2025 National AOD Data Report

ANNUAL OVERVIEW OF DRUG ISSUES IN AUSTRALIA

March 2026

Harm Reduction Australia

ACKNOWLEDGMENTS

About HRA:
Harm Reduction Australia is a national advocacy organisation committed to reducing the health, social and economic harms potentially associated with drug use and drug policies and laws. HRA has a diverse membership including those working in the alcohol and other drugs (AOD) sector, parliamentarians, government employees, people who use drugs, interested family members, young people and other individuals wanting to advocate for the continuation and expansion of harm reduction and drug policy reform in Australia. The Board and members of HRA are people who understand the complexities of drug use and are advocating for the safest, most effective ways to protect the wellbeing of individuals, families and communities. As an organisation, we aim to ensure that drug policies in Australia first and foremost do no harm and provide real benefit to Australian society through evidence-based and humane responses to drug use. HRA takes a non-judgmental approach to drug use within society and is dedicated to ensuring that Australia has drug policies and laws that are just, effective and humane.

FOREWORD

Harm Reduction Australia (HRA) continues to be concerned at the lack of a comprehensive annual national report on drug use issues affecting the community.

The only annual report available was produced by the Australian Criminal Intelligence Commission and called the Illicit Drug Data Report with a heavy focus on law enforcement data and interpretations. While some health-based data was included in this report it was limited and given less prominence than law enforcement data. I write about this in the past tense as this report seems to have ceased being prepared.

In effect, there is no annual national report available for Australia anymore.

It is surely time for the Federal Government to commission the national AOD research centres to deliver a national annual report. How else are we to measure the success or failure of our current policy and program settings without a comprehensive report?

The HRA National AOD Data Report importantly focuses on primary sources of regular national data reports and research to develop this composite summary for your easier understanding of the situation in Australia.

Despite our limited resources, HRA will continue with our goal to develop the HRA National AOD Data Report into a valuable central source of information and data, which will be complemented by a few upcoming papers to provide analysis and commentary on some specific areas of research also released each year.

Your feedback is welcome, especially on how we may improve the report in years to come.

Gino Vumbaca OAM
President
Harm Reduction Australia

INTRODUCTION

This report provides a comprehensive overview of the key national data sources on alcohol and other drugs (AOD) and harm reduction in 2025. Australia is in the fortunate position of having a collection of routine national data sets, early-warning systems and trend-based reports for monitoring drug use and related harms in the Australian community including the National Drug Strategy Household Survey (NDSHS) and the Australian Drug Trends National Reports, to name just two. These data sources not only inform public health policies and programs but provide critical insights into the evolving landscape of drug use and harm reduction in Australia.

As valuable as these data sources are, until the establishment of this report in 2025 there was an absence of a centralised national report that collates key information from each of these data sources in one place. Prior to this report, those with an interest in this data were forced to visit multiple websites and read often lengthy reports to gain the key information they need to inform their advocacy work and program development.

HRA National AOD Data Report was created so that those working in and around harm reduction can find the information they are seeking quickly, easily, and in one place. This report covers key findings from:

- Australian Needle and Syringe Program Survey
- National Drug Strategy Household Survey
- National Drug-Induced Deaths/Overdose Data

- National Opioid Pharmacotherapy Statistics Annual Data
- Ecstasy and Related Drugs Reporting System
- Illicit Drug Reporting System, Australian NSP Survey
- Needle and Syringe Program National Minimum Data Collection

In the pages that follow you will find overview summaries of each data set, with a specific focus on illicit drug use, drug-related harms and harm reduction initiatives. Each summary includes: who the report is produced by, when reporting commenced, the number of reports, the purpose of the report, the data collection method, any limitations, and a summary of the key findings of the most recent report.

The overview summaries of each data set presented within this report are those that were released in 2025, with the exception of the NDSHS which was released in 2023. The NDSHS is updated every three years, and as such this report contains the same summary presented within HRA's '2024 National AOD Data report.

By presenting this information in a convenient and accessible format, the report aims to empower those working in harm reduction and the wider AOD sector with the knowledge needed to support their work. While this report aims to consolidate the most relevant national data sources, it acknowledges that there is a wider body of research and reporting on harm reduction that is not covered here.

CONTENTS

DATA SOURCES SUMMARY

AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE

National Drug Strategy Household Survey

Purpose	To monitor national estimates on patterns in legal and illegal drug use, attitudes, and perceptions related to drugs among the Australian population. This survey provides a broad view of population-level trends in drug use and public attitudes.
Methodology	The NDSHS is a structured survey conducted every three years that collects self-reported data from a sample of individuals aged 14 years and older living in private dwellings across Australia. Participants self-report answer to questions about their use of legal and illegal substances, perceptions of drug-related issues and attitudes towards drug-related policies.
Limitations	It excludes specific groups (e.g., homeless individuals, institutionalized populations), it does not capture the full scope of drug use among marginalised groups.
Note	NDSHS data is updated every three years, therefore the snapshot provided within HRA's '2025 National AOD Data Report' remains the same as presented in the 2024 report.

Alcohol, Tobacco, and Other Drugs – Health Impacts

Purpose	To identify and track national trends in drug-induced deaths (from both acute toxicity and chronic use), hospitalisation and ambulance attendances. This data aims to identify at-risk populations and support health care planning.
Methodology	The AIHW annually compiles reports and data from multiple sources. This report covers AIHW reporting drug-related ambulance attendance, hospitalisations, and drug-induced deaths. Ambulance attendance data is collected by the National Ambulance Surveillance System (NASS), which reviews clinical records from ambulance services in multiple jurisdictions. Hospitalisation data is derived from the National Hospital Morbidity Database (NHMD), which records episode-level details of admitted patient care across Australia's private and public hospitals. Drug-induced deaths

	data is collected from the National Mortality Database and the National Coronial Information System (deaths certified by a coroner).
Limitations	The AIHW's reporting on drug-related health impacts is limited by the inherent constraints of its data sources, including time lags, scope restrictions, and variability in data collection methods. Delays in drug-induced death data due to certification and coronial processes can lead to incomplete reporting of recent trends. Similarly, hospitalisation and ambulance attendance data focus on acute incidents and admitted care, missing broader chronic harms and less severe cases.

National Opioid Pharmacotherapy Statistics Annual Data

Purpose	NOPSAD monitors Australia's opioid pharmacotherapy treatment landscape to identify changes in treatment delivery, patterns of opioid dependence, and client demographics.
Methodology	NOPSAD collects data annually on the number of clients receiving pharmacotherapy for the treatment of opioid dependence, the number of health professionals prescribing opioid pharmacotherapy drugs, dosing points that clients attend to receive their medication, and client demographics. PBS prescription data for the previous financial year is collected from the Australian Government Department of Health, Disability and Ageing's Enterprise Data Warehouse in October 2024.
Limitations	The snapshot methodology does not capture the full scope of treatment activity throughout the year. Clients who do not present on the snapshot day (e.g. takeaway clients) may not be counted. It also does not capture information on individuals who seek alternative treatments outside the pharmacotherapy system. Additionally, the differences in jurisdictional data collection methods impact the data reported and comparability by jurisdiction and year. Finally, NOPSAD and PBS data collection methods differ, with snapshot data and financial year data respectively, so the two data sets cannot be compared.

NATIONAL DRUG AND ALCOHOL RESEARCH CENTRE

Ecstasy and Related Drugs Reporting System

Purpose	This national monitoring system intends to provide an early-warning system that identifies emerging trends in party drug markets, including changes in drug use patterns, drug markets and drug-related harms and risks.
Methodology	The EDRS annually gathers data from structured surveys with regular users of ecstasy and other stimulants in urban settings and analyses this data with information contributed by law enforcement and health professionals.
Limitations	It focuses on a small sample size of regular users in urban areas, so does not capture patterns among occasional users, those in rural or regional settings, or people who regularly use drugs other than ecstasy and related stimulants.

Illicit Drug Reporting System

Purpose	This national monitoring system intends to provide an early-warning system that identifies emerging trends among people who inject drugs, including changes in drug use patterns, drug markets and drug-related harms and risks.
Methodology	The IDRS annually conducts structured surveys with people who regularly inject drugs at harm reduction services in urban settings and analyses this data with information contributed by law enforcement and health professionals.
Limitations	It focuses on a small sample size of regular injectors in urban areas, so does not capture patterns among occasional users, those in rural or regional settings, or people who do not inject drugs, which is a significant issue for the large number of people who use methamphetamine by routes other than injecting.

KIRBY INSTITUTE

Australian Needle and Syringe Program Survey

Purpose	The ANSPS is intended as early-warning system to monitor trends in injecting practices and sexual behaviour, and the prevalence of BBVs like HIV and hepatitis C, among people who inject drugs (PWID).
Methodology	Conducted annually over a two-week period by the Kirby Institute, the ANSPS is a structured survey of people who inject drugs attending participating NSPs across Australia. The voluntary survey collects data on demographics, injecting behaviours, and blood-borne virus prevalence.
Limitations	The survey only captures client data from participating NSP services located in predominantly metropolitan areas, which may impact the generalisability of results as rural and remote areas are underrepresented, and it excludes people who inject drugs who obtain syringes from alternative sources. NSP client participation in the survey is voluntary and the ANSPS has a relatively low response rate ranging from 34% to 45% (2019-2023), although we acknowledge that sentinel, cross-sectional surveys of this kind can have lower response rates over time that do not invalidate the findings but do indicate the need for careful interpretation and clear reporting of results focusing on trends based analysis.

Needle and Syringe Program National Minimum Data Collection

Purpose	It provides a national and jurisdictional overview of NSP service delivery including outlet type, syringe distribution, and client demographics to monitoring service coverage for PWID across Australia.
Methodology	This report annually collects data from state and territory health departments on NSP sites (primary and secondary NSPS, pharmacies, and syringe dispensing machines) nationwide, tracking outlet type and syringe distribution. It also examines client-level data collected through NSP's routine data collection at primary and secondary NSP services on a designated snapshot day.
Limitations	NSP NMDC does not include all pharmacy-based NSP services and may underestimate service use in certain areas as NSP participation is voluntary and differences in reporting practices across NSP types.

ACRYONYMS

1,4-BD	1,4-Butanediol
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ANSPS	Australian Needle and Syringe Program Survey
AOD	Alcohol and Other Drugs
ATOD	Alcohol, Tobacco and Other Drugs
ATSI	Aboriginal and Torres Strait Islander
BBV	Blood-Borne Virus
EDRS	Ecstasy and Related Drugs Reporting System
GBL	Gamma Butyrolactone
GHB	Gamma Hydroxybutyrate
HCV	Hepatitis C Virus
HCV RNA	Hepatitis C Virus Ribonucleic Acid
HIV	Human Immunodeficiency Virus
HRA	Harm Reduction Australia
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Australian Modification
IDRS	Illicit Drug Reporting System
LAI	Long-Acting Injectable
MDMA	Methylenedioxymethamphetamine
NASS	National Ambulance Surveillance System
NCIS	National Coronial Information System
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NHMD	National Hospital Mortality Database
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NSP	Needle and Syringe Program
NSP NMDC	Needle Syringe Program National Minimum Data Collection
NSW	New South Wales
NT	Northern Territory
OOS	Occasions of Service
OPT	Opioid Pharmacotherapy Treatment
OTP	Opioid Treatment Program
PBS	Pharmaceutical Benefits Scheme
PIEDS	Performance and Image Enhancing Drugs
PWID	People Who Inject Drugs
QLD	Queensland
UNSW	University of New South Wales
SA	South Australia
SDM	Syringe Dispensing Machines
TAS	Tasmania
VIC	Victoria
WA	Western Australia

NATIONAL DRUG STRATEGY HOUSEHOLD SURVEY

Produced by: Australian Institute of Health and Welfare (since 1998)

Reporting Commenced: 1985
Most Recent Report: 2023

Number of Reports to Date: 13

Purpose

To monitor national estimates on patterns in legal and illegal drug use, attitudes, and perceptions related to drugs among the Australian population. This survey provides a broad view of population-level trends in drug use and public attitudes and helps to inform policies, programs, and harm reduction initiatives.

Data reported on

- Demographic data such age, gender, ATSI, sexual orientation, gender experience, and geographic area.

- Patterns of drug use (legal and illegal substances) both recently (past 12 months) and across the participant's lifetime.

- Perceptions and attitudes towards drug-related issues and policies.

Data collection method

This structured survey is conducted every three years over a five-to-six-month period. The sample is comprised of people living in private dwellings using a stratified, multistage random sampling. Stratifying the sample size by region is done to produce reliable estimates of states and territories with smaller populations. In each dwelling, the person aged 14 and over who had the most recent birthday is invited to self-complete the survey via a paper form, online or with an interviewer over the telephone.

Limitations

- **Exclusion of marginalised populations**: This survey excludes people who are homeless, people living in non-private dwellings (hotels, motels, boarding houses, etc.), institutional and clinical settings (hospitals, rehabs, prisons, universities etc.), and does not provide data on people who are homeless, and the territories of Jervis Bay, Christmas Islands and Cocos Island. As such the results do not accurately reflect data on the most marginalised populations.

- **Small sample for Indigenous populations:** Estimates for Aboriginal and Torres Strait Islander people are not reliable due to the small sample size.

- **Self-reported data**: The survey relies on self-reported data and cannot be verified for accuracy. Participants report drug use based on their belief of what they consumed, which may not reflect actual substances taken. Respondents may underestimate actual consumption levels, be unwilling to provide information about behaviour regarding illegal activities, incorrectly complete the survey, or mis-remember information.

- **Selection and non-response bias**: As participation is discretionary, the sample may be skewed by those with strong opinions, and drug users may under-participate due to stigma and fears associated with criminalisation.

- **Methodological changes**: There have been multiple changes in how the survey is conducted over the years, including adjustments to questions and survey methods, making it difficult to compare results across different survey periods.

MOST RECENT NDSHS REPORT: 2022-2023

Suggested Citation: Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2022-2023: Detailed findings. Drug Statistic Series, AIHW Canberra; 2024, https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey/contents/about
Link: https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey/contents/about

Key Findings

Please note, this summary provides a snapshot and overview of the key findings related to illicit drug use and harm reduction. For additional information, please refer to the full report.

Data collection period:	Collected in two stages, the first 20 July to 18 December 2022 and the second from 20 March to 31 May 2023.
Sample size:	21,663 completed questionnaires out of 49,389 households contacted.

NDSHS data is updated every three years, therefore the snapshot provided within HRA's '2025 National AOD Data Report' remains the same as presented in the 2024 report. Results for the next NDSHS are expected to be released mid-late 2026.

Illicit drug use

1/2 people (47%) have used an illicit drug in their lifetime. 1/5 people (17.9%) have used an illicit drug in the previous 12 months. This equates to 3.9 million people (an increase from 3.4 million in 2019).

Cannabis	**Hallucinogens**	**Ecstasy**
Cannabis remained the most commonly used illicit drug in 2022-2023 with 2.5 million people having used it recently.	Hallucinogen use increased from 300,000 people in 2019 having used in the previous 12 months to 500,000 people in 2022-2023.	Use of ecstasy has declined since 2019, although it showed signs of rebounding in 2023.
Meth/amphetamine	**Opioids**	**Ketamine**
People who used methamphetamine and amphetamine in 2022-2023 had mainly used ice (43%).	Non-medical use of pain-relievers and opioids continued to decline since 2016, from 3.6% to 2.2% in 2022-2023.	Recent ketamine use increased from 0.9% in 2019 to 1.4% in 2022-2023.

	Lifetime Use (aged 14+)		Recent Use (aged 14+)	
	%	Estimated pop.	%	Estimated pop.
Cannabis	41%*	8.8 million *	12%**	2.5 million**
Cocaine	14%	2.9 million	5%	1 million
Ecstasy	14%*	2.9 million*	2%	400,00
Hallucinogens	12%	2.6 million	2%	500,000
Meth/amphetamine	8%	1.6 million	1%	200,000
Inhalants	6%	1.2 million	1%	300,000
Ketamine	4%	900,000	1%	300,000
Synthetic cannabinoids	3%	600,000	(0.1%)~	20,000
GHB, GBL, 1-4-BD	1%	300,000	(0.2%)	40,000
Heroin	1%	300,000	(0.1%)~	30,000
New and emerging psychoactive Substances	1%	200,000	(0.1%)~	<10,000

^ Used within last 12 months.
* Includes prescribed and non-prescribed use and use in regions where cannabis use and possession is decriminalised.
** Non-medical/non-prescribed/illegal use and use within regions where cannabis use and possession has been decriminalised.
*** No questions regarding prescribed use.
~ Estimate has a relative standard error between 25% and 50% and should be interpreted with caution.

Perceptions

Drug problem

42% Meth/amphetamine	12.9% Cannabis	12.3% Cocaine	11.4% Heroin

The first drug people associated with 'a drug problem' varies with age.		14-17 yrs	60-69 yrs
	Cocaine	26%	8.4%
	Cannabis	28%	12.4%
	Meth/amphetamine	17%	46%
	Heroin	5%	13.2%

Drug policy

Support for harm reduction policies increased between 2019 and 2022-2023.
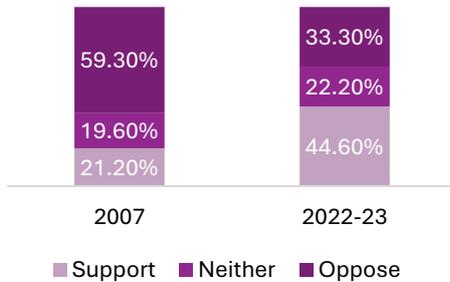
Harm reduction interventions

	2019	2022-2023
Drug checking/ pill testing	57%	64% ⬆
Supervised drug consumption rooms	47%	53% ⬆
Take home naloxone	56%	61% ⬆

Legalisation of personal use

 The majority of people opposed legalising illicit drugs, except for marijuana/cannabis.
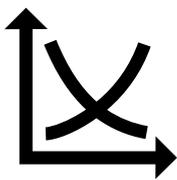
Cannabis

2007
- 59.30%
- 19.60%
- 21.20%

2022-23
- 33.30%
- 22.20%
- 44.60%

■ Support ■ Neither ■ Oppose

|	Heroin	Meth	Cocaine	Ecstasy
Support	6.6%	6.1%	10.3%	12%
Neither	7.9%	7.3%	11.5%	12.1%
Oppose	85.6%	86.6%	78.2%	75.8%

 However, overall there has been a decrease in opposition to all illicit drugs being made legal between 2019 and 2022–2023.

Allocating $100 to reduce illicit drug use

 Participants are asked if they were given $100 to reduce illicit drug use how much they would allocate to education, treatment and law enforcement. **There has been a long-term trend since 2004 which has shown a decreasing support for law enforcement actions and an increase support for funding education and treatment.**

2004	2022-2023

2004
- $25
- $44
- $31

■ Law Enforcement ■ Education ■ Treatment

2022-2023
- $32
- $32
- $37

■ Law Enforcement ■ Education ■ Treatment
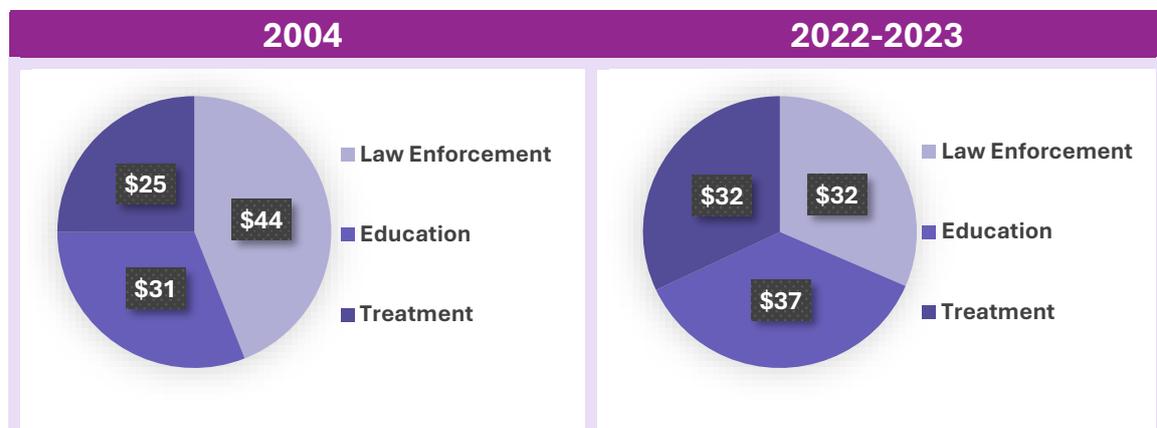
ALCOHOL, TOBACCO AND OTHER DRUGS – HEALTH IMPACTS

Produced by: Australian Institute of Health and Welfare

Reporting Commenced: 1997   **Number of Reports to Date:** N/A*
Most Recent Update: 27.06.25

* This report is released in a web format. Numerous reports have been published since its inception as it is regularly updated from a range of sources with different frequencies in publication.

Purpose

To identify and track national trends in drug-related ambulance attendance, hospitalisation and drug-induced deaths related to both acute toxicity (drug overdose) and chronic use (determined by toxicology and pathology reports), to identify at-risk populations. It aims to aid governments, researchers, and the alcohol and drug sector in understanding the scope of drug-related harm, inform policy development, harm reduction strategies, and healthcare planning.

Data reported on

- Ambulance attendance: Characteristics of patients attended by ambulance services for AOD-related incidents, characterised by demographic factors, geography, the nature of incident (e.g. overdose, multiple drugs, police attendance), and whether the patient is transported to hospital.

- Hospitalisation: Episodes of care linked to drug overdose and drug-related health issues, including patient demographics, drug type, length of stay, and jurisdiction.

- Drug-induced deaths: Trends in mortality rates related to drug use, characterised by drug type, age, gender, and geography.

Data collection method

Multiple nationally representative data sources are used to regularly update this web report and analyse recent trends.

Ambulance attendance data is sourced by the AIHW from the National Ambulance Surveillance System (NASS). Electronic clinical records from ambulance services across most jurisdictions in Australia are submitted monthly. These records are reviewed by trained coders who identify AOD involvement-based paramedic observations, patient self-reporting, third-party accounts, and scene evidence (e.g., paraphernalia). Additional analysis is conducted annually by the AIHW, Monash University and Turning Point.

Hospitalisation data is sourced from the National Hospitality Morbidity Database (NHMD), which annually collects data from state and territory health

departments on episode-level records detailing patient care across Australia's private and public hospitals. Data collected is coded to the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM).

Drug-induced death data is sourced from the AIHW National Mortality Database, which compiles information from the Registrar of Births, Deaths and Marriages in each state and territory and the National Coronial Information System (NCIS) for deaths certified by a coroner. This data is then coded and released by the Australian Bureau of Statistics (ABS). The ABS updates data for the previous year within 10 months post the year's end (e.g. 2023 data was released in September 2024). The AIHW, NDARC, and the Pennington Institute then conduct additional analysis and report on the data in the following year.

Limitations

- **Limited context**: Reported data on ambulance attendance, hospitalisations, and drug-induced deaths does not provide detailed contextual information that explores the complex nature of drug-related harms which are often multifactorial.

Ambulance attendance:

- **Jurisdictional representation:** Not all Australian states and territories participate, leading to gaps in national data coverage. Currently data is not available for South Australia and Western Australia due to system constraints. Additionally, some data for Tasmania, the Australian Capital Territory and the Northern Territory is not included due to small numbers.

- **Subjectivity in reporting:** The data relies on paramedic observations, patient self-reports, and evidence at the scene. The accuracy of substance identification depends on the paramedic's judgment and the availability of reliable information.

- **Data collection variability:** The level of detail in paramedic case narratives and reporting practices varies across jurisdictions, potentially affecting consistency and comparability.

- **Exclusion of non-reported cases:** Cases where AOD involvement is not identified or reported may be excluded, underestimating the true scale of drug-related ambulance attendances.

- **Focus on emergency and acute events:** The data only captures incidents severe enough to warrant ambulance attendance, excluding cases where people do not seek emergency assistance or access other health services. Additionally, it only captures acute AOD harms where an ambulance is called and attends. Chronic harms related to long-term substance use are not included in the dataset.

- **Secondary contribution of AOD**: While AOD consumption must contribute to the ambulance attendance, it may not be the primary reason for the call-out. This complexity can make it challenging to attribute incidents directly to substance use.

- **Geographic barriers:** Although ambulance services are considered universal in Australia, geographic barriers in remote areas and financial costs may restrict access. This could lead to underrepresentation of certain populations, particularly in very remote regions.

Hospitalisations:

- **Coding practices**: Data is coded using the ICD-10-AM classification system, which may vary slightly in application across jurisdictions. Differences in coding practices across jurisdictions can lead to inconsistencies in reporting specific drug-related conditions or comorbidities.

- **Multiple admissions**: A single individual may have multiple admissions for the same condition within a reporting period, potentially inflating the figures for certain diagnoses.

- **Exclusion of patients without explicit drug-related diagnosis**: Only cases with an explicitly coded drug-related diagnosis are included. Instances where substance use contributed indirectly to hospitalisation may be overlooked. This approach can underrepresent the broader health impacts of substance use, including cases where drugs exacerbate existing conditions or contribute to non-specific injuries.

Drug-related deaths:

- **Time lag:** There is often a significant time lag between data collection and reporting due to the nature of death certification and coronial processes. As such, additional data analysis and revision of results occur annually, and results vary between the AIHW, NDARC and the Pennington Institute based on their reporting schedule. The delay also means that the most recent released data is likely to be under-reported.

- **Death registration year:** Deaths recorded in the National Mortality Database are counted according to the year the deaths were registered, and not necessarily the year the death occurred. This means some deaths reported for a specific year may not have occurred during that year.

- **Data source variability:** Data is compiled from multiple sources to provide a detailed picture of current and emerging trends. However, each data source has variations in methodology which complicate interpretation and affect comparability across datasets.

- **Geographic recording:** The geographic location of the death is recorded as the person's usual residence at the time of death, and not where the death occurred.

- **Multiple drugs involved:** Drug-induced deaths may have more than one drug type reported as associated with the cause of death. Consequently, the number of deaths for each drug type may be more than the total number of deaths.

LATEST UPDATE TO ATOD – HEALTH IMPACTS WEB REPORT: 2025

Key Findings

Please note, this summary provides a snapshot and overview of the key findings on illicit drug. For additional information, please refer to the full report.

Data Collection Period: Drug-induced deaths registered in 2023.
Sample Size: In 2023 there were:
                                            1,947 drug-induced deaths.
                                            46,916 drug-related ambulance attendances.
   145,759 drug-related hospitalisations.

Drug-related deaths

⚠️ *The number of drug-induced deaths is expected to rise following standard data revision process*.

- **1,947 drug-induced deaths.**
- **75% (n=1324) of deaths occurred at home.**
- **The majority of deaths were considered accidental (71%, n=1,377), compared to intentional (21%, n=402). *Intentional drug-related deaths include assault and suicide.***
- **The majority of deaths (96% or 1,573) in 2023 were due to acute toxicity effects (overdose). Only 3.8% (62 deaths) were related to the chronic effects of drugs.**

Number of drug-induced deaths, 1997 to 2023
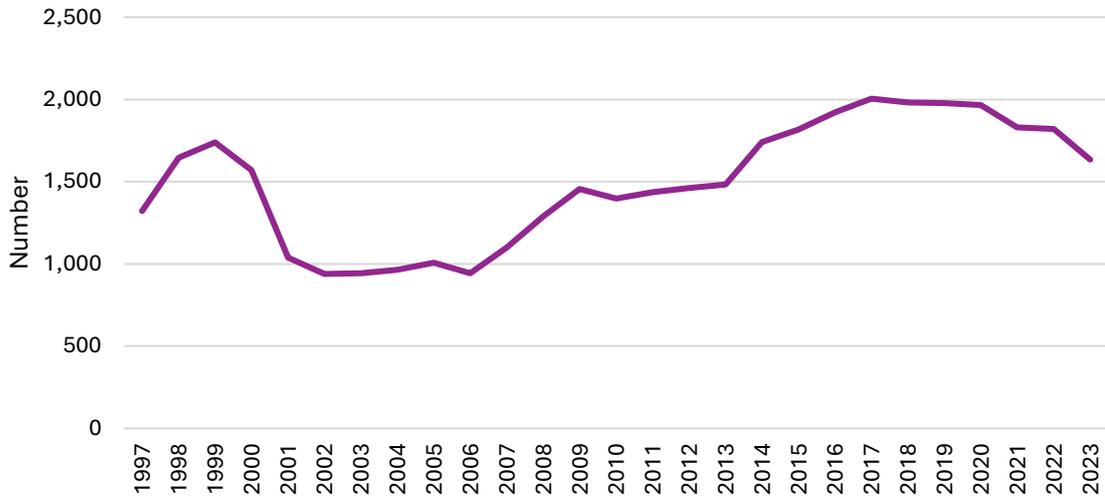
1990s		2000s		2010s		2020s	
1997	1,322	2000	1,570	2010	1,397	2020	1,967
1998	1,646	2001	1,039	2011	1,437	2021	1,830
1999	1,740	2002	939	2012	1,462	2022	1,820
		2003	944	2013	1,483	2023	1,635
		2004	965	2014	1,742		
		2005	1,008	2015	1,816		
		2006	944	2016	1,922		
		2007	1,101	2017	2,005		
		2008	1,288	2018	1,982		
		2009	1,456	2019	1,978		

Socio-demographic characteristics

Gender	Age
	Median age **47.4yrs**
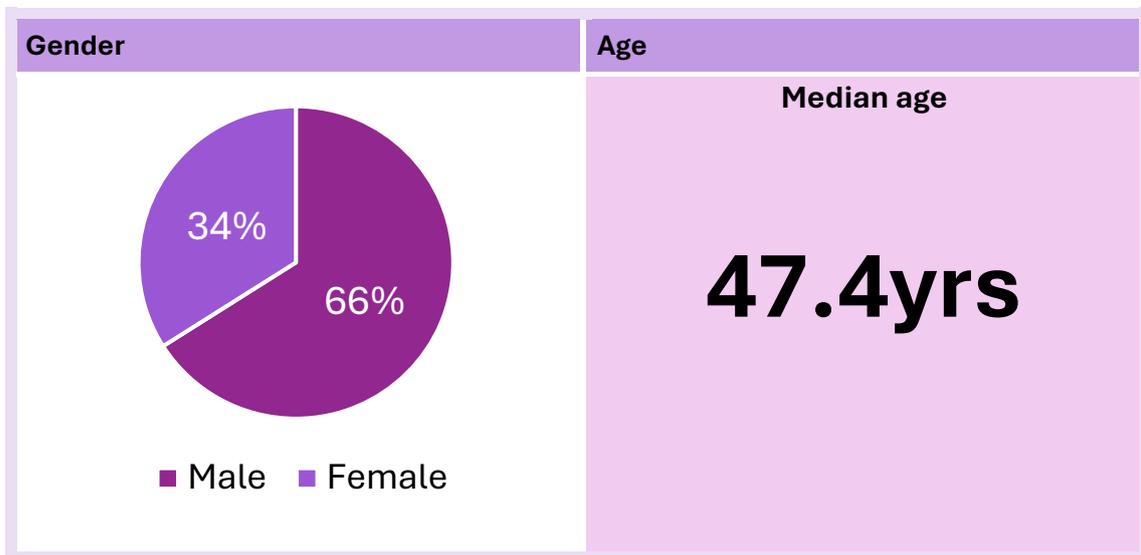
Deaths by drug class and type

> ⚠️ *More than one drug can be associated with a cause of death, as such multiple drugs may be reported on a single death record.*
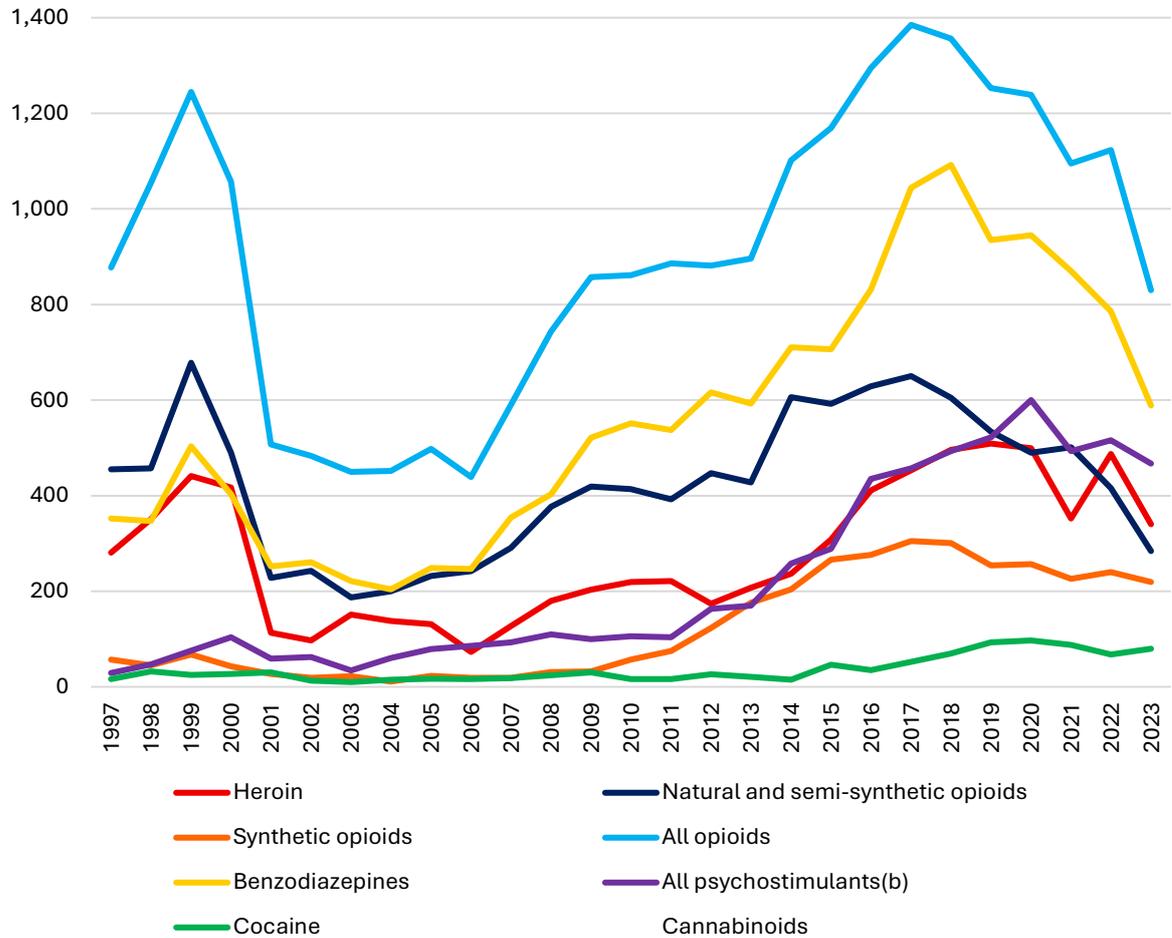
In 2023, drug-induced deaths by drug class or type

|	Number	Percent
All drug-induced deaths	1,635	100%
All opioids	830	50.8%
Heroin	340	20.8%
Natural and semi-synthetic opioids (e.g. Oxycodone, Codeine, Morphine)	284	17.4%
Methadone	166	10.2%
Synthetic opioids (e.g. Fentanyl, Tramadol, Pethidine)	219	13.4%
Benzodiazepines	589	36.0%
All Psychostimulants (excl. cocaine)	467	28.6%
Cocaine	80	4.9%
Cannabinoids	35	2.1%

Drug associated deaths 1997-2022

Benzodiazepines and Opiates largest contributor to drug induced deaths for past:

20 Yrs

Benzodiazepine related deaths decreased since 2018.

Natural and semi-synthetic opioids related deaths have **declined** between 2017 and 2023.

Conversely **heroin** induced deaths have **increased** between 2012 and 2023.

Number of drug-induced deaths, by drug type or class, 1997 to 2023

Legend:
- Heroin
- Synthetic opioids
- Benzodiazepines
- Cocaine
- Natural and semi-synthetic opioids
- All opioids
- All psychostimulants(b)
- Cannabinoids

Polydrug use

Drug-induced deaths involving multiple drugs in 2024

62%
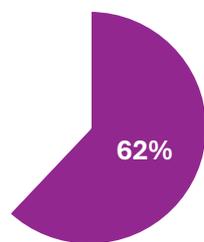
Multiple drugs present

♀ 66%

♂ 60%

Drug-related ambulance attendance

⚠️ *Data is available for NSW, VIC, QLD, TAS, ACT and the NT. Some data for TAS, ACT and NT are unavailable due to small numbers. No data is available for WA or SA.*

In 2023, 27% of all AOD ambulance attendances (n=180,228) were responding to 'illicit drugs' (n=46,916).

	Total		Multiple drugs involved		Transported to hospital		Police attendance	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
All AOD attendances	180,228	100%	34,682	19%	145,074	80%	55,972	31%
Any amphetamines	16,150	9%	6,829	42%	13,268	82%	6,800	42%
Cannabis	18,670	10%	8,610	46%	14,848	80%	5,250	28%
Cocaine	3,645	2%	2,556	70%	2,939	81%	854	23%
Ecstasy	1,950	1%	1,461	75%	1,603	82%	474	24%
GHB	6,729	4%	3,210*	46%*	5,774*	86%*	3,066*	46%
Heroin	4,018	2%	1,579*	39%*	2,573*	64%	1,232*	31%
Benzodiazepines	10,233	6%	7,453	73%	9,109	89%	3,158	31%
All pharmaceutical opioids	4,885	3%	3,552	73%	4,281	88%	1,088	22%

Explanatory Notes:
1. 'All AOD attendances' includes attendances for alcohol intoxication, illicit drugs and pharmaceutical drugs. An attendance may involve more than one drug.
2. 'Any Amphetamines' includes amphetamines and methamphetamines (powder, base crystal)
3. 'Benzodiazepines' includes alprazolam, bromazepam, clobazam, clonazepam, diazepam, flunitrazepam, lorazepam, midazolam, nitrazepam, oxazepam, temazepam, triazolam, zolpidem, zopiclone, benzodiazepine (other).
4. 'All pharmaceutical opioids' includes oxycodone, codeine and other opioid analgesics (dextropropoxyphene, fentanyl, hydromorphone, morphine, pethidine, tramadol and others).

* Caution should be used when interpreting this table as the following state and territory data was unavailable:
No data at all was included from SA and WA.
The number of ambulance attendances for GHB and heroin was not provided for ACT and QLD.
The number of GHB and heroin ambulance attendances where multiple drugs were involved, police attended or there was a transport to hospital was included for the NT and TAS.

Monthly ambulance data

Monthly ambulance data indicate that more attendances are typically recorded around December.

Ambulance attendances by selected drugs by month

Legend:
- Amphetamines (any)
- Cannabis
- GHB
- Heroin
- Pharmaceutical Opioids
- Benzodiazepines
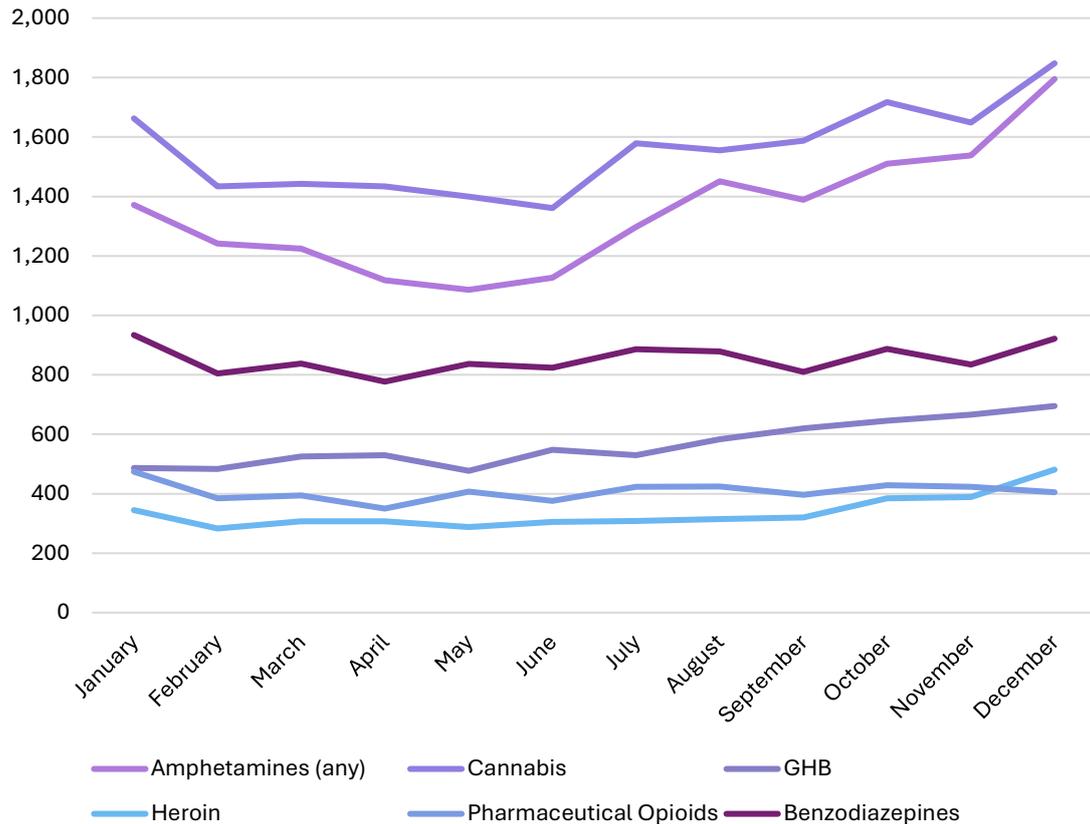
Gender ambulance data

Across all age's groups, pharmaceutical attendances were predominantly for females while most illicit drug attendances were for males.

Drug-related hospitalisations

Hospitalisation definition: *"A hospitalisation is an episode of admitted patient care ending with discharge, transfer or death, or a portion of a hospital stay beginning or ending in a change of type of care." (AIHW 2022)*

Drug-related hospitalisation definition: *"Drug-related hospitalisations are hospitalisations where the principal diagnosis relates to a substance use disorder or direct harm due to selected substances". (AIHW 2018)*

Principle diagnosis: *"The principal diagnosis is considered to be responsible for an episode of admitted patient care to hospital." (AIHW 2018)*

In 2022-23 there were **145,759 hospitalisations** (public and private) with a **drug-related principal diagnosis, accounting for 1.2% of Australia's total hospitalisations.**

Over**, 54% of** all drug-related hospitalisations were due to **"mental and behavioural disorder due to substance use"** and **46%** were due to **drug poisoning/toxicity.**

In 2022-2023 among all drug-related hospitalisations:

	Number	Percent*
Amphetamines and other stimulants**	18,141	12%
Methamphetamine	15,067	10%
Cannabinoids	6,878	5%
Opioids	5,935	4%
GHB	3,674	2.5%
Benzodiazepines	3,307	2.3%
Cocaine	1,322	0.9%
MDMA	493	0.34%
Hallucinogens	392	0.26%

*Percent based of the 145,759 drug related hospitalisations
** Includes 'methamphetamine' and 'other amphetamines and stimulants'. Excludes cocaine.

NATIONAL OPIOID PHARMACOTHERAPY STATISTCS ANNUAL DATA

Produced by: Australian Institute of Health and Welfare

Reporting Commenced: 2006
Most recent Report:2024

Number of Reports to Date: 18

Purpose

NOPSAD monitors Australia's opioid pharmacotherapy treatment landscape to identify trends in treatment delivery, patterns of opioid dependence, and client demographics. It serves as a key resource for policymakers, healthcare providers, and researchers to inform service planning and resource allocation.

Data reported on

- Client demographic data including age, sex, ATSI, and geographic area.

- National data on the number of clients receiving opioid pharmacotherapy treatment.

- Information on pharmacotherapy drugs prescribed, such as methadone, buprenorphine, and long-acting buprenorphine.

- Pharmacotherapy prescribers.

- Dosing points/dispensing sites.

- Pharmaceutical Benefits Scheme (PBS) OTP data.

Data collection method

NOPSAD data is gathered from state and territory health departments across Australia on clients receiving opioid pharmacotherapy treatment, prescribers, and dosing points. Each jurisdiction collects data on a specific snapshot day in or around June each year, though this exact day may vary by location. However, because each jurisdiction has its own data collection practices shaped by local laws, technology, and resources, there are some variations in how data is recorded and reported. PBS data from 2023-2024 was collected for this report by the AIHW from subsidised prescriptions data in the Australian Government Department of Health, Disability and Ageing's Enterprise Data Warehouse in October 2024.

Limitations

- **Data collection variability:** States and territories have different guidelines for collecting and reporting pharmacotherapy data. For instance, New South Wales only started separately identifying different buprenorphine formulations in 2023. Before that, different types were grouped together, making the data less comparable across years and less comparable with other jurisdictions monitoring the different formulations separately. Additionally, in 2023, there was no data was available for Western Australia, and in 2021, data for Queensland was missing. This makes it hard to compare and analyse trends over time.

- **Snapshot day limitations:** Data is collected on a single day and does not account for clients who may not attend a dosing point on that specific day, such as those receiving a takeaway dose of methadone, sublingual buprenorphine, or those on buprenorphine LAI, and those who enter or exit treatment before or after the snapshot day . This data does not capture the full scope of treatment activity throughout the year.

- **Inconsistent prescriber data:** Data on all authorised prescribers is provided for Victoria, Queensland, Northern Territory, Australian Capital Territory and Tasmania. However, in New South Wales, Western Australia, and South Australia, prescribers are only counted if they had at least one active client on the snapshot day. This means the report does not capture all registered prescribers in Australia. Additionally, these three jurisdictions have prescribers who prescribe in more than one location, and as such are counted twice. This affects the accuracy of the client-to-prescriber ratios.

- **Incomplete client data**: In 2023, data on individual client characteristics (like age and gender) were missing from Victoria, Queensland, and Western Australia. This makes it difficult to assess the full demographic picture of pharmacotherapy clients.

- **Unclear opioid drug of dependence:** Data for opioid drug of dependence has a significant portion of clients (42% in 2023) having their opioid drug of dependence listed as "Not stated/not reported". This means that, in many cases, we do not know which opioid the client originally depended on. Also, some clients may have their current treatment drug reported instead of the opioid that led to them seeking treatment.

- **NOPSAD and PBS data comparability:** Different data collection methods are used for these two data sets. NOPSAD data is collected on a snapshot day while PBS data is collected from the full financial year. Additionally, the NOPSAD data includes PBS clients, while PBS data is inclusive of only those who received OTP as part of the PBS. As such the PBS data does not include people who receive OTP from private prescriptions, Medicare ineligible people, people on public programs and those in correctional facilities.

MOST RECENT NOPSAD REPORT: 2024

Key Findings

Please note, this summary provides a snapshot and overview of the key findings. For additional information, please refer to the full report.
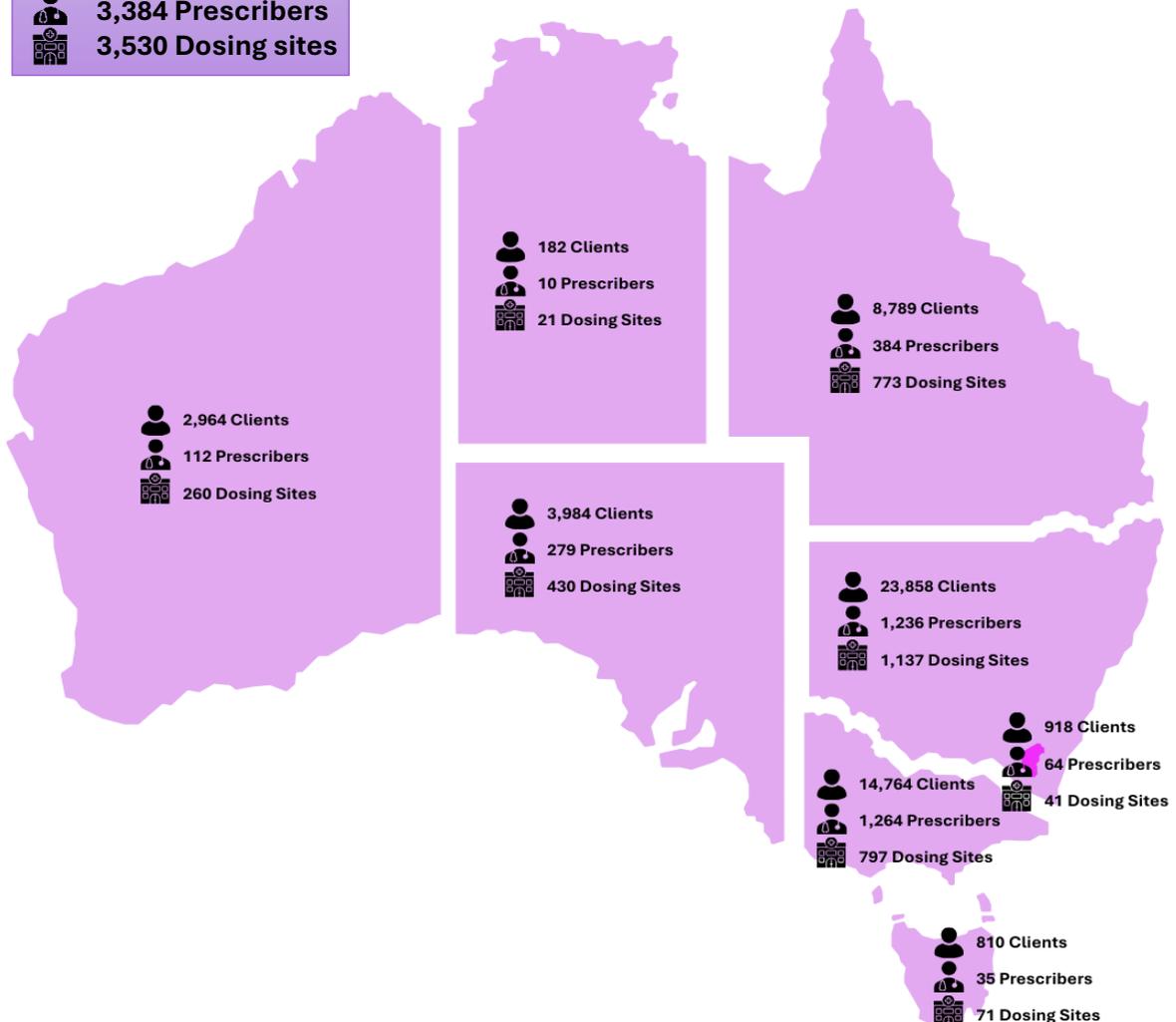
> *Data collection is not based on a nationally agreed data standard. HRA has endeavoured to include information on how this has impacted reported findings. Please refer to the AIHW website for further information.*

Data collection period: June 2024.
Sample size: 55,256 clients. 3,530 dosing sites. 3,384 prescribers.

2024 Snapshot
- 56,256 Clients
- 3,384 Prescribers
- 3,530 Dosing sites

- 182 Clients
- 10 Prescribers
- 21 Dosing Sites

- 8,789 Clients
- 384 Prescribers
- 773 Dosing Sites

- 2,964 Clients
- 112 Prescribers
- 260 Dosing Sites

- 3,984 Clients
- 279 Prescribers
- 430 Dosing Sites

- 23,858 Clients
- 1,236 Prescribers
- 1,137 Dosing Sites

- 918 Clients
- 64 Prescribers
- 41 Dosing Sites

- 14,764 Clients
- 1,264 Prescribers
- 797 Dosing Sites

- 810 Clients
- 35 Prescribers
- 71 Dosing Sites

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	TOTAL
Clients	23,856	14,763	8,789	2,964	3,984	810	918	182	56,256
Prescribers	1,236	1,264	384	112	279	35	64	10	3,384
Dosing sites	1,137	797	773	260	430	71	41	21	3,530

Client data

56,256 clients received pharmacotherapy on snapshot day.

Clients who did not attend a dosing point on snapshot day were not included.

69% Male

46 yrs

Median Age
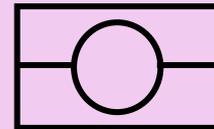
11% ATSI

Client status

⚠️ *In 2024, client status data was not available for Queensland, Western Australia, and South Australia due to the implementation of new systems.*

- **57% were continuing pharmacotherapy.**
- **17% were new to treatment.**
- **9.3% were re-entering treatment.**

## Drug of dependence clients received OTP for

> ⚠️ *A significant portion of clients (37% in 2024) have their opioid drug of dependence listed as "Not stated/not reported". Caution is advised when interpreting data for opioid drug of dependence.*

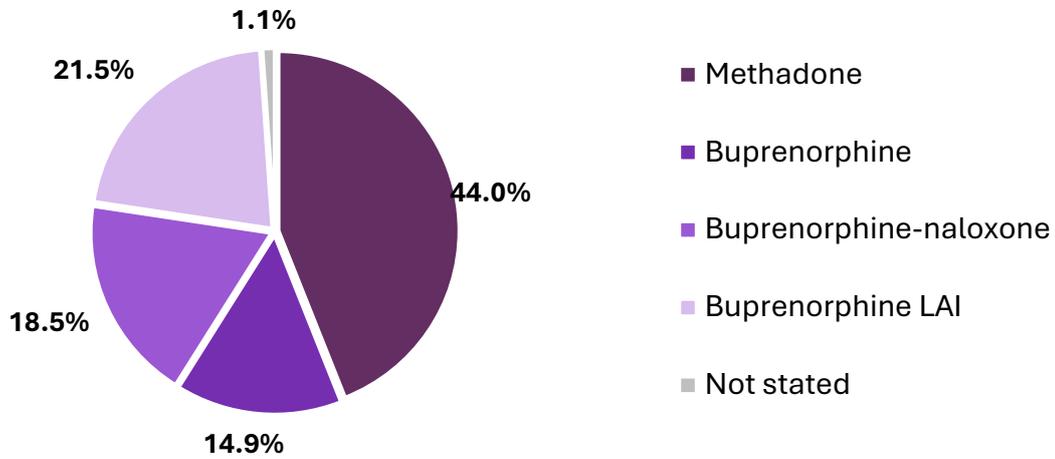|	Number	% all clients	% of clients with drug reported
Not stated/reported	20,622	36.7%	-
Heroin	19,607	34.9%	55%
Buprenorphine	4,147	7.4%	11.6%
Oxycodone	3,764	6.7%	10.6%
Methadone	3,103	5.5%	8.7%
Other pharmaceutical opioid	2,443	4.3%	6.9%
Morphine	1,408	2.5%	4%
Codeine	1,162	2.1%	3.3%

Clients with a drug of dependence reported:

Proportion of 2024 snapshot clients with drug of depdendence reported

- ■ Heroin
- ■ Buprenorphine
- ■ Oxycodone
- ■ Methadone
- ■ Other pharmaceutical opioids
- ■ Morphine
- ■ Codeine
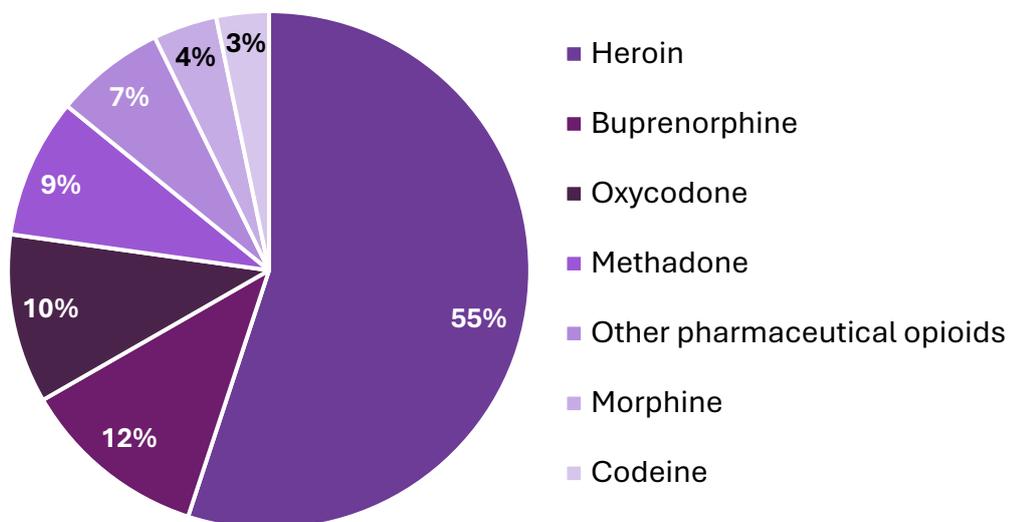
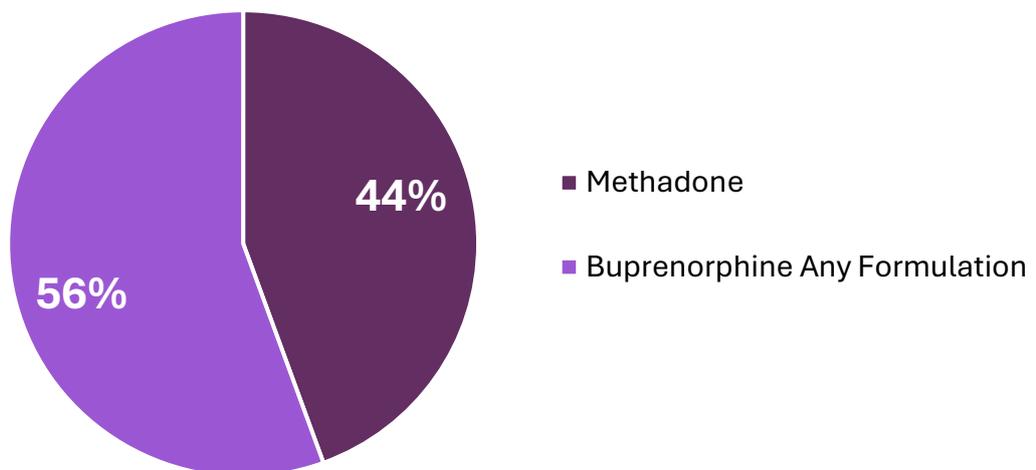## Pharmacotherapy treatment by pharmacotherapy type

Clients receiving pharmacotherapy treatment on 2024 snapshot day, by pharmacotherapy type,

1.1%

21.5%

44.0%

18.5%

14.9%

- ■ Methadone
- ■ Buprenorphine
- ■ Buprenorphine-naloxone
- ■ Buprenorphine LAI
- ■ Not stated

> **In 2024, more clients received a buprenorphine formulation than methadone. This continues the trend towards an increasing proportion of clients receiving buprenorphine while those receiving methadone has fallen.**

Clients receiving methadone or any buprenorphine formulation on 2024 snapshot day

44%

56%

- ■ Methadone
- ■ Buprenorphine Any Formulation

Proportion of clients receiving pharmacotherapy treatment on a snapshot day, by state and territory and pharmacotherapy drug type, 2014 to 2024
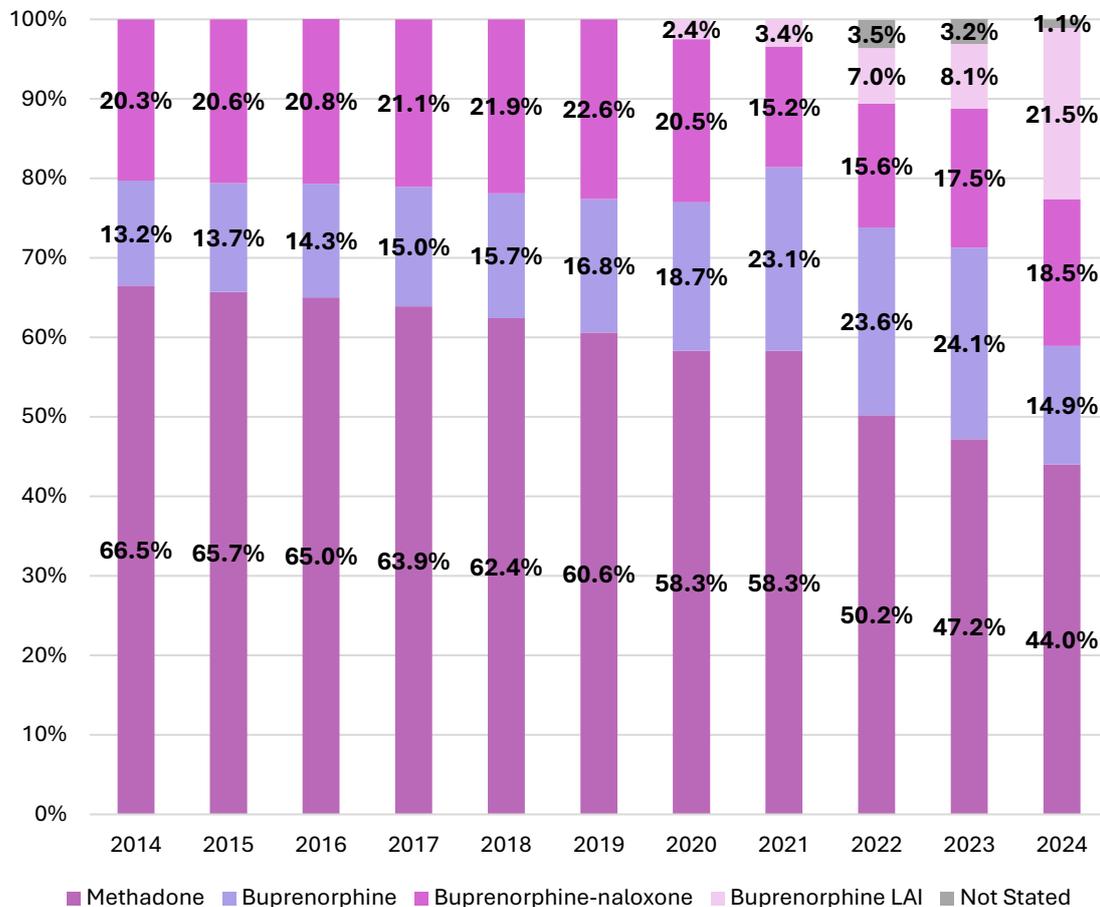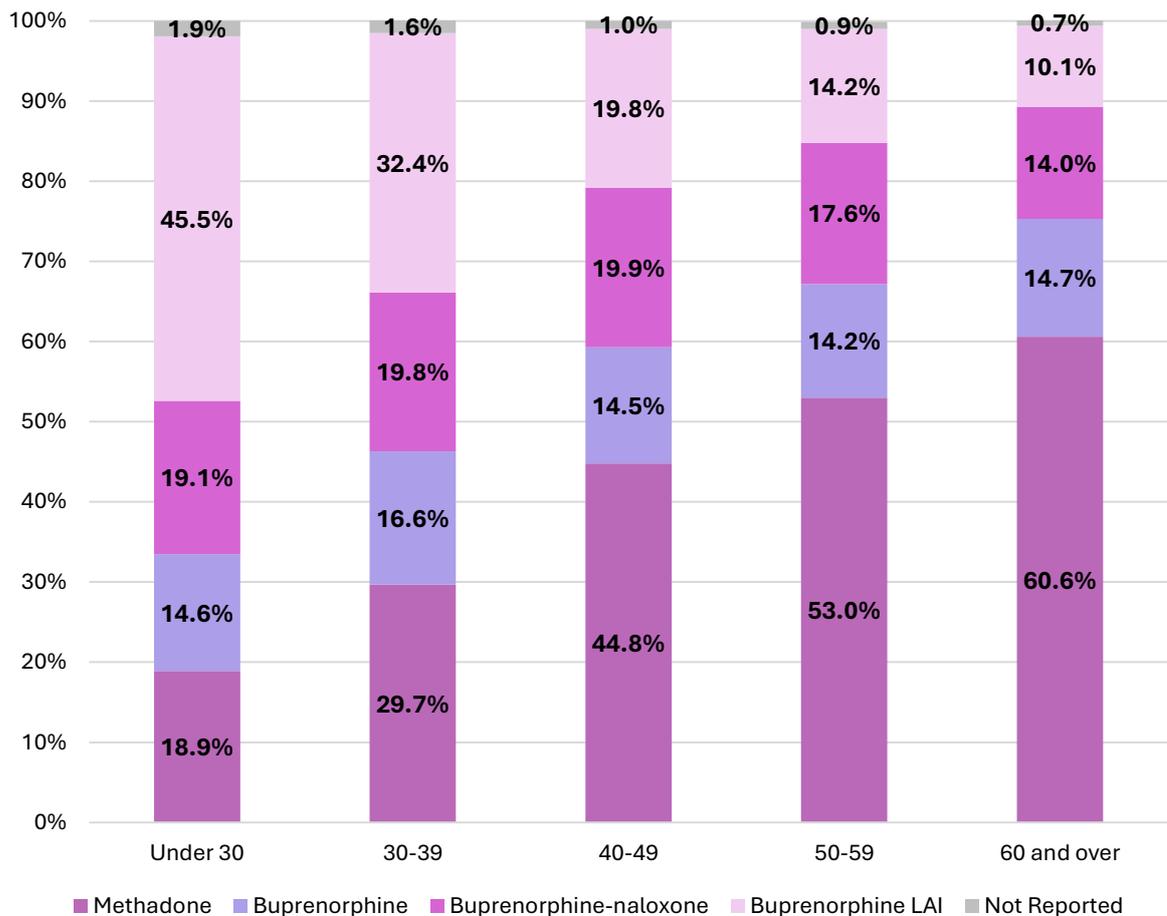

FIGURE NOTES (AIHW, 2024):

1. Prior to 2023, NSW counted 'buprenorphine-naloxone' and 'buprenorphine LAI' as 'buprenorphine'. In 2023, these formulations were reported separately for the first time. Trend data are not comparable.

2. In 2020, buprenorphine LAI was reported for selected states and territories for the first time. The ACT count for buprenorphine LAI in 2020 relates only to clients of the public clinic. The increase in VIC client numbers in 2020 may have been influenced by the implementation of the Victorian Government's SafeScript initiative. SafeScript has identified people with risky prescription opioid use who were previously undetected.

3. In 2020 and 2021, the increase in NSW client numbers could be attributed to the introduction of buprenorphine LAI (reported in the NOPSAD collection for the first time in 2020). Additional prescribing of buprenorphine occurred in correctional facilities, with the introduction of depot buprenorphine LAI during the year contributing to an increase in access to treatment. Some NSW Local Health Districts also reported having capacity to increase the number of new patients due to buprenorphine LAI.

4. In 2021, data for Qld were not available.

5. In 2023, data for WA were not available.

6. In 2023 and 2024, SA submitted data from two sources, resulting in a combination of unit record data and aggregate summary data. Data may not sum to total for some tables.

Pharmacotherapy treatment type varies by age.

	39 yrs. and under	40+ yrs.
Buprenorphine formulation	72%	49%
* Table is of those who reported pharmacotherapy type.		
Methadone	28%	51%

Proportion of clients receiving pharmacotherapy treatment on a 2024 snapshot day, by age group and pharmacotherapy drug type

	Under 30	30-39	40-49	50-59	60 and over
Not Reported	1.9%	1.6%	1.0%	0.9%	0.7%
Buprenorphine LAI	45.5%	32.4%	19.8%	14.2%	10.1%
Buprenorphine-naloxone	19.1%	19.8%	19.9%	17.6%	14.0%
Buprenorphine	14.6%	16.6%	14.5%	14.2%	14.7%
Methadone	18.9%	29.7%	44.8%	53.0%	60.6%

■ Methadone   ■ Buprenorphine   ■ Buprenorphine-naloxone   ■ Buprenorphine LAI   ■ Not Reported

Prescribers

Snapshot day 2024

3,384 authorised opioid prescribers recorded on snapshot day.

Multiple OTP	Almost two in three (2,176 prescribers) were authorised to prescribe more than one type of drug.
Private prescribers	More than four out of five prescribers (82% or 2,763 prescribers) operated in the private sector. The remaining prescribers were in the public sector (16% or 532 prescribers) or worked within correctional facilities (2.4% or 81 prescribers).
17 Avg. clients	Prescribers nationwide treated an average of 17 clients each. WA had the highest average, with 26 clients per prescriber, while VIC had the lowest at 12 clients, followed by the ACT and SA with 14 clients per prescriber.
Public sector 2x client load	Public sector prescribers had about twice as many clients (28 clients) as prescribers in the private sector (12 clients).
Methadone	Methadone was the most commonly prescribed pharmacotherapy treatment across all prescriber types. Clients of private prescribers were most likely to receive methadone (49% or 23,314 clients), while correctional facility clients were most likely to be treated with buprenorphine LAI (73% or 3,356 clients).

Dosing sites

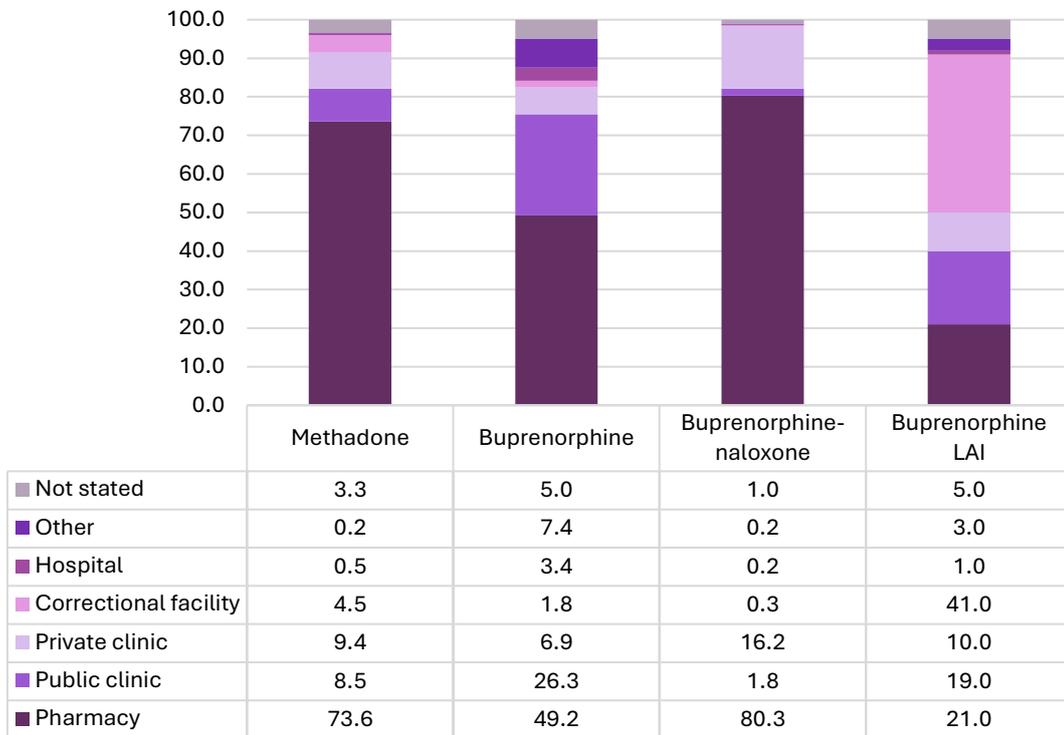**3,530 dosing sites were recorded on snapshot day.**

- The majority (75% or 2,629 sites) of OTP dosing sites were located in pharmacies.
- On snapshot day the majority of clients (60% or 33,446) received treatment at a pharmacy.

	No.	%
Public clinic	92	2.6%
Private clinic	87	2.5%
Pharmacy	2,629	74.5%
Correctional facility	38	1.1%
Other (e.g. hospitals, mobile sites, community health clinics, non-government organisations, doctor's surgeries)	251	7.1%
Not stated	433	12.3%

Dosing site by pharmacotherapy type

Pharmacies were the most common dosing site for all pharmacotherapy drugs except for buprenorphine LAI.

Proportion of clients receiving pharmacotherapy on 2024 snapshot day, by pharmacotherapy drug type and dosing point site type

	Methadone	Buprenorphine	Buprenorphine-naloxone	Buprenorphine LAI
Not stated	3.3	5.0	1.0	5.0
Other	0.2	7.4	0.2	3.0
Hospital	0.5	3.4	0.2	1.0
Correctional facility	4.5	1.8	0.3	41.0
Private clinic	9.4	6.9	16.2	10.0
Public clinic	8.5	26.3	1.8	19.0
Pharmacy	73.6	49.2	80.3	21.0

Legend: Pharmacy · Public clinic · Private clinic · Correctional facility · Hospital · Other · Not stated

Dosing site by location

⚠️ *Data on dosing point location was not available for QLD and WA.*

Over half (53%) of opioid pharmacotherapy dosing sites were located in major cities.

	Number	%
Major cities	1,461	53%
Inner regional areas	606	22%
Outer regional areas	295	11%

Number of clients per dosing site

On snapshot day, nationally the average clients dosed was 16 clients. However, this number varies between sites.

Public clinics	75 per site
Pharmacies	13 per site
Correctional facilities*	165 per site

* This number is inflated as NSW does not count individual correctional dosing point sites. Correctional facilities are counted as 'single' site so all correctional clients across the state are counted to be dosed at this one site.

Client characteristics by dosing site

⚠️ *The data below is based on all states and territories except Victoria and Queensland.*

Client characteristics differ depending on the dosing site.

Age

Public clinics	Private clinics	Pharmacies	Hospitals	Correctional facilities
40yrs+ Over two in three clients were 40 years and over (68% or 4,086 clients).	**40yrs+** Four in five clients were 40 years and over (80% or 1,448 clients).	**50yrs+** Half of the clients were aged 50 and over (48% or 6,979 clients) compared to one in 10 in correctional facilities (9.8% or 283).	**30yrs -40yrs** Over two in three clients were aged in their 30s and 40s (65% or 354 clients).	**30yrs and under** Almost two in three clients were aged in their 30s and under (64% or 2,676).

♂	• All dosing points sites treated more males than females. • Male clients were over six times more likely than female clients to dose in correctional facilities (12% male, 1.8% female).
♀	• Female clients were more likely to dose at pharmacies compared to males (54% female, 40% male).

Pharmaceutical Benefits Scheme

The 2024 NOPSAD report is the first edition to report on OTP on the Pharmaceutical Benefits Scheme (PBS). OTP medications became part of the PBS on 1 July 2023, making these medications accessible through a nationally consistent co-payment system through community pharmacies. The data reported was collected through the PBS between 1 July 2023 and 30 June 2024.

Data reported below does not include private prescriptions, over-the counter medicines, or off-label prescribing. It also does not provide information on medication provided in public hospital to inpatients or correctional facilities (with some exceptions). Additional data reported on the PBS cannot be compared with NOPSAD data, as PBS data is specific to PBS clients while NOPSAD reports on all clients including non-PBS clients.

In 2023-24:

56,500 clients
received at least one PBS OTP medication.

620,800 prescriptions
dispensed for OTP.

40-49yrs
One in three (34% or 19,197) were aged 40-49.

69% male
(38,932) of the clients were male.

ECSTASY AND RELATED DRUG REPORTING SYSTEM

Produced by: National Drug and Alcohol Research Centre

Reporting Commenced: 2003
Most Recent Report: 2025

Number of Reports to Date: 24

Purpose

The Ecstasy and Related Drugs Reporting System (EDRS) is a national monitoring system for ecstasy and related drugs that is intended to identify emerging trends of local and national interest in the markets for these drugs. Data is not considered representative of all people who use drugs.

Data reported on

- Demographics such as age, gender, employment status, student status, and location.

- Patterns of ecstasy and other related drug use.

- Market characteristics, including availability, purity, and price of ecstasy and other party drugs.

- Drug-related harms, risks and harm reduction practices.

- Other behaviours (mental health, drug checking, stigma).

Methodology

The EDRS is an annual structured survey conducted by interviewers either in person, over the phone or via teleconferencing with people across all Australian capital cities. Recruitment occurs via social media, print advertisements, interviewer contacts, and word-of-mouth. Participants are eligible to participate if they I) are at least 17 years of age (16 years in Perth) ii) have used ecstasy and/or other illicit stimulants (including: MDA, methamphetamine, cocaine, non-prescribed stimulants, mephedrone or other simulant NPS) on at least six days in the past six months, and iii) are resident of a capital city the interview is taking place for 10 of the past 12 months.

Limitations

- **Focus on major cities:** Data is collected from participants living in urban areas, so the findings do not represent regional or remote drug use patterns.

- **Self-reported data**: The survey relies on self-reported data and cannot be verified for accuracy. Participants report drug use based on their belief of what they consumed, which may not reflect actual substances taken. Respondents may underestimate actual consumption levels, be unwilling to provide information about behaviour regarding illegal activities, incorrectly complete the survey, or mis-remember information.

- **Focus on stimulant use**: Participants are only eligible if they use ecstasy and/or other illicit stimulants, therefore it is not representative of communities who regularly use psychedelics, dissociatives, cannabis etc.

- **Exclusion of occasional users**: The sample only includes regular ecstasy and stimulant users, omitting those who may use infrequently.

- **Selection and non-response bias**: As participation is discretionary, the sample may be skewed by those with strong opinions, and participation rates may vary based on the stimulant drug of choice due to stigma.

- **Non-representative sample**: The survey recruits a small sample of people who are regular ecstasy and stimulant users, participation is voluntary and therefore cannot provide information on the prevalence or patterns of drug use in the general population.

- **Methodological changes**: There have been changes in how the survey is conducted over the years, including adjustments to questions, interview process (shift from face-to-face interviews to phone/teleconference during the pandemic), and eligibility (in 2013 eligibility criteria changed to include not only regular ecstasy users but also regular users of other illicit stimulant). These changes make it difficult to compare results across different survey periods.
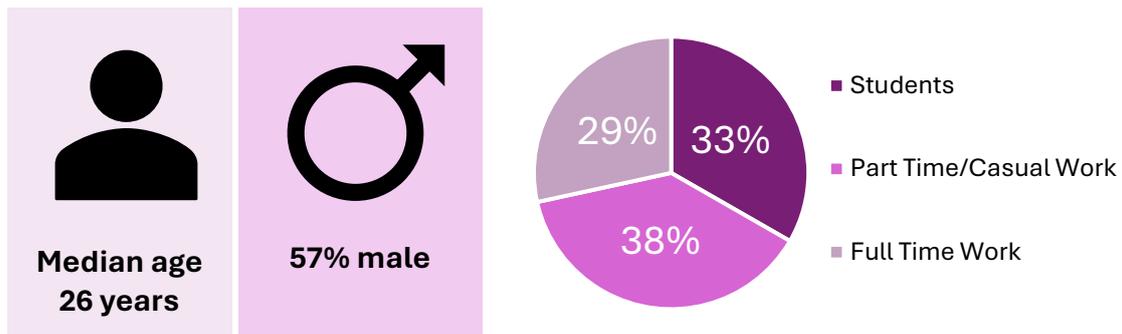
MOST RECENT EDRS REPORT: 2025

Key Findings

Please note, this summary provides a snapshot and overview of the key findings related to illicit drug use. For additional information, please refer to the full report.
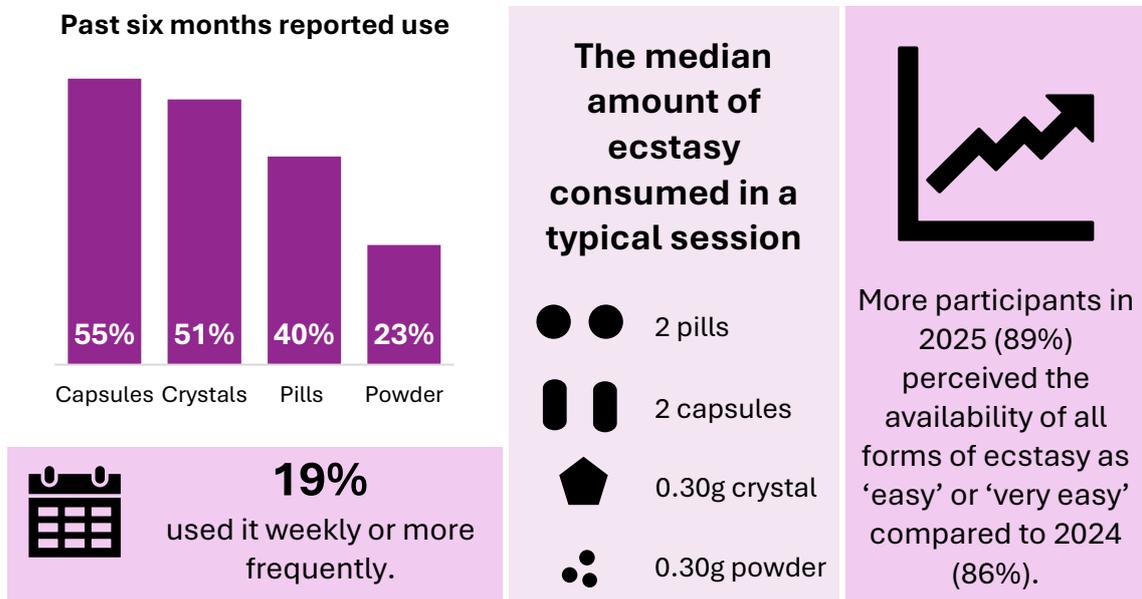
Data collection period: April-July 2025.
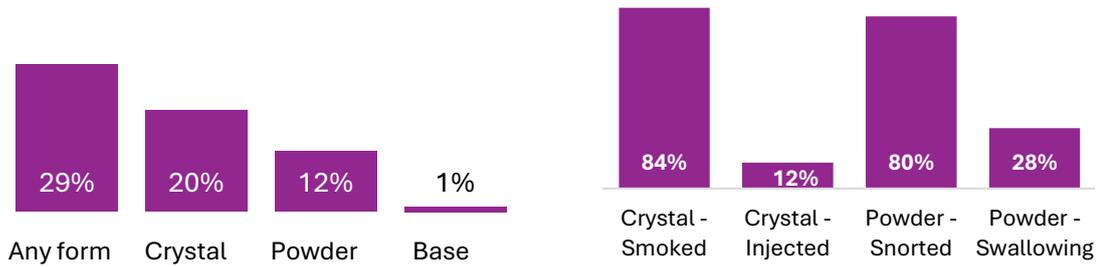**Sample size:** 690 participants.

Sample characteristics

Median age 26 years

57% male

- Students 33%
- Part Time/Casual Work 38%
- Full Time Work 29%

Drug use

Ecstasy

Past six months reported use

Capsules	Crystals	Pills	Powder
55%	51%	40%	23%

19% used it weekly or more frequently.

The median amount of ecstasy consumed in a typical session

- 2 pills
- 2 capsules
- 0.30g crystal
- 0.30g powder

More participants in 2025 (89%) perceived the availability of all forms of ecstasy as 'easy' or 'very easy' compared to 2024 (86%).

Methamphetamine

Past six months reported use

Any form	Crystal	Powder	Base
29%	20%	12%	1%

Crystal - Smoked	Crystal - Injected	Powder - Snorted	Powder - Swallowing
84%	12%	80%	28%

Participants were more likely to smoke crystal and snort powder.

45% used it weekly or more frequently.

94% perceived crystal methamphetamine to be 'easy' or 'very easy' to obtain.

Cocaine

2024	2025
80%	79%
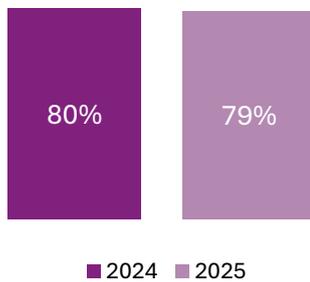
Past six months use of any cocaine remained stable between 2024 and 2025

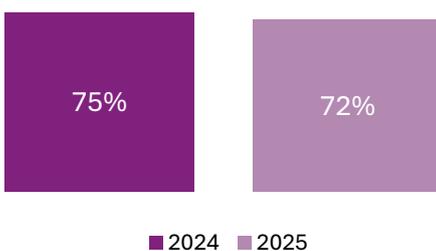**12%** used it weekly or more frequently.

$350 median price of a gram of cocaine.

85% Perceived cocaine to be 'easy' or 'very easy' to obtain.
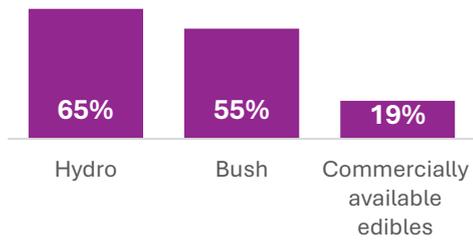
Cannabis and/or cannabinoid-related products

2024	2025
75%	72%

Past six months use remained **stable** between 2024 and 2025

61% used non-prescribed cannabis weekly or more frequently

38

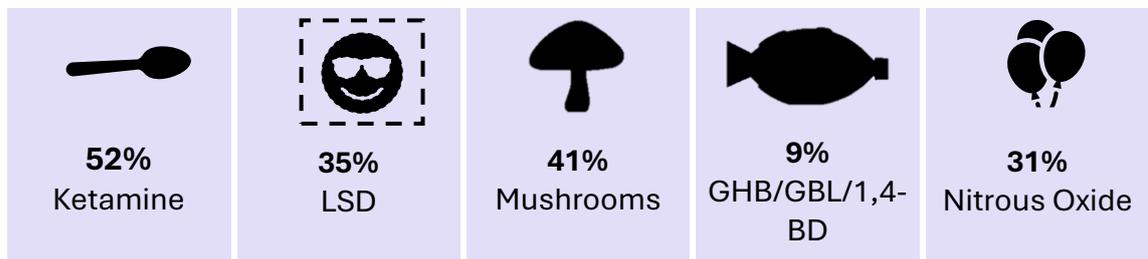**Most commonly used forms of non-prescribed cannabis**

65%	**55%**	**19%**
Hydro	Bush	Commercially available edibles

98% Hydro   98% Bush

Perceived to be **'easy'** or **'very easy'** to **obtain**
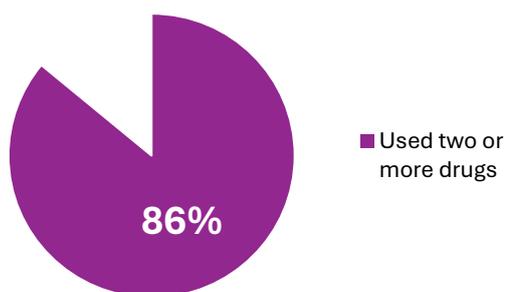
Past 6 months use of other illicit drugs

52% Ketamine	**35%** LSD	**41%** Mushrooms	**9%** GHB/GBL/1,4-BD	**31%** Nitrous Oxide

Drug-related harms

Overdoses in past year

22% Reported a non-fatal **depressant** overdose.	**18%** Reported a non-fatal **stimulant** overdose.

Polysubstance use

On last occasion of ecstacy or related drug use

■ Used two or more drugs

86%

Of 86% who reported using two or more drugs on the last occasion of ecstasy or related drug use:

- 34% used stimulants and depressants.
- 17% used stimulants, depressants, and cannabis.

Other behaviours

Drug checking

39% reported that they or someone else had tested the contents and/or purity of their illicit drugs in Australia in the past year.

Mental health

57% self-reported mental health problems while only 33% had seen a mental health professional.

Naloxone

73% of participants had heard of naloxone, while only 19% had obtained naloxone within the 12 months preceding the interview.

Hazardous alcohol use

73% of participants scored an 8 or more on the AUDIT scale, indicating past year hazardous alcohol use.

ILLICIT DRUGS REPORTING SYSTEM

Produced by: National Drug and Alcohol Research Centre

Reporting Commenced: 1997
Most Recent Report: 2025

Number of Reports to Date: 28

Purpose

The Illicit Drug Reporting System (IDRS) is a national monitoring system intended to identify emerging trends of local and national concern in illicit drug use and markets among people who regularly inject drugs. Its goal is to identify emerging trends and inform public health responses, harm reduction strategies, and law enforcement actions.

Data reported on

- Demographics such as age, gender, employment status, student status, and location.

- Patterns of drug use, including injecting drug use.

- Market characteristics, including availability, purity, and price of ecstasy and other party drugs.

- Drug-related harms, risks and harm reduction practices.

- Other behaviours (mental health, drug checking, stigma).

Methodology

The IDRS is an annual structured survey conducted by interviewers with people who inject drugs across all Australian capital cities. Recruitment is via advertisements at harm reduction services, drug user organisations, and word-of-mouth of participants. Participants are eligible to participate if they i) are at least 18 years of age ii) have injected illicit/non-prescribed substances on at least six days in the past six months, and iii) are resident of a capital city the interview is taking place for 10 of the past 12 months. Interviews are primarily conducted in person at needle and syringe programs, with a small number (10% in 2024) conducted over the phone (primarily in Hobart, Tasmania, and Perth).

Limitations

- **Focus on major cities:** Data is collected from participants living in urban areas, so the findings do not represent regional or remote drug use patterns.

- **Self-reported data**: The survey relies on self-reported data and cannot be verified for accuracy. Participants report drug use based on their belief of what they consumed, which may not reflect actual substances taken. Respondents may underestimate actual consumption levels, be unwilling to provide information about behaviour regarding illegal activities, incorrectly complete the survey, or mis-remember information.

- **Exclusion of occasional users**: The sample only includes people who inject drugs regularly, omitting those who may inject infrequently.

- **Recruitment bias:** Participants are often recruited through harm reduction services, which may attract those more engaged with health services and not capture the experiences of more hidden or less engaged populations. Additionally, some potential participants may be unwilling to engage due to fear of legal repercussions, stigma, or mistrust, leading to an underrepresentation of certain groups.

- **Non-representative sample**: The survey recruits people who are regular injecting drug users attending harm reduction services, and participation is voluntary, therefore the data cannot provide information on the prevalence or patterns of drug use in the general population level.

- **Methodological changes**: There have been changes in how the interview process has been conducted. Particularly the shift from face-to-face to phone or video interviews during the pandemic and beyond may have introduced new biases or inconsistencies in the data collection process, impacting the ability to compare data over time.

MOST RECENT IDRS REPORT: 2025

Key Findings

Please note, this summary provides a snapshot and overview of the key findings. For additional information, please refer to the full report (see above citation).
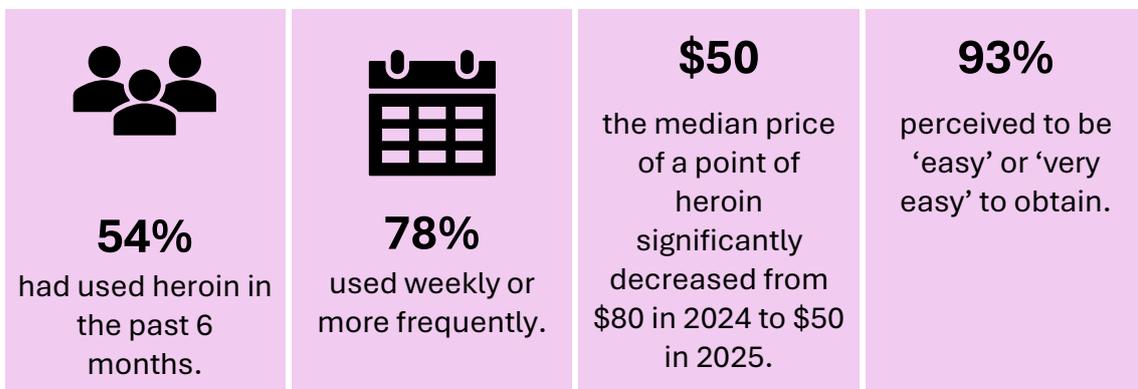
Data collection period: May-July 2025.
Sample size: 865 participants.

Sample characteristics

Median age 47 years

66 male

88% Unemployed

19% No fixed address

Drug use

Heroin

		$50 the median price of a point of heroin significantly decreased from $80 in 2024 to $50 in 2025.	**93%** perceived to be 'easy' or 'very easy' to obtain.
54% had used heroin in the past 6 months.	**78%** used weekly or more frequently.		

Methamphetamine

Past six months reported use

Any form	Crystal	Powder	Base
82%	79%	8%	3%
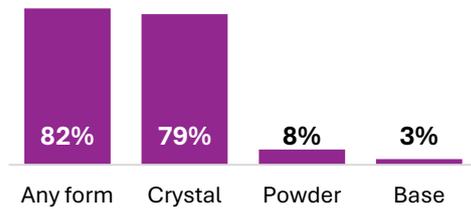
79% used weekly or more frequently.

$50 the median price of a point of crystal methamphetamine.

96% perceived to be 'easy' or 'very easy' to obtain.
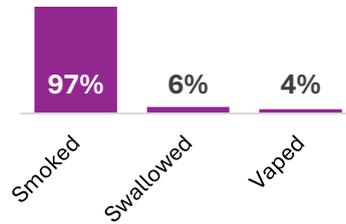
Cannabis and/or cannabinoid-related products

65% had used cannabis and/or cannabis-related products in the past six months.

50% used non-prescribed cannabis weekly or more frequently.

Smoked	Swallowed	Vaped
97%	6%	4%

The majority of participants smoked cannabis.

92% Hydro

85% Bush

Perceived to be 'easy' or 'very easy' to obtain.

Past six months use of other drugs

Non-prescribed morphine	Non-prescribed fentanyl	Non-prescribed oxycodone	GHB/GBL/1,4-B
9%	4%	10%	17%
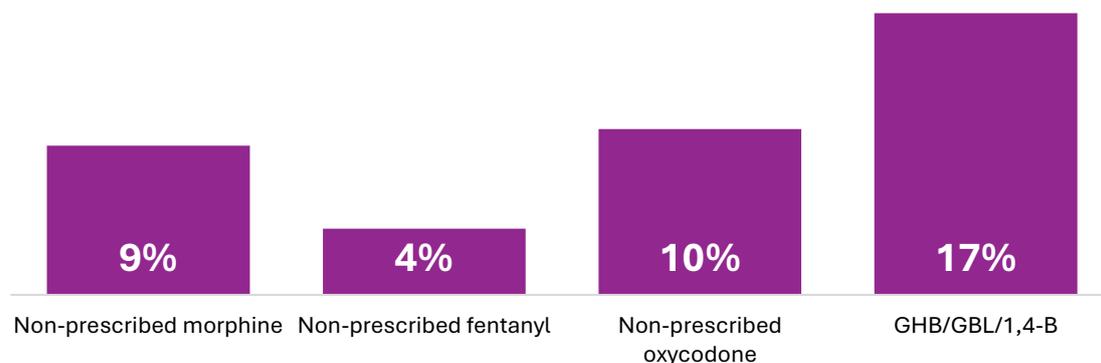
Injecting related harms and risks

← 5%	
→ 8%	

5% reported receptive sharing in the past 6 months, and 8% reported distributive sharing.

31%

Reported **re-using their own needles** in the past month.

35%

Reporting they had **injected someone else after injecting themselves** in the past month.

30% reported having an injection-related health issue in the past month.
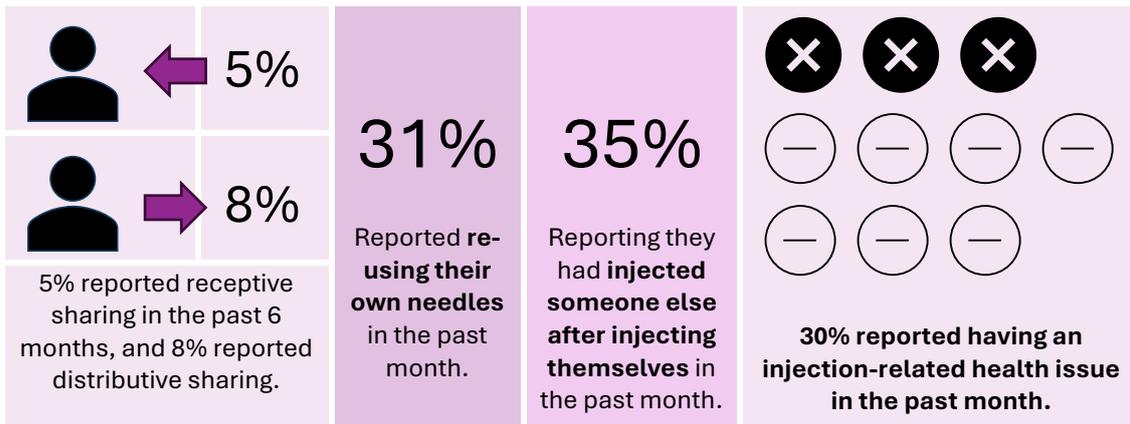
> **Receptive Sharing:** *"Using a needle after someone has else has used it" (IDRS,2025).*
>
> **Distribute Sharing:** *"Somebody else used a needle after them" (IDRS, 2025).*

Drug-related harms and help seeking

Overdose

19%
reported non-fatal overdose.

Drug treatment

38%
reported being currently in drug treatment.

Polysubstance use

Day preceding interview

66% ■ Used two or more drugs
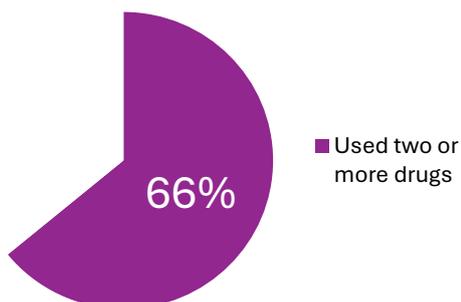
Of 66% who reported using two or more drugs on the day preceding the interview:

- 15% used stimulants and cannabis.
- 11% used opioids and cannabis.

Combining two or more drugs in the same syringe

18%
combined two or more drugs in the same syringe in the previous month. The majority had done so on **multiple occasions.**

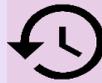| Last occasion	Previous month
+	76% Male
59.2%	65% Daily injecting
Most common combination of two or more drugs in the same syringe was **methamphetamine crystal and heroin**.	84% Used drugs for 48hours or more without sleep
	20% Any needle sharing

Harm reduction strategies and other harms

Drug checking

15%
reported that they or someone else had tested the contents and/or purity of their illicit drugs in Australia in the past year.

Mental health

55%
self-reported mental health problems in the past six months preceding the interview. The three most common mental health problems were depression (63%), anxiety (53%) and PTSD (32%).

Naloxone

80%
of participants had heard of naloxone, and 55% had obtained naloxone within the 12 months preceding the interview. 32% had reported ever using naloxone to resuscitate someone, and 18% had done so within the past year.

AUSTRALIAN NSP SURVEY

Produced by: Kirby Institute

Reporting Commenced: 1995 **Number of Reports to Date**: 29 (19 online)
Most Recent Report: 1995-2024

Purpose

The Australian NSP Survey (ANSPS) functions as a strategic early-warning system designed to monitor trends in injecting practices, sexual behaviour and prevalence of blood-borne viral infections (HIV and HCV) among people who inject drugs (PWID). It aims to inform national health strategies by monitoring prevalence of BBVs, inform service planning, and support advocacy and policy development.

Data reported on

- Demographic data including age, gender, sexual identity, country of birth, language spoken, ATSI status, incarceration and engagement in sex work.

- Injecting drug use patterns and risk behaviours.

- Engagement in drug treatment.

- Prevalence of HIV antibodies, HCV antibodies, HCV RNA prevalence.

- HCV treatment uptake.

Data collection method

The ANSPS is conducted annually over a one-two week period in October at participating NSPs across all Australian jurisdictions. All clients who attend participating NSPs are invited by NSP staff to complete a voluntary anonymous self-administered or assisted questionnaire and to provide a finger prick capillary dried blood sample for HIV and HCV testing. The staff record the age and gender of participants and refusals, and whether the person is a new or repeat client. This is used to calculate the ANSPS response rate.

The selection criteria for NSP participation in 1995 was based on the number of occasions of client service, willingness to participate, and representation across all Australian jurisdictions. The ANSPS has subsequently expanded to recruit additional NSPs who are invited to participate each year and maintains a national network of ~50 sentinel NSP services. NSP service participation is voluntary, as such the number of services and which services participate varies between years. Six services have participated every year since 1995, 15 have participated in 25 or more years.

Limitations

- **Service participation and sampling bias**: Not every NSP in Australia participates in the survey, and service participation is voluntary, leading to gaps in geographical coverage and potentially missing trends from certain regions. The survey only captures data from individuals who access the participating primary NSP services, meaning it may not reflect the experiences of those who access their equipment from secondary NSPs, SDMs, pharmacies, postal services or their peers. If this population is large, then the generalisability of the findings is limited.

- **Self-reported data**: The survey relies on self-reported data and cannot be verified for accuracy. Participants report drug use based on their belief of what they consumed, which may not reflect actual substances taken. Respondents may underestimate actual consumption levels, be unwilling to provide information about behaviour regarding illegal activities, incorrectly complete the survey, or mis-remember information.

- **Regional representation**: The data is collected from selected NSP sites in primarily metropolitan areas, which might not represent drug use patterns and harm reduction access in regional, rural, or remote regions.

- **Snapshot limitations:** Data is collected over a two-week period, missing clients who do not attend over this period. There is the potential to under-represent people who primarily or solely inject performance and image enhancing drugs (PIEDS) or methamphetamine who may inject less than daily or pick up equipment in larger quantities less frequently. This can potentially decrease the chances they will be recruited to the ANSPS.

- **Low response rate and non-response bias**: Participation is voluntary, and without financial reimbursement, individuals in a hurry, involved in illegal activities, or who are fearful of stigma or criminalisation from participation may be less likely to participate. The response rate for 2023 was 37% and ranged from 34% to 45% over the past five years (2019 -2023). While the ANSPS has a relatively low response rate we acknowledge that sentinel, cross sectional surveys of this kind have lower response rates over time that do not invalidate the findings but do indicate the need for careful interpretation and clear reporting of results focusing on trends-based analysis.

- **Methodological changes**: Changes in survey methodology over time, service participation, and the introduction of drug overdose, naloxone utilisation, use of PIEDs, homelessness and COVID-19-related questions affect the comparability of results across years.

- **Testing platform transition**: In 2023, there was a switch to a more sensitive HIV and HCV testing platform, which required a 12mm dried spot compared to 6mm. The change increased the number of insufficient samples (1.45% in 2022 increasing to 16.34% in 2023) but increased the detected HCV antibody prevalence (32% in 2022 to 45% in 2023), making comparisons to previous years difficult.

MOST RECENT ANSPS REPORT: 1995 -2024

Key Findings

Please note, this summary provides a snapshot and overview of the key findings related to illicit drug use and harm reduction. For additional information, please refer to the full report (see above citation).
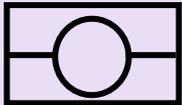
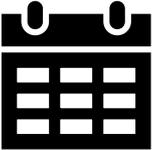|	
Data collection period:	The survey is administered in one-two week period in October.
Sample size:	65,079 participants over 30 years (sample sizes have ranged from 1,072 in 1995 to 2,742 in 2018). An average of 44 NSPs have participated. Six services have participated annually since 1995, and 54 services have participated for 10 or more years. Average response rate of 42%, with a range from 34% in 2022 to 60% in 1997.

Number of participating services by jurisdiction and year

	Establishment	Last five years				
	1995	2020	2021	2022	2023	2024
ACT	1	1	1	1	1	1
NSW	4	12	3	18	19	19
NT	2	3	3	3	3	3
QLD	4	7	11	10	10	10
SA	2	7	8	8	8	8
TAS	1	4	4	4	4	3
VIC	5	0	3	5	6	6
WA	1	4	4	4	4	4
TOTAL	20	37	37	53	55	54

Sample characteristics

Median age	**Gender**	**ATSI**
29yrs in 1995 45yrs in 2024	Around 2/3 have identified as male in all 30 years.	5% in 1995 26% in 2024

Young injectors	**Yrs since first injection**	**<3yrs since first injection**
Decline from a high of 36% in 1997 to 3% in 2024.	Declined from a low of 7yrs in 1998 to 25yrs in 2024.	Proportion of new initiates declined from a high of 19% in 1998 to 6% in 2024.

Imprisonment ever	**Sex work last month**	**Condom use last paid sex work**
45% in 2002 54% in 2024	5% in 1995 6% in 2024	85% in 1995 57% in 2024

Injecting behaviour

57% reported daily or more frequent injecting in the month prior in 2024.

Drug last injected

	The proportion of respondents reporting methamphetamine as the last drug injected increased from 22% in 1995 to 52% in 2024.
	Since 2005, has been the most commonly reported drug last injected, in 2024 it was reported by 52% of respondents.
	Heroin was the most commonly reported drug from 1995 (44%) to 2000 (56%). There was a sudden decline in 2001 to 30%, and in 2024 it was reported by 24% of respondents.
	Pharmaceutical opioid injecting rose from 5% in 1995 to 16% in 2010 and had declined from 2010 to 3% of respondents in 2024.

Receptive Sharing

Receptive sharing of needles and syringes in the last month declined from 31% in 1995 to 19% in 2024.

Receptive sharing of the drug mix and drug preparation equipment (spoons, water, or filters) has fluctuated within in a range of 37% to 25% since data was first collected in 2006. In 2024, this was reported as 31%. Spoons and water were the most commonly shared equipment.

Re-using of needles and syringes, including their own, has fluctuated within a range of 21% to 33% since data was first collected in 1997. In 2024, this was reported as 19%.

Overdose and naloxone

Non-fatal overdose self-reports in past 12 months has fluctuated since data collection for this began in 2013 from 11% to 19%. **In 2024 this was 15%.**

In 2024, **Naloxone had been obtained in the past 12 months by 38% of respondents.**

Drug treatment

	1995	2024
Ever any treatment/therapy	68%	69%
Ever engaged in OTP	56%	51%
Currently engaged in OTP	40%	30%

Blood-borne viruses (BBV)

BBV testing previous 12 months

HIV		HCV	
1995	**2024**	**1997**	**2024**
90%	75%	68%	49%

BBV Prevalence

	1995	2024	Trends	
HIV antibody prevalence	2.1%	2.0%	Fluctuated	HIV antibody prevalence has remained below 2.5% over the past 30 years. In all years, HIV antibody prevalence was **higher among homosexual men**, compared to bisexual or heterosexual men, and compared to women.
HCV antibody prevalence	63%	39%	Fluctuated	**HCV antibody prevalence was 60% or more in 1995 and between 2004 and 2008 and has remained below 50% from 107 onwards.** Across all survey years, prevalence of HCV antibody was **higher among older** than younger respondents and higher among those with **longer injection histories**.

	2015	2024	Trends	
HCV RNA prevalence	51%	8%	Declined	HCV RNA prevalence **declined among both males** (53% in 2015 to 9% in 2024) and **females** (45% in 2015 to 7% in 2024).

HCV treatment uptake

		2008	2024
Lifetime history of HCV treatment	⬆	10%	78%
HCV treatment in last 12 months	⬆	1%	37%

NEEDLE AND SYRINGE PROGRAM NATIONAL MINIMUM DATA COLLECTION

Produced/Published by: Kirby Institute, University of New South Wales

Reporting Commenced: 2016   **Number of Reports to Date:** 9
Most Recent Report: 2024

Purpose

The NSP NMDC provides a national and jurisdictional overview of NSP service delivery, including service/outlet type, syringe distribution, client demographics and health interventions. This data enables reporting against key NSP indicators outlined in the National Surveillance and Monitoring Plan for Australia's National Hepatitis C and National HIV Strategies.

Data reported on

- Data on services that provide sterile injecting equipment to PWID, including:
  - NSP service type: **primary NSP's** (services dedicate to PWID), **secondary NSPs** (services that operate within an existing health or community service but are not solely dedicate to PWID), community retail **pharmacy NSP,** and **syringe dispensing machines (SDMs)** (provide equipment via vending machines or dispensing chutes).
  - Method of service delivery: **fixed sites**, **outreach/mobile services,** formal **peer distribution**, and **postal distribution.**
  - Service location.

- Client level data including:
  - Demographic and behavioural data of NSP attendees, including age, gender, indigenous status, and frequency of drugs injected.
  - Health education interventions and referrals provided to clients.

- National distribution of needles and syringes through the public and pharmacy sector.

Data collection method

This report annually collects data each year from every state and territory health department on all NSPs outlet types and locations operating as of 30 June each year. Each jurisdiction also provides quarterly needle and syringe distribution reports from the public and pharmacy sector. In addition, states and territories provide client-level data on occasion of service (OOS) from public primary and secondary NSPs on a designated snapshot day during the last week of February. OOS data is collected by NSPs staff as part of their normal service operations

anytime they provide equipment to a client, as such clients do not provide direct consent to participate in this study.

Limitations

- **Incomplete pharmacy coverage:** The NSP NMDC does not collect data from community pharmacies that are not associated with a state/territory NSP scheme as it cannot be determined whether equipment was distributed for people who inject drugs or for other medical conditions. Consequently, the number of pharmacies and the amount of equipment distributed by pharmacies to people who inject drugs is under-estimated.

- **Limited reporting on service provision:** The NSP NMDC does not report on the full range of services and activities that NSP provide to people who inject drugs, such as nursing clinics, mental health support, or housing assistance. Thereby, it is not fully representing the broader harm reduction activities and impact NSPs offer.

- **Counting method for NSP sites:** The NSP NMDC counts NSP sites by combing the total primary + secondary + pharmacy + SDMs. If an SDM is connected to a NSP outlet it is counted as a separate service, potentially inflating the total NSP outlet count.

- **Underestimated client level and OOS data:** There is no system in place to record pharmacy OOS, some secondary NSP outlets do not have the capacity to collect OOS data, and not all NSPs participate in the snapshot data collection, as such the number of OSS is under-estimated.

- **Non-random sampling and self-selection bias:** Snapshot data on OOS is collected from a non-random sample of NPS. Participation is voluntary and some NSPs do not participate, which can impact the representativeness of client-level data.

- **Inconsistent drug reporting:** NSP NMDC data on injected drugs does not consistently specify if the drug reported was the one previously injected or intended for the next injection. Reporting standards vary across jurisdictions, leading to inconsistencies in drug use data.

- **Indigenous status data collection**: Data on Indigenous status is collected inconsistently between jurisdictions. One jurisdiction did not collect any Indigenous status data between 2019 - 2022 and another missed this data in 2019. While five jurisdictions followed the ABS standard for collecting Indigenous status, one jurisdiction used a simplified yes/no format, limiting the depth and consistency of demographic information on Indigenous clients. This inconsistency impacts the comparability of Indigenous data across regions, potentially underrepresenting Indigenous clients.

- **Snapshot limitations:** Data is collected on a single snapshot day, missing any clients who do not attend. There is the potential to under-represent people who primarily or solely inject performance and image enhancing drugs (PIEDS) or methamphetamine who may inject less than daily or pick up equipment in larger quantities less frequently.

MOST RECENT NSP NMDC REPORT: 2024

Key Findings

Please note, this summary provides a snapshot and overview of the key findings. For additional information, please refer to the full report (see citation above)

Data Collection Period: February 2024 snapshot day.
Sample Size:
- 4,708 NSPs.
- 2,084 occasions of service.
- 54.6 million needles and syringes distributed.

Australia's NSP Network
4,708 services

112 Primary
918 Secondary
3,220 Pharmacy
458 Syringe Dispensing Machines (SDM)

43
727
1,180
419
1,236
68
90
129
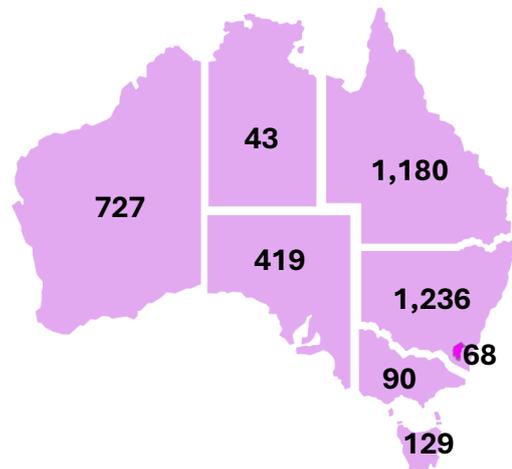
Syringe distribution

	Primary	Secondary	Pharmacy	SDMs
ACT	2	14	42	10
NSW	32	242	666	296
NT	3	13	19	8
QLD	19	141	935	85
SA	8	77	315	19
TAS	7	20	97	5
VIC	20	302	557	27
WA	21	109	589	8

Over the past five years (2020-2024):

10% increase in primary, secondary and pharmacy NSPs
24% increase in SDMs.

In 2023/2024:

54.6 million needle and syringes distributed to an estimated population of 72,984 people who inject drugs (excluding people who inject occasionally).

This equates to 749 needles/syringes each per annum, exceeding the UNAIDS definition of high syringe coverage by more than three-fold. Syringe coverage (syringes per injection) remained high at 121% in 2023/24.

Over the past five years (2019/20-2023/24):

5% decrease in syringe distribution.

9% decline per capita in syringe distribution to Australian population aged 15-64yrs.

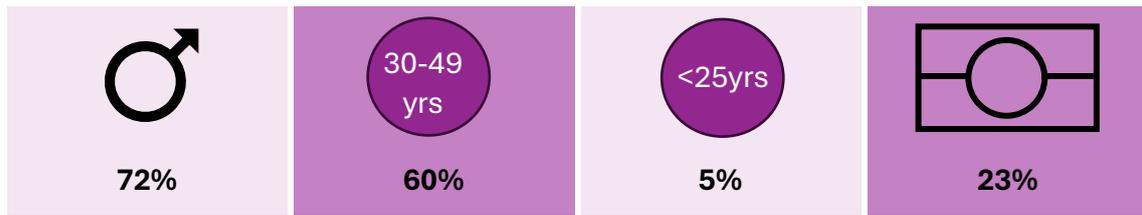## Occasions of service

Snapshot Day 2024

- 2,084 NSP occasions of service (OOS) were recorded at primary and secondary NSPs.
- 1/3 OOS also involved health education or intervention.
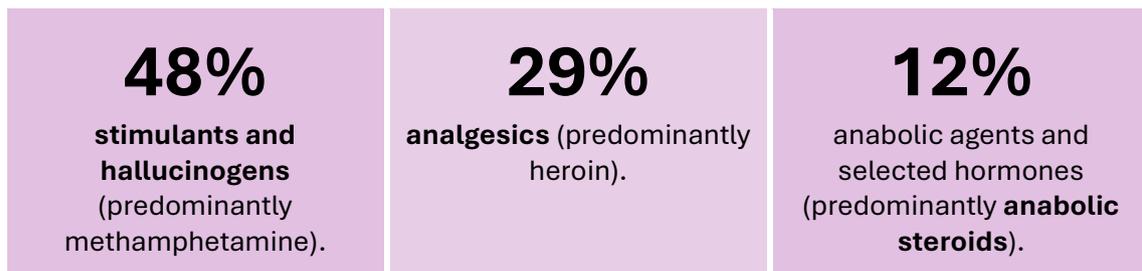- 10% involved a referral.

Over the past five years (2020-2024):

16% decline in the estimated annual OOS observed.

Client demographics

♂ **72%**	30-49 yrs **60%**	<25yrs **5%**	**23%**

Reported drug

48%	**29%**	**12%**
stimulants and hallucinogens (predominantly methamphetamine).	**analgesics** (predominantly heroin).	anabolic agents and selected hormones (predominantly **anabolic steroids**).

DATA SET COMMENTARY

The national routine data sets presented in this report provide important insights into drug use, drug-related harms, NSPs and opioid treatment in Australia. Each data set brings unique strengths to understanding the scope and patterns of substance use, yet as with all studies, there can be methodology-related and other limitations that can affect the comprehensiveness and/or applicability of the data for various communities and regions including:

Population coverage and inclusion

While the data sets covered in this report collect detailed data on drug use trends, methodology limitations may miss some highly marginalised populations, such as the NDSHS exclusion of people who are homeless, living in institutional settings, and the IDRS and the ANSPS collecting data from people already engaged with NSPs. These exclusion/limitations can obscure the full spectrum of drug use and associated risks among people, who may have distinct needs and face unique challenges in accessing harm reduction services.

Urban vs. regional representation

The focus of many data sets, including EDRS, IDRS, ANSPS is primarily populations in urban/major regional centres. Consequently, these data sets may not adequately reflect patterns in smaller regional, rural and remote areas, where access to services and the types of drugs used may differ. Expanding geographic reach would enhance the understanding of regional/rural needs and provide more comprehensive support for harm reduction initiatives in these often-underserved areas.

Scope of harm reduction initiatives

Existing data sets are primarily focused on illicit drug use and injecting behaviours (often reflecting the historical development of these monitoring systems within the context of blood-borne virus prevention, diagnosis and treatment). While ongoing monitoring of these issues remains critical, further work is needed to ensure broader harm reduction initiatives such as naloxone distribution, drug checking services, drug consumption rooms, festival harm reduction initiatives, and peer-based harm reduction programs are also included in our key monitoring systems moving forward. Harm reduction encompasses diverse practices and initiatives future data collection could include these emerging areas to provide a more comprehensive view of harm reduction's impact and scope across Australia.

National minimum data collection standards

NSP NMDC's inconsistencies in Indigenous status reporting highlights the need for standardisation. Inconsistencies in other data sets included in this report (including differences in prescriber data reporting in NOPSAD), underscore the need for a set of nationally aligned data standards to improve data collection, cross-state comparisons and help establish a unified framework for harm reduction policy and programmatic assessment.

Focus on harm and risk

Most data sets concentrate on the harms, risks, and negative health outcomes associated with drug use, often overlooking the broader experiences and motivations of people who use drugs. This emphasis can perpetuate a view of all drug use as inherently risky, reinforcing stigma and limiting a balanced understanding of diverse drug use patterns. Incorporating a broader range of experiences could contribute to a public discourse and service provision that is more nuanced and has less stigmatised view of drug use.