

Northern Territory Drug Trends 2025: Key Findings from the Illicit Drug Reporting System (IDRS) Interviews

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NORTHERN TERRITORY DRUG TRENDS 2025

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



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

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

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

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Research Team

The National Drug and Alcohol Research Centre (NDARC), UNSW Sydney, coordinated the IDRS. The following researchers and research institutions contributed to the IDRS in 2025:

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

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

Participants

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

Contributors

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

Abbreviations

ACT	Australian Capital Territory
1,4-BD	1,4-Butanediol
AIVL	Australian Injecting & Illicit Drug Users League
ALPHA-PVP	α -Pyrrolidinopentiophenone
AOD	Alcohol and Other Drugs
AUDIT-C	Alcohol Use Disorder Identification Test - Concise
CBD	Cannabidiol
COVID-19	Coronavirus Disease of 2019
DSM	Diagnostic and Statistical Manual of Mental Disord
EDRS	Ecstasy and Related Drugs Reporting System
GBL	Gamma-butyrolactone
GHB	Gamma-hydroxybutyrate
GP	General Practitioner
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDRS	Illicit Drug Reporting System
IQR	Interquartile range
K10	Kessler-10
LSD	<i>d</i> -lysergic acid
MDA	3,4-methylenedioxymphetamine
MDPV	Methylenedioxypyrovalerone
N (or n)	Number of participants
NT	Northern Territory
NDARC	National Drug and Alcohol Research Centre
NHS	National Health Survey
NPS	New Psychoactive Substances
NSP	Needle and Syringe Program
NSW	New South Wales
OTC	Over-the-counter
PBS	Pharmaceutical Benefits Scheme
PCR	Polymerase Chain Reaction

QLD	Queensland
RNA	Ribonucleic Acid
SA	South Australia
SD	Standard Deviation
SDS	Severity of Dependence Scale
STI	Sexually Transmitted Infection
TAS	Tasmania
TGA	Therapeutic Goods Administration
THC	Tetrahydrocannabinol
UNSW	University of New South Wales
VIC	Victoria
WA	Western Australia
WHO	World Health Organization

Executive Summary

The IDRS sample comprises a sentinel group of people aged 18 years or older who injected illicit drugs ≥ 6 days in the preceding six months and resided in greater Darwin, Northern Territory. Participants were recruited via advertisements in needle and syringe programs and other harm reduction services, as well as via peer referral. The results are not representative of all people who use illicit drugs, nor of use in the general population.

Data were collected between May and June 2025. Interviews were delivered face-to-face as well as via telephone, to reduce risk of COVID-19 transmission; all interviews prior to 2020 were conducted face-to-face. This methodological change should be factored into all comparisons of data from the 2020-2025 samples relative to previous years.

Sample Characteristics

The IDRS sample recruited from Darwin, Northern Territory (NT) in 2025 (N=53) was largely consistent with samples recruited in previous years, whereby three-fifths (60%) were male (61% in 2024), with a median age of 46 years (49 years in 2024). Four fifths (81%) of the sample were unemployed at the time of interview (86% in 2024), and most (91%) had received a government pension/allowance or benefit in the month prior to interview (94% in 2024). The median income per week was \$500, a significant increase from \$450 in 2024 ($p=0.013$). Current accommodation significantly changed between 2024 and 2025 ($p=0.028$), with more participants reporting no fixed address in 2025 (25%; 14% in 2024), although the majority (66%) continued to report living in a private house/flat (66% in 2024).

In 2025, three quarters (74%) of the sample reported that methamphetamine was their

drug of choice (59% in 2024), and 89% reported that methamphetamine was the drug they had injected most often in the past month, the highest per cent observed since monitoring commenced, although stable from 2024 (86%). Four fifths (79%) of the sample reported using methamphetamine crystal on a weekly or more frequent basis, also stable from 2024 (79%).

Heroin

Recent use of heroin has declined substantially since monitoring commenced, from 64% of the sample in 2000 to few participants ($n \leq 5$) reporting recent use in 2025.

Methamphetamine

Recent use of any methamphetamine has trended upwards since 2014, with 96% of the sample reporting recent use in 2025 (87% in 2024). This was driven entirely by an increase in methamphetamine crystal use – the form most commonly used since 2014 – such that, in 2025, crystal was the only form of methamphetamine used by participants. That is, no participants reported recent use of methamphetamine powder or methamphetamine base in 2025. The median price for one point of methamphetamine crystal was \$100, stable relative to 2024 (\$100). The perceived purity and availability of methamphetamine crystal also remained stable in 2025, relative to 2024. Among those who commented in 2025, half (51%) perceived methamphetamine crystal to be of 'medium' purity (42% in 2024) and 98% perceived it to be 'easy' or 'very easy' to obtain (88% in 2024).

Cocaine

Recent use of cocaine has remained relatively low over time, with less than one quarter of the sample reporting recent use since monitoring commenced in 2000. In 2025, 15% of the sample reported recent use on a median of one

day in the six months preceding interview, stable from 2024. In 2025, few participants ($n \leq 5$) commented on the price, perceived purity and perceived availability of cocaine.

Cannabis and/or Cannabinoid-Related Products

Recent use of non-prescribed cannabis and/or cannabinoid-related products gradually declined between 2000 (84%) and 2017 (58%) and has remained relatively stable since. In 2025, three fifths (60%) of the sample reported recent use, stable from 2024 (69%). Among those who reported recent use of non-prescribed cannabis and/or cannabinoid-related products in 2025, 56% reported daily use (77% in 2024), with hydroponic cannabis remaining the form most commonly used (100%; 96% in 2024). Few participants ($n \leq 5$) reported recent use of any other forms of cannabis. The perceived purity and availability of hydroponic cannabis remained stable in 2025, relative to 2024. Among those who commented in 2025, all participants (100%) perceived hydroponic cannabis as 'easy' or 'very easy' to obtain (100% in 2024), and a majority (96%) perceived it to be of 'medium' or 'high' potency (54% and 42%, respectively).

Pharmaceutical Opioids

Recent use of all non-prescribed opioids has gradually declined over the course of monitoring. Fifteen per cent of participants reported recent use of non-prescribed morphine in 2025, stable relative to 2024 (14%). Few participants ($n \leq 5$) reported use of other non-prescribed opioids in 2025.

Other Drugs

Eleven per cent of the sample reported recent use of pregabalin in 2025 ($n \leq 5$ in 2024), while few participants ($n \leq 5$) reported recent use of non-prescribed benzodiazepines, antipsychotics, gabapentin or any NPS.

Three fifths (62%) of the sample reported recent use of alcohol (53% in 2024), and 81% reported recent use of tobacco (89% in 2024). Thirteen per cent reported recently using illicit tobacco in 2025 ($n \leq 5$ in 2024), while few participants ($n \leq 5$, respectively) reported recent use of non-prescribed e-cigarettes (11% in 2024) or GHB/GBL/1,4-BD ($n \leq 5$ in 2024).

Drug-Related Harms and Other Behaviours

Polysubstance use and bingeing

In 2025, 55% of the sample reported using two or more drugs (excluding tobacco and e-cigarettes) on the day preceding interview.

Forty-six per cent of the sample had binged on one or more drugs for 48 hours or more in the six months preceding interview (59% in 2024).

Injecting behaviours and equipment access

In 2025, few participants ($n \leq 5$) reported receptive or distributive sharing of a needle in the past month ($n \leq 5$ in 2024, respectively). Almost one fifth (17%) reported re-using their own needles in the past month (19% in 2024). Few participants ($n \leq 5$) reported difficulty accessing needles and syringes, filters or sterile water in the past month.

Few participants ($n \leq 5$) reported experiencing any injection-related problems in the past month ($n \leq 5$ in 2024).

Overdose, naloxone and drug checking

Few participants ($n \leq 5$) reported any past 12-month non-fatal overdose ($n \leq 5$ in 2024).

Two fifths (42%) reported lifetime awareness of take-home naloxone (39% in 2024) and one fifth (21%) reported obtaining naloxone in the past year (10% in 2024).

In 2025, few participants ($n \leq 5$) reported that they or someone else had tested the contents

and/or purity of their illicit drugs in Australia in the past year (0% in 2024).

Dependence, drug treatment and HCV

In 2025, 53% of male participants obtained an AUDIT-C score of ≥ 4 (33% in 2024), and 43% of female participants obtained a score of ≥ 3 (35% in 2024), indicative of hazardous alcohol use. The mean AUDIT total score was 3.1, a significant increase from 2.9 in 2024 ($p=0.002$).

Fifty-three per cent of those who reported recent methamphetamine use obtained an SDS score of ≥ 4 , indicating possible dependence, a significant increase from 2024 (26%; $p=0.005$). Few participants ($n \leq 5$) reporting recent opioid use obtained a score of ≥ 5 , indicating possible dependence ($n \leq 5$ in 2024).

Few participants ($n \leq 5$) reported that they were in any drug treatment for their substance use in 2025 (11% in 2024).

Two fifths (42%) of participants reported that they had received a hepatitis C virus (HCV) antibody test in the past year (58% in 2024) and 21% had received a PCR or RNA test in the past year, a significant decrease from 46% in 2024 ($p=0.012$). Few participants ($n \leq 5$) reported having a current HCV infection (0% in 2024). One fifth (21%) of the sample reported having had a test for human immunodeficiency virus in the past six months (20% in 2024).

Sexual activity, mental health and health service access

Three fifths (62%) of the sample reported engaging in sexual activity in the month preceding interview (50% in 2024) and 24% reported a sexual health check-up in the six months preceding interview (16% in 2024).

One quarter (25%) of the 2025 sample self-reported experiencing a mental health problem in the six months preceding interview (37% in 2024), with few participants ($n \leq 5$) citing specific mental health problems.

The K10 score remained stable between 2024 and 2025, with 17% of participants having a score of 30 or more (30% in 2024), indicating a high likelihood of having a mental health problem, and possibly requiring clinical assistance.

Four fifths (81%) reported accessing any health service for alcohol and/or drug support (AOD) in the six months preceding interview, a significant increase from 30% in 2024 ($p<0.001$). This was largely driven by a significant increase in participants accessing an NSP for AOD support in 2025 (77%; 27% in 2024; $p<0.001$).

Driving, contact with police and modes of purchasing drugs

Two thirds (64%) of those who had recently driven reported driving within three hours of consuming an illicit or non-prescribed drug in the past six months (78% in 2024), though few participants ($n \leq 5$) reported driving while over the perceived legal limit of alcohol ($n \leq 5$ in 2024).

Two fifths (41%) of participants reported engaging in 'any' crime in the month preceding interview (36% in 2024). Few participants ($n \leq 5$) reported having been arrested in the past year ($n \leq 5$ in 2024) or having a drug-related encounter with police which did not result in charge or arrest ($n \leq 5$ in 2024).

In 2025, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (96%; 94% in 2024). Eleven per cent reported arranging the purchase of illicit drugs via text messaging, a significant decrease from 2024 (33%; $p=0.012$). Few participants ($n \leq 5$) reported arranging the purchase of illicit or non-prescribed drugs via a phone call, also a significant decrease from 2024 (44%; $p<0.001$).

2025 SAMPLE CHARACTERISTICS

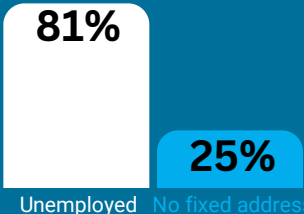


Between May-June, 2025, 53 participants recruited from Darwin, NT, were interviewed.



46 years **Male**

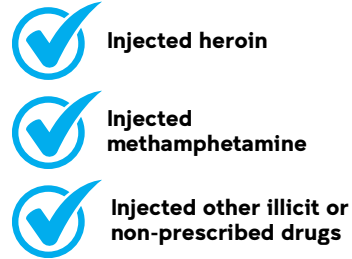
Median age and per cent who identified as male.



81% **25%**

Unemployed No fixed address

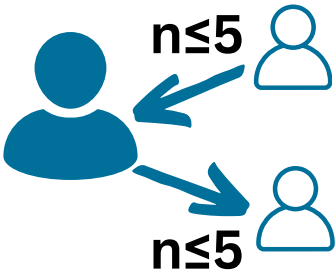
In the 2025 sample, 81% were unemployed and 25% had no fixed address.



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

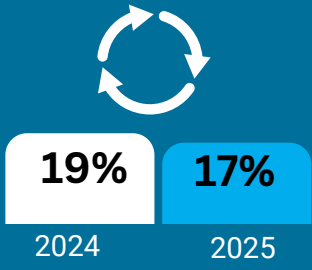
Participants were recruited on the basis that they had injected drugs at least 6 days in the previous 6 months.

INJECTING-RELATED RISKS AND HARMS



n≤5 **n≤5**

Few participants (n≤5) reported receptive sharing in the past month, and few participants (n≤5) reported distributive sharing.



19% **17%**

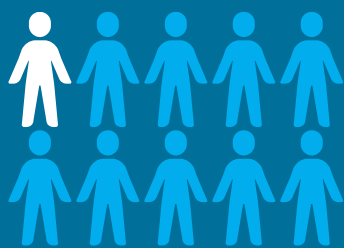
2024 2025

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



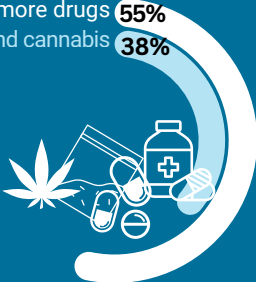
30%

Percentage who reported injecting someone else in the past month.



Few participants (n≤5) reported having an injection-related health issue in the past month.

OTHER HARMS



55% **38%**

Two or more drugs Stimulants and cannabis

In 2025, 55% reported using two or more drugs on the day preceding interview: the most commonly used combination of drug classes was stimulants and cannabis (38%).



n≤5 **n≤5**

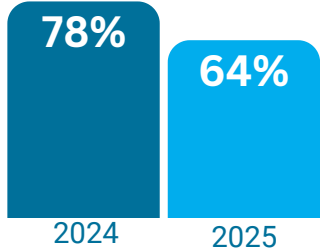
2024 2025

In 2025, few participants (n≤5) reported past year non-fatal overdose.



25%

In 2025, 25% of participants reported a mental health problem in the 6 months preceding interview.

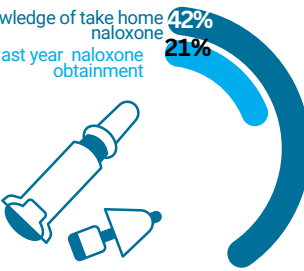


78% **64%**

2024 2025

Driving under the influence of non-prescribed drugs remained stable in 2025, relative to 2024.

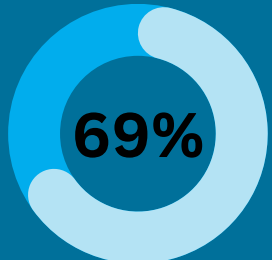
NALOXONE AND OTHER HARM REDUCTION STRATEGIES



42% **21%**

Knowledge of take home naloxone Past year naloxone obtainment

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



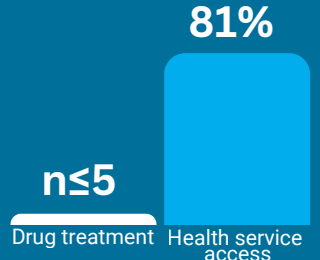
69%

Among those who reported obtaining naloxone at least once in their lifetime (n=9), 69% had a median of one naloxone kit stored away at the time of interview.



n≤5

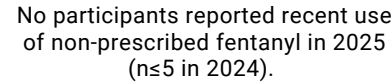
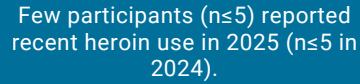
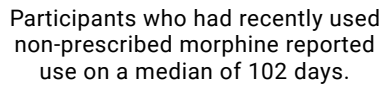
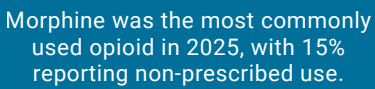
Few participants (n≤5) reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year.



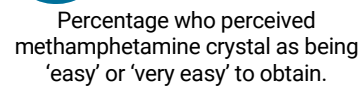
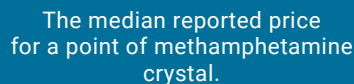
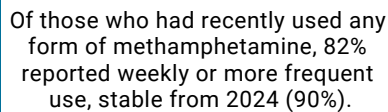
n≤5 **81%**

Drug treatment Health service access

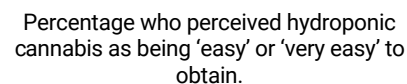
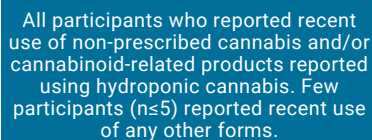
Percentage who reported current drug treatment and health service access for AOD support in the past six months.



Past 6 month use of methamphetamine. No participants reported recent use of powder or base methamphetamine in 2025.



Of those who had recently used non-prescribed cannabis/cannabinoid-related products, 56% reported daily use, stable from 2024 (77%).



Year	Percentage	Count
2024	0%	
2025		$n \leq 5$

n≤5	n≤5
2024	2025

Year	Percentage
2024	$n \leq 5$
2025	11%

Diagram illustrating the number of nodes (n) for the years 2024 and 2025. Both years are represented by a box labeled $n \leq 5$.

Background

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

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

Methods

IDRS 2000-2019

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

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

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

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

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

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

2025 IDRS Sample

Between 26 May-12 July 2025, a total of 865 participants were recruited across capital cities nationally, with 53 participants recruited from Darwin, NT between 26 May-30 June 2025. All interviews were conducted face-to-face.

In 2025, 85% of participants were recruited via Needle Syringe Programs (NSP). Fifty-five per cent of participants in the Darwin 2025 sample had taken part in the 2024 interview (38% of the 2024 sample had taken part in the 2023 interview; $p=0.101$).

Data Analysis

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

Guide to Table/Figure Notes

Table 1: Guide to Table/Figure Notes

Legend	
/	Question not asked in respective year (for tables)
~	Data not presented for Darwin in 2023 due to small sample
-	Missing data points indicate question not asked in respective year or $n \leq 5$ answered the question (for figures)
	Missing data points indicate question not asked in respective year (for figures)
*$p < 0.050$; **$p < 0.010$; ***$p < 0.001$	Statistical significance between 2024 and 2025

Interpretation of Findings

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

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

Additional Outputs

[Infographics](#) and the [executive summary](#) from this report are available for download. There are a range of outputs from the IDRS which triangulates key results from the annual interviews and other data sources and consider the implications of these findings, including national reports, jurisdictional reports, bulletins, and other resources available via the [Drug Trends webpage](#). This includes results from the [Ecstasy and Related Drugs Reporting System \(EDRS\)](#), which focuses on the use of ecstasy and other stimulants.

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

1

Sample Characteristics

In 2025, the median age of the Darwin sample was 46 years (IQR=37-52; 49 years in 2024; IQR=40-53; $p=0.308$). Gender remained stable ($p=0.914$) with a distribution of 60% male and 40% female (61% and 37% in 2024, respectively) (Table 2). Fifty-four per cent of the sample identified as Aboriginal or Torres Strait Islander (51% in 2024; $p=0.851$). The majority (91%) of participants were born in Australia (94% in 2024; $p=0.497$) and spoke English at home (98%; 100% in 2024; $p=0.431$).

Employment status remained stable between 2024 and 2025 ($p=0.593$), whereby four fifths of participants (81%) were unemployed at the time of interview (86% in 2024), and 11% reported part time/casual employment (11% in 2024). Participants reported a mean of 10 years of school in 2025 (range: 7-12) (10 years in 2024; range=7-12; $p=0.478$). Ninety-one per cent had received a government pension, allowance, or benefit in the prior to interview (94% in 2024; $p=0.497$), with a median weekly income of \$500 (IQR=400-606), representing a significant increase relative to 2024 (\$450; IQR=350-550; $p=0.013$). Accommodation status significantly changed between 2024 and 2025 ($p=0.028$), with one quarter (25%) who reported having 'no fixed address', an increase from 14% in 2024. Two thirds (66%) reported living in a private house/flat at the time of interview (66% in 2024) (Table 2).

Drug of choice remained stable between 2024 and 2025 ($p=0.102$). In 2025, almost three quarters (74%) of participants nominated methamphetamine as their drug of choice (59% in 2024), followed by heroin (11%; 17% in 2024) (Figure 1). Drug injected most often in the past month also remained stable between 2024 and 2025, with the majority (89%) of participants reporting that methamphetamine was the drug injected most often in the past month (86% in 2024), overtaking morphine (11%; 13% in 2024), which has been steadily declining since 2014 (Figure 2).

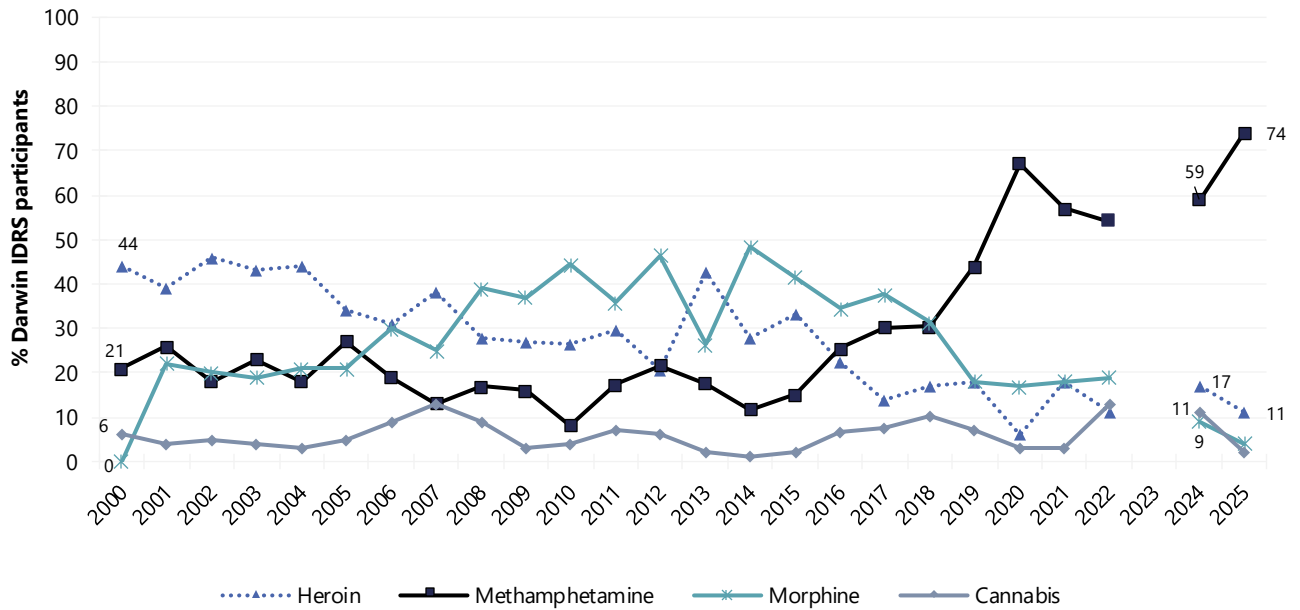
Seventy-nine per cent of the sample reported weekly or more frequent use of methamphetamine crystal in 2025 (79% in 2024), the highest percentage since monitoring commenced and continuing an upward trend that has been observed since 2014. Forty-nine per cent of the sample reported weekly or more frequent use of non-prescribed cannabis (66% in 2024; $p=0.072$) (Figure 3).

Table 2: Demographic characteristics of the sample, nationally, 2025, and Darwin, NT, 2021-2025

	Darwin, NT					National
	2021	2022	2023	2024	2025	2025
	N=94	N=70	N=46	N=70	N=53	N=865
Median age (years; IQR)	45 (37-54)	46 (41-54)	~	49 (40-53)	46 (37-52)	47 (41-54)
% Gender						
Female	35	39	~	37	40	34
Male	65	61	~	61	60	66
Non-binary	0	0	~	-	0	1
% Aboriginal and/or Torres Strait Islander	37	36	~	51	54	29
% Born in Australia	/	/	/	94	91	91
% English primary language spoken at home	/	/	/	100	98	98
% Sexual identity						
Heterosexual	77	83	~	81	83	82
Homosexual	-	-	~	-	-	5
Bisexual	19	14	~	16	-	9
Queer	-	0	~	-	0	2
Other	0	-	~	0	-	1
Mean years of school education (range)	10 (2-12)	10 (2-12)	~	10 (7-12)	10 (7-12)	10 (1-12)
% Post-school qualification(s)^	52	54	~	56	43	57
% Current accommodation					*	
Own home (<i>inc. renting</i>)^	73	81	~	66	66	66
Parents'/family home	-	-	~	9	0	5
Boarding house/hostel	9	7	~	9	-	4
Shelter/refuge	-	-	~	0	-	4
No fixed address	10	-	~	14	25	19
Other	-	0	~	-	-	1
% Current employment status						
Unemployed	83	86	~	86	81	88
Full-time work	7	-	~	-	-	3
Part time/casual	/	/	~	11	11	6
Self-employed	/	/	~	0	0	2
Other	/	/	~	0	0	0
% Past month gov't pension, allowance or benefit	91	96	~	94	91	94
Current median income/week (\$; IQR)	\$384 (300-475)	\$425 (350-500)	~	\$450 (350-550)	\$500 * (400-606)	465 (375-598)

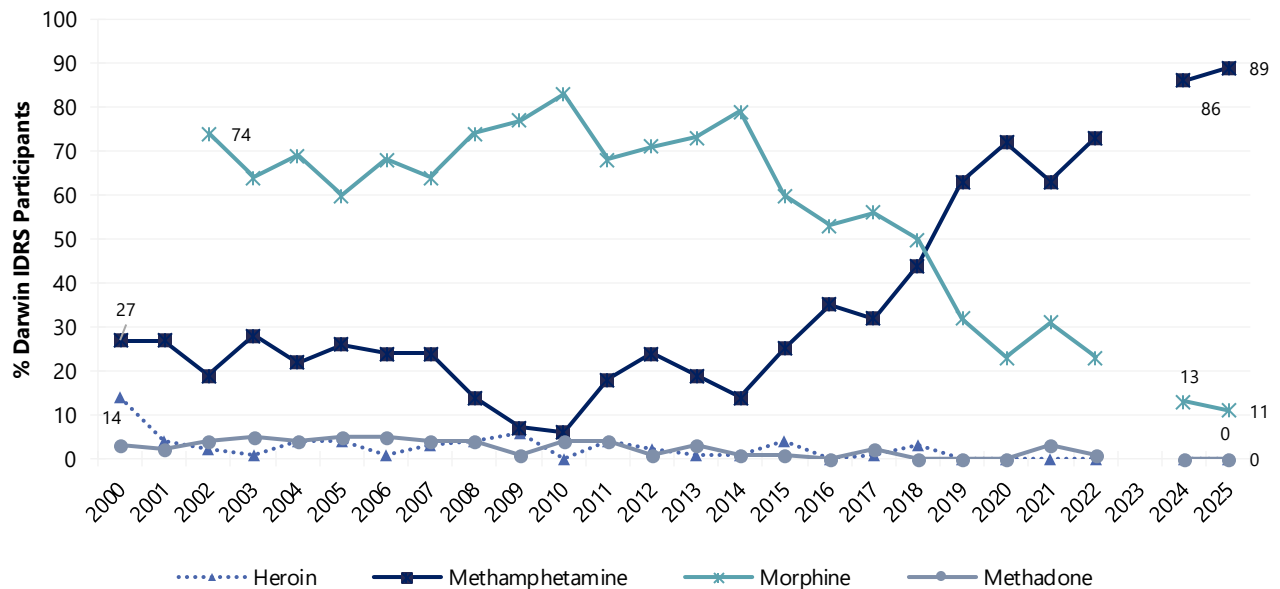
Note. ^Includes trade/technical and university qualifications. ~Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 among the Darwin sample is presented in table; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 1: Drug of choice, Darwin, NT, 2000-2025



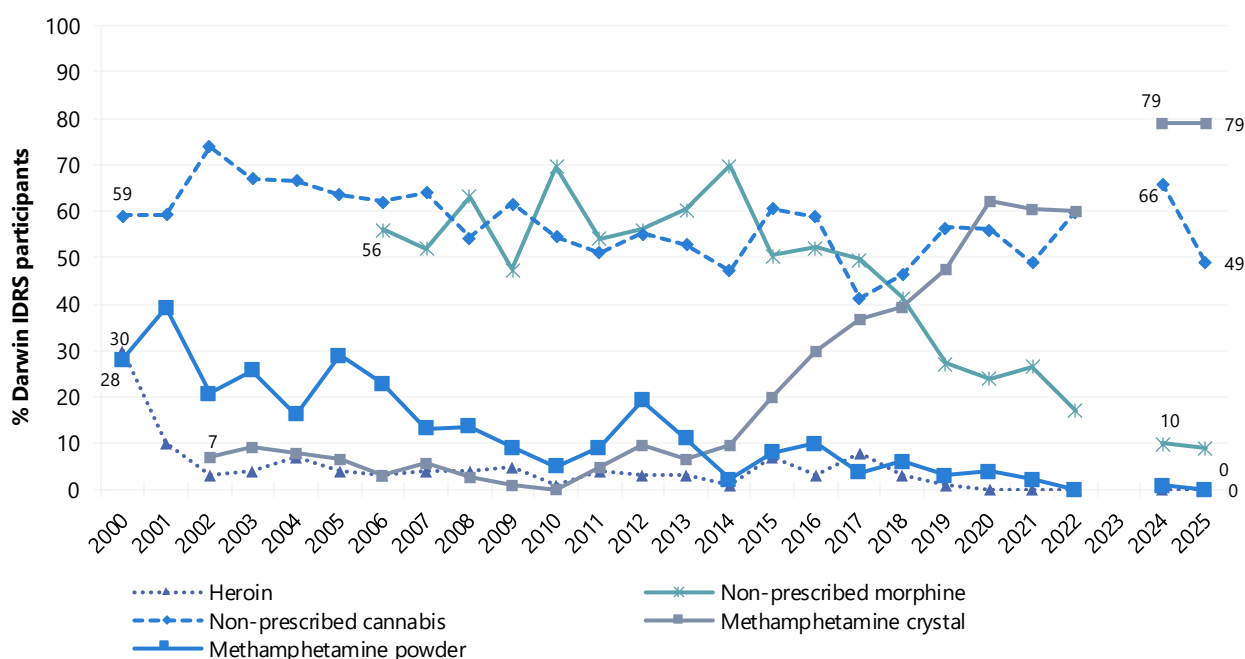
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; a nominal percent endorsed other substances. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 2: Drug injected most often in the past month, Darwin, NT, 2000-2025



Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; a nominal percent endorsed other substances. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

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



Note. Computed of the entire sample regardless of whether they had used the substance in the past six months. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Further, from 2022, we captured use of 'cannabis and/or cannabinoid-related products', while in previous years questions referred only to 'cannabis'. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

2

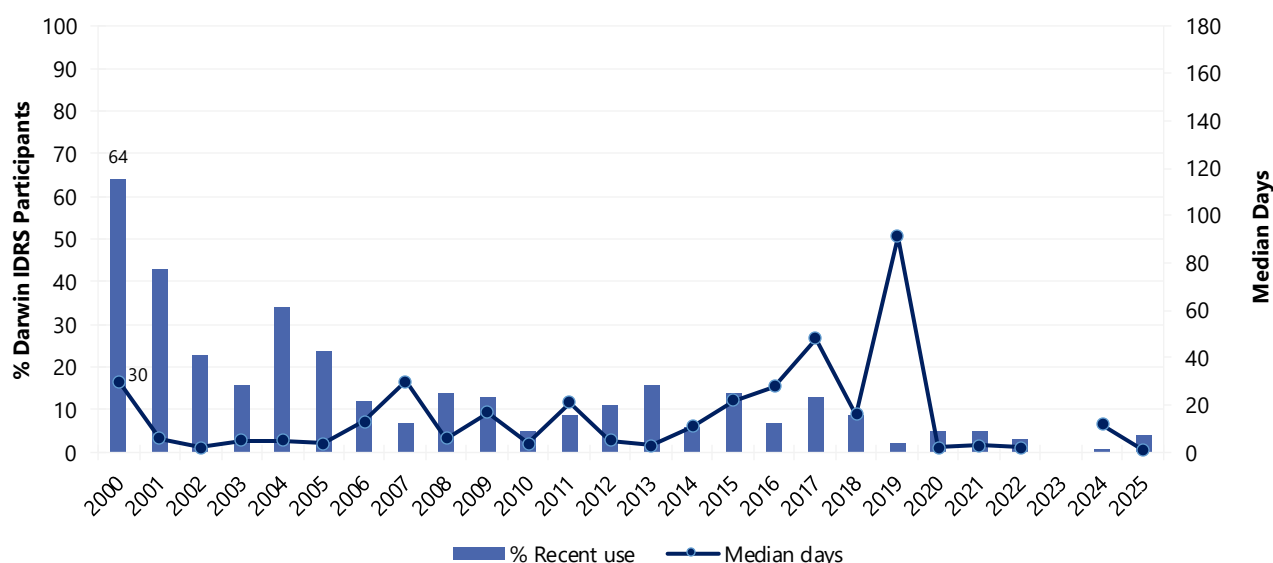
Heroin

Participants were asked about their recent (past six month) use of heroin and homebake heroin. Participants typically describe heroin as white/off-white rock, brown/beige rock or white/off-white powder. Homebake is a form of heroin illicitly produced from pharmaceutical opioid products.

Patterns of Consumption

Few participants ($n \leq 5$) reported recent heroin use in 2025 (Figure 4), therefore, further details regarding frequency of use, routes of administration and quantity of use are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 4: Past six month use and frequency of use of heroin, Darwin, NT, 2000-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Price, Perceived Purity and Perceived Availability

Due to few participants ($n \leq 5$) responding, details on the price, perceived purity and perceived availability of heroin are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

3

Methamphetamine

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

Patterns of Consumption (Any Methamphetamine)

Recent Use (past 6 months)

Since declining from 74% in 2000 to 35% in 2014, past six month use of any methamphetamine use has gradually increased. In 2025, 96% of the sample reported recent use, the highest percent observed since monitoring commenced (87% in 2024; $p=0.113$) (Figure 5).

Frequency of Use

Median days of use remained relatively stable between 2002 and 2016, however, since 2017, has fluctuated considerably. Participants who reported recent use and commented in 2025 ($n=51$) had used any methamphetamine on a median of 72 days (IQR=24-98; 72 days in 2024; IQR=48-96; $p=0.750$). Among those who reported recent use in 2025, four fifths (82%) reported weekly or more frequent use (90% in 2024; $p=0.275$) and 20% reported daily use, stable from 20% in 2024.

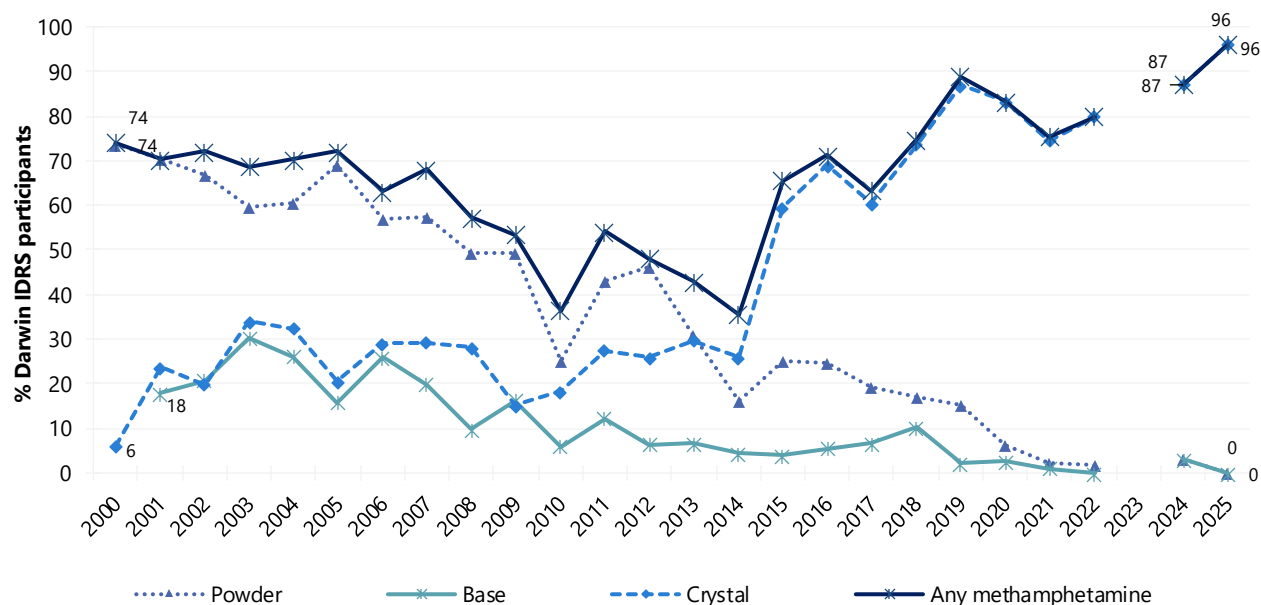
Forms Used

Among participants who had used methamphetamine in the six months preceding interview in 2025 ($n=51$), all participants (100%) had used methamphetamine crystal. No participants reported recent use of base and powder methamphetamine.

Number of Forms Used

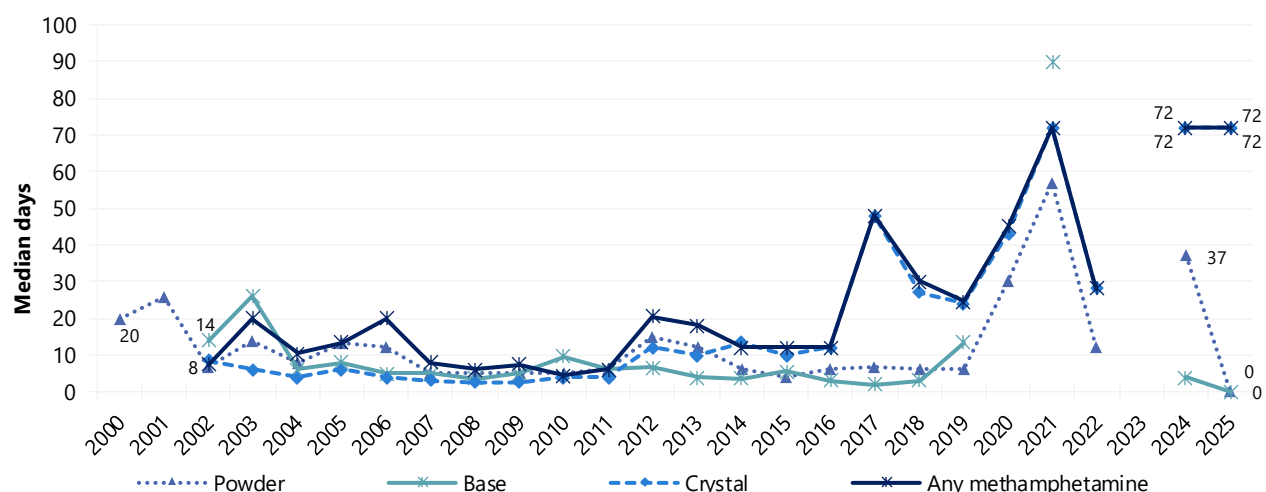
Among participants who had recently consumed any methamphetamine and commented in 2025 ($n=51$), the median number of forms of methamphetamine used was one (IQR=1-1; 1 in 2024; IQR=1-1; $p=0.500$).

Figure 5: Past six month use of any methamphetamine, and of methamphetamine powder, base, and crystal, Darwin, NT, 2000-2025



Note. Any methamphetamine includes crystal, powder, base and liquid methamphetamine combined from 2000-2018, and crystal, powder and base methamphetamine combined from 2019 onwards. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 6: Frequency of use of any methamphetamine, and methamphetamine powder, base, and crystal, Darwin, NT, 2000-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 100 days to improve visibility of trends. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Patterns of Consumption (by form)

Methamphetamine Powder

No participants reported recent use of methamphetamine powder in 2025 ($n \leq 5$ in 2024; $p=0.506$), and therefore, further details regarding frequency of use, routes of administration and quantity of use are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Methamphetamine Base

No participants reported recent use of methamphetamine base in 2025 ($n \leq 5$ in 2024; $p=0.506$), and therefore, further details regarding frequency of use, routes of administration and quantity of use are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Methamphetamine Crystal

Recent Use (past 6 months): Surpassing methamphetamine powder from 2014 onwards, recent use of methamphetamine crystal has been gradually increasing since 2015. In 2025, the majority (96%) of the sample reported recent use in the six months preceding interview, the highest per cent observed since monitoring commenced (87% in 2024; $p=0.113$) (Figure 5).

Frequency of Use: Of those who had recently consumed methamphetamine crystal and commented in 2025 ($n=51$), median days of use was 72 days (IQR=24-98; 72 days in 2024; IQR=48-96; $p=0.750$) (Figure 6). Four fifths (82%) of those who had recently used methamphetamine crystal reported weekly or more frequent use in 2025 (90% in 2024;

$p=0.275$) and one fifth (20%) reported daily use (20% in 2024).

Routes of Administration: Among participants who had recently consumed methamphetamine crystal and commented ($n=51$), all (100%) participants reported injecting methamphetamine crystal in 2025 (100% in 2024), and had done so on a median of 72 days (IQR=24-96; 72 days in 2024; IQR=48-96; $n=61$; $p=0.719$). Forty-nine per cent reported smoking methamphetamine crystal in 2025, a significant increase from 2024 (20%; $p=0.001$).

Quantity: In 2025, the median amount used on a 'typical' day in the past six months was 0.10 grams (IQR=0.10-0.20; $n=50$; 0.20 grams in 2024; IQR=0.10-0.20; $n=60$; $p=0.272$). The median maximum amount of methamphetamine crystal used per day in the last six months in 2025 was 0.20 grams (IQR=0.20-0.30; $n=50$; 0.30 grams in 2024; IQR=0.20-0.40; $n=60$; $p=0.470$).

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

No participants reported on the price, and few participants ($n \leq 5$) reported on the perceived purity or perceived availability of methamphetamine powder in 2025. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Methamphetamine Base

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

Trends team for further information (drugtrends@unsw.edu.au).

Methamphetamine Crystal

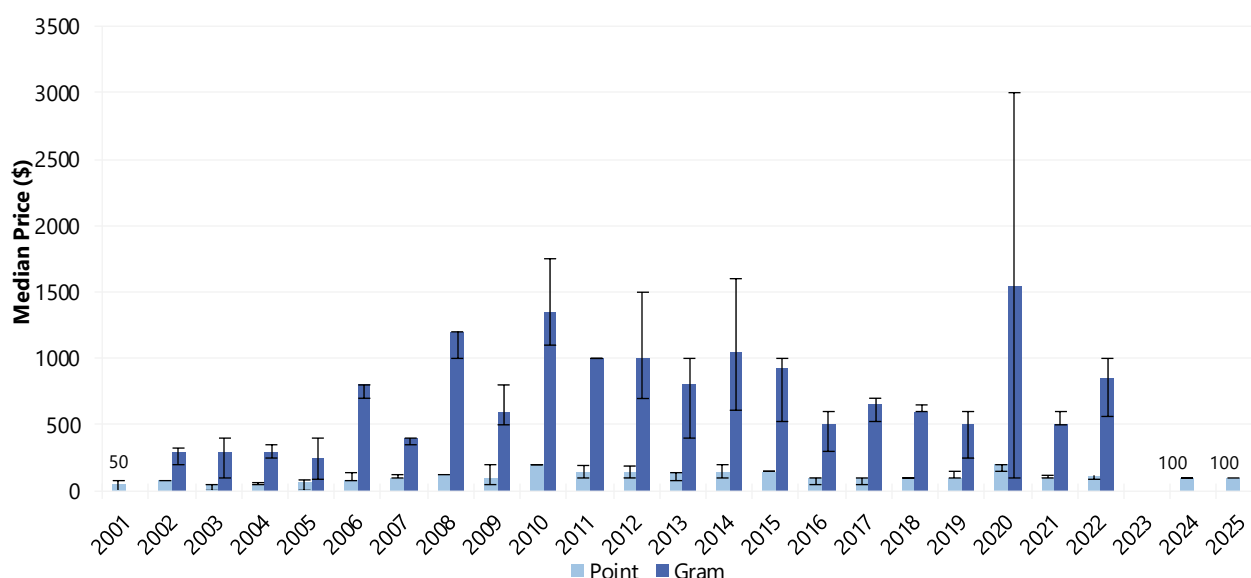
Price: The median price for one point (0.10 of a gram) of methamphetamine crystal was \$100 in 2025 (IQR=100-100; n=34; \$100 in 2024; IQR=100-100; n=36; $p=0.073$) (Figure 7). Few participants ($n \leq 5$) reported on the price of a gram in 2025, therefore, these data are suppressed.

Perceived Purity: The perceived purity of methamphetamine crystal remained stable

between 2024 and 2025 ($p=0.163$). Among those able to respond in 2025 ($n=49$), 51% reported 'medium' purity (42% in 2024), and one third (33%) reported 'high' purity (22% in 2024) (Figure 8).

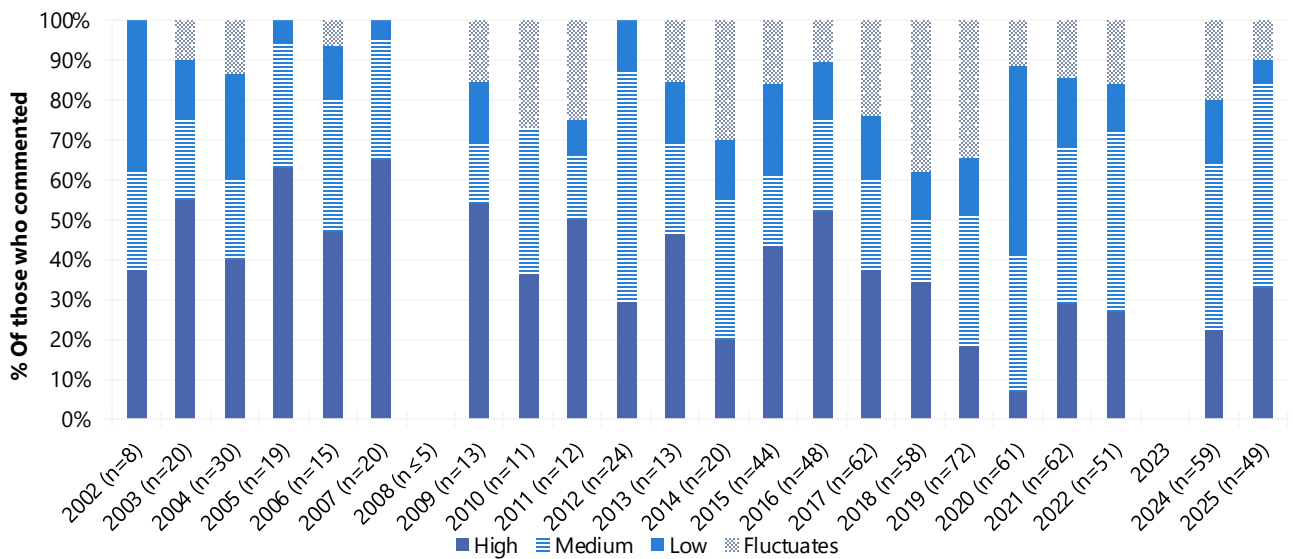
Perceived Availability: The perceived availability of methamphetamine crystal remained stable between 2024 and 2025 ($p=0.289$). Among those able to respond in 2025 ($n=49$), two thirds (67%) of participants perceived methamphetamine crystal as being 'very easy' to obtain (56% in 2024), followed by 31% reporting that it was 'easy' to obtain (32% in 2024) (Figure 9).

Figure 7: Median price of methamphetamine crystal per point and gram, Darwin, NT, 2001-2025



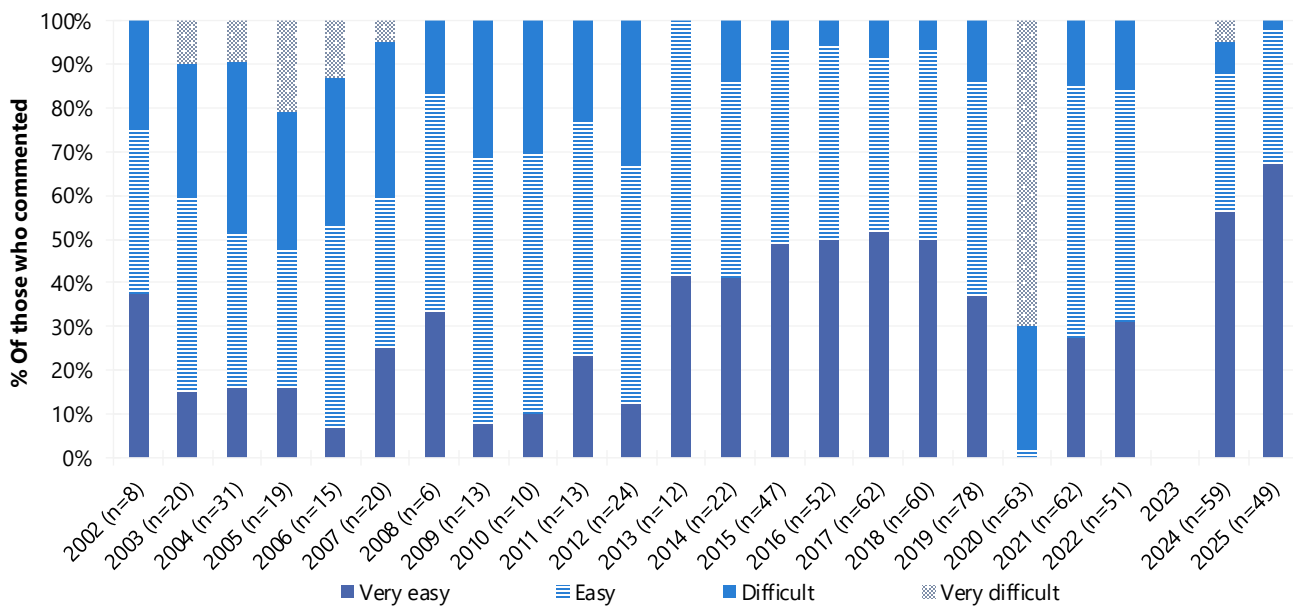
Note. Among those who commented. The error bars represent the IQR. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed in the figure where $n \leq 5$ responded. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 8: Current perceived purity of methamphetamine crystal, Darwin, NT, 2002-2025



Note. Methamphetamine asked separately for the three different forms from 2002 onwards. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 9: Current perceived availability of methamphetamine crystal, Darwin, NT, 2002-2025



Note. Methamphetamine asked separately for the three different forms from 2002 onwards. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

4

Cocaine

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

Patterns of Consumption

Recent Use (past 6 months)

Cocaine use has remained low over the course of monitoring, with 15% of the Darwin sample reporting recent consumption in 2025 (14% in 2024).

Frequency of Use

Of those who had recently consumed cocaine and commented in 2025 ($n=8$), median frequency of use was one day (IQR=1-4) in the preceding six months (1 day in 2024; IQR=1-4). Few participants ($n\leq 5$) reported using cocaine weekly or more frequently in 2025 ($n\leq 5$ in 2024).

Routes of Administration

Among participants who had recently consumed cocaine and commented ($n=8$), three quarters (75%) reported injecting cocaine in 2025 (40% in 2024; $p=0.188$) and did so on a median of one day in the six months preceding interview (IQR=1-3; $n=6$; $n\leq 5$ in 2024; $p=0.287$). Few participants ($n\leq 5$) reported other routes of administration in 2025.

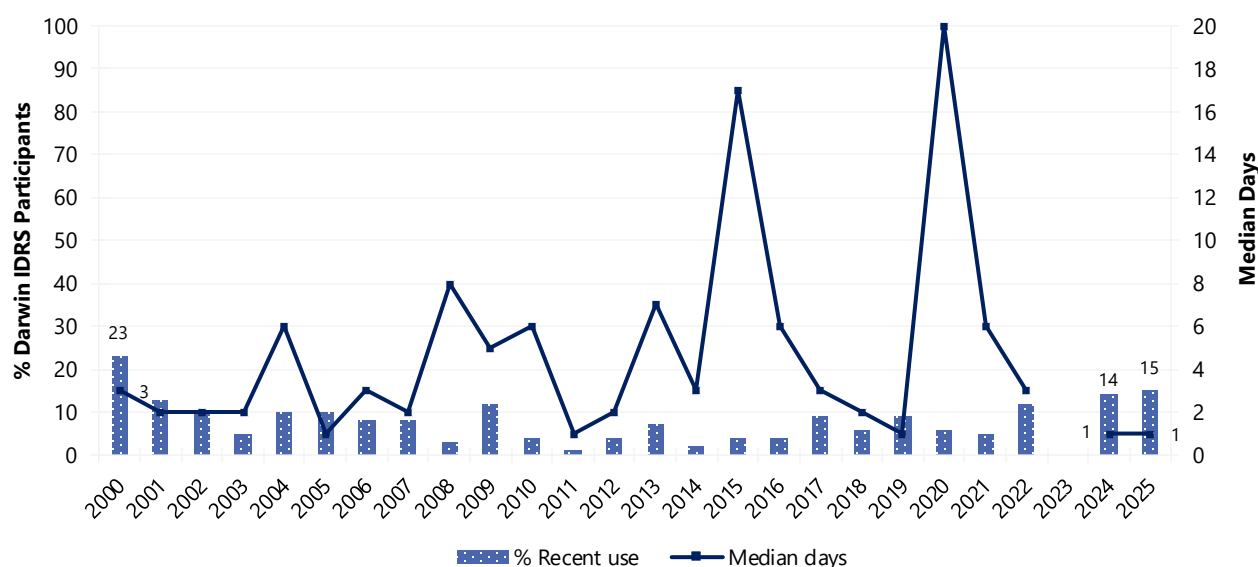
Quantity

Few participants ($n\leq 5$) reported on the median typical amount of cocaine used in 2025, and therefore these data are suppressed. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Forms Used

Among participants who had recently consumed cocaine and commented in 2025 ($n=8$), all participants (100%) reported using powder cocaine (100% in 2024), with no participants reporting use of crack/rock cocaine in 2025 ($n\leq 5$ in 2024).

Figure 10: Past six month use and frequency of use of cocaine, Darwin, NT, 2000-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 20 days to improve visibility of trends. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Price, Perceived Purity and Perceived Availability

Few participants ($n \leq 5$) reported on the price, perceived purity and perceived availability of cocaine, and therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

5

Cannabis and/or Cannabinoid-Related Products

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

Terminology throughout this chapter refers to:

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

Patterns of Consumption

From 2022, participants were asked about their use of both prescribed and non-prescribed cannabis and/or cannabinoid-related products. Few participants ($n \leq 5$) in the Darwin sample reported prescribed use in the six months preceding interview in 2025 (9% in 2024; $p=0.731$).

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

Recent Use (past 6 months)

Recent use of non-prescribed cannabis and/or cannabinoid-related products gradually declined between 2000 (84%) and 2017 (58%) and has remained relatively stable ever since. In 2025, three fifths (60%) of the sample reported use of non-prescribed cannabis and/or cannabinoid-related products in the six months preceding interview (69% in 2024; $p=0.439$) (Figure 11).

Frequency of Use

Frequency of non-prescribed cannabis and/or cannabinoid-related product use has fluctuated over the course of monitoring, though has remained stable from 2020 onwards. In 2025, participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented ($n=32$) reported use on a median of 180 days, with variability increasing significantly

(IQR=42-180; 180 days in 2024; IQR=180-180; $p=0.016$) (Figure 11). Fifty-six per cent of those who had recently used non-prescribed cannabis and/or cannabinoid-related products reported daily use (77% in 2024; $p=0.086$).

Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented ($n=32$), all participants (100%) reported smoking as the route of administration in 2025 (98% in 2024). No participants reported inhaling/vaporising ($n\leq 5$ in 2024) or swallowing non-prescribed cannabis and/or cannabinoid-related products (0% in 2024) in the six months preceding interview in 2025.

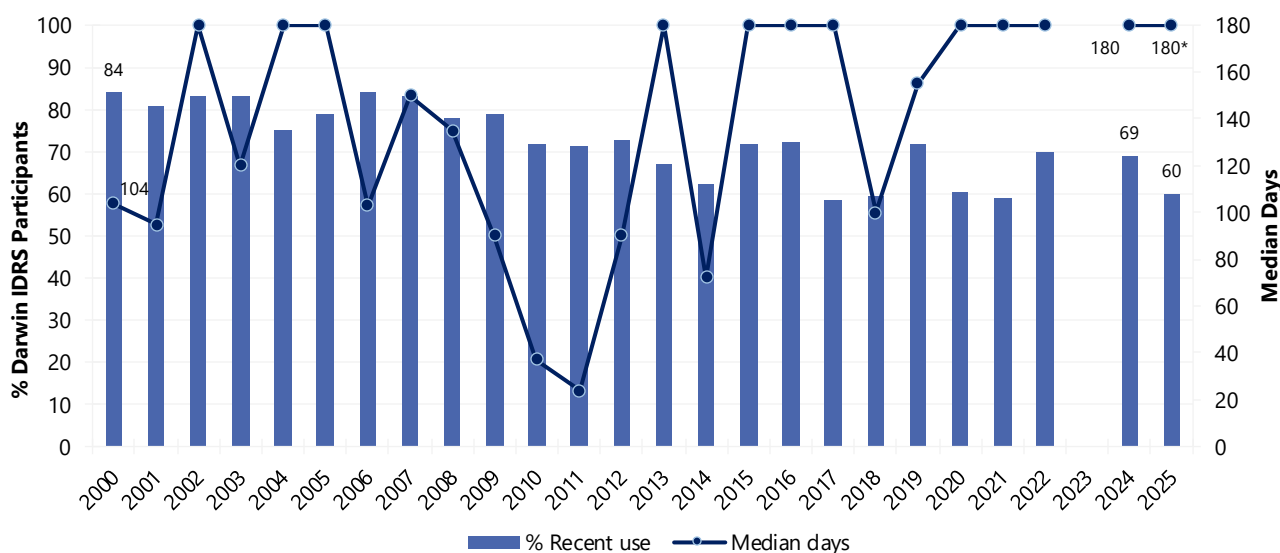
Quantity

Of those who reported recent use of non-prescribed cannabis and/or cannabinoid-related products in 2025, the median 'typical' amount used on the last occasion of use was three cones (IQR=2-4; $n=25$), a significant decrease from 2024 (4 cones; IQR=3-10; $n=41$; $p=0.049$). Few participants ($n\leq 5$) were able to comment on the 'typical' amount of grams or joints on the last occasion of use in 2025.

Forms Used

In 2025, of those who reported recent use of any non-prescribed cannabis and/or cannabinoid-related products and commented ($n=31$), all participants (100%) reported recent use of hydroponic cannabis (96% in 2024; $p=0.517$). Few participants ($n\leq 5$) reported recent use of bush cannabis ($n\leq 5$ in 2024) and no participants reported recent use of hashish, hash oil, CBD extract, THC extract and commercially prepared edibles in 2025 (Figure 12).

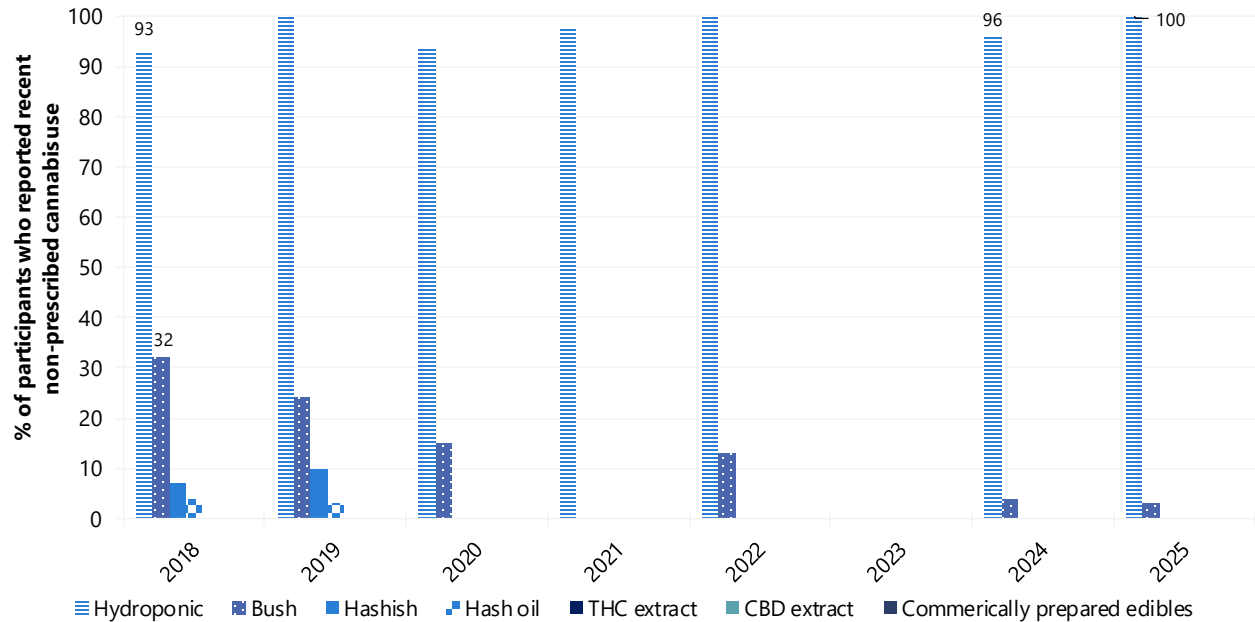
Figure 11: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid-related products, Darwin, NT, 2000-2025



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such, it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australian in November 2016), although we anticipate these numbers would be very low. Further, in 2022, we captured use of 'cannabis and/or cannabinoid related-products', while in previous years questions referred only to 'cannabis'. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels

are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 12: Past six month use of different forms of non-prescribed cannabis and/or cannabinoid-related products, among those who reported recent non-prescribed use, Darwin, NT, 2018-2025



Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2018-2020 figures include some participants who were using prescribed forms of cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Price, Perceived Potency and Perceived Availability

Hydroponic Cannabis

Price: Few participants ($n \leq 5$) reported on the price of hydroponic cannabis, and therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Perceived Potency: The perceived potency of hydroponic cannabis remained stable between 2024 and 2025 ($p=0.291$). Among those who were able to comment in 2025 ($n=26$), 54% reported potency to be 'medium' (40% in 2024) and two fifths (42%) reported potency to be 'high' (40% in 2024) (Figure 14).

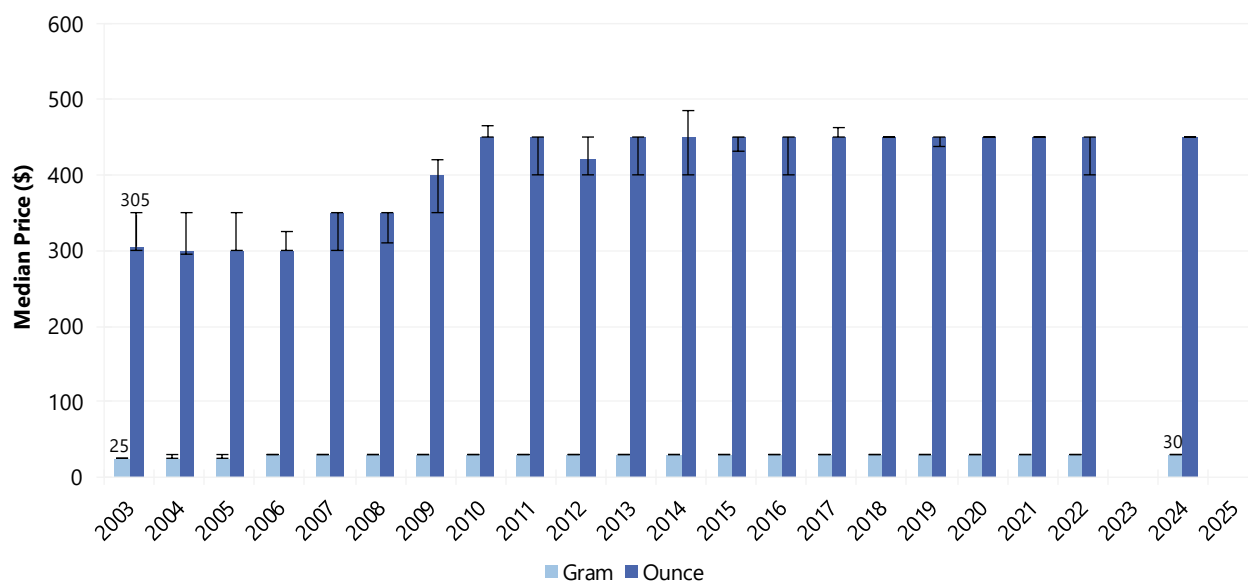
Perceived Availability: The perceived availability of hydroponic cannabis remained stable between 2024 and 2025 ($p=0.507$). Among those who were able to comment in 2025 ($n=26$), almost four fifths (77%) perceived availability as 'very easy' (85% in 2024) and one fifth (23%) perceived it to be 'easy' ($n \leq 5$ in 2024) (Figure 15).

Bush Cannabis

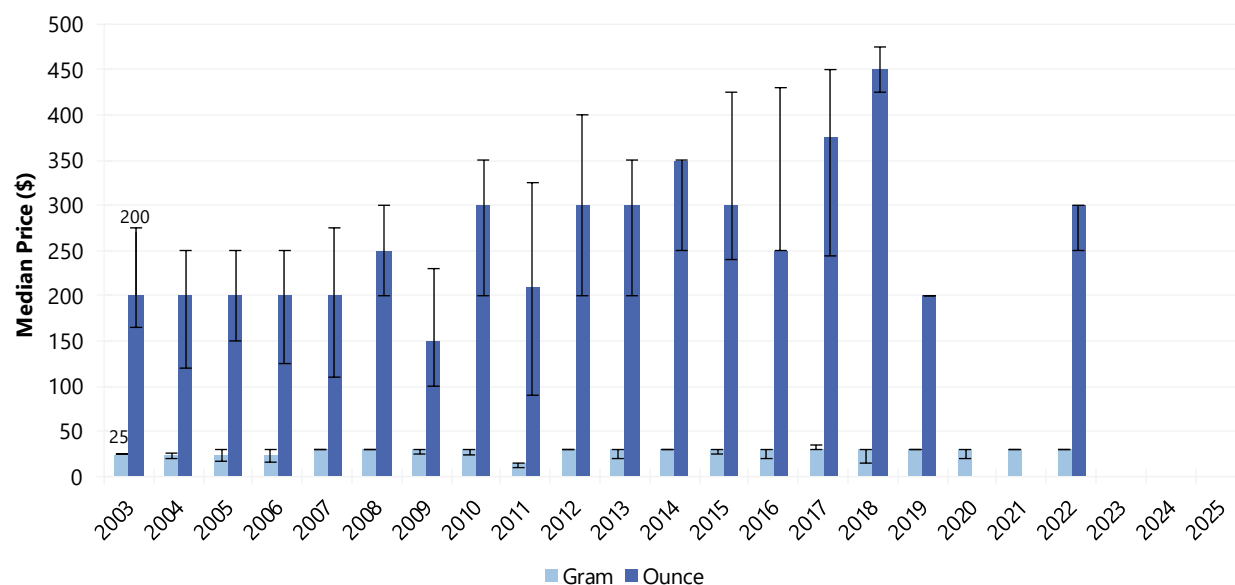
Few participants ($n \leq 5$) were able to report on the price, perceived potency and availability of bush cannabis. Therefore, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 13: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per gram and ounce, Darwin, NT, 2003-2025

(A) Hydroponic Cannabis



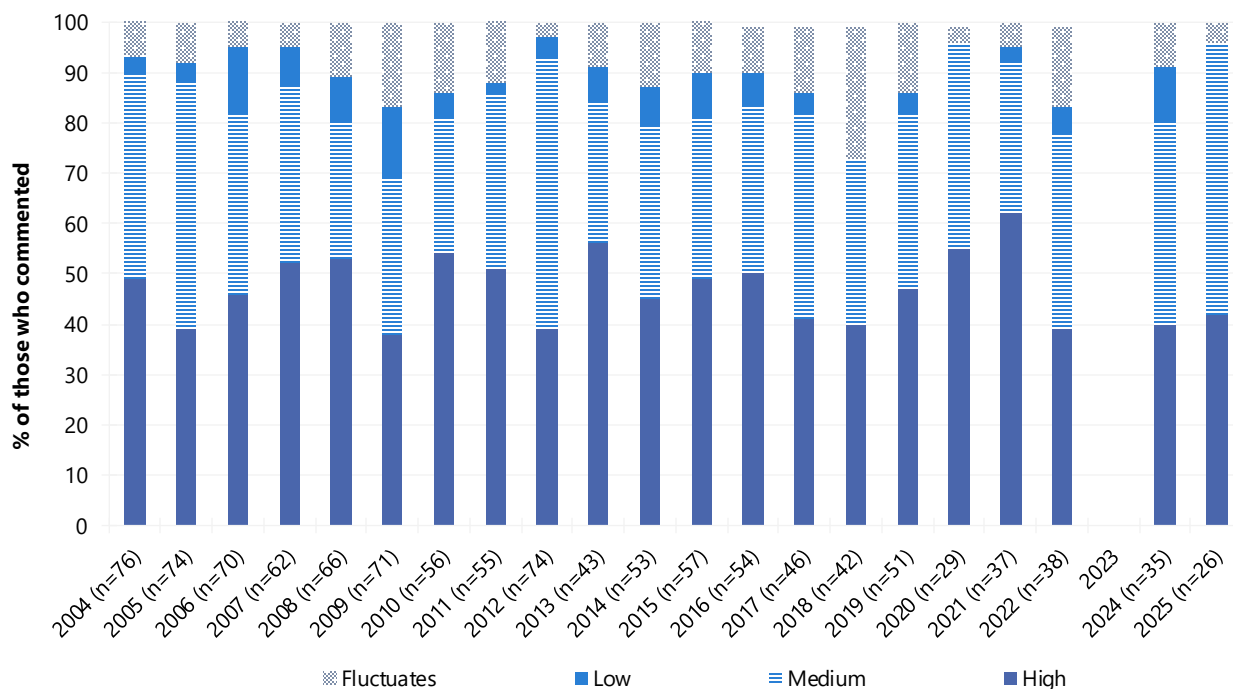
(B) Bush Cannabis



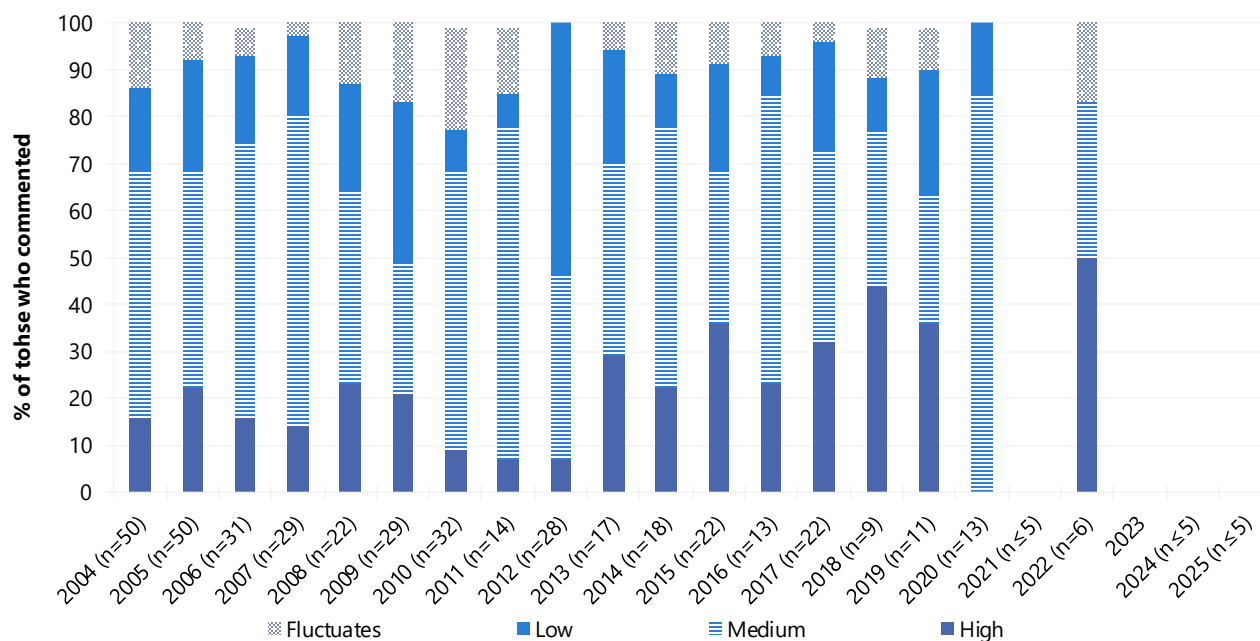
Note. Among those who commented. From 2003 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only: prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who are reporting on the price of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$). Data are suppressed in the figure where $n \leq 5$ responded to the item. The error bars represent the IQR. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 14: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Darwin, NT, 2004-2025

(A) Hydroponic Cannabis



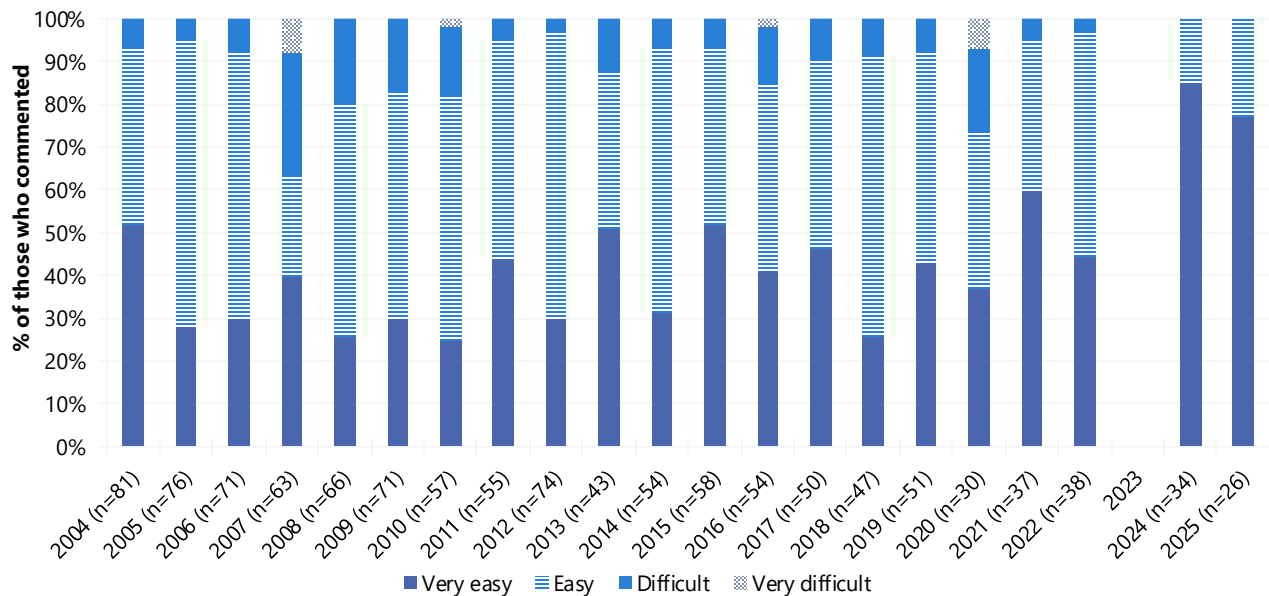
(B) Bush Cannabis



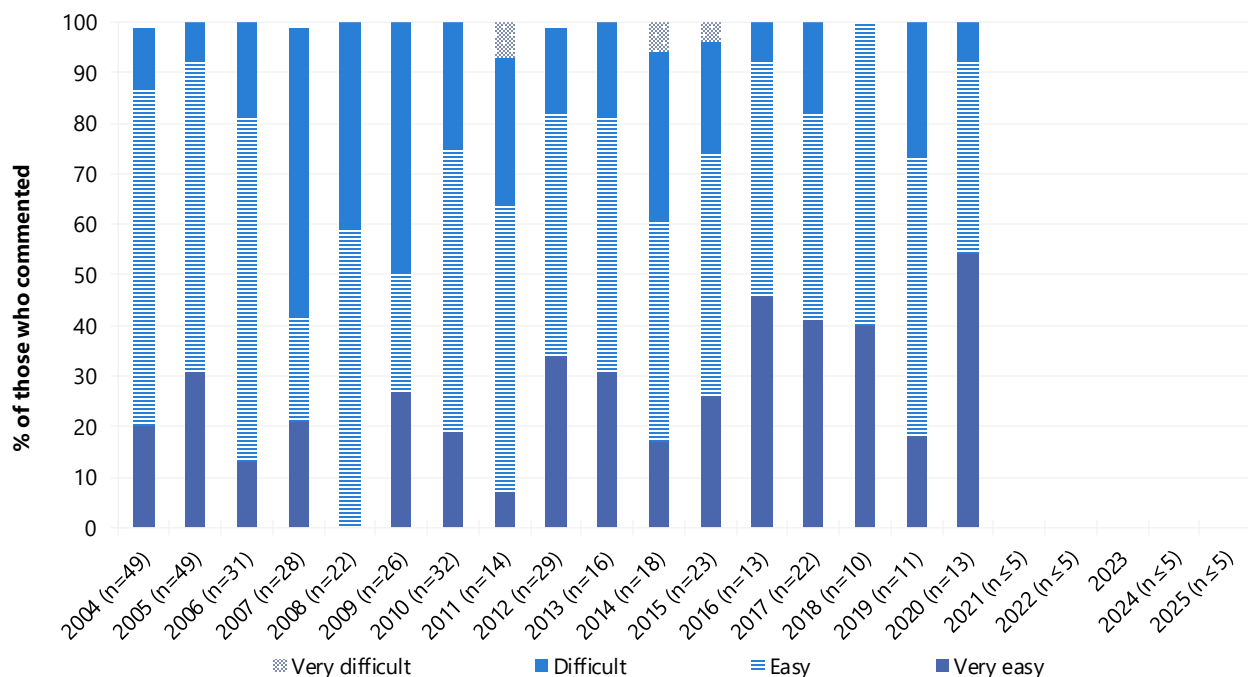
Note. Hydroponic and bush cannabis data collected separately from 2004 onwards. Data from 2022 onwards refers to non-prescribed cannabis only: prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who are reporting on the potency of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 15: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Darwin, NT, 2004-2025

(A) Hydroponic Cannabis



(B) Bush Cannabis



Note. Hydroponic and bush cannabis data collected separately from 2004 onwards. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who are reporting on the availability of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

6

Pharmaceutical Opioids

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

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

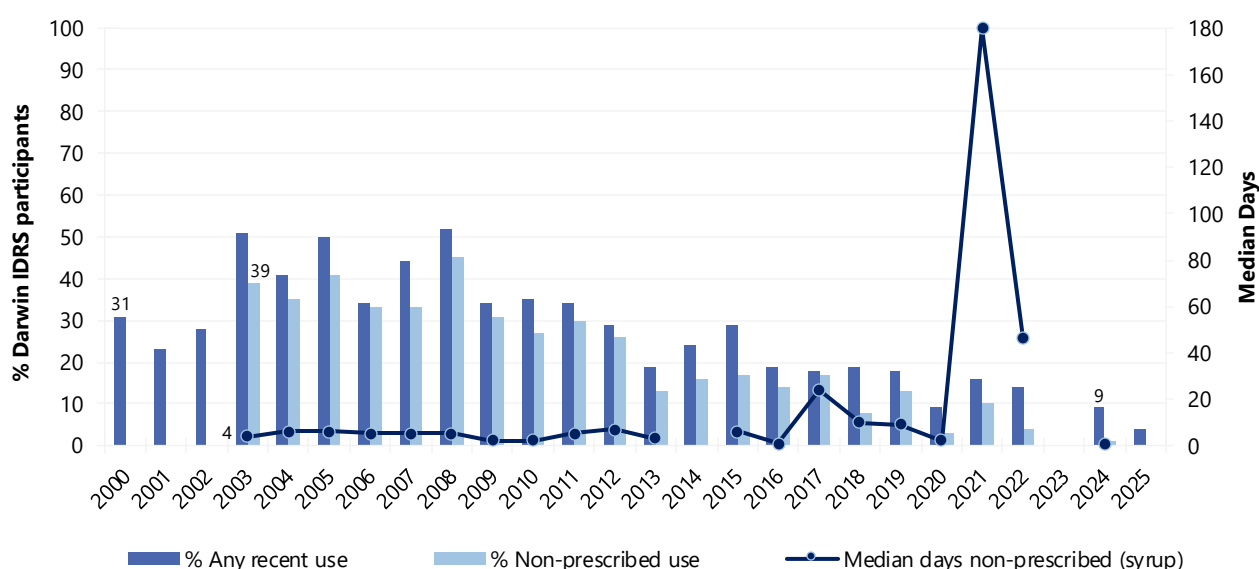
For information on price and perceived availability for non-prescribed pharmaceutical opioids, contact the Drug Trends team (drugtrends@unsw.edu.au).

Methadone

Any Recent Use (past 6 months): The per cent reporting any recent methadone use (including syrup and tablets) gradually decreased between 2008 (52%) and 2020 (9%) and has remained relatively stable since. In 2025, few participants ($n \leq 5$) reported recent use of any methadone in the six months preceding interview (9% in 2024; $p=0.464$), with no participants reporting recent use of non-prescribed methadone in 2025 ($n \leq 5$ in 2024) (Figure 16).

Frequency of Use: Due to no participants reporting recent non-prescribed use in 2025, further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 16: Past six month use (prescribed and non-prescribed) and frequency of use of non-prescribed methadone, Darwin, NT, 2000-2025



Note. Includes methadone syrup and tablets except where otherwise specified. Non-prescribed use not distinguished 2000-2002. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

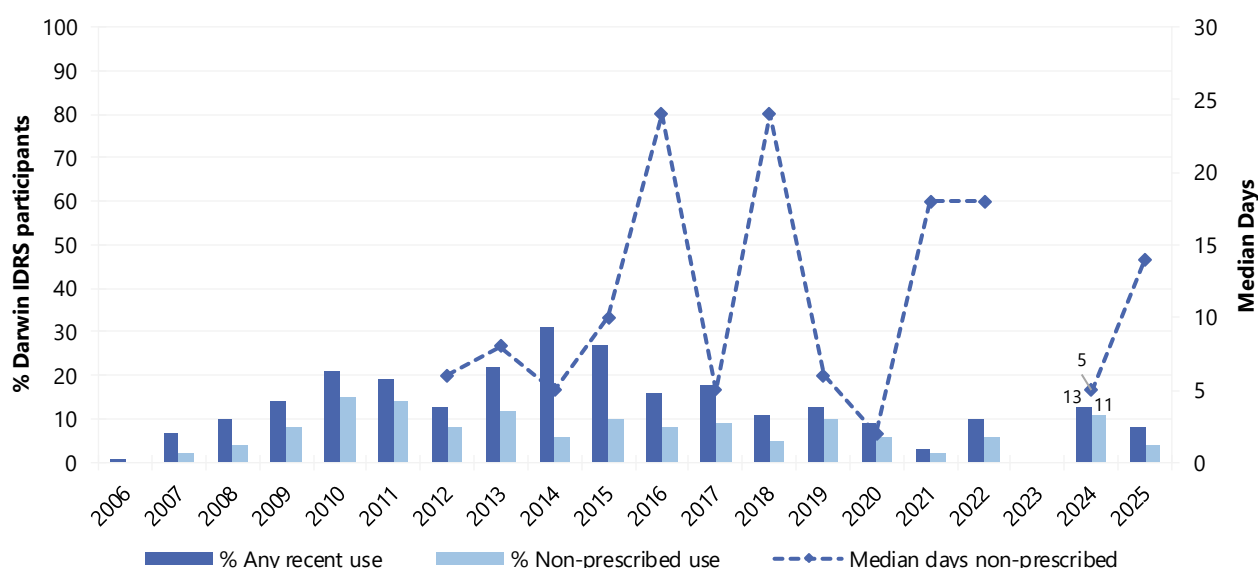
Buprenorphine Tablet

No participants reported using any buprenorphine tablet/s (Subutex) in the six months prior to interview in 2025 ($n \leq 5$ in 2024; $p=0.258$), and therefore no further reporting on patterns of use are included. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Buprenorphine-Naloxone

Few participants ($n \leq 5$) reported using any buprenorphine-naloxone (Suboxone) in the six months prior to interview in 2025 (13% in 2024; $p=0.391$), and therefore no further reporting on patterns of use are included. Please refer to Figure 17 for historical trends in the Darwin sample, and to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 17: Past six month use (prescribed and non-prescribed) and frequency of use of non-prescribed buprenorphine-naloxone, Darwin, NT, 2006-2025



Note. From 2006-2011, participants were asked about the use of buprenorphine-naloxone tablet; from 2012-2016, participants were asked about the use of buprenorphine-naloxone tablet and film; from 2017 onwards, participants were asked about the use of buprenorphine-naloxone film only. Median days of non-prescribed use computed among those who reported recent use (maximum 180 days) and is only reported from 2012 onwards to capture film use. Median days rounded to the nearest whole number. Secondary Y axis reduced to 30 days to improve visibility of trends. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

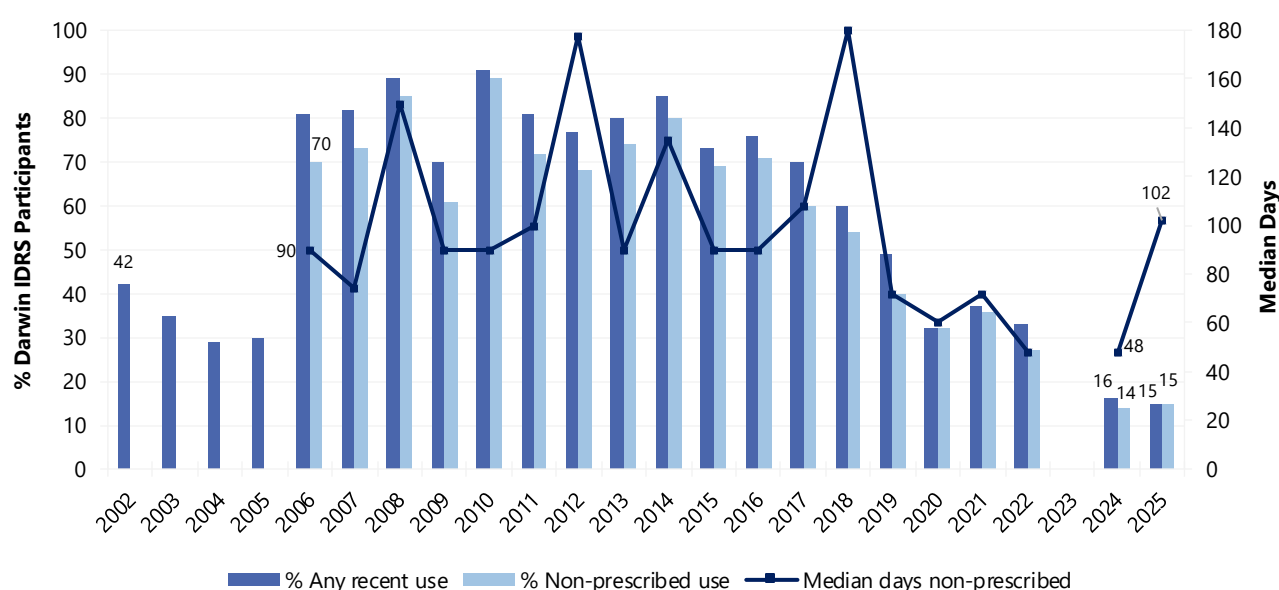
Morphine

Any Recent Use (past 6 months): The Darwin sample has observed a downward trend in recent use of morphine since peaking in 2010 (91%). In 2025, recent use of any morphine was reported by 15% of the sample, the lowest percentage observed since monitoring commenced (16% in 2024) (Figure 18). Consistent with previous years, this mostly comprised non-prescribed use (15%; 14% in 2024).

Frequency of Use: Frequency of non-prescribed morphine use has fluctuated over time, though has been decreasing since 2018. In 2025, participants who had recently consumed non-prescribed morphine and commented (n=8) reported use on a median of 102 days (IQR=14-180; 48 days in 2024; IQR=21-95; $p=0.528$) (Figure 18).

Recent Injecting Use: Of those who had recently used any morphine in 2025 and commented (n=8), all participants reported injecting morphine (100%) on a median of 114 days (IQR=14-180; 90 days in 2024; IQR=30-180).

Figure 18: Past six month use (prescribed and non-prescribed) and frequency of use of non-prescribed morphine, Darwin, NT, 2002-2025

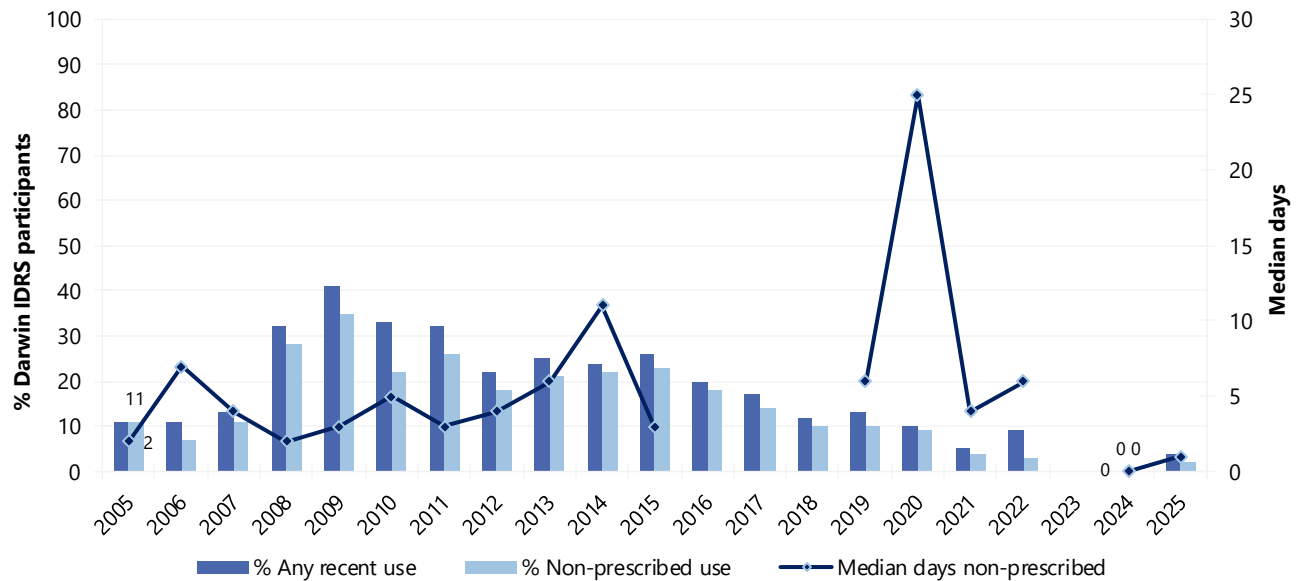


Note. Median days of use computed among those who reported recent use (maximum 180 days). Non-prescribed use not distinguished in 2001-2005. Median days rounded to the nearest whole number. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Oxycodone

Few participants ($n \leq 5$) reported recent use of any oxycodone in 2025 (0% in 2024; $p=0.184$), therefore, details regarding frequency of use and recent injecting use are not reported. Please refer to Figure 19 for historical trends in the Darwin sample, and the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 19: Past six-month use (prescribed and non-prescribed) and frequency of use of non-prescribed oxycodone, Darwin, NT, 2005-2025

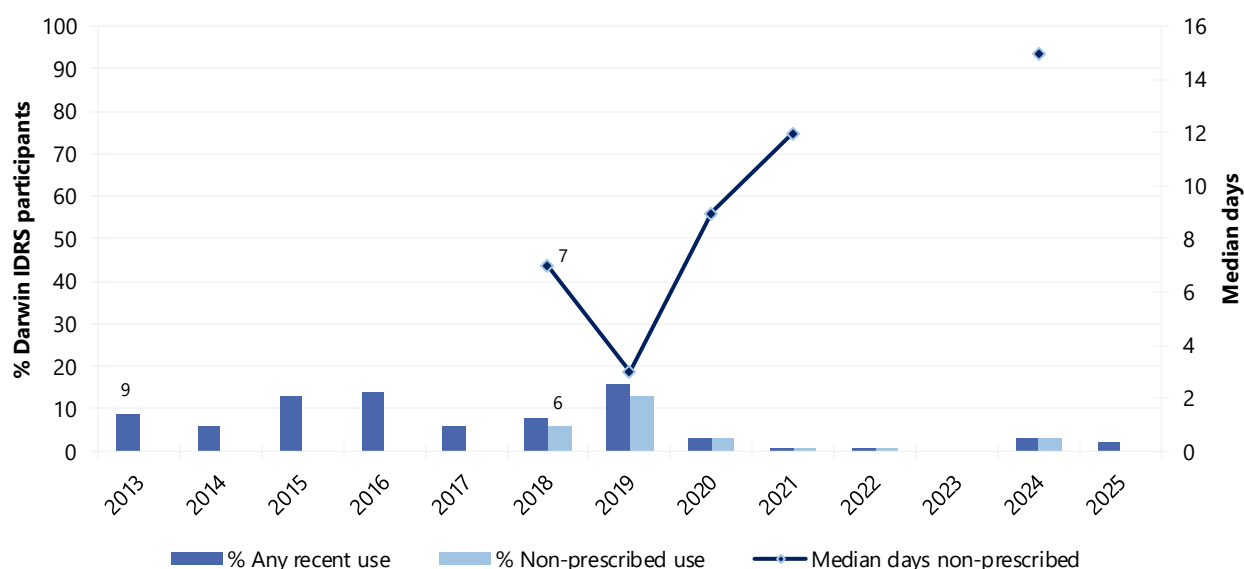


Note. From 2005-2015, participants were asked about recent use and frequency of use for any oxycodone; from 2016-2018, recent use and frequency of use for oxycodone was broken down into three types: tamper resistant ('OP'), non-tamper proof (generic) and 'other oxycodone' (median days non-prescribed use missing from 2016-2018). From 2019-2022, recent use for oxycodone was broken down into four types: tamper resistant ('OP'), non-tamper proof (generic), 'other oxycodone' and oxycodone-naloxone, while frequency of use was asked for any oxycodone. From 2023 onwards, participants were asked about recent use and frequency of use for any oxycodone. Median days of non-prescribed use computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 30 days to improve visibility of trends. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Fentanyl

Few participants ($n \leq 5$) reported any fentanyl use in the six months prior to interview in 2025 ($n \leq 5$ in 2025), therefore no further details regarding patterns of use are included. A historical overview of trends is presented below in Figure 20. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 20: Past six-month use (prescribed and non-prescribed) and frequency of use of non-prescribed fentanyl, Darwin, NT, 2013-2025



Note. Data on fentanyl use not collected from 2000-2012; from 2013-2017, the IDRS did not distinguish between prescribed and non-prescribed use. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 16 days to improve visibility of trends. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Other Opioids

Participants were asked about prescribed and non-prescribed use of other opioids (Table 3). In 2025, few participants ($n \leq 5$) reported recent use of any codeine ($n \leq 5$ in 2024; $p=0.577$) and tapentadol ($n \leq 5$ in 2024; $p=0.577$), and no participants reported recent use of tramadol (0% in 2024). See Figure 20 in the [Northern Territory IDRS 2019 Report](#) for more detailed data on use of codeine.

Table 3: Past six month use of other opioids, Darwin, NT, 2019-2025

% Recent Use (past 6 months)	2019 (N=99)	2020 (N=78)	2021 (N=94)	2022 (N=70)	2023	2024 (N=70)	2025 (N=53)
Codeine[^]							
Any use	25	-	-	-	~	-	-
Non-prescribed use	10	-	0	-	~	-	-
Any injection [#]	-	0	-	0	~	0	0
Tramadol							
Any use	16	-	-	-	~	0	0
Non-prescribed use	8	-	-	-	~	0	0
Any injection [#]	0	-	0	0	~	0	0
Tapentadol							
Any use	0	-	0	0	~	-	-
Non-prescribed use	0	-	0	0	~	0	-
Any injection [#]	0	-	0	0	~	0	0

Note. [^]Includes high and low dose. [#]Of those who reported past six month use. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

7

Other Drugs

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

New Psychoactive Substances (NPS)

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

Few participants ($n \leq 5$) reported using any NPS in the six months prior to interview in 2025 (Table 4). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Table 4: Past six-month use of new psychoactive substances, Darwin, NT, 2013-2025

% Recent Use (past 6 months)	2013 N=91	2014 N=93	2015 N=99	2016 N=90	2017 N=109	2018 N=99	2019 N=99	2020 N=78	2021 N=94	2022 N=69	2023 N=46	2024 N=70	2025 N=53
'New' drugs that mimic the effects of opioids	/	/	/	/	-	-	-	0	0	-	~	0	0
'New' drugs that mimic the effects of ecstasy	/	/	/	/	0 [#]	0	-	0	0	0	~	0	0
'New' drugs that mimic the effects of amphetamine or cocaine	-	-	-	-	0	-	0	0	0	0	~	0	0
'New' drugs that mimic the effects of cannabis	8	-	12	-	0	11	13	-	0	-	~	0	0
'New' drugs that mimic the effects of psychedelic drugs	/	/	/	/	0 [#]	0	0	0	0	0	~	0	-
'New' drugs that mimic the effects of benzodiazepines	/	/	/	/	/	0	0	0	0	0	~	0	0
'New' drugs that mimic the effects of dissociatives	/	/	/	/	/	/	/	/	/	/	/	/	0
Any of the above	11	-	13	7	-	8	9	6	0	-	~	0	-

Note. [#]In 2017, participants were asked about use of 'new drugs that mimic the effects of ecstasy or psychedelic drugs', thus the same value appears in both 'new' drugs that mimic the effects of ecstasy and 'new' drugs that mimic the effects of psychedelic drugs; from 2018 onwards, these two NPS classes were separated out. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Non-Prescribed Pharmaceutical Drugs

Benzodiazepines

Despite some fluctuation, non-prescribed benzodiazepine use has gradually declined since monitoring commenced (Figure 21). Few participants ($n \leq 5$) reported recent use of non-prescribed benzodiazepines in 2025 ($n \leq 5$ in 2024), therefore no further details regarding patterns of use are included. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Pharmaceutical Stimulants

Recent use of non-prescribed pharmaceutical stimulants (e.g., Ritalin, dexamphetamine, Modafinil, Concerta, Vyvanse) peaked in 2015 (24%), and has since declined gradually (Figure 21). In 2025, few participants ($n \leq 5$) reported recent use of non-prescribed pharmaceutical stimulants (9% in 2024; $p=0.464$), therefore no further details regarding patterns of use are included. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Antipsychotics

In 2025, no participants reported recent use of non-prescribed antipsychotics ($n \leq 5$ in 2024; $p=0.258$), therefore no further details regarding patterns of use are included. refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Pregabalin

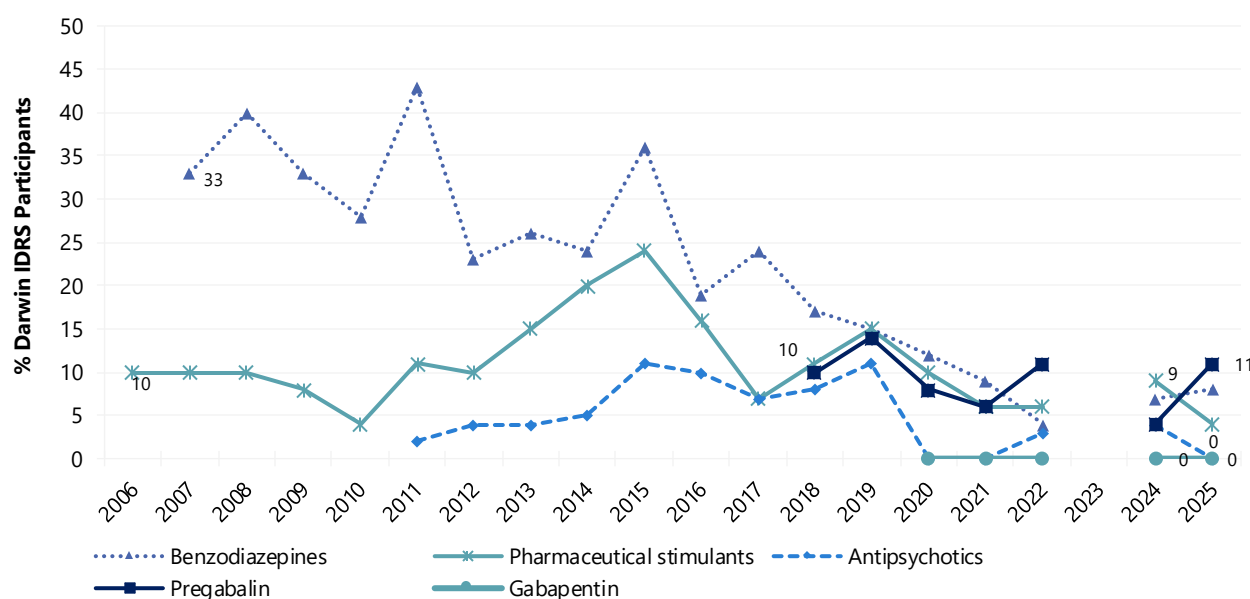
Recent Use (past 6 months): In 2025, recent use of non-prescribed pregabalin was reported by 11% of the sample ($n \leq 5$ in 2024; $p=0.172$) (Figure 21).

Frequency of Use: Among those who reported recent use of non-prescribed pregabalin and commented in 2025 ($n=6$), the median frequency of use was nine days (IQR=4-14; $n \leq 5$ in 2024). Of those who reported recent use of non-prescribed pregabalin, no participants reported injecting as a route of administration in 2025 ($n \leq 5$ in 2024; $p=0.333$).

Gabapentin

No participants reported using non-prescribed gabapentin in the six months prior to interview in 2025 (Figure 21). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 21: Past six month use of non-prescribed pharmaceutical drugs, Darwin, NT, 2006-2025



Note. From 2019 to 2023, participants were asked about their use of non-prescribed alprazolam and non-prescribed use of 'other' benzodiazepines (e.g., diazepam), separately. In 2024, these categories were combined, and as such, participants were asked about non-prescribed use of any benzodiazepines. Benzodiazepines were separated into prescribed and non-prescribed in 2007. Non-prescribed use is reported. Antipsychotics was asked as 'Seroquel' from 2011-2018. Pharmaceutical stimulants were separated into prescribed and non-prescribed from 2006 onwards, and Y axis reduced to 50% to improve visibility of trends. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Licit and Other Drugs

Alcohol

Recent Use (past 6 months): Recent use of alcohol has remained relatively stable over the course of monitoring. In 2025, three fifths (62%) of the sample reported consuming alcohol in the past six months (53% in 2024; $p = 0.360$) (Figure 22).

Frequency of Use: Among those who reported recent use and commented in 2025 ($n = 33$), the median frequency of use was 24 days (IQR=7-48; 12 days in 2024; IQR=6-72; $n = 37$; $p = 0.619$), with few participants ($n \leq 5$) reporting daily consumption (19% in 2024; $p = 0.522$).

Tobacco

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

Recent Use (past 6 months): In 2025, four fifths (81%) of the sample reported recent use of any tobacco (licit or illicit) in the previous six months (89% in 2024; $p = 0.312$) (Figure 22). Thirteen per cent of the sample reported recent use of smoked or non-smoked illicit tobacco in 2025 ($n \leq 5$ in 2024; $p = 0.204$).

Frequency of Use: Among those who reported recent use and commented in 2025 ($n = 43$), the median frequency of use was 180 days (IQR=180-180; $n = 43$; 180 days in 2024; IQR=180-180; $n = 62$; $p = 0.731$), with 95% reporting daily use (97% in 2024).

E-cigarettes/'Vapes'

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

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

In 2025, no participants reported recent use of e-cigarettes that were obtained from a pharmacy. Between 2022 and 2024, no participants reported recent use of prescribed e-cigarettes (0% in 2022, 0% in 2023 and 0% in 2024). The data presented below for 2025 refers only to use of e-cigarettes that were obtained from non-pharmacy locations. 2022-2024 data refers to non-prescribed e-cigarette use, while data for 2021 and earlier years refers to any e-cigarette use (collectively referred to as 'illicit use' from herein).

Recent Use (past 6 months): In 2025, few participants ($n \leq 5$) reported recent use of illicit e-cigarettes (11% in 2024; $p=0.350$), therefore no further details are reported on frequency of use, contents and form used or reasons for use. A historical overview of trends is presented below in Figure 22. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Nicotine Pouches

No participants reported using nicotine pouches in the six months preceding interview in 2025 (Figure 22), therefore no further details regarding patterns of use are included. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Steroids

No participants reported using non-prescribed steroids in the six months preceding interview in 2025, therefore no further details regarding patterns of use are included (Figure 22). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

GHB/GBL/1, 4-BD

Few participants ($n \leq 5$) reported using GHB/GBL/1, 4-BD in the six months prior to interview in 2025 ($n \leq 5$ in 2024), therefore no further details regarding patterns of use are included (Figure 22). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

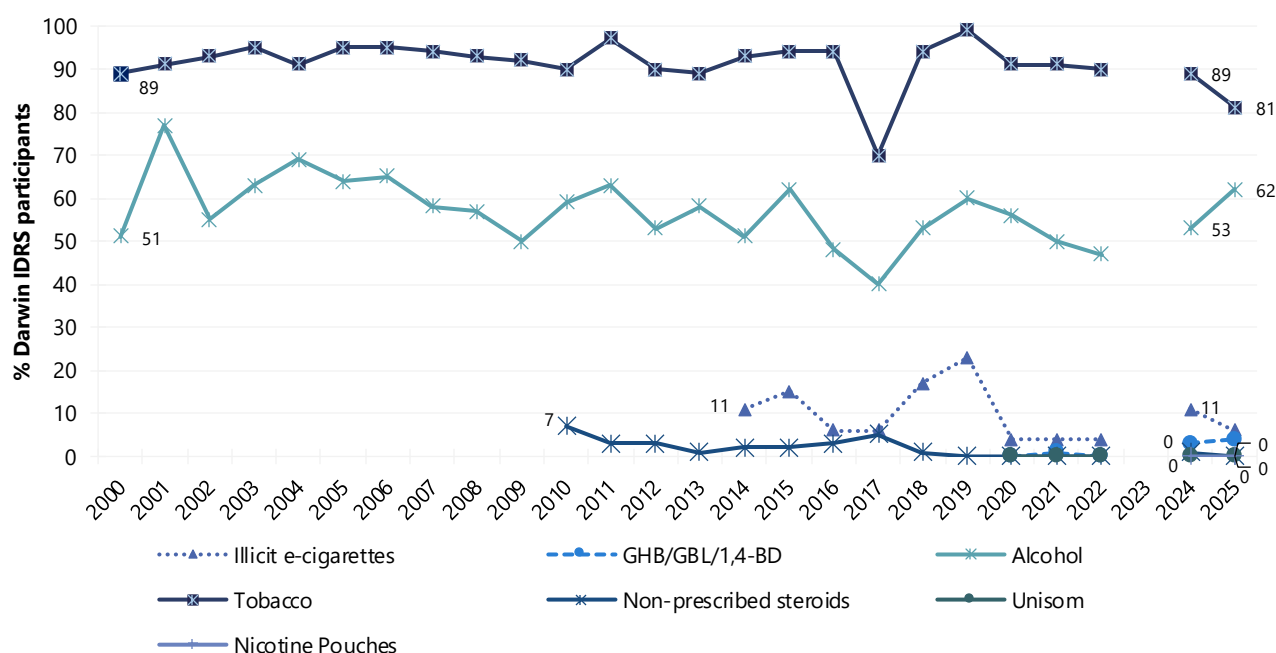
Unisom

Unisom SleepGels is a Schedule 3 medicine containing diphenhydramine that is available over-the-counter from a pharmacist for use as an antihistamine or temporary sleep aid. It comes in a gel capsule

formulation intended for oral use. There have been [reports](#) of injecting use in Australia, raising concern of attendant injecting-related injuries.

In 2025, no participants reported using Unisom in the six months prior to interview (0% in 2024) (Figure 22). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 22: Past six month use of licit and other drugs, Darwin, NT, 2000-2025



Note. Regarding e-cigarette use, on 1 October 2021, legislation came into effect requiring people to obtain a prescription to legally import nicotine vaping products. Data from 2022 onwards refers to non-prescribed e-cigarettes only. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

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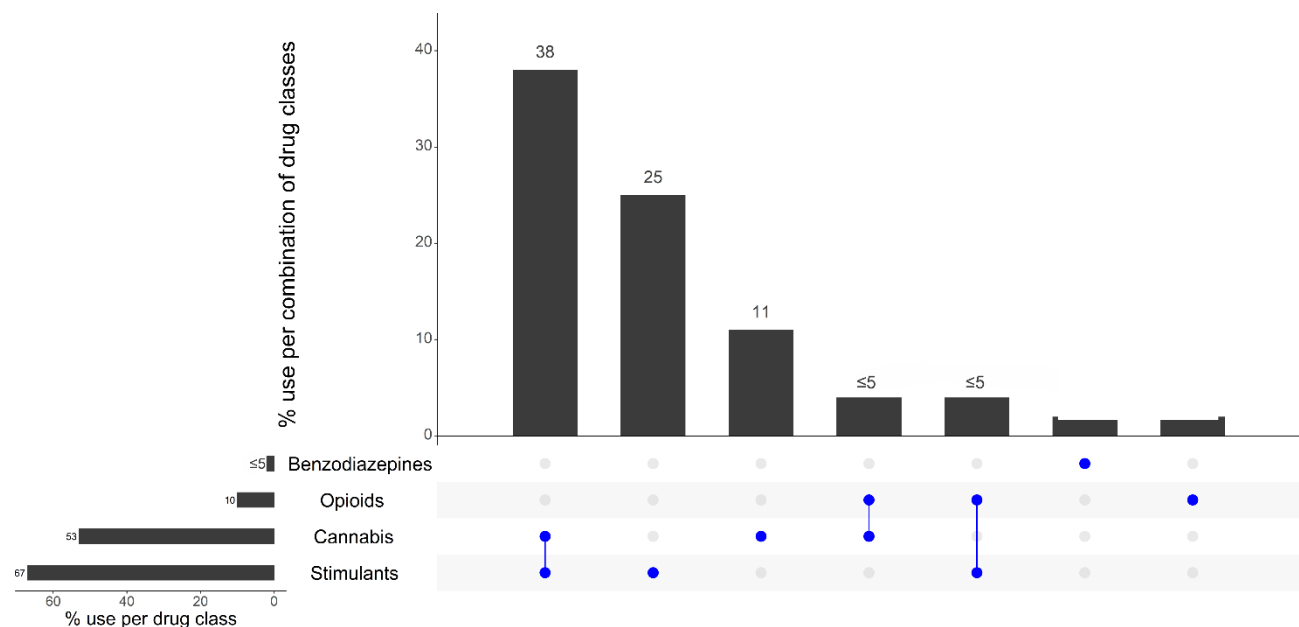
Drug-Related Harms and Other Behaviours

Polysubstance Use

In 2025, 92% of participants reported using one or more drugs (including alcohol and prescription medications but excluding tobacco and e-cigarettes) on the day preceding interview, whilst 55% reported using two or more drugs. Of those who reported using one or more drugs (n=49), the most commonly used substances were opioids (90%), followed by cannabis (57%), stimulants (29%) and alcohol (24%).

Almost two fifths (38%) of participants reported concurrent use of cannabis and stimulants on the day preceding interview. One quarter (25%) reported using stimulants alone and one tenth (11%) reported using cannabis alone (Figure 23).

Figure 23: Use of opioids, stimulants, benzodiazepines and cannabis on the day preceding interview and most common drug pattern profiles, Darwin, NT, 2025

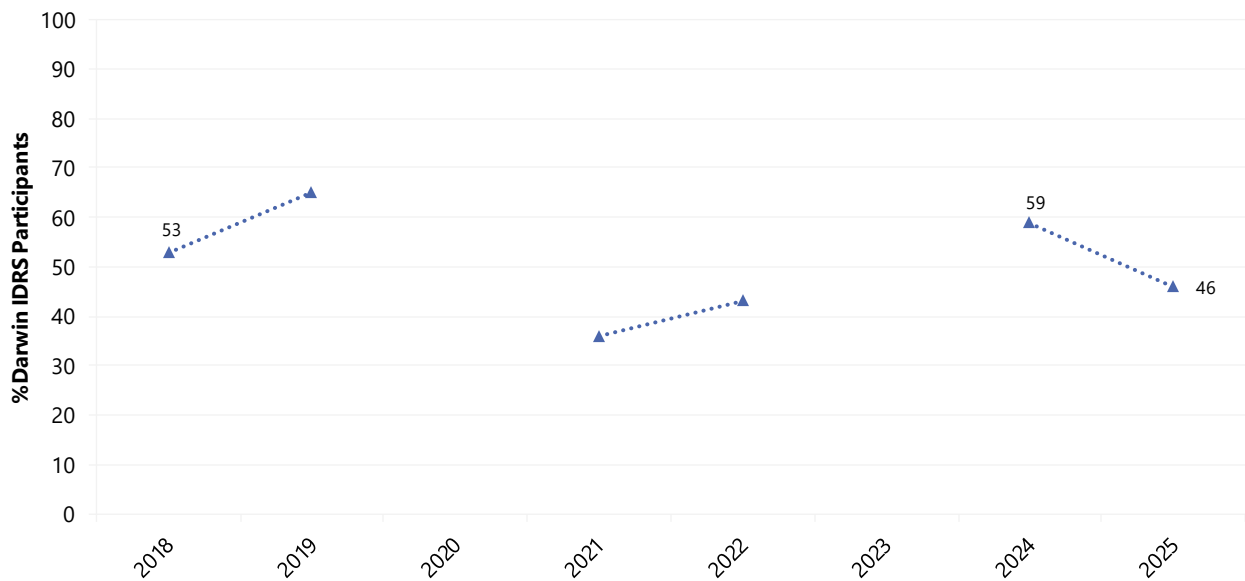


Note. % calculated out of total IDRS 2025 sample. The horizontal bars represent the per cent of participants who reported use of each drug class on the day preceding interview; the vertical columns represent the per cent of participants who used the combination of drug classes represented by the blue circles. Participants who did not report use of any of the four drug classes depicted are not shown in the figure but are counted in the denominator. 'Stimulants' includes methamphetamine, cocaine, MDA, ecstasy, OTC stimulants and/or pharmaceutical stimulants. 'Opioids' includes heroin, methadone, morphine, oxycodone, buprenorphine, buprenorphine-suboxone, fentanyl, other pharmaceutical opioids (codeine, tapentadol, tramadol, etc). Use of benzodiazepines, opioids and stimulants could be prescribed or non-prescribed use. Y axis reduced to 40% to improve visibility of trends.

Binge Drug Use

Participants were asked whether they had used any drug/s for 48 hours or more continuously without sleep (i.e., binged) in the six months preceding interview. In 2025, 46% of the Darwin sample had binged on one or more drugs in the preceding six months, stable relative to 59% in 2024 ($p=0.205$) (Figure 24).

Figure 24: Past six month use of drugs for 48 hours or more continuously without sleep ('binge'), Darwin, NT, 2018-2025



Note. Participants were first asked about bingeing in 2018 and were not asked about bingeing in 2020. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; $*p < 0.050$; $**p < 0.010$; $***p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Overdose Events

Non-Fatal Overdose

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

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

- **Opioid overdose** (e.g., reduced level of consciousness, respiratory depression, turning blue, collapsing and being unable to be roused). Participants who reported this experience were asked to identify all opioids involved in such events in the past 12 months;

- **Non-opioid overdose** (e.g., nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, seizure, extreme paranoia, extreme anxiety, panic, extreme agitation, hallucinations). Drugs other than opioids were split into the following:
 - **Stimulant overdose:** Stimulant drugs include ecstasy, methamphetamine, cocaine, MDA, methylone, mephedrone, pharmaceutical stimulants and stimulant NPS (e.g., MDPV, Alpha PVP); and
 - **Other drug overdose:** 'Other drugs' include (but are not limited to) alcohol, cannabis, GHB/GBL/1,4-BD, amyl nitrite/alkyl nitrite, benzodiazepines and LSD.

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

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

Consistent with previous years, few participants ($n \leq 5$) reported experiencing a non-fatal overdose in the previous 12 months in 2025 ($n \leq 5$ in 2024). Accordingly, further information about overdose is not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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

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

The mean score on the AUDIT-C for the total sample (including participants who had not consumed alcohol in the past 12 months) was 3.1 (SD 3.2) in 2025, a significant increase from a score of 2.9 (SD 3.5) in 2024 ($p=0.002$).

AUDIT-C scores of ≥ 4 (men) and ≥ 3 (women) are likely to indicate hazardous drinking, and potentially, alcohol dependence (Table 5). In 2025, half (53%) of male participants had obtained a score of four or more (33% in 2024; $p=0.102$), and two fifths (42%) of female participants had obtained a score of three or more, indicative of hazardous use (35% in 2024; $p=0.766$) (Table 5).

Table 5: AUDIT-C total scores and per cent of participants scoring above recommended levels, Darwin, NT, 2010-2025

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
	Men															
Mean AUDIT-C score (SD)	4.1 (3.9)	4.7 (4.1)	4.1 (4.1)	6.2 (4.3)	4.9 (3.8)	4.9 (4.0)	3.9 (3.7)	4.1 (4.1)	3.8 (3.6)	4 (4.1)	8.8 (3.1)	7.3 (2.8)	3.3 (4.3)	~	2.8 (3.1)	3.6 (3.2)
Score of ≥4 (%)	46	48	49	67	58	61	45	41	47	47	93	94	38	~	33	53
	Women															
Mean AUDIT-C score (SD)	3.6 (3.7)	3.4 (3.4)	2.9 (3.8)	2.5 (3.8)	4.5 (4.5)	3.5 (4.1)	2.9 (3.6)	3 (3.3)	2.8 (3.1)	3.2 (4.2)	7.9 (2.8)	6.9 (3.2)	2.1 (3.1)	~	2.7 (3.8)	2.5 (3.1)
Score of ≥3 (%)	54	52	39	28	53	40	40	40	43	37	94	94	33	~	35	43

Note. Monitoring of AUDIT-C commenced in 2010. Computed from the entire sample regardless of whether they had consumed alcohol in the past twelve months. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Naloxone Program and Distribution

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

Awareness of Naloxone: Awareness of naloxone gradually decreased between 2017 (85%) and 2020 (49%), before subsequently stabilising. In 2025, 45% of participants reported having heard of naloxone (40% in 2024; $p = 0.580$) (Figure 25).

Awareness of Take-Home Naloxone: Two fifths (42%) of participants reported awareness of take-home naloxone in 2025 (39% in 2024; $p = 0.848$) (Figure 25). In 2025, no participants reported having heard of paid access, however, two fifths (42%) reported having heard of free access (37% in 2024; $p = 0.694$).

Obtained Naloxone: In 2025, one quarter (25%) of participants reported having ever obtained naloxone (11% in 2024; $p = 0.093$), with one fifth (21%) of the total sample having done so in the past year, stable relative to 10% in 2024 ($p = 0.122$) (Figure 26). Among those that had ever accessed naloxone and responded ($n = 13$), most participants reported accessing naloxone from an NSP (85%;

85% in-person the last time. All participants (100%) reported that they did not have to pay the last time they accessed naloxone.

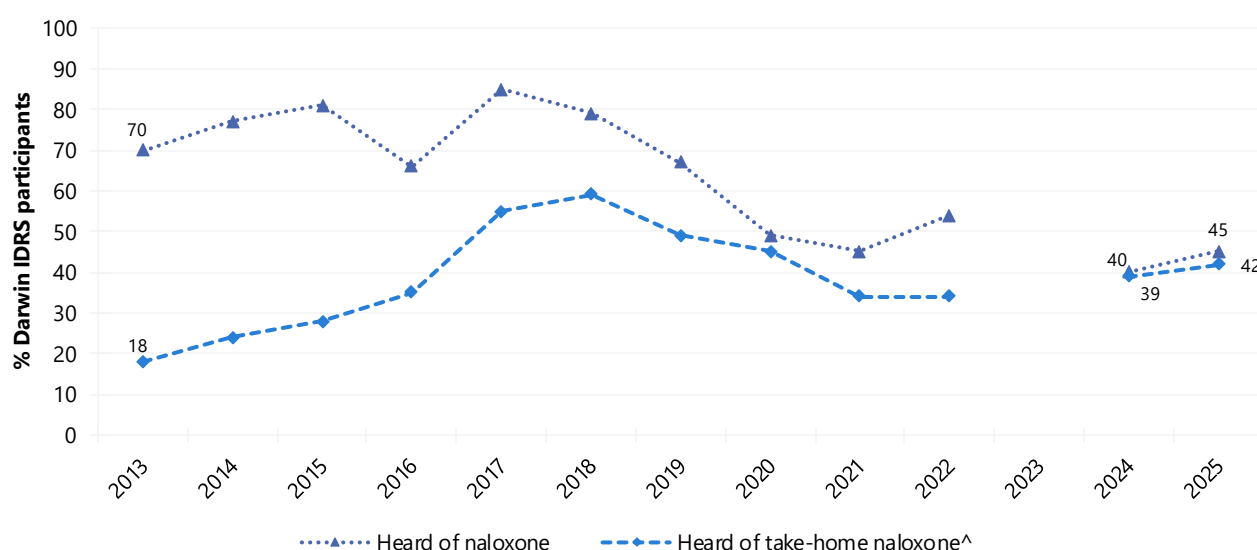
In 2025, of those who reported obtaining naloxone at least once in their lifetime ($n=13$), 69% had a median of one naloxone kit stored away at the time of interview (IQR=0-2; $n=9$). Among those with at least one naloxone kit stored away and who responded ($n=6$), 100% had at least one kit within its expiration date, no participants had at least one kit that was expired, and no participants had both expired and non-expired kits.

No participants reported that they had tried to obtain naloxone in their lifetime but had been unsuccessful (note: a small per cent of participants reported never trying to obtain naloxone despite having obtained it in their lifetime – this could reflect that they had been given naloxone, but never actively sought it out). Out of those who had either ever had trouble obtaining naloxone or never tried to obtain naloxone ($n=38$), the main reason comprised ‘don’t use opioids’ (21%). Few participants ($n\leq 5$) cited other reasons.

Education on Using Naloxone: In 2025, almost one quarter (23%) of the sample reported participation in naloxone training programs in their lifetime, stable relative to 2024 (16%; $p=0.355$), with few participants ($n\leq 5$) reporting having done so in the past year (9% in 2024; $p=0.464$) (Figure 26). No participants reported that the training they received was online.

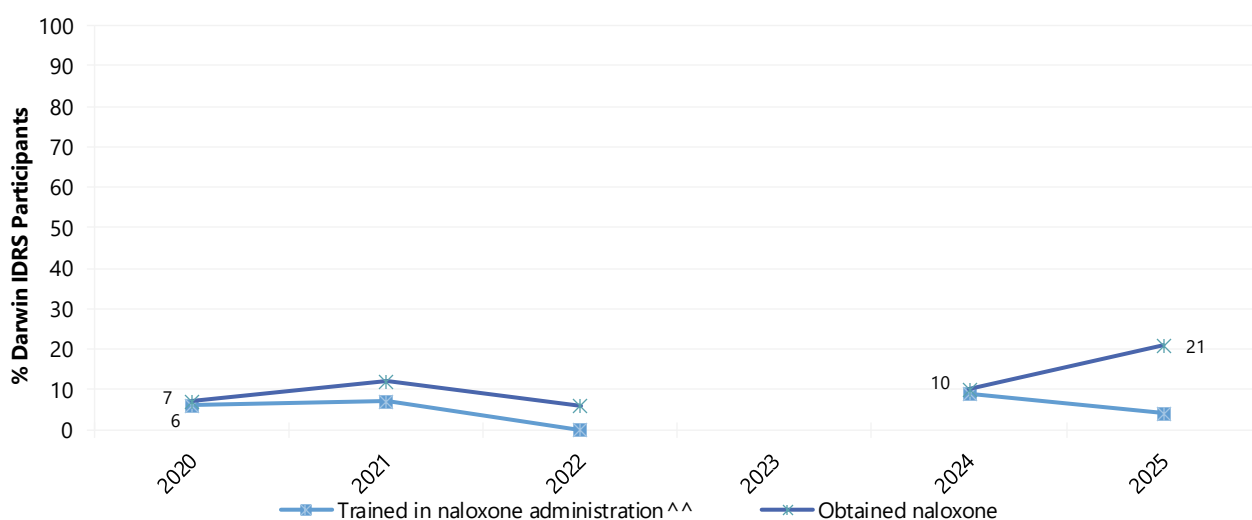
Use of Naloxone to Reverse Overdose: In 2025, few participants ($n\leq 5$) reported that they had resuscitated someone using naloxone (0% in 2024; $p=0.431$) and no participants reported that they had been resuscitated themselves by a peer using naloxone in the past year (0% in 2024). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 25: Lifetime awareness of naloxone and naloxone take-home programs, Darwin, NT, 2013-2025



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

Figure 26: Past 12 month education in naloxone administration, and obtainment of naloxone, Darwin, NT, 2020-2025



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

Equipment Access and Injecting Behaviours

Equipment Access

In 2025, participants reported obtaining a median of 80 new needle and syringes in the month prior to interview (IQR=16-175; 100 in 2024; IQR=44-200; $p=0.134$), having a median of eight needles and syringes 'stored away' (IQR=0-68; 10 in 2024; IQR=2-60; $p=0.266$) and providing a median of 5 needles and syringes to others (IQR=0-33), a significant decrease from 2024 (20 needles; IQR=5-50; $p=0.037$) (Table 6).

In 2025, few participants ($n \leq 5$) reported difficulties obtaining new needles/syringes ($n \leq 5$ in 2024; $p=0.232$) and no participants reported difficulty obtaining filters in the past month ($n \leq 5$ in 2024; $p=0.133$) (Table 6). Few participants ($n \leq 5$) reported difficulties obtaining sterile water (not asked in 2024). The majority (96%) of participants reported that they had obtained needles from an NSP in the month preceding interview in 2025 (99% in 2024; $p=0.579$), and 15% obtained them from an NSP vending machine (25% in 2024; $p=0.262$). No participants reported having obtained needles and syringes from an NSP via the post (not asked in 2024) and a significant increase was observed in participants having obtained needles and syringes from a partner or friend in 2025 (11%; $n \leq 5$ in 2024; $p=0.042$) (Table 6).

Injecting Behaviours

In 2025, few participants ($n \leq 5$) reported receptive ($n \leq 5$ in 2024; $p=0.575$) or distributive ($n \leq 5$ in 2024; $p=0.234$) needle sharing in the month prior to interview (Figure 27), while one fifth (17%) had reused their own needle, stable relative to 2024 (19%).

In 2025, almost one third (30%) of participants reported that they had injected someone else in the past month (24% in 2024; $p=0.534$) and 17% were injected by someone else in the past month (14% in 2024; $p=0.798$) (Table 7). Sharing of other injecting equipment remained low, with few participants ($n \leq 5$) reporting sharing in 2025 ($n \leq 5$ in 2024). Almost one third (32%) of the Darwin sample reported reusing other injecting equipment in the past month, stable relative to 2024 (36%; $p=0.707$), most commonly tourniquets (26%; 30% in 2024; $p=0.693$) (Table 7).

The location of last injection remained stable between 2024 and 2025 ($p=0.303$). Consistent with previous years, the majority of participants (85%) had most recently injected in a private home (93% in 2024) (Table 7).

Two fifths (38%) of the Darwin sample reported injecting alone on the last occasion of injecting, stable relative to 36% in 2024 ($p=0.847$).

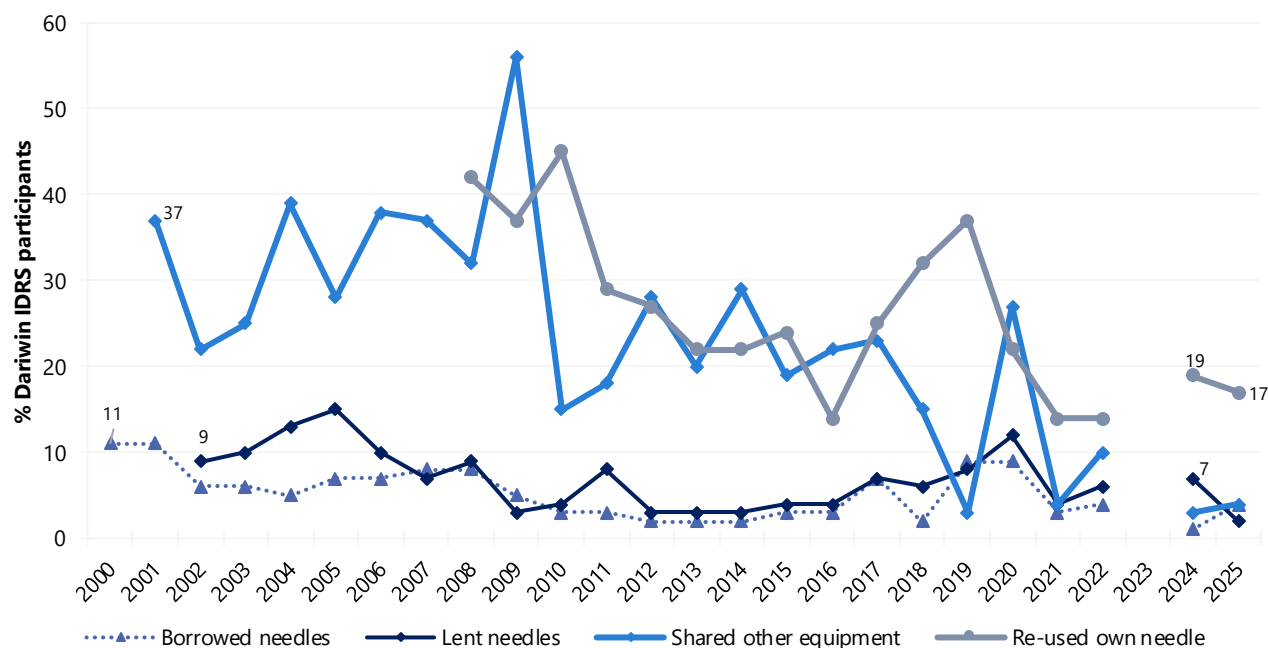
The site of last injection also remained stable between 2024 and 2025 ($p=0.680$). Consistent with previous years, the majority of the sample (85%) reported injecting in their arm on the last occasion of injecting (84% in 2024), with few participants ($n \leq 5$) reporting other injecting sites (Table 7).

Table 6: Injecting equipment access in the past month, Darwin, NT, 2024-2025

	2024 (N=69)	2025 (N=53)
% Location of needle/syringe access past month		
NSP	99	96
NSP vending machine	25	15
Posted from NSP	/	0
Chemist	-	0
Friend/partner	-	11*
Dealer	-	-
Hospital	0	0
Outreach/peer worker	-	-
Medically supervised injecting Centre/Room	0	0
Other	0	0
% Difficulties accessing filters^ in past month	-	0
% Difficulties accessing needles/syringes in past month	-	-
% Equipment used past month	n=69	n=53
Needle and syringe (e.g., 0.5mL, 1mL)	87	92
Syringe or barrel (e.g., 3mL, 5mL, 10mL, 20mL, 50mL)	17	13
Spoons/mixing containers	16	-
Tourniquet	41	38
Swabs	96	91
Water	97	96
Any filters	33	30

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

Figure 27: Borrowing and lending of needles and sharing of injecting equipment in the past month, Darwin, NT, 2000-2025



Note. Borrowed (receptive): used a needle after someone else. Lent (distributive): somebody else used a needle after them. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 7: Injecting behaviours in the past month, and location of last injection use, Darwin, NT, 2015-2025

	2015 N=99	2016 N=90	2017 N=109	2018 N=99	2019 N=99	2020 N=78	2021 N=94	2022 N=70	2023	2024 N=70	2025 N=53
% Injecting behaviours past month											
Borrowed a needle	N=99 -	N=90 -	N=107 7	N=98 -	N=98 9	N=78 9	N=94 -	N=70 -	~	N=70 -	N=52 -
Lent a needle	N=99 -	N=90 -	N=106 7	N=98 -	N=95 8	N=78 12	N=94 -	N=70 -	~	N=70 -	N=53 -
Shared any injecting equipment ^	N=99 22	N=90 22	N=107 25	N=98 16	N=99 -	N=78 27	N=94 -	N=70 10	~	N=70 -	N=53 -
Re-used own needle	N=97 24	N=90 14	N=104 25	N=98 32	N=98 37	N=78 22	N=94 14	N=70 20	~	N=70 19	N=53 17
Re-used any other equipment	N=99 71	N=90 70	N=105 60	N=99 48	N=99 22	/	/	/	~	N=70 36	N=53 32
Injected partner/friend	/	N=90 26	N=106 41	N=98 34	N=99 30	N=78 28	N=94 14	N=70 23	~	N=70 24	N=53 30
Somebody else injected them	/	N=90 18	N=106 20	N=98 16	N=99 21	N=78 18	N=94 7	N=70 13	~	N=70 14	N=53 17
% Location of last injection	N=97	N=90	N=105	N=98	N=98	N=78	N=94	N=69	~	N=70	N=53
Private home	90	96	91	92	86	85	91	88	~	93	85
Car	-	-	-	-	-	13	-	-	~	-	-
Street/car park/beach	-	-	-	-	-	-	-	-	~	-	-
Public toilet	-	-	0	-	6	-	0	-	~	-	-
Medically supervised injecting centre/room	-	0	0	0	-	0	-	0	~	0	0
Prison	0	0	0	0	0	0	0	0	0	0	0
Stairwell	0	0	0	0	0	0	-	0	-	0	0
Other	90	96	91	92	86	85	91	0	~	0	0
% Last injection site											
Arm	58	76	65	73	76	81	85	74	83	84	85
Leg	10	9	14	6	13	8	7	9	-	9	-
Hand/wrist	23	12	13	15	8	9	-	11	-	-	-
Foot	-	0	-	-	0	0	0	-	-	0	0
Groin	-	-	-	-	-	-	-	-	0	-	-
Neck	-	0	-	-	0	-	-	0	0	0	-
Other	-	-	0	-	-	0	0	0	0	0	0

Note. ^ Includes spoons, water, tourniquets and filters; excludes needles/syringes. Borrowed (receptive): used a needle after someone else. Lent (distributive): somebody else used a needle after them. N is the number who responded (denominator). Due to the particularly small

sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Self-Reported Injection-Related Injuries and Diseases

Few participants ($n \leq 5$) reported experiencing an injection-related health problem in the month prior to interview in 2025 ($n \leq 5$ in 2024; $p = 0.465$) (Table 8). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Table 8: Injection-related issues in the past month, Darwin, NT, 2020-2025

	2020	2021	2022	2023	2024	2025
	(N = 78)	(N = 94)	(N = 69)		(N = 68)	(N = 53)
% Artery injection	-	-	0	~	0	0
% Any nerve damage	-	0	-	~	-	-
% Any thrombosis	-	0	-	~	0	0
Blood clot	-	0	-	~	0	0
Deep vein thrombosis	-	0	-	~	0	0
% Any infection/abscess	-	-	-	~	-	-
Skin abscess or cellulitis	0	-	-	~	-	0
Endocarditis	-	0	0	~	-	0
Other serious infection (e.g., osteomyelitis/Sepsis/Septic arthritis)	0	0	0	~	0	-
% Dirty hit	0	-	-	~	-	0
% Any injection-related problem	-	-	16	~	-	-

Note. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Drug Treatment

Few participants ($n \leq 5$) reported currently being in any form of drug treatment for their substance use in 2025 (11% in 2024; $p = 0.552$). Please refer to Table 9 for historical data on drug treatment of the Darwin sample and refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Table 9: Any current drug treatment, Darwin, NT, 2015-2025

	2015 N=98	2016 N=90	2017 N=108	2018 N=108	2019 N=99	2020 N=78	2021 N=94	2022 N=70	2023	2024 N=70	2025 N=53
% Any current drug treatment	23	12	17	22	10	8	11	10	~	11	-
Methadone	12	-	-	-	-	-	6	9	~	-	-
Buprenorphine	-	0	-	0	0	-	-	0	~	-	0
Buprenorphine-naloxone	-	7	7	-	-	-	-	0	~	-	-
Buprenorphine depot injection	/	/	/	/	0	0	-	0	~	0	0
Drug counselling	0	0	-	-	0	-	-	-	~	0	-
Other	-	-	6	-	0	0	0	0	~	0	0

Note. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Opium and Methamphetamine Dependence

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

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

In 2025, of those who had recently used an opium and commented ($n=11$), the median SDS score was one (IQR=0-7; 1 in 2024; IQR=0-2.5). Few participants ($n \leq 5$) scored five or above, indicating possible dependence ($n \leq 5$ in 2024; $p=0.372$) and few participants ($n \leq 5$) obtained a score of zero on the opium SDS, indicating no symptoms of opium dependence (47% in 2024) (Table 10).

Of those who had recently used methamphetamine and commented ($n=51$), the median SDS score was four (IQR=1-5.5; 2 in 2024; IQR=1-4), with half (53%) scoring four or above, indicating possible dependence, a significant increase relative to 2024 (26%; $p=0.005$) (Table 10). Sixteen per cent of participants obtained a score of zero on the methamphetamine SDS, indicative of no or few symptoms of methamphetamine dependence (16% in 2024).

Table 10: Total opioid and methamphetamine SDS scores and per cent of participants scoring above cut-off scores indicative of dependence, among those who reported past six month use, Darwin, NT, 2015-2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Opioid	(N=74)	(N=71)	(N=72)	(N=64)	(N=44)	/	(N=40)	(N=24)	~	(N=19)	(N=11)
Median total score (IQR)	7 (4-11)	6 (3-9)	7 (3-8)	3 (0-6)	5 (1-7)	/	5 (2-7)	5 (2-7)	~	1 (0-2.5)	1 (0-7)
% score = 0	-	11	14	44	20	/	18	-	~	47	-
% score ≥ 5	74	61	69	38	50	/	53	54	~	-	-
Methamphetamine	(N=60)	(N=64)	(N=65)	(N=71)	(N=81)	/	(N=71)	(N=51)	~	(N=61)	(N=51)
Median total score (IQR)	1 (0-3)	1 (0-4)	1 (0-5)	3 (0-8)	1 (0-4)	/	2 (0-6)	3 (0-4)	~	2 (1-4)	4 (1-5.5)
% score = 0	47	42	43	35	46	/	39	29	~	16	16
% score ≥ 4	23	27	29	49	28	/	44	37	~	26	53 **

Note. Severity of Dependence scores calculated out of those who used opioids/methamphetamine recently (past 6 months). A cut-off score of ≥5 and ≥4 is used to indicate screening positive for potential opioid and methamphetamine dependence, respectively. Imputation used for missing scale scores. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in figure; * $p<0.050$; ** $p<0.010$; *** $p<0.001$. Please refer to Table 1 for a guide to table/figure notes.

Bloodborne Virus Testing and Treatment

In 2025, two fifths (42%) of participants reported that they had received a Hepatitis C virus (HCV) antibody test in the past year (58% in 2024; $p=0.136$) and one fifth (21%) had received an RNA test, a significant decrease relative to 2024 (46%; $p=0.012$). Few participants ($n\leq 5$) reported having a current HCV infection (0% in 2024; $p=0.180$) and few participants ($n\leq 5$) reported that they had received HCV treatment in the past year ($n\leq 5$ in 2024) (Table 11).

Amongst those who had undergone an HCV RNA test in the last year and commented ($n=10$), four fifths (80%) reported that it took 1-5 days to receive a result (whether positive or negative), following the administration of the last HCV RNA test.

Three fifths (60%) of participants reported having had a test for human immunodeficiency virus (HIV) in their lifetime (70% in 2024; $p=0.330$) with one fifth (21%) having done so in the six months prior to interview (20% in 2024). No participants reported having ever been diagnosed with HIV, consistent with 2024 (0%) (Table 11).

Table 11: HCV and HIV testing and treatment, Darwin, NT, 2018-2025

	2018 N=99	2019 N=99	2020 N=78	2021 N=94	2022 N=70	2023	2024 N=70	2025 N=53
Past year Hepatitis C test								
Past year hepatitis C antibody test	N=94 41	N=95 47	N=75 36	N=94 27	N=67 40	~	N=66 58	N=48 42
Past year hepatitis C PCR or RNA test	N=90 30	N=90 28	N=74 31	N=94 23	N=65 38	~	N=65 46	N=47 21*
Current hepatitis C status								
Currently have hepatitis C [^]	N=88 13	N=85 14	N=74 -	N=91 7	N=66 -	~	N=63 0	N=47 -

Past year treatment for hepatitis C								
Received treatment in past year	N=94 10	N=95 7	N=75 13	N=92 7	N=67 9	~	N=65 -	N=47 -
Most recent treatment was successful (among those who had received treatment in past year)	N=8 100	-	N=10 80	N=6 -	N=6 -	~	-	-
Re-tested with a PCR or RNA test to determine re-infection (among those who underwent successful treatment)	/	/	/	/	/	~	0	-
HIV test (n)				N=94	N=68		N=70	48
HIV test in past 6 months	/	/	/	9	13	~	20	21
HIV test more than 6 months ago	/	/	/	50	56	~	50	40
HIV status (n)				N=55	N=47		N=49	N=29
Lifetime HIV positive diagnosis	/	/	/	-	-	~	0	0

Note. ^ This includes people who had not been tested for HCV. N is the number who responded (denominator). Timeframes for HCV and HIV differ; i.e., HCV questions focus on lifetime and past year; HIV questions focus on lifetime and past six months. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Sexual Health Behaviours

In 2025, three fifths (62%) of the sample reported some form of sexual activity in the past four weeks (50% in 2024; $p=0.261$) (Table 12). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if the interview was undertaken face-to-face).

Amongst those who reported engaging in sexual activity in the past four weeks and commented ($n=31$), participants reported a median of one partner (IQR=1-2) (1 partner in 2024; IQR=1-2; $p=0.719$). Almost one fifth (19%) reported engaging in sexual activity in the past four weeks in exchange for money, drugs, or other goods and services (24% in 2024; $p=0.770$) (Table 12).

Of those who commented ($n=49$), almost one quarter (24%) reported having a sexual health check-up in the six months prior to interview (16% in 2024; $p=0.346$), whilst two thirds (67%) had done so in their lifetime (54% in 2024; $p=0.186$). Of the total sample who responded ($n=49$), few participants ($n \leq 5$) reported that they had received a positive diagnosis for a sexually transmitted infection (STI) in the six months prior to interview (0% in 2024; $p=0.415$), though 22% had received a positive diagnosis in their lifetime (20% in 2024; $p=0.816$) (Table 12). Given few participants ($n \leq 5$) reported a recent STI diagnosis, data regarding the specific STI diagnosis are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Information about HIV testing provided in Table 11.

Table 12: Sexual health behaviours, Darwin, NT, 2022-2025

	2022	2023	2024	2025
Of those who responded#:	N=68		N=70	N=50
% Any sexual activity in the past four weeks	51	~	50	62
Of those who reported any sexual activity in the past four weeks and responded#:	/	/	n=34	n=31
% Engaged in sexual activity in exchange for money, drugs or other goods or services	/	/	24	19
Of those who responded#:	n=68		n=69	n=49
% Had a sexual health check in the last six months	18	~	16	24
% Had a sexual health check in their lifetime	57	~	54	67
Of those who responded#:	n=68		n=69	49
% Diagnosed with a sexually transmitted infection in the last six months	-	~	0	-
% Diagnosed with a sexually transmitted infection in their lifetime	15	~	20	22

Note. # Due to the sensitive nature of these items, there is missing data for some participants who chose not to respond. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

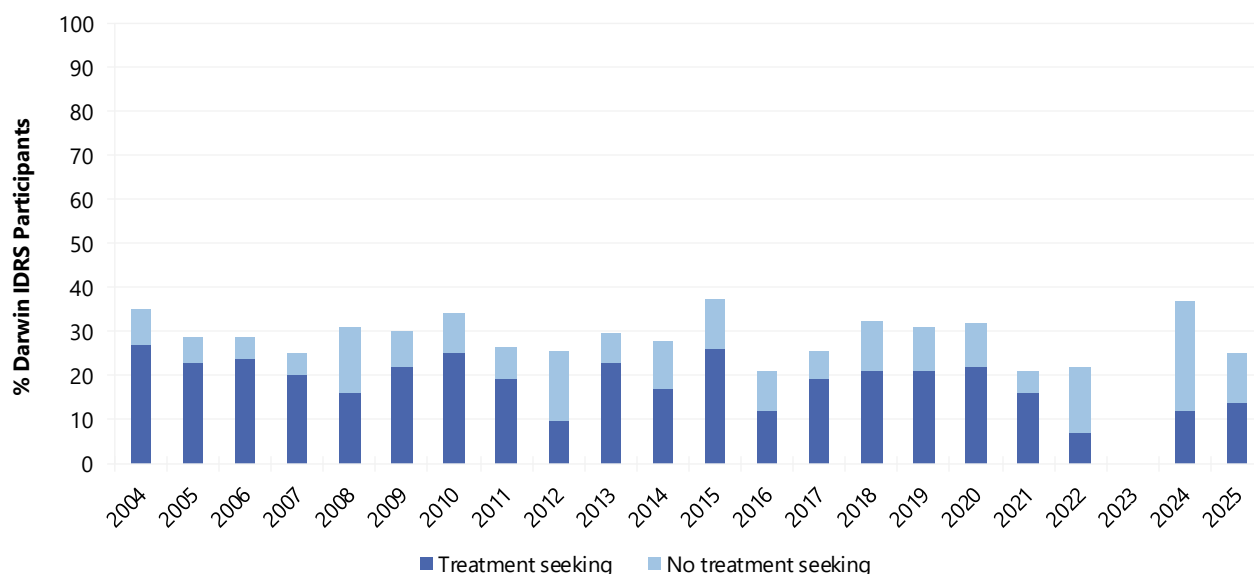
Mental Health and Psychological Distress (K10)

Mental Health

In 2025, one quarter (25%) of the sample self-reported that they had experienced a mental health problem in the preceding six months (37% in 2024; $p=0.239$) (Figure 28). Few participants ($n \leq 5$) were able to report on the specific mental health problems experienced in the six months prior to the interview, as such further details are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Amongst those who self-reported a mental health problem during the past six months, 54% reported seeing a mental health professional during the past six months (32% in 2024; $p=0.304$) (Figure 28). Few participants ($n \leq 5$) reported having been prescribed medication for their mental health problem in 2025 ($n \leq 5$ in 2024). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 28: Self-reported mental health problems and treatment seeking in the past six months, Darwin, NT, 2004-2025



Note. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Psychological Distress (K10)

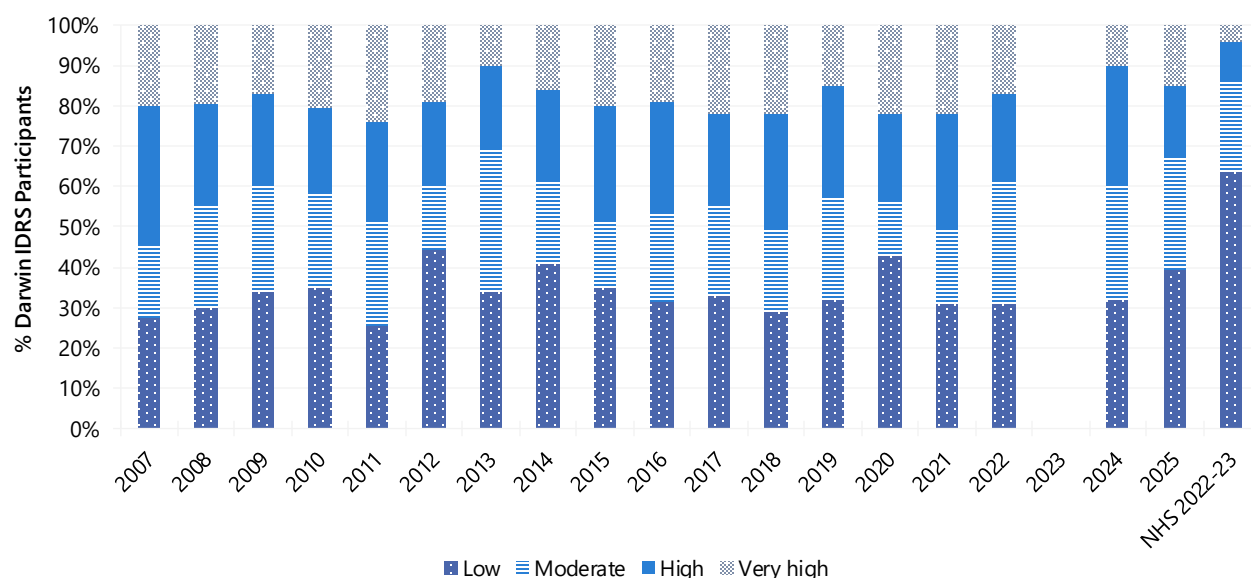
The [Kessler Psychological Distress Scale 10 \(K10\)](#) was administered to obtain a measure of psychological distress in the past four weeks. It is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured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

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

The per cent of participants scoring in each of the four K10 categories remained stable between 2024 and 2025 ($p = 0.448$), with 17% of the Darwin sample having a score of 30 or more in 2025 (30% in 2024) (Figure 29).

The National Health Survey (NHS) 2022-23 provides Australian population data for adult (≥ 18 years) K10 scores. IDRS participants in 2024 reported greater levels of 'high' and 'very high' distress compared to the general population (Figure 29).

Figure 29: K10 psychological distress scores, Darwin, NT, 2007-2025 and among the general population, 2022-23



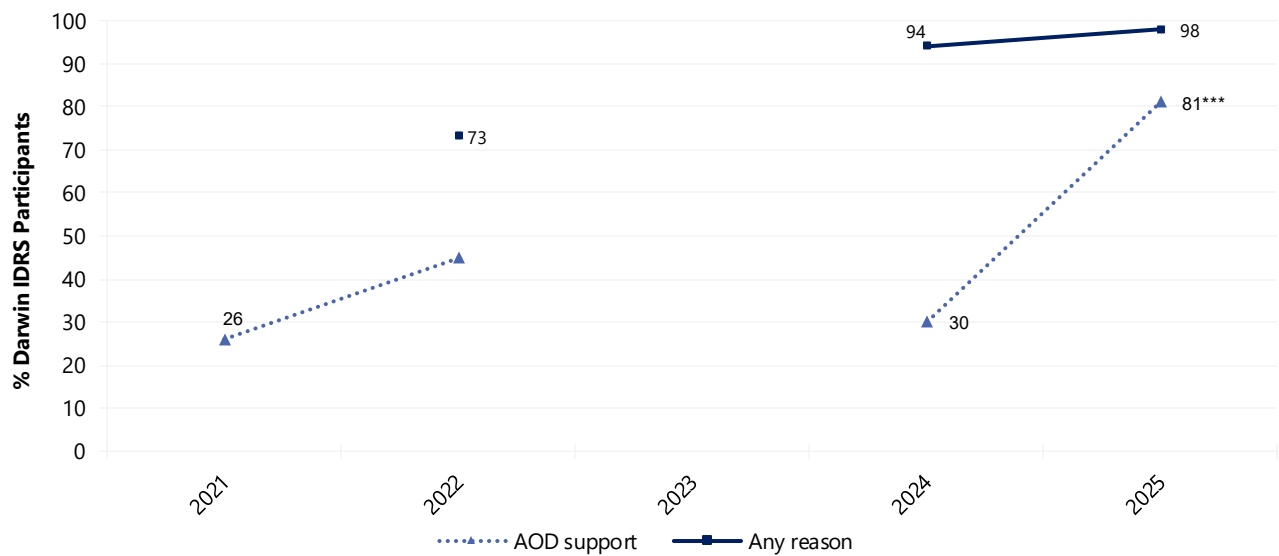
Note. Data from the National Health Survey are a national estimate from 2022-23 for adults 18 or older. Imputation used for missing scale scores (IDRS only). Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Health Service Access

Four fifths (81%) of the Darwin sample reported accessing any health service for alcohol and/or drug (AOD) support in the six months preceding interview in 2025, a significant increase from 2024 (30%; $p < 0.001$) (Figure 30). The most common health service accessed by participants for AOD support in 2025 was an NSP, a significant increase relative to 2024 (77%; 27% in 2024; $p < 0.001$) (Table 13).

The majority (98%) of the Darwin sample reported accessing any health service for any reason in the six months preceding interview in 2025 (94% in 2024; $p = 0.389$) (Figure 30). The most common services accessed by participants for any reason in 2025 were a NSP (91%; 93% in 2024; $p = 0.749$), a general practitioner (GP) (42%; 50% in 2024; $p = 0.366$) and a pharmacy (28%; 40% in 2024; $p = 0.190$) (Table 13).

Figure 30: Health service access for alcohol and other drug reasons, and for any reason, in the past six months, Darwin, NT, 2021-2025



Note. Questions regarding health service access for AUD support were first asked in 2018, however due to differences in response options between 2018 and 2020, data are presented from 2021 onwards. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and most recent year of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Table 13: Types of health services accessed for alcohol and other drug reasons and for any reason, in the past six months, Darwin, NT, 2022-2025

	AOD support				Any reason			
	2022	2023	2024	2025	2022	2023	2024	2025
% accessing health services	(N=69) 45	~	(N=70) 30	(N=53) 81***	(N=70) 73	~	(N=70) 94	(N=53) 98
GP	12	~	-	-	53	~	50	42
<i>In-person</i>	/	/	/	-	/	/	/	42
<i>Telehealth</i>	/	/	/	0	/	/	/	0
Emergency department	-	~	-	-	14	~	-	11
Hospital admission (inpatient)	-	~	-	-	14	~	10	-
Medical tent (e.g., at a festival)	0	~	0	0	0	~	0	0
Drug and Alcohol counsellor	9	~	0	-	-	~	0	-
Hospital as an outpatient	-	~	0	0	10	~	-	-
Specialist doctor (not including a psychiatrist)	-	~	0	0	-	~	0	0
Dentist	-	~	0	0	13	~	-	-
Ambulance attendance	-	~	-	0	-	~	-	0
Pharmacy	/	/	-	-	/	/	40	28
Other health professional (e.g., physiotherapist)	-	~	0	0	-	~	-	-
Psychiatrist	-	~	-	0	-	~	-	0
Psychologist	-	~	-	0	-	~	-	-
NSP	35	~	27	77***	49	~	93	91
Peer based harm reduction service	0	~	0	-	0	~	0	0
Other harm reduction service	0	~	-	0	0	~	-	-

Note. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

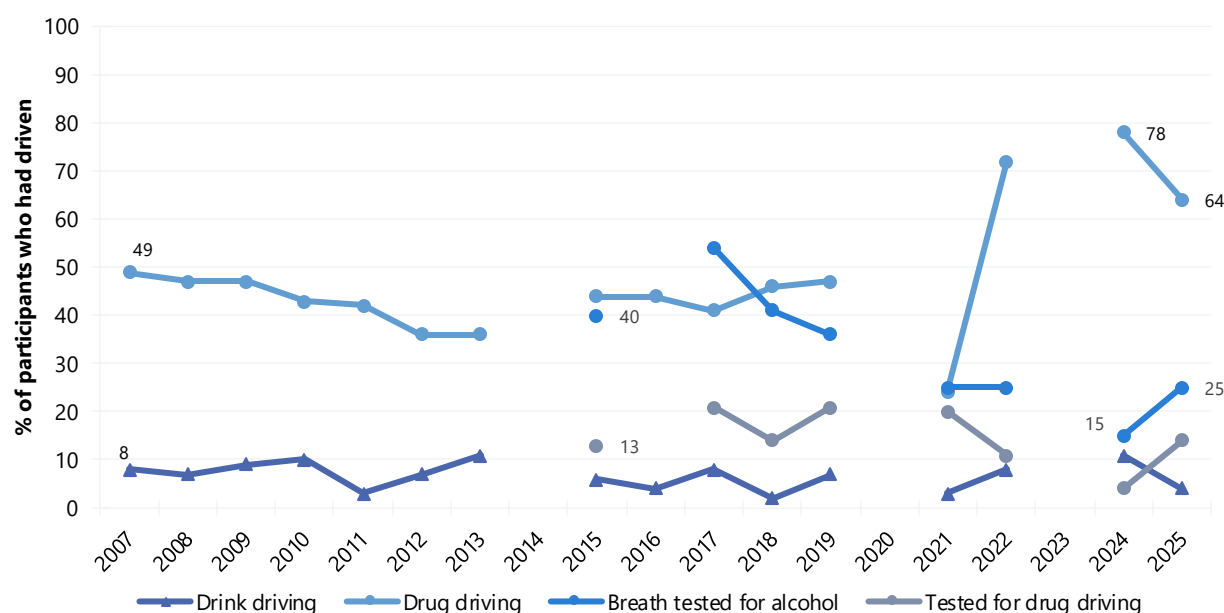
Driving

Fifty-three per cent of the Darwin sample had driven a car, motorcycle or other vehicle in the last six months (Figure 31). Among these participants, few ($n \leq 5$) reported driving while over the perceived legal limit of alcohol ($n \leq 5$ in 2024; $p=0.610$), whilst 64% reported driving within three hours of consuming an illicit drug in the last six months (78% in 2024; $p=0.373$) (Figure 31).

Of those who had driven within three hours of consuming an illicit or non-prescribed drug in the six months preceding interview and responded ($n=18$), participants most commonly reported using methamphetamine crystal (78%) prior to driving in the last six months, followed by cannabis (44%).

One quarter (25%) of participants reported that they had been breath tested for alcohol by the police roadside testing in the 6 months preceding interview (15% in 2024; $p=0.503$) whilst few participants ($n \leq 5$) reported that they had been tested for drug driving ($n \leq 5$ in 2024; $p=0.352$) (Figure 31). As few participants ($n \leq 5$) reported that they had been tested for drug driving, further details on specific drugs detected by drug driving tests will not be reported (not asked in 2024). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 31: Self-reported testing, and driving over the (perceived) legal limit for alcohol or within three hours following illicit drug use, among those who had driven in the last six months, Darwin, NT, 2007-2025



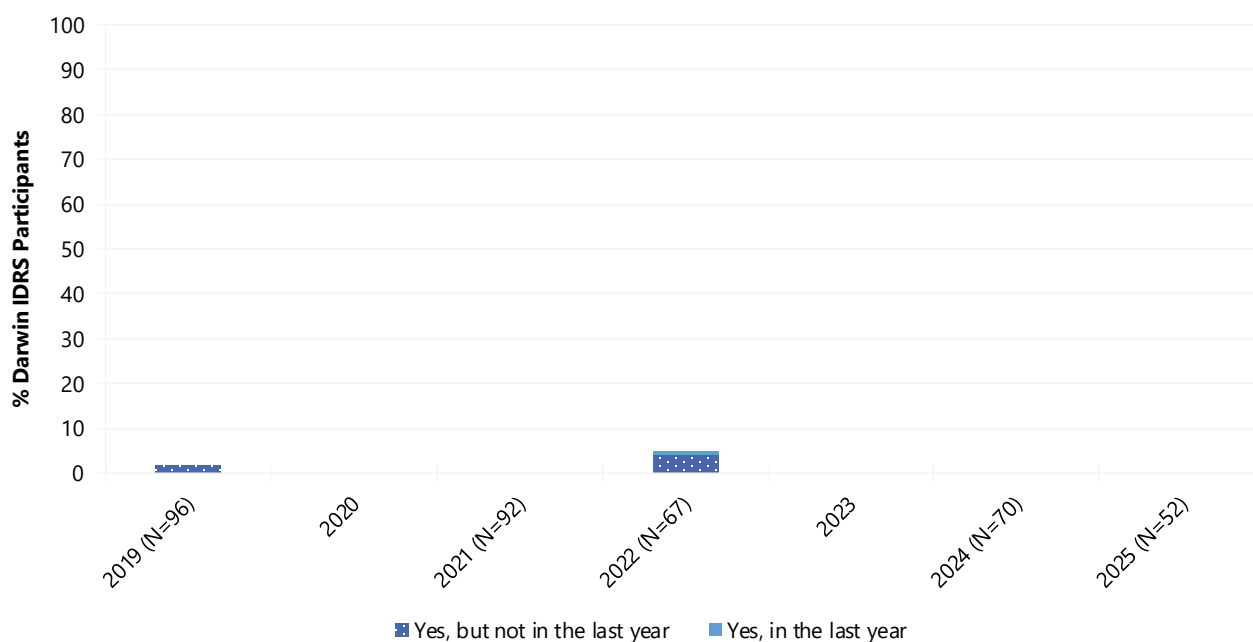
Note. Computed of those who had driven a vehicle in the past six months. Questions about driving behaviour were first asked in 2007. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and most recent year of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Drug Checking

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

In 2025, few participants ($n \leq 5$) reported that they or someone else had ever tested the contents and/or purity of their illicit drugs in Australia (0% in 2024) (Figure 32). Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 32: Lifetime and past year engagement in drug checking, Darwin, NT, 2019-2025



Note. Questions on drug checking commenced in 2019. In 2025, survey questions were separated into 'personal testing kits' and 'drug checking services' and focused on past year use only. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports. Data are suppressed in the figure where $n \leq 5$ responded to the item. Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Experience of Crime and Engagement with the Criminal Justice System

Two fifths (41%) of the Darwin sample reported engaging in 'any' criminal activity in the month prior to interview (36% in 2024; $p=0.692$), with property crime (37%; 31% in 2024; $p=0.567$) and selling drugs for cash profit (14%; 10% in 2024; $p=0.576$), remaining as the most commonly reported crimes (Figure 33).

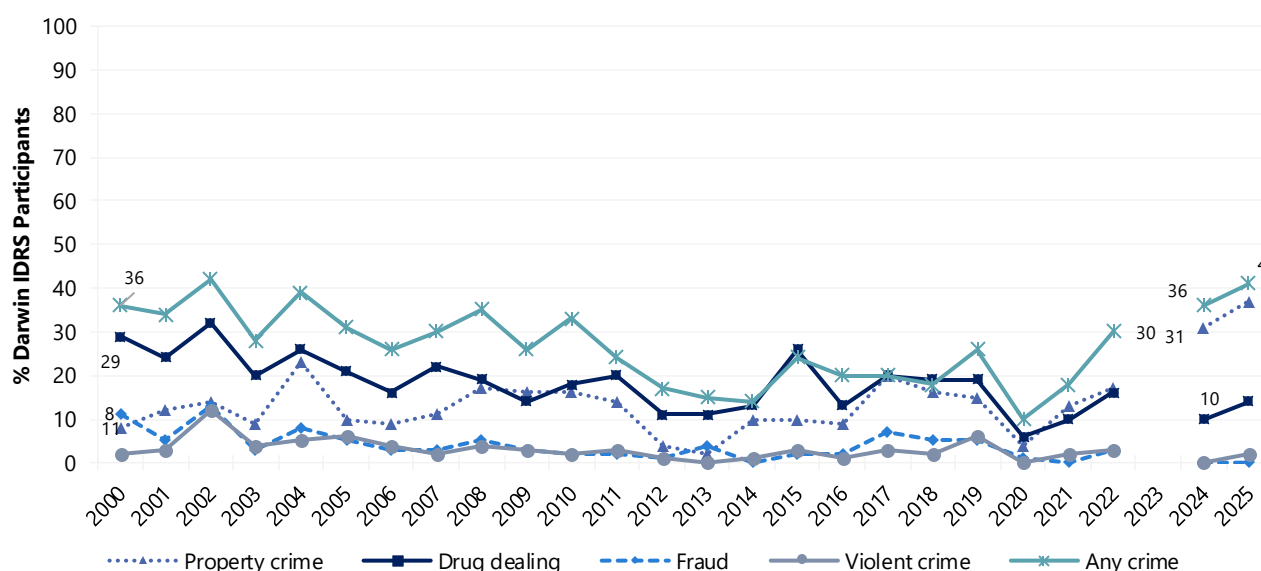
Few participants ($n \leq 5$) reported being the victim of a violent crime in the month preceding interview (12% in 2024; $p=0.185$) (Figure 34).

Few participants ($n \leq 5$) reported being arrested within 12 months of the interview ($n \leq 5$ in 2024; $p=0.135$). As such, few participants ($n \leq 5$) were able to comment on reasons for past 12 month arrest, therefore, these data are not reported. Please refer to the [2025 National IDRS Report](#) for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Few participants ($n \leq 5$) reported a drug-related encounter in the last 12 months which did not result in charge or arrest in 2025 ($n \leq 5$ in 2024). In 2025, few participants ($n \leq 5$) had been convicted of a drug-related offence in the past year ($n \leq 5$ in 2024) or been sentenced to a community corrections order.

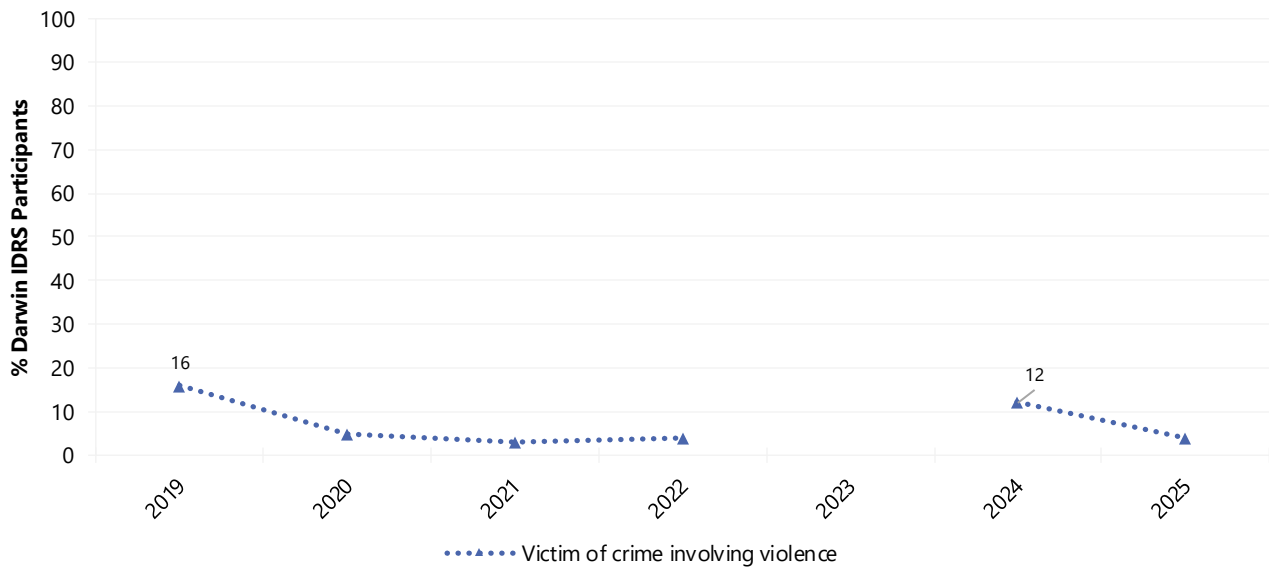
Almost half (48%) of the sample reported a lifetime prison history (52% in 2024; $p=0.719$) (Figure 35).

Figure 33: Self-reported criminal activity in the past month, Darwin, NT, 2000-2025



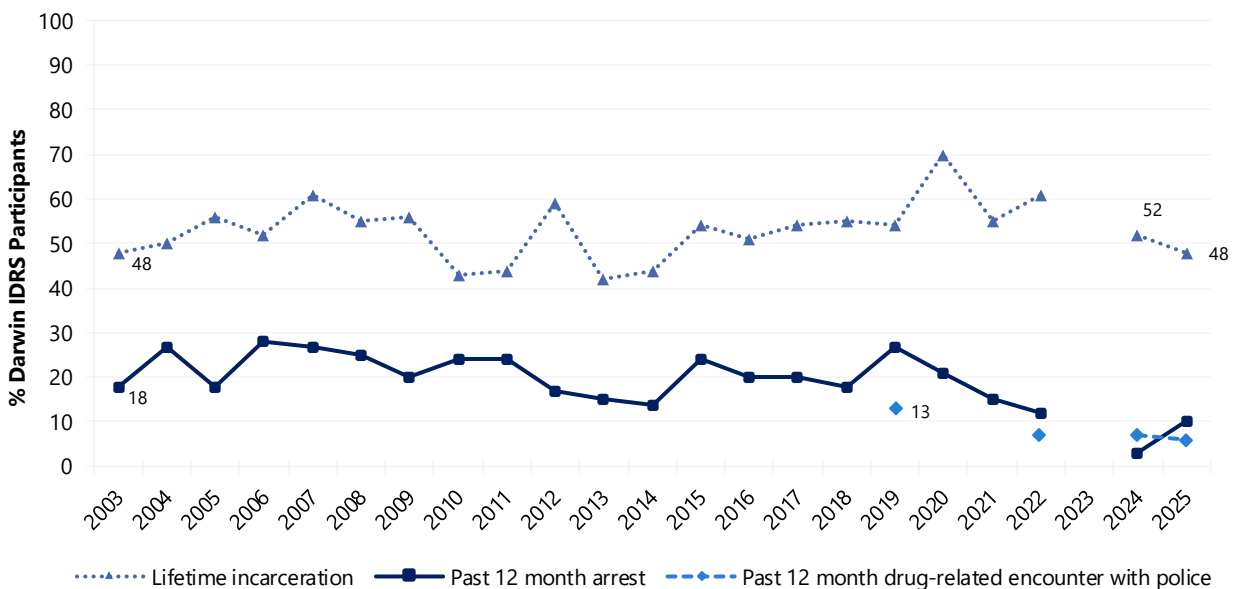
Note. 'Any crime' comprises the per cent who report any property crime, drug dealing, fraud and/or violent crime in the past month. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 34: Victim of crime involving violence in the past month, Darwin, NT, 2019-2025



Note. Questions regarding being the victim of a crime involving violence were first asked in 2019. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Figure 35: Lifetime incarceration, and past 12 month arrest and drug-related encounters with police that did not result in arrest, Darwin, NT, 2003-2025



Note. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Data labels are only provided for the first and two most recent years of monitoring, however labels are suppressed where there are small numbers (i.e., $n \leq 5$ but not 0). Statistical significance for 2024 versus 2025 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.

Modes of Purchasing Illicit or Non-Prescribed Drugs

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

Purchasing Approaches

In 2025, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (96%; 94% in 2024; $p=0.698$), followed by text messaging (11%), which significantly decreased from 2024 (33%; $p=0.012$). Few participants ($n \leq 5$) reported using phone calls as a mode of purchasing illicit or non-prescribed drugs, a significant decrease relative to 44% in 2024 ($p < 0.001$) (Table 14). Few participants ($n \leq 5$) reported arranging the purchase of illicit or non-prescribed drugs via social networking or messaging applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder). It is important to re-iterate that this refers to people *arranging the purchase* of illicit or non-prescribed drugs. This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person.

Table 14: Purchasing approaches in the past 12 months, Darwin, NT, 2022-2025

	2022	2023	2024	2025
% Purchasing approaches in the last 12 months [^] #	N=70		N=70	N=53
Face-to-face	63	~	94	96
Surface web	0	~	0	0
Darknet market	-	~	-	-
Social networking or messaging applications [`]	-	~	0	-
Text messaging	20	~	33	11*
Phone call	33	~	44	- ***
Grew/made my own	/	/	0	-
Other	/	/	0	0

Note. [^] participants could endorse multiple responses. [#]This refers to people *arranging the purchase* of illicit or non-prescribed drugs. [`] This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person. Due to the particularly small sample recruited in 2023, data from this year are not presented in this report. Statistical significance for 2024 versus 2025 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$. Please refer to Table 1 for a guide to table/figure notes.