



**IDRS**



# **SOUTH AUSTRALIAN DRUG TRENDS 2025**

**Key Findings from the South Australian Illicit  
Drug Reporting System (IDRS) Interviews**



# **SOUTH AUSTRALIAN DRUG TRENDS 2025: KEY FINDINGS FROM THE ILLICIT DRUG REPORTING SYSTEM (IDRS) INTERVIEWS**

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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](#).

This report was prepared by the National Drug and Alcohol Research Centre, UNSW Sydney. Please contact the following with any queries regarding this publication: [a.karlsson@unsw.edu.au](mailto:a.karlsson@unsw.edu.au) or [drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)

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### Research Team

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

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### Contributors

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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

<b>ACT</b>	Australian Capital Territory
<b>AIVL</b>	Australian Injecting & Illicit Drug Users League
<b>ALPHA PVP</b>	$\alpha$ -Pyrrolidinopentiophenone
<b>AOD</b>	Alcohol and Other Drugs
<b>AUDIT-C</b>	Alcohol Use Disorders Identification Test-Concise
<b>CBD</b>	Cannabidiol
<b>COVID-19</b>	Coronavirus Disease 2019
<b>DSM</b>	Diagnostic and Statistical Manual of Mental Disorders
<b>EDRS</b>	Ecstasy and Related Drugs Reporting System
<b>GHB/GBL/1,4-BD</b>	Gamma-butyrolactone/Gamma-hydroxybutyrate/1,4-Butanediol
<b>GP</b>	General Practitioner
<b>HCV</b>	Hepatitis C Virus
<b>HIV</b>	Human immunodeficiency virus
<b>IDRS</b>	Illicit Drug Reporting System
<b>IQR</b>	Interquartile range
<b>LSD</b>	<i>d</i> -lysergic acid
<b>MDA</b>	3,4-methylenedioxyamphetamine
<b>MDPV</b>	Methylenedioxypropylone
<b>N (or n)</b>	Number of participants
<b>NDARC</b>	National Drug and Alcohol Research Centre
<b>NHS</b>	National Health Survey
<b>NPS</b>	New psychoactive substances
<b>NSP</b>	Needle and Syringe Program
<b>NSW</b>	New South Wales
<b>NT</b>	Northern Territory
<b>OTC</b>	Over-the-counter
<b>PBS</b>	Pharmaceutical Benefits Scheme
<b>PCR</b>	Polymerase Chain Reaction
<b>PTSD</b>	Post-traumatic stress disorder
<b>REDCap</b>	Research Electronic Data Capture
<b>RNA</b>	Ribonucleic Acid

<b>SA</b>	South Australia
<b>SD</b>	Standard deviation
<b>SDS</b>	Severity of Dependence
<b>STI</b>	Sexually transmitted infection
<b>TAS</b>	Tasmania
<b>TGA</b>	Therapeutic Goods Administration
<b>THC</b>	Tetrahydrocannabinol
<b>UNSW</b>	University of New South Wales
<b>VIC</b>	Victoria
<b>WA</b>	Western Australia
<b>WHO</b>	World Health Organization

## Executive Summary

The IDRS comprises a sentinel sample of people aged 18 years or older who injected illicit drugs  $\geq 6$  days in the preceding six months and resided in Adelaide, South Australia. Participants were recruited via advertisements in needle and syringe programs and other harm reduction services, as well as via peer referral. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in June 2025. Interviews from 2020 were delivered face-to-face as well as via telephone, to reduce 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 IDRS sample recruited from Adelaide, South Australia (SA) in 2025 (N=105) was consistent with the Adelaide profile in previous years, whereby almost three fifths (57%) were male, with a median age of 48 years. Employment status remained stable between 2024 and 2025, with the majority of participants (89%) reporting being unemployed at the time of interview (92% in 2024) and fewer participants (8%) reporting part time or casual employment ( $n \leq 5$  in 2024). One fifth (22%) of the Adelaide sample reported having 'no fixed address' (26% in 2024). Drug of choice and drug injected most often in the month prior to interview remained stable, with most participants reporting methamphetamine as their drug of choice (65%; 73% in 2024), as well as the drug injected most often in the prior month (80%; 90% in 2024). Weekly or more frequent consumption of methamphetamine crystal (66%; 81% in 2024;  $p=0.021$ ) and non-prescribed cannabis

(54%; 69% in 2024;  $p=0.037$ ) significantly decreased in 2025, though significantly more participants reported weekly or more frequent use of methamphetamine powder (20%; 8% in 2024;  $p=0.022$ ).

### Heroin

One quarter (28%) of the Adelaide sample reported recent use in 2025, stable relative to 2024 (21%). Frequency of use also remained stable at a median of 24 days in 2025 (9 days in 2024). The majority of those who had recently used heroin reported using white/off white rock (48%) or white/off white powder (38%). Perceived purity and perceived availability remained stable between 2024 and 2025, with the majority (85%) perceiving that heroin was 'easy' or 'very easy' to obtain (68% in 2024). The price for one point of heroin also remained stable at \$50 (\$50 in 2024).

### Methamphetamine

Notwithstanding a decline in 2020, recent use of any methamphetamine has generally increased since 2017, though remained stable in 2025 (93%; 96% in 2024). However, median days of use significantly decreased, from 96 days in 2024 to 72 days in 2025 ( $p=0.017$ ). Recent use of methamphetamine mostly comprised the crystal form (83%; 92% in 2024), which has remained the most commonly used form since 2010. Almost one quarter (23%) reported recent use of powder (15% in 2024) and few participants ( $n \leq 5$ ) reported recent use of base, a significant decrease from 17% in 2024 ( $p < 0.001$ ). Weekly or more frequent use of powder significantly increased, from 56% of those who reported recent use in 2024 to 91% in 2025 ( $p=0.019$ ). The price, perceived purity and perceived availability remained stable for both powder and crystal, with 83% (87% in 2024) and 94% (94% in 2024) reporting powder and crystal as being 'easy' or 'very easy' to obtain, respectively.

## Cocaine

Recent use of cocaine remained stable in 2025 (16%), relative to 2024 (13%). Frequency of use remained low and stable at a median of two days (2 days in 2024). The majority (88%) of those who had used cocaine in the six months preceding interview reported using powder cocaine (64% in 2024), with few participants ( $n \leq 5$ ) reporting using crack/rock cocaine ( $n \leq 5$  in 2024).

## Cannabis and/or Cannabinoid-Related Products

Recent use of non-prescribed cannabis and/or cannabinoid-related products has remained fairly stable since 2014, however, in 2025, a significant decrease was observed, with three fifths (63%) reporting recent non-prescribed use (76% in 2024;  $p=0.038$ ). Hydroponic cannabis remained the most commonly used form (83%; 86% in 2024), followed by bush cannabis (55%; 67% in 2024). Few participants ( $n \leq 5$ ) reported using hashish, a significant decrease relative to 2024 (26%;  $p=0.001$ ). The price, perceived potency and availability of both hydroponic and bush cannabis remained stable in 2025 relative to 2024, with both forms reported as being 'easy' or 'very easy' to obtain in 2025 (91%; 87% in 2024 and 66%; 84% in 2024, respectively).

## Pharmaceutical Opioids

Recent non-prescribed use of pharmaceutical opioids has generally remained stable or declined over the past 5-15 years of monitoring. In 2025, recent non-prescribed use of methadone (6%), buprenorphine tablet ( $n \leq 5$ ), buprenorphine-naloxone (9%), morphine (9%), oxycodone (10%), fentanyl ( $n \leq 5$ ) and codeine ( $n \leq 5$ ) remained low and stable.

## Other Drugs

Few participants ( $n \leq 5$ ) reported recent use of new psychoactive substances, non-prescribed pharmaceuticals stimulants and antipsychotics, and no participants reported recent use of

non-prescribed gabapentin, steroids or unisom in 2025. Recent non-prescribed benzodiazepine use was reported by 17% of participants in 2025 (22% in 2024). Recent use of alcohol (56%; 49% in 2024) and tobacco (90%; 92% in 2024) remained stable in 2025, as did recent use of illicit e-cigarettes (17%; 25% in 2024). One fifth (21%) reported recent use of GHB/GBL/1,4-BD in 2025, stable relative to 2024 (22%).

## Drug-Related Harms and Other Behaviours

### *Polysubstance use and bingeing*

In 2025, 54% of the Adelaide sample reported using two or more drugs (excluding tobacco and e-cigarettes) on the day preceding interview.

Sixty-nine per cent of the Adelaide sample had binged on one or more drugs for 48 hours or more in the six months preceding interview.

### *Injecting behaviours and equipment access*

In 2025, few participants ( $n \leq 5$ ) reported receptive sharing and/or distributive sharing of a needle or syringe in the past month ( $n \leq 5$  and 8% in 2024, respectively). Almost one quarter (23%) of the Adelaide sample reported that they had re-used their own needles in the past month, a significant decrease from 39% in 2024 ( $p=0.020$ ). Seven per cent of the Adelaide sample reported having difficulty accessing needles in the past month, a significant decrease from 18% in 2024 ( $p=0.022$ ).

Almost one quarter (24%) reported experiencing injection-related problems in the past month, a significant decrease from 40% in 2024 ( $p=0.020$ ), most commonly any infection/abscess (10%; 21% in 2024;  $p=0.038$ ) and any nerve damage (9%; 22% in 2024;  $p=0.013$ ).

***Overdose, naloxone and drug checking***

Thirteen per cent of the Adelaide sample reported overdosing on any drug in the preceding year, a significant decrease from 27% in 2024 ( $p=0.017$ ). Seven per cent reported a non-fatal opioid overdose, and few participants ( $n\leq 5$ ) reported a non-fatal stimulant overdose.

In 2025, two thirds (67%) of the Adelaide sample reported awareness of naloxone, stable relative to 2024 (66%). Almost one third (30%) reported obtaining naloxone in the past year, stable relative to 21% in 2024.

Nine per cent reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year (9% in 2024).

***Dependence, drug treatment and HCV***

In 2025, 32% of male participants obtained an AUDIT-C score of  $\geq 4$ , and 49% of female participants obtained a score of  $\geq 3$ , indicative of hazardous alcohol use.

Forty-five per cent of participants who reported recent opioid use scored five or above on the Severity of Dependence Scale (SDS), and 53% of participants reporting recent methamphetamine use scored four or above, indicating possible dependence on these substances.

Seventeen per cent of the Adelaide sample reported receiving any drug treatment in 2025, stable relative to 2024 (14%).

One third (36%) of the Adelaide sample reported that they had received a hepatitis C virus (HCV) antibody test (35% in 2024) and one fifth (21%) reported receiving an RNA test (23% in 2024) in the past year. Few participants ( $n\leq 5$ ) reported having a current HCV infection (6% in 2024).

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

Half (53%) of the Adelaide sample reported engaging in sexual activity in the past four weeks (59% in 2024) and 14% reported having a sexual health check-up in the six months prior to interview (20% in 2024).

Self-reported mental health problems remained stable in 2025 (56%; 50% in 2024), with depression being the most commonly reported problem (70%), followed by anxiety (51%).

The K10 score remained stable between 2024 and 2025, with 30% of IDRS participants having a score of 30 or more (37% in 2024).

The majority (88%) of the Adelaide sample reported accessing any health service for alcohol and/or drug support in the six months preceding interview (90% in 2024).

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

Of those who had driven recently and commented ( $n=30$ ), 72% reported driving within three hours of consuming an illicit or non-prescribed drug, and 23% reported driving while over the perceived legal limit of alcohol, both stable relative to 2024 (85% and  $n\leq 5$ , respectively).

One third (35%) reported engaging in 'any' crime in the past month in 2025 (40% in 2024). One fifth (20%) reported having been arrested in the past year (25% in 2024), and almost one quarter (23%) reported a drug-related encounter with police which did not result in charge or arrest (33% in 2024).

In 2025, the most common means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (74%), although this was a significant decrease relative to 2024 (88%;  $p=0.015$ ).

# 2025 SAMPLE CHARACTERISTICS

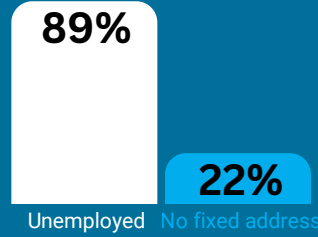


In June 2025, 105 participants, recruited from Adelaide, SA, were interviewed.



**48 years** **Male**

Median age and per cent who identified as male.

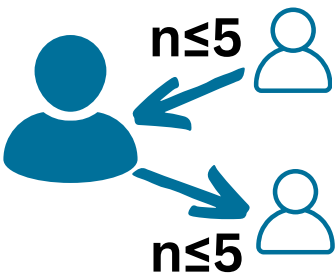


In the 2025 sample, 89% were unemployed and 22% had no fixed address.

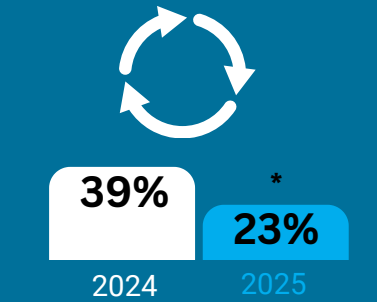
- Injected heroin**
- Injected methamphetamine**
- Injected other illicit or non-prescribed drugs**

Participants were recruited on the basis that they had injected drugs on at least 6 days in the previous 6 months.

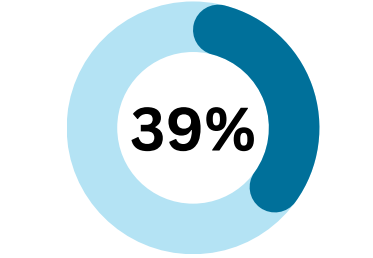
## INJECTING-RELATED RISKS AND HARMS



Few participants reported receptive or distributive sharing in the past month (n ≤ 5, respectively).



Percentage who reported re-using their own needles in the past month.



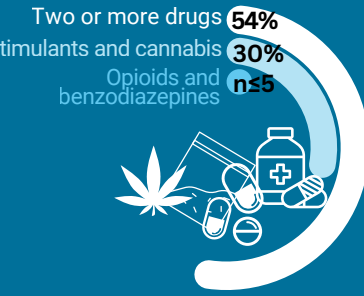
Percentage who reported injecting someone else in the past month.



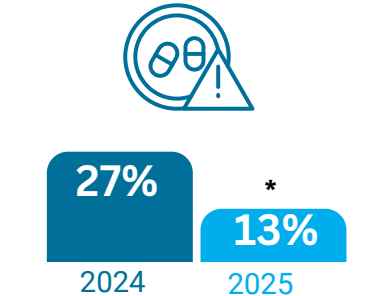
24% of participants reported having an injection-related health issue in the past month, a significant decrease from 40% in 2024.

\*p<0.050; \*\*p<0.010; \*\*\*p<0.001

## OTHER HARMS



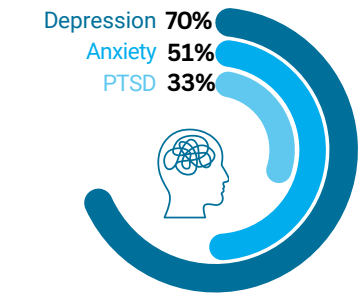
54% reported using two or more drugs on the day preceding interview; the most commonly used combination of drug classes was stimulants and cannabis (30%).



Past year non-fatal overdose significantly decreased in 2025, relative to 2024.



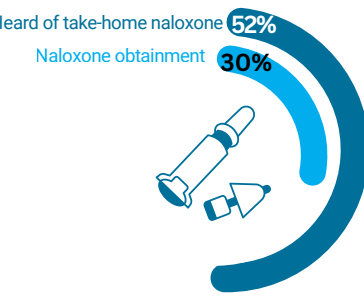
56% of participants self-reported a mental health problem in the 6 months preceding interview.



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

\*p<0.050; \*\*p<0.010; \*\*\*p<0.001

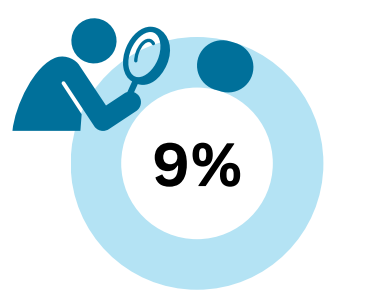
## NALOXONE AND OTHER HARM REDUCTION STRATEGIES



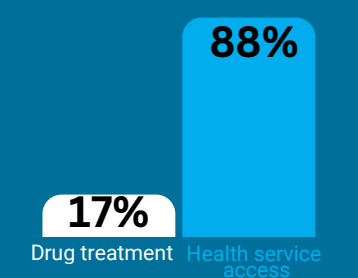
Knowledge of take-home naloxone and past year naloxone obtainment remained stable in 2025.



15% reported ever using naloxone to resuscitate someone who had overdosed, with 11% having done so in the past year.

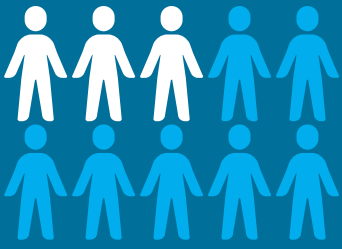


Percentage who reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year.

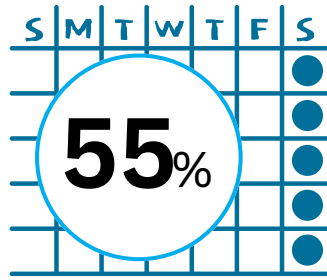


Percentage who reported current drug treatment and health service access for AOD support in the past 6 months.

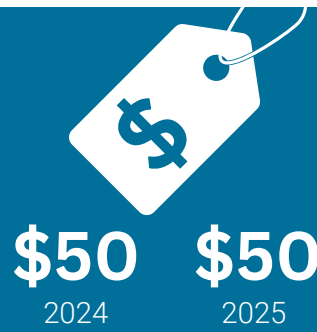
# HEROIN



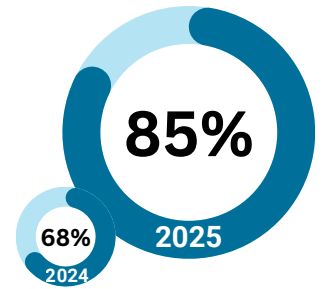
Past 6 month use of heroin remained stable in 2025 (28%) relative to 2024 (21%).



Of those who had recently consumed heroin, 55% reported weekly or more frequent use, stable from 2024 (41%).



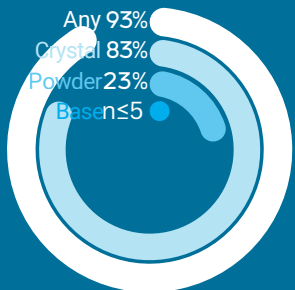
The median reported price for 1 point of heroin.



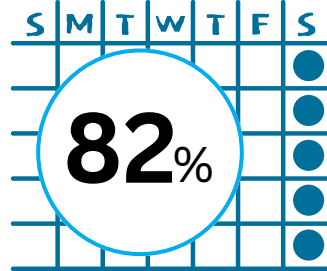
Percentage who perceived heroin as being 'easy' or 'very easy' to obtain.

# METHAMPHETAMINE

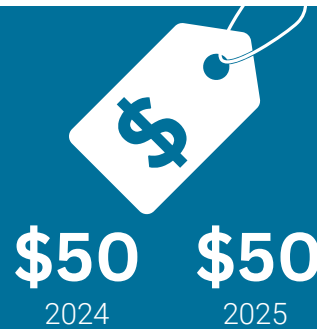
## FORM of methamphetamine



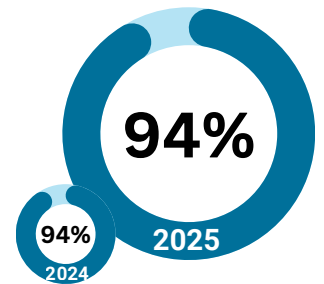
Past 6 month use of methamphetamine crystal & powder remained stable in 2025 relative to 2024.



Of those who had recently used any form of methamphetamine, 82% reported weekly or more frequent use, stable from 2024 (88%).



The median reported price for 1 point of methamphetamine crystal.

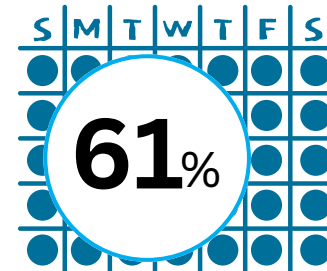


Percentage who perceived methamphetamine crystal as being 'easy' or 'very easy' to obtain.

# CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS



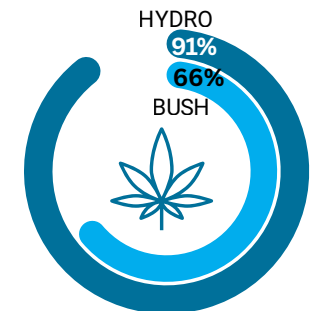
Past 6 month use significantly decreased in 2025 (63%) relative to 2024 (76%).



Of those who had recently used non-prescribed cannabis/cannabinoid-related products, 61% reported daily use, stable from 2024 (56%).



The median reported price for 1 bag (2-3 grams) of hydroponic and bush cannabis.

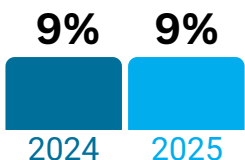


Percentage who perceived cannabis/cannabinoid-related products as being 'easy' or 'very easy' to obtain.

\*p<0.050; \*\*p<0.010; \*\*\*p<0.001

# PAST 6 MONTH USE OF OTHER DRUGS

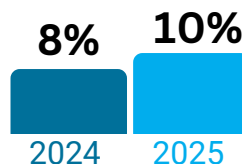
## Non-prescribed morphine



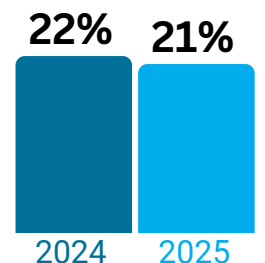
## Non-prescribed fentanyl



## Non-prescribed oxycodone



## GHB/GBL/1,4-BD



## Background

The [Illicit Drug Reporting System \(IDRS\)](#) is an ongoing illicit drug monitoring system which has been conducted in all states and territories of Australia since 2000, and forms part of [Drug Trends](#). The purpose of the IDRS is to provide a coordinated approach to monitoring the use, market features, and harms of illicit drugs.

The IDRS 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 inject drugs and from secondary analyses of routinely-collected indicator data. This report focuses on the key results from the annual interview component of the IDRS.

## Methods

### [IDRS 2000-2019](#)

Full details of the [methods for the annual interviews](#) are available for download. To briefly summarise, participants were recruited using multiple methods (e.g., needle and syringe programs (NSP) and peer referral) and needed to: i) be at least 17 years of age (due to ethical requirements); ii) have injected non-prescribed or illicit drugs on at least six days during the six months preceding interview; 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., treatment services, coffee shops or parks), and in later years were conducted using REDCap (Research Electronic Data Capture), a software program used to collect data on laptops or tablets. Following provision of written informed consent and completion of a structured interview, participants were reimbursed \$40 cash for their time and expenses incurred.

### *[IDRS 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 across all capital cities in 2020, with some capital cities (Darwin, Northern Territory (NT) and Hobart, Tasmania (TAS)) also offering face-to-face interviews;
2. Means of consenting participants: Participants' consent to participate was collected verbally prior to beginning the interview;
3. Means of reimbursement: Participants were given the option of receiving \$40 reimbursement via one of three methods, comprising bank transfer, PayID or gift voucher, where completing the interview via telephone; and
4. Age eligibility criterion: Changed from 17 years old (16 years old in Perth, Western Australia (WA)) to 18 years old.

From 2021 onwards, a hybrid approach was used whereby interviews were conducted face-to-face (with participants 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 IDRS Sample

Between 26 May-15 July 2025, a total of 865 participants were recruited across capital cities nationally, with 105 participants recruited from Adelaide, South Australia (SA) between 16 June-21 June, 2025. A total of eleven interviews were conducted via telephone in Adelaide, SA; the remainder were conducted face-to-face.

Fifteen per cent of the 2025 Adelaide sample completed the interview in 2024, and one fifth (20%) of participants in the Adelaide 2024 sample completed the interview in 2023 ( $p=0.452$ ). In 2025, recruitment methods remained fairly stable compared to 2024; most participants (54%) were recruited via word-of-mouth (45% in 2024), followed by 46% of participants being recruited via an NSP (52% in 2024). Few participants ( $n\leq 5$ ) reported other recruitment methods.

## Data Analysis

For normally distributed continuous variables, means and standard deviations (SD) are reported; for skewed data (i.e., skewness  $> \pm 1$  or kurtosis  $> \pm 3$ ), medians and interquartile ranges (IQR) are reported. Tests of statistical significance have been conducted between estimates for 2024 and 2025. References to 'significant' differences or changes throughout the report are where statistical testing has been conducted and where the  $p$ -value is less than 0.050. Note that no corrections for multiple comparisons have been made and thus comparisons should be treated with caution. Values where cell sizes are  $\leq 5$  have been suppressed with corresponding notation (zero values are reported). References to 'recent' use and behaviours refers to the past six-month time period. The response options 'Don't know' and 'Skip question', which were available to select throughout the interview, were excluded from analysis.

## Guide to Table/Figure Notes

Table 1: Guide to Table/Figure Notes

Legend	
/	Question not asked in respective year (for tables)
-	Per cent suppressed due to small cell size ( $n\leq 5$ but not 0) (for tables)
	Missing data points indicate question not asked in respective year or $n\leq 5$ answered the question (for figures)
<b>*<math>p&lt;0.050</math>; **<math>p&lt;0.010</math>; ***<math>p&lt;0.001</math></b>	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 Adelaide, South Australia, 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 Adelaide, SA (see section on 'Additional Outputs' below for details of other outputs providing such profiles).

## Additional Outputs

[Infographics](#) and the [executive summary](#) from this report are available for download. There are a range of outputs from the IDRS which triangulate key results from the annual interviews and other data sources and consider the implications of these findings, including national reports, jurisdictional reports, bulletins, and other resources available via the [Drug Trends webpage](#). This includes results from the [Ecstasy and Related Drugs Reporting System \(EDRS\)](#), which focuses on the use of ecstasy and other stimulants.

Please contact the research team at [drugtrends@unsw.edu.au](mailto: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 Adelaide IDRS sample, for the most part, was similar to the sample in 2024 and in previous years (Table 2).

Gender identity remained stable between 2024 and 2025 ( $p=0.781$ ), with almost three fifths (57%) identifying as male (61% in 2024). The median age of the sample was 48 years (IQR=43-55; 48 years in 2024; IQR=40-54;  $p=0.179$ ) (Table 2). Employment status remained stable between 2024 and 2025 ( $p=0.172$ ), with most participants reporting being unemployed at the time of interview (89%; 92% in 2024) and fewer participants reporting part time or casual employment (8%;  $n\leq 5$  in 2024). The majority of participants (94%) reported receiving a government pension, allowance or benefit in the past month (92% in 2024;  $p=0.594$ ). The median weekly income remained stable ( $p=0.050$ ), with participants reporting a median of \$441 (IQR=371-550) in 2025 (\$400 in 2024; IQR=350-500). Current accommodation type remained stable between 2024 and 2025 ( $p=0.679$ ), with most participants reporting residing in a private house/flat (65%; 65% in 2024). One fifth (22%) reported having 'no fixed address' in 2025 (26% in 2024).

Drug of choice remained stable between 2024 and 2025 ( $p=0.187$ ). Most participants continued to report that methamphetamine was their drug of choice in 2025 (65%; 73% in 2024), followed by 16% reporting heroin (7% in 2024) and 10% reporting cannabis (12% in 2024) as their drugs of choice (Figure 1). The drug injected most often in the past month also remained stable in 2025, relative to 2024 ( $p=0.222$ ), with four fifths (80%) nominating methamphetamine as the drug injected most often in the past month (90% in 2024), followed by 14% reporting heroin as the drug injected most often in the past month (7% in 2024) (Figure 2).

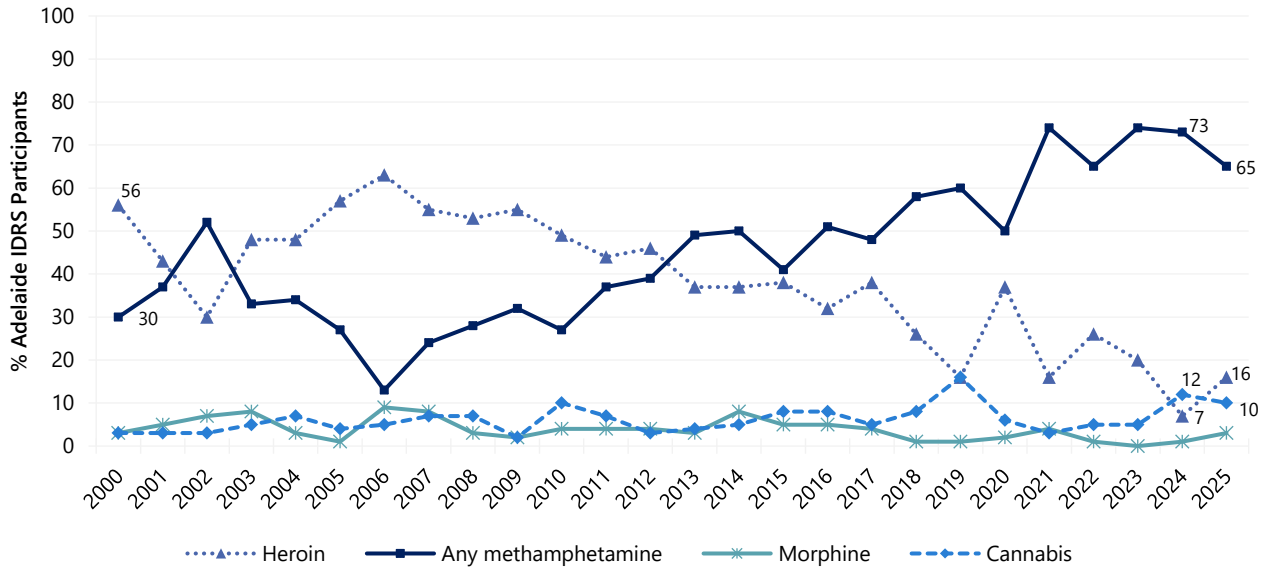
Weekly or more frequent consumption of methamphetamine crystal (66%; 81% in 2024;  $p=0.021$ ) and non-prescribed cannabis (54%; 69% in 2024;  $p=0.037$ ) significantly decreased in 2025, though significantly more participants reported weekly or more frequent use of methamphetamine powder (20%; 8% in 2024;  $p=0.022$ ) (Figure 3). Weekly or more frequent use of heroin remained stable (15%; 8% in 2024;  $p=0.150$ ), as did weekly or more frequent use of any methamphetamine (77%; 85% in 2024;  $p=0.171$ ).

Table 2: Demographic characteristics of the sample, nationally, 2025, and Adelaide, SA, 2021-2025

	Adelaide, SA					National
	2021	2022	2023	2024	2025	2025
	(N=100)	(N=103)	(N=102)	(N=106)	(N=105)	(N=865)
<b>Median age (years; IQR)</b>	47 (40-53)	48 (40-55)	48 (42-54)	48 (40-54)	<b>48</b> <b>(43-55)</b>	47 (41-54)
<b>% Gender</b>						
Female	43	35	34	38	<b>42</b>	34
Male	57	65	66	61	<b>57</b>	66
Non-binary	0	0	0	-	-	1
<b>% Aboriginal and/or Torres Strait Islander</b>	20	25	32	29	<b>29</b>	29
<b>% Born in Australia</b>	/	/	83	91	<b>90</b>	91
<b>% English primary language spoken at home</b>	/	/	95	95	<b>100</b>	98
<b>% Sexual identity</b>						
Heterosexual	93	83	86	80	<b>82</b>	82
Homosexual	-	7	-	-	-	5
Bisexual	6	10	9	16	<b>12</b>	9
Queer	0	0	0	-	-	2
Other identity	0	0	0	-	-	1
<b>Mean years of school education (range)</b>	10 (7-12)	10 (2-12)	10 (6-12)	10 (4-12)	<b>10</b> <b>(4-12)</b>	10 (1-12)
<b>% Post-school qualification(s) ^</b>	59	64	59	66	<b>68</b>	57
<b>% Current accommodation</b>						
Own home ( <i>inc. renting</i> )~	73	73	70	65	<b>65</b>	66
Parents'/family home	6	-	7	-	<b>6</b>	5
Boarding house/hostel	-	14	-	-	-	4
Shelter/refuge	0	-	-	0	-	4
No fixed address	15	11	18	26	<b>22</b>	19
Other	-	0	-	-	-	1
<b>% Current employment status</b>				*		
Unemployed	88	81	84	92	<b>89</b>	88
Full-time work	-	-	-	-	-	3
Part time/casual	/	/	11	-	<b>8</b>	6
Self-employed	/	/	-	-	-	2
Other	/	/	-	0	<b>0</b>	0
<b>% Past month gov't pension, allowance or benefit</b>	96	93	90	92	<b>94</b>	94
<b>Current median income/week (\$; IQR)</b>	\$315 (280-438)	\$350 (293-450)	\$383 (325-500)	\$400 (350-500)	<b>\$441</b> <b>(371-550)</b>	\$465 (375-598)

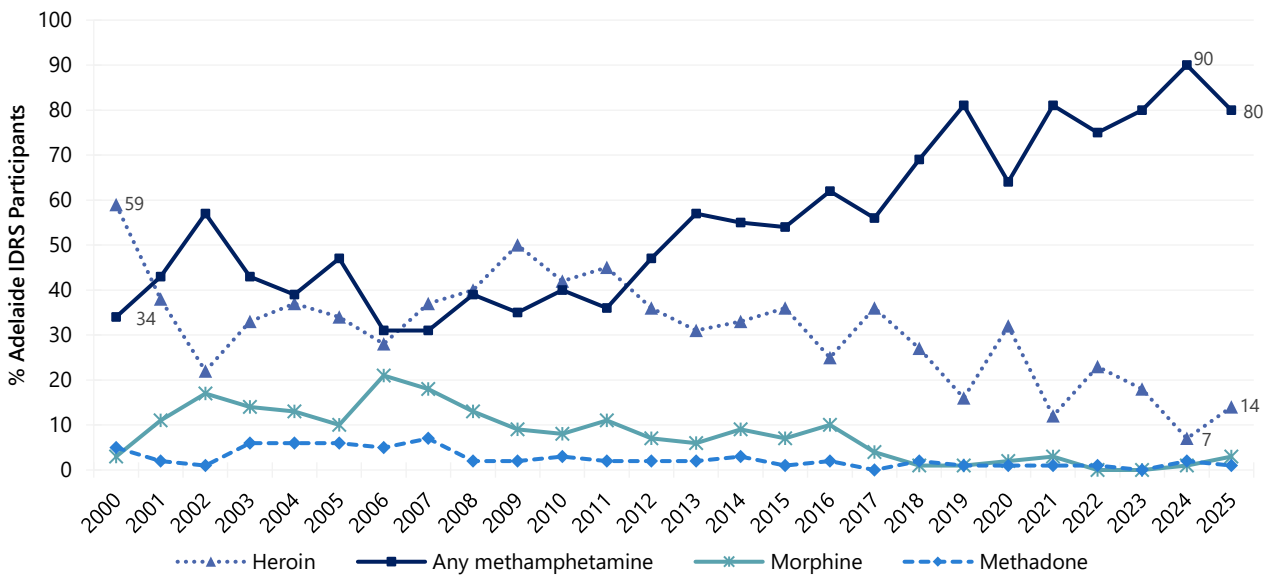
Note. ^Includes trade/technical and university qualifications. Statistical significance for 2024 versus 2025 among the Adelaide sample is presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ . Please refer to Table 1 for a guide to table/figure notes.

Figure 1: Drug of choice, Adelaide, SA, 2000-2025



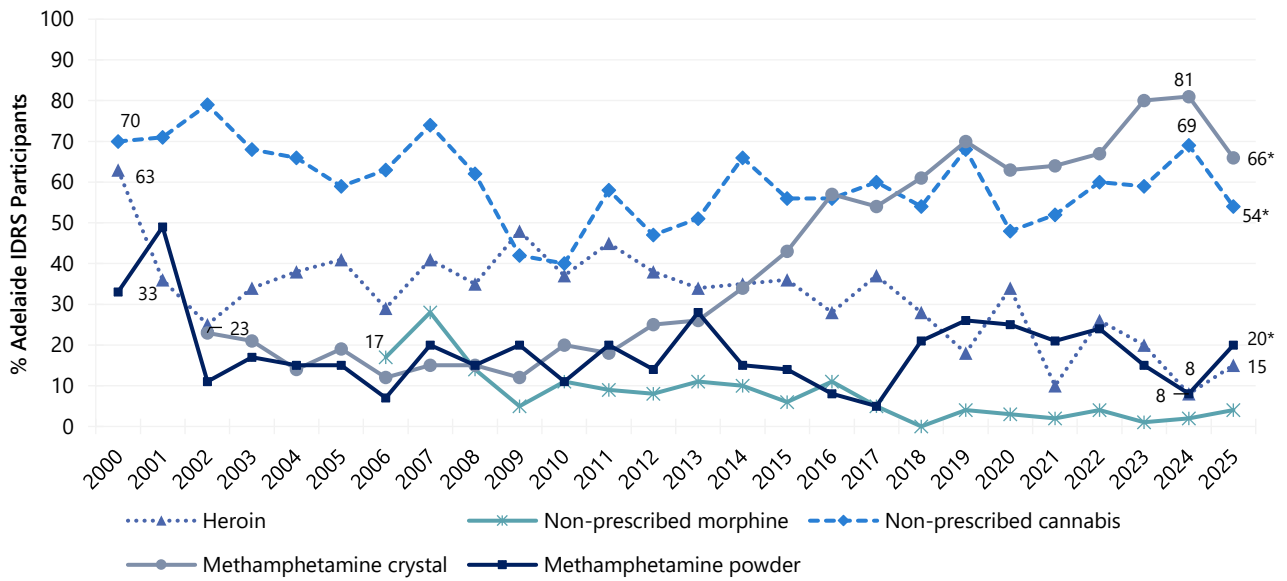
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; a nominal per cent endorsed other substances. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  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 2: Drug injected most often in the past month, Adelaide, SA, 2000-2025



Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; a nominal per cent 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.,  $n \leq 5$  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 3: Weekly or more frequent substance use in the past six months, Adelaide, SA, 2000-2025



Note. Computed of 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.,  $n \leq 5$  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.

# 2

## Heroin

Participants were asked about their recent (past six month) use of heroin and homebake heroin. Participants typically describe heroin as white/off-white rock, brown/beige rock or white/off-white powder. Homebake is a form of heroin illicitly produced from pharmaceutical opioid products.

### Patterns of Consumption

#### Recent Use (past 6 months)

The per cent reporting recent use of any heroin has fluctuated since the commencement of monitoring. In 2025, 28% of the Adelaide sample reported recent use, stable relative to 2024 (21%;  $p=0.265$ ) (Figure 4).

#### Frequency of Use

Frequency of use has fluctuated over the course of monitoring. In 2025, participants who reported recent use and commented ( $n=29$ ) had used heroin on a median of 24 days (IQR=6-120) in the six months preceding interview, stable relative to 2024 (9 days; IQR=2-102;  $n=22$ ;  $p=0.154$ ) (Figure 4). Fifty-five per cent of participants who had recently used heroin reported using heroin on a weekly or more frequent basis in 2025, stable relative to 2024 (41%;  $p=0.399$ ), and few participants ( $n\leq 5$ ) reported daily use, stable relative to 2024 (18%).

#### Routes of Administration

Among participants who had recently consumed heroin and commented ( $n=29$ ), injecting remained the most common route of administration (97%; 100% in 2024). Participants who reported injecting heroin had done so on a median of 36 days (IQR=9-130), stable relative to 2024 (9 days; IQR=2-102;  $p=0.133$ ). Few participants ( $n\leq 5$ ) reported smoking heroin in 2025 ( $n\leq 5$  in 2024).

#### Quantity

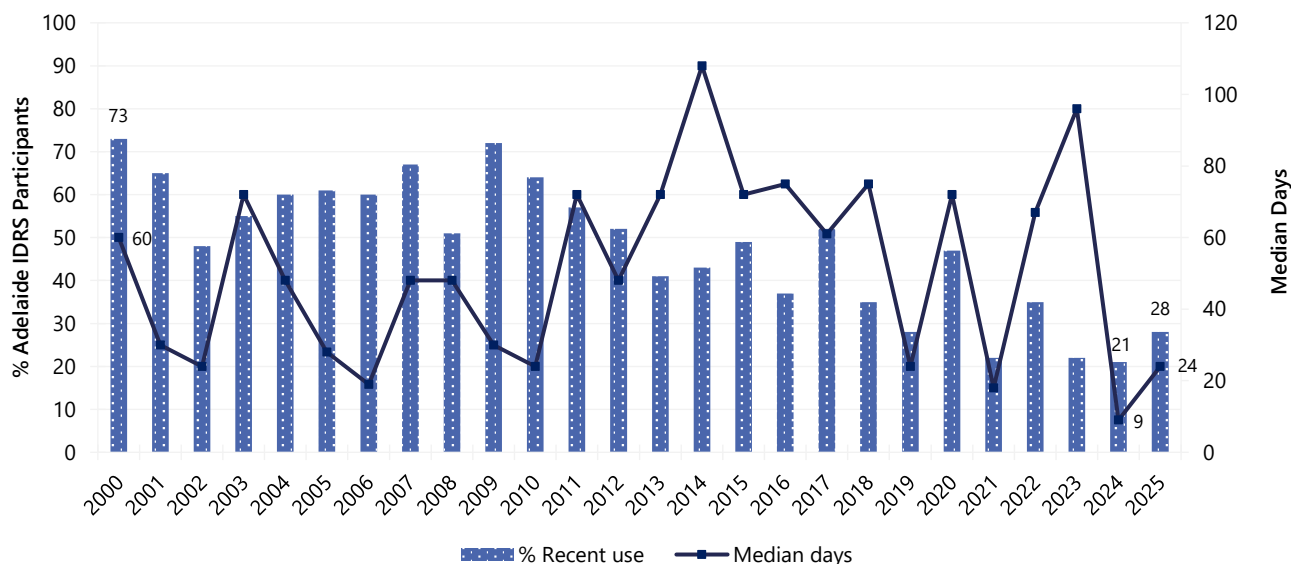
Of those who reported recent use and responded ( $n=26$ ), the median amount of heroin used on a 'typical' day in the six months preceding interview was 0.20 grams (IQR=0.10-0.20; 0.20 grams in 2024; IQR=0.10-0.20;  $n=19$ ;  $p=0.663$ ). Of those who reported recent use and responded ( $n=26$ ), the median maximum amount of heroin used per day in the six months preceding interview was 0.20 grams (IQR=0.10-0.60; 0.30 grams in 2024; IQR=0.10-0.60;  $n=19$ ;  $p=0.908$ ).

#### Forms Used

Among participants who reported recent use of heroin in 2025 and commented ( $n=29$ ), almost two fifths (38%) reported using white/off-white powder heroin, stable relative to 2024 (38%;  $p=0.619$ ). Few participants ( $n\leq 5$ ) reported using brown/beige powder in 2025 (24% in 2024). Almost half (48%) reported using white/off-white rock in 2025 (38% in 2024;  $p=0.263$ ) and almost one third (31%)

reported using brown/beige rock (24% in 2024;  $p=0.408$ ). No participants reported using purple powder or purple rock in 2025 (0% in 2024, respectively). Few participants ( $n\leq 5$ ) reported using homebake in 2025 (0% in 2024;  $p=0.498$ ).

Figure 4: Past six month use and frequency of use of heroin, Adelaide, SA, 2000-2025



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 120 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.,  $n\leq 5$  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.

## Price, Perceived Purity and Perceived Availability

### Price

In 2025, the median price for one point (0.10 of a gram) of heroin remained stable at \$50 (IQR=50-100;  $n=13$ ; \$50 in 2024; IQR=50-75;  $n=11$ ;  $p=0.796$ ) (Figure 5). Participants reported a median price of \$50 per cap (IQR=50-50;  $n=6$ ) in 2025, a significant decrease relative to 2024 ( $n\leq 5$  in 2024;  $p=0.041$ ); few participants ( $n\leq 5$ ) were able to report on the price of a gram.

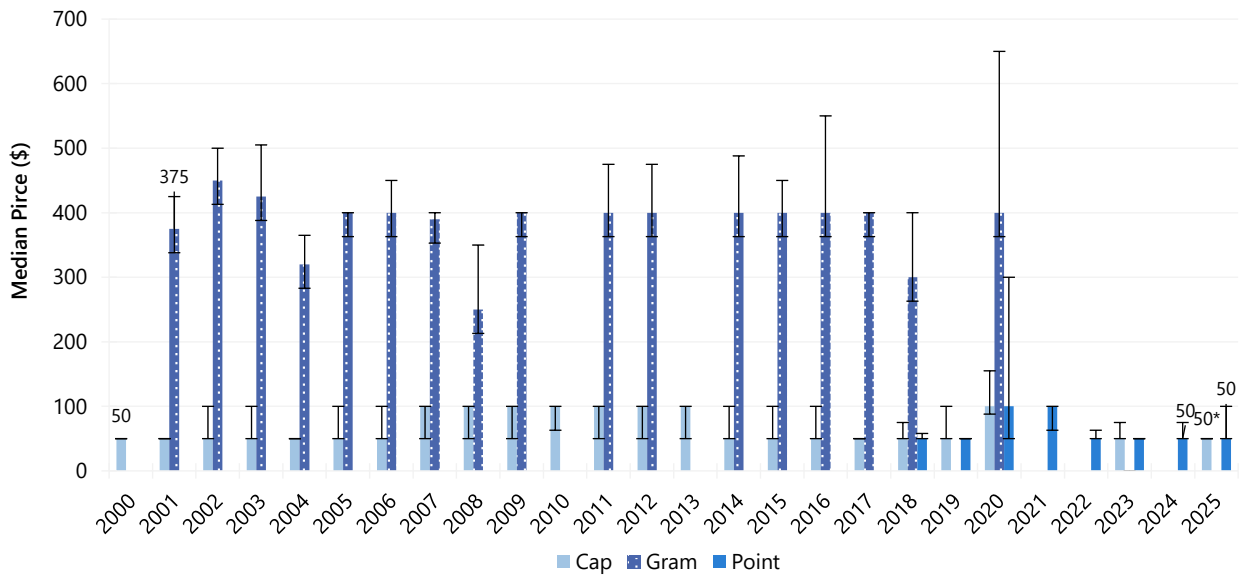
### Perceived Purity

The perceived purity of heroin remained stable between 2024 and 2025 ( $p=0.778$ ) (Figure 6). Among those who were able to comment in 2025 ( $n=27$ ), two fifths (41%) perceived purity to be 'low' (33% in 2024), and in contrast, almost one third (30%) perceived purity to be 'high' (29% in 2024).

### Perceived Availability

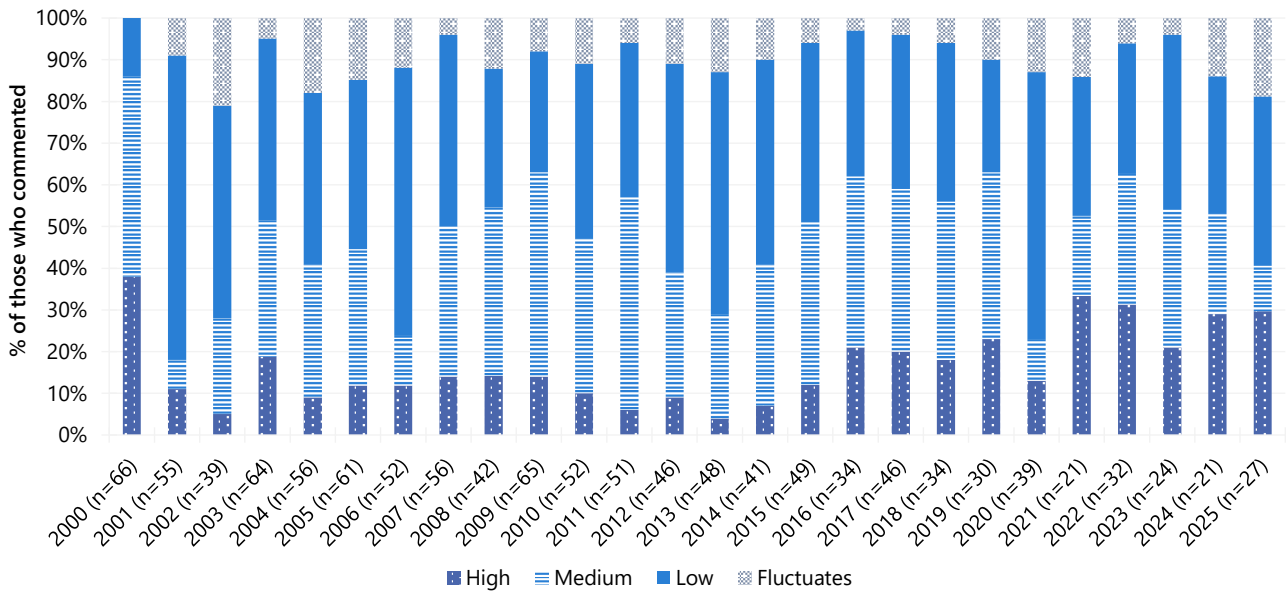
The perceived availability of heroin remained stable between 2024 and 2025 ( $p=0.094$ ) (Figure 7). Among those who were able to comment in 2025 ( $n=28$ ), almost two thirds (64%) perceived current availability as 'very easy' (50% in 2024), and a further one fifth (21%) perceived current availability as 'easy' (18% in 2024).

Figure 5: Median price of heroin per cap, gram and point, Adelaide, SA, 2000-2025



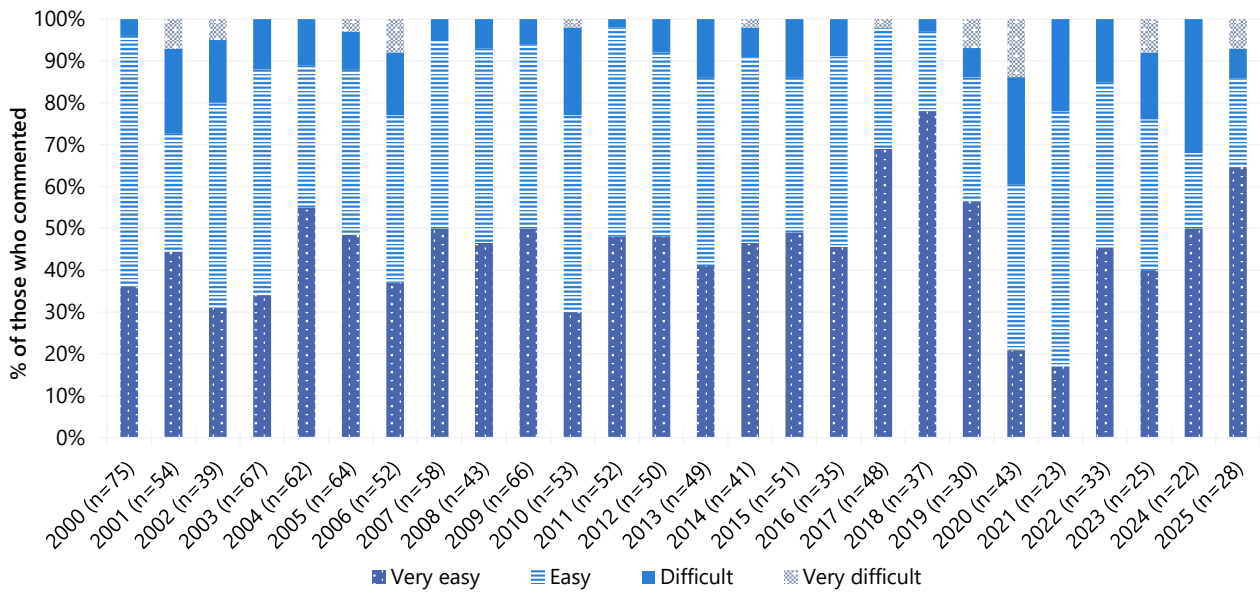
Note. Among those who commented. Between 2009-2017 a cap was referred to as cap/point; in 2018 these measures were separated as their own response options. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where  $n \leq 5$  responded. 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 6: Current perceived purity of heroin, Adelaide, SA, 2000-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where  $n \leq 5$  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 7: Current perceived availability of heroin, Adelaide, SA, 2000-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where  $n \leq 5$  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.

# 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).

### Patterns of Consumption (Any Methamphetamine)

#### Recent Use (past 6 months)

In 2025, the majority (93%) of the Adelaide sample reported recent use of any methamphetamine (powder, base and crystal), stable relative to 2024 (96%;  $p=0.374$ ) (Figure 8).

#### Frequency of Use

Participants who reported recent use and commented ( $n=97$ ) had used any methamphetamine on a median of 72 days (IQR=24-125), a significant decrease relative to 96 days in 2024 (IQR=53-180;  $n=102$ ;  $p=0.017$ ) (Figure 9). Among those who reported recent use, weekly or more frequent use remained stable in 2025 (82%; 88% in 2024;  $p=0.320$ ), as did daily use (19%; 29% in 2024;  $p=0.101$ ).

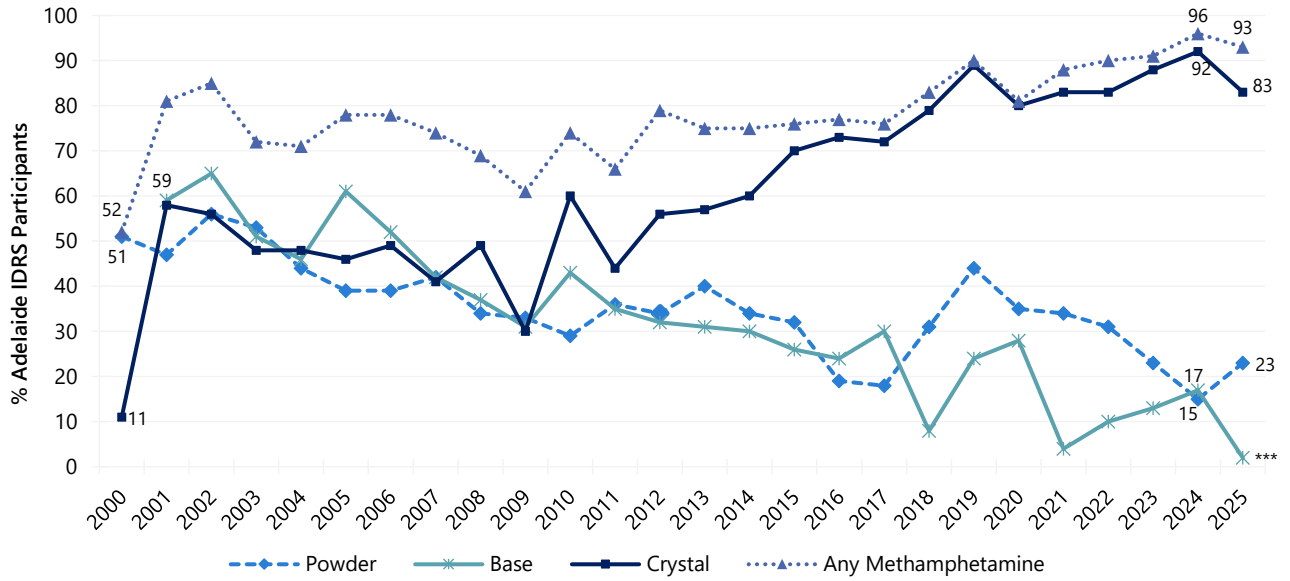
#### Forms Used

There has been a shift over time in the forms of methamphetamine used by participants, with decreasing use of methamphetamine powder and base and increasing use of methamphetamine crystal. Of participants who had used methamphetamine in the six months preceding interview in 2025 ( $n=98$ ), most had used methamphetamine crystal (89%; 95% in 2024;  $p=0.121$ ), followed by powder (24%; 16% in 2024;  $p=0.161$ ). Methamphetamine base significantly decreased in 2025, relative to 2024 ( $n\leq 5$ ; 18% in 2024;  $p<0.001$ ).

#### Number of Forms Used

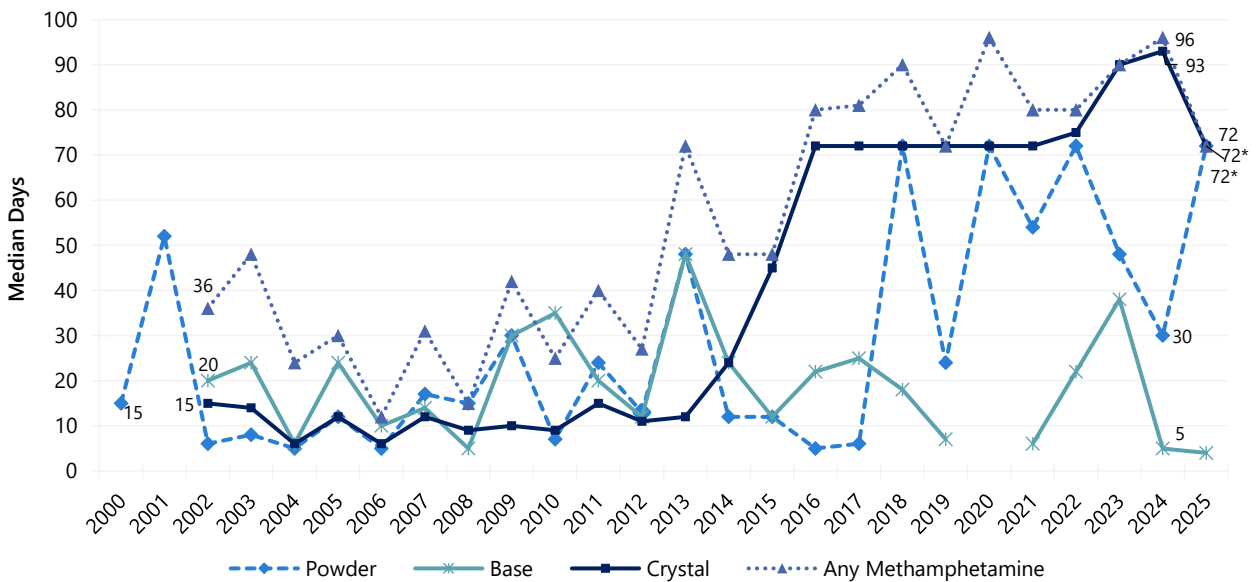
Among participants who had recently consumed any methamphetamine and commented in 2025 ( $n=98$ ), the median number of forms of methamphetamine used was one (IQR=1-1), stable relative to 2024 (1 form; IQR=1-1;  $n=102$ ;  $p=0.065$ ).

Figure 8: Past six month use of any methamphetamine, and of methamphetamine powder, base, and crystal, Adelaide, SA, 2000-2025



Note. 'Any methamphetamine' includes crystal, powder, base and liquid methamphetamine combined from 2000-2018, and methamphetamine crystal, powder and base combined from 2019 onwards. Questions regarding methamphetamine liquid not asked from 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.,  $n \leq 5$  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 9: Frequency of use of any methamphetamine, and of methamphetamine powder, base, and crystal, Adelaide, SA, 2000-2025



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 100 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.,  $n \leq 5$  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.

## Patterns of Consumption (by form)

### Methamphetamine Powder

**Recent Use (past 6 months):** The per cent reporting recent use of methamphetamine powder gradually declined from 2000-2017, before subsequently increasing from 2017-2019, and declining again thereafter. Almost one quarter (23%) of the Adelaide sample reported recent use in 2025, stable relative to 2024 (15%;  $p=0.163$ ) (Figure 8).

**Frequency of Use:** Among those who had recently consumed methamphetamine powder and commented ( $n=23$ ), the median days of use was 72 days (IQR=24-150; 30 days in 2024; IQR=9-98;  $n=16$ ;  $p=0.117$ ) (Figure 9). Ninety-one per cent of those who had recently used powder reported weekly or more frequent use in 2025, a significant increase from 56% in 2024 ( $p=0.019$ ). One quarter (26%) reported daily use ( $n\leq 5$  in 2024;  $p=0.711$ ).

**Routes of Administration:** Among participants who had recently consumed methamphetamine powder and commented ( $n=24$ ), 96% reported injecting as a route of administration (100% in 2024) and had done so on a median of 70 days (IQR=24-120), stable relative to 2024 (27 days; IQR=9-98;  $p=0.087$ ). Forty-six per cent reported smoking methamphetamine powder ( $n\leq 5$  in 2024;  $p=0.318$ ).

**Quantity:** Of those who reported recent use and commented ( $n=24$ ), the median amount of methamphetamine powder used on a 'typical' day in the six months preceding interview was 0.20 grams (IQR=0.10-0.30), a significant decrease relative to 2024 (0.30 grams; IQR=0.30-0.40;  $n=15$ ;  $p=0.033$ ). Of those who reported recent use and commented ( $n=24$ ), the median maximum amount of powder used per day in the six months preceding interview was 0.40 grams (IQR=0.20-0.50) also a

significant decrease relative to 2024 (0.50 grams; IQR=0.50-0.90;  $n=15$ ;  $p=0.024$ ).

### Methamphetamine Base

**Recent Use (past 6 months):** Notwithstanding some fluctuation, recent use of methamphetamine base gradually declined between 2001 and 2021, after which there has been a gradual increase. Nevertheless, in 2025, the per cent of participants reporting recent use of base significantly decreased ( $n\leq 5$ ) relative to 2024 (17% in 2024;  $p<0.001$ ) (Figure 8).

Due to few participants ( $n\leq 5$ ) reporting on recent use of methamphetamine base, further details are not reported on frequency of use, routes of administration and quantity used. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

### Methamphetamine Crystal

**Recent Use (past 6 months):** Surpassing methamphetamine base and powder from 2010 onwards, recent use of methamphetamine crystal has generally increased from 2011 onwards. In 2025, four fifths (83%) of the Adelaide sample reported recent use, stable relative to 2024 (92%;  $p=0.069$ ) (Figure 8).

**Frequency of Use:** Among those who had recently consumed methamphetamine crystal and commented ( $n=86$ ), median days of use significantly decreased, from 93 days (IQR=50-180;  $n=96$ ) in 2024 to 72 days (IQR=26-124) in 2025 ( $p=0.015$ ) (Figure 9). Four fifths (80%) of those who had recently used crystal reported weekly or more frequent use (89% in 2024;  $p=0.156$ ), with 17% reporting daily use (29% in 2024;  $p=0.084$ ).

**Routes of Administration:** Among participants who had recently consumed methamphetamine crystal and commented (n=87), the vast majority (98%) of participants reported injecting (100% in 2024;  $p=0.222$ ) and had done so on a median of 72 days (IQR=24-120; 90 days in 2024; IQR=48-173;  $p=0.099$ ). Almost two fifths (39%) reported smoking methamphetamine crystal (45% in 2024;  $p=0.450$ ). Few participants ( $n\leq 5$ ) reported swallowing as a route of administration (6% in 2024;  $p=0.751$ ).

## Price, Perceived Purity and Perceived Availability

### Methamphetamine Powder

**Price:** The median price for one point (0.10 of a gram) of methamphetamine powder remained stable at \$50 in 2025 (IQR=45-50;  $n=15$ ; \$50 in 2024; IQR=50-50;  $n=8$ ;  $p=0.909$ ) (Figure 10). Few participants ( $n\leq 5$ ) reported on the price of one gram in 2025 ( $n\leq 5$  in 2024) and therefore, no further details are reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

**Perceived Purity:** The perceived purity of methamphetamine powder remained stable between 2024 and 2025 ( $p=0.772$ ). Among those who were able to comment in 2025 ( $n=23$ ), equal percentages (35%) reported 'low' purity (36% in 2024) and 'medium' purity (29% in 2024).

**Perceived Availability:** The perceived availability of methamphetamine powder remained stable between 2024 and 2025. Of those who were able to comment in 2025 ( $n=23$ ), almost three fifths (57%) of participants reported that methamphetamine powder was

**Quantity:** Of those who reported recent use and responded ( $n=84$ ), the median amount of methamphetamine crystal used on a 'typical' day in the six months preceding interview was 0.20 grams (IQR=0.10-0.30; 0.20 grams in 2024; IQR=0.10-0.40;  $n=96$ ;  $p=0.657$ ). Of those who reported recent use and responded ( $n=81$ ), the median maximum amount of crystal used per day in the six months preceding interview was 0.40 grams (IQR=0.20-1.00; 0.50 grams in 2024; IQR=0.20-1.00;  $n=93$ ;  $p=0.229$ ).

'very easy' to obtain (60% in 2024), followed by one quarter (26%) reporting it was 'easy' to obtain (27% in 2024) (Figure 14).

### Methamphetamine Base

Questions pertaining to the price, perceived purity and perceived availability of methamphetamine base were not asked of participants from 2020. For historical information, please refer to the [2019 SA IDRS Report](#) and the [2025 National IDRS Report](#).

### Methamphetamine Crystal

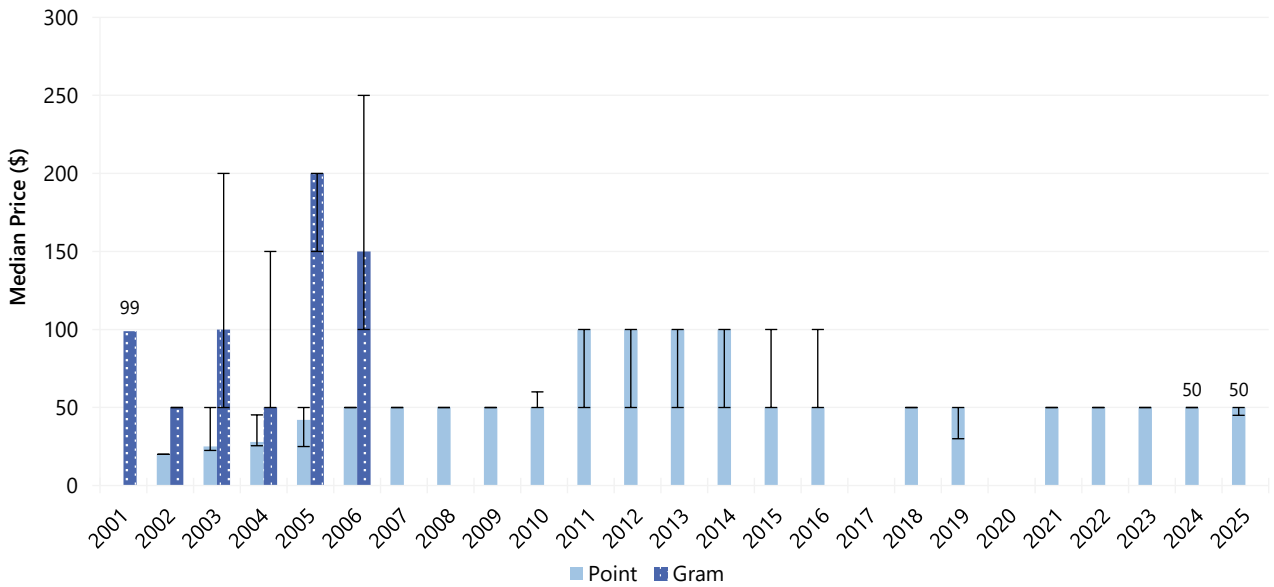
**Price:** Participants reported a median price of \$50 (IQR=30-50;  $n=49$ ) for one point (0.10 of a gram) of crystal (\$50 in 2024; IQR=50-50;  $n=44$ ;  $p=0.179$ ) and \$250 for one gram of crystal in 2025 (IQR=200-300;  $n=7$ ; \$300 in 2024; IQR=125-413;  $n=10$ ;  $p=0.689$ ) (Figure 11).

**Perceived Purity:** The perceived purity of methamphetamine crystal remained stable between 2024 and 2025 ( $p=0.102$ ). Among those who were able to comment in 2025 ( $n=82$ ), almost one third (30%) perceived crystal as having 'medium' purity (32% in 2024), followed by 28% who reported 'low' purity (17% in 2024). Sixteen per cent reported 'high' purity (29% in 2024) (Figure 13).

**Perceived Availability:** The perceived availability of methamphetamine crystal remained stable between 2024 and 2025

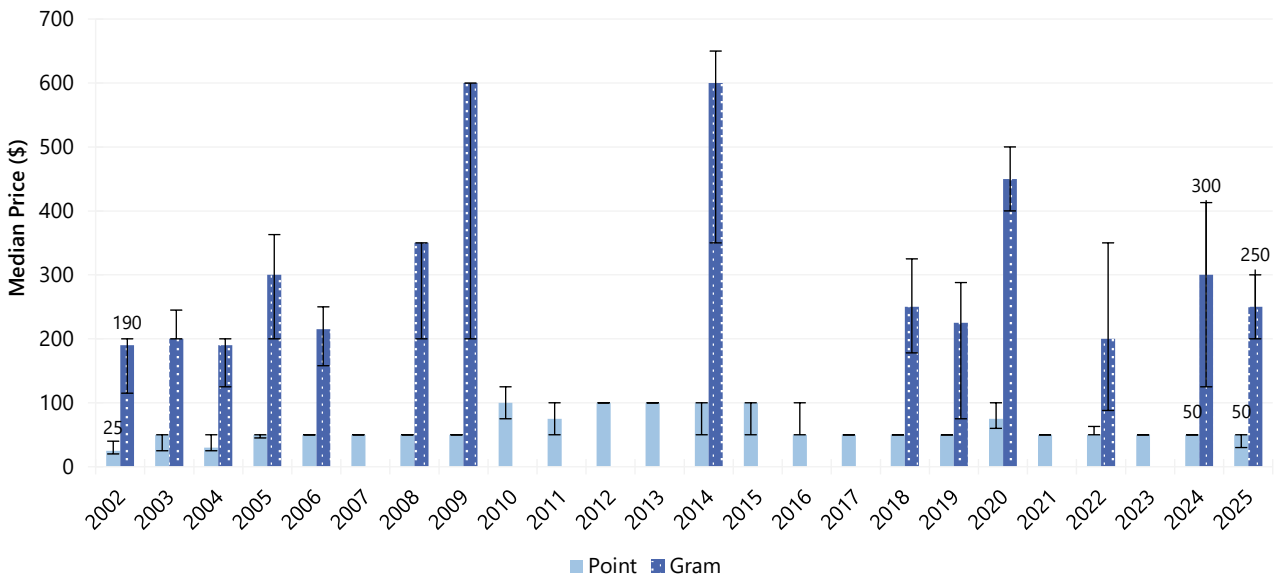
( $p=0.849$ ). Among those who were able to comment in 2025 ( $n=85$ ), three quarters (75%) perceived methamphetamine crystal as being 'very easy' to obtain (75% in 2024) and almost one fifth (19%) reported 'easy' obtainment (19% in 2024) (Figure 15).

Figure 10: Median price of methamphetamine powder per point and gram, Adelaide, SA, 2001-2025



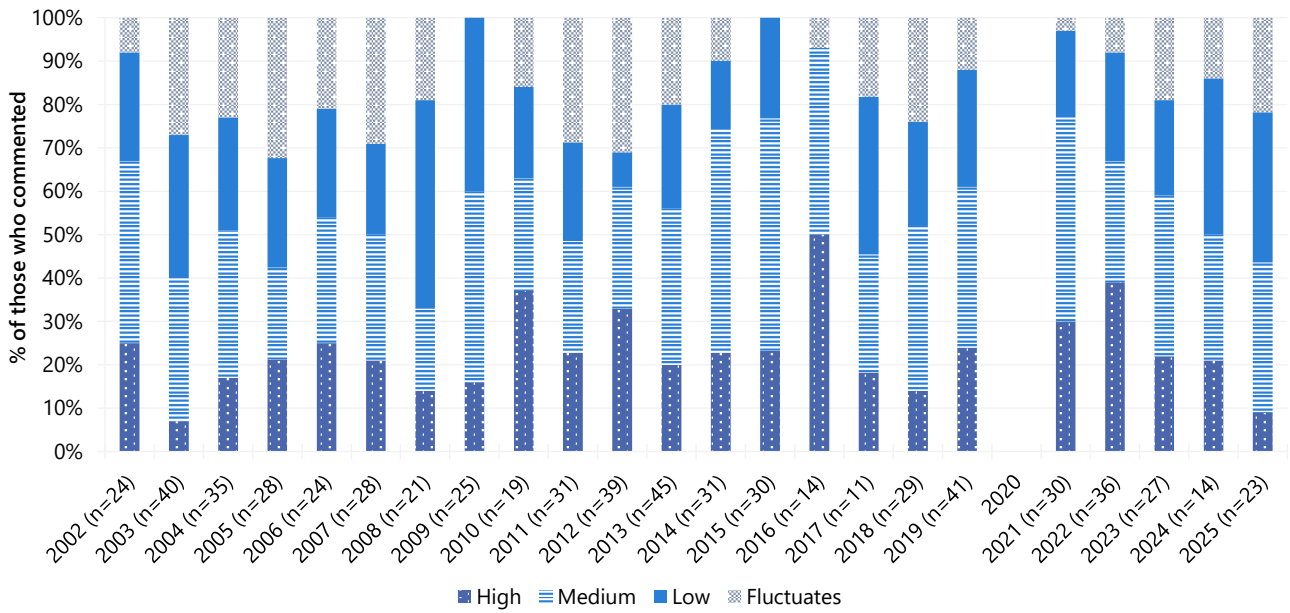
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where  $n \leq 5$  responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ . Please refer to Table 1 for a guide to table/figure notes.

Figure 11: Median price of methamphetamine crystal per point and gram, Adelaide, SA, 2002-2025



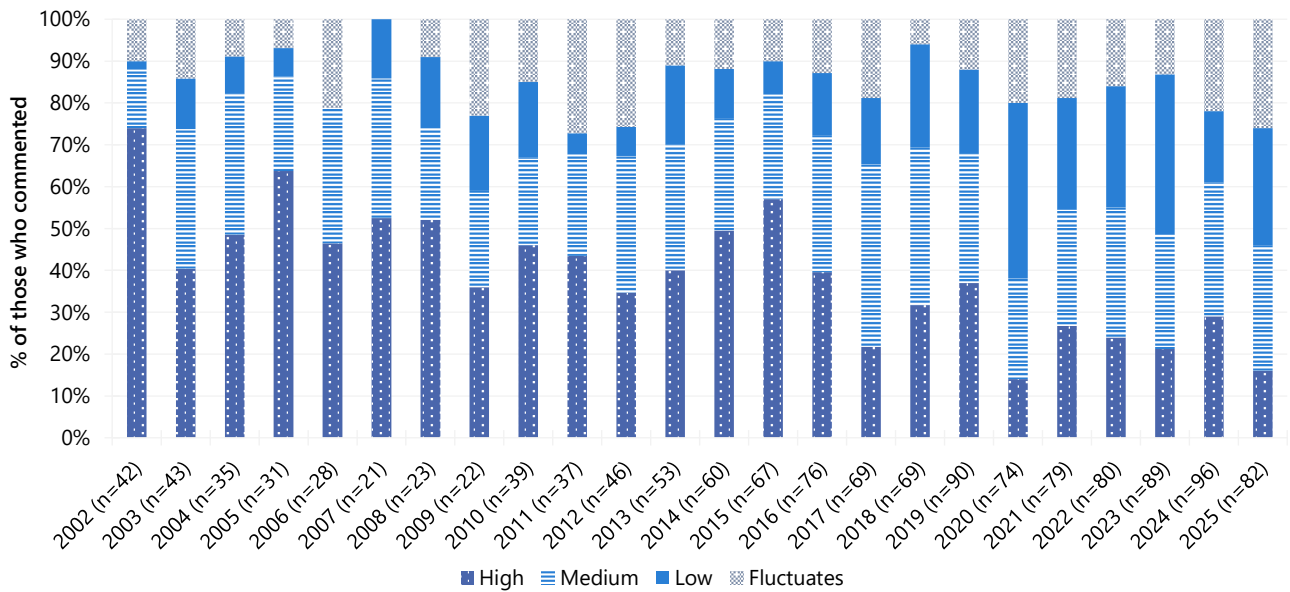
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where  $n \leq 5$  responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ . Please refer to Table 1 for a guide to table/figure notes.

Figure 12: Current perceived purity of methamphetamine powder, Adelaide, SA, 2002-2025



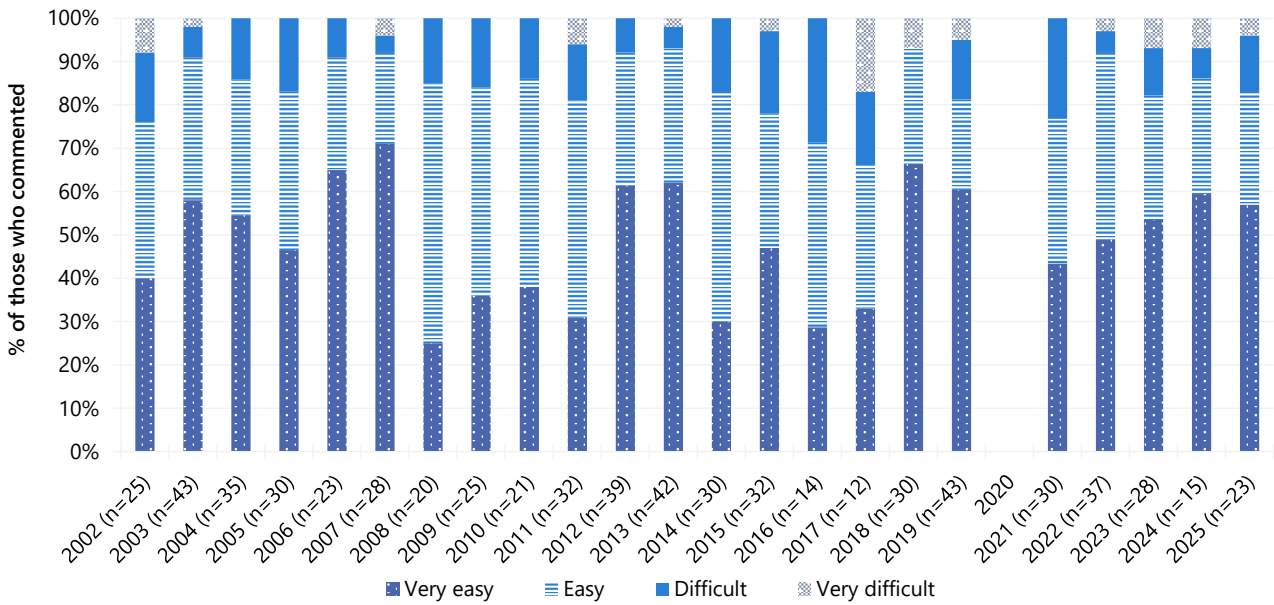
Note. Methamphetamine asked separately for the three different forms from 2002 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where  $n \leq 5$  responded to the item. Statistical significance for 2024 versus 2025 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 13: Current perceived purity of methamphetamine crystal, Adelaide, SA, 2002-2025



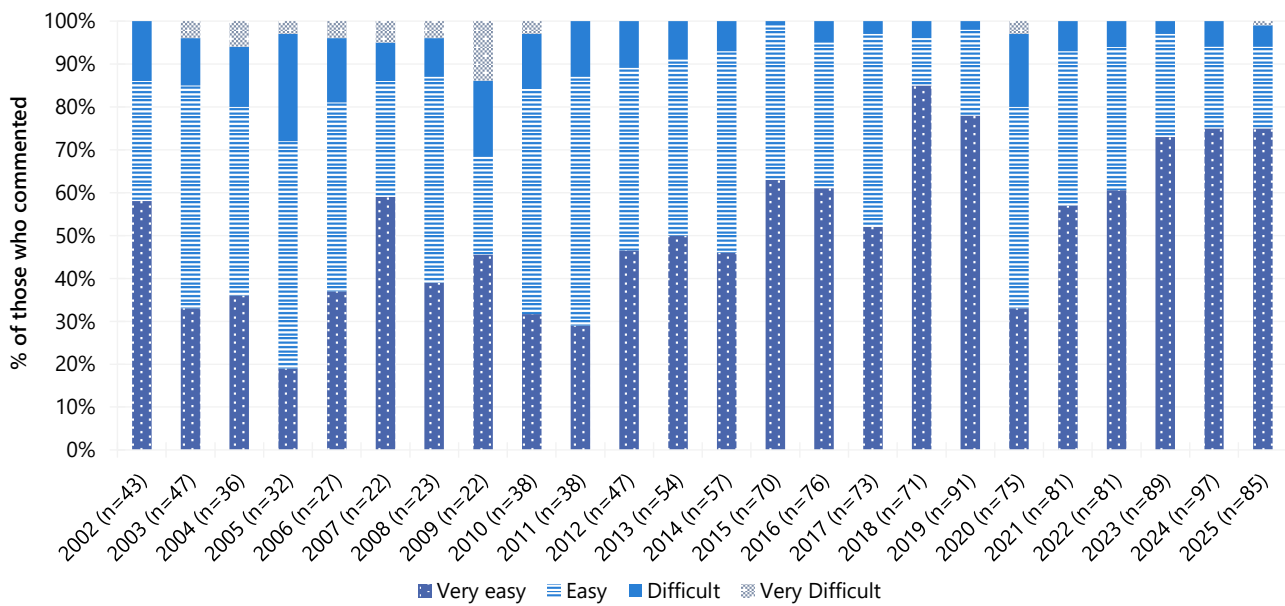
Note. Methamphetamine asked separately for the three different forms from 2002 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where  $n \leq 5$  responded to the item. Statistical significance for 2024 versus 2025 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 14: Current perceived availability of methamphetamine powder, Adelaide, SA, 2002-2025



Note. Methamphetamine asked separately for the three different forms from 2002 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where  $n \leq 5$  responded to the item. Statistical significance for 2024 versus 2025 is presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ . Please refer to Table 1 for a guide to table/figure notes.

Figure 15: Current perceived availability of methamphetamine crystal, Adelaide, SA, 2002-2025



Note. Methamphetamine asked separately for the three different forms from 2002 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where  $n \leq 5$  responded to the item. Statistical significance for 2024 versus 2025 is presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ . Please refer to Table 1 for a guide to table/figure notes.

# 4

## 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 cocaine has fluctuated over the years, with 16% of the Adelaide sample reporting recent use in 2025, stable relative to 2024 (13%;  $p=0.566$ ) (Figure 16).

#### Frequency of Use

Of those who had recently consumed cocaine and commented in 2025 ( $n=17$ ), frequency of use remained stable at a median of two days (IQR=1-3; 2 days in 2024; IQR=1-5;  $n=14$ ;  $p=0.394$ ) (Figure 16). No participants reported using cocaine weekly or more frequently in 2025 ( $n\leq 5$  in 2024;  $p=0.196$ ).

#### Routes of Administration

Among participants who had recently consumed cocaine and commented ( $n=17$ ), four fifths (82%) reported snorting cocaine, stable relative to 2024 (93%;  $p=0.607$ ). Few participants ( $n\leq 5$ ) reported other routes of administration.

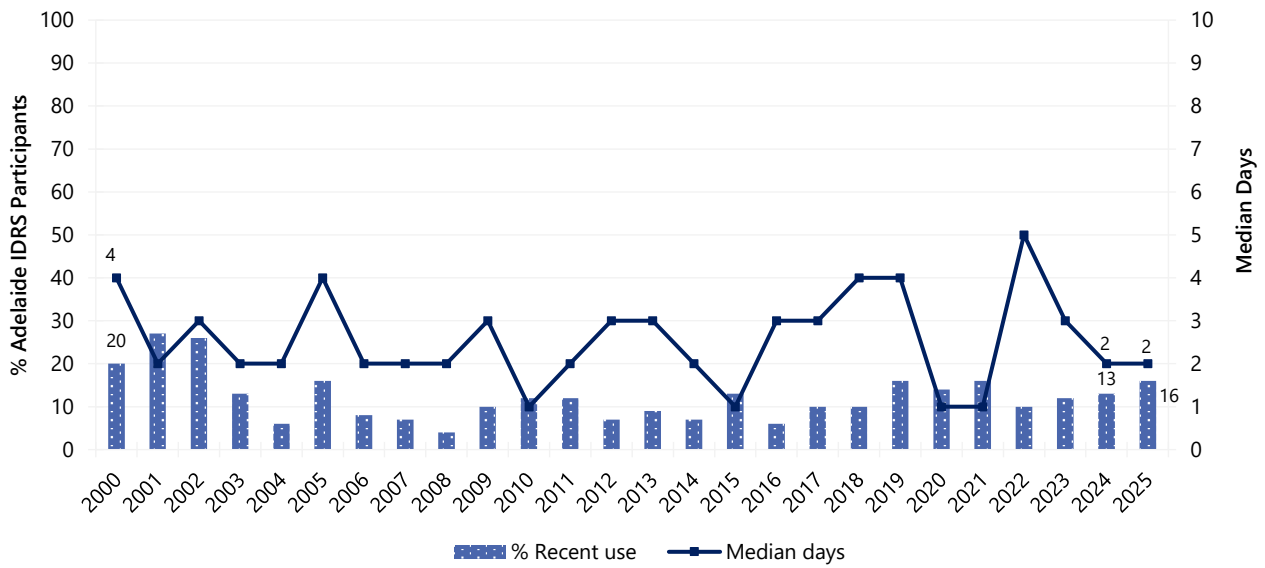
#### Quantity

Of those who reported recent use and responded ( $n=7$ ), the median amount of cocaine used on a 'typical' day in the six months preceding interview was 0.20 grams (IQR=0.20-0.20), a significant decrease relative to 2024 (0.70 grams; IQR=0.50-1.00;  $n=12$ ;  $p=0.016$ ).

#### Forms Used

Among participants who had recently consumed cocaine and commented ( $n=17$ ), the majority (88%) reported using powder cocaine (64% in 2024;  $p=0.199$ ). Few participants ( $n\leq 5$ ) reported using crack/rock cocaine in 2025 ( $n\leq 5$  in 2024;  $p=0.199$ ).

Figure 16: Past six month use and frequency of use of cocaine, Adelaide, SA, 2000-2025

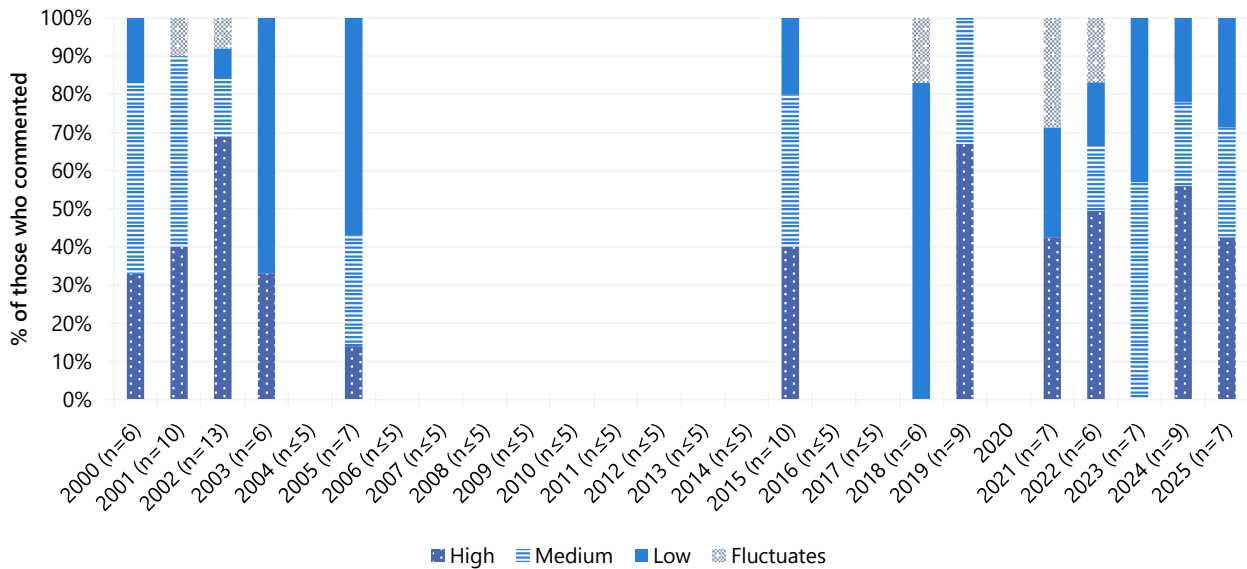


Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  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.

## Price, Perceived Purity and Perceived Availability

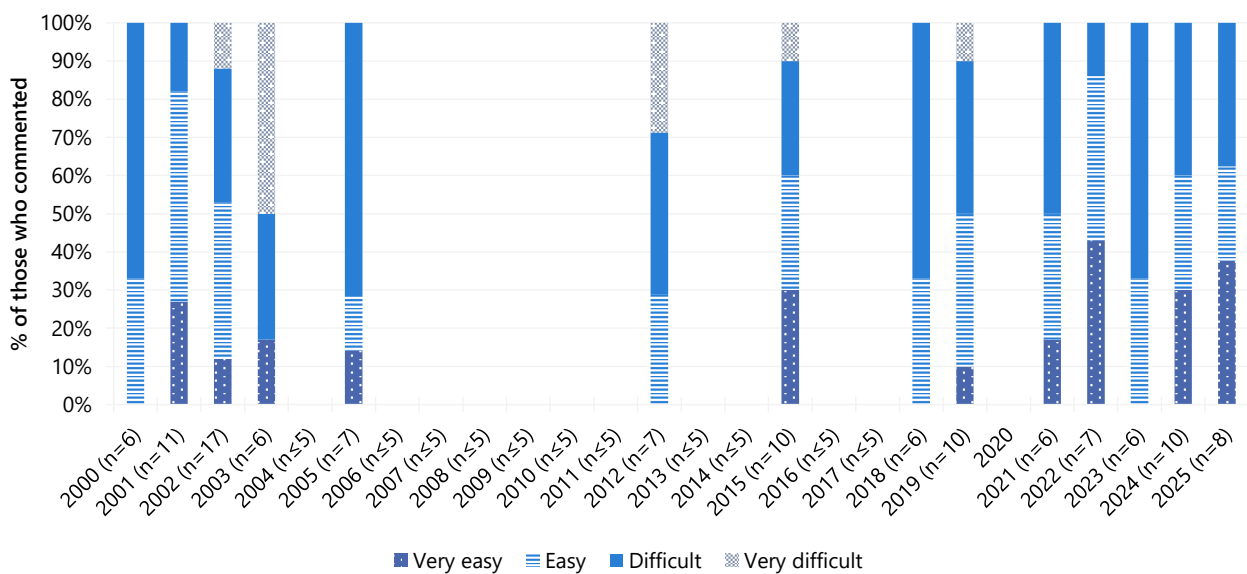
Due to small numbers of participants reporting on price, perceived purity and perceived availability of cocaine in 2025, estimates are shown in Figure 17 and Figure 18 (median price of cocaine is not provided), but are not interpreted further. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Figure 17: Current perceived purity of cocaine, Adelaide, SA, 2000-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where  $n \leq 5$  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 18: Current perceived availability of cocaine, Adelaide, SA, 2000-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where  $n \leq 5$  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

## 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

From 2022, participants were asked about their use of both prescribed and non-prescribed cannabis and/or cannabinoid-related products. Few participants ( $n \leq 5$ ) reported prescribed use in the six months preceding interview in 2025 ( $n \leq 5$  in 2024).

In the remainder of this chapter, data from 2021-2025, and between 2000-2016, refers to non-prescribed cannabis use only, whilst data from 2017-2020 refers to 'any' cannabis use (including hydroponic and bush cannabis, hashish and hash oil). Whilst 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)

The per cent reporting recent use of non-prescribed cannabis and/or cannabinoid-related products has ranged from a peak of 88% in 2000 to a low of 61% in 2009, 2012 and 2013, before increasing again in 2014 and stabilising thereafter. In 2025, 63% of the sample reported past six month use of non-prescribed cannabis and/or cannabinoid-related products, a significant decrease relative to 76% in 2024 ( $p=0.038$ ) (Figure 19).

## Frequency of Use

Of those who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented in 2025 (n=66), frequency of use remained stable at a median of 180 days (i.e., daily use; IQR=92-180; 180 days in 2024; IQR=90-180; n=81;  $p=0.612$ ) (Figure 19). Among those who reported recent use in 2025, three fifths (61%) reported daily use, stable relative to 2024 (56%;  $p=0.615$ ).

## Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented (n=66), smoking continued to be the most common route of administration (88%; 94% in 2024;  $p=0.250$ ), followed by 12% reporting swallowing as a route of administration (16% in 2024;  $p=0.633$ ). Fewer participants reported inhaling/vaporising (9%; 16% in 2024;  $p=0.234$ ).

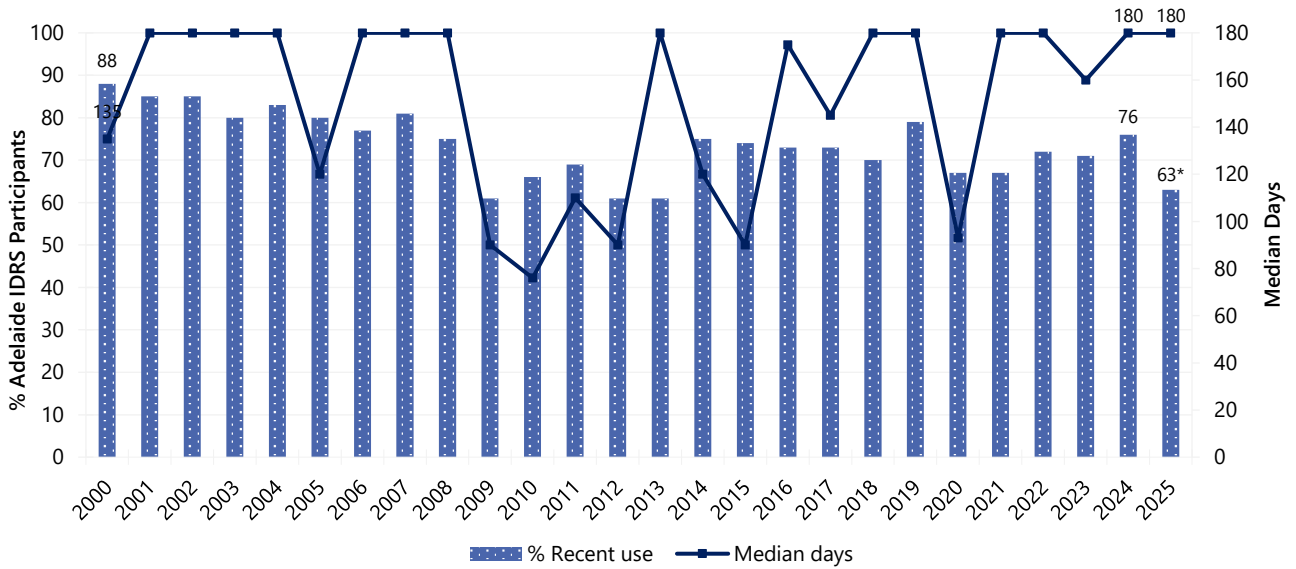
## Quantity

Of those who reported recent use of non-prescribed cannabis and/or cannabinoid-related products in 2025, the median 'typical' amount used on the last occasion of use was one gram (IQR=1.00-2.00; n=26; 1.80 grams in 2024; IQR=0.90-3.00; n=31;  $p=0.348$ ) or two cones (IQR=2-5; n=26; 2 cones in 2024; IQR=1-2; n=22;  $p=0.071$ ). Few participants (n≤5) were able to report on the quantity of joints or puffs used on the last occasion of use.

## Forms Used

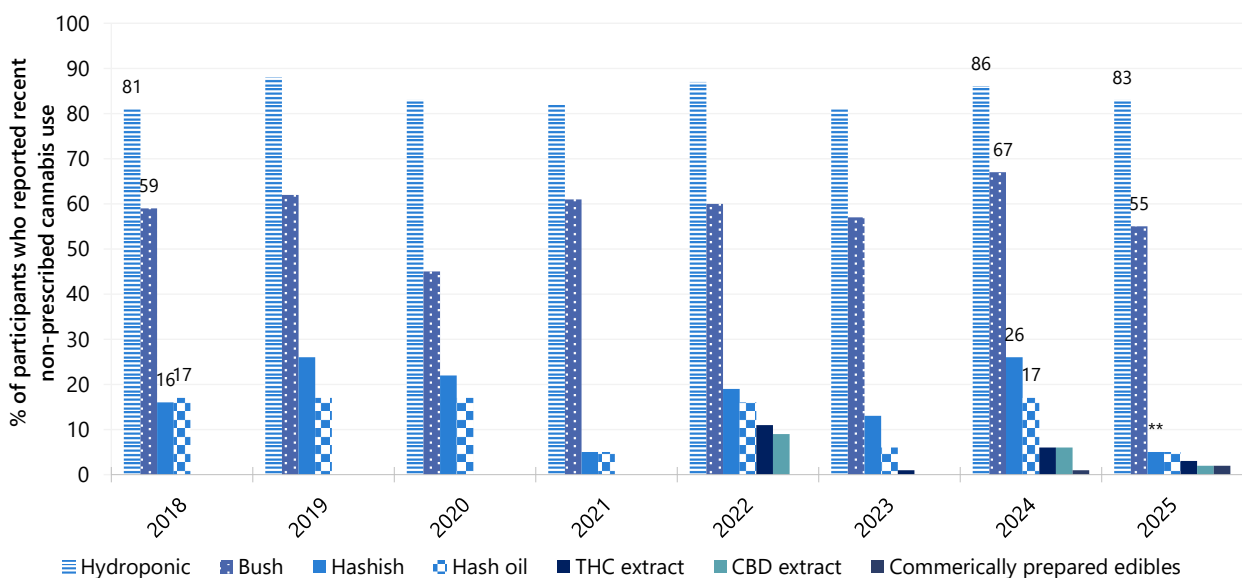
Of those who had used non-prescribed cannabis and/or cannabinoid-related products in the six months preceding interview and commented (n=60), the majority of participants (83%) reported recent use of hydroponic cannabis (86% in 2024;  $p=0.803$ ), and 55% reported recent use of outdoor-grown 'bush' cannabis (67% in 2024;  $p=0.215$ ). Few participants (n≤5) reported using hashish in 2025, a significant decrease relative to 26% in 2024 ( $p=0.001$ ). In 2025, few participants (n≤5) reported using hash oil (17% in 2024;  $p=0.052$ ), CBD extract (n≤5 in 2024;  $p=0.376$ ), THC extract (n≤5 in 2024;  $p=0.688$ ) or commercially prepared edibles (n≤5 in 2024).

Figure 19: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid-related products, Adelaide, SA, 2000-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such, it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low (in 2022, no participants reported use of prescribed cannabis only). 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.,  $n \leq 5$  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 20: Past six month use of different forms of non-prescribed cannabis and/or cannabinoid-related products, among those who reported recent non-prescribed use, Adelaide, SA, 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.,  $n \leq 5$  but not 0). Statistical significance for 2024 versus 2025 is presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ . Please refer to Table 1 for a guide to table/figure notes.

## Price, Perceived Potency and Perceived Availability

### Hydroponic Cannabis

**Price:** The median price per bag (2-3 grams) of hydroponic cannabis remained stable in 2025, relative to 2024 (\$25; IQR=25-25; n=14; \$25 in 2024; IQR=25-25; n=24;  $p=0.712$ ) (Figure 21a). The median price per ounce of hydroponic cannabis also remained stable in 2025 relative to 2024 (\$200; IQR=200-240; n=9; \$225 in 2024; IQR=200-250; n=6;  $p=0.651$ )

**Perceived Potency:** The perceived potency of hydroponic cannabis remained stable between 2024 and 2025 ( $p=0.296$ ). Among those who were able to comment in 2025 (n=41), two thirds (66%) reported 'high' potency (63% in 2024), followed by one quarter (27%) reporting 'medium' potency (19% in 2024) (Figure 22a).

**Perceived Availability:** The perceived availability of hydroponic cannabis remained stable between 2024 and 2025 ( $p=0.905$ ). Among those who were able to comment in 2025 (n=40), two thirds (68%) perceived hydroponic cannabis to be 'very easy' to obtain (63% in 2024), followed by almost one quarter (23%) reporting 'easy' obtainment (24% in 2024) (Figure 23a).

### Bush Cannabis

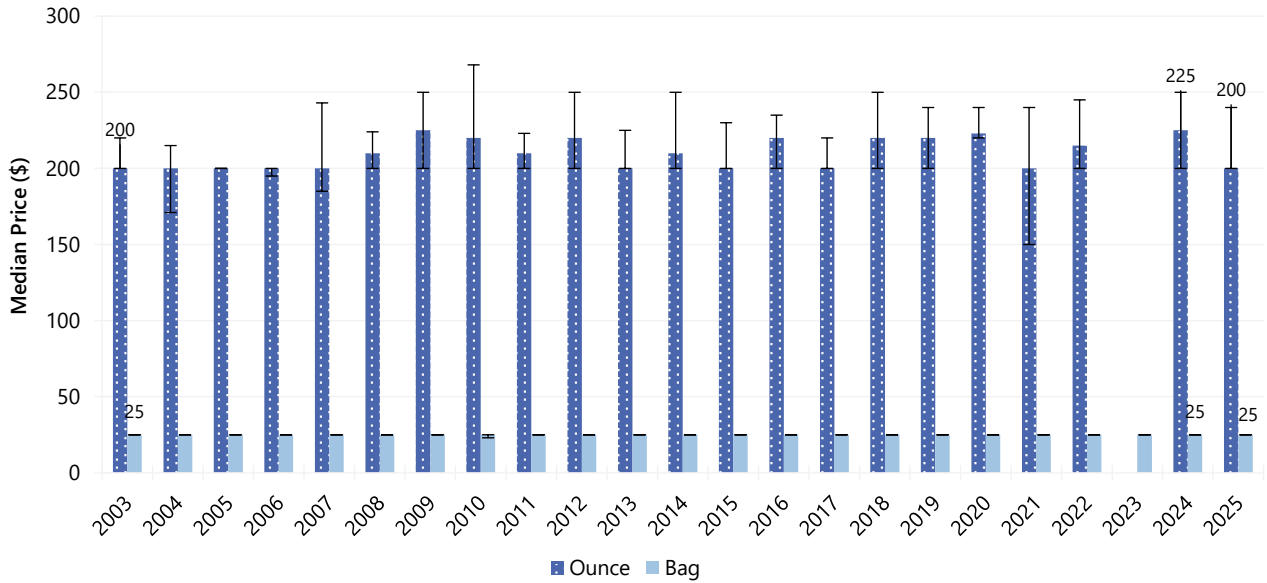
**Price:** The median price per bag (2-3 grams) of bush cannabis in 2025 was \$25 (IQR=25-25; n=6; \$25 in 2024; IQR=25-25; n=15;  $p=0.406$ ) (Figure 21b). Few participants (n≤5) reported on the price of one ounce in 2024 and 2025 and therefore, no further details are reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

**Perceived Potency:** The perceived potency of bush cannabis remained stable between 2024 and 2025. Among those who were able to comment in 2025 (n=19), two fifths (42%) perceived potency to be 'high' (45% in 2024), and almost two fifths (37%) perceived potency to be 'medium' (34% in 2024) (Figure 22b).

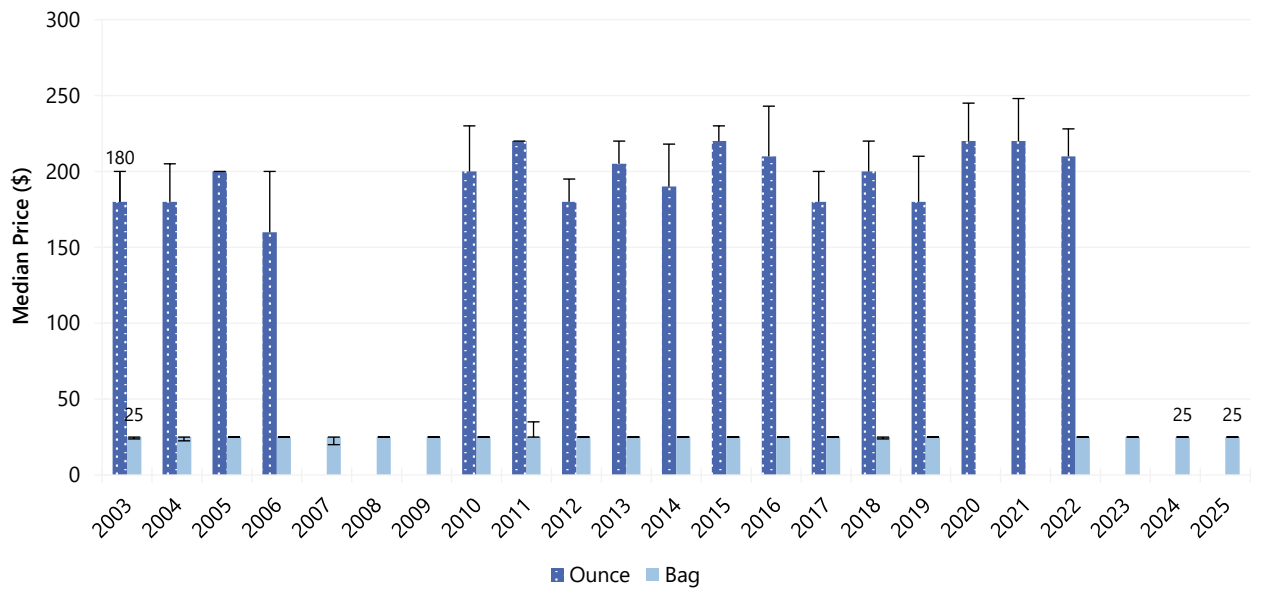
**Perceived Availability:** The perceived availability of bush cannabis remained stable between 2024 and 2025 ( $p=0.179$ ). Among those who were able to comment in 2025 (n=18), equal percentages (33%) perceived that bush was 'very easy' to obtain (58% in 2024), 'easy' to obtain (26% in 2024) and 'difficult' to obtain (16% in 2024), respectively (Figure 23b).

Figure 21: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and bag, Adelaide, SA, 2003-2025

(A) Hydroponic Cannabis



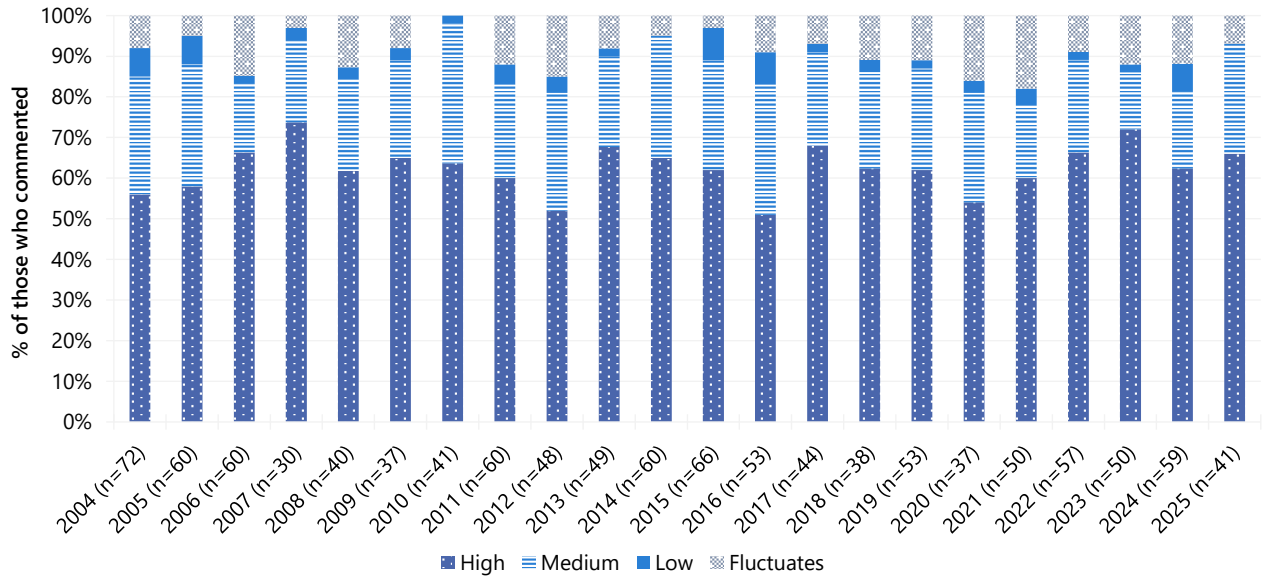
(B) Bush Cannabis



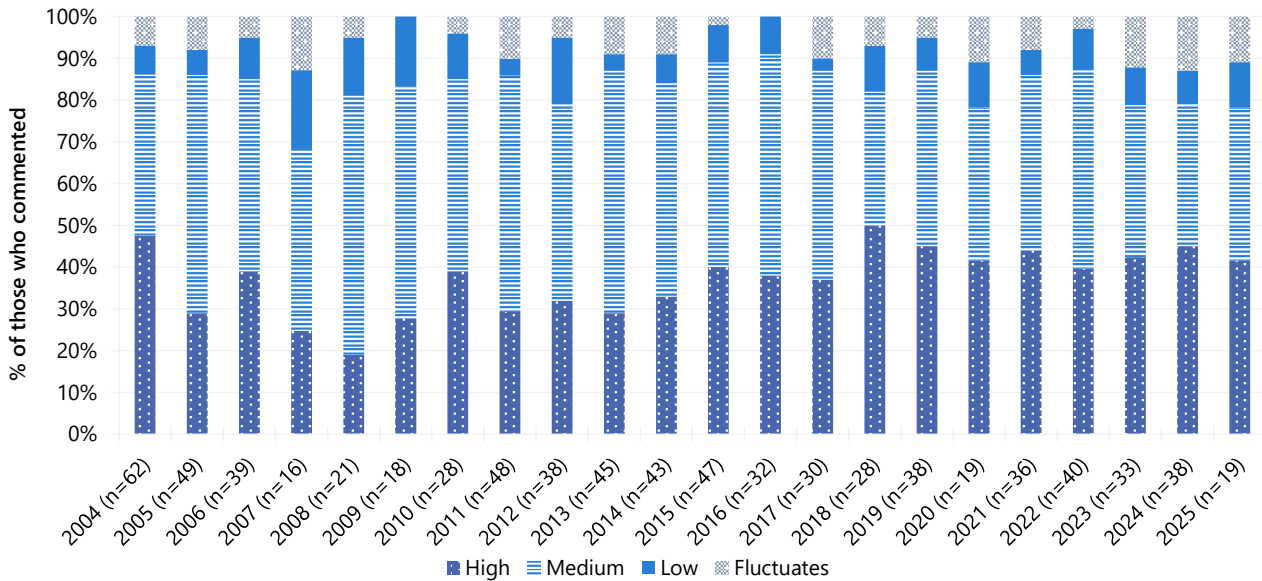
Note. Among those who commented. From 2003 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who are reporting on the 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 data are suppressed in the figure where  $n \leq 5$  responded. 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 22: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Adelaide, SA, 2004-2025

(A) Hydroponic Cannabis



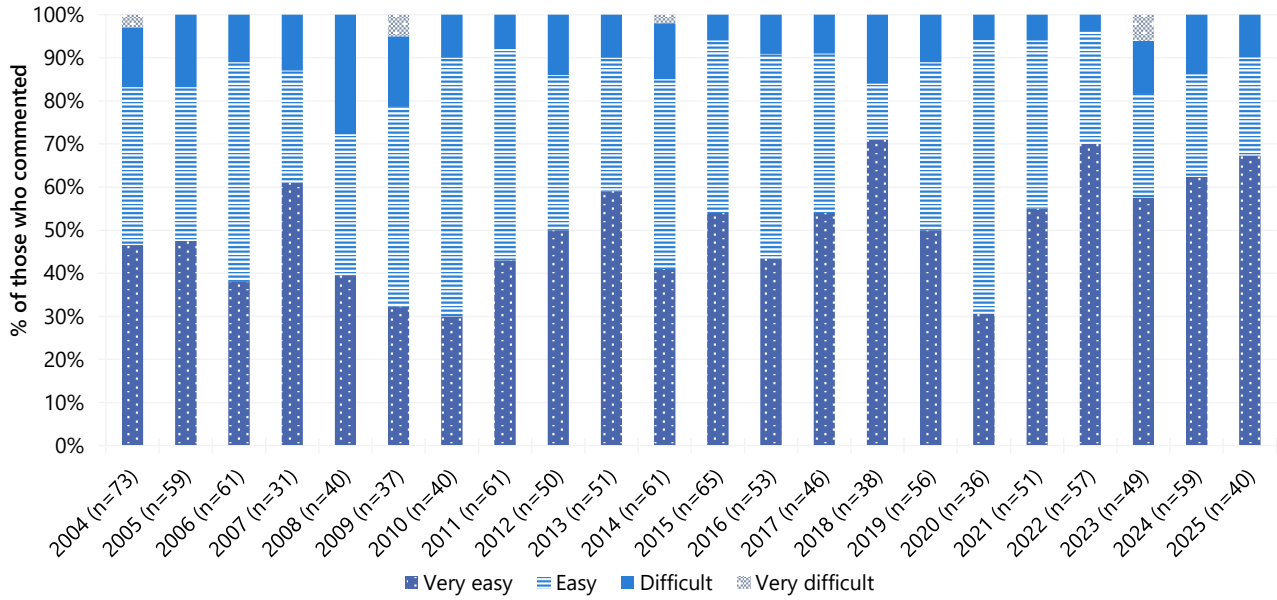
(B) Bush Cannabis



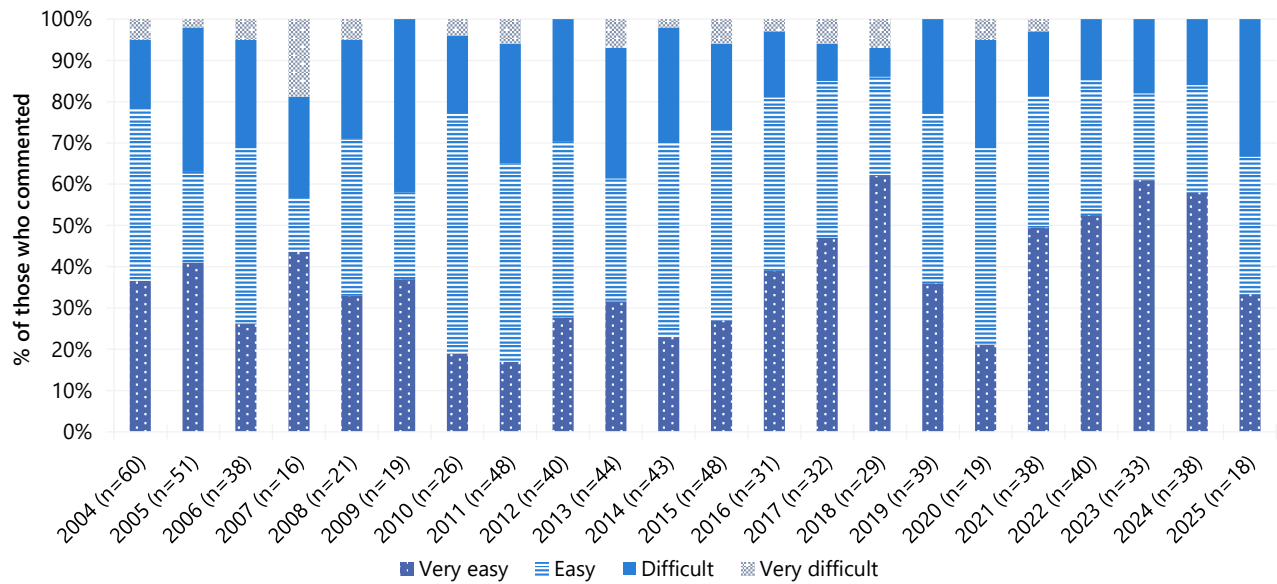
Note. Hydroponic and bush cannabis data collected separately from 2004 onwards. Data from 2022 onwards refers to non-prescribed cannabis only: prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants 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 table/figure notes.

Figure 23: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Adelaide, SA, 2004-2025

(A) Hydroponic Cannabis



(B) Bush Cannabis



Note. Hydroponic and bush cannabis data collected separately from 2004 onwards. 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  $n \leq 5$  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.

# 6

## Pharmaceutical Opioids

The following section describes recent (past six month) use of pharmaceutical opioids amongst the Adelaide sample. Terminology throughout this chapter refers to:

- **Prescribed use:** use of pharmaceutical opioids obtained by a prescription in the person's name;
- **Non-prescribed use:** use of pharmaceutical opioids obtained from a prescription in someone else's name or via another source (e.g., online); and
- **Any use:** use of pharmaceutical opioids obtained through either of the above means.

For information on price and perceived availability for non-prescribed pharmaceutical opioids, contact the Drug Trends team ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

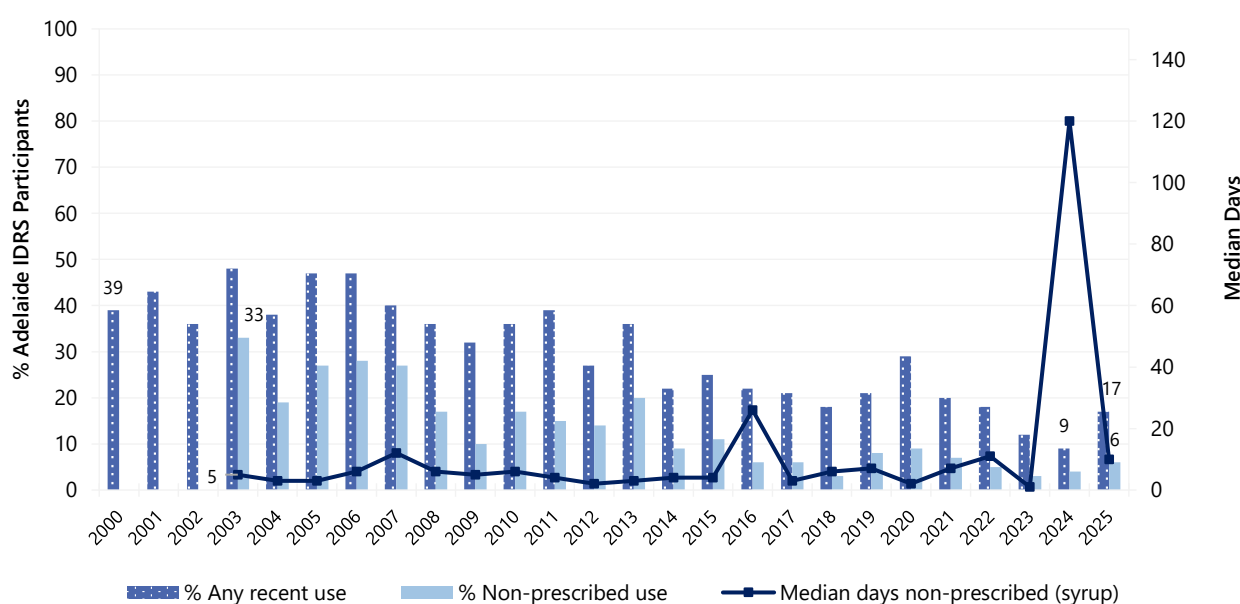
## Methodone

**Any Recent Use (past 6 months):** Notwithstanding some fluctuation, the per cent reporting any recent methadone use (including syrup and tablets) in the Adelaide sample has generally decreased since monitoring commenced. In 2025, 17% of participants reported recent use of any prescribed and/or non-prescribed methadone (9% in 2024;  $p=0.111$ ). Methadone use historically has largely consisted of prescribed use, with 12% reporting recent prescribed use in 2025, stable from 8% in 2024 ( $p=0.263$ ). Six per cent reported non-prescribed methadone use in 2025 ( $n \leq 5$  in 2024;  $p=0.538$ ) (Figure 24).

**Frequency of Use:** Due to few participants ( $n \leq 5$ ) reporting recent non-prescribed use in 2024 and 2025, details regarding frequency of use are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

**Recent Injecting Use:** Few participants ( $n \leq 5$ ) reported recent injection of methadone (prescribed or non-prescribed) in 2024 and 2025, therefore no further details are reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Figure 24: Past six month use (prescribed and non-prescribed) and frequency of use of non-prescribed methadone, Adelaide, SA, 2000-2025



Note. Includes methadone syrup and tablets except where otherwise specified. Non-prescribed use not distinguished in 2000-2002. 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 140 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.,  $n \leq 5$  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.

## Buprenorphine Tablet

In 2025, 6% of the Adelaide sample reported recent use of any buprenorphine tablet ( $n \leq 5$  in 2024;  $p=0.332$ ) and few participants ( $n \leq 5$ ) were able to report on prescribed and non-prescribed use of buprenorphine tablet use in 2024 and 2025. As such, further details regarding frequency of use ( $n \leq 5$  in 2024) and recent injecting use ( $n \leq 5$  in 2024) are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

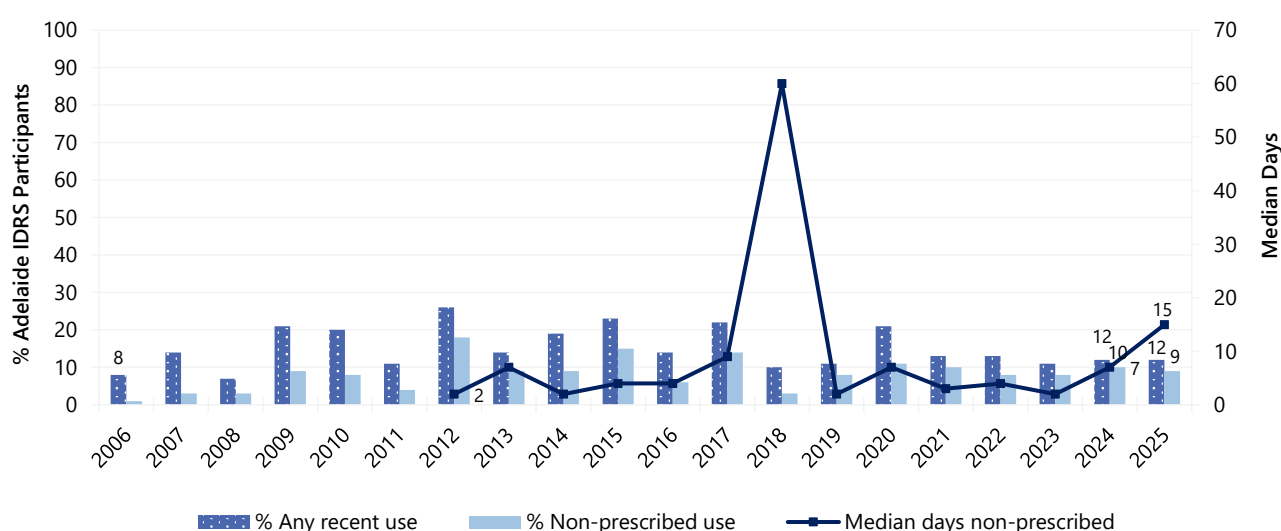
## Buprenorphine-Naloxone

**Any Recent Use (past 6 months):** The per cent reporting recent use of any buprenorphine-naloxone has generally remained low and stable over the course of monitoring. In 2025, 12% of the Adelaide sample reported recent use of any buprenorphine-naloxone (12% in 2024), with almost one tenth (9%) reporting non-prescribed use (10% in 2024;  $p=0.809$ ) (Figure 25). Few participants ( $n \leq 5$ ) reported prescribed use in 2025 ( $n \leq 5$  in 2024;  $p=0.445$ ).

**Frequency of Use:** Participants who had recently consumed non-prescribed buprenorphine-naloxone and commented ( $n=9$ ) reported use on a median of 15 days (IQR=2-72) in the six months preceding interview (7 days in 2024; IQR=5-18;  $n=11$ ;  $p=0.790$ ) (Figure 25).

**Recent Injecting Use:** Of those who had recently used any buprenorphine-naloxone in 2025 and commented ( $n=6$ ), 46% reported recent injection (46% in 2024). Few participants ( $n \leq 5$ ) reported on the frequency of injection in 2025 (7 days in 2024; IQR=1-21;  $p=0.926$ ).

Figure 25: Past six month use (prescribed and non-prescribed) and frequency of use of non-prescribed buprenorphine-naloxone, Adelaide, SA, 2006-2025



Note. From 2006-2011, participants were asked about the use of buprenorphine-naloxone tablet; from 2012-2016, participants were asked about the use of buprenorphine-naloxone tablet and film; from 2017 onwards, participants were asked about the use of buprenorphine-naloxone film only. Median days of non-prescribed use computed among those who reported recent use (maximum 180 days) and is only reported from 2012 onwards to capture film use. Median days rounded to the nearest whole number. Secondary Y axis reduced to 70 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.,  $n \leq 5$  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.

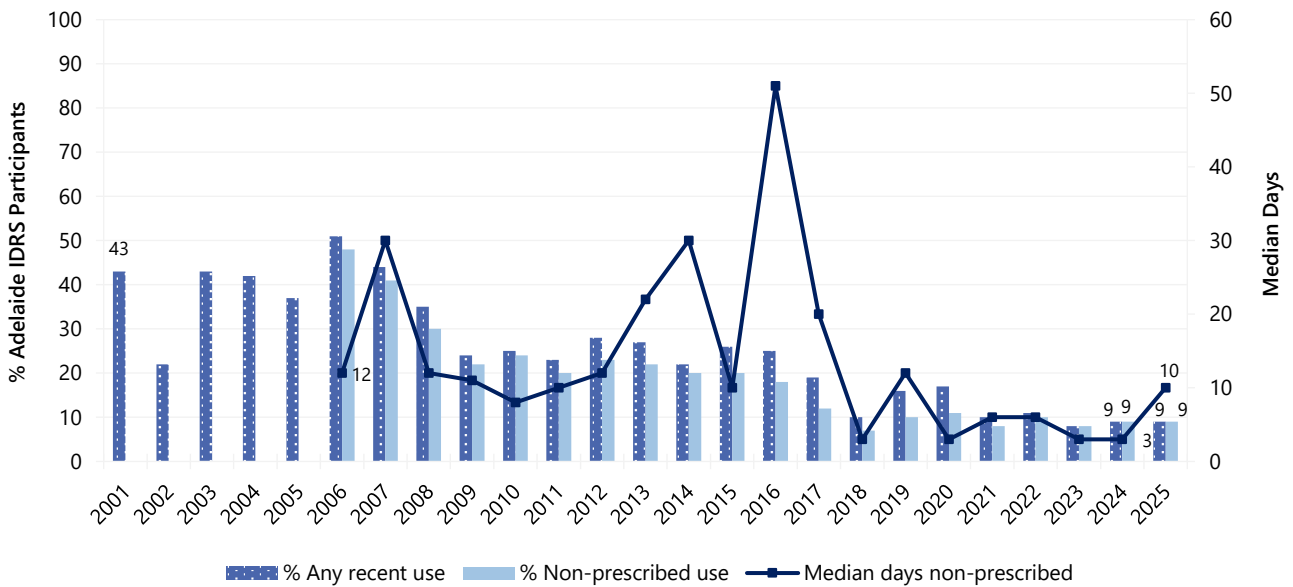
## Morphine

**Any Recent Use (past 6 months):** The Adelaide sample has observed a downward trend in recent use of morphine since peaking in 2006 (Figure 26). In 2025, 9% of the sample reported recent use of any morphine, unchanged from 9% in 2024. This comprised solely of non-prescribed use (9%; 9% in 2024).

**Frequency of Use:** Participants who had recently consumed non-prescribed morphine and commented (n=9) reported use on a median of 10 days (IQR=5-72), stable relative to 2024 (3 days; IQR=1-9; n=10;  $p=0.090$ ) (Figure 26).

**Recent Injecting Use:** Of those who had recently used any morphine in 2025 and commented (n=9), 89% reported injecting morphine (70% in 2024;  $p=0.582$ ) on a median of 20 days (IQR=5-99; 1 day in 2024; IQR=1-8;  $p=0.089$ ).

Figure 26: Past six month use (prescribed and non-prescribed) and frequency of use of non-prescribed morphine, Adelaide, SA, 2001-2025



Note. Median days of use computed among those who reported recent use (maximum 180 days). Non-prescribed use not distinguished in 2001-2005. Secondary Y axis reduced to 60 days to improve visibility of trends. 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.,  $n \leq 5$  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.

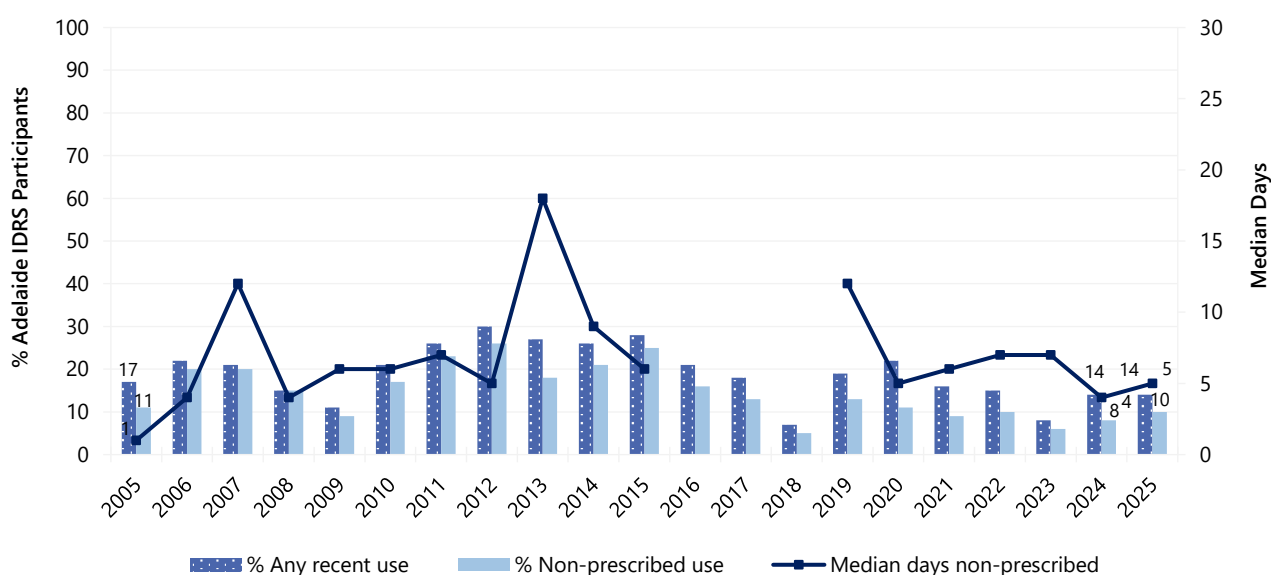
## Oxycodone

**Any Recent Use (past 6 months):** Recent use of oxycodone has fluctuated over the course of monitoring, with 14% of participants reporting any recent use in 2025 (14% in 2024) (Figure 27). In 2025, 10% of the Adelaide sample had used non-prescribed oxycodone (8% in 2024;  $p=0.632$ ), and few participants ( $n\leq 5$ ) had used prescribed oxycodone ( $n\leq 5$  in 2024;  $p=0.569$ ).

**Frequency of Use:** Participants who had recently consumed non-prescribed oxycodone and commented ( $n=11$ ) reported use on a median of five days (IQR=3-8) in the six months preceding interview in 2025 (4 days in 2024; IQR=2-6;  $n=9$ ;  $p=0.729$ ) (Figure 27).

**Recent Injecting Use:** Few participants ( $n\leq 5$ ) reported recent injection of oxycodone (prescribed or non-prescribed) in 2024 and 2025, therefore no further details are reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Figure 27: Past six month use (prescribed and non-prescribed) and frequency of use of non-prescribed oxycodone, Adelaide, SA, 2005-2025

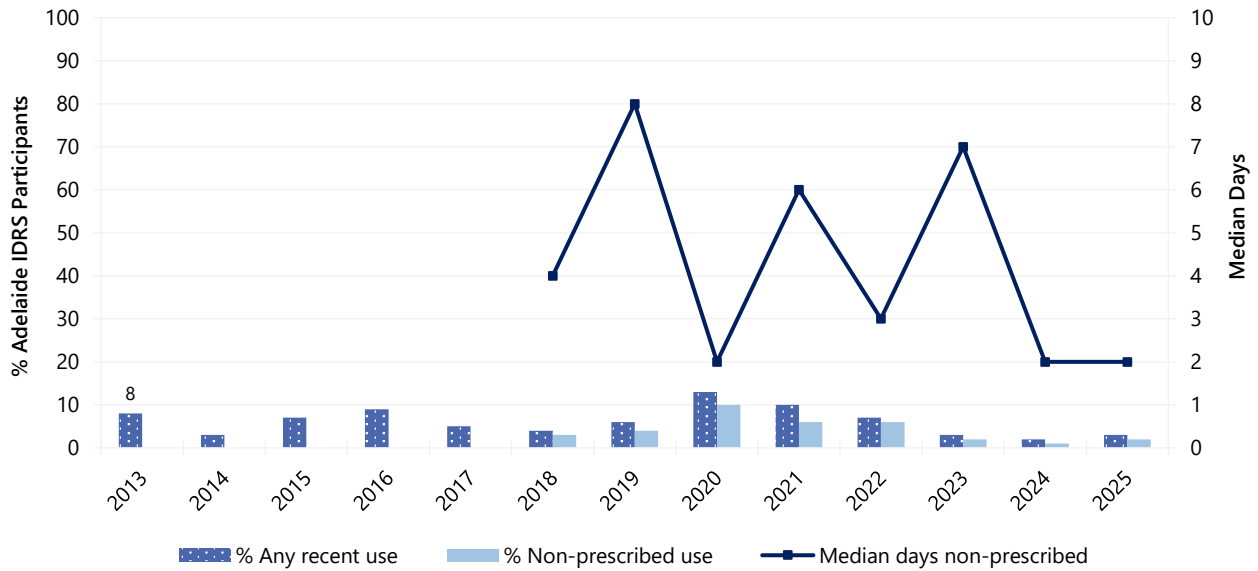


Note. From 2005-2015, participants were asked about recent use and frequency of use for any oxycodone; from 2016-2018, recent use and frequency of use for oxycodone was broken down into three types: tamper resistant ('OP'), non-tamper proof (generic) and 'other oxycodone' (median days non-prescribed use missing from 2016-2018). From 2019-2022, recent use for oxycodone was broken down into four types: tamper resistant ('OP'), non-tamper proof (generic), 'other oxycodone' and oxycodone-naloxone, while frequency of use was asked for any oxycodone. From 2023 onwards, participants were asked about recent use and frequency of use for any oxycodone. Median days of non-prescribed use computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 30 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.,  $n\leq 5$  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.

## Fentanyl

Due to few participants ( $n \leq 5$ ) reporting recent use of any fentanyl in 2024 and 2025, details regarding frequency of use and recent injecting use are not reported. For historical trends please see Figure 28 or refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Figure 28: Past six-month use (prescribed and non-prescribed) and frequency of use of non-prescribed fentanyl, Adelaide, SA, 2013-2025



Note. Data on fentanyl use not collected from 2000-2012; from 2013-2017, the IDRS did not distinguish between prescribed and non-prescribed use. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  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.

## Other Opioids

Participants were asked about prescribed and non-prescribed use of other opioids (Table 3). In 2025, 7% of participants reported recent use of any codeine, stable relative to 2024 (15%;  $p=0.078$ ), though few participants ( $n \leq 5$ ) reported recent prescribed use (9% in 2024;  $p=0.165$ ) and non-prescribed use (6% in 2024;  $p=0.498$ ), respectively.

Few participants ( $n \leq 5$ ) reported recent use of any form of tramadol or any form of tapentadol in 2025 and as such, no further details are reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Table 3: Past six month use of other opioids, Adelaide, SA, 2019-2025

% Recent use (past 6 months)	2019 (N=100)	2020 (N=100)	2021 (N=101)	2022 (N=103)	2023 (N=102)	2024 (N=106)	2025 (N=105)
<b>Codeine<sup>^</sup></b>							
Any use	25	17	22	15	12	15	<b>7</b>
Non-prescribed use	-	7	12	6	-	6	-
Any injection <sup>#</sup>	-	-	0	-	0	-	<b>0</b>
<b>Tramadol</b>							
Any use	15	-	6	13	-	-	-
Non-prescribed use	9	0	-	7	-	-	-
Any injection <sup>#</sup>	-	0	-	-	0	0	<b>0</b>
<b>Tapentadol</b>							
Any use	-	0	-	0	0	-	-
Non-prescribed use	-	0	0	0	0	0	<b>0</b>
Any injection <sup>#</sup>	0	0	0	0	0	-	<b>0</b>

Note. <sup>^</sup>Includes high and low dose. <sup>#</sup>Of those who reported past six month use. 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.

# 7

## Other Drugs

Participants were asked about their recent (past six month) use of various other drugs, including use of new psychoactive substances, non-prescribed use (i.e., use of a medicine obtained from a prescription in someone else's name) of other pharmaceutical drugs, and use of licit substances (e.g., alcohol, tobacco).

### New Psychoactive Substances (NPS)

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.

Few participants ( $n \leq 5$ ) in the Adelaide sample reported recent use of any NPS in 2025 (7% in 2024;  $p=0.332$ ), therefore, no further details on patterns of use are reported. Please refer to Table 4 for historical trends in use amongst the Adelaide sample and the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Table 4: Past six month use of new psychoactive substances, Adelaide, SA, 2013-2025

% Recent Use (past 6 months)	2013 N=100	2014 N=106	2015 N=102	2016 N=101	2017 N=100	2018 N=100	2019 N=100	2020 N=100	2021 N=101	2022 N=102	2023 N=102	2024 N=106	2025 N=105
'New' drugs that mimic the effects of opioids	/	/	/	/	0	-	0	-	-	0	-	0	<b>0</b>
'New' drugs that mimic the effects of ecstasy	/	/	/	/	-#	-	-	0	-	-	0	-	<b>0</b>
'New' drugs that mimic the effects of amphetamine or cocaine	-	-	-	-	/	-	-	-	-	-	-	-	<b>0</b>
'New' drugs that mimic the effects of cannabis	-	-	-	0	-	-	-	-	-	0	-	-	-
'New' drugs that mimic the effects of psychedelic drugs	/	/	/	/	-#	0	-	-	0	0	-	-	<b>0</b>
'New' drugs that mimic the effects of benzodiazepines	/	/	/	/	/	0	0	0	0	0	0	0	<b>0</b>
'New' drugs that mimic the effects of dissociatives	/	/	/	/	/	/	/	/	/	/	/	/	<b>0</b>
<b>Any of the above</b>	-	-	-	0	-	8	9	6	-	-	-	7	-

Note. #In 2017, participants were asked about use of 'new drugs that mimic the effects of ecstasy or psychedelic drugs', thus the same value appears in both 'new' drugs that mimic the effects of ecstasy and 'new' drugs that mimic the effects of psychedelic drugs; from 2018 onwards, these two NPS classes were separated out. 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.

## Non-Prescribed Pharmaceutical Drugs

### Benzodiazepines

**Recent Use (past 6 months):** Recent use of non-prescribed benzodiazepines has fluctuated over the course of monitoring, peaking at 37% in 2014 and generally declining thereafter. Almost one fifth (17%) of the Adelaide sample reported recent use of non-prescribed benzodiazepines (e.g., Valium, Diazepam, Xanax, Kalma) in the six months preceding interview in 2025, stable relative to 2024 (22%;  $p=0.481$ ) (Figure 29).

**Frequency of Use:** In 2025, participants reported using non-prescribed benzodiazepines on a median of six days (IQR=2-21;  $n=18$ ) in the six months preceding interview, stable relative to 2024 (6 days; IQR=2-12;  $n=23$ ;  $p=0.802$ ).

**Recent Injecting Use:** In 2025, few participants ( $n\leq 5$ ) reported recent injection of non-prescribed benzodiazepines, therefore no further details are reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

**Forms Used:** Among those who reported non-prescribed benzodiazepine use and responded in 2025 ( $n=18$ ), the most commonly used benzodiazepine was Valium (diazepam) (72%). Few participants ( $n\leq 5$ ) reported use of other benzodiazepines.

### Pharmaceutical Stimulants

In 2025, few participants ( $n\leq 5$ ) reported using non-prescribed pharmaceutical stimulants in the six months prior to interview (8% in 2024;  $p=0.374$ ) (Figure 29), therefore no further details regarding patterns of use are included. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

### Antipsychotics

In 2025, few participants ( $n\leq 5$ ) reported using non-prescribed antipsychotics in the six months prior to interview ( $n\leq 5$  in 2024;  $p=0.369$ ) (Figure 29), therefore no further details regarding patterns of use are included. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

### Pregabalin

**Recent Use (past 6 months):** In 2025, 6% of the sample reported using non-prescribed pregabalin in the six months preceding interview, stable relative to 10% in 2024 ( $p=0.317$ ) (Figure 29).

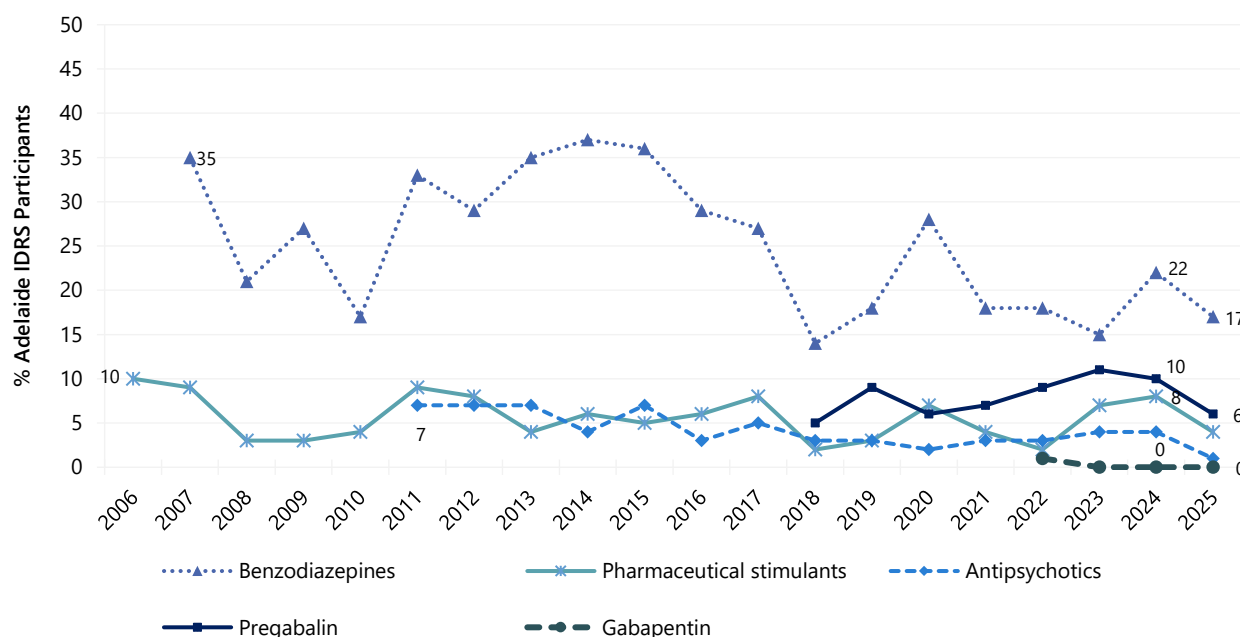
**Frequency of Use:** Participants who had recently consumed non-prescribed pregabalin and commented ( $n=6$ ) reported use on a median of six days (IQR=3-17), stable relative to 2024 (3 days; IQR=2-10;  $n=11$ ;  $p=0.919$ ).

**Recent Injecting Use:** In 2025, few participants ( $n\leq 5$ ) reported recent injection of non-prescribed pregabalin ( $n\leq 5$  in 2024), therefore no further details are reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

## Gabapentin

No participants reported using non-prescribed gabapentin in the six months prior to interview in 2024 or 2025 (Figure 29) and therefore, no further details are reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Figure 29: Past six month use of non-prescribed pharmaceutical drugs, Adelaide, SA, 2006-2025



Note. From 2019 to 2023, participants were asked about their use of non-prescribed alprazolam and non-prescribed use of ‘other’ benzodiazepines (e.g., diazepam), separately. In 2024, these categories were combined, and as such, participants were asked about non-prescribed use of any benzodiazepines. Non-prescribed use is reported. Antipsychotics was asked as ‘Seroquel’ from 2011-2018. Pharmaceutical stimulants were separated into prescribed and non-prescribed from 2006 onwards, and benzodiazepines were separated into prescribed and non-prescribed in 2007. Y axis 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.,  $n \leq 5$  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.

## Licit and Other Drugs

### Alcohol

**Recent Use (past 6 months):** Fifty-six per cent of the Adelaide sample reported recent use of alcohol in 2025, stable relative to 49% in 2024 ( $p=0.338$ ) (Figure 30).

**Frequency of Use:** Participants who had recently consumed alcohol and commented ( $n=59$ ) reported use on a median of 24 days (IQR=6-85; 18 days in 2024; IQR=4-83;  $n=52$ ;  $p=0.901$ ), with 14% reporting daily use (17% in 2024;  $p=0.606$ ).

### Tobacco

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

**Recent Use (past 6 months):** Tobacco use has been consistently high amongst the Adelaide sample. In 2025, the majority (90%) of participants reported recent use of tobacco (92% in 2024;  $p=0.475$ ) (Figure 30), and 56% reported recent use of smoked or non-smoked illicit tobacco, stable relative to 2024 (49%;  $p=0.338$ ).

**Frequency of Use:** Participants who had recently consumed tobacco and commented ( $n=93$ ) reported use on a median of 180 days in 2025 (IQR=180-180; 180 days in 2024; IQR=180-180;  $n=98$ ;  $p=0.846$ ), with 89% reporting daily use (88% in 2024;  $p=0.817$ ).

## 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, few participants ( $n\leq 5$ ) 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 ( $n\leq 5$  in 2022; 0% in 2023 and  $n\leq 5$  in 2024). The 2025 data presented below 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 from 2021 and earlier captures any e-cigarette use (collectively referred to as 'illicit use' from herein).

**Recent Use (past 6 months):** Seventeen per cent of the Adelaide sample reported recent use of illicit e-cigarettes in 2025, stable relative to 2024 (25%;  $p=0.184$ ) (Figure 30).

**Frequency of Use:** Participants who had recently consumed illicit e-cigarettes and commented ( $n=17$ ) reported use on a median of 80 days in 2025 (IQR=5-180), stable relative to 14 days in 2024 (IQR=6-54;  $n=27$ ;  $p=0.212$ ). One third (35%) reported daily use, stable relative to 2024 ( $n\leq 5$ ;  $p=0.068$ ).

**Contents and Forms Used:** Among participants who had recently used e-cigarettes and responded in 2025 ( $n=17$ ), participants most commonly reported using disposable devices (94%) ( $n\leq 5$  reported using re-fillable devices).

**Reason for Use:** Of those who reported *any* e-cigarette use in the six months prior to interview and responded ( $n=20$ ), two fifths (40%) reported using e-cigarettes as a smoking cessation tool, stable relative to 2024 (36%).

## Nicotine Pouches

Few participants ( $n\leq 5$ ) reported using nicotine pouches in the six months prior to interview in 2025 (6% in 2024;  $p=0.119$ ) (Figure 29), and as such, no further details are reported. Please refer to the [2025](#)

[National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

## Steroids

No participants reported using non-prescribed steroids in the six months preceding interview in 2024 or 2025 (Figure 30). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

## GHB/GBL/1,4-BD

**Recent Use (past 6 months):** One fifth (21%) of the Adelaide sample reported recent use of GHB/GBL/1,4-BD, stable relative to 2024 (22%) (Figure 30).

**Frequency of Use:** Participants who had recently consumed GHB/GBL/1,4-BD and commented (n=22) reported use on a median of nine days (IQR=4-29), stable relative to 2024 (17 days; IQR=3-114; n=23;  $p=0.741$ ).

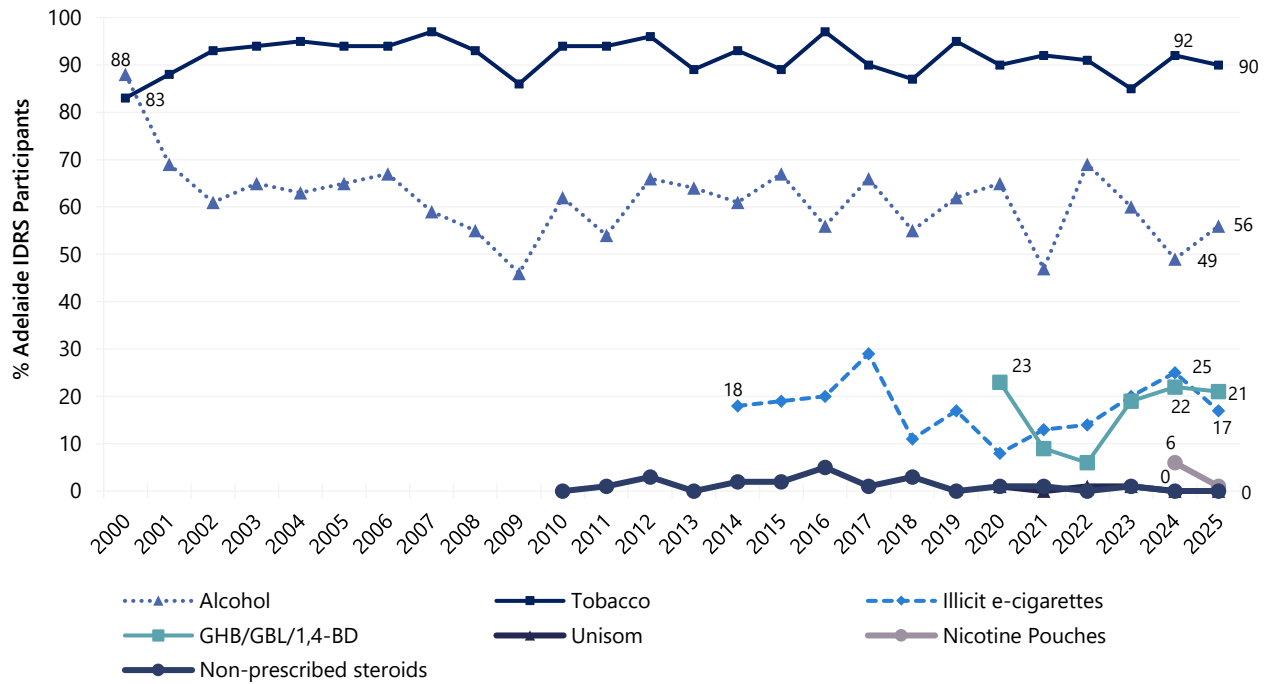
**Recent Injecting Use:** In 2025, no participants reported recent injection of GHB/GBL/1,4-BD (0% in 2024). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

## Unisom

Unisom SleepGels is a Schedule 3 medicine containing diphenhydramine that is available over-the-counter from a pharmacist for use as an antihistamine or temporary sleep aid. It comes in a gel capsule formulation intended for oral use. There have been [reports](#) of injecting use in Australia, raising concern of attendant injecting-related injuries.

In 2025, no participants reported using Unisom in the six months prior to interview (0% in 2024) (Figure 30). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Figure 30: Past six month use of licit and other drugs, Adelaide, SA, 2000-2025



Note. Regarding e-cigarette use, 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.,  $n \leq 5$  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.

# 8

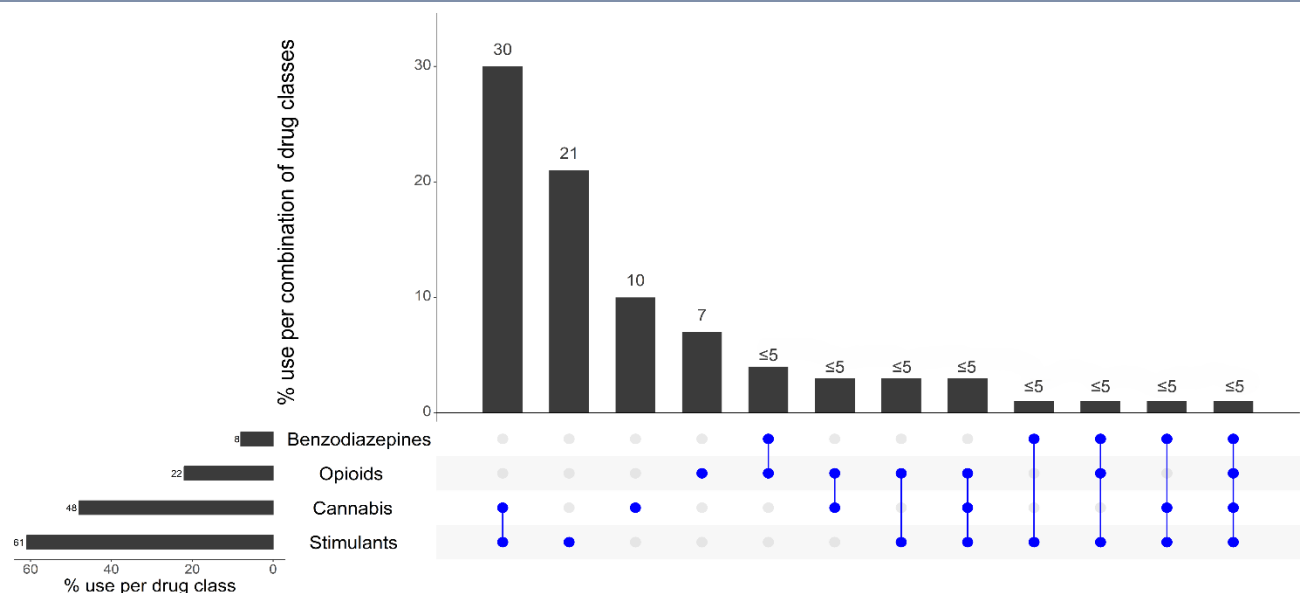
## Drug-Related Harms and Other Behaviours

### Polysubstance Use

In 2025, 90% of the Adelaide sample reported using one or more drugs (including alcohol and prescription medications but excluding tobacco and e-cigarettes) on the day preceding interview. Of those who reported using one or more drugs and commented (n=94), the most commonly used substances comprised opioids (77%), followed by cannabis (54%), stimulants (32%), alcohol (26%) and benzodiazepines (9%).

Fifty-four per cent of the Adelaide sample reported use of two or more drugs on the day preceding interview (excluding tobacco and e-cigarettes). Almost one third (30%) of participants reported concurrent use of cannabis and stimulants on the day preceding interview (Figure 31). One fifth (21%) of respondents reported using stimulants alone, followed by 10% who reported using cannabis alone and 7% using opioids alone.

Figure 31: Use of opioids, stimulants, benzodiazepines and cannabis on the day preceding interview and most common drug pattern profiles, Adelaide, SA, 2025

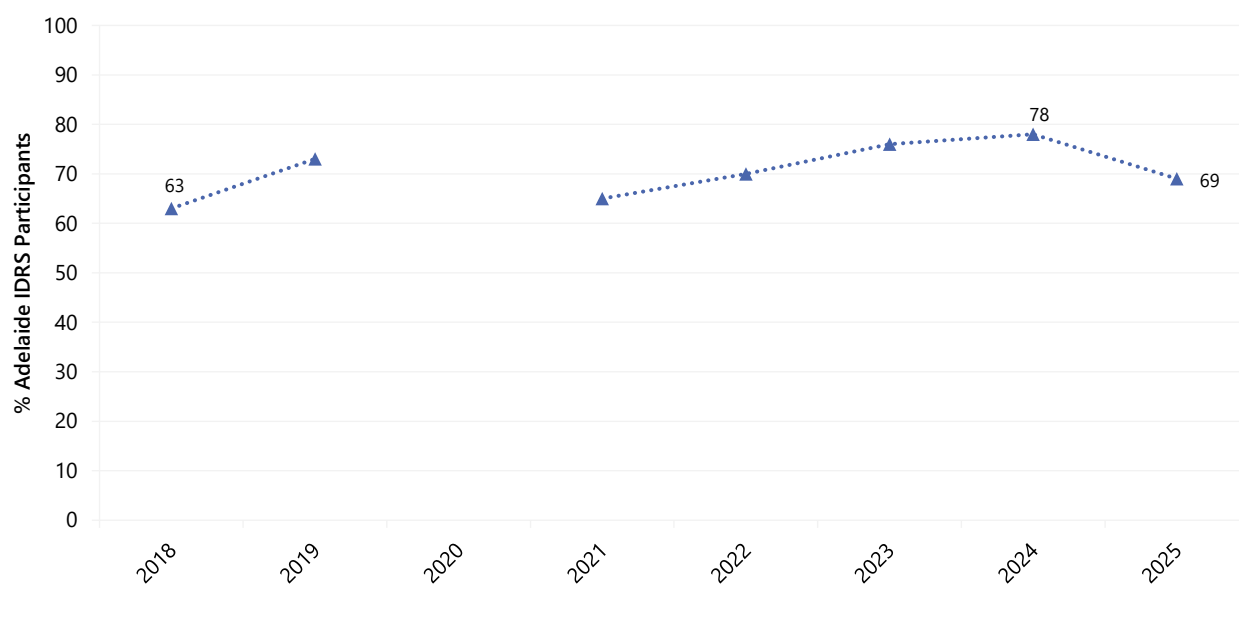


Note. % calculated out of total IDRS 2025 sample. The horizontal bars represent the per cent of participants who reported use of each drug class on the day preceding interview; the vertical columns represent the per cent of participants who used the combination of drug classes represented by the blue circles. Participants who did not report use of any of the four drug classes depicted are not shown in the figure but are counted in the denominator. 'Stimulants' includes methamphetamine, cocaine, MDA, ecstasy and/or pharmaceutical stimulants. 'Opioids' includes heroin, methadone, morphine, oxycodone, buprenorphine, buprenorphine-suboxone, fentanyl, other pharmaceutical opioids (codeine, tapentadol, tramadol, etc). Use of benzodiazepines, opioids and stimulants could be prescribed or non-prescribed use. The response option Y axis reduced to 35% to improve visibility of trends.

## Binge Drug Use

Participants were asked whether they had used any drug/s for 48 hours or more continuously without sleep (i.e., binged) in the six months preceding interview. The per cent of the sample who had reported bingeing has gradually increased over time. In 2025, 69% of the Adelaide sample had binged on one or more drugs in the preceding six months, stable relative to 2024 (78%;  $p=0.168$ ) (Figure 32).

Figure 32: Past six month use of drugs for 48 hours or more continuously without sleep ('binge'), Adelaide, SA, 2018-2025



Note. Participants were first asked about bingeing in 2018. 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.,  $n \leq 5$  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.

## Overdose Events

### Non-Fatal Overdose

There have been some changes in the way questions about overdose have been asked over the years, which may account for some variation in estimates.

From 2019 onwards, participants were asked about their past 12-month experience of overdose where symptoms aligned with examples provided and effects were outside their normal experience, or they felt professional assistance may have been helpful. We specifically asked about:

- **Opioid overdose** (e.g., reduced level of consciousness, respiratory depression, turning blue, collapsing and being unable to be roused). Participants who reported this experience were asked to identify all opioids involved in such events in the past 12 months;
- **Non-opioid overdose** (e.g., nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, seizure, extreme paranoia, extreme anxiety, panic, extreme agitation, hallucinations). Drugs other than opioids were split into the following:

- **Stimulant overdose:** Stimulant drugs include ecstasy, methamphetamine, cocaine, MDA, methylone, mephedrone, pharmaceutical stimulants and stimulant NPS (e.g., MDPV, Alpha PVP); and
- **Other drug overdose:** 'Other drugs' include (but are not limited to) alcohol, cannabis, GHB/GBL/1,4-BD, amyl nitrite/alkyl nitrite, benzodiazepines and LSD.

It is important to note that events reported across the drug types may not be unique given high rates of polysubstance use amongst the sample.

Each year, we compute the total per cent of participants who have experienced any past 12-month overdose event by looking for any endorsement across the drug types queried (see Table 5 below).

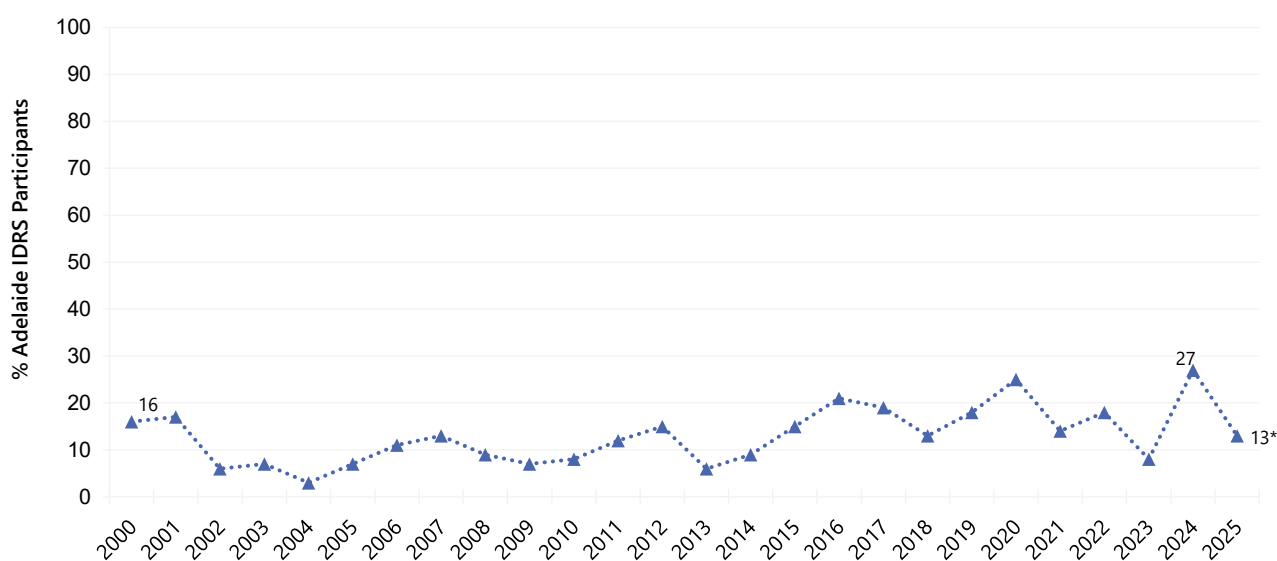
Non-fatal overdose in the Adelaide sample has fluctuated over the years (likely due to differences in the way questions regarding overdose were asked). The per cent reporting **any past 12-month non-fatal overdose** significantly decreased, from 27% in 2024 to 13% in 2025 ( $p=0.017$ ) (Figure 33).

Seven per cent reported a **non-fatal overdose following opioid use** in the 12 months preceding interview (9% in 2024;  $p=0.614$ ) and few participants ( $n\leq 5$ ) reported a **non-fatal overdose following stimulant use** in the past 12 months (10% in 2024;  $p=0.082$ ) (Table 5).

Participants who had overdosed on an opioid ( $n=7$ ) had done so on a median of one occasion (IQR=1-1) in the last 12 months. Few participants ( $n\leq 5$ ) were able to cite the most commonly used opioid involved in past year non-fatal overdose and on the types of treatment received on the last occasion of opioid overdose, therefore, no further details are reported.

Few participants ( $n\leq 5$ ) in the Adelaide sample reported a **non-fatal overdose following other drug use** (10% in 2024;  $p=0.192$ ), and as such, no further details are reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Figure 33: Past 12 month any non-fatal overdose, Adelaide, SA, 2000-2025



Note. Estimates from 2000-2005 refer to heroin and morphine non-fatal overdose 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.,  $n\leq 5$  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 5: Past 12-month non-fatal overdose by drug type, Adelaide, SA, 2015-2025**

	Adelaide, SA										
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
<b>% Any opioid</b>	N=102 10	N=101 -	N=100 9	N=101 -	N=100 -	N=100 15	N=100 6	N=103 9	N=102 -	N=106 9	<b>N=105 7</b>
% Heroin overdose	N=102 10	N=101 -	N=100 8	N=98 -	N=99 -	N=100 13	N=100 -	N=102 6	N=101 -	N=105 6	<b>N=104 -</b>
% Methadone overdose	N=102 0	N=101 0	N=100 0	N=101 -	N=99 0	N=100 -	N=100 0	N=102 -	N=101 0	N=105 0	<b>N=104 0</b>
% Morphine overdose	N=102 -	N=101 -	N=99 -	N=101 -	N=99 0	N=100 0	N=100 0	N=102 -	N=101 -	N=105 0	<b>N=104 0</b>
% Oxycodone overdose	N=102 -	N=101 -	N=99 0	N=99 -	N=99 0	N=100 -	N=100 0	N=102 0	N=101 0	N=105 0	<b>N=104 0</b>
<b>% Stimulant overdose</b>	N=102 -	N=99 14	N=100 11	N=100 -	N=99 13	N=100 -	N=101 8	N=103 9	N=102 -	N=105 10	<b>N=105 -</b>
<b>% Other overdose</b>	N=102 -	N=99 -	N=100 .	N=100 -	N=99 -	N=100 9	N=101 -	N=103 -	N=102 -	N=105 10	<b>N=105 -</b>
<b>% Any drug overdose</b>	N=102 14	N=101 21	N=99 19	N=97 13	N=99 18	N=100 25	N=100 14	N=103 18	N=102 8	N=106 27	<b>N=105 13*</b>

Note. Participants reported on whether they had overdosed following use of the specific substances; other substances may have been involved on the occasion(s) that participants refer to. From 2015-2018, the stimulant overdose percentage represents participants who reported that they had consumed a stimulant drug prior to their most recent past 12-month 'other drug' overdose and therefore may be an underestimation. N is the number who responded (denominator). 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.

## Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

The Alcohol Use Disorders Identification Test ([AUDIT](#)) was designed by the World Health Organization (WHO) as a brief screening scale to identify individuals with problematic alcohol use in the past 12 months. The AUDIT-C is a modified version of the 10 question AUDIT instrument, comprising three questions and is scored on a scale of 0-12.

In 2025, the mean score on the AUDIT-C for the total Adelaide sample (including participants who had not consumed alcohol in the past 12 months) was 2.9 (SD 3.6), a significant increase relative to 2024 (2.8; SD 3.7;  $p = 0.003$ ).

AUDIT-C scores of  $\geq 4$  (men) and  $\geq 3$  (women) are likely to indicate hazardous drinking, and potentially, alcohol dependence. In 2025, almost one third (32%) of male participants had obtained a score of four or more (36% in 2024;  $p = 0.708$ ), and almost half (49%) of female participants had obtained a score of three or more (43% in 2024;  $p = 0.646$ ), indicative of hazardous use (Table 6).

Table 6: AUDIT-C total scores and per cent of participants scoring above recommended levels, Adelaide, SA, 2010-2025

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
<b>Men</b>																
<b>Mean AUDIT-C score (SD)</b>	3.6 (3.9)	3.5 (3.5)	4.2 (3.9)	5.1 (4.3)	3.7 (3.6)	4.1 (3.5)	3.2 (3.6)	5.5 (3.4)	3.4 (3.6)	3.7 (3.6)	5.4 (3.8)	5.5 (3.4)	4.3 (4.0)	3.9 (4.0)	2.8 (3.7)	<b>2.7 (3.4)</b>
<b>Score of ≥4 (%)</b>	40	41	47	58	41	52	36	69	38	44	55	70	52	45	36	<b>32</b>
<b>Women</b>																
<b>Mean AUDIT-C score (SD)</b>	3.1 (2.9)	2.5 (3.2)	3.2 (3.4)	3.9 (4.1)	4.2 (3.9)	3.3 (3.5)	3.8 (3.8)	4.1 (3.0)	4.6 (3.8)	2.9 (3.5)	5.2 (3.6)	4.7 (2.7)	3.9 (4.0)	2.4 (3.3)	2.8 (3.7)	<b>3.3 (3.9)</b>
<b>Score of ≥3 (%)</b>	42	32	47	49	55	45	54	59	63	39	72	70	53	38	43	<b>49</b>

Note. Monitoring of AUDIT-C commenced in 2010. Computed from the entire sample regardless of whether they had consumed alcohol in the past twelve months. 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.

## Naloxone Program and Distribution

Naloxone is a short-acting opioid antagonist that has been used for over 40 years to reverse the effects of opioids. In 2012, a take-home naloxone program commenced in the ACT (followed by NSW, VIC, and WA) through which naloxone was made available to peers and family members of people who inject drugs for the reversal of opioid overdose. In early 2016, the Australian Therapeutic Goods Administration (TGA) placed 'naloxone when used for the treatment of opioid overdose' on a dual listing of Schedule 3 and Schedule 4, meaning naloxone could be purchased OTC at pharmacies without a prescription, and at a reduced cost via prescription. From 1 December 2020 to 30 June 2022, under the take home naloxone pilot program, naloxone was made available free of charge and without a prescription in NSW, SA and WA. Following the evaluation of this pilot, the Australian Government announced that a national take home naloxone program was to be implemented in all Australian states and territories from 1 July 2022. Furthermore, naloxone nasal spray (Nyxoid) is now available in Australia as a PBS-listing, which is expected to increase use of naloxone in the community.

**Awareness of Naloxone:** The per cent of participants who were aware of naloxone has fluctuated somewhat over time, ranging between 48% and 75%. In 2025, two thirds (67%) reported awareness of naloxone, stable relative to 66% in 2024 (Figure 34).

**Awareness of Take-Home Naloxone:** Half (52%) of the Adelaide sample reported awareness of take-home naloxone programs in 2025, the highest percentage since monitoring commenced in 2013, though remained stable relative to 2024 (40%;  $p=0.102$ ) (Figure 34). In 2025, 47% of the Adelaide sample reported having heard of free access to naloxone, stable relative to 2024 (38%;  $p=0.212$ ), and few participants ( $n\leq 5$ ) reported having heard of paid access, also stable compared with 2024 ( $n\leq 5$ ;  $p=0.275$ ).

**Obtained Naloxone:** Almost two fifths (37%) of the Adelaide sample reported having obtained naloxone at least once in their lifetime, a significant increase from 23% in 2024 ( $p=0.028$ ). Almost one third (30%) had obtained naloxone in the past year, the highest percentage over the monitoring period, though remained stable relative to 2024 (21%;  $p=0.120$ ) (Figure 35). Amongst participants who had ever obtained naloxone and responded ( $n=39$ ), almost three fifths (59%) reported most recently accessing naloxone from a Needle and Syringe Program (NSP) (in-person), followed by a pharmacy (18%). All participants who had obtained naloxone and commented ( $n=39$ ) reported that they did not have to pay the last time they obtained naloxone.

In 2025, of those who reported obtaining naloxone at least once in their lifetime ( $n=39$ ), a median of one naloxone kit was stored away at the time of interview (IQR=1-2). Among those with at least one naloxone kit stored away and who responded ( $n=27$ ), 96% had at least one kit within its expiration date, few participants ( $n\leq 5$ ) had at least one kit that was expired, and no participants reported having both expired and non-expired kits.

Few participants ( $n\leq 5$ ) in the Adelaide sample reported that they had tried to obtain naloxone in their lifetime but had been unsuccessful ( $n\leq 5$  in 2024;  $p=0.748$ ), whereas 47% of participants reported never having tried to obtain naloxone, a significant decrease from 82% in 2024 ( $p<0.001$ ). Of those who had ever had trouble obtaining naloxone or had never tried to obtain naloxone and commented ( $n=55$ ), the most common reason comprised: 'didn't consider myself/my peers at risk of overdose'

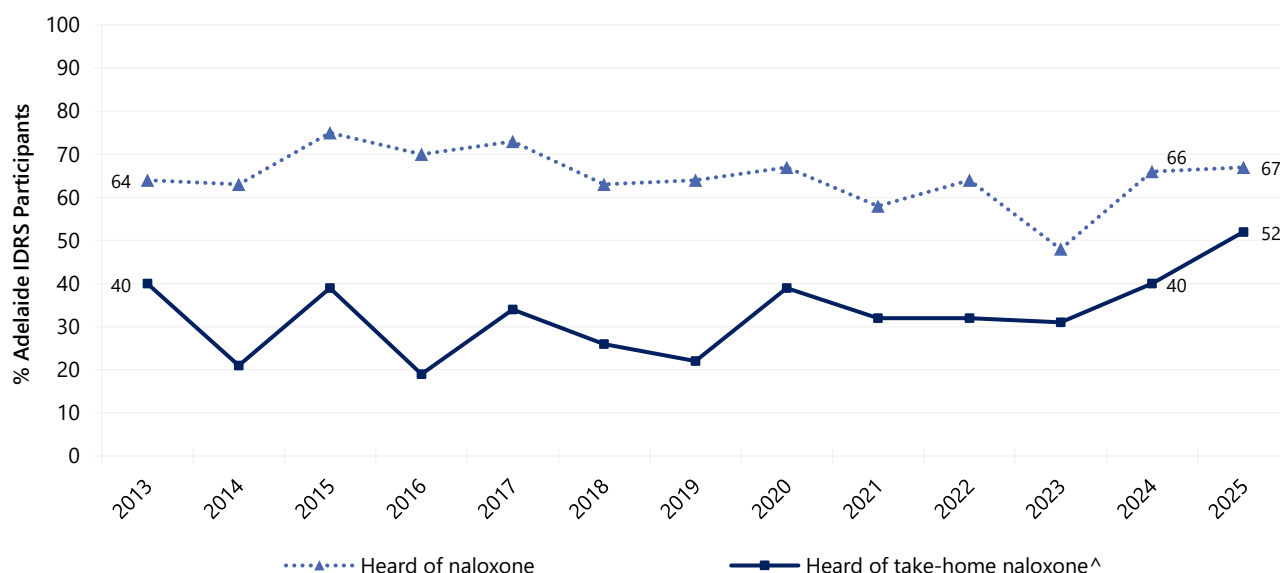
(13%). Few participants ( $n \leq 5$ ) were able to comment on other reasons for being unsuccessful in obtaining naloxone.

Of those who had ever obtained naloxone, had used opioids in the past month and responded ( $n=31$ ), 39% reported that they 'always' had naloxone on hand when using opioids, and one quarter (26%) reported that they 'often' had naloxone on hand. Few participants ( $n \leq 5$ ) reported that they 'sometimes' and 'rarely' had naloxone on hand when using opioids, respectively, and few participants ( $n \leq 5$ ) reported to never have had naloxone on hand.

**Education on Using Naloxone:** In 2025, one quarter (26%) of the sample had been trained in how to administer naloxone in their lifetime, stable relative to 2024 (18%;  $p=0.195$ ), with 18% of participants reporting that they had been trained in the past year (10% in 2024;  $p=0.124$ ) (Figure 35). Among those who had been trained in naloxone administration in the last year and responded ( $n=17$ ), two fifths (41%) were taught how to administer naloxone at an NSP. Few participants ( $n \leq 5$ ) commented on other locations where they had been trained in naloxone administration in the last year, and therefore, these data are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

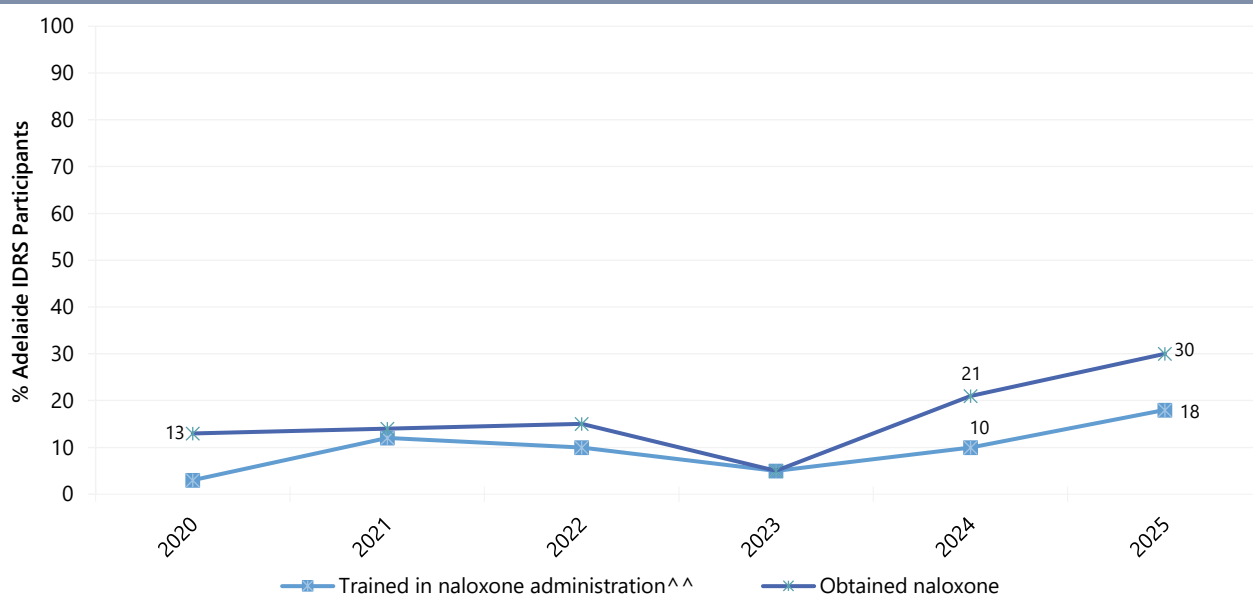
**Use of Naloxone to Reverse Overdose:** In 2025, 15% of the Adelaide sample reported that they had resuscitated someone using naloxone at least once in their lifetime, stable relative to 2024 (8%;  $p=0.092$ ), with 11% having done so in the past year. Few participants ( $n \leq 5$ ) reported that they had been resuscitated by a peer using naloxone in the past year ( $n \leq 5$  in 2024;  $p=0.498$ ).

Figure 34: Lifetime awareness of naloxone and naloxone take-home programs, Adelaide, SA, 2013-2025



Note. ^Wording of this question changed from 'Have you heard about take home naloxone programs' (after receiving a blurb about what these programs entailed: 2013-2022) to 'Are you aware that naloxone is available for people to take home' in 2023. 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.,  $n \leq 5$  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 35: Past 12 month education in naloxone administration, and obtainment of naloxone, Adelaide, SA, 2020-2025



Note. ^^Wording of this question changed from 'Have you ever been through a naloxone training course? This may include brief advice, brief education or more extensive training' (2020-2022) to 'Have you ever been taught how to use naloxone? This may include brief advice, brief education or more extensive training' (2023 onwards). Response options delineated whether this had occurred in the past year or more than a year ago. 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.,  $n \leq 5$  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.

## Equipment Access and Injecting Behaviours

### Equipment Access

In 2025, participants reported obtaining a median of 100 new needles/syringes in the month prior to interview (IQR=26-200; 80 in 2024; IQR=20-200;  $p=0.453$ ), having a median of 20 needles/syringes stored away (IQR=5-50; 12 in 2024; IQR=2-50;  $p=0.324$ ), and providing a median of 10 needles/syringes to others (IQR=0-50; 20 in 2024; IQR=2-80;  $p=0.134$ ).

Seven per cent of the Adelaide sample reported difficulties obtaining new needles/syringes in the past month, a significant decrease relative to 2024 (18%;  $p=0.022$ ), and few participants ( $n \leq 5$ ) reported difficulties accessing filters ( $n \leq 5$  in 2024) (Table 7). Seven per cent of the sample reported difficulties obtaining sterile water (not asked in 2024). The majority of participants reported that they obtained needles from an NSP (85%), stable relative to 2024 (87%;  $p=0.699$ ), followed by a partner or friend (25%; 37% in 2024;  $p=0.078$ ) and an NSP vending machine (20%), a significant decrease relative to 2024 (35%;  $p=0.023$ ) (Table 7).

### Injecting Behaviours

In 2025, participants reported injecting on a median of 20 occasions in the month prior to interview (IQR=8-44; 20 occasions in 2024; IQR=12-31;  $p=0.972$ ). In 2025, few participants ( $n \leq 5$ ) reported receptive sharing ( $n \leq 5$  in 2024;  $p=0.721$ ) and similarly, few participants ( $n \leq 5$ ) reported distributive sharing (8% in 2024;  $p=0.214$ ) in the month prior to interview (Figure 36 and Table 8).

The per cent who reported having shared injecting equipment other than syringes (e.g., spoons, tourniquet, water, and filters) in the past month has fluctuated considerably over the course of monitoring (Figure 36), though remained stable in 2025 (13%), relative to 2024 (19%;  $p=0.259$ ). Almost one quarter (23%) of the Adelaide sample reported that they had re-used their own needles in the past month, a significant decrease relative to 2024 (39%;  $p=0.020$ ) (Figure 36 and Table 8). Three fifths (60%) of the Adelaide sample reported reusing other injecting equipment in the past month, a significant increase relative to 2024 (42%;  $p=0.018$ ), most commonly tourniquets (48%; 33% in 2024;  $p=0.038$ ), followed by spoons and mixing containers (20%; 13% in 2024;  $p=0.203$ ) and water (8%; 7% in 2024;  $p=0.793$ ).

Almost two fifths (39%) of the Adelaide sample reported that they had injected someone else in the past month (41% in 2024;  $p=0.885$ ), and one fifth (21%) were injected by someone else in the past month (23% in 2024;  $p=0.865$ ) (Table 8).

The location of last injection remained stable between 2024 and 2025 ( $p=0.085$ ). Consistent with previous years, most participants (87%) reported that they had last injected in a private home (79% in 2024). An additional 7% of participants reported that they had last injected in a public toilet (6% in 2024) (Table 8). Two fifths (40%) of the Adelaide sample reported injecting alone on the last occasion of injecting, a significant decrease relative to 2024 (58%;  $p=0.015$ ).

The site of last injection remained stable between 2024 and 2025 ( $p=0.261$ ). Consistent with previous years, the majority of the sample (86%) reported injecting in their arm on the last occasion of injecting (90% in 2024), followed by 6% reporting hand/wrist (6% in 2024) (Table 8).

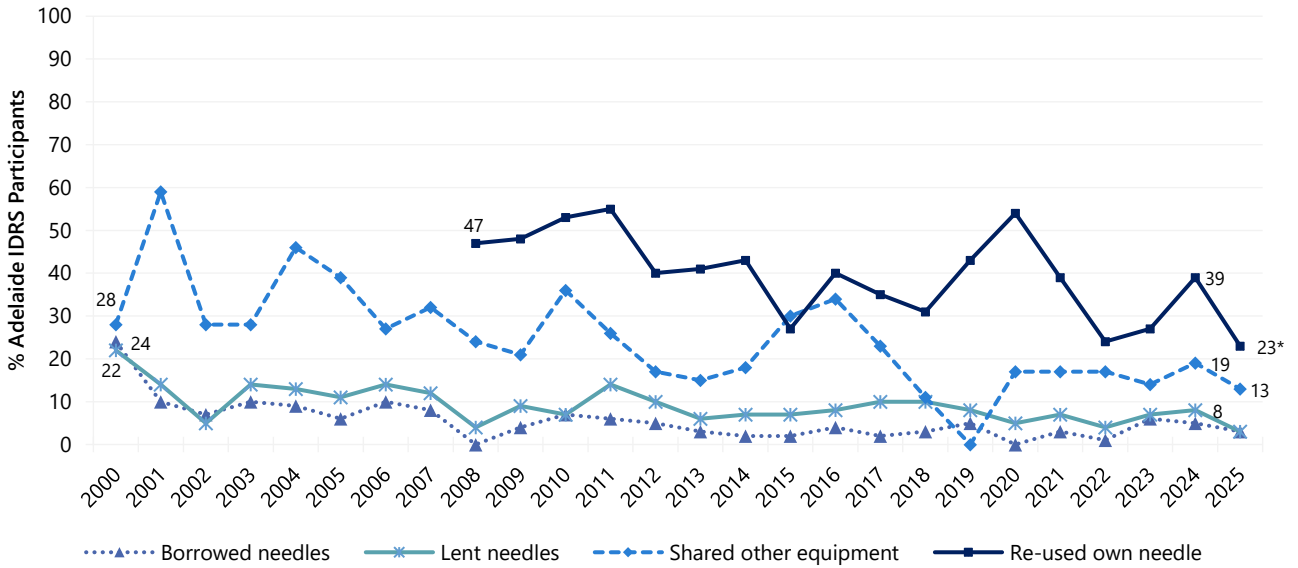
Table 7: Injecting equipment access in the past month, Adelaide, SA, 2023-2025

	2023 (N=102)	2024 (N=106)	2025 (N=105)
<b>% Location of needle/syringe access past month</b>			
NSP	71	87	<b>85</b>
NSP vending machine	27	35	<b>20*</b>
Posted from NSP	/	/	-
Chemist	10	6	<b>6</b>
Friend/partner	29	37	<b>25</b>
Dealer	13	13	<b>6</b>
Hospital	0	0	-
Outreach/peer worker	-	0	-
Medically supervised injecting Centre/Room	0	0	<b>0</b>
Other	-	-	-
<b>% Difficulties accessing filters^ in past month</b>	-	-	-
<b>% Difficulties accessing needles/syringes in past month</b>	7	18	<b>7*</b>
<b>% Equipment used past month</b>	n=102	n=106	<b>n=105</b>
Needle and syringe (e.g., 0.5mL, 1mL)	97	96	<b>96</b>
Syringe or barrel (e.g., 3mL, 5mL, 10mL, 20mL, 50mL)	8	14	<b>9</b>
Spoons/mixing containers	34	30	<b>39</b>
Tourniquet	36	44	<b>63*</b>
Swabs	89	81	<b>89</b>

Water	95	93	<b>97</b>
Any filters	35	36	<b>46</b>

Note. ^Filters included wheel filters, Sterifilt basic filters, sterifilt plus filters and commercial cotton filters (e.g., Stericups). Statistical significance for 2024 versus 2025 is presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ . Please refer to Table 1 for a guide to table/figure notes.

Figure 36: Borrowing and lending of needles and sharing of injecting equipment in the past month, Adelaide, SA, 2000-2025



Note. Borrowed (receptive): used a needle after someone else. Lent (distributive): somebody else used a needle after them. 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.,  $n \leq 5$  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: Injecting behaviours in the past month, and location of last injection use, Adelaide, SA, 2015-2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
	(N=102)	(N=101)	(N=100)	(N=101)	(N=98)	(N=100)	(N=101)	(N=103)	(N=102)	(N=106)	(N=105)
<b>% Injecting behaviours past month</b>											
Borrowed a needle	N=100 -	N=100 -	N=100 -	N=101 -	N=98 -	N=99 0	N=100 -	N=103 -	N=102 6	N=106 -	<b>N=104</b> -
Lent a needle	N=100 7	N=100 8	N=100 10	N=101 10	N=96 8	N=100 -	N=100 7	N=103 -	N=102 7	N=105 8	<b>N=102</b> -
Shared any injecting equipment ^	N=100 .31	N=100 34	N=99 23	N=101 11	N=100 0	N=99 17	N=101 17	N=102 17	N=102 14	N=106 19	<b>N=104</b> <b>13</b>
Re-used own needle	N=100 27	N=100 40	N=100 35	N=100 31	N=98 43	N=99 54	N=101 39	N=103 24	N=101 27	N=105 39	<b>N=103</b> <b>23*</b>
Re-used any other equipment	N=100 52	N=100 56	N=100 61	N=99 35	N=102 28	/	/	/	/	N=105 42	<b>N=104</b> <b>60*</b>
Injected partner/friend	/	/	N=100 35	N=100 29	N=98 27	N=100 39	N=101 35	N=103 21	N=102 30	N=105 41	<b>N=104</b> <b>39</b>
Somebody else injected them	/	/	N=100 19	N=101 14	N=96 25	N=100 24	N=100 20	N=103 10	N=102 19	N=105 23	<b>N=104</b> <b>21</b>
<b>% Location of last injecting use</b>											
Private home	90	88	92	88	95	89	91	87	85	79	<b>87</b>
Car	6	7	-	7	-	-	0	-	-	-	-
Street/car park/beach	0	-	-	-	0	-	-	-	7	10	-
Public toilet	-	-	0	-	-	-	7	7	-	6	<b>7</b>
Medically supervised injecting Centre/Room	/	/	/	/	/	0	0	0	0	0	<b>0</b>
Prison	0	0	0	0	0	0	0	0	0	0	<b>0</b>
Stairwell	0	0	0	0	0	0	0	0	0	-	<b>0</b>
Other	-	-	-	-	-	0	0	0	0	0	-
<b>% Last injection site</b>											
Arm	81	84	78	85	92	75	83	83	88	90	<b>86</b>
Leg	-	0	-	-	-	7	-	-	-	-	-
Hand/wrist	8	8	10	7	-	10	-	-	-	6	<b>6</b>
Foot	-	-	-	0	0	-	0	-	0	0	-

Groin	-	-	0	0	0	-	-	-	0	0	<b>0</b>
Neck	-	-	7	-	0	-	6	-	-	-	-
Other	-	0	0	-	0	-	0	0	0	0	<b>0</b>

Note. Borrowed (receptive): used a needle after someone else. Lent (distributive): somebody else used a needle after them. ^ Includes spoons, water, tourniquets and filters; excludes needles/syringes. N is the number who responded (denominator). 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.

## Self-Reported Injection-Related Injuries and Diseases

The per cent of participants who had experienced any injection-related injuries and diseases in the month preceding interview decreased significantly from 40% in 2024 to 24% in 2025 ( $p=0.020$ ) (Table 9). The most common injection-related injuries and diseases reported by participants was any infection/abscess (10%; 21% in 2024;  $p=0.038$ ; including skin abscess or cellulitis; 9%; 18% in 2024;  $p=0.071$ ) and any nerve damage (9%; 22% in 2024;  $p=0.013$ ).

Table 9: Injection-related issues in the past month, Adelaide, SA, 2020-2025

	2020	2021	2022	2023	2024	2025
	(N=100)	(N=101)	(N=103)	(N=102)	(N=106)	(N=102)
<b>% Artery injection</b>	9	6	6	-	9	-
<b>% Any nerve damage</b>	13	13	9	13	22	<b>9*</b>
<b>% Any thrombosis</b>	8	6	6	-	10	<b>-.*</b>
Blood clot	8	6	-	-	10	<b>-.*</b>
Deep vein thrombosis	-	0	-	0	-	<b>0</b>
<b>% Any infection/abscess</b>	15	12	16	12	21	<b>10*</b>
Skin abscess or cellulitis	14	10	13	11	18	<b>9</b>
Endocarditis	0	-	-	0	-	-
Other serious infection (e.g., osteomyelitis/Sepsis/Septic arthritis)	-	-	-	-	-	<b>0</b>
<b>% Dirty hit</b>	8	11	9	14	10	<b>7</b>
<b>% Any injection-related problem</b>	35	29	25	29	40	<b>24*</b>

Note. 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.

## Drug Treatment

Seventeen per cent of the Adelaide sample reported receiving any drug treatment in 2025, stable relative to 2024 (14%;  $p=0.571$ ), with methadone continuing to be the most commonly received treatment (11%; 8% in 2024;  $p=0.357$ ) (Table 10). Among those who reported methadone or buprenorphine treatment and commented ( $n=14$ ), 86% reported receiving takeaway doses (78% in 2024).

Few participants ( $n\leq 5$ ) reported that they had tried to access treatment in the past six months but were unable to (11% in 2024;  $p=0.127$ ). As such, few participants ( $n\leq 5$ ) commented on the individual services that they had tried to access but were unable to, and on the reasons for why treatment was unable to be accessed, therefore these data are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Table 10: Any current drug treatment, Adelaide, SA, 2015-2025

Adelaide, SA											
	2015 N=102	2016 N=101	2017 N=100	2018 N=101	2019 N=99	2020 N=100	2021 N=100	2022 N=103	2023 N=102	2024 N=106	2025 N=105
<b>% Any current drug treatment</b>	31	33	30	23	19	38	24	25	17	14	<b>17</b>
Methadone	17	21	16	13	12	20	15	14	9	8	<b>11</b>
Buprenorphine	-	-	-	0	0	0	-	-	0	-	-
Buprenorphine-naloxone	8	7	7	6	-	10	-	-	-	-	-
Buprenorphine depot injection	/	/	/	/		-	-	-	-	-	-
Drug counselling	-	-	-	-	-	8	6	-	-	-	-
Other	-	-	-	0	-	-	-	-	-	-	-

Note. 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.

## Opioid and Methamphetamine Dependence

From 2017, participants were asked questions from the Severity of Dependence Scale (SDS) adapted to investigate opioid and methamphetamine dependence. The SDS is a five-item tool designed to screen for potential dependence on a variety of drugs. The SDS focuses on the psychological aspects of dependence, including impaired control of drug use, 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 methamphetamine dependence in the past six months, a [cut-off value of four](#) was used, as this has been found to be a good balance between sensitivity and specificity for identifying dependent methamphetamine use. No validated cut-off for opioid dependence exists; however, researchers typically use a [cut-off value of five](#) as an indicator of likely dependence.

Of those who had recently used an opioid and commented (n=38), the median SDS score was four (IQR=1-8), with 45% scoring five or above, indicating possible dependence (34% in 2024;  $p=0.475$ ) (Table 11). Almost one fifth (18%) of participants obtained a score of zero on the opioid SDS (34% in 2024;  $p=0.194$ ), indicating no symptoms of opioid dependence.

Of those who had recently used methamphetamine and commented (n=93), the median SDS score was four (IQR=1-8), with 53% scoring four or above, indicating possible dependence (55% in 2024;  $p=0.881$ ) (Table 11). One fifth (22%) of participants obtained a score of zero on the methamphetamine SDS (15% in 2024;  $p=0.267$ ), indicative of no symptoms of methamphetamine dependence.

Table 11: Total opioid and methamphetamine SDS scores and per cent of participants scoring above cut-off scores indicative of dependence, among those who reported past six month use, Adelaide, SA, 2015-2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
<b>Opioid</b>	(N=63)	(N=52)	(N=61)	(N=43)	(N=37)	/	(N=40)	(N=48)	(N=32)	(N=38)	<b>(N=38)</b>
<b>Median total score (IQR)</b>	7 (3-11)	6 (3-9)	6 (2-9)	6 (2-9)	6 (1-10)	/	2 (0-6)	4 (0-7)	6 (1-8)	3 (0-6)	<b>4 (1-8)</b>
% score = 0	14	12	15	16	19	/	45	31	22	34	<b>18</b>
% score $\geq$ 5	60	62	61	65	57	/	28	48	56	34	<b>45</b>
<b>Methamphetamine</b>	(N=76)	(N=78)	(N=75)	(N=82)	(N=88)	/	(N=88)	(N=91)	(N=90)	(N=99)	<b>(N=93)</b>

<b>Median total score (IQR)</b>	3 (1-7)	4 (1-7)	3 (1-6)	2 (0-5)	3 (1-7)	/	5 (2-7)	4 (1-6)	4 (1-8)	4 (2-7)	<b>4 (1-8)</b>
% score = 0	25	19	20	38	19	/	14	21	18	15	<b>22</b>
% score ≥ 4	47	54	47	39	49	/	60	52	51	55	<b>53</b>

Note. Severity of Dependence scores calculated out of those who used opioids/methamphetamine recently (past 6 months). A cut-off score of ≥5 and ≥4 is used to indicate screening positive for potential opioid and methamphetamine dependence, respectively. 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.

## Bloodborne Virus Testing and Treatment

In 2025, one third (36%) of participants reported that they had received a hepatitis C virus (HCV) antibody test in the past year, stable relative to 2024 (35%;  $p = 0.880$ ). One fifth (21%) had received a PCR or RNA test (23% in 2024;  $p = 0.860$ ) and few participants ( $n \leq 5$ ) reported having a current HCV infection (6% in 2024;  $p = 0.118$ ) (Table 12). No participants reported that they had received HCV treatment in the past year ( $n \leq 5$  in 2024;  $p = 0.497$ ), and as such, few participants ( $n \leq 5$ ) were able to comment on whether the treatment was successful. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Amongst those who had undergone an HCV RNA test in the last year and commented ( $n = 21$ ), two fifths (43%) reported that it took 1-5 days to receive a result (whether positive or negative), following the administration of the last HCV RNA test, followed by one third (33%) reporting it took 0-14 hours. Few participants ( $n \leq 5$ ) reported that it took more than five days to receive a result.

Almost three quarters (74%) of the Adelaide sample reported to have had a test for human immunodeficiency virus (HIV) in their lifetime (22% within the past six months; 25% in 2024;  $p = 0.619$ ), of which few participants ( $n \leq 5$ ) reported a positive diagnosis ( $n \leq 5$  in 2024) (Table 12).

Table 12: HCV and HIV testing and treatment, Adelaide, SA, 2018-2025

%	2018 (N=101)	2019 (N=100)	2020 (N=100)	2021 (N=101)	2022 (N=103)	2023 (N=102)	2024 (N=106)	2025 (N=105)
<b>Past year Hepatitis C test</b>								
Past year hepatitis C antibody test	N=100 54	N=97 39	N=96 23	N=100 37	N=101 48	N=100 40	N=100 35	<b>N=102 36</b>
Past year hepatitis C PCR or RNA test	N=85 33	N=87 28	N=94 35	N=98 27	N=91 29	N=92 29	N=99 23	<b>N=99 21</b>
<b>Current hepatitis C status</b>								
Currently have hepatitis C^	N=94 14	N=92 10	N=91 9	N=96 10	N=95 6	N=87 7	N=97 6	<b>N=95 -</b>
<b>Past year treatment for hepatitis C</b>								
Received treatment in past year	N=98 8	N=97 9	N=95 8	N=100 10	N=99 -	N=91 -	N=98 -	<b>N=98 0</b>
Most recent treatment was successful (among those who had received treatment in past year)	N=6 100	N=7 86	N=8 50	N=10 60	$n \leq 5$ -	$n \leq 5$ -	$n \leq 5$ -	<b>0</b>
Re-tested with a PCR or RNA test to	/	/	/	/	/	$n \leq 5$ -	$n \leq 5$ -	<b>0</b>

determine re-infection (among those who underwent successful treatment)								
<b>HIV test</b>	/	/	/	N=99	N=100	N=101	N=102	<b>N=102</b>
HIV test in past 6 months	/	/	/	25	22	23	25	<b>22</b>
HIV test more than 6 months ago	/	/	/	55	54	53	44	<b>52</b>
<b>HIV status</b>				N=78	N=76	N=77	N=71	<b>N=75</b>
Lifetime HIV positive diagnosis	/	/	/	-	0	-	-	-

Note. ^This includes people who had not been tested for HCV. N is the number who responded (denominator). Timeframes for HCV and HIV differ; i.e., HCV questions focus on lifetime and past year; HIV questions focus on lifetime and past six months. 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, 53% of the Adelaide sample reported some form of sexual activity in the past four weeks, stable relative to 2024 (59%;  $p = 0.404$ ) (Table 13). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if the interview was undertaken face-to-face).

Amongst those who reported engaging in sexual activity in the past four weeks and commented ( $n = 55$ ), participants reported a median of one partner (IQR = 1-2; 1 partner in 2024; IQR = 1-1;  $p = 0.712$ ). Few participants ( $n \leq 5$ ) reported engaging in sexual activity in the past four weeks in exchange for money, drugs, or other goods and services ( $n \leq 5$  in 2024;  $p = 0.666$ ) (Table 13).

Of those who commented in 2025 ( $n = 99$ ), 14% reported having a sexual health check-up in the six months prior to interview (20% in 2024;  $p = 0.349$ ), whilst almost three fifths (57%) had done so in their lifetime (48% in 2024;  $p = 0.266$ ). Of the total sample who responded ( $n = 98$ ), few participants ( $n \leq 5$ ) reported that they had received a positive diagnosis for a sexually transmitted infection (STI) in the six months prior to interview ( $n \leq 5$  in 2024) and 17% had received a positive diagnosis in their lifetime (15% in 2024;  $p = 0.695$ ) (Table 13). Given few participants ( $n \leq 5$ ) reported a recent STI diagnosis, data regarding the specific STI diagnosis are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Information about HIV testing is provided in Table 12.

Table 13: Sexual health behaviours, Adelaide, SA, 2022-2025

	2022	2023	2024	2025
<b>Of those who responded<sup>#</sup>:</b>	N=101	N=101	N=102	<b>N=104</b>
% Any sexual activity in the past four weeks	54	51	59	<b>53</b>
<b>Of those who reported any sexual activity in the past four weeks and responded<sup>#</sup>:</b>	/	/	n=60	<b>n=54</b>
% Engaged in sexual activity in exchange for money, drugs or other goods or services	/	/	-	-
<b>Of those who responded<sup>#</sup>:</b>	N=101	N=100	N=102	<b>N=99</b>

% Had a sexual health check in the last six months	20	21	20	<b>14</b>
% Had a sexual health check in their lifetime	59	57	48	<b>57</b>
<b>Of those who responded#:</b>	N=101	N=99	N=102	<b>N=98</b>
% Diagnosed with a sexually transmitted infection in the last six months	-	-	-	-
% Diagnosed with a sexually transmitted infection in their lifetime	14	19	15	<b>17</b>

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.

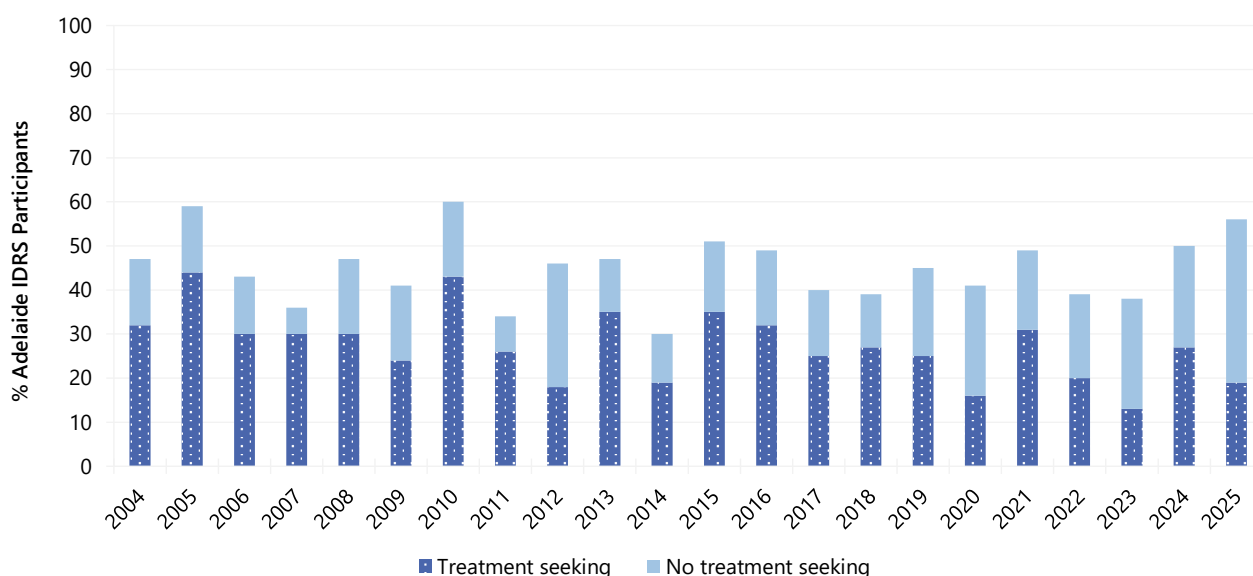
## Mental Health and Psychological Distress (K10)

### Mental Health

In 2025, 56% of the Adelaide sample self-reported that they had experienced a mental health problem in the preceding six months, stable relative to 2024 (50%;  $p = 0.482$ ). Amongst those who had experienced a mental health problem, the most commonly reported problems were depression (70%; 56% in 2024;  $p = 0.113$ ), anxiety (51%; 58% in 2024) and post-traumatic stress disorder (PTSD) (33%; 27% in 2024;  $p = 0.349$ ).

Almost one fifth (19%) of the Adelaide sample had seen a mental health professional during the six months prior to interview, stable relative to 2024 (27%;  $p = 0.256$ ) (Figure 37). This was equivalent to 35% of those who self-reported a mental health problem during the six months preceding interview, stable from 53% in 2024 ( $p = 0.086$ ). Almost two thirds (65%) of those who reported having seen a health professional about a mental health problem reported that they had been prescribed medication for their mental health problem in the six months preceding interview, stable relative to 2024 (71%;  $p = 0.758$ ).

Figure 37: Self-reported mental health problems and treatment seeking in the past six months, Adelaide, SA, 2004-2025



Note. 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. Data are suppressed in the figure where  $n \leq 5$  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.

### Psychological Distress (K10)

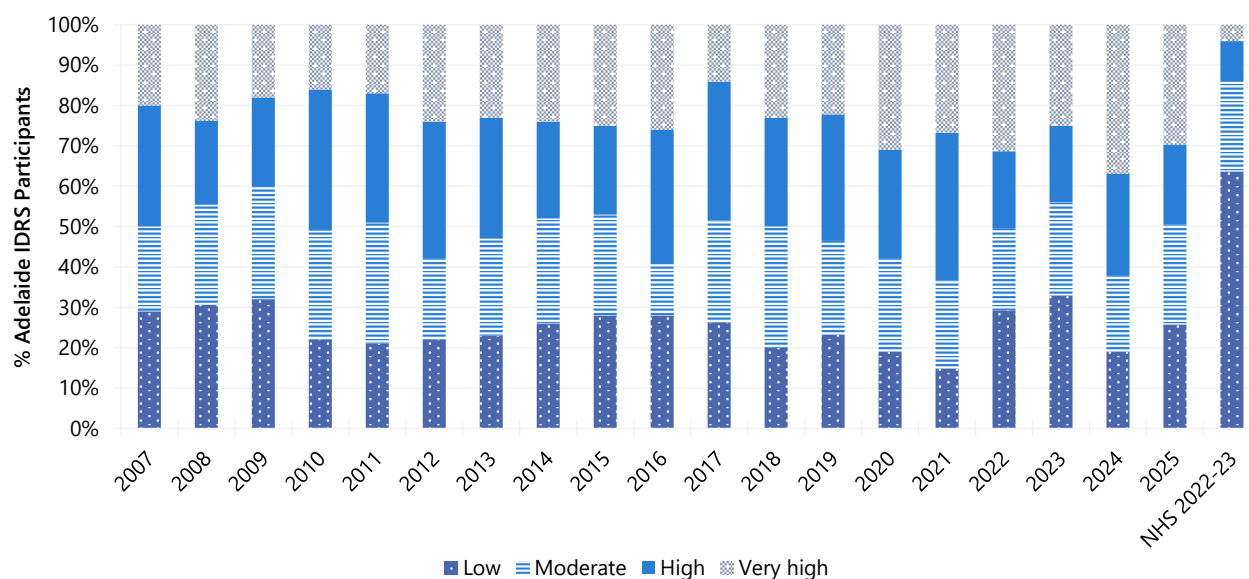
The [Kessler Psychological Distress Scale 10 \(K10\)](#) was administered to obtain a measure of psychological distress in the past four weeks. It is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured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

The minimum score is 10 (indicating no distress) and the maximum is 50 (indicating very high psychological distress). Scores can be coded into four categories to describe degrees of distress: scores from 10–15 are considered to indicate ‘low’ psychological distress; scores between 16–21 indicate ‘moderate’ psychological distress; 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 ( $p = 0.381$ ) (Figure 38), with almost one third (30%) of the 2025 Adelaide sample having a score of 30 or more (37% in 2024).

The National Health Survey (NHS) 2022-23 provides Australian population data for adult ( $\geq 18$  years) K10 scores. IDRS participants in 2024 reported greater levels of ‘high’ and ‘very high’ distress compared to the general population (Figure 38).

Figure 38: K10 psychological distress scores, Adelaide, SA, 2007-2025 and among the general population, 2022-23



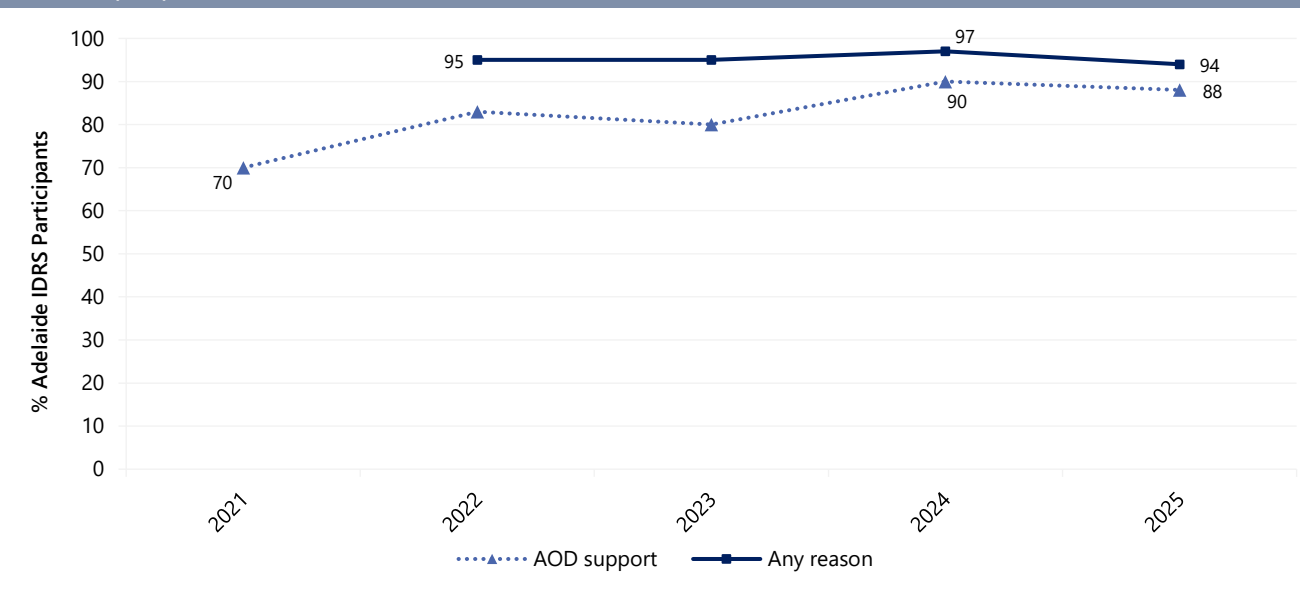
Note. Data from the National Health Survey are a national estimate from 2022-23 for adults 18 or older. Imputation used for missing scale scores (IDRS only). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where  $n \leq 5$  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.

## Health Service Access

Eighty-eight per cent of the Adelaide sample reported accessing any health service for alcohol and/or drug (AOD) support in the six months preceding interview in 2025, stable relative to 2024 (90%;  $p=0.672$ ) (Figure 39). The most common services reported by participants for AOD support in 2025 were an NSP (79%; 75% in 2024;  $p=0.518$ ) and a general practitioner (GP) (20%; 27% in 2024;  $p=0.260$ ) (Table 14).

Ninety-four per cent of the Adelaide sample reported accessing any health service in the six months preceding interview in 2025 (97% in 2024;  $p=0.332$ ) (Figure 39). Primary services reported by participants in 2025 were an NSP (82%; 79% in 2024;  $p=0.713$ ), a GP (57%; 62% in 2024;  $p=0.480$ ) and a pharmacy (37%; 37% in 2024) (Table 14).

Figure 39: Health service access for alcohol and other drug reasons, and for any reason, in the past six months, Adelaide, SA, 2021-2025



Note. Questions regarding health service access for AOD support were first asked in 2018, however due to differences in response options between 2018 and 2020, data are presented from 2021 onwards. Questions regarding health service access for any reason were first asked in 2018. 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.,  $n \leq 5$  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 14: Types of health services accessed for alcohol and other drug reasons and for any reason in the past six months, Adelaide, SA, 2022-2025

	AOD support				Any reason			
	2022	2023	2024	2025	2022	2023	2024	2025
<b>% accessing health services</b>	<b>(N=103)</b> <b>83</b>	<b>(N=102)</b> <b>80</b>	<b>(N=106)</b> <b>90</b>	<b>(N=105)</b> <b>88</b>	<b>(N=103)</b> <b>95</b>	<b>(N=102)</b> <b>95</b>	<b>(N=106)</b> <b>97</b>	<b>(N=105)</b> <b>94</b>
GP	18	21	27	<b>20</b>	58	53	62	<b>57</b>
<i>In-person</i>	/	/	/	<b>20</b>	/	/	/	<b>56</b>
<i>Telehealth</i>	/	/	/	-	/	/	/	<b>12</b>
Emergency department	6	10	14	<b>10</b>	18	20	32	<b>20</b>
Hospital admission (inpatient)	6	8	11	-	19	17	25	<b>15</b>
Medical tent (e.g., at a festival)	0	0	0	<b>0</b>	-	0	0	<b>0</b>
Drug and Alcohol counsellor	11	9	8	<b>9</b>	13	9	8	<b>10</b>
Hospital as an outpatient	-	0	-	-	12	-	-	<b>7</b>
Specialist doctor (not including a psychiatrist)	7	-	-	-	11	7	7	<b>9</b>
Dentist	-	-	6	-	10	12	15	<b>13</b>
Ambulance attendance	-	-	8	-	10	9	17	<b>10</b>
Pharmacy	/	/	15	<b>13</b>	/	/	37	<b>37</b>
Other health professional (e.g., physiotherapist)	-	-	0	-	7	11	-	<b>8*</b>
Psychiatrist	-	-	-	-	8	-	6	<b>8</b>
Psychologist	6	-	-	-	9	7	8	<b>8</b>
NSP	76	78	75	<b>79</b>	79	85	79	<b>82</b>
Peer based harm reduction service	-	-	-	-	-	-	-	-
Other harm reduction service	0	0	-	<b>6</b>	-	0	-	<b>6</b>

Note. 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.

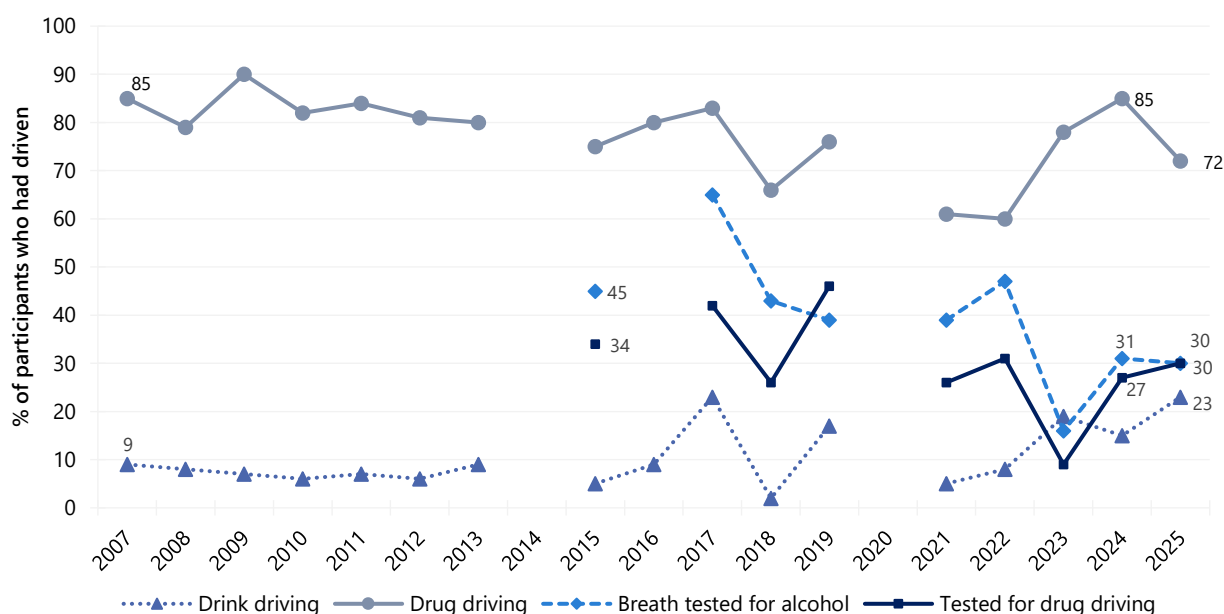
## Driving

Twenty-nine per cent of the Adelaide sample had driven a car, motorcycle or other vehicle in the six months preceding interview in 2025, stable relative to 2024 (25%;  $p = 0.534$ ). Of those who had driven within the last six months and commented ( $n = 30$ ), almost one quarter (23%) reported driving while over the perceived legal limit of alcohol, stable relative to 2024 ( $n \leq 5$ ;  $p = 0.517$ ). Among those who had driven within the six months preceding interview and commented ( $n = 29$ ), almost three quarters (72%) reported driving within three hours of consuming an illicit or non-prescribed drug, stable relative to 2024 (85%;  $p = 0.339$ ) (Figure 40).

Of those who had driven within three hours of consuming an illicit or non-prescribed drug in the six months preceding interview and responded ( $n = 21$ ), participants most commonly reported using methamphetamine crystal (48%) prior to driving in the last six months, followed by heroin (38%).

Of those who had recently driven and responded (n=30), almost one third (30%) of participants reported that they had been tested for drug driving by the police roadside drug testing service (27% in 2024), and another 30% reported that they had been breath tested for alcohol by the police roadside testing service (31% in 2024) in the six months prior to interview. Among those who had had been tested for drug driving by the police roadside drug testing service (n=9), few participants (n≤5) were able to report on the specific drug/s which had been detected, therefore, these data are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Figure 40: Self-reported testing, and driving over the (perceived) legal limit for alcohol or within three hours following illicit drug use, among those who had driven in the last six months, Adelaide, SA, 2007-2025



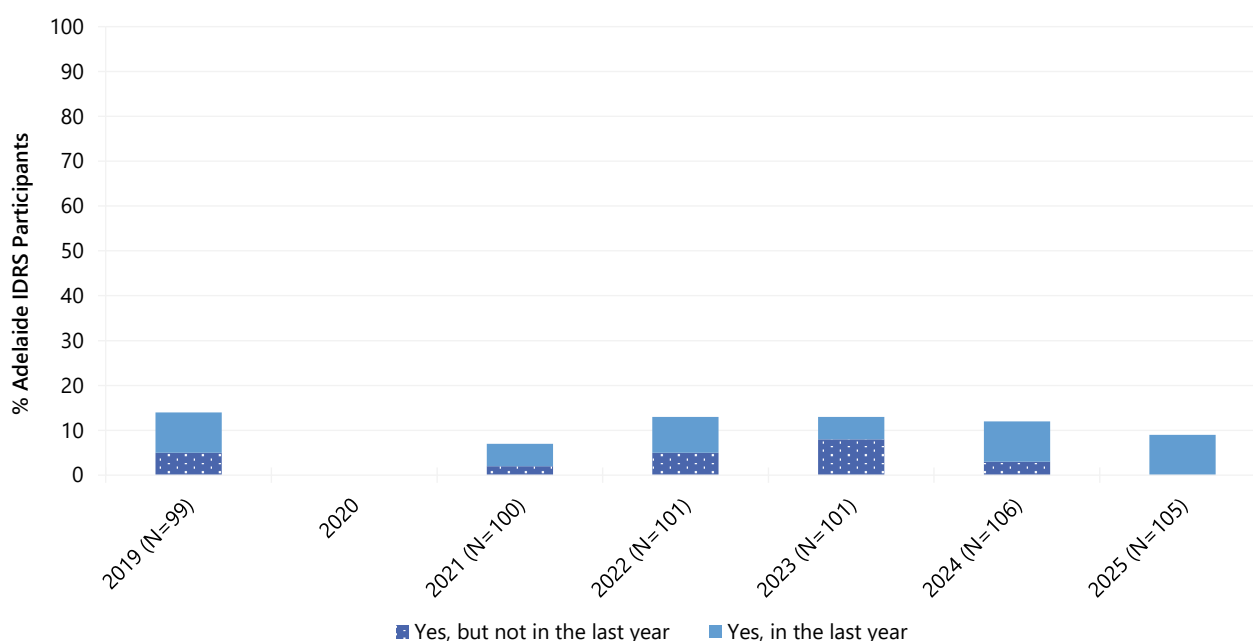
Note. Computed of those who had driven a vehicle in the past six months. Questions about driving behaviour were first asked in 2007. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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.

## Drug Checking

Drug checking is a common strategy used to test the contents and purity 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 20, 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, 9% of the Adelaide sample reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year (9% in 2024) (Figure 41). Of those who reported that they or someone else had tested their illicit drugs in the past year in 2025 and responded (n=9), all participants (100%) reported using a personal testing kit – most commonly colorimetric or reagent test kits (67%). Of those who reported that they or someone else had tested their illicit drugs in the past year (n=9), no participants reported that they had submitted drugs for testing at a drug checking service. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

Figure 41: Lifetime and past year engagement in drug checking, Adelaide, SA, 2019-2025



Note. Questions on drug checking commenced in 2019. In 2025, survey questions were separated into ‘personal testing kits’ and ‘drug checking services’ and focused on past year use only. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where  $n \leq 5$  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.

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

One third (35%) of the Adelaide sample reported engaging in ‘any’ crime in the past month in 2025, stable relative to 2024 (40%;  $p = 0.558$ ). Selling drugs for cash profit (20%; 27% in 2024;  $p = 0.249$ ) and property crime (18%; 21% in 2024;  $p = 0.591$ ) remained the most common self-reported crimes in the month preceding interview (Figure 42).

Almost one fifth (19%) of the Adelaide sample reported being a victim of violence in the past month, unchanged from 19% in 2024 (Figure 43).

Almost one quarter (23%) of the Adelaide sample reported a drug-related encounter with police which did not result in charge or arrest in the 12 months preceding interview (33% in 2024;  $p = 0.132$ ) (Figure 44). This predominantly comprised being stopped and searched (67%; 71% in 2024;  $p = 0.777$ ) and being stopped and questioned, which significantly decreased in 2025, relative to 2024 (33%; 71% in

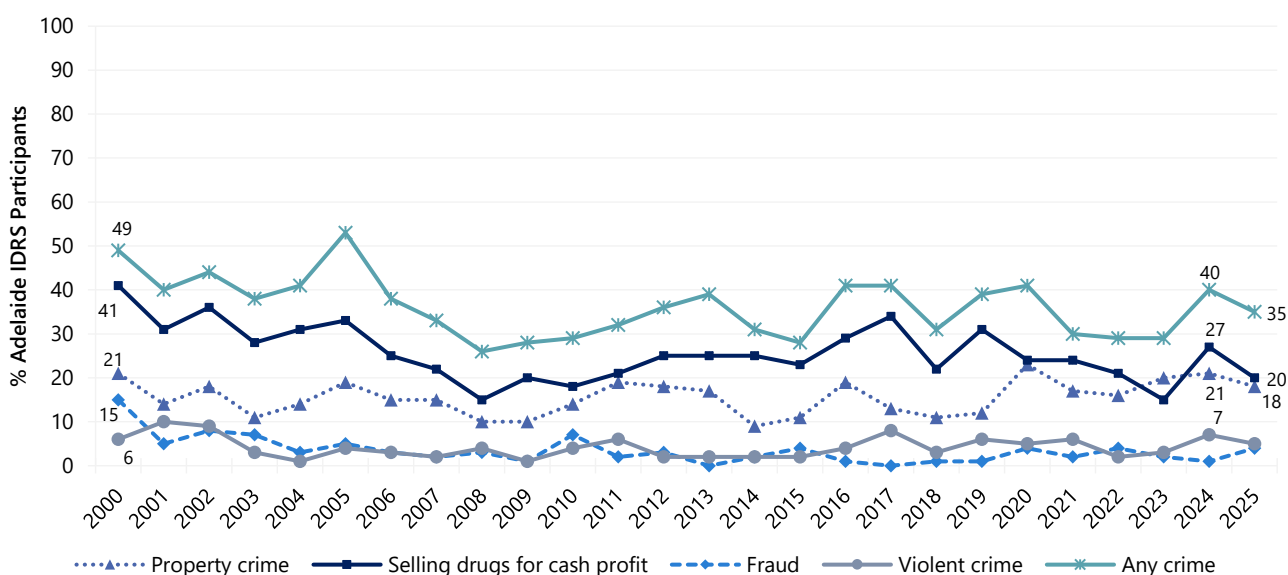
2024;  $p=0.009$ ). Additionally, 29% reported being stopped and issued a drug diversion (11% in 2024;  $p=0.102$ ), and one quarter (25%) reported being stopped and issued with a fine/infringement notice (29% in 2024;  $p=0.777$ ).

In 2025, one fifth (20%) of the Adelaide sample had been arrested in the past year, stable relative to 2024 (25%;  $p=0.405$ ) (Figure 44). Few participants ( $n \leq 5$ ) were able to comment on reasons for past 12 month arrest, therefore, these data are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information ([drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)).

In 2025, 6% of the sample had been convicted of a drug-related offence in the past year (8% in 2024;  $p=0.780$ ), and 8% had been sentenced to a community corrections order (11% in 2024;  $p=0.475$ ).

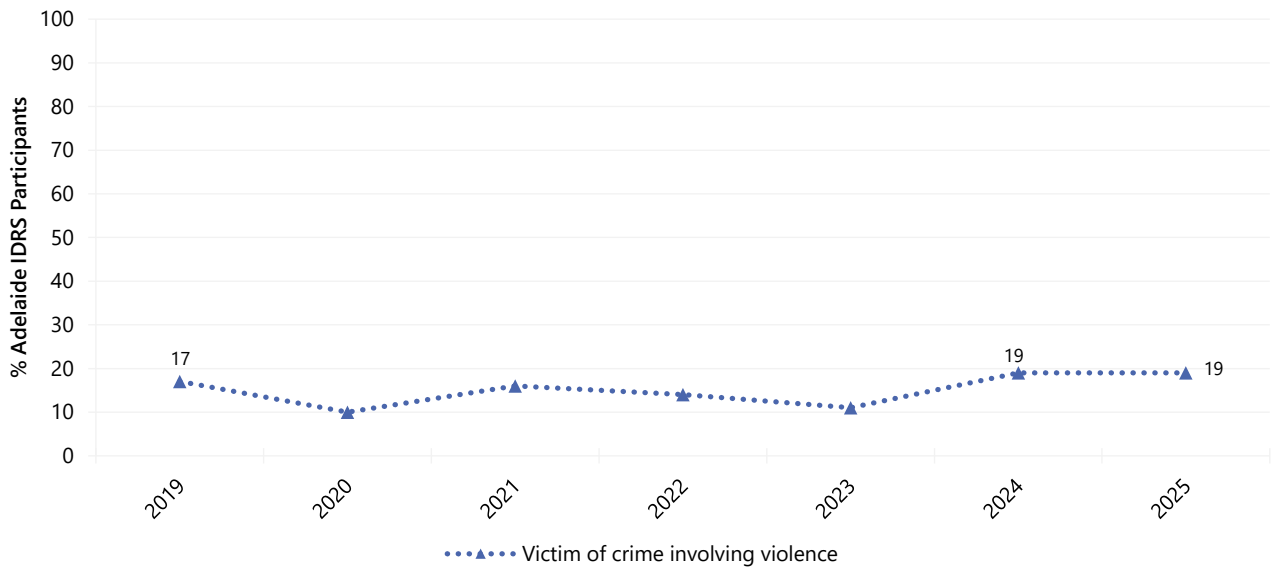
Fifty-four per cent of the Adelaide sample reported a lifetime prison history in 2025, stable relative to 2024 (57%;  $p=0.778$ ) (Figure 44).

Figure 42: Self-reported criminal activity in the past month, Adelaide, SA, 2000-2025



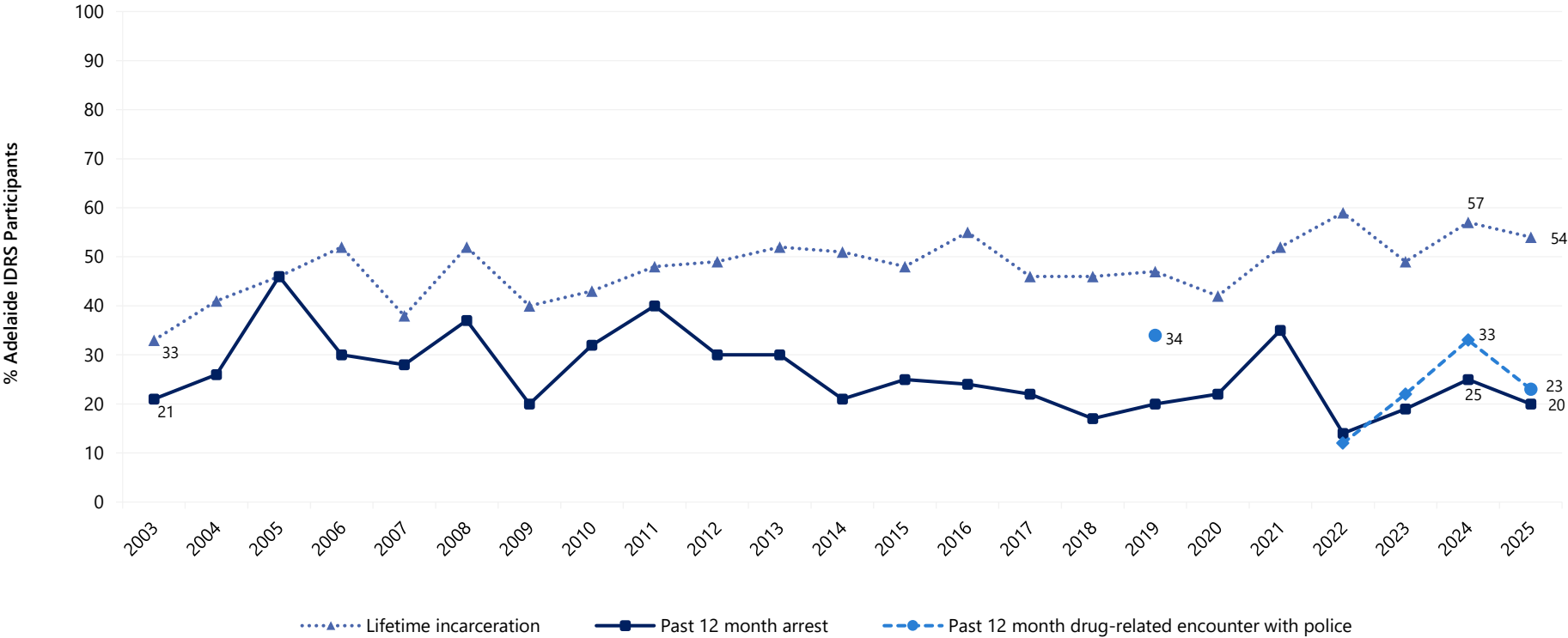
Note. 'Any crime' comprises the per cent who report any property crime, drug dealing, fraud and/or violent crime in the past month. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but 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 43: Victim of crime involving violence in the past month, Adelaide, SA, 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.,  $n \leq 5$  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 44: Lifetime incarceration, and past 12 month arrest and drug-related encounters with police that did not result in arrest, Adelaide, SA, 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 popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (74%), a significant decrease relative to 2024 (88%;  $p=0.015$ ), followed by phone call (50%; 59% in 2024;  $p=0.266$ ) and text messaging (28%; 39% in 2024;  $p=0.113$ ) (Table 15). Seven per cent reported arranging the purchase of illicit or non-prescribed drugs via social networking or messaging applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (9% in 2024;  $p=0.793$ ). 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.

Table 15: Purchasing approaches in the past 12 months, Adelaide, SA, 2022-2025

	2022	2023	2024	2025
<b>% Purchasing approaches in the last 12 months<sup>^#</sup></b>	N=102	N=102	N=105	<b>N=103</b>
Face-to-face	86	89	88	<b>74*</b>
Surface web	-	-	0	-
Darknet market	-	0	-	<b>0</b>
Social networking or messaging applications`	15	9	9	<b>7</b>
Text messaging	56	49	39	<b>28</b>
Phone call	74	68	59	<b>50</b>
Grew/made my own	/	/	-	<b>0</b>
Other	/	/	0	<b>0</b>

Note. <sup>^</sup> participants could endorse multiple responses. <sup>#</sup>This refers to people *arranging the purchase* of illicit or non-prescribed drugs. <sup>`</sup> 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.' 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.