EDRS

# AUSTRALIAN CAPITAL TERRITORY DRUG TRENDS 2022

## Key Findings from the Australian Capital Territory Ecstasy and related Drugs Reporting System (EDRS) Interviews

# AUSTRALIAN CAPITAL TERRITORY 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.

Please contact the Drug Trends team with any queries regarding this publication: drugtrends@unsw.edu.au

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## Research Team

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

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


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

| | |
|---|---|
| **4-AcO-DMT** | 4-Acetoxy-N,N-dimethyltryptamine |
| **4-FA** | 4-Fluoroamphetamine |
| **5-MeO-DMT** | 5-methoxy-N,N-dimethyltryptamine |
| **ACT** | Australian Capital Territory |
| **AIVL** | Australian Injecting & Illicit Drug Users League |
| **Alpha PVP** | α-Pyrrolidinopentiophenone |
| **AUDIT** | Alcohol Use Disorders Identification Test |
| **BZP** | Benzylpiperazine |
| **CBD** | Cannabidiol |
| **DMT** | Dimethyltryptamine |
| **DO-x** | 4-Substituted-2,5-dimethoxyamphetamines |
| **EDRS** | Ecstasy and Related Drugs Reporting System |
| **GBL** | Gamma-butyrolactone |
| **GHB** | Gamma-hydroxybutyrate |
| **HIV** | Human immunodeficiency virus |
| **IQR** | Interquartile range |
| **LSA** | *d*-lysergic acid amide |
| **LSD** | *d*-lysergic acid |
| **MDA** | 3,4-methylenedioxyamphetamine |
| **MDMA** | 3,4-methylendioxymethamphetamine |
| **MDPV** | Methylenedioxypyrovalerone |
| **MXE** | Methoxetamine |
| **N (or n)** | Number of participants |
| **NBOMe** | N-methoxybenzyl |
| **NDARC** | National Drug and Alcohol Research Centre |
| **NPS** | New psychoactive substances |
| **NSW** | New South Wales |
| **OTC** | Over-the-counter |
| **PCR** | Polymerase Chain Reaction |
| **PMA** | Paramethoxyamphetamine |
| **PMMA** | Polymethyl methacrylate |
| **PTSD** | Post-traumatic stress disorder |
| **REDCap** | Research Electronic Data Capture |
| **SD** | Standard deviations |
| **SSDP** | Students for Sensible Drug Policy |
| **STI** | Sexually transmitted infection |
| **THC** | Tetrahydrocannabinol |
| **UNSW** | University of New South Wales |

| | |
|---|---|
| **VIC** | Victoria |
| **WA** | Western Australia |
| **WHO** | World Health Organization |

# Executive Summary

The Canberra, Australian Capital Territory (ACT) 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 Canberra, ACT. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2022 from April-July. Interviews in 2020, 2021 and 2022 were delivered face-to-face as well as via telephone, to reduce the risk of COVID-19 transmission; all interviews prior to 2020 were conducted face-to-face. This methodological change should be factored into all comparisons of data from the 2020-2022 samples, relative to previous years.**

## Sample Characteristics

The EDRS sample (N=100) recruited from Canberra, ACT, were predominantly a young (although older than seen in previous years), educated group, with slightly more participants identifying as male (53%) than female (42%). This is largely consistent with the sample profile in 2021, and in previous years, although median age has been increasing over time. Cannabis and ecstasy were the most common drugs of choice (21% and 20%, respectively). There was a significant change in the drug most often used in the past month between 2021 and 2022 ($p$=0.039). Specifically, there was an increase in participants reporting alcohol (25% versus 15% in 2021) as the drug used most often in the past month and fewer reporting ecstasy (n≤5 versus 13% in 2021).

## Ecstasy

The ecstasy market has diversified over the past few years. Recent (i.e., past six month) use of ecstasy pills have declined since 2013, with 28% of the sample reporting use in 2022, the lowest per cent throughout monitoring. Despite capsules remaining the most commonly used form of ecstasy, recent use significantly decreased from 76% in 2021 to 52% in 2022 ($p$<0.001). Indeed, recent use of 'any' ecstasy declined significantly in 2022 (87% versus 98% in 2021; $p$=0.005) to the lowest per cent observed. However, frequency of use of any form of ecstasy remained stable in 2022 relative to 2021 (i.e., equivalent to monthly use), although lower compared to previous years. There was a significant change in the perceived availability of crystal ($p$=0.001) and capsules ($p$<0.001), with an increase in the per cent perceiving these forms to be 'difficult' to obtain in 2022 compared to 2021 (42% versus 29%, and 52% versus 24%, respectively). Although not significant, the highest per cent reported pills and powder to be 'difficult' or 'very difficult' to obtain.

## Methamphetamine

Use of methamphetamine had been declining, with the lowest per cent (15%) reporting any recent use in 2020. However, recent use increased in 2022 (39%), returning to similar levels of use observed in 2014-2019. This was largely driven by an increase in recent crystal methamphetamine use (31%). Frequency of crystal methamphetamine use was reported at a median of 24 days (i.e., equivalent to weekly use), the highest median days recorded since monitoring began. There was a significant change in the perceived availability of powder and crystal methamphetamine ($p$=0.030 and $p$=0.038, respectively). More participants perceived both forms to be 'easy' and 'very easy' to obtain in 2022 relative to 2021.

## Cocaine

In 2021, the highest per cent reported recent use over the course of monitoring (91%). In 2022, use declined, with three-quarters (76%; $p$=0.007) reporting recent use, similar to levels observed in 2018-2019. Recent use remained infrequent (6 median days), however, 17% of participants who had recently used cocaine reported weekly or more frequent use. The median price for a gram of cocaine has been $300 since 2006. The perceived purity and perceived availability of cocaine remained stable between 2021 and 2022.

## Cannabis and/or Cannabinoid Related Products

At least three in four participants have reported any recent use of non-prescribed

cannabis and/or cannabinoid related products each year (81% in 2022; noting some changes in question wording). The median price for an ounce of bush cannabis increased from $220 in 2021 to $250 in 2022 ($p$=0.027). The perceived purity and availability of non-prescribed cannabis remained stable between 2021 and 2022.

## Ketamine, LSD and DMT

Recent use of ketamine, LSD and DMT has fluctuated over the period of monitoring. In 2022, two-fifths (39%) of participants reported any recent ketamine use, stable from 2021 (51%). Recent use of LSD also remained stable in 2022 (31%; 45% in 2021), although there was a significant decrease in frequency of use, from three median days in 2021 to two median days in 2022 ($p$=0.023). There was a significant change in the perceived availability of LSD in 2022 relative to 2021 ($p$=0.004). More participants perceived LSD to be 'very difficult' to obtain compared to 2021 (22% versus n≤5 in 2021). In 2022, one in ten (9%) participants reported recent use of DMT, stable from 18% in 2021.

## New Psychoactive Substances (NPS)

Nine per cent reported recent use of at least one form of NPS (including plant-based NPS) stable relative to 18% in 2021. Few participants (n≤5) reported any individual NPS use.

## Other Drugs

Half (50%) of the sample reported recent non-prescribed pharmaceutical stimulant use, the highest per cent observed, although stable from 41% in 2021. There was a significant decrease in GHB/GBL/1,4-BD use from 17% in 2021 to 6% in 2022 ($p$=0.027). In 2022, the lowest per cent reported recent use of alcohol (86%) and tobacco (68%). Although recent non-prescribed e-cigarette use remained stable between 2021 and 2022 (67% and 57%, respectively), frequency of use increased from a median of 30 days in 2021 to 120 median days in 2022 ($p$=0.001). Recent use of nitrous oxide also remained stable between 2021 and 2022, however, an increase in frequency of use was observed from 4 days in 2021 to 11 days in 2022 ($p$=0.013).

## Drug-Related Harms and Other Behaviours

On the last occasion of ecstasy or related drug use, 79% of participants in 2022 reported concurrent use of two or more drugs. Twenty-nine per cent reported that they had tested the contents of their illicit drugs in the 12 months preceding interview. There was a significant decrease in the mean AUDIT score in 2022 relative to 2021 (11.6 versus 13.1 in 2021; $p$<0.001). Eleven per cent of the sample reported a non-fatal stimulant overdose and one-fifth (17%) a non-fatal depressant overdose (including alcohol) in the 12 months prior to interview, stable relative to 2021 (15% and 21%, respectively). Nine per cent of participants reported that they were currently in drug treatment. Seventy per cent reported engaging in some form of sexual activity in the past four weeks, of which 28% reported penetrative sex without a condom where they did not know the HIV status of their partner. Mental health problems in the preceding six months were self-reported by 67%, most commonly anxiety and depression. Among recent drivers, 21% reported recently driving while over the (perceived) legal limit of alcohol, whereas 58% reported recently driving within three hours of consuming an illicit or non-prescribed drugs. Past month drug-dealing (20%) and property crime (13%) remained the two main forms of past month criminal activity in 2022. The most popular means of participants arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was in person (68%) and via social networking applications (68%). Significantly more participants obtained their drugs face-to-face in 2022 than 2021 (97% versus 86% in 2021; $p$=0.009). In 2022, 95% of the sample had been tested for SARS-CoV-2, with 57% of participants having been diagnosed with COVID-19 in the past 12 months. Two-thirds (68%) reported that they were 'not at all' worried about contracting COVID-19, and most (91%) had received at least one dose of the COVID-19 vaccine.

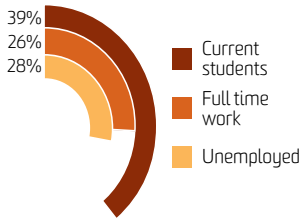
EDRS Ecstasy and Related Drugs Reporting System

# 2022 SAMPLE CHARACTERISTICS

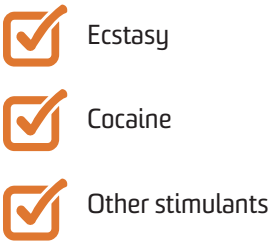
In 2022, 100 participants, recruited from Canberra, ACT were interviewed.

26 years 53%

The median age in 2022 was 26, and 53% identified as male.

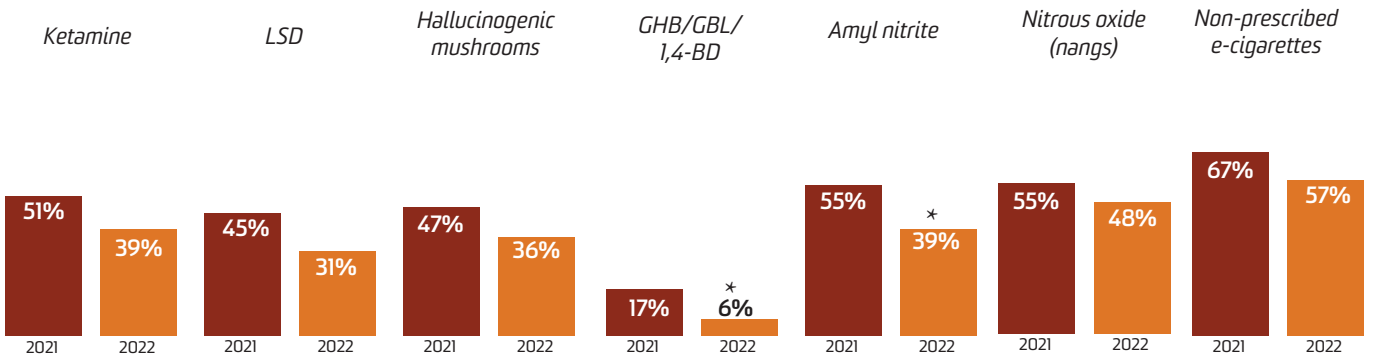



In the 2022 sample, 39% were enrolled students, 26% were employed full time and 28% were unemployed.



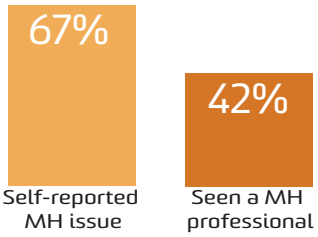

Participants were recruited on the basis that they had consumed ecstasy and/or other illicit stimulants at least monthly in the past 6 months.

# PAST 6 MONTH USE OF SELECTED DRUGS

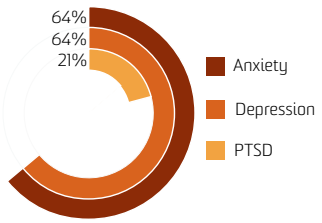



*$p$<0.050; **$p$<0.010; ***$p$<0.001

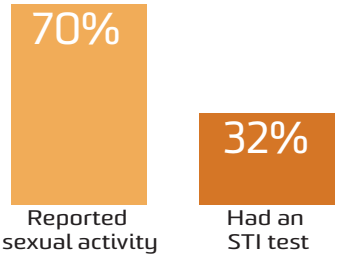
# MENTAL HEALTH AND SEXUAL HEALTH BEHAVIOURS



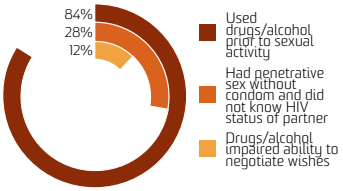

In the total sample, 67% self-reported a mental health issue and 42% had seen a mental health professional in the past 6 months.




Of those who had a mental health condition, the three most common mental health issues reported were anxiety (64%), depression (64%) and PTSD (21%).

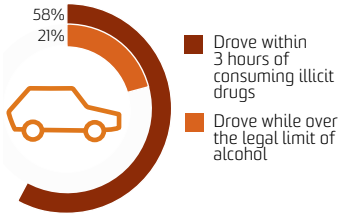



In the total sample, 70% reported sexual activity in the past 4 weeks, and 32% had a sexual health check in the past 6 months.



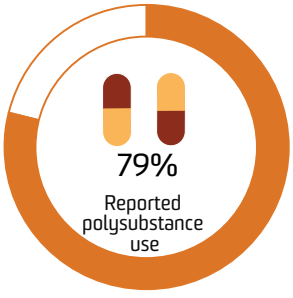

Sexual risk behaviours among those who reported any sexual activity in the past four weeks and were able to comment.

# OTHER RISK BEHAVIOURS

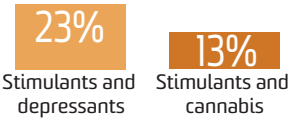



Among recent drivers, 58% reported driving a vehicle within 3 hours of consuming illicit drugs and 21% while over the legal limit of alcohol.

In the 2022 sample, 17% reported a non-fatal depressant overdose in the previous 12 months, stable relative to 2021 (21%).

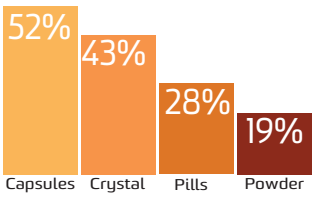



In the total sample, 79% reported concurrent use of two or more substances on the last occasion of ecstasy or related drug use.

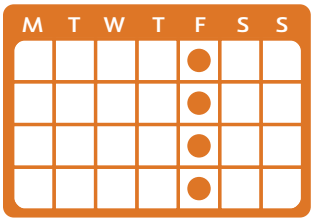



The most commonly used combinations of drug classes on the last occasion of ecstasy or related drug use.

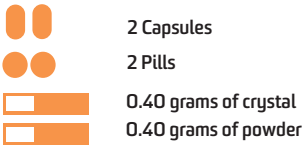
# ECSTASY




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



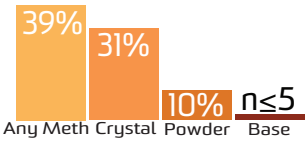

Of those who had recently consumed ecstasy, 14% reported weekly or more frequent use.



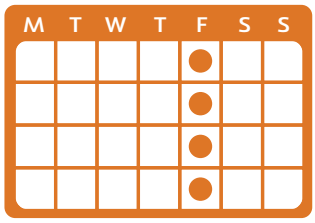

Median amounts of ecstasy consumed in a 'typical' session using each form.

In 2022, more participants perceived the availability of capsules and crystal forms as 'difficult' or 'very difficult' relative to 2021.

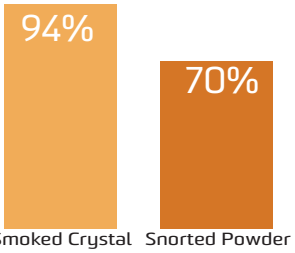
# METHAMPHETAMINE



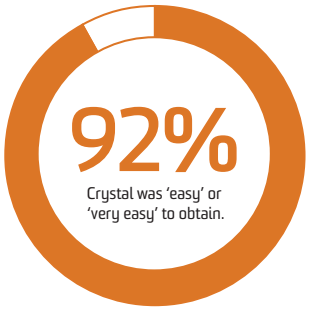

Past 6 month use of any methamphetamine, crystal, powder and base in 2022.




Of those who had recently consumed methamphetamine, 46% reported weekly or more frequent use.

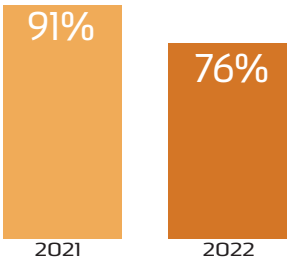



94% of participants who had recently used crystal smoked it. Of those who had recently used powder, 70% snorted it.

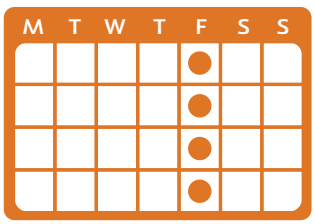



Of those who could comment, 92% perceived crystal methamphetamine to be 'easy' or 'very easy' to obtain.

# COCAINE

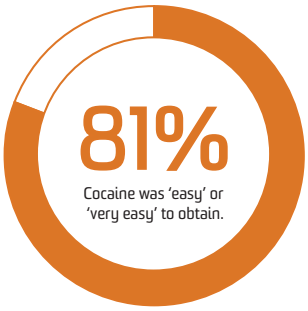



Past 6 month use of any cocaine significantly decreased between 2021 and 2022.



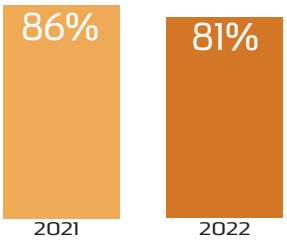

Of those who had recently consumed cocaine, 17% reported weekly or more frequent use.

In 2022, the median price of a gram of cocaine remained stable at $300.

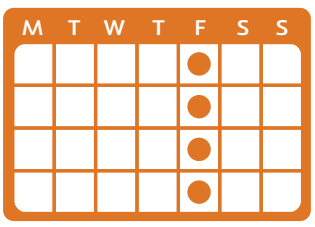



Of those who could comment, 81% perceived cocaine to be 'easy' or 'very easy' to obtain.

# CANNABIS AND/OR CANNABINOID RELATED PRODUCTS

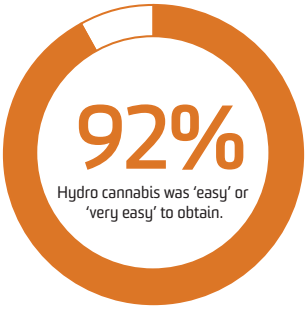



Past 6 month use of non-prescribed cannabis and/or cannabinoid related products remained stable between 2021 and 2022.




Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products, 65% reported weekly or more frequent use.

Of participants who had consumed non-prescribed cannabis and/or cannabinoid related products in the last 6 months, 93% had smoked it.




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

# Background

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

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

# Methods

## EDRS 2003-2019

Full details of the methods for the annual interviews are available for download. To briefly summarise, since the commencement of monitoring up until 2019, participants were recruited primarily via internet postings, print advertisements, interviewer contacts, and snowballing (i.e., peer referral). Participants had to: i) be at least 17 years of age (due to ethical constraints) (16 years of age in Perth, Western Australia (WA)), ii) have used ecstasy or other illicit stimulants (including: MDA, methamphetamine, cocaine, non-prescribed pharmaceutical stimulants, mephedrone or other stimulant NPS) at least six times during the preceding six months; and iii) have been a resident of the capital city in which the interview took place for ten of the past 12 months. Interviews took place in varied locations negotiated with participants (e.g., research institutions, coffee shops or parks), and 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.

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

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

A total of 700 participants were recruited across capital cities nationally (April-July, 2022), with 100 participants interviewed in Canberra, ACT during April-July 2022 (N=100 in 2021). A total of 68 interviews (68%) were conducted via telephone (49% in 2021).

Eleven per cent of the 2022 Canberra sample completed the interview in 2021, and 10% of the 2021 sample completed the interview in 2020 ($p$=0.801). The recruitment methods in 2022 remained stable relative to 2021 ($p$=0.482), with most participants being recruited via the internet (e.g., Facebook and Instagram) (81%; 78% in 2021).

### Data Analysis

For normally distributed continuous variables, means and standard deviations (SD) are reported; for skewed data (i.e. skewness > ±1 or kurtosis > ±3), medians and interquartile ranges (IQR) are reported. Tests of statistical significance have been conducted between estimates for 2021 and 2022, noting that no corrections for multiple comparisons have been made and thus comparisons should be treated with caution. References to significant differences throughout the report are where statistical testing has been conducted and where the p-value is less than 0.050. Values where cell sizes are ≤5 have been suppressed with corresponding notation (zero values are reported). References to 'recent' use and behaviours refers to the 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 Canberra, Australian Capital Territory, and thus do not reflect trends in regional and remote areas. Further, the results are not representative of all people who consume illicit drugs, nor of illicit drug use in the general population, but rather are intended to provide evidence indicative of emerging issues that warrant further monitoring.

This report covers a subset of items asked of participants and does not include implications of findings. These findings should be interpreted alongside analyses of other data sources for a more complete profile of emerging trends in illicit drug use, market features, and harms in Canberra, ACT (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, data tables and executive summary from this report are available for download. There is 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 Illicit Drug Reporting System (IDRS), which focus more so on the use of illicit drugs via injection.

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

# 1

## Sample Characteristics

In the 2022 Canberra EDRS sample, gender identity was similar to the 2021 sample ($p$=0.223), with slightly more of the sample identifying as male (53%; 64% in 2021) than female (42%; 34% in 2021). The median age of the 2022 sample was 26 years (IQR=20-32), the oldest sample since monitoring began, although stable relative to 2021 (23 years; IQR=21-29; $p$=0.078) (Table 1). Three-fifths (62%; 55% in 2021; $p$=0.389) of the sample reported having completed a post-school qualification(s) and two-fifths (39%; 45% in 2021; $p$=0.468) reported being current students. There was no significant change in current employment status between the 2022 and 2021 samples ($p$=0.872), with one-quarter reporting being employed full-time (26%; 27% in 2021) and 28% reporting being unemployed at the time of the interview (24% in 2021). There was also no significant change in participants' accommodation in the 2022 sample relative to the 2021 sample ($p$=0.487). Most participants reported to rent a house or flat (55%; 64% in 2021), followed by 22% reporting to be living at their parent's/family home (15% in 2021) (Table 1).

There was no significant change in the drug of choice nominated by participants between 2022 and 2021 ($p$=0.353). One-fifth nominated cannabis or ecstasy as their drug of choice (21% and 20%, respectively; 23% and 19% in 2021, respectively), followed by one in six nominating alcohol and cocaine (13%, respectively; 10% and 23% in 2021) (Figure 1).

The drug used most often in the past month significantly changed in 2022 compared to 2021 ($p$=0.039). In 2022, more participants reported that alcohol was the drug used most in the last month (25% versus 15% in 2021) and fewer participants reported ecstasy (n≤5 versus 13% in 2021). Similar to previous years, participants typically reported that cannabis was the substance used most often in the month preceding interview (33%; 36% in 2021) (Figure 2).

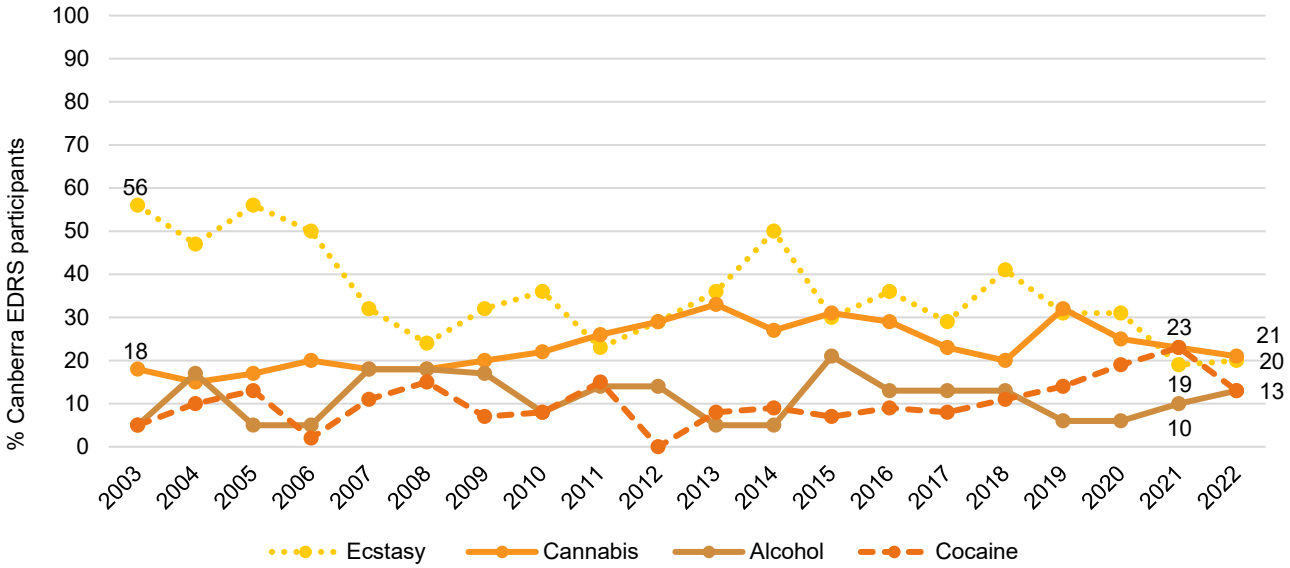
Weekly or more frequent use of cannabis (53%; 56% in 2021; $p$=0.780), ecstasy (12%; 13% in 2021), methamphetamine (18%; 8% in 2021; $p$=0.061) and cocaine (13%; 8% in 2021; $p$=0.353) remained stable in 2022 relative to 2021 (Figure 3).

## Table 1: Demographic characteristics of the sample, nationally, 2022, and Canberra, ACT, 2017-2022

| | Canberra, ACT | | | | | | National |
|---|---|---|---|---|---|---|---|
| | 2017 N=100 | 2018 N=100 | 2019 N=100 | 2020 N=101 | 2021 N=100 | 2022 N=100 | 2022 N=700 |
| **Median age (years; IQR)** | 20 (19-22) | 21 (19-24) | 20 (19-23) | 21 (20-24) | 23 (21-29) | **26 (20-32)** | 25 (21-30) |
| **% Gender** | | | | | | | |
| Female | 34 | 50 | 37 | 44 | 34 | **42** | 40 |
| Male | 64 | 49 | 62 | 56 | 64 | **53** | 56 |
| Non-binary | / | / | - | 0 | - | **-** | 4 |
| **% Aboriginal and/or Torres Strait Islander** | - | **-** | 12 | 6 | 9 | **10** | 5 |
| **% Sexual identity** | | | | | | | |
| Heterosexual | 82 | 79 | 79 | 81 | 69 | **69** | 71 |
| Homosexual | - | - | - | - | - | **-** | 5 |
| Bisexual | 13 | 14 | 15 | 14 | 17 | **20** | 17 |
| Queer | / | / | - | - | 7 | **-** | 6 |
| Different identity | - | - | - | - | - | **-** | 2 |
| **Median years of school education (IQR)** | 12 (12-12) | 12 (11-12) | 12 (11-12) | 12 (8-12) | 12 (8-12) | **11 (6-12)** | 12 (6-12) |
| **% Post-school qualification(s)^** | 27 | 40 | 40 | 48 | 55 | **62** | 61 |
| **% Current employment status** | | | | | | | |
| Employed full-time | 12 | 23 | 23 | 34 | 27 | **26** | 32 |
| Part time/ casual | 55 | 30 | 49 | 32 | 39 | **34** | 41 |
| Self-employed | / | / | - | - | 10 | **11** | 8 |
| Students[#] | 17 | 27 | 44 | 55 | 45 | **39** | 41 |
| Unemployed | 13 | 19 | 22 | 31 | 24 | **28** | 19 |
| **Current median weekly income $ (IQR)** | (N=100) 400 (250-638) | (N=98) 413 (244-800) | (N=90) 600 (300-900) | (N=94) 750 (496-1052) | (N=96) 588 (333-1081) | **(N=100) 550 (336-1000)** | (N=700) 700 (450-1200) |
| **% Current accommodation** | | | | | | | |
| Own house/flat | - | 7 | - | - | 8 | **10** | 12 |
| Rented house/flat | 58 | 44 | 39 | 54 | 64 | **55** | 59 |
| Parents'/family home | 32 | 42 | 46 | 36 | 15 | **22** | 23 |
| Boarding house/hostel | - | 0 | - | - | - | **-** | 2 |
| Public Housing | / | - | - | - | - | **-** | 2 |
| No fixed address+ | 0 | - | 0 | - | - | **-** | 2 |
| Other | - | - | 0 | 0 | - | **-** | 1 |

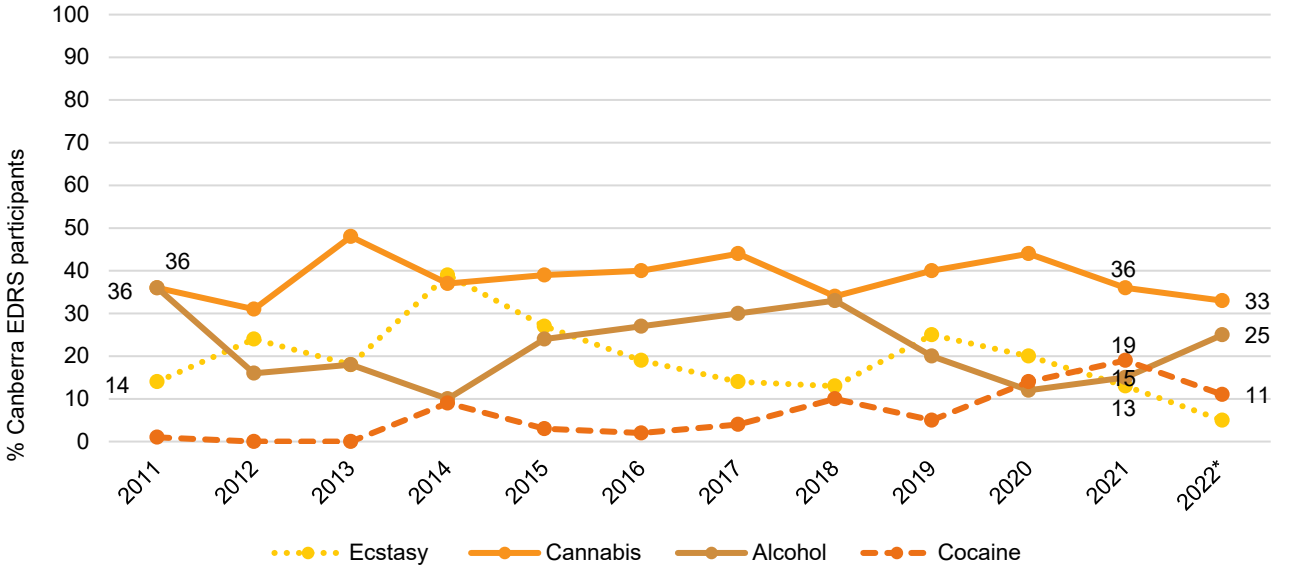
Note. ^Includes trade/technical and university qualifications.[#] 'students' comprised participants who were currently studying for either trade/technical or university/college qualifications. / not asked. + No fixed address included 'couch surfing and rough sleeping or squatting. - Per cent suppressed 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.

## Figure 1: Drug of choice, Canberra, ACT, 2003-2022



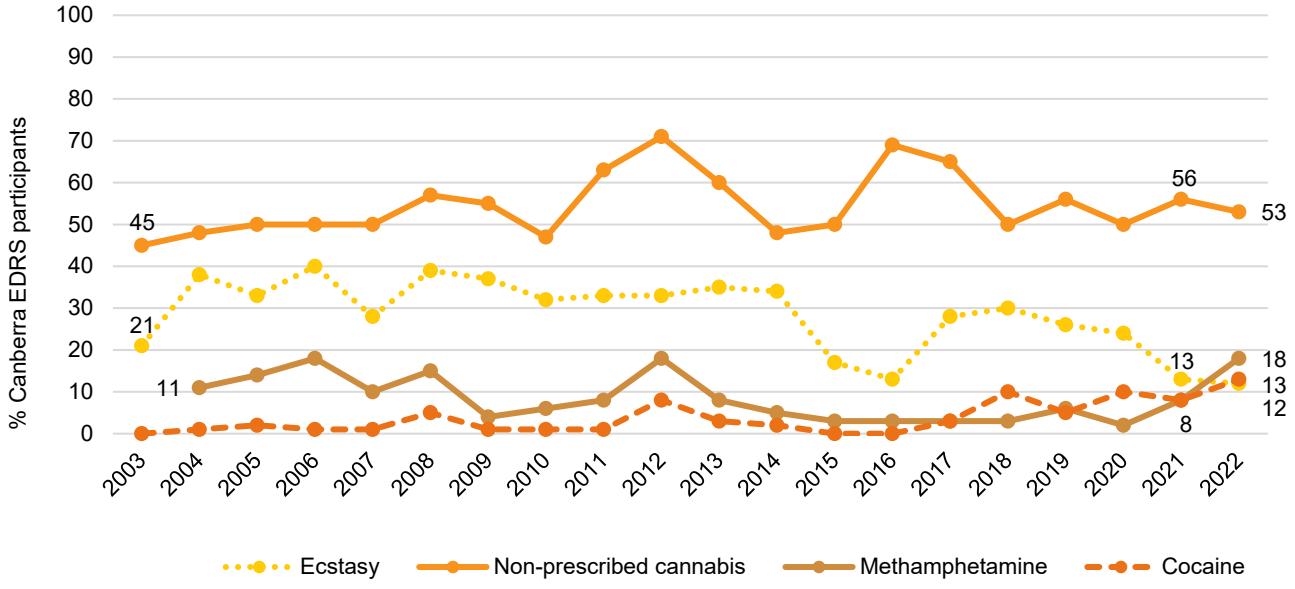

Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed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

## Figure 2: Drug used most often in the past month, Canberra, ACT, 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≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

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




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

# 2

# Ecstasy

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

## Recent Use (past 6 months)

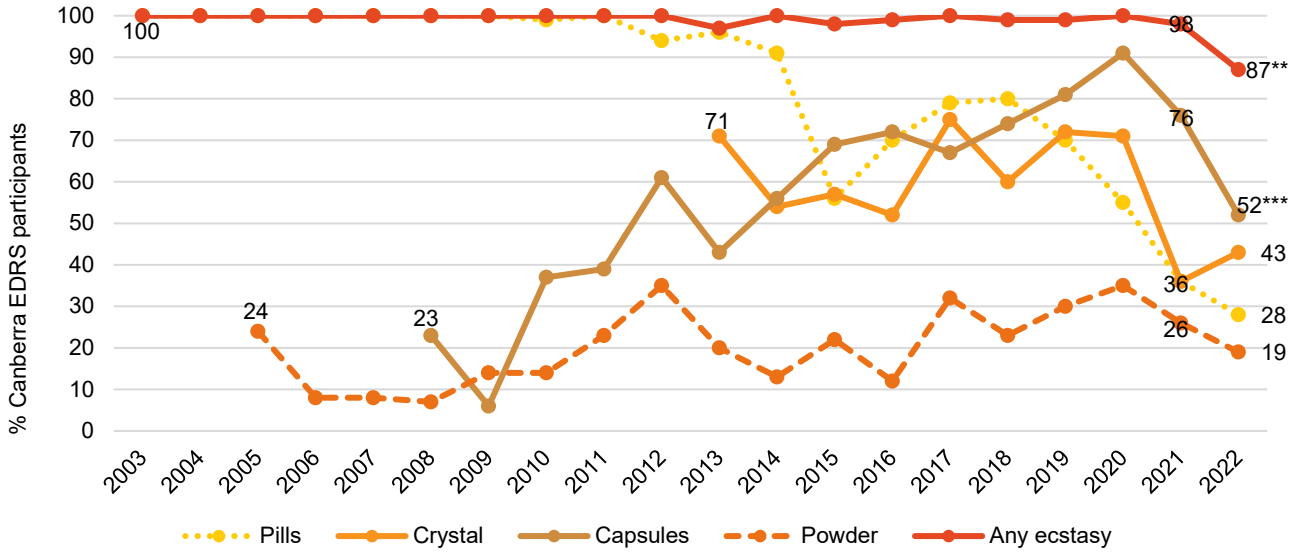
Over the course of monitoring, nearly all participants each year have reported recent ecstasy use. While still the majority of the sample, there was a significant decrease in use in 2022, with 87% reporting past six month use (98% in 2021; $p$=0.005) (Figure 4).

From 2003-2014, pills dominated as the most common form of ecstasy used in the six months preceding interview. However, in more recent years (2015-2020), pills have been competing with the crystal and capsule forms of ecstasy in terms of the per cent reporting recent use. In 2022, capsules were still the most commonly used form of ecstasy, despite a significant decrease from 2021 (52%; 76% in 2021; $p$<0.001). All other forms remained stable, with two-fifths reporting using crystal (43%; 36% in 2021; $p$=0.385), followed by 28% reporting pills (36% in 2021; $p$=0.295) and 19% reporting powder (26% in 2021; $p$=0.312), the least commonly used form historically (Figure 4).

## Frequency of Use

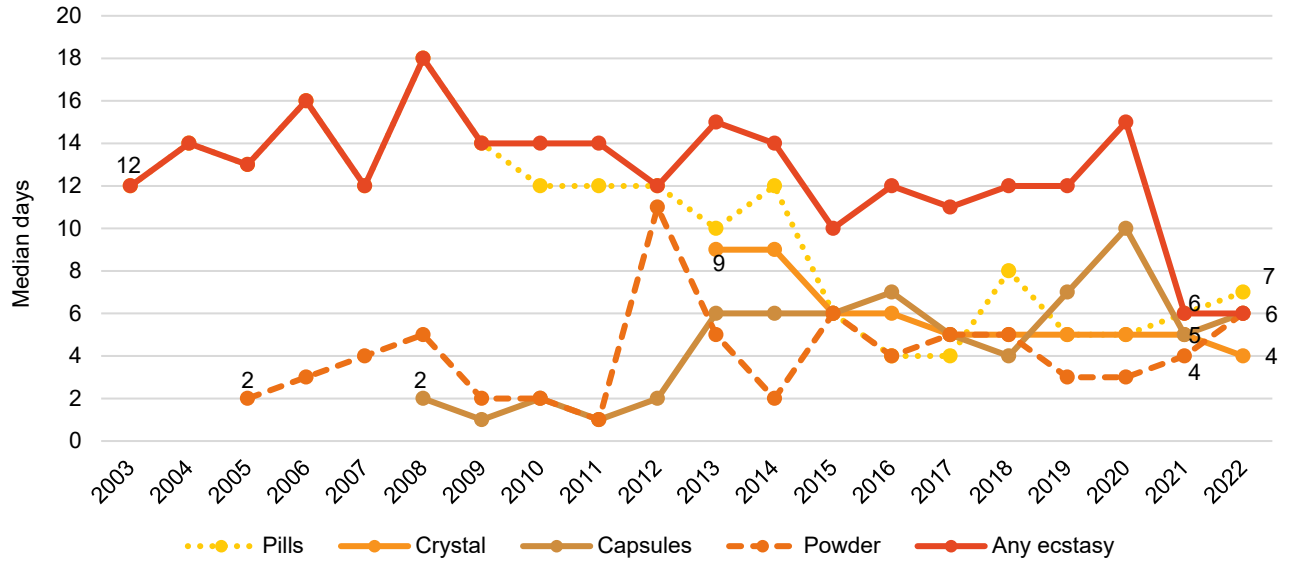
In 2022, participants reported using ecstasy (in any form) on a median of six days (i.e., equivalent to monthly use; IQR=4-15; 6 days in 2021; IQR=4-15; $p$=0.703), which remains lower than what has historically been observed (10-18 days between 2003-2020) (Figure 5). Fourteen per cent of participants who had recently used ecstasy reported weekly or more frequent use in 2022, stable relative from 2021 (13%).

## Figure 4: Past six month use of any ecstasy, and ecstasy pills, powder, capsules, and crystal, Canberra, ACT, 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≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

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




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

# Patterns of Consumption (by form)

## Ecstasy Pills

**Recent Use (past 6 months):** Ecstasy pills dominated as the most common form of ecstasy used since monitoring began in 2003 until 2015, from which point the most common form varied between pills, crystal and capsules. In 2022, one-quarter (28%) reported recent use of ecstasy pills in the past six months (36% in 2021; *p*=0.295) (Figure 4), the lowest per cent observed since monitoring began.

**Frequency of Use:** Frequency of use of pills remained stable in 2022 (median 7 days; IQR=4-12; 6 days in 2021; IQR=2-16; *p*=0.519) (Figure 5). A small per cent reported weekly or more frequent use of ecstasy pills (n≤5; 22% in 2021; *p*=0.527).

**Routes of Administration:** Swallowing remained the main route of administration among those who had used pills (100%; 97% in 2021). Few participants (n≤5) nominated other routes of administration.

**Quantity:** In 2022, the median quantity used in a 'typical' session was two pills (IQR=2-3, n=28; 2 pills in 2021; n=36; IQR=1-3; *p*=0.644). The median maximum number of pills used remained stable at three pills (IQR=2-4, n=28; 3 pills in 2021; n=36; IQR=2-5; *p*=0.821).

## Ecstasy Capsules

**Recent Use (past 6 months):** The per cent reporting recent use of ecstasy capsules has been gradually increasing over time, peaking at 91% in 2020, before significantly declining in 2022 (52%; 76% in 2021; *p*<0.001). Despite this decline, capsules remained the most commonly used form of ecstasy in 2022 (Figure 4).

**Frequency of Use:** Participants reported consuming capsules on a median of six days in 2022 (IQR=3-10), stable relative to 2021 (5 days; IQR=3-8; *p*=0.367) (Figure 5). Of those that reported recent use of ecstasy capsules, small numbers reported weekly or more frequent use in 2022 (n≤5; n≤5 in 2021; *p*=0.269)

**Routes of Administration:** The main route of administration among those who had recently used capsules has consistently been swallowing (94%; 95% in 2021), followed by snorting (23%; 24% in 2021).

**Quantity:** The median quantity used in a 'typical' session was two capsules in 2022 (IQR=2-3; n=52; 2 capsules in 2021; IQR=1-3; n=76; *p*=0.423) and the median maximum number of capsules used in a session was three (IQR=2-5; n=52; 3 capsules in 2021; IQR=2-5; n=76; *p*=0.441).

**Contents of Capsules:** Of those participants who had recently used capsules, most (76%) reported that their last capsule contained crystal, whilst 31% reported that it contained powder. A small number (n≤5) reported that they did not look at the contents the last time they used capsules.

## Ecstasy Crystal

**Recent Use (past 6 months):** Recent use of the crystal form was reported by 43% of participants, stable relative to 36% in 2021 (*p*=0.385) (Figure 4).

**Frequency of Use:** Frequency of use among those who had recently used crystal remained stable at a median of four days (IQR=2-8; 5 days in 2021; IQR=2-11; *p*=0.929) (Figure 5). Small numbers (n≤5) reported weekly or more frequent use (n≤5 in 2021).

**Routes of Administration:** The most common route of administration was swallowing (58%; 78% in 2021; *p*=0.097) and snorting (49%; 50% in 2021).

**Quantity:** The median amount of crystal used in a 'typical' session was 0.40 grams (IQR=0.20-0.50; n=38; 0.30 grams in 2021; IQR=0.20-0.50; n=31; *p*=0.862) and the median maximum amount used was 0.60 grams (IQR=0.30-1.00; n=38; 0.50 grams in 2021; IQR=0.30-1.00; n=31; *p*=0.627).

## Ecstasy Powder

**Recent Use (past 6 months):** With the exception of 2009, ecstasy powder has consistently been the least commonly endorsed form of ecstasy (19%; 26% in 2021; *p*=0.312) (Figure 4).

**Frequency of Use:** Frequency of powder use among those who had recently used powder remained stable (median 6 days; IQR=3-12; 4 days in 2021; IQR=2-10; *p*=0.246) (Figure 5). A small per cent reported weekly or more frequent use of ecstasy powder (n≤5; n≤5 in 2021).

**Routes of Administration:** The main route of administration among those who had recently

used powder has consistently been snorting (89%; 65% in 2021; *p*=0.086), closely followed by swallowing (47%; 62% in 2021; *p*=0.376).

**Quantity:** The median quantity used in a 'typical' session was 0.40 grams (IQR=0.20-0.50; n=16; 0.50 grams in 2021; IQR=0.20-0.60; n=20; *p*=0.571). The median maximum amount consumed in a session was one gram (IQR=0.40-2.00; n=17; 1.00 gram in 2021; IQR=0.40-2.00; n=22, *p*=0.853).

## Price, Perceived Purity and Perceived Availability

### Ecstasy Pills

**Price:** The reported median price of a pill was $35 until 2006, then $30 in 2007, and has since remained relatively stable at $25 ($25 in 2022; IQR=21-25, n=10; $25 in 2021; IQR=20-25; n=34; *p*=0.621) (Figure 6).

**Perceived Purity:** No change was observed in 2022 compared to 2021 in relation to perceived purity of pills (*p*=0.092). Of those who responded in 2022 (n=36), 44% perceived pills to be of 'medium' purity (28% in 2021), followed by one-third (33%) reporting 'high' purity (23% in 2021) (Figure 9).

**Perceived Availability:** The perceived availability of pills remained stable between 2021 and 2022 (*p*=0.052). Equal percentages perceived pills to be 'very easy' and 'difficult' in 2022 (35% respectively; 21% respectively in 2021) (Figure 13). Historically, the highest per cent reported pills to be 'difficult' since monitoring began.

### Ecstasy Capsules

**Price:** The median price per ecstasy capsule has been fluctuating between $20-$30 since monitoring began. After declining to $20 in 2020 and 2021, the median price for capsules was $25 in 2022 (IQR=20-29; n=14; $20 in 2021; IQR=20-25; *p*=0.324) (Figure 6).

**Perceived Purity:** No change was observed in 2022 compared to 2021 in relation to perceived purity of capsules (*p*=0.357). Among those who responded in 2022 (n=53), 45% perceived capsules to be of 'medium' purity (41% in 2021), followed by one-quarter (25%) reporting 'high' purity (38% in 2021) (Figure 10).

**Perceived Availability:** There was a significant change in perceived availability of capsules between 2021 and 2022 (*p*<0.001). Of those who were able to comment in 2022 (n=56), more participants reported perceived availability to be 'difficult' (52%; 24% in 2021) and 'very difficult' (13%; n≤5 in 2021), representing the highest per cent observed since monitoring began (Figure 14).

### Ecstasy Crystal

**Price:** The median price of a gram of crystal was reported at $200 in 2022 (IQR=200-300, n=24; $200 in 2021; IQR=150-200; n=39; *p*<0.001). Few participants reported the price of a point (n≤5; $23 in 2021; IQR=20-26; *p*=0.526) (Figure 7).

**Perceived Purity:** No change was observed in 2022 compared to 2021 in relation to perceived purity of crystal (*p*=0.788). Of those who responded in 2022 (n=46), nearly half (48%) reported purity to be 'medium' (40% in 2021), followed by one-third (35%) reporting 'high' purity (34% in 2021) (Figure 11).

**Perceived Availability:** There was a significant change in perceived availability between 2021 and 2022 (*p*=0.001). Among those who responded in 2022 (n=48), more participants reported perceived availability to be 'difficult' (42%; 29% in 2021) and 'very difficult' (21%; n≤5 in 2021), representing the highest per cent since monitoring began (Figure 15).

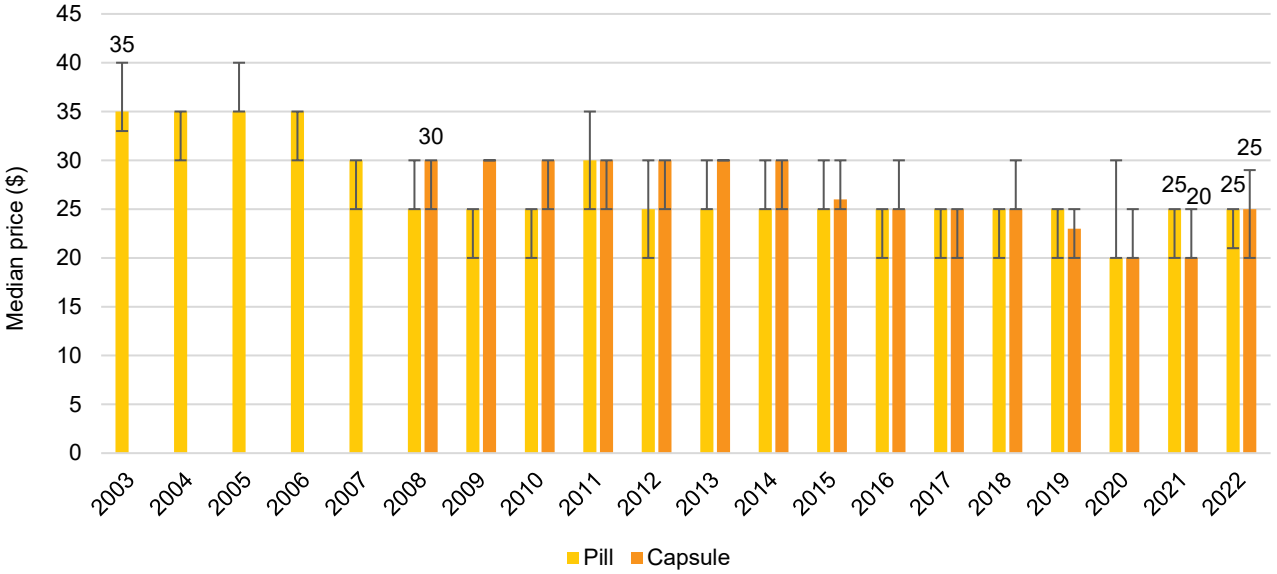
### Ecstasy Powder

**Price:** The median price per gram of ecstasy powder was $200 (IQR=170-200, n=11) in 2022, stable relative to 2021 ($200; IQR=135-200; n=14; *p*=0.555). No participants reported the price for a point ($30 in 2021; IQR=23-38; *p*=0.203) (Figure 8).

**Perceived Purity:** The perceived purity of powder remained stable between 2021 and 2022 (*p*=0.387). Among those who responded in 2022 (n=18), three-fifths perceived powder to be of 'medium' purity (61%; 42% in 2021) (Figure 12).

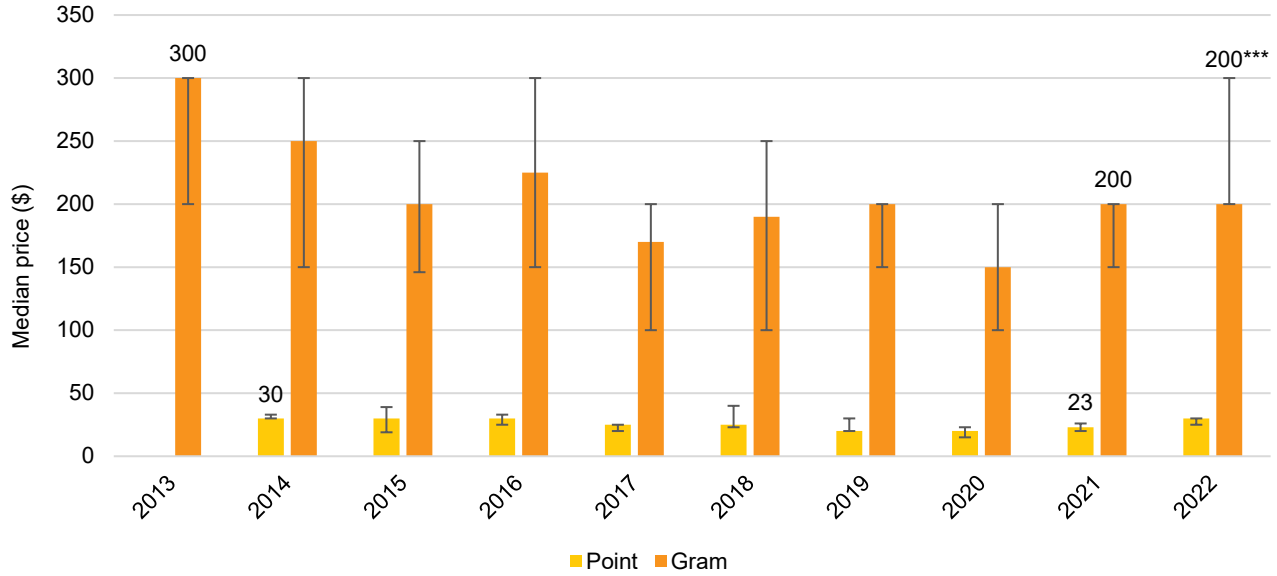
**Perceived Availability:** The perceived availability of ecstasy powder remained stable between 2021 and 2022 ($p$=0.755). Among those who responded in 2022 (n=20), two-fifths (40%) reported that powder was 'difficult' to obtain (40% in 2021) (Figure 16).

## Figure 6: Median price of ecstasy pill and capsule, Canberra, ACT, 2003-2022



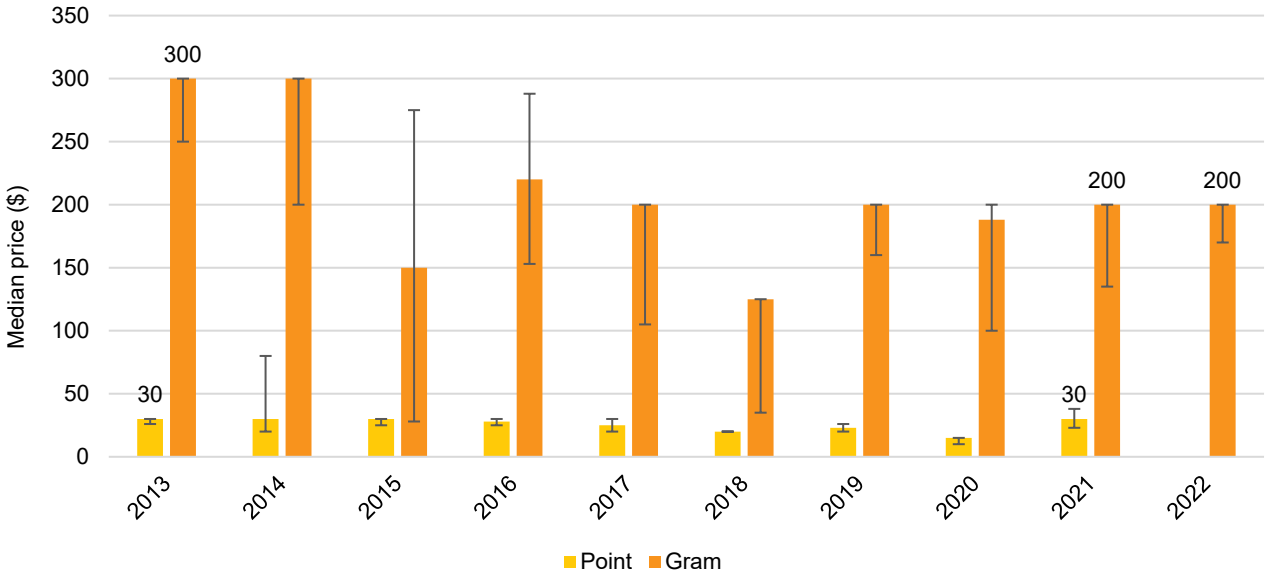

Note. Among those who commented. Data collection for price of ecstasy capsules started in 2008. Data labels are only provided for the first (2003/2008) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response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

## Figure 7: Median price of ecstasy crystal per point and gram, Canberra, ACT, 2013-2022



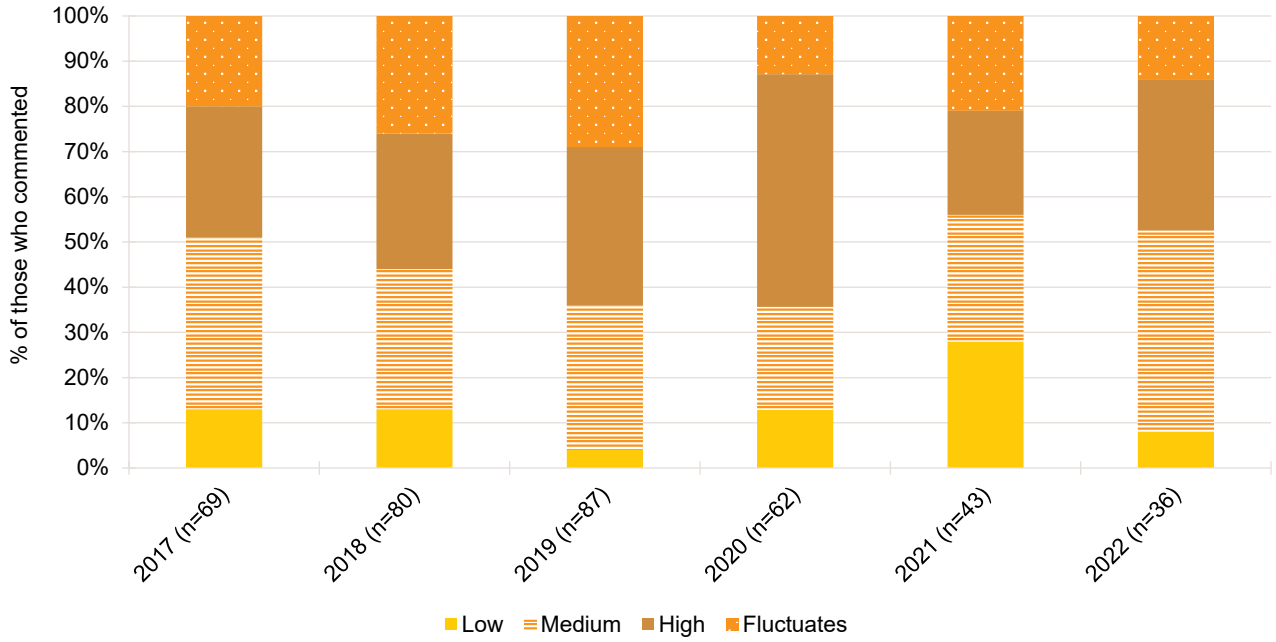

Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) started in 2013. No participants reported price data for a 'point' of ecstasy crystal in 2013. Data labels are only provided for the first (2013/2014) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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: Median price of ecstasy powder per point and gram, Canberra, ACT, 2013-2022



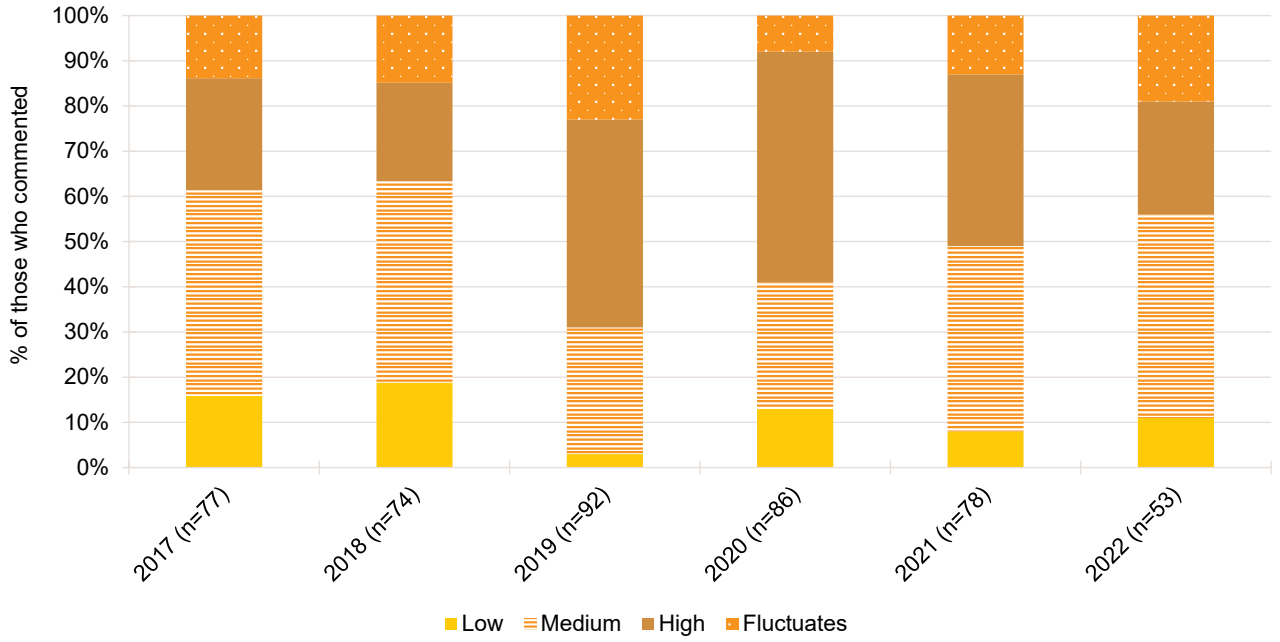

Note. Among those who commented. Data collection for price of ecstasy powder (gram and point) started in 2013. No participants reported price data for a 'point' of ecstasy powder in 2022. Data labels are only provided for the first (2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤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 9: Current perceived purity of ecstasy pills, Canberra, ACT, 2017-2022



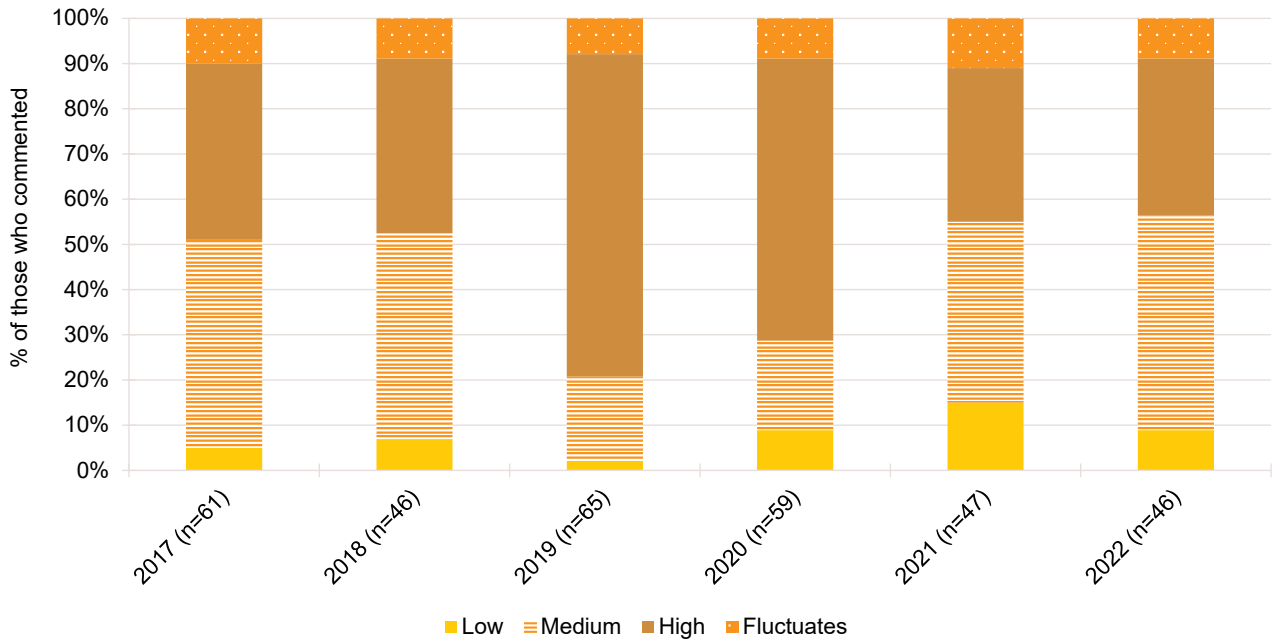

Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤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 capsules, Canberra, ACT, 2017-2022



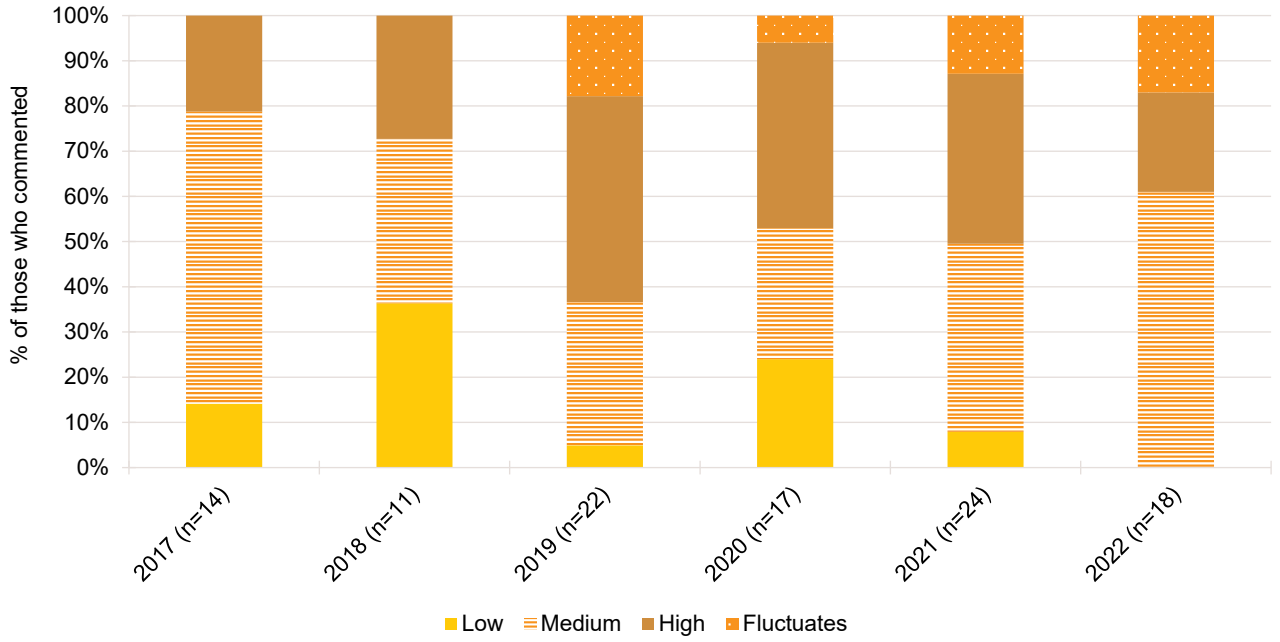

Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤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 crystal, Canberra, ACT, 2017-2022



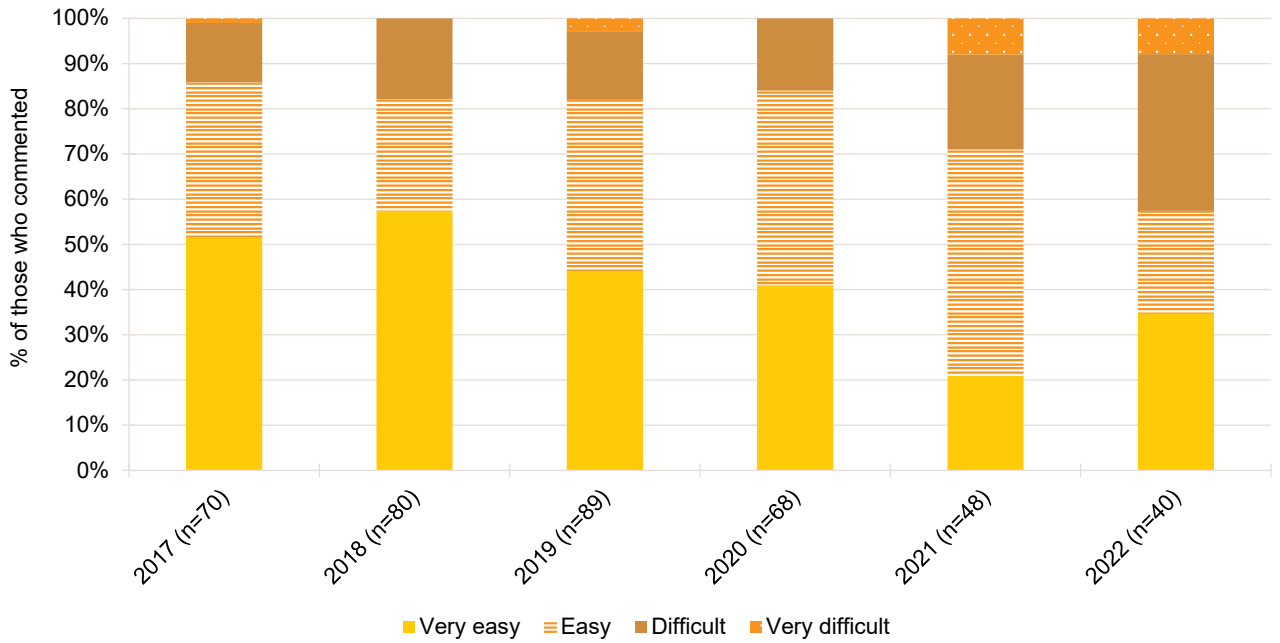

Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤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 purity of ecstasy powder, Canberra, ACT, 2017-2022



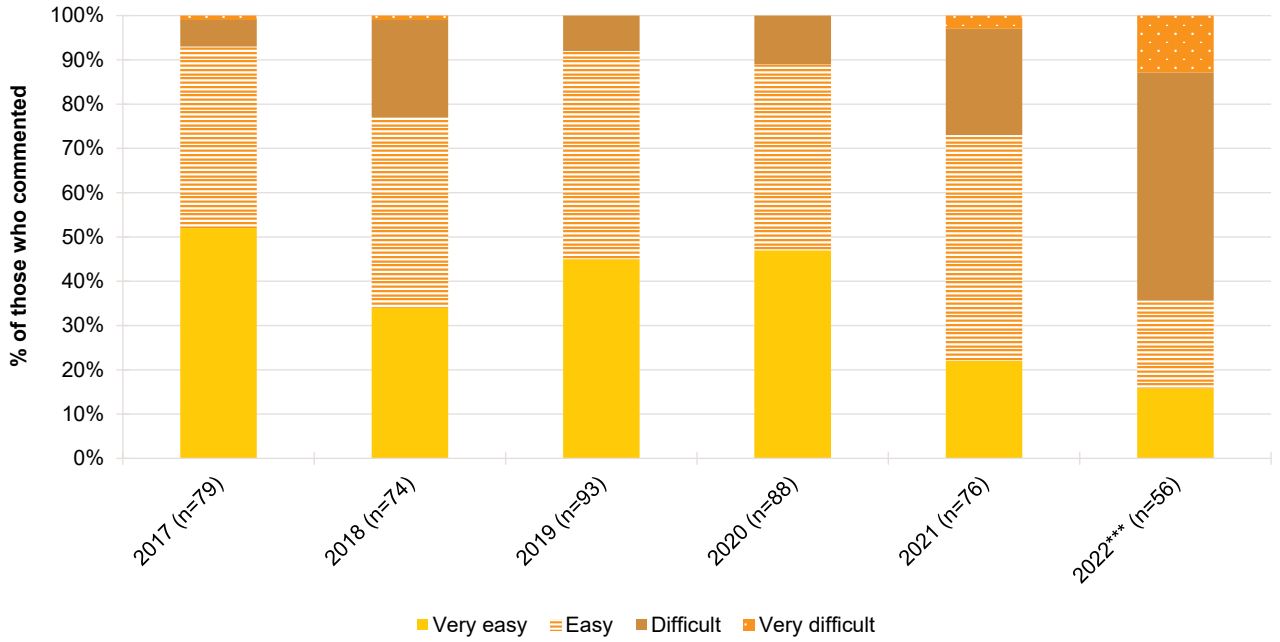

Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤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 pills, Canberra, ACT, 2017-2022



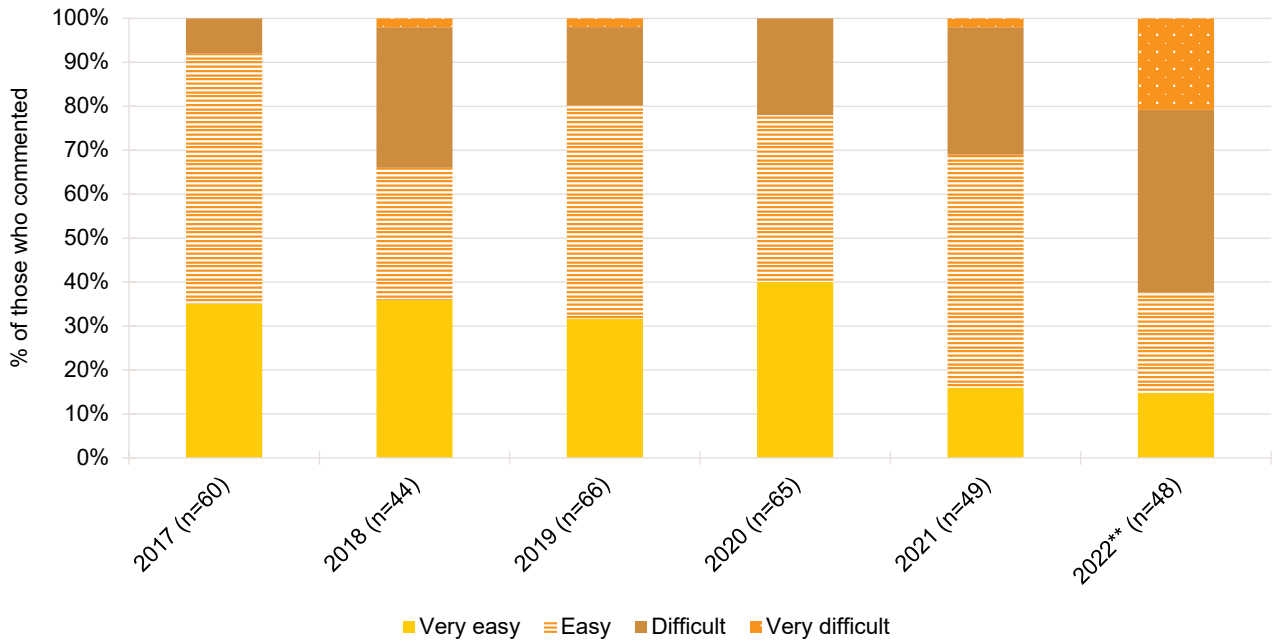

Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤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 capsules, Canberra, ACT, 2017-2022



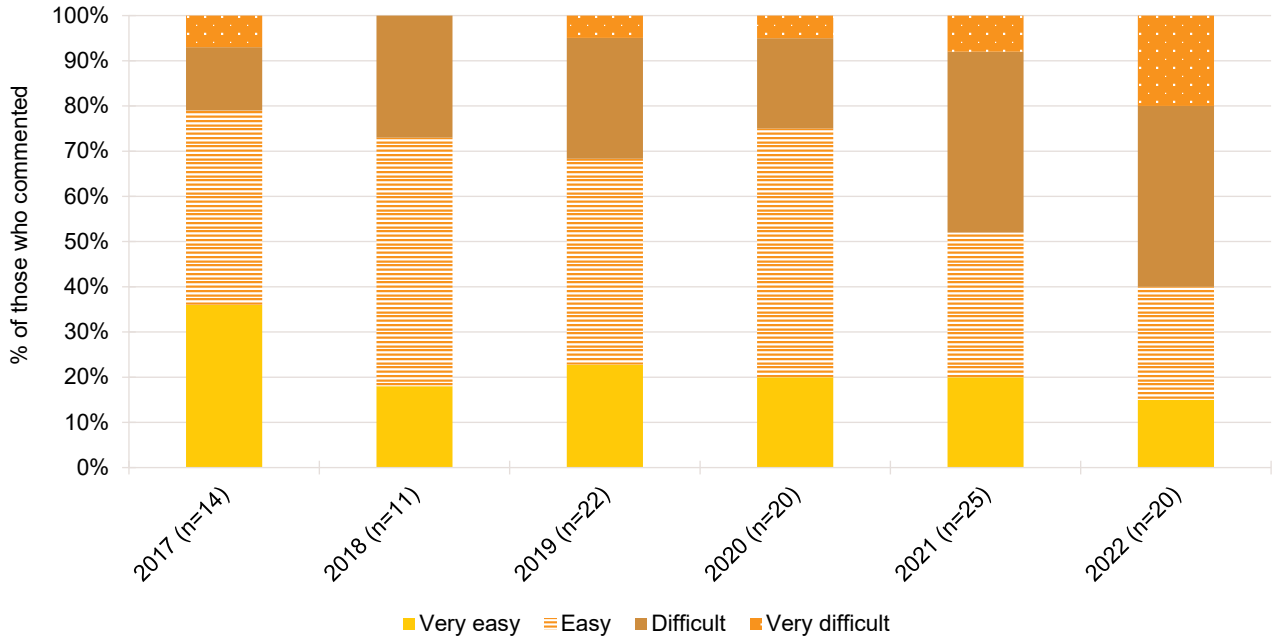

Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and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

## Figure 16: Current perceived availability of ecstasy powder, Canberra, ACT, 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≤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), crystal (clear, ice-like crystals).

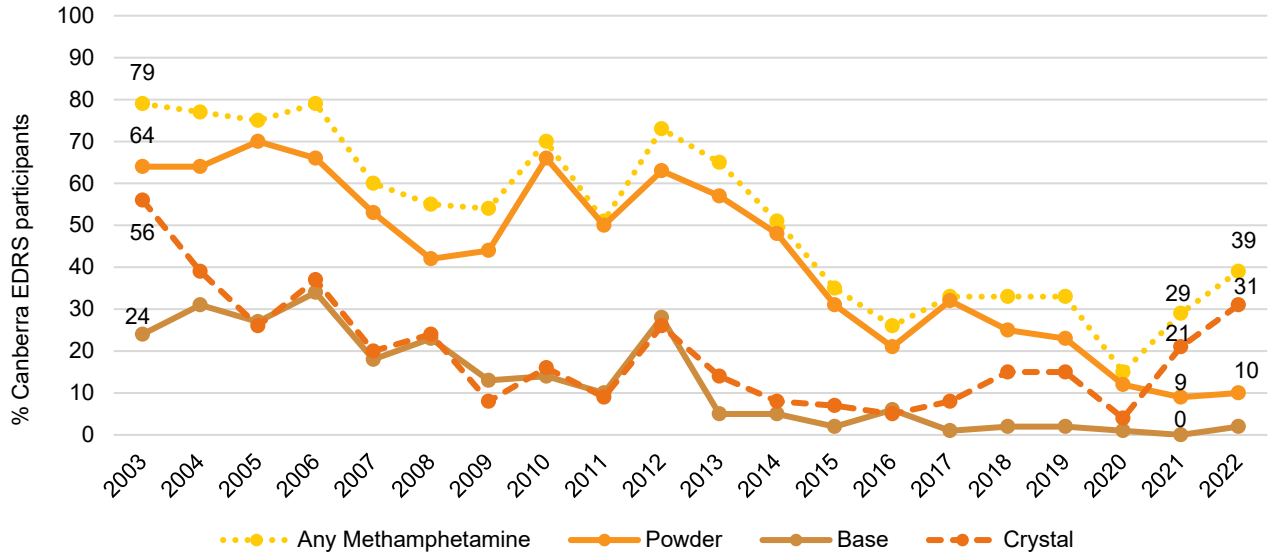
## Recent Use (past 6 months)

Recent use of any methamphetamine has generally been declining since monitoring began, from four in five participants (79%) in 2003 to one in six participants in 2020 (15%), the lowest per cent since monitoring began. However, since 2021, recent use has been increasing and reached two-fifths in 2022 (39%; 29% in 2021; *p*=0.184), the highest per cent since 2014 (Figure 17).

## Frequency of Use

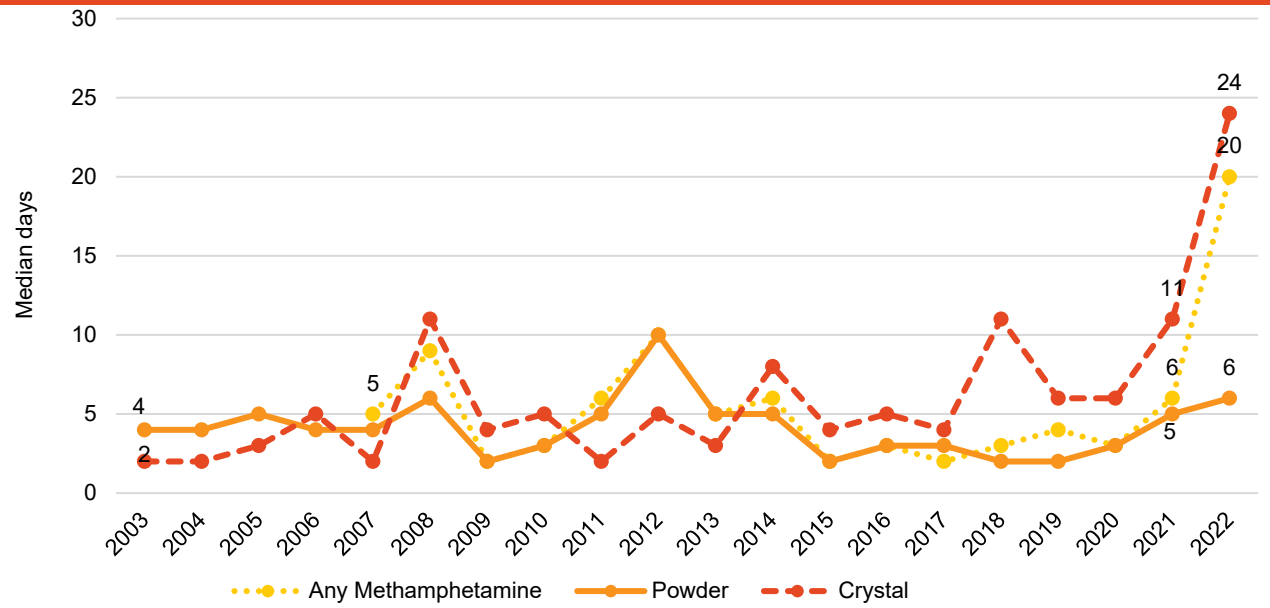
Use has historically been relatively infrequent over the course of monitoring, however in 2022, participants reported a median of 20 days of use (IQR=4-66; 6 days in 2021; IQR=3-25; *p*=0.213), the highest number observed since monitoring began (Figure 18). Amongst participants who reported recent use (n=39), nearly half (46%) reported weekly or more frequent use of any methamphetamine (29% in 2021; *p*=0.207), the highest per cent since monitoring began in 2003.

Figure 17: Past six month use of any methamphetamine, powder, base, and crystal, Canberra, ACT, 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≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

Figure 18: Median days of any methamphetamine, powder, and crystal use in the past six months, Canberra, ACT, 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 30 days to improve visibility of trends. Data labels are only provided for the first (2003/2007) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

# Patterns of Consumption (by form)

## Methamphetamine Powder

**Recent Use (past 6 months):** Powder has historically been the most commonly used form of methamphetamine, although the per recent reporting recent use has been substantially declining over time, with the crystal form surpassing powder for the first time in 2021. In 2022, one in ten (10%) participants reported recent use of methamphetamine powder, the second lowest per cent since monitoring began (9% in 2021) (Figure 17).

**Frequency of Use:** Frequency of use has fluctuated over the years, peaking at a median of 10 days in 2012. In 2022, participants reported using powder equivalent to a monthly frequency in the past six months (6 median days; IQR=1-9; 5 days in 2021; IQR=2-6; $p$=0.741) (Figure 18).

**Routes of Administration:** In 2022, the most common route of administration was snorting (70%; 67% in 2021).

**Quantity:** The median quantity used in a 'typical' session was 0.20 grams (IQR=0.10-0.50; n=10; 0.20 grams in 2021; IQR=0.10-0.50; n=7; $p$=0.766). The median maximum amount consumed in a session was 0.20 grams (IQR=0.10-0.50; n=10; 0.50 grams in 2021; IQR=0.10-0.60; n=7; $p$=0.843).

## Methamphetamine Crystal

**Recent Use (past 6 months):** Recent use of crystal has fluctuated over the years, with 31% of the sample reporting use in 2022 (21% in 2021; $p$=0.154), the highest per cent since 2006 and surpassing powder for the second year in a row (Figure 17).

**Frequency of Use:** In 2022, participants reported using crystal methamphetamine on a weekly basis in the past six months (median 24 days; IQR=5-72; 11 days in 2021; IQR=4-73; $p$=0.343), the highest number since monitoring began (Figure 18).

**Routes of Administration:** In 2022, most participants reported smoking as a route of administration (94%; 100% in 2021; $p$=0.509).

**Quantity:** The median quantity used in a 'typical' session was 0.30 grams (IQR=0.20-0.50; n=30; 0.20 grams in 2021; IQR=0.10-

0.50; n=19; *p*=0.860). The median maximum amount used in a session was 0.50 grams (IQR=0.40-1.00; n=30; 0.50 grams in 2021; IQR=0.20-1.80; n=19; *p*=0.813).

### Methamphetamine Base

Few participants (n≤5) reported recent use of base methamphetamine in 2022 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 (drugtrends@unsw.edu.au).

## Price, Perceived Purity and Perceived Availability

### Methamphetamine Powder

**Price:** Few participants reported on the price of a gram of methamphetamine in 2022 (n≤5; $200 in 2021; IQR=170-200, n=7; *p*=0.848) and no participants commented on the price for a point in 2022 (n≤5 in 2021), therefore these data are suppressed (Figure 19).

**Perceived Purity:** Among those who responded in 2022 (n=13), the perceived availability of powder remained stable in 2022 relative to 2021 (*p*=0.911). Three-fifths reported purity to be 'high' (62%; n≤5 in 2021) (Figure 21).

**Perceived Availability:** There was a significant change in the perceived availability of powder between 2021 and 2022 (*p*=0.030). Of those who responded (n=15), the majority of participants perceived it to be 'easy' to obtain (47%; n≤5 in 2021) whereas no participants perceived it to be 'difficult' (n≤5 in 2021) (Figure 23).

### Methamphetamine Crystal

**Price:** In 2022, the median price of crystal methamphetamine was $70 per point (IQR=50-100; n=9), a significant increase relative to $50 in 2021 (IQR=50-53, n=12; *p*=0.031). Low numbers reported the price for a gram (n≤5 in 2022; n≤5 in 2021) (Figure 20).

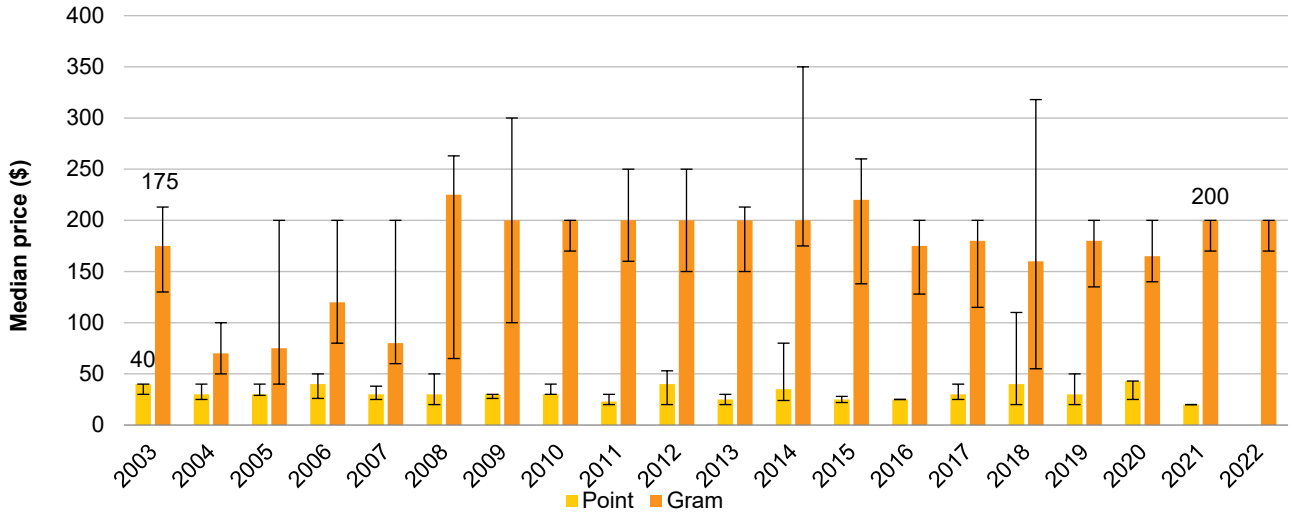
**Perceived Purity:** The perceived purity of crystal methamphetamine remained stable between 2021 and 2022 (*p*=0.268). Among those who responded in 2022 (n=34), almost half (47%) perceived crystal methamphetamine to be of 'high' purity (44% in 2021) and 24% perceived it to be 'fluctuating' (17% in 2021) (Figure 22).

**Perceived Availability:** There was a significant change in the perceived availability of crystal between 2021 and 2022 (*p*=0.038). Of those who responded (n=35), more participants perceived availability of crystal to be 'very easy' in 2022 (63%) than in 2021 (28%) (Figure 24).

### Methamphetamine Base

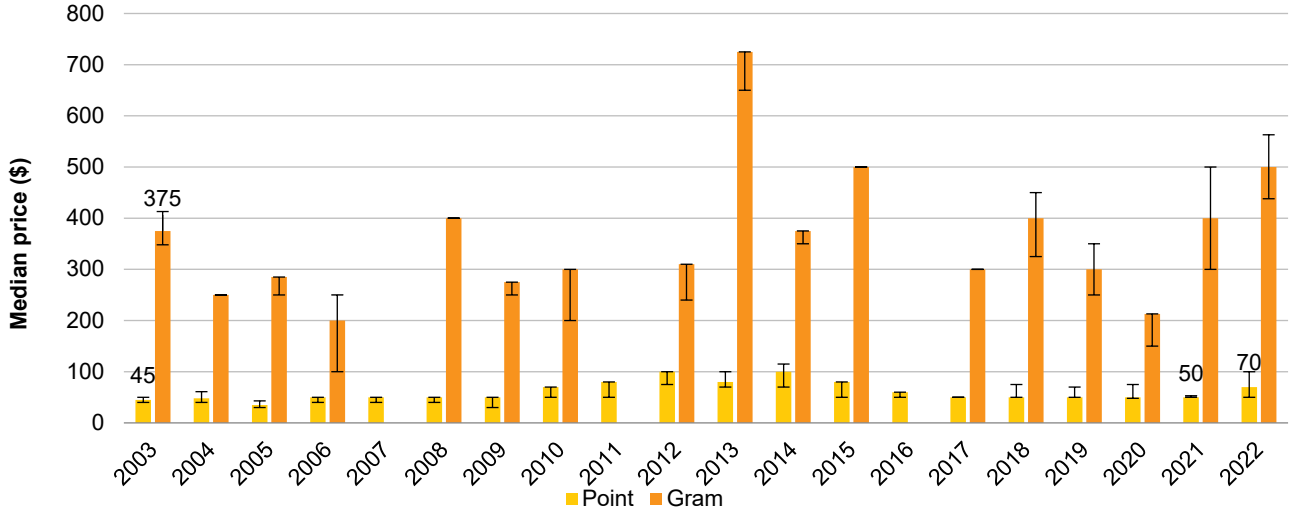
Few participants (n≤5) commented on the perceived price, purity and availability of base methamphetamine and therefore further details are not reported. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

## Figure 19: Median price of powder methamphetamine per point and gram, Canberra, ACT, 2003-2022



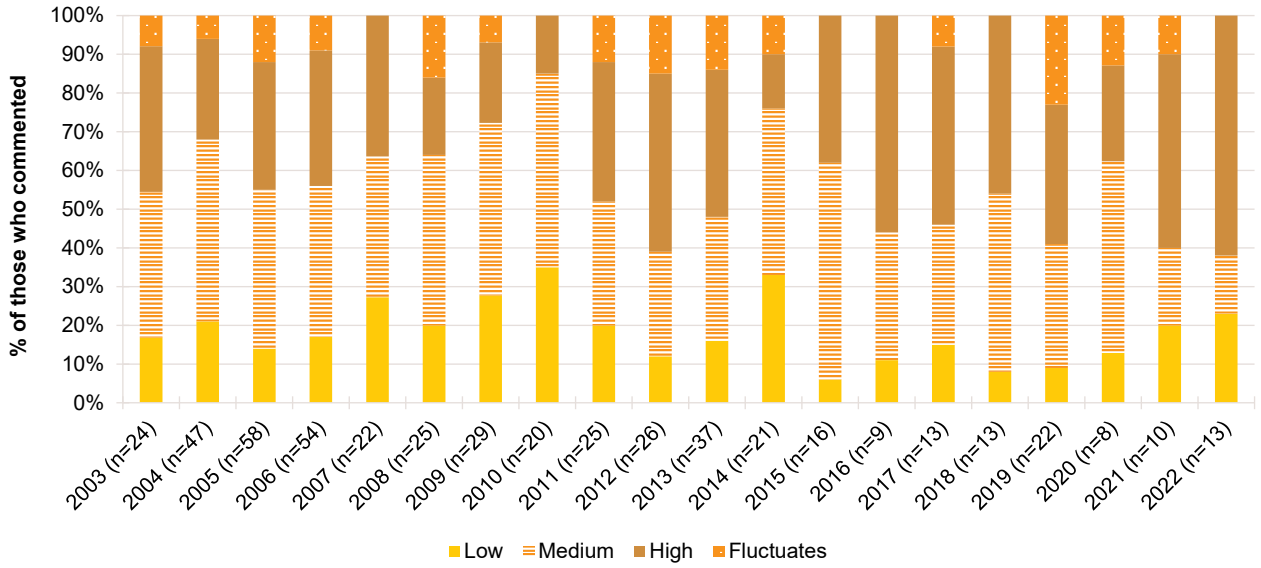

Note. Among those who commented. No participants reported purchasing a point of powder methamphetamine in 2022. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0).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

## Figure 20: Median price of crystal methamphetamine per point and gram, Canberra, ACT, 2003-2022



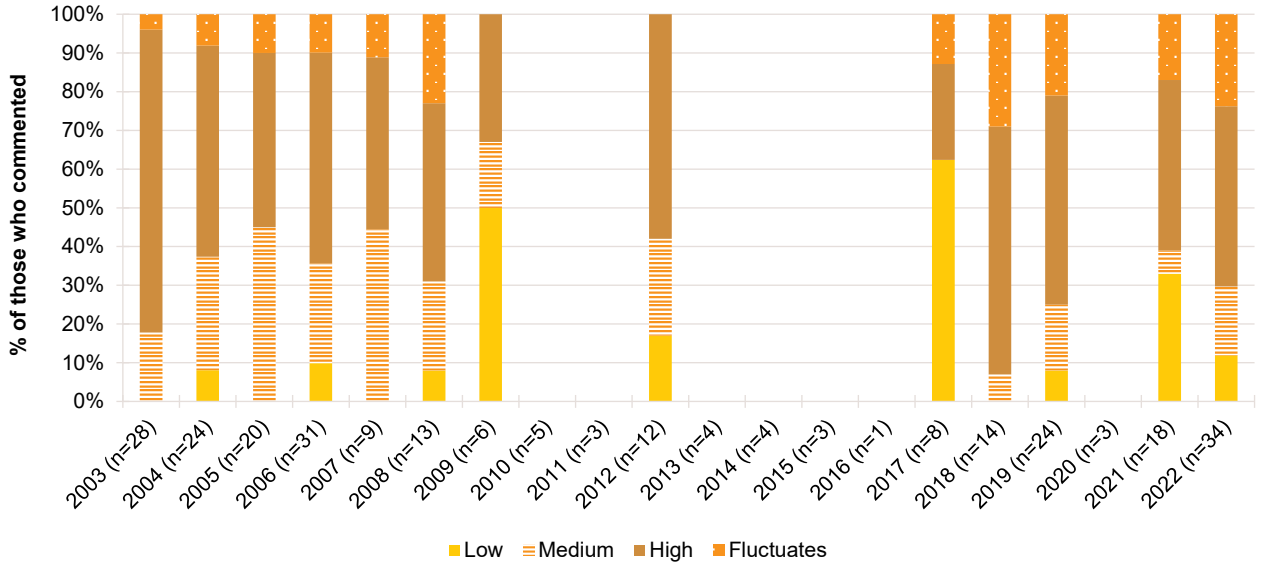

Note. Among those who commented. No participants reported purchasing a gram of crystal methamphetamine in 2007, 2011, 2016. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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 21: Current perceived purity of powder methamphetamine, Canberra, ACT, 2003-2022



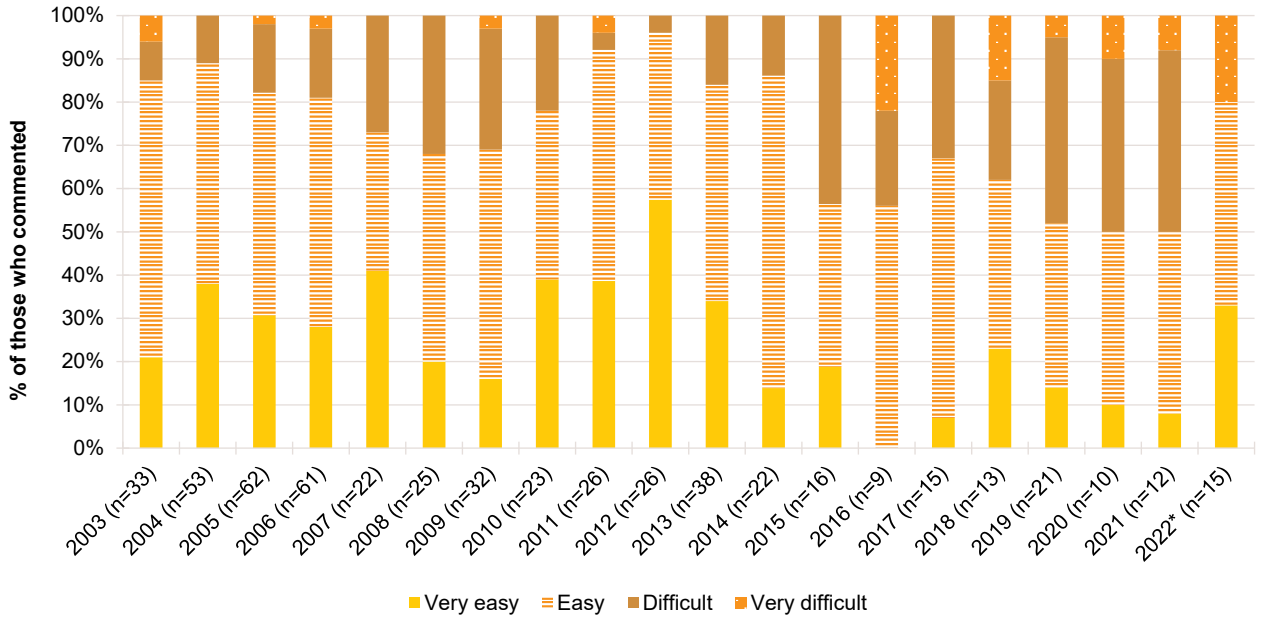

Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2021 versus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

## Figure 22: Current perceived purity of crystal methamphetamine, Canberra, ACT, 2003-2022



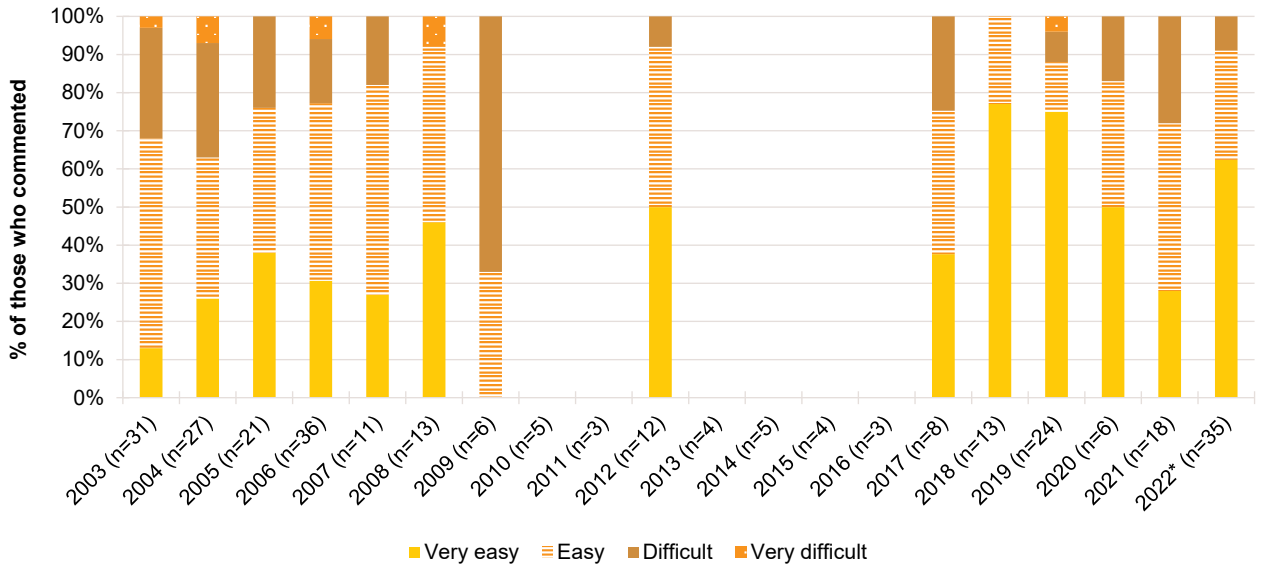

Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2021 versus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

## Figure 23: Current perceived availability of powder methamphetamine, Canberra, ACT, 2003-2022




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

## Figure 24: Current perceived availability of crystal methamphetamine, Canberra, ACT, 2003-2022




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

# 4

# Cocaine

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

## Patterns of Consumption

### Recent Use (past 6 months)

Recent use of any cocaine has fluctuated over the years, from one-quarter (26%) reporting use in 2003 to most participants reporting use in 2021 (91%). In 2022, three-quarters (76%) reported recent use, reaching levels observed in 2018-2019 and a significant decrease relative to 2021 (91%; $p$=0.007) (Figure 25).

### Frequency of Use

Frequency of use has fluctuated between a median of one and six days over the course of monitoring. In 2022, the median days of use amongst participants who had recently used cocaine was six days (i.e., equivalent to monthly use; IQR=3-12; 5 days in 2021; IQR=3-12; $p$=0.358) (Figure 25). Of those who had recently consumed cocaine (n=76), one-fifth (17%) reported using cocaine weekly or more frequently (9% in 2021; $p$=0.166).

### Routes of Administration

In 2022, the main route of administration among those that had recently used cocaine was snorting (100%; 100% in 2021).

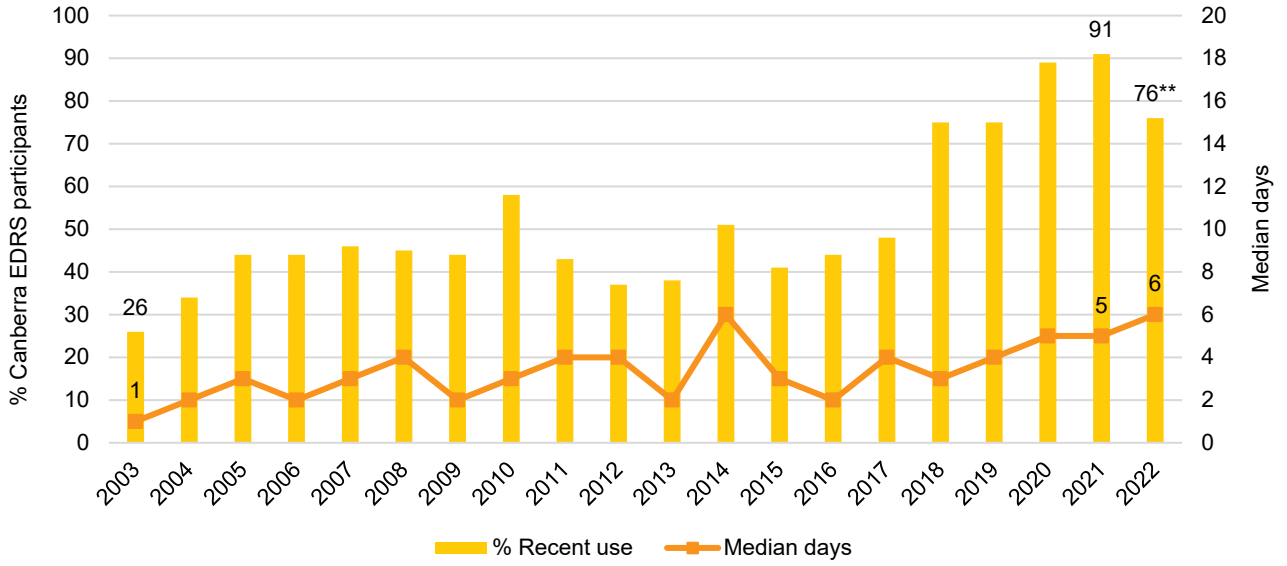
### Quantity

The median intake in a 'typical' session was 0.50 grams (IQR=0.30-1.00; n=54; 0.50 grams in 2021; IQR=0.40-1.00; n=62; $p$=0.491) and the median maximum intake was 1.00 gram (IQR=0.50-2.00, n=53; 1.00 gram in 2021; IQR=0.50-2.00, n=65; $p$=0.694).

### Forms used

Among participants who had recently consumed cocaine and commented (n=76), the vast majority reported using powder cocaine (93%; 90% in 2021; $p$=0.573), with fewer participants reporting use of cocaine in rock form (8%; 24% in 2021; $p$=0.008), and crack cocaine (n≤5; 0% in 2021).

Figure 25: Past six month use and frequency of use of cocaine, Canberra, ACT, 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 (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

# Price, Perceived Purity and Perceived Availability

## Price

Consistent since 2006, the median price per gram of cocaine remained stable at $300 in 2022 (IQR=300-350; n=38; $300 in 2021; IQR=263-350, n=63; $p$=0.120) (Figure 26).

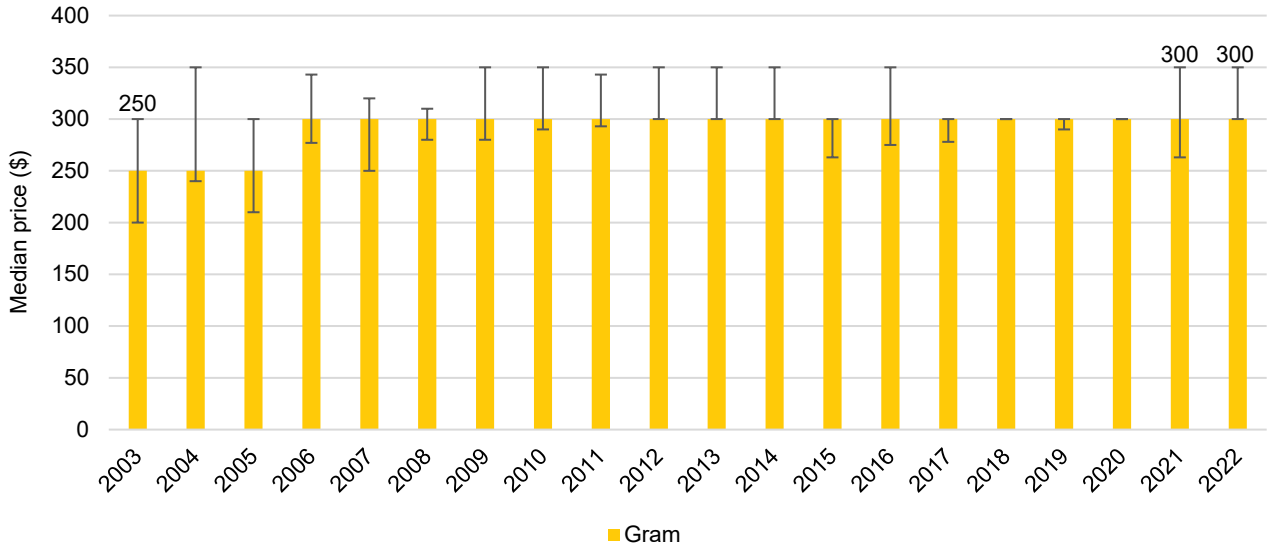
## Perceived Purity

There were no significant changes in perceived purity between 2022 and 2021 ($p$=0.409). Among those able to comment in 2022 (n=64), two-fifths (42%) perceived cocaine to be of 'medium' purity (34% in 2021), followed by one-quarter (25%) that perceived it to be of 'high' purity (22% in 2021) and one-fifth (22%) reporting 'low' purity (22% in 2021) (Figure 27).

## Perceived Availability

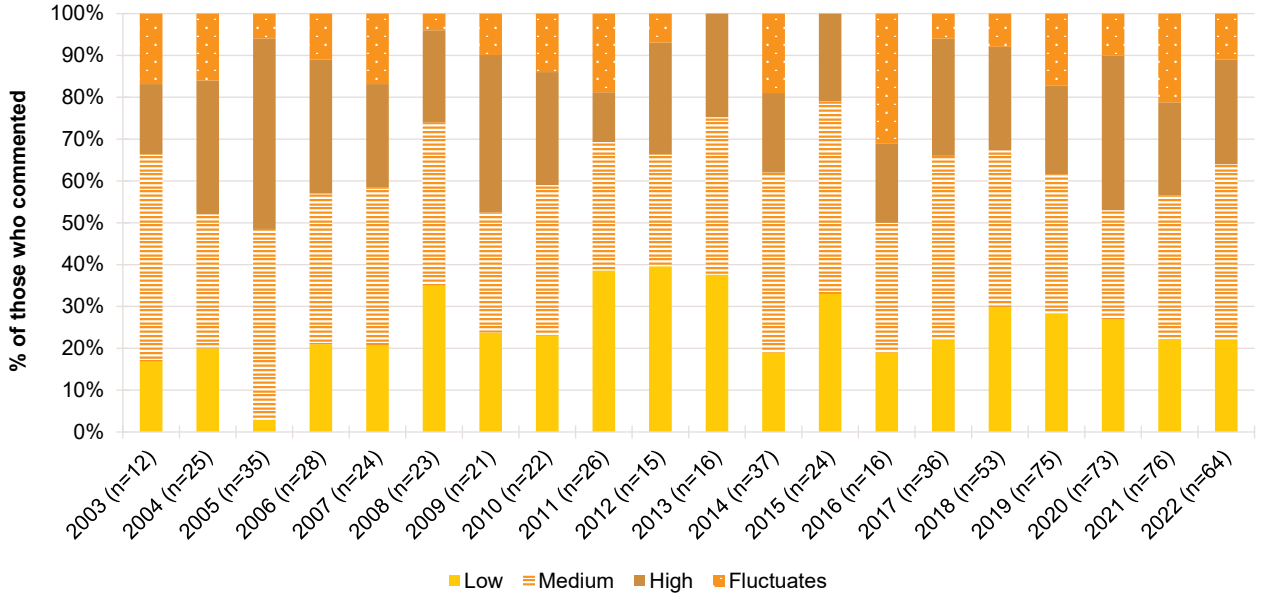
The perceived availability of cocaine remained stable in 2022 compared to 2021 ($p$=0.871). Among those able to comment in 2022 (n=64), two-fifths (42%) perceived cocaine to be 'very easy' to obtain (36% in 2021), the highest per cent since monitoring began. This was followed by 39% that perceived it to be 'easy' to obtain (43% in 2021) (Figure 28).

## Figure 26: Median price of cocaine per gram, Canberra, ACT, 2003-2022



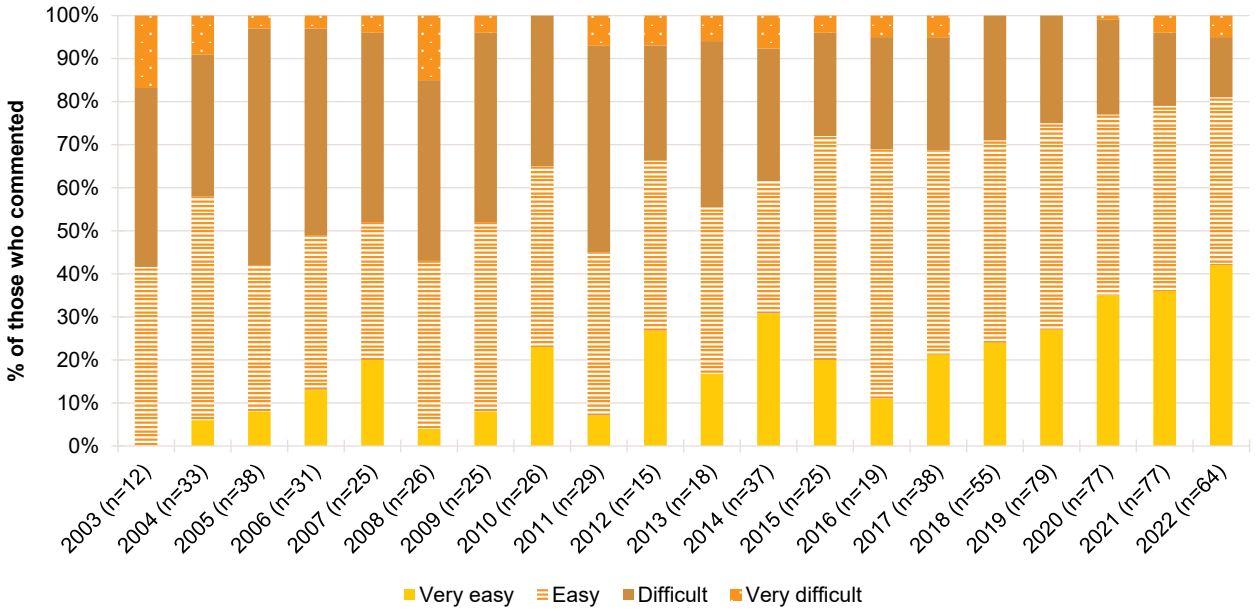

Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent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

## Figure 27: Current perceived purity of cocaine, Canberra, ACT, 2003-2022




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

## Figure 28: Current perceived availability of cocaine, Canberra, ACT, 2003-2022




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

# 5

# Cannabis and/or Cannabinoid Related Products

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

Terminology throughout this chapter refers to:

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

## Patterns of Consumption

In 2022, participants were asked about their use of both prescribed and non-prescribed cannabis and/or cannabinoid related products. The rest of this chapter refers to non-prescribed cannabis use only. Few participants (n≤5) in 2022 reported prescribed use in the six months preceding interview.

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

### Recent Use (past 6 months)

Three in four participants (81%) reported non-prescribed use of cannabis and/or cannabinoid-related products in 2022, stable relative to 2021 (86%; $p$=0.448) (Figure 29) and similar to estimates from earlier years.

### Frequency of Use

Frequency of use has varied between weekly and several times a week in the past six months over the course of monitoring (2022: median 70 days; IQR=10-180; 42 days in 2021; IQR=13-173; $p$=0.616) (Figure 29). Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented (n=81), two-thirds (65%) reported weekly or more frequent use (65% in 2021) and 31% reported daily use (26% in 2021; $p$=0.495).

### Routes of Administration

Across all years, nearly all participants who reported recent use of non-prescribed cannabis and/or cannabinoid related products reported smoking cannabis (93% in 2022; 92% in 2021). In 2022, 28% reported swallowing (31% in 2021; $p$=0.744) and 15% reported inhaling/vaping non-prescribed cannabis and/or cannabinoid products (15% in 2021) in the past six months.

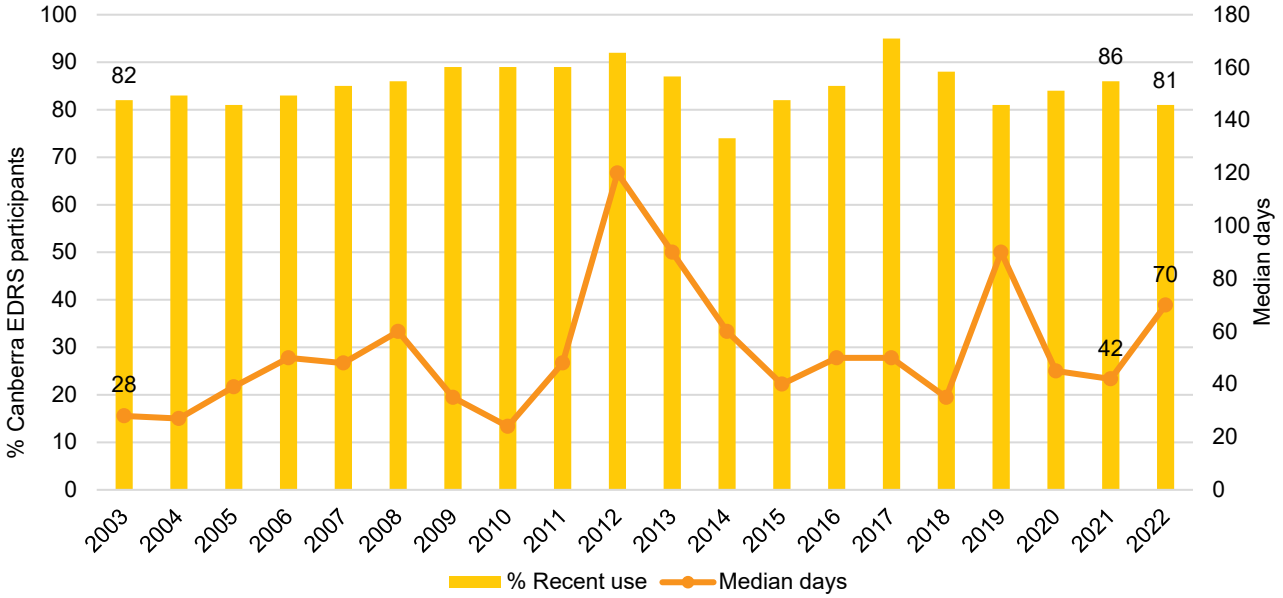
## Quantity

Of those able to comment in 2022, the median amount used on the last occasion of use was one gram (IQR=0.50-1.00; n=27; 1 gram in 2021; IQR=1.00-3.00; n=36; *p*=0.061), two cones (IQR=1-4; n=32; 2 cones in 2021; IQR=1-4; n=22; *p*=0.596) or one joint (IQR=1-1; n=16; 1 joint in 2021; IQR=1-1; n=19; *p*=0.872) of non-prescribed cannabis and/or cannabinoid products.

## Forms Used

Among participants that had recently used non-prescribed cannabis and/or other cannabinoid products, two-thirds (66%) reported using hydroponic cannabis (55% in 2021; *p*=0.201), followed by three-fifths (60%) reporting recent use of outdoor-grown 'bush' cannabis in 2022 (72% in 2021; *p*=0.137). Smaller percentages reported having used hashish (n≤5; 14% in 2021; *p*=0.101) and hash oil (n≤5; 15% in 2021; *p*=0.027) in the preceding six months. Eight per cent reported having used THC extract and few participants(n≤5) reporting using CBD extract (not asked in 2021).

Figure 29: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid products, Canberra, ACT, 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≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001.

# Price, Perceived Potency and Perceived Availability

## Hydroponic Cannabis

**Price:** In 2022, those who commented reported a median price of $300 per ounce (IQR=273-350; n=20; $300 in 2021; IQR=250-305; n=16; *p*=0.794) and $20 for a gram (IQR=20-20; n≤5 in 2021; *p*=0.556) (Figure 30A).

**Perceived Potency:** The perceived potency of non-prescribed hydroponic cannabis remained stable between 2021 and 2022 (*p*=0.716). Of those able to comment in 2022 (n=47), most perceived hydroponic cannabis to be of 'high' potency (62%; 70% in 2021) (Figure 31A).

**Perceived Availability:** The perceived availability of non-prescribed hydroponic cannabis remained stable between 2021 and 2022 (*p*=0.524). Of those able to comment in 2022 (n=47), nearly all participants perceived availability to be 'easy' or 'very easy' (92%; 96% in 2021) (Figure 32A).

## Bush Cannabis

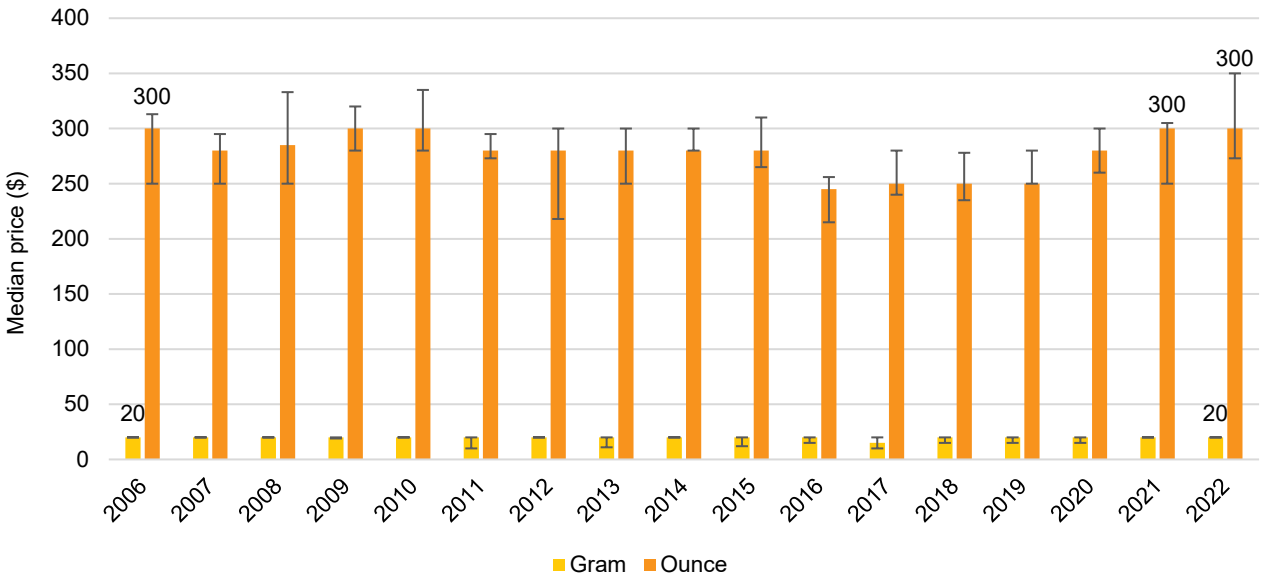
**Price:** In 2022, those who commented reported a median price of $250 per ounce (IQR=250-290; n=11), a significant increase relative to 2021 ($220; IQR=200-245; n=11; *p*=0.027). A gram of bush was reported at $20 (IQR=19-20; n=12; n≤5 in 2021; *p*=0.255) (Figure 30B).

**Perceived Potency:** The perceived potency of non-prescribed bush cannabis remained stable between 2021 and 2022 (*p*=0.109). Among those able to comment in 2022 (n=47), two-fifths perceived bush cannabis to be of 'high' potency (43%; 23% in 2021), followed by 36% reporting that potency was 'medium' (53% in 2021) (Figure 31B).

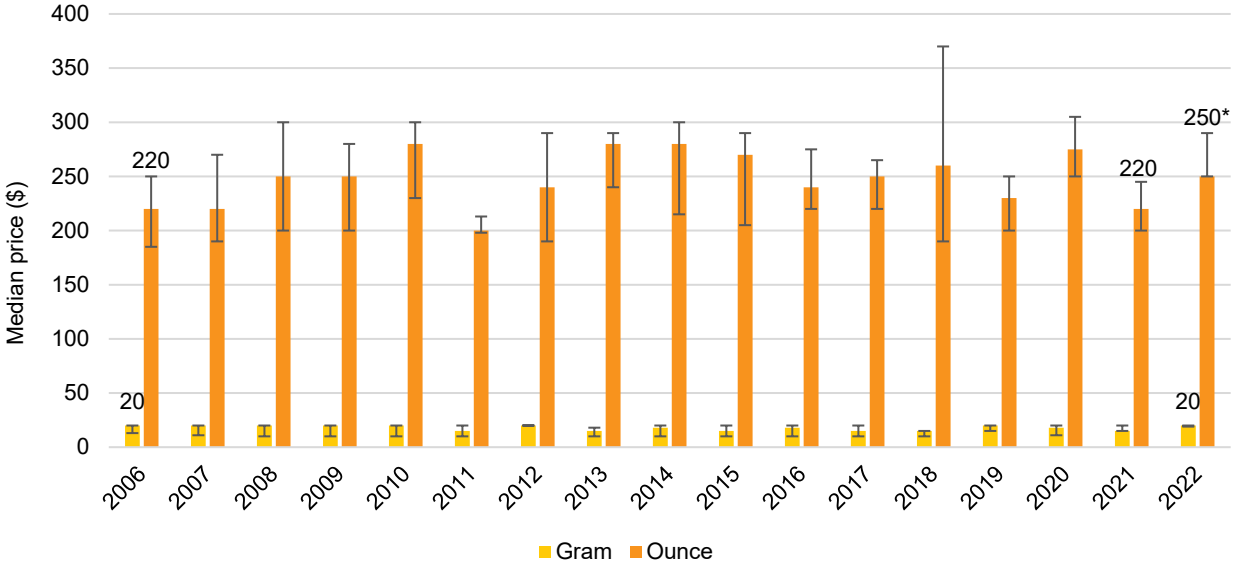
**Perceived Availability:** The perceived availability of non-prescribed bush cannabis remained stable between 2021 and 2022 (*p*=0.303). Similar to hydroponic cannabis, bush cannabis has also historically been perceived as accessible. Of those able to comment in 2022 (n=48), the majority of participants perceived the availability of bush to be 'easy' or 'very easy' (83%; 90% in 2021) (Figure 32B).

## Figure 30: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Canberra, ACT, 2006-2022

### (A) Hydroponic cannabis

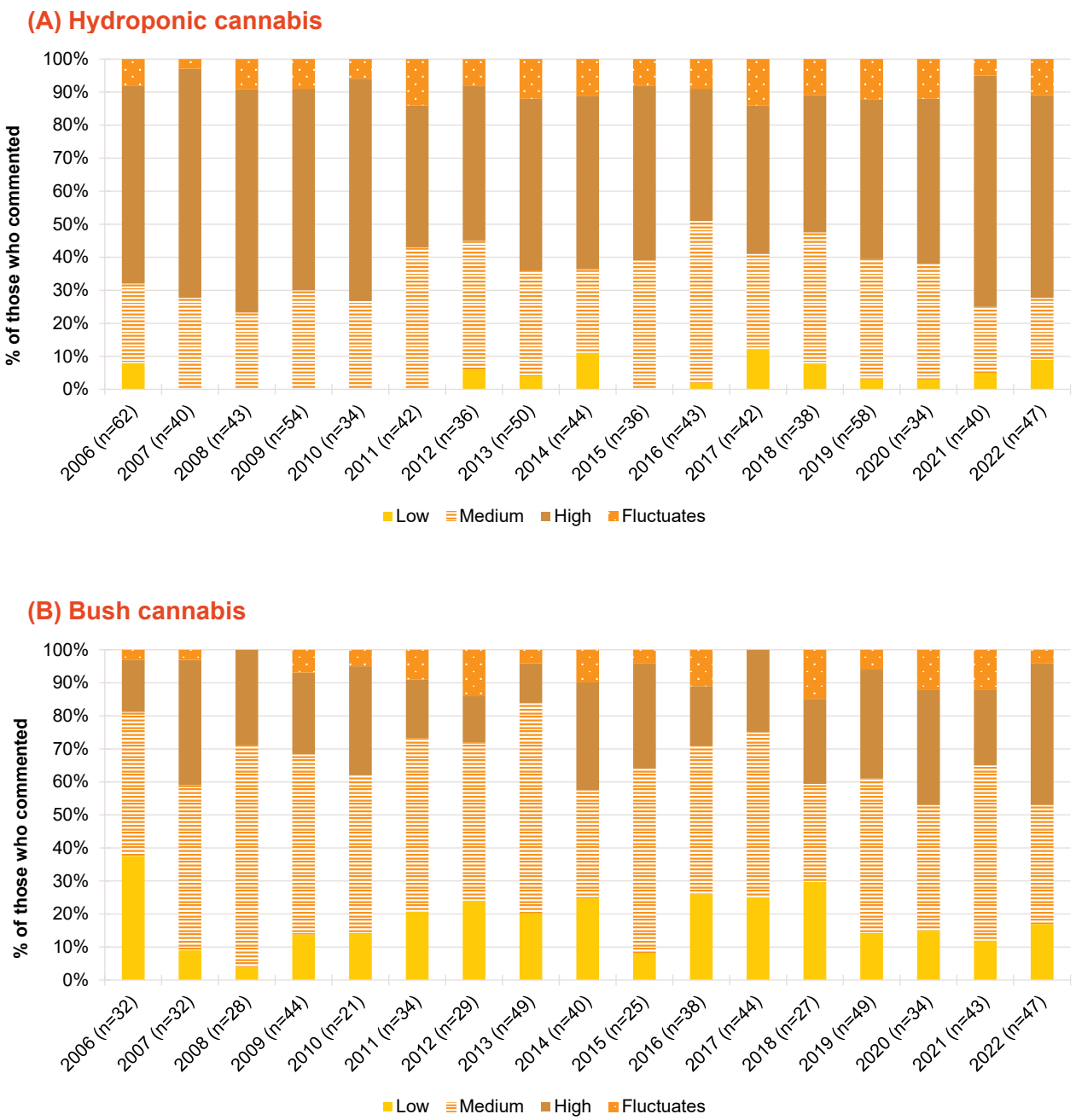



### (B) Bush cannabis



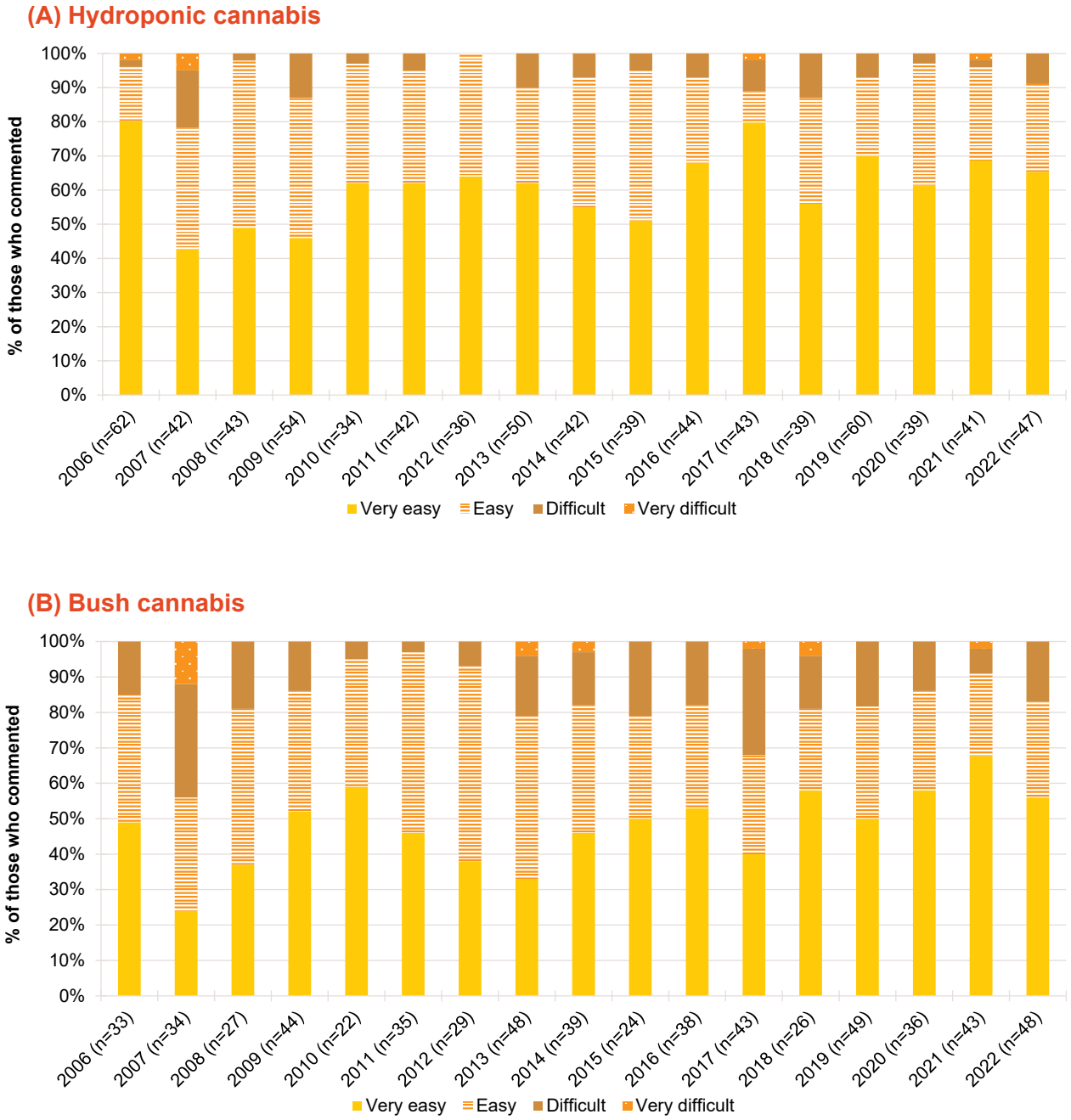

Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels are only provided for the first (2006) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small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

## Figure 31: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Canberra, ACT, 2006-2022




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

## Figure 32: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Canberra, ACT, 2006-2022




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

# 6

# Ketamine, LSD and DMT

## Ketamine

### Patterns of Consumption

**Recent Use (past 6 months):** Recent ketamine use has fluctuated over the period of monitoring, with two-fifths (39%) reporting recent use in 2022 (51% in 2021; *p*=0.123) (Figure 33).

**Frequency of Use:** Frequency of use has historically been low, varying between a median of one and five days (2022: 4 days; IQR=2-10; 3 days in 2021; IQR=2-6; *p*=0.175) (Figure 33). Among participants that reported recent use, few (n≤5) reported using ketamine weekly or more frequently in 2022 (n≤5 in 2021).

**Routes of Administration:** In 2022, the most common route of administration among participants who had recently used ketamine was snorting (97%; 92% in 2021; *p*=0.384).

**Quantity:** The median quantity used in a 'typical' session was 0.30 grams (IQR=0.10-0.90, n=26; 0.30 grams in 2021; IQR=0.20-0.50, n=30; *p*=0.476) and the median maximum amount used was 0.50 grams (IQR=0.20-1.00; n=26; 0.50 grams in 2021; IQR=0.20-0.50; n=33; *p*=0.865).

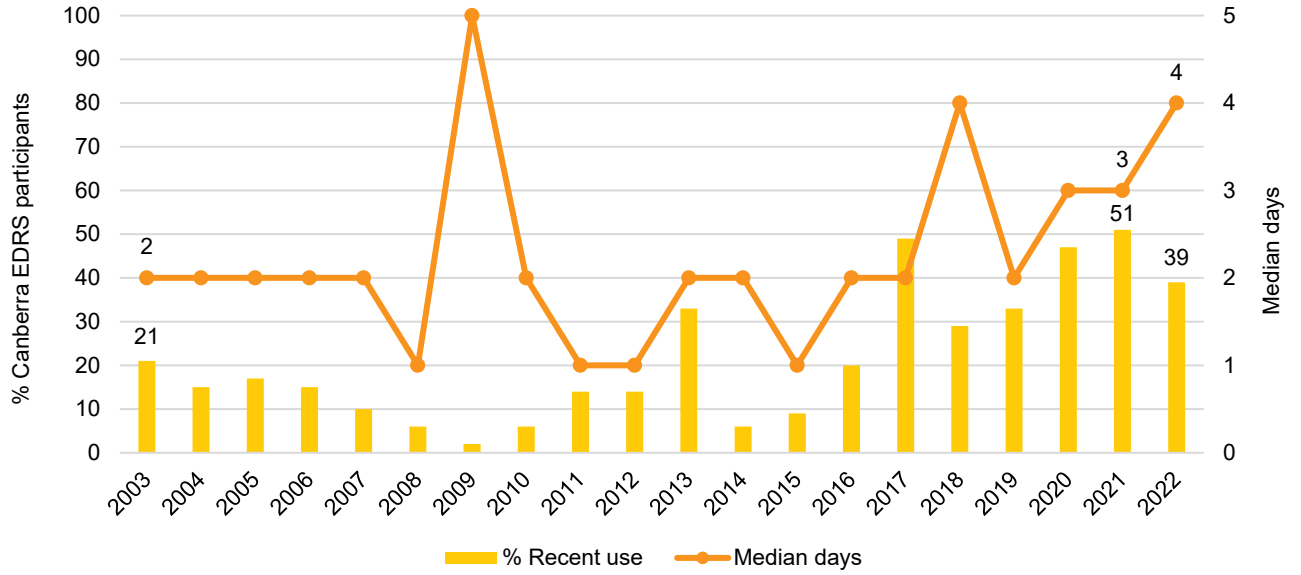
### Price, Perceived Purity and Perceived Availability

**Price:** The reported median price for a gram of ketamine was $200 in 2022 (IQR=200-240; n=19; $200 in 2021; IQR=180-250; n=36; *p*=0.944) (Figure 34).

**Perceived Purity:** The perceived purity of ketamine remained stable between 2022 and 2021 (*p*=0.355). Of those who responded in 2022 (n=33), almost three-quarters (73%) perceived the purity of ketamine to be 'high' (56% in 2021), followed by 21% perceiving it to be 'medium' (28% in 2021) (Figure 35).

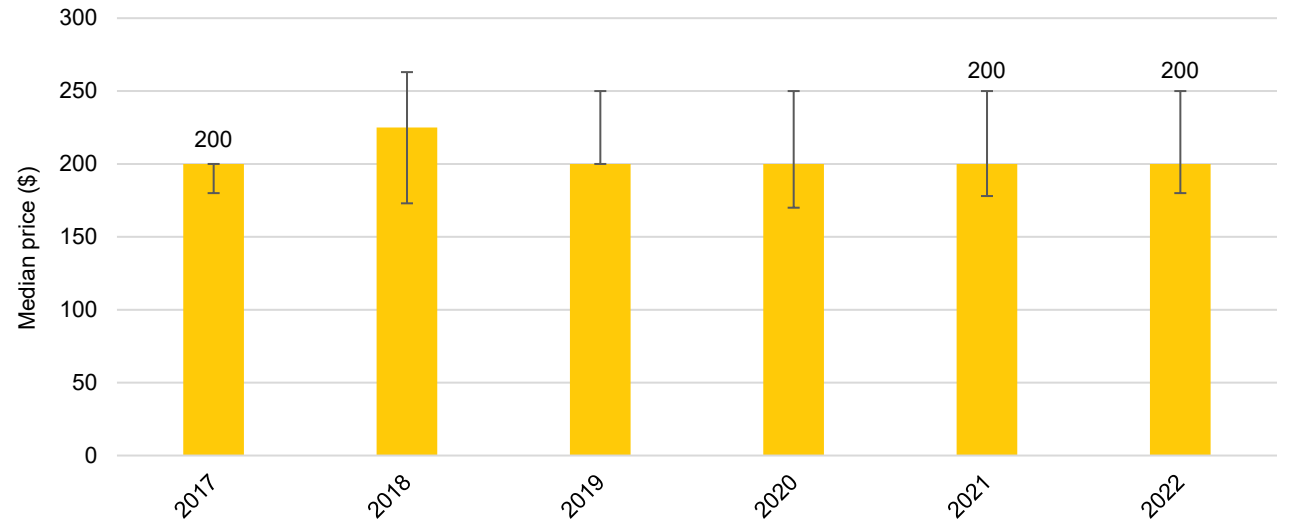
**Perceived Availability:** Perceived availability was also stable between 2022 and 2021 (*p*=0.186). Of those who commented in 2022 (n=32), one-third (34%) reported ketamine to be 'difficult' to obtain (34% in 2021; n=41), followed by 31% reporting 'easy' (41% in 2021) (Figure 36).

## Figure 33: Past six month use and frequency of use of ketamine, Canberra, ACT, 2003-2022



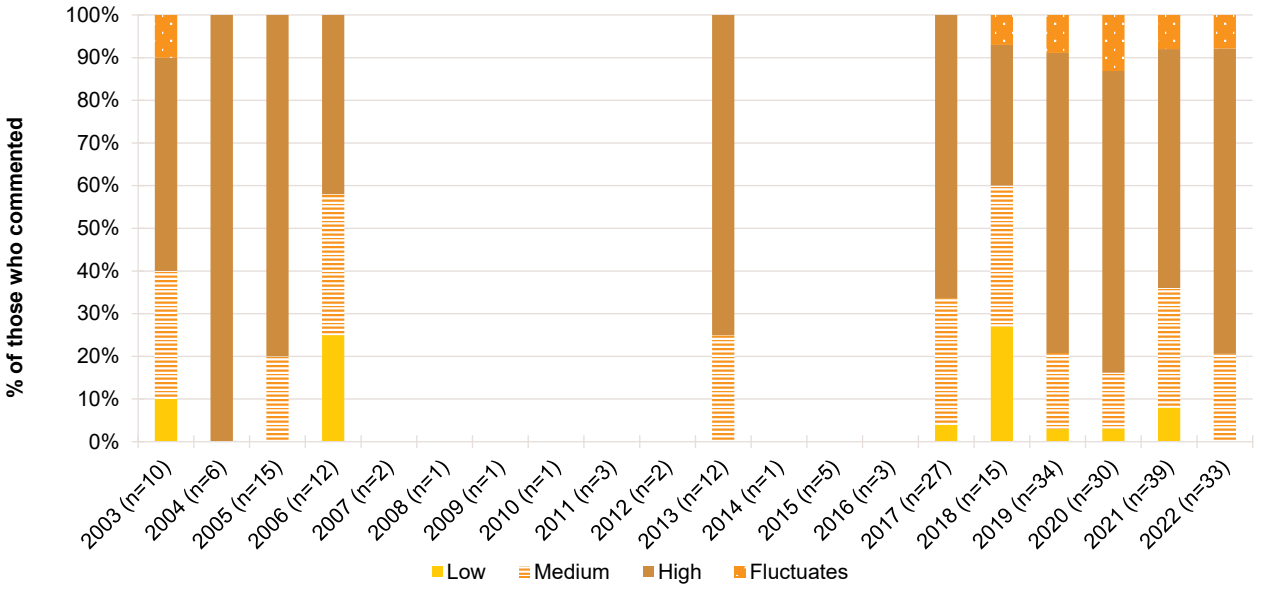

Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 5 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however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

## Figure 34: Median price of ketamine per gram, Canberra, ACT, 2017-2022



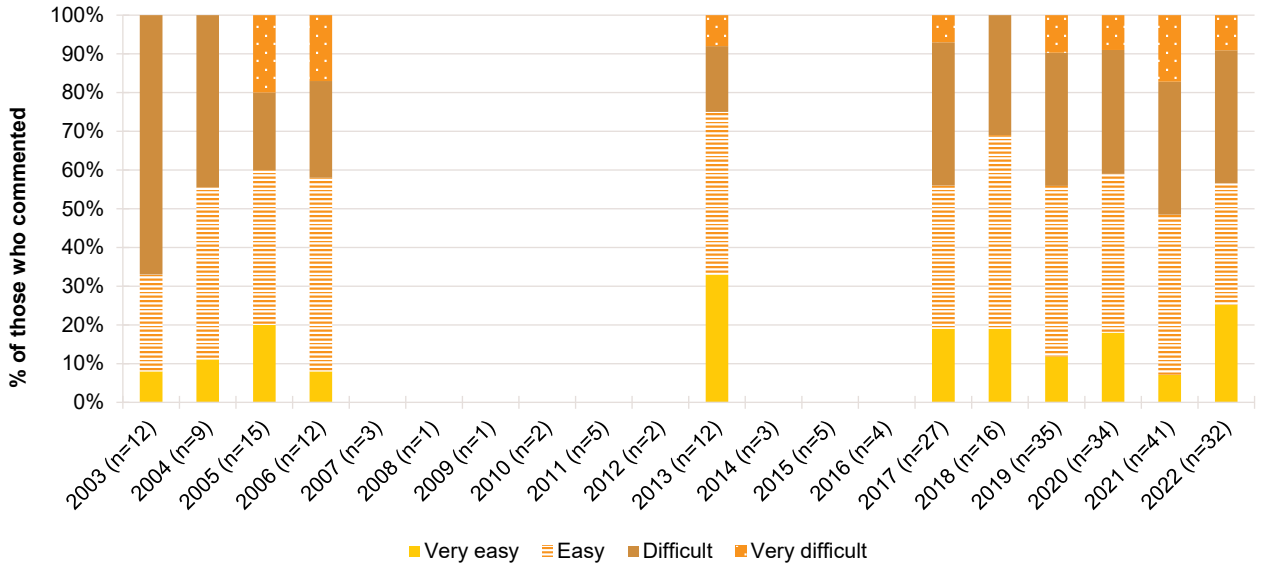

Note. Among those who commented. Data prior to 2017 not provided due to low respondents. Data labels are only provided for the first (2017) and two most recent years (2021 and 2022) provided in the figure, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

## Figure 35: Current perceived purity of ketamine, Canberra, ACT, 2003-2022




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

## Figure 36: Current perceived availability of ketamine, Canberra, ACT, 2003-2022




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

# LSD

## Patterns of Consumption

**Recent Use (past 6 months):** Recent use of LSD has fluctuated over the course of monitoring. In 2022, 31% reported recent use (45% in 2021; *p*=0.062) (Figure 37).

**Frequency of Use:** Use across the years has been infrequent among those who had recently used LSD. In 2022, the median days of use was significantly lower as compared to 2021 (2022: median 2 days: IQR=1-3; 3 days in 2021; IQR=2-7; *p*=0.023) (Figure 37). Few participants reported weekly or more frequent use of LSD in 2022 (n≤5; n≤5 in 2021).

**Routes of Administration:** In 2022, all participants reporting recent use of LSD reported swallowing as a route of administration (100% in 2021).

**Quantity**: In 2022, the median quantity used in a 'typical' session remained stable at one tab (IQR=1-2; n=19; 1 tab in 2021; IQR=1-2; n=15; *p*=0.704). The median maximum number of tabs used was two (IQR=1-2; n=19; 2 tabs in 2021; IQR=1-3; n=15; *p*=0.580).

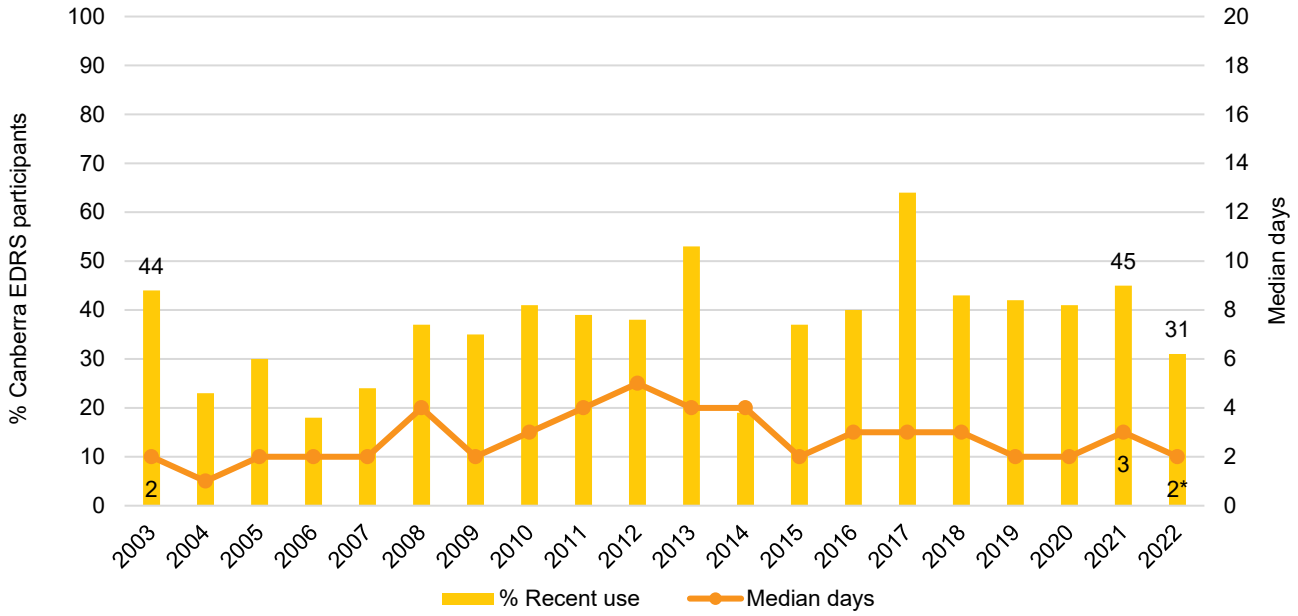
## Price, Perceived Purity and Perceived Availability

**Price:** In 2022, the median price for one tab was $23 (IQR=20-34; n=14), stable compared to 2021 ($25; IQR=15-30; n=31; *p*=0.699) (Figure 38).

**Perceived Purity:** Perceived purity was stable between 2022 and 2021 (*p*=0.468). Of those who responded in 2022 (n=32), the majority perceived purity to be 'high' (63%; 70% in 2021), followed by one-fifth (22%) reporting 'medium' purity (23% in 2021) (Figure 39).

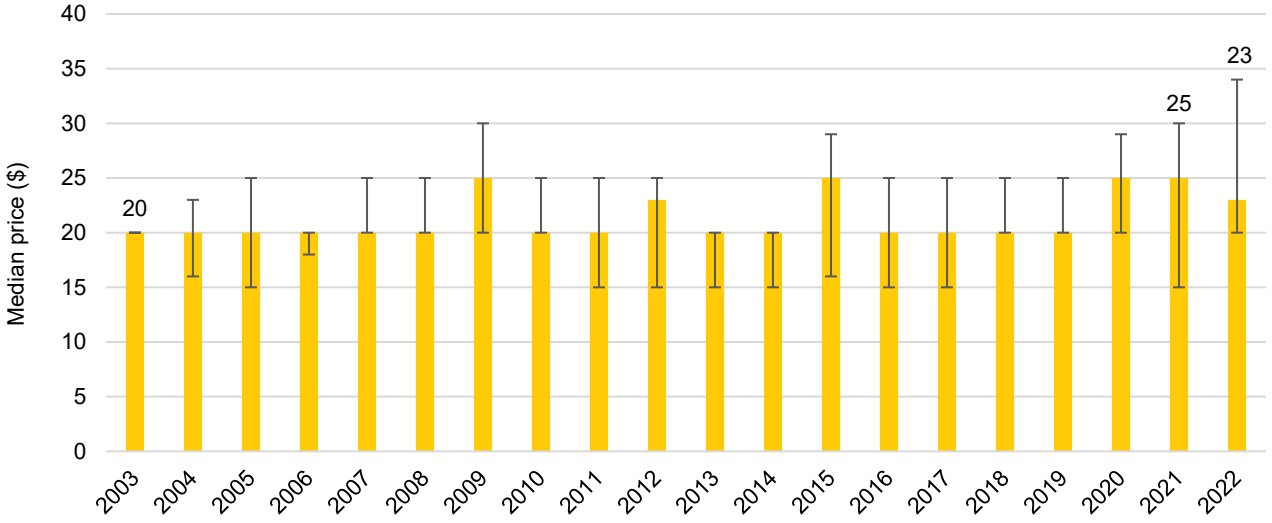
**Perceived Availability:** There was a significant change in perceived availability of LSD in 2022 relative to 2021 (*p*=0.004). More participants perceived LSD to be 'very difficult' to obtain (22%; n≤5 in 2021), the highest per cent since monitoring began. The same per cent also perceived it to be 'very easy' to obtain (22%; 13% in 2021) (Figure 40).

Figure 37: Past six month use and frequency of use of LSD, Canberra, ACT, 2003-2022



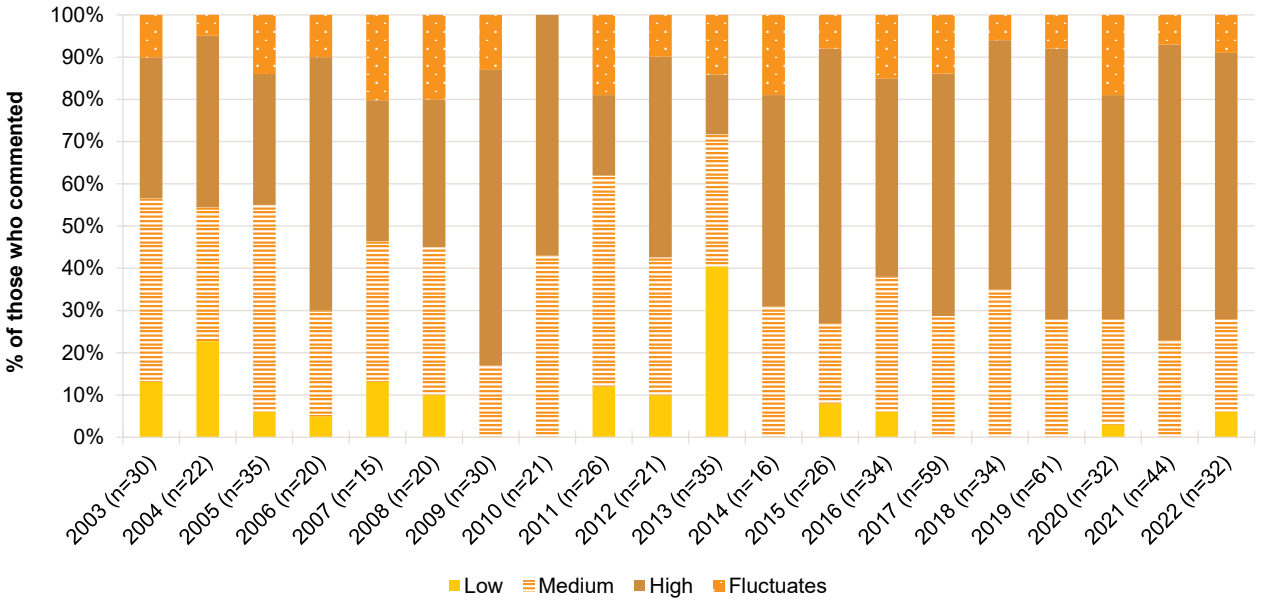

Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 20 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

## Figure 38: Median price of LSD per tab, Canberra, ACT, 2003-2022



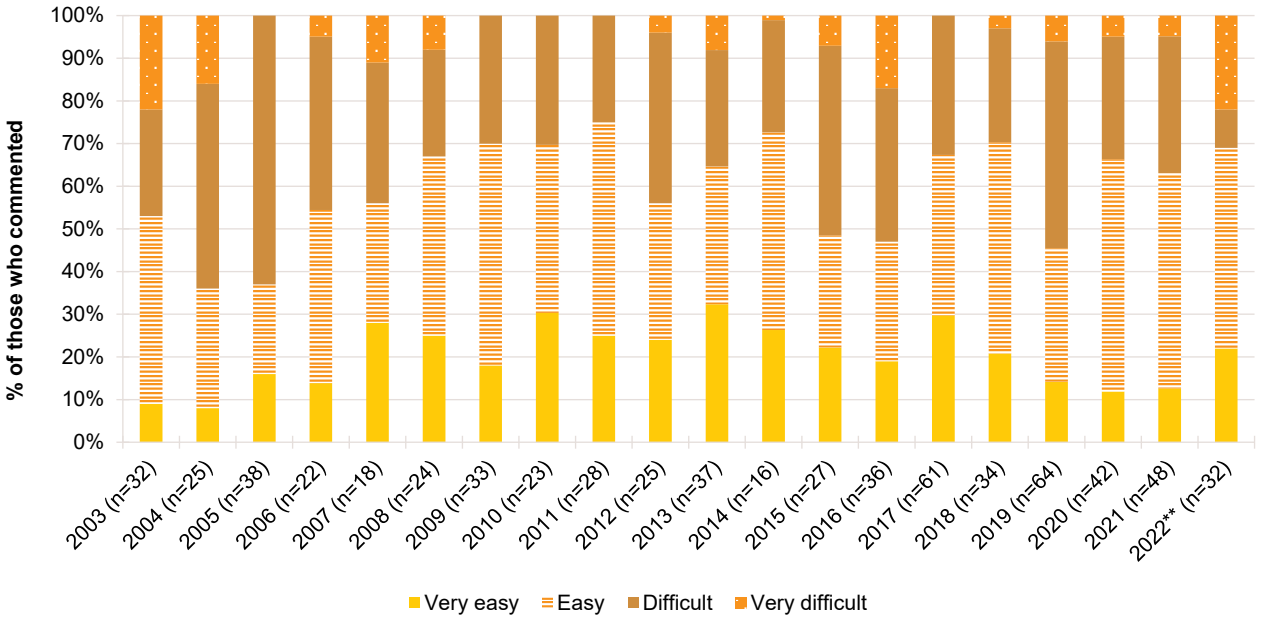

Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent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

## Figure 39: Current perceived purity of LSD, Canberra, ACT, 2003-2022




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

## Figure 40: Current perceived availability of LSD, Canberra, ACT, 2003-2022




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

# DMT

## Patterns of Consumption

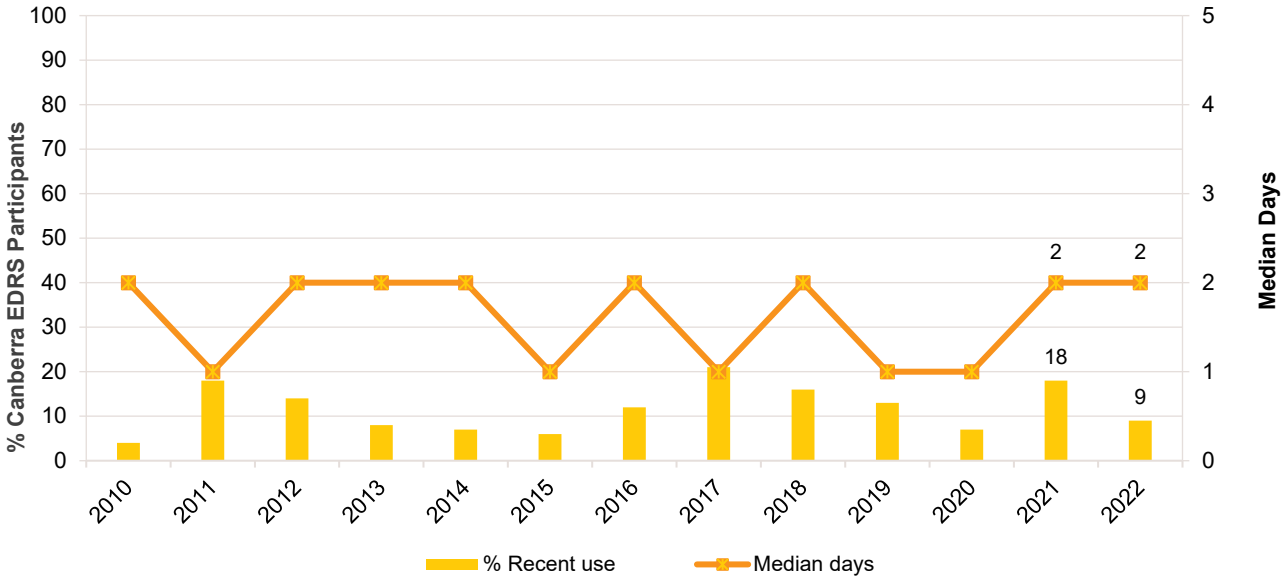
**Recent Use (past 6 months)**: DMT use has fluctuated over the reporting period, with one in ten participants (9%) reporting recent use in 2022, stable compared to 2021 (18%; *p*=0.100) (Figure 41).

**Frequency of Use:** Use across the years has shown to be infrequent and stable, with a median of two days (IQR=2-4) of use in 2022 (2 days in 2021; IQR=1-4; *p*=0.503) (Figure 41).

**Routes of Administration:** Among participants who had recently consumed DMT and commented (n=9), the main route of administration was smoking (89%; 94% in 2021).

**Quantity**: Few participants (n≤5) reported on the median quantity used in a 'typical' session and the maximum amount, hence no further information is provided for 2022 (2021: 100 mgs in a 'typical' session; IQR=16-150; n=7; *p*=0.741, and 100 mgs in a maximum session; IQR=32-250; n=7; *p*=0.624).

Figure 41: Past six month use and frequency of use of DMT, Canberra, ACT, 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 5 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≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

## Price, Perceived Purity and Perceived Availability

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

# 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 has been made to exclude them from this category from hereon-in. 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)

Fifteen per cent of the Canberra sample reported recent use of NPS (including plant-based NPS) when monitoring began in 2010. This increased to 53% in 2012, before declining to 9% in 2022 (18% in 2021; $p$=0.100) (Table 2). Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 49% in 2012 and declining to 7% in 2022 (17% in 2021; $p$=0.052) (Table 3).

## Forms Used

Participants are asked about a range of NPS each year, updated to reflect key emerging substances of interest. NPS use among the sample has fluctuated over time, although 2022 had the lowest percentages of use since monitoring of NPS first commenced in 2010, with few participants (n≤5) reporting use of any individual NPS (Table 4). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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

| % | National | ACT |
|---|---|---|
| 2010 | 24 | 15 |
| 2011 | 36 | 36 |
| 2012 | 40 | 53 |
| 2013 | 44 | 48 |
| 2014 | 35 | 17 |
| 2015 | 37 | 33 |
| 2016 | 28 | 27 |
| 2017 | 26 | 25 |
| 2018 | 23 | 20 |
| 2019 | 20 | 28 |
| 2020 | 15 | 13 |
| 2021 | 16 | 18 |
| **2022** | 11* | **9** |

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

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

| % | National | ACT |
|---|---|---|
| 2010 | 24 | 15 |
| 2011 | 33 | 26 |
| 2012 | 37 | 49 |
| 2013 | 42 | 44 |
| 2014 | 34 | 17 |
| 2015 | 34 | 32 |
| 2016 | 27 | 24 |
| 2017 | 24 | 24 |
| 2018 | 21 | 18 |
| 2019 | 19 | 28 |
| 2020 | 12 | 11 |
| 2021 | 14 | 17 |
| **2022** | 9** | **7** |

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

## Table 4: Past six month use of NPS by drug type, Canberra, ACT, 2010-2022

| | 2010 N=70 % | 2011 N=80 % | 2012 N=51 % | 2013 N=77 % | 2014 N=100 % | 2015 N=99 % | 2016 N=100 % | 2017 N=100 % | 2018 N=98 % | 2019 N=100 % | 2020 N=101 % | 2021 N=100 % | 2022 N=100 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Phenethylamines** | 8 | 9 | 13 | 19 | 12 | 21 | 16 | 16 | 7 | 8 | - | 8 | - |
| Any 2C substance~ | 8 | 8 | 11 | 18 | 9 | 21 | 13 | 14 | 7 | 7 | - | 7 | - |
| NBOMe | / | / | / | / | - | - | - | - | - | - | - | - | **0** |
| DO-x | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | - |
| 4-FA | / | / | / | / | / | / | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| NBOH | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| **Tryptamines** | - | - | - | - | 0 | 0 | - | - | - | - | - | - | **0** |
| 5-MeO-DMT | - | - | - | - | 0 | 0 | - | - | - | - | - | - | **0** |
| 4-AcO-DMT | / | / | / | / | / | / | 0 | 0 | / | / | / | / | **/** |
| **Synthetic cathinones** | - | - | 13 | - | - | 9 | - | - | - | 11 | 0 | 0 | - |
| Mephedrone | - | - | 0 | 0 | 0 | - | 0 | - | 0 | - | 0 | 0 | - |
| Methylone/bk MDMA | / | - | 12 | - | - | 6 | - | - | - | 9 | 0 | 0 | **0** |
| MDPV/Ivory wave | 0 | 0 | - | 0 | 0 | - | - | 0 | 0 | 0 | 0 | 0 | **0** |
| Alpha PVP | / | / | / | / | / | / | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| n-ethyl hexedrone | / | / | / | / | / | / | / | / | / | 0 | 0 | 0 | **0** |
| n-ethylpentylone | / | / | / | / | / | / | / | / | / | 0 | 0 | 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** |
| **Piperazines** | - | - | 0 | 0 | 0 | 0 | 0 | 0 | / | / | / | / | **/** |
| BZP | - | - | 0 | 0 | 0 | 0 | 0 | 0 | / | / | / | / | **/** |
| **Dissociatives** | / | / | - | / | / | - | - | 0 | 0 | - | 0 | - | **0** |
| Methoxetamine (MXE) | / | / | - | 0 | 0 | - | - | 0 | 0 | - | 0 | - | **0** |
| 2-Fluorodeschloroketamine (2-FDCK) | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| 3 CI-PCP/4CI-PCP | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| 3-HO-PCP/4-HO-PCP | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| 3-MeO-PCP/4- MeO-PCP | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| Other drugs that mimic the effects of dissociatives like ketamine | / | / | / | / | / | / | / | / | / | / | 0 | - | **0** |
| **Plant-based NPS** | / | - | - | - | 0 | - | - | - | - | - | - | - | - |
| Ayahuasca | / | / | / | / | / | 0 | 0 | 0 | 0 | - | - | 0 | **0** |
| Salvia divinorum | / | - | - | - | 0 | - | - | - | - | 0 | - | - | **0** |
| Kratom | / | / | / | / | / | / | / | / | / | / | 0 | - | **0** |

| | 2010 N=70 % | 2011 N=80 % | 2012 N=51 % | 2013 N=77 % | 2014 N=100 % | 2015 N=99 % | 2016 N=100 % | 2017 N=100 % | 2018 N=98 % | 2019 N=100 % | 2020 N=101 % | 2021 N=100 % | 2022 N=100 % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mescaline | 0 | 11 | - | 8 | 0 | - | - | - | - | - | - | - | **-** |
| LSA | / | - | - | 0 | - | 0 | 0 | / | / | / | / | / | **/** |
| Datura | 0 | - | - | 0 | 0 | 0 | 0 | / | / | / | / | / | **/** |
| **Benzodiazepines** | / | / | / | / | / | / | 0 | - | - | - | 0 | - | **-** |
| Etizolam | / | / | / | / | / | / | 0 | - | 0 | - | 0 | - | **0** |
| 8-Aminoclonazolam | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| Bromazolam | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| Clonazolam | / | / | / | / | / | / | / | / | / | / | / | / | **-** |
| Flualprazolam | / | / | / | / | / | / | / | / | / | / | / | / | **0** |
| Other drugs that mimic the effect of benzodiazepines | / | / | / | / | / | / | / | / | 0 | 0 | 0 | 0 | **0** |
| **Synthetic cannabinoids** | / | - | 16 | - | - | 0 | - | - | - | - | - | - | **-** |
| **Herbal high#** | / | / | 14 | - | - | 0 | - | - | 0 | - | / | / | **/** |
| Phenibut | / | / | / | / | / | / | / | / | / | - | 0 | 0 | **0** |
| **Other drugs that mimic the effect of opioids** | / | / | / | / | / | / | / | / | - | 0 | 0 | 0 | **0** |
| **Other drugs that mimic the effect of ecstasy** | / | / | / | / | / | / | / | 0 | - | - | 0 | 0 | **0** |
| **Other drugs that mimic the effect of amphetamine or cocaine** | / | / | / | / | / | / | / | - | - | - | 0 | - | **0** |
| **Other drugs that mimic the effect of psychedelic drugs like LSD** | / | / | / | / | / | / | / | 0 | - | - | - | - | **0** |

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

# 8

# Other Drugs

## Non-Prescribed Pharmaceutical Drugs

### Codeine

Before the 1st 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 1st February 2018, legislation changed so that all codeine products, low- and high-dose, require a prescription from a doctor to access.

Up until 2017, participants were only asked about use of OTC codeine for non-pain purposes. Additional items on use of prescription low-dose and prescription high-dose codeine were included in the 2018-2020 EDRS. However, from 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):** In 2022, 8% reported using any non-prescribed codeine (13% in 2021; *p*=0.353) (Figure 42).

**Recent Use for Non-Pain Purposes (past 6 months):** Three-quarters (75%) of participants who had recently used codeine had used it for non-pain purposes (8% of the total sample; 7% in 2021).

**Frequency of Use:** Participants who had recently used any form of non-prescribed codeine (n=8) reported use on a median of five days (IQR=2-11) in the past six months (3 days in 2021; IQR=2-6; n=13; *p*=0.687).

### Pharmaceutical Opioids

**Recent Use (past 6 months):** The per cent of participants reporting past six month use of non-prescribed pharmaceutical opioids (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl, excluding codeine) remained stable from 8% in 2021 to 6% in 2022 (*p*=0.779) (Figure 42).

**Frequency of Use:** Participants who had recently used non-prescribed pharmaceutical opioids reported using it on a median of 10 days (IQR=4-25; n=6) in the six months preceding interview (2 days in 2021; IQR=1-3; n=6; *p*=0.164).

### Pharmaceutical Stimulants

**Recent Use (past 6 months):** Recent non-prescribed use of pharmaceutical stimulants (e.g., dexamphetamine, methylphenidate, modafinil) has fluctuated over time. In 2022, half (50%) reported recent non-prescribed use, the highest per cent since monitoring began, however, stable relative to 2021 (41%; *p*=0.261) (Figure 42).

**Frequency of Use:** Median days of non-prescribed use remained stable between 2021 and 2022 (6 days in 2022; IQR=3-12; n=49; 5 days in 2021: IQR=2-10, n=40; *p*=0.488).

**Quantity:** The median quantity of non-prescribed pharmaceutical stimulants used in a 'typical' session in 2022 was two pills/tablets (IQR=1-4; n=46; 2 pills in 2021; IQR=1-3; n=34; *p*=0.265), and the median maximum amount used per session was three pills/tablets (IQR=2-5; n=47; 2 pills in 2021; IQR=1-4; n=35; *p*=0.166).

**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 (drugtrends@unsw.edu.au).

## Benzodiazepines

**Recent Use (past 6 months):** Recent use of non-prescribed benzodiazepines had been gradually increasing between 2014 (9%) and 2020 (38%), before declining significantly in 2021 (23%). In 2022, recent use was reported by 31% ($p$=0.206) (Figure 42). From 2019 onwards, we asked participants about non-prescribed alprazolam use versus non-prescribed 'other benzodiazepine' use, with 23% (14% in 2021; $p$=0.149) and 17% (17% in 2021) of the total sample reporting recent non-prescribed use in 2022, respectively.

**Frequency of Use:** Participants who had recently used non-prescribed alprazolam reported using it on a median of three days in the past six months (IQR=2-25; n=23; 3 days in 2021; IQR=1-6; n=14; $p$=0.475), while participants who had recently used non-prescribed 'other benzodiazepines' reported use on a median of five days (IQR=2-20; n=17; 5 days in 2021; IQR=1-8; n=17; $p$=0.273).

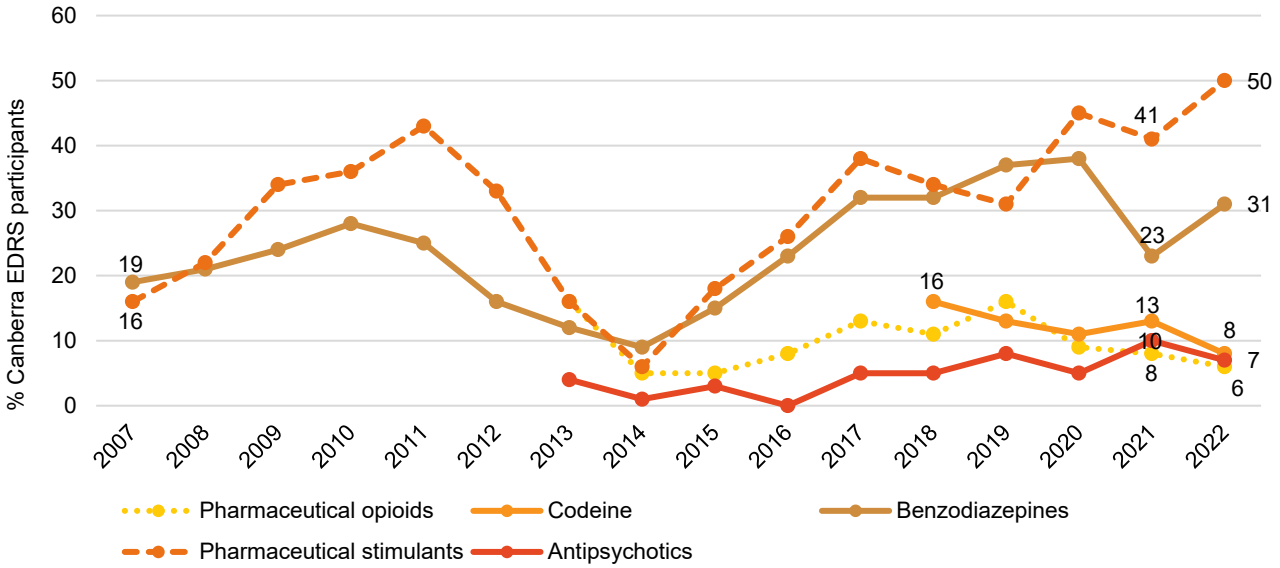
**Price and Perceived Availability:** In 2022, participants were asked questions pertaining to the price and perceived availability of non-prescribed benzodiazepines, however these data will be released separately in 2023. Please contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

## Antipsychotics

**Recent Use (past 6 months):** Historically, recent use of non-prescribed antipsychotics has remained low over the course of monitoring, with 7% of the sample reporting recent non-prescribed use in 2022 (10% in 2021; $p$=0.598) (Figure 42).

**Frequency of Use:** Participants who had recently used non-prescribed antipsychotics reported using it on a median of five days in the past six months (IQR=2-47; n=6; 5 days in 2021; IQR=2-28; n=9; $p$=0.488).

Figure 42: Non-prescribed use of pharmaceutical drugs in the past six months, Canberra, ACT, 2007-2022




Note. Non-prescribed use is reported for prescription medicines. Monitoring of pharmaceutical stimulants and benzodiazepines commenced in 2007, and pharmaceutical opioids and antipsychotics in 2013. Monitoring of over-the-counter (OTC) codeine (low-dose codeine) commenced in 2010, however, in February 2018, the scheduling for codeine changed such that low-dose codeine formerly available OTC was required to be obtained via a prescription. To allow for comparability of data, the time series here represents non-prescribed low- and high dose codeine (2018-2022), with high-dose codeine excluded from pharmaceutical opioids from 2018. Y axis has been reduced to 60% to improve visibility of trends. Data labels are only provided for the first (2007/2009/2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

# Other Illicit Drugs

## Hallucinogenic Mushrooms

**Recent Use (past 6 months):** Recent use of hallucinogenic mushrooms has varied across the years (10% in 2005 to 47% in 2013). In 2022, one-third (36%) of participants reported recent use, stable from 47% reporting recent use in 2021 ($p$=0.150) (Figure 43).

**Frequency of Use:** Recent use has typically been infrequent and stable, with participants reporting a median of two days of use in 2022 (IQR=1-5; n=36; 2 days in 2021; IQR=1-4; n=47; $p$=0.755).

## MDA

**Recent Use (past 6 months):** Recent use of MDA has varied across the years and in 2022, few participants (n≤5) reported recent use, hence further information is not provided (n≤5 in 2021; $p$=0.498) (Figure 43).

## Substance with Unknown Contents

**Capsules (past 6 months):** During the first three years of monitoring, low numbers reported recent use of 'capsules with unknown contents', rising to 45% in 2016. Since then, the percentage of participants reporting recent use has been gradually decreasing, with few reporting recent use in 2022 (n≤5; 8% in 2021; $p$=0.213) (Figure 43).

**Other Unknown Substances (past 6 months):** From 2019 onwards, we asked participants about their use more broadly of substances with 'unknown contents'. These questions were asked by substance form, comprising capsules (as per previous years), pills, powder, crystal and 'other' form. In 2022, 13% reported recent use of any substance with 'unknown contents' (17% in 2021; $p$=0.549) on a median of two days (IQR=1-4; 2 days in 2021; IQR=1-2; $p$=0.432). Six per cent reported using pills with unknown contents in the previous six months (7% in 2021) and 6% reported recently using

powder with unknown contents (6% in 2021). No participants reported using crystal with unknown contents in 2022 (0% in 2021).

**Quantity:** From 2020 onwards, we asked participants about the average amount of pills and capsules used with unknown contents in the last six months. Participants reported using a median of one pill (IQR-1-3; n=6; 3 pill in 2021; IQR=1-5; n=7; *p*=0.186) with unknown contents in a 'typical' session. Few (n≤5) participants reported on average use of capsules with unknown contents, therefore further information is not provided (1 capsule in 2021; IQR=1-2; n=7).

## PMA

**Recent Use (past 6 months):** No participants reported recent used of PMA in 2022 (not asked in 2021) (Figure 43).

## PMMA

**Recent Use (past 6 months):** No participants reported recent used of PMMA in 2022 (not asked in 2021) (Figure 43).

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

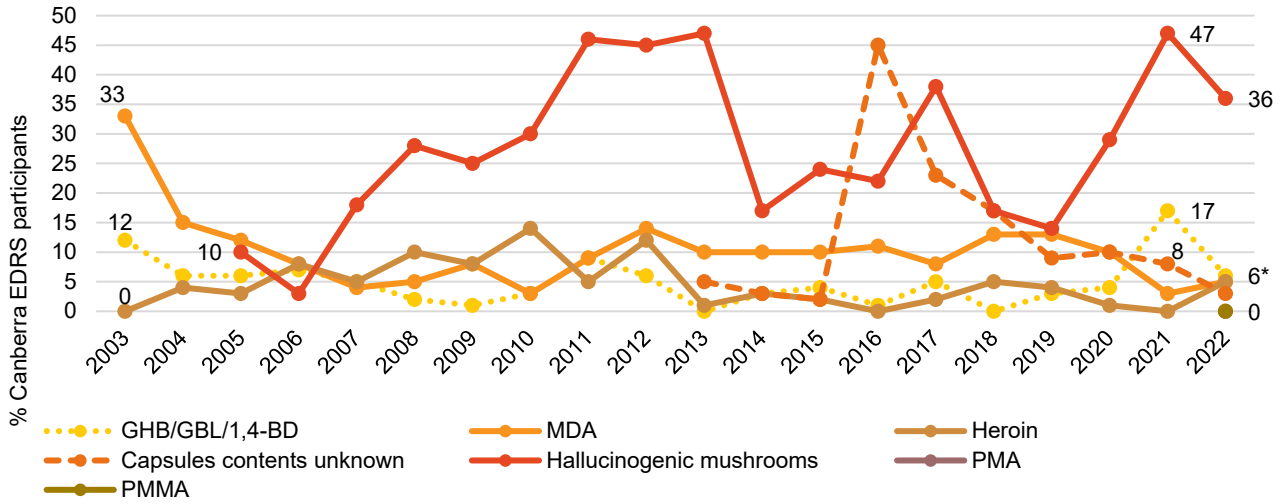
**Recent Use (past 6 months):** Historically, consistently small numbers have reported recent use of GHB/GBL/1,4-BD, however, in 2021, the highest per cent of participants reported past six-month use (17%), before declining significantly in 2022 to 6% (*p*=0.027) (Figure 43).

**Frequency of Use:** In 2022, participants reported use on a median of two days (IQR=1-3; n=6; 4 days in 2021; IQR=2-20; n=17; *p*=0.200).

## Heroin

**Recent Use (past 6 months):** Few participants reported recent use of heroin in 2022 (n≤5; 0% in 2021; *p*=0.059) (Figure 43).

Figure 43: Past six month use of other illicit drugs, Canberra, ACT, 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 and PMMA commenced in 2022. Y axis has been reduced to 50% to improve visibility of trends. Data labels are only provided for the first (2003/2005/2013) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

# Licit and Other Drugs

## Alcohol

**Recent Use (past 6 months):** Most of the sample has reported recent alcohol use across the period of monitoring, however, in 2022, the lowest per cent reported recent use since monitoring began (86%; 95% in 2021; *p*=0.051) (Figure 44).

**Frequency of Use:** In 2022, participants who reported recent alcohol use reported use on a median of 48 days in the past six months (i.e., equivalent to twice weekly; IQR=24-72; n=86; 48 days in 2021; IQR=24-78; n=95; *p*=0.825), with three-quarters (76%) reporting weekly or more frequent use (79% in 2021; *p*=0.596).

## Tobacco

**Recent Use (past 6 months):** Recent tobacco use has fluctuated between 69% and 92% of the sample over the course of monitoring. In 2022, 68% of the sample reported recent tobacco use (72% in 2021; *p*=0.641), the lowest per cent since monitoring began (Figure 44).

**Frequency of Use:** In 2022, participants reported using tobacco on a median of 180 days (i.e., daily; IQR=56-180; n=68; 180 days in 2021; IQR=44-180; n=72; *p*=0.433), with 57% of participants who reported recent use reporting daily use (51% in 2021; *p*=0.503).

## 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. Seven per cent of participants reported recent use of prescribed e-cigarettes in the last six months (not asked in 2021).

**Recent Use (past 6 months):** Recent e-cigarette use remained stable in the initial years of monitoring (2014-2018), however has since been increasing. In 2022, however, a non-significant decrease was observed with nearly three-fifths reporting recent non-prescribed use (57%; 67% in 2021; *p*=0.192) (Figure 44).

**Frequency of Use:** In 2022, frequency of use significantly increased relative to 2021 (120 days; IQR=30-180; n=57; 30 days in 2021; IQR=7-98; n=67; *p*=0.001). In 2022, one-quarter (26%) of those who had recently used non-prescribed e-cigarettes reported daily use (15% in 2021; *p*=0.125).

**Forms Used:** Among those that reported recent non-prescribed e-cigarette use (n=57), all participants (100%) reported using e-cigarettes containing nicotine (96% in 2021) and few reported using e-cigarettes containing cannabis (n≤5; n≤5 in 2021). Few participants (n≤5) reported using e-cigarettes that contained both cannabis and nicotine. No participants reported using e-cigarettes that contained another substance.

**Reason for Use:** Among participants who had recently consumed any (i.e., prescribed and non-prescribed) e-cigarettes in 2022, three-fifths (61%) reported that they did not use e-cigarettes as a smoking cessation tool (51% in 2021; *p*=0.343).

## Nitrous Oxide

**Recent Use (past 6 months):** The per cent reporting recent use of nitrous oxide has been increasing until 2021. In 2022, half (48%) reported recent use (55% in 2021; *p*=0.394) (Figure 44).

**Frequency of Use:** Frequency of use significantly increased to 11 days in 2022 (IQR=3-24; n=48) from four days in 2021 (IQR=2-10; n=55; *p*=0.013).

**Quantity:** Among those who commented in 2022 (n=46), the median amount of nitrous oxide used in a 'typical' session in the six months preceding interview was nine bulbs (IQR=3-14; 5 bulbs in 2021;

IQR=3-12; n=54; *p*=0.166). The median maximum amount used in a session was 16 bulbs (IQR=5-20; n=46; 6 bulbs in 2021; IQR=4-20; n=54; *p*=0.077).

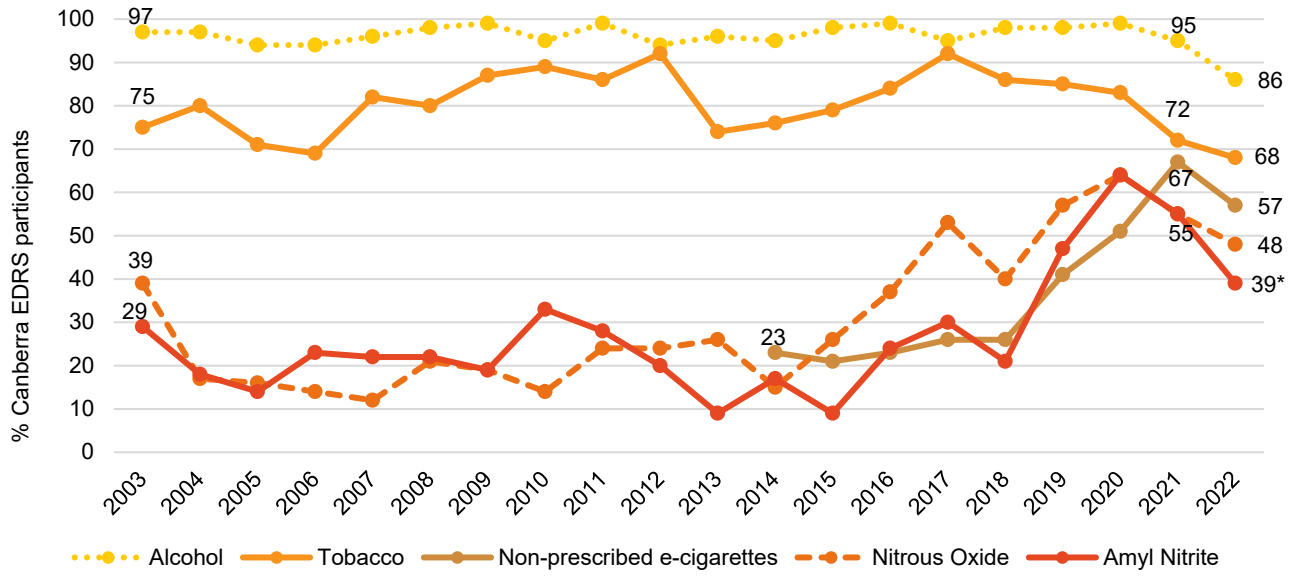
## Amyl Nitrite

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):** Use of amyl nitrite has varied over the course of monitoring. In 2022, recent use was reported by 39% of participants, a significant decrease relative to 2021 (55%; *p*=0.037) (Figure 44).

**Frequency of Use:** In 2022, participants who reported recent use of amyl nitrite reported use on a median of five days (IQR=2-10; n=39; 3 days in 2021; IQR=2-10; n=55; *p*=0.557).

Figure 44: Past six month use of licit and other drugs, Canberra, ACT, 2003-2022




Note. 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≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

# 9

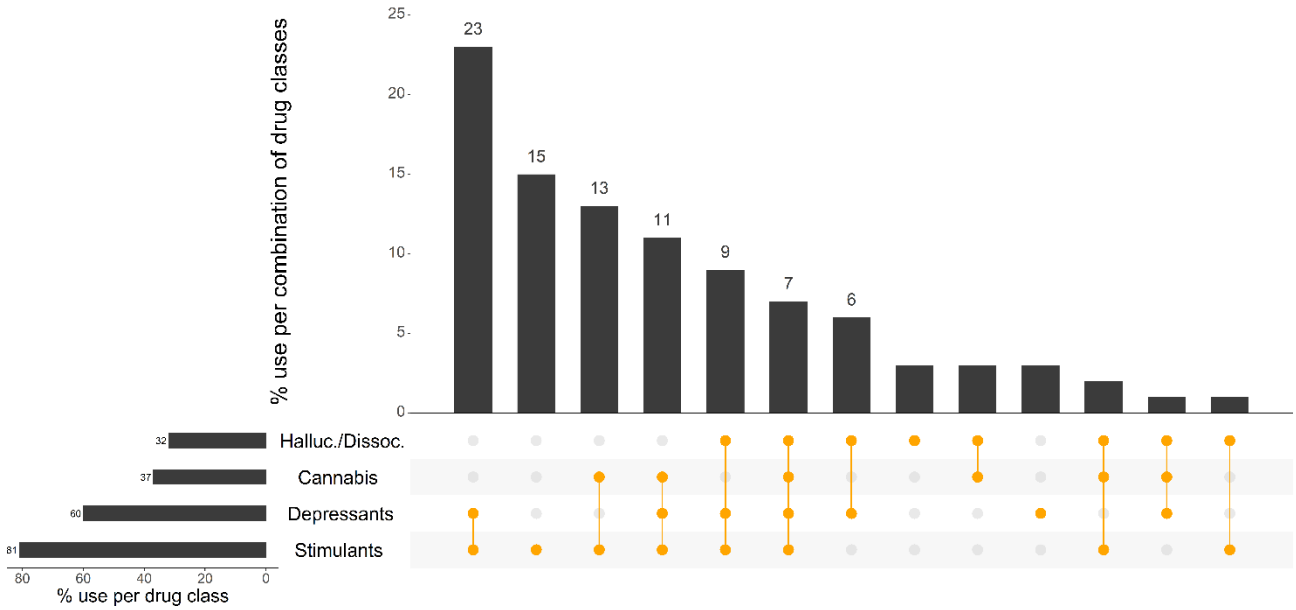
# Drug-Related Harms and Other Behaviours

## Polysubstance Use

On the last occasion of ecstasy or related drug use, the most commonly used substances were alcohol (59%), followed by cannabis (37%), cocaine (35%), methamphetamine (25%) and ecstasy (25%).

The majority (79%) of the Canberra 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 common combinations of drug classes were stimulants and depressants (23%), followed by stimulants and cannabis (13%) and cannabis, depressants and stimulants (11%). Fifteen per cent of participants reported using stimulants alone on the last occasion of ecstasy and related drug use (Figure 45).

Figure 45: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Canberra, ACT, 2022: Most common drug pattern profiles




Note. % calculated out of total EDRS 2022 sample. The horizontal bars represent the per cent of participants who reported use of each substance on their last occasion of ecstasy or related drug use; the vertical columns represent the per cent of participants who used the combination of drug classes represented by the orange circles. Drug use pattern profiles reported by ≤5 participants or which did not include any of the four drug classes depicted are not shown in the figure but are counted in the denominator. Halluc./Dissoc = hallucinogens/dissociatives (LSD, hallucinogenic mushrooms, amyl nitrite, DMT, ketamine and/or nitrous oxide); depressants (alcohol, GHB/GBL,1,4-BD, kava, opioids and/or benzodiazepines); stimulants (cocaine, MDA, ecstasy, methamphetamine, and/or pharmaceutical stimulants). Use of benzodiazepines, opioids and stimulants could be prescribed or non-prescribed use. Note that participants may report use of multiple substances within a class. Y axis reduced to 27% to improve visibility of trends. Data labels are suppressed where there are small numbers (i.e., n≤5 but not 0).

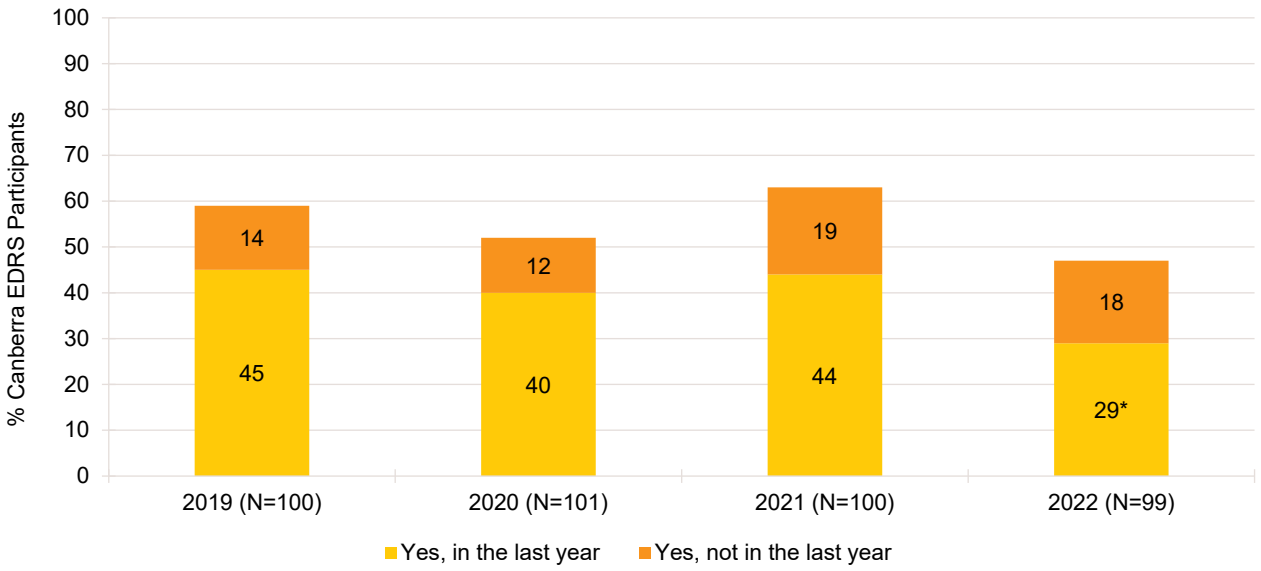
# Drug Checking

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

In 2022, 29% of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year, a significant decline relative to 2021 (44%; *p*=0.042). Of those who reported that they or someone else had tested their illicit drugs in the past year (n=29), nearly all (86%) reported using colorimetric reagent test kits. Few (n≤5) reported using testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips) and testing via professional testing equipment (e.g., Fourier Transform Infrared Spectroscopy).

Of those who reported that they or someone else had tested their illicit drugs in the past year (n=29), half (52%) reported testing the drugs themselves and half (52%) reported having their drugs tested by a friend.

Figure 46: Lifetime and past year engagement in drug checking, Canberra, ACT, 2019-2022




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

## Alcohol Use Disorders Identification Test

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

In 2022, the mean score on the AUDIT for the total sample (including people who had not consumed alcohol in the past six months) was 11.6 (SD 8.2), significantly lower than 13.1 in 2021 (SD 7.7; $p<0.001$) (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. There was no significant change in the per cent of the sample falling into each of these risk categories from 2021 to 2022 ($p=0.239$; Table 6)

Three-fifths (62%) of participants obtained a score of 8 or more, indicative of hazardous use in 2022 (74% in 2021; $p=0.100$) (Table 5).

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

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **N=71** | **N=79** | **N=49** | **N=75** | **N=97** | **N=97** | **N=99** | **N=98** | **N=90** | **N=99** | **N=100** | **N=99** | **N=100** |
| **Mean AUDIT total score (SD)** | 16.2 (7.4) | 13.4 (6.2) | 11.0 (7.0) | 12.2 (5.8) | 11.1 (5.6) | 11.3 (4.7) | 11.8 (6.8) | 11.9 (6.1) | 13.0 (7.3) | 12.8 (6.2) | 15.2 (6.7) | 13.1 (7.7) | **11.6*** (8.2)** |
| **Score 8 or above (%)** | 87 | 80 | 71 | 77 | 71 | 81 | 71 | 74 | 72 | 80 | 91 | 74 | **62** |
| **AUDIT zones:** | | | | | | | | | | | | | |
| Score 0-7 | 13 | 20 | 29 | 23 | 29 | 18 | 29 | 26 | 28 | 20 | 9 | 26 | **38** |
| Score 8-15 | 37 | 42 | 49 | 53 | 50 | 59 | 45 | 49 | 43 | 53 | 53 | 38 | **32** |
| Score 16-19 | 17 | 22 | 14 | 13 | 12 | 17 | 11 | 13 | 19 | 14 | 16 | 16 | **10** |
| Score 20 or higher | 34 | 17 | 8 | 11 | 9 | - | 15 | 12 | 10 | 13 | 22 | 19 | **20** |

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

# Overdose Events

## Non-Fatal Overdose

Previously, participants had been asked about their experience in the past 12-months of i) alcohol overdose; (ii) opioid overdose; (iii) **stimulant overdose**, and iv) **other drug overdose**.

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

- **Alcohol overdose:** experience of symptoms (e.g., reduced level of consciousness and collapsing) where professional assistance would have been helpful.
- **Stimulant overdose:** experience of symptoms (e.g., nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, seizure, extreme paranoia, extreme anxiety, panic, extreme agitation, hallucinations, excited delirium) where professional assistance would have been helpful.
- **Other drug overdose (not including alcohol or stimulant drugs):** similar definition to above. Note that in 2019, participants were prompted specifically for opioid overdose but this was removed in 2020 and onwards 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 or opioid overdose, or other drug overdose where a depressant (e.g., GHB/GBL/1,4-BD, benzodiazepines) was listed.

## Non-Fatal Stimulant Overdose

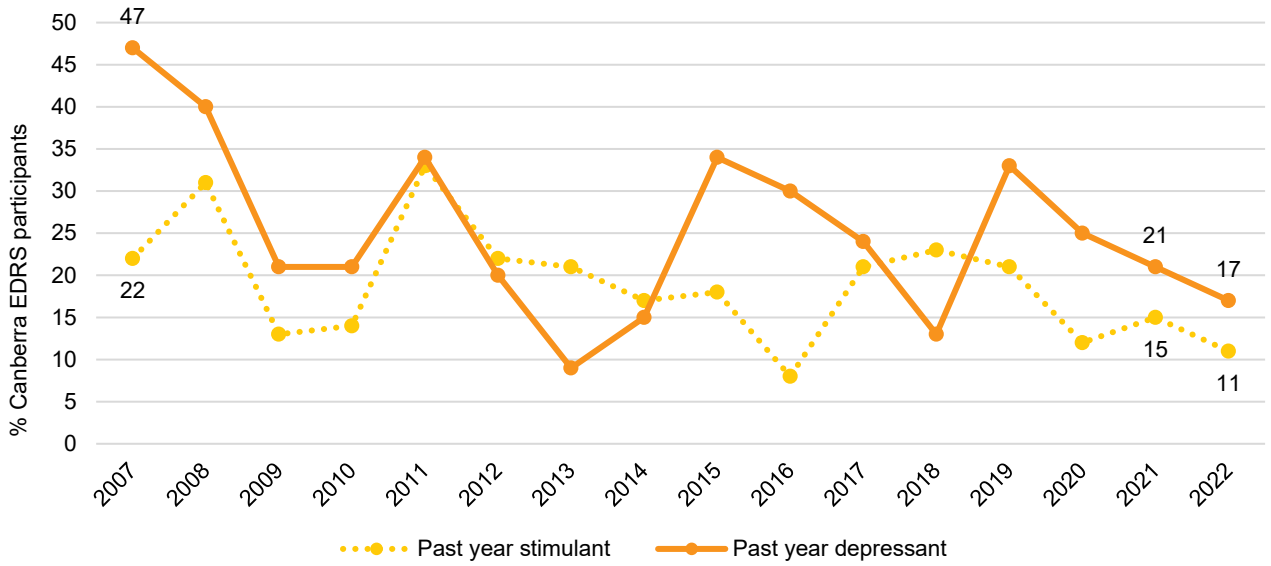
In 2022, one in ten participants (11%; 15% in 2021; $p$=0.527) reported a non-fatal stimulant overdose in the last 12 months (Figure 47). Due to low numbers reporting on the most common stimulants consumed during the most recent past 12 month non-fatal stimulant overdose (n≤5), please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information. All participants reported that they had consumed one or more additional drugs on the last occasion, most commonly alcohol (90%). On the last occasion of non-fatal stimulant overdose, 70% reported that they did not receive treatment or assistance.

## Non-Fatal Depressant Overdose

**Alcohol:** Twelve per cent of the sample reported having experienced a non-fatal alcohol overdose in the past 12 months (19% in 2021; $p$=0.243). Of those who had experienced an alcohol overdose in the past year (n=12), the majority (58%) reported not receiving treatment on the last occasion.

**Any Depressant (including alcohol):** Past 12-month experience of any non-fatal depressant overdose has been fluctuating over the course of monitoring. In 2022, 17% of the sample reported experiencing at least one non-fatal depressant overdose in the past 12 months (21% in 2021; $p$=0.587) (Figure 47). Of those who had experienced any depressant overdose in the last year (n=17), the majority reported alcohol (71%) as the drug being used prior to the event.

## Figure 47: Past year non-fatal stimulant and depressant overdose, Canberra, ACT, 2007-2022

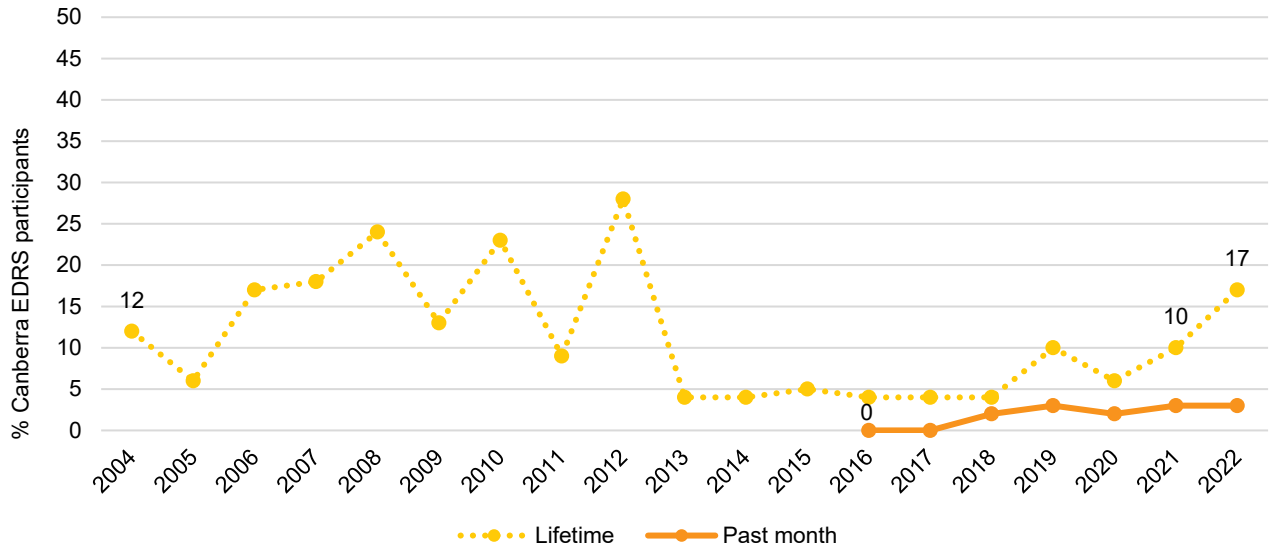



Note. Past year stimulant and depressant overdose was first asked about in 2007. In 2019, items about overdose were revised, and changes relative to 2018 may be a function of greater nuance in capturing depressant events. Y axis has been reduced to 50% to improve visibility of trends. Data labels are 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≤5 but not 0). For historical numbers, please refer to the data tables. The response 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

## Injecting Drug Use and Associated Risk Behaviours

The per cent reporting injecting in their lifetime varied in earlier years of monitoring. In 2022, 17% reported lifetime injection (10% in 2021; *p*=0.221) (Figure 48). Few participants reported past month injection (n≤5; n≤5 in 2021).

Figure 48: Lifetime and past month drug injection, Canberra, ACT, 2004-2022




Note. Items assessing whether participants had injected drugs in the past month were first asked in 2016. Y axis reduced to 50% to improve visibility of trends. 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≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

## Drug Treatment

In 2022, 9% of participants reported that they were currently in drug treatment (n≤5 in 2021; *p*=0.134). For national trends refer to the National EDRS Report, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

## Sexual Health Behaviours

In 2022, 70% of the sample reported some form of sexual activity in the past four weeks, significant fewer relative to 2021 (84%; *p*=0.031). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if conducted face-to-face).

Of those who had engaged in sexual activity in the past four weeks and who responded (n=68), 84% reported using alcohol and/or other drugs prior to, or while engaging in, sexual activity (88% in 2021; *p*=0.634) and 12% reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (7% in 2021; *p*=0.403). Further, of those who had engaged in sexual activity in the past four weeks and who responded (n=67), 28% reported penetrative sex without a condom where they did not know the HIV status of their partner in the past four weeks (27% in 2021; *p*=0.851) (Table 6).

Of those who commented (n=97), 76% reported having a sexual health check-up in their lifetime (76% in 2021), including 32% reporting having a sexual health check-up in the six months prior to interview (45% in 2021; *p*=0.358). Of the total sample and who responded (n=97), 23% had received a positive diagnosis for a sexually transmitted infection (STI) in their lifetime (26% in 2021; *p*=0.650) and few participants reported that they had received a positive diagnosis for a STI in the past six months in 2022 (n≤5 ; n≤5 in 2021) (Table 6).

Of those who commented (n=97), 57% reported having a test for human immunodeficiency virus (HIV) in their lifetime (61% in 2021; *p*=0.560), including 23% having done so in the six months prior to interview (32% in 2021; *p*=0.224). In 2022, no participants had been diagnosed with HIV in their lifetime (0% in 2021) (Table 6).

Table 6: Sexual health behaviours, Canberra, ACT, 2021-2022

| | 2021 | 2022 |
|---|---|---|
| **Of those who responded:** | N=98 | **N=97** |
| **% Any sexual activity in the past four weeks (n)** | 84 (n=82) | **70* (n=68)** |
| **Of those who responded# and reported any sexual activity in the past four weeks:** | n=82 | **n=68** |
| % Drugs and/or alcohol used prior to or while engaging in sexual activity | 88 | **84** |
| **Of those who responded# and reported any sexual activity in the past four weeks:** | n=82 | **n=67** |
| % Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity | 7 | **12** |
| **Of those who responded# and reported any sexual activity in the past four weeks:** | n=82 | **n=67** |
| % Had penetrative sex without a condom and did not know HIV status of partner | 27 | **28** |
| **Of those who responded#:** | n=98 | **n=97** |
| % Had a HIV test in the last six months | 32 | **23** |
| % Had a HIV test in their lifetime | 61 | **57** |
| **Of those who responded#:** | n=98 | **n=97** |
| **%** Diagnosed with HIV in the last six months | 0 | **0** |
| **%** Diagnosed with HIV in their lifetime | 0 | **0** |
| **Of those who responded#:** | n=98 | **n=97** |
| % Had a sexual health check in the last six months | 45 | **32** |
| % Had a sexual health check in their lifetime | 76 | **76** |
| **Of those who responded#:** | n=98 | **n=97** |
| % Diagnosed with a sexually transmitted infection in the last six months | - | **-** |
| % Diagnosed with a sexually transmitted infection in their lifetime | 26 | **23** |

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

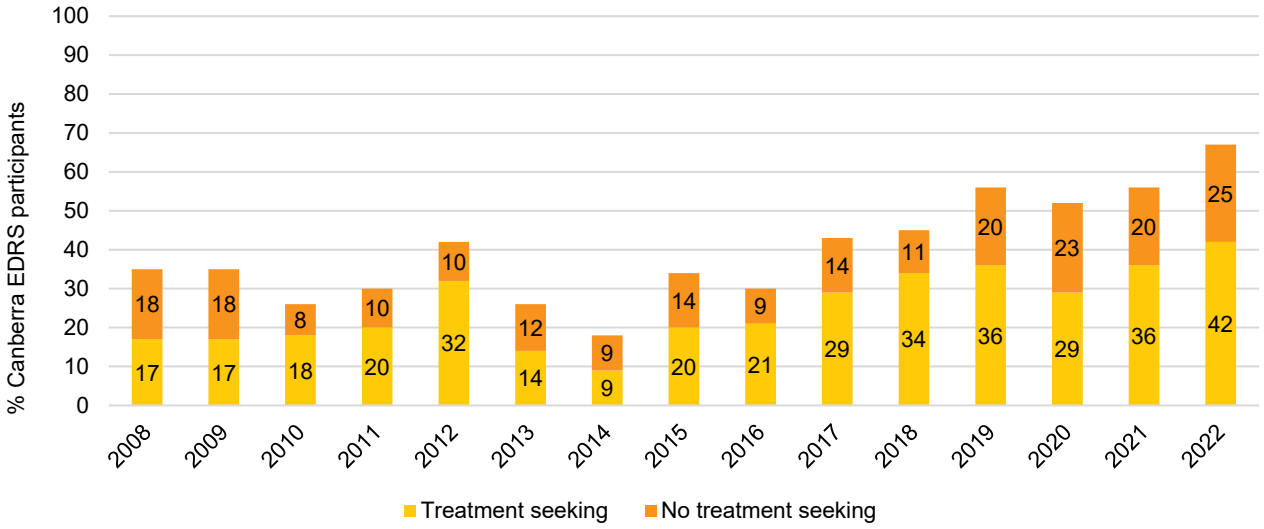
## Mental Health

Sixty-seven per cent of the sample self-reported that they had experienced a mental health problem in the preceding six months (other than drug dependence; 56% in 2021; *p*=0.116) (Figure 49).

Of those who reported a mental health problem and who responded (n=67), the most common mental health problems were anxiety (64%; 83% in 2021; *p*=0.776) and depression (64%; 67% in 2021; *p*=0.386), followed by post-traumatic stress disorder (PTSD) (21%; 17% in 2021; *p*=0.373).

Of those who reported a mental health problem, three-fifths (63%; 42% of the total sample) of participants reported seeing a mental health professional during the past six months (65% in 2021; *p*=0.847). Of this group (n=42), 79% reported being prescribed medication (75% in 2021; *p*=0.788).

Figure 49: Self-reported mental health problems and treatment seeking in the past six months, Canberra, ACT, 2008-2022

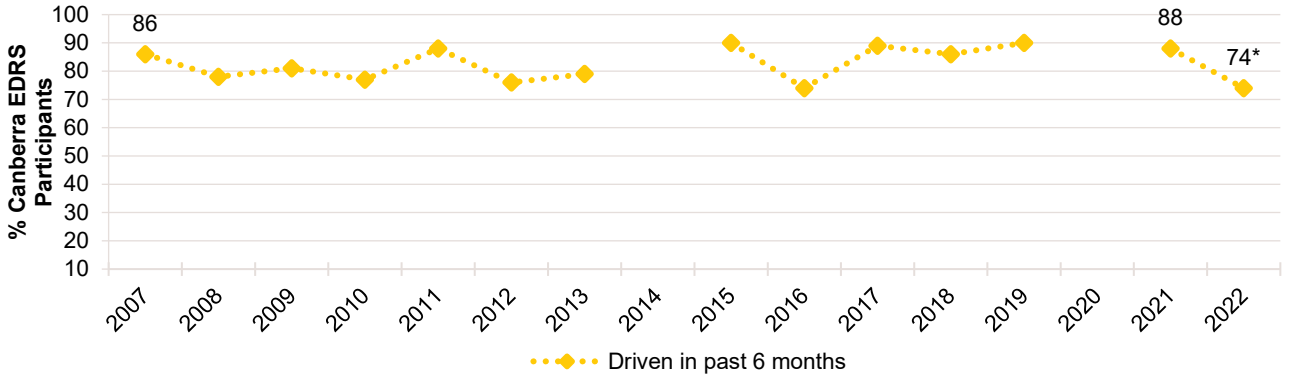



Note. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. Data labels have been removed from figures with small cell size (i.e.. n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001.

## Driving

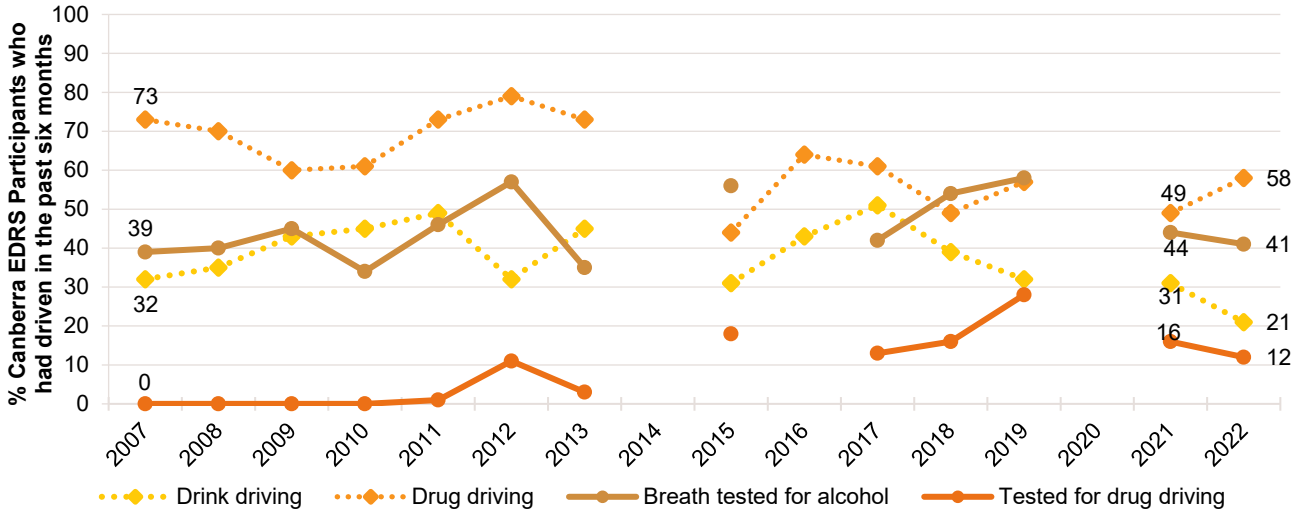
The majority (74%) of the sample had driven a car, motorcycle or other vehicle in the last six months (Figure 50). Of those who had driven in the past six months (n=74), 21% reported driving while over the (perceived) legal limit of alcohol (31% in 2021; *p*=0.207), and nearly three-fifths (58%) reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months (49% in 2021; *p*=0.273) (Figure 51). Among those who had driven in the past six months (n=74), one-tenth (12%) reported that they had been tested for drug driving by the police roadside drug testing service (16% in 2021; *p*=0.504), and 41% reported that they had been breath tested for alcohol by the police roadside testing service in the six months prior to interview (44% in 2021; *p*=0.633) (Figure 51).

Figure 50: Self-reported driving in the past six months, Canberra, ACT, 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≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001.

Figure 51: Self-reported testing and driving in the past six months over the (perceived) legal limit for alcohol and three hours following illicit drug use, among those who had driven in the past six months, Canberra, ACT, 2007-2022



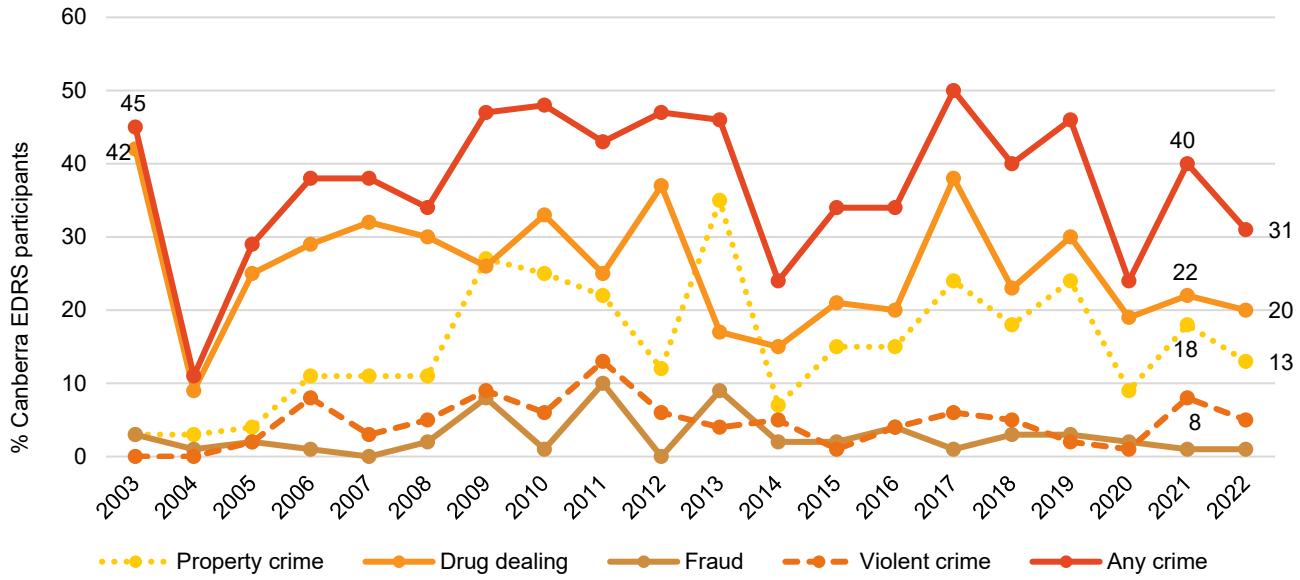

Note. Computed of those who had driven a vehicle in the past six months. Questions about driving behaviour were first asked about in 2007. Questions about driving behaviour not asked in 2014 or 2020. Questions about alcohol and drug driving testing were not asked in 2014, 2016 or 2020. Data labels are 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≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001.

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

The per cent reporting past month criminal activity has fluctuated over time, with drug dealing (20%; 22% in 2021; *p*=0.736) and property crime (13%; 18% in 2021; *p*=0.337) consistently being reported as the main forms of criminal activity (Figure 52). In 2022, 31% of the sample reported 'any' criminal activity in the past month, stable relative to 2021 (40%; *p*=0.187). In 2022, 15% of the Canberra sample reported being the victim of a crime involving violence, a significant increase relative to 2021 (n≤5; *p*=0.032).

Significantly fewer participants reported having been arrested in the 12 months preceding interview in 2022 relative to 2021 (n≤5 versus 16% in 2021; *p*=0.008) and one-fifth (21%) reported a drug-related encounter in the last 12 months which did not result in charge or arrest (data not collected in 2021). One-tenth (11%) of participants reported a lifetime history of imprisonment in 2022 (n≤5 in 2021; *p*=0.191). In 2022, 21% of the Canberra sample reported a drug-related encounter in the last 12 months which did not result in charge or arrest (data not collected in 2021).

Figure 52: Self-reported criminal activity in the past month, Canberra, ACT, 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≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Y axis reduced to 60% to improve visibility of trends. Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.

# Modes of Purchasing Illicit or Non-Prescribed Drugs

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

## Purchasing Approaches

In 2022, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was in person (68%; 63% in 2021; *p*=0.546) and social networking applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (68%; 56% in 2021; *p*=0.111) (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

Six per cent of the sample reported obtaining drugs via the darknet in the past year (7% in 2021); few reported purchasing on the surface net (n≤5 in 2021) and 2022. Half (50%) of participants reported ever obtaining illicit drugs through someone who had purchased them on the surface or darknet, with two-fifths (37%) having done so in the last 12 months (44% in 2021; *p*=0.355).

In 2022, few participants (n≤5) reported selling illicit/non-prescribed drugs via surface or darknet marketplaces in the 12 months preceding interview (n≤5 in 2021; *p*=0.439).

## Obtaining Drugs

The majority of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2022 (83%; 76% in 2021; *p*=0.290), followed by 70% reporting obtaining it from a known dealer/vendor (72% in 2021; *p*=0.872). Twenty-three per cent reported obtaining illicit drugs from an unknown dealer/vendor (19% in 2021; *p*=0.600) (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 (97%), a significant increase relative to 2021 (86%; *p*=0.009), with smaller numbers reporting receiving illicit drugs via post (15%; 8% in 2021; *p*=0.191) and via a collection point (defined as a predetermined location where a drug will be dropped for later collection; 12%; 9% in 2021; *p*=0.632) (Table 7).

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

| | 2019 n=98 | 2020 n=100 | 2021 n=100 | 2022 n=100 |
|---|---|---|---|---|
| **% Purchasing approaches in the last 12 months^** | | | | |
| Face-to-face | 81 | 49 | 63 | **68** |
| Surface web | 6 | - | - | **-** |
| Darknet market | 14 | - | 7 | **6** |
| Social networking applications | 70 | 74 | 56 | **68** |
| Text messaging | 55 | 51 | 48 | **41** |
| Phone call | 54 | 27 | 33 | **30** |
| Grew/ made my own | / | - | 11 | **-*** |
| Other | 0 | - | 0 | **0** |
| **% Means of obtaining drugs in the last 12 months^~** | n=99 | n=99 | n=99 | **n=99** |
| Face-to-face | 99 | 97 | 86 | **97**** |
| Collection point | 9 | 26 | 9 | **12** |
| Post | 13 | 8 | 8 | **15** |
| **% Sources of drugs in the last 12 months^** | n=97 | n=100 | n=99 | **n=99** |
| Friend/relative/partner/colleague | 84 | 83 | 76 | **83** |
| Known dealer/vendor | 71 | 56 | 72 | **70** |
| Unknown dealer/vendor | 37 | 22 | 19 | **23** |

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

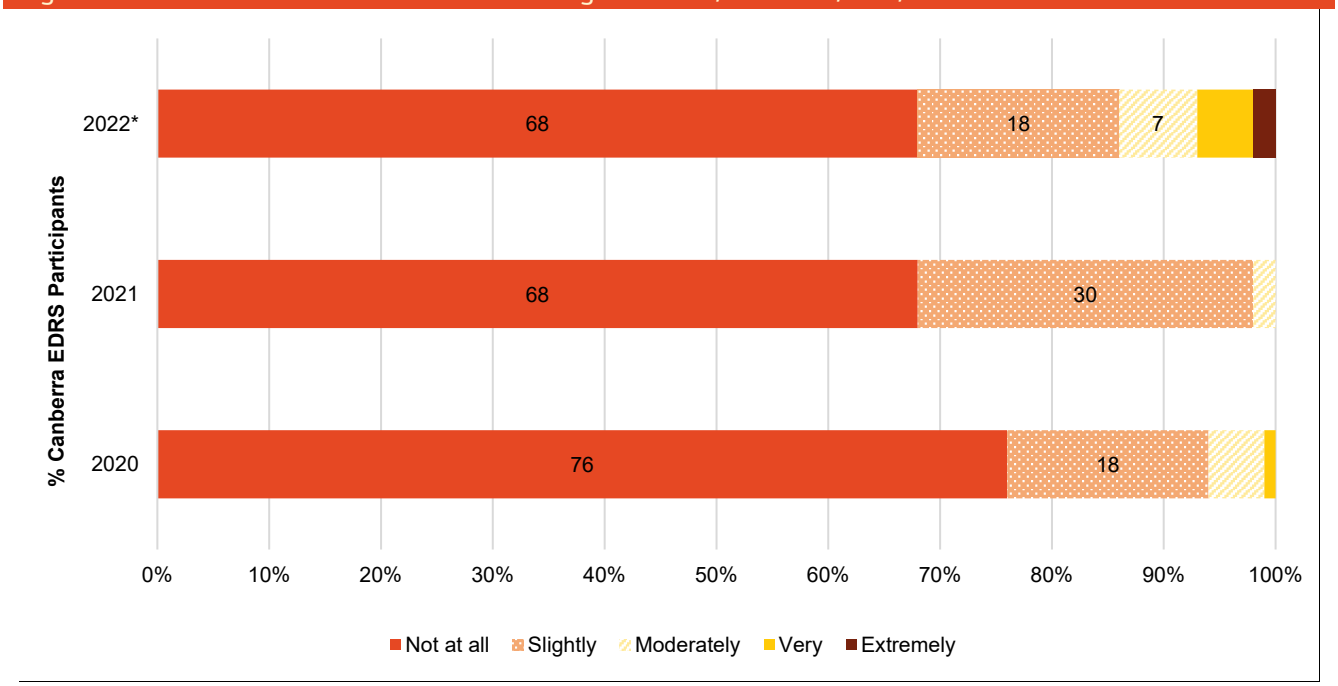
## COVID-19 Testing and Diagnosis

In 2022, nearly the whole sample (95%) had been tested for SARS-CoV-2 by the time of interview (56% in 2021; n≤5 in 2020), of whom 80% had received a PCR test and 87% a rapid antigen test. Nearly three-fifths (57%) of participants reported having been diagnosed with the virus (no participants in 2021 and 2020).

In 2022, 71% of the sample reported quarantining for at least seven days due to a positive test or possible exposure in the past 12 months, with 11% quarantining in the month prior to interview and 49% in the six months prior to interview. At the time of interview, 91% reported that they had received at least one COVID-19 vaccine dose (median 2 doses: few (n≤5) had received one dose, 47% had received two doses, 42% had received three or more doses).

When asked how worried they were currently about contracting COVID-19, 32% of participants reported some level of concern, with one-fifth (18%) responding that they were 'slightly' concerned and seven per cent reporting that they were 'moderately' concerned (Figure 53). Furthermore, 44% of participants reported that they would be concerned about their health if they did contract COVID-19, with one-fifth (22%) reporting that they would be 'slightly' concerned, 8% reporting 'moderately', 12% reporting 'very' and small numbers (n≤5) reporting that they would be 'extremely' concerned.

Figure 53: Current concern related to contracting COVID-19, Canberra, ACT, 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≤5 but not 0). Statistical significance for 2021 versus 2022 presented in figure; *$p$<0.050; **$p$<0.010; ***$p$<0.001.