



TASMANIAN DRUG TRENDS 2025

Key Findings from the Tasmanian Illicit
Drug Reporting System (IDRS) Interviews



TASMANIAN DRUG TRENDS 2025: KEY FINDINGS FROM THE ILLICIT DRUG REPORTING SYSTEM (IDRS) INTERVIEWS

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

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

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Research Team

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- Dr Rachel Sutherland, Antonia Karlsson, Julia Uporova, Udesha Chandrasena, Dr Olivia Price, Haniene Tayeb, Lily Palmer, Agata Chrzanowska, Cate King, Professor Louisa Degenhardt, Professor Michael Farrell and Associate Professor Amy Peacock, National Drug and Alcohol Research Centre, University of New South Wales, New South Wales;
- Dylan Vella-Horne, Joanna Wilson and Professor Paul Dietze, Burnet, Victoria;
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Participants

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Contributors

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Abbreviations

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

REDCap	Research Electronic Data Capture
RNA	Ribonucleic Acid
SA	South Australia
SD	Standard deviation
SDS	Severity of Dependence
STI	Sexually transmitted infection
TAS	Tasmania
TGA	Therapeutic Goods Administration
THC	Tetrahydrocannabinol
UNSW	University of New South Wales
VIC	Victoria
WA	Western Australia
WHO	World Health Organization

Executive Summary

The IDRS comprises a sentinel sample of people aged 18 years or older who injected illicit drugs ≥ 6 days in the preceding six months and resided in Hobart, Tasmania. Participants were recruited via advertisements in needle and syringe programs as well as via peer referral. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in June and July 2025. Interviews from 2020 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 IDRS sample recruited from Hobart, Tasmania (TAS) in 2025 (N=95) was consistent with the Hobart profile in previous years. Gender proportions remained stable between 2024 and 2025, with 65% identifying as male (67% in 2024), with a median age of 45 years (45 years in 2024). Three fifths (58%) held post-school qualifications including trade/technical and university (66% in 2024). Eighty-five per cent of the sample were unemployed at the time of interview (88% in 2024), and the vast majority (97%) had received a government pension/allowance or benefit in the month prior to interview (97% in 2024).

Accommodation remained stable relative to 2024, with 69% residing in their own home (including renting) (64% in 2024). Eighteen per cent of participants reported having no fixed address (17% in 2024), with 7% reporting residing in a boarding house/hostel ($n \leq 5$ in 2024). The median income per week increased significantly to \$540 (\$448 in 2024; $p=0.007$).

Participant drug of choice remained stable between 2024 and 2025, with 56% of the participants nominating methamphetamine as their drug of choice in 2025 (52% in 2024), followed by heroin (15%; 11% in 2024) and cannabis (9%; 12% in 2024). Methamphetamine was also the drug injected most often in the past month (87%; 77% in 2024). Four fifths (80%) of the sample reported weekly or more frequent use of any methamphetamine (76% in 2024), followed by non-prescribed cannabis (59%; 68% in 2024).

Heroin

The per cent reporting recent heroin use has remained relatively stable and low since the commencement of monitoring, with 16% of the Hobart sample reporting recent use in 2025, stable relative to 2024 (12%). Frequency of use remained stable at a median of 10 days in 2025 (3 days in 2024). All participants (100%) reported injecting heroin as the route of administration in 2024 and 2025. The price, perceived purity and availability remained stable between 2024 and 2025.

Methamphetamine

Recent use of any methamphetamine has trended upwards over the past few years with almost nine in ten participants reporting recent use since 2021. In 2025, 95% of participants reported recent use of any methamphetamine (91% in 2024), the highest percentage reporting recent use since monitoring commenced. This mostly comprised of methamphetamine crystal use (97%; 98% in 2024). The median price for one point of crystal was \$50 (\$50 in 2024). Perceived purity of crystal remained stable, with 33% reporting purity to be 'medium' (23% in 2024). Perceived availability of crystal also remained stable, with 98% reporting 'easy' or 'very easy' obtainment.

Cocaine

Recent use of cocaine remained stable at 13% (18% in 2024). Frequency of use remained low and stable at a median of four days (1 day in 2024). Four fifths (83%) of those who had used cocaine in the six months preceding interview reported using powder cocaine.

Cannabis and Related Products

The per cent of participants reporting recent use of non-prescribed cannabis and/or cannabinoid-related products, while overall slowly declining since the early 2000s, remained stable between 2024 and 2025 (68%; 74% in 2024). Three fifths (62%) of participants who had recently used any non-prescribed cannabis reported daily use, stable relative to 2024 (67%). Hydroponic cannabis remained the form most commonly used (83%; 92% in 2024), followed by bush cannabis (50%; 49% in 2024). Smoking remained the most common route of administration and significantly increased in 2025 (95%; 80% in 2024; $p=0.010$), while inhaling/vaping significantly decreased ($n\leq 5$; 31% in 2024; $p<0.001$). The largest per cent of the sample reported that the perceived potency of both hydroponic and bush cannabis was 'high' (55% and 50% of those who responded, respectively) and 'very easy' to obtain (55% and 55% of those who responded, respectively), stable relative to 2024.

Pharmaceutical Opioids

Recent non-prescribed use of pharmaceutical opioids has generally declined over the course of monitoring. In 2025, non-prescribed use remained stable with 22% reporting recent use of morphine (26% in 2024), 16% using methadone (10% in 2024), 7% using buprenorphine tablet (8% in 2024), 11% using buprenorphine-naloxone (10% in 2024), 13% using oxycodone (21% in 2024), 11% using codeine ($n\leq 5$ in 2024), and few participants ($n\leq 5$) using fentanyl ($n\leq 5$ in 2024).

Other Drugs

Few participants ($n\leq 5$) reported recent use of an NPS in 2025, stable relative to 7% in 2024. One tenth (11%) reported recent use of any non-prescribed pharmaceutical stimulant (18% in 2024). In 2025, use of any non-prescribed benzodiazepines (27%; 27% in 2024), pregabalin (19%; 20% in 2024) and GHB (11%; 11% in 2024) remained stable.

The majority (86%) of the sample reported recent tobacco use (93% in 2024). There was a significant increase of participants reporting recent use of illicit tobacco, with 56% reporting recent use in 2025 (18% in 2024; $p<0.001$). Recent use of alcohol (52%; 54% in 2024) and illicit e-cigarettes (15%; 19% in 2024) remained stable. Few participants ($n\leq 5$) reported recent use of nicotine pouches (7% in 2024).

Drug-Related Harms & Other Behaviours

Polysubstance use and bingeing

Three fifths (60%) of participants reported use of two or more drugs on the day preceding interview. Almost three fifths (59%) of the Hobart sample had binged on one or more drugs for 48 hours or more in the six months preceding interview.

Injecting behaviours and equipment

In 2025, participants reported injecting on a median of 24 occasions in the month prior to interview, a significant increase from 15 occasions in 2024 ($p=0.010$). Few participants ($n\leq 5$) reported receptive sharing and 7% reported distributive sharing of a needle or syringe in the past month (6% and 9% in 2024, respectively). One fifth (22%) of the Hobart sample reported that they had re-used their own needles in the past month (25% in 2024). Almost one fifth (17%) of the Hobart sample reported having difficulty accessing needles in the past month, stable relative to 15% in 2024.

Twenty-eight per cent reported experiencing injection-related problems in the past month (30% in 2024), most commonly infection or abscess (16%) or nerve damage (15%).

Overdose, naloxone and drug checking

Fourteen per cent of the Hobart sample reported overdosing on any drug in the preceding year, stable relative to 22% in 2024. Six per cent reported a non-fatal simulant overdose (13% in 2024). Few participants ($n \leq 5$) reported a non-fatal opioid overdose in 2025.

In 2025, the majority (89%) of the Hobart sample reported awareness of naloxone, a significant increase from 75% in 2024 ($p=0.015$). Forty-five per cent reported obtaining naloxone in the past year, stable relative to 32% in 2024.

Twenty-seven per cent reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year (18% in 2024).

Dependence, drug treatment and HCV

In 2025, 30% of male participants obtained an AUDIT-C score of ≥ 4 , and 36% of female participants obtained a score of ≥ 3 , indicative of hazardous alcohol use.

Two fifths (39%) of participants who reported recent opioid use and 67% of those reporting recent methamphetamine use scored at a level indicating possible dependence on the Severity of Dependence Scale (SDS; 5/4+ respectively).

One third (31%) reported receiving any drug treatment in 2025, stable from 2024 (24%).

Fifty-four per cent reported having received a hepatitis C virus (HCV) antibody test in the past year, a significant increase from 35% in 2024 ($p=0.013$). One third (31%) reported receiving an RNA test (28% in 2024) in the past year. Few participants ($n \leq 5$) reported having a current HCV infection in 2024 and 2025.

Sexual activity, mental health and health service access

Almost half (47%) of the Hobart sample reported engaging in sexual activity in the past four weeks (36% in 2024), and one quarter (23%) reported having a sexual health check-up in the previous six months (19% in 2024).

Self-reported mental health problems remained stable in 2025 (64%; 60% in 2024), with depression (67%) and anxiety (53%) most commonly reported. K10 score remained stable between 2024 and 2025, with 37% of participants scoring 30+ (34% in 2024), indicative of 'very high' psychological distress.

Eighty-six per cent of the Hobart sample reported accessing any health service for alcohol and/or drug support in the six months preceding interview (80% in 2024).

Driving, contact with police and modes of purchasing drugs

Eighty-two per cent of those who had recently driven reported driving within three hours of consuming an illicit or non-prescribed drug, stable relative to 2024 (66%). Few participants ($n \leq 5$) reported driving while over the perceived legal limit of alcohol in both 2024 and 2025.

One third (34%) reported engaging in 'any' crime in the past month in 2025 (44% in 2024). Twenty-eight per cent reported being arrested in the past year (31% in 2024), and 26% reported a drug-related encounter with police which did not result in arrest (24% in 2024).

In 2025, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (82%, 84% in 2024).

2025 SAMPLE CHARACTERISTICS

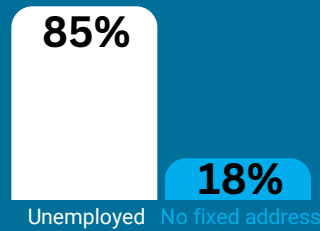


Between June-July, 95 participants, recruited from Hobart, TAS, were interviewed.



45 years **Male**

Median age and per cent who identified as male.

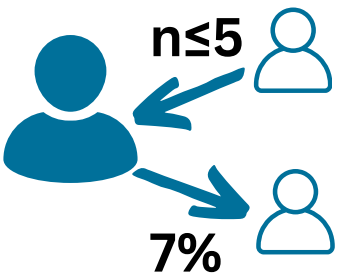


85% were unemployed and 18% had no fixed address.

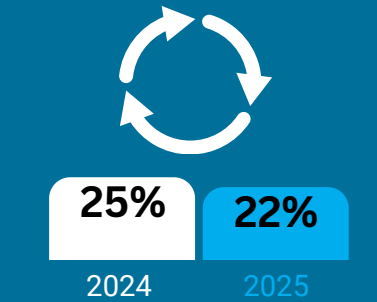
- Injected heroin**
- Injected methamphetamine**
- Injected other illicit or non-prescribed drugs**

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

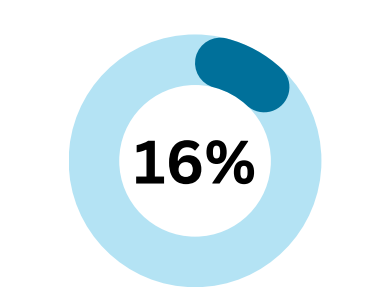
INJECTING-RELATED RISKS AND HARMS



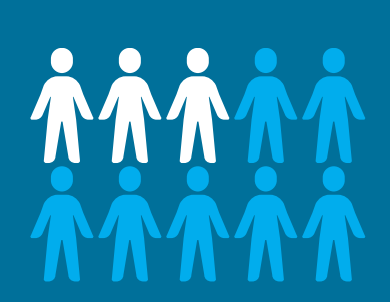
Few participants ($n \leq 5$) reported receptive sharing in the past month, and 7% reported distributive sharing.



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

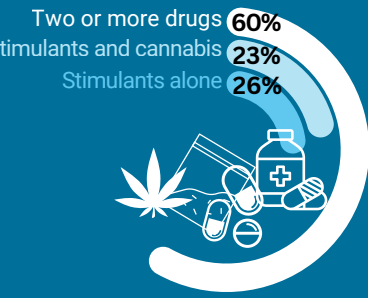


Percentage who reported injecting someone else after injecting themselves in the past month.

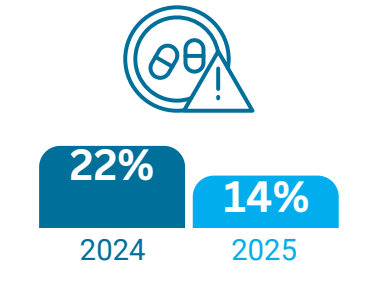


28% of participants reported having an injection-related health issue in the past month, stable from 2024 (30%).

OTHER HARMS



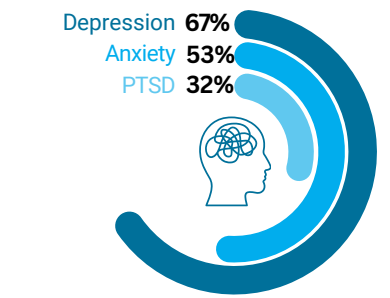
60% reported using two or more drugs on the day preceding interview: the most commonly used combination of drug classes was stimulants and cannabis (23%).



Past year non-fatal overdose remained stable in 2025, relative to 2024.

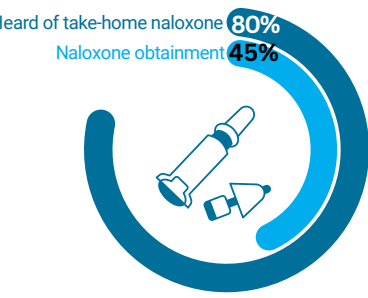


64% of participants reported a mental health problem in the 6 months preceding interview.

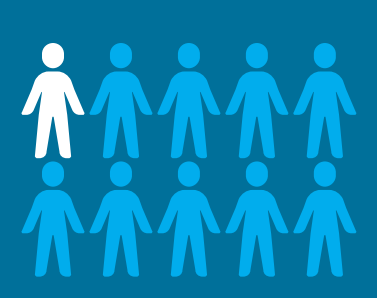


Among those who reported a mental health problem, the 3 most common mental health issues were depression, anxiety and PTSD.

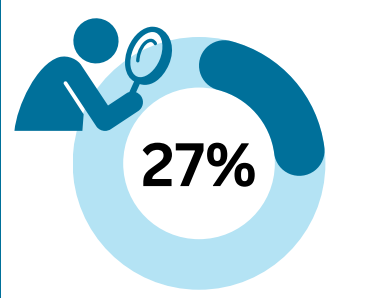
NALOXONE AND OTHER HARM REDUCTION STRATEGIES



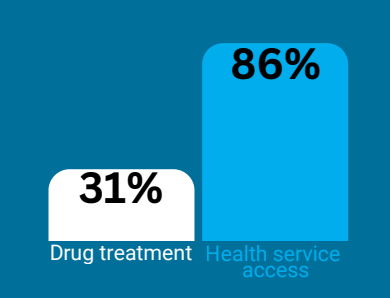
Knowledge of take-home naloxone and past year naloxone obtainment remained stable in 2025.



Among those who were aware of naloxone, 9% reported ever using naloxone to resuscitate someone who had overdosed, with few ($n \leq 5$) having done so in the past year.



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

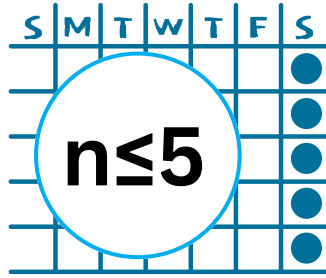


Percentage who reported current drug treatment and health service access for AOD support in the past 6 months.

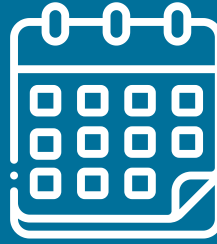
HEROIN



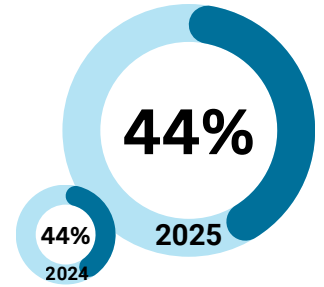
Past 6 month use of heroin remained stable in 2025 (16%) relative to 2024 (12%).



Of those who had recently consumed heroin, n≤5 reported weekly or more frequent use, stable from 2024 (n≤5).



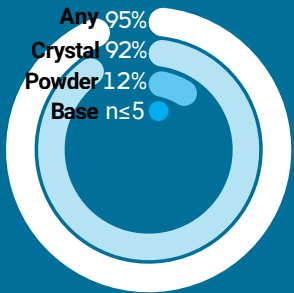
Of those who had recently consumed heroin, frequency of use was reported on 10 median days, stable relative to 2024 (3 days).



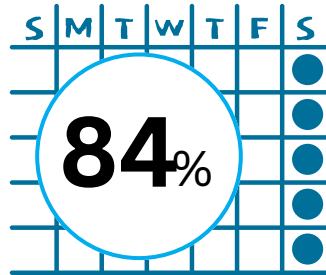
Percentage who perceived heroin as being 'easy' or 'very easy' to obtain.

METHAMPHETAMINE

FORM of methamphetamine



Past 6 month use remained stable in 2025 relative to 2024.

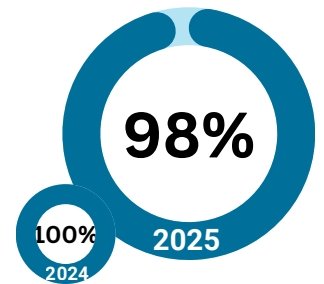


Of those who had recently used any form of methamphetamine, 84% reported weekly or more frequent use, stable from 2024 (84%).



\$50 2024 \$50* 2025

The median reported price for 1 point of methamphetamine crystal significantly changed in 2025 relative to 2024.



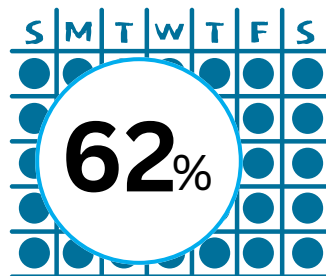
Percentage who perceived methamphetamine crystal as being 'easy' or 'very easy' to obtain.

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

CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS



Past 6 month use remained stable in 2025 (68%) relative to 2024 (74%).

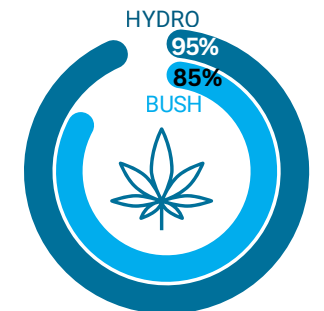


Of those who had recently used non-prescribed cannabis/cannabinoid-related products, 62% reported daily use, stable from 2024 (67%).



\$20 Hydroponic \$23 Bush

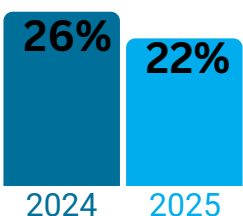
The median reported price for 1 gram of hydroponic and bush cannabis.



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

PAST 6 MONTH USE OF OTHER DRUGS

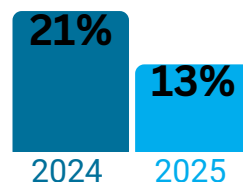
Non-prescribed morphine



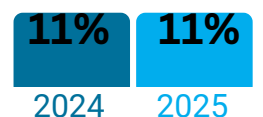
Non-prescribed fentanyl



Non-prescribed oxycodone



GHB/GBL/1,4-BD



Background

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

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

Methods

IDRS 2000-2019

Full details of the [methods for the annual interviews](#) are available for download. To briefly summarise, participants were recruited using multiple methods (e.g., needle and syringe programs (NSP) and peer referral) and needed to: i) be at least 17 years of age (due to ethical requirements); ii) have injected non-prescribed or illicit drugs on at least six days during the six months preceding interview; and iii) have been a resident of the capital city in which the interview took place for ten of the past 12 months. Interviews took place in varied locations negotiated with participants (e.g., treatment services, coffee shops or parks), and in later years were conducted using REDCap (Research Electronic Data Capture), a software program used to collect data on laptops or tablets. Following provision of written informed consent and completion of a structured interview, participants were reimbursed \$40 cash for their time and expenses incurred.

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

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

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

From 2021 onwards, a hybrid approach was used whereby interviews were conducted face-to-face (with participants reimbursed with cash) or via telephone/videoconference (with participants

reimbursed via bank transfer or other electronic means). Face-to-face interviews were the preferred methodology, however telephone interviews were conducted when required (i.e., in accordance with government directives) or when requested by participants. Consent was collected verbally for all participants.

2025 IDRS Sample

Between 26 May-15 July 2025, a total of 865 participants were recruited across capital cities nationally, with 95 participants recruited from Hobart, Tasmania (TAS) between 2 June-15 July 2025. A total of 19 interviews were conducted via telephone in Hobart, TAS; the remainder were conducted face-to-face.

One quarter (24%) of the 2025 Hobart sample completed the interview in 2024, and 23% participants in the Hobart 2024 sample completed the interview in 2023. In 2025, recruitment methods remained similar to previous years, with most participants were recruited via NSPs (76%; 53% in 2024) and word-of-mouth (19%; 36% 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. References to ‘significant’ differences or changes throughout the report are where statistical testing has been conducted and where the *p*-value is less than 0.050. Note that no corrections for multiple comparisons have been made and thus comparisons should be treated with caution. Values where cell sizes are ≤5 have been suppressed with corresponding notation (zero values are reported). References to ‘recent’ use and behaviours refers to the past six-month time period. The response options ‘Don’t know’ and ‘Skip question’, which were available to select throughout the interview, were excluded from analysis.

Guide to Table/Figure Notes

Table 1: Guide to Table/Figure Notes

Legend	
/	Question not asked in respective year (for tables)
-	Per cent suppressed due to small cell size (n≤5 but not 0) (for tables)
	Missing data points indicate question not asked in respective year or n≤5 answered the question (for figures)
*<i>p</i><0.050; **<i>p</i><0.010; ***<i>p</i><0.001	Statistical significance of difference 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 IDRS which triangulate key results from the annual interviews and other data sources and consider the implications of these findings, including national reports, jurisdictional reports, bulletins, and other resources available via the [Drug Trends webpage](#). This includes results from the [Ecstasy and Related Drugs Reporting System \(EDRS\)](#), which focuses on the use of ecstasy and other stimulants.

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

Gender identity remained stable between 2024 and 2025 ($p=0.876$), with two thirds (65%) identifying as male (67% in 2024). The median age of the sample was 45 years (IQR=41-52; 45 years in 2024; IQR=40-52; $p=0.563$) (Table 2). Employment status remained stable between 2024 and 2025 ($p=0.386$), with the majority of participants reporting being unemployed at the time of interview (85%; 88% in 2024), and 6% of participants reporting part time or casual employment (7% in 2024). The majority of participants (97%) reported receiving a government pension, allowance or benefit in the past month (97% in 2024). The median weekly income significantly increased between 2024 and 2025 ($p=0.007$), with participants reporting an income of \$540 (IQR=400-600) in 2025 (\$448 in 2024; IQR=356-550). Current accommodation type remained stable between 2024 and 2025 ($p=0.142$), with most participants reporting residing in a private house/flat (69%; 64% in 2024). One fifth (18%) reported having 'no fixed address' in 2025 (17% in 2024).

Drug of choice remained stable between 2024 and 2025 ($p=0.697$). Fifty-six per cent of the participants reported that methamphetamine was their drug of choice in 2025 (52% in 2024), followed by heroin (15%; 11% in 2024), cannabis (9%; 12% in 2024) and morphine (8%; 8% in 2024) (Figure 1). The drug injected most often in the past month also remained stable between 2024 and 2025 ($p=0.148$), with the majority of participants reporting methamphetamine as the drug injected most often in 2025 (87%; 77% in 2024), with fewer participants nominating morphine as the drug injected most often (6%; 9% in 2024) (Figure 2).

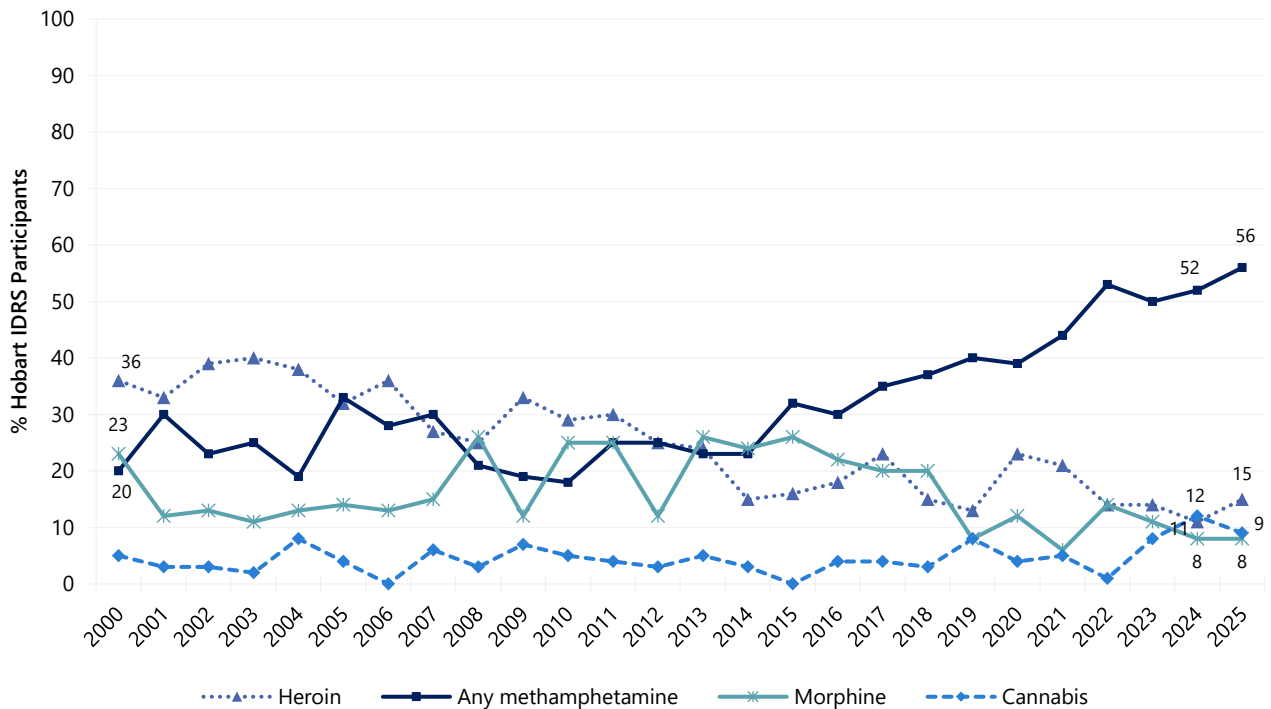
Weekly or more frequent consumption of methamphetamine crystal (75%; 75% in 2024), non-prescribed cannabis (59%; 68% in 2024; $p=0.242$) and non-prescribed morphine (13%; 10% in 2024; $p=0.636$) all remained stable in 2025, relative to 2024 (Figure 3).

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

	Hobart, TAS					National
	2021 N=95	2022 N=102	2023 N=66	2024 N=102	2025 N=95	2025 N=865
Median age (years; IQR)	43 (35-48)	43 (37-49)	45 (40-50)	45 (40-52)	45 (41-52)	47 (41-54)
% Gender						
Female	28	31	30	33	35	34
Male	71	69	70	67	65	66
Non-binary	-	0	0	0	0	-
% Aboriginal and/or Torres Strait Islander	16	15	21	22	29	29
% Born in Australia	/	/	98	97	99	91
% English primary language spoken at home	/	/	100	99	100	98
% Sexual identity						
Heterosexual	83	82	88	89	85	82
Homosexual	-	-	-	-	0	5
Bisexual	13	14	11	6	12	9
Queer	-	-	0	-	-	2
Other	0	0	0	-	0	1
Mean years of school education (range)	10 (7-12)	10 (7-12)	10 (5-12)	10 (7-12)	10 (6-12)	10 (1-12)
% Post-school qualification(s) ^	59	65	67	66	58	57
% Current employment status						
Unemployed	86	85	89	88	85	88
Full-time	-	-	0	-	-	3
Part-time/casual	11	7	-	7	6	6
Self-employed	-	-	-	-	-	2
Other	-	-	0	0	0	0
% Past month gov't pension, allowance or benefit	96	93	97	97	97	94
Current median income/week (\$; IQR)	\$375 (300-500)	\$418 (315-496)	\$420 (350-510)	\$448 (356-550)	\$540** (400-600)	\$465 (375-598)
% Current accommodation						
Own home (including renting)	65	70	59	64	69	66
Parents'/family home	9	10	-	8	-	5
Boarding house/hostel	7	7	-	-	7	4
Shelter/refuge	-	-	12	-	-	4
No fixed address+	18	12	15	17	18	19
Other	0	0	-	-	0	1

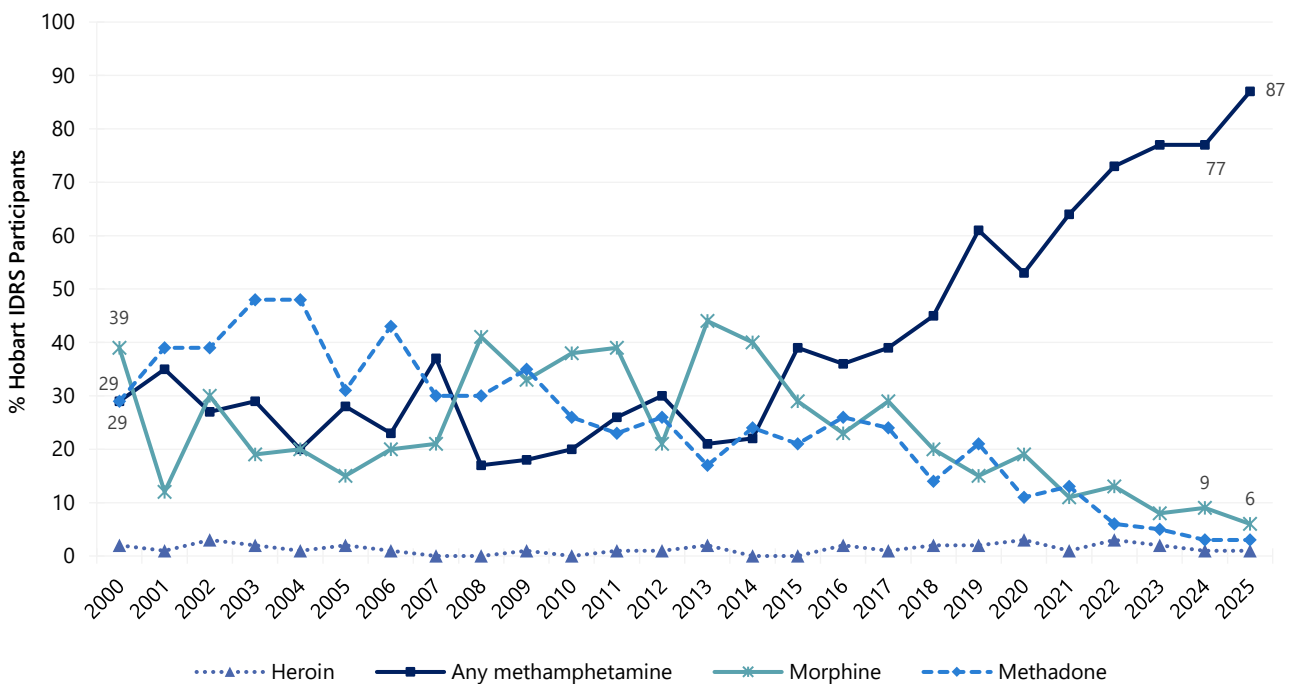
Note. ^Includes trade/technical and university qualifications. + No fixed address included couch surfing and rough sleeping or squatting. Statistical significance for 2024 versus 2025 among the Hobart sample is presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 1: Drug of choice, Hobart, TAS, 2000-2025



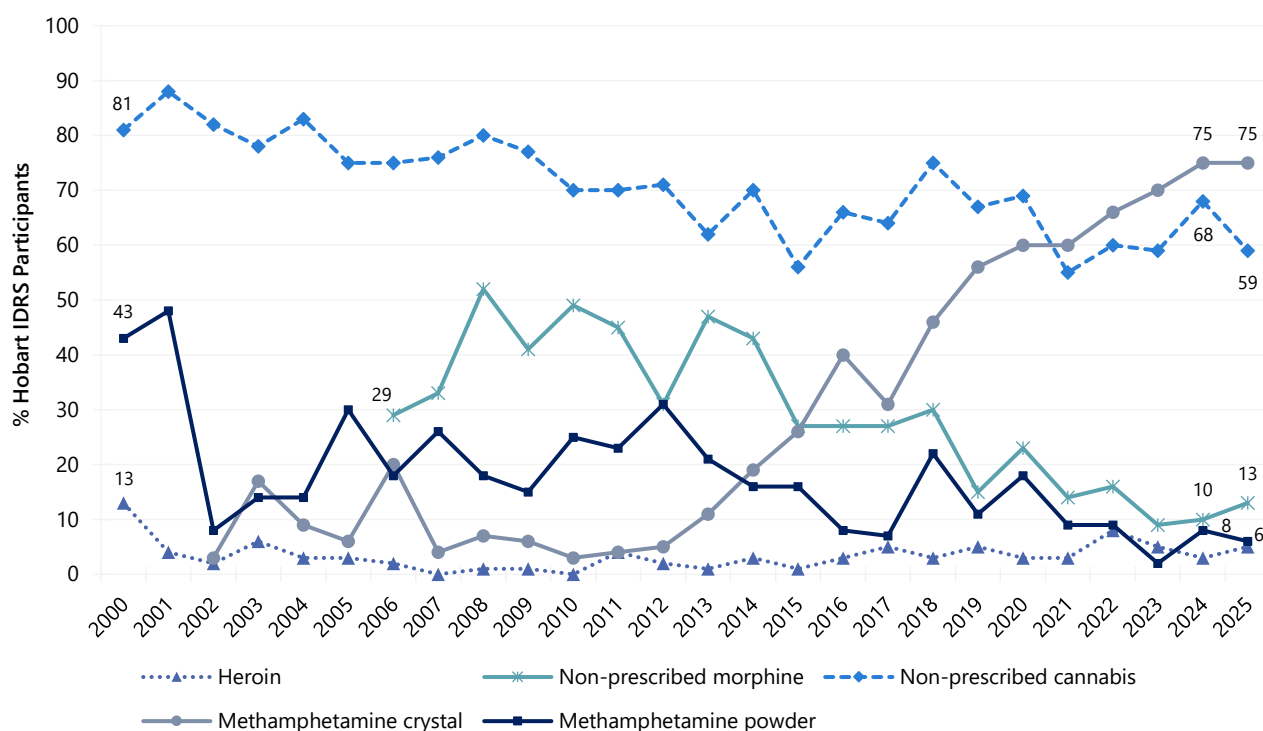
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; a nominal per cent endorsed other substances. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers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

Figure 2: Drug injected most often in the past month, Hobart, TAS, 2000-2025



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

Figure 3: Weekly or more frequent substance use in the past six months, Hobart, TAS, 2000-2025



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

2

Heroin

Participants were asked about their recent (past six month) use of heroin and homebake heroin. Participants typically describe heroin as white/off-white rock, brown/beige rock or white/off-white powder. Homebake is a form of heroin made from pharmaceutical products and involves the extraction of diamorphine from pharmaceutical opioids such as codeine and morphine.

Patterns of Consumption

Recent Use (past 6 months)

In 2025, the per cent reporting recent use of any heroin remained stable, with 16% of the Hobart sample reporting recent use (12% in 2024; $p=0.530$) (Figure 4).

Frequency of Use

Among those who reported recent use of heroin and responded ($n=15$), frequency of use remained stable in 2025 at a median of 10 days (IQR=3-42; 3 days in 2024; IQR=2-49; $n=12$; $p=0.446$) (Figure 4). Few participants ($n\leq 5$) reported weekly use and/or daily use of heroin in 2024 and 2025; therefore, further details are not reported.

Routes of Administration

Among participants who had recently consumed heroin and commented ($n=15$), all participants (100%) reported injecting as the most common route of administration (100% in 2024), and therefore the median frequency of injection was the same as the frequency of use (median 10 days in 2025; IQR=3-42; $n=15$; 3 days in 2024; IQR=2-49; $n=12$; $p=0.446$).

Quantity

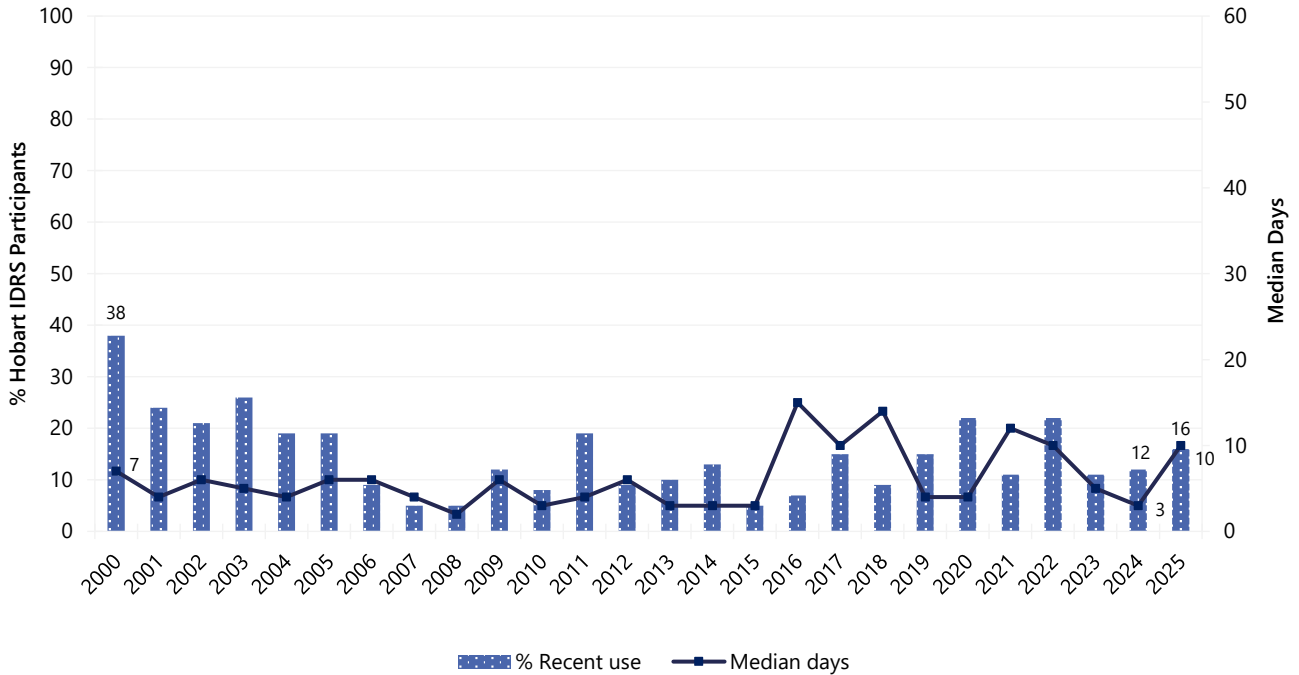
Of those who reported recent use and responded ($n=10$), the median 'typical' amount of heroin used on an average day of consumption in the six months preceding interview was 0.10 grams (IQR=0.10-0.20), stable relative to 2024 (0.10 grams; IQR=0.10-0.20; $n=10$; $p=0.939$). Of those who reported recent use and responded ($n=10$), the median maximum amount of heroin used on a day in the six months preceding interview was 0.20 grams (IQR=0.10-0.20; 0.10 grams in 2024; IQR=0.10-0.40; $n=11$; $p=0.747$).

Forms Used

Among participants who reported recent use of heroin in 2025 and commented ($n=15$), three fifths (60%) reported using white/off-white rock heroin and two fifths (40%) reported using brown/beige

rock heroin, both of which remained stable relative to 2024 ($n \leq 5$; $p=0.154$ and $n \leq 5$; $p=0.318$, respectively). Few participants ($n \leq 5$) reported using white/off-white or brown/beige powder in 2024 and 2025; therefore, further details are not reported. No participants reported using homebake, purple rock or purple powder in 2024 and 2025. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 4: Past six month use and frequency of use of heroin, Hobart, TAS, 2000-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 60 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Price, Perceived Purity and Perceived Availability

Price

In 2025, few participants ($n \leq 5$) reported on the median price for one point (0.10 of a gram) of heroin (\$100 in 2024; $IQR=85-100$; $n=6$; $p=0.842$) (Figure 5). Few participants ($n \leq 5$) reported on the price of a gram and a cap in 2025; therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

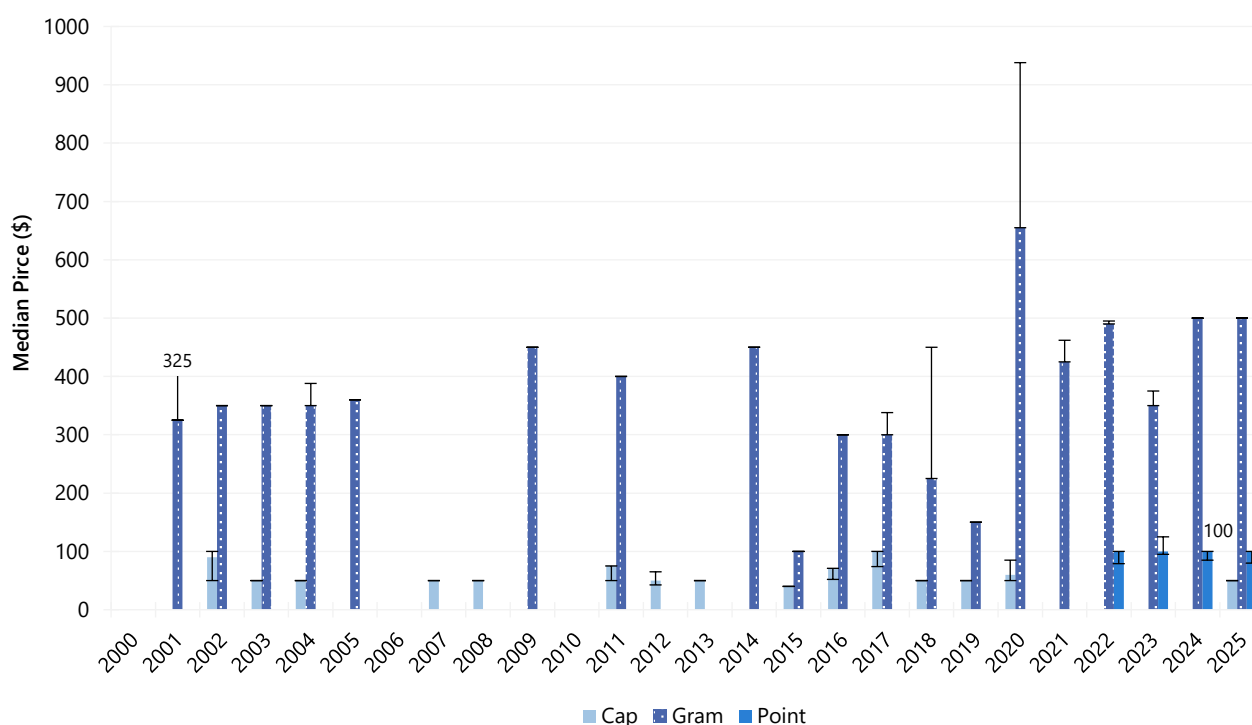
Perceived Purity

The perceived purity of heroin remained stable between 2024 and 2025 ($p=0.420$) (Figure 6). Few participants ($n \leq 5$) reported specific purity levels (e.g., 'high' or 'low'); therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Perceived Availability

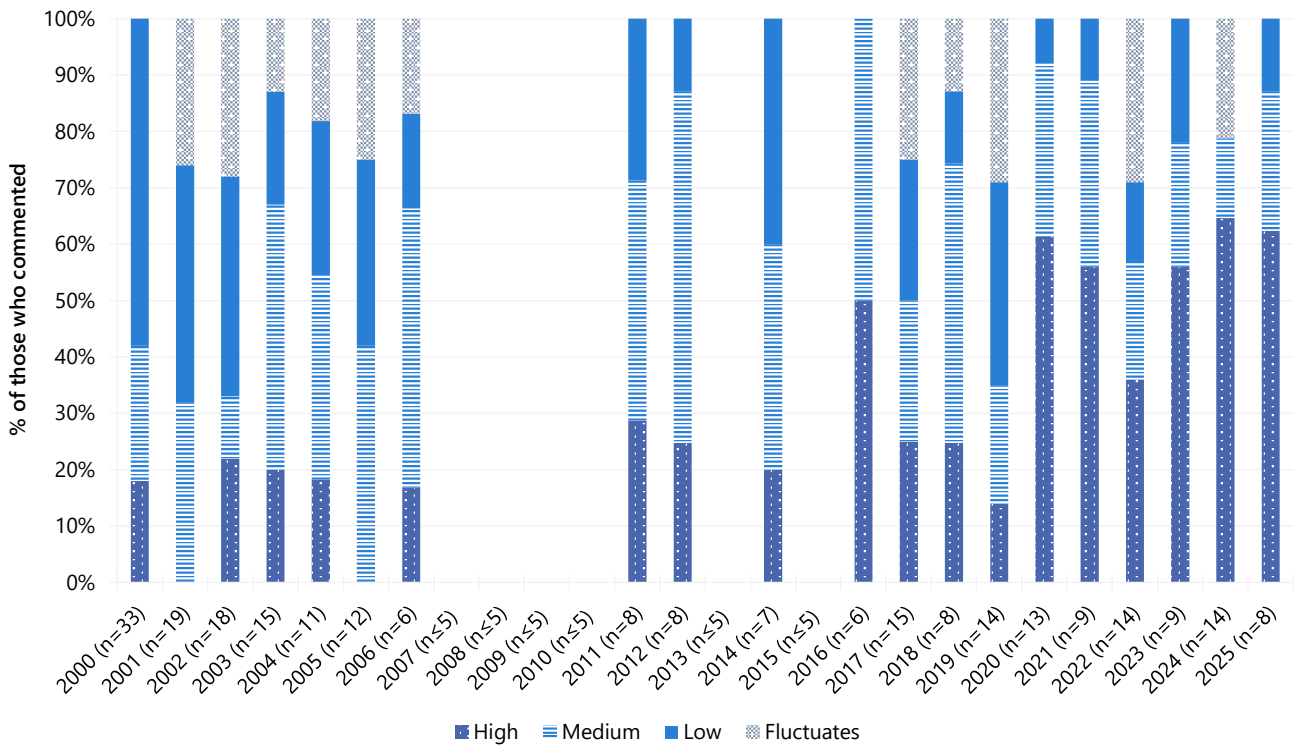
The perceived availability of heroin remained stable between 2024 and 2025 ($p=0.748$) (Figure 7). Few participants ($n \leq 5$) reported specific availability (e.g., 'easy' or 'difficult'); therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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



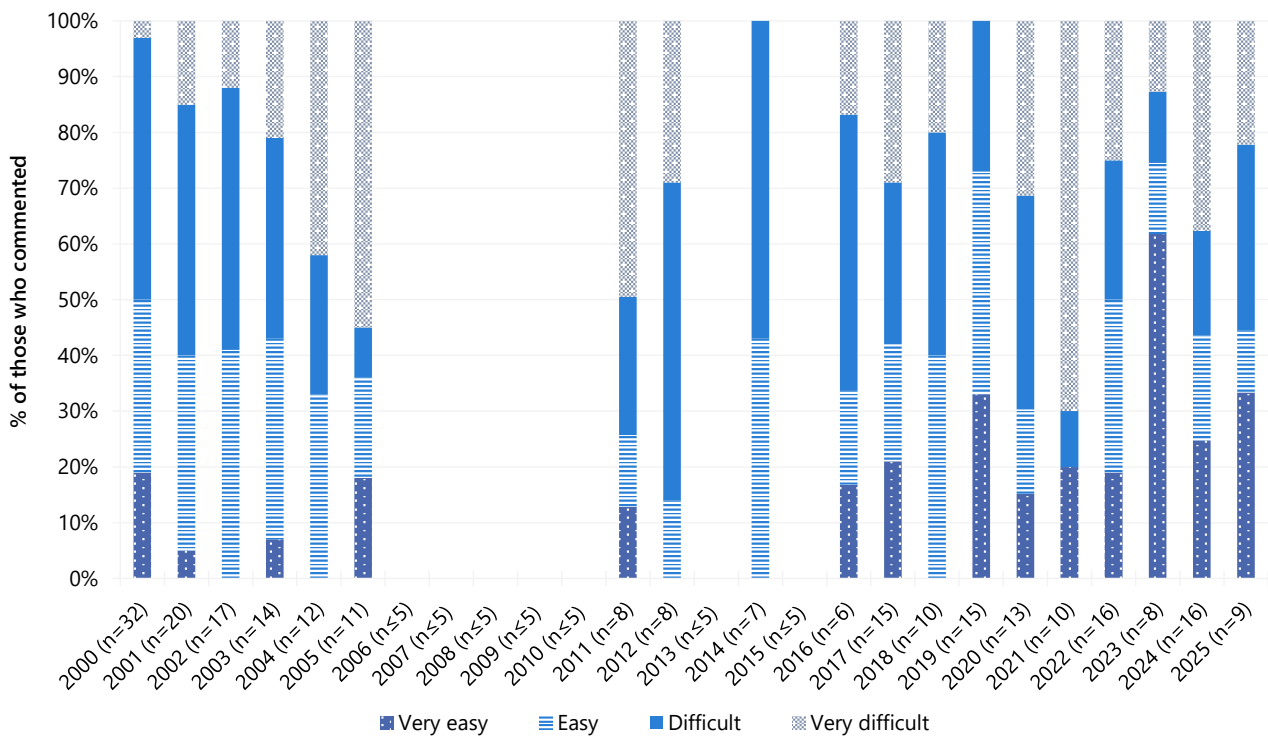
Note. Among those who commented. Between 2009-2017 a cap was referred to as cap/point; in 2018 these measures were separated as their own response options. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where $n \leq 5$ responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; $*p < 0.050$; $**p < 0.010$; $***p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 6: Current perceived purity of heroin, Hobart, TAS, 2000-2025



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

Figure 7: Current perceived availability of heroin, Hobart, TAS, 2000-2025



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

3

Methamphetamine

Participants were asked about their recent (past six month) use of various forms of methamphetamine, including powder (white particles, described as speed), base (wet, oily powder) and crystal (clear, ice-like crystals).

Patterns of Consumption (Any Methamphetamine)

Recent Use (past 6 months)

In 2025, the vast majority (95%) of the sample reported recent use of any methamphetamine (powder, base and crystal), remaining stable relative to 2024 (91%; $p=0.411$) but representing the highest percentage reporting recent use since monitoring commenced (Figure 8).

Frequency of Use

Participants who reported recent use and commented ($n=90$), had used any methamphetamine on a median of 90 days (IQR=27-180), stable from 73 days in 2024 (IQR=30-150; $n=90$; $p=0.173$) (Figure 9). Among those who reported recent use, weekly or more frequent use also remained stable in 2025 (84%; 84% in 2024), as did daily use (32%: 19% in 2024; $p=0.066$).

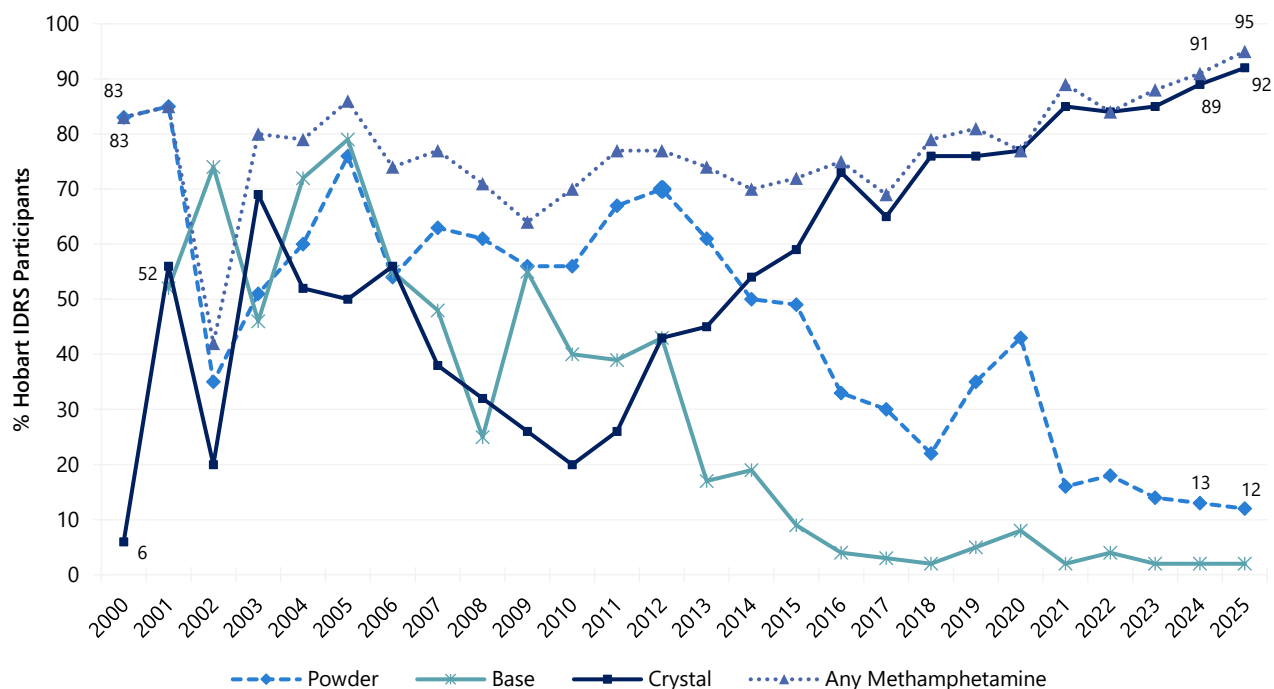
Forms Used

There has been a shift over time in the forms of methamphetamine used by participants, with decreasing use of methamphetamine powder and base and increasing use of methamphetamine crystal. Of participants who had used methamphetamine in the six months preceding interview in 2025 ($n=90$), the majority had used methamphetamine crystal (97%; 98% in 2024; $p=0.679$), followed by powder (12%; 14% in 2024; $p=0.821$). Few participants ($n\leq 5$) reported recent use of methamphetamine base in 2024 and 2025; therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Number of Forms Used

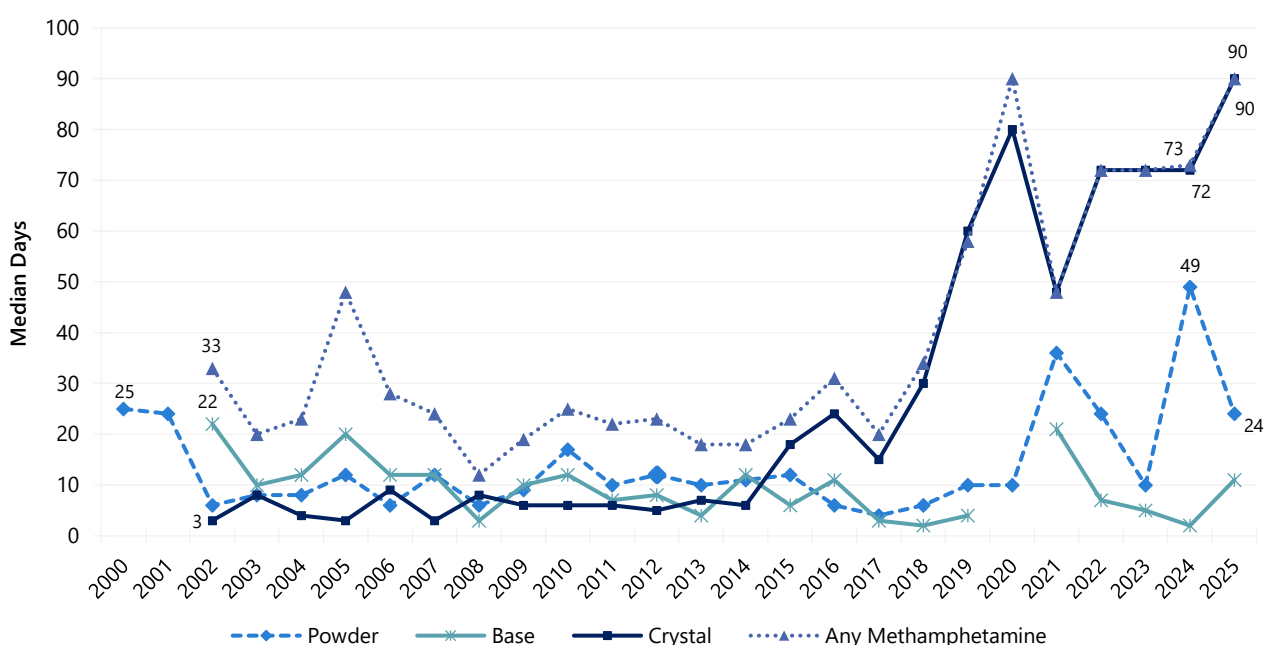
Among participants who had recently consumed any methamphetamine and commented in 2025 ($n=90$), the median number of forms of methamphetamine used was one (IQR=1-1), stable relative to 2024 (1 form; IQR=1-1; $n=93$; $p=0.808$).

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



Note. 'Any methamphetamine' includes crystal, powder, base and liquid methamphetamine combined from 2000-2018, and crystal, powder and base methamphetamine combined from 2019 onwards. Questions regarding liquid methamphetamine not asked from 2019. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 9: Frequency of use of any methamphetamine, and of methamphetamine powder, base, and crystal, Hobart, TAS, 2000-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 100 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Patterns of Consumption (by form)

Methamphetamine Powder

Recent Use (past 6 months): The per cent reporting recent use of methamphetamine powder has generally declined over time. Twelve per cent of the sample reported recent use in 2025, stable relative to 2024 (13%; $p=0.825$), but the lowest percentage observed since monitoring commenced (Figure 8).

Frequency of Use: Among those who had recently consumed powder and commented ($n=11$), the median days of use was 24 days (IQR=16-64; 49 days in 2024; IQR=13-90; $n=12$; $p=0.711$). Fifty-five per cent of those who had recently used powder reported weekly or more frequent use in 2025 (67% in 2024; $p=0.680$), with few participants ($n\leq 5$) reporting daily use in 2024 and 2025 ($p=0.590$) (Figure 9).

Routes of Administration: Among participants who had recently consumed powder and commented ($n=11$), 91% of participants reported injecting as a route of administration (100% in 2024; $p=0.458$). Participants who reported injecting powder ($n=10$) did so on a median of 30 days (IQR=14-72), stable relative to 2024 (48 days; IQR=6-90; $p=0.950$). Few participants ($n\leq 5$) reported having smoked, swallowed or snorted powder in the six months preceding interview in 2024 and 2025.

Quantity: Of those who reported recent use and commented ($n=11$), the median amount of powder used on a 'typical' day in the six months preceding interview was 0.20 grams (IQR=0.10-0.20; 0.20 grams in 2024; IQR=0.10-0.30; $n=12$; $p=0.974$). Of those who reported recent use and commented ($n=11$), the median maximum amount of powder used per day in the six months preceding interview was 0.30 grams (IQR=0.20-0.30; 0.20 grams in 2024; IQR=0.10-0.40; $n=10$; $p=0.592$).

Methamphetamine Base

Recent Use (past 6 months): Due to few participants ($n\leq 5$) reporting recent use of methamphetamine base in 2024 and 2025, further details are not reported. For historical information on recent use and frequency of use, please refer to Figure 8 and Figure 9, respectively. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Methamphetamine Crystal

Recent Use (past 6 months): Reports of recent use of methamphetamine crystal has been increasing since 2010, surpassing methamphetamine powder and base. In 2025, the majority (92%) of the sample reported recent use, stable relative to 2024 (89%; $p=0.622$), and the highest percentage observed since the commencement of monitoring (Figure 8).

Frequency of Use: Among those who had recently consumed crystal and commented ($n=87$), median days of use remained stable at 90 days (IQR=24-180; 72 days in 2024; IQR=29-150; $n=91$; $p=0.194$) (Figure 9). The majority (82%) of those who had recently used crystal reported weekly or more frequent use (84% in 2024; $p=0.841$), with 32% reporting daily use (a non-significant but noteworthy increase from 20% in 2024; $p=0.066$).

Routes of Administration: Among participants who had recently consumed crystal and commented ($n=87$), the majority reported injecting (98%; 99% in 2024; $p=0.615$). Participants who reported injecting crystal ($n=85$) did so on a median of 90 days (IQR=24-180; 72 days in 2024; IQR=27-135; $p=0.180$). One fifth (18%) reported smoking crystal, a significant decrease from 33% in 2024

($p=0.041$). Few participants ($n\leq 5$) reported snorting or swallowing crystal in the six months preceding interview 2025 ($n\leq 5$ and 9% in 2024; $p=0.213$, respectively).

Quantity: Of those who reported recent use and responded ($n=85$), the median amount of crystal used on a 'typical' day in the six months preceding interview was 0.10 grams (IQR=0.10-0.20; 0.10 grams in 2024; IQR=0.10-0.20; $n=87$; $p=0.950$). Of those who reported recent use and responded ($n=84$), the median maximum amount of crystal used per day in the six months preceding interview was 0.30 grams (IQR=0.20-0.70; 0.30 grams in 2024; IQR=0.20-0.60; $n=87$; $p=0.212$).

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Price: The median price for one point (0.10 of a gram) of methamphetamine powder was \$50 in 2025 (IQR=45-63; $n=8$), stable relative to 2024 (\$50; IQR=50-50; $n=13$; $p=0.635$) (Figure 10). Few participants ($n\leq 5$) reported on the price of a gram in 2024 and 2025; therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends.

Perceived Purity: The perceived purity of methamphetamine powder remained stable between 2024 and 2025 ($p=0.659$). However, few participants ($n\leq 5$) reported specific purity levels (e.g., 'high' or 'low'), therefore, further details are not reported (Figure 12). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information.

Perceived Availability: The perceived availability of methamphetamine powder remained stable between 2024 and 2025 ($p=0.198$). However, few participants ($n\leq 5$)

reported specific availability (e.g., 'easy' or 'difficult') (Figure 14). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information.

Methamphetamine Base

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

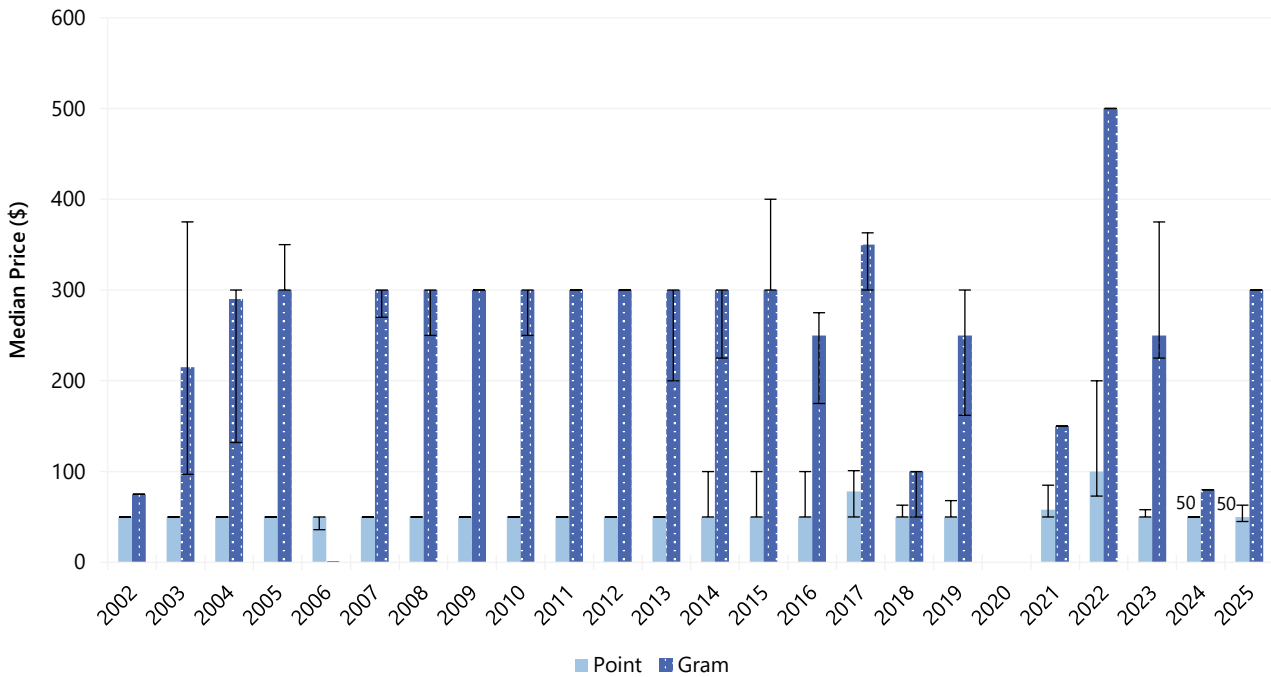
Methamphetamine Crystal

Price: Participants reported a median price of \$50 (IQR=50-50; $n=53$) for one point (0.10 of a gram) of crystal, stable relative to 2024 (\$50; IQR=50-50; $n=66$; $p=0.013$) and \$400 for one gram of crystal in 2025 (IQR=300-400; $n=7$; $n\leq 5$ in 2024; $p=0.079$) (Figure 11).

Perceived Purity: The perceived purity of methamphetamine crystal remained stable between 2024 and 2025 ($p=0.065$). Among those who were able to comment in 2025 ($n=73$), one third (33%) reported that crystal was of 'medium' purity (23% in 2024), followed by 27% reporting crystal was 'low' in purity (20% in 2024). One quarter (26%) perceived the purity to be 'fluctuating' (25% in 2024), and 14% perceived purity to be 'high' (31% in 2024) (Figure 13).

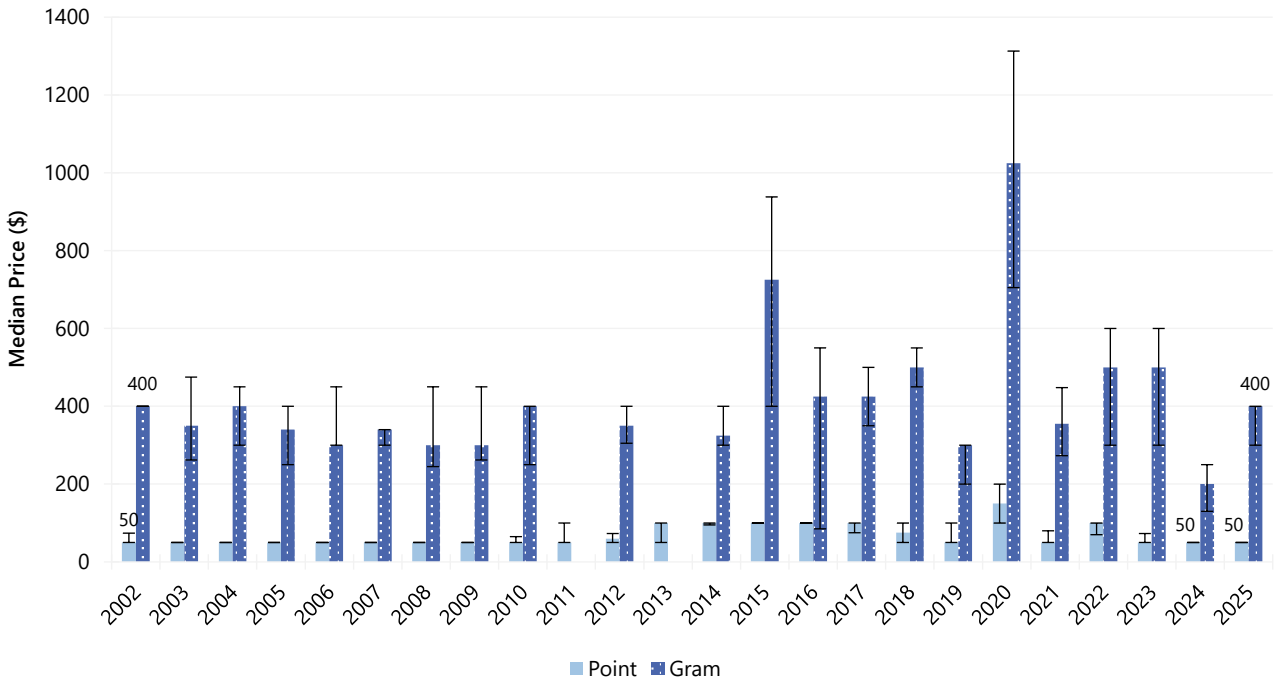
Perceived Availability: The perceived availability of methamphetamine crystal remained stable between 2024 and 2025 ($p=0.378$). Among those who were able to comment in 2025 ($n=75$), the majority (85%) perceived crystal as being 'very easy' to obtain (82% in 2024) and 13% reported 'easy' obtainment (18% in 2024) (Figure 15).

Figure 10: Median price of methamphetamine powder per point and gram, Hobart, TAS, 2002-2025



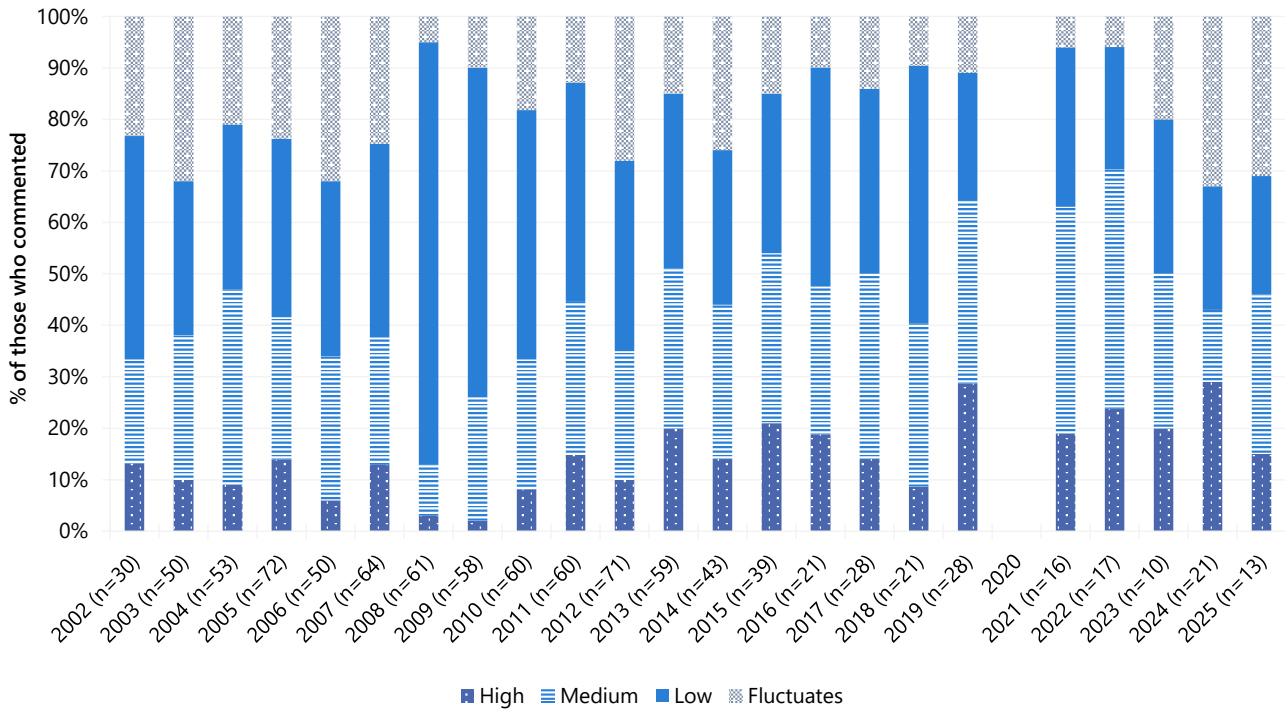
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where $n \leq 5$ responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$;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

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



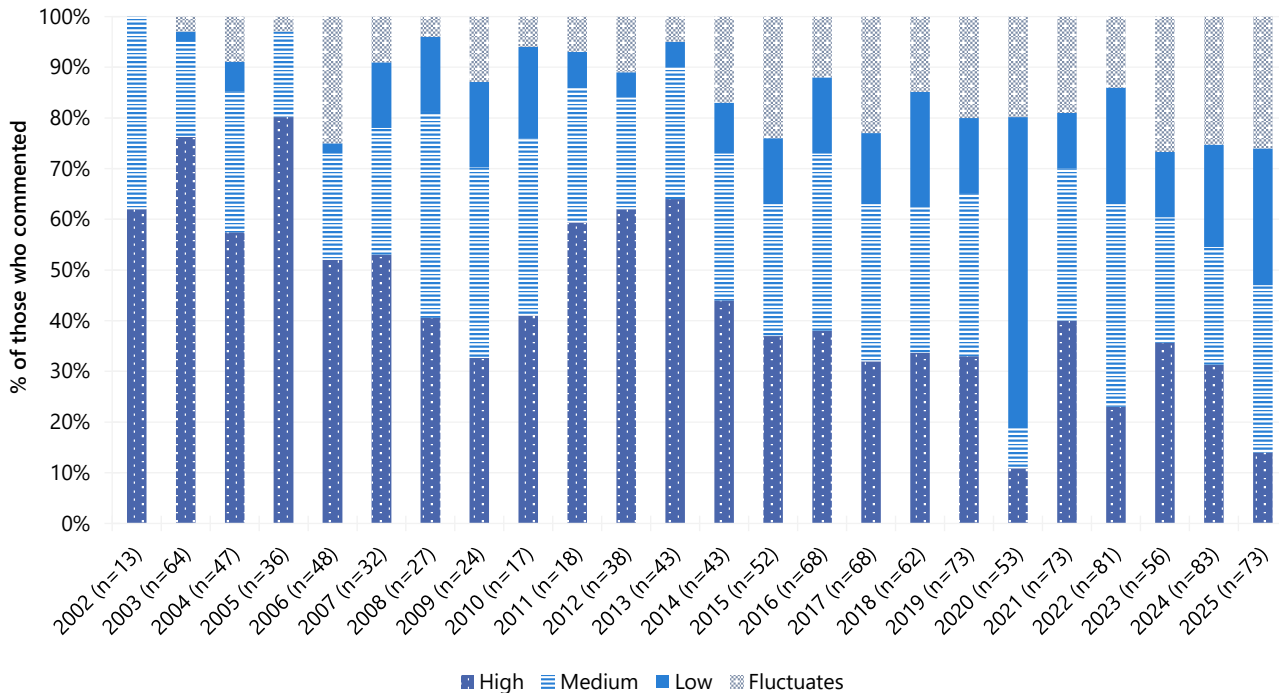
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where $n \leq 5$ responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$;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

Figure 12: Current perceived purity of methamphetamine powder, Hobart, TAS, 2002-2025



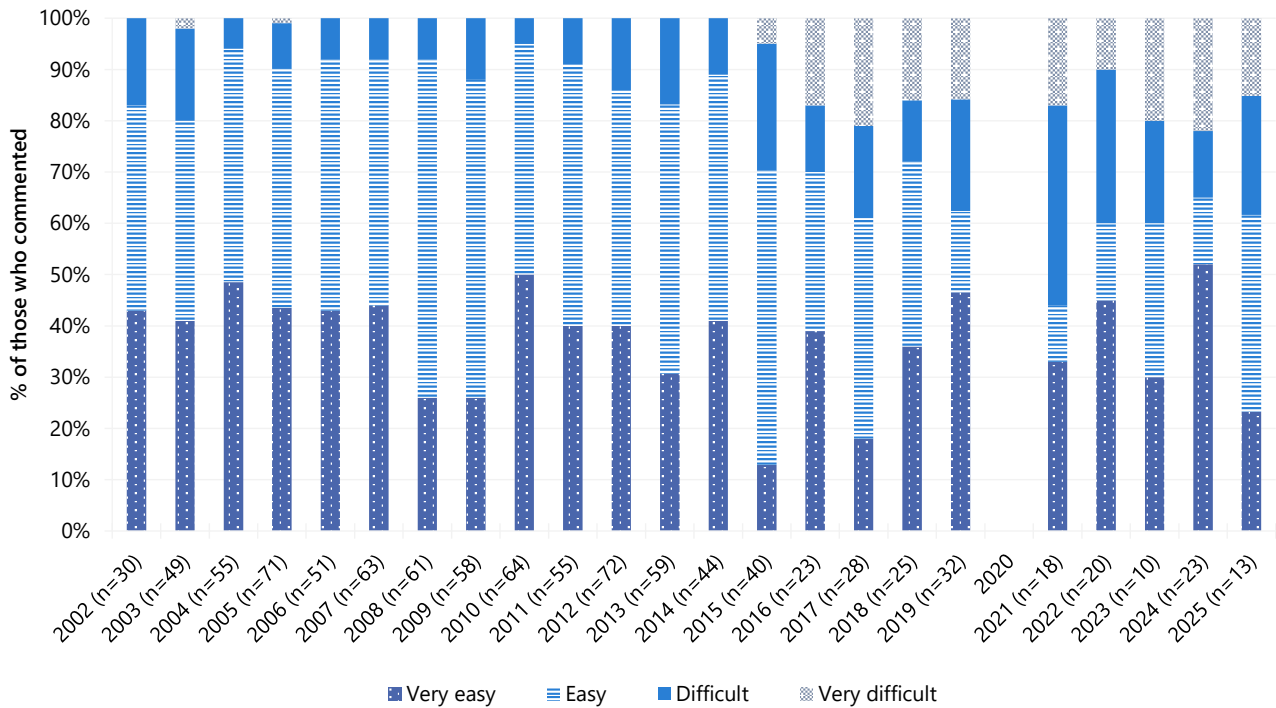
Note. Methamphetamine asked separately for the three different forms from 2002 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented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

Figure 13: Current perceived purity of methamphetamine crystal, Hobart, TAS, 2002-2025



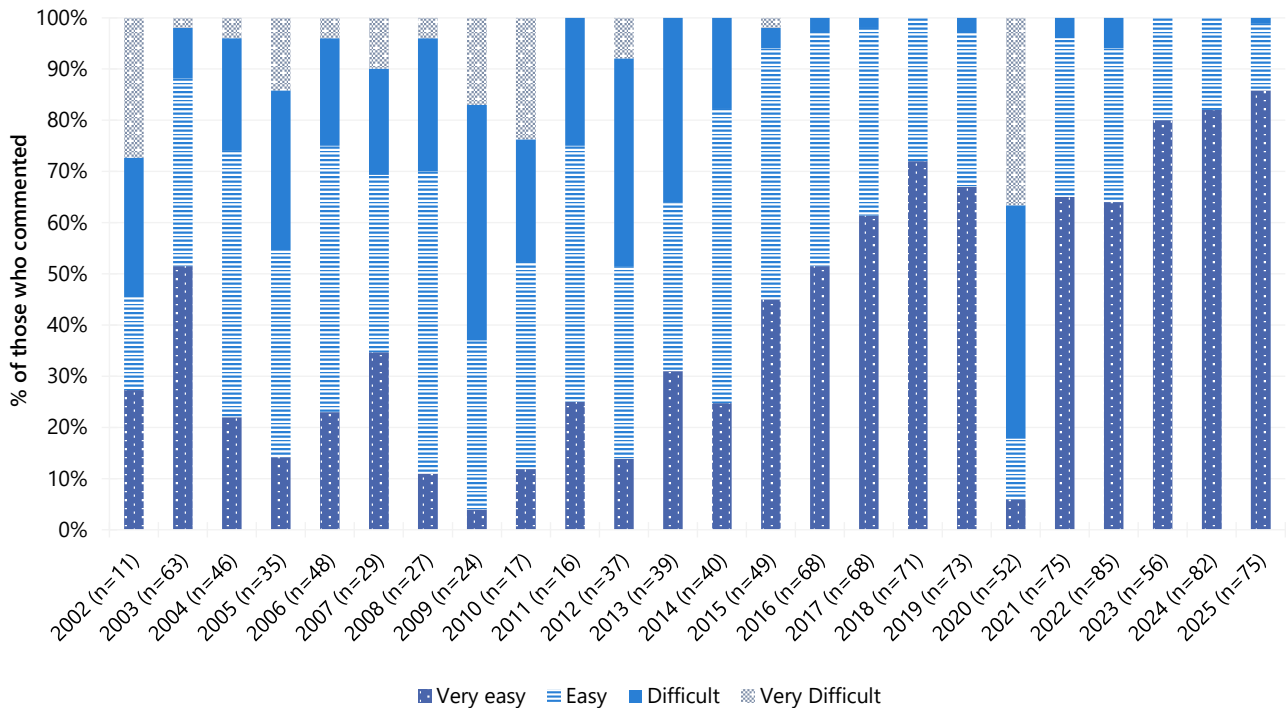
Note. Methamphetamine asked separately for the three different forms from 2002 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented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

Figure 14: Current perceived availability of methamphetamine powder, Hobart, TAS, 2002-2025



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

Figure 15: Current perceived availability of methamphetamine crystal, Hobart, TAS, 2002-2025



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

4

Cocaine

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

Patterns of Consumption

Recent Use (past 6 months)

Recent use of cocaine has fluctuated over the years but has remained at a low level of use. In 2025, 13% of the sample reported recently consuming any cocaine, stable from 2024 (18%; $p=0.429$) (Figure 16).

Frequency of Use

Of those who had recently consumed cocaine and commented in 2025 ($n=12$), frequency of use remained stable at a median of four days (IQR=1-13; 1 days in 2024; IQR=1-9; $n=18$; $p=0.205$). Few participants ($n\leq 5$) reported using cocaine weekly or more frequently in 2024 and 2025 (Figure 16).

Routes of Administration

Among participants who had recently consumed cocaine and commented ($n=12$), four fifths (83%) reported snorting cocaine, stable relative to 2024 (83%). Few participants ($n\leq 5$) reported any other route of administration in 2024 and 2025; therefore, further details are not reported.

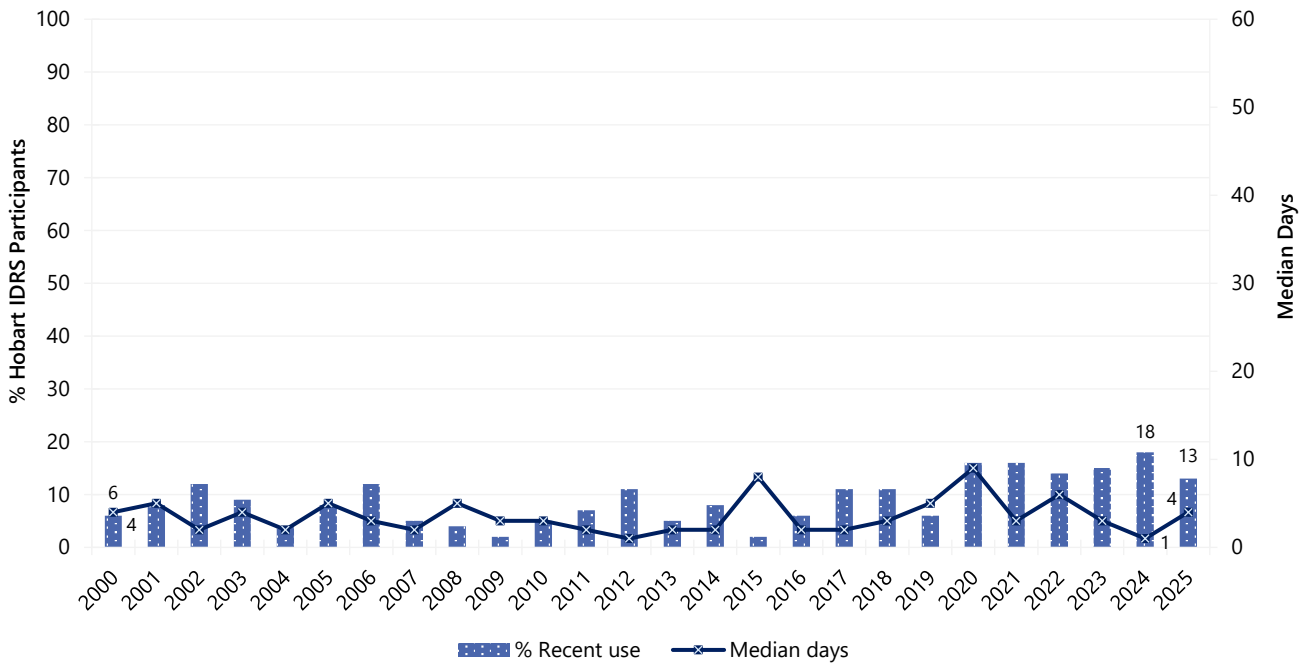
Quantity

Few participants ($n\leq 5$) who reported recent use and responded in 2025 reported on the median amount of cocaine used on a 'typical' day in the six months preceding interview; therefore, further details are not reported (0.40 grams in 2024; IQR=0.20-0.50; $n=16$; $p=0.278$).

Forms Used

Among participants who had recently consumed cocaine and commented ($n=12$), the majority (83%) reported using powder cocaine (83% in 2024). Few participants ($n\leq 5$) reported using crack/rock cocaine in 2024 and 2025.

Figure 16: Past six month use and frequency of use of cocaine, Hobart, TAS, 2000-2025

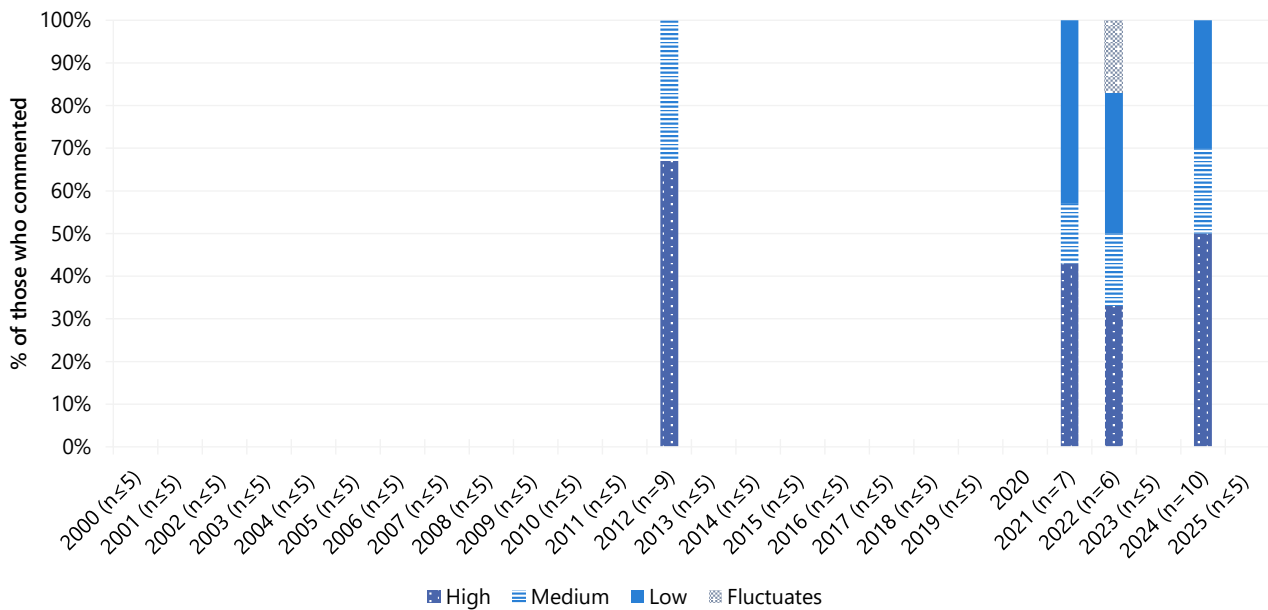


Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 60 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Price, Perceived Purity and Perceived Availability

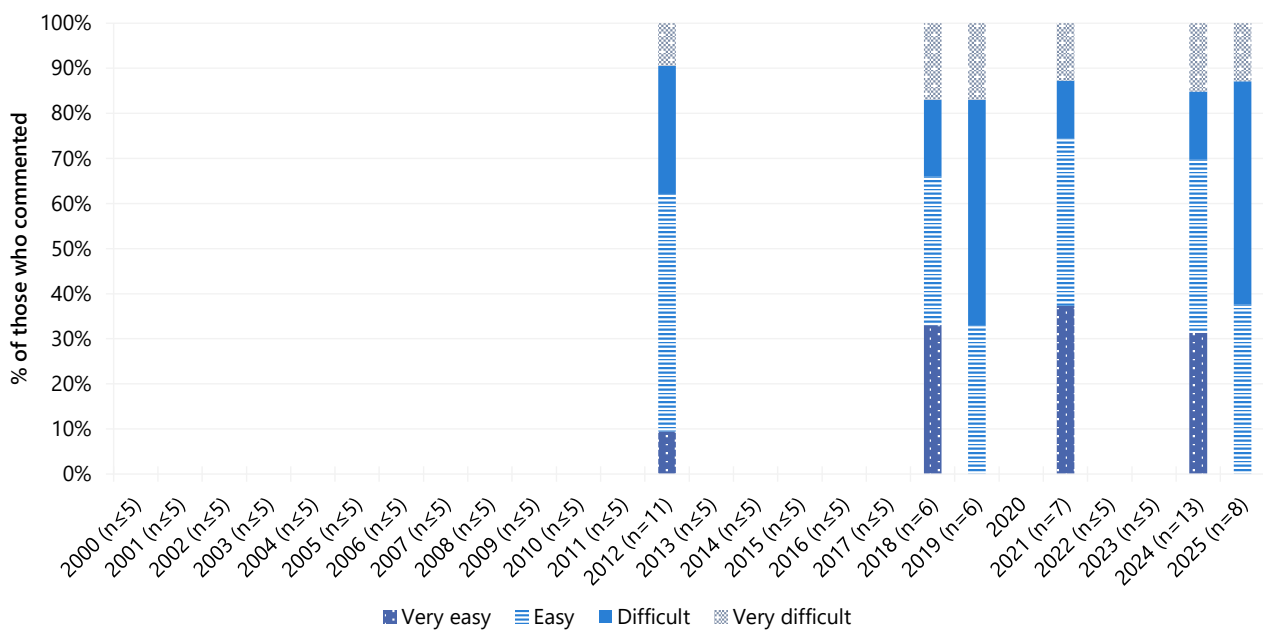
Due to low numbers ($n \leq 5$) of participants reporting on price, perceived purity and perceived availability of cocaine in 2025, estimates are shown in Figure 17 and Figure 18 (median price of cocaine is suppressed), but are not interpreted further. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 17: Current perceived purity of cocaine, Hobart, TAS, 2000-2025



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

Figure 18: Current perceived availability of cocaine, Hobart, TAS, 2000-2025



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

5

Cannabis and/or Cannabinoid-Related Products

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

Terminology throughout this chapter refers to:

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

Patterns of Consumption

From 2022, participants were asked about their use of both prescribed and non-prescribed cannabis and/or cannabinoid-related products. Eight per cent of the Hobart sample reported prescribed use in the six months preceding interview in 2025 (8% in 2024).

In the remainder of this chapter, data from 2021-2025, and between 2000-2016, refers to non-prescribed cannabis use only, whilst data from 2017-2020 refers to 'any' cannabis use (including hydroponic and bush cannabis, hashish and hash oil). Whilst comparison between 2021-2025 and previous years should be treated with caution, the relatively recent legalisation of medicinal cannabis in Australia and the small percentage reporting prescribed use between 2022 and 2023 lends confidence that estimates are relatively comparable.

Recent Use (past 6 months)

The per cent reporting recent non-prescribed cannabis and/or cannabinoid-related products has generally declined slowly since the early 2000s. In 2025, two thirds (68%) reported recent use of non-prescribed cannabis and/or cannabinoid-related products, stable relative to 2024 (74%; $p=0.436$) (Figure 19).

Frequency of Use

Of those who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented in 2025 (n=65), frequency of use remained stable at a median of 180 days (IQR=48-180; 180 days in 2024; IQR=90-180; n=75; $p=0.375$) (Figure 19). Among those who reported recent use in 2025, 62% reported daily use, stable relative to 2024 (67%; $p=0.594$).

Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented (n=65), the majority (95%) reported smoking as the most common route of administration, a significant increase relative to 2024 (80%; $p=0.010$). Few participants (n≤5) reported inhaling/vaporising in 2025, a significant decrease relative to 2024 (31% in 2024; $p<0.001$). Few participants (n≤5) also reported swallowing in 2025 (8% in 2024; $p=0.504$).

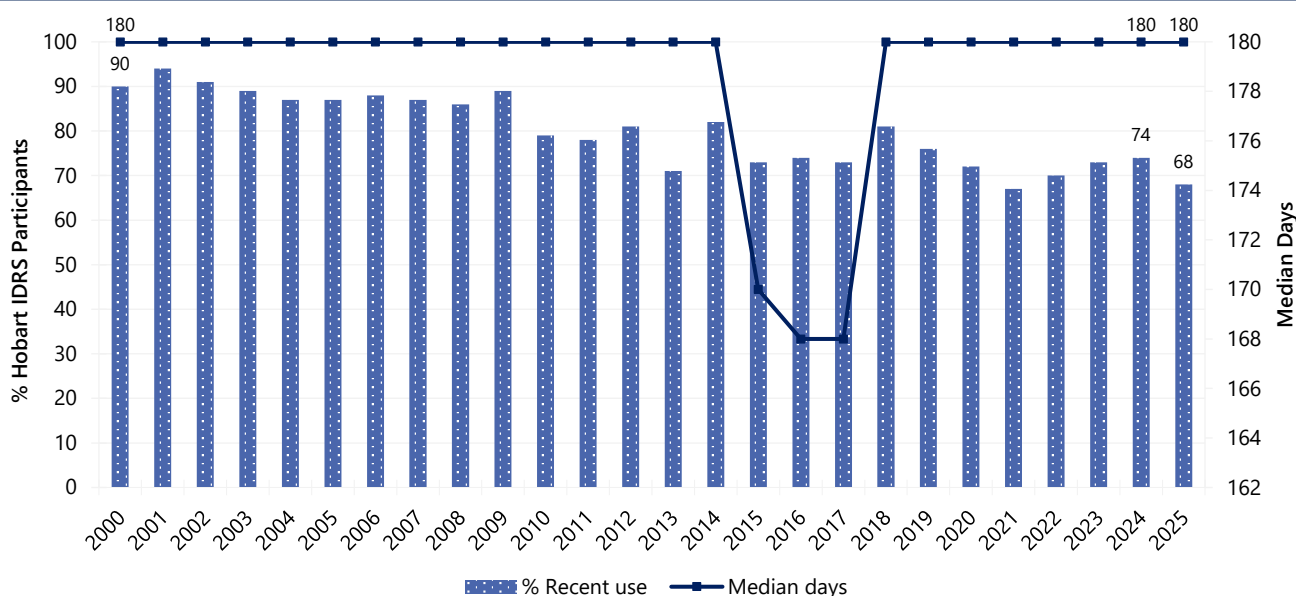
Quantity

Of those who reported recent use of non-prescribed cannabis and/or cannabinoid-related products in 2025 and commented (n=62), the median 'typical' amount used on the last occasion of use was one gram (IQR=1.00-3.00; n=35; 1.00 gram in 2024; IQR=1.00-1.60; n=47; $p=0.081$), two cones (IQR=2-4; n=16; 2 cones in 2024; IQR=2-3; n=17; $p=0.940$) or one joint (IQR=1-3; n=9; 1 joint in 2024 IQR=1-1; n=6; $p=0.231$).

Forms Used

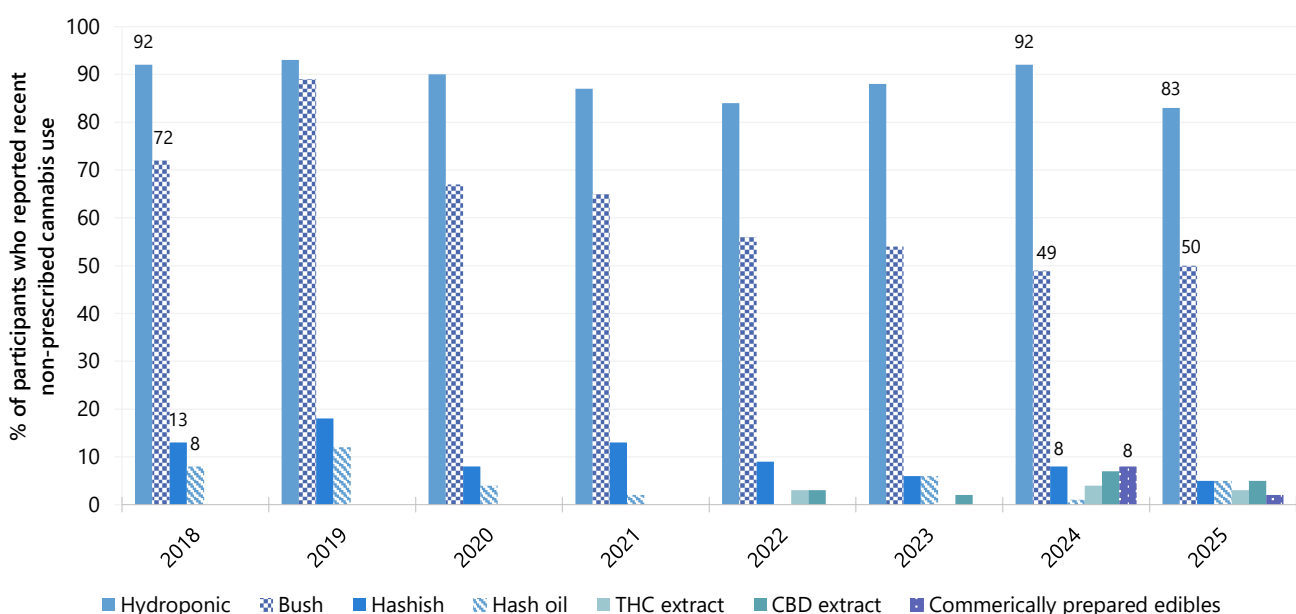
Of those who had used non-prescribed cannabis and/or cannabinoid-related products in the six months preceding interview and commented (n=64), the majority of participants (83%) reported recent use of hydroponic cannabis (92% in 2024; $p=0.129$), and half (50%) reported recent use of outdoor-grown 'bush' cannabis (49% in 2024) (Figure 20). In 2025, few participants (n≤5) reported using hashish (8% in 2024; $p=0.506$) and edibles (8% in 2024; $p=0.124$). Few participants (n≤5) reported recent use of CBD extract, THC extract or hash oil in 2024 and 2025.

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



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such, it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low (in 2022, no participants reported use of prescribed cannabis only). Further, from 2022, we captured use of 'cannabis and/or cannabinoid-related products', while in previous years questions referred only to 'cannabis'. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 20: Past six month use of different forms of non-prescribed cannabis and/or cannabinoid-related products, among those who reported recent non-prescribed use, 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., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 is presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Price, Perceived Potency and Perceived Availability

Hydroponic Cannabis

Price: The median price for one gram of hydroponic cannabis remained stable in 2025, relative to 2024 (\$20 in 2025; IQR=20-25; n=18; \$20 in 2024; IQR=20-25; n=32; $p=0.768$). Few participants ($n\leq 5$) reported on the median price for one ounce of hydroponic cannabis in 2025 (\$250 in 2024; IQR=245-300; n=8; $p=0.861$) (Figure 21A).

Perceived Potency: The perceived potency of hydroponic cannabis remained stable between 2024 and 2025 ($p=0.573$). Among those who were able to comment in 2025 ($n=40$), 55% reported 'high' potency (65% in 2024), followed by 28% reporting 'medium' potency (19% in 2024) (Figure 22A).

Perceived Availability: The perceived availability of hydroponic cannabis significantly changed between 2024 and 2025 ($p=0.035$). Among those who were able to comment in 2025 ($n=40$), there was an increase in participants that perceived hydroponic cannabis to be 'easy' to obtain in 2025 (40%) and a decrease in participants that perceived it

to be 'very easy' to obtain (55%), relative to 2024 (17% and 77% respectively) (Figure 23A).

Bush Cannabis

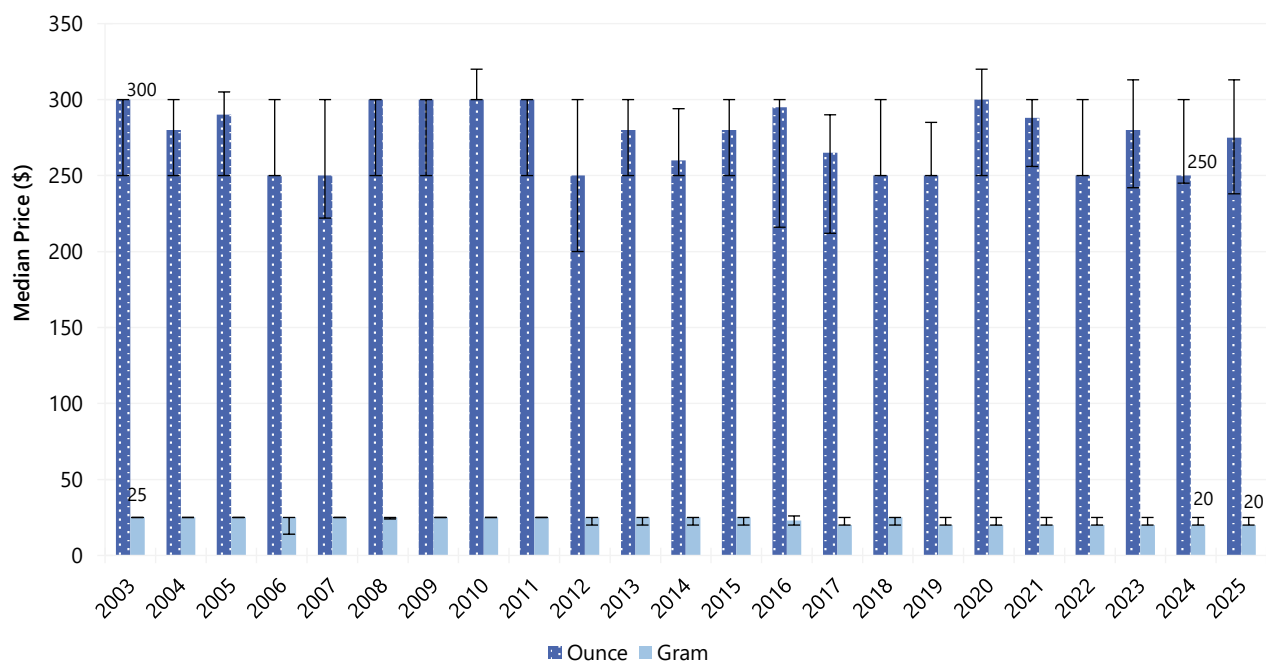
Price: The median price for one gram of bush cannabis in 2025 was \$23 (IQR=19-25; n=8; \$20 in 2024; IQR=20-25; n=8) (Figure 21B). Few participants ($n\leq 5$) reported on the price of an ounce in 2024 and 2025. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Perceived Potency: The perceived potency of bush cannabis remained stable between 2024 and 2025 ($p=0.867$). Among those who were able to comment in 2025 ($n=20$), half (50%) of participants perceived potency to be 'high' (43% in 2024). Few participants ($n\leq 5$) reported 'medium' potency (32% in 2024) (Figure 22B).

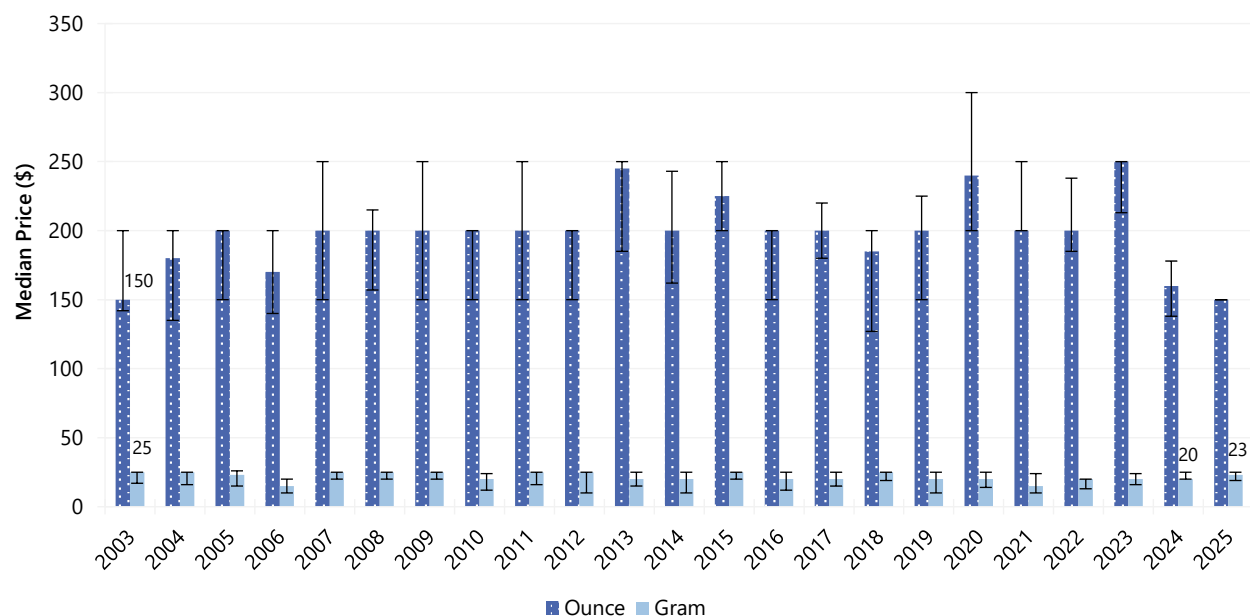
Perceived Availability: The perceived availability of bush cannabis remained stable between 2024 and 2025 ($p=0.791$). Among those who were able to comment in 2025 ($n=20$), 55% perceived that bush was 'very easy' to obtain (45% in 2024), whilst 30% perceived that it was 'easy' to obtain (38% in 2024) (Figure 23B).

Figure 21: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Hobart, TAS, 2003-2025

(A) Hydroponic Cannabis



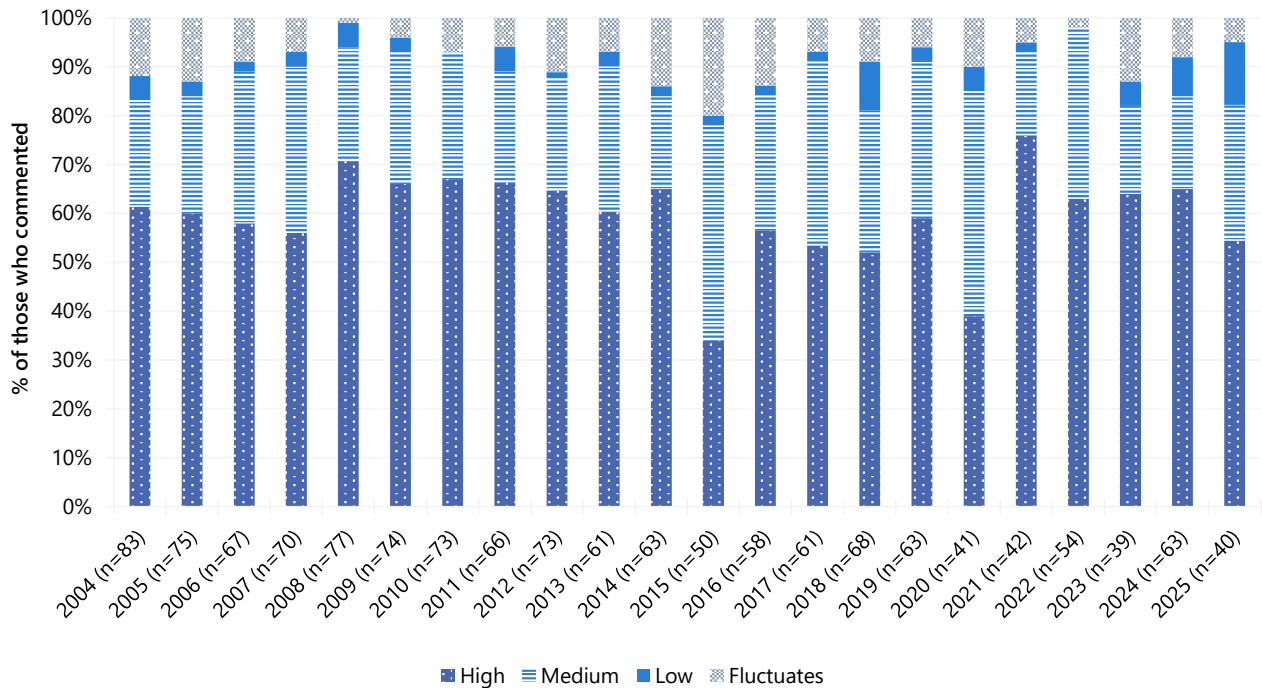
(B) Bush Cannabis



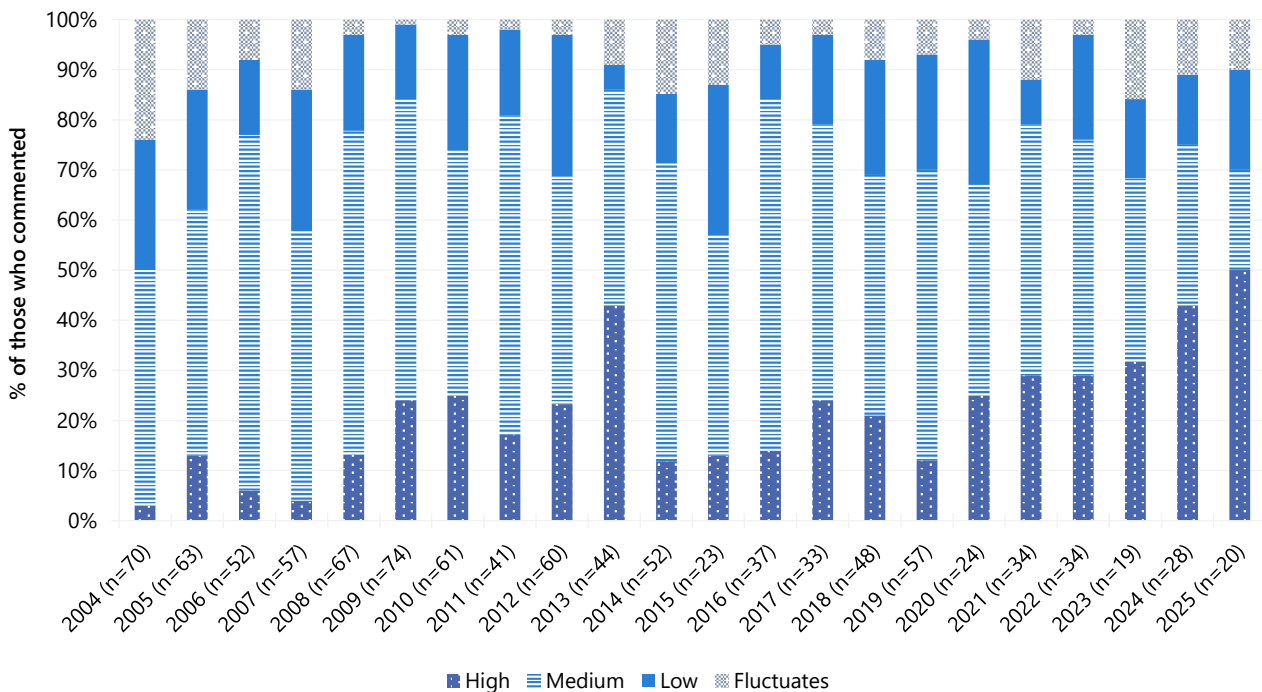
Note. Among those who commented. From 2003 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who are reporting on the price of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are only provided for the first and two most recent years of monitoring, however data are suppressed in the figure where $n \leq 5$ responded. The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 22: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Hobart, TAS, 2004-2025

(A) Hydroponic Cannabis



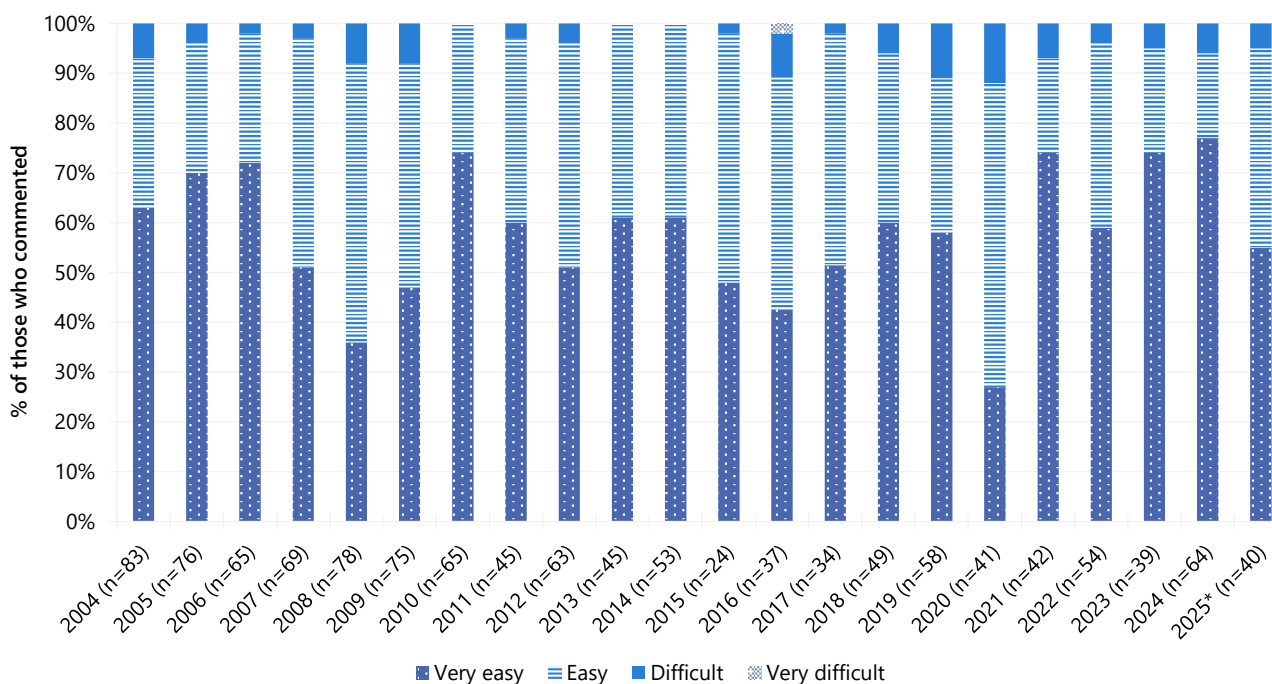
(B) Bush Cannabis



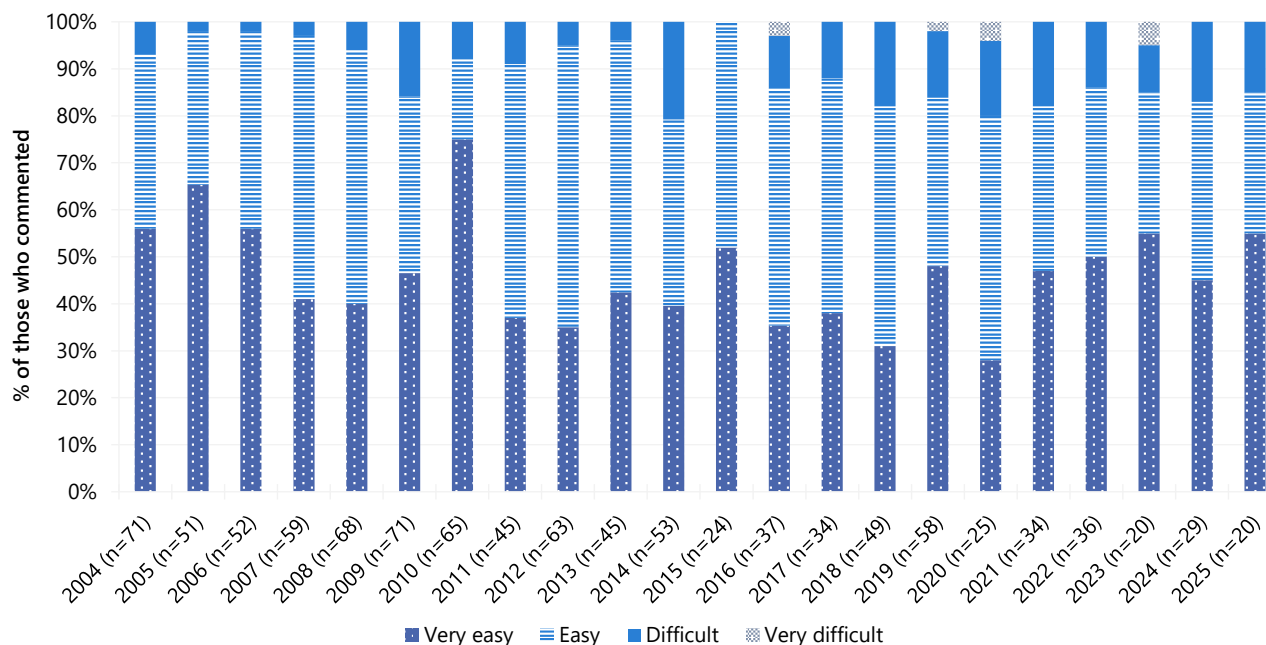
Note. Hydroponic and bush cannabis data collected separately from 2004 onwards. Data from 2022 onwards refers to non-prescribed cannabis only: prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who are reporting on the potency of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

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

(A) Hydroponic Cannabis



(B) Bush Cannabis



Note. Hydroponic and bush cannabis data collected separately from 2004 onwards. Data from 2022 onwards refers to non-prescribed cannabis only: prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who are reporting on the availability of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where n ≤ 5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p < 0.050; **p < 0.010; ***p < 0.001. Please refer to Table 1 for a guide to table/figure notes.

6

Pharmaceutical Opioids

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

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

Contact the Drug Trends team (drugtrends@unsw.edu.au) for information on price and perceived availability of non-prescribed pharmaceutical opioids.

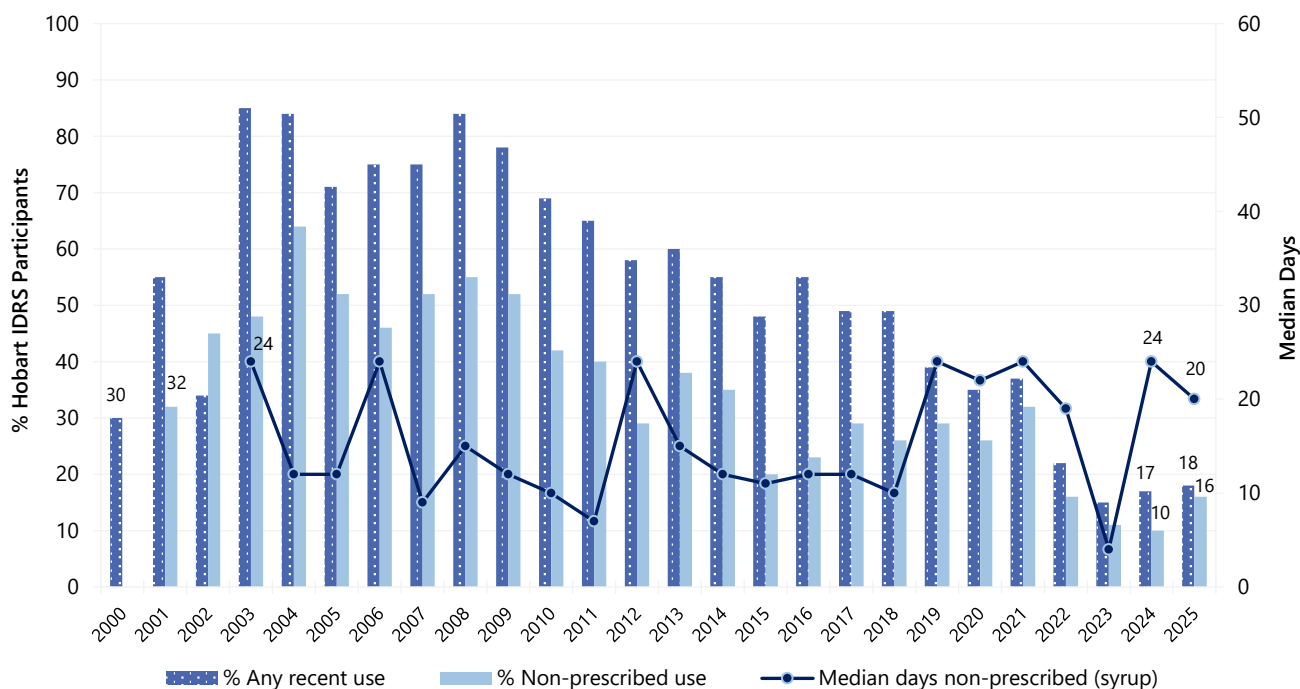
Methodone

Any Recent Use (past 6 months): Notwithstanding some fluctuation, the per recent reporting any recent methadone use (*including* syrup **and** tablets) in the sample has generally decreased since monitoring commenced. In 2025, 18% of participants reported recent use of any prescribed and/or non-prescribed methadone (17% in 2024; $p=0.847$). Methadone use historically has largely consisted of prescribed use. However, in 2025, few participants ($n\leq 5$) reported recent prescribed use (10% in 2024; $p=0.287$). Non-prescribed use remained stable between 2024 and 2025, with 16% of participants reporting recent use in 2025 (10% in 2024; $p=0.289$) (Figure 24).

Frequency of Use: Of those who had recently consumed non-prescribed methadone and commented in 2025 ($n=11$), the median days of use was 20 days (IQR=10-39; 24 days in 2024; IQR=20-29; $n=8$; $p=0.618$) (Figure 24).

Recent Injecting Use: Of those who had recently consumed any methadone in 2025 and commented ($n=13$), three quarters (76%) reported injecting methadone (81% in 2024) on a median of 17 days (IQR=12-101; $n=12$), stable relative to 2024 (24 days; IQR=20-62; $n=12$; $p=0.728$).

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



Note. Includes methadone syrup and tablets except where otherwise specified. Non-prescribed use not distinguished in 2000-2002. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 60 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n\leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Buprenorphine Tablet

Any Recent Use (past 6 months): Twelve per cent of the Hobart sample reported recent use of any buprenorphine tablets in 2025, stable relative to 2024 (13% in 2024; $p=0.825$). Seven per cent reported recent non-prescribed use (8% in 2024). Few participants ($n\leq 5$) reported prescribed use in 2024 and 2025; therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Frequency of Use: Of those who had recently consumed non-prescribed buprenorphine tablets in 2025 and commented ($n=7$), participants reported using on a median of four days (IQR=4-27), a significant decrease from 93 days in 2024 (IQR=66-176; $n=8$; $p=0.031$).

Recent Injecting Use: Of those who had recently used any buprenorphine tablets in 2025 and commented ($n=11$), 64% reported any recent injecting use (69% in 2024). Frequency of recent injecting use was stable at a median of 20 days (IQR=5-93; $n=7$; 81 days in 2024; IQR=10-117; $n=8$, $p=0.383$).

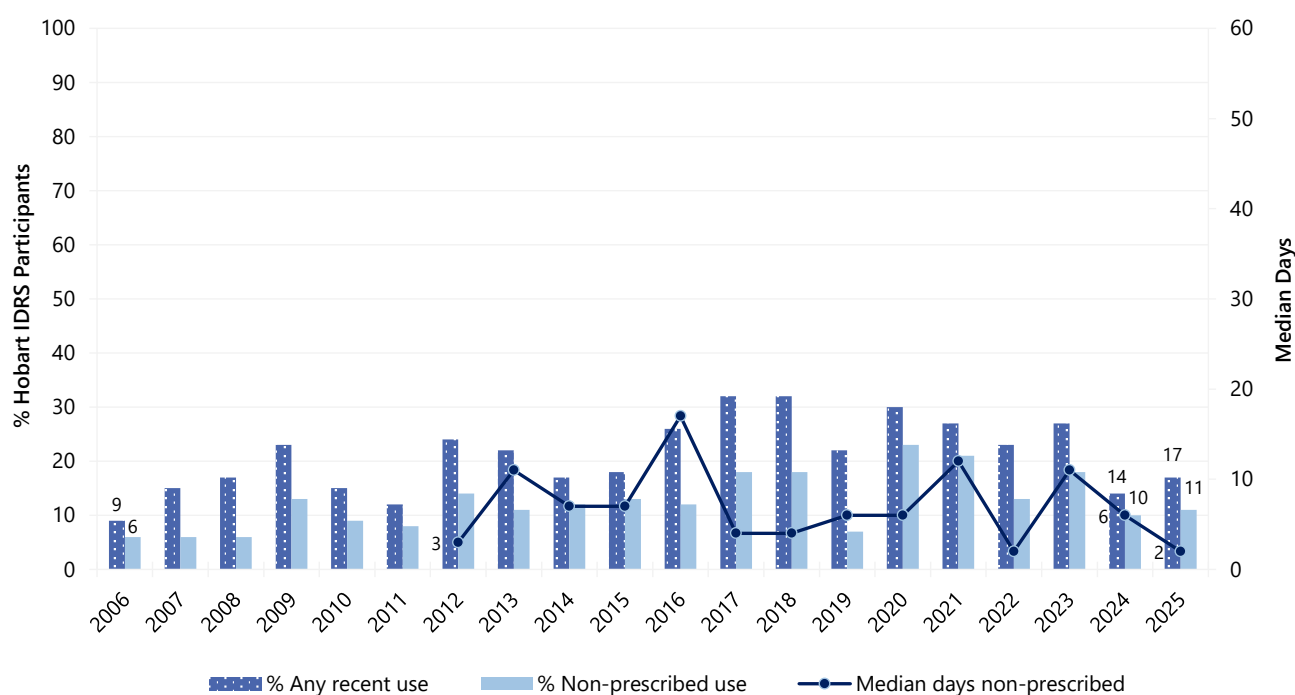
Buprenorphine-Naloxone

Any Recent Use (past 6 months): The per cent reporting any recent buprenorphine-naloxone use has generally remained low and stable over the course of monitoring. In 2025, 17% of the Hobart sample reported recent use of any buprenorphine-naloxone (14% in 2024; $p=0.556$), with one tenth (11%) reporting non-prescribed use (10% in 2024) (Figure 25). Six per cent of participants reported prescribed use in 2025 ($n \leq 5$ in 2024; $p=0.526$).

Frequency of Use: Participants who had recently consumed non-prescribed buprenorphine-naloxone and commented ($n=10$) reported use on a median of two days (IQR=1-16) in the six months preceding interview (6 days in 2024; IQR=3-14; $n=10$; $p=0.356$) (Figure 25).

Recent Injecting Use: Of those who had recently used any buprenorphine-naloxone in 2025 and commented ($n=15$), 53% reported recent injection (71% in 2024; $p=0.450$) on a median of 11 days (IQR=2-26; $n=8$), stable relative to 2024 (9 days; IQR=6-39; $n=8$ $p=0.751$).

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



Note. From 2006-2011, participants were asked about the use of buprenorphine-naloxone tablet; from 2012-2016, participants were asked about the use of buprenorphine-naloxone tablet and film; from 2017 onwards, participants were asked about the use of buprenorphine-naloxone film only. Median days of non-prescribed use computed among those who reported recent use (maximum 180 days) and is only reported from 2012 onwards to capture film use. Median days rounded to the nearest whole number. Secondary Y axis reduced to 60 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

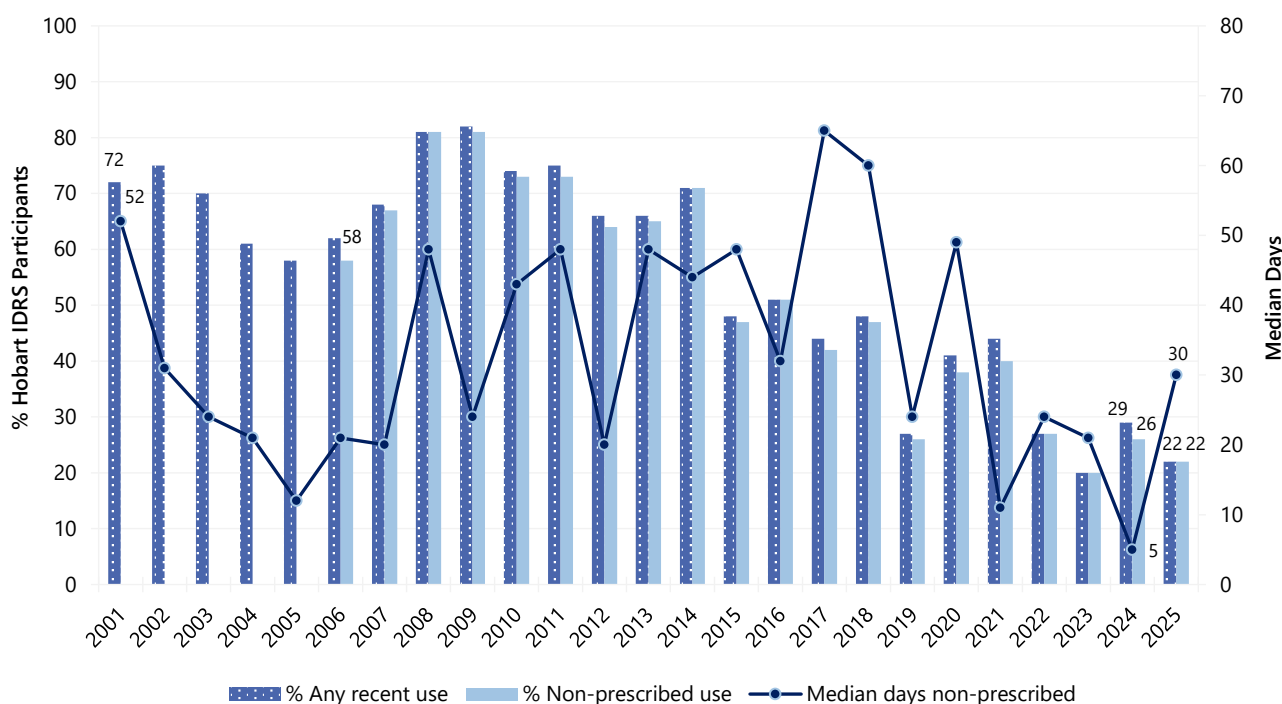
Morphine

Any Recent Use (past 6 months): The Hobart sample has observed a downward trend in recent use of morphine since peaking in 2009 (Figure 26). In 2025, one fifth (22%) of the sample had recently used any morphine (29% in 2024; $p=0.261$). This comprised solely of non-prescribed use (22%; 26% in 2024; $p=0.504$), with no participants reporting recent prescribed use in 2025 ($n \leq 5$ in 2024; $p=0.122$).

Frequency of Use: Participants who had recently consumed non-prescribed morphine and commented ($n=21$) reported use on a median of 30 days (IQR=2-72), stable relative to 2024 (5 days; IQR=2-48; $n=27$; $p=0.358$) (Figure 26).

Recent Injecting Use: Of those who had recently used any morphine in 2025 and commented ($n=21$), the majority (95%) reported injecting morphine (93% in 2024) on a median of 35 days (IQR=2-72; $n=20$; 14 days in 2024; IQR=3-71; $n=28$; $p=0.875$).

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



Note. Median days of use computed among those who reported recent use (maximum 180 days). Non-prescribed use not distinguished in 2001-2005. Secondary Y axis reduced to 80 days to improve visibility of trends. Median days rounded to the nearest whole number. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

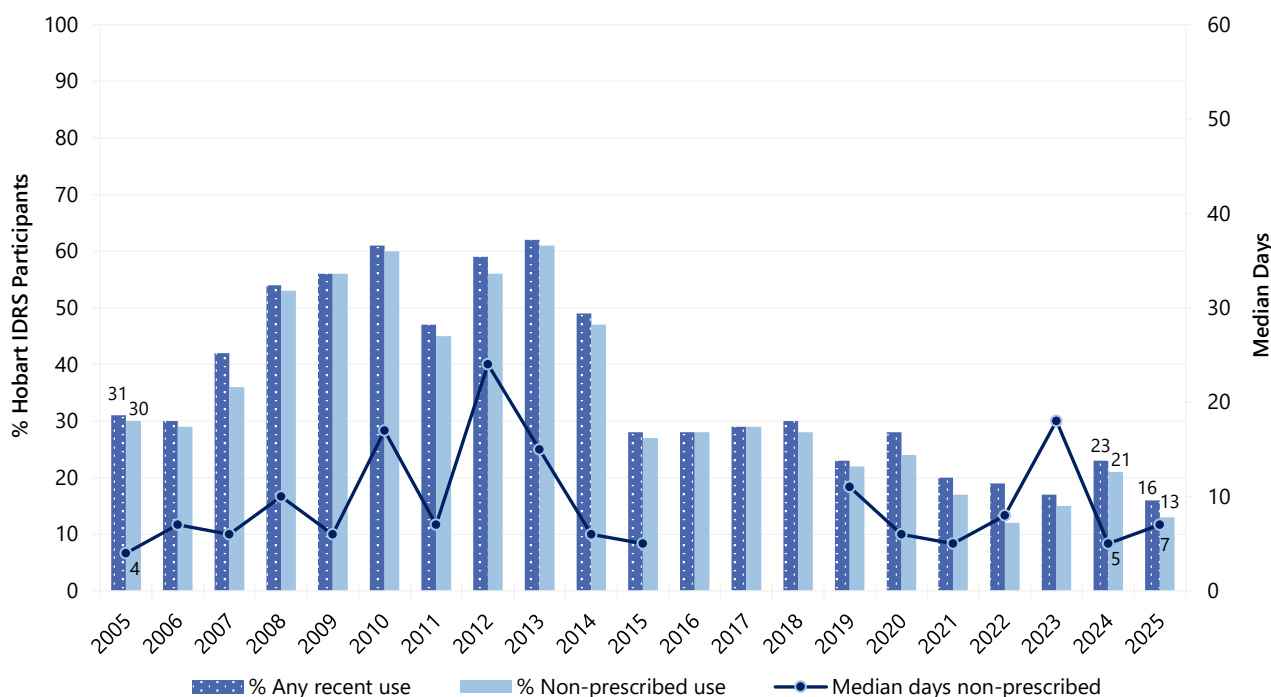
Oxycodone

Any Recent Use (past 6 months): Recent use of oxycodone has fluctuated over the course of monitoring, with 16% of participants reporting any recent use in 2025 (23% in 2024; $p=0.284$) (Figure 27). In 2025, 13% of the Hobart sample had used non-prescribed oxycodone (21% in 2024; $p=0.184$). Few participants ($n \leq 5$) reported recent prescribed use of oxycodone in 2024 and 2025.

Frequency of Use: Participants who had recently consumed non-prescribed oxycodone and commented ($n=12$) reported use on a median of seven days (IQR=5-45) in the six months preceding interview in 2025 (5 days in 2024; IQR=2-12; $n=21$; $p=0.164$) (Figure 27).

Recent Injecting Use: Of those who had recently used any oxycodone in 2025 and commented ($n=15$), three fifths (60%) reported injecting oxycodone (70% in 2024; $p=0.734$) on a median of nine days (IQR=4-55; $n=9$), stable relative to six days in 2024 (IQR=3-11; $n=16$; $p=0.341$).

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

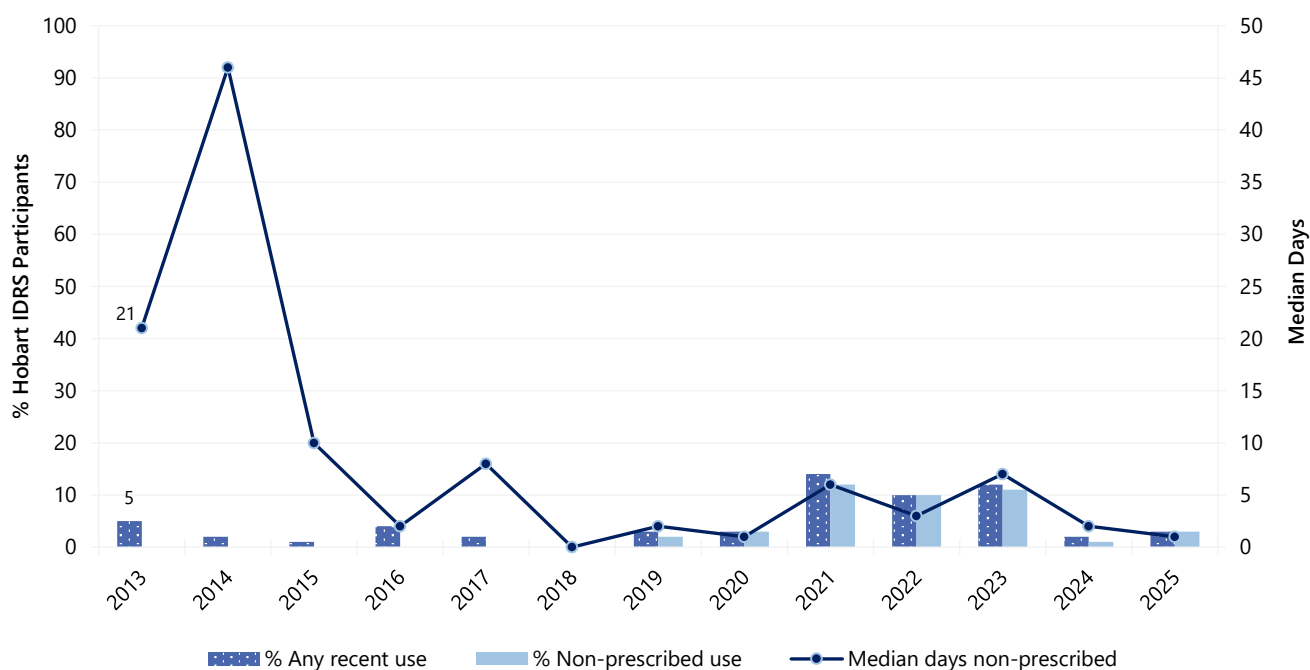


Note. From 2005-2015, participants were asked about recent use and frequency of use for any oxycodone; from 2016-2018, recent use and frequency of use for oxycodone was broken down into three types: tamper resistant ('OP'), non-tamper proof (generic) and 'other oxycodone' (median days non-prescribed use missing from 2016-2018). From 2019-2022, recent use for oxycodone was broken down into four types: tamper resistant ('OP'), non-tamper proof (generic), 'other oxycodone' and oxycodone-naloxone, while frequency of use was asked for any oxycodone. From 2023 onwards, participants were asked about recent use and frequency of use for any oxycodone. Median days of non-prescribed use computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 60 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Fentanyl

The per cent reporting any recent fentanyl use has generally remained low and stable over the course of monitoring. Due to few participants ($n \leq 5$) reporting recent use of any fentanyl in 2024 and 2025 (Figure 28), details regarding frequency of use and recent injecting use are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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



Note. Data on fentanyl use not collected from 2000-2012; from 2013-2017, the IDRS did not distinguish between prescribed and non-prescribed use. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Other Opioids

Participants were asked about prescribed and non-prescribed use of other opioids (Table 3). In 2025, 12% of participants reported recent use of any codeine (10% in 2024; $p=0.812$), with one tenth (11%) recent non-prescribed use ($n\leq 5$ in 2024; $p=0.181$). Few participants ($n\leq 5$) reported recent prescribed codeine use in 2024 and 2025; therefore, further details are not reported.

Seven per cent of participants reported recent use of any form of tramadol (10% in 2024; $p=0.617$), with 6% reporting recent non-prescribed use of tramadol (8% in 2024; $p=0.780$), and few participants ($n\leq 5$) reporting recent prescribed use in 2024 and 2025. Few participants ($n\leq 5$) reported recent use of any form of tapentadol in 2024 and 2025. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Table 3: Past six month use of other opioids, Hobart, TAS, 2019-2025

% Recent use (past 6 months)	2019 N=99	2020 N=74	2021 N=95	2022 N=102	2023 N=66	2024 N=102	2025 N=95
Codeine[^]							
Any use	9	-	12	10	21	10	12
Non-prescribed use	19	14	9	-	9	-	11
Any injection [#]	0	0	0	0	0	0	-
Tramadol							
Any use	26	-	20	16	20	10	7
Non-prescribed use	18	9	7	7	12	8	6
Any injection [#]	12	0	16	6	8	0	-
Tapentadol							
Any use	-	-	-	-	-	-	-
Non-prescribed use	-	-	-	-	0	-	-
Any injection [#]	0	0	0	0	0	0	-

Note. [^]Includes high and low dose. [#]Of those who reported past six month use. Statistical significance for 2024 versus 2025 presented in table; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. - Per cent suppressed due to small cell size ($n\leq 5$ but not 0). Please refer to Table 1 for a guide to table/figure notes.

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Other Drugs

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

New Psychoactive Substances (NPS)

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

Few participants ($n \leq 5$) of the Hobart sample reported using any NPS in the six months prior to interview (7% in 2024; $p=0.334$). Few participants ($n \leq 5$) reported using specific NPS in 2024 and 2025; therefore, no further details on patterns of use are reported. Please refer to Table 4 for trends in use amongst the Hobart sample and the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Table 4: Past six month use of new psychoactive substances, Hobart, TAS, 2013-2025

% Recent Use (past 6 months)	2013 N=105	2014 N=101	2015 N=100	2016 N=99	2017 N=100	2018 N=100	2019 N=99	2020 N=74	2021 N=95	2022 N=102	2023 N=66	2024 N=102	2025 N=95
'New' drugs that mimic the effects of opioids	/	/	/	/	0	0	-	-	-	0	0	-	0
'New' drugs that mimic the effects of ecstasy	/	/	/	/	_ [#]	-	-	-	-	-	-	-	-
'New' drugs that mimic the effects of amphetamine or cocaine	-	/	/	/	/	-	-	-	-	-	-	-	-
'New' drugs that mimic the effects of cannabis	-	-	-	-	-	-	-	-	-	0	0	-	0
'New' drugs that mimic the effects of psychedelic drugs	/	/	/	/	_ [#]	-	-	-	-	-	-	-	0
'New' drugs that mimic the effects of benzodiazepines	/	/	/	/	/	/	-	-	-	-	-	-	-
'New' drugs that mimic the effects of dissociatives	/	/	/	/	/	/	/	/	/	/	/	/	0
Any of the above	-	-	-	0	-	8	9	6	-	-	-	7	-

Note. [#]In 2017, participants were asked about use of 'new drugs that mimic the effects of ecstasy or psychedelic drugs', thus the same value appears in both 'new' drugs that mimic the effects of ecstasy and 'new' drugs that mimic the effects of psychedelic drugs. Statistical significance for 2024 versus 2025 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Non-Prescribed Pharmaceutical Drugs

Benzodiazepines

Recent Use (past 6 months): Recent use of non-prescribed benzodiazepines has fluctuated over the course of monitoring, peaking at 67% in 2011 and generally declining thereafter. Twenty-seven per cent of the Hobart sample reported recent use of non-prescribed benzodiazepines (e.g., diazepam, alprazolam) in the six months preceding interview in 2025, stable relative to 2024 (27% in 2024) (Figure 29).

Frequency of Use: In 2025, participants reported using non-prescribed benzodiazepines on a median of five days (IQR=2-20; n=25) in the six months preceding interview, a significant decrease relative to 2024 (14 days; IQR=6-114; n=28; $p=0.021$).

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

Forms Used: Among those who reported non-prescribed benzodiazepine use and responded in 2025 ($n=26$), the most commonly used benzodiazepine was Valium (diazepam) (81%). Few participants ($n\leq 5$) reported use of other benzodiazepines.

Pharmaceutical Stimulants

Recent Use (past 6 months): In 2025, one tenth (11%) of the Hobart sample had used non-prescribed pharmaceutical stimulants (e.g., Ritalin, dexamphetamine, Modafinil, Concerta, Vyvanse) in the six months preceding interview, stable relative to 2024 (18%; $p=0.169$) (Figure 29).

Frequency of Use: Participants who had recently consumed non-prescribed pharmaceutical stimulants and commented ($n=10$) reported use on a median of eight days (IQR=1-18), stable relative to 2024 (5 days; IQR=2-21; $n=18$; $p=0.942$).

Recent Injecting Use: Of those who had recently used pharmaceutical stimulants in 2025 and commented ($n=10$), 70% of participants reported recently injecting pharmaceutical stimulants (44% in 2024; $n=8$; $p=0.254$) on a median of two days (IQR=1-39) in the past six months, stable from 2024 (5 days; IQR=2-8; $n=8$; $p=0.767$).

Antipsychotics

Few participants ($n\leq 5$) reported using non-prescribed antipsychotics in the six months prior to interview in 2025 (6% in 2024; $p=0.500$) (Figure 29); therefore, no further details regarding patterns of use are included. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Pregabalin

Recent Use (past 6 months): In 2025, one fifth (19%) of participants reported using non-prescribed pregabalin in the six months preceding interview, stable relative to 20% in 2024 (Figure 29).

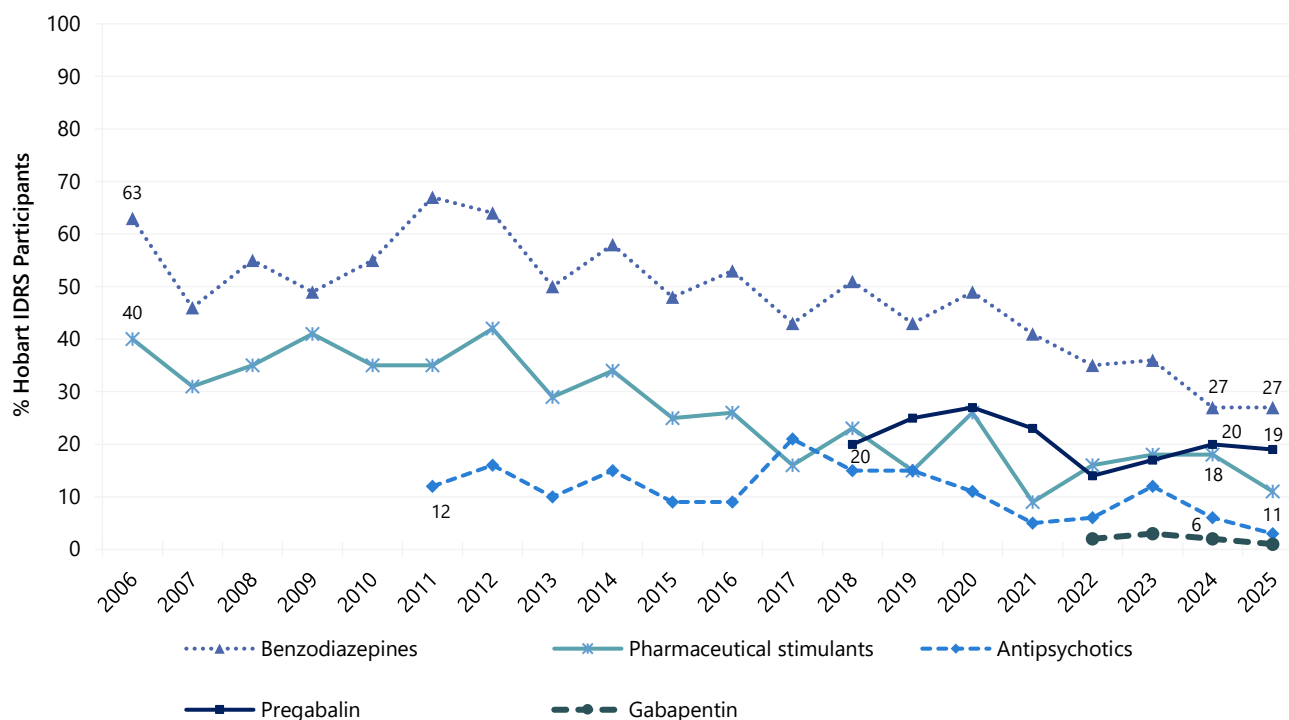
Frequency of Use: Participants who had recently consumed non-prescribed pregabalin and commented (n=17) reported use on a median of 24 days (IQR=2-30), stable relative to 2024 (7 days; IQR=3-35; n=19; $p=0.874$).

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

Gabapentin

Few participants (n≤5) reported using non-prescribed gabapentin in the six months prior to interview in 2024 and 2025; therefore, no further details are reported. (Figure 29). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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



Note. From 2019 to 2023, participants were asked about their use of non-prescribed alprazolam and non-prescribed use of ‘other’ benzodiazepines (e.g., diazepam), separately. In 2024, these categories were combined, and as such, participants were asked about non-prescribed use of any benzodiazepines. Non-prescribed use is reported. Antipsychotics was asked as ‘Seroquel’ from 2011-2018. Pharmaceutical stimulants were separated into prescribed and non-prescribed from 2006 onwards, and benzodiazepines were separated into prescribed and non-prescribed in 2007. Y axis reduced to 50% to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤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): Half (52%) of the Hobart sample reported any recent use of alcohol in 2025, stable relative to 54% in 2024 ($p=0.776$) (Figure 30).

Frequency of Use: Participants who had recently consumed alcohol and commented ($n=49$) reported use on a median of 12 days (IQR=4-90; 40 days in 2024; IQR=6-150; $n=55$; $p=0.092$), with 14% reporting daily use (18% in 2024; $p=0.607$).

Tobacco

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

Recent Use (past 6 months): Tobacco use has been consistently high amongst the Hobart sample. In 2025, the majority (86%) of participants reported recent use of tobacco (93% in 2024; $p=0.162$) (Figure 30). Fifty-six per cent of participants reported recent use of smoked or non-smoked illicit tobacco products, a significant increase from 18% in 2024 ($p<0.001$).

Frequency of Use: Participants who had recently consumed tobacco and commented ($n=82$) reported use on a median of 180 days in 2025 (IQR=180-180; 180 days in 2024; IQR=180-180; $n=95$; $p=0.627$), with 91% reporting daily use (89% in 2024; $p=0.796$).

Forms Used: Among those who reported recent use of illicit tobacco products in the six months preceding interview and responded ($n=52$), the most common reported product used was 'branded packs' (71%), followed by 'branded loose' (44%), 'unbranded pack' (38%), and 'unbranded loose' (31%).

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 2025, all e-cigarette products, regardless of whether they contained nicotine, could only legally be sold in a pharmacy. From 1 October 2024, people 18 years and older could buy e-cigarettes from participating pharmacies with a nicotine concentration of 20 mg/mL or less *without a prescription*, where state and territory laws allowed: products with a nicotine concentration of >20 mg/mL still required a prescription.

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

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

Recent Use (past 6 months): Fifteen per cent of the Hobart sample reported recent use of illicit e-cigarettes in 2025, stable relative to 2024 (19%; $p=0.567$) (Figure 30).

Frequency of Use: Participants who had recently consumed illicit e-cigarettes and commented ($n=14$) reported use on a median of 12 days in 2025 (IQR=2-98), stable relative to 26 days in 2024 (IQR=6-180; $n=19$; $p=0.439$). Few participants ($n\leq 5$) reported daily use (32% in 2024; $p=0.698$).

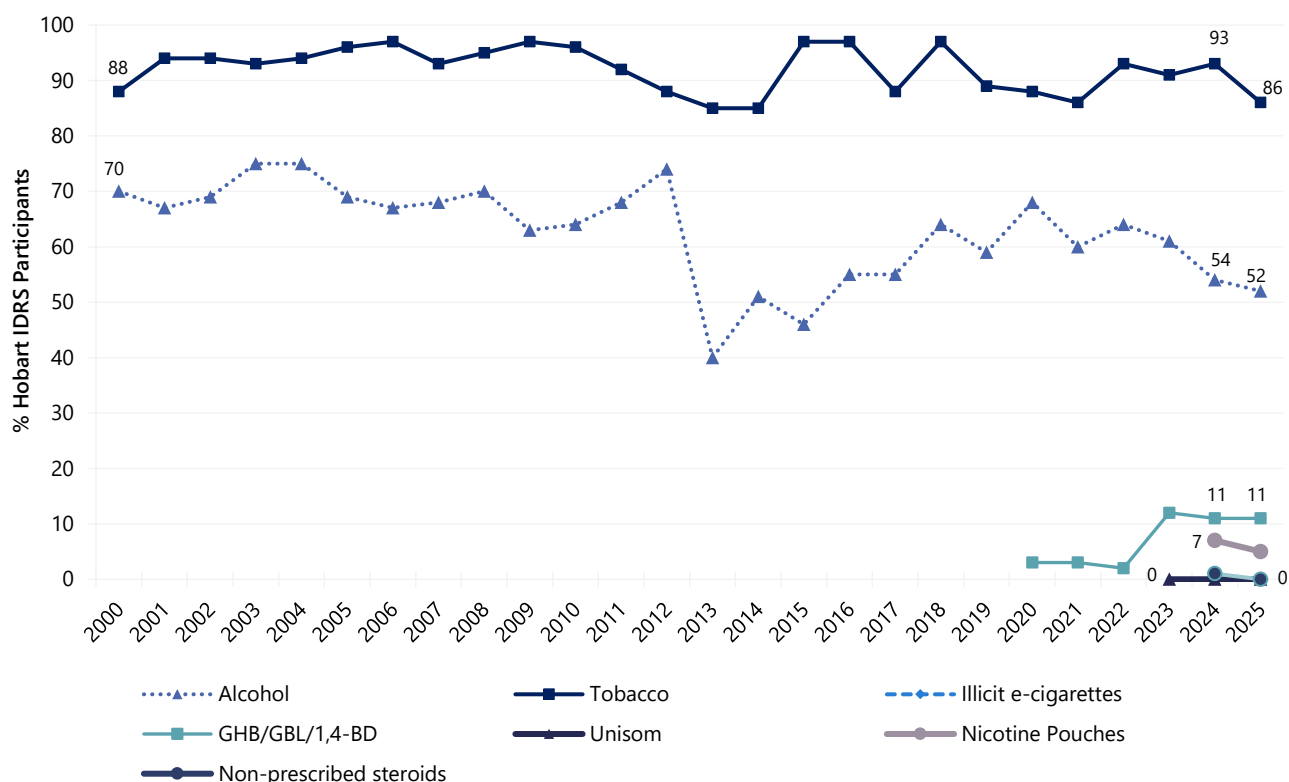
Forms Used: Among participants who had recently used e-cigarettes and responded in 2025 ($n=13$), participants most commonly reported using disposable devices (92%).

Reason for Use: Few participants ($n\leq 5$) who had recently used any illicit e-cigarettes in 2025 reported that they had used e-cigarettes as a smoking cessation tool (35% in 2024; $p=0.250$).

Nicotine Pouches

Few participants ($n\leq 5$) of the Hobart sample reported recent use of nicotine pouches in 2025 (7% in 2024; $p=0.769$); therefore, no further details are reported (Figure 30). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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



Note. Regarding e-cigarette use, on 1 October 2021, legislation came into effect requiring people to obtain a prescription to legally import nicotine vaping products. Data from 2022 onwards refers to 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., $n\leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Steroids

No participants reported using non-prescribed steroids in the six months preceding interview in 2025 ($n \leq 5$ in 2024) (Figure 30). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

GHB/GBL/1,4-BD

Recent Use (past 6 months): One tenth (11%) of the Hobart sample reported recent use of GHB/GBL/1,4-BD in both 2024 and 2025 (Figure 30).

Frequency of Use: Participants who had recently consumed GHB/GBL/1,4-BD and commented ($n=10$) reported use on a median of three days (IQR=2-4), stable relative to 2024 (2 days; IQR=1-6; $n=11$; $p=0.587$).

Recent Injecting Use: In 2025, no participants reported recent injection of GHB/GBL/1,4-BD ($n \leq 5$ in 2024). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Unisom

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

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

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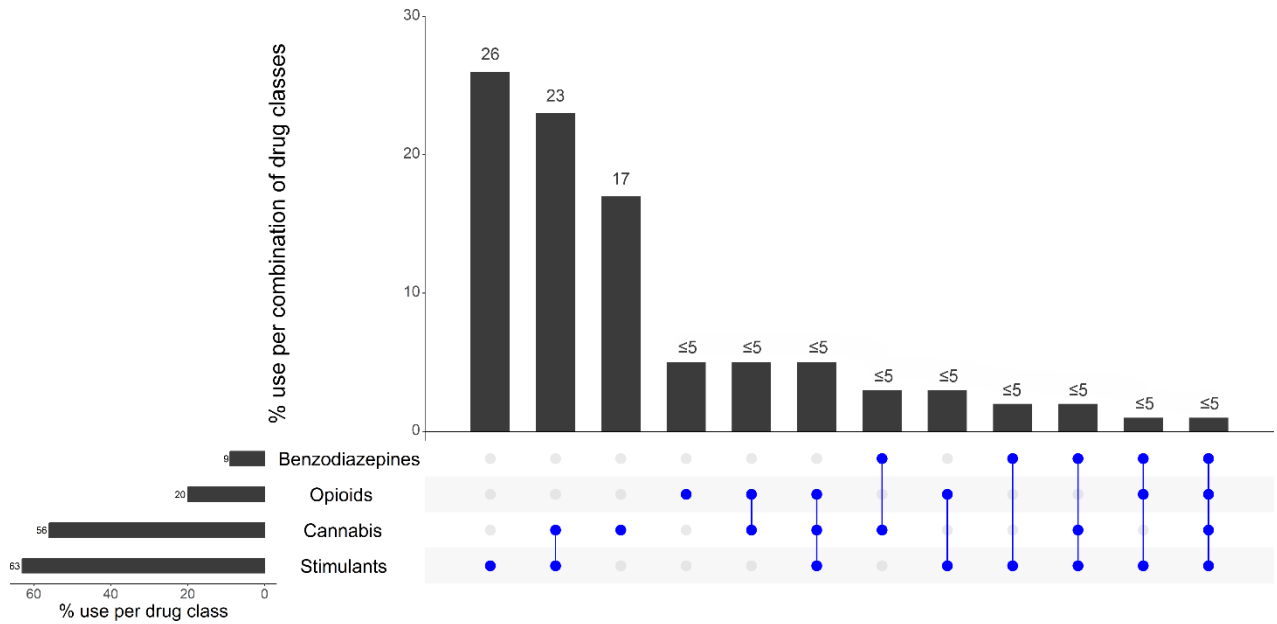
Drug-Related Harms and Other Behaviours

Polysubstance Use

In 2025, 98% of the Hobart sample reported using one or more drugs (including alcohol and prescription medications but excluding tobacco and e-cigarettes) on the day preceding interview. Of those who reported using one or more drugs and commented (n=93), the most commonly used substances comprised of any opioid (78%), followed by cannabis (58%), any stimulant (34%), alcohol (17%), antipsychotics (14%), benzodiazepines (10%) and pregabalin (6%).

Three fifths (60%) of the Hobart sample reported use of two or more drugs on the day preceding interview (excluding tobacco and e-cigarettes). Of those who reported using two or more drugs and commented (n=57), almost one quarter (23%) of participants reported concurrent use of cannabis and stimulants on the day preceding interview (Figure 31). One quarter (26%) of respondents reported using stimulants alone, and 17% reported using cannabis alone.

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

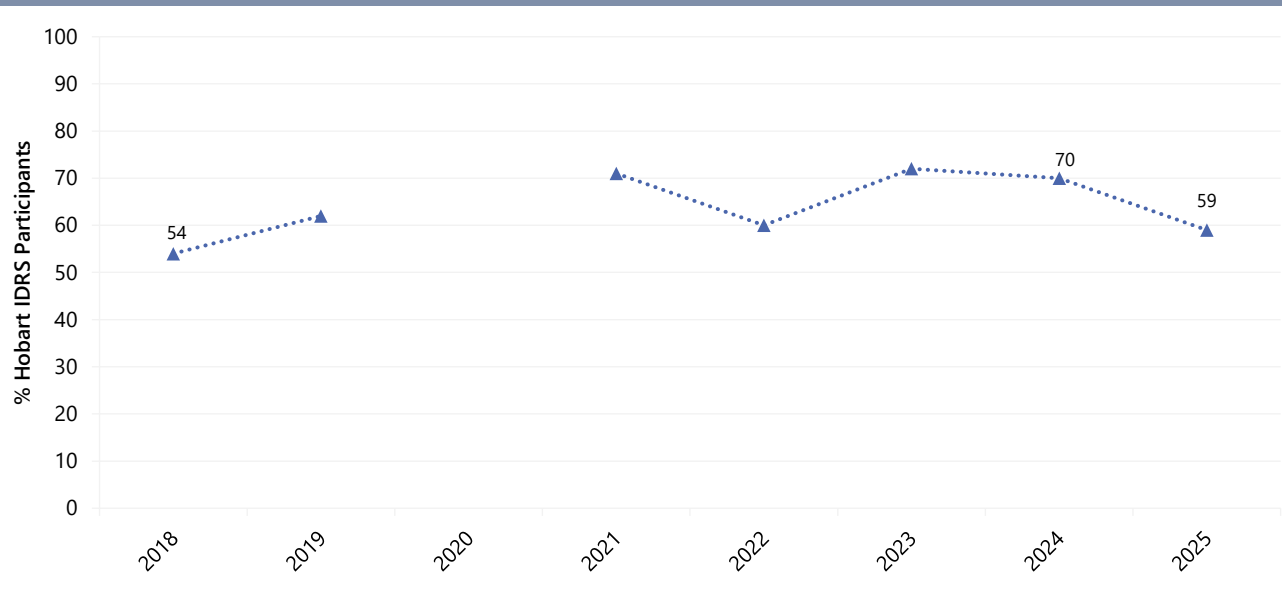


Note. % calculated out of total IDRS 2025 sample. The horizontal bars represent the per cent of participants who reported use of each drug class on the day preceding interview; the vertical columns represent the per cent of participants who used the combination of drug classes represented by the blue circles. Participants who did not report use of any of the four drug classes depicted are not shown in the figure but are counted in the denominator. 'Stimulants' includes methamphetamine, cocaine, MDA, ecstasy and/or pharmaceutical stimulants. 'Opioids' includes heroin, methadone, morphine, oxycodone, buprenorphine, buprenorphine-suboxone, fentanyl, other pharmaceutical opioids (codeine, tapentadol, tramadol, etc). Use of benzodiazepines, opioids and stimulants could be prescribed or non-prescribed use. The response option Y axis reduced to 30% to improve visibility of trends.

Binge Drug Use

Participants were asked whether they had used any drug/s for 48 hours or more continuously without sleep (i.e., binged) in the six months preceding interview. The per cent of the sample who have reported bingeing has generally remained stable. In 2025, almost three fifths (59%) of the Hobart sample had binged on one or more drugs in the preceding six months, stable from 2024 (70%; $p=0.145$) (Figure 32).

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



Note. Participants were first asked about bingeing in 2018. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Overdose Events

Non-Fatal Overdose

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

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

- **Opioid overdose** (e.g., reduced level of consciousness, respiratory depression, turning blue, collapsing and being unable to be roused). Participants who reported this experience were asked to identify all opioids involved in such events in the past 12 months;
- **Non-opioid overdose** (e.g., nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, seizure, extreme paranoia, extreme anxiety, panic, extreme agitation, hallucinations). Drugs other than opioids were split into the following:
 - **Stimulant overdose:** Stimulant drugs include ecstasy, methamphetamine, cocaine, MDA, methylone, mephedrone, pharmaceutical stimulants and stimulant NPS (e.g., MDPV, Alpha PVP); and
 - **Other drug overdose:** 'Other drugs' include (but are not limited to) alcohol, cannabis, GHB/GBL/1,4-BD, amyl nitrite/alkyl nitrite, benzodiazepines and LSD.

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

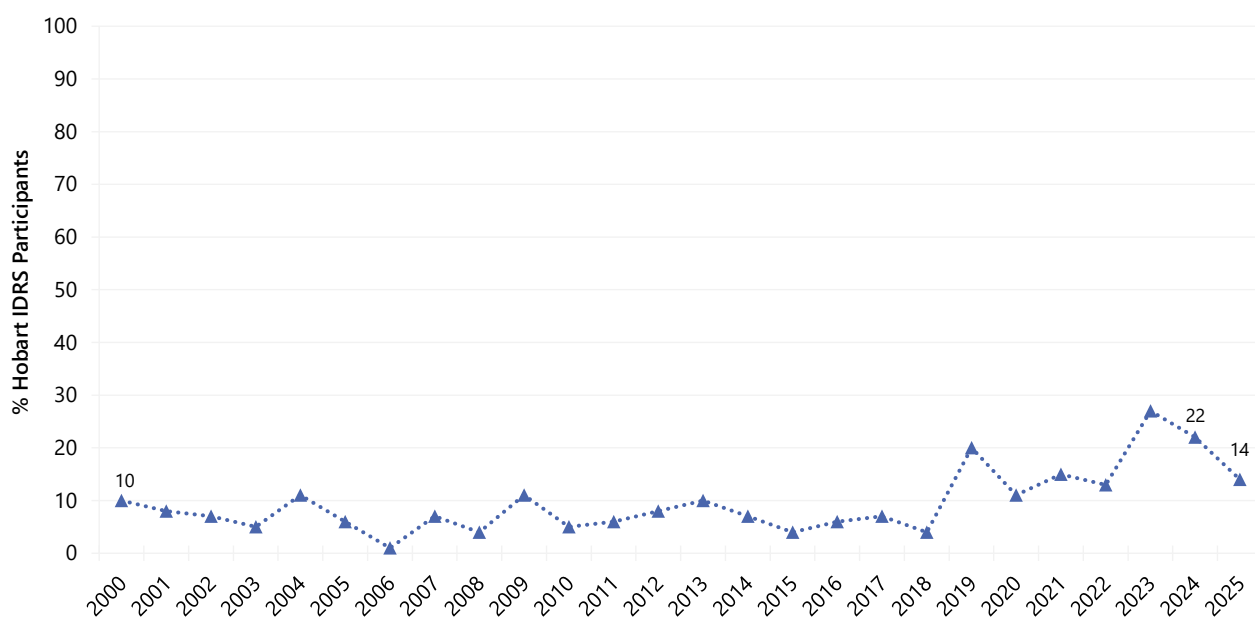
Each year, we compute the total per cent of participants who have experienced any past 12-month overdose event by looking for any endorsement across the drug types queried (see Table 5 below).

Non-fatal overdose in the Hobart sample has fluctuated over the years (likely due to differences in the way questions regarding overdose were asked). In 2025, 14% of participants reported **any non-fatal overdose** in the 12 months preceding interview, stable relative to 22% in 2024 ($p=0.194$) (Figure 33).

Six per cent of participants reported a **non-fatal overdose following stimulant use** in the 12 months preceding interview, stable relative to 2024 (13%; $p=0.155$). Few participants ($n \leq 5$) reported a **non-fatal overdose following opioid use** in the 12 months preceding interview in 2024 and 2025 (Table 5). Few participants ($n \leq 5$) reported a **non-fatal overdose following other drug use** (not including stimulants) during the last occasion of opioid overdose, a significant decrease relative to 2024 (12%; $p=0.010$).

Few participants ($n \leq 5$) reported on any particular stimulant or opioid which was used prior to a non-fatal in the 12 months preceding interview, or other drug(s) used during the last opioid overdose, or whether they had received treatment on the last occasion of opioid overdose. Therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 33: Past 12 month any non-fatal overdose, Hobart, TAS, 2000-2025



Note. Estimates from 2000-2005 refer to heroin and morphine non-fatal overdose only. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 5: Past 12-month non-fatal overdose by drug type, Hobart, TAS, 2015-2025

Hobart, TAS											
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
% Any opioid	N=100 -	N=99 6	N=100 6	N=100 -	N=99 10	N=74 9	N=95 -	N=93 6	N=64 14	N=102 -	N=95 -
% Heroin overdose	N=100 -	N=99 -	N=98 8	N=100 0	N=99 -	N=74 -	N=94 -	N=93 -	N=64 -	N=102 0	N=95 -
% Methadone overdose	N=100 -	N=99 -	N=98 0	N=100 -	N=99 -	N=74 -	N=94 -	N=93 -	N=64 -	N=102 -	N=95 0
% Morphine overdose	N=100 -	N=99 -	N=98 -	N=100 -	N=99 -	N=74 -	N=94 -	N=93 0	N=64 0	N=102 -	N=95 0
% Oxycodone overdose	N=100 -	N=99 -	N=99 -	N=100 -	N=99 0	N=74 0	N=94 0	N=93 0	N=64 0	N=102 0	N=95 -
% Stimulant overdose	N=100 -	N=89 -	N=100 -	N=100 -	N=98 9	N=74 -	N=94 -	N=102 -	N=63 11	N=99 13	N=95 6
% Other overdose	/	/	/	/	N=99 -	N=74 -	N=95 -	N=102 6	N=64 -	N=99 12	N=95 -*
% Any drug overdose	N=100 -	N=99 6	N=99 8	N=97 -	N=99 20	N=74 11	N=95 15	N=94 13	N=64 27	N=102 22	N=95 14

Note. Participants reported on whether they had overdosed following use of the specific substances; other substances may have been involved on the occasion(s) that participants refer to. From 2015-2018, the stimulant overdose percentage represents participants who reported that they had consumed a stimulant drug prior to their most recent past 12-month 'other drug' overdose and therefore may be an underestimation. N is the number who responded (denominator). Statistical significance for 2024 versus 2025 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

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

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

In 2025, the mean score on the AUDIT-C for the total Hobart sample (including participants who had not consumed alcohol in the past 12 months) was 2.9 (SD=3.9), a significant decrease relative to 2024 (3.4; SD=4.2; $p=0.003$).

AUDIT-C scores of ≥ 4 (men) and ≥ 3 (women) are likely to indicate hazardous drinking, and potentially, alcohol dependence. In 2025, 30% of male participants had obtained a score of four or more (44% in 2024; $p=0.105$), and 36% of female participants had obtained a score of three or more (28% in 2024; $p=0.597$), indicative of hazardous use (Table 6).

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

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Men																
Mean AUDIT-C score (SD)	5.1 (4.4)	5.5 (4.1)	5.8 (4.1)	3.8 (3.3)	4.5 (4.2)	3.6 (4.0)	3.8 (3.8)	4.8 (3.3)	2.8 (2.5)	4.0 (3.8)	7.3 (3.2)	7.3 (3.5)	4.2 (4.3)	4.5 (4.2)	3.7 (4.2)	2.8 (3.8)
Score of ≥4 (%)	59	67	63	53	56	47	51	59	44	50	83	82	48	52	44	30
Women																
Mean AUDIT-C score (SD)	2.9 (3.7)	3.3 (3.6)	2.7 (3.0)	3.8 (3.0)	3.1 (3.5)	2.5 (3.4)	3.2 (3.2)	4.9 (3.7)	2.9 (3.7)	3.6 (3.7)	4.8 (3.2)	6.2 (3.6)	4.0 (4.3)	3.0 (4.2)	2.6 (4.1)	3.0 (4.1)
Score of ≥3 (%)	39	42	43	63	44	38	53	58	43	44	80	84	53	35	28	36

Note. Monitoring of AUDIT-C commenced in 2010. Computed from the entire sample regardless of whether they had consumed alcohol in the past twelve months. Statistical significance for 2024 versus 2025 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Naloxone Program and Distribution

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

Awareness of Naloxone: The per cent of participants who were aware of naloxone has remained relatively stable over time, ranging between 73% and 91%. Among participants who responded in 2025 (n=94), 89% reported an awareness of naloxone, a significant increase from 75% in 2024 ($p=0.015$) (Figure 34).

Awareness of Take-Home Naloxone: The per cent of participants who were aware of naloxone take-home programs has generally increased among the Hobart sample since the commencement of monitoring. While not statistically significant there were indications of further positive changes between 2024 and 2025. In 2025, 80% of participants reported having heard of take-home naloxone programs, relative to 68% in 2024 ($p=0.078$). Seventy-nine per cent of participants reported having heard of *free* access to naloxone (67% in 2024; $p=0.057$). Few participants (n≤5) had heard of *paid* access (7% in 2024; $p=0.066$) (Figure 34).

Obtained Naloxone: Three fifths (60%) of the Hobart sample reported having obtained naloxone at least once in their lifetime, stable relative to 49% in 2024 ($p=0.153$), with 45% having done so in the past year (32% in 2024; $p=0.086$) (Figure 35). Of those who had ever obtained naloxone and responded ($n=55$) the majority reported most recently accessing naloxone in-person from a Needle and Syringe Program (NSP) (84%). Amongst participants who had ever obtained naloxone and responded ($n=56$), the majority (95%) reported that they did not have to pay the last time they obtained naloxone.

In 2025, of those who reported having obtained naloxone at least once in their lifetime ($n=56$), reported having a median of one naloxone kits stored away at the time of interview (IQR=0-2). Among those with at least one naloxone kit stored away and who responded ($n=35$), 86% had at least one kit within its expiration date and 17% had at least one kit that was expired. Few participants ($n\leq 5$) reported having both expired and non-expired kits.

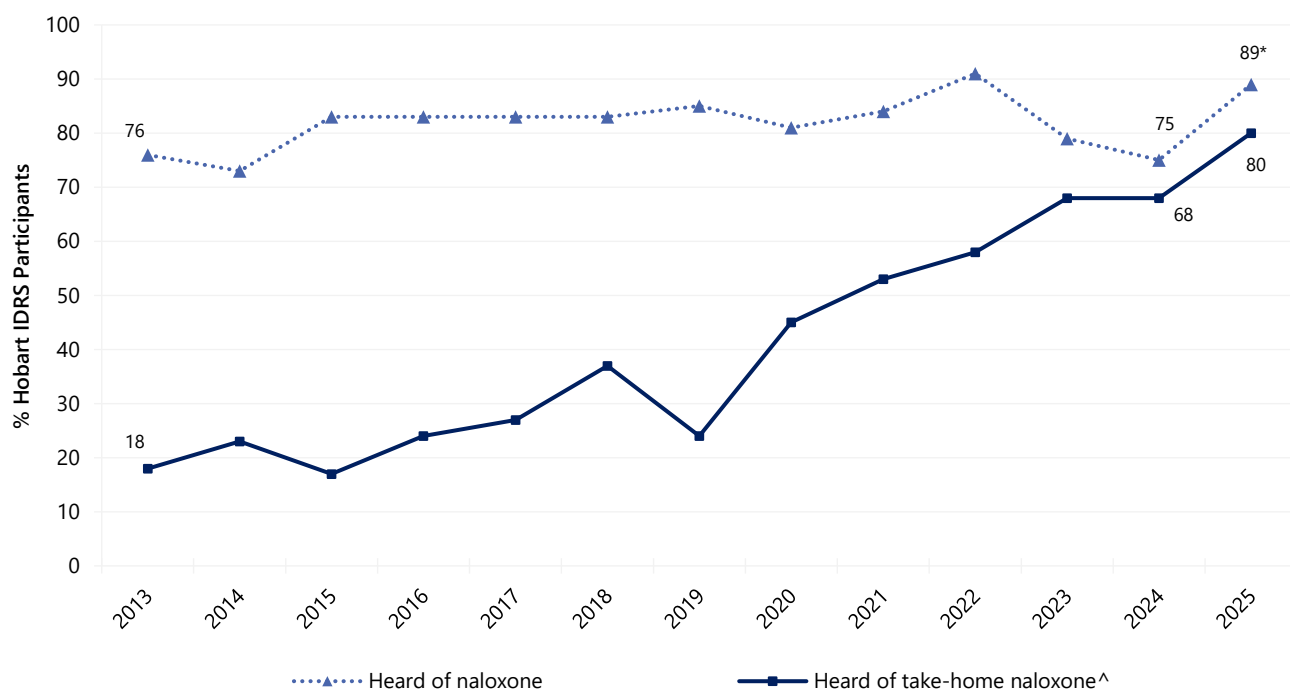
No participants in the Hobart sample reported that they had tried to obtain naloxone in their lifetime but had been unsuccessful ($n\leq 5$ in 2024), whereas almost one third (30%) of participants reported never having tried to obtain naloxone, a significant decrease from 2024 (53%; $p=0.001$). Of those who had trouble obtaining naloxone in their lifetime or had never tried to obtain naloxone and commented ($n=26$), the most common reason was 'don't use opioids' (31%).

Of those who had ever obtained naloxone, used opioids in the past month and responded ($n=41$), three fifths (59%) reported that they 'always' had naloxone on hand when using opioids. Seven per cent reported to each 'often' having or 'sometimes' having naloxone on hand. Twelve per cent reported that they 'rarely' had naloxone on hand when using opioids, with 15% reporting 'never' having naloxone on hand.

Education on Using Naloxone: In 2025, 54% had been trained in how to administer naloxone in their lifetime, stable relative to 2024 (51%; $p=0.670$), with 20% of participants reporting that they had been trained in the past year (25% in 2024; $p=0.490$) (Figure 35). Among those who had been trained in naloxone administration in the last year and responded ($n=19$), the majority (89%) were taught how to administer naloxone at an NSP, with all participants (100%) reporting that the training they received was in-person.

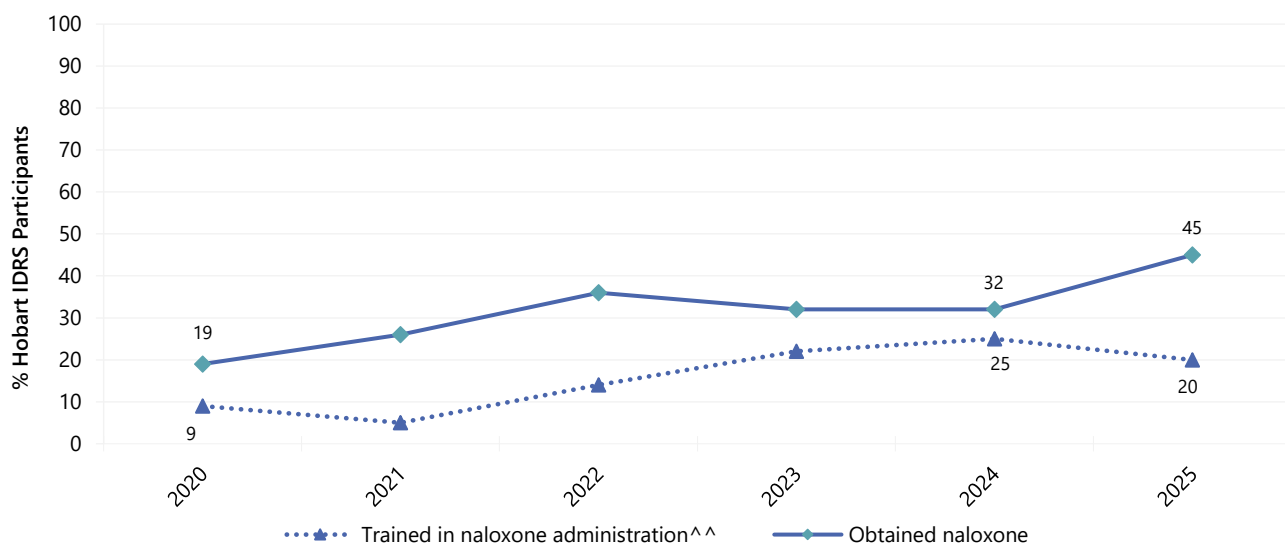
Use of Naloxone to Reverse Overdose: In 2025, of those who responded ($n=94$), almost one tenth (9%) of the Hobart sample reported that they had resuscitated someone using naloxone at least once in their lifetime (13% in 2024; $p=0.366$), with few participants ($n\leq 5$) having done so in the past year. Few participants ($n\leq 5$) reported that they had been resuscitated by a peer using naloxone in the past year in 2024 and 2025.

Figure 34: Lifetime awareness of naloxone and naloxone take-home programs, Hobart, TAS, 2013-2025



Note. ^Wording of this question changed from 'Have you heard about take home naloxone programs' (after receiving a blurb about what these programs entailed: 2013-2022) to 'Are you aware that naloxone is available for people to take home' in 2023. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 35: Past 12 month education in naloxone administration, and obtainment of naloxone, Hobart, TAS, 2020-2025



Note. ^^Wording of this question changed from 'Have you ever been through a naloxone training course? This may include brief advice, brief education or more extensive training' (2020-2022) to 'Have you ever been taught how to use naloxone? This may include brief advice, brief education or more extensive training' (2023 onwards). Response options delineated whether this had occurred in the past year or more than a year ago. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Equipment Access and Injecting Behaviours

Equipment Access

In 2025, participants reported obtaining a median of 100 new needle and syringes in the month prior to interview (IQR=20-100; 30 in 2024; IQR=10-100; $p=0.069$), having a median of 20 'stored away' (IQR=0-70; 15 in 2024; IQR=2-50; $p=0.816$) and providing a median of 10 to others (IQR=0-50; 5 in 2024; IQR=0-25; $p=0.401$).

Almost one fifth (17%) of the Hobart sample reported difficulties obtaining new needles/syringes in the past month, stable relative to 2024 (15%; $p=0.842$), though few participants ($n \leq 5$) reported difficulties accessing filters ($n \leq 5$ in 2024) (Table 7). Fourteen per cent reported difficulties obtaining sterile water (not asked in 2024). In 2025, the majority of participants (86%) reported that they obtained needles from a Needle and Syringe Program (93% in 2024; $p=0.168$), followed by a Needle and Syringe Program vending machine (16%; 20% in 2024; $p=0.451$), a chemist (13%; 18% in 2024; $p=0.327$) and a partner or friend (9%; 11% in 2024; $p=0.808$) (Table 7).

Injecting Behaviours

In 2025, participants reported injecting on a median of 24 occasions in the month prior to interview (IQR=12-50), a significant increase from 15 occasions in 2024 (IQR=8-30; $p=0.010$). Few participants ($n \leq 5$) reported receptive sharing in 2025 (6% in 2024; $p=0.120$) and 7% reported distributive sharing (9% in 2024; $p=0.793$) in the month prior to interview (Figure 36 & Table 8).

The per cent who reported having shared injecting equipment other than syringes (e.g., spoons, tourniquet, water, and filters) in the past month has fluctuated over the course of monitoring (Figure 36), though remained stable in 2025 (12%), relative to 2024 (9%; $p=0.626$). One fifth (22%) of the Hobart sample reported that they had re-used their own needles in the past month, stable relative to 25% in 2024 ($p=0.744$) (Figure 36 & Table 8). Two fifths (43%) of the sample reported re-using other injecting equipment in the past month, a significant increase from 27% in 2024 ($p=0.028$). The most commonly re-used equipment included tourniquets (34%), a significant increase relative to 2024 (15% in 2024; $p=0.004$), followed by spoons and mixing containers (15%; 12% in 2024; $p=0.664$) and water (6%; 13% in 2024; $p=0.155$).

Sixteen per cent of the Hobart sample reported that they had injected someone else in the past month after injecting themselves, a significant decrease from 31% in 2024 ($p=0.020$). Sixteen per cent of the sample were injected by someone else in the past month after they had injected themselves, stable relative to 2024 (19% in 2024; $p=0.708$) (Table 8).

The location of last injection remained stable between 2024 and 2025 ($p=0.249$). Consistent with previous years, most participants (90%) reported that they had last injected in a private home (83% in 2024). Few participants ($n \leq 5$) reported that they had last injected in other locations (Table 8).

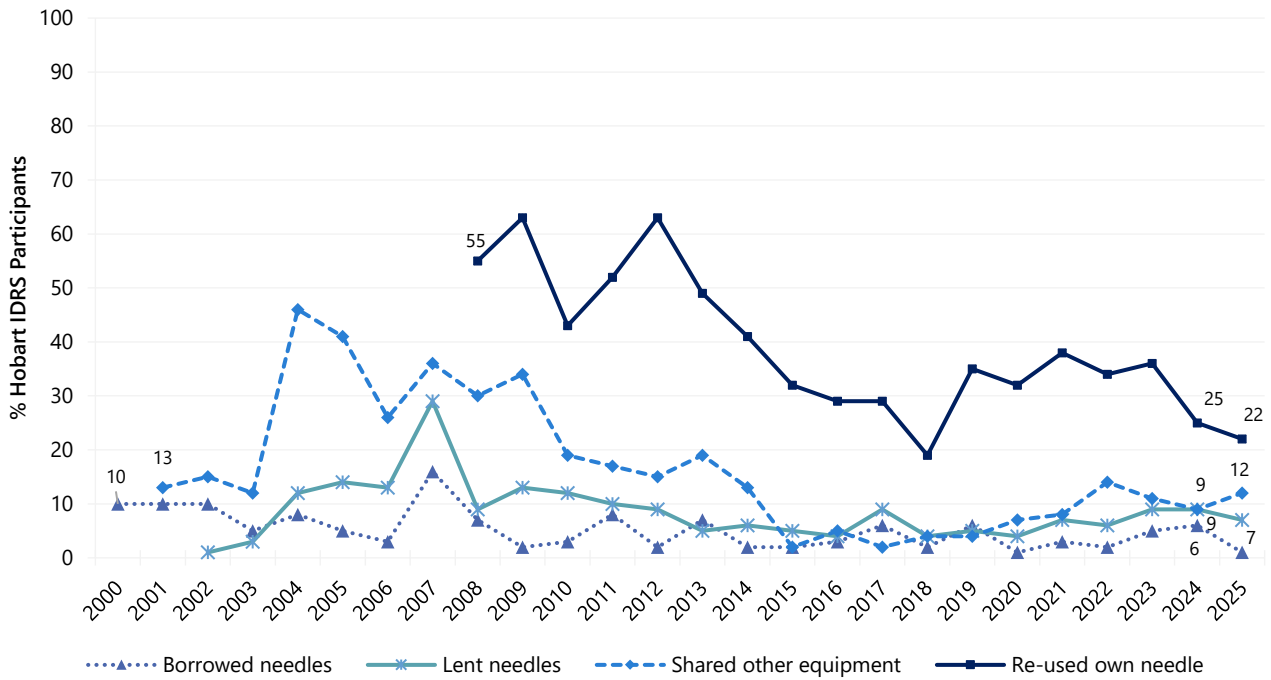
Three fifths (60%) of the Hobart sample reported injecting alone on the last occasion of injecting, stable relative to 2024 (53% in 2024; $p=0.463$). While non-significant, there were some indications of potential changes in the site of last injection between 2024 and 2025 ($p=0.055$). The majority of the sample (79%) reported injecting in their arm on the last occasion of injecting (compared with 92% in 2024), followed by the hand/wrist (7%; $n \leq 5$ in 2024) and the leg (6%; $n \leq 5$ in 2024) (Table 8).

Table 7: Injecting equipment access in the past month, Hobart, TAS, 2023-2025

	2023 N=66	2024 N=98	2025 N=95
% Location of needle/syringe access past month			
NSP	80	93	86
NSP vending machine	-	20	16
Chemist	27	18	13
Friend/partner	14	11	9
Dealer	-	-	-
Hospital	0	-	0
Outreach/peer worker	0	0	0
Medically supervised injecting Centre/Room	0	0	0
Other	-	-	0
% Difficulties accessing filters^ in past month	-	-	-
% Difficulties accessing needles/syringes in past month	16	15	17
% Equipment used in past month	N=66	N=102	N=95
Needle and syringe (e.g., 0.5mL, 1mL)	86	86	94
Syringe or barrel (e.g., 3mL, 5mL, 10mL, 20mL, 50mL)	35	34	37
Spoons/mixing containers	44	30	43
Tourniquet	41	28	56***
Swabs	71	70	66
Water	79	80	71
Any filters	39	50	31**
% Other equipment reused in past month	N=66	N=102	N=94
Spoons or mixing containers	18	12	15
Tourniquets	18	15	34**
Water	12	13	6
Swabs	-	-	-
Any filters	-	-	-
Other	-	-	0

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

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



Note. Borrowed (receptive): used a needle after someone else. Lent (distributive): somebody else used a needle after them. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 8: Injecting behaviours in the past month, and location of last injection use, Hobart, TAS, 2015-2025

	2015 N=100	2016 N=100	2017 N=100	2018 N=101	2019 N=99	2020 N=73	2021 N=94	2022 N=102	2023 N=66	2024 N=101	2025 N=95
% Injecting behaviours past month											
Borrowed a needle	-	-	6	-	6	-	-	-	-	6	-
Lent a needle	-	-	9	-	6	-	7	6	9	9	7
Shared any injecting equipment^	-	-	-	-	-	7	8	14	11	9	12
Re-used own needle	32	29	28	19	35	32	38	34	36	25	22
Reused any other equipment	32	44	35	27	15	/	/	/	39	27	43
Injected partner/friend~	/	/	/	/	27	23	39	19	33	31	16*
Somebody else injected them~	/	/	/	/	12	12	19	11	13	19	16
% Location of last injecting use											
Private home	86	83	87	78	87	87	93	81	78	83	90
Car	-	-	6	6	6	6	5	11	-	-	-
Street/car park/ beach	-	0	-	6	-	-	-	-	-	6	-
Public toilet	-	-	-	-	-	-	-	-	13	-	-
Medically supervised injecting Centre/Room	/	/	/	/	/	/	/	0	0	0	0
Prison	0	0	0	0	0	0	0	0	0	0	0
Stairwell	0	0	0	0	-	0	0	0	0	-	0
Other	0	-	0	0	-	-	-	-	0	-	0
% Last injection site											
Arm	70	70	66	73	78	81	79	83	81	92	79
Leg	8	7	-	-	-	-	-	-	8	-	6
Hand/wrist	16	12	19	16	13	8	13	6	6	-	7
Foot	-	-	-	0	-	0	-	-	-	0	-
Groin	-	-	6	0	-	-	-	-	0	-	0
Neck	-	6	-	6	-	6	-	-	-	-	-
Other	0	0	0	-	-	-	0	-	0	0	-

Note. Borrowed (receptive): used a needle after someone else. Lent (distributive): somebody else used a needle after them. ^Includes spoons, water, tourniquets and filters; excludes needles/syringes. N is the number who responded (denominator). Statistical significance for 2024 versus 2025 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Self-Reported Injection-Related Injuries and Diseases

The per cent of participants who had experienced any injection-related injuries and diseases in the month preceding interview remained stable in 2025, relative to 2024 (28%; 30% in 2024; $p=0.756$) (Table 9). The most common injection-related injuries and diseases reported by participants was any infection/abscess (16%; 14% in 2024; $p=0.837$; including skin abscess or cellulitis; 16%; 11% in 2024; $p=0.404$), any nerve damage (15%; 13% in 2024; $p=0.832$) and a dirty hit (10%; 7% in 2024; $p=0.604$).

Table 9: Injection-related issues in the past month, Hobart, TAS, 2020-2025

	2020 N=74	2021 N=95	2022 N=102	2023 N=66	2024 N=100	2025 N=94
% Artery injection	-	8	-	-	-	-
% Any nerve damage	7	7	12	-	13	15
% Any thrombosis	6	6	-	-	7	-
Blood clot	6	-	-	-	-	-
Deep vein thrombosis	0	-	-	0	-	-
% Any infection/abscess	7	8	9	-	14	16
Skin abscess or cellulitis	7	7	7	-	11	16
Endocarditis	0	-	0	-	0	0
Other serious infection (e.g., osteomyelitis/Sepsis/Septic arthritis)	0	-	-	0	-	0
% Dirty hit	7	-	8	0	7	10
% Any injection-related problem	21	23	22	21	30	28

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

Drug Treatment

Almost one third (31%) of the Hobart sample reported receiving any drug treatment in 2025, stable relative to 2024 (24%; $p=0.334$), with buprenorphine-naloxone nominated as the most commonly received treatment (11%; $n \leq 5$ in 2024; $p=0.096$) (Table 10). Among those who reported methadone or buprenorphine treatment and commented ($n=15$), few participants ($n \leq 5$) reported receiving takeaway doses (38% in 2024; $p=0.433$).

Twelve per cent of participants reported that they had tried to access treatment in the past six months but were unable to (11% in 2024), with the majority of these participants (91%; 64% in 2024; $p=0.311$) reported that they had been trying to access treatment for their methamphetamine use. The most common service that participants had tried to access, but were unable to, were rehabilitation/therapeutic communities (64%; 64% in 2024). Few participants ($n \leq 5$) commented on the reasons for why treatment was unable to be accessed; therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Table 10: Any current drug treatment, Hobart, TAS, 2015-2025

	Hobart, TAS										
	2015 N=100	2016 N=99	2017 N=100	2018 N=100	2019 N=99	2020 N=74	2021 N=95	2022 N=102	2023 N=66	2024 N=102	2025 N=95
% Any current drug treatment	55	57	44	45	47	30	29	25	21	24	31
Methadone	36	35	27	24	23	14	12	9	-	8	-
Buprenorphine	15	16	14	18	-	-	-	-	-	-	-
Buprenorphine-naloxone	0	-	8	11	-	-	6	11	9	-	11
Buprenorphine depot injection	/	/	/	/	0	0	0	0	0	-	8
Drug counselling	-	-	-	-	9	7	11	7	-	-	-
Other	0	-	0	0	9	0	-	0	-	7	6

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

Opioid and Methamphetamine Dependence

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

To assess methamphetamine dependence in the past six months, a [cut-off value of four](#) was used, as this has been found to be a good balance between sensitivity and specificity for identifying dependent methamphetamine use. No validated cut-off for opioid dependence exists; however, researchers typically use a [cut-off value of five](#) as an indicator of likely dependence.

Of those who had recently used an opioid and commented (n=36), the median SDS score was three (IQR=0-7), with 39% scoring five or above, indicating possible dependence (45% in 2024; $p=0.646$) (Table 11). One third (36%) of participants obtained a score of zero on the opioid SDS (23% in 2024; $p=0.218$), indicating no symptoms of opioid dependence.

Of those who had recently used methamphetamine and commented (n=88), the median SDS score was seven (IQR=3-10), with 67% scoring four or above, indicating possible dependence (64% in 2024; $p=0.741$) (Table 11). One tenth (11%) of participants obtained a score of zero on the methamphetamine SDS (15% in 2024; $p=0.501$), indicative of no symptoms of methamphetamine dependence.

Table 11: Total opioid and methamphetamine SDS scores and per cent of participants scoring above cut-off scores indicative of dependence, among those who reported past six month use, Hobart, TAS, 2017-2025

	2017	2018	2019	2020	2021	2022	2023	2024	2025
Opioid	N=62	N=66	N=56	/	N=47	N=47	N=29	N=40	N=36
Median total score (IQR)	6 (3-8)	5 (1-7)	5 (2-7)	/	6 (2-9)	4 (1-8)	2 (0-4)	4 (2-8)	3 (0-7)
% score = 0	13	24	16	/	17	26	31	23	36
% score ≥ 5	60	52	54	/	55	47	21	45	39
Methamphetamine	N=69	N=78	N=76	/	N=81	N=76	N=54	N=86	N=88
Median total score (IQR)	3 (1-6)	0 (0-3)	4 (0-8)	/	3 (0-7)	4 (1-8)	5 (2-8)	5 (2-8)	7 (3-10)
% score = 0	23	58	28	/	30	14	11	15	11
% score ≥ 4	46	21	50	/	43	59	59	64	67

Note. Severity of Dependence scores calculated out of those who used opioids/methamphetamine recently (past 6 months). A cut-off score of ≥5 and ≥4 is used to indicate screening positive for potential opioid and methamphetamine dependence, respectively. Imputation used for missing scale scores. Statistical significance for 2024 versus 2025 presented in table; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Bloodborne Virus Testing and Treatment

Fifty-four per cent of participants reported that they had received a hepatitis C virus (HCV) antibody test in the past year in 2025, a significant increase compared to 35% in 2024 ($p=0.013$). Almost one third (31%) had received a PCR or RNA test (28% in 2024; $p=0.733$), with few participants ($n\leq 5$) reporting having a current HCV infection ($n\leq 5$ in 2024) (Table 12). Few participants ($n\leq 5$) reported that they had received HCV treatment in the past year in both 2024 and 2025; therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Amongst those who had undergone an HCV RNA test in the last year and commented ($n=24$), three fifths (63%) reported it took 0-14 hours to receive a result (whether positive or negative), following the administration of the last HCV RNA test.

Three quarters (72%) of the Hobart sample reported having ever had a test for human immunodeficiency virus (HIV) (27% within the past six months; 22% in 2024; $p=0.488$), of which few participants ($n\leq 5$) reported a positive diagnosis ($n\leq 5$ in 2024) (Table 12).

Table 12: HCV and HIV testing and treatment, Hobart, TAS, 2018-2025

	2018 N=100	2019 N=99	2020 N=74	2021 N=95	2022 N=102	2023 N=60	2024 N=94	2025 N=91
Past year Hepatitis C test								
Past year hepatitis C antibody test	N=90 59	N=95 56	N=69 42	N=86 55	N=87 47	N=60 50	N=94 35	N=91 54*
Past year hepatitis C PCR or RNA test	N=88 44	N=87 40	N=65 25	N=81 53	N=85 36	N=54 28	N=92 28	N=81 31
Current Hepatitis C status								
Currently have hepatitis C [^]	N=87 20	N=92 10	N=69 4	N=82 7	N=84 -	N=54 -	N=92 -	N=79 -
Past year treatment for Hepatitis C								
Received treatment in past year	N=89 22	N=89 11	N=74 11	N=85 12	N=87 8	N=54 -	N=92 -	N=81 -
Most recent treatment was successful (among those who had received treatment in past year)	n=15 100	n=8 100	n=11 100	n=10 60	n=7 -	n≤5 -	n≤5 -	n≤5 -
HIV test								
HIV test in past 6 months	/	/	/	34	74	23	22	27
HIV test more than 6 months ago	/	/	/	48	51	61	55	44
HIV status								
Lifetime HIV positive diagnosis	/	/	/	0	-	-	-	-

Note. [^]This includes people who had not been tested for HCV. N is the number who responded (denominator). Timeframes for HCV and HIV differ; i.e., HCV questions focus on lifetime and past year; HIV questions focus on lifetime and past six months. Statistical significance for 2024 versus 2025 presented in table; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Sexual Health Behaviours

In 2025, almost half (47%) of the sample reported some form of sexual activity in the past four weeks, stable relative to 2024 (36%; $p=0.226$) (Table 13). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if the interview was undertaken face-to-face).

Amongst those who reported engaging in sexual activity in the past four weeks and commented ($n=40$), participants reported a median of one partner (IQR=1-1; 1 partner in 2024; IQR=1-2; $p=0.149$). Few participants ($n\leq 5$) reported engaging in sexual activity in the past four weeks in exchange for money, drugs, or other goods and services in both 2024 and 2025 (Table 13).

Of those who commented in 2025 ($n=87$), one quarter (23%) reported having a sexual health check-up in the six months prior to interview (19% in 2024; $p=0.571$), whilst 57% had done so in their lifetime (60% in 2024; $p=0.762$). Of the total sample who responded ($n=86$), few participants ($n\leq 5$) reported that they had received a positive diagnosis for a sexually transmitted infection (STI) in the six months prior to interview ($n\leq 5$ in 2024) and 8% had received a positive diagnosis in their lifetime (19% in 2024; $p=0.078$) (Table 13). Given few participants ($n\leq 5$) reported a recent STI diagnosis, data regarding the specific STI diagnosis are suppressed. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Information about HIV testing is provided in Table 12.

Table 13: Sexual health behaviours, Hobart, TAS, 2022-2025

	2022	2023	2024	2025
Of those who responded[#]:	N=77	N=60	N=88	N=86
% Any sexual activity in the past four weeks	57	48	36	47
Of those who reported any sexual activity in the past four weeks and responded[#]:	/	/	N=32	N=40
% Engaged in sexual activity in exchange for money, drugs or other goods or services	/	/	-	-
Of those who responded[#]:	N=81	N=59	N=86	N=87
% Had a sexual health check in the last six months	16	12	19	23
% Had a sexual health check in their lifetime	51	59	60	57
Of those who responded[#]:	N=81	N=59	N=86	N=86
% Diagnosed with a sexually transmitted infection in the last six months	0	0	-	-
% Diagnosed with a sexually transmitted infection in their lifetime	7	15	19	8

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

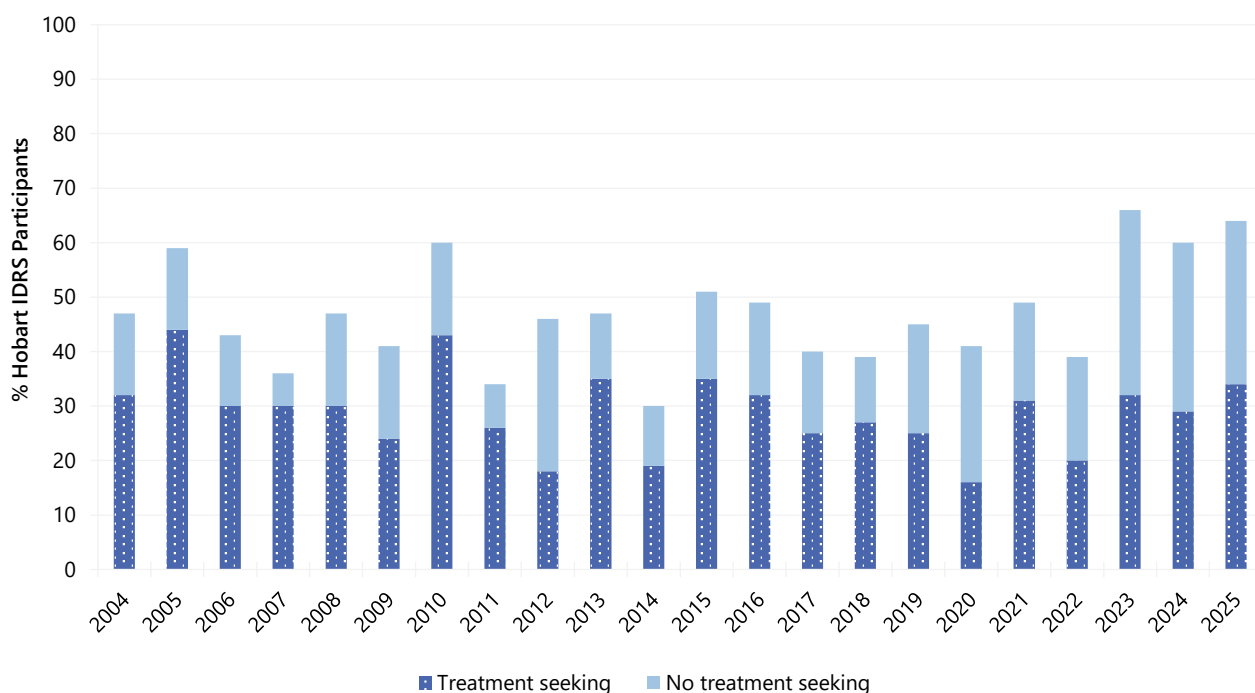
Mental Health and Psychological Distress (K10)

Mental Health

In 2025, 64% of the sample self-reported that they had experienced a mental health problem in the preceding six months, stable relative to 2024 (60%; $p=0.555$). Amongst those who had experienced a mental health problem, the most commonly reported problems were depression (67%; 59% in 2024; $p=0.306$), anxiety (53%; 66% in 2024; $p=0.543$) and post-traumatic stress disorder (PTSD) (32%; 29% in 2024; $p=0.697$).

One third (34%) of the sample had seen a mental health professional during the six months prior to interview, stable relative to 29% in 2024 ($p=0.535$) (Figure 37). This was similar to the trend of 53% of those who self-reported a mental health problem during the six months preceding interview, stable from 49% in 2024 ($p=0.702$). Of those who attended a mental health professional in 2025 ($n=32$), four fifths (81%) reported having seen a health professional about a mental health problem reported that they had been prescribed medication for their mental health problem in the six months preceding interview, stable relative to 2024 (69%; $p=0.371$).

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



Note. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Psychological Distress (K10)

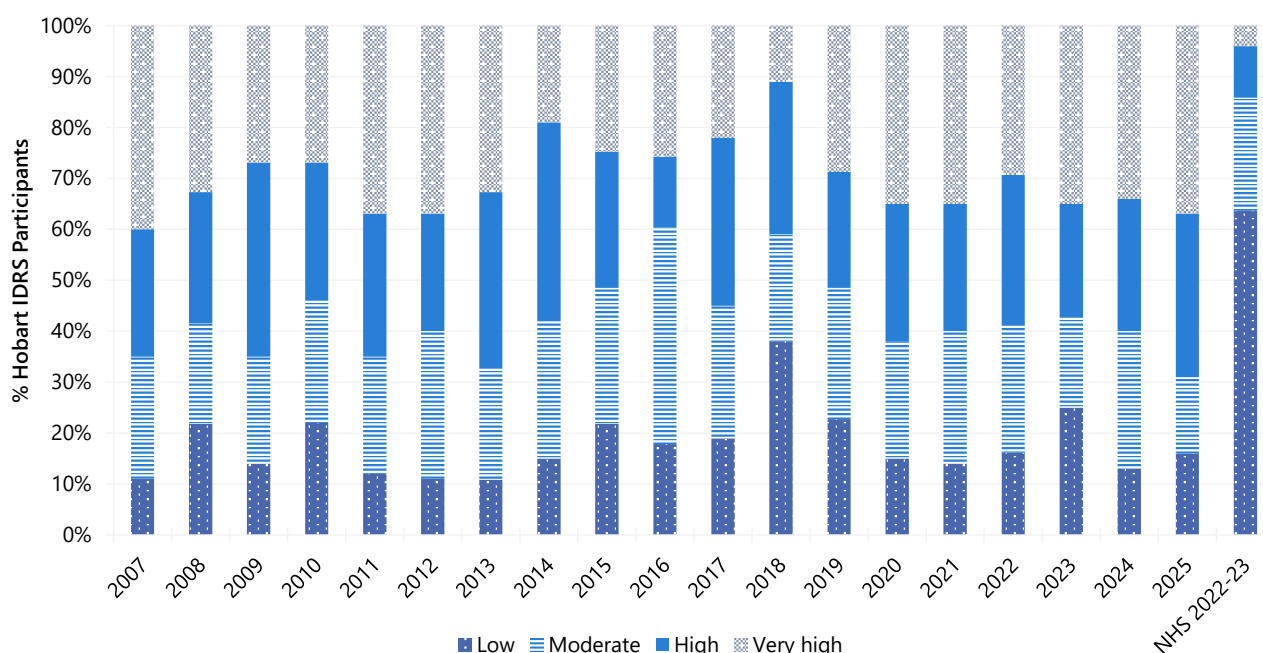
The [Kessler Psychological Distress Scale 10 \(K10\)](#) was administered to obtain a measure of psychological distress in the past four weeks. It is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured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

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

The per cent of participants scoring in each of the four K10 categories remained stable between 2024 and 2025 ($p=0.225$) with two fifths (37%) of the 2025 Hobart sample having a score of 30 or more (34% in 2024), indicative of ‘very high’ psychological distress (Figure 38).

The National Health Survey (NHS) 2022-23 provides Australian population data for adult (≥ 18 years) K10 scores. IDRS participants in 2025 reported greater levels of ‘high’ and ‘very high’ distress compared to the general population (Figure 38).

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



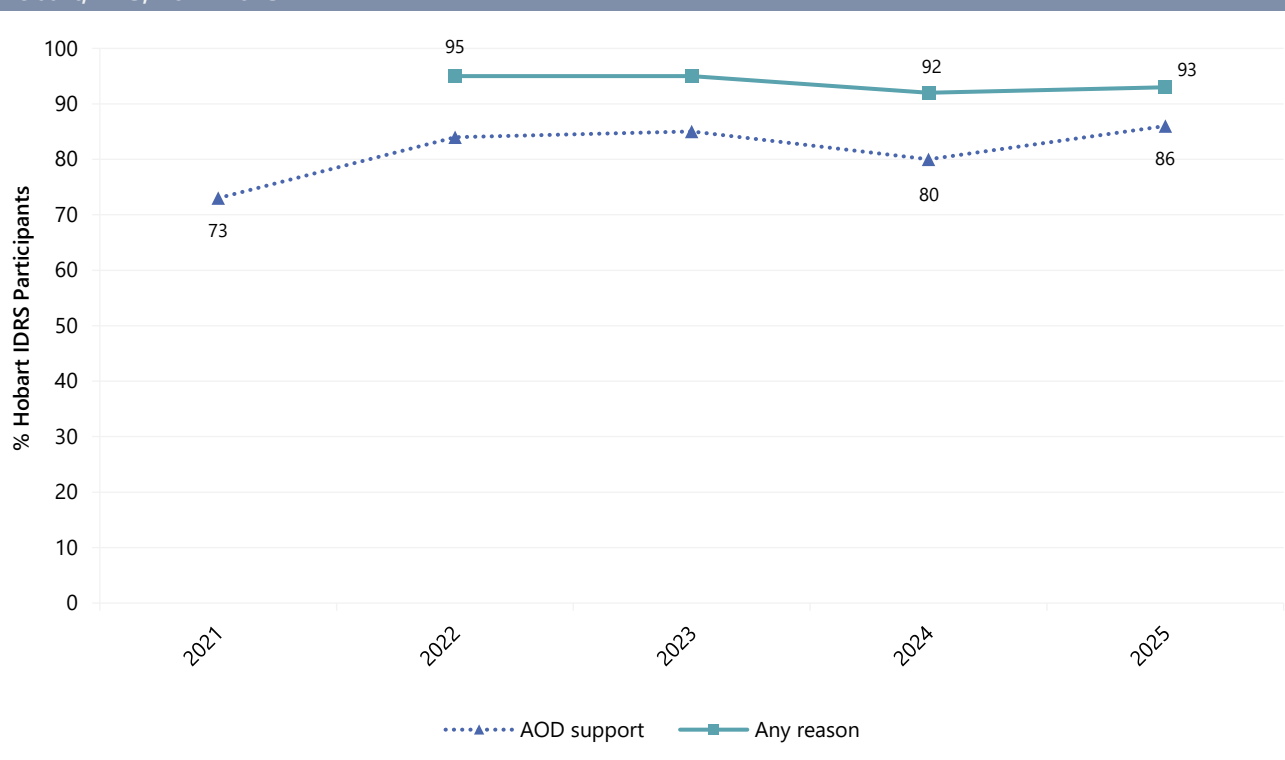
Note. Data from the National Health Survey are a national estimate from 2022-23 for adults 18 or older. Imputation used for missing scale scores (IDRS only). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Health Service Access

Eighty-six per cent of the Hobart sample reported accessing any health service for alcohol and/or drug (AOD) support in the six months preceding interview in 2025, stable relative to 2024 (80%; $p=0.342$) (Figure 39). The most common services reported by participants for AOD support in 2025 were an NSP (79%; 75% in 2024; $p=0.508$), a general practitioner (GP; includes both in-person and telehealth) (22%; 24% in 2024; $p=0.863$), a pharmacy (14%; 14% in 2024), a drug and alcohol counsellor (13%; 18% in 2024; $p=0.429$), and the emergency department (11%; 10% in 2024) (Table 14).

The majority of participants (93%) reported accessing any health service in the six months preceding interview in 2025 (92% in 2024) (Figure 39). Primary services reported by participants in 2025 were an NSP (81%; 82% in 2024; $p=0.851$), a GP (55%; 50% in 2024; $p=0.566$), and a pharmacy (31%; 27% in 2024; $p=0.638$) (Table 14).

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



Note. Questions regarding health service access for AUD support were first asked in 2018, however due to differences in response options between 2018 and 2020, data are presented from 2021 onwards. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 14: Types of health services accessed for alcohol and other drug reasons and for any reason in the past six months, Hobart, TAS, 2022-2025

	AOD support				Any reason			
	2022 N=102	2023 N=66	2024 N=102	2025 N=95	2022 N=102	2023 N=66	2024 N=102	2025 N=95
% Accessed a health service in the past 6 months	84	85	80	86	95	95	92	93
Type of service accessed (participants could select multiple services)								
GP	22	27	24	22	52	67	50	55
<i>In-person</i>	/	/	/	21	/	/	/	53
<i>Telehealth</i>	/	/	/	-	/	/	/	6
Emergency department	8	11	10	11	21	26	20	18
Hospital admission (inpatient)	6	-	-	-	19	17	9	15
Medical tent (e.g., at a festival)	0	0	0	0	-	0	0	0
Drug and Alcohol counsellor	11	14	18	13	13	14	21	13
Hospital as an outpatient	-	0	-	-	10	-	7	-
Specialist doctor (not including a psychiatrist)	-	0	-	-	8	11	-	6
Dentist	8	-	-	-	18	9	13	8
Ambulance attendance	-	-	-	-	6	14	6	-
Pharmacy	/	/	14	14	/	/	27	31
Other health professional (e.g., physiotherapist)	-	-	-	-	7	9	6	-
Psychiatrist	-	0	-	-	7	9	6	13
Psychologist	-	-	-	-	8	11	9	11
NSP	75	67	75	79	80	74	82	81
Peer based harm reduction service	-	0	-	-	-	0	-	-
Other harm reduction service	0	-	-	-	-	-	-	-

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

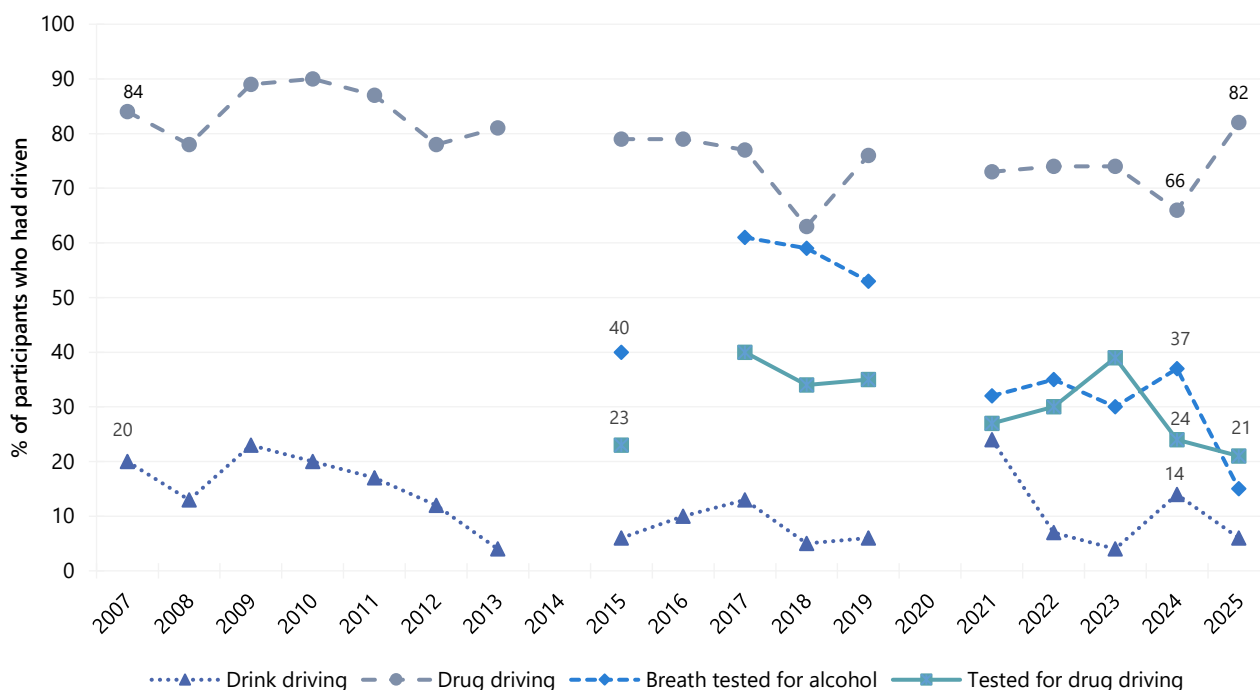
Driving

Thirty-seven per cent of the Hobart sample had driven a car, motorcycle or other vehicle in the six months preceding interview in 2025, stable relative to 2024 (41%; $p=0.655$). Of those who had driven within the last six months and commented ($n=34$), few participants ($n\leq 5$) reported driving while over the perceived legal limit of alcohol ($n\leq 5$ in 2024). Among those who had driven within the six months preceding interview and commented ($n=34$), 82% reported driving within three hours of consuming an illicit or non-prescribed drug, stable relative to 2024 (66%; $p=0.184$) (Figure 40).

Of those who had driven within three hours of consuming an illicit or non-prescribed drug in the six months preceding interview and responded ($n=28$), participants most commonly reported using methamphetamine crystal (75%) prior to driving in the last six months, followed by cannabis (29%).

Of those who had recently driven and responded ($n=34$), one fifth (21%) of participants reported that they had been tested for drug driving by the police roadside drug testing service (24% in 2024; $p=0.780$), and few participants ($n\leq 5$) reported that they had been breath tested for alcohol by the police roadside testing service (37% in 2024; $p=0.059$) in the six months prior to interview. Among those who had had been tested for drug driving by the police roadside drug testing service ($n=7$), 57% reported that a drug/s had been detected (not asked in 2024). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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

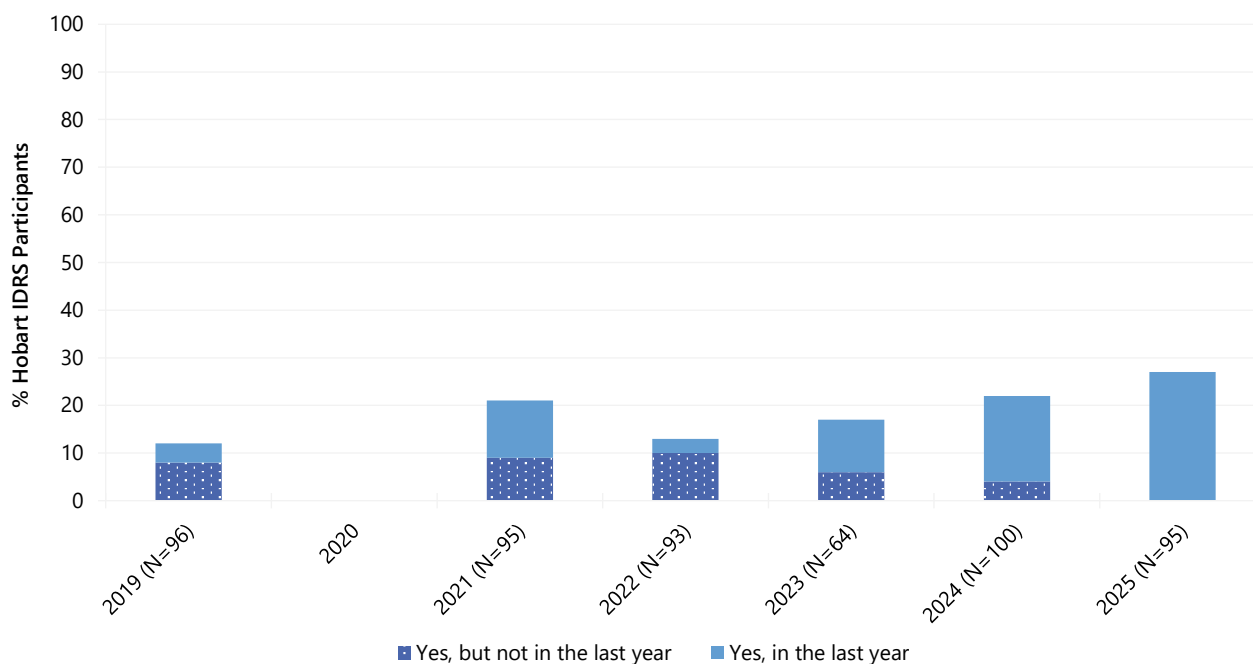


Note. Computed of those who had driven a vehicle in the past six months. Questions about driving behaviour were first asked in 2007. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n\leq 5$ but not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

Drug Checking

Drug checking is a common strategy used to test the contents and purity of illicit drugs. At the time interviewing commenced in 2025, the only government-sanctioned drug checking services that had operated in Australia were in the ACT, QLD, VIC and NSW. In Canberra, ACT, drug checking was provided at the Groovin the Moo festival in 2018 and 2019, and a fixed-site drug checking service (CanTEST) has been operational since 17 July 2022. Queensland’s first fixed-site drug checking service, CheQpoint, opened in Brisbane on 20 April 20, 2024, and a second service opened in the Gold Coast in July 2024. Drug checking services were also provided at 3 festivals in 2024 - Rabbits Eat Lettuce and Wildlands (by Pill Testing Australia) and Earth Frequency (by CheQpoint) - and as part of the 2024 Qld Gov Schoolies Response (CheQpoint). However, all government funded services ceased in April 2025. In Victoria, drug checking was provided at ‘up to’ 10 festivals throughout 2024-2025 during an 18-month implementation trial and in March 2025, NSW commenced a 12-month trial of mobile drug checking at ‘up to’ 12 festivals. In 2025, 27% of the Hobart sample reported that they or someone else had tested the contents and/or purity of their illicit drugs in Australia in the past year (18% in 2024; $p=0.134$) (Figure 41). Of those who reported that they or someone else had tested their illicit drugs in the past year in 2025 and responded ($n=26$), the majority (96%) reported using a personal testing kit, most commonly testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips) (69%), followed by colorimetric or reagent test kits (46%). Of those who reported that they or someone else had tested their illicit drugs in the past year ($n=26$), few participants ($n\leq 5$) reported that they had submitted drugs for testing at a drug checking service; therefore, further detail are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 41: 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. Data are suppressed in the figure where $n\leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented in figure; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Experience of Crime and Engagement with the Criminal Justice System

One third (34%) of the Hobart sample reported engaging in 'any' crime in the past month in 2025, stable relative to 2024 (44%; $p=0.177$).

Selling drugs for cash profit (24%; 23% in 2024; $p=0.856$) and property crime (15%) remained the most common self-reported crimes in the month preceding interview, with a significant decrease in self-reported property crime relative to 2024 (30%; $p=0.034$) (Figure 42).

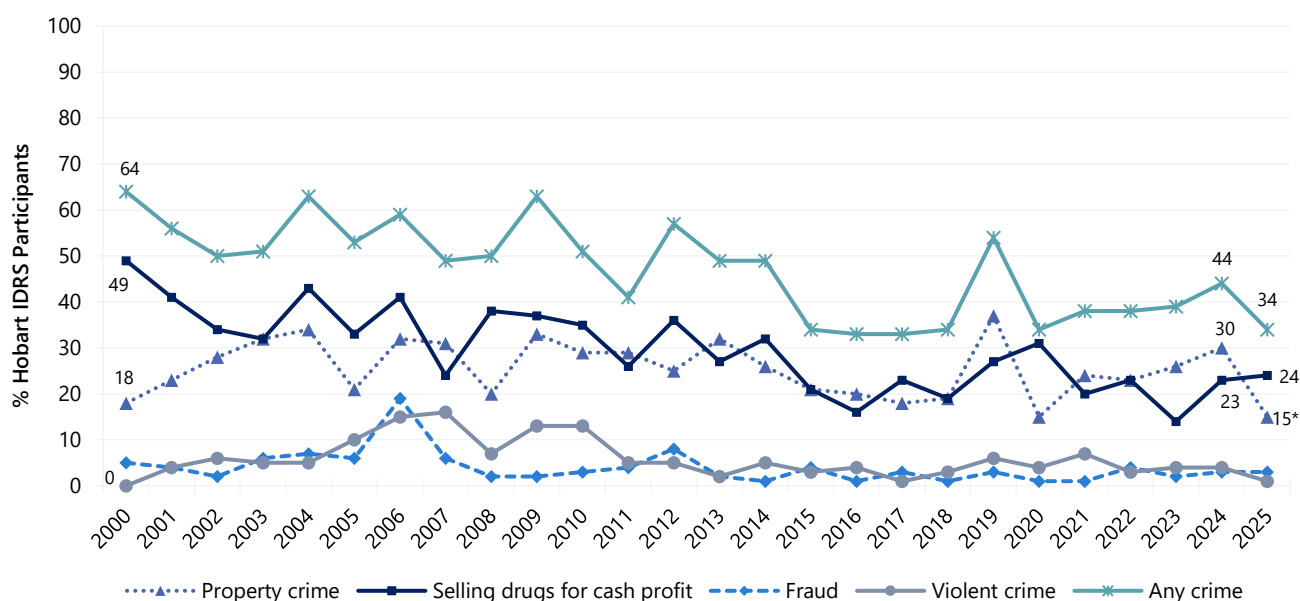
One fifth (22%) of the Hobart sample reported being a victim of violence in the past month (18% in 2024; $p=0.461$) (Figure 43).

One quarter (26%) of participants reported a drug-related encounter with police which did not result in charge or arrest in the 12 months preceding interview (24% in 2024; $p=0.865$) (Figure 44). This predominantly comprised being stopped and questioned (38%; 42% in 2024) and being stopped and searched (33%; 42% in 2024; $p=0.768$), followed by being stopped and issued a fine/infringement notice (25%; 8% in 2024; $p=0.245$).

In 2025, 28% of the Hobart sample had been arrested in the past year, stable relative to 2024 (31%; $p=0.749$) (Figure 44). Of those who had been arrested and commented ($n=24$), the main reasons for arrest in 2025 comprised use/possession of drugs (29%) and violent crime (29%). In 2025, 13% of the sample had been convicted of a drug-related offence in the past year (13% in 2024), and 13% had been sentenced to a community corrections order (8% in 2024; $p=0.321$).

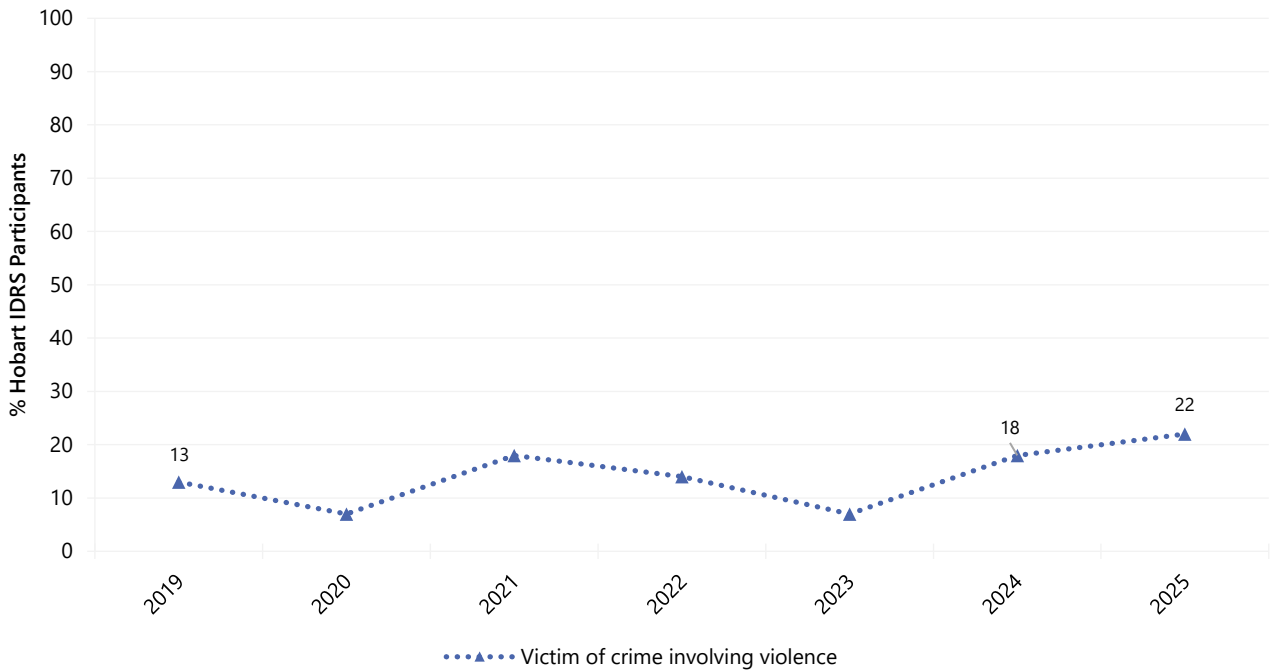
Half (50%) of the Hobart sample reported a lifetime prison history in 2025 (42% in 2024; $p=0.318$) (Figure 44).

Figure 42: Self-reported criminal activity in the past month, Hobart, TAS, 2000-2025



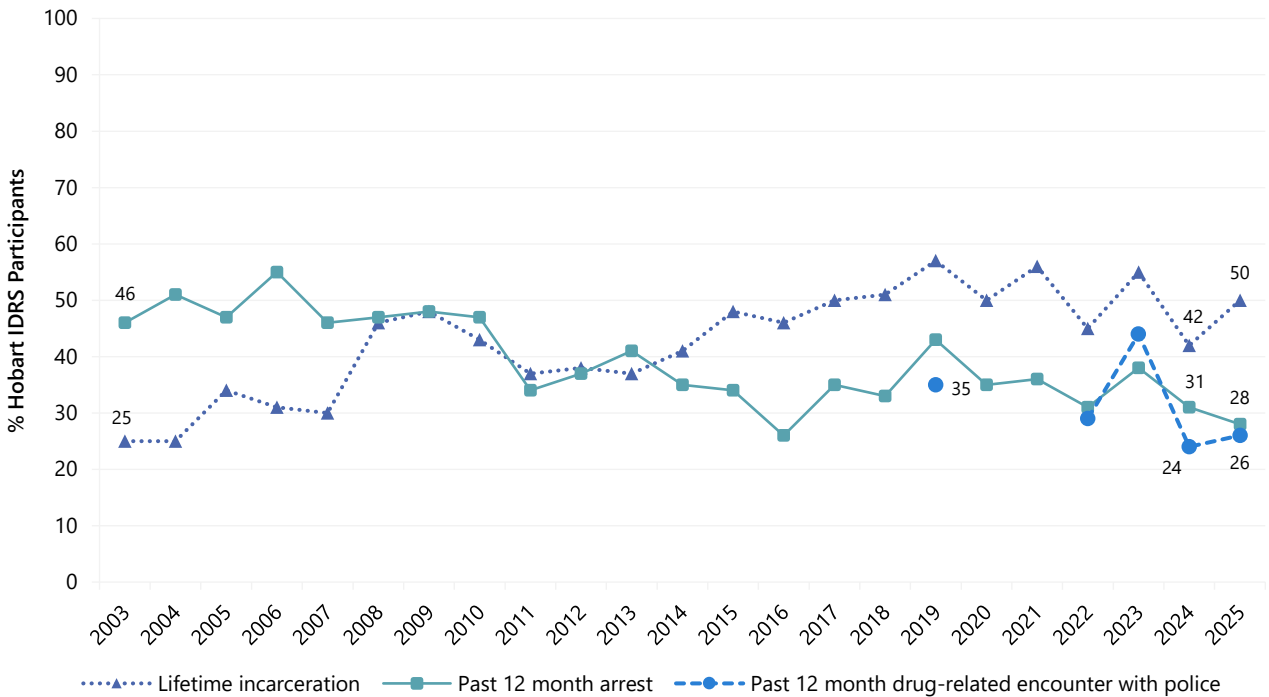
Note. 'Any crime' comprises the per cent who report any property crime, drug dealing, fraud and/or violent crime in the past month. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 43: Victim of crime involving violence in the past month, 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., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 44: Lifetime incarceration, and past 12 month arrest and drug-related encounters with police that did not result in arrest, 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., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Modes of Purchasing Illicit or Non-Prescribed Drugs

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

Purchasing Approaches

In 2025, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (82%; 84% in 2024; $p=0.846$), followed by phone call (46%; 44% in 2024; $p=0.880$) and text messaging (33%; 23% in 2024; $p=0.157$) (Table 15). Six per cent reported arranging the purchase of illicit or non-prescribed drugs via social networking or messaging applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (9% in 2024; $p=0.591$). It is important to re-iterate that this refers to people *arranging the purchase* of illicit or non-prescribed drugs. This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person.

Table 15: Purchasing approaches in the past 12 months, Hobart, TAS, 2022-2025

	2022	2023	2024	2025
% Purchasing approaches in the last 12 months ^{^#}	N=101	N=66	N=98	N=94
Face-to-face	61	70	84	82
Surface web	0	-	-	0
Darknet market	-	-	-	0
Social networking or messaging applications [~]	18	17	9	6
Text messaging	32	38	23	33
Phone call	52	53	44	46
Grew/made my own	/	/	-	-
Other	/	/	-	0

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.' 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.