EDRS

AUSTRALIAN CAPITAL TERRITORY DRUG TRENDS 2025

Key Findings from the Australian Capital Territory Ecstasy and Related Drugs Reporting System (EDRS) Interviews

AUSTRALIAN CAPITAL TERRITORY DRUG TRENDS 2025: KEY FINDINGS FROM THE ECSTASY AND RELATED DRUGS REPORTING SYSTEM (EDRS) INTERVIEWS

Julia Uporova[1], Amy Peacock[1,2] & Rachel Sutherland[1]

[1] National Drug and Alcohol Research Centre, UNSW Sydney

[2] School of Psychology, University of Tasmania

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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.

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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 2025:

- Dr Rachel Sutherland, Antonia Karlsson, Julia Uporova, Udesha Chandrasena, Olivia Price, Haniene Tayeb, Lily Palmer, Agata Chrzanowska, Cate King, 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;
- Mila Sumner, Joanna Wilson and Professor Paul Dietze, Burnet, Victoria;
- Sophie Radke and Professor Raimondo Bruno, School of Psychology, University of Tasmania, Tasmania;
- Dr Jodie Grigg 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 Evie McEachern, Dyah Ayu Kartika, Rosemary Agnew, Sari Dewi and Dananja Wanninayake for conducting the Canberra, ACT EDRS interviews in 2025. We would also like to thank 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

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
Alpha PHP	α-Pyrrolidinohexiophenone
AOD	Alcohol and Other Drug
AUDIT-C	Alcohol Use Disorders Identification Test-Concise
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/GHB/1,4-BD	Gamma-butyrolactone/Gamma-hydroxybutyrate/1,4-Butanediol
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
N (or n)	Number of participants
NBOME	N- methoxybenzyl
NDARC	National Drug and Alcohol Research Centre
NPS	New Psychoactive Substances
NSP	Needle Syringe Program
NSW	New South Wales
NT	Northern Territory
OTC	Over-the-counter
PMA	Paramethoxyamphetamine
PMMA	Polymethyl Methacrylate
QLD	Queensland
REDCAP	Research Electronic Data Capture
SA	South Australia
SD	Standard deviations
VIC	Victoria

Executive Summary

The Canberra, Australian Capital Territory (ACT) 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 Canberra, ACT. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2025 from April-June. 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 2020-2025 samples, relative to previous years.**

Sample Characteristics

The 2025 Canberra EDRS sample (N=100) was broadly similar to 2024 and to previous years. Gender remained stable between 2024 and 2025, with 56% identifying as male in 2025, and participants had a median age of 21 years. Participants reported completing a mean of 12 years of school in 2025 (range: 8-12) and 54% were current students. Current accommodation remained stable between 2024 and 2025, with most participants reporting living in a rented house/flat (66%). There was a significant change in current employment status in 2025 relative to 2024 (p=0.016), with fewer participants reporting full-time employment (14% versus 33% in 2024) and more reporting part-time or casual employment (50% versus 39% in 2024). Median weekly income was also significantly lower in 2025 ($500 versus $650 in 2024; p=0.009). Drug of choice and drug used most often in the preceding month were largely stable between 2024 and 2025. Cannabis remained the most common drug of choice (31% versus 35% in 2024), followed by ecstasy (17%), alcohol (15%), and cocaine (9%). Cannabis was also the drug most often used in the past month (38% versus 47% in 2024). Weekly or more frequent use of non-prescribed cannabis (56%), ecstasy (12%), methamphetamine (12%) and cocaine (11%) all remained stable in 2025, relative to 2024.

Non-Prescribed Ecstasy

Recent use of any non-prescribed ecstasy significantly increased in 2025 (98% versus 90% in 2024; p=0.033), though frequency of use remained stable (median 6 days). Crystal (59%) emerged as the most commonly used form for the first time, followed closely by capsules (58%). Participants reported using a greater number of different forms in 2025 (median 2 versus 1 in 2024; p=0.005). The median price of pills ($25), capsules ($23), crystal ($180/gram), and powder ($155/gram) remained stable in 2025, relative to 2024. Perceptions of purity and availability of all forms also remained stable in 2025, relative to 2024.

Methamphetamine

Recent use of any methamphetamine remained stable in 2025 (18% versus 21% in 2024). However, frequency of use increased significantly, with participants reporting a median of 48 days in the six months preceding interview (twice weekly) compared to five days in 2024 (p=0.029). Among those who reported recent use, two thirds (67%) reported weekly or more frequent use (versus n≤5 in 2024; p=0.011). Among participants who had used methamphetamine, recent use of crystal significantly increased (78% versus 43% in 2024; p=0.049), with smoking the most common route of administration (93%).

Perceptions of price, purity, and availability of methamphetamine powder and crystal were mostly stable in 2025, relative to 2024.

However, there was a significant change in the perceived availability of powder (p=0.020), with more participants reporting it as 'easy' to obtain in 2025 (78% vs. 21% in 2024), and fewer reporting it as 'difficult' to obtain.

Non-Prescribed Pharmaceutical Stimulants

In 2025, 65% of the sample reported recent use of non-prescribed pharmaceutical stimulants, the highest percentage since monitoring commenced, although stable relative to 2024 (56%). Frequency of use also remained stable at a median of six days. The majority (78%) of those who had recently used non-prescribed pharmaceutical stimulants reported using dexamfetamine. Swallowing remained the most common route of administration (89%), followed by snorting (18%). Price and perceived availability remained stable in 2025 relative to 2024.

Cocaine

In 2025, 86% of the sample reported recent use of cocaine on a median of four days, stable relative to 2024. The majority of participants who had recently used cocaine reported using powder cocaine (97%). The median quantity consumed in a typical session (0.50 grams) and maximum session (0.55 grams) both decreased significantly relative to 2024 (0.90 grams; p=0.024 and 1.00 gram; p=0.005, respectively). The median price for one gram of cocaine remained stable at $300, consistent since 2006. Perceived purity and availability remained stable.

Cannabis and/or Cannabinoid-Related Products

In 2025, 87% of the sample reported recent non-prescribed use of cannabis and/or cannabinoid-related products on a median of 72 days, stable relative to 2024. The most commonly used form was bush cannabis (84%), a significant increase from 58% in 2024 (p<0.001), followed by hydroponic cannabis (45%). The price and perceived potency of both hydroponic and bush cannabis remained stable in 2025 relative to 2024. However, there was a significant change in the perceived availability of bush cannabis (p=0.049), with 93% reporting it was 'very easy' to obtain in 2025, an increase from 74% in 2024.

Non-Prescribed Ketamine, LSD and DMT

In 2025, recent use of non-prescribed ketamine (57%), LSD (28%) and DMT (6%) remained stable relative to 2024, as did frequency of use (median 6 days for ketamine, 2 days for LSD, and 1 day for DMT). The median price of ketamine decreased significantly to $175 per gram ($p$=0.006) from $250 in 2024, the lowest price since monitoring commenced. There was a significant change in perceived availability of ketamine (p=0.013), with 90% reporting it was 'easy' or 'very easy' to obtain (64% in 2024). The median price per tab of LSD significantly decreased to $20 ($p$=0.044) from $30 in 2024, and there was a significant change in perceived purity of LSD (p=0.024), with nearly three quarters (73%) rating purity as 'high', an increase from 53% in 2024.

New Psychoactive Substances (NPS)

Recent use of any NPS (excluding plant-based) remained stable in 2025 (16%), relative to 2024 (16%). There were no significant differences in the use of specific NPS in 2025 relative to 2024 and few participants (n≤5) reported use of any individual NPS.

Other Drugs

In 2025, recent use of non-prescribed hallucinogenic mushrooms/psilocybin (38%), non-prescribed benzodiazepines (16%), and

substances with 'unknown contents' (9%) significantly decreased relative to 2024 (56%, p=0.016; 34%, p=0.007; and 21%, p=0.032, respectively). Recent use of non-prescribed pharmaceutical opioids (12%) remained stable relative to 2024, although frequency of use increased significantly (median 18 days versus 2 days in 2024; p=0.047). Three-fifths (60%) of the sample had recently used illicit tobacco products, a significant increase relative to 2024 (37%; p=0.002). Recent alcohol use was reported by 90% of participants, stable relative to 2024, however, weekly or more frequent use significantly increased to 83% (69% in 2024; p=0.040). Recent use of illicit e-cigarettes remained high at 67%, stable relative to 2024 (72%), with one third (33%) reporting daily use. Use of nitrous oxide (40%), amyl nitrite (38%), nicotine pouches (27%), GHB/GBL/1,4-BD (n≤5), PMA (0%), PMMA (0%), heroin (n≤5), steroids (n≤5) and antipsychotics (6%) remained stable in 2025, relative to 2024.

Drug-Related Harms and Other Behaviours

Polysubstance use and bingeing

In 2025, 80% of participants reported using two or more drugs concurrently (excluding tobacco and e-cigarettes) during their last occasion of ecstasy or related drug use.

Twenty-eight per cent of participants reported using stimulants for 48 hours or more continuously without sleep in the six months preceding interview.

Dependence, overdose and injecting

A significant increase was observed in the mean AUDIT score in 2025 relative to 2024 (13.9 versus 13.5; p<0.001) and the per cent obtaining an AUDIT score of ≥8, indicative of hazardous alcohol use (86% versus 70%; p=0.018).

In 2025, 19% of those who reported recent ecstasy use obtained an SDS score of 3 or more, whilst 39% of participants reporting recent methamphetamine use obtained a score of 4 or more, indicating possible dependence on these substances.

Thirty-one per cent of the sample experienced a non-fatal depressant overdose (including alcohol) in the 12 months prior to interview and 19% reported a non-fatal stimulant overdose in the last 12 months, stable relative to 2024.

No participants reported past month injecting drug use.

Drug checking and naloxone awareness

Significantly more participants reported having tested the contents of their illicit drugs in the 12 months preceding interview in 2025 (65%) relative to 2024 (36%; p<0.001).

The majority (79%) of participants reported that they had heard about naloxone, of which two fifths (41%) reported obtaining naloxone in their lifetime, a significant increase from 20% in 2024 (p=0.010).

Sexual activity, mental health and health service access

Seventy-seven per cent of the sample reported engaging in some form of sexual activity in the past four weeks, of which 87% reported using alcohol and/or other drugs prior to or while engaging in sexual activity. Two thirds (64%) of the sample reported having a sexual health check-up in their lifetime, a significant decrease from 80% in 2024 (p=0.029).

In 2025, three fifths (60%) reported experiencing a mental health problem in the six months preceding interview, with depression (65%) and anxiety (63%) the most commonly reported problems. Fifteen per cent of the sample reported a score of ≥30 on the K10, indicating very high psychological distress.

Nearly one third (31%) of participants reported accessing any health service for alcohol and/or drug support in the six months preceding interview, most commonly from a general practitioner (GP) (14%). Six per cent of the sample reported current drug treatment engagement.

Driving, contact with police and modes of purchasing drugs

Among those who had recently driven, one fifth (21%) reported driving while over the perceived legal limit of alcohol, a significant decrease relative to 2024 (40%; p=0.013), and two fifths (42%) reported driving within three hours of consuming an illicit or non-prescribed drug, also a significant decrease relative to 2024 (60%; p=0.023).

Thirty-six per cent of the sample reported 'any' crime in the past month, with property crime significantly increasing from 10% in 2024 to 25% in 2025 (p=0.009).

Seven per cent of participants reported having been arrested in the 12 months preceding interview and 16% reported a drug-related encounter with police which did not result in charge or arrest.

In 2025, the most common means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was via social networking or messaging applications (81%), followed by face-to-face (79%). Most participants continued to report obtaining illicit drugs from a friend/relative/partner/colleague (83%).

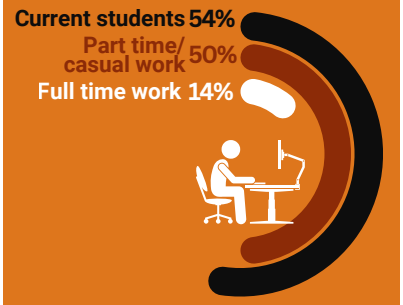
2025 SAMPLE CHARACTERISTICS

EDRS Ecstasy and Related Drugs Reporting System

Between April-June, 100 participants, recruited from Canberra, ACT, were interviewed.

21 years **Male**

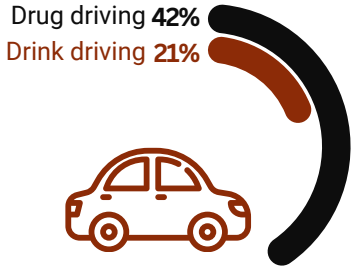
Median age and per cent who identified as male.



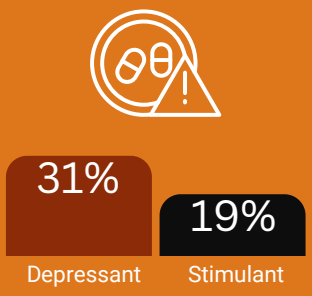
Current student and employment status.

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

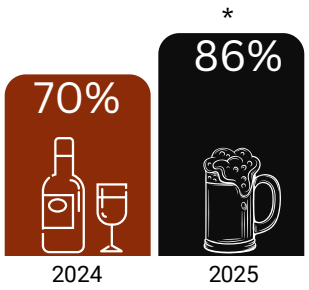
DRUG-RELATED HARMS AND RISKS



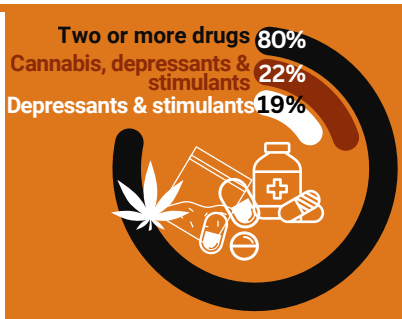
Among recent drivers, 42% reported driving a vehicle within 3 hours of consuming illicit drugs and 21% while over the legal limit of alcohol.



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



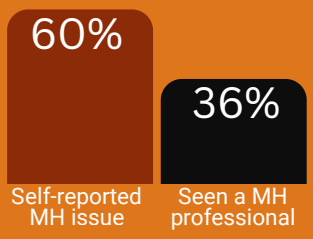
Percentage who obtained an AUDIT score of 8 or more, indicative of past year hazardous alcohol use.



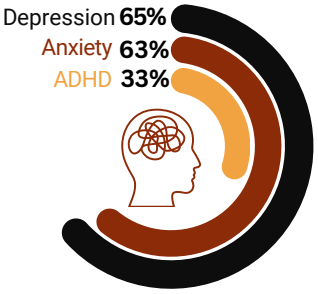
The per cent who reported using ≥2 drugs on their last occasion of ecstasy or related drug use, and the 2 most common polysubstance use profiles.

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

OTHER BEHAVIOURS

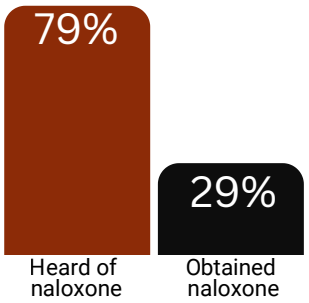


Percentage who self-reported mental health (MH) problems and treatment seeking in the 6 months preceding interview.



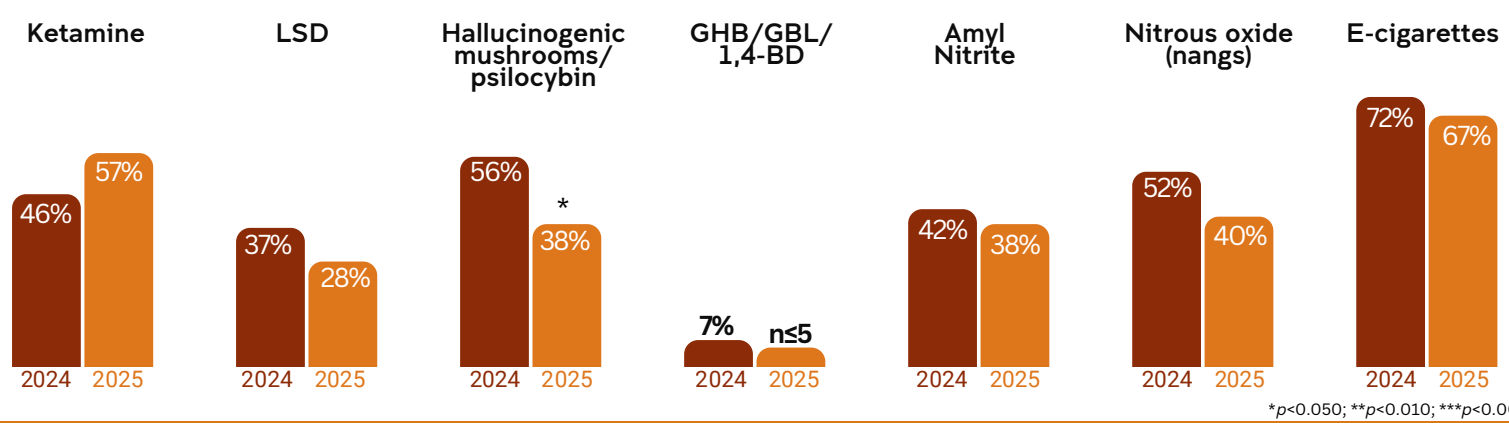
Among those who reported a mental health problem, the 3 most common mental health issues were depression, anxiety and ADHD.

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.



Per cent of participants who had heard of naloxone and who had obtained naloxone in the 12 months preceding interview.

PAST 6 MONTH USE OF SELECT DRUGS

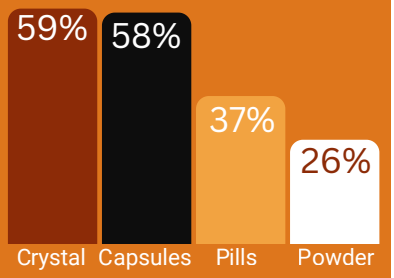


*p<0.050; **p<0.010; ***p<0.001.

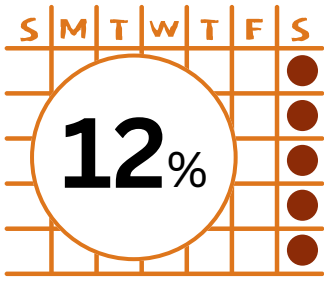
ECSTASY

EDRS Ecstasy and Related Drugs Reporting System

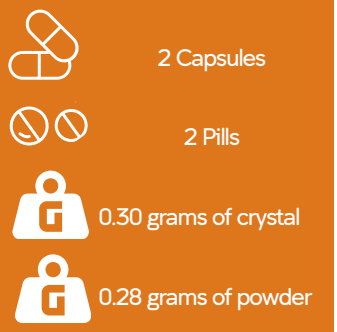
FORM of ecstasy



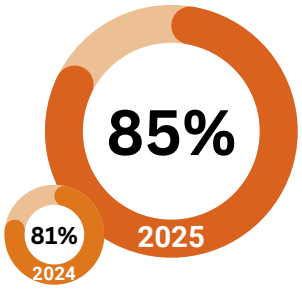
Past 6 month use of ecstasy crystal, capsules, pills, and powder in 2025.



Of those who had recently used any ecstasy, 12% reported weekly or more frequent use, stable from 2024 (10%).



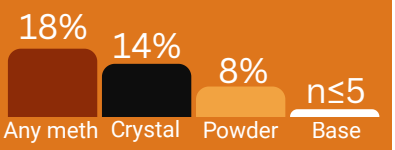
Median amounts of ecstasy consumed in a 'typical' session.



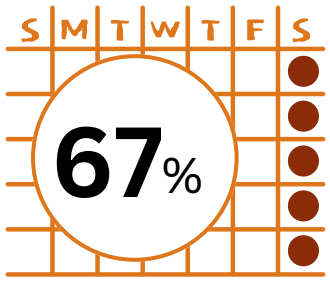
Percentage who perceived ecstasy crystal as being 'easy' or 'very easy' to obtain.

METHAMPHETAMINE

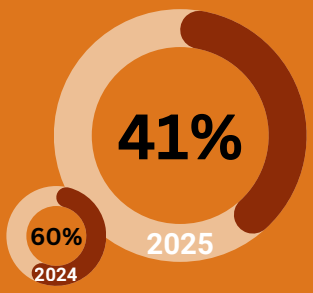
FORM of methamphetamine



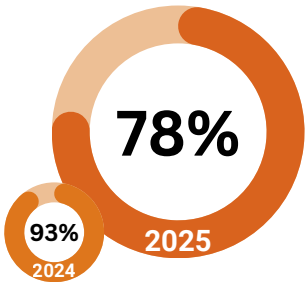
Past 6 month use of any methamphetamine, crystal, powder and base in 2025.



Of those who had recently used any methamphetamine, 67% reported weekly or more frequent use, a significant increase from 2024 (n≤5).

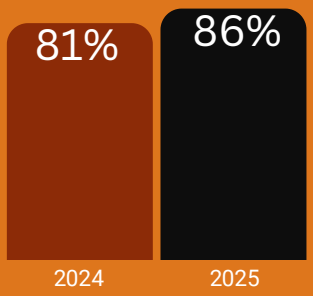


Percentage who perceived methamphetamine crystal as being 'high' in purity.

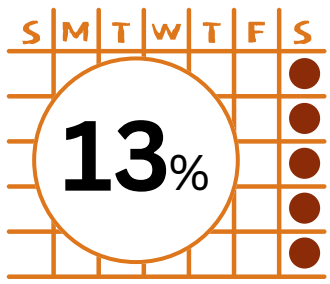


Percentage who perceived methamphetamine crystal as being 'easy' or 'very easy' to obtain.

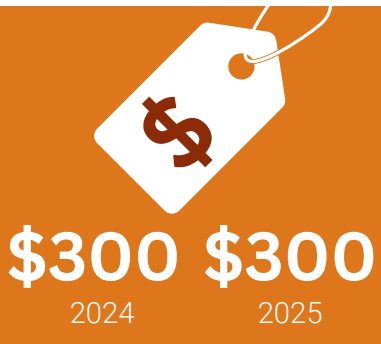
COCAINE



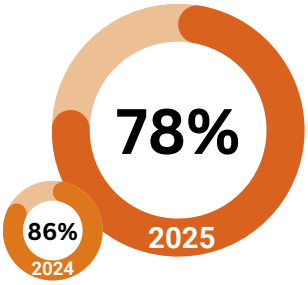
Past 6 month use of any cocaine remained stable between 2024 and 2025.



Of those who had recently consumed cocaine, 13% reported weekly or more frequent use, stable from 2024 (15%).

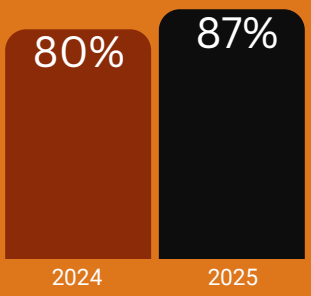


The median reported price for a gram of cocaine.

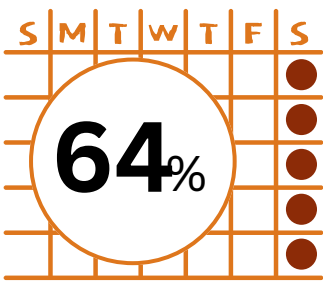


Percentage who perceived cocaine as being 'easy' or 'very easy' to obtain.

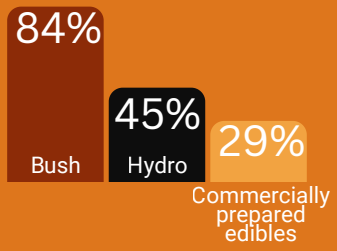
CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS



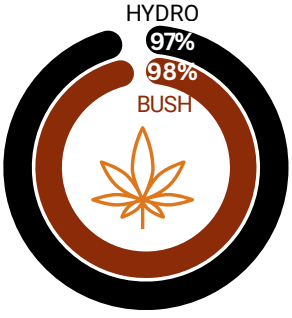
Past 6 month use of non-prescribed cannabis and/or cannabinoid-related products was stable between 2024 and 2025.



Of those who had recently used non-prescribed cannabis, 64% reported weekly or more frequent use, stable from 2024 (76%).



Most commonly used forms of non-prescribed cannabis, among those who reported recent use.



Percentage who perceived cannabis/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 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 2020-2025: 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 undertaken 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.

2025 EDRS Sample

A total of 690 participants were recruited across capital cities nationally (1 April-15 July, 2025), with 100 participants interviewed in Canberra, ACT between 8 April-22 June 2025 (N=100 in 2024). A total of 23 interviews (23%) were conducted via telephone in Canberra, ACT (43% in 2024); the remainder were conducted face-to-face.

Twelve per cent of the 2025 Canberra sample completed the interview in 2024, and 7% of the 2024 sample completed the interview in 2023 (p=0.333). The majority of participants were recruited via the internet (e.g., Facebook and Instagram) (64%; 72% in 2024), followed by word-of-mouth (42%; 18% in 2024).

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 2024 and 2025, 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 (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

%	
/	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 between 2024 and 2025

Interpretation of Findings

Caveats to interpretation of findings are discussed more completely in the methods for the annual interviews but it should be noted that these data are from participants recruited in Canberra, Australian Capital Territory, 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 Canberra, ACT (see section on 'Additional Outputs' below for details of other outputs providing such profiles).

Additional Outputs

Infographics and executive summary 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 2025, the Canberra EDRS sample was mostly similar to the sample in 2024 and in previous years (Table 2).

Gender remained stable between 2024 and 2025, with 56% of the sample identifying as male (55% in 2024). The median age of the sample was 21 years (IQR=19-26), stable relative to 2024 (22 years; IQR=19-29; p=0.541).

Accommodation remained stable (p=0.201), with two thirds (66%) of the sample reporting that they resided in a rented house/flat (55% in 2024), and most of the remaining participants living with their parents/in their family house (17%; 30% in 2024).

Participants reported a mean of 12 years of school in 2025 (range: 8-12; 12 years in 2024; range: 9-12; p=0.705) and 54% were current students (45% in 2024; p=0.262). Nearly half (48%) had obtained a post-school qualification(s) (48% in 2024).

There was a significant change in current employment status between 2024 and 2025 (p=0.016). At the time of interview in 2025, fewer participants reported being employed full-time (14%) relative to 2024 (33%), while more participants reported being employed on a part time/casual basis (50%; 39% in 2024). Almost one third (32%) reported being unemployed, compared with 24% in 2024. This shift was reflected in income, with the median weekly amount significantly lower in 2025 ($500; IQR=313-763) relative to 2024 ($650; IQR=408-1200; p=0.009).

Table 2: Demographic characteristics of the sample, nationally, 2025, and Canberra, ACT, 2021-2025

	Canberra, ACT					National
	2021 N=100	2022 N=100	2023 N=100	2024 N=100	2025 N=100	2025 N=690
Median age (years; IQR)	23 (21-29)	26 (20-32)	22 (20-26)	22 (19-29)	**21 (19-26)**	26 (20-34)
% Gender						
Female	34	42	34	44	**43**	41
Male	64	53	63	55	**56**	57
Non-binary	-	-	-	-	**-**	1
% Aboriginal and/or Torres Strait Islander	9	10	7	7	**10**	8
% Born in Australia	/	/	86	86	**88**	85
% English primary language spoken at home	/	/	99	99	**98**	97
% Sexual identity						

Heterosexual	69	69	71	67	**73**	72
Homosexual	-	-	8	-	**-**	6
Bisexual	17	20	19	19	**16**	17
Queer	7	-	-	8	**6**	4
Other identity	-	-	-	-	**0**	2
Mean years of school education (range)	12 (8-12)	11 (6-12)	12 (9-12)	12 (9-12)	**12 (8-12)**	12 (7-12)
% Post-school qualification(s)^	55	62	48	48	**48**	63
Current Students#	45	39	51	45	**54**	34
% Current employment status					*	
Employed full-time	27	26	29	33	**14**	29
Part time/ casual	39	34	52	39	**50**	39
Self-employed	10	11	-	-	**-**	5
Unemployed	24	28	18	24	**32**	28
Current median weekly income $ (IQR)	$588 (333-1081)	$550 (336-1000)	$600 (379-1072)	$650 (408-1200)	**$500** (313-763)**	$700 (400-1350)
% Current accommodation						
Own house/flat	8	10	7	6	**-**	13
Rented house/flat	64	55	64	55	**66**	50
Parents'/family home	15	22	16	30	**17**	26
Boarding house/hostel	-	-	-	-	**-**	1
Public Housing	-	-	6	-	**-**	5
No fixed address+	-	-	-	-	**-**	2
Other	-	-	-	-	**-**	2

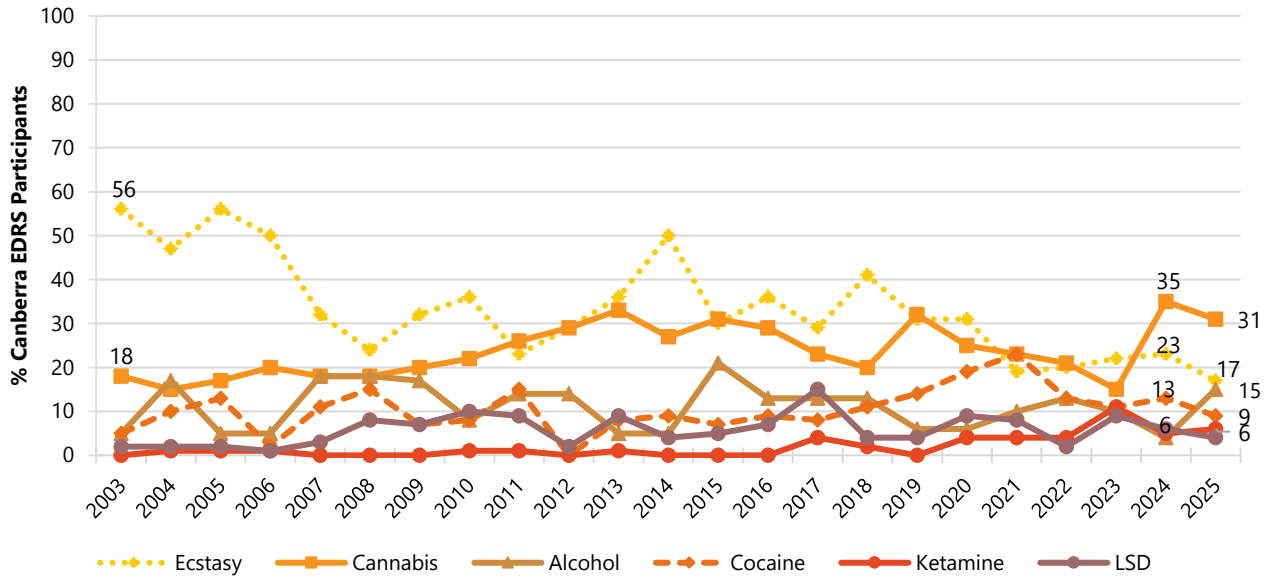
Note. ^Includes trade/technical and university qualifications. #'Current students' comprised participants who were currently studying for either trade/technical or university/college qualifications. + No fixed address included 'couch surfing and rough sleeping or squatting. Statistical significance for 2024 versus 2025 (Canberra) 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 2024 and 2025 ($p=0.083$), with nearly one third (31%) nominating cannabis as their drug of choice in 2025 (35% in 2024), followed by ecstasy (17%; 23% in 2024), alcohol (15%; n≤5 in 2024) and cocaine (9%; 13% in 2024) (Figure 1).

The drug used most often in the past month also remained stable between 2024 and 2025 ($p=0.116$), with nearly two fifths (38%) reporting cannabis (47% in 2024) and one quarter (24%) reporting alcohol (10% in 2024) as the drugs used most often (Figure 2).

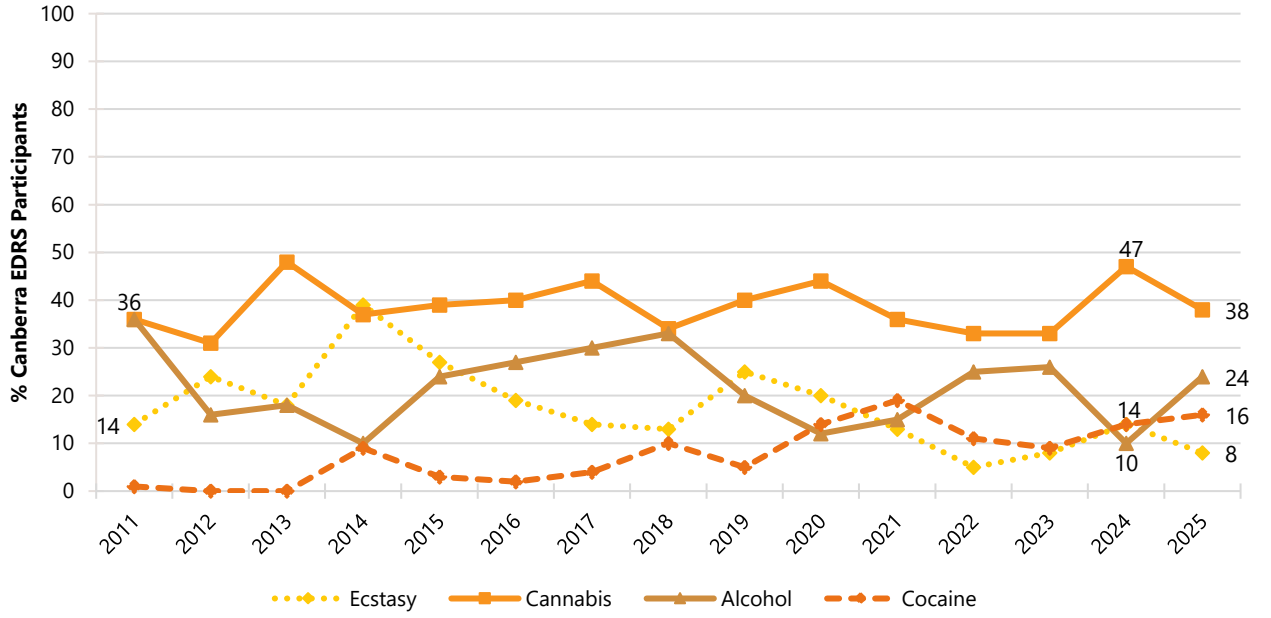
Weekly or more frequent use of cannabis (56%; 61% in 2024; $p=0.566$), ecstasy (12%; 9% in 2024; $p=0.631$), methamphetamine (12%; n≤5 in 2024; $p=0.126$) and cocaine (11%; 12% in 2024), remained stable in 2025, relative to 2024 (Figure 3).

Figure 1: Drug of choice, Canberra, ACT, 2003-2025



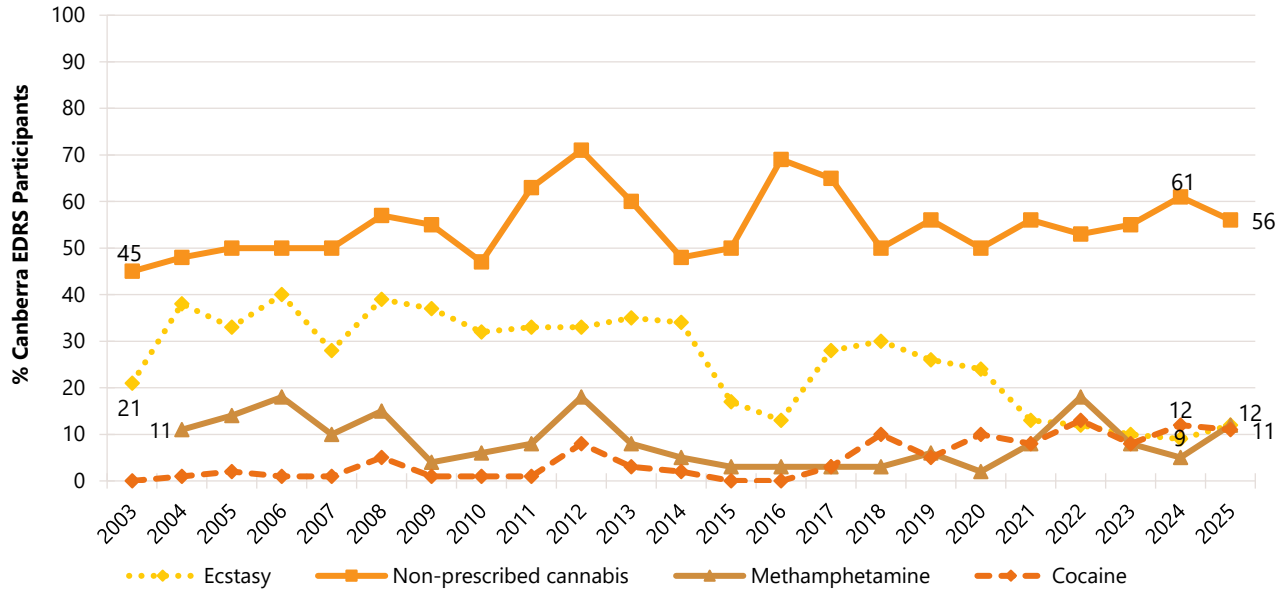
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 2: Drug used most often in the past month, Canberra, ACT, 2011-2025



Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Data are only presented for 2011-2025 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 3: Weekly or more frequent substance use in the past six months, Canberra, ACT, 2003-2025



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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

2

Non-Prescribed Ecstasy

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

Patterns of Consumption (any ecstasy)

Recent Use (past 6 months)

Over the course of monitoring, nearly all participants have reported recent non-prescribed ecstasy use each year. In 2022, however, recent use decreased to a record low of 87%. In 2025, 98% of participants reported recent use of non-prescribed ecstasy, a significant increase relative to 2024 (90%; p=0.033), yet remaining consistent with levels observed in most previous monitoring years (Figure 4).

From 2003-2014, pills dominated as the most common form of non-prescribed ecstasy used in the six months preceding interview. Between 2015-2019, pills competed with the crystal and capsule forms of non-prescribed ecstasy in terms of the per cent reporting recent use, with ecstasy capsules emerging as the most commonly used form of non-prescribed ecstasy from 2019 onwards. In 2025, for the first time, crystal was reported as the most commonly used form of non-prescribed ecstasy with 59% reporting recent use, a significant increase relative to 2024 (37%; p=0.003), closely followed by capsules (58%; 52% in 2024; p=0.471). In 2025, 37% reported recent use of pills (25% in 2024; p=0.097) and 26% reported powder (28% in 2024; p=0.872) (Figure 4).

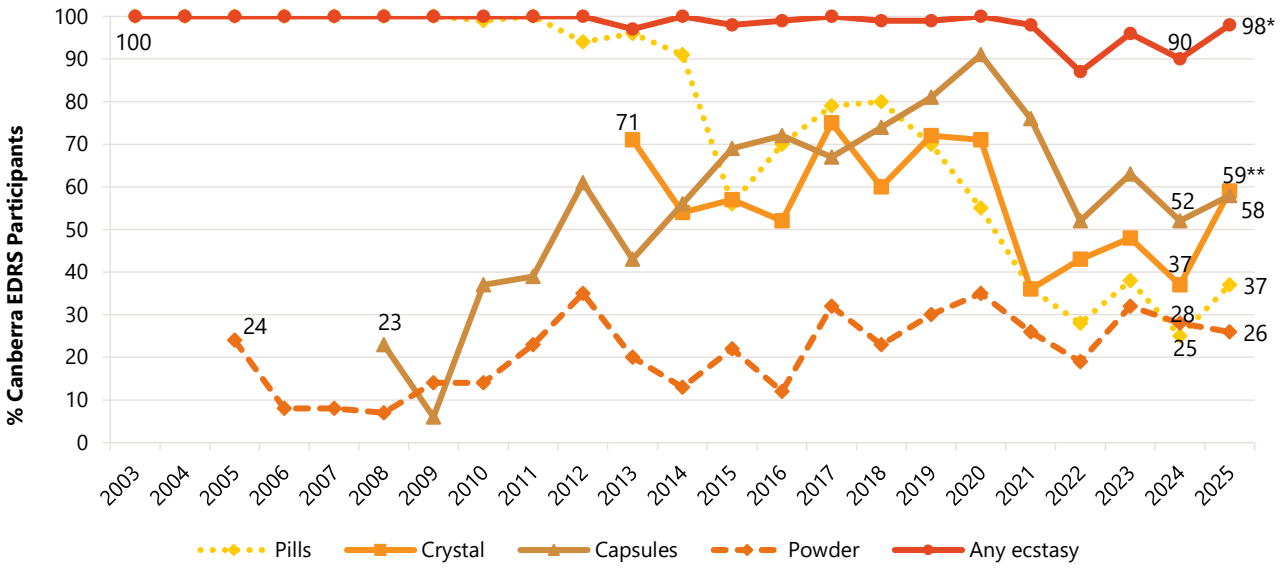
Frequency of Use

In 2025, participants reported using non-prescribed ecstasy (in any form) on a median of six days (i.e., equivalent to monthly use; IQR=3-13; n=98), stable from 2024 (6 days; IQR=3-12; n=90; p=0.945) but remaining lower than what has historically been observed (10-18 days between 2003-2020) (Figure 5). Among those who reported recent non-prescribed ecstasy use in 2025, 12% reported weekly or more frequent use, stable relative to 2024 (10%; p=0.637).

Number of Forms Used

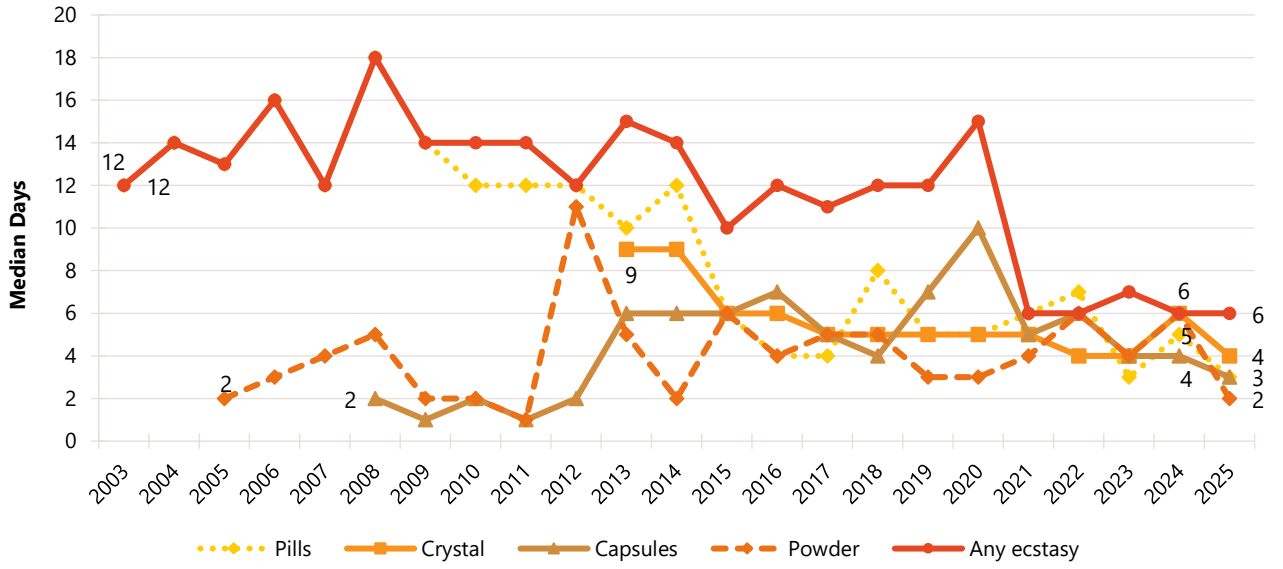
Among participants who had recently consumed non-prescribed ecstasy and commented (n=98), the median number of forms of non-prescribed ecstasy used in the past six months were two (IQR=1-3), a significant increase relative to 2024 (median 1 form; IQR=1-2; n=90; p=0.005).

Figure 4: Past six month use of any non-prescribed ecstasy, and non-prescribed ecstasy pills, powder, capsules, and crystal, Canberra, ACT, 2003-2025



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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 5: Median days of any non-prescribed ecstasy and non-prescribed ecstasy pills, powder, capsules, and crystal use in the past six months, Canberra, ACT, 2003-2025



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 20 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Patterns of Consumption (by form)

Non-Prescribed Ecstasy Pills

Recent Use (past 6 months): Since monitoring began in 2003, ecstasy pills were the most common form of non-prescribed ecstasy used until 2014. From that point, the most common form varied between pills, crystal, and capsules. In 2025, non-prescribed ecstasy pills were the second least commonly used form (37%; 25% in 2024; p=0.097) (Figure 4).

Frequency of Use: Frequency of use of non-prescribed ecstasy pills remained stable at a median of three days in 2025 (IQR=2-10; n=37; 5 days in 2024; IQR=3-12; n=25; p=0.398) (Figure 5). Few participants (n≤5) reported weekly or more frequent use of non-prescribed ecstasy pills in 2025 (n≤5 in 2024).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy pills and commented (n=37), swallowing remained the main route of administration among those who had recently used non-prescribed ecstasy pills (92%; 100% in 2024). Few participants (n≤5) nominated other routes of administration.

Quantity: In 2025, the median quantity used in a 'typical' session was two pills (IQR=1-3, n=37; 2 pills in 2024; n=25; IQR=1-3; p=0.686). The median maximum number of pills was two pills in 2025 (IQR=2-5, n=37; 4 pills in 2024; IQR=2-6; n=25; p=0.093).

Non-Prescribed Ecstasy Capsules

Recent Use (past 6 months): The per cent reporting recent use of non-prescribed ecstasy capsules gradually increased between 2009 (23%) and 2020 (91%), before subsequently declining. Despite this overall decline in more recent years, non-prescribed ecstasy capsules have remained one of the most commonly used forms of ecstasy since 2019. In 2025, nearly three fifths (58%) of the sample reported recent use, stable relative to 2024 (52%; p=0.471) (Figure 4).

Frequency of Use: Participants reported consuming non-prescribed ecstasy capsules on a median of three days in 2025 (IQR=2-6; n=58), stable relative to 2024 (4 days; IQR=2-8; n=51; p=0.254) (Figure 5). Of those who reported recent use of non-prescribed ecstasy capsules, few participants (n≤5) reported weekly or more frequent use in 2025 (n≤5 in 2024; p=0.183).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy capsules and commented (n=58), the most common route of administration among those who had recently used non-prescribed ecstasy capsules has consistently been swallowing (97%; 96% in 2024). Few participants (n≤5) reported other routes of administration in 2025 and 2024.

Quantity: The median quantity used in a 'typical' session was two capsules in 2025 (IQR=1-2; n=58; 2 capsules in 2024; IQR=1-2; n=50; p=0.915) and the median maximum number of capsules used in a session was also two (IQR=1.60-4; n=58; 2 capsules in 2024; IQR=2-5; n=49; p=0.472).

Non-Prescribed Ecstasy Crystal

Recent Use (past 6 months): Recent use of the crystal form of non-prescribed ecstasy was reported by nearly three fifths (59%) of the sample, a significant increase relative to 37% in 2024 (p=0.003) (Figure 4).

Frequency of Use: Frequency of use among those who had recently used non-prescribed ecstasy crystal remained stable at a median of four days (IQR=2-10; n=59; 6 days in 2024; IQR=4-10; n=37; p=0.309) (Figure 5). Twelve per cent reported weekly or more frequent use,

a significant increase relative to 2024 (0%; p=0.041).

Routes of Administration: Among those who had recently used non-prescribed ecstasy crystal and commented (n=59), the most common routes of administration were swallowing (75%; 81% in 2024; p=0.618) and snorting (39%; 51% in 2024; p=0.298).

Quantity: The median amount of crystal used in a 'typical' session was 0.30 grams (IQR=0.13-0.40; n=42; 0.40 grams in 2024; IQR=0.20-0.50; n=31; p=0.238) and the median maximum amount used was 0.50 grams (IQR=0.25-0.75; n=45; 0.50 grams in 2024; IQR=0.30-1.00; n=31; p=0.238).

Non-Prescribed Ecstasy Powder

Recent Use (past 6 months): With the exception of 2009 and 2024, ecstasy powder has consistently been the least commonly endorsed form of non-prescribed ecstasy. In 2025, 26% reported recent use (28% in 2024; p=0.872) (Figure 4).

Frequency of Use: Frequency of non-prescribed ecstasy powder use remained stable at a median of two days in 2025 (IQR=1-6; n=26; 6 days in 2024; IQR=3-6; n=28; p=0.051) (Figure 5). Few participants (n≤5) reported weekly or more frequent use of non-prescribed ecstasy powder (n≤5 in 2024).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy powder and commented (n=26), the most common route of administration among those who had recently used non-prescribed ecstasy powder was swallowing (69%; 50% in 2024; p=0.182), followed by snorting (50%; 64% in 2024; p=0.409).

Quantity: The median quantity used in a 'typical' session was 0.28 grams (IQR=0.19-0.63; n=16; 0.50 grams in 2024; IQR=0.30-0.50; n=18; p=0.227). The median maximum amount consumed in a session was 0.40 grams (IQR=0.25-0.70; n=16; 0.60 grams in 2024; IQR=0.35-1.25; n=19, p=0.287).

Price, Perceived Purity and Perceived Availability

Non-Prescribed Ecstasy Pills

Price: The reported median price of a pill was highest in the first four years of monitoring (2003-2006), after which it declined and then remained relatively stable at $25. In 2025, the median price of a non-prescribed ecstasy pill was $25 (IQR=20-35, n=17), stable relative to 2024 ($28; IQR=24-30; n=16; p=0.595) (Figure 6).

Perceived Purity: The perceived purity of non-prescribed ecstasy pills remained stable between 2024 and 2025 (p=0.962). Of those who responded in 2025 (n=41), two fifths (39%) perceived pills to be of 'high' purity (41% in 2024), followed by 37% reporting 'medium' purity (33% in 2024) (Figure 9).

Perceived Availability: The perceived availability of non-prescribed ecstasy pills remained stable between 2024 and 2025 (p=0.651). Of those who responded in 2025 (n=42), half (50%) perceived availability to be 'easy' (48% in 2024), followed by 29% reporting 'very easy' (30% in 2024), while fewer participants perceived it as being 'difficult' to obtain (21%; 18% in 2024) (Figure 13).

Non-Prescribed Ecstasy Capsules

Price: The median price per ecstasy capsule has fluctuated between $20-$30 since monitoring commenced. After declining to $20 in 2020 and 2021, the median price for non-prescribed ecstasy capsules was $23 in 2025 (IQR=20-25;

n=30), stable relative to 2024 ($25; IQR=20-28; n=19; *p*=0.194) (Figure 6).

Perceived Purity: The perceived purity of non-prescribed ecstasy capsules remained stable between 2024 and 2025 (*p*=0.088). Of those who responded (n=61), 43% perceived capsules to be of 'medium' purity (36% in 2024), followed by 31% reporting 'high' purity (50% in 2024). A further one fifth reported 'fluctuating purity' (n≤5 in 2024) (Figure 10).

Perceived Availability: The perceived availability of non-prescribed ecstasy capsules remained stable between 2024 and 2025 (*p*=0.416). Of those who were able to comment in 2025 (n=61), half (49%) perceived availability as 'very easy' (44% in 2024), followed by two fifths (39%) reporting 'easy' (37% in 2024). A further 11% perceived availability as 'difficult' (15% in 2024) (Figure 14).

Non-Prescribed Ecstasy Crystal

Price: The median price of a gram of crystal was $180 in 2025 (IQR=150-238; n=31; $245 in 2024; IQR=143-250; n=20; *p*=0.242). Few participants (n≤5) reported the price of a point in 2025 (n≤5 in 2024; *p*=0.277) (Figure 7).

Perceived Purity: The perceived purity of non-prescribed ecstasy crystal remained stable between 2024 and 2025 (*p*=0.179). Of those who responded in 2025 (n=57), two thirds (67%) reported purity to be 'high' (67% in 2024), followed by nearly one fifth (18%) reporting 'medium' purity (19% in 2024) (Figure 11).

Perceived Availability: The perceived availability of non-prescribed ecstasy crystal remained stable between 2024 and 2025 (*p*=0.537). Among those who responded in 2025 (n=54), the majority perceived availability to be 'very easy' (44%; 53% in 2024) or 'easy' (41%; 28% in 2024). In contrast, 11% reported availability as 'difficult' (16% in 2024) (Figure 15).

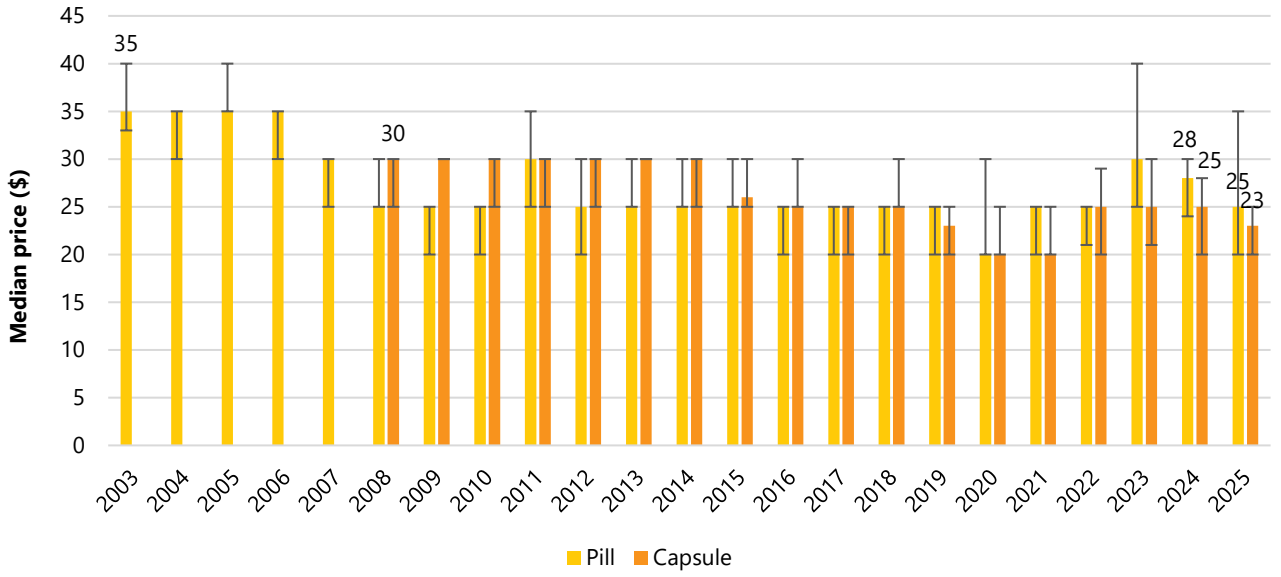
Non-Prescribed Ecstasy Powder

Price: The median price per gram of ecstasy powder was $155 in 2025 (IQR=115-250; n=8; $200 in 2024; IQR=105-250; n=11; *p*=0.934). No participants reported on the price of a point in 2025 (n≤5 in 2024) (Figure 8).

Perceived Purity: The perceived purity of non-prescribed ecstasy powder remained stable between 2024 and 2025 (*p*=0.725). Among those who responded in 2025 (n=16), 56% perceived powder to be of 'high' purity (52% in 2024), followed by 38% reporting 'medium' purity (28% in 2024) (Figure 12).

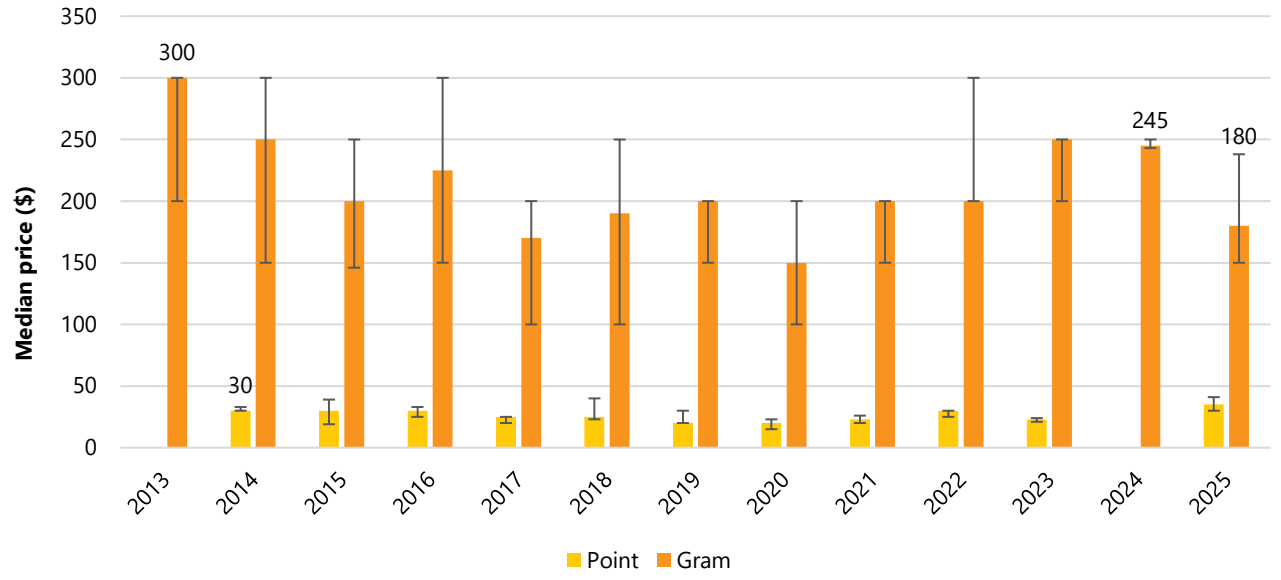
Perceived Availability: The perceived availability of non-prescribed ecstasy powder remained stable between 2024 and 2025. Among those who responded in 2025 (n=15), two fifths (40%) reported that powder was 'easy' to obtain (41% in 2024) (Figure 16).

Figure 6: Median price of non-prescribed ecstasy pills and capsules, Canberra, ACT, 2003-2025



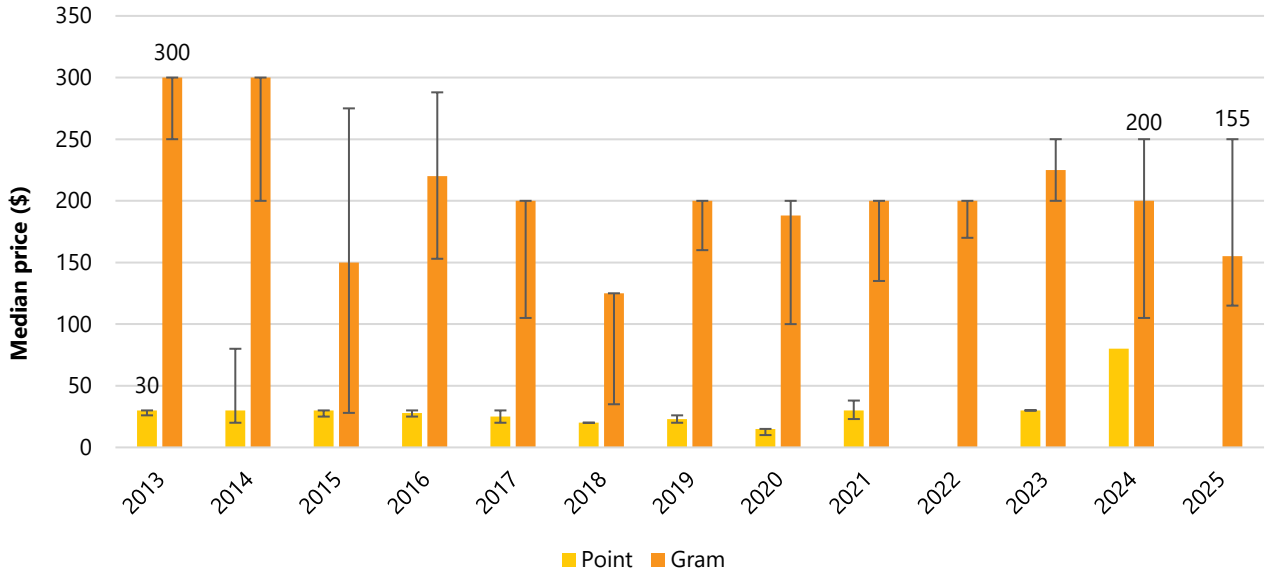
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 7: Median price of non-prescribed ecstasy crystal per point and gram, Canberra, ACT, 2013-2025



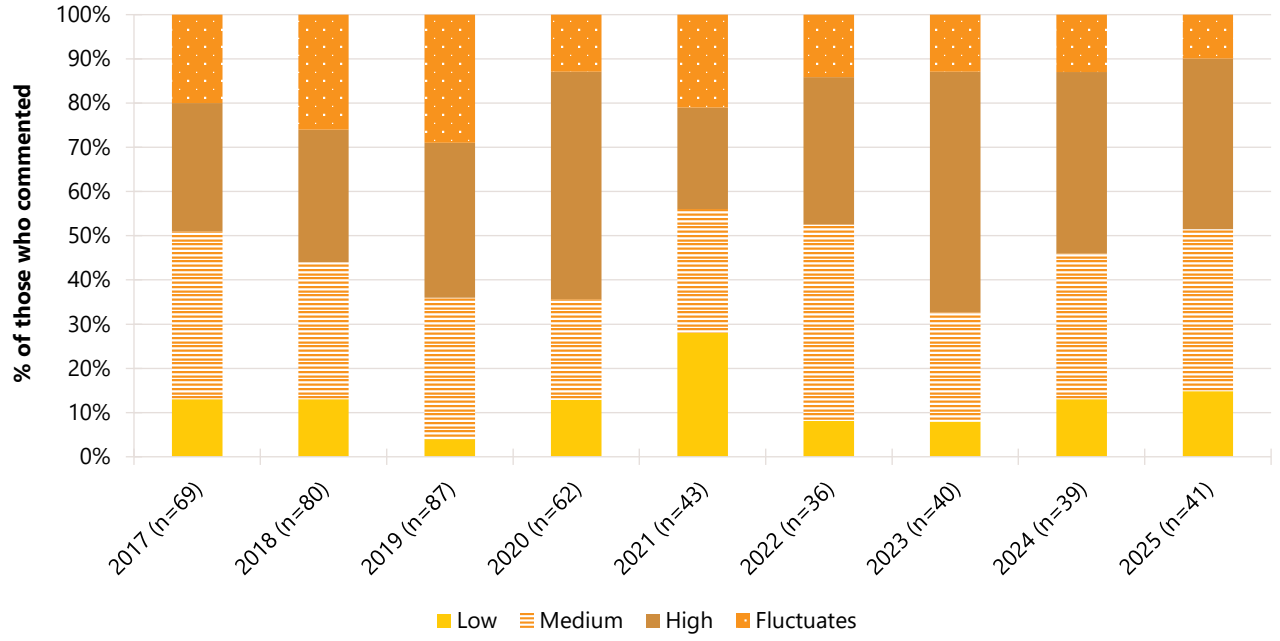
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) started in 2013. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). The error bars represent the IQR. No participants reported on a point of crystal in 2024. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 8: Median price of non-prescribed ecstasy powder per point and gram, Canberra, ACT, 2013-2025



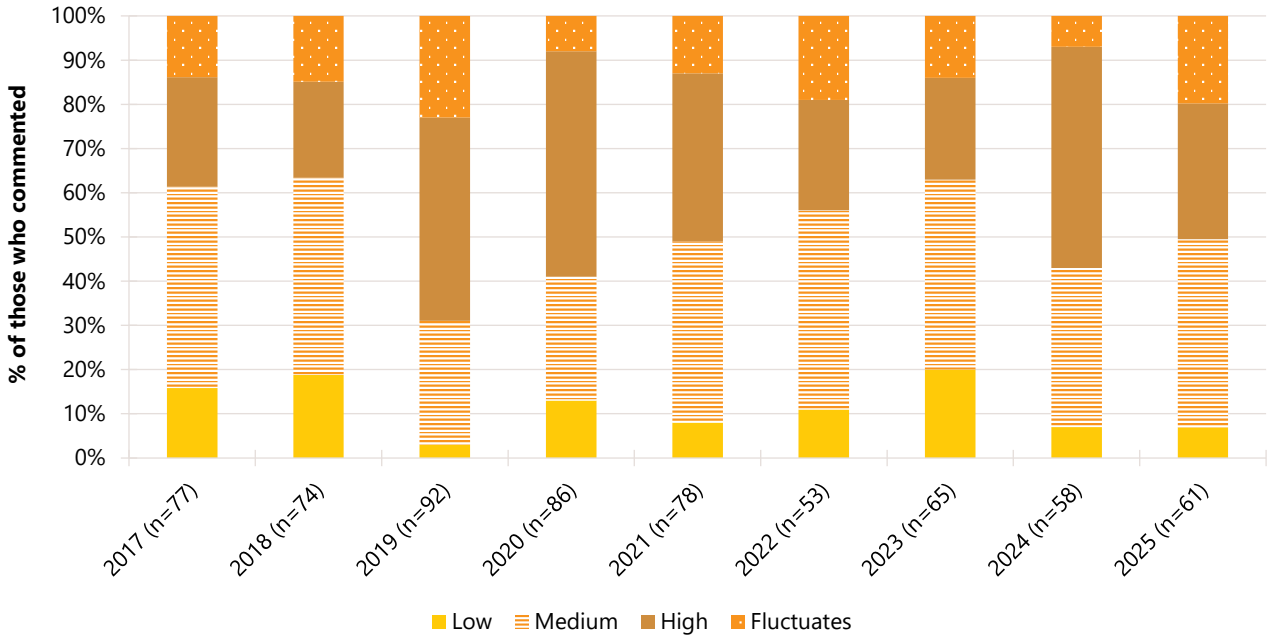
Note. Among those who commented. Data collection for price of ecstasy powder (gram and point) started in 2013. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). No participants reported on a point of powder in 2025. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 9: Current perceived purity of non-prescribed ecstasy pills, Canberra, ACT, 2017-2025



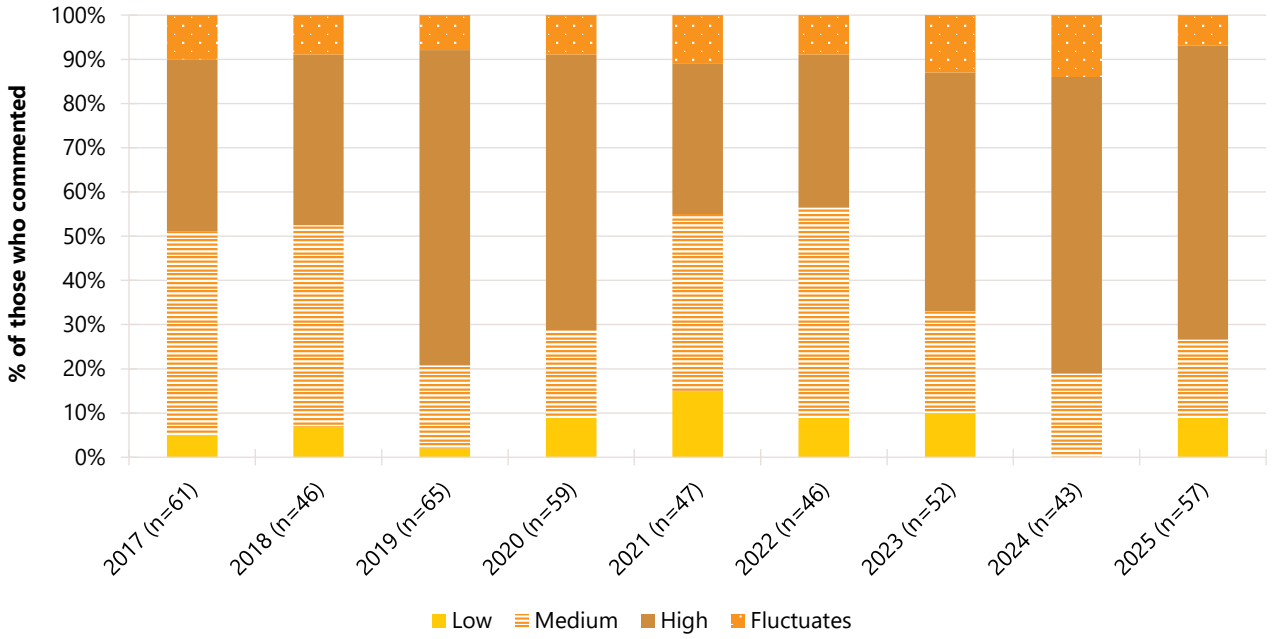
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 10: Current perceived purity of non-prescribed ecstasy capsules, Canberra, ACT, 2017-2025



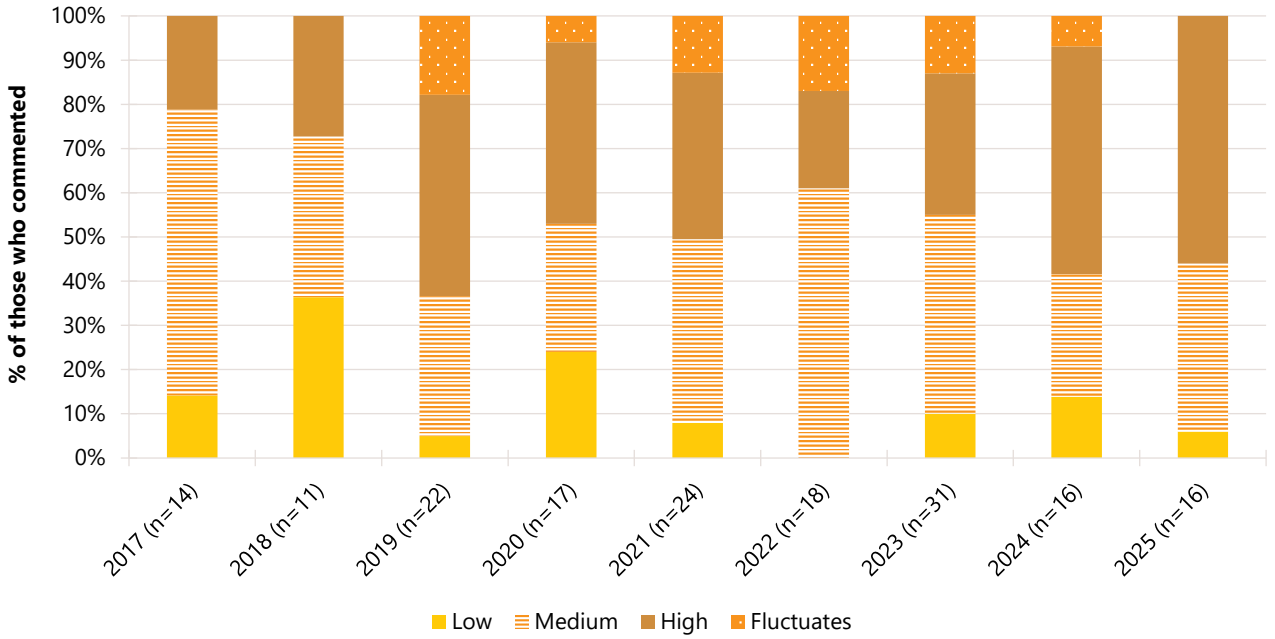
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2024 presented in figure;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

Figure 11: Current perceived purity of non-prescribed ecstasy crystal, Canberra, ACT, 2017-2025



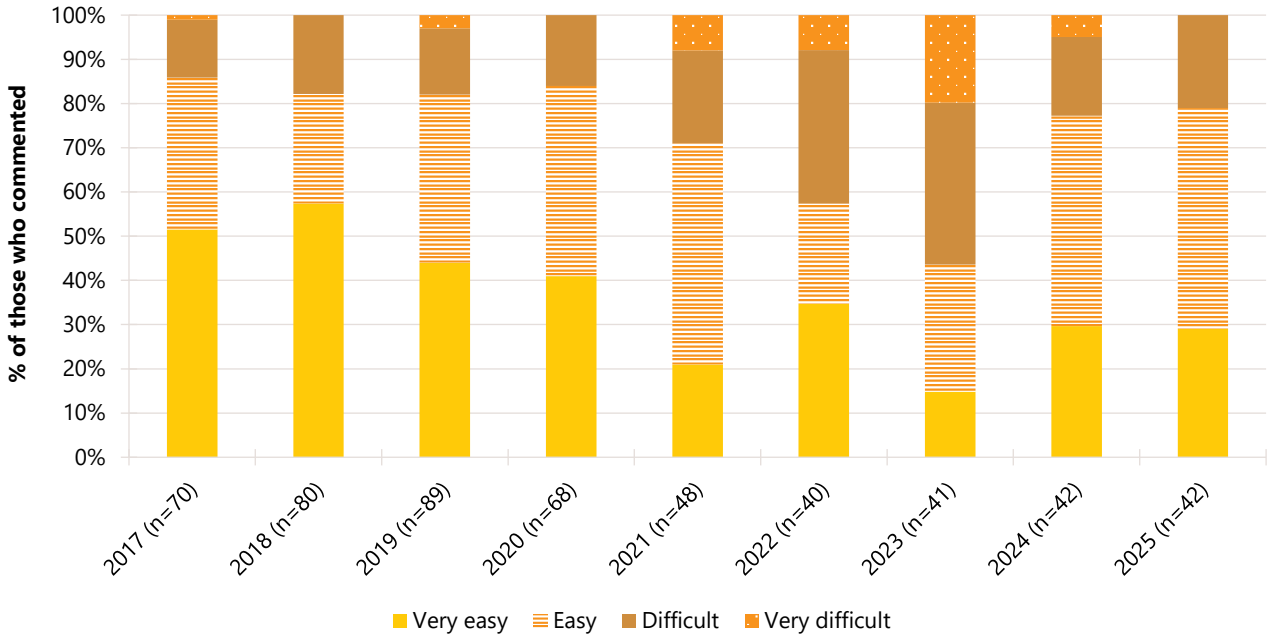
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 12: Current perceived purity of non-prescribed ecstasy powder, Canberra, ACT, 2017-2025



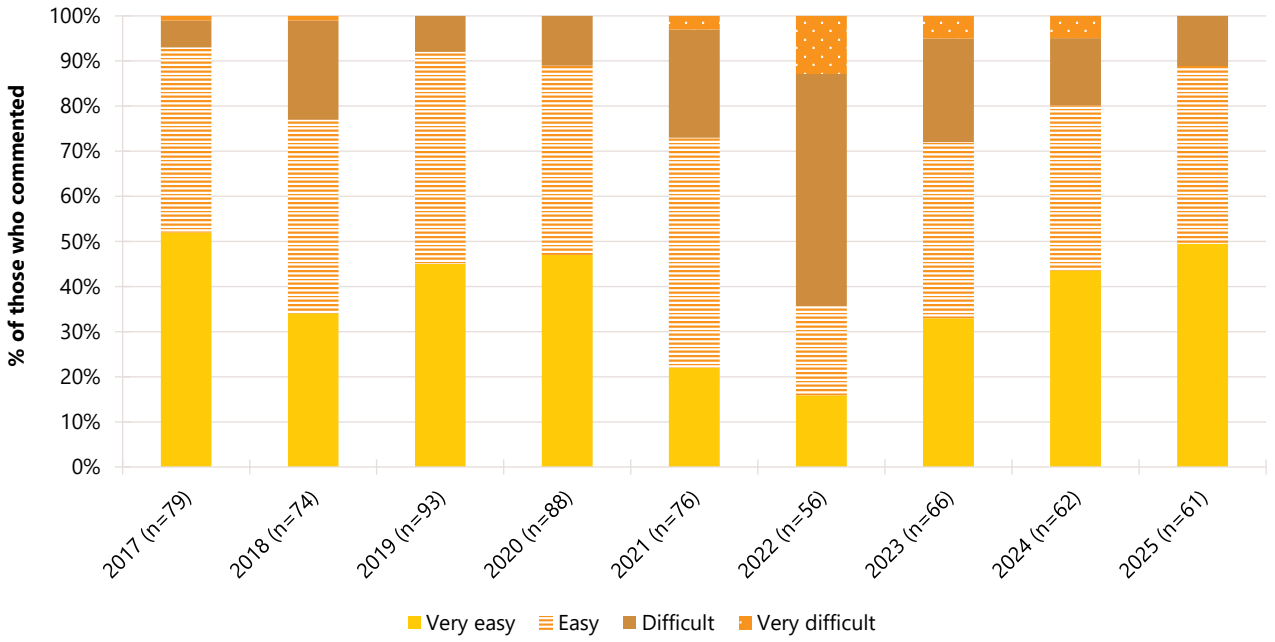
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 13: Current perceived availability of non-prescribed ecstasy pills, Canberra, ACT, 2017-2025



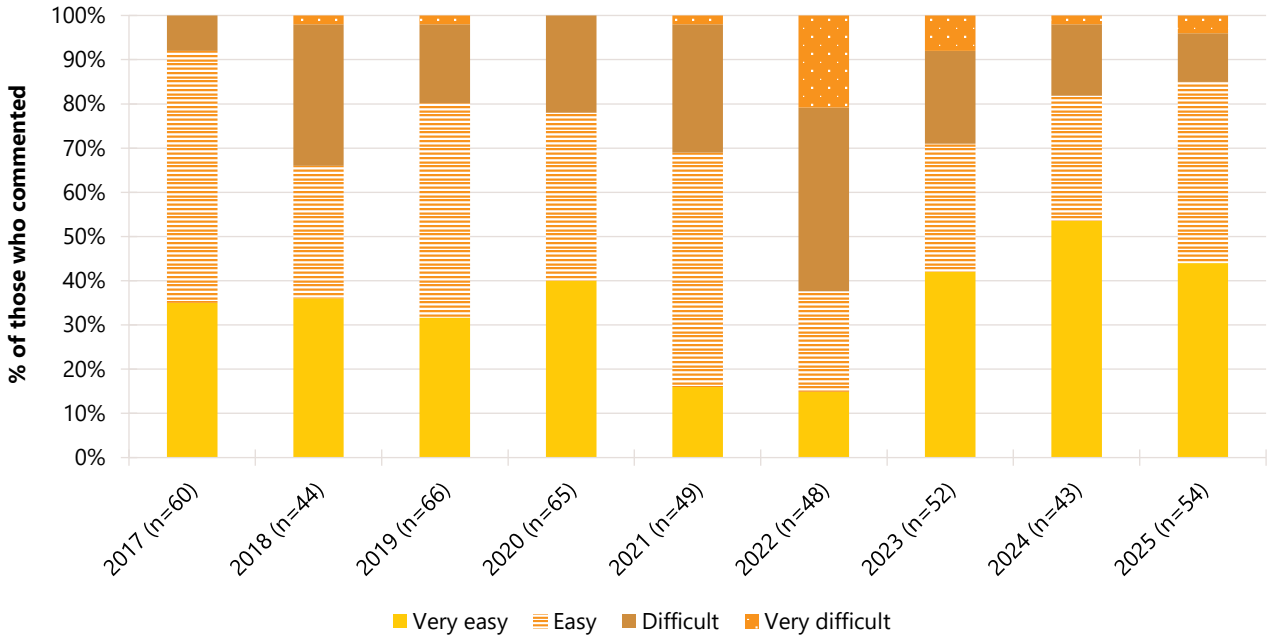
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 14: Current perceived availability of non-prescribed ecstasy capsules, Canberra, ACT, 2017-2025



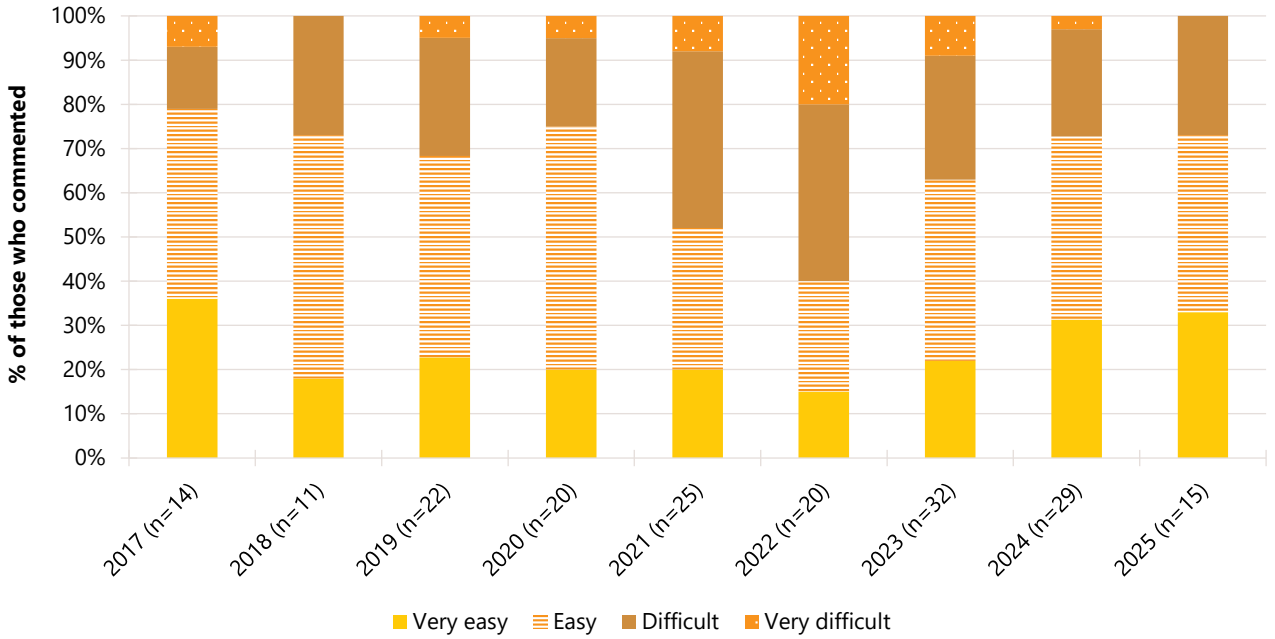
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 15: Current perceived availability of non-prescribed ecstasy crystal, Canberra, ACT, 2017-2025



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. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 16: Current perceived availability of non-prescribed ecstasy powder, Canberra, ACT, 2017-2025



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. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to tables and figures.

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 methamphetamine base are not reported here due to small numbers reporting recent use. For further information on methamphetamine base, please refer to the 2025 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 declined from four in five participants (79%) in 2003 to one in six participants in 2020 (15%), before increasing in 2021 and 2022 and declining again thereafter. In 2025, nearly one fifth (18%) of the sample reported recent use, stable relative to 2024 (21%; p=0.706) (Figure 17). Of participants who had used methamphetamine in the six months preceding interview in 2025 (n=18), most had used methamphetamine crystal (78%), a significant increase relative to 2024 (43%; p=0.049), followed by methamphetamine powder (44%; 76% in 2024; p=0.055). Few participants (n≤5) reported using methamphetamine base in 2025 (n≤5 in 2024).

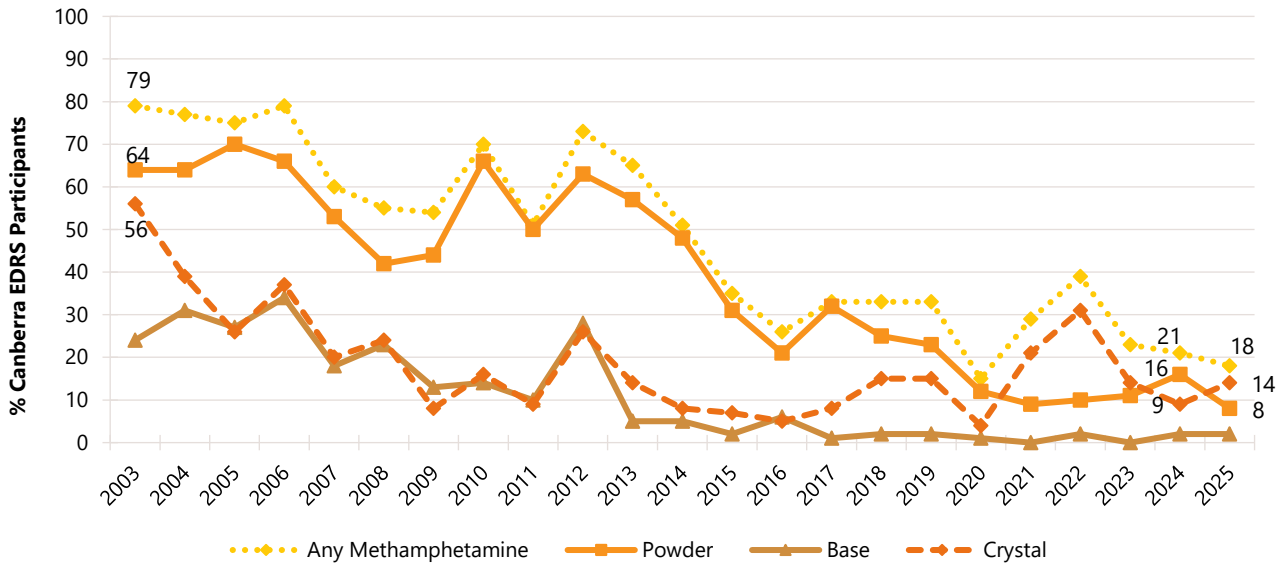
Frequency of Use

Use has historically been relatively infrequent over the course of monitoring, apart from a spike in 2022 and 2025. In 2025, participants reported a median of 48 days of use (i.e., twice weekly; IQR=11-173; n=18), a significant increase relative to five days in 2024 (IQR=1-12; n=21; p=0.029) (Figure 18). Among participants who reported recent use of any methamphetamine (n=18), 67% reported weekly or more frequent use, a significant increase relative to 2024 (n≤5; p=0.011).

Number of Forms Used

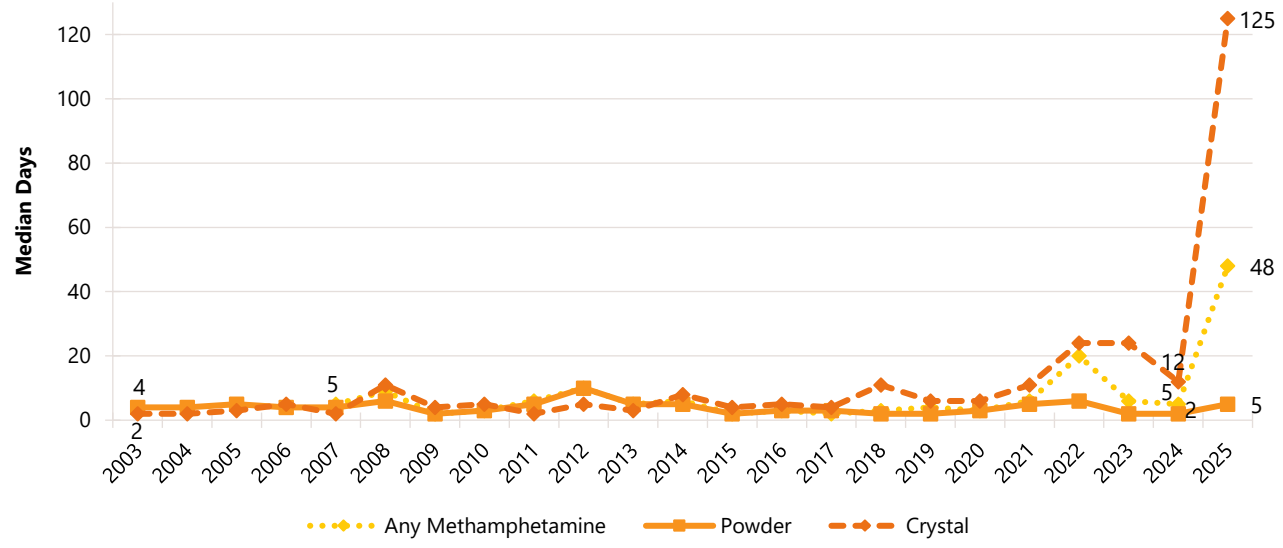
Among participants who had recently consumed any methamphetamine and commented (n=18), the median number of forms used in the six months preceding interview was one (IQR=1-1), stable from 2024 (1 form; IQR=1-1; n=21; p=0.622).

Figure 17: Past six month use of any methamphetamine, and methamphetamine powder, base, and crystal, Canberra, ACT, 2003-2025



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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 18: Median days of any methamphetamine use, and methamphetamine powder and crystal use in the past six months, Canberra, ACT, 2003-2025



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 130 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Patterns of Consumption (by form)

Methamphetamine Powder

Recent Use (past 6 months): Between 2003 and 2020, methamphetamine powder was the most commonly used form, despite declining over time. It was surpassed by the crystal form for the first time in 2021 until 2023. In 2025, 8% of the sample reported recent use of methamphetamine powder (16% in 2024; p=0.134) (Figure 17).

Frequency of Use: Frequency of use has fluctuated over the years, peaking at a median of 10 days in 2012. In 2025, participants reported using powder on a median of five days (IQR=2-13; n=8), stable relative to 2024 (2 days; IQR=1-7; n=16; p=0.453) (Figure 18).

Routes of Administration: Among participants who had recently used powder and commented (n=8), the most common route of administration was swallowing (75%) a significant increase relative to 2024 (n≤5; p=0.032).

Quantity: Few participants (n≤5) reported on the median quantity used in a 'typical' session (0.20 grams in 2024; IQR=0.20-0.50; n=11; p=0.862) and maximum session (0.40 grams in 2024; IQR=0.20-0.50; n=12; p=0.333) and are therefore not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Methamphetamine Crystal

Recent Use (past 6 months): Recent use of crystal has fluctuated over the years, although generally decreased between 2003 and 2020, before increasing and becoming the most commonly used form of methamphetamine between 2021-2023. In 2025, 14% of the sample reported recent use, stable relative to 2024 (9%; p=0.371) (Figure 17).

Frequency of Use: In 2025, participants reported using methamphetamine crystal on a median of 125 days (IQR=24-180; n=14) in the past six months, stable relative to 2024 (12 days in 2024; IQR=10-90; n=9; p=0.159) (Figure 18).

Routes of Administration: Among participants who had recently used crystal and commented (n=14), the majority reported smoking as a route of administration (93%; 67% in 2024; p=0.260).

Quantity: The median quantity used in a 'typical' session was 0.30 grams (IQR=0.20-0.63; n=12; 0.25 grams in 2024; IQR=0.13-0.38; n=6; p=0.295). The median maximum amount used in a session was one gram (IQR=0.50-2.00; n=12; 0.55 grams in 2024; IQR=0.50-0.90; n=6; p=0.253).

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Price: In 2025, few participants (n≤5) reported on the price of a gram (n≤5 in 2024) or a point (n≤5 in 2024) of methamphetamine powder, therefore these data are suppressed (Figure 19).

Perceived Purity: The perceived purity of methamphetamine powder remained stable between 2024 and 2025 (p=0.871). Few participants (n≤5) reported on the perceived purity in 2025, therefore these data are suppressed (Figure 21).

Perceived Availability: There was a significant change in the perceived availability of methamphetamine powder between 2024 and 2025 (p=0.020). Among those who responded in 2025 (n=9), there was an increase in participants reporting methamphetamine powder as 'easy' to obtain in 2025 (78%) relative to 2024 (21%) (Figure 23).

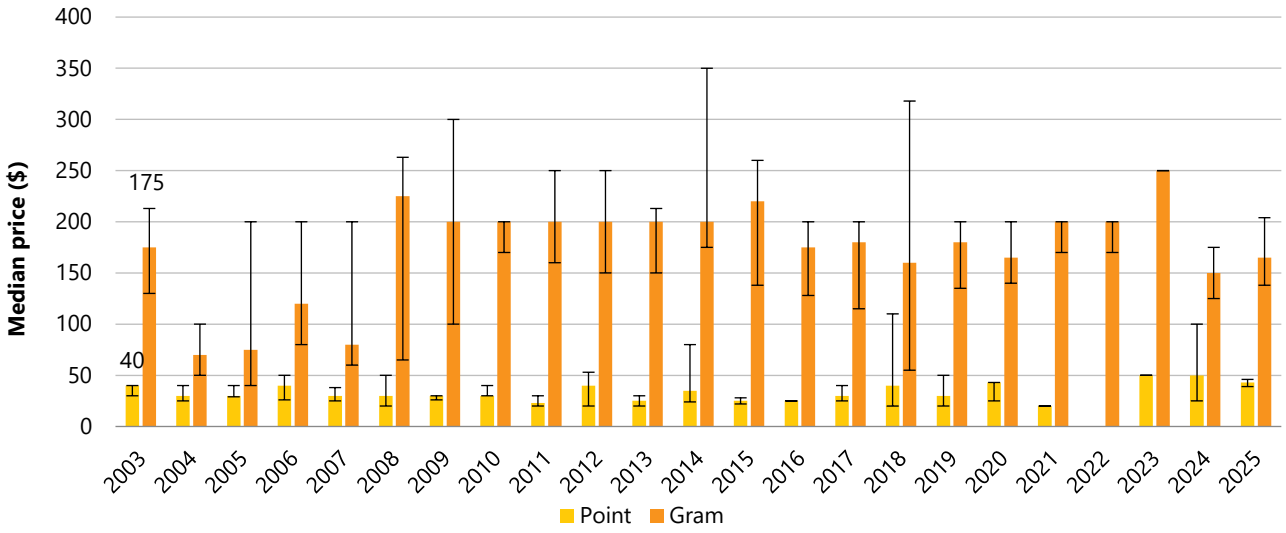
Methamphetamine Crystal

Price: In 2025, few participants (n≤5) reported on the price of a gram (n≤5 in 2024; p=0.639) or a point ($73 in 2024; IQR=50-99; p=0.104) of methamphetamine crystal, therefore these data are suppressed (Figure 20).

Perceived Purity: The perceived purity of methamphetamine crystal remained stable between 2024 and 2025 (p=0.709). Among those who responded in 2025 (n=17), two fifths (41%) perceived methamphetamine crystal to be of 'high' purity (60% in 2024) (Figure 22).

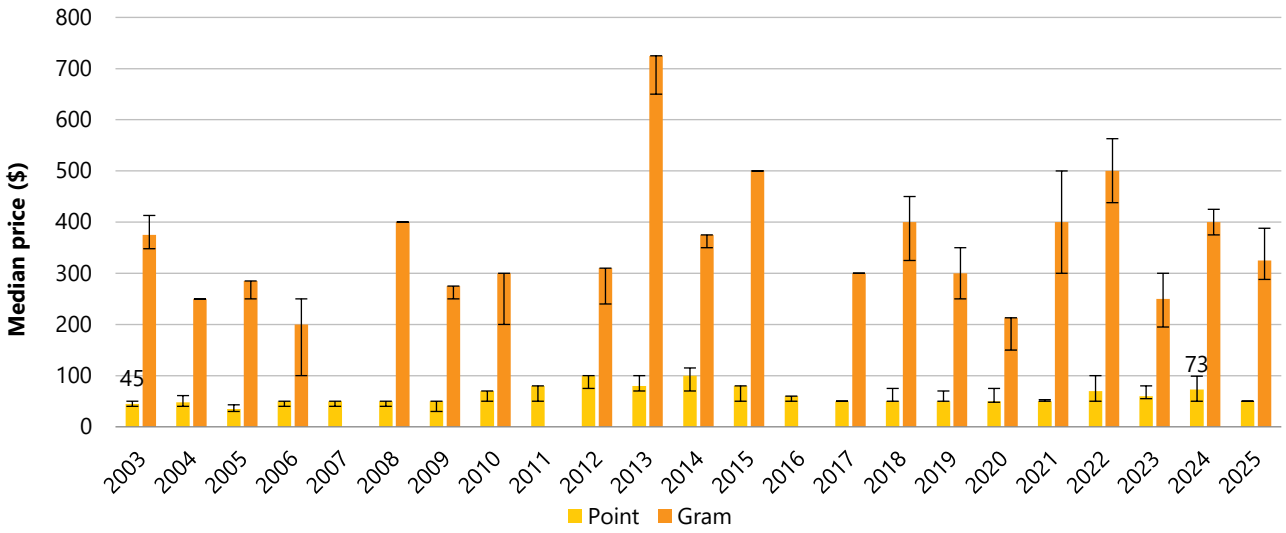
Perceived Availability: The perceived availability of methamphetamine crystal remained stable between 2024 and 2025 (p=0.182). Of those who responded in 2025 (n=18), 56% perceived the availability of crystal to be 'very easy' (60% in 2024) (Figure 24).

Figure 19: Median price of methamphetamine powder per point and gram, Canberra, ACT, 2003-2025



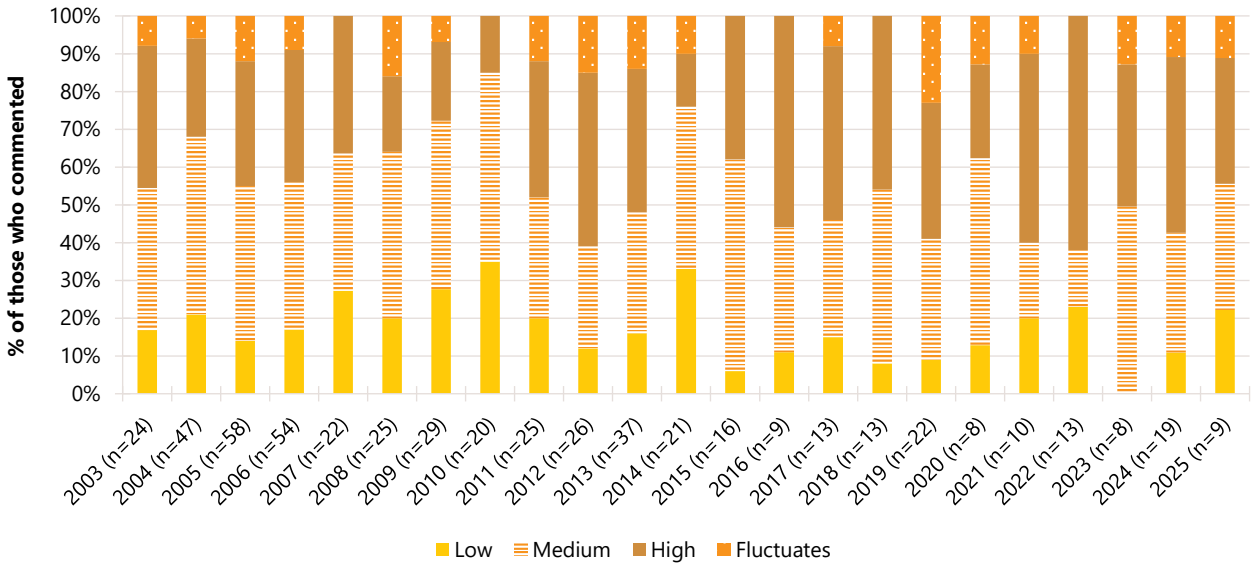
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 20: Median price of methamphetamine crystal per point and gram, Canberra, ACT, 2003-2025



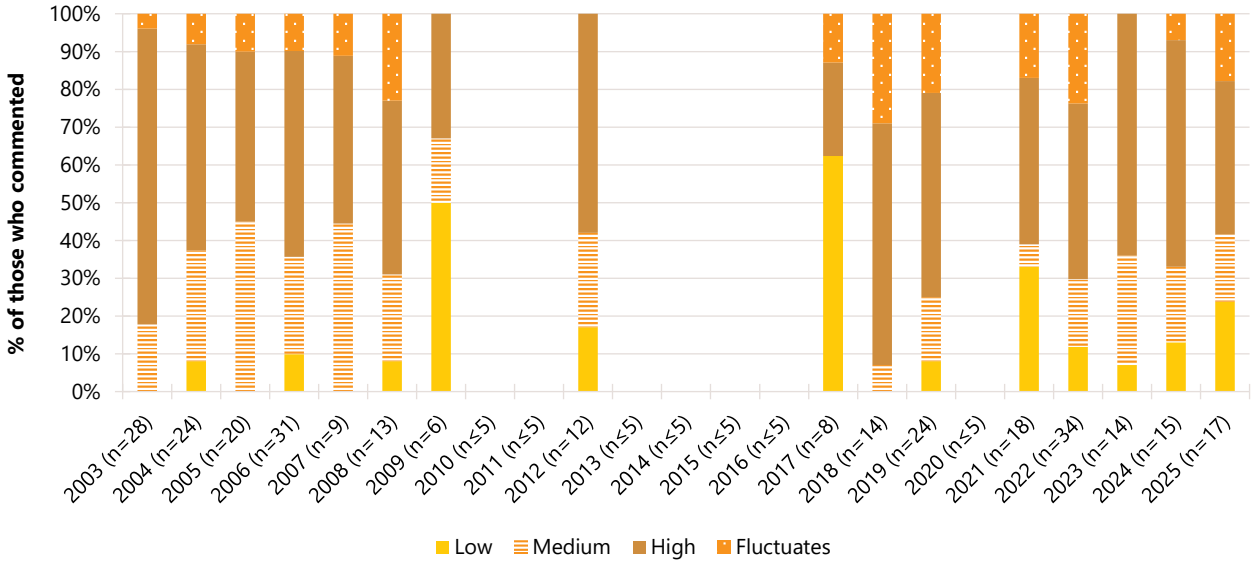
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 21: Current perceived purity of methamphetamine powder, Canberra, ACT, 2003-2025



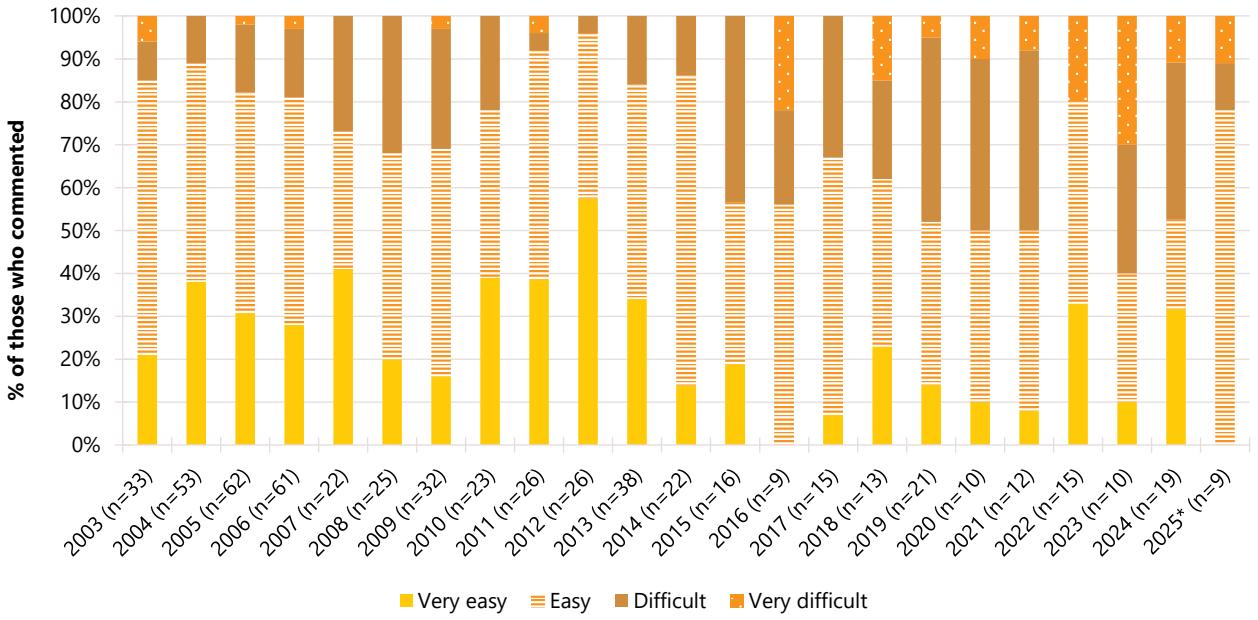
Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 22: Current perceived purity of methamphetamine crystal, Canberra, ACT, 2003-2025



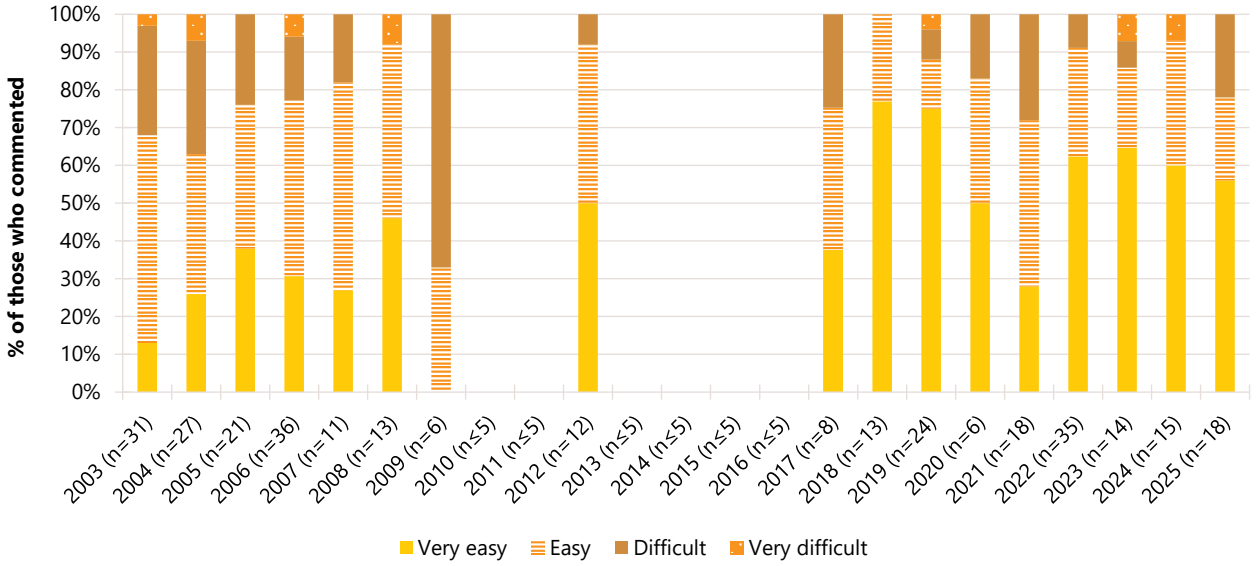
Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 23: Current perceived availability of methamphetamine powder, Canberra, ACT, 2003-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 24: Current perceived availability of methamphetamine crystal, Canberra, ACT, 2003-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

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)

Recent non-prescribed use of pharmaceutical stimulants (e.g., dexamphetamine, methylphenidate, modafinil) has fluctuated over time. In 2025, 65% of the sample reported recent non-prescribed use, the highest per cent since monitoring commenced, although stable relative to 2024 (56%; p=0.254) (Figure 25).

Frequency of Use

Median days of non-prescribed use remained stable between 2024 and 2025 (6 days in 2025; IQR=3-12; n=65; 8 days in 2024; IQR=4-15; n=56; p=0.333) (Figure 25).

Routes of Administration

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=65), in 2025, the main route of administration was swallowing (89%; 93% in 2024; p=0.543), followed by snorting (18%; 18% in 2024).

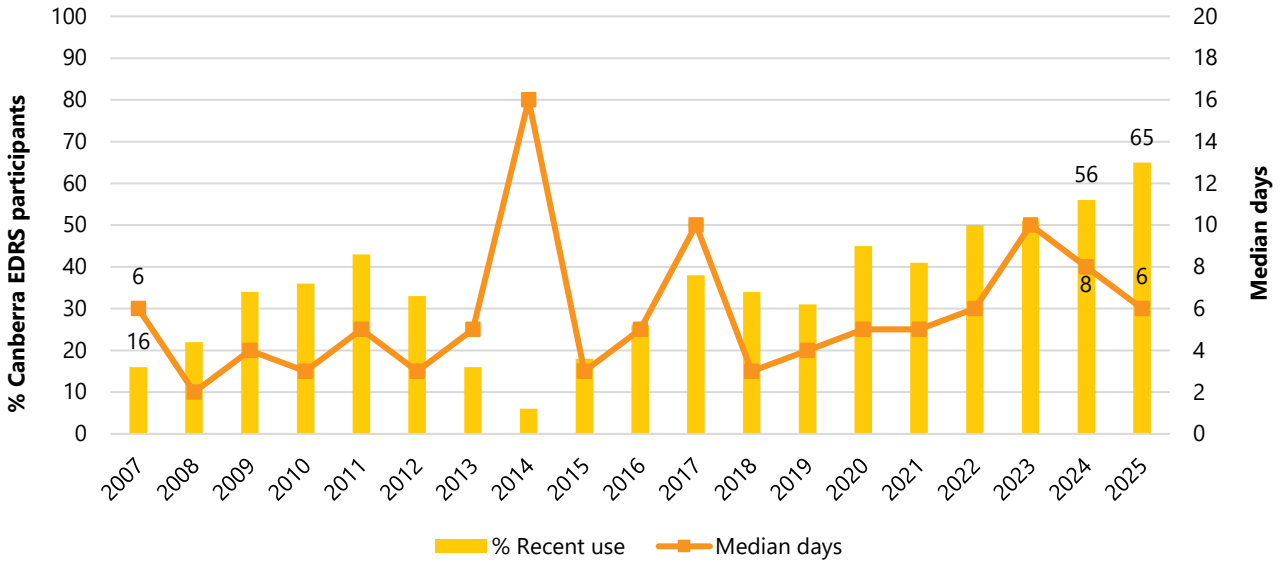
Quantity

The median quantity of non-prescribed pharmaceutical stimulants used in a 'typical' session in 2025 was one pill/tablet (IQR=1-2; n=52; 2 pills/tablets in 2024; IQR=1-3; n=40; p=0.439), and the median maximum amount used per session was two pills/tablets (IQR=1-4.50; n=51; 2.5 pills in 2024; IQR=1.30-5; n=42; p=0.427).

Forms Used

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=64), the majority reported using dexamfetamine (78%; 87% in 2024), with fewer participants reporting use of Ritalin® (53%; 36% in 2024; p=0.100) and lisdexamfetamine (39%; 22% in 2024; p=0.054).

Figure 25: Past six month use and frequency of use of non-prescribed pharmaceutical stimulants, Canberra, ACT, 2007-2025



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 20 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Price and Perceived Availability

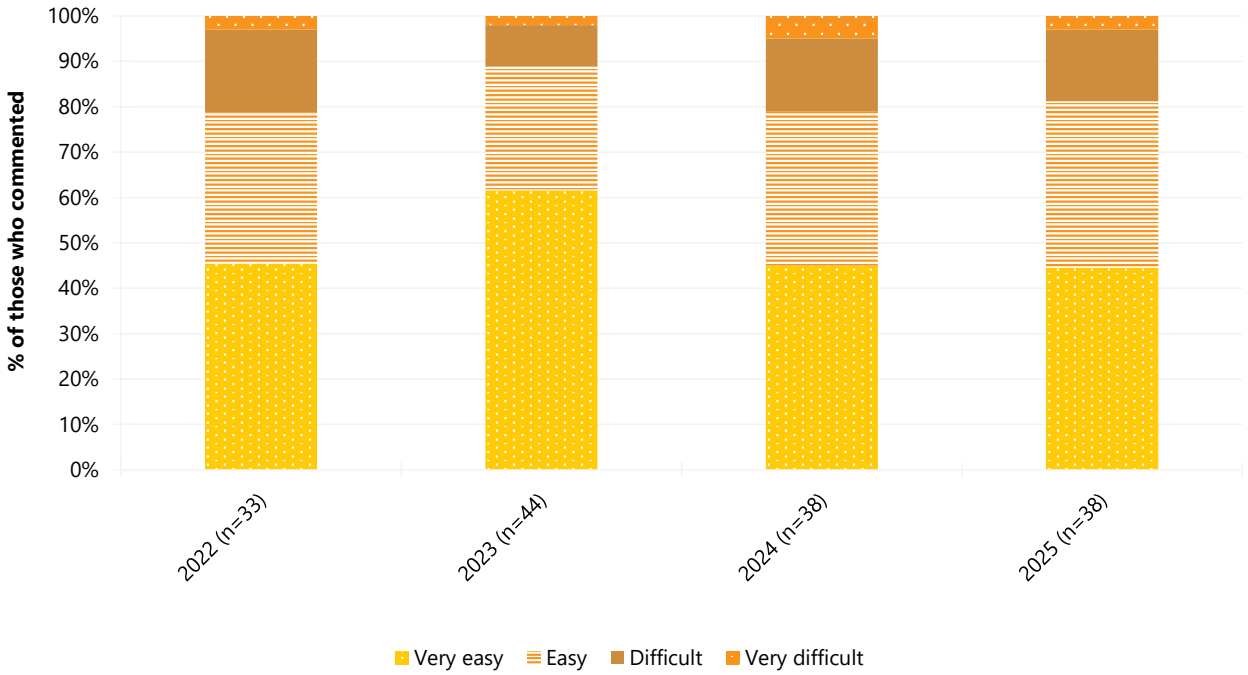
Price

Participants reported a median price of $13 per 5mg tablet in 2025 (IQR=6-20; n=10; $5 in 2024; IQR=5-10; n=16; p=0.109). Few participants (n≤5) reported on the price of a 10mg tablet in 2025 (n≤5 in 2024; p=0.207) and 20mg tablet (n≤5 in 2024).

Perceived Availability

The perceived availability of non-prescribed pharmaceutical stimulants remained stable between 2024 and 2025. Among those who responded in 2025 (n=38), 45% perceived availability to be 'very easy' (45% in 2024), followed by 37% perceiving it to be 'easy' (34% in 2024). Fewer participants (16%) perceived availability as being 'difficult (16% in 2024) (Figure 26).

Figure 26: Current perceived availability of non-prescribed pharmaceutical stimulants, Canberra, ACT, 2022-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 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)

Recent use of any cocaine has fluctuated over the years, from one quarter (26%) reporting use in 2003 to most participants reporting use in 2021 (91%). In 2025, 86% reported recent use, stable relative to 2024 (81%; p=0.448) (Figure 27).

Frequency of Use

Frequency of use has fluctuated between a median of one and six days over the course of monitoring. In 2025, the median days of use among participants who had recently used cocaine was four days (IQR=2-10; n=86), stable relative to 2024 (6 median days; IQR=3-11; n=81; p=0.234) (Figure 27). Of those who had recently consumed cocaine (n=86), 13% reported weekly or more frequent use (15% in 2024; p=0.817).

Routes of Administration

In 2025, the main route of administration among those who had recently used cocaine (n=86) was snorting (100%; 100% in 2024).

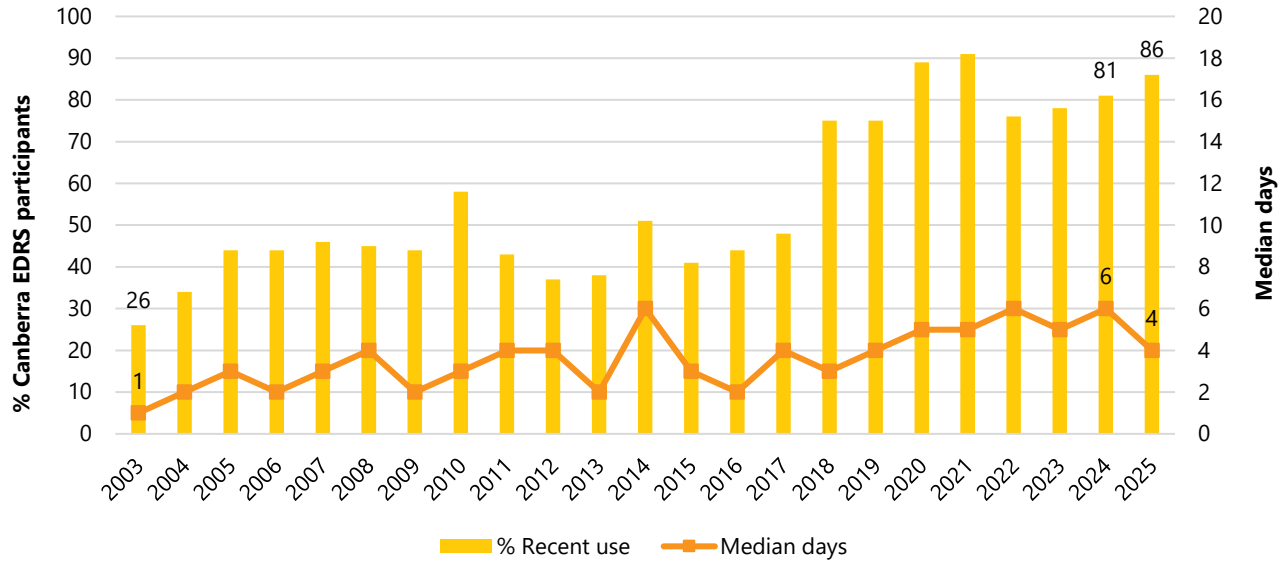
Quantity

The median intake in a 'typical' session was 0.50 grams (IQR=0.25-1.00; n=47) a significant decrease relative to 2024 (0.90 grams; IQR=0.50-1.00; n=48; p=0.024) and the median maximum intake was 0.55 grams (IQR=0.50-1.00, n=52), also a significant decrease relative to 2024 (1.00 gram; IQR=0.80-2.00, n=50; p=0.005).

Forms used

Among participants who had recently consumed cocaine and commented (n=83), the vast majority reported using powder cocaine (97%; 96% in 2024), with fewer participants reporting use of cocaine in crack/rock form (7%; 9% in 2024; p=0.777).

Figure 27: Past six month use and frequency of use of cocaine, Canberra, ACT, 2003-2025



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 20 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Price, Perceived Purity and Perceived Availability

Price

Consistent since 2006, the median price per gram of cocaine remained stable at $300 in 2025 (IQR=300-350; n=42; $300 in 2024; IQR=300-350; n=41; p=0.525) (Figure 28).

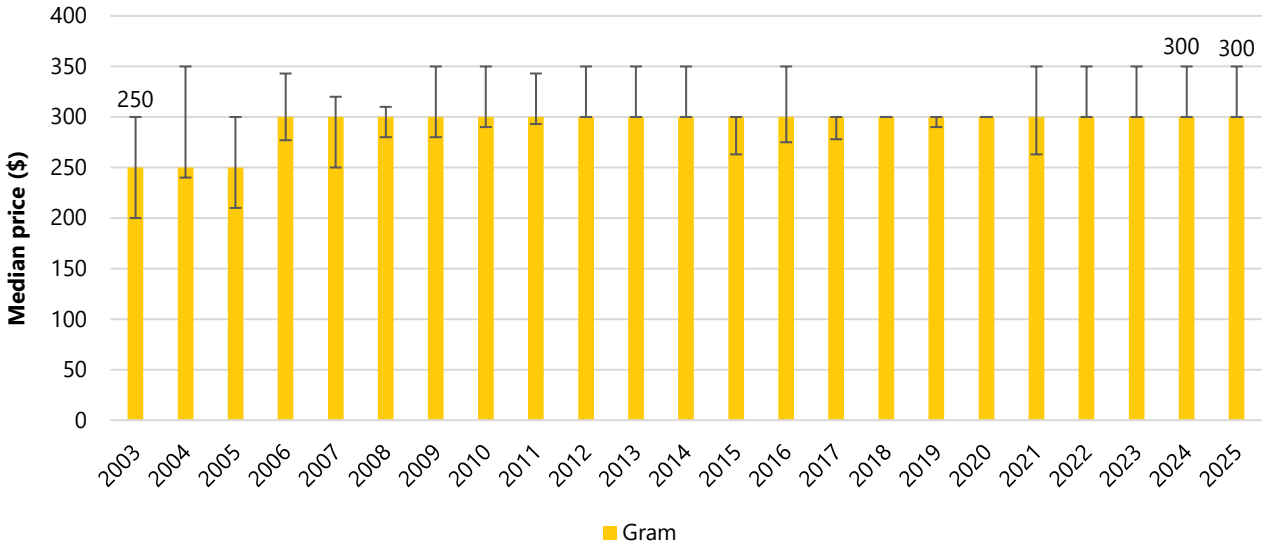
Perceived Purity

There were no significant changes in perceived purity between 2024 and 2025 (p=0.664). Among those able to comment in 2025 (n=70), two fifths (41%) perceived cocaine to be of 'high' purity (32% in 2024), the second highest per cent since monitoring commenced, followed by one third (34%) that perceived it to be of 'medium' purity (36% in 2024). Sixteen per cent reported 'low' purity (18% in 2024) (Figure 29).

Perceived Availability

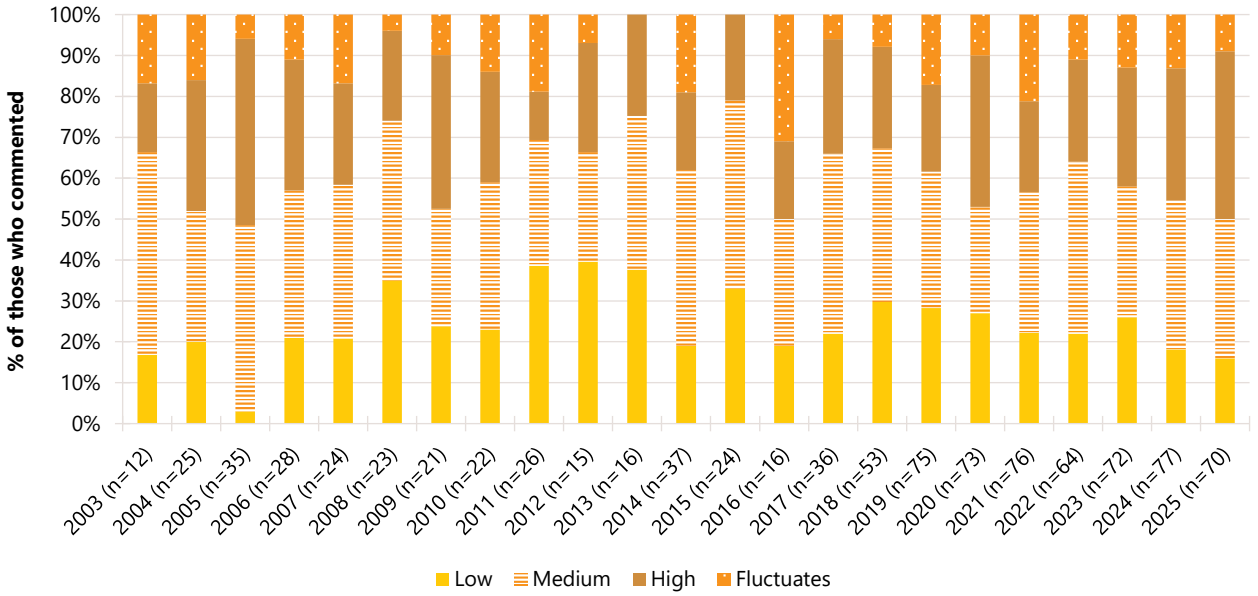
The perceived availability of cocaine remained stable between 2024 and 2025 (p=0.348). Among those able to comment in 2025 (n=69), 45% perceived cocaine to be 'very easy' to obtain (47% in 2024), followed by one third (33%) reporting that it was 'easy' to obtain (39% in 2024) (Figure 30).

Figure 28: Median price of cocaine per gram, Canberra, ACT, 2003-2025



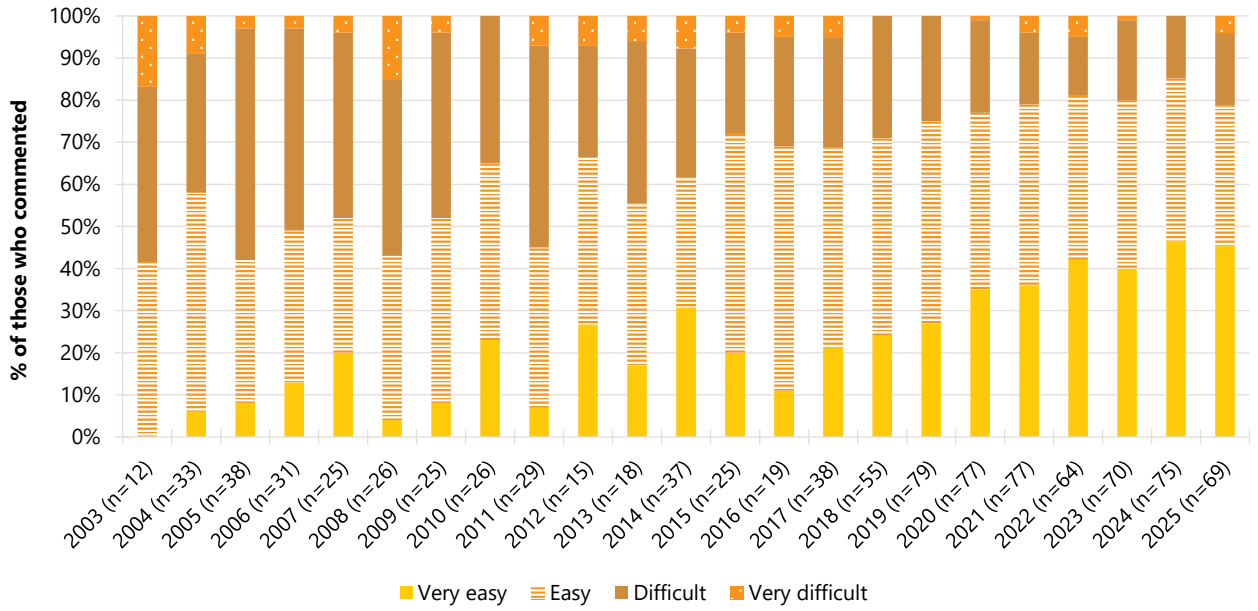
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 29: Current perceived purity of cocaine, Canberra, ACT, 2003-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 30: Current perceived availability of cocaine, Canberra, ACT, 2003-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

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. Eleven per cent reported prescribed use in the six months preceding interview in 2025 (9% in 2024; p=0.808).

In the remainder of this chapter, data from 2021-2025, and from 2003-2016, refers to non-prescribed cannabis use only, while data between 2017-2020 refers to 'any' cannabis use (including hydroponic and bush cannabis, hashish and hash oil). While comparison between 2021-2025 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 2023 lends confidence that estimates are relatively comparable.

Recent Use (past 6 months)

Eighty-seven per cent of the sample reported non-prescribed use of cannabis and/or cannabinoid-related products in 2025, stable relative to 2024 (80%; p=0.249) and similar to estimates from earlier years (Figure 31).

Frequency of Use

Frequency of use has varied between weekly and several times a week in the past six months over the course of monitoring (2025: median 72 days; IQR=12-180; n=87; 72 days in 2024; IQR=24-180; n=80; p=0.755) (Figure 31). Of those who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented (n=87), 64% reported weekly or more frequent use (76% in 2024; p=0.135) and 28% reported daily use (28% in 2024).

Routes of Administration

Across all years, nearly all participants who reported recent use of non-prescribed cannabis and/or cannabinoid-related products and commented (n=87) reported smoking cannabis (98% in 2025; 93% in 2024; p=0.155). In 2025, 31% reported swallowing (29% in 2024; p=0.863) and 7% reported inhaling/vaping non-prescribed cannabis and/or cannabinoid products (16% in 2024; p=0.089) in the past six months.

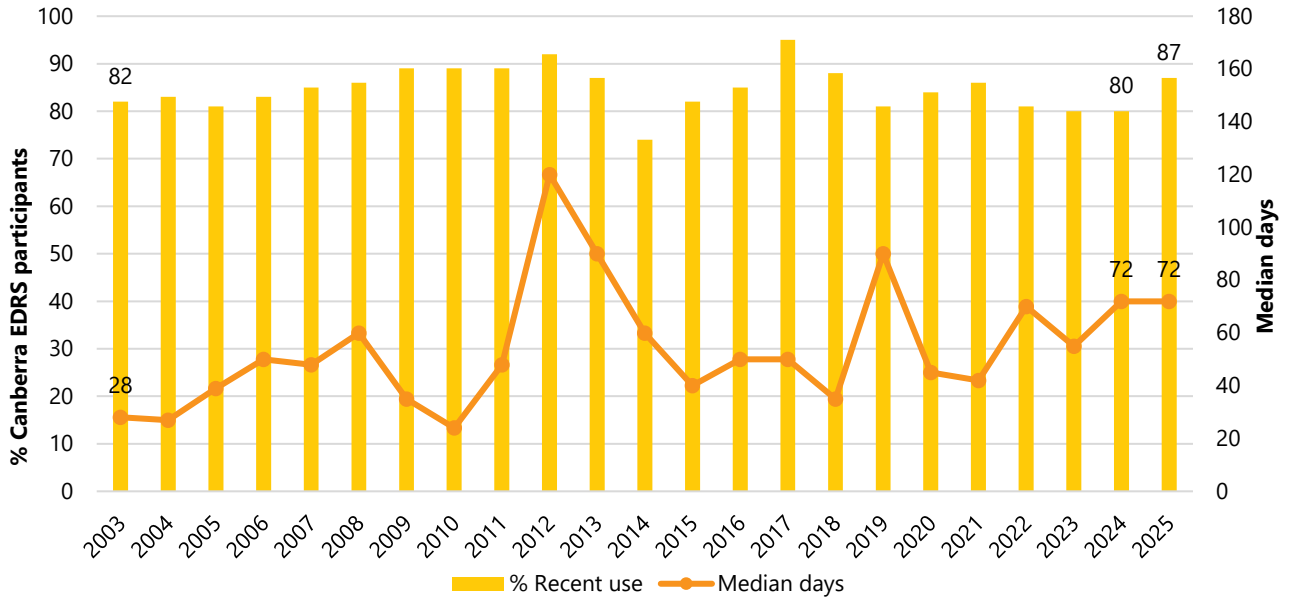
Quantity

Of those able to comment in 2025, the median amount used on the last occasion of use was one gram (IQR=0.45-2.00; n=39; 1 gram in 2024; IQR=0.73-2.13; n=40; p=0.215), two cones (IQR=1.00-3.00; n=23; 2 cones in 2024; IQR=1.00-4.00; n=23; p=0.442) or one joint (IQR=1.00-1.80; n=14; 1.5 joints in 2024; IQR=0.60-2.80; n=6) of non-prescribed cannabis and/or cannabinoid products.

Forms Used

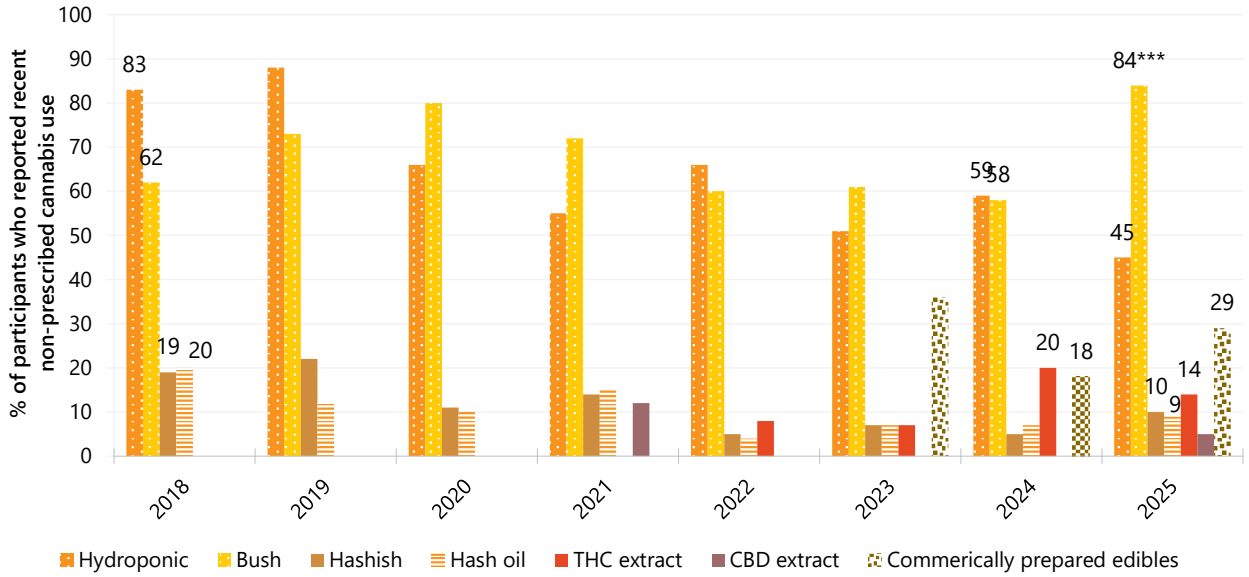
Among participants who had recently used non-prescribed cannabis and/or cannabinoid-related products and responded (n=80), 84% reporting recent use of outdoor-grown 'bush' cannabis in 2025, a significant increase relative to 2024 (58%; p<0.001), followed by 45% reporting using hydroponic cannabis (59% in 2024; p=0.084) (Figure 32). Twenty-nine per cent reported consumption of edibles (18% in 2024; p=0.134), followed by 14% reporting use of THC extract (20% in 2025; p=0.389), 10% reporting hashish (n≤5 in 2024; p=0.370) and 9% reporting hash oil (n≤5 in 2024; p=0.766). Few participants (n≤5) reported having used CBD extract (n≤5 in 2024) in the preceding six months (Figure 32).

Figure 31: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid-related products, Canberra, ACT, 2003-2025



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 only few (n≤5) participants reported use of prescribed cannabis only). Further, from 2022, 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 32: Past six month use of different forms of non-prescribed cannabis and/or cannabinoid-related products, among those who reported recent use, Canberra, ACT, 2018-2025



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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Price, Perceived Potency and Perceived Availability

Hydroponic Cannabis

Price: In 2025, the median price per ounce of non-prescribed hydroponic cannabis was $280 (IQR=276-295; n=6; $265 in 2024; IQR=250-319; n=10; *p*=0.740) and $20 for one gram (IQR=20-20; n=8; n≤5 in 2024; *p*=0.216) (Figure 33A).

Perceived Potency: The perceived potency of non-prescribed hydroponic cannabis remained stable between 2024 and 2025 (*p*=0.452). Of those able to comment in 2025 (n=32), nearly half (47%) perceived hydroponic cannabis to be of 'high' potency (62% in 2024), followed by one third (34%) reporting that potency was 'medium' (26% in 2024) (Figure 34A).

Perceived Availability: The perceived availability of non-prescribed hydroponic cannabis remained stable between 2024 and 2025 (*p*=0.776). Of those able to comment in 2025 (n=32), nearly all participants perceived availability to be 'easy' or 'very easy' (97%; 98% in 2024) (Figure 35A).

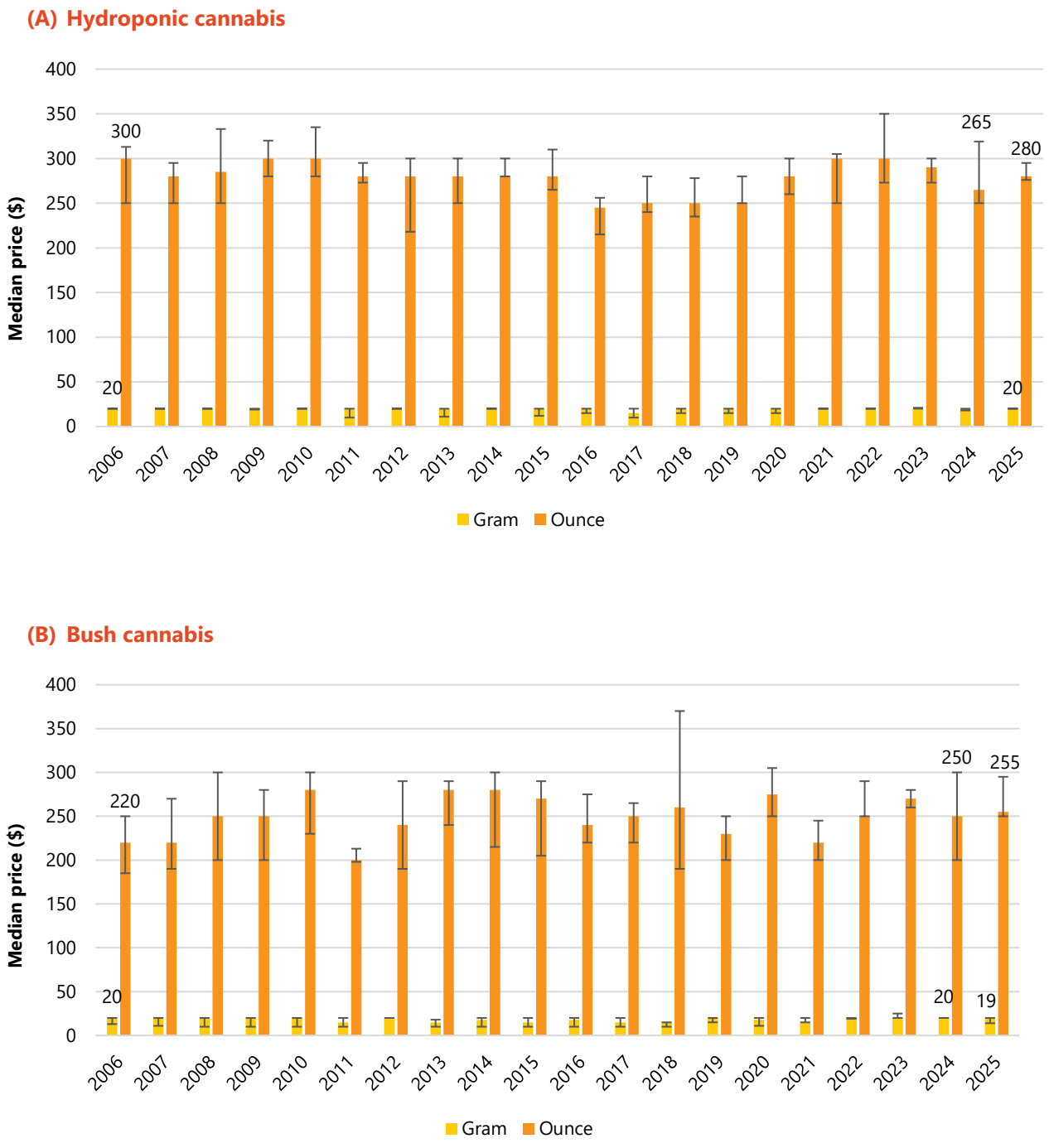
Bush Cannabis

Price: In 2025, the median price per ounce of non-prescribed bush cannabis was $255 (IQR=250-295; n=10; $250 in 2024; IQR=200-300; n=9; *p*=0.564) and $19 for one gram (IQR=14-20; n=16; $20 in 2024; IQR=20-20; n=6; *p*=0.245) (Figure 33B).

Perceived Potency: The perceived potency of non-prescribed bush cannabis remained stable between 2024 and 2025 (*p*=0.603). Among those able to comment in 2025 (n=54), two fifths (39%) perceived bush cannabis to be of 'high' potency (26% in 2024), followed by 37% reporting that potency was 'medium' (45% in 2024) (Figure 34B).

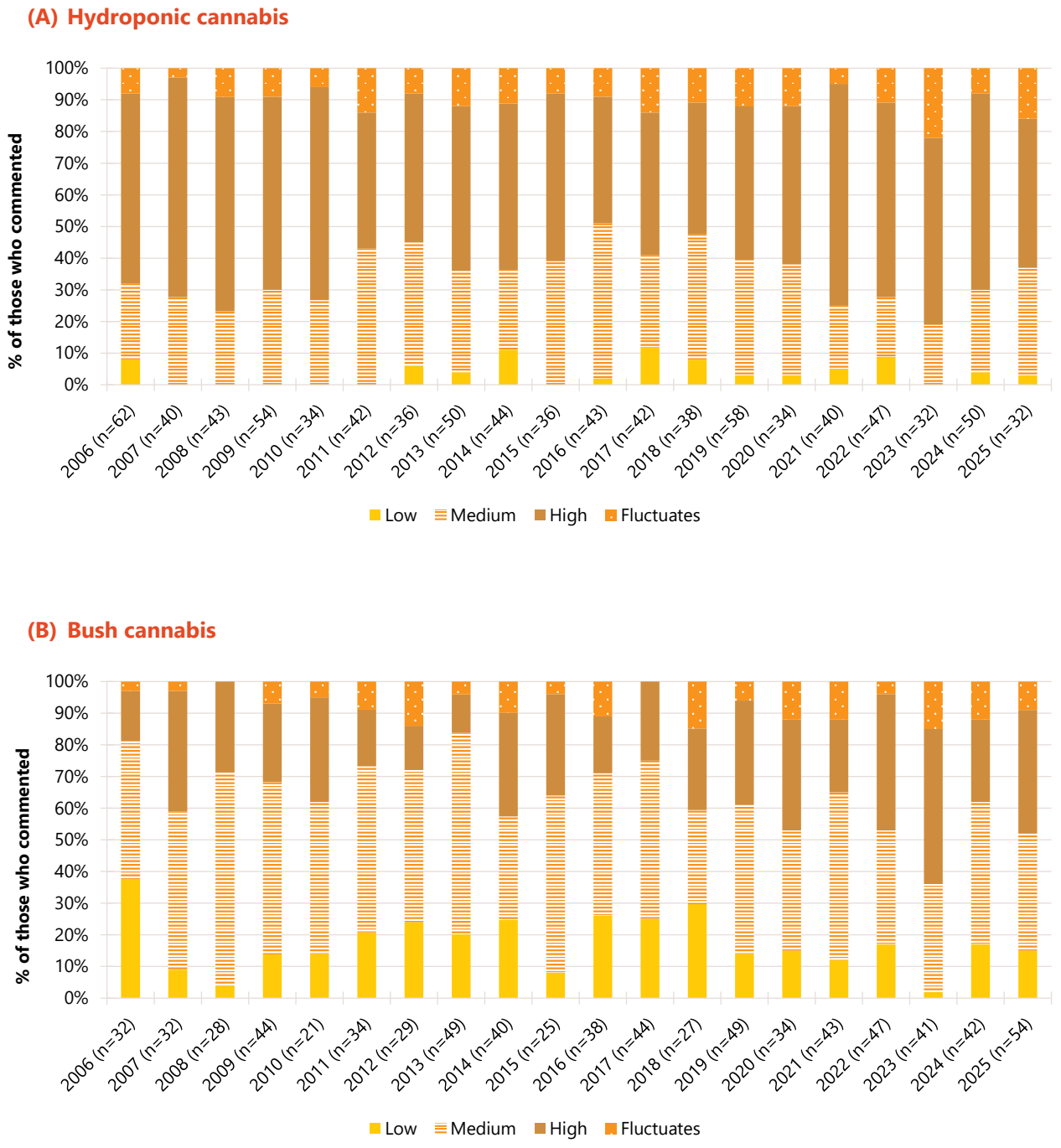
Perceived Availability: There was a significant change in the perceived availability of non-prescribed bush cannabis between 2024 and 2025 (*p*=0.049). Among those able to comment in 2025 (n=55), more participants perceived the availability of bush to be 'very easy' (93%) in 2025 relative to 2024 (74%), and fewer reported 'easy' (n≤5; 17% in 2024) (Figure 35B).

Figure 33: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Canberra, ACT, 2006-2025



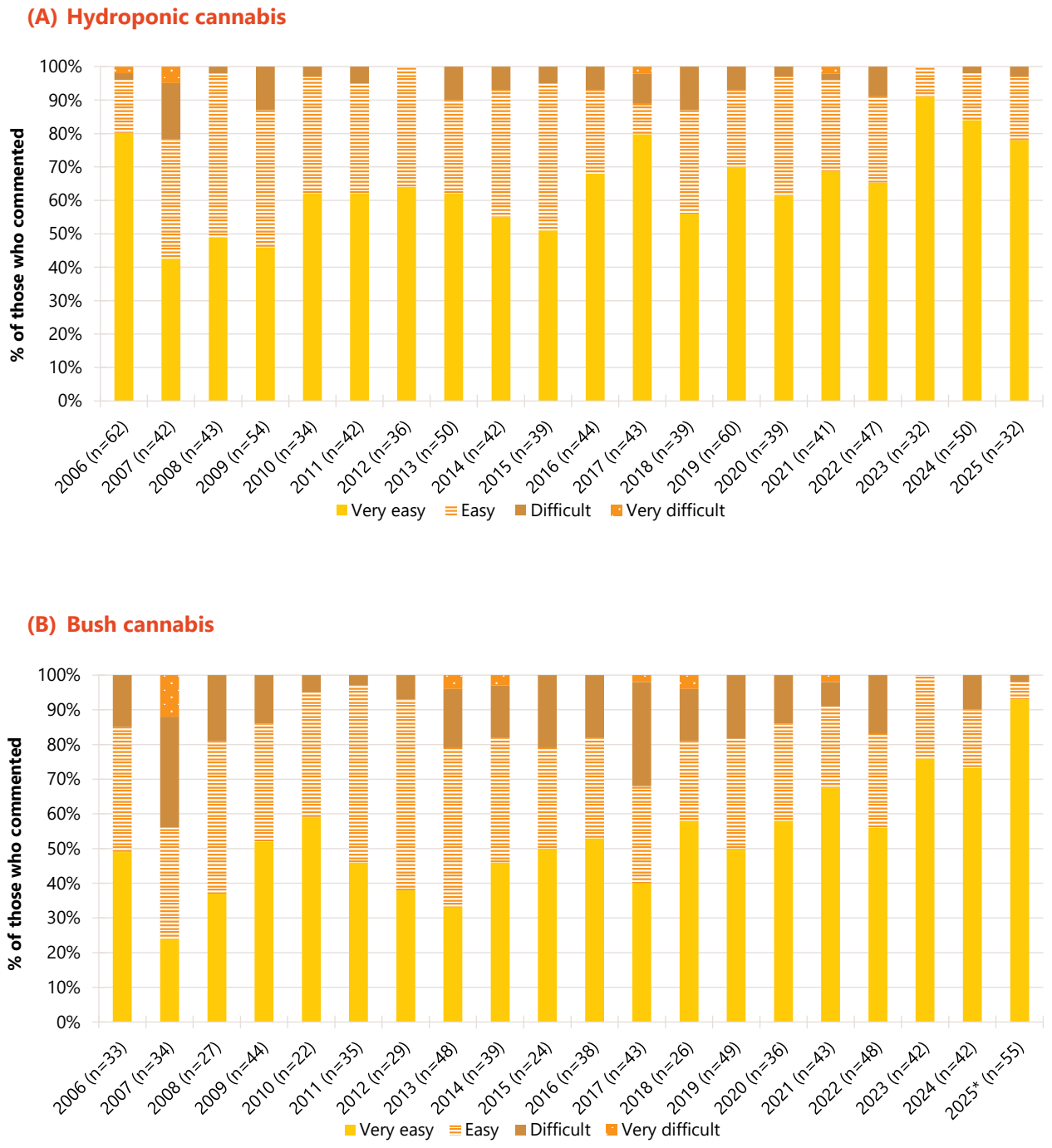
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only: prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants 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 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to tables and figures.

Figure 34: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Canberra, ACT, 2006-2025



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 are reporting on the 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. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 35: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Canberra, ACT, 2006-2025



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 are reporting on the 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. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

7

Ketamine, LSD and DMT

Non-Prescribed Ketamine

Patterns of Consumption

Recent Use (past 6 months): Almost three fifths (57%) of the sample reported using non-prescribed ketamine in the six months prior to interview, the highest per cent since monitoring commenced although remaining stable relative to 2024 (46%; *p*=0.162) (Figure 36).

Frequency of Use: Frequency of use has historically been low, varying between a median of one and six days (2025: 6 days; IQR=3-12; n=57; 5 days in 2024; IQR=2-10; n=46; *p*=0.093) (Figure 36). Among participants who reported recent non-prescribed ketamine use in 2025, 16% reported using weekly or more frequently (n≤5 in 2024; *p*=0.218).

Routes of Administration: In 2025, the most common route of administration among participants who had recently used non-prescribed ketamine was snorting (100%; 93% in 2024; *p*=0.086).

Quantity: The median quantity used in a 'typical' session was 0.30 grams (IQR=0.20-0.50, n=32; 0.40 grams in 2024; IQR=0.20-0.50; n=26; *p*=0.339) and the median maximum amount used was 0.50 grams (IQR=0.30-1.00; n=36; 0.50 grams in 2024; IQR=0.28-1.00; n=26; *p*=0.730).

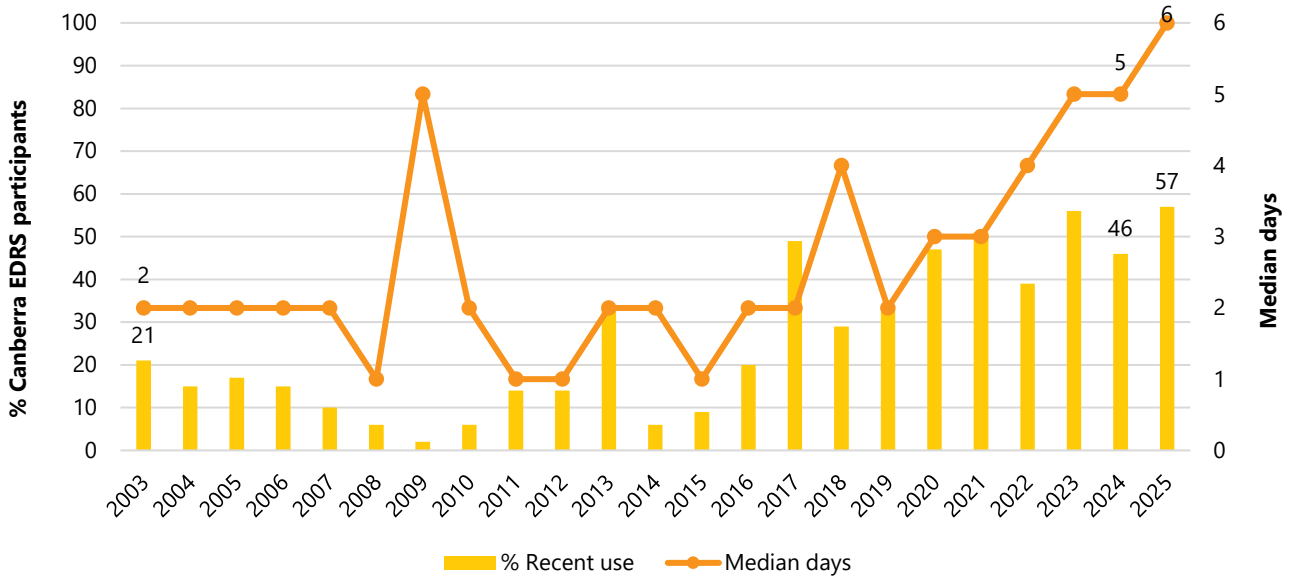
Price, Perceived Purity and Perceived Availability

Price: The reported median price for one gram of non-prescribed ketamine was $175 in 2025 (IQR=100-200; n=29), a significant decrease relative to 2024 ($250; IQR=150-250; n=17; *p*=0.006) and the lowest price recorded since monitoring commenced (Figure 37).

Perceived Purity: The perceived purity of non-prescribed ketamine remained stable between 2024 and 2025 (*p*=0.321). Of those who responded in 2025 (n=48), 69% perceived the purity of ketamine to be 'high' (83% in 2024), followed by 21% perceiving it to be 'medium' (15% in 2024) (Figure 38).

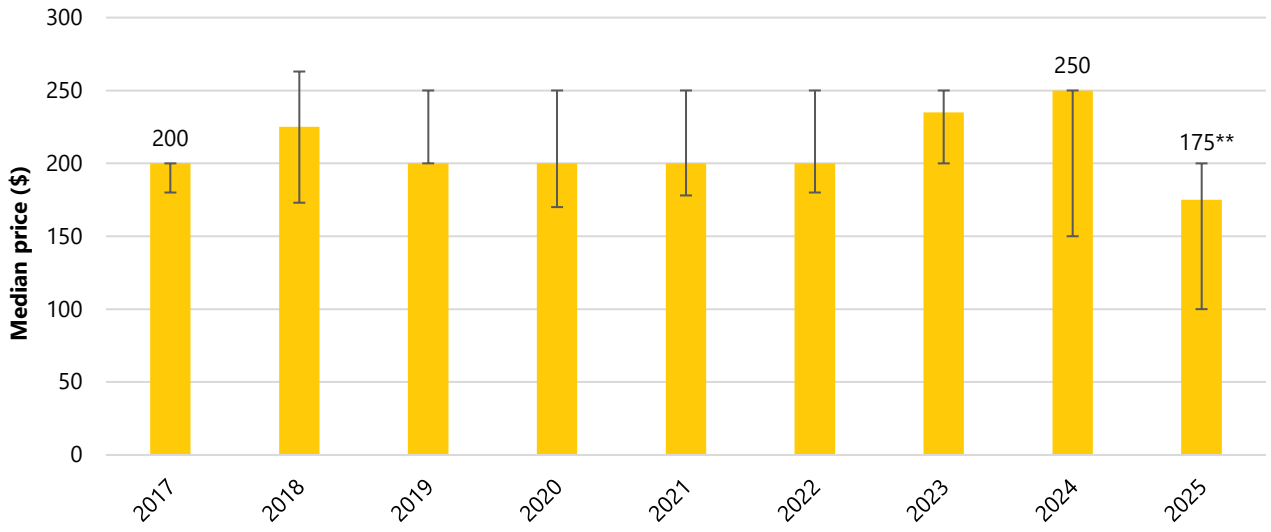
Perceived Availability: There was a significant change in the perceived availability between 2024 and 2025 (*p*=0.013). Of those who commented in 2025 (n=50), more participants reported non-prescribed ketamine to be 'very easy' and 'easy' to obtain (38% and 52%, respectively) relative to 2024 (32% and 32%, respectively) (Figure 39).

Figure 36: Past six month use and frequency of use of non-prescribed ketamine, Canberra, ACT, 2003-2025



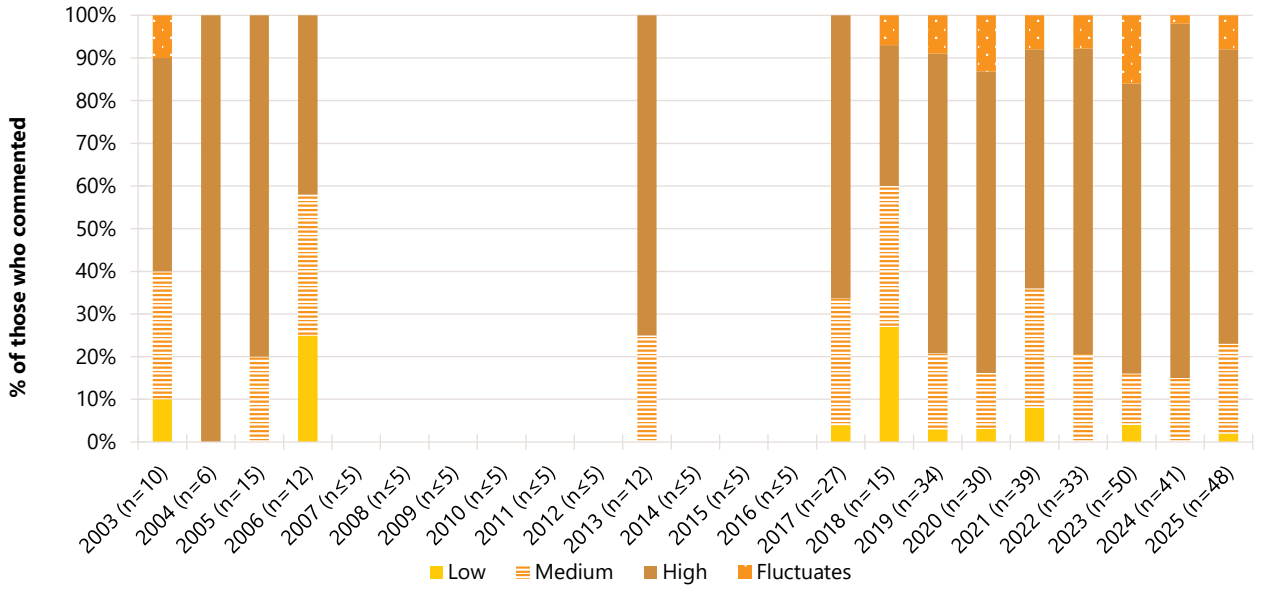
Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 6 days to improve visibility of trends. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been 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). Statistical significance for 2024 versus 2025 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: Median price of non-prescribed ketamine per gram, Canberra, ACT, 2017-2025



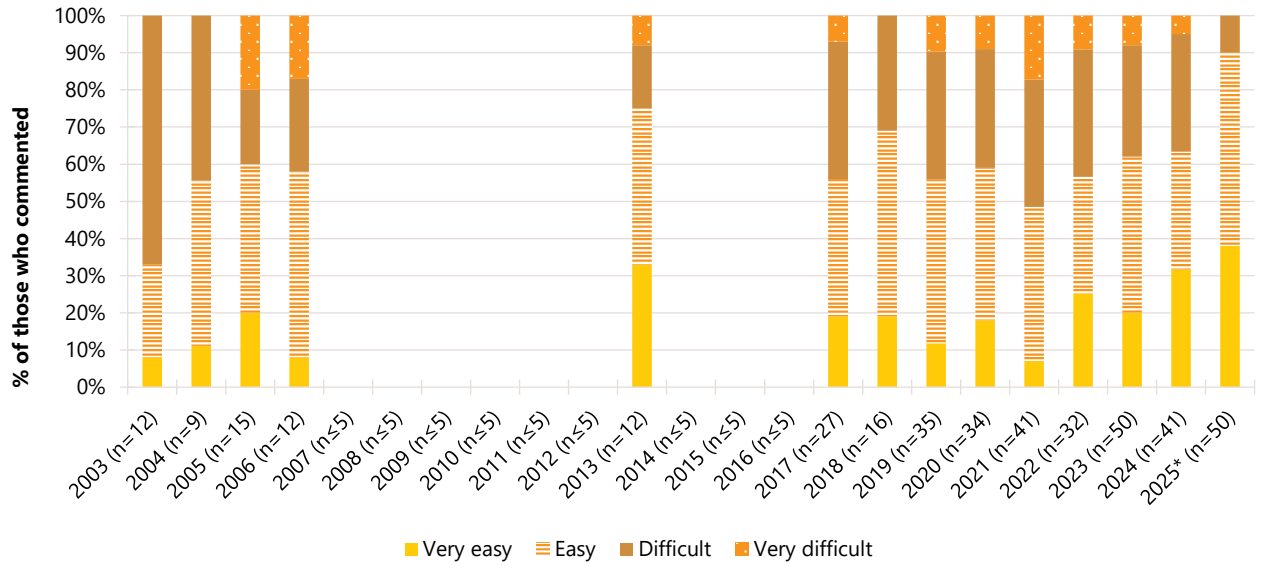
Note. Among those who commented. Data prior to 2017 not provided due to low respondents. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first and two most recent years provided in the figure, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 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 purity of non-prescribed ketamine, Canberra, ACT, 2003-2025



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. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 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 39: Current perceived availability of non-prescribed ketamine, Canberra, ACT, 2003-2025



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. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 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): Recent use of LSD has fluctuated over the course of monitoring. In 2025, 28% reported recent use (37% in 2024; p=0.234) (Figure 40).

Frequency of Use: Frequency of use has historically been low, varying between a median of one and five days. In 2025, participants who reported recent use of LSD reported using it on a median of two days (IQR=1-4; n=28; 2 days in 2024; IQR=1-4; n=37; p=0.630) (Figure 40). Few participants (n≤5) reported weekly or more frequent use of LSD in 2025 (n≤5 in 2024).

Routes of Administration: In 2025, all participants (100%) reporting recent use of LSD reported swallowing as a route of administration (100% in 2024).

Quantity: In 2025, the median quantity used in a 'typical' session was one tab (IQR=0.80-2.00; n=19; 1 tab in 2024; IQR=0.50-2.00; n=28; p=0.562). The median maximum number of tabs used was also one (IQR=0.60-3.50; n=18; 1 tab in 2024; IQR=1.00-2.30; n=28; p=0.688).

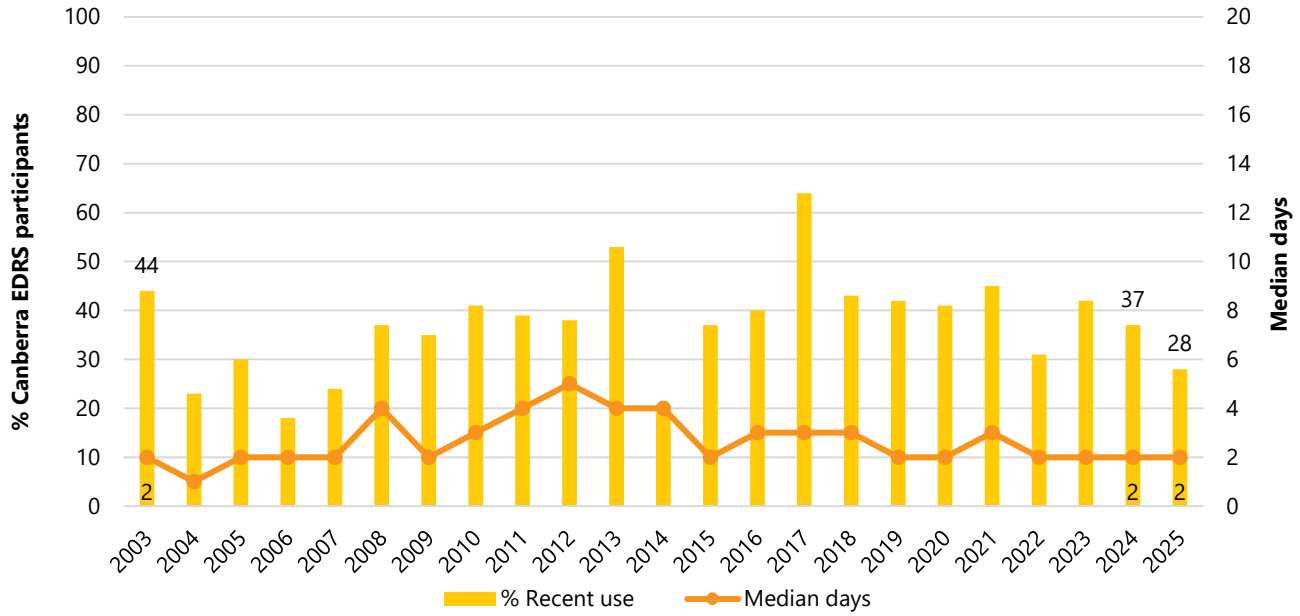
Price, Perceived Purity and Perceived Availability

Price: In 2025, the median price for one tab was $20 (IQR=19-28; n=12), a significant decrease relative to 2024 ($30; IQR=25-30; n=19; p=0.044) (Figure 41).

Perceived Purity: There was a significant change in the perceived purity between 2024 and 2025 (p=0.024). Of those who responded in 2025 (n=30), the majority perceived purity to be 'high' (73%), an increase from 53% in 2024 (Figure 42).

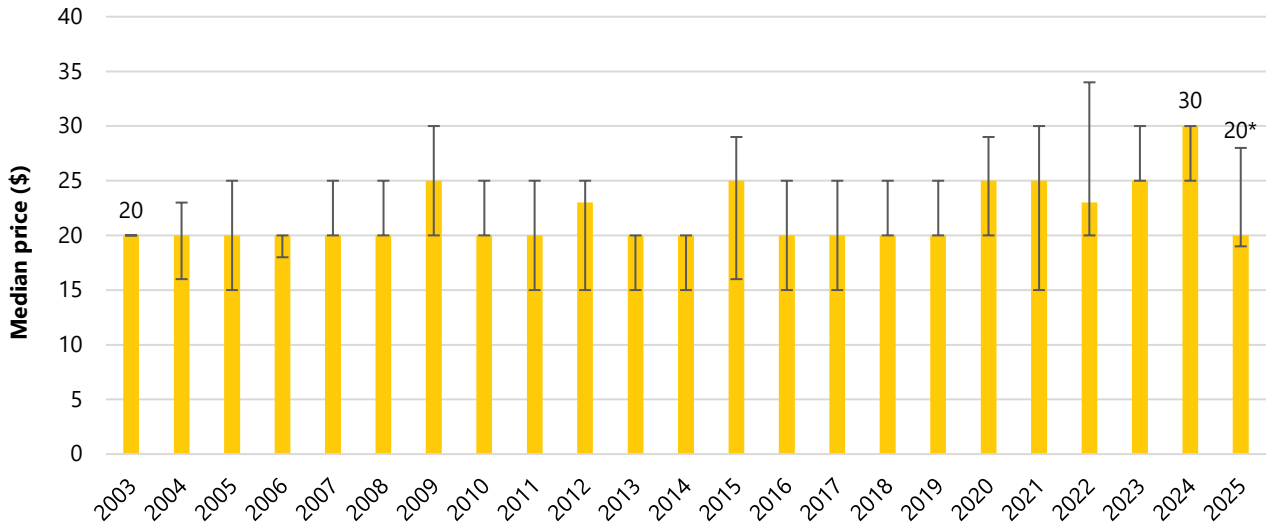
Perceived Availability: Perceived availability remained stable between 2024 and 2025 (p=0.707). Of those who responded in 2025 (n=30), two fifths (40%) perceived LSD to be 'difficult' to obtain (31% in 2024), followed by 27% reporting that it was 'easy' to obtain (26% in 2024) and 23% reporting 'very easy' obtainment (36% in 2024) (Figure 43).

Figure 40: Past six month use and frequency of use of LSD, Canberra, ACT, 2003-2025



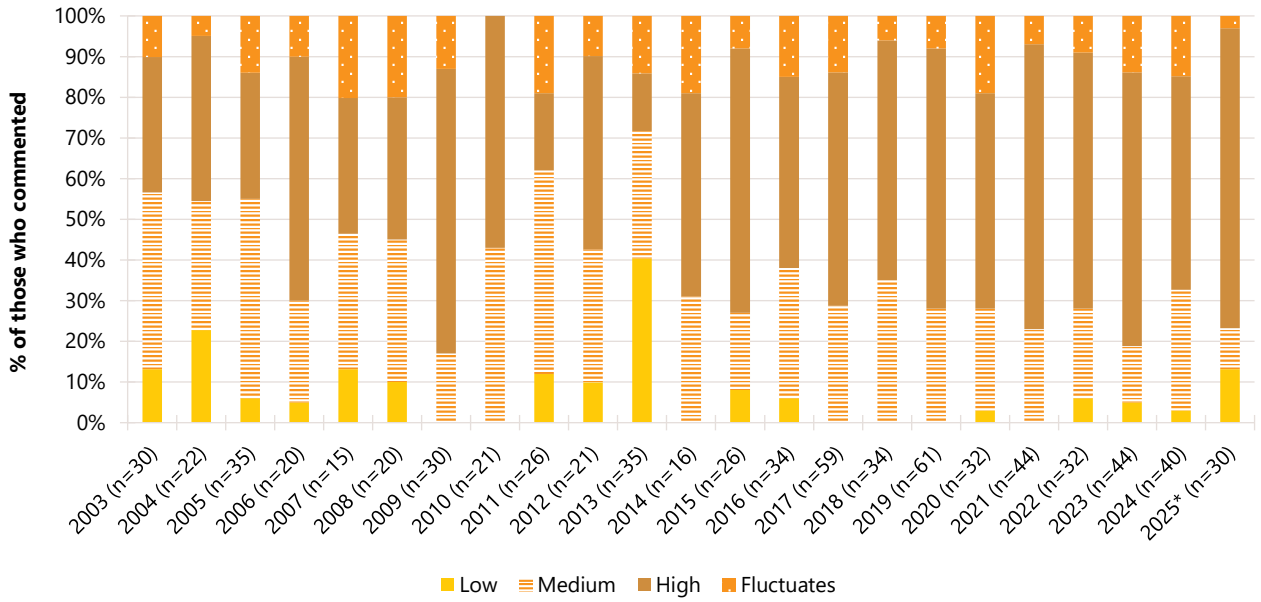
Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 20 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 41: Median price of LSD per tab, Canberra, ACT, 2003-2025



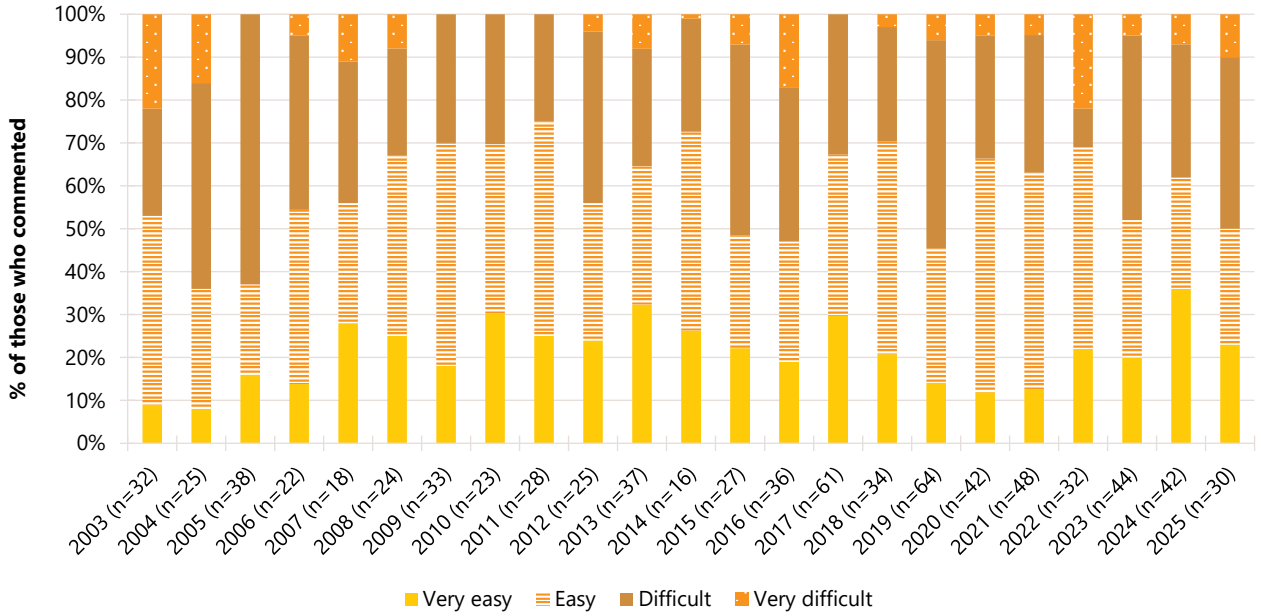
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 42: Current perceived purity of LSD, Canberra, ACT, 2003-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Figure 43: Current perceived availability of LSD, Canberra, ACT, 2003-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

DMT

Patterns of Consumption

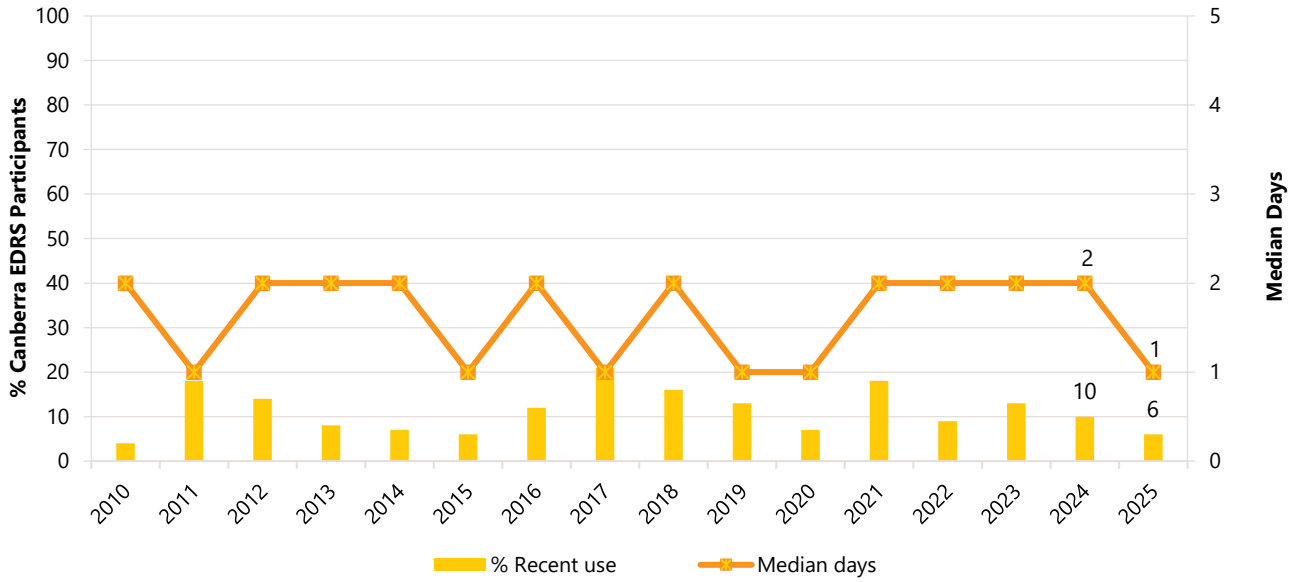
Recent Use (past 6 months): DMT use has fluctuated over the reporting period, with 6% reporting recent use in 2025, stable compared to 2024 (10%; *p*=0.435) (Figure 44).

Frequency of Use: Use across the years has been infrequent and stable, with a median of one day (IQR=1-1; n=6) of use in 2025 (2 days in 2024; IQR=1-3; n=10; *p*=0.168) (Figure 44).

Routes of Administration: Among participants who had recently consumed DMT, the most common route of administration was smoking (100%; 80% in 2024; *p*=0.500).

Quantity: Few participants (n≤5) reported on the median quantity used in a 'typical' session and the maximum amount, hence no further information is provided for 2025 (n≤5 in 2024).

Figure 44: Past six month use and frequency of use of DMT, Canberra, ACT, 2010-2025



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 5 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

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 the decision has been made to exclude them from this category. This means that the figures presented below for recent use of 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, historically, we have presented figures for 'any' NPS use, both including and excluding plant-based NPS. However, in 2025, we did not specifically ask about the use of any specific plant-based NPS (e.g., mescaline, ayahuasca) and thus only present the per cent for 'any' NPS, excluding plant-based NPS.

Patterns of Consumption

Recent Use (past 6 months)

Sixteen per cent of the sample reported recent use of any NPS, excluding plant-based NPS, stable relative to 2024 (16%) (Table 3).

Forms Used

Participants are asked about a range of NPS each year, updated to reflect key emerging substances of interest. NPS use among the sample has fluctuated over time, although 2C substances consistently remained the most commonly used NPS between 2015 and 2023. However, in 2025, few participants (n≤5) reported recent use of 2C substances (n≤5 in 2024) and all the other NPS classes (Table 4). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Table 3: Past six month use of NPS (excluding plant-based NPS), Canberra, ACT, 2010-2025

%	Excluding plant-based NPS
2010	15
2011	26
2012	49
2013	44
2014	17
2015	32
2016	24
2017	24
2018	18
2019	28
2020	11
2021	17
2022	7
2023	18
2024	16
2025	**16**

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 2024 versus 2025 presented in table; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Table 4: Past six month use of NPS by drug type, Canberra, ACT, 2010-2025

%	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Drugs that mimic the effects of ecstasy	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-
Mephedrone	-	-	0	0	0	-	0	-	0	-	0	0	-	-	-	-
Methylone	/	-	12	-	-	6	-	-	-	9	0	0	0	0	0	**0**
N-ethylpentylone (ephylone)	/	/	/	/	/	/	/	/	/	0	0	0	0	0	0	**0**
N-ethylbutylone (eutylone)	/	/	/	/	/	/	/	/	/	/	/	0	0	0	0	**0**
Other drugs that mimic the effects of ecstasy	/	/	/	/	/	/	/	0	-	-	0	0	0	0	0	-
Drugs that mimic the effects of amphetamine or cocaine	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
3-chloromethcathinone (e.g., 3-CMC; clophedrone)	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
3-Methylmethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
4-Chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0	**0**
4-FA	/	/	/	/	/	/	0	0	0	0	0	0	0	0	0	**0**
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
Alpha PVP	/	/	/	/	/	/	0	0	0	0	0	0	0	0	0	**0**
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	-	-	-	**0**
MDPV	0	0	-	0	0	-	-	0	0	0	0	0	0	0	0	**0**
Methcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
N-Ethylhexedrone	/	/	/	/	/	/	/	/	/	0	0	0	0	0	0	**0**
Other drugs that mimic the effects of amphetamine or cocaine	/	/	/	/	/	/	/	-	-	-	0	-	0	0	-	**0**
Drugs that mimic the effects of psychedelic drugs	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-
Any 2C substance (e.g., 2C-I, 2C-B)~	8	8	11	18	9	21	13	14	7	7	-	7	-	8	-	-
4-AcO-DMT	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
5-MeO-DMT	-	-	-	-	0	0	-	-	-	-	-	-	0	-	-	**0**
Dox (e.g., DOB, DOC, DOI, DOM)	0	0	0	0	0	0	0	0	0	0	0	0	-	0	0	**0**
NBOH (e.g., 25I, 25B)	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
NBOMe (e.g., 25I, 25B, 25C, others)	/	/	/	/	-	-	-	-	-	-	-	-	0	-	0	**0**
Other drugs that mimic the effects of psychedelic drugs	/	/	/	/	/	/	/	0	-	-	-	-	0	-	-	-
Drugs that mimic the effects of dissociatives	/	/	-	0	0	-	-	0	0	-	0	-	0	-	7	-
2F-2-oxo PCE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-	-
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	0	-	-	-
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
3F-2-oxo-PCE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	-
3-HO-PCP/4-HO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	-
3-MeO-PCP/4-MeO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	0	-	-
Methoxetamine	/	/	-	0	0	-	-	0	0	-	0	-	0	0	0	**0**

Tiletamine	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-	-
Other drugs that mimic the effects of dissociatives	/	/	/	/	/	/	/	/	/	/	0	-	0	-	-	-
Drugs that mimic the effects of cannabis	/	-	16	-	-	0	-	-	-	-	-	-	-	0	0	-
Drugs that mimic the effects of benzodiazepines	/	/	/	/	/	/	0	-	-	-	0	-	-	-	-	-
8-Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
Bromazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	-	0	-
Clobromazolam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Clonazolam	/	/	/	/	/	/	/	/	/	/	/	/	-	-	-	-
Etizolam	/	/	/	/	/	/	0	-	0	-	0	-	0	0	-	**0**
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
Flubromazepam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	-
Phenazolam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Other drugs that mimic the effects of benzodiazepines	/	/	/	/	/	/	/	/	0	0	0	0	0	-	0	**0**
Drugs that mimic the effects of opioids	/	/	/	/	/	/	/	/	-	0	0	0	0	0	0	-
Drugs that mimic the effect of any other NPS	/	/	/	/	/	/	/	/	0	0	0	-	-	-	0	-

Note. NPS first asked about in 2010. Due to lower numbers reporting use in recent years, in 2025 participants were asked about broad categories of NPS (e.g., drugs that mimic the effects of ecstasy) and then if reported use, were asked to specify the substance. ~ 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 2024 versus 2025 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, 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 2025, 12% of the sample reported using any non-prescribed codeine (e.g., Nurofen Plus, Panadeine, Panadeine Extra) in the six months preceding interview (10% in 2024; p=0.817) (Figure 45).

Frequency of Use: Participants who had recently used non-prescribed codeine (n=12) reported use on a median of four days (IQR=2-15) in the past six months, stable relative to 2024 (1 day; IQR=1-2; n=10; p=0.075).

Pharmaceutical Opioids

Recent Use (past 6 months): The per cent of participants reporting past six month use of non-prescribed pharmaceutical opioids (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl, excluding codeine) remained stable at 12% (8% in 2024; p=0.474) (Figure 45).

Frequency of Use: Participants who had recently used non-prescribed pharmaceutical opioids reported use on a median of 18 days (IQR=4-63; n=12) in the six months preceding interview, a significant increase relative to two days in 2024 (IQR=1-5; n=8; p=0.047).

Forms used: Among participants who had recently consumed non-prescribed pharmaceutical opioids and commented in 2025 (n=12), the most commonly used pharmaceutical opioid was oxycodone (75%).

Benzodiazepines

Between 2019-2023, participants were asked about non-prescribed alprazolam use and non-prescribed use of 'other' benzodiazepines (e.g., diazepam). From 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) gradually increased between 2014 (9%) and 2020 (38%), before declining in 2021 (23%) and fluctuating thereafter. In 2025, recent use of any non-prescribed benzodiazepines was reported by 16% of the sample, a significant decrease relative to 2024 (34%; p=0.007) (Figure 45).

Frequency of Use: Participants who had recently used non-prescribed benzodiazepines (e.g., Valium, Diazepam, Xanax, Kalma) reported use on a median of four days in the past six months (IQR=2-16; n=16; 5 days in 2024; IQR=2-10; n=34; p=0.572).

Forms Used: Among those who reported recent non-prescribed benzodiazepine use and responded in 2025 (n=15), the most commonly used benzodiazepines were Xanax (alprazolam) (47%), followed by Valium (diazepam) (40%).

Steroids

Recent Use (past 6 months): The per cent of the sample reporting recent non-prescribed steroid use has remained low and stable since monitoring commenced. In 2025, few participants (n≤5) reported recent use, stable relative to 2024 (n≤5; p=0.369) (Figure 45).

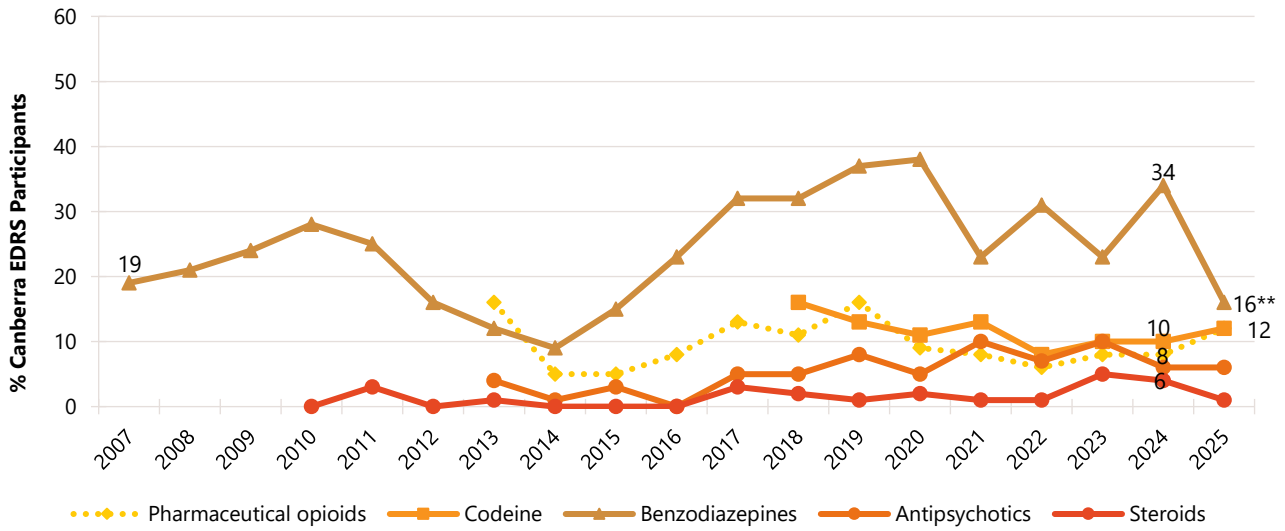
Antipsychotics

Recent Use (past 6 months): Historically, recent use of non-prescribed antipsychotics has remained low over the course of monitoring, with 6% of the sample reporting recent non-prescribed use in 2025 (6% in 2024) (Figure 45).

Frequency of Use: Participants who had recently used non-prescribed antipsychotics reported use on a median of 79 days in the past six months (IQR=15-168; n=6; 4 days in 2024; IQR=2-10; n=6; p=0.333).

Forms Used: Among participants who had recently consumed non-prescribed antipsychotics and commented in 2025 (n=6), the most commonly used antipsychotic comprised Quetiapine (100%).

Figure 45: Non-prescribed use of pharmaceutical medicines in the past six months, Canberra, ACT, 2007-2025



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'. From 2024, 'alprazolam' and 'other benzodiazepines' were combined. Y axis has been reduced to 60% 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Other Illicit Drugs

Non-Prescribed Hallucinogenic Mushrooms/Psilocybin

Recent Use (past 6 months): Recent use of non-prescribed hallucinogenic mushrooms/psilocybin has fluctuated over the course of monitoring. In 2025, almost two fifths (38%) of participants reported recent use, a significant decrease from 56% reporting recent use in 2024 (p=0.016) (Figure 46).

Frequency of Use: Use has typically been infrequent and stable, with participants reporting a median of two days of use in 2025 (IQR=1-3; n=38; 2 days in 2024; IQR=1-4; n=56; p=0.269).

MDA

Recent Use (past 6 months): Recent use of MDA has varied across the years and in 2025, few participants (n≤5) reported recent use, hence further information is not provided (n≤5 in 2024; p=0.721) (Figure 46). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Substance with Unknown Contents

Recent Use (past 6 months): From 2019, we asked participants about their use of substances with 'unknown contents'. One in ten (9%) of the sample reported recent use of any substance with 'unknown contents' in 2025, a significant decrease relative to 2024 (21%; p=0.032) (Figure 46).

When broken down by form, few participants (n≤5) were able to report on the recent use of pills (6% in 2024; *p*=0.748), capsules (7% in 2024; *p*=0.065), powder (10% in 2024; *p*=0.164) and crystal (n≤5 in 2024) with 'unknown contents' in 2025, therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Frequency of Use: Of those who had recently consumed any 'unknown' substance and responded (n=9), participants reported a median of three days (IQR=2-6) of use in the six months preceding interview, a significant increase relative to 2024 (1 day; IQR=1-2; n=21; *p*=0.030).

Quantity: From 2020, we asked participants about the average amount of pills and capsules used with 'unknown contents' in the six months preceding interview. Few participants (n≤5) were able to answer questions regarding the median quantity of pills and/or capsules used in a 'typical' session in 2025, therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

PMA

Recent Use (past 6 months): No participants reported recent use of PMA in 2025 (0% in 2024) (Figure 46). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

PMMA

Recent Use (past 6 months): No participants reported recent use of PMMA in 2025 (0% in 2024) (Figure 46). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

GHB/GBL/1,4-BD

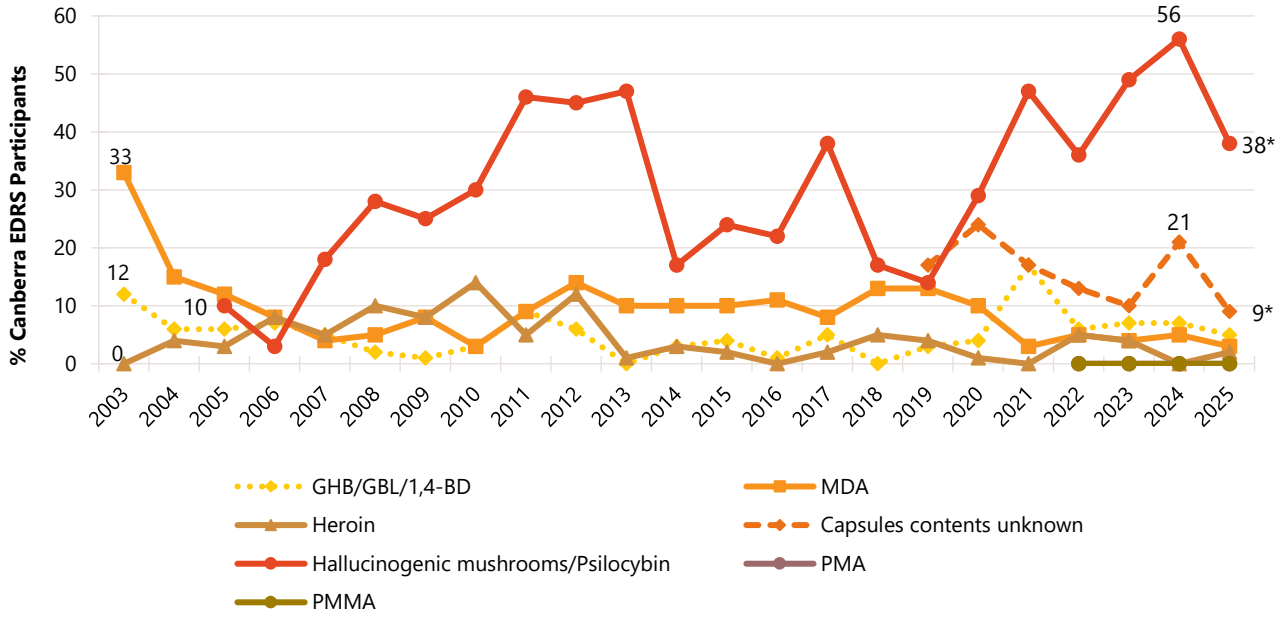
Recent Use (past 6 months): Historically, consistently small numbers have reported recent use of GHB/GBL/1,4-BD (n≤5 in 2025; 7% in 2024; *p*=0.767) (Figure 46).

Frequency of Use: Due to low numbers reporting recent use of GHB/GBL/1,4-BD, further details are not reported (n≤5 in 2025; median 4 days in 2024) (Figure 46). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Heroin

Recent Use (past 6 months): Few participants (n≤5) reported recent use of heroin in 2025 (0% in 2024; *p*=0.497) (Figure 46). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 46: Past six month use of other illicit drugs, Canberra, ACT, 2003-2025



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'. Y axis has been reduced to 60% 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

Licit and Other Drugs

Alcohol

Recent Use (past 6 months): The majority of the sample reported recent alcohol use across the period of monitoring (90% in 2025; 91% in 2024) (Figure 47).

Frequency of Use: In 2025, participants who reported recent alcohol use reported use on a median of 48 days in the past six months (IQR=24-72; n=90; 30 days in 2024; IQR=14-72; n=91; p=0.076), with 83% reporting weekly or more frequent use, a significant increase relative to 2025 (69% in 2024; p=0.040). Few participants (n≤5) reported daily use of alcohol in 2025 (n≤5 in 2024; p=0.444).

Tobacco

From 2024, additional questions were included about illicit tobacco. This was defined as products sold illegally without the necessary taxes added to the price.

Recent Use (past 6 months): Recent tobacco use has fluctuated between 68% and 92% of the sample over the course of monitoring. In 2025, 84% of the sample reported recent tobacco use (82% in 2024; p=0.847) and 60% had recently used smoked or non-smoked illicit tobacco products, a significant increase relative to 2024 (37%; p=0.002) (Figure 47).

Frequency of Use: In 2025, participants reported using tobacco on a median of 90 days (i.e., every other day; IQR=23-180; n=84), stable relative to 2024 (173 median days; IQR=24-180; n=82; p=0.274). Among those reporting recent use, 37% reported daily use, stable relative to 2024 (49%; p=0.164).

E-cigarettes/'Vapes'

Legislation regulating e-cigarettes (also known as vapes) has changed markedly in recent years. From October 2021, Australians were required to have a prescription to legally access nicotine containing e-cigarette products for any purpose, and from 1 July 2024, all e-cigarette products, regardless of whether they contained nicotine, could only legally be sold in a pharmacy. From 1 October 2024, people 18 years and older could buy e-cigarettes from participating pharmacies with a nicotine concentration of 20 mg/mL or less *without a prescription*, where state and territory laws allowed: products with a nicotine concentration of >20 mg/mL still required a prescription.

To capture these changes, in 2022, participants were asked for the first time about their use of both prescribed and non-prescribed e-cigarettes. In 2025, participants were asked about their use of e-cigarettes obtained from pharmacy (with or without a prescription) and 'non-pharmacy' locations.

In 2025, no participants reported recent use of e-cigarettes that were obtained from a pharmacy. Between 2022 and 2024, few participants reported recent use of prescribed e-cigarettes (7% in 2022 and n≤5 in 2023 and 2024, respectively). The data presented below for 2025 refers only to use of e-cigarettes that were obtained from non-pharmacy locations. 2022-2024 data refers to non-prescribed e-cigarette use, while data for 2021 and earlier refers to any e-cigarette use (collectively referred to as 'illicit use' from herein).

Recent Use (past 6 months): Recent e-cigarette use remained stable in the initial years of monitoring (2014-2018), however has since been mostly increasing. In 2025, two thirds (67%) reported recent use, stable relative to 2024 (72%; p=0.538) (Figure 47).

Frequency of Use: In 2025, median days of illicit use remained stable relative to 2024 (90 days; IQR=26-180; n=66; 99 days in 2024; IQR=34-180; n=72; p=0.377). In 2025, one third (33%) of those who had recently used illicit e-cigarettes reported daily use (40% in 2024; p=0.474).

Contents and Forms Used: Among participants who had recently used illicit e-cigarettes and responded (n=66), participants most commonly reported using disposable devices (98%), followed by pods (11%).

Reason for Use: Among participants who had recently consumed *any* e-cigarettes in 2025, one quarter (24%) reported that they use e-cigarettes as a smoking cessation tool (39% in 2024; p=0.073).

Nicotine Pouches

Recent Use (past 6 months): Twenty-seven per cent of the sample reported recent use of nicotine pouches (28% in 2024) (Figure 47).

Frequency of Use: Participants who had recently used nicotine pouches reported use on a median of 10 days (IQR=3-50; n=27; 6 days in 2024; IQR=1-20; n=28; p=0.293).

Nitrous Oxide

Recent Use (past 6 months): In 2025, two fifths (40%) of the sample reported recent use of nitrous oxide, stable relative to 2024 (52%; p=0.124) (Figure 47).

Frequency of Use: Frequency of use remained stable at three days in 2025 (IQR=1-7; n=40; 3 days in 2024; IQR=2-9; n=52; *p*=0.417).

Quantity: Among those who commented in 2025 (n=38), the median amount of nitrous oxide used in a 'typical' session in the six months preceding interview was five bulbs (IQR=2-10; 5 bulbs in 2024; IQR=3-10; n=49; *p*=0.708). The median maximum amount used in a session was six bulbs (IQR=3-20; n=37; 10 bulbs in 2024; IQR=3-20; n=49; *p*=0.487).

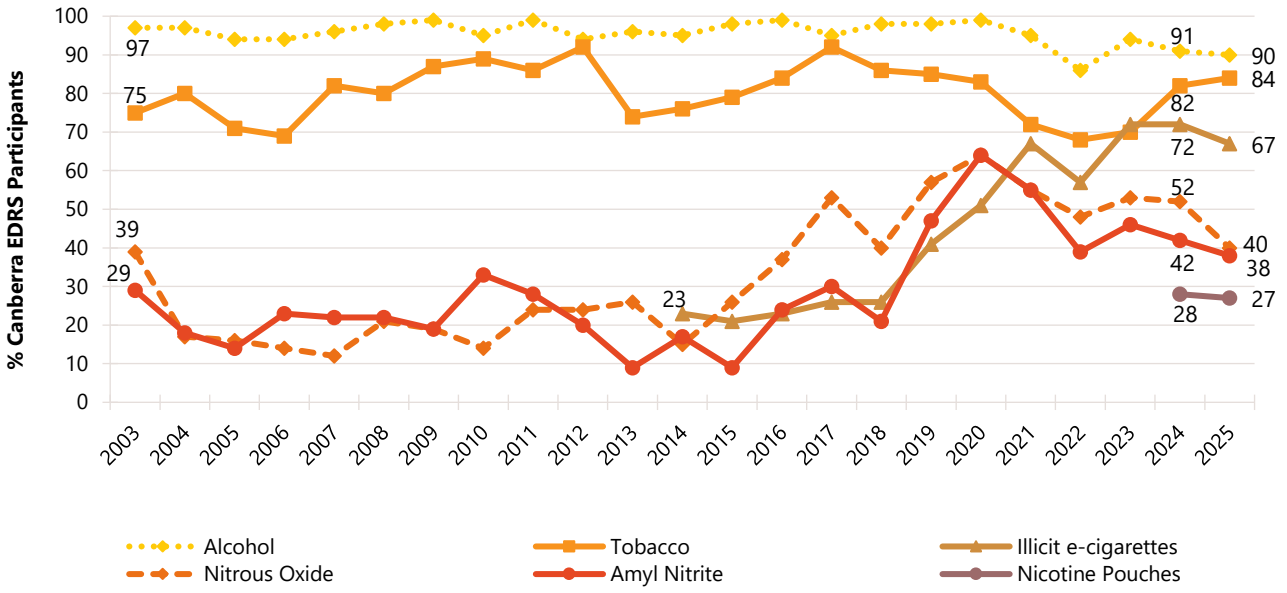
Amyl Nitrite

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 "in preparations for human therapeutic use and packaged in containers with child-resistant closures". However, to our knowledge, the TGA has not yet approved any amyl nitrite products for supply in Australia.

Recent Use (past 6 months): In 2025, recent use of amyl nitrite was reported by 38% of participants, stable relative to 2024 (42%; *p*=0.667) (Figure 47). In 2025, few participants (n≤5) reported that they had obtained amyl nitrite from a pharmacy in the past six months (not asked in 2024).

Frequency of Use: In 2025, participants who reported recent use of amyl nitrite reported use on a median of four days (IQR=2-9; n=38; 3 days in 2024; IQR=2-12; n=42; *p*=0.961).

Figure 47: Past six month use of licit and other drugs, Canberra, ACT, 2003-2025



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 illicit 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

10

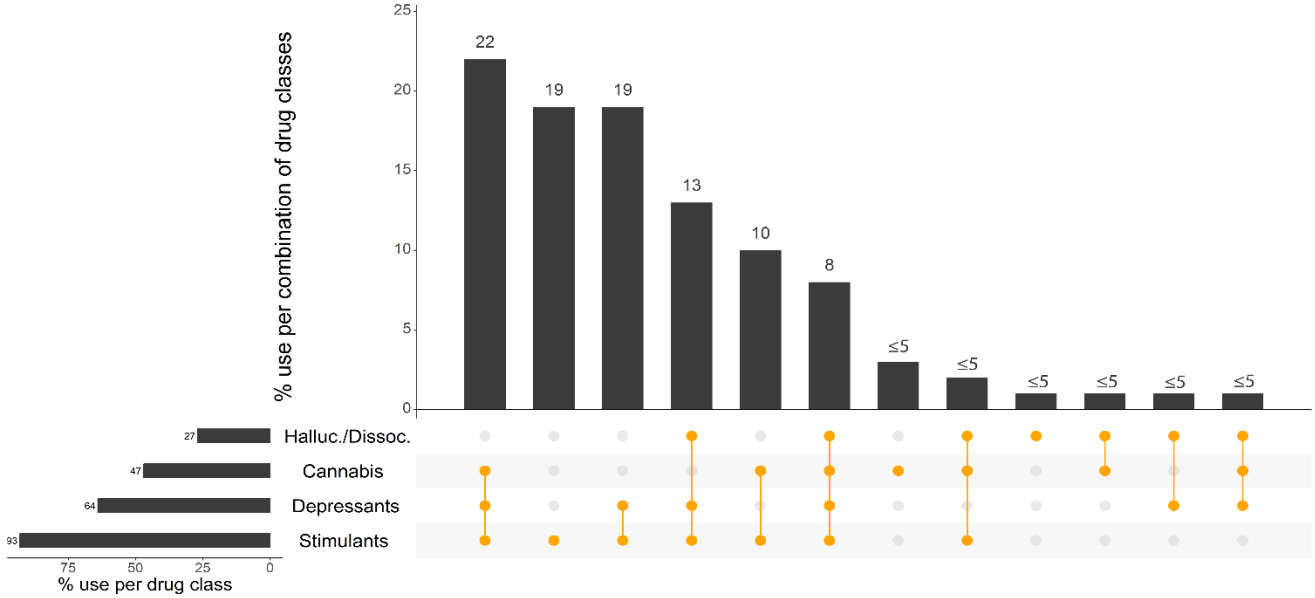
Drug-Related Harms and Other Behaviours

Polysubstance Use

On the last occasion of ecstasy or related drug use and among those who commented (n=100), the most commonly used substances were alcohol (62%), followed by tobacco (53%), ecstasy (48%), cannabis (47%), e-cigarettes (39%) and cocaine (32%).

Four fifths (80%; n=80) of the 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 common combinations of drug classes were stimulants, depressants and cannabis (22%), followed by stimulants and depressants (19%) and stimulants, depressants and hallucinogens/dissociatives (13%). Nineteen per cent of participants reported using stimulants alone on the last occasion of ecstasy and related drug use (Figure 48).

Figure 48: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Canberra, ACT, 2025: Most common drug pattern profiles

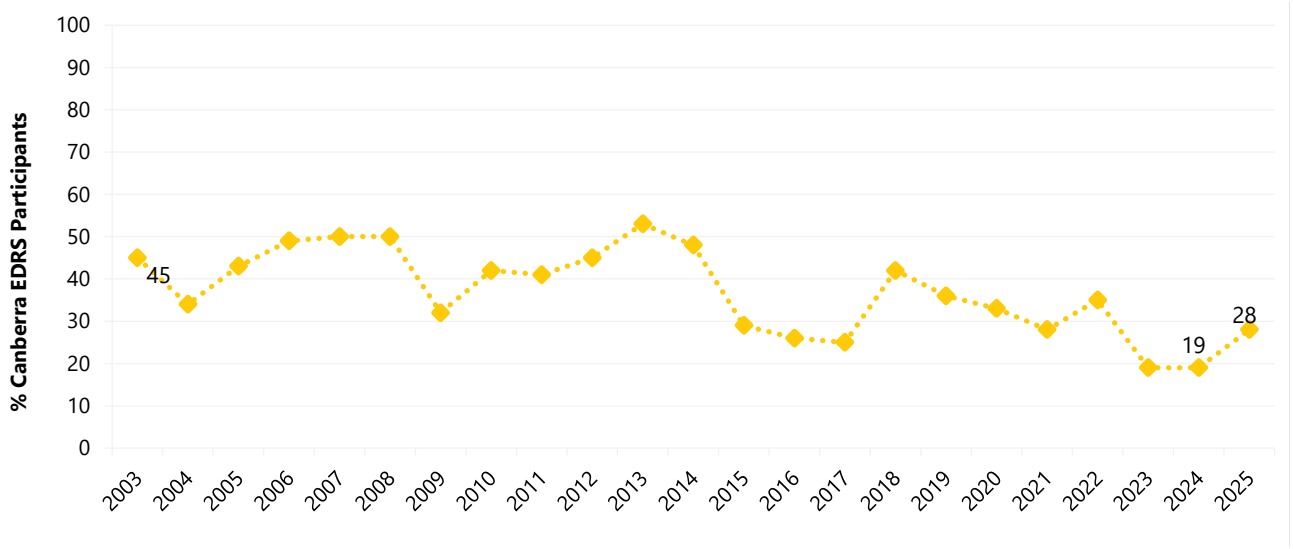


Note. % calculated out of total EDRS 2025 sample. The horizontal bars represent the per cent of participants who reported use of each substance on their last occasion of ecstasy or related drug use; the vertical columns represent the per cent of participants who used the combination of drug classes represented 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 25% to improve visibility of trends. Data labels are suppressed where there are small numbers (i.e., n≤5 but not 0).

Binge Drug Use

Participants were asked whether they had used any stimulant for 48 hours or more continuously without sleep (i.e., binged) in the six months preceding interview. The per cent of the sample who have reported bingeing has fluctuated considerably since the commencement of monitoring. In 2025, 28% of the sample had binged on one or more drugs in the preceding six months, stable from 2024 (19%; p=0.191) (Figure 49).

Figure 49: Past six month use of stimulants for 48 hours or more continuously without sleep ('binge'), Canberra, ACT, 2003-2025



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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

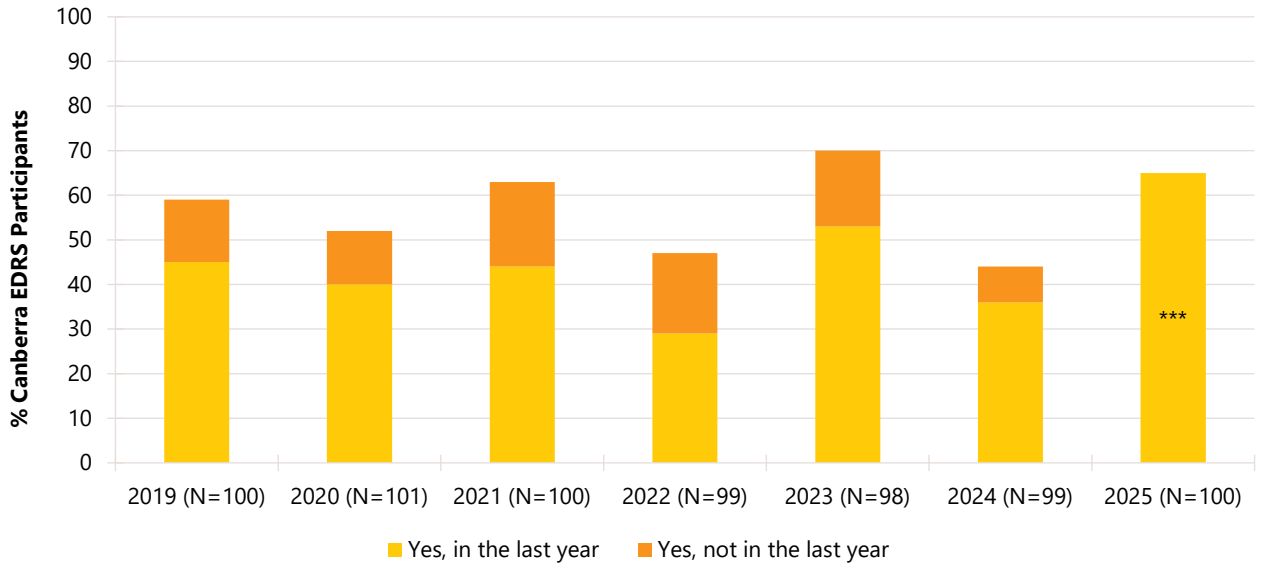
Drug Checking

Drug checking is a common strategy used to test the purity and contents of illicit drugs. At the time interviewing commenced in 2025, the only government-sanctioned drug checking services that had operated in Australia were in the ACT, QLD, VIC and NSW. In Canberra, ACT, drug checking was provided at the Groovin the Moo festival in 2018 and 2019, and a fixed-site drug checking service (CanTEST) has been operational since 17 July 2022. Queensland's first fixed-site drug checking service, CheQpoint, opened in Brisbane on 20 April 2024, and a second service opened in the Gold Coast in July 2024. Drug checking services were also provided at 3 festivals in 2024 - Rabbits Eat Lettuce and Wildlands (by Pill Testing Australia) and Earth Frequency (by CheQpoint) - and as part of the 2024 Qld Gov Schoolies Response (CheQpoint). However, all government funded services ceased in April 2025. In Victoria, drug checking was provided at 'up to' 10 festivals throughout 2024-2025 during an 18-month implementation trial and in March 2025, NSW commenced a 12-month trial of mobile drug checking at 'up to' 12 festivals.

In 2025, two thirds (65%) 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, a significant increase relative to 36% in 2024 (p<0.001). Of those who reported that they or someone else had tested their illicit drugs in the past year and commented (n=65), most (97%) reported testing via a drug checking service, most

commonly at a fixed-site face-to-face drug checking service (e.g., a drop-in service in a central location) (94%), followed by 12% reporting an event-based face-to-face testing service (e.g., festival pill-testing service). In addition, among those who reported that they or someone else had tested the content and/or purity of their drugs in the past year (n=65), one quarter (25%) reported using a personal testing kit, most commonly colorimetric reagent test kits (15%).

Figure 50: Lifetime and past year engagement in drug checking, Canberra, ACT, 2019-2025



Note: Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Statistical significance for 2024 versus 2025 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to tables and figures.

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.

In 2025, the mean score on the AUDIT for the total sample (including people who had not consumed alcohol in the past 12 months) was 13.9 (SD 6.9), significantly higher than 13.5 in 2024 (SD 8.4; $p<0.001$) (Table 5). 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 a significant change in the per cent of the sample falling into each of these risk categories between 2024 and 2025 ($p=0.019$) (Table 5). There were more participants scoring in the 8-15 category in 2025 (53%) compared to 2024 (33%), and less participants scoring in the 0-7 category (14%) in 2025, compared with 2024 (30%).

Eighty-six per cent of the sample obtained a score of eight or more, indicative of hazardous use in 2025, a significant increase relative to 70% in 2024 ($p=0.018$) (Table 5).

Table 5: AUDIT total scores and per cent of participants scoring above recommended levels, Canberra, ACT, 2010-2025

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
	N=71	N=79	N=49	N=75	N=97	N=97	N=99	N=98	N=90	N=99	N=100	N=99	N=100	N=100	N=94	N=91
Mean AUDIT total score (SD)	16.2 (7.4)	13.4 (6.2)	11.0 (7.0)	12.2 (5.8)	11.1 (5.6)	11.3 (4.7)	11.8 (6.8)	11.9 (6.1)	13.0 (7.3)	12.8 (6.2)	15.2 (6.7)	13.1 (7.7)	11.6 (8.2)	12.2 (6.6)	13.5 (8.4)	**13.9*** (6.9)**
Score 8 or above (%)	87	80	71	77	71	81	71	74	72	80	91	74	62	73	70	**86***
AUDIT zones:																
																*
Score 0-7	13	20	29	23	29	18	29	26	28	20	9	26	38	27	30	**14**
Score 8-15	37	42	49	53	50	59	45	49	43	53	53	38	32	41	33	**53**
Score 16-19	17	22	14	13	12	17	11	13	19	14	16	16	10	20	15	**16**
Score 20 or higher	34	17	8	11	9	-	15	12	10	13	22	19	20	12	22	**16**

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 2024 versus 2025 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):** similar definition to above. Note that in 2019, participants were prompted specifically for opioid overdose but this was removed from 2020 onwards 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., GHB/GBL/1,4-BD, benzodiazepines) was listed.

Non-Fatal Stimulant Overdose

In 2025, 19% of the sample reported a non-fatal stimulant overdose in the last 12 months (16% in 2024; p=0.696) (Figure 51). The most common stimulant reported during the most recent non-fatal stimulant overdose in the past 12 months was any form of ecstasy (74%; 37% capsules; 32% crystal and n≤5 powder). Among those who experienced a recent non-fatal stimulant overdose, 84% reported that they had consumed one or more additional drugs on the last occasion, most notably, alcohol (47%; ≥5 standard drinks: 37%; ≤5 standard drinks; n≤5 participants). On the last occasion of non-fatal stimulant overdose, few participants (n≤5) reported that they received treatment or assistance. Due to low numbers (n≤5) reporting on forms of treatment on the last occasion of experiencing a non-fatal stimulant overdose, please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

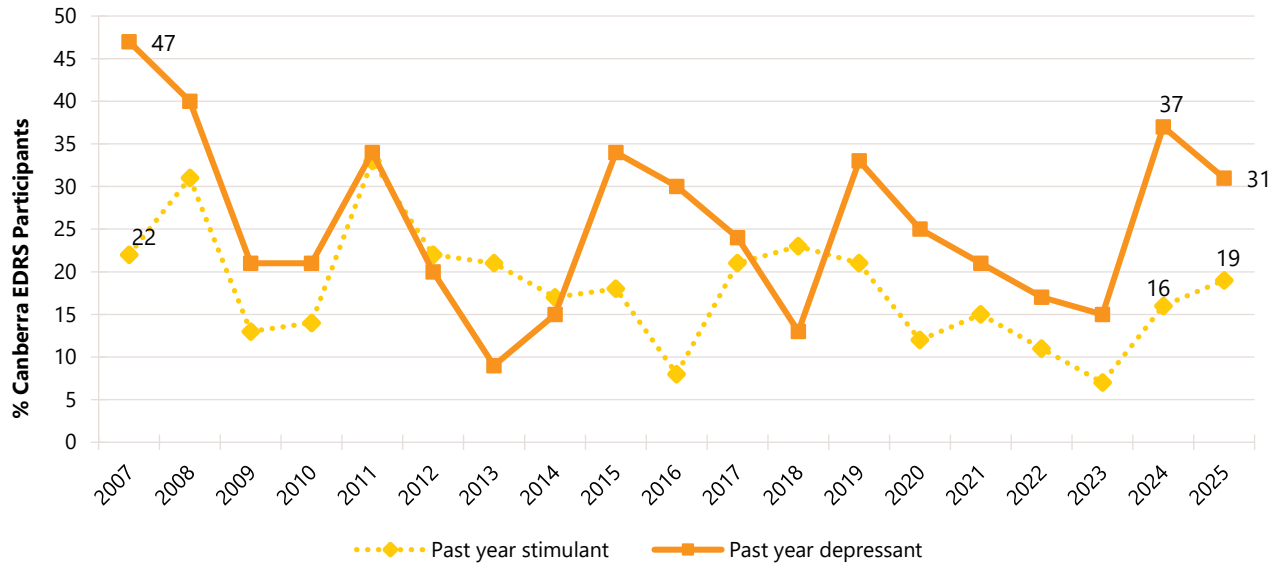
Non-Fatal Depressant Overdose

Alcohol: Twenty-eight per cent of the sample reported having experienced a non-fatal alcohol overdose in the past 12 months, stable relative to 2024 (35%; p=0.363), on a median of three occasions (IQR=1-6). Among those who had experienced an alcohol overdose in the past year (n=28), the majority (82%) reported not receiving treatment on the last occasion. Due to low numbers (n≤5)

reporting that they had received treatment or assistance, please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Any Depressant (including alcohol): Past 12-month experience of any non-fatal depressant overdose has fluctuated over the course of monitoring. In 2025, 31% of the sample reported experiencing at least one non-fatal depressant overdose in the past 12 months, stable relative to 2024 (37%; *p*=0.450) (Figure 51). Of those who had experienced any depressant overdose in the last year (n=31), most participants (90%) reported alcohol as the drug being used prior to the event. Few participants (n≤5) reported a non-fatal depressant overdose due to other drugs, therefore, these data are suppressed. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 51: Past year non-fatal stimulant and depressant overdose, Canberra, ACT, 2007-2025



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. Y axis has been reduced to 50% 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to tables and figures.

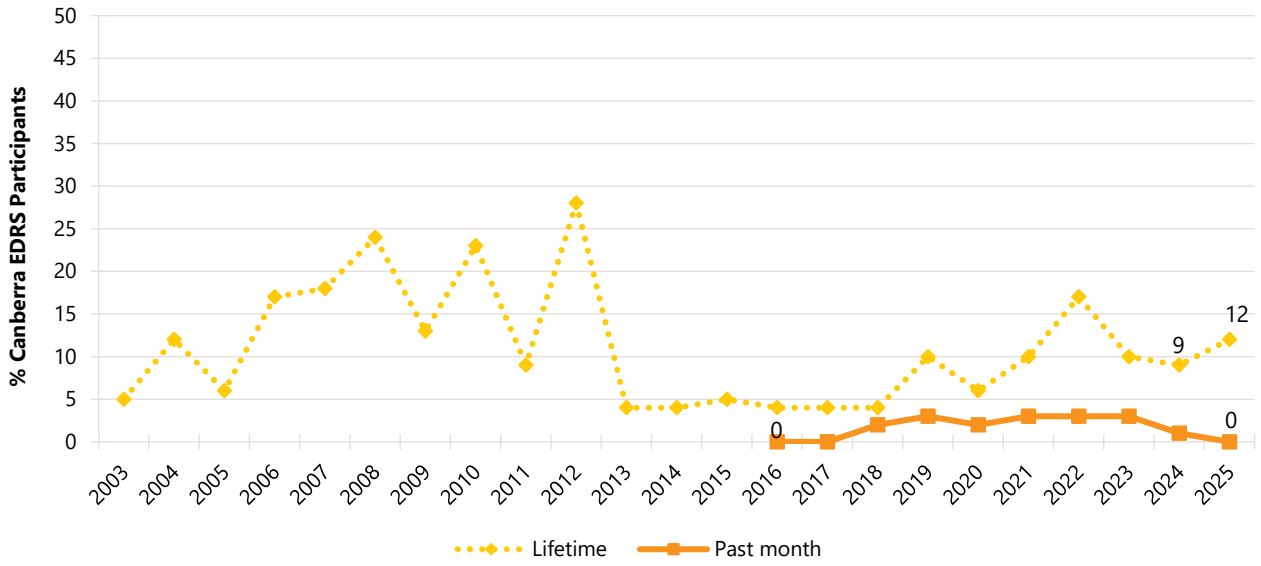
Awareness of Naloxone

In 2025, 79% of participants reported that they had ever heard of naloxone (71% in 2024; p=0.257). Among those who had ever heard of naloxone and responded (n=77), 96% were able to correctly identify the purpose of naloxone (93% in 2024; p=0.473). Among participants who had ever heard of naloxone and responded (n=78), two fifths (41%) reported obtaining naloxone in their lifetime (32% of entire sample), a significant increase from 20% in 2024 (20%; p=0.010), and 37% reported obtaining naloxone in the twelve months prior to interview (29% of entire sample), also a significant increase relative to 2024 (13%; p=0.001).

Injecting Drug Use

The per cent reporting injecting in their lifetime varied in earlier years of monitoring. In 2025, 12% reported lifetime injection (9% in 2024; p=0.629) (Figure 52). No participants reported past month injection (n≤5 in 2024; p=0.495), therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 52: Lifetime and past month drug injection, Canberra, ACT, 2003-2025



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). Statistical significance for 2024 versus 2025 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 2025, 6% of participants reported that they were currently in drug treatment (8% in 2024; p=0.779). The most common form of drug treatment comprised 'other self-help groups' (50%), with few participants (n≤5) reporting other forms of drug treatment. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Ecstasy and Methamphetamine Dependence

From 2015, participants were asked questions from the Severity of Dependence Scale (SDS) adapted to investigate ecstasy and methamphetamine dependence. The SDS is a five-item tool 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, 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. Of those who had recently used ecstasy and responded (n=98), 19% recorded a score of three and above, stable from 16% in 2024 (p=0.570). The median ecstasy SDS score was zero (IQR=0-2). Almost three fifths (57%) of participants obtained a score of zero on the ecstasy SDS (59% in 2024; p=0.878), indicating no or few symptoms of dependence in relation to ecstasy use (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. Of those who had recently used methamphetamine and responded (n=18), two fifths (39%) scored four or above, stable from 24% in 2024 (p=0.488). The median methamphetamine SDS score was three (IQR=0-6). Two fifths (39%) of participants obtained a score of zero on the methamphetamine SDS (52% in 2024; p=0.519), 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 particpants scoring above cut-off scores indicative of dependence, among those who reported past six month use, Canberra, ACT, 2015-2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Ecstasy	N=96	N=98	N=100	N=99	N=99	/	N=95	N=86	**N=95**	**N=87**	**N=98**
Median total score (IQR)	0 (0-1)	1 (0-2)	1 (0-2)	1 (0-2)	0 (0-2)	/	0 (0-2)	0 (0-1)	0 (0-1)	0 (0-1)	**0 (0-2)**
% score = 0	63	39	41	42	53	/	60	62	64	59	**57**
% score ≥ 3	8	21	19	19	22	/	15	16	12	16	**19**
Methamphetamine	N=23	N=15	N=25	N=32	N=33	N=14	N=25	N=37	**N=23**	**N=21**	**N=18**
Median total score (IQR)	**0 (0-1)**	**0 (0-2)**	**0 (0-2)**	**0 (0-2)**	**0 (0-2)**	**0 (0-0)**	**2 (0-6)**	**2 (0-6)**	0 (0-5)	0 (0-3)	**3 (0-6)**
% score = 0	91	53	56	59	58	100	32	30	52	52	**39**
% score ≥ 4	0	13	-	-	-	0	40	49	35	24	**39**

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 2024 versus 2025 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 2025, 77% of the sample reported some form of sexual activity in the past four weeks, stable relative to 2024 (76%). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if conducted face-to-face).

Of those who had engaged in sexual activity in the past four weeks and who responded (n=75), 87% (n=65) reported using alcohol and/or other drugs prior to or while engaging in sexual activity (82% in 2024; p=0.498) and 8% (n=6) reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex, stable relative to 2024 (15%; p=0.212). One third (35%) of participants reported that they had used alcohol and/or other drugs to enhance sexual activity or pleasure with another person, stable relative to 2024 (28%; p=0.483). Few participants (n≤5) had engaged in sexual activity in exchange for money, drugs, or other goods or services (n≤5 in 2024) (Table 7).

Of those who commented (n=98), 64% reported having a sexual health check-up in their lifetime, a significant decrease relative to 2024 (80%; p=0.029), including 37% reporting having a sexual health check-up in the six months prior to interview (45% in 2024; p=0.315). Of those who responded (n=98), 19% had received a positive diagnosis for a sexually transmitted infection (STI) in their lifetime (13% in 2024; p=0.337) although few participants (n≤5) reported that they had received a positive diagnosis for a STI in the past six months (n≤5 in 2024) (Table 7). Due to low numbers reporting on the specific types of STIs diagnosed (n≤5), please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Of those who commented (n=95), 52% reported having a test for human immunodeficiency virus (HIV) in their lifetime (64% in 2024; p=0.084), including 28% who had done so in the six months prior to interview (34% in 2024; p=0.437). In 2025, few participants (n≤5) had been diagnosed with HIV in their lifetime (0% in 2024; p=0.492) (Table 7).

Table 7: Sexual health behaviours, Canberra, ACT, 2021-2025

	2021	2022	2023	2024	2025
Of those who responded[#]:	N=98	N=97	N=94	N=98	**N=98**
% Any sexual activity in the past four weeks (n)	84 (n=82)	70 (n=68)	77 (n=71)	76 (n=74)	**77 (n=75)**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=82	n=68	n=71	n=74	**n=75**
% Drugs and/or alcohol used prior to or while engaging in sexual activity	88	84	77	82	**87**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=82	n=67	n=72	n=74	**n=75**
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	7	12	-	15	**8**
% Drugs and/or alcohol used to enhance sexual activity or pleasure with another person	/	/	/	28	**35**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=82	n=67	n=72	n=74	**n=74**
% Engaged in sexual activity in exchange for money, drugs or other goods or services	/	/	/	-	**-**
Of those who responded[#]:	n=98	n=97	n=93	n=98	**n=98**
% Had a sexual health check in the last six months	45	32	34	45	**37**
% Had a sexual health check in their lifetime	76	76	66	80	**64***
Of those who responded[#]:	n=98	n=97	n=93	n=98	**n=98**
% Diagnosed with a sexually transmitted infection in the last six months	-	-	9	-	**-**
% Diagnosed with a sexually transmitted infection in their lifetime	26	23	18	13	**19**
Of those who responded[#]:	n=98	n=97	n=94	n=98	**n=95**
% Had a HIV test in the last six months	32	23	36	34	**28**
% Had a HIV test in their lifetime	61	57	57	64	**52**
Of those who responded[#]:	n=98	n=97	n=94	n=98	**N=95**
% Diagnosed with HIV in the last six months	0	0	0	0	**0**
% Diagnosed with HIV in their lifetime	0	0	0	0	**-**

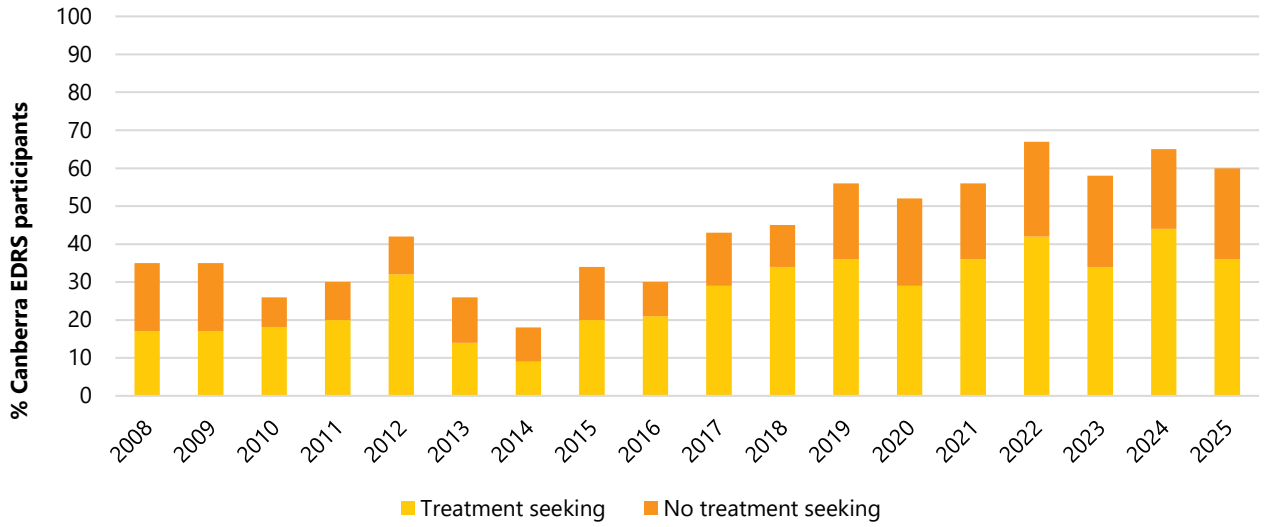
Note. [#] Due to the sensitive nature of these items, there is missing data for some participants who chose not to respond. Statistical significance for 2024 versus 2025 presented in table; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Mental Health and Psychological Distress (K10)

Mental Health

Three fifths (60%) of the sample self-reported that they had experienced a mental health problem in the preceding six months (other than drug dependence; 65% in 2024; p=0.555) (Figure 53). Of those who reported a mental health problem and who responded (n=57), the most common mental health problems were depression (65%; 71% in 2024; p=0.382) and anxiety (63%; 66% in 2024; p=0.556), followed by attention-deficit/hyperactivity disorder (ADHD) (33%; 29% in 2024). Of those who reported a mental health problem, 59% (36% of the total sample) reported seeing a mental health professional during the past six months (69% in 2024; p=0.347). Of this group (n=35), 63% reported being prescribed medication (70% in 2024; p=0.628).

Figure 53: Self-reported mental health problems and treatment seeking in the past six months, Canberra, ACT, 2008-2025



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. Statistical significance for 2024 versus 2025 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)

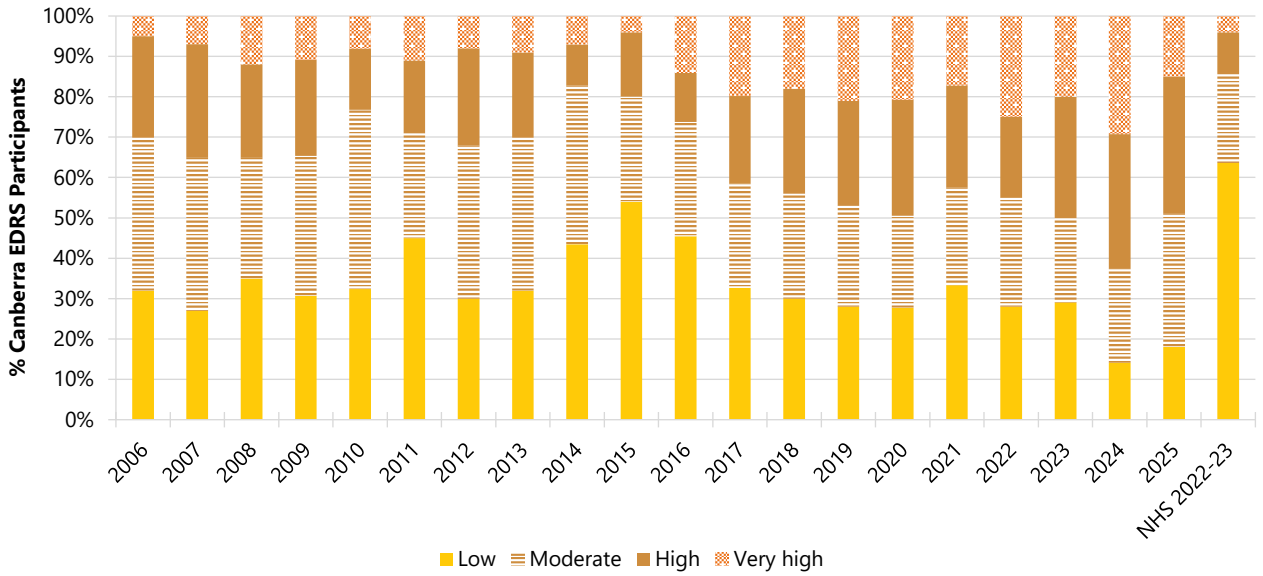
The Kessler Psychological Distress Scale 10 (K10) was administered to obtain a measure of psychological distress in the past four weeks. It is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured by the Diagnostic and Statistical Manual of Mental Disorders/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 indicate 'low' psychological distress; scores between 16–21 indicate 'moderate' psychological distress; score 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 between 2024 and 2025 (p=0.101). Among those who responded in 2025 (n=98), 15% had a score of 30 or more (29% in 2024) (Figure 54).

The National Health Survey 2022-23 provides Australian population data for adult (≥18 years) K10 scores. EDRS participants in 2025 reported greater levels of 'high' and 'very high' distress compared to the general population (Figure 54).

Figure 54: K10 psychological distress scores, Canberra, ACT, 2006-2024 and among the general population, 2022-2023



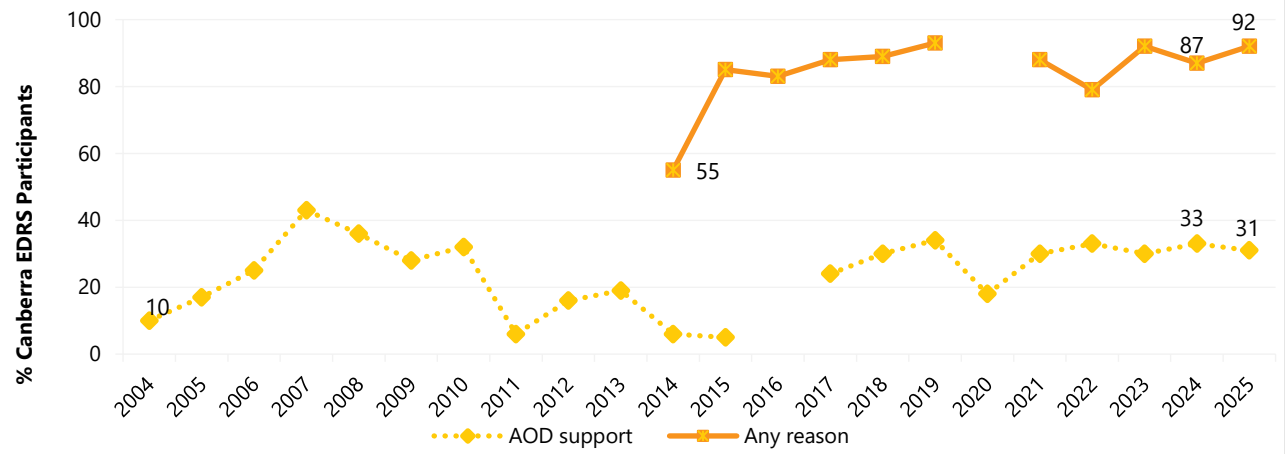
Note. Data from the National Health Survey are a national estimate from 2022-23 for adults 18 or older. Imputation used for missing scale scores (EDRS only). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Statistical significance for 2024 versus 2025 presented 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

In 2025, nearly one third (31%) of the sample reported accessing any health service for alcohol and/or drug (AOD) support in the six months preceding interview (33% in 2024; p=0.876) (Figure 55). The most common services accessed by participants for AOD support included a general practitioner (GP) (14%; 16% in 2024; p=0.840) and a peer based harm reduction service (6%; n≤5 in 2024; p=0.498) (Table 8).

The majority (92%) of the sample reported accessing any health service for any reason in the six months preceding interview in 2025, stable relative to 87% in 2024 (p=0.353) (Figure 55). The most common services accessed by participants for any reason were a GP (76%; 72% in 2024; p=0.627), followed by a pharmacy (64%; 50% in 2024; p=0.066), a dentist (41%; 27% in 2024; p=0.055) and a psychologist (25%; 28% in 2024; p=0.741) (Table 8).

Figure 55: Health service access for alcohol and other drug reasons, and for any reason, in the past six months, Canberra, ACT, 2004-2025



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). Statistical significance for 2024 versus 2025 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 services accessed for alcohol and other drug reasons and for any reason in the past six months, Canberra, ACT, 2022-2025

	AOD support				Any reason			
	2022	2023	2024	2025	2022	2023	2024	2025
% accessing health services	**N=100 33**	**N=100 30**	**N=100 33**	**N=100 31**	**N=100 79**	**N=100 92**	**N=100 87**	**N=100 92**
GP	12	8	16	**14**	65	72	72	**76**
In-person	/	/	/	**14**	/	/	/	**72**
Telehealth	/	/	/	**-**	/	/	/	**25**
Emergency department	-	-	6	**-**	17	27	16	**18**
Hospital admission (inpatient)	9	-	-	**-**	17	11	15	**22**
Medical tent (e.g., at a festival)	-	8	-	**-**	6	10	8	**10**
Drug and Alcohol counsellor	15	11	8	**-**	15	11	8	**-**
Hospital as an outpatient	-	-	-	**-**	-	9	7	**9**
Specialist doctor (not including a psychiatrist)	-	0	-	**0**	10	21	14	**16**
Dentist	-	-	-	**-**	24	45	27	**41**
Ambulance attendance	7	-	-	**-**	10	8	-	**6**
Pharmacy	/	/	-	**-**	/	/	50	**64**
Other health professional (e.g., physiotherapist)	0	-	-	**0**	-	9	12	**16**
Psychiatrist	8	-	8	**-**	13	15	16	**11**
Psychologist	10	7	11	**-**	23	36	28	**25**
NSP	-	-	0	**-**	-	-	-	**-**
Peer based harm reduction service	-	-	-	**6**	-	-	-	**6**
Other harm reduction service	0	-	8	**-**	-	-	7	**8**

Note. ^In 2025, we separated 'GP' into 'GP in person' and 'GP via telehealth'. Statistical significance for 2024 versus 2025 presented in table; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

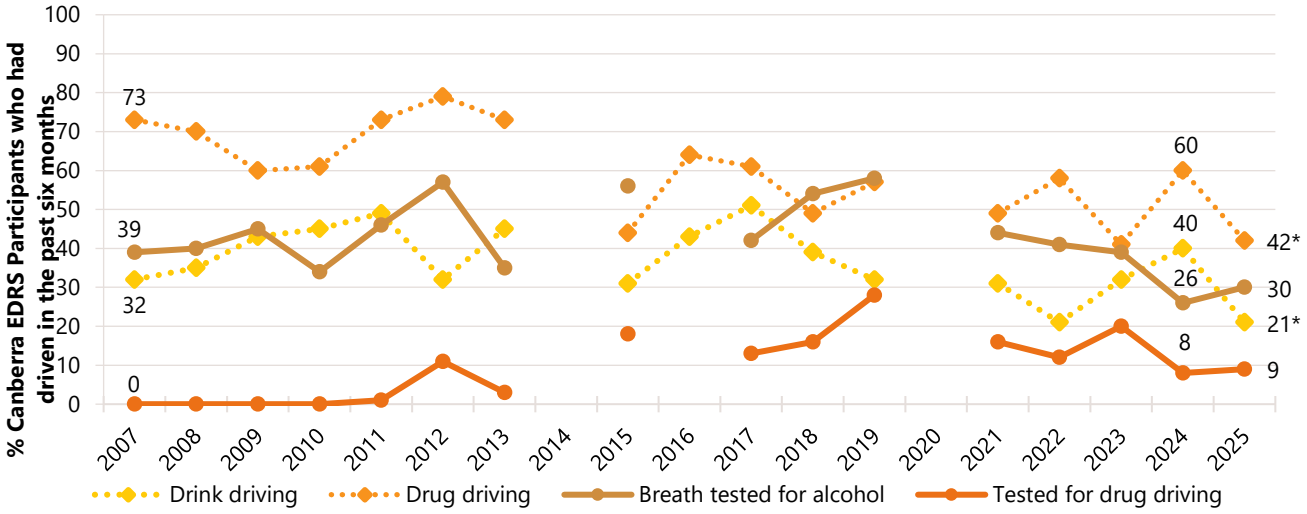
Driving

The majority (81%) of participants 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=78), one fifth (21%) reported driving while over the (perceived) legal limit of alcohol, a significant decrease from two fifths (40%) in 2024 (p=0.013), and two fifths (42%) reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months, also a significant decrease relative to 2024 (60%; p=0.023) (Figure 56).

Of those who had driven within three hours of consuming an illicit or non-prescribed drug in the last six months and responded (n=34), participants most commonly reported using cannabis (71%) prior to driving, followed by cocaine (18%).

Among those who had driven in the past six months and commented (n=81), 9% reported that they had been tested for drug driving by the police roadside drug testing service, stable relative to 2024 (8%), and 30% reported that they had been breath tested for alcohol by the police roadside testing service in the six months prior to interview (26% in 2024; p=0.718) (Figure 56).

Figure 56: 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, Canberra, ACT, 2007-2025



Note. Computed of those who had driven a vehicle in the past six months. 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). Statistical significance for 2024 versus 2025 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

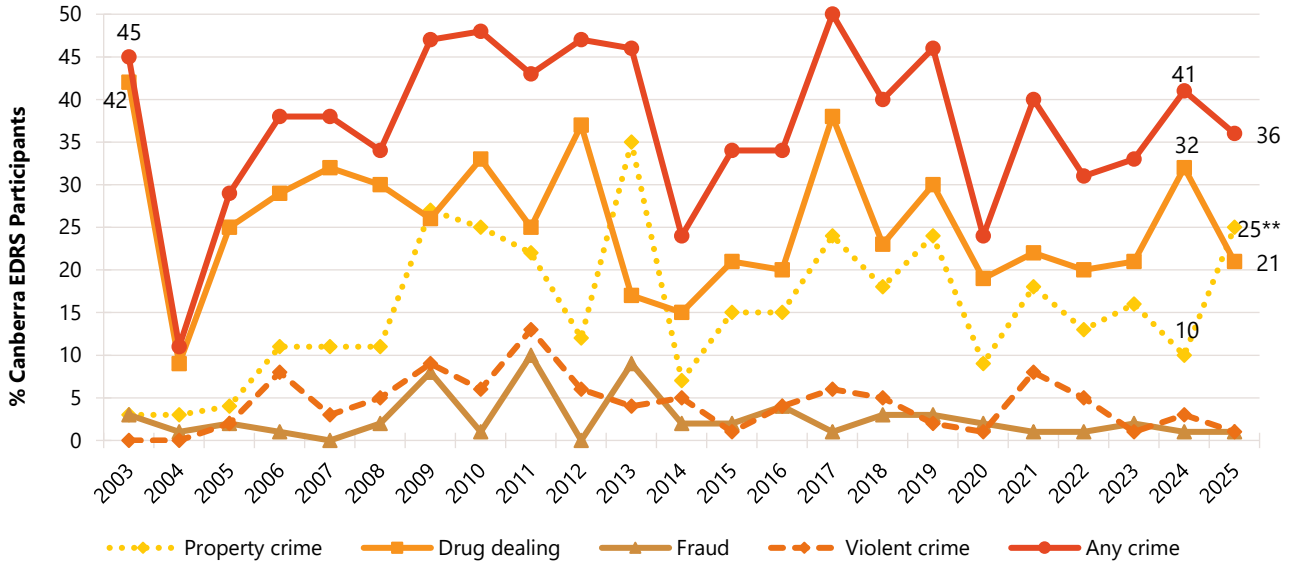
The per cent reporting past month criminal activity has fluctuated over time, with 36% reporting any form of criminal activity in 2025, stable relative to 2024 (41%; p=0.462). The main form of criminal activity in the past month was property crime (25%), a significant increase relative to 10% in 2024 (p=0.009), followed by selling drugs for cash profit (21%; 32% in 2024; p=0.082). In 2025, 12% of the sample reported being the victim of a crime involving violence, stable relative to 2024 (12%) (Figure 58).

Seven per cent of participants reported having been arrested in the 12 months preceding interview in 2025, stable relative to 2024 (8%; p=0.792). Few participants (n≤5) reported reasons for arrest; therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Sixteen per cent of the sample reported a drug-related encounter in the last 12 months which did not result in charge or arrest (17% in 2024) (Figure 59). Few participants (n≤5) reported reasons for a drug-related encounter; therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

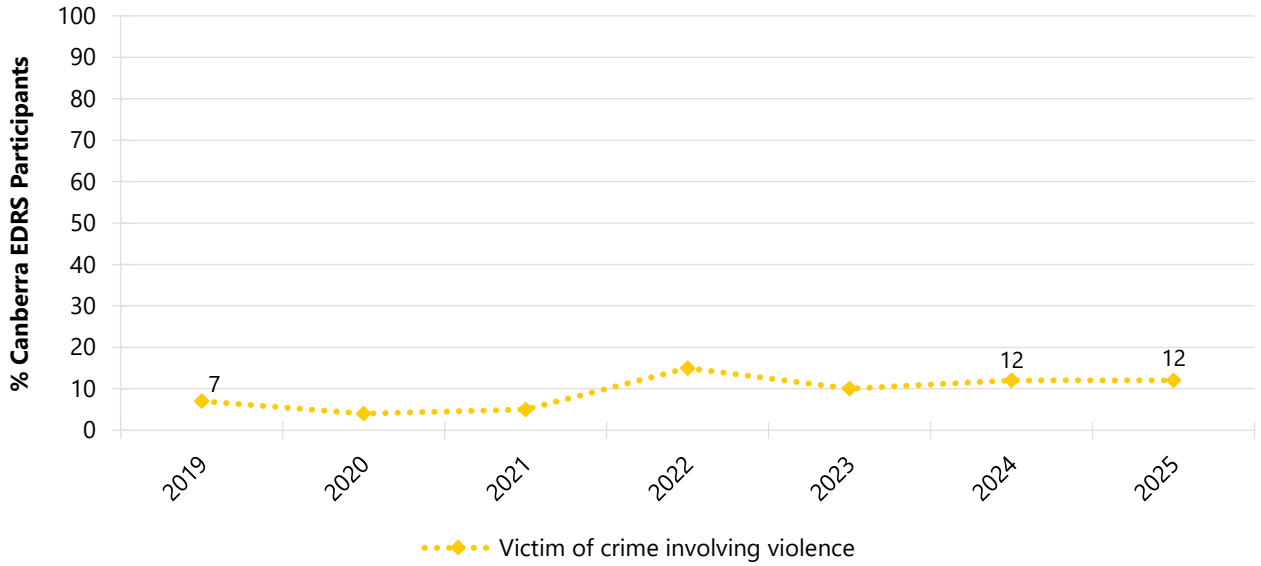
Seven per cent of the sample reported a lifetime history of imprisonment in 2025, stable relative to 2024 (n≤5; p=0.767) (Figure 59).

Figure 57: Self-reported criminal activity in the past month, Canberra, ACT, 2003-2025



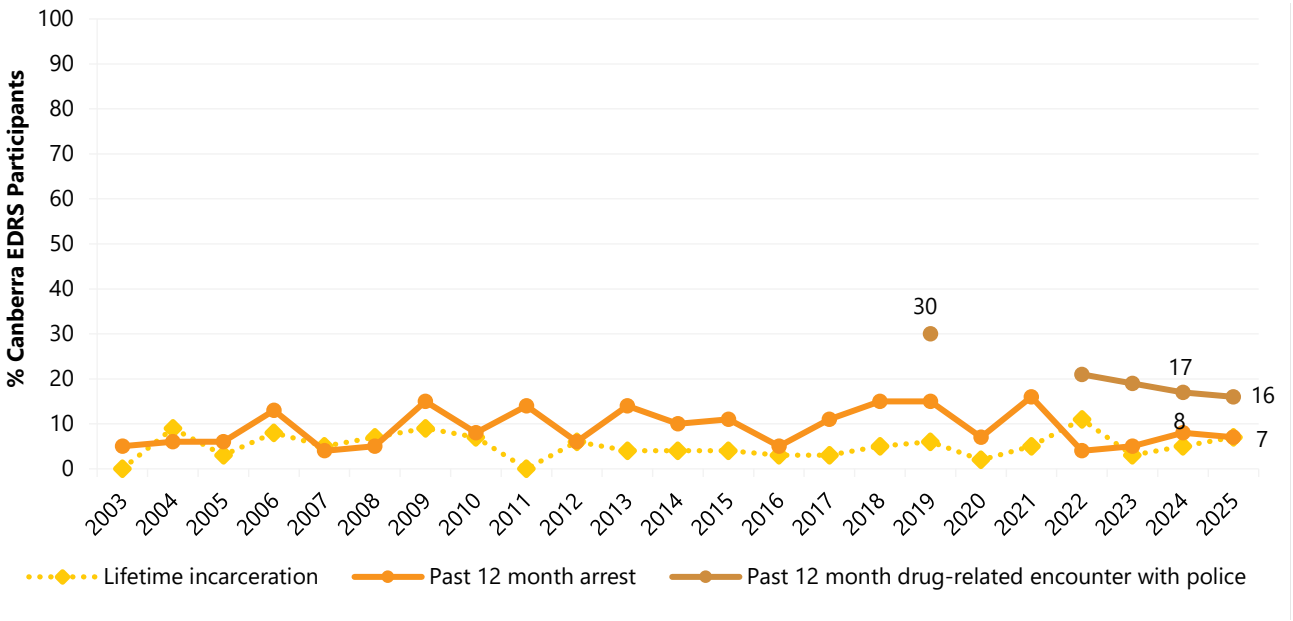
Note. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Y axis reduced to 50% to improve visibility of trends. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 58: Victim of crime involving violence in the past month, Canberra, ACT, 2019-2025



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). Statistical significance for 2024 versus 2025 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 59: Lifetime incarceration, and past 12 month arrest and drug-related encounters with police that did not result in arrest, Canberra, ACT, 2003-2025



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). Statistical significance for 2024 versus 2025 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 2025, the most common means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was via social networking applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (81%; 77% in 2024; p=0.601) and in person (79%; 80% in 2024; p=0.856) (Table 9). 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 common social networking or messaging apps were Snapchat (59%) and Signal (57%), followed by WhatsApp (28%), with substances mostly obtained from a known dealer/vendor (63%), followed by a friend/relative/partner/colleague (58%) and an unknown dealer/vendor (45%).

Buying and Selling Drugs Online

Few participants (n≤5) reported obtaining drugs via the darknet (8% in 2024; p=0.101) and via the surface web (n≤5 in 2024; p=0.118) in the past year. Almost two fifths (38%) of the sample reported that, at some point in their life, they had obtained illicit drugs from someone who had purchased them on the surface web or darknet, with one quarter (26%) having done so in the last 12 months (19% in 2024; p=0.359).

In 2025, few participants (n≤5) reported selling illicit/non-prescribed drugs via surface or darknet marketplaces in the 12 months preceding interview (n≤5 in 2024).

Source and Means of Obtaining Drugs

The majority of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2025 (83%; 86% in 2024; p=0.561), followed by 72% reporting obtaining illicit drugs from a known dealer/vendor (72% in 2024). Nearly two fifths (38%) of participants reported obtaining illicit drugs from an unknown dealer/vendor (32% in 2024; p=0.451) (Table 9).

When asked about how they had received illicit drugs on any occasion in the last 12 months, all participants reported face-to-face (100%), stable relative to 2024 (96%; p=0.121). In 2025, 37% of the sample reported receiving illicit drugs via a collection point (defined as a predetermined location where a drug will be dropped for later collection), stable relative to 2024 (30%; p=0.304). Fewer participants reporting receiving illicit drugs via post (6%; 11% in 2024; p=0.316) (Table 9).

Table 9: Means of purchasing and obtaining illicit drugs in the past 12 months, Canberra, ACT, 2019-2025

	2019 N=98	2020 N=100	2021 N=100	2022 N=100	2023 N=100	2024 N=100	2025 N=100
% Purchasing approaches in the last 12 months^							
Face-to-face	81	49	63	68	74	80	**79**
Surface web	6	-	-	-	-	-	**-**
Darknet market	14	-	7	6	-	8	**-**
Social networking or messaging applications[#]	70	74	56	68	67	77	**81**
Text messaging	55	51	48	41	35	43	**40**
Phone call	54	27	33	30	16	23	**25**
Grew/ made my own	/	-	11	-	7	6	**-**
Other	0	-	0	0	0	-	**0**
% Means of obtaining drugs in the last 12 months^~	n=99	n=99	n=99	n=99	n=100	n=99	**n=99**
Face-to-face	99	97	86	97	93	96	**100**
Collection point	9	26	9	12	11	30	**37**
Post	13	8	8	15	16	11	**6**
% Sources of drugs in the last 12 months^	n=97	n=100	n=99	n=99	n=100	n=99	**n=98**
Friend/relative/partner/colleague	84	83	76	83	84	86	**83**
Known dealer/vendor	71	56	72	70	66	72	**72**
Unknown dealer/vendor	37	22	19	23	23	32	**38**

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 2024 versus 2025 presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.