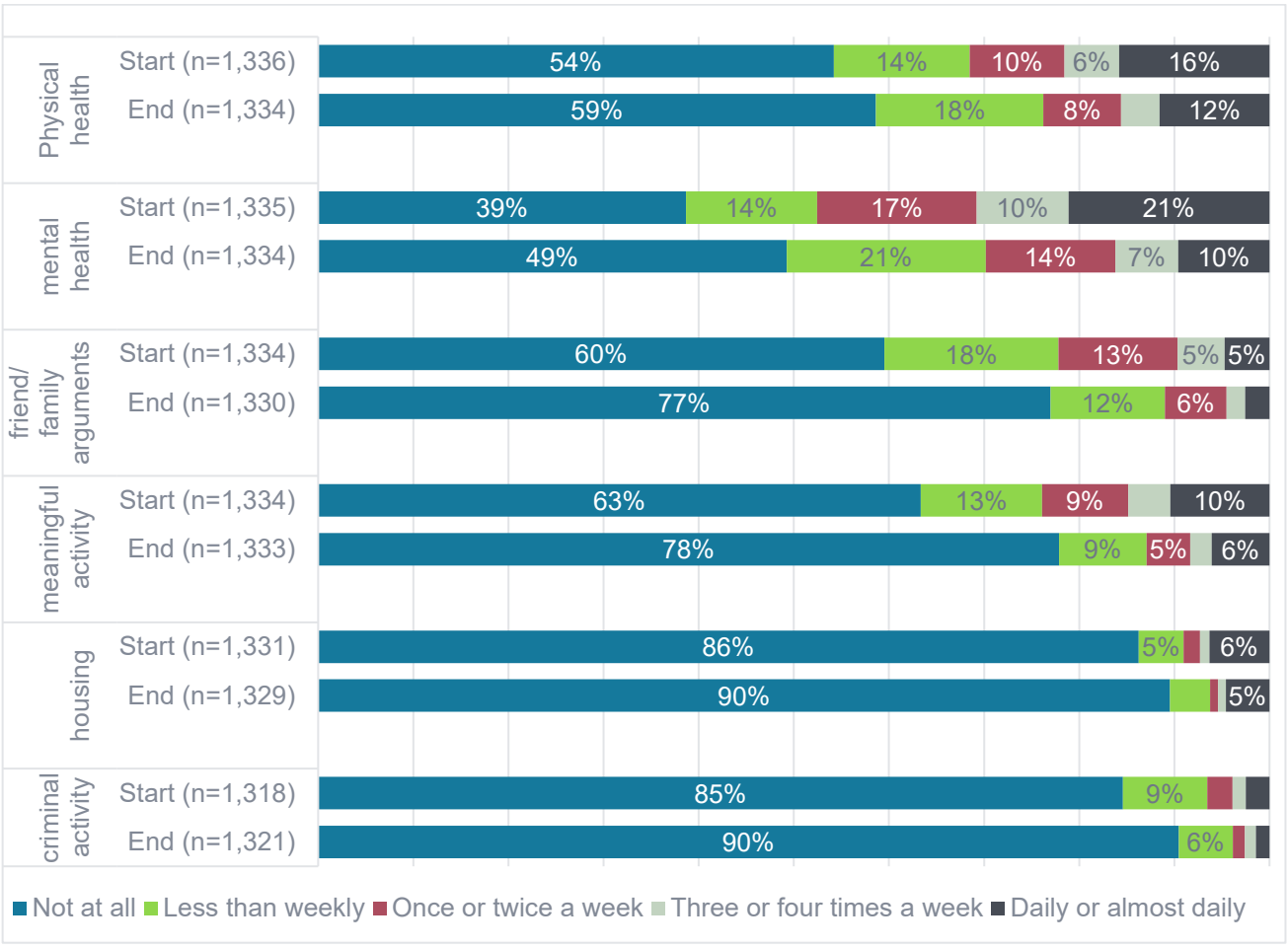
Note. Cohen (1992)[19] reports the following intervals for *d*: .2 to .5: small effect; .5 to .8: medium effect; .8 and higher: large effect.

[19] Cohen, J. (1992). A power primer, quantitative methods in psychology. *Psychological Bulletin, 112*(1), 155-159.

Changes in lifestyle and wellbeing

Figure 20 shows improvements in all areas of lifestyle and wellbeing between treatment start and end. Larger improvements are found for family/friend arguments, engagement with meaningful activities, mental and physical health. Problems with housing show little change throughout treatment.

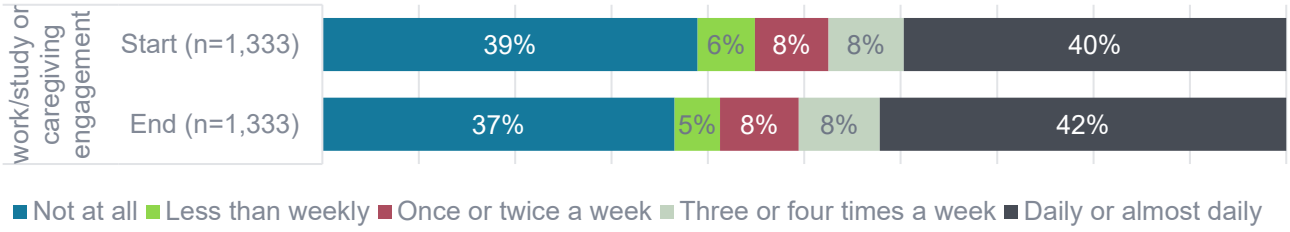
Figure 20. Changes in lifestyle and wellbeing domains between treatment start and end for matched pairs (July 2024 to June 2025)



Note. Proportions of 5 percent or less not labelled.

Figure 21 shows slight improvements in engagement with work, study, or caregiving throughout treatment.

Figure 21. Change in engagement with work/study or caregiving between treatment start and end for matched pairs (July 2024 to June 2025)



Note. Proportions of 5 percent or less not labelled.

Changes in perceptions of recovery progress

Figure 22 shows that on average, tāngata whai ora feel closer to where they want to be in their recovery at the end of treatment compared to the start. People who report alcohol as their main substance of concern tend to have the largest improvements.

Figure 22. Change in self-rated closeness to desired recovery between treatment start and end for matched pairs by main substance of concern (July 2024 to June 2025)

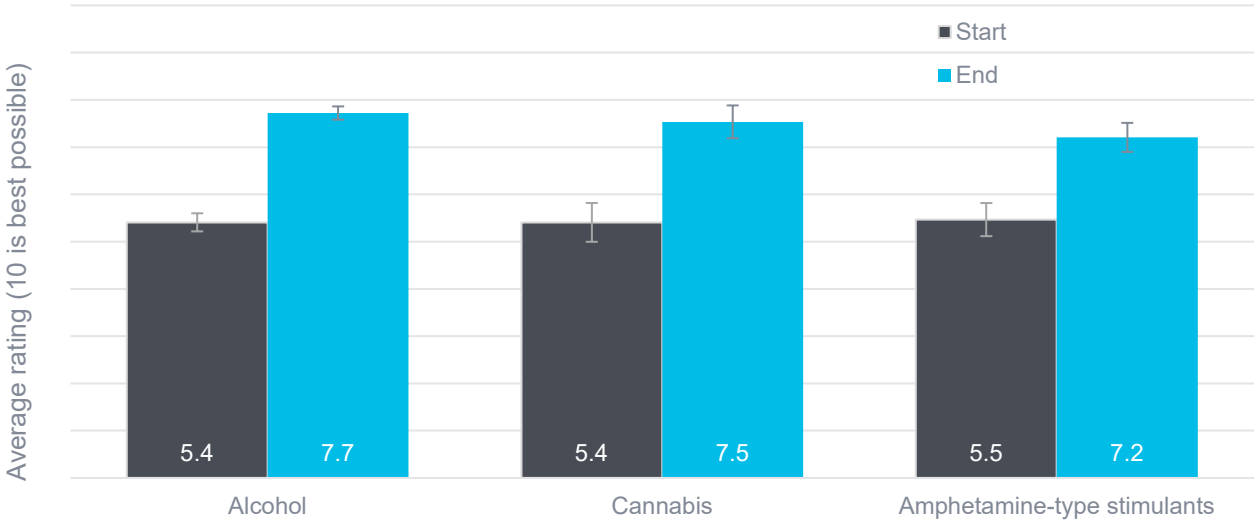
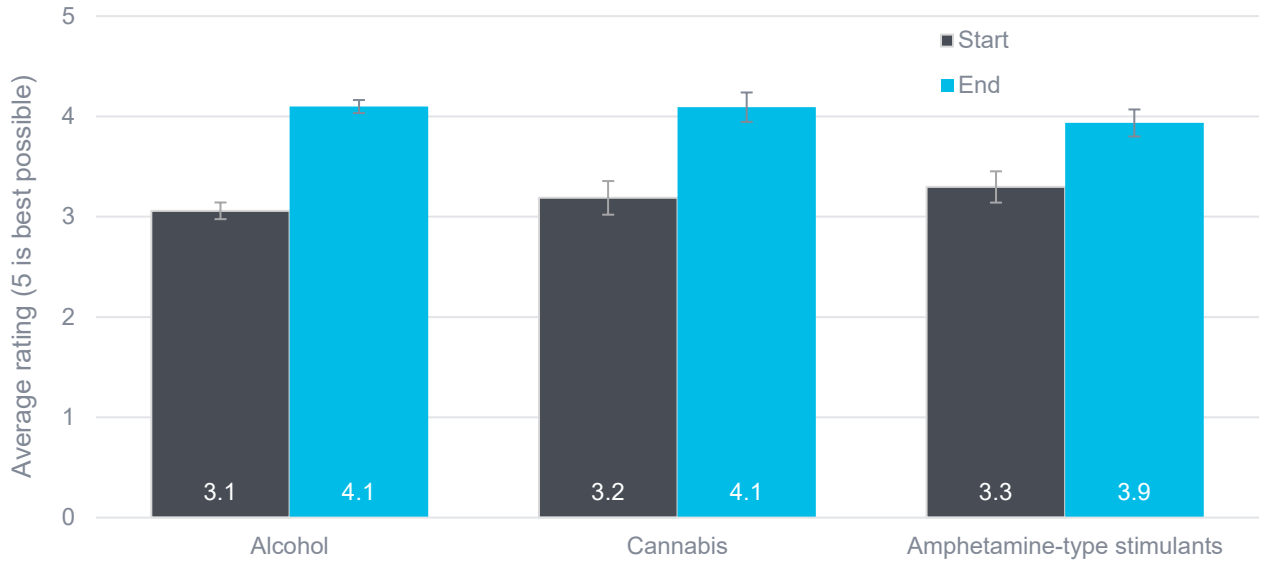


Figure 23 shows tāngata whai ora feel more satisfied with their progress in achieving their recovery goals at the end of treatment compared to the start. Improvements are similar across different main substances of concern.

Figure 23. Change in self-rated satisfaction with recovery progress between treatment start and end for matched pairs by main substance of concern (July 2024 to June 2025)



Conclusion

This report summarises ADOM collections for tāngata whai ora accessing community addiction services between July 2024 and June 2025 based on PRIMHD data.

There have been some notable shifts in ADOM collection rates in some Health New Zealand districts, like Nelson Marlborough and Waikato districts. Collection rates have also increased for some NGO areas like Waikato.

Available ADOM data shows alcohol is the main substance of concern for most tāngata whai ora, particularly those aged 45 years and over. Additionally, alcohol is commonly a secondary substance of concern for people who report another substance of main concern.

Findings indicate moderate reductions in the frequency of alcohol use in the past 28 days from 12 to 5 days on average between treatment start and end, and amount of alcohol consumed on a typical drinking day (from 13 to 6 standard drinks on average). There were also medium reductions in the frequency of amphetamine-type stimulant, and sedatives/tranquiliser use at the end of treatment, and a large reduction in opioids.

Overall, people experience improvements in all areas of lifestyle and wellbeing, particularly in arguments with whānau and friends, engagement with meaningful activities, mental and physical health. At the end of treatment people also feel closer to where they want to be in their recovery and are more satisfied with their progress towards recovery goals compared to the start.

In summary, routinely collected data shows positive changes in substance use, lifestyle and wellbeing, and perceptions of recovery among tāngata whai ora accessing community AOD services.

Appendix A: Method

Below is an overview of the inclusion and exclusion criteria for data used in this report. Please see full details for ADOM report building rules at https://www.tepou.co.nz/resources/adom-report-building-rules/775

Inclusion and exclusion criteria

AOD episode of care entering mandated services:

- includes teams mandated to collect ADOM[12]
- includes team type of alcohol and drug team or a co-existing team
- includes tāngata whai ora aged 18 years and over
- includes referrals with an in-scope contact. Excludes activity settings: WR, PH, SM, OM and exclude activity type: T08, T32, T35, T46, T47 and T49. The activity type is a contact.
- join referrals together to make an episode of care if they overlap or have 14 days or less between referral end and referral start date
- includes those episodes of care which start in the period of the report.

Treatment starts are within the episode of care: include only episodes of care with a treatment start ADOM collection including assessment only (RC13, RC14, RC15) in the analysis.

ADOM collections analysis:

- includes teams recognised or identified as those mandated to collect ADOM
- includes tāngata whai ora are aged 18 years and over
- excludes ADOM collections with five or more missing items[20]
- excludes RC19 – Treatment end – DNA and RC21 – Treatment end – other.

For treatment start ADOM collections (RC13, RC14) are used.

ADOM matched pairs:

- based on ADOM collections above
- includes those for 28 days or longer
- uses the date of the end collection. Start collection can be outside the period but after 1 July 2015.

Other notes

'Not specified' answers to items are excluded for specific questions. For example, substance of main concern analyses exclude a number of collections without a response to this question

[20] Excluding question 7, 9, and 11.

Appendix B: Sensitivity analyses

Table 6 shows sensitivity analyses of the profile of tāngata whai ora with and without ADOM collections included in this report. Overall, while there are slight under- and over-representations across service types and demographic groups, these are not likely to have large impacts on interpretation of data in this report.

In total there were slightly more ADOM collections at NGOs (2 percent) than Health New Zealand services. The overall data has slight over-representation of Pacific peoples (4 percent over), and men (5 percent over); and under-representation of Māori (8 percent under) and women (5 percent under).

Within ADOM Health New Zealand data, people of 'other' ethnicities (mainly New Zealand Europeans; 2 percent) and women (4 percent) are slightly under-representation in relation to all people accessing services.

Within NGOs, there is slight over-representation of people of 'other' ethnicities (2 percent), and men (3 percent).

Table 6. Sensitivity analysis of tāngata whai ora with and without ADOM collections by service type and demographic profile (July 2024 to June 2025)

Group		ADOM	No ADOM	Total	ADOM %	No ADOM %	Difference
Health New Zealand							
HNZ	**All**	**4,224**	**7,186**	**11,410**	**42%**	**44%**	**-2%**
Age group	18 to 24 years	566	1,149	1,715	6%	7%	-1%
	25 to 44 years	2,394	3,778	6,172	24%	23%	1%
	45 to 64 years	1,120	1,990	3,110	11%	12%	-1%
	65 years and over	144	269	413	1%	2%	0%
Ethnicity	Māori	1,264	2,530	3,794	13%	15%	-3%
	Pacific	756	701	1,457	8%	4%	3%
	Other	2,204	3,955	6,159	22%	24%	-2%
Gender	Women	1,208	2,562	3,770	12%	16%	-4%
	Men	3,009	4,617	7,626	30%	28%	2%
NGO							
NGO	**All**	**5,847**	**9,183**	**15,030**	**58%**	**56%**	**2%**
Age group	18 to 24 years	784	1,284	2,068	8%	8%	0%
	25 to 44 years	3,544	5,641	9,185	35%	34%	1%
	45 to 64 years	1,373	2,055	3,428	14%	13%	1%

Group		ADOM	No ADOM	Total	ADOM %	No ADOM %	Difference
	65 years and over	146	203	349	1%	1%	0%
Ethnicity	Māori	2,381	4,634	7,015	24%	28%	-5%
	Pasifika	458	539	997	5%	3%	1%
	Other	3,008	4,010	7,018	30%	24%	5%
Gender	Women	1,868	3,260	5,128	19%	20%	-1%
	Men	3,970	5,914	9,884	39%	36%	3%
Overall							
Overall	**All**	**10,071**	**16,369**	**26,440**	**100%**	**100%**	**0%**
Age group	18 to 24 years	1,350	2,433	3,783	13%	15%	-1%
	25 to 44 years	5,938	9,419	15,357	59%	58%	1%
	45 to 64 years	2,493	4,045	6,538	25%	25%	0%
	65 years and over	290	472	762	3%	3%	0%
Ethnicity	Māori	3,645	7,164	10,809	36%	44%	-8%
	Pacific	1,214	1,240	2,454	12%	8%	4%
	Other	5,212	7,965	13,177	52%	49%	3%
Gender	Women	3,076	5,822	8,898	31%	36%	-5%
	Men	6,979	10,531	17,510	69%	64%	5%

Note. Very few people had gender recorded as ‘other’ or ‘unknown’; they were included in analyses but not reported here.

Appendix C: ADOM Section 2 questions

Table 7. ADOM section two questions (lifestyle and wellbeing)

Question key
Q12 How often has your physical health caused problems in your daily life?
Q13 How often has your general mental health caused problems in your daily life?
Q14 How often has your alcohol or drug use led to problems or arguments with friends or family members?
Q15 How often has your alcohol or drug use caused problems with your work or other activities in any of the following: social, recreational, looking after children or other family members, study or other personal activities?
Q16 How often have you engaged in any of the following: paid work, voluntary work, study, looking after children or other caregiving activities?
Q17 Have you had difficulties with housing or finding somewhere stable to live?
Q18 How often have you been involved in any criminal or illegal activity such as driving a motor vehicle under the influence of alcohol or drugs, assault, shoplifting, supplying an illicit substance to another person?