EDRS

VICTORIAN DRUG TRENDS 2025

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

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

Zachary Lloyd[1], Mila Sumner[1], Joanna Wilson[1], and Paul Dietze[1,2]

[1] Disease Elimination Program, Burnet Institute

[2] National Drug Research Institute, Curtin University

ISSN 2981-958X

Suggested citation: Lloyd Z, Sumner M, Wilson J, & Dietze P. Victorian Drug Trends 2025: Key Findings from the Ecstasy and Related Drugs Reporting System (EDRS) Interviews. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney; 2025. Available from: https://doi.org/10.26190/unsworks/31831

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: paul.dietze@burnet.edu.au or drugtrends@unsw.edu.au

Table of Contents

List of Tables

List of Figures

Acknowledgements

Funding

In 2025, the Ecstasy and Related Drugs Reporting System (EDRS), falling within the Drug Trends program of work, was supported by funding from the Australian Government Department of Health, Disability and Ageing under the Drug and Alcohol Program.

Research Team

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

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

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

Participants

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

Contributors

We thank all the individuals who contributed to questionnaire development and assisted with the collection and input of data at a jurisdictional and national level. In particular, we would like to thank Zachary Lloyd, Joanna Wilson, Marika Burgess, Mila Sumner, Tarryn Beardmore, Oisin Stronach, Matthew Cowman, Doriano Raffaele, Zoe Gleeson, Bebhinn Schaible, and Dylan Vella-Horne for conducting the Melbourne, Victoria EDRS interviews in 2025. We would like to thank Turning Point for providing drug-related ambulance attendance and DirectLine data, the Victoria Police Forensic Services Department for providing drug seizure purity levels, and the Victorian Department of Health for providing data collected via the Alcohol and Drug Information System (ADIS) and the Victorian Alcohol and Drug Collection (VADC). We would also like to thank the Drug Trends Advisory Committee for their contribution to the EDRS.

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

Abbreviations

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

THC	Tetrahydrocannabinol
UNSW	University of New South Wales
WA	Western Australia
WHO	World Health Organization

Executive Summary

The Melbourne Victoria (VIC) EDRS comprises a sentinel sample of people who regularly use ecstasy and/or other illicit stimulants, recruited via social media and word-of mouth in Melbourne, VIC. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2025 from April-June. Interviews from 2020 onwards were delivered face-to-face as well as via telephone, to reduce the risk of COVID-19 transmission; all interviews prior to 2020 were conducted face-to-face. This methodological change should be factored into all comparisons of data from the 2020-2025 samples, relative to previous years.**

Sample Characteristics

The EDRS sample (N=100) recruited from Melbourne in 2025 was similar to the sample in 2024 and in previous years. Gender remained stable between 2024 and 2025, with 55% identifying as male (46% in 2024), and participants had a median age of 28 years. The per cent of respondents that reported being a current student (28%; 39% in 2024) or holding a tertiary qualification (68%; 60% in 2024) remained stable. Employment status remained stable in 2025; 36% reported fulltime work (23% in 2024) and 43% reported part time/casual work (56% in 2024). The median weekly income significantly increased to $1050 in 2025 (IQR=550–1500; $600 in 2024; IQR=392–1029; $p<0.001$). There was a significant change in drug of choice between 2024 and 2025 ($p<0.001$), with fewer participants nominating ketamine (6%; 20% in 2024) and more nominating alcohol (18%; 0%in 2024) and cocaine (24%; 19% in 2024) as their drug of choice. Drug used most often in the month preceding interview also changed significantly in 2025 ($p<0.001$), with fewer participants nominating ecstasy (8%; 15% in 2024) and cannabis (19%; 31% in 2024) and more nominating alcohol (39%; 6% in 2024).

Non-Prescribed Ecstasy

Recent use of any non-prescribed ecstasy in the six months prior to interview remained stable in 2025 relative to 2024 (94%; 95% in 2024). Pills (52%) and capsules (56%) remained the most commonly used forms of non-prescribed ecstasy. Frequency of use remained stable for all four forms of non-prescribed ecstasy, although there was a significant increase in the per cent of participants reporting weekly or more frequent use of ecstasy capsules (n≤5; 0% in 2024; $p=0.020$). The perceived availability of non-prescribed ecstasy pills, capsules, crystal and powder remained stable in 2025. There was a significant change in the perceived purity of ecstasy capsules in 2025 relative to 2024, with 40% of the sample perceiving ecstasy capsules to be of 'medium' purity (28% in 2024) and a further 19% nominating 'low' purity (9% in 2024). In 2025, the median reported price of all forms of non-prescribed ecstasy remained stable relative to 2024.

Methamphetamine

Twenty-nine per cent of the Melbourne sample reported recent use of any methamphetamine, stable compared to 2024 (29%). Frequency of use also remained stable, with participants reporting a median of 5 days in 2025 (6 days in 2024). One fifth (20%) reported recent use of methamphetamine powder, while 10% reported recent use of methamphetamine crystal. The perceived price, purity and availability of methamphetamine remained stable between 2024 and 2025.

Non-Prescribed Pharmaceutical Stimulants

The percentage of participants reporting any recent non-prescribed pharmaceutical

stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has increased since the commencement of monitoring, from 9% in 2007, peaking at 66% in 2022, and remaining stable at this level since (65% in 2025).

Cocaine

The percentages of participants reporting recent use of cocaine remained stable at 84% in 2025 (80% in 2024). Frequency of use of cocaine in the six months prior to interview remained stable at 9 days in 2025 (8 days in 2024). One fifth (19%) of those who had recently used cocaine reported weekly or more frequent use. Perceived purity and perceived availability for cocaine remained stable between 2024 and 2025. The median price of cocaine in 2025 was $350 per gram ($350 in 2024; p=0.001).

Cannabis and/or Cannabinoid-Related Products

Sixty-five per cent of the sample reported any recent use of non-prescribed cannabis and/or cannabinoid-related products in 2025, stable compared to 2024 (72%). In 2025, 22% of the Melbourne sample reported daily use of cannabis (26% in 2024). There was a significant decrease in the number of participants reporting swallowing (23%; 44% in 2024; p=0.013) or inhaling/vaporising (n≤5; 28% in 2024; p=0.003) cannabis in 2025.

Non-Prescribed Ketamine, LSD and DMT

Recent use of non-prescribed ketamine remained stable at 76% in 2025, although frequency of use in the previous six months significantly decreased from a median of 10 days in 2024 to 6 days in 2025 (p=0.047). Recent use of LSD remained stable in 2025 (38%; 38% in 2024) as did frequency of use (2 days; 3 days in 2024). Eleven per cent of participants reported recent use of DMT in 2025 and frequency of use remained low at 3 days.

New Psychoactive Substances (NPS)

In 2025, 17% of the sample reported recent use of any NPS (including plant-based NPS). Of recently used NPS, drugs that mimic psychedelic drugs were the most commonly reported (9%), particularly any 2C substance (7%).

Other Drugs

Recent use and frequency of use of all other drugs remained stable between 2024 and 2025. Recent use of nicotine pouches was reported by 20% of the sample (17% in 2024), with a median frequency of use of 3 days (3 days in 2024).

Drug-Related Harms and Other Behaviours

Polysubstance use and bingeing

Most participants (93%) reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). Of those who responded, 24% reported using stimulants or related drugs for 48 hours of more continuously without sleep in the 6 months preceding interview (29% in 2024).

Dependence, injecting and overdose

Three quarters (73%) of participants obtained a score of eight or more on the AUDIT, indicative of hazardous use (77% in 2024).

In 2025, 11% of those who reported recent ecstasy use obtained an SDS score of 3 or more (23% in 2024), whilst 21% of participants reporting recent methamphetamine use obtained a score of 4 or more (25% in 2024), indicating possible dependence on these substances.

Past year non-fatal stimulant overdose (16%; 15% in 2024) and non-fatal depressant overdose (21%; 29% in 2024) remained stable in 2025 relative to 2024.

Past month injecting drug use remained low in 2025 (n≤5).

Drug checking and naloxone awareness

Two fifths of the sample (40%) reported having tested the contents of their drugs in the past year, stable relative to 30% in 2024. Participants most commonly reported using colorimetric or reagent test kits (66%), followed by event-based face-to-face drug checking services (29%).

In 2025, 85% reported that they had ever heard of naloxone, stable relative to 2024 (76%), of whom 88% were able to correctly identify the purpose of naloxone (92% in 2024). There was a significant increase in the number of participants who reported ever obtaining naloxone (41%; 19% in 2024; p=0.003) and obtaining naloxone in the past year (34%; 15% in 2024; p=0.008).

Sexual activity, mental health and health service access

Three quarters (75%) of the sample reported engaging in some form of sexual activity in the four weeks prior to interview, of which 61% reported use of alcohol/drugs before or during sex. In 2025, three fifths (59%) of the sample reported ever having a HIV test, with one fifth (20%) reporting being tested in the six months preceding interview. One quarter (27%) of the sample reported having a sexual health check-up in the six months prior to interview.

Mental health remained stable relative to 2024, with 55% reporting experiencing a mental health problem in the six months preceding interview (63% in 2024), with depression (69%) and anxiety (63%) most commonly reported. Fifteen per cent of the sample screened positive for 'very high' psychological distress.

Eighteen per cent of participants reported accessing any health service for alcohol and/or drug support in the six months preceding interview.

Driving, contact with police and modes of purchasing drugs

Amongst those who had recently driven, 11% reported driving while over the perceived legal limit of alcohol and 31% reported driving within three hours of consuming an illicit or non-prescribed drug in the six months prior to interview, a significant decrease from 49% in 2024 (p=0.028). Cannabis was the most commonly reported drug used prior to driving in 2025 at 38%.

One third (32%) of the sample reported 'any' crime in the past month, a significant decrease from 52% in 2024 (p=0.008). Property crime was the most common form of criminal activity reported (26%; 37% in 2024). Reports of drug dealing also decreased significantly, from 29% in 2024 to 14% in 2025 (p=0.015). Few participants (n≤5) reported having been arrested in the 12 months preceding interview, and 11% reported a drug-related encounter with police which did not result in charge or arrest.

Social networking applications were the most common method in which participants arranged the purchase of illicit or non-prescribed drugs in the 12 months preceding interview (81%; 77% in 2024). The majority (89%) of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2025. Obtaining drugs face-to-face was the most common means of collecting drugs (100%), although there was a significant decline in those reporting obtaining drugs at a collection point (13%; 32% in 2025; p=0.001).

2025 SAMPLE CHARACTERISTICS

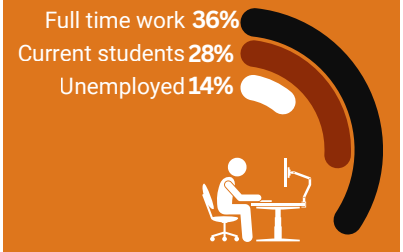
EDRS Ecstasy and Related Drugs Reporting System

Between April and June, 100 participants, recruited from Melbourne, Victoria, were interviewed.

28 years

Male

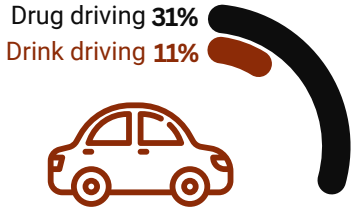
Median age and per cent who identified as male.



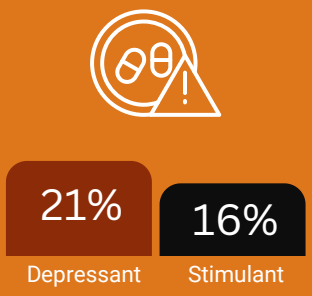
Current student and employment status.

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

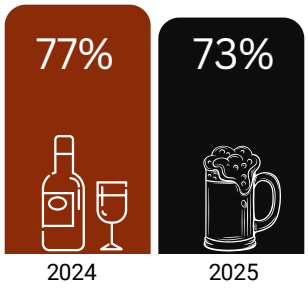
DRUG-RELATED HARMS AND RISKS



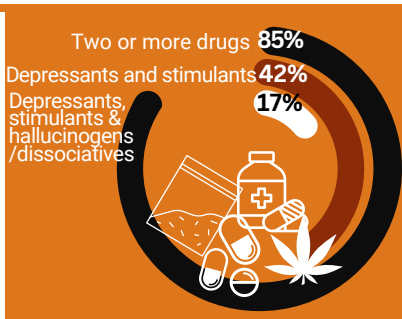
Among recent drivers, 31% reported driving a vehicle within 3 hours of consuming illicit drugs and 11% while over the legal limit of alcohol.



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

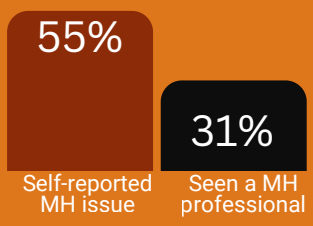


Percentage who obtained an AUDIT score of 8 or more, indicative of past year hazardous alcohol use.

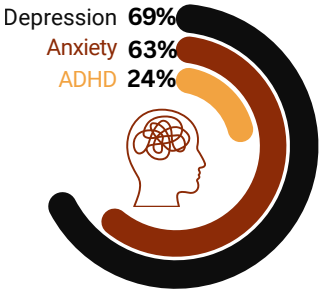


In 2025, 93% reported using two or more drugs on the last occasion of ecstasy or related drug use: the most commonly used combination of drug classes was depressants and stimulants (29%).

OTHER BEHAVIOURS

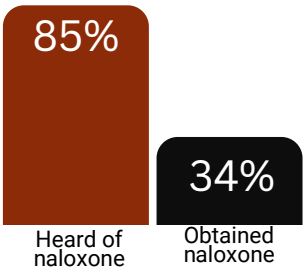


Percentage who self-reported mental health (MH) problems and treatment seeking in the six months preceding interview.



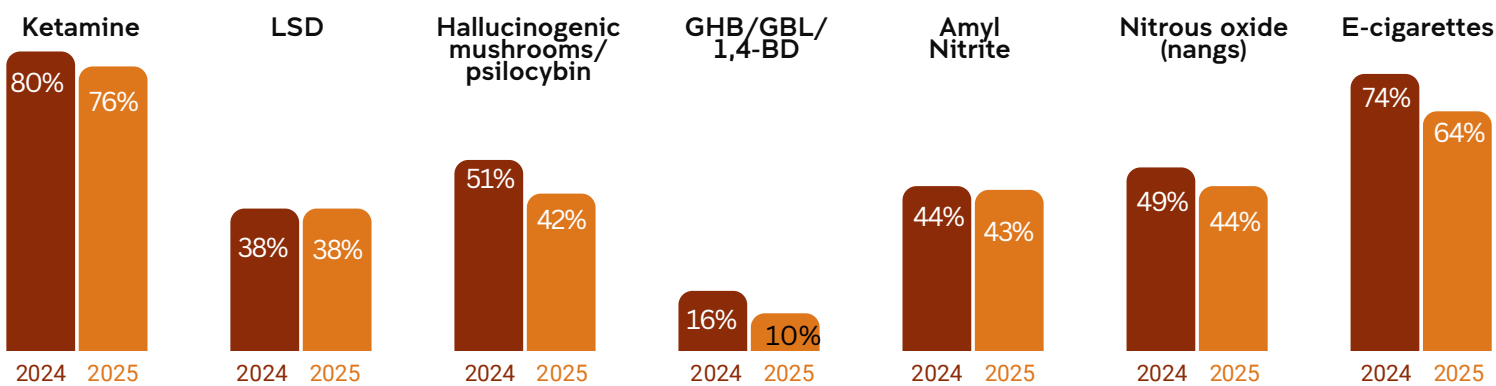
Among those who reported a mental health (MH) problem, the three most common mental health issues were depression, anxiety and ADHD.

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



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

PAST 6 MONTH USE OF SELECT DRUGS

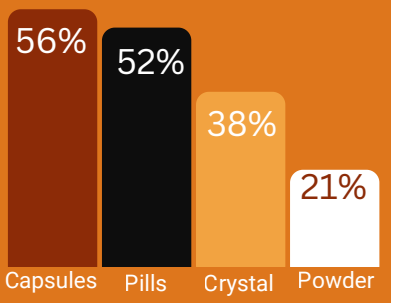


*p<0.050; **p<0.010; ***p<0.001.

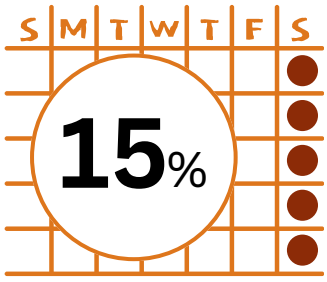
ECSTASY

EDRS Ecstasy and Related Drugs Reporting System

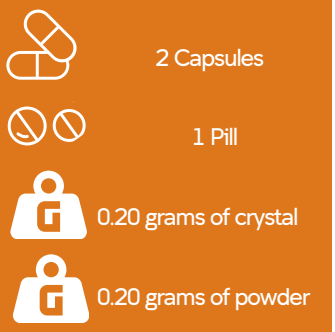
FORM of ecstasy



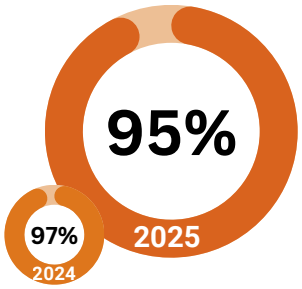
Past 6 month use of ecstasy capsules, crystal, pills and powder in 2025.



Of those who had recently used any ecstasy, 15% reported weekly or more frequent use, stable from 2024 (19%).



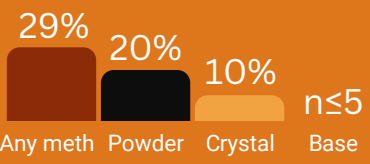
Median amounts of ecstasy consumed in a 'typical' session.



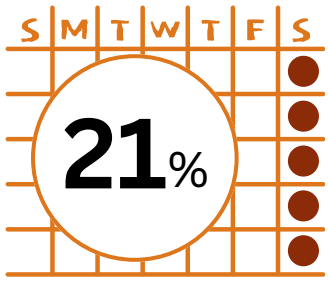
Percentage who perceived ecstasy capsules as being 'easy' or 'very easy' to obtain.

METHAMPHETAMINE

FORM of methamphetamine

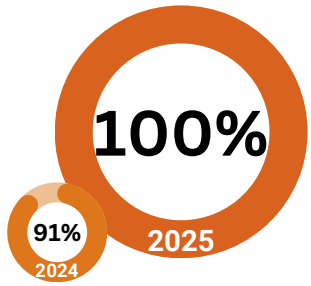


Past 6 month use of any methamphetamine, crystal, powder and base in 2025.



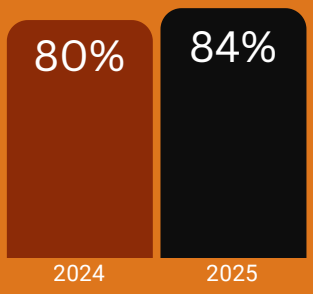
Of those who had recently used any methamphetamine, 21% reported weekly or more frequent use, stable from 2024 (18%).

The median reported price for a point of methamphetamine crystal.

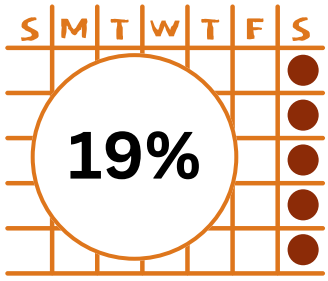


Percentage who perceived methamphetamine crystal as being 'easy' or 'very easy' to obtain.

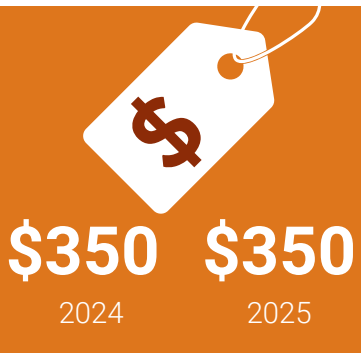
COCAINE



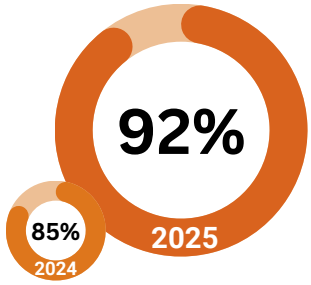
Past 6 month use of any cocaine remained stable between 2024 and 2025.



Of those who had recently consumed cocaine, 19% reported weekly or more frequent use, stable from 2024 (15%).

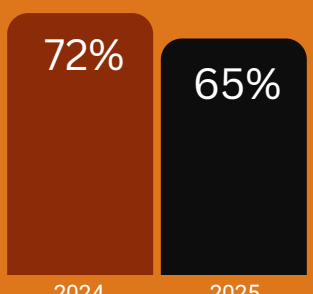


The median reported price for a gram of cocaine

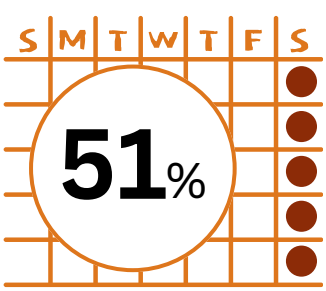


Percentage who perceived cocaine as being 'easy' or 'very easy' to obtain.

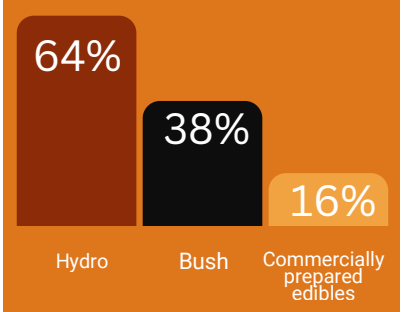
CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS



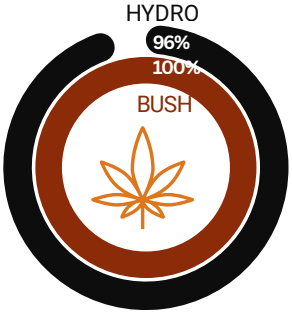
Past 6 month use of non-prescribed cannabis and/or cannabinoid-related products was stable between 2024 and 2025.



Of those who had recently used non-prescribed cannabis, 51% reported weekly or more frequent use, stable from 2024 (49%).



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



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

Background

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

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

Methods

EDRS 2003-2019

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

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

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

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

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

2025 EDRS Sample

A total of 690 participants were recruited across capital cities nationally (1st April-15th July 2025), with 100 participants interviewed in Melbourne, VIC between 8th April and 30th June 2025 (n=100 in 2024). A total of 95 interviews (95%) were conducted via telephone (n=95 in 2024; 95%), 1 interview (1%) was conducted via video conference (n=4 in 2024; 4%) and 4 interviews (4%) were done face-to-face (n=2 in 2024; 2%).

Seven per cent of the 2025 Melbourne sample also completed the interview in 2024, stable from 4% of the 2024 Melbourne sample who completed the interview in 2023. In 2025, 60% of participants were recruited via the internet (e.g., Facebook and Instagram) (77% in 2024), and 35% recruited via word-of-mouth (17% in 2024).

Routinely Collected Data

Four different types of routinely collected data are presented in this report.

Drug seizure purity levels

The Drug Analysis Branch of the Victoria Police Forensic Services Department conducts purity analyses for all Victoria Police's drug seizures. The Victoria Police Forensic Services Department provided drug purity data for seizures of drugs in VIC for inclusion in this report for the 2023/24 financial year.

Ambulance attendances at non-fatal drug-related events

Turning Point manages an electronic drug-related ambulance attendance database containing information from Ambulance Victoria records. Data for the period between January 2005 and December 2024 are presented in this report. Due to paramedic industrial action from March to September 2024, data are missing and numbers of reported ambulance attendances are reduced during this period.

Specialist drug treatment presentations

The Victorian Department of Health funds community-based agencies to provide specialist alcohol and other drug treatment services across the state. Data on people seeking treatment from specialist alcohol and other drug agencies in VIC were collected via the Alcohol and Drug Information System (ADIS), now called the Victorian Alcohol and Drug Collection (hereafter ADIS/VADC). During the 2023/24 financial year, 97,509 courses of treatment were delivered to 38,700 clients, compared to 65,799 courses of treatment delivered to 29,971 clients in the 2022/23 financial year.

Alcohol and other drug helpline calls

DirectLine is a 24-hour specialist telephone service in VIC (operated by Turning Point) that provides counselling, referral and advice about drug use and related issues. All calls to DirectLine are logged

to an electronic database that can provide information about caller drugs of concern, calls from or about people who use drugs. This report presents data for the period between 1999 and 2024.

Data Analysis

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

Guide to Table/Figure Notes

Table 1: Guide to Table/Figure Notes

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

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 Melbourne, Victoria, 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 Melbourne, VIC (see section on 'Additional Outputs' below for details of other outputs providing such profiles).

Additional Outputs

Infographics and the executive summary from this report are available for download. There are a range of outputs from the EDRS which triangulate key findings from the annual interviews and other data sources, including national reports, jurisdictional reports, bulletins, and other resources available via

the Drug Trends webpage. This includes results from the Illicit Drug Reporting System (IDRS), which focuses more so on the use of illicit drugs via injection.

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

1

Sample Characteristics

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

The gender distribution of the 2025 sample remained stable from 2024 (p=0.493), with 55% of the sample identifying as male (46% in 2024). The median age of the sample was 28 years (IQR=23–33), stable relative to 2024 (25 years; IQR=20–32; p=0.108).

Accommodation status remained stable in 2025 compared to 2024 (p=0.753). Fifty-five per cent reported residing in a rented house/flat (50% in 2024), 26% in a parents'/family home (36% in 2024), and 14% in their own home/flat (10% in 2024).

Twenty-eight per cent of the sample were current students (39% in 2024; p=0.137), while two thirds (68%) had obtained a post-school qualification(s) in 2025 (60% in 2024; p=0.310).

Participants' current employment status remained stable (p=0.129) in 2025 compared to 2024. Forty-three per cent of participants reported being employed on a part time/casual basis (56% in 2024), 36% reported being employed full-time (23% in 2024), and a further 14% reported being unemployed (18% in 2024).

Median weekly income increased significantly from $600 in 2024 (IQR=392–1029) to $1050 in 2025 (IQR=550–1500; p<0.001).

Table 2: Demographic characteristics of the sample, nationally, 2025, and Melbourne, VIC, 2017-2025

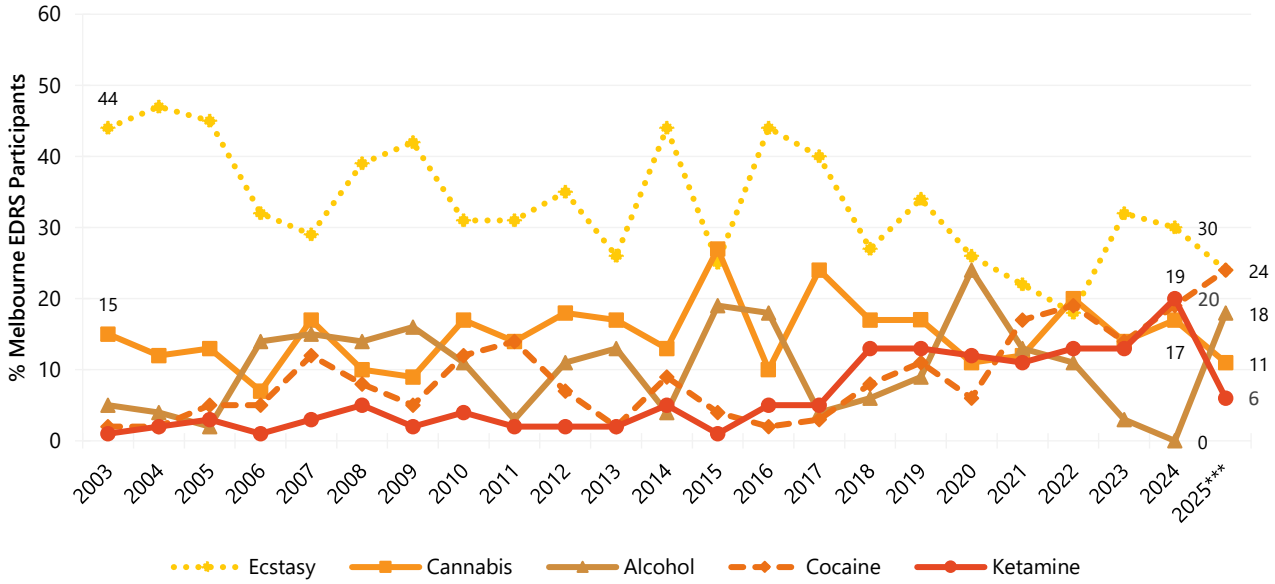
	Melbourne, VIC					National
	2021	2022	2023	2024	2025	2025
	(N=100)	(N=100)	(N=100)	(N=100)	(N=100)	(N=690)
Median age (years; IQR)	25 (23–28)	25 (22–28)	29 (23–33)	25 (20–32)	**28 (23–33)**	26 (20–34)
% Gender						
Female	26	43	42	48	**41**	41
Male	67	52	54	46	**55**	57
Non-binary	-	0	-	-	**-**	1
% Aboriginal and/or Torres Strait Islander	-	7	-	-	**-**	8
% Born in Australia	/	/	/	75	**79**	85
% English primary language spoken at home	/	/	/	96	**95**	97
% Sexual identity						
Heterosexual	64	64	61	56	**67**	72
Homosexual	-	-	13	10	**6**	6
Bisexual	11	18	15	20	**17**	17
Queer	17	11	9	10	**7**	4
Other identity	6	-	-	-	**-**	2
Mean years of school education (range)	12 (8–12)	12 (9–12)	12 (9–12)	12 (8–12)	**12 (9–12)**	12 (7–12)
% Post-school qualification(s)^	69	62	71	60	**68**	63
% Current students#	42	50	31	39	**28**	34
% Current employment status						
Employed full-time	18	29	51	23	**36**	29
Part time/casual	51	52	32	56	**43**	39
Self-employed	8	10	-	-	**6**	5
Unemployed	23	9	12	18	**14**	28
Current median weekly income $ (IQR)	$540 (350–906)	$700 (490–1154)	$1200 (700–1737)	$600 (392–1029)	**$1050 (550–1500)*** **	700 (400–1350)
% Current accommodation						
Own house/flat	-	-	11	10	**14**	13
Rented house/flat	75	69	69	50	**55**	50
Parents'/family home	19	26	19	36	**26**	26
Boarding house/hostel	-	0	-	-	-	1
Public housing	0	-	0	-	-	5
No fixed address+	-	0	0	-	-	2
Other	0	0	0	0	**-**	2

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

The distribution of reported drug of choice changed significantly between 2024 and 2025 ($p<0.001$), with one quarter (24%) nominating ecstasy as their drug of choice in 2025 (30% in 2024), followed by 24% nominating cocaine (19% in 2024) and 18% nominating alcohol (no participants in 2024) (Figure 1). Six per cent of the Melbourne sample nominated ketamine as their drug of choice in 2025, down from 20% in 2024. The distribution of reported drug used most often in the month prior to interview also changed significantly between 2024 and 2025 ($p<0.001$), with more participants reporting alcohol in 2025 (39%; 6% in 2024), followed by 19% reporting cannabis (31% in 2024), 18% reporting cocaine (18% in 2024), and 8% reporting ecstasy (15% in 2024) (Figure 2).

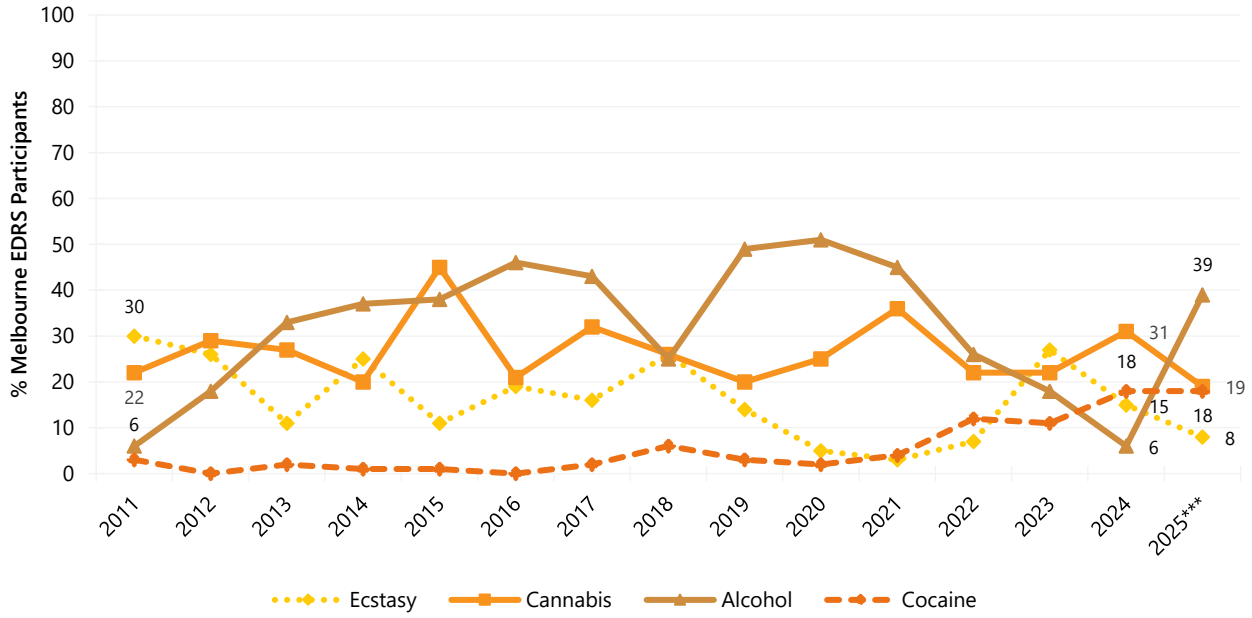
Weekly or more frequent use of various drugs remained stable between 2024 and 2025. One third (33%) of the Melbourne sample reported weekly or more frequent use of cannabis (35% in 2024; $p=0.878$), 16% reported weekly or more frequent use of cocaine (12% in 2024; $p=0.537$), and 14% reported weekly or more frequent non-prescribed ecstasy use (18% in 2024; $p=0.562$) (Figure 3).

Figure 1: Drug of choice, Melbourne, VIC, 2003-2025



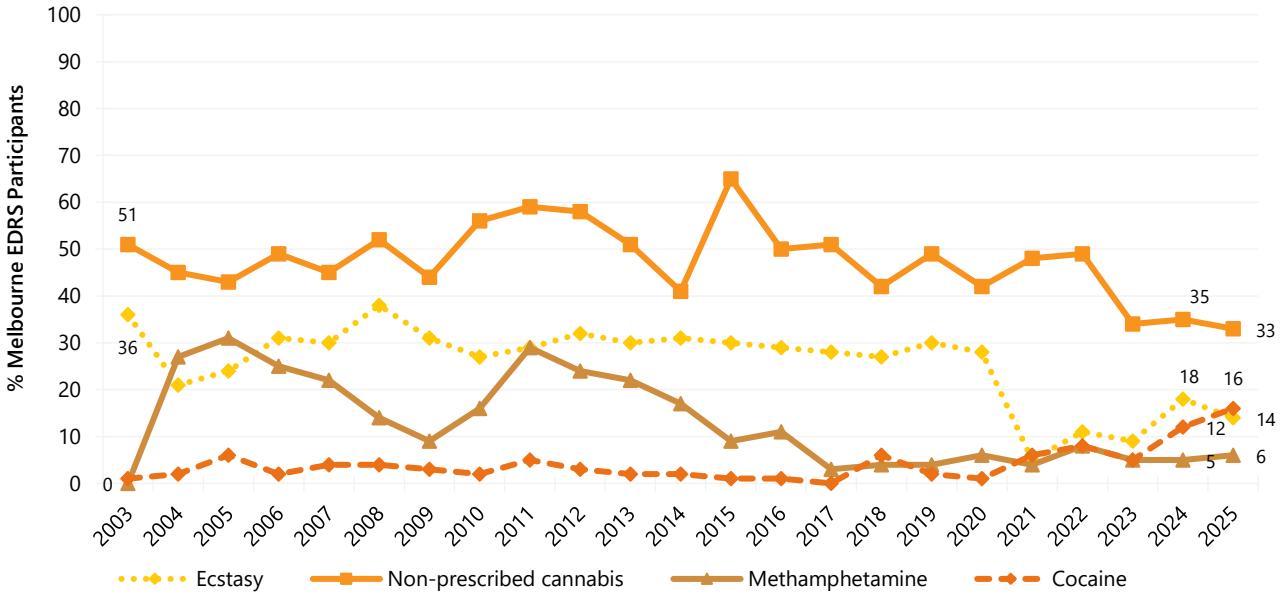
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; smaller percentages have endorsed other substances. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small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

Figure 2: Drug used most often in the past month, Melbourne, VIC, 2011-2025



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

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



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

2

Non-Prescribed Ecstasy

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

Recent Use (past 6 months)

Recent use of any non-prescribed ecstasy in the six months prior to interview remained stable in 2025 (94%; 95% in 2024) (Figure 4). There has been a shift over time to use of non-prescribed ecstasy capsules (56% in 2025; 64% in 2024; p=0.318), which peaked in 2017 (90%) and 2019 (90%), while reported use of non-prescribed ecstasy pills has trended downwards over time (52% in 2025; 65% in 2024; p=0.089). Reported use of non-prescribed ecstasy powder has fluctuated over the years (21% in 2025; 34% in 2024; p=0.059) while reported recent use of non-prescribed ecstasy crystal has remained stable since data collection began (38% in 2025; 43% in 2024; p=0.563).

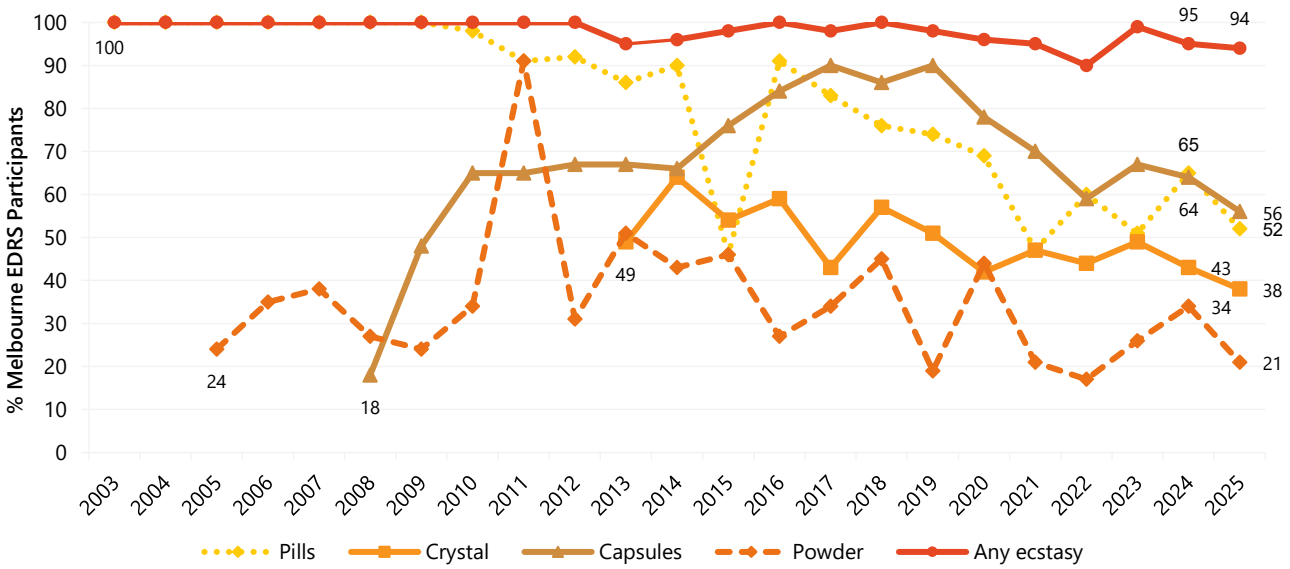
Frequency of Use

Among those who reported recent use of any non-prescribed ecstasy and commented (n=94), participants reported using non-prescribed ecstasy (in any form) on a median of seven days (IQR=4–14) in the six months preceding interview, remaining stable relative to 2024 (8 days; IQR=5–20; n=95; p=0.151) (Figure 5). Weekly or more frequent use of any form of non-prescribed ecstasy remained stable at 15% in 2025 (19% in 2024; p=0.559).

Number of Forms Used

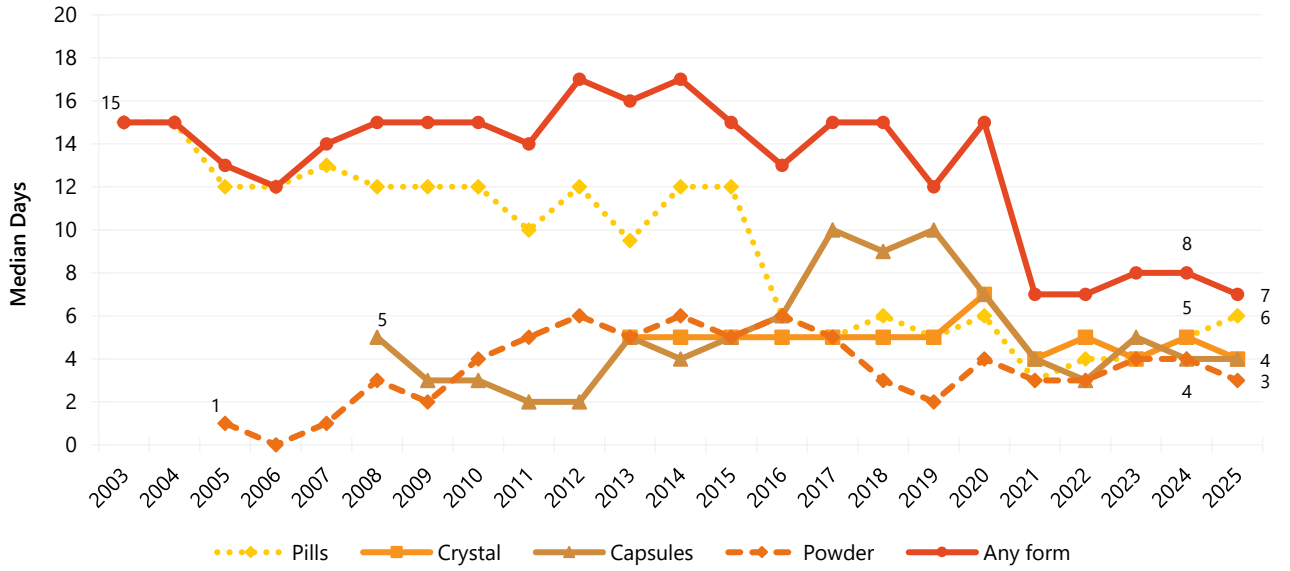
Among participants who had recently consumed non-prescribed ecstasy and commented (n=94), although the median number of forms of non-prescribed ecstasy used in the six months preceding interview remained stable at two (IQR 1–2) the variability decreased compared to 2024; IQR in 2024=1–3; n=95; p=0.009).

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



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

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



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Median days computed among those who reported past 6-month use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 20 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Patterns of Consumption (by form)

Non-Prescribed Ecstasy Pills

Recent Use (past 6 months): Around half (52%) of the 2025 sample reported recent use of non-prescribed ecstasy pills, stable relative to 2024 (65%; *p*=0.089) (Figure 4).

Frequency of Use: Of those who had recently consumed non-prescribed ecstasy pills and commented (n=52), participants reported using non-prescribed ecstasy pills on a median of 6 days (IQR=2–12) in the six months preceding interview in 2025, stable from 2024 (5 days; IQR=2–12; n=65; *p*=0.802) (Figure 5). Twelve per cent of those who had recently consumed non-prescribed ecstasy pills reported weekly or more frequent use in 2025, stable relative to 2024 (14%; *p*=0.782).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy pills and commented (n=52), the most common route of administration in 2025 was swallowing (100%; 97% in 2024; *p*=0.502), followed by snorting (15%; 15% in 2024), consistent with previous years. No participants reported recent smoking and injecting (n≤5 in 2024).

Quantity: Of those who reported recent use and responded (n=52), the median number of non-prescribed ecstasy pills used in a 'typical' session was one (IQR=1–2; 2 pills in 2024; IQR=1–2; n=65; *p*=0.182). Of those who reported recent use and responded (n=52), the median maximum number of non-prescribed ecstasy pills used in a session was two (IQR=1–4; 2 pills in 2024; IQR=1.5–4; n=65; *p*=0.643).

Non-Prescribed Ecstasy Capsules

Recent Use (past 6 months): Fifty-six per cent of participants reported recent use of non-prescribed ecstasy capsules in 2025, stable from 64% in 2024 (*p*=0.318) (Figure 4).

Frequency of Use: Among those who reported recent use and commented (n=56), participants reported consuming non-prescribed ecstasy capsules on a median of four days (IQR=2–8) in the six months preceding interview in 2025, stable from 2024 (4 days; IQR=2–8 n=64; *p*=0.806) (Figure 5). Few participants (n≤5) who had recently consumed ecstasy capsules reported weekly or more frequent use in 2025, though this was a significant increase relative to 2024 (0%; *p*=0.020).

Routes of Administration: Among those who had recently consumed non-prescribed ecstasy capsules and commented (n=56), the majority (96%) reported swallowing (91% in 2024; *p*=0.281), while one tenth (11%) reported snorting (20% in 2024; *p*=0.215). No participants reported recent smoking or injecting (no participants in 2024).

Quantity: Of those who reported recent use and responded (n=56), although the median number of non-prescribed ecstasy capsules used in a 'typical' session remained stable at two in 2025 (IQR=1–2), the variability decreased significantly compared to 2024 (IQR=1–3; n=64; *p*=0.037). Of those who reported recent use and responded (n=56), although the median maximum number of non-prescribed ecstasy capsules used in a session remained stable at two in 2025 (IQR=1.9–3; the variability decreased significantly compared to 2024 (IQR=2–5; n=64; *p*=0.012).

Non-Prescribed Ecstasy Crystal

Recent Use (past 6 months): Around two fifths (38%) of the sample reported recent use of non-prescribed ecstasy crystal, stable from 2024 (43%; *p*=0.563) (Figure 4).

Frequency of Use: Among those who reported recent use and commented (n=38), participants reported using non-prescribed ecstasy crystal on a median of four days

(IQR=3–6) in the six months preceding interview, stable from five days in 2024 (IQR=2–11; n=43; *p*=0.909) (Figure 5). Few participants (n≤5) who had recently consumed non-prescribed ecstasy crystal reported weekly or more frequent use in 2025 (n≤5 in 2024).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy crystal and commented (n=38), 79% reported swallowing (74% in 2024; *p*=0.792), while 45% reported snorting (47% in 2024). Few participants (n≤5) reported smoking (n≤5 in 2024).

Quantity: Of those who reported recent use and responded (n=32), the median amount of non-prescribed ecstasy crystal used in a 'typical' session was 0.20 grams (IQR=0.15–0.32), a significant decrease from 2024 (0.25 grams; IQR=0.20–0.50; n=41; *p*=0.038). Of those who reported recent use and responded (n=32), the median maximum amount of non-prescribed ecstasy crystal used in a session was 0.28 grams (IQR=0.20–0.57; 0.40 grams in 2024; IQR=0.25–1.00; n=41; *p*=0.135).

Non-Prescribed Ecstasy Powder

Recent Use (past 6 months): Around one fifth (21%) of the sample reported recent use of non-prescribed ecstasy powder in 2025, stable from 2024 (34%; *p*=0.059) (Figure 4).

Frequency of Use: Amongst those who reported recent use and commented (n=21), participants reported consuming non-prescribed ecstasy powder on a median of three days (IQR=2–8) in the six months preceding interview in 2025, stable from 2024 (4 days; IQR=2–7; n=34; *p*=0.766) (Figure 5). No participants (0%) who had recently consumed non-prescribed ecstasy powder reported weekly or more frequent use in 2025 (n≤5 in 2024; *p*=0.519).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy powder and commented (n=21) around four fifths (81%) reported snorting (79% in 2024), with a further 57% reporting swallowing (47% in 2024; *p*=0.578).

Quantity: Of those who reported recent use and responded (n=16), the median amount of non-prescribed ecstasy powder used in a 'typical' session was 0.20 grams (IQR=0.15–0.35; 0.40 grams in 2024; IQR=0.23–0.50; n=31; *p*=0.069). Of those who reported recent use and responded (n=17), the median maximum amount of non-prescribed powder used in a session was 0.20 grams (IQR=0.20–0.60; 0.50 grams in 2024; IQR=0.30–0.70; n=31; *p*=0.075).

Price, Perceived Purity and Perceived Availability

Non-Prescribed Ecstasy Pills

Price: The median reported price of a non-prescribed ecstasy pill was $30 in 2025 (IQR=25–35; n=31), stable from $30 in 2024 (IQR=25–35; n=29; *p*=0.677) (Figure 6).

Perceived Purity: The perceived purity of non-prescribed ecstasy pills remained stable between 2024 and 2025 (*p*=0.149). Among those who responded in 2025 (n=50), 36% reported purity to be 'fluctuating' (30% in 2024), 34% reported purity as 'high' (38% in 2024), and 28% reported purity to be 'medium' (20% in 2024) (Figure 8).

Perceived Availability: The perceived availability of non-prescribed ecstasy pills remained stable between 2024 and 2025 (*p*=0.115). Among those who were able to comment in 2025 (n=49), 53% reported that non-prescribed ecstasy pills were 'very easy' to obtain (35% in 2024), with a further 37%

reporting 'easy' obtainment (48%% in 2024) (Figure 12).

Non-Prescribed Ecstasy Capsules

Price: The reported median price of a non-prescribed ecstasy capsule in 2025 was $25 (IQR=24–30; n=32), stable relative to 2024 ($25; IQR=20–30; n=40; *p*=0.267) (Figure 6).

Perceived Purity: There was a significant change in the perceived purity of non-prescribed ecstasy capsules between 2024 and 2025 (*p*=0.040). Among those who were able to comment in 2025 (n=53), 40% perceived purity to be 'medium' (28% in 2024) and a further 32% perceived purity to be 'high' (34% in 2024). One fifth (19%) perceived purity to be 'low' (9% in 2024) (Figure 9).

Perceived Availability: The perceived availability of non-prescribed ecstasy capsules remained stable between 2024 and 2025 (*p*=0.769). Among those who responded in 2025 (n=52), three fifths (60%) of respondents perceived non-prescribed ecstasy capsules to be 'very easy' to obtain (55% in 2024), with a further 35% perceiving it as 'easy' to obtain (42% in 2024) (Figure 13).

Non-Prescribed Ecstasy Crystal

Price: The median price of a gram of non-prescribed ecstasy crystal remained stable in 2025 ($200; IQR=173–200; n=20) relative to 2024 ($200; IQR=150–250; n=28) (Figure 7).

Perceived Purity: The perceived purity of non-prescribed ecstasy crystal remained stable between 2024 and 2025 (*p*=0.641). Among those who responded in 2025 (n=30), half (50%) perceived the purity of non-prescribed ecstasy crystal to be 'high' (38% in 2024), with a further 30% perceiving purity to be 'medium' (35% in 2024) (Figure 10).

Perceived Availability: The perceived availability of non-prescribed ecstasy crystal remained stable between 2024 and 2025 (*p*=0.404). Among those who were able to comment in 2025 (n=31), the majority reported that non-prescribed ecstasy crystal was either 'very easy' (55%) or 'easy' (39%) to obtain (44% and 36%, respectively, in 2024). (Figure 14).

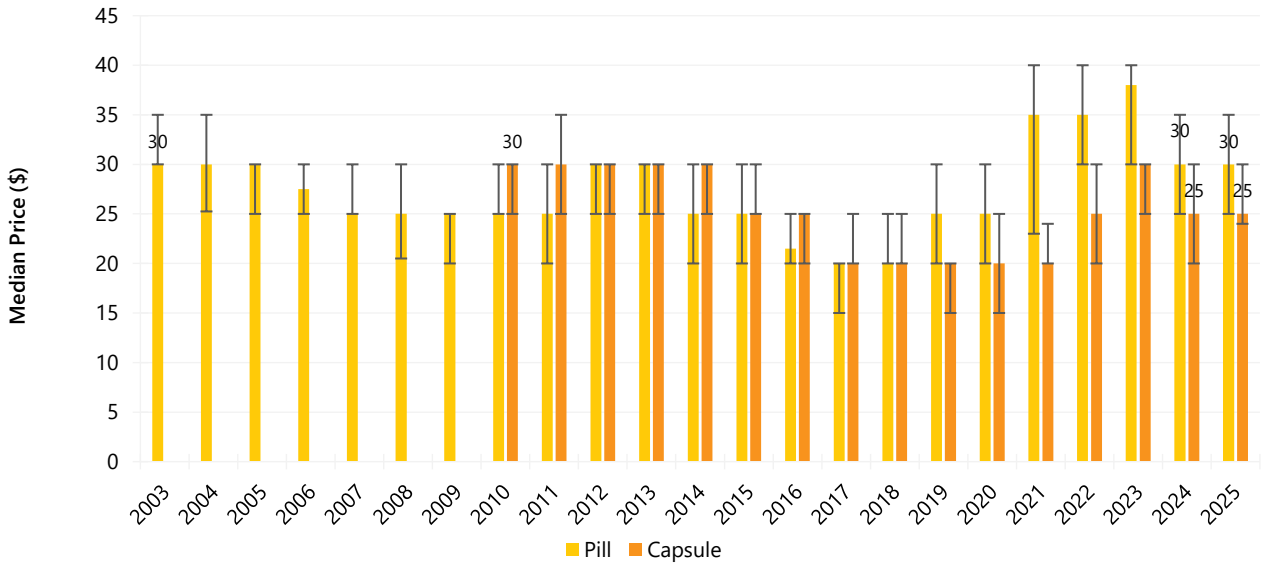
Non-Prescribed Ecstasy Powder

Price: The median price of a gram of non-prescribed ecstasy powder remained stable in 2025 at $200 (IQR=200–250; n=11; $200 in 2024; IQR=180–250; n=11; *p*=0.839) (Figure 7).

Perceived Purity: The perceived purity of non-prescribed ecstasy powder remained stable between 2024 and 2025 (*p*=0.523). Among those who were able to comment in 2025 (n=14), 43% perceived purity to be 'high (36% in 2024) (Figure 11).

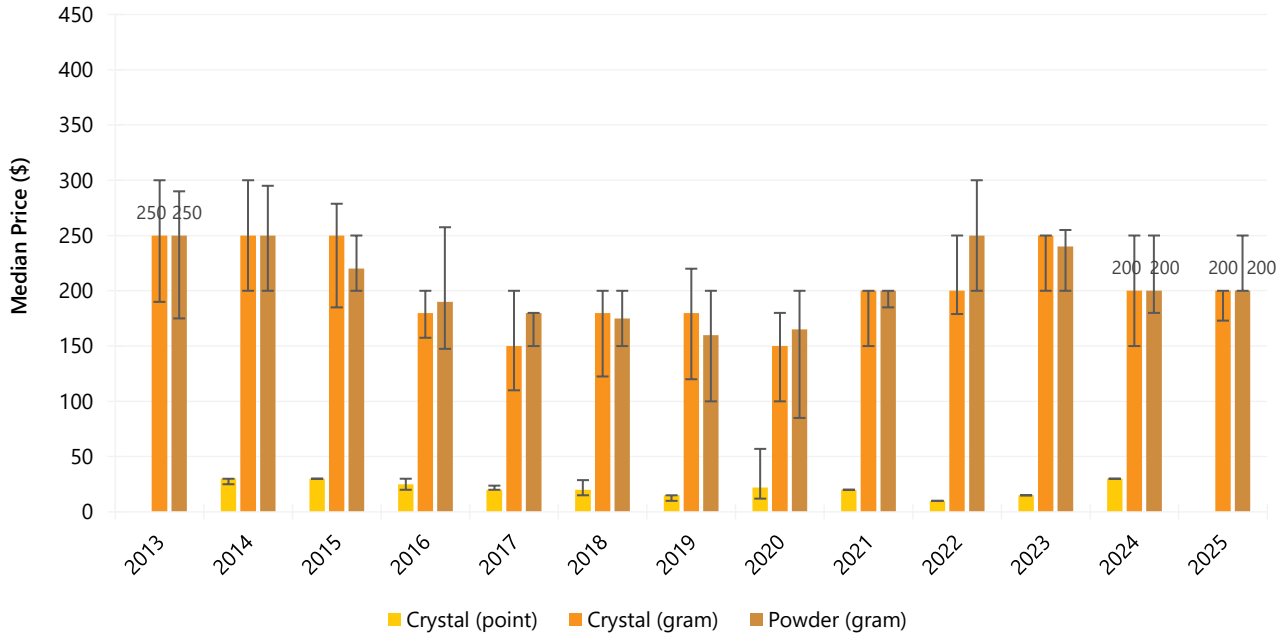
Perceived Availability: The perceived availability of non-prescribed ecstasy powder remained stable between 2024 and 2025 (*p*=0.281). Among those who were able to comment in 2025 (n=15), 67% perceived non-prescribed ecstasy powder as 'easy' to obtain (36% in 2024) (Figure 15).

Figure 6: Median price of non-prescribed ecstasy pill and capsule, Melbourne, VIC, 2003-2025



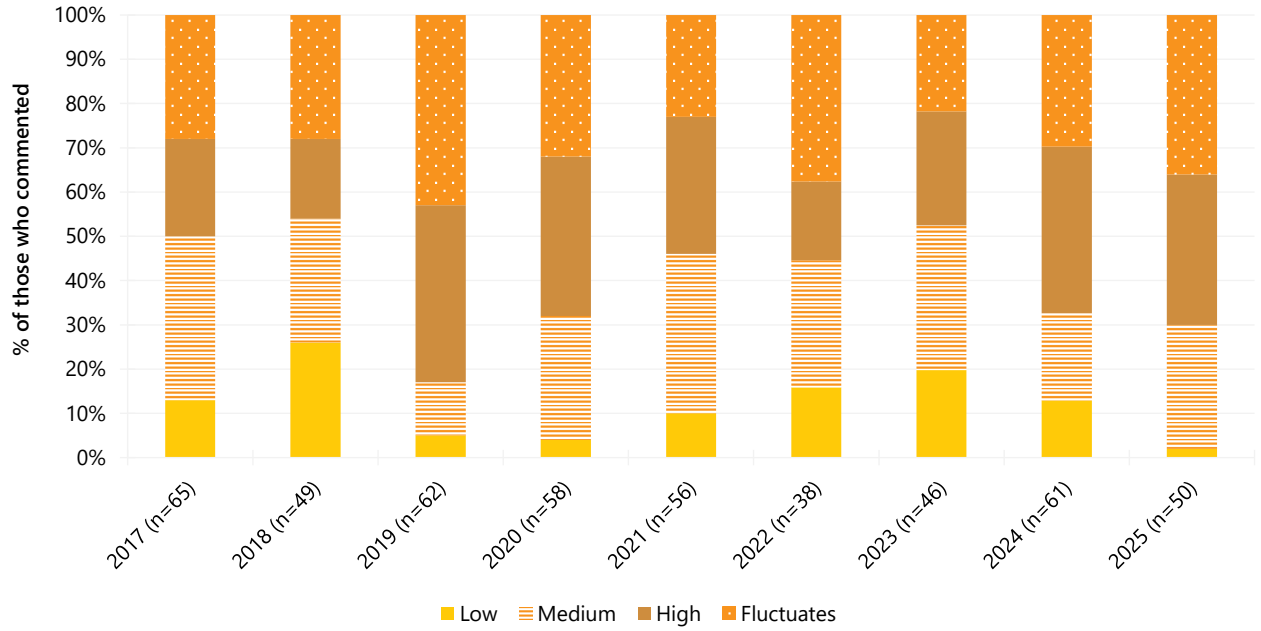
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure;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

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



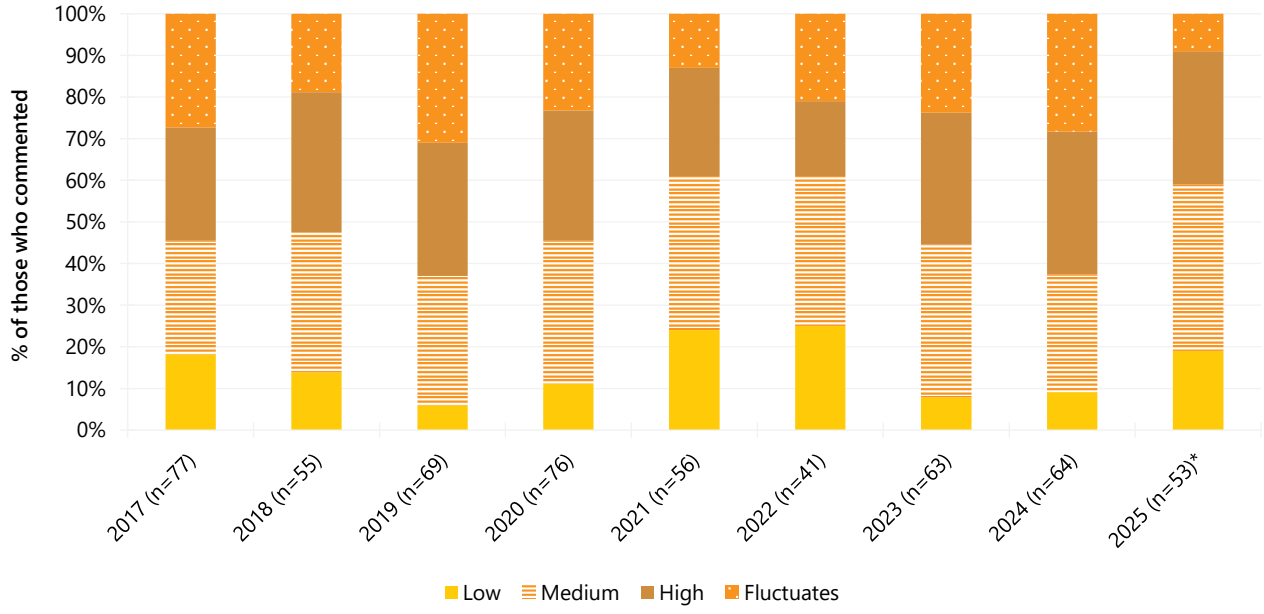
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) and ecstasy powder (gram) started in 2013. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 8: Current perceived purity of non-prescribed ecstasy pills, Melbourne, VIC, 2017-2025



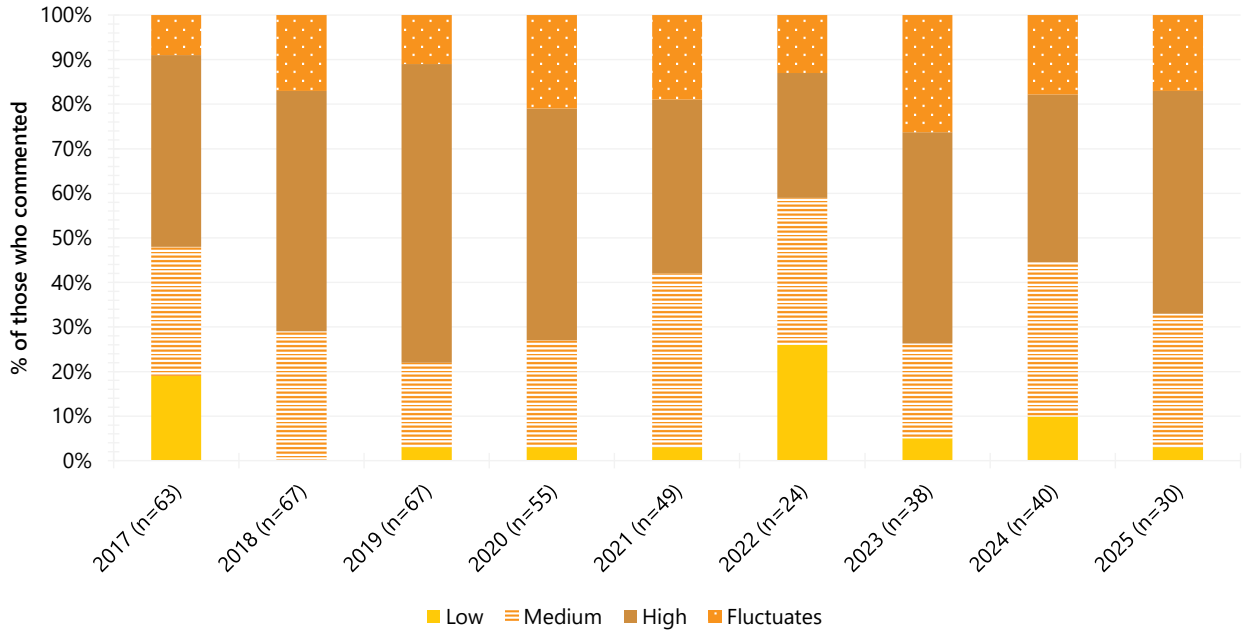
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2024 versus 2025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

Figure 9: Current perceived purity of non-prescribed ecstasy capsules, Melbourne, VIC, 2017-2025



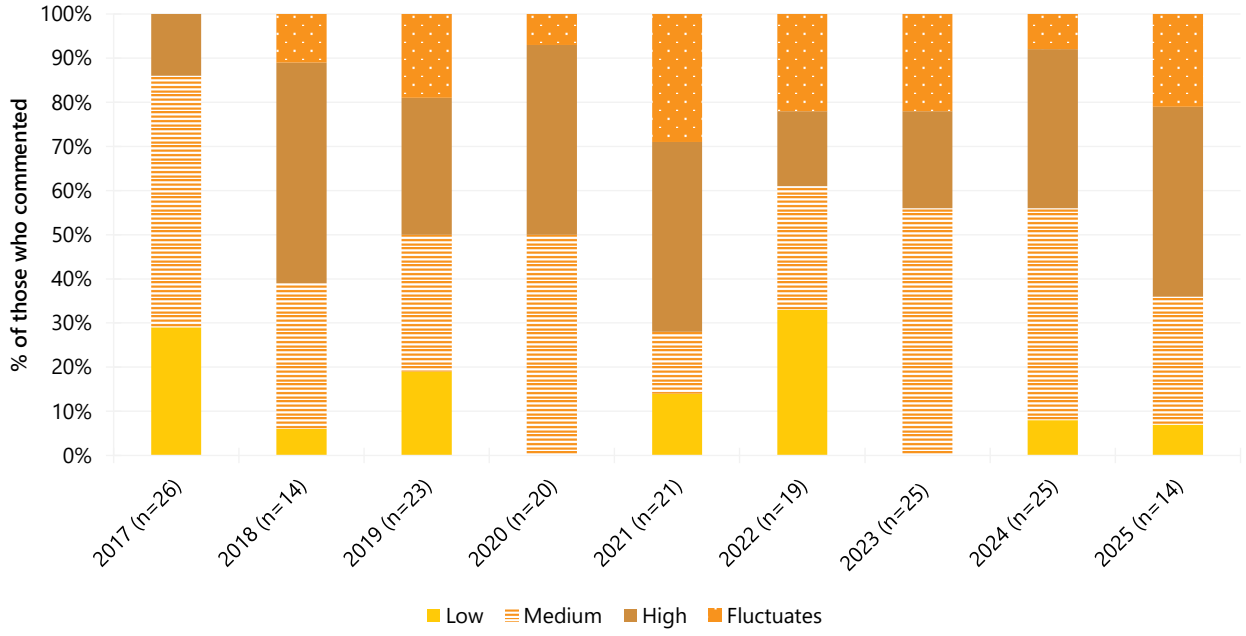
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2024 versus 2025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

Figure 10: Current perceived purity of non-prescribed ecstasy crystal, Melbourne, VIC, 2017-2025



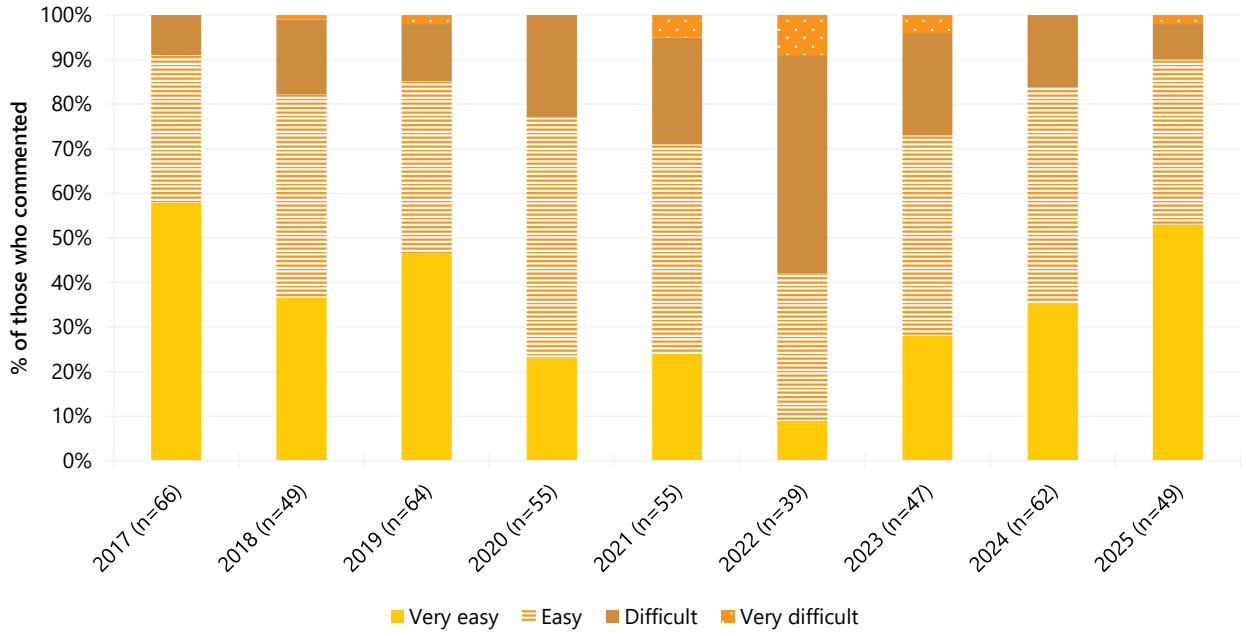
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2024 versus 2025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

Figure 11: Current perceived purity of non-prescribed ecstasy powder, Melbourne, VIC, 2017-2025



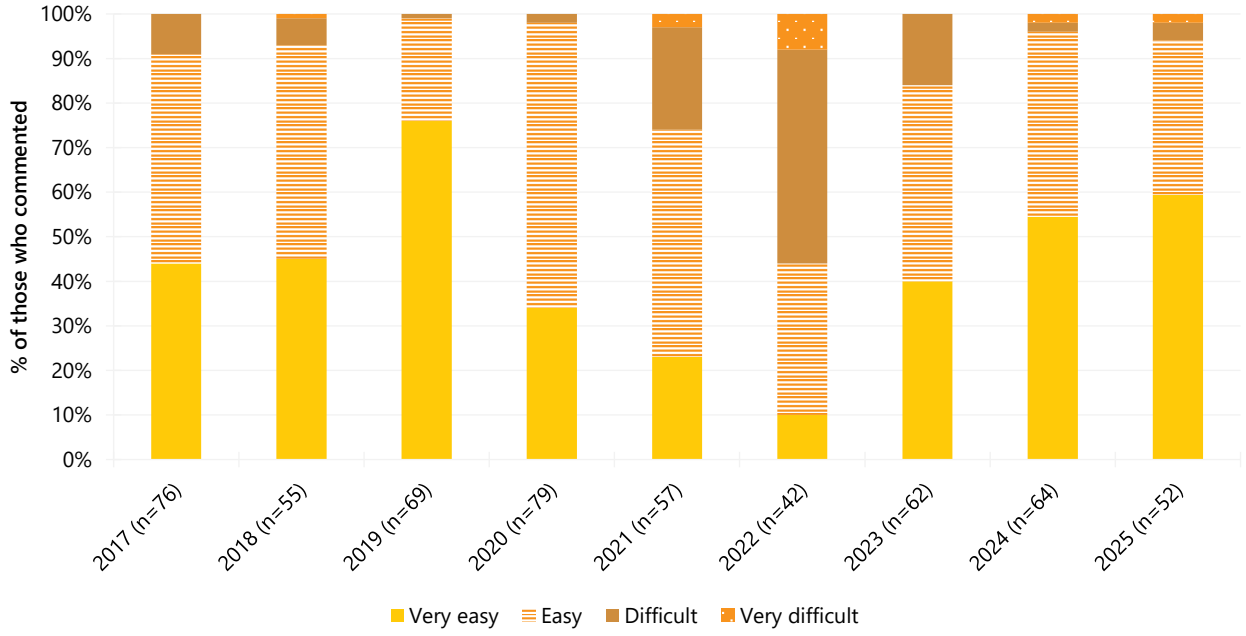
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2024 versus 2025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

Figure 12: Current perceived availability of non-prescribed ecstasy pills, Melbourne, VIC, 2017-2025



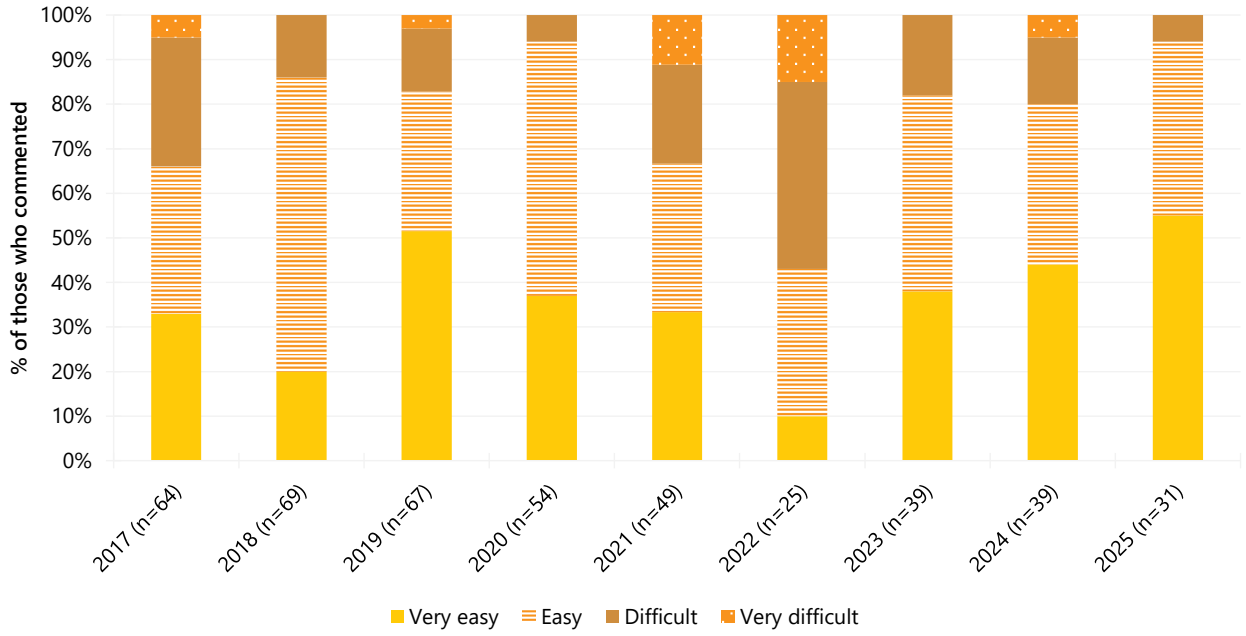
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2024 versus 2025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

Figure 13: Current perceived availability of non-prescribed ecstasy capsules, Melbourne, VIC, 2017-2025



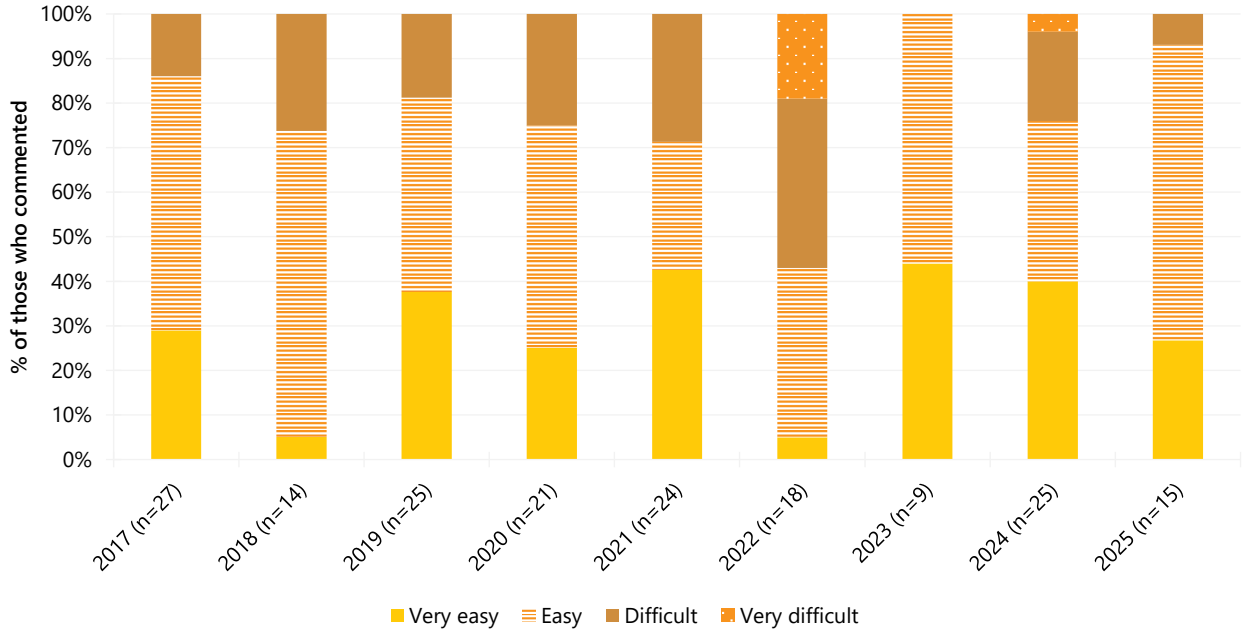
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2024 versus 2025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

Figure 14: Current perceived availability of non-prescribed ecstasy crystal, Melbourne, VIC, 2017-2025



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

Figure 15: Current perceived availability of non-prescribed ecstasy powder, Melbourne, VIC, 2017-2025



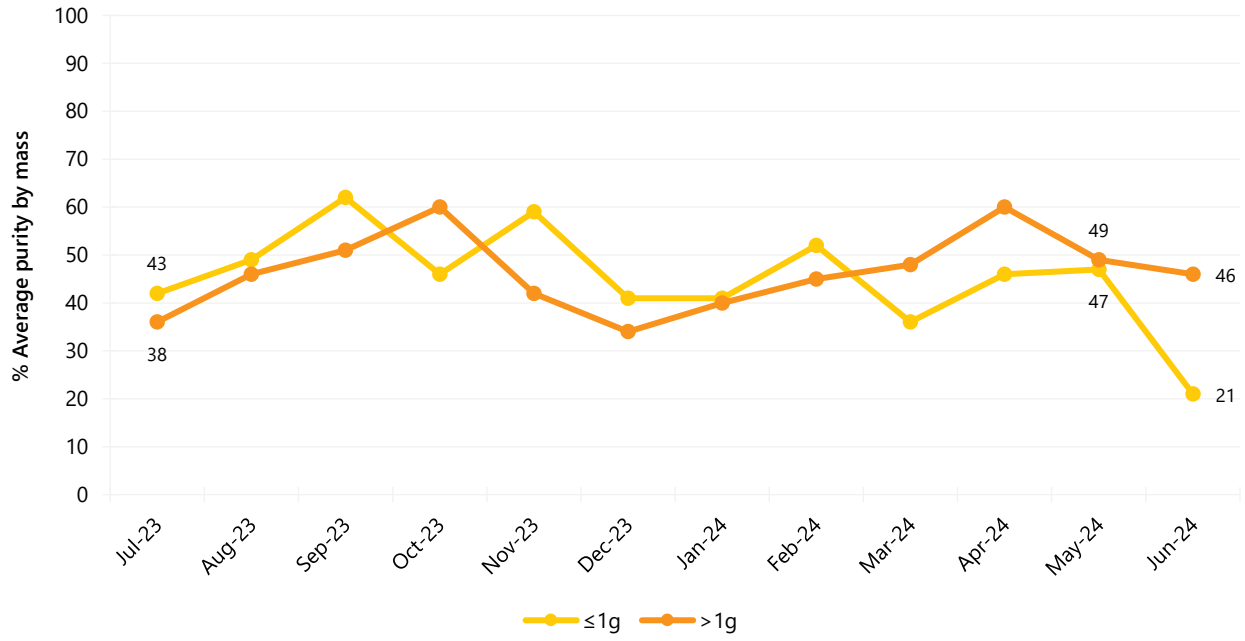
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2024 versus 2025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

Routinely Collected Data

Victoria Police Seizure Purity

Ecstasy seizures analysed by the Victoria Police Forensic Services Department during the 2023/24 financial year, weighing one gram or less and more than one gram, were on average 45% (IQR=41–50%, range=21–62) and 46% (IQR=42–50, range=34–60) pure, respectively (Figure 16).

Figure 16: Purity of ecstasy seizures (includes MDMA, MDEA and MDA) by Victorian law enforcement, July 2023–June 2024

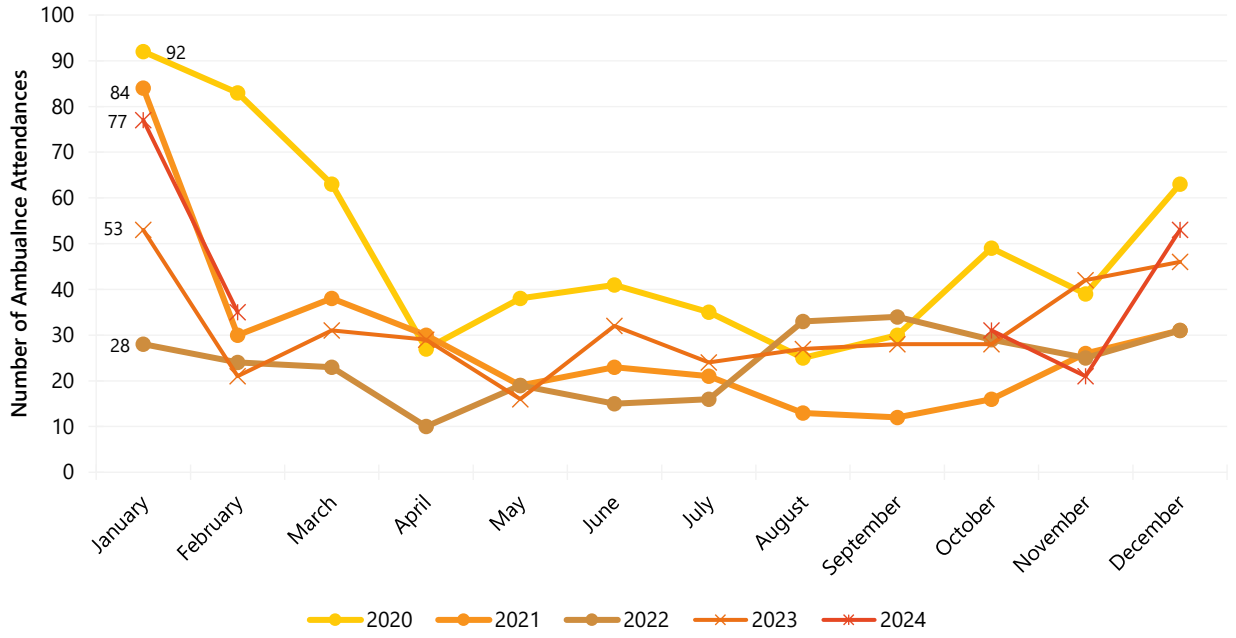


Note. Includes all forms (e.g., pill, capsule, powder and crystal) of MDMA, MDEA and MDA seized by Victoria Police. May not include every drug seized, because not all seized drugs undergo purity analysis. Data labels provided are only provided for the first (Jul-23) and last two months (May-24, Jun-24) of monitoring.

Ambulance Attendances at Non-Fatal Drug Events

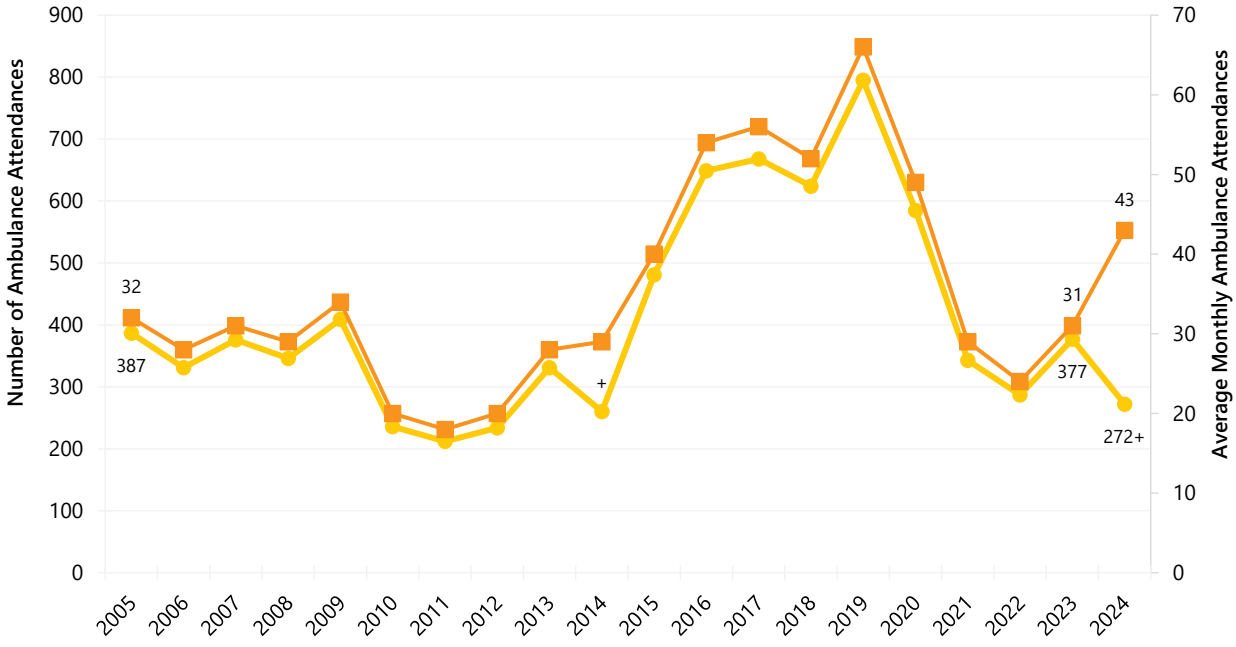
Due to paramedic industrial action from March to September 2024, data are missing and numbers of reported ambulance attendances are reduced during this period. The number of ecstasy-related ambulance attendances in metropolitan Melbourne ranged between 10 and 107 per month during 2017–2024 (excluding March to September 2024) (Figure 17). The total annual number of ecstasy-related attendances rose steadily between 2014 and 2019 but has been declining in recent years. In 2024 there were 272 attendances, a decrease from 2023 (Figure 18). The median age of patients in Melbourne in 2024 was 23 years (range 19–30), consistent with previous years.

Figure 17: Number of ecstasy-related events attended by Ambulance Victoria, Melbourne, 2020–2024



Note. Data suppressed from March to September 2024 due to industrial action. Source: Turning Point. Data labels are only provided for the first (January) month of monitoring in each year.

Figure 18: Number of ecstasy-related events attended by Ambulance Victoria, Melbourne, 2005–2024



Note. + = Data missing from October-December 2014 and March-September 2024 due to industrial action. Source: Turning Point. Data labels provided are only provided for the first (2005) and the two most recent years (2023 and 2024) of monitoring.

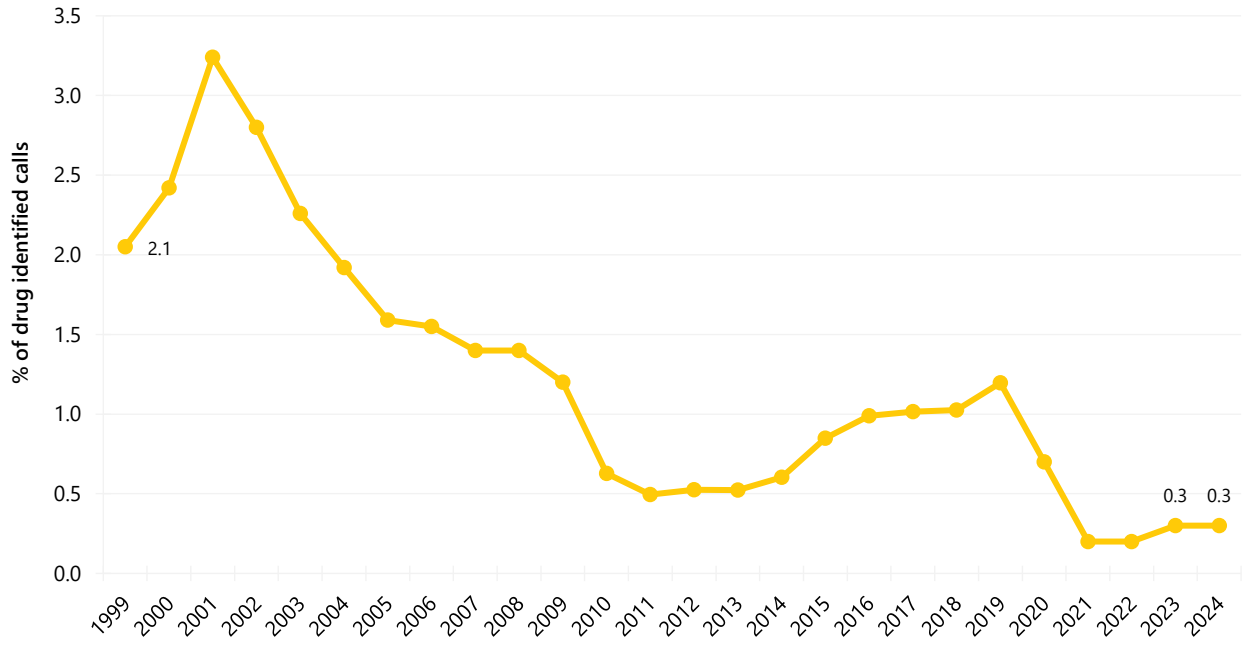
ADIS\VADC

In 2023/24, 195 courses of treatment were delivered for ecstasy, equivalent to 0.2% of the total courses delivered. This represents an increase of 14.7% in courses delivered from 2022/23 (170).

DirectLine

During 2024, DirectLine received 72 calls in which ecstasy was identified as the drug of concern, representing 0.3% of all drug-identified calls to DirectLine in that year, stable from 0.3% of drug-identified calls reported in 2023 (Figure 19).

Figure 19: Percentage of calls to DirectLine in which ecstasy was identified as drug of concern, Victoria 1999–2024



Source: DirectLine, Turning Point. Data labels provided are only provided for the first year (1999) and the two most recent years (2023 and 2024) of monitoring.

3

Methamphetamine

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

Patterns of Consumption (Any Methamphetamine)

Recent Use (past 6 months)

Recent use of any methamphetamine has fluctuated since 2003 but declined gradually overall (Figure 20). In 2025, 29% of participants reported recent use of any form of methamphetamine, stable relative to 2024 (29%).

Frequency of Use

Median frequency of use reported by participants in the six months prior to interview was five days (IQR=2–16; n=28) in 2025, stable relative to six days in 2024 (IQR=2–20; n=29; p=0.921) (Figure 21). Weekly or more frequent use of methamphetamine remained stable in 2025 (21%; 18% in 2024).

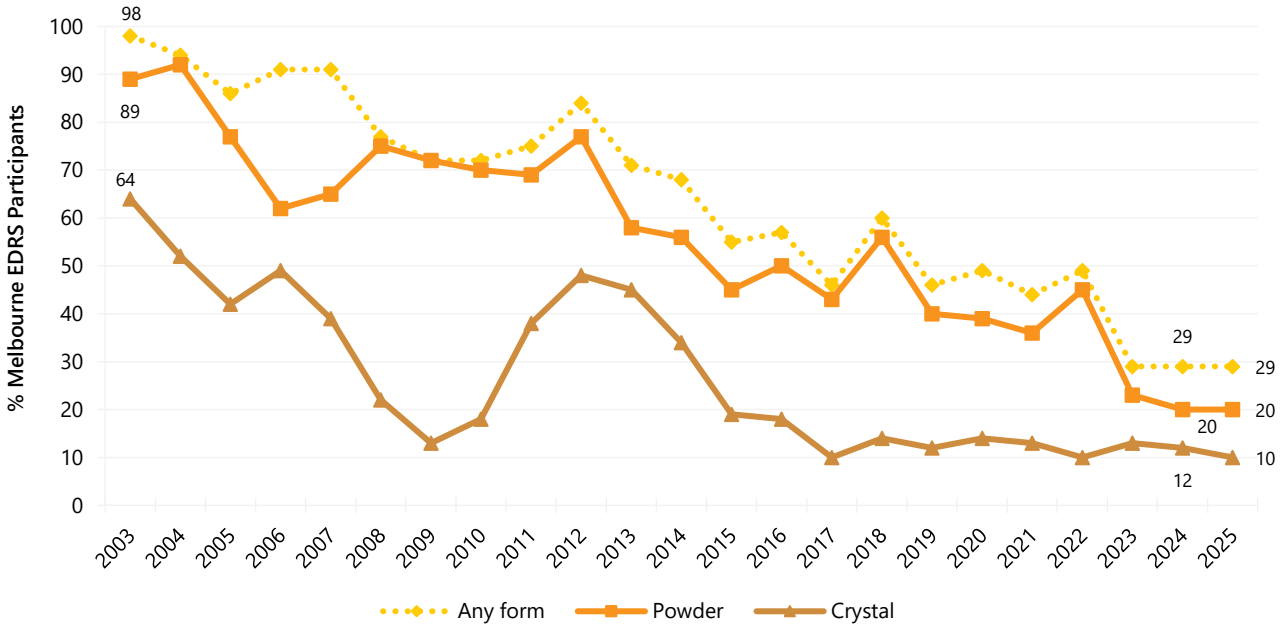
Forms Used

Use of all forms of methamphetamine has decreased since the start of monitoring. Of participants who had used methamphetamine in the six months preceding interview in 2025 (n=29), 69% had used powder methamphetamine (69% in 2024), followed by crystal methamphetamine (34%; 41% in 2024; p=0.783). Few participants (n≤5) reported use of base in 2025 (no participants in 2024).

Number of Forms Used

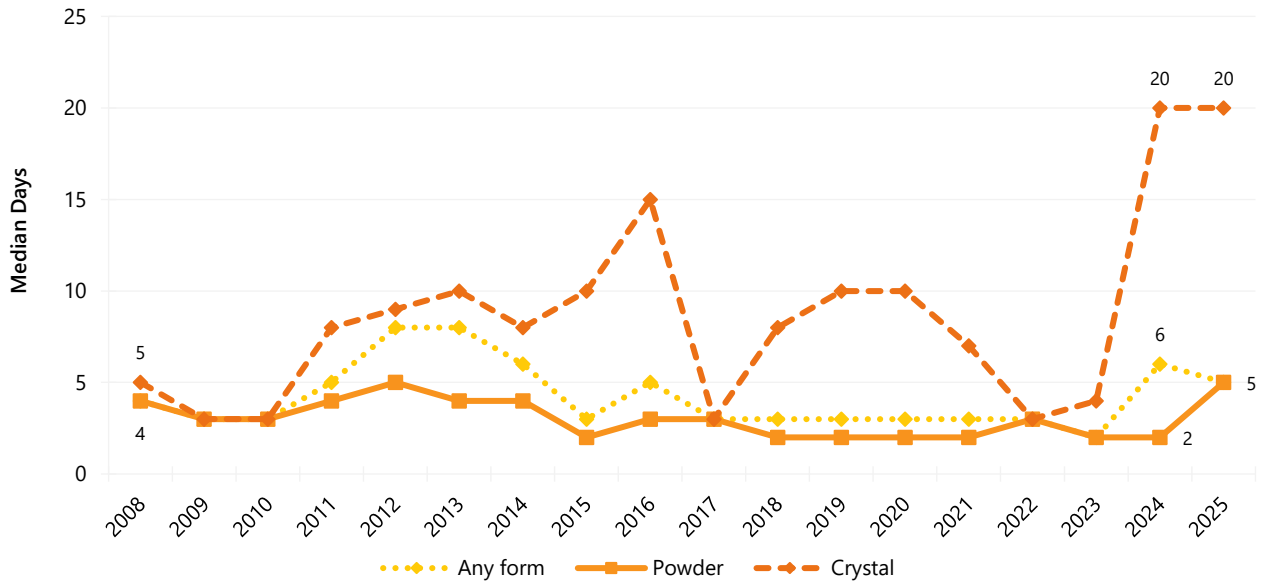
Among participants who had recently consumed any methamphetamine and commented (n=29), the median number of forms of methamphetamine used was one (IQR 1–1; 1 in 2024; IQR=1–1; n=29; p=0.222).

Figure 20: Past six month use of any methamphetamine, powder, and crystal, Melbourne, VIC, 2003-2025



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

Figure 21: Median days of any methamphetamine, powder, and crystal use in the past six months, Melbourne, VIC, 2003-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 25 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Patterns of Consumption (by form)

Methamphetamine Powder

Recent Use (past 6 months): Since 2003, methamphetamine powder has been the main methamphetamine form reportedly used. Use has declined over the period of monitoring, though remained stable in 2025 at 20% (20% in 2024) (Figure 20).

Frequency of Use: Amongst those who had recently consumed methamphetamine powder and commented (n=19), participants reported use on a median of five days (IQR=2–6) in the six months preceding interview in 2025, stable relative to 2024 (2 days; IQR=1–5; n=20; p=0.309) (Figure 21). Few participants (n≤5) reported weekly or more frequent use of powder in 2025.

Routes of Administration: Among participants who had recently consumed methamphetamine powder and commented (n=20), snorting was the most common route of administration, with all (100%) reporting this method in 2025 (85% in 2024; p=0.231). Few participants (n≤5) reported swallowing (n≤5 in 2024; p=0.605), smoking (n≤5 in 2024) or injecting as a route of administration (no participants in 2024).

Quantity: Of those who reported recent use and responded (n=12), the median amount of methamphetamine powder used in a 'typical' session was 0.20 grams (IQR=0.10–0.35; 0.30 grams in 2024; IQR=0.20–0.50 n=18; p=0.304). Of those who reported recent use and responded (n=12), the median maximum amount of powder used in a session was 0.25 grams (IQR=0.18–0.63) stable from 0.50 grams in 2024 (IQR=0.20–0.70; n=18; p=0.639).

Methamphetamine Crystal

Recent Use (past 6 months): Use of methamphetamine crystal has remained stable in recent years. In 2025, 10% of participants reported recent use of methamphetamine crystal (12% in 2024; p=0.817) (Figure 20).

Frequency of Use: Of those who had recently consumed methamphetamine crystal and commented (n=10), participants reported use on a median of 20 days (IQR=3–108) in the six months preceding interview in 2025, stable from 20 days in 2024 (IQR=6–93; n=12; p=0.750) (Figure 21). Few participants (n≤5) reported weekly or more frequent use of methamphetamine crystal in 2025 (n≤5 in 2024).

Routes of Administration: Among participants who had recently consumed methamphetamine crystal and commented (n=10), smoking remained the most common route of administration (70%; 92% in 2024; p=0.293).

Quantity: Of those who reported recent use and responded (n=9), the median amount of methamphetamine crystal used in a 'typical' session was 0.25 grams (IQR=0.10–0.40; 0.50 grams in 2024; IQR=0.30–1.00; n=10; p=0.163). Of those who reported recent use and responded (n=9), the median maximum amount of methamphetamine crystal used in a session was 0.80 grams (IQR=0.25–1.00; 1.93 grams in 2024; IQR=0.43–3.38; n=10; p=0.286).

Methamphetamine Base

Few participants (n≤5) reported use of methamphetamine base in 2025, therefore, details are supressed. For further information, please refer to the 2025 National IDRS report, or contact the Drug Trends team (drugtrends@unsw.edu.au).

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Price: Participants reported a median price of $200 per gram of methamphetamine powder in 2025 (IQR=195–200; n=12), stable from 2024 ($200; IQR=188–200; n=8; *p*=0.634).

Perceived purity: The perceived purity of methamphetamine powder in 2025 was comparable to 2024 (*p*=0.377). Of those who reported recent use and commented (n=15), 53% perceived methamphetamine powder purity to be 'medium' (Figure 23).

Perceived availability: The perceived availability of methamphetamine powder remained stable in 2025 (*p*=0.322) Among those who reported use and commented (n=15), 40% perceived methamphetamine powder as 'easy' to obtain (64% in 2024) (Figure 25).

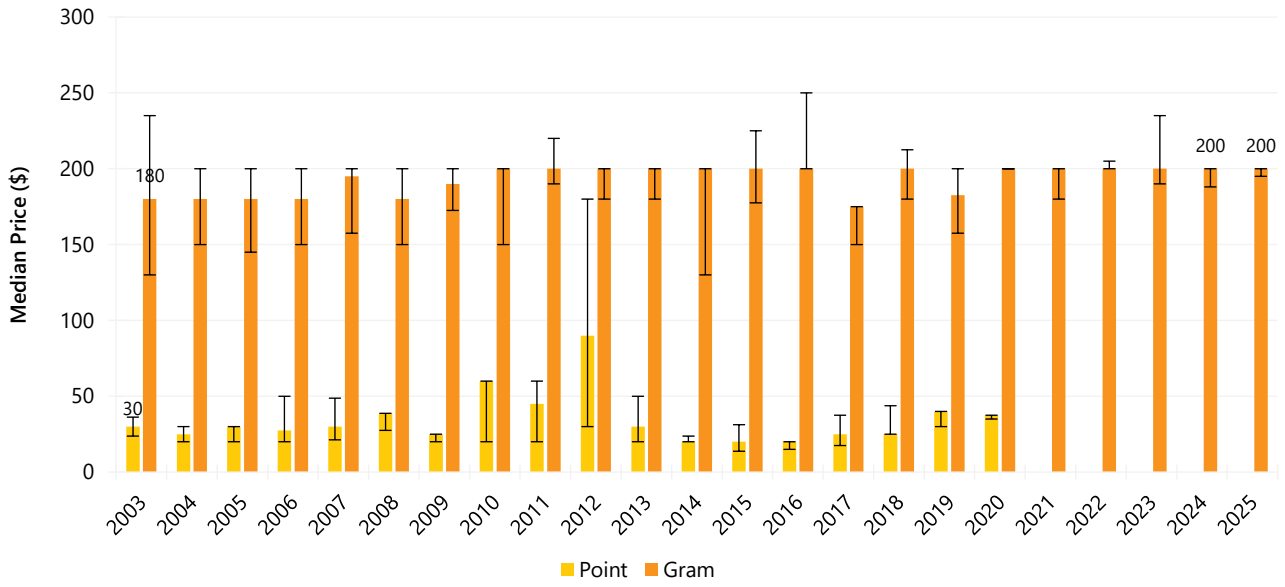
Methamphetamine Crystal

Price: Few (n≤5) participants were able to comment on the price of methamphetamine crystal in 2025 (n≤5 in 2024). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Perceived Purity: The perceived purity of methamphetamine crystal remained stable between 2024 and 2025 (*p*=0.588) (Figure 24). Due to low numbers (n≤5) for each of the responses, further details are suppressed.

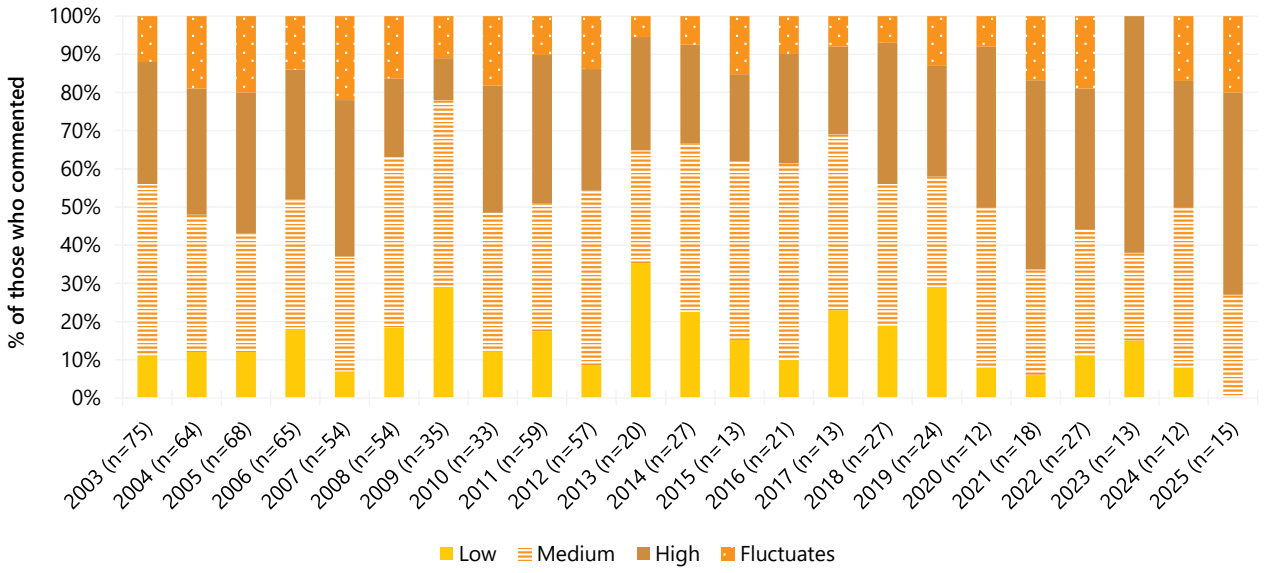
Perceived Availability: The perceived availability of methamphetamine crystal remained stable between 2024 and 2025 (*p*=0.754). Among those who were able to respond in 2025 (n=8), 88% reported methamphetamine crystal to be 'very easy' to obtain (64% in 2024) (Figure 26).

Figure 22: Median price of powder methamphetamine per point and gram, Melbourne, VIC, 2003-2025



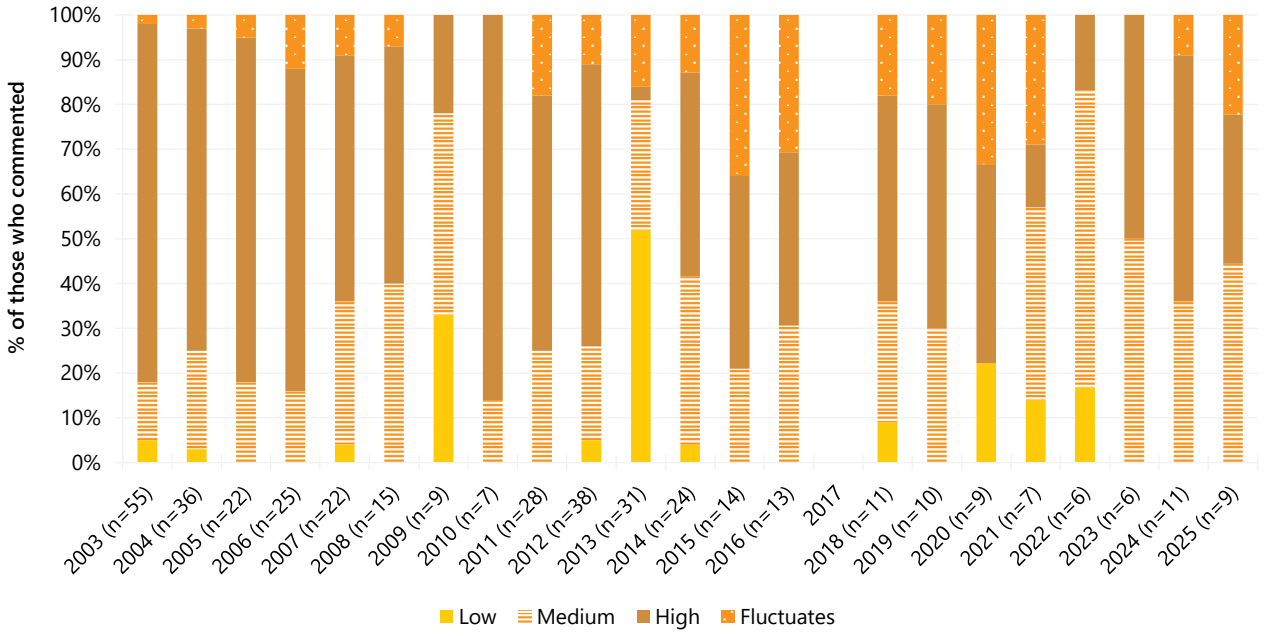
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure;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

Figure 23: Current perceived purity of powder methamphetamine, Melbourne, VIC, 2003-2025



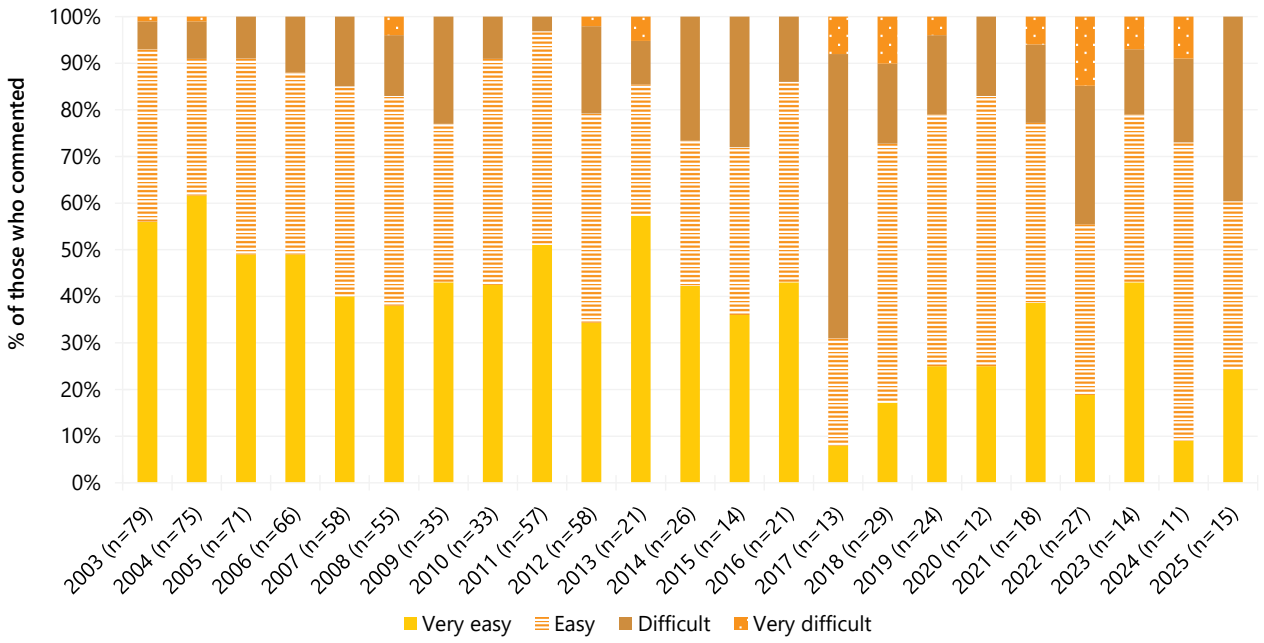
Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table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

Figure 24: Current perceived purity of methamphetamine crystal, Melbourne, VIC, 2003-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item (e.g. 2017). 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 25: Current perceived availability of powder methamphetamine, Melbourne, VIC, 2003-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables 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 26: Current perceived availability of methamphetamine crystal, Melbourne, VIC, 2003-2025

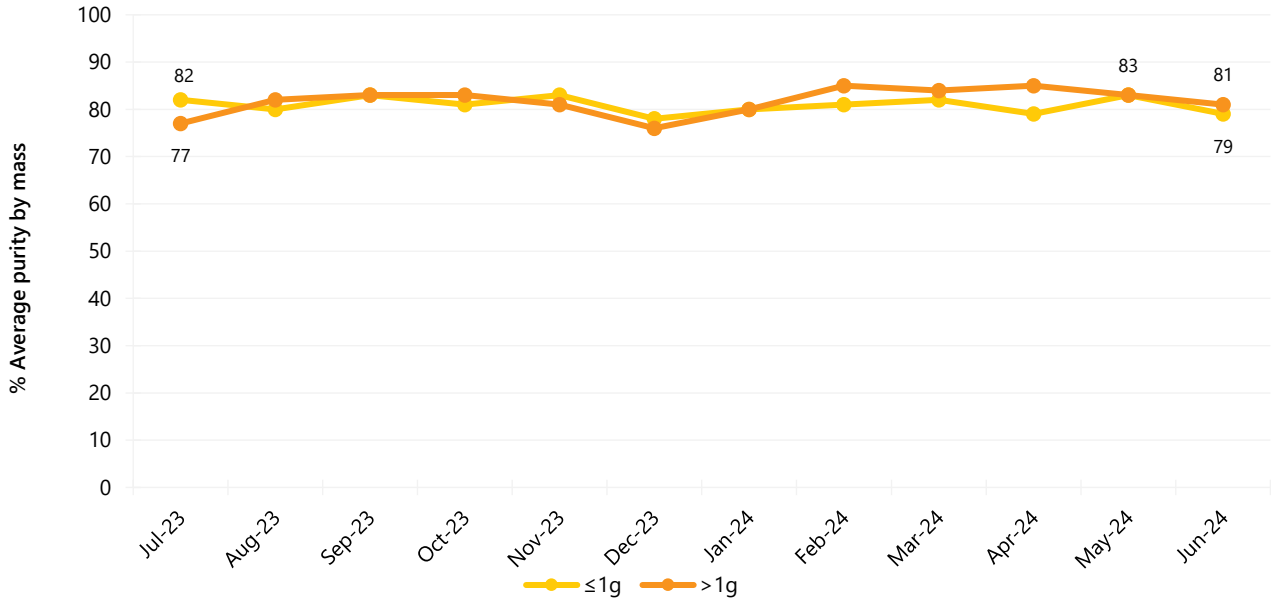
Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item (e.g. 2017). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Routinely Collected Data

Victoria Police Seizure Purity

Methamphetamine seizures analysed by the Victoria Police Forensic Services Department during the 2023/2024 financial year averaged 81% purity in those weighing one gram or less (IQR=80–82, range=78–83) and 82% in those weighing over one gram (IQR=81–83, range=76–85) (Figure 27).

Figure 27: Purity of methamphetamine seizures by Victorian law enforcement, July 2023–June 2024



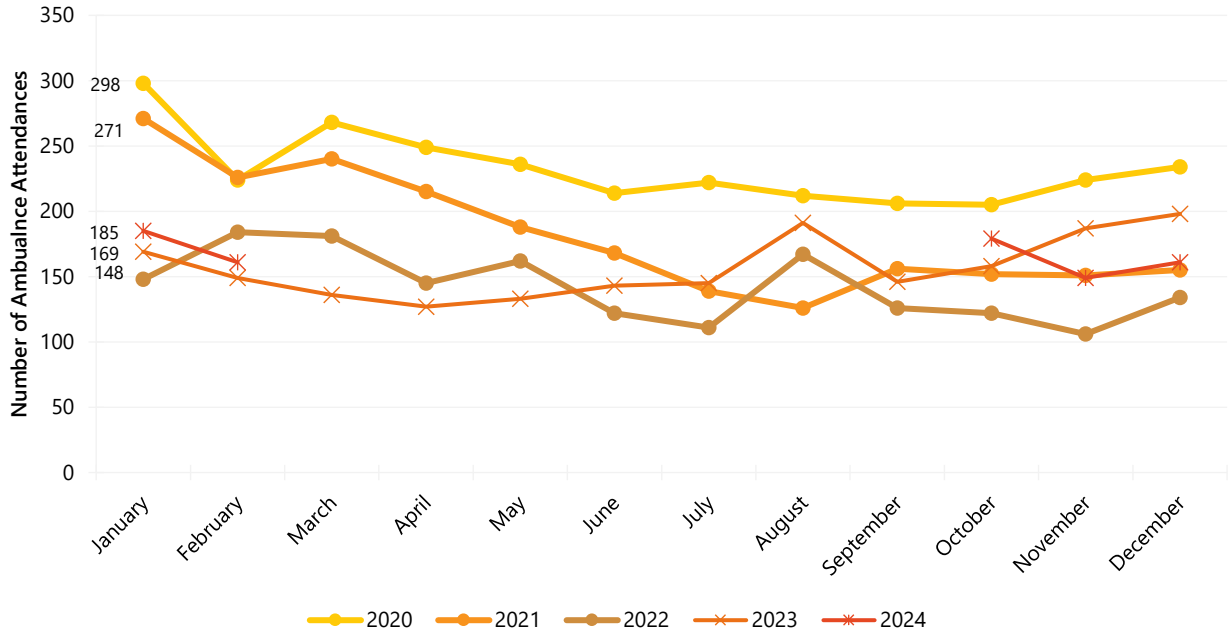
Note. Includes all forms (e.g., powder, base and crystal) of methamphetamine seized by Victoria Police. May not include every drug seized, as not all seized drugs undergo purity analysis. Data labels are only provided for first (Jul-23) and two most recent months (May-24, Jun-24) of monitoring.

Ambulance Attendances at Non-Fatal Drug Events

Due to paramedic industrial action from March to September 2024, data are missing and numbers of reported ambulance attendances are reduced during this period. Use of methamphetamine crystal was categorised separately from use of amphetamines in metropolitan Melbourne ambulance attendances for the first time in 2012.

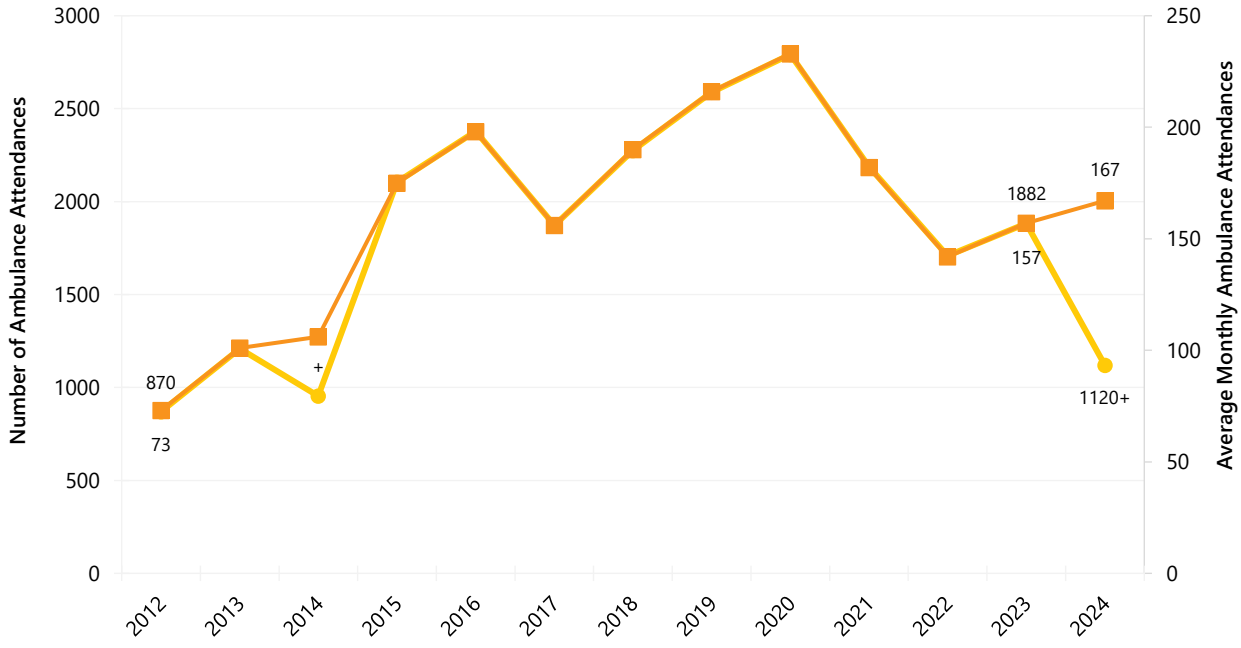
The number of methamphetamine-related ambulance attendances in metropolitan Melbourne ranged between 106 and 298 per month during 2017–2024 (excluding March to September 2024) (Figure 28). The annual number of methamphetamine-related attendances rose steadily between 2012 and 2022. In 2024 there were 1120 attendances, a decrease from 2023 (Figure 29). The median age of patients in 2024 was 34 years (range 28–43), consistent with recent years.

Figure 28: Number of methamphetamine-related events attended by Ambulance Victoria, Melbourne, 2020–2024



Note. Data suppressed from March to September 2024 due to industrial action. Source: Turning Point. Data labels are only provided for the first (January) month of monitoring in each year.

Figure 29: Number of methamphetamine-related events attended by Ambulance Victoria, Melbourne, 2012–2024



Note. + = Data missing from October-December 2014 and March-September 2024 due to industrial action. Source: Turning Point. Data labels are only provided for the first (2012) and two most recent years (2023 and 2024) of monitoring.

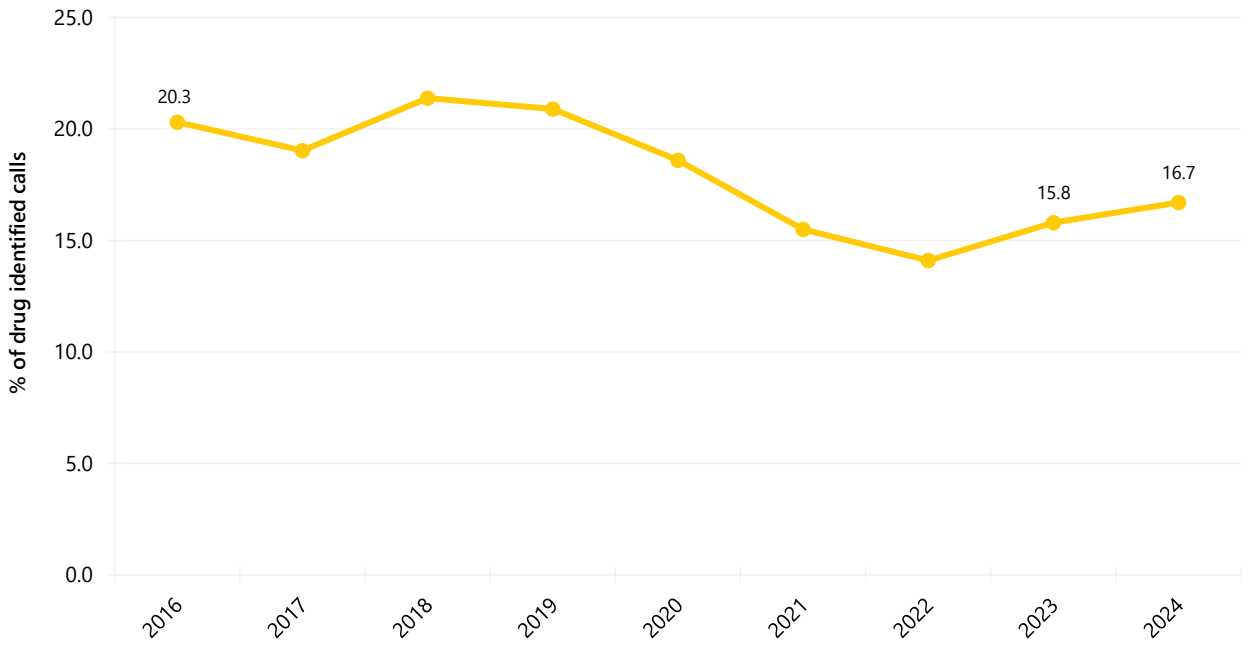
ADIS\VADC

In 2023/2024, 15,447 courses of treatment were delivered for methamphetamine, equivalent to 18.5% of the total courses delivered. This represents an increase of 27.2% in courses delivered from 2022/23 (12,145).

DirectLine

During 2024, DirectLine received 3,615 calls in which methamphetamine was identified as the drug of concern, representing 16.7% of all drug-identified calls to DirectLine in that year. The percentage of drug-related calls in which methamphetamine was identified as the drug of concern has remained fairly stable since monitoring began in 2016 (Figure 30).

Figure 30: Percentage of calls to DirectLine in which methamphetamine was identified as drug of concern, Victoria 2016–2024



Source: DirectLine, Turning Point. Data labels are provided only for the first (2016) and two most recent years of monitoring (2023 and 2024).

4

Non-Prescribed Pharmaceutical Stimulants

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

Patterns of Consumption

Recent Use (past 6 months)

The percentage of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has steadily increased since the commencement of monitoring, from 9% in 2007 to a peak of 66% in 2021 (Figure 31). Self-reported recent use of non-prescribed stimulants in 2025 was similar to 2024 (65%; 60% in 2024; p=0.557).

Frequency of Use

Frequency of use remained stable in 2025, at a median of six days in the six months prior to interview (IQR=2–12; n=65; 5 days in 2024; IQR=2–12; n=60; p=0.907) (Figure 31).

Routes of Administration

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=65), the vast majority reported swallowing as a route of administration (97%; 95% in 2024; p=0.670), with fewer participants reporting snorting (15%; 22% in 2024; p=0.482).

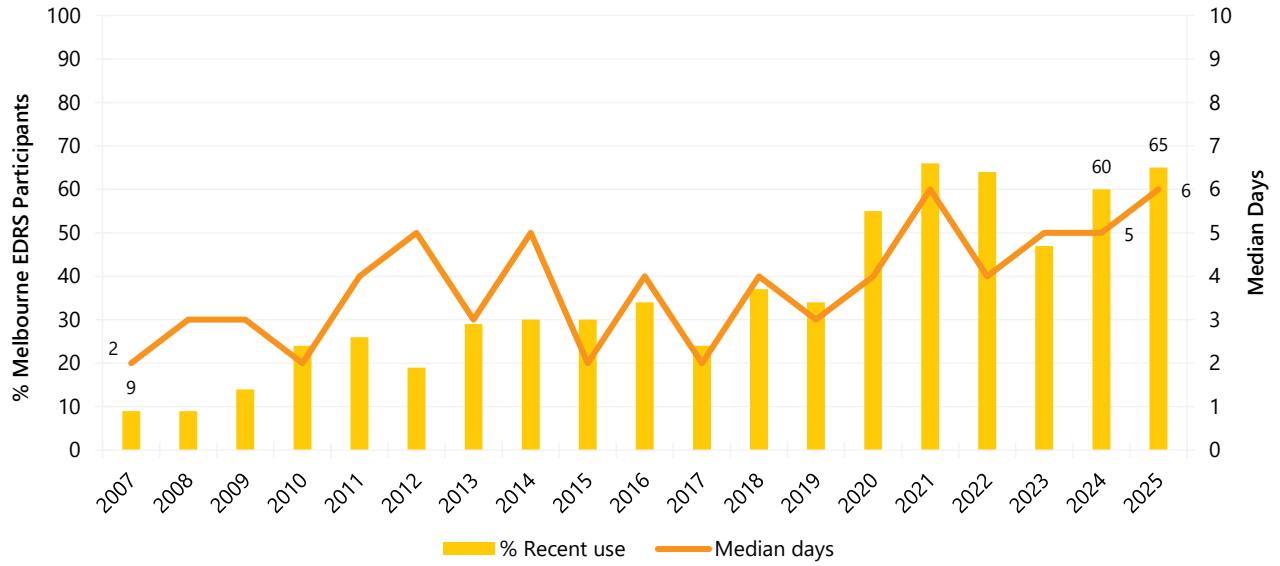
Quantity

Among those who reported recent use and responded (n=53), the median amount used in a 'typical' session was one pill/tablet (IQR=1–2; 1.5 pills/tablets in 2024; IQR=1–2; n=53; p=0.070). Of those who reported recent use and responded (n=53), the median maximum amount used in a session was two pills/tablets (IQR=1–3; 2 pills/tablets in 2024; IQR=1–3.8; n=54; p=0.481).

Forms Used

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=65), the majority reported using dexamphetamine (89%; 82% in 2024; p=0.307). There was a significant decline in reported use of Ritalin in 2025 (25%; 43% in 2024; p=0.039). One fifth (22%) reported recent use of lisdexamfetamine (25% in 2024; p=0.678), while few participants (n≤5) reported recent use of modafinil (n≤5 in 2024; p=0.197).

Figure 31: Past six month use and frequency of use of non-prescribed pharmaceutical stimulants, Melbourne, VIC, 2007-2025



Note. Monitoring of pharmaceutical stimulants commenced in 2007. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Price and Perceived Availability

Price and availability data for non-prescribed pharmaceutical stimulants were collected from 2022.

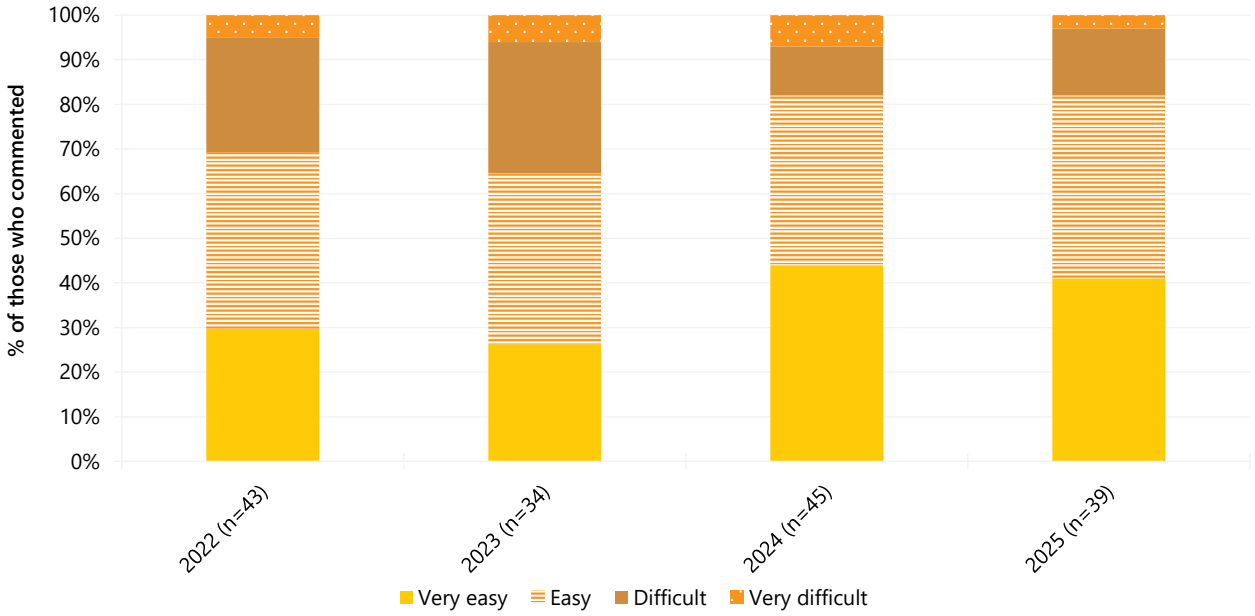
Price

Participants reported a median price of $7 per 5mg tablet in 2025 (IQR=5–10; n=14; $5 in 2024; IQR=4–8; n=7; p=0.336). Few participants (n≤5) reported on the price of 10mg tablets/pills in 2025 ($7 per 10mg in 2024; IQR=3–10; n=6; p=0.686).

Perceived Availability

The perceived availability of non-prescribed pharmaceutical stimulants remained stable in 2025 relative to 2024 (p=0.805). Among those who responded in 2025 (n=39), 41% perceived non-prescribed pharmaceutical stimulants to be 'very easy' to obtain (44% in 2024), with a further 41% perceiving availability as 'easy' (38% in 2024) (Figure 32).

Figure 32: Current perceived availability of non-prescribed pharmaceutical stimulants, Melbourne, VIC, 2022-2025



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

5

Cocaine

Participants were asked about their recent (past six month) use of various forms of cocaine, including powder and crack/rock cocaine. Cocaine hydrochloride, a salt derived from the coca plant, is the most common form of cocaine available in Australia. 'Crack' cocaine is a form of freebase cocaine (hydrochloride removed). '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 gradually increased since monitoring began but has since plateaued. In 2025, 84% of the Melbourne sample reported recent use, stable relative to 80% in 2024 (p=0.576) (Figure 33).

Frequency of Use

Reported frequency of use of cocaine has also gradually increased in recent years, with a median of 9 days (IQR=3–15; n=84) of use in the six months preceding interview in 2025, stable relative to 8 days in 2024 (IQR=3–14; p=0.525). Around one fifth (19%) of those who had recently used cocaine reported weekly or more frequent use, stable relative to 2024 (15%; p=0.533).

Routes of Administration

Among participants who had recently consumed cocaine and commented (n=84), the majority (99%) reported snorting cocaine, stable relative to 2024 (99%). Few participants (n≤5) reported swallowing cocaine in 2025 (n≤5 in 2024; p=0.682).

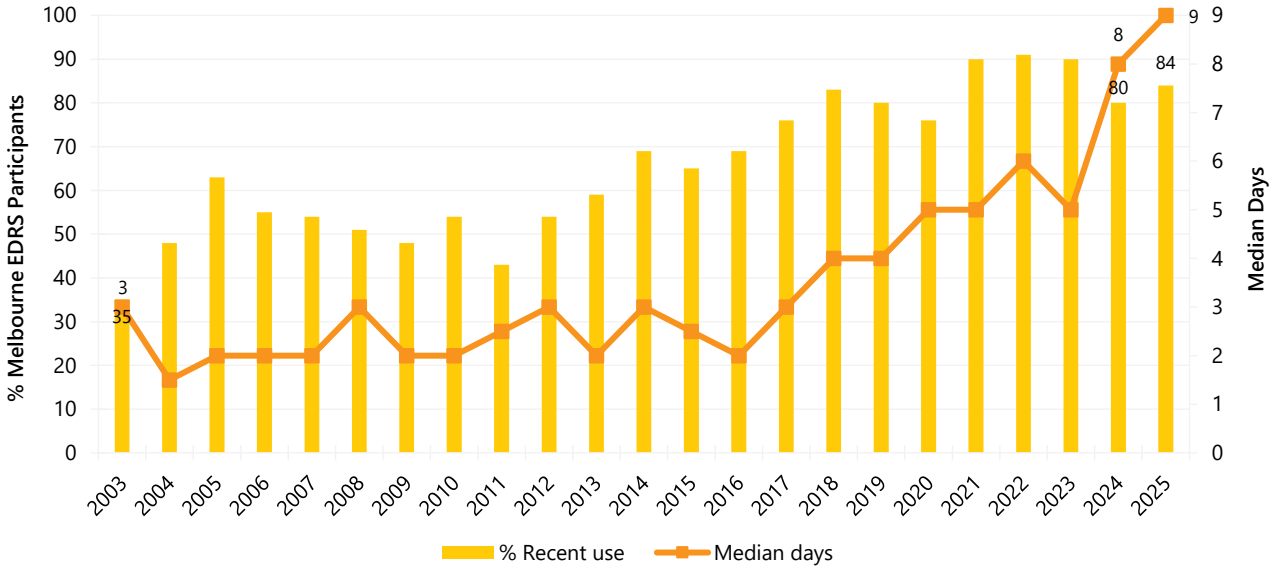
Quantity

Of those who reported recent use and responded (n=64), the median amount of cocaine used in a 'typical' session was 0.50 grams (IQR=0.25–0.85; 0.50 grams in 2024; IQR=0.20–0.50; n=62; p=0.609). Of those who reported recent use and responded (n=64), the median maximum amount of cocaine used in a session was 0.70 grams (IQR=0.48–1.00; 0.50 grams in 2024; IQR=0.38–1.00; n=64; p=0.718).

Forms Used

Among participants who had recently consumed cocaine and commented (n=84), the majority (96%) reported using powder cocaine (93% in 2024; p=0.320), with 15% reporting recent use of crack/rock cocaine (9% in 2024; p=0.240).

Figure 33: Past six month use and frequency of use of cocaine, Melbourne, VIC, 2003-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 8 days to improve visibility of trends for days of use. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Price, Perceived Purity and Perceived Availability

Price

Although the median reported price per gram of cocaine in 2025 was stable at $350, (IQR=350–350 variability decreased compared to 2024 ($350; IQR=300–350; p=0.010) (Figure 34).

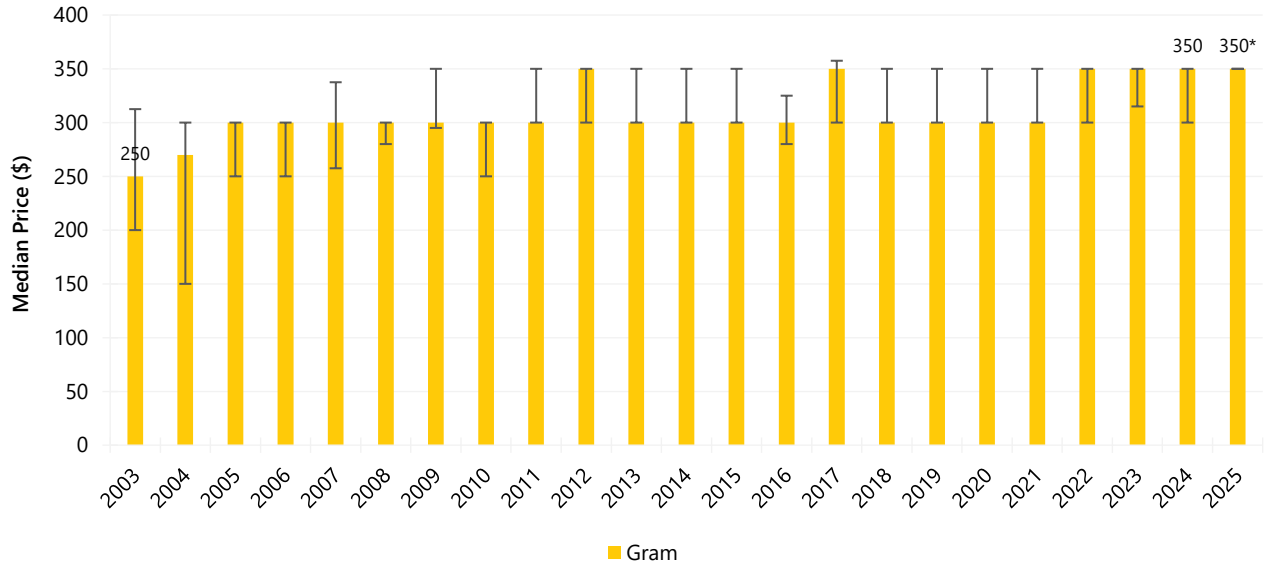
Perceived Purity

The perceived purity of cocaine remained stable between 2024 and 2025 (p=0.444). Among those who were able to respond in 2025 (n=65), 34% perceived purity to be 'medium' (35% in 2024), with 28% reporting it to be 'high' (20% in 2024). A further 22% reported that purity 'fluctuates' (18% in 2024), while 17% perceived purity to be 'low' (27% in 2024) (Figure 35).

Perceived Availability

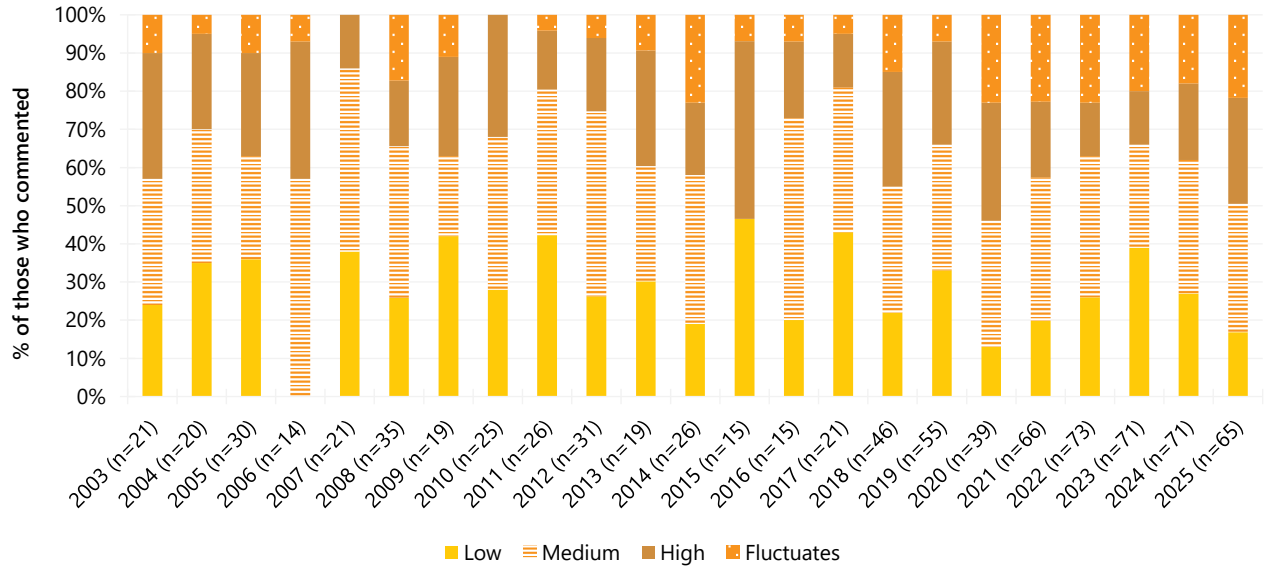
The perceived availability of cocaine remained stable between 2024 and 2025 (p=0.154). Among those who were able to respond in 2025 (n=65), 57% reported cocaine to be 'very easy' to obtain (46% in 2024), with a further 35% reporting it to be 'easy' to obtain (39% in 2024) (Figure 36).

Figure 34: Median price of cocaine per gram, Melbourne, VIC, 2003-2025



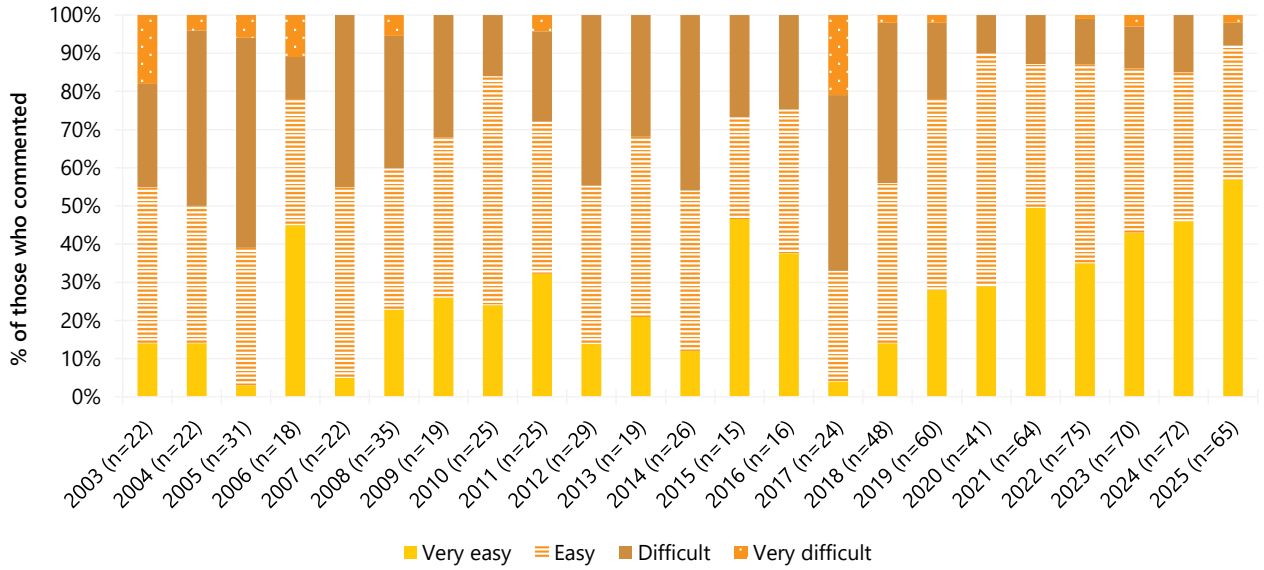
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure;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

Figure 35: Current perceived purity of cocaine, Melbourne, VIC, 2003-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables 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 36: Current perceived availability of cocaine, Melbourne, VIC, 2003-2025



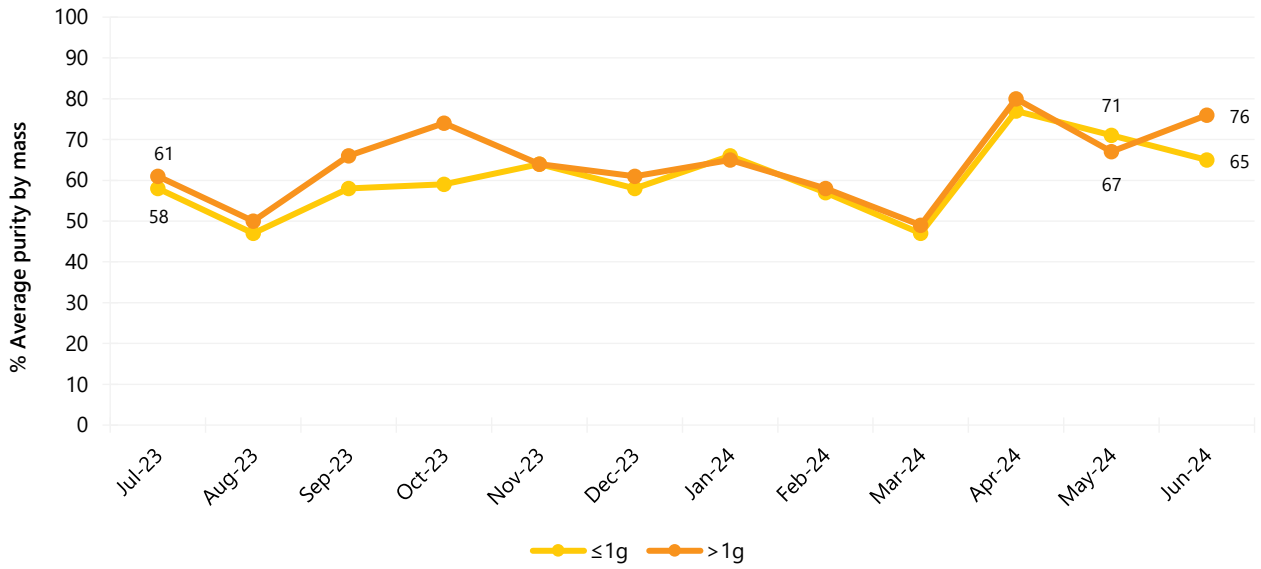
Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table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

Routinely Collected Data

Victoria Police Seizure Purity

Cocaine seizures analysed by the Victoria Police Forensic Services Department during the 2023/24 financial year averaged 61% purity in those weighing one gram or less (IQR=58–65, range=47–77) and 64% in those weighing over one gram (IQR=60–69, range=49–80) (Figure 37).

Figure 37: Purity of cocaine seizures by Victorian law enforcement, July 2023–June 2024

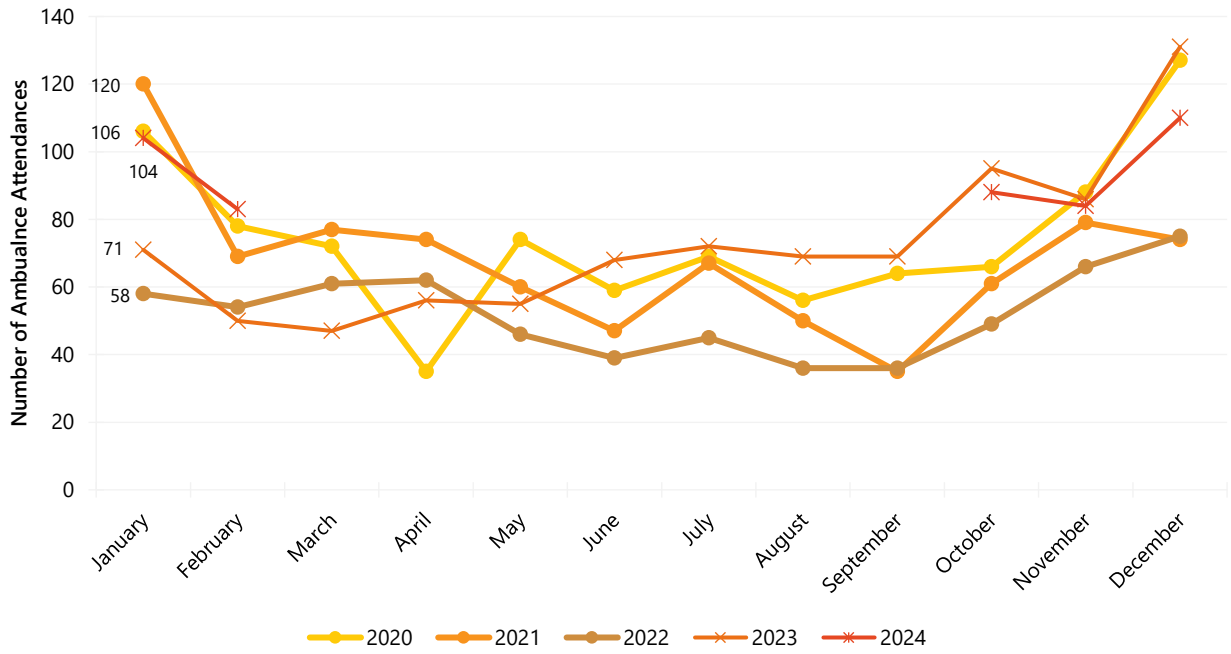


Note. May not include every drug seized, as not all seized drugs undergo purity analysis. Data labels are only provided for the first (Jul-23) and last two months (May-24, Jun-24) of monitoring.

Ambulance Attendances at Non-Fatal Drug Events

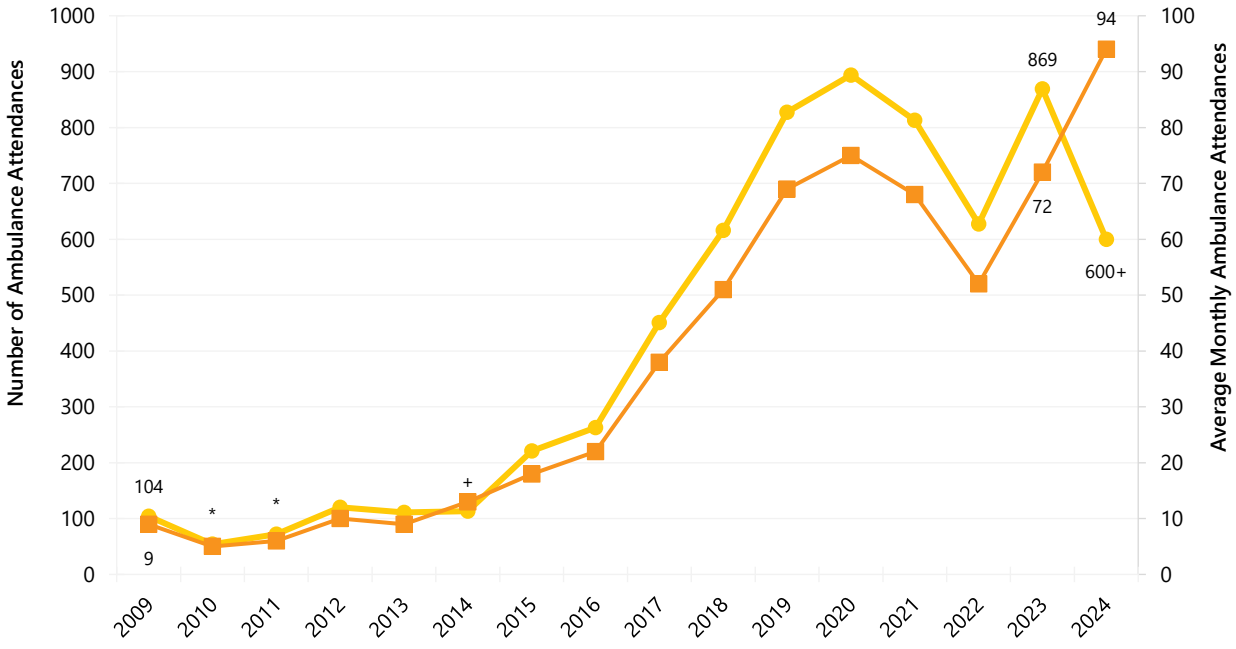
Due to paramedic industrial action from March to September 2024, data are missing and numbers of reported ambulance attendances are reduced during this period. The number of cocaine-related ambulance attendances in metropolitan Melbourne ranged between 25 and 131 per month during 2017–2024 (excluding March to September 2024) (Figure 38). The annual number of cocaine-related attendances rose steadily between 2015 and 2023. In 2024 there were 600 attendances, a decrease from 2023 (Figure 39). The median age of patients in 2024 was 27 years (range=22–33), consistent with previous years.

Figure 38: Number of cocaine-related events attended by Ambulance Victoria, Melbourne, 2020–2024



Note. Data suppressed from March to September 2024 due to industrial action. Source: Turning Point. Data labels are only provided for the first (January) month of monitoring in each year.

Figure 39: Number of cocaine-related events attended by Ambulance Victoria, Melbourne, 2009-2024



Note. * = Some months excluded due to small numbers (≤5). + = Data missing from October-December 2014 and March-September 2024 due to industrial action. Source: Turning Point. Data labels are only provided for the first (2009) and two most recent years (2023 and 2024) of monitoring.

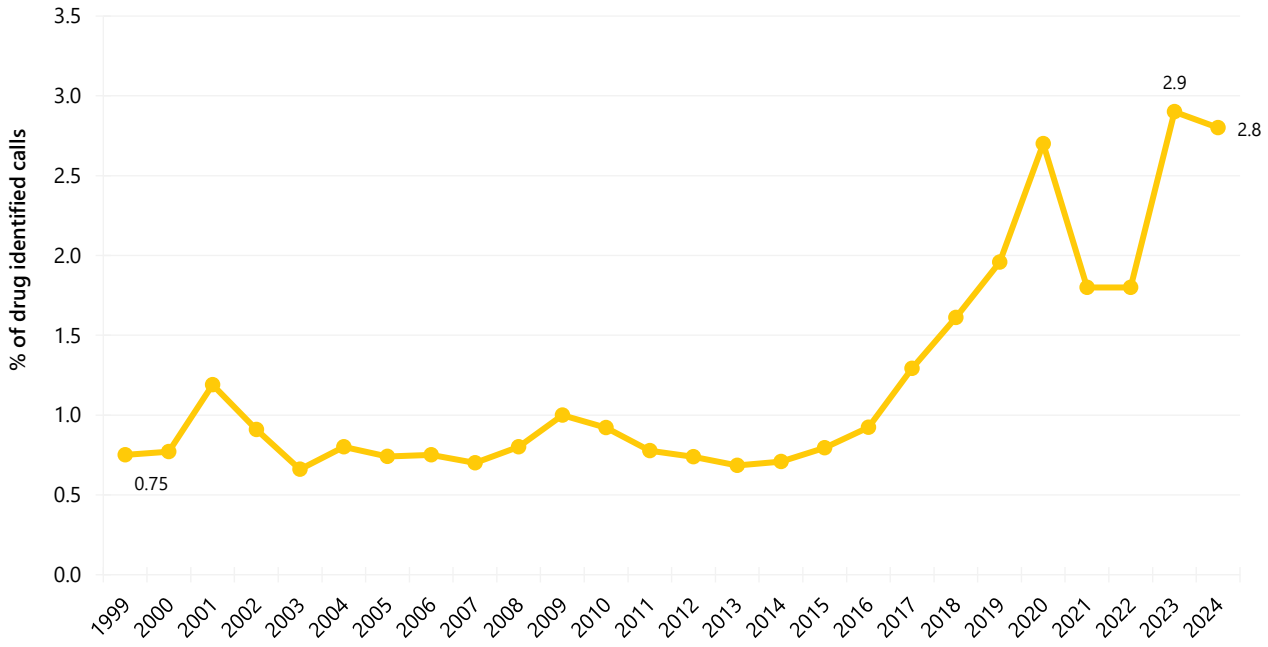
ADIS\VADC

In 2023/2024, 975 courses of treatment were delivered for cocaine, equivalent to 1.0% of the total courses delivered. This represents an increase of 89% in courses delivered from 2022/23 (516).

DirectLine

During 2024, DirectLine received 612 calls in which cocaine was identified as the drug of concern, representing 2.8% of all drug-identified calls to DirectLine in that year, stable from 2023 (Figure 40).

Figure 40: Percentage of calls to DirectLine in which cocaine was identified as drug of concern, Victoria 1999–2024



Source: DirectLine, Turning Point. Data labels are only provided for the first (1999) and two most recent years (2023 and 2024) of monitoring.

6

Cannabis and/or Cannabinoid-Related Products

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

Terminology throughout this chapter refers to:

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

Patterns of Consumption

Participants were asked about their use of both prescribed and non-prescribed cannabis and/or cannabinoid-related products. In 2025, 11% of participants reported prescribed use in the six months preceding interview (12% in 2024).

In the remainder of this chapter, data from 2021-2025, and from 2003-2016, refers to non-prescribed cannabis use only, while data from 2017-2020 refers to 'any' cannabis use (including hydroponic and bush cannabis, hashish and hash oil). While comparison between 2021-2025 and previous years should be treated with caution, the relatively recent legalisation of medicinal cannabis in Australia and the small percentage reporting prescribed use between 2022 and 2025 lends confidence that estimates are relatively comparable.

Recent Use (past 6 months)

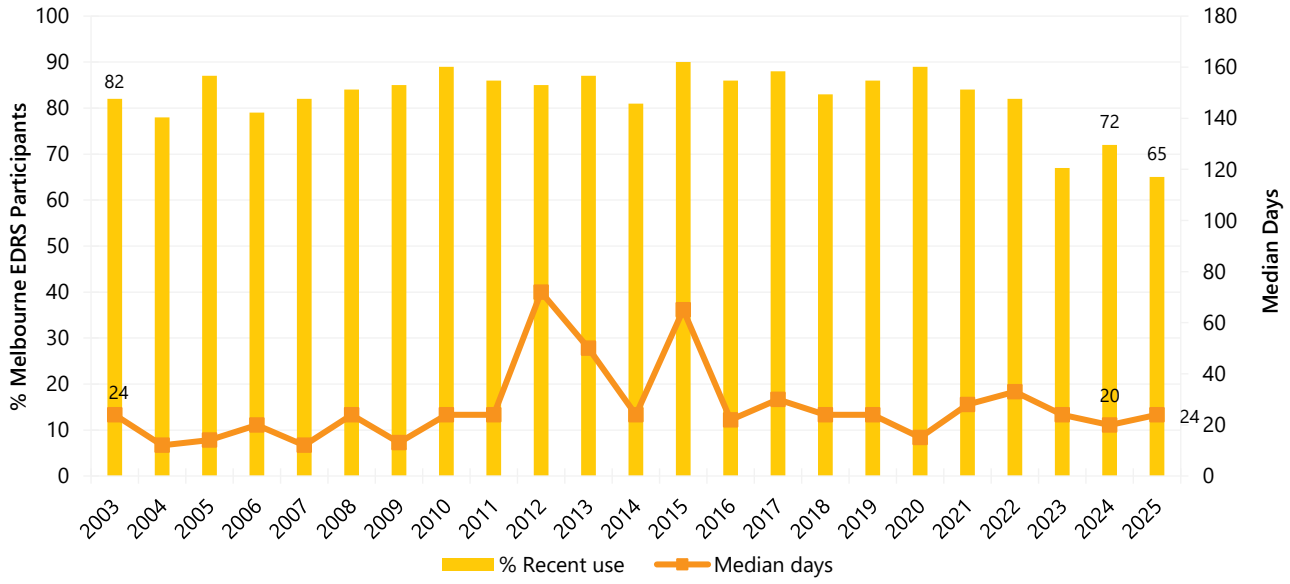
Sixty-five per cent of the Melbourne sample reported recent use of non-prescribed cannabis and/or cannabinoid-related products in 2025, stable relative to 2024 (72%; p=0.363) (Figure 41).

Frequency of Use

Frequency of reported cannabis use has varied between fortnightly and several times per week over the course of monitoring. Of those who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented (n=65), participants reported a median of 24 days (IQR=4–160) of use in the six months preceding interview in 2025, stable relative to 2024 (20 days; IQR=7–180; n=72; p=0.415) (Figure 42). Half (51%) of those who had recently used non-prescribed

cannabis and/or cannabinoid-related products reported weekly or more frequent use (49% in 2024; *p*=0.861), including 22% who reported daily use, stable from 2024 (26%; *p*=0.549).

Figure 41: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid-related products, Melbourne, VIC, 2003-2025



Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Further, from 2022 onwards, we captured use of 'cannabis and/or cannabinoid-related products', while in previous years questions referred only to 'cannabis'. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented (n=65), the majority (91%) reported smoking, stable relative to 2024 (90%). One quarter (23%) reported swallowing, a significant decrease relative to 2024 (44%; *p*=0.013). Few participants (n≤5) reported inhaling/vaporising in 2025, a significant decrease from 2024 (28% in 2024; *p*=0.003).

Quantity

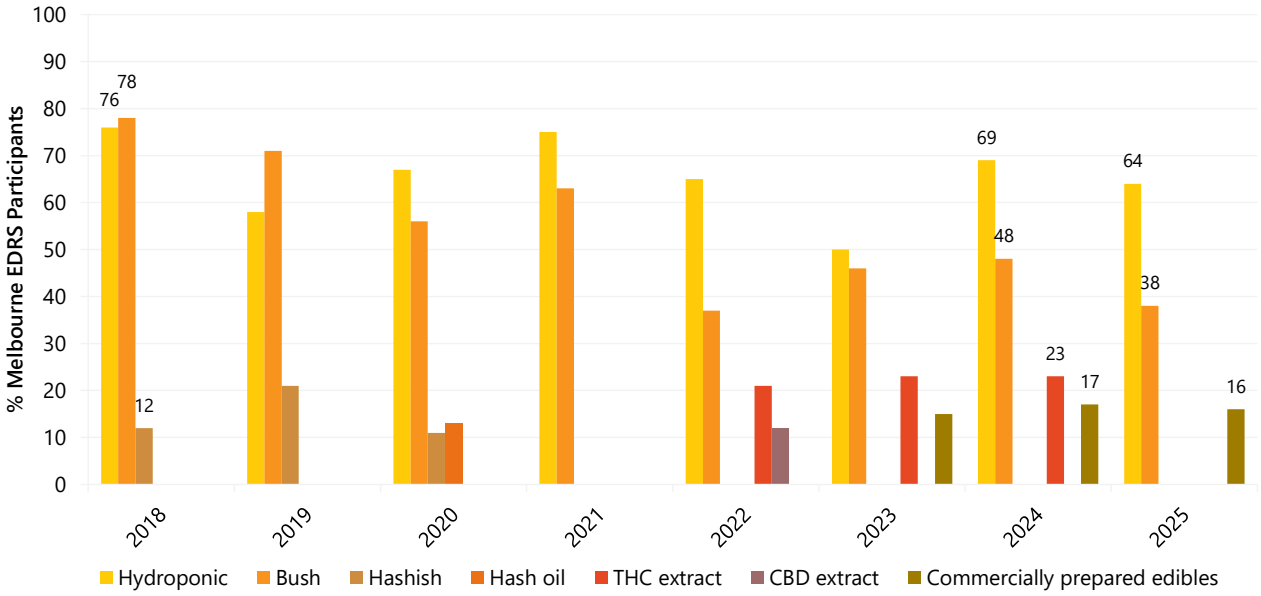
Of those who reported recent non-prescribed use and responded, the median amount of non-prescribed cannabis and/or cannabinoid-related products used on the last occasion of use was two cones (IQR=2–4; n=14; 2 cones in 2024; IQR=1-6; *p*=0.701) or 1.0 grams (IQR=0.63–1.50; n=18; 0.70 grams in 2024; IQR=0.50–1.00; n=25; *p*=0.238) or one joint (IQR=0.5–1.0; n=19; 1 joint in 2024; IQR=0.5–1.3; n=20; *p*=0.728).

Forms Used

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and responded (n=55), 64% reported recent use of hydroponic cannabis (69% in 2024; *p*=0.680). This was followed by 38% reporting recent use of outdoor grown 'bush' cannabis,

stable 2024 (48%; p=0.425). Sixteen per cent of participants reported recent use of commercially prepared edibles (17% in 2024). Few participants (n≤5) reported recent use of THC extract, a significant decrease from 2024 (23%; p=0.019). Few participants (n≤5) reported having used hashish, hash oil and non-prescribed CBD extract in the preceding six months.

Figure 42: Past six month use of different forms of non-prescribed cannabis and/or cannabinoid-related products, among those who reported recent non-prescribed use, nationally, 2018-2024



Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2018-2020 figures include some participants who were using prescribed forms of cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. *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: Due to low numbers (n≤5) reporting on the price of non-prescribed hydroponic cannabis in 2025, data are supressed. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Perceived Potency: The perceived potency of non-prescribed hydroponic cannabis remained stable between 2024 and 2025 (p=0.450). Among those who were able to respond in 2025 (n=23), half (52%) perceived non-prescribed hydroponic cannabis to be of 'high' potency (64% in 2024), with a further 30% perceiving it to be 'medium' (27% in 2024) (Figure 44A).

Perceived Availability: The perceived availability of non-prescribed hydroponic cannabis remained stable between 2024 and 2025. Among those who were able to respond in 2025 (n=24), 75% perceived non-prescribed hydroponic cannabis to be 'very easy' to obtain (71% in 2024) (Figure 45A).

Bush Cannabis

Price: Due to low numbers (n≤5) reporting on the price of non-prescribed bush cannabis in 2025, further details are supressed. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Perceived Potency: The perceived potency of non-prescribed bush cannabis remained stable between 2024 and 2025 (p=0.369). Among those who were able to respond in 2025 (n=11), 55% perceived the potency of non-prescribed bush cannabis to be 'medium' (43% in 2024) (Figure 44B).

Perceived Availability: The perceived availability of non-prescribed bush cannabis remained stable between 2024 and 2025 (p=0.353). Among those who were able to respond in 2025 (n=11), 64% perceived non-prescribed bush cannabis to be 'very easy' to obtain (76% in 2024) (Figure 45B).

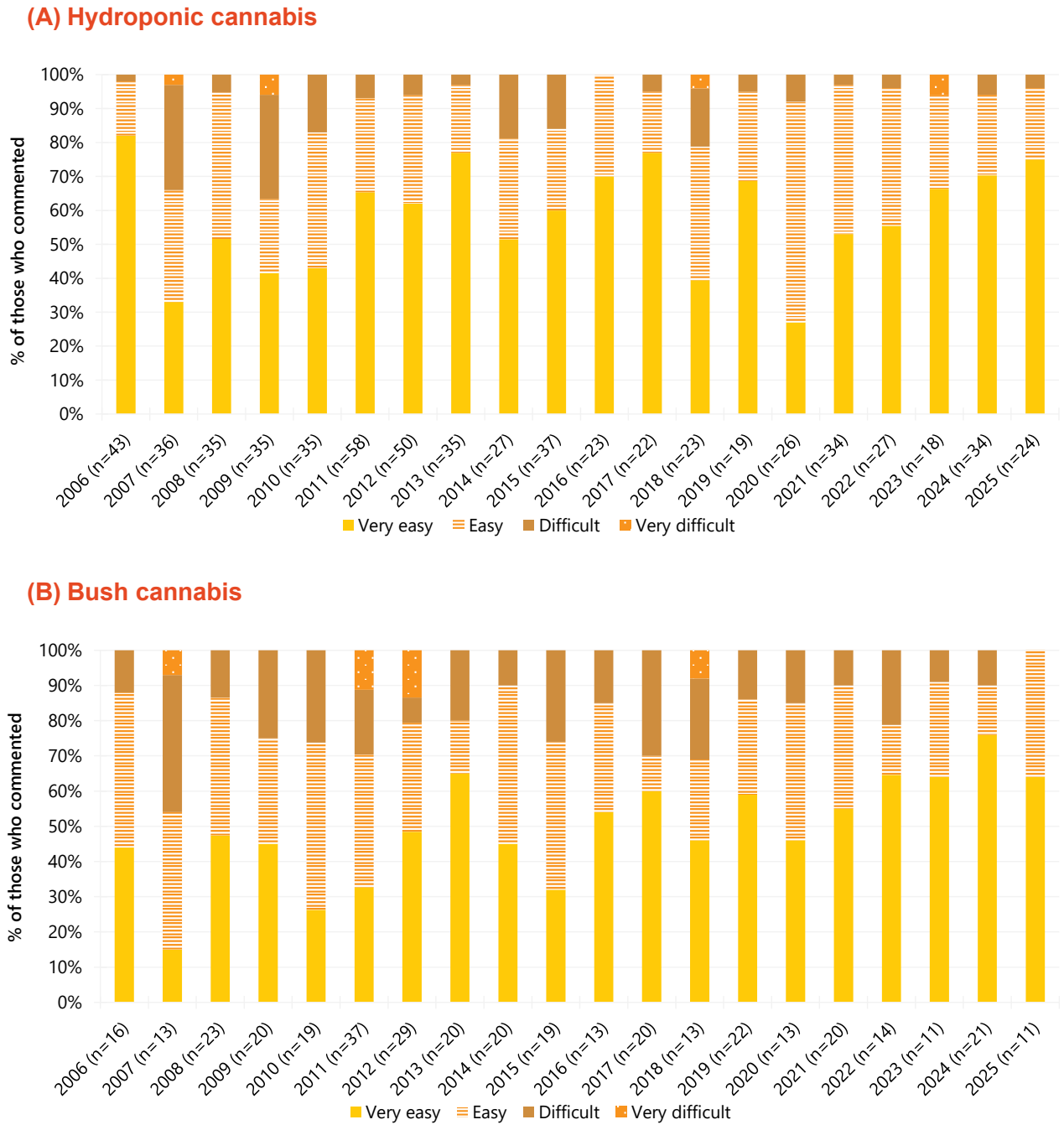
Figure 43: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Melbourne, VIC, 2006-2025

Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the price of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 44: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Melbourne, VIC, 2006-2025

Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the perceived potency of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables 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 45: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Melbourne, VIC, 2006-2025



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

Routinely Collected Data

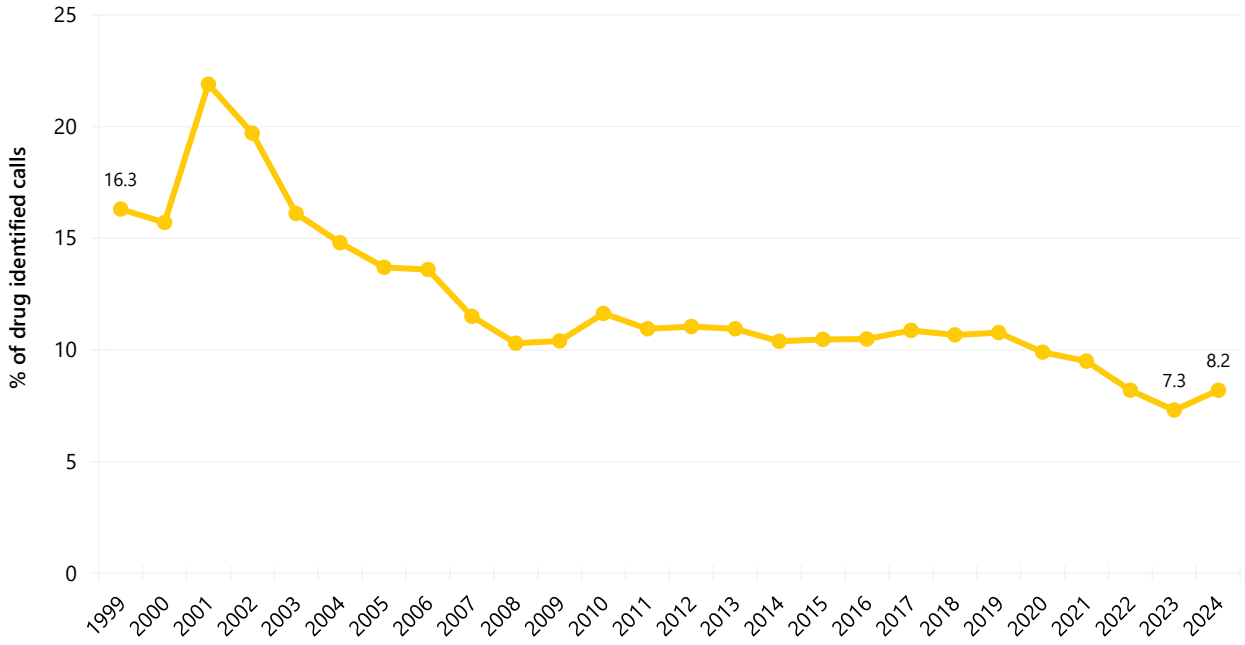
ADIS\VADC

In 2023/24, 15,601 courses of treatment were delivered for cannabis, equivalent to 16.0% of the total courses delivered. This represents an increase of 66.7% from courses delivered in 2022/23 (9,356).

DirectLine

During 2024, DirectLine received 1,767 calls in which cannabis was identified as the drug of concern, accounting for 8.2% of all drug-identified calls to DirectLine in 2024. The percentage of drug-related calls in which cannabis was identified as the drug of concern has been largely consistent since 2008, but declining since 2019 (Figure 46).

Figure 46: Percentage of calls to DirectLine in which cannabis was identified as drug of concern, Victoria 1999–2024



Source: DirectLine, Turning Point. Data labels provided are only provided for the first (1999) and the two most recent years (2023 and 2024) of monitoring.

7

Ketamine, LSD and DMT

Non-Prescribed Ketamine

Patterns of Consumption

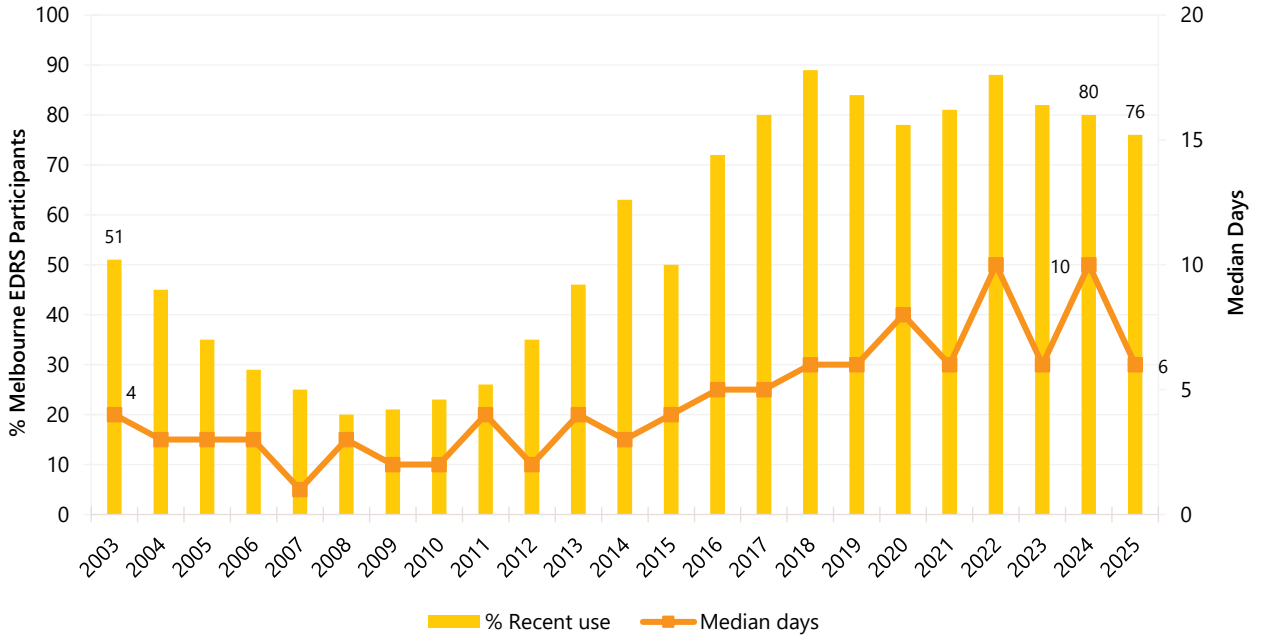
Recent Use (past 6 months): Around three quarters (76%) of the Melbourne sample reported using non-prescribed ketamine in the six months prior to interview, stable from 2024 (80%; *p*=0.607) (Figure 47).

Frequency of Use: Of those who had recently consumed non-prescribed ketamine and commented (n=76), median days of use decreased significantly to 6 days in 2025 (IQR=3–12), relative to 2024 (10 days; IQR=4–20; n=80; *p*=0.047) (Figure 47). Around one tenth (12%) of the sample reported weekly or more frequent use in 2025 (18% in 2024; *p*=0.370).

Routes of Administration: Among participants who had recently consumed non-prescribed ketamine and commented (n=76), 99% reported snorting in 2025, stable from 2024 (98%).

Quantity: Of those who reported recent use and responded (n=49), the median amount of non-prescribed ketamine used in a 'typical' session was 0.20 grams (IQR=0.10–0.40; 0.25 grams in 2024; IQR=0.10–0.50; n=67; *p*=0.344). Of those who reported recent use and responded (n=49), the median maximum amount of non-prescribed ketamine used in a session was 0.30 grams (IQR=0.20–0.80; 0.50 grams in 2024; IQR=0.25–1.00; n=67; *p*=0.289).

Figure 47: Past six month use and frequency of use of non-prescribed ketamine, Melbourne, VIC, 2003-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 20 days to improve visibility of trends. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

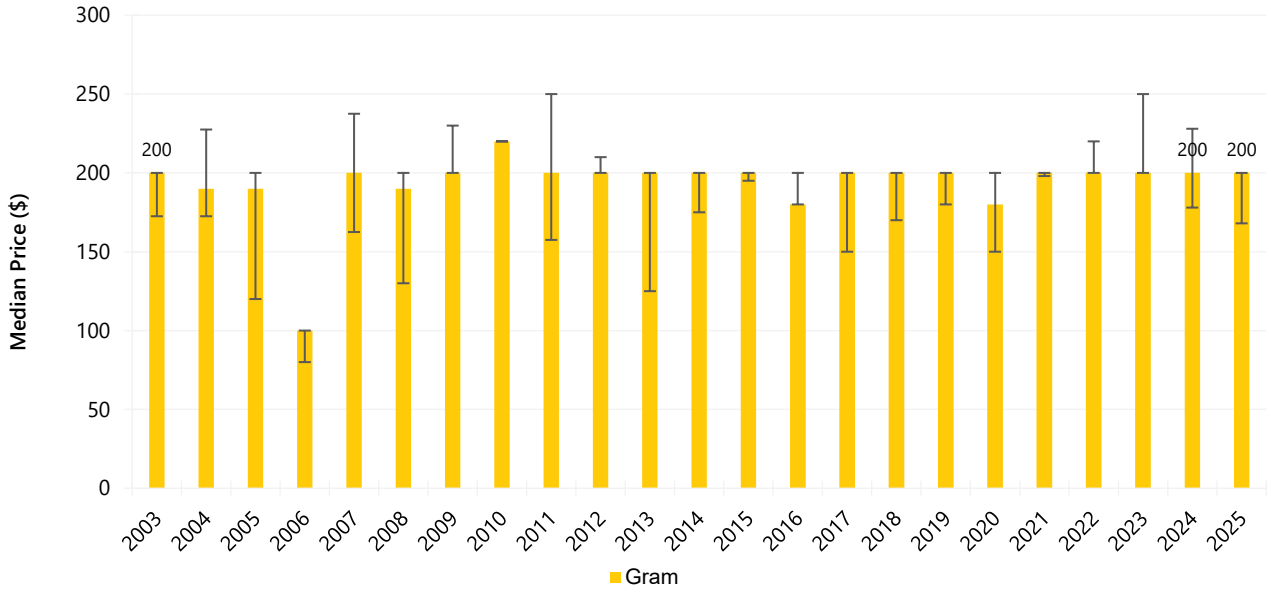
Price, Perceived Purity and Perceived Availability

Price: The median price per gram of ketamine in 2025 was $200 (IQR=168–200; n=30; $200 in 2024; IQR=178–228; n=40) (Figure 48).

Perceived Purity: The perceived purity of non-prescribed ketamine remained stable between 2024 and 2025 (p=0.838). Among those who were able to comment in 2025 (n=48), 56% perceived the purity of ketamine to be 'high' (53% in 2024) and 23% perceived it to be 'medium' (26% in 2024) (Figure 49).

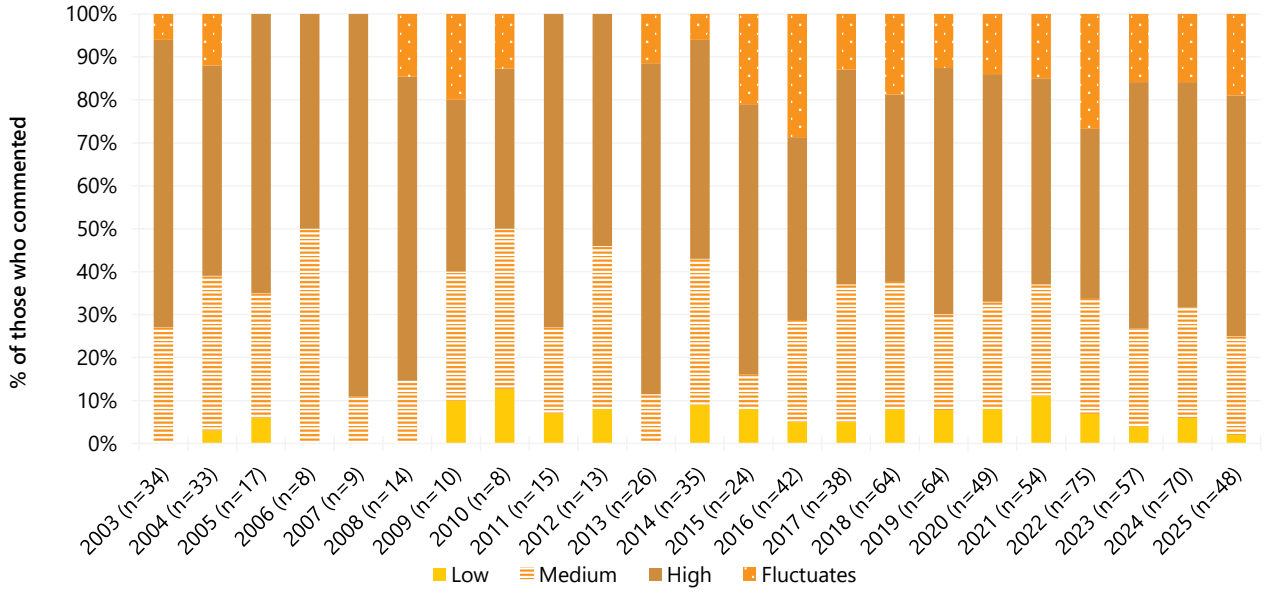
Perceived Availability: The perceived availability of non-prescribed ketamine was comparable between 2024 and 2025 (p=0.906). Of those who were able to comment in 2025 (n=49), 55% reported ketamine to be 'very easy' to obtain (56% in 2024), with a further 39% perceiving it to be 'easy' to obtain (40% in 2024) (Figure 50).

Figure 48: Median price of non-prescribed ketamine per gram, Melbourne, VIC, 2003-2025



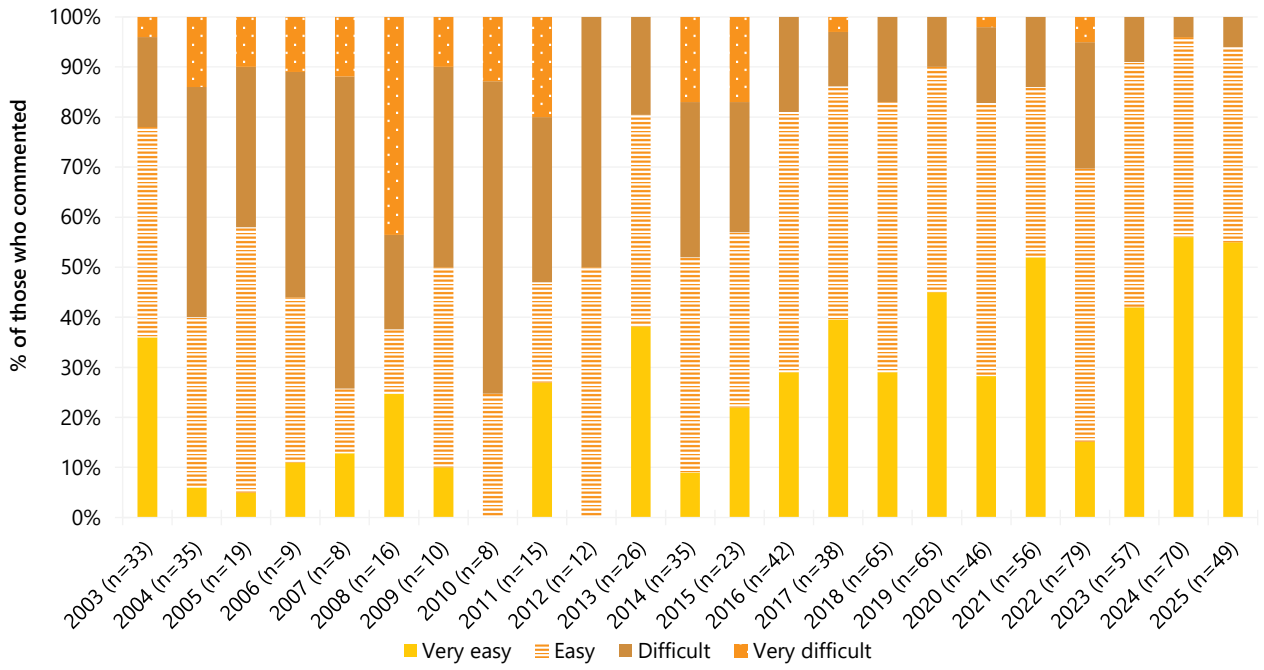
Note. Among those who commented. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only became available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Figure 49: Current perceived purity of non-precribed ketamine, Melbourne, VIC, 2003-2025



Note. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only became available via prescription, for treatment resistant depression, in 2021). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables 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 50: Current perceived availability of non-prescribed ketamine, Melbourne, VIC, 2003-2025



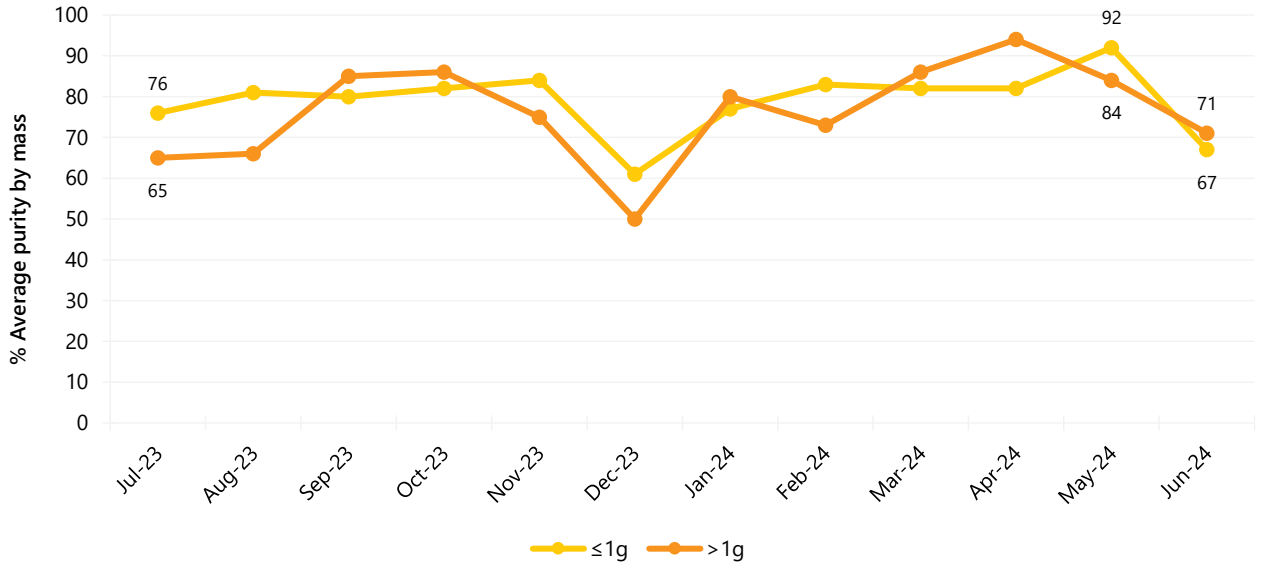
Note. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only became available via prescription, for treatment resistant depression, in 2021). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables 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.

Routinely Collected Data

Victoria Police Seizure Purity

Ketamine seizures analysed by the Victoria Police Forensic Services Department during the 2023/24 financial year averaged 79% purity in samples weighing one gram or less (IQR=77–82, range=61–92) and 76% in samples weighing over one gram (IQR=70–85, range=50–94) (Figure 51).

Figure 51: Purity of ketamine seizures by Victorian law enforcement, July 2023–June 2024



Note. May not include every drug seized, as not all seized drugs undergo purity analysis. Data labels are only provided for the first (Jul-23) and last two months (May-24, Jun-24) of monitoring.

LSD

Patterns of Consumption

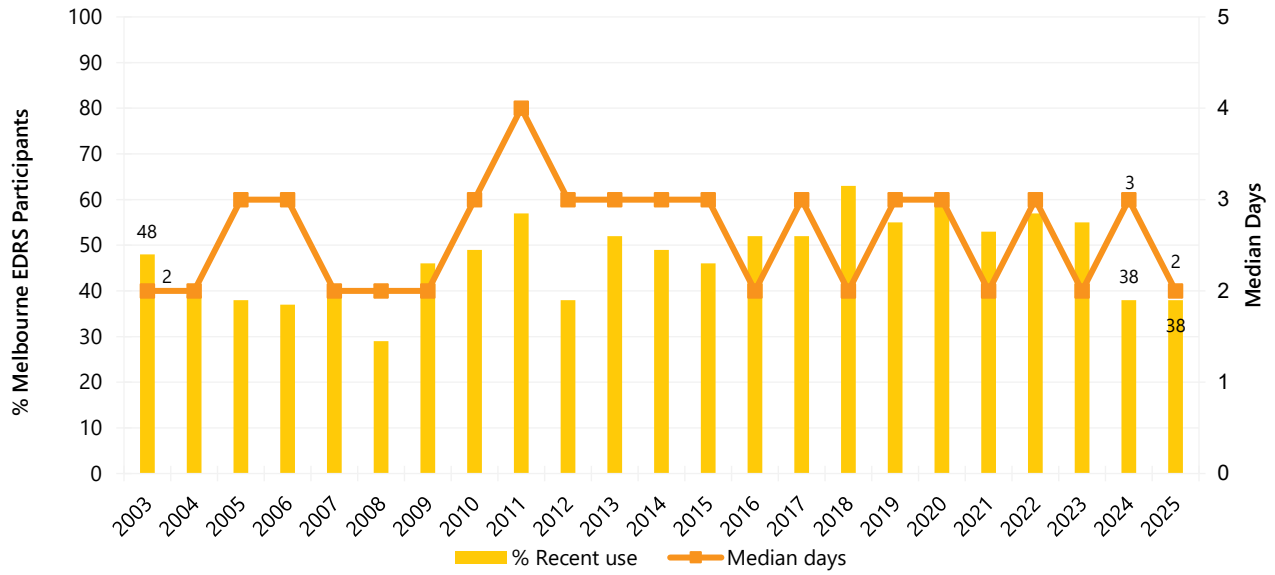
Recent Use (past 6 months): Two fifths (38%) of the Melbourne sample reported use of LSD in the six months preceding interview, stable from 2024 (38%) (Figure 52).

Frequency of Use: Of those who had recently consumed LSD in 2025 and commented (n=37), frequency of use remained stable at a median of two days (IQR=1–5) in the six months preceding interview (3 days in 2024; IQR=1–5; n=38; *p*=0.828) (Figure 52). No participants who had recently consumed LSD reported weekly or more frequent use in 2025 (n≤5 in 2024).

Routes of Administration: Among participants who had recently consumed LSD and commented (n=38), all participants (100%) reported swallowing LSD in 2025, stable from 2024 (100%).

Quantity: Of those who reported recent use and responded (n=29), the median amount of LSD used in a 'typical' session was one tab (IQR=0.5–1; 1 tab in 2024; IQR=0.5–1.0; n=25; *p*=0.226). Of those who reported recent use and responded (n=29), the median maximum amount of LSD used in a session was one tab (IQR=0.5–1.5; 1 tab in 2024; IQR=0.7–2.0; n=25; *p*=0.421).

Figure 52: Past six month use and frequency of use of LSD, Melbourne, VIC, 2003-2025



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

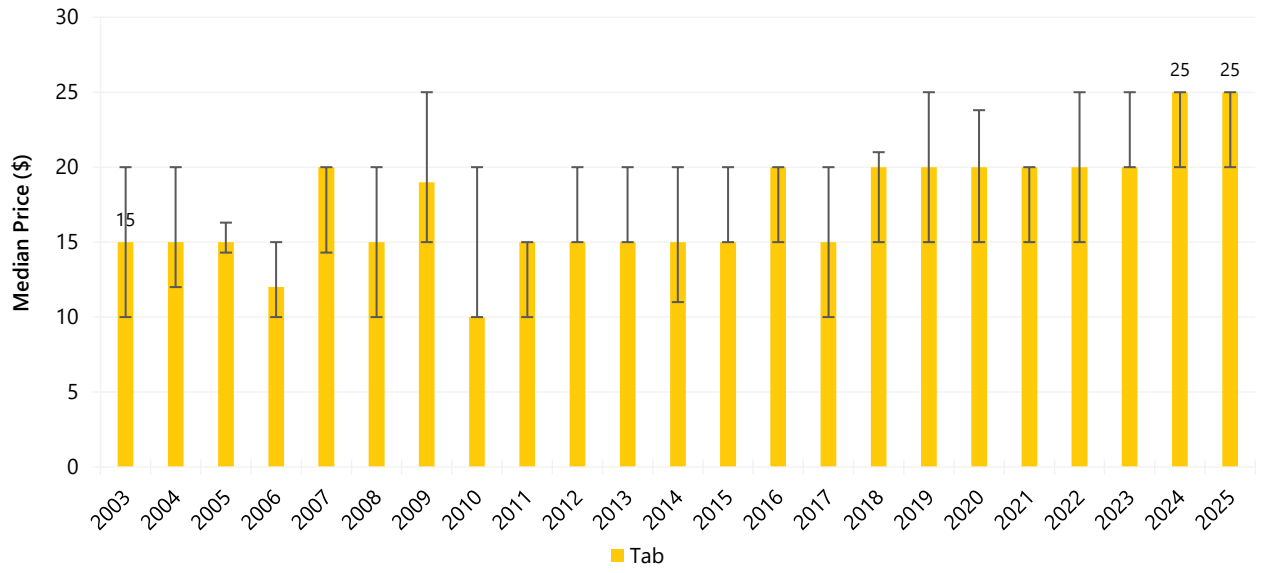
Price, Perceived Purity and Perceived Availability

Price: In 2025, the median price of a tab remained stable at $25 (IQR=20–25; n=20; $25 in 2024; IQR=20–25; n=15; p=0.564) (Figure 53).

Perceived Purity: The perceived purity of LSD remained stable between 2024 and 2025 (p=0.078). Among those who were able to respond in 2024 (n=30), 53% perceived the purity of LSD to be 'high' (48% in 2024), followed by 27% reporting purity to be 'medium' (27% in 2024) (Figure 54).

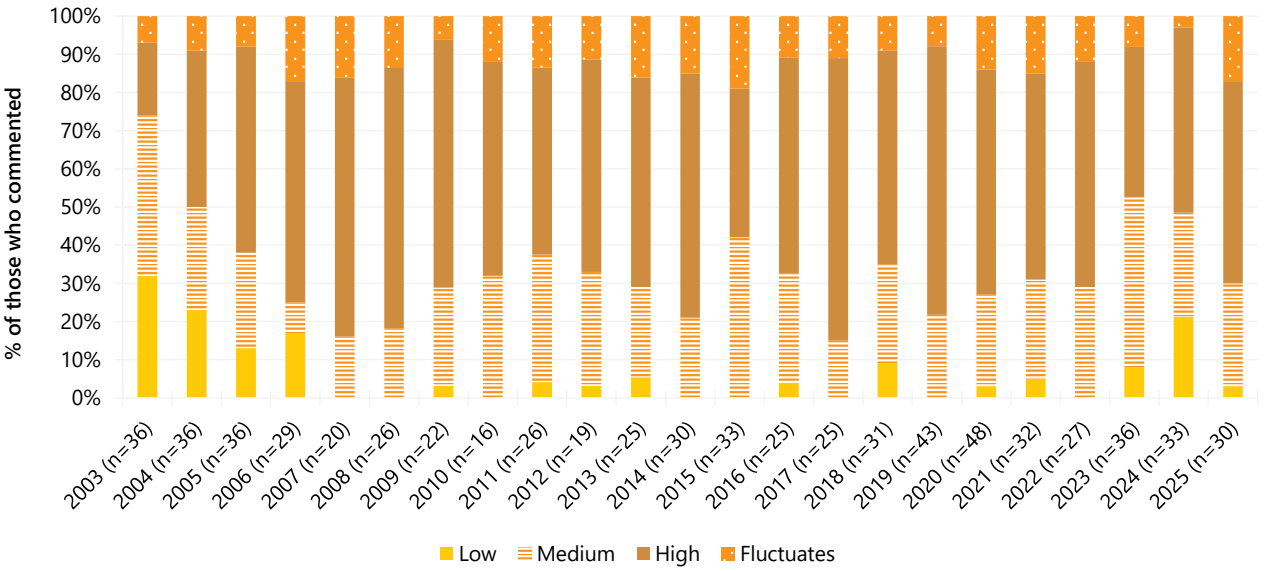
Perceived Availability: The perceived availability of LSD remained stable between 2024 and 2025 (p=0.397). Of those able to comment in 2025 (n=34), 47% reported LSD as being 'easy' to obtain (30% in 2024) and 24% reported it as 'very easy'. In contrast, 29% reported LSD as 'difficult' to obtain (36% in 2024). (Figure 55).

Figure 53: Median price of LSD per tab, Melbourne, VIC, 2003-2025



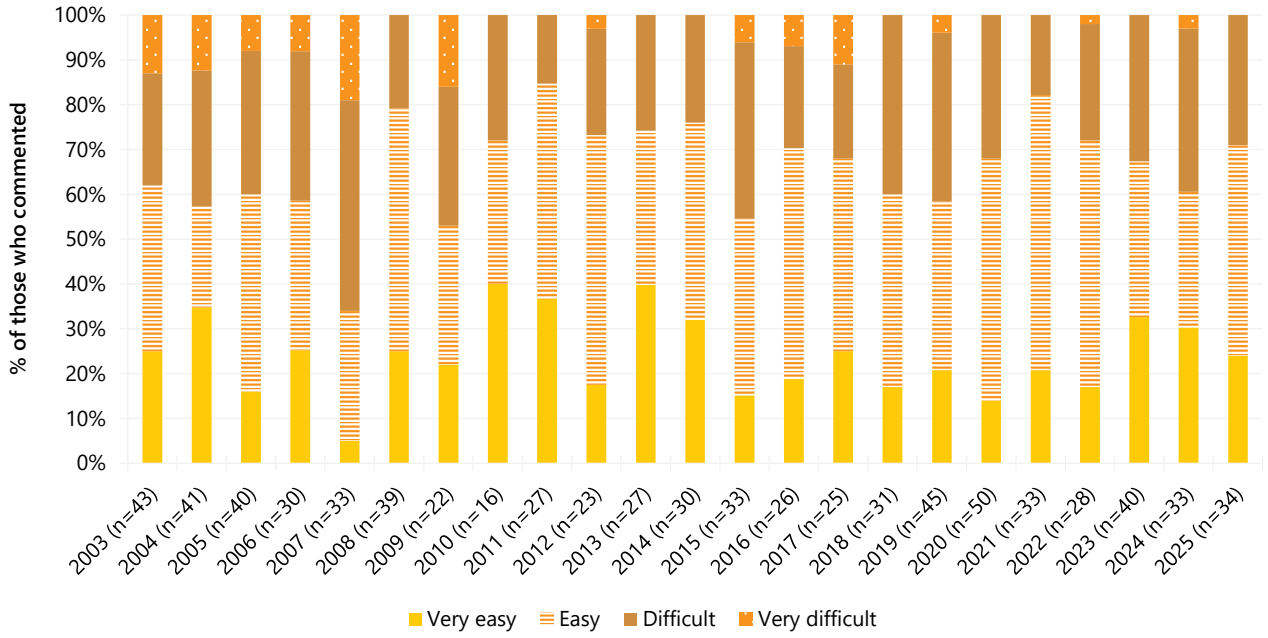
Note. Among those who commented. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The error bars represent the IQR. Statistical significance for 2024 versus 2025 presented in figure;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

Figure 54: Current perceived purity of LSD, Melbourne, VIC, 2003-2025



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure and data tables 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 55: Current perceived availability of LSD, Melbourne, VIC, 2003-2025



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

DMT

Patterns of Consumption

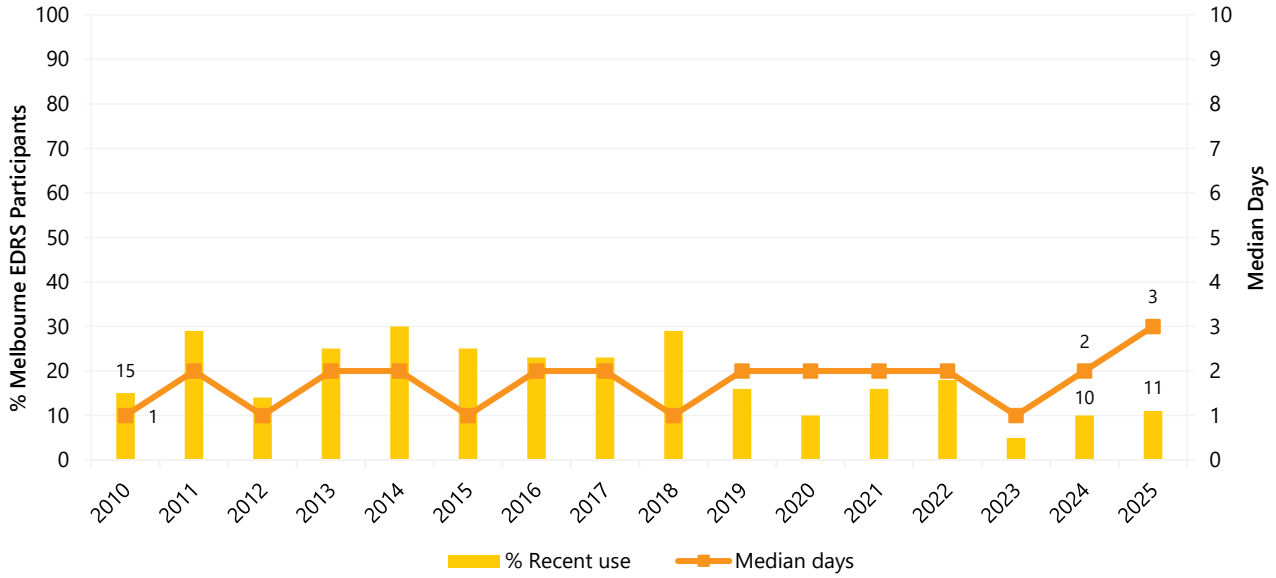
Recent Use (past 6 months): In 2025, 11% of the Melbourne sample reported recent use of DMT (10% in 2024) (Figure 56).

Frequency of Use: Median days of DMT use across the years has been infrequent and stable, with a median of 3 days of use (IQR=2–5; n=11) reported in the six months preceding interview in 2025 (2 days in 2024; IQR=1–3; n=10; p=0.208) (Figure 56).

Routes of Administration: Among participants who had recently consumed DMT and commented (n=11), all participants (100%) reported smoking (100% in 2024).

Quantity: Due to low numbers (n≤5) reporting on quantity of DMT use in 2025, further details are suppressed (n≤5 in 2024). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 56: Past six month use and frequency of use of DMT, Melbourne, VIC, 2010-2025



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

8

New Psychoactive Substances

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

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

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

Recent Use (past 6 months)

Any NPS use, including plant-based NPS, has fluctuated over time, peaking at 45% in 2013 and declining to 17% in 2025 (25% in 2024; p=0.227) (Table 3).

Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 45% in 2012 and 2013 and declining to 17% in 2025 (21% in 2024; p=0.587) (Table 3).

Forms Used

Participants are asked about a range of NPS, updated each year to reflect key emerging substances of interest. The NPS most frequently reported was 'drugs that mimic psychedelic drugs', with 9% reporting recent use in 2025 (Not collected in 2024), followed by any 2C substance (7%; 14% in 2024; p=0.174) (Table 4). Few participants (n≤5) reported recent use of any other NPS. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Table 3: Past six month use of NPS (excluding and including plant-based NPS), Melbourne, VIC, 2010-2025

%	Excluding plant-based NPS
2010	29
2011	40
2012	45
2013	45
2014	34
2015	36
2016	31
2017	29
2018	28
2019	17
2020	12
2021	23
2022	16
2023	15
2024	21
2025	**17**

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

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

%	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Drugs that mimic the effects of ecstasy	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-
Mephedrone	28	25	8	10	6	7	-	-	-	0	0	0	28	-	-	-
Methylone	/	12	-	6	-	-	-	-	-	-	0	-	/	0	0	-
N-ethylpentylone (ephylone)	/	/	/	/	/	/	/	/	/	0	0	-	/	0	0	**0**
N-ethylbutylone (eutylone)	/	/	/	/	/	/	/	/	/	/	/	0	/	0	0	**0**
Drugs that mimic the effects of amphetamine or cocaine	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
3-chloromethcathinone (e.g., 3-CMC; clophedrone)	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0	**0**
3-Methylmethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0	-	0	**0**
4-Chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0	**0**
4-FA	/	/	/	/	/	/	0	-	0	0	0	-	-	0	0	**0**
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	-	0	0	**0**
Alpha PVP	/	/	/	/	/	/	-	0	0	0	0	0	/	0	0	**0**
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
MDPV	-	-	-	-	-	0	0	-	0	0	0	0	-	0	0	**0**
Methcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
N-Ethylhexedrone	/	/	/	/	/	/	/	/	/	0	0	0	/	0	0	**0**
Other	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Drugs that mimic the effects of psychedelic drugs	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**9**
2C - any (e.g., 2C-I, 2C-B)	-	-	10	20	16	7	12	9	8	-	8	16	9	6	14	**7**
4-AcO-DMT	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
5-MeO-DMT	0	-	-	-	0	0	0	-	-	0	0	0	0	0	0	**0**
Dox (e.g., DOB, DOC, DOI, DOM)	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
NBOH (e.g., 25I, 25B)	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
NBOMe (e.g., 25I, 25B, 25C, others)	/	/	/	/	8	7	0	-	-	-	0	0	-	0	-	-
Other	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Drugs that mimic the effects of dissociatives	/	/	-	6	/	10	9	-	6	-	-	6	-	7	-	-
2F-2-oxo PCE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	0	0	-	**0**
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
3F-2-oxo-PCE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
3-HO-PCP/4-HO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	-	0	0	**0**

3-MeO-PCP/4-MeO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	-	0	**0**
Methoxetamine	/	/	-	6	/	10	9	-	6	-	-	-	-	-	0	**0**
Tiletamine	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Other	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-	**0**
Drugs that mimic the effects of cannabis	/	-	16	18	9	8	-	-	-	0	0	-	-	-	-	**-**
Drugs that mimic the effects of benzodiazepines	/	/	/	/	/	/	/	/	/	/	-	-	-	-	-	**-**
8-Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	-	-	-	-	0	**0**
Bromazolam	/	/	/	/	/	/	/	/	/	/	-	-	-	-	0	**0**
Clobromazolam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Clonazolam	/	/	/	/	/	/	/	/	/	/	-	-	-	-	0	**-**
Etizolam	/	/	/	/	/	/	/	/	/	/	-	-	-	-	0	**0**
Flualprazolam	/	/	/	/	/	/	/	/	/	/	-	-	-	-	-	**0**
Flubromazepam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Phenazolam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Other	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Drugs that mimic the effects of opioids	/	/	/	/	/	/	/	/	0	0	0	0	/	0	-	**-**
Drugs that mimic the effect of any other NPS	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-	**-**

Note. NPS first asked about in 2010. Due to lower numbers reporting use in recent years, in 2025 participants were asked about broad categories of NPS (e.g., drugs that mimic the effects of ecstasy) and then if reported use, were asked to specify the substance. ~ In 2010 and between 2017-2019, three forms of 2C were asked about whereas between 2011-2016 four forms were asked about. From 2020 onwards, 'any' 2C use is captured. Statistical significance for 2024 versus 2025 presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Please refer to **Error! Reference source not found.** for a guide t o table/figure notes.

.

9

Other Drugs

Non-Prescribed Pharmaceutical Drugs

Codeine

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

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

Recent Use (past 6 months): In 2025, few participants (n≤5) reported using any non-prescribed codeine (e.g., Nurofen Plus, Panadeine, Panadeine Extra) in the six months prior to interview (12% in 2024; p=0.065), therefore further details are supressed (Figure 57). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Pharmaceutical Opioids

Recent Use (past 6 months): Seven per cent of the Melbourne sample had recently used non-prescribed pharmaceutical opioids (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl; codeine excluded) in 2025, stable from 2024 (13%; p=0.243) (Figure 57).

Frequency of Use: Participants who had recently used non-prescribed pharmaceutical opioids reported use on a median of two days (IQR=2–9; n=7) in the six months preceding interview (2 days in 2024; IQR=1–7; n=13; p=0.656).

Forms used: Due to low numbers (n≤5) reporting on the form of non-prescribed opioid used in the 6 months preceding interviewing, data are suppressed. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Benzodiazepines

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

Recent Use (past 6 months): Reports of recent use of non-prescribed benzodiazepines (e.g., Valium, Diazepam, Xanax, Kalma) remained stable in 2025, with 36% reporting recent use (36% in 2024) (Figure 57).

Frequency of Use: Participants who had recently used non-prescribed benzodiazepines reported use on a median of three days (IQR=2–8; n=35) in the six months preceding interviewing in 2025 (4 days in 2024; IQR=2–11; n=36; *p*=0.346).

Forms Used: Amongst participants who reported recent use of non-prescribed benzodiazepines and were able to comment (n=34), 68% reported use of Valium (diazepam), followed by 38% reporting use of Xanax (Alprazolam).

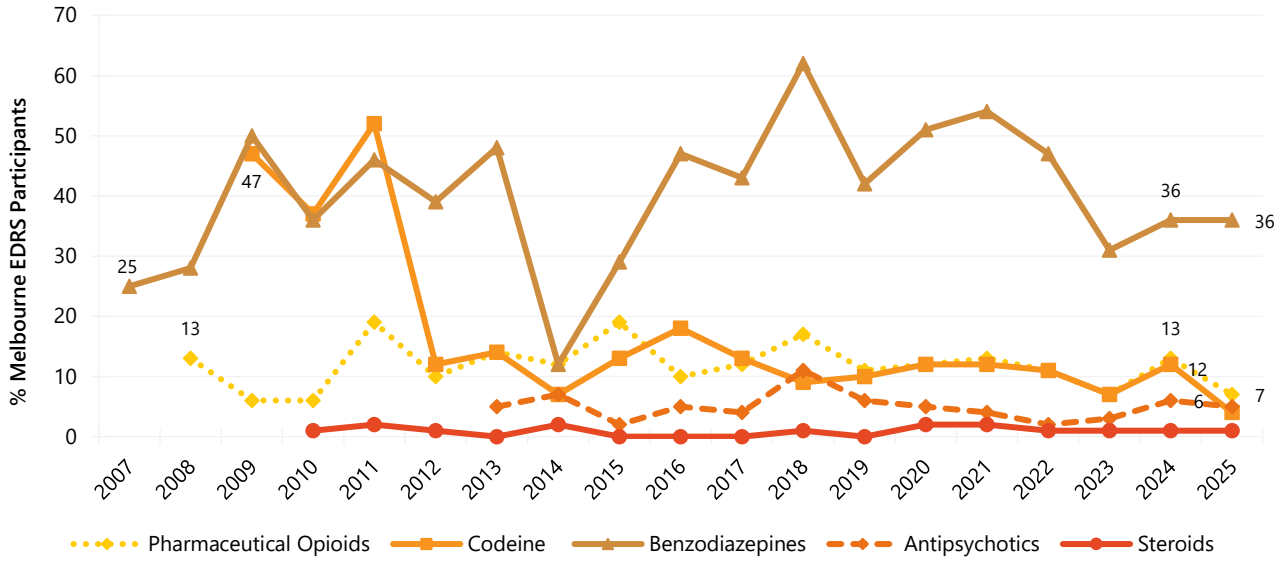
Steroids

Due to low numbers (n≤5) reporting recent use of non-prescribed steroids in 2025, further details are not reported (n≤5 in 2024) (Figure 57). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Antipsychotics

Due to low numbers (n≤5) reporting recent use of non-prescribed anti-psychotics in 2025 (6% in 2024), further details are supressed (Figure 57). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 57: Non-prescribed use of pharmaceutical medicines in the past six months, Melbourne, VIC, 2007-2025



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

Other Illicit Drugs

Non-Prescribed Hallucinogenic Mushrooms/Psilocybin

Recent Use (past 6 months): In 2025, 42% of the Melbourne sample reported recent use of non-prescribed hallucinogenic mushrooms/psilocybin in the six months prior to the interview, stable relative to 51% in 2024 (p=0.260) (Figure 58).

Frequency of Use: Participants who had recently used non-prescribed hallucinogenic mushrooms reported use on a median of two days (IQR=1–4; n=41) in the six months prior to interview in 2025 (2 days in 2024; IQR=1–5; n=51; p=0.734).

MDA

Due to low numbers (n≤5) reporting recent use of MDA in 2025, further details are not reported (n≤5 in 2024) (Figure 58). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Substance with Unknown Contents

Recent Use (past 6 months): From 2019, we asked participants about their use of substances with 'unknown contents'. Around one fifth (21%) of the sample reported use of any substance with 'unknown contents' in 2025 (25% in 2024; p=0.615) on a median of one day (IQR=1–2; n=21), stable from 2024 (1 day; IQR=1–2; n=25; p=0.539).

When broken down by substance form, 15% of participants reported recent use of powder with 'unknown contents' (17% in 2024; p=0.845). Few participants (n≤5) reported recent use of crystal, pills or capsules with 'unknown contents' in 2025.

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

PMA

No participants reported recent use of PMA in 2025 (no participants in 2024) (Figure 58). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

PMMA

No participants reported recent use of PMMA in 2025 (no participants in 2024) (Figure 58). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Heroin

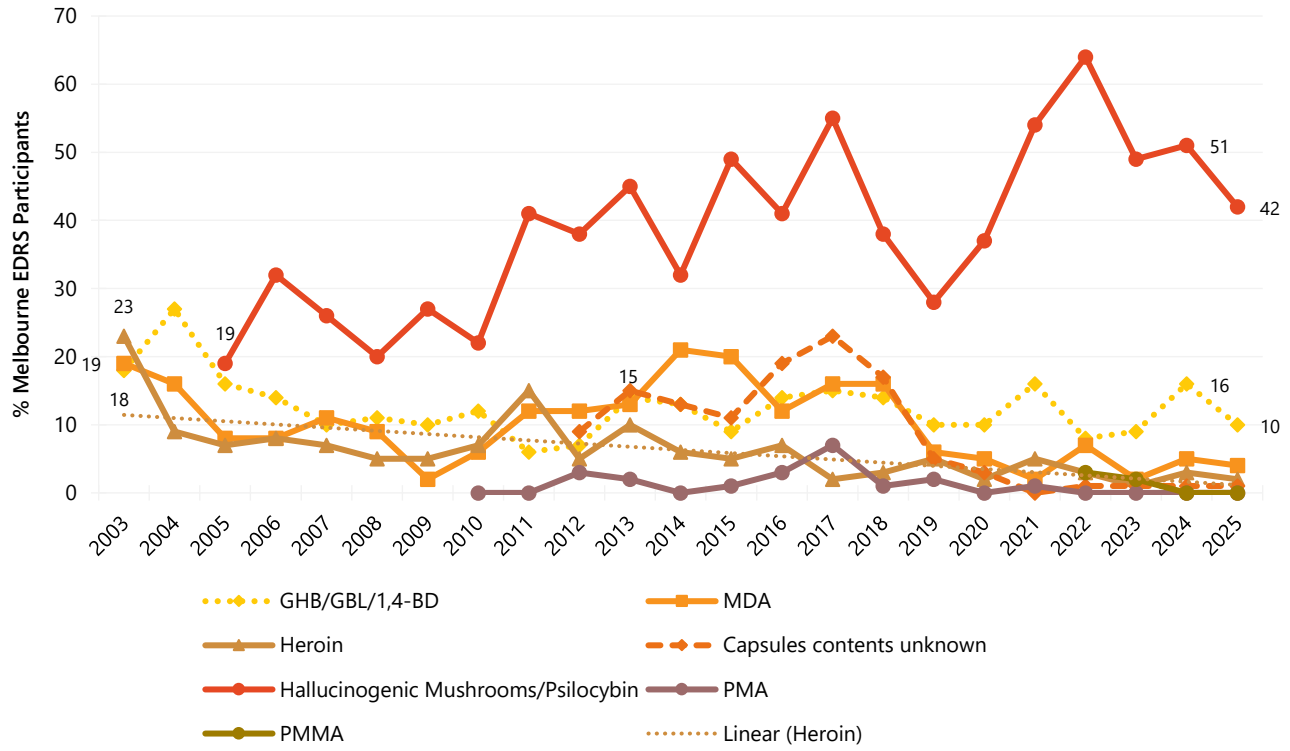
Few participants (n≤5) reported recent use of heroin in 2025, therefore, further details are not reported (n≤5 in 2024) (Figure 58). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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

Recent Use (past 6 months): One tenth (10%) of the Melbourne sample reported recent use of GHB/GBL/1,4-BD in the six months prior to the interview in 2025, stable from 2024 (16%; p=0.299) (Figure 58).

Frequency of Use: Although the median of 28 days (IQR=10–53; n=10) of GHB/GBL/1,4-BD use reported in the six months prior to interview in 2025 appears higher than 2024 (4 days; IQR=1–11; n=16) high variability means that this difference was not significant (p=0.116).

Figure 58: Past six month use of other illicit drugs, Melbourne, VIC, 2003-2025



Note. In 2019, participants were asked more broadly about 'substances contents unknown' (with further ascertainment by form) which may have impacted the estimate for 'capsules contents unknown'. Y axis has been reduced to 70% 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). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Licit and Other Drugs

Alcohol

Recent Use (past 6 months): The majority of the Melbourne sample continued to report recent use of alcohol in 2025 (95%), stable relative to 2024 (94%) (Figure 59).

Frequency of Use: Participants who had recently used alcohol reported use on a median of 48 days (IQR=24–72; n=95) in the six months preceding interview in 2025 (48 days in 2024; IQR=24–72; n=95; p=0.470). Four fifths (81%) of those who recently consumed alcohol had done so on a weekly or more frequent basis in 2025, stable from 2024 (77%; p=0.480). Few participants (n≤5) reported daily use of alcohol in 2025 (no participants in 2024; p=0.246).

Tobacco

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

Recent Use (past 6 months): Seventy per cent of the Melbourne sample reported recent tobacco use in 2025, stable from 70% in 2024 (Figure 59). Half (51%) of the Melbourne sample reported recent use of smoked or non-smoked illicit tobacco products in 2025, a significant increase from 2024 (32%; p=0.009)

Frequency of Use: Participants who had recently used tobacco reported use on a median of 76 days (IQR=12–180; n=70) in the six months preceding interview in 2025, stable from 55 days in 2024 (IQR=15–180; n=70; *p*=0.830). Thirty-seven per cent of participants who had recently used tobacco reported daily use in 2025 (33% in 2024; *p*=0.707).

E-cigarettes/Vapes

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

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

No participants reported recent use of prescribed e-cigarettes in 2024 (n≤5 in 2024; *p*=0.497). The data presented below for 2025 refers only to use of e-cigarettes that were obtained from non-pharmacy locations. 2022-2024 data refers to non-prescribed e-cigarette use, while data for 2021 and earlier refers to any e-cigarette use (collectively referred to as 'illicit use' from herein).

Recent Use (past 6 months): In 2025, two thirds (64%) of the Melbourne sample reported use of illicit e-cigarettes in the six months preceding interview (74% in 2024; *p*=0.177) (Figure 59).

Frequency of Use: Participants who had recently used illicit e-cigarettes reported use on a median of 60 days (IQR=19–180; n=64) in the six months preceding interview in 2025, considerably less than the 180 days seen in 2024, with large variability meaning the difference was not statistically significant (IQR=30–180; n=74; *p*=0.094). Two fifths (40%) of participants who had recently used non-prescribed e-cigarettes reported daily use, also stable from 2024 (53%; *p*=0.131).

Contents and Forms Used: Among participants who had recently used illicit e-cigarettes and responded (n=60), the majority (95%) reported using disposable devices (96% in 2024).

Reason for Use: Of those who reported *any* non-prescribed e-cigarette use and responded (n=62), 16% reported that they used e-cigarettes as a smoking cessation tool in 2025, a significant decrease from 2024 (33%; *p*=0.033).

Nicotine Pouches

Recent Use (past 6 months): One fifth (20%) of the Melbourne sample reported recent use of nicotine pouches in the 6 months prior to interview, stable from 2024 (17%; *p*=0.699) (Figure 59).

Frequency of Use: Participants who had recently used nicotine pouches reported use on a median of three days (IQR=1–11; n=20) in the six months preceding interview in 2025 (3 days in 2024; IQR=1–5; n=17; *p*=0.673).

Nitrous Oxide

Recent Use (past 6 months): Forty-four per cent of the Melbourne sample reported recent use of nitrous oxide in 2025, stable relative to 2024 (49%; p=0.568) (Figure 59).

Frequency of Use: Participants who had recently used nitrous oxide reported use on a median of three days (IQR=2–6; n=44) in the six months preceding interview in 2025 (3 days in 2024; IQR=1–7; n=49; p=0.737).

Quantity: Among those who reported recent use and responded (n=33), the median amount used in a 'typical' session was 6 bulbs (IQR=3–10; 5 bulbs in 2024; IQR=2–11.5; n=42; p=0.523). Of those who reported recent use and responded (n=31), the median maximum amount used was 8 bulbs (IQR=4–15; 9 bulbs in 2024; IQR=3–23.8; n=42; p=0.871).

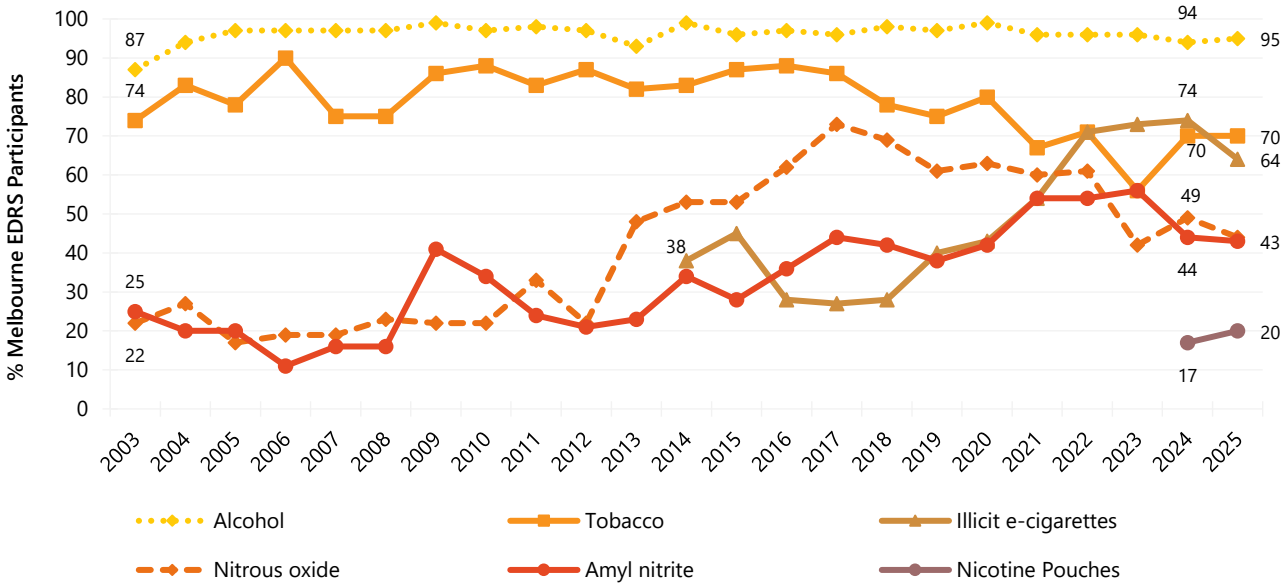
Amyl Nitrite

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

Recent Use (past 6 months): Forty-three per cent of the Melbourne sample reported recent use of amyl nitrite in 2025, stable relative to 2024 (44%) (Figure 59). In 2025, no participants reported that they had obtained amyl nitrite from a pharmacy in the past six months (not asked in 2024).

Frequency of Use: Participants who had recently used amyl nitrite and commented, reported use on a median of four days (IQR=2–5; n=42) in the six months preceding interview in 2025 (3 days in 2024; IQR=2–9; n=44; p=0.990).

Figure 59: Licit and other drugs used in the past six months, Melbourne, VIC, 2003-2025



Note. Regarding e-cigarettes, on 1 October 2021, legislation came into effect requiring people to obtain a prescription to legally import nicotine vaping products. Data from 2022 onwards refers to illicit e-cigarettes only. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

10

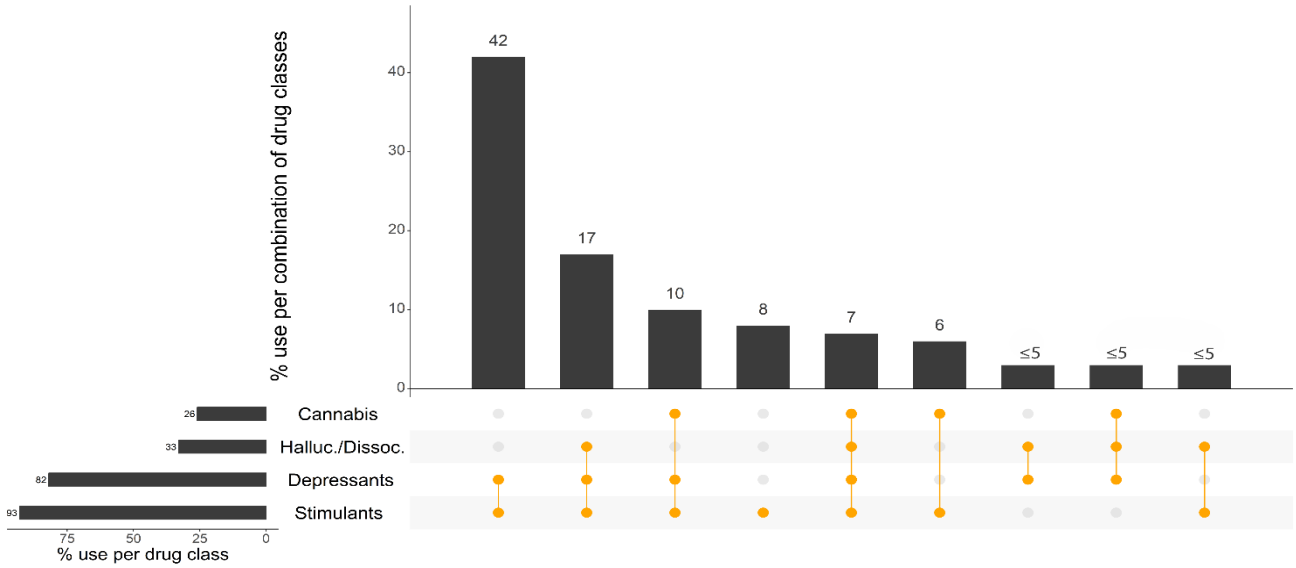
Drug-Related Harms and Other Behaviours

Polysubstance Use and Bingeing

On the last occasion of ecstasy or related drug use and among those who responded (n=92), the most commonly used substances were alcohol (80%) and cocaine (47%), followed by tobacco (42%), MDMA (41%), e-cigarettes (40%), cannabis (26%), ketamine (22%), and pharmaceutical stimulants (16%).

The large majority (85%) of the Melbourne sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most commonly used combinations of drug classes were stimulants and depressants (29%), followed by stimulants, depressants, and hallucinogens/dissociatives (11%). Nine per cent reported using depressants and hallucinogens/dissociatives and a further 9% reporting using stimulants alone (Figure 60).

Figure 60: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Melbourne, VIC, 2025: Most common drug pattern profiles

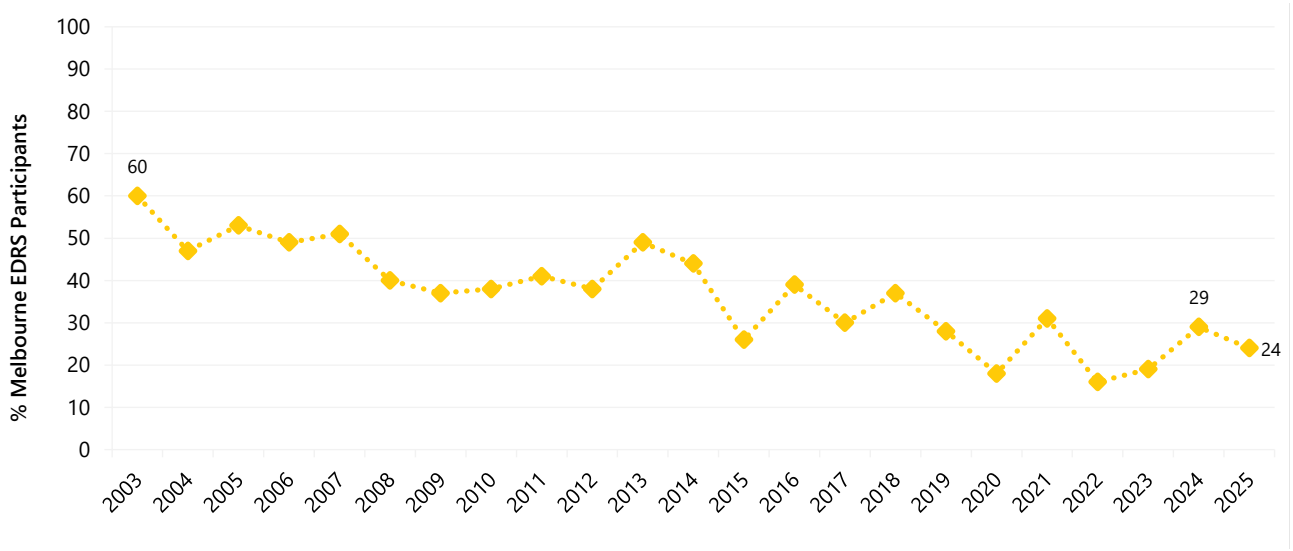


Note. % calculated out of total EDRS 2025 sample. The horizontal bars represent the per cent of participants who reported use of each substance on their last occasion of ecstasy or related drug use; the vertical columns represent the per cent of participants who used the combination of drug classes represented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

Binge Drug Use

Participants were asked whether they had binged (used drugs for 48 hours or more continuously without sleep) on any stimulant in the six months preceding interview. One quarter (24%) of the Melbourne sample reported bingeing on one or more drugs in the preceding six months (29% in 2024; p=0.426) (Figure 61).

Figure 61: Past six month bingeing for 48 hours or more, Melbourne, VIC, 2003-2025



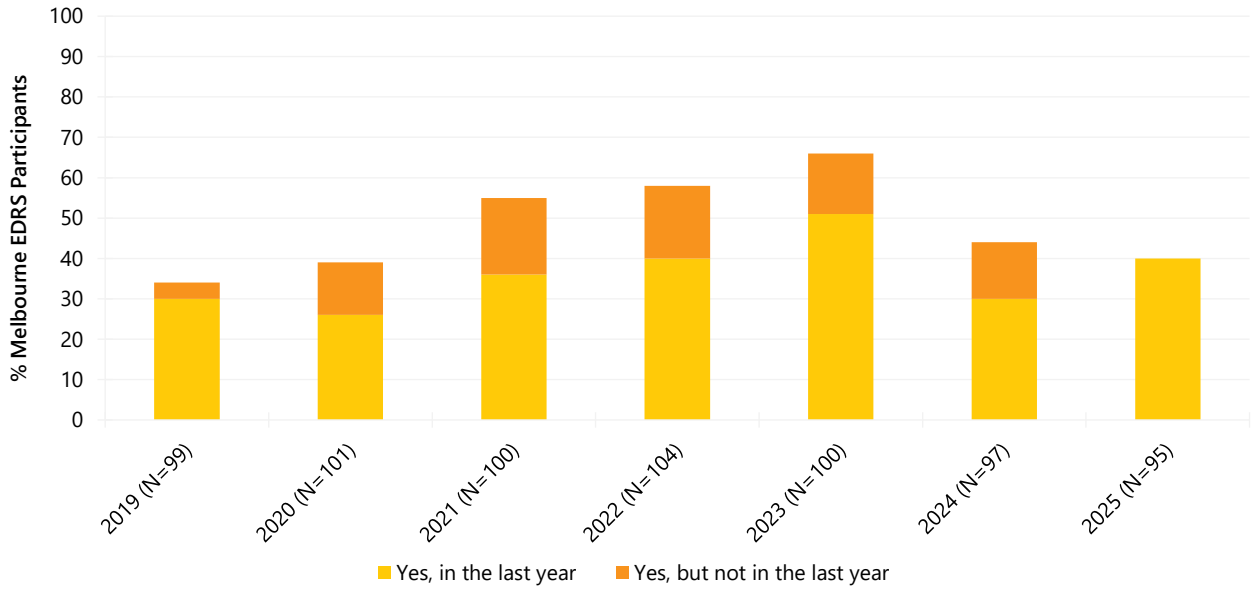
Note. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p <0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for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

Drug Checking

Drug checking is a common strategy used to test the purity and contents of illicit drugs. At the time interviewing commenced in 2025, the only government-sanctioned drug checking services that had operated in Australia were in the ACT, QLD, VIC and NSW. In Canberra, ACT, drug checking was provided at the Groovin the Moo festival in 2018 and 2019, and a fixed-site drug checking service (CanTEST) has been operational since 17 July 2022. Queensland's first fixed-site drug checking service, CheQpoint, opened in Brisbane on 20 April 2024, and a second service opened in the Gold Coast in July 2024. Drug checking was 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, 40% of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year, stable from 2024 (p=0.180) (Figure 62). Of those who reported that they or someone else had tested their illicit drugs in the past year and responded (n=38), two thirds (66%) reported using colorimetric reagent test kits. One third (32%) reported testing via a drug checking service, most commonly at an event-based face-to-face service (e.g., festival pill testing service) (29%). Few participants(n≤5) reported use of a fixed-site face-to-face drug checking/pill testing service in 2025. Please refer to the 2025 National EDRS Report for national trends or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 62: Lifetime and past year engagement in drug checking, Melbourne, VIC, 2019-2025



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

Alcohol Use Disorders Identification Test

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

The mean score on the AUDIT for the total Melbourne sample (including people who had not consumed alcohol in the past 12 months) was 12.2 (SD 6.6) in 2025, a small but significant decrease from 12.5 (SD 6.3) in 2024 ($p<0.001$). AUDIT scores are divided into four 'zones' which indicate risk level. Specifically, scores between 0-7 indicate low risk drinking or abstinence; scores between 8-15 indicate alcohol use in excess of low-risk guidelines; scores between 16-19 indicate harmful or hazardous drinking; and scores 20 or higher indicate possible alcohol dependence. Three quarters (73%) of the sample obtained a score of eight or more (77% in 2024; $p=0.613$), indicative of hazardous use (Table 5).

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

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
	N=97	N=98	N=97	N=96	N=100	N=97	N=97	N=97	N=98	N=98	N=98	N=100	N=98	N=100	N=91	N=95
Mean AUDIT total score (SD)	14.1 (7.1)	13.3 (7.2)	15 (7.5)	12.1 (6.8)	12 (6.1)	11.5 (6.3)	11.5 (6.6)	10.4 (6.6)	12.6 (6.2)	12 (7.5)	11.8 (5.4)	12.1 (6.4)	12.9 (7.2)	12.3 (7.3)	12.5 (6.3)	**12.2 (6.6)*** **
Score 8 or above (%)	86	90	88	86	89	81	74	83	85	74	77	72	76	74	77	**73**
AUDIT zones:																
Score 0-7	22	19	18	30	22	29	34	38	19	26	18	27	24	26	23	**27**
Score 8-15	31	43	40	41	51	47	43	43	55	50	57	43	44	43	44	**44**
Score 16-19	24	22	12	10	13	12	12	7	12	7	15	18	14	15	21	**15**
Score 20 or higher	24	15	30	19	14	11	10	11	14	17	9	12	17	16	12	**14**

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

Overdose Events

Non-Fatal Overdose

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

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

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

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

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

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

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

Non-Fatal Stimulant Overdose

In 2025, 16% of the Melbourne sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview, stable relative to 2024 (15%) (Figure 63).

The most commonly reported stimulants during the most recent non-fatal stimulant overdose in the past 12 months were any form of ecstasy (44%) and cocaine (44%). Among those who experienced a recent non-fatal stimulant overdose (n=16), 75% reported that they had also consumed one or more additional drugs on the last occasion, most notably, alcohol (63%; ≥5 standard drinks: 38%; ≤5 standard drinks: n≤5). Due to low numbers (n≤5) reporting on forms of treatment on the last occasion of experiencing a non-fatal stimulant overdose, please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Non-Fatal Depressant Overdose

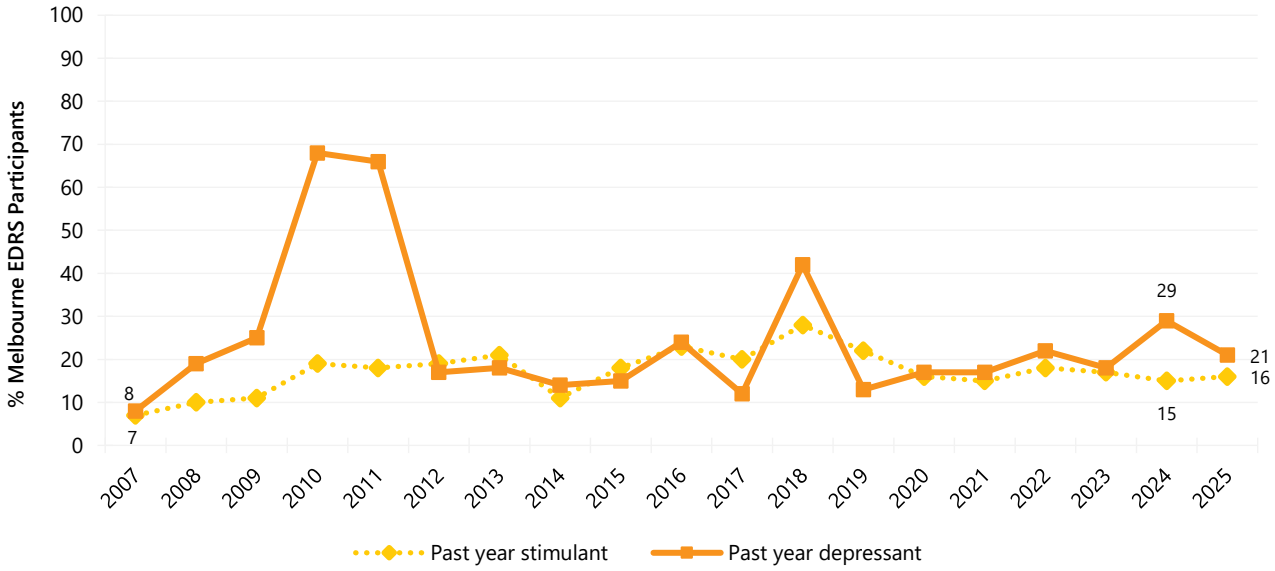
Alcohol: Seventeen per cent of the Melbourne sample reported a non-fatal alcohol overdose in the 12 months preceding interview (21% in 2024; p=0.467) on a median of one occasion (IQR=1–1). Of those who had experienced an alcohol overdose in the past year (n=17), the majority (88%) reported not receiving treatment on the last occasion. Due to low numbers (n≤5) reporting that they had received treatment or assistance, further data are suppressed. Please refer to the 2025 National EDRS

Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Any depressant (including alcohol): In 2025, 21% of participants reported that they had experienced a non-fatal depressant overdose (including alcohol) in the past 12 months, stable relative to 2024 (29%; *p*=0.198) (Figure 63).

Of those who had experienced any depressant overdose in the past 12 months (n=29), four fifths (81%) reported alcohol as the most common depressant drug. Few participants (n≤5) reported a non-fatal depressant overdose due to other drugs, therefore, these data are suppressed. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 63: Past 12 month non-fatal stimulant and depressant overdose, Melbourne, VIC, 2007-2025



Note. Past year stimulant and depressant overdose was first asked about in 2007. In 2019, items about overdose were revised, and changes relative to 2018 may be a function of greater nuance in capturing depressant events. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Statistical significance for 2024 versus 2025 presented in figure; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Awareness of Naloxone

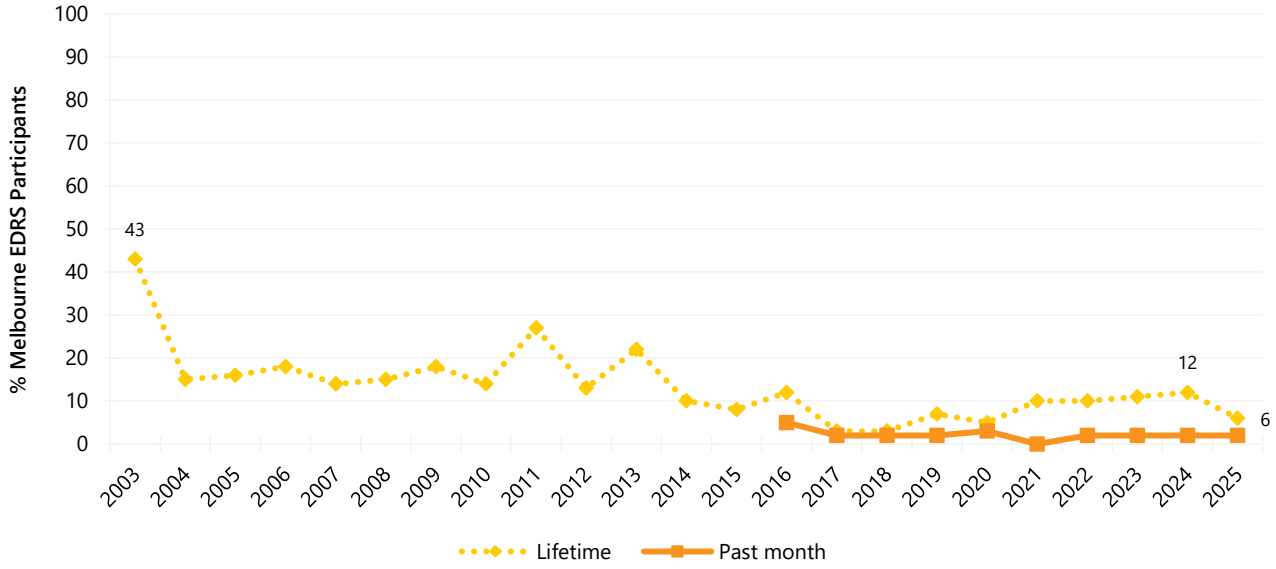
In 2025, 85% reported that they had ever heard of naloxone, stable relative to 2024 (76%; *p*=0.117). Among those who had ever heard of naloxone and responded (n=83), 88% were able to correctly identify the purpose of naloxone, stable from 92% in 2024 (*p*=0.595). Among participants who had ever heard of naloxone and responded (n=85), 41% reported (ever) obtaining naloxone, a significant increase from 19% in 2024 (*p*=0.003) and 34% reported obtaining naloxone in the twelve months prior to interview, a significant increase from 2024 (15%; *p*=0.008).

Injecting Drug Use and Associated Risk Behaviours

Six per cent of the Melbourne sample reported lifetime injection in 2025 (12% in 2024; *p*=0.152). Few participants (n≤5) reported injecting drugs in the past month (n≤5 in 2024), therefore, these data are

suppressed (Figure 64). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 64: Lifetime and past month drug injection, Melbourne, VIC, 2003-2025



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

Drug Treatment

Few participants (n≤5) of the Melbourne sample reported currently receiving drug treatment in 2025 (7% in 2024; p=0.373).

Ecstasy and Methamphetamine Dependence

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

To assess ecstasy dependence in the past six months, a cut-off score of three or more was used, as this has been found to be a good balance between sensitivity and specificity for identifying problematic dependent ecstasy use. Among those who reported recent ecstasy use and commented (n=93), one tenth (11%) recorded a score of three or above, stable from 23% in 2024 (p=0.052). The median ecstasy SDS score was zero (IQR=0–1; 0 in 2024; IQR=0–2). Around two thirds (68%) of participants obtained a score of zero on the ecstasy SDS, indicating that the majority of respondents reported no or few symptoms of dependence in relation to ecstasy use (57% in 2024; p=0.179) (Table 6).

To assess methamphetamine dependence in the past six months, the cut-off of four and above, which is a more conservative estimate, has been used previously in the literature as a validated cut-off for methamphetamine dependence. Of those who reported recent methamphetamine use and responded (n=28), around one fifth (21%) scored four or above, stable relative to 2024 (25%). The median methamphetamine SDS score was zero (IQR=0–1.3). In 2025, around two thirds (64%) of participants obtained a score of zero on the methamphetamine SDS (50% in 2024; *p*=0.420) (Table 6).

Table 6: Total ecstasy and methamphetamine SDS scores, and per cent of participants scoring above cut-off scores indicative of dependence, among those who reported past six month use, Melbourne, VIC, 2017-2025

	2017	2018	2019	2020	2021	2022	2023	2024	2025
Ecstasy	**(N=97)**	**(N=98)**	**(N=97)**	**/**	**(N=95)**	**(N=88)**	**(N=99)**	**(N=93)**	**(N=93)**
Median total score (IQR)	1 (0–2)	1 (0–3)	1 (0–3)	/	0 (0–1)	0 (0–1)	0 (0–1)	0 (0–2)	**0 (0-1)**
% score = 0	47	37	38	/	74	65	68	57	**68**
% score ≥3	18	31	30	/	6	6	9	23*	**11**
Methamphetamine	**(N=43)**	**(N=59)**	**(N=43)**	**(N=48)**	**(N=44)**	**(N=47)**	**(N=29)**	**(N=28)**	**(N=28)**
Median total score (IQR)	0 (0–0)	0 (0–0)	0 (0–1)	0 (0–0)	0 (0–0)	0 (0–0)	0 (0–3)	1 (0–3.3)	**0 (0-1.3)**
% score = 0	86	76	72	85	75	79	66	50	**64**
% score ≥4	7	10	12	8	11	11	24	25	**21**

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

Sexual Health Behaviours

In 2025, three quarters (75%) of the Melbourne sample reported some form of sexual activity in the four weeks prior to interview (80% in 2024; *p*=0.487) (Table 7). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if the interview was undertaken face-to-face).

Of those who had engaged in sexual activity in the past four weeks and responded (n=70), around three fifths (61%) reported using alcohol and/or other drugs prior to or while engaging in sexual activity, stable relative to 2024 (75%; *p*=0.081). Of those who had engaged in sexual activity in the past four weeks and responded (n=71), few participants (n≤5) reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (8% in 2024; *p*=0.497), while one fifth (20%) reported that they had used alcohol and/or other drugs to enhance sexual activity or pleasure with another person (30% in 2024; *p*=0.186). Few participants (n≤5) had engaged in sexual activity in exchange for money, drugs, or other goods or services (no participants in 2024) (Table 7).

Of those who commented (n=98), 27% reported having a sexual health check-up in the six months prior to interview in 2025 (36% in 2024; p=0.177), whilst around three quarters (76%) had done so in their lifetime (74% in 2024; p=0.868). In 2025, of the total sample who responded (n=98), 6% of participants reported that they had received a positive diagnosis for a sexually transmitted infection (STI) in the six months preceding interviewing (n≤5 in 2024; p=0.331), although around one quarter (26%) had received a positive diagnosis in their lifetime, stable from 2024 (27%; p=0.869) (Table 7). Due to low numbers (n≤5) reporting on the specific types of STIs diagnosed, please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Of those who commented (n=95), one fifth (20%) of the sample reported having a test for human immunodeficiency virus (HIV) in the six months prior to interview (22% in 2024; p=0.854), while around three fifths (59%) had done so in their lifetime (55% in 2024; p=0.559). In 2025, no participants had been diagnosed with HIV in the past six months (no participants in 2024) and few participants (n≤5) had been diagnosed with HIV in their lifetime (no participants in 2024; p=0.495) (Table 7).

Table 7: Sexual health behaviours, Melbourne, VIC, 2021-2025

	2021	2022	2023	2024	2025
Of those who responded[#]:	N=100	N=100	N=100	N=99	**N=97**
% Any sexual activity in the past four weeks (n)	78 (n=78)	76 (n=76)	80 (n=80)	80 (n=79)	**75 (n=73)**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=78	n=76	n=79	n=77	**n=70**
% Drugs and/or alcohol used prior to or while engaging in sexual activity	95	84	82	75	**61**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=78	n=76	n=79	n=77	**n=71**
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	-	11	13	8	**-**
% Drugs and/or alcohol used to enhance sexual activity or pleasure with another person	/	/	/	30	**20**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=78	n=76	n=78	n=79	**n=73**
% Engaged in sexual activity in exchange for money, drugs or other goods or services	/	/	/	0	**-**
Of those who responded[#]:	n=100	n=99	n=100	n=99	**n=98**
% Had a sexual health check in the last six months	39	29	39	36	**27**
% Had a sexual health check in their lifetime	83	76	82	74	**76**
Of those who responded[#]:	n=100	n=99	n=100	n=99	**n=98**
% Diagnosed with a sexually transmitted infection in the last six months	-	-	10	-	**6**
% Diagnosed with a sexually transmitted infection in their lifetime	20	24	29	27	**26**
Of those who responded[#]:	n=100	n=99	n=100	n=99	**n=98**
% Had a sexual health check in the last six months	39	29	39	36	**27**
% Had a sexual health check in their lifetime	83	76	82	74	**76**
Of those who responded[#]:	n=100	n=99	n=100	n=99	**n=98**
% Diagnosed with a sexually transmitted infection in the last six months	-	-	10	-	**6**
% Diagnosed with a sexually transmitted infection in their lifetime	20	24	29	27	**26**

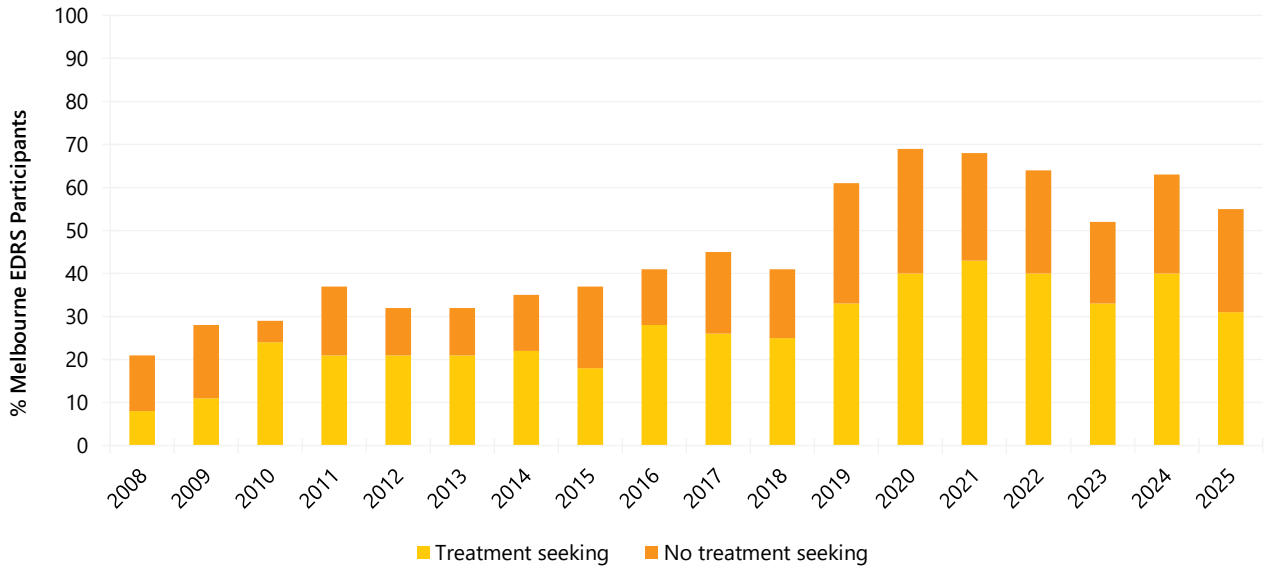
Note. [#] Due to the sensitive nature of these items, there is missing data for some participants who chose not to respond. Statistical significance for 2024 versus 2025 presented in table; *p<0.050; **p<0.010; ***p<0.001. Please refer to Table 1 for a guide to table/figure notes.

Mental Health and Psychological Distress (K10)

Mental Health

In 2025, 55% of the Melbourne sample reported that they had experienced a mental health problem in the preceding six months (other than drug dependence), stable relative to 2024 (63%; p=0.318). Of those who reported a mental health problem in 2025 and commented (n=51), the most common mental health problems reported were depression (69%; 70% in 2024; p=0.377), anxiety (63%; 70% in 2024; p=0.187), and ADHD (24%; 18% in 2024; p=0.822). Of those who reported experiencing a mental health problem (n=54), 56% reported seeing a mental health professional during the past six months (64% in 2024; p=0.440) (31% of the total sample) (Figure 65). Of those who reported seeing a mental health professional in 2025 (n=31), 42% reported being prescribed medication for their mental health problem, a significant decrease from 2024 (69%; p=0.033).

Figure 65: Self-reported mental health problems and treatment seeking in the past six months, Melbourne, VIC, 2008-2025



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

Psychological Distress (K10)

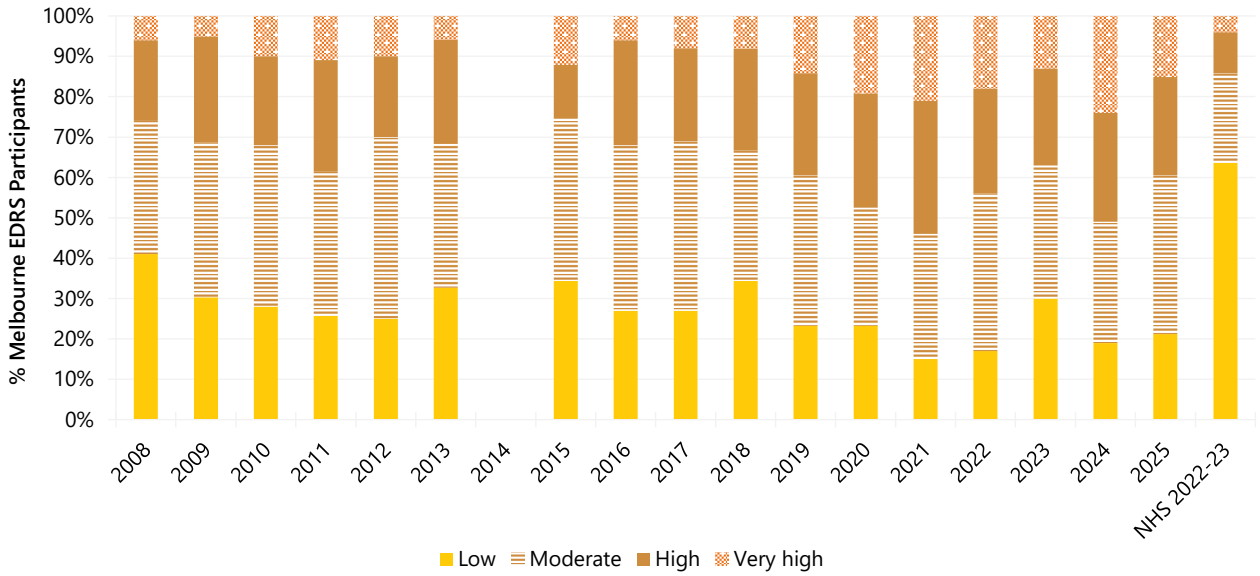
The Kessler Psychological Distress Scale 10 (K10) was administered to obtain a measure of psychological distress in the past four weeks. It is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured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

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

Among those who responded in 2025 (n=99), the per cent of participants scoring in each of the four K10 categories remained stable from 2024 (p=0.323). In 2025, 15% of the Melbourne sample obtained a 'very high' score of 30 or more (24% in 2024), 24% scored 'high' (27% in 2024) and 39% scored 'moderate' (30% in 2024) (Figure 66).

The National Health Survey 2022-23 provides Australian population data for adult (≥18 years) K10 scores. EDRS participants in 2024 reported greater levels of 'high' and 'very high' distress compared to the general population (Figure 66).

Figure 66: K10 psychological distress scores, Melbourne, VIC, 2006-2025 and among the general population, 2022-2023



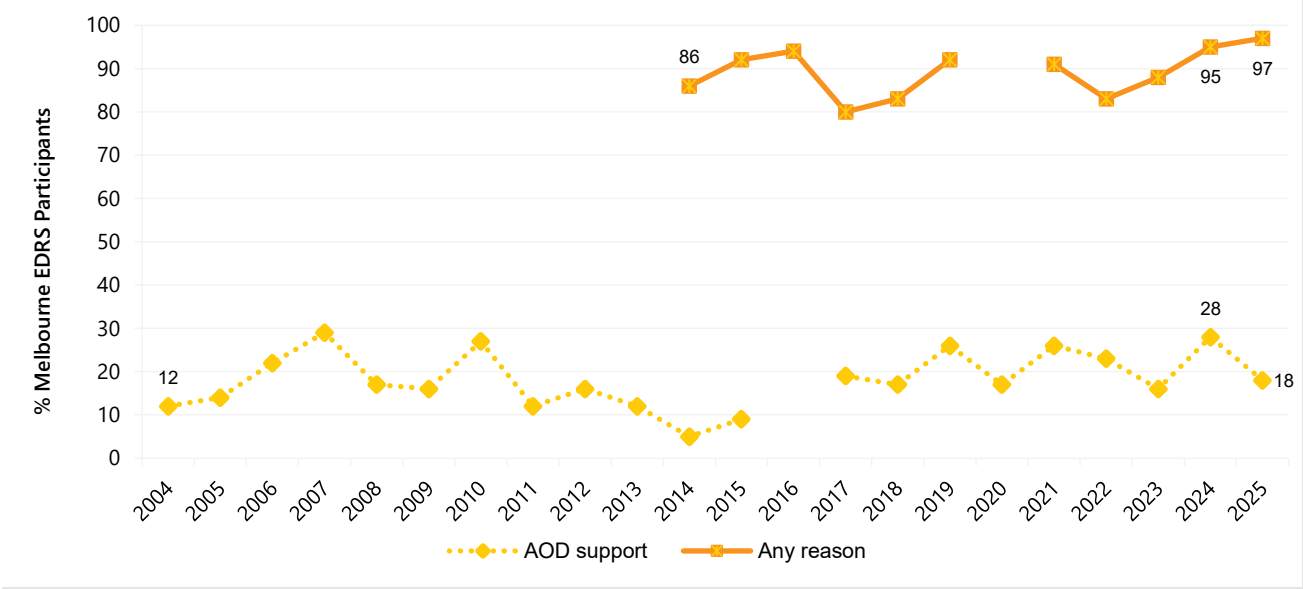
Note. Data from the National Health Survey are a national estimate from 2022-23 for adults 18 or older. Imputation used for missing scale scores (EDRS only). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Statistical significance for 2024 versus 2025 presented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

Health Service Access

Around one fifth (18%) of the Melbourne sample reported accessing any health service for alcohol and/or drug (AOD) support in the six months preceding interview in 2025 (26% in 2024; p=0.233) (Figure 67). The most common services reported by participants in 2025 included general practitioners (GPs) (9%; n≤5 in 2024; p=0.251) and a psychologist (6%; n≤5 in 2024) (Figure 67).

The majority (97%) of participants reported accessing any health service for any reason in the six months preceding interview in 2025 (95% in 2024; p=0.495). Primary services reported by participants in 2025 were GPs (86%; 81% in 2024; p=0.448), pharmacies (60%; 51% in 2024; p=0.261), dentists (42%; 28% in 2024; p=0.056) and psychologists (25%; 30% in 2024; p=0.526) (Figure 67 and Table 8).

Figure 67: Health service access for alcohol and other drug reasons and any reason in the past six months, Melbourne, VIC, 2004-2025



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

Table 8: Types of health service access for alcohol and other drug reasons and for any reason in the past six months, Melbourne, VIC, 2022-2025

	AOD support				Any reason			
	2022	2023	2024	2025	2022	2023	2024	2025
% accessing health service	**N=100**	**N=100**	**N= 100**	**N=100**	**N=100**	**N=100**	**N= 100**	**N=100**
GP	8	-	-	**9**	76	74	81	**86**
In person	/	/	/	**9**	/	/	/	**84**
Telehealth	/	/	/	**-**	/	/	/	**34**
Emergency department	-	-	6	**-**	13	19	28	**19**
Hospital admission (inpatient)	-	-	-	**-**	9	12	12	**13**
Medical tent (e.g., at a festival)	-	-	-	**-**	-	11	8	**-**
Drug and Alcohol counsellor	7	-	7	**-**	6	-	8	**-**
Hospital as an outpatient	0	0	-	**-**	7	9	13	**12**
Specialist doctor (not including a psychiatrist)	-	-	-	**0**	15	18	18	**15**
Dentist	-	-	-	**0**	28	41	28	**42**
Ambulance attendance	0	-	7	**-**	-	-	11	**6**
Pharmacy	/	/	-	**-**	/	/	51	**60**
Other health professional (e.g., physiotherapist)	0	0	0	**-**	23	23	16	**23**
Psychiatrist	-	-	-	**-**	14	10	17	**7**
Psychologist	-	-	-	**6**	30	34	30	**25**
NSP	0	0	-	**-**	0	0	-	**-**
Peer based harm reduction service	6	-	6	**-**	7	9	10	**7**
Other harm reduction service	0	0	0	**0**	-	-	-	**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.

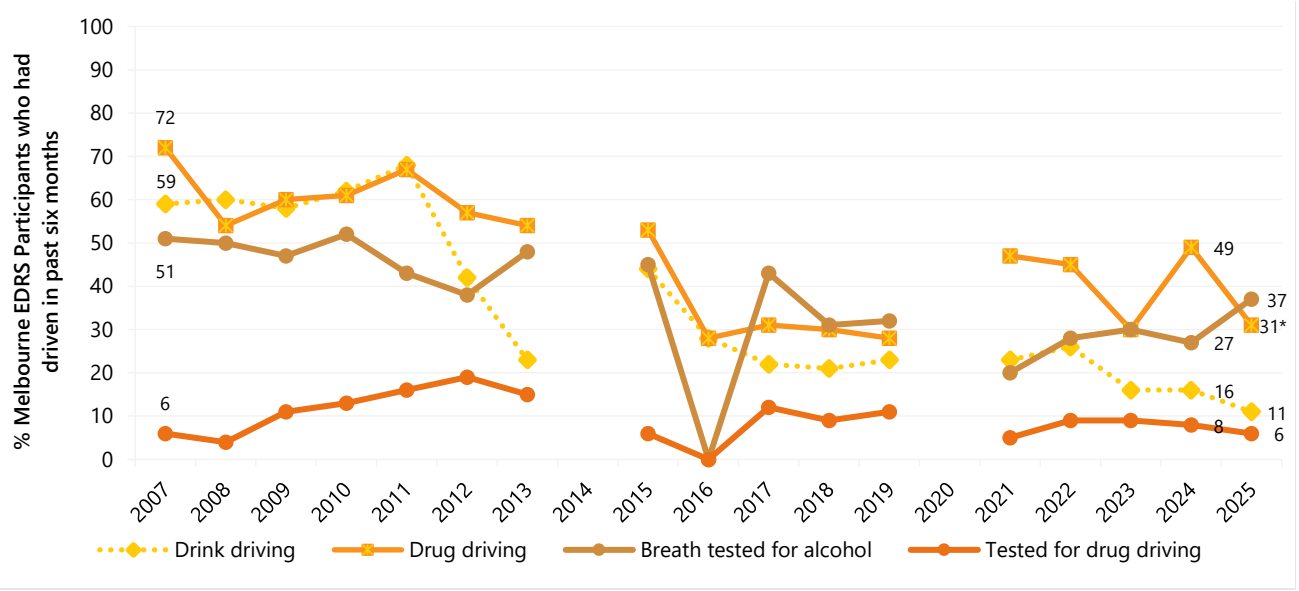
Driving

In 2025, 84% of the Melbourne sample had driven a car, motorcycle, or other vehicle in the six months preceding interview. Of those who had driven in the past six months and responded (n=81), 11% reported driving while over the (perceived) legal limit of alcohol (16% in 2024; p=0.476).

Of those who had driven in the past six months and responded in 2025 (n=83), 31% reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months, a significant decrease from 2024 (49%; p=0.028) (Figure 68). Participants most commonly reported using cannabis (38%) prior to driving in the last six months, followed by cocaine (23%) and ketamine (23%).

Among those who had driven in the past six months (n=84), few participants (n≤5) reported that they had been tested for drug driving by the police roadside drug testing service (8% in 2024; p=0.761). Of those who had driven (n=84), 37% reported they had been breath tested for alcohol by the police roadside drug testing service in the six months prior to interview (27% in 2024; p=0.191) (Figure 68).

Figure 68: Self-reported testing, and driving over the (perceived) legal limit for alcohol or three hours following illicit drug use, among those who had driven in the past six months, Melbourne, VIC, 2007-2025



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

Experience of Crime and Engagement with the Criminal Justice System

In 2025, around one third (32%) of the sample reported engaging in 'any' crime in the month prior to interview, a significant decrease from 2024 (52%; p=0.008). Property crime (26%; 37% in 2024; p=0.132) was the main form of criminal activity reported in 2025. There was a significant decrease in participants reporting selling drugs for cash profit in the month preceding interviewing in 2025 (14%), relative to 2024 (29%; p=0.015) (Figure 69).

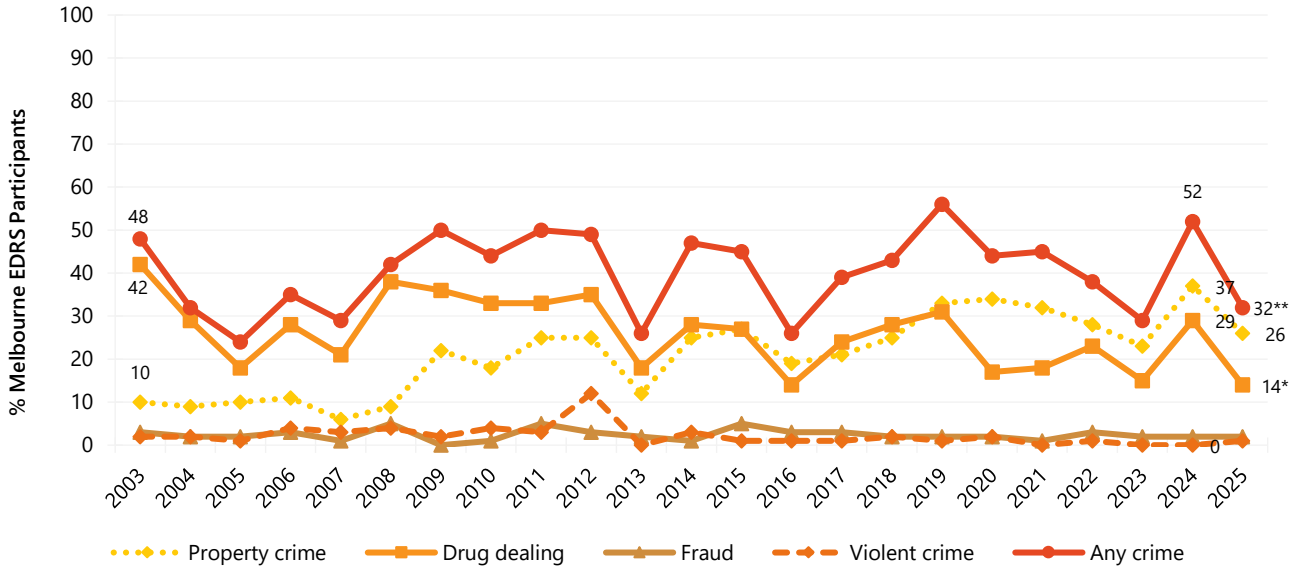
In 2025, few participants (n≤5) reported being the victim of a crime involving violence (6% in 2024; p=0.765).

Few participants (n≤5) reported having ever been in prison in 2025 (n≤5 in 2024; p=0.681) (Figure 70). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Few participants (n≤5) reported being arrested in the 12 months preceding interview (n≤5 in 2024; 0.495) (Figure 70). Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

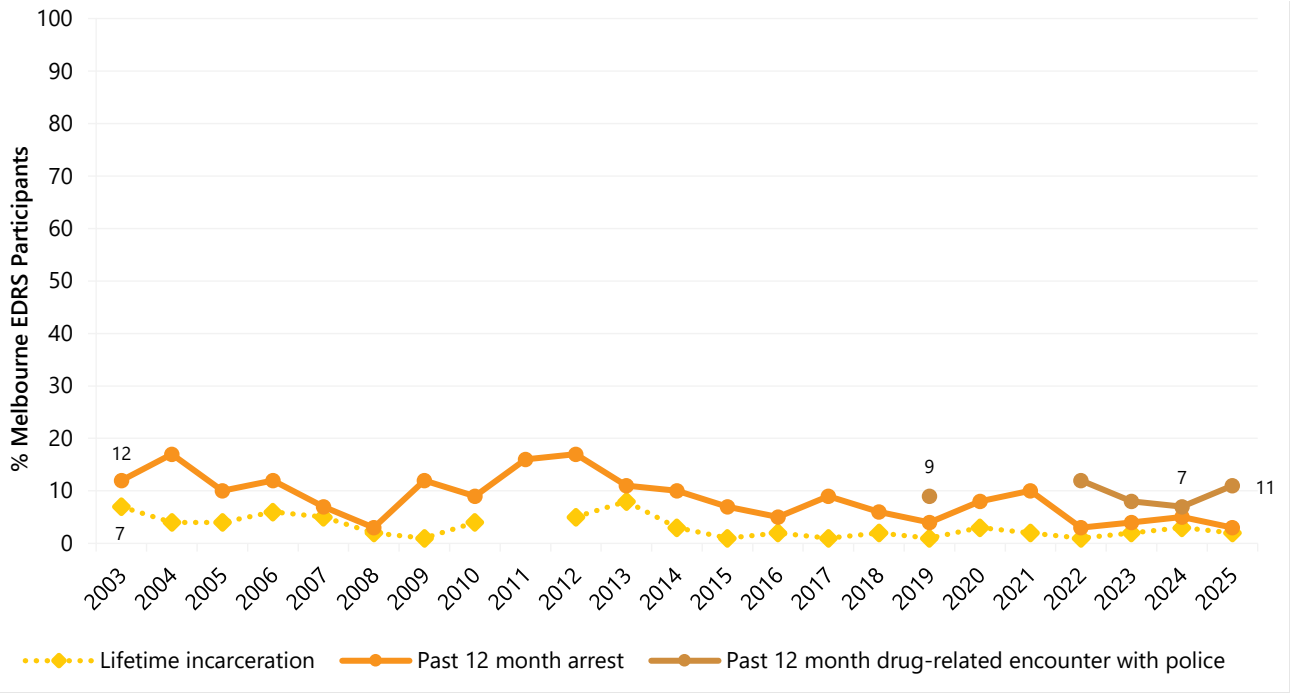
In 2025, 11% of the sample reported a drug-related encounter with law enforcement in the last 12 months that did not result in charge or arrest, stable from 2024 (7%; p=0.453) (Figure 70). Few participants (n≤5) reported what the drug-related encounter comprised; therefore, further details are not reported. Please refer to the 2025 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 69: Self-reported criminal activity in the past month, Melbourne, VIC, 2003-2025



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

Figure 70: Lifetime incarceration, and past 12 month arrest and drug-related encounters with police that did not result in arrest, Melbourne, Victoria, 2003-2025



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

Modes of Purchasing Illicit or Non-Prescribed Drugs

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

Purchasing Approaches

In 2025, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was reported to be social networking or messaging applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder; 81%), similar to 2024 (77%; p=0.601). This was followed by face-to-face communication (74%; 72% in 2024; p=0.872) (Table 9). It is important to reiterate 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. In 2025, the most common social networking or messaging apps used to arrange the purchase of illicit drugs was Signal (67%), followed by Snapchat (22%) and Facebook (21%), and these were mostly obtained by a known dealer/vendor (73%), followed by a friend/relative/partner/colleague (64%).

Buying and Selling Drugs Online

In 2025, 7% of participants reported obtaining drugs via the darknet in the past year (n≤5 in 2024; p=0.373) and few participants (n≤5) reported buying the on the surface web (n≤5 in 2024). Around half (48%) of the sample reported ever obtaining illicit drugs through someone who had purchased them on the surface web or darknet, with 29% having done so in the last 12 months (20% in 2024; p=0.222). In 2025, no participants reported selling illicit/non-prescribed drugs via surface or darknet marketplaces in the 12 months preceding interview, a significant decrease from 6% in 2024 (p=0.014).

Source and Means of Obtaining Drugs

Most participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2025 (89%; 80% in 2024; p=0.116), followed by 74% reporting obtaining them from a known dealer/vendor (76% in 2024; p=0.750). Around two fifths (39%) reported obtaining illicit drugs from an unknown dealer/vendor, stable relative to 2024 (42%; p=0.774) (Table 9).

When asked about how they had received illicit drugs on any occasion in the last 12 months, all participants reported face-to-face (100%; 96% in 2024; p=0.059), followed by a collection point (defined as a predetermined location where a drug will be dropped for later collection; 13%), a significant decrease from 32% in 2024 (p=0.001). Fewer participants reporting receiving illicit drugs via post in 2025 (13%; 8% in 2024; p=0.354) (Table 9).

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

	2019 (N=99)	2020 (N=100)	2021 (N=100)	2022 (N=100)	2023 (N=100)	2024 (N=100)	2025 (N=99)
% Purchasing approaches in the last 12 months^#	(n=99)	(n=100)	(n=99)	(n=99)	(n=99)	**(n=100)**	**(n=99)**
Face-to-face	82	68	52	56	63	72	**74**
Surface web	-	7	-	-	-	-	**-**
Darknet market	7	7	6	12	6	-	**7**
Social networking or messaging applications`	77	81	88	84	82	77	**81**
Text messaging	51	48	20	30	26	42	**44**
Phone call	34	36	19	14	11	24	**30**
Grew/made my own	/	-	0	-	-	-	**-**
Other	-	-	0	-	-	0	**-**
% Means of obtaining drugs in the last 12 months^~	(n=99)	(n=100)	(n=99)	(n=99)	(n=100)	(n=99)	**(n=100)**
Face-to-face	99	94	94	96	97	96	**100**
Collection point	-	18	-	-	14	32	**13****
Post	11	12	10	15	10	8	**13**
% Source of drugs in the last 12 months^	(n=99)	(n=100)	(n=99)	(n=100)	(n=99)	(n=100)	**(n=99)**
Friend/relative/partner/colleague	85	82	73	78	72	80	**89**
Known dealer/vendor	83	75	75	78	74	76	**74**
Unknown dealer/vendor	33	49	33	45	23	42	**39**

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