EDRS

TASMANIAN DRUG TRENDS 2022

Key Findings from the Tasmanian Ecstasy and related Drugs Reporting System (EDRS) Interviews

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

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Table of Contents

SAMPLE CHARACTERISTICS 7

ECSTASY 11

METHAMPHETAMINE 21

COCAINE 28

CANNABIS AND/OR CANNABINOID RELATED PRODUCTS 32

KETAMINE AND LSD 38

NEW PSYCHOACTIVE SUBSTANCES 45

OTHER DRUGS 49

DRUG-RELATED HARMS AND OTHER BEHAVIOURS 55

List of Tables

TABLE 1: DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE, NATIONALLY,2022, AND HOBART, TAS, 2017-2022.... 7
TABLE 2: PAST SIX MONTH USE OF NPS (INCLUDING PLANT-BASED NPS), NATIONALLY AND HOBART, TAS 2010-2022.... 46
TABLE 3: PAST SIX MONTH USE OF NPS (EXCLUDING PLANT-BASED NPS), NATIONALLY AND HOBART, TAS, 2010-2022.... 46
TABLE 4: PAST SIX MONTH USE OF NPS BY DRUG TYPE, HOBART, TAS, 2010-2022.... 47
TABLE 5: AUDIT TOTAL SCORES AND PER CENT OF PARTICIPANTS SCORING ABOVE RECOMMENDED LEVELS, HOBART, TAS, 2010-2022.... 57
TABLE 6: SEXUAL HEALTH BEHAVIOURS, HOBART, TAS, 2021-2022.... 61
TABLE 7: MEANS OF PURCHASING ILLICIT DRUGS IN THE PAST 12 MONTHS, HOBART, TAS, 2019-2022.... 66

List of Figures

FIGURE 1: DRUG OF CHOICE, HOBART, TAS, 2003-2022 9
FIGURE 2: DRUG USED MOST OFTEN IN THE PAST MONTH, HOBART, TAS, 2011-2022 9
FIGURE 3: WEEKLY OR MORE FREQUENT SUBSTANCE USE IN THE PAST SIX MONTHS, HOBART, TAS, 2003-2022.. 10
FIGURE 4: PAST SIX MONTH USE OF ANY ECSTASY, AND ECSTASY PILLS, POWDER, CAPSULES, AND CRYSTAL, HOBART, TAS, 2003-2022 11
FIGURE 5: MEDIAN DAYS OF ANY ECSTASY AND ECSTASY PILLS, POWDER, CAPSULES, AND CRYSTAL USE IN THE PAST SIX MONTHS, HOBART, TAS, 2003-2022 12
FIGURE 6: MEDIAN PRICE OF ECSTASY PILL AND CAPSULE, HOBART, TAS, 2003-2022 16
FIGURE 7: MEDIAN PRICE OF ECSTASY CRYSTAL (PER POINT AND GRAM) AND POWDER (PER GRAM ONLY), HOBART, TAS, 2013-2022 16
FIGURE 8: CURRENT PERCEIVED PURITY OF ECSTASY PILLS, HOBART, TAS, 2017-2022 17
FIGURE 9: CURRENT PERCEIVED PURITY OF ECSTASY CAPSULES, HOBART, TAS, 2017-2022 17
FIGURE 10: CURRENT PERCEIVED PURITY OF ECSTASY CRYSTAL, HOBART, TAS, 2017-2022 18
FIGURE 11: CURRENT PERCEIVED PURITY OF ECSTASY POWDER, HOBART, TAS, 2017-2022 18
FIGURE 12: CURRENT PERCEIVED AVAILABILITY OF ECSTASY PILLS, HOBART, TAS, 2017-2022 19
FIGURE 13: CURRENT PERCEIVED AVAILABILITY OF ECSTASY CAPSULES, HOBART, TAS, 2017-2022 19
FIGURE 14: CURRENT PERCEIVED AVAILABILITY OF ECSTASY CRYSTAL, HOBART, TAS, 2017-2022 20
FIGURE 15: CURRENT PERCEIVED AVAILABILITY OF ECSTASY POWDER, HOBART, TAS, 2017-2022 20
FIGURE 16: PAST SIX MONTH USE OF ANY METHAMPHETAMINE, POWDER, BASE, AND CRYSTAL, HOBART, TAS, 2003-2022 21
FIGURE 17: MEDIAN DAYS OF ANY METHAMPHETAMINE, POWDER, BASE, AND CRYSTAL USE IN THE PAST SIX MONTHS, HOBART, TAS, 2003-2022 22
FIGURE 18: MEDIAN PRICE OF POWDER METHAMPHETAMINE PER POINT AND GRAM, HOBART, TAS, 2003-2022 . 25
FIGURE 19: MEDIAN PRICE OF CRYSTAL METHAMPHETAMINE PER POINT AND GRAM, HOBART, TAS, 2003-2022 . 25
FIGURE 20: CURRENT PERCEIVED PURITY OF POWDER METHAMPHETAMINE, HOBART, TAS, 2003-2022 26
FIGURE 21: CURRENT PERCEIVED PURITY OF CRYSTAL METHAMPHETAMINE, HOBART, TAS, 2003-2022 26
FIGURE 22: CURRENT PERCEIVED AVAILABILITY OF POWDER METHAMPHETAMINE, HOBART, TAS, 2003-2022 27
FIGURE 23: CURRENT PERCEIVED AVAILABILITY OF CRYSTAL METHAMPHETAMINE, HOBART, TAS, 2003-2022 27
FIGURE 24: PAST SIX MONTH USE AND FREQUENCY OF USE OF COCAINE, HOBART, TAS, 2003-2022 29
FIGURE 25: MEDIAN PRICE OF COCAINE PER GRAM, HOBART, TAS, 2003-2022 30
FIGURE 26: CURRENT PERCEIVED PURITY OF COCAINE, HOBART, TAS, 2003-2022 30
FIGURE 27: CURRENT PERCEIVED AVAILABILITY OF COCAINE, HOBART, TAS, 2003-2022 31
FIGURE 28: PAST SIX MONTH USE AND FREQUENCY OF USE OF NON-PRESCRIBED CANNABIS AND/OR CANNABINOID RELATED PRODUCTS, HOBART, TAS, 2003-2022 33
FIGURE 29: MEDIAN PRICE OF NON-PRESCRIBED HYDROPONIC (A) AND BUSH (B) CANNABIS PER OUNCE AND GRAM, HOBART, TAS, 2006-2022 35
FIGURE 30: CURRENT PERCEIVED POTENCY OF NON-PRESCRIBED HYDROPONIC (A) AND BUSH (B) CANNABIS, HOBART, TAS, 2006-2022 36
FIGURE 31: CURRENT PERCEIVED AVAILABILITY OF NON-PRESCRIBED HYDROPONIC (A) AND BUSH (B) CANNABIS, HOBART, TAS, 2006-2022 37
FIGURE 32: PAST SIX MONTH USE AND FREQUENCY OF USE OF KETAMINE, HOBART, TAS, 2003-2022 38
FIGURE 33: MEDIAN PRICE OF KETAMINE PER GRAM, HOBART, TAS, 2003-2022 39
FIGURE 34: CURRENT PERCEIVED PURITY OF KETAMINE, HOBART, TAS, 2003-2022 40
FIGURE 35: CURRENT PERCEIVED AVAILABILITY OF KETAMINE, HOBART, TAS, 2003-2022 40
FIGURE 36: PAST SIX MONTH USE AND FREQUENCY OF USE OF LSD, HOBART, TAS, 2003-2022 41
FIGURE 37: MEDIAN PRICE OF LSD PER TAB, HOBART, TAS, 2003-2022 42
FIGURE 38: CURRENT PERCEIVED PURITY OF LSD, HOBART, TAS, 2003-2022 42
FIGURE 39: CURRENT PERCEIVED AVAILABILITY OF LSD, HOBART, TAS, 2003-2022 43
FIGURE 40: PAST SIX MONTH USE AND FREQUENCY OF USE OF DMT, HOBART, TAS, 2010-2022 44
FIGURE 41: NON-PRESCRIBED USE OF PHARMACEUTICAL DRUGS IN THE PAST SIX MONTHS, HOBART, TAS, 2007-2022 50
FIGURE 42: PAST SIX MONTH USE OF OTHER ILLICIT DRUGS, HOBART, TAS, 2003-2022 52

FIGURE 43: LICIT AND OTHER DRUGS USED IN THE PAST SIX MONTHS, HOBART, TAS, 2003-2022 54
FIGURE 44: USE OF CANNABIS, HALLUCINOGENS AND DISSOCIATIVES ON THE LAST OCCASION OF ECSTASY OR RELATED DRUG USE, HOBART, TAS, 2022: MOST COMMON DRUG PATTERN PROFILES 55
FIGURE 45: LIFETIME AND PAST YEAR ENGAGEMENT IN DRUG CHECKING, HOBART, TAS, 2019-2022 56
FIGURE 46: PAST 12 MONTH NON-FATAL STIMULANT AND DEPRESSANT OVERDOSE, HOBART, TAS, 2007-2022 .. 59
FIGURE 47: LIFETIME AND PAST MONTH DRUG INJECTION, HOBART, TAS, 2003-2022 59
FIGURE 48: SELF-REPORTED MENTAL HEALTH PROBLEMS AND TREATMENT SEEKING IN THE PAST SIX MONTHS, HOBART, TAS, 2008-2022 62
FIGURE 49: SELF-REPORTED DRIVING IN THE PAST SIX MONTHS, HOBART, TAS, 2007-2022 63
FIGURE 50: SELF-REPORTED TESTING AND DRIVING IN THE PAST SIX MONTHS OVER THE (PERCEIVED) LEGAL LIMIT FOR ALCOHOL AND THREE HOURS FOLLOWING ILLICIT DRUG USE, AMONG THOSE WHO HAD DRIVEN IN THE PAST SIX MONTHS, HOBART, TAS, 2007-2022 63
FIGURE 51: SELF-REPORTED CRIMINAL ACTIVITY IN THE PAST MONTH, HOBART, TAS, 2003-2022 64
FIGURE 52: CURRENT CONCERN RELATED TO CONTRACTING COVID-19, HOBART, TAS, 2020-2022 67

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Research Team

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- Dr Rachel Sutherland, Fiona Jones, Antonia Karlsson, Julia Uporova, Cate King, Daisy Gibbs, Olivia Price, Professor Louisa Degenhardt, Professor Michael Farrell and Associate Professor Amy Peacock, National Drug and Alcohol Research Centre, University of New South Wales, New South Wales;
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- Yalei Wilson and Associate Professor Raimondo Bruno, School of Psychology, University of Tasmania, Tasmania;
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Participants

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Contributors

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Abbreviations

4-AcO-DMT	4-Acetoxy-N,N-dimethyltryptamine
4-FA	4-Fluoroamphetamine
5-MeO-DMT	5-methoxy-N,N-dimethyltryptamine
2C-B	4-bromo-2,5-dimethoxyphenethylamine
AIVL	Australian Injecting and 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
IDRS	Illicit Drug Reporting System
IQR	Interquartile range
LSD	*d*-lysergic acid
MDA	3,4-methylenedioxyamphetamine
MDMA	3,4-methylenedioxymethamphetamine
MDPV	Methylenedioxypyrovalerone
MXE	Methoxetamine
N (or n)	Number of participants
NBOME	N-methoxybenzyl
NDARC	National Drug and Alcohol Research Centre
NPS	New psychoactive substances
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
TAS	Tasmania
THC	Tetrahydrocannabinol
UNSW	University of New South Wales
WHO	World Health Organization

Executive Summary

The Hobart Tasmania (TAS) 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 Hobart, TAS. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2022 from May-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 TAS EDRS sample (N=72) recruited from Hobart, Tasmania, was demographically very similar to the sample in 2021 and in previous years; the sample comprised predominantly young males (48%), most of whom held tertiary qualifications (60% completed post-school qualifications) and most of whom were living in a rental house/flat (56%) or residing with their parents/at their family home (17%) at the time of interview. Drug of choice remained stable in 2022, with one fifth (22%) nominating ecstasy as the drug of choice, followed by cannabis (19%). The drug used most often in the last month significantly changed (p=0.002), with cannabis and cocaine the drugs used most often in the preceding month (38% and 19%, respectively) in 2022.

Ecstasy

The ecstasy market has diversified over the past few years, with the per cent reporting any recent (i.e., past six month) use of any ecstasy pills declining and the per cent reporting recent use of other forms of ecstasy increasing since 2014. In 2022, there was a significant decrease in the recent use of ecstasy crystal, from 66% in 2021 to 47% in 2022 (p=0.022), which was counter to the trend of increasing use of ecstasy crystal since 2014. Median days of any ecstasy significantly decreased in 2022 from ten days in 2021 to seven days (p=0.002). There was a significant change in the perceived availability of capsules between 2021 and 2022 (p=0.006), with fewer participants reporting that capsules were 'easy' to obtain, and more participants reporting that capsules were 'difficult' to obtain. There was a significant change in the route of administration of ecstasy capsules, with fewer participants who reported snorting capsule contents (16%; 38% in 2021; p=0.030).

Methamphetamine

Recent use of any methamphetamine has been declining amongst the Hobart sample since the commencement of monitoring, however the per cent reporting any recent use remained stable at 39% in 2022 (31% in 2021). Participants reported using methamphetamine less than monthly on average, with a median of four days of any methamphetamine use in the preceding six months. Perceived price, purity and availability of all methamphetamine forms remained stable between 2021 and 2022.

Cocaine

Recent use of cocaine has generally increased over the years of monitoring. In 2022, 78% reported recent use, stable from 84% in 2021. Frequency of use remained stable at six days in the previous six months (5 days in 2021). The quantity used in a 'typical' session and a maximum session significantly increased to 0.50 grams and 1.00 gram, respectively (0.30 grams and 0.50 grams in 2021). Perceived price, purity and availability of cocaine remained stable between 2021 and 2022.

Cannabis and/or Cannabinoid Related Products

At least three in five participants have reported recent use of non-prescribed cannabis and/or cannabinoid related products each year since monitoring commenced. Eighty-one per cent of participants reported recent use in 2022, stable from 75% in 2021. Participants who had recently used non-prescribed cannabis and/or cannabinoid related products reported use on a median of 54 days in the preceding six months (55 days in 2021), with 67% reporting weekly or more frequent use (63% in 2021) and 28% reporting daily use (28% in 2021). One ounce of bush cannabis significantly increased in price to a median of $250 ($210 in 2021;

p=0.013), and availability of hydroponic cannabis significantly changed between 2021 and 2022 (*p*=0.035), with more participants reporting it was 'very easy' to obtain (56%; 41% in 2021).

Ketamine, LSD and DMT

Recent use of ketamine, LSD and DMT remained stable in 2022 relative to 2021. In 2022, 38%, 57% and 10% reported any recent use, respectively. The median price remained stable at $250 per gram of ketamine and $25 per tab of LSD. Frequency of use for all three substances remained low and stable in 2022.

New Psychoactive Substances (NPS)

Any NPS use, including plant-based NPS, has remained low over time. Few participants (n≤5) reported recent use in 2022; therefore, further details are suppressed (stable from 11% in 2021). A similar percentage was observed for any NPS use, excluding plant-based NPS (n≤5; 10% in 2021). These are the lowest percentages of use since monitoring of NPS first commenced in 2010.

Other Drugs

Almost all participants (94%) reported recent alcohol consumption, of which three-quarters (75%) reported drinking on a weekly or more frequent basis. Tobacco remained common, with 79% reporting recent use and 39% reporting daily use. Fifty-fix per cent reported recent use of non-prescribed e-cigarettes, stable relative to 2021 (50%). Hallucinogenic mushrooms remain commonly but infrequently used among EDRS participants, with 51% reporting recent use with a median of four days of use in the preceding six months. One-quarter (26%) reported recent use of nitrous oxide in 2022, relatively stable from 41% in 2021, and at a median frequency of three days. One-quarter (26%) reported recent use of any substance with unknown contents, stable from 28% in 2021. Thirty-five per cent of participants reported recent use of amyl nitrite, stable from 46% in 2021.

Drug-Related Harms and Other Behaviours

On the last occasion of ecstasy or related drug use, 86% of the sample reported concurrent use of more than one drug (excluding tobacco and e-cigarettes). One-third (34%) reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year. Almost four-fifths (79%) of the sample obtained a score of eight or more on the AUDIT, indicative of hazardous alcohol use. The mean AUDIT score significantly increased from 13.5 in 2021 to 13.6 in 2022. Almost one-quarter (24%) reported a non-fatal stimulant overdose (10% in 2021; *p*=0.052), and 28% reported a non-fatal depressant overdose (including alcohol) in the past year. The per cent reporting recent injecting drug use remained low, as did the number currently in drug treatment (n≤5, respectively). The majority of the sample (79%) reported engaging in any sexual activity in the past four weeks, of which few participants (n≤5) reported penetrative sex without a condom where they did not know the HIV status of their partner (16% in 2021). Three in five participants (63%) self-reported that they had experienced a mental health problem in the preceding six months, the most common problems being anxiety, depression and post-traumatic stress disorder (PTSD) (71%, 69% and 24% of those who reported having experienced a mental health problem in the preceding six months, respectively). One-quarter (27%) of recent drivers reported driving while over the perceived legal limit of alcohol and 40% reported driving within three hours of consuming an illicit or non-prescribed drug. Any criminal activity in the month preceding interview was stable at 39% in 2022 (32% in 2021). Interestingly, two-fifths (42%) of participants reported obtainment of illicit drugs from an unknown dealer/vender, a significant increase compared to 22% in 2021 (*p*=0.011). Almost two-fifths (38%) of the sample reported obtaining illicit drugs through someone who had purchased them on the surface or darknet in the last 12 months, stable compared to 2021. Sixty-one per cent of the sample reported having been diagnosed with COVID-19 (no participants in 2020 and 2021). Eighty-six per cent reported that they had received at least one COVID-19 vaccine dose and the median number of doses received was three. Thirty-six per cent reported some level of concern about contracting COVID-19.

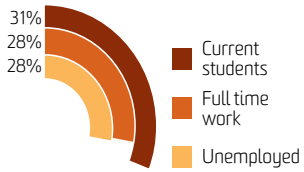
EDRS Ecstasy and Related Drugs Reporting System

2022 SAMPLE CHARACTERISTICS

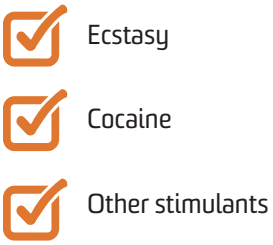
In 2022, 72 participants, recruited from Hobart, TAS were interviewed.

26 years 48%

The median age in 2022 was 26, and 48% identified as male.

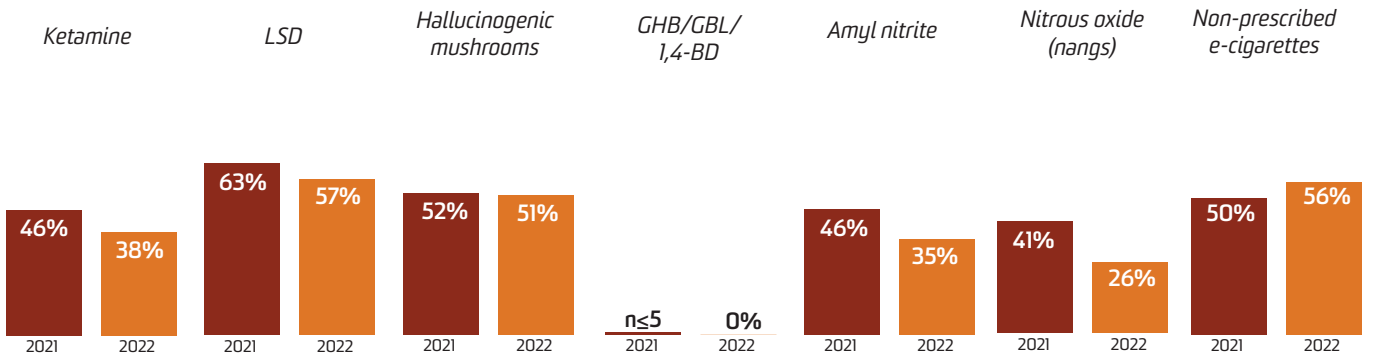


In the 2022 sample, 31% were enrolled students, 28% were employed full time and 28% were unemployed.



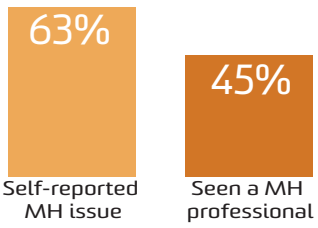
Participants were recruited on the basis that they had consumed ecstasy and/or other illicit stimulants at least monthly in the past 6 months.

PAST 6 MONTH USE OF SELECTED DRUGS

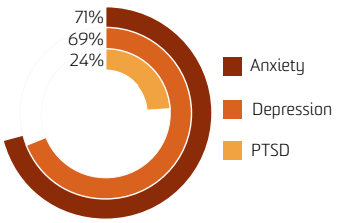


*p<0.050; **p<0.010; ***p<0.001

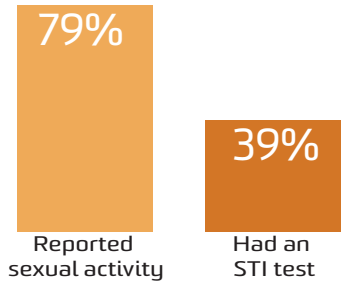
MENTAL HEALTH AND SEXUAL HEALTH BEHAVIOURS



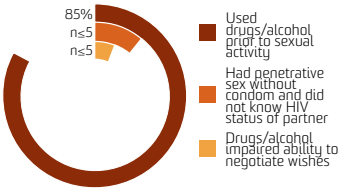
In the total sample, 63% self-reported a mental health issue and 45% had seen a mental health professional in the past 6 months.



Of those who had a mental health condition, the three most common mental health issues reported were anxiety (71%), depression (69%) and PTSD (24%).



In the total sample, 79% reported sexual activity in the past 4 weeks, and 39% had a sexual health check in the past 6 months.

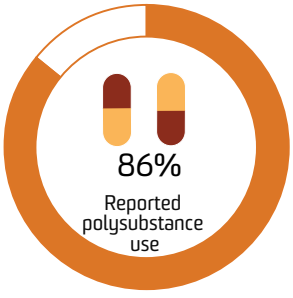


Sexual risk behaviours among those who reported any sexual activity in the past four weeks and were able to comment.

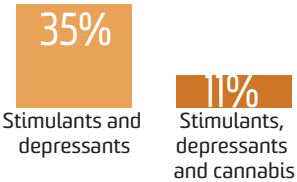
OTHER RISK BEHAVIOURS

Among recent drivers, 40% reported driving a vehicle within 3 hours of consuming illicit drugs and 27% while over the legal limit of alcohol.

In the 2022 sample, 28% reported a non-fatal depressant overdose in the previous 12 months, stable relative to 2021 (16%).

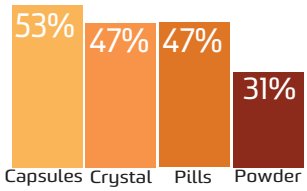


In the total sample, 86% reported concurrent use of two or more substances on the last occasion of ecstasy or related drug use.

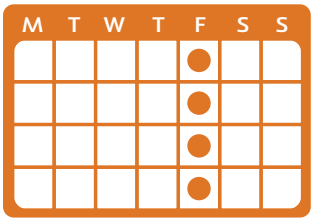


The most commonly used combinations of drug classes on the last occasion of ecstasy or related drug use.

ECSTASY



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



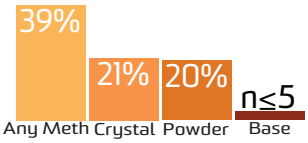
Of those who had recently consumed ecstasy, 12% reported weekly or more frequent use.

2 Capsules
2 Pills
0.20 grams of crystal
0.20 grams of powder

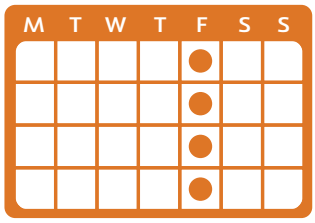
Median amounts of ecstasy consumed in a 'typical' session using each form.

In 2022, more participants perceived the availability of the capsule form as 'difficult' or 'very difficult' relative to 2021.

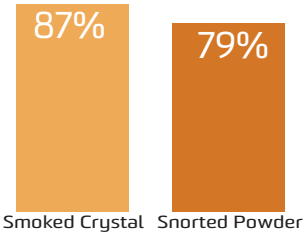
METHAMPHETAMINE



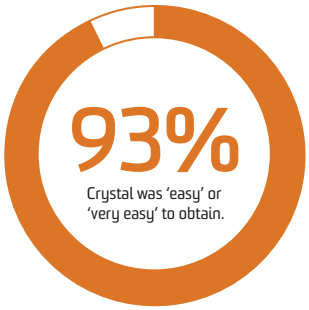
Past 6 month use of any methamphetamine, crystal, powder and base in 2022.



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

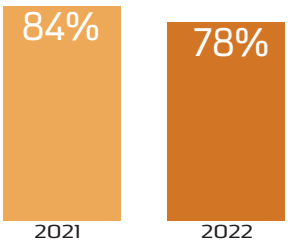


87% of participants who had recently used crystal smoked it. Of those who had recently used powder, 79% snorted it.

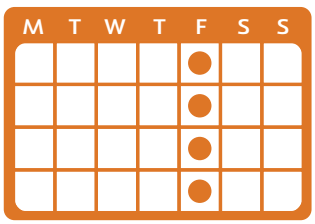


Of those who could comment, 93% perceived crystal methamphetamine to be 'easy' or 'very easy' to obtain.

COCAINE

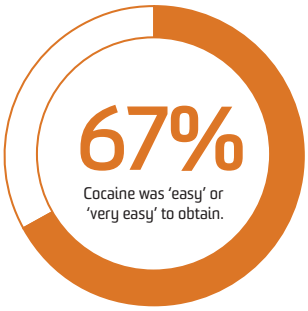


Past 6 month use of any cocaine was stable between 2021 and 2022.



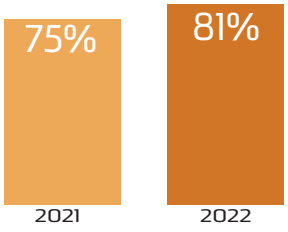
Of those who had recently consumed cocaine, n≤5 reported weekly or more frequent use.

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

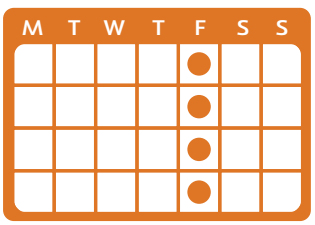


Of those who could comment, 67% perceived cocaine to be 'easy' or 'very easy' to obtain.

CANNABIS AND/OR CANNABINOID RELATED PRODUCTS

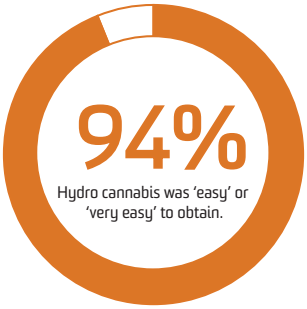


Past 6 month use of non-prescribed cannabis and/or cannabinoid related products remained stable between 2021 and 2022.



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

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



Of those who could comment, 94% 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, mephedrone, non-prescribed pharmaceutical stimulants or other stimulant NPS) at least six times during the preceding six months; and iii) have been a resident of the capital city in which the interview took place for ten of the past 12 months. Interviews took place in varied locations negotiated with participants (e.g., research institutions, coffee shops or parks), and were conducted using REDCap (Research Electronic Data Capture), a software program used to collect data on laptops or tablets. Following provision of written informed consent and completion of a structured interview, participants were reimbursed $40 cash for their time and expenses incurred.

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

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

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

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

Almost all capital cities, including Hobart, TAS, experienced challenges 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 72 participants interviewed in Hobart, TAS between 10th May-13th July, 2022. A total of 43 interviews were conducted via telephone.

Eighteen per cent of the 2022 Hobart sample had completed the interview in 2021, whereas 11% of the 2021 Hobart sample completed the interview in 2020 (p=0.189). There was a significant change in recruitment methods between 2021 and 2022 (p=0.005), with more participants being recruited via the internet (e.g., Facebook and Instagram) (71%; 51% in 2021), and less via word-of-mouth (29%; 42% 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 or changes 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 Hobart, Tasmania, 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 Hobart, Tasmania (see section on 'Additional Outputs' below for details of other outputs providing such profiles).

Differences in the methodology, and the events of 2021-22, must be taken into consideration when comparing 2021-22 data to previous years, and treated with caution.

Additional Outputs

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

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

1

Sample Characteristics

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

Gender remained stable between 2021 and 2022 (p=0.087), with almost half (48%) of the 2022 Hobart sample being male (62% in 2021). The median age of the sample was 26 years (IQR=22-30), stable relative to 2021 (25 years; IQR=22-30; p=0.657).

Accommodation remained stable (p=0.204), with almost half of the 2022 Hobart sample reporting that they lived in a rented house/flat (56%; 49% in 2021), and most of the remaining participants living with their parents/in their family house (17%; 28% in 2021).

Almost one-third (31%) were current students (44% in 2021; p=0.086), and three-fifths (60%) had obtained a post-school qualification(s) in 2022 (69% in 2021; p=0.263).

Employment status remained stable between 2022 and 2021 (p=0.682). Specifically, two-fifths (38%) of the TAS sample reported being employed on a part time/casual basis (43% in 2021), 28% reported being employed full time (29% in 2021) and 28% reported being unemployed at the time of interview (24% in 2021).

Table 1: Demographic characteristics of the sample, nationally, 2022, and Hobart, TAS, 2017-2022

	Hobart, TAS						National
	2017	2018	2019	2020	2021	2022	2022
	N=100	N-=100	N=98	N=100	N=102	N=72	N=774
Median age (years; IQR)	23 (17-39)	25 (17-42)	24 (21-27)	23 (19-28)	25 (22-30)	**26 (22-30)**	25 (21-30)
% Gender							
Female	35	35	38	44	36	**44**	40
Male	65	64	60	54	64	**48**	56
Non-binary	/	/	0	-	-	**8**	4
% Aboriginal and/or Torres Strait Islander	-	-	7	-	9	**-**	5
% Sexual identity							
Heterosexual	85	87	86	78	77	**72**	87
Homosexual	-	-	-	-	-	**-**	0
Bisexual	13	10	10	9	11	**18**	12
Queer	/	/	-	-	6	**7**	0
Different identity	0	0	-	6	-	**-**	1
Mean years of school education (range)	12 (8-12)	12 (8-12)	12 (8-12)	12 (8-12)	12 (7-12)	**11 (7-12)**	12 (6-12)

	Hobart, TAS						National
	2017	2018	2019	2020	2021	2022	2022
% Post-school qualification(s)^	40	57	78	57	69	**60**	61
% Current students#	**34**	**12**	36	48	44	**31**	41
% Current employment status							
Employed full-time	21	13	21	28	29	**28**	35
Part time/casual	27	50	45	34	43	**38**	45
Self-employed	/	/	-	-	-	**7**	0
Unemployed	15	23	29	34	24	**28**	20
Current median weekly income $ (IQR)	(N=98) 300 (214-750)	(N=98) 552 (358-800)	(N=97) 500 (300-800)	(N=100) 700 (406-891)	(N=100) 500 (350-951)	**(N=72) 700 (350-1168)**	(N=700) 700 (450-1200)
% Current accommodation							
Own house/flat	-	-	-	6	15	**15**	12
Rented house/flat	63	54	63	57	49	**56**	60
Parents'/family home	36	40	27	34	28	**17**	24
Boarding house/hostel	-	-	-	-	0	**-**	2
Public housing	/	-	-	-	-	**0**	2
No fixed address+	0	-	-	0	-	**8**	0
Other	-	0	0	0	-	**-**	1

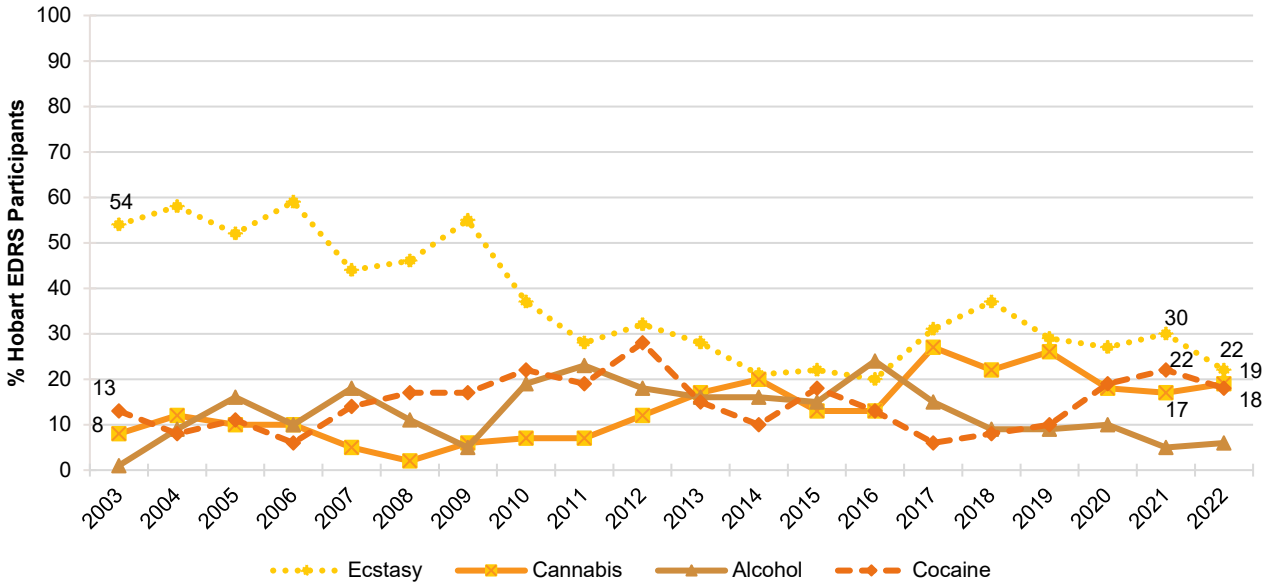
Note. ^Includes trade/technical and university qualifications.# 'students' comprised participants who were currently studying for either trade/technical or university/college qualifications. / not asked. + No fixed address included 'couch surfing and rough sleeping or squatting. - Per cent suppressed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

Drug of choice remained stable in 2022 compared to 2021 (p=0.634), with participants typically reporting that ecstasy (22%) was their drug of choice in 2022 (30% in 2021), followed by cannabis (19%; 17% in 2021) and cocaine (18%; 22% in 2021) (Figure 1).

A significant change was observed in the drug used most often in the past month (p=0.002). Specifically, there was a noticeable increase in the per cent of participants nominating cannabis as the drug used most often in the month preceding interview (38%; 29% in 2021) and an increase in the per cent of participants nominating cocaine as the drug used most often (19%; 9% in 2021). There was a decrease in the per cent reporting ecstasy as the drug used most often in the preceding month (10%; 22% in 2021). A decrease was also observed in those who reported alcohol as the drug used most often in the month preceding interview (10%; 27 in 2021) (Figure 2).

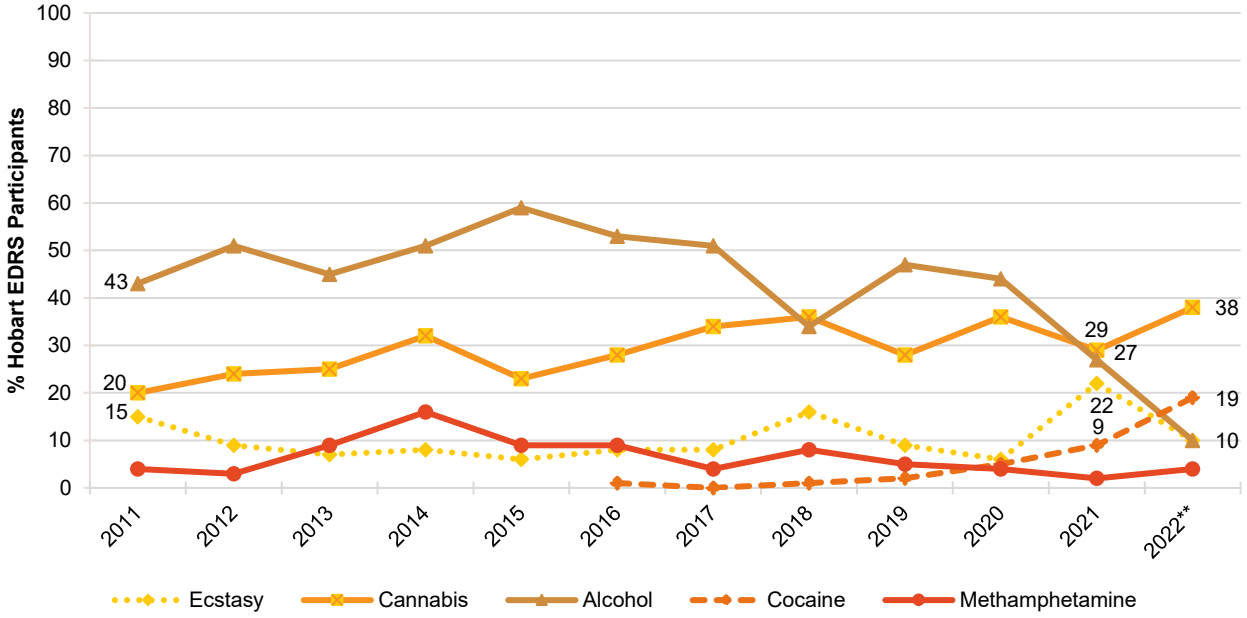
Fifty-four per cent of the Hobart sample reported weekly or more frequent cannabis use (48% in 2021; p=0.437) and one-tenth (11%) reported weekly or more frequent ecstasy use (20% in 2021; p=0.210) (Figure 3).

Figure 1: Drug of choice, Hobart, TAS, 2003-2022



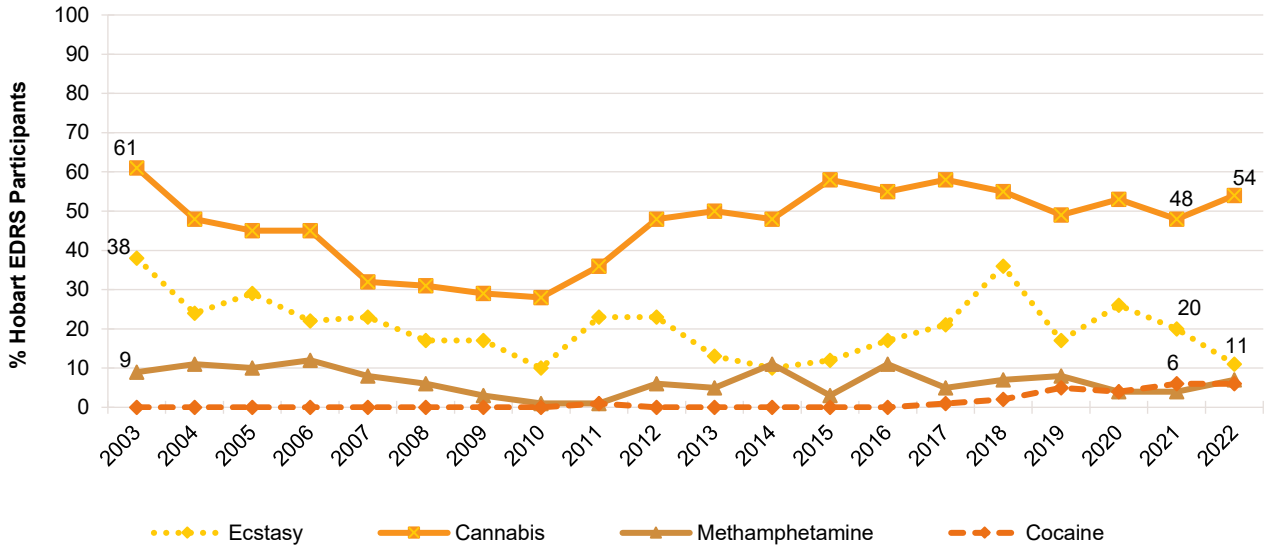
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed 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, Hobart, TAS, 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, Hobart, TAS, 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) 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.

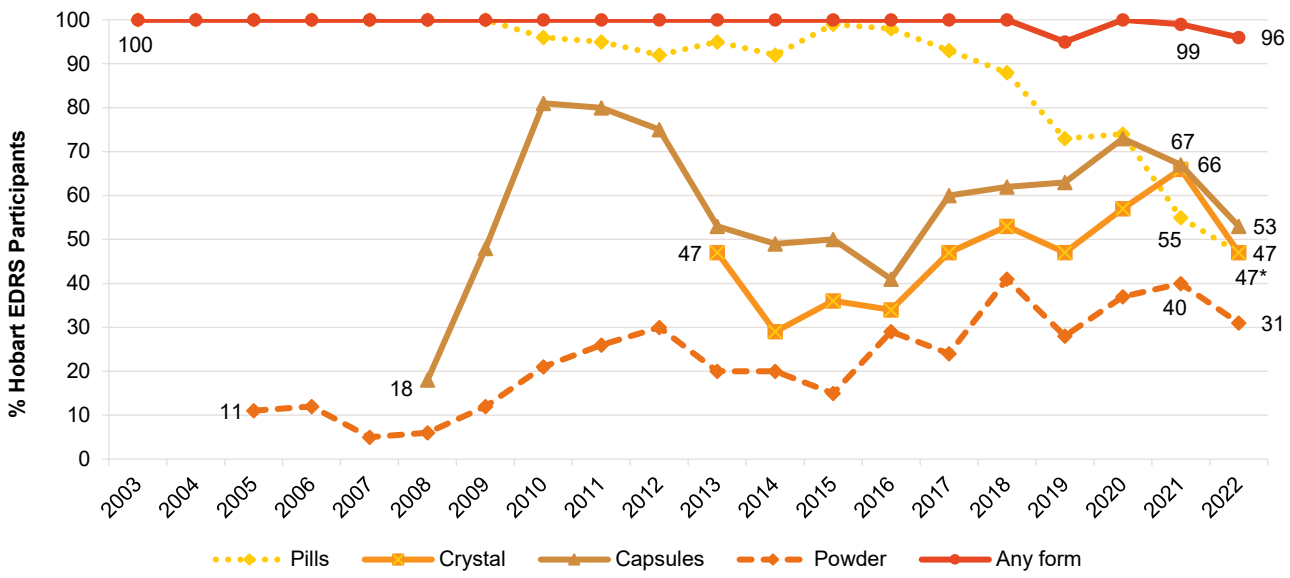
Recent Use (past 6 months)

In 2022, nearly all participants (96%) reported use of any ecstasy in the past six months, consistent with 2021 (99%; *p*=0.308) and previous years of reporting. Participants are primarily recruited on the basis of their recent ecstasy use, and as such the proportion of participants reporting that they had recently used any form of ecstasy had remained stable in 2022. However, significant declines in the proportions using each form of ecstasy (pills, powder, capsules and crystal) was apparent (Figure 4).

Frequency of Use

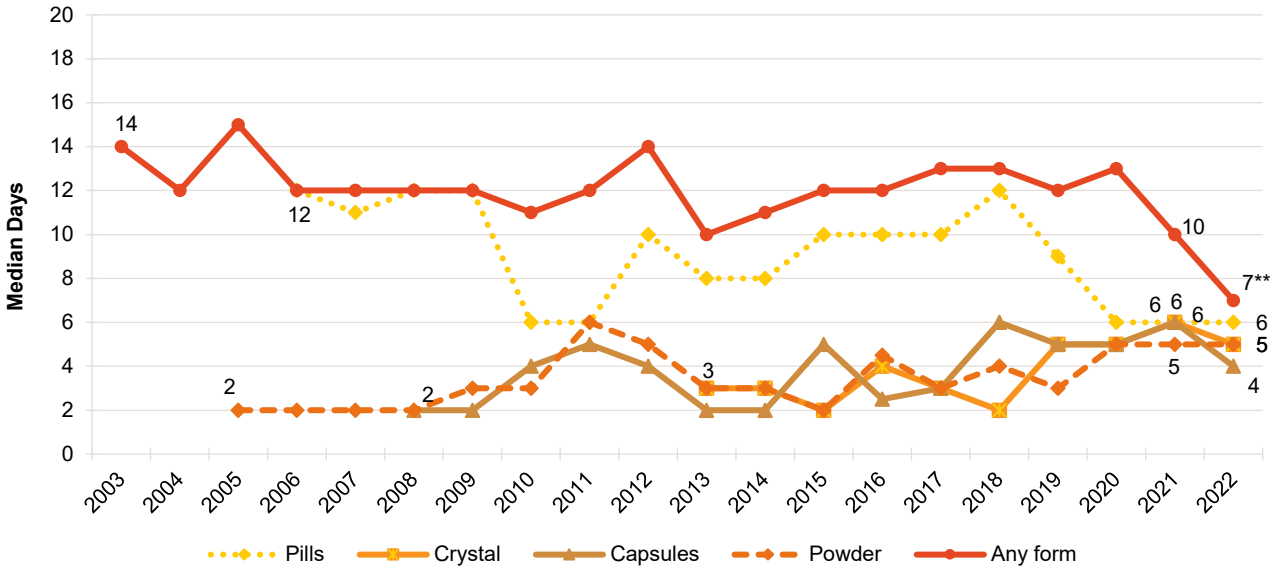
Frequency of use of any ecstasy had been relatively stable since monitoring began, however since 2020, there has been a significant decline in the median days of use. Among those that reported recent use of any ecstasy and commented (n=67), participants reported using ecstasy (in any form) on a median of seven days (IQR=4-12) in 2022, equivalent to monthly use in the preceding six months. This was a significant decline from 10 days in 2021 (IQR=6-19; *p*=0.002) (Figure 5). Weekly or more frequent use of any form of ecstasy remained stable relative to 2021 (12%; 20% in 2021; *p*=0.212).

Figure 4: Past six month use of any ecstasy, and ecstasy pills, powder, capsules, and crystal, Hobart, TAS, 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, Hobart, TAS, 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): Whilst the per cent reporting recent use of ecstasy pills remained stable in 2022 at 47% (55% in 2021; *p*=0.359), use has declined considerably since 2016 (88%) (Figure 4).

Frequency of Use: Among those that reported recent use and commented (n=34), ecstasy pills were used on a median of six days (IQR=2-12) in the six months preceding interview in 2022, stable from 2021 (6 days; IQR=3-12; *p*=0.442) (Figure 4). Few participants (n≤5) who had recently consumed ecstasy pills reported weekly or more frequent use in 2022, therefore, these data are suppressed (16% in 2021; *p*=0.759).

Routes of Administration: Among participants who had recently consumed ecstasy pills and commented (n=34), the most common route of administration in 2022 was swallowing (94%; 98% in 2021; *p*=0.554). One-quarter (26%) of respondents reported snorting ecstasy pills, which was a significant decrease from 50% in 2021 (*p*=0.049). Few participants (n≤5) reported recent smoking (n≤5 in 2021).

Quantity: Of those who reported recent use and responded (n=33), the median number of pills used in a 'typical' session was two (IQR=1-2; 2 pills in 2021; IQR=1-3; *p*=0.430). Of those who reported recent use and responded (n=33), the median maximum number of pills used was two (IQR=1-4), which was a significant decrease from three pills in 2021 (IQR=2-5; *p*=0.045).

Ecstasy Capsules

Recent Use (past 6 months): Over half (53%) of the sample reported recent use of ecstasy capsules, stable relative to 2021 (67%; *p*=0.086) (Figure 4).

Frequency of Use: Among those who reported recent use and commented (n=37), participants reported consuming capsules on a median of four days in 2022 (IQR=3-8), stable from 2021 (6 days; IQR=3-10; *p*=0.597) (Figure 8). Few participants (n≤5) who had recently consumed ecstasy capsules reported weekly or more frequent use in 2022, therefore, these data are suppressed (9% in 2021; *p*=0.710).

Routes of Administration: Among participants who had recently consumed ecstasy capsules and commented (n=38), the most common route of administration in 2022 was swallowing (92%; 99% in 2021; *p*=0.130), followed by snorting (16%), which was a significant decrease relative to 2021 (38%; *p*=0.030). No participants reported recent shelving/shafting and smoking in 2022 (n≤5 in 2021).

Quantity: Of those who reported recent use and responded (n=37), the median number of capsules used in a 'typical' session was two (IQR=1-2; 2 capsules in 2021; IQR=1-2; *p*=0.798). Of those who reported recent use and responded (n=36), the median maximum number of capsules used was two (IQR=1-3; 2 capsules in 2021; IQR=2-5; *p*=0.310).

Contents of Capsules: Of those who reported recent use and responded (n=34), two-thirds (68%) reported that their last capsule contained crystal (64% in 2021), whilst 50% reported that it contained powder (44% in 2021). Few participants (n≤5) did not look at the contents the last time they had used capsules.

Ecstasy Crystal

Recent Use (past 6 months): Almost half (47%) of the Hobart sample reported recent use of ecstasy crystal in 2022, a significant decrease from 66% in 2021 (*p*=0.022) (Figure 4).

Frequency of Use: Among those that reported recent use and commented (n=33) participants reported using crystal on a median of five days (IQR=2-10) in 2022, stable from six days in 2021 (IQR=3-10; *p*=0.270) (Figure 5). Few participants (n≤5) who had recently consumed crystal reported weekly or more frequent use in 2022; therefore, these data are suppressed (n≤5 in 2021).

Routes of Administration: Among participants who had recently consumed ecstasy crystal and commented (n=34), the majority (82%) reported swallowing (96% in 2021; *p*=0.058), while half (50%) reported snorting (55% in 2021; *p*=0.677).

Quantity: Of those who reported recent use and responded (n=23), the median amount of crystal used in a 'typical' session was 0.20 grams (IQR=0.10-0.50; 0.20 grams in 2021; IQR=0.10-0.30; *p*=0.661). Of those who reported recent use and responded (n=23), the median maximum amount of crystal used was 0.30 grams (IQR=0.10-1.00; 0.30 grams in 2021; IQR=0.20-0.50; *p*=0.846).

Ecstasy Powder

Recent Use (past 6 months): Recent use of powder remained stable in 2022 (31%; 40% in 2021; *p*=0.207) (Figure 4).

Frequency of Use: Among those that reported recent use and commented (n=22), participants reported consuming powder on a median of five days (IQR=2-12) in 2022. This remained stable from five days in 2021 (IQR=2-10; *p*=0.685) (Figure 5). Few participants (n≤5) who had recently consumed powder reported weekly or more frequent use in 2022; therefore, these data are suppressed (n≤5 in 2021; *p*=0.413).

Routes of Administration: Among participants who had recently consumed ecstasy powder and commented (n=22), 73% reported snorting (76% in 2021), with 45% reporting swallowing (63% in 2021; *p*=0.194).

Quantity: Of those who reported recent use and responded (n=16), the median amount of powder used in a 'typical' session was 0.20 grams (IQR=0.20-50; 0.30 grams in 2021; IQR=0.20-0.50; *p*=0.612). Of those who reported recent use and responded (n=17), the median maximum amount of powder used was 0.20 grams (IQR=0.20-1.00; 0.50 grams in 2021; IQR=0.30-1.00; *p*=0.066).

Price, Perceived Purity and Perceived Availability

Ecstasy Pills

Price: The median price of a pill remained stable, recorded as $25 in 2022 (IQR=25-30; n=19) and $25 in 2021 (IQR=25-30; n=34; *p*=0.962) (Figure 6).

Perceived Purity: The perceived purity of ecstasy pills remained stable between 2021 and 2022 (*p*=0.510). Among those who responded in 2022 (n=38), two-thirds (42%) reported purity as 'fluctuates' (30% in 2021), and equal percentages (26%, respectively) reported purity as being 'low' (25% in 2021), or 'medium' (32% in 2021) (Figure 8).

Perceived Availability: The perceived availability of ecstasy pills remained stable between 2021 and 2022 (*p*=0.278). Among those who were able to comment in 2022 (n=39), 46% reported that pills were 'difficult' to obtain (33% in 2021), 21% reported pills as being 'easy' to obtain (38% in 2021) and a further 21% reported pills as being 'very easy' to obtain (19% in 2021) (Figure 12).

Ecstasy Capsules

Price: The reported median price of an ecstasy capsule was $26 in 2022 (IQR=24-30; n=19), consistent with the reported median price of $25 in 2021 (IQR=25-25; n=48; *p*=0.142) (Figure 6).

Perceived Purity: The perceived purity of ecstasy capsules was stable between 2021 and 2022 (*p*=0.378). Among those who were able to comment in 2022 (n=39), one-third (33%) perceived purity to be 'medium' (46% in 2021), and 31% perceived purity to be 'low' (19% in 2021) (Figure 9).

Perceived Availability: The perceived availability of ecstasy capsules significantly changed between 2021 and 2022 (*p*=0.006). Among those who responded in 2022 (n=39), almost half (49%) reported that capsules were 'difficult' to obtain, an increase from 20% in 2021, whereas one-third (33%) reported that capsules were 'easy' to obtain, a decrease from 58% in 2021 (Figure 13).

Ecstasy Crystal

Price: The median price of a gram of crystal remained stable in 2022 at $255 (IQR=218-283; n=20; $250 in 2021; IQR=215-250; n=31; *p*=0.267) (Figure 10). Few participants (n≤5) reported purchasing a point of crystal in 2022, therefore, these data are suppressed ($35 in 2021; IQR=35-53; n=8; *p*=0.599).

Perceived Purity: The perceived purity of ecstasy crystal remained stable between 2021 and 2022 (p=0.635). Among those who responded in 2022 (n=35), two-fifths (40%) perceived the purity of crystal to be 'medium' (37% in 2021) and 29% perceived purity to be 'high' (37% in 2021) (Figure 10).

Perceived Availability: The perceived availability of ecstasy crystal remained stable between 2021 and 2022 (p=0.197). Specifically, among those who were able to comment in 2022 (n=36), almost two-fifths (39%) reported crystal as being 'difficult' to obtain (26% in 2021). One-third (33%) reported crystal as being 'easy' to obtain (44% in 2021) (Figure 14).

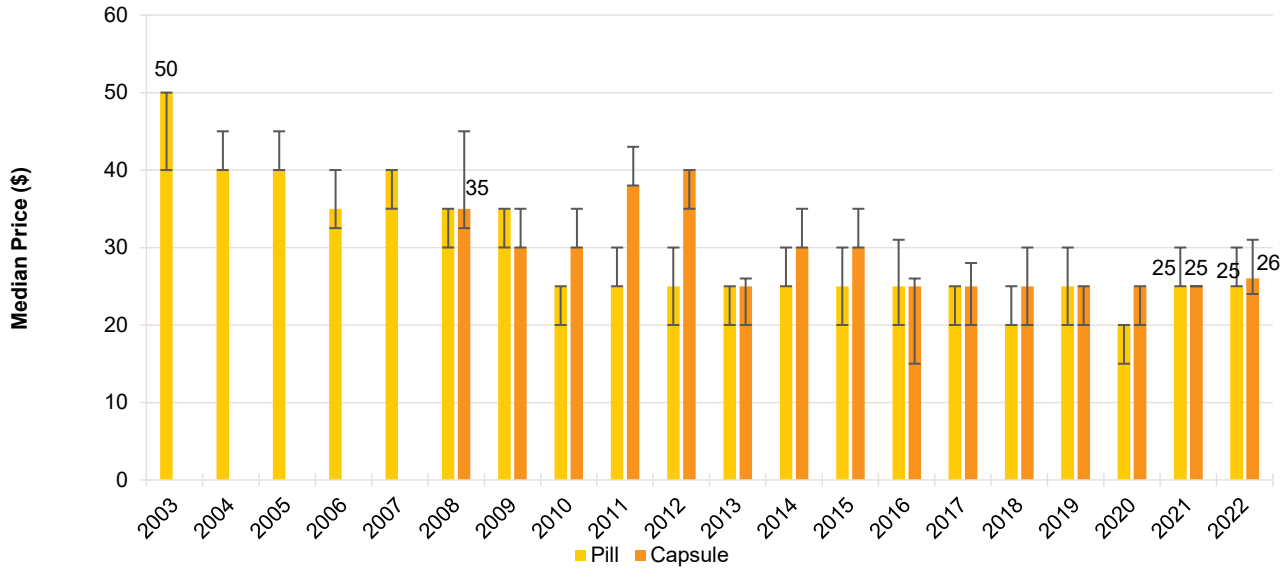
Ecstasy Powder

Price: The median price of a gram of powder significantly increased in 2022 to $250 (IQR=243-250; n=6), from a median price of $200 in 2021 (IQR=165-220; n=12; p=0.012) (Figure 7).

Perceived Purity: The perceived purity of ecstasy powder remained stable between 2021 and 2022 (p=0.895). Among those who responded in 2022 (n=11), few participants (n≤5) reported the purity of powder as 'high' or 'low'; therefore, these data are suppressed (Figure 11).

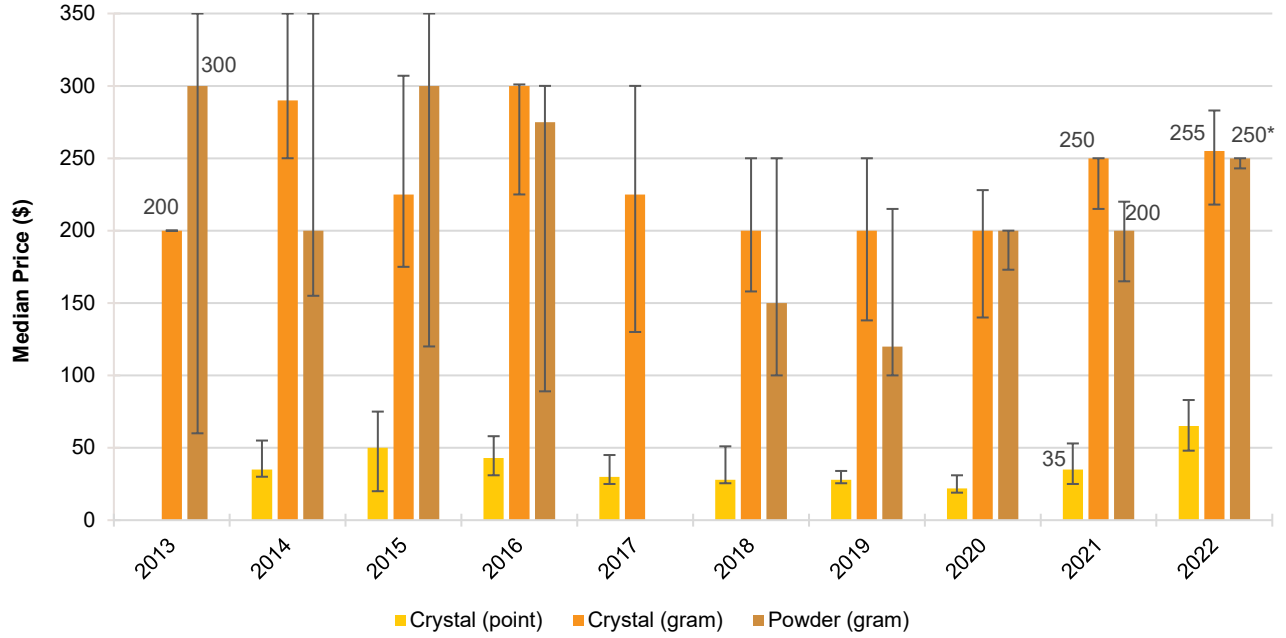
Perceived Availability: The perceived availability of ecstasy powder remained stable between 2021 and 2022 (p=0.780). Among those who responded in 2021 (n=12), few participants (n≤5) reported perceived availability of powder as 'easy' or 'difficult' to obtain, therefore, these data are suppressed (Figure 15).

Figure 6: Median price of ecstasy pill and capsule, Hobart, TAS, 2003-2022



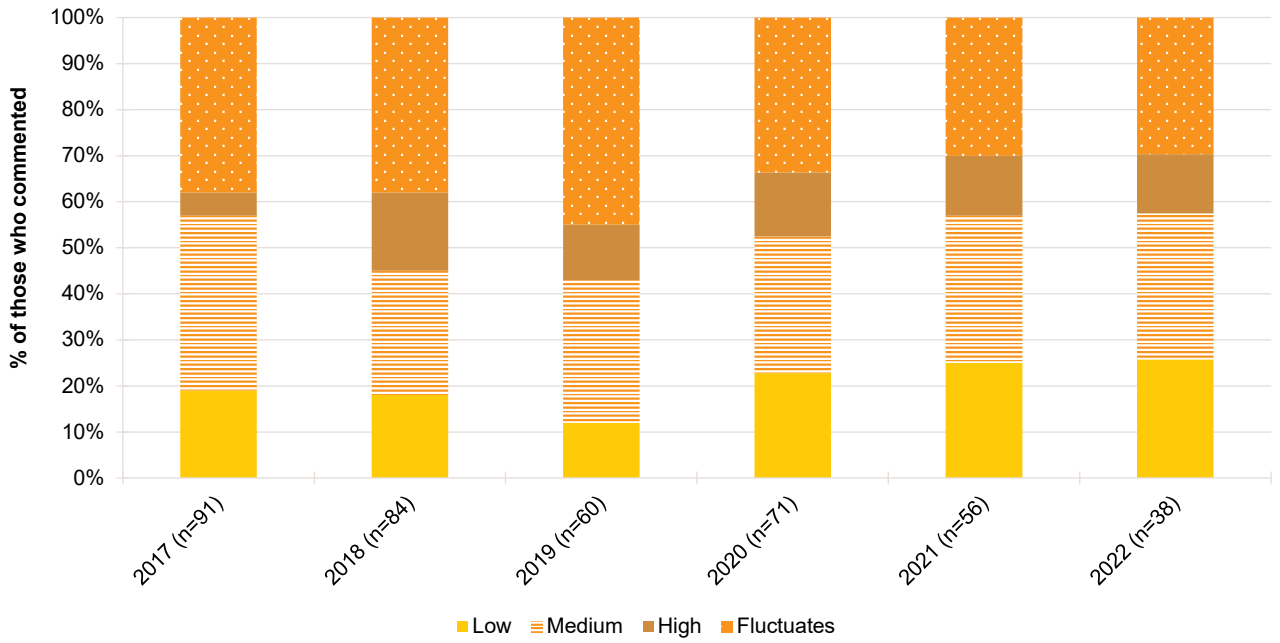
Note. Among those who commented. Data collection for price of ecstasy capsules started in 2008. Data labels are only provided for the first (2003/2008) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response 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) and powder (per gram only), Hobart, TAS, 2013-2022



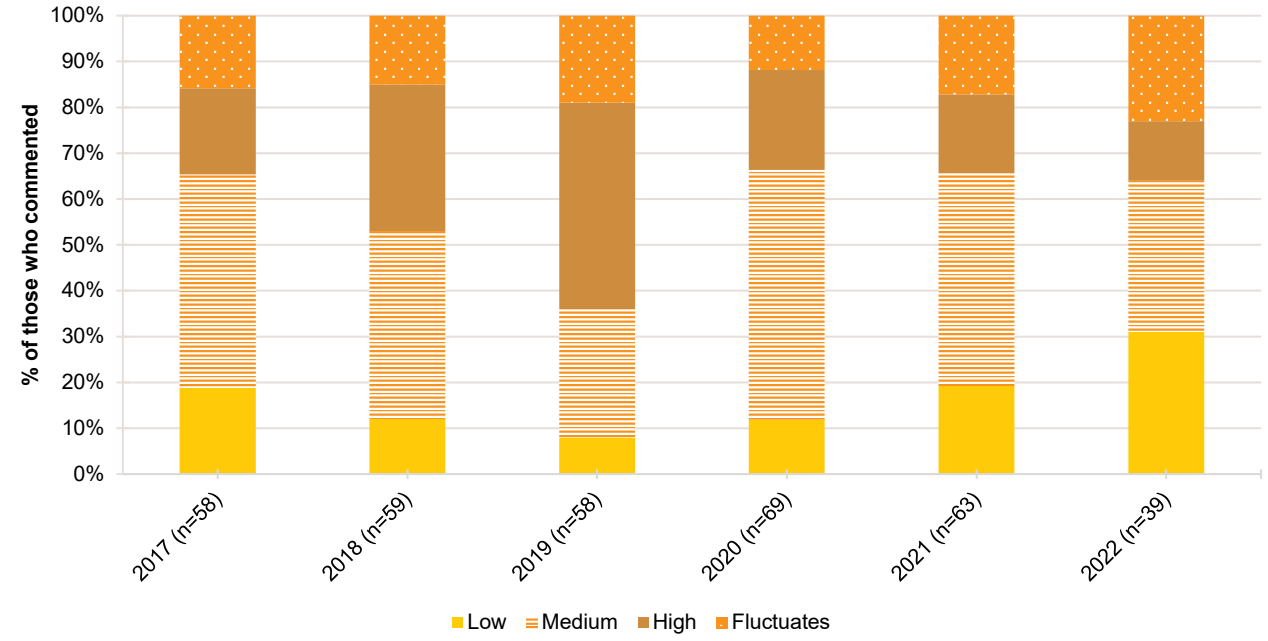
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) and ecstasy powder (gram) started in 2013. No participants reported price data for a 'point' of ecstasy crystal in 2021. Data labels are only provided for the first (2013) and two most recent years (2021 and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

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



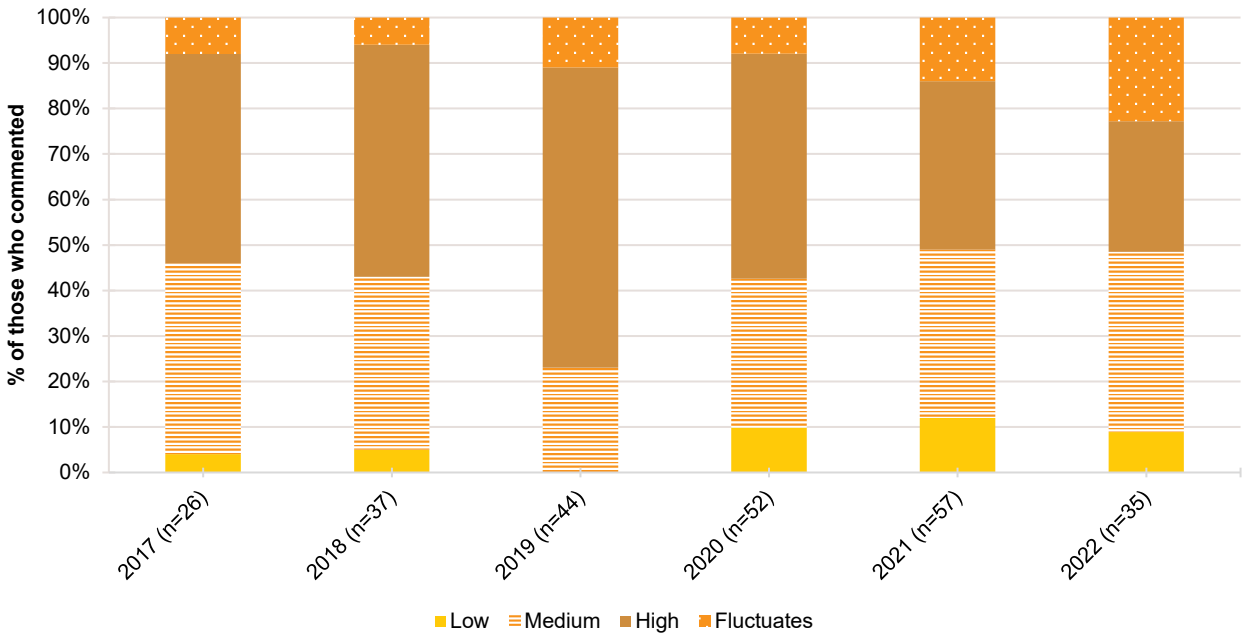
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



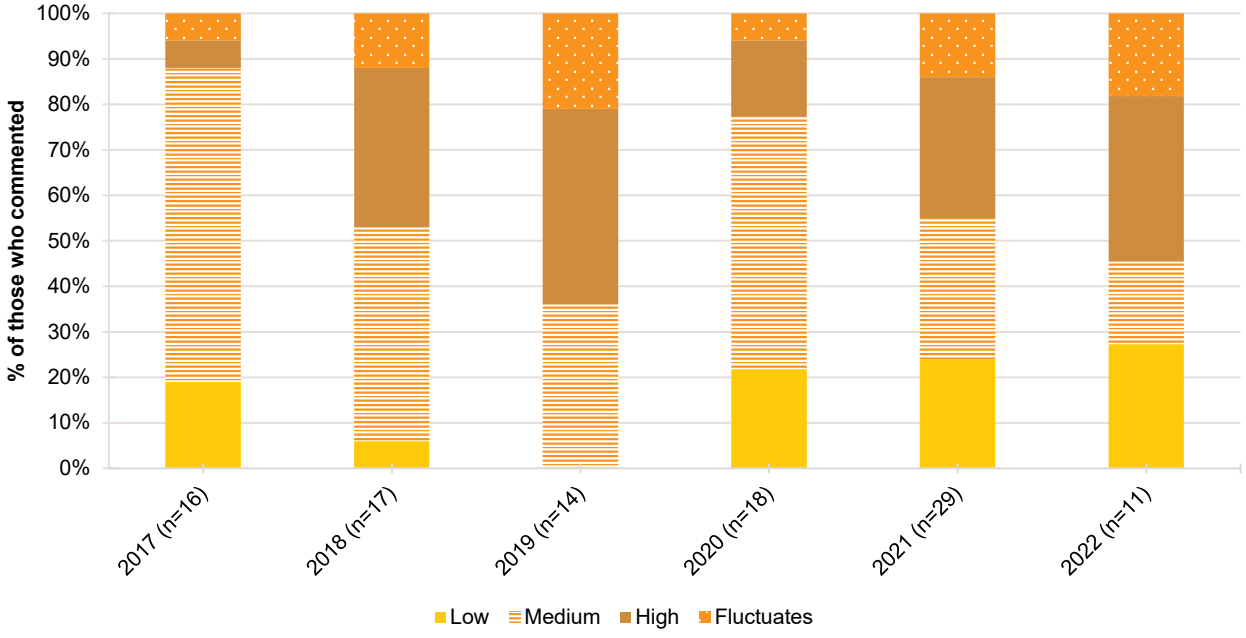
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



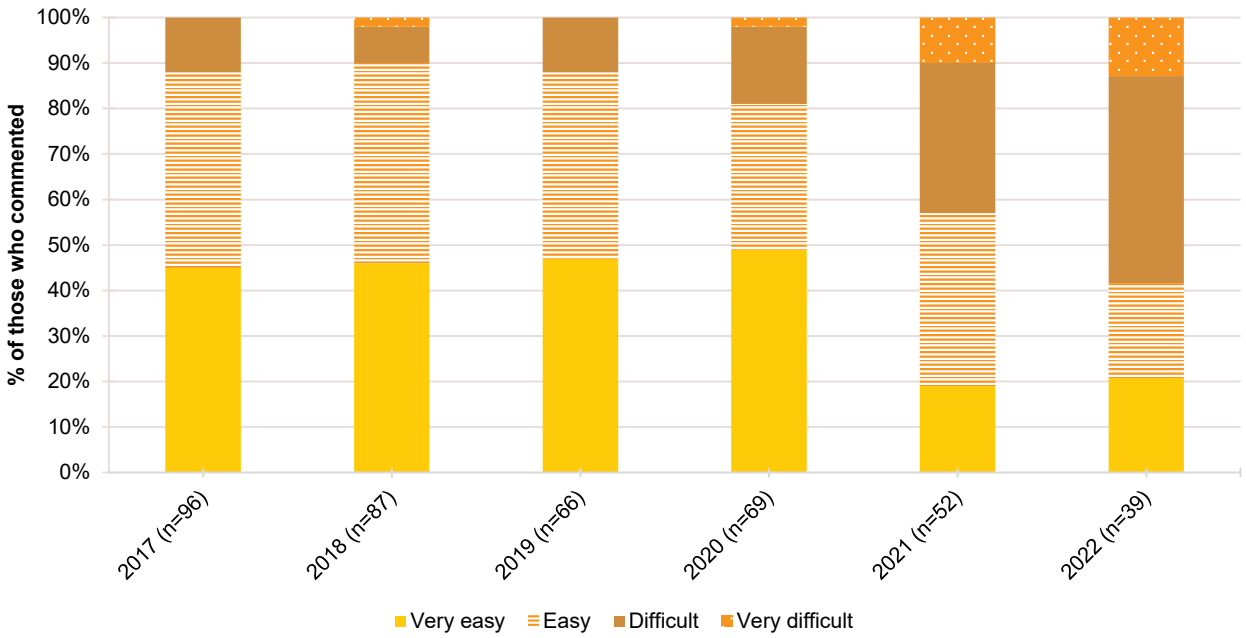
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



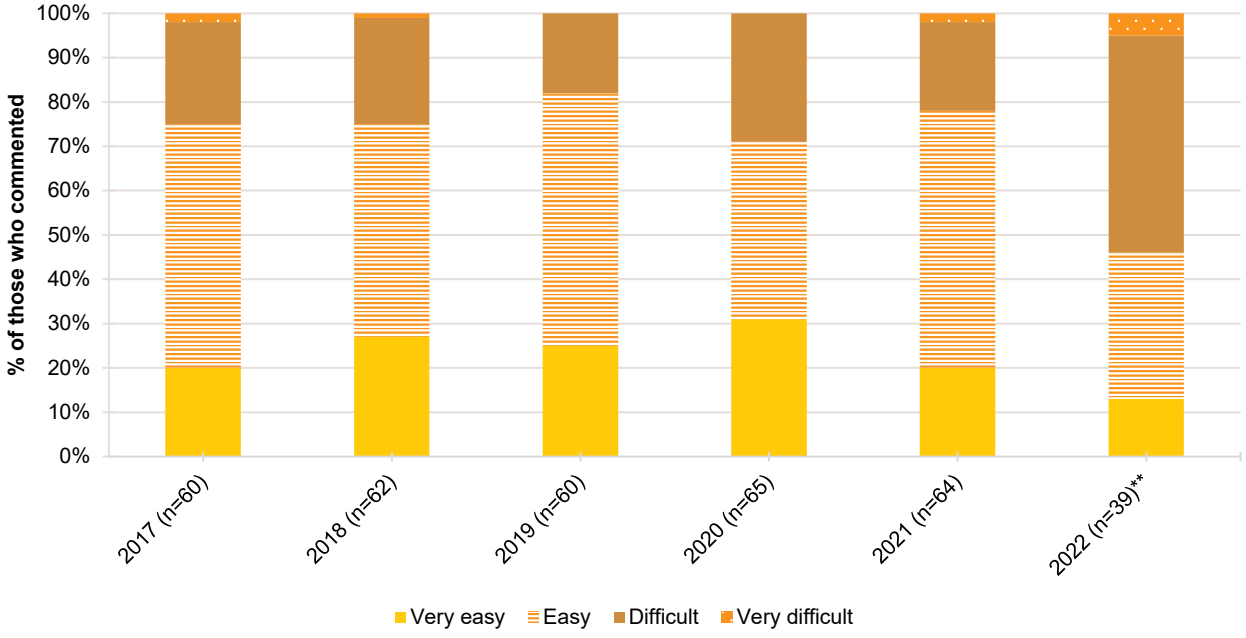
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



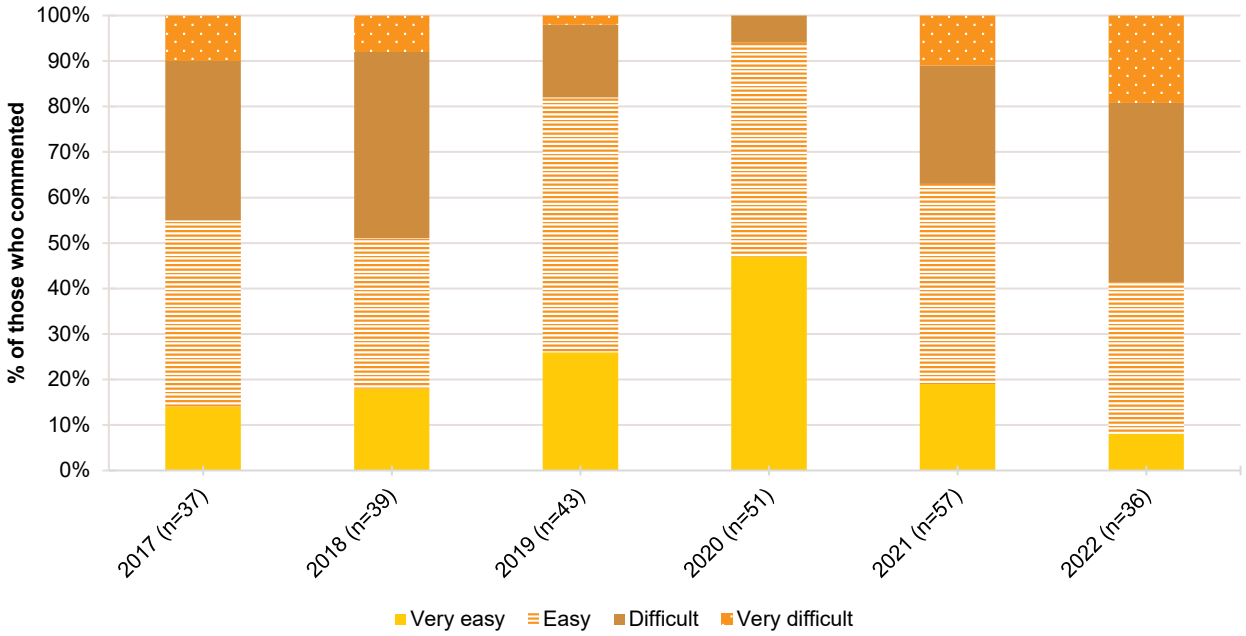
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



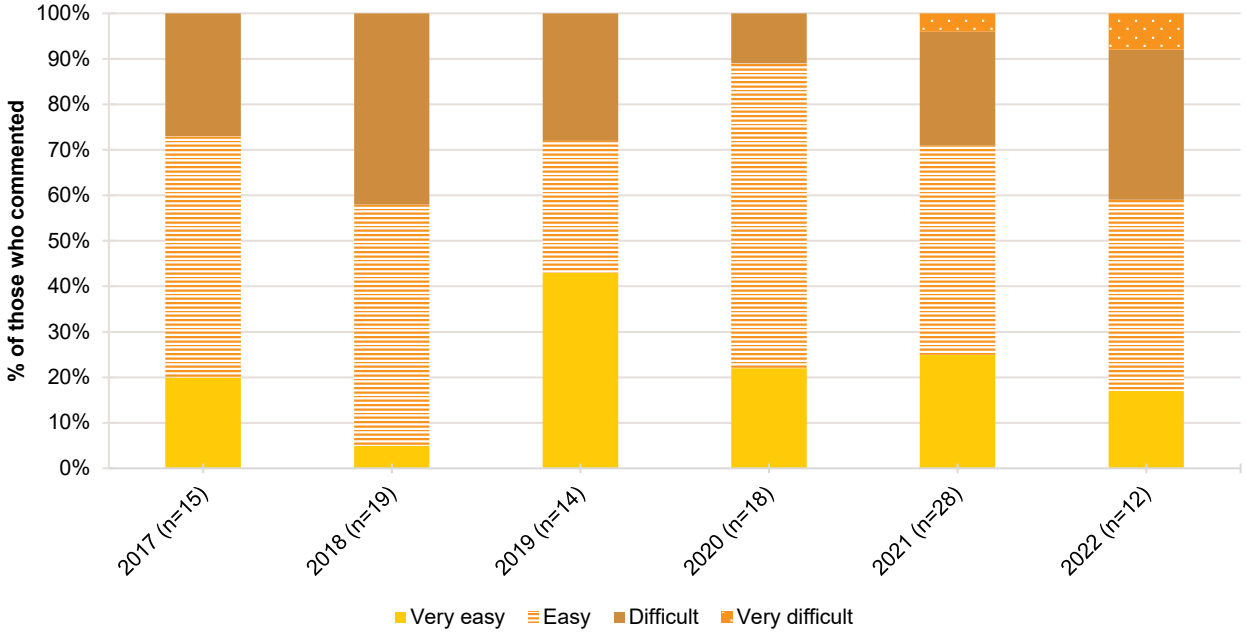
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 14: Current perceived availability of ecstasy crystal, Hobart, TAS, 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 suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 15: Current perceived availability of ecstasy powder, Hobart, TAS, 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 suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

3

Methamphetamine

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

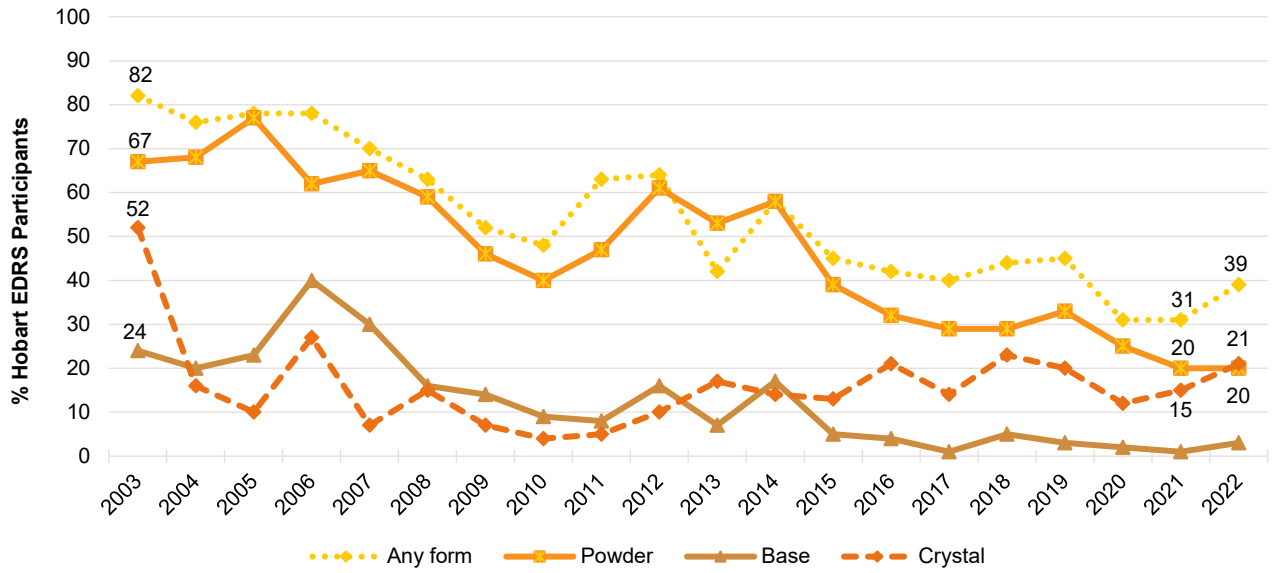
Recent Use (past 6 months)

Recent use of any methamphetamine has been in general decline since monitoring commenced (Figure 11), from more than eight –in ten participants in 2003 (82%) to almost four –in ten participants (39%) in 2022. The per cent reporting recent use of any methamphetamine remained stable in 2022 (39%) compared to 2021 (31%; *p*=0.259).

Frequency of Use

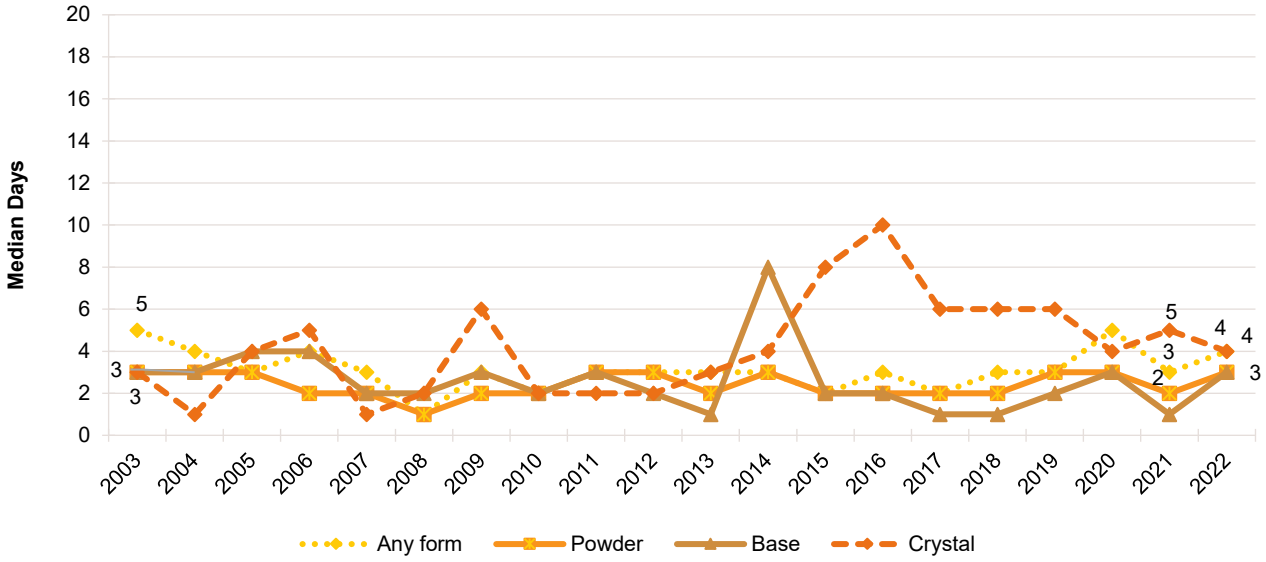
Frequency of use remained stable in 2022 at median of four days (IQR=2-14; 3 days in 2021; IQR=2-11; *p*=0.525) (Figure 17). Among those that reported recent use, few (n≤5) participants reported using methamphetamine weekly or more frequently in 2022 (n≤5 in 2021; *p*=0.723).

Figure 16: Past six month use of any methamphetamine, powder, base, and crystal, Hobart, TAS, 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 17: Median days of any methamphetamine, powder, base, and crystal use in the past six months, Hobart, TAS, 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). 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 use has decreased over the period of monitoring. In 2022, 20% of participants reported recent use, stable from 20% in 2021 (Figure 16).

Frequency of Use: Median days of use in the past six months was three days in 2022 (IQR=1-7) consistent with two days in 2021 (IQR=1-3; *p*=0.442) (Figure 17). Few participants (n≤5) reported weekly or more use of methamphetamine powder in 2021 and 2022; therefore, these data are suppressed.

Routes of Administration: Of those who were able to comment in 2022 (n=14), the main route of administration among participants that reported recent use was snorting (79%; 70% in 2021; *p*=0.704) and swallowing (43%; 55% in 2021; *p*=0.734).

Quantity: Of those who reported recent use and responded (n=10), the median amount used in a 'typical' session was 0.20 grams (IQR=0.10-0.40), stable from 0.10 grams reported in 2021 (IQR=0.10-0.50; n=12, *p*=0.702). The median maximum amount used was 0.20 grams (IQR=0.10-1.00; n=10; 0.20 grams in 2021; IQR=0.10-0.60; n=12, *p*=0.614).

Methamphetamine Crystal

Recent Use (past 6 months): One-fifth (21%) of the Hobart sample reported recent use of crystal, stable from 15% in 2021 (*p*=0.318) (Figure 16).

Frequency of Use: Of those who had recently consumed crystal and commented (n=15), frequency of use was reported on a median of four days (IQR=3-27) in 2022, stable relative to five days (IQR=3-12) in 2021 (*p*=0.868) (Figure 17). Among those that reported recent use of crystal methamphetamine, few participants (n≤5) reported weekly or greater use of crystal in 2021 and 2022; therefore, these data are suppressed.

Methamphetamine Crystal Cont.

Routes of Administration: Among participants who had recently consumed methamphetamine crystal and commented (n=15), smoking remained the most common route of administration, with 87% reporting this method in 2022, stable from 80% in 2021.

Quantity: Of those who reported recent use and responded (n=14), the median amount of crystal used in a 'typical' session was 0.20 grams (IQR=0.10-0.40; 0.10 grams in 2021; IQR=0.10-0.40; n=10; *p*=0.961). Of those who reported recent use and responded (n=14) the median maximum amount of crystal used was 0.40 grams (IQR=0.20-0.60; 0.30 grams in 2021; IQR=0.20-1.00; *p*=0.961).

Methamphetamine Base

Few (n≤5) participants reported recent use of methamphetamine base, and therefore, further details are not reported. For historical overview, please refer to Figure 11 and Figure 12. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Price: Few participants (n≤5) could report on the price of powder per point and per gram in 2021 and 2022; therefore, these data are suppressed (Figure 18).

Perceived Purity: The perceived purity of methamphetamine powder remained stable between 2021 and 2022. Few participants (n≤5) reported on the perceived purity of powder as being 'medium' or 'fluctuates' in 2021 and 2022; therefore, these data are suppressed. Please refer to Figure 20 for a historical overview.

Perceived Availability: The perceived available of powder remained stable between 2021 and 2022 (p=0.386). Among those who responded in 2022 (n=12), half (50%) reported that powder was 'easy' to obtain. Few participants (n≤5) reported perceived availability of powder as 'very easy' or 'very difficult' to obtain in 2021 and 2022; therefore, further details area suppressed (Figure 22).

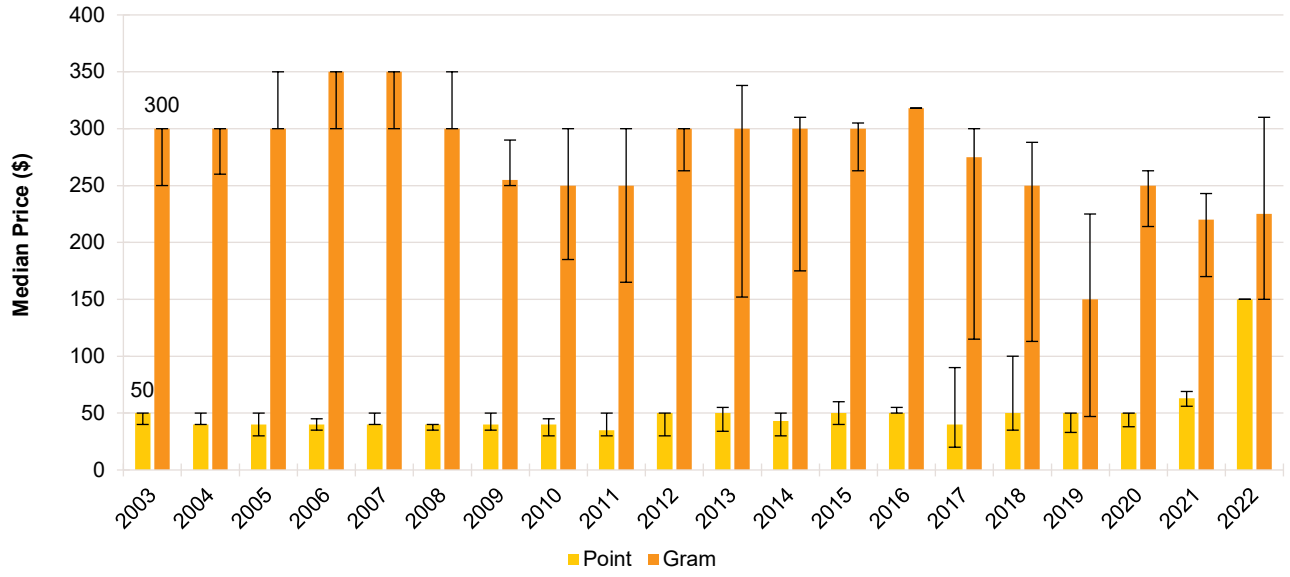
Methamphetamine Crystal

Price: Participants reported a median price of $100 per point (IQR=70-100; n=9; $70 in 2021; IQR=50-100; n=9; p=0.197) (Figure 19).

Perceived Purity: The perceived purity of methamphetamine crystal remained stable between 2021 and 2022 (p=0.223). Among those who were able to comment in 2022 (n=13), the greatest per cent reported purity to be 'high' (54%; 64% in 2021). Few participants (n≤5) reported purity to 'fluctuate' or be 'medium' in 2021 and 2022, data are suppressed (Figure 21).

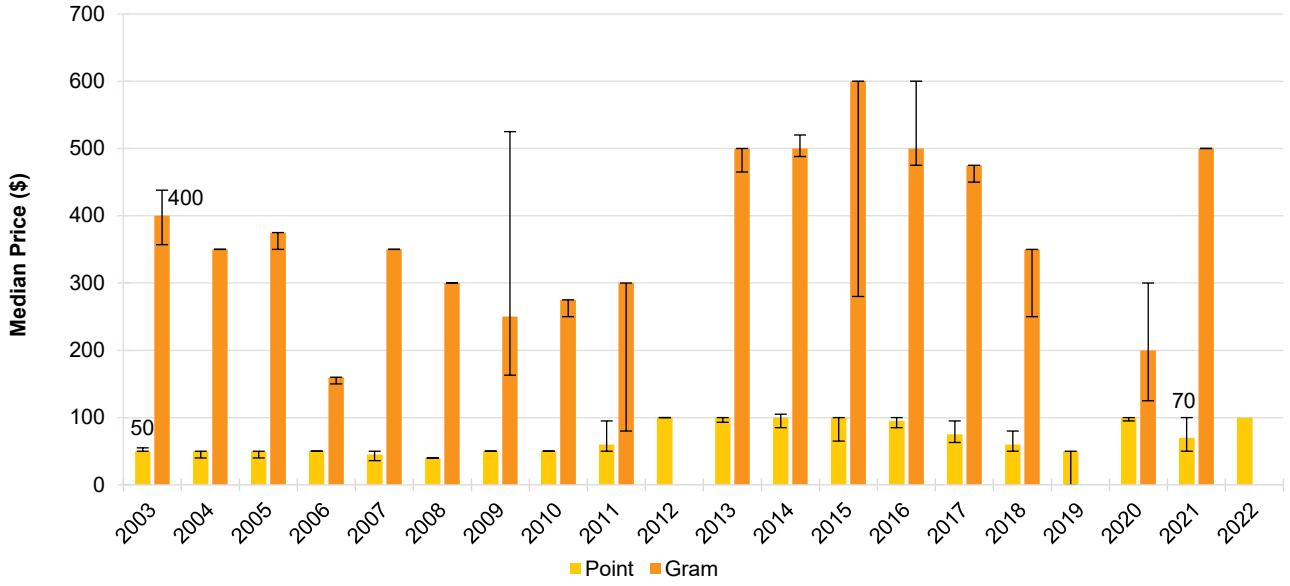
Perceived Availability: The perceived availability of crystal methamphetamine remained stable between 2021 and 2022 (p=0.111). Among those who were able to respond in 2022 (n=14), 64% reported availability as 'very easy' (n≤5 in 2021) (Figure 23).

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



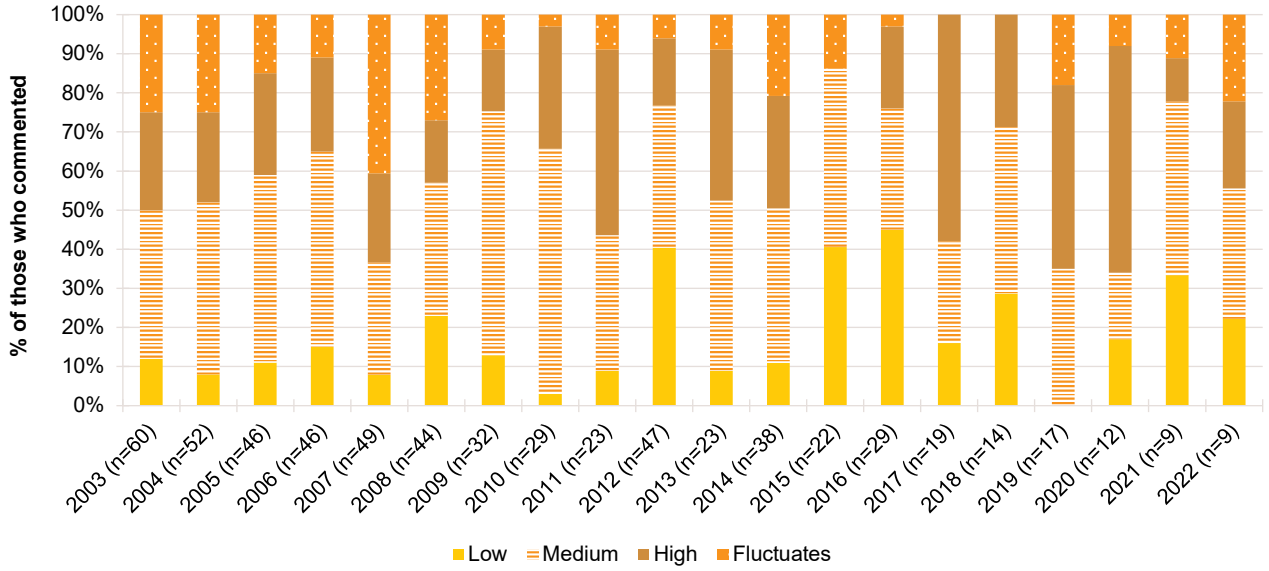
Note. Among those who commented.. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical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

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



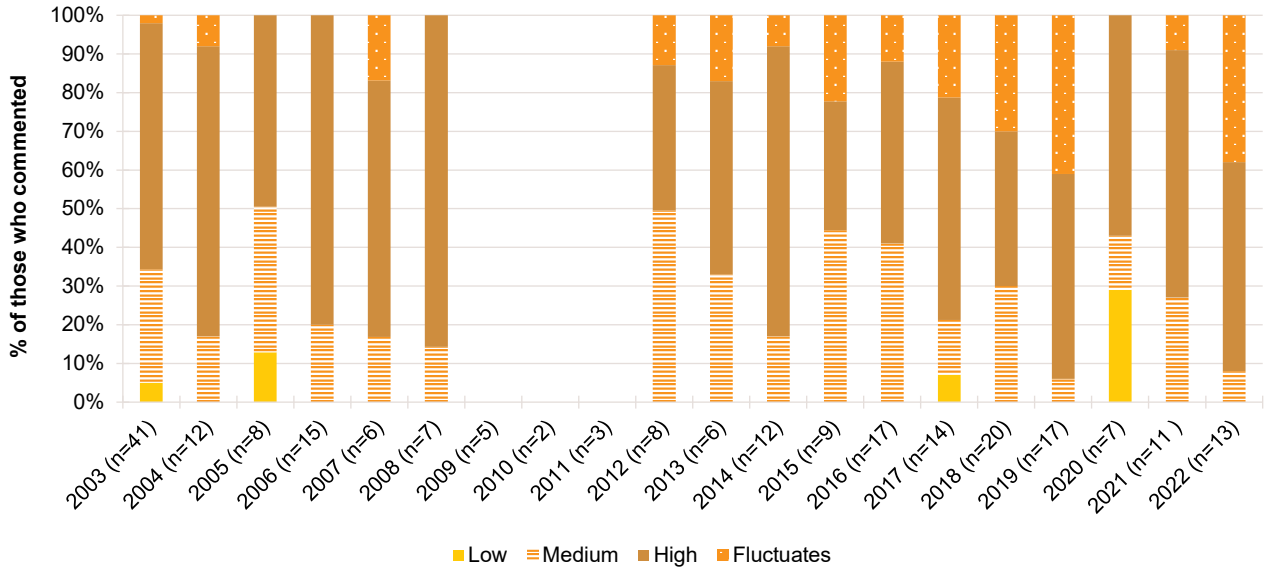
Note. Among those who commented. No participants reported purchasing a gram of crystal methamphetamine in 2011, 2019, and 2022. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., 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: Current perceived purity of powder methamphetamine, Hobart, TAS, 2003-2022



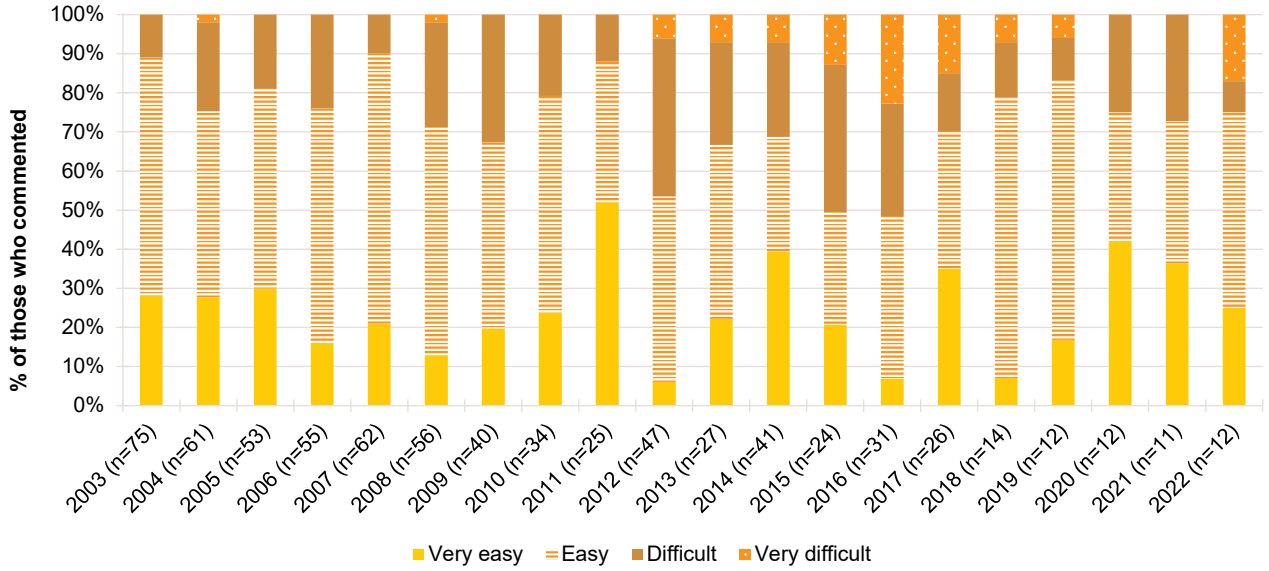
Note. The response 'Don't know' was excluded from analysis. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



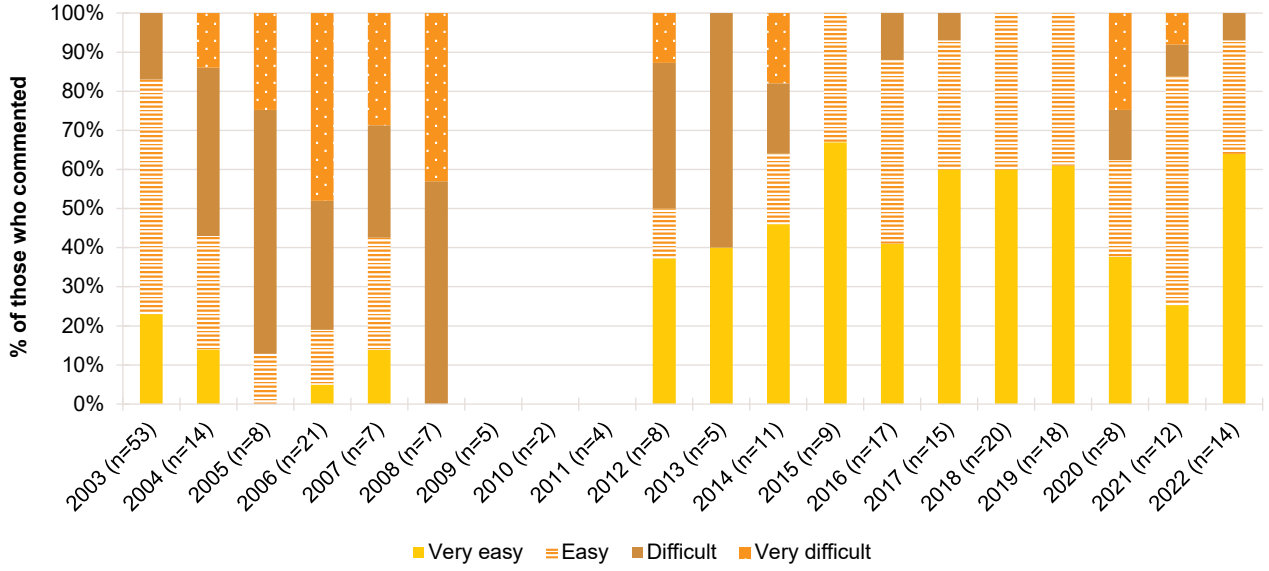
Note. The response 'Don't know' was excluded from analysis. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



Note. The response 'Don't know' was excluded from analysis. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



Note. The response 'Don't know' was excluded from analysis. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

4

Cocaine

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

Patterns of Consumption

Recent Use (past 6 months)

Since 2013, the per cent reporting any recent cocaine use has substantially increased. In 2022, 78% of the Hobart sample reported recent use, stable from 84% in 2021 (p=0.327) (Figure 24).

Frequency of Use

Frequency of use has been stable in recent years. Of those who had recently consumed cocaine and commented (n=56), participants reported a median of six days (IQR=4-11) of use in 2022, stable from five days in 2021 (IQR=2-7; p=0.083) (Figure 24). This is equivalent to less than monthly use. Of those who had recently consumed cocaine (n=56), few participants (n≤5) reported consuming cocaine on a weekly or more frequent basis, therefore, further details are suppressed (7% in 2021).

Routes of Administration

Among participants who had recently consumed cocaine and commented (n=56), 96% of participants reported snorting cocaine, stable relative to 2021 (97%). Thirty per cent reported swallowing cocaine (19% in 2021; p=0.161).

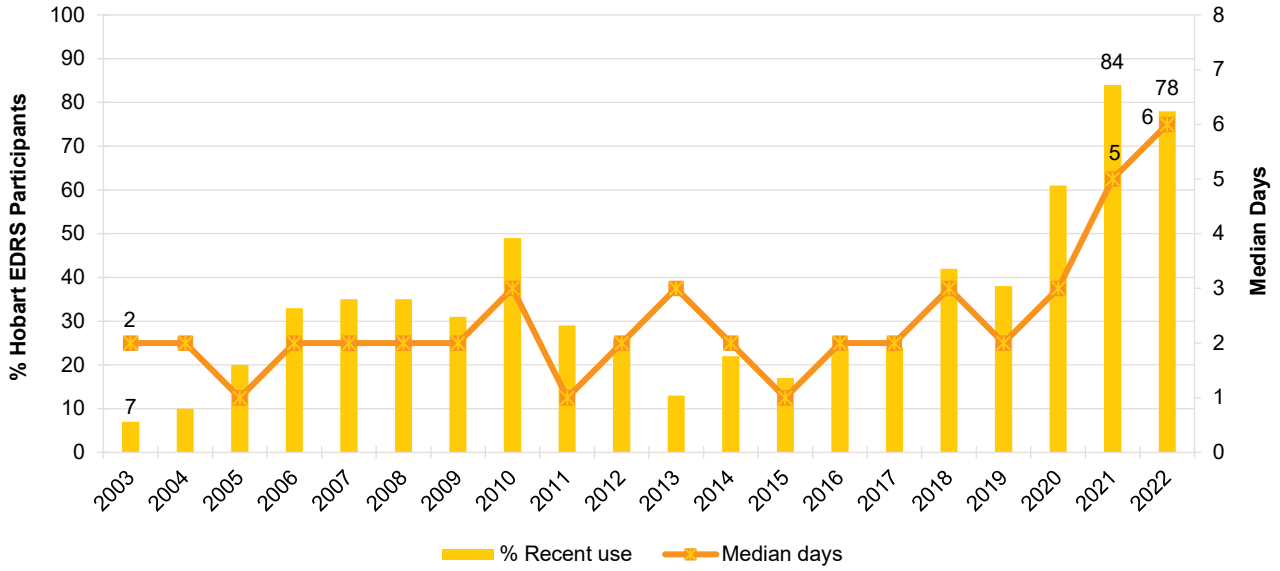
Quantity

Of those who reported recent use and responded (n=39), the median amount of cocaine used in a 'typical' session significantly increased to 0.50 grams (IQR=0.30-1.00) from 0.30 grams in 2021 (IQR=0.10-0.50; p=0.048). Of those who reported recent use and responded (n=40), the median maximum amount used in a session also significantly increased to 1.00 gram (IQR=0.50-1.30; 0.50 grams in 2021; IQR=0.20-1.00; p=0.014).

Forms Used

Among participants who had recently consumed cocaine and commented (n=56), 100% reported using powder cocaine (99% in 2021). Few participants (n≤5) reported use of crack cocaine or rock cocaine in 2021 and 2022, therefore, further details are suppressed.

Figure 24: Past six month use and frequency of use of cocaine, Hobart, TAS, 2003-2022



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 8 days to improve visibility of trends for days of use. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Price, Perceived Purity and Perceived Availability

Price

The median price per gram of cocaine was $350 in 2022 (IQR=350-350; n=37), stable relative to 2021 ($350; IQR=300-350; n=42; p=0.081) (Figure 25).

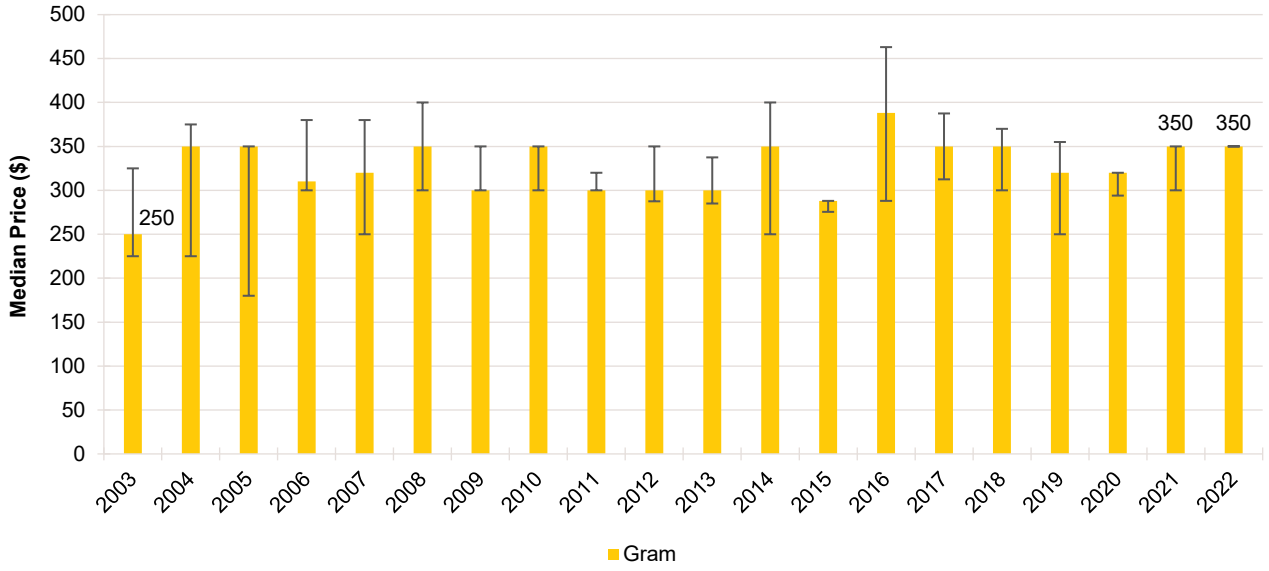
Perceived Purity

The perceived purity of cocaine remained stable between 2021 and 2022 (p=0.447). Among those who were able to respond in 2022 (n=50), the largest percentage of participants reported cocaine to be of 'low' purity (42%; 28% in 2021), followed by 'medium' purity (32%; 40% in 2021) (Figure 26).

Perceived Availability

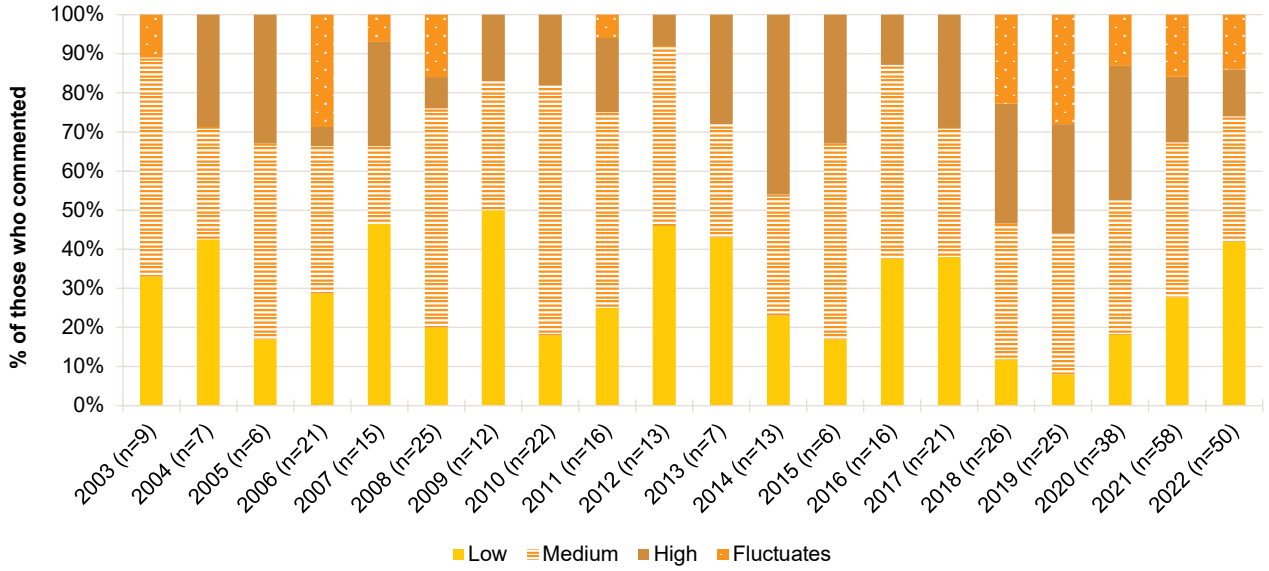
The perceived availability of cocaine largely remained stable between 2021 and 2022 (p=0.411). Among those who were able to respond in 2022 (n=52), two-fifths (40%) reported cocaine to be 'easy' to obtain (49% in 2021). In contrast, one-third (33%) perceived cocaine to be 'difficult' to obtain (28% in 2021) (Figure 27).

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



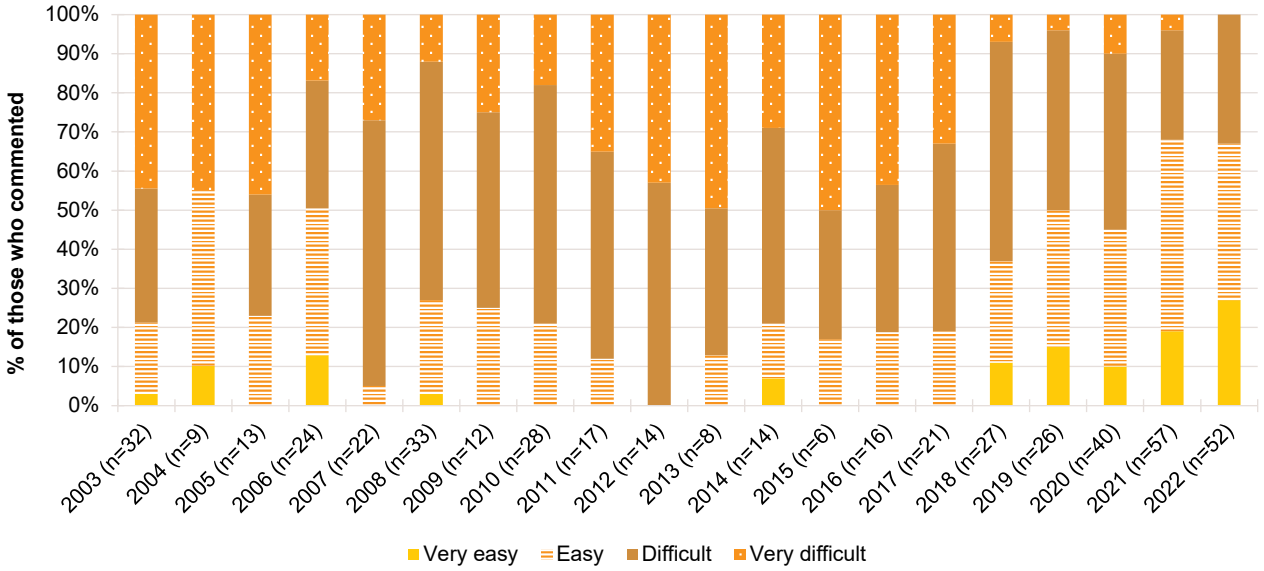
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent 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 26: Current perceived purity of cocaine, Hobart, TAS, 2003-2022



Note. The response option 'Don't know' was excluded from analysis Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



Note. The response option 'Don't know' was excluded from analysis. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

5

Cannabis and/or Cannabinoid Related Products

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

Terminology throughout this chapter refers to:

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

Patterns of Consumption

In 2022, participants were asked for the first time about their use of both prescribed and non-prescribed cannabis and/or cannabinoid related products (including hydroponic and bush cannabis, hash, hash oil, CBD extract, THC extract); no participants in Hobart 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)

At least three in five participants have reported recent use of non-prescribed cannabis and/or cannabinoid related products each year since 2003, with the only exception being 2011 (50%). Four-fifths (81%) of participants reported recent use of non-prescribed cannabis and/or cannabinoid related products in 2022, stable from 2021 (75%; p=0.471) (Figure 28).

Frequency of Use

Typical frequency of use has varied between at least once per month to up to four days per week over the course of monitoring. Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented (n=58), participants reported a median of 54 days (IQR=13-180) of use in 2022, stable relative to 2021 (55 days; IQR=10-180; p=0.817) (Figure 28). Almost two-thirds (67%) reported using non-prescribed cannabis and/or cannabinoid related products on a weekly or more frequent basis (63% in 2021; p=0.700), including 28% who reported using non-prescribed cannabis and/or cannabinoid related products on a daily basis (28% in 2021).

Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented (n=58), the vast majority of participants (90%) reported smoking, stable from 2021 (95%; *p*=0.326). Two-fifths (40%) reported swallowing cannabis (35% in 2021; *p*=0.591) and 28% reported inhaling/vaporising (22% in 2021; *p*=0.540).

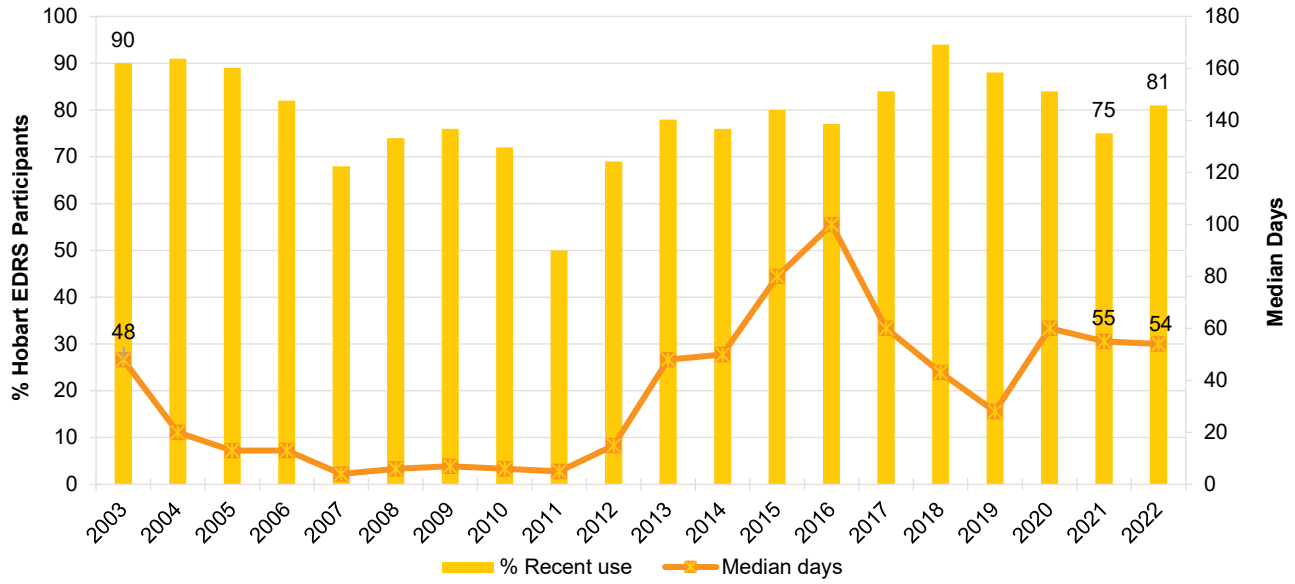
Quantity

Of those who reported recent non-prescribed use and responded, the median amount of cannabis used on the last occasion of use was one joint (IQR=1.00-2.00; n=27; one joint in 2021; IQR=0.50-1.00; n=34; *p*=0.032) or three cones (IQR=2-6; n=24; five cones in 2021; IQR=4-9; n=15; *p*=0.168) or three grams (IQR=1.30-4.30; n=11; 1.00 gram in 2021; IQR=1.30-4.50; n=39; *p*=0.006).

Forms Used

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid related products and responded (n=57), the majority reported recent use of outdoor-grown 'bush' cannabis (68%; 80% in 2021; *p*=0.164) and almost two-thirds (65%) reported recent use of hydroponic cannabis (65% in 2021). One-fifth (21%) of participants reported recent use of (non-prescribed) CBD extract in 2022 (13% reported recent use of CBD oil in 2021) and 16% reported use of THC extract (question not asked in 2021). Fewer participants reported having used hashish (12%; 12% in 2021) and hash oil (12%; 16% in 2021; *p*=0.617) in the preceding six months.

Figure 28: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid related products, Hobart, TAS, 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: The median price per ounce of non-prescribed hydroponic cannabis has fluctuated between $250 and $300 since 2006. In 2022, participants paid a median of $300 per ounce (IQR=288-300;

n=8), similar to the median price of $260 in 2021 (IQR=200-300; n=11; *p*=0.183) (Figure 29a)**.** Few participants (n≤5) reported on the price of a gram in 2022; therefore, these data are suppressed ($20 in 2021; IQR=16-20; n=10; *p*=0.670).

Perceived Potency: The perceived potency of non-prescribed hydroponic cannabis remained stable between 2021 and 2022 (*p*=0.685). Among those who were able to respond in 2022 (n=33), the majority (61%) perceived non-prescribed hydroponic cannabis to be of 'high' potency, consistent with reports in 2021 (63%) and in previous years (Figure 30a).

Perceived Availability: The perceived availability of non-prescribed hydroponic cannabis significantly changed between 2021 and 2022 (*p*=0.035). Among those who were able to respond in 2022 (n=34), the majority (56%) perceived non-prescribed hydroponic cannabis to be 'very easy' to obtain, an increase from 41% in 2021. In contrast, no participants perceived non-prescribed hydroponic cannabis to be 'difficult' to obtain, a decrease from 18% in 2021 (Figure 31a).

Bush Cannabis

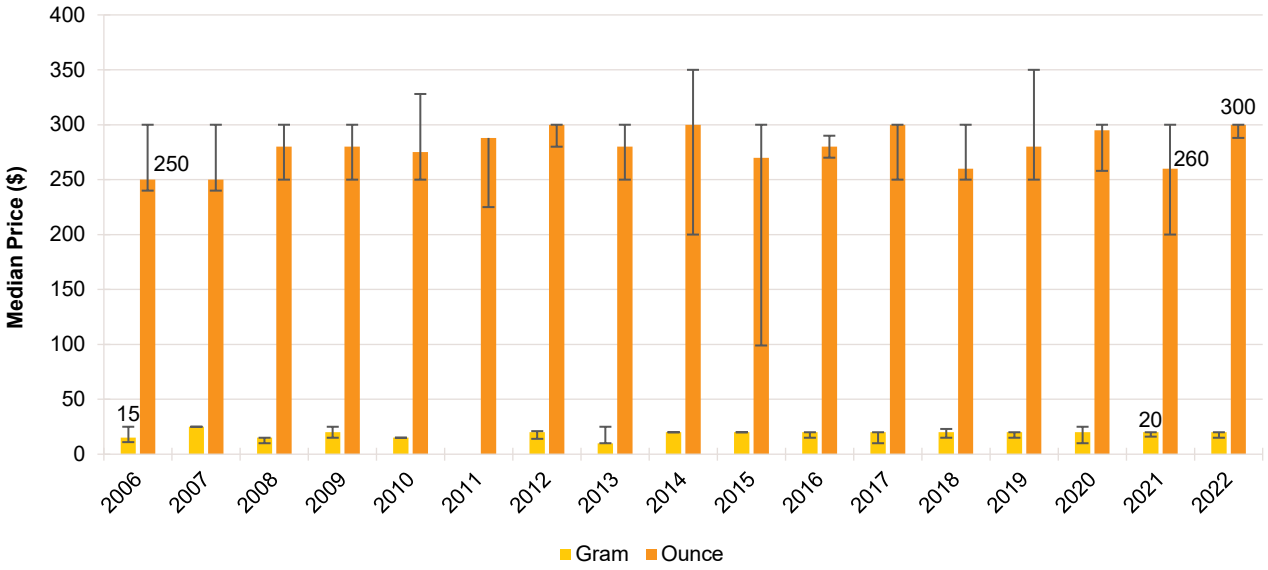
Price: The median price per ounce of non-prescribed bush cannabis increased significantly, from $210 (IQR=178-240; n=14) in 2021 to $250 (IQR=250-275; n=11; *p*=0.013) in 2022 (Figure 29b). The median price per gram of non-prescribed bush cannabis remained stable at $15 in 2022 (IQR=13-19; n=6; n≤5 in 2021; *p*=0.826).

Perceived Potency: The perceived potency of non-prescribed bush cannabis remained stable between 2021 and 2022 (*p*=0.182). Among those who were able to respond in 2022 (n=33), 39% perceived the potency of non-prescribed bush cannabis to be 'medium' (63% in 2021), with a further 27% perceiving potency to be 'high' (14% in 2021) (Figure 30b).

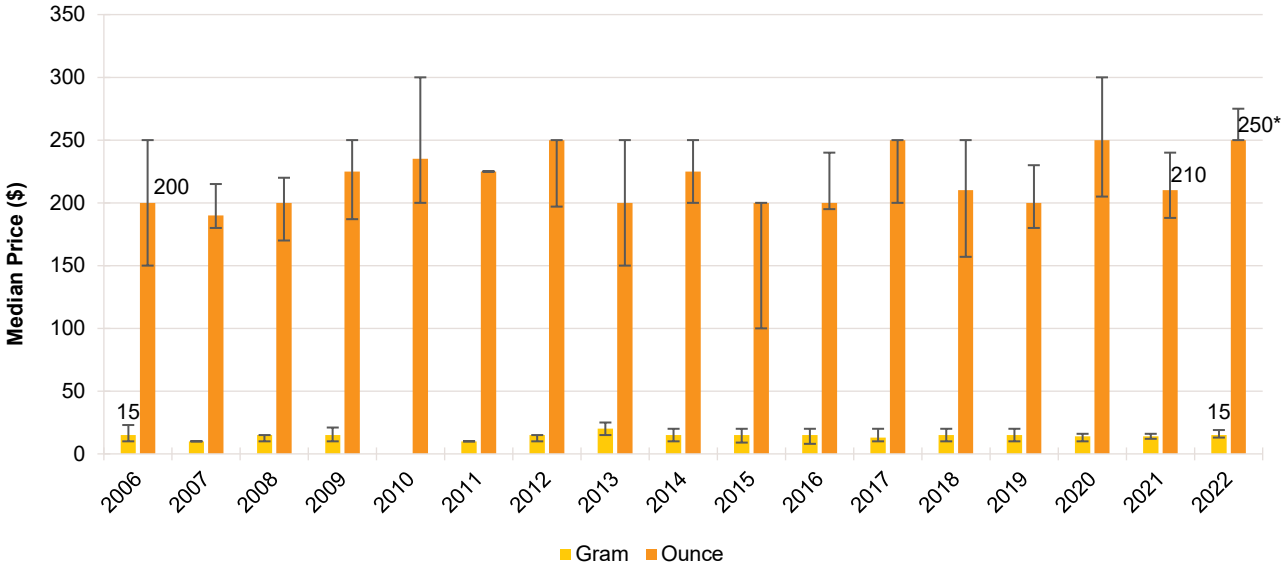
Perceived Availability: The perceived availability of non-prescribed bush cannabis remained stable between 2021 and 2022 (*p*=0.701). Among those who were able to respond in 2022 (n=34), half (53%) perceived non-prescribed bush cannabis to be 'very easy' to obtain (44% in 2021) and 29% perceived it as 'easy' to obtain (37% in 2021) (Figure 31b).

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

(A) Hydroponic cannabis



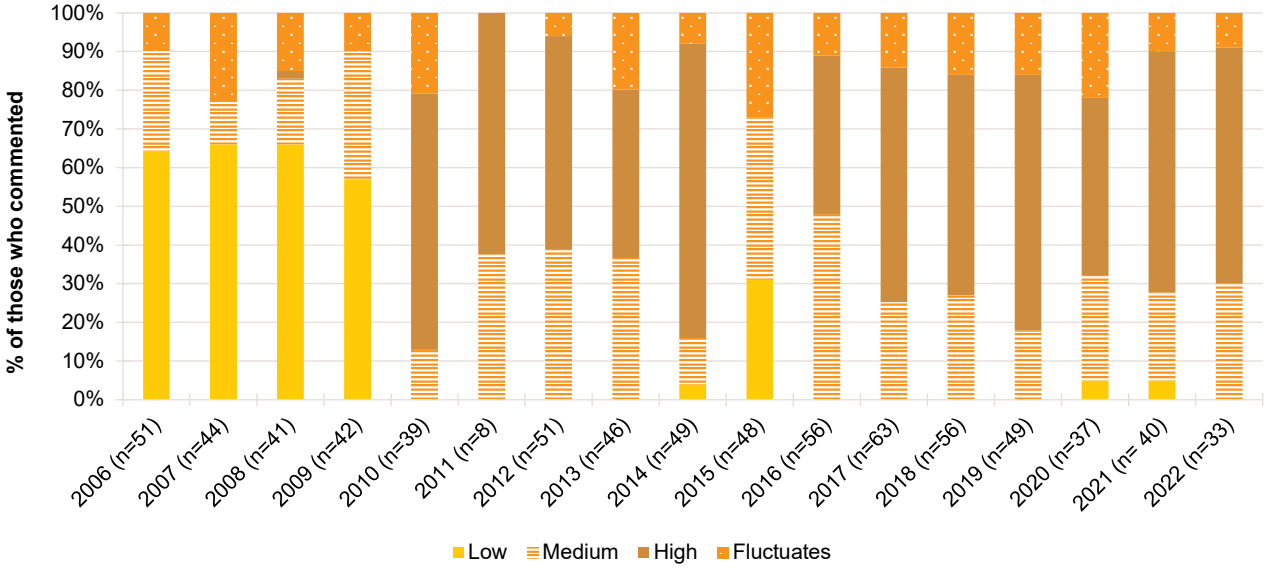
(B) Bush cannabis



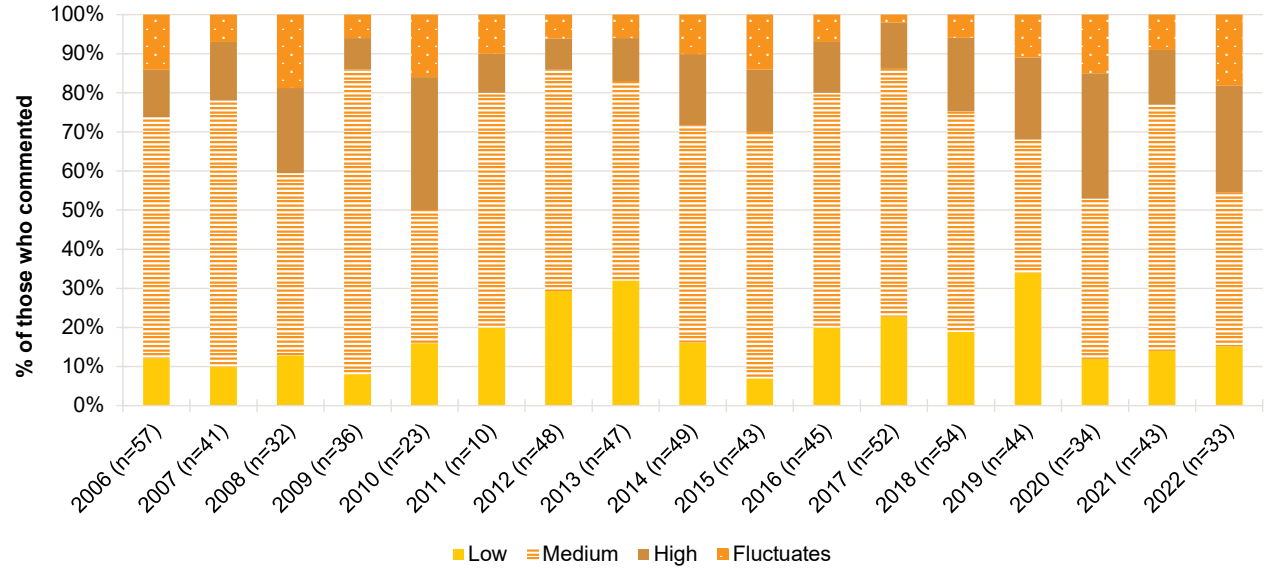
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels are only provided for the first (2006) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small 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 30: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Hobart, TAS, 2006-2022

(A) Hydroponic cannabis



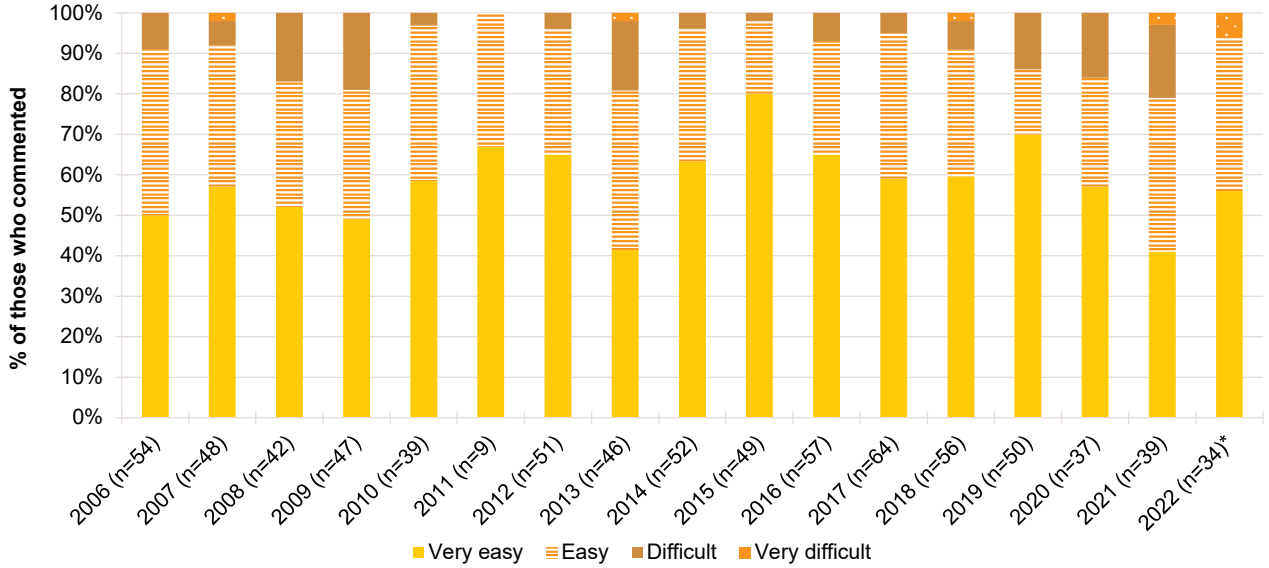
(B) Bush cannabis



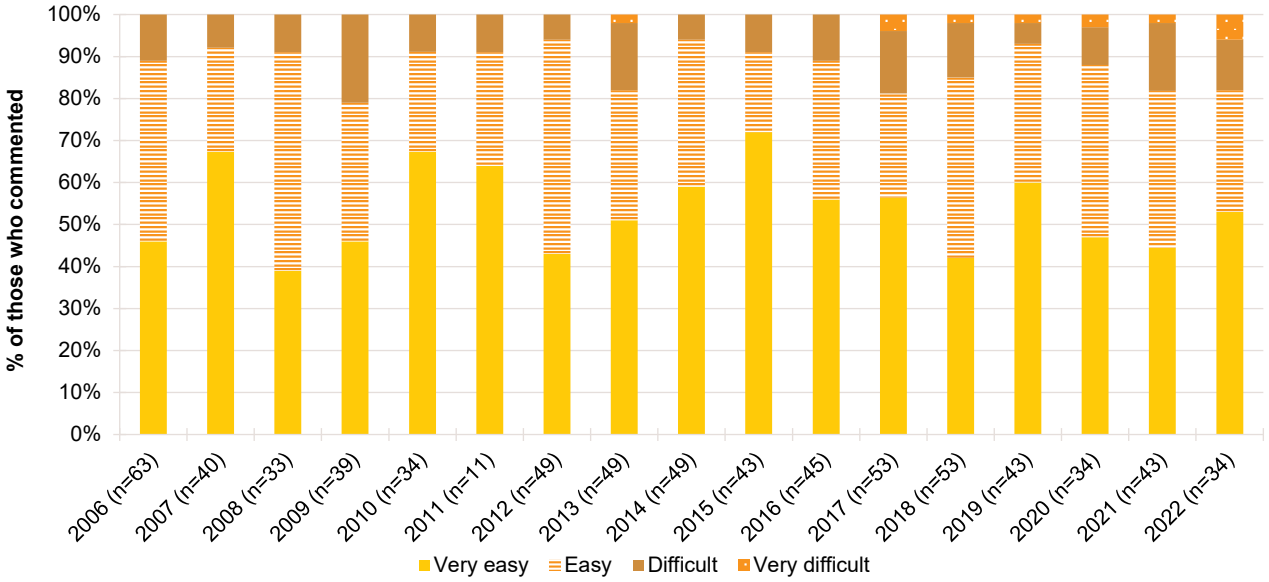
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 31: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Hobart, TAS, 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 suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. 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

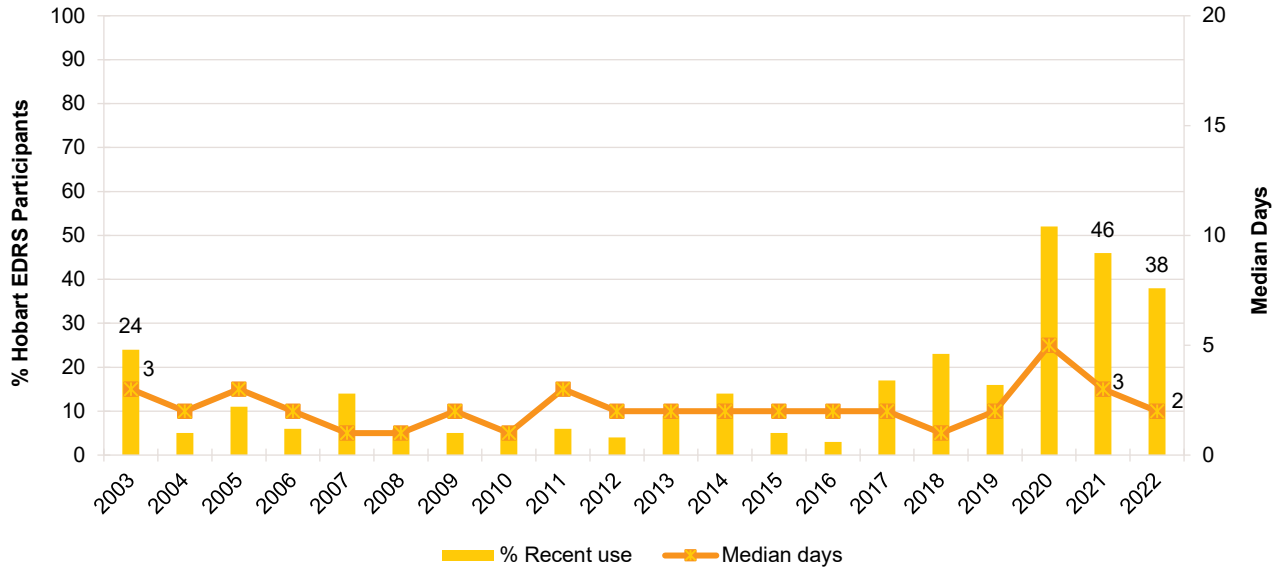
Recent Use (past 6 months): Thirty-eight per cent of the Hobart sample reported using any ketamine in the six months prior to interview. This remained stable from 46% in 2021 (p=0.284) (Figure 32).

Frequency of Use: Of those who had recently consumed ketamine and commented (n=27), frequency of use remained low and stable in 2022 compared to 2021 (median 2 days; IQR=1-4; 3 days in 2021; IQR=1-6; p=0.581) (Figure 32). Few participants (n≤5) who had recently consumed any ketamine reported weekly or more frequent use in 2022, therefore, these data are suppressed (n≤5 in 2021).

Routes of Administration: Among participants who had recently consumed ketamine and commented (n=27), the vast majority of participants (89%) reported snorting in 2022, stable from 2021 (94%; p=0.662).

Quantity: Of those who reported recent use and responded (n=15), the median amount of ketamine used in a 'typical' session was 0.20 grams (IQR=0.10-0.30; 0.20 grams in 2021; IQR=0.10-0.30; p=0.599). Of those who reported recent use and responded (n=15), the median maximum amount used was 0.40 grams (IQR=0.20-0.50; 0.30 grams in 2021; IQR=0.20-0.50; p=0.708).

Figure 32: Past six month use and frequency of use of ketamine, Hobart, TAS, 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.

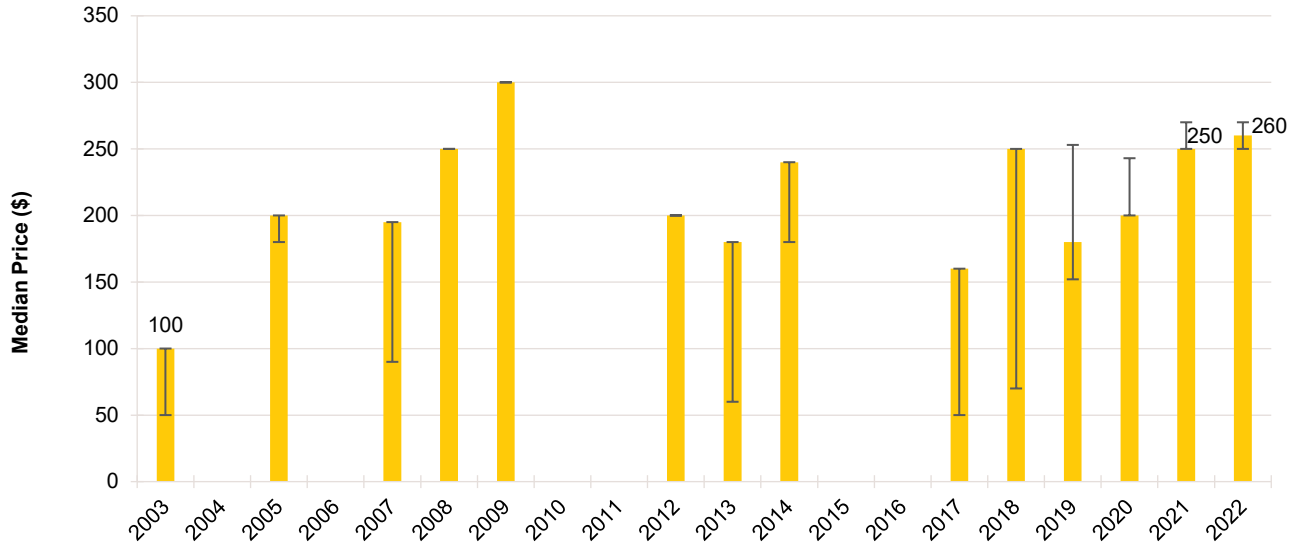
Price, Perceived Purity and Perceived Availability

Price: The median reported price of ketamine has fluctuated somewhat since the commencement of monitoring, however it remained stable between 2021 and 2022. The median price per gram of ketamine in 2022 was $260 (IQR=250-270; n=10; $250 in 2021; IQR=250-270; n=21) (Figure 33).

Perceived Purity: The perceived purity of ketamine remained stable between 2021 and 2022 (*p*=0.158). Among those who were able to respond in 2022 (n=16), two-thirds (69%) perceived the purity of ketamine to be 'high' (38% in 2021) (Figure 34).

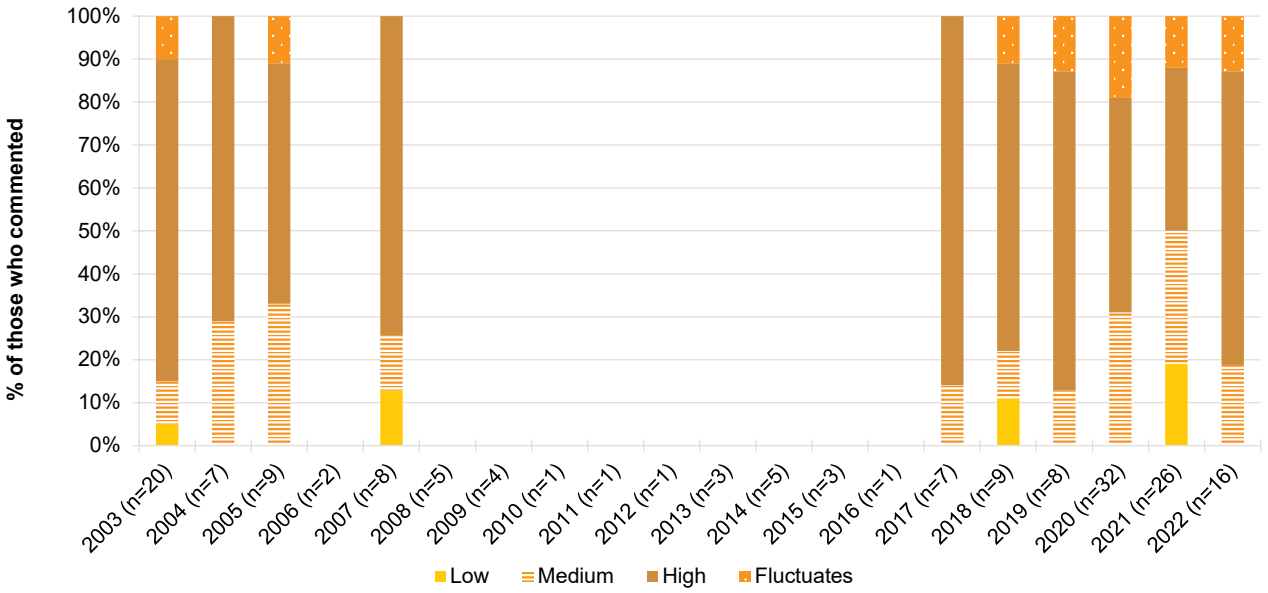
Perceived Availability: The perceived availability of ketamine remained stable between 2021 and 2022. Of those who were able to respond in 2022 (n=17), 35% reported ketamine to be 'easy' to obtain (33% in 2021) (Figure 35).

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



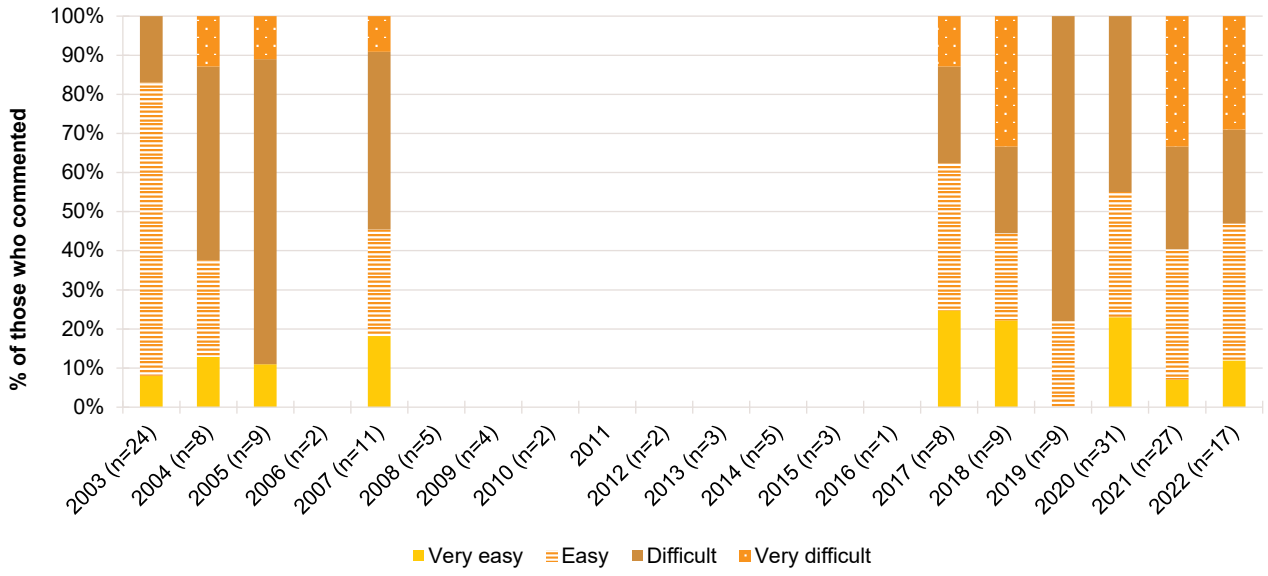
Note. Among those who commented. No participants reported purchasing ketamine in 2004, 2006, 2010, 2011, 2015 and 2016. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001.

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



Note. The response option 'Don't know' was excluded from analysis. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded._The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



Note. The response option 'Don't know' was excluded from analysis. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

LSD

Patterns of Consumption

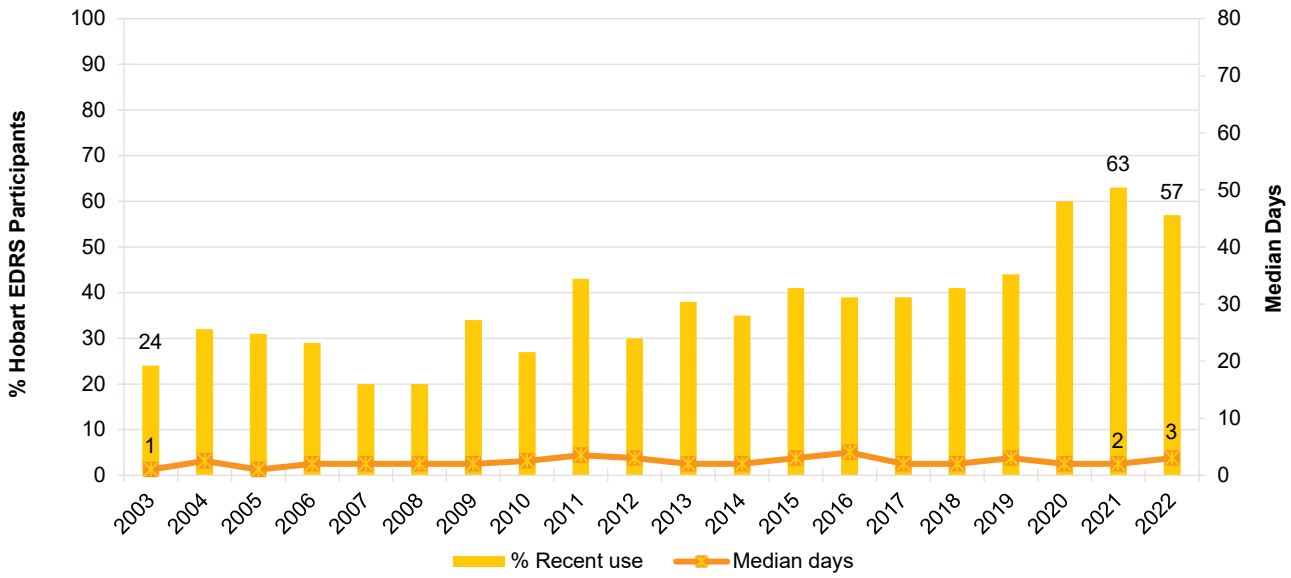
Recent Use (past 6 months): Fifty-seven per cent of the Hobart sample had used LSD in the six months preceding interview, stable from 63% in 2021 (p=0.527) (Figure 36).

Frequency of Use: Median days of LSD use over the years has remained low. Of those who had recently consumed LSD in 2022 and commented (n=41), frequency of use remained stable at three days (IQR=2-7; 2 days in 2021; IQR=1-6; p=0.344) (Figure 36). Few participants (n≤5) who had recently consumed LSD reported weekly or more frequent use in 2022, therefore, these data are suppressed (n≤5 in 2021).

Routes of Administration: Among participants who had recently consumed LSD and commented (n=41), the vast majority of participants (98%) reported swallowing LSD in 2022, stable from 2021 (100%; p=0.390).

Quantity: Of those who reported recent use and responded (n=32), the median amount of LSD used in a 'typical' session was one tab (IQR=1-2; 1 tab in 2021; IQR=1-1; p=0.272). Of those who reported recent use and responded (n=32), the median maximum amount used was two tabs (IQR=1-2; 1 tab in 2021; IQR=1-2; p=0.111).

Figure 36: Past six month use and frequency of use of LSD, Hobart, TAS, 2003-2022



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 80 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

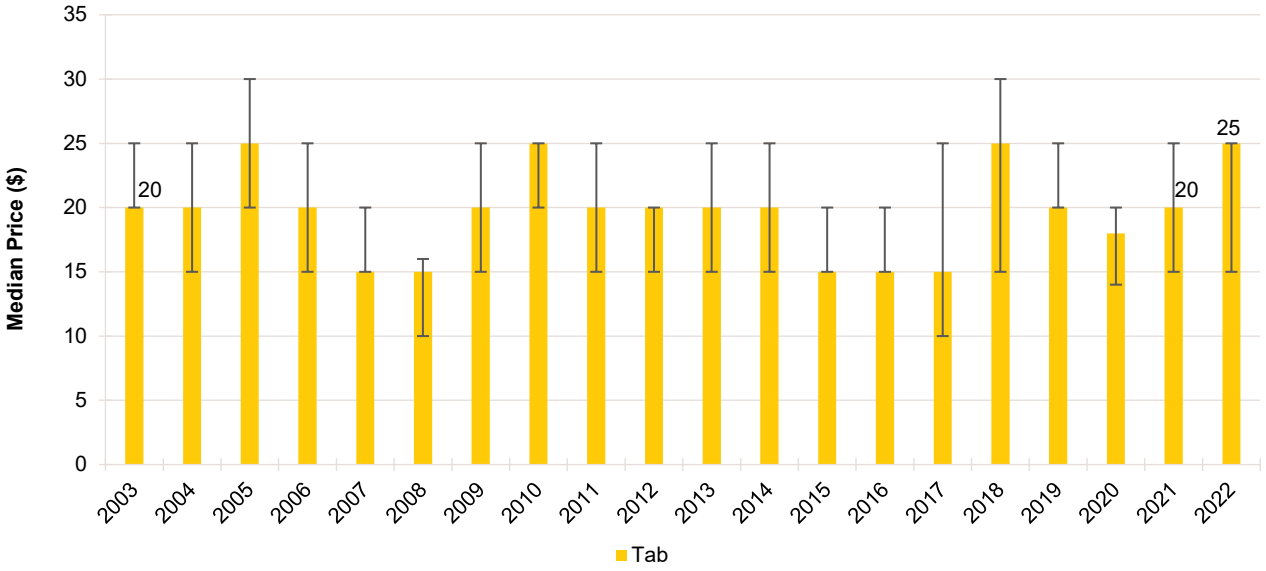
Price, Perceived Purity and Perceived Availability

Price: The median price for one tab of LSD was $25 (IQR=15-25; n=17), stable from $20 in 2021 (IQR=15-25; n=46; p=0.946) (Figure 37).

Perceived Purity: The perceived purity of LSD remained stable between 2021 and 2022 (p=0.613). Among those who were able to respond in 2022 (n=32), two-thirds (66%) perceived the purity of LSD to be 'high' (51% in 2021), followed by 22% who reported the purity to be 'medium' (33% in 2021) (Figure 38).

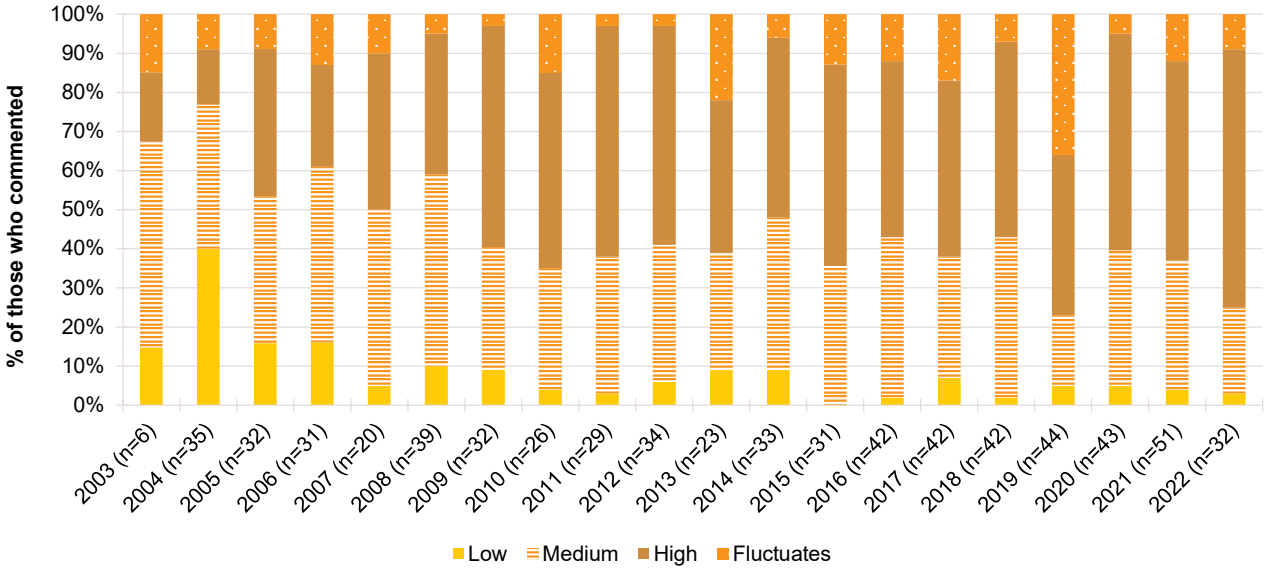
Perceived Availability: The perceived availability of LSD between 2021 and 2022 was stable (*p*=0.218). Of those able to comment in 2022 (n=31), half (52%) reported LSD as being 'easy' to obtain, (33% in 2021). A further 26% reported that LSD was 'very easy' to obtain (22% in 2021) (Figure 39).

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



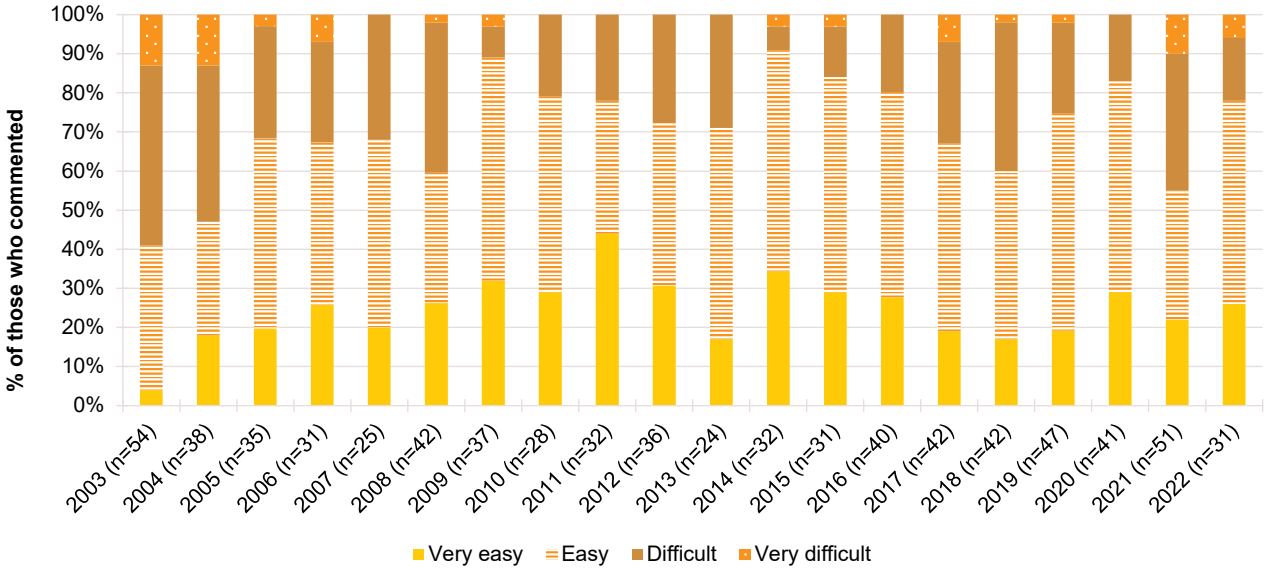
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent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

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



Note. The response option 'Don't know' was excluded from analysis. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

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



Note. The response option 'Don't know' was excluded from analysis. Data labels suppressed for all stacked bar charts, with data not provided for years where fewer than six participants (n≤5) responded. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

DMT

Patterns of Consumption

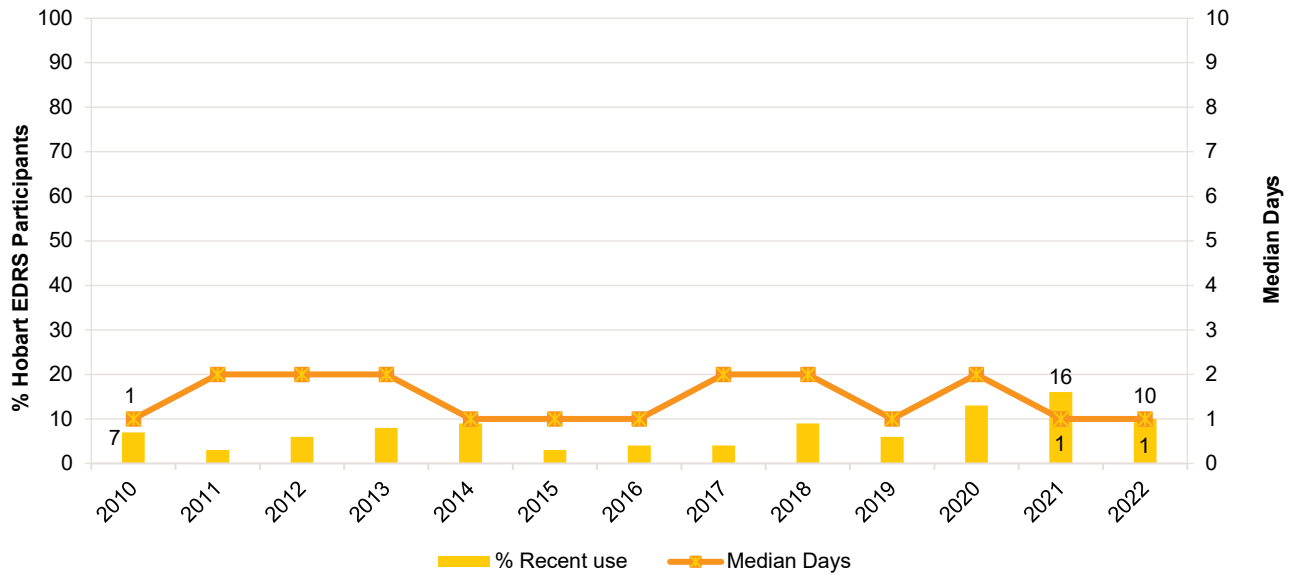
Recent Use (past 6 months): Ten per cent of the sample reported recent use of DMT in 2022, which was stable compared to 2021 (16%; *p*=0.269) (Figure 40).

Frequency of Use: Median days of DMT use across the years has been infrequent and stable, with a median of one (IQR=1-2) day of use reported in 2022 (1 day in 2021; IQR=1-2; *p*=0.785) (Figure 40).

Routes of Administration: Among participants who had recently consumed DMT and commented (n=7), the only route of administration was smoking (100%; 94% in 2021).

Quantity: Few participants (n≤5) reported on the 'typical' and maximum quantity of DMT used in a session in 2022, therefore, these data are suppressed.

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



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 10 days to improve visibility of trends. Data labels are only provided for the first (2010) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤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.

7

New Psychoactive Substances

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

In previous (2010-2020) EDRS reports, DMT and paramethoxyamphetamine (PMA) were categorised as NPS. However, the classification of these substances as NPS is not universally accepted, and the decision was made to exclude them from this category from 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)

Any NPS use, including plant-based NPS, has fluctuated over time peaking at 49% in 2010 and declining in recent years (Table 2). In 2022, few participants (n≤5) reported recent use of NPS (including plant-based NPS); therefore, further details are suppressed (11% in 2021; p=0.280).

Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 48% in 2011 and since declining (n≤5 in 2022; details are suppressed; 10% in 2021; p=0.243) (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 Hobart 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.

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

%	National	Hobart, TAS
2010	24	49
2011	36	33
2012	40	26
2013	44	34
2014	35	38
2015	37	22
2016	28	14
2017	26	17
2018	23	23
2019	20	18
2020	15	10
2021	16	11
2022	11	-

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 EDRS reports. 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.

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

%	National	Hobart, TAS
2010	24	48
2011	33	33
2012	37	24
2013	42	33
2014	34	36
2015	34	18
2016	27	14
2017	24	17
2018	21	21
2019	19	18
2020	12	8
2021	14	10
2022	**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 EDRS reports. The response option 'Don't know' was excluded from analysis. Statistical significance for 2021 versus 2022 presented in table; *p<0.050; **p<0.010; ***p<0.001.

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

	2010 N=100	2011 N=75	2012 N=97	2013 N=76	2014 N=100	2015 N=78	2016 N=100	2017 N=100	2018 N=100	2019 N=99	2020 N=100	2021 N=102	2022 N=72
% Phenethylamines ^	15	-	-	10	15	10	-	17	-	6	-	6	**-**
Any 2C substance~	12	-	-	10	10	-	-	9	-	-	-	-	**0**
NBOMe	/	/	/	/	-	-	0	6	-	-	-	-	**0**
DO-x	-	0	0	0	0	0	0	-	-	0	0	0	**0**
4-FA	/	/	/	/	/	/	0	0	0	0	0	0	**-**
NBOH	/	/	/	/	/	/	/	/	/	/	/	/	**0**
% Tryptamines^^	0	-	-	-	-	0	0	0	0	-	-	-	**0**
5-MeO-DMT	0	-	-	-	-	0	0	0	0	-	-	-	**0**
4-AcO-DMT	/	/	/	/	/	/	0	0	/	/	/	/	**0**
% Synthetic cathinones	44	31	13	29	32	15	9	-	-	-	-	0	**-**
Mephedrone	42	27	10	24	23	9	-	-	-	0	-	0	**0**
Methylone/bk MDMA	/	-	-	-	-	-	-	-		0	-	0	**-**
MDPV/Ivory wave	-	-	-	-	-	-	0	-	0	-	0	0	**0**
Alpha PVP	/	/	/	/	/	/	0	0	/	/	-	0	**0**
Other substituted cathinone	/	/	0	/	-	0	0	/	/	/	/	/	**0**
N-ethylhexedrone	/	/	/	/	/	/	/	/	/	/	0	0	**0**
N-ethylpentylone	/	/	/	/	/	/	/	/	/	/	0	0	**0**
N-ethylbutylone	/	/	/	/	/	/	/	/	/	/	/	0	**0**
3-chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	**0**
3 –methylmethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	**0**
N, N-Dimethyl Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	**0**
% Piperazines	-	0	0	0	0	0	0	/	/	/	/	/	**/**
BZP	-	0	0	0	0	0	0	0	/	/	/	/	**/**
% Dissociatives	/	/	0	-	10	-	-	-	0	-	-	-	**0**
Methoxetamine (MXE)	/	/	0	-	10	-	-	-	0	-	0	0	**0**
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	**0**
3 Cl-PCP/4Cl-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**
% Plant-based NPS	-	-	-	-	6	6	-	-	-	-	-	-	**-**
Ayahuasca	/	/	/	/	/	0	0	0	0	0	0	0	**0**
Mescaline	-	-	-	-	-	-	-	-	-	0	-	-	**0**
Salvia divinorum	/	0	-	-	-	-	0	-	-	-	-	-	**0**
Kratom	/	/	/	/	/	/	/	/	/	/	0	-	**-**
LSA	/	-	-	0	-	0	0	/	/	/	/	/	**0**
Datura	-	0	-	-	0	0	0	/	/	/	/	/	**/**

	2010 N=100	2011 N=75	2012 N=97	2013 N=76	2014 N=100	2015 N=78	2016 N=100	2017 N=100	2018 N=100	2019 N=99	2020 N=100	2021 N=102	2022 N=72
% Benzodiazepines	/	/	/	/	/	/	0	-	-	-	0	-	-
Etizolam	/	/	/	/	/	/	0	-	-	-	0	0	-
8 – Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Bromazolam	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Clonazolam	/	/	/	/	/	/	/	/	/	/	/	/	-
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Other drugs that mimic the effect of benzodiazepines	/	/	/	/	/	/	/	/	0	0	0	-	**0**
% Synthetic cannabinoids	/	/	8	/	-	-	-	-	7	-	-	-	**0**
% Herbal high#	/	/	8	/	-	-	0	-	-	-	0	-	/
Phenibut	/	/	8	/	-	-	0	-	-	-	0	-	**0**
% Other drugs that mimic the effect of opioids	/	/	/	/	/	/	/	0	0	-	0	0	**0**
% Other drugs that mimic the effect of ecstasy	/	/	/	/	/	/	/	-	-	-	0	0	-
% Other drugs that mimic the effect of amphetamine or cocaine	/	/	/	/	/	/	/	-	-	-	-	-	**0**
% Other drugs that mimic the effect of psychedelic drugs like LSD	/	/	/	/	/	/	/	0	-	-	0	-	**0**

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

8

Other Drugs

Non-Prescribed Pharmaceutical Drugs

Codeine

Before the 1 February 2018, people could access low-dose codeine products (<30mg, e.g., Nurofen Plus) over-the-counter (OTC), while high-dose codeine (≥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 in 2021, participants were only asked about prescribed and non-prescribed codeine use, regardless of whether it was low- or high-dose.

Recent Use (past 6 months): In 2022, 15% reported using any non-prescribed codeine (15% in 2021) (Figure 41).

Recent Use for Non-Pain Purposes: Few participants (n≤5) reported using codeine for non-pain purposes in 2022 (80% of participants who reported recent use of codeine in 2021; n=12).

Frequency of Use: Participants who had recently used non-prescribed codeine and commented (n=11) reported use on a median of three days (IQR=2-5) in the past six months (2 days in 2021; IQR=1-4; n=13; *p*=0.359).

Pharmaceutical Opioids

Recent Use (past 6 months): Few participants (n≤5) reported recent use of non-prescribed pharmaceutical opioids (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl, excluding codeine) in 2022; therefore, further details are supressed (11% in 2021; *p*=0.158) (Figure 41).

Frequency of Use: Few participants (n≤5) reported on median days use of non-prescribed pharmaceutical opioids (details suppressed; median of 4 days in 2021; IQR=1-6; n=9; *p*=0.777).

Pharmaceutical Stimulants

Recent Use (past 6 months): Two-fifths (40%) of the Hobart sample had recently consumed non-prescribed pharmaceutical stimulants (e.g., dexamphetamine, methylphenidate, modafinil), stable relative to 2021 (30%; *p*=0.200) (Figure 41).

Frequency of Use: A median of three days of non-prescribed pharmaceutical stimulant use (IQR=1-7; n=29) was reported in the six months prior to interview in 2022 (3 days in 2021; IQR=2-6; n=29; *p*=0.969).

Quantity: Of those who reported recent use and responded (n=20), the median amount of non-prescribed pharmaceutical stimulants used in a 'typical' session was one pill/tablet (IQR=1-1; 1 pill/tablet in 2021; IQR=1-2; n=25; *p*=0.236). Of those who reported recent use and responded (n=21), the median maximum amount used was one pill/tablet (IQR=1-3; 2 pills/tablets in 2021; IQR=1-3; n=25; *p*=0.517).

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

Benzodiazepines

Recent Use (past 6 months): Thirty-six per cent of the sample reported recent use of non-prescribed benzodiazepines in 2022, similar to 29% in 2021 (p=0.412) (Figure 41). From 2019, participants were asked about non-prescribed alprazolam use versus 'other' non-prescribed benzodiazepine use. In 2022, 18% and 29% of the total sample reported recent use of non-prescribed alprazolam and non-prescribed 'other-benzodiazepine' use, respectively (14%; in 2021; p=0.522; and 20% in 2021; p=0.152, respectively).

Frequency of Use: Participants who reported recent use reported a median of five days (IQR=2-20; n=13; 3 days in 2021; IQR=2-6; n=13; p=0.659) and two days (IQR=1-6; n=21; 2 days in 2021; IQR=1-7; n=19; p=0.894) of non-prescribed alprazolam and other benzodiazepine use in the past six months, respectively.

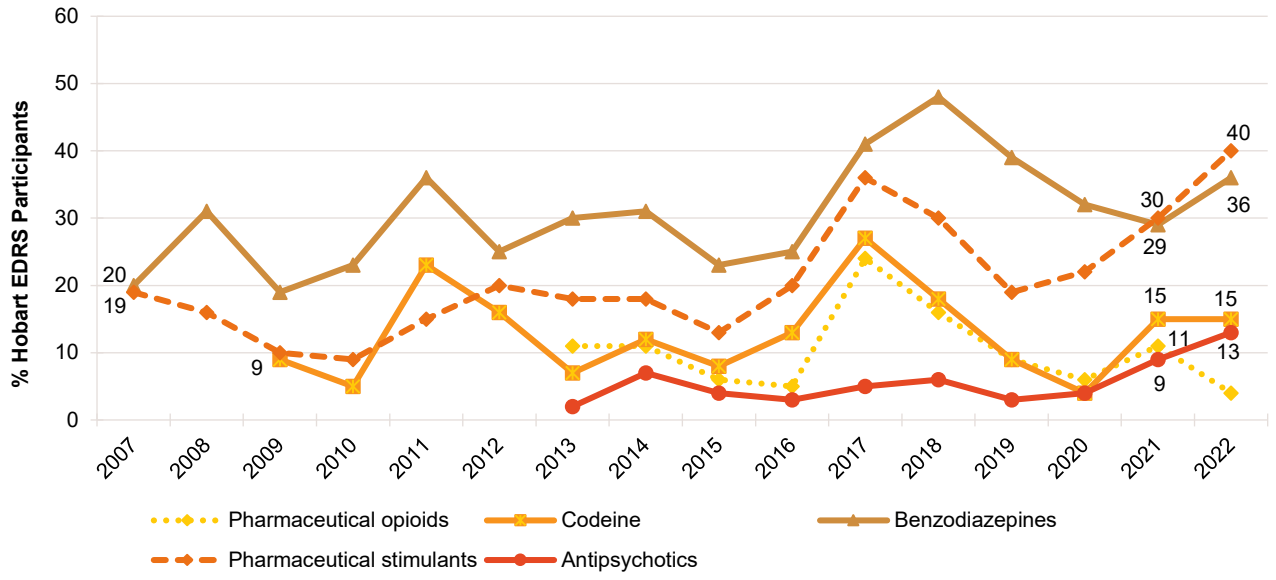
Price and Perceived Availability: In 2022, participants were asked questions pertaining to the price and perceived availability of non-prescribed benzodiazepines, however these data will be released separately in 2023. Please contact the Drug Trends team for further information.

Antipsychotics

Recent Use (past 6 months): Participants reporting recent use of non-prescribed antipsychotics has remained low over the course of monitoring, with 13% of participants reporting recent use in 2022 (9% in 2021; p=0.451) (Figure 41).

Frequency of Use: Participants who reported recent use reported a median of six days (IQR=2-12; n=9) of non-prescribed antipsychotic use in 2022 (2 days in 2021; IQR=1-68; p=0.969).

Figure 41: Non-prescribed use of pharmaceutical drugs in the past six months, Hobart, TAS, 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): In 2022, 51% of the Hobart sample reported recent use of hallucinogenic mushrooms in the six months prior to the interview, stable from 52% in 2021 (Figure 42).

Frequency of Use: A median of four days of hallucinogenic mushroom use (IQR=2-12; n=37) was reported in the six months prior to interview in 2022 (3 days in 2021; IQR=1-6; n=53; p=0.055).

MDA

Recent Use (past 6 months): Eleven per cent reported recent use of MDA in 2022 (n≤5 in 2021; p=0.148).

Frequency of Use: Participants reported a median of two days of MDA use in the preceding six months (n≤5 in 2021; p=0.936).

Substance with Unknown Contents

Capsules: Few (n≤5) participants reported recent use of capsules with unknown contents in 2022, therefore these data are suppressed (16% in 2021; p=0.099) (Figure 42). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Other Unknown Substances: From 2019, we asked participants about their use more broadly of substances with 'unknown contents'. Almost one-quarter (26%) of participants reported use of any substance with 'unknown contents' in 2022 (28% in 2021; p=0.860) on a median of two days (IQR=1-4; 4 days in 2021; IQR=2-6; p=0.057).

When broken down by substance form, 13% reported using pills with unknown contents in the previous six months (17% in 2021; p=0.515). Thirteen per cent reported using powder with unknown contents in 2022 (8% in 2021; p=0.436). Few participants (n≤5) reported using crystal with unknown contents in 2021 and 2022; therefore, these numbers are suppressed.

Quantity: From 2020, we asked participants about the average amount of pills and capsules used with unknown contents in the six months preceding interview. In a 'typical' session, participants reported using a median of two capsules/pills (IQR=1-3; n=8) with unknown contents (median of 3 capsules/pills in 2021; IQR=1-5; n=26; p=0.057).

PMA

No participants reported recent use of PMA in 2022 or 2021. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

PMMA

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

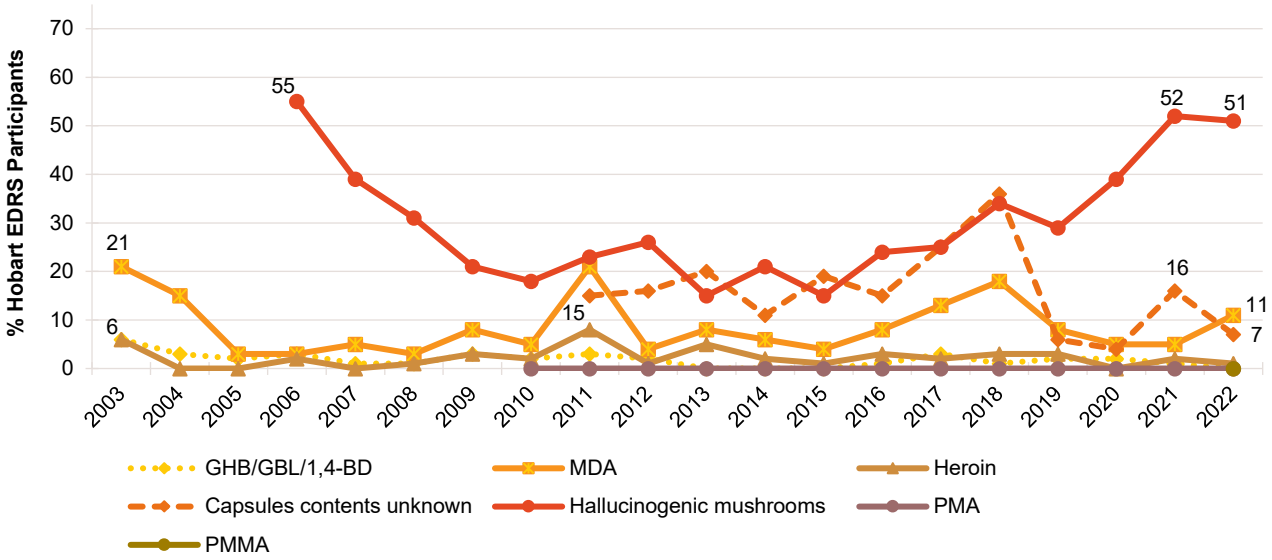
Heroin

Due to low numbers reporting on recent use of heroin in 2022, numbers have been suppressed. For further information, please refer to the National EDRS Report, or contact the Drug Trends team for further information.

GHB/GBL/1,4-BD

No participants reported recent use of GHB/GBL/1,4-BD in 2022 (n≤5 in 2021), therefore, numbers have been suppressed. For further information, please refer to the National EDRS Report, or contact the Drug Trends team for further information.

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



Note. Monitoring of hallucinogenic mushrooms commenced in 2005. Monitoring of capsules contents unknown commenced in 2013; note that in 2019, participants were asked more broadly about 'substances contents unknown' (with further ascertainment by form) which may have impacted the estimate for 'capsules contents unknown'. Monitoring of PMA commenced in 2010 and PMMA commenced in 2022. Y axis has been reduced to 70% 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): The majority of the sample reported recent use of alcohol in 2022 (94%), consistent with the per cent observed in 2021 (97%; p=0.450) and since monitoring began in 2003 (Figure 43).

Frequency of Use: Participants reported consuming alcohol on a median of 48 days in 2022 (IQR=23-74; n=68; 48 days in 2021; IQR=24-72; n=99; p=0.732). Seventy-five per cent of those who had recently consumed alcohol reported weekly or more frequent use, consistent with 2021 (75%). Few participants (n≤5) reported daily use of alcohol in 2021 and 2022; therefore, these data are suppressed.

Tobacco

Recent Use (past 6 months): Seventy-nine per cent of the sample reported recent use of tobacco in 2022, consistent with the per cent observed in 2021 (76%; p=0.701) (Figure 43).

Frequency of Use: Participants reported using tobacco on a median of 100 days in 2022 (IQR=12-180; n=57; 65 days in 2021; IQR=10-180; n=87; p=0.570). Thirty-nine per cent of those who had recently consumed tobacco reported daily use (36% in 2021; p=0.852).

E-cigarettes

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

Recent Use (past 6 months): Fifty-six per cent of the 2022 Hobart sample had used non-prescribed e-cigarettes in the six months preceding interview, stable relative to 2021 (50%; *p*=0.537) (Figure 43).

Frequency of Use: A median frequency of 24 days of non-prescribed use was reported in the past six months in 2022 (IQR=9-60; n=40), stable from 15 days in 2022 (IQR=5-30; n=49; *p*=0.195).

Forms Used: Among participants who responded (n=39), the majority (90%) reported using e-cigarettes containing nicotine. No participants reported using e-cigarettes containing nicotine and cannabis (n≤5 in 2021) few (n≤5) reported using e-cigarettes containing cannabis (20% in 2021). One-third (33%) reported using e-cigarettes that did not contain nicotine nor cannabis in 2022 (n≤5 in 2021), and no participants reported using e-cigarettes containing another substance.

Reason for Use: Of those who reported any (i.e., prescribed and non-prescribed) e-cigarette use and responded (n=41), 71% reported that they did not use e-cigarettes as a smoking cessation tool in 2022.

Nitrous Oxide

Recent Use (past 6 months): One-quarter (26%) of the Hobart sample reported recent use of nitrous oxide in 2022, trending toward a significant decline from 41% reporting recent use in 2021 (*p*=0.056) (Figure 43).

Frequency of Use: Frequency of use remained stable at a median of three days (IQR=2-7; n=19) in 2021 (2 days in 2021; IQR=1-6; n=41; *p*=0.777).

Quantity: Among those who reported recent use and responded (n=19), the median amount used in a 'typical' session was eight bulbs (IQR=5-20; 5 bulbs in 2021; IQR=2-10; n=40; *p*=0.136). Of those who reported recent use and responded (n=19), the median maximum amount used was ten bulbs (IQR=8-30; 6 bulbs in 2021; IQR=3-16; *p*=0.074).

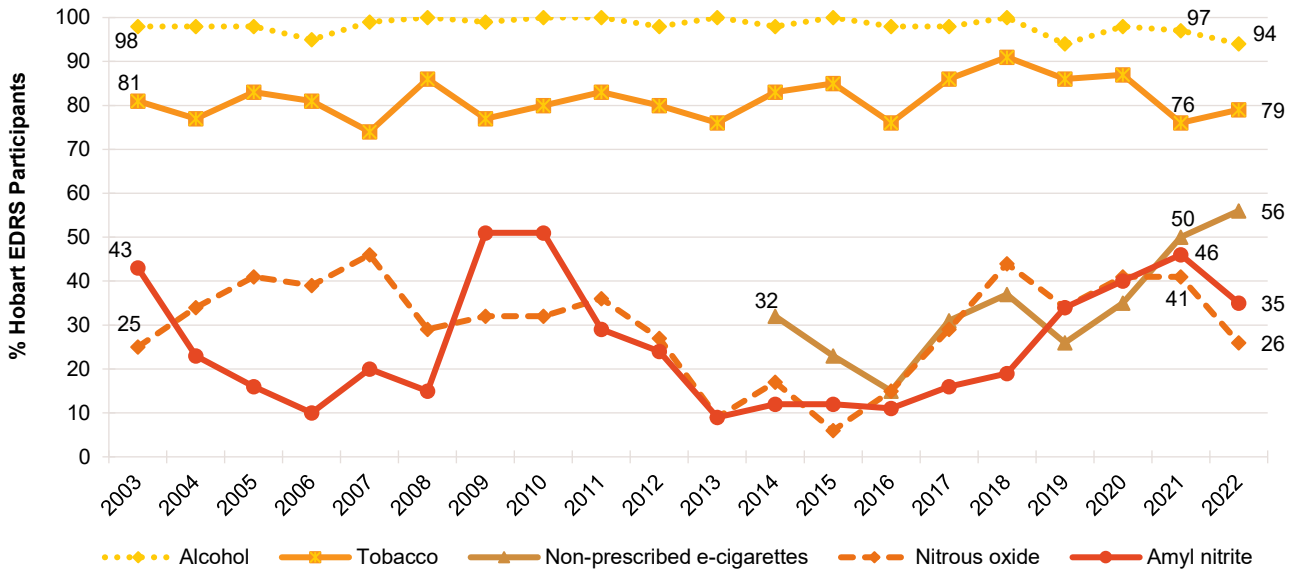
Amyl Nitrite

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

Recent Use (past 6 months): After considerable fluctuation over the course of monitoring, 35% of the Hobart sample reported recent use of amyl nitrite in 2022, stable relative to 2021 (46%; *p*=0.168) (Figure 43).

Frequency of Use: A median of two days of use was reported in 2022 (IQR=1-7; n=25; 3 days in 2021; IQR=1-6; n=46; *p*=0.941).

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



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

9

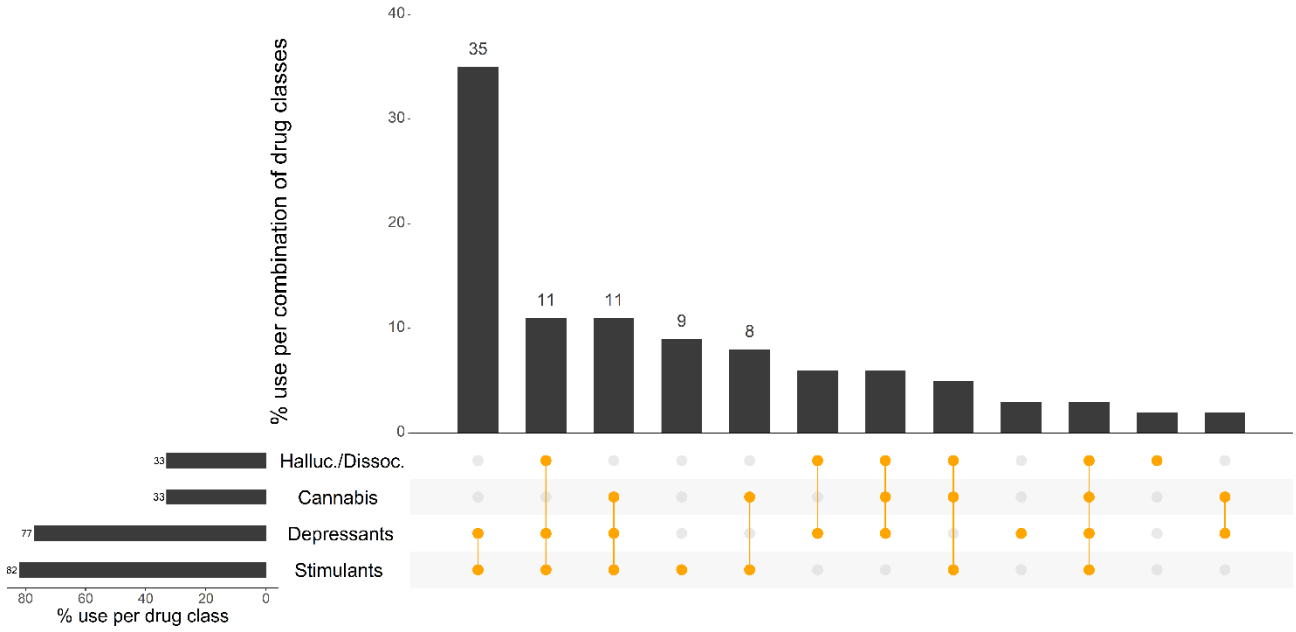
Drug-Related Harms and Other Behaviours

Polysubstance Use

On the last occasion of ecstasy or related drug use and among those who answered (n=66), the most commonly used substances were alcohol (76%) and cocaine (39%) followed by ecstasy (38%) (Figure 44).

The majority (86%; n=56) of the Hobart sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most commonly used combinations of drug classes were stimulants and depressants (35%), followed by stimulants, depressants, and cannabis (11%), and stimulants, depressants and hallucinogens/dissociatives (11%). Nine in ten participants reported using stimulants alone (Figure 44).

Figure 44: Use of cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Hobart, TAS, 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 40% to improve visibility of trends.

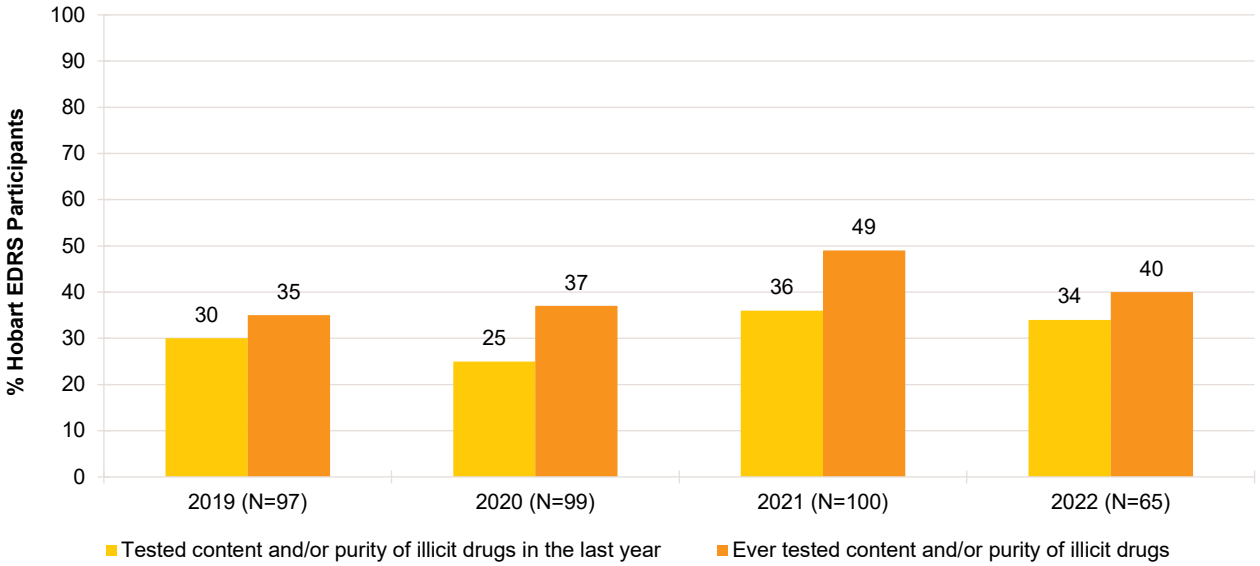
Drug Checking

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

In 2022, 34% 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 (36% in 2021; p=0.865). Of those who reported that they or someone else had tested their illicit drugs in the past year (n=22), the majority (84%) reported using colorimetric or reagent test kits. Few participants (n≤5) reported having their drugs tested using testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips) or other method of spectroscopy/ chromatography; therefore, further details are suppressed. No participants reporting having their drugs tested using Fourier Transform Infrared Spectroscopy.

Of those who reported that they or someone else had tested their illicit drugs in the past year (n=22), the majority (68%) reported having the drugs tested by a friend, followed by 36% who reported testing the drugs themselves. Few participants (n≤5) reported having their drugs tested by a dealer; therefore, further details are suppressed.

Figure 45: Lifetime and past year engagement in drug checking, Hobart, TAS, 2019-2022



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

Alcohol Use Disorders Identification Test

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

The mean score on the AUDIT for the total Hobart sample (including people who had not consumed alcohol in the past six months) was 13.6 (SD 7.8) in 2022, a significant increase from 13.5 (SD 6.7) in 2021 (p<0.001). AUDIT scores are divided into four 'zones' which indicate risk level. Specifically, scores between 0-7 indicate low risk drinking or abstinence; scores between 8-15 indicate alcohol use in excess of low-risk guidelines; scores between 16-19 indicate harmful or hazardous drinking; and scores 20 or higher indicate possible alcohol dependence.

Almost four-fifths (79%) of the sample obtained a score of eight or more (87% in 2021; *p*=0.216), indicative of hazardous use (Table 5).

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

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
	N=100	N=75	N=100	N=75	N=100	N=78	N=100	N=100	N=100	N=98	N=100	N=102	N=74
Mean AUDIT total score (SD)	/	/	/	/	/	/	/	/	14.2 (7.0)	12.5 (6.1)	12.5 (5.5)	13.5 (6.7)	**13.6*** (7.8)**
Score 8 or above (%)	93	94	92	85	95	96	78	83	80	78	81	87	**79**
AUDIT zones:													
Score 0-7	7	6	8	15	5	19	26	17	19	17	19	13	**21**
Score 8-15	52	32	33	45	50	48	51	42	37	53	56	56	**42**
Score 16-19	20	26	26	11	17	23	13	22	17	18	12	15	**18**
Score 20 or higher	21	36	33	29	28	10	10	19	24	12	13	16	**19**

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. / data not available. Statistical significance for 2021 versus 2022 presented in table; *p<0.050; **p<0.010; ***p<0.001.

Overdose Events

Non-Fatal Overdose

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

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

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

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

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

Non-Fatal Stimulant Overdose

In 2022, almost one-quarter (24%) of the Hobart sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview, a significant increase relative to 2021 (10%; *p*=0.021) (Figure 46).

The most common stimulants reported during the most recent non-fatal stimulant overdose in the past 12 months comprised any form of ecstasy (71%; individual numbers for forms too low to report (n≤5 participants)). Few participants (n≤5) reported stimulant overdose from methamphetamine or cocaine; therefore, these data are suppressed. The vast majority (88%) reported that they had consumed one or more additional drugs on the last occasion, with alcohol being most commonly reported (71%; ≥5 standard drinks: 41%; ≤5 standard drinks: n≤5 participants) followed by cannabis (41%). On the last occasion of experiencing a non-fatal stimulant overdose, 94% reported that they did not receive treatment or assistance. Due to low numbers reporting that they had received treatment or assistance (n≤5), please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

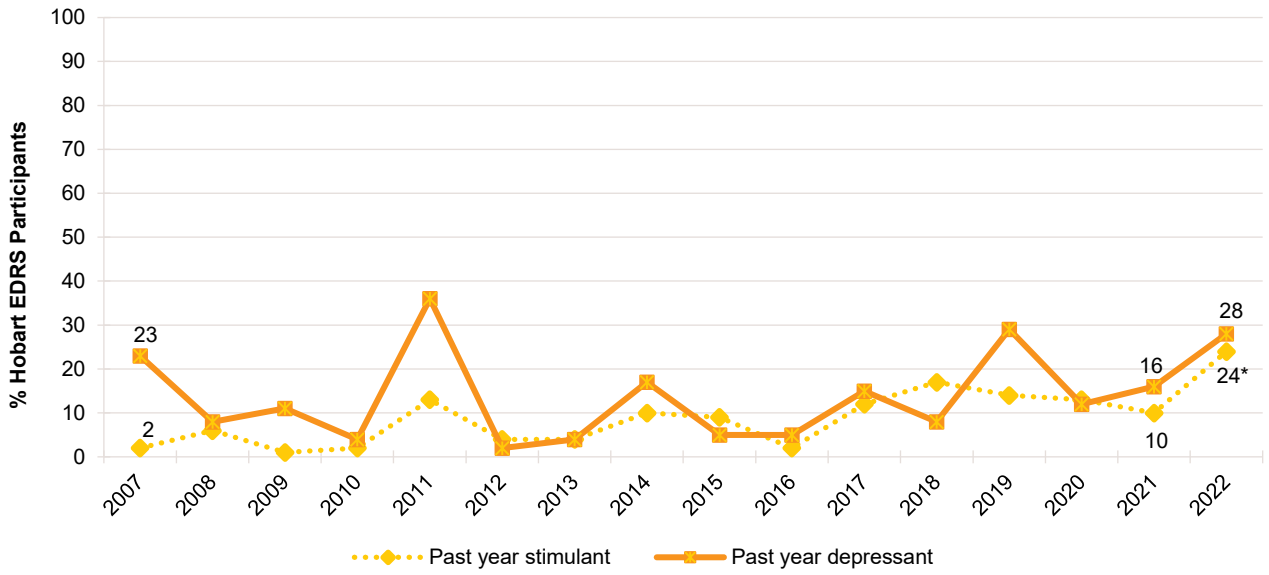
Non-Fatal Depressant Overdose

Alcohol: One-quarter (25%) of the Hobart sample reported a non-fatal alcohol overdose in the 12 months preceding interview (13%; *p*=0.052) on a median of two occasions (IQR=2-5; median of one occasion in 2021; IQR=1-4). Of those who had experienced an alcohol overdose in the past year (n=18), the majority (83%) reported not receiving treatment on the last occasion. Due to low numbers reporting that they had received treatment or assistance (n≤5), please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Any depressant (including alcohol): In 2022, 28% of participants reported that they had experienced a non-fatal depressant overdose in the past 12 months, trending toward an increase from the percentage in 2021 (16%; *p*=0.090) (Figure 46).

Of those who had experienced any depressant overdose in the past 12 months (n=18), the majority of participants reported alcohol as the most common depressant drug (90%). Few participants (n≤5) reported an overdose due to other drugs, therefore, these data are suppressed. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

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

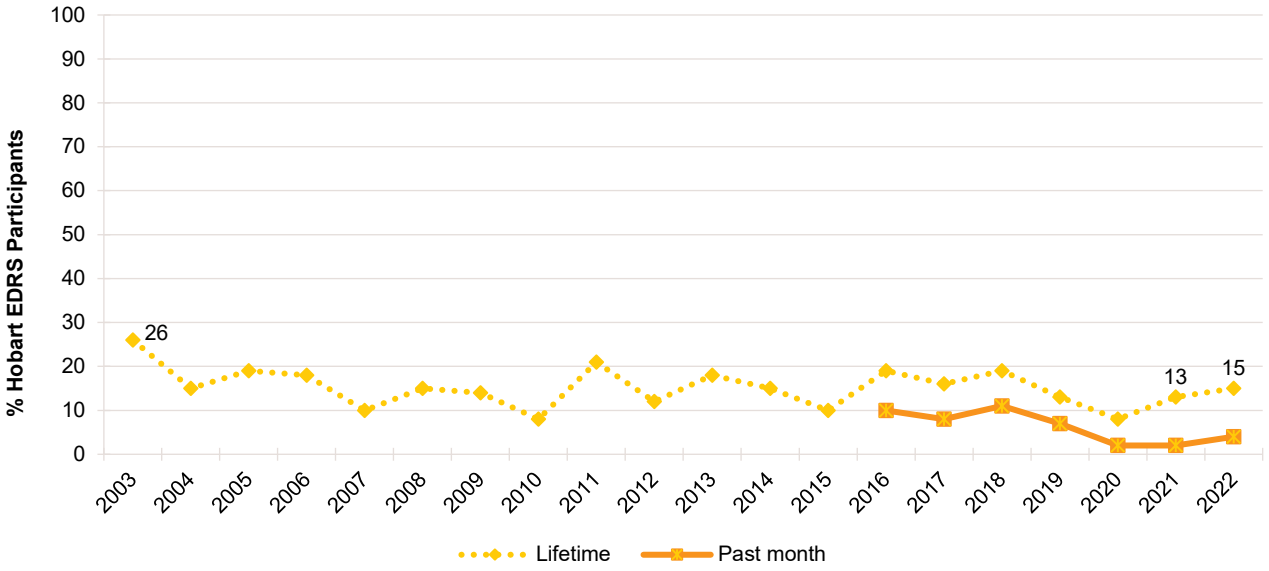


Note. Past year stimulant and depressant overdose was first asked about in 2007. In 2019, items about overdose were revised, and changes relative to 2018 may be a function of greater nuance in capturing depressant events. Data labels are only provided for the first (2007) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤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

Fifteen per cent of the Hobart sample reported lifetime injection in 2022 (13% in 2021; p=0.814). The per cent who reported injecting drugs in the past month remained low in 2021 and 2022 (n≤5; data are suppressed) (Figure 47). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

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



Note. Items assessing whether participants had injected drugs in the past month were first asked in 2016. Data labels are only provided for the first (2003/2016) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤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

A nominal per cent reported currently receiving drug treatment (n≤5); this is consistent with reporting in previous years. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Sexual Health Behaviours

In 2022, of those who were able to comment (n=61), 79% of the Hobart sample reported engaging in some form of sexual activity in the past four weeks (82% in 2021; *p*=0.683). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if interview undertaken face-to-face).

Of those who had engaged in sexual activity in the past four weeks and who responded (n=47), 85% reported using alcohol and/or other drugs prior to or while engaging in sexual activity (82% in 2021; *p*=0.632). Of those who had engaged in sexual activity in the past four week and responded (n=48), few participants (n≤5) reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (11% in 2021; *p*=0.533). Furthermore, of those who had engaged in sexual activity in the past four weeks and who responded (n=47), few participants (n≤5) reported penetrative sex without a condom where they did not know the HIV status of their partner (16% in 2021; *p*=0.443) (Table 6).

Of the total Hobart sample who responded (n=61), 39% reported having had a sexual health check-up in the six months prior to interview (39% in 2021; *p*=0.335), whilst 89% had done so in their lifetime (80% in 2021; *p*=0.035). Of the total Hobart sample who responded (n=60), few (n≤5) participants reported that they had received a positive diagnosis for a sexually transmitted infection (STI) in the past six months in 2022 (n≤5 in 2021; *p*=0.353); and 27% had received a positive diagnosis in their lifetime (18% in 2021; *p*=0.247).

Of those who commented (n=60), one-fifth (22%) of the sample reported having a test for human immunodeficiency virus (HIV) in the six months prior to interview (18% in 2021; *p*=0.645), whilst 57% had done so in their lifetime (53% in 2021; *p*=0.736). In 2022, no participants had been diagnosed with HIV in the past six months (0% in 2021; *p*=0.003) and no participants had been diagnosed with HIV in their lifetime (n≤5 in 2021).

Table 6: Sexual health behaviours, Hobart, TAS, 2021-2022

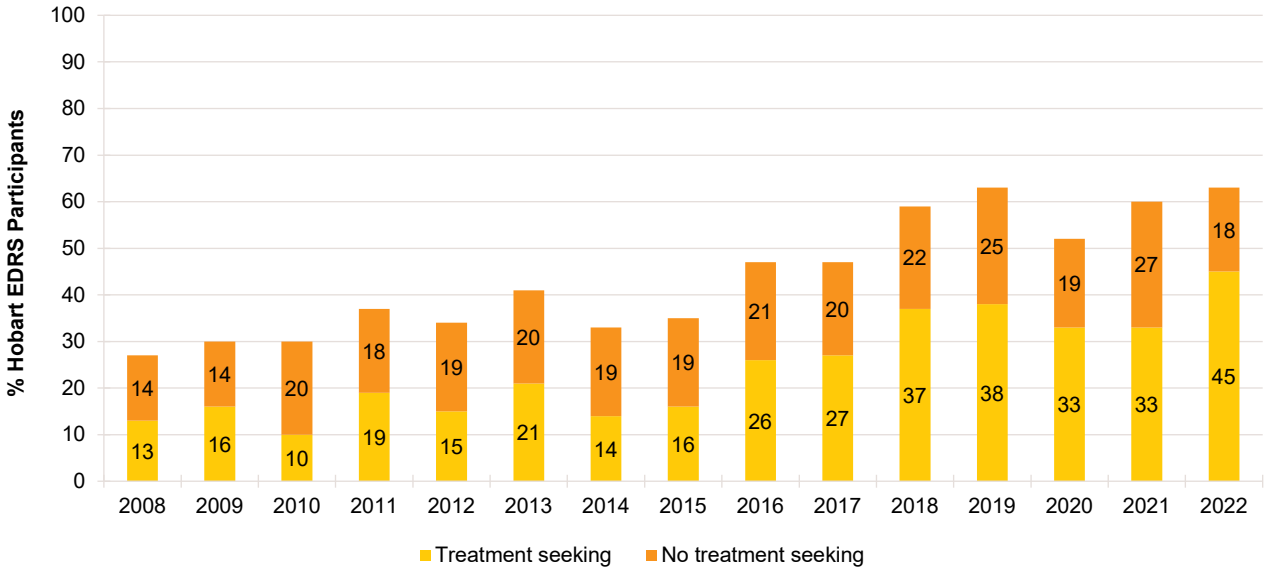
	2021	2022
Of those who responded:	N=99	**N=61**
% Any sexual activity in the past four weeks (n)	82 (n=81)	**79 (n=48)**
Of those who responded# and reported any sexual activity in the past four weeks	n=82	**n=47**
% Drugs and/or alcohol used prior to or while engaging in sexual activity	82	**85**
Of those who responded# and reported any sexual activity in the past four weeks:	n=82	**n=48**
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	11	**-**
Of those who responded# and reported any sexual activity in the past four weeks:	n=81	**n=47**
% Had penetrative sex without a condom and did not know HIV status of partner	16	**-**
Of those who responded#:	n=98	**n=60**
% Had a HIV test in the last six months	18	**22**
% Had a HIV test in their lifetime	53	**57**
Of those who responded#:	n=98	**n=60**
% Diagnosed with HIV in the last six months	0	**0**
% Diagnosed with HIV in their lifetime	--	**0**
Of those who responded#:	n=100	**n=61**
% Had a sexual health check in the last six months	39	**39**
% Had a sexual health check in their lifetime	80	**89***
Of those who responded#:	n=98	**n=60**
% Diagnosed with a sexually transmitted infection in the last six months	-	**-**
% Diagnosed with a sexually transmitted infection in their lifetime	18	**27**

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. Statistical significance for 2021 versus 2022 presented in table; *p<0.050; **p<0.010; ***p<0.001.

Mental Health

Sixty-three per cent of the Hobart sample self-reported that they had experienced a mental health problem in the preceding six months (other than substance use disorder), stable relative to 2021 (60%; p=0.741). Of those who reported a mental health problem in 2022 (n=45), the most common mental health problem was anxiety (71%), followed by depression (69%) and post-traumatic stress disorder (PTSD; 24%). Of those that reported experiencing a mental health problem (n=45), 71% reported seeing a mental health professional during the past six months (55% in 2021; p=0.111) (45% of the total sample in 2022) (Figure 48). Of those who reported seeing a mental health professional in 2022 (n=32), 72% reported being prescribed medication for their mental health problem (36% in 2021; p=0.008).

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

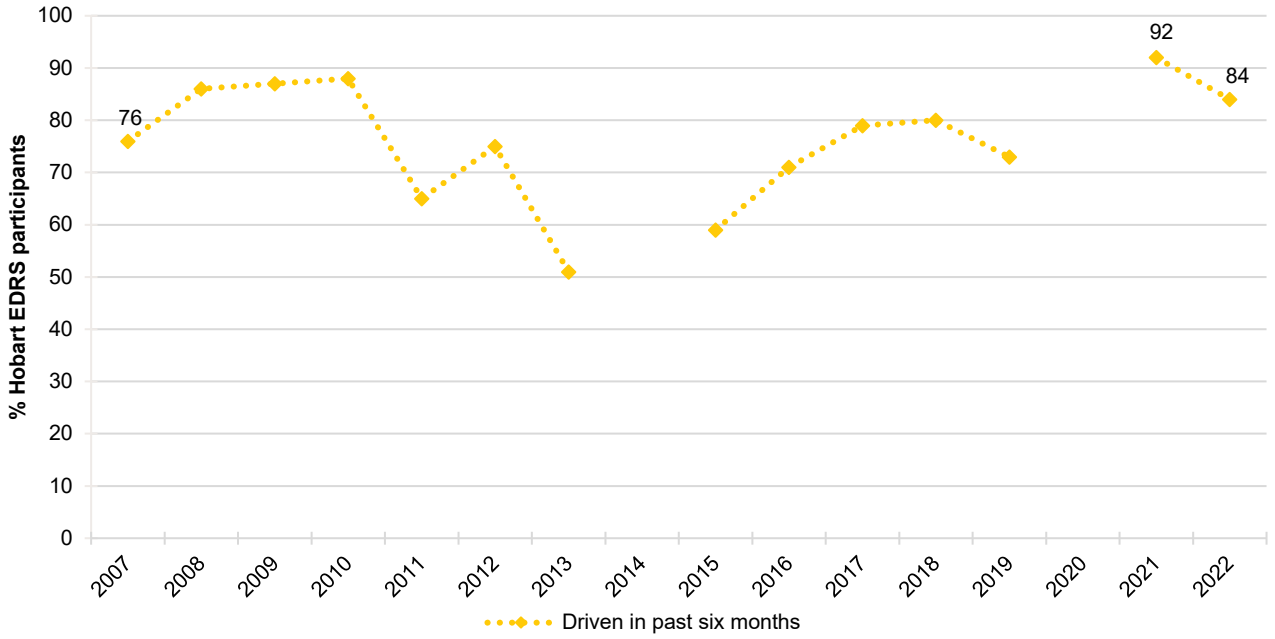


Note. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. Data labels have been removed from figures with small cell size (i.e., n≤5 but not 0). The response option 'Don't know' was excluded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

Driving

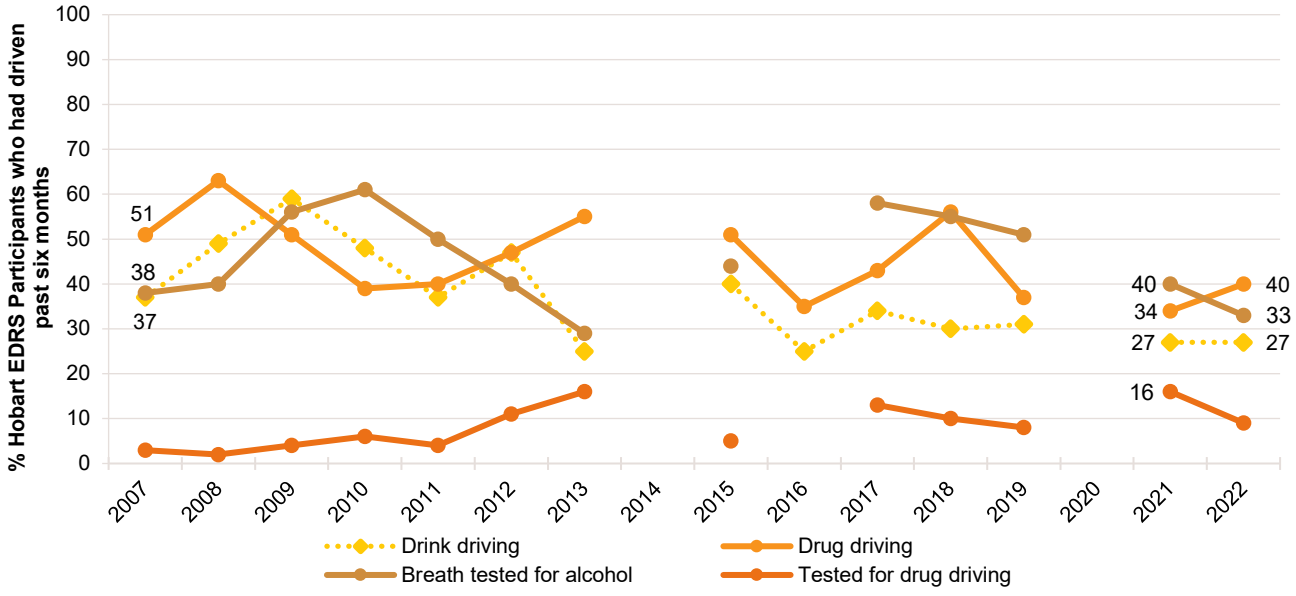
In 2022, 84% of the Hobart sample had driven a car, motorcycle or other vehicle in the last six months (Figure 49). Of those who had driven in the past six months and responded (n=52), 27% reported driving while over the (perceived) legal limit of alcohol (27% in 2021) and two-fifths (40%) reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months (34% in 2021; p=0.488) (Figure 50). Among those who had driven in the past six months and responded (n=57), one-third (33%) reported that they had been breath tested for alcohol by the police roadside testing service (28%in 2021; p=0.481), whereas few participants (n≤5) reported that they had been tested for drug driving by the police roadside drug testing service in the six months prior to interview; therefore, further details are suppressed (11% in 2021, p=0.224) (Figure 50).

Figure 49: Self-reported driving in the past six months, Hobart, TAS, 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 50: Self-reported testing and driving in the past six months over the (perceived) legal limit for alcohol and three hours following illicit drug use, among those who had driven in the past six months, Hobart, TAS, 2007-2022



Note. Computed of those who had driven a vehicle in the past six months. Questions about driving behaviour were first asked about in 2007. Questions about driving behaviour not asked in 2014 or 2020. Questions about alcohol and drug driving testing were not asked in 2014, 2016 and 2020. Data labels are only provided for the first (2007) and two most recent years (2021 and 2022) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤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

Thirty-nine per cent of the Hobart sample reported 'any' crime in the past month (32% in 2021; *p*=0.323), with drug dealing (27%; 15% in 2021; *p*=0.077) and property crime (23%; 24% in 2021) being the two main forms of criminal activity in 2021 (Figure 51).

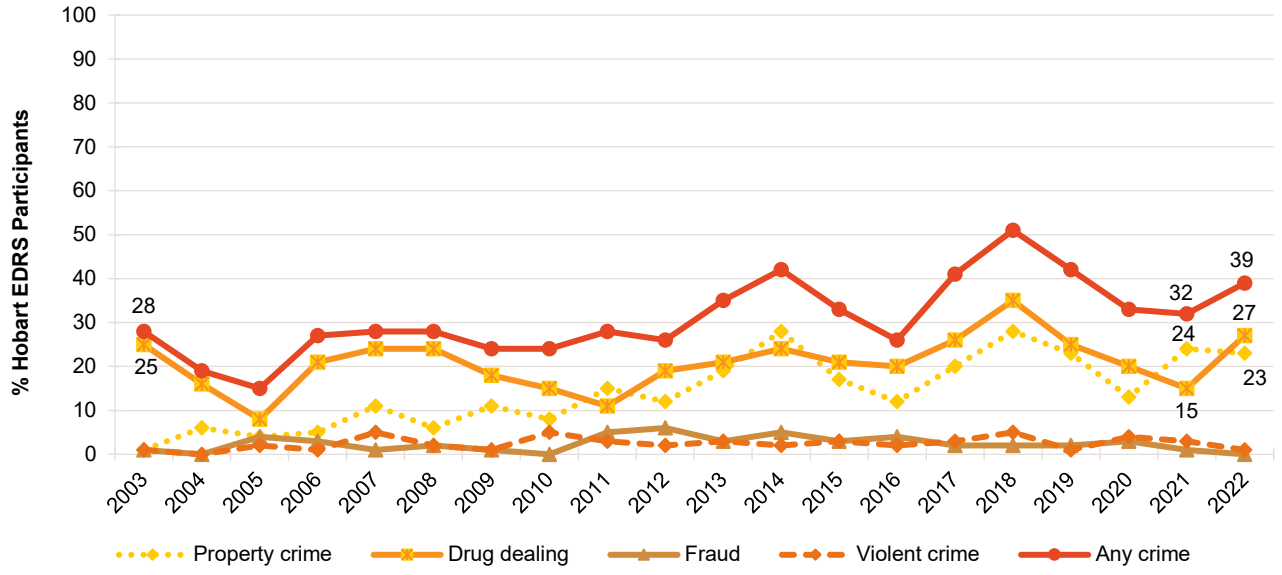
In 2022, one-tenth (10%) of the Hobart sample reported being the victim of a crime involving violence, stable relative to 2021 (8%; *p*=0.589).

Ten per cent of the 2022 Hobart sample reported having been arrested in the 12 months preceding interview (12% in 2021; *p*=0.804). Few participants (n≤5) reported reasons for arrest; therefore, these data are suppressed. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

In 2022, few participants (n≤5) reported a drug-related encounter in the last 12 months which did not result in charge or arrest; therefore, further details are suppressed (data not collected in 2021).

Few participants (n≤5) reported having ever been in prison in 2022, consistent with previous years. Please refer to the National EDRS Report or contact the Drug Trends team for further information.

Figure 51: Self-reported criminal activity in the past month, Hobart, TAS, 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. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Modes of Purchasing Illicit or Non-Prescribed Drugs

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

Purchasing Approaches

In 2022, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (73%), stable relative to 2021 (70%; *p*=0.853). This was closely followed by social networking applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (67%; 66% in 2021). It is important to re-iterate that this refers to people *arranging the purchase* of illicit or non-prescribed drugs. This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person. In 2022, 35% reported arranging the purchase of illicit or non-prescribed drugs via text messaging (37% in 2021; *p*=0.864) and almost one-quarter (24%) arranged the purchase via a phone call (27% in 2021; *p*=0.720). Few (n≤5) participants reported arranging the purchase of illicit or non-prescribed drugs via the darknet; therefore, further details are suppressed (Table 7).

Obtaining Drugs

When asked about how they had received illicit drugs on any occasion in the last 12 months, the vast majority of participants reported face-to-face (95%), stable relative to 2021 (91%; *p*=0.527). In 2022, reports of receiving illicit drugs via post remained stable (11%; 7% in 2021; *p*=0.567). Few participants (n≤5) reported receiving illicit drugs via a collection point (collection point defined as a predetermined location where a drug will be left for later collection) (10% in 2021; *p*=0.782) (Table 7).

The majority of participants in 2022 reported obtaining illicit drugs from a friend/relative/partner/colleague (86%; 94% in 2021; *p*=0.173), followed by obtaining illicit drugs from a known dealer/vendor (63%; 68% in 2021; *p*=0.610). A significant increase was observed in the percentage of participants reporting obtaining illicit drugs from an unknown dealer/vendor in 2022 (42%; 22% in 2021; *p*=0.011) (Table 7).

Buying and Selling Drugs Online

In 2022, few (n≤5) participants reported that they had sold illicit drugs on the surface web or darknet market, in the 12 months preceding interview (n≤5 in 2021; *p*=0.862). On the other hand, 47% reported they had ever obtained illicit drugs through someone who had purchased them on the surface web or darknet market, with 38% having done so in the last 12 months (34% in 2021; *p*=0.708).

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

	2019	2020	2021	2022
	n=98	n=100	n=98	**n=63**
% Purchasing approaches in the last 12 months^				
Face-to-face	88	60	70	**73**
Surface web	4	-	-	**-**
Darknet market	7	8	4	**-**
Social networking applications#	68	71	66	**67**
Text messaging	43	34	37	**35**
Phone call	35	33	27	**24**
Grew/made my own	/	-	-	**-**
Other	0	-	0	**0**
% Means of obtaining drugs in the last 12 months^~				
Face-to-face	87	94	91	**95**
Collection point	/	11	10	**-**
Post	/	12	7	**11**
% Source of drugs in the last 12 months^				
Friend/relative/partner/colleague	91	86	94	**86**
Known dealer/vendor	62	69	68	**63**
Unknown dealer/vendor	32	22	22	**42***

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.

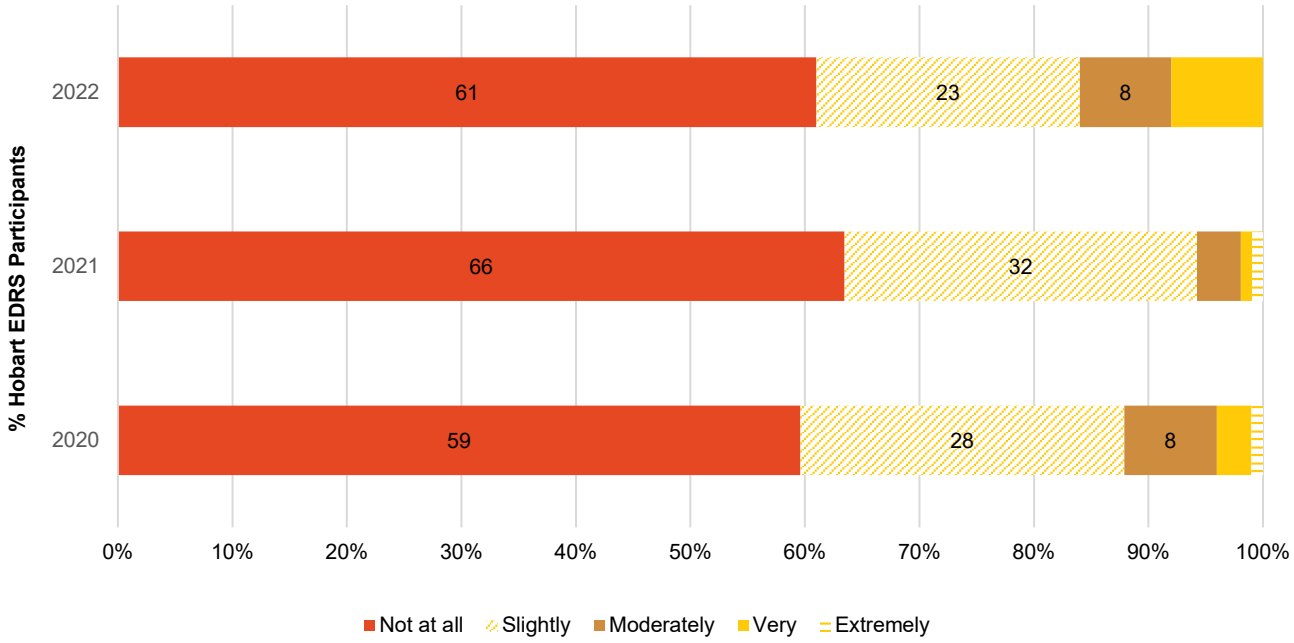
COVID-19 Testing and Diagnosis

In 2022, the majority (93%) of the sample had been tested for SARS-CoV-2 by the time of interview (50% in 2021; 6% in 2020), of whom 55% had received a PCR test and 92% a Rapid Antigen Test. Sixty-one per cent 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 15% quarantining in the month prior to interview and 61% in the six months prior to interview. At the time of interview, 86% reported that they had received at least one COVID-19 vaccine dose and the median number of doses received was three. No participants reported having received one dose, 39% reported that they had received two doses, and 54% of participants reported having received three or more doses.

When asked how worried they were currently about contracting COVID-19, 36% of participants reported some level of concern, with almost one-quarter (23%) responding that they were 'slightly' concerned and eight per cent reporting that they were 'moderately' concerned (Figure 52). Furthermore, 61% of participants reported that they would be concerned about their health if they did contract COVID-19, with 28% reporting that they would be 'slightly' concerned and 23% reporting that they would be 'moderately' concerned.

Figure 52: Current concern related to contracting COVID-19, Hobart, TAS, 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.