



EDRS



AUSTRALIAN DRUG TRENDS 2022

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



AUSTRALIAN DRUG TRENDS 2022: KEY FINDINGS FROM THE NATIONAL ECSTASY AND RELATED DRUGS REPORTING SYSTEM (EDRS) INTERVIEWS

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Table of Contents

BACKGROUND AND METHODS	6
SAMPLE CHARACTERISTICS	10
ECSTASY	15
METHAMPHETAMINE	28
COCAINE	39
CANNABIS AND/OR CANNABINOID RELATED PRODUCTS	45
KETAMINE, LSD AND DMT	55
NEW PSYCHOACTIVE SUBSTANCES	70
OTHER DRUGS	75
DRUG-RELATED HARMS AND OTHER BEHAVIOURS	84

List of Tables

TABLE 1: DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE, NATIONALLY, 2021-2022, AND BY CAPITAL CITY, 2022	11
TABLE 2: PAST SIX MONTH USE OF ANY ECSTASY, BY CAPITAL CITY, 2003-2022.....	17
TABLE 3: PAST SIX MONTH USE OF ECSTASY PILLS, BY CAPITAL CITY, 2003-2022	18
TABLE 4: PAST SIX MONTH USE OF ECSTASY CAPSULES, BY CAPITAL CITY, 2008-2022.....	18
TABLE 5: PAST SIX MONTH USE OF ECSTASY CRYSTAL, BY CAPITAL CITY, 2013-2022.....	19
TABLE 6: PAST SIX MONTH USE OF ECSTASY POWDER, BY CAPITAL CITY, 2005-2022.....	19
TABLE 7: PAST SIX MONTH USE OF ANY METHAMPHETAMINE, BY CAPITAL CITY, 2003-2022	30
TABLE 8: PAST SIX MONTH USE OF METHAMPHETAMINE POWDER, BY CAPITAL CITY, 2003-2022.....	31
TABLE 9: PAST SIX MONTH USE OF METHAMPHETAMINE CRYSTAL, BY CAPITAL CITY, 2003-2022	31
TABLE 10: PAST SIX MONTH USE OF COCAINE, BY CAPITAL CITY, 2003-2022.....	41
TABLE 11: PAST SIX MONTH NON-PRESCRIBED USE OF CANNABIS AND CANNABINOID PRODUCTS, BY CAPITAL CITY, 2003-2022	48
TABLE 12: PAST SIX MONTH USE OF KETAMINE, BY CAPITAL CITY, 2003-2022	58
TABLE 13: PAST SIX MONTH USE OF LSD, BY CAPITAL CITY, 2003-2022	64
TABLE 14: PAST SIX MONTH USE OF DMT, BY CAPITAL CITY, 2010-2022	69
TABLE 15: PAST SIX MONTH USE OF ANY NPS (INCLUDING PLANT-BASED NPS), NATIONALLY, 2010-2022, AND BY CAPITAL CITY, 2010-2022	72
TABLE 16: PAST SIX MONTH USE OF ANY NPS (EXCLUDING PLANT-BASED NPS), NATIONALLY, 2010-2022, AND BY CAPITAL CITY, 2010-2022	72
TABLE 17: PAST SIX MONTH USE OF NPS BY DRUG TYPE, NATIONALLY, 2010-2022.....	73
TABLE 18: AUDIT TOTAL SCORES AND PER CENT OF PARTICIPANTS SCORING ABOVE RECOMMENDED LEVELS, NATIONALLY, 2010-2022	87
TABLE 19: SEXUAL HEALTH BEHAVIOURS, NATIONALLY, 2021-2022	90
TABLE 20: MEANS OF PURCHASING ILLICIT DRUGS IN THE PAST 12 MONTHS, NATIONALLY, 2019-2022	96

List of Figures

FIGURE 1: DRUG OF CHOICE, NATIONALLY, 2003-2022.....	13
FIGURE 2: DRUG USED MOST OFTEN IN THE PAST MONTH, NATIONALLY, 2011-2022	13
FIGURE 3: WEEKLY OR MORE FREQUENT SUBSTANCE USE IN THE PAST SIX MONTHS, NATIONALLY, 2003-2022.....	14
FIGURE 4: PAST SIX MONTH USE OF ANY ECSTASY, AND ECSTASY PILLS, CAPSULES, CRYSTAL, AND POWDER, NATIONALLY, 2003-2022.....	16
FIGURE 5: MEDIAN DAYS OF ANY ECSTASY AND ECSTASY PILLS, POWDER, CAPSULES AND CRYSTAL USE IN THE PAST SIX MONTHS, NATIONALLY, 2003-2022.....	17
FIGURE 6: MEDIAN PRICE OF ECSTASY PILLS AND CAPSULES, NATIONALLY, 2003-2022.....	23
FIGURE 7: MEDIAN PRICE OF ECSTASY CRYSTAL (PER GRAM AND POINT) AND POWDER (PER GRAM ONLY), NATIONALLY, 2013-2022	23
FIGURE 8: CURRENT PERCEIVED PURITY OF ECSTASY PILLS, NATIONALLY, 2017-2022	24
FIGURE 9: CURRENT PERCEIVED PURITY OF ECSTASY CAPSULES, NATIONALLY, 2017-2022	24
FIGURE 10: CURRENT PERCEIVED PURITY OF ECSTASY CRYSTAL, NATIONALLY, 2017-2022	25
FIGURE 11: CURRENT PERCEIVED PURITY OF ECSTASY POWDER, NATIONALLY, 2017-2022.....	25
FIGURE 12: CURRENT PERCEIVED AVAILABILITY OF ECSTASY PILLS, NATIONALLY, 2017-2022	26
FIGURE 13: CURRENT PERCEIVED AVAILABILITY OF ECSTASY CAPSULES, NATIONALLY, 2017-2022	26
FIGURE 14: CURRENT PERCEIVED AVAILABILITY OF ECSTASY CRYSTAL, NATIONALLY, 2017-2022.....	27
FIGURE 15: CURRENT PERCEIVED AVAILABILITY OF ECSTASY POWDER, NATIONALLY, 2017-2022.....	27
FIGURE 16: PAST SIX MONTH USE OF ANY METHAMPHETAMINE, AND METHAMPHETAMINE POWDER, BASE, AND CRYSTAL, NATIONALLY, 2003-2022.....	29
FIGURE 17: MEDIAN DAYS OF ANY METHAMPHETAMINE USE, AND METHAMPHETAMINE POWDER, BASE, AND CRYSTAL IN THE PAST SIX MONTHS, NATIONALLY, 2003-2022.....	30
FIGURE 18: MEDIAN PRICE OF POWDER METHAMPHETAMINE PER POINT AND GRAM, NATIONALLY, 2003-2022.....	33
FIGURE 19: MEDIAN PRICE OF CRYSTAL METHAMPHETAMINE PER POINT AND GRAM, NATIONALLY, 2003-2022.....	34
FIGURE 20: CURRENT PERCEIVED PURITY OF POWDER METHAMPHETAMINE, NATIONALLY, 2003-2022	35
FIGURE 21: CURRENT PERCEIVED PURITY OF CRYSTAL METHAMPHETAMINE, NATIONALLY, 2003-2022	36
FIGURE 22: CURRENT PERCEIVED AVAILABILITY OF POWDER METHAMPHETAMINE, NATIONALLY, 2003- 2022	37
FIGURE 23: CURRENT PERCEIVED AVAILABILITY OF CRYSTAL METHAMPHETAMINE, NATIONALLY, 2003- 2022	38
FIGURE 24: PAST SIX MONTH USE AND FREQUENCY OF USE OF COCAINE, NATIONALLY, 2003-2022	41
FIGURE 25: MEDIAN PRICE OF COCAINE PER GRAM, NATIONALLY, 2003-2022	42
FIGURE 26: CURRENT PERCEIVED PURITY OF COCAINE, NATIONALLY, 2003-2022	43
FIGURE 27: CURRENT PERCEIVED AVAILABILITY OF COCAINE, NATIONALLY, 2003-2022.....	44
FIGURE 28: PAST SIX MONTH USE AND FREQUENCY OF USE OF NON-PRESCRIBED CANNABIS, NATIONALLY, 2003-2022.....	47
FIGURE 29: MEDIAN PRICE OF NON-PRESCRIBED HYDROPONIC (A) AND BUSH (B) CANNABIS PER OUNCE AND GRAM, NATIONALLY, 2006-2022	50
FIGURE 30: CURRENT POTENCY OF NON-PRESCRIBED HYDROPONIC (A) AND BUSH (B) CANNABIS, NATIONALLY, 2006-2022	51
FIGURE 31: CURRENT PERCEIVED AVAILABILITY OF NON-PRESCRIBED HYDROPONIC (A) AND BUSH (B) CANNABIS, NATIONALLY, 2006-2022.....	53
FIGURE 32: PAST SIX MONTH USE AND FREQUENCY OF USE OF KETAMINE, NATIONALLY, 2003-2022....	57

FIGURE 33: MEDIAN PRICE OF KETAMINE PER GRAM, NATIONALLY, 2003-2022	59
FIGURE 34: CURRENT PERCEIVED PURITY OF KETAMINE, NATIONALLY, 2003-2022	60
FIGURE 35: CURRENT PERCEIVED AVAILABILITY OF KETAMINE, NATIONALLY, 2003-2022.....	61
FIGURE 36: PAST SIX MONTH USE AND FREQUENCY OF USE OF LSD, NATIONALLY, 2003-2022	63
FIGURE 37: MEDIAN PRICE OF LSD PER TAB, NATIONALLY, 2003-2022.....	65
FIGURE 38: CURRENT PERCEIVED PURITY OF LSD, NATIONALLY, 2003-2022.....	66
FIGURE 39: CURRENT PERCEIVED AVAILABILITY OF LSD, NATIONALLY, 2003-2022	67
FIGURE 40: PAST SIX MONTH USE AND FREQUENCY OF USE OF DMT, NATIONALLY, 2010-2022.....	68
FIGURE 41: NON-PRESCRIBED USE OF PHARMACEUTICAL DRUGS IN THE PAST SIX MONTHS, NATIONALLY, 2007-2022.....	78
FIGURE 42: PAST SIX MONTH USE OF OTHER ILLICIT DRUGS, NATIONALLY, 2003-2022.....	80
FIGURE 43: PAST SIX MONTH USE OF LICIT DRUGS, NATIONALLY, 2003-2022.....	83
FIGURE 44: USE OF DEPRESSANTS, STIMULANTS, CANNABIS, HALLUCINOGENS AND DISSOCIATIVES ON THE LAST OCCASION OF ECSTASY OR RELATED DRUG USE, NATIONALLY, 2022: MOST COMMON DRUG PATTERN PROFILES.....	85
FIGURE 45: ENGAGEMENT IN DRUG CHECKING, NATIONALLY, 2019-2022	86
FIGURE 46: PAST 12 MONTH NON-FATAL STIMULANT AND DEPRESSANT OVERDOSE, NATIONALLY, 2007-2022.....	88
FIGURE 47: LIFETIME AND PAST MONTH DRUG INJECTION, NATIONALLY, 2003-2022	89
FIGURE 48: SELF-REPORTED MENTAL HEALTH PROBLEMS AND TREATMENT SEEKING IN THE PAST SIX MONTHS, NATIONALLY, 2008-2022	91
FIGURE 49: SELF-REPORTED DRIVING IN THE PAST SIX MONTHS, NATIONALLY, 2007-2022.....	91
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, NATIONALLY, 2007-2022.....	92
FIGURE 51: SELF-REPORTED CRIMINAL ACTIVITY IN THE PAST MONTH, NATIONALLY, 2003-2022.....	94
FIGURE 52: CURRENT CONCERN RELATED TO CONTRACTING COVID-19, NATIONALLY, 2020-2022	97

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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 EDRS 2022:

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- 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

4-AcO-DMT	4-Acetoxy-N,N-dimethyltryptamine
4-FA	4-Fluoroamphetamine
5-MeO-DMT	5-methoxy-N,N-dimethyltryptamine
ACT	Australian Capital Territory
ADE	Adelaide
AIVL	Australian Injecting and Illicit Drug Users League
Alpha PVP	α -Pyrrolidinopentiophenone
AUDIT	Alcohol Use Disorders Identification Test
BRI	Brisbane
BZP	Benzylpiperazine
CAN	Canberra
CBD	Cannabidiol
DAR	Darwin
DMT	Dimethyltryptamine
DO-x	4-Substituted-2,5-dimethoxyamphetamines
EDRS	Ecstasy and Related Drugs Reporting System
GBL	Gamma-butyrolactone
GHB	Gamma-hydroxybutyrate
HIV	Human immunodeficiency virus
HOB	Hobart
IDRS	Illicit Drug Reporting System
IQR	Interquartile range
LSD	<i>d</i> -lysergic acid
MDA	3,4-methylenedioxyamphetamine
MDMA	3,4-methylenedioxymethamphetamine
MDPV	Methylenedioxypropylvalerone
MELB	Melbourne
MXE	Methoxetamine
N (or n)	Number of participants
NDARC	National Drug and Alcohol Research Centre
NPS	New psychoactive substances
NSW	New South Wales
NT	Northern Territory
OTC	Over-the-counter
PCR	Polymerase Chain Reaction
PER	Perth
PMA	Paramethoxyamphetamine
PMMA	Polymethyl methacrylate

PTSD	Post-Traumatic Stress Disorder
QLD	Queensland
REDCAP	Research Electronic Data Capture
SD	Standard deviations
SA	South Australia
SSDP	Students for Sensible Drug Policy
SYD	Sydney
STI	Sexually transmitted infection
TAS	Tasmania
THC	Tetrahydrocannabinol
UNSW	University of New South Wales
VIC	Victoria
WA	Western Australia
WHO	World Health Organisation

Executive Summary

The EDRS sample is a sentinel sample of people who regularly use ecstasy and other illicit stimulants recruited via social media, advertisement on websites and word-of-mouth in the capital cities of Australia. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2022 from April-July. Interviews in 2020, 2021 and 2022 were delivered face-to-face as well as via telephone and videoconference, to reduce risk of COVID-19 transmission. This methodological change should be factored into all comparisons of data from the 2020-2022 samples relative to previous years.**

Sample Characteristics

In 2022, the national EDRS sample (n=700) differed in some ways to the sample in 2021. Specifically, there was a significant change in gender identity, with fewer participants identifying as male (56%; 63% in 2021; $p=0.015$), as well as an increase in median age (25 years; 24 years in 2021; $p=0.024$). Three-fifths of the sample held tertiary qualifications (61%) and lived in a rental house/flat at the time of interview (59%). The current median weekly income significantly increased, from \$600 in 2021 to \$700 in 2022 ($p<0.001$). Cannabis and ecstasy continued to be the main drugs of choice nominated by participants, and cannabis and alcohol were the drugs used most often in the past month. Weekly or more frequent cocaine use significantly increased from 5% in 2021 to 9% in 2022 ($p=0.015$).

Ecstasy

Recent use of any ecstasy significantly decreased in 2022 (88%; 95% in 2021; $p<0.001$), reaching the lowest percentage since monitoring began. Ecstasy capsules remained the most commonly used form of ecstasy, although recent use declined significantly in 2022 (56%; 70% in 2021; $p<0.001$), as did recent use of ecstasy crystal (43%; 53% in 2021; $p=0.001$). Significant

increases were observed in the median price for one gram of crystal (\$250; \$200 in 2021; $p=0.002$) and one gram of powder (\$245; \$200 in 2021; $p=0.007$). Significant changes were observed in the perceived availability for all forms of ecstasy, with more participants nominating availability as 'difficult' or 'very difficult' in 2022.

Methamphetamine

Whilst recent methamphetamine use has been declining over time, a significant increase was observed in 2022 (31%) relative to 2021 (26%; $p=0.030$). This was mostly driven by an increase in recent powder use (16%; 12% in 2021; $p=0.024$), although crystal remained the most commonly used form of methamphetamine (18%) for the second year running. Frequency of use remained stable for both powder and crystal, as did the price and perceived purity. There was a significant change in the perceived availability of crystal, however ($p=0.005$), with more participants reporting that it was 'very easy' to obtain in 2022.

Cocaine

Recent use of cocaine remained stable in 2022 (79%; 80% in 2021), however weekly or more frequent use increased (11%; 7% in 2021; $p=0.009$). The vast majority of participants who had recently consumed cocaine reported using powder cocaine (95%), with fewer participants reporting use of rock cocaine (9%). The price, perceived purity and perceived availability of cocaine remained stable between 2021 and 2022.

Cannabis and/or Cannabinoid Related Products

Approximately four in five participants have reported recent use of non-prescribed cannabis each year since monitoring began. There was, however, a significant decline in 2022 (79%) relative to 2021 (84%; $p=0.026$), which was mostly driven by a decrease in the percentage of participants reporting recent use of outdoor grown 'bush' (58%; 67% in 2021; $p=0.001$). Frequency of use, however, remained stable. The price, perceived purity

and perceived availability of hydroponic cannabis remained mostly stable in 2022, though there were significant changes in the perceived potency ($p=0.041$) and availability ($p=0.043$) of 'bush' cannabis. Specifically, in 2022, more participants reported 'bush' cannabis to be of 'low' or 'fluctuating' purity and that it was 'easy' to obtain.

Ketamine, LSD and DMT

Recent use of ketamine and DMT remained stable in 2022, though recent use of LSD significantly decreased (46%; 53% in 2021; $p=0.003$). Frequency of use for all three substances remained low and stable. Price and perceived purity remained stable for both ketamine and LSD in 2022, though there was a significant change in the perceived availability of ketamine ($p=0.022$), with more participants reporting ketamine to be 'easy' to obtain in 2022 relative to 2021.

New Psychoactive Substances (NPS)

Any NPS use, including plant-based NPS, significantly declined from 16% in 2021 to 11% in 2022 ($p=0.029$). Mescaline and any 2C substance were the most commonly used NPS in 2022 (3%, respectively), although the latter declined relative to 2021 (6%; $p=0.032$).

Other Drugs

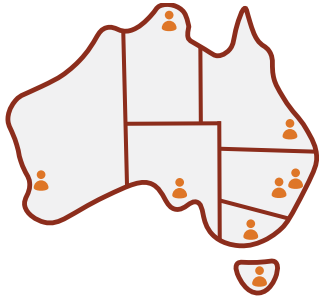
Recent use of non-prescribed pharmaceutical stimulants significantly increased in 2022 (52%; 46% in 2021; $p=0.014$), as did the per cent reporting any non-prescribed e-cigarette use (65%; 58% in 2021; $p=0.007$). Median days of non-prescribed e-cigarette use also increased, from 30 days in 2021 to 72 days in 2022 ($p<0.001$). Whilst recent use of hallucinogenic mushrooms remained stable, frequency of use significantly increased, from 2 days in 2021 to 3 days in 2022 ($p=0.012$).

Drug-Related Harms and Other Behaviours

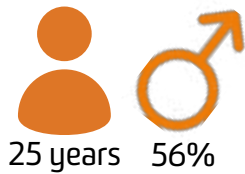
On the last occasion of ecstasy or related drug use, 81% of participants reported concurrent use of two or more drugs (excluding tobacco and e-cigarettes). One-third (32%) of participants reported that they or someone else

had tested the content and/or purity of their illicit drugs in Australia in the past year, most commonly using a colorimetric or reagent test kit (88%). Three-quarters (74%) of participants obtained an AUDIT score of eight or more, indicative of hazardous alcohol use. Reported past year non-fatal stimulant overdose remained stable in 2022 (15%), whilst past year non-fatal depressant overdose (mostly comprising alcohol) significantly increased (24%; 19% in 2021; $p=0.012$). Reported past month injecting drug use remained low (2%), as did current drug treatment engagement (5%). Almost four-fifths of the sample (78%) reported engaging in sexual activity in the past four weeks, of which 22% reported penetrative sex without a condom where they did not know the HIV status of their partner. Three-fifths (62%) of the sample self-reported that they had experienced a mental health problem in the preceding six months. Among recent drivers, one-quarter (27%) reported driving while over the perceived legal limit of alcohol, and 51% reported driving within three hours of consuming an illicit or non-prescribed drug. One in ten participants reported being the victim of a crime involving violence in 2022, a significant increase from 6% in 2021 ($p=0.003$). Social networking applications remained the most popular means by which participants arranged the purchase of illicit or non-prescribed drugs in the past 12 months (73%; 71% in 2021), however significantly more participants reported obtaining illicit drugs from an unknown dealer/vendor in 2022 (37%; 30% in 2021; $p=0.005$). The majority (95%) of the sample had been tested for SARS-CoV-2, with almost two-thirds (64%) reporting having been diagnosed with the virus. At the time of interview, 90% reported that they had received at least one COVID-19 vaccine dose, with participants reporting a median of three vaccine doses. One-third (33%) of participants reported some level of concern about contracting COVID-19, and two-fifths (42%) reported that they would be concerned about their health if they were to contract COVID-19.

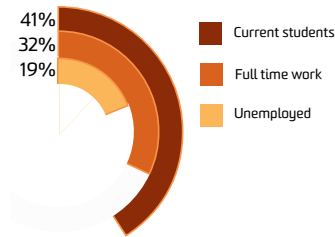
2022 SAMPLE CHARACTERISTICS



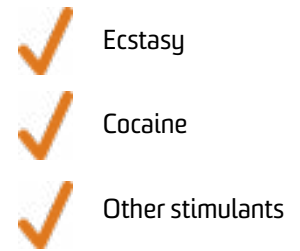
In 2022, 700 participants, recruited from all capital cities across Australia, were interviewed.



The median age in 2022 was 25, and 56% identified as male.

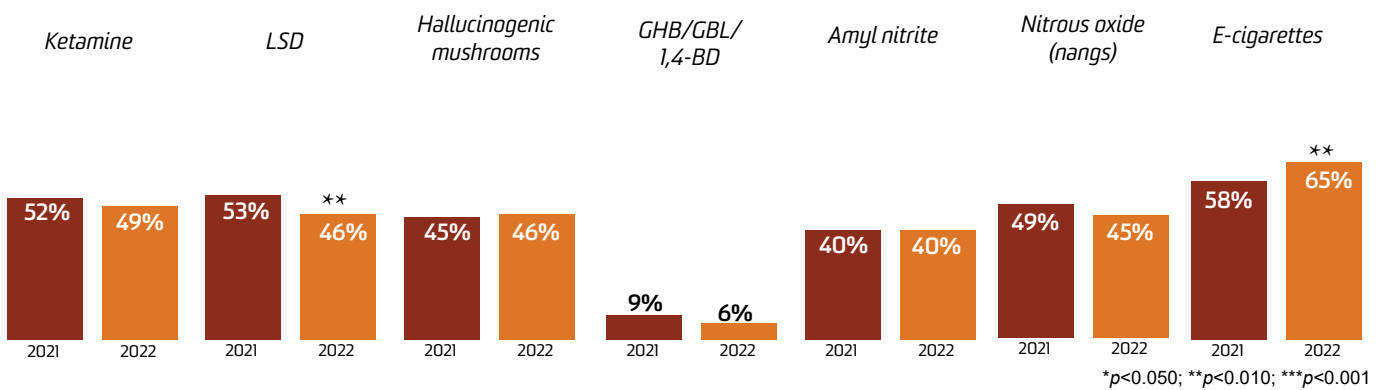


In the 2022 sample, 41% were enrolled students, 32% were employed full time and 19% were unemployed.

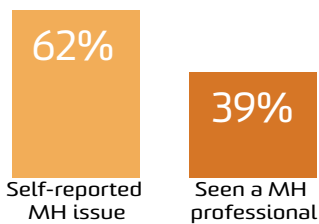


Participants were recruited on the basis that they had consumed ecstasy or other illicit stimulants at least monthly in the past 6 months.

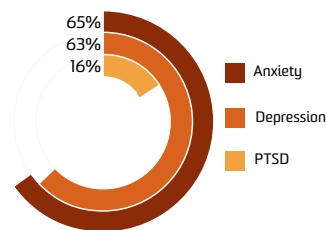
PAST 6 MONTH USE OF OTHER DRUGS



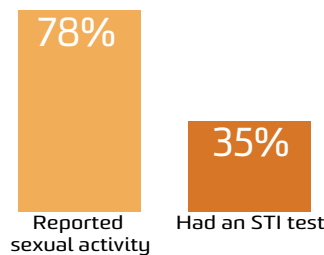
MENTAL HEALTH AND SEXUAL HEALTH BEHAVIOURS



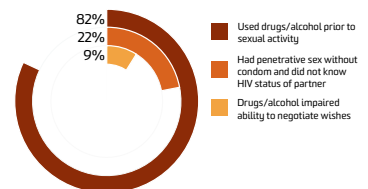
In the total sample, 62% self-reported a mental health issue and 39% had seen a mental health professional in the past 6 months.



Of those who commented, the three most common mental health issues reported were anxiety (65%), depression (63%) and PTSD (16%).

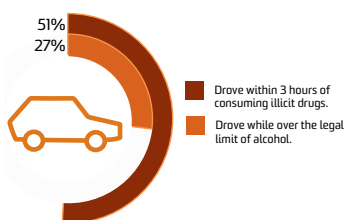


In the total sample, 78% reported sexual activity in the past 4 weeks, and 35% had a sexual health check in the past 6 months.



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

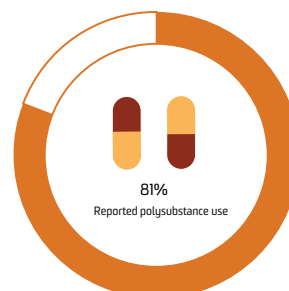
OTHER RISK BEHAVIOURS



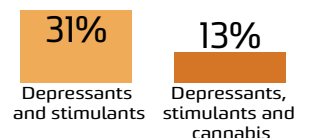
Among recent drivers, 51% reported driving a vehicle within 3 hours of consuming illicit drugs and 27% while over the legal limit of alcohol.



In the 2022 sample, 24% reported a non-fatal depressant overdose in the previous 12 months, a significant increase from 2021 (19%).

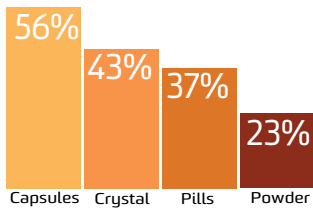


In the total sample, 81% reported concurrent use of two or more substances on the last occasion of ecstasy or related drug use.

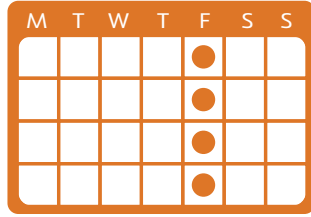


The most commonly used combinations of drug classes on the last occasion of ecstasy or related drug use.

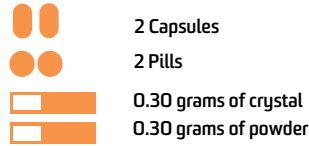
ECSTASY



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



Of those who had recently consumed ecstasy, 15% used it weekly or more frequently.

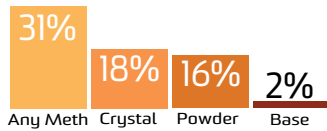


Median amounts of ecstasy consumed in a 'typical' session using each form.

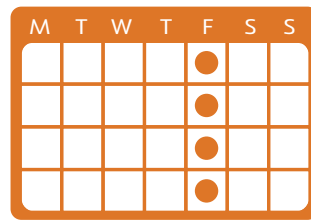


In 2022, more participants perceived the availability of all forms of ecstasy as 'difficult' or 'very difficult' relative to 2021.

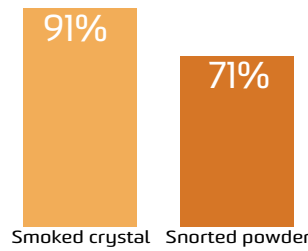
METHAMPHETAMINE



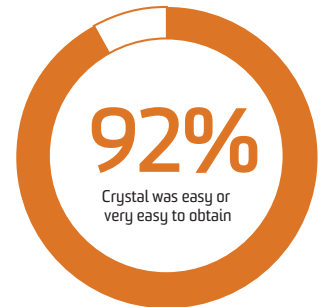
Past 6 month use of any methamphetamine, crystal, powder and base in 2022.



Of those who had recently consumed methamphetamine, 31% used it weekly or more frequently.

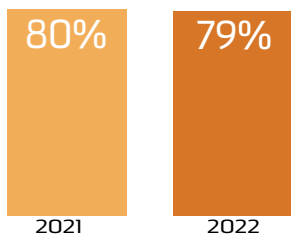


91% of participants who had recently used crystal smoked it. Of those who had recently used powder, 71% snorted it.

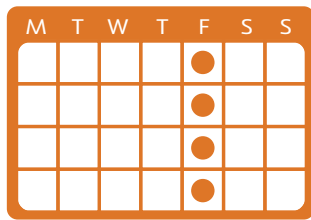


Of those who could comment 92% perceived crystal methamphetamine to be 'easy' or 'very easy' to obtain.

COCAINE



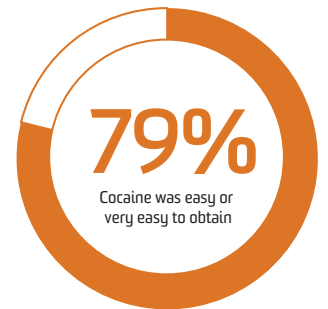
Past 6 month use of any cocaine remained stable between 2021 and to 2022.



Of participants who had consumed cocaine recently, 11% reported weekly or more frequent use.

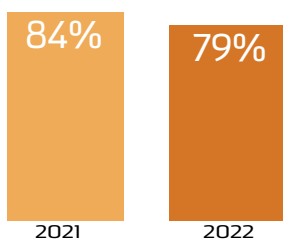


In 2022, the median price of a gram of cocaine remained stable at \$350.

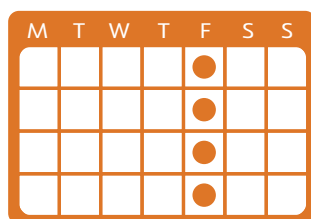


Of those who could comment 79% perceived cocaine to be 'easy' or 'very easy' to obtain.

CANNABIS



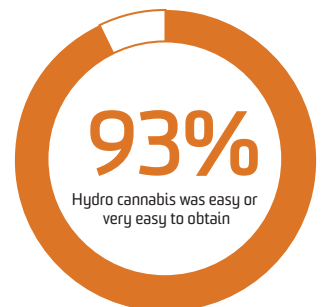
Past 6 month use of non-prescribed cannabis significantly decreased between 2021 and 2022.



Of those who had consumed non-prescribed cannabis recently, 64% reported weekly or more frequent use.



Of participants who had consumed cannabis in the last 6 months 92% had smoked it.



Of those who could comment 93% perceived hydro to be 'easy' or 'very easy' to obtain.

1

Background and Methods

The Ecstasy and Related Drugs Reporting System (EDRS) interviews are conducted annually with a sentinel cross-sectional group of people who regularly use ecstasy and other stimulants, recruited from all capital cities of Australia (n=700 in 2022). The results from the EDRS interviews are not representative of all people who consume drugs, nor of illicit drug use in the general population, but this is not the aim of these data. Rather, these data are intended to provide evidence indicative of trends that warrant further monitoring. These findings should be interpreted alongside analyses of other data sources for a more complete profile of trends in illicit drug use, market features, and harms in Australia.

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 illicit stimulants and from secondary analyses of routinely-collected indicator data. This report focuses on the key findings from the annual interview component of the EDRS.

Methods

EDRS 2003-2019

Full details of the [methods for the annual interviews](#) are available for download. To briefly summarise, since the commencement of monitoring up until 2019, participants were recruited primarily via internet postings, print advertisements, interviewer contacts, and snowballing (i.e., peer referral). Participants had to: i) be at least 17 years of age (due to ethical constraints) (16 years of age in Perth), 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 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) to 18 years old.

In 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 experienced some trouble in recruitment of participants in 2021, with an increase (in some capital cities) in people not meeting the residency criteria (i.e., residence in the capital city in which the interview took place for at least ten out of the past 12 months). This criterion was therefore eased mid-way through the 2021 data collection period to include residency for six out of the past 12 months, with the full residency criteria reinstated in 2022.

2022 EDRS sample

Through 6th April-20th July 2022, a total of 700 participants were recruited across capital cities nationally. The sample sizes recruited from each capital city were: Sydney, NSW n=100; Melbourne, VIC, n=100; Adelaide, SA, n=104; Canberra, ACT, n=100; Hobart, TAS, n=72; Brisbane and Gold Coast, QLD, n=102; Darwin, NT, n=22; and Perth, WA, n=100. Of this number, 507 interviews were conducted via telephone/videoconference: Sydney, NSW, n=92; Melbourne, VIC, n=83; Adelaide, SA, n=41; Canberra, ACT, n=68; Hobart, TAS, n=43; Brisbane and Gold Coast, QLD, n=62; Darwin, NT, n=18; and Perth, WA, n=100.

In 2022, there was considerable difficulty in recruiting participants from Darwin, despite extensive recruitment efforts and screening of interested people. While it is difficult to provide a definitive reason for this, it seems that this was reflective of a disruption to drug markets in that jurisdiction, as well as a genuine reduction in the frequency of ecstasy and other illicit stimulant use due to government restrictions and the cancellation of many music festivals and events in 2021. Data from the NT EDRS are included in the national estimates but are not presented specific to jurisdiction for 2022 (and 2010-2012) due to small numbers (n<30) reporting.

Eleven per cent of the 2022 national sample had taken part in the 2021 interview (10% of the 2021 sample had taken part in the 2020 interview; $p=0.606$). There was a significant change in how participants found out about the study in 2022 compared to 2021 ($p<0.001$), with more participants recruited via the internet (e.g., Facebook and Instagram) (67%; 59% in 2021), and less via word-of-mouth (27%; 37% in 2021).

Data Analysis

For normally distributed continuous variables, means and standard deviations (SD) are reported; for skewed data (i.e., skewness $> \pm 1$ or kurtosis $> \pm 3$), medians and interquartile ranges (IQR) are reported. Tests of statistical significance have been conducted between estimates for 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 capital cities, and thus do not reflect trends in regional and remote areas. Further, the results are not representative of all people who consume illicit drugs, nor of illicit drug use in the general population, but rather are intended to provide evidence indicative of emerging issues that warrant further monitoring.

This report covers a subset of items asked of participants and does not include jurisdictional-level results beyond estimates of recent use of various substances (included in jurisdiction outputs; see below), nor does it include implications of findings. These findings should be interpreted alongside analyses of other data sources for a more complete profile of emerging trends in illicit drug use, market features, and harms in Australia (see section on 'Additional Outputs' below for details of other outputs providing such profiles).

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](#) 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](#). There are also results from the [Illicit Drug Reporting System \(IDRS\)](#), which focus more so on the use of illicit drugs via injection.

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

2

Sample Characteristics

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

Sample Characteristics

The national EDRS sample in 2022 varied in a number of ways to the 2021 sample (Table 1). Specifically, there was a significant change in gender identity ($p=0.015$), with 56% of the sample identifying as male (63% in 2021) and two-fifths (40%) identifying as female (34% in 2021). Four per cent of participants identified as non-binary in 2022 (3% in 2021). The median age of the 2022 sample was 25 years (IQR=21-30), a significant increase from 24 years in 2021 (IQR=21-29; $p=0.024$).

A significant change was observed in participants' living situation ($p<0.001$), whereby three-fifths (59%) of participants reported living in a rented house/flat (60% in 2021), one-quarter (23%) reported living with their parents/in their family home (26% in 2021), and 12% reported living in their own house/flat, an increase from 6% in 2021.

The mean years of school remained stable in 2022 relative to 2021 (12 years; range=6-12; 12 years in 2021; range=6-12; $p=0.168$), as did the percentage of participants who reported having a post-school qualification(s) (61%; 60% in 2021; $p=0.669$).

Current employment status changed between 2021 and 2022 ($p=0.034$); one-third (32%) reported being employed full-time, an increase from 27% in 2021, and one-fifth (19%) reported being unemployed at the time of interview (22% in 2021). Furthermore, 41% reported being employed on a part time/casual basis at the time of interview (45% in 2021). The median weekly income in 2022 was \$700 (IQR=450-1200), significantly higher than what was reported in 2021 (\$600; IQR=375-1000; $p<0.001$).

Table 1: Demographic characteristics of the sample, nationally, 2021-2022, and by capital city, 2022

	National		Syd	Can	Mel	Hob	Ade	Per	Bri
	N=774	N=700	N=100	N=100	N=100	N=72	N=104	N=100	N=102
	2021	2022	2022	2022	2022	2022	2022	2022	2022
Median age (years; IQR)	24 (21-29)	25* (21-30)	29 (23-34)	26 (20-32)	25 (22-28)	26 (22-30)	26 (22-31)	21 (20-24)	23 (20-27)
% Gender		*							
Female	34	40	31	42	43	43	49	27	42
Male	63	56	64	52	52	47	50	70	53
Non-binary	3	4	-	-	-	8	0	-	-
% Aboriginal and/or Torres Strait Islander	6	5	-	10	-	-	7	-	-
% Sexual identity									
Heterosexual	73	71	69	69	64	72	74	84	63
Homosexual	4	5	7	-	-	-	-	-	-
Bisexual	14	17	17	20	18	18	17	7	24
Queer	6	6	-	-	11	-	-	6	6
Different identity	2	2	-	-	-	-	-	-	-
Mean years of school education (range)	12 (6-12)	12 (6-12)	12 (9-12)	11 (6-12)	12 (9-12)	11 (7-12)	11 (9-12)	12 (9-12)	12 (8-12)

	National		Syd	Can	Mel	Hob	Ade	Per	Bri
% Post-school qualification(s) [^]	60	61	69	62	62	60	69	50	59
% Current students [#]	45	41	31	39	50	31	44	37	51
% Current employment status		*							
Employed full-time	27	32	49	26	32	30	21	38	33
Part time/casual	45	41	24	34	58	40	41	46	56
Self-employed	6	8	13	11	10	-	10	-	7
Unemployed	22	19	14	28	10	30	27	15	12
Current median weekly income \$ (IQR)	600 (375-1000)	700*** (450-1200)	1000 (550-1600)	550 (336-1000)	700 (490-1154)	700 (350-1168)	550 (350-900)	800 (500-1154)	800 (600-1200)
% Current accommodation		***							
Own house/flat	6	12	14	10	-	15	16	12	10
Rented house/flat	60	59	66	55	69	61	50	53	65
Parents'/family home	26	23	16	22	26	18	28	32	23
Boarding house/hostel	4	2	0	-	0	-	-	-	-
Public Housing	2	2	-	-	-	0	-	-	0
No fixed address ⁺	2	2	0	-	0	8	-	-	-
Other	1	1	-	-	0	-	0	-	-

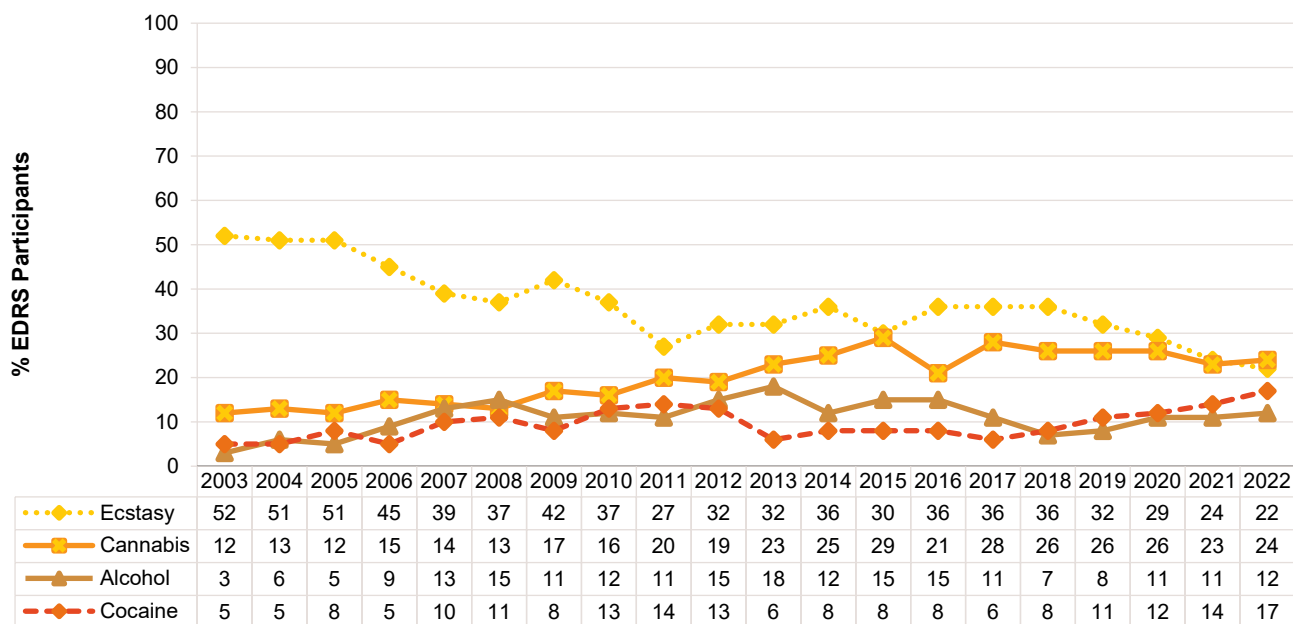
Note. [^] Includes trade/technical and university qualifications. [#] 'Current students' comprised participants who were currently studying for either trade/technical or university/college qualifications. ⁺ No fixed address included 'couch surfing and rough sleeping or squatting. - Per cent suppressed due to small cell size (n≤5 but not 0). Bri (Brisbane) includes Brisbane and the Gold Coast. Due to the particularly small sample recruited in Darwin in 2022 (n=22), data from Darwin are not presented in this table. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 among the national sample presented in table; *p<0.050; **p<0.010; ***p<0.001. For sample characteristics over the whole duration of the project, see [methods for the annual interviews](#).

Drug of choice remained stable between 2021 and 2022 ($p=0.600$). Most participants reported cannabis as their drug of choice in 2022 (24%; 23% in 2021), closely followed by ecstasy (22%; 24% in 2021). Cocaine was nominated as the drug of choice by 17% of participants (14% in 2021), the highest percentage observed since the commencement of monitoring (Figure 1).

A significant change was observed for the drug used most often in the past month ($p<0.001$). Specifically, there were decreases in the percentage of participants who reported that cannabis (31%; 36% in 2021), ecstasy (8%; 11% in 2021) and alcohol (25%; 31% in 2021) were the drugs used most often in the month preceding interview. An inverse increase, however, was observed in those who reported that cocaine was the drug used most often in the month preceding interview (12%; 7% in 2021), reaching the highest percentage since monitoring began (Figure 2).

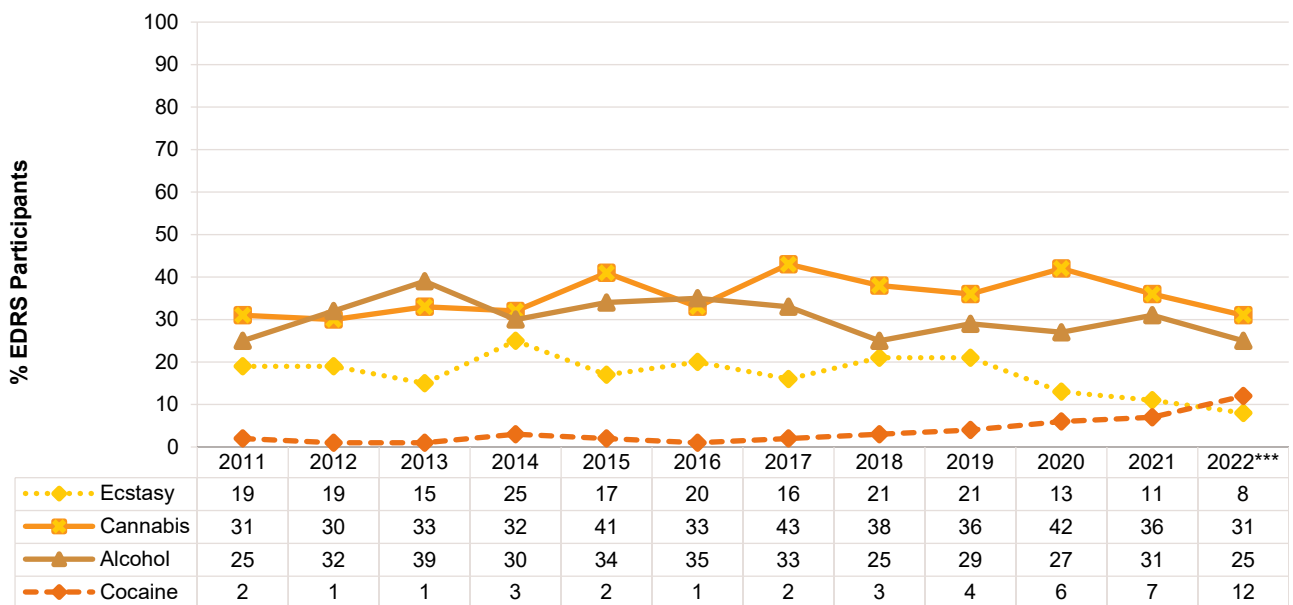
Thirteen per cent of the national sample reported weekly or more frequent ecstasy use in 2022, stable relative to 2021 (12%; $p=0.803$). Weekly or more frequent methamphetamine use also remained stable in 2022 (10%; 7% in 2021; $p=0.077$), as did weekly or more frequent use of non-prescribed cannabis (51%; 54% in 2021; $p=0.249$). In contrast, weekly or more frequent cocaine use significantly increased, from 5% in 2021 to 9% in 2022 ($p=0.015$) (Figure 3).

Figure 1: Drug of choice, nationally, 2003-2022



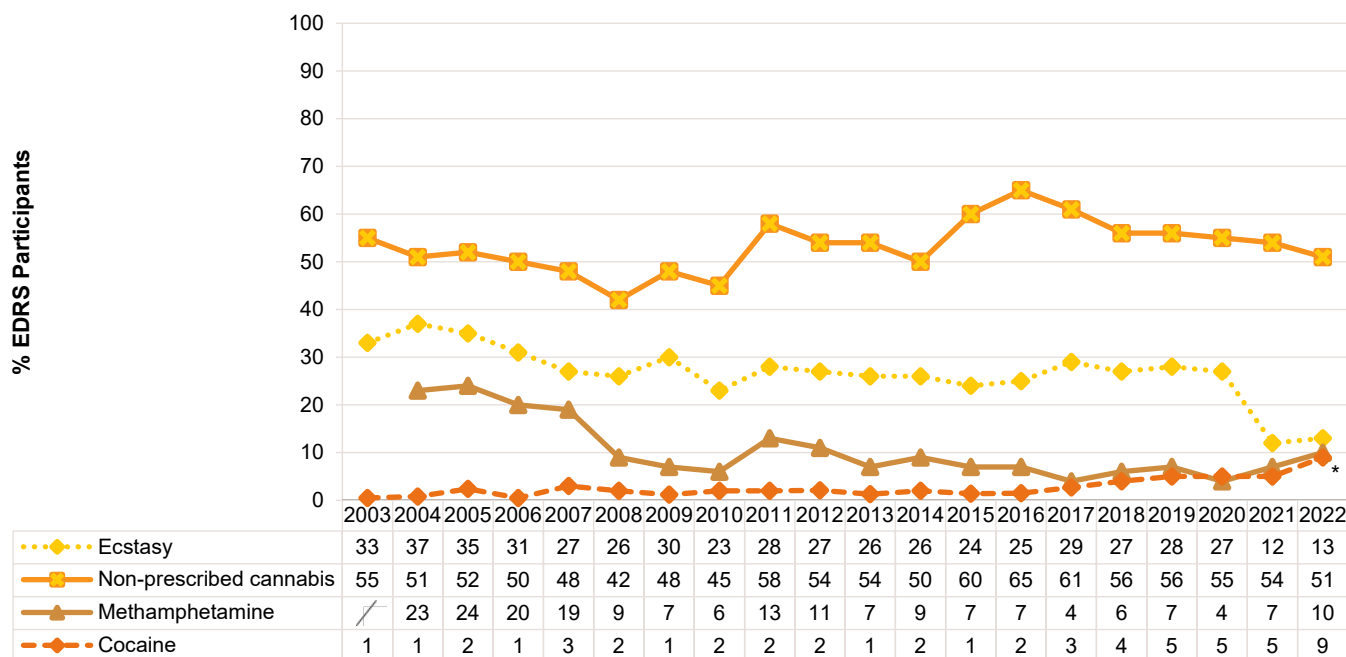
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. – Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 2: Drug used most often in the past month, nationally, 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. – 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 figure; *p<0.050; **p<0.010; ***p<0.001.

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



Note. Computed from the entire sample regardless of whether they had used the substance in the past six months. – Per cent suppressed due to small cell size (n≤5 but not 0). / Not asked. 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.

3

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.

Patterns of Consumption (any ecstasy)

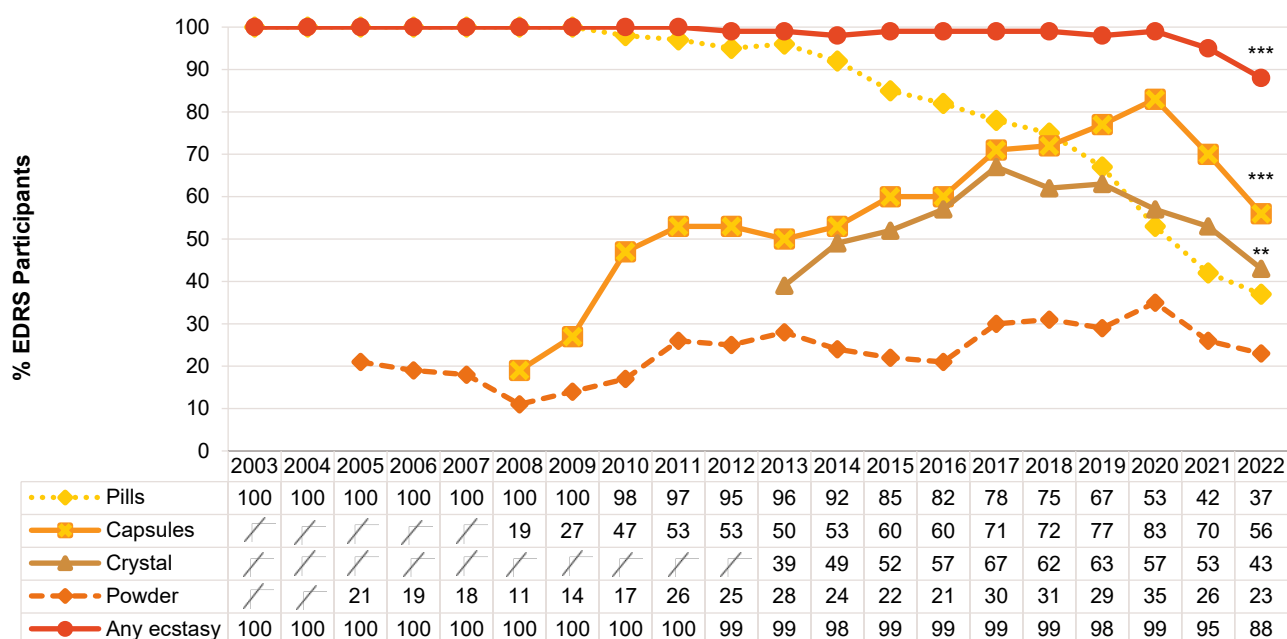
Recent Use (past 6 months)

Almost nine in ten (88%) participants reported any recent use of ecstasy in 2022, a significant decline relative to 2021 (95%; $p<0.001$), and the lowest percentage observed since the commencement of monitoring. Consistent with the previous few years, capsules and crystal were the most commonly used forms of ecstasy in the six months preceding interview, followed by pills. Powder remained the least commonly used form of ecstasy, consistent with the entirety of the reporting period (Figure 4). Declines in recent use of 'any' ecstasy were most noticeable in the Sydney (83%; 96% in 2021; $p=0.005$), Canberra (87%; 98% in 2021; $p=0.005$), and Adelaide (74%; 87% in 2021; $p=0.025$) samples (Table 2).

Frequency of Use

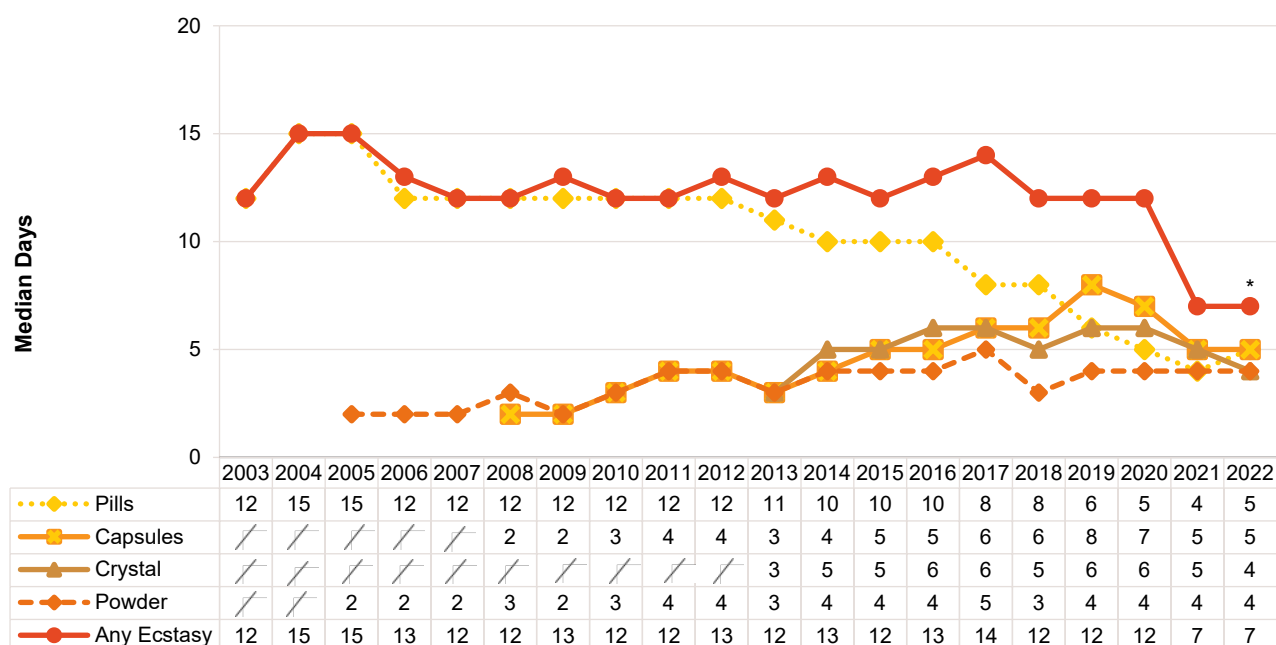
In 2022, participants reported using ecstasy (in any form) on a median of 7 days (IQR=4-13; $n=612$; 7 days in 2021; IQR=5-15; $n=737$; $p=0.022$), which remains lower than what has historically been observed (12-15 days between 2003 and 2020) (Figure 5). Weekly or more frequent use of any form of ecstasy remained stable in 2022 (15%) relative to 2021 (13%; $p=0.365$).

Figure 4: Past six month use of any ecstasy, and ecstasy pills, capsules, crystal, and powder, nationally, 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. – Per cent suppressed due to small cell size ($n\leq 5$ but not 0). / Not asked. 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 5: Median days of any ecstasy and ecstasy pills, powder, capsules and crystal use in the past six months, nationally, 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. Y axis reduced to 20 days to improve visibility of trends. – Per cent suppressed due to small cell size (n≤5 but not 0). / Not asked. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; * $p<0.050$; ** $p<0.010$; *** $p<0.001$.

Table 2: Past six month use of any ecstasy, by capital city, 2003-2022

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2003	100	100	100	100	100	100	100	100
2004	100	100	100	100	100	100	100	100
2005	100	100	100	100	100	100	100	100
2006	100	100	100	100	100	100	100	100
2007	100	100	100	100	100	100	100	100
2008	100	100	100	100	100	100	100	100
2009	100	100	100	100	100	100	100	100
2010	100	100	100	100	100	100	~	100
2011	100	100	100	100	100	100	~	100
2012	100	100	100	100	100	72	~	100
2013	100	97	95	100	100	100	100	100
2014	100	100	96	100	98	100	99	94
2015	99	98	98	100	98	100	98	98
2016	99	99	100	100	99	100	97	97
2017	100	100	98	100	99	100	99	98
2018	100	99	100	100	100	100	98	97
2019	99	99	98	95	97	99	99	99
2020	100	100	96	100	98	98	100	98
2021	96	98	95	99	87	97	99	92
2022	83**	87**	90	96	74*	96	~	93

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). – 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; * $p<0.050$; ** $p<0.010$; *** $p<0.001$.

Table 3: Past six month use of ecstasy pills, by capital city, 2003-2022

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2003	100	100	100	100	100	100	100	100
2004	100	100	100	100	100	100	100	100
2005	100	100	100	100	100	100	100	100
2006	100	100	100	100	100	100	100	100
2007	100	100	100	100	100	99	100	100
2008	100	100	100	100	100	100	100	100
2009	100	100	100	100	99	100	100	100
2010	99	99	98	96	99	100	~	98
2011	99	100	90	95	100	100	~	99
2012	99	94	92	92	98	100	~	95
2013	99	96	86	93	98	99	96	99
2014	89	91	90	92	96	98	99	81
2015	69	56	84	99	94	99	98	86
2016	52	70	93	95	96	98	90	67
2017	42	79	83	93	71	93	86	78
2018	41	80	77	88	56	92	90	76
2019	40	70	74	74	62	68	92	56
2020	41	55	69	74	52	25	63	43
2021	17	36	47	55	54	37	56	27
2022	33*	28	60	47	38	21*	~	36

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Table 4: Past six month use of ecstasy capsules, by capital city, 2008-2022

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

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2008 and 2013 should be interpreted with caution. Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Table 5: Past six month use of ecstasy crystal, by capital city, 2013-2022

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

Note. ~Due to the particularly small samples recruited in Darwin in 2022, data are not presented in this table; furthermore, data from Darwin in 2013 should be interpreted with caution. Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Table 6: Past six month use of ecstasy powder, by capital city, 2005-2022

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2005	15	24	27	11	31	27	14	20
2006	8	19	35	13	27	9	8	31
2007	20	8	38	5	28	11	11	18
2008	15	7	27	6	11	9	-	6
2009	11	14	24	12	9	10	20	17
2010	7	14	34	21	19	6	~	20
2011	21	23	30	26	29	7	~	32
2012	20	35	31	30	11	26	~	31
2013	29	20	51	20	16	25	18	36
2014	15	13	43	20	18	20	26	36
2015	19	22	46	15	14	18	15	22
2016	15	12	51	28	21	13	22	34
2017	21	32	34	24	44	36	20	28
2018	18	23	45	41	27	24	42	27
2019	18	30	20	28	41	30	42	22
2020	33	35	44	37	37	27	35	31
2021	25	26	21	40	22	17	38	19
2022	21	19	17	31	26	32*	~	20

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. Data collection for powder started in 2005. Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Patterns of Consumption (by form)

Ecstasy Pills

Recent Use (past 6 months): Reported recent use of ecstasy pills was at its lowest in 2022 (37%), though remained stable relative to 2021 (42%; $p = 0.090$) (Figure 4). Recent use significantly increased in the Sydney sample (33%; 17% in 2021; $p = 0.016$), but significantly decreased in the Perth sample (21%; 37% in 2021; $p = 0.019$) (Table 3).

Frequency of Use: Of those who had recently consumed ecstasy pills and commented ($n = 261$), ecstasy pills were used on a median of 5 days (IQR=2-12) in the six months preceding interview, stable relative to 2021 (4 days; IQR=2-9; $n = 323$; $p = 0.141$) (Figure 5). Among those had recently used ecstasy pills, the percentage reporting weekly or more frequent use remained stable at 12% in 2022 (8% in 2021; $p = 0.120$).

Routes of Administration: Among participants who had recently consumed ecstasy pills and commented (n=261), the most common route of administration was swallowing (97%; 96% in 2021; $p=0.361$), followed by snorting (23%; 34% in 2021; $p=0.003$). Few participants reported recent shelving/shafting (n≤5; 2% in 2021; $p=0.047$).

Quantity: Of those who reported recent use and responded (n=260), the median number of pills used in a 'typical' session was 2 (IQR=1-2; 2 pills in 2021; IQR=1-3; $p=0.711$). Of those who reported recent use and responded (n=260), the median maximum number of pills used in 2022 was 2 (IQR=2-4; 3 pills in 2021; IQR=2-5; $p=0.157$).

Ecstasy Capsules

Recent Use (past 6 months): Capsules remained the most common form of ecstasy used in 2022. Nevertheless, a significant decline was observed, with 56% of the national sample reporting any recent use (70% in 2021; $p<0.001$) (Figure 4). This was largely driven by declines in the Sydney (52%; 82% in 2021; $p<0.001$) and Canberra (52%; 76% in 2021; $p=0.001$) samples (Table 4).

Frequency of Use: Of those who recently consumed ecstasy capsules and commented (n=386), capsules were used on a median of 5 days (IQR=2-10), stable relative to 2021 (5 days; IQR=3-9; n=543; $p=0.383$) (Figure 5). Among those who had recently used ecstasy capsules, 7% reported weekly or more frequent use, stable from 2021 (6%; $p=0.328$).

Routes of Administration: Among participants who had recently consumed ecstasy capsules and commented (n=389), swallowing remained the main route of administration in 2022 (96%; 97% in 2021; $p=0.276$). Seventeen per cent reported snorting capsules, a significant decline from 27% in 2021 ($p=0.002$). Few participants (n≤5) reported shelving/shafting.

Quantity: Of those who reported recent use and responded (n=386), the median number of capsules used in a 'typical' session in 2022 was 2 (IQR=1-3; 2 capsules in 2021; IQR=1-3;

$p=0.066$). Of those who reported recent use and responded (n=385), the median maximum number of capsules used was 3 (IQR=2-5; 3 capsules in 2021; IQR=2-4; $p=0.482$).

Contents of Capsules: Of those who reported recent use and responded (n=374), three-quarters (76%) reported that their last capsule contained crystal (76% in 2021), whilst 29% reported that it contained powder (27% in 2021). Six per cent of participants did not look at the contents the last time they used capsules (8% in 2021).

Ecstasy Crystal

Recent Use (past 6 months): Recent use of crystal was reported by two-fifths (43%) of the national sample, a significant decrease from 53% in 2021 ($p=0.001$) (Figure 4). This decline was most prominent in the Sydney (37%; 62% in 2021; $p=0.001$), Hobart (47%; 66% in 2021; $p=0.023$) and Adelaide samples (22%; 49% in 2021; $p<0.001$) (Table 5).

Frequency of Use: Of those who had recently consumed ecstasy crystal and commented (n=303), participants reported use on a median of 4 days (IQR=2-8) in the six months preceding interview, stable from 5 days in 2021 (IQR=2-10; n=406; $p=0.930$) (Figure 5). Among those who had recently used ecstasy crystal, 6% reported weekly or greater use, stable relative to 2021 (5%; $p=0.498$).

Routes of Administration: Among participants who had recently consumed ecstasy crystal and commented (n=304), the main route of administration reported was swallowing (78%; 83% in 2021; $p=0.156$), followed by snorting (48%; 56% in 2021; $p=0.074$). Few participants who had recently used crystal reported shelving/shafting (n≤5; 3% in 2021; $p=0.326$).

Quantity: Of those who reported recent use and responded (n=228), the median amount of crystal used in a 'typical' session was 0.30 grams (IQR=0.20-0.50; 0.30 grams in 2021; IQR=0.20-0.50; $p=0.098$). Of those who reported recent use and responded (n=230), the median maximum amount used was 0.50

grams (IQR=0.30-1.00; 0.40 grams in 2021; IQR=0.20-0.70; $p=0.016$).

Ecstasy Powder

Recent Use (past 6 months): Consistent with previous years, powder was the least used form of ecstasy in 2022, with almost one-quarter (23%) of participants having recently used this form, stable relative to 2021 (26%; $p=0.188$) (Figure 4). Recent use significantly increased in the Perth sample (32%; 17% in 2021; $p=0.021$) (Table 6).

Frequency of Use: Of those who had recently used ecstasy powder and commented ($n=164$), powder was used on a median of 4 days (IQR=2-10) in the previous six months, stable relative to 2021 (4 days; IQR=2-8; $n=204$; $p=0.519$) (Figure 5). Among those who had recently used ecstasy powder, 8% reported weekly or more frequent use, stable from 2021 (6%; $p=0.692$).

Routes of Administration: Among participants who had recently used ecstasy powder and commented ($n=164$), snorting was the most common route of administration, consistent with previous years, and stable from 2021 (80%; 73% in 2021; $p=0.127$). Forty-five per cent reported swallowing ecstasy powder, a significant decrease from 57% in 2021 ($p=0.023$). Few participants who had recently used powder reported shelving/shafting ($n\leq 5$; 0% in 2021; $p=0.446$).

Quantity: Of those who reported recent use and responded ($n=116$), the median quantity of powder used in a 'typical' session was 0.30 grams (IQR=0.20-0.50; 0.30 grams in 2021; IQR=0.20-0.50; $p=0.993$). Of those who reported recent use and responded ($n=120$), the median maximum amount used was 0.50 grams (IQR=0.30-1.00; 0.50 grams in 2021; IQR=0.30-1.00; $p=0.585$).

Price, Perceived Purity and Perceived Availability

Ecstasy Pills

Price: The reported price of a pill remained relatively stable in 2022, with participants

reporting \$30 per pill (IQR=25-35; $n=149$; \$25 in 2021; IQR=20-35; $n=180$; $p=0.264$) (Figure 6).

Perceived Purity: Among those who responded in 2022 ($n=277$), the perceived purity of ecstasy pills remained stable relative to 2021 ($p=0.958$). The largest percentage of participants reported perceived purity to be 'medium' (30%; 29% in 2021), with almost equal percentages reporting perceived purity to be 'high' (23%; 24% in 2021), 'low' (22%; 23% in 2021) or 'fluctuating' (26%; 25% in 2021) (Figure 8).

Perceived Availability: Among those who responded in 2022 ($n=288$), there was a significant change in the perceived availability of ecstasy pills relative to 2021 ($p=0.011$). Almost two-fifths (39%) of participants reported ecstasy pills to be 'difficult' to obtain, an increase from 29% in 2021, and 14% reported that they were 'very difficult' to obtain (10% in 2021). In contrast, a decrease was observed in those reporting that ecstasy pills were 'easy' (30%; 37% in 2021) or 'very easy' (18%; 24% in 2021) to obtain (Figure 12).

Ecstasy Capsules

Price: The median price of a capsule remained stable at \$25 (IQR=20-30; $n=183$; \$25 in 2021; IQR=20-30; $n=291$; $p=0.209$) (Figure 6).

Perceived Purity: Among those who responded in 2022 ($n=385$), there was a significant change in the perceived purity of capsules relative to 2021 ($p=0.030$). Participants predominantly perceived capsules as being of 'medium' purity (34%; 38% in 2022), with fewer participants reporting 'high' (19%; 24% in 2021) or 'low' (22%; 18% in 2021) purity (Figure 9).

Perceived Availability: Among those who responded in 2022 ($n=397$), there was a significant change in the perceived availability of capsules relative to 2021 ($p<0.001$). Specifically, there was an increase in the percentage of participants who reported availability to be 'difficult' (40%; 22% in 2021) and 'very difficult' (11%; 4% in 2021). In contrast, fewer participants reported ecstasy

capsules as being ‘easy’ (33%; 47% in 2021) or ‘very easy’ (16%; 28% in 2021) to obtain (Figure 13).

Ecstasy Crystal

Price: The median price per gram of crystal significantly increased from \$200 (IQR=150-250; n=209) in 2021 to \$250 (IQR=180-300; n=160; $p=0.002$) in 2022. The median price per point of crystal remained stable at \$28 (IQR=25-30; n=16; \$25 in 2021; IQR=20-35; n=27; $p=0.609$) (Figure 7).

Perceived Purity: Among those who responded in 2022 (n=297), the perceived purity of crystal remained stable relative to 2021 ($p=0.432$). The largest percentage of participants reported perceived purity to be ‘high’ (35%; 31% in 2021), or ‘medium’ (31%; 36% in 2021). Fewer participants perceived purity to be ‘low’ (14%; 12% in 2021) (Figure 10).

Perceived Availability: Among those who responded in 2022 (n=305), the perceived availability of crystal changed significantly relative to 2021 ($p<0.001$). The largest percentage of participants perceived crystal to be ‘difficult’ to obtain in 2022 (34%; 27% in 2021), and a decrease was observed in the percentage of participants reporting that it was

‘easy’ (30%; 43% in 2021) or ‘very easy’ (19%; 23% in 2021) to obtain (Figure 14).

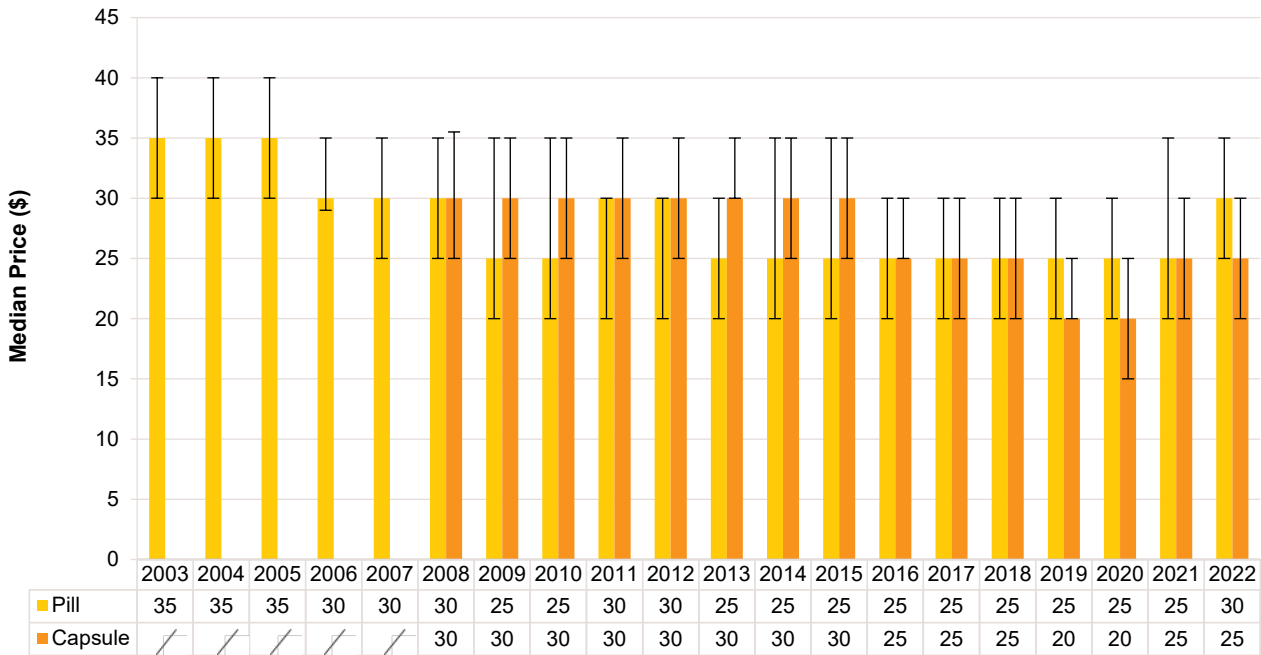
Ecstasy Powder

Price: The reported median price per gram of powder significantly increased in 2022, from \$200 (IQR=150-250; n=69) in 2021 to \$245 (IQR=200-293; n=62) in 2022 ($p=0.007$) (Figure 7).

Perceived Purity: Among those who responded in 2022 (n=122), the perceived purity of powder remained stable relative to 2021 ($p=0.395$). Almost two-fifths (38%) perceived ecstasy powder to be of ‘medium’ purity (34% in 2021), one-quarter (25%) perceived it as ‘high’ (30% in 2021) and one-fifth (21%) perceived it to be ‘low’ in purity (15% in 2021) (Figure 11).

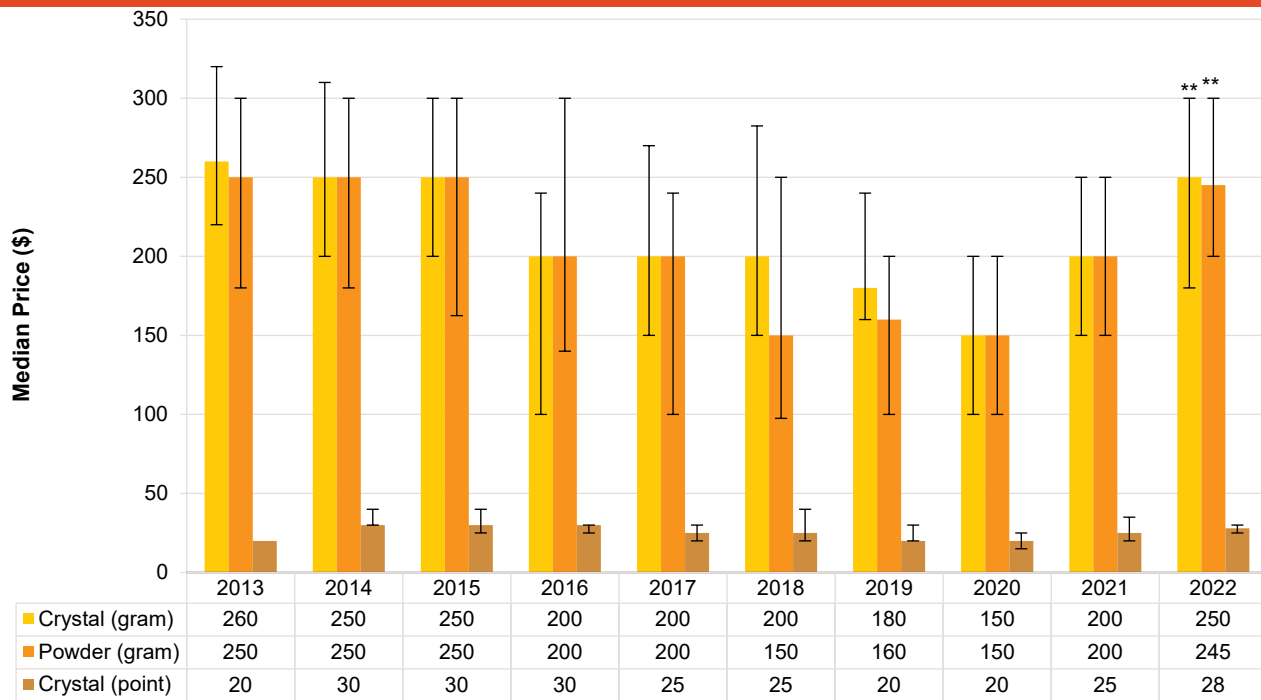
Perceived Availability: Among those who responded in 2022 (n=128), the perceived availability of powder significantly changed relative to 2021 ($p<0.001$). An increase was observed in those reporting availability to be ‘difficult’ (44%; 27% in 2021), with a further 14% perceiving powder as being ‘very difficult’ to obtain (5% in 2021). In contrast, a decrease was observed in those who reported availability as being ‘easy’ (32%; 41% in 2021) or ‘very easy’ (10%; 27% in 2021) (Figure 15).

Figure 6: Median price of ecstasy pills and capsules, nationally, 2003-2022



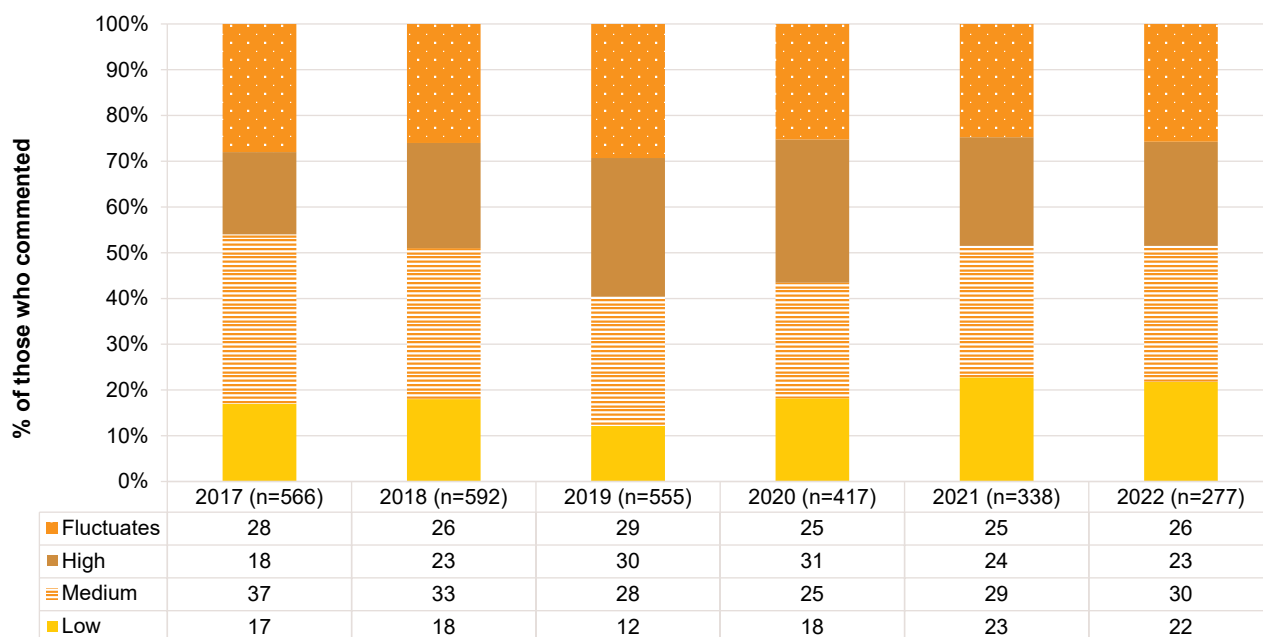
Note. Among those who commented. Data collection for price of ecstasy capsules started in 2008. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. / Not asked. Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



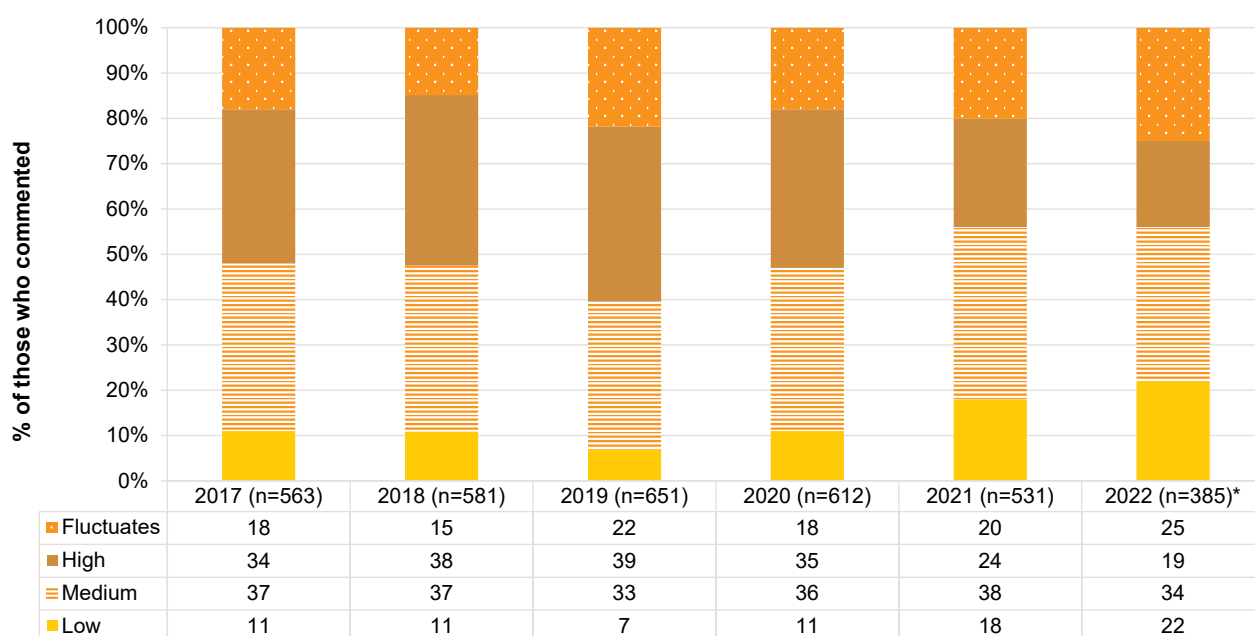
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) and ecstasy powder (gram) started in 2013. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



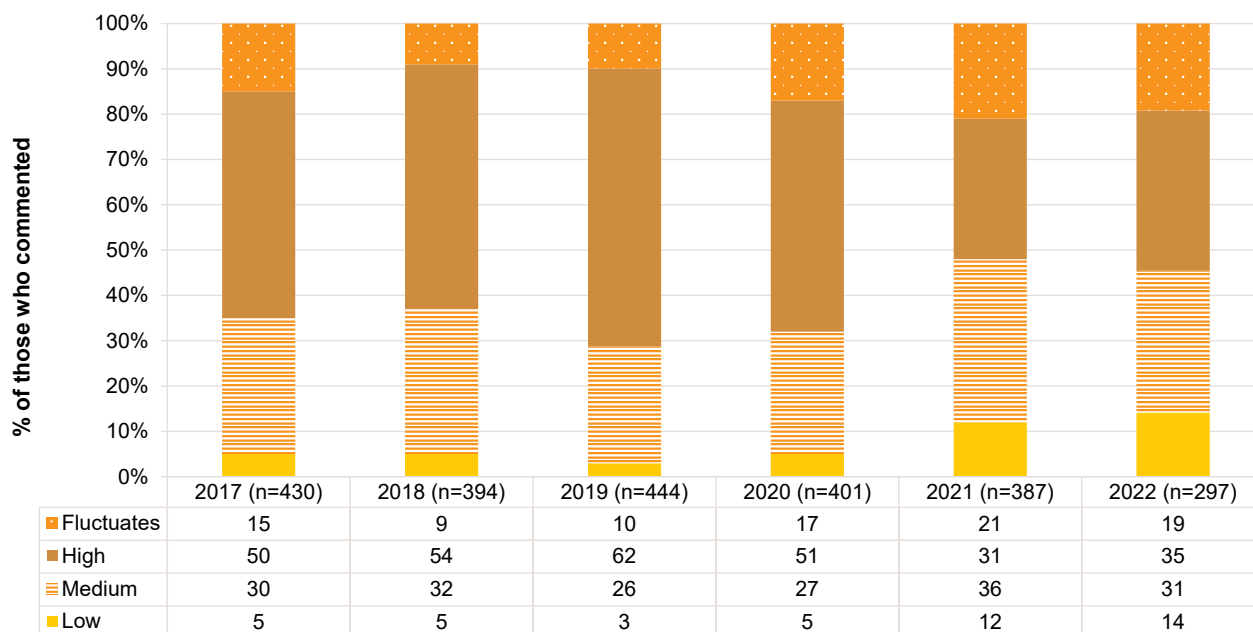
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



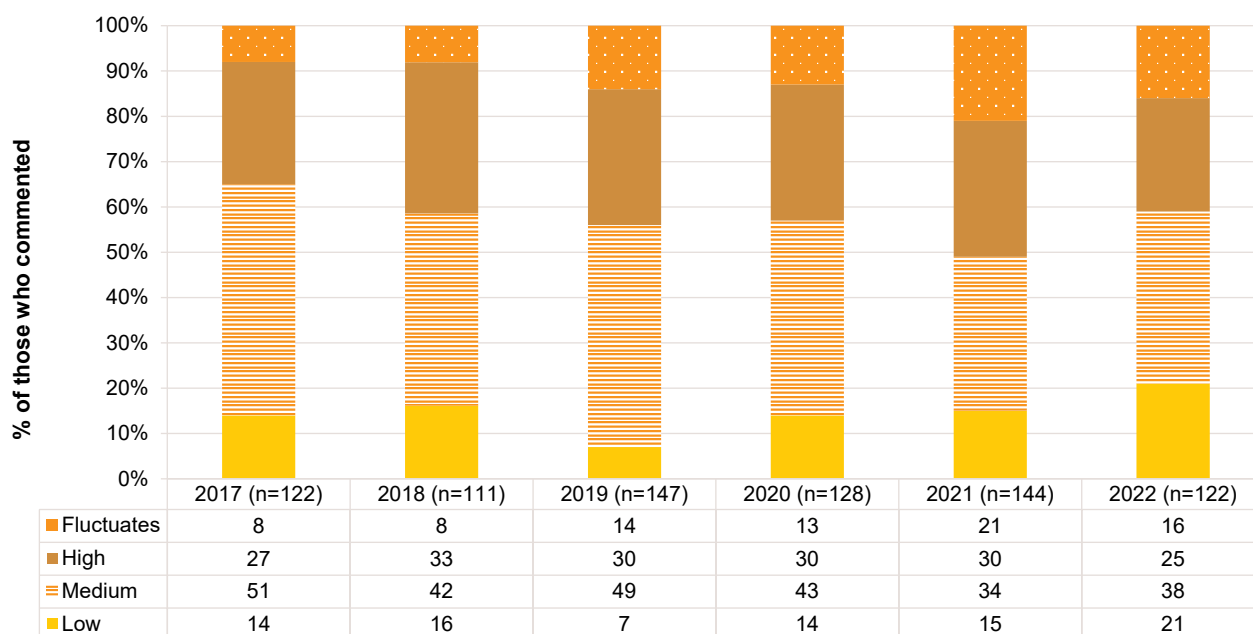
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



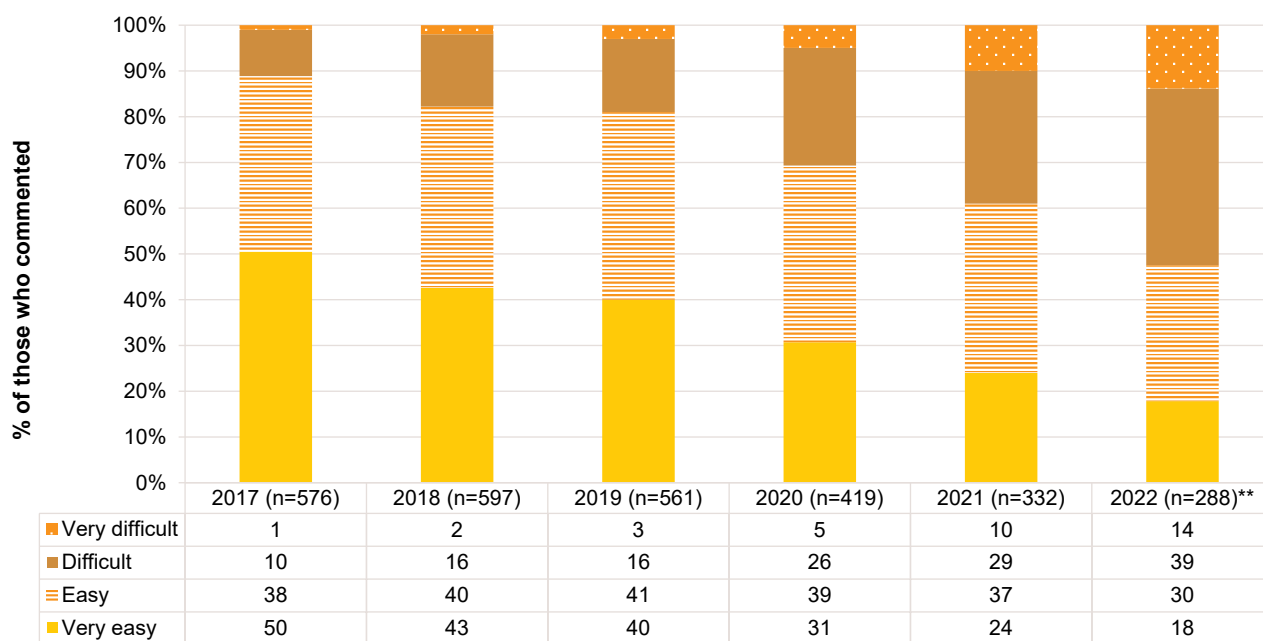
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



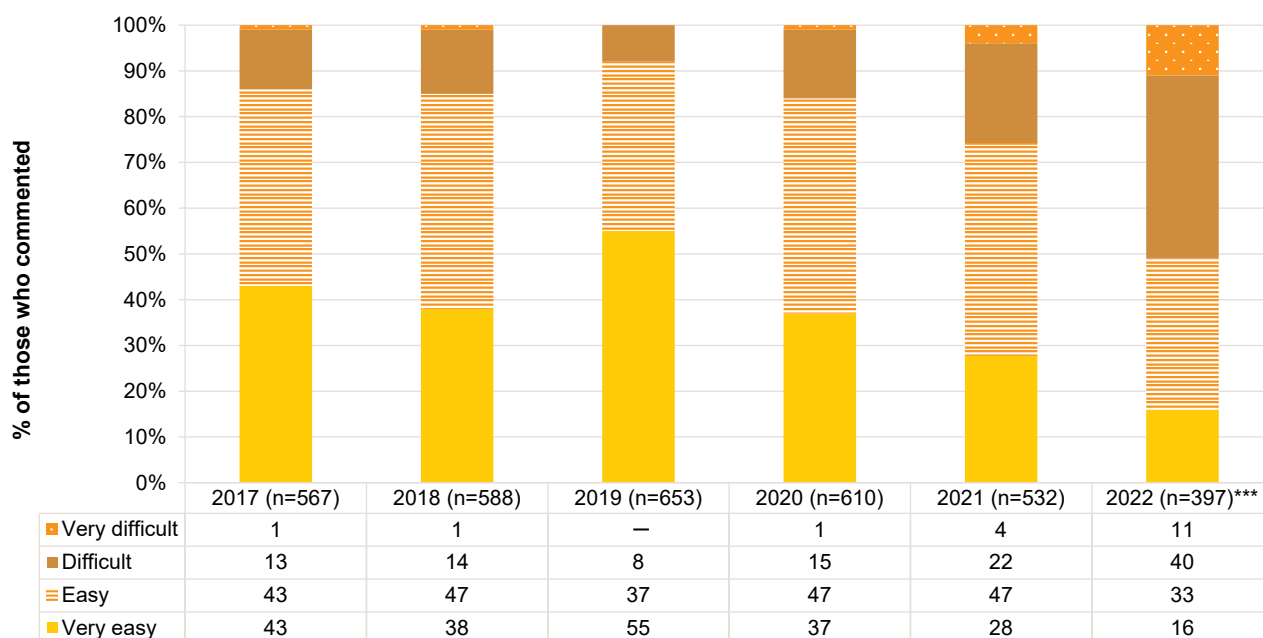
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



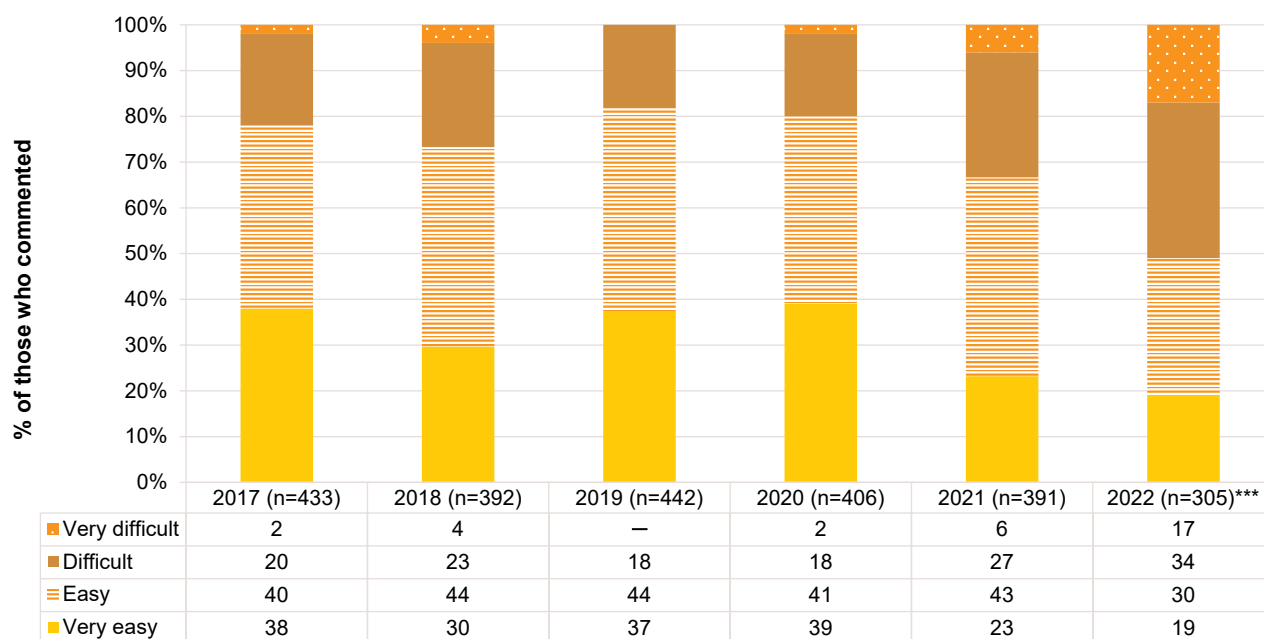
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



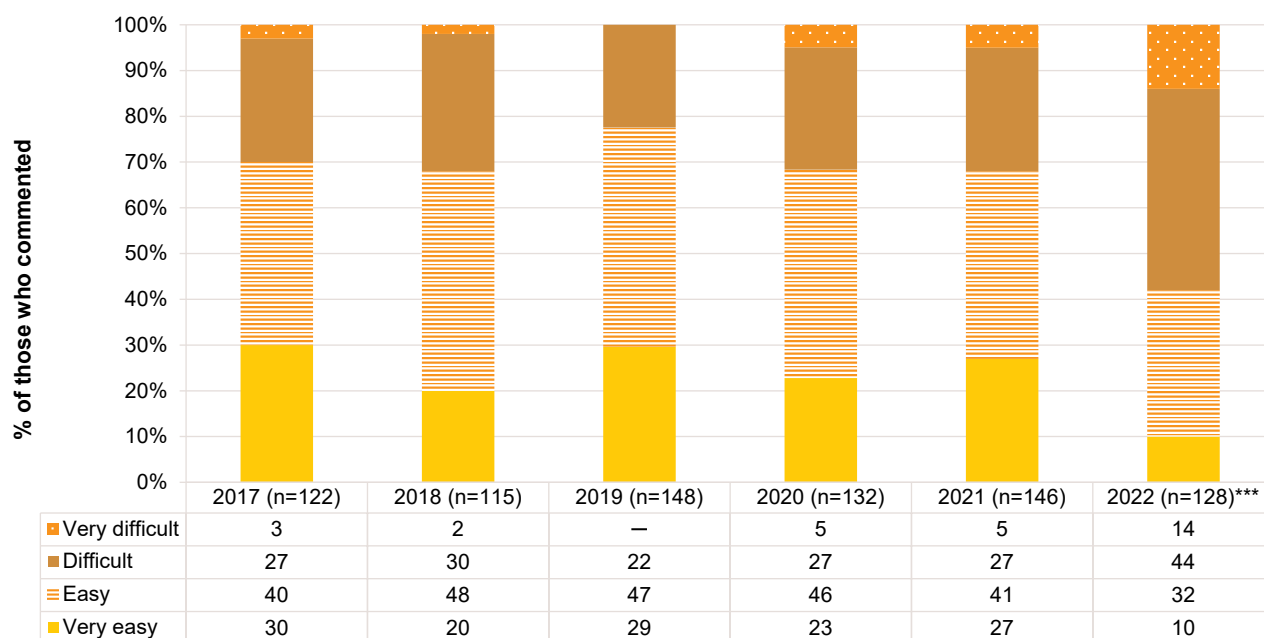
Note. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Market questions were only asked for all forms of ecstasy from 2017 onwards. Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



Note. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Market questions were only asked for all forms of ecstasy from 2017 onwards. 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, nationally, 2017-2022



Note. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Market questions were only asked for all forms of ecstasy from 2017 onwards. Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

4

Methamphetamine

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

Patterns of Consumption (any methamphetamine)

Recent Use (past 6 months)

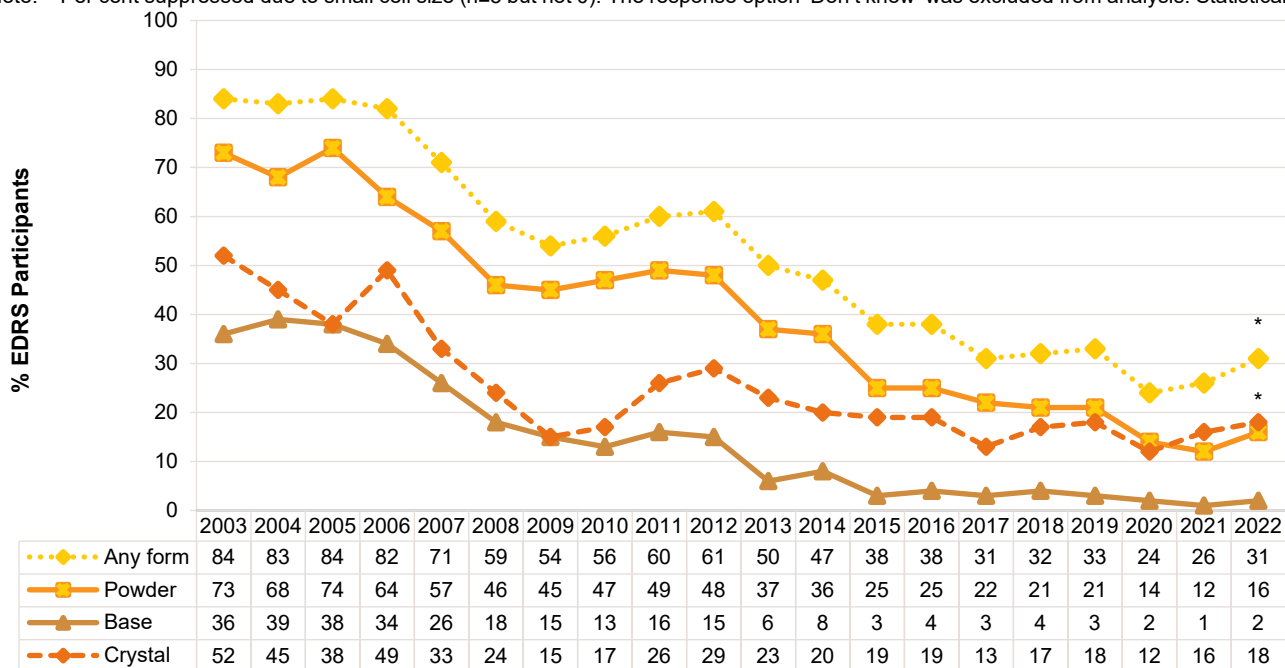
The per cent reporting any recent use of methamphetamine has been declining since monitoring began (Figure 17), with 84% of participants reporting recent use in 2003. A significant increase was observed in 2022 (31%) relative to 2021 (26%; $p=0.029$) (Figure 16). This increase was most noticeable in the Sydney sample (29%; 15% in 2021; $p=0.026$). Conversely, recent use of any methamphetamine decreased in the Brisbane sample (15%; 30% in 2021; $p=0.025$) (Table 7).

Frequency of Use

Use has remained relatively infrequent over the course of monitoring, with participants reporting use on a median of 5 days (IQR=2-31; $n=219$) in 2022 (5 days in 2021; IQR=2-24; $n=200$; $p=0.393$) (Figure 17). Among those who reported recent use of any methamphetamine, almost one-third (31%) reported weekly or more frequent use, stable from 28% in 2021 ($p=0.525$).

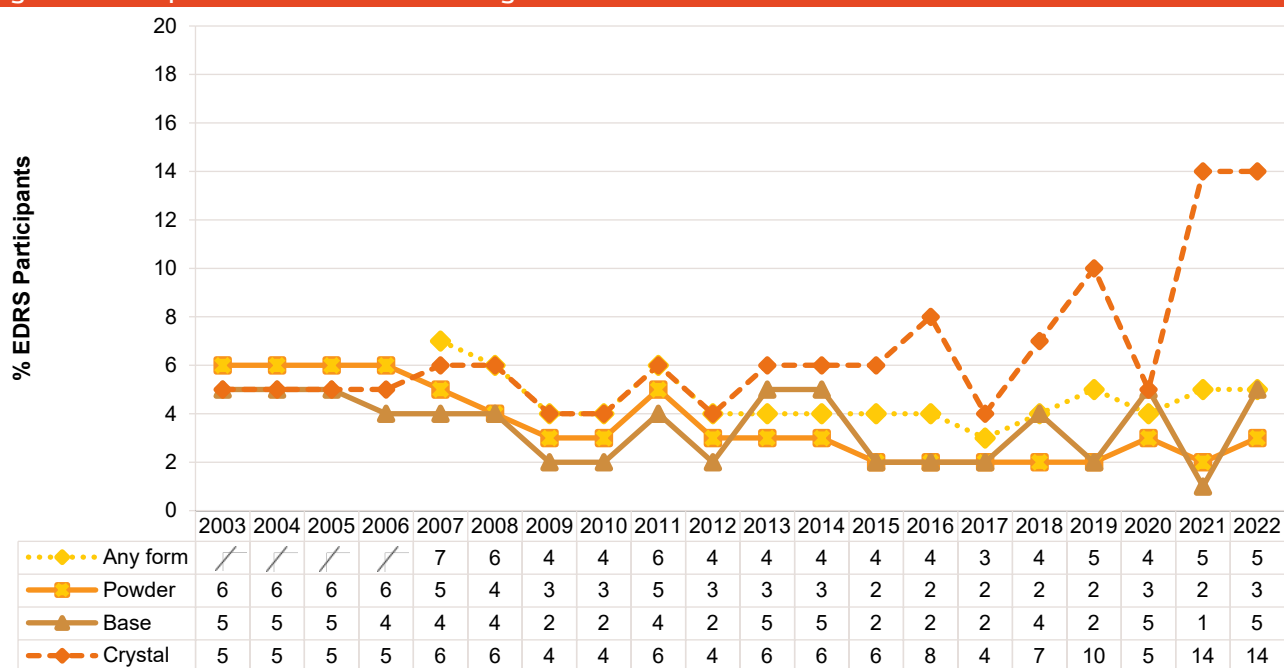
Figure 16: Past six month use of any methamphetamine, and methamphetamine powder, base, and crystal, nationally, 2003-2022

Note. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). 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 17: Median days of any methamphetamine use, and methamphetamine powder, base, and crystal in the past six months, nationally, 2003-2022



Note. Data collection for median days of any form of methamphetamine started in 2007. / Not asked. 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. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Table 7: Past six month use of any methamphetamine, by capital city, 2003-2022

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2003	87	79	98	82	92	91	82	66
2004	89	77	94	76	90	95	82	70
2005	83	75	86	78	94	92	76	84
2006	76	79	91	78	92	88	67	78
2007	66	60	91	70	90	62	67	58
2008	66	55	77	63	58	50	24	57
2009	49	54	72	52	53	44	64	47
2010	50	70	72	48	57	45	~	51
2011	49	51	75	52	67	64	~	60
2012	42	73	84	64	48	47	~	76
2013	36	65	71	57	46	31	44	48
2014	32	51	68	64	32	31	47	47
2015	33	35	55	45	33	20	49	31
2016	27	26	57	42	36	27	52	39
2017	30	33	46	40	37	12	35	14
2018	19	33	60	46	45	11	27	18
2019	26	33	46	45	34	11	44	24
2020	17	15	49	31	26	12	24	18
2021	15	29	44	31	33	13	14	30
2022	29*	39	49	39	36	14	~	15*

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Table 8: Past six month use of methamphetamine powder, by capital city, 2003-2022

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2003	79	64	89	67	65	83	81	57
2004	81	64	92	68	62	78	72	42
2005	76	70	85	77	66	85	73	57
2006	55	66	91	62	51	65	59	58
2007	45	53	90	65	53	46	55	46
2008	48	42	75	59	30	38	24	34
2009	37	44	72	46	30	37	61	41
2010	29	66	70	40	38	38	~	47
2011	32	50	69	47	45	44	~	49
2012	31	63	77	61	24	27	~	58
2013	25	57	58	53	21	17	34	41
2014	21	48	56	58	13	19	39	34
2015	27	31	45	39	11	6	31	11
2016	18	21	50	32	12	18	27	25
2017	18	32	43	29	19	7	20	9
2018	14	25	56	30	15	-	14	10
2019	17	23	41	33	16	-	28	9
2020	8	12	39	25	6	-	14	8
2021	8	9	36	20	-	-	-	15
2022	13	10	45	20	14**	-	~	10

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. - Per cent suppressed due to small cell size (n≤5 but not 0). Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). 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.

Table 9: Past six month use of methamphetamine crystal, by capital city, 2003-2022

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2003	48	56	64	52	48	77	40	38
2004	46	39	52	16	47	80	35	42
2005	40	26	42	10	41	69	32	50
2006	56	37	49	27	62	77	26	50
2007	42	20	39	7	49	52	24	23
2008	33	24	22	15	34	36	0	26
2009	9	8	13	7	32	20	15	17
2010	21	16	18	-	26	22	~	8
2011	19	9	38	-	43	46	~	32
2012	18	26	48	10	32	33	~	40
2013	11	14	45	17	28	22	21	21
2014	13	8	34	14	20	17	27	26
2015	12	7	19	13	26	16	36	20
2016	15	5	18	21	33	12	32	18
2017	12	8	10	14	26	6	24	7
2018	6	15	14	24	40	8	21	12
2019	13	15	12	20	26	8	31	16
2020	10	4	14	12	21	10	12	14
2021	-	21	13	15	32	10	12	16
2022	16*	31	10	21	30	11	~	6*

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. - Per cent suppressed due to low numbers (n≤5 but not 0). Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). 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.

Patterns of Consumption (by form)

Methamphetamine Powder

Recent Use (past 6 months): Powder had historically been the most commonly used form of methamphetamine, however was overtaken by crystal from 2021 onwards (Figure 16). Overall, recent use of powder has declined substantially since 2005, although there was significant increase in 2022 (16%) relative to 2021 (12%; $p=0.024$). This appears to have largely been driven by a significant increase among the Adelaide sample (14%; $n \leq 5$ in 2021; $p=0.003$) (Table 8).

Frequency of Use: Of those who had recently consumed powder and commented ($n=111$), median days of use remained low and stable at 3 days in 2022 (IQR=2-7; 2 days in 2021; IQR=1-5; $n=93$; $p=0.097$) (Figure 17), with 13% reporting weekly or more frequent use (6% in 2021; $p=0.165$).

Routes of Administration: Among participants who had recently consumed powder and commented ($n=112$), the main route of administration in 2022 was snorting (71%; 78% in 2021; $p=0.201$), followed by swallowing (30%; 30% in 2021). Smaller numbers reported smoking (14%; 10% in 2021 (significance testing not undertaken due to small numbers).

Quantity: Of those who reported recent use and responded ($n=69$), the median amount used in a 'typical' session was 0.20 grams (IQR=0.10-0.50; 0.20 grams in 2021; IQR=0.10-0.50; $p=0.767$). Of those who reported recent use and responded ($n=72$), the median maximum amount used was 0.30 grams (IQR=0.20-1.00; 0.30 grams in 2021; IQR=0.10-0.70; $p=0.647$).

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Price: Participants reported a median price of \$200 per gram in 2022 (IQR=173-235; $n=36$;

Methamphetamine Crystal

Recent Use (past 6 months): As with all forms of methamphetamine, crystal use has generally decreased over time (Figure 16). Almost one-fifth (18%) of the national sample had recently consumed crystal in 2022 (16% in 2021; $p=0.189$), with use significantly increasing in the Sydney sample (16%; $n \leq 5$ in 2021; $p=0.021$) but decreasing in the Brisbane sample (6%; 16% in 2021; $p=0.046$) (Table 9).

Frequency of Use: Of those who had recently consumed crystal and commented ($n=127$), frequency of use remained stable at a median of 14 days (IQR=3-72; 14 days in 2021; IQR=4-48; $n=119$; $p=0.584$) (Figure 17), with 46% reporting weekly or more frequent use (44% in 2021; $p=0.798$).

Routes of Administration: Among those who had used crystal and commented ($n=127$), smoking remained the most common route of administration in 2022 (91%; 93% in 2021; $p=0.663$), followed by injecting (17%; 13% in 2021; $p=0.482$). Equal percentages reported snorting (9%; 8% in 2021) and swallowing (9%; 8% in 2021; $p=0.657$).

Quantity: Of those who reported recent use and responded ($n=113$), the median amount used in a 'typical' session was 0.20 grams (IQR=0.10-0.40; 0.20 grams in 2021; IQR=0.10-0.40; $p=0.787$). Of those who reported recent use and responded ($n=112$), the median maximum amount used was 0.50 grams (IQR=0.20-0.80; 0.40 grams in 2021; IQR=0.20-0.90; $p=0.973$).

\$200 in 2021; IQR=165-200, $n=24$; $p=0.158$) and \$50 for one point in 2022 (IQR=50-74; $n=8$; \$50 in 2021; IQR=40-63; $n=7$; $p=0.502$) (Figure 18).

Perceived Purity: Among those who responded in 2022 ($n=77$), the perceived purity

of powder remained stable relative to 2021 ($p=0.552$). The largest percentage of participants perceived powder to be of 'high' purity (42%; 38% in 2021), with equal percentages perceiving powder to be of 'medium' (23%; 34% in 2021) and 'low' (23%; 18% in 2021) purity (Figure 20).

Perceived Availability: Among those who responded in 2022 ($n=84$), the perceived availability of powder remained stable relative to 2021 ($p=0.179$). Almost two-fifths (38%) reported that powder was 'easy' (27% in 2021) to obtain, and equal percentages reported that it was 'very easy' (21% 32% in 2021) and 'difficult' (21%; 29% in 2021) to obtain. One-fifth (19%) perceived powder as being 'very difficult' to obtain (12% in 2021) (Figure 22).

Methamphetamine Crystal

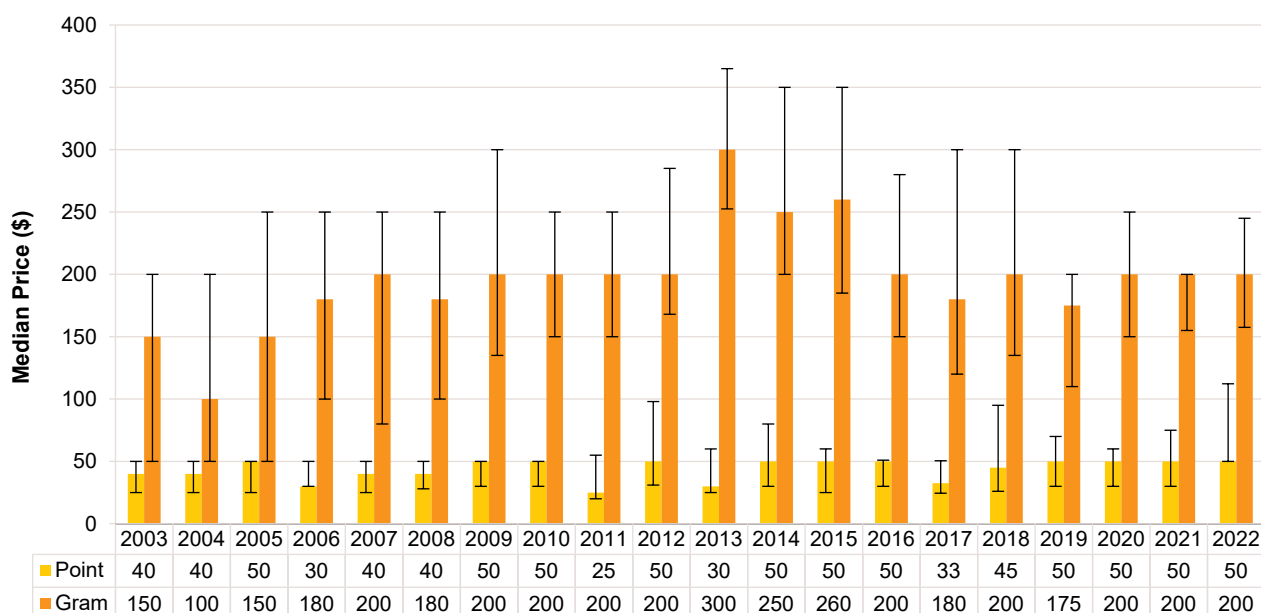
Price: Participants reported a median price of \$475 per gram (IQR=388-563; $n=16$; \$425 in 2021; IQR=250-500; $n=16$; $p=0.289$) and \$70

per point (IQR=50-100; $n=44$; \$60 in 2021; IQR=50-100; $n=44$; $p=0.172$) (Figure 19).

Perceived Purity: Among those who responded in 2022 ($n=123$), the perceived purity of crystal remained stable relative to 2021 ($p=0.492$). The largest per cent (44%) reported purity as 'high' (46% in 2021). One-quarter (25%) reported purity as 'fluctuating' (19% in 2021) and smaller percentages reported 'medium' (17%; 23% in 2021) and 'low' purity (14%; 12% in 2021) (Figure 21).

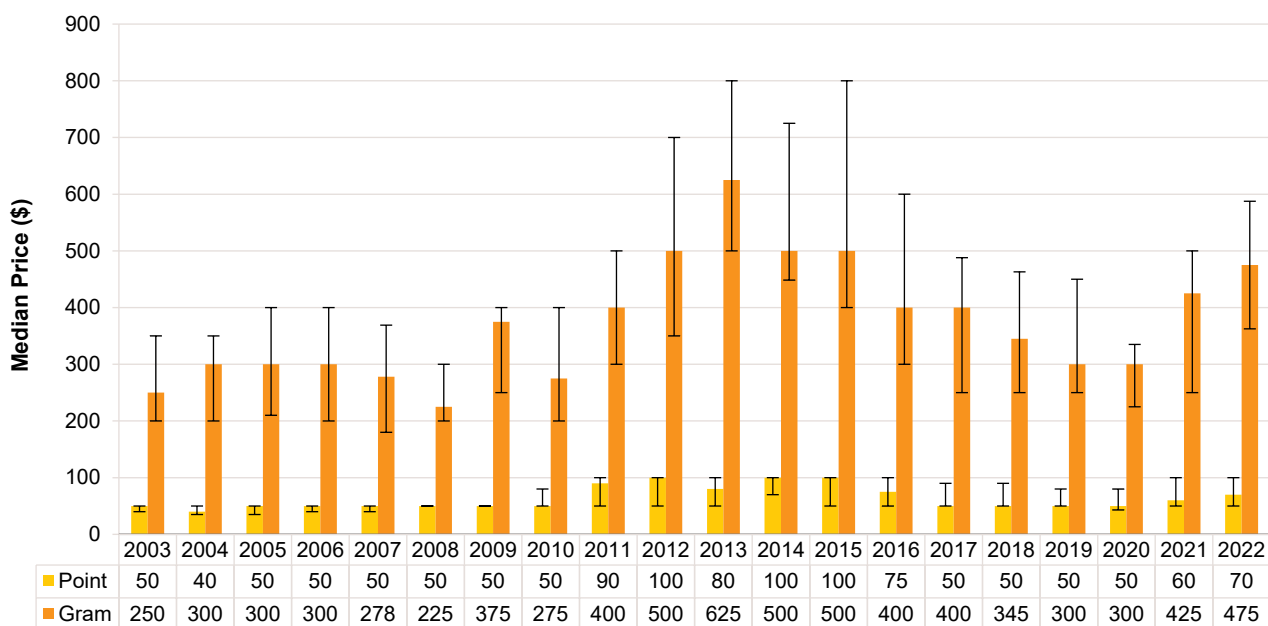
Perceived Availability: Among those who responded in 2022 ($n=128$), the perceived availability of crystal significantly changed relative to 2021 ($p=0.005$). An increase was observed in those reporting crystal as being 'very easy' to obtain (62%; 44% in 2021), with an inverse decrease in those perceiving availability as 'easy' (30%; 38% in 2021) or 'difficult' (8%; 16% in 2021) (Figure 23).

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



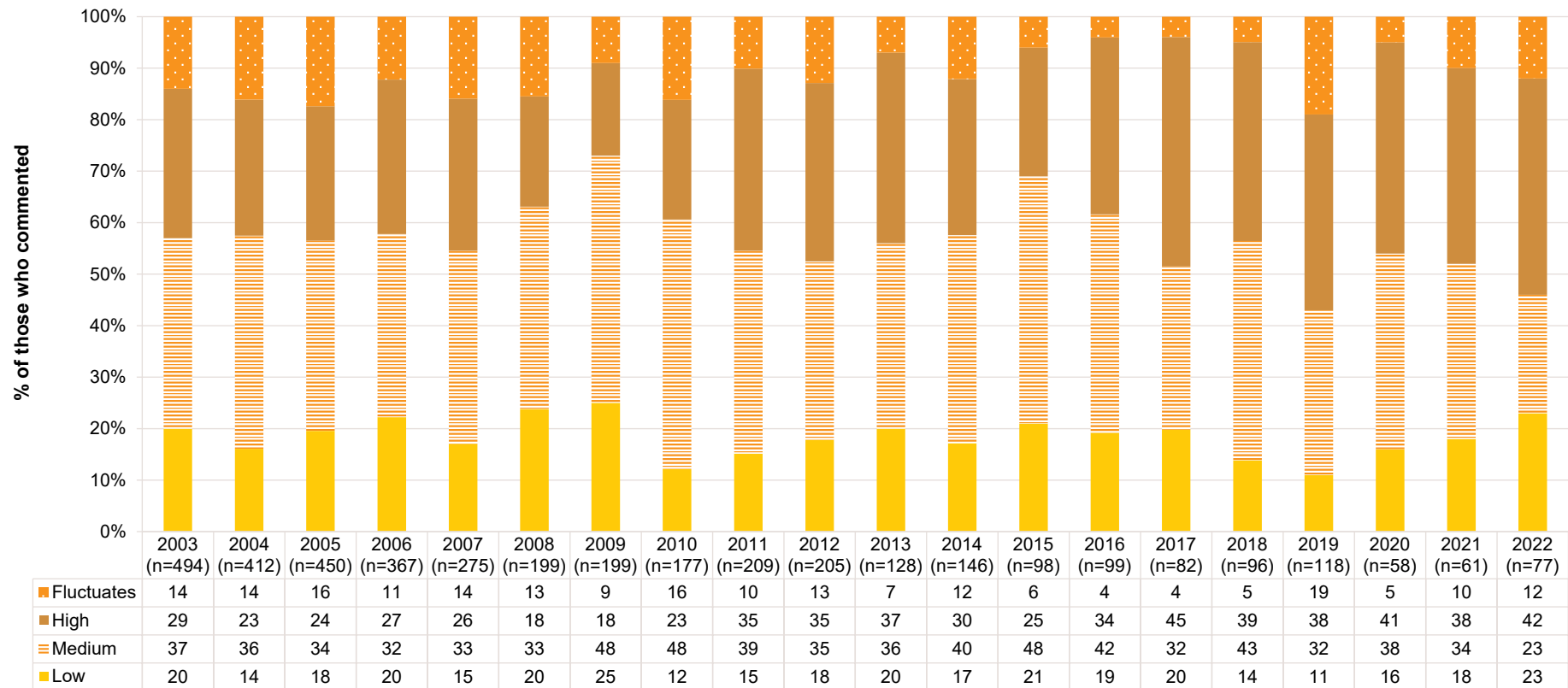
Note. Among those who commented. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; * $p<0.050$; ** $p<0.010$; *** $p<0.001$.

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



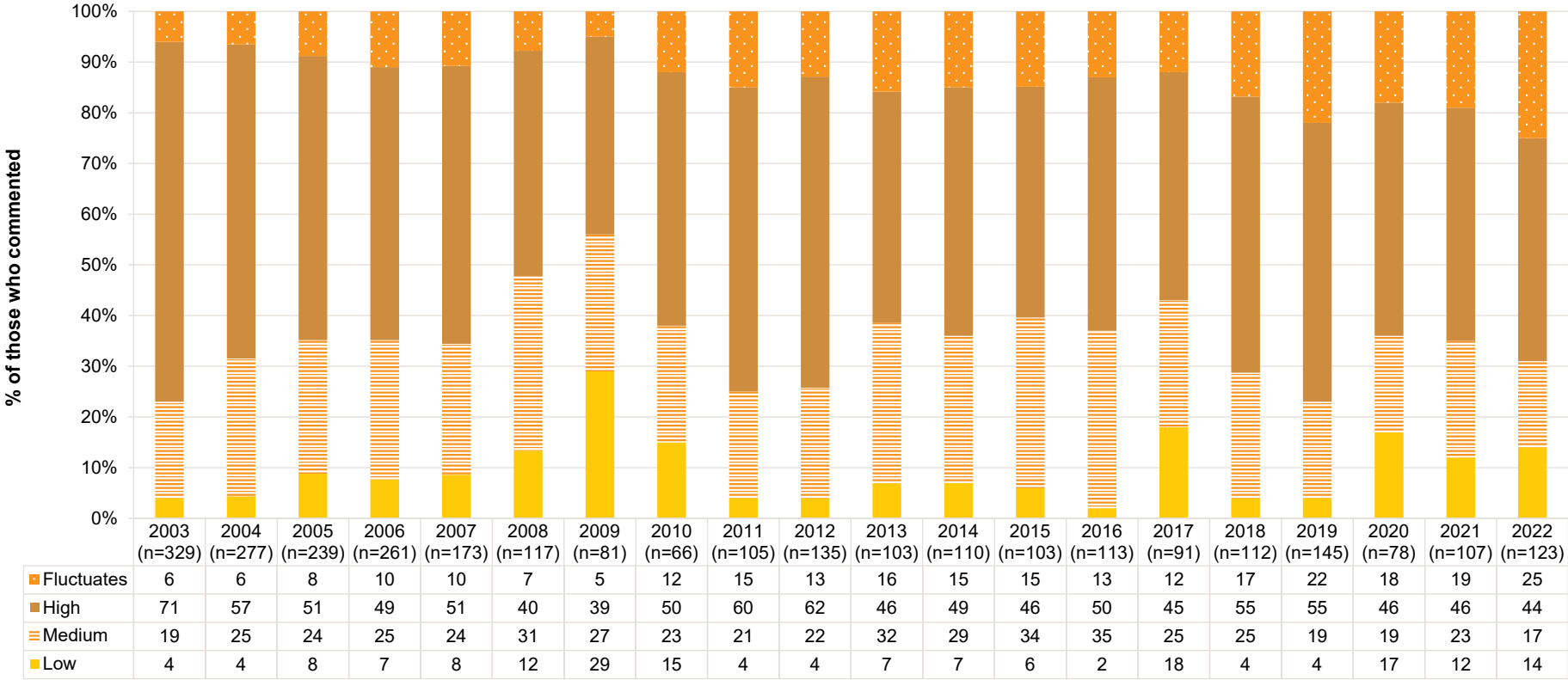
Note. Among those who commented. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



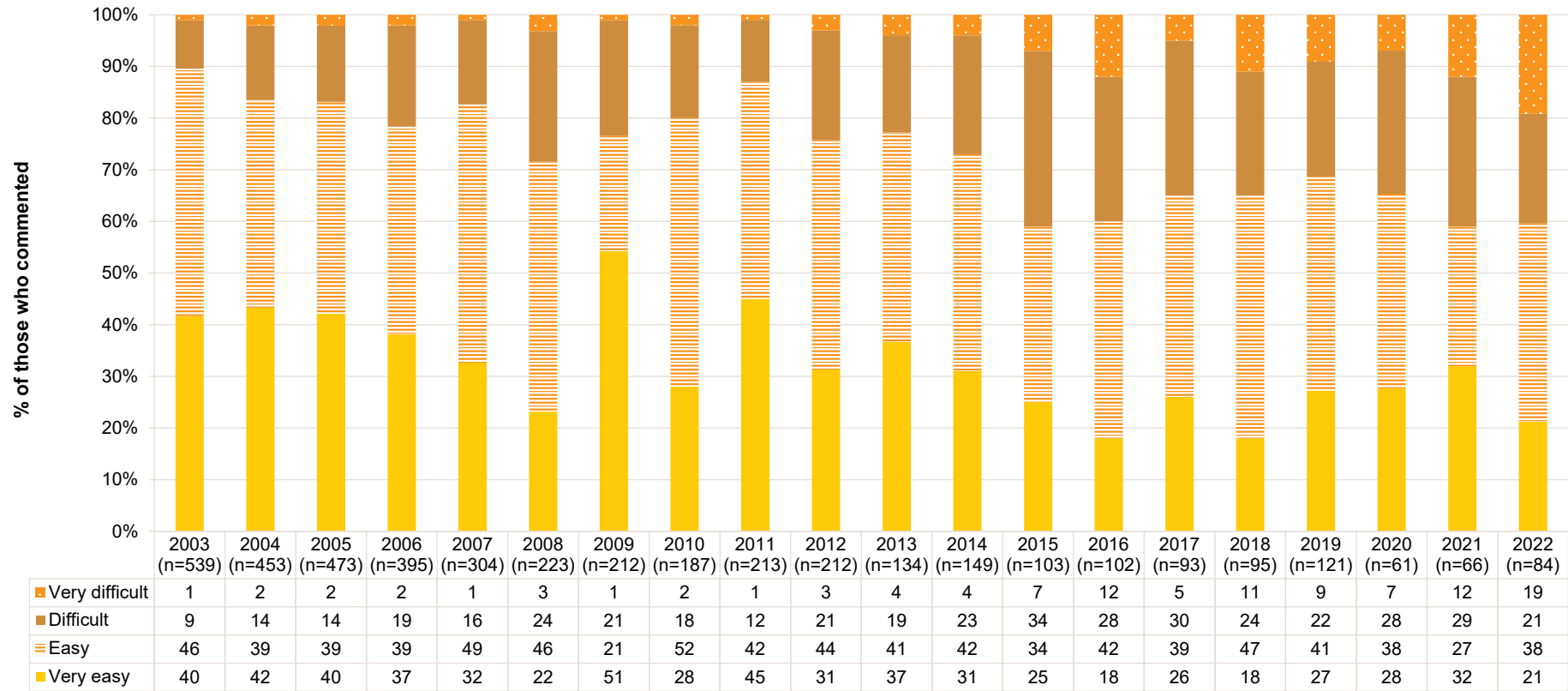
Note. The response 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size (n≤5 but not 0). Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



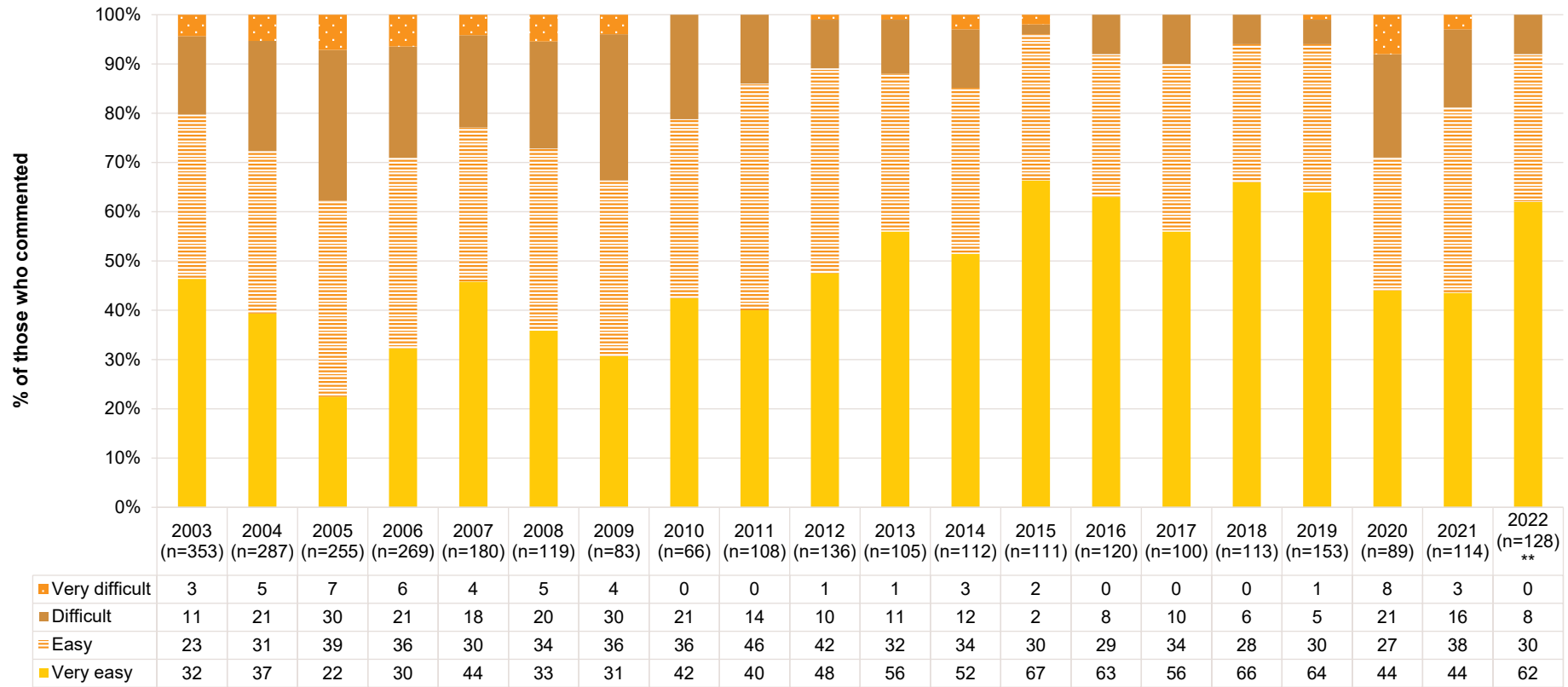
Note. The response 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size (n≤5 but not 0). Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



Note. The response '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 figure; *p<0.050; **p<0.010; ***p<0.001.

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



Note. The response '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 figure; *p<0.050; **p<0.010; ***p<0.001.

5

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)

Whilst recent cocaine use has gradually increased over the years, past six month use remained stable in 2022 (79%) relative to 2021 (80%; $p=0.606$) (Figure 24), although a significant decrease was observed in the Canberra sample (76%; 91% in 2021; $p=0.006$) (Table 10).

Frequency of Use

Of those who had recently consumed cocaine and commented in 2022 ($n=554$), participants reported a median of 5 days of use in the six months preceding interview (IQR=3-12; 5 days in 2021; IQR=2-10; $n=618$; $p=0.036$) (Figure 24), equivalent to less than monthly use. One-tenth (11%) of those who had recently used cocaine reported weekly or more frequent use, a significant increase from 7% in 2021 ($p=0.009$).

Routes of Administration

Among participants who had recently consumed cocaine and commented ($n=554$), the vast majority reported snorting as a route of administration (99%; 98% in 2021; $p=0.334$), with fewer participants reporting swallowing (10%; 9% in 2021; $p=0.543$).

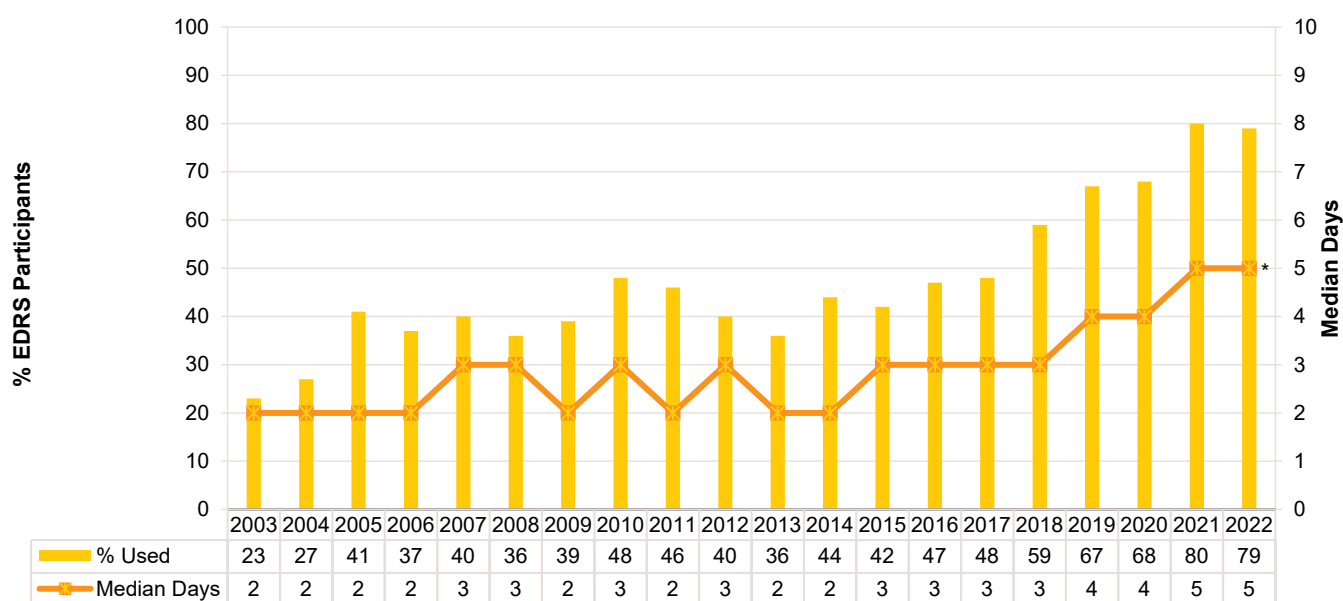
Quantity

Among those who reported recent use and responded ($n=345$), the median amount used in a 'typical' session was 0.50 grams (IQR=0.30-1.00; 0.50 grams in 2021; IQR=0.30-1.00; $p=0.009$). Of those who reported recent use and responded ($n=358$), the median maximum amount used was 1.00 gram (IQR=0.50–1.80; 1.00 gram in 2021; IQR=0.50-1.10; $p=0.001$).

Forms used

Among participants who had recently consumed cocaine and commented ($n=552$), the majority reported using powder cocaine (95%; 96% in 2021; $p=0.773$), with fewer participants reporting use of rock cocaine (9%; 13% in 2021; $p=0.070$) and crack cocaine (1%; 0% in 2021; $p=0.121$).

Figure 24: Past six month use and frequency of use of cocaine, nationally, 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 10 days to improve visibility of trends. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Table 10: Past six month use of cocaine, by capital city, 2003-2022

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2003	46	26	35	7	37	17	-	18
2004	46	34	48	10	26	16	16	21
2005	55	44	63	20	49	35	11	41
2006	45	44	55	33	31	29	-	36
2007	62	46	54	35	36	27	-	41
2008	51	45	51	35	20	40	-	30
2009	64	44	48	31	20	24	23	55
2010	59	58	54	49	42	26	~	51
2011	59	43	43	39	45	32	~	52
2012	57	37	54	26	37	31	~	34
2013	42	38	46	17	35	34	34	40
2014	67	51	58	22	45	30	39	42
2015	61	41	46	17	45	29	52	39
2016	70	44	56	24	57	38	42	41
2017	62	48	53	24	60	31	57	50
2018	71	75	84	42	55	47	40	60
2019	83	75	80	38	71	47	74	67
2020	84	89	76	61	69	48	59	61
2021	94	91	90	84	78	59	71	73
2022	86	76**	91	78	78	66	~	80

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. - Per cent suppressed due to low numbers ($n \leq 5$ but not 0). Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Price, Perceived Purity and Perceived Availability

Price

Participants reported a median price of \$350 per gram (IQR=300-350; n=301), stable from 2021 (\$350 in 2021; IQR=300-350; n=310; $p=0.316$) but remaining higher than reported in 2003-2020 (Figure 25).

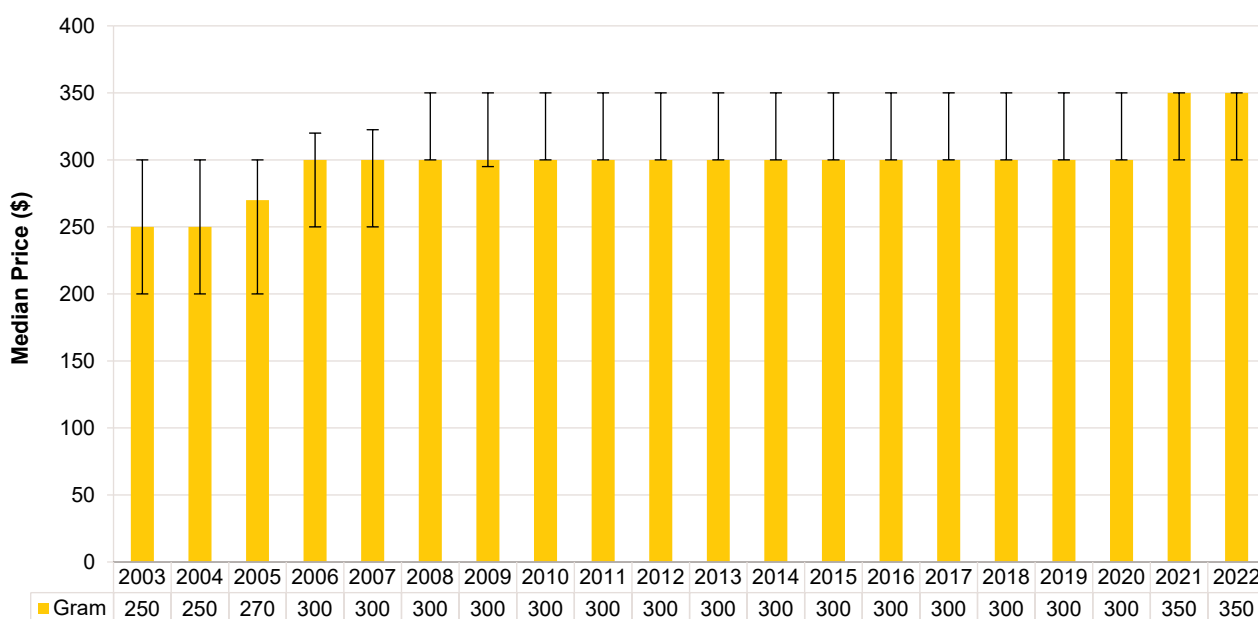
Perceived Purity

Among those able to comment in 2022 (n=464), perceived purity remained stable relative to 2021 ($p=0.527$). Equal percentages reported purity as being 'low' (30%; 28% in 2021) or 'medium' (30%; 33% in 2021), with almost one-quarter (23%) reporting purity to be 'fluctuating' (20% in 2021) (Figure 26).

Perceived Availability

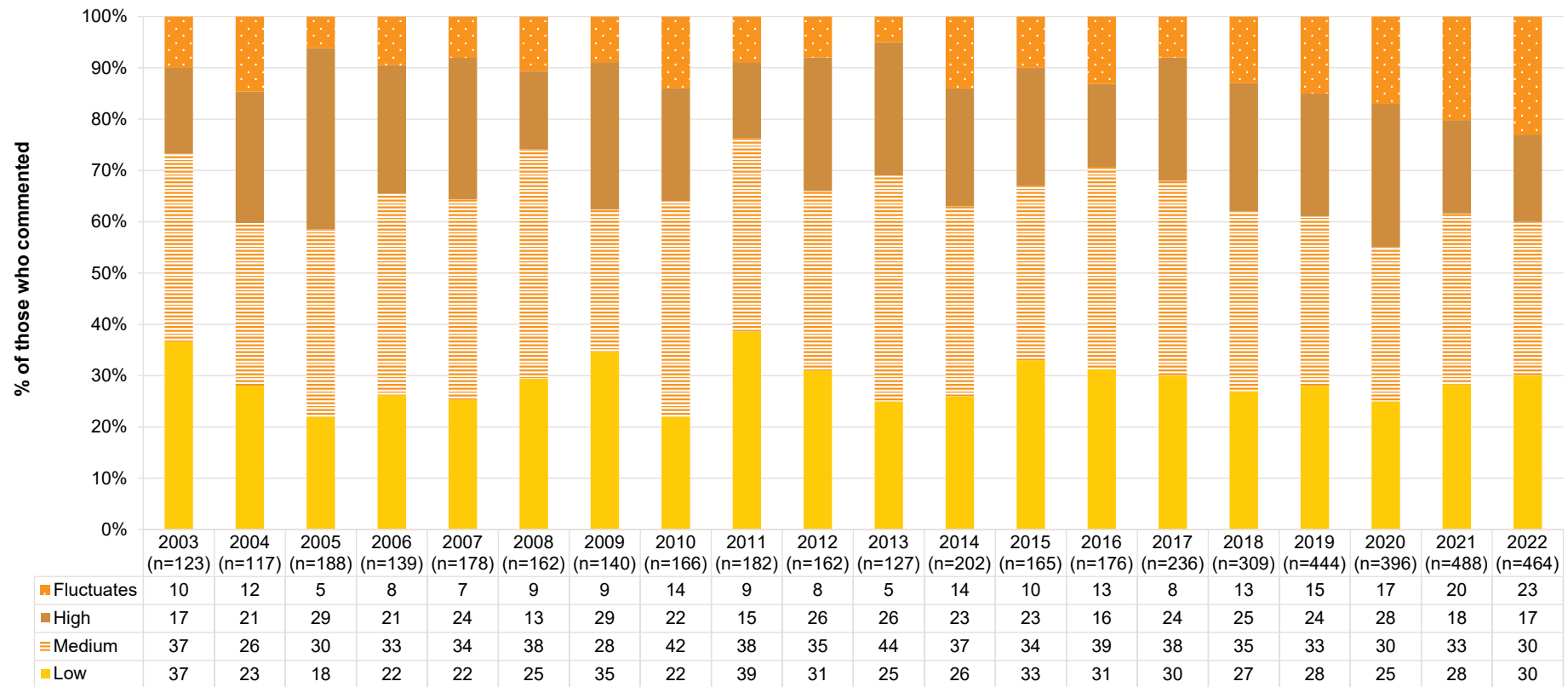
Among those able to comment in 2022 (n=471), perceived availability remained stable relative to 2021 ($p=0.725$). Forty-five per cent of participants reported cocaine to be 'easy' to obtain in 2022 (44% in 2021), with a further one-third (34%) reporting availability as 'very easy' (33% in 2021). Almost one-fifth (18%) reported cocaine as being 'difficult' to obtain in 2022 (21% in 2021) (Figure 27).

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



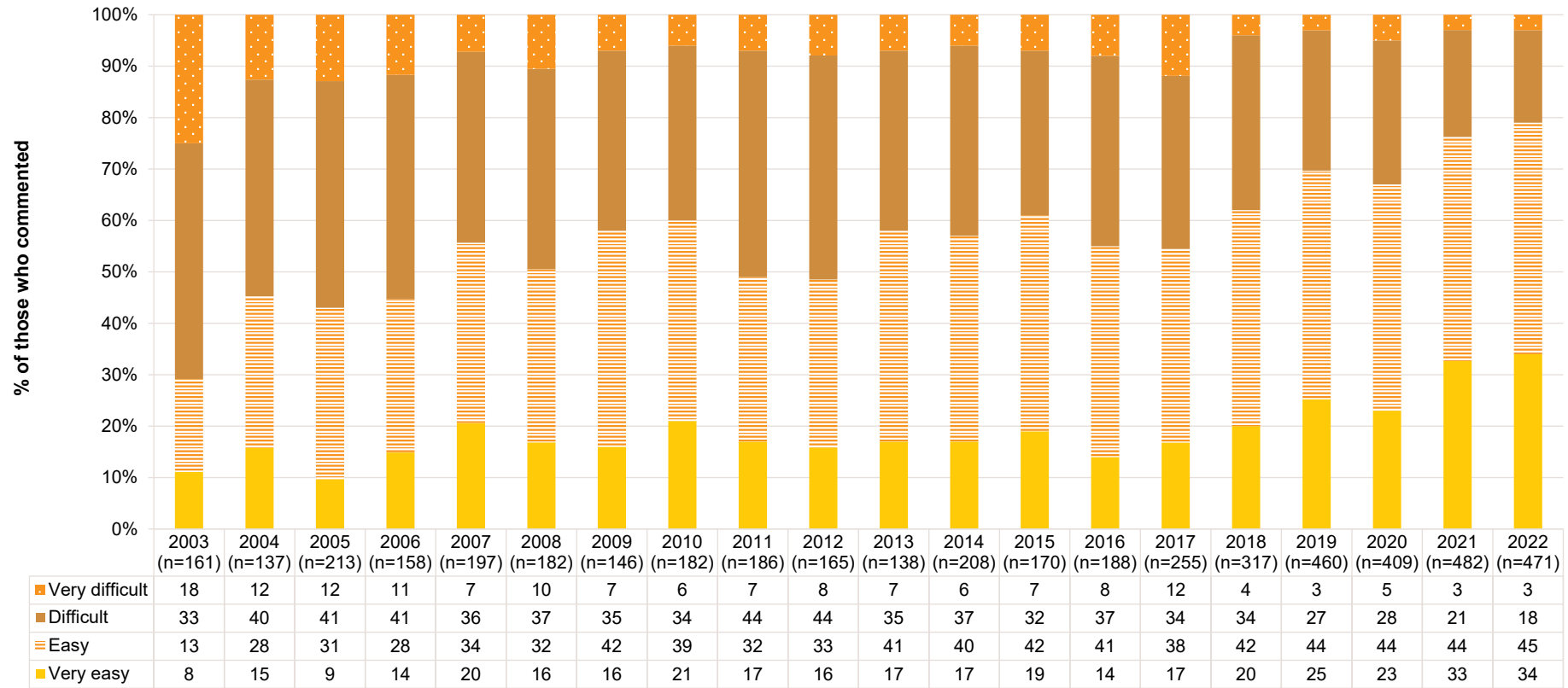
Note. Among those who commented. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; * $p<0.050$; ** $p<0.010$; *** $p<0.001$.

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



Note. The response '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 figure; *p<0.050; **p<0.010; ***p<0.001.

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



Note. The response '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 figure; *p<0.050; **p<0.010; ***p<0.001.

6

Cannabis and/or Cannabinoid Related Products

Participants were asked about their recent (past six month) use of indoor-cultivated cannabis via a hydroponic system ('hydroponic') 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 cannabinoids related products obtained by a prescription in the person's name; **non-prescribed use**: use of cannabis and/or cannabinoids 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 cannabinoids related products obtained through either of the above means.

Patterns of Consumption

In 2022, participants were asked 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); few participants (4%; n=29) reported prescribed use in the six months preceding interview.

In this chapter, data from 2021 and 2022, and from 2000-2016, 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)

In 2022, 79% of the national sample reported recent use of non-prescribed cannabis and/or cannabinoid related products, a significant decrease from 2021 (84%; $p=0.026$), and the lowest percentage observed since 2008 (Figure 28). This appears to have been largely driven by a decrease in the Sydney sample (71%; 88% in 2021; $p=0.006$), with use in all other capital city samples remaining stable (Table 11).

Frequency of Use

Typical frequency of use has varied between weekly and several times a week over the course of monitoring. Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented (n=553), participants reported a median of 48 days of use (IQR=10-160) in 2022, stable relative to 2021 (48 days; IQR=10-170; n=646; $p=0.839$) (Figure 28). Sixty-four per cent of those who had recently used non-prescribed cannabis reported weekly or more frequent use, unchanged from 2021 (64%; $p=0.954$), including one-fifth (22%; n=123) who reported daily use (24% in 2021; $p=0.444$).

Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented (n=553), the majority (92%) reported smoking as a route of administration (95% in 2021; $p=0.012$). One-third (35%) reported swallowing (34% in 2021; $p=0.631$) and almost one-quarter (24%) reported inhaling/vaporising non-prescribed cannabis (24% in 2021).

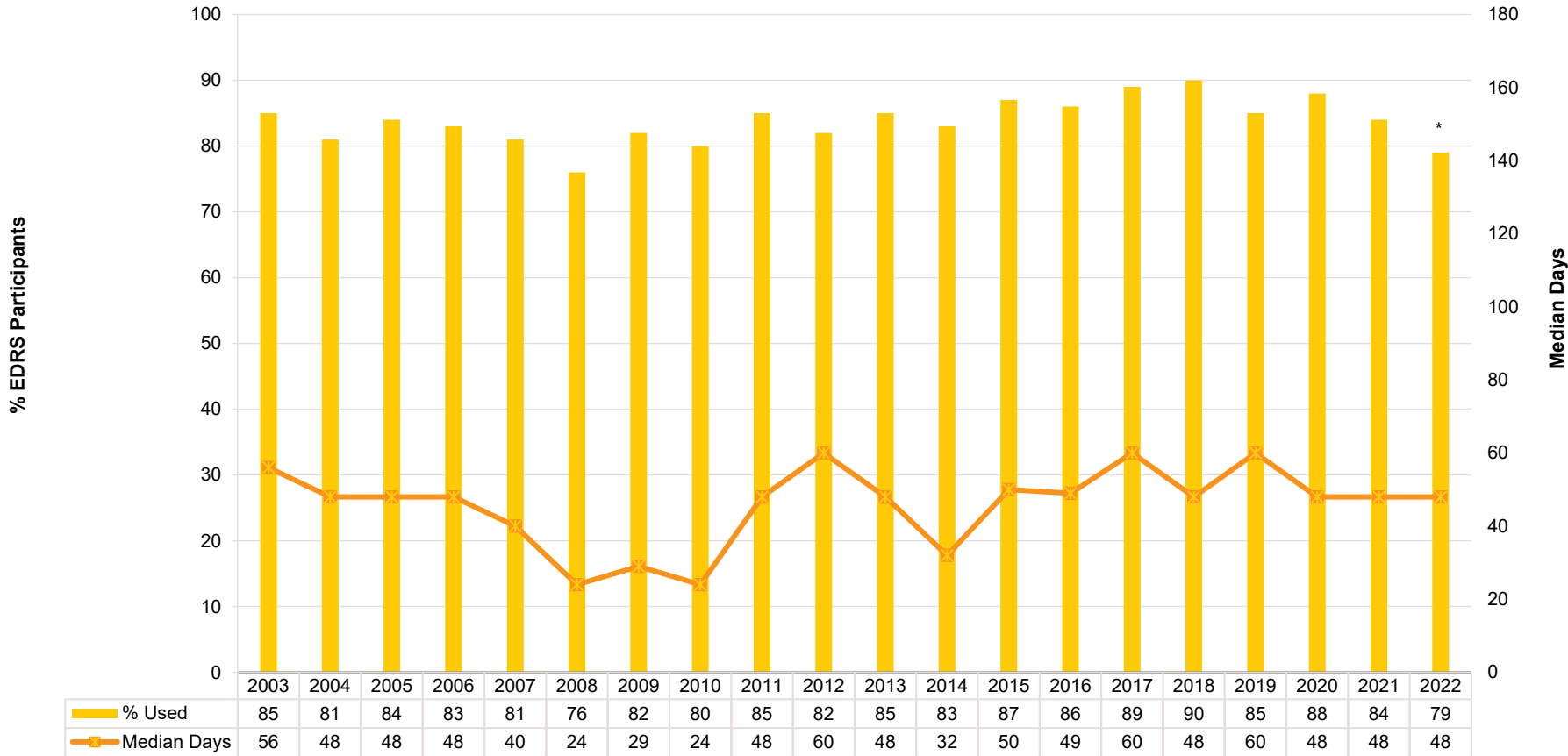
Quantity

Of those who reported recent non-prescribed use, the median 'typical' amount used on the last occasion of use was 1.00 gram (IQR=0.50-2.00; n=182; 1 gram in 2021; IQR=0.50-2.00; $p=0.950$), 2 cones (IQR=1-4; n=141; 2 cones in 2021; IQR=1-4; $p=0.883$) or 1 joint (IQR=0.5-1; n=170; 1 joint in 2021; IQR=0.5-1.5; $p=0.886$).

Forms Used

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented (n=499), the majority reported recent use of hydroponic cannabis (70%; 71% in 2021; $p=0.643$) and almost three-fifths (58%) reported recent use of outdoor-grown 'bush', a significant decrease relative to 2021 (67%; $p=0.001$). In 2022, 9% of participants reported they had used hash (11% in 2021; $p=0.239$) and 8% had used hash oil (11% in 2021; $p=0.087$) in the preceding six months. Eleven per cent of participants reported recent use of (non-prescribed) CBD extract in 2022 (10% reported use of CBD oil in 2021; $p=0.379$), and 13% reported use of THC extract. Use of THC extract was not asked in 2021.

Figure 28: Past six month use and frequency of use of non-prescribed cannabis, nationally, 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. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. 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 figure; *p<0.050; **p<0.010; ***p<0.001.

Table 11: Past six month non-prescribed use of cannabis and cannabinoid products, by capital city, 2003-2022

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2003	82	82	82	90	88	91	95	73
2004	85	83	78	91	81	84	87	70
2005	82	81	88	89	87	83	79	83
2006	73	83	79	82	83	85	84	92
2007	74	85	82	68	80	80	96	87
2008	71	86	84	74	74	85	40	81
2009	83	89	85	76	86	85	60	84
2010	78	89	89	72	84	81	~	72
2011	83	89	86	67	92	86	~	93
2012	86	92	85	69	88	77	~	81
2013	90	87	87	78	85	92	73	84
2014	85	74	81	76	87	86	84	87
2015	91	82	90	80	92	86	82	93
2016	85	85	86	77	97	87	82	86
2017	93	95	88	84	89	82	88	93
2018	91	88	84	94	85	86	93	95
2019	81	81	86	88	82	86	83	92
2020	91	85	89	84	90	87	91	90
2021	88	86	84	75	84	82	83	89
2022	71**	81	82	81	75	84	~	76

Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Price, Perceived Potency and Perceived Availability

Hydroponic Cannabis

Price: The median price per gram of non-prescribed hydroponic cannabis nationally in 2022 was \$20 (IQR=15-20; n=54; \$20 in 2021; IQR=17-28; n=39; $p=0.022$). The median price paid per ounce of non-prescribed hydroponic cannabis nationally was \$300 (IQR=250-400; n=77), stable relative to 2021 (\$330; IQR=250-400; n=86; $p=0.550$) (Figure 29A).

Perceived Potency: Among those that were able to comment in 2022 (n=302), the perceived potency of non-prescribed hydroponic cannabis remained stable relative to 2021 ($p=0.240$). The majority (56%) of participants reported potency to be 'high' (62% in 2021), and almost one-quarter (23%) reported potency to be 'medium', unchanged from 2021 (23%) (Figure 30A).

Perceived Availability: Among those that were able to comment in 2022 (n=304), the perceived availability of non-prescribed hydroponic cannabis remained relatively stable relative to 2021 ($p=0.050$). The majority (64%) of participants reported non-prescribed hydroponic cannabis to be 'very easy' to obtain (56% in 2021), and 29% reported that it was 'easy' to obtain (33% in 2021) (Figure 31A).

Bush Cannabis

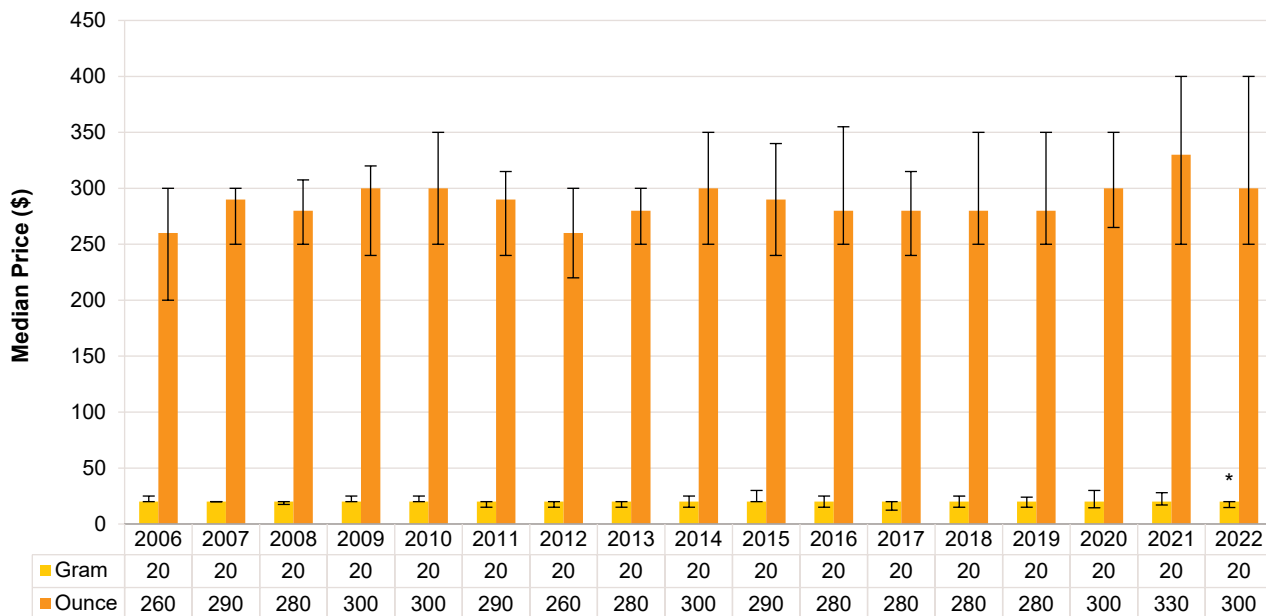
Price: The median price per gram of non-prescribed bush cannabis remained stable in 2022 at \$17 (IQR=12-20; n=46; \$20 in 2021; IQR=15-28; n=27; $p=0.109$). The median price for an ounce of non-prescribed bush cannabis also remained stable in 2022, at a median of \$250 (IQR=230-300; n=55; \$250 in 2021; IQR=200-320; n=69; $p=0.814$) (Figure 29B).

Perceived Potency: Among those that were able to comment in 2022 (n=231), the perceived potency of non-prescribed bush cannabis significantly changed relative to 2021 ($p=0.041$). Specifically, there was a decrease in the percentage of participants who reported potency as 'medium' (37%; 49% in 2021), and an increase in those perceiving potency as 'low' (17%; 13% in 2021) or 'fluctuating' (13%; 8% in 2021). Almost one-third (32%) perceived potency to be 'high', unchanged from 30% in 2021 (Figure 30B).

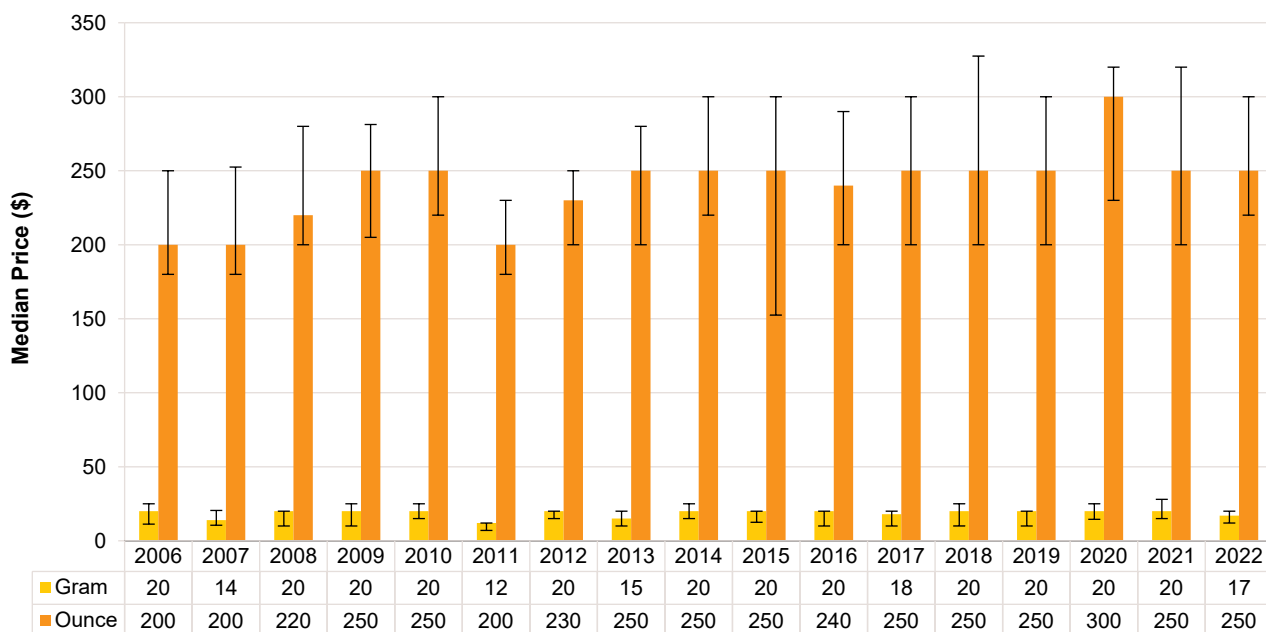
Perceived Availability: Among those that were able to comment in 2022 (n=234), the perceived availability of non-prescribed bush cannabis significantly changed relative to 2021 ($p=0.043$). Specifically, in 2022, more participants perceived non-prescribed bush cannabis as being 'easy' to obtain (32%; 26% in 2021), while fewer perceived it as being 'difficult' (13%; 16% in 2021) or 'very difficult' (1%; 5%) to obtain. The majority of participants, however, perceived non-prescribed bush cannabis as being 'very easy' to obtain, unchanged from 2021 (53%, respectively) (Figure 31B).

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

(A) Hydroponic cannabis



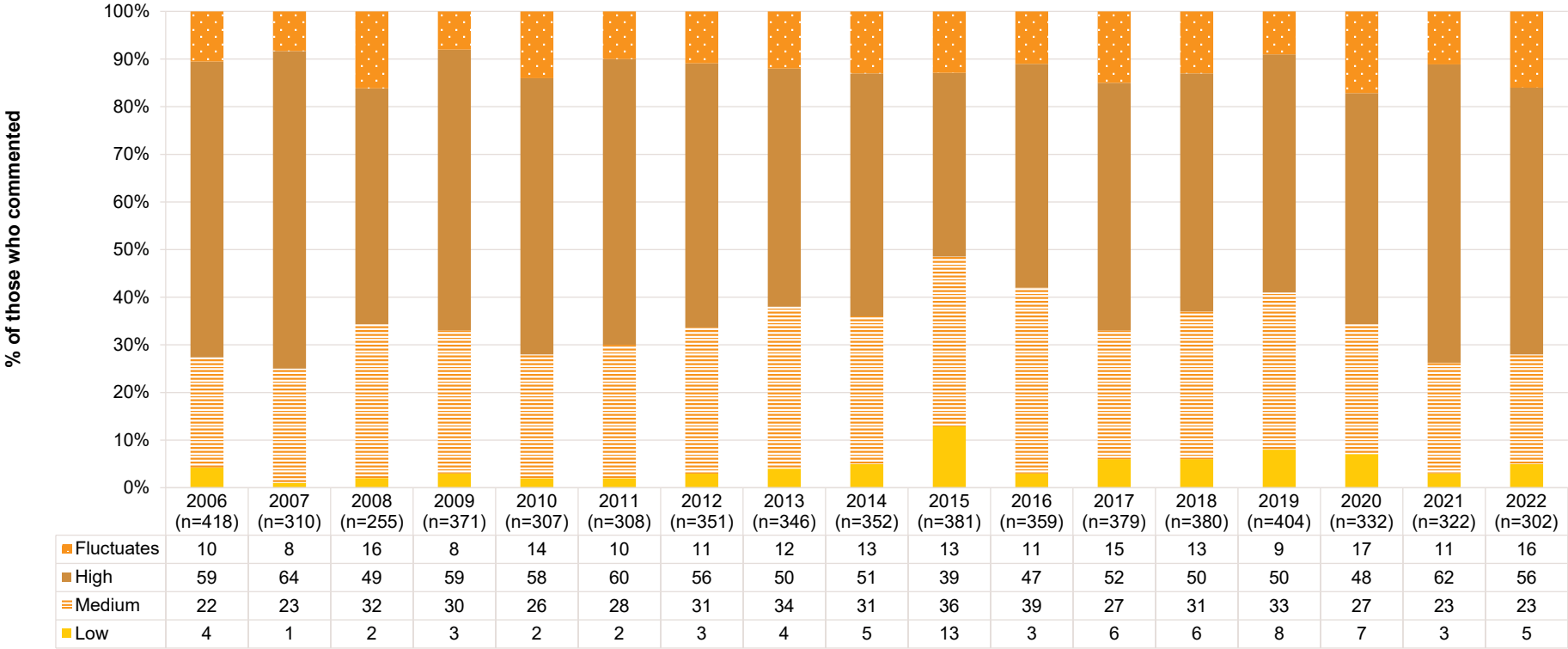
(B) Bush cannabis



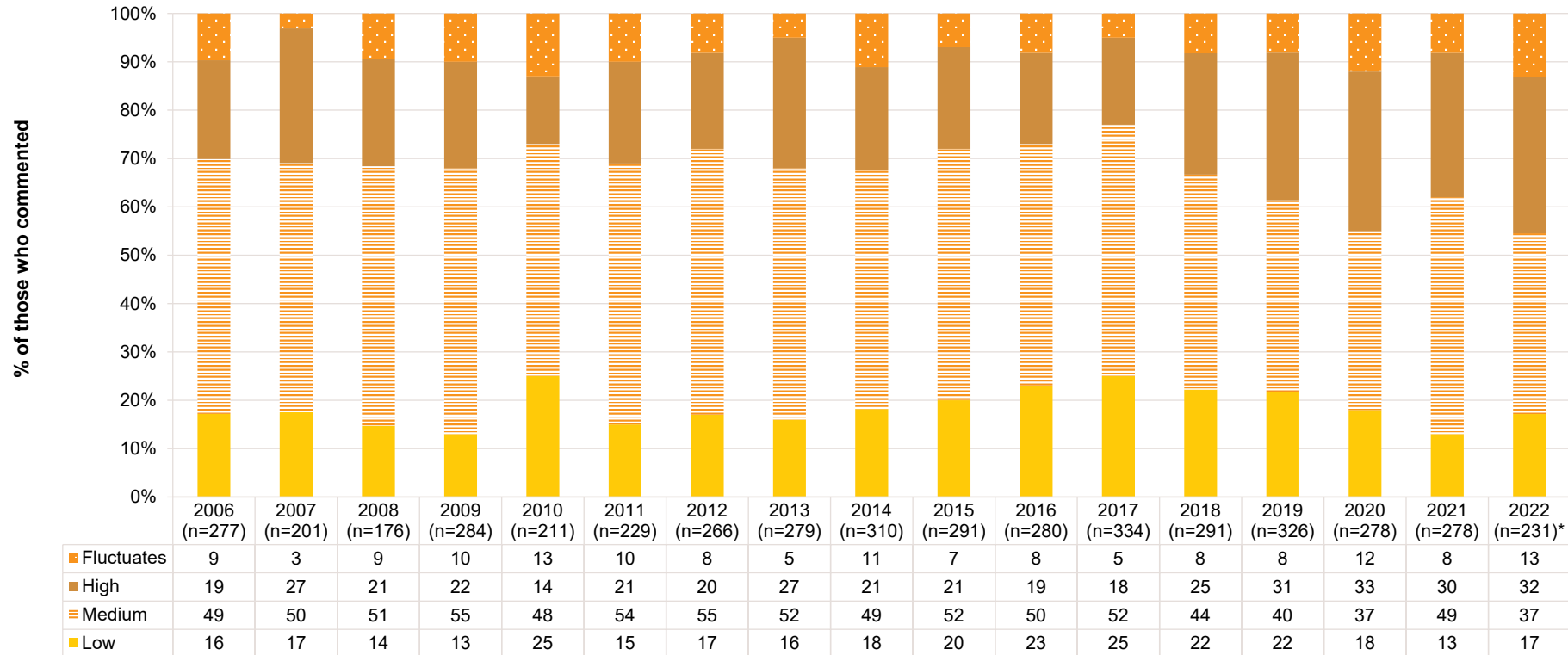
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. The error bars represent the IQR. Data from 2022 onwards refers to non-prescribed cannabis only. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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

(A) Hydroponic cannabis



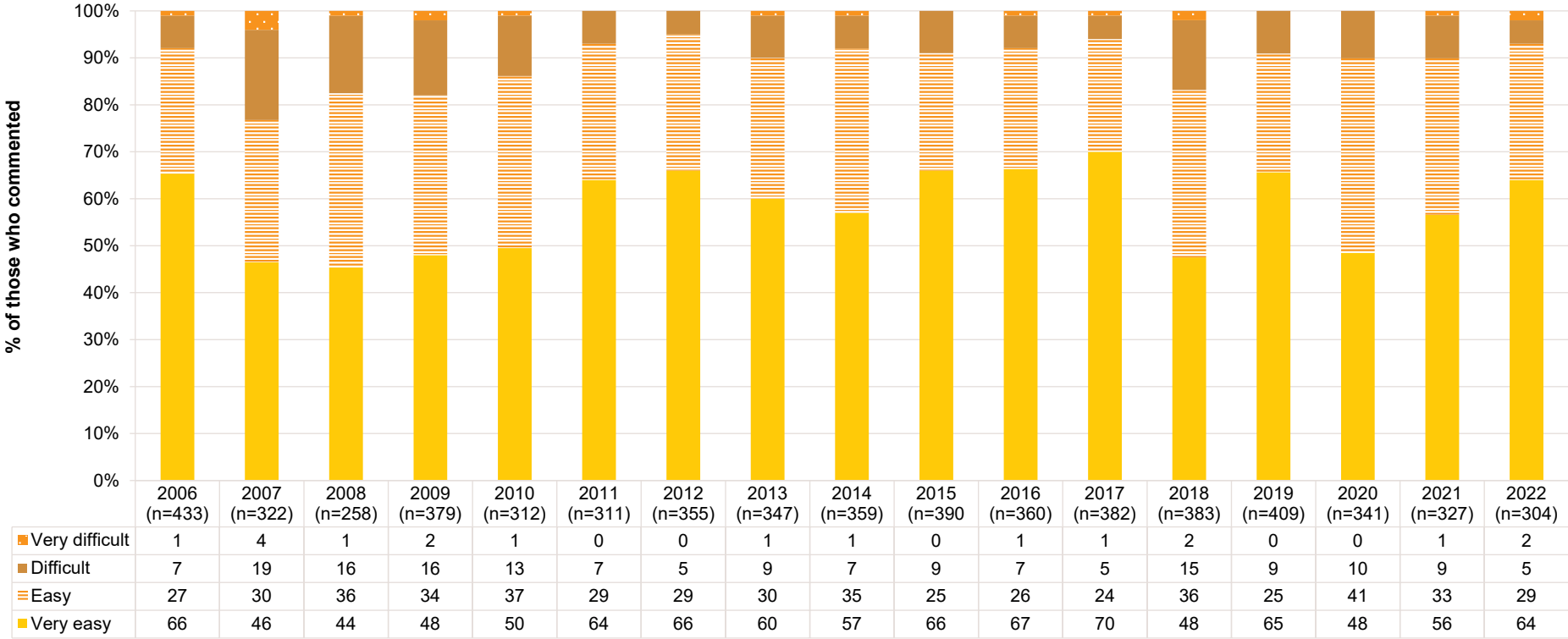
(B) Bush cannabis



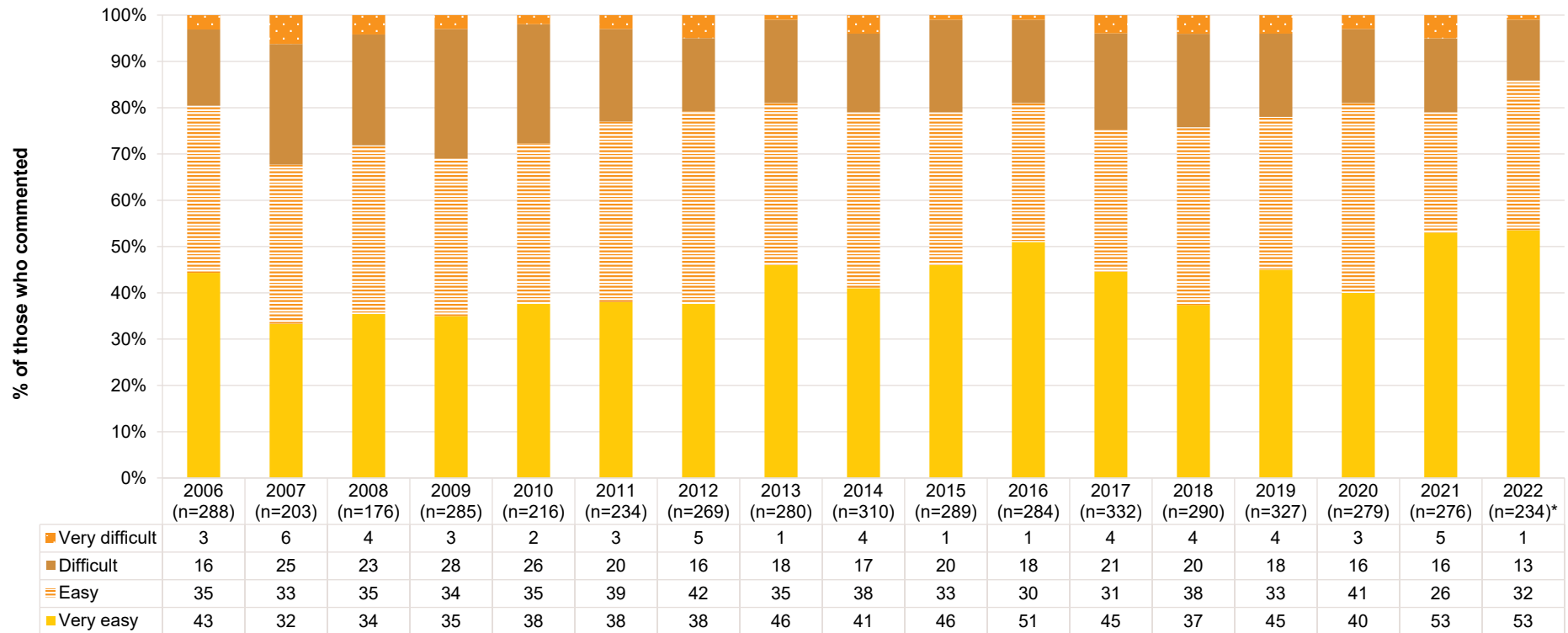
Note. The response option 'Don't know' was excluded from analysis. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. – Per cent suppressed due to small cell size (n≤5 but not 0). Statistical significance for 2021 versus 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, nationally, 2006-2022

(A) Hydroponic cannabis



(B) Bush cannabis



Note. The response option 'Don't know' was excluded from analysis. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. – Per cent suppressed due to small cell size (n≤5 but not 0). Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

7

Ketamine, LSD and DMT

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

Ketamine

Patterns of Consumption

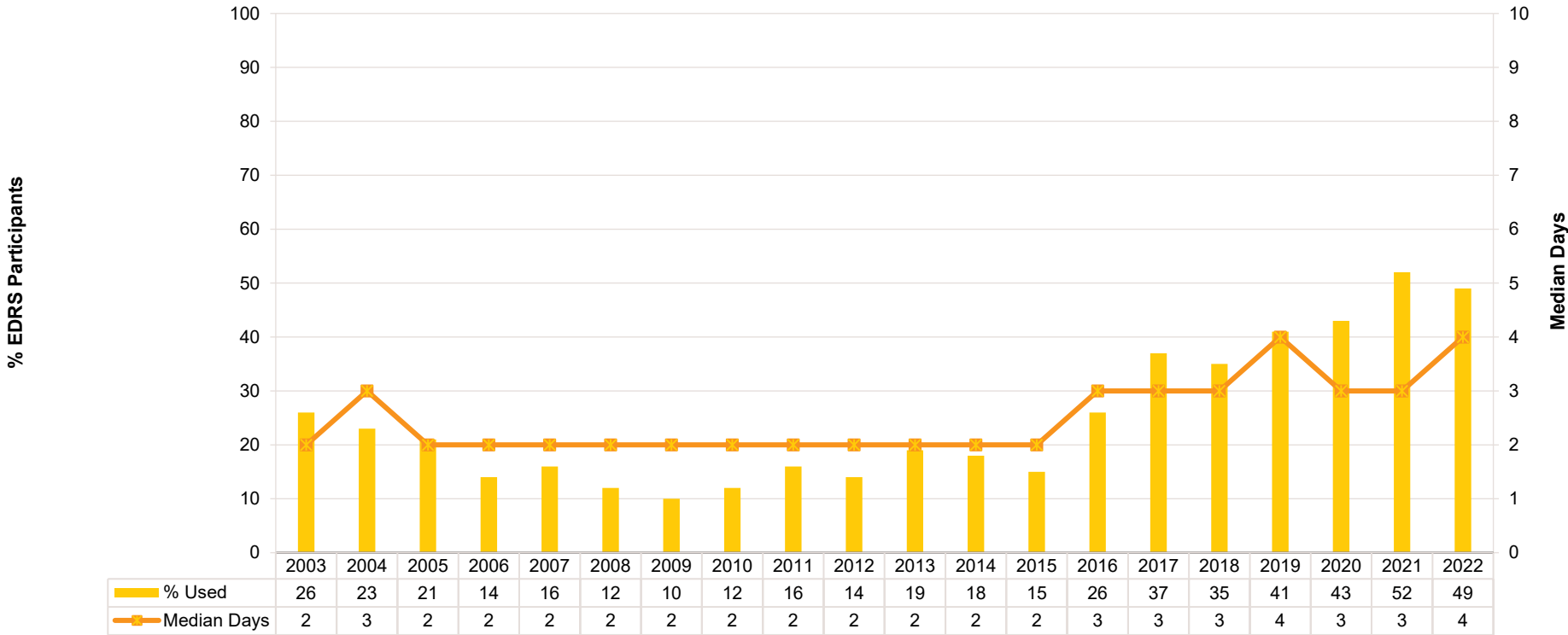
Recent Use (past 6 months): The per cent of the sample reporting any recent use of ketamine declined from the beginning of monitoring to 2009, with an increase observed from then onwards. In 2022, almost half (49%) of the national sample reported recent use, stable from 2021 (52%; $p=0.180$) (Figure 32). Use remained stable across all capital cities, except Sydney, in which there was a significant decrease in 2022 (56%) relative to 2021 (76%; $p=0.005$), returning to similar levels of use observed in 2016-2020 (Table 12).

Frequency of Use: Of those who had recently consumed ketamine and commented in 2022 ($n=341$), frequency of use remained stable at a median of 4 days in the six months preceding interview (IQR=2-10; 3 days in 2021; IQR=2-8; $n=404$; $p=0.257$) (Figure 32), with 7% reporting weekly or more frequent use (7% in 2021; $p=0.882$).

Routes of Administration: Among participants who had recently consumed ketamine and commented ($n=342$), the most common route of administration was snorting (95%; 96% in 2021; $p=0.737$) followed by swallowing (7%; 5% in 2021; $p=0.206$). Smaller percentages ($n\leq 5$) reported smoking and shelving/shafting; therefore, numbers are suppressed.

Quantity: Among those who reported recent use and responded ($n=183$), the median amount used in a 'typical' session was 0.30 grams (IQR=0.20-0.50; 0.30 grams in 2021; IQR=0.20-0.50; $p=0.676$). Of those who reported recent use and responded ($n=189$), the median maximum quantity used was 0.50 grams (IQR=0.30-1.00; 0.50 grams in 2021; IQR=0.30-1.00; $p=0.382$).

Figure 32: Past six month use and frequency of use of ketamine, nationally, 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 10 days to improve visibility of trends. – 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 figure; *p<0.050; **p<0.010; ***p<0.001.

Table 12: Past six month use of ketamine, by capital city, 2003-2022

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2003	49	21	51	24	36	12	7	14
2004	39	15	45	-	39	10	18	16
2005	39	17	35	11	24	11	7	20
2006	27	15	29	6	11	-	-	12
2007	36	10	25	14	26	-	-	-
2008	30	6	20	6	20	-	0	-
2009	19	-	21	-	19	6	0	6
2010	24	6	23	6	13	-	~	8
2011	39	14	26	8	8	0	~	-
2012	24	14	35	-	10	-	~	7
2013	24	33	46	9	6	7	-	13
2014	23	6	63	14	-	11	15	-
2015	24	9	50	-	-	-	18	-
2016	50	20	72	-	15	18	11	22
2017	50	49	80	17	48	16	11	21
2018	54	29	90	23	24	22	11	28
2019	68	33	84	17	33	25	39	27
2020	53	47	78	52	32	31	24	28
2021	76	51	81	46	28	41	55	37
2022	56**	39	88	38	29	39	~	51

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

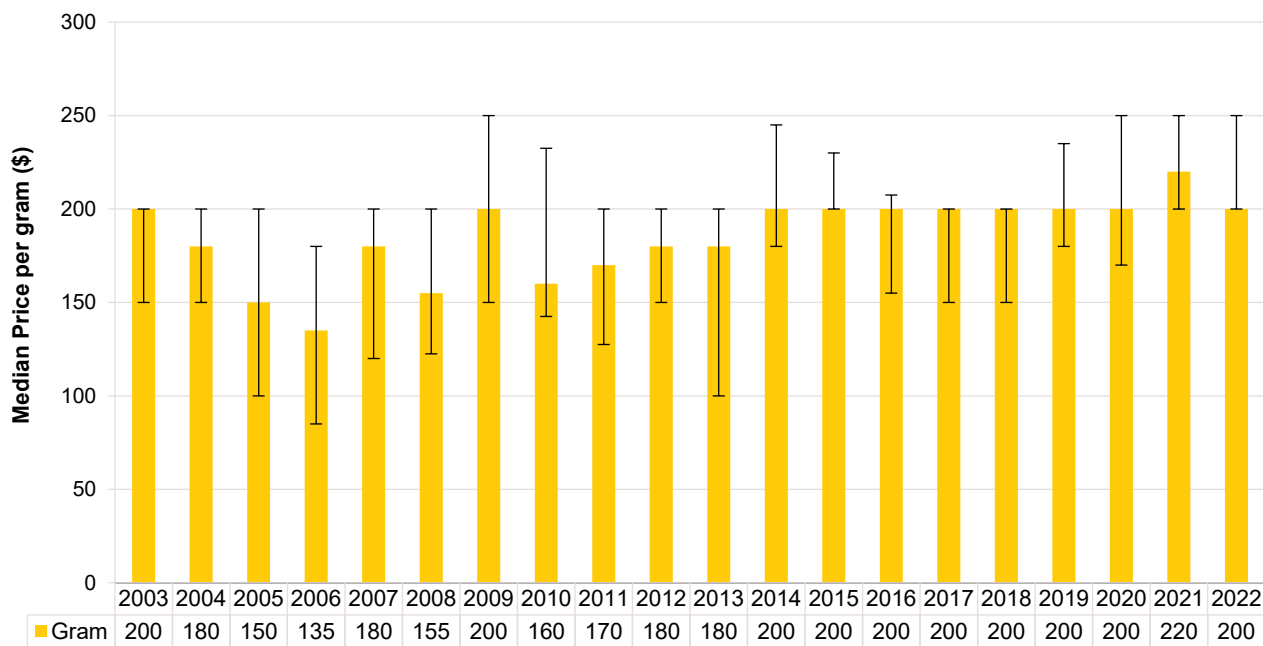
Price, Perceived Purity and Perceived Availability

Price: In 2022, participants reported a median price of \$200 (IQR=200-250; $n=163$) per gram of ketamine, stable relative to 2021 (\$220; IQR=200-250; $n=157$; $p=0.497$) (Figure 33).

Perceived Purity: Among those able to comment in 2022 ($n=251$), the perceived purity of ketamine remained stable relative to 2021 ($p=0.349$). Fifty-five per cent of participants perceived purity as being 'high', unchanged from 2021 (55%), and one-quarter (25%) reported 'medium' perceived purity, also unchanged from 2021 (25%) (Figure 34).

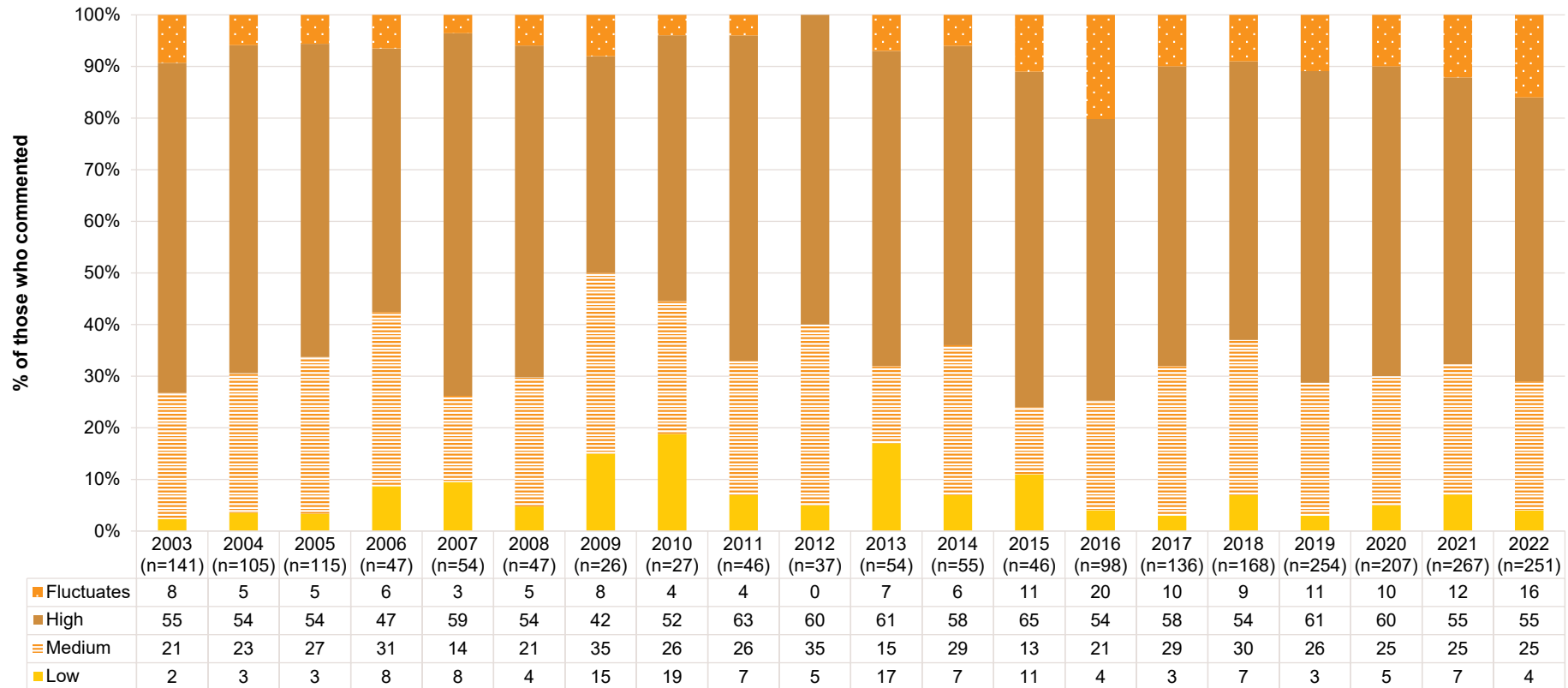
Perceived Availability: Of those able to comment in 2022 ($n=256$), the perceived availability of ketamine significantly changed relative to 2021 ($p=0.022$). Two-fifths (43%) perceived ketamine to be 'easy' to obtain, an increase from 34% in 2021. Conversely, 14% perceived ketamine to be 'very easy' to obtain, a decrease from 24% in 2021 (Figure 35).

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



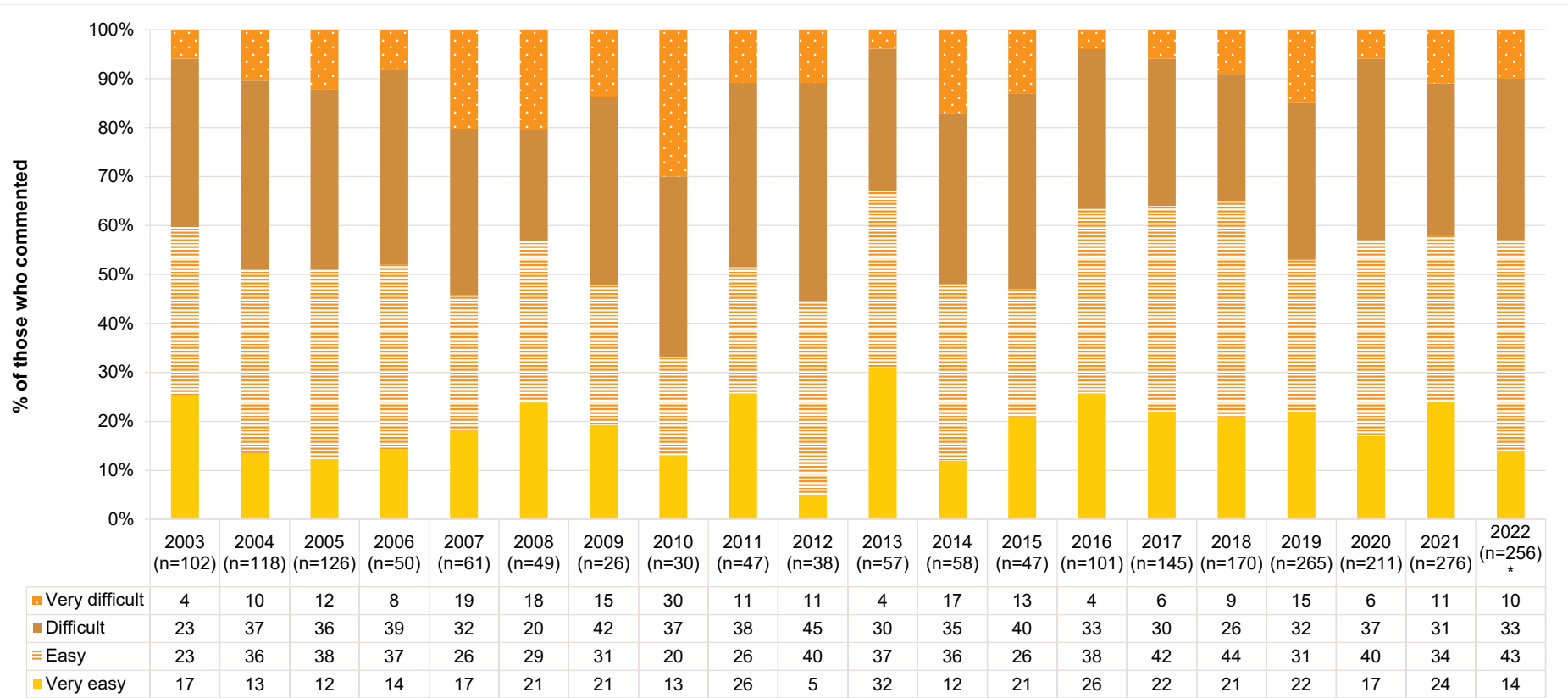
Note. Among those who commented. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



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

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



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

LSD

Patterns of Consumption

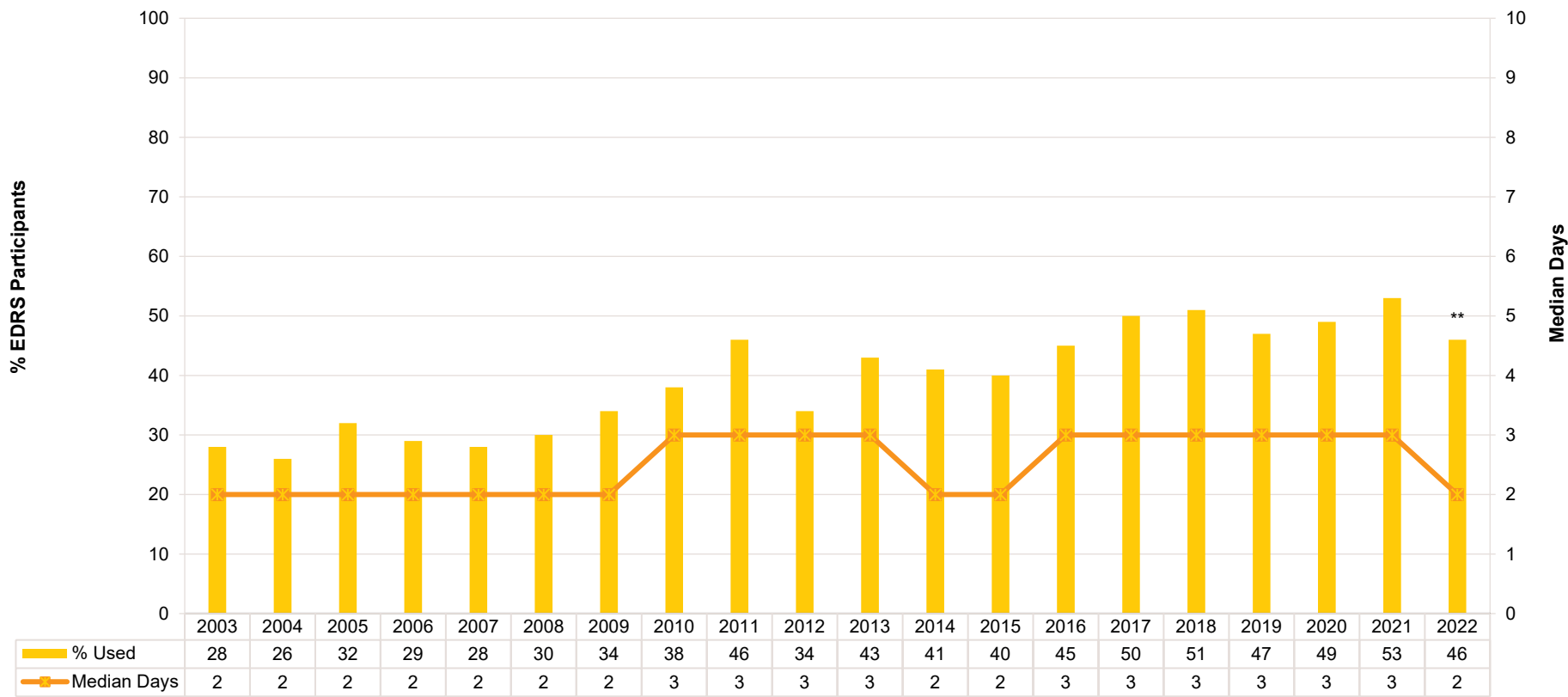
Recent Use (past 6 months): The per cent reporting any recent use of LSD gradually increased between 2003 and 2016, however has remained relatively stable from there on. In 2022, however, there was a significant decrease relative to 2021 (46%; 53% in 2021; $p=0.003$) (Figure 36), which appears to have been largely driven by a significant decrease among the Sydney sample (41%; 57% in 2021; $p=0.040$) (Table 13).

Frequency of Use: Of those who had recently consumed LSD and commented ($n=319$), use was infrequent and stable, with a median of 2 days of use (IQR=1-5) in 2022 (3 days in 2021; IQR=1-6; $n=411$; $p=0.068$) (Figure 36). In addition, 3% of those who had recently used LSD reported weekly or more frequent use (4% in 2021; $p=0.534$).

Routes of Administration: Among participants who had recently consumed LSD and commented ($n=319$), the most common route of administration was swallowing (99%; 100% in 2021; $p=0.324$). Few participants ($n\leq 5$) reported smoking, snorting and shelving/shafting; therefore, numbers are suppressed.

Quantity: Among those who reported recent use and responded ($n=213$), the median amount used in a 'typical' session was one tab (IQR=0.50-1.00; 1 tab in 2021; IQR=0.50-1.00; $p=0.411$). Of those who reported recent use and responded ($n=214$), the median maximum amount used was one tab (IQR=1.00–2.00; 1 tab in 2021; IQR=1.00-2.00; $p=0.328$).

Figure 36: Past six month use and frequency of use of LSD, nationally, 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 10 days to improve visibility of trends.
 – 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 figure; *p<0.050; **p<0.010; ***p<0.001.

Table 13: Past six month use of LSD, by capital city, 2003-2022

%	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2003	27	44	48	24	30	22	25	18
2004	20	23	40	32	36	11	31	18
2005	33	30	38	31	48	35	15	23
2006	17	18	37	29	34	25	41	38
2007	22	24	39	20	33	23	33	28
2008	18	37	29	41	35	21	16	32
2009	37	35	46	34	37	31	11	30
2010	44	41	49	27	35	35	~	38
2011	46	39	57	43	30	36	~	52
2012	43	38	38	30	19	33	~	34
2013	51	53	52	38	25	41	40	41
2014	43	19	49	35	35	45	43	57
2015	60	37	46	41	37	24	32	41
2016	65	40	52	39	30	50	32	55
2017	73	64	52	39	36	33	47	52
2018	71	43	64	41	36	39	52	61
2019	48	42	55	44	43	43	52	53
2020	44	41	61	60	52	43	42	49
2021	57	45	53	63	35	55	59	60
2022	41*	31	57	57	30	54	~	53

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

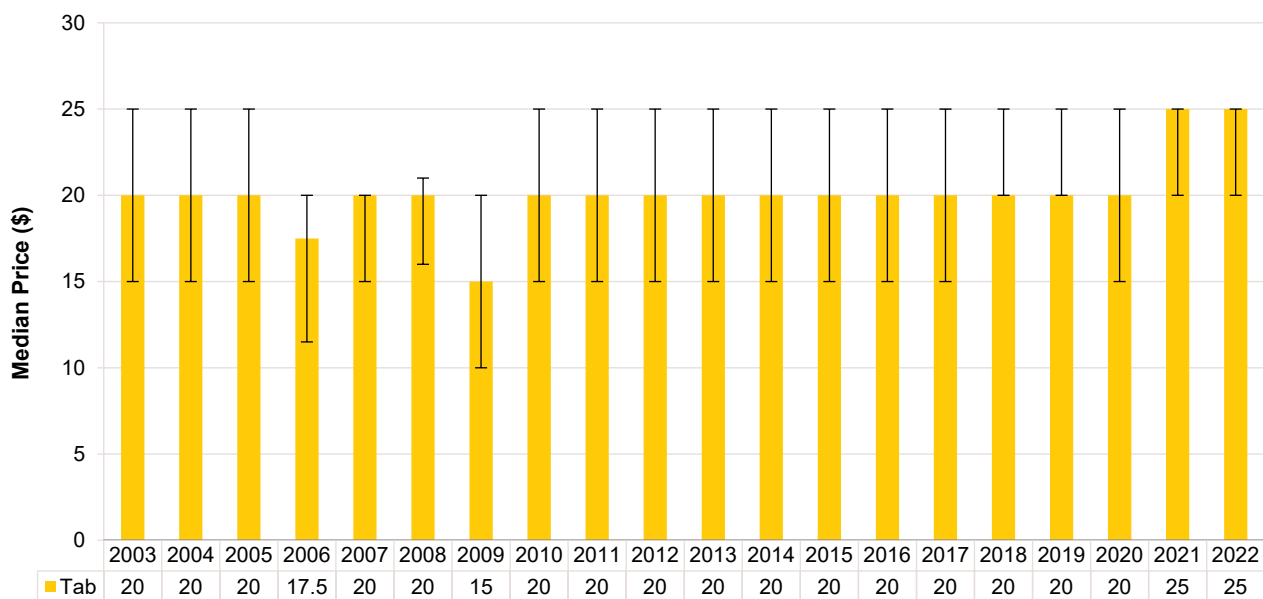
Price, Perceived Purity and Perceived Availability

Price: In 2022, participants reported a median price of \$25 per tab (IQR=20-25; $n=148$), unchanged from \$25 in 2021 (IQR=20-25; $n=189$; $p=0.375$), but higher than reported between 2003 and 2020 (Figure 37).

Perceived Purity: Among those who commented in 2022 ($n=273$), the perceived purity of LSD remained stable relative to 2021 ($p=0.576$). Specifically, three-fifths (60%) reported purity as 'high' (61% in 2021), and one-quarter (23%) reported it as 'medium' (26% in 2021) (Figure 38).

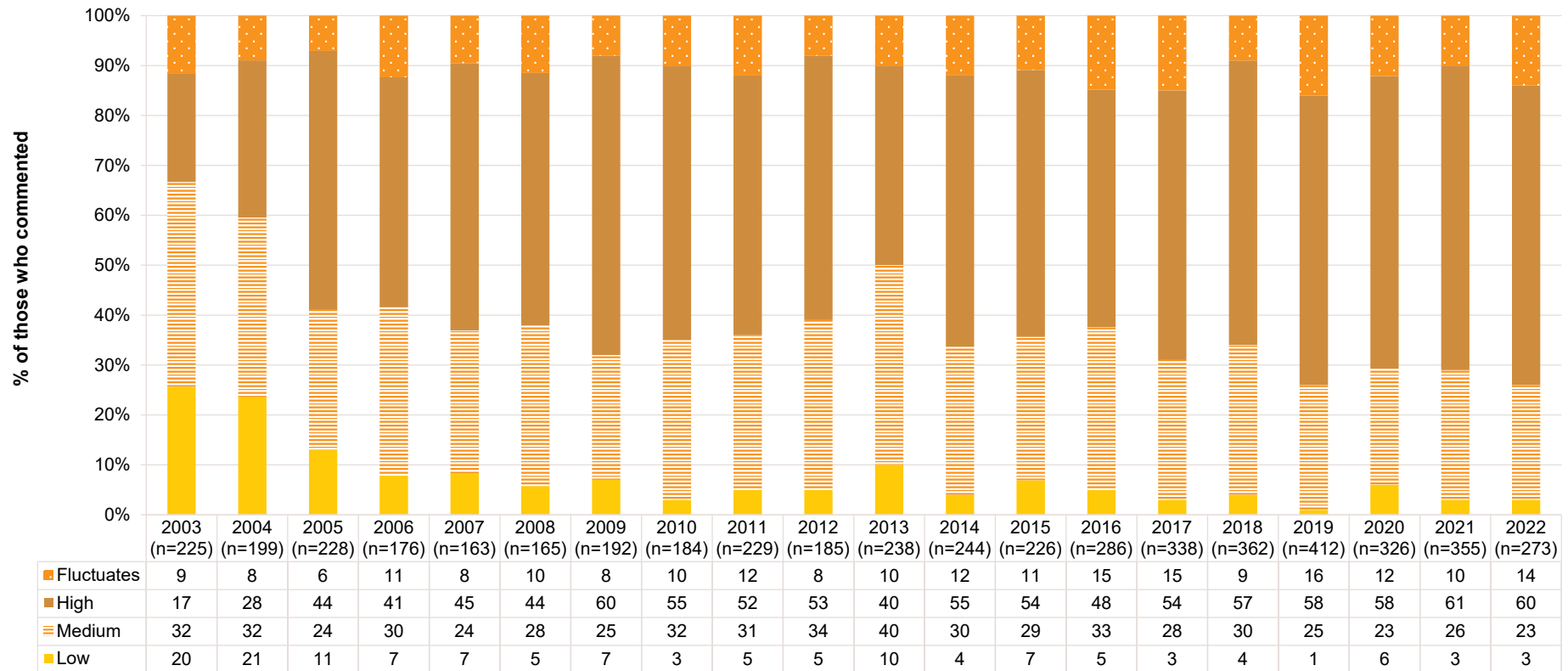
Perceived Availability: Among those able to comment in 2022 ($n=272$), the perceived availability of LSD remained stable relative to 2021 ($p=0.079$). Forty-six per cent perceived LSD to be 'easy' to obtain (44% in 2021), whilst one-quarter (24%) reported LSD to be 'very easy' to obtain (25% in 2021). One-fifth (22%) reported LSD as being 'difficult' to obtain (27% in 2021) (Figure 39).

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



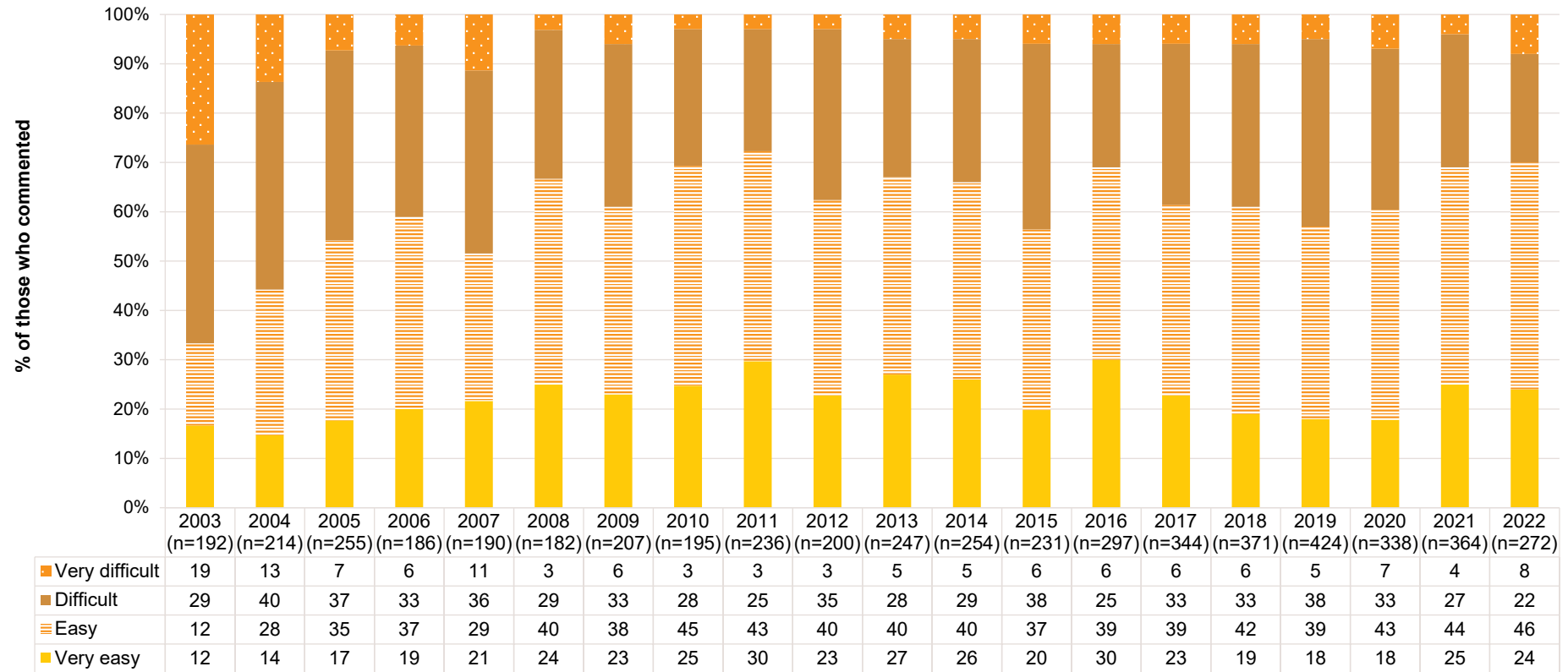
Note. Among those who commented. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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



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

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



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

DMT

Patterns of Consumption

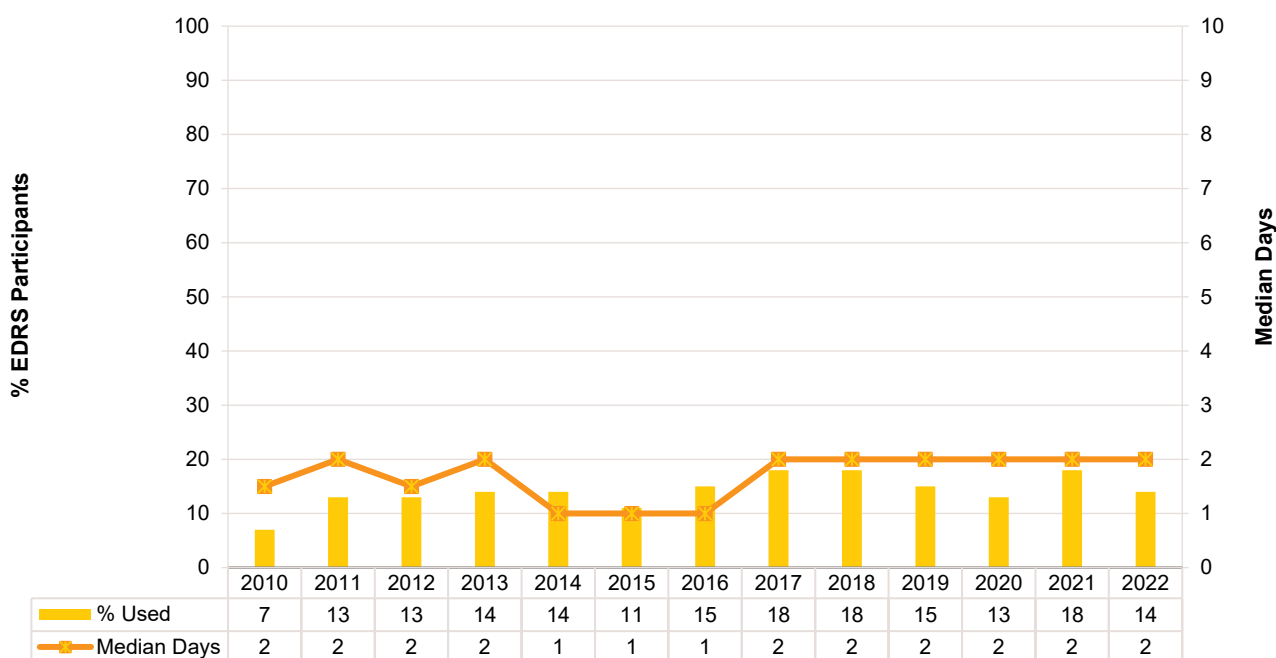
Recent Use (past 6 months): The per cent reporting recent DMT use has fluctuated over the reporting period, however, has consistently remained below 20%. In 2022, 14% of participants reported recent use, stable relative to 2021 (18%; $p=0.065$) (Figure 40). Use remained stable in all capital cities except Brisbane, where a significant decrease was observed (12%; 26% in 2021; $p=0.025$) (Table 14).

Frequency of Use: Use has remained infrequent and stable over the monitoring period, with a median of 2 days of use (IQR=1-3; $n=98$) reported by participants in 2022 (2 days in 2021; IQR=1-3; $n=135$; $p=0.899$) (Figure 40).

Routes of Administration: Among participants who had recently consumed DMT and commented ($n=98$), the most common route of administration was smoking (97%; 98% in 2021; $p=0.697$). Few participants ($n\leq 5$) reported swallowing and snorting; therefore, numbers are suppressed. No participants reported shelving/shafting DMT in 2022.

Quantity: Among those who reported recent use and responded ($n=29$), the median amount used in a 'typical' session was 30 mgs (IQR=1-50; 25 mgs in 2021; IQR=2-100; $p=0.765$). Of those who reported recent use and responded ($n=29$), the median maximum amount used was 40 mgs (IQR=1-70; 40 mgs in 2021; IQR=3-100; $p=0.667$).

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



Note. Data collection for DMT started in 2010. 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. – Per cent suppressed due to small cell size ($n\leq 5$ but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; * $p<0.050$; ** $p<0.010$; *** $p<0.001$.

Table 14: Past six month use of DMT, by capital city, 2010-2022

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

Note. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. – Per cent suppressed due to small cell size (n≤5 but not 0). Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). 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.

Price, Perceived Purity and Perceived Availability

Data on the price, perceived purity and perceived availability for DMT were not collected in 2022.

8

New Psychoactive Substances

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

New Psychoactive Substances (NPS)

In previous (2010-2020) EDRS reports, DMT and *paramethoxyamphetamine* (PMA) were categorised as NPS. However, the classification of these substances as NPS is not universally accepted, and in 2021, 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.

Patterns of Consumption

Recent Use (past 6 months)

Any NPS use, including plant-based NPS, has fluctuated over time, peaking at 44% in 2013 and declining to 11% in 2022, the lowest percentage reported since monitoring commenced, and a significant decrease relative to 2021 (16%; $p=0.029$) (Table 15).

Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 42% in 2013 and declining to 9% in 2022, also the lowest percentage observed since monitoring commenced, and a significant decline relative to 2021 (14%; $p=0.006$) (Table 16).

Whilst no significant changes were observed in any of the capital city samples, any NPS use (both including and excluding plant-based NPS) was highest in the Melbourne sample (16% and 15%, respectively) and lowest in the Hobart sample ($n\leq 5$) (Table 15; Table 16).

Forms Used

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

Whilst the 2C class and synthetic cannabinoids have been highly endorsed over the course of monitoring, both peaking in 2013 (20% and 16%, respectively), use of these substances has declined in recent years, with 3% reporting recent use of any 2C substance in 2022, a significant decline from 2021 (6%; $p=0.032$), and 1% reporting recent use of synthetic cannabinoids (2% in 2021; $p=0.516$).

Similarly, recent use of mephedrone (the most commonly reported NPS in 2010) has decreased considerably over the past decade, with few participants ($n\leq 5$) reporting use in 2021 and 2022. Indeed, less than 5% of the sample endorsed use of any specific NPS in 2022, with mescaline and 2C substances the most commonly used NPS (3%, respectively) (Table 17).

Two per cent of the national sample reported recent use of new drugs that mimic the effects of psychedelic drugs like LSD in 2022 (2% in 2021). Two per cent of the national sample also reported recent use of benzodiazepine NPS in 2022 (2% in 2021; $p<0.001$), with $n\leq 5$ reporting recent use of etizolam in 2022 (1% in 2021; $p=0.124$). One per cent reported recent use of dissociative NPS, a significant decline from 2021 (2%; $p<0.001$).

Few participants ($n\leq 5$) reported recent use of new drugs that mimic the effects of opioids, new drugs that mimic the effects of ecstasy or new drugs that mimic the effect of amphetamines or cocaine, respectively (Table 17).

Table 15: Past six month use of any NPS (including plant-based NPS), nationally, 2010-2022, and by capital city, 2010-2022

%	National	Syd	Can	Mel	Hob	Ade	Per	Dar	Bri
2010	24	10	15	29	49	23	32	~	16
2011	36	35	36	40	33	49	54	~	22
2012	40	42	53	45	26	43	29	~	48
2013	44	52	48	45	34	38	45	38	47
2014	35	34	17	34	38	38	39	25	56
2015	37	40	33	36	22	49	32	39	39
2016	28	38	27	31	14	28	21	25	41
2017	26	32	25	29	17	31	22	26	26
2018	23	26	20	28	23	29	13	17	27
2019	20	16	28	17	18	27	8	19	27
2020	15	23	13	12	10	17	9	13	21
2021	16	17	18	23	11	10	10	20	15
2022	11*	12	9	16	-	12	13	~	13

Note. Monitoring of NPS first commenced in 2010. In 2021, the decision was made to remove DMT and PMA from the NPS category, with these substances now presented in Chapter 7 and Chapter 9, respectively. This has had a substantial impact on the percentage of the sample reporting 'any' NPS use in the past six months and means that the figures presented above will not align with those presented in previous (2010-2020) EDRS reports. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. – Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from figure. Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). Statistical significance for 2021 versus 2022 presented in table; * $p<0.050$; ** $p<0.010$; *** $p<0.001$.

Table 16: Past six month use of any NPS (excluding plant-based NPS), nationally, 2010-2022, and by capital city, 2010-2022

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

Note. Monitoring of NPS first commenced in 2010. In 2021, the decision was made to remove DMT and PMA from the NPS category, with these substances now presented in Chapter 7 and Chapter 9, respectively. This has had a substantial impact on the percentage of the sample reporting 'any' NPS use in the past six months and means that the figures presented above will not align with those presented in previous (2010-2020) EDRS reports. ~Due to the particularly small samples recruited in Darwin in 2010-2012 and 2022, data from these years are not presented in this table; furthermore, data from Darwin in 2006, 2008 and 2013 should be interpreted with caution. – Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from figure. Bri (Brisbane) includes Brisbane and the Gold Coast (and the Sunshine Coast in 2014-2016). Statistical significance for 2021 versus 2022 presented in table; * $p<0.050$; ** $p<0.010$; *** $p<0.001$.

Table 17: Past six month use of NPS by drug type, nationally, 2010-2022

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
	N=693	N=574	N=607	N=686	N=800	N=763	N=795	N=785	N=799	N=797	N=805	N=774	N=700
% Phenethylamines^	7	14	12	20	20	18	13	12	9	7	6	7	4
Any 2C substance~	6	14	12	20	15	14	11	9	8	6	5	6	3*
NBOMe	/	/	/	/	9	7	4	5	2	2	1	1	1
DO-x	1	1	0	-	-	0	0	1	-	-	0	0	0
4-FA	/	/	/	/	/	/	-	-	0	0	0	0	0
NBOH	/	/	/	/	/	/	/	/	/	/	/	/	0
% Tryptamines^^	0	2	-	1	1	0	1	1	1	2	1	2	1
5-MeO-DMT	-	5	-	1	1	-	1	1	1	2	1	2	1
4-AcO-DMT	/	/	/	/	/	/	-	-	/	/	/	/	/
% Synthetic cathinones	19	18	11	9	8	8	3	5	4	5	1	1	1
Mephedrone	16	13	5	6	5	3	1	1	-	1	0	-	-
Methylone/bk MDMA	/	5	5	3	3	4	2	4	3	3	0	0	0
MDPV/Ivory wave	-	2	3	1	1	1	0	-	0	-	0	0	0
Alpha PVP	/	/	/	/	/	/	-	-	-	-	0	0	0
Other substituted cathinone	/	/	-	0	-	-	0	-	-	/	/	/	/
N-ethylpentylone	/	/	/	/	/	/	/	/	/	0	0	0	0
N-ethylhexedrone	/	/	/	/	/	/	/	/	/	0	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
% Piperazines	5	2	1	-	-	0	0	-	/	/	/	/	/
BZP	5	2	1	-	-	0	0	-	/	/	/	/	/
% Dissociatives	/	/	1	2	2	2	3	2	0	2	1	2	1***
Methoxetamine (MXE)	/	/	1	2	2	2	3	2	0	2	0	1	0
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	0
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0
3-HO-PCP/4-HO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0
3-MeO-PCP/4- MeO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0
% Other drugs that mimic the effects of dissociatives like ketamine	/	/	/	/	/	/	/	/	/	/	-	1	0
% Plant-based NPS	2	7	8	6	4	5	5	5	3	3	5	5	4

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
	N=693	N=574	N=607	N=686	N=800	N=763	N=795	N=785	N=799	N=797	N=805	N=774	N=700
Ayahuasca	/	/	/	/	/	0	-	1	-	1	1	1	1
Mescaline	2	4	2	3	2	2	2	3	2	2	2	3	3
Salvia divinorum	/	2	3	2	2	1	2	2	1	1	2	-	1
Kratom											-	1	-
LSA	/	1	3	2	1	1	1	/	/	/	/	/	/
Datura	0	-	-	0	0	0	0	/	/	/	/	/	/
% Benzodiazepines	/	/	/	/	/	/	1	1	1	2	1	2	2***
Etizolam	/	/	/	/	/	/	1	1	1	1	0	1	-
8 - Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0
Bromazolam	/	/	/	/	/	/	/	/	/	/	/	/	0
Clonazolam	/	/	/	/	/	/	/	/	/	/	/	/	1
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	0
% Other drugs that mimic the effect of benzodiazepines	/	/	/	/	/	/	/	/	-	1	0	0	0
% Synthetic cannabinoids	/	6	15	16	7	6	4	2	3	3	4	2	1
% Herbal high[#]	/	/	12	8	4	5	4	2	2	2	/	/	/
% Phenibut	/	/	/	/	/	/	/	/	/	2	0	1	0*
% Other drugs that mimic the effect of opioids	/	/	/	/	/	/	/	-	-	-	0	0	0
% Other drugs that mimic the effect of ecstasy	/	/	/	/	/	/	/	-	1	1	0	-	-
% Other drugs that mimic the effect of amphetamine or cocaine	/	/	/	/	/	/	/	1	-	1	1	-	0
% Other drugs that mimic the effect of psychedelic drugs like LSD	/	/	/	/	/	/	/	-	1	2	1	2	2

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 8 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.

9

Other Drugs

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

Non-Prescribed Pharmaceutical Drugs

Codeine

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

Up until 2017, participants were only asked about use of OTC codeine for non-pain purposes. Additional items on 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, 12% of the sample reported using non-prescribed codeine in the past six months, stable relative to 2021 (12%; $p=0.867$) (Figure 41).

Recent Use for Non-Pain Purposes: Seven per cent of the sample reported recently using non-prescribed codeine for non-pain purposes (60% of those who had recently used non-prescribed codeine).

Frequency of Use: Participants who had recently used non-prescribed codeine and commented ($n=85$) reported use on a median of 3 days (IQR=2-6) in the past six months, stable from 2021 (2 days; IQR=1-5; $n=89$; $p=0.122$).

Pharmaceutical Opioids

Recent Use (past 6 months): The per cent of participants reporting any past six month use of non-prescribed pharmaceutical opioids (e.g., methadone, buprenorphine, oxycodone, morphine, fentanyl, excluding codeine) remained stable, from 10% in 2021 to 8% in 2022 ($p=0.326$) (Figure 41).

Frequency of Use: Frequency of use remained low and stable in 2022 at a median of 3 days (IQR=1-7; $n=57$) in the six months prior to interview (2 days in 2021; IQR=1-5; $n=73$; $p=0.388$).

Pharmaceutical Stimulants

Recent Use (past 6 months): The per cent of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has steadily increased since the commencement of monitoring, from 17% in 2007 to 52% in 2022 (46% in 2021; $p=0.014$), signifying the highest percentage of use since monitoring commenced (Figure 41).

Frequency of Use: Frequency of use remained stable in 2022, at a median of 6 days in the six months prior to interview (IQR=2-15; $n=366$; 5 days in 2021; IQR=2-12; $n=353$; $p=0.320$).

Quantity: Among those who reported recent use of non-prescribed pharmaceutical stimulants and responded ($n=302$), the median amount used in a 'typical' session was 2 pills/tablets (IQR=1-3; 2 pills/tablets in 2021; IQR=1-2; $p=0.006$). Of those who reported recent use and responded ($n=308$), the median maximum amount used was 3 pills/tablets (IQR=2-5; 2 pills/tablets in 2021; IQR=1-4; $p=0.033$).

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 gradually increased between 2007 and 2018, however has remained relatively stable since. In 2022, 36% of the sample reported recent use, stable from 2021 (35%; $p=0.832$) (Figure 41). From 2019, participants were asked about non-prescribed alprazolam use versus 'other' non-prescribed benzodiazepine use. In 2022, one-fifth (20%) of participants reported recent use of non-prescribed alprazolam, stable relative to 2021 (19%; $p=0.646$). Recent use of non-prescribed 'other' benzodiazepines remained unchanged, with one-quarter (26%) reporting recent use in 2022 (26% in 2021; $p=0.953$).

Frequency of Use: Participants who had recently used non-prescribed alprazolam and commented ($n=142$), reported use on a median of 4 days in the six months preceding interview (IQR=2-10; 3 days in 2021; IQR=1-6; $n=148$; $p=0.060$). Similarly, those who had recently used 'other' benzodiazepines and could comment ($n=181$), reported use on a median of 4 days (IQR=2-10; 3 days in 2021; IQR=2-10; $n=201$; $p=0.830$).

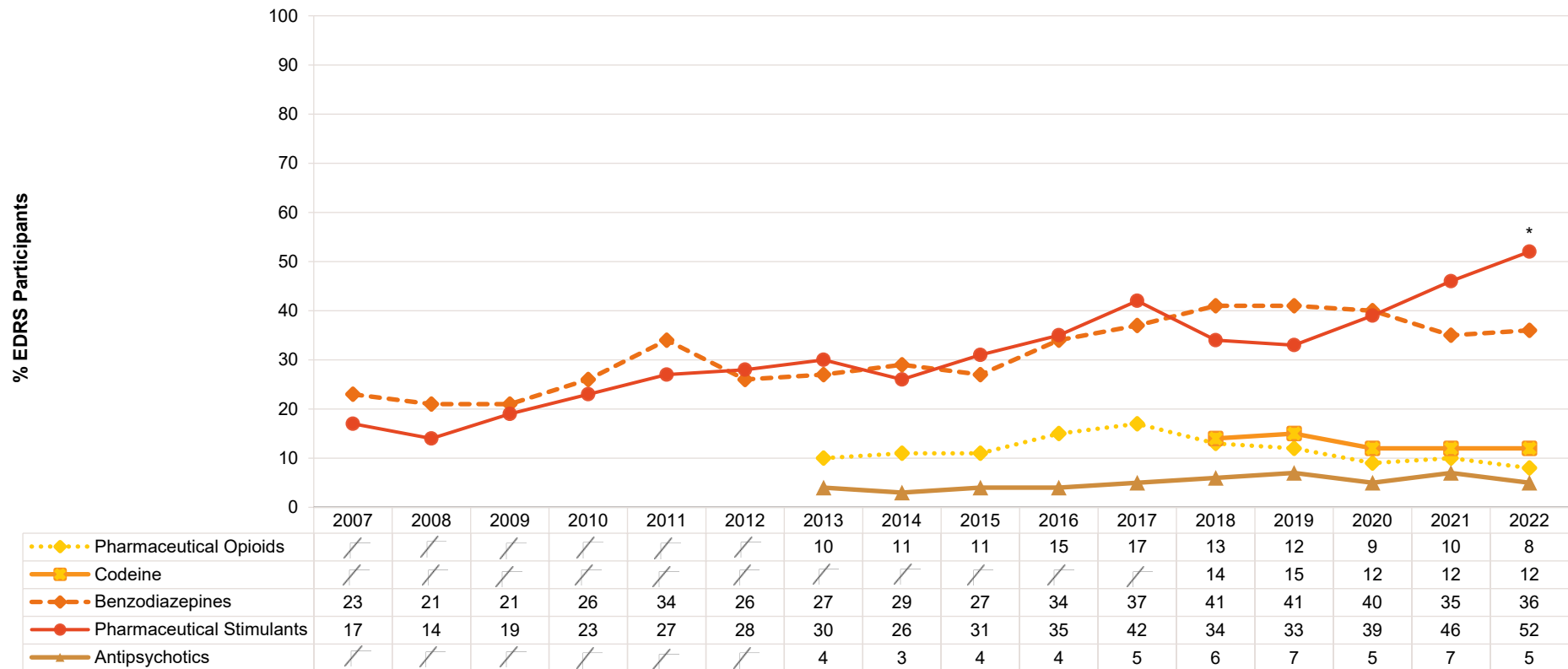
Price and Perceived Availability: In 2022, participants were asked questions pertaining to the price and perceived availability of non-prescribed benzodiazepines, however these data will be released separately in 2023. Please contact the Drug Trends team for further information.

Antipsychotics

Recent Use (past 6 months): Few participants reported recent use of non-prescribed antipsychotics (5% in 2022; 7% in 2021; $p=0.168$) (Figure 41).

Frequency of Use: Participants reported using non-prescribed antipsychotics on median of 4 days in the six months preceding interview (IQR=2-15; $n=37$; 5 days in 2021; IQR=1-65; $n=55$; $p=0.320$).

Figure 41: Non-prescribed use of pharmaceutical drugs in the past six months, nationally, 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. – Per cent suppressed due to small cell size (n≤5 but not 0). / Not asked. 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): Forty-six per cent of the national sample had used hallucinogenic mushrooms in the six months preceding interview, stable relative to 2021 (45%; $p=0.703$) (Figure 42).

Frequency of Use: While use of hallucinogenic mushrooms remained infrequent in 2022, median days of use significantly increased, from 2 days (IQR=1-4; $n=346$) in 2021 to 3 days (IQR=1-5; $n=320$; $p=0.012$) in 2022.

MDA

Recent Use (past 6 months): Five per cent of the national sample reported using MDA in the six months preceding interview, stable from 2021 (5%; $p=0.471$) (Figure 42).

Frequency of Use: Use remained infrequent, at a median of 2 days in the six months preceding interview (IQR=1-4; $n=38$), stable from 2021 (2 days; IQR=1-3; $n=35$; $p=0.908$).

Substance with Unknown Contents

Capsules: Use of capsules with unknown contents peaked in 2017 (20%), however has since declined. In 2022, 4% of the sample reported recent use, stable from 2021 (6%; $p=0.127$) (Figure 42).

Other Unknown Substances: From 2019, we asked participants about their use more broadly of substances with 'unknown contents'. In 2022, 16% of participants reported use of any substance with 'unknown contents' (15% in 2021; $p=0.671$) on a median of 1 day in the preceding six months (IQR=1-3; $n=112$), stable from 2021 (1 day; IQR=1-4; $n=114$; $p=0.370$).

When broken down by substance form, 6% of the 2022 sample reported using pills with unknown contents (5% in 2021; $p=0.642$), 9% had recently used powder with unknown contents (7% in 2021; $p=0.251$) and 2% had recently consumed crystal with unknown contents (1% in 2021; $p=0.205$).

Quantity: From 2020, we asked participants about the average amount of pills and capsules used with unknown contents in the six months preceding interview. In 2022, among those who reported recent use of pills with unknown contents and responded ($n=39$), the median 'typical' amount used in a session was one pill (IQR=1-3; 2 pills in 2021; IQR=1-4; $p=0.002$). Of those who reported recent use of capsules with unknown contents and responded ($n=27$), the median 'typical' amount used in a session was 1.5 capsules (IQR=1-3; 2 capsules in 2021; IQR=1-3; $p=0.452$).

PMA

Due to low numbers ($n\leq 5$) reporting recent use of PMA, numbers have been suppressed (Figure 42).

PMMA

Due to low numbers ($n\leq 5$) reporting recent use of PMMA, numbers have been suppressed (Figure 42).

Heroin

Recent Use (past 6 months): Consistently small numbers have reported recent use of heroin (2% in 2022; 3% in 2021; $p=0.740$) (Figure 42).

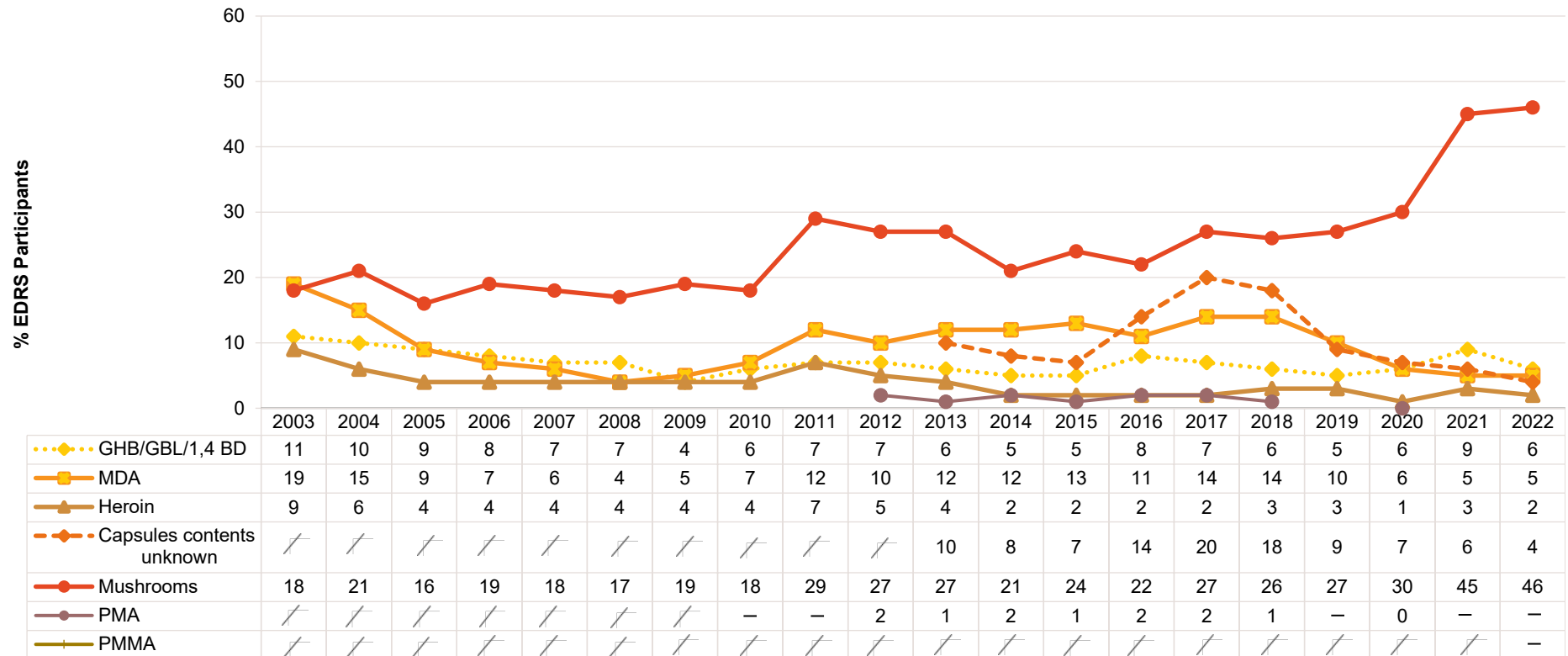
Frequency of Use: Participants reported a median of 3 days of use (IQR=2-6; $n=16$) in 2022, stable from 2021 (2 days; IQR=1-5; $n=20$; $p=0.485$).

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

Recent Use (past 6 months): Six per cent of the national sample reported recent use of GHB/GBL/1,4-BD in 2022, stable from 9% in 2021 ($p=0.098$) (Figure 42).

Frequency of Use: GHB/GBL/1,4-BD was used on a median of 2 days (IQR=1-6, $n=45$) in 2022, unchanged from 2 days in 2021 (IQR=1-6; $n=67$; $p=0.473$), indicating infrequent use.

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



Note. Monitoring of capsules contents unknown commenced in 2013; note that from 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 reduced to 60% to improve visibility of trends. - Per cent suppressed due to small cell size (n≤5 but not 0). / Not asked. 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 sample have reported recent alcohol use in each year since monitoring began (95% in 2022; 96% in 2021; $p=0.389$) (Figure 43).

Frequency of Use: Frequency of use between 2021 and 2022 remained stable, with participants reporting use on a median of 48 days (IQR=24-72; $n=663$) in 2022, compared to 48 days (IQR=24-72; $n=738$) in 2021 ($p=0.734$). Three-quarters (78%) of participants who had recently consumed alcohol reported weekly or more frequent use (78% in 2021; $p=0.893$); this includes 4% who reported daily use (4% in 2021; $p=0.686$).

Tobacco

Recent Use (past 6 months): Almost three-quarters (72%) of participants reported recent use of tobacco in 2022, stable from 2021 (73%; $p=0.659$) (Figure 43).

Frequency of Use: Participants who had recently used tobacco reported use on a median of 90 days (IQR=12-180; $n=503$; 90 days in 2021; IQR=15-180; $n=566$; $p=0.904$), with two-fifths (41%) reporting daily use (39% in 2021; $p=0.659$).

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.

Recent Use (past 6 months): Almost two-thirds (65%) of the national sample reported non-prescribed e-cigarette use in the six months preceding interview, a significant increase from 2021 (58%; $p=0.007$) (Figure 43). Three per cent of participants reported recent use of prescribed e-cigarettes ($n=21$; data not collected in 2021).

Frequency of Use: Median days of non-prescribed use in the past six months also significantly increased, from 30 days (IQR=7-120; $n=444$) in 2021 to 72 days (IQR=14-180; $n=452$; $p<0.001$) in 2022. Almost one-fifth (19%) of those who had recently used non-prescribed e-cigarettes reported daily use, unchanged from 2021 (19%).

Forms Used: Among those who had recently used e-cigarettes and responded in 2022 ($n=445$), the majority (94%) reported using e-cigarettes containing nicotine. Smaller percentages reported using e-cigarettes containing cannabis (9%), or e-cigarettes containing both nicotine and cannabis (1%), although 27% reported using e-cigarettes which contained neither cannabis nor nicotine. Few participants ($n\leq 5$) reported using e-cigarettes that contained another substance.

Reason for Use: Of those who reported any (i.e., prescribed or non-prescribed) e-cigarette use and responded ($n=468$), two-thirds (66%) reported that they did not use e-cigarettes as a smoking cessation tool in 2022, stable relative to 2021 (61%; $p=0.121$).

Nitrous Oxide

Recent Use (past 6 months): The per cent of the sample reporting any recent use of nitrous oxide remained stable in 2022 (45%) relative to 2021 (49%; $p=0.127$) (Figure 43). However, there was high variation amongst capital city samples, ranging from 26% in the Hobart sample to 70% in the Perth sample.

Frequency of Use: Frequency of use also remained stable, with a median of 4 days (IQR=2-10; $n=314$) of use reported in 2022 (4 days in 2021; IQR=2-10; $n=378$; $p=0.396$), equivalent to less than monthly use.

Quantity: In 2022, participants reported using a median of 10 bulbs in a 'typical' session (IQR=3-20; $n=309$), a significant increase relative to 2021 (5 bulbs; IQR=3-15; $p=0.011$). Of those who reported

recent use and responded (n=308), the median maximum amount used was 15 bulbs (IQR=5-40), also a significant increase from 2021 (10 bulbs; IQR=4-30; $p=0.017$).

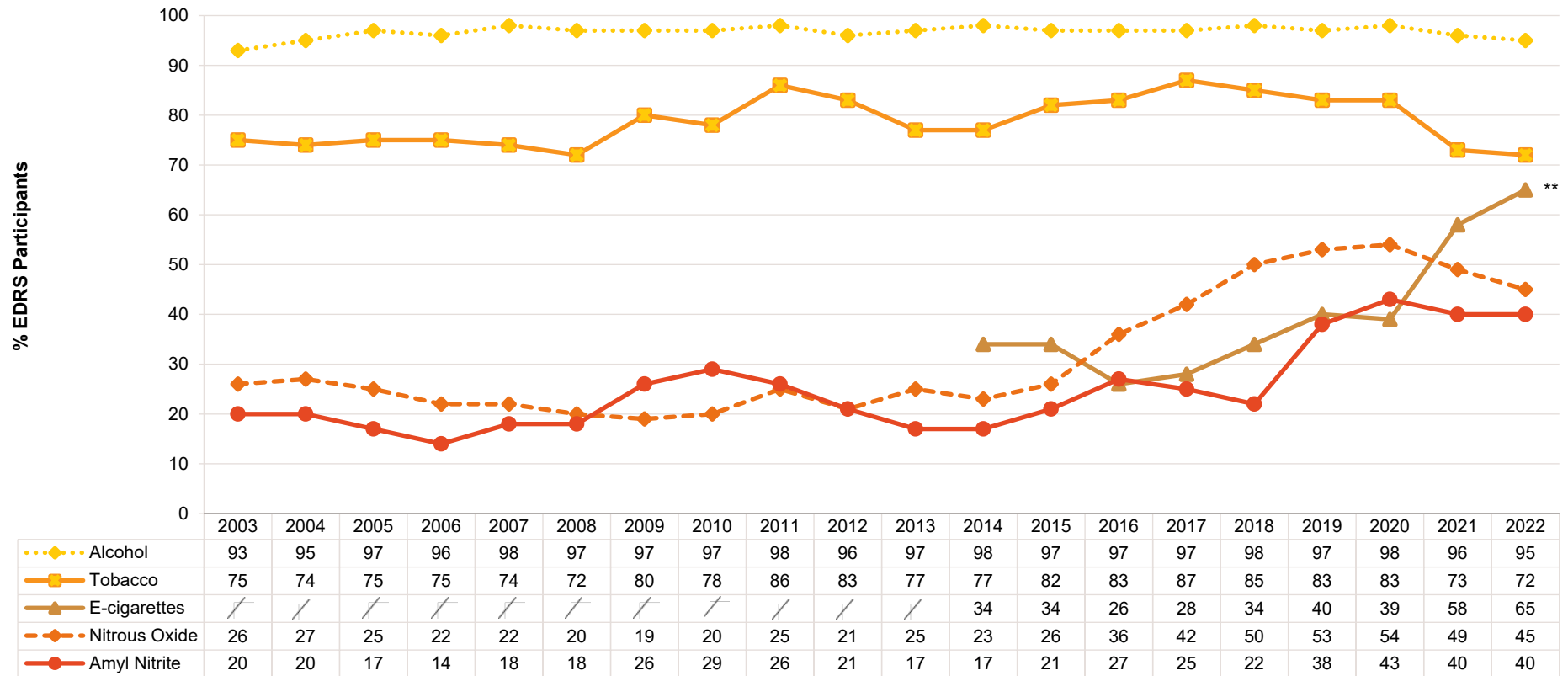
Amyl Nitrite

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): Use of amyl nitrite has fluctuated over the course of monitoring (Figure 43). In 2022, two-fifths (40%) of participants reported any recent use of amyl nitrite, remaining stable from 2021 (40%).

Frequency of Use: Frequency of amyl nitrite use remained generally low and stable, with participants reporting a median of 3 days of use (IQR=1-6; n=280) in 2022 (3 days in 2021; IQR=1-7; n=308; $p=0.898$).

Figure 43: Past six month use of licit drugs, nationally, 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. – Per cent suppressed due to small cell size (n≤5 but not 0). / Not asked. 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.

10

Drug-Related Harms and Other Behaviours

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

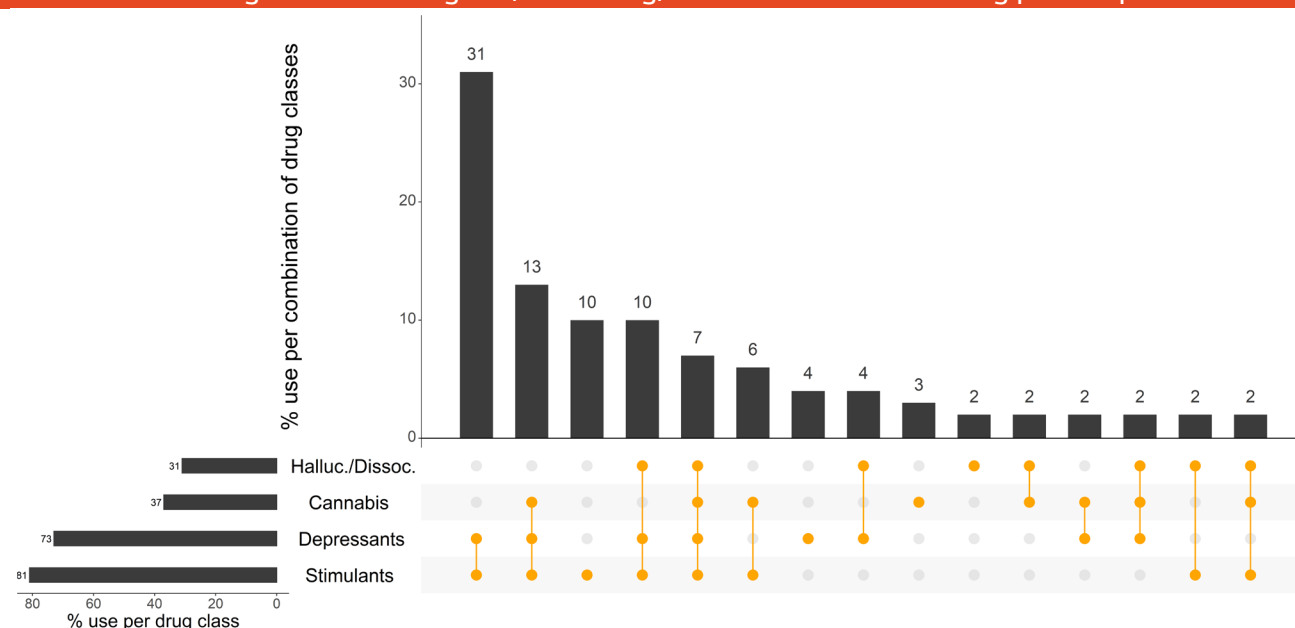
Participants were also asked about COVID-19 testing, diagnosis, vaccination and current concern of contracting COVID-19.

Polysubstance Use

On the last occasion of ecstasy or related drug use, among those who answered (n=688), the most commonly used substances were alcohol (70%) and ecstasy (39%), followed by cannabis (36%) and cocaine (33%).

The majority (81%; n=555) of the sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most commonly used combinations of substances were depressants and stimulants (31%), followed by cannabis, depressants and stimulants (13%). One-tenth (10%) reported using hallucinogens/dissociatives, depressants and stimulants, and 10% of the sample 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, nationally, 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 35% to improve visibility of trends.

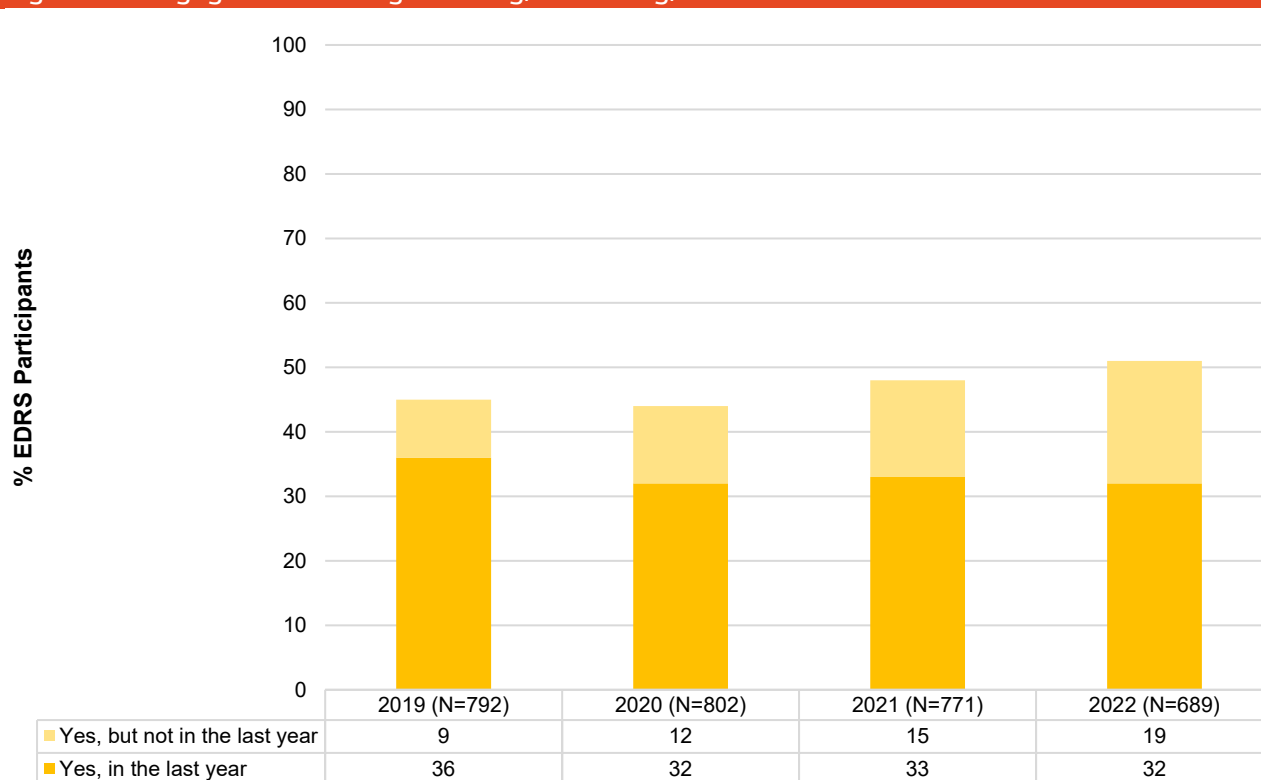
Drug Checking

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

In 2022, 32% 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 (33% in 2021; $p=0.732$) (Figure 45). Of those who reported that they or someone else had tested their illicit drugs in the past year (n=219), 88% reported using colorimetric or reagent test kits, with fewer participants (17%) using testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips). Few participants (n ≤ 5) reported having their drugs tested via Fourier Transform Infrared Spectroscopy or other method of spectroscopy/chromatography, therefore, these numbers are suppressed.

Of those who reported that they or someone else had tested their illicit drugs in the past year (n=219), the majority (58%) reported having their drugs tested by a friend, followed by 50% who reported testing the drugs themselves. Smaller numbers (10%) reported having their drugs tested by a dealer.

Figure 45: Engagement in drug checking, nationally, 2019-2022



Note. 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 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 sample (including participants who had not consumed alcohol in the past six months) was 12.9 (SD 7.4) in 2022 (12.9 (SD 7) 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.

Almost three-quarters (74%) of participants obtained a score of eight or more (77% in 2021; $p = 0.264$), indicative of hazardous use (Table 18).

Table 18: AUDIT total scores and per cent of participants scoring above recommended levels, nationally, 2010-2022

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
	N=674	N=566	N=592	N=682	N=790	N=756	N=789	N=780	N=787	N=791	N=800	N=766	N=694
Mean AUDIT total score (SD)	14.8 (7.0)	15.0 (7.3)	14.8 (7.4)	13.5 (7.0)	13.3 (6.5)	13.1 (6.3)	12.3 (6.8)	12.4 (8.5)	12.8 (6.8)	13.5 (7.0)	13.1 (6.4)	12.9 (7.0)	12.9 (7.4) ***
Score 8 or above (%)	84	84	83	79	82	79	73	77	75	79	81	77	74
AUDIT zones													
Score 0-7:	16	16	17	21	18	21	27	23	25	21	19	23	26
Score 8-15:	39	38	37	42	48	45	43	48	43	45	51	43	39
Score 16-19:	20	21	19	13	17	18	15	14	15	17	15	17	14
Score 20 or higher:	26	26	27	24	17	17	15	15	17	18	16	16	20

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. Imputation used for missing scale scores. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

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

Fifteen per cent of the national sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview in 2022, stable relative to 2021 (16%; $p = 0.944$) (Figure 46).

The most common stimulants reported during the most recent non-fatal stimulant overdose in the past 12 months comprised any form of ecstasy (56%; capsules: 30%; crystal: 11%; pills: 13% and powder: 8%), cocaine (32%), any form of methamphetamine (16%; crystal: 14%; powder: n≤5) and pharmaceutical stimulants (16%). Eight per cent reported that they had also consumed one or more additional drugs on the last occasion, most notably, any quantity of alcohol (70%; ≥5 standard drinks: 54%; ≤5 standard drinks: 16%) and cannabis (31%). On the last occasion of experiencing a non-fatal stimulant overdose, 87% reported that they did not receive treatment or assistance. Of those that did report receiving treatment or assistance (n=14) most reported emergency department attendance (71%; n=10) and ambulance attendance (64%; n=9).

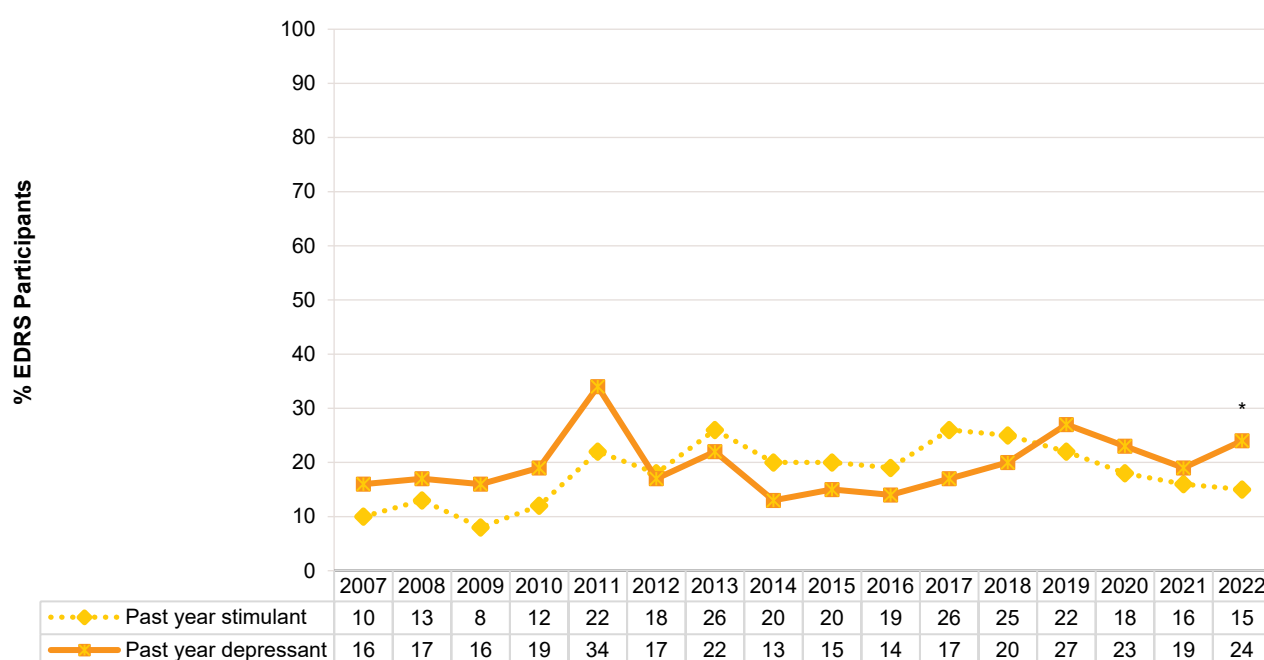
Non-Fatal Depressant Overdose

Alcohol: One-fifth (21%) of the national sample reported a non-fatal alcohol overdose in the 12 months preceding interview on a median of two occasions (IQR=1-4). This represents a significant increase from the per cent who reported experiencing a non-fatal alcohol overdose in 2021 (15%; $p=0.008$). Of those who had experienced an alcohol overdose in the past year in 2022 (n=146), the majority (88%) reported not receiving treatment on the last occasion. Of those who reported receiving treatment (n=17), the majority reported hospital emergency department admission (41%; n=7), with smaller numbers reporting ambulance attendance and GP attendance (n≤5, respectively).

Any depressant (including alcohol): Almost one-quarter (24%) of participants reported that they had experienced a non-fatal depressant overdose in the past 12 months, a significant increase relative to 2021 (19%; $p=0.012$) (Figure 46).

Of those who had experienced any depressant overdose in the past 12 months (n=167), the majority reported alcohol as the most common depressant drug (87%), with a smaller per cent reporting benzodiazepines (including alprazolam) (7%) and opioids (including heroin and pharmaceutical opioids) (5%). Few participants (n≤5) reported a non-fatal overdose due to GHB/GBL/1,4 BD.

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

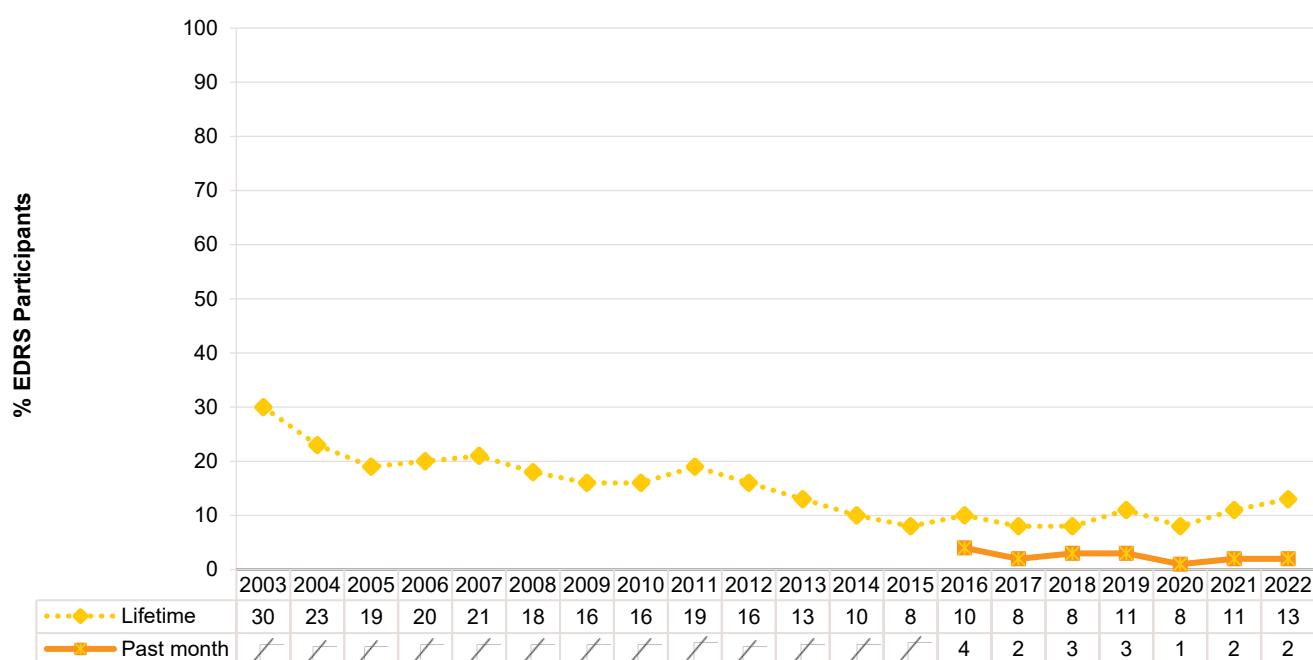


Note. Past year stimulant and depressant overdose was first asked about in 2007. In 2019, items about overdose were revised, and changes relative to 2018 and earlier may be a function of greater nuance in capturing depressant events. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size (n≤5 but not 0). Statistical significance for 2021 versus 2022 presented in figure; * $p<0.050$; ** $p<0.010$; *** $p<0.001$.

Injecting Drug Use and Associated Risk Behaviours

For the past several years, approximately one in ten participants have reported ever injecting drugs (13% in 2022, 11% in 2021; $p=0.206$). The per cent who reported injecting drugs in the past month has remained low and stable, with 2% reporting past month injection in 2022 (2% in 2021; $p=0.440$) (Figure 47).

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



Note. Items assessing whether participants had injected drugs in the past month were first asked in 2016. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). / Not asked. Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Drug Treatment

A nominal per cent reported currently receiving drug treatment in 2022 (5%), stable compared with 2021 (3% in 2021; $p=0.244$). Of those who had reported being in treatment in 2022 ($n=33$), the majority (61%) reported drug counselling as their main form of treatment (70% in 2021).

Sexual Health Behaviours

In 2022, 78% of the sample reported some form of sexual activity in the past four weeks (82% in 2021; $p=0.054$). 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 ($n=526$), 82% reported using alcohol and/or other drugs prior to or while engaging in sexual activity, stable relative to 2021 (86%; $p=0.128$). Of those who had engaged in sexual activity in the past four weeks and responded ($n=525$), 9% reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (11% in 2021; $p=0.505$). Furthermore, of those who had engaged in sexual activity in the past four weeks and who responded ($n=524$), 22% reported penetrative sex without a condom where they did not know the HIV status of their partner, unchanged from 2021 (22%) (Table 19).

Of those who commented (n=678), one-third (35%) reported having a sexual health check-up in the six months prior to interview (36% in 2021; $p=0.827$), whilst 78% had done so in their lifetime (76% in 2021; $p=0.148$). Of the total sample who responded (n=676), 3% reported that they had received a positive diagnosis for a sexually transmitted infection (STI) in the past six months in 2022 (3% in 2021; $p=0.744$); and 23% had received a positive diagnosis in their lifetime (22% in 2021; $p=0.568$).

Of those who commented (n=669), one-quarter (25%) of the sample reported having a test for human immunodeficiency virus (HIV) in the six months prior to interview (24% in 2021; $p=0.631$), whilst 60% had done so in their lifetime (57% in 2021; $p=0.394$). In 2022, no participants had been diagnosed with HIV in the past six months (n≤5 in 2021; $p=0.252$) and no participants had been diagnosed with HIV in their lifetime (n≤5 in 2021; $p=0.378$).

Table 19: Sexual health behaviours, nationally, 2021-2022

Note. # Due to the sensitive nature of these items, there is missing data for some participants who chose not to respond. The response

	National	
	2021	2022
Of those who responded:	N=749	N=677
% Any sexual activity in the past four weeks (n)	82 (n=615)	78 (n=528)
Of those who responded# and reported any sexual activity in the past four weeks:	n=612	n=526
% Drugs and/or alcohol used prior to or while engaging in sexual activity	86	82
Of those who responded# and reported any sexual activity in the past four weeks:	n=608	n=525
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	11	9
Of those who responded# and reported any sexual activity in the past four weeks:	n=608	n=524
% Had penetrative sex without a condom and did not know HIV status of partner	22	22
Of those who responded#:	n=748	N=669
% Had a HIV test in the last six months	24	25
% Had a HIV test in their lifetime	57	60
Of those who responded#:	n=757	n=676
% Diagnosed with HIV in the last six months	-	0
% Diagnosed with HIV in their lifetime	-	-
Of those who responded#:	n=759	n=678
% Had a sexual health check in the last six months	36	35
% Had a sexual health check in their lifetime	76	78
Of those who responded#:	n=757	n=676
% Diagnosed with a sexually transmitted infection in the last six months	3	3
% Diagnosed with a sexually transmitted infection in their lifetime	22	23

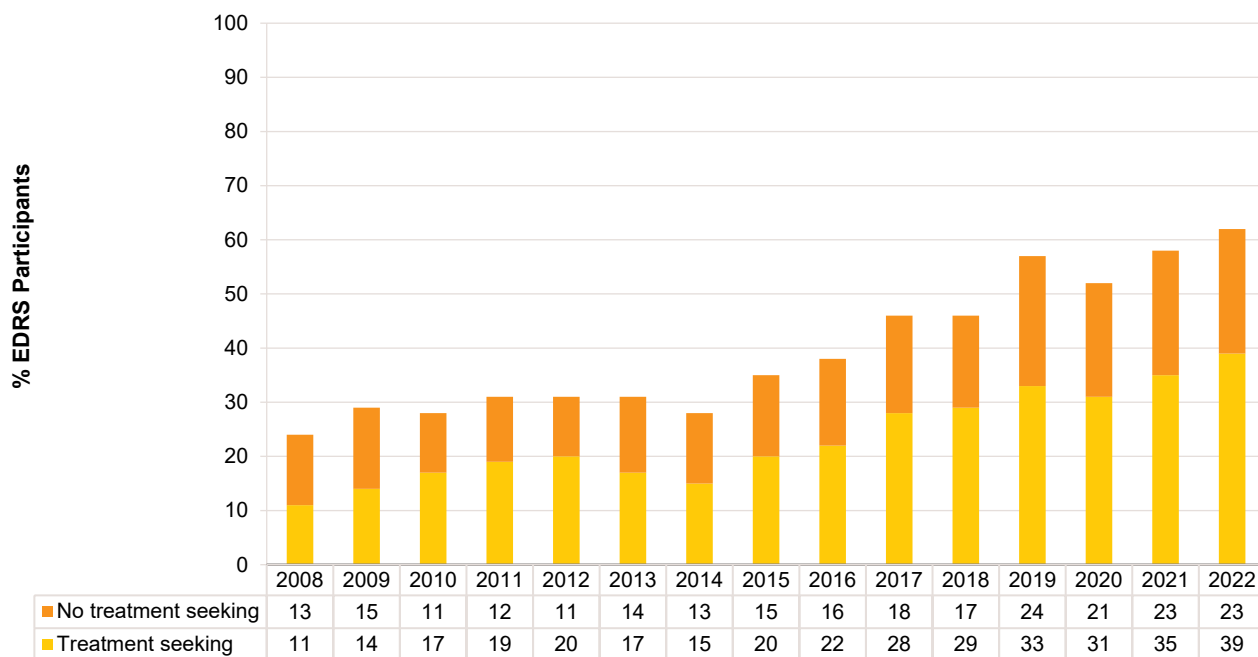
option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size (n≤5 but not 0). Statistical significance for 2021 versus 2022 presented in table; * $p<0.050$; ** $p<0.010$; *** $p<0.001$.

Mental Health

Three-fifths (62%) of the national sample self-reported that they had experienced a mental health problem in the preceding six months (other than drug dependence), stable relative to 2021 (58%; $p=0.093$) (Figure 48). Of those who reported a mental health problem and commented (n=426), the most common mental health problem reported was anxiety (65%; 71% in 2021; $p=0.151$), followed by depression (63%; 62% in 2021; $p=0.911$) and post-traumatic stress disorder (PTSD) (16%; 14%

in 2021; $p=0.360$). Of those that reported experiencing a mental health problem ($n=431$), 63% (39% of the total sample) reported seeing a mental health professional during the past six months (60% in 2021; $p=0.425$). Of those who attended a mental health professional in 2022 ($n=273$), 62% reported being prescribed medication for their mental health problem (54% in 2021; $p=0.072$).

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

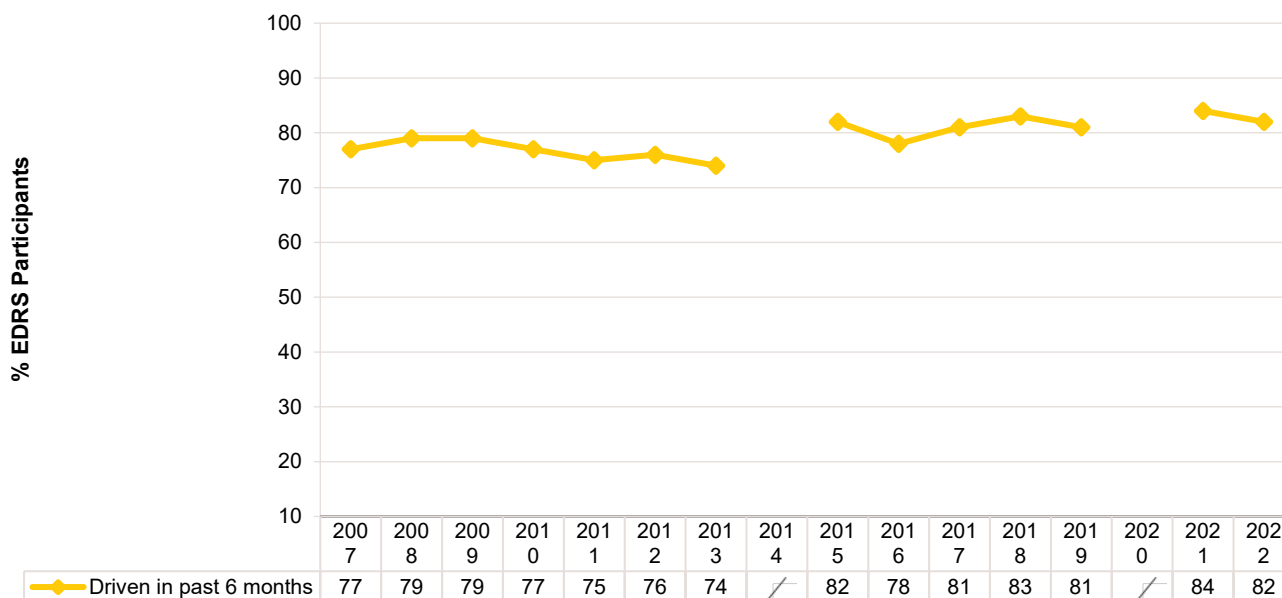


Note. Questions about treatment seeking were first asked in 2008. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). Statistical significance for 2021 versus 2022 presented in figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.

Driving

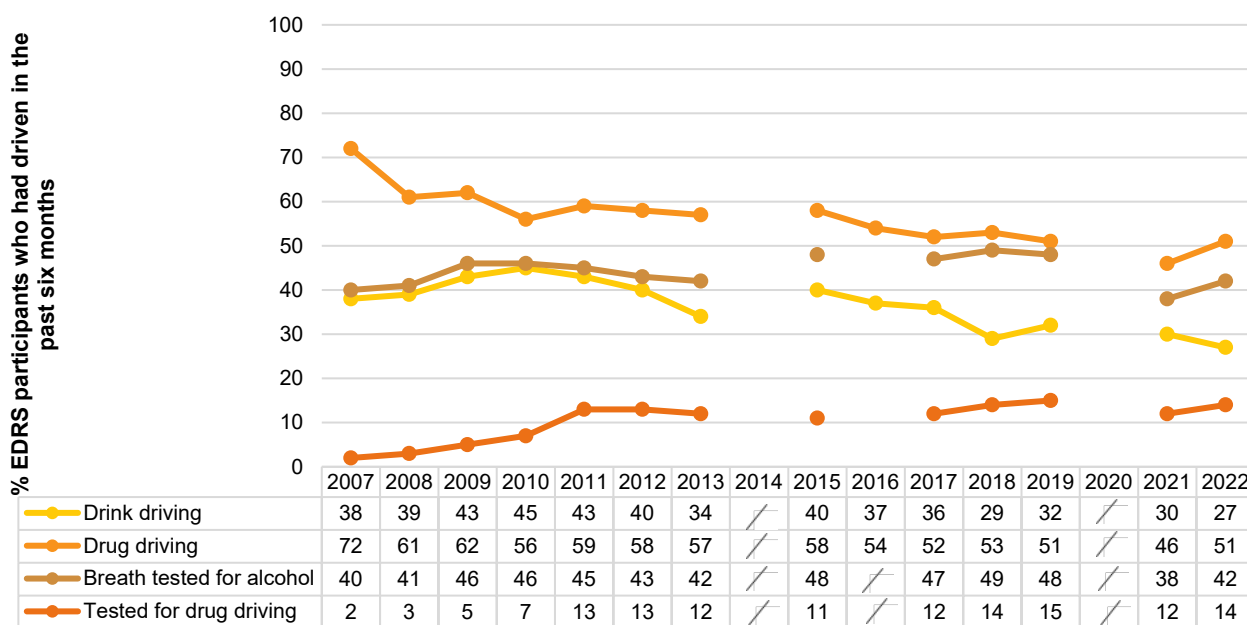
In 2022, 82% of the national sample had driven a car, motorcycle or other vehicle in the last six months (Figure 49). Of those who had driven in the past six months and commented ($n=524$), 27% reported driving while over the perceived legal limit of alcohol (30% in 2021; $p=0.328$), and half (51%) reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months (46% in 2021; $p=0.120$). Of those who had recently driven and commented ($n=567$), 14% reported that they had been tested for drug driving by the police roadside drug testing service, and 42% reported that they had been breath tested for alcohol by the police roadside testing service in the six months prior to interview (Figure 50).

Figure 49: Self-reported driving in the past six months, nationally, 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. / Not asked. – 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 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, nationally, 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 were not asked in 2014 or 2020. Questions about alcohol and drug driving testing were not asked in 2016. / Not asked. – 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 figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$

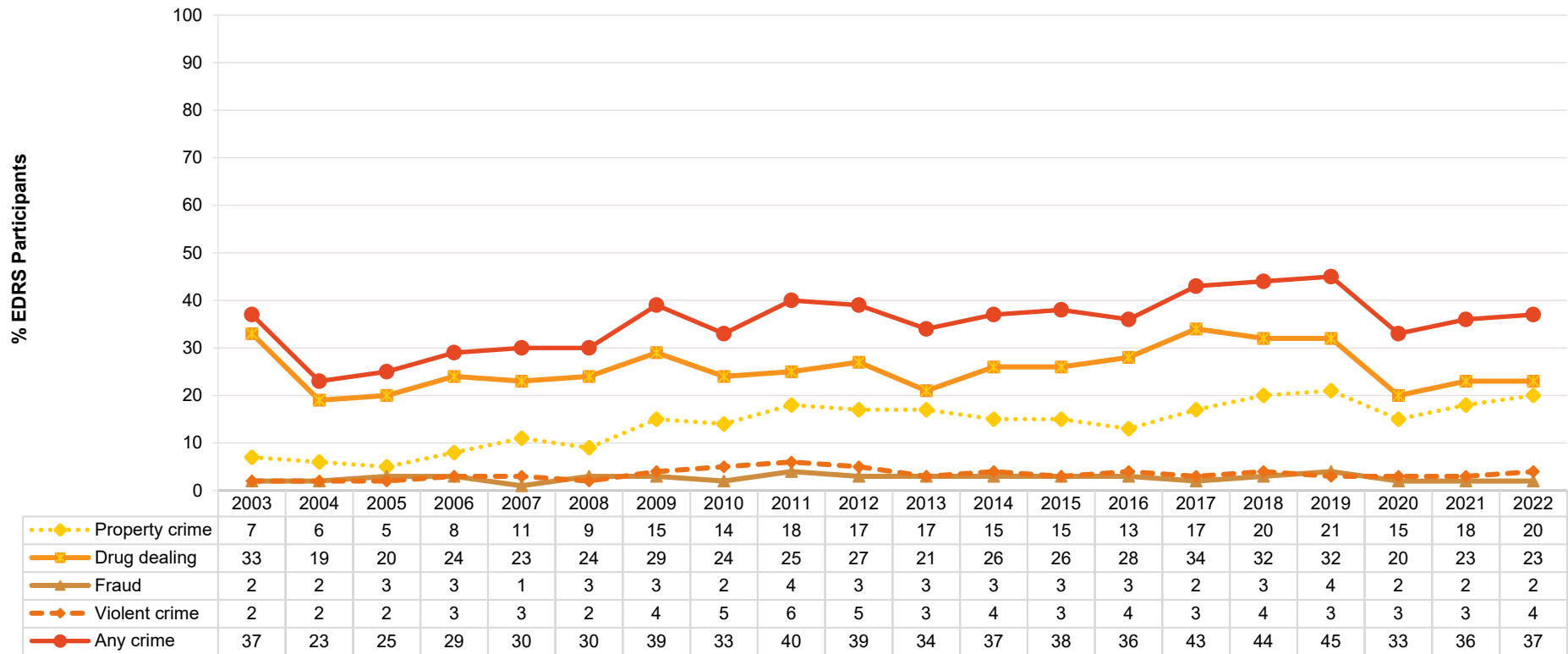
Crime

Past month self-reported criminal activity has fluctuated over time, with 37% reporting 'any' crime in the past month in 2022, stable relative to 2021 (36%; $p=0.866$). Drug dealing (23%) and property crime (20%) remained the two main forms of criminal activity in 2022, both of which remained stable from 2021 (23% and 18%; $p=0.194$, respectively) (Figure 51). Ten per cent reported being the victim of a crime involving violence (e.g., assault) in 2022, a significant increase from 6% in 2021 ($p=0.003$).

Seven per cent of the 2022 national sample reported having been arrested in the 12 months preceding interview, stable relative to 2021 (10%; $p=0.051$). Of those who commented ($n=49$), the main reasons for arrest in 2022 were use/possession of drugs (22%), violent crime (18%) and property crime (18%). In 2022, 15% 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): this was highest in the Sydney sample (28%) and lowest in the Hobart sample ($n\leq 5$).

Six per cent of the national sample reported a lifetime history of imprisonment in 2022, stable relative to 2021 (4%; $p=0.111$).

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



Note. 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 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.

In 2022, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was via social networking applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (73%; 71% in 2021; $p=0.403$). 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. In 2022, 69% of participants reported arranging the purchase of illicit or non-prescribed drugs face-to-face (72% in 2021; $p=0.236$), followed by text messaging (42%; 39% in 2021; $p=0.265$) and phone call (26%; 28% in 2021; $p=0.444$). Seven per cent had arranged to obtain drugs via the darknet market in the past year (7% in 2021; $p=0.834$), most commonly ecstasy crystal (18%), other benzodiazepines (15%), cannabis (15%) and ketamine (10%). Four per cent had arranged to purchase drugs on the surface web in 2022 (4% in 2021) (Table 20).

When asked about how they had received illicit drugs on any occasion in the last 12 months, the majority of participants reported face-to-face (96%), a significant increase relative to 2021 (92%; $p=0.004$). An increase was also observed in those receiving illicit drugs via a collection point (16%; 10% in 2021; $p=0.001$) (collection point defined as a predetermined location where a drug will be left for later collection), or via post (12%; 8% in 2021; $p=0.012$) (Table 20).

The majority of participants in 2022 reported obtaining illicit drugs from a friend/relative/partner/colleague (82%; 83% in 2021; $p=0.515$), followed by a known dealer/vendor (68%; 66% in 2021; $p=0.709$). However, significantly more participants reported obtaining illicit drugs from an unknown dealer/vendor in 2022 (37%; 30% in 2021; $p=0.005$) (Table 20).

In 2022, 3% of participants reporting selling illicit drugs on the surface web or darknet market in the 12 months preceding interview (2% in 2021; $p=0.117$). Fifty-five per cent reported they had ever obtained illicit drugs through someone who had purchased them on the surface web or darknet market, with 37% doing so in the last 12 months (39% in 2021; $p=0.511$).

Table 20: Means of purchasing illicit drugs in the past 12 months, nationally, 2019-2022

	National			
	n=792 2019	n=799 2020	n=774 2021	n=700 2022
% Purchasing approaches in the last 12 months^{^#}	n=792	n=799	n=764	n=683
Face-to-face	82	67	72	69
Surface web	4	7	4	4
Darknet market	10	7	7	7
Social networking applications [#]	73	75	71	73
Text messaging	53	48	39	42
Phone call	39	35	28	26
Grew/made my own	-	4	4	3
Other	0	1	0	1*
% Means of obtaining drugs in the last 12 months^{^~}			n=761	n=685
Face-to-face	0	0	92	96**
Collection point	10	20	10	16**
Post	12	12	8	12*
% Source of drugs in the last 12 months[^]			n=763	n=687
Friend/relative/ partner/colleague	88	83	83	82
Known dealer/vendor	70	67	66	68
Unknown dealer/vendor	38	37	30	37**

Note. – Per cent suppressed due to small cell size ($n \leq 5$ but not 0). [^] 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 in 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, 95% of the national sample had been tested for SARS-CoV-2 by the time of interview (55% in 2021; 9% in 2020), of whom 78% had received a PCR test and 88% a rapid antigen test in the 12 months preceding interview. Almost two-thirds (64%) of participants reported having been diagnosed with the virus ($n \leq 5$ in 2021 and 2020, respectively).

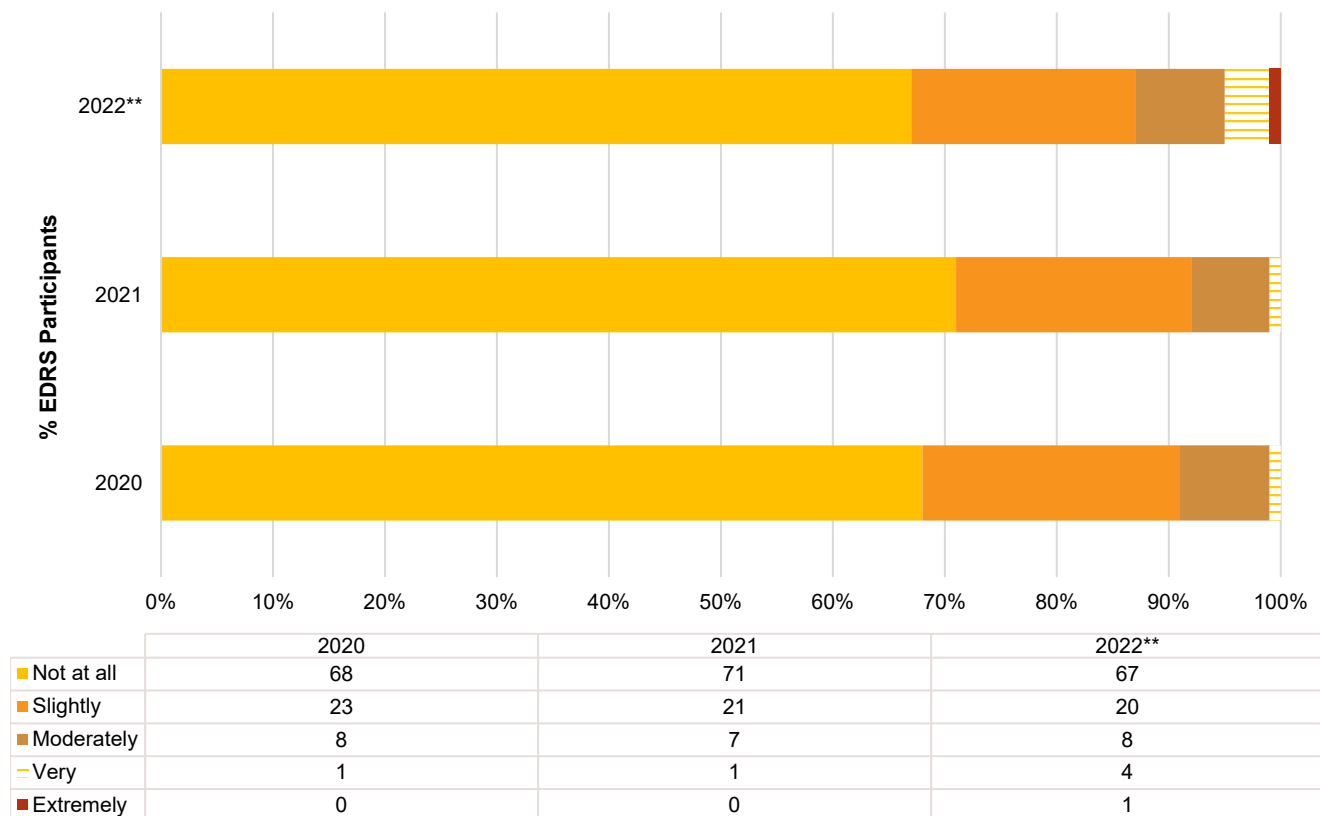
In 2022, 86% of the national sample reported quarantining for at least seven days due to a positive test or possible exposure in the past 12 months, with 15% quarantining in the month prior to interview and 58% in the six months prior to interview.

At the time of interview, nine in ten participants (90%) reported that they had received at least one COVID-19 vaccine dose (median three doses (IQR=2-3): 2% received one dose, 47% received two doses and 42% received three or more doses).

When asked how worried they were currently about contracting COVID-19, one-third (33%) of participants reported some level of concern (29% in 2021; $p=0.002$): 20% responded that they were 'slightly' concerned, 8% reported 'moderately', 4% reported 'very' and 1% reported being 'extremely' concerned (Figure 52). Furthermore, two-fifths (42%) of participants reported that they would be

concerned about their health if they did contract COVID-19, with 26% reporting they would be 'slightly' concerned, 9% reporting 'moderately', 5% reporting 'very' and 2% reporting that they would be 'extremely' concerned.

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



Note. 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 figure; * $p < 0.050$; ** $p < 0.010$; *** $p < 0.001$.