EDRS

# TASMANIAN DRUG TRENDS 2024

Key Findings from the Tasmanian Ecstasy and Related Drugs Reporting System (EDRS) Interviews

# TASMANIAN DRUG TRENDS 2024: KEY FINDINGS FROM THE ECSTASY AND RELATED DRUGS REPORTING SYSTEM (EDRS) INTERVIEWS

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ISSN 2981-961X 



**Suggested citation:** Radke S & Bruno R. Tasmanian Drug Trends 2024: Key Findings from the Ecstasy and Related Drugs Reporting System (EDRS) Interviews. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney; 2024. Available from: https://doi.org/10.26190/unsworks/30682

Please note that as with all statistical reports there is the potential for minor revisions to data in this report over its life. Please refer to the online version at Drug Trends.

This report was prepared by the National Drug and Alcohol Research Centre, UNSW Sydney. Please contact the following with any queries regarding this publication: Raimondo.Bruno@utas.edu.au or drugtrends@unsw.edu.au

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# Acknowledgements


## Funding

In 2024, the Ecstasy and Related Drugs Reporting System (EDRS), falling within the Drug Trends program of work, was supported by funding from the Australian Government Department of Health and Aged Care under the Drug and Alcohol Program.

## Research Team

The National Drug and Alcohol Research Centre (NDARC), University of New South Wales (UNSW) Sydney, coordinated the EDRS. The following researchers and research institutions contributed to the EDRS in 2024:

- Dr Rachel Sutherland, Antonia Karlsson, Julia Uporova, Olivia Price, Udesha Chandrasena, Haniene Tayeb, Professor Louisa Degenhardt, Professor Michael Farrell and Associate Professor Amy Peacock, National Drug and Alcohol Research Centre, University of New South Wales, New South Wales;

- Zachary Lloyd and Professor Paul Dietze, Burnet, Victoria;

- Sophie Radke and Associate Professor Raimondo Bruno, School of Psychology, University of Tasmania, Tasmania;

- Dr Jodie Grigg, Dr Sophie Haywood and Professor Simon Lenton, National Drug Research Institute and enAble Institute, Curtin University, Western Australia; and

- Catherine Daly, Dr Jennifer Juckel, Dr Natalie Thomas and Associate Professor Caroline Salom, Institute for Social Science Research, The University of Queensland, Queensland.

We would like to thank past and present members of the research team.

## Participants

We would like to thank all the participants who were interviewed for the EDRS in the present and in previous years.

## Contributors

We thank all the individuals who contributed to questionnaire development and assisted with the collection and input of data at a jurisdictional and national level. In particular, we would like to thank Victoria Watts, Freya Wrigley, Kate Jacklin, Lillijana Murphy, Yvonne Steimle, Luke Pash, Callum Thompson, Mateus Viana Dos Santos, Gabrielle Feather and Rohan Moore for conducting the Hobart, Tasmania EDRS interviews in 2024. We would also like to thank the Students for Sensible Drug Policy (SSDP) and the Drug Trends Advisory Committee for their contribution to the EDRS.

We acknowledge the traditional custodians of the land on which the work for this report was undertaken. We pay respect to Elders past, present, and emerging.

## Abbreviations

| | |
|---|---|
| **1,4-BD** | 1,4-Butanediol |
| **4-FA** | 4-Fluoroamphetamine |
| **5-MeO-DMT** | 5-methoxy-N,N-dimethyltryptamine |
| **ACT** | Australian Capital Territory |
| **ADHD** | Attention-deficit/hyperactivity disorder |
| **Alpha PVP** | α-Pyrrolidinopentiophenone |
| **AOD** | Alcohol and Other Drug |
| **AUDIT** | Alcohol Use Disorders Identification Test |
| **CBD** | Cannabidiol |
| **COVID-19** | Coronavirus Disease 2019 |
| **DMT** | Dimethyltryptamine |
| **DO-x** | 4-Substituted-2,5-dimethoxyamphetamines |
| **DSM** | Diagnostic and Statistical Manual of Mental Disorders |
| **EDRS** | Ecstasy and Related Drugs Reporting System |
| **GBL** | Gamma-butyrolactone |
| **GHB** | Gamma-hydroxybutyrate |
| **GP** | General Practitioner |
| **HIV** | Human immunodeficiency virus |
| **IDRS** | Illicit Drug Reporting System |
| **IQR** | Interquartile range |
| **LSD** | *d*-lysergic acid |
| **MDA** | 3,4-methylenedioxyamphetamine |
| **MDMA** | 3,4-methylenedioxymethamphetamine |
| **MDPV** | Methylenedioxypyrovalerone |
| **MXE** | Methoxetamine |
| **N (or n)** | Number of participants |
| **NBOME** | N-methoxybenzyl |
| **NDARC** | National Drug and Alcohol Research Centre |
| **NHS** | National Health Service |
| **NPS** | New psychoactive substances |
| **NSP** | Needle Syringe Program |
| **NSW** | New South Wales |
| **OTC** | Over-the-counter |
| **PMA** | Para*methoxyamphetamine* |
| **PMMA** | Polymethyl methacrylate |
| **PTSD** | Post-Traumatic Stress Disorder |
| **REDCAP** | Research Electronic Data Capture |
| **SA** | South Australia |
| **SD** | Standard deviation |

| | |
|---|---|
| **SDS** | Severity of Dependence Scale |
| **SSDP** | Students for Sensible Drug Policy |
| **STI** | Sexually Transmitted Infection |
| **THC** | Tetrahydrocannabinol |
| **UNSW** | University of New South Wales |
| **WA** | Western Australia |
| **WHO** | World Health Organization |

# Executive Summary

The Hobart Tasmania (TAS) EDRS comprises a sentinel sample of people who regularly use ecstasy and/or other illicit stimulants, recruited via social media and word-of mouth in Hobart, TAS. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2024 from April-July. Interviews from 2020 onwards were delivered face-to-face as well as via telephone, to reduce the risk of COVID-19 transmission; all interviews prior to 2020 were conducted face-to-face. This methodological change should be factored into all comparisons of data from the 2020-2024 samples, relative to previous years.**

## Sample Characteristics

The EDRS sample (N=87) recruited from Hobart, Tasmania, was similar to the sample in 2023 and in previous years. Gender remained stable between 2023 and 2024, with half (52%) identifying as male (55% in 2023), and participants had a median age of 25 years. One third (31%) reported being current students (37% in 2023), with almost three fifths (57%) holding post-school qualifications (65% in 2023). One fifth (19%) of the sample reported full-time employment (26% in 2023) and 40% reported being employed on a part-time/casual basis (43% in 2023). Accommodation remained stable relative to 2023, with half the sample (49%; 49% in 2023) living in a rental house/flat, and one quarter (24%; 25% in 2023) residing with their parents/at their family home at the time of interview. Drug of choice and drug used most often remained stable between 2023 and 2024, with 36% nominating non-prescribed ecstasy as their drug of choice (25% in 2023), and 28% nominating cannabis as the drug used most often in the month preceding interview (34% in 2023).

## Non-Prescribed Ecstasy

Recent use of any non-prescribed ecstasy in the six months prior to interview remained stable in 2024, relative to 2023 (91%; 91% in 2023). In 2024, recent use of non-prescribed ecstasy pills (49%), capsules (59%), crystal (47%) and powder (30%) all remained stable from 2023. Participants reported use of any non-prescribed ecstasy on a median of 11 days in 2024 (9 days in 2023), with the frequency of use, including weekly use, remaining stable for all four forms. Swallowing remained the most common route of administration for capsules (96%), pills (95%) and crystal (80%), with snorting remaining the most common route for powder (92%). The perceived price, purity and availability of all forms of non-prescribed ecstasy remained stable between 2023 and 2024.

## Methamphetamine

Two fifths (40%) of the Hobart sample reported recent use of any methamphetamine, stable relative to 2023 (40%). Frequency of use also remained stable, with participants reporting a median of 24 days of use in 2024 (9 days in 2023). The perceived purity of methamphetamine powder was significantly different to 2023 ($p$=0.042). The perceived purity of methamphetamine crystal remained stable between 2023 and 2024. The availability of powder and crystal also remained stable between 2023 and 2024, with the greatest percentage (74%) reporting methamphetamine crystal to be 'very easy' to obtain (81% in 2023).

## Non-Prescribed Pharmaceutical Stimulants

The per cent of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has generally increased since the commencement of monitoring, from 19% in 2007 to 36% in 2024

(34% in 2023), signifying the second highest percentage of use since monitoring commenced. Frequency of use remained stable, with participants reporting a median of six days in 2024 (4 days in 2023), the highest frequency of use since the commencement of monitoring

## Cocaine

Recent use of cocaine has increased over the course of monitoring. In 2024, three quarters (77%) reported recent use, stable from 75% in 2023. Powder cocaine remained the most commonly reported form used (97%; 96% in 2023), with snorting remaining the most common route of administration (97%; 96% in 2023). Perceived price, purity and availability of cocaine remained stable between 2023 and 2024.

## Cannabis and/or Cannabinoid-Related Products

At least three in five participants of the Hobart sample have reported recent use of non-prescribed cannabis and/or cannabinoid-related products each year since 2003, with the only exception being 2011 (50%) (noting some changes in question wording over time). In 2024, 69% of the Hobart sample reported recent use of non-prescribed cannabis and/or cannabinoid-related products (78% in 2023). Frequency of use amongst those who had recently used cannabis and/or cannabinoid-related products in the preceding six months significantly increased to a median of 67 days in 2024 (25 days in 2023; $p$=0.017). Weekly use remained stable between 2023 and 2024 (68%; 52% in 2023), however daily use significantly increased from 14% in 2023 to 32% in 2024 ($p$=0.044). Hydroponic and bush cannabis remained stable as the most consumed forms of cannabis (75% and 68%, respectively), with smoking remaining the most common route of administration (90%; 92% in 2023). Market characteristics of non-prescribed hydroponic and bush cannabis remained stable between 2023 and 2024. In 2024, almost one fifth (17%) of participants reported recent use of prescribed cannabis and/or cannabinoid-related products in 2024, a significant increase from 2023 (n≤5; $p$=0.022).

## Non-Prescribed Ketamine, LSD and DMT

The per cent of participants reporting recent use of non-prescribed ketamine significantly decreased from 51% in 2023 to 30% in 2024 ($p$=0.013), with frequency of use remaining stable. While recent use of LSD remained stable in 2024 (32%; 38% in 2023), this was the lowest per cent reporting recent use since 2013. Recent use of DMT (13%; 10% in 2023) and frequency of use remained stable in 2024. Perceived price, purity and availability of non-prescribed ketamine and LSD remained stable between 2023 and 2024.

## New Psychoactive Substances (NPS)

Any NPS use, including both plant-based NPS and excluding plant-based NPS, has remained low in recent years, with few participants (n≤5) reporting recent use in 2022, 2023 and 2024. These are the lowest percentages of use since monitoring of NPS first commenced in 2010.

## Other Drugs

The per cent of participants reporting recent use of other non-prescribed pharmaceutical drugs remained relatively stable from 2023 to 2024. Recent use of non-prescribed codeine (14%; 18% in 2023) and any non-prescribed benzodiazepines (29%; 32% in 2023) remained stable, as did frequency of use. Twenty-nine per cent of the sample reported recent use of non-prescribed hallucinogenic mushrooms/ psilocybin, stable relative to 2023 (40%). In 2024, few participants (n≤5) reported recent use of Kava (0% in 2023) or GHB/GBL/1,4-BD (11% in 2023) in the six months prior to interview. Three quarters (77%) of the Hobart sample reported recent tobacco use, stable from 2023 (72%). A median frequency of 180 days of tobacco use was reported in the six months prior to interview in 2024, a significant increase from 90 days in 2023 ($p$=0.017). One quarter (25%) of participants reported recent use of illicit tobacco, with the most common product used being unbranded loose tobacco (62%), followed by branded packets of cigarettes (43%). Almost three fifths (57%) of the Hobart sample had used non-prescribed e-cigarettes in the six months preceding interview in 2024, stable from 2023 (54%), although the highest percentage observed since the commencement of monitoring. Almost one fifth (17%) reported using substances other than nicotine/vape juice in an e-cigarette in 2024, with three fifths (60%; n=15) reporting having vaped cannabis via an e-cigarette.

## Drug-Related Harms and Other Behaviours

### *Polysubstance use and bingeing*

Four fifths (80%; n=65) of the Hobart sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most commonly used combinations of drug classes were stimulants and depressants (30%), followed by stimulants, depressants, and cannabis (19%). Twelve per cent reported using stimulants and cannabis, whilst 15% reported using stimulants alone.

Two fifths (40%) of the Hobart sample reported using stimulants or related drugs for 48 hours or more continuously without sleep in the preceding six months, a significant increase from 19% in 2023 ($p$=0.009).

### *Dependence, overdose and injecting*

Eighty-four per cent of the sample obtained a score of eight or more on the AUDIT, indicative of hazardous alcohol use (78% in 2023).

In 2024, one fifth (22%) of those who reported recent ecstasy use obtained an SDS score of 3 or more (9% in 2023), whilst 52% of participants reporting recent methamphetamine use obtained a score of 4 or more (27% in 2023), indicating possible dependence on these substances.

Past year non-fatal stimulant overdose (35%; 23% in 2023) and non-fatal depressant overdose (28%; 22% in 2023) remained stable in 2024.

Reported past month injecting drug use remained low (n≤5).

### *Drug checking and naloxone awareness*

One quarter (24%) of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year, stable from 34% in 2023, all via colorimetric or immunoassay testing strips.

In 2024, only three fifths (62%) reported that they had ever heard of naloxone (64% in 2023), with 96% correctly identifying the purpose of naloxone (91% in 2023).

### *Sexual activity, mental health and health service access*

Almost three quarters (72%) of the Hobart sample reported engaging in some form of sexual activity in the past four weeks (81% in 2023), of which 78% reported using alcohol and/or other drugs prior to or while engaging in sexual activity (68% in 2023). One tenth reported that their use of alcohol and/or other drugs impaired their ability to negotiate their wishes during sex (n≤5 in 2023).

One quarter (27%) of the sample reported having a HIV test in the six months preceding interview (15% in 2023), and 37% reported having a sexual health check-up in the six months prior to interview (31% in 2023).

Mental health remained stable relative to 2023, with 64% (54% in 2023) reporting experiencing a mental health problem in the six months preceding interview in 2024, with anxiety (71%) and depression (58%) most commonly reported. There was a significant increase of participants who self-reported experiencing attention-deficit/hyperactivity disorder (ADHD), with almost two fifths (38%) reporting ADHD as a mental health problem (n≤5 in 2023; p=0.004). Almost one third (31%) of the sample reported a score of 30 or more on the K10, indicative of 'very high' psychological distress.

Thirty-seven per cent of participants reported accessing any health service for alcohol and/or drug support in the six months preceding interview, a significant increase from 17% in 2023 ($p$=0.014). One tenth (10%) of participants reported that they were currently engaging in drug treatment.

Almost two fifths (38%) of the sample reported experiencing stigma because of their illicit drug use in any health/non-health care setting in the six months preceding interview.

### *Driving, contact with police and modes of purchasing drugs*

Amongst those who had recently driven, 15% reported driving while over the perceived legal limit of alcohol, and 37% reported driving within three hours of consuming an illicit or non-prescribed drug in the prior six months.

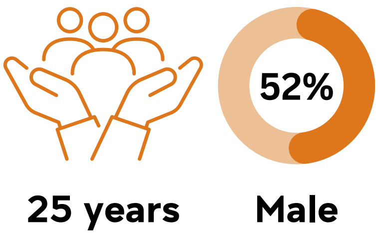
Two fifths (41%) of the sample reported engaging in 'any' type of crime in the past month (30% in 2023). Drug dealing (26%) was the main form of crime reported in 2024, followed by property crime (24%). Eleven per cent of the sample reported having been arrested in the 12 months preceding interview, and 18% reported a drug-related encounter with police which did not result in charge or arrest. One tenth (9%) of the Hobart sample reported being the victim of a crime involving violence, a significant increase from 2023 (0%; $p$=0.011).

Face-to-face (73%; 73% in 2023) remained the most common way in which participants arranged the purchase of illicit or non-prescribed drugs in the 12 months preceding interview. Seventy-seven per cent of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2024, stable from 2023 (68%).

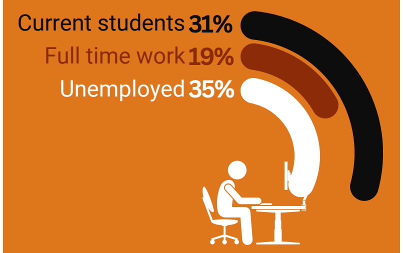
# 2024 SAMPLE CHARACTERISTICS

EDRS Ecstasy and Related Drugs Reporting System

In 2024, 87 participants, recruited from Hobart, TAS, were interviewed.




The median age in 2024 was 25 years, and 52% identified as male.

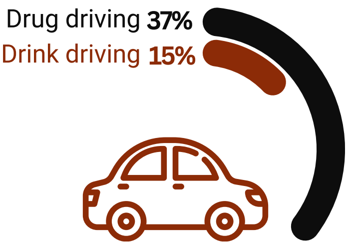



In the 2024 sample, 31% were current students, 19% were employed full time and 35% were unemployed.

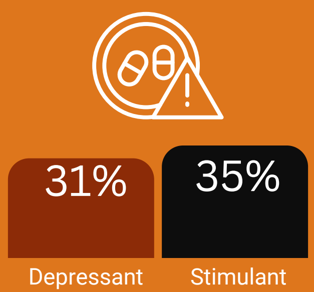
- Ecstasy
- Cocaine
- Other stimulants

Participants were recruited on the basis that they had consumed ecstasy and/or other illicit stimulants at least monthly in the past 6 months.

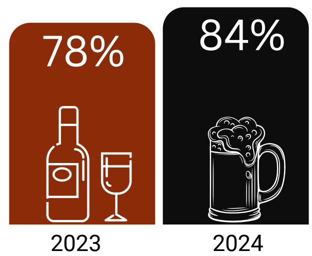
# DRUG-RELATED HARMS AND RISKS



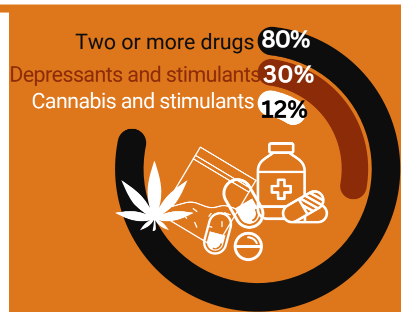

Among recent drivers, 37% reported driving a vehicle within 3 hours of consuming illicit drugs and 15% while over the legal limit of alcohol.




Percentage who reported past year non-fatal depressant and stimulant overdose.

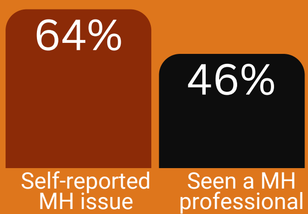



Percentage who obtained an AUDIT score of eight or more, indicative of past year hazardous alcohol use.

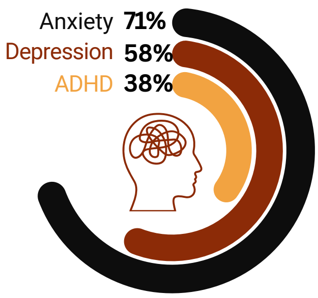



In 2024, 80% reported using two or more drugs on the last occasion of ecstasy or related drug use: the most commonly used combination of drug classes was depressants and stimulants (30%).

# OTHER BEHAVIOURS




Percentage who self-reported mental health problems and treatment seeking in the six months preceding interview.

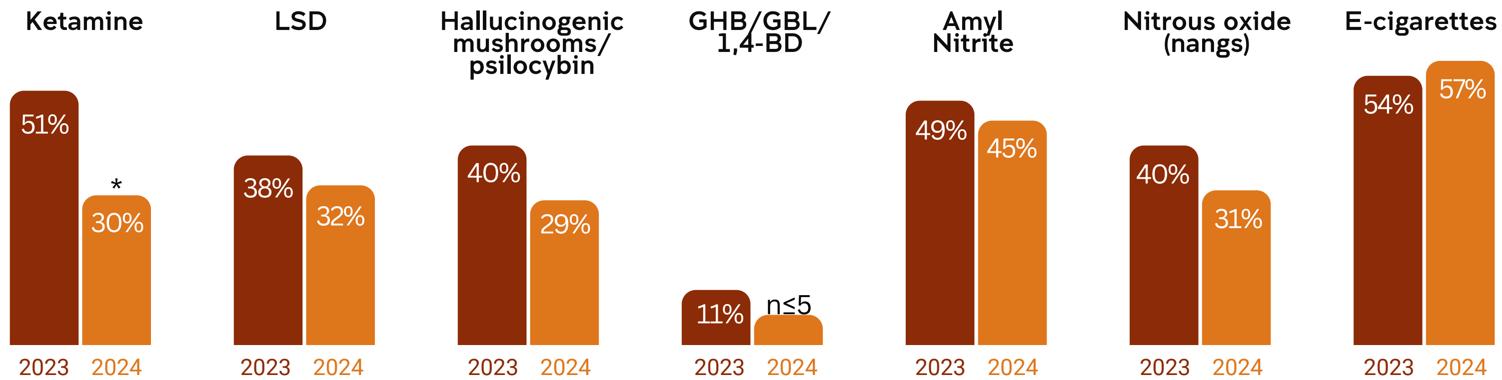



Among those who reported a mental health problem, the three most common mental health issues were anxiety, depression and ADHD.


Percentage who reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year.

38% of the sample reported experiencing stigma because of their illicit drug use in the six months preceding interview, most commonly from police (17%).

# PAST 6 MONTH USE OF SELECT DRUGS




*$p<0.050$; **$p<0.010$; ***$p<0.001$.

EDRS Ecstasy and Related Drugs Reporting System

# ECSTASY

FORM of ecstasy

59% Capsules
47% Crystal
49% Pills
30% Powder

Past 6 month use of ecstasy capsules, crystal, pills and powder in 2024.

S M T W T F S

22%

Of those who had recently used any ecstasy, 22% reported weekly or more frequent use, stable from 2023 (17%).

2 Capsules

2 Pills

0.50 grams of crystal

0.50 grams of powder

Median amounts of ecstasy consumed in a 'typical' session.

82%

85%

Percentage who perceived ecstasy capsules as being 'easy' or 'very easy' to obtain.

# METHAMPHETAMINE

FORM of methamphetamine

40% Any meth
26% Crystal
18% Powder
n≤5 Base

Past 6 month use of any methamphetamine, crystal, powder and base in 2024.

S M T W T F S

51%

Of those who had recently used any methamphetamine, 51% reported weekly or more frequent use, stable from 2023 (31%).

74% Smoked crystal
88% Snorted powder

74% of participants who had recently used crystal smoked it. Of those who had recently used powder, 88% snorted it.

96% 2024

94% 2023

Percentage who perceived methamphetamine crystal as being 'easy' or 'very easy' to obtain.

# COCAINE

75% 2023
77% 2024

Past 6 month use of any cocaine remained stable between 2023 and 2024.

S M T W T F S

n≤5

Of those who had recently consumed cocaine, n≤5 reported weekly or more frequent use, stable from 2023 (n≤5).

$

$350 2023
$350 2024

The median reported price for a gram of cocaine.

73% 2024

68% 2023

Percentage who perceived cocaine as being 'easy' or 'very easy' to obtain.

# CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS

78% 2023
69% 2024

Past 6 month use of non-prescribed cannabis and/or cannabinoid-related products was stable between 2023 and 2024.

S M T W T F S

68%

Of those who had recently used non-prescribed cannabis, 68% reported weekly or more frequent use, stable from 2023 (52%).

Of participants who had consumed cannabis in the last 6 months, 90% had smoked it (28% swallowed and 20% vaped it).

HYDRO 97%
93% BUSH

Percentage who perceived cannabis and/or cannabinoid-related products as being 'easy' or 'very easy' to obtain.

# Background

The Ecstasy and Related Drugs Reporting System (EDRS) is an illicit drug monitoring system which has been conducted in all states and territories of Australia since 2003, and forms part of Drug Trends. The purpose is to provide a coordinated approach to monitoring the use, market features, and harms of ecstasy and related drugs. This includes drugs that are routinely used in the context of entertainment venues and other recreational locations, including ecstasy, methamphetamine, cocaine, new psychoactive substances, LSD (*d*-lysergic acid), and ketamine.

The EDRS is designed to be sensitive to emerging trends, providing data in a timely manner rather than describing issues in extensive detail. It does this by studying a range of data sources, including data from annual interviews with people who regularly use ecstasy and/or other illicit stimulants and from secondary analyses of routinely-collected indicator data. This report focuses on the key findings from the annual interview component of the EDRS.

# Methods

## EDRS 2003-2019

Full details of the methods for the annual interviews are available for download. To briefly summarise, since the commencement of monitoring up until 2019, participants were recruited primarily via internet postings, print advertisements, interviewer contacts, and snowballing (i.e., peer referral). Participants had to: i) be at least 17 years of age (due to ethical constraints) (16 years of age in Perth, Western Australia (WA)), ii) have used ecstasy and/or other illicit stimulants (including: MDA, methamphetamine, cocaine, non-prescribed pharmaceutical stimulants, mephedrone or other stimulant NPS) at least six times during the preceding six months; and iii) have been a resident of the capital city in which the interview took place for ten of the past 12 months. Interviews took place in varied locations negotiated with participants (e.g., research institutions, coffee shops or parks), and in later years were conducted using REDCap (Research Electronic Data Capture), a software program used to collect data on laptops or tablets. Following provision of written informed consent and completion of a structured interview, participants were reimbursed $40 cash for their time and expenses incurred.

## EDRS 2020-2024: COVID-19 Impacts on Recruitment and Data Collection

Given the emergence of COVID-19 and the resulting restrictions on travel and people's movement in Australia (which first came into effect in March 2020), face-to-face interviews were not always possible due to the risk of infection transmission for both interviewers and participants. For this reason, all methods in 2020 were similar to previous years as detailed above, with the exception of:

1. Means of data collection: Interviews were conducted via telephone or via videoconferencing across all capital cities in 2020;
2. Means of consenting participants: Participants consent to participate was collected verbally prior to beginning the interview;
3. Means of reimbursement: Once the interview was completed via REDCap, participants were given the option of receiving $40 reimbursement via one of three methods, comprising bank transfer, PayID or gift voucher; and
4. Age eligibility criterion: Changed from 17 years old (16 years old in Perth, WA) to 18 years old.

From 2021 onwards, a hybrid approach was used with interviews conducted either face-to-face (whereby participants were reimbursed with cash) or via telephone/videoconference (with participants reimbursed via bank transfer or other electronic means). Face-to-face interviews were the preferred methodology, however telephone interviews were conducted when required (i.e., in accordance with government directives) or when requested by participants. Consent was collected verbally for all participants.

### 2024 EDRS Sample

Between 9 April and 13 July 2024, a total of 740 participants were recruited across capital cities nationally, with 87 participants interviewed in Hobart, TAS between 11 April and 10 July 2024 (n=65 in 2023). A total of 76 interviews (87%) were conducted via telephone (n=53 in 2023; 82%), the remainder were conducted face-to-face.

Thirteen per cent of the 2024 Hobart sample completed the interview in 2023, whereas 10% of the 2023 Hobart sample completed the interview in 2022 ($p$=0.609). Recruitment methods remained stable between 2023 and 2024 ($p$=0.449), with 70% of participants being recruited via the internet (e.g., Facebook and Instagram) (71% in 2023), and 23% via word-of-mouth (28% in 2023).

## Data Analysis

For normally distributed continuous variables, means and standard deviations (SD) are reported; for skewed data (i.e., skewness > ±1 or kurtosis > ±3), medians and interquartile ranges (IQR) are reported. Tests of statistical significance have been conducted between estimates for 2023 and 2024, noting that no corrections for multiple comparisons have been made and thus comparisons should be treated with caution. References to significant differences throughout the report are where statistical testing has been conducted and where the p-value is less than 0.050. Values where cell sizes are ≤5 have been suppressed with corresponding notation (Table 1; zero values are reported). References to 'recent' use and behaviours refers to the six months preceding interview. The response options 'Don't know' and 'Skip question', which were available to select throughout the interview, was excluded from analysis.

## Guide to Table/Figure Notes

**Table 1: Guide to Table/Figure Notes**

| Legend | |
|---|---|
| / | Question not asked in respective year (for tables) |
| - | Per cent suppressed due to small cell size (n≤5 but not 0) (for tables) |
| | Missing data points indicate question not asked in respective year or n≤5 answered the question (for figures) |
| ***p*<0.050; ****p*<0.010; *****p*<0.001** | Statistical significance of difference between 2023 and 2024 |

## Interpretation of Findings

Caveats to interpretation of findings are discussed more completely in the method for the annual interviews but it should be noted that these data are from participants recruited in Hobart, Tasmania, and thus do not reflect trends in regional and remote areas. Further, the results are not representative of all people who consume illicit drugs, nor of illicit drug use in the general population, but rather are intended to provide evidence indicative of emerging issues that warrant further monitoring.

This report covers a subset of items asked of participants and does not include implications of findings. These findings should be interpreted alongside analyses of other data sources for a more complete profile of emerging trends in illicit drug use, market features, and harms in Hobart, TAS (see section on 'Additional Outputs' below for details of other outputs providing such profiles).

**Differences in the methodology, and the events of 2020-2024, must be taken into consideration when comparing 2020-2024 data to previous years, and treated with caution.**

## Additional Outputs

Infographics, the executive summary and data tables from this report are available for download. There are a range of outputs from the EDRS which triangulate key findings from the annual interviews and other data sources, including national reports, jurisdictional reports, bulletins, and other resources available via the Drug Trends webpage. This includes results from the Illicit Drug Reporting System (IDRS), which focuses more so on the use of illicit drugs via injection.

Please contact the research team at drugtrends@unsw.edu.au with any queries; to request additional analyses using these data; or to discuss the possibility of including items in future interviews.

# 1

## Sample Characteristics

In 2024, the Hobart EDRS sample was mostly similar to the sample in 2023 and in previous years (Table 2).

Gender representation remained stable between 2023 and 2024 ($p$=0.883), with half (52%) of the sample identifying as male (55% in 2023). The median age of the sample was 25 years (IQR=21-35), stable relative to 2023 (26 years; IQR=21-33; $p$=0.847).

Accommodation remained stable ($p$=0.807), with half (49%) of the sample reporting that they resided in a rented house/flat (49% in 2023), and most of the remaining participants living with their parents/in their family house (24%; 25% in 2023).

Participants reported a mean of 11 years of school in 2024 (range: 7-12), a significant decrease relative to 2023 (12 years; range: 10-12; $p$=0.027). Almost one third (31%) were current students, stable relative to 2023 (37%; $p$=0.482). Fifty-seven per cent had obtained a post-school qualification(s) (65% in 2023; $p$=0.405).

Current employment status remained stable between 2023 and 2024 ($p$=0.548). Specifically, one fifth (19%) reported being employed full-time at the time of interview (26% in 2023), 40% reported being employed on a part-time/casual basis (43% in 2023), and 35% reported being unemployed at the time of interview (28% in 2023).

## Table 2: Demographic characteristics of the sample, nationally, 2024, and Hobart, TAS, 2020-2024

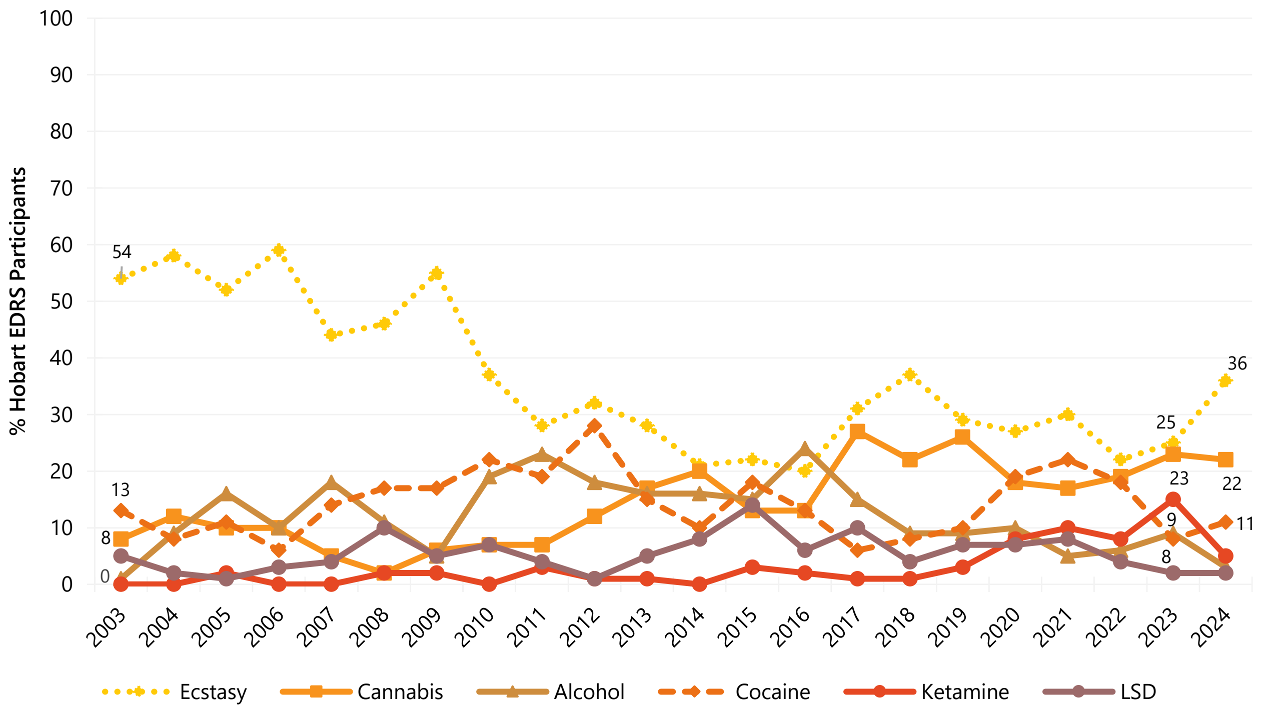
| | Hobart, TAS | | | | | National |
|---|---|---|---|---|---|---|
| | 2020<br>N=100 | 2021<br>N=102 | 2022<br>N=72 | 2023<br>N=65 | 2024<br>N=87 | 2024<br>N=740 |
| **Median age (years; IQR)** | 23 (19-28) | 25 (22-30) | 26 (22-30) | 26 (21-33) | **25 (21-35)** | 23 (20-32) |
| Female | 44 | 36 | 44 | 43 | **46** | 43 |
| Male | 54 | 64 | 48 | 55 | **52** | 55 |
| Non-binary | - | - | 8 | - | - | 3 |
| **% Aboriginal and/or Torres Strait Islander** | - | 9 | - | - | **21*** | 9 |
| **% Born in Australia** | / | / | / | 93 | **93** | 84 |
| **% English primary language spoken at home** | / | / | / | 98 | **100** | 97 |
| **% Sexual identity** | | | | | | |
| Heterosexual | 78 | 77 | 72 | 80 | **71** | 69 |
| Homosexual | - | - | - | - | **6** | 7 |
| Bisexual | 9 | 11 | 18 | 12 | **21** | 17 |
| Queer | - | 6 | 7 | - | **0** | 4 |
| Other identity | 6 | - | - | 0 | **-** | 3 |
| **Mean years of school education (range)** | 12 (8-12) | 12 (7-12) | 11 (7-12) | 12 (10-12) | **11 (7-12)*** | 12 (7-12) |
| **% Post-school qualification(s)^** | 57 | 69 | 60 | 65 | **57** | 56 |
| **% Current students#** | 48 | 44 | 31 | 37 | **31** | 39 |
| **% Current employment status** | | | | | | |
| Full-time | 28 | 29 | 28 | 26 | **19** | 30 |
| Part-time/casual | 34 | 43 | 38 | 43 | **40** | 42 |
| Self-employed | - | - | 7 | - | **6** | 5 |
| Unemployed | 34 | 24 | 28 | 28 | **35** | 23 |
| **Current median weekly income ($; IQR)** | $700 (406-891) | $500 (350-951) | $700 (350-1168) | $696 (426-1345) | **$563 (385-838)** | $700 (400-1200) |
| **% Current accommodation** | | | | | | |
| Own house/flat | 6 | 15 | 15 | 13 | **8** | 10 |
| Rented house/flat | 57 | 49 | 56 | 49 | **49** | 48 |
| Parents'/family home | 34 | 28 | 17 | 25 | **24** | 34 |
| Boarding house/hostel | - | 0 | - | 0 | **0** | 1 |
| Public housing | - | - | 0 | - | **8** | 3 |
| No fixed address+ | 0 | - | 8 | - | **-** | 2 |
| Other | 0 | - | - | - | **6** | 1 |

Note. ^Includes trade/technical and university qualifications. # 'Current students' comprised participants who were currently studying for either trade/technical or university/college qualifications. + No fixed address included couch surfing and rough sleeping or squatting. For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 (Hobart) presented in table; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

Drug of choice remained stable between 2023 and 2024 ($p$=0.166), with 36% nominating ecstasy as their drug of choice in 2024 (25% in 2023), followed by one fifth (22%) nominating cannabis as their drug of choice (23% in 2023) and one tenth (11%) nominating cocaine (8% in 2023). Few participants (n≤5) reported alcohol (9% in 2023), ketamine (15% in 2023) or LSD (n≤5 in 2023) as the drug of choice in 2024 (Figure 1). The drug used most often in the past month also remained stable between 2023 and 2024 ($p$=0.134), with one quarter each reporting cannabis (28%) and ecstasy (26%) as the drug used most often (34% and 14% in 2023, respectively). One tenth reported alcohol (13%) and cocaine (9%) as the drugs used most often (26% and 11% in 2023, respectively) (Figure 2).

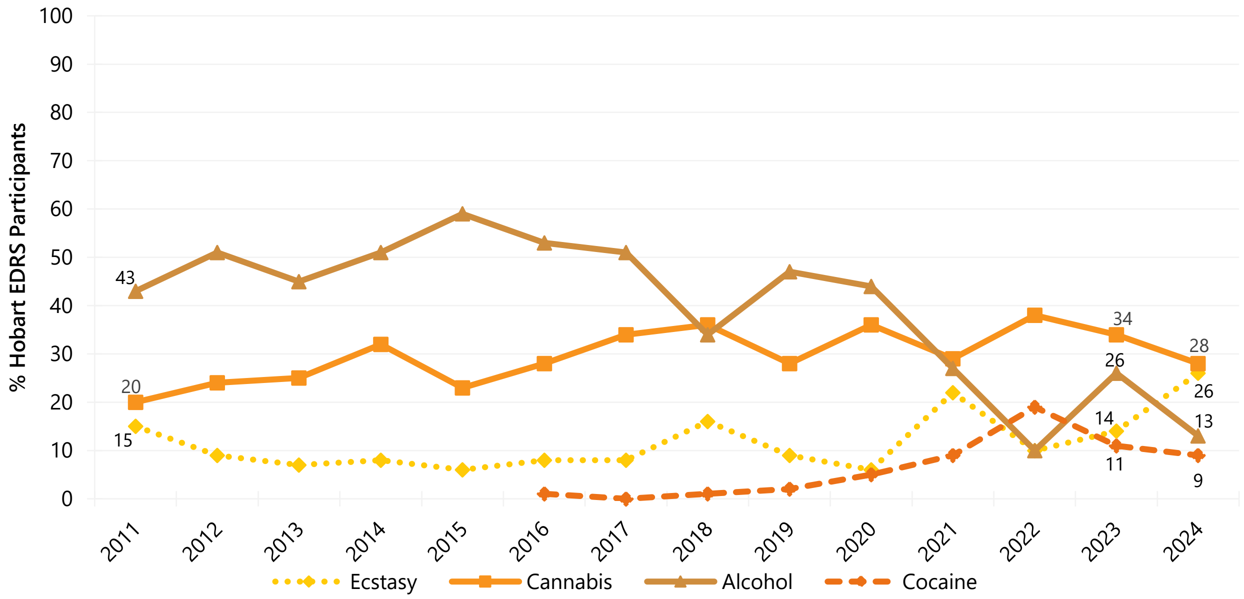
Weekly or more frequent use of various drugs remained stable between 2023 and 2024. Specifically, almost half (47%) of the Hobart sample reported weekly or more frequent cannabis use (41% in 2023; $p$=0.510). One fifth reported weekly or more frequent use of methamphetamine (21%; 12% in 2023; $p$=0.207) and ecstasy (20%; 16% in 2023; $p$=0.527). Few participants (n≤5) reported weekly or more frequent use of cocaine in 2023 and 2024 (Figure 3).

**Figure 1: Drug of choice, Hobart, TAS, 2003-2024**



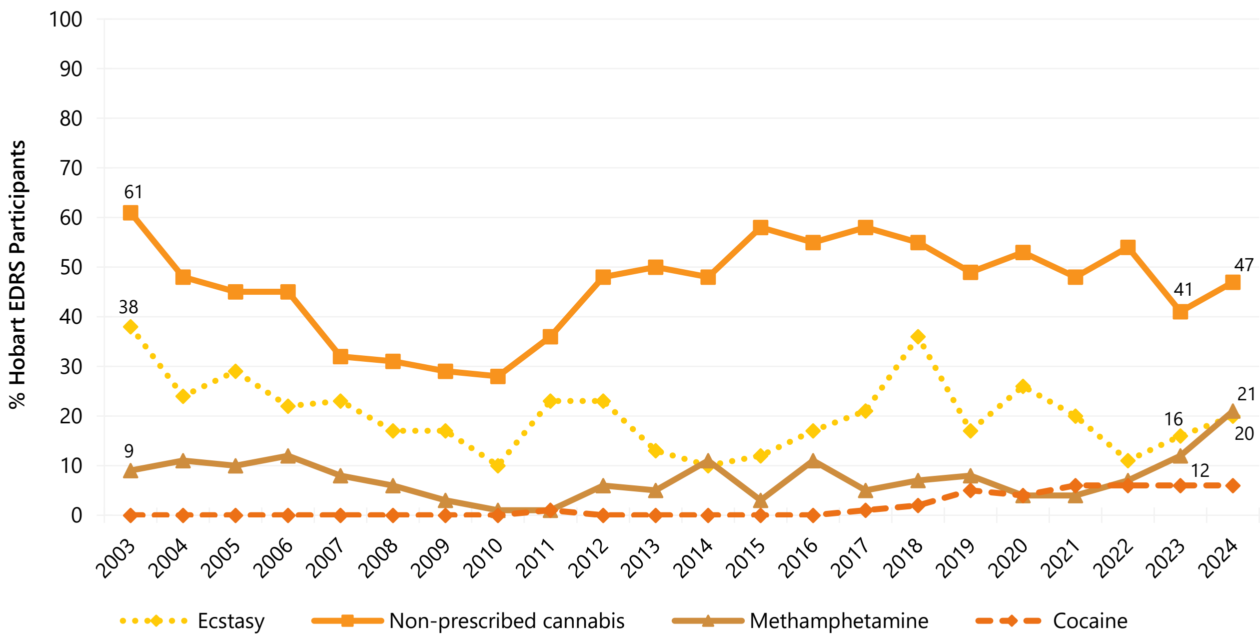

Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; smaller percentages have endorsed other substances. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Figure 2: Drug used most often in the past month, Hobart, TAS, 2011-2024




Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; smaller percentages have endorsed other substances. Data are only presented for 2011-2024 as this question was not asked in 2003-2010. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Figure 3: Weekly or more frequent substance use in the past six months, Hobart, TAS, 2003-2024




Note. Computed from the entire sample regardless of whether they had used the substance in the past six months. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Further, from 2022, we captured use of 'cannabis and/or cannabinoid-related products', while in previous years questions referred only to 'cannabis'. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

# 2

# Non-Prescribed Ecstasy

Participants were asked about their recent (past six month) use of various forms of non-prescribed ecstasy (3,4-methylenedoxymethamphetamine), including pills, capsules, crystal, ands powder.

## Patterns of Consumption (Any Ecstasy)

### Recent Use (past 6 months)

Recent use of any non-prescribed ecstasy in the six months prior to interview remained stable in 2024, relative to 2023 (91%; 91% in 2023) (Figure 4). Capsules (59%; 46% in 2023; $p$=0.150) were the most commonly used forms of ecstasy in the six months preceding interview in 2024, followed by pills (49%; 48% in 2023; $p$=0.868) and crystal (47%; 55% in 2023; $p$=0.333). Powder remained the least commonly used form of ecstasy (30%; 26% in 2023; $p$=0.703), consistent with the entirety of the reporting period.

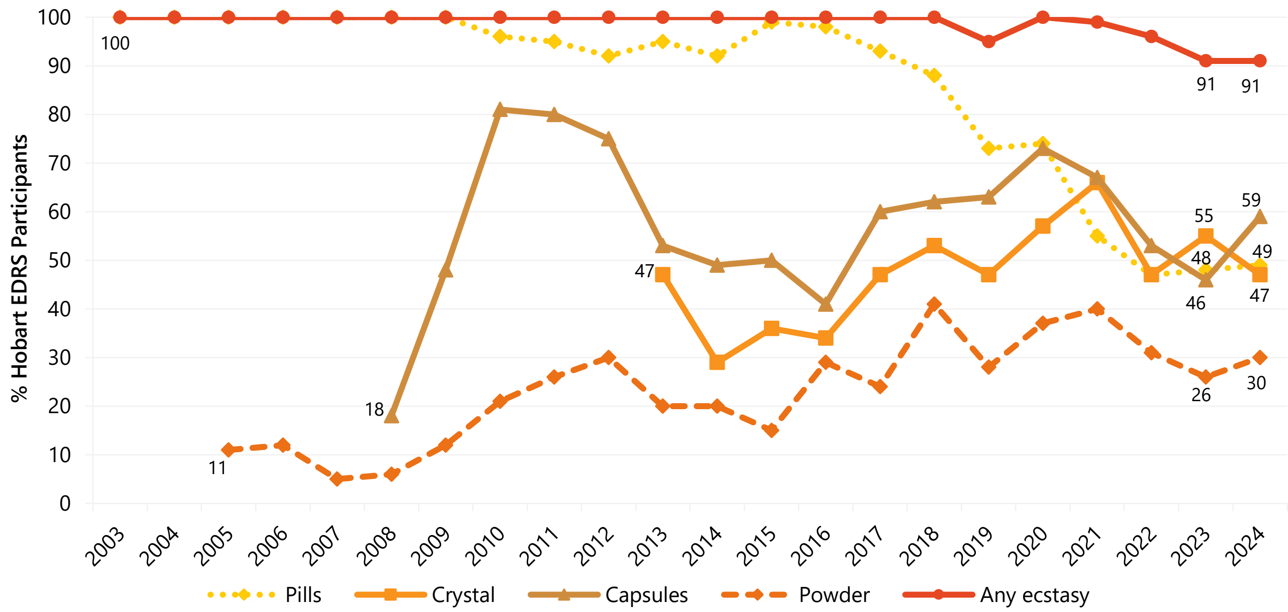
### Frequency of Use

Among those who reported recent use of any non-prescribed ecstasy and commented (n=78), participants reported using ecstasy (in any form) on a median of eleven days (IQR=5-20) in 2024, equivalent to almost fortnightly use in the preceding six months, and remaining stable relative to 2023 (9 days; IQR=5-16; n=58; $p$=0.372) (Figure 5). Weekly or more frequent use of any form of ecstasy also remained stable relative to 2023 (22%; 17% in 2023; $p$=0.522).

### Number of Forms Used

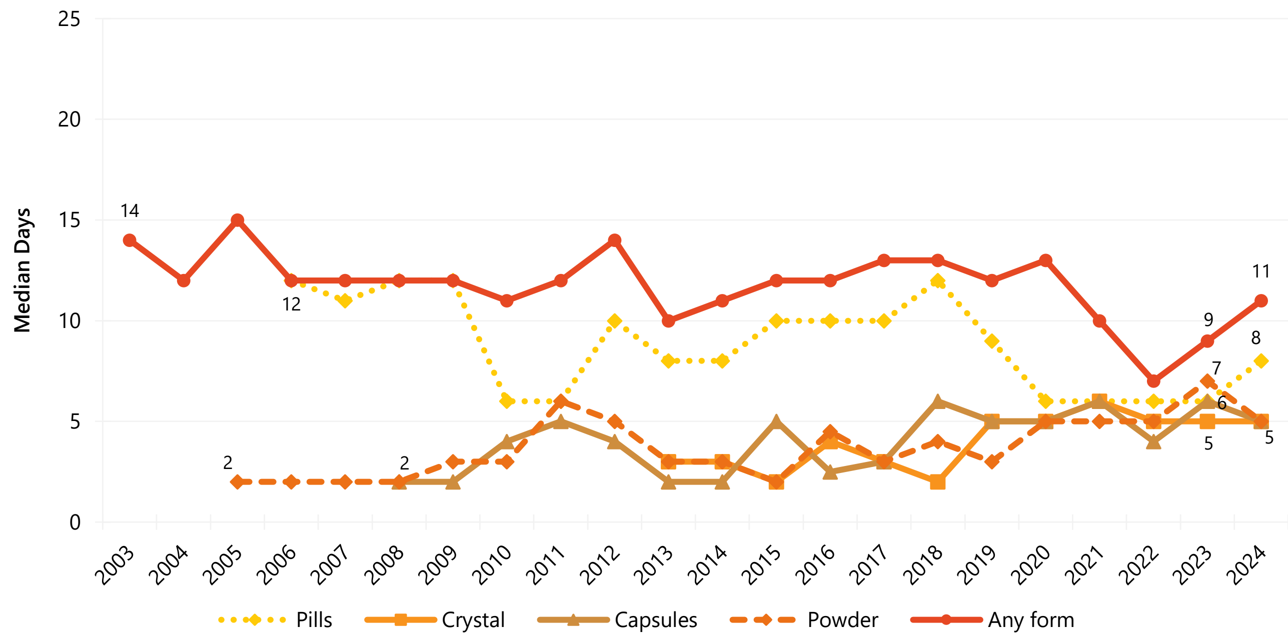
Among participants who had recently consumed non-prescribed ecstasy and commented (n=79), participants reported using a median of two forms of ecstasy (IQR=1-3), stable relative to 2023 (2 forms; IQR=1-3; n=58; $p$=0.918).

**Figure 4: Past six month use of any non-prescribed ecstasy, and non-prescribed ecstasy pills, crystal, capsules, and powder, Hobart, TAS, 2003-2024**




Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

**Figure 5: Median days of any non-prescribed ecstasy use, and non-prescribed ecstasy pills, crystal, capsules, and powder use in the past six months, Hobart, TAS, 2003-2024**




Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Median days computed among those who reported past 6-month use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 25 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# Patterns of Consumption (by form)

## Non-Prescribed Ecstasy Pills

**Recent Use (past 6 months):** Half (49%) of participants reported recent use of non-prescribed ecstasy pills in 2024, stable relative to 2023 (48%; *p*=0.868), with the use of pills having considerably declined since 2016 (Figure 4).

**Frequency of Use:** Of those who had recently consumed ecstasy pills and commented (n=43), a median of eight days (IQR=4-19) was reported in the six months preceding interview in 2024, stable from 2023 (6 days; IQR=3-12; n=30; *p*=0.288) (Figure 5). One fifth (21%) of those who had recently consumed ecstasy pills reported weekly or more frequent use in 2024, stable relative to 2023 (n≤5; *p*=0.337).

**Routes of Administration:** Among participants who had recently consumed ecstasy pills and commented (n=43), the most common route of administration in 2024 was swallowing (95%; 90% in 2023; *p*=0.644), followed by snorting (44%; 42% in 2023), consistent with previous years. No participants reported recent smoking or injecting as a route of administration in 2023 and 2024.

**Quantity:** Of those who reported recent use and responded (n=43), the median number of ecstasy pills used in a 'typical' session was two (IQR=1-3.3; 2 pills in 2023; IQR=1-2; n=32; *p*=0.154). Of those who reported recent use and responded (n=43), the median maximum number of pills used in a session was three (IQR=2-6; 2.5 pills in 2023; IQR=1.9-4; n=33; *p*=0.338).

## Non-Prescribed Ecstasy Capsules

**Recent Use (past 6 months):** Three fifths (59%) of participants reported recent use of non-prescribed ecstasy capsules, stable from 46% in 2023 (*p*=0.150) (Figure 4).

**Frequency of Use:** Among those who reported recent use and commented (n=51), participants reported consuming capsules on a median of five days in 2024 (IQR=4-12), stable from 2023 (6 days; IQR=4-12; n=30; *p*=0.552) (Figure 5). Twelve per cent of participants who had recently consumed ecstasy capsules reported weekly or more frequent use in 2024 (n≤5 in 2023; *p*=0.703).

**Routes of Administration:** Among those who had recently consumed ecstasy capsules and commented (n=51), the vast majority (96%) of participants reported swallowing (90% in 2023; *p*=0.354) as a route of administration. Twenty-nine per cent reported snorting, stable relative to 2023 (43%; *p*=0.236). No participants reported recent smoking or injecting as a route of administration in 2023 and 2024.

**Quantity:** Of those who reported recent use and responded (n=52), the median number of ecstasy capsules used in a 'typical' session was two (IQR=1-4; 2 capsules in 2023; IQR=1.1-2.8; n=30; *p*=0.116). Of those who reported recent use and responded (n=50), the median maximum number of capsules used in a session was three (IQR=2-6; 3 capsules in 2023; IQR=2-4; n=30; *p*=0.264).

## Non-Prescribed Ecstasy Crystal

**Recent Use (past 6 months):** Forty-seven per cent of participants reported recent use of non-prescribed ecstasy crystal, stable relative to 2023 (55%; *p*=0.333) (Figure 4).

**Frequency of Use:** Among those who reported recent use and commented (n=41), participants reported using crystal on a median of five days (IQR=2-12) in 2024, stable from five days in 2023 (IQR=3-12; n=36; *p*=0.964) (Figure 5). Seventeen per cent of participants who had recently consumed crystal reported weekly or more frequent use in 2024 (n≤5 in 2023; *p*=0.321).

**Routes of Administration:** Among participants who had recently consumed ecstasy crystal and commented (n=41), four fifths (80%) reported swallowing (67% in 2023; $p$=0.202), while 46% reported snorting (50% in 2023; $p$=0.816). Few participants (n≤5) reported recent smoking (n≤5 in 2023), and no participants reported recent injecting in 2023 and 2024.

**Quantity:** Of those who reported recent use and responded (n=33), the median amount of ecstasy crystal used in a 'typical' session was 0.50 grams (IQR=0.40-1.00; 0.30 grams in 2023; IQR=0.20-0.50; n=30; $p$=0.116). Of those who reported recent use and responded (n=32), the median maximum amount of crystal used in a session was one gram (IQR=0.50-1.00), a significant increase compared to 2023 (0.50 grams; IQR=0.30-0.80; n=29; $p$=0.031).

### Non-Prescribed Ecstasy Powder

**Recent Use (past 6 months):** One third (30%) of participants reported recent use of non-prescribed ecstasy powder, stable relative to 2023 (26%; $p$=0.703) (Figure 4).

**Frequency of Use:** Amongst those who reported recent use and commented (n=26), participants reported consuming powder on a median of five days (IQR=3-11) in 2024, stable from seven days in 2023 (IQR=3-12; n=16; $p$=0.676) (Figure 5). Few participants (n≤5) who had recently consumed powder reported weekly or more frequent use in 2023 and 2024.

**Routes of Administration:** Among participants who had recently consumed ecstasy powder and commented (n=26), 92% reported snorting (76% in 2023; $p$=0.193), followed by two fifths (42%) who reported swallowing (29% in 2023; $p$=0.523).

**Quantity:** Of those who reported recent use and responded (n=20), the median amount of powder used in a 'typical' session was 0.50 grams (IQR=0.20-1.00; 0.35 grams in 2023; IQR=0.20-0.50; n=12; $p$=0.218). Of those who reported recent use and responded (n=21), the median maximum amount of powder used in a session was 0.50 grams (IQR=0.40-1.00; 0.60 grams in 2023; IQR=0.40-1.00; n=11; $p$=0.920).

## Price, Perceived Purity and Perceived Availability

### Non-Prescribed Ecstasy Pills

**Price:** The reported median price of an ecstasy pill was $30 in 2024 (IQR=25-35; n=32), stable relative to $25 in 2023 (IQR=25-35; n=26; $p$=0.609) (Figure 6).

**Perceived Purity:** Among those who responded (n=44), the perceived purity of ecstasy pills remained stable between 2023 and 2024 ($p$=0.077). The largest percentage of participants reported perceived purity to be 'high' (36%; 33% in 2023). In contrast, 25% reported 'low' purity (n≤5 in 2023). A further 23% reported purity to be 'medium' (31% in 2023) and 16% reported purity to be 'fluctuating' (31% in 2023) (Figure 8).

**Perceived Availability:** The perceived availability of ecstasy pills remained stable between 2023 and 2024 ($p$=0.843). Among those who were able to comment in 2024 (n=45), half (49%) reported that pills were 'very easy' to obtain (45% in 2023), with a further 27% reporting 'easy' obtainment (32% in 2023). In contrast, one fifth (18%) reported that pills were 'difficult' to obtain (21% in 2023). Few participants (n≤5) reported pills to be 'very difficult' to obtain in 2023 and 2024 (Figure 12).

### Non-Prescribed Ecstasy Capsules

**Price:** The reported median price of a non-prescribed ecstasy capsule was $30 in 2024

(IQR=25-35; n=25), stable relative to $28 in 2023 (IQR=21-30; n=18; $p$=0.064) (Figure 6).

**Perceived Purity:** The perceived purity of ecstasy capsules remained relatively stable between 2023 and 2024 ($p$=0.435). Among those who were able to comment in 2024 (n=45), almost two fifths (38%) perceived purity to be 'high' (31% in 2023) and 24% perceived purity to be 'medium' (38% in 2023). Conversely, 22% perceived purity to be 'fluctuating' (25% in 2023) and a further 16% perceived purity to be 'low' (n≤5 in 2023) (Figure 9).

**Perceived Availability:** The perceived availability of ecstasy capsules remained relatively stable between 2023 and 2024 ($p$=0.595). Among those who responded in 2024 (n=45), the largest percentage of participants reported that capsules were 'easy' to obtain (44%; 41% in 2023). A further 38% of participants reported that capsules were 'very easy' to obtain (44% in 2023), whereas 18% reported that capsules were 'difficult' to obtain (n≤5 in 2023). No participants reported capsules as being 'very difficult' to obtain (n≤5 in 2023) (Figure 13).

## Non-Prescribed Ecstasy Crystal

**Price:** The median price of a gram of crystal remained stable in 2024 at $250 (IQR=188-285; n=31; $250 in 2023; IQR=200-300; n=20; $p$=0.338) (Figure 7). Few participants (n≤5) reported on the median price of a point of crystal in 2023 and 2024.

**Perceived Purity:** The perceived purity of ecstasy crystal remained stable between 2023 and 2024 ($p$=0.060). Among those who responded in 2024 (n=40), half (50%) perceived purity to be 'high' (55% in 2023) and 35% perceived purity to be 'medium' (13% in 2023) (Figure 10). Few participants (n≤5) perceived purity to be 'low' in 2023 and 2024.

**Perceived Availability:** The perceived availability of ecstasy crystal remained stable between 2023 and 2024 ($p$=0.641). Among those who were able to comment in 2024 (n=38), 45% reported that crystal was 'very easy' to obtain (43% in 2023), and 34% reported that crystal was 'easy' to obtain (23% in 2023). In contrast, 18% of participants reported that crystal was 'difficult' to obtain (30% in 2023). Few participants (n≤5) reported crystal to be 'very difficult' to obtain in 2023 and 2024 (Figure 14).

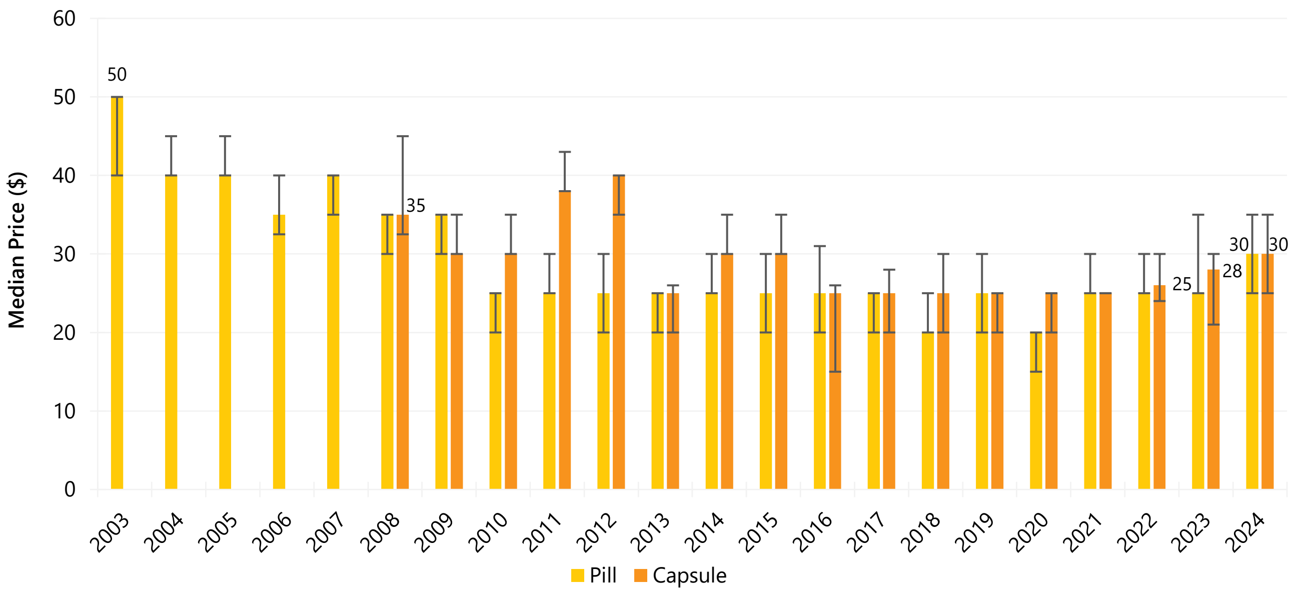
## Non-Prescribed Ecstasy Powder

**Price:** The median price of a gram of powder remained stable in 2024 at $235 (IQR=138-263; n=8; $275 in 2023; IQR=250-300; n=6; $p$=0.509), with few participants (n≤5) reporting on the median price of a point of powder in 2023 and 2024 (Figure 7).

**Perceived Purity:** The perceived purity of ecstasy powder remained stable between 2023 and 2024 ($p$=0.608). Among those who were able to comment in 2024 (n=15), two fifths (40%) perceived purity to be 'medium' (n≤5 in 2023). Few participants (n≤5) reported on the perceived purity of powder being 'low,' 'medium' or 'fluctuating' in 2024 (Figure 11).

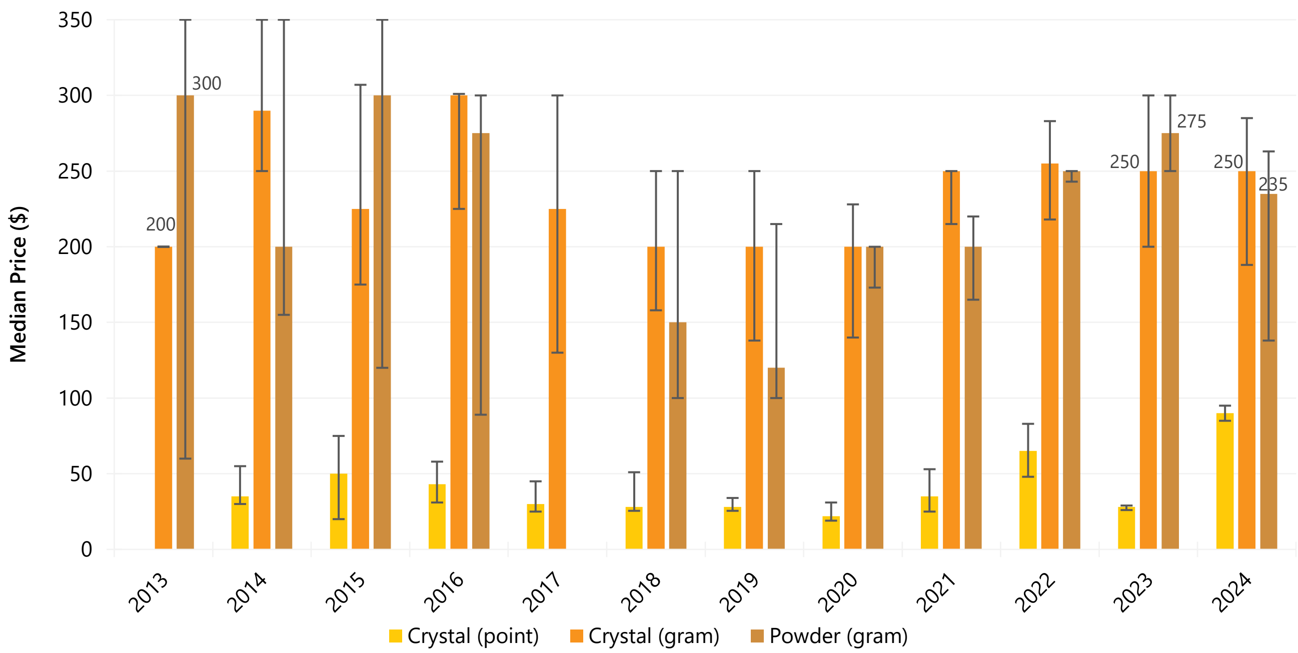
**Perceived Availability:** The perceived availability of ecstasy powder remained stable between 2023 and 2024 ($p$=0.658). Among those who were able to respond in 2024 (n=14), 64% of participants reported powder as being 'very easy' to obtain (43% in 2023). Few participants (n≤5) reported on the perceived availability of powder being 'easy' or 'difficult' to obtain in 2023 and 2024, with no participants reporting powder to be 'very difficult' to obtain (n≤5 in 2023) (Figure 15).

## Figure 6: Median price of non-prescribed ecstasy pill and capsule, Hobart, TAS, 2003-2024



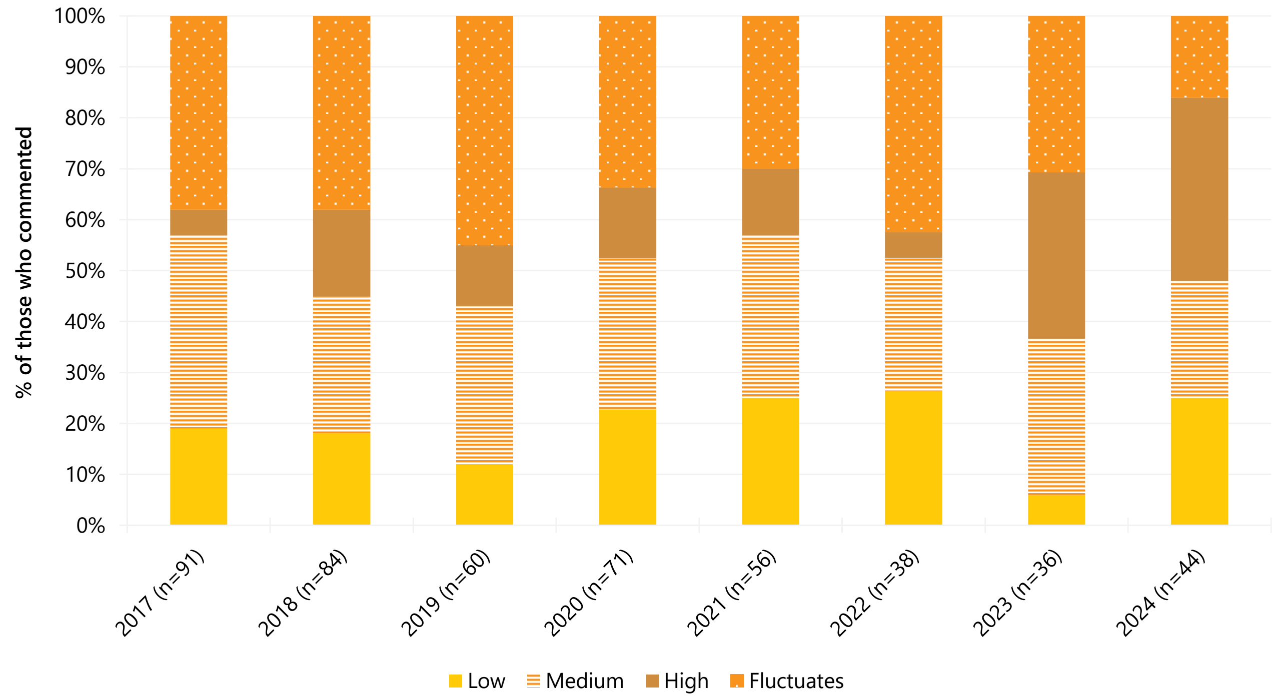

Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). For historical numbers, please refer to the data tables. The error bars represent the IQR. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Figure 7: Median price of non-prescribed ecstasy crystal (per point and gram) and powder (per gram only), Hobart, TAS, 2013-2024



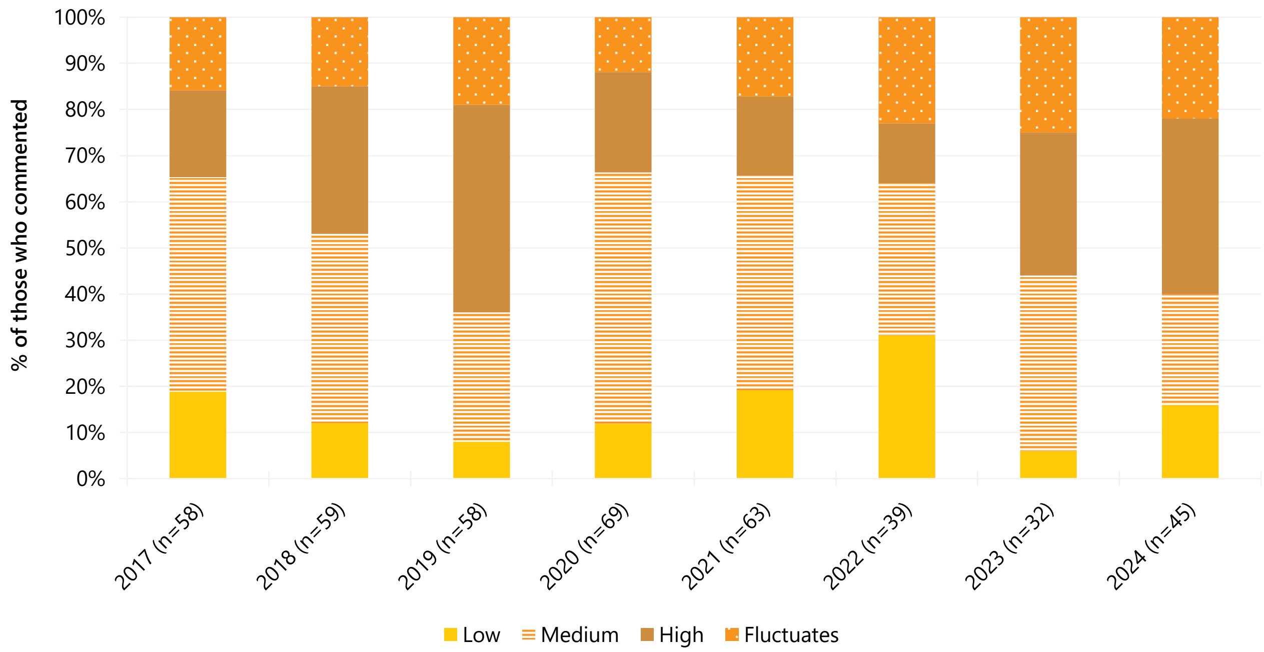

Note. Among those who commented. Data collection for price of non-prescribed ecstasy crystal (gram and point) and ecstasy powder (gram) started in 2013. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). For historical numbers, please refer to the data tables. The error bars represent the IQR. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Figure 8: Current perceived purity of non-prescribed ecstasy pills, Hobart, TAS, 2017-2024



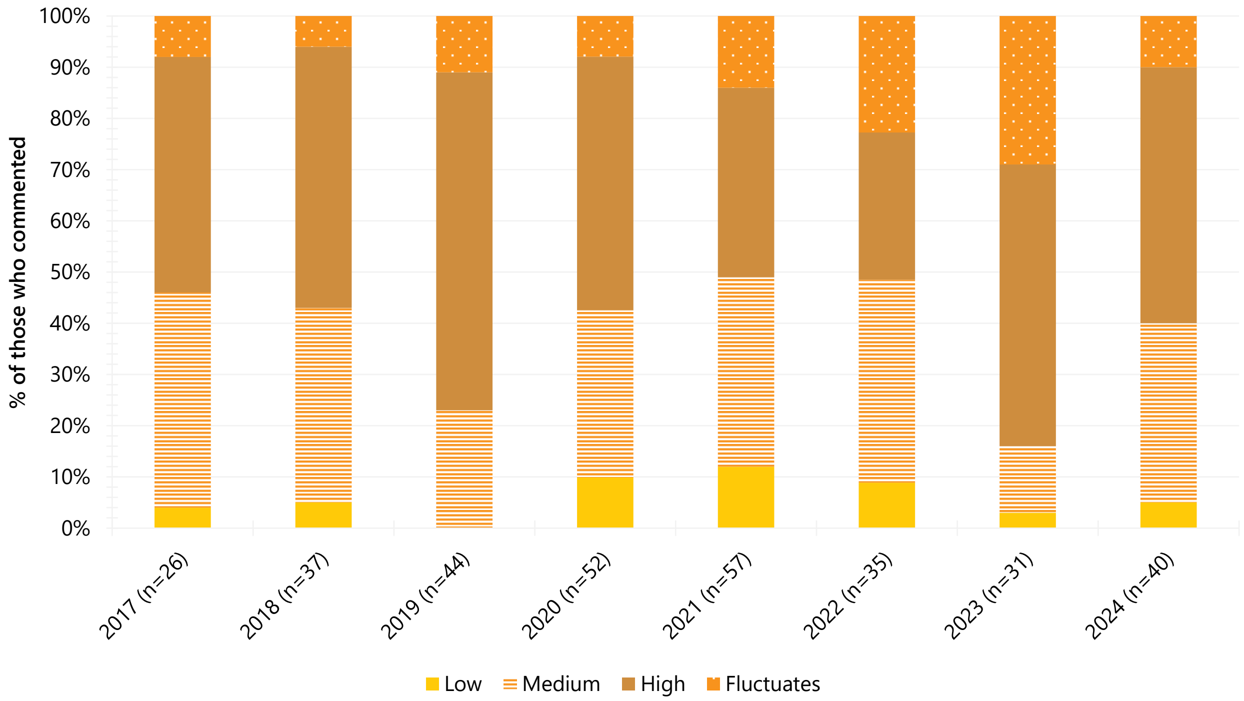

Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Figure 9: Current perceived purity of non-prescribed ecstasy capsules, Hobart, TAS, 2017-2024



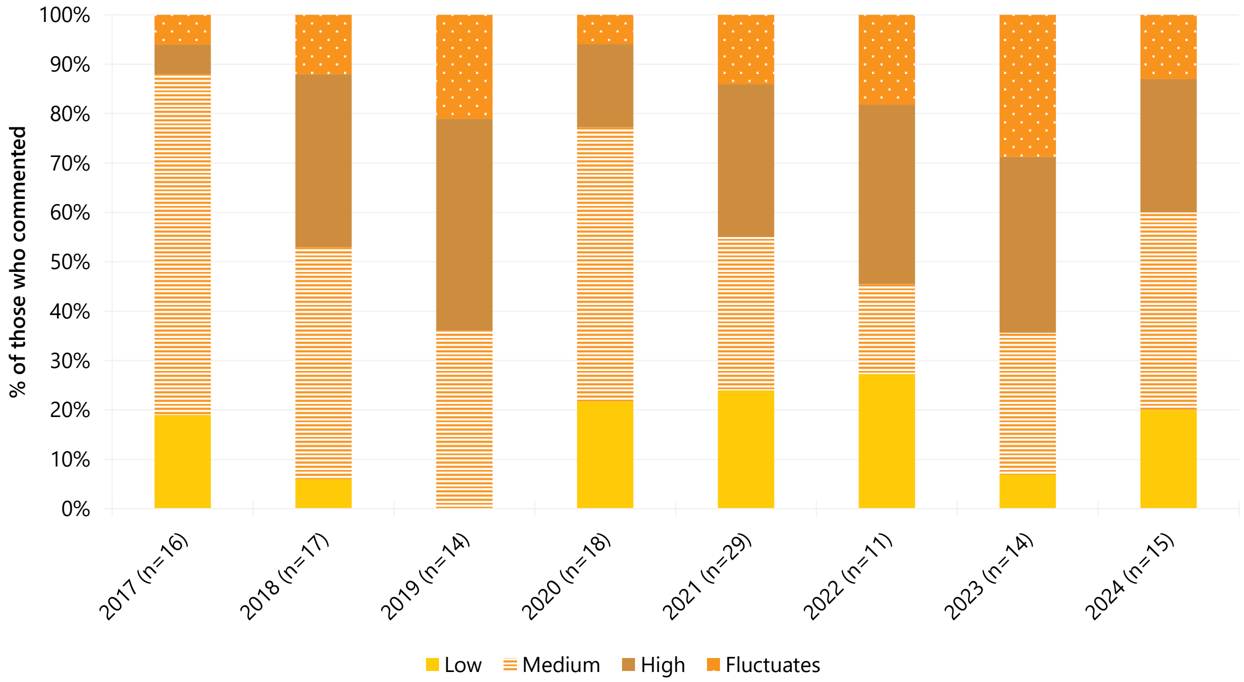

Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

**Figure 10: Current perceived purity of non-prescribed ecstasy crystal, Hobart, TAS, 2017-2024**



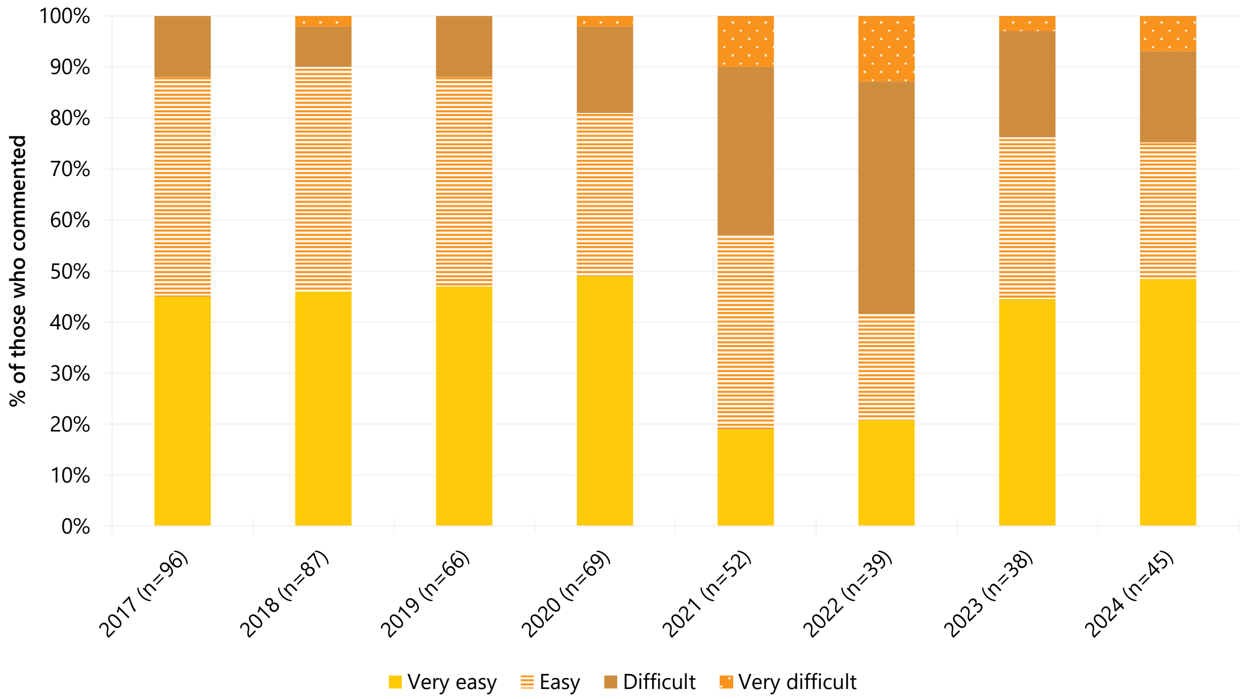

Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

**Figure 11: Current perceived purity of non-prescribed ecstasy powder, Hobart, TAS, 2017-2024**



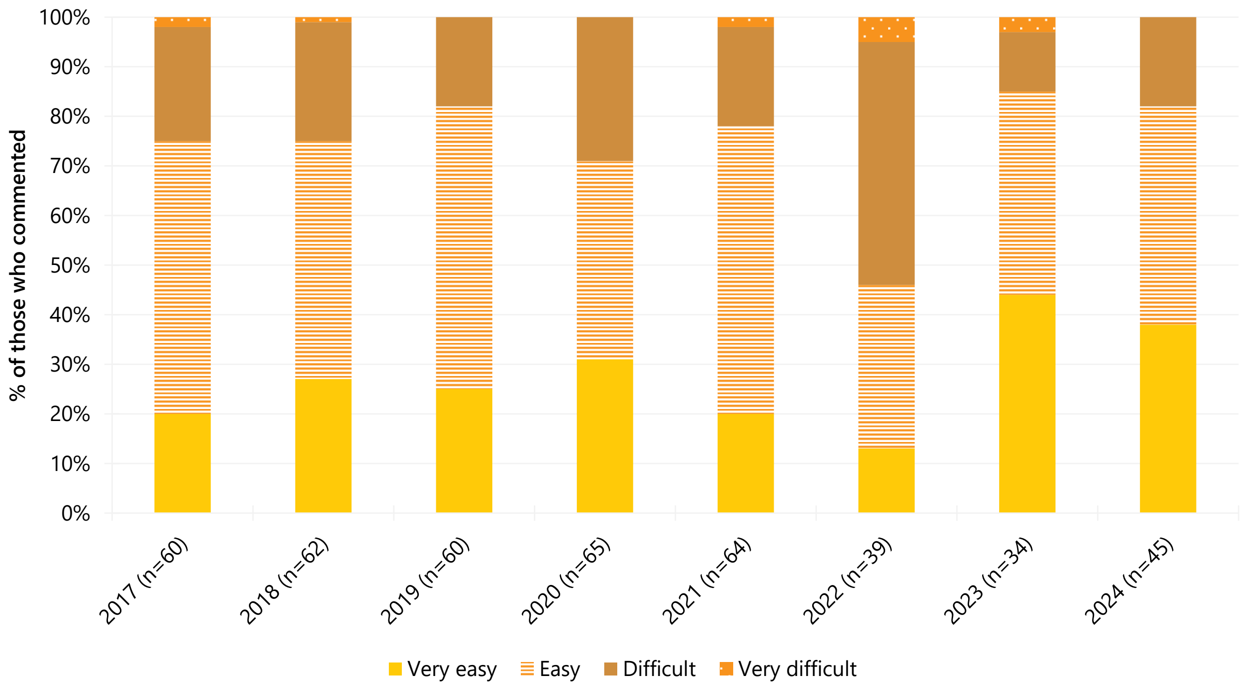

Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 12: Current perceived availability of non-prescribed ecstasy pills, Hobart, TAS, 2017-2024



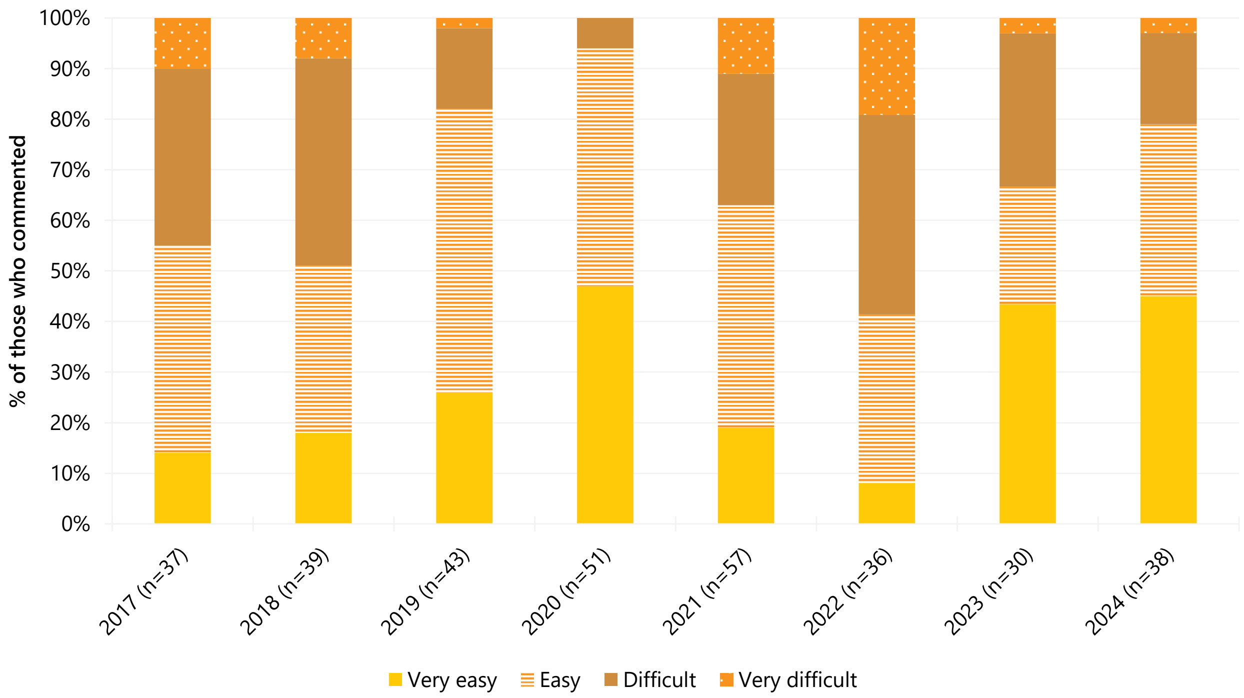

Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 13: Current perceived availability of non-prescribed ecstasy capsules, Hobart, TAS, 2017-2024



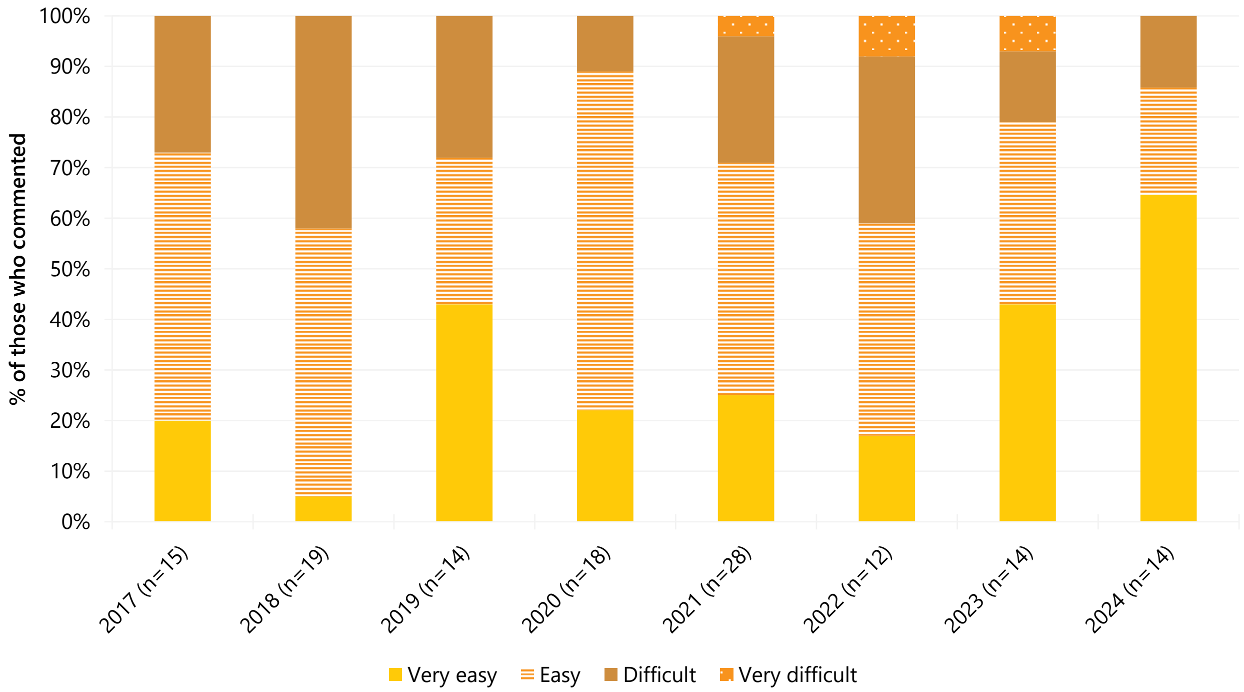

Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

## Figure 14: Current perceived availability of non-prescribed ecstasy crystal, Hobart, TAS, 2017-2024




Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

## Figure 15: Current perceived availability of non-prescribed ecstasy powder, Hobart, TAS, 2017-2024




Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

# 3

# Methamphetamine

Participants were asked about their recent (past six month) use of various forms of methamphetamine, including powder (white particles, described as 'speed'), base (wet, oily powder) and crystal (clear, ice-like crystals). Findings for base methamphetamine are not reported here due to small numbers reporting recent use. For further information on base methamphetamine, please refer to the 2024 National IDRS Report for national trends, or contact the Drug Trends team (drugtrends@unsw.edu.au).

## Patterns of Consumption (Any Methamphetamine)

### Recent Use (past 6 months)

Recent use of any methamphetamine has declined since monitoring commenced (Figure 16), from more than eight in ten participants reporting recent use in 2003 (82%), down to four in ten participants in 2023 and 2024 (40%, respectively).

### Frequency of Use

Median frequency of use reported by participants in the past six months was 24 days (IQR=4-93; n=35) in 2024, stable relative to nine days in 2023 (IQR=3-29; n=26; $p$=0.195) (Figure 17). Half (51%) of those who had recently used methamphetamine and commented (n=35) reported using methamphetamine weekly or more frequently, stable relative to 2023 (31%; $p$=0.122).

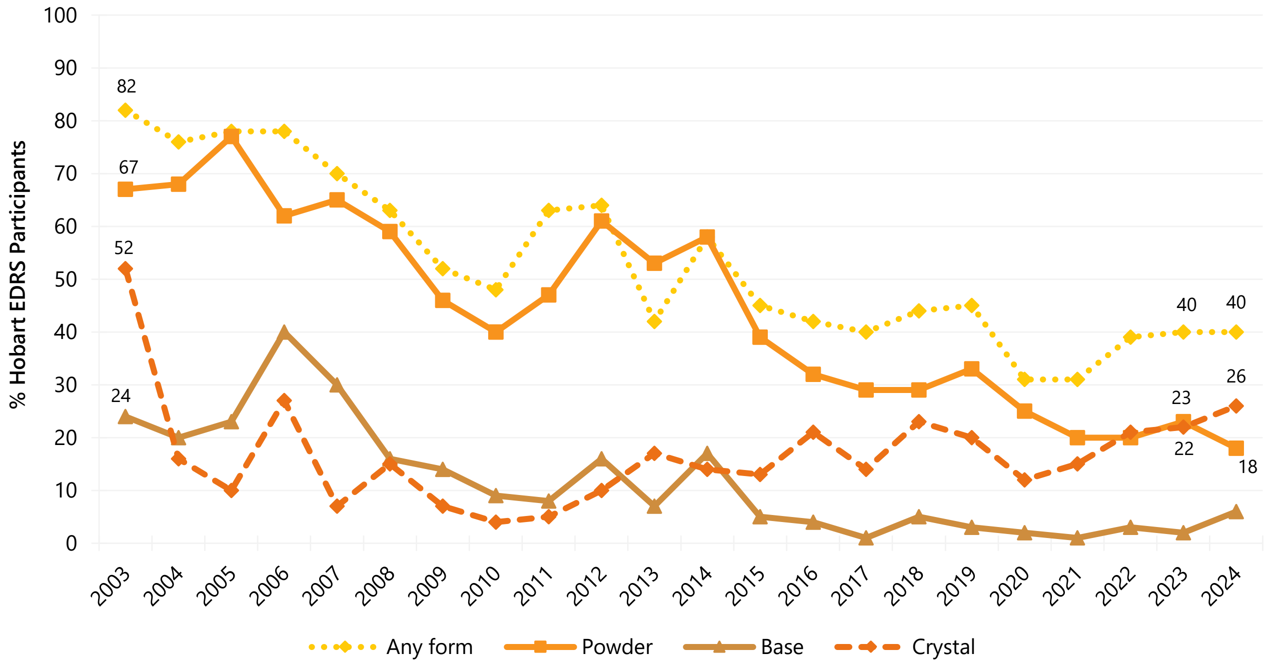
### Forms Used

Use of all forms of methamphetamine have decreased since the start of monitoring. Of participants who had used methamphetamine in the six months preceding interview in 2024 (n=35), two thirds (66%) had used methamphetamine crystal (54% in 2023; $p$=0.430), followed by powder (46%; 58% in 2023; $p$=0.437). Few participants (n≤5) reported using methamphetamine base in 2023 and 2024 ($p$=0.227).

### Number of Forms Used

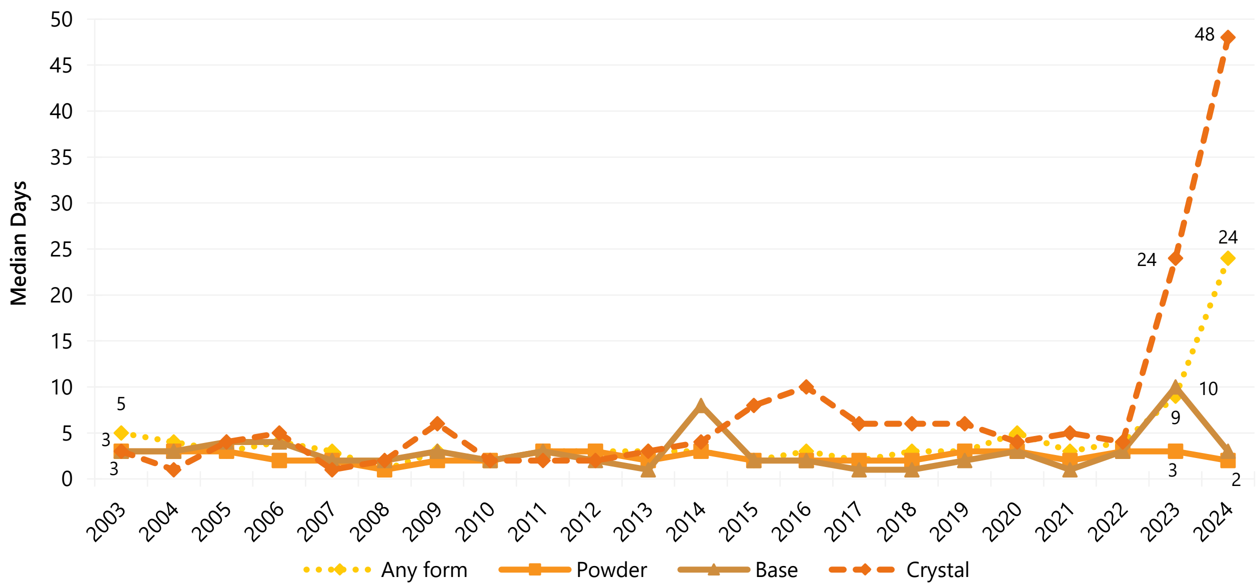
Among participants who had recently consumed any methamphetamine and commented (n=35), participants reported using a median of one form of methamphetamine (IQR=1-1), stable relative to 2023 (1 form; IQR=1-1; n=26; $p$=0.388).

**Figure 16: Past six month use of any methamphetamine, and methamphetamine powder, base, and crystal, Hobart, TAS, 2003-2024**




Note. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the [data tables](). Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

**Figure 17: Median days of any methamphetamine, and methamphetamine powder, base, and crystal use in the past six months, Hobart, TAS, 2003-2024**




Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 50 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# Patterns of Consumption (by form)

## Methamphetamine Powder

**Recent Use (past 6 months):** Recent use of methamphetamine powder has declined over the course of monitoring, though remained stable in 2024 at 18% (23% in 2023; $p$=0.538) (Figure 16).

**Frequency of Use:** Amongst those who had recently consumed methamphetamine powder and commented (n=16), participants reported use on a median of two days (IQR=1-6) in 2024, stable relative to 2023 (3 days; IQR=1-6; n=15; $p$=0.761) (Figure 17). Few participants (n≤5) reported weekly or more frequent use of powder in 2024 (n≤5 in 2023; $p$=0.600).

**Routes of Administration:** Among participants who had recently consumed methamphetamine powder and commented (n=16), snorting was the most common route of administration, with 88% reporting this method in 2024 (53% in 2023; $p$=0.054). There was a significant decrease of participants reporting swallowing powder, with few participants (n≤5) reporting this method in 2024 (67% in 2023; $p$=0.032). No participants reported recent smoking or injecting as a route of administration in 2023 and 2024.

**Quantity:** Of those who reported recent use and responded (n=13), the median amount of methamphetamine powder used in a 'typical' session was 0.50 grams (IQR=0.20-1.00; 0.25 grams in 2023; IQR=0.10-0.30; n=9; $p$=0.069). Of those who reported recent use and responded (n=12), the median maximum amount of powder used in a session was 0.65 grams (IQR=0.38-1.00; 0.30 grams in 2023 (IQR=0.20-0.60; n=9; $p$=0.372).

## Methamphetamine Crystal

**Recent Use (past 6 months):** One quarter (26%) of participants reported recent use of methamphetamine crystal in 2024, stable relative to 2023 (22%; $p$=0.568) (Figure 16).

**Frequency of Use:** Of those who had recently consumed methamphetamine crystal and commented (n=23), participants reported use on a median of 48 days (IQR=11-120) in 2024, compared to 24 days in 2023 (IQR=10-80; n=14; $p$=0.396) (Figure 17). Seventy per cent of participants who had recently used crystal reported weekly or more frequent use in 2024, stable relative to 2023 (57%; $p$=0.512).

**Routes of Administration:** Among participants who had recently consumed methamphetamine crystal and commented (n=23), smoking remained the most common route of administration, with three quarters (74%) reporting this method in 2024, unchanged from 100% in 2023 ($p$=0.065). Few participants (n≤5) reported swallowing, snorting or injecting crystal in 2024, stable relative to 2023.

**Quantity:** Of those who reported recent use and responded (n=21), the median amount of methamphetamine crystal used in a 'typical' session was 0.20 grams (IQR=0.10-0.30; 0.18 grams in 2023; IQR=0.10-0.45; n=14; $p$=0.563). Of those who reported recent use and responded (n=21), the median maximum amount of crystal used in a session was 0.40 grams (IQR=0.25-0.50; 0.40 grams in 2023; IQR=0.23-0.88; n=14; $p$=0.825).

# Price, Perceived Purity and Perceived Availability

## Methamphetamine Powder

Due to low numbers reporting (n≤5), further details are not presented on price (Figure 18), perceived purity (Figure 20) and perceived availability (Figure 22) for methamphetamine powder. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

## Methamphetamine Base

Due to low numbers reporting (n≤5) recent use of methamphetamine base in 2024 (n≤5 in 2023), further details are not reported. For historical information on recent use and frequency of use, please refer to Figure 16 and Figure 17, respectively. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

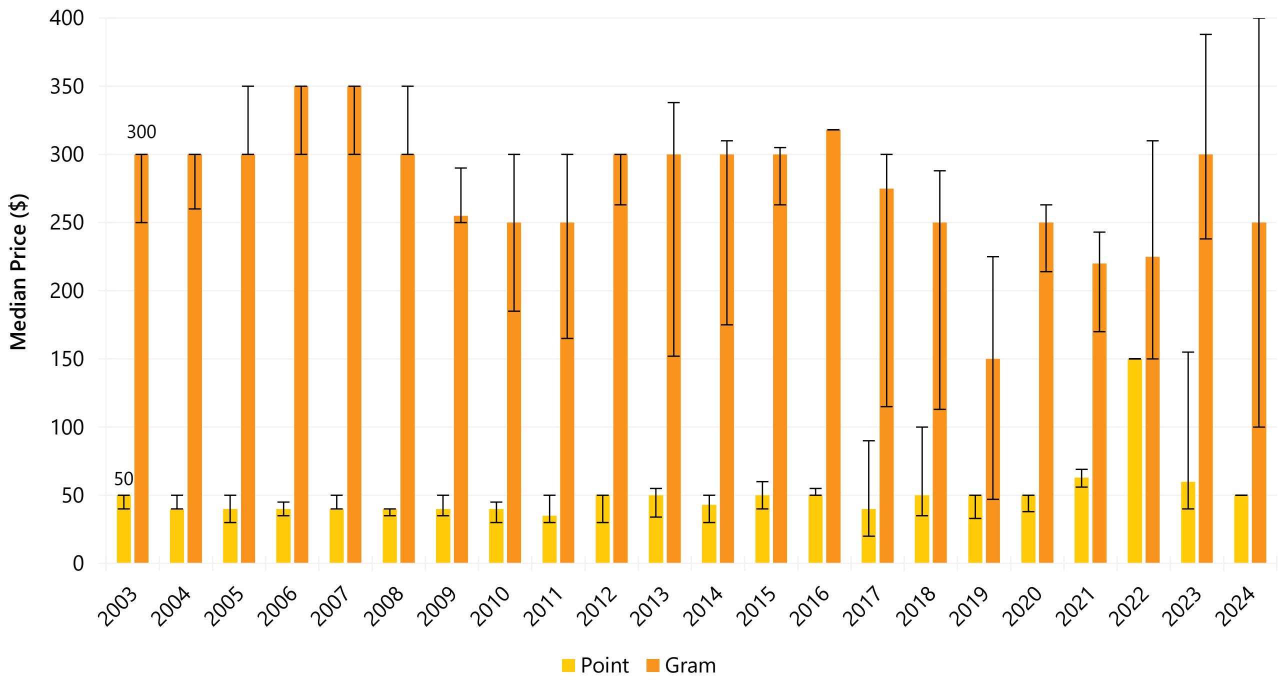
## Methamphetamine Crystal

**Price:** The median price of a point of methamphetamine crystal remained stable in 2024 at \$50 (IQR=50-55; n=15; \$70 in 2023; IQR=50-80; n=7; $p$=0.322) (Figure 19). Few participants (n≤5) reported on the median price of a gram of crystal in 2023 and 2024 ($p$=0.471).

**Perceived Purity:** The perceived purity of methamphetamine crystal remained stable between 2023 and 2024 ($p$=0.207). Among those who were able to comment in 2024 (n=27), the largest per cent reported purity to be 'high' (44%; 77% in 2023). One fifth (22%) reported purity as 'fluctuating' (n≤5 in 2023). Few participants (n≤5) reported purity to be 'medium' and 'low' (n≤5 and 0% in 2023, respectively) (Figure 21).

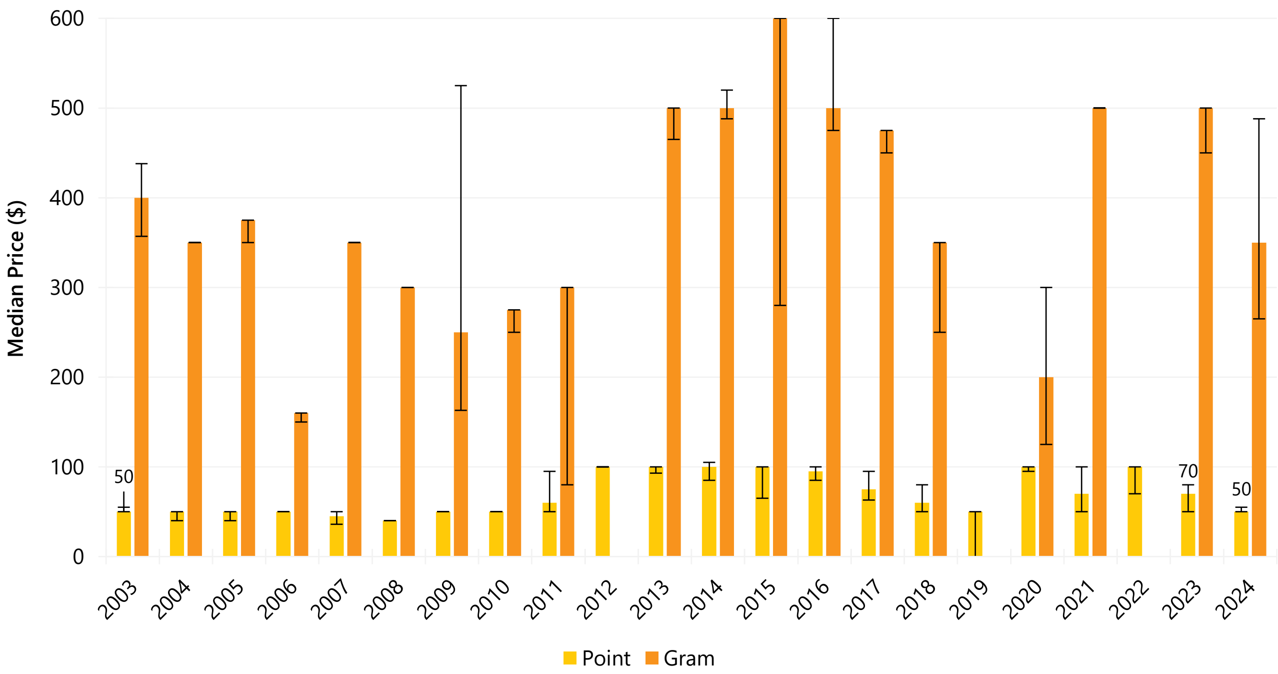
**Perceived Availability:** The perceived availability of methamphetamine crystal remained stable between 2023 and 2024 ($p$=0.846). Among those who were able to respond in 2024 (n=27), three quarters (74%) reported availability as 'very easy' (81% in 2023), with a further 22% reporting it as 'easy' to obtain (n≤5 in 2023) (Figure 23).

## Figure 18: Median price of methamphetamine powder per point and gram, Hobart, TAS, 2003-2024



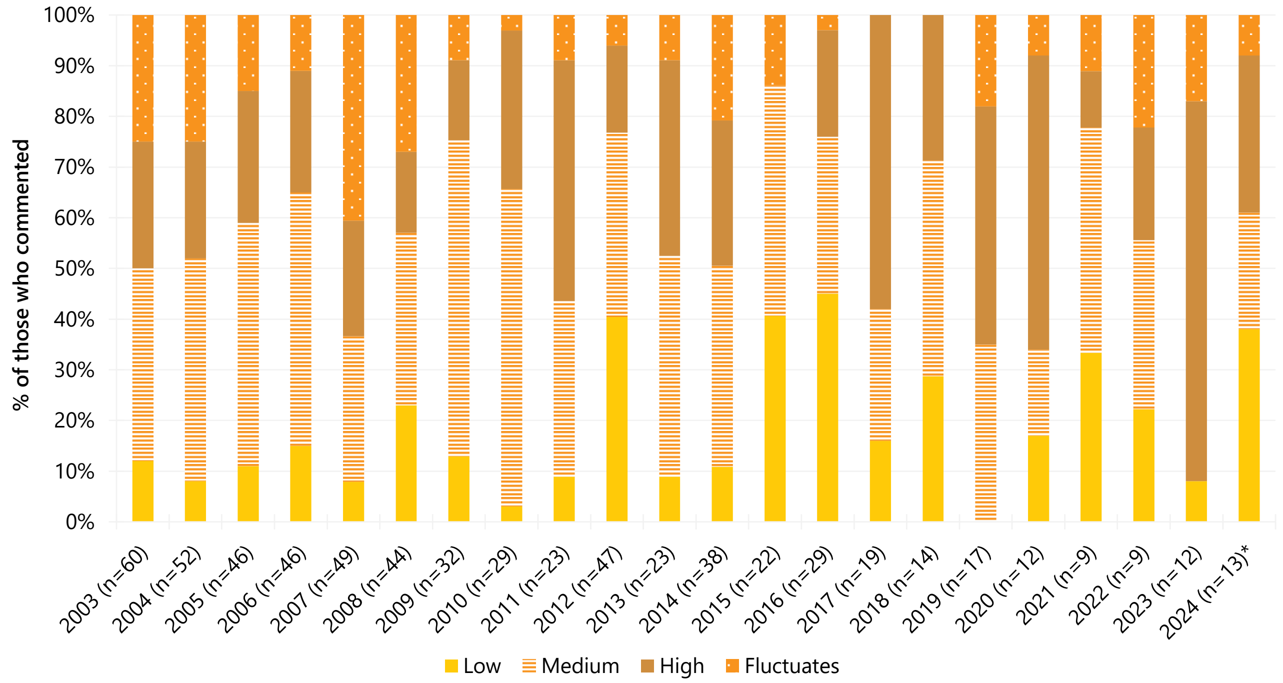

Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). For historical numbers, please refer to the [data tables](). The error bars represent the IQR. Statistical significance for 2023 versus 2024 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Figure 19: Median price of methamphetamine crystal per point and gram, Hobart, TAS, 2003-2024



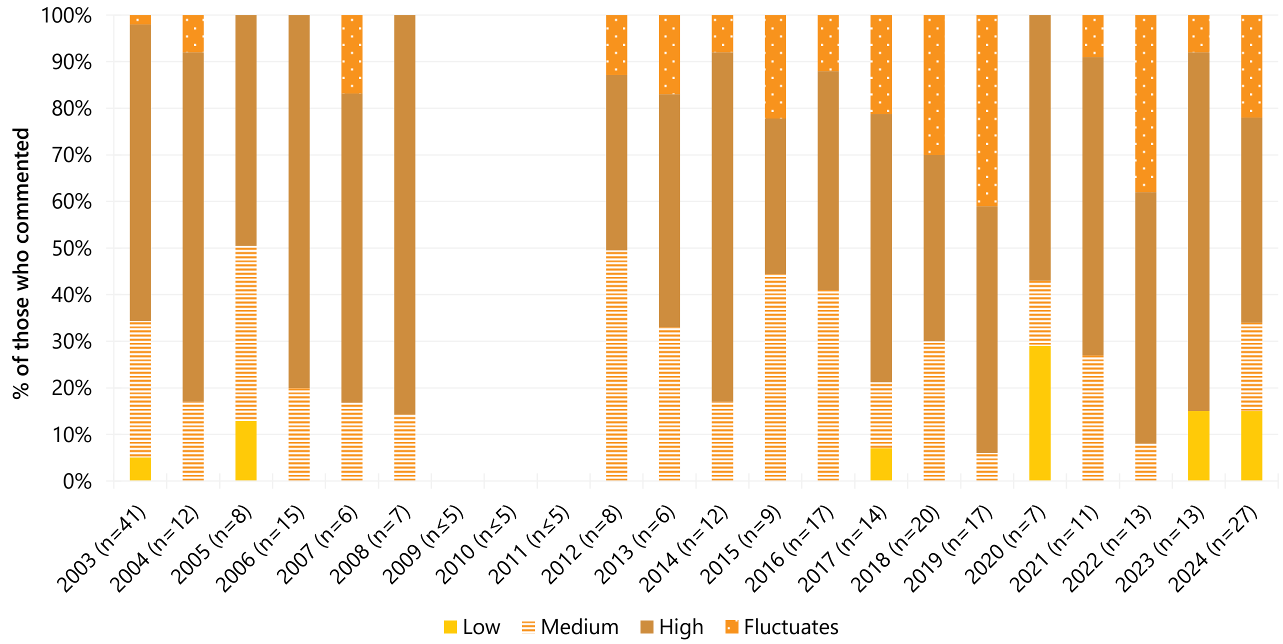

Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). For historical numbers, please refer to the [data tables](). The error bars represent the IQR. Statistical significance for 2023 versus 2024 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 20: Current perceived purity of methamphetamine powder, Hobart, TAS, 2003-2024



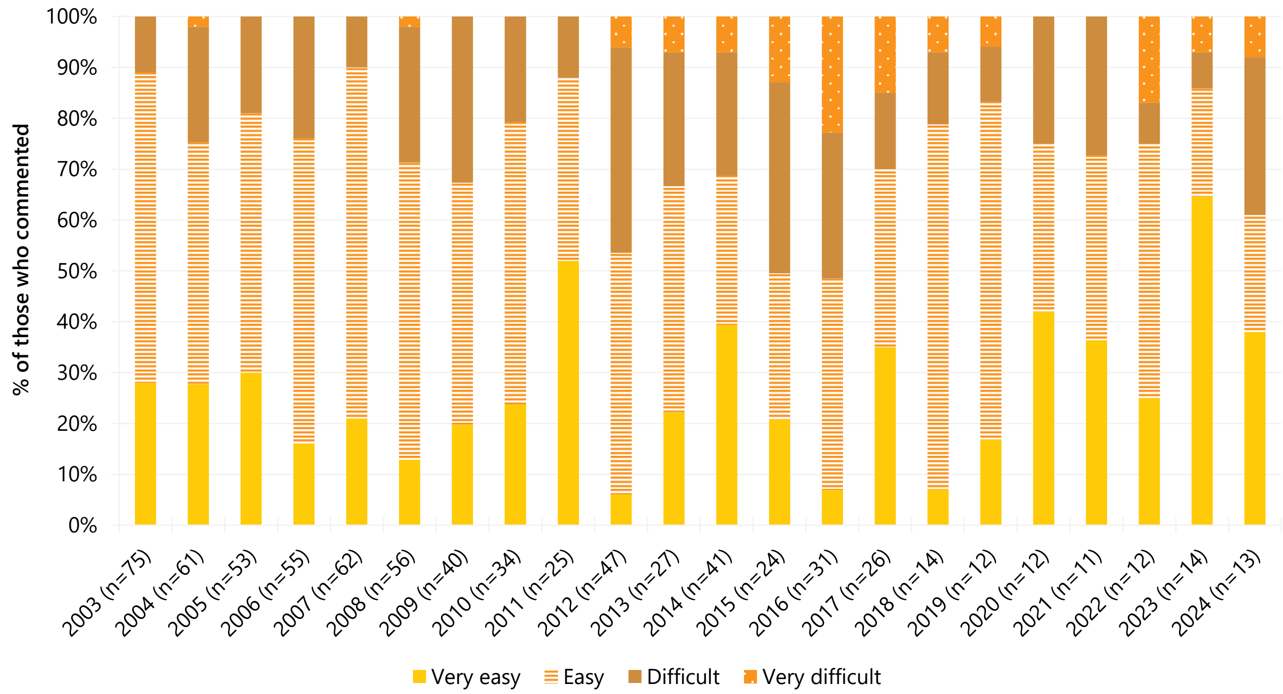

Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 21: Current perceived purity of methamphetamine crystal, Hobart, TAS, 2003-2024



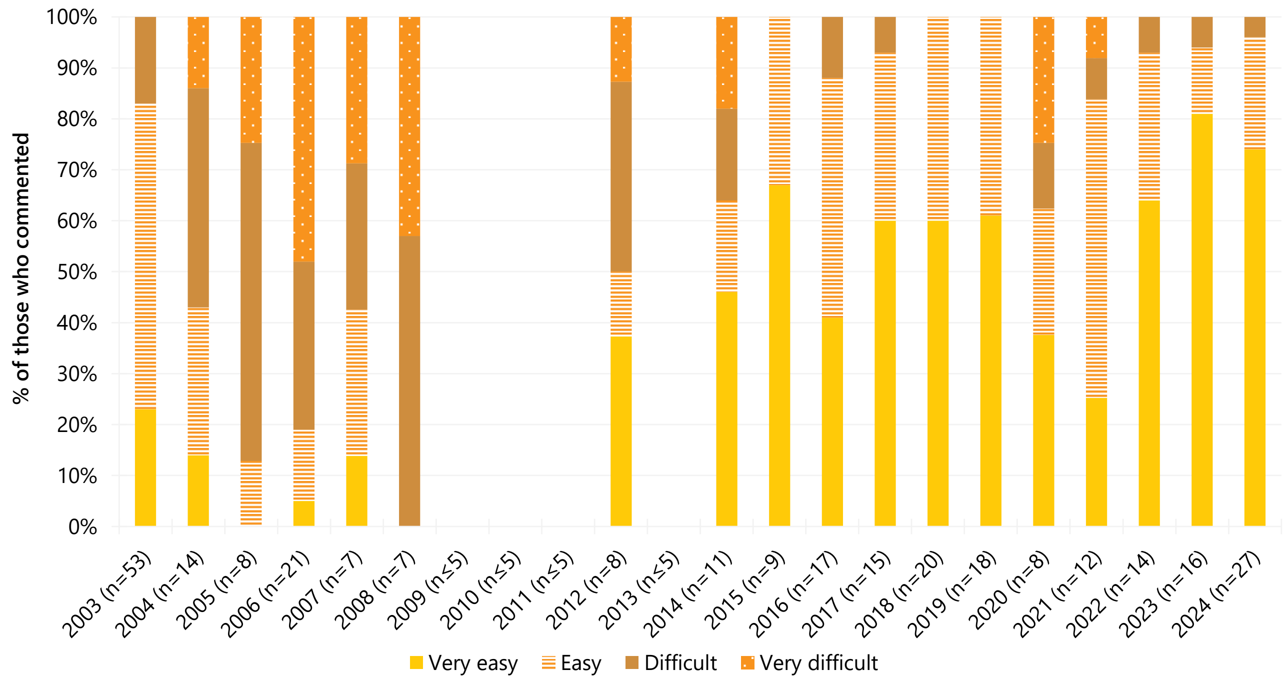

Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 22: Current perceived availability of methamphetamine powder, Hobart, TAS, 2003-2024




Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 23: Current perceived availability of methamphetamine crystal, Hobart, TAS, 2003-2024




Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# 4

# Non-Prescribed Pharmaceutical Stimulants

Participants were asked about their recent (past six month) use of non-prescribed pharmaceutical stimulants, such as dexamfetamine, lisdexamfetamine (Vyvanse®), or methylphenidate (Concerta®, Ritalin®, Ritalin LA®). These substances are commonly prescribed to treat attention-deficit/hyperactivity disorder (ADHD) and narcolepsy.

## Patterns of Consumption

### Recent Use (past 6 months)

The per cent of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has generally increased since the commencement of monitoring, from 19% in 2007 to 36% in 2024 (but has not changed from 2023: 34%) (Figure 24).

### Frequency of Use

Frequency of use remained stable in 2024, at a median of six days in the six months prior to interview (IQR=3-20; n=31; 4 days in 2023; IQR=2-12; n=64; $p$=0.350) (Figure 24).

### Routes of Administration

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=31), the majority reported swallowing as a route of administration (87%; 95% in 2023; $p$=0.389), followed by snorting (32%; n≤5 in 2023; $p$=0.195).

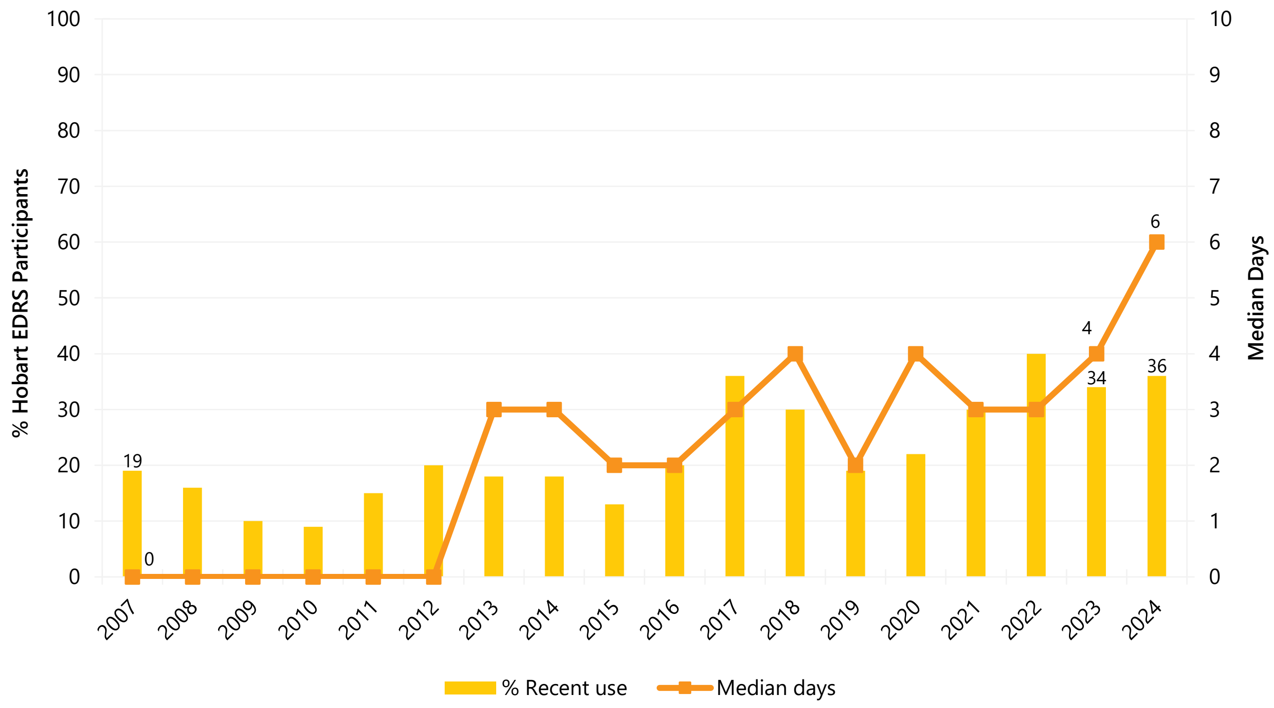
### Forms Used

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=31), the majority reported using dexamfetamine (68%; 57% in 2023; $p$=0.561), and 29% reported using methylphenidate (33% in 2023; $p$=0.770).

### Quantity

Among those who reported recent use and responded (n=26), the median amount used in a 'typical' session was two pills/tablets (IQR=1-4; 2.5 pills/tablets in 2023; IQR=1-3; n=16; $p$=0.729). Of those who reported recent use and responded (n=27), the median maximum amount used in a session was three pills/tablets (IQR=2–6.5; 3 pills/tablets in 2023; IQR=1.8-3; $p$=0.444).

Figure 24: Past six month use and frequency of use of non-prescribed pharmaceutical stimulants, Hobart, TAS, 2007-2024




Note. Monitoring of pharmaceutical stimulants commenced in 2007. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# Price and Perceived Availability

Price and availability data for non-prescribed pharmaceutical stimulants have been collected from 2022 onwards.

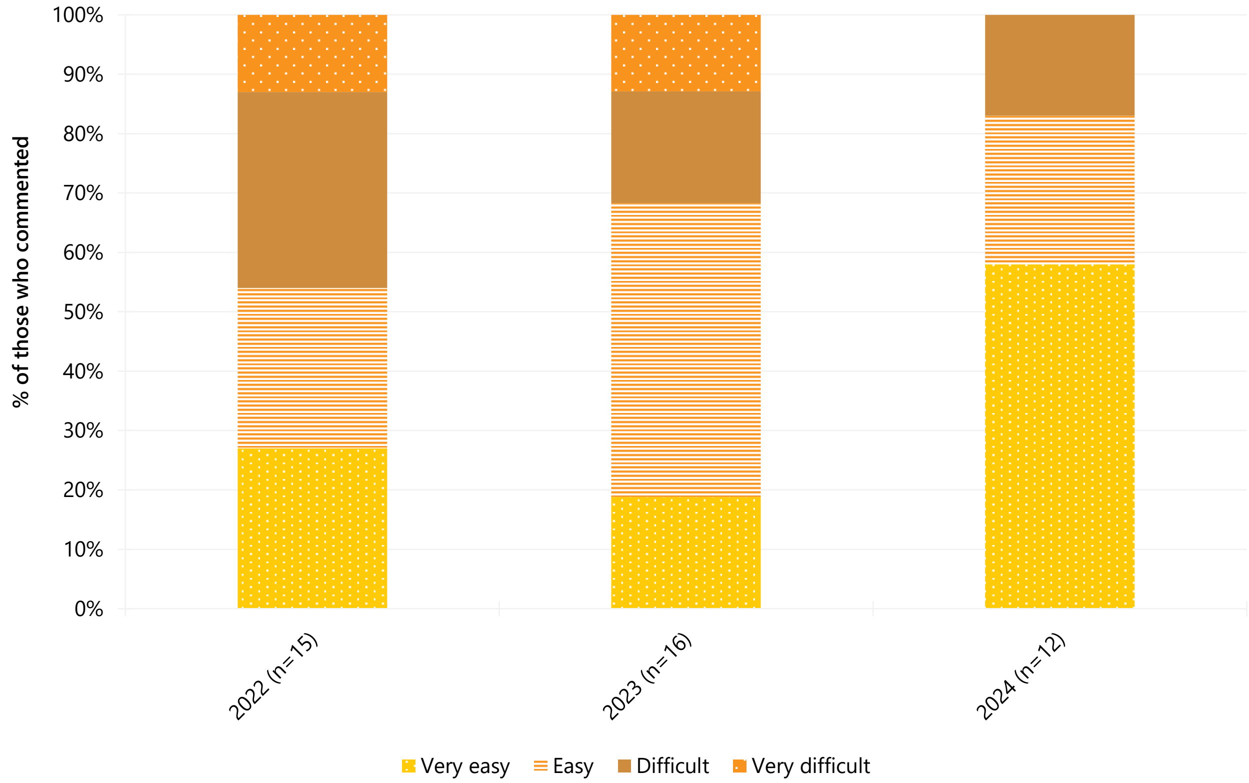
## Price

Due to low numbers reporting (n≤5), further details are not reported on price. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

## Perceived Availability

Among those who responded in 2024 (n=12), the perceived availability of non-prescribed pharmaceutical stimulants remained stable, relative to 2023 ($p$=0.131). Three fifths (58%) perceived non-prescribed pharmaceutical stimulants to be 'very easy' to obtain (n≤5 in 2023) (Figure 25).

**Figure 25: Current perceived availability of non-prescribed pharmaceutical stimulants, Hobart, TAS, 2022-2024**




Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# 5

# Cocaine

Participants were asked about their recent (past six month) use of various forms of cocaine, including powder and crack/rock cocaine. Cocaine hydrochloride, a salt derived from the coca plant, is the most common form of cocaine available in Australia. 'Crack' cocaine is a form of freebase cocaine (hydrochloride removed), which is particularly pure. 'Crack' is most prevalent in North America and infrequently encountered in Australia.

## Patterns of Consumption

### Recent Use (past 6 months)

Since 2013, the per cent reporting any recent cocaine use has substantially increased. In 2024, 77% of the Hobart sample reported recent use, stable relative to 75% in 2023 ($p$=0.846) (Figure 26).

### Frequency of Use

Frequency of use has remained stable in recent years. Of those who had recently consumed cocaine and commented (n=67), participants reported a median of four days (IQR=2-10) of use in 2024, stable from five days in 2023 (IQR=3-10; n=49; $p$=0.399) (Figure 26). Few participants (n≤5) who had recently used cocaine reported weekly or more frequent use in 2023 and 2024.

### Routes of Administration

Among participants who had recently consumed cocaine and commented (n=67), 97% of participants reported snorting cocaine, stable relative to 96% in 2023. Sixteen per cent of participants reported swallowing cocaine in 2024 (n≤5 in 2023; $p$=0.420).

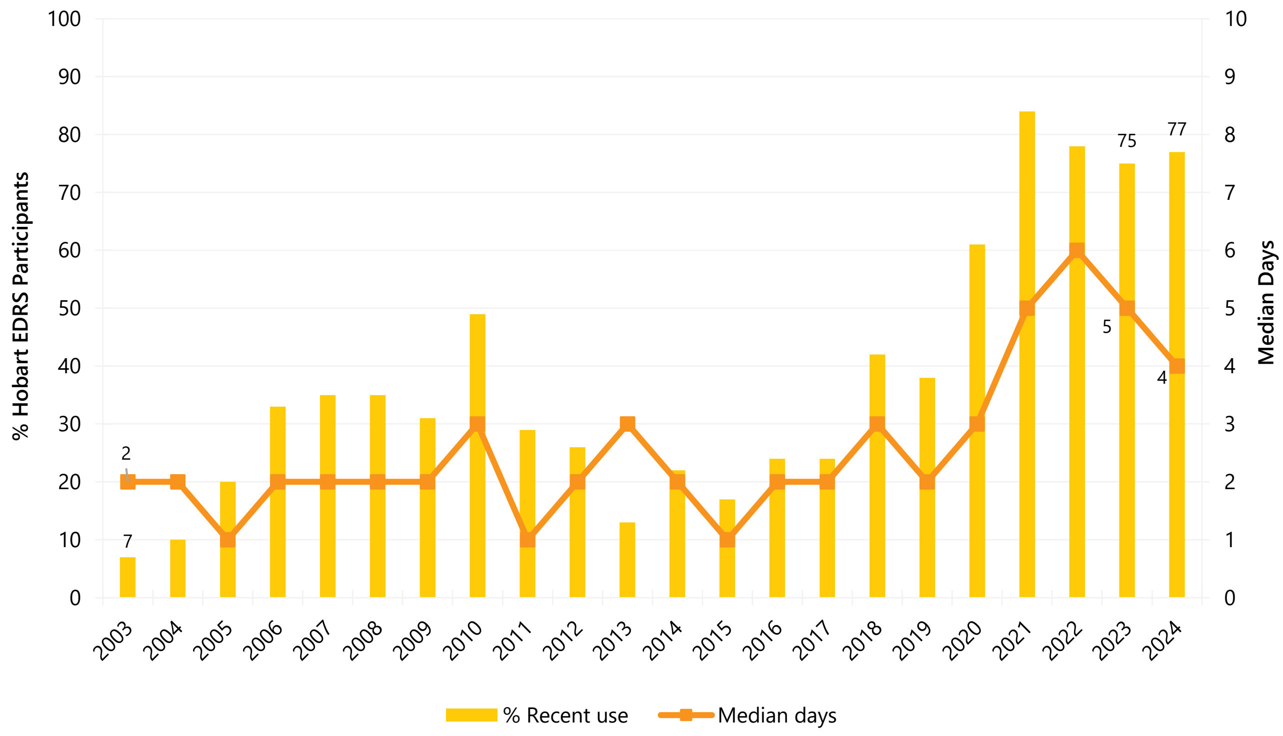
### Quantity

Of those who reported recent use and responded (n=41), the median amount of cocaine used in a 'typical' session was 0.50 grams (IQR=0.25-1.00; 0.55 grams in 2023; IQR=0.48-1.00; n=32; $p$=0.632). Of those who reported recent use and responded (n=38), the median maximum amount of cocaine used in a session was one gram (IQR=0.29-1.20; 1.00 gram in 2023; IQR=0.50-1.50; n=34; $p$=0.623).

### Forms Used

Among participants who had recently consumed cocaine and commented (n=66), the vast majority reported using powder cocaine (97%; 96% in 2023). From 2021-2023, participants were asked about crack cocaine versus rock cocaine. In 2024, these forms were combined to form crack/rock cocaine. Few participants (n≤5) in the Hobart sample reported recent use of crack/rock cocaine (n≤5 in 2023; $p$=0.399).

Figure 26: Past six month use and frequency of use of cocaine, Hobart, TAS, 2003-2024




Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends for days of use. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# Price, Perceived Purity and Perceived Availability

## Price

The median price per gram of cocaine was $350 in 2024 (IQR=300-350; n=33), stable relative to 2023 ($350; IQR=300-350; n=27; $p$=0.913) (Figure 27).

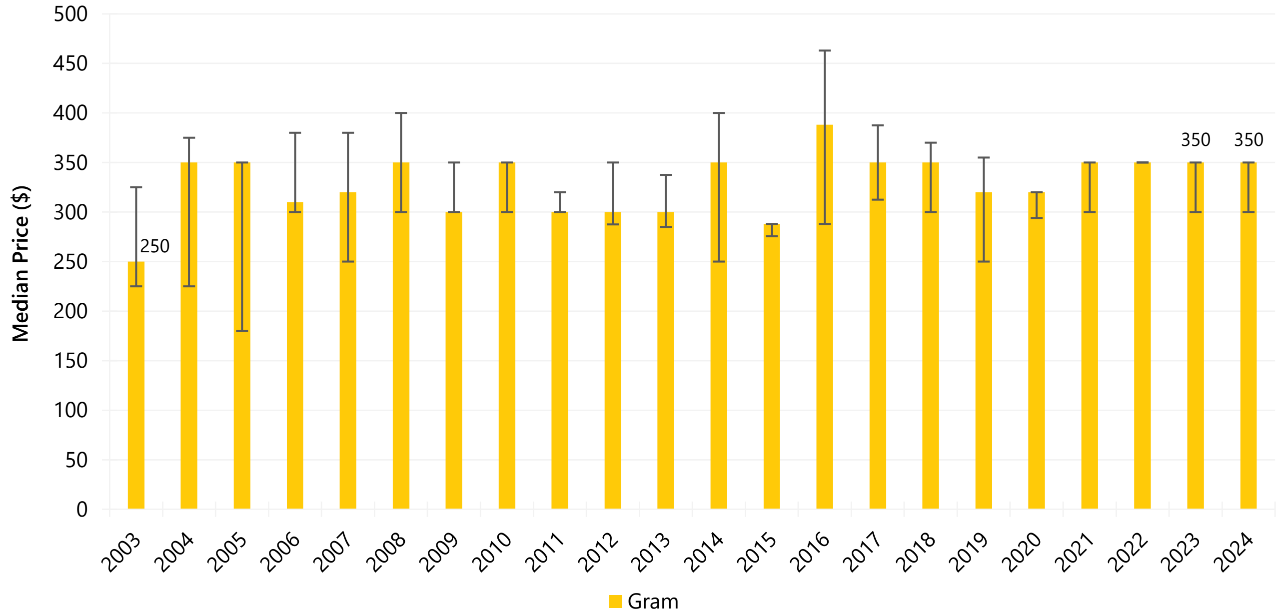
## Perceived Purity

The perceived purity of cocaine remained stable between 2023 and 2024 ($p$=0.574). Among those who were able to respond in 2024 (n=44), one third reported purity to be 'medium' (34%; 32% in 2023) and 'high' (30%; 18% in 2023). One quarter (23%) perceived purity to be 'low' (29% in 2023) and a further 14% perceived purity to be 'fluctuating' (21% in 2023) (Figure 28).

## Perceived Availability

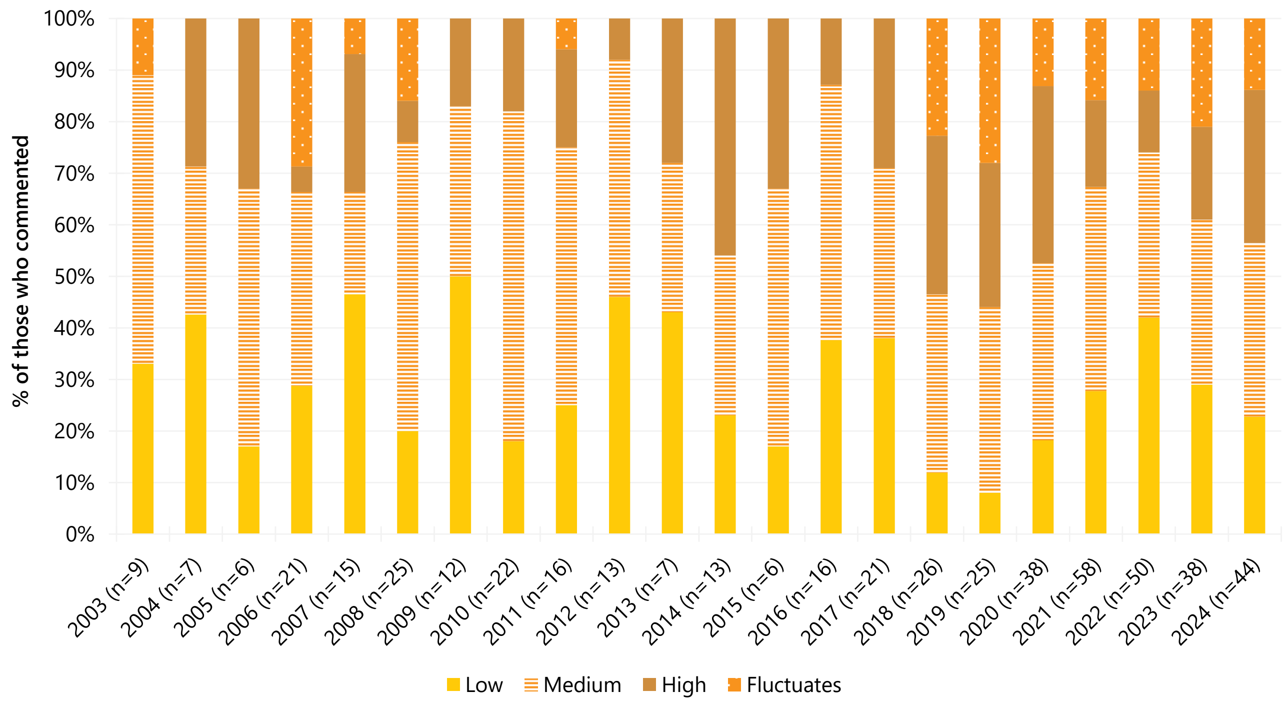
The perceived availability of cocaine remained stable between 2023 and 2024 ($p$=0.523). Among those who were able to respond in 2024 (n=45), 42% reported cocaine to be 'easy' to obtain (39% in 2023). A further 31% reported cocaine to be 'very easy' to obtain (29% in 2023). Almost one fifth (18%) perceived cocaine to be 'difficult' to obtain in 2024 (29% in 2023) (Figure 29).

## Figure 27: Median price of cocaine per gram, Hobart, TAS, 2003-2024



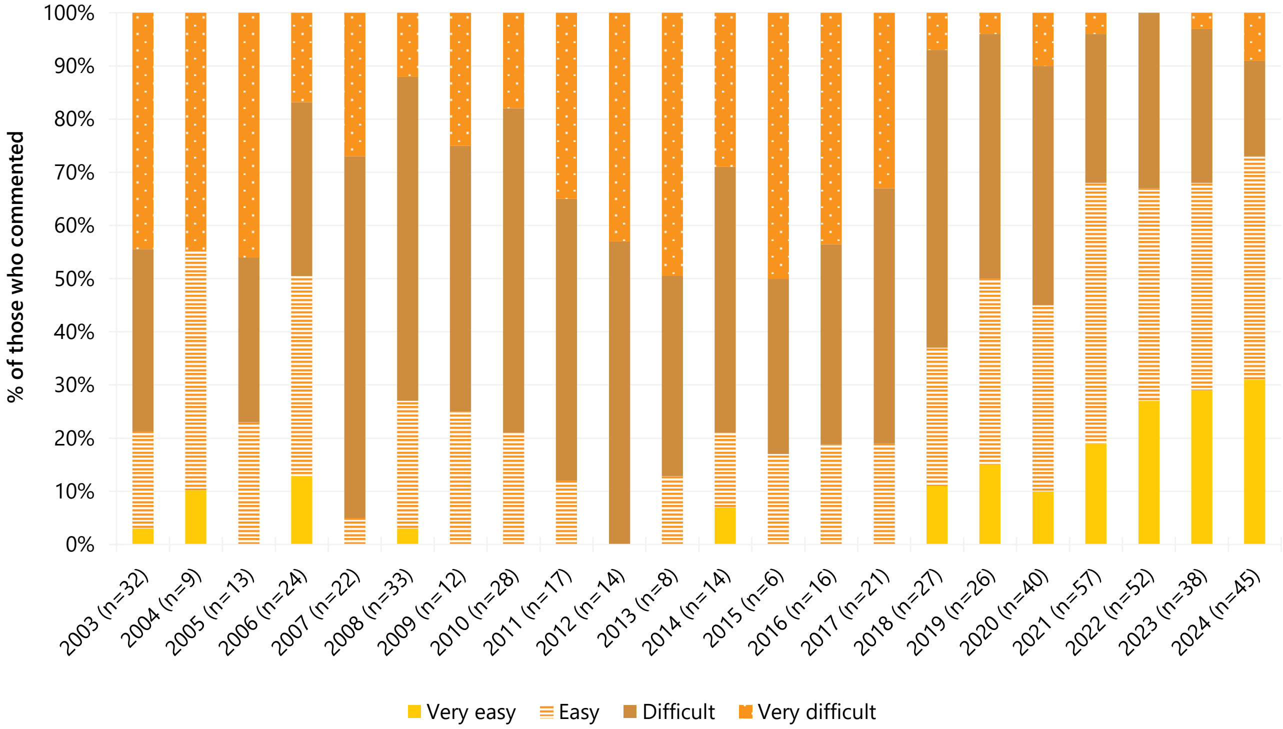

Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). For historical numbers, please refer to the [data tables](). The error bars represent the IQR. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Figure 28: Current perceived purity of cocaine, Hobart, TAS, 2003-2024




Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables]() for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

**Figure 29: Current perceived availability of cocaine, Hobart, TAS, 2003-2024**




Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

# 6

## Cannabis and/or Cannabinoid-Related Products

Participants were asked about their recent (past six month) use of various forms of cannabis, including indoor-cultivated cannabis via a hydroponic system ('hydroponic'), outdoor-cultivated cannabis ('bush'), hashish, hash oil, commercially prepared edibles and CBD and THC extract.

Terminology throughout this chapter refers to:

• **Prescribed use:** use of cannabis and/or cannabinoid-related products obtained by a prescription in the person's name;
• **Non-prescribed use:** use of cannabis and/or cannabinoid-related products which the person did not have a prescription for (i.e., illegally sourced or obtained from a prescription in someone else's name); and
• **Any use:** use of cannabis and/or cannabinoid-related products obtained through either of the above means.

## Patterns of Consumption

Participants were asked about their use of both prescribed and non-prescribed cannabis and/or cannabinoid-related products. Seventeen per cent of the Hobart sample reported prescribed use in the six months preceding interview, a significant increase relative to 2023 (n≤5; $p$=0.022).

In the remainder of this chapter, data from 2021-2024, and from 2003-2016, refers to non-prescribed cannabis use only, while data from 2017-2020 refers to 'any' cannabis use (including hydroponic and bush cannabis, hashish and hash oil). While comparison between 2021-2024 and previous years should be treated with caution, the relatively recent legalisation of medicinal cannabis in Australia and the small percentage reporting prescribed use between 2022 and 2024 lends confidence that estimates are relatively comparable.

### Recent Use (past 6 months)

At least three in five participants in the Hobart sample have reported recent use of non-prescribed cannabis and/or cannabinoid-related products each year since 2003, with the only exception being 2011 (50%). Sixty-nine per cent of the Hobart sample reported recent use of non-prescribed cannabis and/or cannabinoid-related products in 2024, stable relative to 2023 (78%; $p$=0.266) (Figure 30).

### Frequency of Use

Median frequency of use has varied between at least once per week to up to four days per week over the course of monitoring. Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented (n=60), participants reported a median of 67 days

(IQR=10-180) of use in 2024, a significant increase from 25 days in 2023 (IQR=4-90; n=50; $p$=0.017) (Figure 30). Two thirds (68%) of those who had recently used non-prescribed cannabis and/or cannabinoid-related products reported weekly or more frequent use (52% in 2023; $p$=0.117). One third (32%) reported daily use, a significant increase from 14% in 2023 ($p$=0.044).

## Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented (n=60), the majority (90%) reported smoking as the route of administration, stable relative to 2023 (92%; $p$=0.753). Twenty-eight per cent reported swallowing (42% in 2023; $p$=0.169) and one fifth (20%) reported inhaling/vaporising (12% in 2023; $p$=0.303).

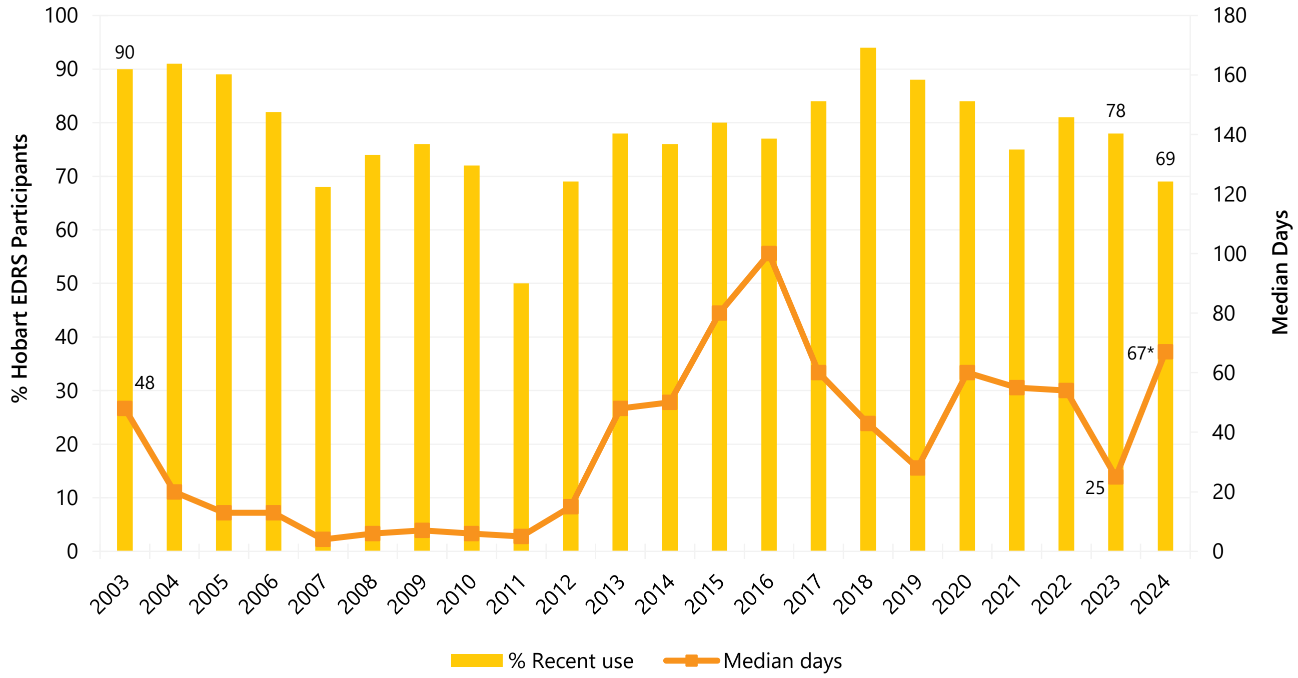
## Quantity

Of those who reported recent non-prescribed use and responded, the median amount of cannabis and/or cannabinoid-related products used on the last occasion of use was 1.35 grams (IQR=1.00-3.00; n=26; 2.00 grams in 2023; IQR=1.00-2.00; n=13; $p$=0.988) or two cones (IQR=1-4; n=17; 3 cones in 2023; IQR=2-15; n=9; $p$=0.204) or one and a half joints (IQR=0.5-2; n=12; 1 joint in 2023; IQR=1-2; n=17; $p$=0.509).

## Forms Used

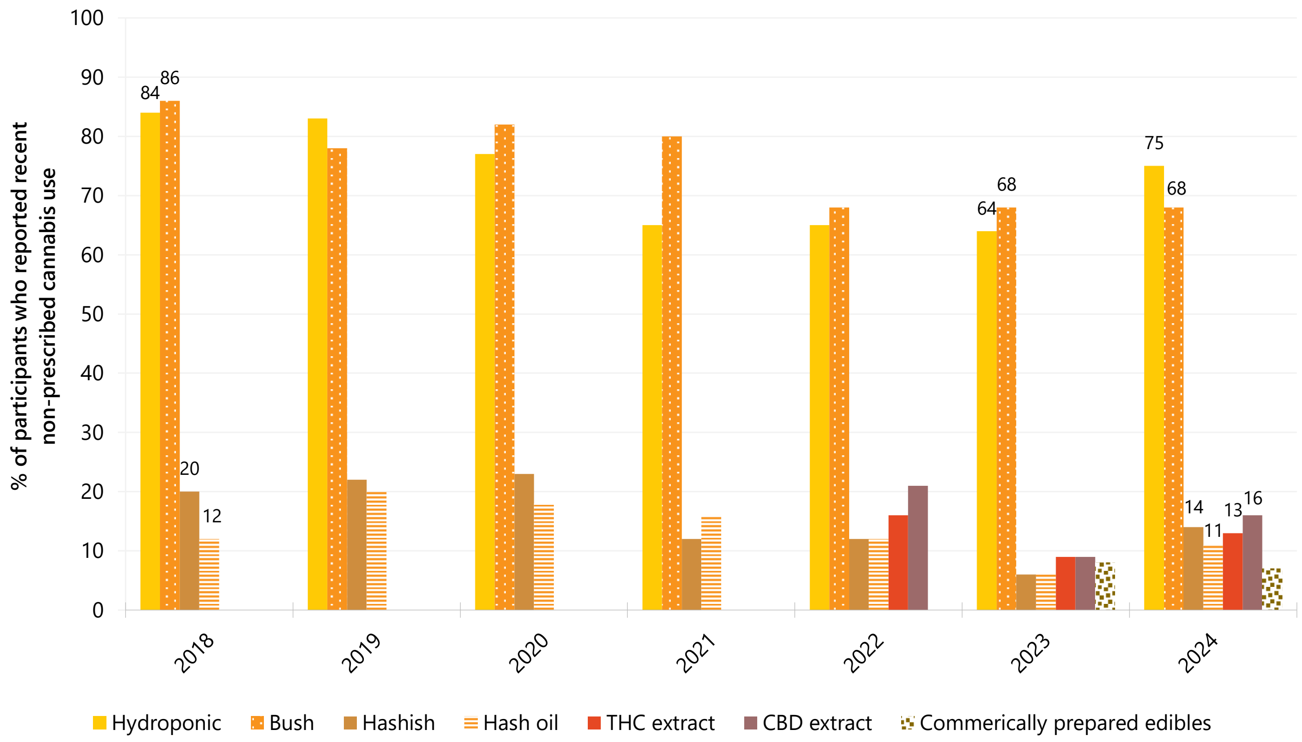
Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and responded (n=56), three quarters (75%) reported recent use of hydroponic cannabis, stable relative to 2023 (64%; $p$=0.286). Two thirds (68%) reported recent use of outdoor grown 'bush' cannabis in both 2023 and 2024. Fewer participants reported having used hashish (14%; n≤5 in 2023; $p$=0.221) and hash oil (11%; n≤5 in 2023; $p$=0.504) in the preceding six months. Sixteen per cent of participants reported recent use of CBD extract (n≤5 in 2023; $p$=0.373) and 13% reported recent use of THC extract (n≤5 in 2023; $p$=0.750). Few participants (n≤5) reported recent use of commercially prepared edibles (n≤5 in 2023) (Figure 31).

**Figure 30: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid-related products, Hobart, TAS, 2003-2024**




Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low (in 2022, no participants reported use of prescribed cannabis). Further, from 2022 onwards, we captured use of 'cannabis and/or cannabinoid-related products', while in previous years questions referred only to 'cannabis'. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 31: Past six month use of different forms of non-prescribed cannabis and/or cannabinoid-related products, among those who reported recent non-prescribed use, Hobart, TAS, 2018-2024




Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2018-2020 figures include some participants who were using prescribed forms of cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# Price, Perceived Potency and Perceived Availability

## Hydroponic Cannabis

**Price:** The median price per gram of non-prescribed hydroponic cannabis was $20 (IQR=16-25; n=16), stable relative to 2023 ($20; IQR=20-20; n=6; *p*=0.843). The median price per ounce of hydroponic cannabis has fluctuated between $250 and $300 since 2006. The median price per ounce of hydroponic cannabis in 2024 was $300 (IQR=300-350; n=11), stable relative to $250 in 2023 (n≤5 in 2023; *p*=0.075) (Figure 32A).

**Perceived Potency:** The perceived potency of non-prescribed hydroponic cannabis remained stable between 2023 and 2024 (*p*=0.299). Among those who were able to respond in 2024 (n=44), three fifths (59%) perceived hydroponic cannabis to be of 'high' potency (52% in 2023). Sixteen per cent perceived potency to be 'medium' (24% in 2023), and 14% perceived potency to be 'fluctuating' (24% in 2023). Few participants (n≤5) perceived potency to be 'low' (0% in 2023) (Figure 33A).

**Perceived Availability:** The perceived availability of non-prescribed hydroponic cannabis remained stable between 2023 and 2024 (*p*=0.841). Among those who were able to respond in 2024 (n=45), almost two thirds (64%) perceived non-prescribed hydroponic cannabis to be 'very easy' to obtain (71% in 2023), and a further one third (33%) reported that it was 'easy' to obtain (29% in 2023) (Figure 34A).

## Bush Cannabis

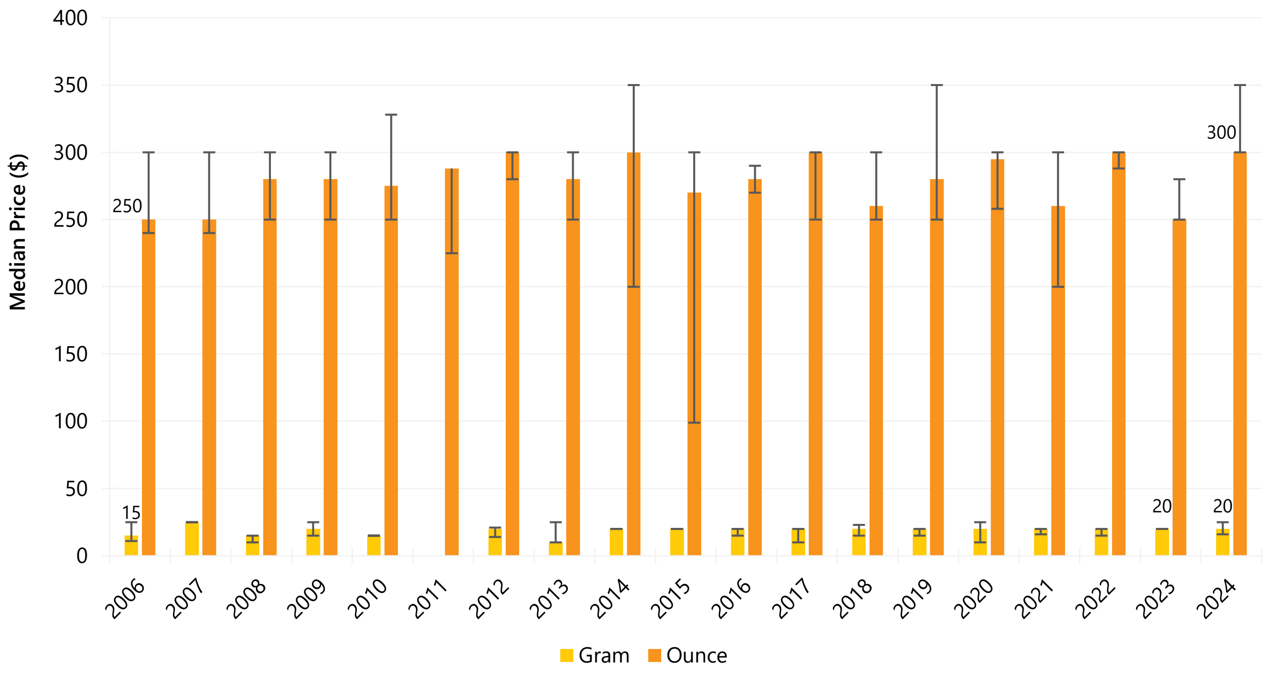
**Price:** The median price per ounce of non-prescribed bush cannabis remained stable at $225 (IQR=200-280; n=13) in 2024 (n≤5 in 2023; *p*=0.667) in 2023. Few participants (n≤5) reported on the median price per gram of non-prescribed bush cannabis in 2023 and 2024; therefore, further details are not reported (Figure 32B).

**Perceived Potency:** The perceived potency of non-prescribed bush cannabis remained stable between 2023 and 2024 (*p*=0.866). Among those who were able to respond in 2024 (n=28), 54% perceived the potency of non-prescribed bush cannabis to be 'medium' (42% in 2023). Few participants (n≤5) reported non-prescribed bush cannabis to be 'high' (n≤5 in 2023), 'low' (23% in 2023) and 'fluctuating' (n≤5 in 2023) (Figure 33B).

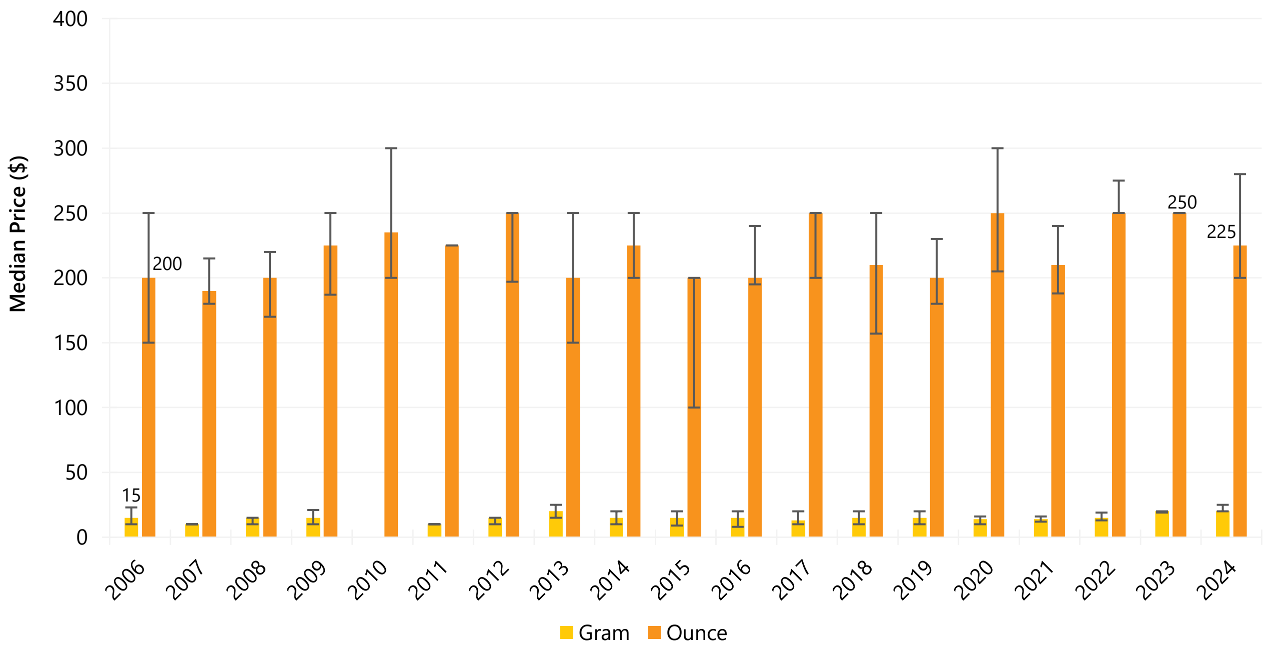
**Perceived Availability:** The perceived availability of non-prescribed bush cannabis remained relatively stable between 2023 and 2024 (*p*=0.098). Among those who were able to respond in 2024 (n=29), almost half (48%) perceived non-prescribed bush cannabis to be 'easy' to obtain (31% in 2023), with a further 45% perceiving it to be 'very easy' to obtain (69% in 2023) (Figure 34B).

**Figure 32: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Hobart, TAS, 2006-2024**

## (A) Hydroponic cannabis



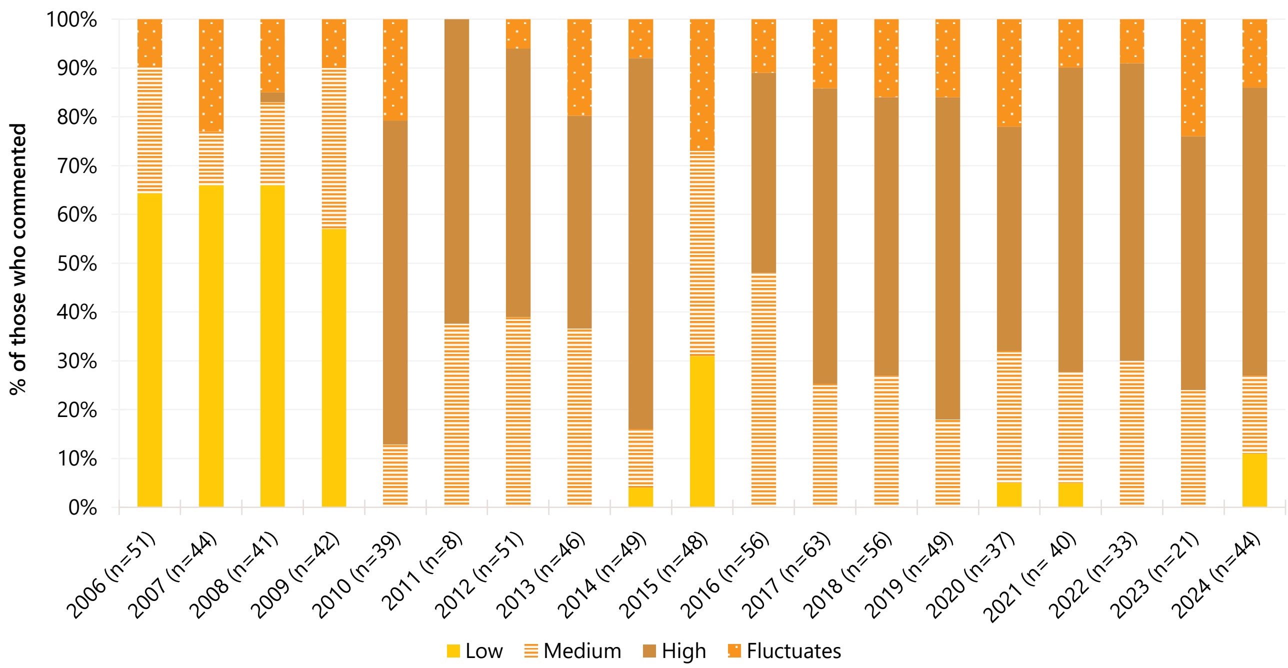

## (B) Bush cannabis



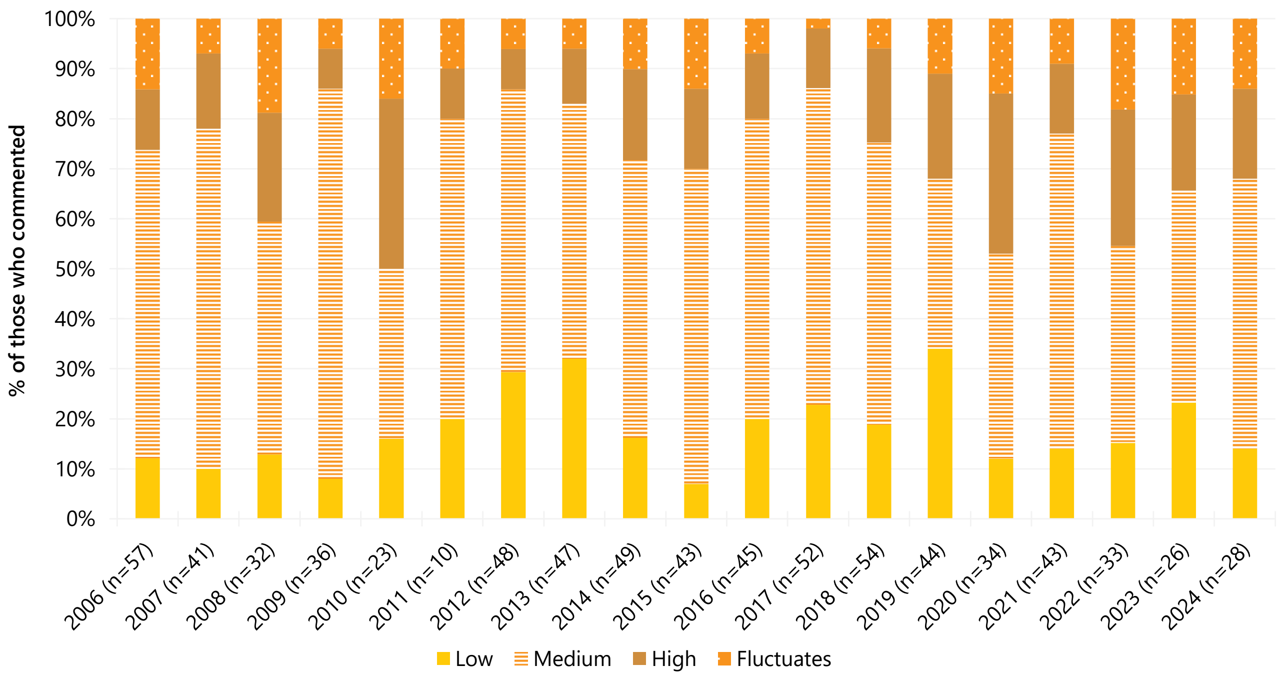

Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the price of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). For historical numbers, please refer to the data tables. The error bars represent the IQR. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

**Figure 33: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Hobart, TAS, 2006-2024**

(A) Hydroponic cannabis



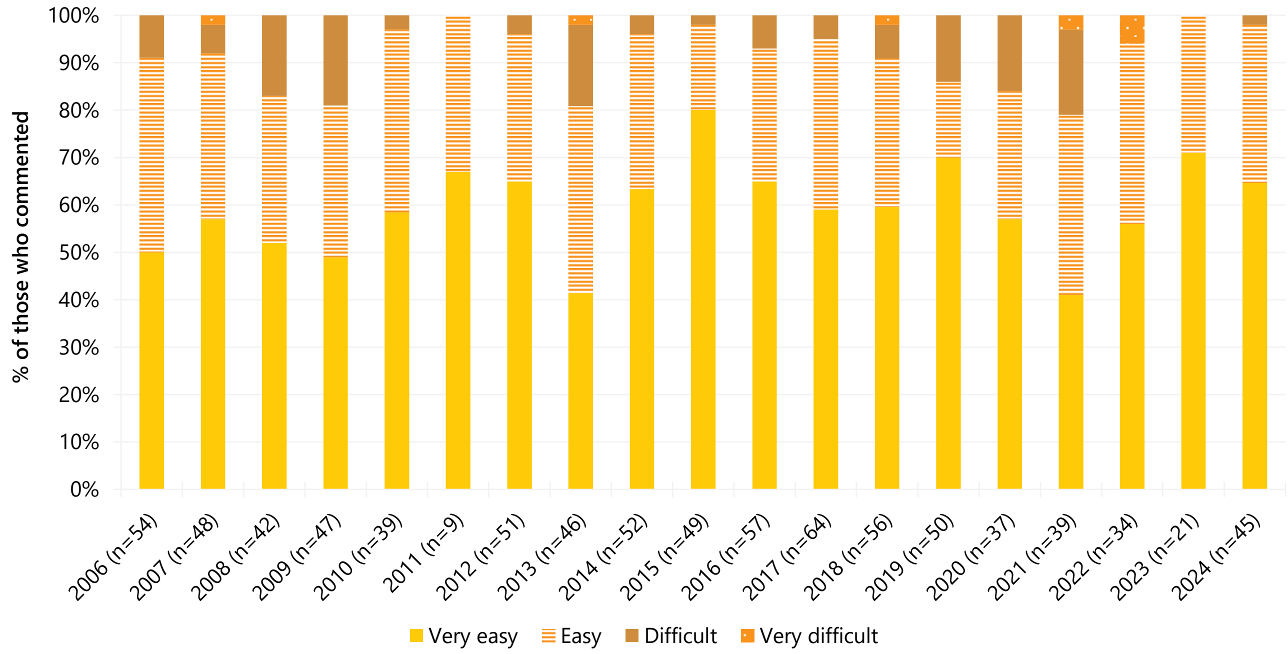

(B) Bush cannabis



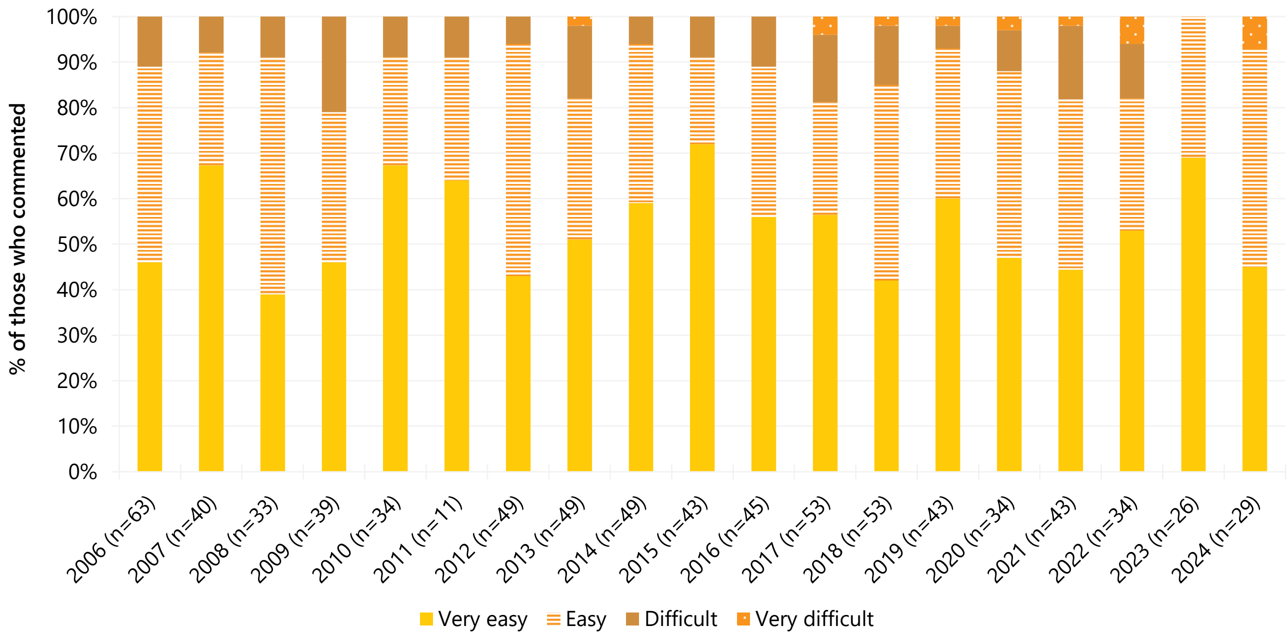

Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the perceived potency of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

**Figure 34: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Hobart, TAS, 2006-2024**

## (A) Hydroponic cannabis




## (B) Bush cannabis




Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the perceived availability of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# 7

# Ketamine, LSD and DMT

## Non-Prescribed Ketamine

### Patterns of Consumption

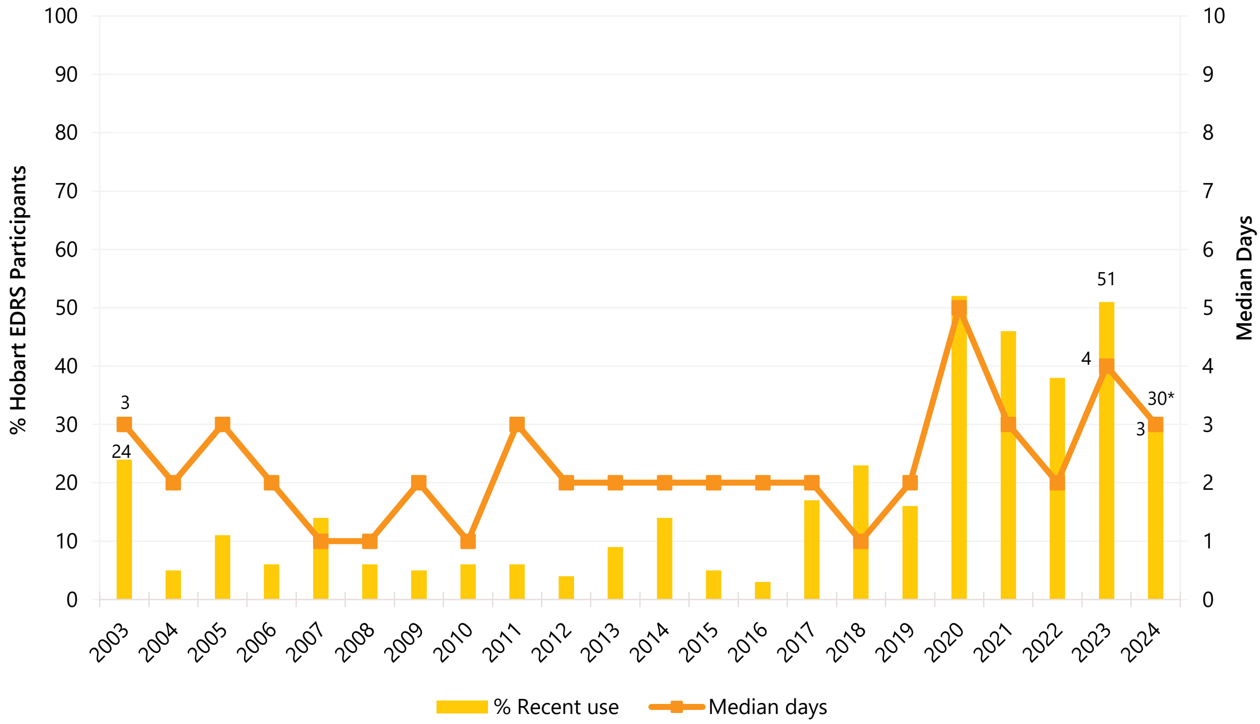
**Recent Use (past 6 months):** Almost one third (30%) of the Hobart sample reported using non-prescribed ketamine in the six months prior to interview, a significant decrease from 51% in 2023 (*p*=0.013) (Figure 35).

**Frequency of Use:** Of those who had recently consumed non-prescribed ketamine and commented (n=26), median days of use remained low and stable in 2024 (3 days; IQR=2-7), relative to 2023 (4 days; IQR=1-6; n=33; *p*=0.728) (Figure 35). Few participants (n≤5) reported weekly or more frequent use in 2023 and 2024 (*p*=0.159); therefore, further details are not reported.

**Routes of Administration:** Among participants who had recently consumed non-prescribed ketamine and commented (n=26), the majority of participants (92%) reported snorting in 2024, stable from 2023 (82%; *p*=0.446).

**Quantity:** Of those who reported recent use and responded (n=18), the median amount of non-prescribed ketamine used in a 'typical' session was 0.40 grams (IQR=0.13-0.88; 0.28 grams in 2023; IQR=0.11-0.50; n=22; *p*=0.361). Of those who reported recent use and responded (n=18), the median maximum amount of non-prescribed ketamine used in a session was 0.50 grams (IQR=0.21-1.75; 0.50 grams in 2023; IQR=0.16-1.00; n=22; *p*=0.398).

Figure 35: Past six month use and frequency of use of non-prescribed ketamine, Hobart, TAS, 2003-2024




Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

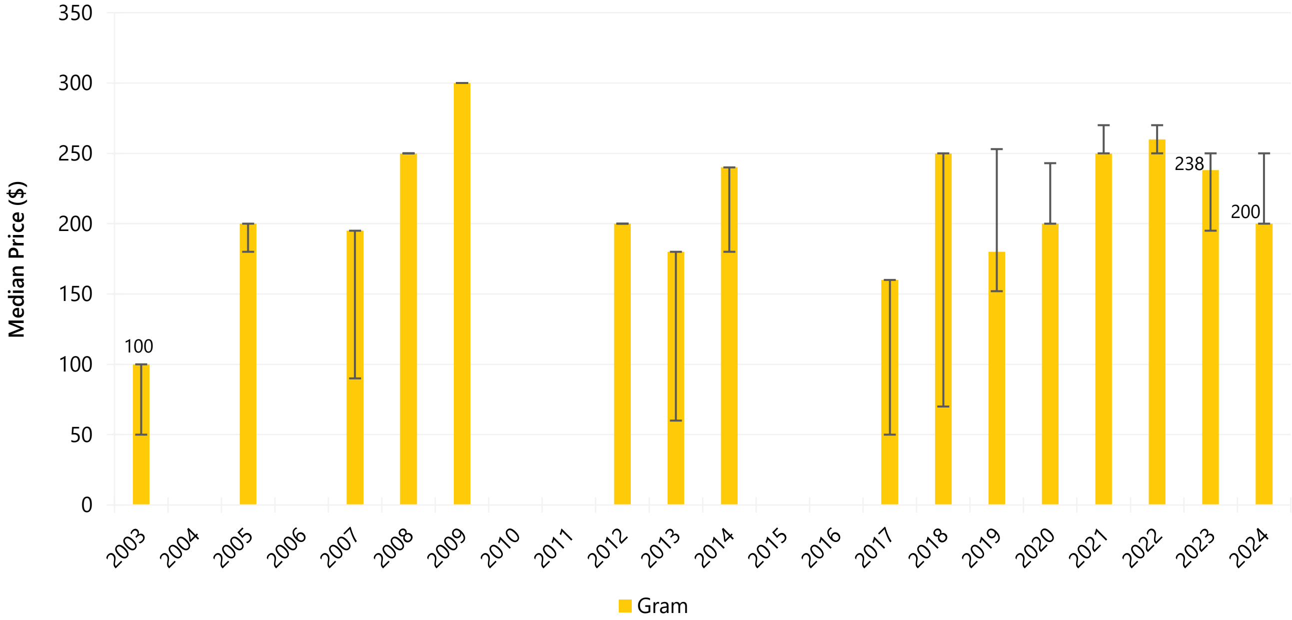
## Price, Perceived Purity and Perceived Availability

**Price:** The median reported price of non-prescribed ketamine has fluctuated somewhat since the commencement of monitoring. The median price per gram of ketamine in 2024 was $200 (IQR=200-250; n=8; $238 in 2023; IQR=195-250; n=12; $p$=0.751) (Figure 36).

**Perceived Purity:** The perceived purity of non-prescribed ketamine remained stable between 2023 and 2024 ($p$=0.201). Among those who were able to respond in 2024 (n=15), two thirds (40%) perceived the purity of ketamine to be 'high' (65% in 2023) and 'fluctuating' (40%; n≤5 in 2023) (Figure 37).

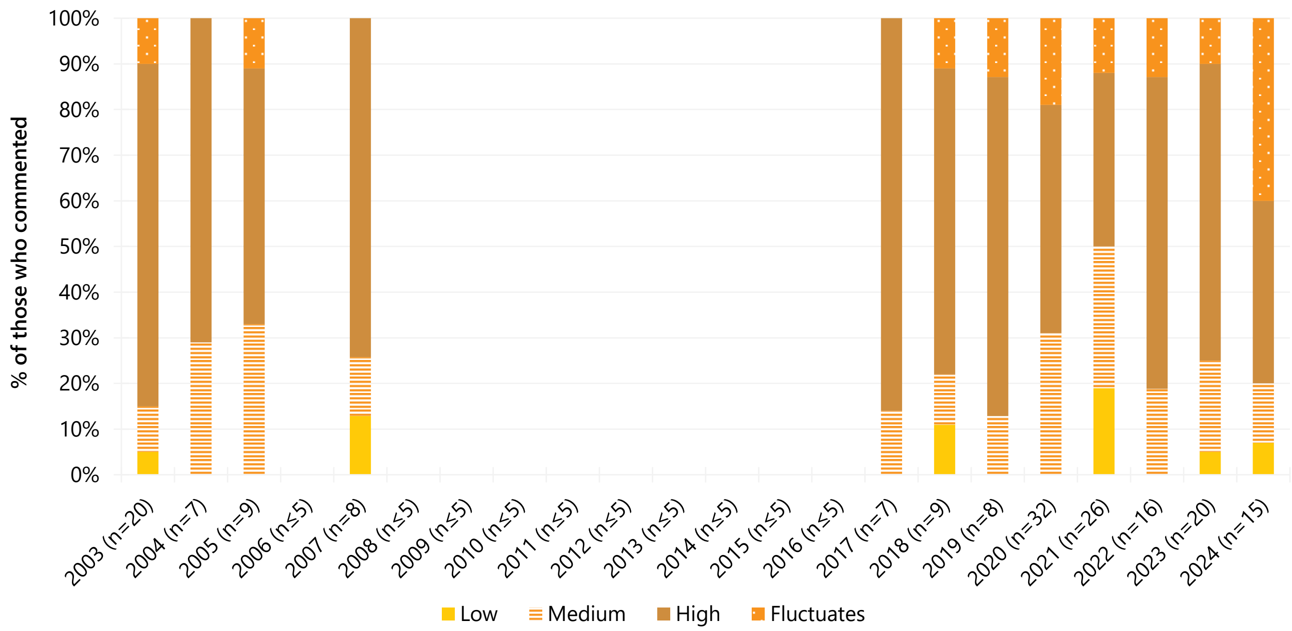
**Perceived Availability:** The perceived availability of non-prescribed ketamine remained stable between 2023 and 2024 ($p$=0.310). Of those who were able to respond in 2024 (n=15), two fifths (40%) perceived non-prescribed ketamine to be 'very easy' to obtain (n≤5 in 2023). Few participants (n≤5) perceived it to be 'easy' (45% in 2023) and 'difficult' (35% in 2023) to obtain in 2024 (Figure 38).

## Figure 36: Median price of non-prescribed ketamine per gram, Hobart, TAS, 2003-2024



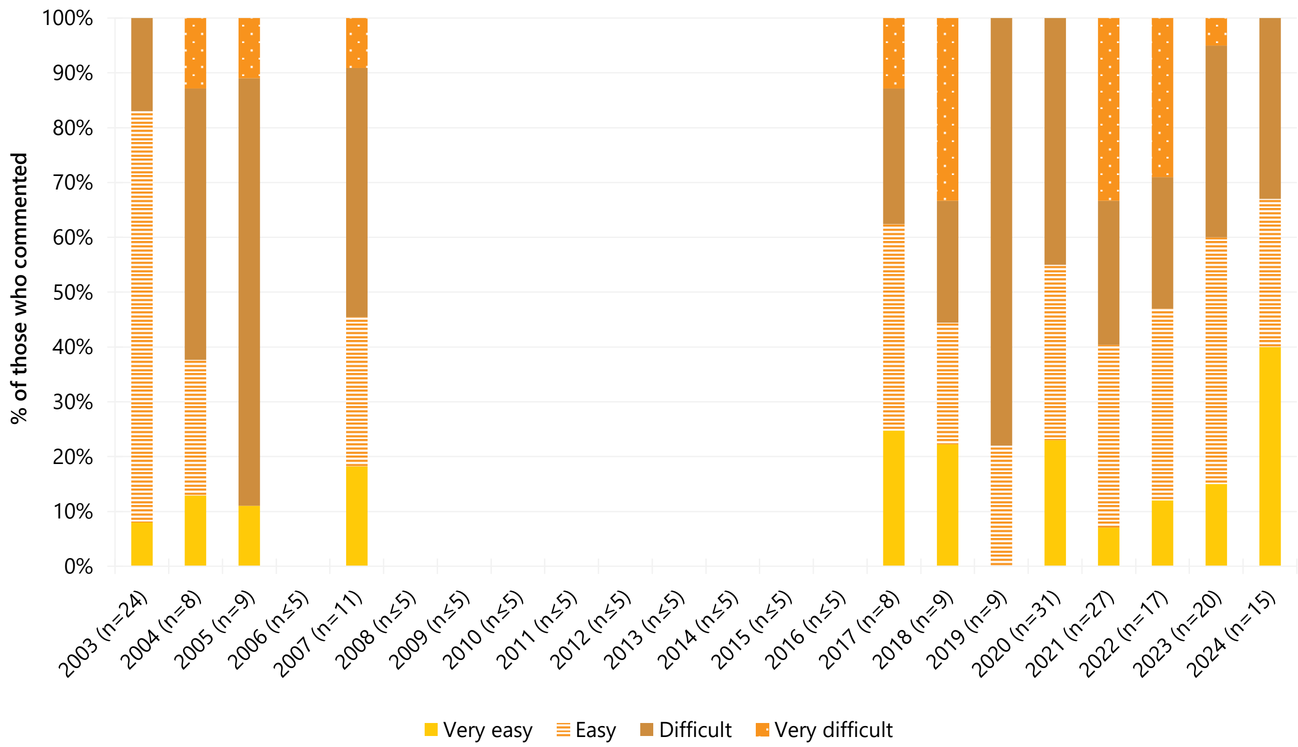

Note. Among those who commented. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). For historical numbers, please refer to the data tables. The error bars represent the IQR. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Figure 37: Current perceived purity of non-precribed ketamine, Hobart, TAS, 2003-2024




Note. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 38: Current perceived availability of non-prescribed ketamine, Hobart, TAS, 2003-2024




Note. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

# LSD

## Patterns of Consumption

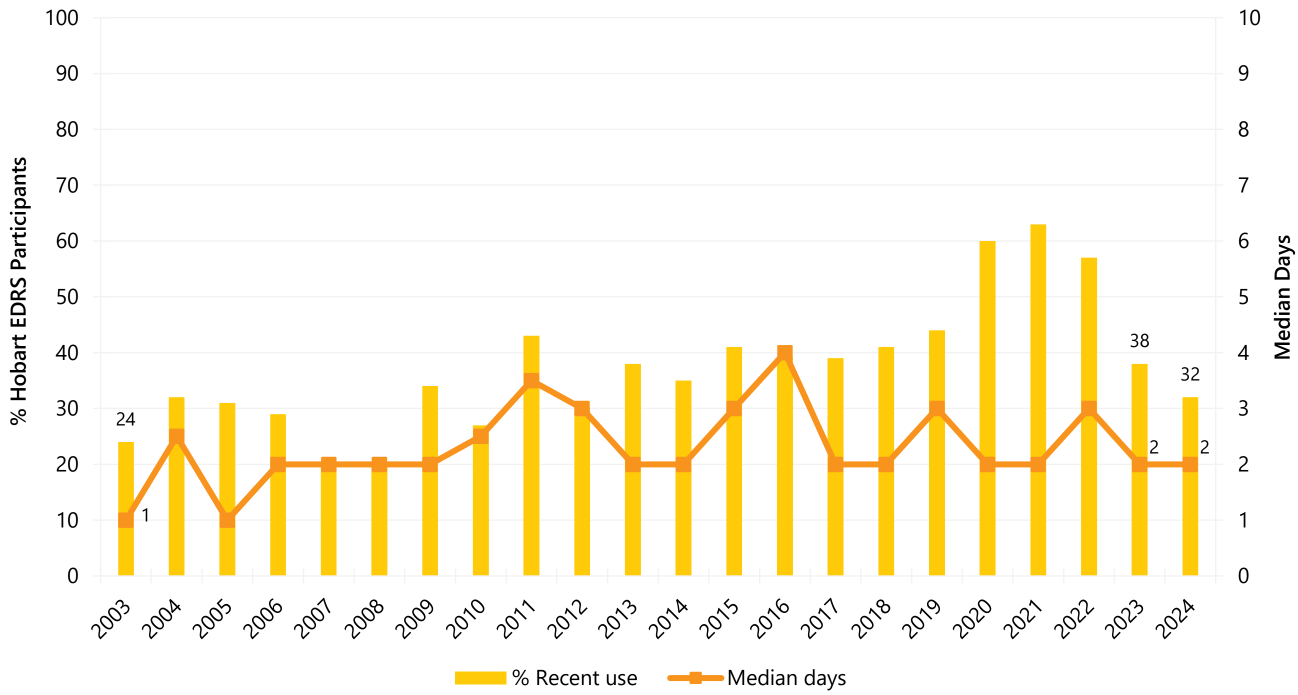
**Recent Use (past 6 months):** One third (32%) of the Hobart sample had used LSD in the six months preceding interview, stable relative to 2023 (38%; $p$=0.484) (Figure 39).

**Frequency of Use:** Median days of LSD use over the years has remained low. Of those who had recently consumed LSD in 2024 and commented (n=28), frequency of use remained stable at a median of two days (IQR=1-4; 2 days in 2023; IQR=1-3; n=25; $p$=0.506) (Figure 39). No participants who had recently consumed LSD reported weekly or more frequent use in 2023 and 2024.

**Routes of Administration:** Among participants who had recently consumed LSD and commented (n=28), the vast majority of participants (93%) reported swallowing LSD in 2024, stable from 2023 (100%; $p$=0.492).

**Quantity:** Of those who reported recent use and responded (n=25), the median amount of LSD used in a 'typical' session was one tab (IQR=1-2; 1 tab in 2023; IQR=1-1; n=22; $p$=0.072). Of those who reported recent use and responded (n=24), the median maximum amount of LSD used in a session was one tab (IQR=1-2; 1 tab in 2023; IQR=1-1.8; n=22; $p$=0.273).

Figure 39: Past six month use and frequency of use of LSD, Hobart, TAS, 2003-2024




Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

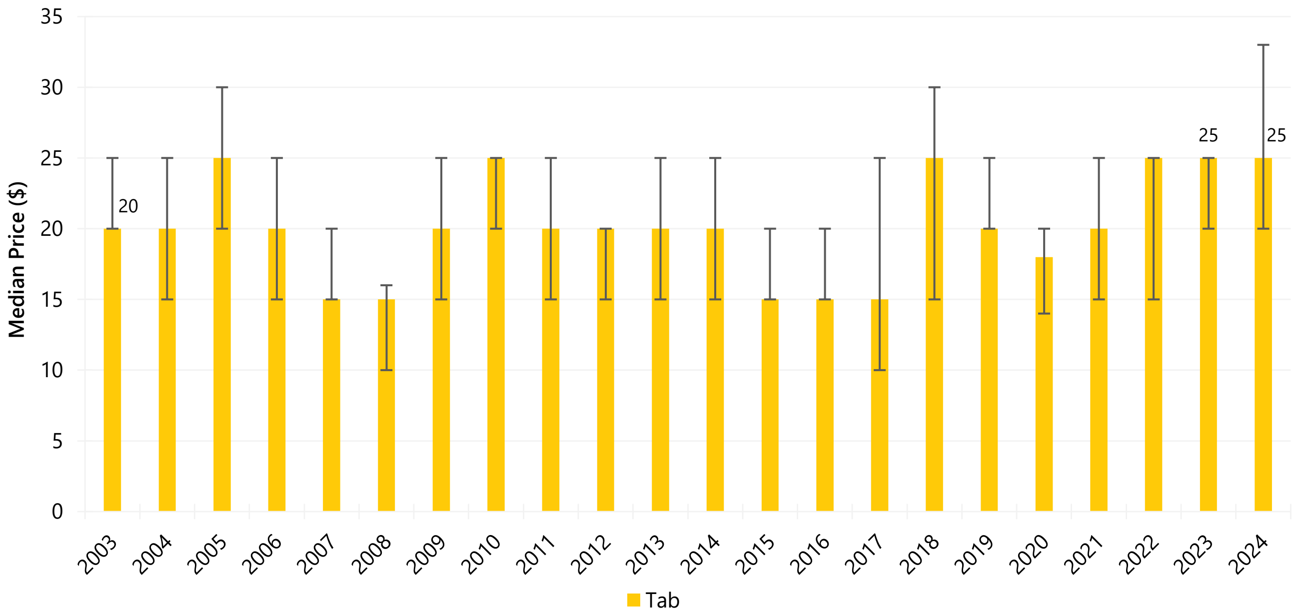
## Price, Perceived Purity and Perceived Availability

**Price:** The median price for one tab of LSD was $25 (IQR=20-33; n=19) in 2024, stable from $25 in 2023 (IQR=20-25; n=18; $p$=0.875) (Figure 40).

**Perceived Purity:** The perceived purity of LSD remained stable between 2023 and 2024 ($p$=0.466). Among those who were able to respond in 2024 (n=25), two thirds (64%) perceived the purity of LSD to be 'high' (58% in 2023), followed by 28% who reported the purity to be 'medium' (27% in 2023) (Figure 41).

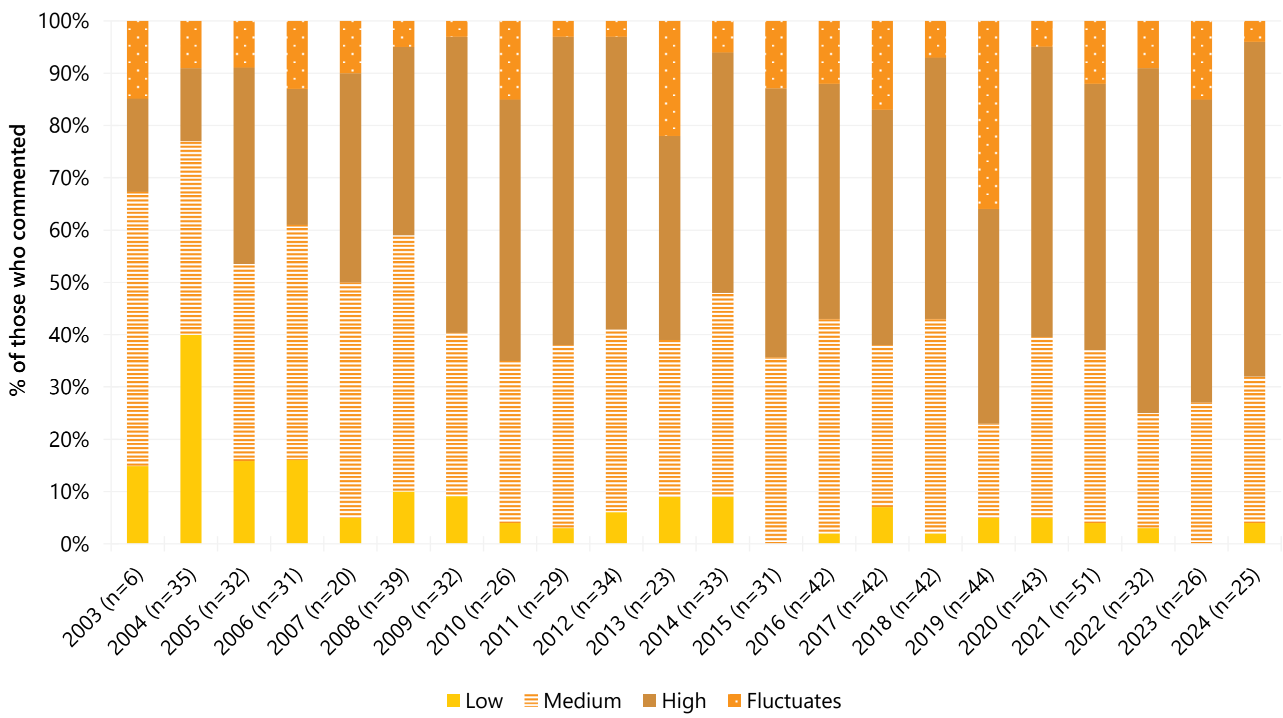
**Perceived Availability:** The perceived availability of LSD remained stable between 2023 and 2024. Of those able to comment in 2024 (n=25), one third (36%) reported LSD as being 'easy' to obtain (38% in 2023), and a further one quarter (24%) reported it as 'very easy' obtain (27% in 2023). Conversely, one third (32%) reported LSD as being 'difficult' to obtain (27% in 2023) (Figure 42).

**Figure 40: Median price of LSD per tab, Hobart, TAS, 2003-2024**



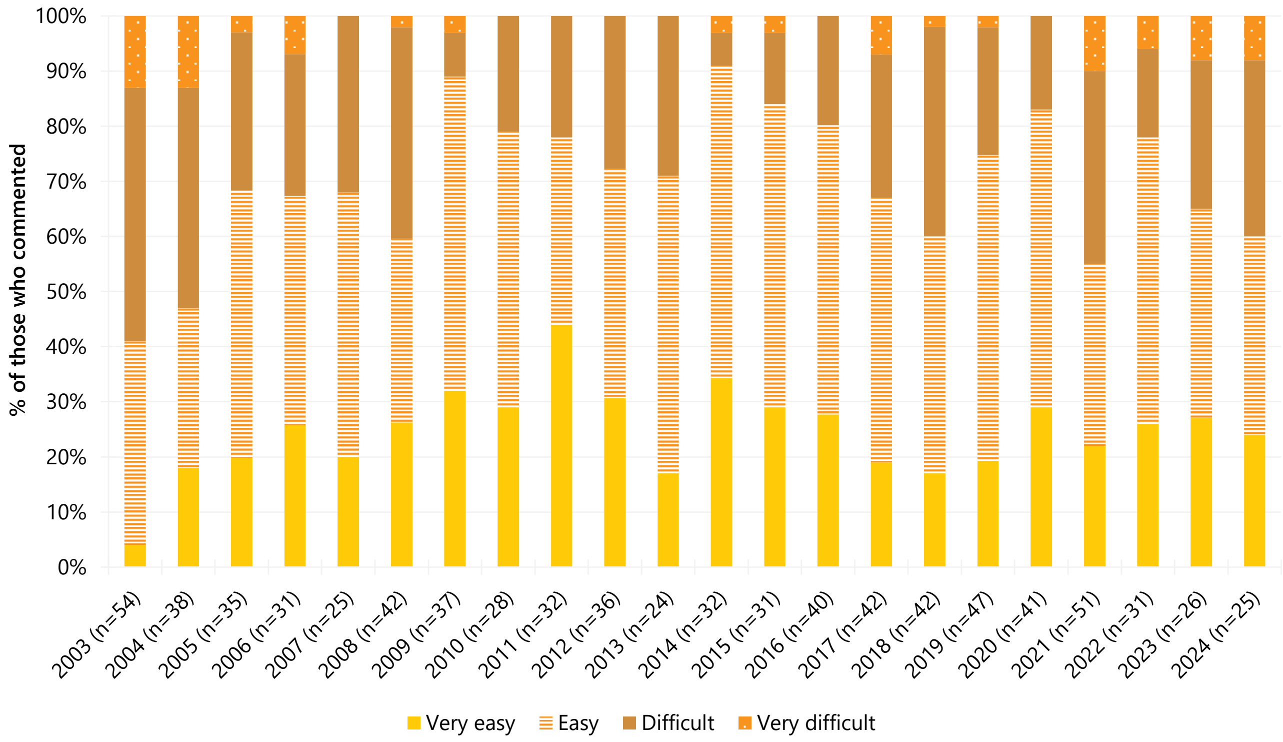

Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). For historical numbers, please refer to the data tables. The error bars represent the IQR. Statistical significance for 2023 versus 2024 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

**Figure 41: Current perceived purity of LSD, Hobart, TAS, 2003-2024**




Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

**Figure 42: Current perceived availability of LSD, Hobart, TAS, 2003-2024**




Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# DMT

## Patterns of Consumption

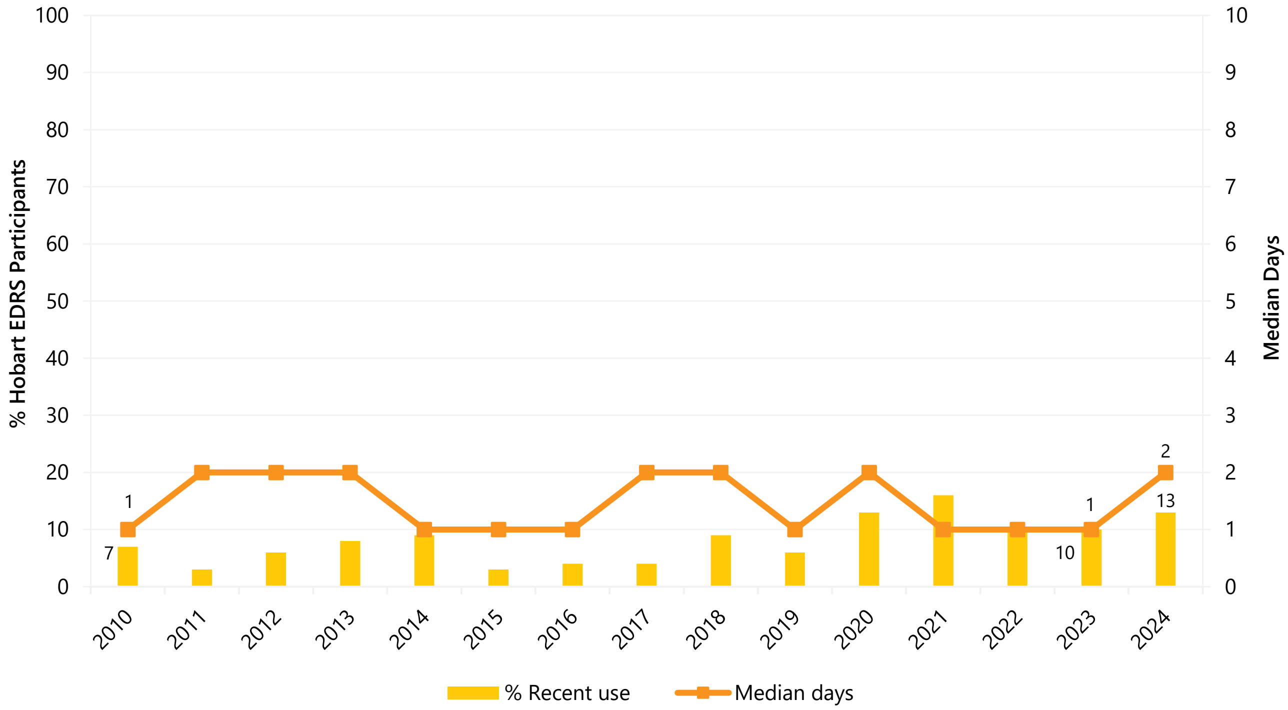
**Recent Use (past 6 months)**: Thirteen per cent of the Hobart sample reported recent use of DMT in 2024, stable relative to 2023 (10%; $p$=0.608) (Figure 43).

**Frequency of Use:** Median days of DMT use across the years has been infrequent and stable, with a median of two days of use (IQR=2-2; n=11) reported in 2024 (1 day in 2023; IQR=1-19; n=6; $p$=0.631) (Figure 43).

**Routes of Administration:** Among participants who had recently consumed DMT and commented (n=11), all participants (100%) reported smoking DMT in 2024, unchanged from 2023 (100%). No participants reported any other route of administration.

**Quantity**: Few participants (n≤5) reported on the 'typical' and maximum quantity of DMT used in a session in 2023 and 2024; therefore, further details are not reported.

Figure 43: Past six month use and frequency of use of DMT, Hobart, TAS, 2010-2024




Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# 8

## New Psychoactive Substances

New psychoactive substances (NPS) are often defined as substances which do not fall under international drug control, but which may pose a public health threat. However, there is no universally accepted definition, and in practicality the term has come to include drugs which have previously not been well-established in recreational drug markets.

In previous (2010-2020) EDRS reports, DMT and para*methoxyamphetamine* (PMA) were categorised as NPS. However, the classification of these substances as NPS is not universally accepted, and in 2021, the decision was made to exclude them from this category. This means that the figures presented below for recent use of tryptamine, phenethylamine and any NPS will not align with those in our 2010-2020 reports.

Further, some organisations (e.g., the United Nations Office on Drugs and Crime) include plant-based substances in their definition of NPS, whilst other organisations exclude them. To allow comparability with both methods, we present figures for 'any' NPS use, both including and excluding plant-based NPS.

### Recent Use (past 6 months)

Any NPS use, including plant-based NPS, has fluctuated over time, peaking at 49% in 2010 and declining in recent years. In 2024, few participants (n≤5) reported recent use of NPS (including plant-based NPS); therefore, further details are not reported (n≤5 in 2023; $p$=0.699) (Table 3).

Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 48% in 2010 and since declining (n≤5 in 2023 and 2024; $p$=0.699) (Table 3).

### Forms Used

Participants are asked about a range of NPS, updated each year to reflect key emerging substances of interest. NPS use among the Hobart sample has fluctuated over time, with few (n≤5) or no participants reporting use of any individual NPS (Table 4). Please refer to the [2024 National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

## Table 3: Past six month use of NPS (including and excluding plant-based NPS), Hobart, TAS, 2010-2024

| % | Including plant-based NPS | Excluding plant-based NPS |
|---|---|---|
| **2010** | 49 | 48 |
| **2011** | 33 | 33 |
| **2012** | 26 | 24 |
| **2013** | 34 | 33 |
| **2014** | 38 | 36 |
| **2015** | 22 | 18 |
| **2016** | 14 | 14 |
| **2017** | 17 | 17 |
| **2018** | 23 | 21 |
| **2019** | 18 | 18 |
| **2020** | 10 | 8 |
| **2021** | 11 | 10 |
| **2022** | - | - |
| **2023** | - | - |
| **2024** | **-** | **-** |

Note. Monitoring of NPS first commenced in 2010. In 2021, the decision was made to remove DMT and PMA from the NPS category, with these substances now presented in Chapter 7 and Chapter 9, respectively. This has had a substantial impact on the percentage of the sample reporting 'any' NPS use in the past six months and means that the figures presented above will not align with those presented in previous (2010-2020) EDRS reports. Statistical significance for 2023 versus 2024 presented in table; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Table 4: Past six month use of NPS by drug type, Hobart, TAS, 2010-2024

| | 2010 N=100 | 2011 N=75 | 2012 N=97 | 2013 N=76 | 2014 N=100 | 2015 N=78 | 2016 N=100 | 2017 N=100 | 2018 N=100 | 2019 N=99 | 2020 N=100 | 2021 N=102 | 2022 N=72 | 2023 N=65 | 2024 N=87 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **% Phenethylamines ^** | 15 | - | - | 10 | 15 | 10 | - | 17 | - | 6 | - | 6 | - | 0 | **0** |
| Any 2C substance~ | 12 | - | - | 10 | 10 | - | - | 9 | - | - | - | - | 0 | 0 | **0** |
| NBOMe | / | / | / | / | - | - | - | 8 | - | - | - | - | 0 | 0 | **0** |
| DO-x | - | 0 | 0 | 0 | 0 | 0 | 0 | - | - | 0 | 0 | 0 | 0 | 0 | **0** |
| Tuci | / | / | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| 4-FA | / | / | / | / | / | / | 0 | 0 | 0 | 0 | 0 | 0 | - | 0 | **0** |
| NBOH | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| **% Tryptamines^^** | 0 | - | - | - | - | 0 | 0 | 0 | 0 | - | - | - | 0 | 0 | **0** |
| 5-MeO-DMT | 0 | - | - | - | - | 0 | 0 | 0 | 0 | - | - | - | 0 | 0 | **0** |
| **% Synthetic cathinones** | 44 | 31 | 13 | 29 | 32 | 15 | 9 | - | - | - | - | 0 | - | - | **0** |
| Mephedrone | 42 | 27 | 10 | 24 | 23 | 9 | - | - | - | 0 | - | 0 | 0 | - | **0** |
| Methcathinone | / | / | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| Methylone/bk MDMA | / | - | - | - | - | - | - | - | - | 0 | - | 0 | - | 0 | **0** |
| MDPV/Ivory wave | - | - | - | - | - | - | 0 | - | 0 | - | 0 | 0 | 0 | 0 | **0** |
| Alpha PVP | / | / | / | / | / | / | 0 | 0 | / | / | - | 0 | 0 | 0 | **0** |
| N-ethylhexedrone | / | / | / | / | / | / | / | / | / | / | 0 | 0 | 0 | 0 | **0** |
| N-ethylpentylone | / | / | / | / | / | / | / | / | / | / | 0 | 0 | 0 | 0 | **0** |
| N-ethylbutylone | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | 0 | **0** |
| 3-chloromethcathinone | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| 4-chloromethcathinone | / | / | / | / | / | / | / | / | / | / | / | / | / | 0 | **0** |
| 3-methylmethcathinone | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| Alpha PHP | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| Dimethylpentylone | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| N, N-Dimethyl Pentylone | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| Pentylone | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| **% Piperazines** | - | 0 | 0 | 0 | 0 | 0 | 0 | / | / | / | / | / | / | / | **/** |
| **% Dissociatives** | / | / | 0 | - | 10 | - | - | - | 0 | - | - | - | 0 | 0 | **-** |
| Methoxetamine (MXE) | / | / | 0 | - | 10 | - | - | - | 0 | - | 0 | 0 | 0 | 0 | **0** |
| 2F-2-oxo PCE | / | / | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| 2-Fluorodeschloroketamine (2-FDCK) | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| 3 Cl-PCP/4Cl-PCP | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| 3F-2-oxo PCE | / | / | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| 3-HO-PCP/4-HO-PCP | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |

| | 2010 N=100 | 2011 N=75 | 2012 N=97 | 2013 N=76 | 2014 N=100 | 2015 N=78 | 2016 N=100 | 2017 N=100 | 2018 N=100 | 2019 N=99 | 2020 N=100 | 2021 N=102 | 2022 N=72 | 2023 N=65 | 2024 N=87 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-MeO-PCP/4- MeO-PCP | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| Tiletamine | / | / | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| Other drugs that mimic the effects of dissociatives like ketamine | / | / | / | / | / | / | / | / | / | / | - | - | 0 | 0 | **-** |
| **% Plant-based NPS** | - | - | - | - | 6 | 6 | - | - | - | - | - | - | - | 0 | **0** |
| Ayahuasca | / | / | / | / | / | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Mescaline | - | - | - | - | - | - | - | - | - | 0 | - | - | 0 | 0 | **0** |
| Salvia divinorum | / | 0 | - | - | - | - | 0 | - | - | - | - | - | - | 0 | **0** |
| Kratom/mitragynine | / | / | / | / | / | / | / | / | / | / | 0 | - | 0 | 0 | **0** |
| **% Benzodiazepines** | / | / | / | / | / | / | 0 | - | - | - | 0 | - | - | 0 | **0** |
| Etizolam | / | / | / | / | / | / | 0 | - | - | - | - | - | - | 0 | **0** |
| 8-Aminoclonazolam | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| Bromazolam | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| Clonazolam | / | / | / | / | / | / | / | / | / | / | / | / | - | 0 | **0** |
| Flualprazolam | / | / | / | / | / | / | / | / | / | / | / | / | 0 | 0 | **0** |
| Flubromazepam | / | / | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| Phenazolam | / | / | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| Other drugs that mimic the effect of benzodiazepines | / | / | / | / | / | / | / | / | 0 | 0 | 0 | - | 0 | 0 | **0** |
| **% Xylazine** | / | / | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| **% Synthetic cannabinoids (e.g., ADB-BUTINACA, 4F-MDMB-BUTICA, FUB-AM)** | / | / | 8 | / | - | - | - | - | 7 | - | - | - | 0 | - | **0** |
| **% Herbal high#** | / | / | 8 | / | - | - | 0 | - | - | - | 0 | - | / | / | **0** |
| Phenibut | / | / | 8 | / | - | - | 0 | - | - | - | 0 | - | - | 0 | **0** |
| 4F-phenibut | / | / | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| Glaucine | / | / | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| **% Other drugs that mimic the effect of opioids (e.g., acetylfentanyl, nitazenes)** | / | / | / | / | / | / | / | 0 | 0 | - | 0 | 0 | 0 | 0 | **-** |
| **% Other drugs that mimic the effect of ecstasy** | / | / | / | / | / | / | / | - | - | - | 0 | 0 | - | 0 | **0** |
| **% Other drugs that mimic the effect of amphetamine or cocaine** | / | / | / | / | / | / | / | - | - | - | - | - | 0 | - | **-** |
| **% Other drugs that mimic the effect of psychedelic drugs like LSD** | / | / | / | / | / | / | / | 0 | - | - | 0 | - | 0 | 0 | **-** |
| **Other new and emerging psychoactive substances** | / | / | / | / | / | / | / | / | - | 0 | - | 0 | - | - | **-** |

Note. NPS first asked about in 2010. ^In previous EDRS reports, PMA was included as a NPS under 'phenethylamines' and mescaline was included under both 'phenethylamines' and 'plant-based NPS'. In 2021, the decision was made to remove PMA from the NPS category altogether, while mescaline was removed from 'phenethylamines' and is now only coded under 'plant-based NPS'. This means that the percentages reported for any phenethylamine NPS use in the 2021-2023 EDRS reports will not align with those presented in earlier (2010-2020) reports. ^^In previous (2010-2020) EDRS reports, DMT was included as a NPS under 'tryptamines', however, was removed from the NPS category in 2021 (refer to Chapter 7 for further information on DMT use among the sample). This means that the percentages reported for any tryptamine NPS use in the 2021-2024 EDRS reports will not align with those presented in earlier (2010-2020) reports. # The terms 'herbal highs' and 'legal highs' appear to be used interchangeably to mean drugs that have similar effects to illicit drugs like cocaine or cannabis but are not covered by current drug law scheduling or legislation. ~ In 2010 and between 2017-2019, three forms of 2C were asked about whereas between 2011-2016 four forms were asked about. From 2020 onwards, 'any' 2C use is captured. Statistical significance for 2023 versus 2024 presented in table; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# 9

# Other Drugs

## Non-Prescribed Pharmaceutical Drugs

### Codeine

Before 1 February 2018, people could access low-dose codeine products (<30mg, e.g., Nurofen Plus) over-the-counter (OTC), while high-dose codeine (≥30mg, e.g., Panadeine Forte) required a prescription from a doctor. On 1 February 2018, legislation changed so that all codeine products, low- and high-dose, require a prescription from a doctor to access.

Up until 2017, participants were only asked about use of OTC codeine for non-pain purposes. Additional items on use of prescription low-dose and prescription high-dose codeine were included in the 2018-2020 EDRS. However, from 2021 onwards, participants were only asked about prescribed and non-prescribed codeine use, regardless of whether it was low- or high-dose.

**Recent Use (past 6 months):** In 2024, 14% of participants reported using any non-prescribed codeine in the past six months, stable relative to 2023 (18%; $p$=0.495) (Figure 44).

**Frequency of Use:** Participants who had recently used non-prescribed codeine and commented (n=12) reported use on a median of three days (IQR=1-3) in the past six months, stable relative to 2023 (4 days; IQR=1-14; n=12; $p$=0.328).

### Pharmaceutical Opioids

**Recent Use (past 6 months):** Due to low numbers (n≤5) reporting recent use, further details are not reported on non-prescribed pharmaceutical opioids (Figure 44). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

### Benzodiazepines

From 2019-2023, participants were asked about non-prescribed alprazolam use and non-prescribed use of 'other' benzodiazepines (e.g., diazepam). In 2024, the two forms were combined, such that participants were asked about non-prescribed use of any benzodiazepines.

**Recent Use (past 6 months):** Recent use of non-prescribed benzodiazepines (e.g., Valium, Diazepam, Xanax, Kalma) has fluctuated over the course of monitoring, with 29% of the Hobart sample reporting recent use in 2024, stable relative to 2023 (32%; $p$=0.726) (Figure 44).

**Frequency of Use:** Participants who reported recent use of non-prescribed benzodiazepines reported using on a median of seven days (IQR=2-24; n=25) in 2024, stable relative to six days in 2023 (IQR=2-28; n=10; $p$=0.425).

**Forms Used:** Among those who had recently used non-prescribed benzodiazepines and commented on the main brand used in the six months preceding interview (n=20), four fifths (80%) of the Hobart sample reported using Valium (diazepam), and almost one third (30%) reported using Xanax (alprazolam).

## Steroids

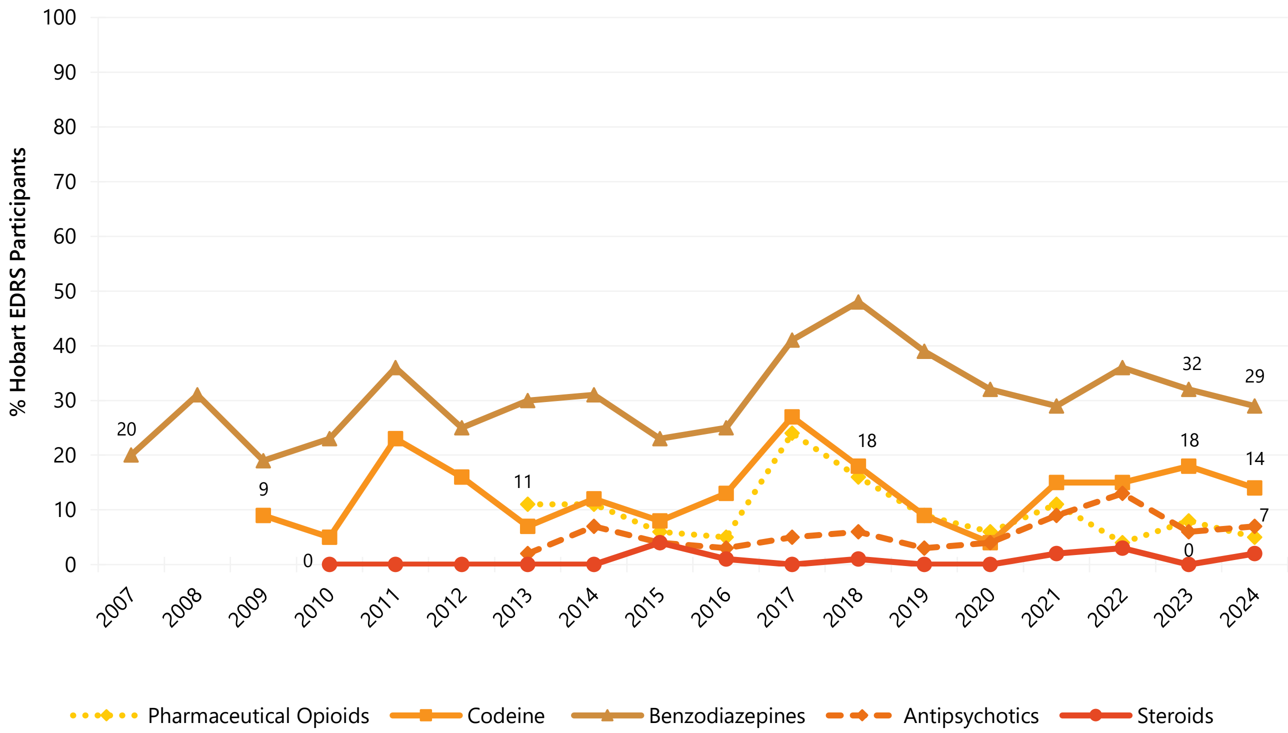
**Recent Use (past 6 months):** The per cent of the Hobart sample reporting recent steroid use has remained low and stable since monitoring commenced. In 2024, few participants (n≤5) reported recent steroid use (0% in 2023; *p*=0.508) (Figure 44).

## Antipsychotics

**Recent Use (past 6 months):** Seven per cent of the Hobart sample reported recent use of non-prescribed antipsychotics in 2024, stable relative to 2023 (n≤5) (Figure 44).

**Frequency of Use:** Participants who had recently used non-prescribed antipsychotics and commented (n=6) reported use on a median of two days (IQR=1-5) in the six months preceding interview (n≤5 in 2023; *p*=0.350).

Figure 44: Non-prescribed use of pharmaceutical medicines in the past six months, Hobart, TAS, 2007-2024




Note. Non-prescribed use is reported for prescription medicines. Monitoring of over-the-counter (OTC) codeine (low-dose codeine) commenced in 2010, however, in February 2018, the scheduling for codeine changed such that low-dose codeine formerly available OTC was required to be obtained via a prescription. To allow for comparability of data, the time series here represents non-prescribed low- and high dose codeine (2018-2024), with high-dose codeine excluded from pharmaceutical opioids from 2018. Between 2019 and 2023, participants were asked about 'alprazolam' and 'other benzodiazepines'. In 2024, 'alprazolam' and 'other benzodiazepines' were combined. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

# Other Illicit Drugs

## Non-Prescribed Hallucinogenic Mushrooms/Psilocybin

**Recent Use (past 6 months):** In 2024, 29% of the Hobart sample reported recent use of non-prescribed hallucinogenic mushrooms/psilocybin in the six months prior to interview, stable relative to 40% in 2023 ($p$=0.176) (Figure 45).

**Frequency of Use:** Participants who reported recent use of non-prescribed hallucinogenic mushrooms/psilocybin and commented (n=25) reported using on a median of two days (IQR=1-7) in the six months prior to interview in 2024 (3 days in 2023; IQR=1-5; n=26; $p$=0.984).

## Kava

Few participants (n≤5) reported recent use of kava in 2024 (0% in 2023; $p$=0.507); therefore, further details are not reported (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

## MDA

**Recent Use (past 6 months):** In 2024, 14% of the Hobart sample reported recent use of MDA, stable relative to 11% in 2023 ($p$=0.621) (Figure 45).

**Frequency of Use:** Participants who reported recent use of MDA and commented (n=12) reported use on a median of three days (IQR=1-6) in the six months prior to interview in 2024 (2 days in 2023; IQR=2-3; n=7; $p$=0.311).

## Substance with Unknown Contents

**Capsules:** Sixteen per cent of participants reported recent use of capsules with 'unknown content' in 2024 (n≤5 in 2023; $p$=0.076) (Figure 45).

**Other Unknown Substances:** From 2019, we asked participants about their use more broadly of substances with 'unknown contents'. Twenty-eight per cent of participants reported use of any substance with 'unknown contents' in 2024 (23% in 2023; $p$=0.571) on a median of two days (IQR=1-4; n=24), stable relative to two days in 2023 (IQR=2-4; n=15; $p$=0.530).

When broken down by substance form, 12% of participants reported recent use of pills with 'unknown contents' (12% in 2023). Thirteen per cent of participants reported recent use of powder with 'unknown content' (n≤5 in 2023; $p$=0.272), and 7% reported use of crystal with 'unknown content' (n≤5 in 2023; $p$=0.240).

**Quantity:** From 2020, we asked participants about the average amount of pills and capsules used with 'unknown contents' in the six months preceding interview. Of those who reported recent use of pills with 'unknown content' and commented (n=10), the median amount used i**Figure 45**n a 'typical' session was one and a half pills (IQR=1-2; 1.5 pills in 2023; IQR=1-3.9; n=8; $p$=0.393). Of those who reported recent use of capsules with 'unknown content' and commented (n=14), the median amount used in a 'typical' session was two capsules (IQR=1-2.8; n≤5 in 2023; $p$=0.430).

## PMA

No participants reported recent use of PMA in 2023 and 2024 (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

## PMMA

No participants reported recent use of PMMA in 2023 and 2024 (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

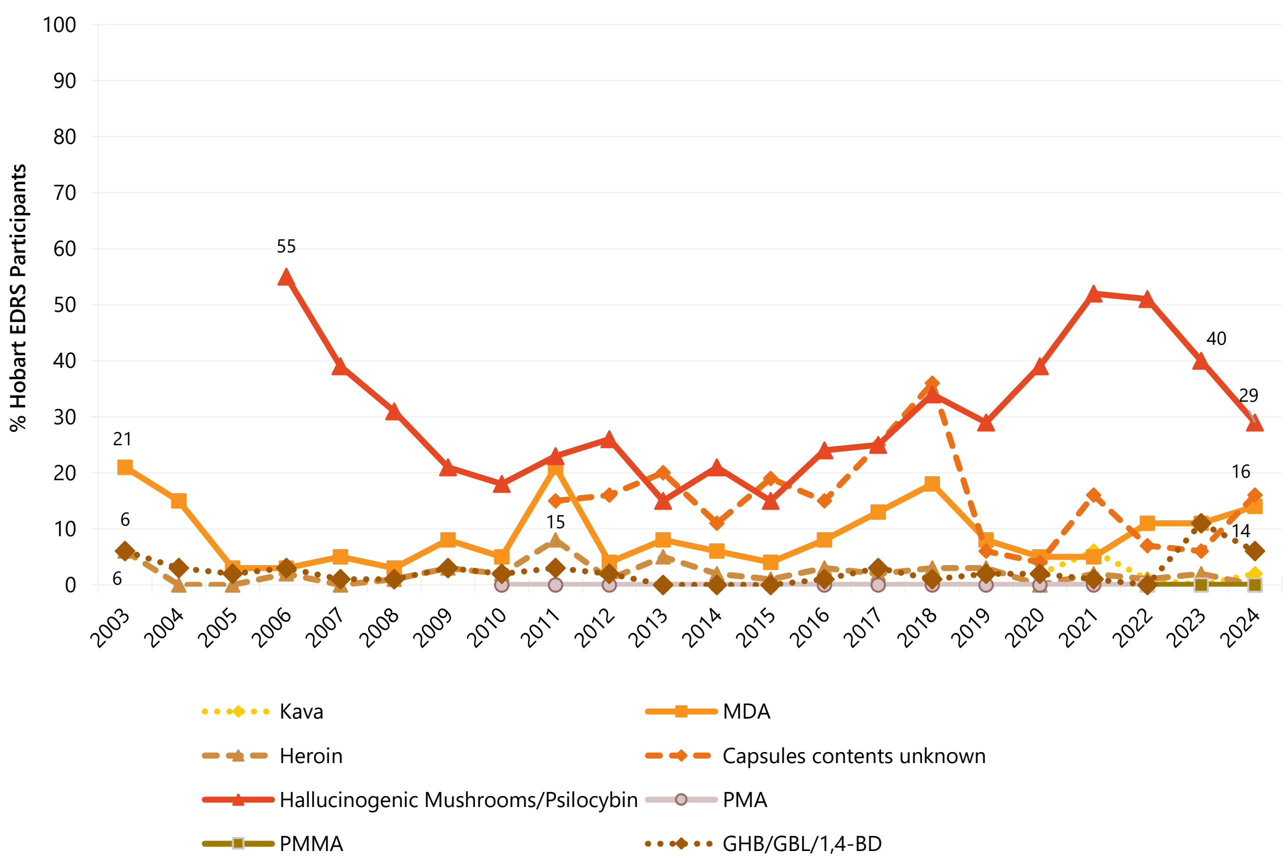
## Heroin

No participants reported recent use of heroin in 2024; therefore, further details are not reported (n≤5 in 2023; *p*=0.428) (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

## GHB/GBL/1,4-BD

Few participants (n≤5) in the Hobart sample reported recent use of GHB/GBL/1,4-BD in the six months prior to the interview in 2024; therefore, further details are not reported (11% in 2023; *p*=0.364) (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

**Figure 45: Past six month use of other illicit drugs, Hobart, TAS, 2003-2024**




Note. In 2019, participants were asked more broadly about 'substances contents unknown' (with further ascertainment by form) which may have impacted the estimate for 'capsules contents unknown'. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

# Licit and Other Drugs

## Alcohol

**Recent Use (past 6 months):** The majority of the Hobart sample reported recent use of alcohol in 2024 (92%), stable relative to 2023 (92%) (Figure 46).

**Frequency of Use:** Participants who had recently used alcohol reported use on a median of 35 days in the past six months (IQR=12-71; n=80) in 2024 (24 days in 2023; IQR=22-72; n=59; $p$=0.937). Sixty-nine per cent of those who recently consumed alcohol had done so on a weekly or more frequent basis in 2024, stable from 2023 (75%; $p$=0.570). Few participants (n≤5) reported daily use of alcohol in 2023 and 2024.

## Tobacco

In 2024, for the first time, questions were included about illicit tobacco. Illicit tobacco was defined as products sold illegally without the necessary taxes added to the price.

**Recent Use (past 6 months):** Three quarters (77%) of the Hobart sample reported recent tobacco use in 2024, remaining stable from 72% in 2023 ($p$=0.570) (Figure 46). One quarter (25%) of participants reported recent use of smoked or non-smoked illicit tobacco products (data not collected in 2023).

**Frequency of Use:** Participants reported using tobacco on a median of 180 days in 2024 (IQR=50-180; n=67), a significant increase from 90 days in 2023 (IQR=14-180; n=47; $p$=0.017). Almost three fifths (57%) of participants who had recently used tobacco reported daily use (38% in 2023; $p$=0.063).

## E-cigarettes

From October 2021, Australians were required to have a prescription to legally access nicotine containing e-cigarette products for any purpose. In 2022, participants were asked for the first time about their use of both prescribed and non-prescribed e-cigarettes. Few participants (n≤5) reported recent use of prescribed e-cigarettes in 2022 (n≤5), 2023 (n≤5) and 2024 (n≤5). Data below for 2022 to 2024 refer only to non-prescribed e-cigarette use; data for 2021 and earlier refers to any e-cigarette use.

**Recent Use (past 6 months):** Almost three fifths (57%) of the Hobart sample had used non-prescribed e-cigarettes in the six months preceding interview in 2024 (54% in 2023; $p$=0.735) (Figure 46), the highest percentage observed since the commencement of monitoring.

**Frequency of Use:** A median frequency of 66 days of non-prescribed use was reported in the past six months in 2024 (IQR=20-180; n=50), stable relative to 60 days in 2023 (IQR=25-180; n=35; $p$=0.887). Two fifths (40%) of participants who had recently used non-prescribed e-cigarettes reported daily use (29% in 2023; $p$=0.356).

**Contents and Forms Used:** Among participants who had recently used non-prescribed e-cigarettes and commented (n=49), the majority (98%) reported using e-cigarettes containing nicotine (100% in 2023). Among participants who had recently used e-cigarettes and responded in 2024 (n=50), participants most commonly reported using disposable devices (100%), with few participants (n≤5) reporting having used re-fillable devices.

Almost one fifth (17%) of the total sample reported vaping substances other than nicotine/vape juice. Among those who vaped substances other than nicotine/vape juice and commented (n=15), the most commonly vaped substance was cannabis (60%).

**Reason for Use:** Of those who reported any (i.e., prescribed and non-prescribed) recent e-cigarette use and commented (n=52), 44% reported that they had used e-cigarettes as a smoking cessation tool, stable relative to 2023 (42%; n=36; $p$=0.825).

## Nicotine Pouches

In 2024, participants were asked for the first time about their use of nicotine pouches. Nicotine pouches are small pouches (or bags) containing synthetic nicotine and sometimes other ingredients such as sweeteners and flavours. They are designed to be placed between the lip and gum.

**Recent Use (past 6 months):** Seventeen per cent of the Hobart sample had used nicotine pouches in the six months preceding interview in 2024 (not asked prior to 2024) (Figure 46).

**Frequency of Use:** A median frequency of two days of use was reported in 2024 (IQR=1-25; n=15).

## Nitrous Oxide

**Recent Use (past 6 months):** One third (31%) of the Hobart sample reported recent use of nitrous oxide in 2024, stable relative to 2023 (40%; $p$=0.311) (Figure 46).

**Frequency of Use:** Frequency of use remained stable at a median of four days (IQR=2-7; n=27) in 2024 (3 days in 2023; IQR=1-6; n=26; $p$=0.235).

**Quantity:** Among those who reported recent use and responded (n=24), the median amount used in a 'typical' session was 4.5 bulbs (IQR=2.0-10.5; 10 bulbs in 2023; IQR=2-16; n=24; $p$=0.507). Of those who reported recent use and responded (n=24), the median maximum amount used was 7 bulbs (IQR=3-20; 10 bulbs in 2023; IQR=2-27; n=24; $p$=0.764).

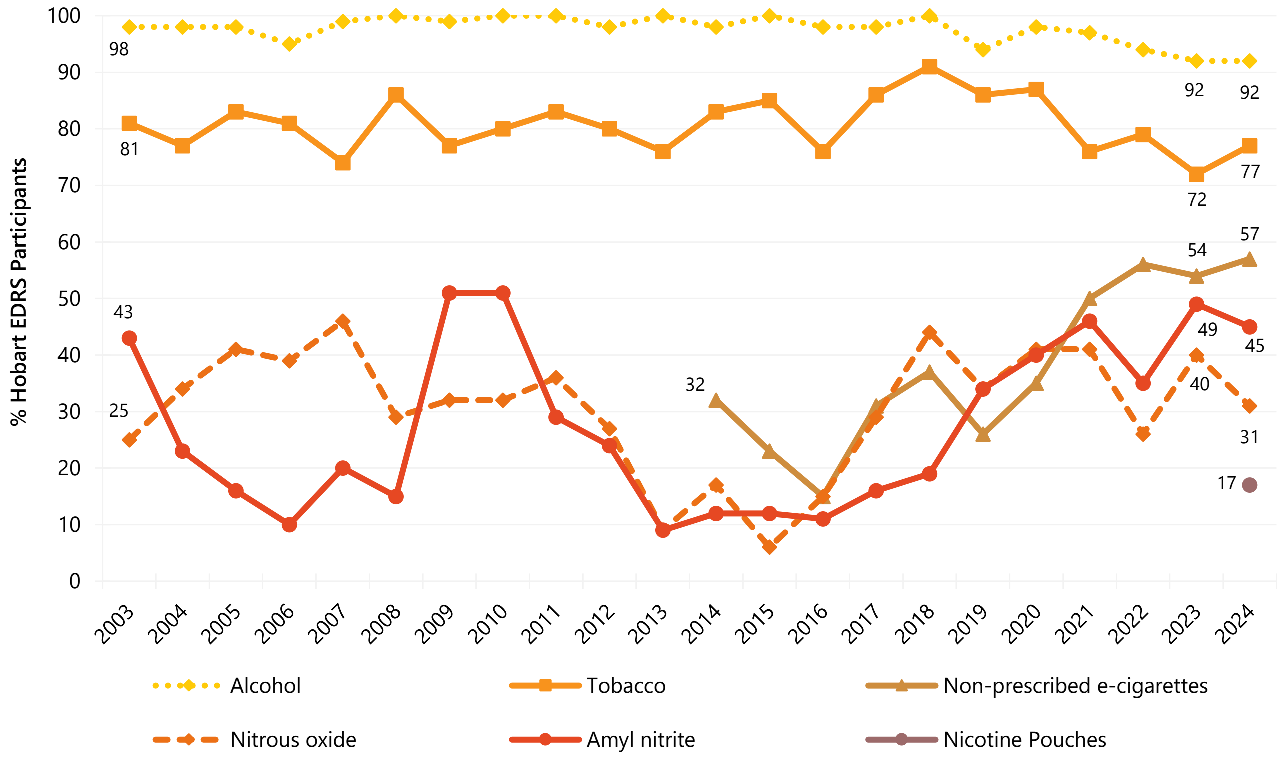
## Amyl Nitrite

Amyl nitrite is an inhalant which is currently listed as a Schedule 4 substance in Australia (i.e., available only with prescription) yet is often sold under-the-counter in sex shops. Following a review by the Therapeutic Goods Administration, amyl nitrite was listed as Schedule 3 (i.e., for purchase over-the-counter) from 1 February 2020 when sold for human therapeutic purpose.

**Recent Use (past 6 months):** After considerable fluctuation over the course of monitoring, 45% of the Hobart sample reported recent use of amyl nitrite in 2024, stable relative to 2023 (49%; $p$=0.622) (Figure 46).

**Frequency of Use:** A median of four days of use was reported in 2024 (IQR=2-9; n=39; 5 days in 2023; IQR=2-15; n=32; $p$=0.816).

**Figure 46: Licit and other drugs used in the past six months, Hobart, TAS, 2003-2024**




Note. Regarding e-cigarettes, on 1 October 2021, legislation came into effect requiring people to obtain a prescription to legally import nicotine vaping products. Data from 2022 onwards refers to non-prescribed e-cigarettes only. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# 10

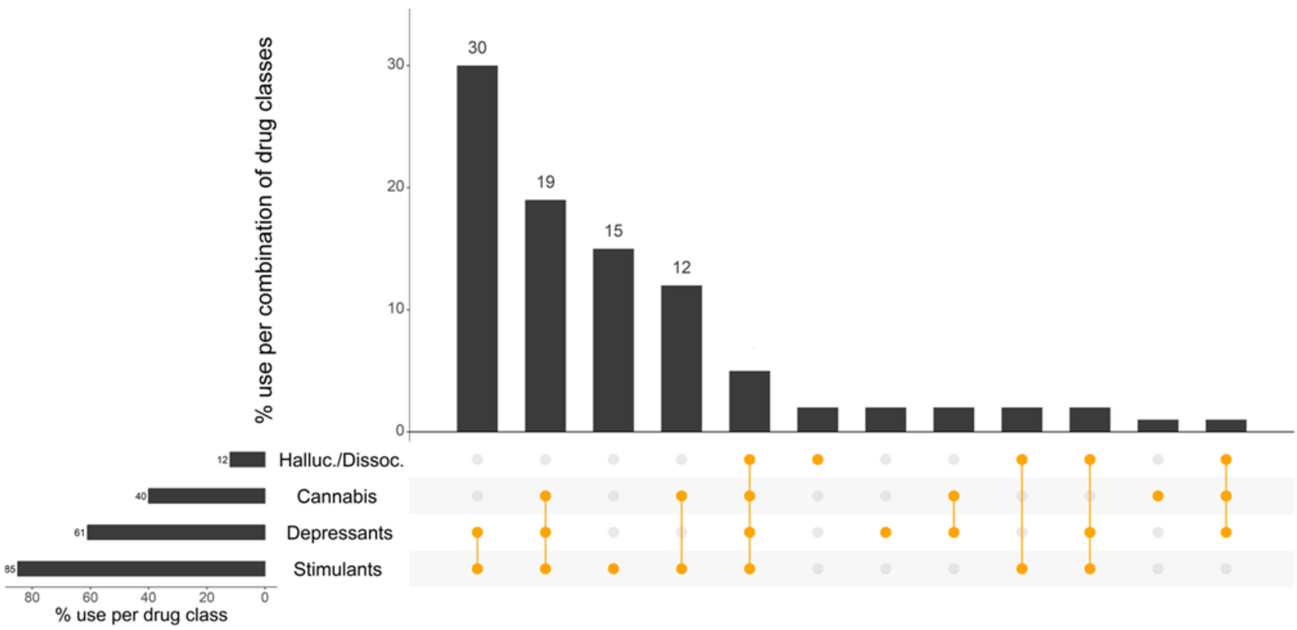
## Drug-Related Harms and Other Behaviours

## Polysubstance Use and Bingeing

Among those who responded (n=86), the most commonly used substances on the last occasion of ecstasy or related drug use were alcohol (60%) and ecstasy (49%), followed by cannabis (40%) and tobacco (26%).

Four fifths (80%; n=65) of the Hobart sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most commonly used combinations of drug classes were stimulants and depressants (30%), followed by stimulants, depressants, and cannabis (19%). Twelve per cent reported using stimulants and cannabis, whilst 15% reported using stimulants alone (Figure 47).

**Figure 47: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Hobart, TAS, 2024: Most common drug pattern profiles**

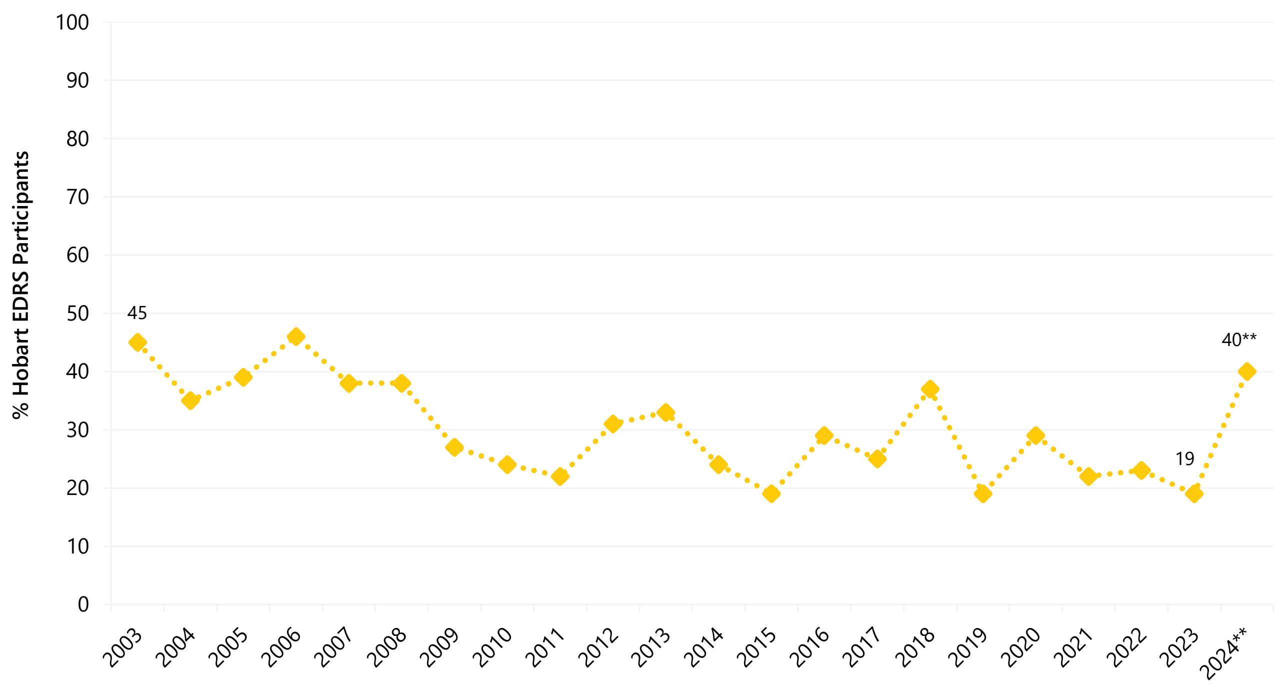



Note. % calculated out of total EDRS 2024 sample. The horizontal bars represent the per cent of participants who reported use of each substance on their last occasion of ecstasy or related drug use; the vertical columns represent the per cent of participants who used the combination of drug classes represented by the orange circles. Drug use pattern profiles reported by ≤5 participants or which did not include any of the four drug classes depicted are not shown in the figure but are counted in the denominator. Halluc./Dissoc = hallucinogens/dissociatives (LSD, hallucinogenic mushrooms, amyl nitrite, DMT, ketamine and/or nitrous oxide); depressants (alcohol, GHB/GBL,1,4-BD, kava, opioids and/or benzodiazepines); stimulants (cocaine, MDA, ecstasy, methamphetamine, and/or pharmaceutical stimulants). Use of benzodiazepines, opioids and stimulants could be prescribed or non-prescribed use. Note that participants may report use of multiple substances within a class. Y axis reduced to 30% to improve visibility of trends. Please refer to Table 1 for a guide to table/figure notes.

## Binge Drug Use

Participants were asked whether they had used any stimulant or related drugs for 48 hours or more continuously without sleep (i.e., binged) in the six months preceding interview. Two fifths (40%) of the Hobart sample had binged on one or more drugs in the preceding six months, a significant increase from 19% in 2023 (*p*=0.009) (Figure 48).

**Figure 48: Past six month use of stimulants or related drugs for 48 hours or more continuously without sleep ('binge'), Hobart, TAS, 2003-2024**




Note. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$ <0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

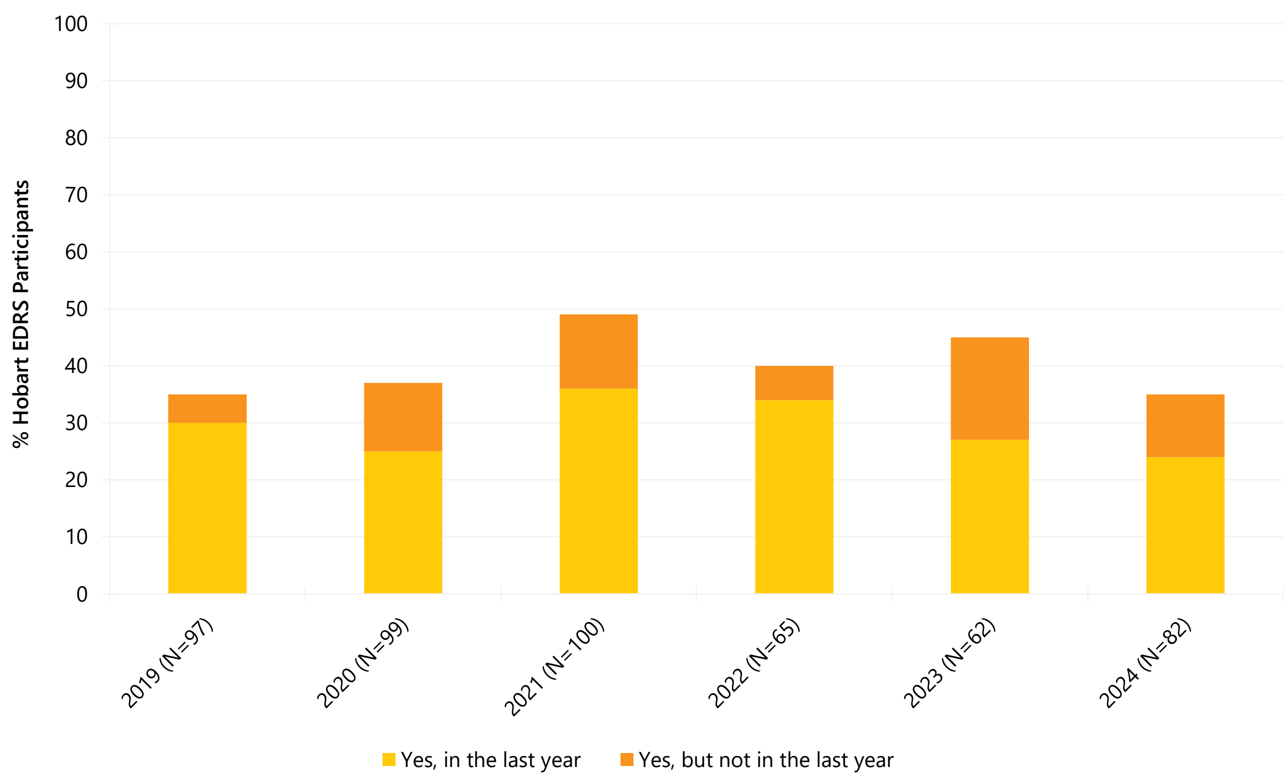
# Drug Checking

Drug checking is a common strategy used to test the purity and contents of illicit drugs. At the time interviewing commenced in 2024, the only government-sanctioned drug checking services that had operated in Australia were at the Groovin the Moo festival in Canberra, ACT (2018, 2019) and CanTEST, a pilot fixed-site drug checking service in Canberra which has been operational since 17 July 2022. Queensland's first fixed-site drug checking service, CheQpoint, opened its doors in Brisbane shortly after EDRS recruitment commenced (April 20, 2024), and a second service opened on the Gold Coast shortly after recruitment had finished (July 2024).

In 2024, one quarter (24%) of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year, stable relative to 2023 (34%; $p=0.707$) (Figure 49). Of those who reported that they or someone else had tested their illicit drugs in the past year (n=20), 56% reported using colorimetric reagent test kits, and 50% reported having their drugs tested via testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips). No participants (n≤5) reported testing via professional testing equipment (e.g., Fourier Transform Infrared Spectroscopy).

Of those who reported that they or someone else had tested their illicit drugs in the past year (n=20), the majority (60%) reported having their drugs tested by a friend, followed by 50% who reported testing the drugs themselves. Few participants (n≤5) reported having their drugs tested by a dealer.

**Figure 49: Lifetime and past year engagement in drug checking, Hobart, TAS, 2019-2024**




Note: Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Statistical significance for 2023 versus 2024 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

## Alcohol Use Disorders Identification Test

The Alcohol Use Disorders Identification Test (AUDIT) was designed by the World Health Organization (WHO) as a brief screening scale to identify individuals with problematic alcohol use in the past 12 months.

The mean score on the AUDIT for the total Hobart sample (including people who had not consumed alcohol in the past 12 months) was 14.5 (SD 7.6) in 2024, a significant increase from 13.2 (SD 8.2) in 2023 ($p$<0.001). AUDIT scores are divided into four 'zones' which indicate risk level. Specifically, scores between 0-7 indicate low risk drinking or abstinence; scores between 8-15 indicate alcohol use in excess of low-risk guidelines; scores between 16-19 indicate harmful or hazardous drinking; and scores 20 or higher indicate possible alcohol dependence. There was no significant change in the per cent of the sample falling into each of these risk categories from 2023 to 2024 ($p$=0.703) (Table 5).

Eighty-four per cent of the sample obtained a score of eight or more (78% in 2023; $p$=0.515), indicative of hazardous use (Table 5).

Table 5: AUDIT total scores and per cent of participants scoring above recommended levels, Hobart, TAS, 2010-2024

| | 2010 N=99 | 2011 N=72 | 2012 N=98 | 2013 N=75 | 2014 N=99 | 2015 N=78 | 2016 N=99 | 2017 N=98 | 2018 N=99 | 2019 N=98 | 2020 N=100 | 2021 N=99 | 2022 N=72 | 2023 N=65 | 2024 N=81 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mean AUDIT total score (SD)** | 14.6 (5.4) | 19.3 (6.0) | 17.3 (6.1) | 15.5 (7.7) | 15.9 (6.5) | 16.1 (5.2) | 13.4 (6.6) | 14.2 (6.3) | 14.2 (7.0) | 12.5 (6.1) | 12.5 (5.5) | 13.5 (6.7) | 13.6 (7.8) | 13.2 (8.2) | **14.5*** (7.6)** |
| **Score 8≤ (%)** | 93 | 99 | 94 | 85 | 96 | 96 | 79 | 85 | 81 | 78 | 81 | 87 | 79 | 78 | **84** |
| **AUDIT zones (%)** | | | | | | | | | | | | | | | |
| **Score 0-7** | 7 | - | 6 | 15 | - | - | 21 | 15 | 19 | 22 | 19 | 13 | 21 | 22 | **16** |
| **Score 8-15** | 52 | 28 | 34 | 45 | 51 | 44 | 47 | 43 | 39 | 49 | 56 | 56 | 42 | 49 | **48** |
| **Score 16-19** | 20 | 19 | 27 | 11 | 17 | 23 | 14 | 22 | 17 | 18 | 12 | 15 | 18 | 11 | **16** |
| **Score 20≤** | 21 | 51 | 34 | 29 | 28 | 29 | 17 | 19 | 24 | 11 | 13 | 16 | 19 | 18 | **20** |

Note. Monitoring of AUDIT first commenced in 2010. Computed from the entire sample regardless of whether they had consumed alcohol in the past twelve months. Total AUDIT score range is 0-40, with higher scores indicating greater likelihood of hazardous and harmful drinking. Imputation used for missing scale scores. Statistical significance for 2023 versus 2024 presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

# Overdose Events

## Non-Fatal Overdose

Previously, participants had been asked about their experience in the past 12-months of i) stimulant overdose, and ii) depressant overdose.

From 2019, changes were made to this module, with participants asked about alcohol, stimulant and other drug overdose, prompted by the following definitions:

- **Alcohol overdose:** experience of symptoms (e.g., reduced level of consciousness and collapsing) where professional assistance would have been helpful.
- **Stimulant overdose:** experience of symptoms (e.g., nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, seizure, extreme paranoia, extreme anxiety, panic, extreme agitation, hallucinations, excited delirium) where professional assistance would have been helpful.
- **Other drug overdose (not including alcohol or stimulant drugs):** experience of symptoms where professional assistance would have been helpful. Note that in 2019, participants were prompted specifically for opioid overdose, but this was removed in 2020 as few participants endorsed this behaviour.

It is important to note that events reported on for each drug type may not be unique given high rates of polysubstance use among the sample.

For the purpose of comparison with previous years, we computed the per cent reporting any depressant overdose, comprising any endorsement of alcohol overdose, or other drug overdose where a depressant (e.g., opioid, GHB/GBL/1,4-BD, benzodiazepines) was listed.

## Non-Fatal Stimulant Overdose

In 2024, 35% of the Hobart sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview, stable relative to 2023 (23%; $p$=0.151) (Figure 50).

The most common stimulant reported during the most recent non-fatal stimulant overdose in the past 12 months was any form of ecstasy (48%), with 28% reporting this was after consuming ecstasy capsules, and 21% after consuming ecstasy crystal (n≤5 reported ecstasy pills). Two fifths (41%) reported using any form of methamphetamine during the most recent non-fatal stimulant overdose, with 38% reporting this was after consuming methamphetamine crystal (n≤5 reported methamphetamine powder).

Among those who experienced a recent non-fatal stimulant overdose and responded (n=28), 86% reported that they had also consumed one or more additional drugs on the last occasion, most notably, alcohol (61%; ≤5 standard drinks: 39%; ≥5 standard drinks: 21%) and cannabis (36%). On the last occasion of experiencing a non-fatal stimulant overdose (n=29), few participants (n≤5) reported receiving treatment or assistance. The most common reasons for not seeking treatment during the most recent non-fatal stimulant overdose was that the participant decided the overdose was not serious enough (52%), followed by fear of legal issues (24%). Due to low numbers (n≤5) reporting that they had received treatment or assistance, please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

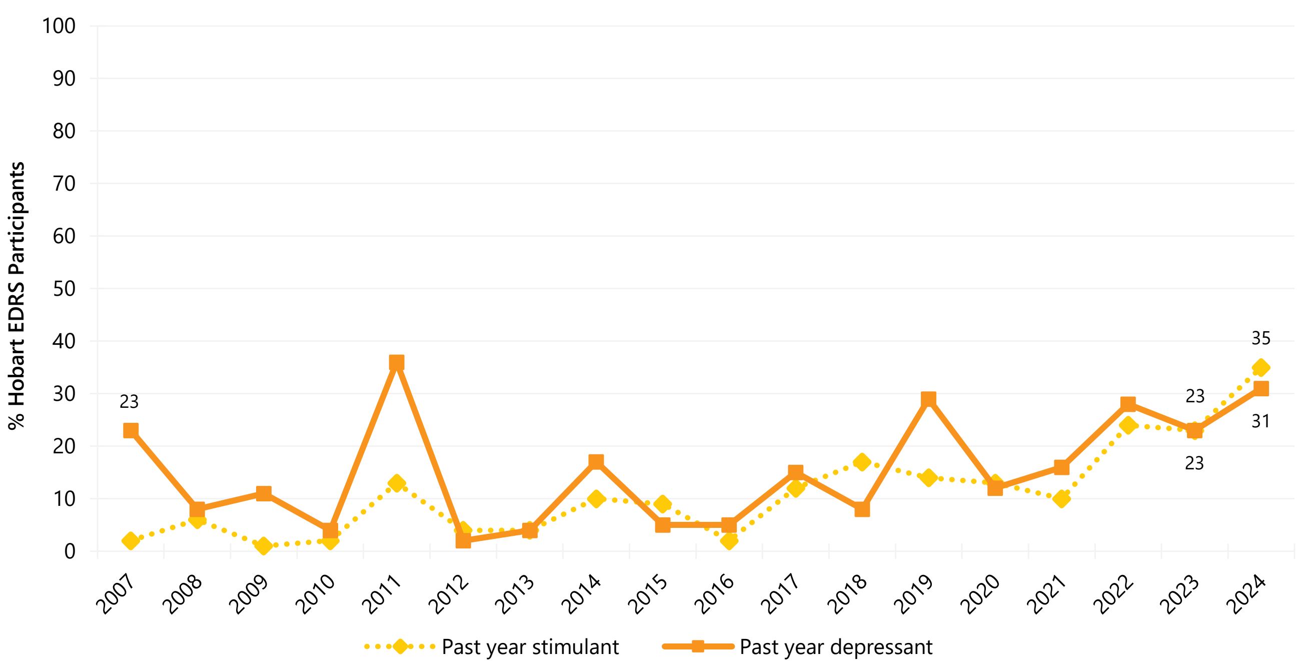
## Non-Fatal Depressant Overdose

**Alcohol:** Twenty-eight per cent of the Hobart sample reported a non-fatal alcohol overdose in the 12 months preceding interview (22% in 2023; $p$=0.457) on a median of two occasions (IQR=1-5). Of those who had experienced an alcohol overdose in the past year and commented (n=24), the majority (83%) reported not receiving treatment on the last occasion. The most common reason for not seeking treatment during the most recent non-fatal depressant overdose was that the participant decided the overdose was not serious enough (33%). Due to low numbers (n≤5) reporting that they had received treatment or assistance, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

**Any depressant (including alcohol):** In 2024, almost one third (31%) of participants reported that they had experienced a non-fatal depressant overdose in the past 12 months, stable relative to 2023 (23%; $p$=0.360) (Figure 50).

Of those who had experienced any depressant overdose in the past 12 months (n=27), the majority (89%) of participants reported alcohol as the most common depressant drug. Few participants (n≤5) reported a non-fatal depressant overdose due to other drugs; therefore, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

**Figure 50: Past 12 month non-fatal stimulant and depressant overdose, Hobart, TAS, 2007-2024**




Note. Past year stimulant and depressant overdose was first asked about in 2007. In 2019, items about overdose were revised, and changes relative to 2018 may be a function of greater nuance in capturing depressant events. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

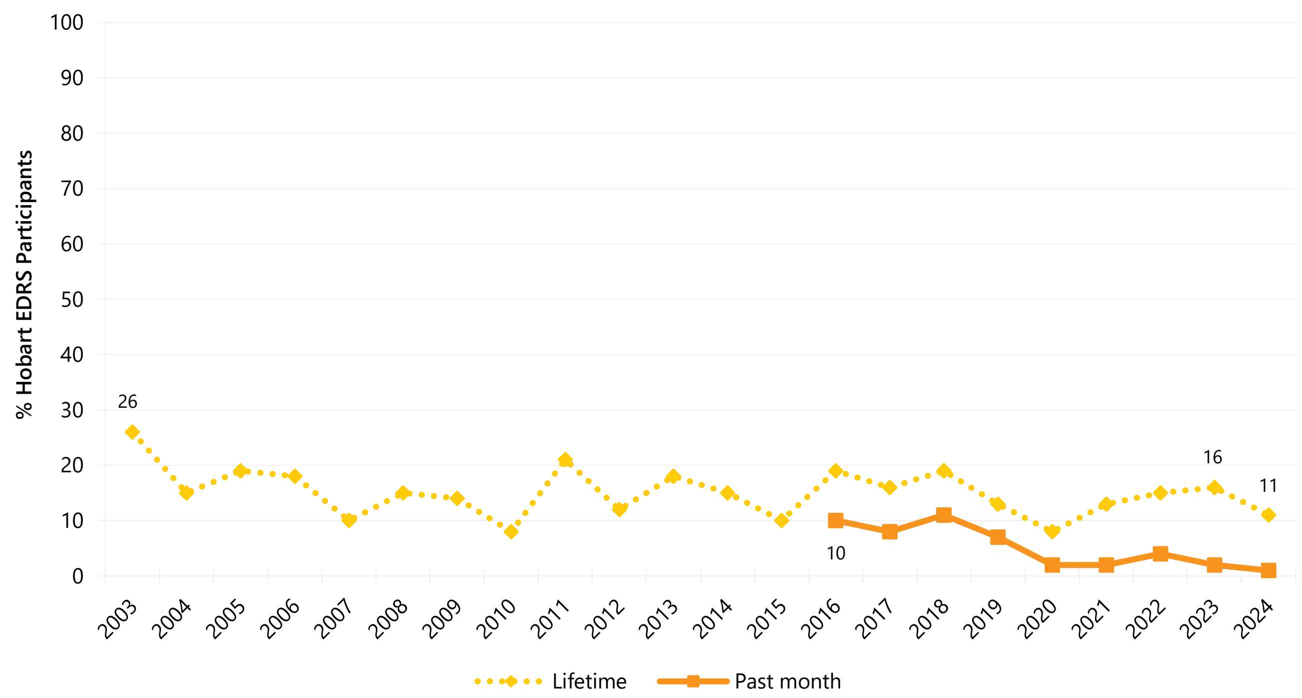
## Awareness of Naloxone

In 2024, three fifths (62%) reported that they had ever heard of naloxone, stable relative to 2023 (64%; $p$=0.856). Among those who had ever heard of naloxone and responded (n=51), 96% were able to correctly identify the purpose of naloxone, stable from 91% reporting so in 2023 ($p$=0.385). Among participants who had ever heard of naloxone and responded (n=51), one fifth (20%) reported (ever) obtaining naloxone (12% of entire sample). Few participants (n≤5) reported obtaining naloxone in the past 12 months preceding interview in 2023 and 2024 ($p$=0.741).

## Injecting Drug Use and Associated Risk Behaviours

Eleven per cent of the Hobart sample reported lifetime injection in 2024, stable relative to 2023 (16%; $p$=0.451). The per cent who reported injecting drugs in the past month remained low in 2024 (n≤5; n≤5 in 2023) (Figure 51); therefore, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

**Figure 51: Lifetime and past month drug injection, Hobart, TAS, 2003-2024**




Note. Items assessing whether participants had injected drugs in the past month were first asked in 2016. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Drug Treatment

In 2024, one tenth (10%) of the Hobart sample reported currently receiving drug treatment (11% in 2023). Among those who were currently receiving drug treatment and responded (n=9), the most common form of treatment reported was drug counselling (78%). Due to low numbers (n≤5) reporting on the other forms of treatment received, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

## Ecstasy and Methamphetamine Dependence

From 2017, participants were asked questions from the Severity of Dependence Scale (SDS) adapted to investigate ecstasy and methamphetamine dependence. The SDS is a five-item questionnaire designed to measure the degree of dependence on a variety of drugs. The SDS focuses on the psychological aspects of dependence, including impaired control of drug use, and preoccupation with, and anxiety about, use. A total score was created by summing responses to each of the five questions. Possible scores range from 0 to 15.

To assess ecstasy dependence in the past six months, a cut-off score of three or more was used, as this has been found to be a good balance between sensitivity and specificity for identifying problematic dependent ecstasy use. Among those who reported recent ecstasy use and responded (n=77), one fifth (22%) recorded a score of three or above (9% in 2023; $p$=0.059), indicating possible dependence in relation to ecstasy use. The median ecstasy SDS score was zero (IQR=0-2), with half (49%) of participants obtaining a score of zero, a significant decrease from 2023 (71%; $p$=0.022), indicating that less respondents reported no or few symptoms of dependence in relation to ecstasy use in 2024 (Table 6).

To assess methamphetamine dependence in the past six months, the cut-off of four and above, which is a more conservative estimate, has been used previously in the literature as a validated cut-off for methamphetamine dependence. Among those who reported recent methamphetamine use and responded (n=33), half (52%) scored four or above (27% in 2023; $p$=0.070), indicating possible dependence in relation to methamphetamine use. The median methamphetamine SDS score was four (IQR=0-8), with one third (33%) of participants obtaining a score of zero (38% in 2023; $p$=0.782), indicating no or few symptoms of dependence in relation to methamphetamine use (Table 6).

Table 6: Total ecstasy and methamphetamine SDS scores, and per cent of participants scoring above cut-off scores indicative of dependence, among those who reported past six month use, Hobart, TAS, 2017-2024

| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|
| **Ecstasy** | **n=100** | **n=99** | **n=93** | **/** | **n=88** | **n=68** | **n=55** | **n=77** |
| **Median total score (IQR)** | 0 (0-1) | 1 (0-2) | 0 (0-1) | / | 0 (0-2) | 0 (0-1) | 0 (0-1) | **0 (0-2)** |
| % score =0 | 57 | 47 | 63 | / | 51 | 62 | 71 | **49*** |
| % score ≥3 | 10 | 16 | 13 | / | 25 | 10 | - | **22** |
| **Methamphetamine** | **n=40** | **n=42** | **n=44** | **n=30** | **n=21** | **n=27** | **n=26** | **n=33** |
| **Median total score (IQR)** | 0 (0-2) | 0 (0-1) | 0 (0-1) | 0 (0-1) | 1 (0-4) | 0 (0-3) | 1 (0-5) | **4 (0-8)** |
| % score =0 | 58 | 62 | 68 | 70 | 48 | 56 | 38 | **33** |
| % score ≥4 | 23 | - | 20 | - | 29 | 22 | 27 | **52** |

Note. Severity of Dependence scores calculated out of those who used ecstasy/methamphetamine recently (past 6 months). A cut-off score of ≥3 and ≥4 is used to indicate screening positive for potential ecstasy and methamphetamine dependence, respectively. Imputed values used for missing scale scores. Statistical significance for 2023 versus 2024 presented in table; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Sexual Health Behaviours

In 2024, almost three quarters (72%) of the Hobart sample reported some form of sexual activity in the past four weeks (81% in 2023; $p$=0.231) (Table 7). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if the interview was undertaken face-to-face).

Of those who had engaged in sexual activity in the past four weeks and responded (n=59), 78% reported using alcohol and/or other drugs prior to or while engaging in sexual activity, stable relative to 2023 (68%; $p$=0.358). Of those who had engaged in sexual activity in the past four weeks and responded (n=59), 10% reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (n≤5 in 2023), while 39% reported that they had used alcohol and/or other drugs to enhance sexual activity or pleasure with another person (not asked prior to 2024). Few participants (n≤5) had engaged in sexual activity in exchange for money, drugs, or other goods or services (not asked prior to 2024) (Table 7).

Of those who commented (n=82), almost two fifths (37%) reported having a sexual health check-up in the six months prior to interview (31% in 2023; $p$=0.578), whilst 73% had done so in their lifetime (84% in 2023; $p$=0.215). Of the total sample who responded (n=82), few participants (n≤5) reported having received a positive diagnosis for a sexually transmitted infection (STI) in the past six months in 2024 (n≤5 in 2023), with one fifth (22%) having received a positive STI diagnosis in their lifetime (29% in 2023; $p$=0.422) (Table 7). Due to low numbers (n≤5) reporting on the specific types of STIs diagnosed, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

Of those who commented (n=79), one quarter (27%) of the Hobart sample reported having a test for human immunodeficiency virus (HIV) in the six months prior to interview (15% in 2023; $p$=0.145), whilst 62% had done so in their lifetime (70% in 2023; $p$=0.451). No participants had been diagnosed with HIV in the past six months prior to interview or within their lifetime in 2023 and 2024 (Table 7).

Table 7: Sexual health behaviours, Hobart, TAS, 2021-2024

| | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|
| **Of those who responded#:** | n=81 | n=48 | n=44 | **n=59** |
| **% Any sexual activity in the past four weeks** | 82 | 79 | 81 | **72** |
| **Of those who responded# and reported any sexual activity in the past four weeks:** | n=82 | n=47 | n=44 | **n=59** |
| % Drugs and/or alcohol used prior to or while engaging in sexual activity | 82 | 85 | 68 | **78** |
| **Of those who responded# and reported any sexual activity in the past four weeks:** | n=82 | n=48 | n=42 | **n=59** |
| % Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity | 11 | - | - | **10** |
| % Drugs and/or alcohol used to enhance sexual activity or pleasure with another person | / | / | / | **39** |
| **Of those who responded# and reported any sexual activity in the past four weeks:** | / | / | / | **n=59** |
| % Engaged in sexual activity in exchange for money, drugs or other goods or services^ | / | / | / | **-** |
| **Of those who responded#:** | n=98 | n=60 | n=53 | **n=79** |
| % Had a HIV test in the last six months | 18 | 22 | 15 | **27** |
| % Had a HIV test in their lifetime | 53 | 57 | 70 | **62** |
| **Of those who responded#:** | n=98 | n=60 | n=53 | **n=79** |
| % Diagnosed with HIV in the last six months | 0 | 0 | 0 | **0** |
| % Diagnosed with HIV in their lifetime | - | 0 | 0 | **0** |
| **Of those who responded#:** | n=100 | n=61 | n=55 | **n=82** |
| % Had a sexual health check in the last six months | 39 | 39 | 31 | **37** |
| % Had a sexual health check in their lifetime | 80 | 89 | 84 | **73** |
| **Of those who responded#:** | n=98 | n=60 | n=55 | **n=82** |
| % Diagnosed with a sexually transmitted infection in the last six months | - | - | - | **-** |
| % Diagnosed with a sexually transmitted infection in their lifetime | 18 | 26 | 29 | **22** |

Note. #Due to the sensitive nature of these items, there is missing data for some participants who chose not to respond. Statistical significance for 2023 versus 2024 presented in table; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

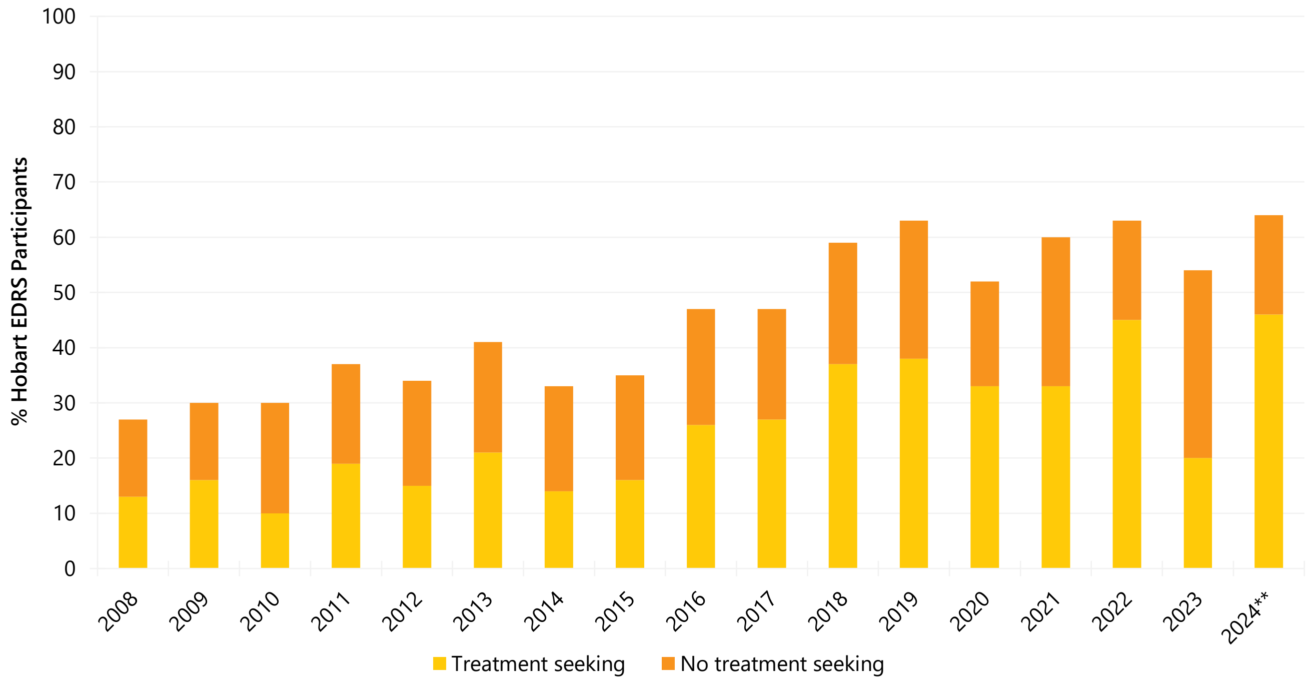
# Mental Health and Psychological Distress (K10)

## Mental Health

In 2024, almost two thirds (64%) of the Hobart sample self-reported that they had experienced a mental health problem in the preceding six months (other than drug dependence), stable relative to 2023 (54%; $p$=0.246). Of those who reported a mental health problem and commented (n=55), the common mental health problems reported, stable relative to 2023, were anxiety (71%; 68% in 2023; $p$=0.316), depression (58%; 53% in 2023; $p$=0.291), and post-traumatic stress disorder (PTSD) (29%; 21% in 2023; $p$=0.259). In contrast, there was a significant increase of participants who self-reported experiencing attention-deficit/hyperactivity disorder (ADHD), with almost two fifths (38%) reporting ADHD as a mental health problem (n≤5 in 2023; $p$=0.004).

Of those who reported experiencing a mental health problem (n=56), 71% reported seeing a mental health professional during the past six months (46% of the total sample), a significant increase from 34% in 2023 ($p$=0.001) (Figure 52). Of those who reported seeing a mental health professional (n=40), four fifths (80%) of the Hobart sample reported being prescribed medication for their mental health problem (62% in 2023; $p$=0.265).

**Figure 52: Self-reported mental health problems and treatment seeking in the past six months, Hobart, TAS, 2008-2024**




Note. Questions about treatment seeking were first asked in 2008. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Psychological Distress (K10)

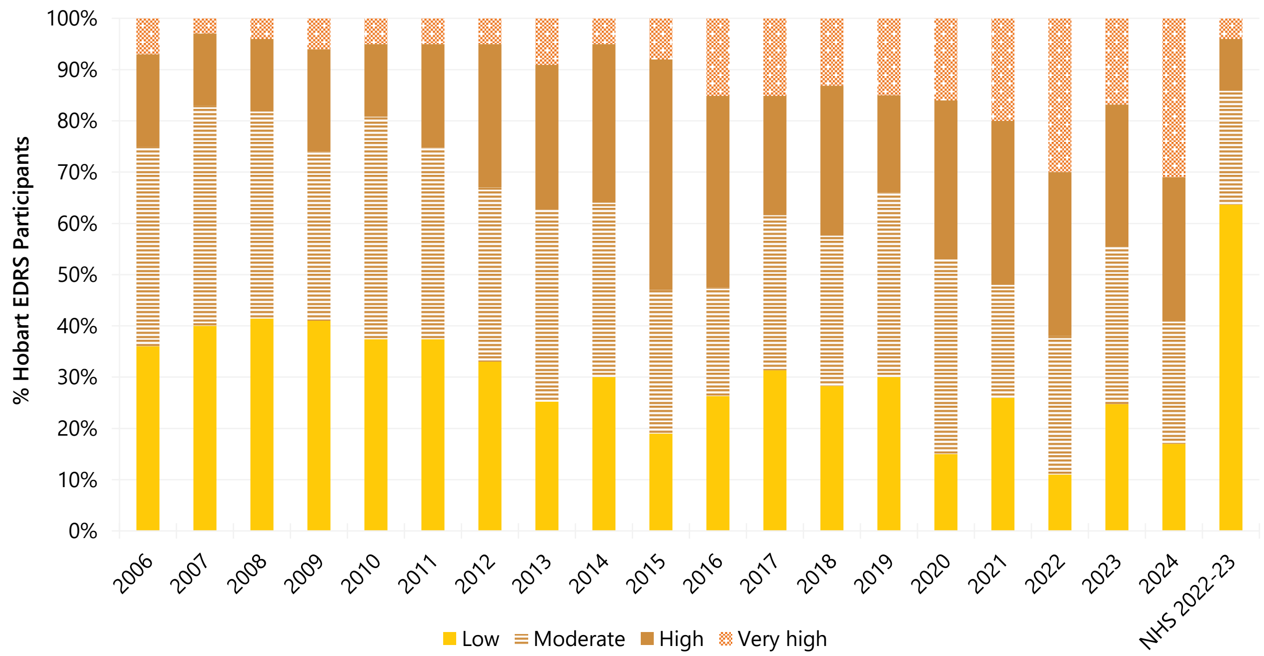
The Kessler Psychological Distress Scale 10 (K10) was administered to obtain a measure of psychological distress in the past four weeks. It is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured by the Diagnostic and Statistical Manual of Mental Disorders and the Structured Clinical Interview for DSM disorders.

The minimum score is 10 (indicating no psychological distress) and the maximum is 50 (indicating very high psychological distress). Scores can be coded into four categories to describe degrees of distress: scores from 10–15 are considered to indicate 'low' psychological distress; scores between 16–21 indicate 'moderate' psychological distress; scores between 22–29 indicate 'high' psychological distress; and scores between 30–50 indicate 'very high' psychological distress. Among the general population, scores of 30 or more have been demonstrated to indicate a high likelihood of having a mental health problem, and possibly requiring clinical assistance.

The per cent of participants scoring in each of the four K10 categories remained stable relative to 2023 ($p$=0.201). Among those who responded in 2024 (n=87), 31% had a score of 30 or more (17% in 2023) (Figure 53).

The National Health Survey 2022-23 provides Australian population data for adult (≥18 years) K10 scores. EDRS participants in 2024 reported greater levels of 'high' and 'very high' distress compared to the general population (Figure 53).

**Figure 53: K10 psychological distress scores, Hobart, TAS, 2006-2024 and among the general population, 2022-2023**




Note. Data from the National Health Survey are a national estimate from 2022-23 for adults 18 or older. Imputation used for missing scale scores (EDRS only). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2023 versus 2024 presented in table; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

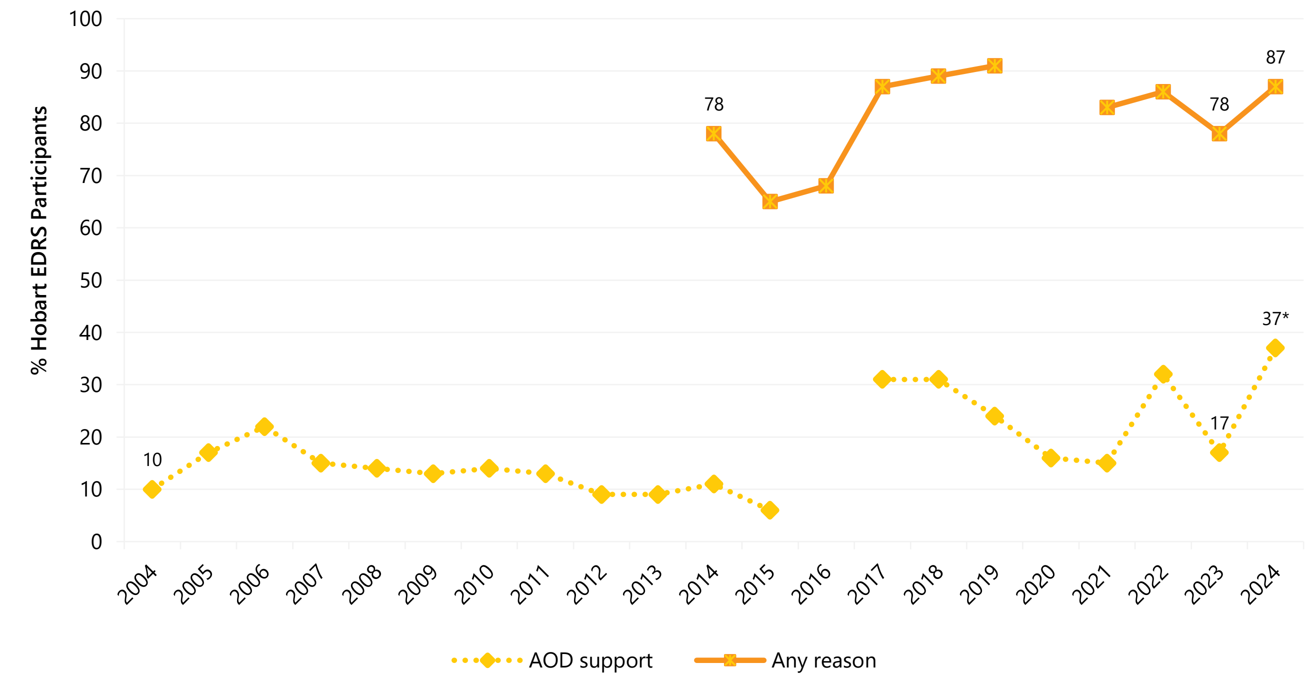
## Health Service Access

Almost two fifths (37%) of participants in the Hobart sample reported accessing any health service for alcohol and/or drug support (AOD) in the six months preceding interview, a significant increase from 2023 (17%; *p*=0.014) (**Error! Reference source not found.**). In 2024, the most common services r eported as accessed by participants included a general practitioner (GP) (20%; 9% in 2023; *p*=0.115), followed by the emergency department (9%; n≤5 in 2023; *p*=0.560) and a drug and alcohol counsellor (9%; n≤5 in 2023; *p*=0.560) (Table 8).

The majority (87%) of participants reported accessing any health service for any reason in the six months preceding interview in 2024, stable from 78% in 2023 (*p*=0.190) (**Error! Reference source not f ound.**). In 2024, the most common services accessed by participants was a GP (76%; 58% in 2023; *p*=0.037), followed by a pharmacy (38%; not asked prior to 2024), the emergency department (29%; 22% in 2023; *p*=0.353), a psychologist (28%; 20% in 2023; *p*=0.343) and a dentist (24%; 32% in 2023; *p*=0.282) (Table 8).

Of the twenty-nine per cent of participants who reported attending the emergency department for any reason in the past six months (22% in 2023; *p*=0.353), the most common reason for attending was injury (13%). Furthermore, one tenth (10%) of participants reported being attended to by an ambulance for any reason in the past six months (n≤5 in 2023; *p*=0.778). Due to low numbers (n≤5) reporting on the specific reasons for being attended to by an ambulance, further details are not reported. Please refer to the [2024 National EDRS Report] for national trends, or contact the Drug Trends team for further information.

**Figure 54: Health service access for alcohol and other drug reasons and any reason in the past six months, Hobart, TAS, 2004-2024**




Note. Questions about health service access for any reason were first asked about in 2015. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

Table 8: Types of health service accessed for alcohol and other drug reasons and for any reason in the past six months, Hobart, TAS, 2022-2024

| | AOD support | | | Any reason | | |
|---|---|---|---|---|---|---|
| | 2022 N=72 | 2023 N=65 | 2024 N=87 | 2022 N=72 | 2023 N=65 | 2024 N=87 |
| **% Accessing health services** | 32 | 17 | **37*** | 86 | 78 | **87** |
| **% Type of service accessed *(participants could select multiple services)*** | | | | | | |
| GP | 15 | 9 | **20** | 76 | 58 | **76*** |
| Emergency department | - | - | **9** | 14 | 22 | **29** |
| Hospital admission (inpatient) | - | - | **-** | 13 | 14 | **8** |
| Medical tent (e.g., at a festival) | - | - | **-** | 0 | - | **-** |
| Drug and Alcohol counsellor | 8 | - | **9** | 8 | - | **9** |
| Hospital as an outpatient | - | - | **-** | - | 11 | **8** |
| Specialist doctor (not including a psychiatrist) | 0 | - | **0** | 17 | - | - |
| Dentist | - | - | **-** | 28 | 32 | **24** |
| Ambulance attendance | - | - | **-** | - | - | **10** |
| Pharmacy | / | / | **-** | / | / | **38** |
| Other health professional (e.g., physiotherapist) | - | - | **0** | 13 | - | **9** |
| Psychiatrist | - | - | **-** | 13 | - | **8** |
| Psychologist | 13 | - | **-** | 36 | 20 | **28** |
| NSP | - | 0 | **-** | - | 0 | **-** |
| Peer based harm reduction service | 0 | - | **-** | - | - | **-** |
| Other harm reduction service | - | 0 | **-** | - | - | **-** |

Note. Statistical significance for 2023 versus 2024 presented in table; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# Stigma

Questions regarding stigma were derived from the Stigma Indicators Monitoring Project, with stigma defined as people being treated negatively or differently because of their illicit drug use. These questions have been asked, in part, since 2022.

In 2024, almost two fifths (38%) of the Hobart sample reported experiencing stigma because of their illicit drug use in any health/non-health care setting in the six months preceding interview (28% in 2023; $p$=0.229) (Table 9).

One tenth (11%) of participants reported experiencing stigma within specialist alcohol and other drug (AOD) services in the six months preceding interview (n≤5 in 2023; $p$=0.114). A larger percentage, however, reported experiencing stigma within general health care services in the six months preceding interview (18%; 20% of those who had attended general health care services), stable relative to 2023

(20% in 2023; $p=0.828$). Almost one third (30%) of participants reported experiencing stigma in non-health care settings (17% in 2023; $p=0.090$), most commonly from police (17%; 9% in 2023), followed by welfare/social services (9%; n≤5 in 2023) (Table 9).

Half (52%) of participants reported engaging in some form of avoidance behaviour to avoid being treated negatively or differently by an AOD specialist or general healthcare services (47% in 2023; $p=0.618$). This most commonly involved not telling health workers about their drug use (37%), followed by delaying accessing health care (25%) and downplaying need for pain medication (19%).

**Table 9: Self-reported experiences of stigma due to illicit drug use in the past six months, Hobart, TAS, 2022-2024**

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| **% Experienced stigma in specialist AOD service** | N=71<br>14 | N=64<br>- | **N=83**<br>**11** |
| **% Experienced stigma in general health care service** | N=71<br>18 | N=51<br>20 | **N=83**<br>**18** |
| **% Experienced stigma in non-health care service** | / | n=64<br>17 | **n=87**<br>**30** |
| Welfare and social services | / | - | **9** |
| Current or potential employer | / | - | **8** |
| School/uni/TAFE | / | - | **-** |
| Police | / | 9 | **17** |
| Other legal services | / | 0 | **-** |
| Housing and homelessness services | / | - | **-** |
| Other | / | - | **-** |
| **% Experienced stigma in any of the above settings^** | / | 28 | **38** |
| **% Did any of the following to avoid being treated negatively or differently by AOD specialist or general healthcare services** | / | n=64<br>47 | **n=83**<br>**52** |
| Delayed accessing healthcare | / | 13 | **25** |
| Did not tell health worker about drug use | / | 38 | **37** |
| Downplayed need for pain medication | / | 9 | **19** |
| Looked for different services | / | - | **16** |
| Did not attend follow-up appointment | / | 16 | **16** |
| Other | / | - | **-** |

Note. N is the number who responded (denominator). ^Includes specialist AOD service, general health care service and non-health care services. Statistical significance for 2023 versus 2024 presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

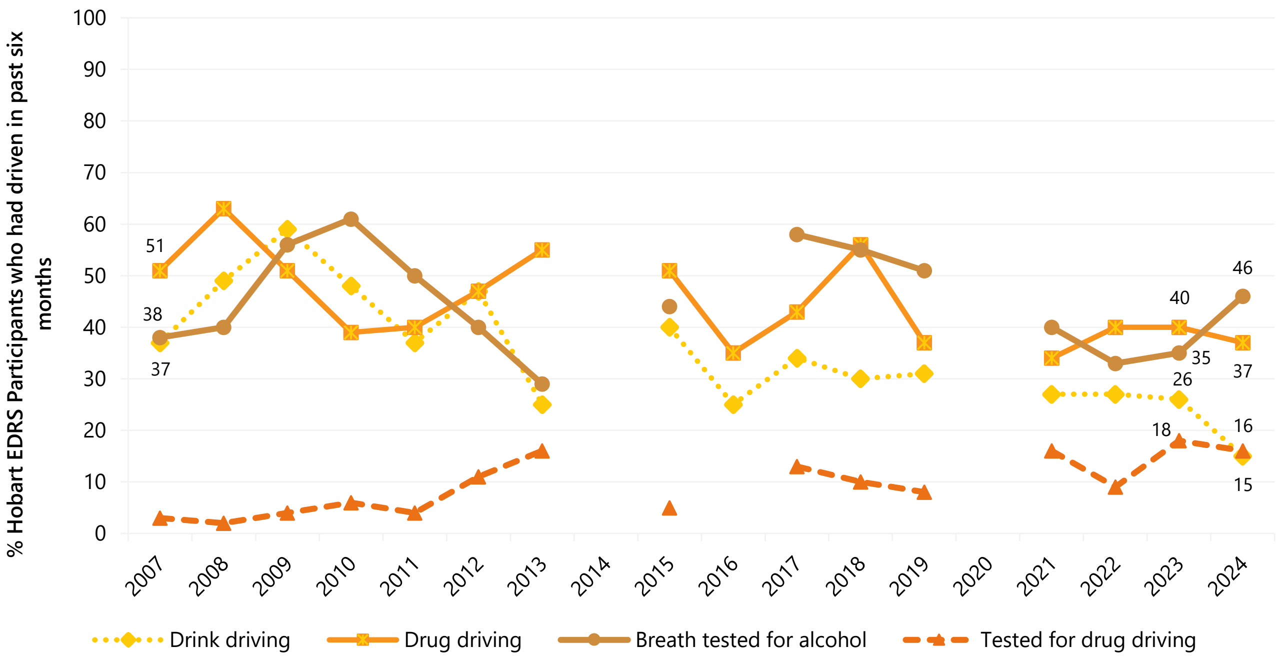
## Driving

In 2024, almost three quarters (74%) of the Hobart sample had driven a car, motorcycle, or other vehicle in the last six months. Of those who had driven in the past six months and responded (n=61), 15% perceived that they had driven while over the perceived legal limit of alcohol (26% in 2023; *p*=0.173).

Of those who had driven in the past six months and responded (n=63), 37% reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months (40% in 2023; *p*=0.709) (Figure 55). Participants most commonly reported using cannabis (65%) prior to driving in the last six months, followed by methamphetamine crystal (26%).

Among those who had driven in the past six months (n=63), 46% reported that they had been breath tested for alcohol by the police roadside testing service in the six months prior to interview (35% in 2023; *p*=0.258), and 16% reported that they had been tested for drug driving by the police roadside drug testing service (18% in 2023; *p*=0.803) (Figure 55).

**Figure 55: Self-reported testing, and driving over the (perceived) legal limit for alcohol or three hours following illicit drug use, among those who had driven in the past six months, Hobart, TAS, 2007-2024**




Note. Computed of those who had driven a vehicle in the past six months (n=63). Questions about driving behaviour were first asked about in 2007. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Experience of Crime and Engagement with the Criminal Justice System

In 2024, two fifths (41%) of the Hobart sample reported ‘any’ engagement in crime in the past month (30% in 2023; *p*=0.178), with selling drugs for cash profit (26%; 16% in 2023; *p*=0.168) and property crime (24%; 19% in 2023; *p*=0.545) being the two main forms of self-reported criminal activity in the month preceding interview (Figure 56).

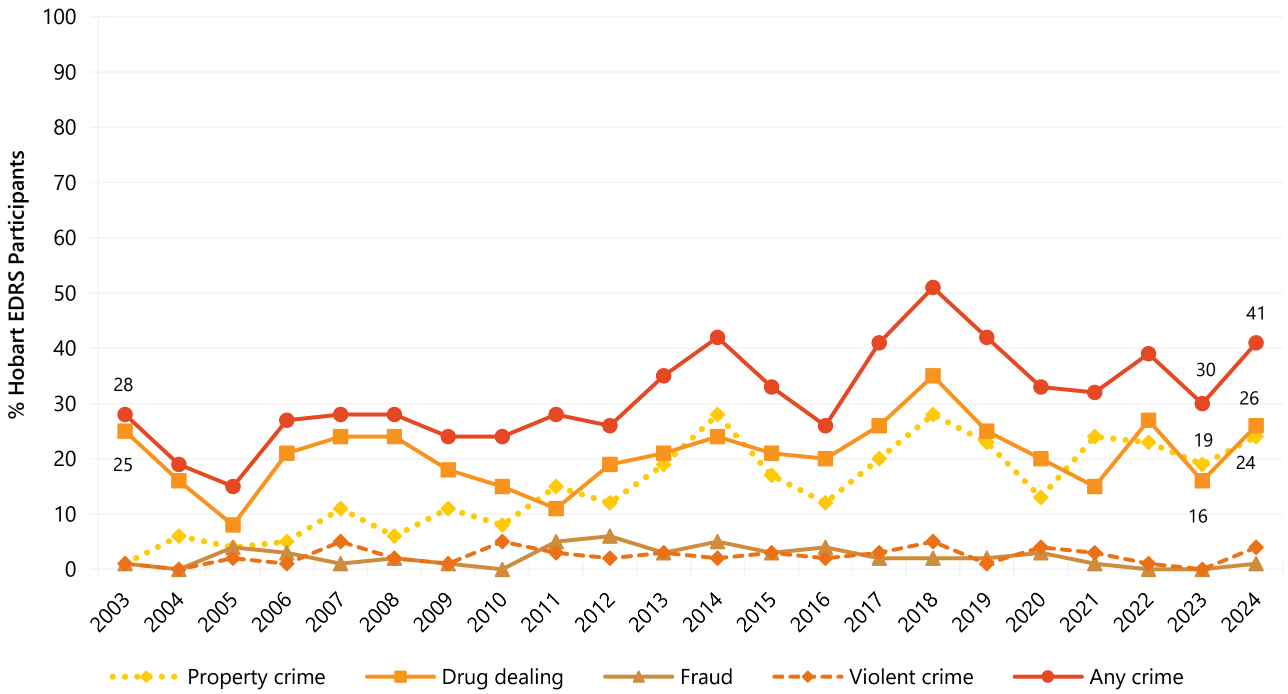
In 2024, one tenth (9%) of the Hobart sample reported being the victim of a crime involving violence, a significant increase relative to 2023 (0%; *p*=0.011) (Figure 57).

Eight per cent reported having ever been in prison in 2024, stable relative to 2023 (n≤5) (Figure 58).

Eleven per cent of the Hobart sample reported having been arrested in the 12 months preceding interview (n≤5 in 2023; *p*=0.559) (Figure 58). Few participants (n≤5) reported specific reasons for arrest; therefore, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

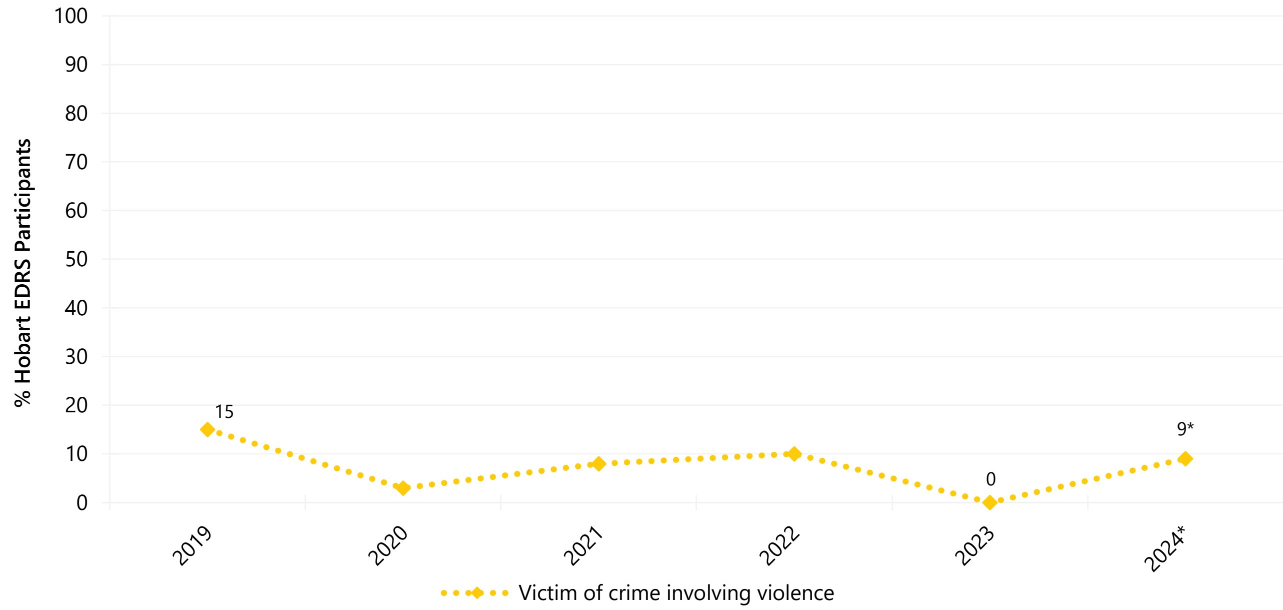
Almost one fifth (18%) of participants reported a drug-related encounter with police, which did not result in charge or arrest in the past 12 months (9% in 2023; *p*=0.171) (Figure 58). This predominantly comprised of being stopped for questioning (63%; 50% in 2023; *p*=0.655).

**Figure 56: Self-reported criminal activity in the past month, Hobart, TAS, 2003-2024**



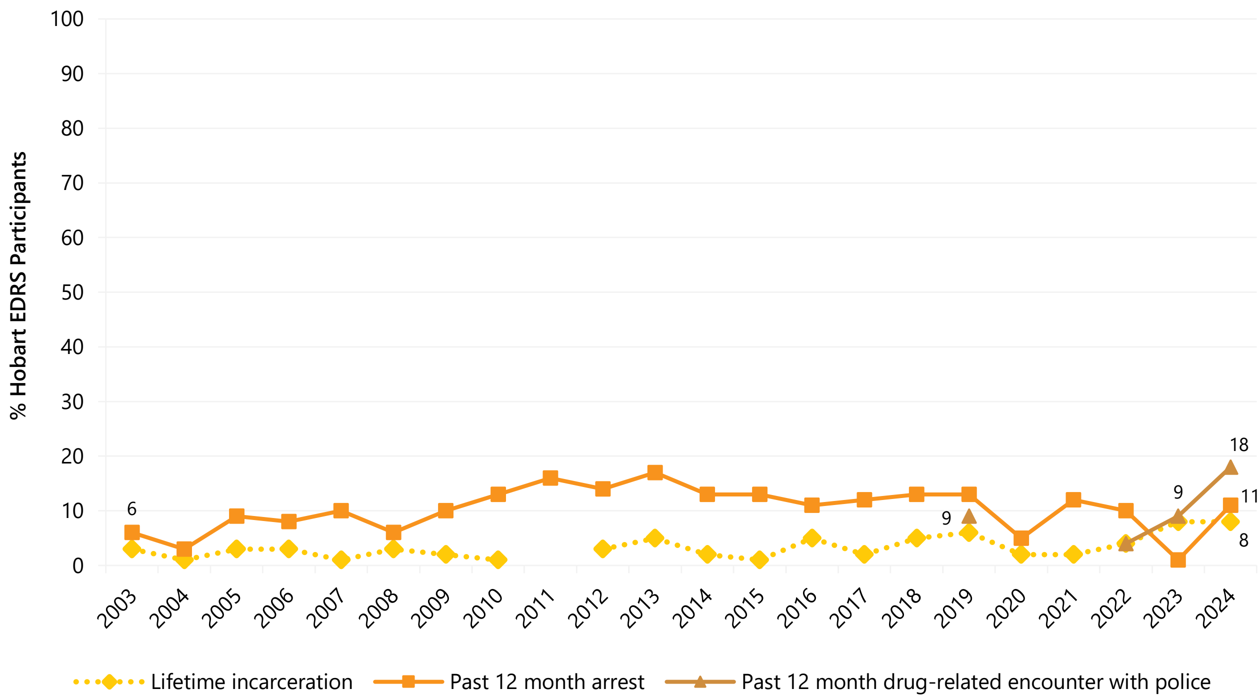

Note. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Figure 57: Victim of crime involving violence in the past month, Hobart, TAS, 2019-2024




Note. Questions regarding being the victim of a crime involving violence were first asked in 2019. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

## Figure 58: Lifetime incarceration, and past 12 months arrest and drug-related encounters with police that did not result in arrest, Hobart, TAS, 2003-2024




Note. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2023 versus 2024 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001. Please refer to Table 1 for a guide to table/figure notes.

# Modes of Purchasing Illicit or Non-Prescribed Drugs

In interviewing and reporting, 'online sources' were defined as either surface or darknet marketplaces.

## Purchasing Approaches

In 2024, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (73%; 73% in 2023) and via social networking or messaging applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (57%; 51% in 2023; $p$=0.511) (Table 10). It is important to re-iterate that this refers to people *arranging the purchase* of illicit or non-prescribed drugs. This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person.

Among those who had used social networking or messaging applications to arrange the purchase of illicit or non-prescribed drugs in the 12 months preceding interview, the most commonly used social networking or messaging apps were Snapchat (76%) and Facebook (45%), with substances mostly obtained from a friend/relative/partner/colleague (69%), followed by a known dealer/vendor (69%). Among those who used social networking or messaging apps to arrange the purchase of drugs in 2024 and responded (n=49), 41% reported that the person they had obtained drugs from advertised the sale of illicit drug/s via these platforms.

## Buying and Selling Drugs Online

Few participants (n≤5) reported obtaining drugs via the darknet (n≤5 in 2023) or the surface web (0% in 2023; $p$=0.509) in the past year. However, one third (33%) of participants reported ever obtaining illicit drugs through someone who had purchased them on the surface web or darknet, with 21% having done so in the last 12 months, a significant decrease from 2023 (38%; $p$=0.048).

In 2024, few participants (n≤5) reported selling illicit/non-prescribed drugs via surface or darknet marketplaces in the 12 months preceding interview (n≤5 in 2023).

## Source and Means of Obtaining Drugs

Three quarters (77%) of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2024 (68% in 2023; $p$=0.262), followed by 51% reporting obtaining illicit drugs from a known dealer/vendor (55% in 2023; $p$=0.747). One fifth (22%) reported obtaining illicit drugs from an unknown dealer/vendor (16% in 2023; $p$=0.414) (Table 10).

When asked about how they had received illicit drugs on any occasion in the last 12 months, the majority of participants (92%) reported face-to-face (87% in 2023; $p$=0.412), followed by one quarter (26%) reporting using a collection point (defined as a predetermined location where a drug will be dropped for later collection), a significant increase from 2023 (8%; $p$=0.009). One tenth (9%) of participants reporting receiving illicit drugs via the post (10% in 2023) (Table 10).

**Table 10: Means of purchasing and obtaining illicit drugs in the past 12 months, Hobart, TAS, 2019-2024**

| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|
| | N=98 | N=100 | N=98 | N=64 | N=63 | N=86 |
| **% Purchasing approaches in the last 12 months^#** | n=98 | n=100 | n=98 | n=63 | n=63 | **n=86** |
| Face-to-face | 88 | 60 | 70 | 73 | 73 | **73** |
| Surface web | 4 | - | - | - | 0 | **-** |
| Darknet market | 7 | 8 | 4 | - | - | **-** |
| Social networking or messaging applications` | 68 | 71 | 66 | 67 | 51 | **57** |
| Text messaging | 43 | 34 | 37 | 35 | 30 | **37** |
| Phone call | 35 | 33 | 27 | 24 | 25 | **31** |
| Grew/made my own | / | - | - | - | - | **-** |
| Other | 0 | - | 0 | 0 | 0 | **-** |
| **% Means of obtaining drugs in the last 12 months^~** | n=98 | n=100 | n=98 | n=64 | n=62 | **n=86** |
| Face-to-face | 87 | 94 | 91 | 95 | 87 | **92** |
| Collection point | 10 | 11 | 10 | - | - | **26**** |
| Post | 8 | 12 | 7 | 11 | 10 | **9** |
| **% Source of drugs in the last 12 months^** | n=98 | n=98 | n=98 | n=64 | n=62 | **n=86** |
| Friend/relative/partner/colleague | 91 | 86 | 94 | 86 | 68 | **77** |
| Known dealer/vendor | 62 | 69 | 68 | 63 | 55 | **51** |
| Unknown dealer/vendor | 32 | 22 | 22 | 42 | 16 | **22** |

Note. ^Participants could endorse multiple responses. #This refers to people *arranging the purchase* of illicit or non-prescribed drugs. `This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person. ~The face-to-face response option from 2021 was combined by those responding, 'I went and picked up the drugs', 'The drugs were dropped off to my house by someone' and/or 'Was opportunistic – I arranged and collected at the same time (e.g., at an event/club.)' Statistical significance for 2023 versus 2024 presented in table; **p*<0.050; ***p*<0.010; ****p*<0.001. Please refer to Table 1 for a guide to table/figure notes.