EDRS

TASMANIAN DRUG TRENDS 2025

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

TASMANIAN DRUG TRENDS 2025: KEY FINDINGS FROM THE ECSTASY AND RELATED DRUGS REPORTING SYSTEM (EDRS) 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: Raimondo.Bruno@utas.edu.au or drugtrends@unsw.edu.au

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Acknowledgements

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Research Team

The National Drug and Alcohol Research Centre (NDARC), University of New South Wales (UNSW) Sydney, coordinated the EDRS. The following researchers and research institutions contributed to the EDRS in 2025:

- Dr Rachel Sutherland, Antonia Karlsson, Julia Uporova, Olivia Price, Udesha Chandrasena, Haniene Tayeb, Lily Palmer, Agata Chrzanowska, Cate King, Professor Louisa Degenhardt, Professor Michael Farrell and Associate Professor Amy Peacock, National Drug and Alcohol Research Centre, University of New South Wales, New South Wales;
- Mila Sumner, Joanna Wilson and Professor Paul Dietze, Burnet, Victoria;
- Sophie Radke and Professor Raimondo Bruno, School of Psychological Sciences, University of Tasmania, Tasmania;
- Dr Jodie Grigg and Professor Simon Lenton, National Drug Research Institute and enAble Institute, Curtin University, Western Australia; and
- Catherine Daly, Dr Jennifer Juckel, Dr Natalie Thomas and Associate Professor Caroline Salom, Institute for Social Science Research, The University of Queensland, Queensland.

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

Participants

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

Contributors

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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

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

SSDP	Students for Sensible Drug Policy
STI	Sexually Transmitted Infection
THC	Tetrahydrocannabinol
UNSW	University of New South Wales
WA	Western Australia
WHO	World Health Organization

Executive Summary

The Hobart Tasmania (TAS) EDRS comprises a sentinel sample of people who regularly use ecstasy and/or other illicit stimulants, recruited via social media and word-of mouth in Hobart, TAS. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2025 from April-July. Interviews from 2020 onwards were delivered face-to-face as well as via telephone; 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 EDRS sample (N=68) recruited from Hobart, Tasmania, was similar to the sample in 2024 and in previous years. Gender remained stable between 2024 and 2025, with 56% identifying as male (52% in 2024), and participants had a median age of 28 years (25 years in 2024). One quarter (24%) were current students (31% in 2024), with almost three quarters (72%) holding post-school qualifications (57% in 2024). One fifth (21%) of the sample were employed full-time (19% in 2024) and 29% were employed on a part-time/casual basis (40% in 2024). Drug of choice and drug used most often remained stable with 31% nominating ecstasy as their drug of choice (36% in 2024), and 28% nominating cannabis as the drug used most often in the month preceding interview (28% in 2024).

Non-Prescribed Ecstasy

Recent use of any non-prescribed ecstasy in the six months prior to interview remained stable in 2025 (91%), relative to 2024 (91%). In 2025, recent use of ecstasy pills (60%), capsules (43%), crystal (53%) and powder (29%) all remained stable from 2024. Swallowing remained the most common route of administration for pills (90%), capsules (90%) and crystal (72%), with snorting remaining the most common route for powder (85%). In 2025, there was a significant decrease in the price of capsules ($25; $30 in 2024; p=0.024), and for a point of crystal ($30; $90 in 2024; p=0.034). The price of pills and powder remained stable between 2024 and 2025, as did the perceived purity and availability of all forms of non-prescribed ecstasy.

Methamphetamine

Half (52%) of the Hobart sample reported recent use of any methamphetamine, stable relative to 2024 (40%). Participants reported a median of 48 days of use in 2025 (24 days in 2024), and three fifths (63%) reported weekly or more frequent use (51% in 2024). While these changes did not meet criteria for statistical significance, all three trends were consistently pointing toward increasing use. The majority (71%) of participants reported methamphetamine crystal (66% in 2024) as the form of methamphetamine recently used, with the greatest percentage (81%) reporting methamphetamine crystal to be 'very easy' to obtain (74% in 2024). The perceived price, purity and availability for all forms of methamphetamine remained stable between 2024 and 2025.

Non-Prescribed Pharmaceutical Stimulants

The per cent of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, modafinil, methylphenidate) use has generally increased since the commencement of monitoring, from 19% in 2007 to 37% in 2025 (36% in 2024), signifying the second highest percentage of use since monitoring commenced. Frequency of use remained stable, with participants reporting a median of six days in 2025 (6 days in 2024).

Cocaine

Use of cocaine has increased over the course of monitoring. In 2025, three quarters (75%) reported recent use, stable from 77% in 2024. Powder cocaine remained the most commonly reported form used (94%; 97% in 2024), with snorting remaining the most common route of administration (92%; 97% in 2024). Perceived price, purity and availability of cocaine remained stable between 2024 and 2025.

Cannabis and Related Products

Recent use of non-prescribed cannabis and/or cannabinoid-related products remained stable in 2025 (72%), relative to 2024 (69%). Forty-five per cent of those who had recently used non-prescribed cannabis and/or cannabinoid-related products reported daily use (32% in 2024). Hydroponic cannabis was the most used form of non-prescribed cannabis in 2025 (73%; 75% in 2024), followed by bush cannabis (61%; 68% in 2024). Price per ounce of hydroponic cannabis decreased significantly in 2025 ($265; $300 in 2024; p=0.046), with price remaining stable for all other measures of hydroponic and bush cannabis. The availability of bush cannabis significantly differed between 2024 and 2025, with four fifths (80%) reporting bush to be 'very easy' to obtain (45% in 2024; p=0.008). All participants reported hydroponic cannabis as being 'very easy' or 'easy' to obtain in 2025.

Ketamine, LSD and DMT

The per cent of participants reporting recent use of non-prescribed ketamine remained stable in 2025 (40%; 30% in 2024), with frequency of use remaining stable at a median of 3 days. Perceived purity of ketamine differed significantly between 2024 and 2025, with 88% perceiving purity to be 'high' (40% in 2024). Recent use of LSD (40%; 32% in 2024) and DMT (13%; 13% in 2024) remained stable in 2025. Perceived price, purity and availability of non-prescribed ketamine and LSD remained stable between 2024 and 2025.

New Psychoactive Substances (NPS)

Use of any NPS (including plant-based NPS) has remained low in recent years. In 2025, one tenth (10%) reported recent use (n≤5 in 2022, 2023 and 2024), the highest per cent reporting since 2021.

Other Drugs

Most other drugs remained stable between 2024 and 2025. Recent alcohol (88%; 92% in 2024) and tobacco (76%; 77% in 2024) use remained high and stable. Three fifths (63%) of participants who had recently used tobacco reported daily use (57% in 2024). Forty-seven per cent reported recent use of smoked or non-smoked illicit tobacco products in 2025, a significant increase relative to 2024 (25%; p=0.006).

Three fifths of the sample (60%) reported using illicit e-cigarettes in 2025 (57% in 2024), the highest percentage observed since the commencement of monitoring. A median frequency of 180 days of illicit use was reported in 2025, a significant increase from 66 days in 2024 (p=0.018). Fifty-four per cent of participants who had recently used illicit e-cigarettes reported daily use, stable relative to 40% in 2024.

Drug-Related Harms and Other Behaviours

Polysubstance use and bingeing

Four fifths (79%) of the Hobart sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use, most commonly combining stimulants and depressants (31%).

Almost half (48%) of participants reported using stimulants for 48 hours or more continuously without sleep in the six months

preceding interview, the highest percentage since monitoring commenced.

Dependence, overdose and injecting

Seventy-three per cent of the sample obtained an AUDIT score indicative of hazardous alcohol use (8+; 84% in 2024).

One fifth (20%) of those recently using ecstasy use obtained an SDS indicative of risk of dependence (3+: 22% in 2024); while 36% of those who recently used methamphetamine reported scores in this range (4+; 52% in 2024).

Past year reports of non-fatal stimulant (25%; 35% in 2024) and depressant overdose (21%; 31% in 2024) remained stable in 2025.

One tenth (11%) reported they had injected a drug in the past month, a significant increase from 2024 (n≤5 in 2024; p=0.022).

Drug checking and naloxone awareness

Thirty-six per cent of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in the past year, stable from 24% in 2024, all via a personal testing kit.

In 2025, 63% reported that they had ever heard of naloxone (62% in 2024), of which 90% were able to correctly identify the purpose of naloxone (96% in 2024). Forty-four per cent of participants reported obtaining naloxone in their lifetime, a significant increase from 20% in 2024 (p=0.015), with 39% having obtained in the past 12 months, also a significant increase (n≤5 in 2024; p=0.001).

Sexual activity, mental health and health service access

Almost three quarters (73%) of the Hobart sample reported engaging in some form of sexual activity in the past four weeks (72% in 2024), of which 80% reported using alcohol and/or other drugs prior to or while engaging in sexual activity (78% in 2024). Sixteen per cent reported that their use of alcohol and/or other drugs impaired their ability to negotiate their wishes during sex (10% in 2024).

Fifty-four per cent of participants reported experiencing a mental health problem in the preceding six months (64% in 2024), with anxiety (69%) and depression (51%) most commonly reported. There was a significant decrease of participants who reported experiencing attention deficit/hyperactivity disorder (ADHD), with 20% reporting ADHD as a mental health problem in 2025 (38% in 2024; p=0.038). One fifth (20%) of the sample reported a score of 30 or more on the K10, indicative of 'very high' psychological distress.

One fifth (22%) of participants reported accessing any health service for alcohol and/or drug support in the six months preceding interview, stable relative to 36% in 2024. Few participants (n≤5) reported they were currently engaging in drug treatment (10% in 2024).

Driving, contact with police and modes of purchasing drugs

Among recent drivers, one quarter (16%) reported driving while over the perceived legal limit of alcohol (15% in 2024), and 51% reported driving within three hours of consuming an illicit or non-prescribed drug in the six months preceding interview (37% in 2024).

Twelve per cent of participants reported being arrested in the past 12 months, with 24% reporting a drug-related encounter with police which did not result in arrest.

Face-to-face remained the most common way in which participants arranged the purchase of illicit or non-prescribed drugs in the 12 months preceding interview (65%; 73% in 2024). Two thirds (66%) of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2025, stable from 77% in 2024.

2025 SAMPLE CHARACTERISTICS

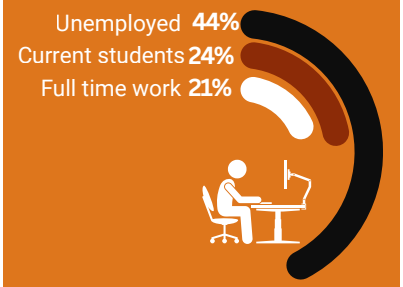
EDRS Ecstasy and Related Drugs Reporting System

Between April and June, 68 participants, recruited from Hobart, Tasmania, were interviewed.

28 years

Male

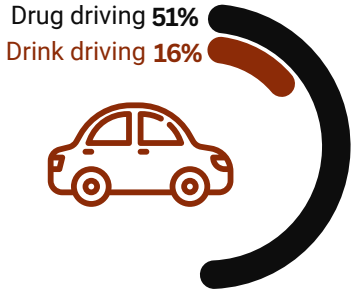
Median age and per cent who identified as male.



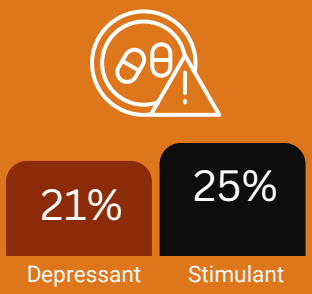
Current student and employment status.

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

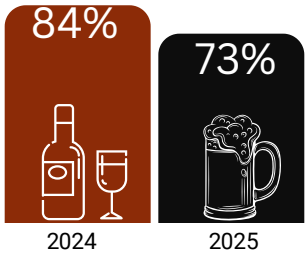
DRUG-RELATED HARMS AND RISKS



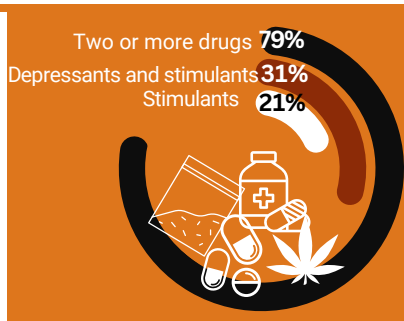
Among recent drivers, 51% reported driving a vehicle within 3 hours of consuming illicit drugs and 16% while over the legal limit of alcohol.



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

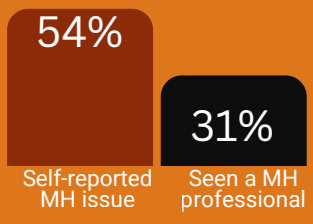


Percentage who obtained an AUDIT score of 8 or more, indicative of past year hazardous alcohol use.

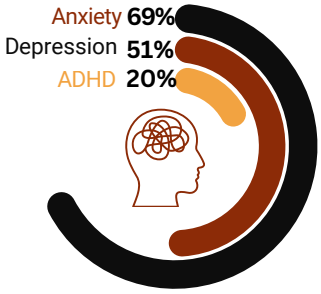


In 2025, 79% reported using two or more drugs on the last occasion of ecstasy or related drug use: the most commonly used combination of drug classes was depressants and stimulants (31%).

OTHER BEHAVIOURS

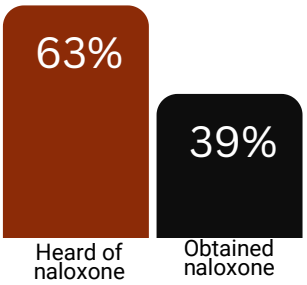


Percentage who self-reported mental health (MH) problems and treatment seeking in the six months preceding interview.



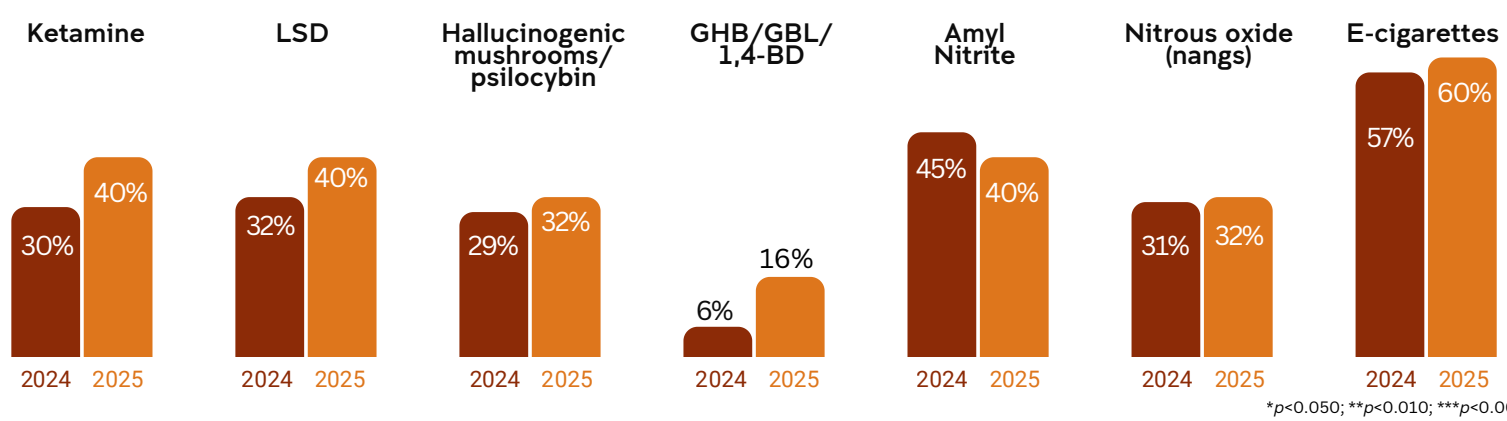
Among those who reported a mental health problem, the three most common mental health issues were anxiety, depression and ADHD.

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



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

PAST 6 MONTH USE OF SELECT DRUGS

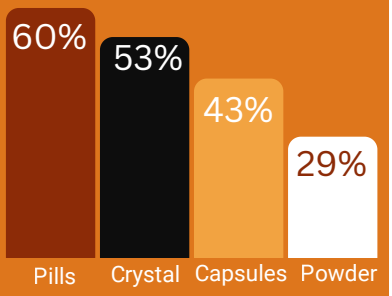


*p<0.050; **p<0.010; ***p<0.001.

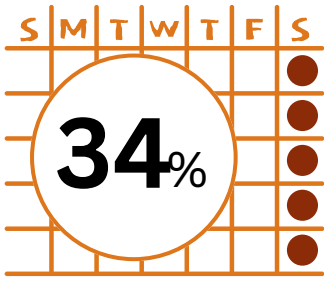
ECSTASY

EDRS Ecstasy and Related Drugs Reporting System

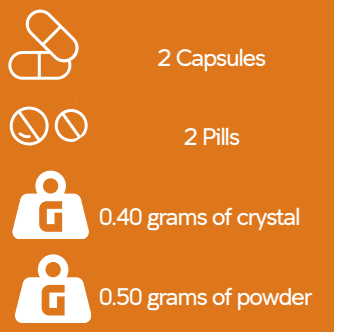
FORM of ecstasy



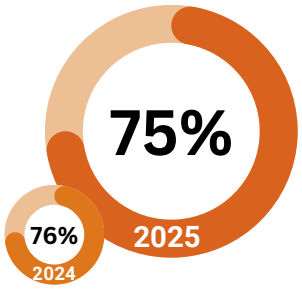
Past 6 month use of ecstasy capsules, crystal, pills and powder in 2025.



Of those who had recently used any ecstasy, 34% reported weekly or more frequent use, stable from 2024 (22%).



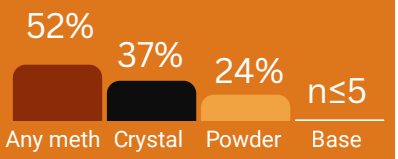
Median amounts of ecstasy consumed in a 'typical' session.



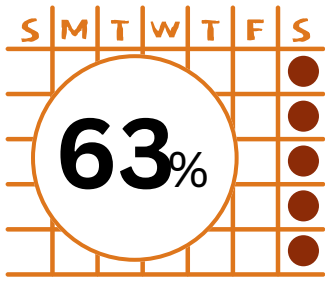
Percentage who perceived ecstasy pills as being 'easy' or 'very easy' to obtain.

METHAMPHETAMINE

FORM of methamphetamine

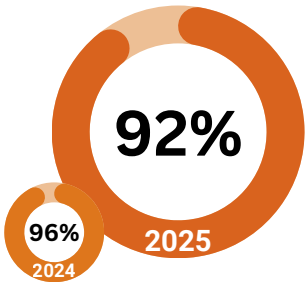


Past 6 month use of any methamphetamine, crystal, powder and base in 2025.



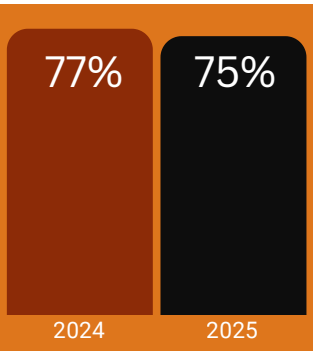
Of those who had recently used any methamphetamine, 63% reported weekly or more frequent use, stable from 2024 (51%).

The median reported price for a point of methamphetamine crystal.

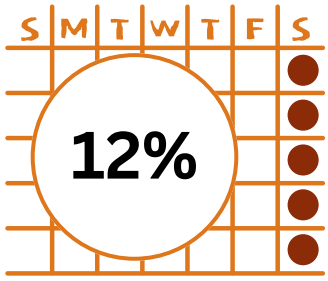


Percentage who perceived methamphetamine crystal as being 'easy' or 'very easy' to obtain.

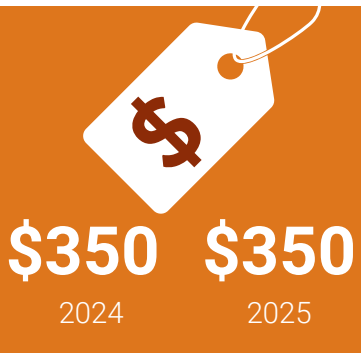
COCAINE



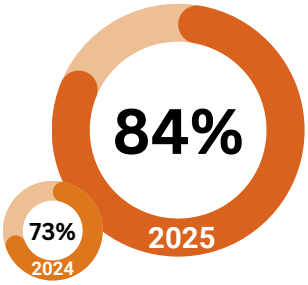
Past 6 month use of any cocaine remained stable between 2024 and 2025.



Of those who had recently consumed cocaine, 12% reported weekly or more frequent use, stable from 2024 (7%).

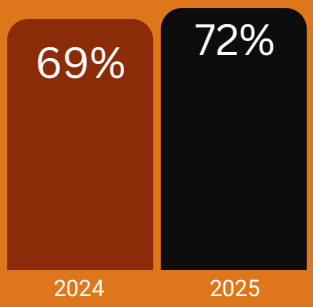


The median reported price for one gram of cocaine.

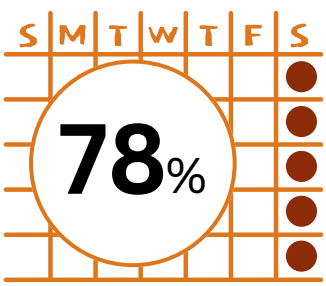


Percentage who perceived cocaine as being 'easy' or 'very easy' to obtain.

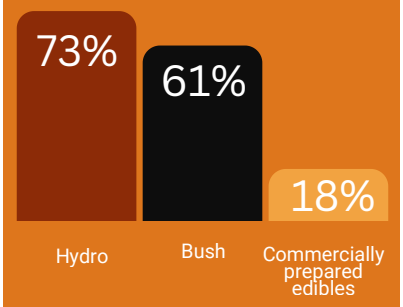
CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS



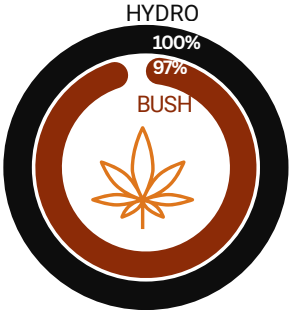
Past 6 month use of non-prescribed cannabis and/or cannabinoid-related products was stable between 2024 and 2025.



Of those who had recently used non-prescribed cannabis, 78% reported weekly or more frequent use, stable from 2024 (68%).



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



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

Background

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

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

Methods

EDRS 2003-2019

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

EDRS 2020-2025: COVID-19 Impacts on Recruitment and Data Collection

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

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

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

2025 EDRS Sample

Between 8 April – 13 July 2025, a total of 690 participants were recruited across capital cities nationally, with 68 participants interviewed in Hobart, TAS between 8 April and 15 July 2025 (n=87 in 2024). A total of 62 interviews (91%) were conducted via telephone (n=76 in 2024; 87%), the remainder were conducted face-to-face.

Fifteen per cent of the 2025 Hobart sample completed the interview in 2024, and 13% of the 2024 Hobart sample completed the interview in 2023 (p=0.807). Recruitment methods remained stable, relative to 2024, with three quarters (72%) recruited via the internet (e.g., Facebook and Instagram) (70% in 2024), and 25% recruited via word-of-mouth (23% in 2024). Few participants (n≤5) reported 'other' recruitment methods (n≤5 in 2024).

Data Analysis

For normally distributed continuous variables, means and standard deviations (SD) are reported; for skewed data (i.e., skewness > ±1 or kurtosis > ±3), medians and interquartile ranges (IQR) are reported. Tests of statistical significance have been conducted between estimates for 2024 and 2025, noting that no corrections for multiple comparisons have been made and thus comparisons should be treated with caution. References to significant differences throughout the report are where statistical testing has been conducted and where the p-value is less than 0.050. Values where cell sizes are ≤5 have been suppressed with corresponding notation (zero values are reported). References to 'recent' use and behaviours refers to the six months preceding interview. The response options 'Don't know' and 'Skip question', which were available to select throughout the interview, 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≤5 but not 0) (for tables)
	Missing data points indicate question not asked in respective year or n≤5 answered the question (for figures)
***p*<0.050; ***p*<0.010; ****p*<0.001**	Statistical significance between 2024 and 2025

Interpretation of Findings

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

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

Additional Outputs

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

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

1

Sample Characteristics

In 2025, the Hobart EDRS sample was mostly similar to the sample in 2024 and in previous years (Table 2).

Gender remained stable between 2024 and 2025 (p=0.579), with 56% of the sample identifying as male (52% in 2024). The median age of the sample was 28 years (IQR=21-40), stable relative to 2024 (25 years; IQR=21-35; p=0.243).

Participants reported a mean of 11 years of school in 2025 (range: 10-12), stable from 11 years in 2024 (range: 7-12; p=0.579). One quarter (24%) of participants were current students, stable relative to 2024 (31%; p=0.366), and almost three quarters (72%) had obtained a post-school qualification(s) (57% in 2024; p=0.069).

Current employment status remained stable between 2024 and 2025 (p=0.573). Specifically, one fifth (21%) reported being employed full-time (19% in 2024), with 29% being employed on a part time/casual basis (40% in 2024), and 44% being unemployed at the time of interview (35% in 2024).

Accommodation remained stable between 2024 and 2025 (p=0.646), with the majority of participants (46%) reporting residing in a rented house/flat in 2025 (49% in 2024), followed by 22% reporting residing with their parents/in their family house (24% in 2024) and 16% residing in a rented house/flat (8% in 2024).

Table 2: Demographic characteristics of the sample, nationally, 2025, and Hobart, TAS, 2021-2025

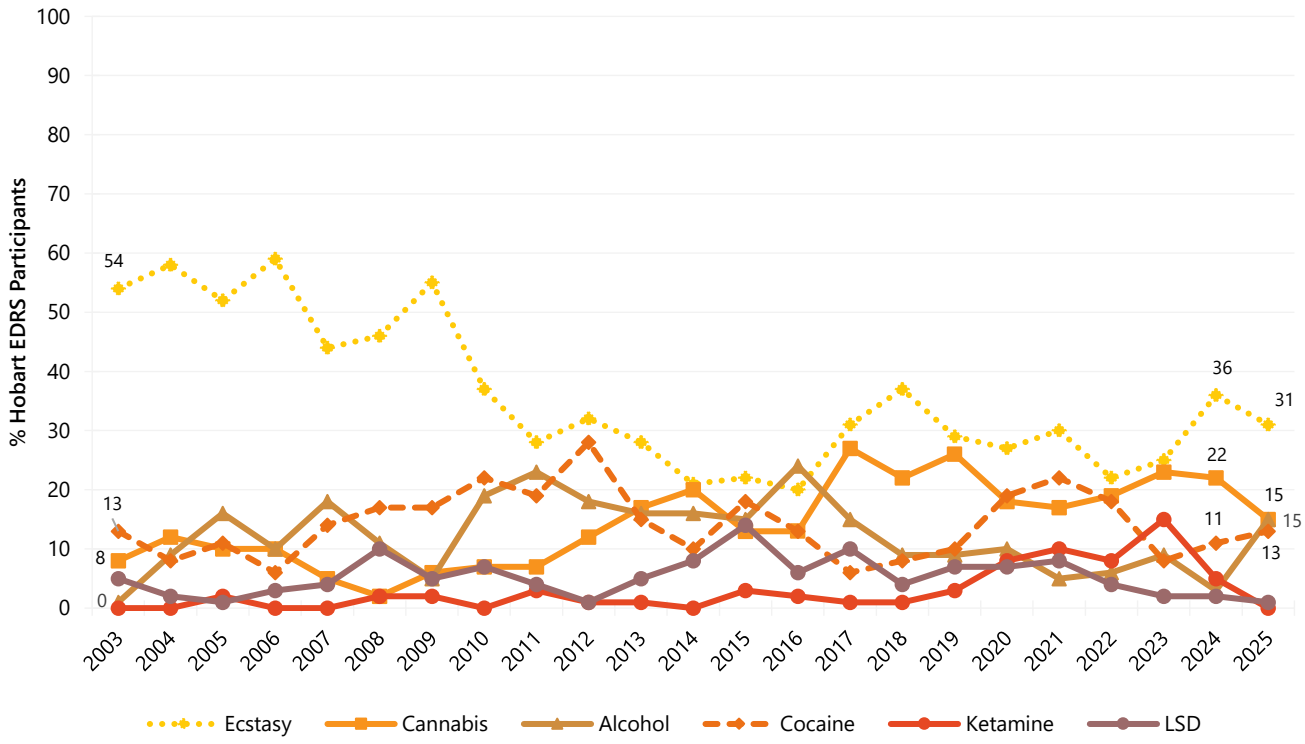
	Hobart, TAS					National
	2021 N=102	2022 N=72	2023 N=65	2024 N=87	2025 N=68	2025 N=690
Median age (years; IQR)	25 (22-30)	26 (22-30)	26 (21-33)	25 (21-35)	**28 (21-40)**	26 (20-34)
% Gender						
Female	36	44	43	46	**44**	41
Male	64	48	55	52	**56**	57
Non-binary	-	8	-	-	**0**	1
% Aboriginal and/or Torres Strait Islander	9	-	-	21	**24**	8
% Born in Australia	/	/	93	93	**97**	85
% English primary language spoken at home	/	/	98	100	**99**	97
% Sexual identity						
Heterosexual	77	72	80	71	**79**	72
Homosexual	-	-	-	6	**-**	6
Bisexual	11	18	12	21	**12**	17
Queer	6	7	-	0	**-**	4
Other identity	-	-	0	-	**-**	2
Mean years of school education (range)	12 (7-12)	11 (7-12)	12 (10-12)	11 (7-12)	**11 (10-12)**	12 (7-12)
% Post-school qualification(s)^	69	60	65	57	**72**	63
% Current students#	44	31	37	31	**24**	34
% Current employment status						
Full-time	29	28	26	19	**21**	29
Part-time/casual	43	38	43	40	**29**	39
Self-employed	-	7	-	6	**-**	5
Unemployed	24	28	28	35	**44**	28
Current median weekly income $ (IQR)	$500 (350-951)	$700 (350-1168)	$696 (426-1345)	$563 (385-838)	**$625 (375-1088)**	$700 (400-1350)
% Current accommodation						
Own house/flat	15	15	13	8	**16**	13
Rented house/flat	49	56	49	49	**46**	50
Parents'/family home	28	17	25	24	**22**	26
Boarding house/hostel	0	-	0	0	**-**	1
Public housing	-	0	-	8	**-**	5
No fixed address+	-	8	-	-	**-**	2
Other	-	-	-	6	**-**	2

Note. ^ Includes trade/technical and university qualifications. #'Current students' comprised participants who were currently studying for either trade/technical or university/college qualifications. + No fixed address included couch surfing and rough sleeping or squatting. Statistical significance for 2024 versus 2025 (Hobart) presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Drug of choice remained stable between 2024 and 2025 (p=0.171), with almost one third (31%) nominating ecstasy as their drug of choice in 2025 (36% in 2024), followed by 15% nominating cannabis as their drug of choice (22% in 2024), 15% nominating alcohol (n≤5 in 2024) and 13% nominating cocaine (11% in 2024) (Figure 1). The drug used most often in the past month also remained stable between 2024 and 2025 (p=0.499), with one quarter each reporting cannabis (28%) and alcohol (24%) as the drug used most often (28% and 13% in 2024, respectively), and one fifth (19%) reporting ecstasy as the drug used most often (Figure 2).

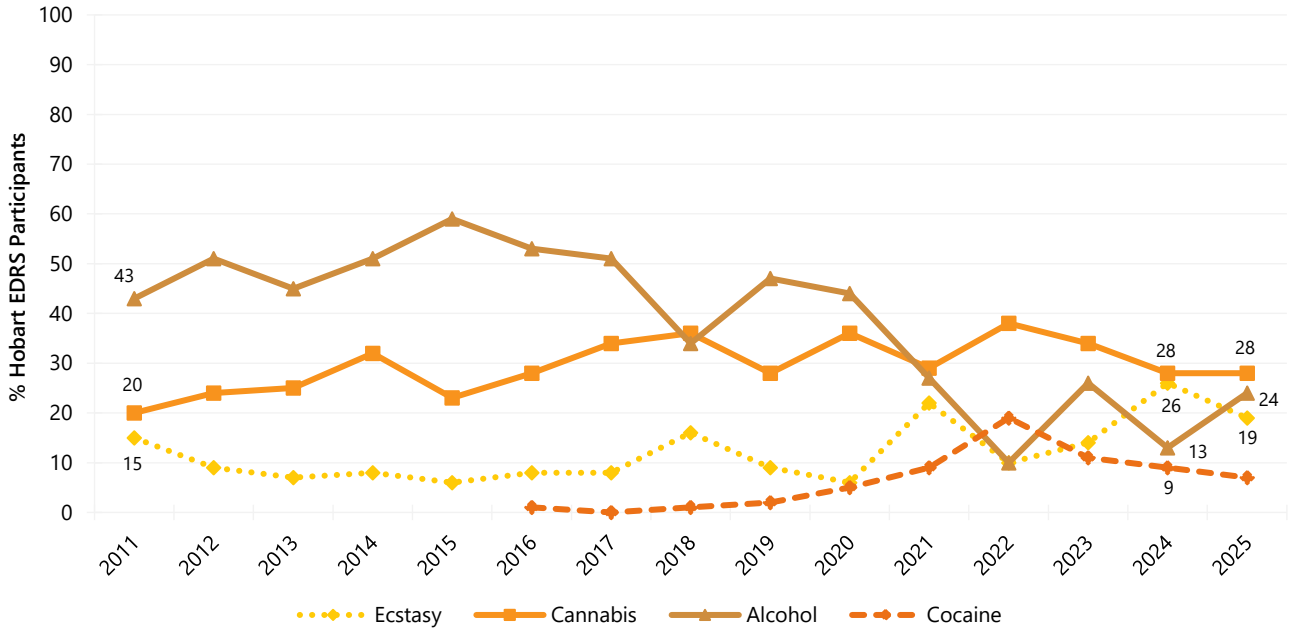
Weekly or more frequent use of various drugs remained stable between 2024 and 2025, with 56% of the Hobart sample reporting weekly or more frequent cannabis use (47% in 2024; p=0.336), and one third (33%) reporting weekly or more frequent methamphetamine use (21% in 2024; p=0.102). One third (31%) also reported weekly or more frequent use of ecstasy (20% in 2024; p=0.133), and one tenth (9%) reported weekly or more frequent use of cocaine (n≤5 in 2024) (Figure 3).

Figure 1: Drug of choice, Hobart, TAS, 2003-2025



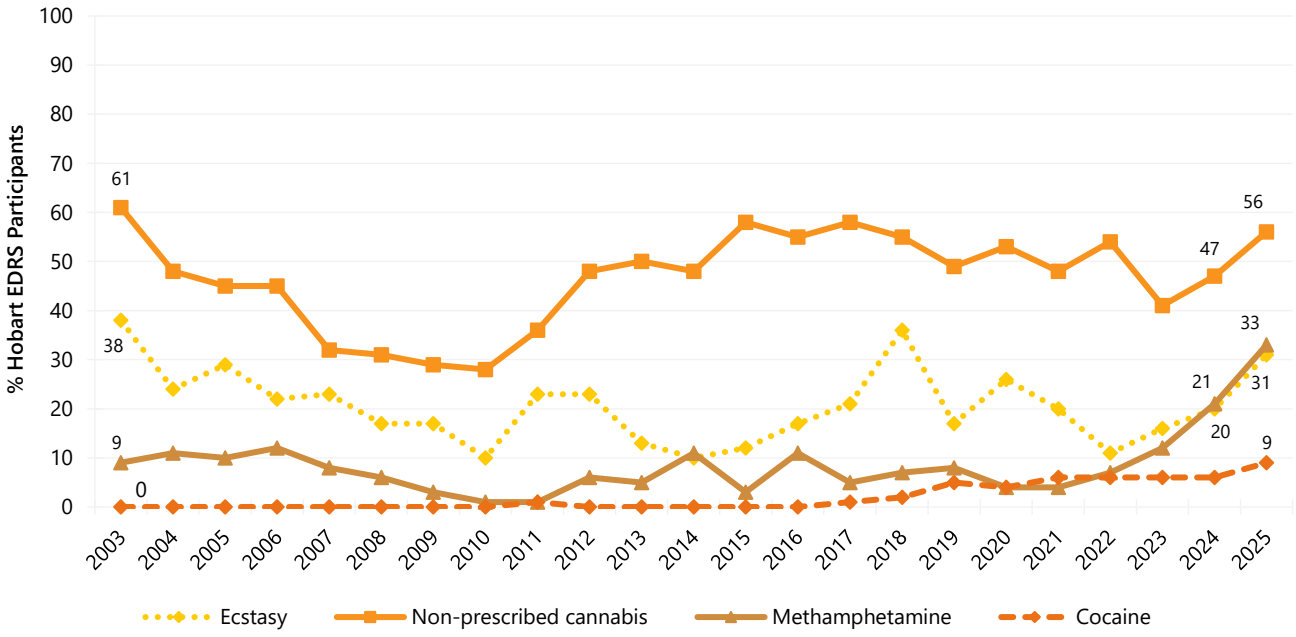
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; smaller percentages have endorsed other substances. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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 used most often in the past month, Hobart, TAS, 2011-2025



Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; smaller percentages have endorsed other substances. Data are only presented for 2011-2025 as this question was not asked in 2003-2010. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

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



Note. Computed from the entire sample regardless of whether they had used the substance in the past six months. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Further, from 2022, we captured use of 'cannabis and/or cannabinoid-related products', while in previous years questions referred only to 'cannabis'. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

2

Non-Prescribed Ecstasy

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

Patterns of Consumption (Any Ecstasy)

Recent Use (past 6 months)

Recent use of any non-prescribed ecstasy in the six months prior to interview remained stable in 2025, relative to 2024 (91%; 91% in 2024) (Figure 4). Pills (60%; 49% in 2024; p=0.204) were the most commonly used form of non-prescribed ecstasy in the six months preceding interview in 2025, followed by crystal (53%; 47% in 2024; p=0.520) and capsules (43%; 59% in 2024; p=0.056). Powder remained the least commonly used form of non-prescribed ecstasy (29%; 30% in 2024), consistent with the entirety of the reporting period.

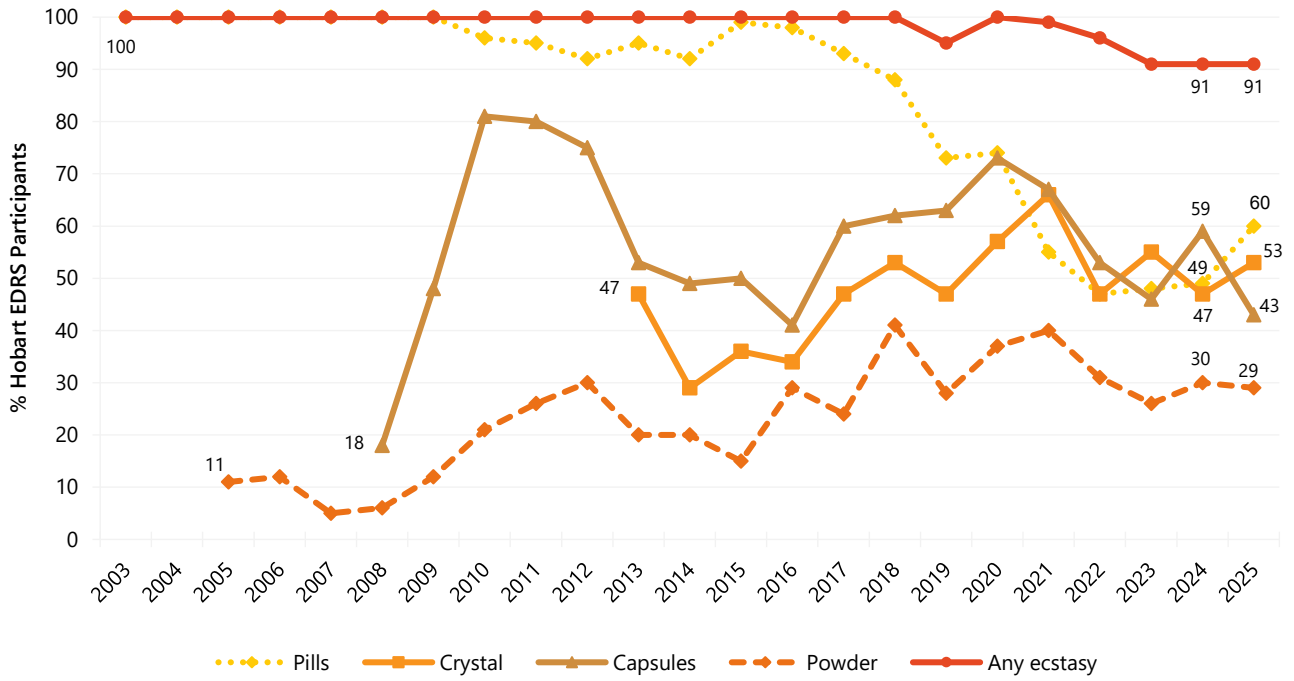
Frequency of Use

Among those who reported recent use of any non-prescribed ecstasy and commented (n=62), participants reported use (in any form) on a median of 14 days (IQR=6-24) in 2025, equivalent to fortnightly use in the preceding six months, and remaining stable relative to 2024 (11 days; IQR=5-20; n=78; p=0.181) (Figure 5). Among those who had recently used any non-prescribed ecstasy and commented (n=62), weekly or more frequent use of any form of ecstasy remained stable in 2025 relative to 2024 (34%; 22% in 2024; p=0.126).

Number of Forms Used

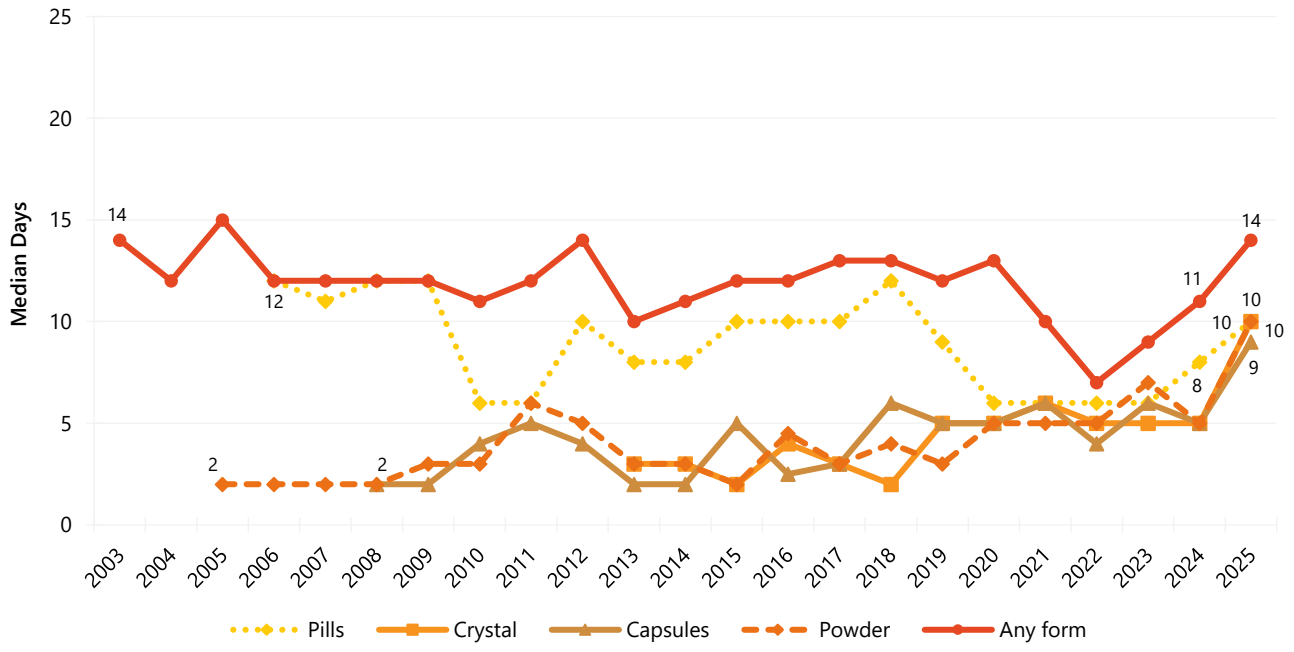
Among participants who had recently consumed non-prescribed ecstasy and commented in 2025 (n=62), the median number of forms of non-prescribed ecstasy used in the six months preceding interview was two (IQR=1-3), stable from 2024 (median 2 forms; IQR=1-3; n=79; p=0.999).

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



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

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



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Median days computed among those who reported past 6-month use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 25 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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)

Non-Prescribed Ecstasy Pills

Recent Use (past 6 months): Three fifths (60%) of participants reported recent use of non-prescribed ecstasy pills in 2025, stable relative to 2024 (49%; p=0.204), with the use of pills having considerably declined since 2016 (Figure 4).

Frequency of Use: Of those who had recently consumed non-prescribed ecstasy pills and commented (n=41), ecstasy pills were used on a median of ten days (IQR=4-20) in the six months preceding interview in 2025, stable relative to 2024 (8 days; IQR=4-19; n=43; p=0.593) (Figure 5). One quarter (24%) of those who had recently consumed ecstasy pills reported weekly or more frequent use in 2025, stable relative to 2024 (21%; p=0.794).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy pills and commented (n=41), the most common route of administration in 2025 was swallowing (90%; 95% in 2024; p=0.427), followed by snorting (37%; 44% in 2024; p=0.505), consistent with previous years. Few participants (n≤5) reported recent smoking or injecting as a route of administration (0% for both in 2024).

Quantity: Of those who reported recent use and responded (n=41), the median number of non-prescribed ecstasy pills used in a 'typical' session was two (IQR=1-2; 3 pills in 2024; IQR=1-3.3; n=43; p=0.478). Of those who reported recent use and responded (n=41), the median maximum number of pills used in a session was three (IQR=2-5; 3 pills in 2024; IQR=2-6; n=43; p=0.971).

Non-Prescribed Ecstasy Capsules

Recent Use (past 6 months): Two fifths (43%) of participants reported recent use of non-prescribed ecstasy capsules in 2025, stable from 59% in 2024 (p=0.056) (Figure 4).

Frequency of Use: Among those who reported recent use of non-prescribed ecstasy capsules and commented (n=29), participants reported use on a median of nine days in the six months preceding interview (IQR=5-20), stable relative to 2024 (5 days; IQR=4-12; n=51; p=0.170) (Figure 5). One fifth (21%) of participants who had recently consumed ecstasy capsules reported weekly or more frequent use in 2025 (12% in 2024; p=0.338).

Routes of Administration: Among those who had recently consumed non-prescribed ecstasy capsules and commented (n=29), the vast majority (90%) of participants reported swallowing as a route of administration (96% in 2024; p=0.347), and 28% reported snorting (29% in 2024). No participants reported smoking or injecting as a route of administration in 2024 and 2025.

Quantity: Of those who reported recent use and responded (n=29), the median number of non-prescribed ecstasy capsules used in a 'typical' session was two (IQR=1.5-2; 2 capsules in 2024; IQR=1-4; n=52; p=0.290). Of those who reported recent use and responded (n=28), the median maximum number of non-prescribed ecstasy capsules used in a session was three (IQR=2-5; 3 capsules in 2024; IQR=2-6; n=50; p=0.912).

Non-Prescribed Ecstasy Crystal

Recent Use (past 6 months): Fifty-three per cent of participants reported recent use of non-prescribed ecstasy crystal in 2025, stable relative to 2024 (47%; p=0.520) (Figure 4).

Frequency of Use: Among those who reported recent use and commented (n=36),

participants reported using non-prescribed ecstasy crystal on a median of ten days (IQR=3-20) in the six months preceding interview, stable from five days in 2024 (IQR=2-12; n=41; *p*=0.115) (Figure 5). One fifth (22%) of participants who had recently consumed crystal reported weekly or more frequent use in 2025 (17% in 2024; *p*=0.774).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy crystal and commented (n=36), three quarters (72%) reported swallowing as a route of administration (80% in 2024; *p*=0.430), whilst 56% reported snorting (46% in 2024; *p*=0.487). Few participants (n≤5) reported smoking or injecting as a route of administration (n≤5 and 0% in 2024, respectively).

Quantity: Of those who reported recent use and responded (n=33), the median amount of non-prescribed ecstasy crystal used in a 'typical' session was 0.40 grams (IQR=0.20-0.50; 0.50 grams in 2024; IQR=0.40-1.00; n=33; *p*=0.291). Of those who reported recent use and responded (n=34), the median maximum amount of non-prescribed ecstasy crystal used in a session was one gram (IQR=0.50-1.88; 1.00 gram in 2024; IQR=0.50-1.00; n=32; *p*=0.510).

Non-Prescribed Ecstasy Powder

Recent Use (past 6 months): Twenty-nine per cent of participants reported recent use of non-prescribed ecstasy powder, stable relative to 30% in 2024 (Figure 4).

Frequency of Use: Amongst those who reported recent use and commented (n=20), participants reported consuming non-prescribed ecstasy powder on a median of ten days (IQR=4-18) in the six months preceding interview, stable from five days in 2024 (IQR=3-11; n=26; *p*=0.196) (Figure 5). Few participants (n≤5) who had recently consumed powder reported weekly or more frequent use in 2024 and 2025.

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy powder and commented (n=20), 85% reported snorting as a route of administration (92% in 2024; *p*=0.640), followed by two fifths (40%) who reported swallowing as a route of administration (42% in 2024).

Quantity: Of those who reported recent use and responded (n=15), the median amount of non-prescribed ecstasy powder used in a 'typical' session was 0.50 grams (IQR=0.50-1.00; 0.50 grams in 2024; IQR=0.20-1.00; n=20; *p*=0.174). Of those who reported recent use and responded (n=16), the median maximum amount of non-prescribed ecstasy powder used in a session was one gram (IQR=0.90-1.63), a significant increase from 0.50 grams in 2024 (IQR=0.40-1.00; n=21; *p*=0.037).

Price, Perceived Purity and Perceived Availability

Non-Prescribed Ecstasy Pills

Price: The median price reported of a non-prescribed ecstasy pill was $28 in 2025 (IQR=25-30; n=34), stable relative to $30 in 2024 (IQR=25-35; n=32; *p*=0.494) (Figure 6).

Perceived Purity: Among those who responded (n=44), the perceived purity of non-prescribed ecstasy pills remained stable between 2024 and 2025 (*p*=0.658). The largest percentage of participants reported perceived purity to be 'high' (32%; 36% in 2024), followed by one quarter (25%) reporting purity to be 'medium' and 'fluctuating' (23% and 16% in 2024, respectively). In contrast, almost one fifth (18%) reported 'low' purity (25% in 2024) (Figure 8).

Perceived Availability: The perceived availability of non-prescribed ecstasy pills remained stable between 2024 and 2025. Among those who responded in 2025 (n=44), half (50%) reported that pills were 'very easy' to obtain (49% in 2024), with a further one quarter (25%) reporting 'easy' obtainment (27% in 2024). In contrast, one fifth (20%) reported pills as being 'difficult' to obtain (18% in 2024). Few participants (n≤5) reported pills to be 'very difficult' to obtain in 2024 and 2025 (Figure 12).

Non-Prescribed Ecstasy Capsules

Price: The reported median price of a non-prescribed ecstasy capsule was $25 in 2025 (IQR=25-29; n=22), a significant decrease from $30 in 2024 (IQR=25-35; n=25; *p*=0.024) (Figure 6).

Perceived Purity: The perceived purity of non-prescribed ecstasy capsules remained stable between 2024 and 2025 (*p*=0.956). Among those who responded in 2025 (n=30), two fifths (40%) perceived purity to be 'high' (38% in 2024) and one quarter (27%) perceived purity to be 'medium' (24% in 2024). Conversely, 23% perceived purity to be 'fluctuating' (22% in 2024) (Figure 9).

Perceived Availability: The perceived availability of non-prescribed ecstasy capsules remained stable in 2025 (*p*=0.634). Among those who responded in 2025 (n=30), 47% reported that capsules were 'easy' to obtain (44% in 2024), and one third (30%) reported 'very easy' obtainment (38% in 2024). In contrast, 20% reported that capsules were 'difficult' to obtain (18% in 2024) (Figure 13).

Non-Prescribed Ecstasy Crystal

Price: The median price for a gram of non-prescribed ecstasy crystal remained stable in 2025 at $250 (IQR=150-288; n=22; $250 in 2024; IQR=188-285; n=31; *p*=0.884) (Figure 7). The median price for a point of crystal was $30 in 2025, a significant decrease from 2024 (n≤5; *p*=0.034).

Perceived Purity: The perceived purity of non-prescribed ecstasy crystal remained stable between 2024 and 2025 (*p*=0.526). Among those who responded in 2025 (n=42), two fifths (43%) perceived the purity of crystal to be 'high' (50% in 2024). Twenty-nine per cent perceived purity to be 'medium' (35% in 2024), and 17% perceived purity to be 'fluctuating' (n≤5 in 2024). Few participants (n≤5) perceived purity to be 'low' in 2024 and 2025 (Figure 10).

Perceived Availability: The perceived availability of non-prescribed ecstasy crystal remained stable between 2024 and 2025 (*p*=0.822). Among those who responded in 2025 (n=40), two fifths (38%) reported crystal as being 'easy' to obtain (34% in 2024), and a further 35% perceived crystal as being 'very easy' to obtain (45% in 2024). Conversely, one quarter (25%) reported crystal as being 'difficult' to obtain (18% in 2024) (Figure 14).

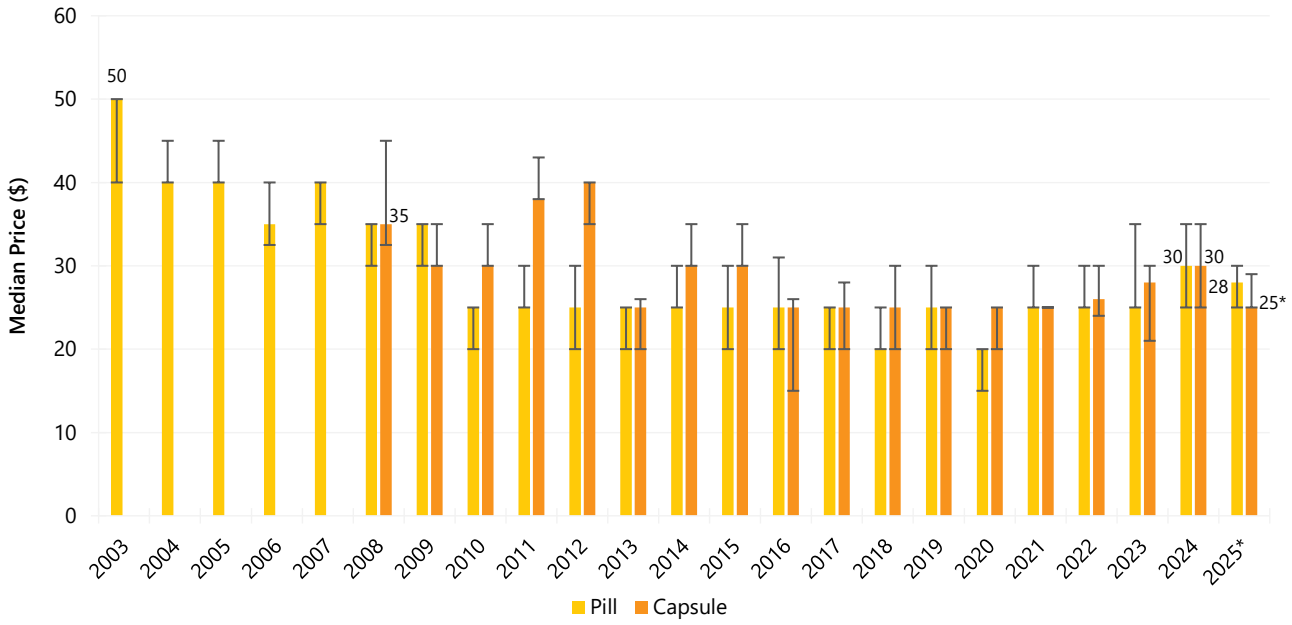
Non-Prescribed Ecstasy Powder

Price: The median price of a gram of non-prescribed ecstasy powder remained stable in 2025 ($225; IQR=138-263; n=8; $235 in 2024; IQR=138-263; n=8; *p*=0.958) (Figure 7).

Perceived Purity: The perceived purity of non-prescribed ecstasy powder remained stable between 2024 and 2025 (*p*=0.373). Few participants (n≤5) reported on individual levels of purity (e.g., 'low,' 'high'); therefore, further details are not reported (Figure 11).

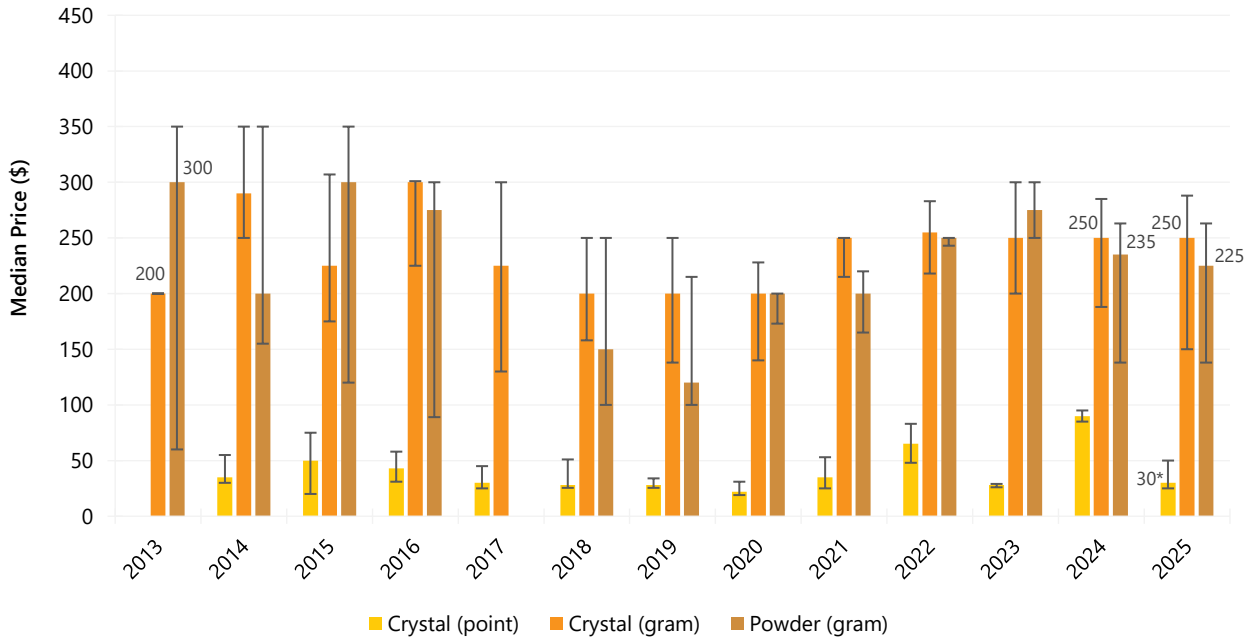
Perceived Availability: The perceived availability of non-prescribed ecstasy powder remained stable in 2025 (*p*=0.368). Among those who responded in 2025 (n=14), 43%) reported powder as being 'easy' to obtain (21% in 2024), and few participants (n≤5) reported powder as being 'very easy' to obtain (64% in 2024). (Figure 15).

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



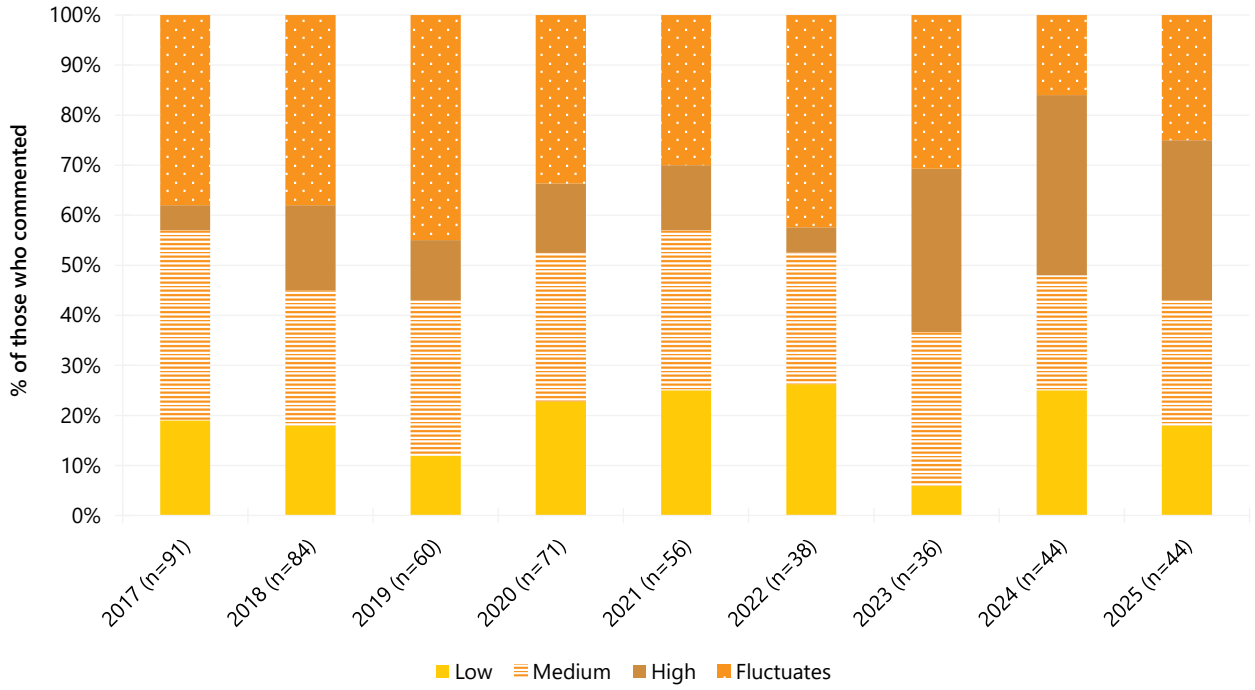
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where n≤5 responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010;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

Figure 7: Median price of non-prescribed ecstasy crystal (per point and gram) and powder (per gram only), Hobart, TAS, 2013-2025



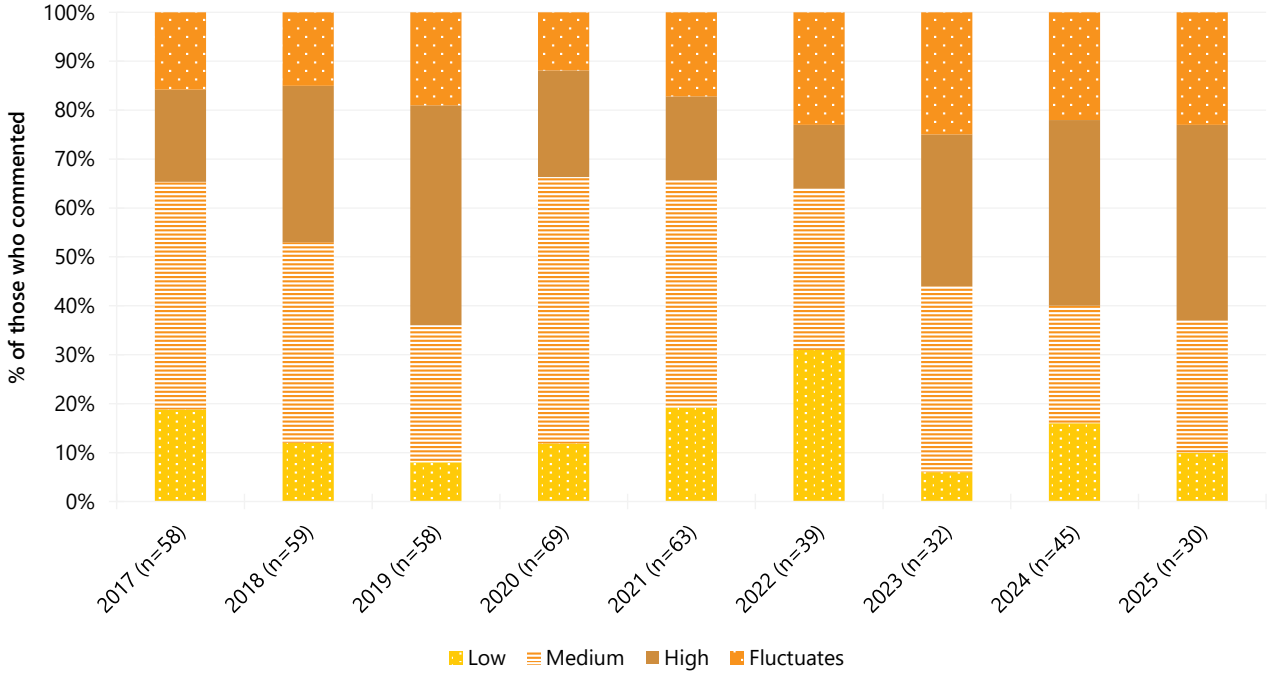
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) and ecstasy powder (gram) started in 2013. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where n≤5 responded. The error bars 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 8: Current perceived purity of non-prescribed ecstasy pills, Hobart, TAS, 2017-2025



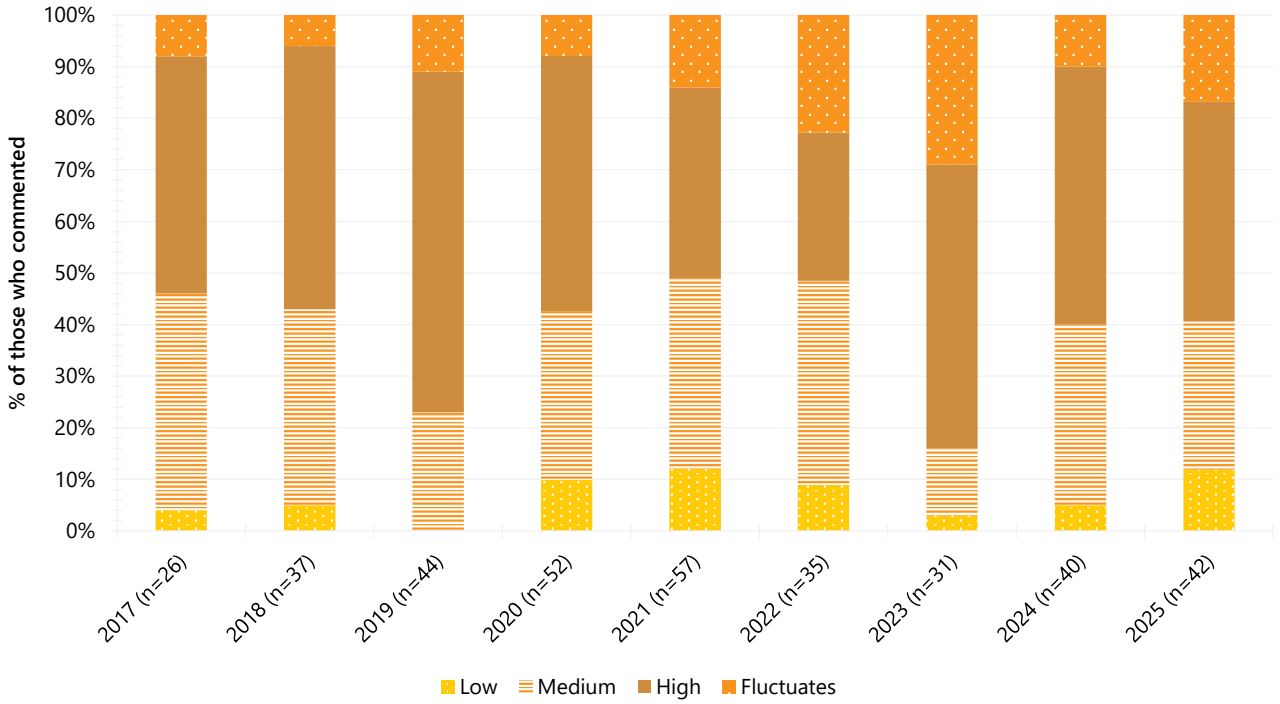
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure;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

Figure 9: Current perceived purity of non-prescribed ecstasy capsules, Hobart, TAS, 2017-2025



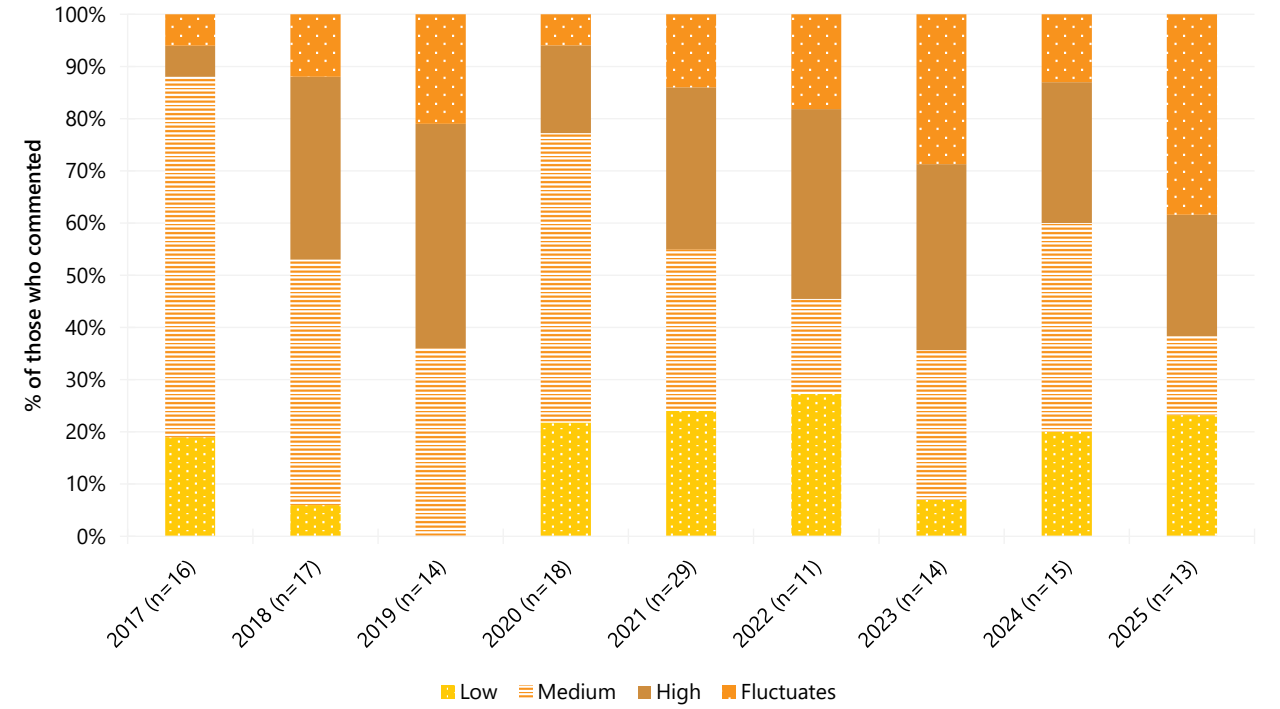
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure;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

Figure 10: Current perceived purity of non-prescribed ecstasy crystal, Hobart, TAS, 2017-2025



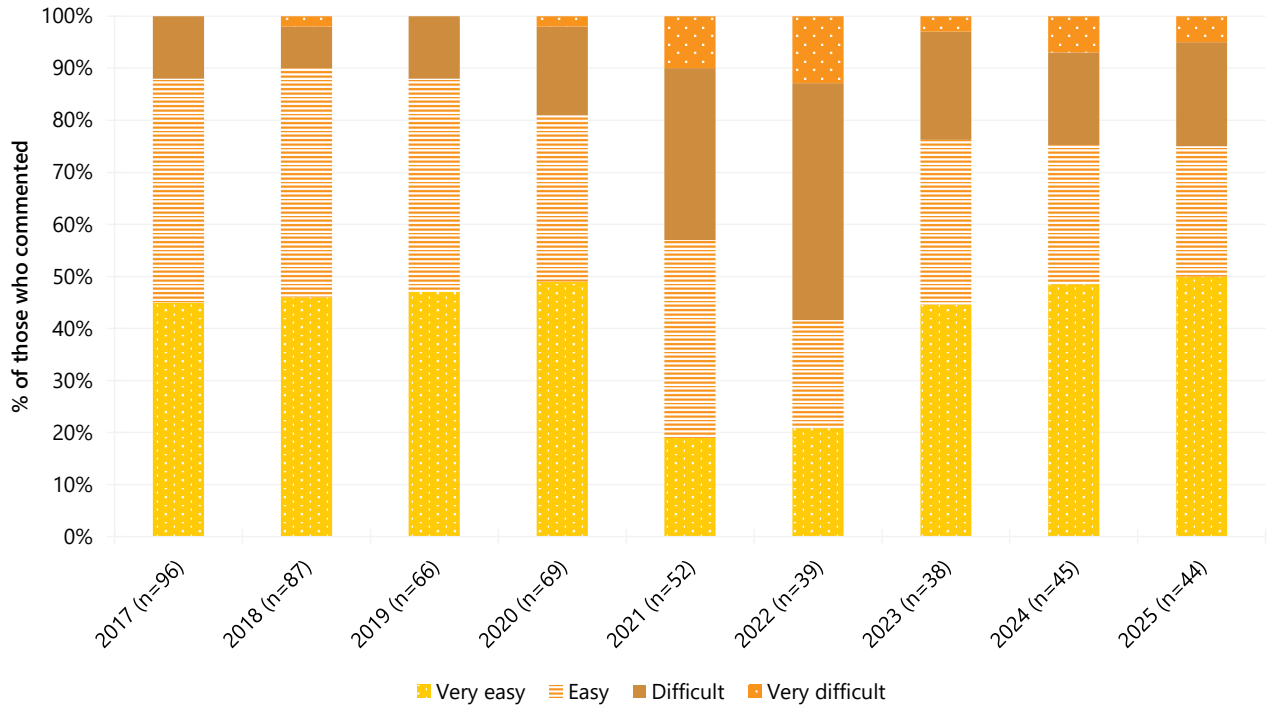
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure;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

Figure 11: Current perceived purity of non-prescribed ecstasy powder, Hobart, TAS, 2017-2025



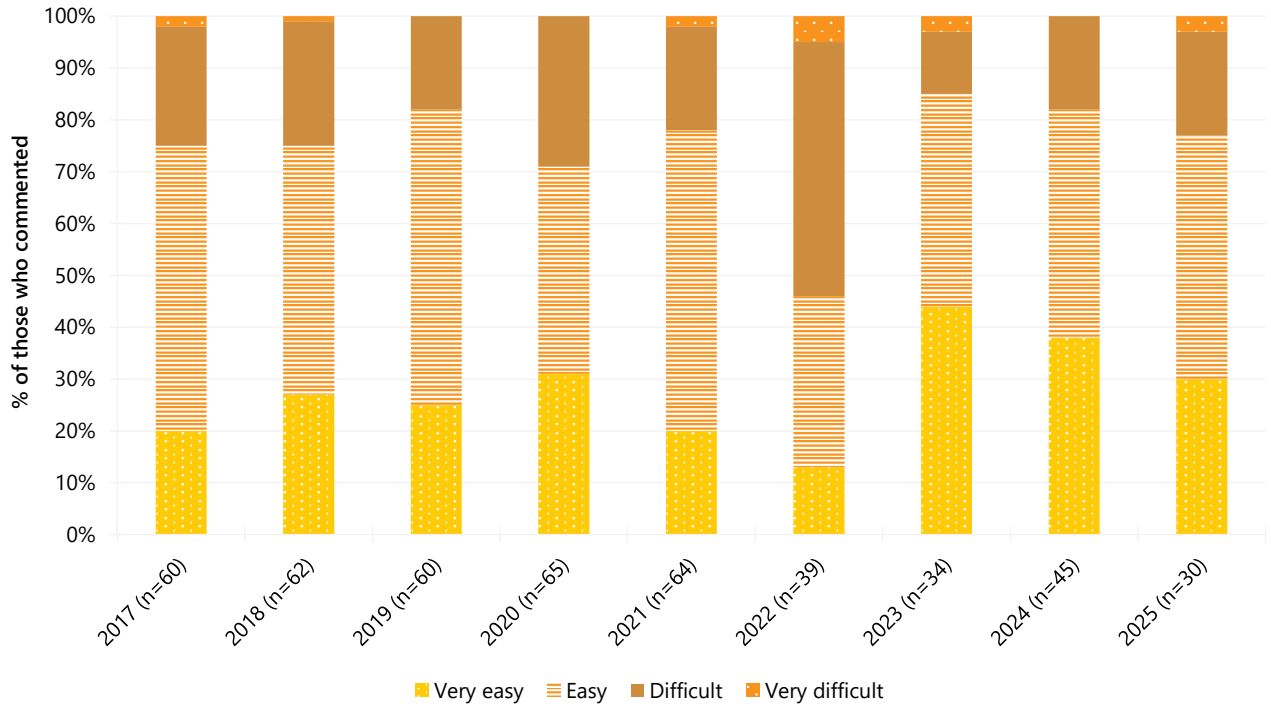
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure;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

Figure 12: Current perceived availability of non-prescribed ecstasy pills, Hobart, TAS, 2017-2025



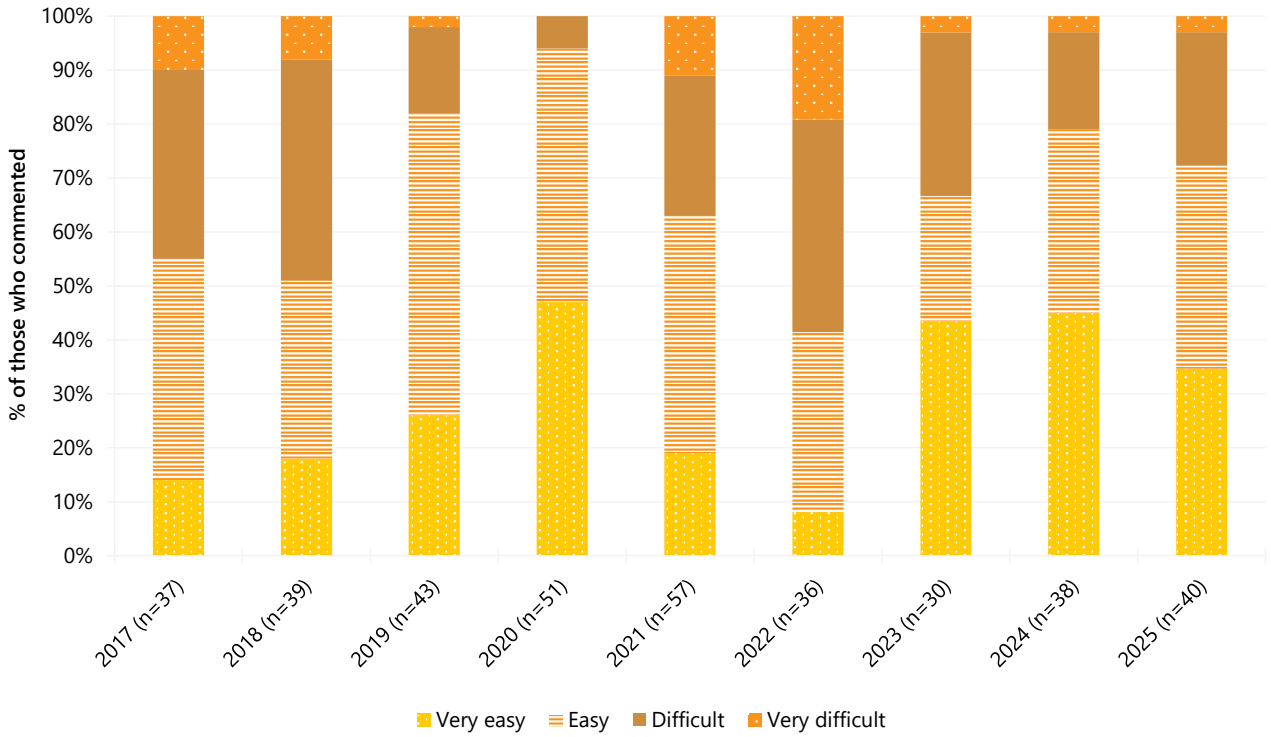
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure;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

Figure 13: Current perceived availability of non-prescribed ecstasy capsules, Hobart, TAS, 2017-2025



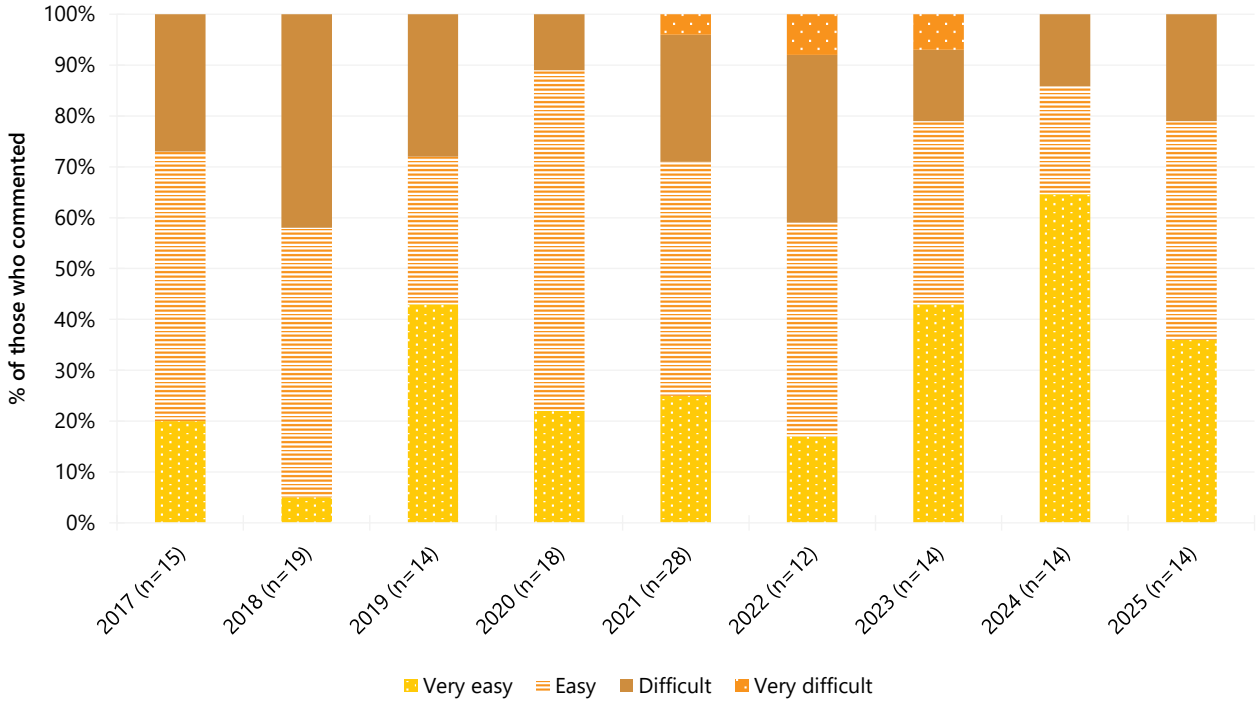
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure;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

Figure 14: Current perceived availability of non-prescribed ecstasy crystal, Hobart, TAS, 2017-2025



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

Figure 15: Current perceived availability of non-prescribed ecstasy powder, Hobart, TAS, 2017-2025



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

3

Methamphetamine

Participants were asked about their recent (past six month) use of various forms of methamphetamine, including powder (white particles, described as 'speed'), base (wet, oily powder) and crystal (clear, ice-like crystals). Findings for base methamphetamine are not reported here due to small numbers reporting recent use. For further information on base methamphetamine, please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team (drugtrends@unsw.edu.au).

Patterns of Consumption (Any Methamphetamine)

Recent Use (past 6 months)

Recent use of any methamphetamine has largely declined since monitoring commenced (Figure 16), from more than eight in ten participants reporting recent use in 2003 (82%), down to three in ten participants in 2020 and 2021 (31%, respectively). In 2025, half (52%) of participants reported recent use of any methamphetamine, stable relative to 2024 (40%; p=0.154).

Form of methamphetamine used has remained consistent over the past decade. In 2025, the majority (71%) of participants reported recent use of methamphetamine crystal (66% in 2024; p=0.795), and 46% reported recent use of methamphetamine powder (46% in 2024). Few participants (n≤5) reported use of methamphetamine base (14% in 2024; p=0.198).

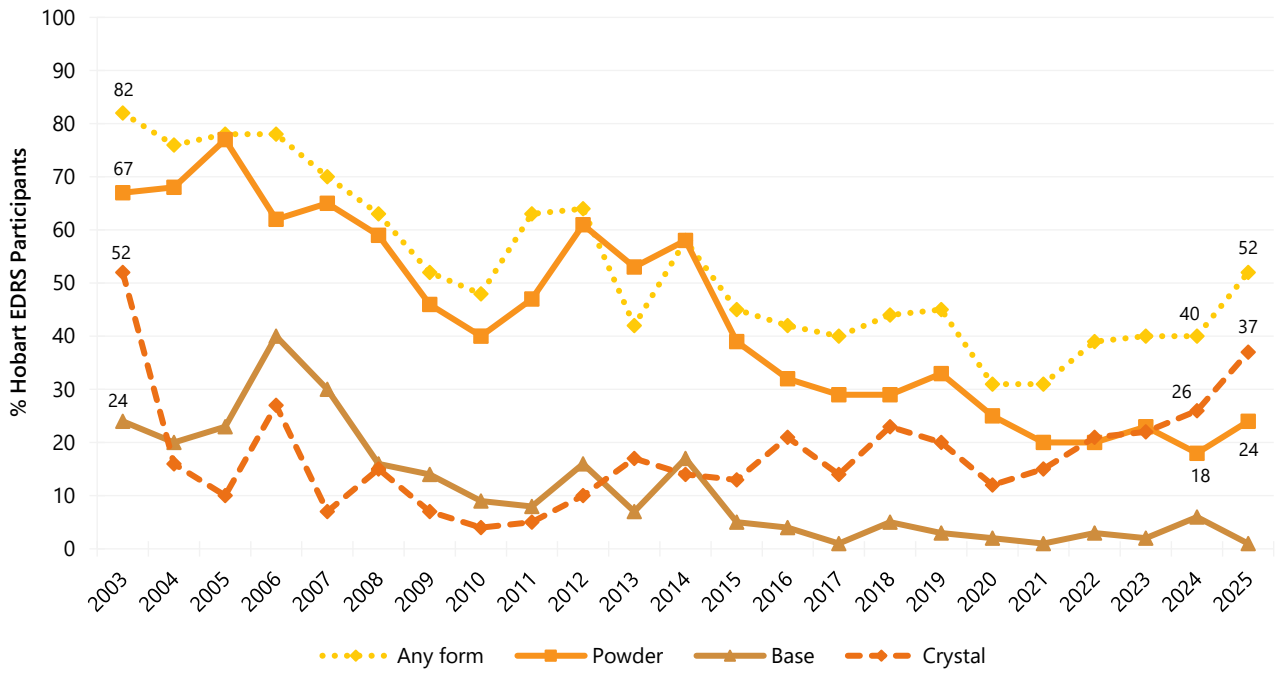
Frequency of Use

In 2025, the median frequency of use reported by participants in the six months preceding interview was 48 days (IQR=6-110; n=35), stable relative to 24 days in 2024 (IQR=4-93; n=35; p=0.364) (Figure 17). Three fifths (63%) of those who had recently used methamphetamine and commented (n=35) reported using methamphetamine weekly or more frequently, stable relative to 2024 (51%; p=0.463).

Number of Forms Used

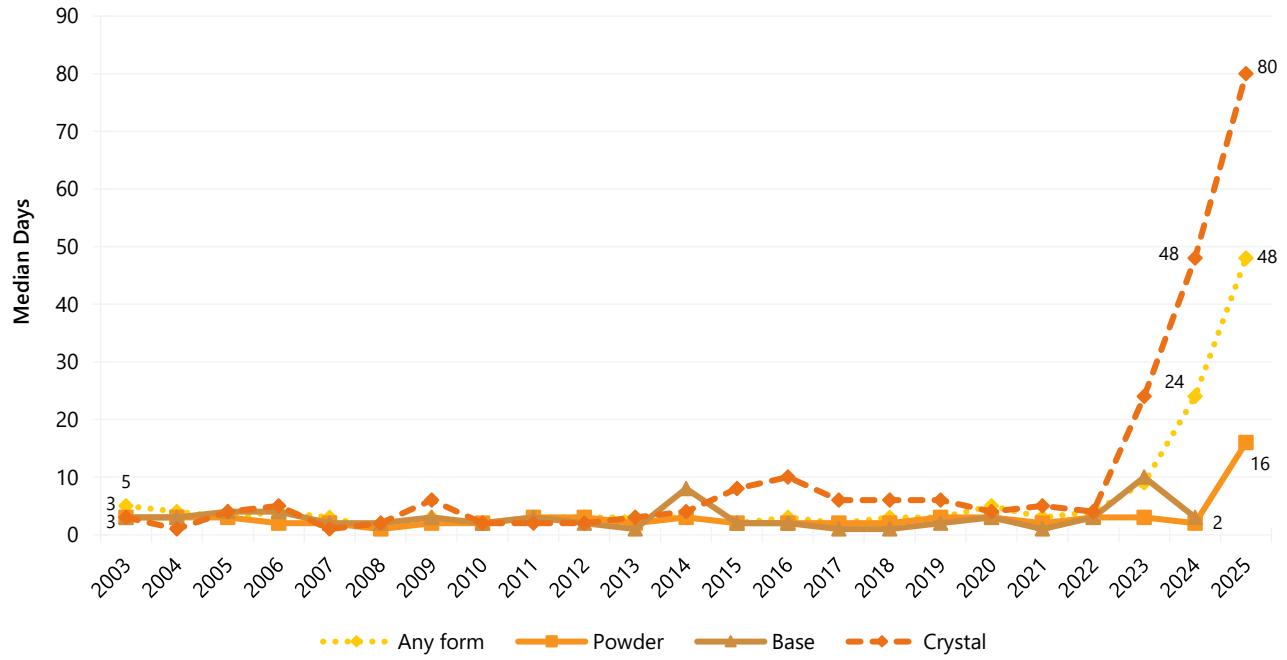
Among participants who had recently consumed any methamphetamine and commented (n=35), the median number of forms used was one (IQR=1-1), stable relative to 2024 (1 form; IQR=1-1; n=35; p=0.867).

Figure 16: Past six month use of any methamphetamine, and methamphetamine powder, base, and crystal, Hobart, TAS, 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.

Figure 17: Median days of any methamphetamine use, and methamphetamine powder, base, and crystal use in the past six months, Hobart, TAS, 2003-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 90 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Patterns of Consumption (by form)

Methamphetamine Powder

Recent Use (past 6 months): Recent use of methamphetamine powder has declined over the course of monitoring, though remained stable in 2025 at 24% (18% in 2024; *p*=0.431) (Figure 16).

Frequency of Use: Amongst those who had recently consumed methamphetamine powder and commented (n=16), participants reported use on a median of 16 days (IQR=2-59) in 2025, stable relative to 2024 (2 days; IQR=1-6; n=16; *p*=0.120) (Figure 17). Half (50%) of those who had recent use of methamphetamine powder and commented (n=16) reported using methamphetamine powder weekly or more frequently in 2025 (n≤5 in 2024; *p*=0.135).

Routes of Administration: Among participants who had recently consumed methamphetamine powder and commented (n=16), snorting was the most common route of administration in 2025 (63%; 88% in 2024; *p*=0.220), followed by swallowing (38%; n≤5 in 2024; *p*=0.704). Few participants (n≤5) reported recent smoking or injecting as a route of administration in 2025 (0% in 2024, respectively).

Quantity: Of those who reported recent use and responded (n=13), the median amount of methamphetamine powder used in a 'typical' session was 0.50 grams (IQR=0.15-0.75; 0.50 grams in 2024; IQR=0.20-1.00; n=13; *p*=0.698). Of those who reported recent use and responded (n=14), the median maximum amount of powder used in a session was 0.75 grams (IQR=0.20-1.75; 0.65 grams in 2024; IQR=0.38-1.00; n=12; *p*=0.959).

Methamphetamine Crystal

Recent Use (past 6 months): Two fifths (37%) of participants reported recent use of methamphetamine crystal in 2025, stable relative to 2024 (26%; *p*=0.165) (Figure 16).

Frequency of Use: Of those who had recently consumed methamphetamine crystal and commented (n=25), participants reported use on a median of 80 days (IQR=10-178) in the six months preceding interview, stable relative to 2024 (48 days; IQR=11-120; n=23; *p*=0.679) (Figure 17). Almost three quarters (72%) of participants who had recently used methamphetamine crystal reported weekly or greater use in 2025 (70% in 2024).

Routes of Administration: Among participants who had recently consumed methamphetamine crystal and commented (n=25), smoking remained the most common (64%) route of administration in 2025, stable from 2024 (74%; *p*=0.538). One third (32%) of participants reporting swallowing crystal (n≤5 in 2024; *p*=0.324). Few participants (n≤5) reported injecting or snorting crystal in 2024 in 2025.

Quantity: Of those who reported recent use and responded (n=23), the median amount of methamphetamine crystal used in a 'typical' session was 0.20 grams (IQR=0.10-0.35; 0.20 grams in 2024; IQR=0.10-0.30; n=21; *p*=0.189). Of those who reported recent use and responded (n=24), the median maximum amount of methamphetamine crystal used in a session was 0.50 grams (IQR=0.20-1.00; 0.40 grams in 2024; IQR=0.25-0.50; n=21; *p*=0.422).

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Price: The median price for a point of methamphetamine powder was $50 in 2025 (IQR=50-50; n≤5 in 2024) (Figure 18).

Perceived Purity: The perceived purity of methamphetamine powder remained stable in 2025 (*p*=0.197), with two fifths (43%) reporting purity to be 'high' (n≤5 in 2024) (Figure 20).

Perceived Availability: The perceived availability of methamphetamine powder remained stable between 2024 and 2025 (*p*=0.490). Few participants (n≤5) reported on any level of perceived availability (e.g., 'easy,' 'difficult'); therefore, further details are not reported (Figure 22). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

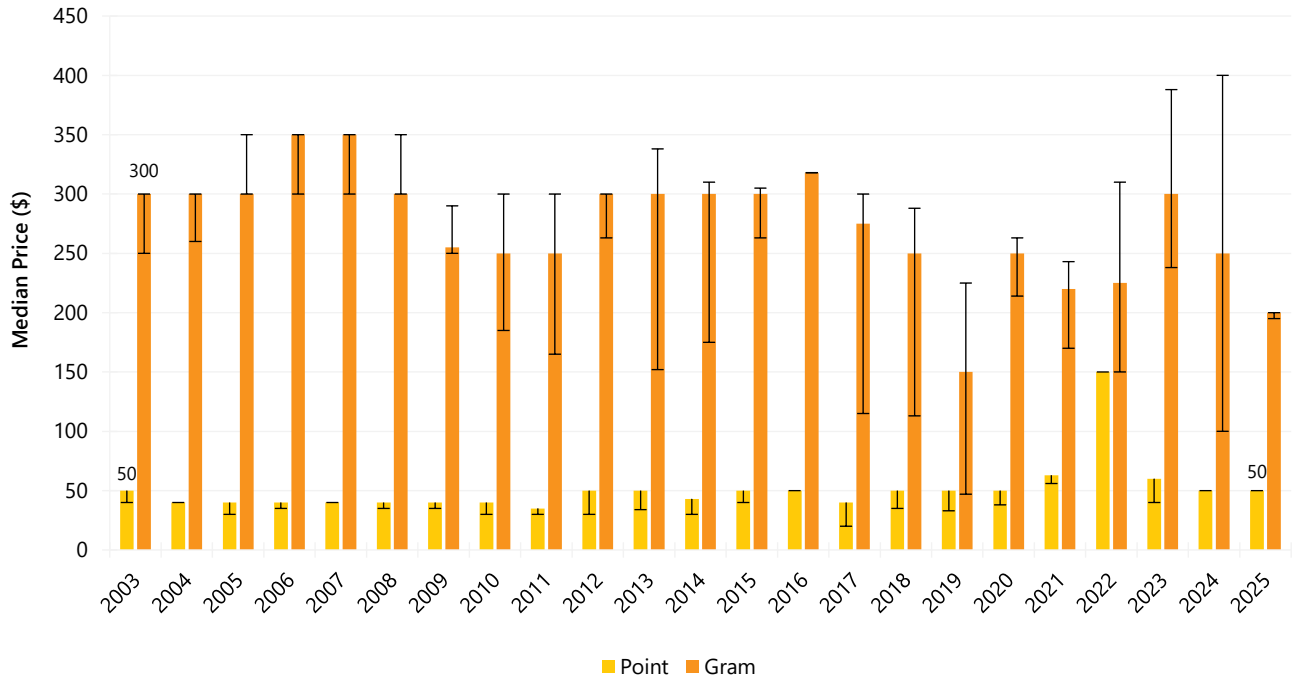
Methamphetamine Crystal

Price: The median price of a point of methamphetamine crystal remained stable in 2025 at $50 (IQR=50-50; n=17; $50 in 2024; IQR=50-55; n=15; *p*=0.158). Few participants (n≤5) reported on the price of a gram of crystal in 2024 and 2025; therefore, further details are not reported (Figure 19). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Perceived Purity: The perceived purity of methamphetamine crystal remained stable between 2024 and 2025 (*p*=0.770). Among those who were able to comment in 2025 (n=26), one third (35%) reported purity to be 'high' (44% in 2024). Conversely, 27% reported purity as 'low' (27% in 2024). Few participants (n≤5) reported purity to be 'medium' and 'fluctuating' (n≤5 and 22% in 2024, respectively) (Figure 21).

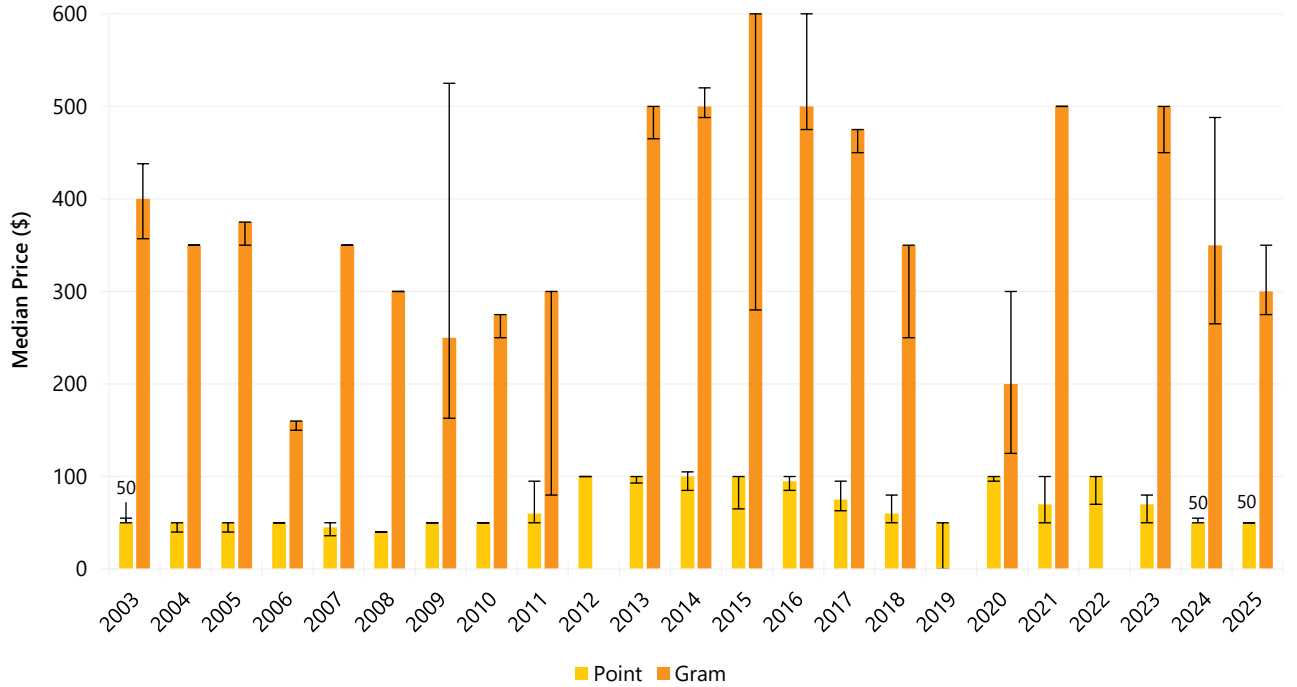
Perceived Availability: The perceived availability of methamphetamine crystal remained stable between 2024 and 2025 (*p*=0.589). Among those who responded in 2025 (n=27), the majority (81%) reported perceived availability as 'very easy' (74% in 2024). Few participants (n≤5) reported availability to be 'easy' and 'difficult' (22% and n≤5 in 2024, respectively) (Figure 23).

Figure 18: Median price of methamphetamine powder per point and gram, Hobart, TAS, 2003-2025



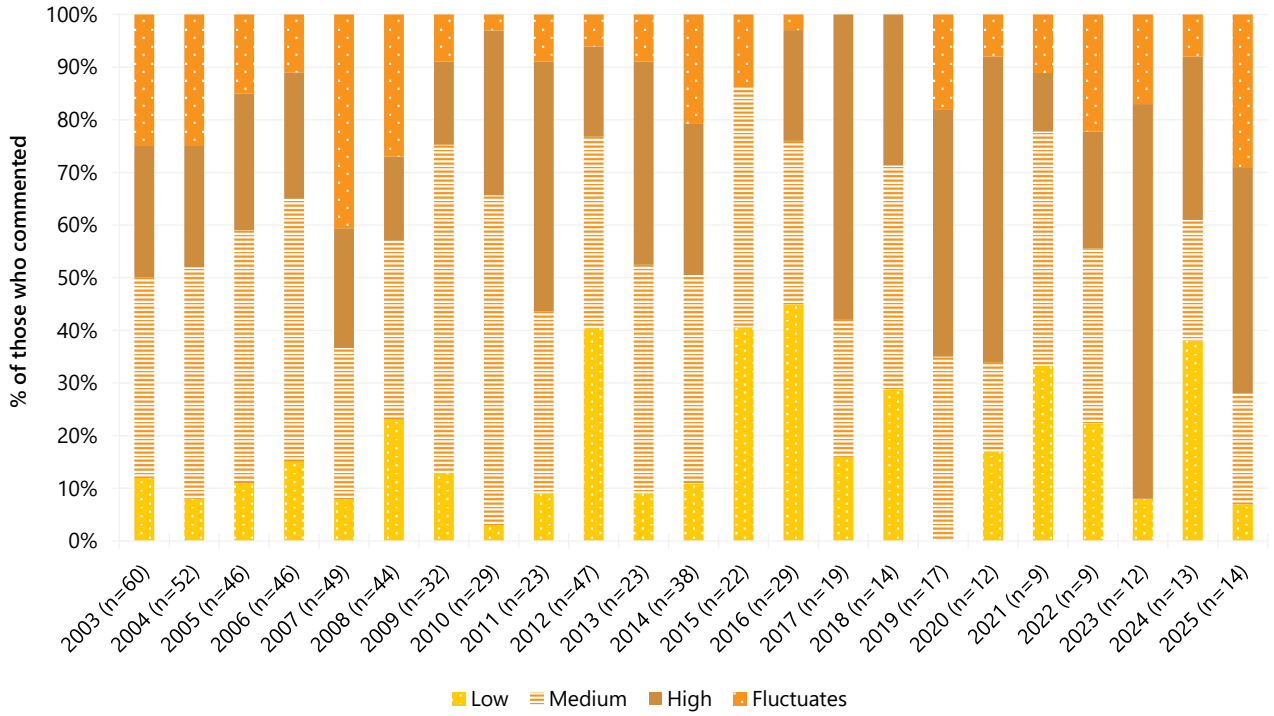
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where n≤5 responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010;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

Figure 19: Median price of methamphetamine crystal per point and gram, Hobart, TAS, 2003-2025



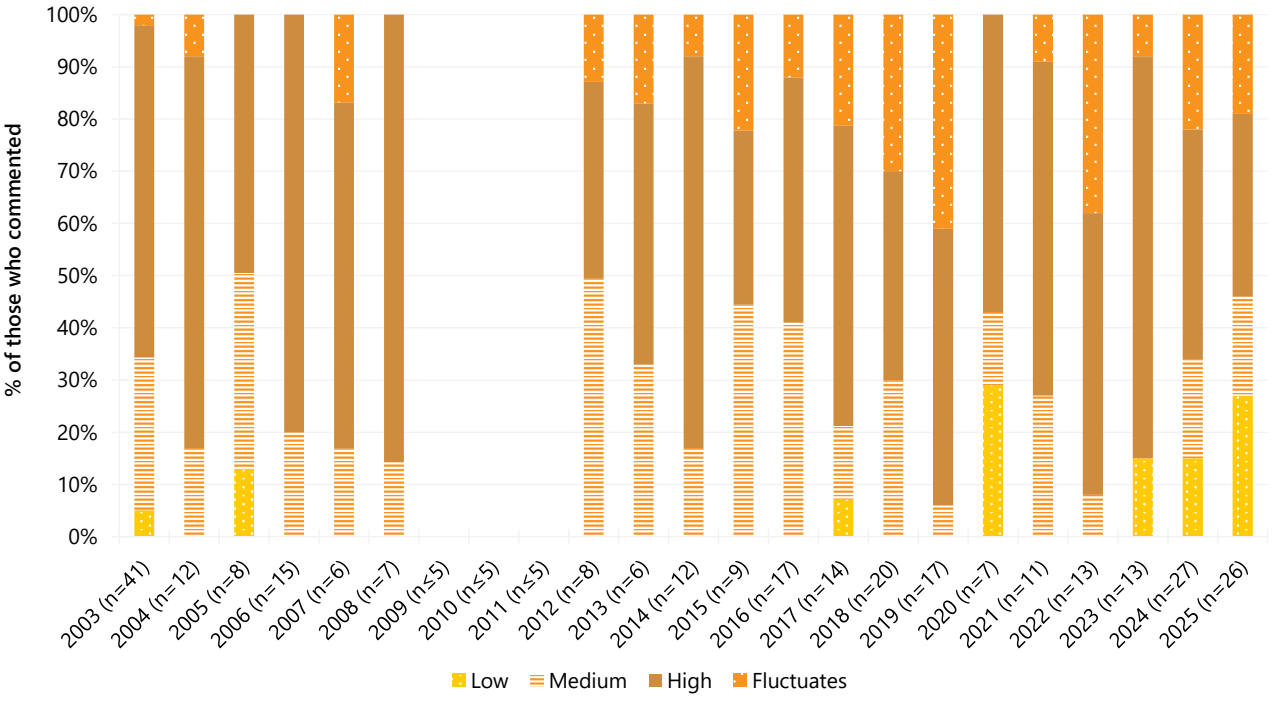
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where n≤5 responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010;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

Figure 20: Current perceived purity of methamphetamine powder, Hobart, TAS, 2003-2025



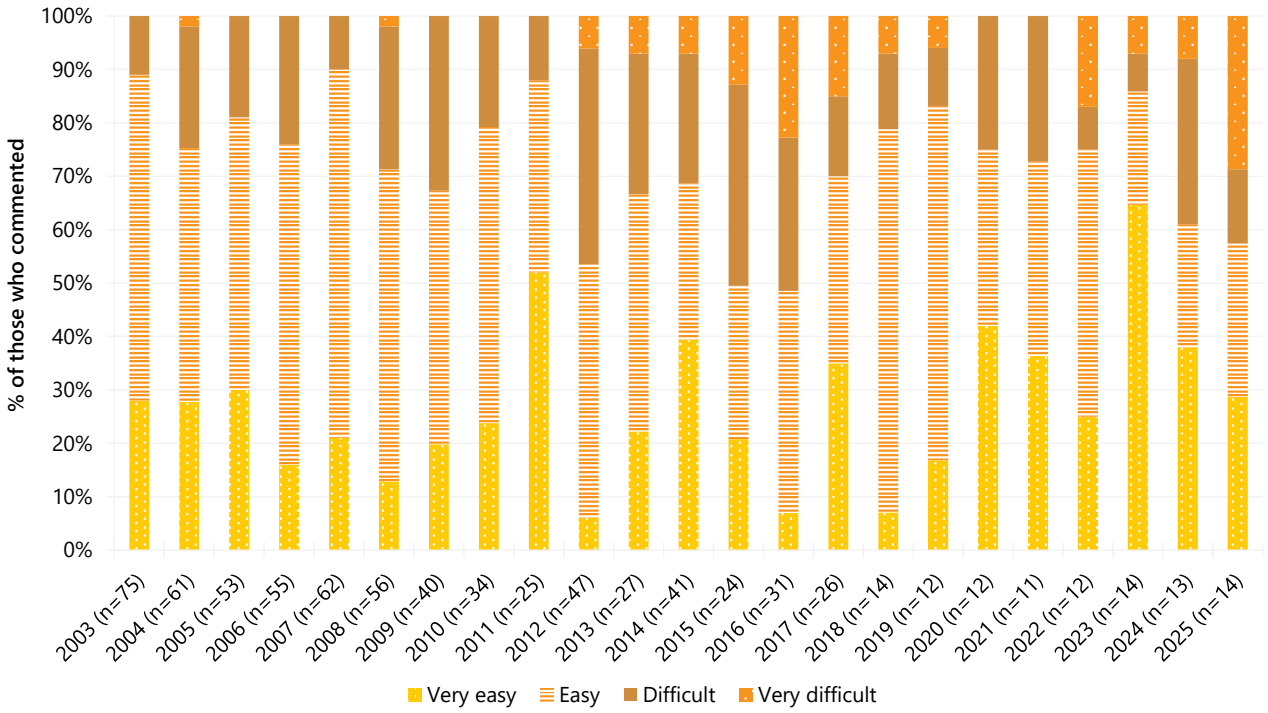
Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to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

Figure 21: Current perceived purity of methamphetamine crystal, Hobart, TAS, 2003-2025



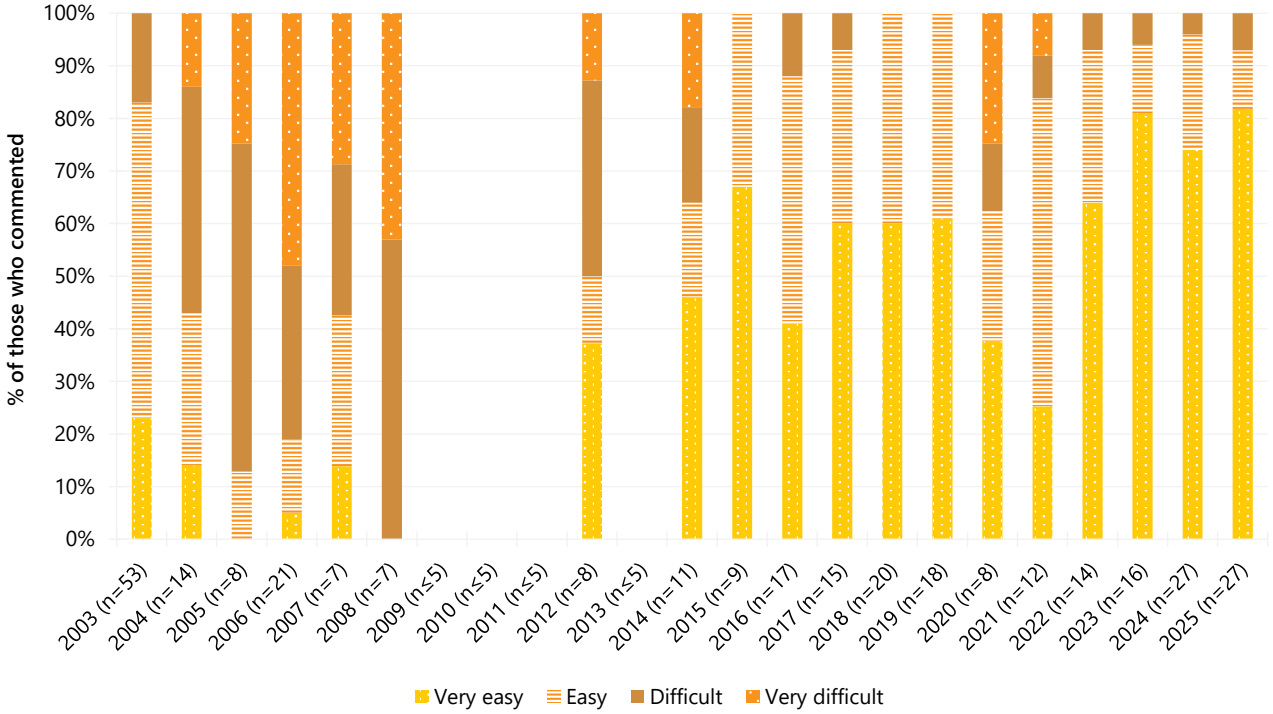
Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to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

Figure 22: Current perceived availability of methamphetamine powder, Hobart, TAS, 2003-2025



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

Figure 23: Current perceived availability of methamphetamine crystal, Hobart, TAS, 2003-2025



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

4

Non-Prescribed Pharmaceutical Stimulants

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

Patterns of Consumption

Recent Use (past 6 months)

The per cent of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has generally increased since the commencement of monitoring, from 19% in 2007 to 37% in 2025 (but has not changed from 2024: 36%) (Figure 24).

Frequency of Use

Frequency of use remained stable in 2025, at a median of six days in the six months prior to interview (IQR=3-20; n=25; 6 days in 2024; IQR=3-20; n=31; p=0.779) (Figure 24).

Routes of Administration

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=25), the vast majority reported swallowing as a route of administration (88%; 87% in 2024), with a smaller proportion of participants reporting snorting (24%; 32% in 2024; p=0.561).

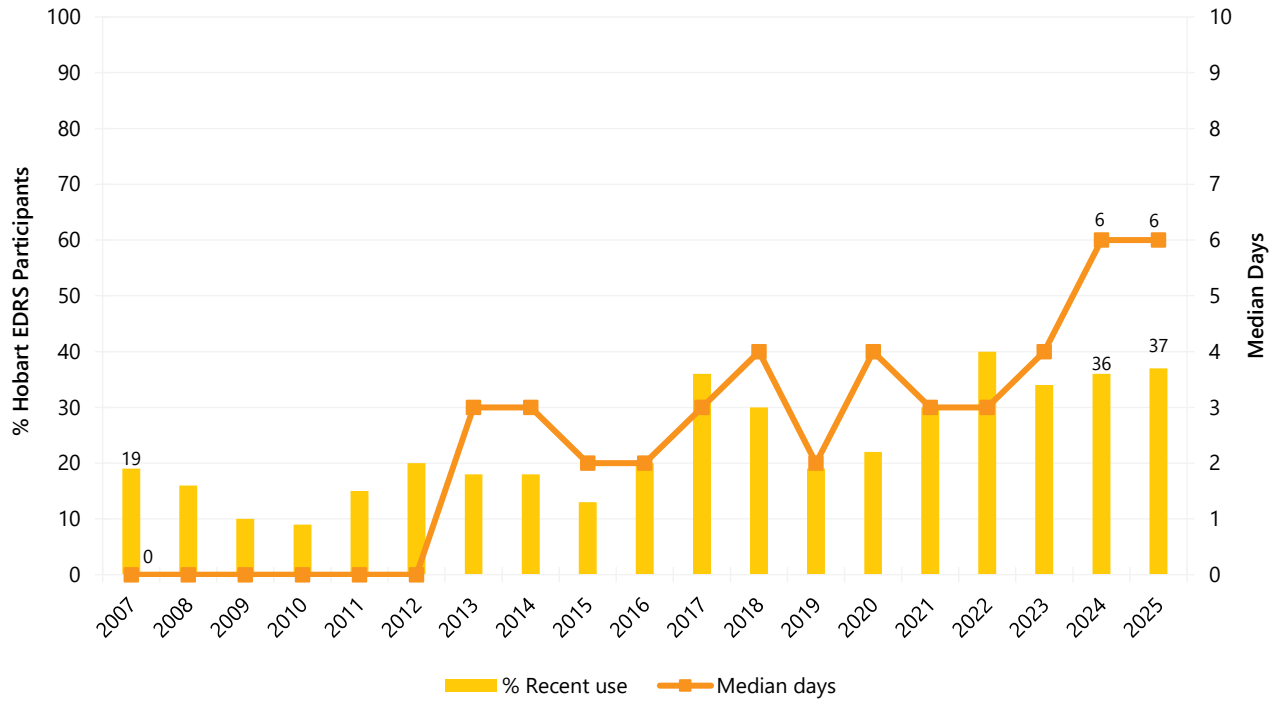
Quantity

Among those who reported recent use and responded (n=18), the median amount used in a 'typical' session was two pills/tablets (IQR=1-2; 2 pills/tablets in 2024; IQR=1-4; n=26; p=0.084). Of those who reported recent use and responded (n=18), the median maximum amount used in a session was two and a half pills/tablets (IQR=1–3.8; 3 pills/tablets in 2024; IQR=2-6.5; n=27; p=0.165).

Forms Used

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=25), the majority reported using dexamfetamine (84%; 68% in 2024; p=0.227), followed by methylphenidate (36%; 29% in 2024; p=0.774) and lisdexamfetamine (28%; n≤5 in 2024; p=0.066). No participants reported using modafinil in 2025 (16% in 2024; p=0.062).

Figure 24: Past six month use and frequency of use of non-prescribed pharmaceutical stimulants, Hobart, TAS, 2007-2025



Note. Monitoring of pharmaceutical stimulants commenced in 2007. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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 and Perceived Availability

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

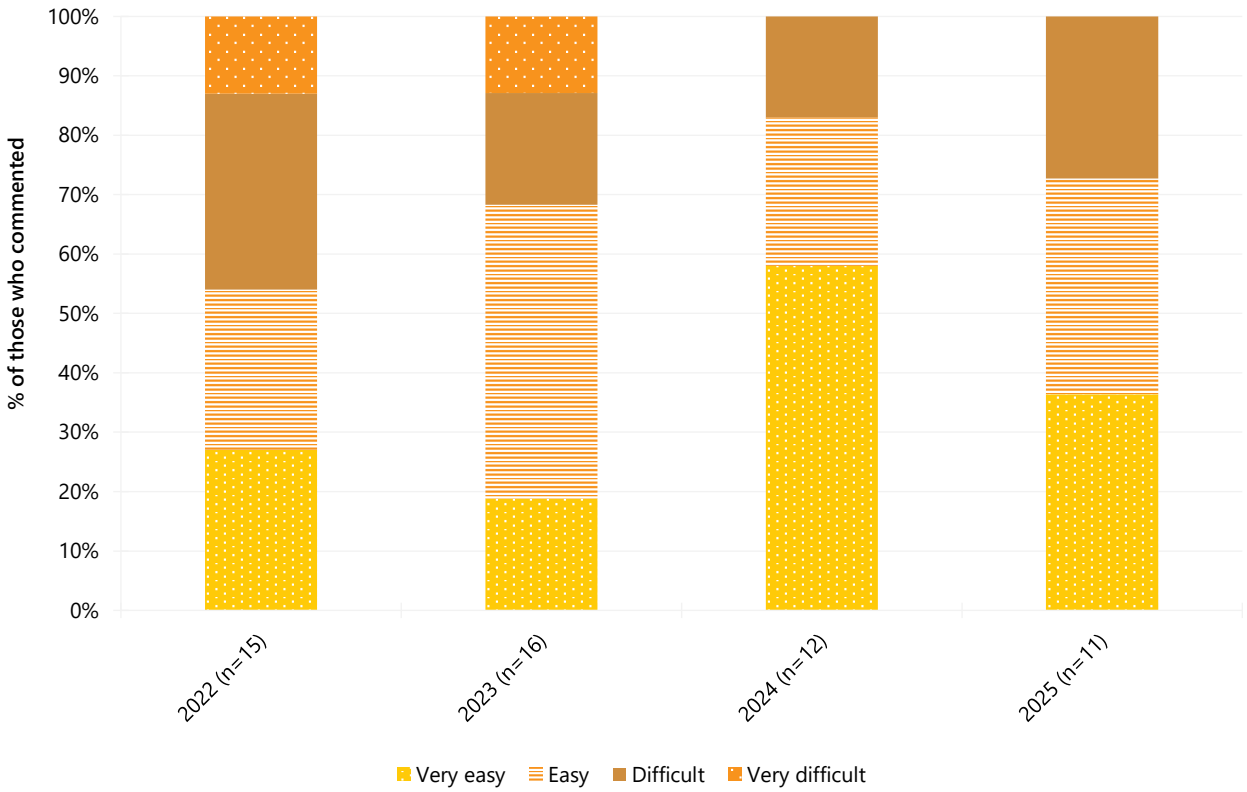
Price

In 2025, few participants (n≤5) were able to comment on the price per 5mg ($10 in 2024; IQR=6-19; n=8; p=0.480) or 10mg (n≤5 in 2024) tablet.

Perceived Availability

The perceived availability of non-prescribed pharmaceutical stimulants remained stable between 2024 and 2025 (p=0.634). Few participants (n≤5) reported on any individual perceived level of availability (e.g., 'easy,' 'difficult'); therefore, further details are not reported (Figure 25). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 25: Current perceived availability of non-prescribed pharmaceutical stimulants, Hobart, TAS, 2022-2025



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

5

Cocaine

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

Patterns of Consumption

Recent Use (past 6 months)

Since 2013, the per cent reporting any recent cocaine use has substantially increased. In 2025, three quarters (75%) of the Hobart sample reported recent use, stable relative to 2024 (77%; p=0.846) (Figure 26).

Frequency of Use

Frequency of use has remained stable in recent years. Of those who had recently consumed cocaine and commented (n=50), participants reported a median of six days (IQR=3-12) of use in the six months preceding interview, stable from four days in 2024 (IQR=2-10; n=67; p=0.165) (Figure 26), equating to monthly use. Twelve per cent of those who had recently used cocaine reported weekly or more frequent use, stable relative to 2024 (n≤5; p=0.525).

Routes of Administration

Among participants who had recently consumed cocaine and commented (n=50), the majority (92%) of participants reported snorting cocaine, stable relative to 2024 (97%; p=0.400). One fifth (20%) reported swallowing as a route of administration, stable relative to 2024 (16%; p=0.628).

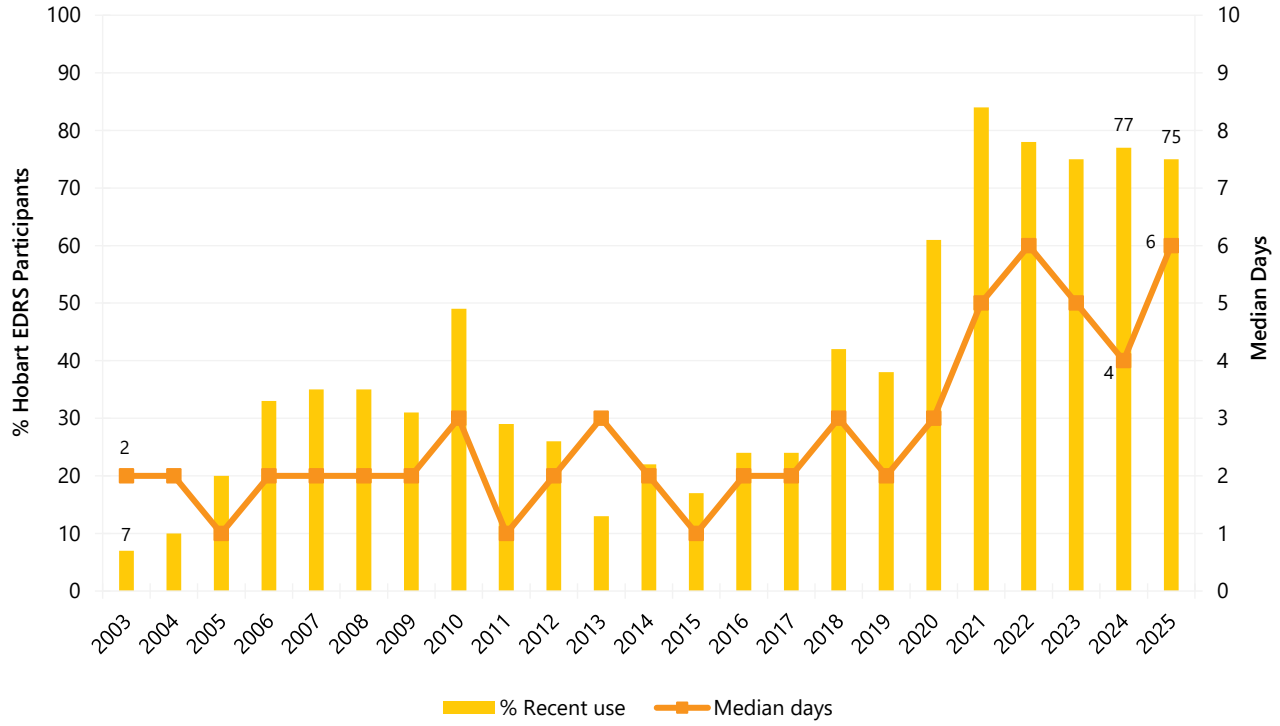
Forms Used

Among participants who had recently consumed cocaine and commented (n=50), the majority reported using powder cocaine (94%; 97% in 2024; p=0.651). Few participants (n≤5) in the Hobart sample reported recent use of crack/rock cocaine in 2024 and 2025.

Quantity

Of those who reported recent use and responded (n=40), the median amount of cocaine used in a 'typical' session was 0.50 grams (IQR=0.30-1.00; 0.50 grams in 2024; IQR=0.25-1.00; n=41; *p*=0.838). Of those who reported recent use and responded (n=40), the median maximum amount of cocaine used in a session was 1.00 grams (IQR=0.50-2.00; 1.00 gram in 2024; IQR=0.29-1.20; n=38; *p*=0.804).

Figure 26: Past six month use and frequency of use of cocaine, Hobart, TAS, 2003-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends for days of use. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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 per gram of cocaine was $350 (IQR=300-400; n=27), stable relative to 2024 ($350; IQR=300-350; n=33; *p*=0.385) (Figure 27).

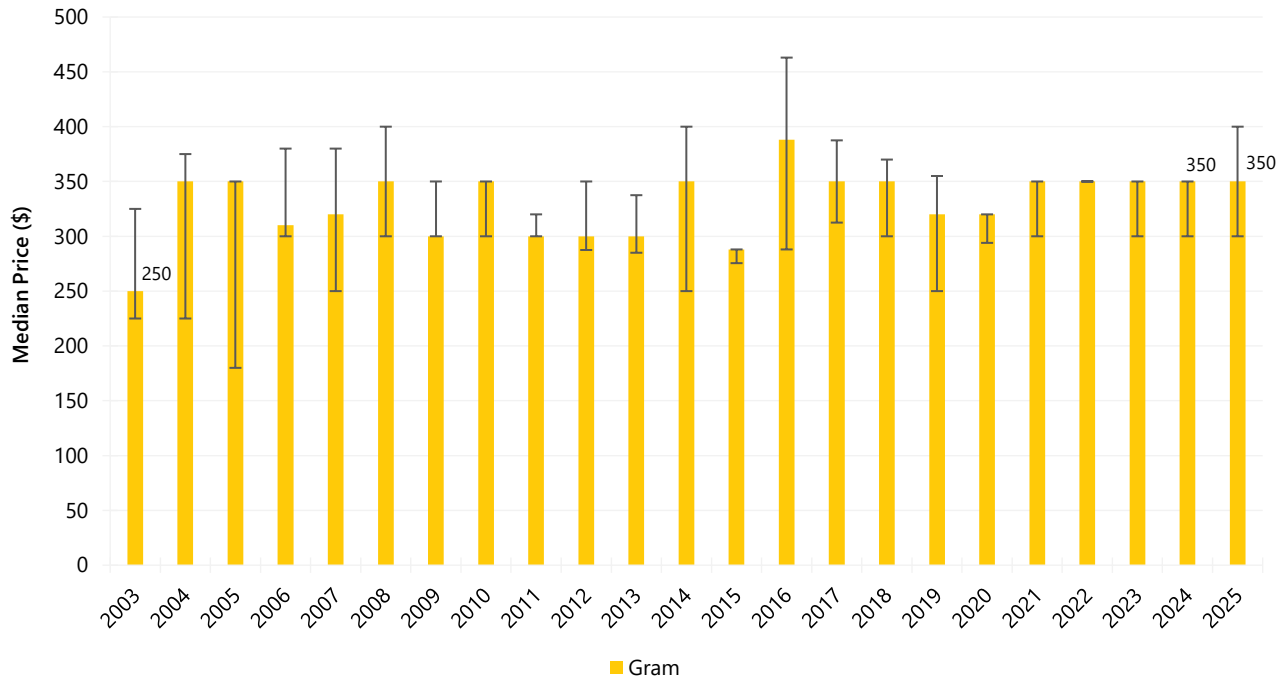
Perceived Purity

The perceived purity of cocaine remained stable between 2024 and 2025 (*p*=0.280). Among those who were able to respond in 2025 (n=37), 46% perceived purity to be 'high' (30% in 2024), and 19% perceived purity to be 'medium' (34% in 2024). In contrast, 27% perceived purity to be 'low' (23% in 2024). Few participants (n≤5) perceived purity to be 'fluctuating' (14% in 2024) (Figure 28).

Perceived Availability

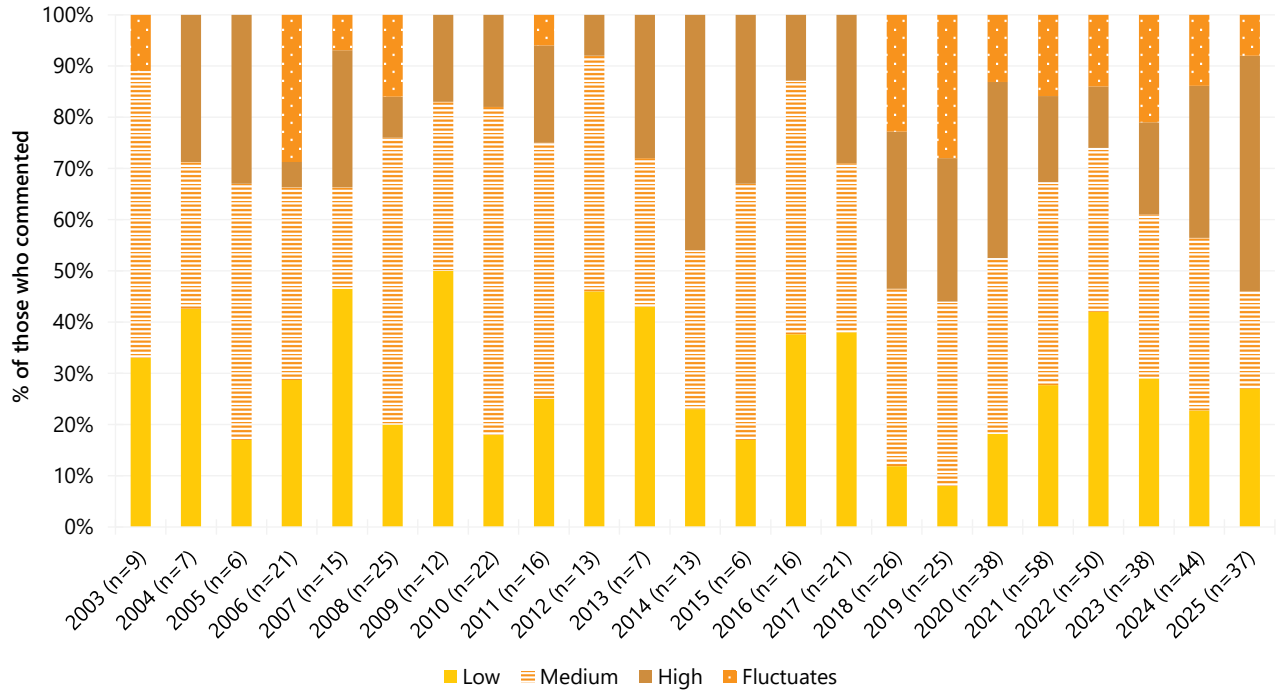
The perceived availability of cocaine remained stable between 2024 and 2025 (*p*=0.566). Among those who were able to respond in 2025 (n=37), 54% perceived cocaine to be 'easy' to obtain (42% in 2024) and 30% perceived it to be 'very easy' to obtain (31% in 2024). Few participants (n≤5) perceived cocaine to be 'difficult' to obtain in 2025 (18% in 2024) (Figure 29).

Figure 27: Median price of cocaine per gram, Hobart, TAS, 2003-2025



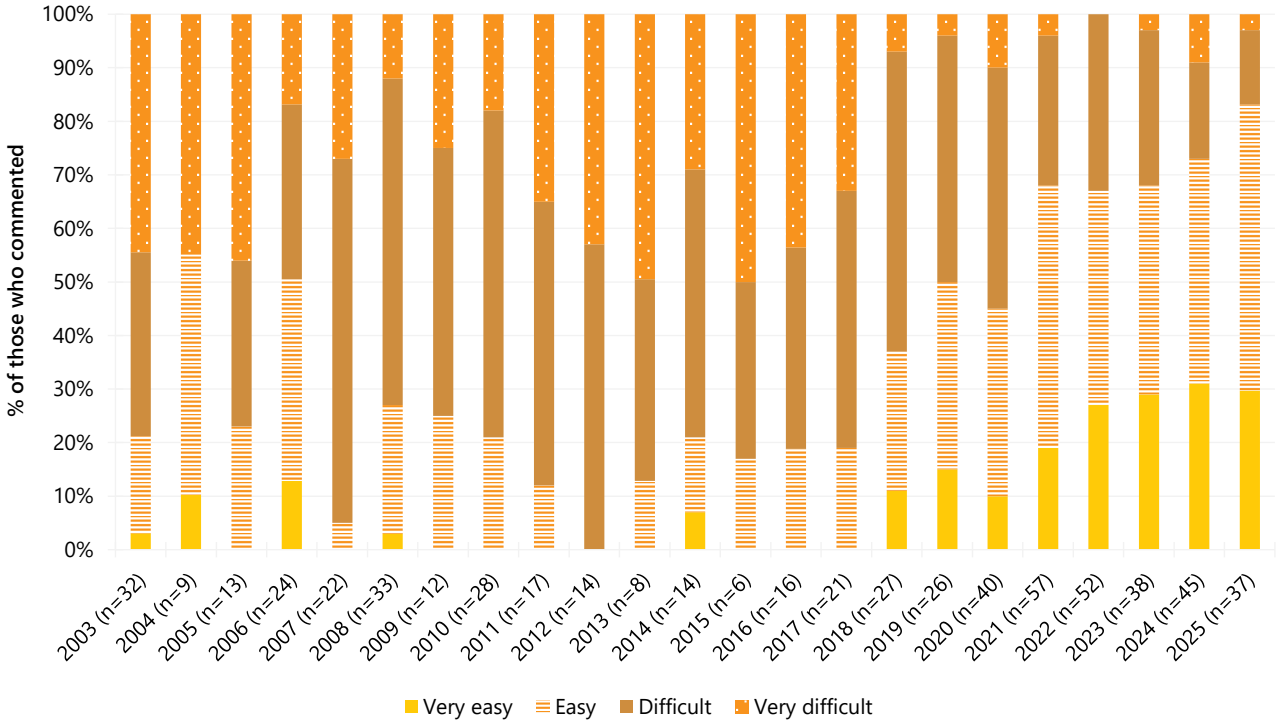
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where n≤5 responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010;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

Figure 28: Current perceived purity of cocaine, Hobart, TAS, 2003-2025



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

Figure 29: Current perceived availability of cocaine, Hobart, TAS, 2003-2025



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

6

Cannabis and/or Cannabinoid-Related Products

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

Terminology throughout this chapter refers to:

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

Patterns of Consumption

Participants were asked about their use of both prescribed and non-prescribed cannabis and/or cannabinoid-related products. Thirteen per cent of the Hobart sample reported prescribed use in the six months preceding interview, stable relative to 2024 (17%; p=0.507).

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

Almost three quarters (72%) of the Hobart sample reported recent use of non-prescribed cannabis and/or cannabinoid-related products in 2025, stable relative to 2024 (69%; p=0.711) (Figure 30).

Frequency of Use

Median frequency of use has varied between at least once per week to up to four days per week over the course of monitoring. Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented in 2025 (n=49), participants reported a median of 150

days (IQR=30-180) of use in the six months preceding interview, stable relative to 2024 (67 days; IQR=10-180; n=60; *p*=0.112) (Figure 30). Almost four fifths (78%) of those who had recently used non-prescribed cannabis and/or cannabinoid-related products reported weekly or more frequent use (68% in 2024; *p*=0.393), including 45% who reported daily use (32% in 2024; *p*=0.177).

Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented (n=49), the majority (86%) reported smoking as a route of administration, stable relative to 2024 (90%; *p*=0.558). One fifth reported inhaling/vaporising (20%; 20% in 2024) or swallowing (18%; 28% in 2024; *p*=0.265) as a route of administration.

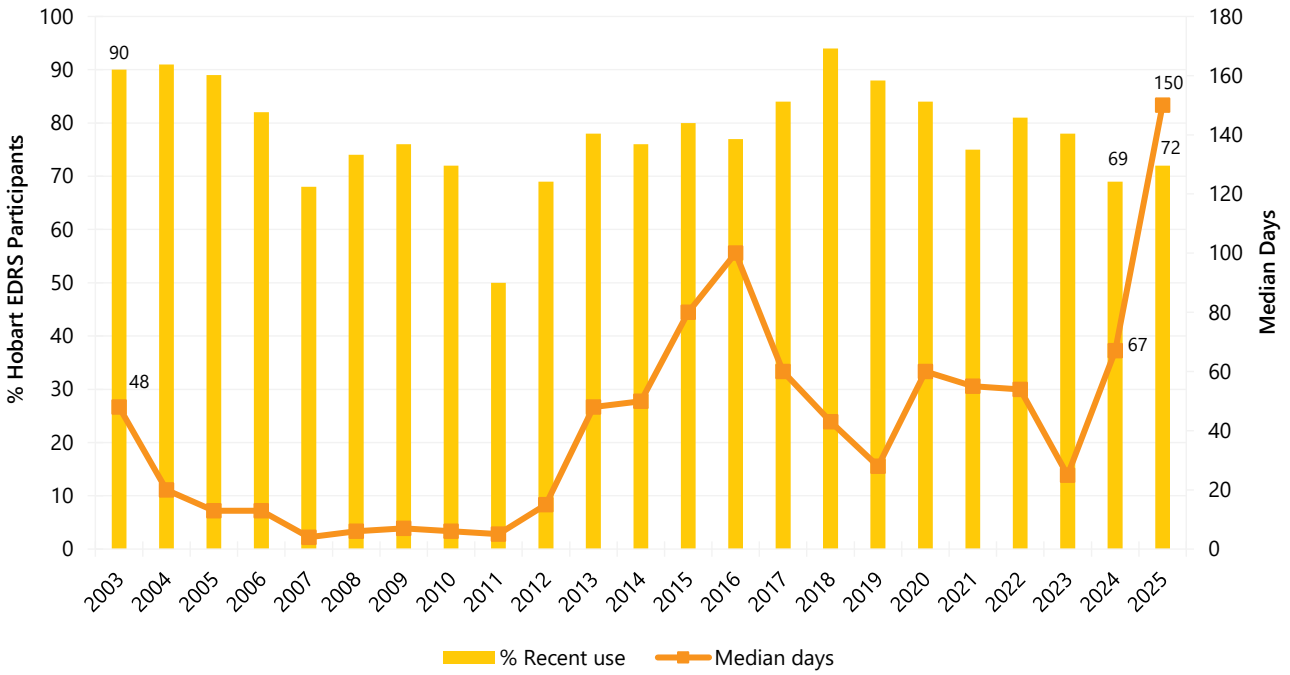
Quantity

Of those who reported recent non-prescribed use and responded, the median amount of non-prescribed cannabis and/or cannabinoid-related products used on the last occasion of use was two grams (IQR=1.00-3.00; n=26; 1.35 grams in 2024; IQR=1.00-3.00; n=26; *p*=0.963) or four and a half cones (IQR=2.8-10.3; n=8; 2 cones in 2024; IQR=1-4; n=17; *p*=0.090) or one joint (IQR=1-1; n=7; 1.5 joints in 2024; IQR=0.5-2; n=12; *p*=0.930).

Forms Used

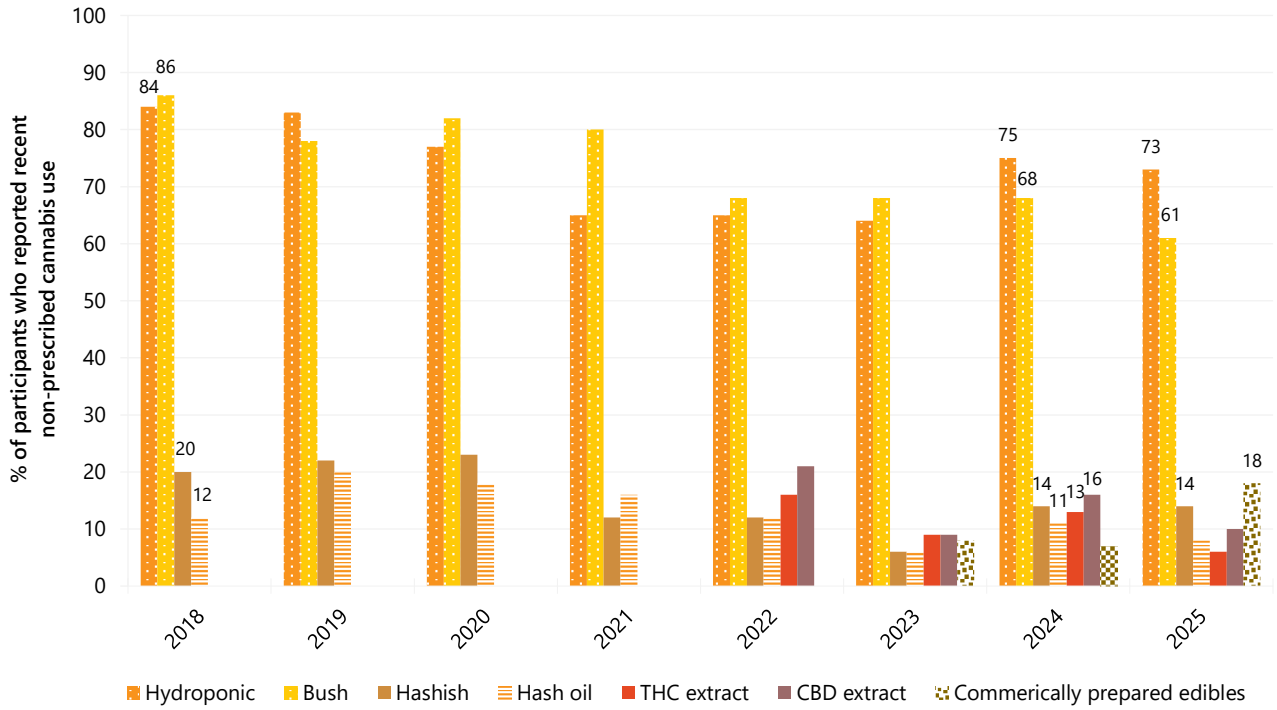
Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and responded (n=49), almost three quarters (73%) reported recent use of hydroponic cannabis, stable relative to 75% in 2024. Three fifths (61%) reported recent use of outdoor grown 'bush' cannabis in 2025 (68% in 2024; *p*=0.537). Fewer participants reported recent use of commercially prepared edibles (18%; n≤5 in 2024; *p*=0.136) and hashish (14%; 14% in 2024). In 2025, few participants (n≤5) reported recent use of THC extract (13% in 2024; *p*=0.767), hash oil (11% in 2024; *p*=0.748) or CBD extract (16% in 2024; *p*=0.134) (Figure 31).

Figure 30: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid-related products, Hobart, TAS, 2003-2025



Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low (in 2022, no participants reported use of prescribed cannabis only). Further, from 2022 onwards, we captured use of 'cannabis and/or cannabinoid-related products', while in previous years questions referred only to 'cannabis'. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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 31: Past six month use of different forms of non-prescribed cannabis and/or cannabinoid-related products, among those who reported recent non-prescribed use, Hobart, TAS, 2018-2025



Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2018-2020 figures include some participants who were using prescribed forms of cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 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 Potency and Perceived Availability

Hydroponic Cannabis

Price: In 2025, the median price per gram of non-prescribed hydroponic cannabis was $20 (IQR=20-20; n=9), stable relative to 2024 ($20; IQR=16-25; n=16; *p*=0.766). The median price per ounce of hydroponic cannabis has fluctuated between $250 and $300 since 2006. The median price per ounce of hydroponic cannabis in 2025 was $265 (IQR=228-295; n=6), a significant decrease from $300 in 2024 (*p*=0.046) (Figure 32A).

Perceived Potency: The perceived potency of non-prescribed hydroponic cannabis remained stable between 2024 and 2025 (*p*=0.754). Among those who were able to respond in 2025 (n=34), three fifths (59%) perceived hydroponic cannabis to be of 'high' potency (59% in 2024), and one quarter (24%) perceived potency to be 'medium' (16% in 2024). and 14% perceived potency to be 'fluctuating' (24% in 2023). Few participants (n≤5) perceived potency to be 'fluctuating' (14% in 2024) or 'low' (n≤5 in 2024) (Figure 33A).

Perceived Availability: The perceived availability of non-prescribed hydroponic cannabis remained stable between 2024 and 2025 (*p*=0.156). Among those who were able to respond in 2025 (n=34), four fifths (82%) perceived non-prescribed hydroponic cannabis to be 'very easy' to obtain (64% in 2024), and one fifth (18%) perceived it to be 'easy' to obtain (33% in 2024) (Figure 34A).

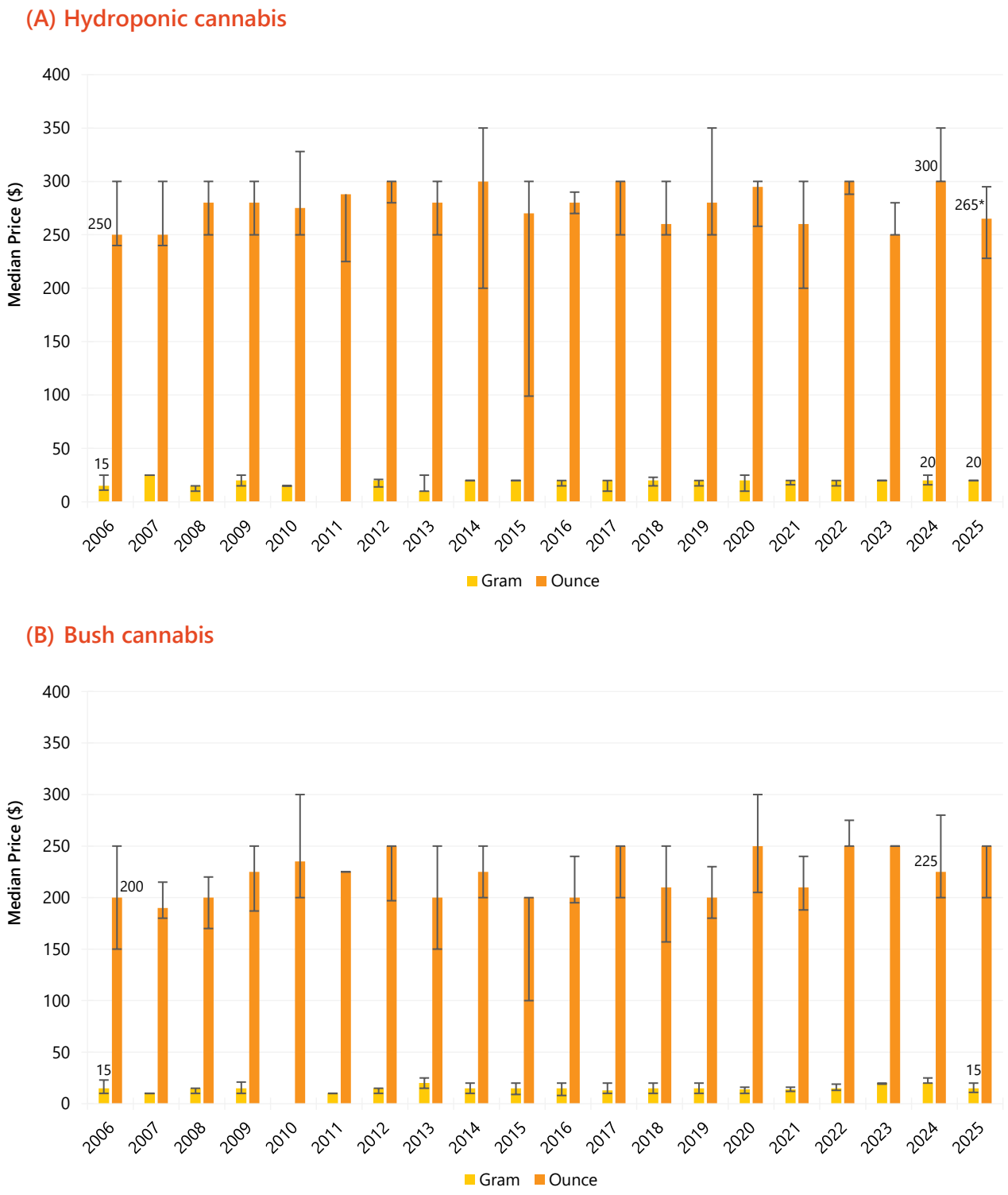
Bush Cannabis

Price: The median price per gram of non-prescribed bush cannabis remained stable at $15 in 2025 (IQR=11-20; n=7; n≤5 in 2024; *p*=0.174). Few participants (n≤5) reported on the median price per ounce of non-prescribed bush cannabis in 2025 ($225 in 2024; IQR=200-280; n=13); therefore, further details are not reported (Figure 32B).

Perceived Potency: The perceived potency of non-prescribed bush cannabis remained stable between 2024 and 2025 (*p*=0.847). Among those who were able to respond in 2025 (n=30), almost three fifths (57%) perceived the potency of non-prescribed bush cannabis to be 'medium' (54% in 2024), with a further 20% perceiving potency to be 'high' (18% in 2024). Few participants (n≤5) reported non-prescribed bush cannabis to be 'low' or 'fluctuating' in 2024 and 2025 (Figure 33B).

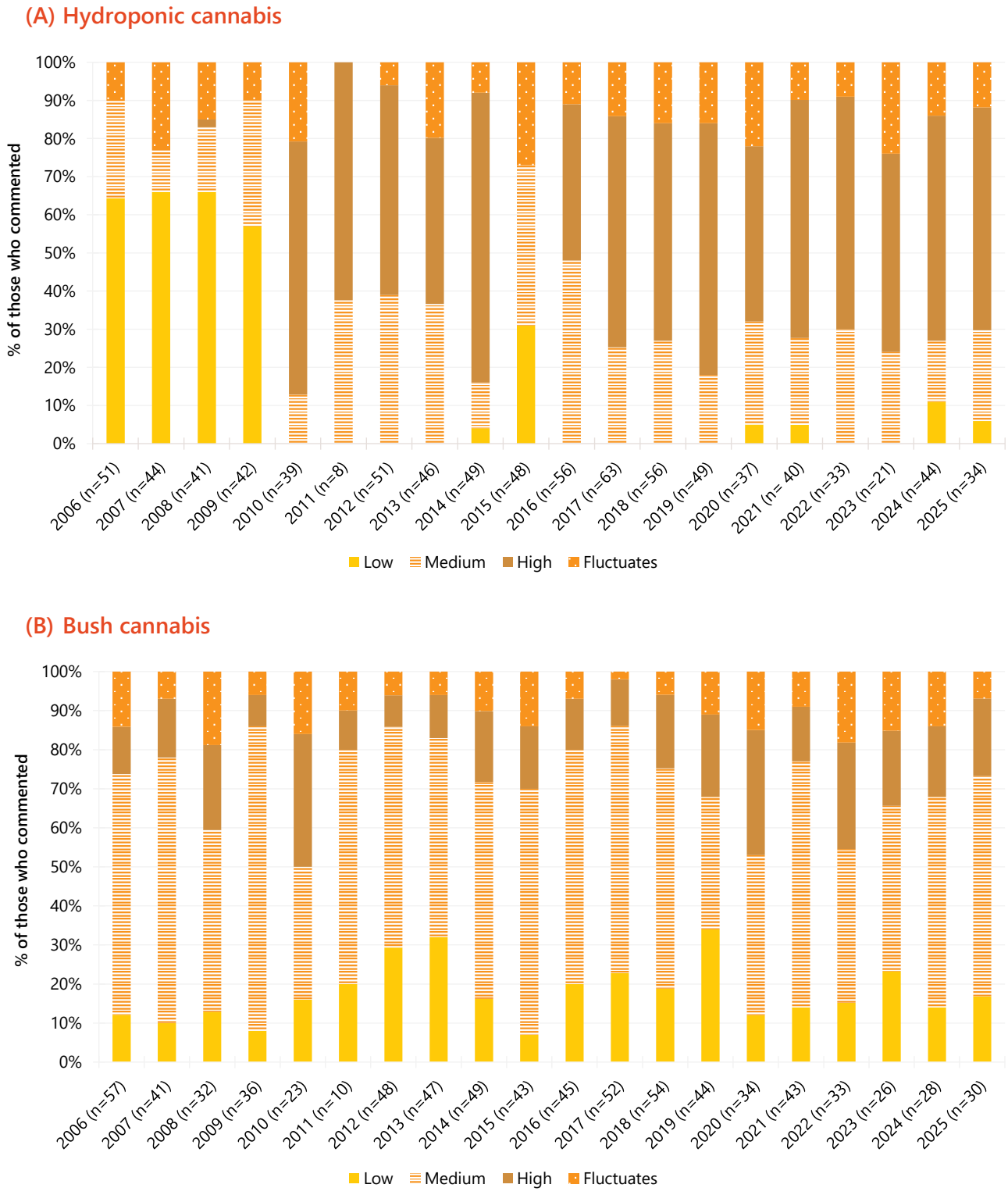
Perceived Availability: The perceived availability of non-prescribed bush cannabis appeared to be significantly greater in 2025 compared to 2024 (*p*=0.008). Among those who were able to respond in 2025 (n=30), the majority (80%) perceived non-prescribed bush cannabis to be 'very easy' to obtain (45% in 2024) (Figure 34B).

Figure 32: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Hobart, TAS, 2006-2025



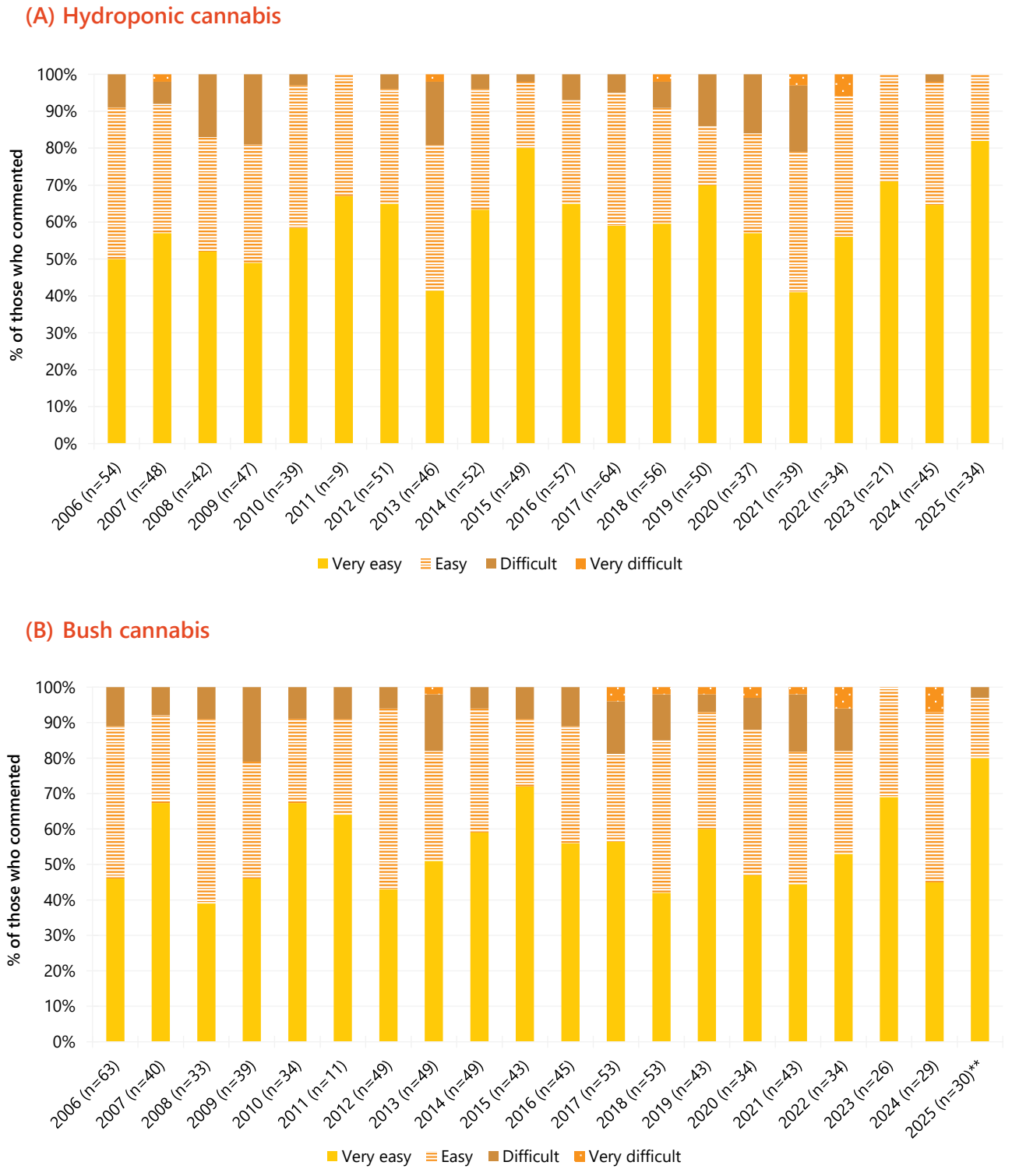
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the price of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where n≤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 33: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Hobart, TAS, 2006-2025



Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the perceived potency of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. 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 34: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Hobart, TAS, 2006-2025



Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the perceived availability of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. 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.

7

Ketamine, LSD and DMT

Non-Prescribed Ketamine

Patterns of Consumption

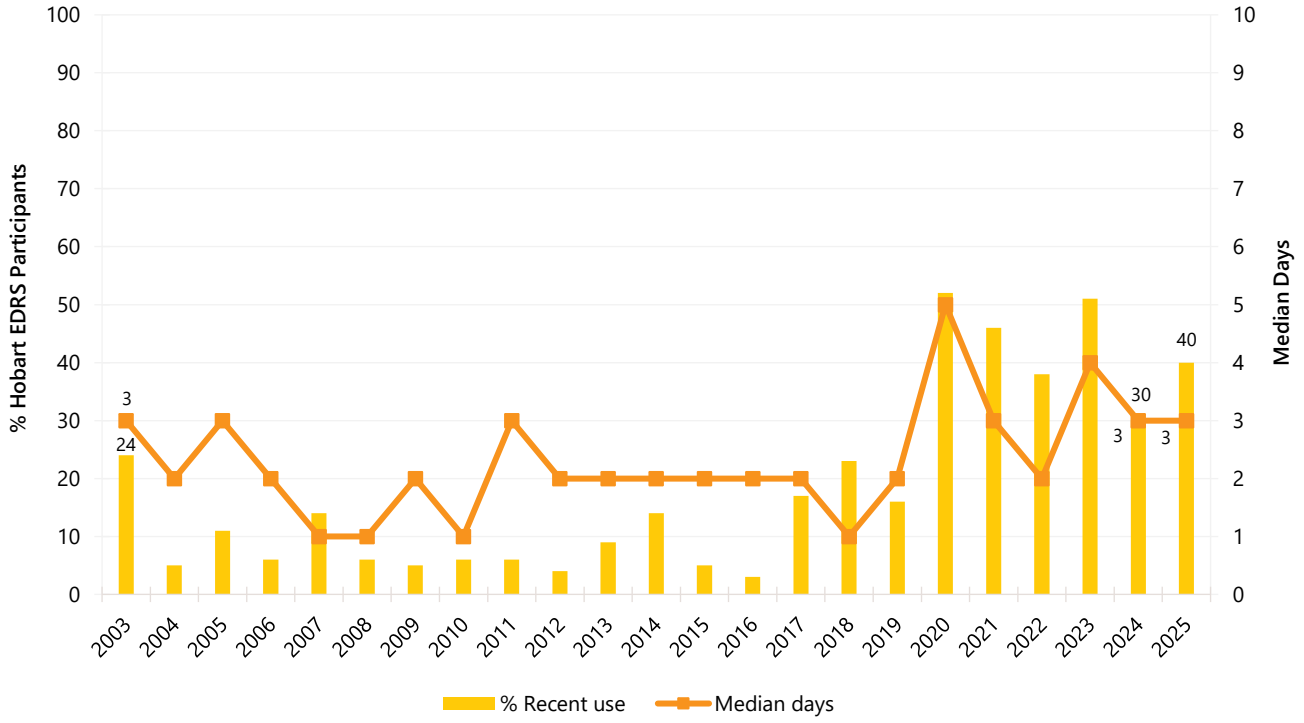
Recent Use (past 6 months): Two fifths (40%) of the Hobart sample reported using non-prescribed ketamine in the six months prior to interview, remaining stable relative to 2024 (30%; p=0.238) (Figure 35).

Frequency of Use: Of those who had recently consumed non-prescribed ketamine and commented (n=27), median days of use remained low and stable in 2025 (3 days; IQR=2-5), relative to 2024 (3 days; IQR=2-7; n=26; p=0.392) (Figure 35). Few participants (n≤5) reported weekly or more frequent use in 2024 and 2025 (p=0.420); therefore, further details are not reported.

Routes of Administration: Among participants who had recently consumed non-prescribed ketamine and commented (n=27), the majority (93%) of participants reported snorting as a route of administration, stable relative to 92% in 2024.

Quantity: Of those who reported recent use and responded (n=21), the median amount of non-prescribed ketamine used in a 'typical' session was 0.50 grams (IQR=0.20-0.70; 0.40 grams in 2024; IQR=0.13-0.88; n=18; p=0.807). Of those who reported recent use and responded (n=21), the median maximum amount of non-prescribed ketamine used in a session was 0.75 grams (IQR=0.25-1.00; 0.50 grams in 2024; IQR=0.21-1.75; n=18; p=0.932).

Figure 35: Past six month use and frequency of use of non-prescribed ketamine, Hobart, TAS, 2003-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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.

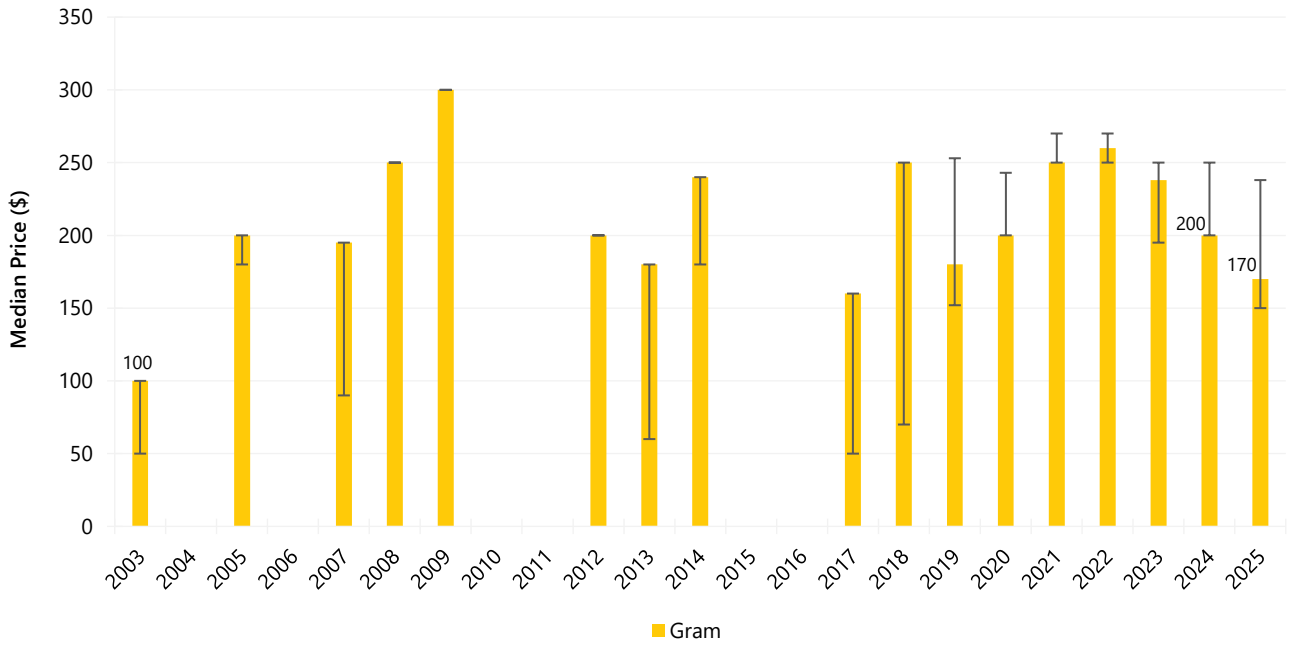
Price, Perceived Purity and Perceived Availability

Price: The median reported price of non-prescribed ketamine has fluctuated somewhat since the commencement of monitoring. The median price per gram of ketamine in 2025 was $170 (IQR=150-238; n=10; $200 in 2024; IQR=200-250; n=8; p=0.172) (Figure 36).

Perceived Purity: The perceived purity of non-prescribed ketamine differed significantly between 2024 and 2025 (p=0.004). Among those who were able to respond in 2025 (n=16), the majority (88%) perceived the purity of ketamine to be 'high' (40% in 2024). Few participants (n≤5) perceived purity to be 'medium' in 2024 and 2025. No participants perceived purity to be 'fluctuating' in 2025 (40% in 2024) (Figure 37).

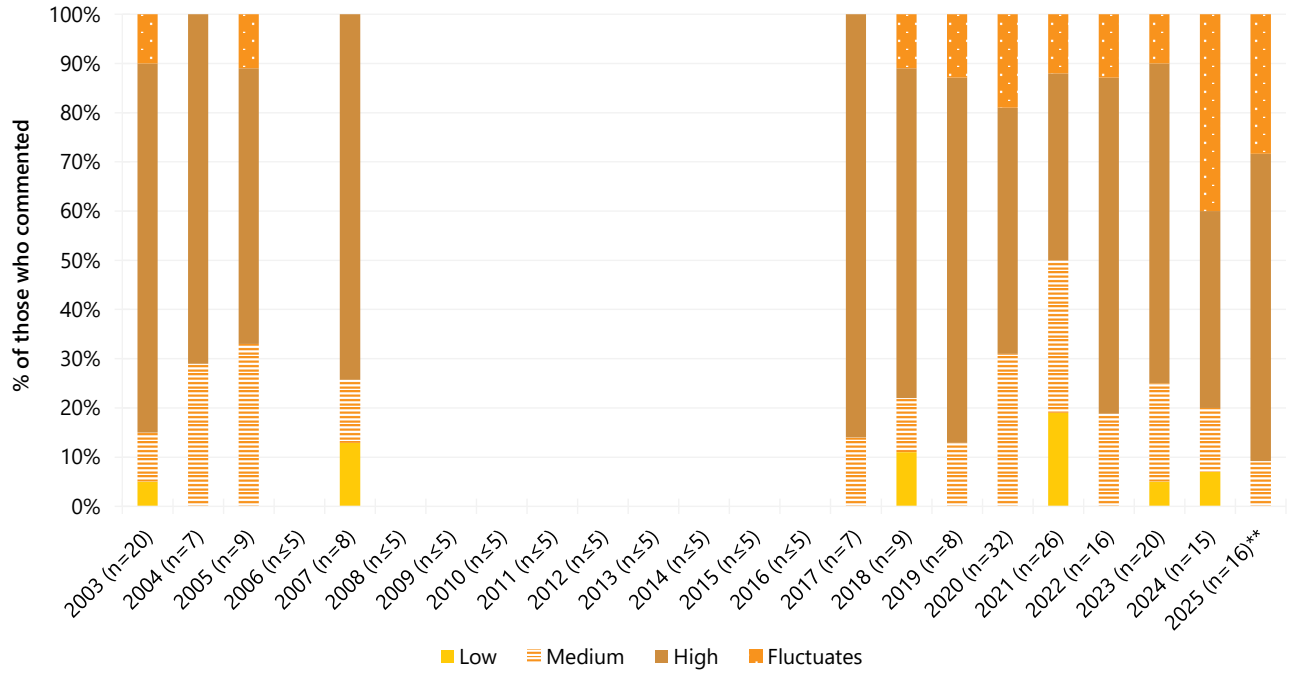
Perceived Availability: The perceived availability of non-prescribed ketamine remained stable between 2024 and 2025 (p=0.362). Of those who were able to respond in 2025 (n=16), 44% perceived non-prescribed ketamine to be 'easy' to obtain (27% in 2024). Few participants (n≤5) perceived it to be 'very easy' (40% in 2024), 'difficult' (n≤5 in 2024) or 'very difficult' (0% in 2024) to obtain (Figure 38).

Figure 36: Median price of non-prescribed ketamine per gram, Hobart, TAS, 2003-2025



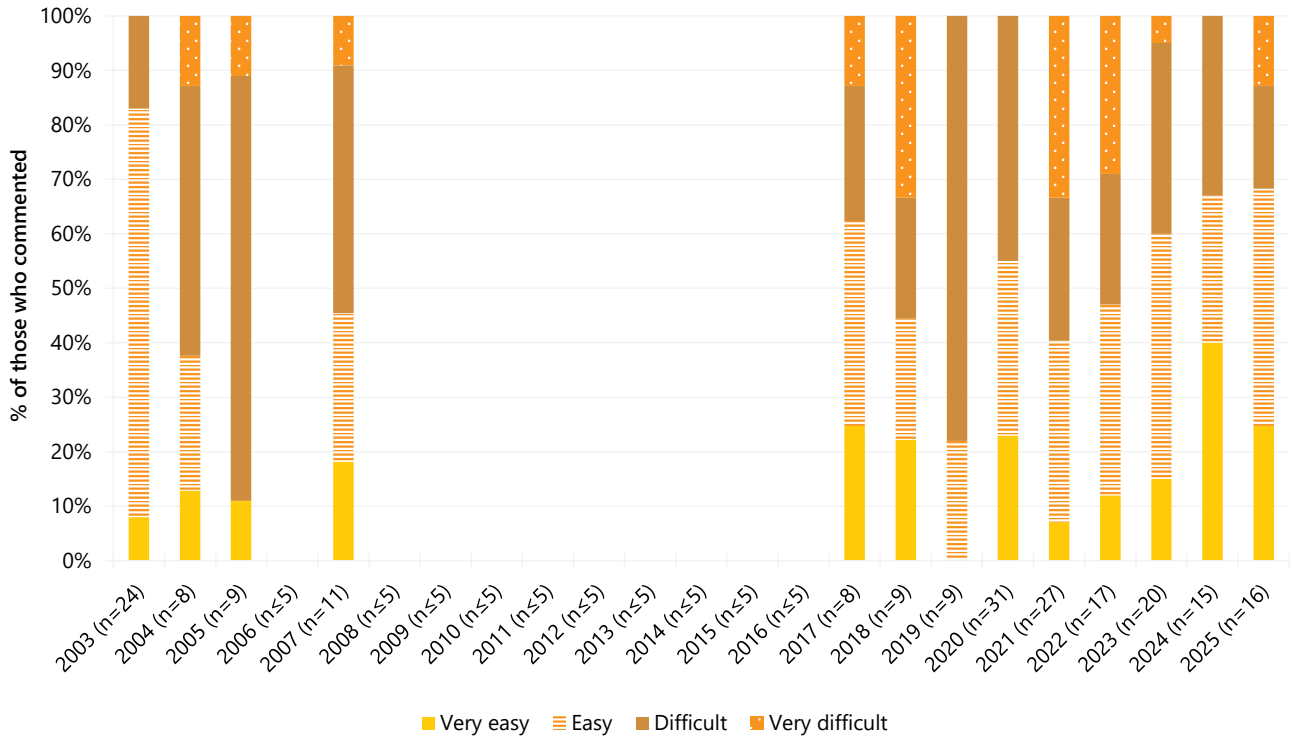
Note. Among those who commented. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only became available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where n≤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 37: Current perceived purity of non-prescribed ketamine, Hobart, TAS, 2003-2025



Note. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only became available via prescription, for treatment resistant depression, in 2021). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 38: Current perceived availability of non-prescribed ketamine, Hobart, TAS, 2003-2025



Note. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only became available via prescription, for treatment resistant depression, in 2021). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

LSD

Patterns of Consumption

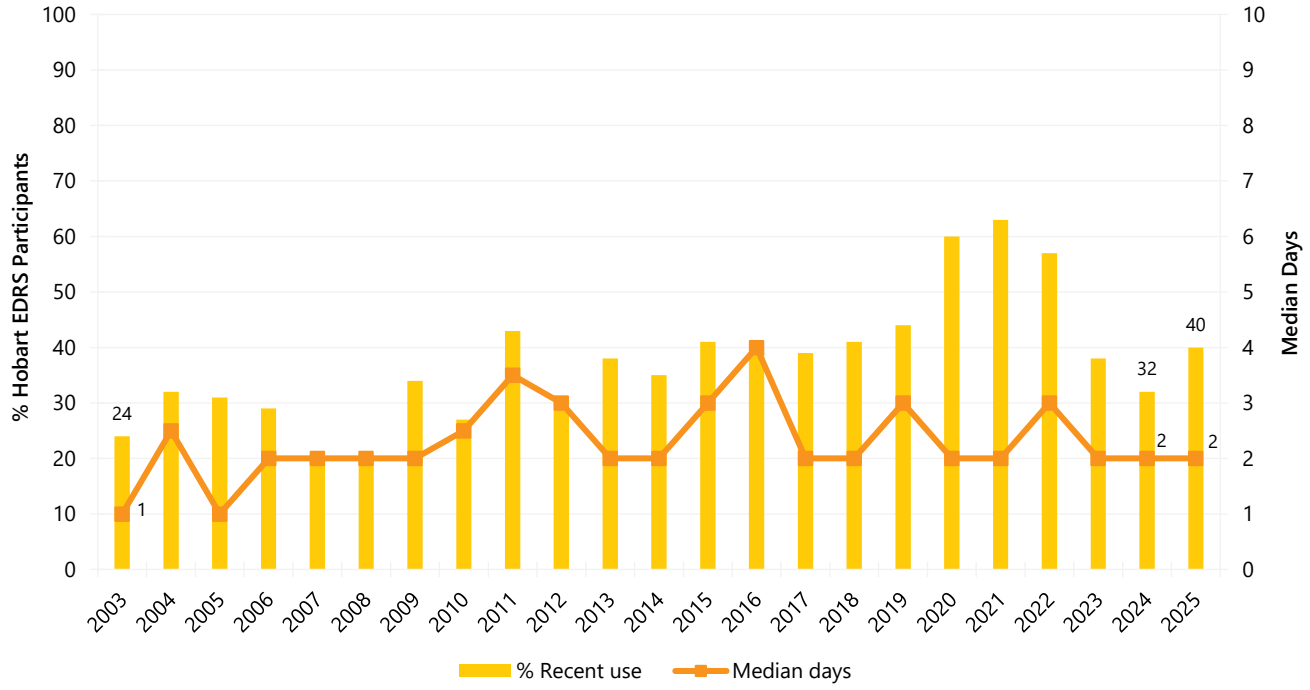
Recent Use (past 6 months): Two fifths (40%) of the Hobart sample had used LSD in the six months preceding interview, stable relative to 2024 (32%; p=0.395) (Figure 39).

Frequency of Use: Median days of LSD use over the years has remained low. Of those who had recently consumed LSD in 2025 and commented (n=27), frequency of use remained stable at two days (IQR=2-6; 2 days in 2024; IQR=1-4; n=28; p=0.479) (Figure 39). Few participants (n≤5) who had recently consumed LSD reported weekly or more frequent use in 2025 (0% in 2024; p=0.491).

Routes of Administration: Among participants who had recently consumed LSD and commented (n=27), all participants (100%) reported swallowing LSD in 2025, stable relative to 2024 (93%; p=0.491).

Quantity: Of those who reported recent use and responded (n=11), the median amount of LSD used in a 'typical' session was one tab (IQR=1-1.5; 1 tab in 2024; IQR=1-2; n=25; p=0.542). Of those who reported recent use and responded (n=12), the median maximum amount of LSD used in a session was two tabs (IQR=1-3; 1 tab in 2024; IQR=1-2; n=24; p=0.449).

Figure 39: Past six month use and frequency of use of LSD, Hobart, TAS, 2003-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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.

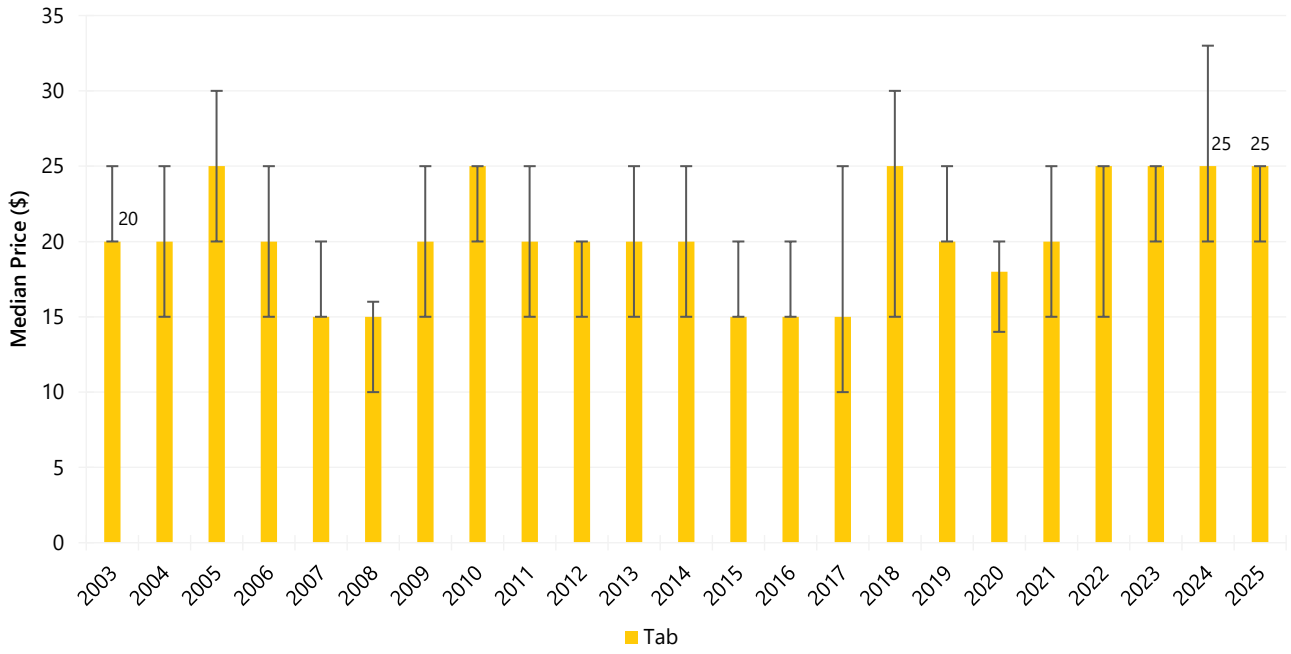
Price, Perceived Purity and Perceived Availability

Price: The median price for one tab of LSD was $25 (IQR=20-25; n=18), stable relative to 2024 ($25; IQR=20-33; n=19; p=0.963) (Figure 40).

Perceived Purity: The perceived purity of LSD remained stable between 2024 and 2025 (p=0.619). Among those who were able to respond in 2025 (n=23), 65% perceived the purity of LSD to be 'high' (64% in 2024). Few participants (n≤5) perceived purity to be 'medium' (22% in 2024) or 'fluctuating' (n≤5 in 2024) (Figure 41).

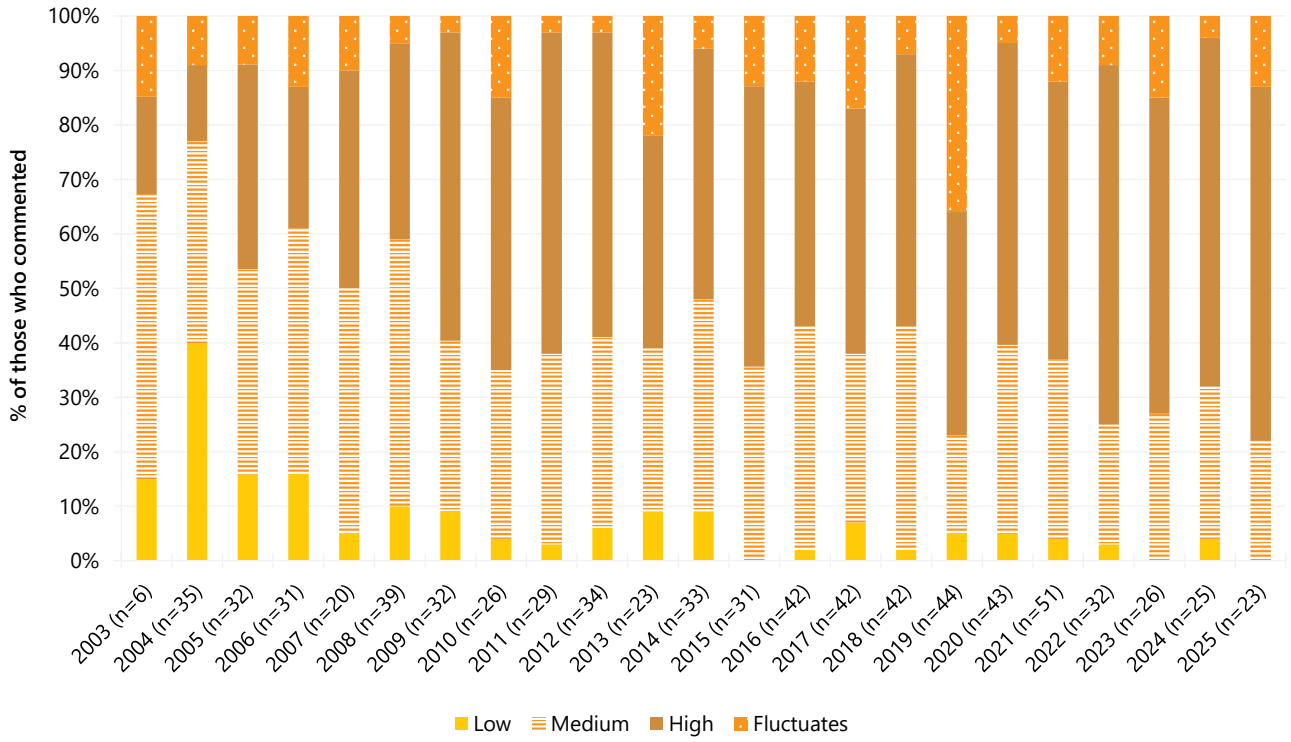
Perceived Availability: The perceived availability of LSD remained stable between 2024 and 2025 (p=0.928). Of those able to comment in 2025 (n=30), one third perceived LSD as being 'very easy' (33%; 24% in 2024) and 'easy' (33%; 36% in 2024) to obtain. Conversely, one quarter (27%) perceived LSD as being 'difficult' to obtain (32% in 2024) (Figure 42).

Figure 40: Median price of LSD per tab, Hobart, TAS, 2003-2025



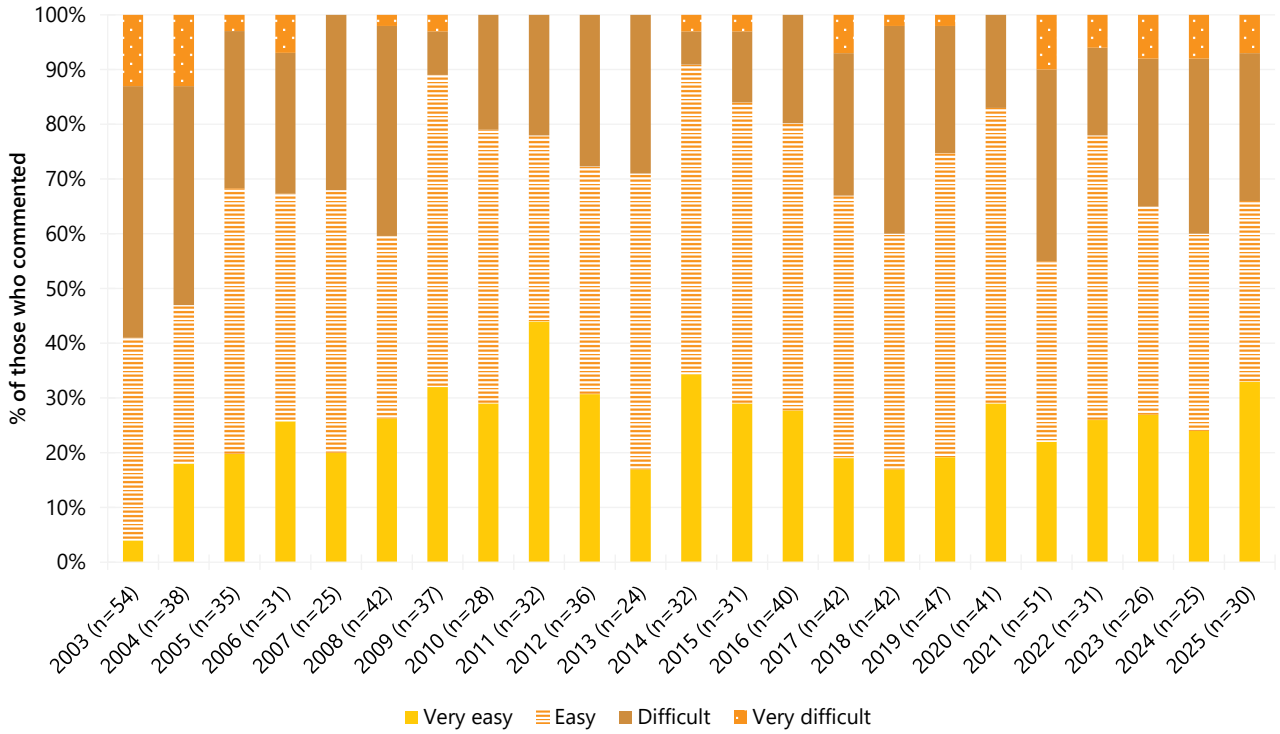
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where n≤5 responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010;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

Figure 41: Current perceived purity of LSD, Hobart, TAS, 2003-2025



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

Figure 42: Current perceived availability of LSD, Hobart, TAS, 2003-2025



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

DMT

Patterns of Consumption

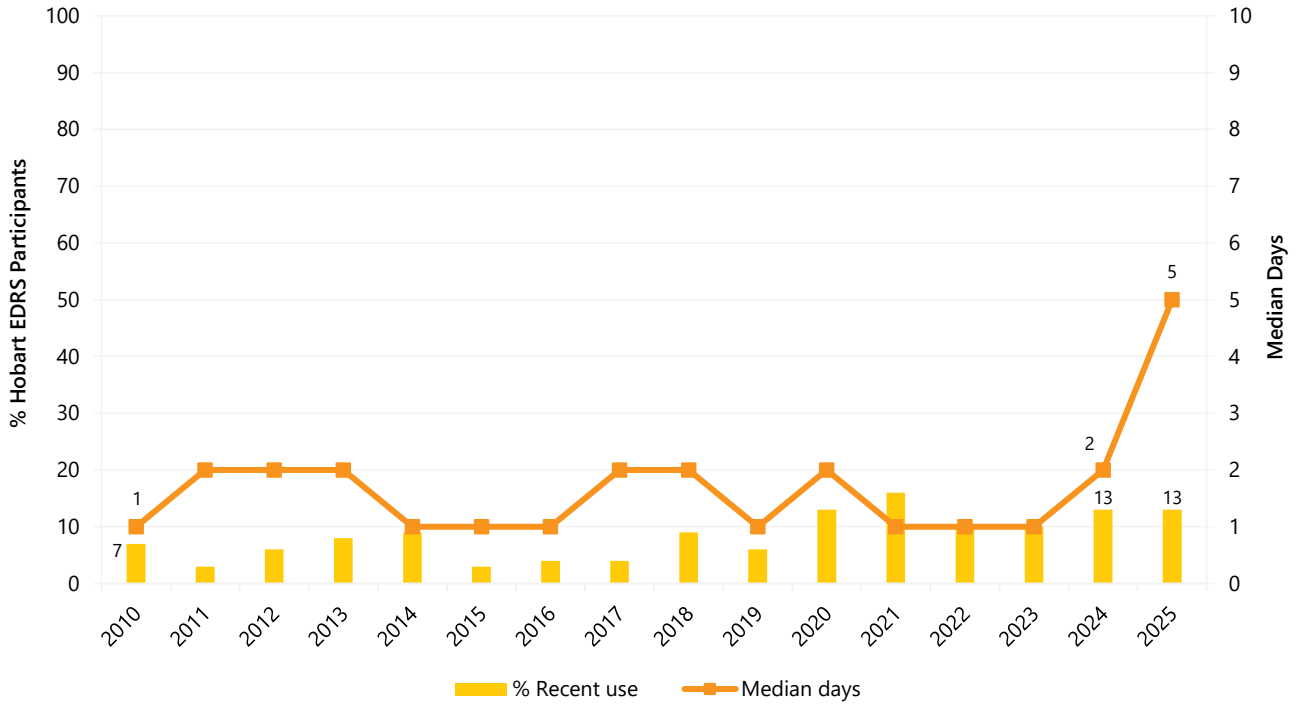
Recent Use (past 6 months): Thirteen per cent of the Hobart sample reported recent use of DMT in 2025, stable relative to 13% in 2024 (Figure 43).

Frequency of Use: Median days of DMT use across the years has been infrequent and stable, with a median of five days of use (IQR=2-6; n=9) reported in 2025 (2 day in 2024; IQR=2-2; n=11; p=0.060) (Figure 43).

Routes of Administration: Among participants who had recently consumed DMT and commented (n=9), the majority (89%) reported smoking as a route of administration, stable relative to 2024 (100%; p=0.450).

Quantity: Few participants (n≤5) reported on the 'typical' and maximum quantity of DMT used in a session in 2024 and 2025; therefore, further details are not reported.

Figure 43: Past six month use and frequency of use of DMT, Hobart, TAS, 2010-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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

New Psychoactive Substances

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

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

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

Recent Use (past 6 months)

Any NPS use, including plant-based NPS, has fluctuated over time, peaking at 49% in 2010 and declining in recent years. In 2025, one tenth (10%) of the Hobart sample reported recent use of NPS (including plant-based NPS), stable relative to 2024 (n≤5; p=0.369) (Table 3).

Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 48% in 2010, declining in recent years and remaining low, with one tenth (10%) reporting recent use in 2025 (n≤5 in 2024; p=0.369) (Table 3).

Forms Used

Participants are asked about a range of NPS, updated each year to reflect key emerging substances of interest. NPS use among the Hobart sample has fluctuated over time, with few (n≤5) or no participants reporting use of any individual NPS (Table 4). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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

%	Excluding plant-based NPS
2010	48
2011	33
2012	24
2013	33
2014	36
2015	18
2016	14
2017	17
2018	21
2019	18
2020	8
2021	10
2022	-
2023	-
2024	-
2025	**10**

Note. Monitoring of NPS first commenced in 2010. In 2021, the decision was made to remove DMT and PMA from the NPS category, with these substances now presented in Chapter 7 and Chapter 9, respectively. This has had a substantial impact on the percentage of the sample reporting 'any' NPS use in the past six months and means that the figures presented above will not align with those presented in previous (2010-2020) EDRS reports. Statistical significance for 2024 versus 2025 presented in table; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Table 4: Past six month use of NPS by drug type, Hobart, TAS, 2013-2025

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
%	N=100	N=75	N=97	N=76	N=100	N=78	N=100	N=100	N=100	N=99	N=100	N=102	N=72	N=65	N=87	N=68
Drugs that mimic the effects of ecstasy	44	31	13	29	32	15	9	-	-	-	-	0	-	-	0	**-**
Mephedrone	42	27	10	24	23	9	-	-	-	0	-	0	0	-	0	**-**
Methylone	/	-	-	-	-	-	-	-	-	0	-	0	-	0	0	**0**
N-ethylbutylone (eutylone)	/	/	/	/	/	/	/	/	/	/	/	0	0	0	0	**0**
N-ethylpentylone (ephylone)	/	/	/	/	/	/	/	/	/	/	0	0	0	0	0	**-**
Other drugs that mimic the effect of ecstasy	/	/	/	/	/	/	/	-	-	-	0	0	-	0	0	**0**
Drugs that mimic the effects of amphetamine or cocaine	-	0	0	0	0	0	0	/	/	/	/	/	/	/	/	**0**
3-Chloromethcathinone (e.g., 3-CMC; clophedrone)	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
3-Methylmethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
4-Chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0	**0**
4-FA	/	/	/	/	/	/	0	0	0	0	0	0	-	0	0	**0**
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
Alpha PVP	/	/	/	/	/	/	0	0	/	/	-	0	0	0	0	**0**
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
MDPV	-	-	-	-	-	-	0	-	0	-	0	0	0	0	0	**0**
Methcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
N-Ethylhexedrone	/	/	/	/	/	/	/	/	/	/	0	0	0	0	0	**0**
Other drugs that mimic the effect of amphetamine or cocaine	/	/	/	/	/	/	/	-	-	-	-	-	0	-	-	**0**
Drugs that mimic the effects of psychedelic drugs	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**-**
Any 2C substance (e.g., 2C-I, 2C-B)~	12	-	-	10	10	-	-	9	-	-	-	-	0	0	0	**0**
4-AcO-DMT	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
5-MeO-DMT	0	-	-	-	-	0	0	0	0	-	-	-	0	0	0	**0**
DO-x (e.g., DOB, DOC, DOI, DOM)	-	0	0	0	0	0	0	-	-	0	0	0	0	0	0	**0**
NBOH (e.g., 25I, 25B)	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
NBOMe (e.g., 25I, 25B, 25C, others)	/	/	/	/	-	-	-	8	-	-	-	-	0	0	0	**-**
Other drugs that mimic the effect of psychedelic drugs like LSD	/	/	/	/	/	/	/	0	-	-	0	-	0	0	-	**0**
Drugs that mimic the effects of dissociatives	/	/	/	/	/	/	/	/	/	/	-	-	0	0	**-**	**-**
2F-2-oxo PCE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**

%	2010 N=100	2011 N=75	2012 N=97	2013 N=76	2014 N=100	2015 N=78	2016 N=100	2017 N=100	2018 N=100	2019 N=99	2020 N=100	2021 N=102	2022 N=72	2023 N=65	2024 N=87	2025 N=68
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
3F-2-oxo PCE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
3-HO-PCP/4-HO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
3-MeO-PCP/4- MeO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
Methoxetamine	/	/	0	-	10	-	-	-	0	-	0	0	0	0	0	**0**
Tiletamine	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Other drugs that mimic the effects of dissociatives	/	/	/	/	/	/	/	/	/	/	-	-	0	0	-	**-**
Drugs that mimic the effects of cannabis	/	/	8	/	-	-	-	-	7	-	-	-	0	-	0	**-***
Drugs that mimic the effects of benzodiazepines	/	/	/	/	/	/	/	/	0	0	0	-	0	0	0	**0**
8-Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
Bromazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
Clobromazolam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Clonazolam	/	/	/	/	/	/	/	/	/	/	/	/	-	0	0	**0**
Etizolam	/	/	/	/	/	/	0	-	-	-	-	-	-	0	0	**0**
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
Flubromazepam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Phenazolam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Other drugs that mimic the effect of benzodiazepines	/	/	/	/	/	/	/	/	0	0	0	-	0	0	0	**0**
Drugs that mimic the effects of opioids	/	/	/	/	/	/	/	0	0	-	0	0	0	0	-	**0**
Drugs that mimic the effects of any other NPS	/	/	/	/	/	/	/	/	-	0	-	0	-	-	-	**-**

Note. NPS first asked about in 2010. Due to lower numbers reporting use in recent years, in 2025 participants were asked about broad categories of NPS (e.g., drugs that mimic the effects of ecstasy) and then if reported use, were asked to specify the substance. ~ In 2010 and between 2017-2019, three forms of 2C were asked about whereas between 2011-2016 four forms were asked about. From 2020 onwards, 'any' 2C use is captured. Statistical significance for 2024 versus 2025 presented in table; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

9

Other Drugs

Non-Prescribed Pharmaceutical Drugs

Codeine

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

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

Recent Use (past 6 months): In 2025, one fifth (18%) of the Hobart sample reported using any non-prescribed codeine (e.g., Nurofen Plus, Panadeine, Panadeine Extra) in the six months preceding interview, stable relative to 2024 (14% in 2024; p=0.641) (Figure 44).

Frequency of Use: Participants who had recently used non-prescribed codeine and commented (n=12) reported use on a median of sixteen days (IQR=4-38) in the six months preceding interview, a significant increase from three days in 2024 (IQR=1-3; n=12; p=0.012).

Pharmaceutical Opioids

Recent Use (past 6 months): In 2025, 12% of the Hobart sample reported recent use non-prescribed pharmaceutical opioids, excluding codeine (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl), stable relative to 2024 (n≤5; p=0.131) (Figure 44).

Frequency of Use: Participants who had recently used non-prescribed pharmaceutical opioids and commented (n=8), reported use on a median of fourteen days (IQR=3-32) in the six months preceding interview (n≤5 in 2024).

Forms used: Few participants (n≤5) reported on any specific forms of non-prescribed pharmaceutical opioids used in 2025; therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Benzodiazepines

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

Recent Use (past 6 months): Recent use of non-prescribed benzodiazepines (e.g., Valium, Diazepam, Xanax, Kalma) has fluctuated considerably over the course of monitoring, with one quarter (26%) of the Hobart sample reporting recent use in 2025, stable relative to 2024 (29%; p=0.851) (Figure 44).

Frequency of Use: Participants who reported recent non-prescribed use of benzodiazepines (e.g., Valium, Diazepam, Xanax, Kalma) and commented (n=18), reported use on a median of eleven days (IQR=4-19) in the six months preceding interview, stable relative to 2024 (5 days; IQR=2-10; n=25; p=0.116).

Forms Used: Among those who reported recent non-prescribed benzodiazepine use and responded in 2025 (n=14), Valium (diazepam) (64%) was the most commonly used benzodiazepine.

Steroids

Recent Use (past 6 months): The per cent of the sample reporting recent non-prescribed steroid use has remained low and stable since monitoring commenced. In 2025, no participants reported recent use, stable relative to 2024 (n≤5; p=0.504) (Figure 44). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

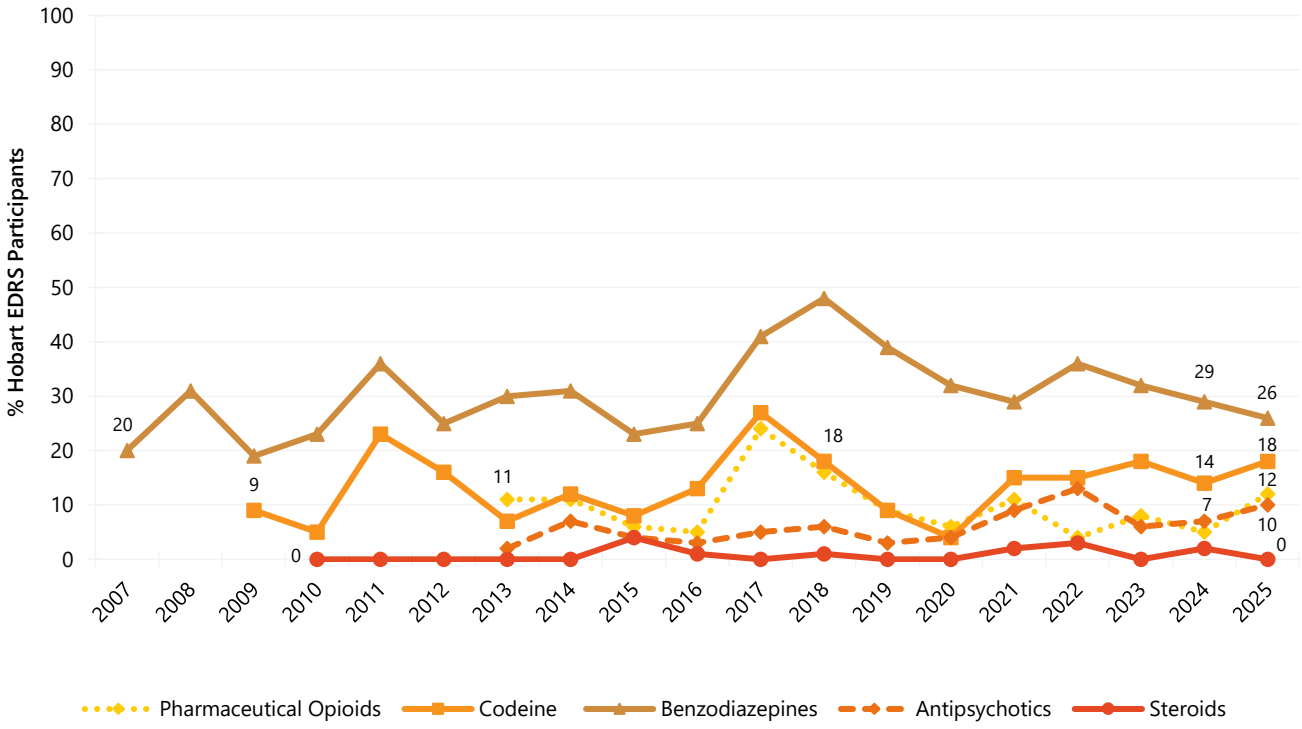
Antipsychotics

Recent Use (past 6 months): Ten per cent of the Hobart sample had recently used non-prescribed antipsychotics in 2025, stable relative to 2024 (7%; p=0.563) (Figure 44).

Frequency of Use: Participants who had recently used non-prescribed antipsychotics and commented (n=7) reported use on a median of eight days (IQR=5-68) in the six months preceding interview (2 days in 2024; IQR=1-5; n=6; p=0.779).

Forms Used: Few participants (n≤5) reported on any specific forms of non-prescribed antipsychotics in 2025; therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 44: Non-prescribed use of pharmaceutical medicines in the past six months, Hobart, TAS, 2007-2025



Note. Non-prescribed use is reported for prescription medicines. Monitoring of over-the-counter (OTC) codeine (low-dose codeine) commenced in 2010, however, in February 2018, the scheduling for codeine changed such that low-dose codeine formerly available OTC was required to be obtained via a prescription. To allow for comparability of data, the time series here represents non-prescribed low- and high dose codeine (2018-2024), with high-dose codeine excluded from pharmaceutical opioids from 2018. Between 2019 and 2023, participants were asked about 'alprazolam' and 'other benzodiazepines'. In 2024, 'alprazolam' and 'other benzodiazepines' were combined. Y axis has been reduced to 60% to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Other Illicit Drugs

Non-Prescribed Hallucinogenic Mushrooms/Psilocybin

Recent Use (past 6 months): In 2025, one third (32%) of the Hobart sample reported recent use of non-prescribed hallucinogenic mushrooms/psilocybin in the six months prior to interview, stable relative to 2024 (29%; p=0.710) (Figure 45).

Frequency of Use: Participants who had recently used non-prescribed hallucinogenic mushrooms/psilocybin and commented (n=22), reported use on a median of three days (IQR=1-13) in the six months prior to interview in 2025, stable relative to 2024 (2 days; IQR=1-7; n=25; p=0.471).

MDA

Recent Use (past 6 months): In 2025, 14% of the Hobart sample reported recent use of MDA, stable relative to 14% in 2024 (Figure 45).

Frequency of Use: Participants who reported recent use of MDA and commented (n=9), reported use on a median of five days (IQR=2-12) in the six months prior to interview in 2025 (3 days in 2024; IQR=1-6; n=12; *p*=0.564).

Substance with Unknown Contents

Recent Use (past 6 months): From 2019, we asked participants about their use of substances with 'unknown contents'. Almost one quarter (24%) of the Hobart sample reported recent use of any substance with 'unknown contents' in 2025 (28% in 2024; *p*=0.578) (Figure 45). Of those who had recently consumed any 'unknown' substance and responded (n=16), participants reported use on a median of three days (IQR=2-7) in the six months preceding interview in 2025, stable relative to 2024 (2 days; IQR=1-4; n=24; *p*=0.113).

When broken down by form, 13% of participants reported recent use of both powder (13% in 2024) and pills (12% in 2024; *p*=0.138) with 'unknown contents' in 2025. Few participants (n≤5) reported recent use of capsules (16% in 2024; *p*=0.138) and crystal (n≤5 in 2024; *p*=0.138) with 'unknown contents' in 2025.

Quantity: From 2020, we asked participants about the average amount of pills and capsules used with 'unknown contents' in the six months preceding interview. Of those who reported recent use of pills with 'unknown contents' and commented (n=8), the median amount used in a 'typical' session was two pills (IQR=1-3) in 2025 (1.5 pills in 2024; IQR=1-2; n=10; *p*=0.201). Few participants (n≤5) were able to answer questions regarding the median quantity of capsules used in a 'typical' session in 2025; therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

PMA

Few participants (n≤5) reported recent use of PMA in 2025 (0% in 2024; *p*=0.435) (Figure 45). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

PMMA

No participants reported recent use of PMMA in 2024 and 2025 (Figure 45). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Heroin

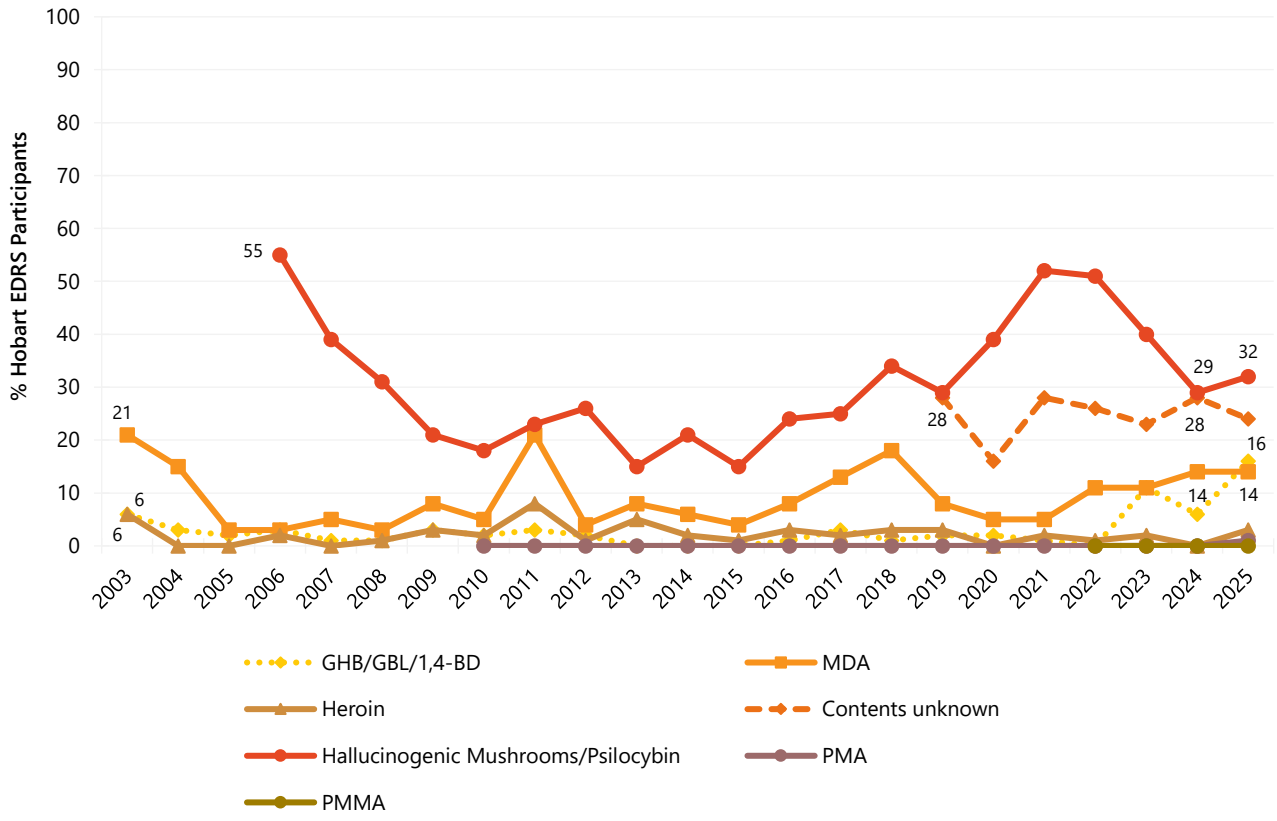
Few participants (n≤5) reported recent use of heroin in 2025; therefore, further details are not reported (0% in 2024; *p*=0.191) (Figure 45). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

GHB/GBL/1,4-BD (Liquid E)

Recent Use (past 6 months): In 2025, sixteen per cent of the Hobart sample reported recent use of GHB/GBL/1,4-BD in the six months prior to interview (n≤5 in 2024; *p*=0.060) (Figure 45).

Frequency of Use: Participants who reported recent use of GHB/GBL/1,4-BD and commented (n=11), reported use on a median of three days (IQR=2-4) in the six months prior to interview in 2025 (n≤5 in 2024; *p*=0.909).

Figure 45: Past six month use of other illicit drugs, Hobart, TAS, 2003-2025



Note. From 2019, participants were asked about 'substances contents unknown' (with further ascertainment by form). 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.

Licit and Other Drugs

Alcohol

Recent Use (past 6 months): The majority of the Hobart sample continued to report recent use of alcohol in 2025 (88%), stable relative to 2024 (92%; p=0.582) (Figure 46).

Frequency of Use: A median of 24 days of alcohol use in the six months preceding interview (IQR=14-60; n=60) was reported in 2025 (35 days in 2024; IQR=12-71; n=80; p=0.385). Almost three fifths (58%) of those who had recently consumed alcohol had done so on a weekly or more frequent basis in 2025, stable relative to 2024 (69%; p=0.221). One tenth (10%) reported daily use of alcohol in 2025 (n≤5 in 2024; p=0.326).

Tobacco

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

Recent Use (past 6 months): Three quarters (76%) of the Hobart sample reported recent tobacco use in 2025, stable from 77% reporting recent use in 2024 (Figure 46). Forty-seven per cent of reported

recent use of smoked or non-smoked illicit tobacco products in 2025, a significant increase relative to 2024 (25%; *p*=0.006).

Frequency of Use: Participants reported using tobacco on a median of 180 days in 2025 (IQR=90-180; n=52), stable relative to 2024 (180 days; IQR=50-180; n=67; *p*=0.517), with three fifths (63%) of participants who had recently used tobacco reporting daily use (57% in 2024; *p*=0.570).

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, regardless of whether they contained nicotine. In 2025, participants were asked about their use of e-cigarettes obtained from pharmacy (with or without a prescription) and 'non-pharmacy' locations.

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

Recent Use (past 6 months): Three fifths (60%) of the 2024 Hobart sample had used illicit e-cigarettes in the six months preceding interview (57% in 2024; *p*=0.736) (Figure 46), the highest percentage observed since the commencement of monitoring.

Frequency of Use: A median frequency of 180 days of illicit use was reported in the past six months in 2025 (IQR=90-180; n=41), a significant increase from 66 days in 2024 (IQR=20-180; n=50; *p*=0.018). Fifty-four per cent of participants who had recently used illicit e-cigarettes reported daily use, stable relative to 2024 (40%; *p*=0.226).

Contents and Forms Used: Among participants who had recently used illicit e-cigarettes and responded (n=41), participants most commonly reported using disposable devices (95%), followed by re-fillable devices (27%).

Reason for Use: Of those who reported *any* e-cigarette use and responded (n=41), 46% of the Hobart sample reported that they had used e-cigarettes as a smoking cessation tool in 2025, stable relative to 44% in 2024.

Nicotine Pouches

Recent Use (past 6 months): One tenth (10%) of the Hobart sample reported recent use of nicotine pouches in the six months preceding interview in 2025 (17% in 2024; *p*=0.258) (Figure 46).

Frequency of Use: Participants who had recently used nicotine pouches reported use on a median of four days (IQR=3-15; n=7), stable relative to 2024 (2 days; IQR=1-25; n=15; *p*=0.405).

Nitrous Oxide

Recent Use (past 6 months): One third (32%) of the Hobart sample reported recent use of nitrous oxide in 2025, stable relative to 31% in 2024 (Figure 46).

Frequency of Use: Frequency of use remained stable at a median of three days (IQR=1-10; n=22) in 2025 (4 days in 2024; IQR=2-7; n=27; *p*=0.509).

Quantity: Among those who reported recent use and responded (n=19), the median amount used in a 'typical' session was four bulbs (IQR=2-7.5; 4.5 bulbs in 2024; IQR=2-10.5; n=24; *p*=0.537). Of those who reported recent use and responded (n=19), the median maximum amount used was 5 bulbs (IQR=2.5-10; 7 bulbs in 2024; IQR=3-20; n=24; *p*=0.411).

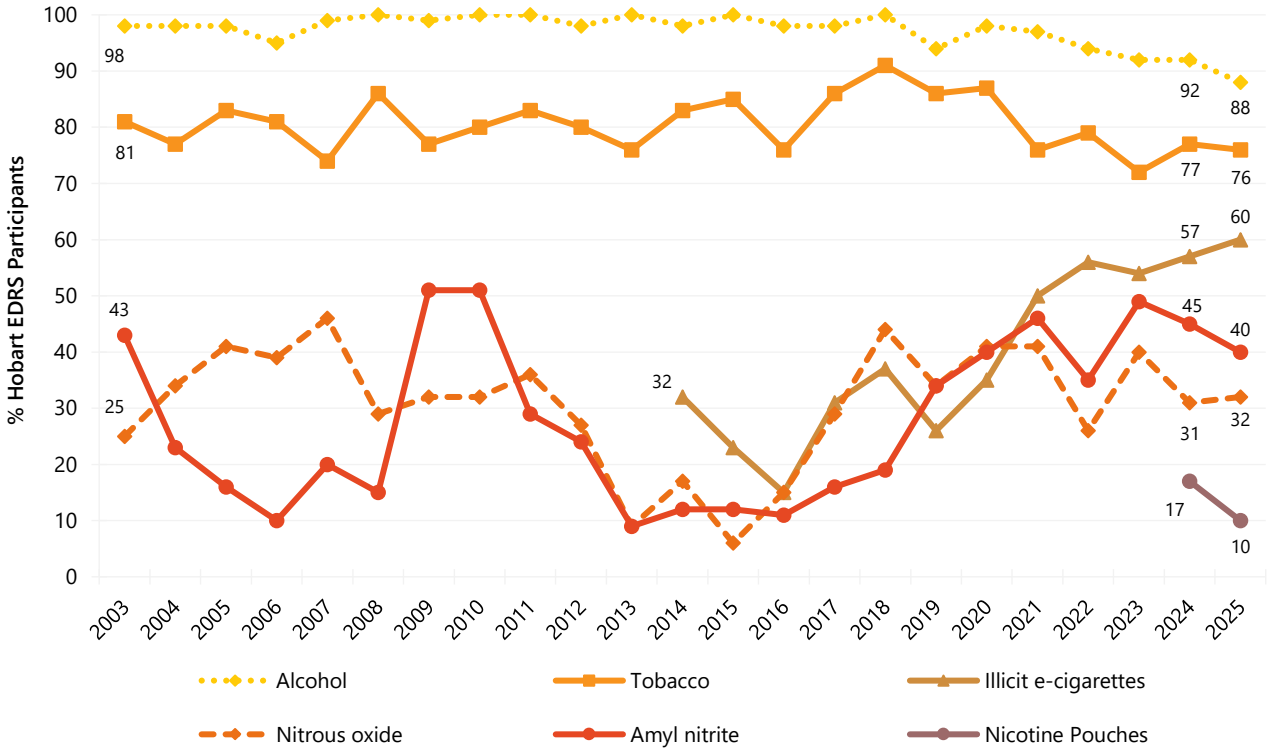
Amyl Nitrite

Following a review by the Therapeutic Goods Administration, amyl nitrite was listed as Schedule 3 (i.e., for purchase over-the-counter) from 1 February 2020 when sold "in preparations for human therapeutic use and packaged in containers with child-resistant closures". However, to our knowledge, the TGA has not yet approved any amyl nitrite products for supply in Australia.

Recent Use (past 6 months): After considerable fluctuation over the course of monitoring, two fifths (40%) of the Hobart sample reported recent use of amyl nitrite in 2025, stable relative to 2024 (45%; *p*=0.622) (Figure 46). In 2025, few participants (n≤5) reported that they had obtained amyl nitrite from a pharmacy in the past six months (not asked in 2024).

Frequency of Use: A median of seven days of use was reported in 2025 (IQR=3-24; n=27; 4 days in 2024; IQR=2-9; n=39; *p*=0.179).

Figure 46: Licit and other drugs used in the past six months, Hobart, TAS, 2003-2025



Note. Regarding e-cigarettes, on 1 October 2021, legislation came into effect requiring people to obtain a prescription to legally import nicotine vaping products. Data from 2022 onwards refers to non-prescribed e-cigarettes only. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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.

10

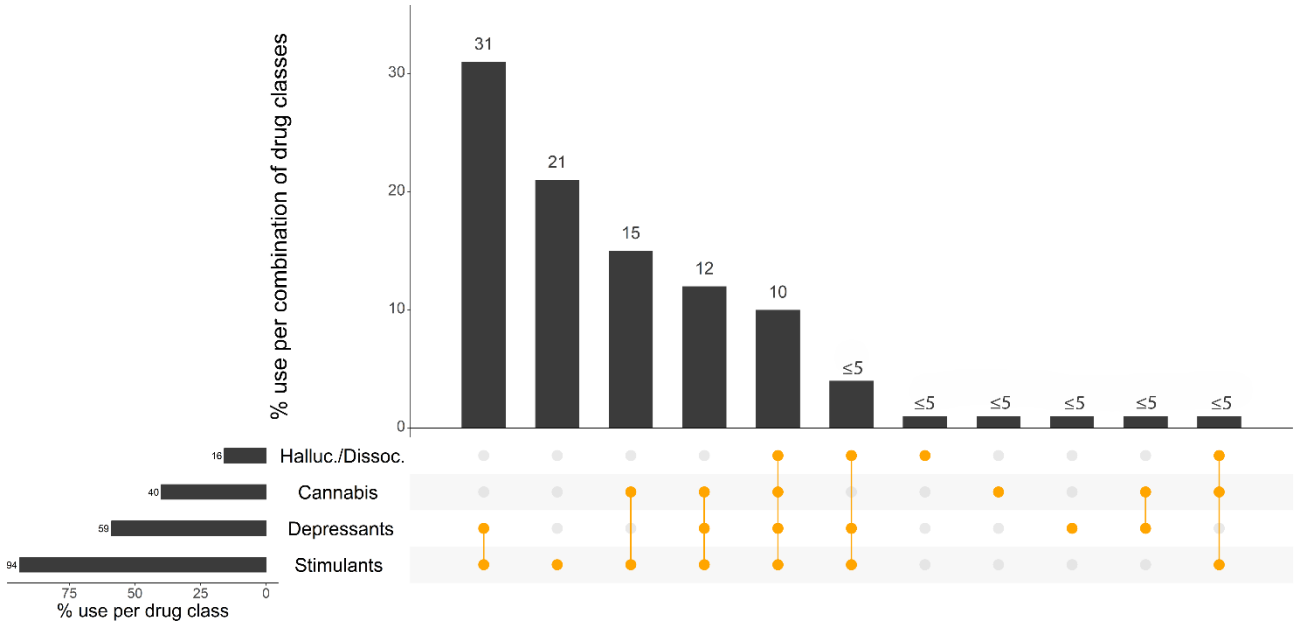
Drug-Related Harms and Other Behaviours

Polysubstance Use

Among those who responded (n=54), the most commonly used substances on the last occasion of ecstasy or related drug use were ecstasy (63%) and alcohol (60%), followed by tobacco (47%), cannabis (41%), methamphetamine (28%) and cocaine (28%).

Four fifths (79%; n=54) of the Hobart sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most commonly used combination of drug classes was stimulants and depressants (31%), followed by stimulants alone (21%). Fifteen per cent reported using stimulants and cannabis, and 12% reported using stimulants, depressants and cannabis (Figure 47).

Figure 47: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Hobart, TAS, 2025: Most common drug pattern profiles

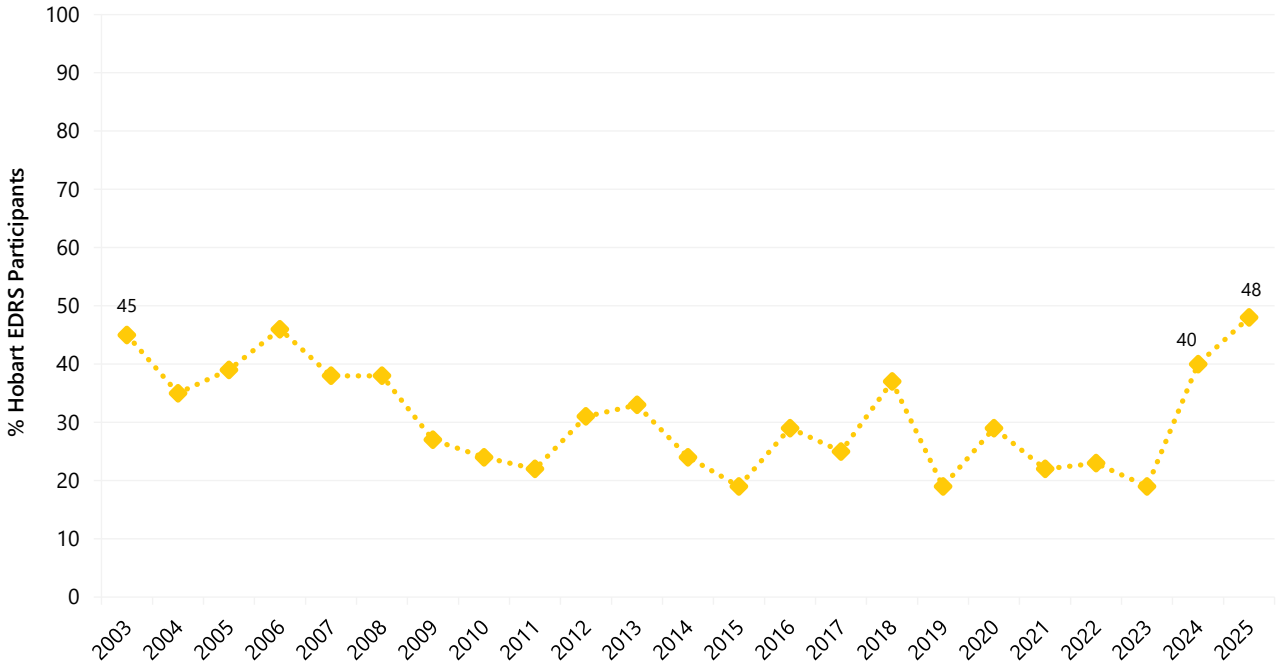


Note. % calculated out of total EDRS 2025 sample. The horizontal bars represent the per cent of participants who reported use of each substance on their last occasion of ecstasy or related drug use; the vertical columns represent the per cent of participants who used the combination of drug classes represented by the orange circles. Drug use pattern profiles reported by ≤5 participants or which did not include any of the four drug classes depicted are not shown in the figure but are counted in the denominator. Halluc./Dissoc = hallucinogens/dissociatives (LSD, hallucinogenic mushrooms, amyl nitrite, DMT, ketamine and/or nitrous oxide); depressants (alcohol, GHB/GBL,1,4-BD, kava, opioids and/or benzodiazepines); stimulants (cocaine, MDA, ecstasy, methamphetamine, and/or pharmaceutical stimulants). Use of benzodiazepines, opioids and stimulants could be prescribed or non-prescribed use. Note that participants may report use of multiple substances within a class. Y axis reduced to 30% to improve visibility of trends.

Binge Drug Use

Participants were asked whether they had used any stimulant for 48 hours or more continuously without sleep (i.e., binged) in the six months preceding interview. Almost half (48%) of the Hobart sample had binged on one or more drugs in the preceding six months (40% in 2024; p=0.321), the highest percentage observed since monitoring commenced (Figure 48).

Figure 48: Past six month use of stimulants or related drugs for 48 hours or more continuously without sleep ('binge'), Hobart, TAS, 2003-2025



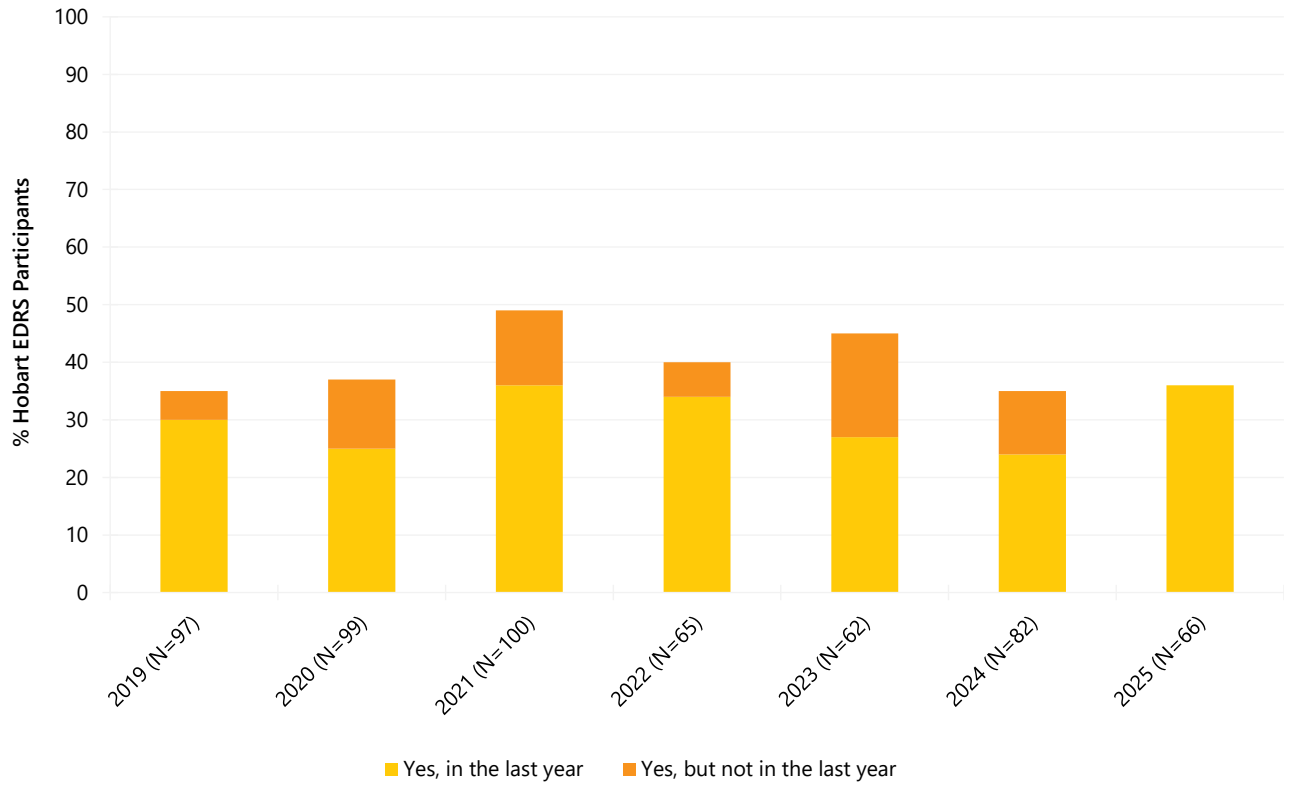
Note. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p <0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for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

Drug Checking

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

In 2025, 36% of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year, stable relative to 2024 (24%; p=0.149) (Figure 49). Of those who reported that they or someone else had tested their illicit drugs in the past year and commented (n=24), all participants (100%) reported using a personal testing kit – most commonly, 71% reported using colorimetric reagent test kits, followed by 33% using professional testing equipment (e.g., Fourier Transform Infrared Spectroscopy) or testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips). Few participants (n≤5) reported that they or someone else had tested their illicit drugs in the past year at an event-based face-to-face testing service (e.g., festival pill-testing service. No participants reported submitting samples at a fixed-site face-to-face drug checking service (e.g., a drop-in service in a central location) or via a postal/online testing service (e.g., Energy Control, Ecstasy Data).

Figure 49: Lifetime and past year engagement in drug checking, Hobart, TAS, 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; see data tables for values. 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.

Alcohol Use Disorders Identification Test

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

In 2025, the mean score on the AUDIT for the total Hobart sample (including people who had not consumed alcohol in the past 12 months) was 13.0 (SD 8.4), a significant decrease from 14.5 (SD 7.6) in 2024 (p<0.001). AUDIT scores are divided into four 'zones' which indicate risk level. Specifically, scores between 0-7 indicate low risk drinking or abstinence; scores between 8-15 indicate alcohol use in excess of low-risk guidelines; scores between 16-19 indicate harmful or hazardous drinking; and scores 20 or higher indicate possible alcohol dependence. There was no significant change in the per cent of the sample falling into each of these risk categories from 2024 to 2025 (p=0.268) (Table 5).

Almost three quarters (73%) of the sample obtained a score of eight or more (84% in 2024; p=0.150), indicative of hazardous use (Table 5).

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

	2010 N=99	2011 N=72	2012 N=98	2013 N=75	2014 N=99	2015 N=78	2016 N=99	2017 N=98	2018 N=99	2019 N=98	2020 N=100	2021 N=99	2022 N=72	2023 N=65	2024 N=81	2025 N=59
Mean AUDIT total score (SD)	14.6 (5.4)	19.3 (6.0)	17.3 (6.1)	15.5 (7.7)	15.9 (6.5)	16.1 (5.2)	13.4 (6.6)	14.2 (6.3)	14.2 (7.0)	12.5 (6.1)	12.5 (5.5)	13.5 (6.7)	13.6 (7.8)	13.2 (8.2)	14.5 (7.6)	**13.0*** (8.4)**
Score 8≤ (%)	93	99	94	85	96	96	79	85	81	78	81	87	79	78	84	**73**
AUDIT zones (%)																
Score 0-7	7	-	6	15	-	-	21	15	19	22	19	13	21	22	16	**27**
Score 8-15	52	28	34	45	51	44	47	43	39	49	56	56	42	49	48	**42**
Score 16-19	20	19	27	11	17	23	14	22	17	18	12	15	18	11	16	**8**
Score 20≤	21	51	34	29	28	29	17	19	24	11	13	16	19	18	20	**22**

Note. Monitoring of AUDIT first commenced in 2010. Computed from the entire sample regardless of whether they had consumed alcohol in the past twelve months. Total AUDIT score range is 0-40, with higher scores indicating greater likelihood of hazardous and harmful drinking. Imputation used for missing scale scores. Statistical significance for 2024 versus 2025 presented in table; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Overdose Events

Non-Fatal Overdose

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

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

- **Alcohol overdose:** experience of symptoms (e.g., reduced level of consciousness and collapsing) where professional assistance would have been helpful.

- **Stimulant overdose:** experience of symptoms (e.g., nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, seizure, extreme paranoia, extreme anxiety, panic, extreme agitation, hallucinations, excited delirium) where professional assistance would have been helpful.

- **Other drug overdose (not including alcohol or stimulant drugs):** similar definition to above. Note that in 2019, participants were prompted specifically for opioid overdose, but this was removed in 2020 as few participants endorsed this behaviour.

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

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

Non-Fatal Stimulant Overdose

In 2025, one quarter (25%) of the Hobart sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview, stable relative to 2024 (35%; p=0.221) (Figure 50).

The most common stimulant reported during the most recent non-fatal stimulant overdose in the past 12 months comprised any form of ecstasy (50%; n≤5 for pills, crystal, capsules and powder). Among those who experienced a recent non-fatal stimulant overdose and responded (n=16), 69% reported that they had also consumed one or more additional drugs on the last occasion, most notably, alcohol (41%; ≥5 standard drinks: 41%; ≤5 standard drinks: 0% participants). On the last occasion of experiencing a non-fatal stimulant overdose (n=29), few participants (n≤5) reported receiving treatment or assistance. Due to few participants (n≤5) reporting on forms of treatment on the last occasion of experiencing a non-fatal stimulant overdose, please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Non-Fatal Depressant Overdose

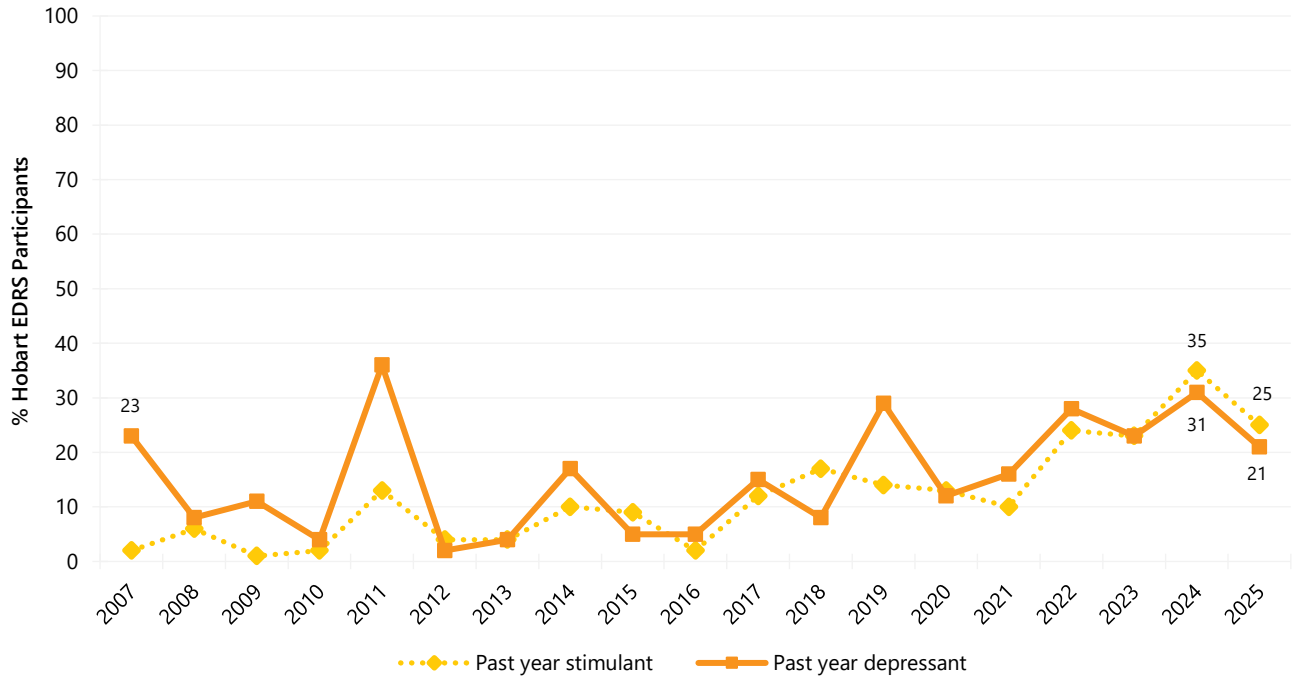
Alcohol: Almost one fifth (19%) of the Hobart sample reported a non-fatal alcohol overdose in the 12 months preceding interview (28% in 2024; p=0.259) on a median of two occasions (IQR=1-3). Of those who had experienced an alcohol overdose in the past year (n=13), the majority (69%) reported

not receiving treatment on the last occasion. Due to few participants (n≤5) reporting that they had received treatment or assistance, please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Any depressant (including alcohol): In 2025, one fifth (21%) of participants reported that they had experienced a non-fatal depressant overdose in the past 12 months, stable relative to 2024 (31%; *p*=0.154) (Figure 50).

Of those who had experienced any depressant overdose in the past 12 months (n=14), the majority (93%) of participants reported alcohol as the most common depressant drug. Few participants (n≤5) reported a non-fatal depressant overdose due to other drugs; therefore, these data are suppressed. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 50: Past 12 month non-fatal stimulant and depressant overdose, Hobart, TAS, 2007-2025



Note. Past year stimulant and depressant overdose was first asked about in 2007. In 2019, items about overdose were revised, and changes relative to 2018 may be a function of greater nuance in capturing depressant events. 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.

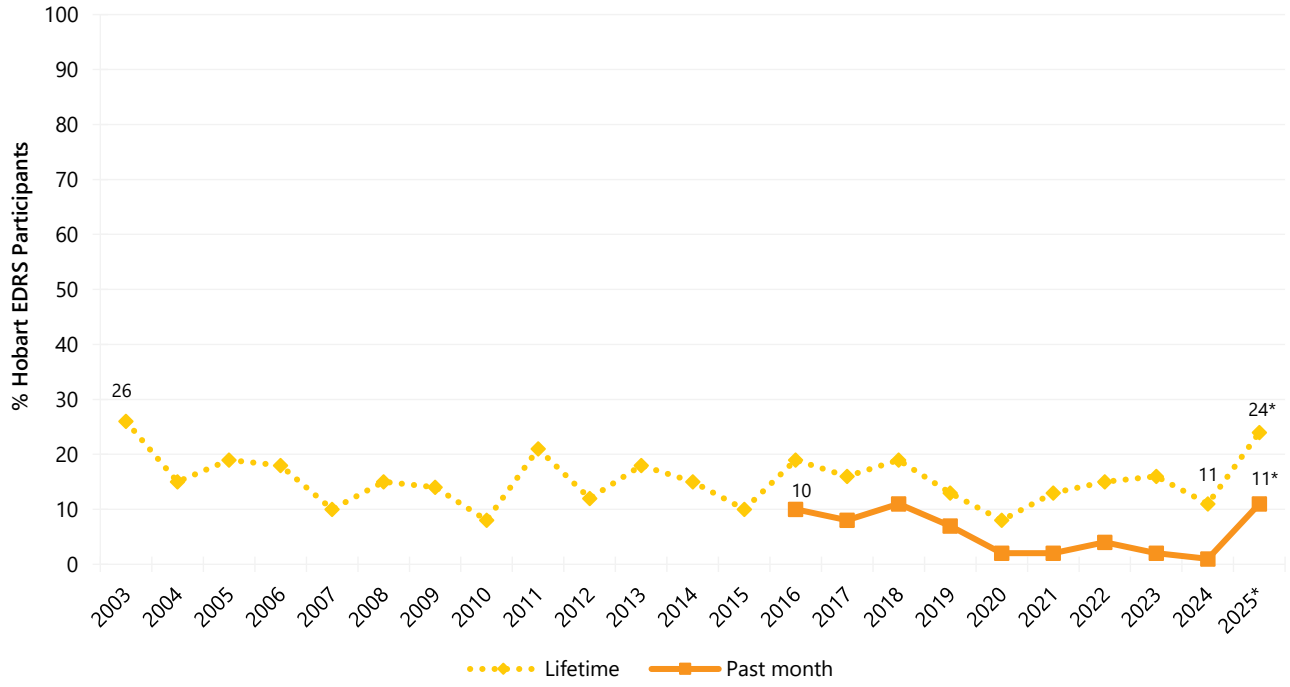
Awareness of Naloxone

In 2025, 63% reported that they had ever heard of naloxone, stable relative to 62% in 2024. Among those who had ever heard of naloxone and responded (n=39), 90% were able to correctly identify the purpose of naloxone, stable from 96% in 2024 (p=0.397). Among participants who had ever heard of naloxone and responded (n=41), 44% reported obtaining naloxone in their lifetime (27% of the entire sample), a significant increase relative to 20% in 2024 (p=0.015), and 39% reported obtaining naloxone in the 12 months prior to interview (24% of the entire sample), also a significant increase relative to 2024 (n≤5; p=0.001).

Injecting Drug Use and Associated Risk Behaviours

One quarter (24%) of the Hobart sample reported lifetime injection in 2025, a significant increase to 11% in 2024 (p=0.029), and one tenth (11%) reported injecting drugs in the past month, also a significant increase relative to 2024 (n≤5; p=0.022) (Figure 51).

Figure 51: Lifetime and past month drug injection, Hobart, TAS, 2003-2025



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

Drug Treatment

In 2025, few participants (n≤5) of the Hobart sample reported currently receiving drug treatment (10% in 2024; p=0.391); therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Ecstasy and Methamphetamine Dependence

From 2015, participants were asked questions from the Severity of Dependence Scale (SDS) adapted to investigate ecstasy and methamphetamine dependence. The SDS is a five-item questionnaire designed to measure the degree of dependence on a variety of drugs. The SDS focuses on the psychological aspects of dependence, including impaired control of drug use, and preoccupation with, and anxiety about use. A total score was created by summing responses to each of the five questions. Possible scores range from 0 to 15.

To assess ecstasy dependence in the past six months, a cut-off score of three or more was used, as this has been found to be a good balance between sensitivity and specificity for identifying problematic dependent ecstasy use. Among those who reported recent ecstasy use and commented (n=59), one fifth (20%) recorded a score of three or above, stable relative to 2024 (22%; p=0.832). The median ecstasy SDS score was zero (IQR=0-2). Forty-nine per cent of participants obtained a score of zero on the ecstasy SDS (49% in 2024), indicating that half the respondents reported no or few symptoms of dependence in relation to ecstasy use (Table 6).

To assess methamphetamine dependence in the past six months, the cut-off of four and above, which is a more conservative estimate, has been used previously in the literature as a validated cut-off for methamphetamine dependence. Of the 33 participants who reported recent methamphetamine use and completed this section, thirty-six per cent scored four or above, stable relative to 2024 (52%; p=0.320). The median methamphetamine SDS score was two (IQR=0-7). In 2025, thirty per cent of participants obtained a score of zero on the methamphetamine SDS, stable relative to 33% in 2024 (Table 6).

Table 6: Total ecstasy and methamphetamine SDS scores, and per cent of participants scoring above cut-off scores indicative of dependence, among those who reported past six month use, Hobart, TAS, 2015-2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Ecstasy	**n=77**	**n=97**	**n=100**	**n=99**	**n=93**	**/**	**n=88**	**n=68**	**n=55**	**n=77**	**n=59**
Median total score (IQR)	2 (0-4)	1 (0-4)	0 (0-1)	1 (0-2)	0 (0-1)	/	0 (0-2)	0 (0-1)	0 (0-1)	0 (0-2)	**0 (0-2)**
% score =0	32	47	57	47	63	/	51	62	71	49	**49**
% score ≥3	42	34	10	16	13	/	25	10	-	22	**20**
Methamphetamine	**n=31**	**n=39**	**n=40**	**n=42**	**n=44**	**n=30**	**n=21**	**n=27**	**n=26**	**n=33**	**n=33**
Median total score (IQR)	2 (0-4)	1 (0-4)	0 (0-2)	0 (0-1)	0 (0-1)	0 (0-1)	1 (0-4)	0 (0-3)	1 (0-5)	4 (0-8)	**2 (0-7)**
% score =0	29	36	58	62	68	70	48	56	38	33	**30**
% score ≥4	29	46	23	-	20	-	29	22	27	52	**36**

Note. Severity of Dependence scores calculated out of those who used ecstasy/methamphetamine recently (past 6 months). A cut-off score of ≥3 and ≥4 is used to indicate screening positive for potential ecstasy and methamphetamine dependence, respectively. Imputed values used for missing scale scores. Statistical significance for 2024 versus 2025 presented in table; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Sexual Health Behaviours

In 2025, almost three quarters (73%) of the Hobart sample reported some form of sexual activity in the past four weeks, stable relative to 2024 (72%) (Table 7). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if the interview was undertaken face-to-face).

Of those who had engaged in sexual activity in the past four weeks and who responded (n=45), three fifths (80%) reported using alcohol and/or other drugs prior to or while engaging in sexual activity, stable relative to 2024 (78%; p=0.808). Of those who had engaged in sexual activity in the past four weeks and responded (n=45), 16% reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (10% in 2024; p=0.554), whilst 27% reported that they had used alcohol and/or other drugs to enhance sexual activity or pleasure with another person (39% in 2024; p=0.218). Few participants (n≤5) had engaged in sexual activity in exchange for money, drugs, or other goods or services (n≤5 in 2024; p=0.577) (Table 7).

Of those who commented (n=63), one quarter (25%) reported having a sexual health check-up in the six months prior to interview (37% in 2024; p=0.212), whilst 62% had done so in their lifetime (73% in 2024; p=0.162). Of the total sample who responded (n=63), few participants (n≤5) reported that they had received a positive diagnosis for a sexually transmitted infection (STI) in the past six months in 2025 (n≤5 in 2024; p=0.388), whilst one fifth (21%) had received a positive diagnosis in their lifetime, stable relative to 2024 (22%) (Table 7). No participants reported on the specific types of STIs diagnosed in 2025. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Of those who commented (n=63), one fifth (22%) of the sample reported having a test for human immunodeficiency virus (HIV) in the six months prior to interview (27% in 2024; p=0.564), whilst 62% had done so in their lifetime, stable relative to 62% in 2024. In 2024 and 2025, no participants had been diagnosed with HIV in the past six months or within their lifetime (Table 7).

Table 7: Sexual health behaviours, Hobart, TAS, 2021-2025

	2021	2022	2023	2024	2025
Of those who responded[#]:	n=99	n=61	n=54	n=82	**n=62**
% Any sexual activity in the past four weeks	82	79	81	72	**73**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=82	n=47	n=44	n=59	**n=45**
% Drugs and/or alcohol used prior to or while engaging in sexual activity	82	85	68	78	**80**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=82	n=48	n=42	n=59	**n=45**
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	11	-	-	10	**16**
% Drugs and/or alcohol used to enhance sexual activity or pleasure with another person	/	/	/	39	**27**
Of those who responded[#] and reported any sexual activity in the past four weeks:	/	/	/	n=59	**n=45**
% Engaged in sexual activity in exchange for money, drugs or other goods or services^	/	/	/	-	**-**
Of those who responded[#]:	n=98	n=60	n=53	n=79	**n=63**
% Had a HIV test in the last six months	18	22	15	27	**22**
% Had a HIV test in their lifetime	53	57	70	62	**62**
Of those who responded[#]:	n=98	n=60	n=53	n=79	**n=63**
% Diagnosed with HIV in the last six months	0	0	0	0	**0**
% Diagnosed with HIV in their lifetime	-	0	0	0	**0**
Of those who responded[#]:	n=100	n=61	n=55	n=82	**n=63**
% Had a sexual health check in the last six months	39	39	31	37	**25**
% Had a sexual health check in their lifetime	80	89	84	73	**62**
Of those who responded[#]:	n=98	n=60	n=55	n=82	**n=63**
% Diagnosed with a sexually transmitted infection in the last six months	-	-	-	-	**-**
% Diagnosed with a sexually transmitted infection in their lifetime	18	26	29	22	**21**

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.

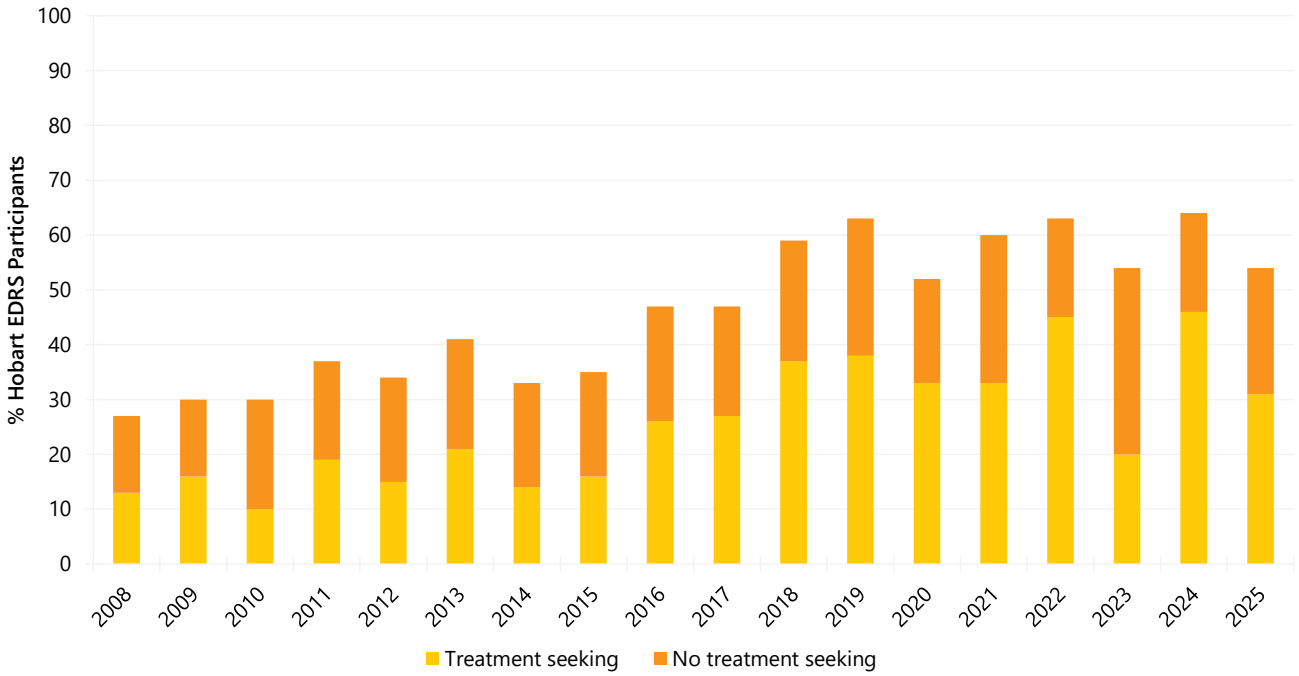
Mental Health and Psychological Distress (K10)

Mental Health

Fifty-four per cent of the Hobart sample self-reported that they had experienced a mental health problem in the preceding six months (other than drug dependence), stable relative to 2024 (64%; p=0.192). Of those who reported a mental health problem in 2025 and commented (n=35), the most common mental health problem reported was anxiety (69%; 71% in 2024; p=0.256), followed by depression (51%; 58% in 2024; p=0.227), and post-traumatic stress disorder (PTSD) (17%; 29% in 2024; p=0.113). In contrast, there was a significant decrease of participants who self-reported experiencing attention-deficit/hyperactivity disorder (ADHD), with one fifth (20%) reporting ADHD as a mental health problem (38% in 2024; p=0.038).

Of those who reported experiencing a mental health problem (n=36), almost three fifths (58%) (31% of the total sample) reported seeing a mental health professional during the six months preceding interview (71% in 2024; p=0.262) (Figure 52). Of those who reported seeing a mental health professional in 2025 (n=21), seventy per cent reported being prescribed medication for their mental health problem (80% in 2024; p=0.513).

Figure 52: Self-reported mental health problems and treatment seeking in the past six months, Hobart, TAS, 2008-2025



Note. Questions about treatment seeking were first asked in 2008. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Psychological Distress (K10)

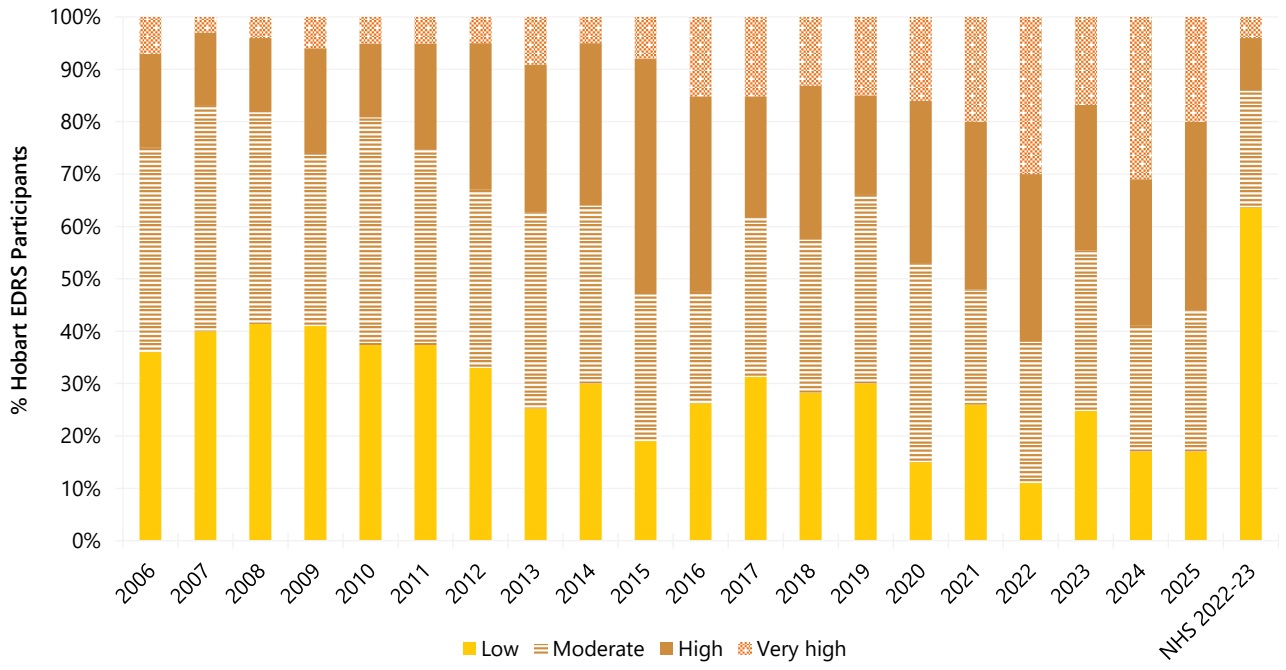
The Kessler Psychological Distress Scale 10 (K10) was administered to obtain a measure of psychological distress in the past four weeks. It is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured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

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

The per cent of participants scoring in each of the four K10 categories remained relatively stable between 2024 and 2025 (p=0.399). Among those who responded in 2025 (n=66), one fifth (20%) had a score of 30 or more (31% in 2024) (Figure 53).

The National Health Survey 2022-23 provides Australian population data for adult (≥18 years) K10 scores. EDRS participants in 2025 reported greater levels of 'high' and 'very high' distress compared to the general population (Figure 53).

Figure 53: K10 psychological distress scores, Hobart, TAS, 2006-2025 and among the general population, 2022-2023



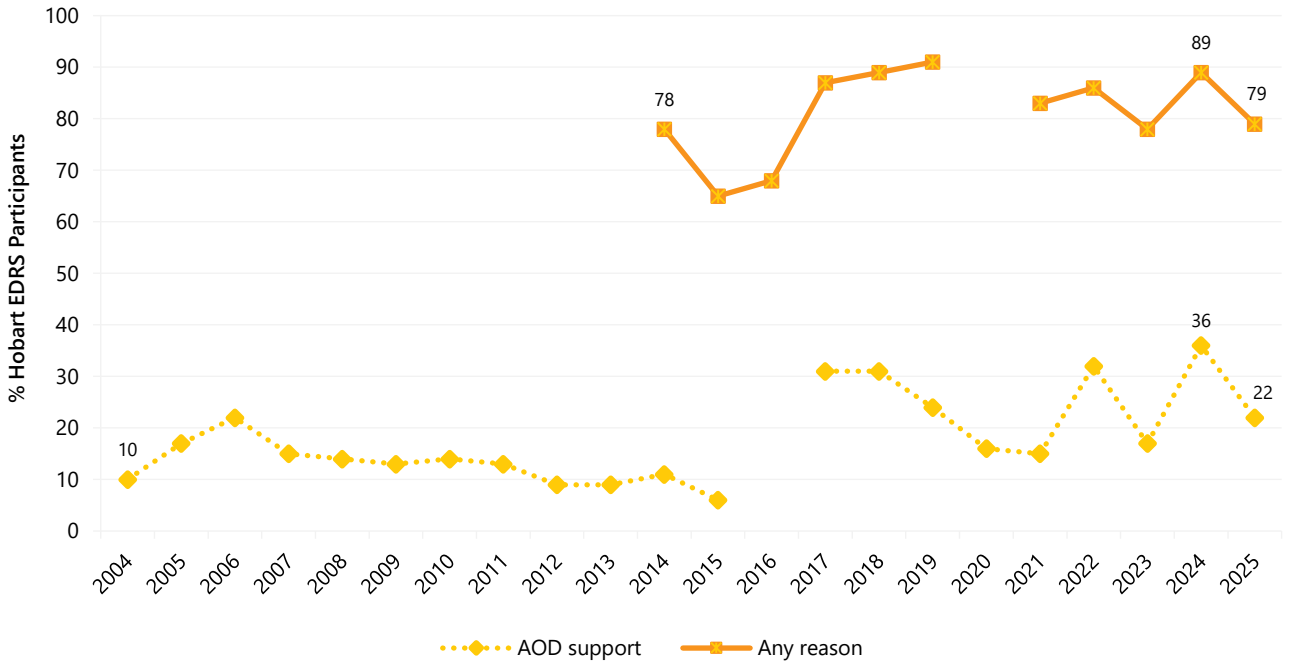
Note. Data from the National Health Survey are a national estimate from 2022-23 for adults 18 or older. Imputation used for missing scale scores (EDRS only). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Statistical significance for 2024 versus 2025 presented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

In 2025, one fifth (22%) of the Hobart sample reported accessing any health service for alcohol and/or drug support (AOD) in the six months preceding interview, stable relative to 2024 (36%; p=0.079) (Figure 54). The most common service accessed by participants in 2025 was a general practitioner (GP) (12%; 20% in 2024; p=0.273) (Table 8).

Four fifths (79%) of participants reported accessing any health service for any reason in the six months preceding interview in 2025, stable relative to 2024 (89%; p=0.184) (Figure 54). The most common services accessed by participants in 2025 was a GP (63%; 76% in 2024; p=0.117), followed by a pharmacy (40%; 38% in 2024; p=0.866), a dentist (24%; 24% in 2024) and the emergency department (22%; 29% in 2024; p=0.363) (Table 8).

Figure 54: Health service access for alcohol and other drug reasons, and for any reason, in the past six months, Hobart, TAS, 2004-2025



Note. Questions about health service access for any reason were first asked about in 2015. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Table 8: Types of health services accessed for alcohol and other drug reasons and for any reason in the past six months, Hobart, TAS, 2022-2025

	AOD support				Any reason			
	2022 N=72	2023 N=65	2024 N=87	2025 N=68	2022 N=72	2023 N=65	2024 N=87	2025 N=68
% Accessing health services	32	17	36	**22**	86	78	89	**79**
% Type of service accessed *(participants could select multiple services)*								
GP^	15	9	20	**12**	76	58	76	**63**
In-person	/	/	/	**12**	/	/	/	**59**
Telehealth	/	/	/	**0**	/	/	/	**16**
Emergency department	-	-	9	**-**	14	22	29	**22**
Hospital admission (inpatient)	-	-	-	**-**	13	14	8	**10**
Medical tent (e.g., at a festival)	-	-	-	**-**	0	-	-	**-**
Drug and Alcohol counsellor	8	-	9	**-**	8	-	9	**-**
Hospital as an outpatient	-	-	-	**0**	-	11	8	**-**
Specialist doctor (not including a psychiatrist)	0	-	0	**-**	17	-	-	**15**
Dentist	-	-	-	**0**	28	32	24	**24**
Ambulance attendance	-	-	-	**-**	-	-	10	**-**
Pharmacy	/	/	-	**-**	/	/	38	**40**
Other health professional (e.g., physiotherapist)	-	-	0	**-**	13	-	9	**19**
Psychiatrist	-	-	-	**-**	13	-	8	**-**
Psychologist	13	-	-	**-**	36	20	28	**13**
NSP	-	0	-	**-**	-	0	-	**-**
Peer based harm reduction service	0	-	-	**-**	-	-	-	**-**
Other harm reduction service	-	0	-	**0**	-	-	-	**0**

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

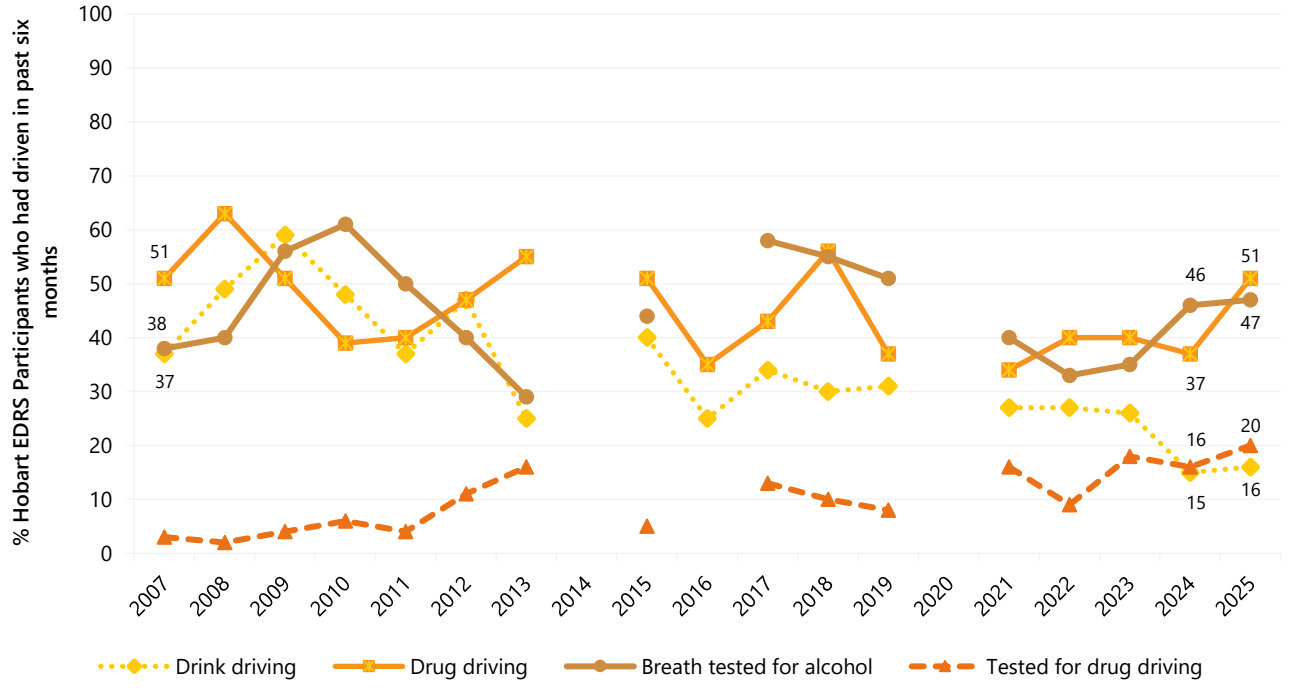
Driving

In 2025, 67% of the Hobart sample had driven a car, motorcycle, or other vehicle in the six months prior to interview. Of those who had driven in the past six months and responded (n=43), sixteen per cent reported driving while over the (perceived) legal limit of alcohol (15% in 2024).

Of those who had driven in the past six months and responded (n=45), half (51%) reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months (37% in 2024; *p*=0.177) (Figure 55). Participants most commonly reported using cannabis (61%) prior to driving in the six months preceding interview, followed by methamphetamine crystal (30%).

Among those who had driven in the past six months (n=45), one fifth (20%) reported that they had been tested for drug driving by the police roadside drug testing service (16% in 2024; *p*=0.609), and 47% reported that they had been breath tested for alcohol by the police roadside testing service in the six months prior to interview (46% in 2024) (Figure 55). Among those who had had been tested for drug driving by the police roadside drug testing service (n=9), one third (33%) reported that a drug/s had been detected. Few participants (n≤5) reported on any single drug that was detected by the drug driving text; therefore, further details are not reported (not asked in 2024). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 55: Self-reported testing, and driving over the (perceived) legal limit for alcohol or three hours following illicit drug use, among those who had driven in the past six months, Hobart, TAS, 2007-2025



Note. Computed of those who had driven a vehicle in the past six months. Questions about driving behaviour were first asked about in 2007. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Experience of Crime and Engagement with the Criminal Justice System

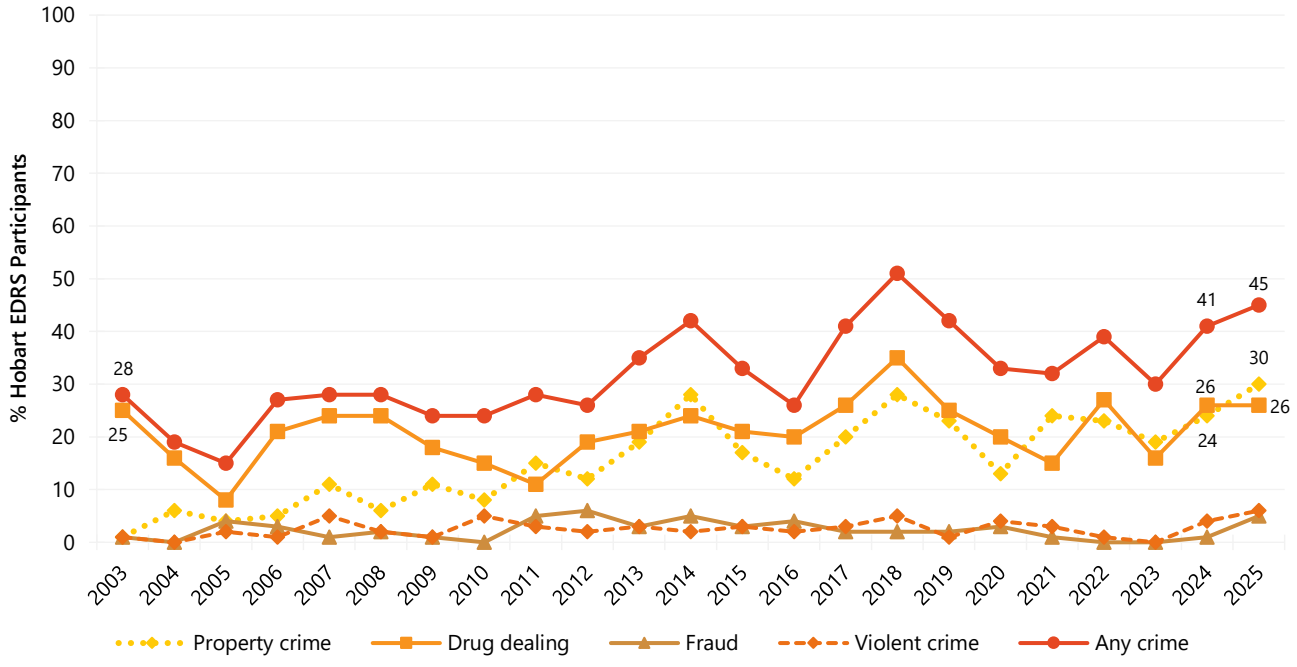
In 2025, 45% of the Hobart sample reported 'any' crime in the past month, stable relative to 2024 (41% in 2024; p=0.621). Property crime (30%; 24% in 2024; p=0.361) and selling drugs for cash profit (26%; 26% in 2024) remained the two main forms of criminal activity in 2025 (Figure 56). Eleven per cent of the Hobart sample reported being the victim of a crime involving violence (e.g., assault) in the past month in 2025, stable relative to 9% in 2024 (Figure 57).

Fifteen per cent reported having ever been in prison in 2025, stable relative to 2024 (8%; p=0.203) (Figure 58).

Twelve per cent of the Hobart sample reported having been arrested in the 12 months preceding interview (11% in 2024; p=0.796) (Figure 58). In 2025, few participants (n≤5) reported reasons for arrest, had been convicted of a drug-related offence in the past year (8% in 2024; p=0.757) or had been sentenced to a community corrections order (n≤5 in 2024; p=0.469), therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

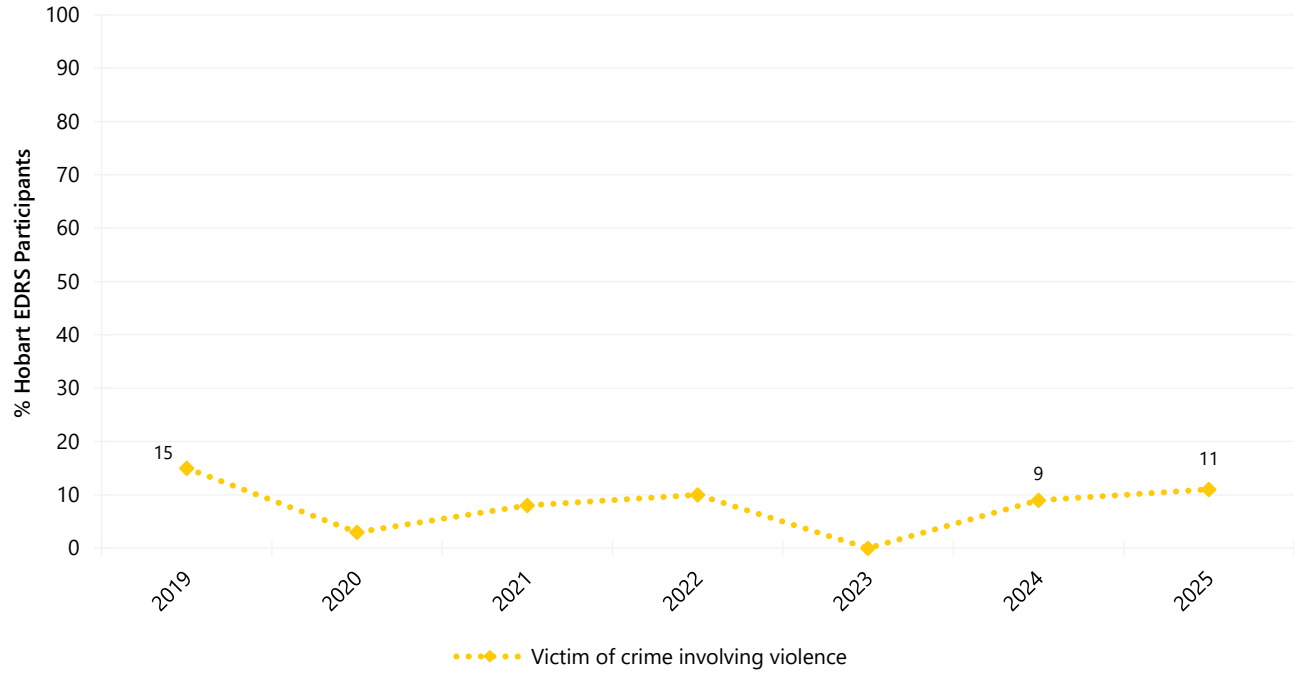
One quarter (24%) of participants reported a drug-related encounter with police which did not result in charge or arrest in the past 12 months, stable relative to 2024 (18%; p=0.430) (Figure 58). Few participants (n≤5) commented on the type of drug-related encounter they had with police in 2025; therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 56: Self-reported criminal activity in the past month, Hobart, TAS, 2003-2025



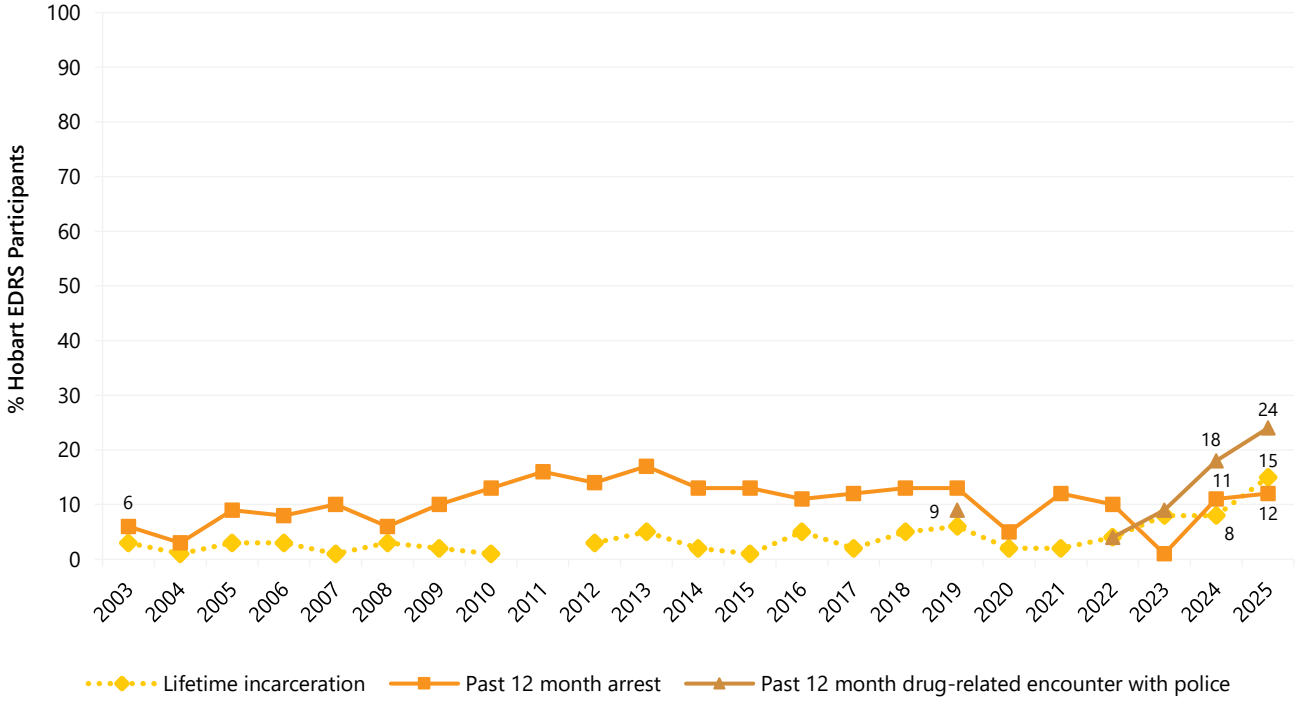
Note. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for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

Figure 57: Victim of crime involving violence in the past month, Hobart, TAS, 2019-2025



Note. Questions regarding being the victim of a crime involving violence were first asked in 2019. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 58: Lifetime incarceration, and past 12 month arrest and drug-related encounters with police that did not result in arrest, Hobart, TAS, 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 in person (65%; 73% in 2024; p=0.299) and via social networking or messaging applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (50%; 57% in 2024; p=0.420) (Table 9). It is important to re-iterate that this refers to people *arranging the purchase* of illicit or non-prescribed drugs. This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person.

Among those who had used social networking or messaging applications to arrange the purchase of illicit or non-prescribed drugs in the 12 months preceding interview, the most commonly used social networking or messaging apps were Snapchat (71%), Facebook (44%) and Instagram (32%), with substances mostly obtained from a friend/relative/partner/colleague (79%), followed by a known dealer/vendor (68%).

Buying and Selling Drugs Online

Few participants (n≤5) reported obtaining drugs via the darknet or the surface web in the past 12 months preceding interview in 2024 and 2025. However, two fifths (40%) of participants reported ever obtaining illicit drugs through someone who had purchased them on the surface web or darknet, with 29% having done so in the last 12 months, stable relative to 2024 (21%; p=0.418).

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

Source and Means of Obtaining Drugs

The majority of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2025 (66%; 77% in 2024; p=0.159), followed by 57% reporting obtaining illicit drugs from a known dealer/vendor (51% in 2024; p=0.518), and 29% reported obtaining illicit drugs from an unknown dealer/vendor (22% in 2024; p=0.354) (Table 9).

When asked about how they had received illicit drugs on any occasion in the last 12 months, the majority of participants reported face-to-face (91%; 92% in 2024), followed by receiving via post (16%; 9% in 2024; p=0.223). One tenth (10%) of participants also reported receiving illicit drugs from a collection point (defined as a predetermined location where a drug will be dropped for later collection), a significant decrease from 2024 (26% in 2024; p=0.025) (Table 9).

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

	2019	2020	2021	2022	2023	2024	2025
	N=98	N=100	N=98	N=64	N=63	N=86	N=68
% Purchasing approaches in the last 12 months^#	n=98	n=100	n=98	n=63	n=63	n=86	**n=68**
Face-to-face	88	60	70	73	73	73	**65**
Surface web	4	-	-	-	0	-	**-**
Darknet market	7	8	4	-	-	-	**-**
Social networking or messaging applications`	68	71	66	67	51	57	**50**
Text messaging	43	34	37	35	30	37	**40**
Phone call	35	33	27	24	25	31	**31**
Grew/made my own	/	-	-	-	-	-	**-**
Other	0	-	0	0	0	-	**-**
% Means of obtaining drugs in the last 12 months^~	n=98	n=100	n=98	n=64	n=62	n=86	**n=67**
Face-to-face	87	94	91	95	87	92	**91**
Collection point	10	11	10	-	-	26	**10***
Post	8	12	7	11	10	9	**16**
% Source of drugs in the last 12 months^	n=98	n=98	n=98	n=64	n=62	n=86	**n=68**
Friend/relative/partner/colleague	91	86	94	86	68	77	**66**
Known dealer/vendor	62	69	68	63	55	51	**57**
Unknown dealer/vendor	32	22	22	42	16	22	**29**

Note. ^Participants could endorse multiple responses. #This refers to people *arranging the purchase* of illicit or non-prescribed drugs. `This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person. ~ The face-to-face response option from 2021 was combined by those responding, 'I went and picked up the drugs', 'The drugs were dropped off to my house by someone' and/or 'Was opportunistic – I arranged and collected at the same time (e.g., at an event/club.)' Statistical significance for 2024 versus 2025 presented in table; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.