



**EDRS**



# **SOUTH AUSTRALIAN DRUG TRENDS 2022**

**Key Findings from the South Australian Ecstasy and  
related Drugs Reporting System (EDRS) Interviews**



# SOUTH AUSTRALIAN DRUG TRENDS 2022: KEY FINDINGS FROM THE ECSTASY AND RELATED DRUGS REPORTING SYSTEM (EDRS) 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](#).

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### Research Team

The National Drug and Alcohol Research Centre (NDARC), University of New South Wales (UNSW) Sydney, coordinated the EDRS. The following researchers and research institutions contributed to the EDRS in 2022:

- Dr Rachel Sutherland, Fiona Jones, Antonia Karlsson, Julia Uporova, Cate King, Daisy Gibbs, Olivia Price, 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;
- Joanna Wilson, Sarah Eddy, Dr Campbell Aiken and Professor Paul Dietze, Burnet Institute, Victoria;
- Yalei Wilson and Associate Professor Raimondo Bruno, School of Psychology, University of Tasmania, Tasmania;
- Dr Jodie Grigg and Professor Simon Lenton, National Drug Research Institute and enAble Institute, Curtin University, Western Australia; and
- Catherine Daly, Dr Jennifer Juckel, Dr Natalie Thomas and Associate Professor Caroline Salom, Institute for Social Science Research, The University of Queensland, Queensland.

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### Participants

We would like to thank all the participants who were interviewed for the EDRS 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

<b>1,4-BD</b>	1,4-Butanediol
<b>4-AcO-DMT</b>	4-Acetoxy-N,N-dimethyltryptamine
<b>4-FA</b>	4-Fluoroamphetamine
<b>5-MeO-DMT</b>	5-methoxy-N,N-dimethyltryptamine
<b>2C-B</b>	4-bromo-2,5-dimethoxyphenethylamine
<b>AIVL</b>	Australian Injecting and Illicit Drug Users League
<b>Alpha PVP</b>	$\alpha$ -Pyrrolidinopentiophenone
<b>AUDIT</b>	Alcohol Use Disorders Identification Test
<b>BZP</b>	Benzylpiperazine
<b>CBD</b>	Cannabidiol
<b>DMT</b>	Dimethyltryptamine
<b>DO-x</b>	4-Substituted-2,5-dimethoxyamphetamines
<b>EDRS</b>	Ecstasy and Related Drugs Reporting System
<b>GBL</b>	Gamma-butyrolactone
<b>GHB</b>	Gamma-hydroxybutyrate
<b>HIV</b>	Human immunodeficiency virus
<b>IDRS</b>	Illicit Drug Reporting System
<b>IQR</b>	Interquartile range
<b>LSD</b>	<i>d</i> -lysergic acid
<b>MDA</b>	3,4-methylenedioxyamphetamine
<b>MDMA</b>	3,4-methylenedioxymethamphetamine
<b>MDPV</b>	Methylenedioxypropylvalerone
<b>MXE</b>	Methoxetamine
<b>N (or n)</b>	Number of participants
<b>NBOME</b>	N-methoxybenzyl
<b>NDARC</b>	National Drug and Alcohol Research Centre
<b>NPS</b>	New psychoactive substances
<b>NSW</b>	New South Wales
<b>OTC</b>	Over-the-counter
<b>PCR</b>	Polymerase Chain Reaction
<b>PMA</b>	Paramethoxyamphetamine
<b>PMMA</b>	Polymethyl methacrylate
<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>REDCAP</b>	Research Electronic Data Capture
<b>SA</b>	South Australia
<b>SD</b>	Standard deviation
<b>SSDP</b>	Students for Sensible Drug Policy
<b>STI</b>	Sexually transmitted infection

<b>THC</b>	Tetrahydrocannabinol
<b>UNSW</b>	University of New South Wales
<b>WA</b>	Western Australia
<b>WHO</b>	World Health Organization

## Executive Summary

The Adelaide South Australia (SA) EDRS comprises a sentinel sample of people who regularly use ecstasy and other illicit stimulants recruited via social media, advertisements on websites and word-of mouth in Adelaide, SA. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2022 from May-June. Interviews in 2020, 2021 and 2022 were delivered face-to-face as well as via telephone, to reduce the risk of COVID-19 transmission; all interviews prior to 2020 were conducted face-to-face. This methodological change should be factored into all comparisons of data from the 2020-2022 samples, relative to previous years.**

### Sample Characteristics

The EDRS sample (N=104) recruited from Adelaide was similar to the sample in 2021 and in previous years. Gender remained stable between 2021 and 2022, with half (50%) identifying as male (57% in 2021), and participants had a median age of 26 years. Most participants held tertiary qualifications (69%), with one-fifth (21%) reporting full-time employment and 42% reporting part time/casual employment. Accommodation remained stable relative to 2021, with half the sample (50%; 49% in 2021) living in a rental house/flat or residing with their parents/at their family home (28%; 40% in 2021) at the time of interview. Drug of choice and drug used most often remained stable between 2021 and 2022, with almost one-third (31%) nominating cannabis as the drug of choice (22% in 2021), and alcohol was reported as the drug used most often in the month preceding interview (33%; 34% in 2021).

### Ecstasy

In 2022, significantly fewer participants reported use of any ecstasy in the six months prior to interview (74%; 87% in 2021;  $p=0.025$ ). Recent use of ecstasy pills declined significantly in 2022 ( $p=0.038$ ), as did ecstasy crystal ( $p<0.001$ ), with both forms reporting the lowest percentage reported since the commencement of monitoring (38% and 22%, respectively).

Frequency of use remained stable for all four forms of ecstasy. No significant market changes were reported in 2022.

### Methamphetamine

Thirty-six per cent of the Adelaide sample reported recent use of any methamphetamine, stable compared to 2021 (33%). Nevertheless, 43% of those who had recently used methamphetamine reported weekly or more frequent use, a significant decrease from 70% in 2021 ( $p=0.036$ ). Recent use of methamphetamine powder significantly increased, from  $n\leq 5$  in 2021 to 14% in 2022 ( $p=0.002$ ). Almost one-third of the sample (30%) reported recent crystal use; forty-five per cent of this group reported weekly or greater use of methamphetamine crystal in 2022, a significant decrease from 72% in 2021 ( $p=0.044$ ). Methamphetamine crystal was largely reported to be 'easy' (30%) or 'very easy' (67%) to obtain.

### Cocaine

Recent use of cocaine has increased over the years of monitoring, with the largest per cent reporting any recent use for the second year running in 2022 (78%). Fourteen per cent of those who had recently used cocaine reported weekly or more frequent use. Perceived purity of cocaine significantly changed between 2021 and 2022 ( $p=0.012$ ), with more participants reporting 'high' purity in 2022 (22%), compared with 2021 reports ( $n\leq 5$ ).

### Cannabis and/or Cannabinoid Related Products

At least three in four participants have reported any recent use of non-prescribed cannabis and/or cannabinoid related products each year since 2003 (noting some changes in question wording over time). Three-quarters (75%) of participants reported non-prescribed recent use in 2022, stable relative to 2021 (84%). Weekly or more frequent use amongst those who had recently used cannabis and/or cannabinoid related products remained stable (67%; 74% in 2021), as did daily use (26%; 29% in 2021). The majority reported recent use of hydroponic cannabis (78%), a significant increase from 59% in 2021 ( $p=0.034$ ). The median price per ounce of hydroponic

cannabis remained stable in 2022 (\$235; \$230 in 2021), though proved to be the highest median price since the commencement of monitoring.

### Ketamine, LSD and DMT

Recent use of ketamine (29%; 28% in 2021), LSD (30%; 35% in 2021) and DMT (6%; 13% in 2021) remained stable in 2022, relative to 2021, as did frequency of use. Whilst market changes for ketamine and LSD remained stable between 2021 and 2022, the median price for one tab of LSD was the highest median price observed since the commencement of monitoring in 2022, at \$25 per tab.

### New Psychoactive Substances (NPS)

Any NPS use, including plant-based NPS, has fluctuated over time, with 12% reporting recent use in 2022, stable from 2021 (10%). A similar percentage was observed for any NPS use, excluding plant-based NPS (7%; 8% in 2021) which proved to be the lowest percentage of use since monitoring of NPS first commenced in 2010.

### Other Drugs

Participants who had recently used non-prescribed codeine (13%) reported use on a median of seven days in the preceding six months, a significant increase from three days in 2021 ( $p=0.042$ ). Almost two-fifths (37%) of the sample reported recent use of hallucinogenic mushrooms in the six months prior to the interview, the greatest per cent reporting recent use over the period of monitoring. Sixty-two per cent reported recent use of non-prescribed e-cigarettes, also the highest percentage of recent use over the course of monitoring. Seven per cent reported recent use of GHB/GBL/1,4-BD in 2022.

### Drug-Related Harms and Other Behaviours

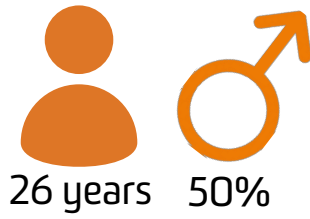
Three-quarters (75%;  $n=77$ ) of the Adelaide sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). One-fifth (22%) of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year. Seventy per cent of participants obtained a score of eight or more on the

AUDIT, indicative of hazardous use. Past year non-fatal stimulant overdose (16%; 19% in 2021) and non-fatal depressant overdose (23%; 23% in 2021) remained stable in 2022, relative to 2021. Reported past month injecting drug use remained low ( $n\leq 5$ ), as did drug treatment engagement (6%). Sixty-nine per cent of the sample reported engaging in some form of sexual activity in the past four weeks, of which 29% reported penetrative sex without a condom where they did not know the HIV status of their partner. One-fifth (20%) of the sample reported having a HIV test in the six months preceding interview, and one-third (31%) reported having a sexual health check-up in the six months prior to interview. Mental health remained stable relative to 2021, with 61% (57% in 2021) reporting experiencing a mental health problem in the six months preceding interview, with depression (65%) and anxiety (58%) most commonly reported. Amongst those who had recently driven, one-fifth (20%) reported driving while over the perceived legal limit of alcohol and 46% reported driving within three hours of consuming an illicit or non-prescribed drug in the prior six months. Thirty per cent of the sample reported 'any' crime in the past month, with drug dealing (15%) and property crime (15%) remaining the two main forms of criminal activity in 2022. Face-to-face and social networking applications were the most popular means of participants arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview (72%, respectively). In 2022, the vast majority of the sample (95%) had been tested for SARS-CoV-2, with almost three-fifths (59%) of participants having been diagnosed with COVID-19. Fifty-eight per cent reported that they were 'not at all' worried about contracting COVID-19, and 86% reported that they had received at least one COVID-19 vaccine dose at the time of interview.

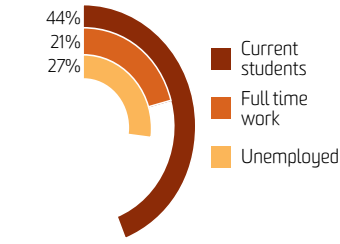
## 2022 SAMPLE CHARACTERISTICS



In 2022, 104 participants, recruited from Adelaide, SA were interviewed.



The median age in 2022 was 26, and 50% identified as male.

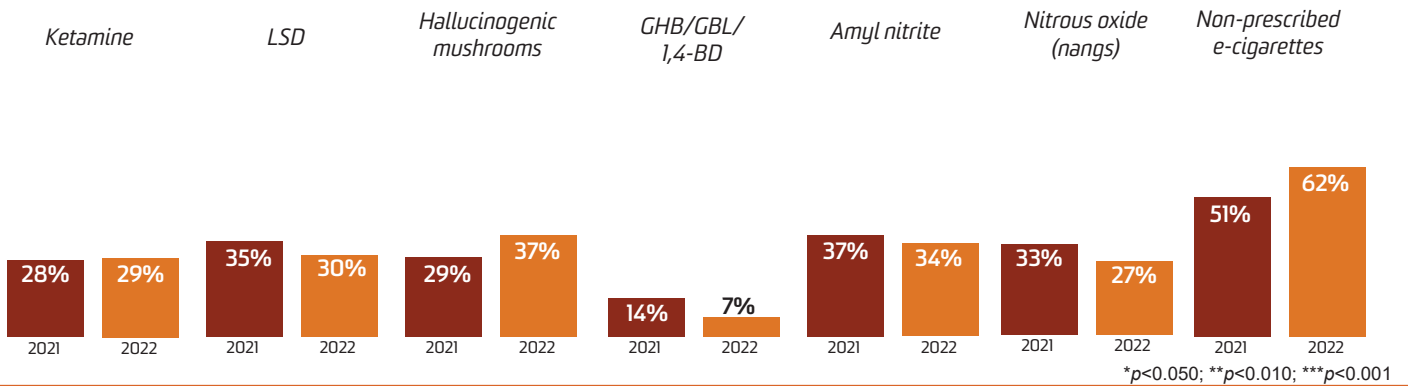


In the 2022 sample, 44% were enrolled students, 21% were employed full time and 27% were unemployed.

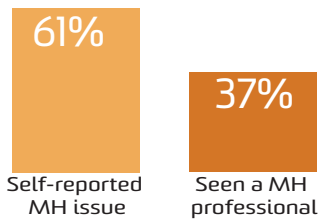
- Ecstasy
- Cocaine
- Other stimulants

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

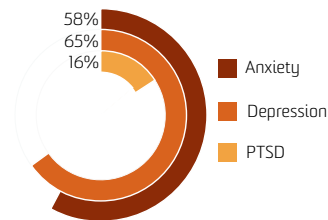
## PAST 6 MONTH USE OF SELECTED DRUGS



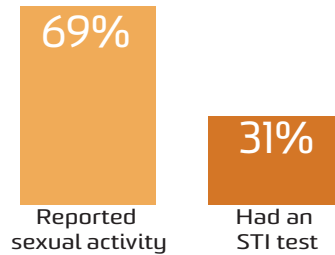
## MENTAL HEALTH AND SEXUAL HEALTH BEHAVIOURS



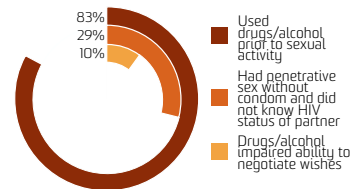
In the total sample, 61% self-reported a mental health issue and 37% had seen a mental health professional in the past 6 months.



Of those who had a mental health condition, the three most common mental health issues reported were anxiety (58%), depression (65%) and PTSD (16%).



In the total sample, 69% reported sexual activity in the past 4 weeks, and 31% had a sexual health check in the past 6 months.



Sexual risk behaviours among those who reported any sexual activity in the past four weeks and were able to comment.

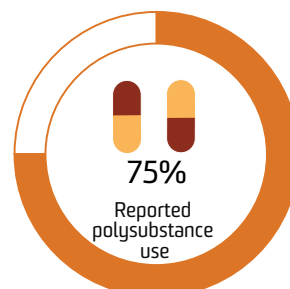
## OTHER RISK BEHAVIOURS



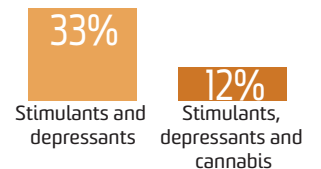
Among recent drivers, 46% reported driving a vehicle within 3 hours of consuming illicit drugs and 20% while over the legal limit of alcohol.



In the 2022 sample, 23% reported a non-fatal depressant overdose in the previous 12 months, stable relative to 2021 (23%).

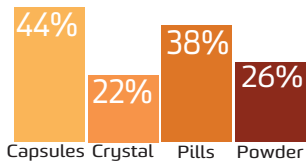


In the total sample, 75% reported concurrent use of two or more substances on the last occasion of ecstasy or related drug use.

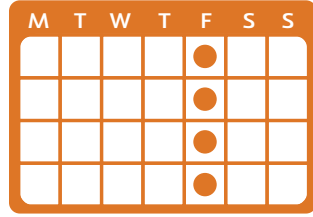


The most commonly used combinations of drug classes on the last occasion of ecstasy or related drug use.

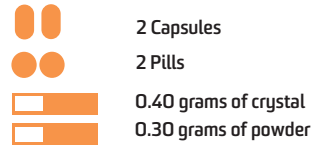
# ECSTASY



Past 6 month use of ecstasy capsules, crystal, pills, and powder in 2022.



Of those who had recently consumed ecstasy, 17% reported weekly or more frequent use.

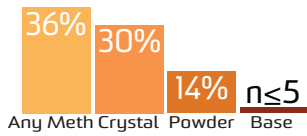


Median amounts of ecstasy consumed in a 'typical' session using each form.

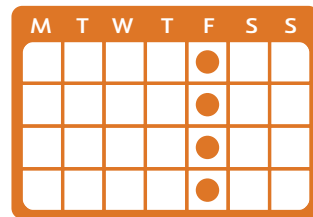


In 2022, the perceived purity and perceived availability of all forms of ecstasy remained stable in 2022 relative to 2021.

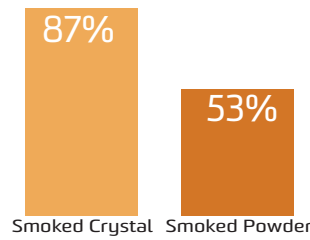
# METHAMPHETAMINE



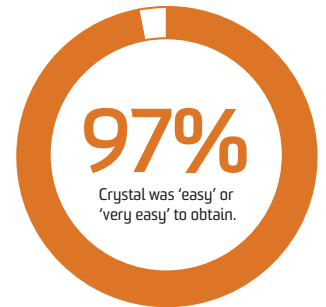
Past 6 month use of any methamphetamine, crystal, powder and base in 2022.



Of those who had recently consumed methamphetamine, 43% reported weekly or more frequent use.

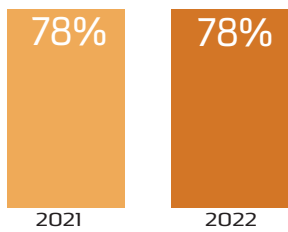


87% of participants who had recently used crystal smoked it. Of those who had recently used powder, 53% smoked it.

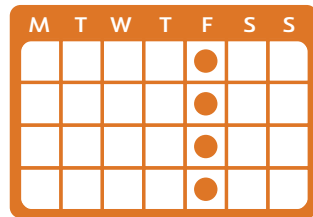


Of those who could comment, 97% perceived crystal methamphetamine to be 'easy' or 'very easy' to obtain.

# COCAINE



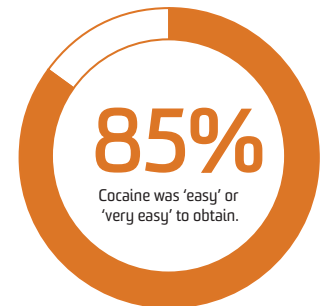
Past 6 month use of any cocaine remained stable between 2021 and 2022.



Of those who had recently consumed cocaine, 14% reported weekly or more frequent use.

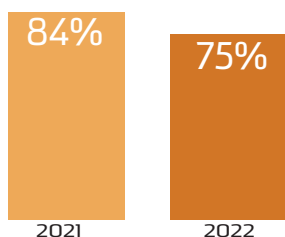


In 2022, the median price of a gram of cocaine remained stable at \$350.

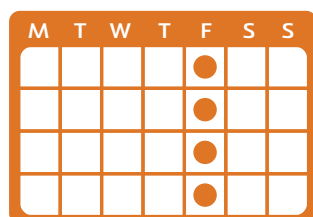


Of those who could comment, 85% perceived cocaine to be 'easy' or 'very easy' to obtain.

# CANNABIS AND/OR CANNABINOID RELATED PRODUCTS



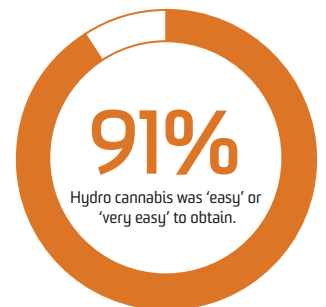
Past 6 month use of non-prescribed cannabis and/or cannabinoid related products remained stable between 2021 and 2022.



Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products, 67% reported weekly or more frequent use.



Of participants who had consumed non-prescribed cannabis and/or cannabinoid related products in the last 6 months, 90% had smoked it.



Of those who could comment, 91% perceived hydro to be 'easy' or 'very easy' to obtain.



## Background

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

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

## Methods

### EDRS 2003-2019

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

### EDRS 2020-2022: COVID-19 Impacts on Recruitment and Data Collection

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

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

These changes were carried through to 2021 and 2022. A hybrid approach was used, with interviews conducted either face-to-face (whereby participants were reimbursed with cash) or via telephone/videoconference (with participants reimbursed via bank transfer or other electronic means). Face-to-face interviews were the preferred methodology, however telephone interviews were conducted when required (i.e., in accordance with government directives) or when requested by participants. Consent was collected verbally for all participants.

Almost all capital cities, including Adelaide, SA, experienced trouble recruiting participants in 2021 and 2022. While it is difficult to provide a definitive reason for this, it is possible that this was reflective of a reduction in ecstasy and other illegal stimulant use due to ongoing government restrictions, and the cancellation of many music festivals and events in 2021.

A total of 700 participants were recruited across capital cities nationally (April-July, 2022), with 104 participants interviewed in Adelaide, SA between 11<sup>th</sup> April-19<sup>th</sup> June 2022 (n=100 in 2021). A total of 41 interviews (39%) were conducted via telephone (n=35 in 2021; 35%).

Sixteen per cent of the 2022 Adelaide sample completed the interview in 2021, whereas 6% of the 2021 Adelaide sample completed the interview in 2020 ( $p=0.043$ ). There was a significant change in recruitment methods compared to 2021 ( $p=0.008$ ), with fewer participants being recruited via the internet (e.g., Facebook and Instagram) (38%; 45% in 2021), and fewer via word-of-mouth (44%; 51% in 2021). Almost one-fifth (17%) responded 'other' (n≤5 in 2021), which likely was the result of many print advertisements displayed at Adelaide University.

## Data Analysis

For normally distributed continuous variables, means and standard deviations (SD) are reported; for skewed data (i.e., skewness > ±1 or kurtosis > ±3), medians and interquartile ranges (IQR) are reported. Tests of statistical significance have been conducted between estimates for 2021 and 2022, noting that no corrections for multiple comparisons have been made and thus comparisons should be treated with caution. References to significant differences throughout the report are where statistical testing has been conducted and where the  $p$ -value is less than 0.050. Values where cell sizes are ≤5 have been suppressed with corresponding notation (zero values are reported). References to 'recent' use and behaviours refers to the six months preceding interview.

## 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 Adelaide, South Australia, 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 Adelaide, SA (see section on 'Additional Outputs' below for details of other outputs providing such profiles).

Differences in the methodology, and the events of 2020-2022, must be taken into consideration when comparing 2020-2022 data to previous years, and treated with caution.

## Additional Outputs

[Infographics, the executive summary and data tables](#) from this report are available for download. There are a range of outputs from the EDRS which triangulate key findings from the annual interviews and other data sources, including [jurisdictional reports](#), [bulletins](#), and other resources available via the [Drug Trends webpage](#). This includes results from the [Illicit Drug Reporting System \(IDRS\)](#), which focuses more so on the use of illicit drugs via injection.



Please contact the research team at [drugtrends@unsw.edu.au](mailto: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 2022, the Adelaide EDRS sample was mostly similar to the sample in 2021 and to previous years (Table 1).

Gender remained stable between 2021 and 2022 ( $p=0.324$ ), with half (50%) of the sample identifying as male (57% in 2021). The median age of the sample was 26 years (IQR=22-31), stable relative to 2021 (25 years; IQR=21-32;  $p=0.572$ ).

Accommodation remained relatively stable ( $p=0.073$ ), with half (50%) of the sample reporting that they resided in a rented house/flat (49% in 2021), and most of the remaining participants living with their parents/in their family house (28%; 40% in 2021).

Forty-four per cent were current students (41% in 2021;  $p=0.673$ ), and 69% had obtained a post-school qualification(s) (62% in 2021;  $p=0.311$ ).

Employment status remained stable between 2021 and 2022 ( $p=0.426$ ). Specifically, one-fifth (21%) reported being employed full-time (20% in 2021), two-fifths (42%) reported being employed on a part time/casual basis (47% in 2021), and one-quarter (27%) reported being unemployed at the time of interview (29% in 2021).

Table 1: Demographic characteristics of the sample, nationally, 2022, and Adelaide, SA, 2017-2022

	Adelaide, SA						National
	2017	2018	2019	2020	2021	2022	2022
	N=100	N=100	N=100	N=101	N=100	N=104	N=700
<b>Median age (years; IQR)</b>	20 (19-22)	21 (18-28)	22 (19-25)	23 (19-27)	25 (21-32)	<b>26 (22-31)</b>	25 (21-30)
<b>% Gender</b>							
Female	40	29	28	37	42	<b>50</b>	40
Male	60	70	69	63	57	<b>50</b>	56
Non-binary	/	/	-	0	-	<b>0</b>	4
<b>% Aboriginal and/or Torres Strait Islander</b>	-	7	-	-	-	<b>7</b>	5
<b>% Sexual identity</b>							
Heterosexual	87	84	81	84	70	<b>74</b>	71
Homosexual	-	0	6	0	-	<b>-</b>	5
Bisexual	11	10	10	11	23	<b>17</b>	17
Queer	/	/	-	-	-	<b>-</b>	6
Different identity	0	-	-	-	-	<b>-</b>	2
<b>Mean years of school education (range)</b>	12 (7-12)	11 (8-12)	11 (8-12)	12 (9-12)	12 (6-12)	<b>11 (9-12)</b>	12 (6-12)

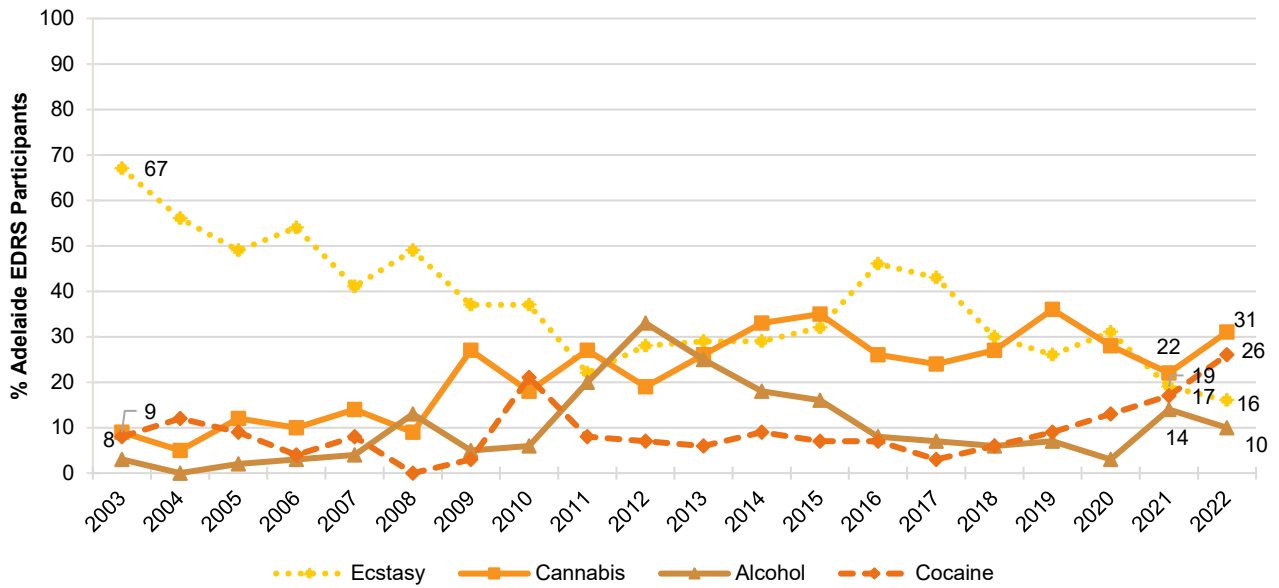
	Adelaide, SA						National
	2017	2018	2019	2020	2021	2022	2022
% Post-school qualification(s) <sup>^</sup>	40	53	62	60	62	<b>69</b>	61
% Current students <sup>#</sup>	52	8	36	32	41	<b>44</b>	41
% Current employment status							
Employed full-time	18	21	22	20	20	<b>21</b>	32
Part time/casual	/	/	/	30	47	<b>42</b>	41
Self-employed	/	/	/	8	-	<b>10</b>	8
Unemployed	7	30	38	43	29	<b>27</b>	19
Current median weekly income \$ (IQR)	(N=100) \$625 (370-1075)	(N=98) \$552 (358-800)	(N=93) \$460 (250-750)	(N=95) \$550 (348-800)	(N=100) \$500 (332-850)	<b>(N=104) \$550 (350-900)</b>	(N=700) \$700 (450-1200)
% Current accommodation							
Own house/flat	-	-	-	9	-	<b>16</b>	12
Rented house/flat	39	41	46	49	49	<b>50</b>	59
Parents'/family home	53	47	48	40	40	<b>28</b>	23
Boarding house/hostel	0	-	0	0	-	-	2
Public housing	/	-	-	-	-	-	2
No fixed address <sup>+</sup>	0	-	-	-	-	-	2
Other	-	0	0	0	0	<b>0</b>	1

Note. <sup>^</sup>Includes trade/technical and university qualifications. <sup>#</sup>students' comprised participants who were currently studying for either trade/technical or university/college qualifications. / not asked. + No fixed address included 'couch surfing and rough sleeping or squatting. - Per cent suppressed due to small cell size (n≤5 but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 (Adelaide) presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Drug of choice remained stable between 2021 and 2022 ( $p = 0.135$ ), with almost one-third (31%) nominating cannabis as the drug of choice in 2022 (22% in 2021), followed by one-quarter (26%) nominating cocaine as the drug of choice (17% in 2021) and 16% nominating ecstasy (19% in 2021) (Figure 1). The drug used most often in the past month also remained stable between 2021 and 2022 ( $p = 0.570$ ), with one-third (33%) reporting alcohol as the drug used most often (34% in 2021), followed by cannabis (31%; 29% in 2021) (Figure 2).

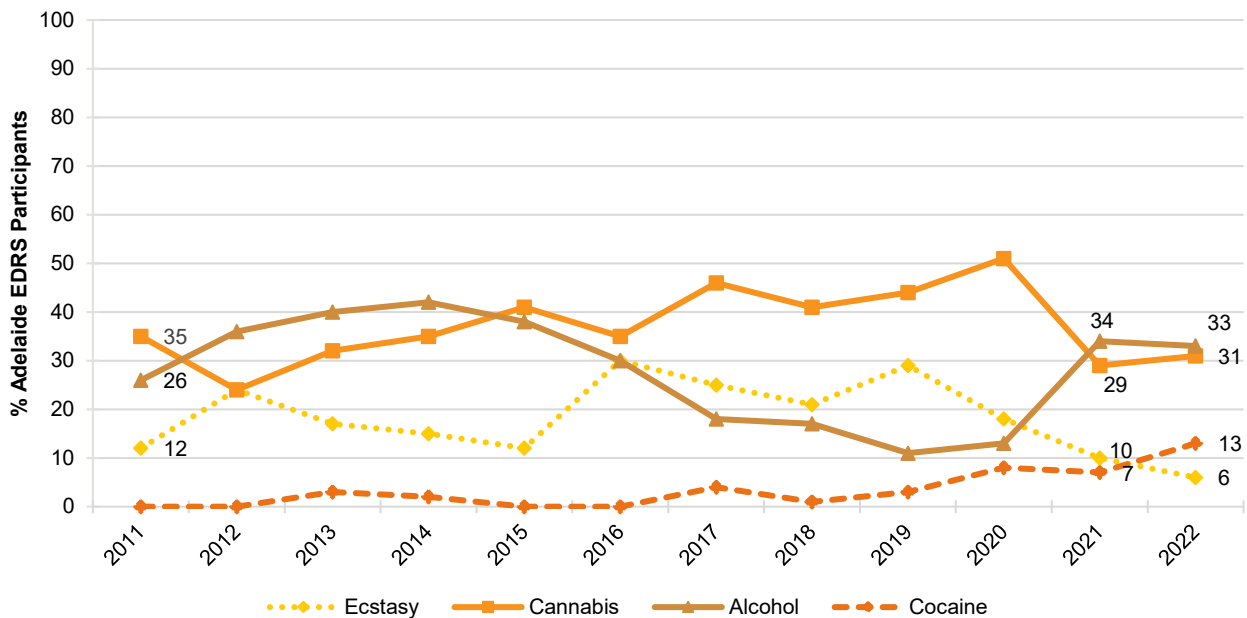
Half (50%) of the Adelaide sample reported weekly or more frequent cannabis use (62% in 2021;  $p = 0.097$ ) and 15% reported weekly or more frequent methamphetamine use (23% in 2021;  $p = 0.217$ ). Thirteen per cent reported weekly or more frequent use of ecstasy (15% in 2021;  $p = 0.685$ ) and 11% reported weekly or more frequent use of cocaine (8% in 2021;  $p = 0.619$ ) (Figure 3).

Figure 1: Drug of choice, Adelaide, SA, 2003-2022



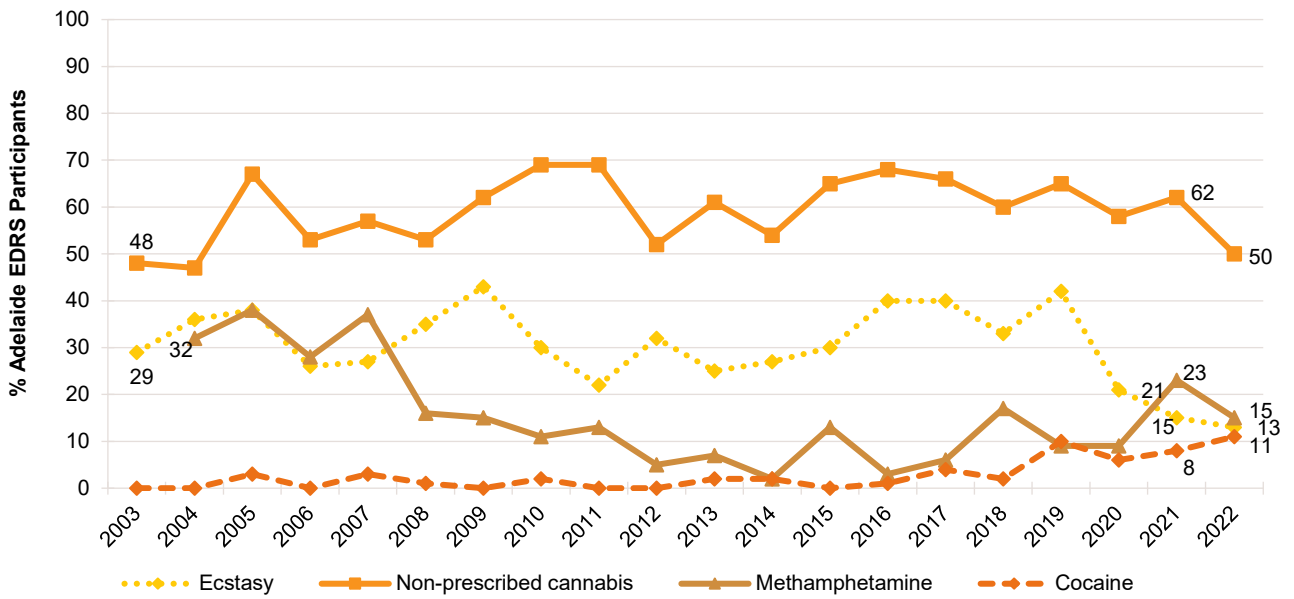
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 2: Drug used most often in the past month, Adelaide, SA, 2011-2022



Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Data are only presented for 2011-2022 as this question was not asked in 2003-2010. Data labels are only provided for the first (2011) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 3: Weekly or more frequent substance use in the past six months, Adelaide, SA, 2003-2022



Note. Computed from the entire sample regardless of whether they had used the substance in the past six months. Data labels are only provided for the first (2003/2004) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## 2

## Ecstasy

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

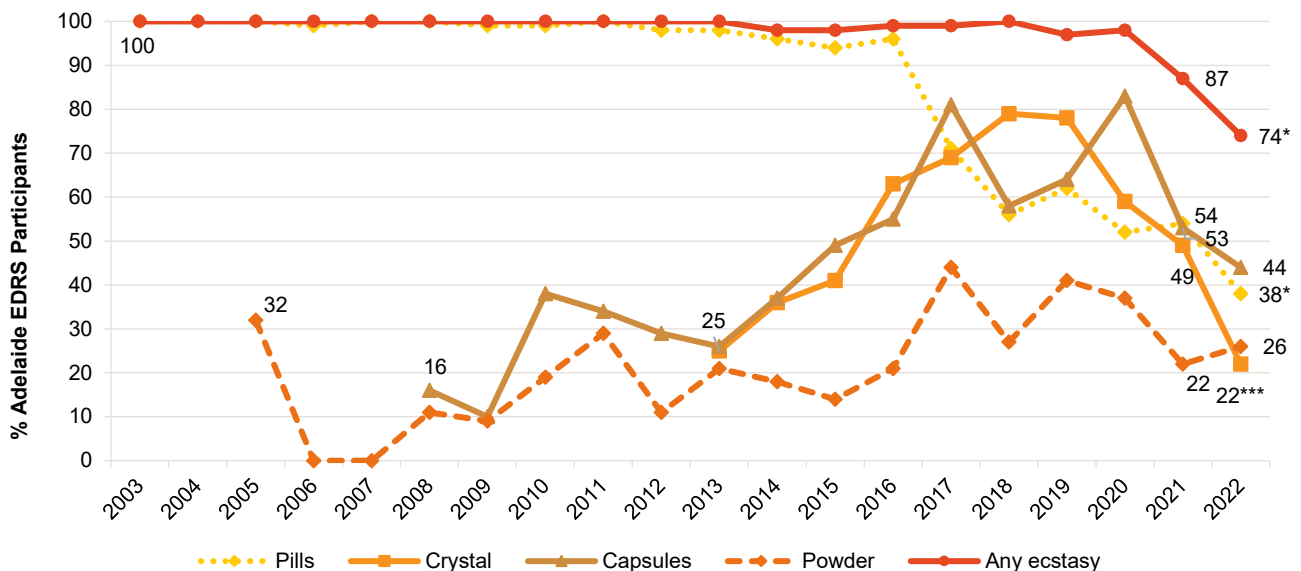
## Recent Use (past 6 months)

In 2022, significantly fewer participants reported use of any ecstasy in the six months prior to interview relative to 2021 (74%; 87% in 2021;  $p=0.025$ ) (Figure 4). Indeed, this was the lowest percentage reported over the course of monitoring. This was mostly driven by a significant decline in recent use of ecstasy pills, as well as a sharp decrease in use of ecstasy crystal. The per cent of the sample reporting recent use of ecstasy capsules peaked in 2020 and then declined (although no statistically significant difference was observed between 2021 and 2022).

## Frequency of Use

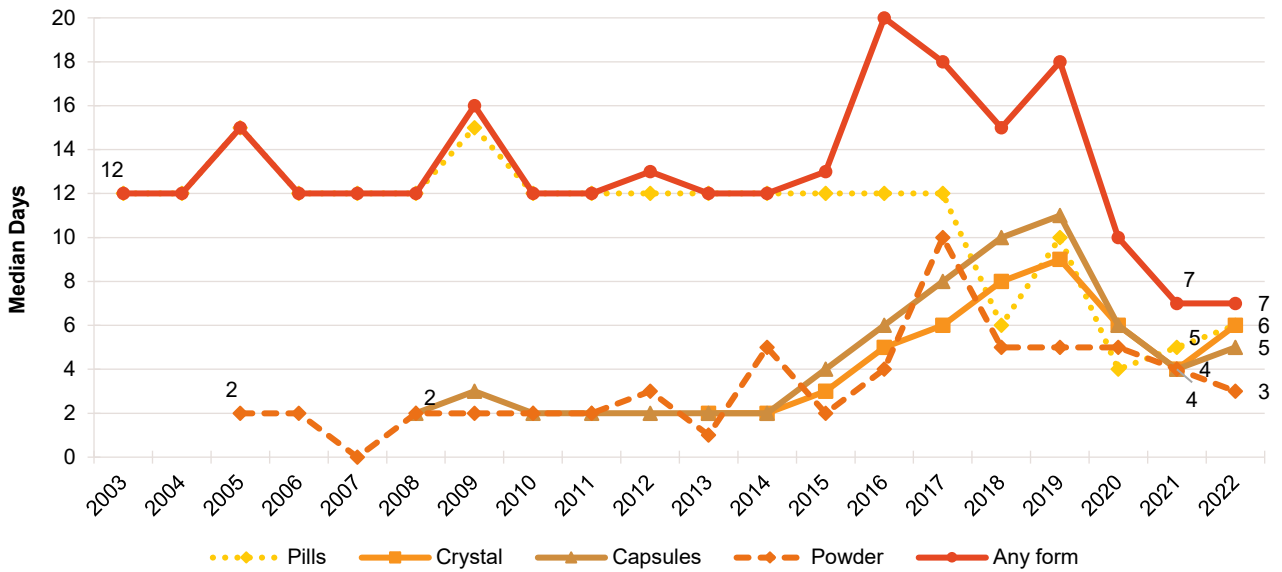
Among those that reported recent use of any ecstasy and commented ( $n=77$ ), participants reported using ecstasy (in any form) on a median of seven days (IQR=3-12) in 2022, equivalent to monthly use in the preceding six months (7 days in 2021; IQR=4-13;  $n=86$ ;  $p=0.411$ ). Weekly or more frequent use of any form of ecstasy remained stable, relative to 2021 (17%; 17% in 2021) (Figure 5).

Figure 4: Past six month use of any ecstasy, and ecstasy pills, powder, capsules, and crystal, Adelaide, SA, 2003-2022



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Data collection for powder started in 2005, capsules in 2008 and crystal in 2013. The response option 'Don't know' was excluded from analysis. Data labels are only provided for the first (2003/2005/2008/2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 5: Median days of any ecstasy and ecstasy pills, powder, capsules, and crystal use in the past six months, Adelaide, SA, 2003-2022



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Data collection for powder started in 2005, capsules in 2008 and crystal in 2013. Median days computed among those who reported past 6-month use (maximum 180 days). Median days rounded to the nearest whole number. The response option 'Don't know' was excluded from analysis. Y axis reduced to 20 days to improve visibility of trends. Data labels are only provided for the first (2003/2005/2008/2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Patterns of Consumption (by form)

### Ecstasy Pills

**Recent Use (past 6 months):** Recent use of ecstasy pills has declined considerably in the past few years. While 96%-100% of participants reported recent use from 2003-2016, 38% of participants reported recent use in 2022, a significant decrease from 54% in 2021 ( $p=0.038$ ), and the lowest percentage reported since monitoring commenced (Figure 4).

**Frequency of Use:** Of those who had recently consumed ecstasy pills and commented ( $n=40$ ), ecstasy pills were used on a median of six days (IQR=2-12) in the six months preceding interview in 2022, stable from 2021 (5 days; IQR=2-9;  $n=54$ ;  $p=0.797$ ) (Figure 5). Few participants ( $n\leq 5$ ) who had recently consumed ecstasy pills reported weekly or more frequent use in 2022, therefore, further details are not reported ( $n\leq 5$  in 2021).

**Routes of Administration:** Among participants who had recently consumed ecstasy pills and commented ( $n=40$ ), the most common route of administration in 2022 was swallowing (98%; 96% in 2021), followed by snorting (15%; 31% in 2021;  $p=0.095$ ), consistent with previous years. Few participants ( $n\leq 5$ ) reported recent smoking, and no participants reporting shelving/shafting in 2022.

**Quantity:** Of those who reported recent use and responded ( $n=40$ ), the median number of pills used in a 'typical' session was two (IQR=1-3; 2 pills in 2021; IQR=2-4;  $p=0.034$ ). Of those who reported recent use and responded ( $n=40$ ), the median maximum number of pills used was three (IQR=1.5-4; 4 pills in 2021; IQR=2-6;  $p=0.011$ ).

### Ecstasy Capsules

**Recent Use (past 6 months):** Forty-four per cent of participants reported recent use of ecstasy capsules, stable from 53% in 2021 ( $p=0.265$ ) (Figure 4).

**Frequency of Use:** Among those that reported recent use and commented ( $n=46$ ), participants reported consuming capsules on a median of five days in 2022 (IQR=2-10), stable

from 2021 (4 days; IQR=3-10;  $n=53$ ;  $p=0.470$ ) (Figure 5). Few participants ( $n\leq 5$ ) who had recently consumed ecstasy capsules reported weekly or more frequent use in 2022, therefore, further details are not reported ( $n\leq 5$  in 2021).

**Routes of Administration:** Among those who had recently consumed ecstasy capsules and commented ( $n=46$ ), all participants reported swallowing (96% in 2021;  $p=0.497$ ). Few participants ( $n\leq 5$ ) reported snorting, a significant decrease from 28% in 2021 ( $p=0.020$ ).

**Quantity:** Of those who reported recent use and responded ( $n=46$ ), the median number of capsules used in a 'typical' session was two (IQR=1-2; 2 capsules in 2021; IQR=2-3;  $p=0.039$ ). Of those who reported recent use and responded ( $n=46$ ), the median maximum number of capsules used was two (IQR=1-4; 4 capsules in 2021; IQR=3-5;  $p=0.008$ ).

**Contents of Capsules:** Of those who reported recent use and responded ( $n=44$ ), two-thirds (66%) reported that their last capsule contained crystal (78% in 2021), whilst 36% reported that it contained powder (28% in 2021). Few participants ( $n\leq 5$ ) did not look at the contents the last time they had used capsules.

### Ecstasy Crystal

**Recent Use (past 6 months):** One-fifth (22%) of participants reported recent use of ecstasy crystal, a significant decrease from 2021 (49%;  $p<0.001$ ), the lowest percentage reporting recent use since monitoring of crystal commenced in 2013 (Figure 4).

**Frequency of Use:** Among those that reported recent use and commented ( $n=23$ ), participants reported using crystal on a median of six days (IQR=3-10) in 2022, stable from four days in 2021 (IQR=3-10;  $n=49$ ;  $p=0.430$ ) (Figure 5). Few participants ( $n\leq 5$ ) who had recently consumed crystal reported weekly or more frequent use in 2022; therefore, further details are not reported ( $n\leq 5$  in 2021).

**Routes of Administration:** Among participants who had recently consumed ecstasy crystal and commented ( $n=23$ ), two-thirds (65%) reported swallowing (86% in 2021;



$p=0.066$ ), while two-fifths (43%) reported snorting (53% in 2021;  $p=0.598$ ).

**Quantity:** Of those who reported recent use and responded ( $n=19$ ), the median amount of crystal used in a 'typical' session was 0.40 grams (IQR=0.20-0.50; 0.30 grams in 2021; IQR=0.20-0.50;  $p=0.853$ ). Of those who reported recent use and responded ( $n=19$ ), the median maximum amount of crystal used was 0.50 grams (IQR=0.30-1.00; 0.50 grams in 2021; IQR=0.30-1.00;  $p=0.916$ ).

### Ecstasy Powder

**Recent Use (past 6 months):** Recent use of ecstasy powder remained stable, relative to 2021 (26%; 22% in 2021;  $p=0.523$ ) (Figure 4).

**Frequency of Use:** Among those that reported recent use and commented ( $n=27$ ), participants reported consuming powder on a median of three days (IQR=2-6) in 2022, stable from four days in 2021 (IQR=2-15;  $n=22$ ;

## Price, Perceived Purity and Perceived Availability

### Ecstasy Pills

**Price:** The median price of a pill remained stable, recorded at \$28 in 2022 (IQR=20-36;  $n=24$ ) and \$25 in 2021 (IQR=16-30;  $n=24$ ;  $p=0.110$ ) (Figure 6).

**Perceived Purity:** The perceived purity of ecstasy pills remained stable between 2021 and 2022 ( $p=0.719$ ). Among those who responded in 2022 ( $n=38$ ), one-third (34%) reported purity as being 'low' (25% in 2021), with a further 29% reporting purity to be 'medium' (27% in 2021). 'High' purity was reported by one-fifth (21%) of participants (27% in 2021) (Figure 8).

**Perceived Availability:** The perceived availability of ecstasy pills remained stable between 2021 and 2022 ( $p=0.233$ ). Among those who were able to comment in 2022 ( $n=39$ ), one-third (33%) reported that pills were 'very easy' to obtain (44% in 2021), though 28% reported pills as being 'difficult' to obtain (27% in 2021) (Figure 12).

$p=0.092$ ) (Figure 5). No participants who had recently consumed powder reported weekly or more frequent use in 2022 ( $n\leq 5$  in 2021;  $p=0.084$ ).

**Routes of Administration:** Among participants who had recently consumed ecstasy powder and commented ( $n=27$ ), 85% reported snorting (77% in 2021;  $p=0.713$ ), followed by one-quarter (26%) who reported swallowing (32% in 2021;  $p=0.758$ ).

**Quantity:** Of those who reported recent use and responded ( $n=19$ ), the median amount of powder used in a 'typical' session was 0.30 grams (IQR=0.20-0.50; 0.50 grams in 2021; IQR=0.30-1.00;  $p=0.222$ ). Of those who reported recent use and responded ( $n=19$ ), the median maximum amount of powder used was 0.40 grams (IQR=0.30-0.80; 0.70 grams in 2021; IQR=0.50-1.50;  $p=0.217$ ).

### Ecstasy Capsules

**Price:** The reported median price of an ecstasy capsule was \$25 in 2022 (IQR=16-25;  $n=18$ ), and \$20 in 2021 (IQR=19-25;  $n=26$ ;  $p=0.715$ ) (Figure 6).

**Perceived Purity:** The perceived purity of ecstasy capsules remained stable between 2021 and 2022 ( $p=0.076$ ). Among those who were able to comment in 2022 ( $n=41$ ), 29% perceived purity to be 'fluctuating' (23% in 2021) and one-quarter (27%) perceived purity to be 'medium' (52% in 2021). Whilst almost one-quarter (24%) perceived purity to be 'low' (11% in 2021), one-fifth (20%) perceived purity to be 'high' (14% in 2021) (Figure 9).

**Perceived Availability:** The perceived availability of ecstasy capsules remained stable between 2021 and 2022 ( $p=0.217$ ). Among those who responded in 2022 ( $n=42$ ), 36% reported that capsules were 'easy' to obtain (40% in 2021), whereas one-third (33%) reported that capsules were 'difficult' to obtain (21% in 2021) (Figure 13).

### Ecstasy Crystal

**Price:** The median price of a gram of crystal remained stable in 2022 at \$150 (IQR=138-210;  $n=7$ ; \$150 in 2021; IQR=150-200;  $n=17$ ;

$p=0.922$ ) (Figure 7). Few participants ( $n\leq 5$ ) reported purchasing a point of crystal in 2022 (0% in 2021).

**Perceived Purity:** The perceived purity of ecstasy crystal remained stable between 2021 and 2022 ( $p=0.593$ ). Among those who responded in 2022 ( $n=24$ ), two-fifths (42%) perceived the purity of crystal to be 'high' (33% in 2021) and one-third (33%) perceived purity to be 'medium' (29% in 2021) (Figure 10).

**Perceived Availability:** The perceived availability of ecstasy crystal remained stable between 2021 and 2022 ( $p=0.202$ ). Among those who were able to comment in 2022 ( $n=25$ ), one-third (36%) reported that crystal was 'difficult' to obtain (33% in 2021), though a further one-third (32%) perceived crystal as being 'very easy' to obtain (24% in 2021) (Figure 14).

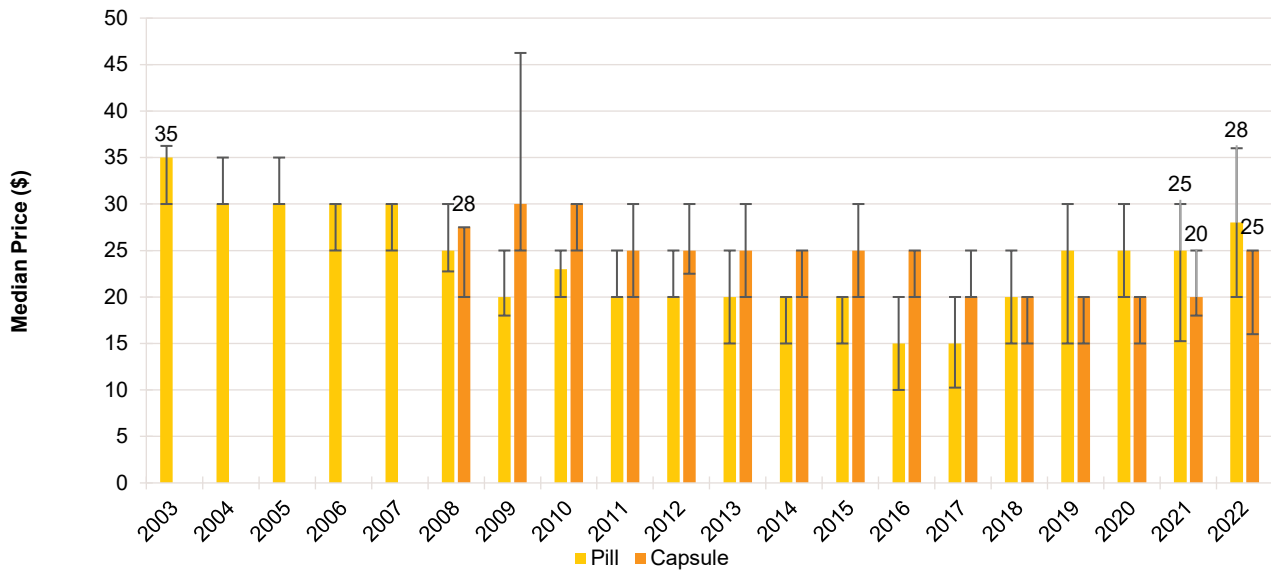
### Ecstasy Powder

**Price:** Whilst the median price of a gram of powder remained stable in 2022 ( $p=0.611$ ), few participants ( $n\leq 5$ ) were able to report on the median price of a gram of powder (\$150 in 2021; IQR=150-175;  $n=7$ ;  $p=0.611$ ) (Figure 7).

**Perceived Purity:** The perceived purity of ecstasy powder remained stable between 2021 and 2022 ( $p=0.389$ ). Among those who were able to comment in 2022 ( $n=19$ ), two-fifths (42%) perceived purity to be 'medium' (19% in 2021). Few participants ( $n\leq 5$ ) were able to comment on further market changes (Figure 11).

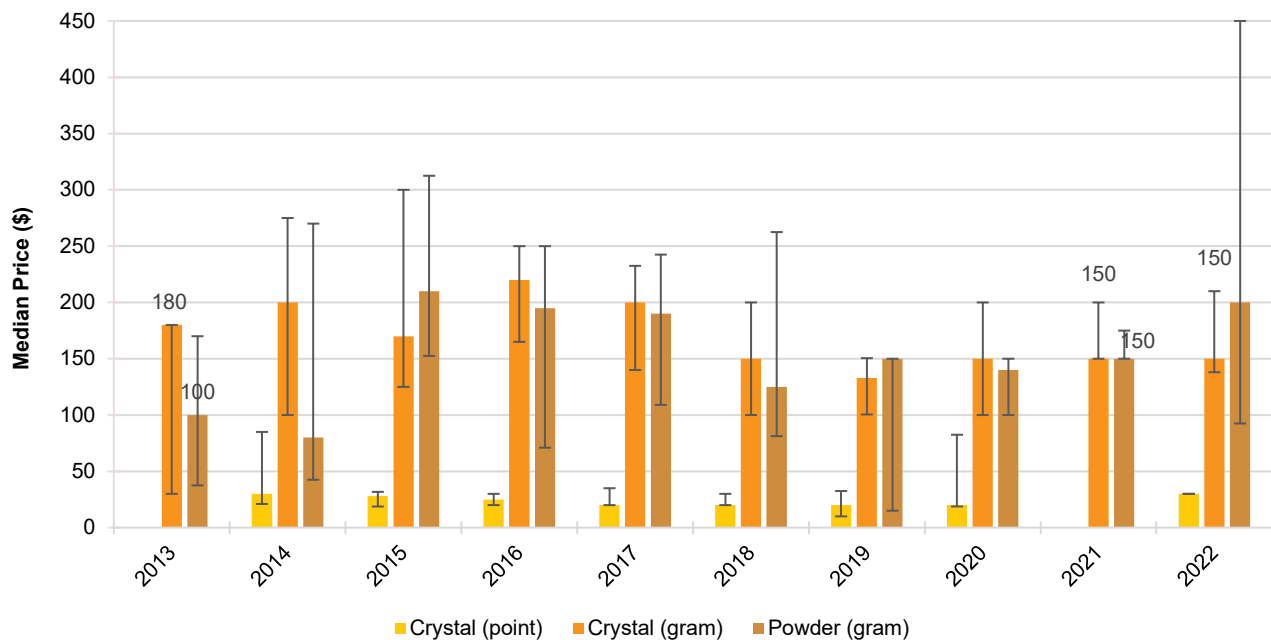
**Perceived Availability:** The perceived availability of ecstasy powder remained stable between 2021 and 2022 ( $p=0.585$ ). Among those who were able to respond in 2022 ( $n=18$ ), one-third (33%) reported powder as being 'difficult' to obtain in 2022 (29% in 2021). Few participants ( $n\leq 5$ ) were able to comment on further market changes (Figure 15).

Figure 6: Median price of ecstasy pill and capsule, Adelaide, SA, 2003-2022



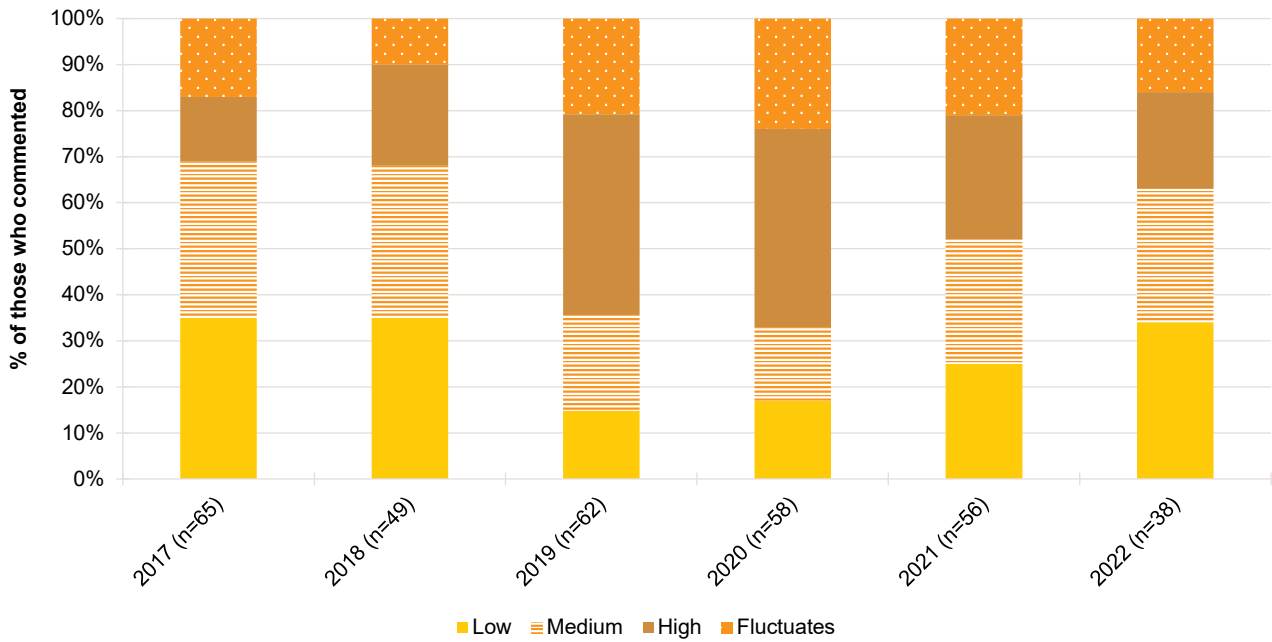
Note. Among those who commented. Data collection for price of ecstasy capsules started in 2008. Data labels are only provided for the first (2003/2008) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 7: Median price of ecstasy crystal (per point and gram) and powder (per gram only), Adelaide, SA, 2013-2022



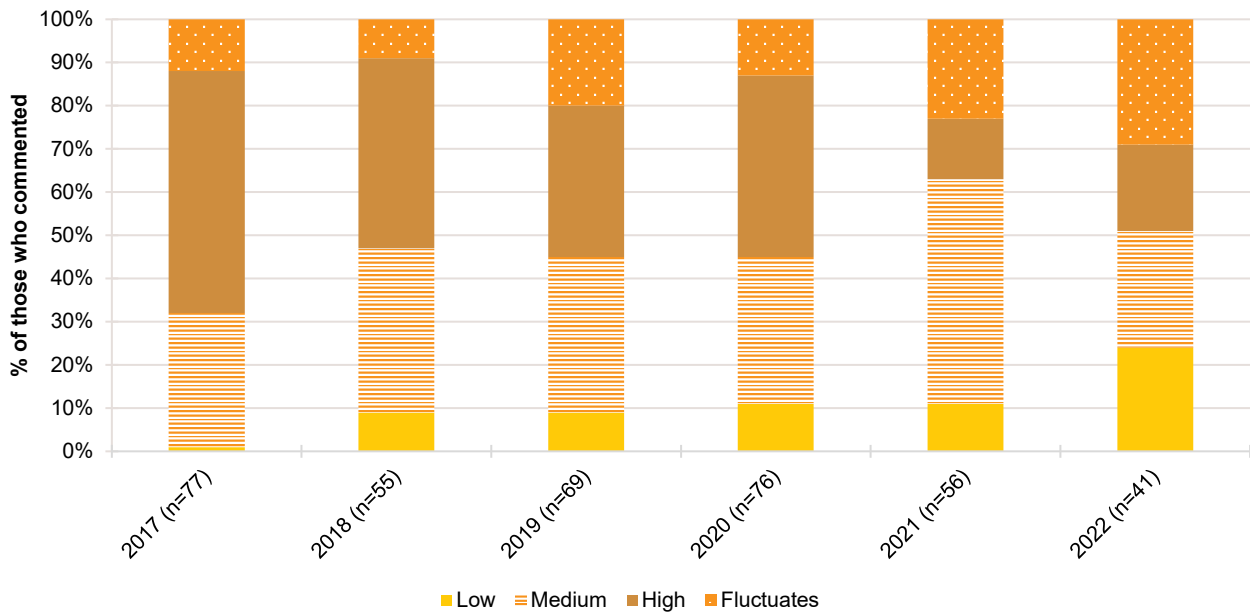
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) and ecstasy powder (gram) started in 2013. No participants reported price data for a 'point' of ecstasy crystal in 2013 or 2021. Data labels are only provided for the first (2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 8: Current perceived purity of ecstasy pills, Adelaide, SA, 2017-2022



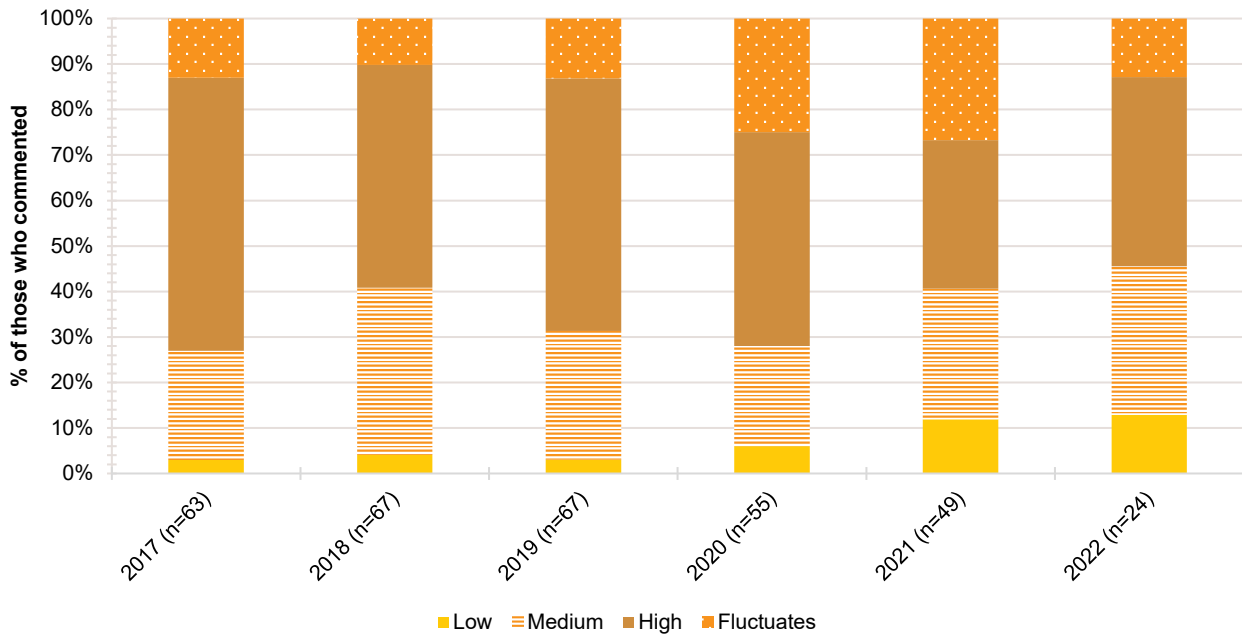
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 9: Current perceived purity of ecstasy capsules, Adelaide, SA, 2017-2022



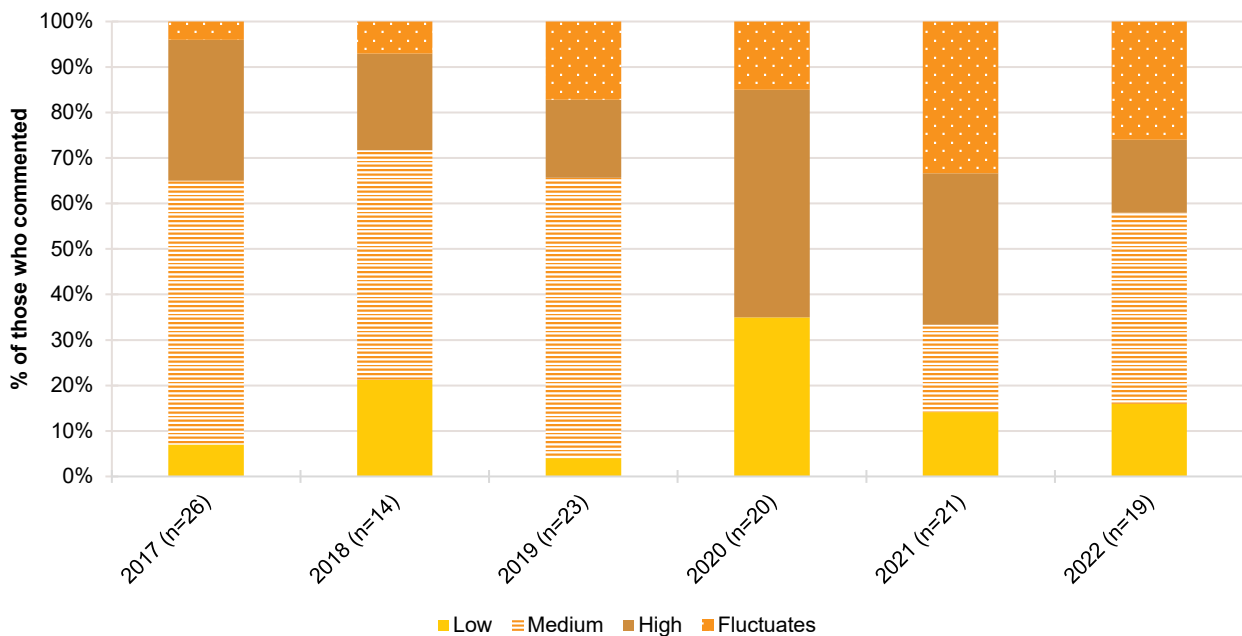
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 10: Current perceived purity of ecstasy crystal, Adelaide, SA, 2017-2022



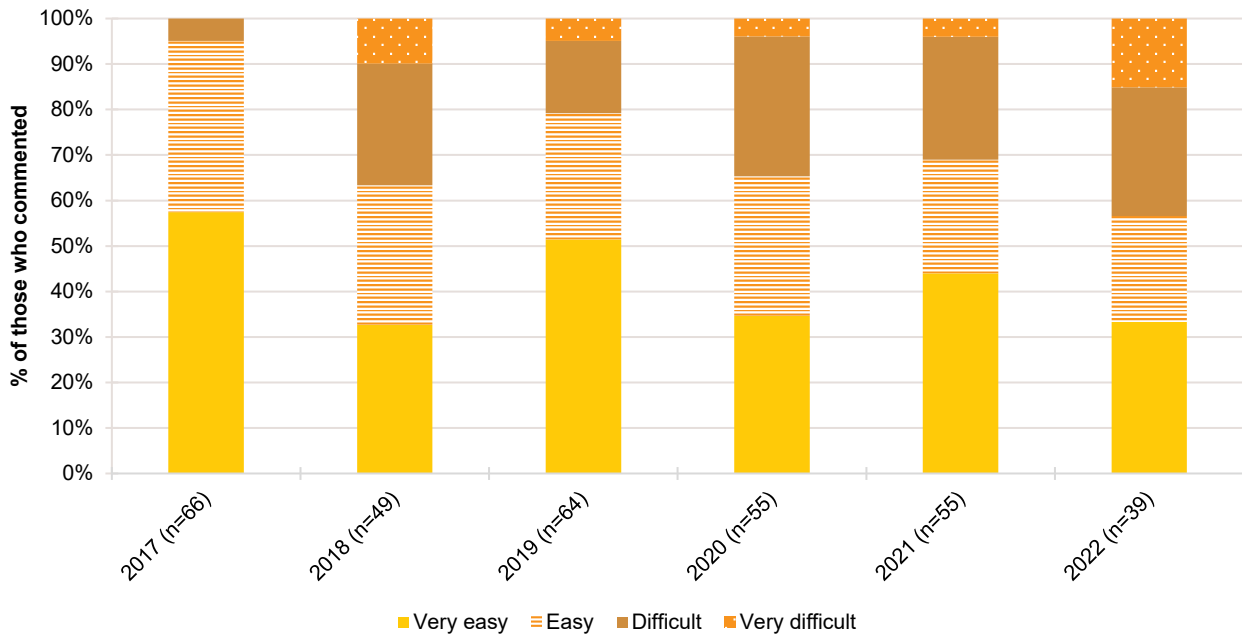
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 11: Current perceived purity of ecstasy powder, Adelaide, SA, 2017-2022



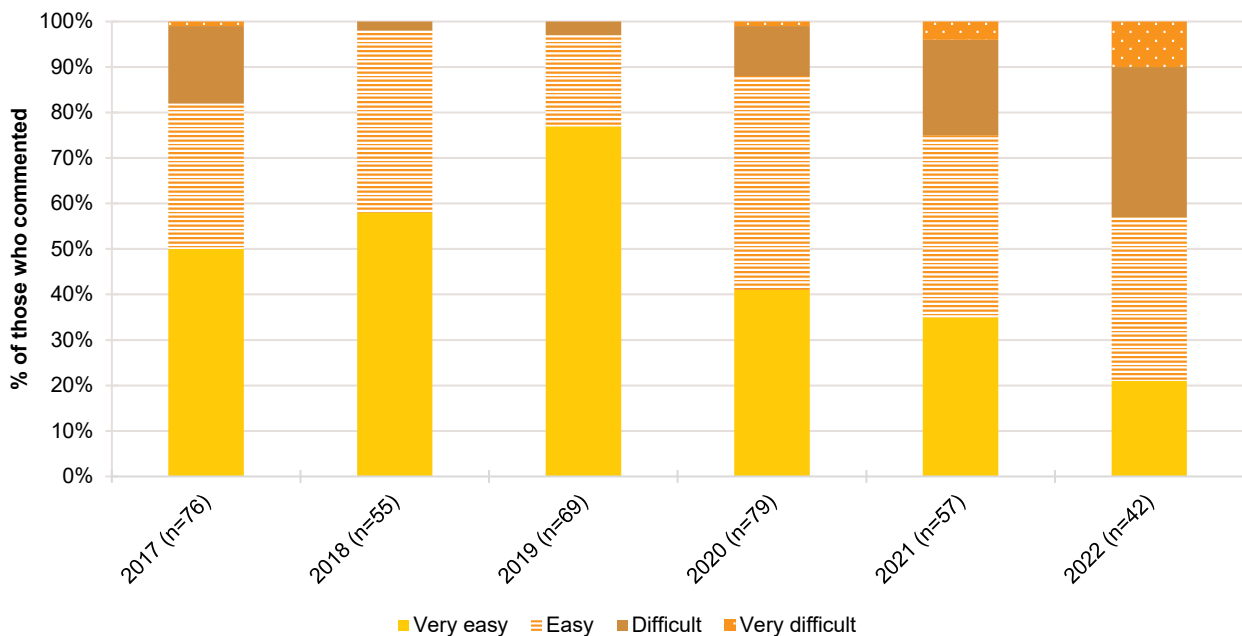
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 12: Current perceived availability of ecstasy pills, Adelaide, SA, 2017-2022



Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 13: Current perceived availability of ecstasy capsules, Adelaide, SA, 2017-2022



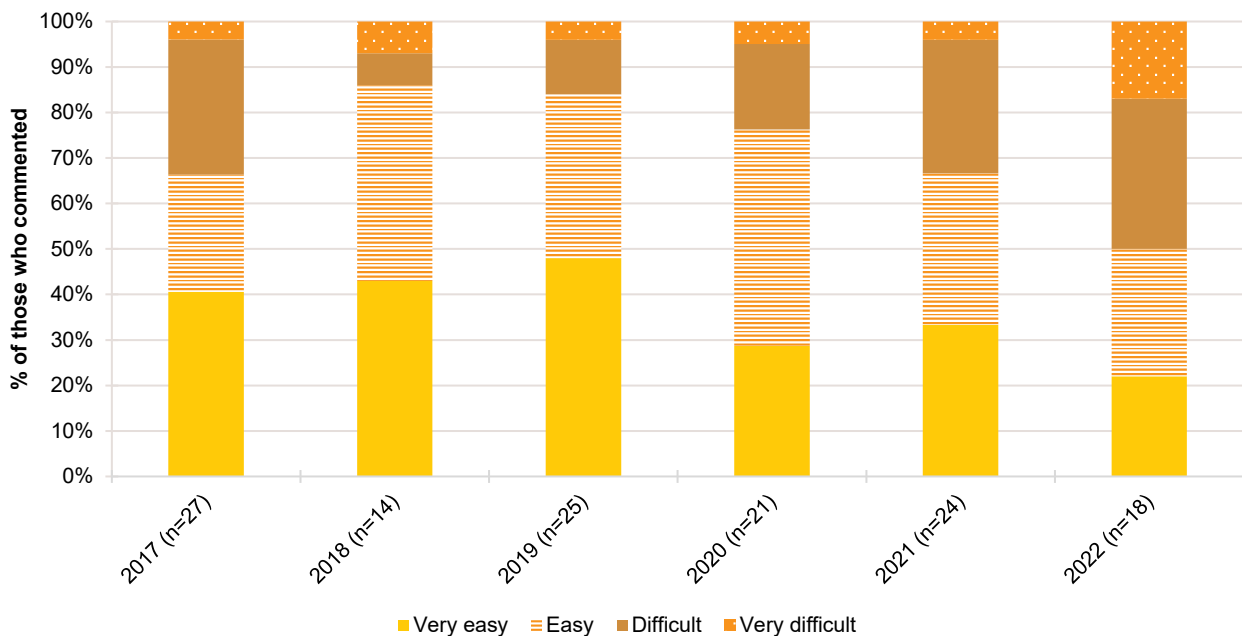
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 14: Current perceived availability of ecstasy crystal, Adelaide, SA, 2017-2022



Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 15: Current perceived availability of ecstasy powder, Adelaide, SA, 2017-2022



Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## 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).

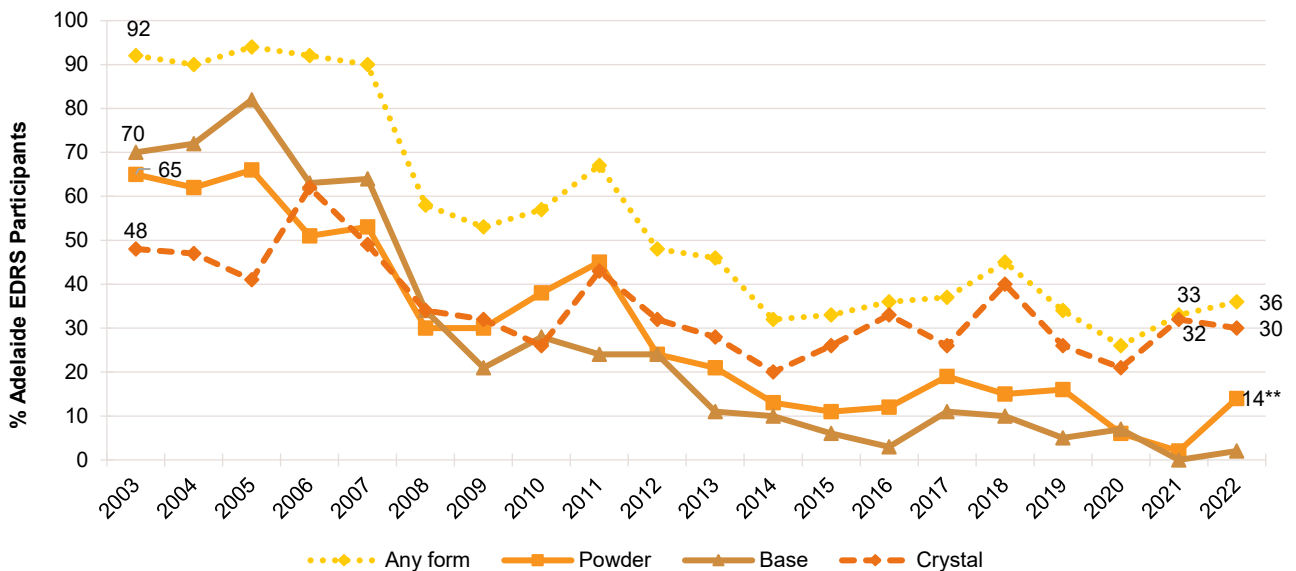
## Recent Use (past 6 months)

Recent use of any methamphetamine has been declining since monitoring commenced (Figure 16), from more than nine in ten participants in 2003 (92%) to one in three participants in 2022 (36%; 33% in 2021;  $p=0.765$ ).

## Frequency of Use

Median frequency of use in the past six months was 14 days (IQR=2-48;  $n=37$ ) in 2022 versus 45 days in 2021 (IQR=15-72;  $n=33$ ;  $p=0.057$ ) (Figure 17). Two-fifths (43%) of those who commented reported using methamphetamine weekly or more frequently, a significant decrease from 70% in 2021 ( $p=0.036$ ).

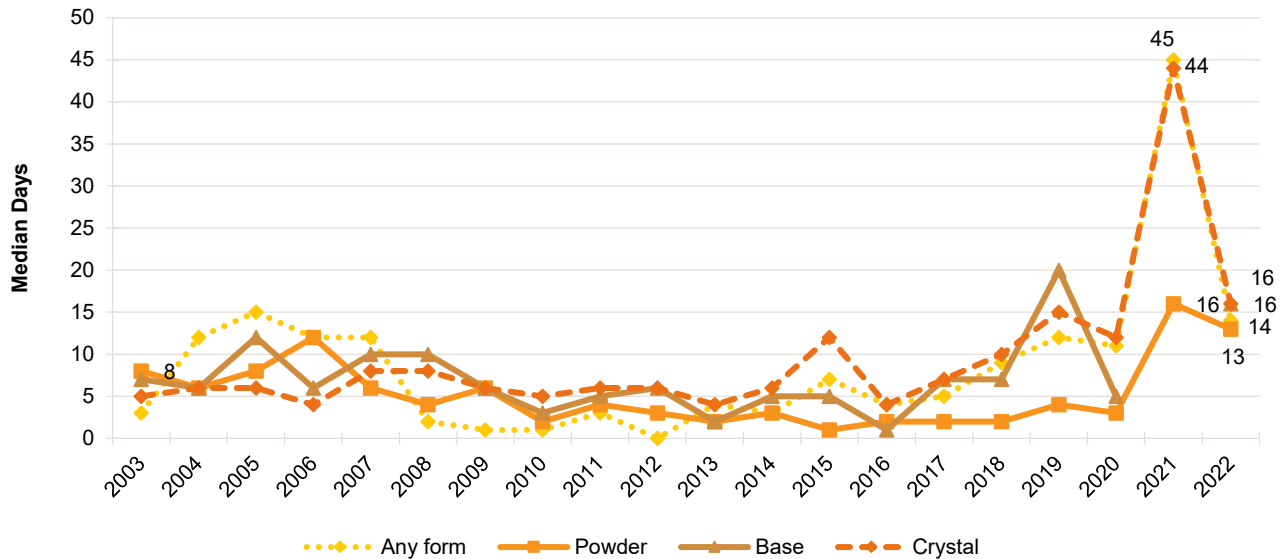
Figure 16: Past six month use of any methamphetamine, powder, base, and crystal, Adelaide, SA, 2003-2022



Note. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .



Figure 17: Median days of any methamphetamine, powder, base, and crystal use in the past six months, Adelaide, SA, 2003-2022



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 50 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Patterns of Consumption (by form)

### Methamphetamine Powder

**Recent Use (past 6 months):** Recent use of powder has declined over the course of monitoring, though increased significantly in 2022, from  $n \leq 5$  in 2021 to 14% ( $p = 0.002$ ) (Figure 16).

**Frequency of Use:** Amongst those who had recently consumed powder and commented ( $n = 14$ ), frequency of use was reported on a median of 13 days (IQR=2-24) in 2022, stable relative to 2021 ( $n \leq 5$ ;  $p = 0.748$ ) (Figure 17). Few participants ( $n \leq 5$ ) reported weekly or more frequent use of powder ( $n \leq 5$  in 2021).

**Routes of Administration:** Among participants who had recently consumed methamphetamine powder and commented ( $n = 15$ ), smoking was the most common route of administration, with 53% reporting this method in 2022 ( $n \leq 5$  in 2021). Few participants ( $n \leq 5$ ) were able to comment on further routes of administration.

**Quantity:** Of those who reported recent use and responded ( $n = 11$ ), the median amount of powder used in a 'typical' session was 0.20 grams (IQR=0.10-0.30; 0.30 grams in 2021; IQR=0.20-0.40). Of those who reported recent use and responded ( $n = 11$ ), the median maximum amount of powder used was 0.50 grams (IQR=0.30-0.80; 0.10 grams in 2021 (IQR=0.10-0.10;  $p = 0.185$ ).

### Methamphetamine Crystal

**Recent Use (past 6 months):** Since 2012, crystal has consistently been the main form of methamphetamine used. Almost one-third (30%) of participants reported recent use of crystal in 2022, stable relative to 2021 (32%;  $p = 0.766$ ) (Figure 16).

**Frequency of Use:** Of those who had recently consumed crystal and commented ( $n = 31$ ), frequency of use was reported on a median of 16 days (IQR=4-54) in 2022, as compared to 44 days in 2021 (IQR=19-74;  $n = 32$ ;  $p = 0.079$ ) (Figure 17). Forty-five per cent of participants reported weekly or greater use of crystal in 2022, a significant decrease from 72% in 2021 ( $p = 0.044$ ).

**Routes of Administration:** Among participants who had recently consumed methamphetamine crystal and commented (n=31), smoking remained the most common route of administration, with 87% reporting this method in 2022, stable from 94% in 2021 ( $p=0.426$ ). Almost one-fifth (19%) of participants reported swallowing crystal, also stable from 13% in 2021 ( $p=0.509$ ).

**Quantity:** Of those who reported recent use and responded (n=29), the median amount of crystal used in a 'typical' session was 0.20 grams (IQR=0.20-0.30; 0.30 grams in 2021;

IQR=0.20-0.50;  $p=0.161$ ). Of those who reported recent use and responded (n=28), the median maximum amount of crystal used was 0.30 grams (IQR=0.20-0.50; 0.60 grams in 2021; IQR=0.50-1.00;  $p=0.007$ ).

### Methamphetamine Base

Few participants (n≤5) reported recent use of methamphetamine base, and therefore, further details are not reported. For historical overview, please refer to Figure 16 and Figure 17. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### Price, Perceived Purity and Perceived Availability

contact the Drug Trends team for further information.

### Methamphetamine Powder

**Price:** Due to low numbers reporting (n≤5), further details are not reported on price for methamphetamine powder (Figure 18). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

**Perceived Purity:** The perceived purity of methamphetamine powder remained stable between 2021 and 2022 ( $p=0.195$ ). Among those who were able to comment in 2022 (n=13), the greatest per cent reported purity to be 'low' (46%; n≤5 in 2021) (Figure 20).

**Perceived Availability:** Due to low numbers reporting (n≤5), further details are not reported on perceived availability (Figure 22) for methamphetamine powder. Please refer to the [National EDRS Report](#) for national trends, or

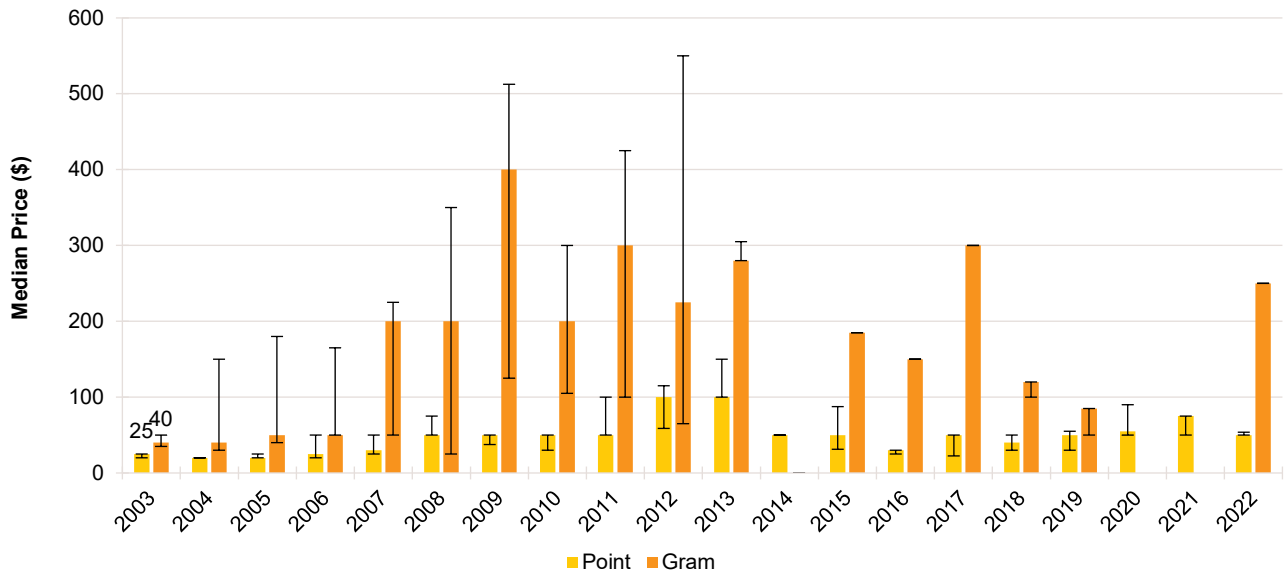
### Methamphetamine Crystal

**Price:** Participants reported a median price of \$50 per point (IQR=50-60; n=12; \$50 in 2021; IQR=50-78; n=8;  $p=0.650$ ) (Figure 19).

**Perceived Purity:** The perceived purity of methamphetamine crystal remained relatively stable between 2021 and 2022 ( $p=0.077$ ). Among those who were able to comment in 2022 (n=29), the greatest per cent reported purity to be 'fluctuating' (34%; 21% in 2021), with a further 31% reporting purity as 'high' (48% in 2021) (Figure 21).

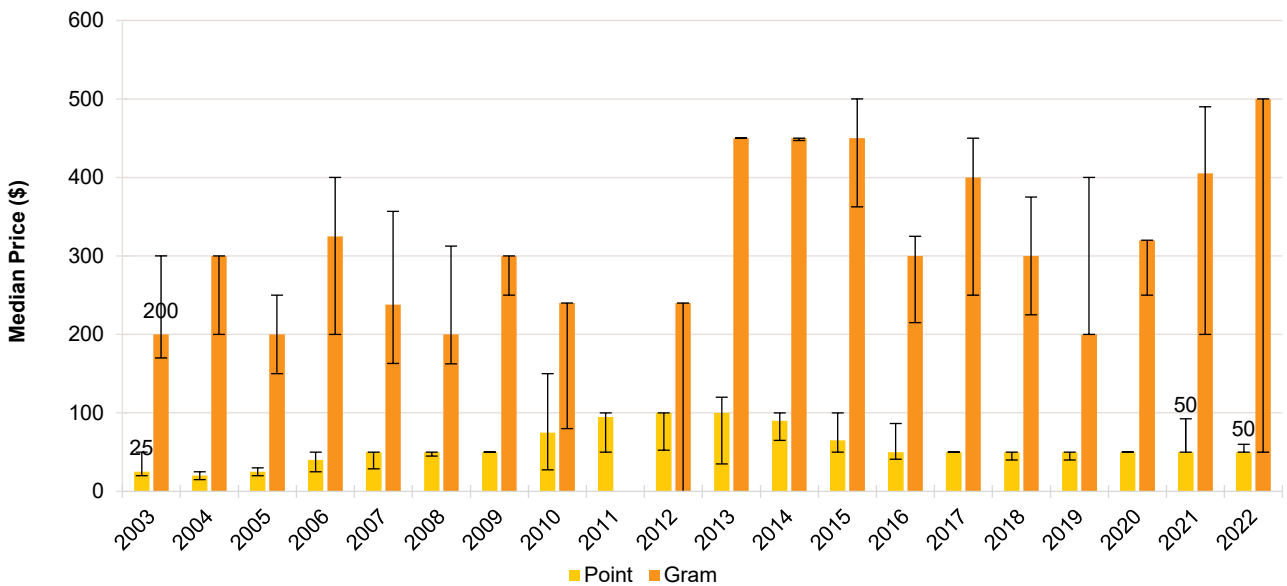
**Perceived Availability:** The perceived availability of methamphetamine crystal remained stable between 2021 and 2022 ( $p=0.586$ ). Among those who were able to respond in 2022 (n=30), 67% reported availability as 'very easy' (69% in 2021), with a further 30% reporting it as 'easy' (20% in 2021) (Figure 23).

Figure 18: Median price of powder methamphetamine per point and gram, Adelaide, SA, 2003-2022



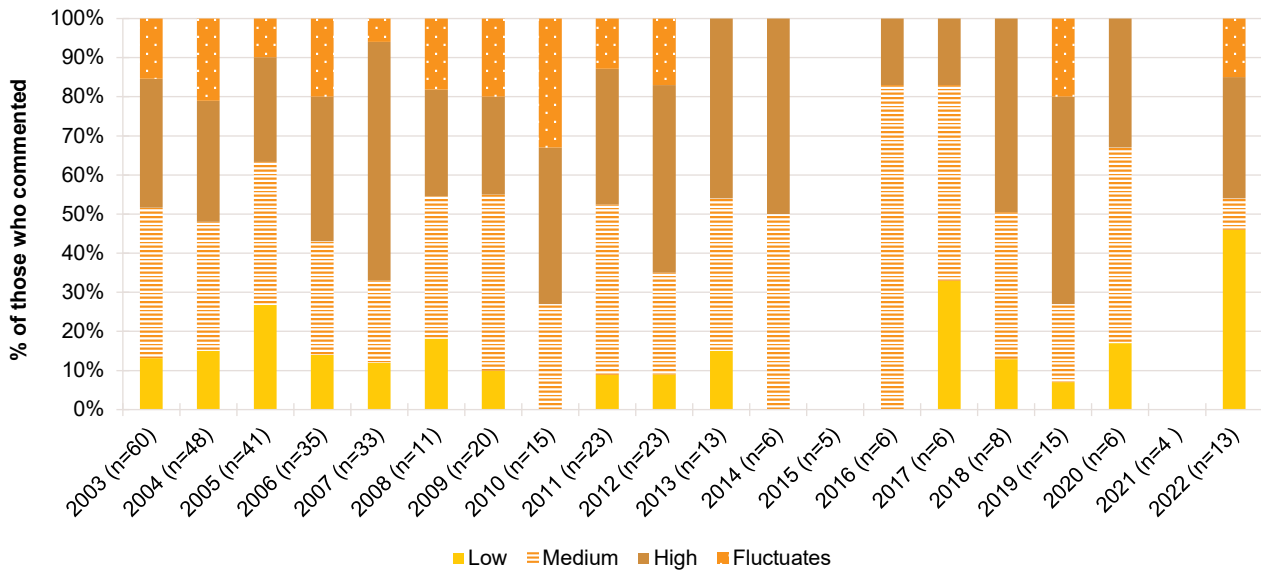
Note. Among those who commented. No participants reported purchasing a gram of powder methamphetamine in 2014, 2020 and 2021. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 19: Median price of crystal methamphetamine per point and gram, Adelaide, SA, 2003-2022



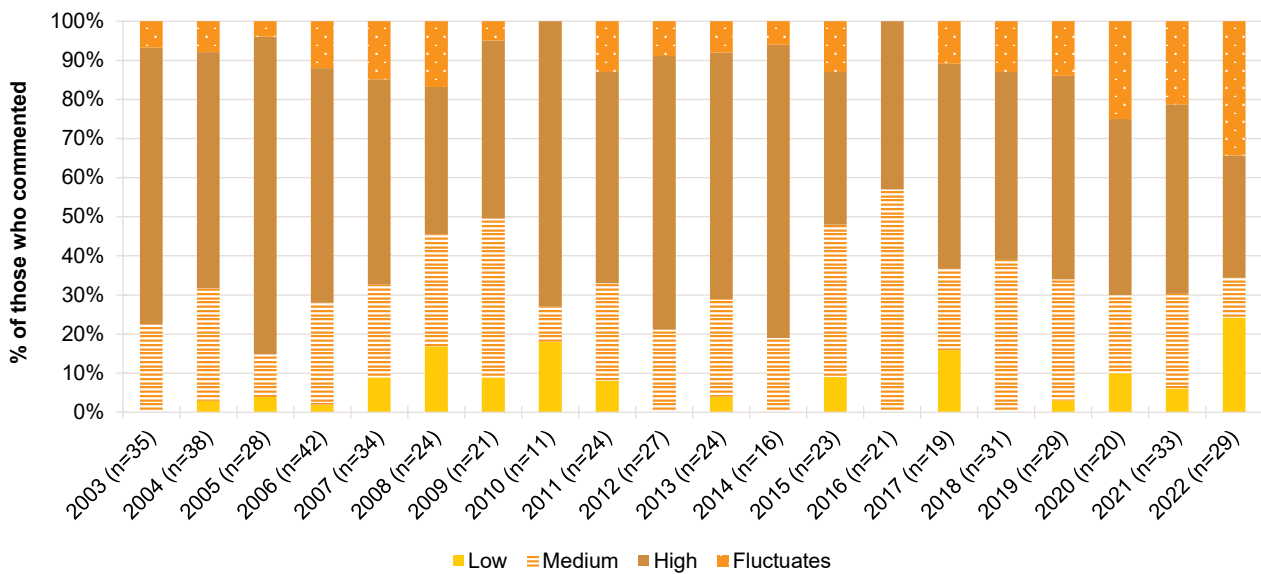
Note. Among those who commented. No participants reported purchasing a gram of crystal methamphetamine in 2011. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 20: Current perceived purity of powder methamphetamine, Adelaide, SA, 2003-2022



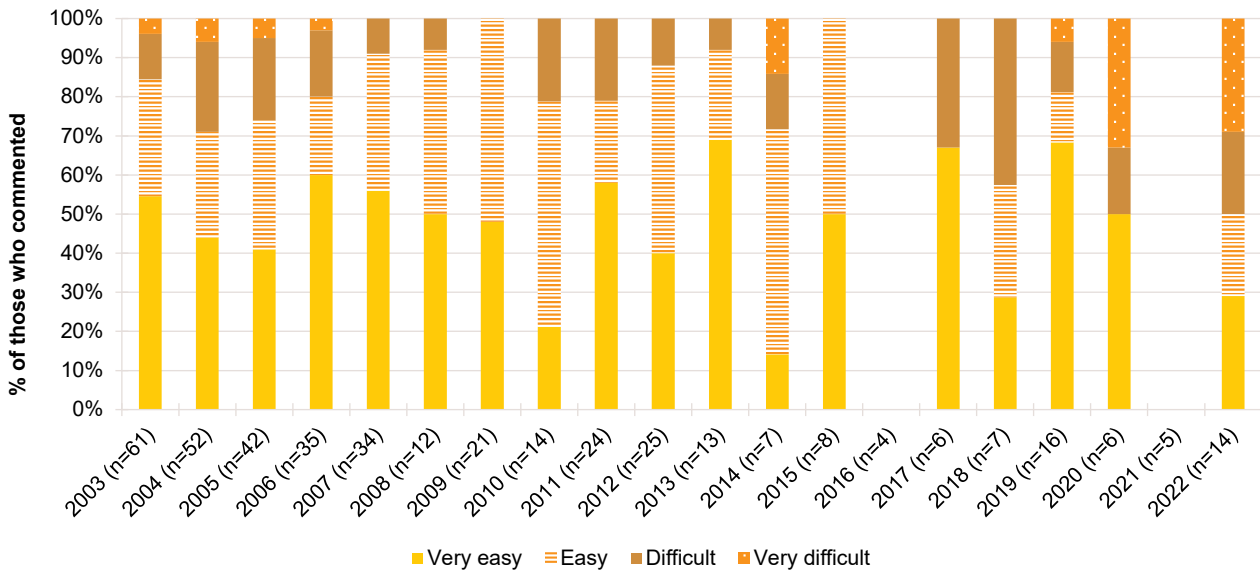
Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

Figure 21: Current perceived purity of crystal methamphetamine, Adelaide, SA, 2003-2022



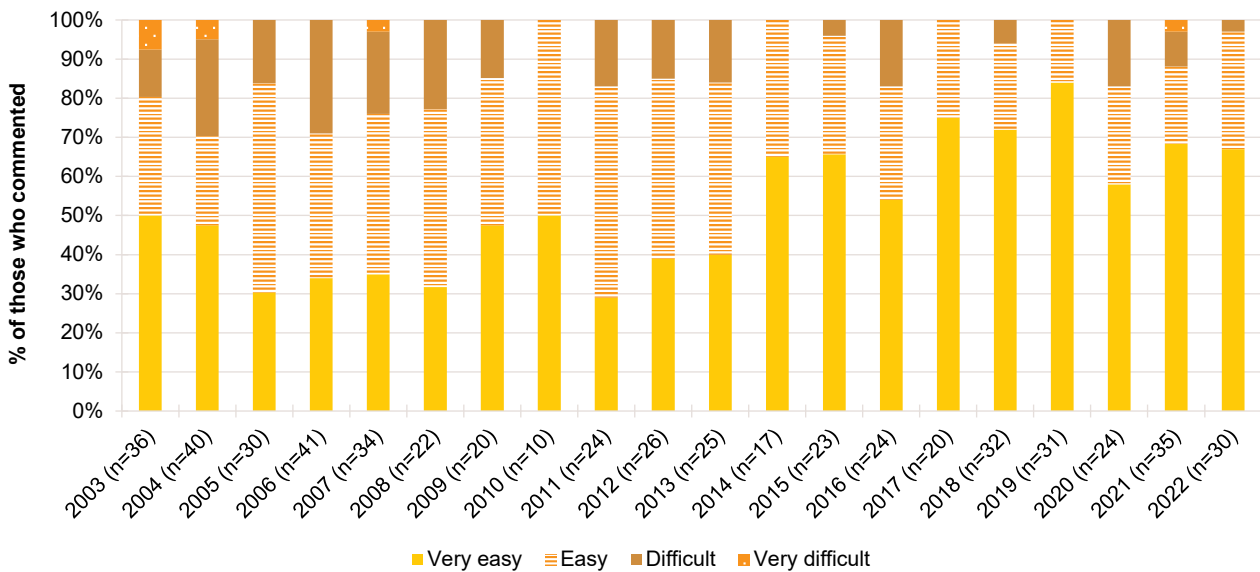
Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

Figure 22: Current perceived availability of powder methamphetamine, Adelaide, SA, 2003-2022



Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

Figure 23: Current perceived availability of crystal methamphetamine, Adelaide, SA, 2003-2022



Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

# 4

## Cocaine

Participants were asked about their recent (past six month) use of various forms of cocaine, including powder and 'crack' 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)

Since 2015, the per cent reporting any recent cocaine use has gradually increased. In 2022, 78% of the Adelaide sample reported recent use (unchanged from 78% in 2021), representing the greatest per cent reporting recent use for the second year running over the course of monitoring (Figure 24).

#### Frequency of Use

Frequency of use has fluctuated in recent years. Of those who had recently consumed cocaine and commented (n=81), participants reported a median of six days (IQR=3-12) of use in 2022, stable from five days in 2021 (IQR=3-10; n=77;  $p=0.585$ ) (Figure 24) and equivalent to monthly use. Fourteen per cent reported consuming cocaine on a weekly or more frequent basis, stable relative to 2021 (10%;  $p=0.615$ ).

#### Routes of Administration

Among participants who had recently consumed cocaine and commented (n=81), 99% of participants reported snorting cocaine, unchanged from 99% in 2021.

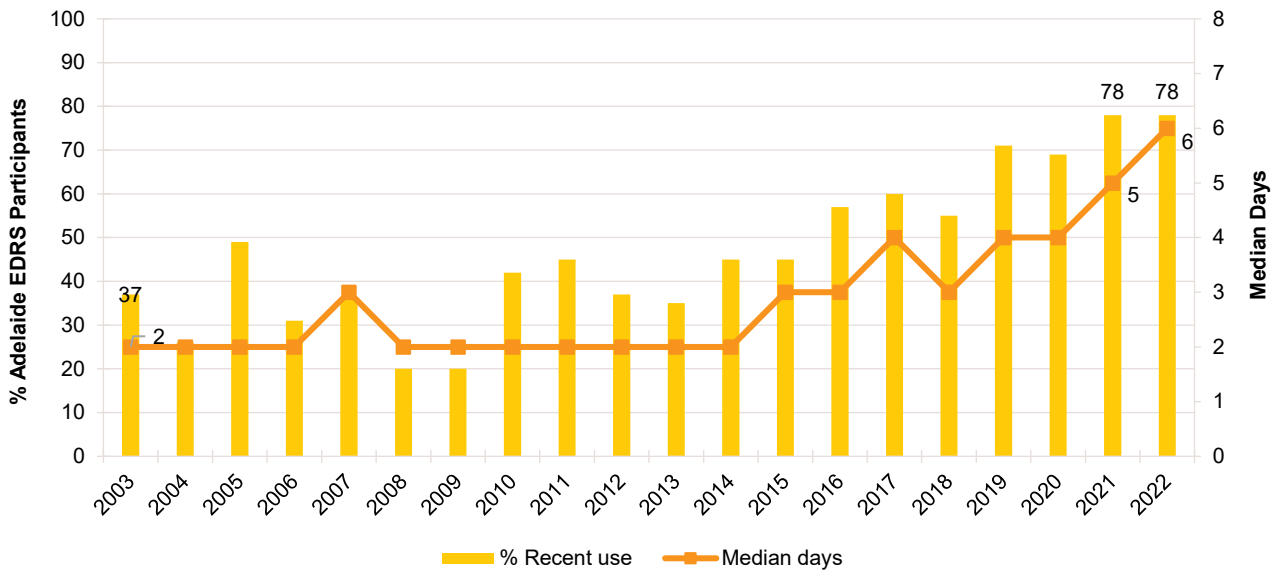
#### Quantity

Of those who reported recent use and responded (n=55), the median amount of cocaine used in a 'typical' session was 0.50 grams (IQR=0.50-1.00; 0.50 grams in 2021; IQR=0.30-1.00;  $p=0.463$ ). Of those who reported recent use and responded (n=57), the median maximum amount of cocaine used was 1.00 gram (IQR=0.50-2.00; 1.00 gram in 2021; IQR=0.50-2.00;  $p=0.557$ ).

#### Forms Used

Among participants who had recently consumed cocaine and commented (n=80), the vast majority reported using powder cocaine (89%; 92% in 2021;  $p=0.587$ ), with fewer participants reporting use of rock cocaine (15%; 15% in 2021). No participants reported using crack cocaine in 2021 or 2022.

Figure 24: Past six month use and frequency of use of cocaine, Adelaide, SA, 2003-2022



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 8 days to improve visibility of trends for days of use. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Price, Perceived Purity and Perceived Availability

### Price

The median price per gram of cocaine was \$350 in 2022 (IQR=300-350;  $n=39$ ), stable relative to 2021 (\$350; IQR=300-350;  $n=38$ ;  $p=0.983$ ) (Figure 25).

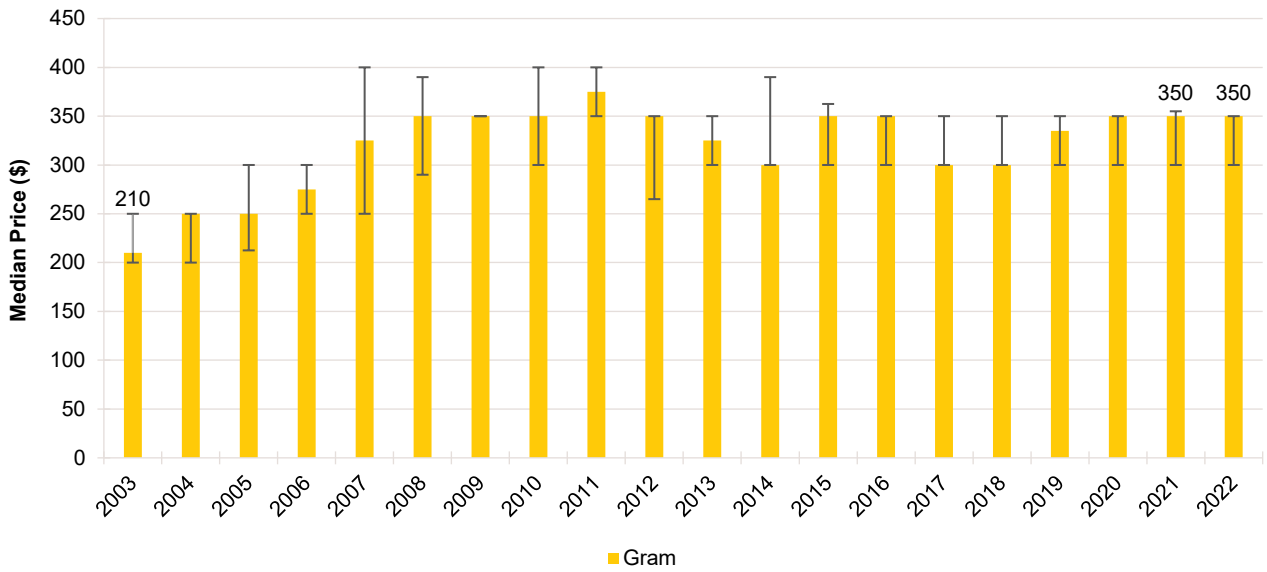
### Perceived Purity

There was a statistically significant change in the perceived purity of cocaine between 2021 and 2022 ( $p=0.012$ ). Among those who were able to respond in 2022 ( $n=72$ ), more participants perceived purity to be 'high' in 2022 (22%) relative to 2021 ( $n \leq 5$ ). On the contrary, a decrease was observed in those who reported purity to be 'medium' (28%; 39% in 2021) or 'low' (18%; 26% in 2021) (Figure 26).

### Perceived Availability

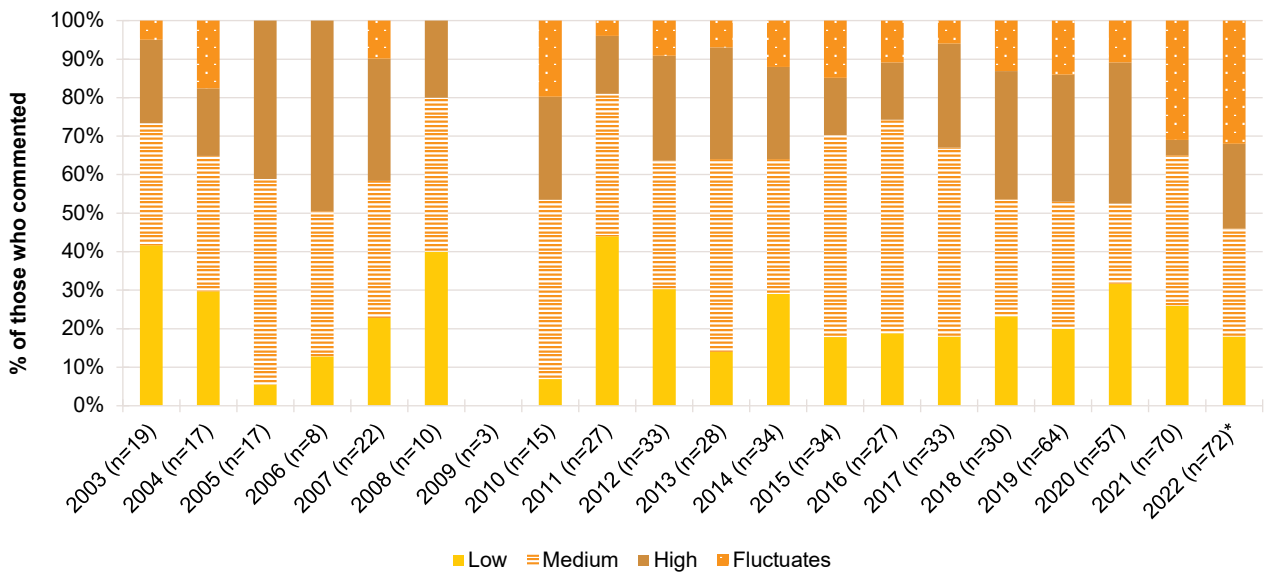
The perceived availability of cocaine largely remained stable between 2021 and 2022 ( $p=0.508$ ). Among those who were able to respond in 2022 ( $n=72$ ), almost two-thirds (63%) reported cocaine to be 'easy' to obtain (50% in 2021). In contrast, 14% perceived cocaine to be 'difficult' to obtain (17% in 2021) (Figure 27).

Figure 25: Median price of cocaine per gram, Adelaide, SA, 2003-2022



Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

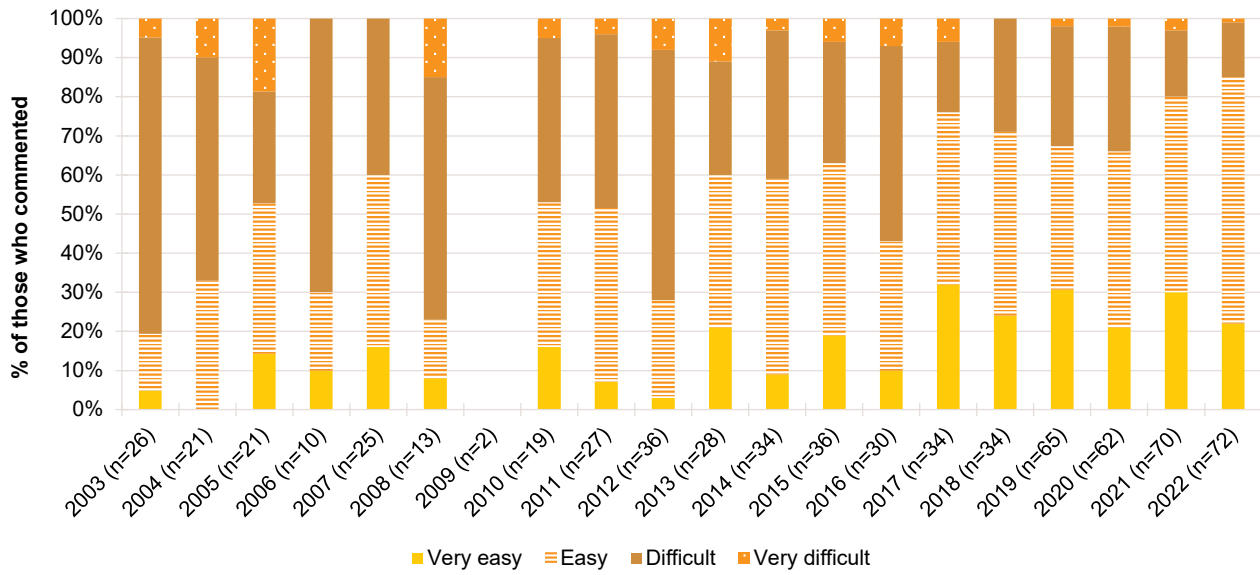
Figure 26: Current perceived purity of cocaine, Adelaide, SA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .



Figure 27: Current perceived availability of cocaine, Adelaide, SA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

# 5

## Cannabis and/or Cannabinoid Related Products

Participants were asked about their recent (past six month) use of indoor-cultivated cannabis via a hydroponic system ('hydro') and outdoor-cultivated cannabis ('bush'), as well as hashish, hash oil 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

In 2022, participants were asked for the first time about their use of both prescribed and non-prescribed cannabis and/or cannabinoid related products (including hydroponic and bush cannabis, hash, hash oil, CBD extract, THC extract). No participants in Adelaide reported prescribed use in the six months preceding interview.

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

### Recent Use (past 6 months)

Three-quarters (75%) reported recent use of non-prescribed cannabis and/or cannabinoid related products in 2022, stable from 2021 (84%;  $p=0.129$ ), and similar to estimates from earlier years (Figure 28).

### Frequency of Use

Frequency of use has varied between at least once per week to up to four days per week over the course of monitoring. Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented ( $n=78$ ), participants reported a median of 70 days (IQR=10-179) of use in 2022, stable relative to 2021 (56 days;  $n=84$ ; IQR=20-180;  $p=0.582$ ) (Figure 28). Two-thirds (67%) reported using non-prescribed cannabis and/or cannabinoid related products on a weekly or more frequent basis (74% in 2021;  $p=0.387$ ), including one-quarter (26%) who reported use on a daily basis (29% in 2021;  $p=0.731$ ).

## Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented (n=78), nine in ten participants (90%) reported smoking, stable relative to 2021 (96%;  $p=0.121$ ). Two-fifths (41%) reported inhaling/vaporising (35% in 2021;  $p=0.422$ ) and 37% reported swallowing (30% in 2021;  $p=0.404$ ).

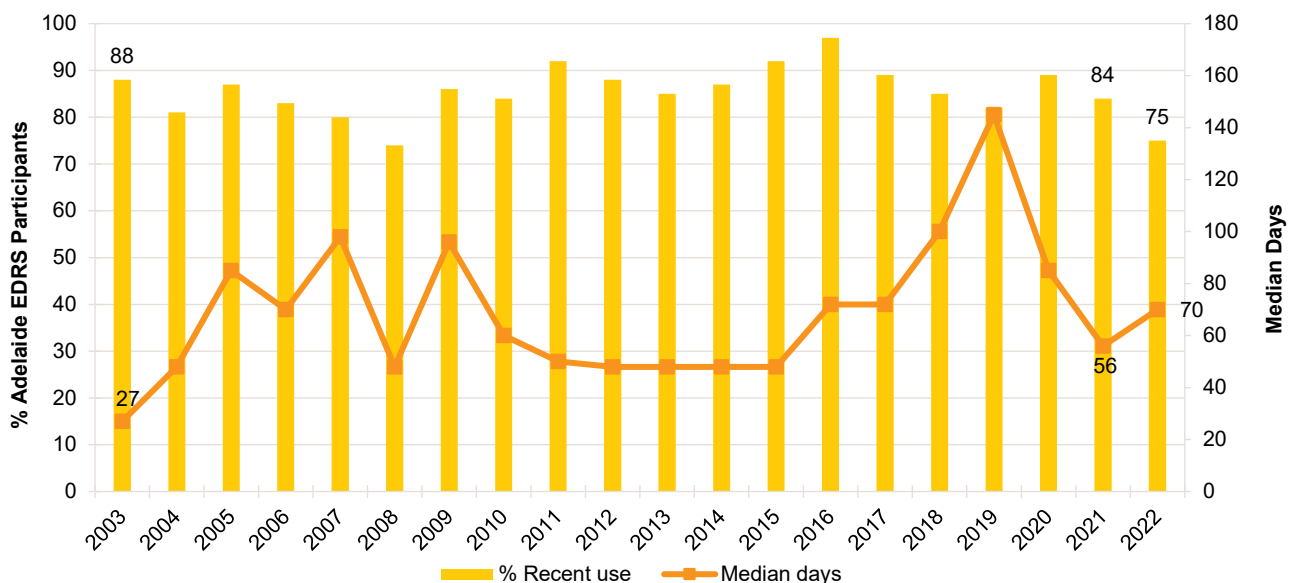
## Quantity

Of those who reported recent non-prescribed use and responded, the median amount of cannabis used on the last occasion of use was one cone (IQR=1-2; n=28; 2 cones in 2021; IQR=1-3;  $p=0.316$ ) or 2.50 grams (IQR=1.10-3.00; n=22; 1.30 grams in 2021; IQR=0.50-2.10;  $p=0.068$ ) or one joint (IQR=1-2; n=16; 1 joint in 2021; IQR=1-1;  $p=0.321$ ).

## Forms Used

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid related products and responded (n=63), the majority reported recent use of hydroponic cannabis (78%), a significant increase from 59% in 2021 ( $p=0.034$ ). This was closely followed by outdoor grown 'bush' cannabis, with 75% reporting recent use (78% in 2021;  $p=0.691$ ). Fewer participants reported having used hashish (19%; 23% in 2021;  $p=0.682$ ) and hash oil (13%; 16% in 2021;  $p=0.633$ ) in the preceding six months. Fourteen per cent of participants reported recent use of THC extract and 6% reported recent use of (non-prescribed) CBD extract (8% reported recent use of CBD oil in 2021).

Figure 28: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid related products, Adelaide, SA, 2003-2022



Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Further, in 2022, we captured use of 'cannabis and/or cannabinoid related products', while in previous years questions referred only to 'cannabis'. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Price, Perceived Potency and Perceived Availability

### Hydroponic Cannabis

**Price:** The median price per ounce of non-prescribed hydroponic cannabis has fluctuated over the years. In 2022, participants paid a median of \$235 per ounce (IQR=220-240; n=10), similar to the median price of \$230 in 2021 (IQR=215-255; n=8;  $p=0.964$ ) (Figure 29a), and the highest median price since the commencement of monitoring. The median price per gram of non-prescribed hydroponic cannabis was \$10 (IQR=10-10; n=7; n≤5 in 2021).

**Perceived Potency:** The perceived potency of non-prescribed hydroponic cannabis remained stable between 2021 and 2022 ( $p=0.436$ ). Among those who were able to respond in 2022 (n=48), almost two-thirds (63%) perceived non-prescribed hydroponic cannabis to be of 'high' potency (73% in 2021), and one-quarter (25%) perceived potency to be 'medium' (12% in 2021) (Figure 30a).

**Perceived Availability:** The perceived availability of non-prescribed hydroponic cannabis remained stable between 2021 and 2022. Among those who were able to respond in 2022 (n=49), two-thirds (67%) perceived non-prescribed hydroponic cannabis to be 'very easy' to obtain, unchanged from 67% in 2021. Almost one-quarter (24%) perceived non-prescribed hydroponic cannabis to be 'easy' to obtain (26% in 2021) (Figure 31a).

### Bush Cannabis

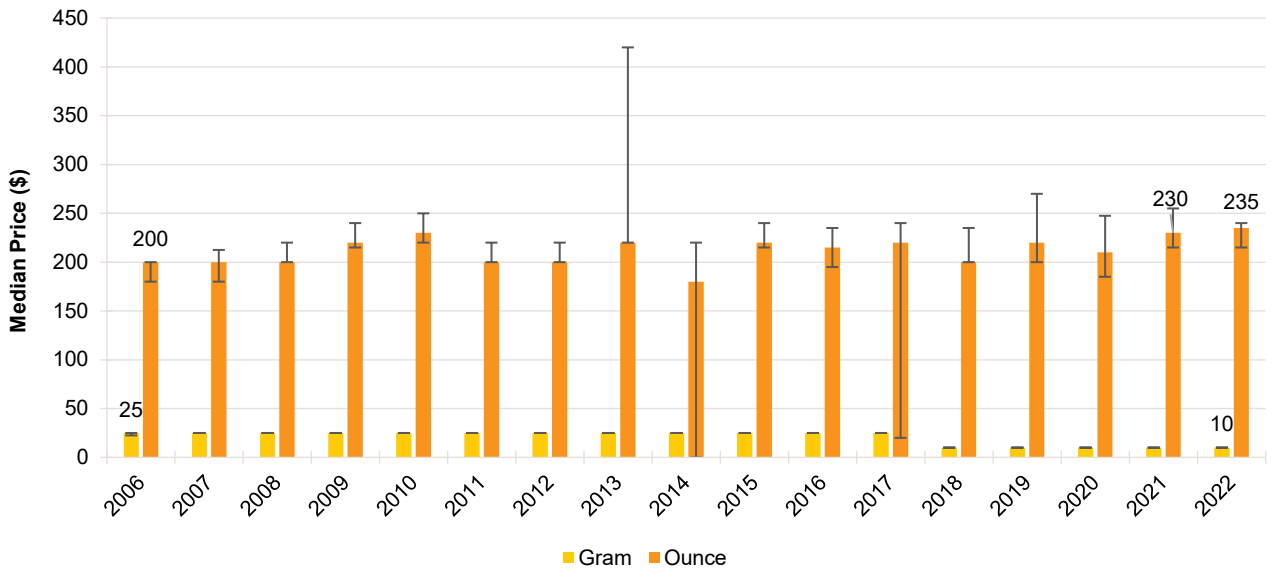
**Price:** The median price per ounce of non-prescribed bush cannabis remained stable, from \$260 (IQR=240-275; n=10) in 2021 to \$220 (IQR=210-240; n=9;  $p=0.077$ ) in 2022 (Figure 29b). Few participants (n≤5) reported on the price of a gram in 2022; therefore, further details are not reported (n≤5 in 2021;  $p=0.206$ ).

**Perceived Potency:** The perceived potency of non-prescribed bush cannabis remained stable between 2021 and 2022 ( $p=0.437$ ). Among those who were able to respond in 2022 (n=42), almost half (48%) perceived the potency of non-prescribed bush cannabis to be 'high' (40% in 2021), with a further 29% perceiving potency to be 'medium' (44% in 2021) (Figure 30b).

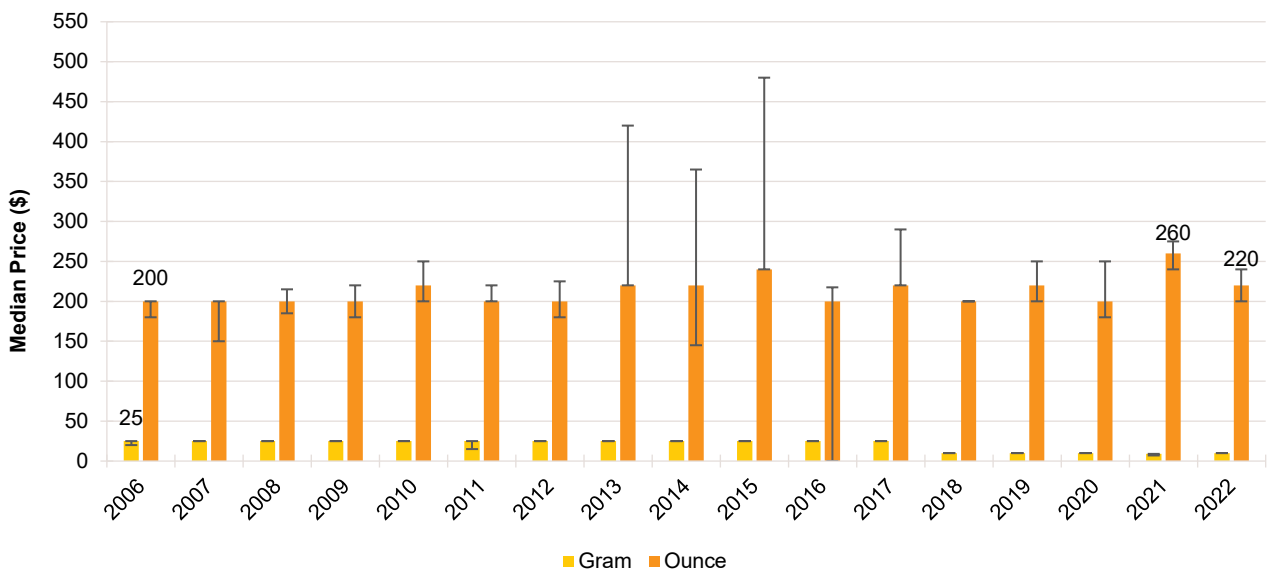
**Perceived Availability:** The perceived availability of non-prescribed bush cannabis remained stable between 2021 and 2022 ( $p=0.596$ ). Among those who were able to respond in 2022 (n=43), almost three-fifths (58%) perceived non-prescribed bush cannabis to be 'very easy' to obtain (51% in 2021) and one-quarter (26%) perceived it as 'easy' to obtain (22% in 2021). A further 16% reported that non-prescribed bush cannabis was 'difficult to obtain' (22% in 2021) (Figure 31b).

Figure 29: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Adelaide, SA, 2006-2022

**(A) Hydroponic cannabis**



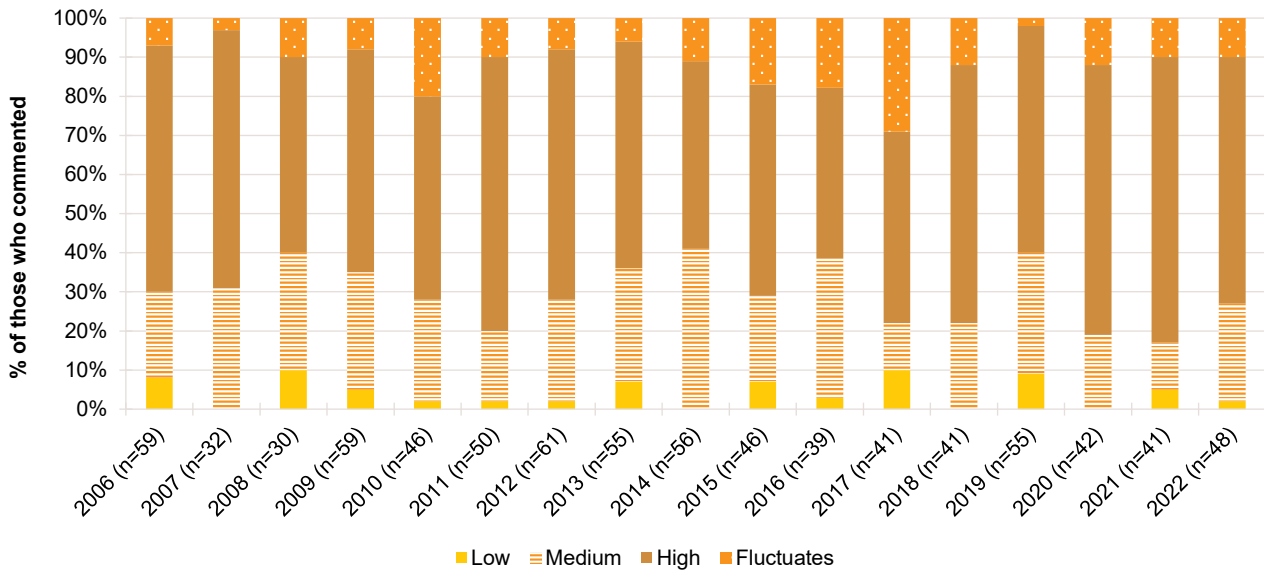
**(B) Bush cannabis**



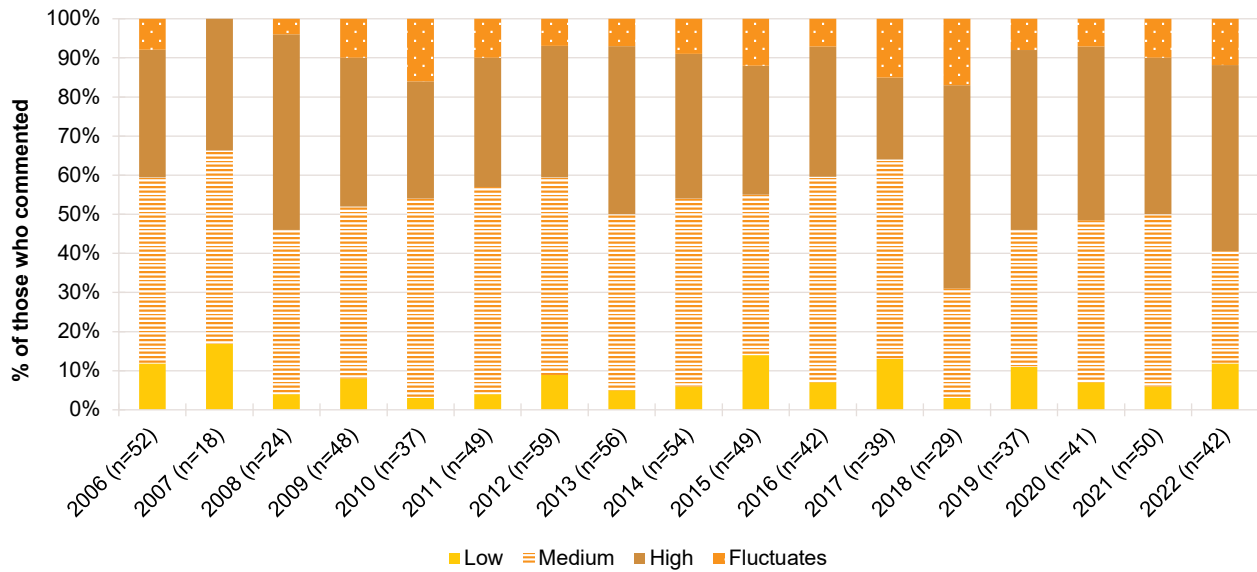
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels are only provided for the first (2006) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 30: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Adelaide, SA, 2006-2022

**(A) Hydroponic cannabis**



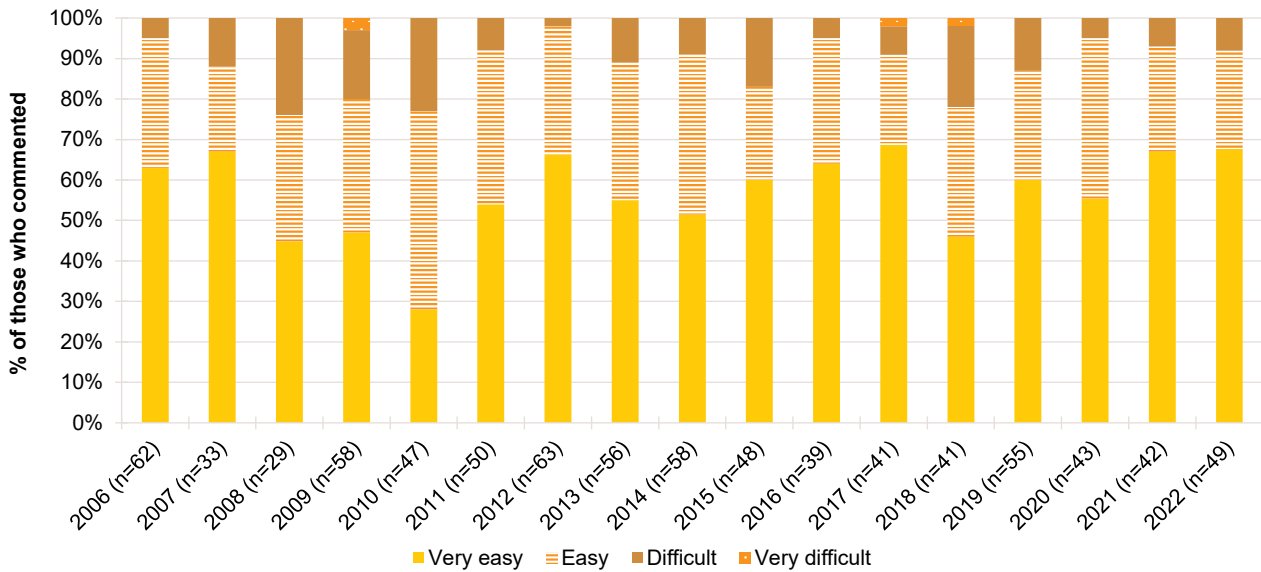
**(B) Bush cannabis**



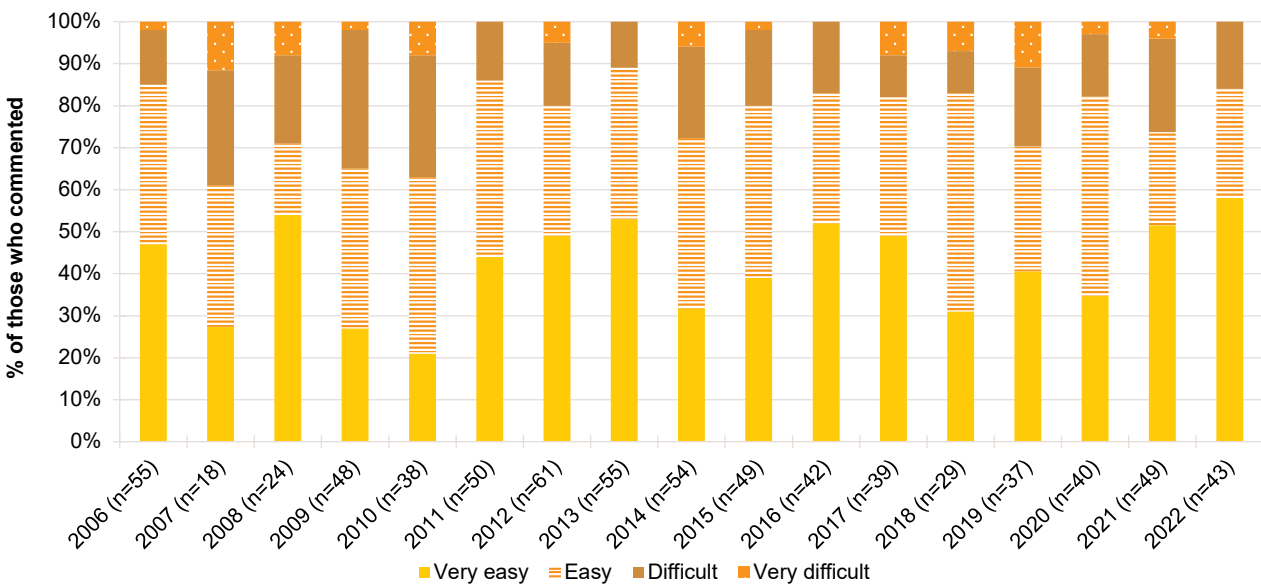
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

Figure 31: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Adelaide, SA, 2006-2022

**(A) Hydroponic cannabis**



**(B) Bush cannabis**



Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

## 6

## Ketamine, LSD and DMT

## Ketamine

## Patterns of Consumption

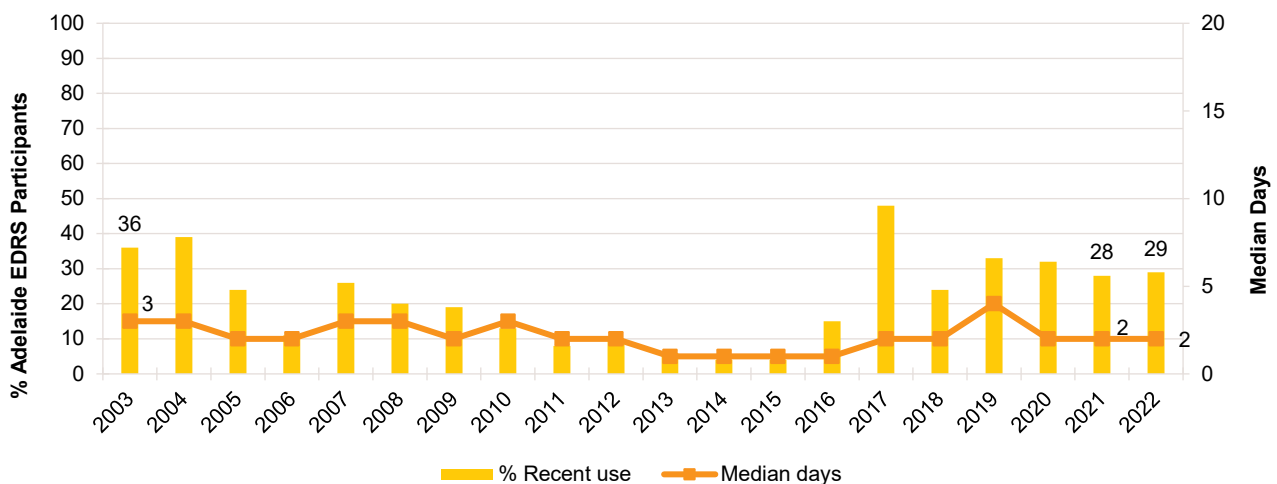
**Recent Use (past 6 months):** Twenty-nine per cent of the Adelaide sample reported using any ketamine in the six months prior to interview. This remained stable from 28% in 2021 (Figure 32).

**Frequency of Use:** Of those who had recently consumed ketamine and commented (n=30), median days of use remained low and stable in 2022 compared to 2021 (2 days; IQR=1-4; 2 days in 2021; IQR=1-4; n=28;  $p=0.650$ ) (Figure 32). No participants who had recently consumed any ketamine reported weekly or more frequent use in 2022, therefore, these data are suppressed (n≤5 in 2021;  $p=0.483$ ).

**Routes of Administration:** Among participants who had recently consumed ketamine and commented (n=30), all participants reported snorting in 2022, stable from 2021 (96%;  $p=0.483$ ).

**Quantity:** Of those who reported recent use and responded (n=14), the median amount of ketamine used in a 'typical' session was 0.20 grams (IQR=0.10-0.50; 0.30 grams in 2021; IQR=0.10-0.50;  $p=0.681$ ). Of those who reported recent use and responded (n=13), the median maximum amount of ketamine used was 0.30 grams (IQR=0.30-1.00; 0.50 grams in 2021; IQR=0.30-0.50;  $p=0.440$ ).

Figure 32: Past six month use and frequency of use of ketamine, Adelaide, SA, 2003-2022



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 20 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .



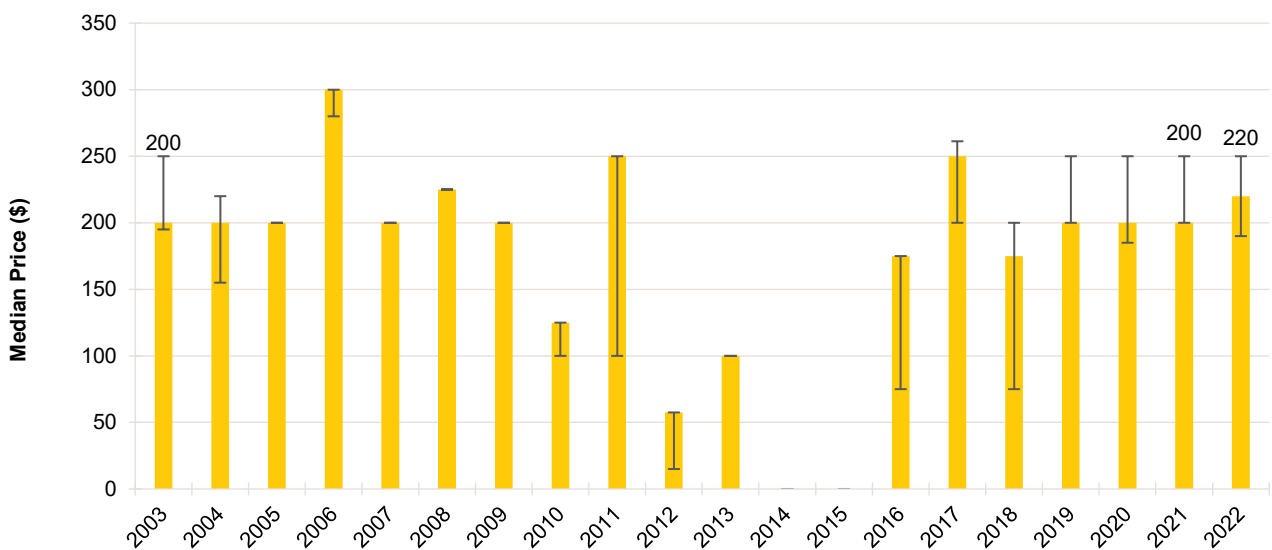
## Price, Perceived Purity and Perceived Availability

**Price:** The median reported price of ketamine has fluctuated somewhat since the commencement of monitoring. The median price per gram of ketamine in 2022 was \$220 (IQR=190-250; n=11; \$200 in 2021; IQR=200-250; n=9) (Figure 33).

**Perceived Purity:** The perceived purity of ketamine remained stable between 2021 and 2022 ( $p=0.759$ ). Among those who were able to respond in 2022 (n=19), almost two-thirds (63%) perceived the purity of ketamine to be 'high' (59% in 2021) (Figure 34).

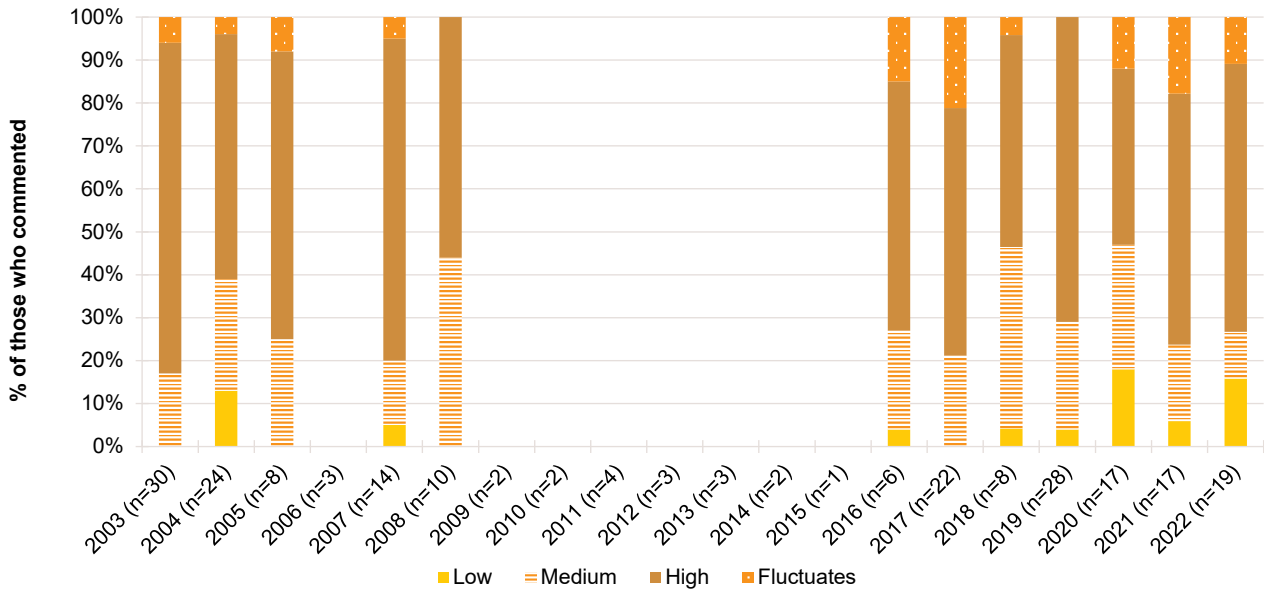
**Perceived Availability:** The perceived availability of ketamine remained stable between 2021 and 2022 ( $p=0.576$ ). Of those who were able to respond in 2022 (n=19), almost half (47%) reported ketamine to be 'difficult' to obtain (44% in 2021), though in contrast, 37% perceived ketamine to be 'easy' to obtain (22% in 2021) (Figure 35).

Figure 33: Median price of ketamine per gram, Adelaide, SA, 2003-2022



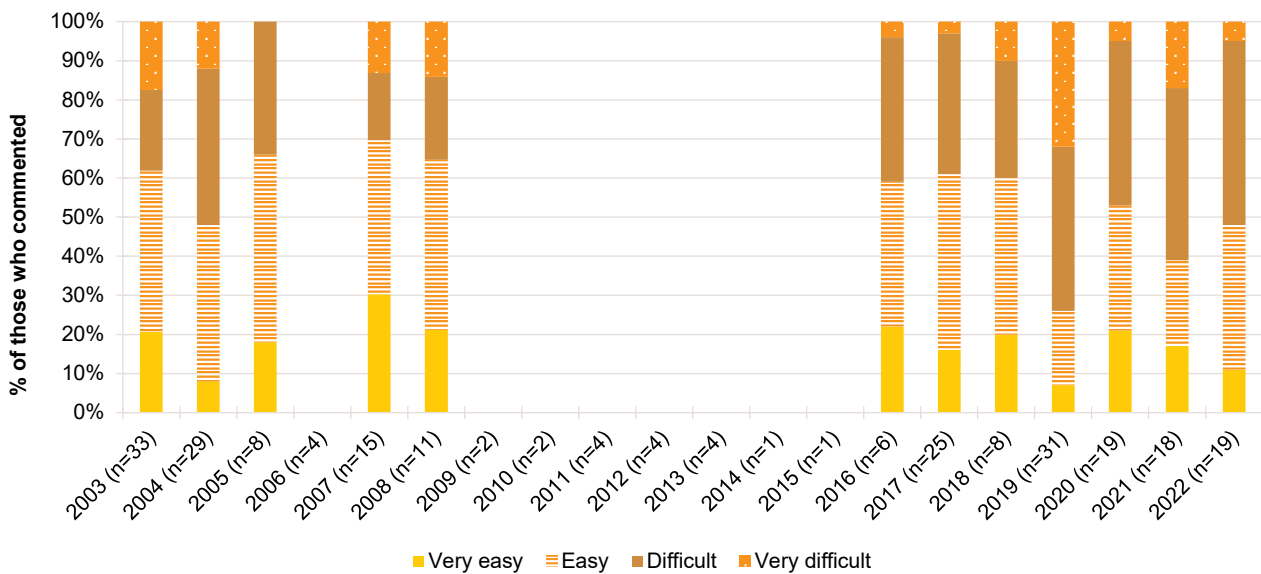
Note. Among those who commented. No participants reported purchasing ketamine in 2014 and 2015. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 34: Current perceived purity of ketamine, Adelaide, SA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

Figure 35: Current perceived availability of ketamine, Adelaide, SA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

## LSD

### Patterns of Consumption

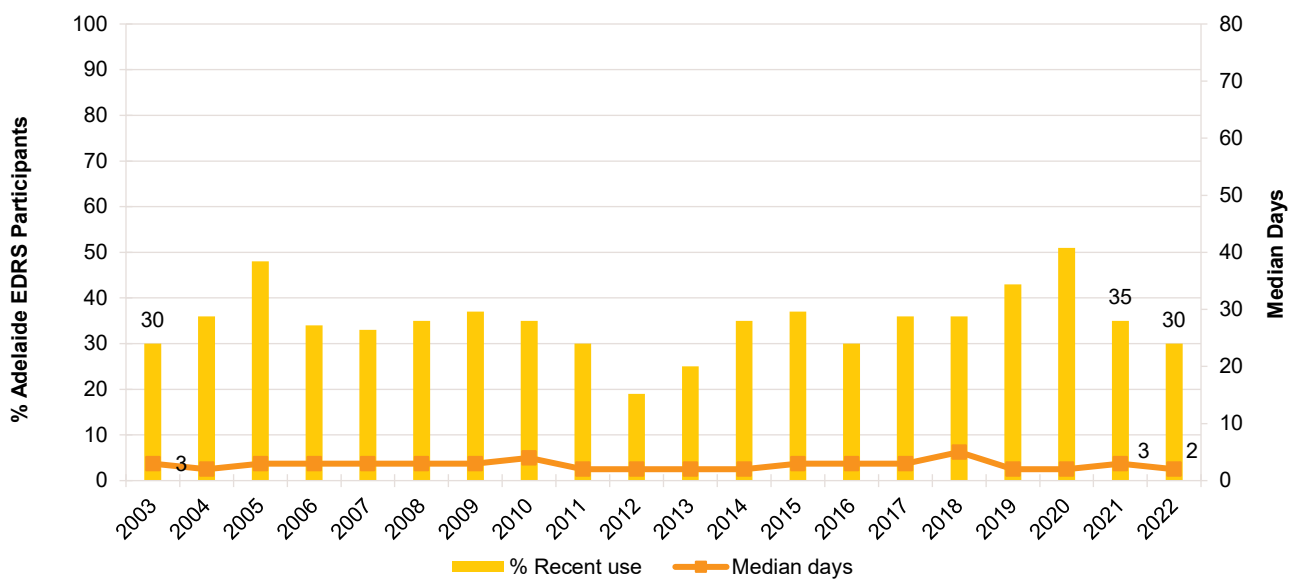
**Recent Use (past 6 months):** Almost one-third (30%) of the Adelaide sample had used LSD in the six months preceding interview, stable relative to 2021 (35%;  $p=0.451$ ) (Figure 36).

**Frequency of Use:** Median days of LSD use over the years has remained low. Of those who had recently consumed LSD in 2022 and commented (n=31), frequency of use remained stable at two days (IQR=1-4; 3 days in 2021; IQR=1-7; n=35;  $p=0.132$ ) (Figure 36). No participants who had recently consumed LSD reported weekly or more frequent use in 2022 (n≤5 in 2021).

**Routes of Administration:** Among participants who had recently consumed LSD and commented (n=31), the majority of participants (97%) reported swallowing LSD in 2022, stable from 2021 (100%;  $p=0.470$ ).

**Quantity:** Of those who reported recent use and responded (n=15), the median amount of LSD used in a 'typical' session was one tab (IQR=0.50-1.00; 1 tab in 2021; IQR=0.80-1.00;  $p=0.480$ ). Of those who reported recent use and responded (n=15), the median maximum amount of LSD used was one tab (IQR=0.80-2.00; 1 tab in 2021; IQR=1.00-2.00;  $p=0.836$ ).

Figure 36: Past six month use and frequency of use of LSD, Adelaide, SA, 2003-2022



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 80 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p<0.050$ ; \*\* $p<0.010$ ; \*\*\* $p<0.001$ .

### Price, Perceived Purity and Perceived Availability

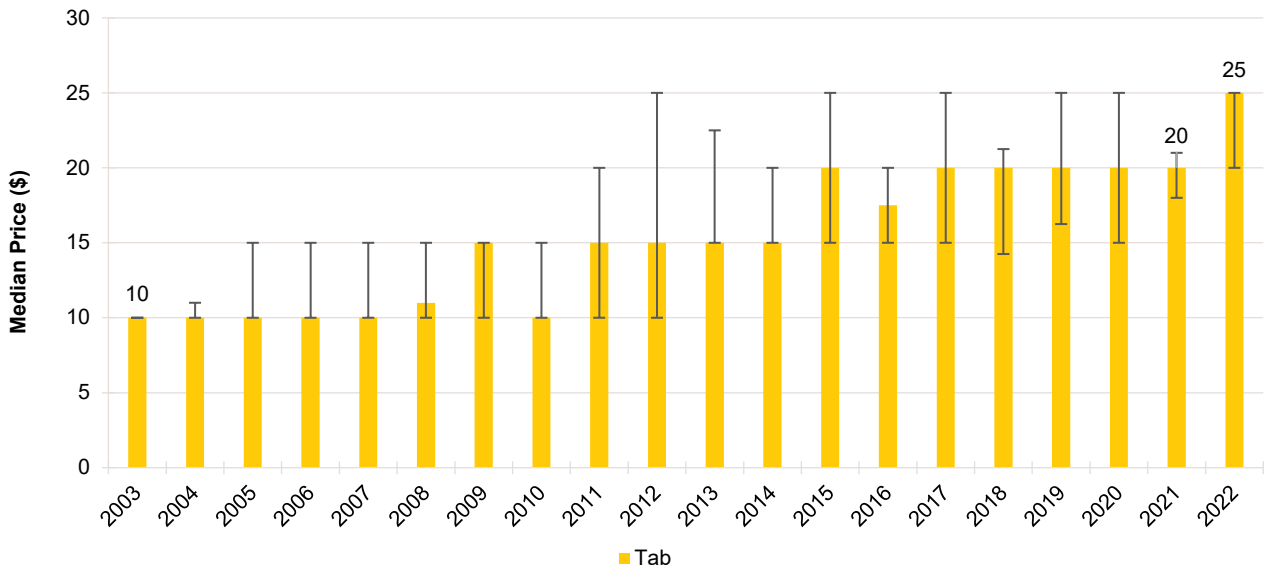
**Price:** The median price for one tab of LSD has doubled since the start of monitoring. In 2022 the median price was \$25 (IQR=20-25; n=14; 20 in 2021; IQR=19-21; n=16;  $p=0.224$ ). This is the highest median price observed across the monitoring period (Figure 37).

**Perceived Purity:** The perceived purity of LSD remained stable between 2021 and 2021 ( $p=0.589$ ). Among those who were able to respond in 2022 (n=27), almost three-fifths (59%) perceived the purity of LSD to be 'high' (63% in 2021), followed by 30% who reported the purity to be 'medium' (31% in 2021) (Figure 38).

**Perceived Availability:** The perceived availability of LSD remained stable between 2021 and 2022 ( $p=0.970$ ). Of those able to comment in 2022 (n=28), almost two-fifths (39%) reported LSD as being 'easy' to obtain (42% in 2021), followed by almost one-third (32%) who reported LSD as being 'very

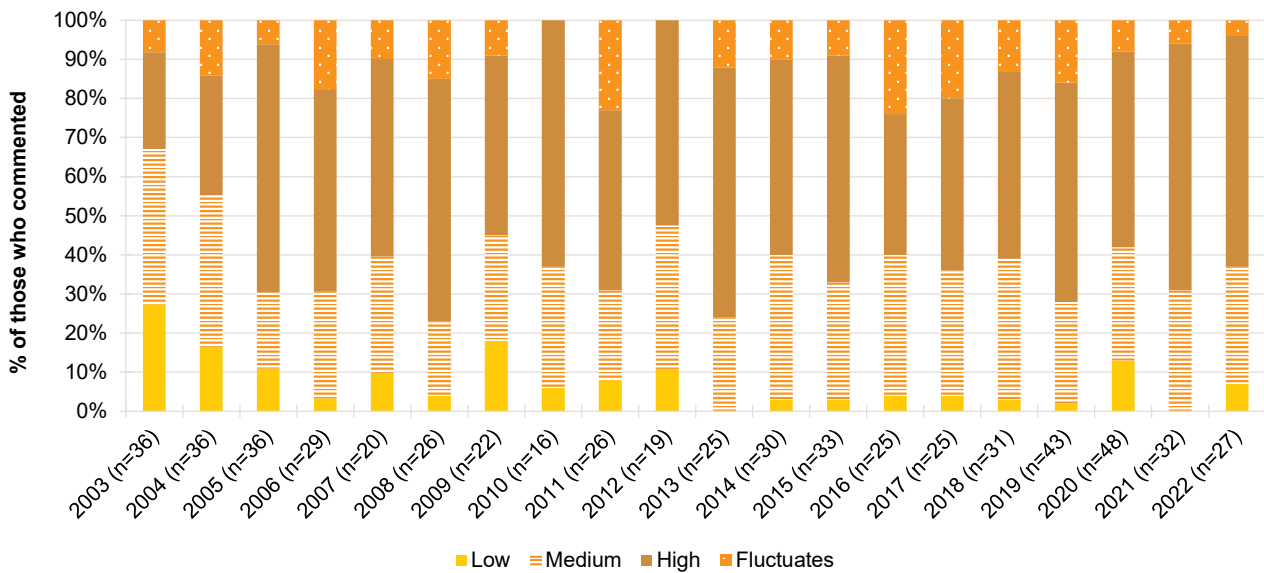
easy' to obtain (30% in 2021). On the contrary, 29% reported LSD as being 'difficult' to obtain (24% in 2021) (Figure 39).

Figure 37: Median price of LSD per tab, Adelaide, SA, 2003-2022



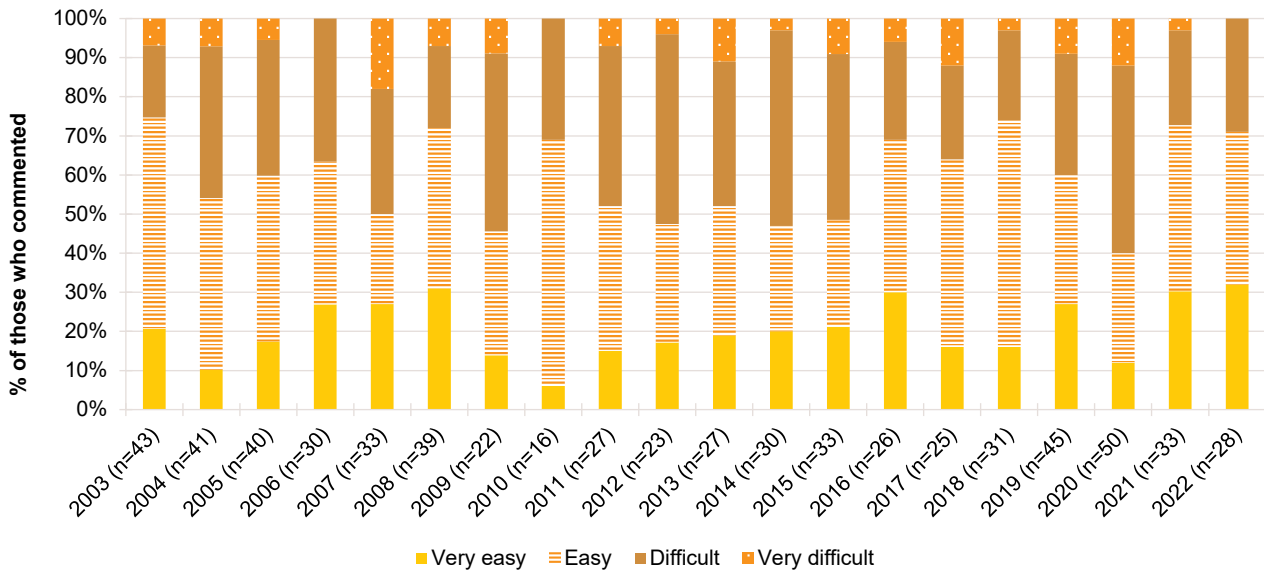
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

Figure 38: Current perceived purity of LSD, Adelaide, SA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed where n≤5 responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

Figure 39: Current perceived availability of LSD, Adelaide, SA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## DMT

### Patterns of Consumption

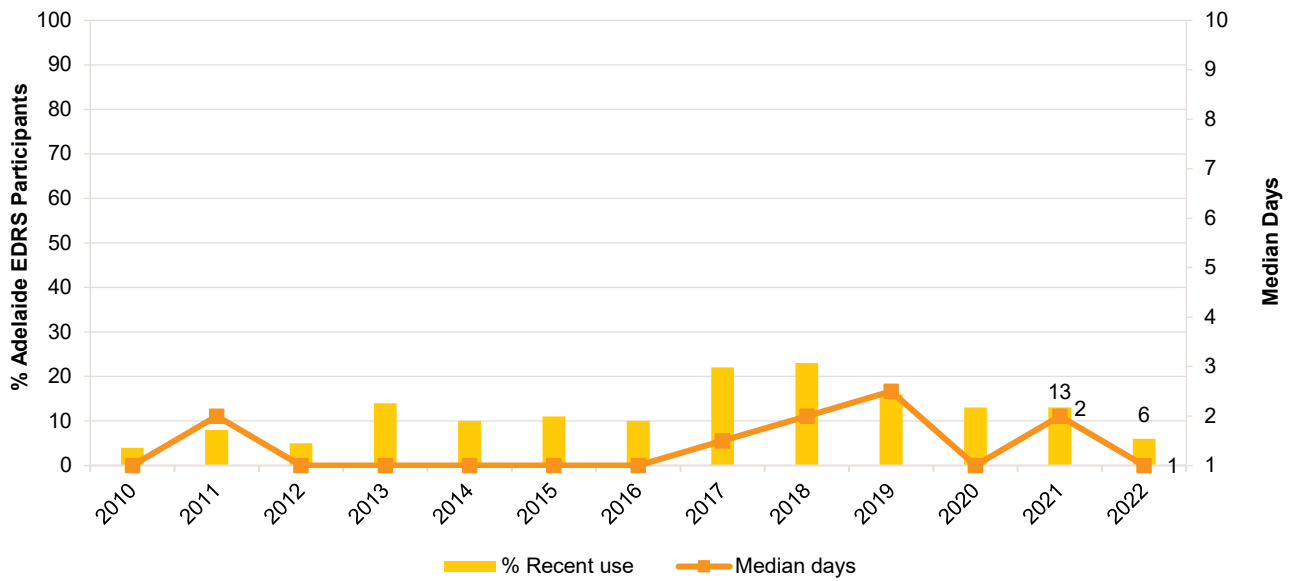
**Recent Use (past 6 months):** DMT use has fluctuated over the reporting period, with six per cent reporting recent use in 2022 (13% in 2021;  $p = 0.099$ ). This was the lowest percentage reporting recent use since 2012 (Figure 40).

**Frequency of Use:** Median days of DMT use across the years has been infrequent and stable, with a median of one day of use (IQR=1-2;  $n=6$ ) reported in 2022 (2 days in 2021; IQR=1-2;  $n=13$ ;  $p = 0.299$ ) (Figure 40).

**Routes of Administration:** Among participants who had recently consumed DMT and commented ( $n=6$ ), route of administration remained unchanged, with 100% reporting smoking (100% in 2021).

**Quantity:** Few participants ( $n \leq 5$ ) reported on the 'typical' and maximum quantity of DMT used in a session in 2022, therefore, further details are not reported ( $n \leq 5$  in 2021).

Figure 40: Past six month use and frequency of use of DMT, Adelaide, SA, 2010-2022



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 10 days to improve visibility of trends. Data labels are only provided for the first (2010) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

### Price, Perceived Purity and Perceived Availability

Data on the price, perceived purity and perceived availability for DMT were not collected.

# 7

## New Psychoactive Substances

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

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

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

### Recent Use (past 6 months)

Any NPS use, including plant-based NPS, has fluctuated over time, peaking at 49% in 2011 and 2015 and declining to 12% in 2022 (10% in 2021;  $p=0.817$ ), the second lowest per cent since the commencement of monitoring (Table 2).

Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 47% in 2011 and declining to 7% in 2022 (8% in 2021;  $p=0.791$ ), the lowest percentage reporting recent use since the commencement of monitoring (Table 3).

### Forms Used

Participants are asked about a range of NPS each year, updated to reflect key emerging substances of interest. NPS use among the Adelaide sample has fluctuated over time, although 2022 observed the lowest percentages of use since monitoring of NPS first commenced in 2010, with few participants ( $n\leq 5$ ) reporting use of any individual NPS (Table 4), with the exception of mescaline (6%;  $n\leq 5$  in 2021;  $p=0.498$ ). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

Table 2: Past six month use of NPS (including plant-based NPS), nationally and Adelaide, SA, 2010-2022

%	National	Adelaide, SA
2010	24	23
2011	36	49
2012	40	43
2013	44	38
2014	35	38
2015	37	49
2016	28	28
2017	26	31
2018	23	29
2019	20	27
2020	15	17
2021	16	10
2022	11	12

Note. Monitoring of NPS first commenced in 2010. In 2021, the decision was made to remove DMT and PMA from the NPS category, with these substances now presented in Chapter 6 and Chapter 8, respectively. This has had a substantial impact on the percentage of the sample reporting 'any' NPS use in the past six months and means that the figures presented above will not align with those presented in previous (2010-2020) EDRS reports. – Per cent suppressed due to small cell size ( $n \leq 5$  but not 0). The response option 'Don't know' was excluded from figure. Statistical significance for 2021 versus 2022 presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Table 3: Past six month use of NPS (excluding plant-based NPS), nationally and Adelaide, SA, 2010-2022

%	National	Adelaide, SA
2010	24	22
2011	33	47
2012	37	37
2013	42	36
2014	34	35
2015	34	44
2016	27	25
2017	24	25
2018	21	26
2019	19	24
2020	12	12
2021	14	8
2022	9	7

Note. Monitoring of NPS first commenced in 2010. In 2021, the decision was made to remove DMT and PMA from the NPS category, with these substances now presented in Chapter 6 and Chapter 8, respectively. This has had a substantial impact on the percentage of the sample reporting 'any' NPS use in the past six months and means that the figures presented above will not align with those presented in previous (2010-2020) EDRS reports. – Per cent suppressed due to small cell size ( $n \leq 5$  but not 0). The response option 'Don't know' was excluded from figure. Statistical significance for 2021 versus 2022 presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .



Table 4: Past six month use of NPS by drug type, Adelaide, SA, 2010-2022

	2010 N=92	2011 N=76	2012 N=92	2013 N=100	2014 N=100	2015 N=100	2016 N=100	2017 N=100	2018 N=100	2019 N=100	2020 N=100	2021 N=100	2022 N=104
<b>% Phenethylamines ^</b>	13	42	11	20	26	36	14	15	12	14	7	-	-
Any 2C substance~	11	18	10	19	15	29	9	9	12	14	7	-	-
NBOMe	/	/	/	/	16	18	9	8	-	-	0	0	-
DO-x	-	7	0	-	0	0	0	-	0	-	0	0	0
4-FA	/	/	/	/	/	/	0	0	0	0	0	0	0
NBOH	/	/	/	/	/	/	/	/	/	/	/	/	0
<b>% Tryptamines^^</b>	-	-	-	-	0	0	0	-	-	-	-	-	0
5-MeO-DMT	-	-	-	-	0	0	0	0	-	-	-	-	0
4-AcO-DMT	/	/	/	/	/	/	0	-	/	/	/	/	/
<b>% Synthetic cathinones</b>	9	10	10	-	-	-	-	-	7	8	-	-	-
Mephedrone	9	8	-	-	-	0	0	0	-	-	-	-	0
Methylone/bk MDMA	/	-	-	-	-	-	-	-	7	-	0	-	0
MDPV/Ivory wave	-	-	-	-	0	-	0	0	0	0	0	0	0
Alpha PVP	/	/	/	/	/	/	0	0	-	0	0	0	0
Other substituted cathinone	/	/	0	0	0	0	0	0	0	/	/	/	/
N-ethylhexedrone	/	/	/	/	/	/	/	/	/	/	0	0	0
N-ethylpentylone	/	/	/	/	/	/	/	/	/	/	0	0	0
N-ethylbutylone	/	/	/	/	/	/	/	/	/	/	/	0	0
3-chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0
3-methylmethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	0
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	0
N, N-Dimethyl Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	0
Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	0
<b>% Piperazines</b>	0	-	-	0	0	0	0	0	/	/	/	/	/
BZP	0	-	-	0	0	0	0	0	/	/	/	/	/
<b>% Dissociatives</b>	/	/	0	/	/	0	0	-	-	0	-	0	0
Methoxetamine (MXE)	/	/	0	/	/	0	0	-	-	0	-	0	0
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	0
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0

	2010 N=92	2011 N=76	2012 N=92	2013 N=100	2014 N=100	2015 N=100	2016 N=100	2017 N=100	2018 N=100	2019 N=100	2020 N=100	2021 N=100	2022 N=104
3-HO-PCP/4-HO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0
3-MeO-PCP/4- MeO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0
Other drugs that mimic the effects of dissociatives like ketamine	/	/	/	/	/	/	/	/	/	/	0	0	0
<b>% Plant-based NPS</b>	-	-	12	8	-	8	9	10	-	8	7	-	7
Ayahuasca	/	/	/	/	/	0	-	-	0	-	0	-	0
Mescaline	-	-	-	-	-	-	6	6	-	-	-	-	6
Salvia divinorum	/	-	-	-	0	-	-	-	-	-	-	0	0
Kratom	/	/	/	/	/	/	/	/	/	/	-	-	-
LSA	/	-	11	-	0	-	-	/	/	/	/	/	/
Datura	-	-	0	-	0	0	0	/	/	/	/	/	/
<b>% Benzodiazepines</b>	/	/	/	/	/	/	0	-	-	-	-	-	0
Etizolam	/	/	/	/	/	/	0	-	-	-	-	-	0
8-Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0
Bromazolam	/	/	/	/	/	/	/	/	/	/	/	/	0
Clonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	0
Other drugs that mimic the effect of benzodiazepines	/	/	/	/	/	/	/	/	0	0	0	-	0
<b>% Synthetic cannabinoids</b>	0	0	10	/	/	0	/	/	/	-	-	0	-
<b>% Herbal high#</b>	/	/	17	10	6	7	-	-	-	-	/	/	/
Phenibut	/	/	/	/	/	/	/	/	/	/	0	-	0
<b>% Other drugs that mimic the effect of opioids</b>	/	/	/	/	/	/	/	/	-	0	0	0	0
<b>% Other drugs that mimic the effect of ecstasy</b>	/	/	/	/	/	/	/	0	-	-	-	-	-
<b>% Other drugs that mimic the effect of amphetamine or cocaine</b>	/	/	/	/	/	/	/	-	-	-	-	0	0
<b>% Other drugs that mimic the effect of psychedelic drugs like LSD</b>	/	/	/	/	/	/	/	0	0	-	-	0	-

Note. NPS first asked about in 2010. / not asked. ^In previous EDRS reports, PMA was included as a NPS under ‘phenethylamines’ and mescaline was included under both ‘phenethylamines’ and ‘plant-based NPS’. In 2021, the decision was made to remove PMA from the NPS category altogether, while mescaline was removed from ‘phenethylamines’ and is now only coded under ‘plant-based NPS’. This means that the percentages reported for any phenethylamine NPS use in the 2022 and 2021 EDRS reports will not align with those presented in earlier (2010-2020) reports. ^^In previous (2010-2020) EDRS reports, DMT was included as a NPS under ‘tryptamines’, however, was removed from the NPS category in 2021 (refer to Chapter 6 for further information on DMT use among the sample). This means that the percentages reported for any tryptamine NPS use in the 2022 and 2021 EDRS reports will not align with those presented in earlier (2010-2020) reports. # The terms ‘herbal highs’ and ‘legal highs’ appear to be used interchangeably to mean drugs that have similar effects to illicit drugs like cocaine or cannabis but are not covered by current drug law scheduling or legislation. ~ In 2010 and between 2017-2019, three forms of 2C were asked about whereas between 2011-2016 four forms were asked about. From 2020 onwards, ‘any’ 2C use is captured. - Per cent suppressed due to small cell size (n≤5 but not 0). The response option ‘Don’t know’ was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

## 8

## Other Drugs

## Non-Prescribed Pharmaceutical Drugs

## Codeine

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

Up until 2017, participants were only asked about use of OTC codeine for non-pain purposes. Additional items on use of prescription low-dose and prescription high-dose codeine were included in the 2018-2020 EDRS, however in 2021-2022, participants were only asked about prescribed and non-prescribed codeine use, regardless of whether it was low- or high-dose.

**Recent Use (past 6 months):** In 2022, 13% reported using any non-prescribed codeine in the past six months, stable relative to 2021 (13% in 2021) (Figure 41).

**Recent Use for Non-Pain Purposes:** Eight per cent of the Adelaide sample reported using non-prescribed codeine for non-pain purposes in 2022 (57% of participants who had recently used non-prescribed codeine; 54% in 2021).

**Frequency of Use:** Participants who had recently used non-prescribed codeine and commented (n=14) reported use on a median of seven days (IQR=4-10) in the past six months, a significant increase from three days (IQR=1-6; n=13) in 2021 ( $p=0.042$ ).

## Pharmaceutical Opioids

**Recent Use (past 6 months):** Almost one-tenth (8%) of the Adelaide sample had recently used non-prescribed pharmaceutical opioids in 2022 (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl, excluding codeine) in 2022, stable from 9% in 2021 ( $p=0.799$ ) (Figure 41).

**Frequency of Use:** Participants who had recently used non-prescribed pharmaceutical opioids and commented (n=8) reported use on a median of six days (IQR=4-11) in the six months preceding interview (3 days in 2021; IQR=1-6; n=19;  $p=0.333$ ).

## Pharmaceutical Stimulants

**Recent Use (past 6 months):** Two-fifths (41%) of the Adelaide sample had recently consumed non-prescribed pharmaceutical stimulants in 2022 (e.g., dexamphetamine, methylphenidate, modafinil), stable relative to 2021 (31%;  $p=0.147$ ) (Figure 41).

**Frequency of Use:** A median of four days of non-prescribed pharmaceutical stimulant use (IQR=2-11; n=43) was reported in the six months prior to interview in 2022 (3 days in 2021; IQR=2-6; n=31;  $p=0.353$ ).

**Quantity:** Of those who reported recent use and responded (n=35), the median amount of non-prescribed pharmaceutical stimulants used in a 'typical' session was two pills/tablets (IQR=1-3; 2 pills/tablets in 2021; IQR=1-3;  $p=0.569$ ). Of those who reported recent use and responded (n=37),

the median maximum amount of non-prescribed pharmaceutical stimulants used was two pills/tablets (IQR=2-4; 2.3 pills/tablets in 2021; IQR=2-5;  $p=0.472$ ).

**Price and Perceived Availability:** In 2022, participants were asked questions pertaining to the price and perceived availability of non-prescribed pharmaceutical stimulants, however these data will be released separately in 2023. Please contact the Drug Trends team for further information.

### Benzodiazepines

**Recent Use (past 6 months):** Recent use of non-prescribed benzodiazepines has fluctuated considerably over the course of monitoring, with 29% of the Adelaide sample reporting recent use in 2022, stable relative to 2021 (30%;  $p=0.876$ ) (Figure 41). From 2019, participants were asked about non-prescribed alprazolam use versus 'other' non-prescribed benzodiazepine use. Thirteen per cent of participants reported recent use of non-prescribed alprazolam, stable relative to 19% in 2021 ( $p=0.254$ ). Recent use of non-prescribed 'other' benzodiazepines also remained stable, with almost one-quarter (23%) reporting recent use in 2022 (20% in 2021;  $p=0.614$ ).

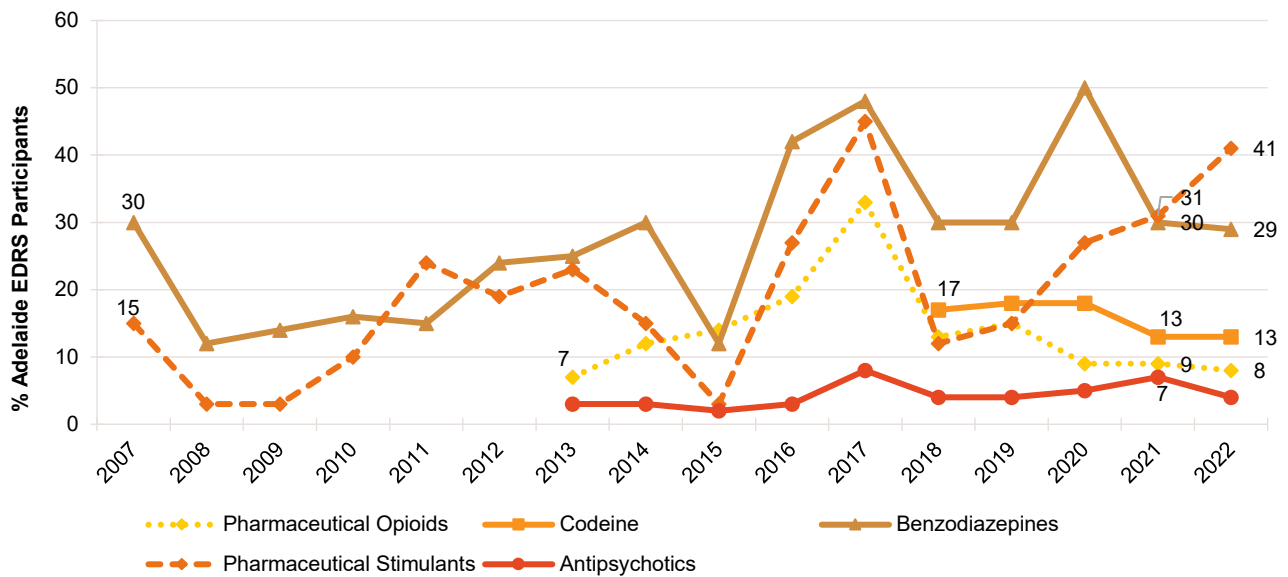
**Frequency of Use:** Participants who reported recent non-prescribed use reported a median of three days (IQR=2-5;  $n=13$ ; 2 days in 2021; IQR=2-5;  $n=19$ ;  $p=0.507$ ) and four days (IQR=2-6;  $n=24$ ; 4 days in 2021; IQR=2-9;  $n=20$ ;  $p=0.990$ ) of non-prescribed alprazolam and other benzodiazepine use in the past six months, respectively.

**Price and Perceived Availability:** In 2022, participants were asked questions pertaining to the price and perceived availability of non-prescribed benzodiazepines, however these data will be released separately in 2023. Please contact the Drug Trends team for further information.

### Antipsychotics

Few ( $n\leq 5$ ) participants reported recent non-prescribed use of antipsychotics in 2022, therefore, further details are not reported (7% in 2021;  $p=0.367$ ) (Figure 41). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

Figure 41: Non-prescribed use of pharmaceutical medicines in the past six months, Adelaide, SA, 2007-2022



Note. Non-prescribed use is reported for prescription medicines. Monitoring of pharmaceutical stimulants and benzodiazepines commenced in 2007, and pharmaceutical opioids and antipsychotics in 2013. Monitoring of over-the-counter (OTC) codeine (low-dose codeine) commenced in 2010, however, in February 2018, the scheduling for codeine changed such that low-dose codeine formerly available OTC was required to be obtained via a prescription. To allow for comparability of data, the time series here represents non-prescribed low- and high dose codeine (2018-2022), with high-dose codeine excluded from pharmaceutical opioids from 2018. Y axis has been reduced to 60% to improve visibility of trends. Data labels are only provided for the first (2007/2013/2018) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Other Illicit Drugs

### Hallucinogenic Mushrooms

**Recent Use (past 6 months):** In 2022, almost two-fifths (37%) of the Adelaide sample reported recent use of hallucinogenic mushrooms in the six months prior to the interview (Figure 42). Whilst this was stable from 29% in 2021 ( $p = 0.304$ ), this proved to be the greatest per cent reporting recent use since the commencement of monitoring.

**Frequency of Use:** A median of two days of hallucinogenic mushroom use (IQR=2-3;  $n = 38$ ) was reported in the six months prior to interview in 2022 (2 days in 2021; IQR=1-7;  $n = 29$ ;  $p = 0.596$ ).

### MDA

Due to low numbers reporting recent use of MDA, further details are not reported ( $n \leq 5$  in 2021;  $p = 0.362$ ) (Figure 42). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### Substance with Unknown Contents

**Capsules:** Few ( $n \leq 5$ ) participants reported recent use of capsules with unknown contents in 2022, therefore, further details are not reported ( $n \leq 5$  in 2021) (Figure 42). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

**Other Unknown Substances:** From 2019, we asked participants about their use more broadly of substances with 'unknown contents'. Thirteen per cent of participants reported use of any substance with 'unknown contents' in 2022 (10% in 2021;  $p = 0.645$ ) on a median of one day (IQR=1-1;  $n = 13$ ; 1 day in 2021; IQR=1-3;  $n = 10$ ;  $p = 0.322$ ).

When broken down by substance form, 8% of participants reported recent use of pills with unknown contents ( $n \leq 5$  in 2021;  $p=0.569$ ). Few ( $n \leq 5$ ) participants reported on recent use of powder and crystal with unknown contents in 2022, therefore, further details are not reported. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

**Quantity:** From 2020, we asked participants about the average amount of pills and capsules used with unknown contents in the six months preceding interview. Of those who reported recent use and responded ( $n=8$ ), the median number of pills with unknown contents used in a 'typical' session was one pill (IQR=1-2;  $n \leq 5$  in 2021;  $p=0.043$ ). Few ( $n \leq 5$ ) participants were able to answer questions regarding the median quantity of capsules used in a 'typical' session in 2022, therefore, further details are not reported. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### PMA

No participants reported recent use of PMA in 2022 ( $n \leq 5$  in 2021). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### PMMA

No participants reported recent use of PMMA in 2022. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### Heroin

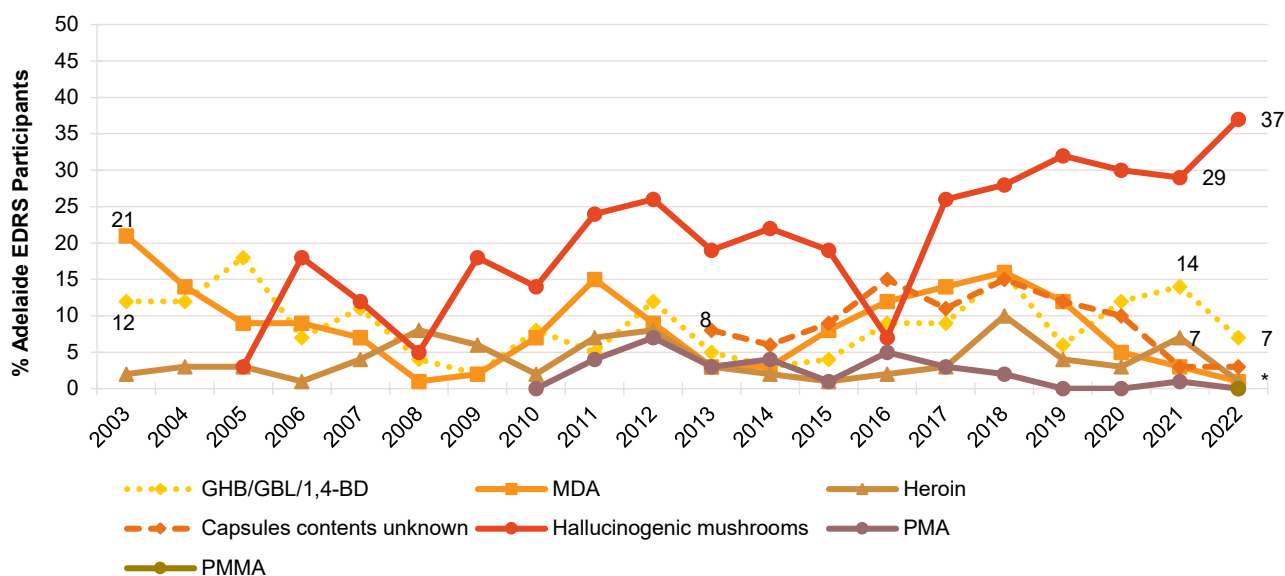
Few ( $n \leq 5$ ) participants reported recent use of heroin in 2022, therefore, further details are not reported (7% in 2021;  $p=0.033$ ) (Figure 42). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### GHB/GBL/1,4-BD

**Recent Use (past 6 months):** In 2022, seven per cent of the Adelaide sample reported recent use of GHB/GBL/1,4-BD in the six months prior to the interview (14% in 2021;  $p=0.113$ ) (Figure 42 **Error! Reference source not found.**).

**Frequency of Use:** A median of 20 days of GHB/GBL/1,4-BD use (IQR=3-60;  $n=7$ ) was reported in the six months prior to interview in 2022 (4 days in 2021; IQR=1-12;  $n=14$ ;  $p=0.098$ ).

Figure 42: Past six month use of other illicit drugs, Adelaide, SA, 2003-2022



Note. Monitoring of hallucinogenic mushrooms commenced in 2005. Monitoring of capsules contents unknown commenced in 2013; note that in 2019, participants were asked more broadly about 'substances contents unknown' (with further ascertainment by form) which may have impacted the estimate for 'capsules contents unknown'. Monitoring of PMA commenced in 2010 and monitoring of PMMA commenced in 2022. Y axis has been reduced to 50% to improve visibility of trends. Data labels are only provided for the first (2003/2005/2010/2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Licit and Other Drugs

### Alcohol

**Recent Use (past 6 months):** The majority of the Adelaide sample continued to report recent use of alcohol in 2022 (93%), stable relative to 2021 (90%;  $p = 0.448$ ) (Figure 43).

**Frequency of Use:** A median of 28 days of alcohol use in the past six months (IQR=18-72;  $n = 97$ ) was reported in 2022 (36 days in 2021; IQR=12-72;  $n = 90$ ;  $p = 0.825$ ). Seventy-two per cent of those who recently consumed alcohol had done so on a weekly or more frequent basis in 2022, stable from 2021 (72%). Few ( $n \leq 5$ ) participants reported daily use of alcohol in 2022 (6% in 2021).

### Tobacco

**Recent Use (past 6 months):** Four-fifths (80%) of the Adelaide sample reported recent tobacco use in 2022, which remained stable from 72% reporting recent use in 2021 ( $p = 0.256$ ) (Figure 43).

**Frequency of Use:** Participants reported using tobacco on a median of 140 days in 2022 (IQR=13-180;  $n = 82$ ; 175 days in 2021; IQR=29-180;  $n = 72$ ;  $p = 0.524$ ), with 48% of these participants reporting daily use (50% in 2021;  $p = 0.869$ ).

### E-cigarettes

In Australia, legislation came into effect on 1 October 2021, requiring people to obtain a prescription to legally import nicotine vaping products. Thus, in 2022, participants were asked about their use of both prescribed and non-prescribed e-cigarettes. Few participants in Adelaide reported recent use of prescribed e-cigarettes in 2022 ( $n \leq 5$ ).

**Recent Use (past 6 months):** Three-fifths (62%) of the 2022 Adelaide sample had used non-prescribed e-cigarettes in the six months preceding interview (51% in 2021;  $p = 0.129$ ) (Figure 43).

**Frequency of Use:** A median frequency of 74 days of non-prescribed use was reported in the past six months in 2022 (IQR=18-180; n=64; 24 days in 2021; IQR=6-180; n=50;  $p=0.206$ ), with 15% of these participants reporting daily use (29% in 2021;  $p=0.083$ ).

**Forms Used:** Among participants who responded (n=64), the majority (94%) reported using e-cigarettes containing nicotine, whereas few participants (n≤5) reported using e-cigarettes containing cannabis. Few participants (n≤5) reported using e-cigarettes containing both nicotine and cannabis, and 41% reported using e-cigarettes which did not contain nicotine nor cannabis. No participants reported using e-cigarettes that contained another substance.

**Reason for Use:** Of those who reported any (i.e., prescribed and non-prescribed) e-cigarette use and responded (n=67), almost three-quarters (72%) of the Adelaide sample reported that they did not use e-cigarettes as a smoking cessation tool in 2022 (50% in 2021).

### Nitrous Oxide

**Recent Use (past 6 months):** One-quarter (27%) of the Adelaide sample reported recent use of nitrous oxide in 2022, stable relative to 2021 (33%;  $p=0.363$ ) (Figure 43).

**Frequency of Use:** Frequency of use remained stable at a median of three days (IQR=2-8; n=28) in 2022 (4 days in 2021; IQR=2-8; n=33;  $p=0.573$ ).

**Quantity:** Among those who reported recent use and responded (n=27), the median amount used in a 'typical' session was 10 bulbs (IQR=4-20; 15 bulbs in 2021; IQR=5-23; n=33;  $p=0.395$ ). Of those who reported recent use and responded (n=27), the median maximum amount used was 20 bulbs (IQR=5-30; 20 bulbs in 2021; IQR=9-33; n=32;  $p=0.454$ ).

### Amyl Nitrite

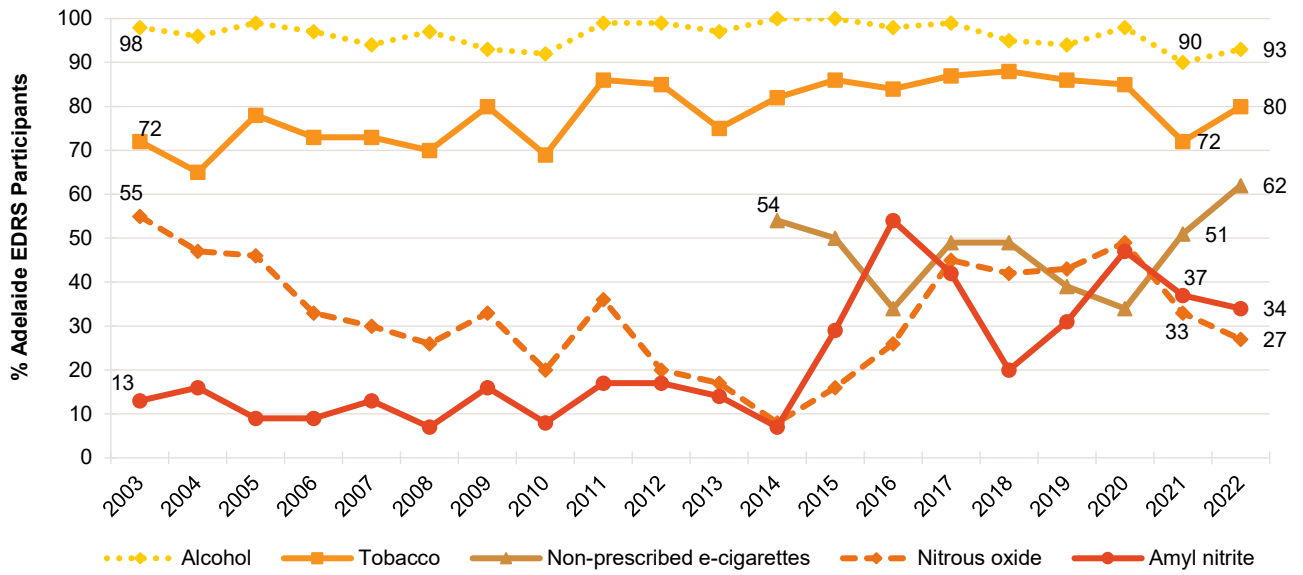
Amyl nitrite is an inhalant which is currently listed as a Schedule 4 substance in Australia (i.e., available only with prescription) yet is often sold under-the-counter in sex shops. Following a review by the [Therapeutic Goods Administration](#), amyl nitrite was listed as Schedule 3 (i.e., for purchase over-the-counter) from 1 February 2020 when sold for human therapeutic purpose.

**Recent Use (past 6 months):** After considerable fluctuation over the course of monitoring, one-third (34%) of the Adelaide sample reported recent use of amyl nitrite in 2022, stable relative to 2021 (37%;  $p=0.663$ ) (Figure 43).

**Frequency of Use:** A median of four days of use was reported in 2022 (IQR=2-6; n=35; 3 days in 2021; IQR=1-10; n=37;  $p=0.869$ ).



Figure 43: Licit and other drugs used in the past six months, Adelaide, SA, 2003-2022



Note. Monitoring of e-cigarettes commenced in 2014, however on 1 October 2021, legislation came into effect requiring people to obtain a prescription to legally import nicotine vaping products. Data from 2022 onwards refers to non-prescribed e-cigarettes only. Data labels are only provided for the first (2003/2014) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

# 9

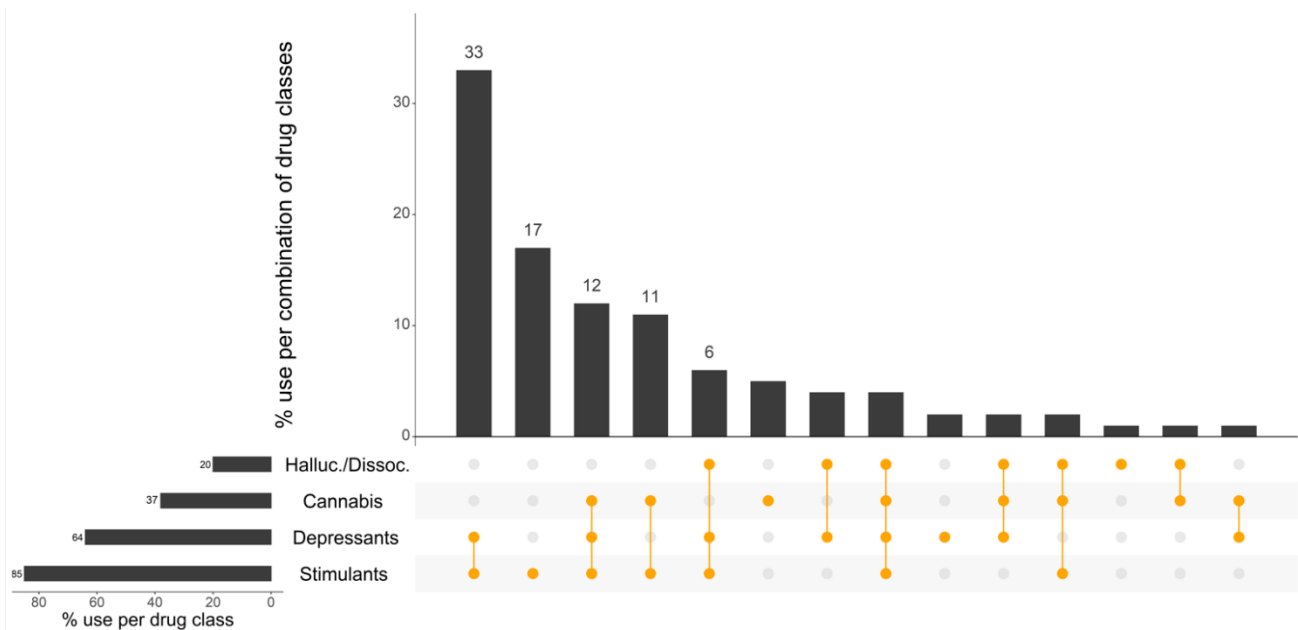
## Drug-Related Harms and Other Behaviours

### Polysubstance Use

On the last occasion of ecstasy or related drug use and among those who answered (n=104), the most commonly used substances were alcohol (60%) and cocaine (39%), followed by cannabis (37%) and ecstasy (23%).

Three-quarters (75%; n=77) of the Adelaide sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most commonly used combinations of drug classes were stimulants and depressants (33%), followed by stimulants, depressants, and cannabis (12%). One in ten participants reported using stimulants and cannabis (11%), whilst 17% reported using stimulants alone (Figure 44).

**Figure 44: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Adelaide, SA, 2022: Most common drug pattern profiles**



Note. % calculated out of total EDRS 2022 sample. The horizontal bars represent the per cent of participants who reported use of each substance on their last occasion of ecstasy or related drug use; the vertical columns represent the per cent of participants who used the combination of drug classes represented by the orange circles. Drug use pattern profiles reported by ≤5 participants or which did not include any of the four drug classes depicted are not shown in the figure but are counted in the denominator. Halluc./Dissoc = hallucinogens/dissociatives (LSD, hallucinogenic mushrooms, amyl nitrite, DMT, ketamine and/or nitrous oxide); depressants (alcohol, GHB/GBL, 1,4-BD, kava, opioids and/or benzodiazepines); stimulants (cocaine, MDA, ecstasy, methamphetamine, and/or pharmaceutical stimulants). Use of benzodiazepines, opioids and stimulants could be prescribed or non-prescribed use. Note that participants may report use of multiple substances within a class. Y axis reduced to 38% to improve visibility of trends.

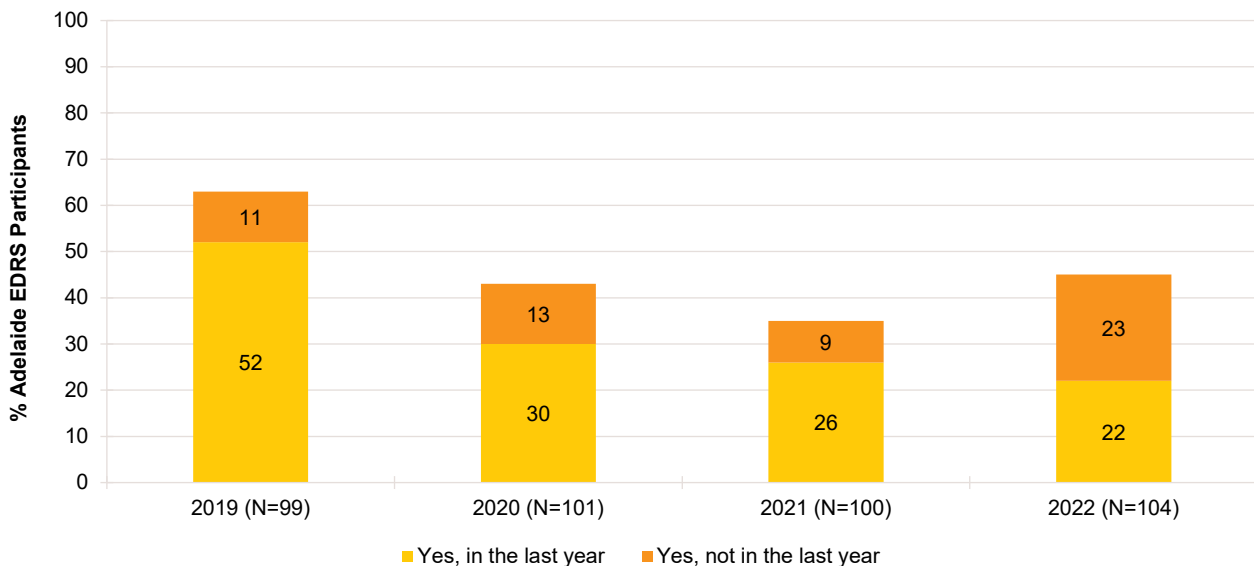
## Drug Checking

Drug checking is a common strategy used to test the purity and contents of illicit drugs.

In 2022, 22% of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year (26% in 2021;  $p=0.622$ ) (Figure 45). Of those who reported that they or someone else had tested their illicit drugs in the past year ( $n=23$ ), 86% reported using colorimetric reagent test kits. Few participants ( $n\leq 5$ ) reported having their drugs tested via testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips) and no participants reported testing via professional testing equipment (e.g., Fourier Transform Infrared Spectroscopy).

Of those who reported that they or someone else had tested their illicit drugs in the past year ( $n=23$ ), the majority (65%) reported having their drugs tested by a friend, followed by 48% who reported testing the drugs themselves. Few participants ( $n\leq 5$ ) reported having their drugs tested by a dealer, a partner or an acquaintance, respectively.

Figure 45: Lifetime and past year engagement in drug checking, Adelaide, SA, 2019-2022



Note: The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p<0.050$ ; \*\* $p<0.010$ ; \*\*\* $p<0.001$ .

## Alcohol Use Disorders Identification Test

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

The mean score on the AUDIT for the total Adelaide sample (including people who had not consumed alcohol in the past six months) was 12.9 (SD 7.9) in 2022, a significant increase from 12.1 (SD 7.0) in 2021 ( $p<0.001$ ). AUDIT scores are divided into four 'zones' which indicate risk level. Specifically, scores between 0-7 indicate low risk drinking or abstinence; scores between 8-15 indicate alcohol use in excess of low-risk guidelines; scores between 16-19 indicate harmful or hazardous drinking; and scores 20 or higher indicate possible alcohol dependence. There was no significant change in the per cent of the sample falling into each of these risk categories from 2021 to 2022 ( $p=0.370$ ; Table 5). Seventy per cent of the sample obtained a score of eight or more (72% in 2021;  $p=0.875$ ), indicative of hazardous use (Table 5).

Table 5: AUDIT total scores and per cent of participants scoring above recommended levels, Adelaide, SA, 2010-2022

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
	N=92	N=76	N=92	N=100	N=100	N=100	N=100	N=100	N=100	N=100	N=101	N=100	N=104
<b>Mean AUDIT total score (SD)</b>	14.9 (6.8)	15.8 (7.2)	16.2 (6.8)	14.8 (6.9)	14.7 (6.2)	13.1 (5.3)	11.2 (5.7)	12.8 (6.2)	14.9 (7.4)	13.7 (7.6)	12.8 (7.4)	12.1 (7.0)	<b>12.9 (7.9)***</b>
<b>Score 8 or above (%)</b>	86	90	88	86	89	81	74	83	85	74	77	72	<b>70</b>
<b>AUDIT zones:</b>													
Score 0-7	14	11	12	14	11	19	26	17	15	26	23	28	<b>30</b>
Score 8-15	42	42	34	43	44	48	51	51	40	38	46	43	<b>32</b>
Score 16-19	19	18	21	20	25	23	13	18	21	16	12	15	<b>19</b>
Score 20 or higher	25	29	33	22	20	10	10	14	24	19	20	14	<b>19</b>

Note. Monitoring of AUDIT first commenced in 2010. Total AUDIT score range is 0-40, with higher scores indicating greater likelihood of hazardous and harmful drinking. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Overdose Events

### Non-Fatal Overdose

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

From 2019, changes were made to this module. Participants were asked about the following in 2022, prompted by the definitions provided:

- **Alcohol overdose:** experience of symptoms (e.g., reduced level of consciousness and collapsing) where professional assistance would have been helpful.
- **Stimulant overdose:** experience of symptoms (e.g., nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, seizure, extreme paranoia, extreme anxiety, panic, extreme agitation, hallucinations, excited delirium) where professional assistance would have been helpful.
- **Other drug overdose (not including alcohol or stimulant drugs):** similar definition to above. Note that in 2019, participants were prompted specifically for opioid overdose but this was removed in 2020 as few participants endorsed this behaviour.

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

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

## Non-Fatal Stimulant Overdose

In 2022, 16% of the Adelaide sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview, stable relative to 2021 (19%;  $p=0.718$ ) (Figure 46).

The most common stimulants reported during the most recent non-fatal stimulant overdose in the past 12 months comprised cocaine (47%) and any form of ecstasy (35%; individual numbers for forms too low to report ( $n \leq 5$  participants)). Among those that experienced a recent non-fatal stimulant overdose, 88% ( $n=15$ ) reported that they had also consumed one or more additional drugs on the last occasion, most notably, alcohol (59%;  $\geq 5$  standard drinks: 41%;  $\leq 5$  standard drinks;  $n \leq 5$  participants) and tobacco (41%). On the last occasion of experiencing a non-fatal stimulant overdose, 82% reported that they did not receive treatment or assistance. Due to low numbers reporting that they had received treatment or assistance ( $n \leq 5$ ), please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

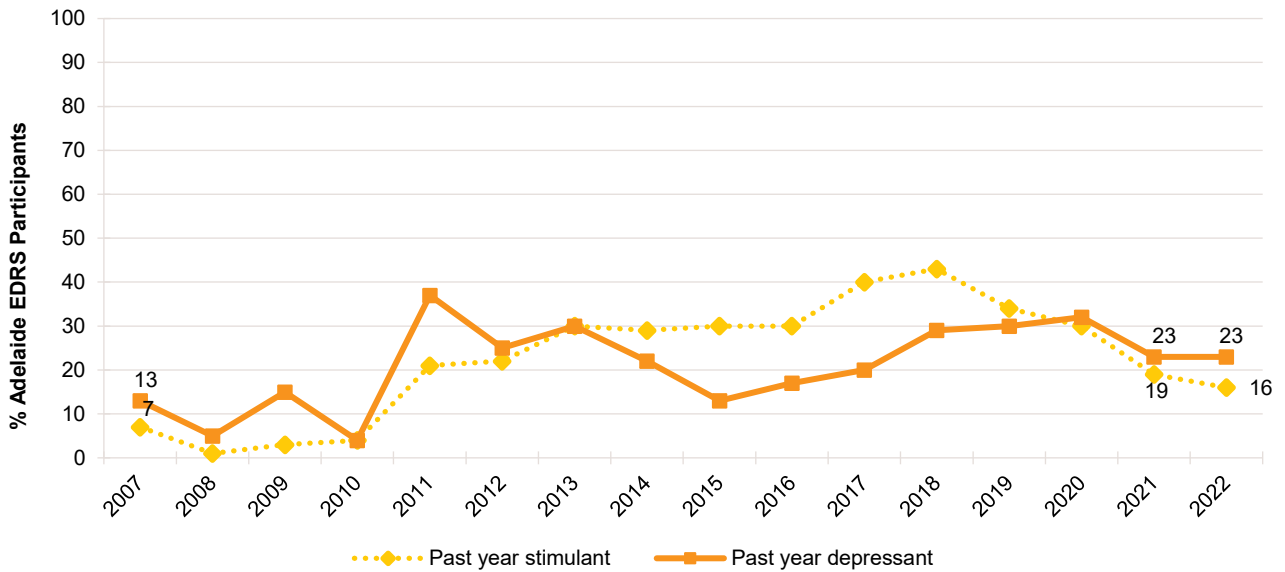
## Non-Fatal Depressant Overdose

**Alcohol:** One-fifth (20%) of the Adelaide sample reported a non-fatal alcohol overdose in the 12 months preceding interview (16% in 2021;  $p=0.474$ ) on a median of two occasions (IQR=1-3). Of those who had experienced an alcohol overdose in the past year ( $n=21$ ), the majority (95%) reported not receiving treatment on the last occasion. Due to low numbers reporting that they had received treatment or assistance ( $n \leq 5$ ), please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

**Any depressant (including alcohol):** In 2022, almost one-quarter (23%) of participants reported that they had experienced a non-fatal depressant overdose in the past 12 months, stable relative to 2021 (23%) (Figure 46).

Of those who had experienced any depressant overdose in the past 12 months ( $n=24$ ), the majority of participants reported alcohol as the most common depressant drug (88%). Few participants ( $n \leq 5$ ) reported an overdose due to other drugs, therefore, these data are suppressed. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

Figure 46: Past 12 month non-fatal stimulant and depressant overdose, Adelaide, SA, 2007-2022

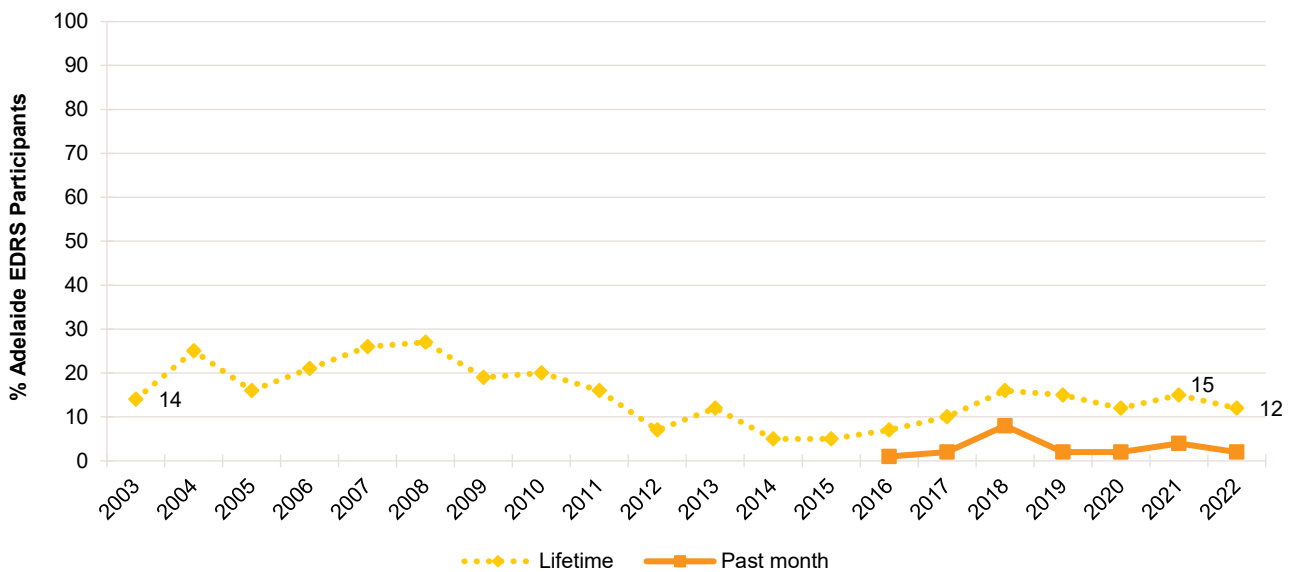


Note. Past year stimulant and depressant overdose was first asked about in 2007. In 2019, items about overdose were revised, and changes relative to 2018 may be a function of greater nuance in capturing depressant events. Data labels are only provided for the first (2007) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Injecting Drug Use and Associated Risk Behaviours

Since 2017, at least one in ten participants have reported ever injecting drugs, with 12% reporting lifetime injection in 2022 (15% in 2021;  $p = 0.533$ ). The per cent who reported injecting drugs in the past month remained low in 2022 ( $n \leq 5$ ;  $n \leq 5$  in 2021;  $p = 0.440$ ), therefore, further details are not reported (Figure 47). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

Figure 47: Lifetime and past month drug injection, Adelaide, SA, 2003-2022



Note. Items assessing whether participants had injected drugs in the past month were first asked in 2016. Data labels are only provided for the first (2003/2016) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Drug Treatment

In 2022, six per cent of the Adelaide sample reported currently receiving drug treatment ( $n \leq 5$  in 2021;  $p = 0.748$ ). Due to low numbers reporting on the forms of treatment received ( $n \leq 5$ ), please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

## Sexual Health Behaviours

In 2022, 69% of the sample reported some form of sexual activity in the past four weeks (82% in 2021;  $p = 0.066$ ) (Table 6). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if the interview was undertaken face-to-face).

Of those who had engaged in sexual activity in the past four weeks and who responded ( $n = 69$ ), 83% reported using alcohol and/or other drugs prior to or while engaging in sexual activity, stable relative to 2021 (84%;  $p = 0.817$ ). Of those who had engaged in sexual activity in the past four weeks and responded ( $n = 68$ ), 10% reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (10% in 2021). Furthermore, of those who had engaged in sexual activity in the past four weeks and who responded ( $n = 68$ ), 29% reported penetrative sex without a condom where they did not know the HIV status of their partner (16% in 2021;  $p = 0.077$ ) (Table 6).

Of those who commented ( $n = 100$ ), 76% reported having a sexual health check-up in their lifetime (73% in 2021;  $p = 0.632$ ), including 31% reporting having a sexual health check-up in the six months prior to interview (33% in 2021). Of the total sample who responded ( $n = 100$ ), 14% had received a positive diagnosis for a sexually transmitted infection (STI) in their lifetime (20% in 2021;  $p = 0.262$ ), though no participants reported that they had received a positive diagnosis for a STI in the past six months in 2022 ( $n \leq 5$  in 2021;  $p = 0.469$ ) (Table 6).

Of those who commented ( $n = 96$ ), 51% reported having a test for human immunodeficiency virus (HIV) in their lifetime (53% in 2021;  $p = 0.880$ ), including 20% having done so in the six months prior to interview (25% in 2021;  $p = 0.573$ ). In 2022, no participants had been diagnosed with HIV in their lifetime (0% in 2021;  $p = 0.832$ ) (Table 6).

Table 6: Sexual health behaviours, Adelaide, SA, 2021-2022

	2021	2022
<b>Of those who responded:</b>	<b>N=88</b>	<b>N=100</b>
% Any sexual activity in the past four weeks (n)	82 (n=72)	69 (n=69)
<b>Of those who responded<sup>#</sup> and reported any sexual activity in the past four weeks</b>	<b>n=70</b>	<b>n=69</b>
% Drugs and/or alcohol used prior to or while engaging in sexual activity	84	83
<b>Of those who responded<sup>#</sup> and reported any sexual activity in the past four weeks:</b>	<b>n=70</b>	<b>n=68</b>
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	10	10
<b>Of those who responded<sup>#</sup> and reported any sexual activity in the past four weeks:</b>	<b>n=73</b>	<b>n=68</b>
% Had penetrative sex without a condom and did not know HIV status of partner	16	29
<b>Of those who responded<sup>#</sup>:</b>	<b>n=93</b>	<b>n=96</b>
% Had a HIV test in the last six months	25	20
% Had a HIV test in their lifetime	53	51
<b>Of those who responded<sup>#</sup>:</b>	<b>n=94</b>	<b>n=100</b>
% Diagnosed with HIV in the last six months	0	0
% Diagnosed with HIV in their lifetime	0	0
<b>Of those who responded<sup>#</sup>:</b>	<b>n=94</b>	<b>n=100</b>
% Had a sexual health check in the last six months	33	31
% Had a sexual health check in their lifetime	73	76
<b>Of those who responded<sup>#</sup>:</b>	<b>n=94</b>	<b>n=100</b>
% Diagnosed with a sexually transmitted infection in the last six months	-	0
% Diagnosed with a sexually transmitted infection in their lifetime	20	14

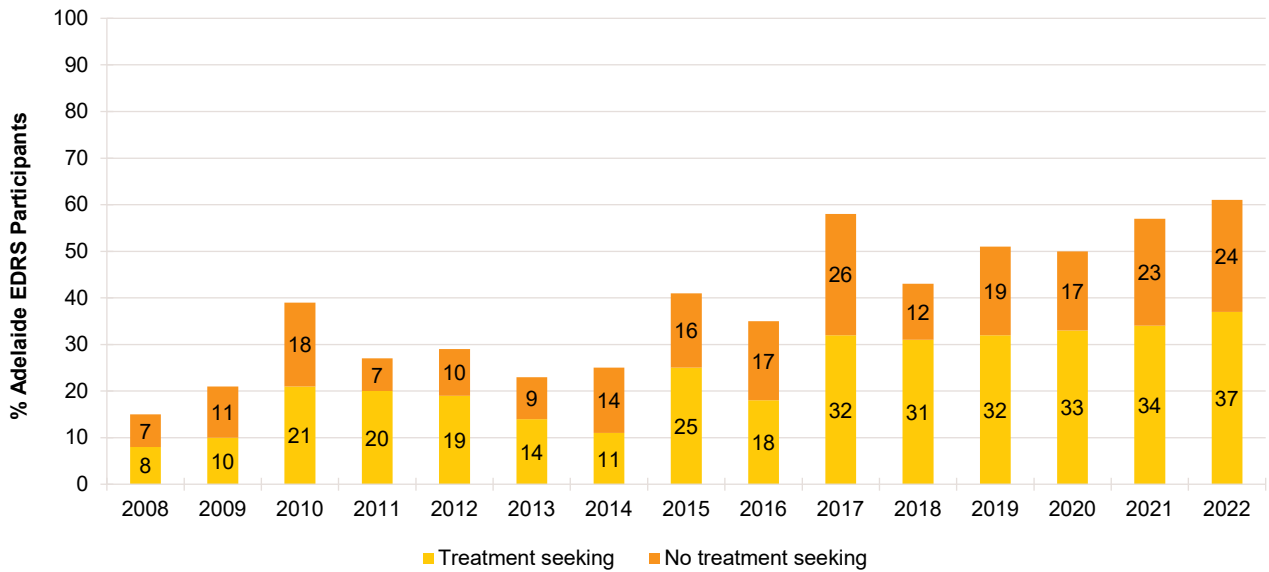
Note. <sup>#</sup> Due to the sensitive nature of these items, there is missing data for some participants who chose not to respond. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size (n≤5 but not 0). Statistical significance for 2021 versus 2022 presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Mental Health

Three-fifths (61%) of the Adelaide sample self-reported that they had experienced a mental health problem in the preceding six months (other than drug dependence), stable relative to 2021 (57%;  $p = 0.668$ ). Of those who reported a mental health problem in 2022 (n=62), the most common mental health problem was depression (65%), followed by anxiety (58%), post-traumatic stress disorder (PTSD) (16%) and any personally disorder (16%). Of those that reported experiencing a mental health problem (n=62), 61% reported seeing a mental health professional during the past six months (60% in 2021) (37% of the total sample) (Figure 48). Of those who reported seeing a mental health professional (n=38), 47% reported being prescribed medication for their mental health problem (68% in 2021;  $p = 0.102$ ).



Figure 48: Self-reported mental health problems and treatment seeking in the past six months, Adelaide, SA, 2008-2022

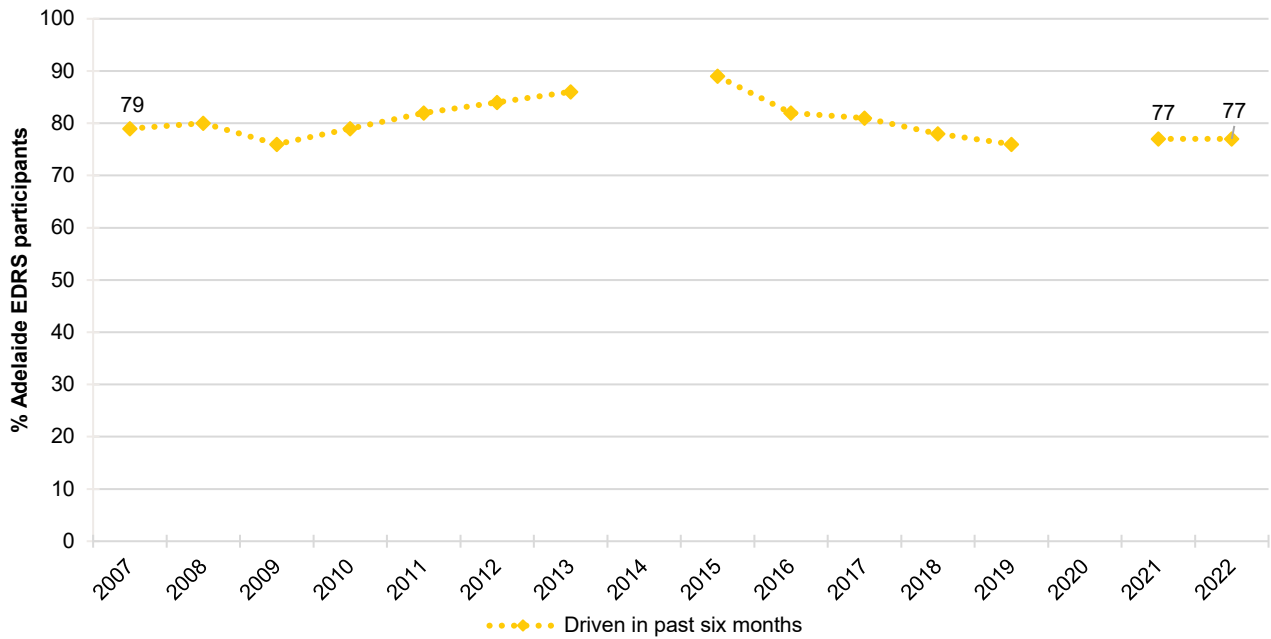


Note. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Driving

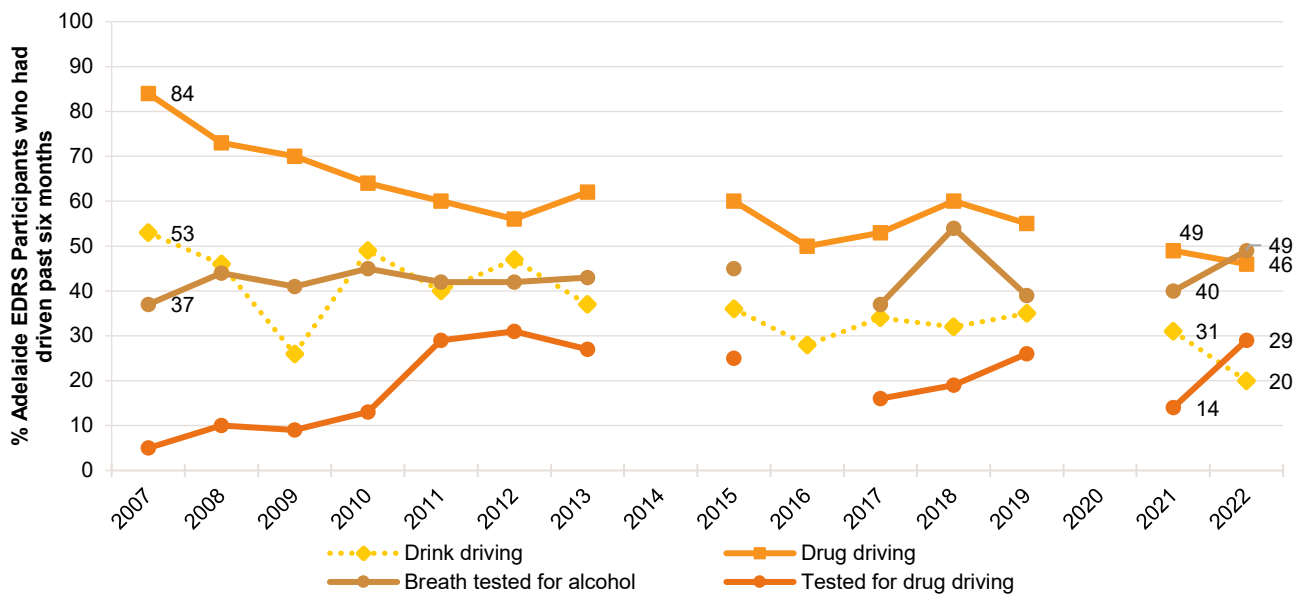
In 2022, 77% of the Adelaide sample had driven a car, motorcycle, or other vehicle in the last six months (Figure 49). Of those who had driven in the past six months and responded ( $n=69$ ), one-fifth (20%) reported driving while over the (perceived) legal limit of alcohol (31% in 2021;  $p=0.184$ ). Of those who had driven in the past six months and responded ( $n=80$ ), 46% reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months (49% in 2021;  $p=0.754$ ) (Figure 50). Among those who had driven in the past six months ( $n=80$ ), 29% reported that they had been tested for drug driving by the police roadside drug testing service (14% in 2021;  $p=0.037$ ), and almost half (49%) reported that they had been breath tested for alcohol by the police roadside testing service in the six months prior to interview (40% in 2021,  $p=0.336$ ) (Figure 50).

Figure 49: Self-reported driving in the past six months, Adelaide, SA, 2007-2022



Note. Computed of the entire sample. Questions about driving behaviour were first asked about in 2007. Questions about driving behaviour were not asked in 2014 or 2020. Data labels are only provided for the first (2007) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 50: Self-reported testing and driving in the past six months over the (perceived) legal limit for alcohol and three hours following illicit drug use, among those who had driven in the past six months, Adelaide, SA, 2007-2022



Note. Computed of those who had driven a vehicle in the past six months. Questions about driving behaviour were first asked about in 2007. Questions about driving behaviour not asked in 2014 or 2020. Questions about alcohol and drug driving testing were not asked in 2014, 2016 and 2020. Data labels are only provided for the first (2007) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Experience of Crime and Engagement with the Criminal Justice System

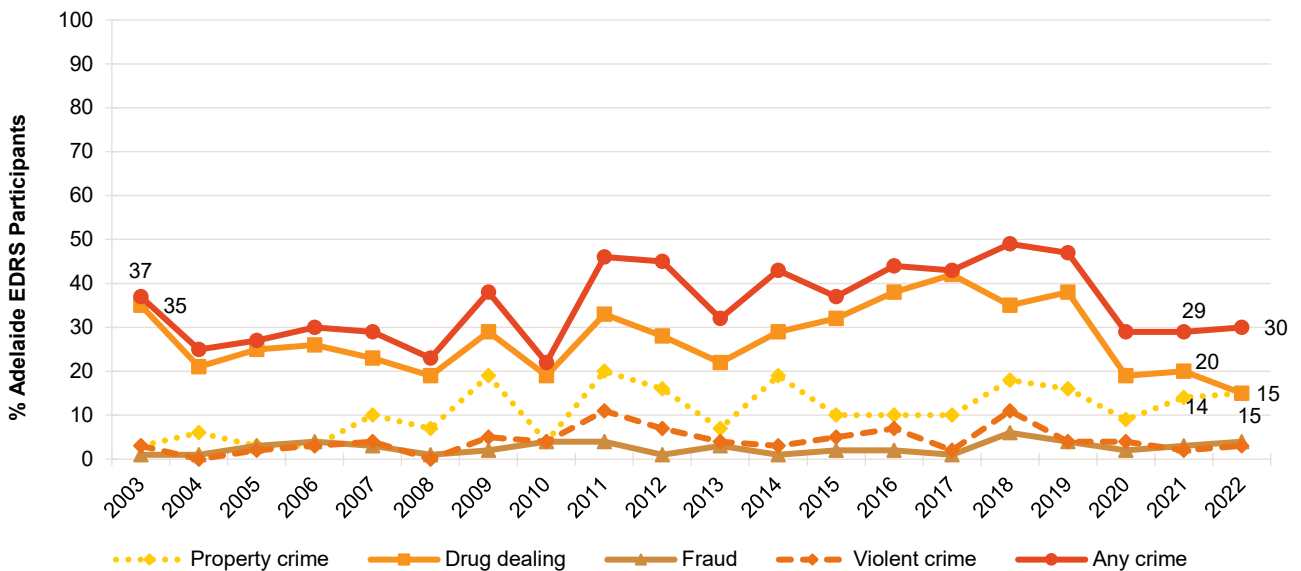
In 2022, 30% of the Adelaide sample reported 'any' crime in the past month (29% in 2021), with drug dealing (15%; 20% in 2021;  $p=0.455$ ) and property crime (15%; 14% in 2021;  $p=0.843$ ) being the two main forms of criminal activity in 2022 (Figure 51).

In 2022, almost one-tenth (8%) of the Adelaide sample reported being the victim of a crime involving violence, stable relative to 2021 (10%;  $p=0.625$ ).

Eight per cent of the 2022 sample reported having been arrested in the 12 months preceding interview (9% in 2021;  $p=0.799$ ). Few participants ( $n \leq 5$ ) reported reasons for arrest; therefore, further details are not reported. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information. In 2022, 17% of the sample reported a drug-related encounter in the last 12 months which did not result in charge or arrest (data not collected in 2021).

Thirteen per cent reported having ever been in prison in 2022, stable relative to 2021 (6%;  $p=0.151$ ).

Figure 51: Self-reported criminal activity in the past month, Adelaide, SA, 2003-2022



Note. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## 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 2022, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was in person (72%; 83% in 2021;  $p=0.098$ ) and social networking applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (72%; 72% in 2021) (Table 7). 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.

### Buying and Selling Drugs Online

Few participants ( $n\leq 5$ ) reported obtaining drugs via the darknet in the past year (9% in 2021;  $p=0.155$ ); and few ( $n\leq 5$ ) reported purchasing on the surface web ( $n\leq 5$  in 2021). Half (51%) of participants reported ever obtaining illicit drugs through someone who had purchased them on the surface web or darknet, with one-third (32%) having done so in the last 12 months (29% in 2021;  $p=0.719$ ).

In 2022, few participants ( $n\leq 5$ ) reported selling illicit/non-prescribed drugs via surface or darknet marketplaces in the 12 months preceding interview ( $n\leq 5$  in 2021;  $p=0.331$ ).

### Obtaining Drugs

The majority of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2022 (89%; 89% in 2021), followed by 70% reporting obtaining it from a known dealer/vendor (78% in 2021;  $p=0.266$ ). Almost two-fifths (38%) reported obtaining illicit drugs from an unknown dealer/vendor (33% in 2021;  $p=0.551$ ) (Table 7).

When asked about how they had received illicit drugs on any occasion in the last 12 months, the majority of participants reported face-to-face (94%; 96% in 2021), followed by a collection point (defined as a predetermined location where a drug will be dropped for later collection; 24%; 20% in 2021;  $p=0.613$ ), and fewer participants reporting receiving illicit drugs via post (7%; 6% in 2021) (Table 7).

Table 7: Means of purchasing illicit drugs in the past 12 months, Adelaide, SA, 2019-2022

	2019 n=100	2020 n=99	2021 n=98	2022 n=104
<b>% Purchasing approaches in the last 12 months<sup>^</sup></b>				
Face-to-face	79	72	83	72
Surface web	-	-	-	-
Darknet market	8	6	9	-
Social networking applications <sup>#</sup>	74	81	72	72
Text messaging	44	43	54	52
Phone call	37	34	35	39
Grew/made my own	0	-	-	-
Other	-	0	0	-
<b>% Means of obtaining drugs in the last 12 months<sup>^~</sup></b>				
Face-to-face	0	0	96	94
Collection point	12	25	20	24
Post	10	14	6	7

% Source of drugs in the last 12 months <sup>^</sup>				
Friend/relative/partner/colleague	91	86	89	<b>89</b>
Known dealer/vendor	75	78	78	<b>70</b>
Unknown dealer/vendor	50	50	33	<b>38</b>

Note. - Per cent suppressed due to small cell size ( $n \leq 5$  but not 0). <sup>^</sup> participants could endorse multiple responses. \*This refers to people *arranging the purchase* of illicit or non-prescribed drugs. This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person. ~ The face-to-face response option from 2021 was combined by those responding, 'I went and picked up the drugs', 'The drugs were dropped off to my house by someone' and/or 'Was opportunistic – I arranged and collected at the same time (e.g., at an event/club.)' The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

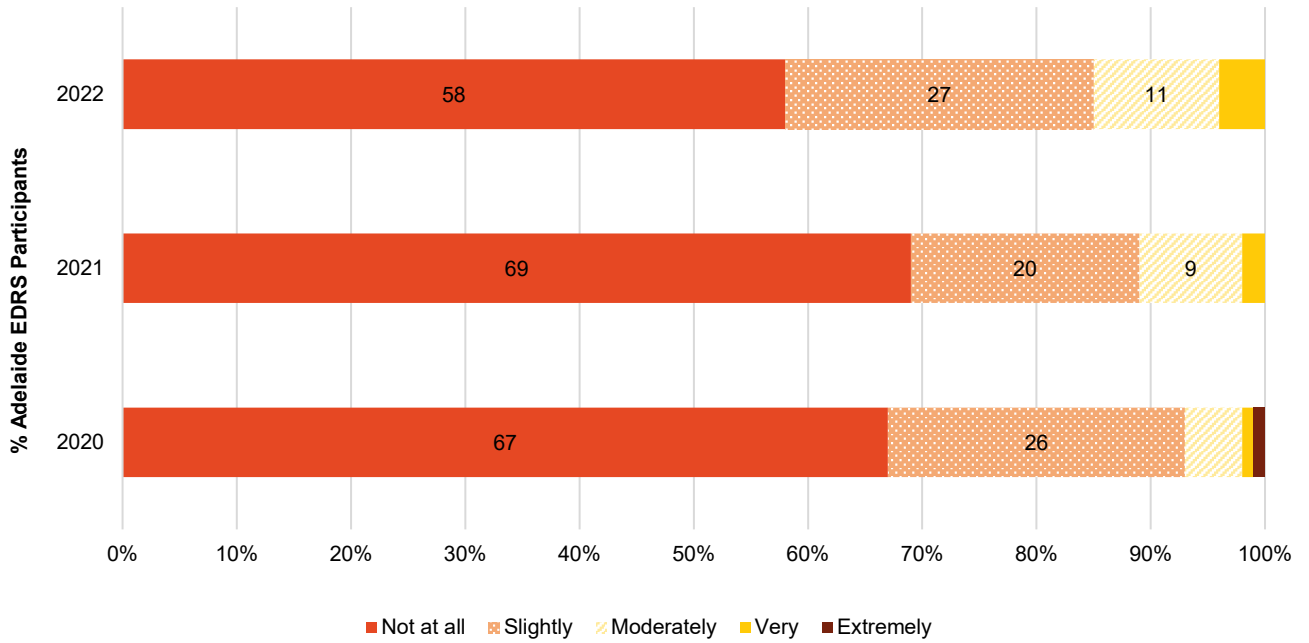
## COVID-19 Testing and Diagnosis

In 2022, the vast majority (95%) of the Adelaide EDRS sample had been tested for SARS-CoV-2 by the time of interview (49% in 2021; 9% in 2020), of whom 80% had undergone a PCR test and 84% a rapid antigen test. Almost three-fifths (59%) of participants reported having been diagnosed with the virus (no participants were diagnosed with the virus in 2021 and 2020).

In 2022, 80% of the sample reported quarantining for at least seven days due to a positive test or possible exposure in the 12 months prior to interview, with 16% quarantining in the month prior to interview and 65% in the six months prior to interview. At the time of interview, 86% reported that they had received at least one COVID-19 vaccine dose (median two doses:  $n \leq 5$  received one dose, 45% received two doses, 38% received three or more doses).

When asked how worried they were currently about contracting COVID-19, 42% of participants reported some level of concern (31% in 2021;  $p = 0.416$ ), with one-quarter (27%) responding that they were 'slightly' concerned and one-tenth (11%) reporting that they were 'moderately' concerned (Figure 52). Furthermore, 54% of participants reported that they would be concerned about their health if they did contract COVID-19, with one-third (32%) reporting that they would be 'slightly' concerned, 12% reporting 'moderately', and 7% reporting that they would be 'very' concerned.

Figure 52: Current concern related to contracting COVID-19, Adelaide, SA, 2020-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels have been removed from figures with small cell size (i.e.,  $n \leq 5$  but not 0). Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .