



**EDRS**



# **WESTERN AUSTRALIAN DRUG TRENDS 2022**

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



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

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

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[drugtrends@unsw.edu.au](mailto:drugtrends@unsw.edu.au)

## Table of Contents

SAMPLE CHARACTERISTICS	8
ECSTASY	12
METHAMPHETAMINE	21
COCAINE	26
CANNABIS AND/OR CANNABINOID RELATED PRODUCTS	30
KETAMINE, LSD AND DMT	36
NEW PSYCHOACTIVE SUBSTANCES	43
OTHER DRUGS	48
DRUG-RELATED HARMS AND OTHER BEHAVIOURS	55

## List of Tables

TABLE 1: DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE, NATIONALLY, 2022, AND PERTH, WA, 2017-2022 .....	8
TABLE 2: PAST SIX MONTH USE OF NPS (INCLUDING PLANT-BASED NPS), NATIONALLY, AND PERTH, WA, 2010-2022 .....	44
TABLE 3: PAST SIX MONTH USE OF NPS (EXCLUDING PLANT-BASED NPS), NATIONALLY, AND PERTH, WA, 2010-2022 .....	44
TABLE 4: PAST SIX MONTH USE OF NPS BY DRUG TYPE, PERTH, WA, 2010-2022 .....	45
TABLE 5: AUDIT TOTAL SCORES AND PER CENT OF PARTICIPANTS SCORING ABOVE RECOMMENDED LEVELS, PERTH, WA, 2010-2022.....	57
TABLE 6: SEXUAL HEALTH BEHAVIOURS, PERTH, WA, 2021-2022 .....	61
TABLE 7: MEANS OF PURCHASING ILLICIT DRUGS IN THE PAST 12 MONTHS, PERTH, WA, 2020-2022 .....	67

## List of Figures

FIGURE 1: DRUG OF CHOICE, PERTH, WA, 2003-2022.....	10
FIGURE 2: DRUG USED MOST OFTEN IN THE PAST MONTH, PERTH, WA, 2011-2022.....	10
FIGURE 3: WEEKLY OR MORE FREQUENT SUBSTANCE USE IN THE PAST SIX MONTHS, PERTH, WA, 2003-2022.....	11
FIGURE 4: PAST SIX MONTH USE OF ANY ECSTASY, AND ECSTASY PILLS, POWDER, CAPSULES, AND CRYSTAL, PERTH, WA, 2003-2022.....	12
FIGURE 5: MEDIAN DAYS OF ANY ECSTASY AND ECSTASY PILLS, POWDER, CAPSULES, AND CRYSTAL USE IN THE PAST SIX MONTHS, PERTH, WA, 2003-2022.....	13
FIGURE 6: MEDIAN PRICE OF ECSTASY PILLS AND CAPSULES, PERTH, WA, 2003-2022.....	16
FIGURE 7: MEDIAN PRICE OF ECSTASY CRYSTAL (PER GRAM AND POINT) AND POWDER (GRAM ONLY), PERTH, WA, 2013-2022.....	16
FIGURE 8: CURRENT PERCEIVED PURITY OF ECSTASY PILLS, PERTH, WA, 2017-2022.....	17
FIGURE 9: CURRENT PERCEIVED PURITY OF ECSTASY CAPSULES, PERTH, WA, 2017-2022.....	17
FIGURE 10: CURRENT PERCEIVED PURITY OF ECSTASY CRYSTAL, PERTH, WA, 2017-2022.....	18
FIGURE 11: CURRENT PERCEIVED PURITY OF ECSTASY POWDER, PERTH, WA, 2017-2022.....	18
FIGURE 12: CURRENT PERCEIVED AVAILABILITY OF ECSTASY PILLS, PERTH, WA, 2017-2022.....	19
FIGURE 13: CURRENT PERCEIVED AVAILABILITY OF ECSTASY CAPSULES, PERTH, WA, 2017-2022.....	19
FIGURE 14: CURRENT PERCEIVED AVAILABILITY OF ECSTASY CRYSTAL, PERTH, WA, 2017-2022.....	20
FIGURE 15: CURRENT PERCEIVED AVAILABILITY OF ECSTASY POWDER, PERTH, WA, 2017-2022.....	20
FIGURE 16: PAST SIX MONTH USE OF ANY METHAMPHETAMINE, AND METHAMPHETAMINE POWDER, BASE, AND CRYSTAL, PERTH, WA, 2003-2022.....	21
FIGURE 17: MEDIAN DAYS OF ANY METHAMPHETAMINE, POWDER, BASE, AND CRYSTAL USE IN THE PAST SIX MONTHS, PERTH, WA, 2003-2022.....	22
FIGURE 18: MEDIAN PRICE OF METHAMPHETAMINE CRYSTAL PER POINT AND GRAM, PERTH, WA, 2003-2022.....	24
FIGURE 19: CURRENT PERCEIVED PURITY OF METHAMPHETAMINE CRYSTAL, PERTH, WA, 2003-2022.....	24
FIGURE 20: CURRENT PERCEIVED AVAILABILITY OF METHAMPHETAMINE CRYSTAL, PERTH, WA, 2003-2022.....	25
FIGURE 21: PAST SIX MONTH USE AND FREQUENCY OF USE OF COCAINE, PERTH, WA, 2003-2022.....	27
FIGURE 22: MEDIAN PRICE OF COCAINE PER GRAM, PERTH, WA, 2003-2022.....	28
FIGURE 23: CURRENT PERCEIVED PURITY OF COCAINE, PERTH, WA, 2003-2022.....	28
FIGURE 24: CURRENT PERCEIVED AVAILABILITY OF COCAINE, PERTH, WA, 2003-2022.....	29
FIGURE 25: PAST SIX MONTH USE AND FREQUENCY OF USE OF NON-PRESCRIBED CANNABIS AND/OR CANNABINOID RELATED PRODUCTS, PERTH, WA, 2003-2022.....	31
FIGURE 26: MEDIAN PRICE OF NON-PRESCRIBED HYDROPONIC (A) AND BUSH (B) CANNABIS PER OUNCE AND GRAM, PERTH, WA, 2006-2022.....	33
FIGURE 27: CURRENT PERCEIVED POTENCY OF NON-PRESCRIBED HYDROPONIC (A) AND BUSH (B) CANNABIS, PERTH, WA, 2006-2022.....	34
FIGURE 28: CURRENT PERCEIVED AVAILABILITY OF NON-PRESCRIBED HYDROPONIC (A) AND BUSH (B) CANNABIS, PERTH, WA, 2006-2022.....	35
FIGURE 29: PAST SIX MONTH USE AND FREQUENCY OF USE OF KETAMINE, PERTH, WA, 2003-2022.....	36
FIGURE 30: MEDIAN PRICE OF KETAMINE PER GRAM, PERTH, WA, 2003-2022.....	37
FIGURE 31: CURRENT PERCEIVED PURITY OF KETAMINE, PERTH, WA, 2003-2022.....	38
FIGURE 32: CURRENT PERCEIVED AVAILABILITY OF KETAMINE, PERTH, WA, 2003-2022.....	38
FIGURE 33: PAST SIX MONTH USE AND FREQUENCY OF USE OF LSD, PERTH, WA, 2003-2022.....	39
FIGURE 34: MEDIAN PRICE OF LSD PER TAB, PERTH, WA, 2003-2022.....	40
FIGURE 35: CURRENT PERCEIVED PURITY OF LSD, PERTH, WA, 2003-2022.....	40
FIGURE 36: CURRENT PERCEIVED AVAILABILITY OF LSD, PERTH, WA, 2003-2022.....	41
FIGURE 37: PAST SIX MONTH USE AND FREQUENCY OF USE OF DMT, PERTH, WA, 2010-2022.....	42
FIGURE 38: NON-PRESCRIBED USE OF PHARMACEUTICAL DRUGS IN THE PAST SIX MONTHS, PERTH, WA, 2007-2022.....	50
FIGURE 39: PAST SIX MONTH USE OF OTHER ILLICIT DRUGS, PERTH, WA, 2003-2022.....	52
FIGURE 40: LICIT AND OTHER DRUGS USED IN THE PAST SIX MONTHS, PERTH, WA, 2003-2022.....	54
FIGURE 41: USE OF DEPRESSANTS, STIMULANTS, CANNABIS, HALLUCINOGENS AND DISSOCIATIVES ON THE LAST OCCASION OF ECSTASY OR RELATED DRUG USE, PERTH, WA, 2022: MOST COMMON DRUG PATTERN PROFILES.....	55
FIGURE 42: LIFETIME AND PAST YEAR ENGAGEMENT IN DRUG CHECKING, PERTH, WA, 2019-2022.....	56
FIGURE 43: PAST 12 MONTH NON-FATAL STIMULANT AND DEPRESSANT OVERDOSE, PERTH, WA, 2007-2022.....	59

FIGURE 44: LIFETIME AND PAST MONTH DRUG INJECTION, PERTH, WA, 2003-2022 .....60

FIGURE 45: SELF-REPORTED MENTAL HEALTH PROBLEMS AND TREATMENT SEEKING IN THE PAST SIX MONTHS, PERTH, WA, 2008-2022 ..... 62

FIGURE 46: SELF-REPORTED DRIVING IN THE PAST SIX MONTHS, PERTH, WA, 2007-2022..... 63

FIGURE 47: SELF-REPORTED TESTING AND DRIVING AT LEAST ONCE 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, PERTH, WA, 2007-2022 ..... 64

FIGURE 48: SELF-REPORTED CRIMINAL ACTIVITY IN THE PAST MONTH, PERTH, WA, 2003-2022 ..... 65

FIGURE 49: CURRENT CONCERN RELATED TO CONTRACTING COVID-19, PERTH, WA, 2020-2022..... 68

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### Research Team

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- Dr Rachel Sutherland, Fiona Jones, Antonia Karlsson, Julia Uporova, Cate King, Daisy Gibbs, Olivia Price, Professor Louisa Degenhardt, Professor Michael Farrell and Associate Professor Amy Peacock, National Drug and Alcohol Research Centre, University of New South Wales, New South Wales;
- Joanna Wilson, Sarah Eddy, Dr Campbell Aiken and Professor Paul Dietze, Burnet Institute Victoria;
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- Dr Jodie Grigg and Professor Simon Lenton, National Drug Research Institute and enAble Institute, Curtin University, Western Australia; and
- Catherine Daly, Dr Jennifer Juckel, Dr Natalie Thomas and Associate Professor Caroline Salom, Institute for Social Science Research, The University of Queensland, Queensland.

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

### Participants

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

### Contributors

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



## Abbreviations

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

## Executive Summary

The Perth Western Australia (WA) EDRS comprises a sentinel sample of people who regularly use ecstasy and other illicit stimulants recruited via social media, advertisements on websites and via word-of mouth in Perth, WA. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2022 from May-June. All interviews were conducted via telephone to reduce the risk of COVID-19 transmission in 2022 (as per 2020), while a hybrid approach was employed in 2021 (involving both face-to-face and telephone interviews); all interviews prior to 2020 were conducted face-to-face. These methodological changes should be factored into all comparisons of data from the 2020-2022 samples, relative to previous years.**

### Sample Characteristics

The EDRS sample (N=100) recruited from Perth, WA, was similar to the sample in 2021 and in previous years. Whilst fewer participants reported studying in 2022 (37%; 59% in 2021;  $p=0.003$ ) and the median weekly income increased to \$800 (\$600 in 2021;  $p=0.012$ ), the sample continued to comprise predominantly males (71%), many with tertiary qualifications (50%) and most of whom were living in a rental house/flat or residing with their parents/at their family home (52% and 32%, respectively) at the time of interview. Ecstasy, alcohol and cannabis continued to be the three most commonly reported drugs of choice (20%, 21% and 35%, respectively). However, there was a significant change in the drug used most often in the past month ( $p=0.016$ ). Specifically, the per cent nominating alcohol decreased (26%; 44% in 2021), while the per cent nominating cannabis slightly increased (37%; 32% in 2021).

### Ecstasy

The vast majority reported recent (past 6 month) use of ecstasy (any form: 96%), consistent with 2021 and earlier years. Crystal and capsule forms continued to be the most commonly reported forms used (60% and 57% respectively). Meanwhile, there was a

significant increase in the per cent reporting recent use of powder ecstasy (32%; 17% in 2021;  $p=0.020$ ), and a significant decrease in recent use of pressed pills (21%; 37% in 2021;  $p=0.021$ ). Frequency of recent use (in any form) remained stable, but the per cent reporting weekly or more frequent use significantly increased (10%;  $\leq 5$  participants in 2021;  $p=0.018$ ). No significant differences were observed in perceived availability or purity of ecstasy pills, capsules or crystal. However, the perceived purity and availability of powder ecstasy significantly changed between 2021 and 2022 ( $p=0.009$  and  $p=0.032$ , respectively), with more participants perceiving the purity of powder as being 'low' (33%; 17% in 2021) and 'difficult' to access (63%; 17% in 2021). Finally, for the second consecutive year, the median price per ecstasy capsule increased (\$30; \$28 in 2021;  $p=0.009$ ), as did the price per gram of crystal (\$300; \$250 in 2021;  $p=0.001$ ).

### Methamphetamine

While recent (past six month) use of methamphetamine has declined among the Perth sample since the commencement of monitoring in 2003, it has remained stable in recent years (14% in 2022). In recent years, crystal has been the main form of methamphetamine reportedly used. Frequency of methamphetamine crystal use remained low and stable and few participants ( $n\leq 5$ ) reported weekly or more frequent use. Market changes for methamphetamine remained stable in 2022 relative to 2021.

### Cocaine

Recent use of cocaine has increased since monitoring began, and this trend continued in 2022 (66%; 59% in 2021). However, relative to 2021, there was a significant decrease in the frequency of cocaine use in the preceding six months (median of 2 days; 5 days in 2021;  $p=0.001$ ) and few ( $n\leq 5$ ) participants reported weekly or more frequent use. Market changes for cocaine remained stable in 2022 relative to 2021.

### Cannabis and/or Cannabinoid Related Products

Each year since monitoring began, at least three in four participants have reported any recent use of non-prescribed cannabis and/or cannabinoid related products. In 2022, 84% reported recent use and among these, 25% reported daily use. When asked about forms used, there was a significant decline in the per cent reporting hydroponic cannabis (64%; 82% in 2021;  $p=0.020$ ), making bush cannabis equally as popular in 2022 (also 64%). Market changes for hydroponic and bush cannabis remained stable in 2022, relative to 2021.

### Ketamine, LSD and DMT

Whilst recent use of ketamine, LSD and DMT remained stable (39%, 54% and 29%, respectively), there has been an upward trend in self-reported use of these substances in recent years. However, frequency of recent use has remained low and stable for all three substances. In 2022, the price per tab of LSD increased (\$30; \$25 in 2021;  $p=0.009$ ). However, perceived purity and availability remained stable for ketamine and LSD. No market trend data for DMT was collected.

### New Psychoactive Substances (NPS)

Any NPS use, including plant-based NPS, has fluctuated over time, with 13% reporting recent use in 2022, stable from 10% in 2021. Similar results were observed for any NPS use, excluding plant-based NPS (13%; 9% in 2021).

### Other Drugs

Reported use of most other drugs remained stable relative to 2021. However, there were significant increases in the per cent reporting recent use of amyl nitrite (40%; 21% in 2021;  $p=0.006$ ), nitrous oxide (70%; 45% in 2021;  $p=0.001$ ), and non-prescribed e-cigarettes (81%; 55% in 2021;  $p<0.001$ ). Whilst frequency of use remained low for amyl nitrite and nitrous oxide, frequency of recent use for non-prescribed e-cigarettes increased from a median of 24 days to a median of 90 days (i.e., every second day,  $p=0.012$ ). Lastly, the upward trend in reported recent use of pharmaceutical stimulants continued into 2022 (81%).

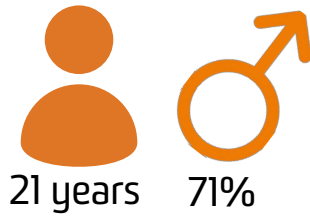
### Drug-Related Harms and Other Behaviours

On the last occasion of ecstasy or related drug use, 87% of the Perth sample in 2022 reported concurrent use of two or more drugs (excluding tobacco and e-cigarettes), most commonly alcohol (81%). Almost half the sample (48%) reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year. Most of the sample (82%) obtained an AUDIT score of eight or more, indicative of hazardous alcohol use in the past 12 months. Reported past year non-fatal stimulant overdose remained stable in 2022 (21%), whilst past year non-fatal depressant overdose (mostly comprising alcohol) significantly increased (31%; 17% in 2021;  $p=0.023$ ). Three-quarters (76%) reported engaging in sexual activity in the past four weeks, of which 12% reported penetrative sex without a condom where they did not know the HIV status of their partner. Almost three-fifths (57%) self-reported that they had experienced a mental health problem in the preceding six months. Among recent drivers, 35% reported driving while over the perceived legal limit of alcohol, while 55% reported driving within three hours of consuming an illicit or non-prescribed drug. Around two-fifths (43%) reported 'any' crime in the past month, with drug dealing most common (32%). Twelve per cent reported being the victim of a crime involving violence in 2022, a significant increase relative to 2021 ( $n\leq 5$ ;  $p=0.029$ ). Face-to-face remained the most popular means of arranging the purchase of illicit or non-prescribed drugs in the past 12 months (74%; 90% in 2021;  $p=0.007$ ), although social networking applications were almost equally as popular in 2022 (73%). Significantly more participants reported obtaining illicit drugs from an unknown dealer/vendor in 2022 (43%; 29% in 2021;  $p=0.044$ ). The majority (95%) of the sample had been tested for SARS-CoV-2, with 52% reporting having been diagnosed with the virus. At the time of interview, 95% reported that they had received at least one COVID-19 vaccine dose, with participants reporting a median of three vaccine doses.

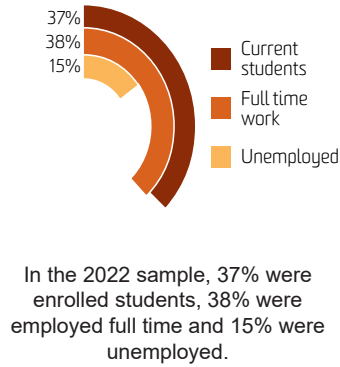
## 2022 SAMPLE CHARACTERISTICS



In 2022, 100 participants, recruited from Perth, WA were interviewed.



The median age in 2022 was 21, and 71% identified as male.

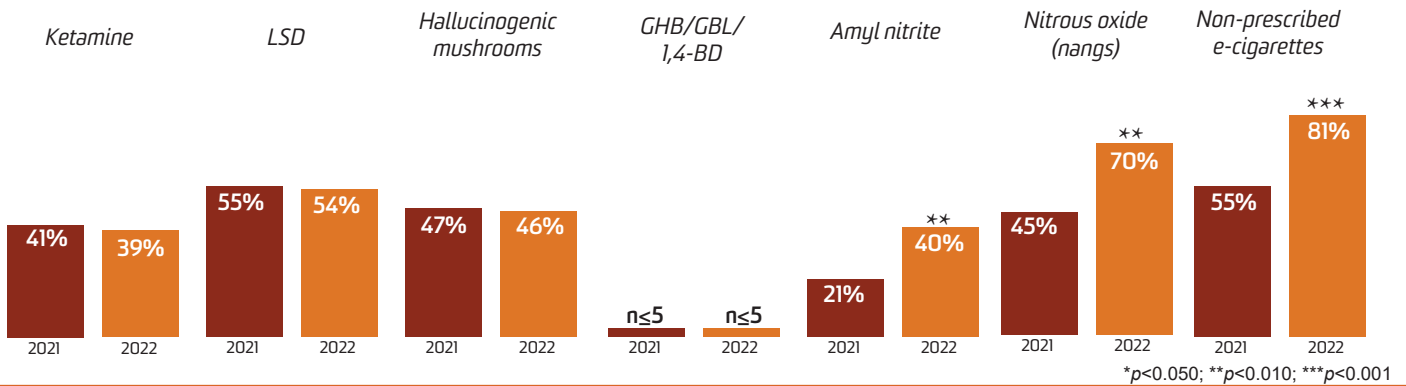


In the 2022 sample, 37% were enrolled students, 38% were employed full time and 15% were unemployed.

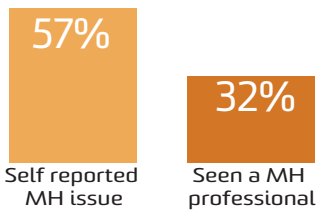
- Ecstasy
- Cocaine
- Other stimulants

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

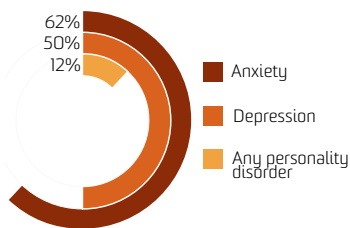
## PAST 6 MONTH USE OF SELECTED DRUGS



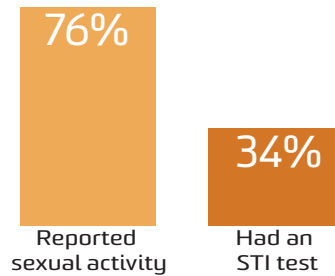
## MENTAL HEALTH AND SEXUAL HEALTH BEHAVIOURS



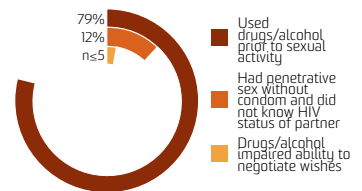
In the total sample, 57% self-reported a mental health issue and 32% had seen a mental health professional in the past 6 months.



Of those who had a mental health condition, the three most common mental health issues reported were anxiety (62%), depression (50%) and any personality disorder (12%).



In the total sample, 76% reported sexual activity in the past 4 weeks, and 34% 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.

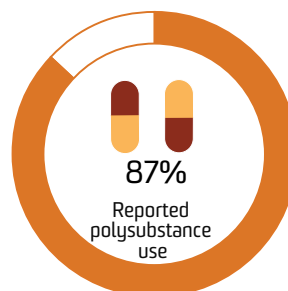
## OTHER RISK BEHAVIOURS



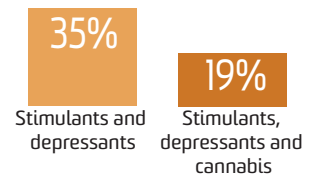
Among recent drivers, 55% reported driving a vehicle within 3 hours of consuming illicit drugs and 35% while over the legal limit of alcohol.



In the 2022 sample, 31% reported a non-fatal depressant overdose in the previous 12 months, an increase relative to 2021 (17%).

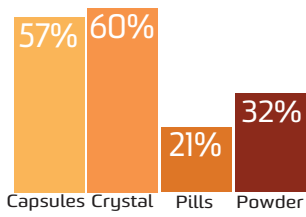


In the total sample, 87% reported concurrent use of two or more substances on the last occasion of ecstasy or related drug use.

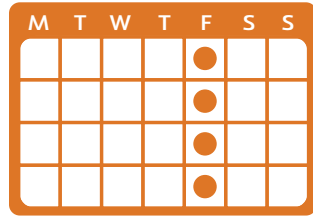


The most commonly used combinations of drug classes on the last occasion of ecstasy or related drug use.

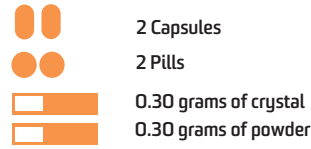
# ECSTASY



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



Of those who had recently consumed ecstasy, 10% reported weekly or more frequent use.



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

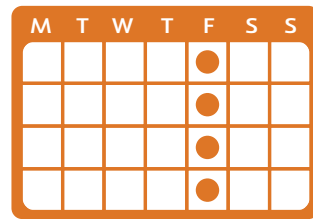


In 2022, more participants perceived the availability of the powder form of ecstasy as 'difficult' relative to 2021.

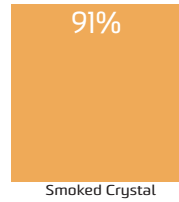
# METHAMPHETAMINE



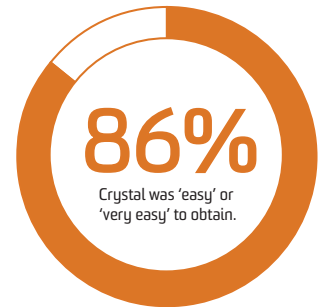
Past 6 month use of any methamphetamine, crystal, powder and base in 2022.



Of those who had recently consumed methamphetamine, small numbers reported weekly or more frequent use (n≤5).

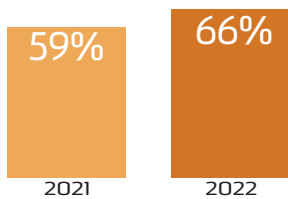


91% of participants who had recently used crystal smoked it.

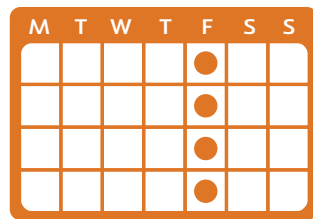


Of those who could comment, 86% perceived crystal methamphetamine to be 'easy' or 'very easy' to obtain.

# COCAINE



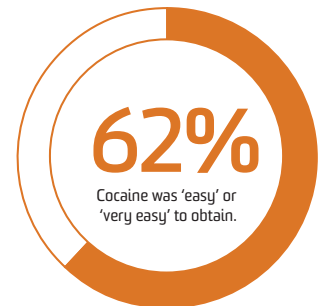
Past 6 month use of any cocaine remained stable between 2021 and 2022.



Of those who had recently consumed cocaine, small numbers reported weekly or more frequent use (n≤5).

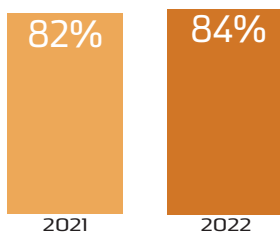


In 2022, the median price of a gram of cocaine remained stable at \$400.

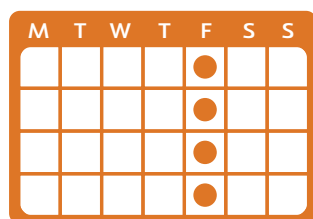


Of those who could comment, 62% perceived cocaine to be 'easy' or 'very easy' to obtain.

# CANNABIS AND/OR CANNABINOID RELATED PRODUCTS



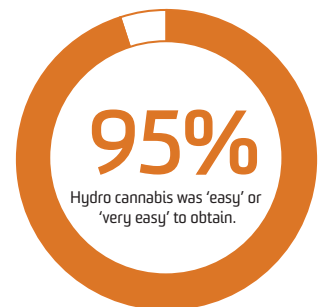
Past 6 month use of non-prescribed cannabis and/or cannabinoid related products remained stable between 2021 and 2022.



Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products, 63% reported weekly or more frequent use.



Of participants who had consumed non-prescribed cannabis and/or cannabinoid related products in the last 6 months, 94% had smoked it.



Of those who could comment, 95% perceived hydro to be 'easy' or 'very easy' to obtain.

## Background

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

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

## Methods

### EDRS 2003-2019

Full details of the [methods for the annual interviews](#) are available for download. To briefly summarise, since the commencement of monitoring up until 2019, participants were recruited primarily via internet postings, print advertisements, interviewer contacts, and snowballing (i.e., peer referral). Participants had to: i) be at least 17 years of age (due to ethical constraints) (16 years of age in Perth, Western Australia (WA)), ii) have used ecstasy or other illicit stimulants (including: MDA, methamphetamine, cocaine, mephedrone, non-prescribed pharmaceutical stimulants 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 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, WA) to 18 years old.

In 2021, 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. Whilst most other jurisdictions continued with the hybrid approach in 2022, Perth interviews were conducted entirely via telephone due to local COVID-19 outbreaks occurring in the lead up to and during the recruitment period.

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

A total of 700 participants were recruited across capital cities nationally (April-July, 2022), with 100 participants interviewed in Perth, WA between 12<sup>th</sup> April- 22<sup>nd</sup> June 2022.

Thirteen per cent of the 2022 Perth sample completed the interview in 2021, whereas 8% of the 2021 Perth sample completed the interview in 2020. In 2022, about two-thirds of the Perth participants reported being recruited via the internet (e.g., Facebook and Instagram) (64%; 64% in 2021), and one-third via word-of-mouth (35%; 34% in 2021;  $p=0.909$ ).

## 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  $\leq 5$  have been suppressed with corresponding notation (zero values are reported). References to 'recent' use and behaviours refers to the past six-month time period.

## 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 Perth, Western Australia, and thus do not reflect trends in regional and remote areas. Further, the results are not representative of all people who consume illicit drugs, nor of illicit drug use in the general population, but rather are intended to provide evidence indicative of emerging issues that warrant further monitoring.

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

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

## Additional Outputs

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

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



## 1

## Sample Characteristics

In 2022, the Perth EDRS sample was mostly similar to the sample in 2021 and in previous years (Table 1).

Gender remained stable between 2021 and 2022 ( $p=0.493$ ), with 71% of the sample identifying as male (64% in 2021;  $p=0.493$ ) and median age was 21 years (IQR=20-24; 22 years in 2021; IQR=19-26;  $p=0.606$ ).

Accommodation did not significantly change between 2021 and 2022 ( $p=0.192$ ), with approximately half the sample reporting that they lived in a rented house/flat (52%; 46% in 2021), almost one-third reporting that they lived with their parents/in their family house (32%; 46% in 2021) and the remainder reporting living in their own house (12%; 7% in 2021).

There was a significant decline in the per cent of current students in 2022, with almost two-fifths reporting studying (37%; 59% in 2021;  $p=0.003$ ). However, the percentage reporting a post-school qualification(s) remained stable (50% in 2022; 54% in 2021;  $p=0.672$ ).

Employment status also remained stable between 2021 and 2022 ( $p=0.301$ ), with almost half the sample reporting part-time/casual employment (46%; 54% in 2021), around two-fifths reporting full-time employment (38%; 30% in 2021) and 15% reporting being unemployed at the time of interview (12% in 2021). However, there was a significant increase in the median weekly income of the sample in 2022 (\$800; IQR=500-1154), relative to 2021 (\$600; IQR=354-950;  $p=0.012$ ).

**Table 1: Demographic characteristics of the sample, nationally, 2022, and Perth, WA, 2017-2022**

	Perth, WA						National
	2017	2018	2019	2020	2021	2022	2022
	N=100	N=100	N=100	N=101	N=100	N=100	N=700
<b>Median age (years; IQR)</b>	19 (18-21)	20 (18-22)	19 (18-21)	20 (19-23)	22 (19-26)	<b>21</b> <b>(20-24)</b>	25 (21-30)
<b>% Gender</b>							
Female	30	48	38	34	32	<b>27</b>	40
Male	69	52	62	65	64	<b>71</b>	56
Non-binary	/	/	0	-	-	-	4
<b>% Aboriginal and/or Torres Strait Islander</b>	-	-	-	0	-	-	5
<b>% Sexual identity</b>							
Heterosexual	87	94	88	91	77	<b>84</b>	71
Homosexual	-	-	-	-	-	-	5
Bisexual	10	-	8	6	8	<b>7</b>	17

	Perth, WA						National
	2017	2018	2019	2020	2021	2022	2022
Queer	0	0	-	0	6	<b>6</b>	6
Different identity	0	0	-	0	-	-	2
<b>Mean years of school education (range)</b>	12 (9-12)	12 (10-12)	12 (9-12)	12 (8-12)	12 (9-12)	<b>12 (9-12)</b>	12 (6-12)
<b>% Post-school qualification(s)^</b>	30	36	30	42	54	<b>50</b>	61
<b>% Current students#</b>	40	19	58	60	59	<b>37**</b>	41
<b>% Current employment status</b>							
Employed full-time	24	22	12	18	30	<b>38</b>	32
Part time/casual	26	41	63	40	54	<b>46</b>	41
Self-employed	0	0	-	7	-	-	8
Unemployed	8	16	20	34	12	<b>15</b>	19
<b>Current median weekly income \$ (IQR)</b>	\$350 (144-700)	\$400 (200-800)	\$300 (150-500)	\$550 (300-750)	\$600 (354-950)	<b>\$800*</b> <b>(500-1154)</b>	\$700 (450-1200)
<b>% Current accommodation</b>							
Own house/flat	-	-	-	-	7	<b>12</b>	12
Rented house/flat	26	33	27	32	46	<b>52</b>	59
Parents'/family home	71	61	71	64	46	<b>32</b>	23
Boarding house/hostel	-	-	0	0	0	-	2
Public housing	0	0	0	0	0	-	2
No fixed address+	-	-	0	0	0	-	2
Other	-	-	-	-	-	-	1

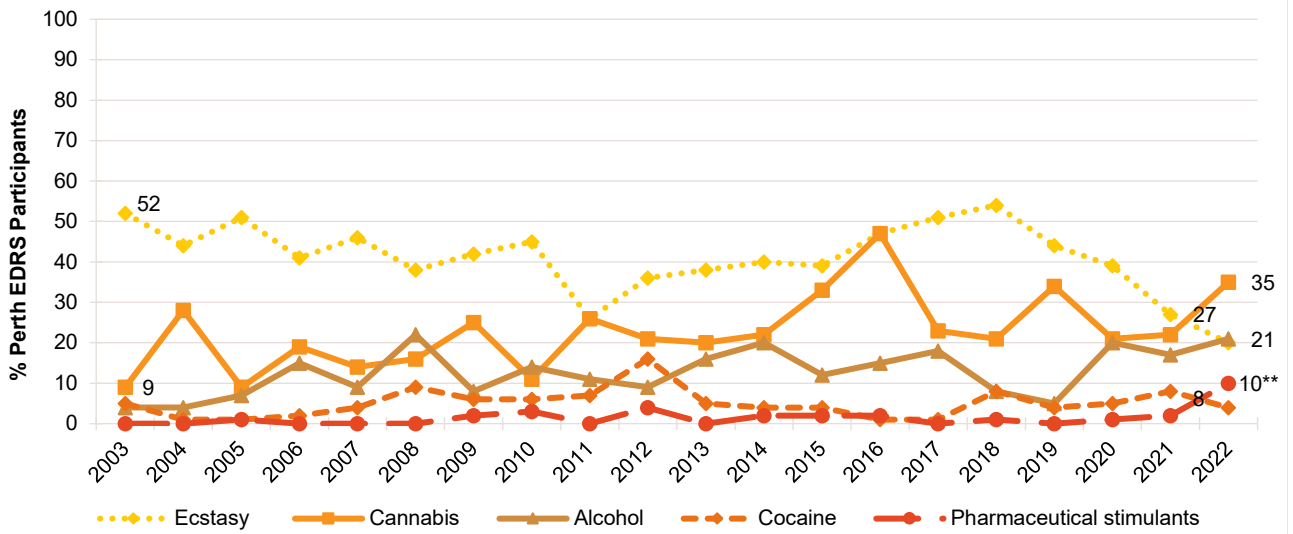
Note. ^Includes trade/technical and university qualifications.# 'students' comprised participants who were currently studying for either trade/technical or university/college qualifications. / not asked. + No fixed address included 'couch surfing and rough sleeping or squatting. - Per cent suppressed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

Drug of choice remained stable between 2021 and 2022 ( $p=0.165$ ), despite a further decline in the per cent nominating ecstasy as their preferred drug (20%; 27% in 2021) (Figure 1). However, a significant change was observed for the drug reportedly used most often in the past month ( $p=0.016$ ). Specifically, the per cent of participants reporting using alcohol most often in the month preceding the interview decreased (26%; 44% in 2021), while the per cent reporting cannabis slightly increased (37%; 32% in 2021) (Figure 2).

One-tenth (10%) of the sample reported weekly or more frequent ecstasy use in 2022; while this per cent is still substantially lower than what was observed in earlier monitoring years, this represents a significant increase relative to 2021 ( $p=0.033$ ) (Figure 3). Meanwhile, the per cent reporting weekly or more frequent cannabis use remained stable in 2022 (53%; 46% in 2021;  $p=0.395$ ).

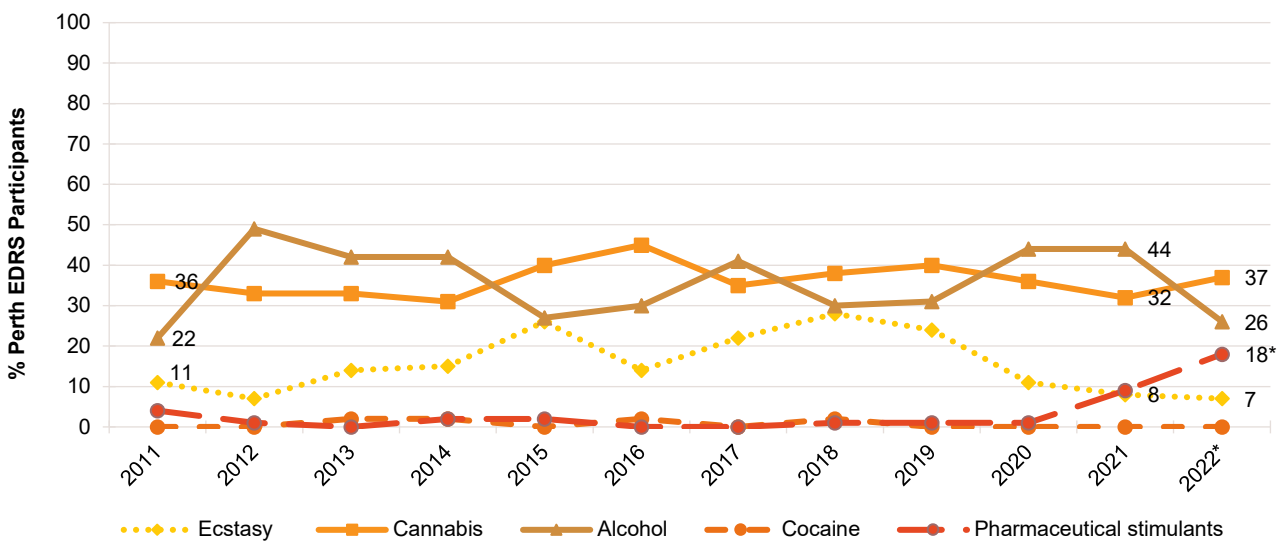
While few participants (n≤5) have nominated non-prescribed pharmaceutical stimulants as their drug of choice in earlier monitoring years, one-tenth (10%) of the sample did so in 2022 (n≤5 in 2021;  $p=0.004$ ). Moreover, almost one-fifth (18%) nominated non-prescribed pharmaceutical stimulants as the drug most commonly used in the month preceding their interview (9% in 2021;  $p=0.014$ ; n≤5 in earlier monitoring years). One-quarter (24%) of the sample reported using non-prescribed pharmaceutical stimulants weekly or more frequently in the preceding six months.

Figure 1: Drug of choice, Perth, WA, 2003-2022



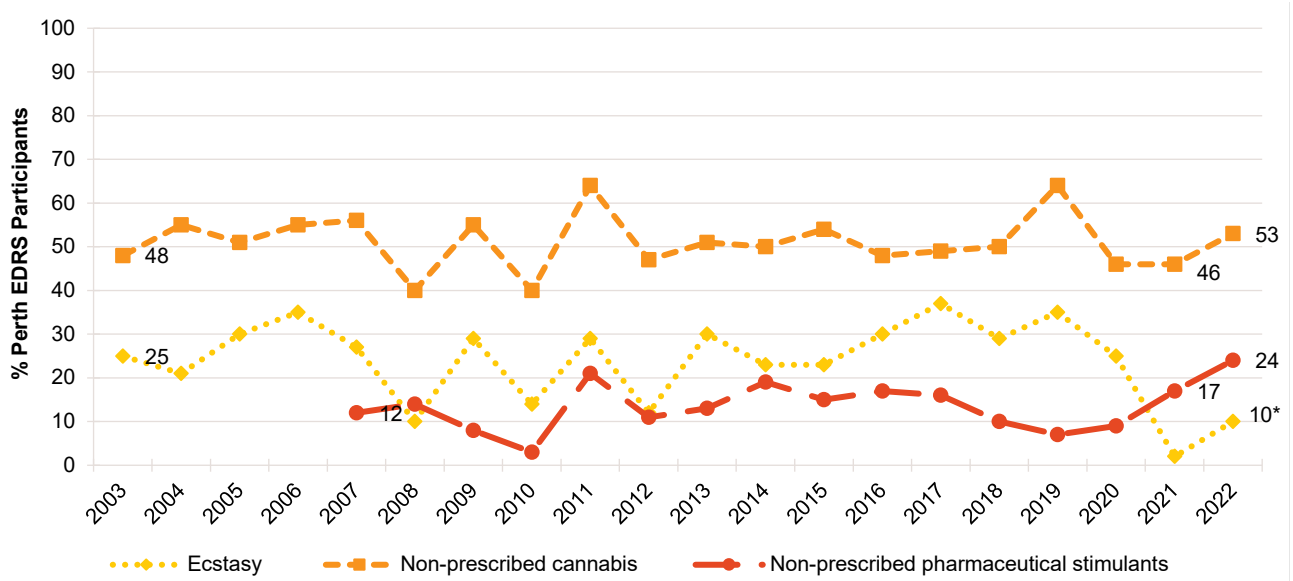
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. 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, Perth, WA, 2011-2022



Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Data are only presented for 2011-2022 as this question was not asked in 2003-2010. Data labels are only provided for the first (2011) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. 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, Perth, WA, 2003-2022



Note. Computed from the entire sample regardless of whether they had used the substance in the past six months. Monitoring of pharmaceutical stimulants commenced in 2007. Data labels are only provided for the first (2003/2004/2007) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## 2

## Ecstasy

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

## Patterns of Consumption (any ecstasy)

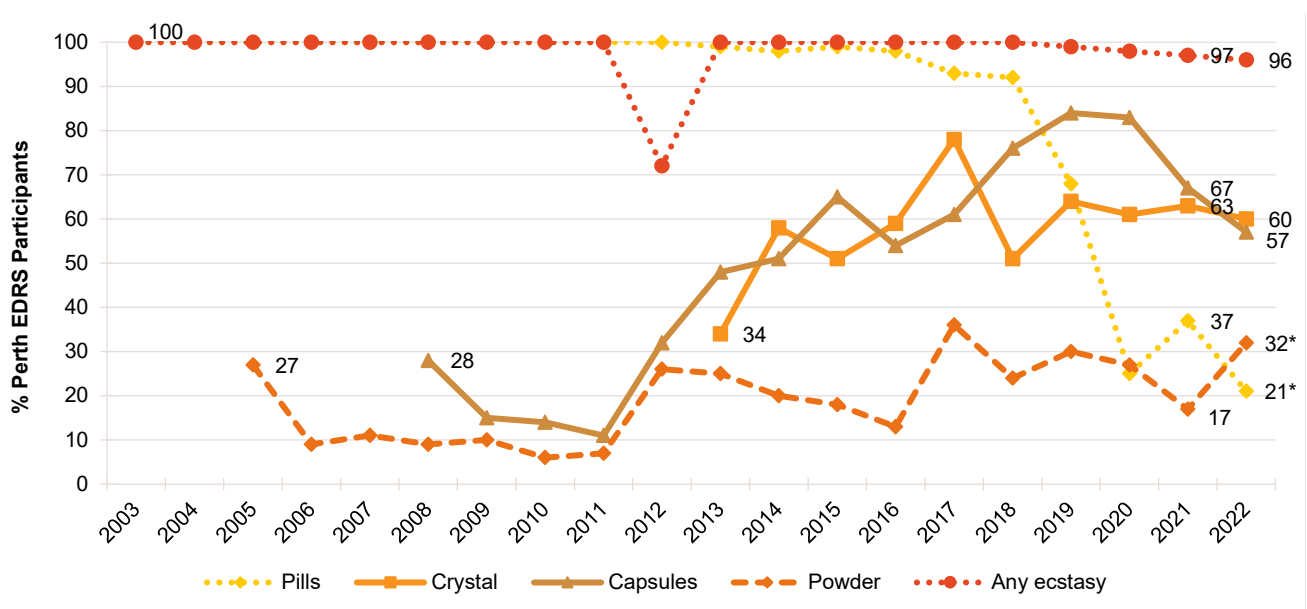
## Recent Use (past 6 months)

Nearly all participants (96%) reported use of any ecstasy in the six months preceding their interview, consistent with previous years (Figure 4) and reflecting the eligibility criteria (see [methods](#)). While the per cent reporting crystal and capsule forms remained stable between 2021 and 2022 ( $p=0.770$  and  $p=0.192$ , respectively), the per cent reporting recent use of pressed pills significantly decreased (21%; 37% in 2021;  $p=0.021$ ), while recent use of powder increased (32%; 17% in 2021;  $p=0.020$ ).

## Frequency of Use

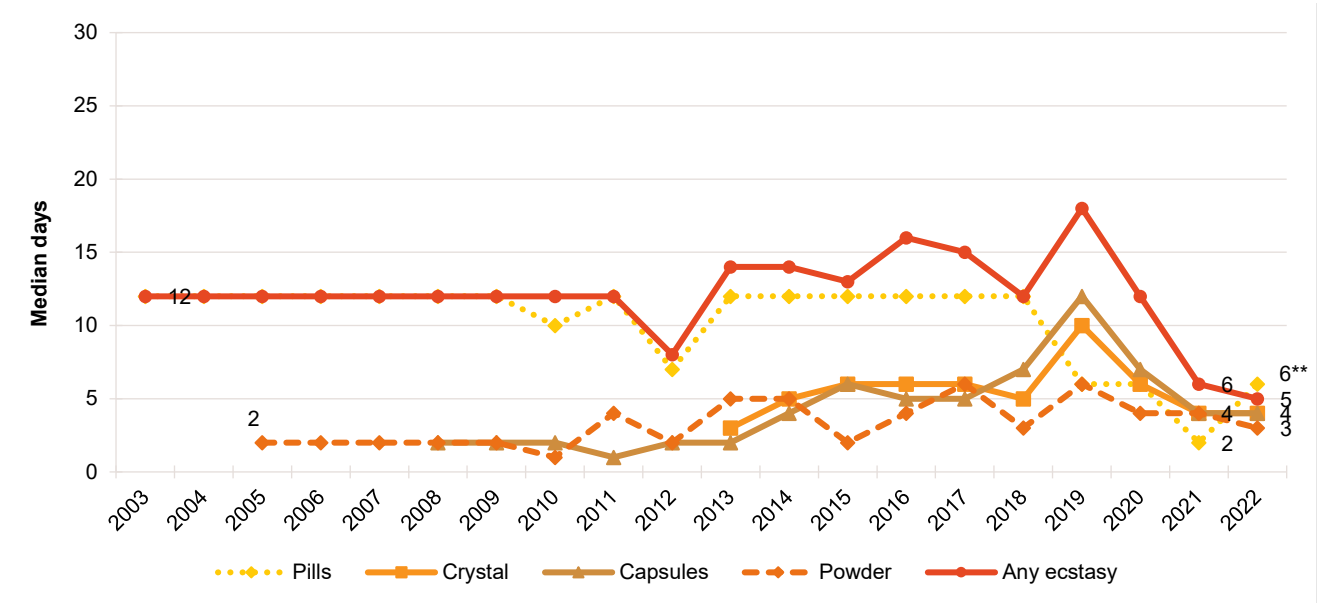
Participants reported using ecstasy (in any form) on a median of 5 days in the six months preceding their interview (IQR=3-12;  $n=96$ ), which remains lower than what has historically been observed, but is not significantly different relative to 2021 (6 days; IQR=4-12;  $p=0.545$ ) (Figure 5). However, the per cent reporting weekly or more frequent use of ecstasy (in any form) significantly increased in 2022 (10%;  $\leq 5$  participants in 2021;  $p=0.018$ ).

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



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Data collection for powder started in 2005, capsules in 2008 and crystal in 2013. The response option 'Don't know' was excluded from analysis. Data labels are only provided for the first (2003/2005/2008/2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. 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, Perth, WA, 2003-2022



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Data collection for powder started in 2005, capsules in 2008 and crystal in 2013. Median days computed among those who reported past 6-month use (maximum 180 days). Median days rounded to the nearest whole number. The response option 'Don't know' was excluded from analysis. Y axis reduced to 30 days to improve visibility of trends. Data labels are only provided for the first (2003/2005/2008/2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Patterns of Consumption (by form)

### Ecstasy Pills

**Recent Use (past 6 months):** One-fifth of the sample (21%) reported recent use of ecstasy pills in 2022, a significant decline from 37% in 2021 ( $p=0.021$ ) (Figure 4).

**Frequency of Use:** Ecstasy pills were used on a median of 6 days in the preceding six months (IQR=3-13;  $n=21$ ), a significant increase from 2 days in 2021 (IQR=1-5;  $p=0.001$ ) (Figure 5). Few participants reported weekly or more frequent use ( $n \leq 5$ ; 0% in 2021;  $p=0.043$ ).

**Routes of Administration:** Swallowing remained the most common route of administration (ROA) (95%; 92% in 2021), although two-fifths (43%) reported snorting (35% in 2021;  $p=0.583$ ).

**Quantity:** Of those who reported recent use and responded ( $n=21$ ), the median 'typical' amount used per session was 2 pills (IQR=2-3;

2 pills in 2021; IQR=1-2;  $n=37$ ;  $p=0.026$ ). Meanwhile, the median maximum amount used per session was 4 pills (IQR=3-6;  $n=21$ ), a significant increase from 2 pills in 2021 (IQR=1-3;  $n=37$ ;  $p=0.006$ ).

### Ecstasy Capsules

**Recent Use (past 6 months):** Whilst the per cent reporting recent use of capsules remained stable in 2022 (57%; 67% in 2021;  $p=0.192$ ), reported use of capsules has been declining since 2019 (83%) (Figure 4).

**Frequency of Use:** Capsules were used on a median of 4 days in the six months preceding interview (IQR=3-7;  $n=57$ ), stable from 4 days in 2021 (IQR=3-7;  $p=0.722$ ) (Figure 5). Few participants reported weekly or more frequent capsule use in 2022 ( $n \leq 5$ ; 0% in 2021;  $p=0.094$ ).

**Routes of Administration:** The most common ROA for capsules remained swallowing (100%; 97% in 2021;  $p=0.499$ ). Few participants reported snorting capsules in 2022 ( $n \leq 5$ ),

representing a significant decline from 34% in 2021 ( $p=0.001$ ).

**Quantity:** Among those who reported recent use and responded ( $n=57$ ), the median ‘typical’ amount used per session remained stable at 2 capsules (IQR=1-3; 2 capsules in 2021; IQR=1-3;  $n=67$ ;  $p=0.354$ ), while the median maximum amount used per session increased non-significantly to 4 capsules (IQR=2-5;  $n=57$ ; 2 capsules in 2021; IQR=2-4;  $n=67$ ;  $p=0.127$ ).

**Contents of Capsules:** Of those who reported recent use and responded ( $n=55$ ), most reported that their last capsule contained ecstasy in crystal form (84%; 90% in 2021), while one-quarter reported that it contained powder (25%; 18% in 2021). Few participants ( $n\leq 5$ ) reported that they did not look at the contents.

### Ecstasy Crystal

**Recent Use (past 6 months):** Recent use of ecstasy crystal remained stable at 60% (63% in 2021;  $p=0.770$ ) (Figure 4).

**Frequency of Use:** Participants reported using crystal on a median of 4 days in the preceding six months (IQR=3-7;  $n=60$ ), stable from 2021 (4 days; IQR=2-8;  $p=0.658$ ) (Figure 5). Few participants reported weekly or more frequent use of ecstasy crystal in 2022 ( $n\leq 5$ ;  $n\leq 5$  in 2021;  $p=0.357$ ).

**Routes of Administration:** The most common ROA for crystal remained swallowing (82%; 83% in 2021), followed by snorting (60%; 62% in 2021;  $p=0.851$ ).

**Quantity:** Of those able to respond ( $n=41$ ), the median ‘typical’ amount of ecstasy crystal used per session was 0.30 grams (IQR=0.20-0.50; 0.30 grams in 2021; IQR=0.20-0.40;  $n=53$ ;  $p=0.008$ ), while the median maximum amount used per session was 0.50 grams (IQR=0.50-1.00;  $n=42$ ), representing a significant increase from a maximum of 0.40 grams in 2021 (IQR=0.20-0.50;  $n=53$ ;  $p=0.001$ ).

### Ecstasy Powder

**Recent Use (past 6 months):** Recent use of ecstasy powder was reported by one-third (32%) of the sample in 2022, a significant

increase from 17% in 2021 ( $p=0.020$ ) (Figure 4).

**Frequency of Use:** Ecstasy powder was used on a median of 3 days in the preceding six months (IQR=2-10;  $n=32$ ), stable from 4 days in 2021 (IQR=1-6;  $p=0.687$ ) (Figure 5). Few participants ( $n\leq 5$ ) reported weekly or more frequent use of ecstasy powder in 2022 (0% in 2021).

**Routes of Administration:** The most common ROA for ecstasy powder remained snorting (88%; 94% in 2021;  $p=0.646$ ), while 44% reported swallowing (35% in 2021;  $p=0.763$ ).

**Quantity:** Of those able to respond ( $n=21$ ), the median ‘typical’ amount of powder used per session was 0.30 grams (IQR=0.20-0.50; 0.30 grams in 2021; IQR=0.10-0.50;  $n=13$ ;  $p=0.259$ ), while the median maximum amount used per session was 0.60 grams (IQR=0.30-1.00;  $n=22$ ; 0.50 grams in 2021; IQR=0.30-0.60;  $n=13$ ;  $p=0.309$ ).

## Price, Perceived Purity and Perceived Availability

### Ecstasy Pills

**Price:** Few participants ( $n\leq 5$ ) commented on the price of a single ecstasy pill in 2022 and therefore data are suppressed (\$25 in 2021; IQR=25-30;  $p=0.403$ ) (Figure 6).

**Perceived Purity:** Perceived purity of ecstasy pills remained stable between 2021 and 2022 ( $p=0.627$ ). Of those able to comment in 2022 ( $n=23$ ), the greatest percentage perceived the purity of pills as ‘low’ (39%; 37% in 2021), while remaining views were mixed (Figure 8). The proportion perceiving the purity of pills as being ‘low’ has been increasing since 2020.

**Perceived Availability:** No significant change was identified between 2021 and 2022 in terms of perceived availability ( $p=0.310$ ). Among those able to comment in 2022 ( $n=25$ ), about half perceived access as ‘difficult’ (52%; 31% in 2021), followed by ‘easy’ (28%; 29% in 2021). However, the proportion perceiving access to pills as ‘difficult’ has been increasing since 2020 (Figure 12).

## Ecstasy Capsules

**Price:** The median price per ecstasy capsule in 2022 was \$30 (IQR=30-35; n=19), representing a significant increase from \$28 in 2021 (IQR=25-30;  $p=0.009$ ) (Figure 7).

**Perceived Purity:** Perceived purity of ecstasy capsules remained stable between 2021 and 2022 ( $p=0.281$ ). Among those able to comment in 2022 (n=60), capsules were most commonly perceived as being of 'fluctuating' purity (33%; 26% in 2021), followed by 'low' purity (32%; 23% in 2021) (Figure 9).

**Perceived Availability:** No significant change was identified in the perceived availability of capsules between 2021 and 2022 ( $p=0.080$ ). Among those able to comment in 2022 (n=59), capsules were most commonly perceived as 'easy' to access (42%; 38% in 2021). However, the proportion perceiving access to capsules as 'difficult' has been increasing since 2020 (41% in 2022; 31% in 2021; 11% in 2020) (Figure 13).

## Ecstasy Crystal

**Price:** The median price per gram of ecstasy crystal significantly increased from \$250 in 2021 (IQR=200-300) to \$300 in 2022 (IQR=295-350; n=24;  $p=0.001$ ). The median price per gram has more than doubled since 2020 (\$125; IQR=100-150) (Figure 7).

**Perceived Purity:** Perceived purity of ecstasy crystal remained stable between 2021 and 2022 ( $p=0.507$ ). Among those able to comment in 2022 (n=49), crystal was most commonly perceived as 'high' (33%; 28% in 2021), followed by 'medium' (24%; 33% in 2021) and

'fluctuating' (24%; 29% in 2021). However, the proportion perceiving crystal as 'high' purity has been declining since 2021 (Figure 10).

**Perceived Availability:** Perceived availability remained stable between 2021 and 2022 ( $p=0.375$ ). Among those able to comment in 2022 (n=50), access was most commonly perceived as 'easy' (40%; 54% in 2021), followed by 'difficult' (32%; 25% in 2021) (Figure 14).

## Ecstasy Powder

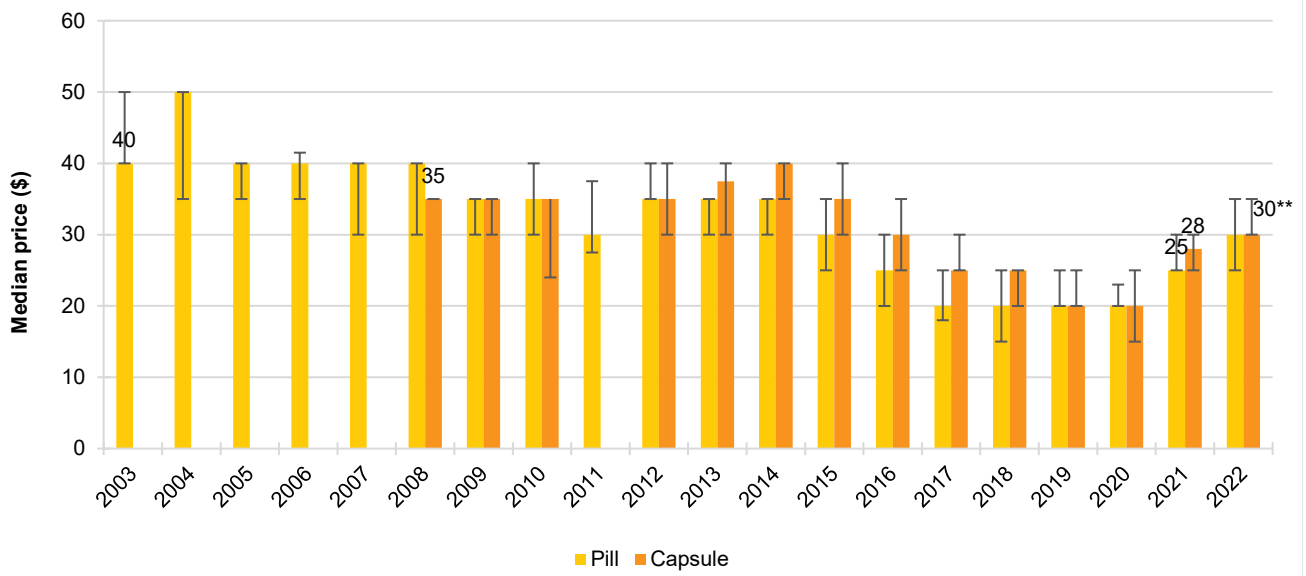
**Price:** The median price per gram of ecstasy powder in 2022 was \$350 (IQR=350-350; n=9). Few participants (n≤5) were able to comment on the price of ecstasy powder in 2021 ( $p=0.014$ ) (Figure 7).

**Perceived Purity:** A significant change was identified in the perceived purity of powder between 2021 and 2022 ( $p=0.009$ ). Among those able to comment in 2022 (n=24), there was an increase in the per cent reporting 'low' (33%; 17% in 2021) and 'medium' purity (46%; 33% in 2021), and a decrease in the per cent reporting 'fluctuating' purity (0%; 42% in 2021) (Figure 11).

**Perceived Availability:** A significant change was also identified in the perceived availability of powder between 2021 and 2022 ( $p=0.032$ ). Specifically, among those able to comment in 2022 (n=24), there was an increase in the per cent perceiving powder as being 'difficult' to obtain in 2022 (63%; 17% in 2021), while there was an inverse decrease in those reporting powder as 'easy' to access (29%; 58% in 2021) (Figure 15).

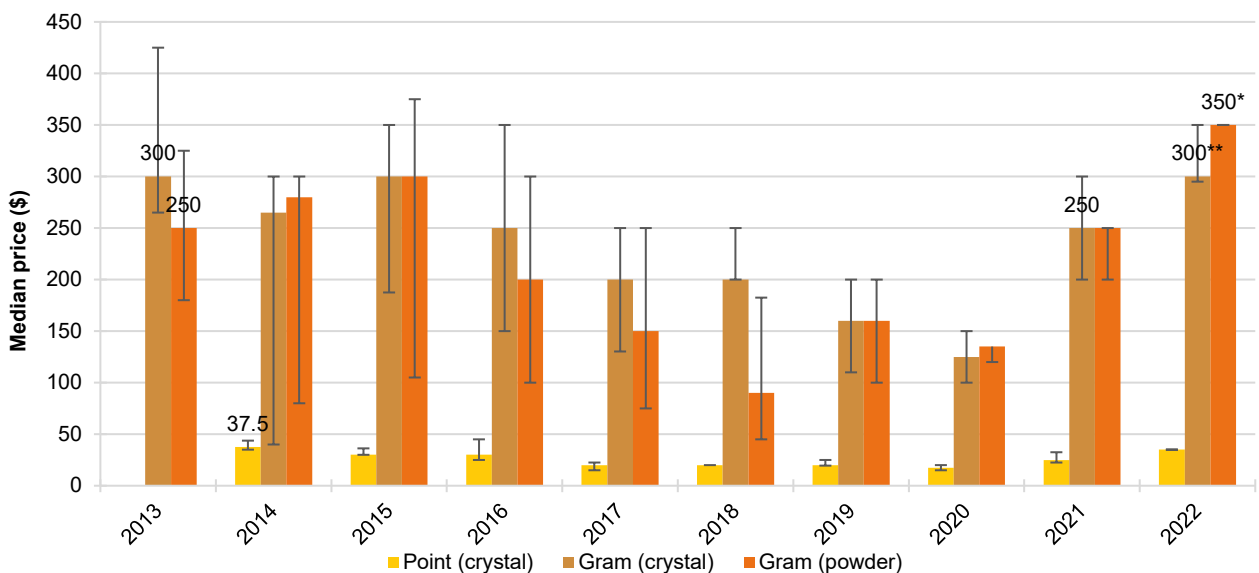


Figure 6: Median price of ecstasy pills and capsules, Perth, WA, 2003-2022



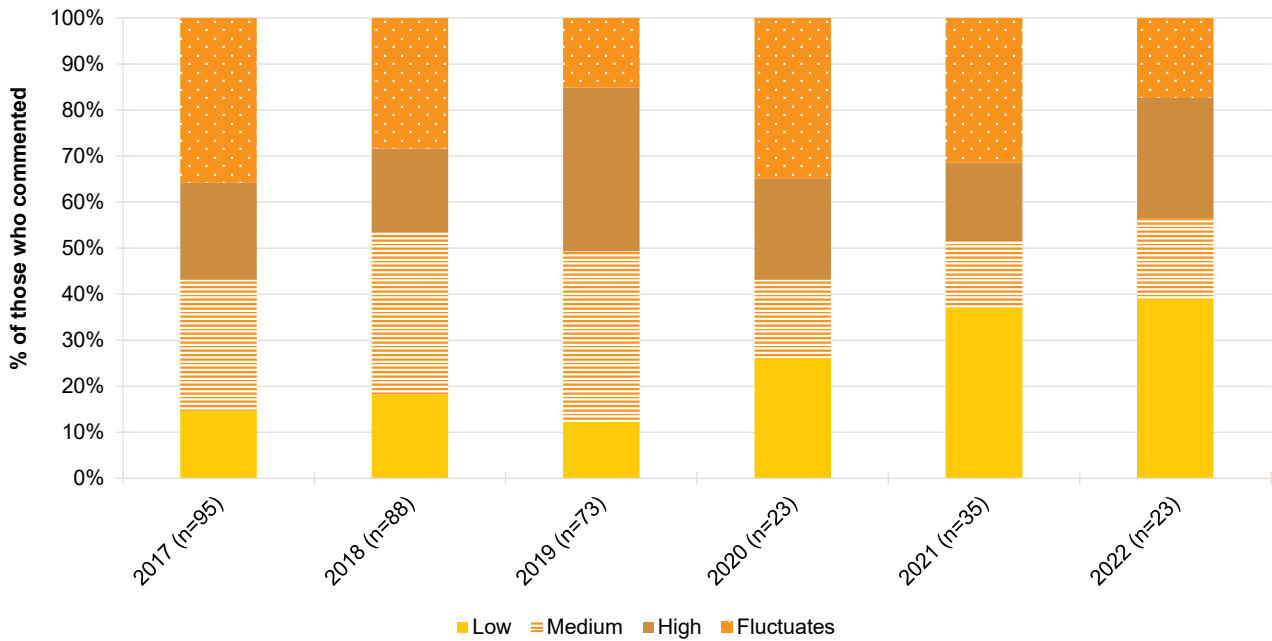
Note. Among those who commented. Data collection for price of ecstasy capsules started in 2008. Data labels are only provided for the first (2003/2008) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. 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 (gram only), Perth, WA, 2013-2022



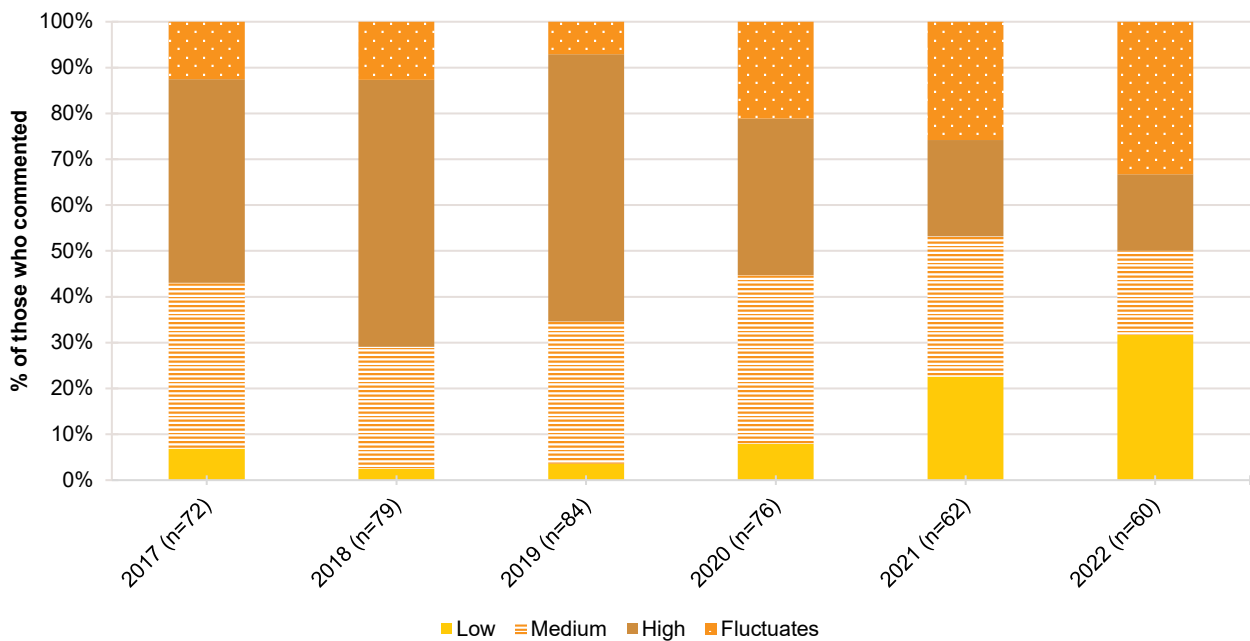
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) and ecstasy powder (gram) started in 2013. No participants reported price data for a 'point' of ecstasy crystal in 2013. Data labels are only provided for the first (2013) and two most recent years (2021 and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

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



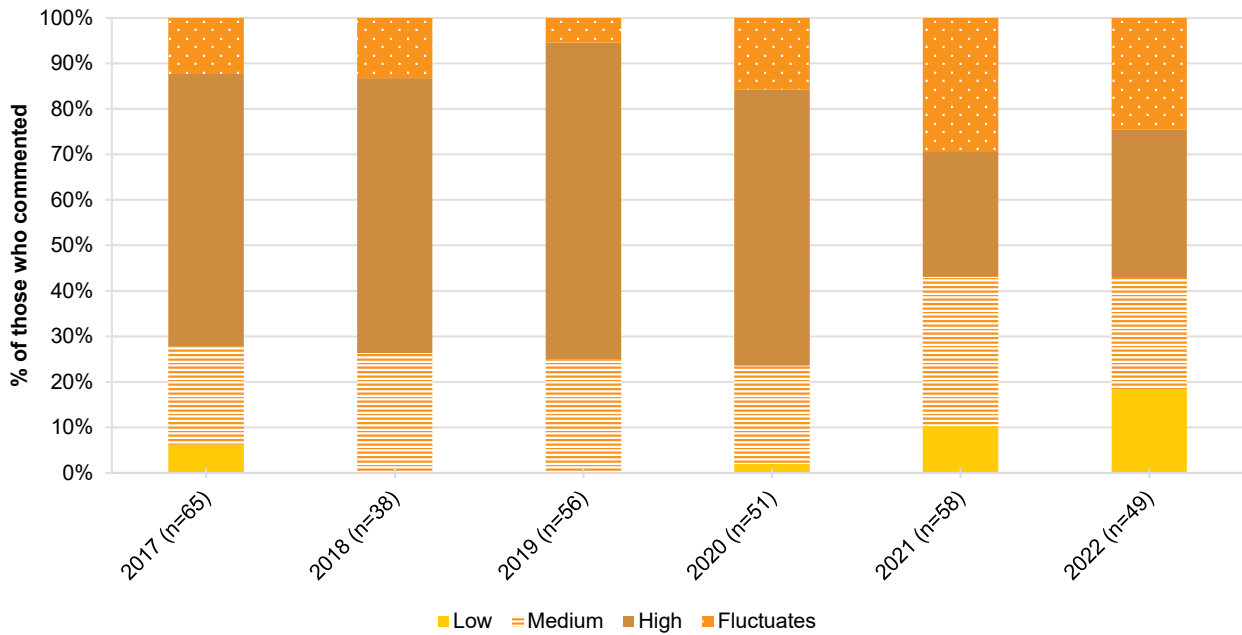
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure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

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



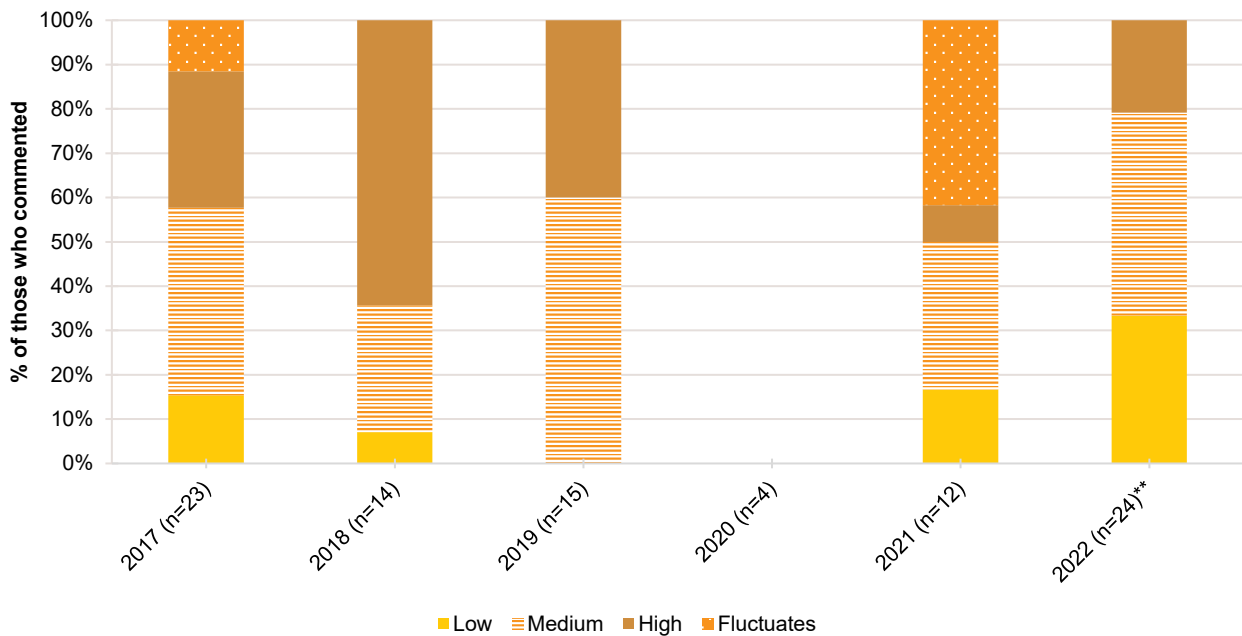
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure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

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



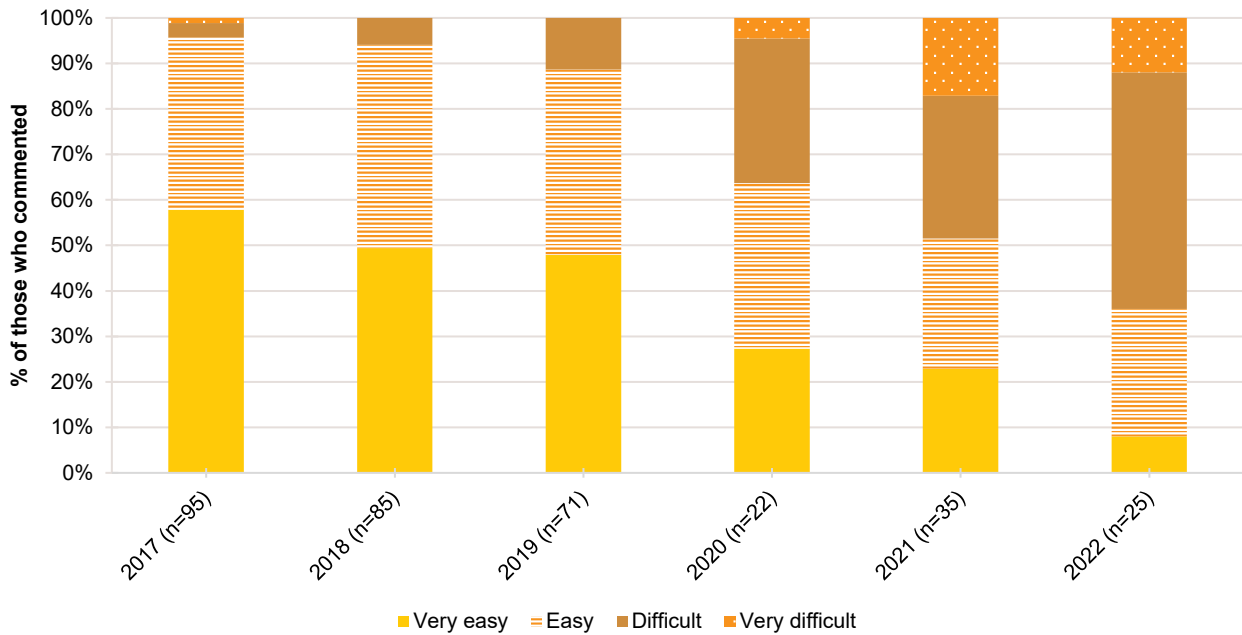
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure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

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



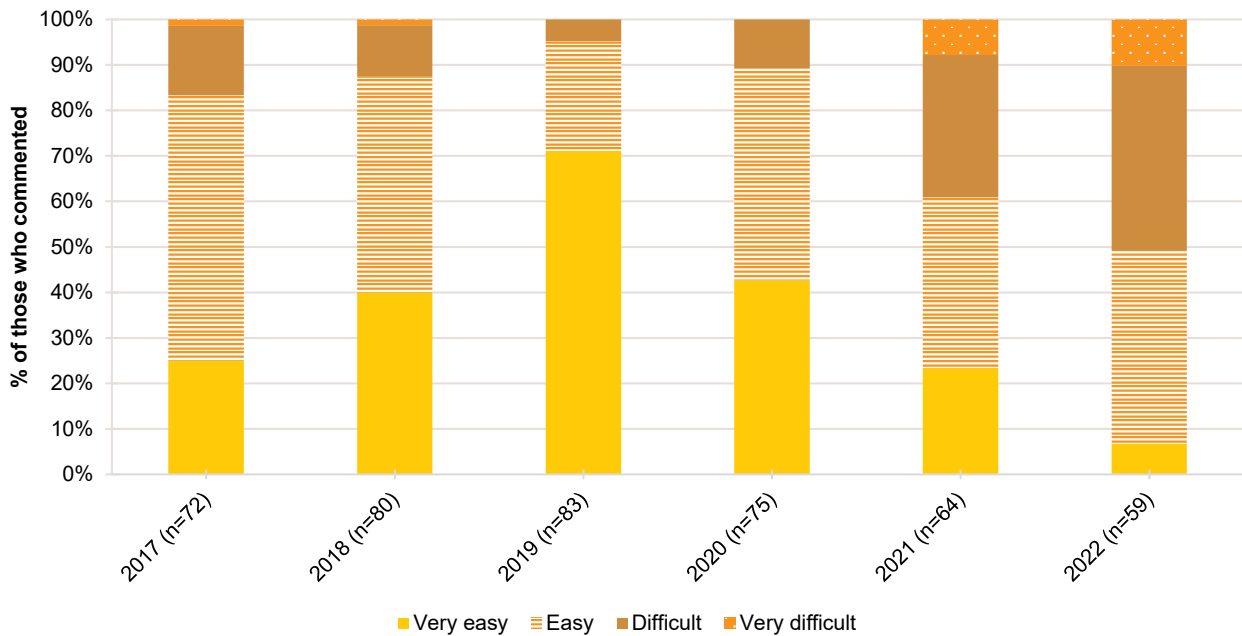
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure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

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



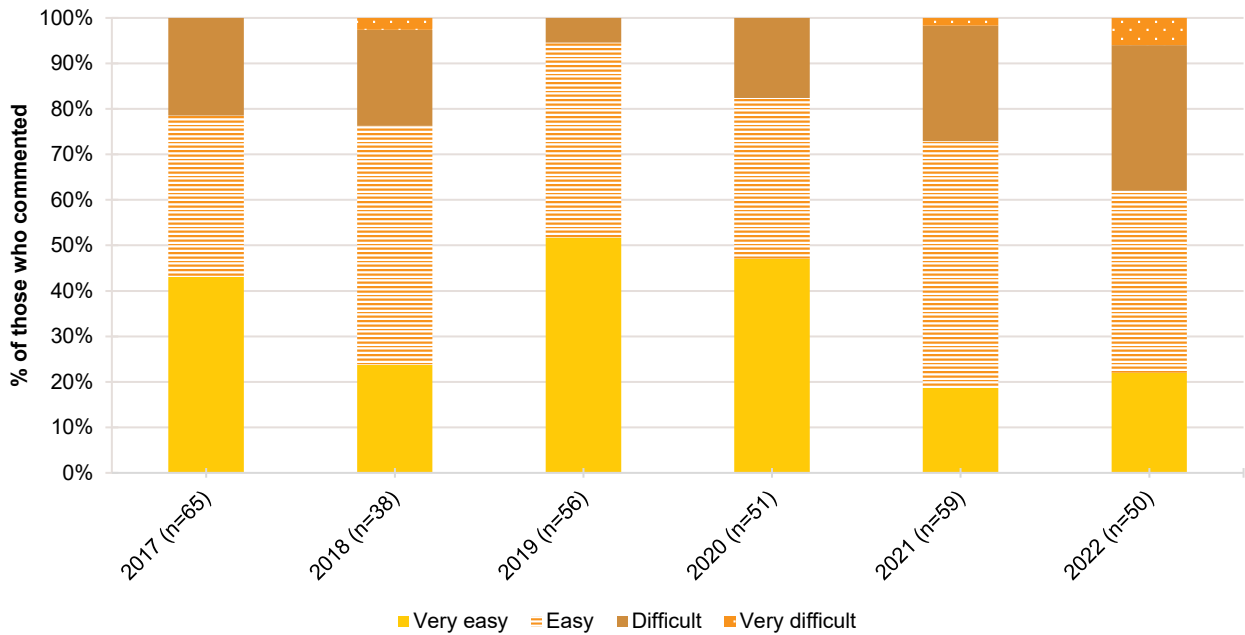
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure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

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



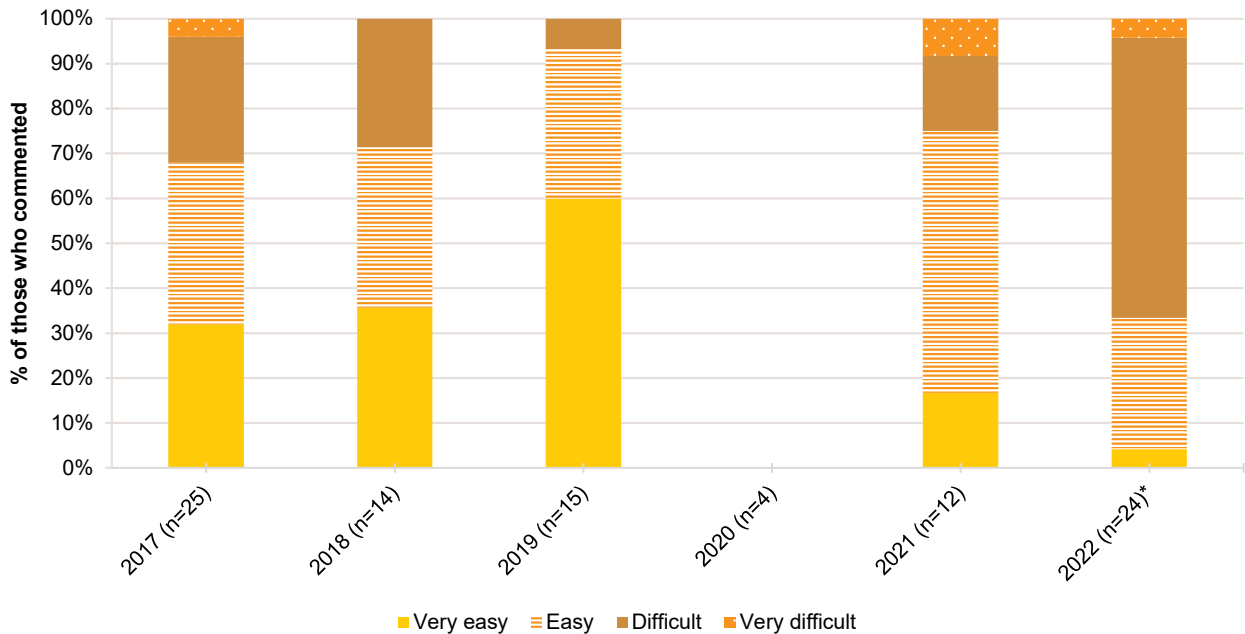
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure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

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



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

Figure 15: Current perceived availability of ecstasy powder, Perth, WA, 2017-2022



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

## 3

## Methamphetamine

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

### Patterns of Consumption (any methamphetamine)

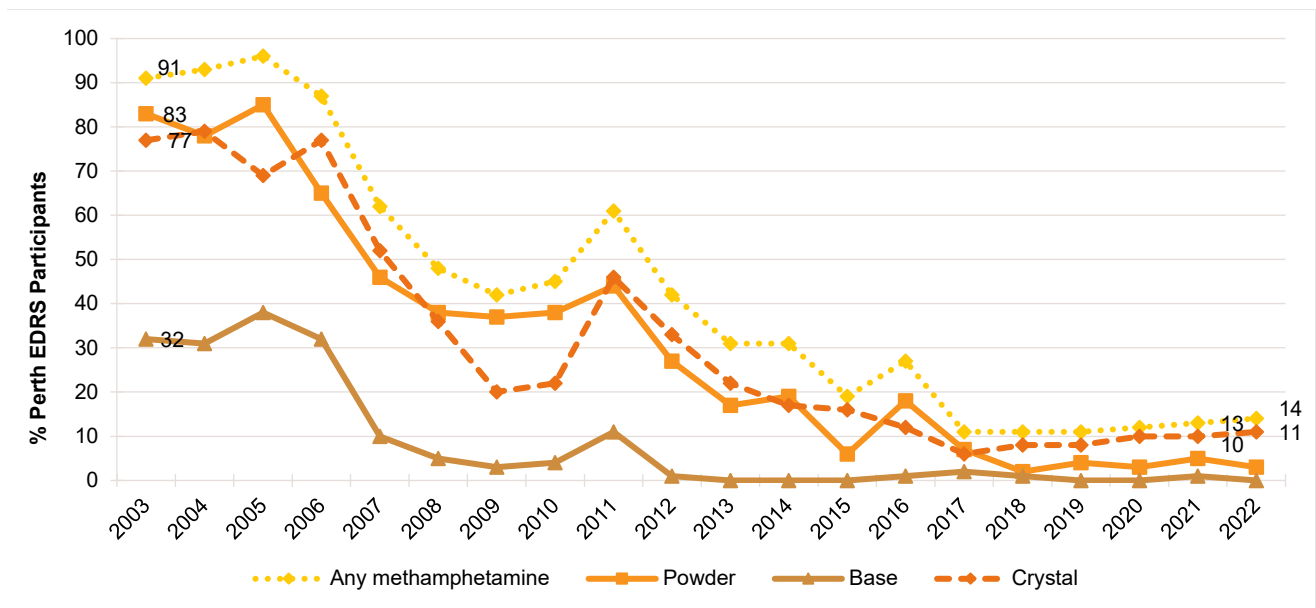
#### Recent Use (past 6 months)

In 2022, 14% of the sample reported recent use of any methamphetamine. Whilst the per cent reporting use has remained stable in recent years (13% in 2021), recent use of methamphetamine among the Perth sample has considerably declined since monitoring began in 2003 (91%) (Figure 16).

#### Frequency of Use

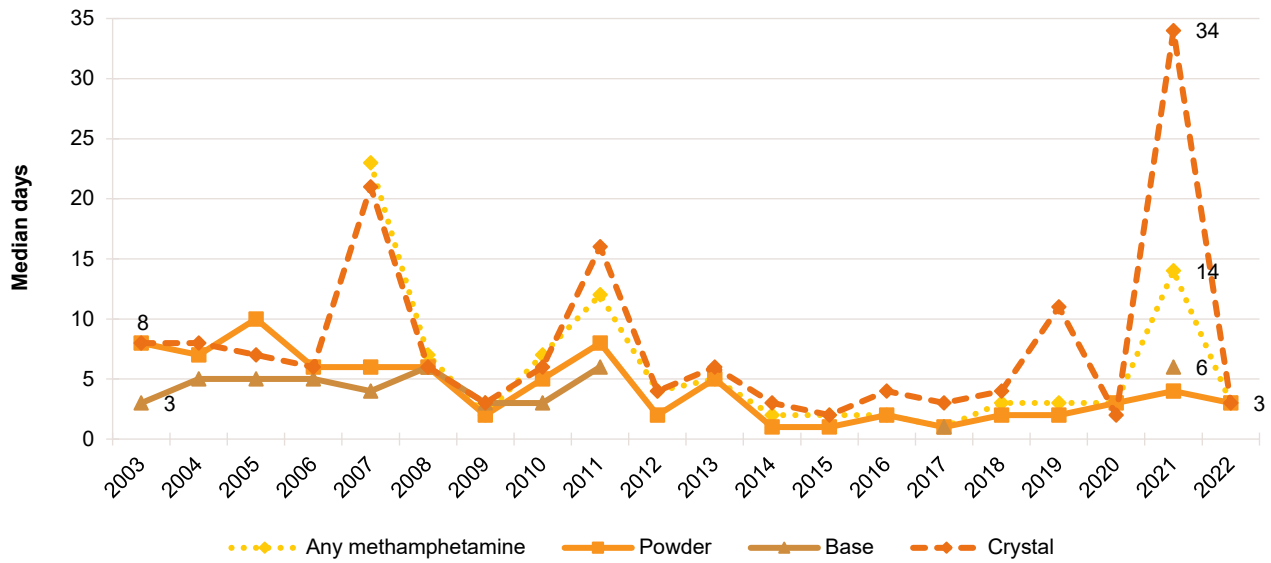
Participants reported using methamphetamine (in any form) on a median of 3 days in the six months preceding the interview (IQR=2-11), which represents a non-significant decline from 14 days in 2021 (IQR=4-60;  $p=0.107$ ), but is consistent with the type of low frequency use typically observed in the Perth EDRS sample (Figure 17). Among participants who had recently used methamphetamine (in any form), few ( $n\leq 5$ ) reported weekly or more frequent use ( $n\leq 5$  in 2021).

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



Note. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n\leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p<0.050$ ; \*\* $p<0.010$ ; \*\*\* $p<0.001$ .

Figure 17: Median days of any methamphetamine, powder, base, and crystal use in the past six months, Perth, WA, 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 35 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Patterns of Consumption (by form)

### Methamphetamine Powder

Few participants ( $n \leq 5$ ) reported recent use of methamphetamine powder in 2022 and preceding years, and therefore, further details are not reported. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### Methamphetamine Base

No participants reported recent use of methamphetamine base in 2022 and few ( $n \leq 5$ ) in preceding years, therefore, further details are not reported. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### Methamphetamine Crystal

**Recent Use (past 6 months):** Approximately one-tenth (11%) of the sample reported recent use of methamphetamine crystal in 2022, stable from 10% in 2021 (Figure 16).

**Frequency of Use:** Methamphetamine crystal was used on a median of 3 days in the six months preceding interview (IQR=2-18,  $n=11$ ), representing a decrease (non-significant) from 34 days in 2021 (IQR=11-57;  $p=0.103$ ), but consistent with low frequency use observed in past years (Figure 17). Few participants ( $n \leq 5$ ) reported weekly or more frequent use ( $\leq 5$  in 2021;  $p=0.387$ ).

**Routes of Administration:** Among those reporting crystal methamphetamine use ( $n=11$ ), most reported smoking it (91%;  $n=11$ ; 100% in 2021). No participants reported swallowing crystal methamphetamine in 2022 (0%; 0% in 2021).

**Quantity:** Among those able to respond ( $n=9$ ), the median 'typical' amount used per session was 0.10 grams (IQR=0.10-0.20; 0.20 grams in 2021; IQR=0.10-0.50;  $n=10$ ;  $p=0.080$ ), while the median maximum amount used was 0.30 grams (IQR=0.10-0.40;  $n=10$ ; 0.30 grams in 2021; IQR=0.20-0.90;  $n=10$ ;  $p=0.357$ ).

## Price, Perceived Purity and Perceived Availability

Due to low numbers ( $n \leq 5$ ), details will not be reported on the price, perceived purity and perceived availability for methamphetamine powder or base. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### Methamphetamine Crystal

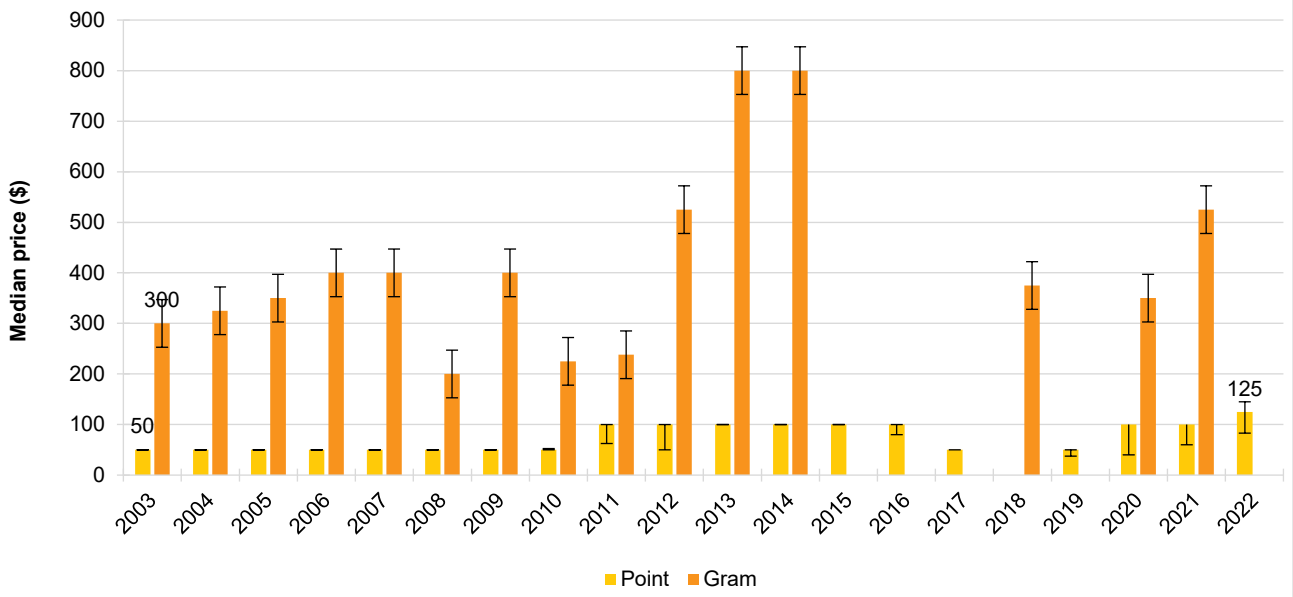
**Price:** Among those able to comment ( $n=6$ ), the median price per point of crystal methamphetamine was \$125 (IQR=83-145;  $n \leq 5$  were able to comment on price in 2021;  $p=0.364$ ).

**Perceived Purity:** The perceived purity of methamphetamine crystal remained stable between 2021 and 2022 ( $p=0.367$ ). Among those who were able to comment in 2022 ( $n=14$ ), the greatest per cent perceived purity as 'high' (64%; 38% in 2021) (Figure 19).

**Perceived Availability:** The perceived availability of crystal methamphetamine also remained stable between 2021 and 2022 ( $p=0.687$ ). Among those able to comment in 2022 ( $n=14$ ), 43% reported access as being 'easy' (44% in 2021), with a further 43% nominating 'very easy' (56% in 2021) (Figure 20).

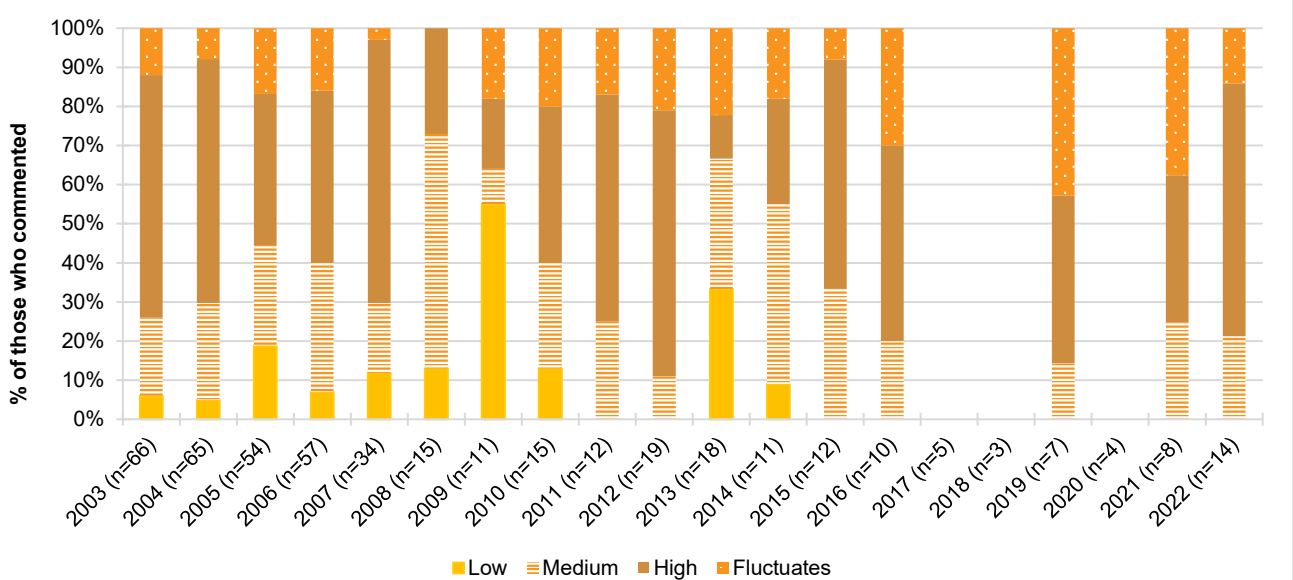


Figure 18: Median price of methamphetamine crystal per point and gram, Perth, WA, 2003-2022



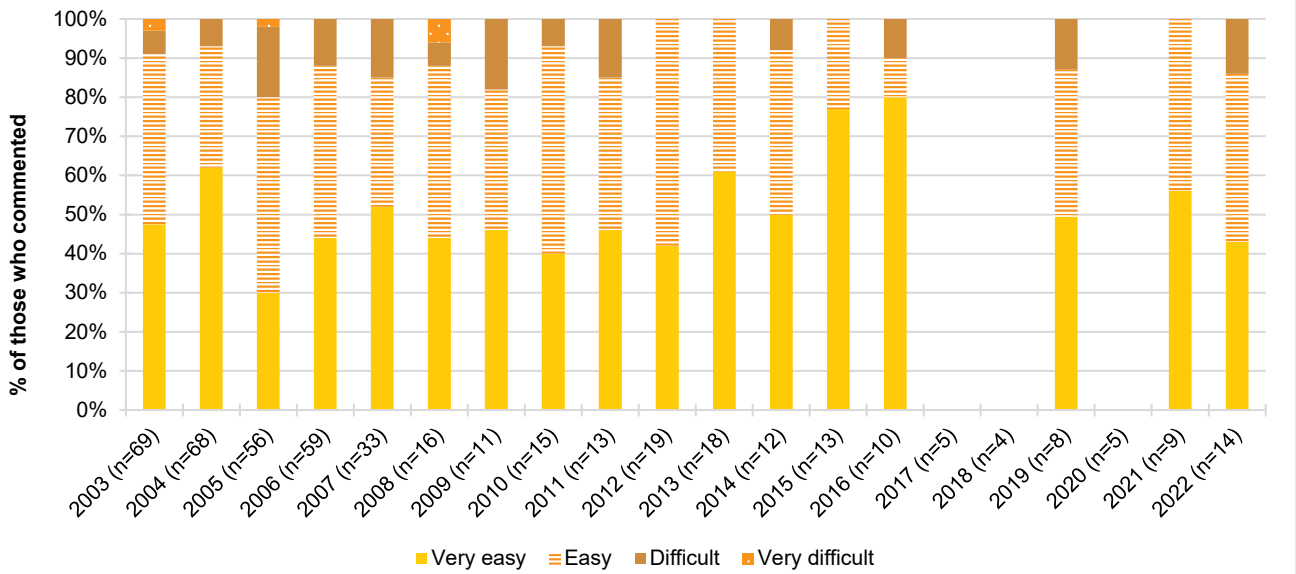
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 19: Current perceived purity of methamphetamine crystal, Perth, WA, 2003-2022



Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 20: Current perceived availability of methamphetamine crystal, Perth, WA, 2003-2022



Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

# 4

## Cocaine

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

### Patterns of Consumption

#### Recent Use (past 6 months)

Since 2016, the per cent reporting any recent cocaine use has steadily increased. In 2022, two-thirds (66%) of the Perth sample reported recent use (59% in 2021;  $p=0.381$ ), representing the highest per cent observed since monitoring began (Figure 21).

#### Frequency of Use

Cocaine was used on a median of 2 days in the six months preceding interview (IQR=1-4). While this represents a significant decrease from 5 days in 2021 (IQR=2-7;  $p=0.001$ ), it is consistent with the type of low frequency use typically observed in past years (Figure 21). Weekly or more frequent use of cocaine remained uncommon ( $n\leq 5$ ).

#### Routes of Administration

The main route of administration for cocaine has consistently been 'snorting' (100% in 2022; 98% in 2021;  $p=0.472$ ). Few participants ( $n\leq 5$ ) reported 'swallowing' cocaine in 2022, representing a significant decline from 20% in 2021 ( $p=0.029$ ).

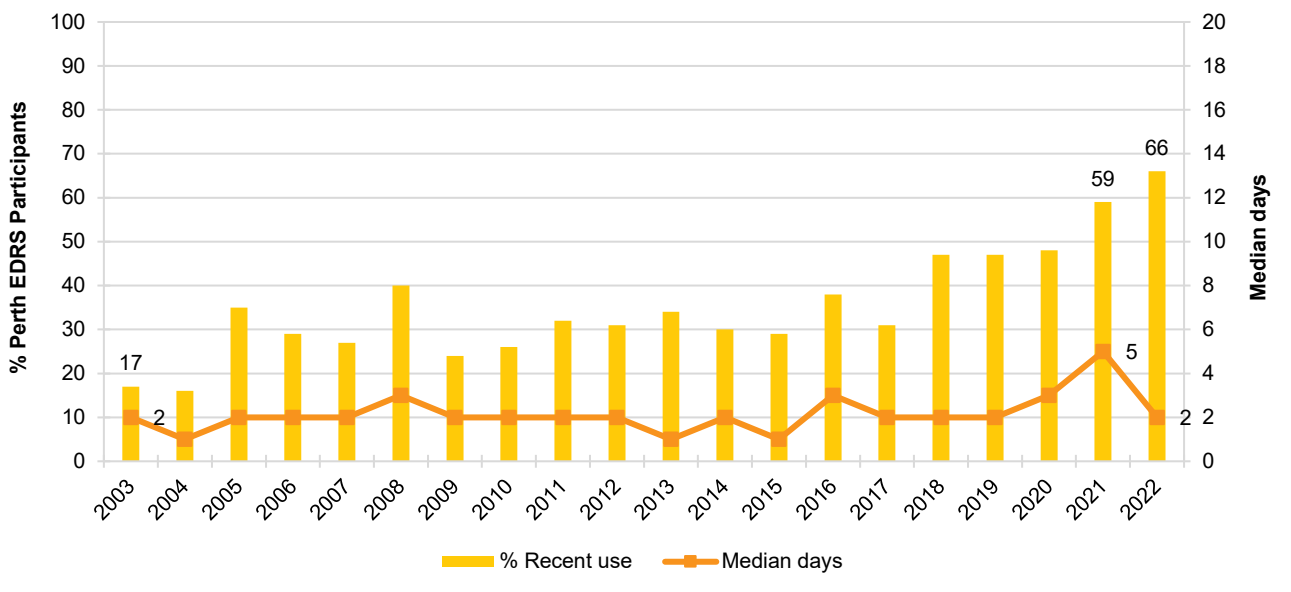
#### Quantity

Of those who reported recent cocaine use and were able to comment on quantities ( $n=29$ ), the median 'typical' amount used per session was 0.50 grams (IQR=0.30-1.00; 0.50 grams in 2021; IQR=0.20-0.50;  $n=41$ ;  $p=0.272$ ), while the median maximum amount used per session was 1 gram (IQR=0.30-1.80;  $n=29$ ; 0.50 grams in 2021; IQR=0.30-1.00;  $n=40$ ;  $p=0.350$ ).

#### Forms used

Among participants who had recently used cocaine ( $n=66$ ), the vast majority reported using the powder form (97%; 98% in 2021). Few participants ( $n\leq 5$ ) reported using cocaine which came in rock form.

Figure 21: Past six month use and frequency of use of cocaine, Perth, WA, 2003-2022



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 20 days to improve visibility of trends for days of use. Data labels are only provided for the first (2003) and two most recent years (2020 and 2021) of monitoring, however labels are suppressed where there are small numbers (i.e.  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Price, Perceived Purity and Perceived Availability

### Price

The median price per gram of cocaine in 2022 was \$400 (IQR=350-400), which was stable relative to 2021 (\$400; IQR=388-400;  $p=0.950$ ) (Figure 22).

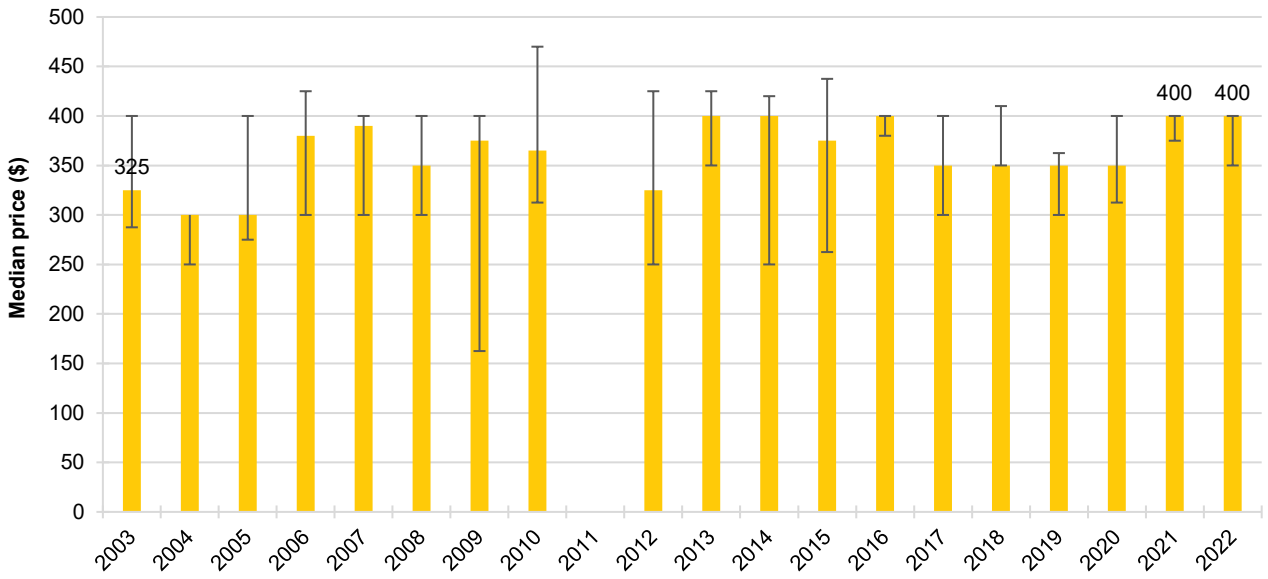
### Perceived Purity

There was no significant difference in perceived purity of cocaine between 2021 and 2022 ( $p=0.847$ ). Among those able to comment in 2022 ( $n=45$ ), the most commonly reported perception was that cocaine was 'low' purity (36%; 28% in 2021), followed by 'medium' (29%; 28% in 2021) (Figure 23).

### Perceived Availability

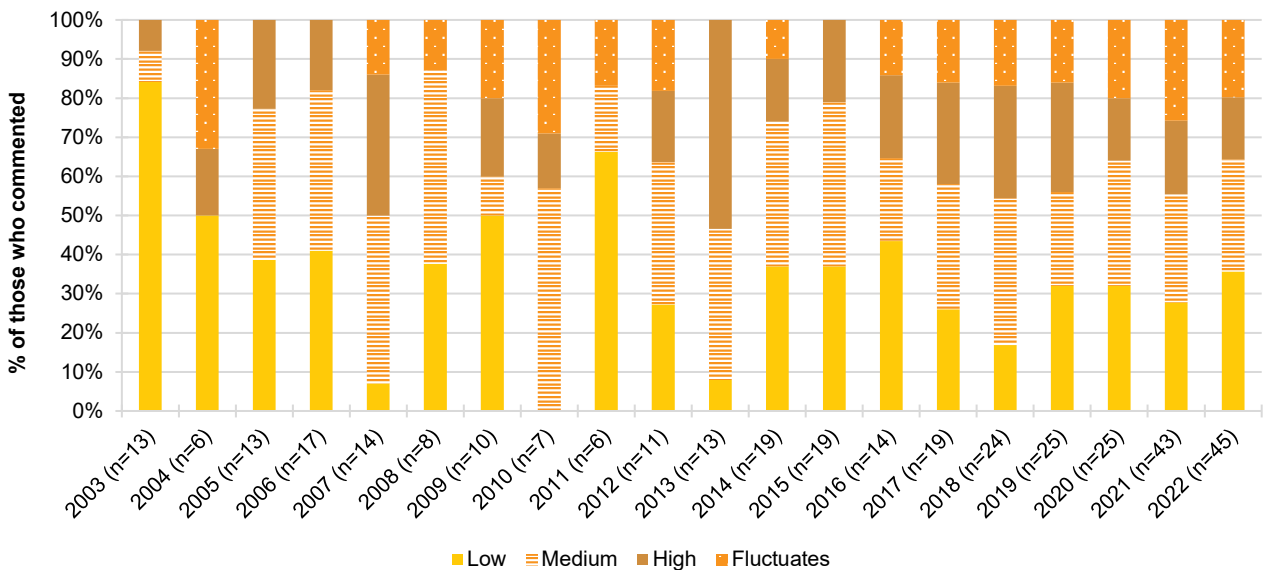
There was also no significant difference in the perceived availability of cocaine between 2021 and 2022 ( $p=0.163$ ). Among those able to comment in 2022 ( $n=45$ ), most (62%) considered cocaine as being 'easy' or 'very easy' to obtain (76% in 2021), while almost one-third considered it 'difficult' (31%; 23% in 2021) to obtain (Figure 24).

Figure 22: Median price of cocaine per gram, Perth, WA, 2003-2022



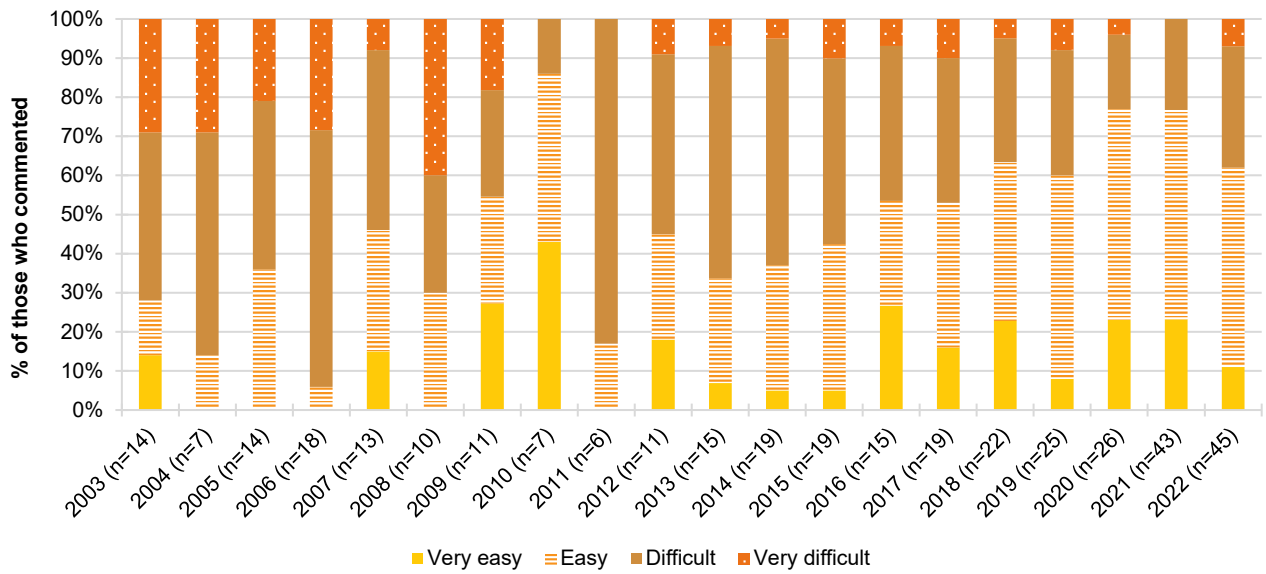
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 23: Current perceived purity of cocaine, Perth, WA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 24: Current perceived availability of cocaine, Perth, WA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

# 5

## Cannabis and/or Cannabinoid Related Products

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

Terminology throughout this chapter refers to:

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

## Patterns of Consumption

In 2022, participants were asked for the first time about their use of both prescribed and non-prescribed cannabis and/or cannabinoid related products (including hydroponic and bush cannabis, hash, hash oil, CBD extract, THC extract); few participants ( $n \leq 5$ ) in Perth reported prescribed use in the six months preceding interview.

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

### Recent Use (past 6 months)

In 2022, most (84%) of the Perth participants reported use of non-prescribed cannabis and/or cannabinoid related products (82% in 2021;  $p=0.847$ ). At least three-in-four participants have reported any recent use of non-prescribed cannabis and/or cannabinoid related products each year since 2003 (Figure 25).

### Frequency of Use

Median frequency of cannabis use has varied between weekly and twice weekly over the course of monitoring. Among those who reported recent use of non-prescribed cannabis and/or cannabinoid related products ( $n=84$ ), cannabis was used on a median of 50 days (IQR=10-175) in the preceding six months, stable relative to 2021 (42 days; IQR=6-144;  $p=0.450$ ) (Figure 25). Almost two-thirds (63%;  $n=53$ ) reported using non-prescribed cannabis on a weekly or more frequent basis (57% in 2021;  $p=0.430$ ), including one-quarter (25%) who reported using it daily (21% in 2021;  $p=0.578$ ).

### Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid related products ( $n=84$ ), the vast majority (94%) reported smoking it in the past six months (98% in 2021;

$p=0.443$ ), 29% reported swallowing it (48% in 2021;  $p=0.017$ ) and 11% reported inhaling or vaporising (20% in 2021;  $p=0.139$ ).

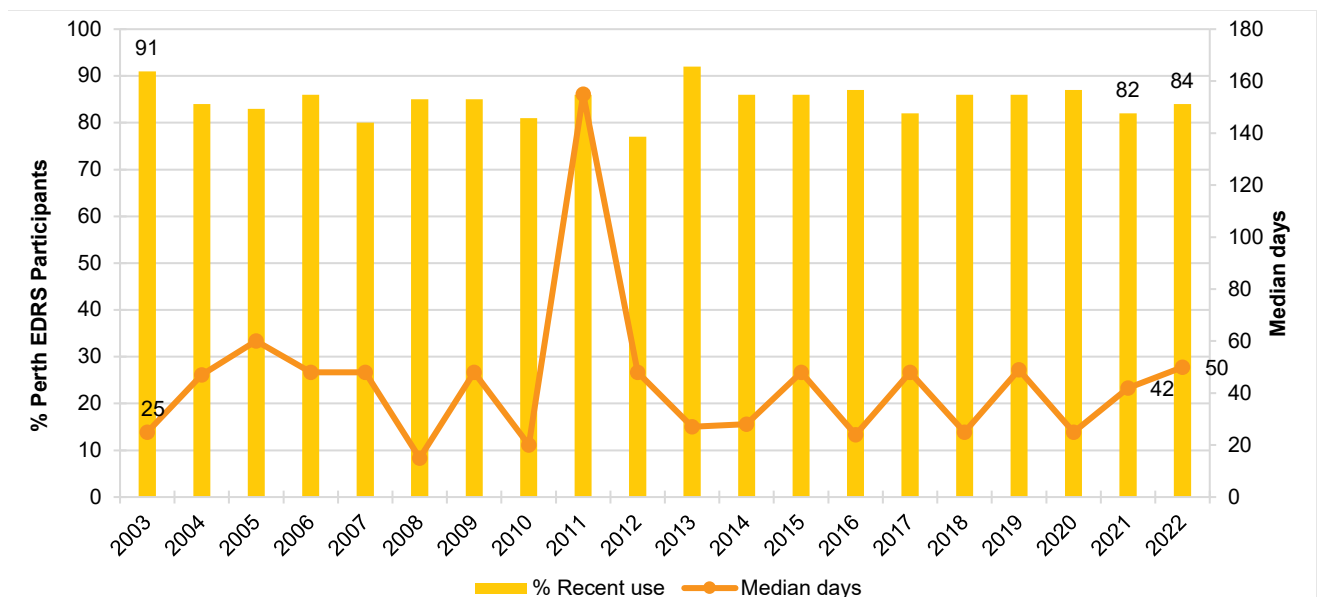
### Quantity

Among participants who reported recent non-prescribed cannabis use, the median amount used on the last occasion of use was 1.00 gram (IQR=0.50-1.50 grams;  $n=30$ ; 1.10 grams in 2021; IQR=0.50-2.00;  $n=16$ ;  $p=0.633$ ), 3 cones (IQR=1-4;  $n=36$ ; 3 cones in 2021; IQR=2-5;  $n=28$ ;  $p=0.859$ ) or 1 joint (IQR=1-1;  $n=22$ ; 2 joints in 2021; IQR=1-3;  $n=28$ ;  $p=0.122$ ).

### Forms Used

Among participants who had recently used non-prescribed cannabis and/or cannabinoid related products and were able to comment ( $n=78$ ), about two-thirds reported recent use of hydroponic cannabis (64%), representing a significant decline from 82% in 2021 ( $p=0.020$ ). Meanwhile, two-thirds also reported recent use of outdoor-grown 'bush' (64%; 55% in 2021;  $p=0.318$ ). In 2022, few participants ( $n\leq 5$ ) reported recent use of hashish (11% in 2021;  $p=0.118$ ) or hash oil (6% in 2021;  $p=0.425$ ), respectively. However, 12% reported recent use of (non-prescribed) CBD extract in 2022 ( $n\leq 5$  reported CBD oil in 2021). Few participants ( $n\leq 5$ ) reported use of THC extract in 2022. Use of THC extract was not asked in 2021.

Figure 25: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid related products, Perth, WA, 2003-2022



Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Further, in 2022, we captured use of 'cannabis and/or cannabinoid related products', while in previous years questions referred only to 'cannabis'. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n\leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p<0.050$ ; \*\* $p<0.010$ ; \*\*\* $p<0.001$ .

## Price, Perceived Potency and Perceived Availability

### Hydroponic Cannabis

**Price:** The median price per gram of hydroponic cannabis in 2022 was \$25 (IQR=19-25;  $n=11$ ; \$25 in 2021; IQR=25-25;  $p=0.370$ ); this price has been mostly consistent since monitoring began in 2006.



The median price per ounce was \$400 (IQR=350-400; n=13), stable relative to 2021 (\$400; IQR=380-400;  $p=0.680$ ), but more expensive than the median price in earlier monitoring years (Figure 26a).

**Perceived Potency:** There was no significant change in perceptions of non-prescribed hydroponic cannabis potency between 2021 and 2022 ( $p=0.443$ ). Of those who commented in 2022 (n=46), half perceived the potency as 'high' (52%; 51% in 2021), 15% as 'medium' (27% in 2021) and 30% as 'fluctuating' (22% in 2021) (Figure 27a).

**Perceived Availability:** There was no significant change in perceptions of non-prescribed hydroponic cannabis availability between 2021 and 2022 ( $p=0.184$ ). Of those who commented in 2022 (n=45), the vast majority (95%) perceived the availability of hydroponic cannabis as being 'easy' or 'very easy' to obtain (88% in 2021) (Figure 28a).

### Bush Cannabis

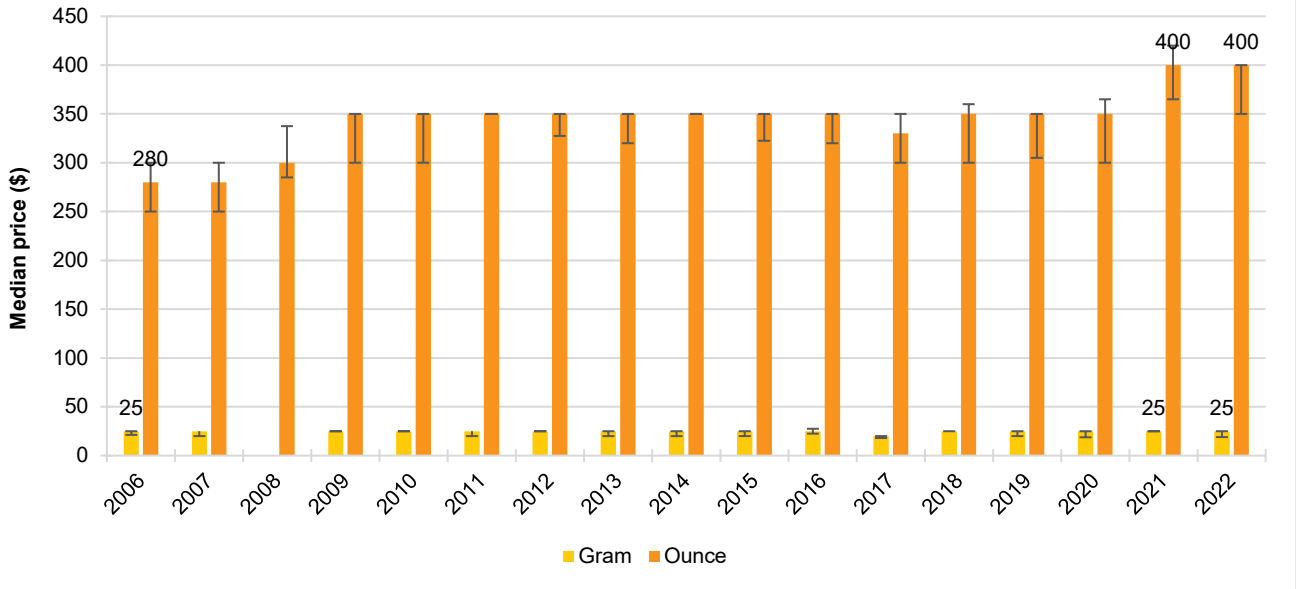
**Price:** The median price per gram of non-prescribed bush cannabis in 2022 was \$20 (IQR=15-25; n=10). Few participants (n≤5) were able to comment in 2021, but the price per gram of bush has fluctuated between \$20 and \$25 since monitoring began. Meanwhile, the median price per ounce of non-prescribed bush cannabis in 2022 was \$280 (IQR=260-350; n=9), stable relative to 2021 (\$300; IQR=300-350;  $p=0.503$ ), although the price has fluctuated between about \$250 and \$350 across reporting years (Figure 26b).

**Perceived Potency:** There was no significant change in perceptions of non-prescribed bush cannabis potency between 2021 and 2022 ( $p=0.850$ ). Of those who commented in 2022 (n=32), the highest percentage perceived the potency as 'medium' (41%; 44% in 2021), followed by 'low' (31%; 28% in 2021) (Figure 27b).

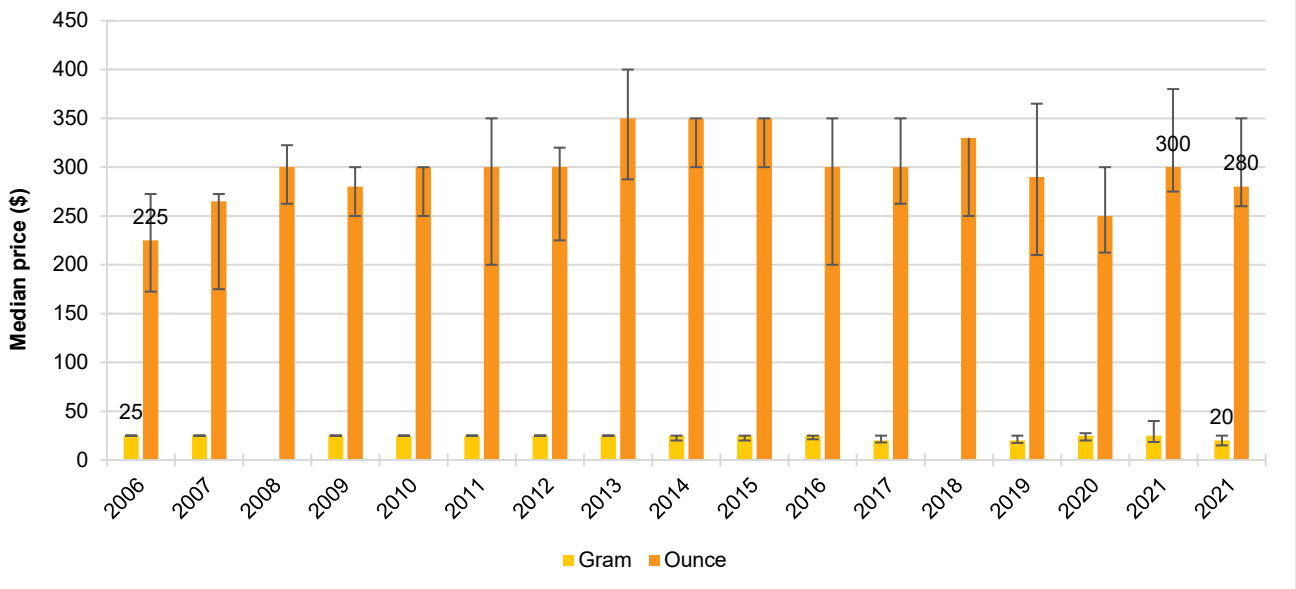
**Perceived Availability:** The perceived availability of non-prescribed bush cannabis also remained stable between 2021 and 2022 ( $p=0.917$ ). Of those who commented in 2022 (n=33), most (91%) reported that non-prescribed bush cannabis was 'easy' or 'very easy' to obtain (92% in 2021) (Figure 28b).

Figure 26: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Perth, WA, 2006-2022

(A) Hydroponic cannabis



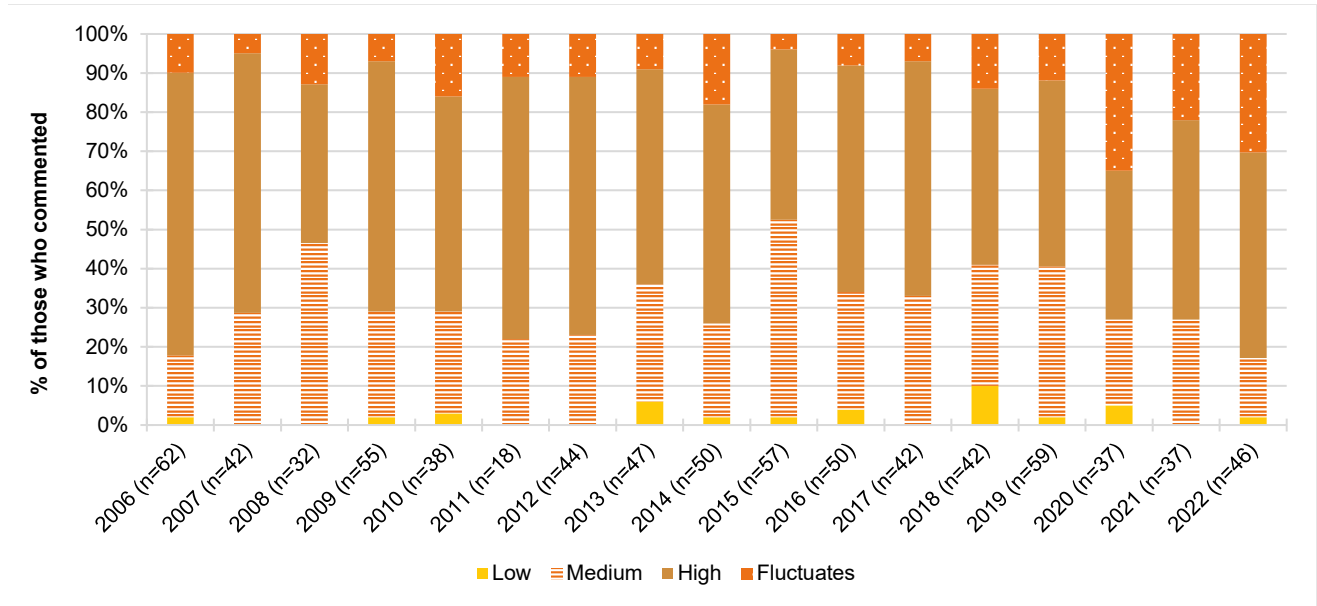
(B) Bush cannabis



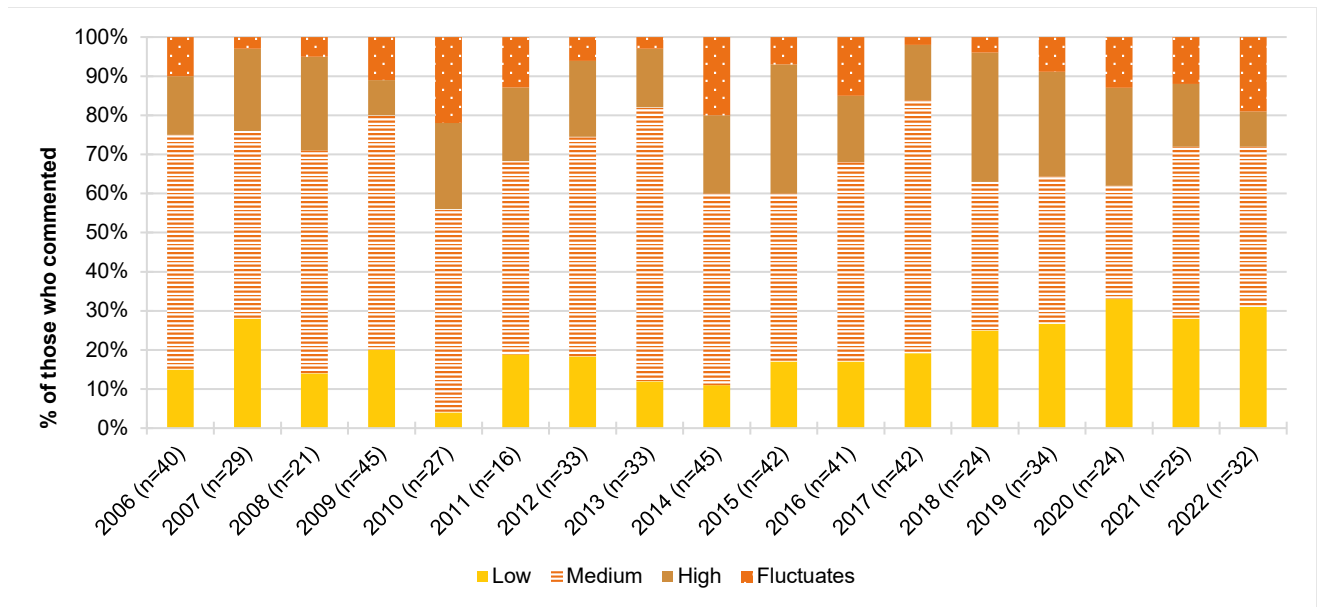
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels are only provided for the first (2006) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 27: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Perth, WA, 2006-2022

(A) Hydroponic cannabis



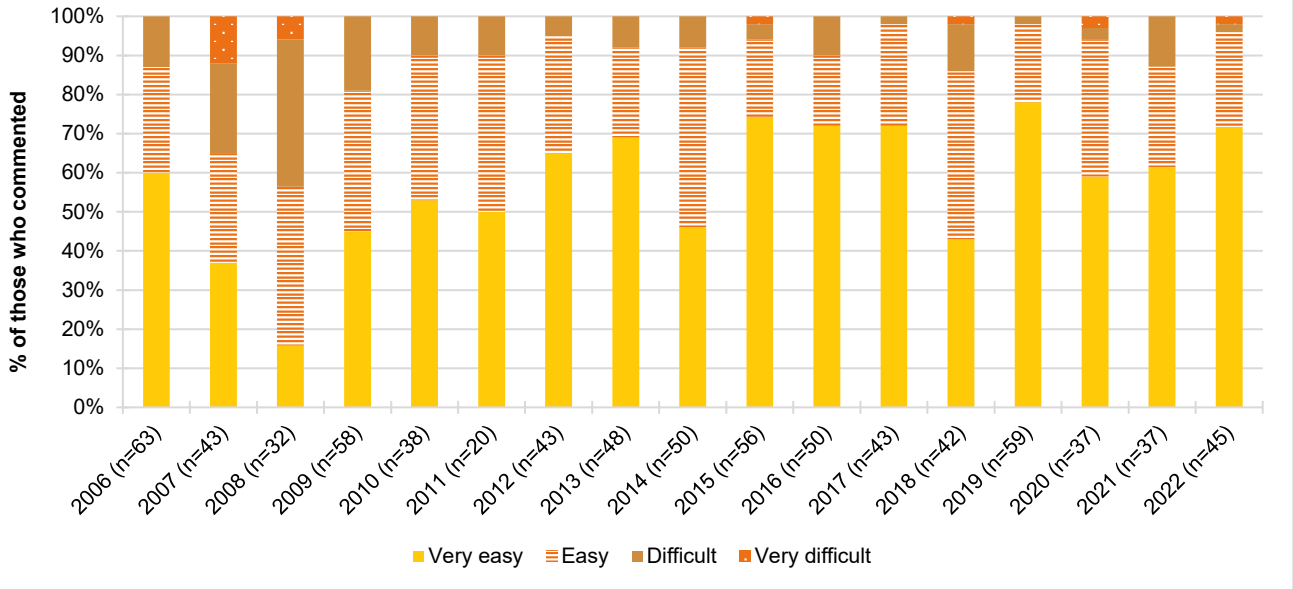
(B) Bush cannabis



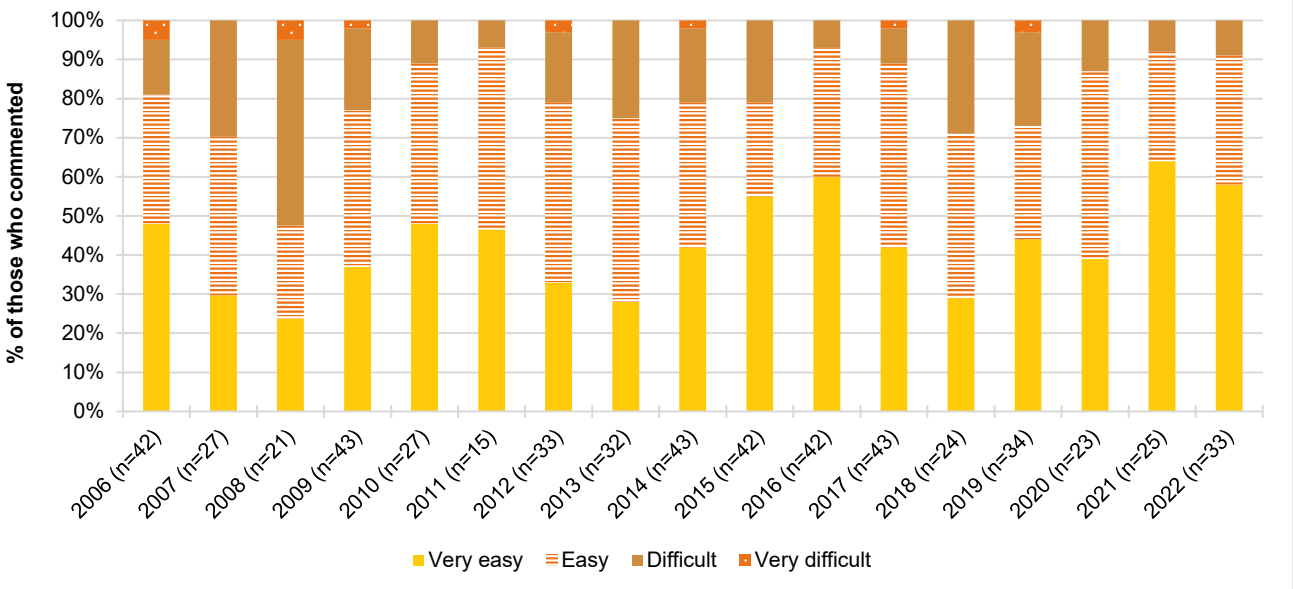
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. The error bars represent the IQR. Recruitment difficulties were experienced in 2011 (total sample N=28) therefore all data from this year should be interpreted with caution. 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 28: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Perth, WA, 2006-2022

(A) Hydroponic cannabis



(B) Bush cannabis



Note. The response '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. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Recruitment difficulties were experienced in 2011 (total sample N=28) therefore all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

## 7

## Ketamine, LSD and DMT

## Ketamine

## Patterns of Consumption

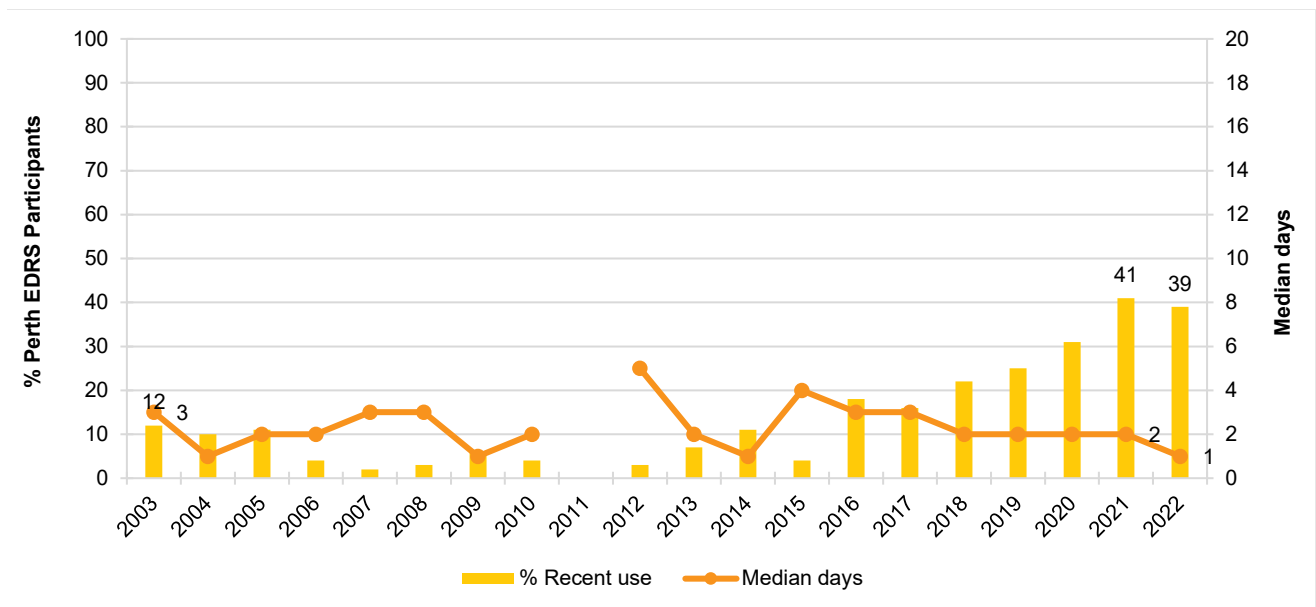
**Recent Use (past 6 months):** Almost two-fifths (39%) of the sample reported recent ketamine use in 2022. While stable relative to 2021 (41%;  $p=0.881$ ), reports of recent ketamine use have been increasing among the Perth EDRS samples since 2016 (Figure 29).

**Frequency of Use:** Frequency of ketamine use has remained low and stable across monitoring years. In 2022, ketamine was used on a median of 1 day in the six months preceding interview (IQR=1-2;  $n=39$ ; 2 days in 2021; IQR=1-3;  $p=0.394$ ) (Figure 29). No participants reported weekly or more frequent use of ketamine in 2022 ( $n \leq 5$  in 2021;  $p=0.494$ ).

**Routes of Administration:** Among participants who had recently used ketamine ( $n=39$ ), the vast majority (85%) reported snorting it in the past six months (90% in 2021;  $p=0.513$ ), while 15% reported swallowing in 2022 (17% in 2021).

**Quantity:** Of those who reported recent use and were able to comment on quantities ( $n=16$ ), the median 'typical' amount used per session was 0.40 grams (IQR=0.20-0.80; 0.30 grams in 2021; IQR=0.10-0.50;  $n=20$ ;  $p=0.071$ ), while the median maximum amount used per session was 0.50 grams (IQR=0.30-1.00;  $n=16$ ; 0.30 grams in 2021; IQR=0.20-0.50;  $n=21$ ;  $p=0.090$ ).

Figure 29: Past six month use and frequency of use of ketamine, Perth, WA, 2003-2022



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 20 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

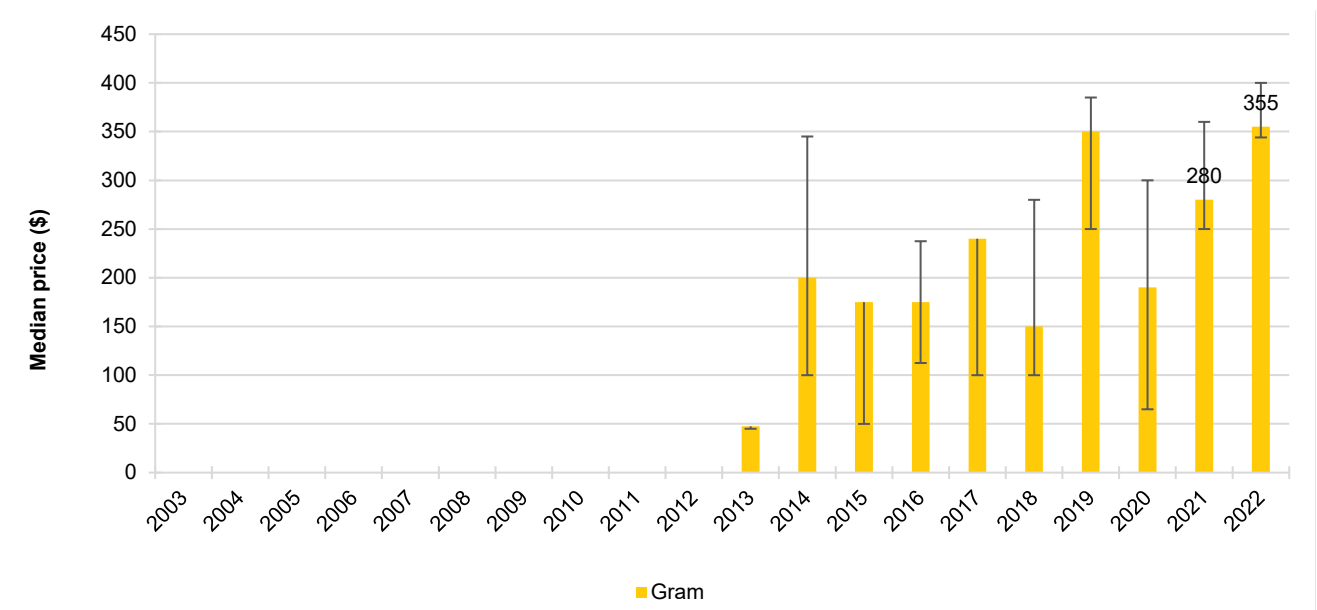
## Price, Perceived Purity and Perceived Availability

**Price:** The median price per gram of ketamine was \$355 in 2022 (IQR=344-400; n=16), representing a non-significant increase from \$280 in 2021 (IQR=250-355;  $p=0.122$ ) (Figure 30).

**Perceived Purity:** There was no significant change in perceptions of ketamine purity between 2021 and 2022 ( $p=0.431$ ). Among those able to comment in 2022 (n=21), most perceived the purity of ketamine as ‘high’ (62%; 77% in 2021), followed by ‘medium’ (29%; 14% in 2021) (Figure 31).

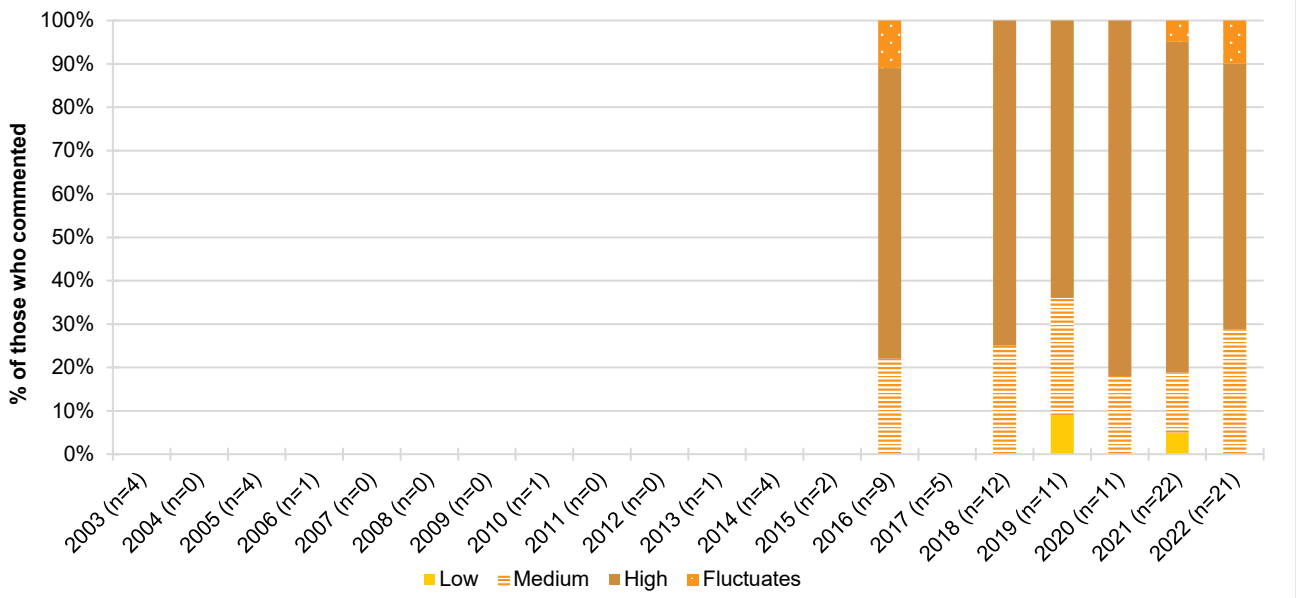
**Perceived Availability:** No significant change in perceptions of ketamine availability was identified between 2021 and 2022 ( $p=0.123$ ). Among those able to comment in 2022 (n=23), almost three-quarters (74%) reported ketamine as being ‘difficult’ or ‘very difficult’ to obtain (52% in 2021) (Figure 32).

Figure 30: Median price of ketamine per gram, Perth, WA, 2003-2022



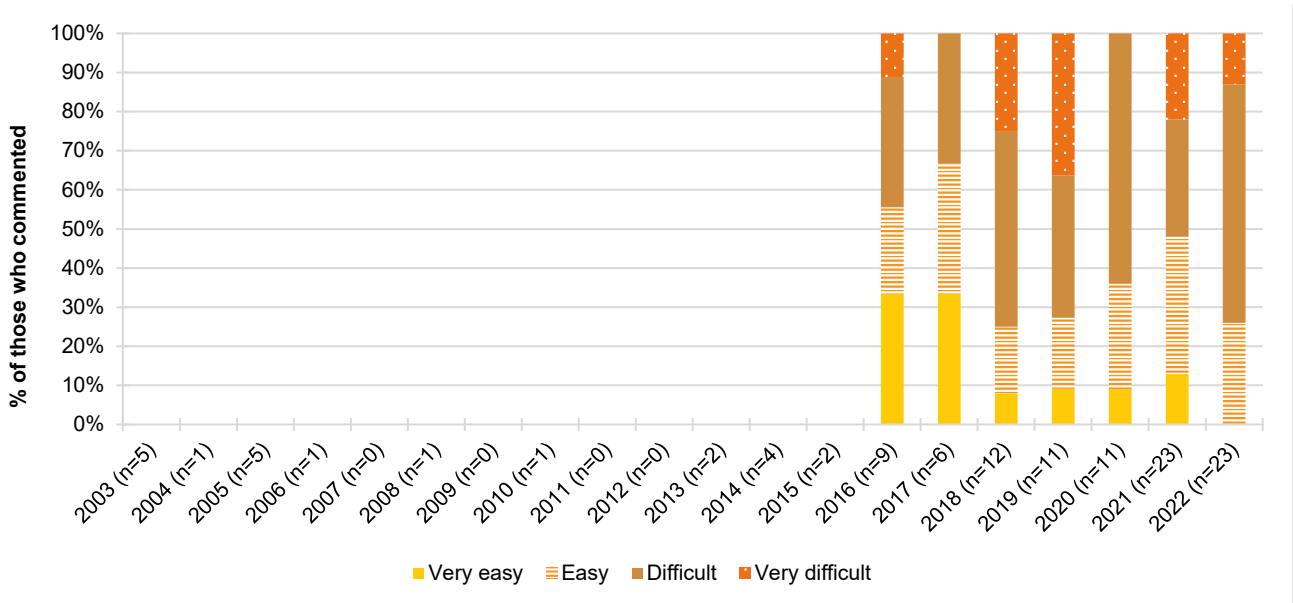
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. The response option ‘Don’t know’ was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 31: Current perceived purity of ketamine, Perth, WA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 32: Current perceived availability of ketamine, Perth, WA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## LSD

### Patterns of Consumption

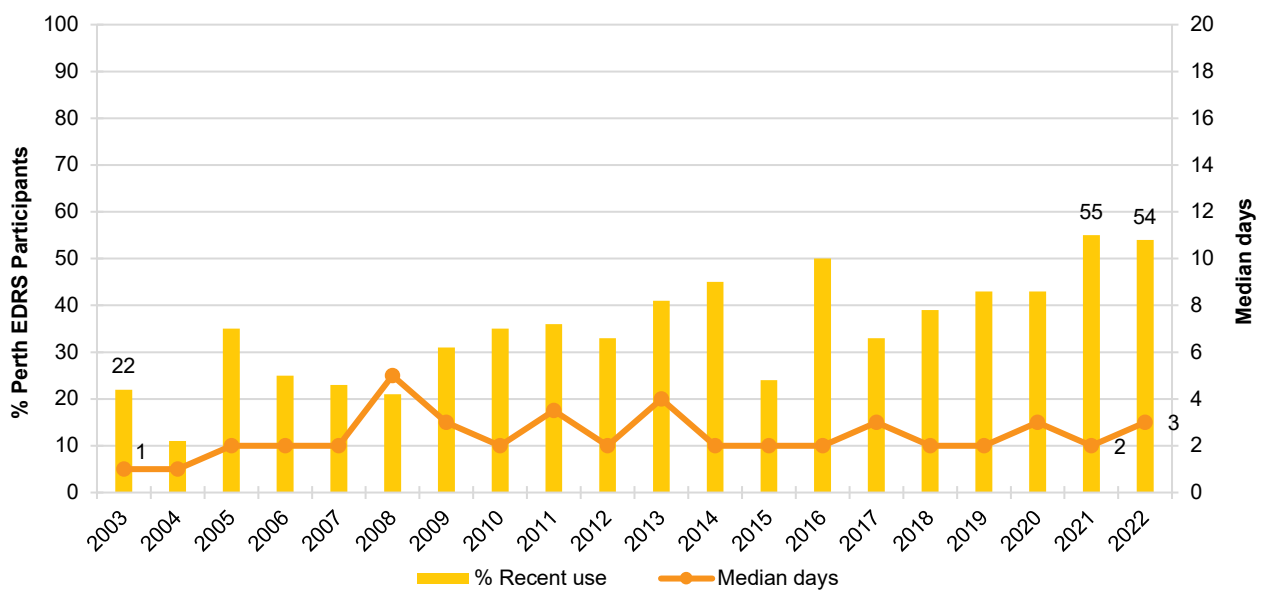
**Recent Use (past 6 months):** Fifty-four per cent of the sample reported recent LSD use in 2022, stable from 55% reporting use in 2021 (Figure 33).

**Frequency of Use:** The median frequency of LSD use has remained low over monitoring years. Among those reporting recent use in 2022 (n=54), LSD was used on a median of 3 days in the preceding six month period (IQR=1-6), not significantly different to 2 days in 2021 (IQR=1-6;  $p=0.606$ ) (Figure 33). Consistent with previous data collection years, few participants (n≤5) reported weekly or more frequent LSD use.

**Routes of Administration:** Consistent with past monitoring years, the only route of administration for consuming LSD that was reported in 2022 was swallowing (i.e., sublingual).

**Quantity:** Of those who had recently used LSD and responded to quantities in 'tabs' (n=32), the median 'typical' amount used per session was 1 tab (IQR=1-1; 1 tab in 2021; IQR=1-2; n=36;  $p=0.378$ ), and the median maximum amount used per session was also 1 tab (IQR=1-2; n=31; 1 tab in 2021; IQR=1-3; n=35;  $p=0.666$ ).

Figure 33: Past six month use and frequency of use of LSD, Perth, WA, 2003-2022



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 20 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

### Price, Perceived Purity and Perceived Availability

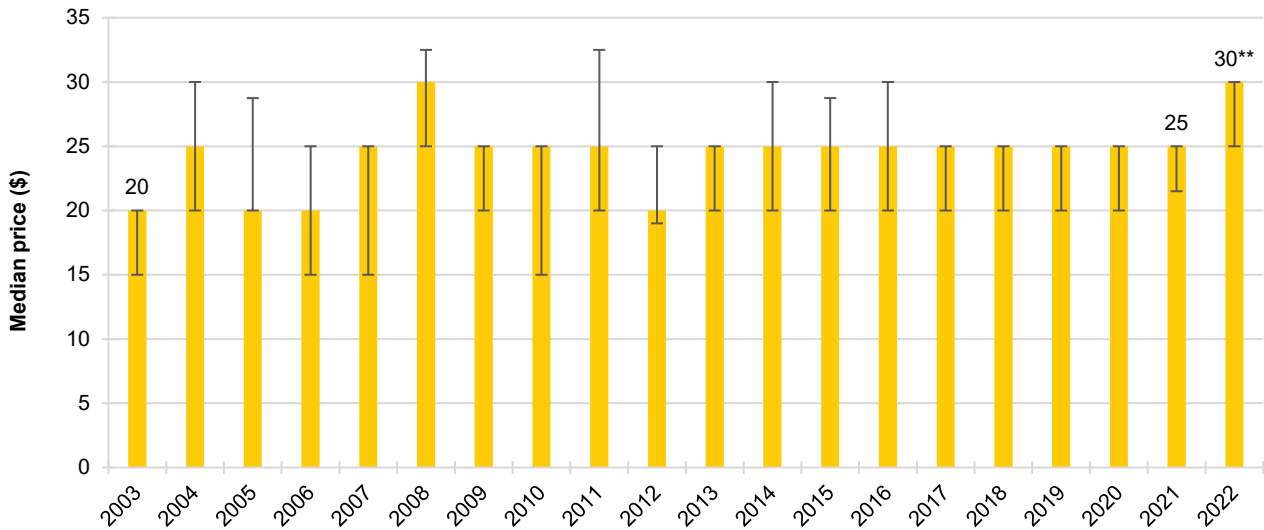
**Price:** The median price per tab of LSD significantly increased from \$25 in 2021 (IQR=23-25) to \$30 in 2022 (IQR=25-30;  $p=0.009$ ) (Figure 34).

**Perceived Purity:** No significant change was identified in the perceived purity of LSD between 2021 and 2022 ( $p=0.154$ ). Among those able to comment in 2022 (n=41), half (51%) perceived the purity of LSD as 'high' (68% in 2021), while 29% perceived that purity had 'fluctuated' (12% in 2021) (Figure 35).



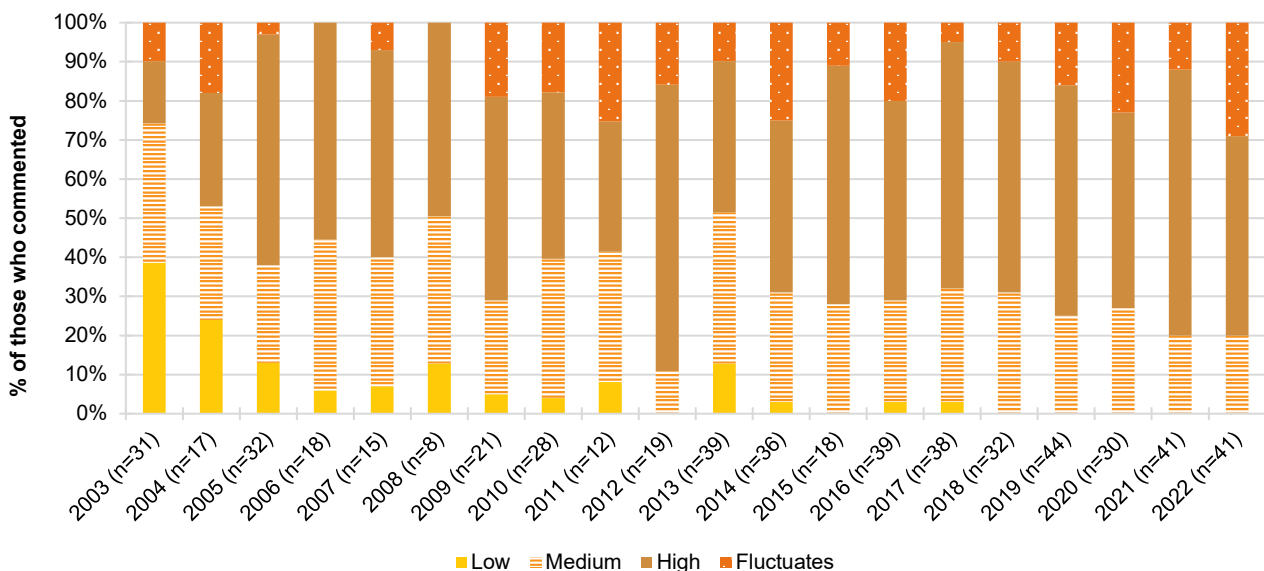
**Perceived Availability:** No significant change was identified in the perceived availability of LSD between 2021 and 2022 ( $p=0.410$ ). Among those able to comment in 2022 ( $n=43$ ), most considered LSD as being either 'easy' or 'very easy' to access (82%; 83% in 2021) (Figure 36).

Figure 34: Median price of LSD per tab, Perth, WA, 2003-2022



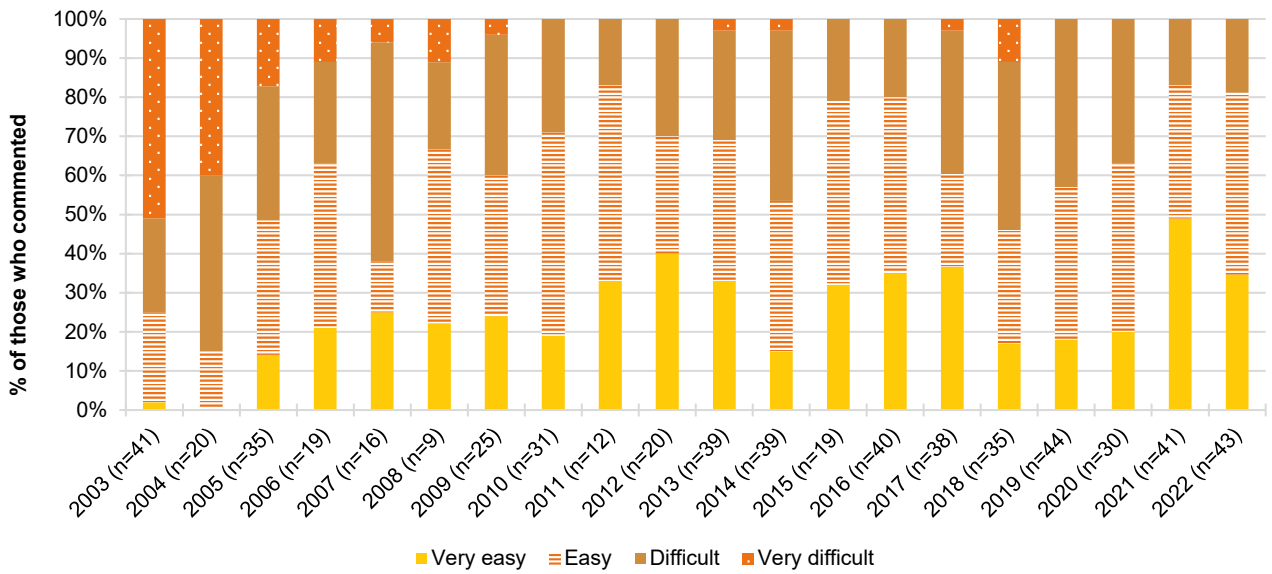
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 35: Current perceived purity of LSD, Perth, WA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where  $n \leq 5$  responded to the item. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

Figure 36: Current perceived availability of LSD, Perth, WA, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see [data tables](#) for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Recruitment difficulties were experienced in 2011 (total sample N=28); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \*p<0.050; \*\*p<0.010; \*\*\*p<0.001.

## DMT

### Patterns of Consumption

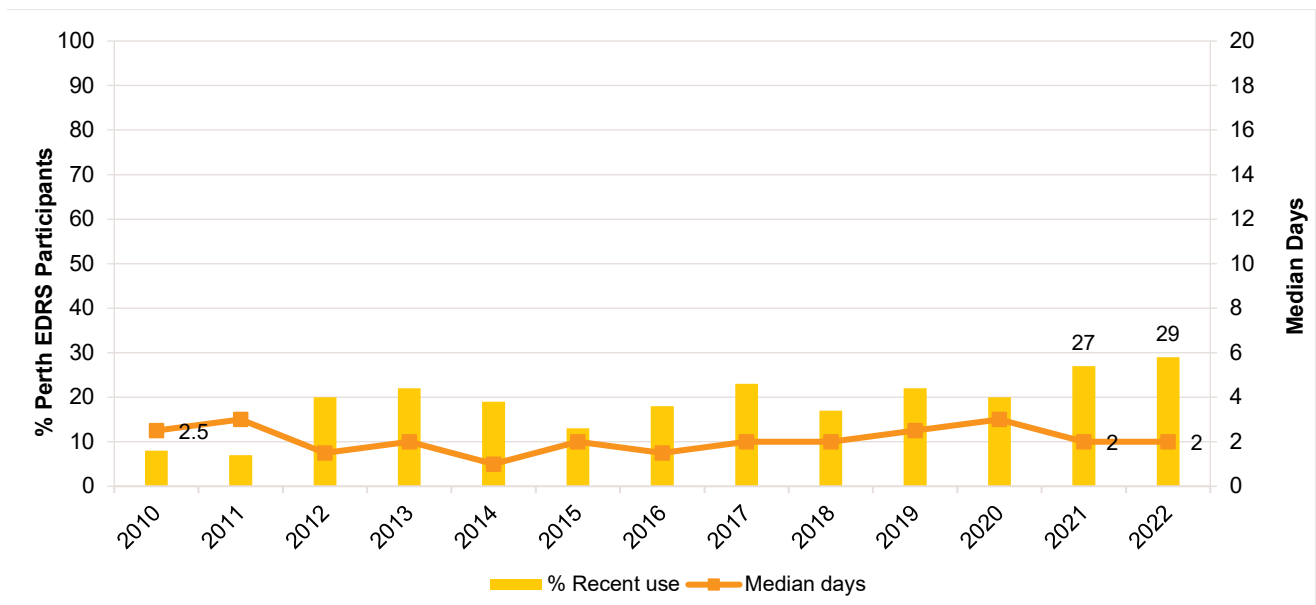
**Recent Use (past 6 months):** Twenty-nine per cent of the Perth sample reported recent DMT use in 2022, stable relative to 2021 (27%;  $p=0.872$ ) (Figure 38).

**Frequency of Use:** Median days of DMT use has been infrequent and stable across monitoring years. In 2022, DMT was used on a median of 2 days in the six months preceding interview (IQR=1-4; 2 days in 2021; IQR=1-4;  $p=0.498$ ) (Figure 37). Few participants ( $n\leq 5$ ) reported weekly or more frequent use of DMT ( $n\leq 5$  in 2021;  $p=0.498$ ).

**Routes of Administration:** Among those who had recently used DMT ( $n=29$ ), almost everyone reported smoking it in the past six months (97%; 96% in 2021). Few participants ( $n\leq 5$ ) reported other routes of administration, which is consistent with past monitoring years.

**Quantity:** Of those who reported recent DMT use and were able to comment on quantities ( $n=6$ ), the median 'typical' amount used per session was 50 mgs (IQR=35-238), while the median maximum amount used per session was 68 mgs (IQR=60-281). Few participants ( $n\leq 5$ ) were able to comment on amounts of DMT used in 2021 or earlier reporting years.

Figure 37: Past six month use and frequency of use of DMT, Perth, WA, 2010-2022



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 20 days to improve visibility of trends. Data labels are only provided for the first (2010) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n\leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p<0.050$ ; \*\* $p<0.010$ ; \*\*\* $p<0.001$ .

### Price, Perceived Purity and Perceived Availability

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

# 7

## New Psychoactive Substances

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

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

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

### Recent Use (past 6 months)

Any NPS use, including plant-based NPS, has fluctuated over time among the Perth sample, peaking at 45% in 2013 and dropping to 8% in 2019. In 2022, 13% reported any NPS, stable relative to 2021 (10%  $p=0.643$ ) (Table 2). Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 43% in 2013 and dropping to 6% in 2019 (13% in 2022; 9% in 2021;  $p=0.492$ ) (Table 3).

### Forms Used

Participants are asked about a range of NPS each year, updated to reflect key emerging substances of interest. In 2022, consistent with past years, few participants ( $n\leq 5$ ) reported use of any individual NPS, with the exception of 5-MeO-DMT which was reported by 7% of the sample ( $n\leq 5$  in 2021) (Table 4). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

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

%	National	Perth, WA
2010	24	32
2011	36	15
2012	40	26
2013	44	45
2014	35	39
2015	37	32
2016	28	21
2017	26	22
2018	23	13
2019	20	8
2020	15	9
2021	16	10
2022	11	<b>13</b>

Note. Monitoring of NPS first commenced in 2010. DMT and PMA have been removed as NPS in this year's report (i.e., 2010-2022 figures exclude DMT and PMA; refer to Chapter 6 for further information on DMT use among the sample). 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 EDRS reports. The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample N=28); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

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

%	National	Perth, WA
2010	24	31
2011	33	14
2012	37	24
2013	42	43
2014	34	39
2015	34	32
2016	27	21
2017	24	21
2018	21	12
2019	19	6
2020	12	7
2021	14	9
2022	9	<b>13</b>

Note. Monitoring of NPS first commenced in 2010. DMT and PMA have been removed as NPS in this year's report (i.e., 2010-2022 figures exclude DMT and PMA; refer to Chapter 6 for further information on DMT use among the sample). 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 EDRS reports. The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample N=28); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

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

	2010 N=100	2011 N=28	2012 N=90	2013 N=100	2014 N=100	2015 N=100	2016 N=100	2017 N=100	2018 N=100	2020 N=100	2020 N=100	2021 N=100	2022 N=100
<b>% Phenethylamine^</b>	-	-	-	23	23	12	12	11	-	-	-	-	-
Any 2C substance~	-	-	-	23	16	7	9	8	-	-	-	-	-
NBOMe	/	/	/	/	10	-	-	6	-	0	0	-	-
DO-x	0	0	0	0	-	0	0	0	-	0	0	-	0
4-FA	/	/	/	/	/	/	0	0	0	0	0	0	0
<b>NBOH</b>	/	/	/	/	/	/	/	/	/	/	/	/	0
<b>% Tryptamines^^</b>	-	0	0	0	-	0	-	-	-	-	-	-	7
5-MeO-DMT	-	0	0	0	-	0	0	-	-	-	-	-	7
4-AcO-DMT	/	/	/	/	/	/	-	-	/	/	/	/	/
<b>% Synthetic cathinones</b>	16	18	7	8	6	8	-	-	-	0	0	0	0
Mephedrone	16	14	-	-	-	-	0	-	0	0	0	0	0
Methylone/bk MDMA	/	-	-	-	-	-	-	-	-	0	0	0	0
MDPV/Ivory wave	0	0	-	-	0	0	0	0	0	0	0	0	0
Alpha PVP	/	/	/	/	/	/	-	0	0	0	0	0	0
n-ethylhexedrone	/	/	/	/	/	/	/	/	/	0	0	0	0
n-ethylpentylone	/	/	/	/	/	/	/	/	/	0	-	0	0
N-ethylbutylone	/	/	/	/	/	/	/	/	/	/	/	0	0
Other substituted cathinone	/	/	-	0	0	0	0	0	0	/	/	/	0
3-chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0
3-methylmethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	0
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	0
N, N-Dimethyl Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	0
Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	0
<b>% Piperazines</b>	25	-	-	0	0	0	0	-	/	/	/	/	/
<b>BZP</b>	25	-	-	0	0	0	0	-	/	/	/	/	/
<b>% Dissociatives</b>	/	/	/	-	0	0	0	0	0	0	0	0	0
<b>Methoxetamine (MXE)</b>	/	/	/	-	0	0	0	0	0	0	0	0	0

	2010 N=100	2011 N=28	2012 N=90	2013 N=100	2014 N=100	2015 N=100	2016 N=100	2017 N=100	2018 N=100	2020 N=100	2020 N=100	2021 N=100	2022 N=100
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 effects of dissociatives like ketamine	/	/	/	/	/	/	/	/	/	/	0	0	0
<b>% Plant-based NPS</b>	-	-	-	-	-	0	-	-	-	-	-	-	-
Ayahuasca	/	/	/	/	/	0	-	-	-	-	-	0	0
Salvia divinorum	/	-	-	-	-	0	0	-	-	-	-	0	0
Kratom	/	/	/	/	/	/	/	/	/	/	0	0	0
Mescaline	-	-	-	0	-	0	-	-	-	0	-	-	-
LSA	/	0	-	-	-	0	-	/	/	/	/	/	/
Datura	-	0	-	0	0	0	0	/	/	/	/	/	/
<b>% Benzodiazepines</b>	/	/	/	/	/	/	0	0	0	0	0	-	-
Etizolam	/	/	/	/	/	/	0	0	0	0	0	-	-
8 – Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0
Bromazolam	/	/	/	/	/	/	/	/	/	/	/	/	0
Clonazolam	/	/	/	/	/	/	/	/	/	/	/	/	-
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	-
Other drugs that mimic effect of benzodiazepines	/	/	/	/	/	/	/	/	/	/	0	0	0
<b>% Synthetic cannabinoids</b>	/	32	18	19	12	6	-	0	-	-	-	-	-
<b>% Herbal high# %</b>	/	/	11	-	-	-	-	0	-	0	/	/	/
<b>Phenibut</b>	/	/	/	/	/	/	/	/	/	/	0	-	0
<b>% Other drugs that mimic the effect of opioids</b>	/	/	/	/	/	/	/	0	0	0	0	0	0
<b>% Other drugs that mimic the effect of ecstasy</b>	/	/	/	/	/	/	/	-	0	0	0	0	0
<b>% Other drugs that mimic the effect of amphetamine or cocaine</b>	/	/	/	/	/	/	/	0	0	0	0	0	0
<b>% Other drugs that mimic the effect of psychedelic drugs like LSD</b>	/	/	/	/	/	/	/	-	-	0	0	-	0

Note. NPS first asked about in 2010. / not asked. ^In previous EDRS reports, PMA was included as a NPS under 'phenethylamines' and mescaline was included under both 'phenethylamines' and 'plant-based NPS'. This year, PMA has been deleted as a NPS 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 (2010-2020) will not align with those presented in previous EDRS reports. ^^In previous EDRS reports, DMT was included as a NPS under 'tryptamines'. This year, DMT has

been removed as a NPS (refer to Chapter 7 for further information on DMT use among the sample), which means that the percentages reported for any tryptamine NPS use (2010-2020) will not align with those presented in previous EDRS 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. – not reported, due to small numbers ( $n \leq 5$  but not 0). ~ In 2010 and between 2017-2019 three forms of 2C were asked whereas between 2011-2016 four forms were asked. From 2020 onwards, 'any' 2C use is captured. The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in table; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.000$ .



# 8

## Other Drugs

### Non-Prescribed Pharmaceutical Drugs

#### Codeine

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

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

**Recent Use (past 6 months):** Almost three-fifths (28%) reported recent use of any codeine (18% in 2021;  $p=0.137$ ). Almost one-fifth (17%) reported any prescribed codeine use (10% in 2021;  $p=0.221$ ), whilst 13% reported using any non-prescribed codeine (9% in 2021;  $p=0.492$ ) (Figure 38).

**Recent Use for Non-Pain Purposes (past 6 months):** Of those who had recently used non-prescribed codeine ( $n=13$ ), most (92%) reported that they had used it for non-pain purposes.

**Frequency of Use:** Participants who had recently used non-prescribed codeine ( $n=13$ ) reported use on a median of 4 days (IQR=3-5) in the past six months (2 days in 2021; IQR=1-3;  $p=0.165$ ).

#### Pharmaceutical Opioids

**Recent Use (past 6 months):** Almost one-tenth (9%) of the sample reported recent use of non-prescribed pharmaceutical opioids (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl, excluding codeine) (also 9% in 2021) (Figure 38).

**Frequency of Use:** Participants who had recently used non-prescribed pharmaceutical opioids and commented ( $n=8$ ) reported use on a median of 5 days in the six months preceding interview (IQR=2-11), not significantly different to 2 days in 2021 (IQR=1-3;  $p=0.806$ ).

## Pharmaceutical Stimulants

**Recent Use (past 6 months):** Four-fifths of the sample (81%) reported recent use of non-prescribed pharmaceutical stimulants in 2022 (e.g., dexamphetamine, methylphenidate, modafinil). While this per cent was stable relative to 2021 (77%;  $p=0.601$ ), it represents the highest per cent observed since monitoring began in 2003 (Figure 38).

**Frequency of Use:** Participants who had recently used non-prescribed pharmaceutical stimulants ( $n=81$ ) reported use on a median of 10 days (IQR=4-24) in the six months preceding interview, stable relative to 2021 (10 days; IQR=4-20;  $p=0.284$ ). Of those reporting recent use ( $n=81$ ), 30% reported weekly or more frequent use (22% in 2021;  $p=0.279$ ).

**Quantity:** Of those who reported recent non-prescribed use of pharmaceutical stimulants and responded ( $n=70$ ), the median 'typical' amount used per session was 2 pills/tablets (IQR=2-4; 2 pills/tablets in 2021; IQR=1-3;  $p=0.067$ ), while the median maximum amount used per session was 4 pills/tablets (IQR=2-6;  $n=70$ ; 3 pills/tablets in 2021; IQR=2-6;  $p=0.107$ ).

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

## Benzodiazepines

**Recent Use (past 6 months):** Recent use of non-prescribed benzodiazepines has remained stable in the past few years with around one-third of the sample reporting recent use (36% in 2022; 36% in 2021; 37% in 2020) (Figure 38). From 2019, participants were asked about non-prescribed alprazolam (Xanax) use versus 'other benzodiazepines' (e.g., diazepam/Valium). One-fifth (21%) of the sample reported recent use of non-prescribed alprazolam (22% in 2021), whilst 29% reported use of 'other' non-prescribed benzodiazepines (28% in 2021).

**Frequency of Use:** Participants reported using non-prescribed alprazolam on a median of 5 days in the six months preceding interview (IQR=3-10), stable from 5 days in 2021 (IQR=2-10;  $p=0.779$ ). Meanwhile, 'other' non-prescribed benzodiazepines were also used on a median of 5 days (IQR=2-10), stable from 4 days in 2021 (IQR=2-12;  $p=0.791$ ).

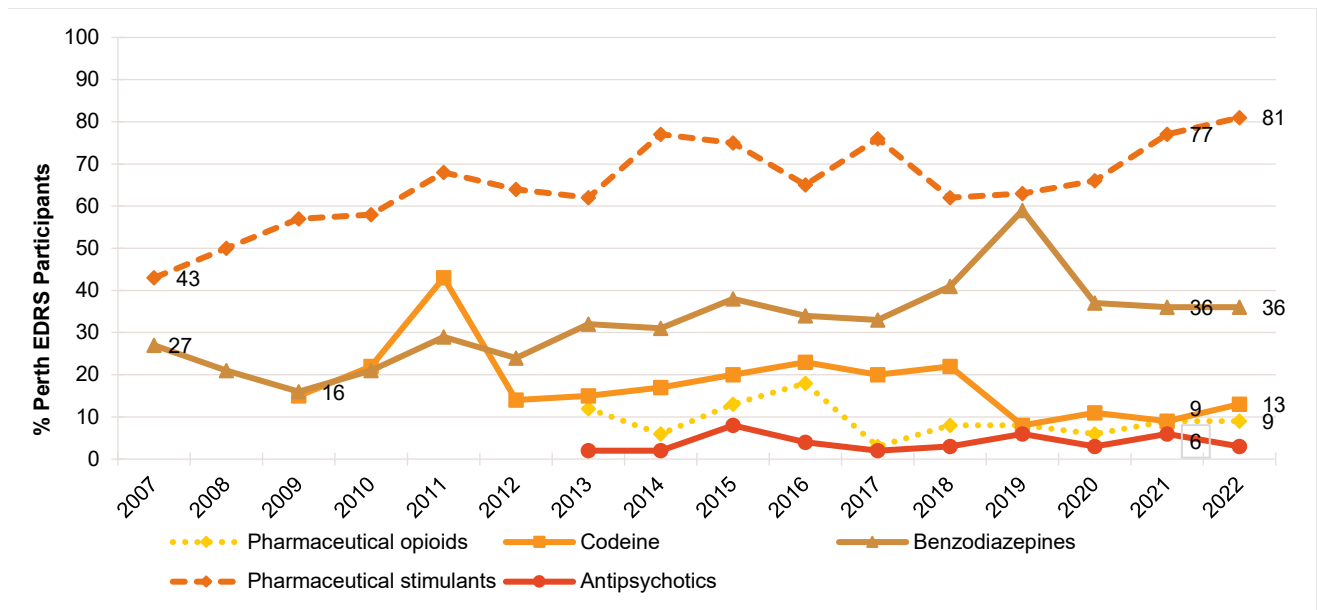
**Price and Perceived Availability:** In 2022, participants were asked questions pertaining to the price and perceived availability of non-prescribed benzodiazepines, however these data will be released separately in 2023. Please contact the Drug Trends team for further information.

## Antipsychotics

**Recent Use (past 6 months):** Due to low numbers reporting recent use of antipsychotics in 2022 ( $n\leq 5$ ), numbers have been suppressed (6% in 2021;  $p=0.331$ ) (Figure 38).

**Frequency of Use:** Due to low numbers reporting recent use of antipsychotics in 2022 ( $n\leq 5$ ), numbers have been suppressed (median of 4 days of use in 2021; IQR=1-9;  $p=0.284$ ).

Figure 38: Non-prescribed use of pharmaceutical drugs in the past six months, Perth, WA, 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. Data labels are only provided for the first (2007/2009/2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. 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):** Almost half (46%) the sample reported recent use of hallucinogenic mushrooms in 2022. While stable relative to 2021 (47%), reports of recent use have doubled since 2020 (Figure 39).

**Frequency of Use:** Participants reported using mushrooms on a median of 2 days in the six months preceding interview (IQR=1-3;  $n=46$ ; 2 days in 2021; IQR=2-3;  $p=0.937$ ) (Figure 39). Consistent with previous reporting years, few participants ( $n \leq 5$ ) reported weekly or more frequent use of mushrooms.

### MDA

**Recent Use (past 6 months):** In 2022, 7% of the sample reported recent use of MDA ( $n < 5$  in 2021;  $p=0.331$ ) (Figure 39). Further information on use of MDA over time, please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

**Frequency of Use:** Participants reported using MDA on a median of 2 days in the six months preceding their interview (IQR=1-4;  $n=7$ ;  $n < 5$  in 2021;  $p=0.626$ ) (Figure 39). For further information on use of MDA over time, please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### Substances with Unknown Contents

**Capsules:** Six per cent reported recent use of capsules with unknown contents (0% in 2021;  $p=0.014$ ).

**Other Unknown Substances:** From 2019, we asked participants about their use more broadly of substances with 'unknown contents'. Fourteen per cent of participants reported use of any substance

with 'unknown contents' in 2022 ( $n \leq 5$  in 2021;  $p=0.002$ ) on a median of one day (IQR=1-2;  $n=14$ ;  $n \leq 5$  in 2021;  $p=0.465$ ).

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

**Quantity:** From 2020, we asked participants about the average amount of pills and capsules used with unknown contents in the six months preceding interview. Few ( $n \leq 5$ ) participants were able to answer questions regarding the median quantity of pills and capsules used in a 'typical' session in 2022, therefore, further details are not reported. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### PMA

No participants reported recent use of PMA in 2022 (Figure 39). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

### PMMA

No participants reported recent use of PMMA in 2022 (Figure 39). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

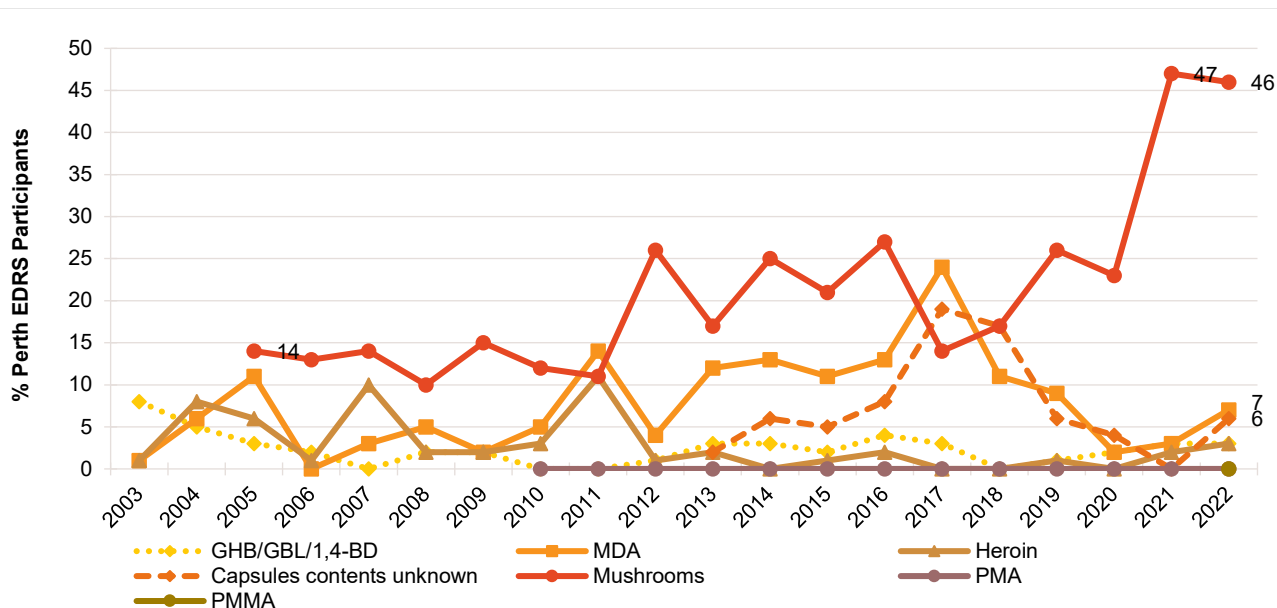
### Heroin

Due to low numbers reporting on recent use of heroin ( $n \leq 5$ ) (Figure 39), further details are not reported. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information on use of heroin.

### GHB/GBL/1,4-BD (liquid E)

Due to low numbers reporting recent use of GHB/GBL/1,4-BD ( $n \leq 5$ ) (Figure 39), further details are not reported. For further information on GHB/GBL/1,4-BD use, please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team.

Figure 39: Past six month use of other illicit drugs, Perth, WA, 2003-2022



Note. Monitoring of hallucinogenic mushrooms commenced in 2005. Monitoring of capsules contents unknown commenced in 2013; note that in 2019, participants were asked more broadly about 'substances contents unknown' (with further ascertainment by form) which may have impacted the estimate for 'capsules contents unknown'. Monitoring of PMA commenced in 2010 and monitoring of PMMA commenced in 2022. Y axis has been reduced to 50% to improve visibility of trends. Data labels are only provided for the first (2003/2005/2010/2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. 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):** Almost all participants (99%) reported recent use of alcohol in 2022, which has remained consistent since monitoring began (95% in 2021;  $p=0.212$ ) (Figure 40).

**Frequency of Use:** Among those who had consumed alcohol recently ( $n=99$ ), alcohol was reportedly used on a median of 48 days in the six months preceding interview (i.e., twice per week,  $IQR=30-72$ ), a significant increase relative to 2021 (48 days;  $IQR=24-71$ ;  $p=0.014$ ). Additionally, the per cent who reported drinking alcohol weekly or more frequent significantly increased (89% in 2022; 76% in 2021;  $p=0.022$ ), although few participants ( $n \leq 5$ ) reported daily alcohol use in 2022 or 2021.

### Tobacco

**Recent Use (past 6 months):** Three-quarters (75%) of the sample reported recent tobacco use in 2022 (72% in 2021;  $p=0.741$ ) (Figure 40).

**Frequency of Use:** Participants reported using tobacco on a median of 104 days in the six months preceding the interview ( $IQR=22-180$ ;  $n=75$ ), not significantly different to 71 days in 2021 ( $IQR=12-180$ ;  $p=0.142$ ). Among those who had recently used tobacco ( $n=75$ ), two-fifths (40%) reported daily use (26% in 2021;  $p=0.121$ ).

### 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. However, few participants ( $n \leq 5$ ) in the Perth sample reported recent use of prescribed e-cigarettes in 2022.

**Recent Use (past 6 months):** Recent use of non-prescribed e-cigarettes was reported by 81% of the sample in 2022, a significant increase from 55% in 2021 ( $p<0.001$ ) and by far the highest per cent observed in the Perth EDRS sample since monitoring of e-cigarettes began (Figure 40).

**Frequency of Use:** Participants reported using non-prescribed e-cigarettes on a median of 90 days in six months preceding interview (i.e., every second day, IQR=14-180), a significant increase from 24 days in 2021 (IQR=6-93;  $p=0.012$ ). Additionally, among those reporting past six month e-cigarette use, one-third (35%) reported daily use (16% in 2021;  $p=0.034$ ).

**Forms Used:** Of those who reported e-cigarette use in the last 6 months and responded ( $n=79$ ), 96% reported that the e-cigarettes contained nicotine (93% in 2021),  $n\leq 5$  reported cannabis (18% in 2021) and 15% reported neither ( $n\leq 5$  in 2021). Few participants  $n\leq 5$  reported using e-cigarettes that contained another substance.

**Reason for Use:** Of those who reported any (i.e., prescribed and non-prescribed) e-cigarette use in the last six months and responded ( $n=82$ ), two-fifths (41%) reported using it as a smoking cessation tool (38% in 2021;  $p=0.701$ ).

### Nitrous Oxide

**Recent Use (past 6 months):** Seventy per cent of the Perth sample reported recent use of nitrous oxide in 2022, a significant increase from 45% in 2021 ( $p=0.001$ ) and the highest per cent observed in Perth since monitoring began (Figure 40).

**Frequency of Use:** Nitrous oxide was used on a median of 4 days in the six months preceding interview (IQR=2-10;  $n=70$ ), which was stable relative to 2021 (4 days; IQR=1-8;  $p=0.454$ ).

**Quantity:** Of those who reported recent use and responded ( $n=70$ ), the median 'typical' amount used per session was 15 bulbs (IQR=5-50), which represents a non-significant increase from 10 bulbs in 2021 (IQR=5-25;  $p=0.148$ ). Meanwhile, the median maximum amount used per session was 30 bulbs (IQR=10-50), representing another non-significant increase from 15 bulbs in 2021 (IQR=6-50;  $p=0.215$ ).

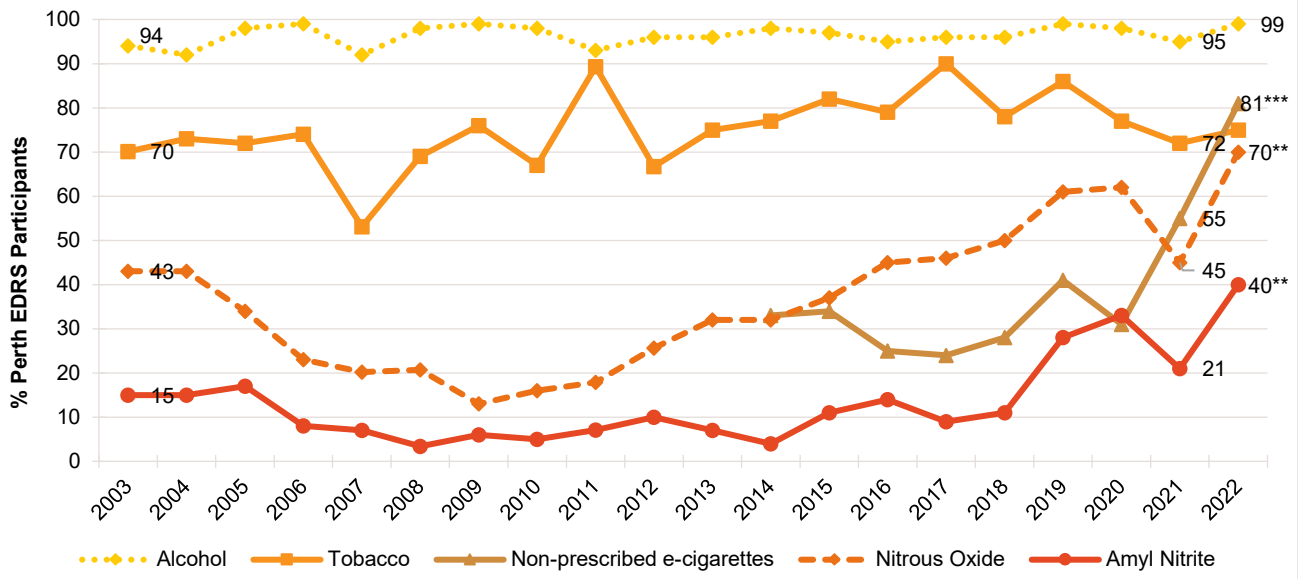
### Amyl Nitrite

Amyl nitrite is an inhalant which is currently listed as 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):** Two-fifths (40%) of the Perth sample reported recent use of amyl nitrite in 2022, a significant increase from one-fifth (21%) in 2021 ( $p=0.006$ ) (Figure 40).

**Frequency of Use:** Amyl nitrite was used on a median of 3 days in the six months preceding the interview (IQR=1-4;  $n=40$ ), not significantly different to 4 days in 2021 (IQR=1-10;  $p=0.337$ ).

Figure 40: Licit and other drugs used in the past six months, Perth, WA, 2003-2022



Note. Monitoring of e-cigarettes commenced in 2014, however on 1 October 2021, legislation came into effect requiring people to obtain a prescription to legally import nicotine vaping products. Data from 2022 onwards refers to non-prescribed e-cigarettes only. Data labels are only provided for the first (2003/2014) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

# 10

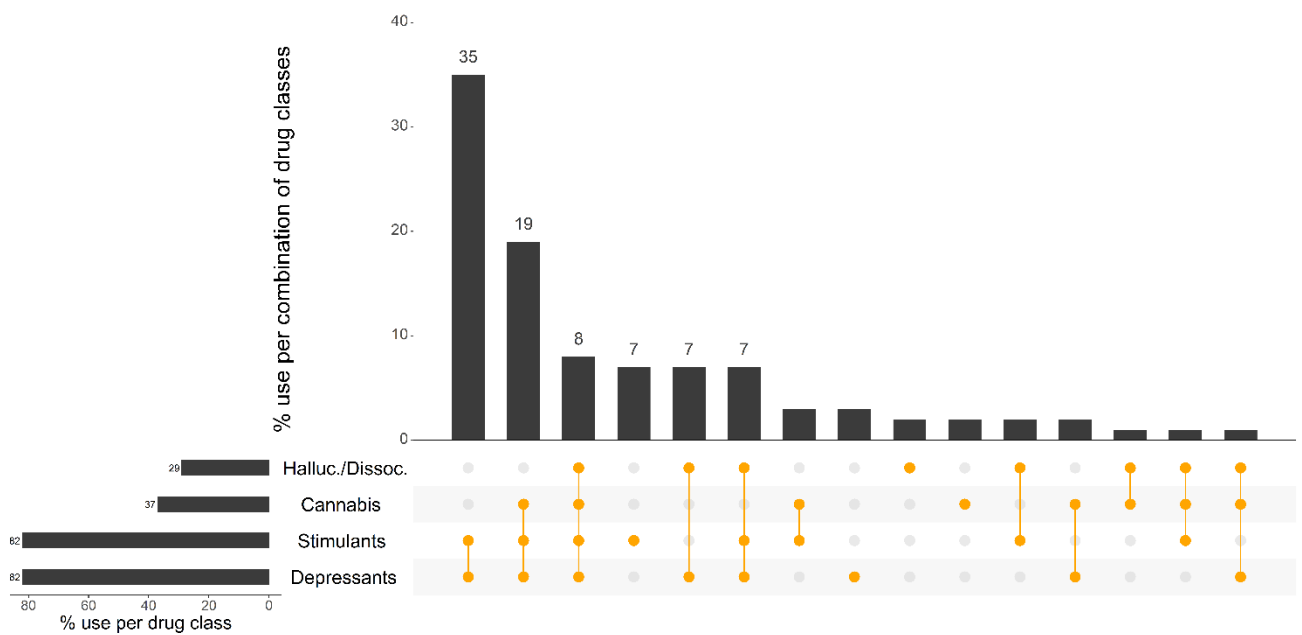
## Drug-Related Harms and Other Behaviours

### Polysubstance Use

On the last occasion of ecstasy or related drug use, among those who answered (n=100), the most commonly used substances were alcohol (81%), ecstasy (55%), cannabis (37%) and pharmaceutical stimulants (30%).

The majority (87%) of the Perth 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 combination of drug classes were depressants (predominantly alcohol) and stimulants (35%), followed by depressants, stimulants and cannabis (19%) and then depressants, stimulants, cannabis and hallucinogens/dissociatives (8%). Seven per cent reported using stimulants alone (Figure 41).

**Figure 41: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Perth, WA, 2022: Most common drug pattern profiles**



Note. % calculated out of total 2022 Perth EDRS 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 40% to improve visibility of trends.



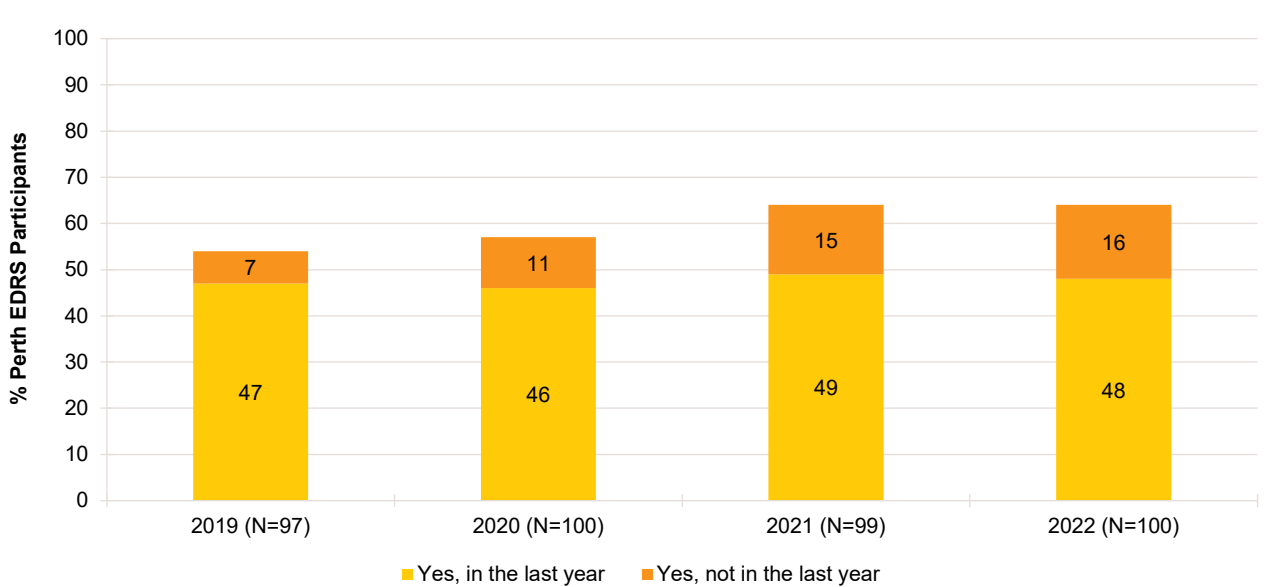
## Drug Checking

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

In 2022, almost half (48%) the sample reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year (49% in 2021;  $p=0.884$ ). Of those who reported that they or someone else had tested their illicit drugs in the past year and could comment on the testing method ( $n=43$ ), all (100%) reported using colorimetric or reagent test kits. Few participants ( $n\leq 5$ ) reported having their drugs tested via testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips), and no participants reported using Fourier Transform Infrared Spectroscopy or other method of spectroscopy/ chromatography.

Among those who reported that they or someone else had tested their illicit drugs in the past year ( $n=48$ ), 54% reported testing the drugs themselves and 56% reported a friend testing the drugs. Few participants ( $n\leq 5$ ) reported having their drugs tested via their dealer in the past year.

Figure 42: Lifetime and past year engagement in drug checking, Perth, WA, 2019-2022



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

## Alcohol Use Disorders Identification Test

The Alcohol Use Disorders Identification Test ([AUDIT](#)) was designed by the World Health Organisation (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 Perth sample (including people who had not consumed alcohol in the past six months) was 14.1 (SD 6.5), a significant increase from 12.5 in 2021 (SD 6.3;  $p<0.001$ ) (Table 5). 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.

Four-fifths (82%) obtained a score of eight or more, indicative of hazardous use (77% in 2021;  $p=0.483$ ). There was also a significant change in the per cent of participants falling into each of these zones between 2021 and 2022 ( $p=0.049$ ). Specifically, a greater per cent scored 20 or more and therefore fell into the category of 'possible alcohol dependence' (29% in 2022; 13% in 2021).

**Table 5: AUDIT total scores and per cent of participants scoring above recommended levels, Perth, WA, 2010-2022**

	2010 n=99	2011 N=28	2012 N=90	2013 N=100	2014 N=100	2015 n=98	2016 n=97	2017 n=99	2018 n=96	2019 n=98	2020 N=100	2021 n=96	2022 n=98
<b>Mean AUDIT total score (SD)</b>	12.5 (6.9)	15.8 (8.6)	15.0 (7.6)	14.1 (6.9)	13.2 (5.5)	12.8 (5.6)	12.6 (7.1)	12.0 (5.2)	13.0 (6.6)	13.8 (6.3)	12.3 (6.2)	12.5 (6.3)	<b>14.1 (6.5)* **</b>
<b>Score 8 or above (%)</b>	72	82	79	85	87	81	77	86	73	84	81	77	<b>82</b>
<b>AUDIT zones:</b>													*
Score 0-7	28	18	21	15	13	19	23	14	27	16	19	23	<b>18</b>
Score 8-15	35	25	28	47	55	48	47	65	30	38	52	48	<b>42</b>
Score 16-19	16	21	22	17	19	20	16	12	23	26	19	17	<b>11</b>
Score 20 or higher	20	36	29	21	13	12	14	9	20	18	10	13	<b>29</b>

Note. Monitoring of AUDIT first commenced in 2010. Total AUDIT score range is 0-40, with higher scores indicating greater likelihood of hazardous and harmful drinking. The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample N=28); therefore, all data from this year should be interpreted with caution. 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, respiratory depression, turning blue and collapsing) where professional assistance would have been helpful.
- **Stimulant overdose:** experience of symptoms (e.g., nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, seizure, extreme paranoia, extreme anxiety, panic, extreme agitation, hallucinations, excited delirium) where professional assistance would have been helpful.
- **Other drug overdose (not including alcohol or stimulant drugs):** similar definition to above. Note that in 2019, participants were prompted specifically for opioid overdose but this was removed in 2020 as few participants endorsed this behaviour.

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

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

### Non-Fatal Stimulant Overdose

In 2022, one-fifth of the sample (21%) reported that they had experienced a non-fatal stimulant overdose in the preceding 12 months (16% in 2021;  $p=0.471$ ).

The most common stimulants reported during the most recent non-fatal stimulant overdose in the past 12 months comprised ecstasy (any form: 71%; capsules: 43%; other ecstasy forms:  $n\leq 5$ ) and pharmaceutical stimulants (33%). Among those that experienced a recent non-fatal stimulant overdose, all (100%) reported that they had also consumed one or more additional drugs on the last occasion, most notably, alcohol (71%;  $\geq 5$  standard drinks: 57%;  $\leq 5$  standard drinks:  $n\leq 5$  participants) and cannabis (38%).

On the last occasion of experiencing a non-fatal stimulant overdose, 76% reported that they did not receive treatment or assistance. Due to low numbers reporting that they had received treatment or assistance ( $n\leq 5$ ), please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

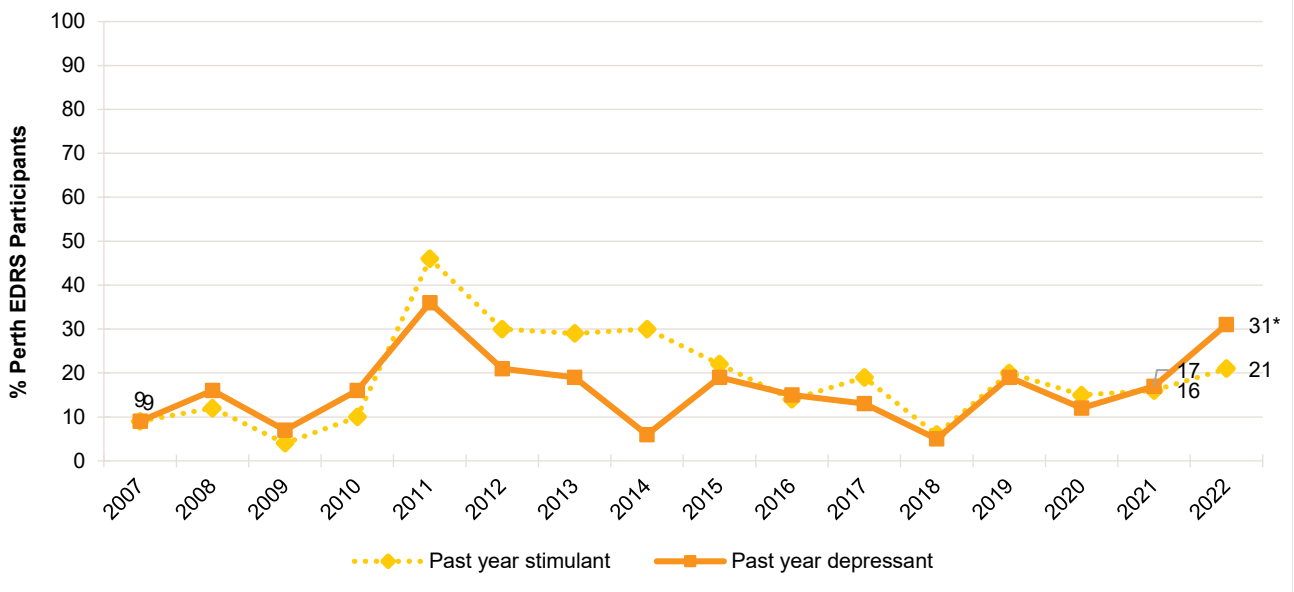
### Non-Fatal Depressant Overdose

**Alcohol:** In 2022, 29% of the Perth sample reported a non-fatal alcohol overdose in the 12 months preceding interview (on a median of two occasions; IQR=1-4), representing a significant increase from 13% in 2021 ( $p=0.006$ ). Of those who had experienced an alcohol overdose in the past year ( $n=29$ ), the vast majority (93%) reported that they had not received treatment on the last occasion. Due to low numbers reporting that they had received treatment or assistance ( $n\leq 5$ ), please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

**Any depressant (including alcohol):** In 2022, almost one-third (31%) reported that they had experienced any non-fatal depressant overdose in the past 12 months, representing a significant increase from 17% in 2021 ( $p=0.023$ ).

Of those who had experienced any depressant overdose in the past 12 months ( $n=31$ ), the vast majority (94%) reported alcohol as the most common depressant drug involved. Few participants ( $n\leq 5$ ) reported an overdose due to other drugs, therefore, these data are suppressed. Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

Figure 43: Past 12 month non-fatal stimulant and depressant overdose, Perth, WA, 2007-2022

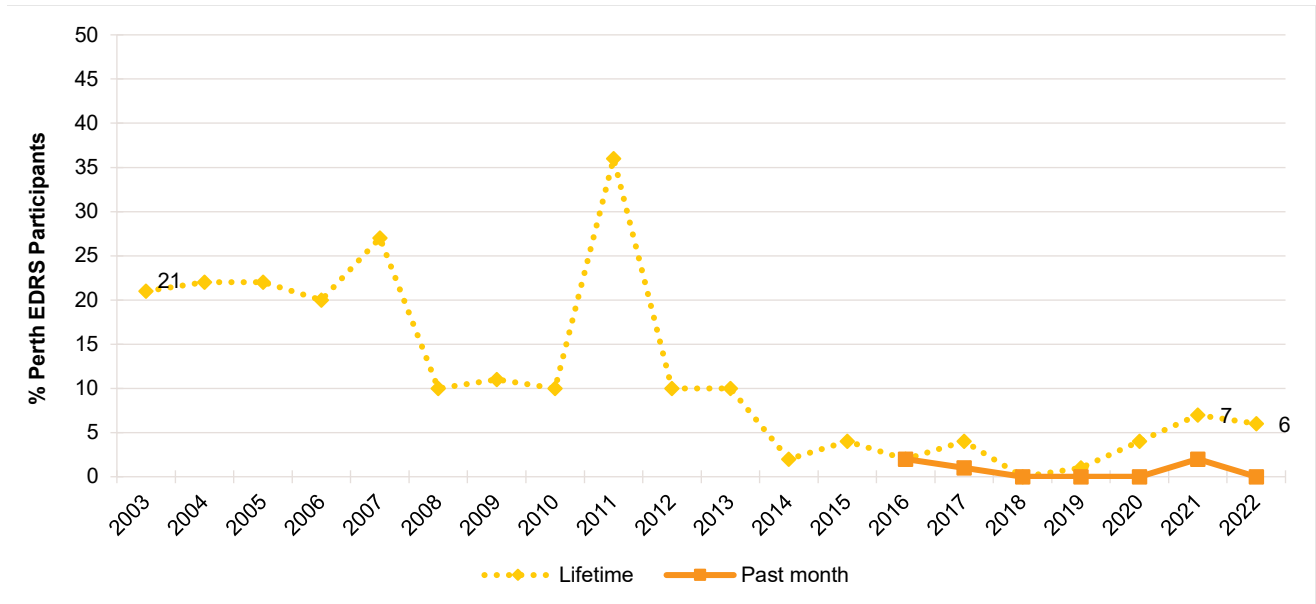


Note. Past year stimulant and depressant overdose was first asked about in 2007. In 2019, items about overdose were revised, and changes relative to 2018 may be a function of greater nuance in capturing depressant events. Data labels are only provided for the first (2007) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n\leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. 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

In 2022, 6% of the Perth sample reported that they had ever injected a drug, stable from 7% in 2021. No participants reported injecting a drug in the preceding month, stable relative to 2021 ( $n \leq 5$ ;  $p=0.497$ ) (Figure 44). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information on injecting use.

Figure 44: Lifetime and past month drug injection, Perth, WA, 2003-2022



Note. Items assessing whether participants had injected drugs in the past month were first asked in 2016. Data labels are only provided for the first (2003/2016) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Drug Treatment

Few participants ( $n \leq 5$ ) reported that they were currently receiving drug treatment; this is consistent with reporting in previous years ( $n \leq 5$  in 2021;  $p=0.683$ ). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information.

## Sexual Health Behaviours

Three-quarters (76%) of the Perth sample reported engaging in some form of sexual activity in the four weeks preceding their interview (86% in 2021;  $p=0.109$ ).

Of those who had engaged in sexual activity in the past four weeks and responded ( $n=75$ ), almost three-fifths (79%;  $n=59$ ) reported that they had used alcohol and/or other drugs before or during sexual activity in the preceding month (76% in 2021;  $p=0.702$ ). Of those who had engaged in sexual activity in the past four weeks and responded ( $n=76$ ), few ( $n \leq 5$ ) reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (16% in 2021;  $p=0.016$ ). Of those who had engaged in sexual activity in the preceding four weeks and responded ( $n=76$ ), 12% reported penetrative sex without a condom where they did not know the HIV status of their partner (10% in 2021;  $p=0.796$ ).

Of the total sample ( $N=100$ ), 71% reported having a sexual health check-up in their lifetime (66% in 2021;  $p=0.685$ ), including one-third (34%) reporting having a sexual health check-up in the six months

prior to interview (30% in 2021;  $p=0.479$ ). Of the total sample who responded ( $N=100$ ), 15% reported a positive diagnosis for a sexually transmitted infection (STI) in their lifetime (21% in 2021;  $p=0.275$ ), including few participants ( $n\leq 5$ ) who reported that they had been diagnosed with a STI in the past six months ( $n\leq 5$  in 2021).

Of the total sample who responded ( $n=99$ ), 49% reported having a test for human immunodeficiency virus (HIV) in their lifetime (45% in 2021;  $p=0.490$ ), including one-fifth (22%) reported having done so in the six months prior to interview (16% in 2021;  $p=0.340$ ). No participants in the Perth sample reported that they had ever been diagnosed with HIV ( $n\leq 5$  in 2021) (Table 6).

**Table 6: Sexual health behaviours, Perth, WA, 2021-2022**

	2021	2022
<b>Of those who responded:</b>	<b>N=99</b>	<b>N=100</b>
% Any sexual activity in the past four weeks (n)	86 (n=85)	76 (n=76)
<b>Of those who responded<sup>#</sup> and reported any sexual activity in the past four weeks:</b>	<b>n=83</b>	<b>n=75</b>
% Drugs and/or alcohol used prior to or while engaging in sexual activity	76	79
<b>Of those who responded<sup>#</sup> and reported any sexual activity in the past four weeks:</b>	<b>n=80</b>	<b>n=76</b>
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	16	.*
<b>Of those who responded<sup>#</sup> and reported any sexual activity in the past four weeks:</b>	<b>n=83</b>	<b>n=76</b>
% Had penetrative sex without a condom and did not know HIV status of partner	10	12
<b>Of those who responded<sup>#</sup>:</b>	<b>n=95</b>	<b>n=100</b>
% Had a HIV test in the last six months	16	22
% Had a HIV test in their lifetime	45	49
<b>Of those who responded<sup>#</sup>:</b>	<b>n=98</b>	<b>n=100</b>
% Diagnosed with HIV in the last six months	-	0
% Diagnosed with HIV in their lifetime	0	0
<b>Of those who responded<sup>#</sup>:</b>	<b>n=98</b>	<b>n=100</b>
% Had a sexual health check in the last six months	30	34
% Had a sexual health check in their lifetime	66	71
<b>Of those who responded<sup>#</sup>:</b>	<b>n=98</b>	<b>n=100</b>
% Diagnosed with a sexually transmitted infection in the last six months	-	-
% Diagnosed with a sexually transmitted infection in their lifetime	21	15

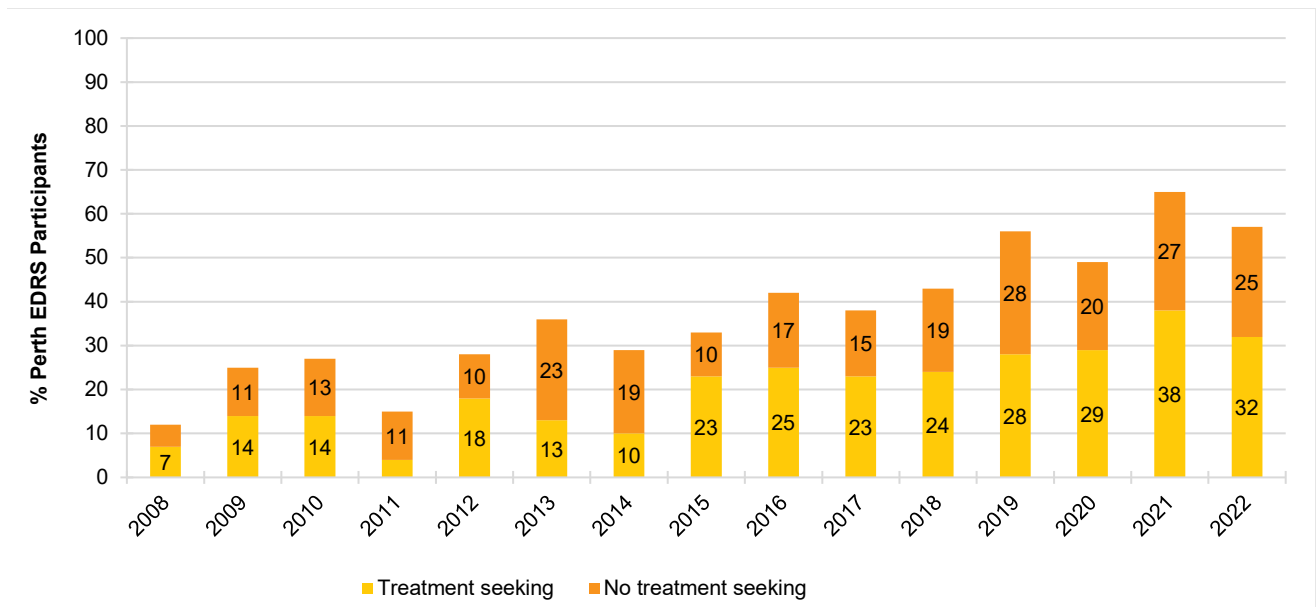
Note. <sup>#</sup>Due to the sensitive nature of these items there is missing data for some participants who chose not to respond. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; \* $p<0.050$ ; \*\* $p<0.010$ ; \*\*\* $p<0.001$ .

## Mental Health

In 2022, 57% self-reported that they had experienced a mental health problem in the six months preceding the interview, stable relative to 66% in 2021 ( $p=0.251$ ) (Figure 45). Among those self-reporting a recent mental health problem and able to respond ( $n=52$ ), the three most commonly reported problems were anxiety (62%), followed by depression (50%) and any personality disorder (12%).

Of those that reported experiencing a recent mental health problem ( $n=56$ ), 57% reported seeing a mental health professional during the past six months (58% in 2021) (32% of the total sample in 2022) (Figure 45). Of those who reported seeing a mental health professional ( $n=32$ ), 44% reported being prescribed medication for their mental health problem (45% in 2021).

Figure 45: Self-reported mental health problems and treatment seeking in the past six months, Perth, WA, 2008-2022

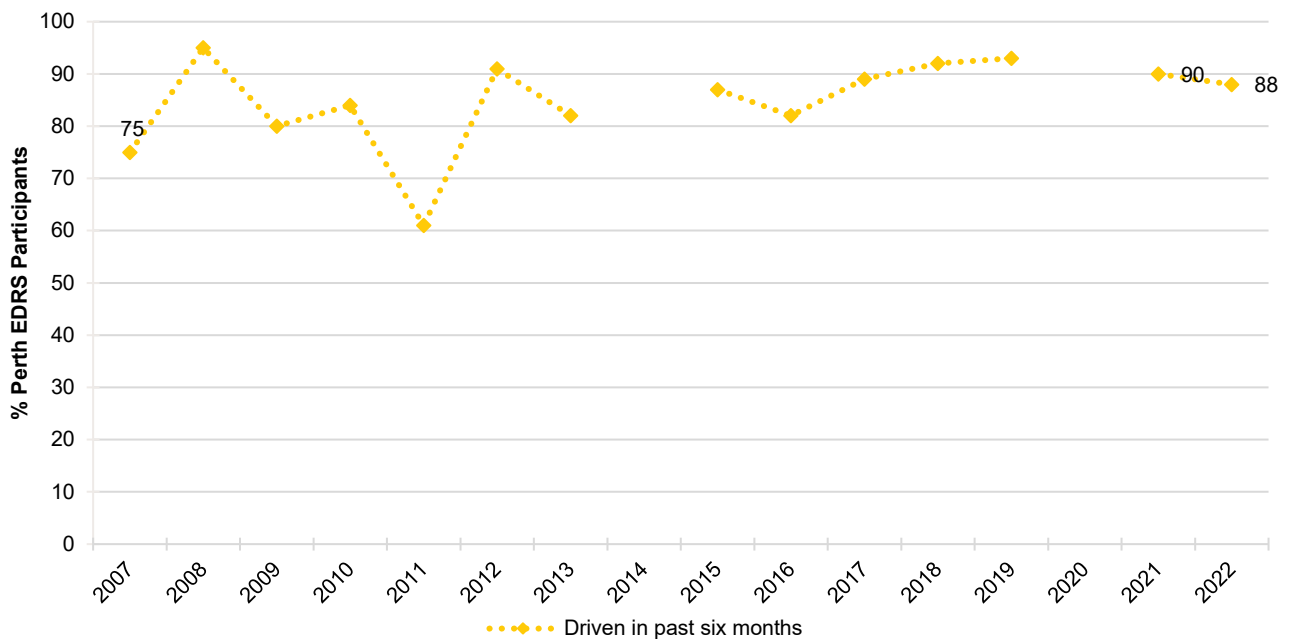


Note. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. Data labels have been removed from figures with small cell size (i.e.  $n \leq 5$  but not 0). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Driving

In 2022, most (88%) of the Perth sample had driven a car, motorcycle or other vehicle in the last six months (Figure 46). Of those who had driven in the past six months and responded ( $n=81$ ), one-third (35%) reported driving while over the legal limit of alcohol at least once in that period (34% in 2021), while over half of all recent drivers reported driving within three hours of consuming an illicit or non-prescribed drug, at least once in the last six months (55%; 49% in 2021;  $p=0.452$ ). Among all participants who driven recently ( $n=88$ ), 8% reported that they had been tested for drug driving by the police roadside drug testing service (14% in 2021;  $p=0.240$ ), while 58% reported that they had been breath tested for alcohol by the police roadside testing service in the six months prior to interview (60% in 2021;  $p=0.876$ ) (Figure 47).

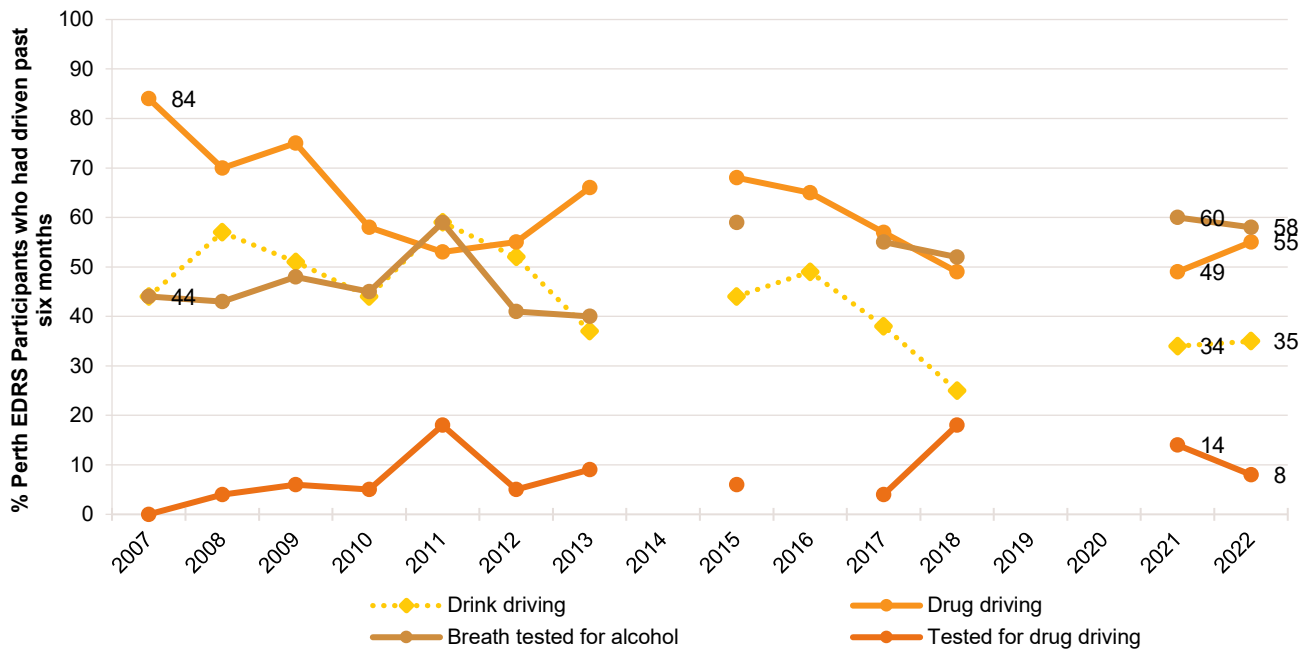
Figure 46: Self-reported driving in the past six months, Perth, WA, 2007-2022



Note. Computed of the entire sample. Questions about driving behaviour were first asked about in 2007. Questions about driving behaviour were not asked in 2014 or 2020. Data labels are only provided for the first (2007) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .



Figure 47: Self-reported testing and driving at least once 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, Perth, WA, 2007-2022



Note. Computed of those who had driven a vehicle in the past six months. Questions about driving behaviour were first asked about in 2007. Questions about driving behaviour not asked in 2014 or 2020. Questions about alcohol and drug driving testing were not asked in 2014, 2016 and 2020. Data labels are only provided for the first (2007) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

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

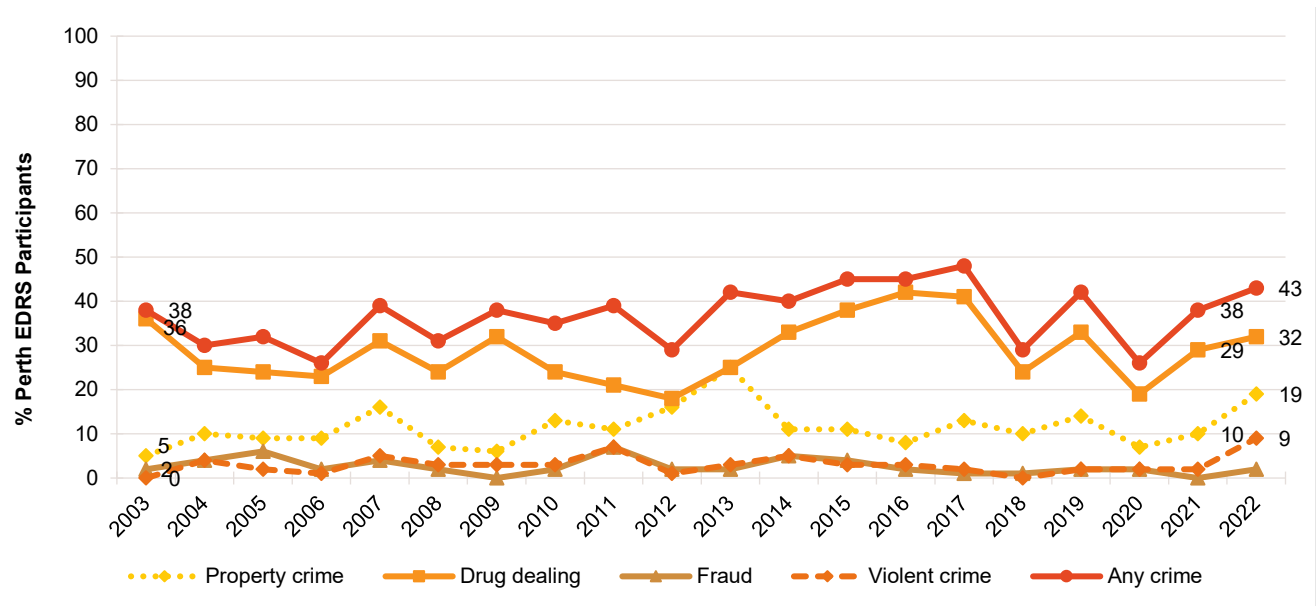
In 2022, approximately two-fifths (43%) of the Perth sample reported 'any' crime in the past month (38% in 2021;  $p=0.465$ ), with drug dealing (32%; 29% in 2021;  $p=0.644$ ) and property crime (19%; 10% in 2021;  $p=0.112$ ) being the two main forms of criminal activity (Figure 48).

Twelve per cent of the sample reported being the victim of a crime involving violence in the past month, representing a significant increase relative to 2021 ( $n \leq 5$ ;  $p=0.029$ ).

About one-tenth (9%) of the sample reported having been arrested in the 12 months preceding interview, stable relative to 2021 (10%;  $p=0.808$ ). Few participants ( $n \leq 5$ ) reported reasons for arrest; therefore, these data are suppressed. In 2022, 9% of the sample reported a drug-related encounter with law enforcement in the last 12 months which did not result in charge or arrest (data not collected in 2021).

Few participants ( $n \leq 5$ ) reported having ever been to prison, stable relative to 2021 ( $n \leq 5$ ). Please refer to the [National EDRS Report](#) for national trends, or contact the Drug Trends team for further information on experience of crime.

Figure 48: Self-reported criminal activity in the past month, Perth, WA, 2003-2022



Note. Any crime is comprised of the percentage who endorse any property crime, drug dealing, fraud and/or violent crime in the past month. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e.,  $n \leq 5$  but not 0). For historical numbers, please refer to the [data tables](#). The response option 'Don't know' was excluded from analysis. Recruitment difficulties were experienced in 2011 (total sample  $N=28$ ); therefore, all data from this year should be interpreted with caution. Statistical significance for 2021 versus 2022 presented in figure; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

## Modes of Purchasing Illicit or Non-Prescribed Drugs

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

### Purchasing Approaches

In 2022, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (74%; 90% in 2021;  $p=0.007$ ) and social networking applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (73%; 73% in 2021) (Table 7). It is important to re-iterate that this refers to people *arranging the purchase* of illicit or non-prescribed drugs. This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person.

### Buying and Selling Drugs Online

Few participants ( $n\leq 5$ ) reported obtaining drugs via the darknet in the past year (12% in 2021;  $p=0.029$ ); and few ( $n\leq 5$ ) reported purchasing on the surface web ( $n\leq 5$  in 2021;  $p=0.212$ ). Sixty per cent of participants reported ever obtaining illicit drugs through someone who had purchased them on the surface web or darknet, with 43% having done so in the last 12 months (44% in 2021;  $p=0.872$ ).

In 2022, few participants ( $n\leq 5$ ) reported selling illicit/non-prescribed drugs via surface or darknet marketplaces in the 12 months preceding interview ( $n\leq 5$  in 2021;  $p=0.872$ ).

### Obtaining Drugs

The majority of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2022 (82%; 88% in 2021;  $p=0.245$ ), followed by 54% reporting obtaining it from a known dealer/vendor (50% in 2021;  $p=0.672$ ). Two-fifths (43%) reported obtaining illicit drugs from an unknown dealer/vendor (29% in 2021;  $p=0.044$ ) (Table 7).

When asked about how they had received illicit drugs on any occasion in the last 12 months, the majority of participants reported face-to-face (98%; 93% in 2021;  $p=0.170$ ), followed by a collection point (defined as a predetermined location where a drug will be dropped for later collection; 6%;  $n\leq 5$  in 2021;  $p=0.767$ ), and fewer participants reporting receiving illicit drugs via post ( $n\leq 5$ ; 10% in 2021;  $p=0.164$ ) (Table 7).

Table 7: Means of purchasing illicit drugs in the past 12 months, Perth, WA, 2020-2022

	2020 n=99	2021 N=100	2022 N=100
<b>% Purchasing approaches in the last 12 months<sup>^#</sup></b>			
Face-to-face	82	90	74**
Surface web	14	-	-
Darknet market	8	12	-
Social networking applications	79	73	73
Text messaging	47	35	31
Phone call	33	21	14
Grew/made my own	-	-	-
Other	0	0	-
<b>% Means of obtaining drugs in the last 12 months<sup>^~</sup></b>			
Face-to-face	99	93	98
Collection point	18	-	6
Post	13	10	-
<b>% Source of drugs in the last 12 months<sup>^</sup></b>			
Friend/relative/partner/colleague	91	88	82
Known dealer/vendor	63	50	54
Unknown dealer/vendor	39	29	43*

Note. - not reported, due to small numbers ( $n \leq 5$  but not 0). <sup>^</sup> participants could endorse multiple responses. <sup>#</sup>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. <sup>~</sup> 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; \* $p < 0.050$ ; \*\* $p < 0.010$ ; \*\*\* $p < 0.001$ .

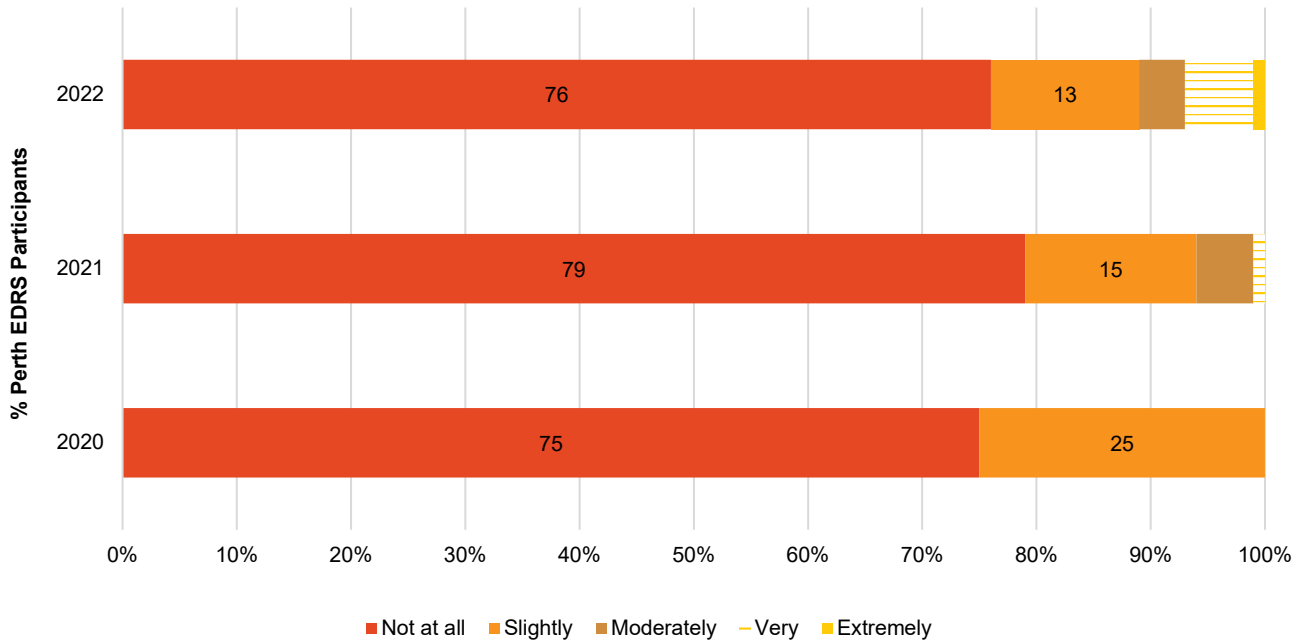
## COVID-19 Testing and Diagnosis

In 2022, the vast majority (95%) of the Perth EDRS sample had been tested for SARS-CoV-2 by the time of interview (37% in 2021; 7% in 2020), of whom two-thirds (66%) had undergone a PCR test and 93% a Rapid Antigen Test. Half (52%) reported having been diagnosed with the virus (no participants were diagnosed with the virus in 2021 and 2020).

In 2022, 68% of the sample reported quarantining for at least seven days due to a positive test or possible exposure in the 12 months prior to interview, with 29% quarantining in the month prior to interview and 40% in the six months prior to interview. At the time of interview, 95% reported that they had received at least one COVID-19 vaccine dose (median three doses:  $n \leq 5$  received one dose; 38% received two doses; 55% received three or more doses).

When asked how worried they were currently about contracting COVID-19, 24% of participants reported some level of concern (21% in 2021;  $p = 0.156$ ), with 13% reporting that they were 'slightly' concerned (Figure 49). Furthermore, 29% of participants reported that they would be concerned about their health if they did contract COVID-19, with 16% reporting that they would be 'slightly' concerned, 7% reporting 'moderately', and 6% reporting that they would be 'very' concerned.

Figure 49: Current concern related to contracting COVID-19, Perth, WA, 2020-2022



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