



AUSTRALIAN DRUG TRENDS 2026

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



AUSTRALIAN DRUG TRENDS 2026: KEY FINDINGS FROM THE NATIONAL ECSTASY AND RELATED DRUGS REPORTING SYSTEM (EDRS) INTERVIEWS

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Please note that, as with all statistical reports, the data in this report may be subject to minor revisions over time. For the most up-to-date information, please refer to the online version at [Drug Trends](#).

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Research Team

The National Drug and Alcohol Research Centre (NDARC), University of New South Wales (UNSW) Sydney, coordinated the EDRS. The following researchers and research institutions contributed to the EDRS in 2026:

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- Joanna Wilson, Dorian Raffaele and Professor Paul Dietze, Disease Elimination Program, Burnet, Victoria;
- Sophie Radke and Professor Raimondo Bruno, School of Psychology, University of Tasmania, Tasmania; and
- Dr Jodie Grigg and Professor Simon Lenton, National Drug Research Institute and enAble Institute, Curtin University, Western Australia.

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Participants

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Contributors

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Abbreviations

4-FA	4-Fluoroamphetamine
5-MeO-DMT	5-methoxy-N,N-dimethyltryptamine
ACT	Australian Capital Territory
ADE	Adelaide
ADHD	Attention-Deficit Hyperactivity Disorder
Alpha PVP	α -Pyrrolidinopentiophenone
Alpha PHP	α -Pyrrolidinohexiophenone
AOD	Alcohol and Other Drug
AUDIT-C	Alcohol Use Disorders Identification Test-Concise
BRI/GC	Brisbane and the Gold Coast
CAN	Canberra
CBD	Cannabidiol
COVID-19	Coronavirus Disease 2019
DAR	Darwin
DMT	Dimethyltryptamine
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDRS	Ecstasy and Related Drugs Reporting System
GBL/GHB/1,4-BD	Gamma-butyrolactone/Gamma-hydroxybutyrate/1,4-Butanediol
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HOB	Hobart
IDRS	Illicit Drug Reporting System
IQR	Interquartile range
K10	Kessler Psychological Distress Scale 10
LSD	<i>d</i> -lysergic acid
MDA	3,4-methylenedioxyamphetamine
MDMA	3,4-methylenedioxymethamphetamine
MDPV	Methylenedioxypyrovalerone
MELB	Melbourne
N (or n)	Number of participants
NBOME	N- methoxybenzyl
NDARC	National Drug and Alcohol Research Centre
NPS	New Psychoactive Substances
NSP	Needle Syringe Program
NSW	New South Wales
NT	Northern Territory
OTC	Over-the-counter

PER	Perth
PMA	Paramethoxyamphetamine
PMMA	Polymethyl Methacrylate
QLD	Queensland
REDCAP	Research Electronic Data Capture
SA	South Australia
SD	Standard deviations
SDS	Severity of Dependence Scale
SYD	Sydney
STI	Sexually Transmitted Infection
TAS	Tasmania
TGA	Therapeutic Goods Administration
THC	Tetrahydrocannabinol
UNSW	University of New South Wales
VIC	Victoria
WA	Western Australia
WHO	World Health Organization

Executive Summary

The EDRS comprises a sentinel sample of people who regularly use ecstasy and/or other illicit stimulants, recruited via social media and word-of-mouth across each capital city of Australia. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2026 from March-July. Interviews from 2020 onwards were delivered face-to-face as well as via telephone and videoconference; all interviews prior to 2020 were conducted face-to-face. This methodological change should be factored into all comparisons of data from the 2020-2026 samples relative to previous years.**

Sample Characteristics

In 2026, the national EDRS sample ($n=698$) remained largely similar to the sample in 2025. Specifically, gender identity (59% male; 57% in 2025) and median age (25 years; 26 years in 2025) remained stable. Current employment status also remained stable, with most participants employed on a part time/casual (37%; 39% in 2025) or full time (31%; 29% in 2025) basis, although the median weekly income significantly increased, from \$700 in 2025 to \$890 in 2026 ($p=0.002$). Drug of choice significantly changed ($p<0.001$), with more participants nominating cocaine (20%; 13% in 2025) and fewer reporting cannabis (16%; 23% in 2025) as their drugs of choice in 2026. The drugs used most often in the month preceding interview also significantly changed in 2026 ($p=0.030$), with more participants reporting alcohol (38%; 29% in 2025) and fewer reporting cannabis (22%; 29% in 2025) as the drugs used most often.

Non-Prescribed Ecstasy

Recent use of any non-prescribed ecstasy remained stable in 2026 (94%; 93% in 2025), though the frequency of use significantly decreased (7 days; 8 days in 2025; $p=0.010$). Capsules remained the most commonly used form of non-prescribed ecstasy in 2026 (55%; 55% in 2025), followed by crystal (43%; 51% in 2025; $p=0.006$) which declined significantly relative to 2025. Recent use of pills (40%; 40% in 2025) and powder (21%; 23% in 2025) remained stable. The median price for both one non-prescribed ecstasy pill and one non-prescribed ecstasy capsule was \$25, stable from 2025. The median price for one point of non-prescribed ecstasy crystal significantly decreased, from \$30 in 2025 to \$20 in 2026 ($p=0.017$). Perceived purity for all forms of non-prescribed ecstasy remained stable in 2026, relative to 2025, though the perceived availability of ecstasy pills significantly changed between 2025 and 2026 ($p=0.011$), with more participants reporting 'easy' obtainment in 2026 (47%; 34% in 2025).

Methamphetamine

Recent methamphetamine use among this sample has declined over time, with a further decrease observed between 2025 (29%) and 2026 (20%) ($p<0.001$). Recent use of methamphetamine crystal (15%; 20% in 2025; $p=0.005$) and powder (6%; 12% in 2025; $p<0.001$) both significantly decreased in 2026, though frequency of use for both forms remained stable. Few participants ($n\leq 5$) reported using base in 2026. The price, perceived purity and perceived availability of methamphetamine powder and methamphetamine crystal remained stable between 2025 and 2026.

Non-Prescribed Pharmaceutical Stimulants

Past six month use of non-prescribed pharmaceutical stimulants remained stable in 2026 (53%; 55% in 2025), as did frequency of use (6 days). Among those who reported recent use, the majority reported using dexamfetamine (79%), followed by ritalin (33%). Median price (\$5 per 5mg tablet) and perceived availability both remained stable relative to 2025, with 80% reporting 'easy' or 'very easy' obtainment.

Cocaine

A significant increase was observed in recent use of cocaine, from 79% in 2025 to 84% in 2026 ($p=0.019$), the highest per cent observed over the reporting period. Median frequency of use also significantly increased, from 5 days in 2025 to 6 days in 2026 ($p<0.001$). The majority of participants who had recently consumed cocaine reported using powder cocaine (93%; 96% in 2025; $p=0.020$), with 14% reporting use of crack/rock cocaine (9% in 2025; $p=0.013$). Perceived purity and perceived availability of cocaine remained stable between 2025 and 2026. While the median price of a gram of cocaine remained stable at \$350, the distribution of reported prices differed significantly between 2025 and 2026 ($p=0.019$).

Cannabis and/or Cannabinoid-Related Products

Recent use of non-prescribed cannabis and/or cannabinoid-related products remained stable in 2026 (71%) relative to 2025 (72%), though frequency of use significantly decreased (30 days; 48 days in 2025; $p=0.005$). Among those who reported recent use in 2026, hydroponic cannabis was the most commonly used form of non-prescribed cannabis (62%), followed by bush cannabis (53%). The price, perceived potency and perceived availability of

hydroponic cannabis remained stable in 2026 relative to 2025. However, the median price of a gram of bush cannabis significantly increased (\$20; \$15 in 2025; $p=0.040$), and the perceived availability significantly changed, relative to 2025 ($p<0.001$), with less participants reporting 'very easy' obtainment (60%; 79% in 2025), and more participants reporting 'easy' obtainment (34%; 19% in 2025).

Non-Prescribed Ketamine, LSD and DMT

Recent use of non-prescribed ketamine (53%; 52% in 2025), LSD (34%; 35% in 2025) and DMT (9%; 11% in 2025) remained stable in 2026, relative to 2025. Median frequency of use remained low for all three substances, though median days of non-prescribed ketamine significantly increased from 5 days of use in 2025 to 6 days in 2026 ($p=0.031$). Price, perceived purity and perceived availability for non-prescribed ketamine and LSD remained stable between 2025 and 2026.

New Psychoactive Substances (NPS)

Recent use of any NPS (excluding plant-based NPS) remained stable in 2026 (10%; 13% in 2025), with any 2C substance the most commonly used NPS (6%; 4% in 2025).

Other Drugs

In 2026, 95% reported recent alcohol use, a significant increase relative to 2025 (92%; $p=0.031$), though frequency of use remained stable (30 days; 40 days in 2025). Recent use of any tobacco remained stable in 2026, relative to 2025 (72%, respectively), although there were significant decreases in median days of use (85 days; 120 days in 2025; $p=0.010$) and daily use (34%; 43% in 2025; $p=0.003$). The per cent reporting recent use of smoked or non-smoked illicit tobacco products significantly increased in 2026 (55%; 46% in 2025; $p<0.001$). Recent use of all other monitored drugs remained stable between 2025 and 2026.

Drug-Related Harms and Other Behaviours

Polysubstance use and bingeing

On the last occasion of ecstasy or related drug use, 88% of participants reported concurrent use of two or more drugs (excluding tobacco and e-cigarettes).

One quarter (25%) of participants reported using stimulants or related drugs for 48 hours or more continuously without sleep in the six months preceding interview.

Dependence, overdose and injecting

Three quarters (75%) of participants obtained an AUDIT score of ≥ 8 , indicative of hazardous alcohol use. Seventeen per cent of those who reported recent ecstasy use obtained an SDS score of ≥ 3 , while 45% of participants reporting recent methamphetamine use obtained a score of ≥ 4 (32% in 2025; $p=0.032$), indicating possible dependence on these substances.

Past year non-fatal stimulant overdose remained stable in 2026 (15%; 18% in 2025), however, past year non-fatal depressant overdose significantly decreased (17%; 22% in 2025; $p=0.023$).

Past month injecting drug use remained low and stable (1%; 2% in 2025).

Drug checking and naloxone awareness

One third (33%) of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year, a significant decrease from 39% in 2025 ($p=0.044$).

In 2026, 77% of the sample reported that they had ever heard of naloxone, of which 21% reported that they had obtained naloxone in the year prior to interview, both stable from 2025 (73% and 27%, respectively)

Sexual activity, mental health and health service access

Almost four fifths (77%) of the sample reported engaging in sexual activity in the past four weeks, of which 82% reported using alcohol and/or other drugs prior to or while engaging in sexual activity.

Fifty-five per cent of the sample self-reported that they had experienced a mental health problem in the preceding six months. Fifteen per cent reported a score of ≥ 30 on the K10, indicating very high psychological distress.

Twenty-eight per cent of participants reported accessing any health service for alcohol and/or drug support in the six months preceding interview. Current drug treatment engagement remained low (6%).

Driving, contact with police and modes of purchasing drugs

In 2026, the per cent of recent drivers who reported driving while over the perceived legal limit of alcohol (24%; 20% in 2025; $p<0.001$) or within three hours of consuming an illicit or non-prescribed drug (35%; 44% in 2025; $p=0.003$) both significantly changed relative to 2025, albeit in opposite directions.

Five per cent of participants reported past year arrest (8% in 2025; $p=0.029$), while 11% reported a drug-related encounter with police which did not result in arrest (15% in 2025; $p=0.035$).

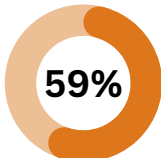
In 2026, the most common means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (75%), closely followed by social networking or messaging applications (73%). Most participants continued to report obtaining illicit drugs face-to-face (96%), primarily from a friend/relative/partner/colleague (79%) or from a known dealer (67%).



Between March-July, 698 participants, recruited from all capital cities across Australia (excluding Darwin, NT), were interviewed.



25 years



Male

Median age and per cent who identified as male.

Part time / casual work 37%

Current Student 35%

Full time work 31%



Current student and employment status.



Ecstasy

Cocaine

Other stimulants

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

DRUG-RELATED HARMS AND RISKS

Drug driving 35%**

Drink driving 24%***



Among recent drivers, 35% reported driving a vehicle within 3 hours of consuming illicit drugs (a significant decrease from 44% in 2025) and 24% while over the legal limit of alcohol (a significant increase from 20% in 2025).

17%*

15%

Depressant

Stimulant

Percentage who reported past year non-fatal depressant (a significant decrease from 22% in 2025) and stimulant overdose.

73%

75%



2025

2026

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

Two or more drugs 88%

Depressants & stimulants 40%

Depressants, stimulants & cannabis 14%



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

OTHER BEHAVIOURS

55%

33%

Self-reported MH issue

Seen a MH professional

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

Depression 60%

Anxiety 59%

ADHD 26%



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

33%*



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, a significant decrease from 2025 (39%).

77%

21%

Heard of naloxone

Obtained naloxone

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

Any methamphetamine

71%

29% ***

20%

2007 2025 2026

LSD

28%

35%

34%

2007 2025 2026

Hallucinogenic mushrooms/psilocybin

18%

41%

42%

2007 2025 2026

GHB/GBL/1,4-BD

7%

9%

6%

2007 2025 2026

Amyl Nitrite

18%

33%

35%

2007 2025 2026

Nitrous oxide (nangs)

22%

31%

32%

2007 2025 2026

E-cigarettes

34%

65%

68%

2014 2025 2026

*p<0.050; **p<0.010; ***p<0.001. The first data point shown is the earliest available observation within the reporting period (2007-2026) and differs across drugs.

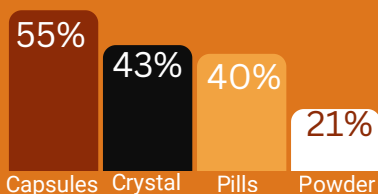
ECSTASY



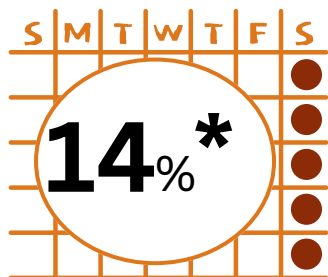
EDRS

Ecstasy and Related Drugs Reporting System

FORM of ecstasy



Past 6 month use of ecstasy capsules, crystal, pills, and powder in 2026.



Of those who had recently used any ecstasy, 14% reported weekly or more frequent use, a significant decrease from 2025 (19%).



2 Capsules



2 Pills

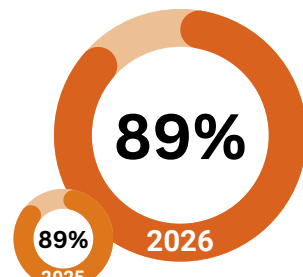


0.30 grams of crystal



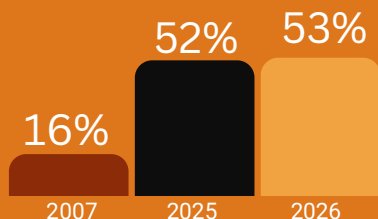
0.30 grams of powder

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

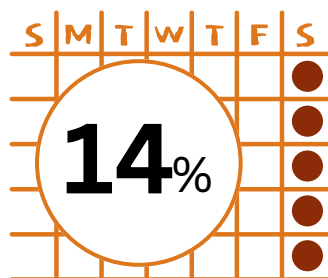


Percentage who perceived ecstasy capsules as being 'easy' or 'very easy' to obtain.

KETAMINE



Past 6 month use of ketamine remained stable between 2025 and 2026.



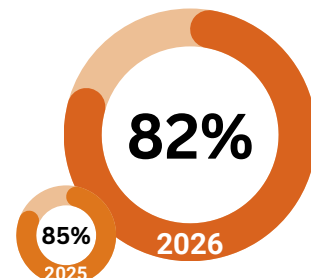
Of those who had recently used ketamine, 14% reported weekly or more frequent use, stable from 2025 (11%).



\$200 \$200

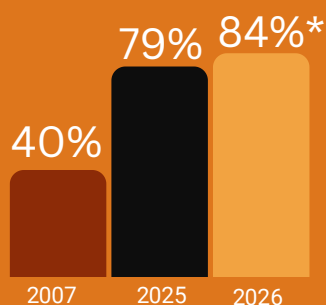
2025 2026

The median reported price for a gram of ketamine.

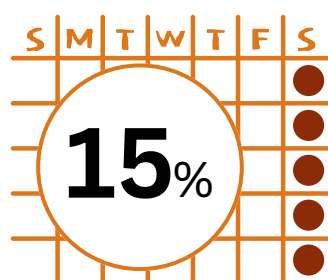


Percentage who perceived ketamine as being 'easy' or 'very easy' to obtain.

COCAINE



Past 6 month use of any cocaine significantly increased in 2026, relative to 2025.



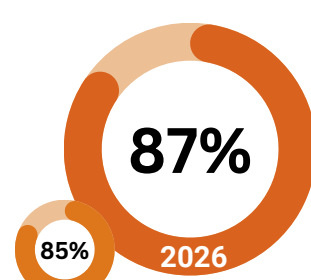
Of those who had recently consumed cocaine, 15% reported weekly or more frequent use, stable from 2025 (12%).



\$350 \$350*

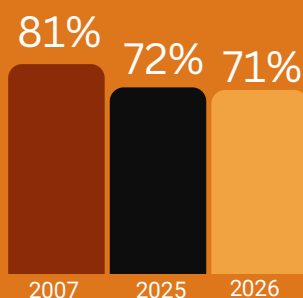
2025 2026

The median reported price for a gram of cocaine.

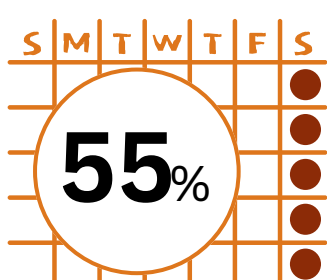


Percentage who perceived cocaine as being 'easy' or 'very easy' to obtain.

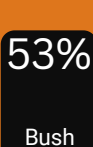
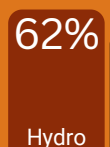
CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS



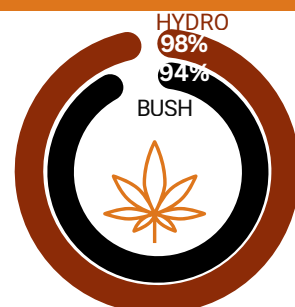
Past 6 month use of non-prescribed cannabis and/or cannabinoid-related products remained stable between 2025 and 2026.



Of those who had recently used non-prescribed cannabis, 55% reported weekly or more frequent use, stable from 2025 (61%).



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



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

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

Background and Methods

The Ecstasy and Related Drugs Reporting System (EDRS) interviews are conducted annually with a sentinel cross-sectional group of people who regularly use ecstasy and/or other illicit stimulants, recruited from all capital cities of Australia (N=698 in 2026). Darwin, NT, was not included in recruitment in 2026, but was included in previous years. The results from the EDRS interviews are not representative of all people who consume drugs, nor of illicit drug use in the general population, but this is not the aim of these data. Rather, these data are intended to provide evidence indicative of trends that warrant further monitoring. These findings should be interpreted alongside analyses of other data sources for a more complete profile of trends in illicit drug use, market features, and harms in Australia.



1

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 (2003) 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), ii) have used ecstasy and/or other illicit stimulants (including: MDA, methamphetamine, cocaine, non-prescribed pharmaceutical stimulants, mephedrone or other stimulant NPS) on at least six days during the preceding six months; and iii) have been a resident of the capital city in which the interview took place for ten of the past 12 months. Interviews took place in varied locations negotiated with participants (e.g., research institutions, coffee shops or parks), and in later years were conducted using REDCap (Research Electronic Data Capture), a software program 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 2020-2026

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) to 18 years old.

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

In 2026, participant reimbursement increased from \$40 (2003-2025) to \$50 to provide more appropriate remuneration for participation and to better align with community expectations and contemporary research reimbursement practices.

2026 EDRS Sample

Between 16 March-10 July 2026, a total of 698 participants were recruited across capital cities nationally, except Darwin. The sample sizes recruited from each capital city were: Sydney, NSW, n=101; Melbourne, VIC, n=98; Adelaide, SA, n=101; Canberra, ACT, n=100; Hobart, TAS, n=100; Brisbane and Gold Coast, QLD, n=98; and Perth, WA, n=100. Ninety-three per cent of these interviews (n=650) were conducted via telephone/videoconference: Sydney, NSW, n=97; Melbourne, VIC, n=92; Adelaide, SA, n=78; Canberra, ACT, n=92; Hobart, TAS, n=94; Brisbane and Gold Coast, QLD, n=97; and Perth, WA, n=100.

One tenth (10%) of the 2026 national sample had taken part in the 2025 interview (10% of the 2025 sample had taken part in the 2024 interview). The majority of participants were recruited via the internet (e.g., Facebook and Instagram) (70%; 69% in 2025; $p=0.642$), and one quarter (25%) were recruited via word-of-mouth (30% in 2025; $p=0.084$).

Data Analysis

For normally distributed continuous variables, means and standard deviations (SD) are reported; for skewed data (i.e., skewness $> \pm 1$ or kurtosis $> \pm 3$), medians and interquartile ranges (IQR) are reported. Tests of statistical significance have been conducted between estimates for 2025 and 2026, noting that no corrections for multiple comparisons have been made and thus comparisons should be treated with caution. Values where cell sizes are ≤ 5 have been suppressed with corresponding notation (zero values are reported). References to 'recent' use and behaviours refers to the six months preceding interview. The response options 'Don't know' and 'Skip question', which were available to select throughout the interview, were excluded from analysis.

Between 2022 and 2025, there was considerable difficulty in recruiting participants from Darwin, Northern Territory (NT), despite extensive recruitment efforts and screening of interested people. Whilst it is difficult to provide a definitive reason for this, it seems that this was reflective of a sustained disruption to drug markets, and a subsequent reduction in the frequency of ecstasy and other illicit stimulant use. As such, recruitment was not undertaken in Darwin in 2026. Historical data from the NT EDRS are included in the national estimates but are not presented individually in jurisdictional tables for 2022, 2023 and 2025 (and 2010-2012) due to small numbers ($n \leq 50$) reporting.

Although national EDRS data collection commenced in 2003, this report presents data from the last 20 years only (2007-2026). Data from earlier years can be found in historical EDRS reports, available via the [Drug Trends webpage](#).

Guide to Table/Figure Notes

Table 1: Guide to Table/Figure Notes

Legend	
	Empty cell(s) indicates question not asked in respective year (for figures)
/	Question not asked in respective year (for tables)
-	Per cent suppressed due to small cell size ($n \leq 5$ but not 0) (for figures and tables)
*$p < 0.050$; **$p < 0.010$; ***$p < 0.001$	Statistical significance between 2025 and 2026
Syd	Sydney
Can	Canberra
Mel	Melbourne
Hob	Hobart
Ade	Adelaide
Per	Perth
Dar	Darwin
Bri/GC	Brisbane and the Gold Coast (and the Sunshine Coast 2014-16)

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 capital cities, 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 jurisdictional-level results beyond estimates of recent use of various substances (comprehensive jurisdictional findings are provided separately; see below), nor does it 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 Australia (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](#). There are also results from the [Illicit Drug Reporting System \(IDRS\)](#), which focus 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.

2 Sample Characteristics

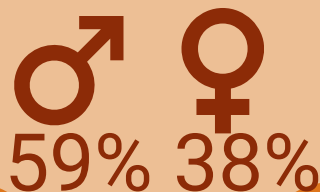
Participants were asked questions about select sociodemographic characteristics, as well as key drug use characteristics of interest.

N= 698

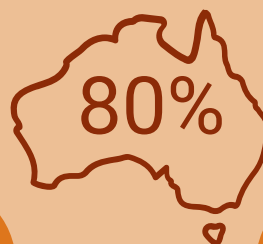
Median age



Gender



Born in Australia



Sexual identity



Mean years of school education



Post-school qualification(s)



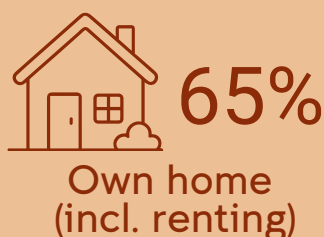
Current students



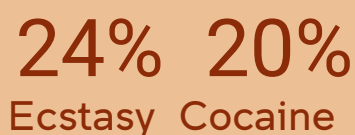
Median weekly income



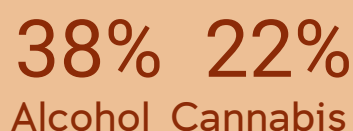
Accommodation



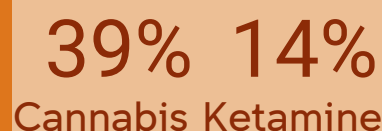
Drug of choice



Drug used most often in the past month



Weekly or more frequent use in the past 6 months



Sample Characteristics

The median age of the 2026 national sample was 25 years (IQR=20-32), stable relative to 26 years in 2025 (IQR=20-34; $p=0.314$) (Table 2). Gender remained stable ($p=0.078$), with 59% of the sample identifying as male (57% in 2025). Current accommodation remained stable between 2025 and 2026 ($p=0.125$), whereby half (51%) of the sample reported living in a rented house/flat at the time of the interview (50% in 2025), and 29% reported living with their parents/in their family home (26% in 2025).

The mean years of school completed remained stable in 2026, relative to 2025 (12 years; range=8-12; 12 years in 2025; range=7-12; $p=0.157$). The percentage of participants who reported having a post-school qualification(s) also remained stable in 2026, relative to 2025 (61%; 63% in 2025; $p=0.437$).

Current employment status remained stable in 2026, relative to 2025 ($p=0.235$); almost one third (31%) reported being employed full-time at the time of interview (29% in 2025), and almost two fifths (37%) reported being employed on a part time/casual basis (39% in 2025). Furthermore, one quarter (25%) reported being unemployed at the time of interview (28% in 2025). The median weekly income significantly increased in 2026 (\$890; IQR=480-1500), relative to 2025 (\$700; IQR=400-1350; $p=0.002$).

Table 2: Demographic characteristics of the sample, nationally, 2025-2026, and by capital city, 2026

	National		Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
	N=690	N=698	N=101	N=100	N=98	N=100	N=101	N=100	/	N=98
	2025	2026	2026	2026	2026	2026	2026	2026	2026	2026
Median age (years; IQR)	26 (20-34)	25 (20-32)	27 (21-37)	21 (19-34)	27 (21-32)	28 (21-35)	24 (21-30)	25 (21-27)	/	23 (20-31)
% Gender										
Female	41	38	36	45	19	45	33	50	/	37
Male	57	59	58	54	76	54	65	49	/	59
Non-binary	1	3	6	-	-	-	-	-	/	-
% Aboriginal and/or Torres Strait Islander	8	5*	-	7	-	9	8	-	/	-
% Born in Australia	85	80*	74	87	79	89	86	65	/	81
% English primary language spoken at home	97	96	92	99	90	98	98	98	/	98
% Sexual identity										
Heterosexual	72	75	69	79	76	76	75	79	/	72
Homosexual	6	6	9	-	8	-	8	7	/	6
Bisexual	17	13	11	13	9	15	13	13	/	18
Queer	4	3	8	-	6	-	-	0	/	-
Other identity	2	2	-	-	0	-	-	-	/	-
Mean years of school education (range)	12 (7-12)	12 (8-12)	12 (10-12)	12 (9-12)	12 (8-12)	11 (8-12)	11 (9-12)	12 (8-12)	/	12 (9-12)
% Post-school qualification(s)^	63	61	65	48	68	65	52	63	/	63
% Current students#	34	35	39	42	39	26	26	32	/	42
% Current employment status										
Employed full-time	29	31	46	26	26	19	33	38	/	33
Part time/casual	39	37	33	36	42	32	32	39	/	45
Self-employed	5	6	-	-	9	12	-	-	/	8
Unemployed	28	25	18	35	23	36	32	18	/	14
Current median weekly income \$ (IQR)	700 (400-1350)	890 (480-1500)**	1150 (525-1740)	660 (425-1385)	800 (497-1200)	700 (400-1200)	785 (400-1457)	1038 (750-1731)	/	1000 (577-1600)
% Current accommodation										
Own house/flat	13	14	16	11	9	17	20	10	/	13

Rented house/flat	50	51	54	59	50	52	36	54	/	51
Parents'/family home	26	29	29	15	39	23	36	33	/	31
Boarding house/hostel	1	1	0	-	0	0	0	-	/	-
Public Housing	5	3	0	11	-	-	6	-	/	-
No fixed address+	2	1	0	-	0	-	-	0	/	-
Other	2	1	-	-	0	-	0	0	/	-

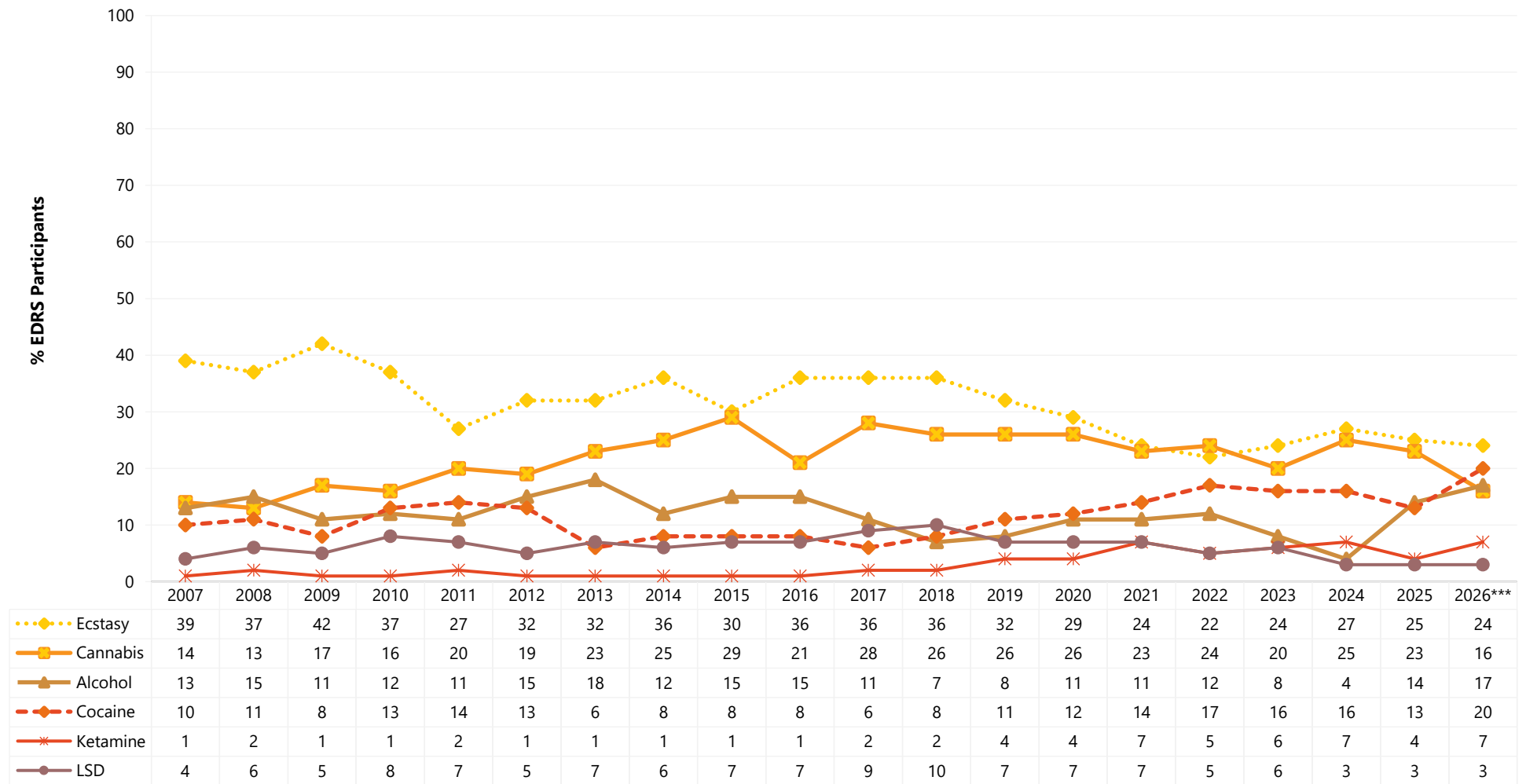
Note. ^ Includes trade/technical and university qualifications. # 'Current students' comprised participants who were currently studying for either trade/technical or university/college qualifications. + No fixed address included couch surfing and rough sleeping or squatting. / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 is presented for the national sample only; comparisons for individual capital cities are not presented; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes. For sample characteristics over the whole duration of the project, see [methods for the annual interviews](#).

Drug of choice significantly changed between 2025 and 2026 ($p<0.001$). The largest proportion of participants reported ecstasy as their drug of choice in 2026 (24%; 25% in 2025), closely followed by 20% of participants nominating cocaine as their drug of choice, an increase from 13% in 2025. Seventeen per cent of participants nominated alcohol as their drug of choice, similar to 14% in 2025, and 16% nominated cannabis, a decrease from 23% in 2025 (Figure 1). Few participants nominated ketamine (7%; 4% in 2025), LSD (3%; 3% in 2025), hallucinogenic mushrooms/psilocybin (2%; 2% in 2025) or pharmaceutical stimulants (2%; 2% in 2025) as their drugs of choice.

A significant change was also observed for the drug used most often in the past month ($p=0.030$). Specifically, in 2026, there was an increase in the percentage of participants who reported that alcohol was the drug used most often in the month preceding interview (38%; 29% in 2025), and a decrease in the percentage of participants who reported that cannabis was the drug used most often in the month prior to interview (22%; 29% in 2025). The percentage reporting ecstasy as the drug used most often remained stable (12%; 12% in 2025) (Figure 2).

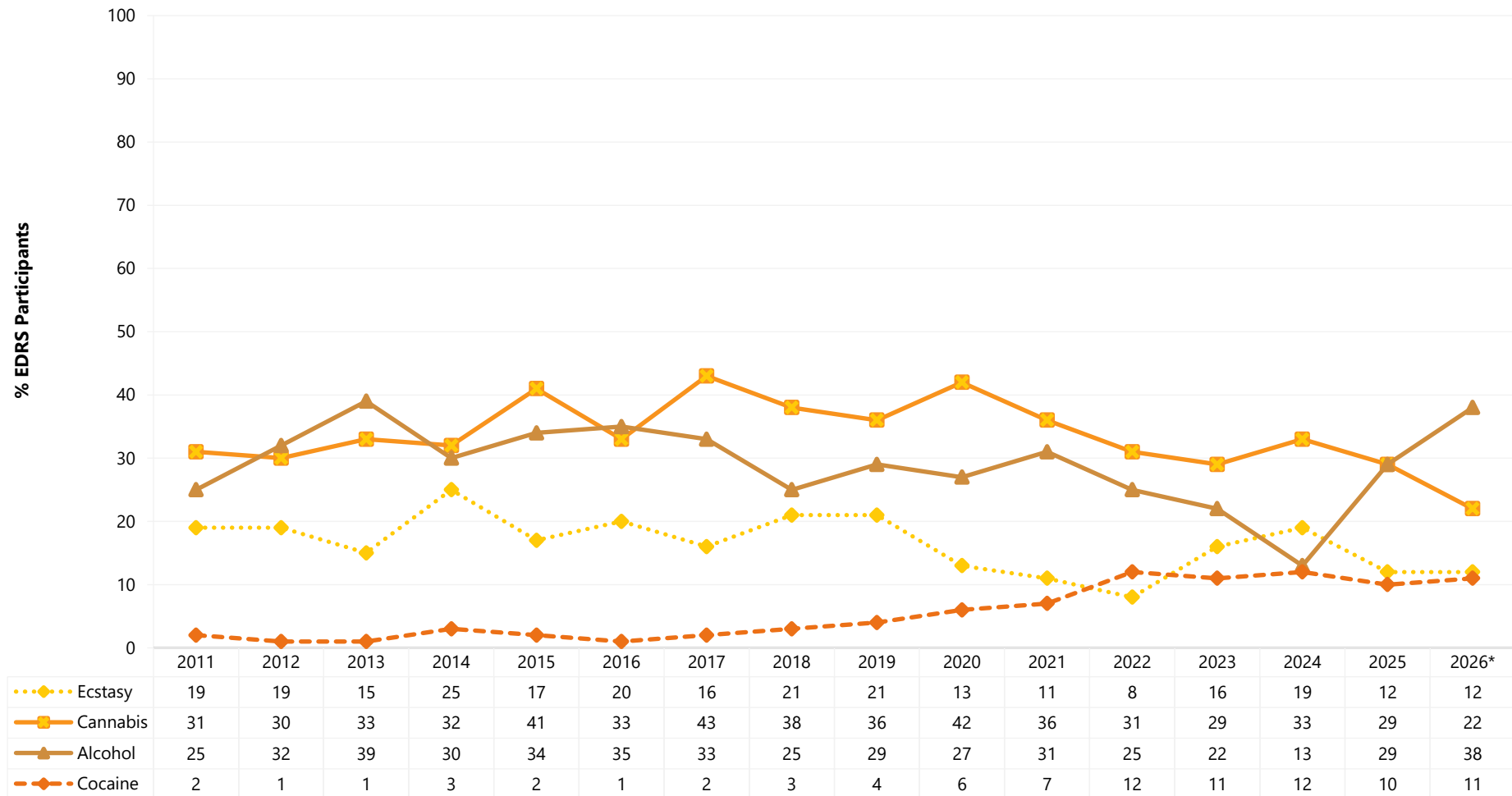
Almost two fifths (39%) of the sample reported weekly or more frequent use of non-prescribed cannabis in 2026, stable relative to 2025 (44%; $p=0.076$). Weekly or more frequent use of ketamine also remained stable in 2026 (14%; 11% in 2025; $p=0.324$). Weekly or more frequent use of ecstasy significantly decreased in 2026 (13%; 18% in 2025; $p=0.007$), as did weekly or more frequent use of methamphetamine (7%; 13% in 2025; $p=0.001$). In contrast, weekly or more frequent use of cocaine significantly increased in 2026, relative to 2025 (13%; 9% in 2025; $p=0.045$) (Figure 3).

Figure 1: Drug of choice, nationally, 2007-2026



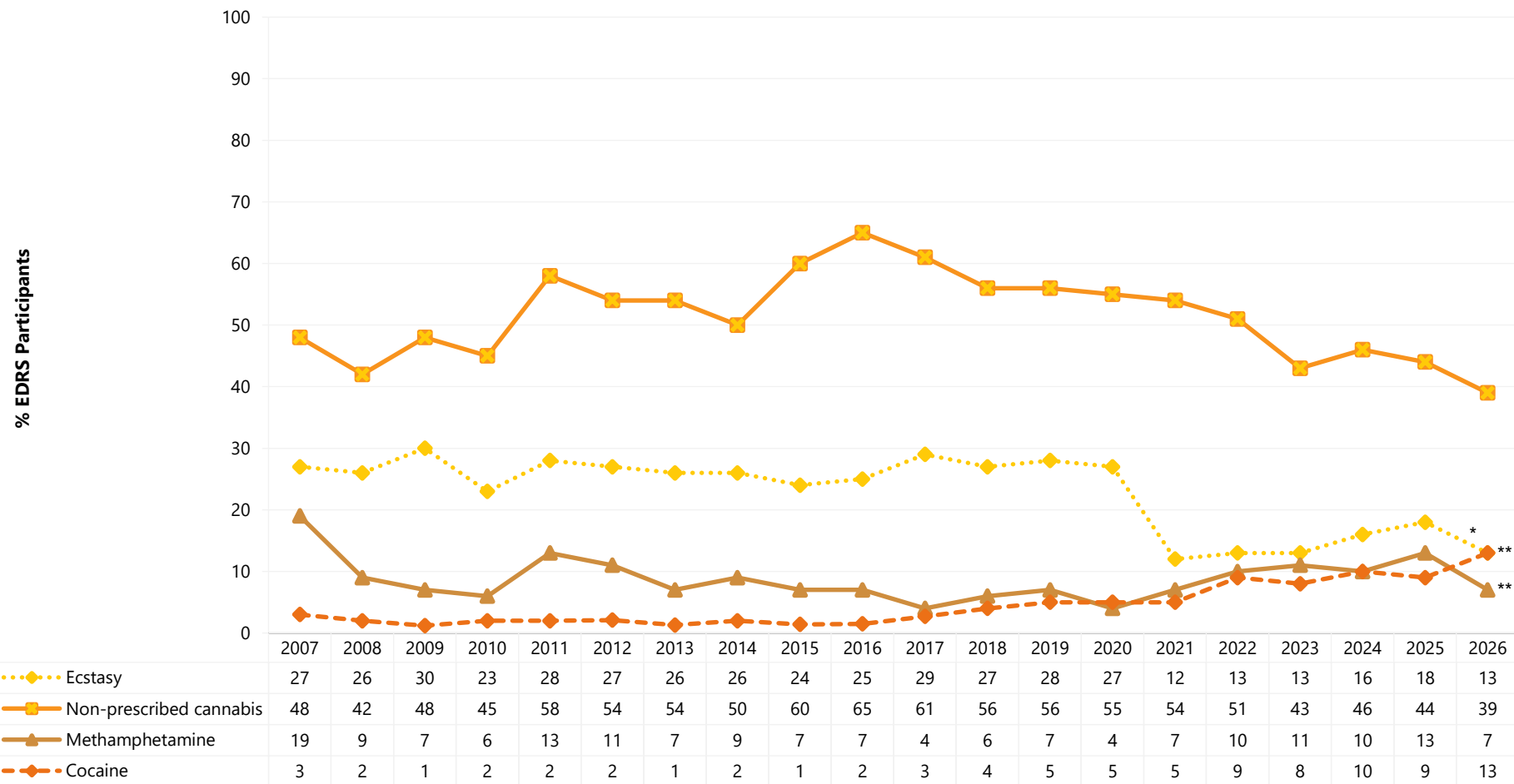
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; smaller percentages have endorsed other substances (in 2026, 2% endorsed hallucinogenic mushrooms/psilocybin and 2% endorsed pharmaceutical stimulants). National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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, nationally, 2011-2026



Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; smaller percentages have endorsed other substances (in 2026, 5% endorsed ketamine, 3% endorsed pharmaceutical stimulants, 1% endorsed LSD and 1% endorsed hallucinogenic mushrooms/psilocybin). National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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, nationally, 2007-2026



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, in 2022, we captured use of 'cannabis and/or cannabinoid-related products', while in previous years, questions referred only to 'cannabis'. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Past 6 months use

94%

3

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.

Median days*

7 days

*Among those whom reported past 6 month use in 2026:

F
O
R
M
S

55% capsules

43% crystal

40% pills

21% powder

Median Amount Used

Typical day

2
capsules

2
pills

0.30
grams
of
crystal

0.30
grams
of
powder

Median Price (Capsules & Crystal)

\$25
Per capsule

\$20
Per point of
crystal

\$200
Per gram of
crystal

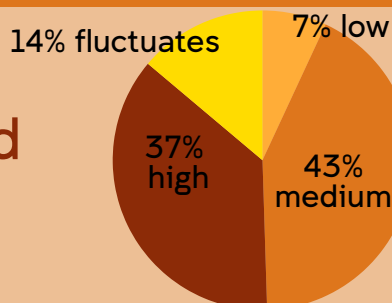
Median Price (Pills & Powder)

\$25
Per pill

\$200
Per gram of powder

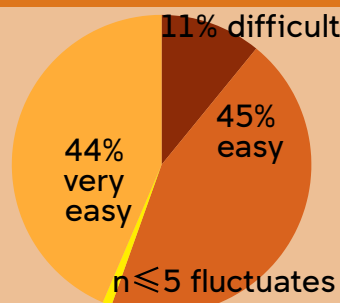
(Capsules)

Perceived
Purity



(Capsules)

Perceived
Availability



Patterns of Consumption (Any Ecstasy)

Recent Use (past 6 months)

The majority (94%) of participants reported any recent use of non-prescribed ecstasy in 2026, stable relative to 2025 (93%; $p=0.437$) (Figure 4). Similarly, non-prescribed ecstasy use remained stable in all capital cities (Table 3).

Consistent with the previous few years, capsules (55%) and crystal (43%) were the most commonly used forms of non-prescribed ecstasy in the six months preceding interview, followed by pills (40%). Powder remained the least commonly used form of non-prescribed ecstasy (21%), consistent with the entirety of the reporting period (Figure 4).

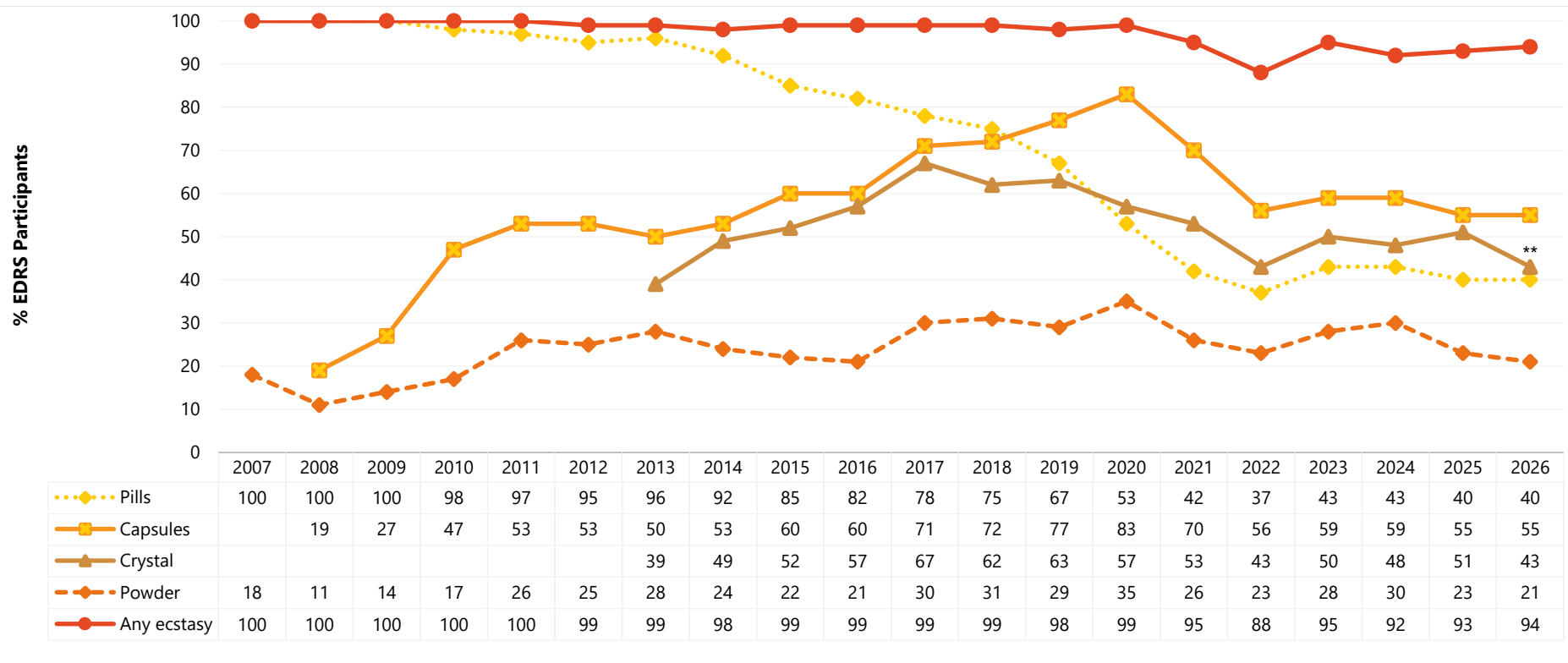
Frequency of Use

In 2026, participants reported using non-prescribed ecstasy (in any form) on a median of seven days (IQR=4-13; $n=653$), a significant decrease from 2025 (8 days; IQR=4-16; $n=643$; $p=0.010$), and lower than what has historically been observed (12-15 days between 2007 and 2020) (Figure 5). Among those who had recently used any non-prescribed ecstasy and commented ($n=653$), weekly or more frequent use significantly decreased in 2026 (14%), relative to 2025 (19%; $p=0.013$).

Number of Forms Used

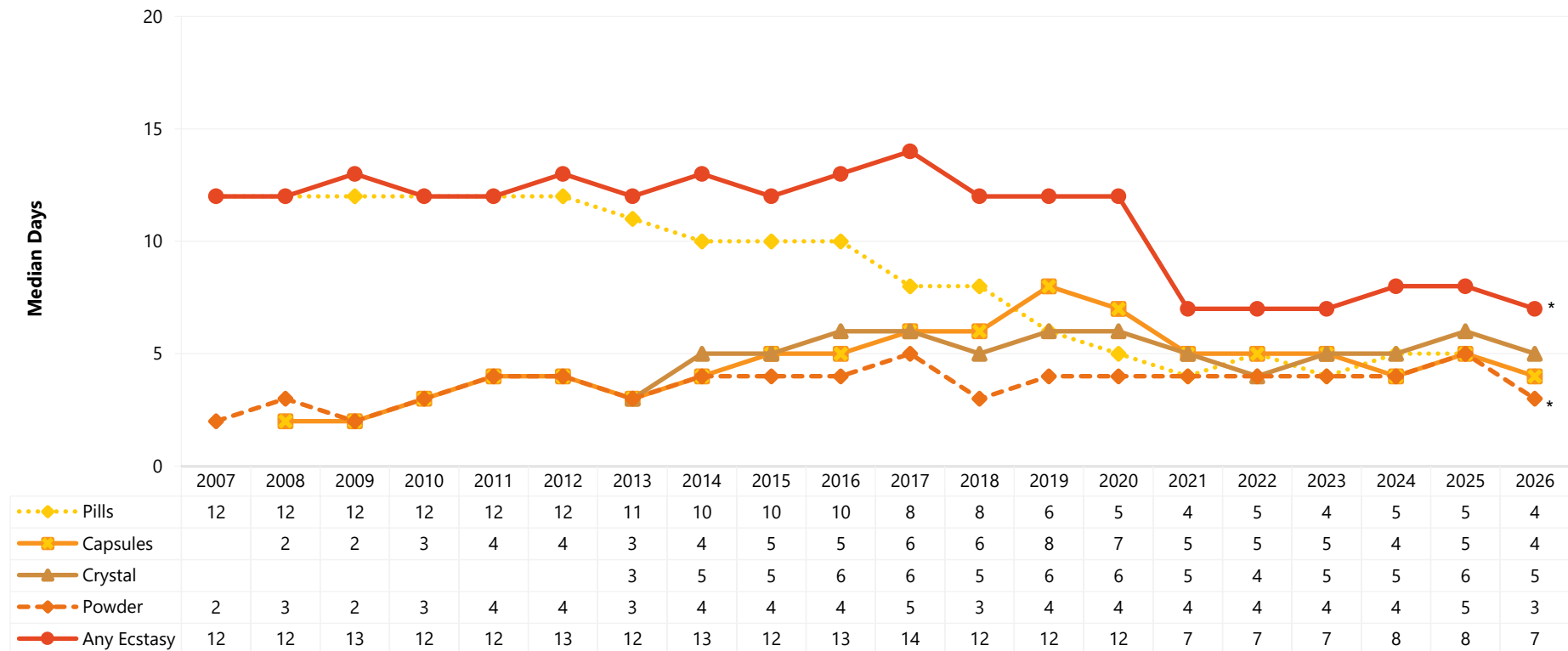
Among participants who had recently consumed non-prescribed ecstasy and commented ($n=658$), participants reported using a median of one form (IQR=1-2) in 2026 (1 form in 2025; IQR=1-2; $p=0.015$). This varied across capital cities, with participants in Melbourne (IQR=1-2), Hobart (IQR=1-2) and Adelaide (IQR=1-2) reporting use of a median of two forms of ecstasy in the six months preceding interview.

Figure 4: Past six month use of any non-prescribed ecstasy, and non-prescribed ecstasy pills, capsules, crystal, and powder, nationally, 2007-2026



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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-prescribed ecstasy use, and non-prescribed ecstasy pills, powder, capsules and crystal use, in the past six months, nationally, 2007-2026



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. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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 3: Past six month use of any non-prescribed ecstasy, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	100	100	100	100	100	100	100	100
2008	100	100	100	100	100	100	100	100
2009	100	100	100	100	100	100	100	100
2010	100	100	100	100	100	100	~	100
2011	100	100	100	100	100	100	~	100
2012	100	100	100	100	100	72	~	100
2013	100	97	95	100	100	100	~	100
2014	100	100	96	100	98	100	99	94
2015	99	98	98	100	98	100	98	98
2016	99	99	100	100	99	100	97	97
2017	100	100	98	100	99	100	99	98
2018	100	99	100	100	100	100	98	97
2019	99	99	98	95	97	99	99	99
2020	100	100	96	100	98	98	100	98
2021	96	98	95	99	87	97	99	92
2022	83	87	90	96	74	96	~	93
2023	99	96	99	91	84	98	~	95
2024	96	90	95	91	93	89	92	92
2025	92	98	94	91	91	93	~	93
2026	93	91	95	96	90	99	/	96

Note. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2024 should be interpreted with caution due to small samples (2006: $n=51$; 2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 4: Past six month use of non-prescribed ecstasy pills, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	100	100	100	100	100	99	100	100
2008	100	100	100	100	100	100	100	100
2009	100	100	100	100	99	100	100	100
2010	99	99	98	96	99	100	~	98
2011	99	100	90	95	100	100	~	99
2012	99	94	92	92	98	100	~	95
2013	99	96	86	93	98	99	~	99
2014	89	91	90	92	96	98	99	81
2015	69	56	84	99	94	99	98	86
2016	52	70	93	95	96	98	90	67
2017	42	79	83	93	71	93	86	78
2018	41	80	77	88	56	92	90	76
2019	40	70	74	74	62	68	92	56
2020	41	55	69	74	52	25	63	43
2021	17	36	47	55	54	37	56	27
2022	33	28	60	47	38	21	~	36
2023	49	38	51	48	52	33	~	32
2024	57	25	65	49	47	27	39	34
2025	43	37	52	60	43	21	~	31
2026	42	31	60	53	48	19	/	26

Note. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2024 should be interpreted with caution due to small samples (2006: $n=51$; 2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 5: Past six month use of non-prescribed ecstasy capsules, by capital city, 2008-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2008	24	23	18	18	16	28	9	17
2009	33	6	48	48	10	15	31	27
2010	35	37	65	81	38	14	~	42
2011	55	39	64	80	34	11	~	57
2012	57	61	67	75	29	32	~	52
2013	59	43	69	53	26	48	~	67
2014	76	56	66	49	37	51	32	53
2015	64	69	76	50	49	65	44	62
2016	68	72	84	40	55	54	44	64
2017	76	67	90	60	81	61	57	72
2018	77	74	87	62	58	76	74	72
2019	82	81	90	62	64	84	76	78
2020	88	91	78	73	83	83	90	78
2021	82	76	70	67	53	67	82	64
2022	52	52	59	53	44	57	~	74
2023	69	63	67	46	53	59	~	55
2024	66	52	64	59	59	54	55	63
2025	61	58	56	43	63	45	~	56
2026	65	50	53	55	65	38	/	55

Note. Data collection for capsules commenced in 2008. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2024 should be interpreted with caution due to small samples (2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 6: Past six month use of non-prescribed ecstasy crystal, by capital city, 2013-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2013	28	71	51	48	25	34	~	23
2014	61	54	64	29	36	58	43	45
2015	68	57	54	36	41	51	65	42
2016	81	52	59	33	63	59	43	68
2017	75	75	43	47	69	78	71	78
2018	64	60	57	53	79	51	69	67
2019	68	72	52	48	78	64	54	65
2020	47	71	42	57	59	61	51	71
2021	62	36	47	66	49	63	38	63
2022	37	43	44	47	22	60	~	55
2023	47	48	49	55	39	57	~	56
2024	53	37	43	47	50	51	49	54
2025	42	59	38	53	33	68	~	66
2026	31	37**	43	47	25	63	/	56

Note. Data collection for crystal commenced in 2013. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2024 should be interpreted with caution due to small samples (2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 7: Past six month use of non-prescribed ecstasy powder, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	20	8	38	5	28	11	11	18
2008	15	7	27	6	11	9	-	6
2009	11	14	24	12	9	10	20	17
2010	7	14	34	21	19	6	~	20
2011	21	23	30	26	29	7	~	32
2012	20	35	31	30	11	26	~	31
2013	29	20	51	20	16	25	~	36
2014	15	13	43	20	18	20	26	36
2015	19	22	46	15	14	18	15	22
2016	15	12	51	28	21	13	22	34
2017	21	32	34	24	44	36	20	28
2018	18	23	45	41	27	24	42	27
2019	18	30	20	28	41	30	42	22
2020	33	35	44	37	37	27	35	31
2021	25	26	21	40	22	17	38	19
2022	21	19	17	31	26	32	~	20
2023	27	32	26	26	28	29	~	25
2024	29	28	34	30	36	28	27	29
2025	17	26	21	29	28	25	~	21
2026	22	29	18	20	23	15	/	22

Note. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2024 should be interpreted with caution due to small samples (2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. 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): Recent use of non-prescribed ecstasy pills was reported by two fifths (40%) of participants, stable relative to 2025 (40%; $p=0.909$) (Figure 4). The proportion of participants reporting recent use of non-prescribed ecstasy pills remained stable across all capital city samples in 2026, relative to 2025 (Table 4).

Frequency of Use: Of those who had recently consumed non-prescribed ecstasy pills and commented ($n=276$), participants reported a median of four days (IQR=2-10) of use in the six months preceding interview, stable relative to 2025 (5 days; IQR=2-12; $n=275$; $p=0.082$) (Figure 5). Among those had recently used non-prescribed ecstasy pills and commented ($n=276$), the percentage reporting weekly or more frequent use significantly decreased in 2026 (7%), relative to 2025 (15%; $p=0.005$).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy pills and commented ($n=277$), the most common route of administration was swallowing (97%; 97% in 2025; $p=0.797$), followed by snorting (14%; 19% in 2025; $p=0.118$).

Quantity: Of those who reported recent non-prescribed use and responded ($n=274$), the median number of ecstasy pills used in a 'typical' session was two (IQR=1-2; 2 pills in 2025; IQR=1-2; $p=0.221$). Of those who reported recent use and responded ($n=274$), the median maximum number of pills used in a session was two (IQR=1-4; 2.5 pills in 2025; IQR=1.5-4.5; $p=0.112$).

Non-Prescribed Ecstasy Capsules

Recent Use (past 6 months): Capsules remained the most commonly used form of non-prescribed ecstasy, with 55% reporting recent use in 2026, stable relative to 2025 (55%; $p=0.958$) (Figure 4). Recent use of ecstasy capsules remained stable in all capital city samples, relative to 2025 (Table 5).

Frequency of Use: Of those who had recently consumed non-prescribed ecstasy capsules and commented ($n=380$), capsules were used on a median of four days (IQR=2-10), stable relative to 2025 (5 days; IQR=2-10; $n=378$; $p=0.780$) (Figure 5). Among those who had recently used non-prescribed ecstasy capsules and commented ($n=380$), almost one tenth (9%) reported weekly or more frequent use, stable relative to 2025 (10%; $p=0.721$).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy capsules and commented ($n=381$), swallowing remained the most common route of administration in 2026 (97%; 97% in 2025). Eleven per cent reported snorting capsules, stable relative to 2025 (13%; $p=0.431$).

Quantity: Of those who reported recent non-prescribed use and responded ($n=381$), the median number of ecstasy capsules used in a 'typical' session in 2026 was two (IQR=1-3; 2 capsules in 2025; IQR=1-3; $p=0.802$). Of those who reported recent use and responded ($n=381$), the median maximum number of capsules used in a session was three (IQR=2-5; 3 capsules in 2025; IQR=2-4; $p=0.559$).

Non-Prescribed Ecstasy Crystal

Recent Use (past 6 months): Recent use of non-prescribed ecstasy crystal was reported by two fifths (43%) of the national sample, a significant decrease from 51% in 2025 ($p=0.006$) (Figure 4). This was largely driven by

a significant decrease in the Canberra sample (37%; 59% in 2025; $p=0.003$), with use in all other capital cities remaining stable in 2026 relative to 2025 (Table 6).

Frequency of Use: Of those who had recently consumed non-prescribed ecstasy crystal and commented ($n=300$), participants reported use on a median of five days (IQR=3-10) in the six months preceding interview, stable from six days in 2025 (IQR=3-12; $n=349$; $p=0.110$) (Figure 5). Among those who had recently used non-prescribed ecstasy crystal and commented ($n=300$), 7% reported weekly or greater use, a significant decrease relative to 2025 (13%; $p=0.031$).

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy crystal and commented ($n=300$), 88% reported swallowing as the most common route of administration, a significant increase from 80% in 2025 ($p=0.006$). Two fifths (43%) reported snorting as the most common route of administration, stable relative to 2025 (48%; $p=0.162$).

Quantity: Of those who reported recent non-prescribed use and responded ($n=242$), the median amount of ecstasy crystal used in a 'typical' session was 0.30 grams (IQR=0.20-0.50; 0.30 grams in 2025; IQR=0.20-0.50; $p=0.950$). Of those who reported recent use and responded ($n=244$), the median maximum amount used in a session was 0.50 grams (IQR=0.30-1.00; 0.50 grams in 2025; IQR=0.30-1.00; $p=0.323$).

Non-Prescribed Ecstasy Powder

Recent Use (past 6 months): Consistent with previous years, non-prescribed ecstasy powder was the least commonly used form of ecstasy in 2026. One fifth (21%) of participants reported recent use, stable relative to 2025

(23%; $p=0.366$) (Figure 4). Recent use remained stable across all capital city samples (Table 7).

Frequency of Use: Of those who had recently used non-prescribed ecstasy powder and commented ($n=149$), participants reported use on a median of three days (IQR=2-6) in the previous six months, a significant decrease relative to 2025 (5 days; IQR=2-10; $n=149$; $p=0.011$) (Figure 5). Among those who had recently used non-prescribed ecstasy powder and commented ($n=149$), 6% reported weekly or more frequent use, stable from 2025 (7%; $p=0.661$).

Routes of Administration: Among participants who had recently used non-prescribed ecstasy powder and commented ($n=149$), snorting was the most common route of administration (65%), consistent with previous years, and stable from 2025 (72%; $p=0.228$). Almost three fifths (58%) of participants reported swallowing ecstasy powder, stable relative to 2025 (54%; $p=0.503$).

Quantity: Of those who reported recent non-prescribed use and responded ($n=108$), the median quantity of ecstasy powder used in a 'typical' session was 0.30 grams (IQR=0.20-0.50; 0.30 grams in 2025; IQR=0.20-0.50; $p=0.226$). Of those who reported recent use and responded ($n=107$), the median maximum amount used in a session was 0.50 grams (IQR=0.22-1.00; 0.50 grams in 2025; IQR=0.27-1.00; $p=0.269$).

Price, Perceived Purity and Perceived Availability

Non-Prescribed Ecstasy Pills

Price: The reported price of a non-prescribed ecstasy pill in 2026 was \$25 (IQR=20-34; $n=131$), stable relative to 2025 (\$30; IQR=25-35; $n=184$; $p=0.149$) (Figure 6).

Perceived Purity: Among those who responded in 2026 (n=269), the perceived purity of non-prescribed ecstasy pills remained stable relative to 2025 ($p=0.830$). Almost two fifths (37%) of participants reported the perceived purity to be 'high' (41% in 2025). Thirty per cent reported 'medium' purity (28% in 2025), followed by 22% reporting 'fluctuating' purity (21% in 2025). Eleven per cent reported 'low' purity (11% in 2025) (Figure 8).

Perceived Availability: Among those who responded in 2026 (n=272), the perceived availability of non-prescribed ecstasy pills significantly changed relative to 2025 ($p=0.011$). Almost half (47%) of participants reported ecstasy pills to be 'easy' to obtain, an increase from 34% in 2025. A further 36% reported that they were 'very easy' to obtain, a decrease from 43% in 2025. Fourteen per cent reported that ecstasy pills were 'difficult' to obtain (19% in 2025), and few participants ($n\leq 5$) reported non-prescribed ecstasy pills to be 'very difficult' to obtain (4% in 2025) (Figure 12).

Non-Prescribed Ecstasy Capsules

Price: The median price of a non-prescribed ecstasy capsule was \$25 (IQR=20-30; n=183) in 2026, stable relative to 2025 (\$25; IQR=20-30; n=239; $p=0.507$) (Figure 6).

Perceived Purity: Among those who responded in 2026 (n=359), the perceived purity of non-prescribed ecstasy capsules remained stable, relative to 2025 ($p=0.117$). Two fifths (43%) perceived purity to be 'medium' (38% in 2025), with 37% reporting 'high' purity (34% in 2025) and 7% reporting 'low' purity (9% in 2025). A further 14% perceived purity to be 'fluctuating' (19% in 2025) (Figure 9).

Perceived Availability: Among those who responded in 2026 (n=367), the perceived availability of non-prescribed ecstasy capsules remained stable, relative to 2025 ($p=0.148$). The largest percentage (45%) perceived availability to be 'easy' (38% in 2025), followed closely by 44% reporting 'very easy' obtainment (51% in 2025). In contrast, fewer participants reported ecstasy capsules as being 'difficult' (11%; 10% in 2025) or 'very difficult' ($n\leq 5$; $n\leq 5$ in 2025) to obtain (Figure 13).

Non-Prescribed Ecstasy Crystal

Price: The median price per gram of non-prescribed ecstasy crystal remained stable at \$200 (IQR=160-250; n=157; \$200 in 2025; IQR=150-250; n=202; $p=0.981$). The median price per point of ecstasy crystal significantly decreased in 2026 (\$20; IQR=18-28; n=11), relative to 2025 (\$30; IQR=23-43; n=23; $p=0.017$) (Figure 7).

Perceived Purity: Among those who responded in 2026 (n=283), the perceived purity of non-prescribed ecstasy crystal remained stable relative to 2025 ($p=0.095$). The largest percentage of participants reported perceived purity to be 'high' (45%; 55% in 2025). Almost one third (32%) of participants perceived purity to be 'medium' (26% in 2025), with fewer participants perceiving purity to be 'fluctuating' (16%; 13% in 2025) or 'low' (7%; 6% in 2025) (Figure 10).

Perceived Availability: Among those who responded in 2026 (n=283), the perceived availability of non-prescribed ecstasy crystal remained stable relative to 2025 ($p=0.639$). Forty-five per cent perceived ecstasy crystal as being 'very easy' to obtain in 2026 (46% in 2025), followed by two fifths (40%) reporting 'easy' obtainment (38% in 2025). In contrast, fewer participants perceived availability to be

'difficult' (14%; 13% in 2025) or 'very difficult' ($n \leq 5$; 2% in 2025) (Figure 14).

Non-Prescribed Ecstasy Powder

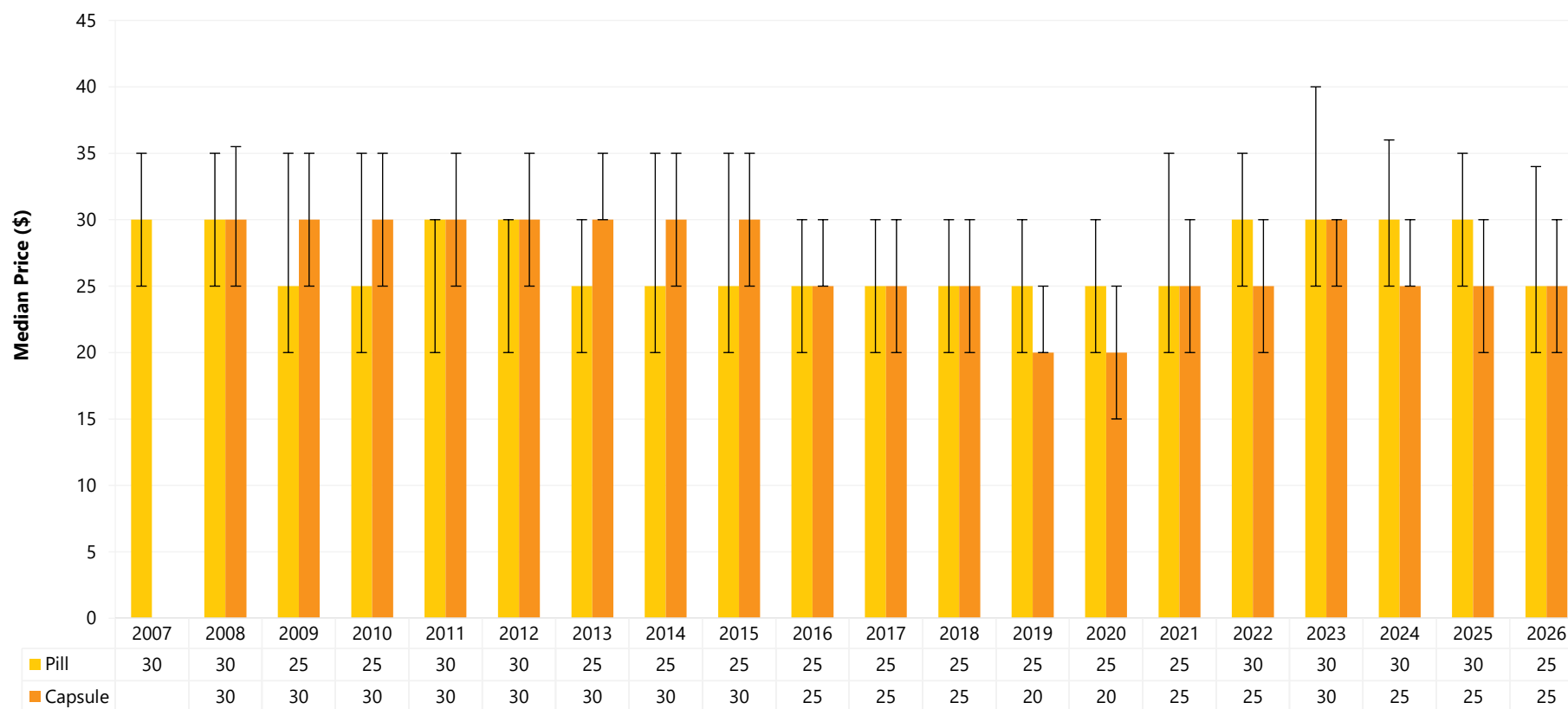
Price: The reported median price per gram of non-prescribed ecstasy powder remained stable in 2026 (\$200; IQR=150-250; $n=61$), relative to 2025 (\$200; IQR=150-250; $n=80$; $p=0.887$) (Figure 7).

Perceived Purity: Among those who responded in 2026 ($n=105$), the perceived purity of non-prescribed ecstasy powder remained stable, relative to 2025 ($p=0.652$). Forty-five per cent perceived ecstasy powder to

be of 'medium' purity (38% in 2025), 32% perceived it as 'high' (37% in 2025), and equal percentages (11%, respectively) perceived it as 'low' (10% in 2025) or 'fluctuating' (15% in 2025) (Figure 11).

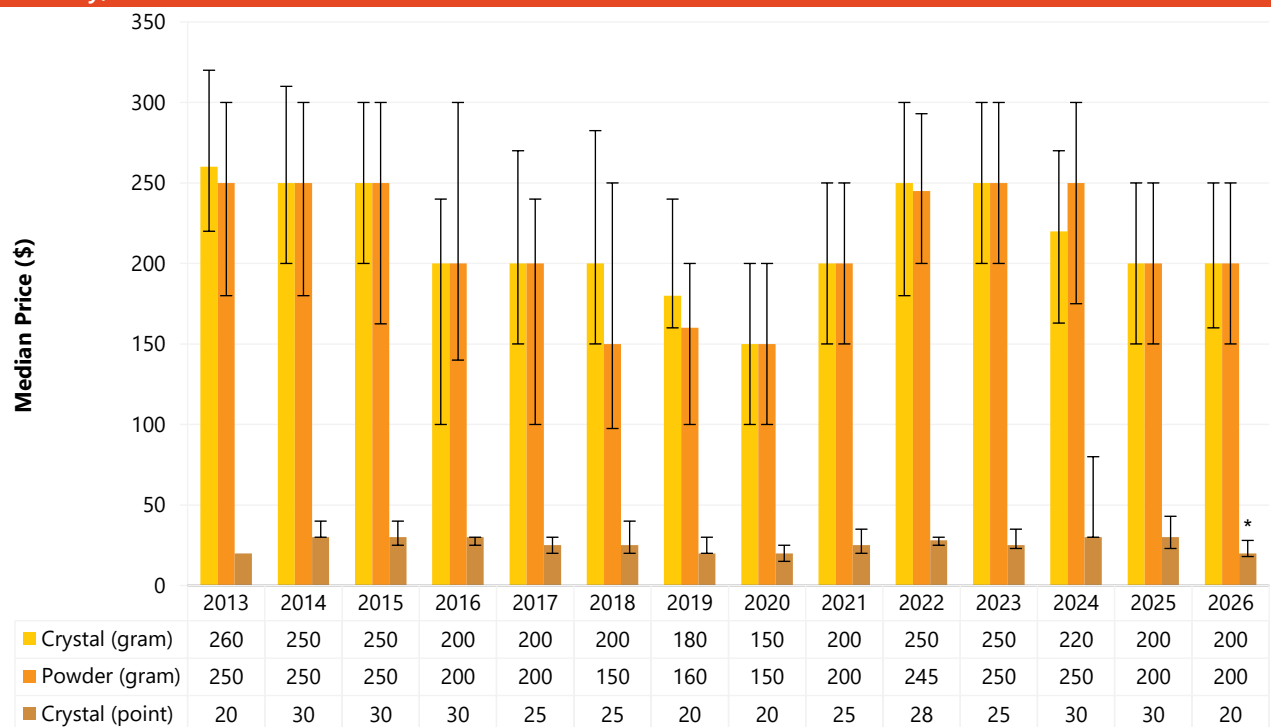
Perceived Availability: Among those who responded in 2026 ($n=105$), the perceived availability of non-prescribed ecstasy powder remained stable, relative to 2025 ($p=0.491$). Forty-four per cent reported availability to be 'very easy' (39% in 2025), and a further 36% reported availability to be 'easy' (42% in 2025). In contrast, one fifth (20%) reported availability as being 'difficult' (17% in 2025) (Figure 15).

Figure 6: Median price of non-prescribed ecstasy pills and capsules, nationally, 2007-2026



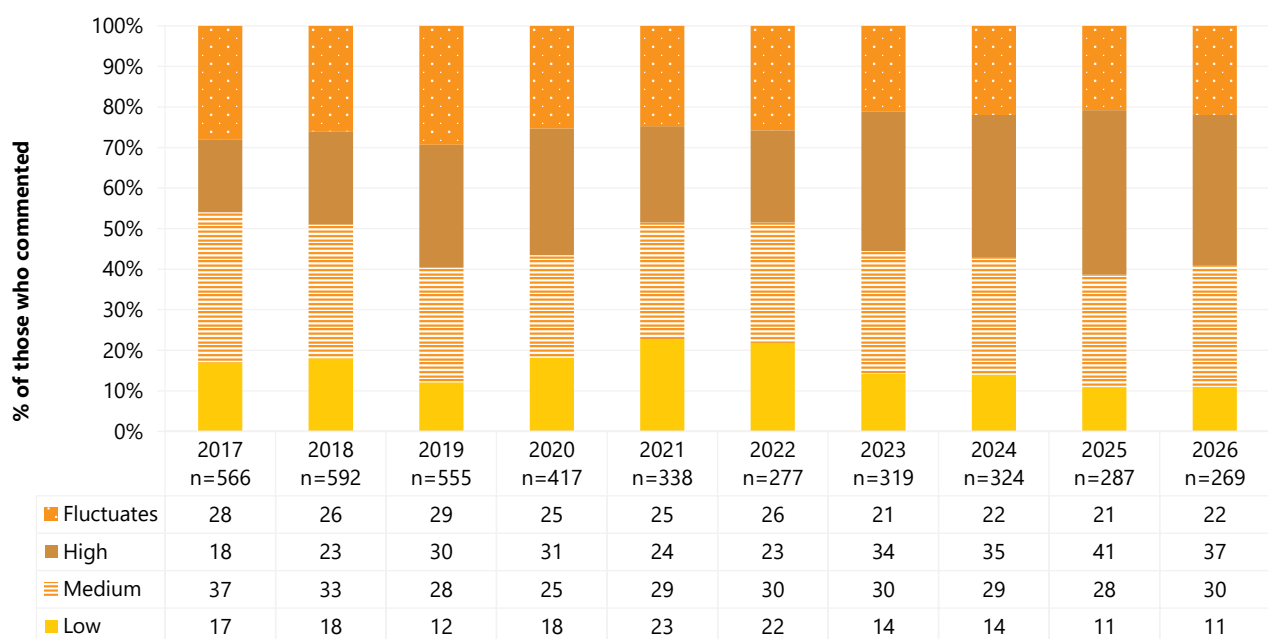
Note. Among those who commented. The error bars represent the IQR. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 7: Median price of non-prescribed ecstasy crystal (per gram and point) and powder (per gram only), nationally, 2013-2026



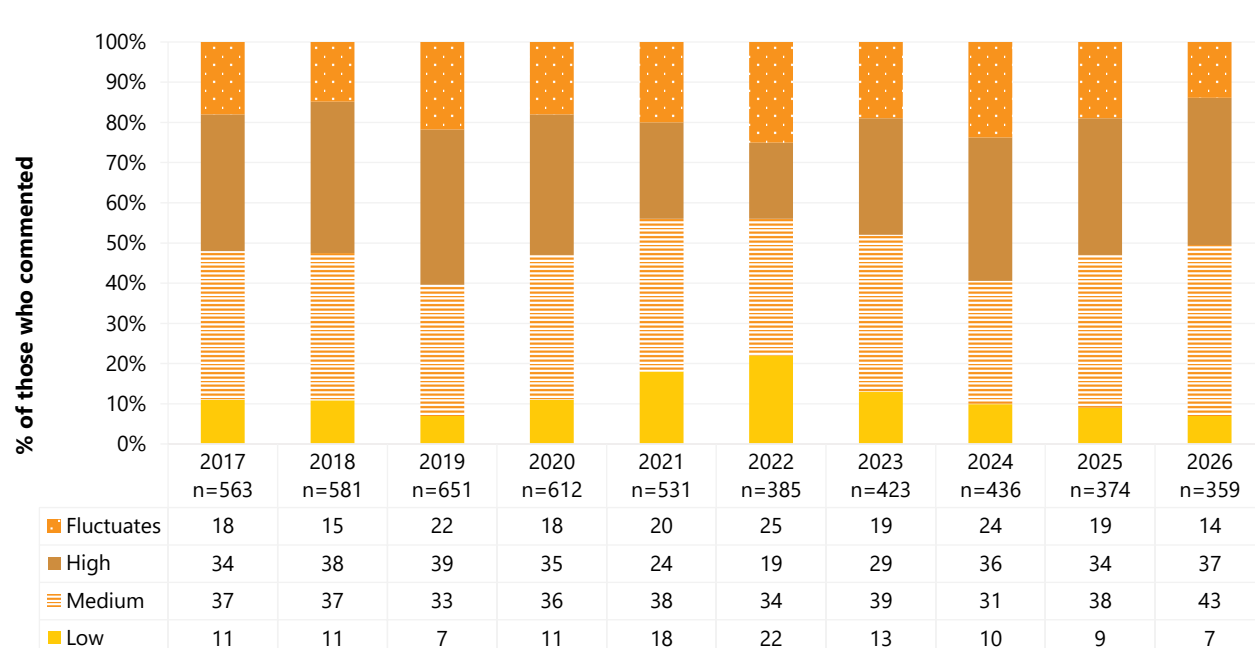
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) and ecstasy powder (gram) commenced in 2013. The error bars represent the IQR. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 8: Current perceived purity of non-prescribed ecstasy pills, nationally, 2017-2026



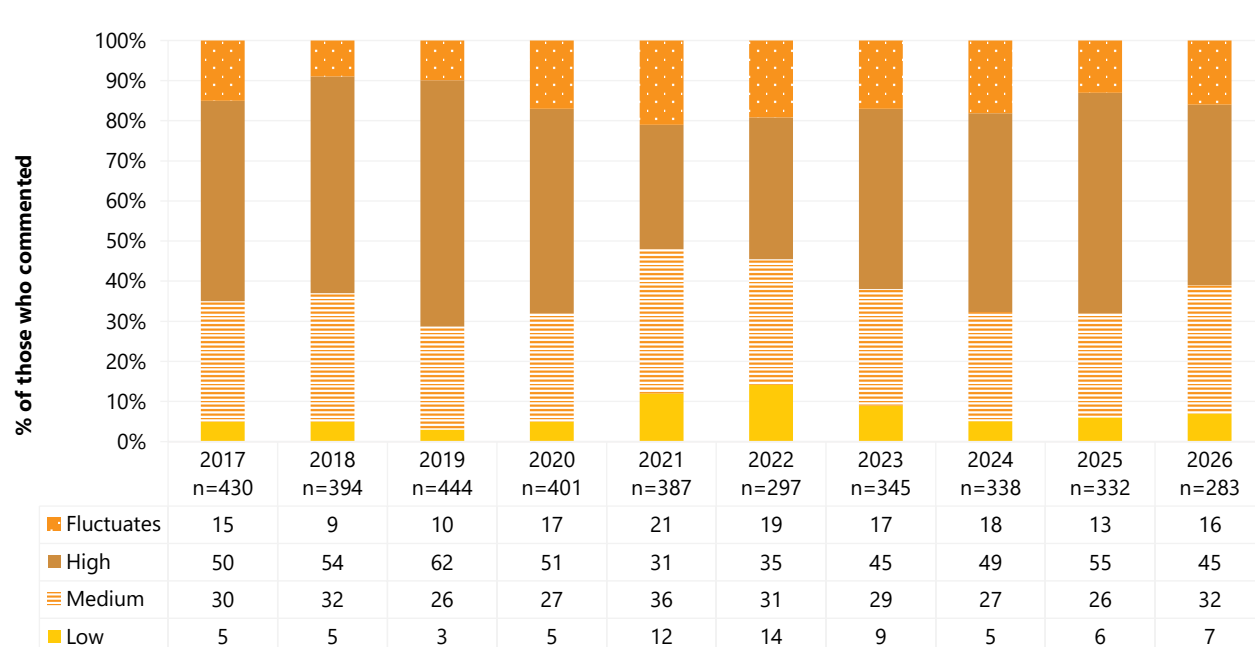
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 9: Current perceived purity of non-prescribed ecstasy capsules, nationally, 2017-2026



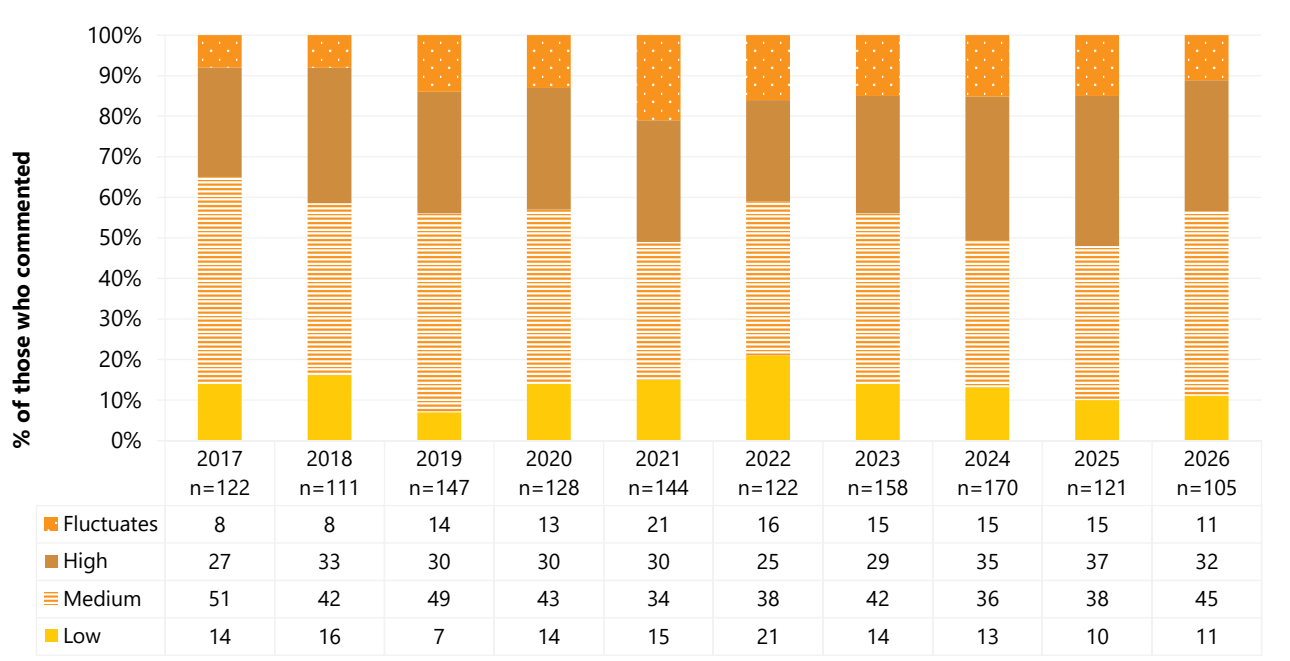
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 10: Current perceived purity of non-prescribed ecstasy crystal, nationally, 2017-2026



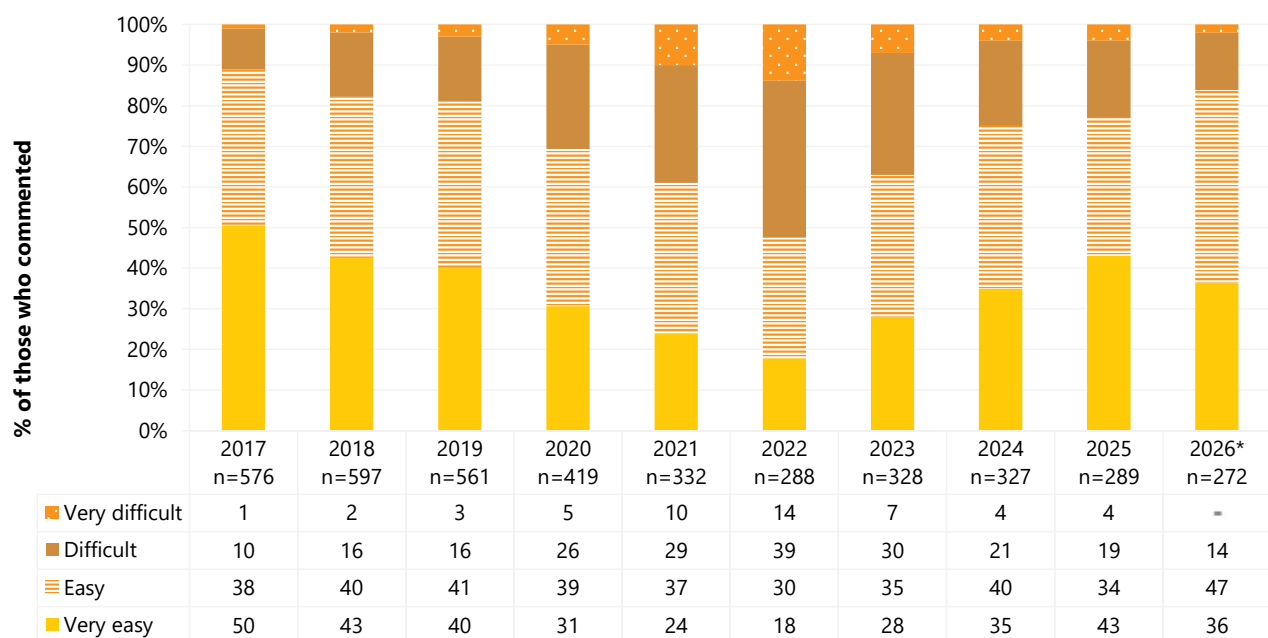
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 11: Current perceived purity of non-prescribed ecstasy powder, nationally, 2017-2026



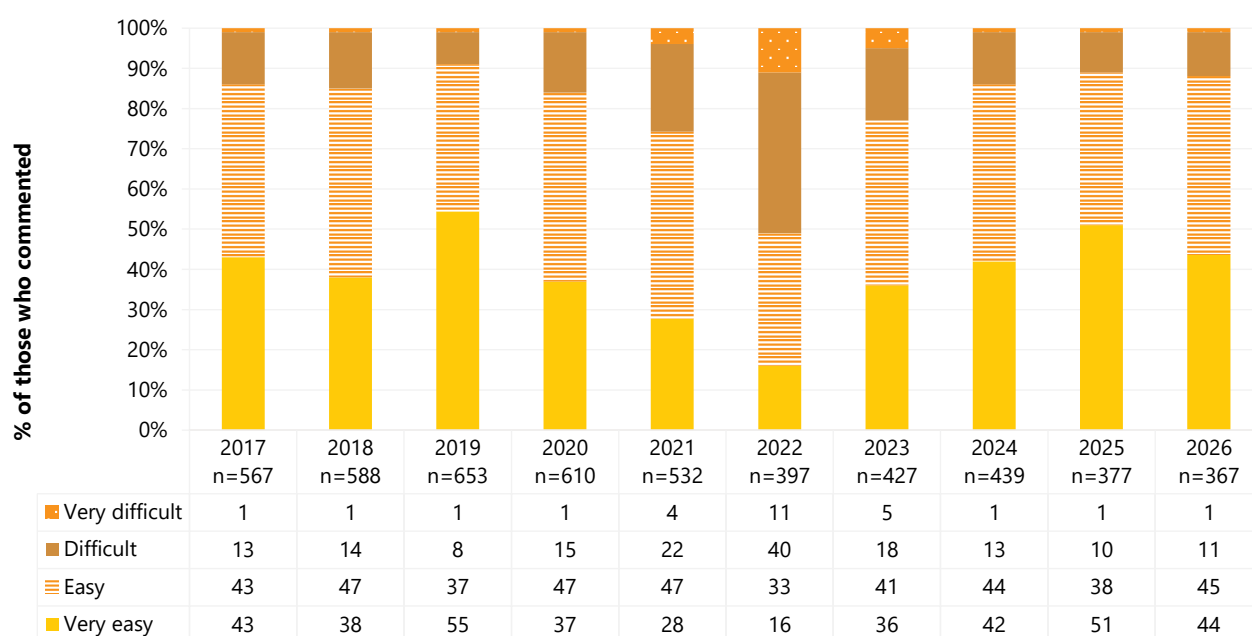
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 12: Current perceived availability of non-prescribed ecstasy pills, nationally, 2017-2026



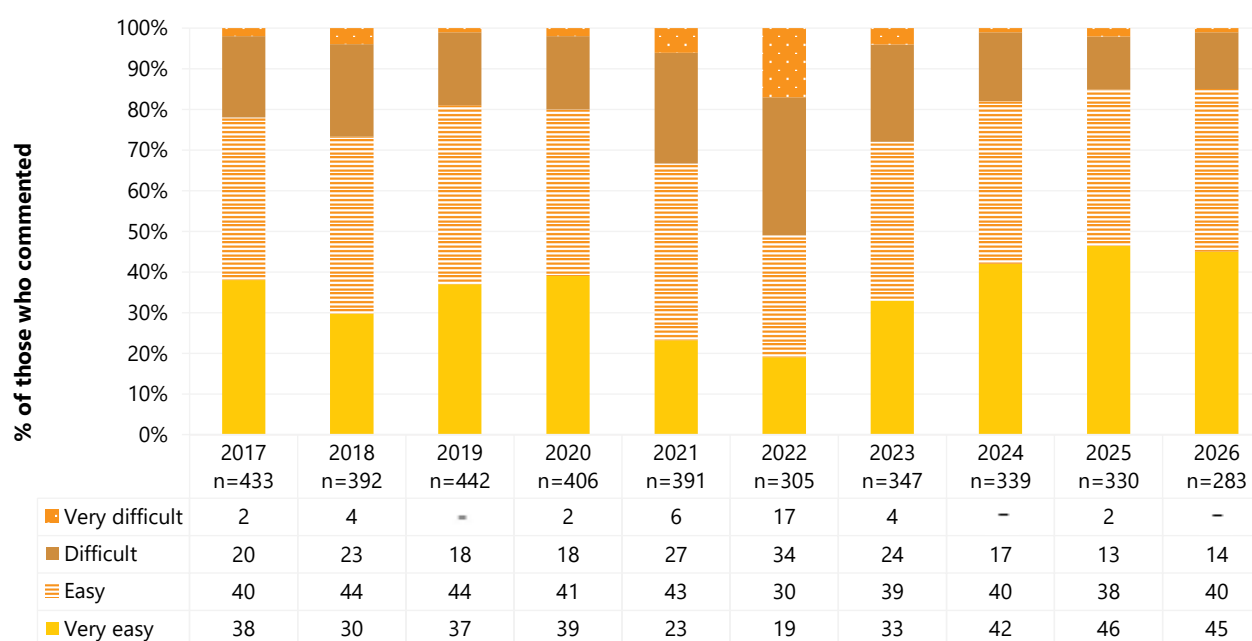
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 13: Current perceived availability of non-prescribed ecstasy capsules, nationally, 2017-2026



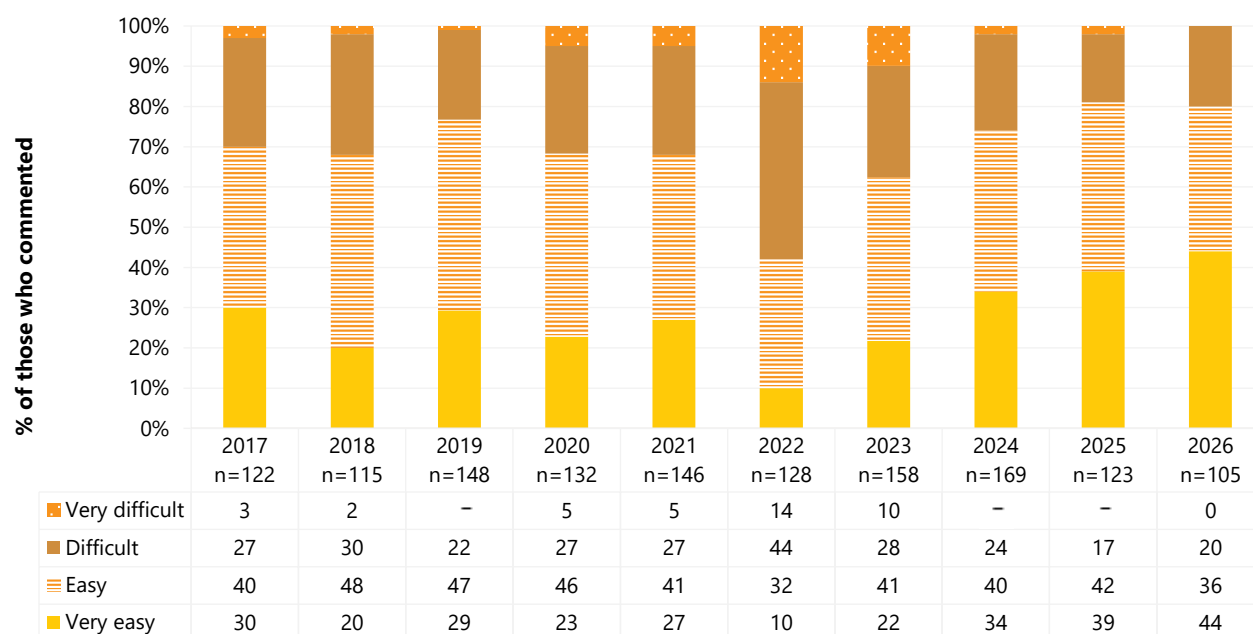
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 14: Current perceived availability of non-prescribed ecstasy crystal, nationally, 2017-2026



Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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, nationally, 2017-2026



Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Past 6 months use

20%

4

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).

Median days*

12 days

*Among those whom reported past 6 month use in 2026:

F
O
R
M
S

15% crystal

6% powder

n≤5 base

Median Amount Used
(Crystal)

Typical day:

0.20 grams

Maximum:

0.50 grams

Routes of administration
(Crystal)

Smoking
90%

Swallowing
13%

Snorting
12%

Injecting
9%

Median Price
(Crystal)

\$ 50
Per point

\$ 200
Per gram

(Crystal)

Perceived
Purity

21% fluctuates

15%
low

26%
medium

38%
high

(Crystal)

Perceived
Availability

9% difficult

28%
easy

63%
very
easy

Patterns of Consumption (Any Methamphetamine)

Recent Use (past 6 months)

The per cent reporting any recent use of methamphetamine has been declining since monitoring commenced (Figure 16). This decline continued in 2026, with one fifth (20%) reporting recent use of any methamphetamine, a significant decrease relative to 2025 (29%; $p<0.001$) (Figure 16). The decrease observed in 2026 was largely driven by significant declines in the Sydney (10%; 30% in 2025; $p<0.001$), Hobart (36%; 52% in 2025; $p=0.042$) and Brisbane/Gold Coast (8%; 25% in 2025; $p=0.002$) samples (Table 8).

In 2026, the per cent of participants reporting methamphetamine crystal (15%) and powder (6%) were broadly comparable, with few participants ($n\leq 5$) reporting use of base; this has remained consistent over the past decade.

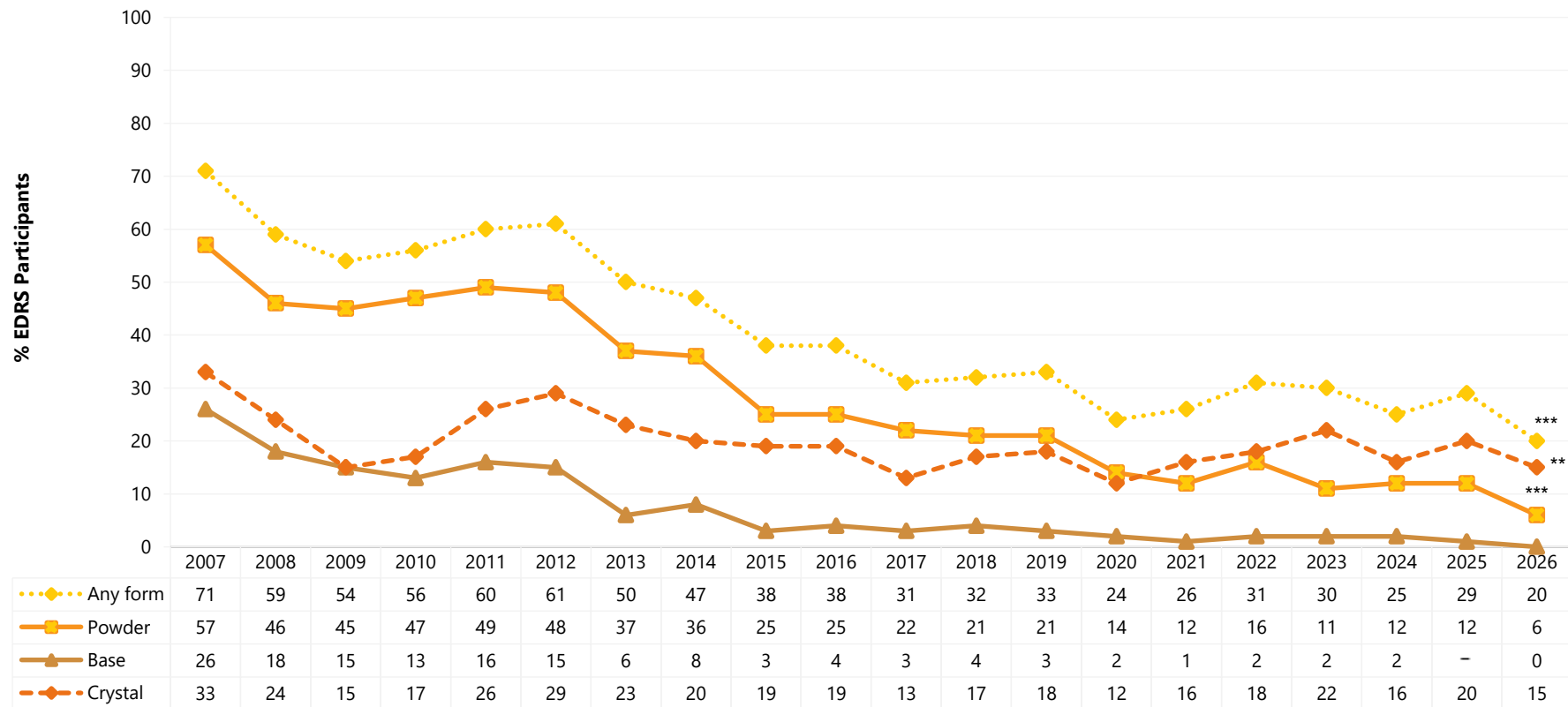
Frequency of Use

In 2026, participants reported use on a median of 12 days (IQR=2-52; $n=137$) in the six months preceding interview, stable relative to 2025 (13 days; IQR=3-72; $n=137$; $p=0.168$) (Figure 17). Among those who had recently used methamphetamine and commented ($n=137$), almost two fifths (38%) reported weekly or more frequent use, stable from 45% in 2025 ($p=0.220$).

Number of Forms Used

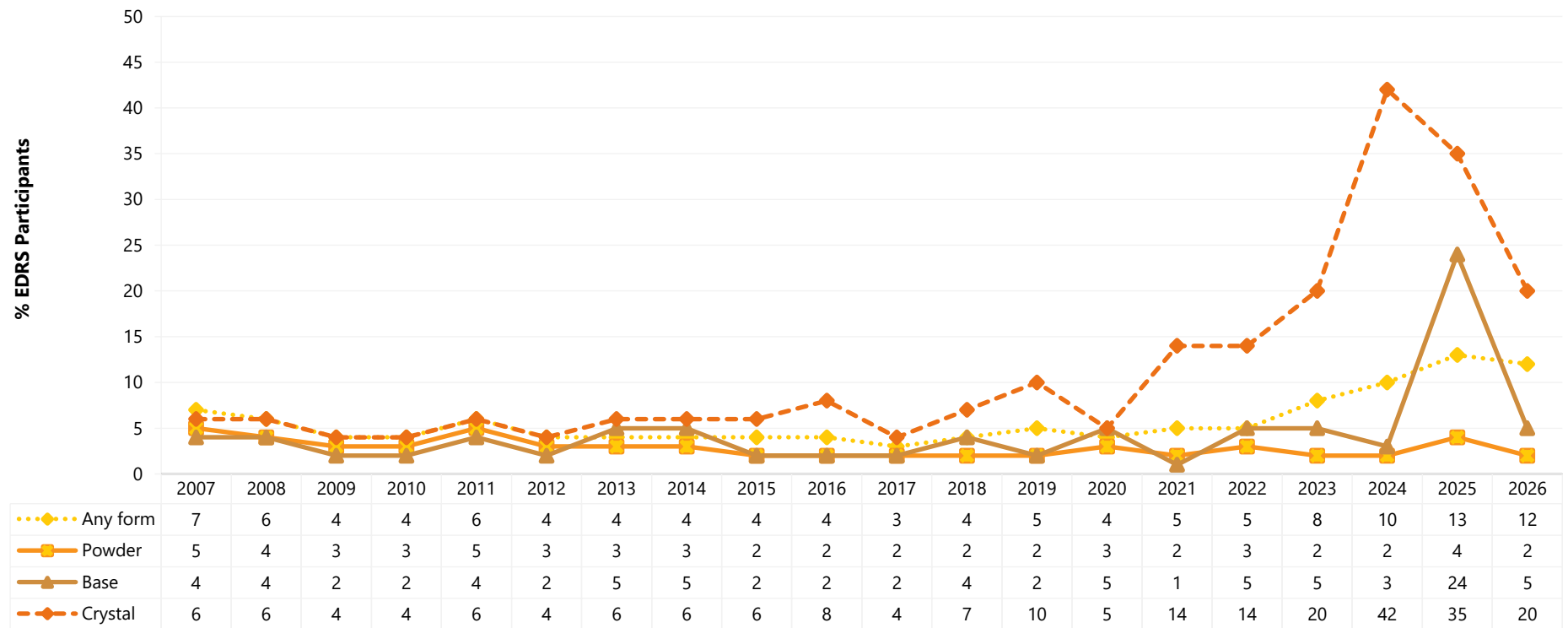
Among participants who had recently consumed any methamphetamine and commented in 2026 ($n=137$), the median number of forms used was one (IQR=1-1), a significant change relative to 2025 (1 form; IQR=1-1; $n=199$; $p=0.039$). This was consistent across all capital cities.

Figure 16: Past six month use of any methamphetamine, and methamphetamine powder, base, and crystal, nationally, 2007-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 17: Median days of any methamphetamine use, and methamphetamine powder, base and crystal in the past six months, nationally, 2007-2026



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 50 days to improve visibility of trends. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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: Past six month use of any methamphetamine, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	66	60	91	70	90	62	67	58
2008	66	55	77	63	58	50	24	57
2009	49	54	72	52	53	44	64	47
2010	50	70	72	48	57	45	~	51
2011	49	51	75	52	67	64	~	60
2012	42	73	84	64	48	47	~	76
2013	36	65	71	57	46	31	~	48
2014	32	51	68	64	32	31	47	47
2015	33	35	55	45	33	20	49	31
2016	27	26	57	42	36	27	52	39
2017	30	33	46	40	37	12	35	14
2018	19	33	60	46	45	11	27	18
2019	26	33	46	45	34	11	44	24
2020	17	15	49	31	26	12	24	18
2021	15	29	44	31	33	13	14	30
2022	29	39	49	39	36	14	~	15
2023	21	23	29	40	46	29	~	27
2024	26	21	29	40	26	9	39	18
2025	30	18	29	52	35	15	~	25
2026	10***	21	23	36*	27	12	/	8**

Note. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2024 should be interpreted with caution due to small samples (2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 9: Past six month use of methamphetamine powder, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	45	53	90	65	53	46	55	46
2008	48	42	75	59	30	38	24	34
2009	37	44	72	46	30	37	61	41
2010	29	66	70	40	38	38	~	47
2011	32	50	69	47	45	44	~	49
2012	31	63	77	61	24	27	~	58
2013	25	57	58	53	21	17	~	41
2014	21	48	56	58	13	19	39	34
2015	27	31	45	39	11	6	31	11
2016	18	21	50	32	12	18	27	25
2017	18	32	43	29	19	7	20	9
2018	14	25	56	30	15	-	14	10
2019	17	23	41	33	16	-	28	9
2020	8	12	39	25	6	-	14	8
2021	8	9	36	20	-	-	-	15
2022	13	10	45	20	14	-	~	10
2023	8	11	23	23	12	-	~	-
2024	10	16	20	18	8	-	14	8
2025	14	8	20	24	7	-	~	7
2026	.*	10	9*	15	-	0	/	-

Note. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2024 should be interpreted with caution due to small samples (2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 10: Past six month use of methamphetamine crystal, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	42	20	39	7	49	52	24	23
2008	33	24	22	15	34	36	0	26
2009	9	8	13	7	32	20	15	17
2010	21	16	18	-	26	22	~	8
2011	19	9	38	-	43	46	~	32
2012	18	26	48	10	32	33	~	40
2013	11	14	45	17	28	22	~	21
2014	13	8	34	14	20	17	27	26
2015	12	7	19	13	26	16	36	20
2016	15	5	18	21	33	12	32	18
2017	12	8	10	14	26	6	24	7
2018	6	15	14	24	40	8	21	12
2019	13	15	12	20	26	8	31	16
2020	10	4	14	12	21	10	12	14
2021	-	21	13	15	32	10	12	16
2022	16	31	10	21	30	11	~	6
2023	14	14	13	22	39	28	~	23
2024	17	9	12	26	23	8	31	13
2025	18	14	10	37	31	13	~	20
2026	6*	14	15	23	24	12	/	7*

Note. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2024 should be interpreted with caution due to small samples (2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Patterns of Consumption (by form)

Methamphetamine Powder

Recent Use (past 6 months): Historically, powder was the most commonly used form of methamphetamine; however, its use has declined substantially since 2006 and was overtaken by crystal from 2021 onwards (Figure 16). In 2026, 6% of the national sample reported recent use, a significant decrease from 12% in 2025 ($p<0.001$) and the lowest percentage recorded in the past 20 years. Recent use significantly decreased in the Sydney ($n\leq 5$; 14% in 2025; $p=0.014$) and Melbourne (9%; 20% in 2025; $p=0.046$) samples (Table 9).

Frequency of Use: Of those who had recently consumed methamphetamine powder and commented in 2026 ($n=42$), median days of use remained low and stable at two days (IQR=1-5; 4 days in 2025; IQR=1-7; $n=79$; $p=0.124$) (Figure 17), with few participants ($n\leq 5$) reporting weekly or more frequent use (15% in 2025; $p=0.135$).

Routes of Administration: Among participants who had recently consumed methamphetamine powder and commented in 2026 ($n=42$), the most common route of administration was snorting (71%; 80% in 2025; $p=0.365$), followed by swallowing (26%; 28% in 2025). Few participants reported smoking as a route of administration ($n\leq 5$; 8% in 2025).

Quantity: Of those who reported recent use and responded ($n=26$), the median amount used in a 'typical' session was 0.25 grams (IQR=0.10-0.50; 0.25 grams in 2025; IQR=0.10-0.50; $p=0.887$). Of those who reported recent use and responded ($n=27$), the median maximum amount used in a session was 0.30

grams (IQR=0.10-0.88; 0.33 grams in 2025; IQR=0.20-1.00; $p=0.739$).

Methamphetamine Crystal

Recent Use (past 6 months): As with all forms of methamphetamine, crystal use has generally decreased over time, albeit stabilising from 2014-2025 (Figure 16). In 2026, 15% of the national sample had recently consumed methamphetamine crystal, a significant decrease relative to 2025 (20%; $p=0.005$). Recent use significantly decreased in the Sydney (6%; 18% in 2025; $p=0.012$) and Brisbane/Gold Coast (7%; 20% in 2025; $p=0.013$) samples (Table 10).

Frequency of Use: Of those who had recently consumed methamphetamine crystal and commented ($n=101$), participants reported use on a median of 20 days (IQR=4-72), stable from 35 days in 2025 (IQR=6-97; $n=140$; $p=0.061$) (Figure 17). Among those who had recently consumed methamphetamine crystal and commented ($n=101$), 50% reported weekly or more frequent use in 2026 (59% in 2025; $p=0.192$).

Routes of Administration: Among those who had recently used methamphetamine crystal and commented ($n=101$), smoking remained the most common route of administration in 2026 (90%; 84% in 2025; $p=0.186$), with fewer participants reporting swallowing (13%; 20% in 2025; $p=0.176$), snorting (12%; 9% in 2025; $p=0.526$) or injecting (9%; 12% in 2025; $p=0.527$).

Quantity: Of those who reported recent use and responded ($n=90$), the median amount used in a 'typical' session was 0.20 grams (IQR=0.10-0.50; 0.25 grams in 2025; IQR=0.10-0.50; $p=0.472$). Of those who reported recent use and responded ($n=90$), the median maximum amount used in a session was 0.50

grams (IQR=0.20-1.00; 0.50 grams in 2025; IQR=0.25-1.00; $p=0.385$).

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Price: Participants reported a median price of \$185 per gram of methamphetamine powder in 2026 (IQR=131-200; $n=14$; \$200 in 2025; IQR=180-200; $n=31$; $p=0.436$). Few participants ($n\leq 5$) were able to comment on the price of a point in 2026 (\$50 in 2025; IQR=48-50; $n=11$; $p=0.429$) (Figure 18).

Perceived Purity: Among those who responded in 2026 ($n=27$), the perceived purity of methamphetamine powder remained stable, relative to 2025 ($p=0.378$). Almost three fifths (59%) perceived powder to be of 'high' purity (40% in 2025), with a further 30% perceiving powder to be of 'medium' purity (39% in 2025) (Figure 20). Few participants ($n\leq 5$) perceived purity to be 'low' (12% in 2025) or 'fluctuating' ($n\leq 5$; 9% in 2025) (Figure 20).

Perceived Availability: Among those who responded in 2026 ($n=27$), the perceived availability of methamphetamine powder remained stable, relative to 2025 ($p=0.411$). Equal percentages (33%, respectively) perceived powder to be 'easy' (35% in 2025) or 'difficult' (18% in 2025) to obtain. One fifth (22%) perceived powder to be 'very easy' to obtain (29% in 2025), and few participants ($n\leq 5$) perceived powder to be 'very difficult' to obtain (18% in 2025) (Figure 22).

Methamphetamine Crystal

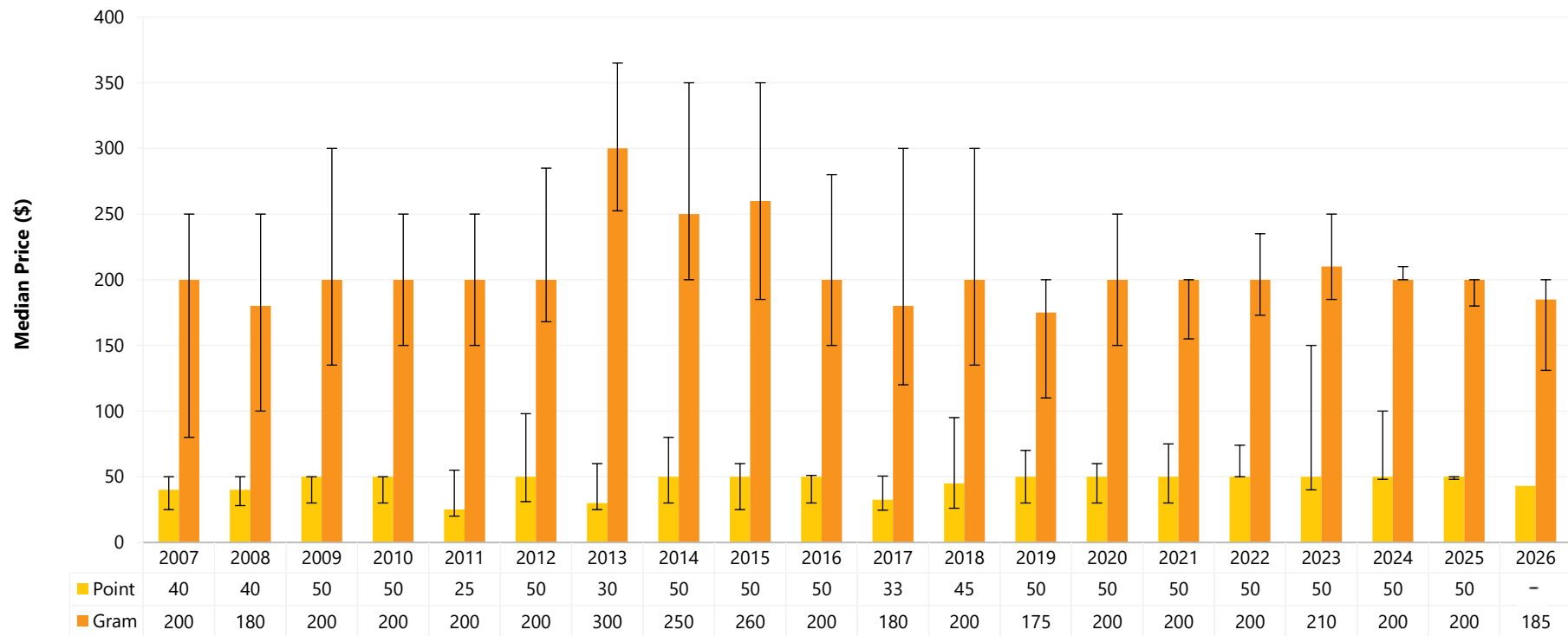
Price: Participants reported a median price of \$200 per gram of methamphetamine crystal (IQR=163-238; $n=14$), stable relative to 2025

(\$250; IQR=200-300; $n=37$; $p=0.054$). The median price per point of crystal was \$50 (IQR=40-50; $n=24$), also stable relative to 2025 (\$50; IQR=50-50; $n=53$; $p=0.075$) (Figure 19).

Perceived Purity: Among those who responded in 2026 ($n=92$), the perceived purity of methamphetamine crystal remained stable, relative to 2025 ($p=0.969$). Almost two fifths (38%) perceived crystal to be of 'high' purity (40% in 2025), followed by one quarter (26%) perceiving it to be of 'medium' purity (24% in 2025). One fifth (21%) perceived it to be of 'fluctuating' purity (19% in 2025), and 15% perceived purity to be 'low' (16% in 2025) (Figure 21).

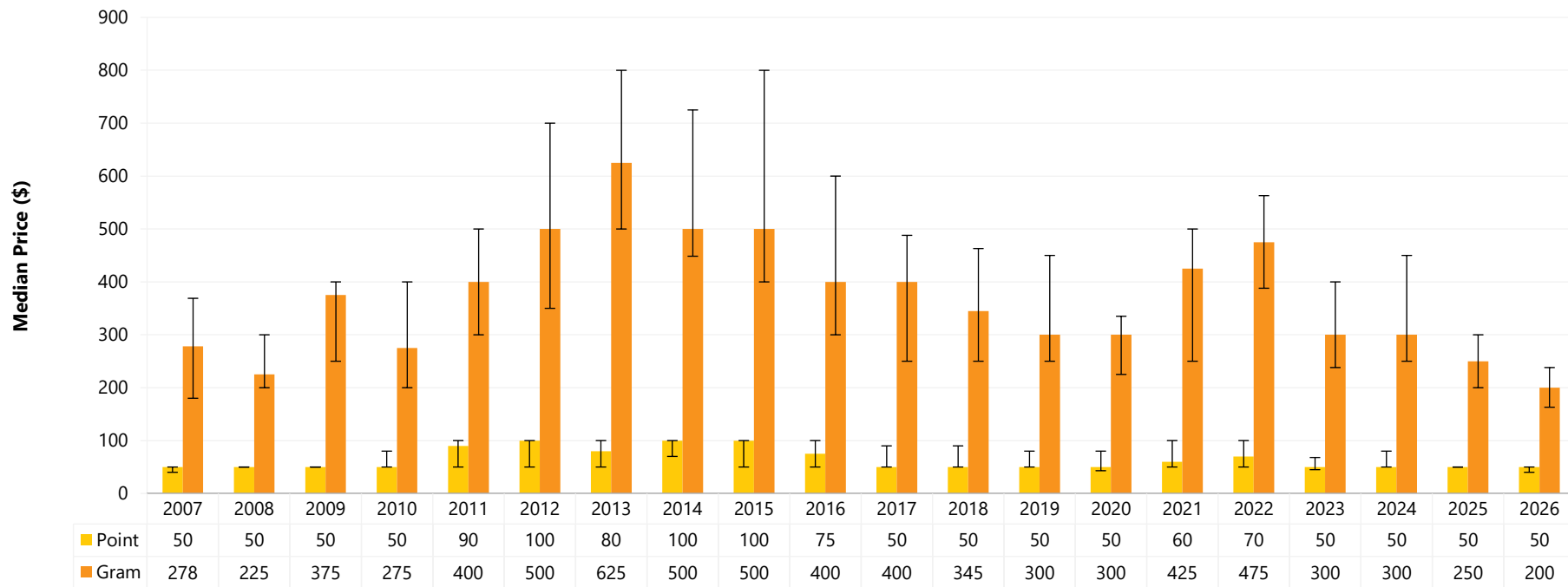
Perceived Availability: Among those who responded in 2026 ($n=93$), the perceived availability of methamphetamine crystal remained stable, relative to 2025 ($p=0.395$). Almost two thirds (63%) reported availability to be 'very easy' (72% in 2025), and a further 28% reported it to be 'easy' (22% in 2025). Fewer participants perceived availability to be 'difficult' (9%; 6% in 2025), and no participants perceived availability to be 'very difficult' (0% in 2025) (Figure 23).

Figure 18: Median price of methamphetamine powder per point and gram, nationally, 2007-2026



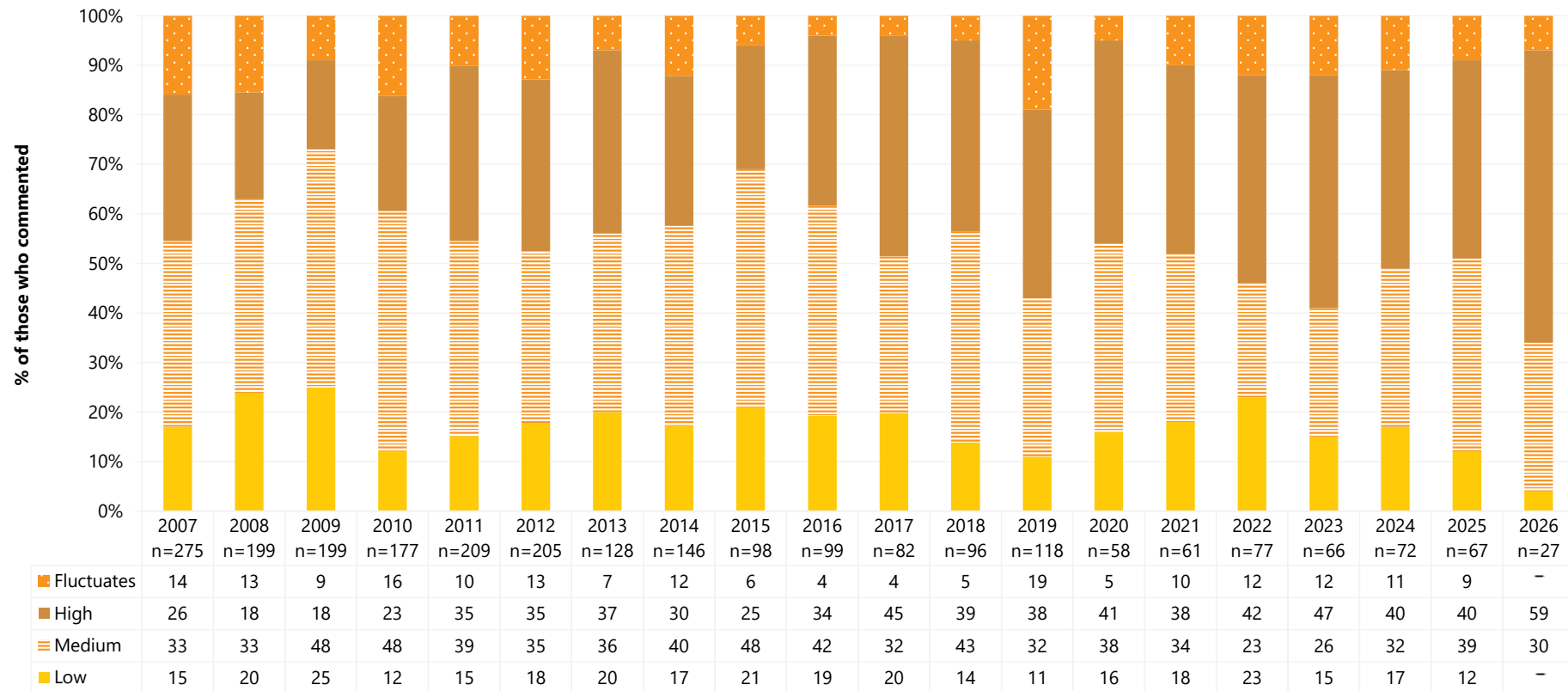
Note. Among those who commented. The error bars represent the IQR. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 19: Median price of methamphetamine crystal per point and gram, nationally, 2007-2026



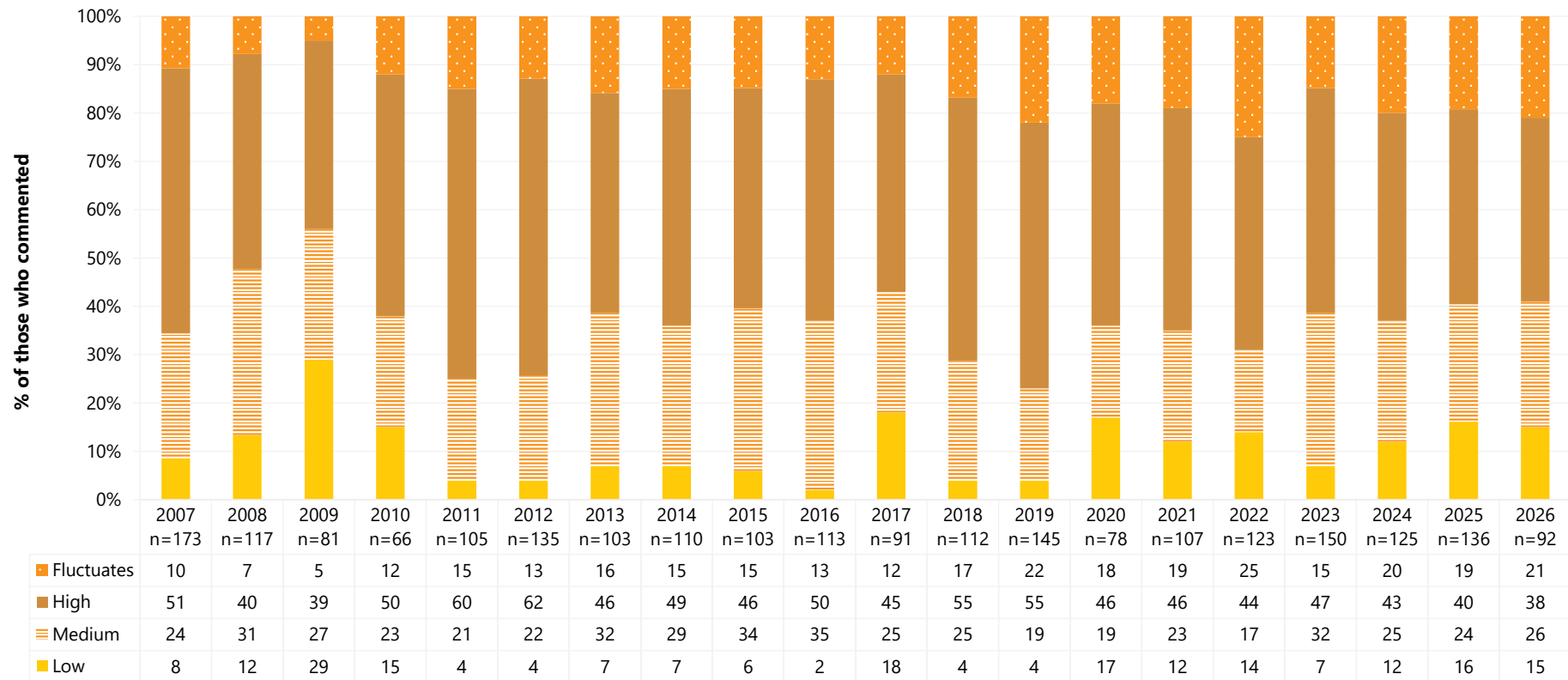
Note. Among those who commented. The error bars represent the IQR. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 20: Current perceived purity of methamphetamine powder, nationally, 2007-2026



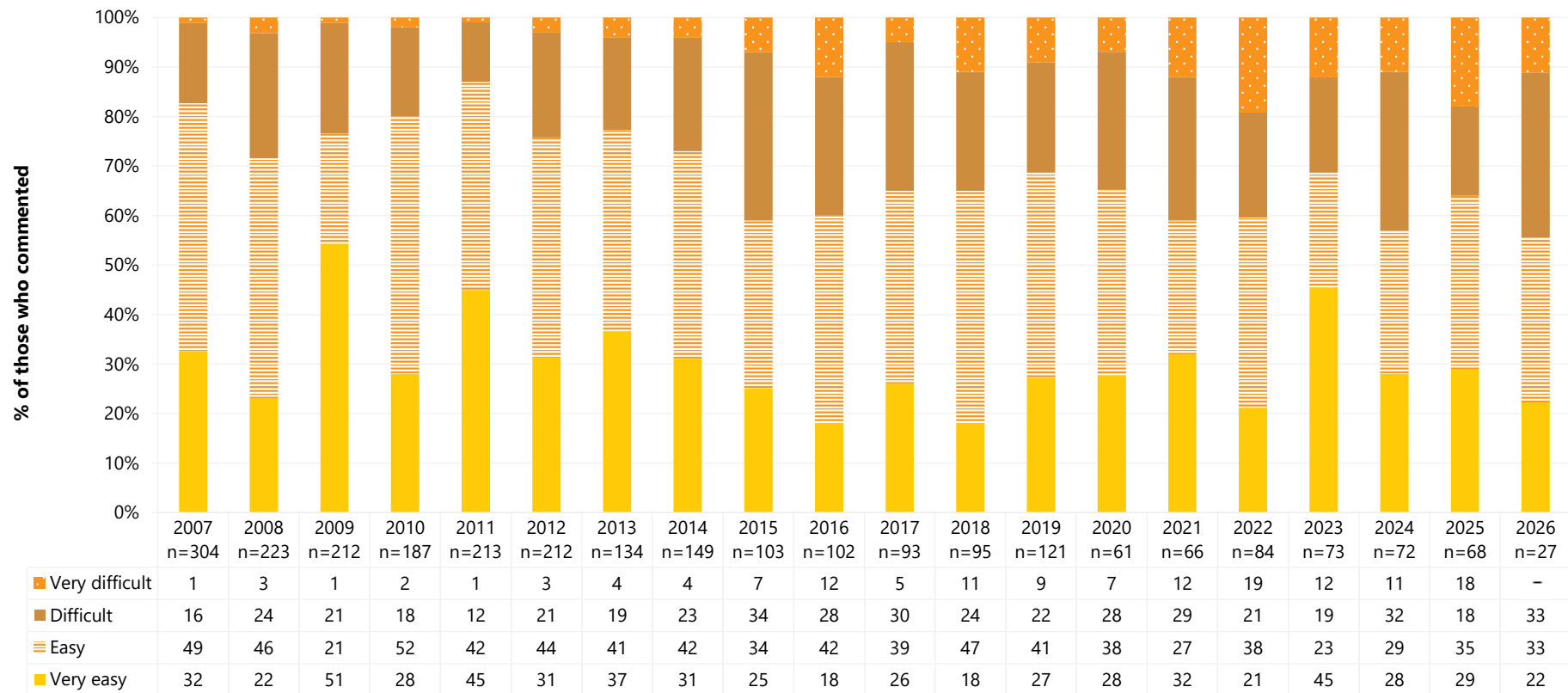
Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 21: Current perceived purity of methamphetamine crystal, nationally, 2007-2026



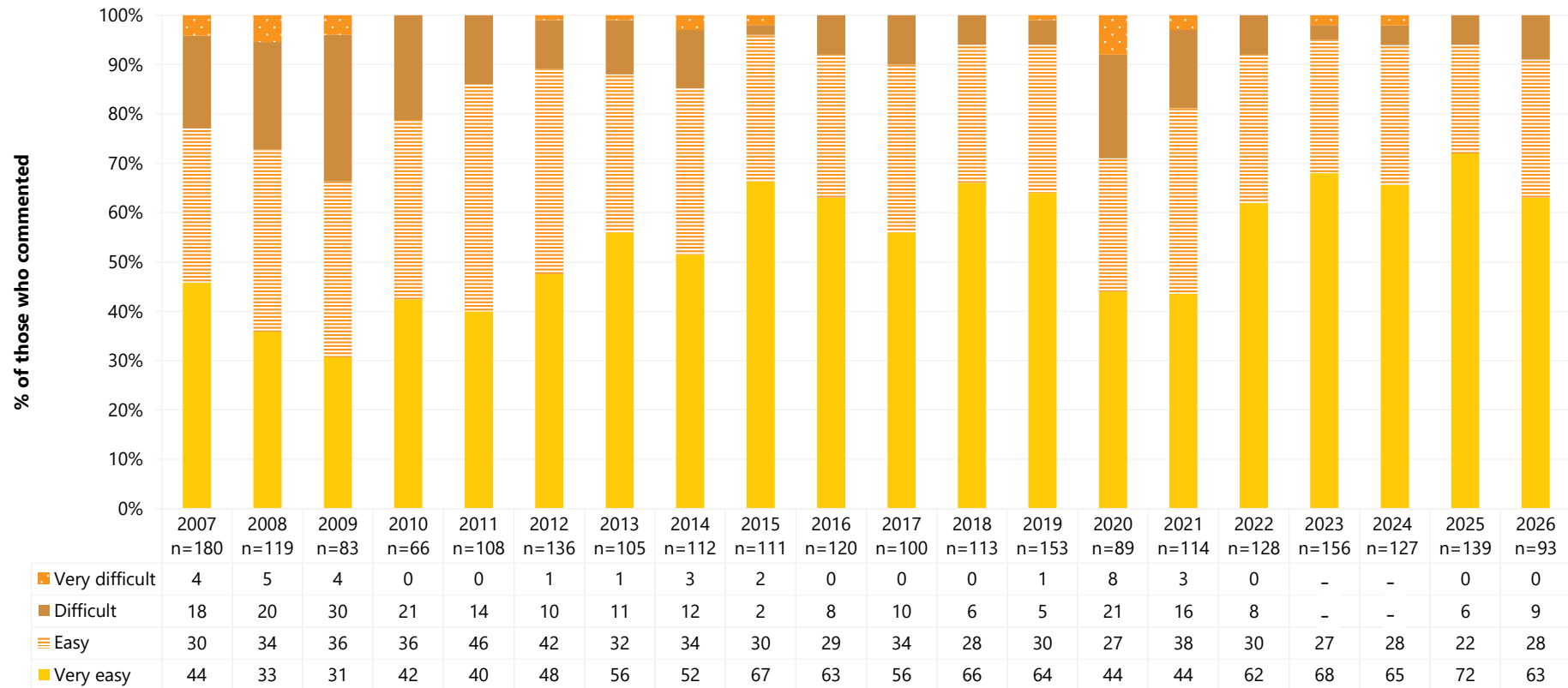
Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 22: Current perceived availability of methamphetamine powder, nationally, 2007-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 23: Current perceived availability of methamphetamine crystal, nationally, 2007-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Past 6 months use

53%

5 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 and narcolepsy.

Median days*

6 days

*Among those whom reported past 6 month use in 2026:

FORMS

79% dexamfetamine

33% ritalin

28% lisdexamfetamine

2% modafinal

Median Amount Used

Typical day:

2 pills/tablets

Maximum:

3 pills/tablets

Routes of administration

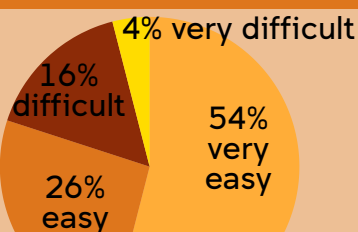
Swallowing
94%

Snorting
17%

Median Price

\$ 5
5mg tablet

$n \leq 5$
10mg tablet



Perceived
Availability

Patterns of Consumption

Recent Use (past 6 months)

The per cent of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has steadily increased in the past 20 years of monitoring, from 17% in 2007 to 55% in 2025. In 2026, recent use of non-prescribed pharmaceutical stimulants remained stable at 53% ($p=0.312$) (Figure 24). Recent use of non-prescribed pharmaceutical stimulants remained stable in all capital city samples, relative to 2025 (Table 11).

Frequency of Use

Frequency of use remained stable in 2026 at a median of six of days in the six months prior to interview (IQR=3-15; $n=366$; 7 days in 2025; IQR=3-15; $n=382$; $p=0.438$) (Figure 24).

Routes of Administration

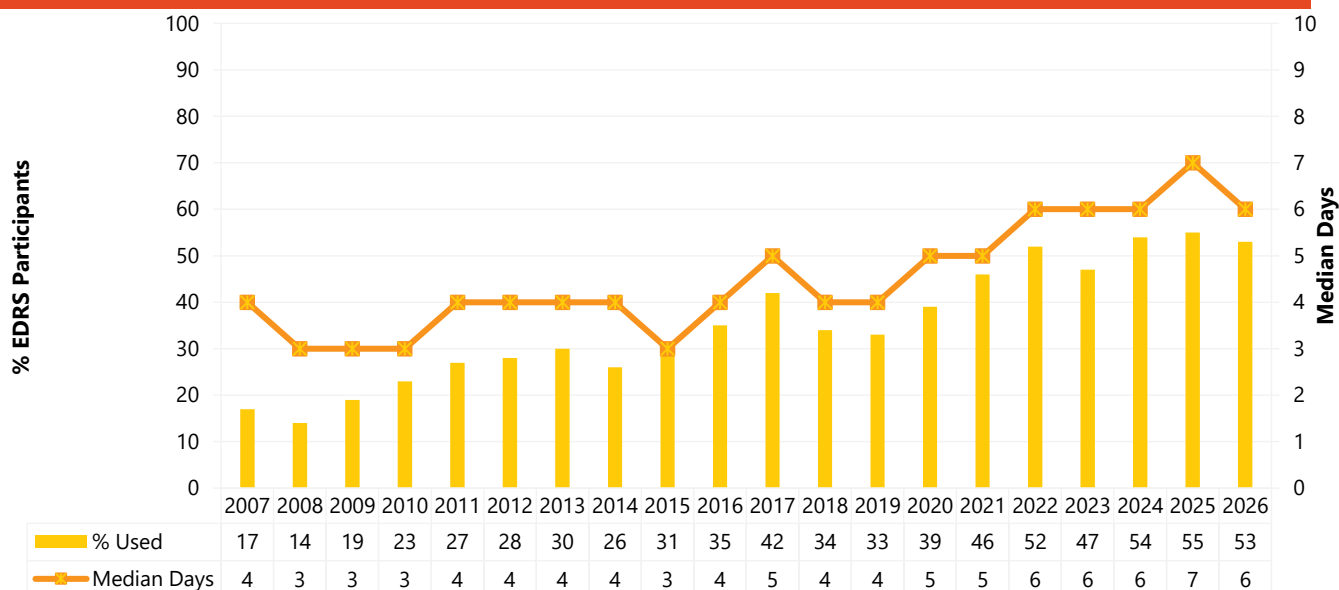
Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented ($n=367$), the majority (94%) reported swallowing as a route of administration (95% in 2025; $p=0.761$), followed by snorting (17%; 19% in 2025; $p=0.631$).

Quantity

Among those who reported recent use and responded ($n=290$), the median amount used in a 'typical' session was two pills/tablets (IQR=1-3; 2 pills/tablets in 2025; IQR=1-3; $p=0.107$). Of those who reported recent use and responded ($n=292$), the median maximum amount used in a session was three pills/tablets (IQR=2-4; 3 pills/tablets in 2025; IQR=2-5; $p=0.954$).

Forms Used

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented ($n=362$), almost four fifths reported using dexamfetamine (79%; 84% in 2025; $p=0.115$), followed by one third (33%) of participants reporting use of Ritalin[®] (36% in 2025; $p=0.531$). Twenty-eight per cent reported using lisdexamfetamine (30% in 2025; $p=0.626$), and 2% reported using modafinil (2% in 2025; $p=0.780$).

Figure 24: Past six month use and frequency of use of non-prescribed pharmaceutical stimulants, nationally, 2007-2026

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. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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 11: Past six month use of non-prescribed pharmaceutical stimulants, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	10	16	9	19	15	43	-	12
2008	9	22	9	16	-	50	-	8
2009	13	34	14	10	-	57	-	9
2010	16	36	24	9	10	58	~	12
2011	18	43	26	15	24	68	~	26
2012	24	33	19	20	19	64	~	19
2013	30	16	29	18	23	62	~	41
2014	23	6	30	18	15	77	13	22
2015	37	18	30	13	-	75	13	31
2016	44	26	34	20	27	65	14	50
2017	43	38	24	36	45	76	14	58
2018	41	34	37	30	12	62	15	42
2019	40	31	34	19	15	63	17	39
2020	38	45	55	22	27	66	29	30
2021	61	41	66	30	31	77	20	42
2022	39	50	64	40	41	81	~	53
2023	41	51	47	34	42	68	~	41
2024	46	56	60	36	50	73	39	61
2025	50	65	65	37	31	84	~	55
2026	42	55	51	39	44	76	/	62

Note. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2024 should be interpreted with caution due to small samples (2008: $n = 55$; 2024: $n = 51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Price and Perceived Availability

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

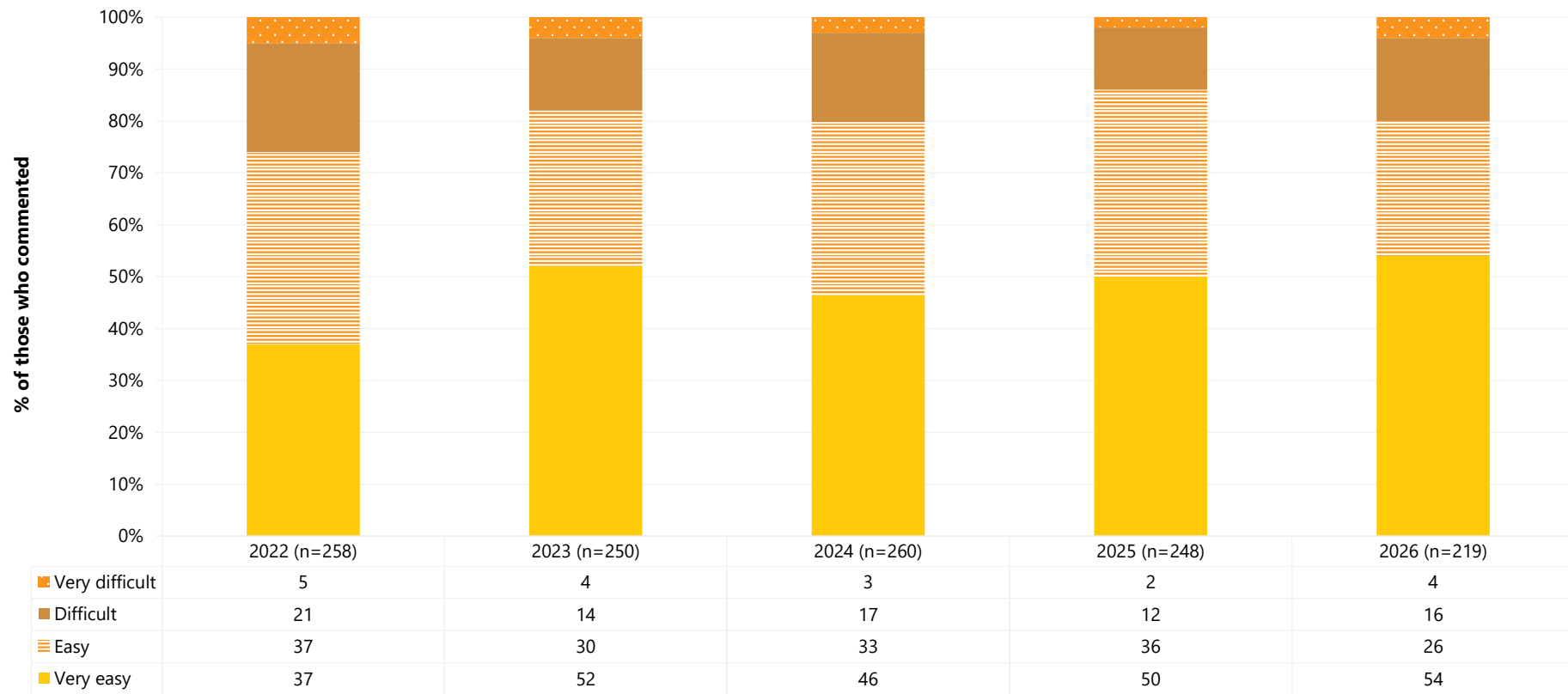
Price

In 2026, participants reported a median price of \$5 per 5mg tablet (IQR=5-10; $n=79$; \$5 in 2025; IQR=5-10; $n=85$; $p=0.558$) and few participants ($n\leq 5$) reported on the price for 10mg tablets (\$10 in 2025; IQR=3-10; $n=18$; $p=0.019$).

Perceived Availability

Among those who responded in 2026 ($n=219$), the perceived availability of non-prescribed pharmaceutical stimulants remained stable, relative to 2025 ($p=0.072$). The largest percentage of participants perceived non-prescribed pharmaceutical stimulants as being 'very easy' to obtain (54%; 50% in 2025), followed by 26% perceiving it to be 'easy' to obtain (36% in 2025). In contrast, 16% perceived it to be 'difficult' to obtain (12% in 2025), with a further 4% perceiving it as being 'very difficult' to obtain (2% in 2025) (Figure 25).

Figure 25: Current perceived availability of non-prescribed pharmaceutical stimulants, nationally, 2022-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Past 6 months use

84%

6 Cocaine

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

Median days*

6 days

*Among those whom reported past 6 month use in 2026:

Routes of administration

Snorting
99%

Swallowing
8%

Median Amount Used

Typical day:

0.50 grams

Maximum:

1 gram

F
O
R
M
S

93% powder

14% crack/rock

Median Price

\$350
Per gram

Perceived Purity

16% fluctuates

18% low

35% high

31% medium

11% difficult

n ≤ 5 very difficult

40% easy

47% very easy

Perceived Availability

Patterns of Consumption

Recent Use (past 6 months)

Recent cocaine use increased threefold between 2007 and 2021, before subsequently stabilising between 2021 and 2025. In 2026, however, 84% of the national sample reported recent use, a significant increase from 79% in 2025 ($p=0.019$), and the highest percentage observed in the past 20 years (Figure 26). Recent cocaine use remained high and stable among most capital city samples, with a significant increase observed in the Perth sample (77%; 60% in 2025; $p=0.017$) (Table 12).

Frequency of Use

Of those who had recently consumed cocaine and commented in 2026 ($n=586$), participants reported a median of six days of use in the six months preceding interview (IQR=3-15), a significant increase from five days in 2025 (IQR=3-12; $n=545$; $p<0.001$) (Figure 25), equivalent to monthly use. Fifteen per cent of those who had recently used cocaine reported weekly or more frequent use, stable relative to 2025 (12%; $p=0.104$).

Routes of Administration

Among participants who had recently consumed cocaine and commented ($n=586$), the vast majority reported snorting as a route of administration (99%), a significant increase relative to 2025 (97%; $p=0.005$), with fewer participants reporting swallowing (8%; 8% in 2025; $p=0.817$).

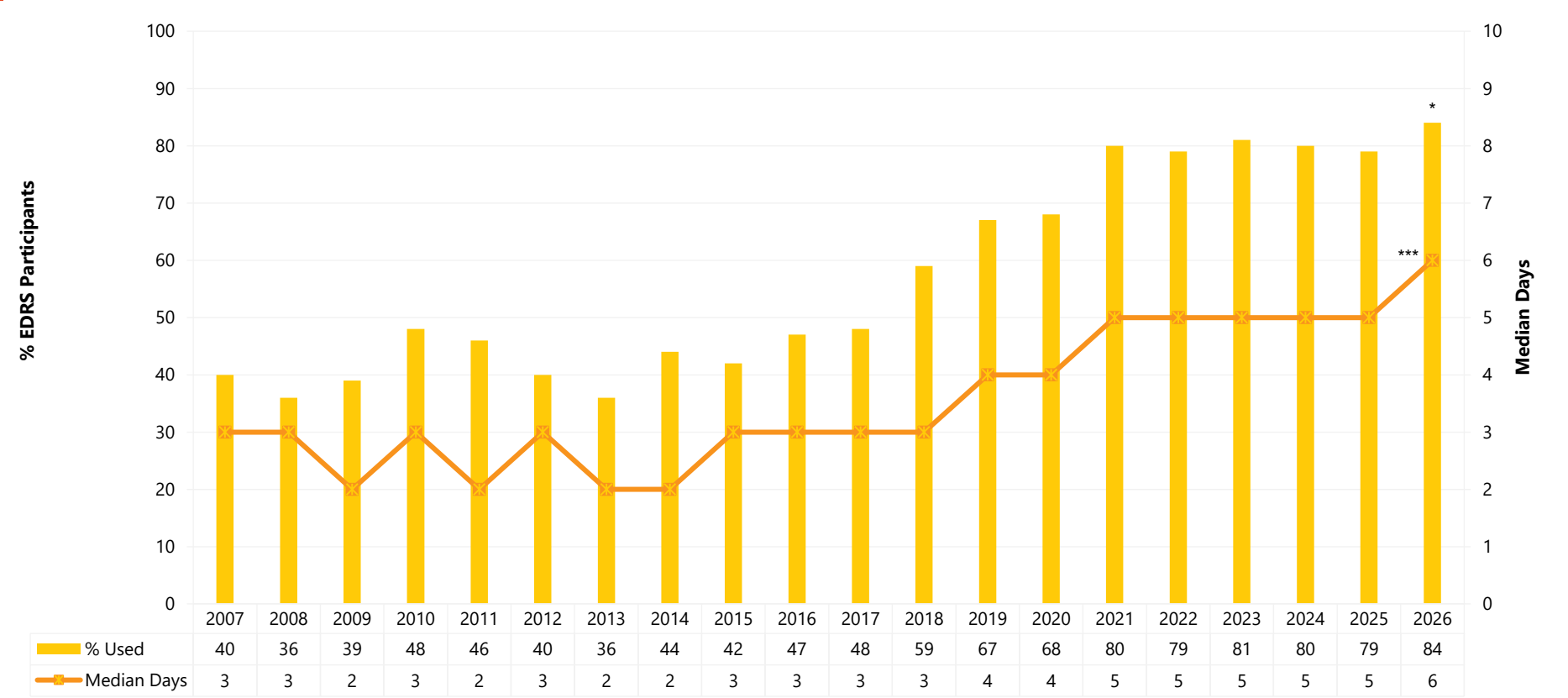
Quantity

Among those who reported recent use and responded ($n=398$), the median amount used in a 'typical' session was 0.50 grams (IQR=0.25-1.00; 0.50 grams in 2025; IQR=0.25-1.00; $p=0.420$). Of those who reported recent use and responded ($n=406$), the median maximum amount used in a session was one gram (IQR=0.50-1.50; 0.75 grams in 2025; IQR=0.50-1.20; $p=0.065$).

Forms Used

Among participants who had recently consumed cocaine and commented ($n=585$), the majority of participants reported using powder cocaine (93%), a significant decrease relative to 2025 (96%; $p=0.020$), and 14% reported using crack/rock cocaine, a significance increase relative to 2025 (9%; $p=0.013$).

Figure 26: Past six month use and frequency of use of cocaine, nationally, 2007-2026



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. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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 12: Past six month use of cocaine, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	62	46	54	35	36	27	-	41
2008	51	45	51	35	20	40	-	30
2009	64	44	48	31	20	24	23	55
2010	59	58	54	49	42	26	~	51
2011	59	43	43	39	45	32	~	52
2012	57	37	54	26	37	31	~	34
2013	42	38	46	17	35	34	~	40
2014	67	51	58	22	45	30	39	42
2015	61	41	46	17	45	29	52	39
2016	70	44	56	24	57	38	42	41
2017	62	48	53	24	60	31	57	50
2018	71	75	84	42	55	47	40	60
2019	83	75	80	38	71	47	74	67
2020	84	89	76	61	69	48	59	61
2021	94	91	90	84	78	59	71	73
2022	86	76	91	78	78	66	~	80
2023	86	78	90	75	77	62	~	95
2024	87	81	80	77	77	71	78	87
2025	81	86	84	75	76	60	~	88
2026	85	85	91	79	83	77*	/	89

Note. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2024 should be interpreted with caution due to small samples (2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Price, Perceived Purity and Perceived Availability

Price

Participants reported a median price of \$350 per gram of cocaine in 2026 (IQR=300-350; $n=291$; \$350 in 2025; IQR=300-400; $n=283$; $p=0.019$), remaining higher than the median price reported between 2007-2020 (Figure 27).

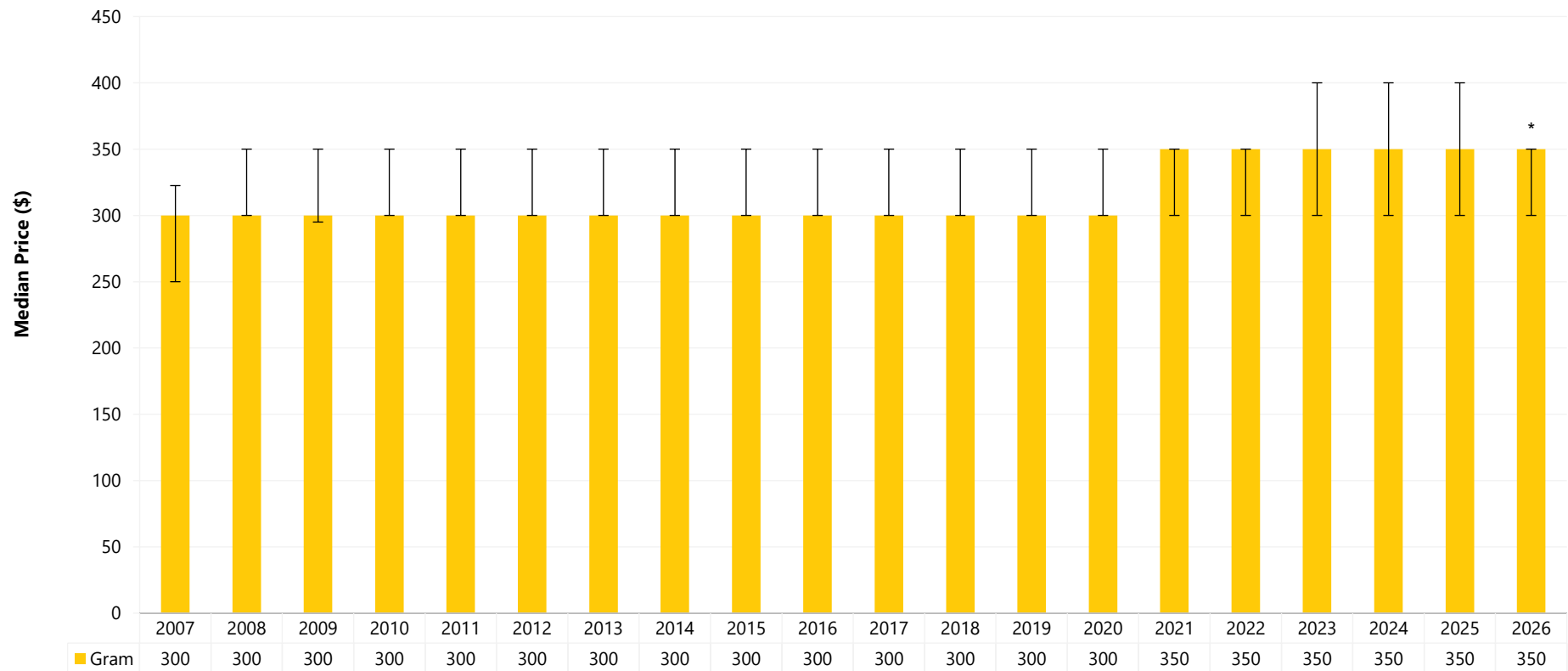
Perceived Purity

Among those able to comment in 2026 ($n=492$), the perceived purity of cocaine remained stable, relative to 2025 ($p=0.486$). One third (35%) perceived purity to be 'high' (32% in 2025) and 31% perceived purity to be 'medium' (31% in 2025). In contrast, almost one fifth (18%) perceived purity to be 'low' (22% in 2025), and a further 16% perceived purity to be 'fluctuating' (15% in 2025) (Figure 28).

Perceived Availability

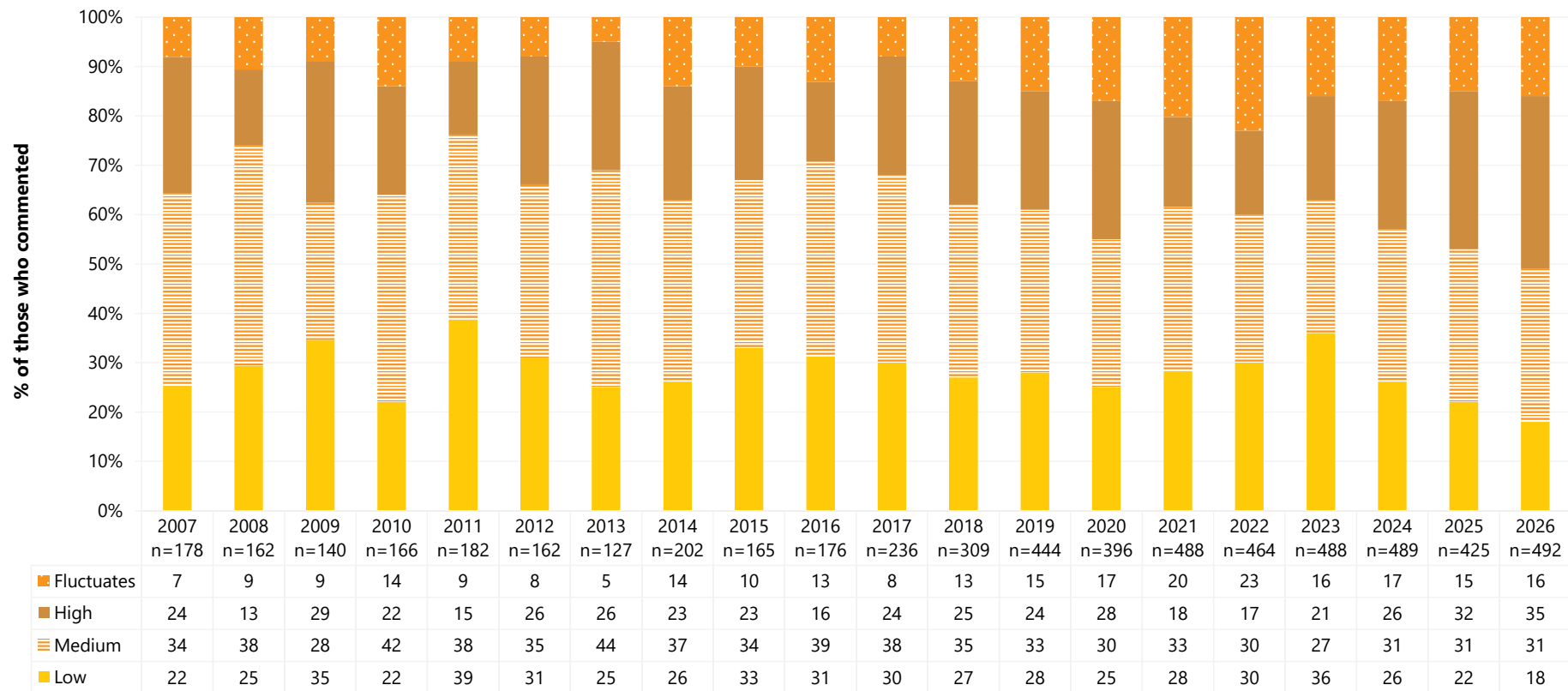
Among those able to comment in 2026 ($n=497$), the perceived availability of cocaine remained stable relative to 2025 ($p=0.537$). The largest percentage of participants perceived cocaine to be 'very easy' (47%; 45% in 2025) or 'easy' (40%; 40% in 2025) to obtain. In contrast, 11% of participants perceived cocaine as being 'difficult' to obtain (13% in 2025), with few participants ($n \leq 5$) perceiving it as 'very difficult' to obtain (2% in 2025) (Figure 29).

Figure 27: Median price of cocaine per gram, nationally, 2007-2026



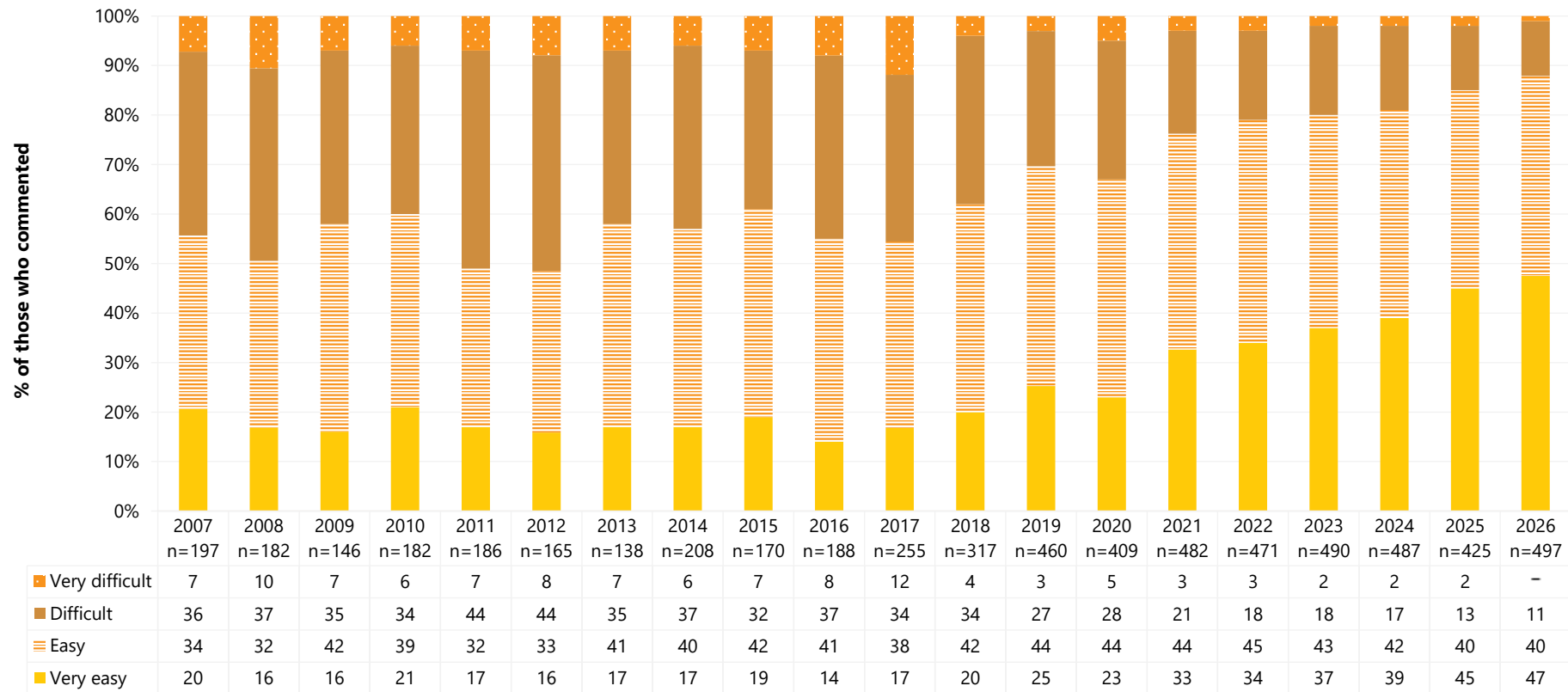
Note. Among those who commented. The error bars represent the IQR. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 28: Current perceived purity of cocaine, nationally, 2007-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 29: Current perceived availability of cocaine, nationally, 2007-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Past 6 months
non-prescribed use

71%

7 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.

Median days*

30 days

*Among those whom reported past 6 month non-prescribed use in 2026:

Routes of administration

Smoked
89%

Swallowed
31%

Inhaled/vaped
18%

Applied
topically
n ≤ 5

Median Amount Used Typical day:

1 gram

2 cones

1 joint

F
O
R
M
S

62% hydroponic

53% bush

10% hashish/hash oil

15% CBD or THC extract

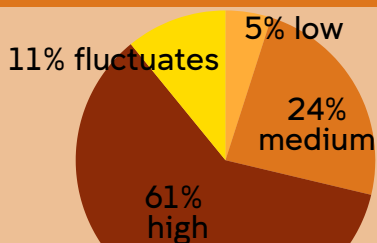
21% edibles

Median Price

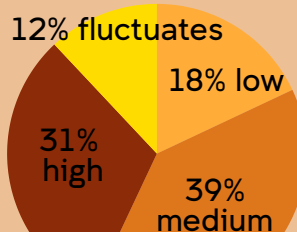
Hydroponic:
\$ 20
Per gram

Bush:
\$ 20
Per gram

Hydroponic: Perceived Potency



Bush: Perceived Potency



Patterns of Consumption

From 2022, participants were asked about their use of both prescribed and non-prescribed cannabis and/or cannabinoid-related products. In 2026, 13% of participants ($n=89$) reported prescribed use in the six months preceding interview, stable compared to 2025 (15%; $p=0.281$), although higher than reported in 2024 (11%), 2023 (6%) and 2022 (4%). Of those who reported recent prescribed use and commented ($n=89$), the vast majority (98%) reported using products that contained THC (question not asked in 2025).

In the remainder of this chapter, data from 2021-2026, and between 2007-2016, refers to non-prescribed cannabis use only, while data between 2017-2020 refers to 'any' cannabis use (including hydroponic and bush cannabis, hashish and hash oil). While comparison between 2021-2026 and previous years should be treated with caution, the relatively recent legalisation of medicinal cannabis in Australia and the small percentage reporting prescribed use in 2022 and 2023 lends confidence that estimates are relatively comparable.

Recent Use (past 6 months)

Recent use of non-prescribed cannabis and/or cannabinoid-related products gradually increased between 2008 and 2018, peaking at 90% in 2018. Since 2018, however, a gradual decline in recent use can be observed. In 2026, 71% of the sample reported recent use of non-prescribed cannabis and/or cannabinoid-related products, the lowest per cent observed in the past 20 years, albeit stable relative to 2025 (72%; $p=0.591$) (Figure 30). Recent use remained stable in most capital cities, apart from a significant decrease observed in the Perth sample (61%; 80% in 2025; $p=0.005$), representing the lowest percentage of use in the past 20 years (Table 13).

Frequency of Use

Frequency of use has varied between weekly and several times a week over the course of monitoring. In 2026, median days of use significantly decreased from 48 days in 2025 (IQR=8-180; $n=498$) to 30 days of use (IQR=5-132; $n=494$) in the six months preceding interview ($p=0.005$) (Figure 30). Fifty-five per cent of those who had recently used non-prescribed cannabis and/or cannabinoid-related products reported weekly or more frequent use (61% in 2025; $p=0.086$), including one fifth (20%) who reported daily use, a significant decrease from 27% in 2025 ($p=0.015$).

Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented ($n=494$), smoking was the most commonly reported route of administration (89%; 91% in 2025; $p=0.450$). Almost one third of participants (31%) reported swallowing (26% in 2025; $p=0.111$) and 18% reported inhaling/vaporising non-prescribed cannabis and/or cannabinoid-related products (16% in 2025; $p=0.500$).

Quantity

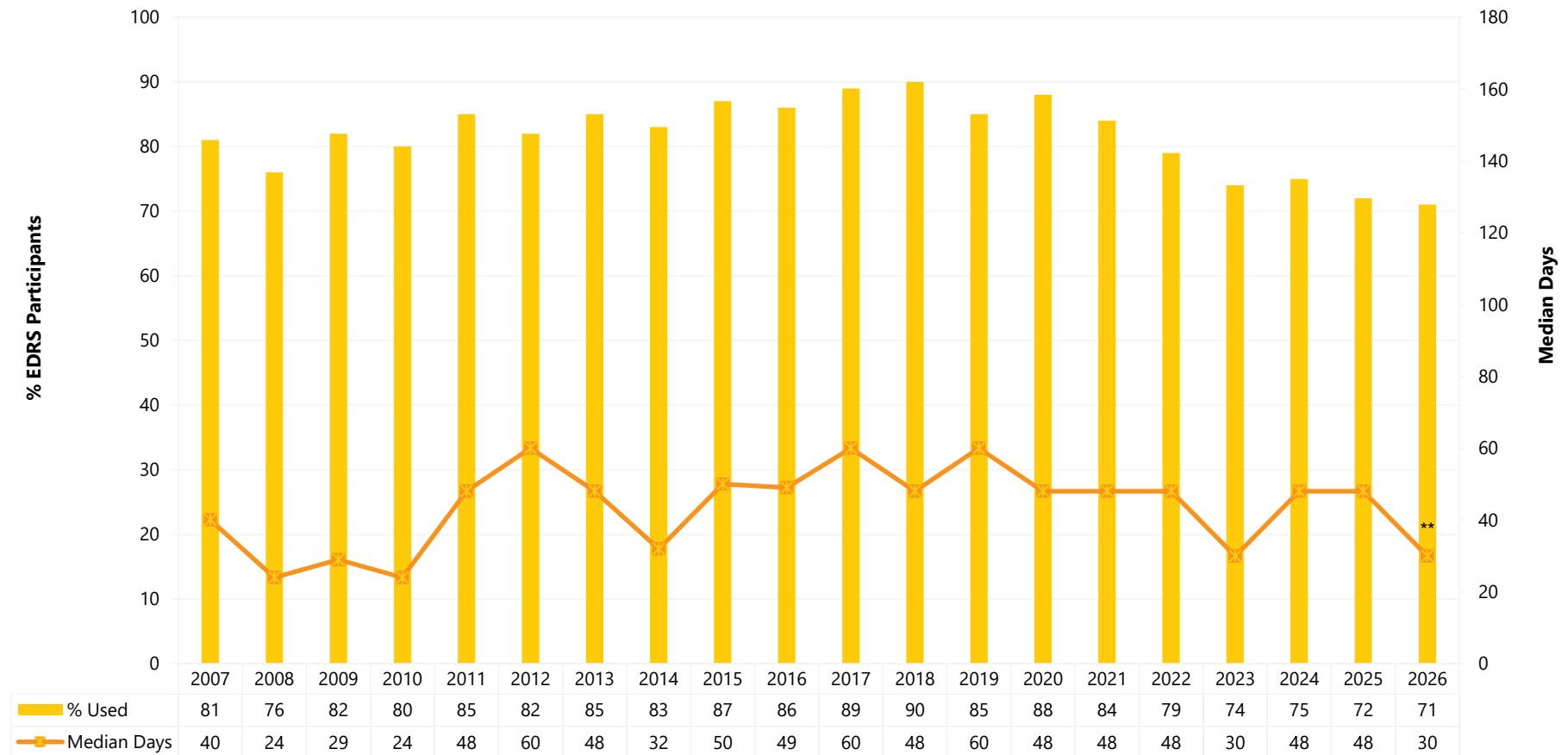
Of those who reported recent use of non-prescribed cannabis and/or cannabinoid-related products and commented ($n=148$), the median 'typical' amount used on the last occasion of use was one gram (IQR=0.50-2.00; 1 gram in 2025; IQR=0.50-2.00; $n=194$; $p=0.960$), two cones (IQR=1-3; $n=123$; 2 cones

in 2025; IQR=1-4; n=131; $p=0.040$) or one joint (IQR=1-2; n=125; 1 joint in 2025; IQR=0.5-1; n=99; $p=0.071$).

Forms Used

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented in 2026 (n=397), three fifths (62%) reported recent use of hydroponic cannabis (65% in 2025; $p=0.387$) and 53% reported recent use of outdoor-grown 'bush' cannabis (55% in 2025; $p=0.527$). One fifth (21%) reported recent use of commercially prepared edibles (19% in 2025; $p=0.490$), with smaller percentages reporting use of hashish (6%; 9% in 2025; $p=0.066$) and hash oil (4%; 6% in 2025; $p=0.348$) in the preceding six months. Eleven per cent reported recent use of non-prescribed THC extract (10% in 2025; $p=0.834$), and 4% reported recent use of non-prescribed CBD extract (5% in 2025; $p=0.517$) (Figure 31).

Figure 30: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid-related products, nationally, 2007-2026



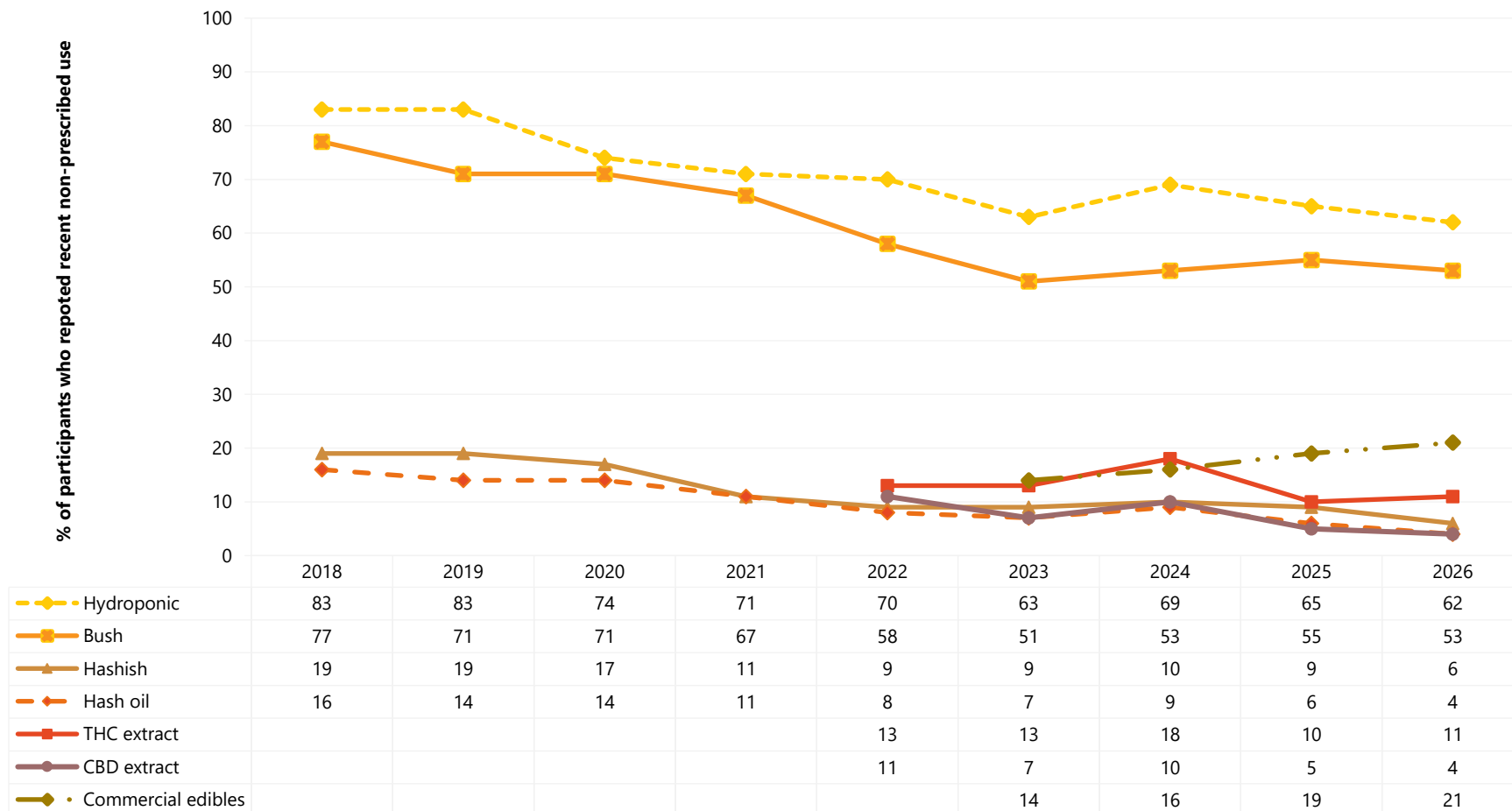
Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low (e.g., in 2022, 10 participants reported use of prescribed cannabis only). Further, from 2022 onwards, we captured use of 'cannabis and/or cannabinoid-related products', while in previous years questions referred only to 'cannabis'. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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 13: Past six month non-prescribed use of cannabis and/or cannabinoid-related products, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	74	85	82	68	80	80	96	87
2008	71	86	84	74	74	85	40	81
2009	83	89	85	76	86	85	60	84
2010	78	89	89	72	84	81	~	72
2011	83	89	86	67	92	86	~	93
2012	86	92	85	69	88	77	~	81
2013	90	87	87	78	85	92	~	84
2014	85	74	81	76	87	86	84	87
2015	91	82	90	80	92	86	82	93
2016	85	85	86	77	97	87	82	86
2017	93	95	88	84	89	82	88	93
2018	91	88	84	94	85	86	93	95
2019	81	81	86	88	82	86	83	92
2020	91	85	89	84	90	87	91	90
2021	88	86	84	75	84	82	83	89
2022	71	81	82	81	75	84	~	76
2023	66	80	67	78	70	85	~	75
2024	74	80	72	69	73	77	69	81
2025	58	87	65	72	67	80	~	78
2026	61	81	72	76	76	61**	/	67

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. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2024 should be interpreted with caution due to small samples (2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 31: Past six month use of different forms of non-prescribed cannabis and/or cannabinoid-related products, among those who reported recent use, nationally, 2018-2026



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. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Price, Perceived Potency and Perceived Availability

Hydroponic Cannabis

Price: In 2026, the median price per gram of non-prescribed hydroponic cannabis was \$20 (IQR=10-20; n=30), stable relative to 2025 (\$20; IQR=14-20; n=44; $p=0.904$) and consistent with the median price observed over the past two decades. The median price per ounce has fluctuated over time. In 2026, the median price per ounce of hydroponic cannabis was \$250 (IQR=245-300; n=31; \$280 in 2025; IQR=220-320; n=37; $p=0.303$), the lowest price observed over the reporting period (Figure 32A).

Perceived Potency: Among those who were able to comment in 2026 (n=200), the perceived potency of non-prescribed hydroponic cannabis remained stable, relative to 2025 ($p=0.502$). Three fifths (61%) of participants reported potency to be 'high' (61% in 2025), almost one quarter (24%) reported potency to be 'medium' (21% in 2025) and 5% reported potency to be 'low' (n≤5 in 2025) (Figure 33A).

Perceived Availability: Among those who were able to comment in 2026 (n=199), the perceived availability of non-prescribed hydroponic cannabis remained stable, relative to 2025 ($p=0.971$). Three quarters (75%) of participants reported non-prescribed hydroponic cannabis to be 'very easy' to obtain (76% in 2025), and almost one quarter (23%) reported that it was 'easy' to obtain (22% in 2025). Few participants (n≤5) reported that it was 'difficult' to obtain (n≤5 in 2025) and no participants reported that it was 'very difficult' to obtain (Figure 34A).

Bush Cannabis

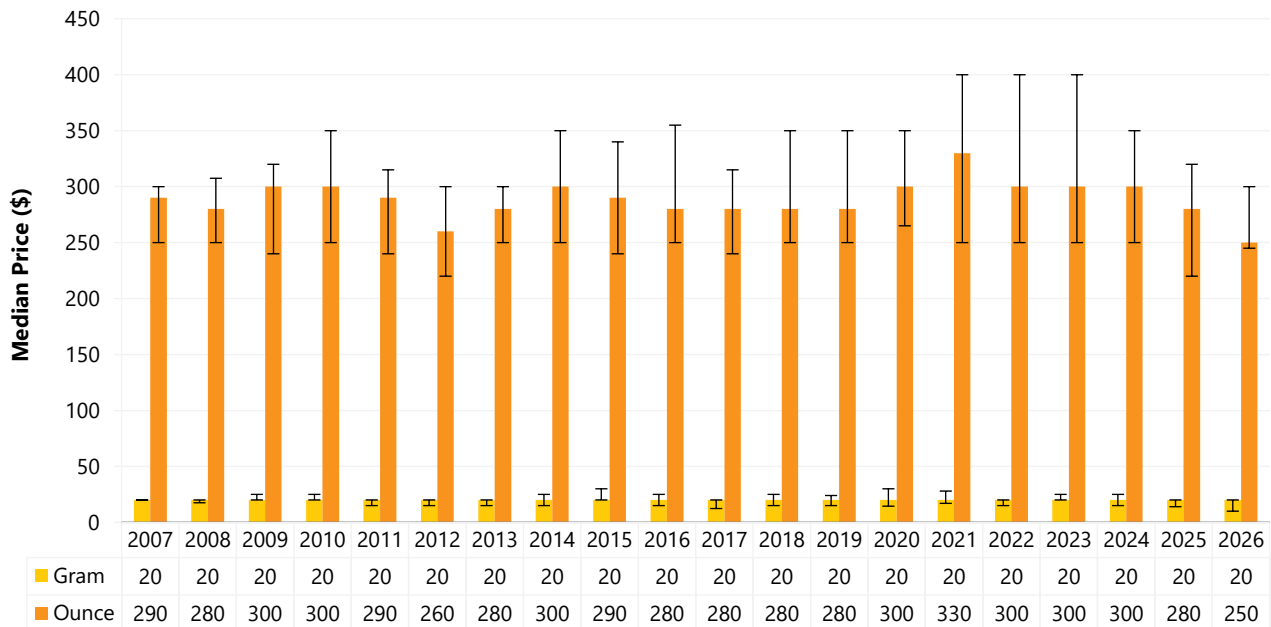
Price: In 2026, the median price per gram of non-prescribed bush cannabis was \$20 (IQR=15-20; n=18), a significant increase from \$15 in 2025 (IQR=10-20; n=41; $p=0.040$). Despite some fluctuation, the median price for an ounce of non-prescribed bush cannabis has remained largely stable since 2009, with a median price of \$250 in 2026 (IQR=205-300; n=18; \$250 in 2025; IQR=195-285; n=24; $p=0.368$) (Figure 32B).

Perceived Potency: Among those who were able to comment in 2026 (n=137), the perceived potency of non-prescribed bush cannabis remained stable, relative to 2025 ($p=0.903$). Almost two fifths (39%) of participants reported potency as 'medium' (41% in 2025) and a further 31% reported 'high' potency (30% in 2025). Eighteen per cent reported potency to be 'low' (19% in 2025) and 12% reported it to be 'fluctuating' (10% in 2025) (Figure 33B).

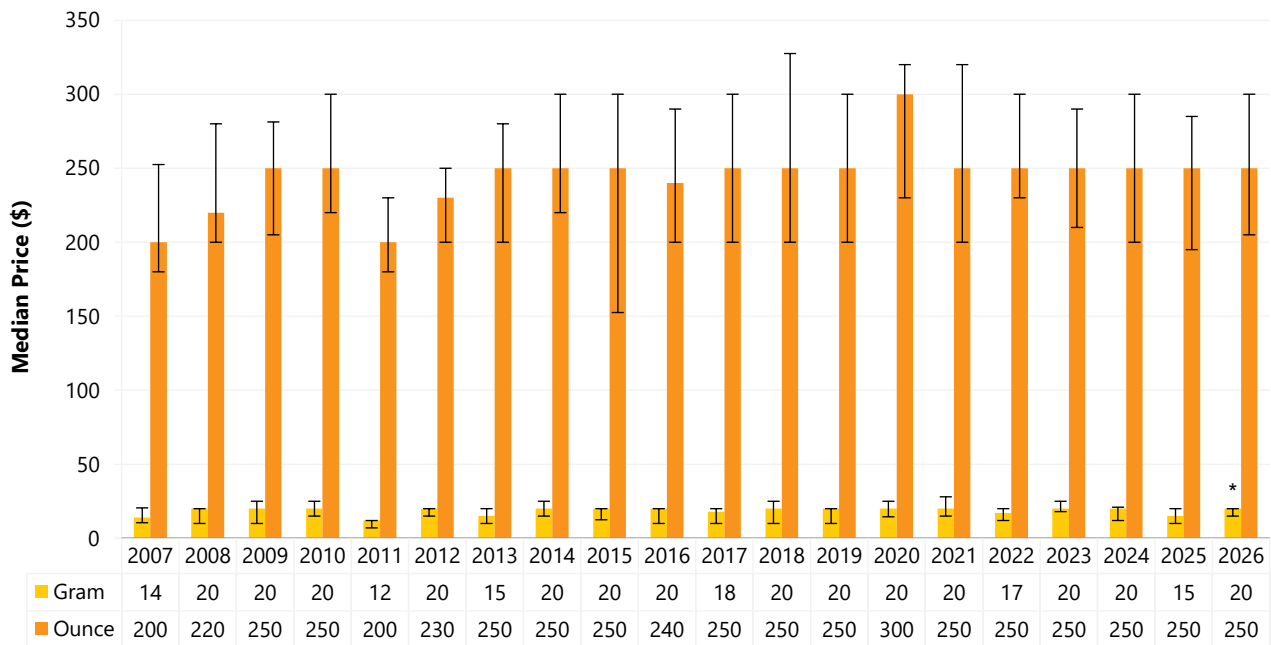
Perceived Availability: Among those who were able to comment in 2026 (n=136), the perceived availability of non-prescribed bush significantly changed, relative to 2025 ($p<0.001$). Three fifths (60%) of participants perceived non-prescribed bush cannabis as being 'very easy' to obtain, a decrease from 79% in 2025, and one third (34%) perceived it as being 'easy' to obtain, an increase from 19% in 2025. Few participants perceived non-prescribed bush cannabis as being 'difficult' (n≤5, respectively) or 'very difficult' (n≤5, respectively) to obtain (Figure 34B).

Figure 32: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, nationally, 2007-2026

(A) Hydroponic cannabis



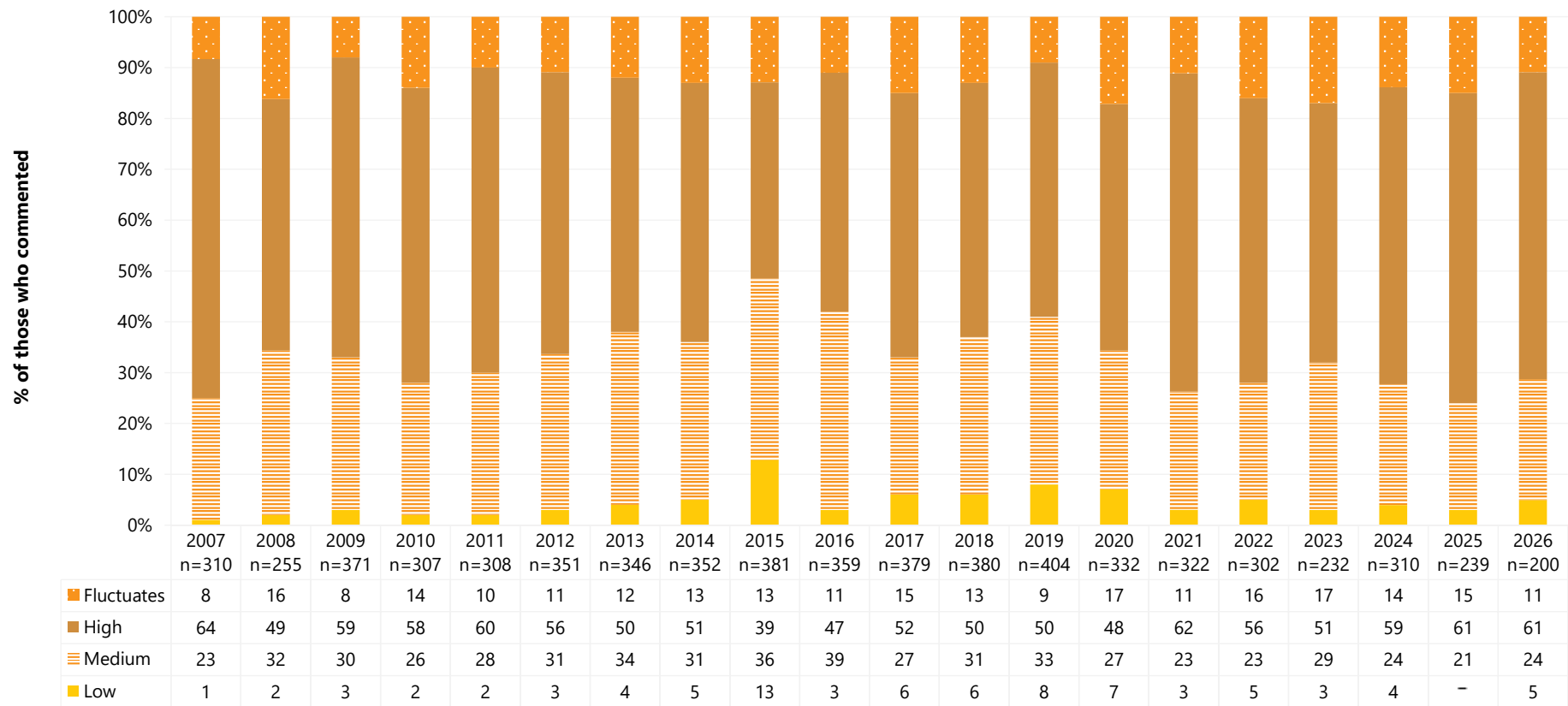
(B) Bush cannabis

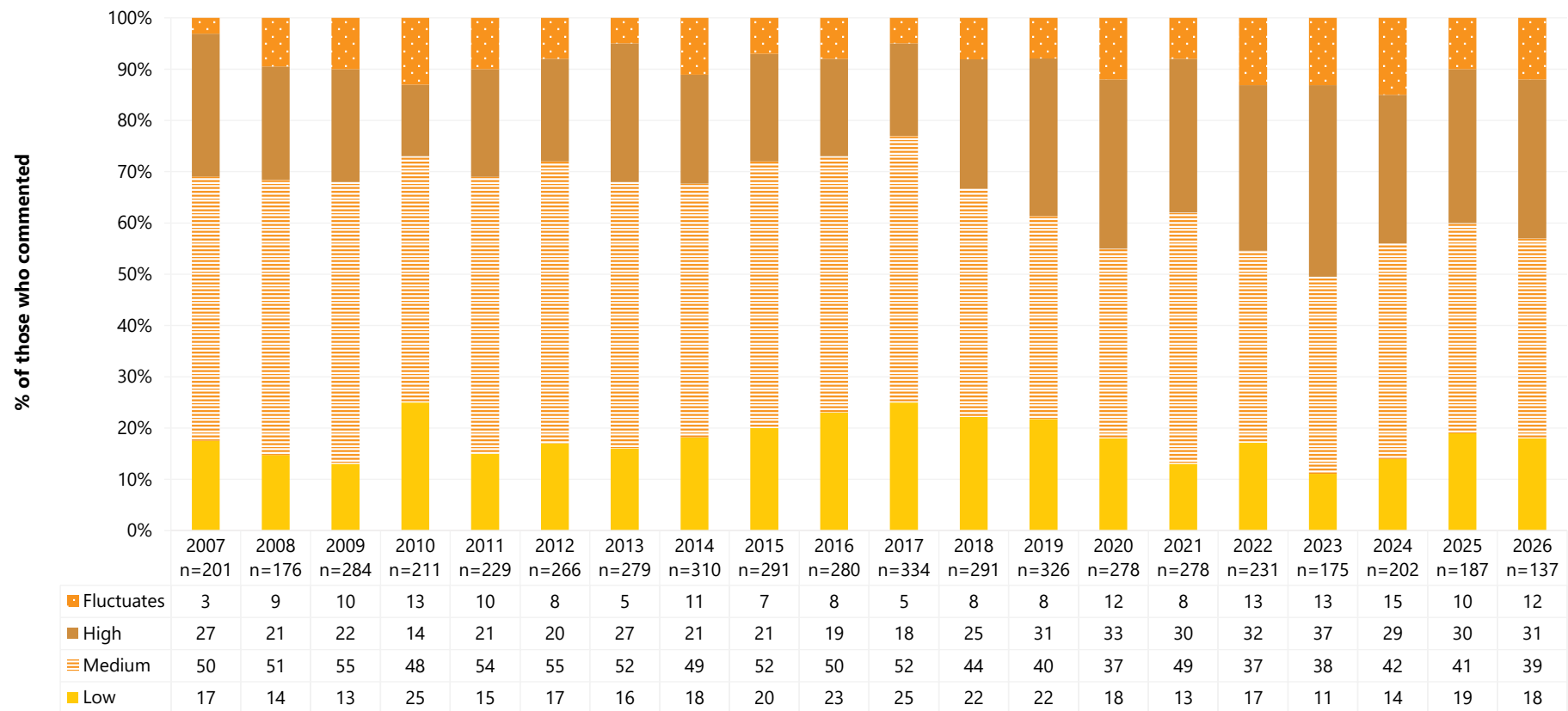


Note. The error bars represent the IQR. Data from 2022 onwards refers to non-prescribed cannabis only: prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the price of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 33: Current potency of non-prescribed hydroponic (A) and bush (B) cannabis, nationally, 2007-2026

(A) Hydroponic cannabis

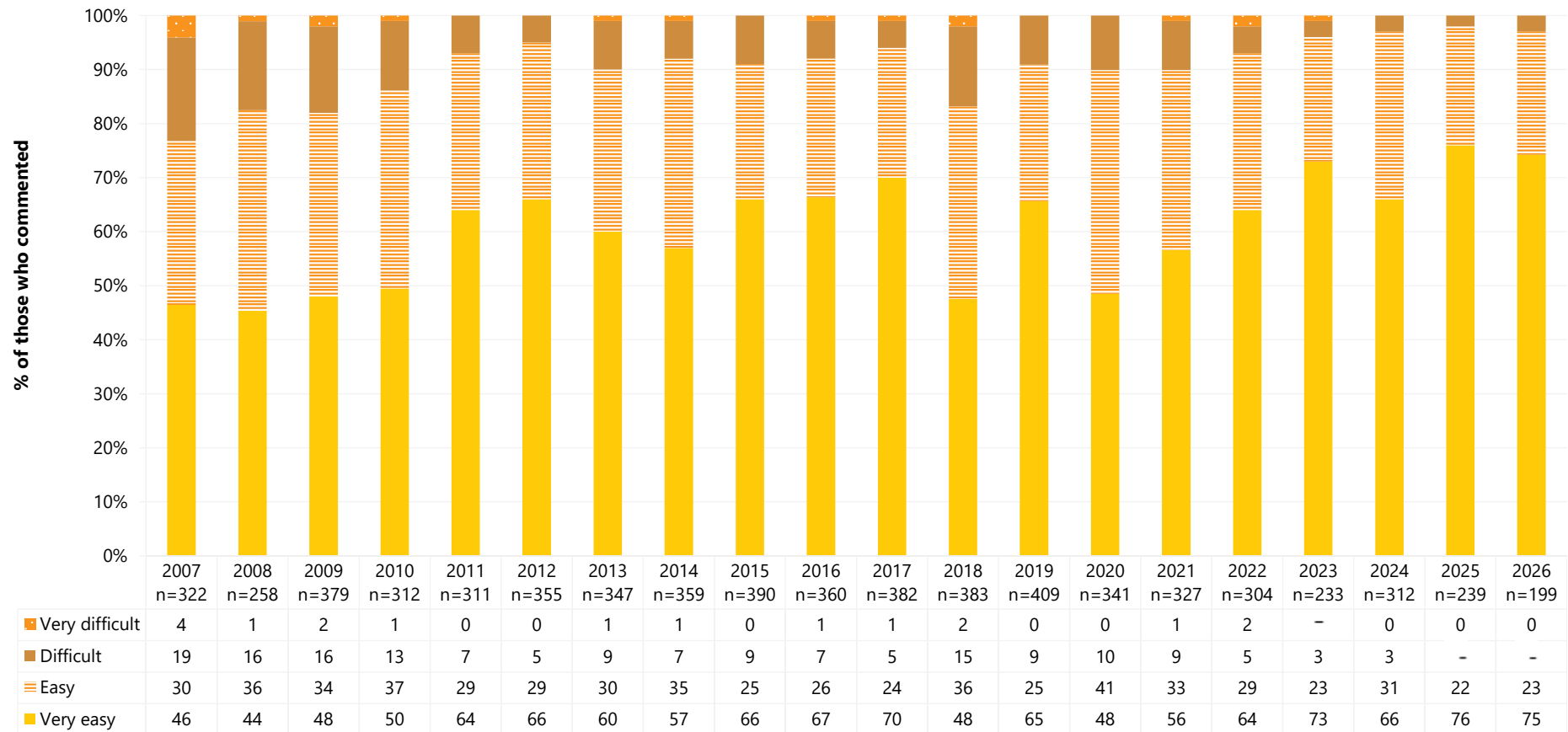


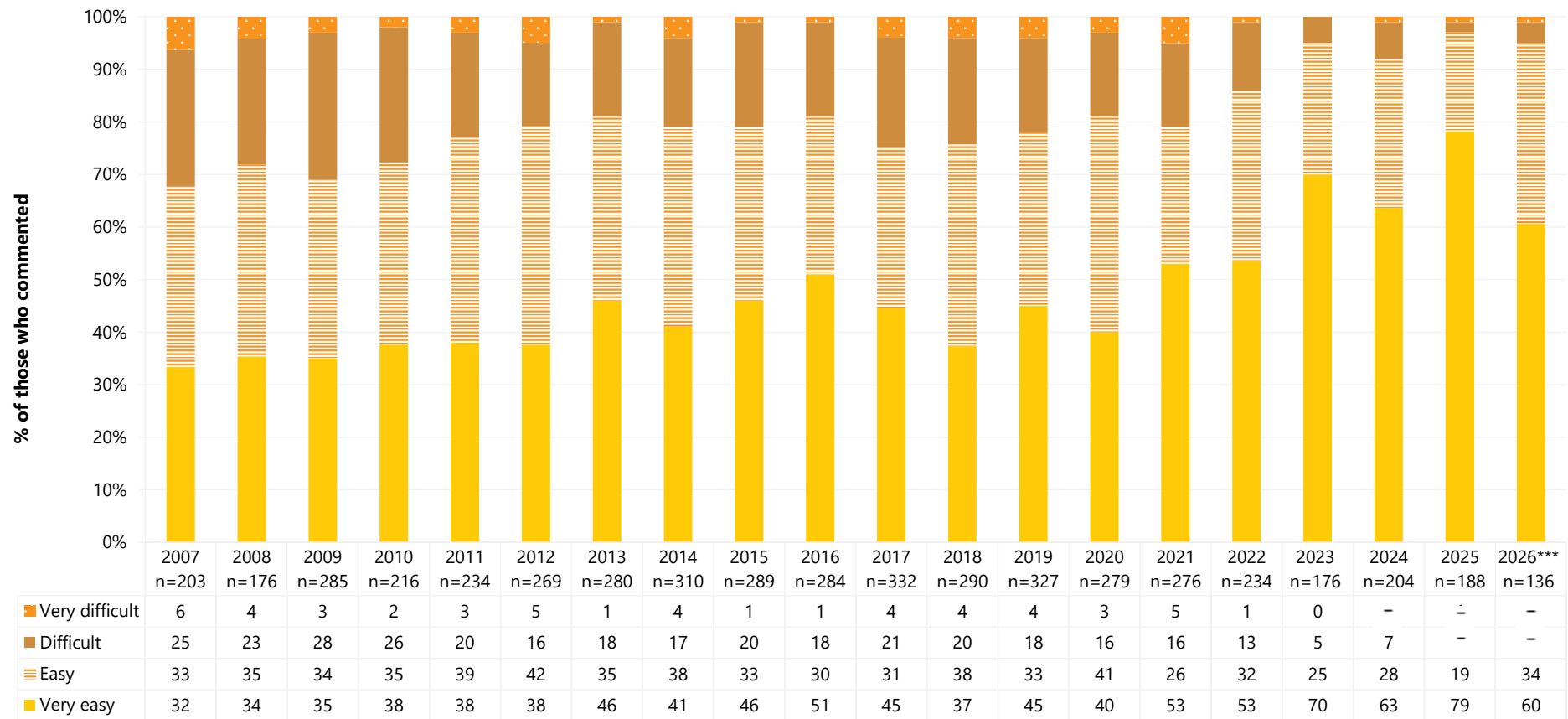
(B) Bush cannabis

Note. Data from 2022 onwards refers to non-prescribed cannabis only: prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who are reporting on the potency of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 34: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, nationally, 2007-2026

(A) Hydroponic cannabis



(B) Bush cannabis

Note. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017–2021 figures include some participants who are reporting on the availability of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

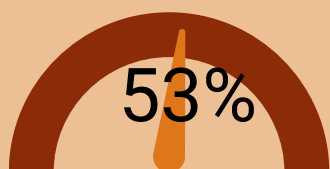
Ketamine, LSD and DMT

Participants were asked about their recent (past six month) use of various forms of non-prescribed ketamine, lysergic acid diethylamide (LSD) and N,N-Dimethyltryptamine (DMT).

8

Past 6 month non-prescribed use in 2026:

Non-Prescribed Ketamine



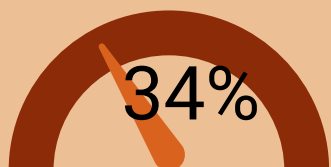
Median Typical
Amount Used

0.25grams

Median Price

\$ 200
Per gram

LSD



Median Typical
Amount Used

1 tab

Median Price

\$ 20
Per tab

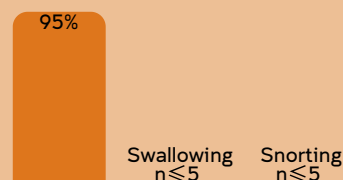
DMT



Median Typical
Amount Used

50 mg

Routes of
administration



Non-Prescribed Ketamine

Patterns of Consumption

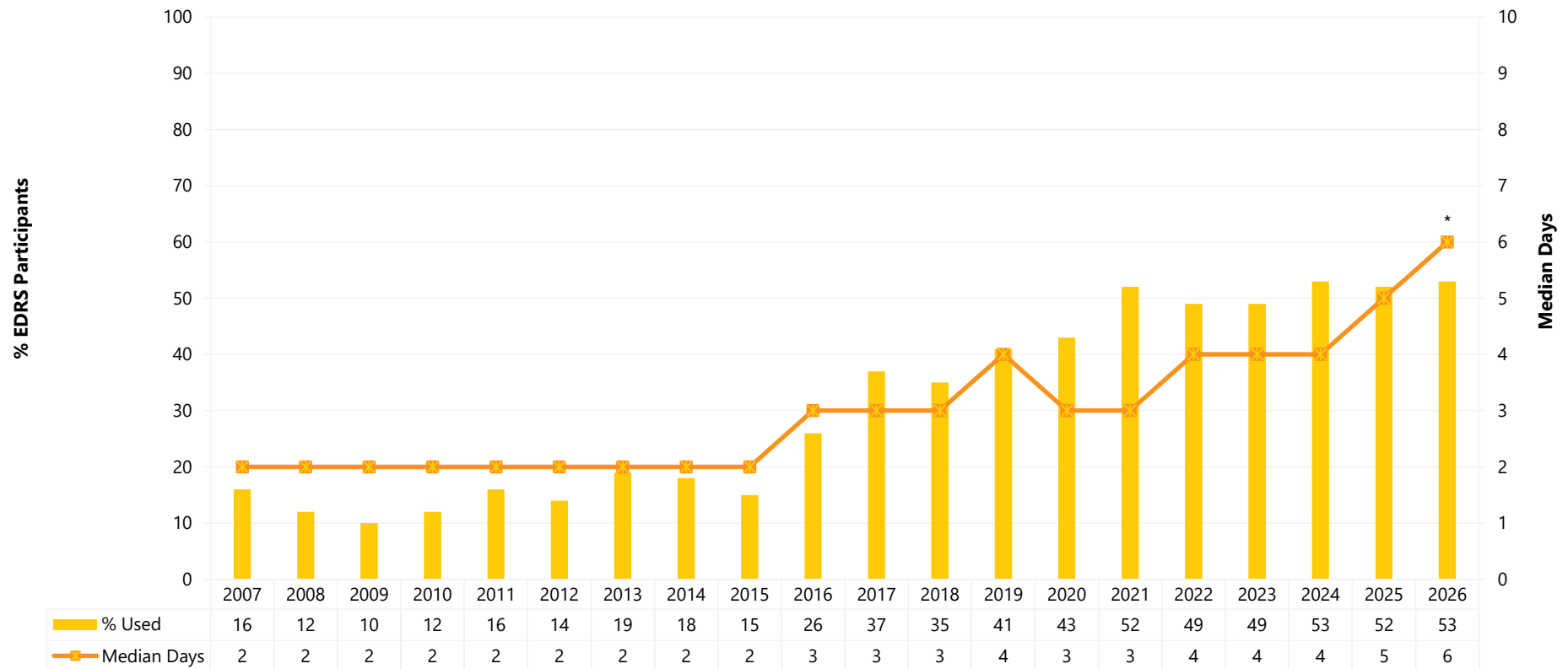
Recent Use (past 6 months): Recent use of non-prescribed ketamine increased from 16% in 2007 to 52% in 2021 and has remained relatively stable since. Indeed, in 2026, 53% of the sample reported recent use, stable relative to 2025 (52%; $p=0.785$) (Figure 35). Recent use remained stable across all capital cities (Table 14).

Frequency of Use: Participants who had recently consumed non-prescribed ketamine and commented in 2026 ($n=371$) reported a median of six days of use in the six months preceding interview (IQR=2-15), a significant increase relative to 2025 (5 days; IQR=2-12; $n=361$; $p=0.031$) (Figure 35). Fourteen per cent of those who had recently used non-prescribed ketamine reported weekly or more frequent use (11% in 2025; $p=0.324$).

Routes of Administration: Among participants who had recently consumed non-prescribed ketamine and commented ($n=371$), the most common route of administration was snorting (96%; 96% in 2025; $p=0.845$), followed by swallowing (6%; 6% in 2025). Few participants ($n\leq 5$) reported smoking or injecting; therefore, these numbers are suppressed.

Quantity: Among those who reported recent use and responded ($n=231$), the median amount used in a 'typical' session was 0.25 grams (IQR=0.20-0.50; 0.25 grams in 2025; IQR=0.19-0.50; $p=0.325$). Among those who reported recent use and responded ($n=235$), the median maximum quantity used in a session was 0.50 grams (IQR=0.25-1.00; 0.50 grams in 2025; IQR=0.20-0.80; $p=0.022$).

Figure 35: Past six month use and frequency of use of non-prescribed ketamine, nationally, 2007-2026



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 10 days to improve visibility of trends. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only became available via prescription, for treatment resistant depression, in 2021). National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 14: Past six month use of non-prescribed ketamine, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	36	10	25	14	26	-	-	-
2008	30	6	20	6	20	-	0	-
2009	19	-	21	-	19	6	0	6
2010	24	6	23	6	13	-	~	8
2011	39	14	26	8	8	0	~	-
2012	24	14	35	-	10	-	~	7
2013	24	33	46	9	6	7	~	13
2014	23	6	63	14	-	11	15	-
2015	24	9	50	-	-	-	18	-
2016	50	20	72	-	15	18	11	22
2017	50	49	80	17	48	16	11	21
2018	54	29	90	23	24	22	11	28
2019	68	33	84	17	33	25	39	27
2020	53	47	78	52	32	31	24	28
2021	76	51	81	46	28	41	55	37
2022	56	39	88	38	29	39	~	51
2023	54	56	82	51	37	36	~	35
2024	61	46	80	30	49	55	41	52
2025	63	57	76	40	34	48	~	48
2026	69	58	80	42	38	47	/	39

Note. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2024 should be interpreted with caution due to small samples (2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

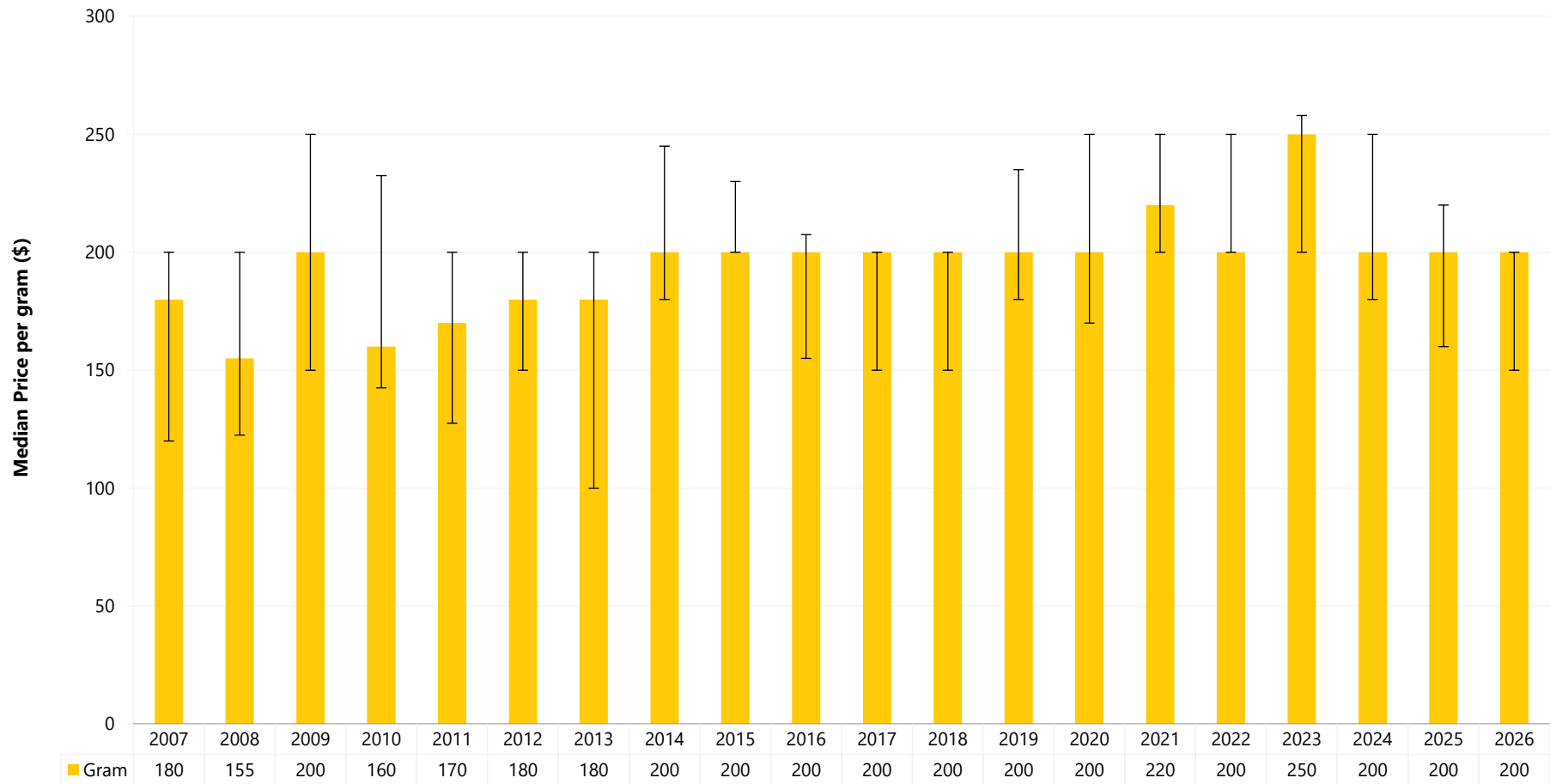
Price, Perceived Purity and Perceived Availability

Price: In 2026, participants reported a median price of \$200 (IQR=150-200; $n=164$) per gram of non-prescribed ketamine, stable relative to 2025 (\$200; IQR=160-220; $n=161$; $p=0.053$) (Figure 36).

Perceived Purity: Among those able to comment in 2026 ($n=259$), the perceived purity of non-prescribed ketamine remained stable, relative to 2025 ($p=0.157$). Almost three fifths (57%) perceived purity as being 'high' (65% in 2025), and one quarter (27%) perceived purity as being 'medium' (22% in 2025). Twelve per cent perceived purity to be 'fluctuating' (11% in 2025), with few participants (4%) perceiving purity to be 'low' ($n \leq 5$ in 2025) (Figure 37).

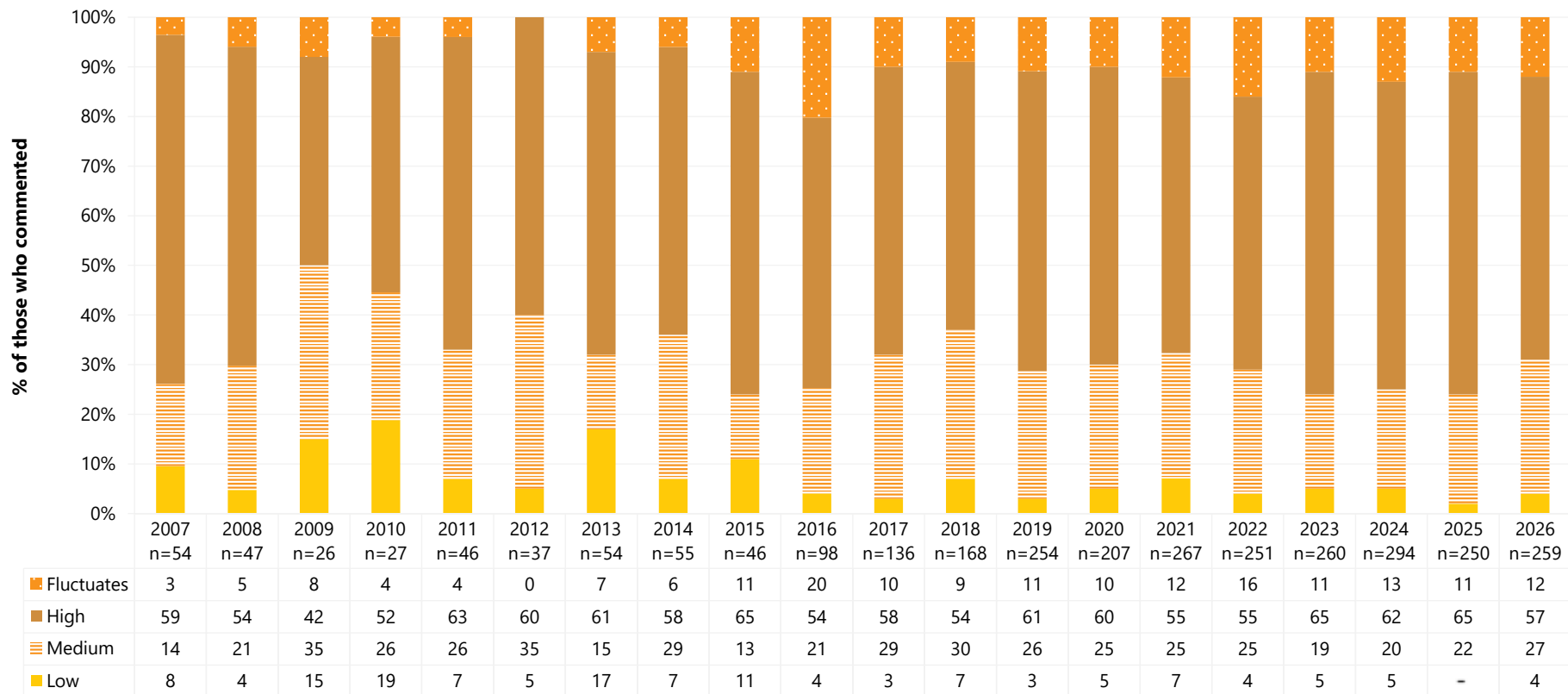
Perceived Availability: Among those able to comment in 2026 ($n=265$), the perceived availability of non-prescribed ketamine remained stable, relative to 2025 ($p=0.489$). Two fifths (42%) perceived non-prescribed ketamine to be 'very easy' to obtain (42% in 2025), with a further 40% perceiving it to be 'easy' to obtain (43% in 2025). In contrast, 17% perceived ketamine to be 'difficult' to obtain in 2026 (13% in 2025), and few participants ($n \leq 5$) perceived ketamine to be 'very difficult' to obtain (2% in 2025) (Figure 38).

Figure 36: Median price of non-prescribed ketamine per gram, nationally, 2007-2026



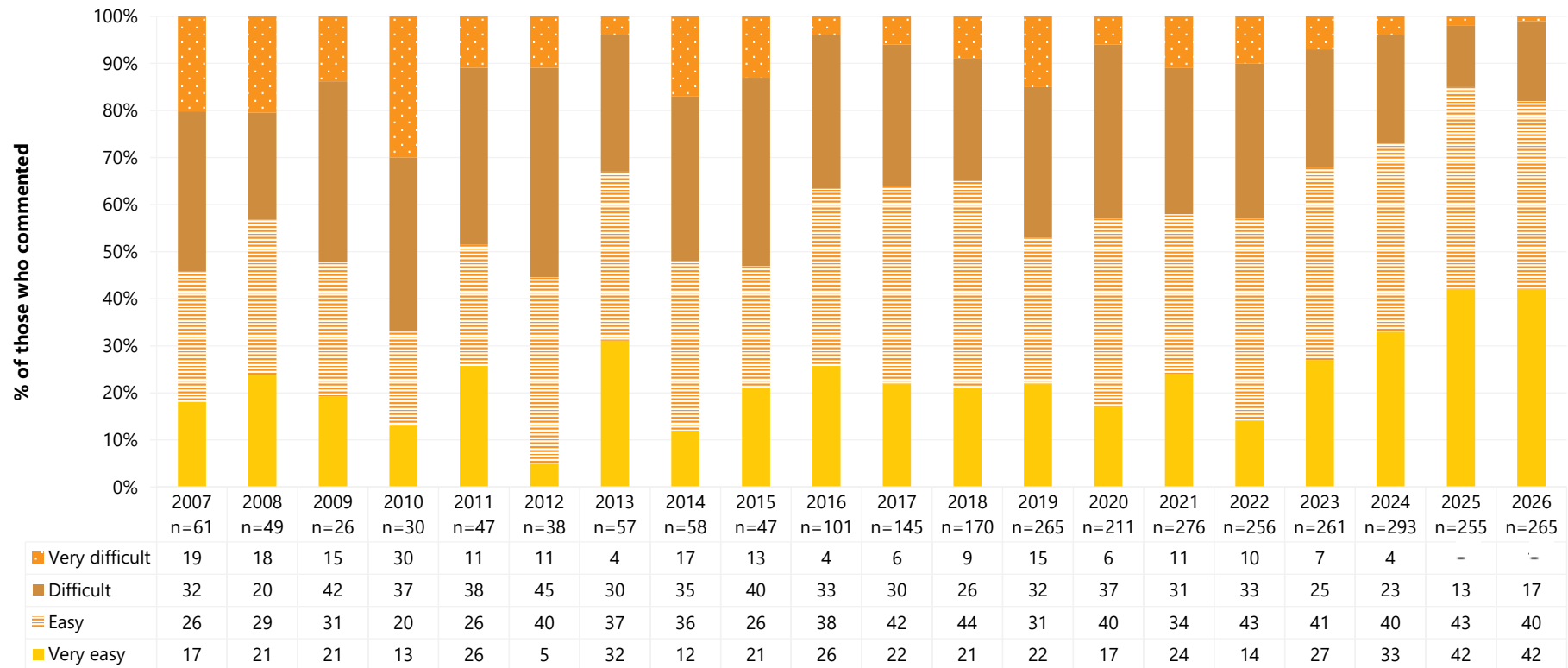
Note. Among those who commented. The error bars represent the IQR. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only became available via prescription, for treatment resistant depression, in 2021). National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 37: Current perceived purity of non-prescribed ketamine, nationally, 2007-2026



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). National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 38: Current perceived availability of non-prescribed ketamine, nationally, 2007-2026



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). National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

LSD

Patterns of Consumption

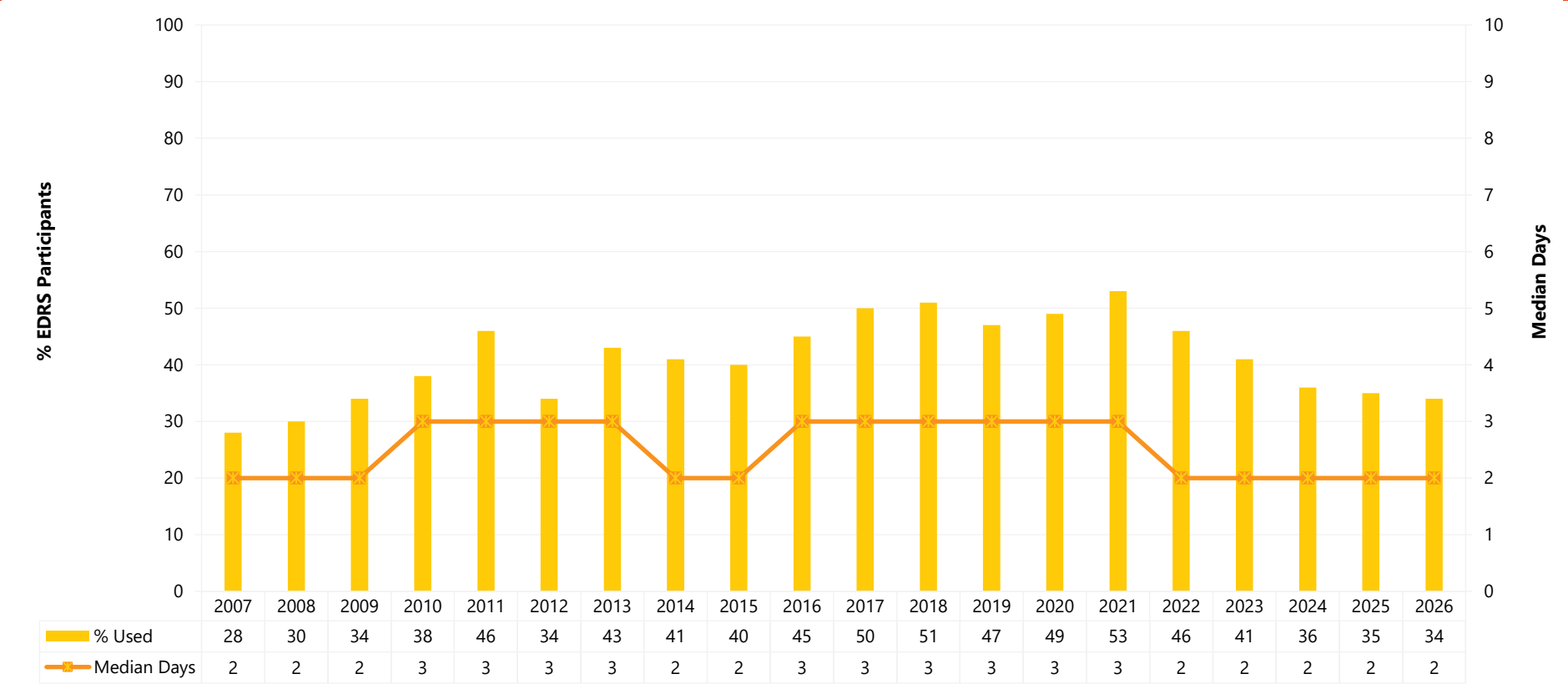
Recent Use (past 6 months): The per cent reporting any recent use of LSD has fluctuated over time. Notwithstanding some year-to-year variation, recent use gradually increased between 2007 and 2017, stabilised between 2017 and 2021, and then gradually declined from 2021 onwards. In 2026, one third (34%) of the national sample reported recent use of LSD, stable relative to 2025 (35%; $p=0.816$) (Figure 39). In 2026, recent use remained stable across most capital cities, apart from a significant decrease in the Perth sample (17%; 30% in 2025; $p=0.048$) (Table 15).

Frequency of Use: Of those who had recently consumed LSD and commented in 2026 ($n=239$), use was infrequent and stable, with participants reporting use on a median of two days (IQR=1-5) in the six months preceding interview (2 days in 2025; IQR=1-4; $n=240$; $p=0.951$) (Figure 39). Four per cent of those who had recently used LSD reported weekly or more frequent use (3% in 2025; $p=0.441$).

Routes of Administration: Among participants who had recently consumed LSD and commented ($n=239$), 100% of participants reported swallowing as a route of administration (100% in 2025). Few participants ($n\leq 5$) reported any other routes of administration.

Quantity: Among those who reported recent use and responded ($n=165$), the median amount used in a 'typical' session was one tab (IQR=1.00-2.00; 1 tab in 2025; IQR=1.00-2.00; $p=0.779$). Among those who reported recent use and responded ($n=167$), the median maximum amount used in a session was one tab (IQR=1.00-2.00; 1 tab in 2025; IQR=1.00-2.00; $p=0.835$).

Figure 39: Past six month use and frequency of use of LSD, nationally, 2007-2026



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. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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 15: Past six month use of LSD, by capital city, 2007-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2007	22	24	39	20	33	23	33	28
2008	18	37	29	41	35	21	16	32
2009	37	35	46	34	37	31	11	30
2010	44	41	49	27	35	35	~	38
2011	46	39	57	43	30	36	~	52
2012	43	38	38	30	19	33	~	34
2013	51	53	52	38	25	41	~	41
2014	43	19	49	35	35	45	43	57
2015	60	37	46	41	37	24	32	41
2016	65	40	52	39	30	50	32	55
2017	73	64	52	39	36	33	47	52
2018	71	43	64	41	36	39	52	61
2019	48	42	55	44	43	43	52	53
2020	44	41	61	60	52	43	42	49
2021	57	45	53	63	35	55	59	60
2022	41	31	57	57	30	54	~	53
2023	37	42	55	38	33	36	~	42
2024	43	37	38	32	28	33	39	42
2025	37	28	38	40	28	30	~	49
2026	37	41	43	38	27	17*	/	38

Note. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2024 should be interpreted with caution due to small samples (2008: $n=55$; 2024: $n=51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

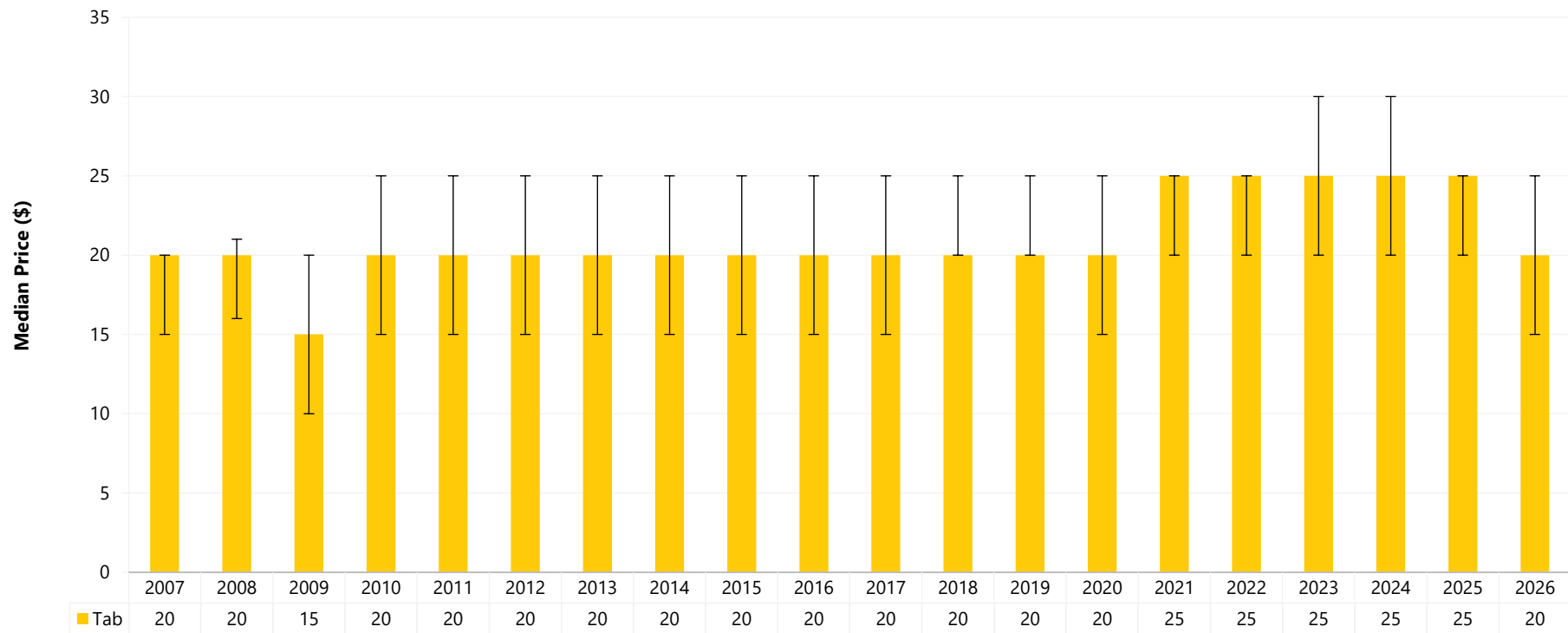
Price, Perceived Purity and Perceived Availability

Price: The median price of LSD remained stable at \$20 per tab between 2010 and 2020, followed by an increase in price to \$25 between 2021-2025. In 2026, participants reported a median price of \$20 per tab (IQR=15-25; $n=88$), returning to the prices observed between 2010 and 2020, although stable relative to 2025 (\$25; IQR=20-25; $n=124$; $p=0.054$) (Figure 40).

Perceived Purity: Among those who commented in 2026 ($n=190$), the perceived purity of LSD remained stable, relative to 2025 ($p=0.908$). Specifically, almost three fifths (57%) reported purity as 'high' (56% in 2025), and 29% reported it as 'medium' (27% in 2025). Eleven per cent of participants reported that purity had 'fluctuated' in 2026 (12% in 2025), and 4% reported purity as 'low' (5% in 2025) (Figure 41).

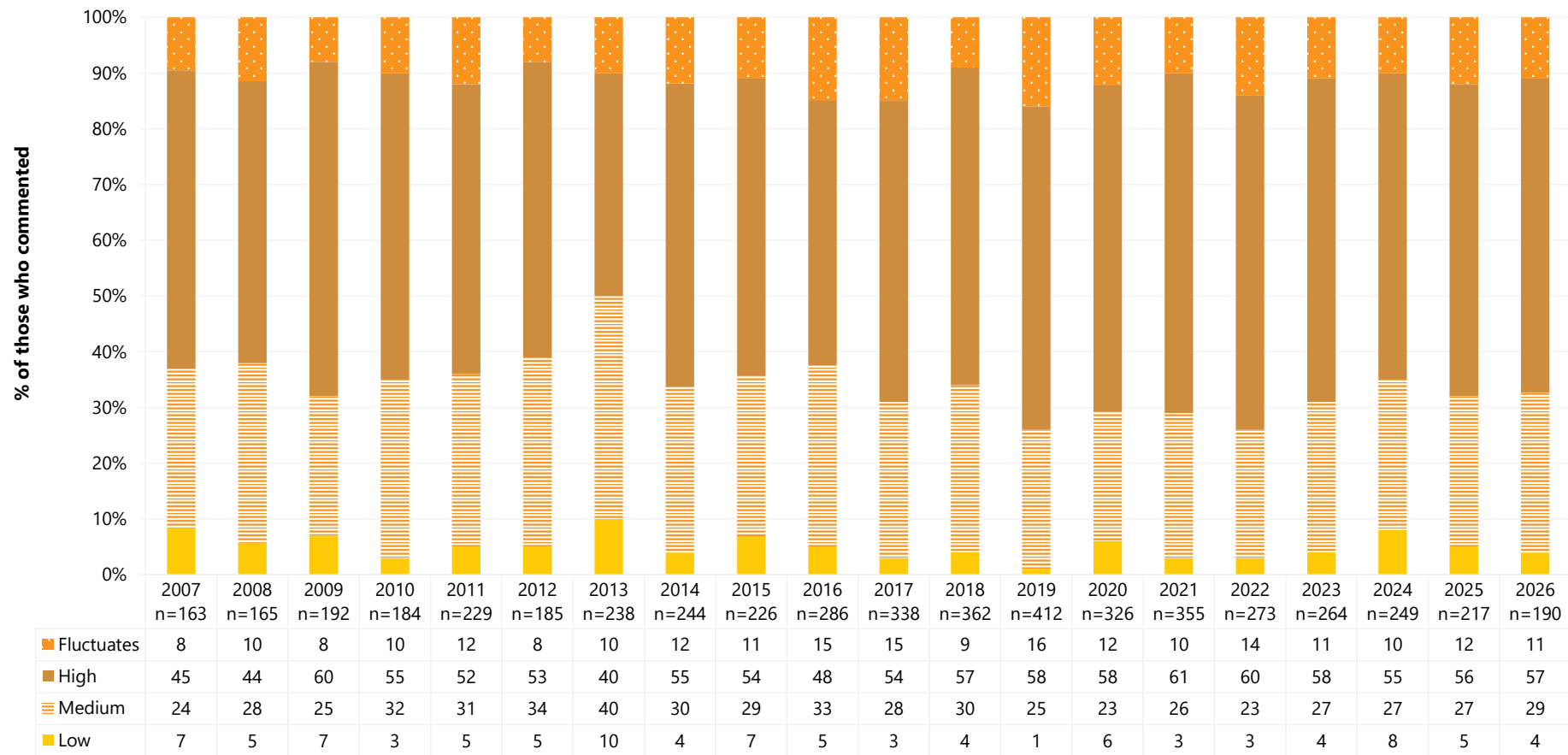
Perceived Availability: Among those able to comment in 2026 ($n=198$), the perceived availability of LSD remained stable, relative to 2025 ($p=0.654$). Forty-five per cent perceived LSD to be 'easy' to obtain (40% in 2025), with a further 24% reporting that it was 'very easy' to obtain (29% in 2025). In contrast, 27% reported LSD to be 'difficult' to obtain (28% in 2025), with a further 4% reporting it 'very difficult' to obtain (4% in 2025) (Figure 42).

Figure 40: Median price of LSD per tab, nationally, 2007-2026



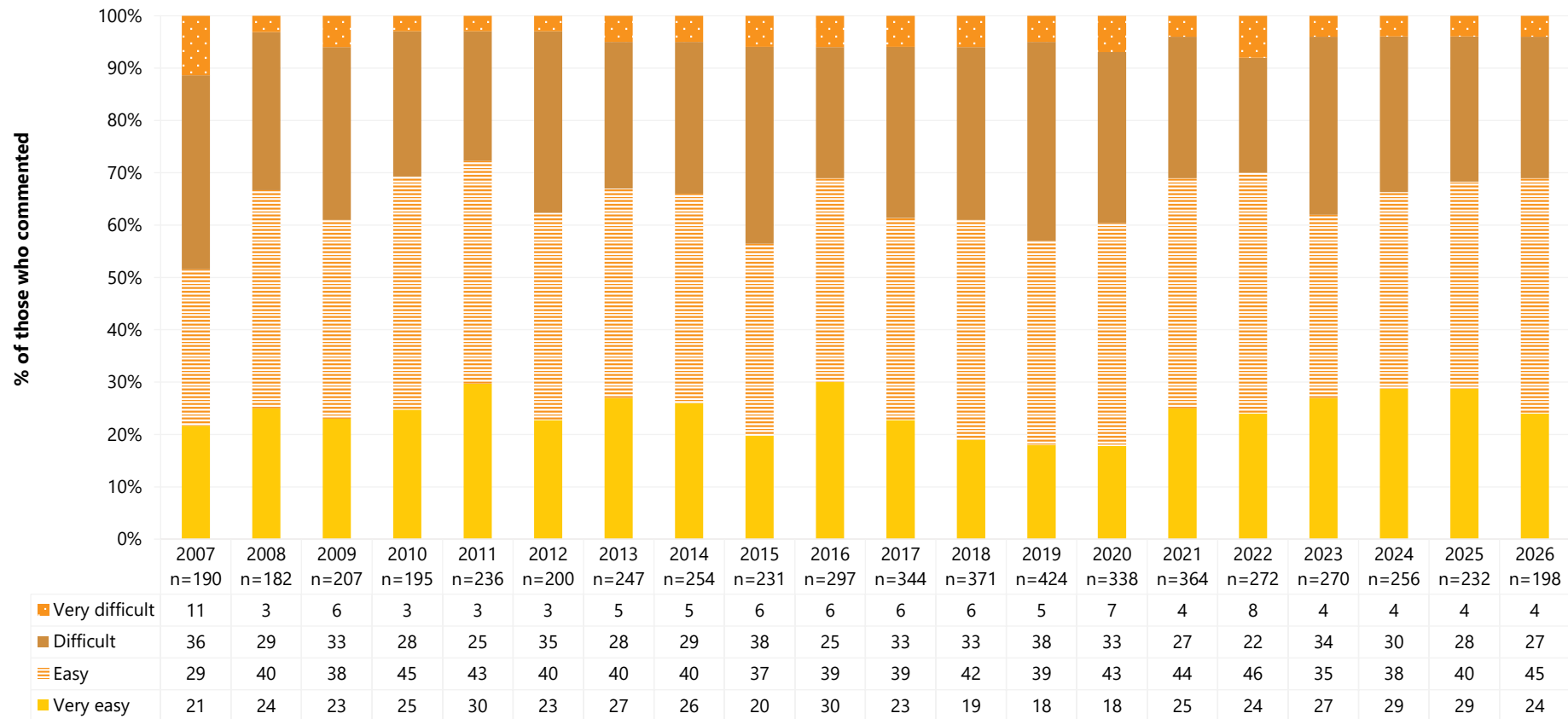
Note. Among those who commented. The error bars represent the IQR. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 41: Current perceived purity of LSD, nationally, 2007-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 42: Current perceived availability of LSD, nationally, 2007-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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

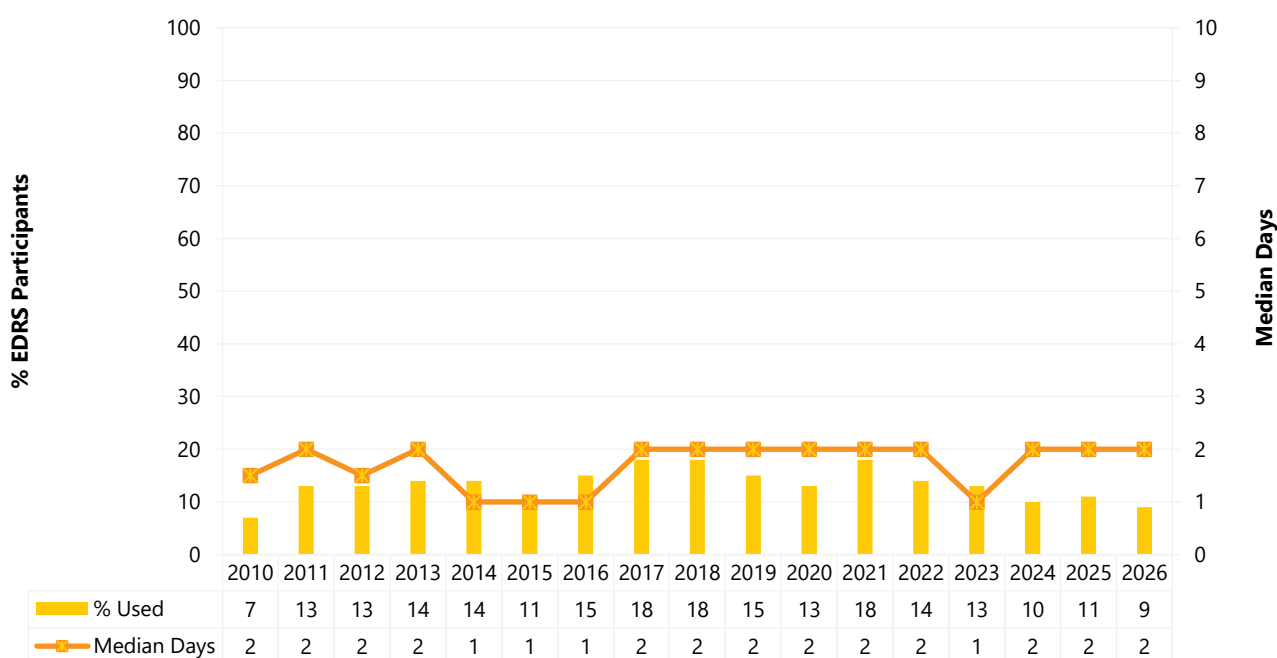
Recent Use (past 6 months): The per cent reporting recent DMT use has fluctuated over the reporting period, however, has consistently remained below 20%. In 2026, 9% of participants reported recent use, stable relative to 2025 (11%; $p=0.256$) (Figure 43). Recent use remained stable in all capital city samples (Table 16).

Frequency of Use: Use has remained infrequent and stable over the monitoring period, with a median of two days of use (IQR=1-3; $n=65$) reported by participants in 2026 (2 days in 2025; IQR=1-3; $n=78$; $p=0.846$) (Figure 43).

Routes of Administration: Among participants who had recently consumed DMT and commented in 2026 ($n=65$), the most common route of administration was smoking (95%; 97% in 2025; $p=0.659$). Few participants ($n\leq 5$) reported swallowing and snorting, respectively; therefore, these numbers are suppressed.

Quantity: Among those who reported recent use and responded ($n=9$), the median amount used in a 'typical' session was 50 mgs (IQR=20-50; 25 mgs in 2025; IQR=15-100; $p=0.882$). Of those who reported recent use and responded ($n=9$), the median maximum amount used in a session was 50 mgs (IQR=30-100; 50 mgs in 2025; IQR=10-100; $p=0.984$).

Figure 43: Past six month use and frequency of use of DMT, nationally, 2010-2026



Note. Data collection for DMT commenced in 2010. 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. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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 16: Past six month use of DMT, by capital city, 2010-2026

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2010	7	-	15	7	-	8	~	-
2011	8	18	29	-	8	25	~	6
2012	15	14	14	6	-	22	~	15
2013	9	8	25	11	14	22	~	14
2014	11	7	30	9	10	19	8	18
2015	10	6	25	-	11	13	6	9
2016	15	12	23	-	10	18	16	23
2017	20	21	23	-	22	23	13	18
2018	17	16	29	9	23	17	12	16
2019	17	13	16	6	16	22	17	16
2020	18	7	10	13	13	20	7	16
2021	14	18	16	16	13	27	13	26
2022	15	9	18	10	6	29	~	12
2023	8	13	-	10	12	26	~	16
2024	-	10	10	13	10	11	-	15
2025	7	6	11	13	16	17	~	11
2026	-	9	13	7	14	12	/	-

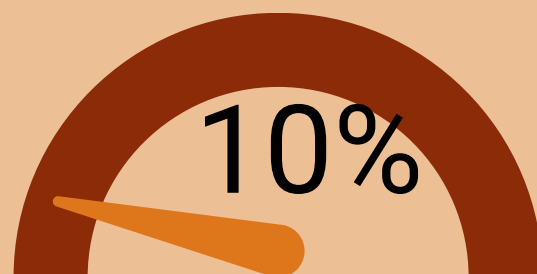
Note. Data collection for DMT commenced in 2010. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2024 should be interpreted with caution due to small samples (2024: $n = 51$). / Data from Darwin not collected in 2026. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

9 New Psychoactive Substances (NPS)

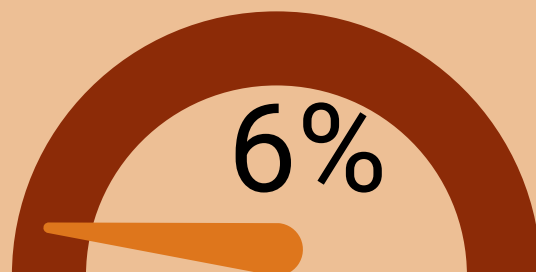
New psychoactive substances (NPS) are often defined as substances which do not fall under international drug control, but which may pose a public health threat. However, there is no universally accepted definition, and in practicality the term has come to include drugs which have previously not been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

Past 6 month use in 2026:

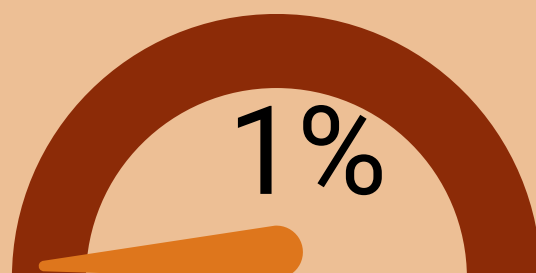
Any NPS, excluding plant-based



Any 2C substance



Mephedrone



New Psychoactive Substances (NPS)

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 in 2021 onwards, the decision was made to exclude them from this category. This means that the figures presented below for recent use of any NPS will not align with those in our 2010-2020 reports.

Further, some organisations (e.g., the United Nations Office on Drugs and Crime) include plant-based substances in their definition of NPS, whilst other organisations exclude them. To allow comparability with both methods, historically we have presented figures for 'any' NPS use, both including and excluding plant-based NPS. However, from 2025, we did not specifically ask about the use of any specific plant-based NPS (e.g., mescaline, ayahuasca) and thus only present the per cent for 'any' NPS, excluding plant-based NPS.

Patterns of Consumption

Recent Use (past 6 months)

Any NPS use, excluding plant-based NPS, has fluctuated over time, peaking at 42% in 2013 and declining to 9% in 2022, before subsequently stabilising. In 2026, 10% of the sample reported recent NPS use, stable relative to 2025 (13%; $p=0.184$). Recent use remained stable in most capital city samples, apart from a significant decrease in the Hobart sample ($n\leq 5$; 10% in 2025; $p=0.008$) (Table 17).

Forms Used

Participants are asked about a range of NPS each year, updated to reflect key emerging substances of interest.

The 2C class has remained the most highly endorsed NPS class since 2013, although its use has declined considerably. In 2026, 6% of the sample reported recent use of any 2C substance, stable relative to 2025 (4%; $p=0.224$).

Recent use of mephedrone (the most commonly reported NPS in 2010) has decreased considerably over the past decade, with 1% reporting recent use in 2026 (2% in 2025; $p=0.509$). In 2026, a significant decrease was observed in participants reporting use of 5-MeO-DMT ($n\leq 5$; 2% in 2025; $p=0.001$) (Table 18).

Table 17: Past six month use of any NPS (excluding plant-based NPS), nationally, and by capital city, 2010-2026

%	National	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
2010	24	9	15	28	48	22	31	~	15
2011	33	31	26	37	33	47	50	~	21
2012	37	42	49	40	24	37	27	~	48
2013	42	52	44	45	33	36	43	~	44
2014	34	34	17	34	36	35	39	22	52
2015	34	36	32	33	18	44	32	38	39
2016	27	35	24	29	14	25	21	25	40
2017	24	29	24	27	17	25	21	24	25
2018	21	26	18	27	21	26	12	16	25
2019	19	16	28	16	18	24	6	19	22
2020	12	18	11	12	8	12	7	10	19
2021	14	16	17	21	10	8	9	14	14
2022	9	9	7	15	-	7	13	~	8
2023	11	2	18	15	-	12	7	~	10
2024	14	15	16	21	-	15	16	-	16
2025	13	12	16	17	10	11	-	~	14
2026	10	12	16	17	-**	10	-	/	11

Note. Monitoring of NPS 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 8 and Chapter 10, 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. ~Due to the particularly small samples ($n < 50$) recruited in Darwin in 2010-2013, 2022-2023 and 2025, data from these years are not presented in this table; furthermore, data from Darwin in 2024 should be interpreted with caution due to small samples (2024: $n = 51$). / Data from Darwin not collected in 2026. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in table (except for Darwin); * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 18: Past six month use of NPS by drug type, nationally, 2010-2026

%	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Drugs that mimic the effects of ecstasy	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	3	2
Mephedrone	16	13	5	6	5	3	1	1	-	1	0	-	-	-	1	2	1
Methylone	/	5	5	3	3	4	2	4	3	3	0	0	-	0	-	-	0
N-ethylbutylone (eutylone)	/	/	/	/	/	/	/	/	/	/	/	0	-	-	0	-	0
N-ethylpentylone (ephylone)	/	/	/	/	/	/	/	/	/	0	0	0	-	-	0	-	0
Other drugs that mimic the effects of ecstasy	/	/	/	/	/	/	/	-	1	1	0	-	-	0	2	-	-
Drugs that mimic the effects of amphetamine or cocaine	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-	1
3-chloromethcathinone (e.g., 3-CMC; clophedrone)	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	0	0
3-Methylmethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	-	-	-	-	0
4-Chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0	-	0
4-FA	/	/	/	/	/	/	-	-	0	0	0	0	-	-	0	0	0
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	-	0	0	0	0
Alpha PVP	/	/	/	/	/	/	-	-	-	-	0	0	-	0	0	0	0
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	-	-	-	-	0
MDPV	-	2	3	1	1	1	0	-	0	-	0	0	-	0	0	0	0
Methcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0
N-Ethylhexedrone	/	/	/	/	/	/	/	/	/	0	0	0	-	0	0	0	0
Other drugs that mimic the effects of amphetamine or cocaine	/	/	/	/	/	/	/	1	-	1	1	-	-	-	1	0	-
Drugs that mimic the effects of psychedelic drugs	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	6	7
Any 2C substance (e.g., 2C-I, 2C-B) ~	6	14	12	20	15	14	11	9	8	6	5	6	3	5	5	4	6
4-AcO-DMT	/	/	/	/	/	/	-	-	/	/	/	/	/	/	/	-	-
5-MeO-DMT	-	5	-	1	1	-	1	1	1	2	1	2	1	1	1	2	-**
Dox (e.g., DOB, DOC, DOI, DOM)	1	1	0	-	-	/	/	1	-	-	-	-	-	-	0	0	0
NBOH (e.g., 25I, 25B)	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0	0	0
NBOMe (e.g., 25I, 25B, 25C, others)	/	/	/	/	9	7	4	5	2	2	1	1	1	-	-	-	-
Other drugs that mimic the effects of psychedelic drugs	/	/	/	/	/	/	/	/	-	1	-	-	-	-	0	0	-
Drugs that mimic the effects of dissociatives	/	/	1	2	2	2	3	2	0	2	1	2	1	2	4	2	1
2F-2-oxo PCE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	1	-	-
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	-	-	1	-	-
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	/	/	/	-	0	-	0	-
3F-2-oxo-PCE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	-	-

3-HO-PCP/4-HO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	/	-	0	0	-	-
3-MeO-PCP/4-MeO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	/	-	-	-	-	0
Methoxetamine	/	/	1	2	2	2	3	2	0	2	0	1	-	-	1	0	-	-
Tiletamine	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-	0	0
Other drugs that mimic the effects of dissociatives	/	/	-	/	/	/	/	/	/	/	-	1	-	2	1	1	1	-
Drugs that mimic the effects of cannabis	/	6	15	16	7	6	4	2	3	3	4	2	1	-	-	-	2	1
4F-MDMB-BUTICA	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
ADB-BUTINACA	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
FUB-AM	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
K2/Spice	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-	-
Kronic	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-	-
MDMB-4en-PINACA	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
MDMB-CHMICA	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Other drugs that mimic the effects of cannabis	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Drugs that mimic the effects of benzodiazepines	/	/	/	/	/	/	1	1	1	2	1	2	1	0	1	2	1	1
8-Aminoclonazepam	/	/	/	/	/	/	/	/	/	/	/	/	/	-	0	0	0	0
Bromazepam	/	/	/	/	/	/	/	/	/	/	/	/	/	-	-	-	-	-
Clobromazepam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Clonazepam	/	/	/	/	/	/	/	/	/	/	/	/	/	1	1	-	1	-
Etizolam	/	/	/	/	/	/	1	1	1	1	0	1	-	-	-	-	-	-
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	/	-	-	-	0	-
Flubromazepam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	-	-	0
Phenazepam	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0	0
Other drugs that mimic the effects of benzodiazepines	/	/	/	/	/	/	/	/	-	1	-	-	-	-	-	0	0	0
Drugs that mimic the effects of opioids	/	/	/	/	/	/	/	-	-	-	0	0	-	0	-	-	-	-
Acetylfentanyl	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Acryloylfentanyl	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Carfentanil	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Etodesnitazene	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Furanylfentanyl	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Isotonitazene	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Metonitazene	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Orphines	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0

Other fentanyl analogues	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	-
Other nitazene	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	-
Protonitazene	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
U-47700	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
W-18	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Other drugs that mimic the effects of opioids	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	0	0
Drugs that mimic the effect of any other NPS	/	/	/	/	/	/	/	/	/	1	-	-	-	1	-	1	-

Note. Monitoring of NPS commenced in 2010. ~ 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. / Question not asked in respective year. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

10

Other Drugs

Participants were asked about their recent (past 6 month) use of various other drugs, including non-prescribed use of pharmaceutical drugs (i.e., use of a prescribed drug obtained from a prescription in someone else's name) and use of licit substances (e.g., alcohol, tobacco).

Past 6 month use in 2026 (median days among those who reported use)

Non-prescribed codeine 9% 3 days	Non-prescribed pharmaceutical opioids 6% 3 days	Non-prescribed benzodiazepines 22% 5 days	Non-prescribed steroids 2%	Non-prescribed antipsychotics 4% 7 days
Non-prescribed hallucinogenic mushrooms/psilocybin 42% 2 days	MDA 4% 2 days	Any unknown substance 12% 1 day	GHB/GBL/1,4-BD 6% 4 days	Alcohol 95% 30 days
Tobacco 72%	Illicit e-cigarettes/vapes 68% 90 days	Nicotine pouches 19% 5 days	Nitrous oxide 32% 3 days	Amyl nitrite 35% 3 days

Non-Prescribed Pharmaceutical Drugs

Codeine

Before the 1 February 2018, people could access low-dose codeine products (<30mg, e.g., Nurofen Plus) over-the-counter (OTC), while high-dose codeine ($\geq$ 30mg, e.g., Panadeine Forte) required a prescription from a doctor. On the 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 the use of prescription low-dose and prescription high-dose codeine were included in the 2018-2020 EDRS, however from 2021, participants were only asked about prescribed and non-prescribed codeine use, regardless of whether it was low- or high-dose.

Recent Use (past 6 months): In 2026, almost one tenth (9%) of the sample reported using non-prescribed codeine (e.g., Nurofen Plus, Panadeine, Panadeine Extra) in the six months preceding interview, stable relative to 2025 (11%; $p=0.251$) (Figure 44).

Frequency of Use: Participants who had recently used non-prescribed codeine and commented ($n=63$) reported use on a median of three days (IQR=2-7) in the six months preceding interview, stable from 2025 (4 days; IQR=2-9; $n=75$; $p=0.670$).

Pharmaceutical Opioids

Recent Use (past 6 months): The per cent of participants reporting any past six month use of non-prescribed pharmaceutical opioids, excluding codeine (e.g., methadone, buprenorphine, oxycodone, morphine, fentanyl), remained stable at 6% (9% in 2025; $p=0.111$) (Figure 44).

Frequency of Use: Frequency of use remained low and stable in 2026 at a median of three days (IQR=2-8; $n=45$) in the six months prior to interview (4 days in 2025; IQR=2-15; $n=61$; $p=0.819$).

Forms used: Among participants who had recently consumed non-prescribed pharmaceutical opioids and commented in 2026 ($n=43$), oxycodone (65%) was the most commonly used pharmaceutical opioid, followed by tapentadol (30%). Few participants ($n\leq 5$) reported using other opioids, including morphine, fentanyl, buprenorphine and methadone.

Benzodiazepines

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

Recent Use (past 6 months): Recent use of non-prescribed benzodiazepines (e.g., Valium, Diazepam, Xanax, Kalma) has fluctuated over time, peaking at 41% in 2018 and 2019, and declining shortly thereafter. In 2026, one fifth (22%) of the sample reported recent use of non-prescribed benzodiazepines, stable relative to 2025 (23%; $p=0.702$) (Figure 44).

Frequency of Use: Participants who had recently used non-prescribed benzodiazepines (e.g., Valium, Diazepam, Xanax, Kalma) and commented ($n=153$) reported use on a median of five days in the six months preceding interview (IQR=2-10; 5 days in 2025; IQR=2-16; $n=158$; $p=0.050$).

Forms Used: Among those who reported non-prescribed benzodiazepine use and responded in 2026 (n=146), Valium (diazepam) (63%) was the most commonly used benzodiazepine, followed by Xanax (alprazolam) (25%), the generic form of diazepam (12%), the generic form of clonazepam (10%) and the generic form of alprazolam (5%).

Steroids

Recent Use (past 6 months): The per cent of the sample reporting recent steroid use has remained low and stable since monitoring commenced. In 2026, two per cent of the sample reported recent use, stable relative to 2025 (1%; $p=0.662$) (Figure 44).

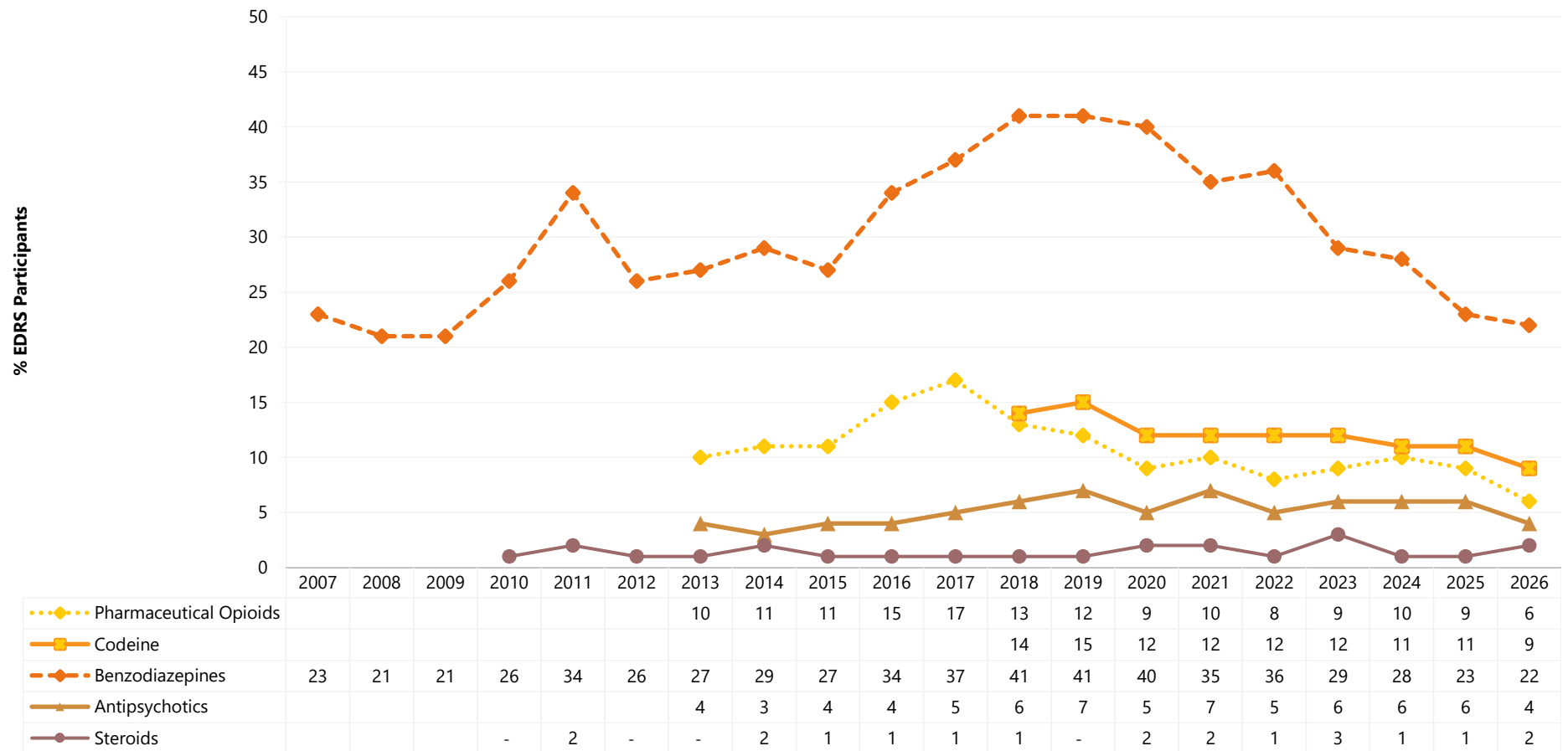
Antipsychotics

Recent Use (past 6 months): Four per cent of the sample reported recent use of non-prescribed antipsychotics in 2026 (6% in 2025; $p=0.053$) (Figure 44).

Frequency of Use: Participants reported using non-prescribed antipsychotics on a median of seven days (IQR=3-15; n=27) in the six months preceding interview (7 days in 2025; IQR=2-95; n=43; $p=0.985$).

Forms Used: Among participants who had recently consumed non-prescribed antipsychotics and commented in 2026 (n=25), Quetiapine (88%) was the most commonly used antipsychotic.

Figure 44: Non-prescribed use of pharmaceutical medicines in the past six months, nationally, 2007-2026



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 reduced to 50% to improve visibility of trends. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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): The per cent reporting recent non-prescribed hallucinogenic mushrooms/psilocybin use has fluctuated over the reporting period, however, an overall increase in use was observed between 2008 and 2021 and has remained relatively stable since. In 2026, 42% of the sample had used non-prescribed hallucinogenic mushrooms/psilocybin in the six months preceding interview, stable relative to 2025 (41%; $p=0.737$) (Figure 45).

Frequency of Use: Use of non-prescribed hallucinogenic mushrooms/psilocybin remained infrequent in 2026, with participants reporting a median of two days of use (IQR=1-5; $n=293$), stable relative to 2025 (2 days; IQR=1-4; $n=281$; $p=0.137$).

MDA

Recent Use (past 6 months): Four per cent of the sample reported using MDA in the six months preceding interview, stable from 2025 (5%; $p=0.707$) (Figure 45).

Frequency of Use: Use remained infrequent and stable, with participants reporting a median of two days of use in the six months preceding interview (IQR=1-4; $n=31$; 2 days in 2025; IQR=1-7; $n=34$; $p=0.807$).

Substance with Unknown Contents

Recent Use (past 6 months): From 2019, we asked participants about their use of substances with 'unknown contents'. In 2026, 12% of participants reported use of any substance with 'unknown contents', stable relative to 2025 (13%; $p=0.462$) (Figure 45).

When broken down by form, 7% of the 2026 sample reported using powder with 'unknown contents' (8% in 2025; $p=0.688$), and 4% reported recent use of pills with 'unknown contents' (4% in 2025; $p=0.779$). Two per cent of the sample reported use of capsules with 'unknown contents', stable relative to 3% in 2025 ($p=0.293$). Few participants ($n\leq 5$) reported consuming crystal with 'unknown contents' (2% in 2025; $p=0.092$).

Frequency of Use: Of those who had recently consumed any 'unknown substance' and responded ($n=83$), participants reported a median of one day (IQR=1-2) of use in the six months preceding interview, stable relative to 2025 (1 day; IQR=1-2; $n=92$; $p=0.374$).

Quantity: From 2020, we asked participants about the average amount of pills and capsules with 'unknown contents' used in the six months preceding interview. In 2026, among those who reported recent use of pills with 'unknown contents' and responded ($n=26$), the median 'typical' amount used in a session was one pill (IQR=1-2; 1 pill in 2025; IQR=1-2; $n=27$; $p=0.444$). Of those who reported recent use of capsules with 'unknown contents' and responded ($n=13$), the median 'typical' amount used in a session was two capsules (IQR=1-2; 1 capsule in 2025; IQR=1-2; $n=19$; $p=0.382$).

PMA

No participants reported recent use of PMA in 2026 (0% in 2025; $p=0.496$) (Figure 45).

PMMA

No participants reported recent use of PMMA in 2026 (0% in 2025) (Figure 45).

Heroin

Recent Use (past 6 months): Consistently small numbers have reported recent use of heroin (1% in 2026; 2% in 2025; $p=0.226$) over the reporting period (Figure 45).

Frequency of Use: Participants who had recently used heroin reported a median of 12 days of use (IQR=1-40; $n=9$) in the six months preceding interview, stable from 2025 (4 days; IQR=2-7; $n=14$; $p=0.631$).

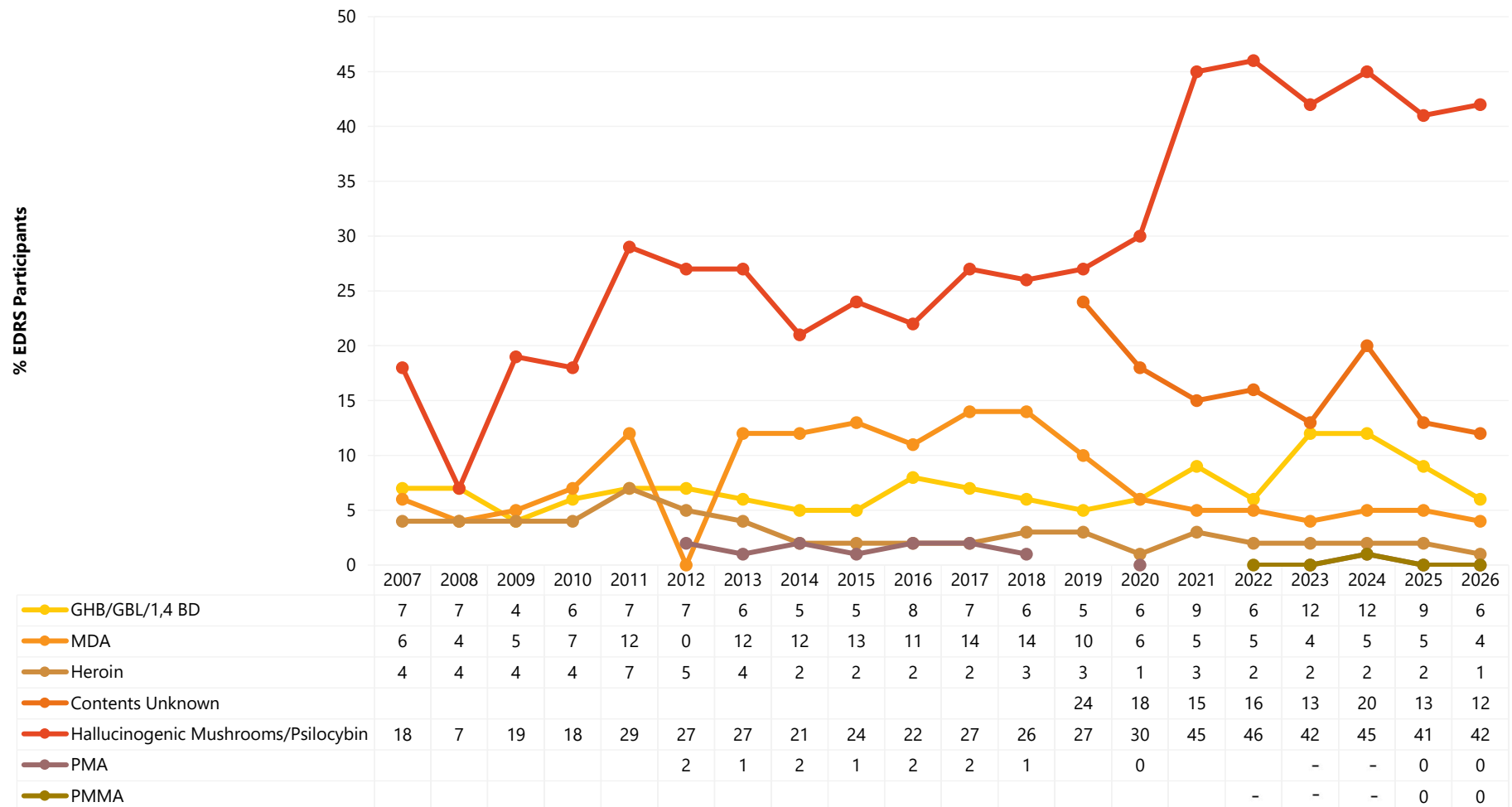
GHB/GBL/1,4-BD (Liquid E, Fanta)

Recent Use (past 6 months): Six per cent of the sample reported recent use of GHB/GBL/1,4-BD in 2026, stable relative to 2025 (9%; $p=0.056$) (Figure 45).

Frequency of Use: Participants who had recently used GHB/GBL/1,4-BD reported use on a median of four days (IQR=2-15, $n=43$) in the six months preceding interview, stable relative to 2025 (4 days; IQR=1-14; $n=62$; $p=0.633$).

Forms Used: Among participants who had recently consumed GHB/GBL/1,4-BD and commented ($n=43$), the majority reported using GHB (56%), with smaller proportions reporting use of 1,4-BD (19%) and GBL ($n\leq 5$). Almost one quarter (23%) reported that they did not know what form they had used. This question was not asked in 2025.

Figure 45: Past six month use of other illicit drugs, nationally, 2007-2026



Note. From 2019, participants were asked about 'substances contents unknown' (with further ascertainment by form). Y axis reduced to 50% to improve visibility of trends. Statistical significance for 2025 versus 2026 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 sample have reported recent alcohol use in each year since monitoring commenced. In 2026, 95% reported recent use, a significant increase relative to 2025 (92%; $p=0.031$), although similar to percentages reported in earlier years (Figure 46).

Frequency of Use: Participants who had recently used alcohol reported use on a median of 30 days (IQR=20-60; $n=662$; 40 days in 2025; IQR=20-72; $n=633$; $p=0.309$). Seventy-one per cent of those who had recently used alcohol reported weekly or more frequent use, stable relative to 2025 (72%; $p=0.668$). This percentage includes 3% who reported daily use (3% in 2025; $p=0.515$).

Tobacco

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

Recent Use (past 6 months): Almost three quarters (72%) of participants reported recent use of any tobacco in 2026, stable relative to 2025 (72%; $p=0.853$) (Figure 46). Fifty-five per cent of participants reported recent use of smoked or non-smoked illicit tobacco products, a significant increase relative to 46% in 2025 ($p<0.001$).

Frequency of Use: Participants who had recently used any tobacco reported use on a median of 85 days (IQR=20-180; $n=502$), a significant decrease from 120 days in 2025 (IQR=24-180; $n=493$; $p=0.010$), with one third (34%) reporting daily use, also a significant decrease relative to 2025 (43%; $p=0.003$).

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. From 2025, participants were asked about their use of e-cigarettes obtained from pharmacy (with or without a prescription) and 'non-pharmacy' locations.

In 2026, two per cent of participants reported recent use of e-cigarettes that were obtained from a pharmacy ($n\leq 5$ in 2025; $p=0.058$). Between 2022 and 2024, few participants reported recent use of prescribed e-cigarettes (3%, $n=21$ in 2022; 3%, $n=18$ in 2023; 1%, $n=11$ in 2024). The 2025-2026 data presented below refers only to use of e-cigarettes that were obtained from non-pharmacy locations, 2022-2024 data refers to non-prescribed e-cigarette use, while data from 2021 and earlier captures any e-cigarette use (collectively referred to as 'illicit use' from herein).

Recent Use (past 6 months): Sixty-eight per cent of the sample reported illicit e-cigarette use in the six months preceding interview, stable relative to 2025 (65%; $p=0.144$) (Figure 46).

Frequency of Use: Median days of illicit use in the past six months remained stable in 2026, relative to 2025 (90 days; IQR=24-180; n=469; 90 days in 2025; IQR=24-180; n=444; $p=0.624$). Almost two fifths (38%) of those who had recently used illicit e-cigarettes reported daily use, stable relative to 2025 (40%; $p=0.537$).

Contents and Forms Used: Among participants who had recently used illicit e-cigarettes and responded in 2026 (n=476), participants most commonly reported using disposable devices (97%), followed by re-fillable devices (5%) and pods (5%).

Reason for Use: Of those who reported *any* e-cigarette use and responded (n=485), the main reasons for use included 'enjoyment of vaping/using e-cigarettes' (54%) and 'addicted to nicotine' (47%), followed by 'tastes better than regular cigarettes' (25%), 'can use them in places where regular cigarettes are banned' (23%), 'social pressure' (22%) and 'smoking cessation' (17%). In 2026, 17% reported that they used e-cigarettes as a smoking cessation tool (25% in 2025), however given differences in how the question was asked in 2026, significance testing was not undertaken.

Nicotine Pouches

Recent Use (past 6 months): Almost one fifth (19%) of the sample reported recent use of nicotine pouches (20% in 2025) (Figure 46).

Frequency of Use: Participants who had recently used nicotine pouches reported use on a median of five days (IQR=2-24; n=136; 4 days in 2025; IQR=1-22; n=135; $p=0.350$).

Reason for Use: Of those who reported recent use and responded (n=135), the most common reasons for use included 'out of curiosity' (37%) and 'enjoyment' (25%), followed by 'addiction to nicotine' (20%), 'to help quit vaping' (16%), 'can use them in places where cigarettes/vapes are banned' (14%) and 'to help quit smoking cigarettes' (13%).

Nitrous Oxide

Recent Use (past 6 months): Almost one third (32%) of the sample reported any recent use of nitrous oxide, stable relative to 2025 (31%; $p=0.773$) (Figure 46).

Frequency of Use: Frequency of use remained stable in 2026, with a median of three days (IQR=2-6; n=223) of use reported in the six months preceding interview (3 days in 2025; IQR=1-7; n=215; $p=0.864$), equivalent to less than monthly use.

Quantity: Amongst those who reported recent use and responded (n=123), the median 'typical' amount used per session in 2026 was five bulbs (IQR=2-10; 5 bulbs in 2025; IQR=3-10; n=169; $p=0.447$). Of those who reported recent use and responded (n=121), the median maximum amount used in a session was eight bulbs (IQR=3-15; 7 bulbs in 2025; IQR=4-16; n=165; $p=0.582$).

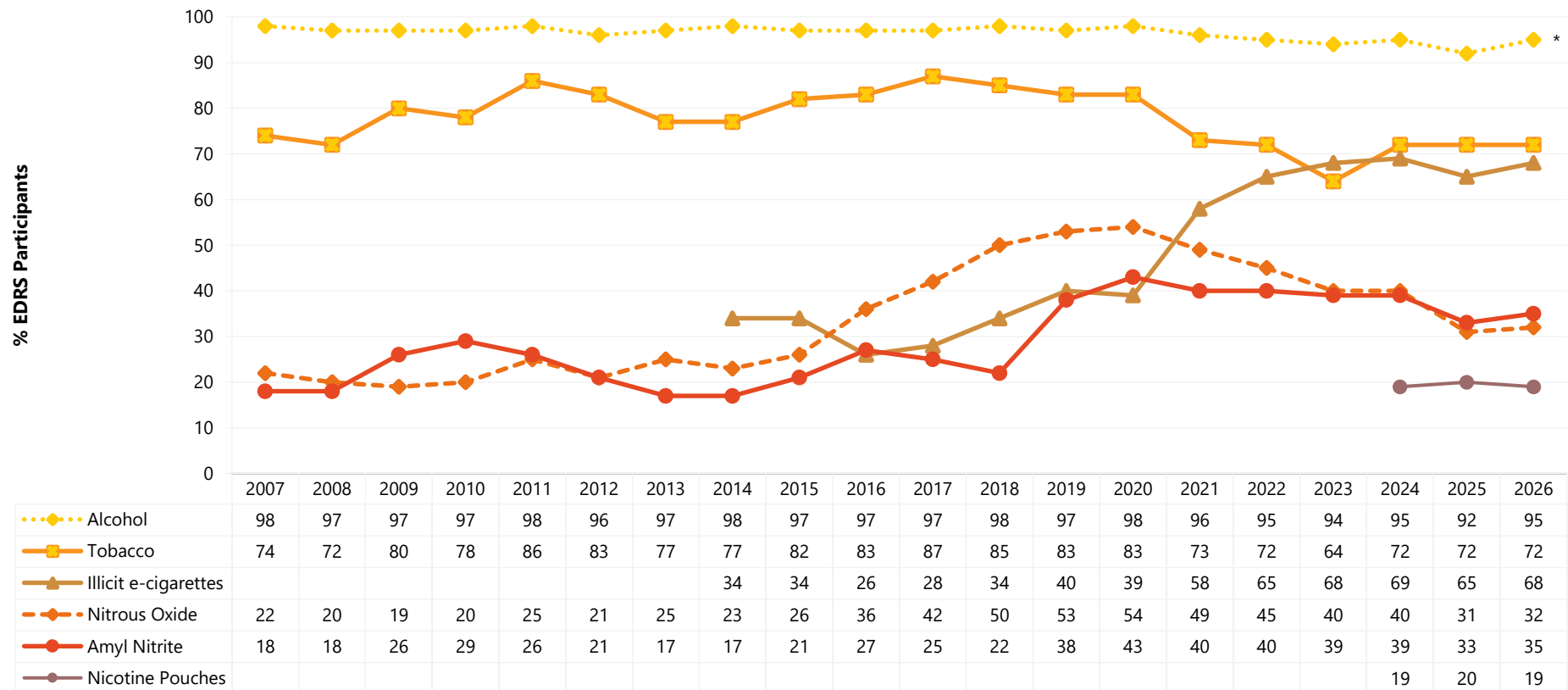
Amyl Nitrite

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): Use of amyl nitrite fluctuated between 2007 and 2019, although remained relatively stable between 2019 and 2024 (Figure 46). In 2026, one third (35%) of the sample reported any recent use of amyl nitrite, stable relative to 2025 (33%; $p=0.453$). Among those who reported past six month amyl nitrite use and responded ($n=239$), few ($n\leq 5$) reported that they had obtained amyl nitrite from a pharmacy in the past six months ($n\leq 5$ in 2025), with 30% reporting that they had not obtained amyl themselves (not asked in 2025).

Frequency of Use: Frequency of amyl nitrite use remained stable (3 days; IQR=2-10; $n=244$) in 2026, relative to 2025 (4 days; IQR=2-10; $n=227$; $p=0.707$).

Figure 46: Licit and other drugs used in the past six months, nationally, 2007-2026



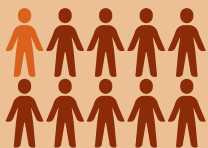
Note. Data from 2022 onwards refers to illicit e-cigarettes only. This was defined as non-prescribed use in 2022-2024 and as use of e-cigarette products obtained from non-pharmacy locations in 2025-2026. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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-Related Harms and Other Behaviours

Participants were asked about various drug-related harms and other behaviours, including polysubstance use and bingeing, drug checking, hazardous alcohol use, non-fatal overdose following drug use, awareness of naloxone, injecting drug use, drug treatment, ecstasy and methamphetamine dependence, sexual health, mental health and psychological distress, health service access, driving under the influence of drugs, crime and modes of purchasing drugs. It should be noted that the following data refer to participants' understanding of these behaviours (e.g., may not necessarily represent medical diagnoses in the case of reporting on health conditions).

11

Polysubstance use
use of two or more drugs
the day before interview



88%

Drug checking
(past 12 months)

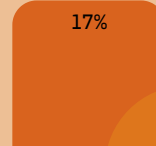
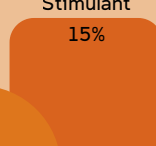


33%

Non-fatal overdose
(past 12 months)

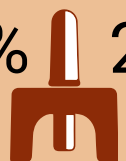
Stimulant
15%

Depressant
17%



Obtained Naloxone

Lifetime: 28%
past 12 months: 21%



Bingeing

Past 6 month use of
any stimulant for 48
hours or more
without sleep

25%



Mental health issues
(past 6 months)

55%



**Self reported
mental health problems***

60% depression

59% anxiety

26% ADHD

(past 6 months)

*among those who reported a
mental health problem

Health service access
(past 6 months)

28%



(for AOD support)

Driving under influence
(past 6 months)



35%



(among recent drivers)

Sexual health test



29%

(past 6 months)

Drug-related encounter with the police
(past 12 months)



11%

Modes of purchasing
(past 12 months)

75%



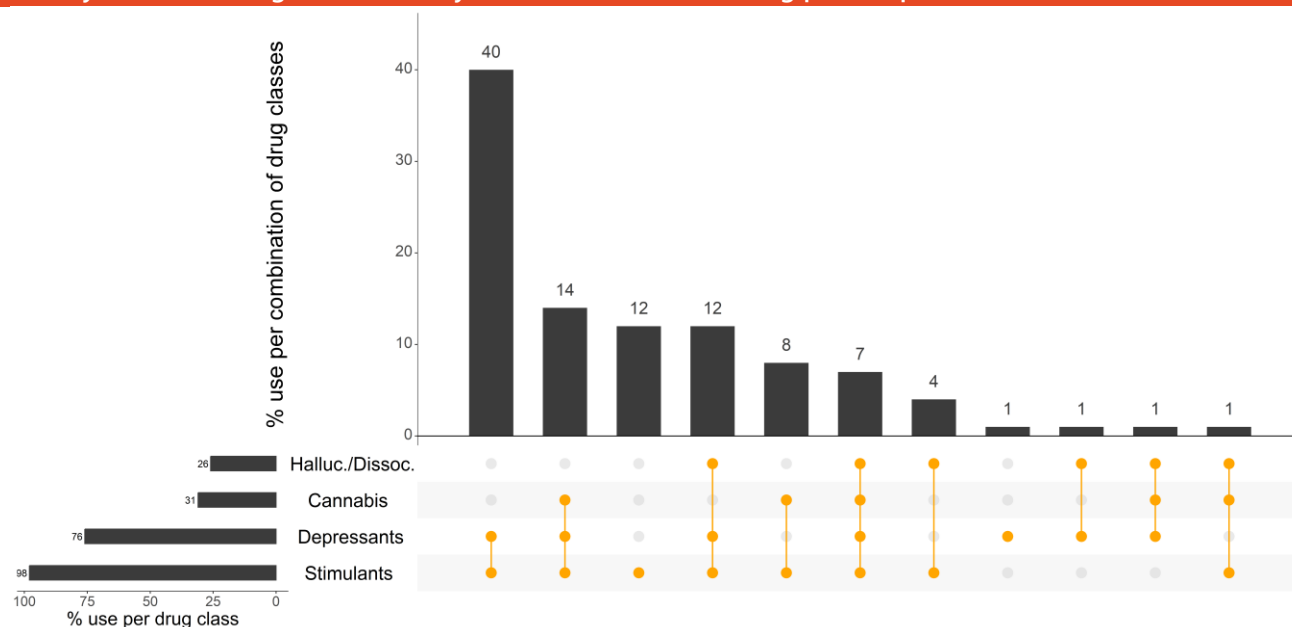
(face-to-face)

Polysubstance Use

On the last occasion of ecstasy or related drug use, among those who answered (n=697), the most commonly used substances were alcohol (72%) and ecstasy (53%), followed by tobacco (45%), cocaine (45%), e-cigarettes (43%), cannabis (30%) and ketamine (18%).

The majority (88%; n=614) of the sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most commonly used combinations of drug classes were depressants and stimulants (40%), followed by the use of cannabis, depressants and stimulants (14%). Twelve per cent reported using hallucinogens/dissociatives, depressants and stimulants, 8% reported using cannabis and stimulants, and 7% reported using hallucinogens/dissociatives, cannabis, depressants and stimulants. Twelve per cent reported using stimulants alone (Figure 47).

Figure 47: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, nationally, 2026: Most common drug pattern profiles

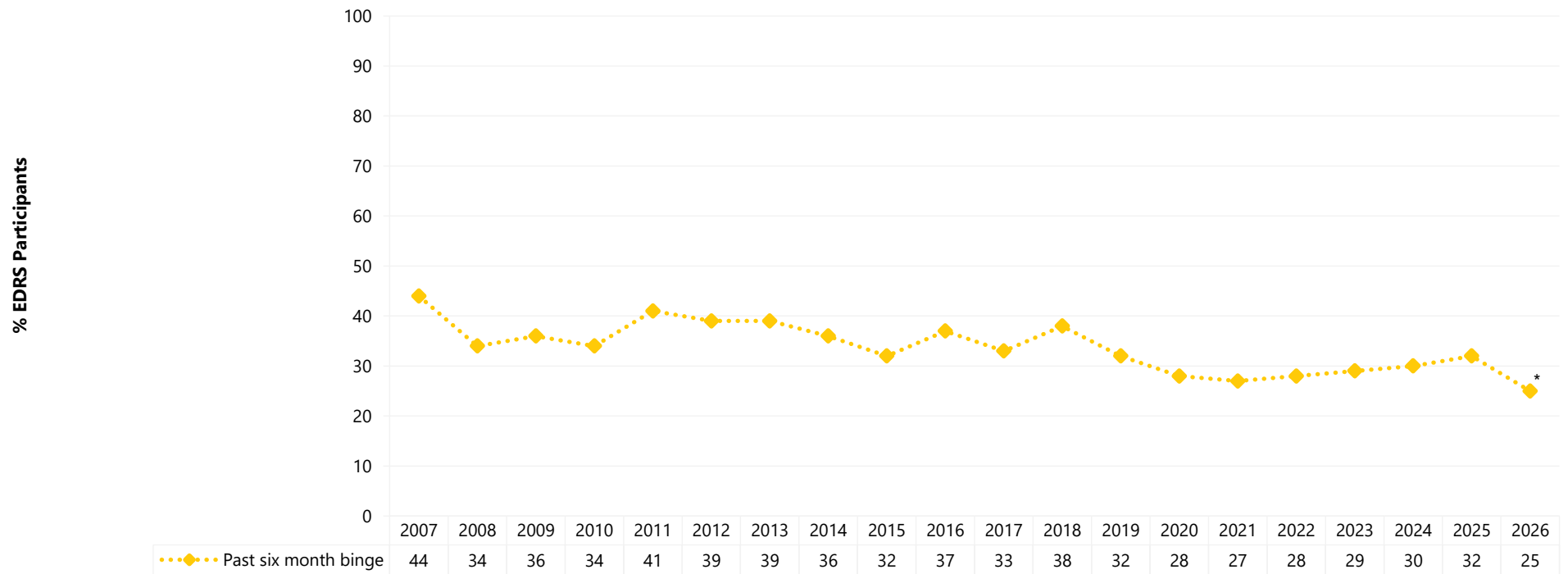


Note. % calculated out of total EDRS 2026 sample. The horizontal bars represent the per cent of participants who reported use of each substance on their last occasion of ecstasy or related drug use; the vertical columns represent the per cent of participants who used the combination of drug classes represented 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. Secondary Y axis reduced to 40% to improve visibility of trends. National percentages in 2026 do not include data from Darwin. Please refer to Table 1 for a guide to table/figure notes.

Binge Drug Use

Participants were asked whether they had used any stimulant for 48 hours or more continuously without sleep (i.e., binged) in the six months preceding interview. The per cent of the sample who have reported bingeing has fluctuated over time, albeit remaining relatively stable between 2019 and 2025. In 2026, one quarter (25%) of the sample had binged on one or more drugs in the preceding six months, a significant decrease relative to 2025 (32%; $p=0.010$) (Figure 48).

Figure 48: Past six month use of stimulants for 48 hours or more continuously without sleep ('binge'), nationally, 2007-2026



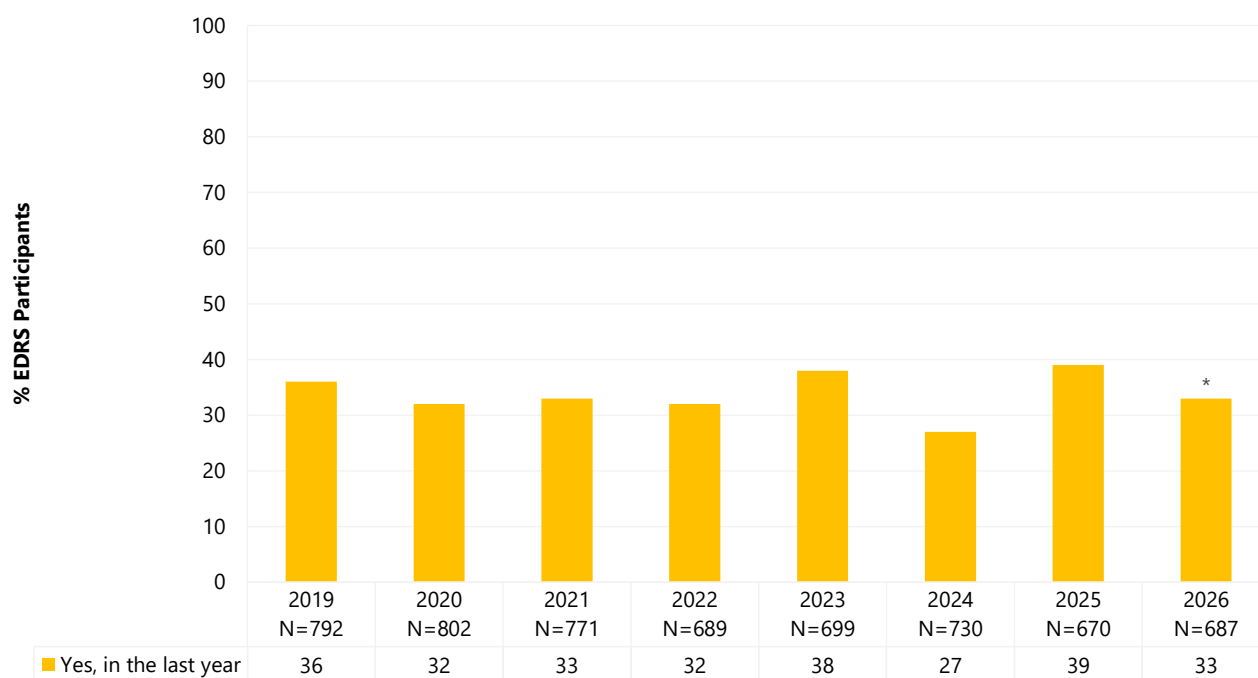
Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Drug Checking

Drug checking is a common strategy used to test the purity and contents of illicit drugs. At the time interviewing commenced in 2026, the only government-sanctioned drug checking services that had operated in Australia were in the ACT, QLD, VIC and NSW. In Canberra, ACT, drug checking was provided at the Groovin the Moo festival in 2018 and 2019, and a fixed-site drug checking service (CanTEST) has been operational since 17 July 2022. Queensland's first fixed-site drug checking service, CheQpoint, opened in Brisbane on 20 April 2024, and a second service opened in the Gold Coast in July 2024. Drug checking services were also provided at 3 festivals in 2024 - Rabbits Eat Lettuce and Wildlands (by Pill Testing Australia) and Earth Frequency (by CheQpoint) - and as part of the 2024 Qld Gov Schoolies Response (CheQpoint). However, all government funded services ceased in April 2025. In Victoria, drug checking was provided at 'up to' 10 festivals throughout 2024-2025 during an 18-month implementation trial, followed by the establishment of a fixed site service in August 2025. In March 2025, NSW commenced a 12-month trial of mobile drug checking at 'up to' 12 festivals. Following the trial, the NSW Government announced that drug checking would become a permanent service, with testing to be provided at up to 15 festivals annually from October 2026 onwards.

In 2026, one third (33%) of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year, a significant decrease from 39% in 2025 ($p=0.044$), although similar to the percentages reported in earlier years (Figure 49). Of those who reported that they or someone else had tested their illicit drugs in the past year ($n=228$), 64% reported using a personal testing kit – most commonly colorimetric or reagent test kits (56%), with fewer participants (11%) using testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips). Of those who reported that they or someone else had tested their illicit drugs in the past year ($n=228$), 51% reported that they had submitted drugs for testing at a drug checking service, most commonly at a fixed-site face-to-face drug checking service (e.g., a drop-in service in a central location) (30%), followed by an event-based face-to-face testing service (e.g., festival pill-testing service) (24%), with few participants ($n\leq 5$) reporting submitting samples via a postal/online testing service (e.g., Energy Control, Ecstasy Data).

Figure 49: Past year engagement in drug checking, nationally, 2019-2026



Note. Questions on drug checking commenced in 2019. From 2025, survey questions were separated into 'personal testing kits' and 'drug checking services' and focused on past year use only. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Alcohol Use Disorders Identification Test

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

In 2026, the mean score on the AUDIT for the total sample (including participants who had not consumed alcohol in the past 12 months) was 12.5 (SD 6.8), a significant increase from 12.2 (SD 7.0) in 2025 ($p<0.001$). 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.

Among those who responded in 2026 ($n=666$), participants scoring in each of the four 'zones' between 2025 and 2026 remained stable ($p=0.791$). The per cent who obtained a score of eight or more, indicative of hazardous use, also remained stable (75%; 73% in 2025; $p=0.345$) (Table 19).

Table 19: AUDIT total scores and per cent of participants scoring above recommended levels, nationally, 2010-2026

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
	N=667	N=558	N=573	N=667	N=790	N=753	N=778	N=769	N=790	N=791	N=800	N=766	N=694	N=704	N=702	N=641	N=666
Mean AUDIT total score (SD)	14.9 (6.9)	17.4 (6.6)	15.3 (7)	13.9 (6.8)	14.7 (6.2)	13.3 (6.2)	12.5 (6.7)	12.6 (6.3)	12.8 (6.8)	13.5 (7.1)	13.1 (6.4)	12.9 (7)	12.9 (7.4)	12.7 (7.4)	13.4 (7.4)	12.2 (7.0)	12.5*** (6.8)
Score 8 or above (%)	85	95	85	81	89	80	75	79	75	79	81	77	74	72	76	73	75
AUDIT zones																	
Score 0-7:	15	5	15	19	11	20	25	21	25	21	19	23	26	28	24	27	25
Score 8-15:	39	38	38	46	44	46	44	49	43	45	51	43	39	39	40	44	44
Score 16-19:	20	20	20	15	25	18	15	14	15	17	15	17	14	15	17	14	15
Score 20 or higher:	26	37	37	20	20	17	16	15	17	18	16	16	20	19	20	15	16

Note. Monitoring of AUDIT 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. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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

Fifteen per cent of the sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview in 2026, stable relative to 2025 (18%; $p=0.086$) (Figure 50).

The most common stimulants reported during the most recent non-fatal stimulant overdose in the past 12 months comprised any form of ecstasy (63%; capsules: 31%; crystal: 16%; pills: 15% and powder: $n\leq 5$), cocaine (35%), any form of methamphetamine (9%; crystal: 7%; powder: $n\leq 5$; base: $n\leq 5$) and pharmaceutical stimulants (8%). Of those who reported a non-fatal stimulant overdose in the past year and responded ($n=103$), 83% reported that they had also consumed one or more additional drugs on the last occasion, most notably, any quantity of alcohol (60%; ≥ 5 standard drinks: 46%; ≤ 5 standard drinks: 15%), e-cigarettes (35%), tobacco (28%), cannabis (20%) and ketamine (12%). On the last occasion of experiencing a non-fatal stimulant overdose, 78% reported that they did not receive treatment. Of those who reported receiving treatment ($n=23$), most participants reported ambulance attendance (43%; $n=10$) and hospital emergency department attendance (39%; $n=9$).

Non-Fatal Depressant Overdose

Alcohol: In 2026, 15% of the sample reported a non-fatal alcohol overdose in the 12 months preceding interview, a significant decrease relative to 2025 (20%; $p=0.031$). This occurred on a median of two occasions (IQR=1-5). Of those who had experienced an alcohol overdose in the past year in 2026 and responded ($n=104$), the majority (85%) reported not receiving treatment on the last

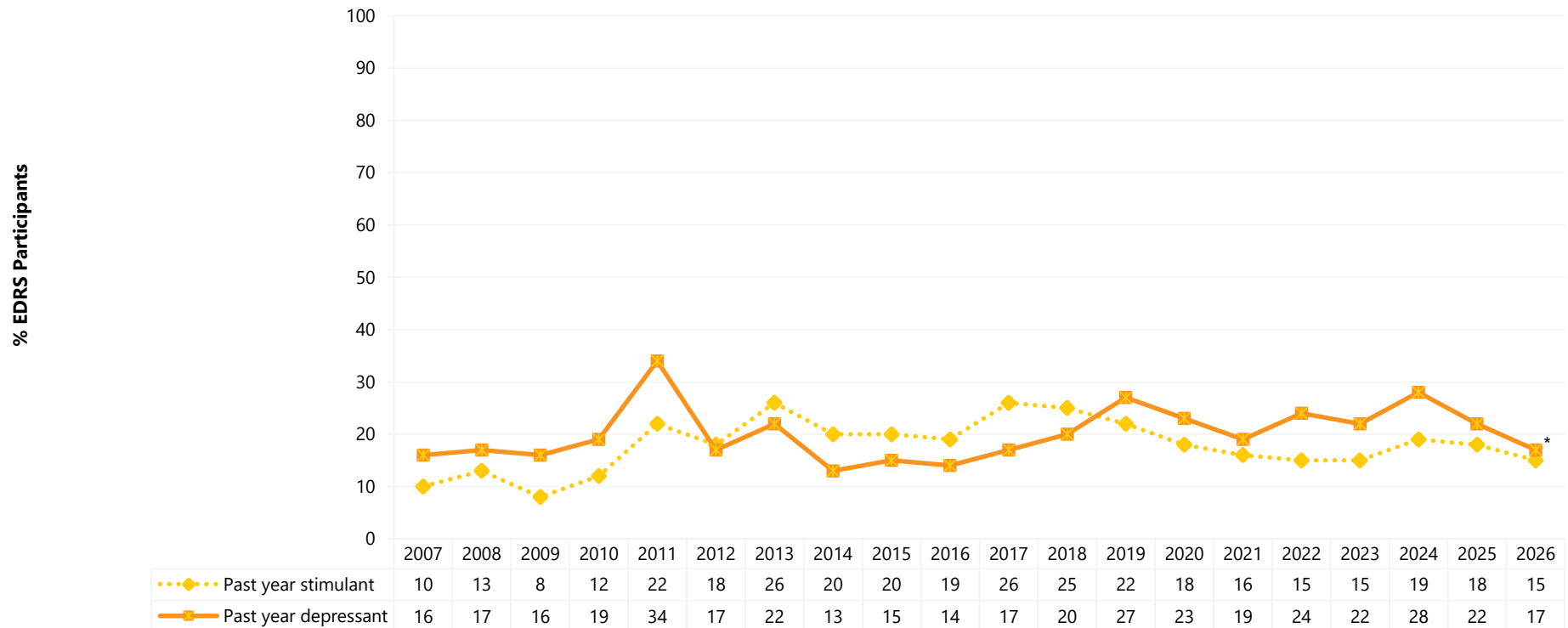
occasion. Of those who reported receiving treatment and who commented (n=17), 71% reported ambulance attendance (n=12), followed by hospital emergency department attendance (53%; n=9).

Any depressant (including alcohol): Almost one fifth (17%) of the sample reported that they had experienced a non-fatal depressant overdose (including alcohol) in the past 12 months, a significant decrease from 22% in 2025 ($p=0.023$) (Figure 50).

Of those who had experienced any depressant overdose in the past 12 months and commented (n=118), the majority reported alcohol as the most common depressant drug (89%), with fewer participants reporting GHB/GBL/1,4-BD (7%), benzodiazepines (including alprazolam) and opioids (including heroin and pharmaceutical opioids) (6%, respectively).

Any overdose: Among those who reported a non-fatal overdose in the past year and responded (n=137), 12% reported that they thought an opioid may have been present without their knowledge.

Figure 50: Past 12 month non-fatal stimulant and depressant overdose, nationally, 2007-2026



Note. In 2019, items about overdose were revised, and changes relative to 2018 and earlier may be a function of greater nuance in capturing depressant events. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

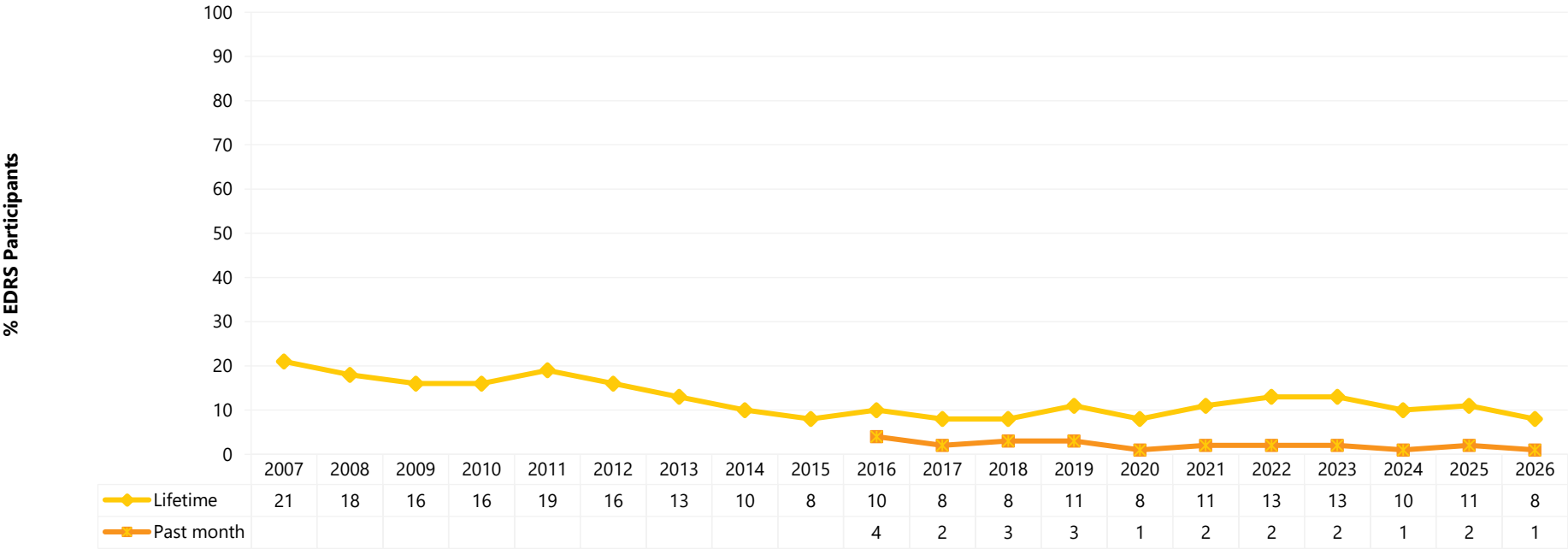
Awareness of Naloxone

In 2026, three quarters (77%) of the sample reported that they had ever heard of naloxone, stable relative to 2025 (73%; $p=0.161$). Among participants who had ever heard of naloxone and responded ($n=534$), 28% reported obtaining naloxone in their lifetime (21% of entire sample), stable relative to 32% in 2025 ($p=0.123$) and one fifth (21%) reported obtaining naloxone in the twelve months prior to interview (16% of entire sample), also stable relative to 2025 (27%; $p=0.052$).

Injecting Drug Use

For the past decade, approximately one in ten participants have reported ever injecting drugs (8% in 2026; 11% in 2025; $p=0.177$). The per cent who reported injecting drugs in the past month has remained low and stable, with one per cent reporting past month injection in 2026 (2% in 2025; $p=0.245$) (Figure 51).

Figure 51: Lifetime and past month drug injection, nationally, 2007-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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

A nominal per cent reported currently receiving drug treatment in 2026 (6%), stable compared with 2025 (4%; $p=0.281$). Of those who had reported being in treatment in 2026 ($n=41$), the majority (63%) reported drug counselling as their main form of treatment (58% in 2025; $p=0.802$).

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, preoccupation with use, 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 dependent ecstasy use. Among those who reported recent ecstasy use and commented ($n=635$), almost one fifth (17%) recorded a score of three and above, stable relative to 2025 (17%; $p=0.710$). The median ecstasy SDS score was zero (IQR=0-1) (0 in 2025; IQR=0-2). In 2026, 58% of participants obtained a score of zero on the ecstasy SDS, indicating that the majority of respondents reported no symptoms of dependence in relation to ecstasy use (57% in 2025; $p=0.726$) (Table 20).

To assess methamphetamine dependence in the past six months, [a cut-off of four and above](#) was used, as this has been found to be a good balance between sensitivity and specificity for identifying dependent methamphetamine use. Among those who reported recent methamphetamine use and commented ($n=136$), 45% scored four or above, a significant increase relative to 32% in 2025 ($p=0.032$). The median methamphetamine SDS score was three (IQR=0-6) (1 in 2025; IQR=0-5). In 2026, one third (34%) of participants obtained a score of zero on the methamphetamine SDS (40% in 2025; $p=0.256$), indicative of no symptoms of dependence in relation to methamphetamine use (Table 20).

Table 20: 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, nationally, 2015-2026

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Ecstasy	n=753	n=778	n=775	n=787	n=778	/	n=717	n=611	n=664	n=674	n=639	n=635
Median total score (IQR)	1 (0-2)	1 (0-3)	1 (0-2)	1 (0-2)	1 (0-2)	/	0 (0-1)	0 (0-1)	0 (0-1)	0 (0-2)	0 (0-2)	0 (0-1)
% score = 0	41	42	46	42	48	/	60	65	63	53	57	58
% score ≥3	25	26	20	21	21	/	15	11	14	16	17	17
Methamphetamine	n=238	n=245	n=212	n=244	n=255	n=189	n=182	n=209	n=210	n=179	n=194	n=136
Median total score (IQR)	1 (0-3)	0 (0-4)	0 (0-3)	0 (0-2)	0 (0-4)	0 (0-1)	1 (0-5)	1 (0-4)	1 (0-6)	2 (0-5)	1 (0-5)	3 (0-6)
% score = 0	50	51	58	59	54	67	47	48	41	40	40	34
% score ≥4	23	29	22	21	28	18	33	32	40	41	32	45*

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. National figures in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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 2026, almost fourth fifths (77%) of the sample reported some form of sexual activity in the past four weeks (73% in 2025; $p=0.165$). 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 ($n=519$), 82% ($n=427$) reported using alcohol and/or other drugs prior to or while engaging in sexual activity, stable relative to 2025 (79%; $p=0.269$). Of those who had engaged in sexual activity in the past four weeks and responded ($n=519$), 8% ($n=42$) reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex, stable relative to 2025 (7%; $p=0.469$), while one third (33%; $n=169$) reported that they had used alcohol and/or other drugs to enhance sexual activity or pleasure with another person (32% in 2025). Three per cent ($n=17$) had engaged in sexual activity in exchange for money, drugs, or other goods or services (2% in 2025; $p=0.243$) (Table 21).

Of those who commented ($n=680$), 29% reported having a sexual health check-up in the six months prior to interview, unchanged from 2025 (29%), whilst 66% had done so in their lifetime (68% in 2025; $p=0.559$). Of the total sample who responded in 2026 ($n=680$), 3% reported that they had received a positive diagnosis for a sexually transmitted infection (STI) in the past six months, stable relative to 2025 (4%; $p=0.437$) and almost one fifth (17%) had received a positive diagnosis in their lifetime (20% in 2025; $p=0.128$). The most common STI reported amongst participants who commented ($n=18$) was chlamydia (56%), followed by gonorrhoea (33%).

Of those who commented ($n=673$), one fifth (21%) of the sample reported having a test for human immunodeficiency virus (HIV) in the six months prior to interview (21% in 2025), whilst 52% had done so in their lifetime (54% in 2025; $p=0.661$). In 2026, no participants had been diagnosed with HIV in the past six months ($n\leq 5$ in 2025; $p=0.058$), and few participants ($n\leq 5$) had been diagnosed with HIV within their lifetime, a significant decrease relative to 2025 (2%; $p=0.032$).

Table 21: Sexual health behaviours, nationally, 2022-2026

	2022	2023	2024	2025	2026
Of those who responded[#]:	N=677	N=682	N=722	N=656	N=683
% Any sexual activity in the past four weeks	78	79	78	73	77
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=526	n=538	n=558	n=474	n=519
% Drugs and/or alcohol used prior to or while engaging in sexual activity	82	81	81	79	82
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=525	n=535	n=556	n=475	n=519
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	9	10	11	7	8

% Drugs and/or alcohol used to enhance sexual activity or pleasure with another person	/	/	36	32	33
Of those who responded[#] and reported any sexual activity in the past four weeks:			n=560	n=478	n=522
% Engaged in sexual activity in exchange for money, drugs or other goods or services	/	/	2	2	3
Of those who responded[#]:	n=678	n=680	n=727	n=660	n=680
% Had a sexual health check in the last six months	35	33	35	29	29
% Had a sexual health check in their lifetime	78	75	72	68	66
Of those who responded[#]:	n=676	n=680	n=727	n=660	n=680
% Diagnosed with a sexually transmitted infection in the last six months	3	6	5	4	3
% Diagnosed with a sexually transmitted infection in their lifetime	29	26	22	20	17
Of those who responded[#]:	N=669	n=678	n=717	n=651	n=673
% Had a HIV test in the last six months	25	26	26	21	21
% Had a HIV test in their lifetime	60	65	56	54	52
Of those who responded[#]:	n=676	n=678	n=717	n=651	n=673
% Diagnosed with HIV in the last six months	0	-	0	-	0
% Diagnosed with HIV in their lifetime	0	-	-	2	-*

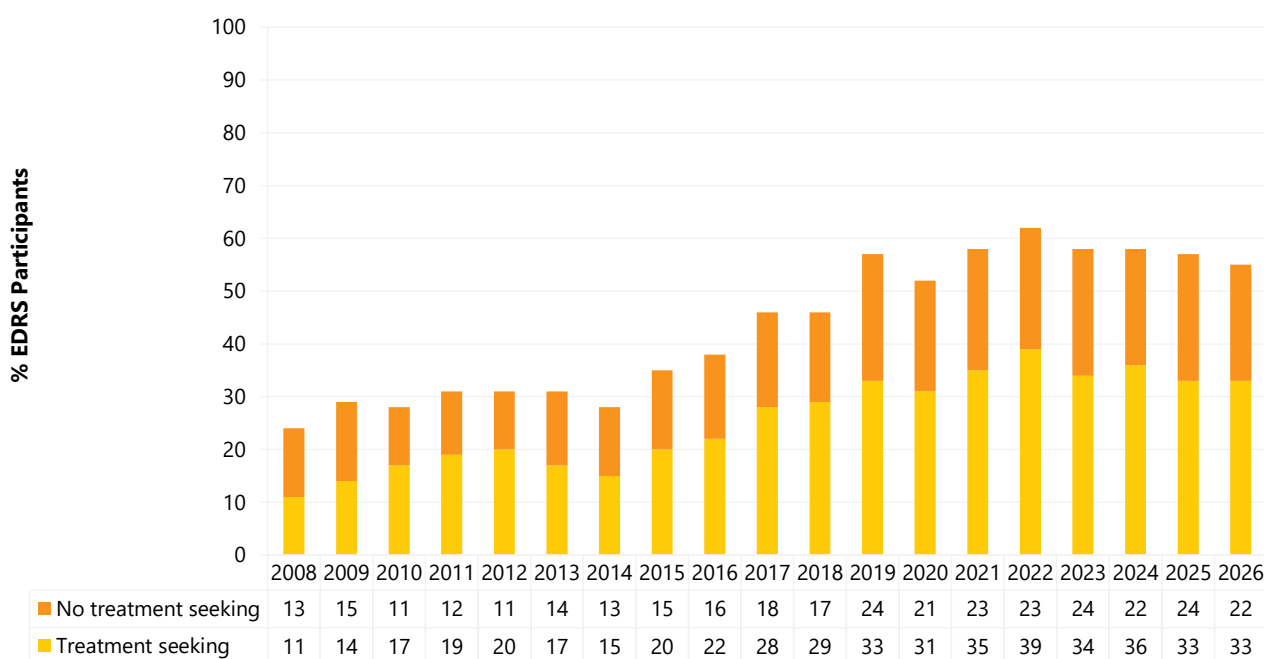
Note. [#]Due to the sensitive nature of these items, there is missing data for some participants who chose not to respond. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in table; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Mental Health, Psychological Distress (K10) and Disability

Mental Health

In 2026, 55% of the sample self-reported that they had experienced a mental health problem in the preceding six months (other than drug dependence), stable relative to 2025 (57%; $p=0.508$) (Figure 52). Of those who reported a mental health problem and commented ($n=375$), the most common mental health problems reported were depression (60%; 61% in 2025; $p=0.568$) and anxiety (59%; 60% in 2025; $p=0.688$), followed by attention-deficit hyperactivity disorder (ADHD) (26%; 32% in 2025; $p=0.080$). Of those who reported experiencing a mental health problem ($n=383$), three fifths (60%) (33% of the total sample) reported seeing a mental health professional during the six months preceding interview (57% in 2025; $p=0.505$). Of those who attended a mental health professional in 2026 ($n=228$), two thirds (67%) reported being prescribed medication for their mental health problem, a significant increase relative to 57% in 2025 ($p=0.035$).

Figure 52: Self-reported mental health problems and treatment seeking in the past six months, nationally, 2008-2026



Note. Questions about treatment seeking commenced 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. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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)

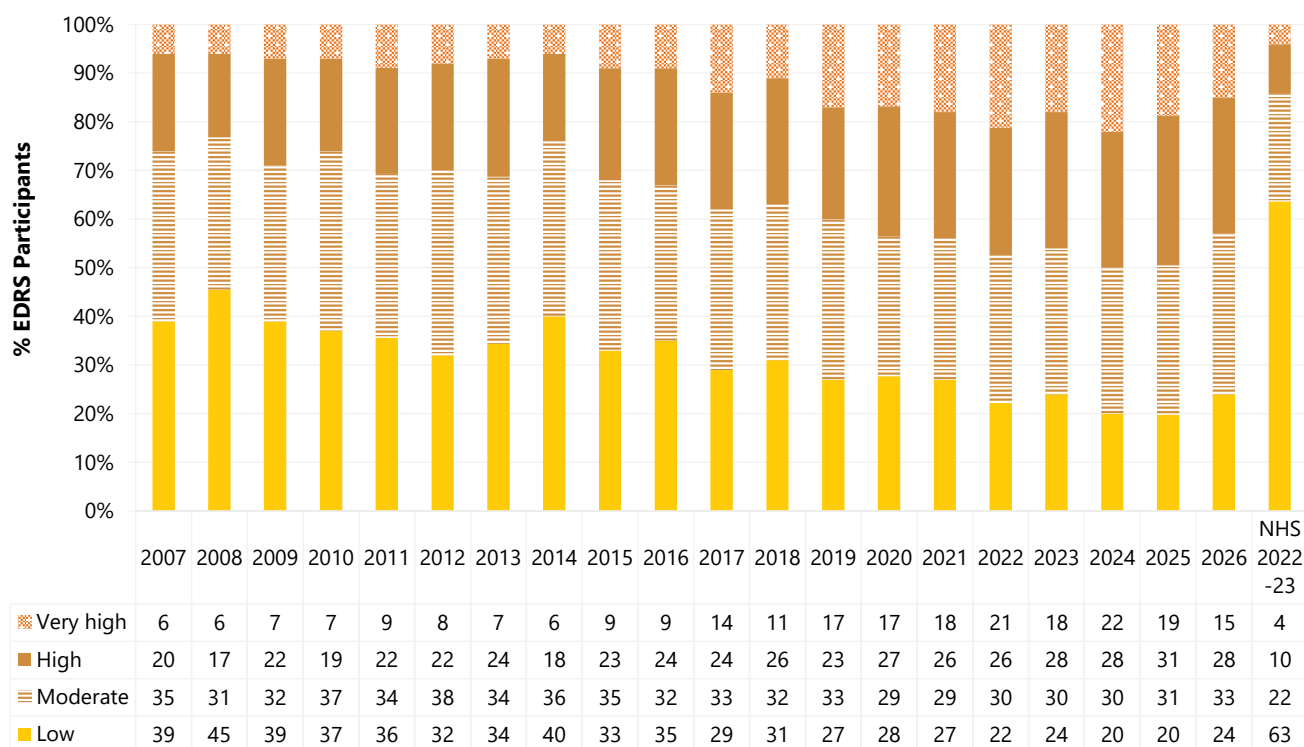
The [Kessler Psychological Distress Scale 10 \(K10\)](#) was administered to obtain a measure of psychological distress in the past four weeks. It is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured 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 2026 ($n=698$), the per cent of participants scoring in each of the four K10 categories remained stable relative to 2025 ($p=0.055$). In 2026, 15% of the EDRS sample had a score of 30 or more (19% in 2025) (Figure 53).

The [National Health Survey 2022-2023](#) provides Australian population data for adult (≥ 18 years) K10 scores. EDRS participants in 2026 reported greater levels of 'moderate', 'high' and 'very high' distress compared to the general population (Figure 53).

Figure 53: K10 psychological distress scores, nationally, 2007-2026, 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). National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Disability

In 2026, 17% of the sample self-reported that they identified as a person living with a disability (22% in 2025; $p = 0.018$). Among participants who identified as a person with a disability and who commented in 2026 ($n = 115$), the most common disability types were neurodivergence (55%) and mental health (33%), followed by a physical disability (19%) and pain-related neurological disorder (7%) (Table 22).

In 2026, 3% of the entire sample reported that they had received support from the National Disability Insurance Scheme (NDIS) in their lifetime (3% in 2025; $p = 0.841$), with 2% having done so in the past six months.

Table 22 : Nature of disability, among those who self-identified as a person living with a disability, nationally, 2026, and by capital city, 2026

	National	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri/GC
	N=115	N=20	N=25	N=14	N=19	N=13	N=10	/	N=14
% Nature of disability									
Physical disability (e.g., injury, amputation, rheumatoid arthritis)	19	-	-	-	-	-	0	/	-
Vision or hearing impairment	-	0	-	0	0	0	-	/	-
Mental health (excluding substance use disorder)	33	-	40	-	37	46	-	/	-
Neurodivergence (e.g., ADHD, ASD, dyslexia or other learning disabilities)	55	65	56	64	58	-	-	/	43
Brain injury	-	0	-	0	0	0	0	/	0
Intellectual disability	-	0	-	0	-	0	0	/	-
Pain-related neurological disorder (e.g., Complex Regional Pain Syndrome, Fibromyalgia)	7	-	-	0	-	0	-	/	-
Other neurological disorder (e.g., chronic fatigue, epilepsy, MS, Alzheimer's, Tourettes, cerebral palsy, Sneddon syndrome)	7	0	-	0	-	0	0	/	0
Other	-	-	-	0	0	-	0	/	0

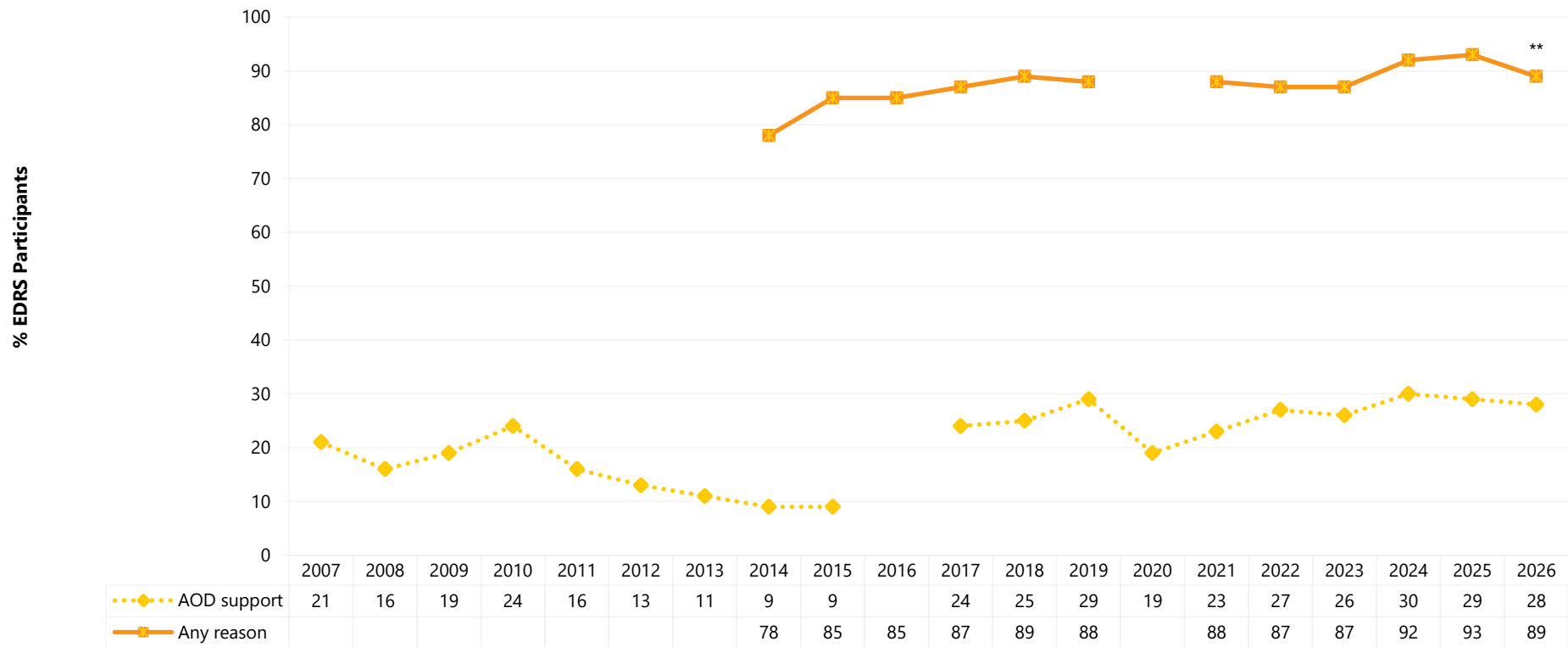
Note: National percentages in 2026 do not include data from Darwin. Please refer to Table 1 for a guide to table/figure notes.

Health Service Access

Twenty-eight per cent of participants reported accessing any health service for alcohol and/or drug support (AOD) in the six months preceding interview, stable relative to 2025 (29%; $p=0.768$). Eight per cent of participants reported accessing a general practitioner (GP) in 2026, a significant decrease from 12% in 2025 ($p=0.042$). This was followed by a drug and alcohol counsellor (7%; 7% in 2025) and a psychologist (6%; 6% in 2025; $p=0.570$) (Table 23).

Eighty-nine per cent of participants reported accessing any health service for any reason in the six months preceding interview in 2026, a significant decrease relative to 2025 (93%; $p=0.004$). The most common service accessed by participants in 2026 was a GP (75%; 73% in person; 27% via telehealth), stable from 2025 (79%; $p=0.115$), followed by a pharmacy (59%; 59% in 2025), a dentist (36%; 36% in 2025; $p=0.864$) and a psychologist (23%; 24% in 2025; $p=0.755$) (Table 23).

Figure 54: Health service access for alcohol and other drug reasons, and for any reason, in the past six months, nationally, 2007-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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 23: Types of health services accessed for alcohol and other drug reasons and for any reason in the past six months, nationally, 2022-2026

	AOD support					Any reason				
	2022	2023	2024	2025	2026	2022	2023	2024	2025	2026
	N=698	N=708	N=740	N=689	N=697	N=698	N=708	N=740	N=642	N=698
% accessing health services	27	26	30	29	28	87	87	92	93	89**
GP [^]	11	9	10	12	8*	75	70	77	79	75
<i>In-person</i>	/	/	/	11	8*	/	/	/	76	73
<i>Telehealth</i>	/	/	/	2	1	/	/	/	25	27
Emergency department	4	6	6	4	4	17	21	22	19	17
Hospital admission (inpatient)	4	4	3	2	3	12	13	13	12	12
Medical tent (e.g., at a festival)	3	4	4	3	4	5	7	8	6	6
Drug and Alcohol counsellor	7	8	8	7	7	7	8	8	7	7
Hospital as an outpatient	1	1	2	-	-	6	9	8	6	6
Specialist doctor (not including a psychiatrist)	1	1	1	-	1	13	15	13	13	13
Dentist	-	1	1	-	-	34	37	33	36	36
Ambulance attendance	2	3	4	3	3	6	7	8	5	6
Pharmacy	/	/	4	3	3	/	/	52	59	59
Other health professional (e.g., physiotherapist)	-	2	1	-	0*	18	18	17	17	17
Psychiatrist	4	3	4	3	2	14	13	14	12	12
Psychologist	11	7	8	6	6	31	29	28	24	23
NSP	2	3	2	2	2	2	3	2	3	2
Peer based harm reduction service	3	3	4	4	4	4	5	5	6	4
Other harm reduction service	-	2	2	2	3	1	2	3	3	4

Note. [^] In 2025, we separated 'GP' into 'GP in person' and 'GP via telehealth'. NSP: Needle and Syringe Program. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

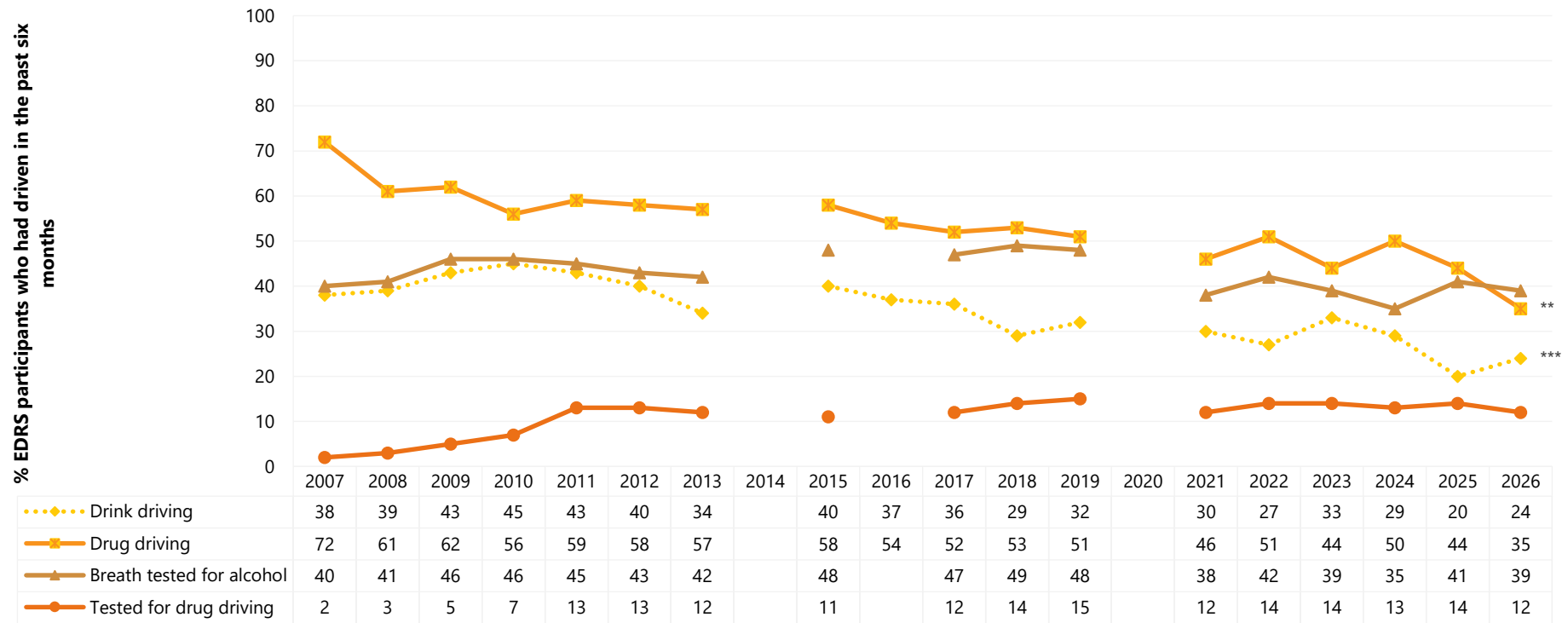
Driving

In 2026, 83% of the sample had driven a car, motorcycle or other vehicle in the last six months. Of those who had driven in the past six months and commented ($n=572$), almost one quarter (24%) reported driving while over the perceived legal limit of alcohol in the past six months, a significant increase relative to 20% in 2025 ($p<0.001$). Among those who had driven and commented ($n=569$), 35% reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months, a significant decrease relative to 2025 (44%; $p=0.003$), and the lowest per cent observed in the past 20 years (Figure 55).

Of those who had driven within three hours of consuming an illicit or non-prescribed drug in the last six months and responded ($n=197$), participants most commonly reported using cannabis (49%) prior to driving, followed by cocaine (37%), pharmaceutical stimulants (14%) and methamphetamine crystal (13%). Additionally, 11% reported using ketamine three hours prior to driving in the six months preceding interview.

Of those who had recently driven and commented ($n=577$), 12% reported that they had been tested for drug driving by the police roadside drug testing service (14% in 2025; $p=0.374$), and 39% reported that they had been breath tested for alcohol by the police roadside testing service (41% in 2025; $p=0.538$) in the six months prior to interview (Figure 55). Among those who had had been tested for drug driving by the police roadside drug testing service ($n=70$), 14% reported that a drug/s had been detected. Due to small numbers ($n\leq 5$) reporting on the most common drugs detected during roadside drug testing, numbers are suppressed.

Figure 55: Self-reported testing, and driving over the (perceived) legal limit for alcohol or three hours following illicit drug use, among those who had driven in the past six months, nationally, 2007-2026



Note. Questions about driving behaviour commenced in 2007. Computed of those who had driven a vehicle in the past six months. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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

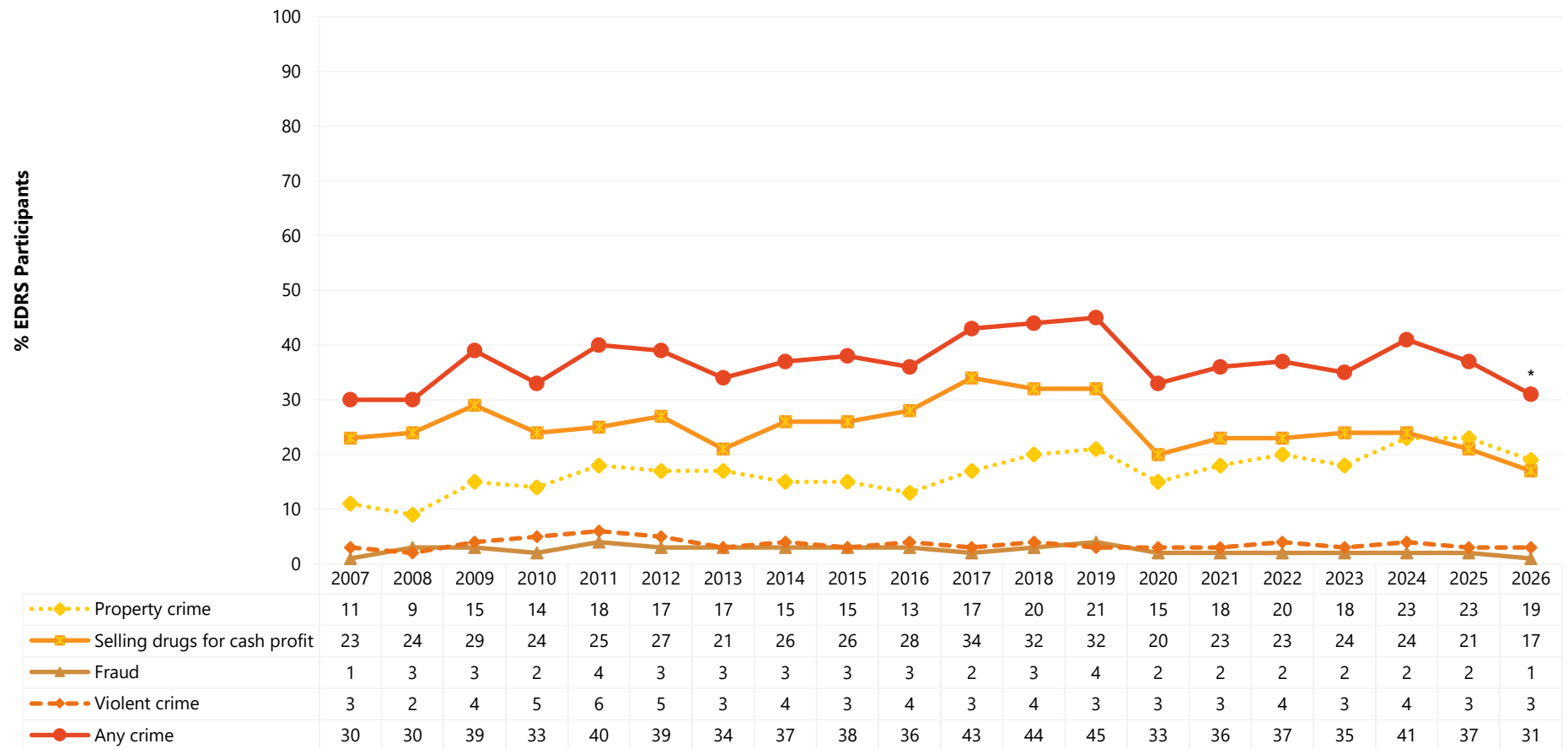
Past month self-reported criminal activity has fluctuated over time, with almost one third (31%) reporting 'any' crime in the past month in 2026, a significant decrease relative to 2025 (37%; $p=0.034$). Selling drugs for cash profit (17%) and property crime (19%) remained the two main forms of criminal activity in 2026 (21% in 2025; $p=0.102$ and 23% in 2025; $p=0.087$, respectively) (Figure 56). Seven per cent reported being the victim of a crime involving violence (e.g., assault) in the past month in 2026, which remained stable compared to 2025 (9%; $p=0.320$) (Figure 57).

Four per cent of the sample reported a lifetime history of imprisonment in 2026, a significant decrease relative to 2025 (7%; $p=0.013$) (Figure 58).

Five per cent of respondents in the 2026 sample reported having been arrested in the 12 months preceding interview, a significant decrease relative to 2025 (8%; $p=0.029$) (Figure 58). Of those who had been arrested in the prior 12 months and commented ($n=29$), the main reason for arrest in 2026 was property crime (28%). In 2026, 3% had been convicted of a drug-related offence in the past year (2% in 2025; $p=0.857$), and 1% had been sentenced to a community corrections order (2% in 2025; $p=0.395$).

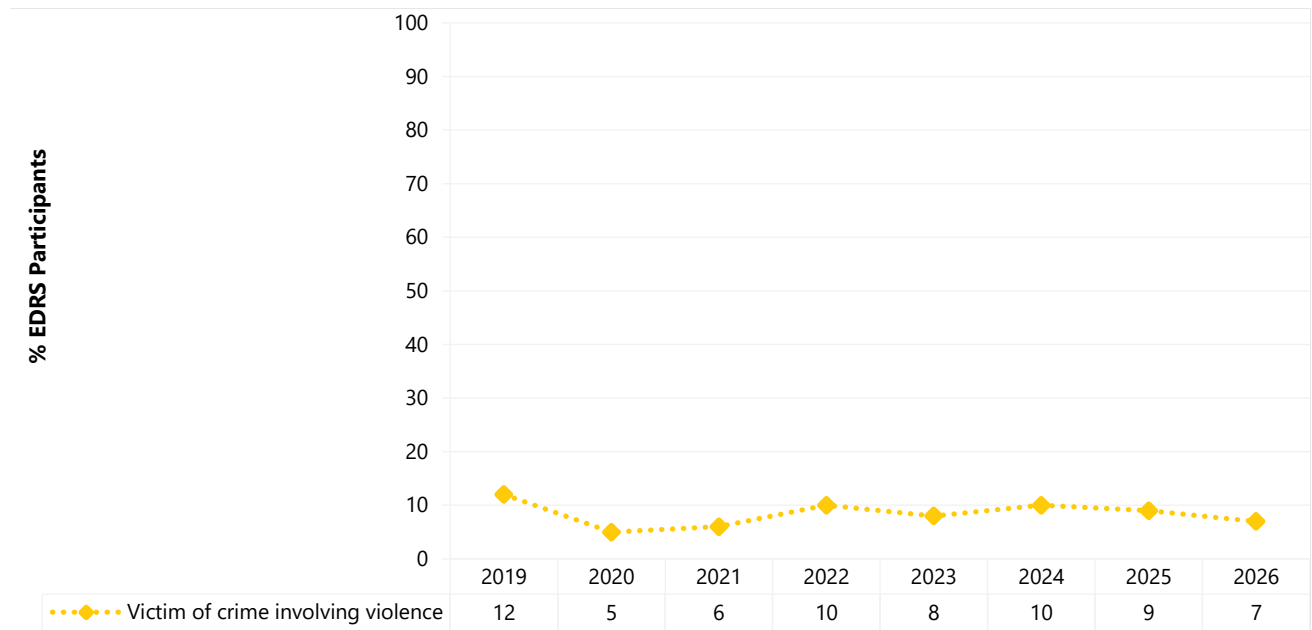
Eleven per cent of participants reported a drug-related encounter with police in the year preceding interview which did not result in charge or arrest, a significant decrease from 15% in 2025 ($p=0.035$) (Figure 58). This predominantly comprised being stopped and searched (41%; 45% in 2025; $p=0.652$) and stopped and questioned (35%; 32% in 2025; $p=0.741$), followed by being issued a court attendance notice (22%; 11% in 2025; $p=0.063$) and being requested or suggested to move along (19%; 26% in 2025; $p=0.372$). Ten per cent reported being stopped and issued with a caution (16% in 2025; $p=0.286$) and 12% reported being stopped and issued with a fine/infringement notice ($n\leq 5$ in 2025; $p=0.101$). Few participants ($n\leq 5$) reported being stopped and issued with a drug diversion ($n\leq 5$ in 2025; $p=0.394$).

Figure 56: Self-reported criminal activity in the past month, nationally, 2007-2026



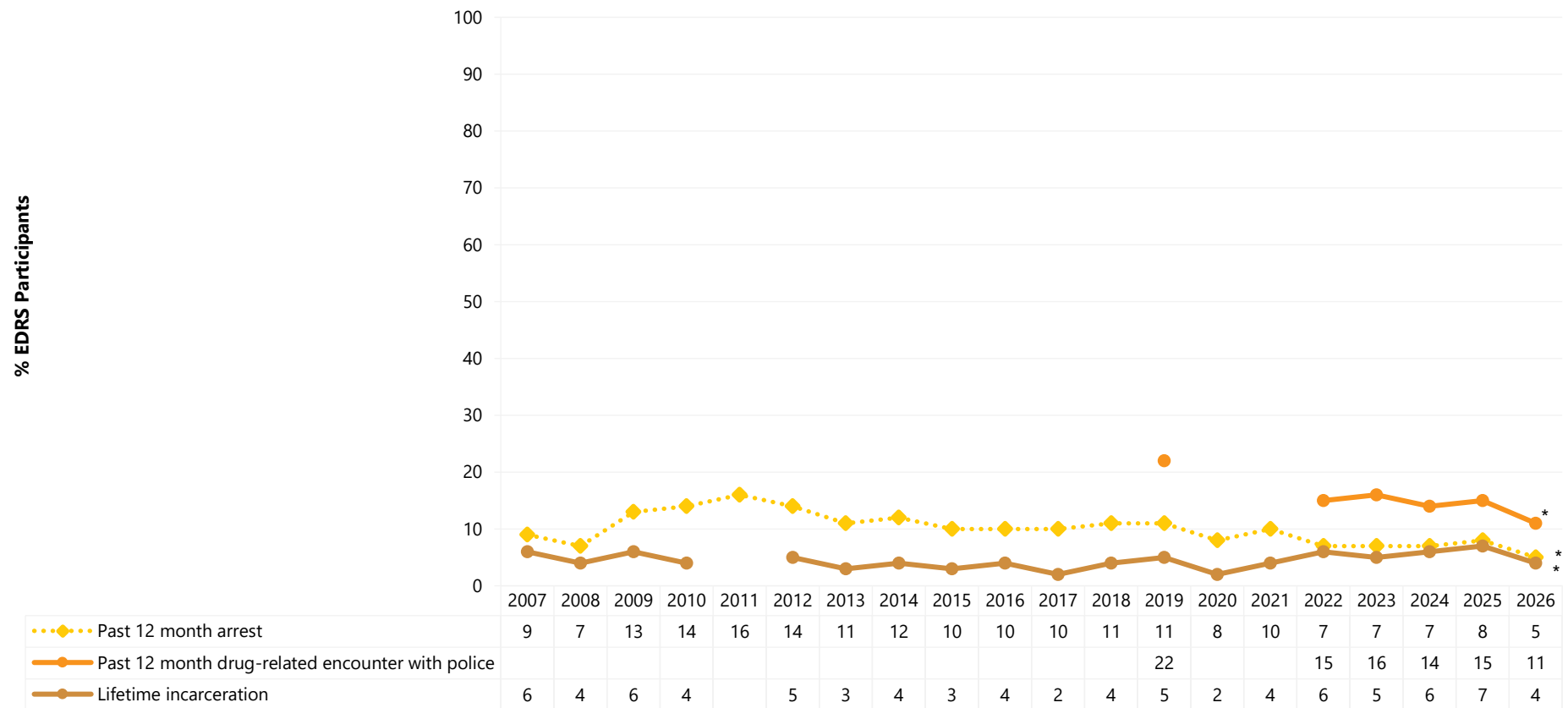
Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 57: Victim of crime involving violence in the past month, nationally, 2019-2026



Note. Questions regarding being the victim of a crime involving violence commenced in 2019. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 58: Lifetime incarceration, and past 12 month arrest and drug-related encounters with police that did not result in arrest, nationally, 2007-2026



Note. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 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 2026, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (75%; 73% in 2025; $p=0.534$) (Table 24), followed closely by social networking or messaging applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (73%; 70% in 2025; $p=0.316$). It is important to re-iterate that this refers to people *arranging the purchase* of illicit or non-prescribed drugs. This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person. Among those who had used social networking or messaging apps to arrange the purchase of illicit drugs in 2026 and commented ($n=502$), the most commonly used app was Snapchat (45%), followed by Telegram (31%) and Signal (30%), with substances mostly obtained from a known dealer/vendor (69%), followed by a friend/relative/partner/colleague (63%).

One third (35%) reported arranging the purchase of illicit or non-prescribed drugs via text messaging, stable from 40% in 2025 ($p=0.068$), followed by phone call (21%), a significant decrease relative to 2025 (27%; $p=0.031$) (Table 24).

Buying and Selling Drugs Online

Five per cent of the sample reported obtaining drugs via the surface web or darknet market in the past year (6% in 2025), most commonly ecstasy crystal (2%) and cocaine (1%). One third (34%) reported that they had ever obtained illicit drugs through someone who had purchased them on the surface web or darknet market, with one fifth (20%) doing so in the 12 months prior to interview (25% in 2025; $p=0.066$).

In 2026, 1% of participants reporting selling illicit drugs on the surface web or darknet market in the 12 months preceding interview (3% in 2025; $p=0.137$).

Source and Means of Obtaining Drugs

Almost four fifths (79%) of participants in 2026 reported obtaining illicit drugs from a friend/relative/partner/colleague, stable relative to 2025 (79%; $p=0.789$). This was followed by a known dealer/vendor (67%; 66% in 2025; $p=0.727$) and an unknown dealer/vendor (33%; 32% in 2025; $p=0.644$) (Table 24).

When asked about how they had received illicit drugs on any occasion in the last 12 months, the majority of participants reported face-to-face (96%), stable relative to 2025 (97%; $p=0.110$). Almost one quarter (24%) of participants reported a collection point as a means of receiving illicit drugs in the 12 months preceding interview, a significant increase relative to 2025 (18%; $p=0.002$) (collection point defined as a predetermined location where a drug will be left for later collection). Smaller percentages reported that their drugs had been delivered by post (9%; 10% in 2025; $p=0.505$) or via a car ride (e.g., Uber/Didi) service (7%; 9% in 2025; $p=0.159$) (Table 24).

Table 24: Means of purchasing and obtaining illicit drugs in the past 12 months, nationally, 2019-2026

	2019 N=792	2020 N=799	2021 N=774	2022 N=700	2023 N=708	2024 N=740	2025 N=690	2026 N=698
% Purchasing approaches in the last 12 months^{^#}	n=792	n=799	n=764	n=683	n=701	n=735	n=685	n=689
Face-to-face	82	67	72	69	72	74	73	75
Surface web	4	7	4	4	4	3	4	2
Darknet market	10	7	7	7	4	6	4	4
Social networking or messaging applications [`]	73	75	71	73	71	70	70	73
Text messaging	53	48	39	42	42	42	40	35
Phone call	39	35	28	26	27	27	27	21*
Grew/made my own	-	4	4	3	4	5	2	2
Other	0	1	0	1	-	1	-	-
% Means of obtaining drugs in the last 12 months^{^~}	n=797	n=800	n=761	n=685	n=699	n=731	n=683	n=691
Face-to-face	97	96	92	96	96	96	97	96
Collection point	10	20	10	16	17	23	18	24**
Post	12	12	8	12	10	10	10	9
Delivered via car ride service	/	/	/	/	/	/	9	7
% Source of drugs in the last 12 months[^]	n=797	n=805	n=763	n=687	n=697	n=732	n=684	n=686
Friend/relative/partner/colleague	88	83	83	82	79	84	79	79
Known dealer/vendor	70	67	66	68	65	64	66	67
Unknown dealer/vendor	38	37	30	37	30	33	32	33

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. [~] From 2021, the face-to-face response option 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).' Car ride service refers to Uber/Didi, taxi or other similar service. National percentages in 2026 do not include data from Darwin. Statistical significance for 2025 versus 2026 presented in table; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. Please refer to Table 1 for a guide to table/figure notes.