EDRS

VICTORIAN DRUG TRENDS 2022

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

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

Joanna Wilson[1], Sarah Eddy[1] & Paul Dietze[1,2]

[1] Burnet Institute

[2] National Drug Research Institute, Curtin University

ISBN 978-0-7334-4065-6

Suggested citation: Wilson, J., Eddy, S., & Dietze, P., (2022). Victorian Drug Trends 2022: Key Findings from the Ecstasy and Related Drugs Reporting System (EDRS) Interviews. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney. DOI: 10.26190/y23h-mq26

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

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

Table of Contents

List of Tables

List of Figures

Acknowledgements

Funding

In 2022, the Ecstasy and Related Drugs Reporting System (EDRS), falling within the Drug Trends program of work, was supported by funding from the Australian Government Department of Health and Aged Care under the Drug and Alcohol Program.

Research Team

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

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

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

Participants

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

Contributors

We thank all the individuals who assisted with the collection and input of data at a jurisdictional and national level. In particular we would like to thank Bianca Whiteside, Doriano Raffaele and Matt Cowman for conducting the Victorian EDRS interviews in 2022. We would also like to thank the Students for Sensible Drug Policy (SSDP) for their assistance in piloting the interview. We would also like to thank the members of the Drug Trends Advisory Committee, as well as the Australian Injecting & Illicit Drug Users League (AIVL), for their contributions to the EDRS.

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

Abbreviations

4-AcO-DMT	4-Acetoxy-*N,N*-dimethyltryptamine
4-FA	4-Fluoroamphetamine
5-MeO-DMT	5-methoxy-*N*,N-dimethyltryptamine
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
MDEA	3,4-Methylenedioxy-N-ethylamphetamine
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 deviation
SSDP	Students for Sensible Drug Policy
STI	Sexually transmitted infection
THC	Tetrahydrocannabinol
UNSW	University of New South Wales

VIC	Victoria
WA	Western Australia
WHO	World Health Organization

Executive Summary

The Melbourne, Victoria (VIC) 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 Melbourne, VIC. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected from April to July in 2022. 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 and those from previous samples.**

Sample Characteristics

The EDRS sample (N=100) recruited from Melbourne, VIC, was similar to the sample in 2021 and in previous years. The sample continued to predominantly comprise young men (52%) with a median age of 25 (IQR=22–28), most of whom held tertiary qualifications (62%) and were living in a rental house/flat (69%) or residing with their parents/at their family home (26%) at the time of interview. Drug of choice remained stable in 2022, with cannabis and cocaine nominated as the main drugs of choice (20% and 19%, respectively). There was a significant difference in the drug used most often in the past month in 2022 compared to 2021 (p<0.001). Specifically, there were fewer participants who nominated alcohol and cannabis as the substances used most often (26%; 45% in 2021; 22%; 36% in 2021, respectively). Weekly or more frequent use of ecstasy, cannabis, methamphetamine and cocaine remained stable between 2021 and 2022.

Ecstasy

In 2022, 90% of the sample reported use of 'any' ecstasy in the six months prior to interview, a percentage comparable to recent years (95% in 2021). Frequency of use also remained stable, with median days of 'any' ecstasy use at seven days in 2022. Four-fifths (82%) reported that their last ecstasy capsule contained the crystalline form ('crystal'), whilst 19% reported that it contained the powder form. The price of capsules increased significantly from $20 in 2021 to $25 in 2022 ($p$<0.001). The perceived availability of pills and capsules declined significantly between 2021 and 2022 (p=0.031 and p=0.010, respectively): more participants perceived availability to be 'difficult' in 2022 (49%; 24% in 2021, 48%; 23% in 2021, respectively). The perceived purity of crystal also changed significantly between 2021 and 2022 (p=0.031), with more participants perceiving purity as 'low' (26%; n≤5 in 2021).

Methamphetamine

Almost half (49%) of the sample reported any past six month use of methamphetamine in 2022, stable from 2021, with the majority (45% of the total sample) having used methamphetamine powder in the past six months (36% in 2021). Sixteen per cent of those who reported recent use reported weekly or more frequent use, stable from 2021. Frequency of use of crystal methamphetamine also remained stable at a median of 3 days. The vast majority of participants (90%) who reported crystal methamphetamine use reported smoking this form.

Cocaine

Recent use of cocaine has increased over the years of monitoring, with 91% of the sample reporting recent use – the highest recorded percentage over the years of the EDRS. Frequency of reported use remained stable compared to previous years, at six days, with 9% of participants who reported recent use reporting weekly or more frequent use. The median price of a gram of cocaine was reported as $350 in 2022, stable compared to previous years.

Cannabis and/or Cannabinoid Related Products

At least 80% of participants have reported recent use of non-prescribed cannabis and/or cannabinoid related products each year since monitoring commenced. Eighty-two per cent of participants reported recent use in 2022, stable from 2021. Weekly or more frequent use amongst those who reported recent non-

prescribed cannabis use remained stable at 60%, as did daily use (15%). Significantly fewer participants in 2022 reported use of non-prescribed bush cannabis (37%; 63% in 2021; p=0.003).

Ketamine, LSD and DMT

Relative to 2021, the percentages of the sample reporting recent use of ketamine, LSD, and DMT remained stable in 2022. Most of the sample (88%) reported recent use of ketamine, with 57% and 18% reporting recent use of LSD and DMT, respectively. Frequency of use of ketamine increased significantly to a median of 10 days in 2022 (6 days in 2021; p=0.020). There was a significant difference in the perceived availability of ketamine from 2021 to 2022 (p<0.001), with fewer participants reporting it to be 'very easy' to obtain in 2022 (15%; 52% in 2021). The median frequency of use of both LSD and DMT remained low in 2022 (3 days and 2 days, respectively).

New Psychoactive Substances (NPS)

Sixteen per cent reported recent use of any NPS (including plant-based NPS) in 2022. Any substance of the 2C class was the most frequently reported NPS used in 2022 (9%).

Other Drugs

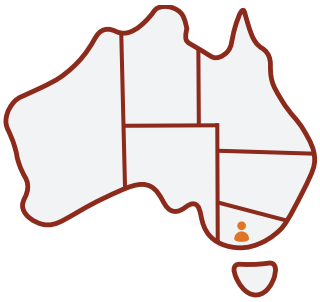
Reports of recent use of non-prescribed e-cigarettes significantly increased from 54% in 2021 to 71% in 2022 (p=0.020). Two-thirds (64%) of the sample reported recent use of non-prescribed pharmaceutical stimulants and hallucinogenic mushrooms, respectively, and 47% reported recent use of non-prescribed benzodiazepines, stable relative to 2021.

Drug-Related Harms and Other Behaviours

Most participants (87%) reported concurrent use of two or more drugs on the last occasion of ecstasy or other drug use, most commonly stimulants and depressants. Three-fifths (58%) of participants reported ever having tested the contents of their illicit drugs in Australia, with 40% doing so in the past year, most commonly using colorimetric or reagent test kits (91%). Hazardous alcohol use remained common, with 76% of the sample scoring above the hazardous range in the Alcohol Use Disorders Identification Test (AUDIT). Twelve per cent reported a non-fatal stimulant overdose, and 22% a non-fatal depressant overdose (including alcohol), in the past year. Few participants reported past month injecting drug use in 2022, and small numbers (n≤5) reported receiving drug treatment. Three-quarters (76%) reported engaging in some form of sexual activity in the past four weeks, of whom 21% reported penetrative sex without a condom where they did not know the HIV status of their partner. Significantly fewer participants reported that they had used alcohol and/or other drugs before or during sexual activity in the previous month in 2022 (84%; 95% in 2021; p=0.036). Two-thirds (64%) of the sample self-reported that they had experienced a mental health problem in the preceding six months. Of those participants, the most common problems identified were anxiety (71%), depression (67%) and post-traumatic stress disorder (PTSD). Of those who had driven in the past six months and commented (n=70), 26% reported having driven a motor vehicle while over (what they perceived to be) the legal blood-alcohol limit, while 45% reported driving within three hours of consuming an illicit or non-prescribed substance (most commonly cannabis). Thirty-eight per cent of participants reported 'any' crime in the past month in 2022, with property crime reported as the main form of self-reported criminal activity in 2022 (28%), followed by drug dealing (23%). The most popular means of arranging the purchase of illicit drugs remained social networking applications (84%), followed by face-to-face (56%). Almost all (96%) participants reported obtaining illicit drugs face-to-face. Almost all (97%) of the sample had been tested for SARS-CoV-2 in the 12 months preceding interview in 2022, with 79% reporting having been diagnosed with COVID-19. Most (72%) reported that they were 'not at all' worried about contracting COVID-19, and almost all (98%) reported that they had received at least one dose of the COVID-19 vaccine (median of three doses).

EDRS Ecstasy and Related Drugs Reporting System

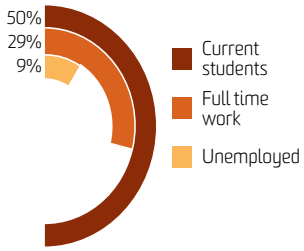
2022 SAMPLE CHARACTERISTICS



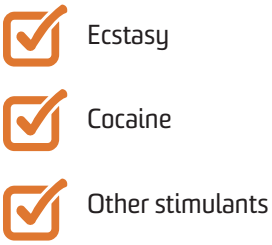
In 2022, 100 participants, recruited from Melbourne, VIC were interviewed.

25 years 52%

The median age in 2022 was 25, and 52% identified as male.

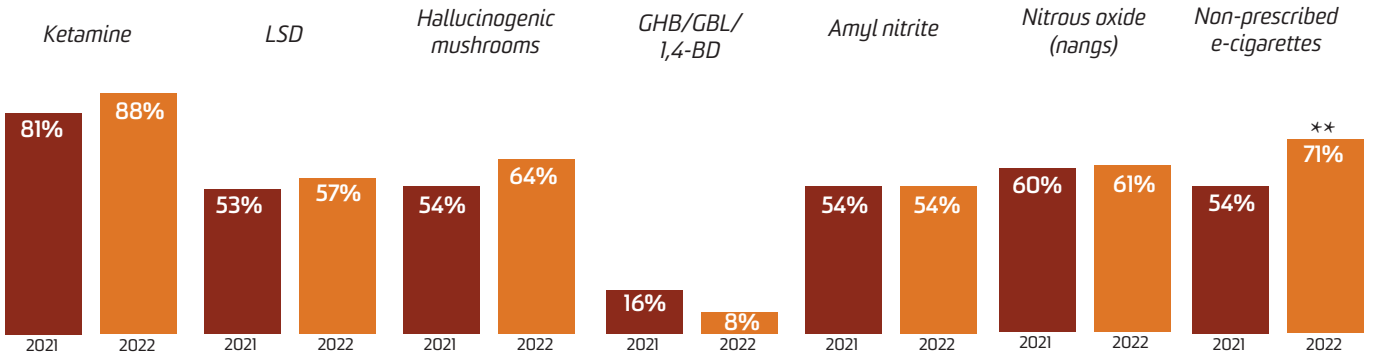


In the 2022 sample, 50% were enrolled students, 29% were employed full time and 9% were unemployed.



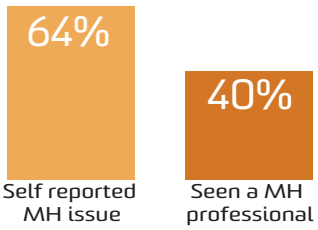
Participants were recruited on the basis that they had consumed ecstasy and/or other illicit stimulants at least monthly in the past 6 months.

PAST 6 MONTH USE OF SELECTED DRUGS

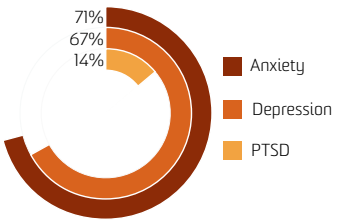


*p<0.050; **p<0.010; ***p<0.001

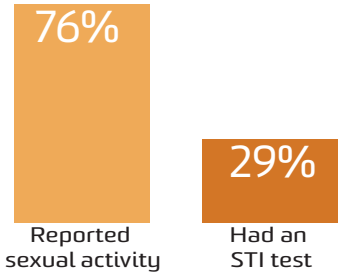
MENTAL HEALTH AND SEXUAL HEALTH BEHAVIOURS



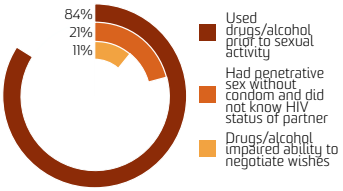
In the total sample, 64% self-reported a mental health issue and 40% had seen a mental health professional in the past 6 months.



Of those who had a mental health condition, the three most common mental health issues reported were anxiety (71%), depression (67%) and PTSD (14%).

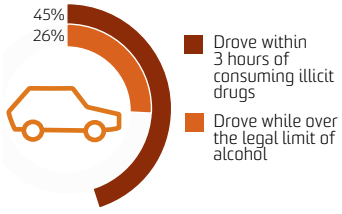


In the total sample, 76% reported sexual activity in the past 4 weeks, and 29% had a sexual health check in the past 6 months.



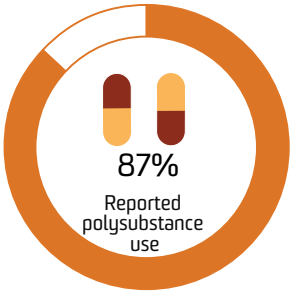
Sexual risk behaviours among those who reported any sexual activity in the past four weeks and were able to comment.

OTHER RISK BEHAVIOURS

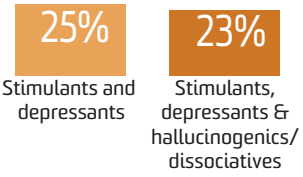


Among recent drivers, 45% reported driving a vehicle within 3 hours of consuming illicit drugs and 26% while over the legal limit of alcohol.

In the 2022 sample, 18% reported a non-fatal depressant overdose in the previous 12 months, stable relative to 2021 (14%).

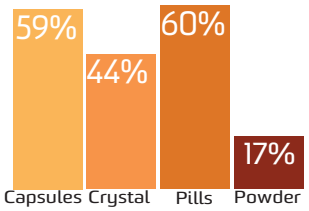


In the total sample, 87% reported concurrent use of two or more substances on the last occasion of ecstasy or related drug use.

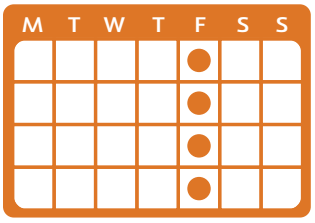


The most commonly used combinations of drug classes on the last occasion of ecstasy or related drug use.

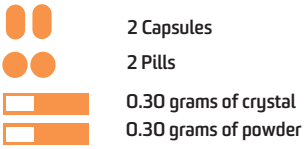
ECSTASY



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



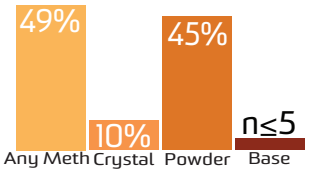
Of those who had recently consumed ecstasy, 12% reported weekly or more frequent use.



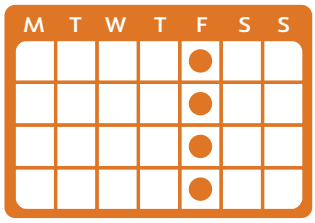
Median amounts of ecstasy consumed in a 'typical' session using each form.

In 2022, more participants perceived the availability of pills and capsule forms as 'difficult' relative to 2021.

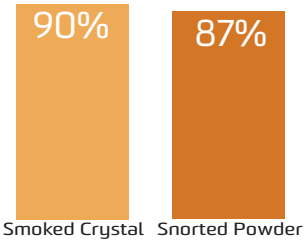
METHAMPHETAMINE



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



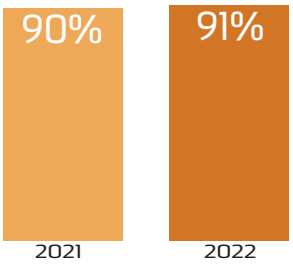
Of those who had recently consumed methamphetamine, 16% reported weekly or more frequent use.



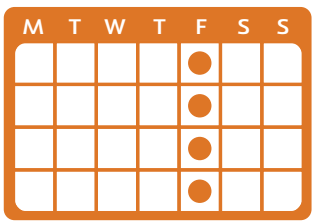
90% of participants who had recently used crystal smoked it. Of those who had recently used powder, 87% snorted it.

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

COCAINE

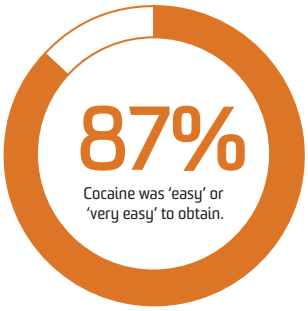


Past 6 month use of any cocaine remained stable between 2021 and 2022.



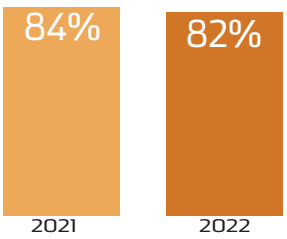
Of those who had recently consumed cocaine, 9% reported weekly or more frequent use.

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

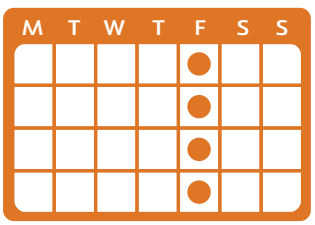


Of those who could comment, 87% perceived cocaine to be 'easy' or 'very easy' to obtain.

CANNABIS AND/OR CANNABINOID RELATED PRODUCTS

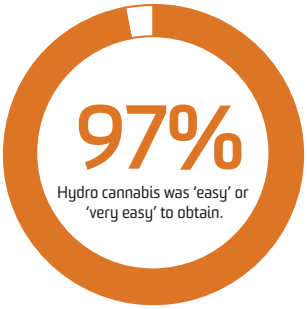


Past 6 month use of non-prescribed cannabis and/or cannabinoid related products remained stable between 2021 and 2022.



Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products, 60% reported weekly or more frequent use.

Of participants who had consumed non-prescribed cannabis and/or cannabinoid related products in the last 6 months, 91% had smoked it.



Of those who could comment, 97% 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. Its 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, but 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 Melbourne, VIC, struggled to recruit participants in 2021 and 2022. While it is difficult to provide a definitive reason for this, it is possible that it reflected a reduction in ecstasy and other illegal stimulant use due to ongoing government restrictions, and the cancellation of many music festivals and events in 2021.

A total of 700 participants were recruited across capital cities nationally (April-July, 2022), with 100 participants interviewed in Melbourne, VIC between 13th April and 8th July 2022. Seventy-one interviews were conducted via telephone.

Nine per cent of the 2022 Melbourne sample completed the interview in 2021, whereas few (n≤5) of the 2021 Melbourne sample completed the interview in 2020 (p=0.033). Recruitment methods remained stable in 2022 compared to 2021 (p=0.182), with 72% of participants being recruited via the internet (e.g., Facebook and Instagram) (62% in 2021), and 28% via word of mouth (38% in 2021).

Routinely Collected Data

Four different types of routinely collected data are presented in this report.

Drug seizure purity levels

The Drug Analysis Branch of the Victoria Police Forensic Services Department conducts purity analyses for all Victoria Police's drug seizures. The Victoria Police Forensic Services Department provided drug purity data for seizures of drugs in VIC for inclusion in this report for the 2020/21 financial year.

Ambulance attendances at non-fatal drug-related events

Turning Point manages an electronic drug-related ambulance attendance database containing information from Ambulance Victoria records. Data for the period between January 2005 and December 2021 are presented in this report.

Specialist drug treatment presentations

The Victorian Department of Health funds community-based agencies to provide specialist alcohol and other drug treatment services across the state. Data on people seeking treatment from specialist alcohol and other drug agencies in VIC are collected via the Alcohol and Drug Information System (ADIS) that has now become the Victorian Alcohol and Drug Collection (hereafter ADIS/VADC). During the 2020/21 financial year, 58,202 courses of treatment were delivered to 26,098 clients, compared to 57,298 courses of treatment delivered to 26,557 clients in the 2019/20 financial year.

Alcohol and other drug helpline calls

DirectLine is a 24-hour specialist telephone service in VIC (operated by Turning Point) that provides counselling, referral and advice about drug use and related issues. All calls to DirectLine are logged to an electronic database that can provide information about caller drugs of concern, calls from or about people who use drugs. This report presents data for the period between 1999 and 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 the statistical significance of differences between estimates for 2021 and 2022 have been conducted, noting that no corrections for multiple comparisons have been made and thus comparisons should be treated with caution. References to significant differences throughout the report are where statistical testing has been conducted and where the p-value is less than 0.050. Values with cell sizes ≤5 have been suppressed, with corresponding notation (zero values are reported). References to 'recent' use and behaviours mean the six months before interview.

Interpretation of Findings

Caveats to interpretation of findings are discussed more completely in the methods for the annual interviews, but it should be noted that these data are from participants recruited in Melbourne, VIC, and thus do not reflect trends in regional and remote areas. Further, the results are not representative of all people who consume illicit drugs, or of illicit drug use in the general population; rather, the study is 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 Melbourne, VIC (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 data from previous years, and treated with caution.

Additional Outputs

Infographics, executive summary and data tables from this report are available for download. A range of outputs from the EDRS 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 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 characteristics of the Melbourne EDRS sample were mostly similar to those of the sample in 2021 and in previous years (Table 1).

The gender identity distribution in 2022 was significantly different to 2021 (p=0.045), with 52% identifying as male (67% in 2021) and 43% identifying as female (26% in 2021). The median age of the sample was 25 years (IQR=22–28), similar to previous years (25 years in 2021; IQR=23–28; p=0.585). Accommodation also remained largely unchanged (p=0.086), with the majority of the 2022 Melbourne sample reporting that they lived in a rented house/flat (69%; 75% in 2021), and most of the remaining participants reporting living with their parents/in their family house (26%; 19% in 2021). Half (50%) reported that they were current students (42% in 2021; p=0.327), and almost three-fifths (62%) reported having obtained a post-school qualification(s) in 2022 (69% in 2021; p=0.374).

There was a significant change in employment status between 2021 and 2022 (p=0.031). Half (52%) of the participants reported part time/casual work, stable from 51% in 2021, while the percentage reporting that they were unemployed dropped from 23% in 2021 to 9% in 2022, andthe percentage reporting full-time employment rising from 18% in 2021 to 29% in 2022. There was also a significant increase in reported median weekly income, with participants earning a median of $700 (IQR=490-1154) per week in 2022 compared to $540 (IQR=350-906) in 2021 (p=0.008).

Table 1: Demographic characteristics of the sample, nationally, 2022, and Melbourne, VIC, 2017-2022

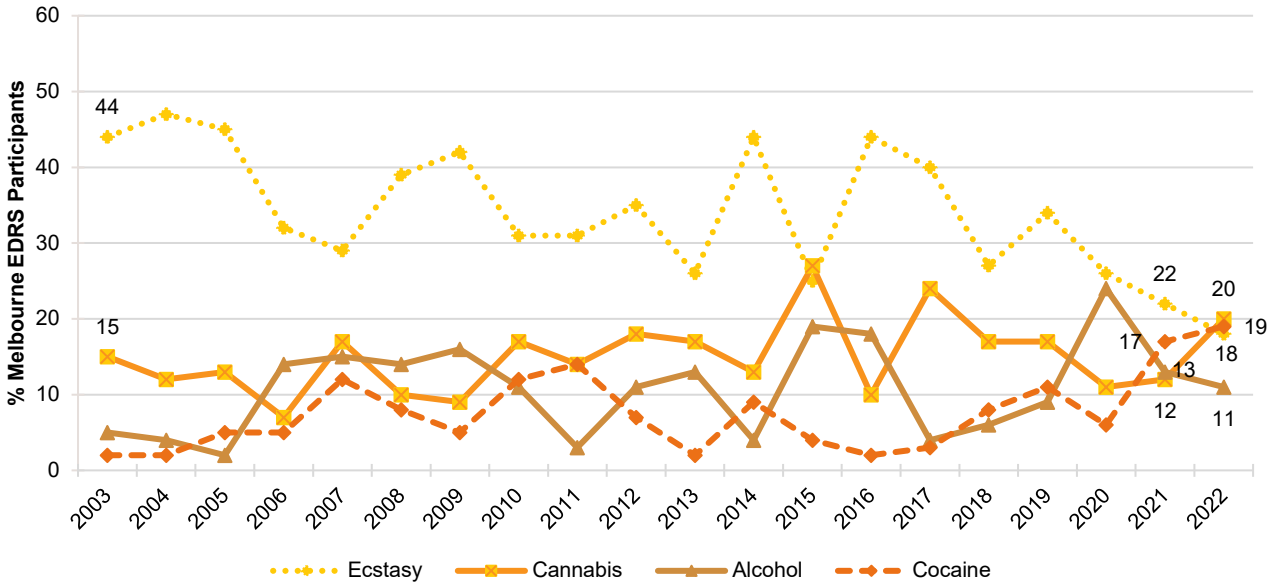
	Melbourne, VIC						National
	2017	2018	2019	2020	2021	2022	2022
	N=100	N-=100	N=99	N=100	N=100	N=100	N=700
Median age (years; IQR)	21 (19–23)	23 (20–25)	21 (17–26)	26 (22–30)	25 (23–28)	**25 (22–28)**	25 (21–30)
% Gender						*	
Female	43	41	48	38	26	**43**	40
Male	57	57	51	60	67	**52**	56
Non-binary	0	0	-	-	7	**-**	4
% Aboriginal and/or Torres Strait Islander	0	--	0	-	-	**-**	5
% Sexual identity					*		
Heterosexual	79	74	82	70	64	**64**	71
Homosexual	-	6	6	8	-	**-**	5
Bisexual	17	17	10	12	11	**18**	17
Queer	17	17	10	10	17	**11**	6
Different identity	0	-	-	0	6	**-**	2
Mean years of school education (range)	12 (9–12)	12 (9–12)	12 (8–12)	12 (8–12)	12 (8–12)	**12 (9-12)**	12 (6-12)
% Post-school qualification(s)^	42	32	57	64	69	**62**	61
% Current students#	**-**	**8**	51	40	42	**50**	41
% Current employment status						*	
Employed full-time	18	21	22	24	18	**29**	32
Part time/casual	/	/	/	37	51	**52**	41
Self-employed	/	/	/	-	8	**10**	8
Unemployed	17	14	25	34	23	**9**	19
Current median weekly income $ (IQR)	$300 (175–500)	$400 (250–760)	$450 (230–900)	$750 (441–963)	$540 (350–906)	**$700** (490-1154)**	700 (450-1200)
% Current accommodation							
Own house/flat	0	-	7	-	-	**-**	12
Rented house/flat	36	50	50	63	75	**69**	59
Parents'/family home	62	48	41	26	19	**26**	23
Boarding house/hostel	0	-	0	-	-	**0**	2
Public housing	/	-	-	-	0	**-**	2
No fixed address+	-	0	0	-	-	**0**	2
Other	-	0	-	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. - Percentage 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.

The pattern of participants' reported drug of choice in 2022 was similar to that observed in 2021 (p=0.557), although cannabis was most frequently nominated as the drug of choice in 2022 (20%; 12% in 2021), a change from 2021 where ecstasy was most commonly nominated (18% in 2022; 22% in 2021) (Figure 1). A significant change was observed in the drug used most often in the past month in 2022 (p<0.001). Specifically, there was a noticeable decrease in the proportion of participants nominating alcohol as the drug used most often in the month preceding interview (26%; 45% in 2021), as well as cannabis (22%; 36% in 2021), while there was an increase in reports of cocaine as the drug used most often (12%; n≤5 in 2021) (Figure 2).

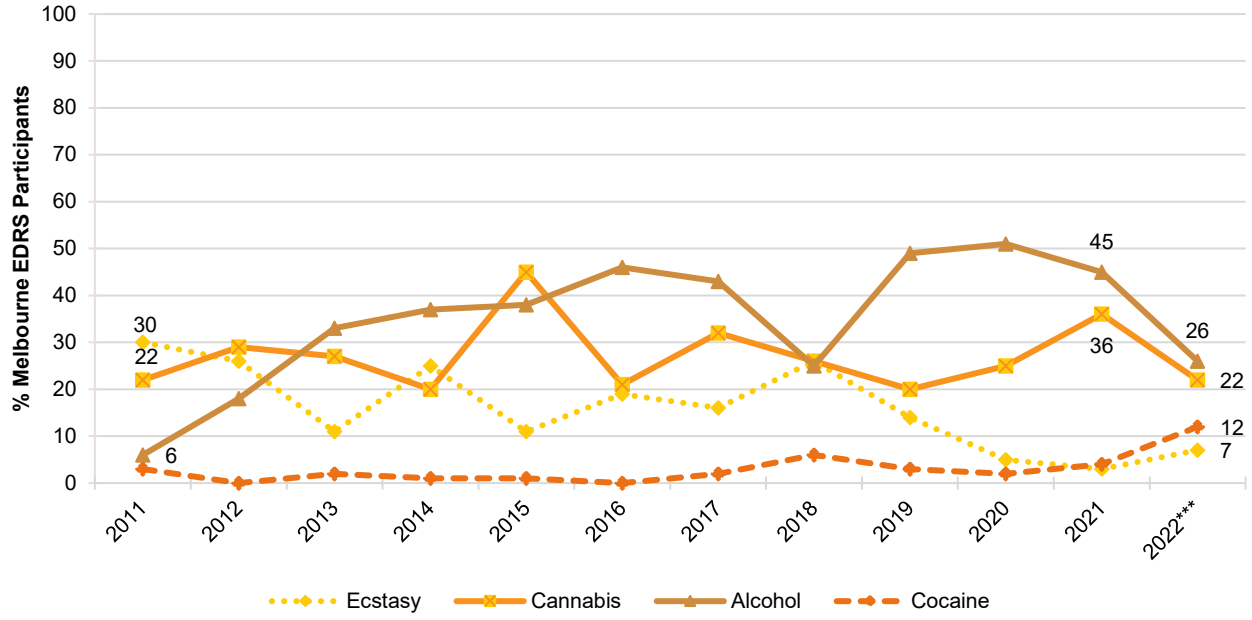
In 2022, almost half (49%) of the Melbourne sample reported weekly or more frequent cannabis use (48% in 2021) and 11% reported weekly or more frequent ecstasy use (n≤5 in 2021; p=0.126) (Figure 3). Almost one-tenth of participants (8%) also reported weekly or more frequent methamphetamine (n≤5 in 2021; p=0.373) and cocaine use (8%; 6% in 2021; p=0.779) (Figure 3).

Figure 1: Drug of choice, Melbourne, VIC, 2003-2022



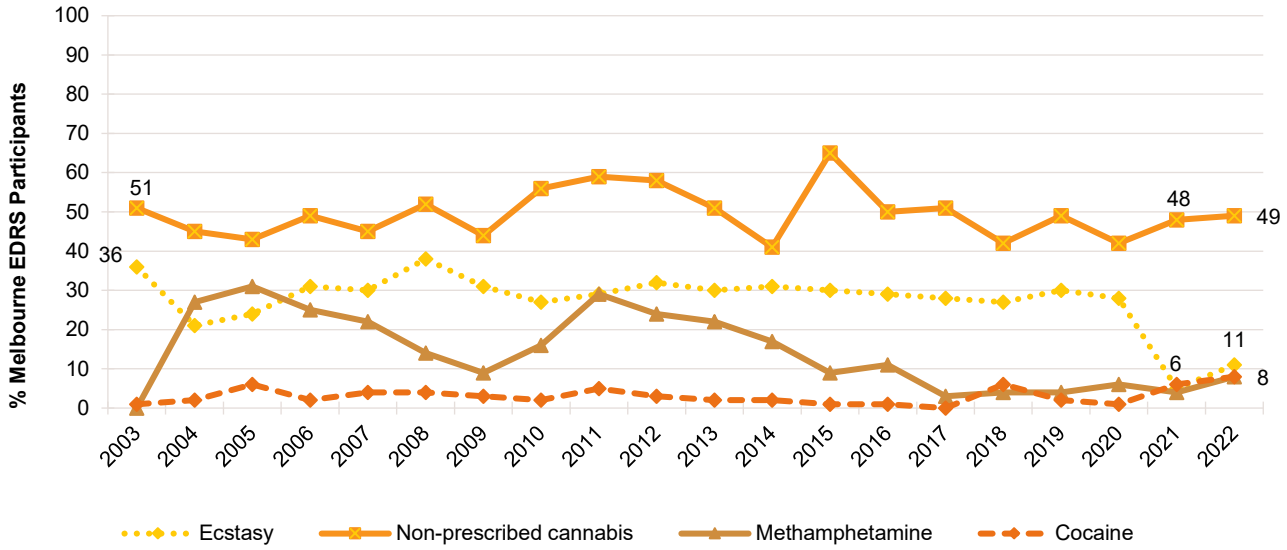
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Y axis reduced to 60% to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, and are suppressed for 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, Melbourne, VIC, 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 because 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, and are suppressed for 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, Melbourne, VIC, 2003-2022



Note. Computed from the entire sample regardless of whether they had used the substance in the past six months. Data labels are only provided for the first (2003/2004) and two most recent years (2021 and 2022) of monitoring, and are suppressed for 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.

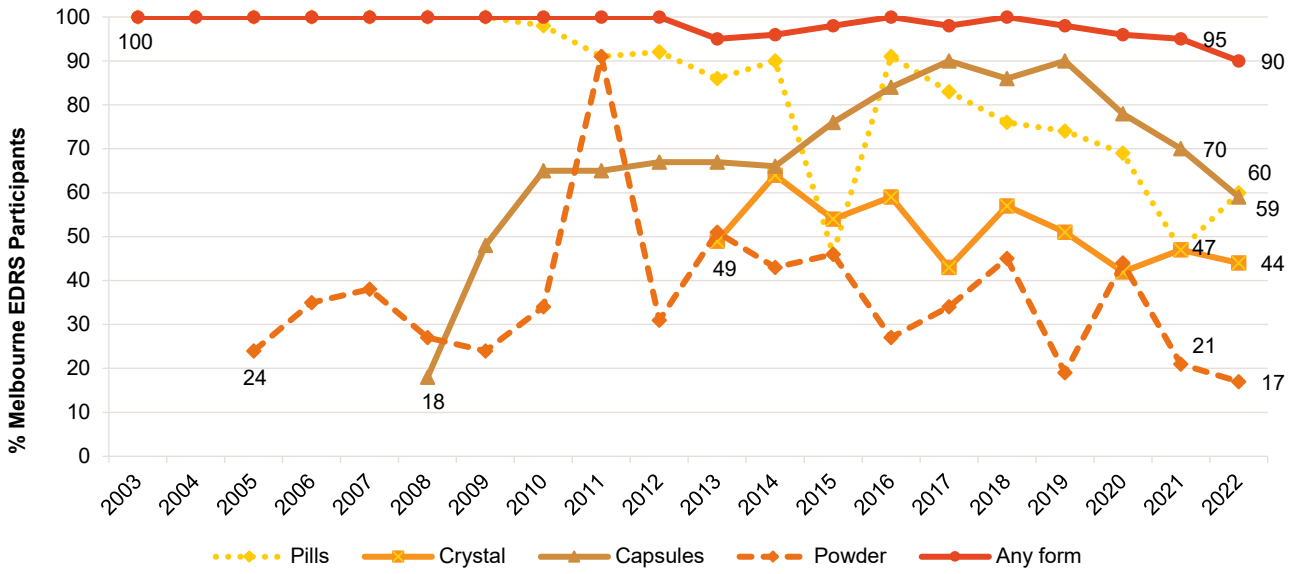
Recent Use (past 6 months)

Most participants (90%) reported use of any ecstasy in the past six months, consistent with previous years (95% in 2021; *p*=0.283) (Figure 4). There has been a shift over time to more frequent use of ecstasy capsules, which peaked in 2017 and 2019, with a decline evident afterwards, while reported use of ecstasy pills has declined since 2016. Past six month use of ecstasy in crystal and powder forms have fluctuated in recent years (discussed further below).

Frequency of Use

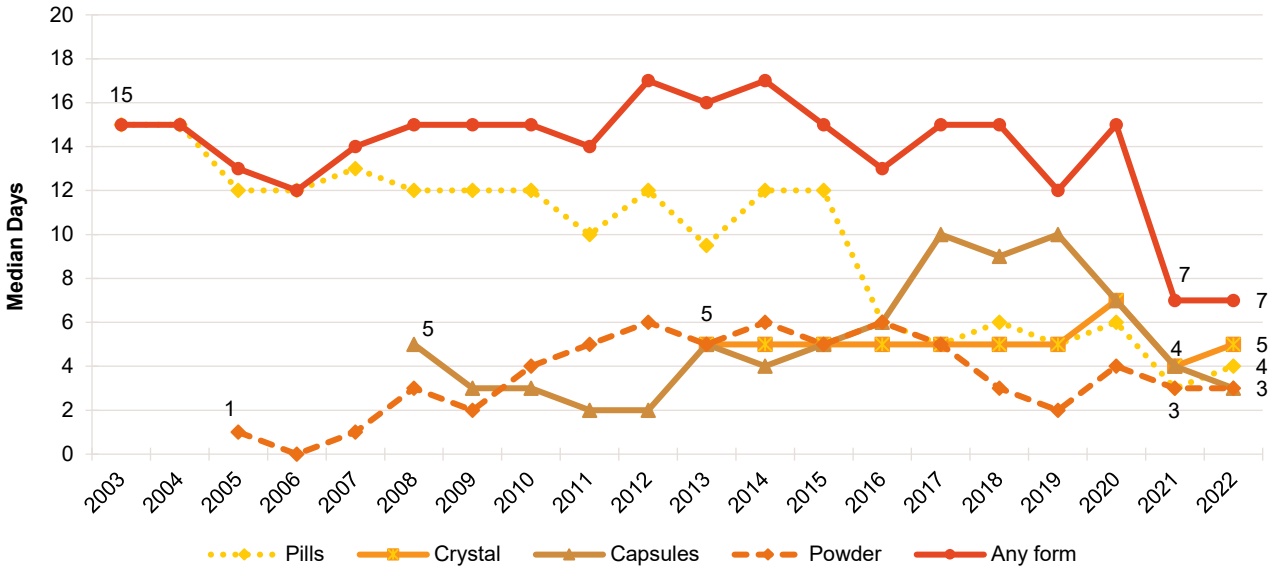
In 2022, among those who reported recent use of any ecstasy and commented (n=89), participants reported using ecstasy (in any form) on a median of seven days (IQR=4–12), equivalent to monthly use in the preceding six months (7 days in 2021; IQR=4–12; *p*=0.740). Weekly or more frequent use of any form of ecstasy remained stable from 2021 (12%; n≤5 in 2021; *p*=0.117) (Figure 5).

Figure 4: Past six month use of any ecstasy, and ecstasy pills, powder, capsules, and crystal, Melbourne, VIC, 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, and are suppressed for 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, Melbourne, VIC, 2003-2022



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; it was then 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, and are suppressed for 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): Recent use of ecstasy pills (60% in 2022) was comparable to 2021 (47% *p*=0.095) (Figure 4).

Frequency of Use: Among those who reported recent use and commented (n=60), ecstasy pills were reportedly used on a median of four days (IQR=2–6) in the six months preceding interview in 2022, stable from 2021 (3 days; IQR=2–5; *p*=0.534) (Figure 5). Few participants (n≤5) who reported recent consumption of ecstasy pills reported weekly or more frequent use in 2022, therefore these data are suppressed (n≤5 in 2021).

Routes of Administration: The most commonly reported route of administration was swallowing (98%; 100% in 2021), followed by snorting (27%; 26% in 2021). Few participants (n≤5) reported recent shelving/shafting.

Quantity: Of those who reported recent use and responded (n=60), the median number of pills reportedly used in a 'typical' session was two (IQR=1–2; 1 pill in 2021; IQR=1–2; *p*=0.190). The median maximum number of pills reportedly used was two (IQR=1–3; 2 pills in 2021; IQR=1–3; *p*=0.652).

Ecstasy Capsules

Recent Use (past 6 months): Recent use of ecstasy capsules was reported by 59% of participants in 2022, comparable to 2021 (70%; *p*=0.139) (Figure 4).

Frequency of Use: In 2022, among those who reported recent use and commented (n=58), participants reported consuming capsules on a median of three days in the past six months (IQR=2–7), a figure comparable to 2021 (4 days; IQR=3–6; *p*=0.337) (Figure 5). Few participants (n≤5) who reported recent ecstasy capsule consumption reported weekly or more frequent use in 2022, therefore these data are suppressed (n≤5 in 2021).

Routes of Administration: In 2022, among participants who reported recent ecstasy capsule consumption and commented (n=59), the majority (93%) reported swallowing, a significant decrease from 2021 (100%; *p*=0.041), and 19% reported snorting (19% in 2021). Few participants (n≤5) reported recent shelving/shafting.

Quantity: Of those who reported recent use and responded (n=58), the median number of capsules used in a 'typical' session was two (IQR=1–3), an increase from 2021 (1.3 capsules; IQR=1–2; *p*=0.047). The median maximum number of capsules used per session was three (IQR=2–4; 2 capsules in 2021; IQR=2–3; *p*=0.071).

Contents of Capsules: Of those who reported recent use and responded (n=57), most (82%) reported that their last capsule contained crystal (84% in 2021), whilst 19% reported that it contained powder (12% 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): Recent use of ecstasy crystal in 2022 was comparable to 2021 (44%; 47% in 2021; *p*=0.780) (Figure 4).

Frequency of Use: In 2022, among those who reported recent ecstasy crystal use and commented (n=44), participants reported using crystal on a median of five days (IQR=3–10), stable from four days in 2021 (IQR=2–9; *p*=0.350) (Figure 5). A small number (n≤5) who reported recent ecstasy crystal consumption reported weekly or more frequent use in 2022; therefore, these data are suppressed (n≤5 in 2021).

Routes of Administration: Among participants who had reported recent ecstasy crystal consumption and commented (n=44), 80% reported swallowing (68% in 2021; *p*=0.246), while 57% reported snorting (68% in 2021; *p*=0.292).

Quantity: Of those who reported recent ecstasy crystal use and responded (n=29), the median amount of ecstasy crystal reportedly used in a 'typical' session was 0.30 grams (IQR=0.20–0.40; 0.20 grams in 2021; IQR=0.20–0.40; *p*=0.516). Of those who reported recent use and responded (n=30), the median maximum amount of ecstasy crystal reportedly used was 0.50 grams (IQR=0.30–

0.50; 0.30 grams in 2021; IQR=0.20–0.50; *p*=0.740).

Ecstasy Powder

Recent Use (past 6 months): Recent use of ecstasy powder remained stable at 17% in 2022 (21% in 2021; *p*=0.587) (Figure 4).

Frequency of Use: In 2022, among those who reported recent ecstasy powder use and commented (n=17), ecstasy powder was reportedly consumed on a median of three days (IQR=2–6) in the past six months (3 days in 2021; IQR=2–4; *p*=0.466) (Figure 5). Few participants (n≤5) who reported recent ecstasy powder use reported weekly or more frequent use in 2022; therefore, these data are suppressed (0% in 2021; *p*=0.447).

Routes of Administration: Among participants who had recently consumed ecstasy powder and commented (n=17), 71% reported snorting (71% in 2021), with 41% reporting swallowing (52% in 2021; *p*=0.527).

Quantity: Of those who reported recent ecstasy powder use and responded (n=9), the median amount of ecstasy powder used in a 'typical' session was 0.30 grams (IQR=0.20–0.50; 0.30 grams in 2021; IQR=0.20–0.30; *p*=0.393). Of those who reported recent ecstasy powder use and responded (n=10), the median maximum amount of powder used was 0.50 grams (IQR=0.30–1.00; 0.50 grams in 2021; IQR=0.30–0.70; *p*=0.833).

Price, Perceived Purity and Perceived Availability

Ecstasy Pills

Price: The median reported price of a pill was $35 in 2022 (IQR=30–40; n=41), stable relative to 2021 (IQR=23–40; n=27; *p*=0.303) (Figure 6).

Perceived Purity: The perceived purity of ecstasy pills remained largely stable between 2021 and 2022 (*p*=0.260). Among those who responded in 2022 (n=56), 38% reported purity as 'fluctuating' (23% in 2021), while 29% reported purity as 'medium' (36% in 2021), 18% as 'high' (31% in 2021), and 16% as 'low' (10% in 2021) (Figure 8).

Perceived Availability: There was a significant difference in perceived availability of ecstasy pills between 2021 and 2022 (*p*=0.031). Among those who were able to comment in 2022 (n=57), 49% reported that pills were 'difficult' to obtain, a significant increase from 24% in 2021. A corresponding decrease was observed in those reporting pills as being 'easy' to obtain (33%; 47% in 2021) (Figure 12).

Ecstasy Capsules

Price: The median reported price of an ecstasy capsule was $25 in 2022 (IQR=20–30; n=40), a significant increase from $20 in 2021 (IQR=20–24; n=48; *p*<0.001) (Figure 6).

Perceived Purity: The perceived purity of ecstasy capsules remained stable between 2021 and 2022 (*p*=0.540). Among those who were able to comment in 2022 (n=56), 36% perceived purity to be 'medium' (37% in 2021) and 25% perceived purity to be 'low' (24% in 2021) (Figure 9).

Perceived Availability: There was a significant difference in perceived availability of ecstasy capsules between 2021 and 2022 (*p*=0.010). Among those who responded in 2022 (n=61), 48% reported that capsules were 'difficult' to obtain, a significant increase from 23% in 2021. A corresponding decrease was observed in those reporting capsules being 'easy' to obtain (34%; 51% in 2021) (Figure 13).

Ecstasy Crystal

Price: The median reported price of a gram of ecstasy crystal in 2022 was $200 (IQR=179–250; n=38; $200 in 2021; IQR=150–200; n=24; *p*=0.017) (Figure 7). Few participants (n≤5) reported purchasing a point of ecstasy crystal in 2022, therefore, these data are supressed (n≤5 in 2021).

Perceived Purity: There was a significant difference in the perceived purity of ecstasy crystal between 2021 and 2022 (*p*=0.031).

Among those who responded in 2022 (n=46), fewer participants perceived the purity of crystal to be 'medium' (33%; 39% in 2021) or 'high' (28%; 39% in 2021), with a corresponding increase in the number perceiving purity to be 'low' (26%; n≤5 in 2021) (Figure 10).

Perceived Availability: The perceived availability of ecstasy crystal remained largely stable between 2021 and 2022 (p=0.061). Among those who were able to comment in 2022 (n=48), 42% reported crystal as being 'difficult' to obtain (22% in 2021), and 33% reported crystal as being 'easy' to obtain (33% in 2021) (Figure 14).

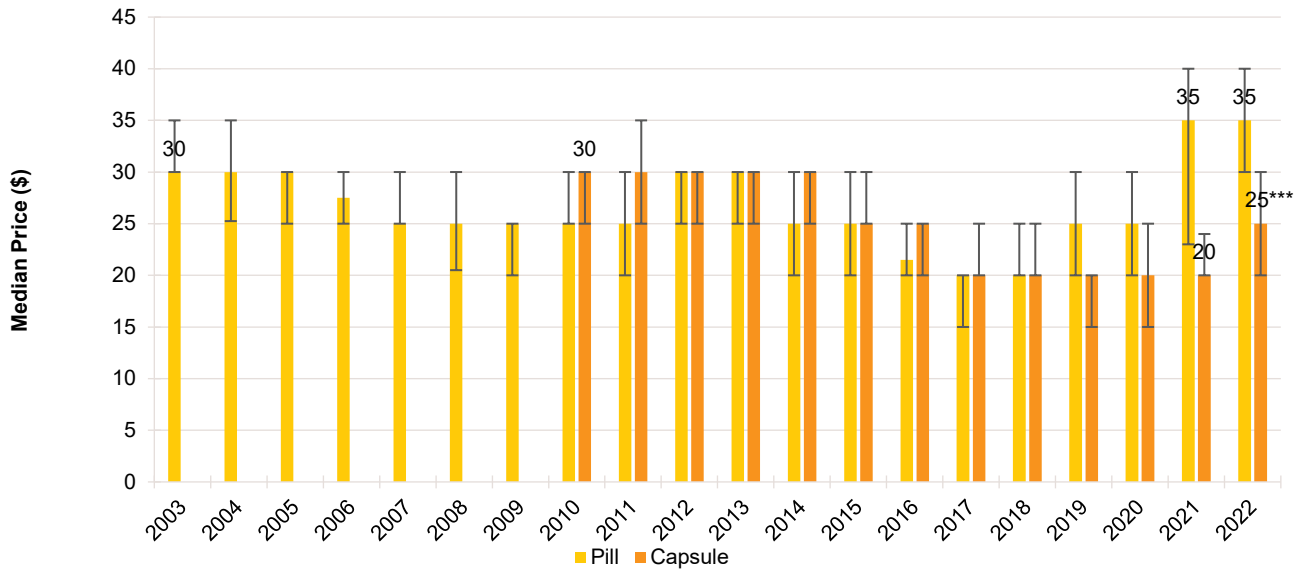
Ecstasy Powder

Price: The median price of a gram of ecstasy powder was $250 in 2022 (IQR=200–250; n=13), stable from $200 recorded in 2021 (IQR=185–200; n=6; p=0.059) (Figure 7).

Perceived Purity: The perceived purity of ecstasy powder remained stable between 2021 and 2022 (p=0.538). Among those who were able to comment in 2022 (n=18), one-third (33%) perceived purity to be 'low' (n≤5 in 2021) (Figure 11).

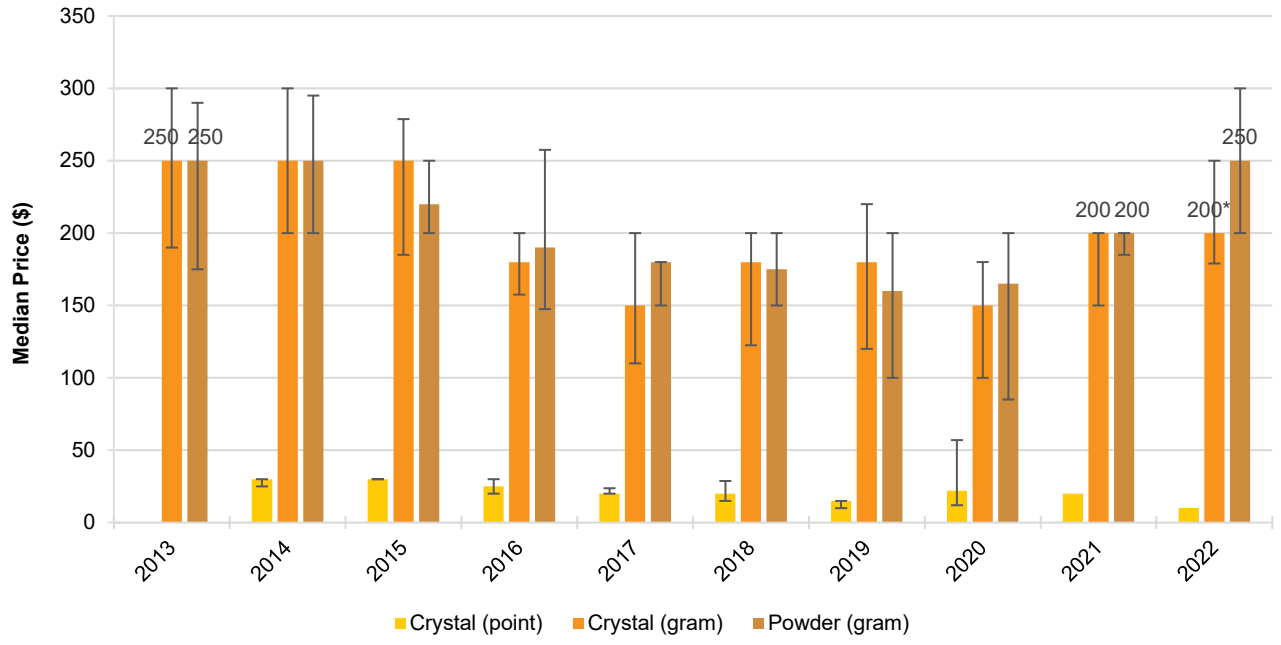
Perceived Availability: The perceived availability of ecstasy powder remained stable between 2021 and 2022 (p=0.127). Among those who were able to respond in 2022 (n=21), 38% reported powder as being 'easy' (29% in 2021) and 'difficult' (29% in 2021) to obtain in 2022, respectively (Figure 15).

Figure 6: Median price of ecstasy pill and capsule, Melbourne, VIC, 2003-2022



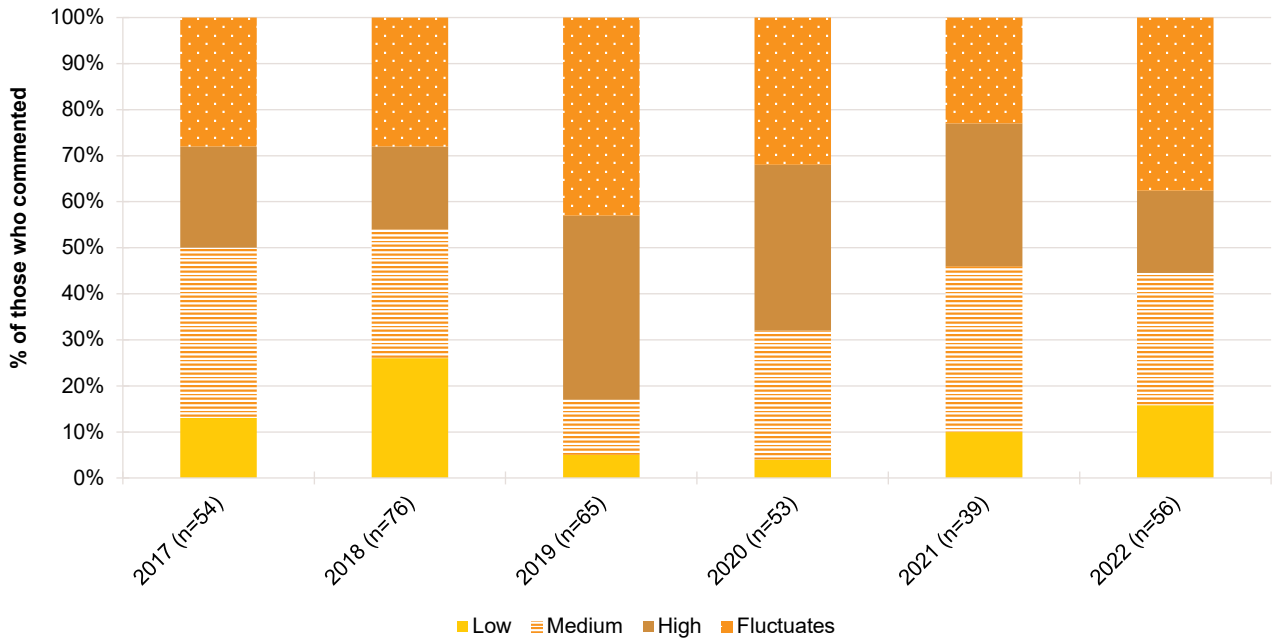
Note. Among those who commented. Data collection for price of ecstasy capsules started in 2008. Data labels are only provided for the first (2003/2010) and two most recent years (2021 and 2022) of monitoring, and are suppressed for small numbers (i.e., n≤5 but not 0). The response option 'Don't know' 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), Melbourne, VIC, 2013-2022



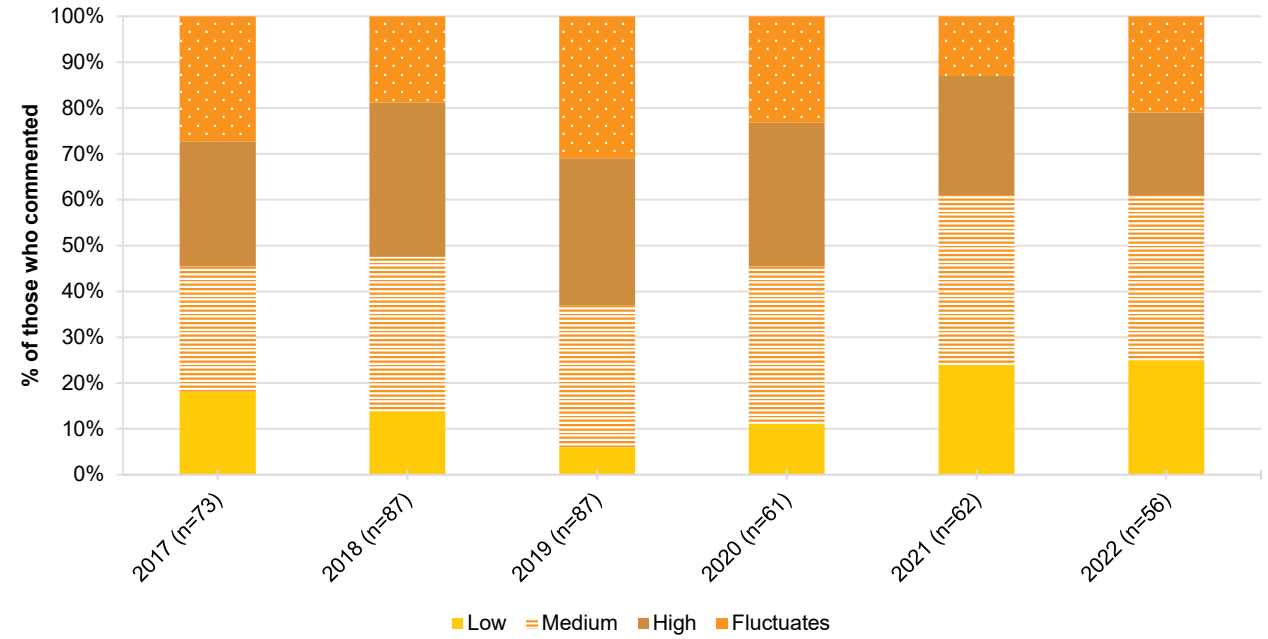
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) and ecstasy powder (gram) started in 2013. No participants reported price data for a 'point' of ecstasy crystal in 2021. Data labels are only provided for the first (2013) and two most recent years (2021 and 2022) of monitoring, and are suppressed for 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, Melbourne, VIC, 2017-2022



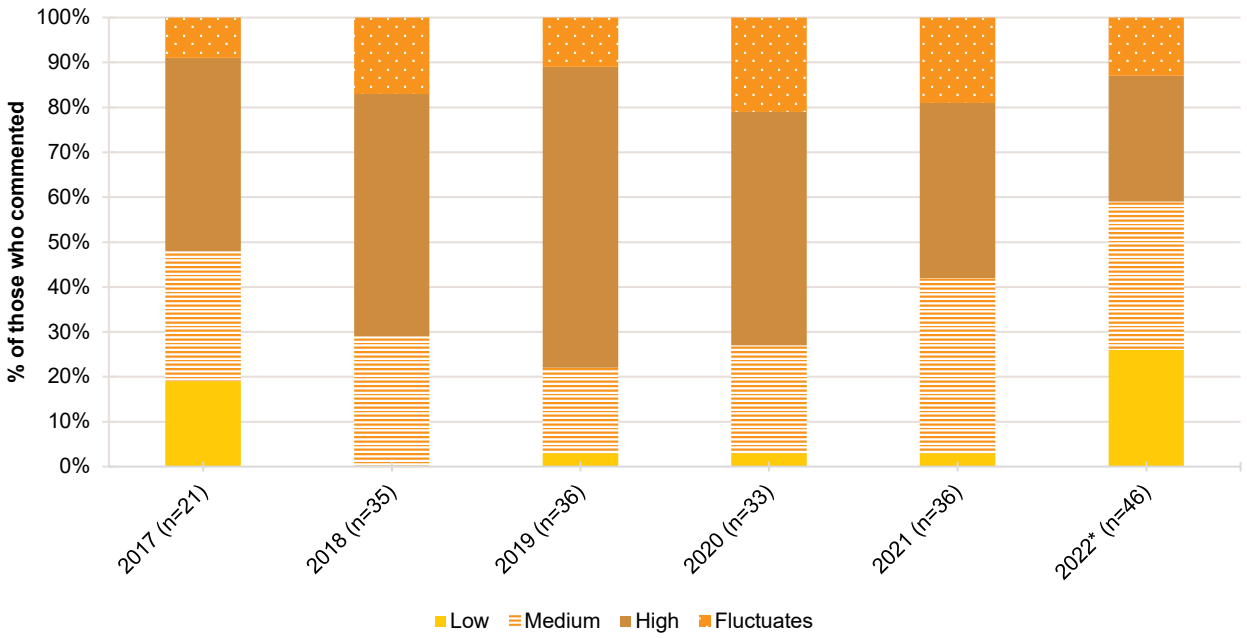
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 9: Current perceived purity of ecstasy capsules, Melbourne, VIC, 2017-2022



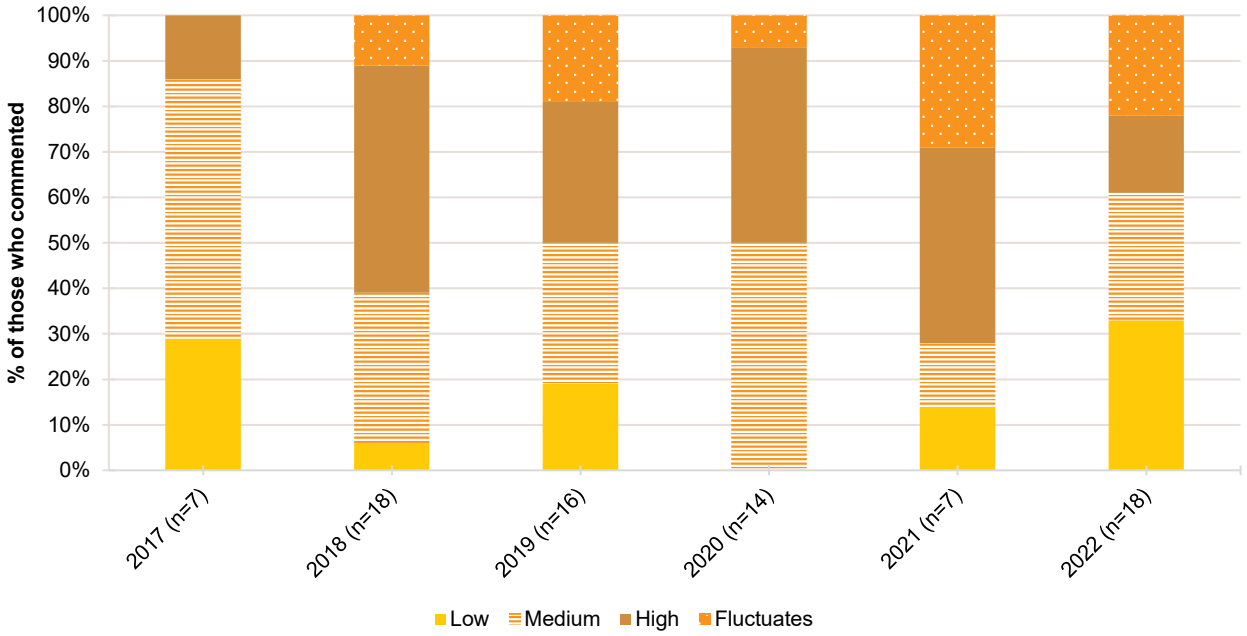
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 10: Current perceived purity of ecstasy crystal, Melbourne, VIC, 2017-2022



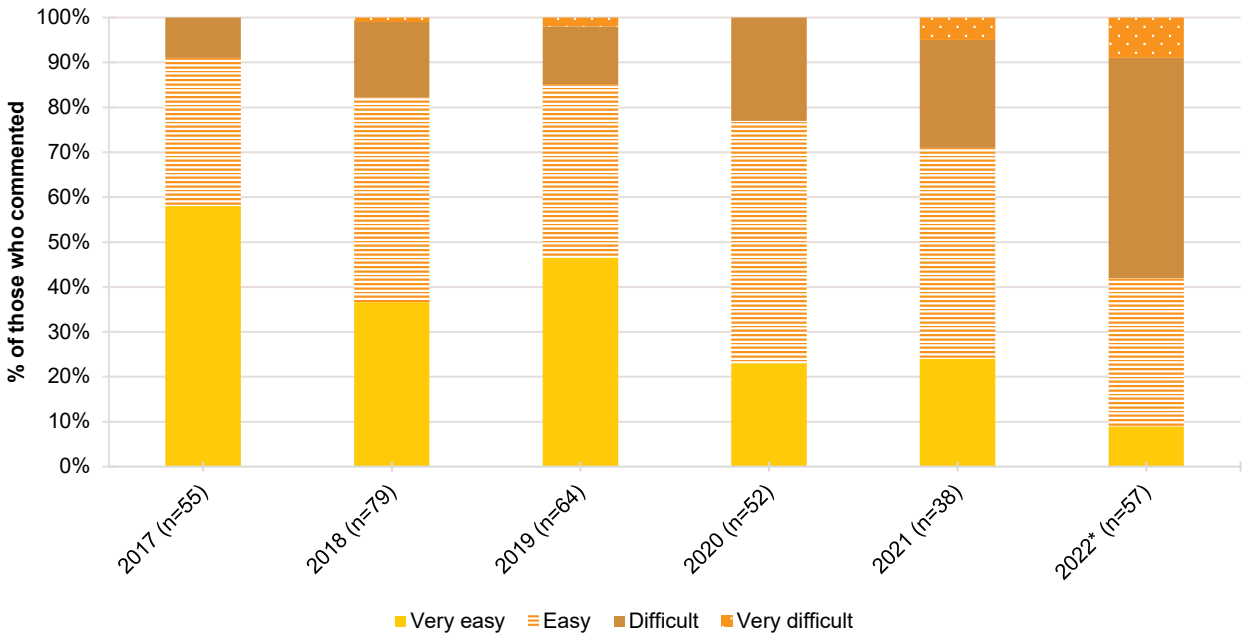
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 11: Current perceived purity of ecstasy powder, Melbourne, VIC, 2017-2022



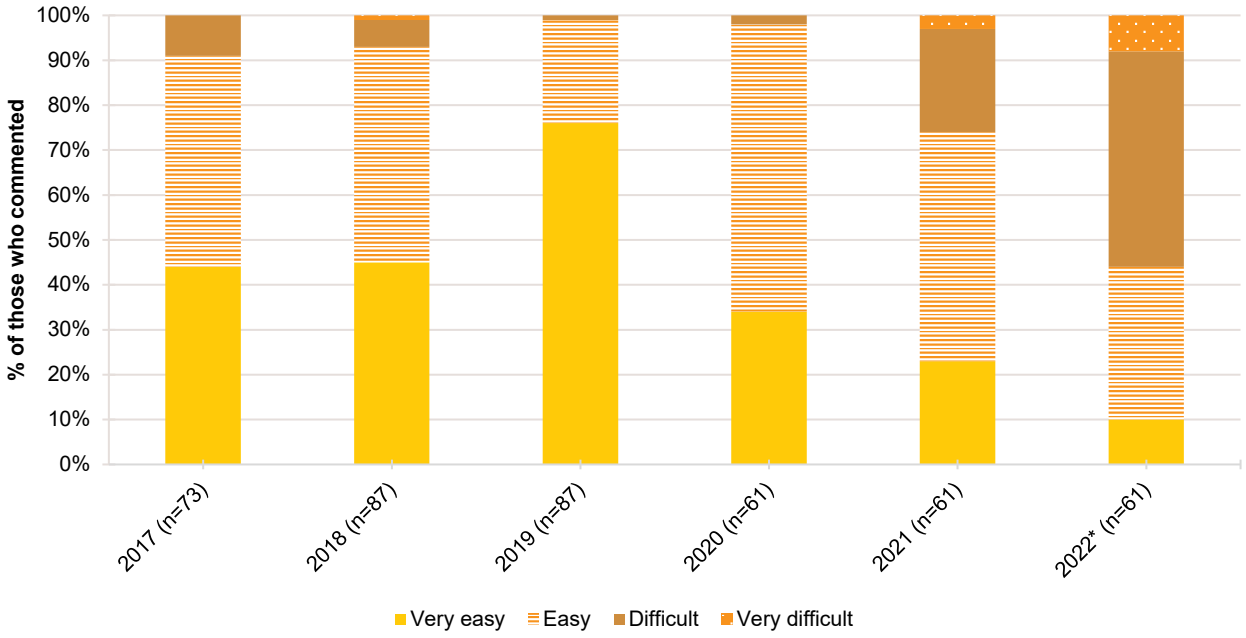
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 12: Current perceived availability of ecstasy pills, Melbourne, VIC, 2017-2022



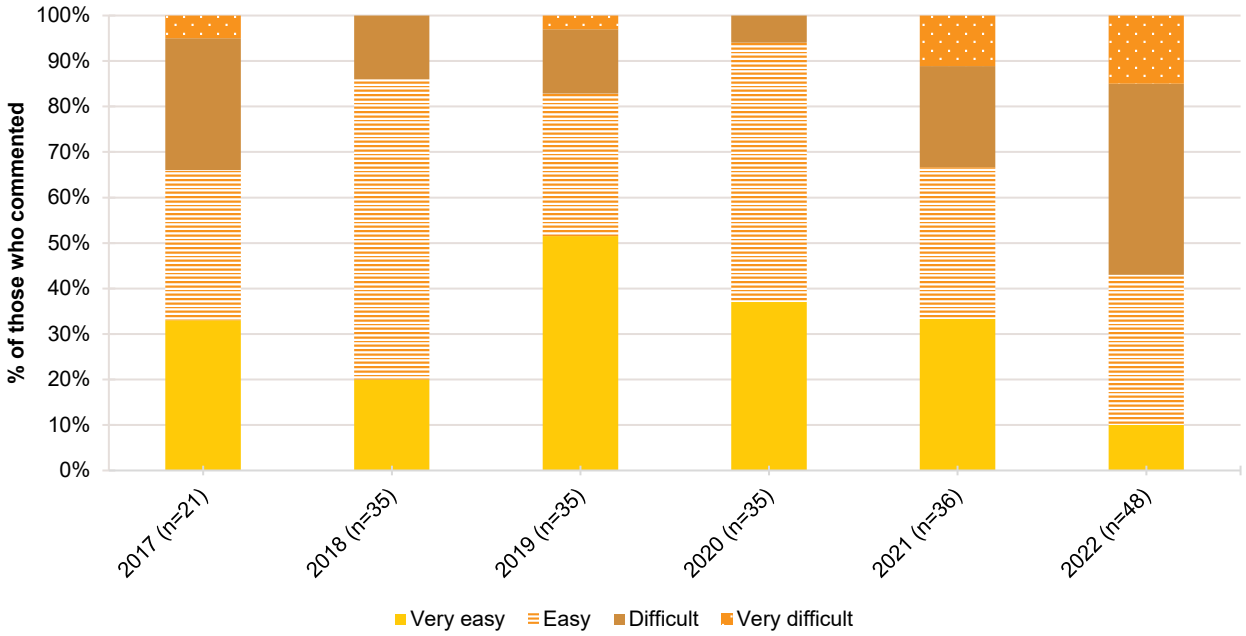
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 13: Current perceived availability of ecstasy capsules, Melbourne, VIC, 2017-2022



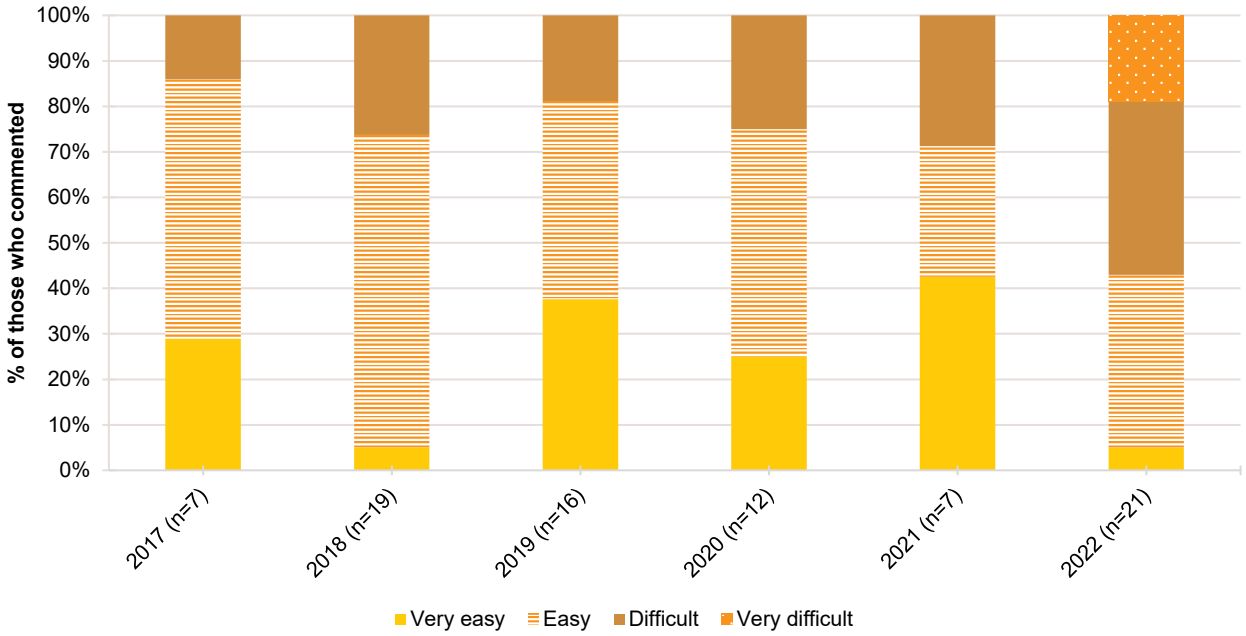
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 14: Current perceived availability of ecstasy crystal, Melbourne, VIC, 2017-2022



Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 15: Current perceived availability of ecstasy powder, Melbourne, VIC, 2017-2022



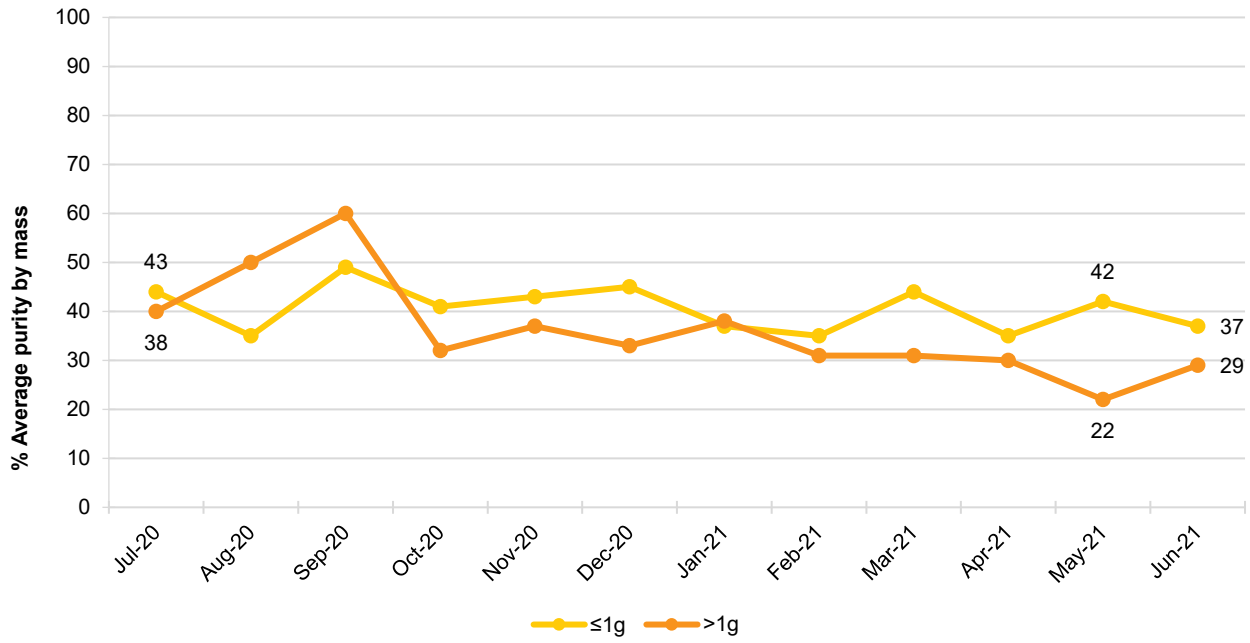
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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.

Routinely Collected Data

Victoria Police Seizure Purity

Ecstasy seizures analysed by the Victoria Police Forensic Services Department during the 2020/21 financial year, weighing one gram or less and more than one gram, were on average 41% (IQR=37–44, range=35–49) and 36% (IQR=31–39, range=22–60) pure, respectively (Figure 16).

Figure 16: Purity of ecstasy seizures (includes MDMA, MDEA and MDA) by Victorian law enforcement, July 2020–June 2021

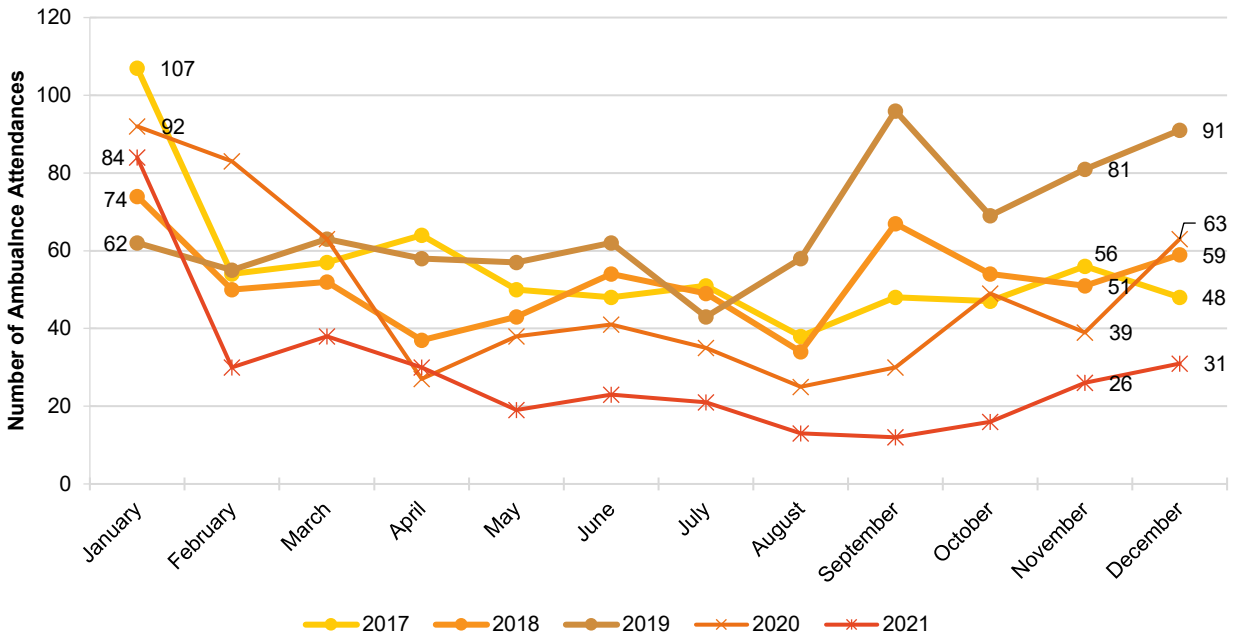


Note. Includes all forms (e.g., pill, capsule, powder and crystal) of MDMA, MDEA and MDA seized by Victoria Police. May not include every drug seized, because not all seized drugs undergo purity analysis. Data labels provided are only provided for the first (July 2020) and two most recent months (May and June 2021) of monitoring.

Ambulance Attendances at Non-Fatal Drug Events

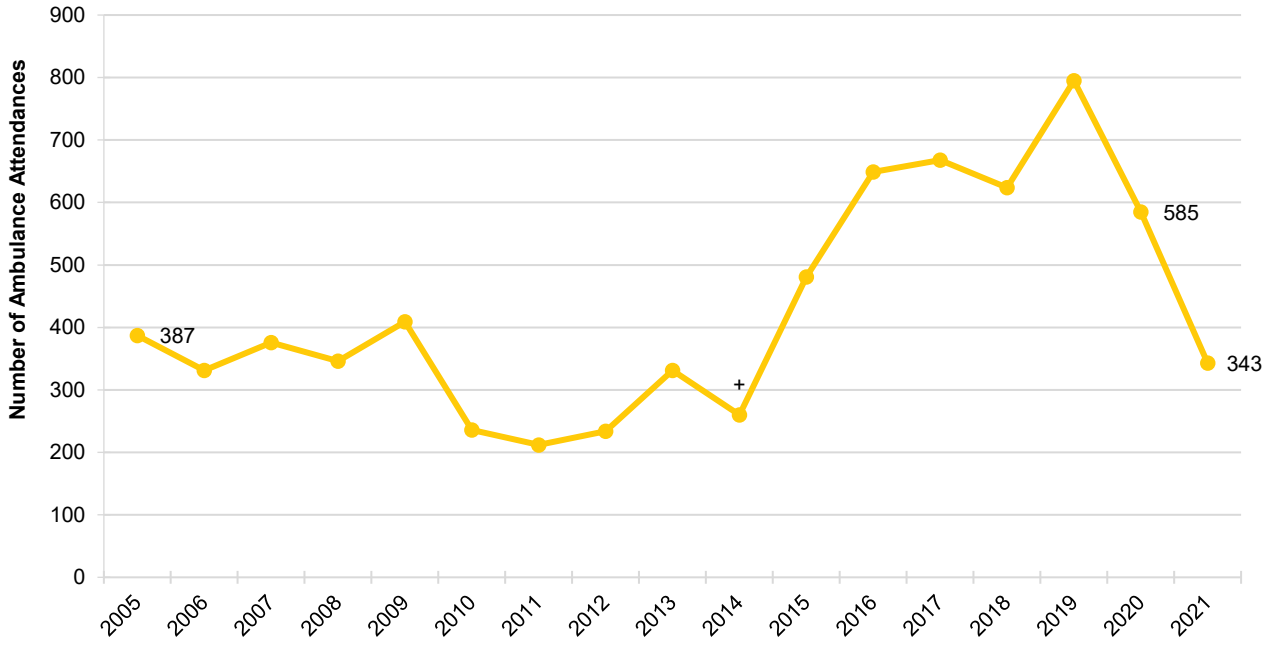
The number of ecstasy-related ambulance attendances in metropolitan Melbourne ranged between 12 and 107 per month during 2017–2021 (Figure 17). The total annual number of ecstasy-related attendances has risen steadily since 2014, when 260 attendances were recorded. In 2021 there were 343 attendances, a reduction from 2020 (Figure 18). The median age of patients in Melbourne in 2021 was 23 years (range 19–28), consistent with previous years.

Figure 17: Number of ecstasy-related events attended by Ambulance Victoria, Melbourne, 2017–2021



Source: Turning Point. Data labels are only provided for the first (January) and the last two months (November and December) of monitoring in each year.

Figure 18: Number of ecstasy-related events attended by Ambulance Victoria, Melbourne, 2005–2021



Note. + = Data missing from October-December due to industrial action. Source: Turning Point. Data labels provided are only provided for the first (2005) and the two most recent years (2020 and 2021) of monitoring.

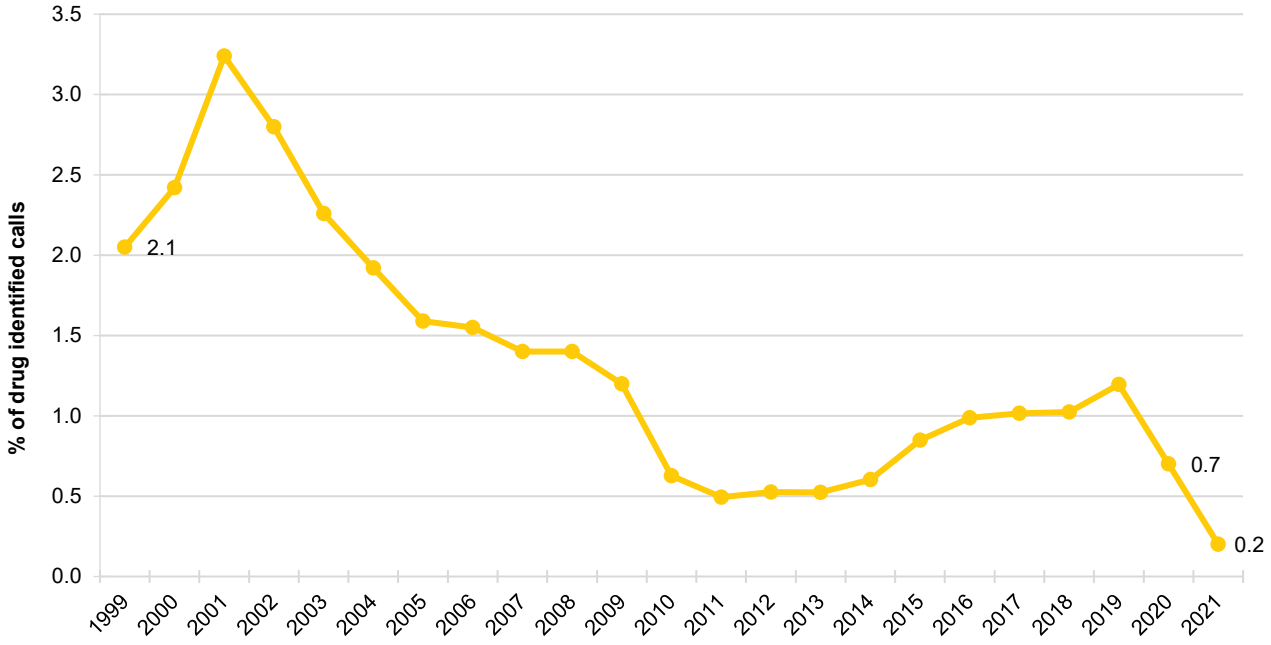
ADIS\VADC

In 2020/21, 140 courses of treatment were delivered to 97 clients for ecstasy, equivalent to 0.2% and 0.3% of the total courses delivered and clients treated. This represents a decrease of 48.3% and 58.2% in courses delivered and clients treated from 2019/20 (271 and 232, respectively).

DirectLine

During 2021, DirectLine received 37 calls in which ecstasy was identified as the drug of concern, representing 0.2% of all drug-identified calls to DirectLine in that year. This is a decrease from 0.7% of drug-identified calls reported in 2020 (Figure 19).

Figure 19: Percentage of calls to DirectLine in which ecstasy was identified as drug of concern, Victoria 1999–2021



Source: DirectLine, Turning Point. Data labels provided are only provided for the first year (1999) and the two most recent years (2020 and 2021) of monitoring.

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).

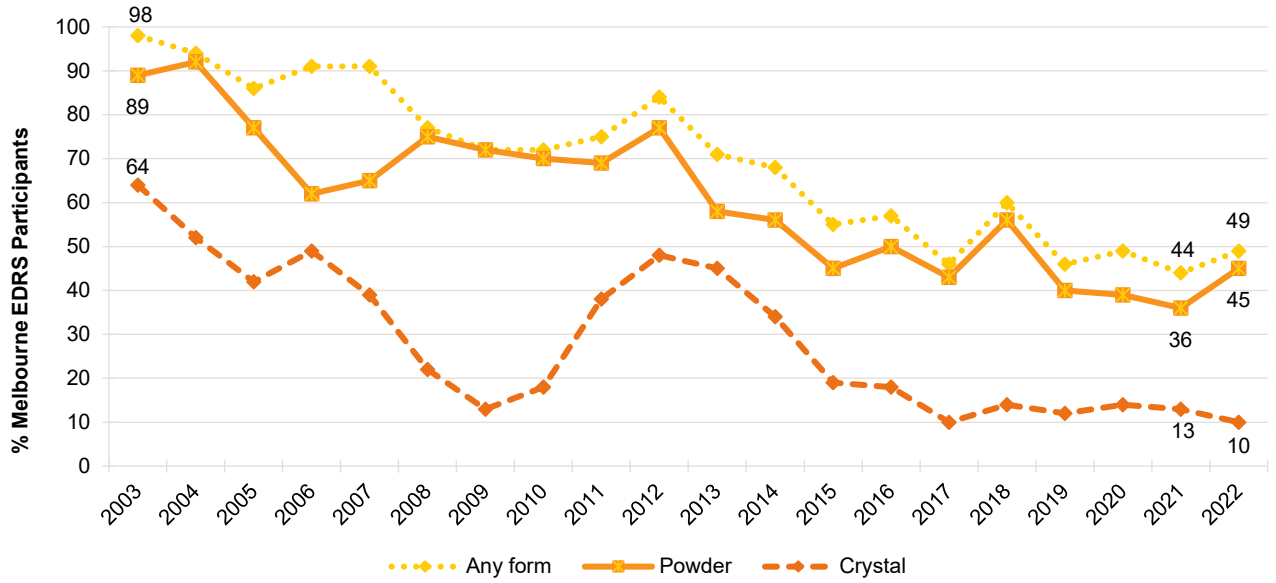
Recent Use (past 6 months)

Recent use of any methamphetamine has fluctuated since 2003 but declined gradually overall (Figure 20). In 2022, 49% of participants reported recent use of any form of methamphetamine, stable relative to 2021 (44%; *p*=0.568).

Frequency of Use

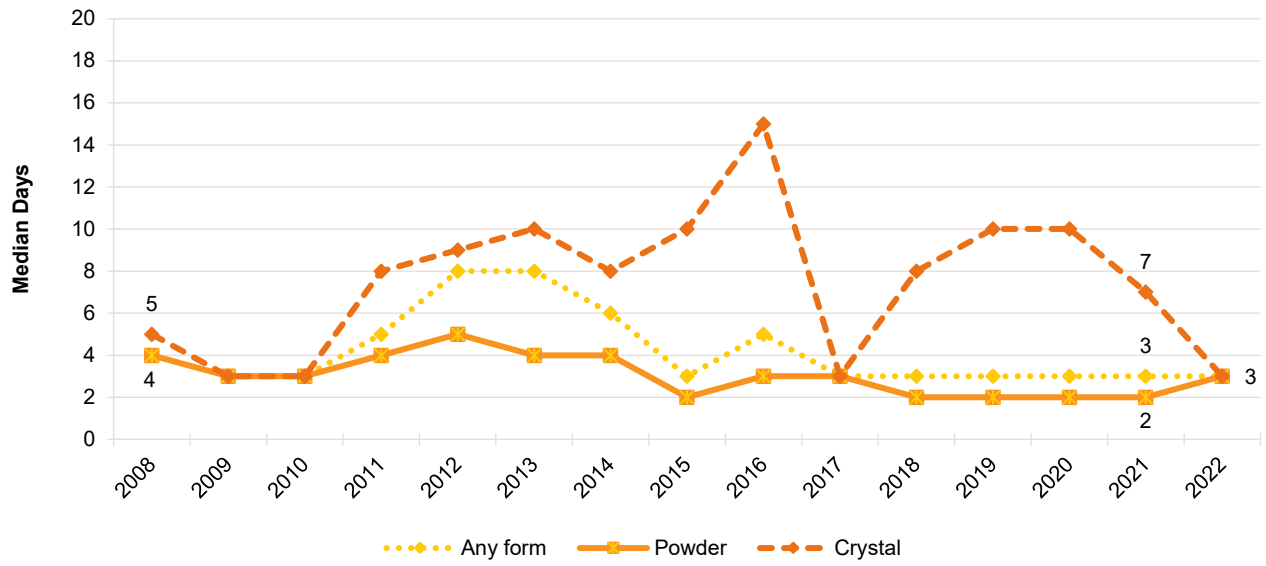
Frequency of use remained stable in 2022, at a median of three days in the past six months (IQR=2–10; 3 days in 2021; IQR=1–10; *p*=0.476) (Figure 21). Among participants who reported recent use (n=49), 16% reported using methamphetamine weekly or more frequently in 2022 (n≤5 in 2021; *p*=0.364).

Figure 20: Past six month use of any methamphetamine, powder, base, and crystal, Melbourne, VIC, 2003-2022



Note. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, and are suppressed for 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 21: Median days of any methamphetamine, powder, base, and crystal use in the past six months, Melbourne, VIC, 2008-2022



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 (2008) and two most recent years (2021 and 2022) of monitoring, and are suppressed for 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): Since 2003, methamphetamine powder has been the main form used. Use has declined over the period of monitoring, but remained stable in recent years, with 45% of the 2022 sample reporting recent use (36% in 2021; p=0.257) (Figure 20).

Frequency of Use: In 2022, median days of reported methamphetamine powder use remained stable at three days in the past six months (IQR=2–5; n=45; 2 days in 2021; IQR=1–4; n=36; p=0.098) (Figure 21). Among participants who reported recent use, few (n≤5) reported weekly or greater use of powder, stable from 2021 (n≤5; p=0.454).

Routes of Administration: In 2022, the most common route of administration among participants who reported recent methamphetamine powder use continued to be snorting (87%; 92% in 2021; p=0.724), with a further 13% reporting swallowing (n≤5 in 2021).

Quantity: The median amount of methamphetamine powder reportedly used in a 'typical' session was 0.30 grams (IQR=0.20–0.50; n=22), stable from 2021 (0.30 grams; IQR=0.20–0.50; n=11; p=0.853). The median 'maximum' amount reportedly used was 0.50 grams (IQR=0.20–1.00; n=24), also stable from 2021 (0.50 grams; IQR=0.20–1.00; n=11; p=0.900).

Methamphetamine Crystal

Recent Use (past 6 months): Use of methamphetamine crystal has remained stable in recent years. In 2022, 10% of participants reported recent use of methamphetamine crystal, stable from 2021 (13%; p=0.643) (Figure 20).

Frequency of Use: In 2022, of those who reported recent use of methamphetamine crystal and commented (n=10), frequency of reported use was a median of three days (IQR=1–90) in the past six months, stable from seven days (IQR=3–14) in 2021 (p=0.730) (Figure 21). Few participants (n≤5) reported

weekly or greater use of methamphetamine crystal, stable from 2021 (n≤5; *p*=0.650).

Routes of Administration: Among participants who reported recent methamphetamine crystal use and commented (n=10), smoking remained the most common route of administration, with 90% reporting this method in 2022 (100% in 2021; *p*=0.435).

Quantity: Of those who reported recent use and responded (n=6), the median amount of crystal used in a 'typical' session was 0.30 grams (IQR=0.10–0.90; 0.20 grams in 2021; IQR=0.10–0.30; *p*=0.384). Of those who reported recent use and responded (n=6), the median maximum amount of crystal used was 0.40 grams (IQR=0.10–1.70; 0.30 grams in 2021;IQR=0.20–0.50; *p*=0.687).

Methamphetamine Base

Due to low numbers, details on base are not reported. For further information, please refer to the National EDRS report, or contact the Drug Trends team.

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Price: The median reported price for a gram of methamphetamine powder was $200 in 2022 (IQR=200–205; n=20), stable from 2021 ($200; IQR=180–200; n=9; *p*=0.185) (Figure 22). No participants reported on the price of a point in 2022 and 2021.

Perceived Purity: The perceived purity of methamphetamine powder remained stable between 2021 and 2022 (*p*=0.484). Among those who commented in 2022 (n=27), 37% reported methamphetamine powder purity to be 'medium' (n≤5 in 2021), and 33% reported purity to be 'high' (50% in 2021) (Figure 23).

Perceived Availability: The perceived availability of methamphetamine powder remained stable between 2021 and 2022 (*p*=0.404). Among those who responded in 2022 (n=27), 37% reported methamphetamine powder to be 'easy' to obtain (39% in 2021), and 30% reported it to be 'difficult' to obtain (n≤5 in 2021) (Figure 25).

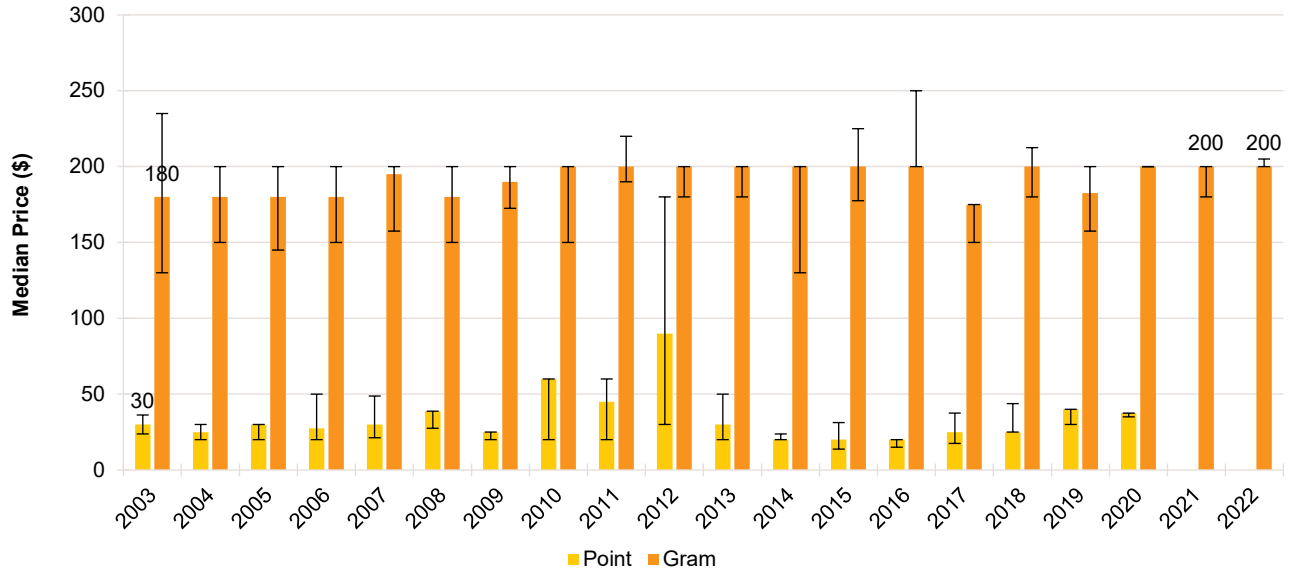
Methamphetamine Crystal

Price: Few participants commented on the price of methamphetamine crystal in 2022. For further details, please refer to the National EDRS report, or contact the Drug Trends team.

Perceived Purity: The perceived purity of methamphetamine crystal remained stable between 2021 and 2022 (*p*=0.342). Due to low numbers for each of the responses, further details have been suppressed (Figure 24).

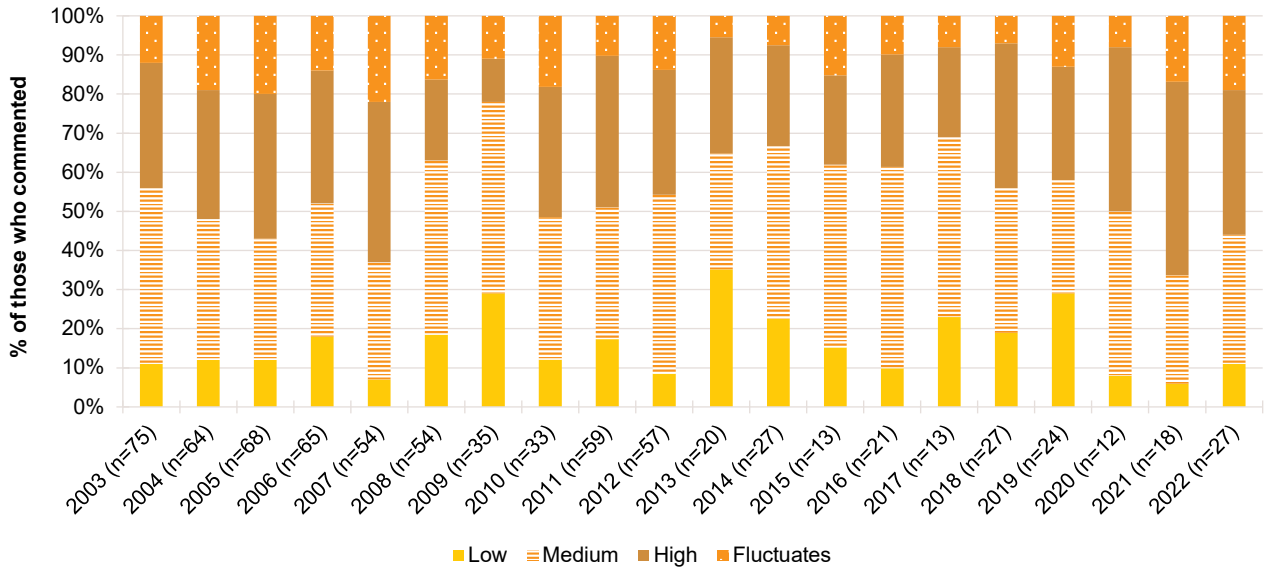
Perceived Availability: The perceived availability of methamphetamine crystal remained stable between 2021 and 2022 (*p*=0.301). Due to low numbers for each of the responses, further details have been suppressed (Figure 26).

Figure 22: Median price of powder methamphetamine per point and gram, Melbourne, VIC, 2003-2022



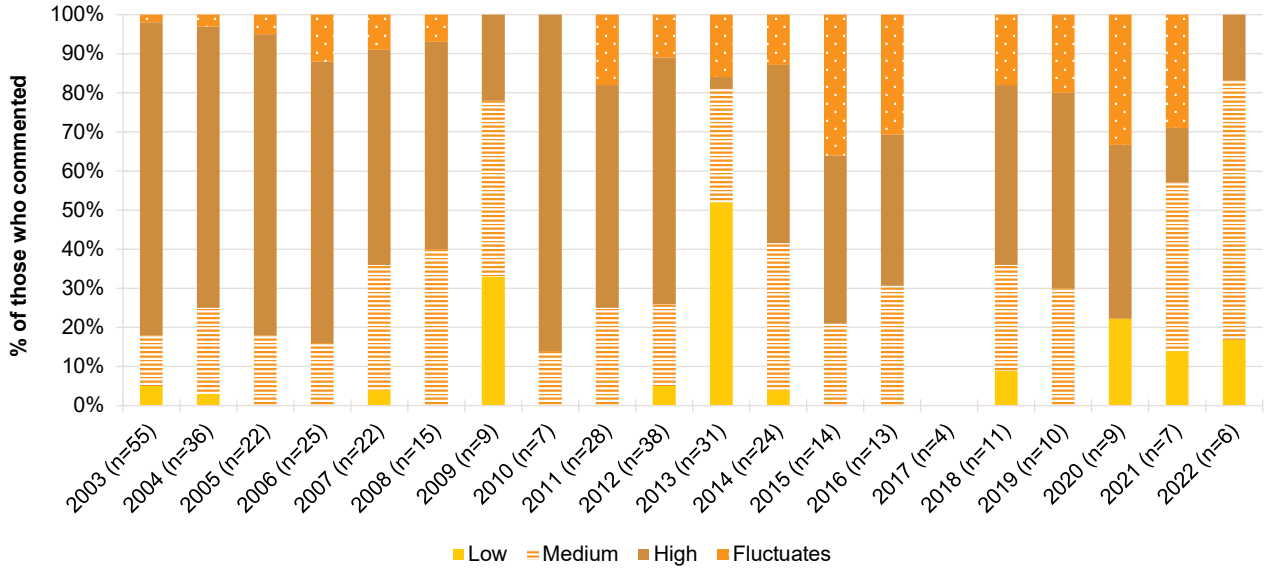
Note. Among those who commented. Participants asked to report on the price of a point of powder methamphetamine from 2011. No participants reported purchasing a point of powder methamphetamine in 2021 and 2022. Data labels are only provided for the first (2003/2011) and two most recent years (2021 and 2022) of monitoring, and are suppressed for 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 23: Current perceived purity of powder methamphetamine, Melbourne, VIC, 2003-2022



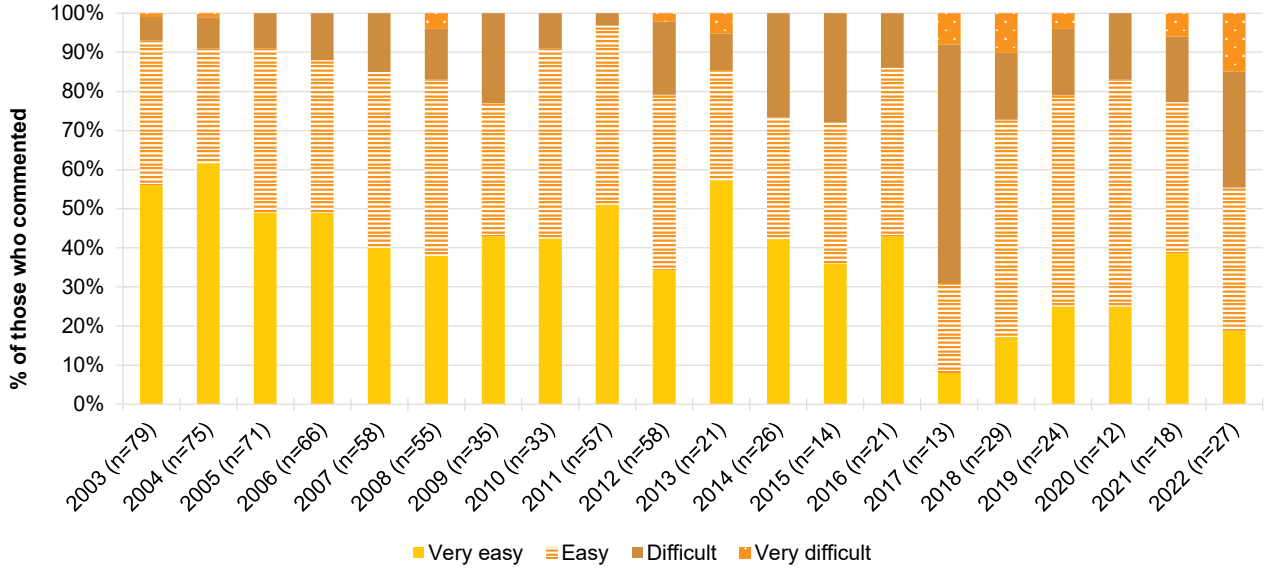
Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. For historical numbers, please refer to the data tables. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 24: Current perceived purity of crystal methamphetamine, Melbourne, VIC, 2003-2022



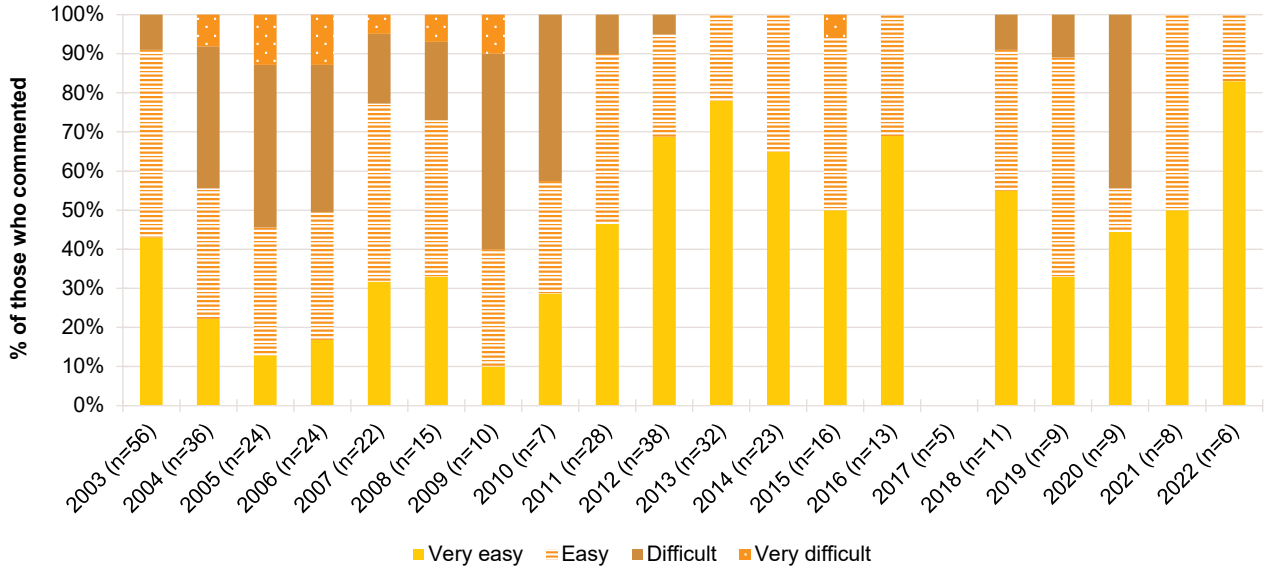
Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. For historical numbers, please refer to the data tables. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 25: Current perceived availability of powder methamphetamine, Melbourne, VIC, 2003-2022



Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 26: Current perceived availability of crystal methamphetamine, Melbourne, VIC, 2003-2022



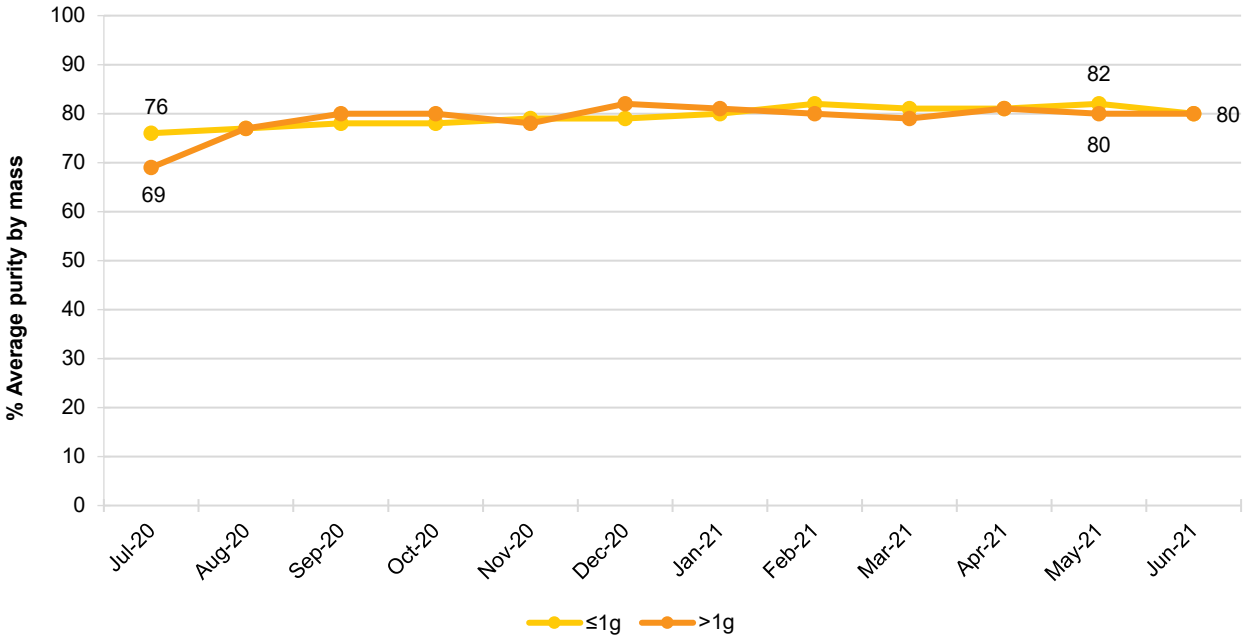
Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. For historical numbers, please refer to the data tables. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Routinely Collected Data

Victoria Police Seizure Purity

Methamphetamine seizures analysed by the Victoria Police Forensic Services Department during the 2020/2021 financial year averaged 79% purity in those weighing one gram or less (IQR=78–81, range=76–82) and also 79% in those weighing over 1 gram (IQR=79–80, range=77–82) (Figure 27).

Figure 27: Purity of methamphetamine seizures by Victorian law enforcement, July 2020–June 2021



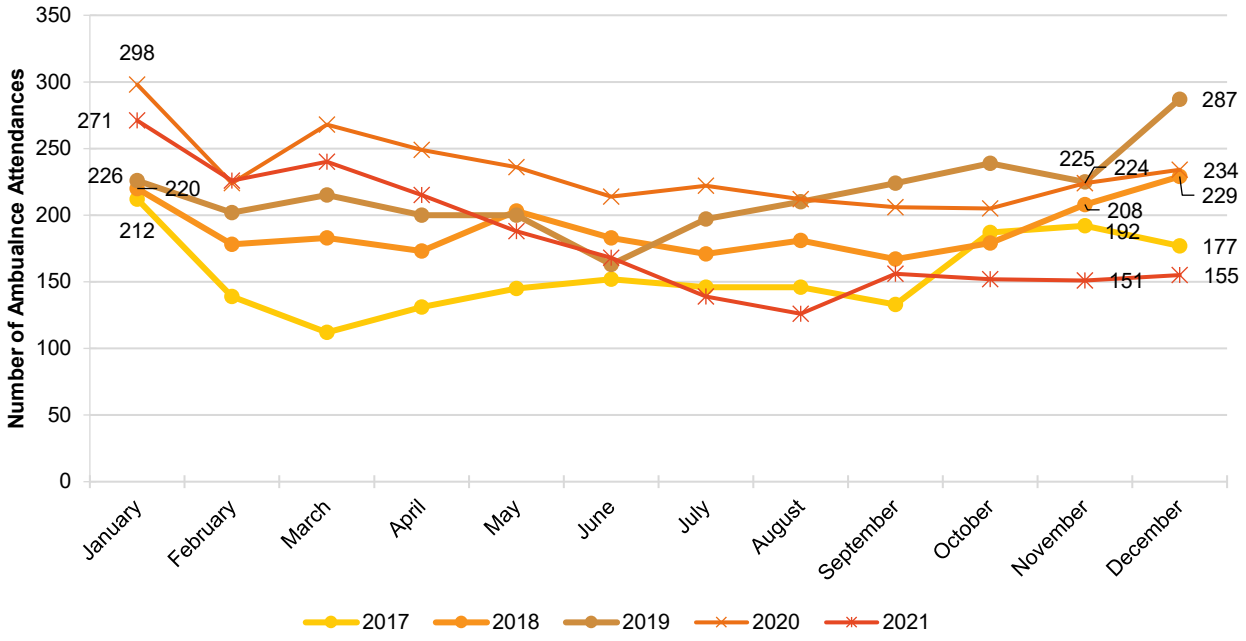
Note. Includes all forms (e.g., powder, base and crystal) of methamphetamine seized by Victoria Police. May not include every drug seized, as not all seized drugs undergo purity analysis. Data labels are only provided for first (July 2020) and two most recent months (May and June 2021) of monitoring.

Ambulance Attendances at Non-Fatal Drug Events

Use of crystal methamphetamine was categorised separately from use of amphetamines in metropolitan Melbourne ambulance attendances for the first time in 2012.

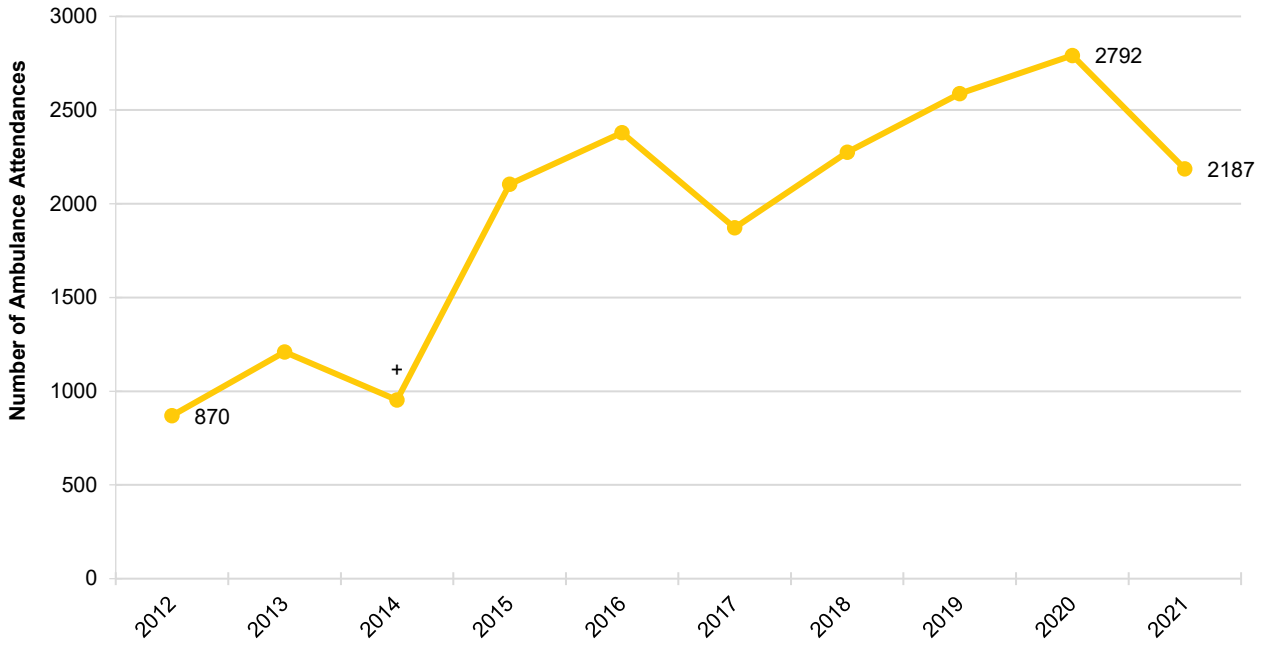
The number of methamphetamine-related ambulance attendances in metropolitan Melbourne ranged between 112 and 298 per month during 2017–2021 (Figure 28). The annual number of methamphetamine-related attendances has risen steadily since 2012, when 870 attendances were recorded. In 2021 there were 2187 attendances, a reduction from 2020 (Figure 29). The median age of patients in 2021 was 32 years (range 26–41), consistent with recent years.

Figure 28: Number of methamphetamine-related events attended by Ambulance Victoria, Melbourne, 2017–2021



Source: Turning Point. Data labels are only provided for the first (January) and last two months (November and December) of monitoring in each year.

Figure 29: Number of methamphetamine-related events attended by Ambulance Victoria, Melbourne, 2012–2021



Note. + = Data missing from October-December due to industrial action. Source: Turning Point. Data labels are only provided for the first (2012) and two most recent years (2020 and 2021) of monitoring.

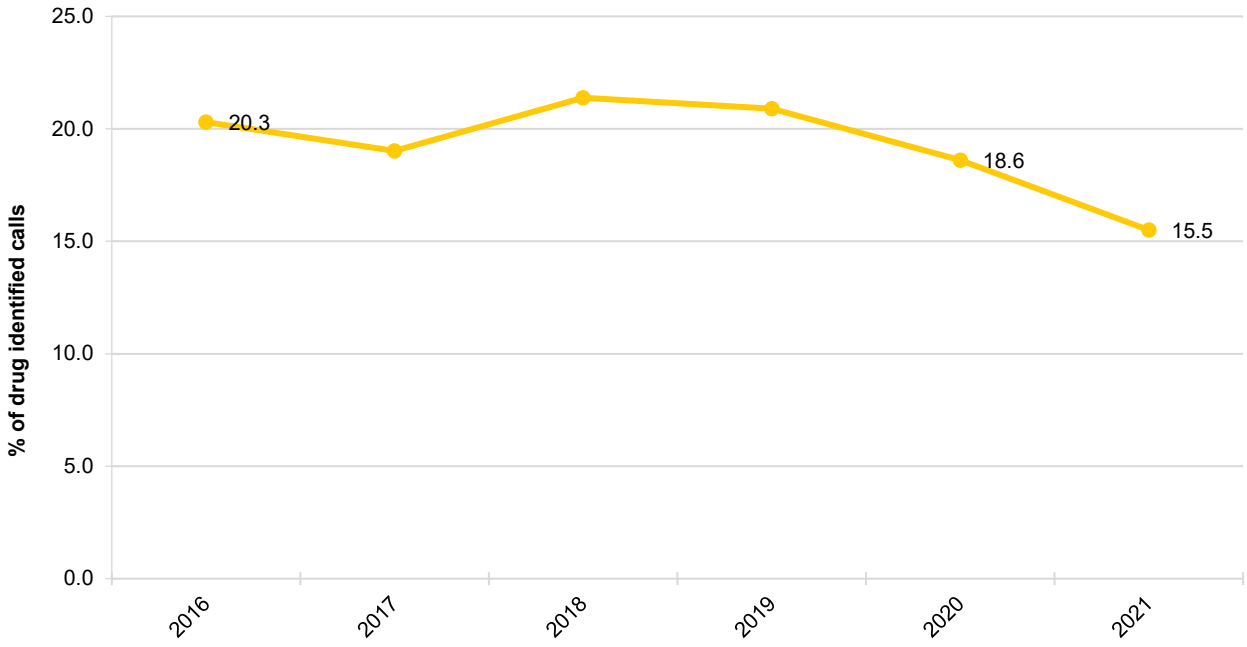
ADIS\VADC

In 2020/2021, 8,875 courses of treatment were delivered to 5,159 clients for methamphetamine, equivalent to 15.3% and 15.5% of the total courses delivered and clients treated, respectively. This represents a decrease of 5.5% and 9.7% in courses delivered and clients treated from 2019/20 (9,394 and 5,716, respectively).

DirectLine

During 2021, DirectLine received 2,359 calls in which methamphetamine was identified as the drug of concern, representing 15.5% of all drug-identified calls to DirectLine in that year. The percentage of drug-related calls in which methamphetamine was identified as the drug of concern has remained fairly stable since monitoring began in 2016 (Figure 30).

Figure 30: Percentage of calls to DirectLine in which methamphetamine was identified as drug of concern, Victoria 2016–2021



Source: DirectLine, Turning Point. Data labels are provided only for the first (2016) and two most recent years of monitoring (2020 and 2021).

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 encountered infrequently in Australia.

Patterns of Consumption

Recent Use (past 6 months)

Recent use of cocaine has gradually increased since monitoring began. In 2022, 91% of the sample reported recent use, the highest percentage since monitoring began in 2003. The figure was 90% in 2021 (Figure 31).

Frequency of Use

Frequency of cocaine use has also increased gradually in recent years, with a median of six days (IQR=3–10) of use reported in 2022, stable from 2021 (5 days; IQR=3–10; *p*=0.221) (Figure 31) and equivalent to monthly use. Of those who reported recent cocaine use (n=91), 9% reported weekly or more frequent use of cocaine (7% in 2021; *p*=0.779).

Routes of Administration

Among participants who reported recent cocaine use and commented (n=91), 99% of participants reported snorting cocaine, stable from 2021 (98%; *p*=0.621).

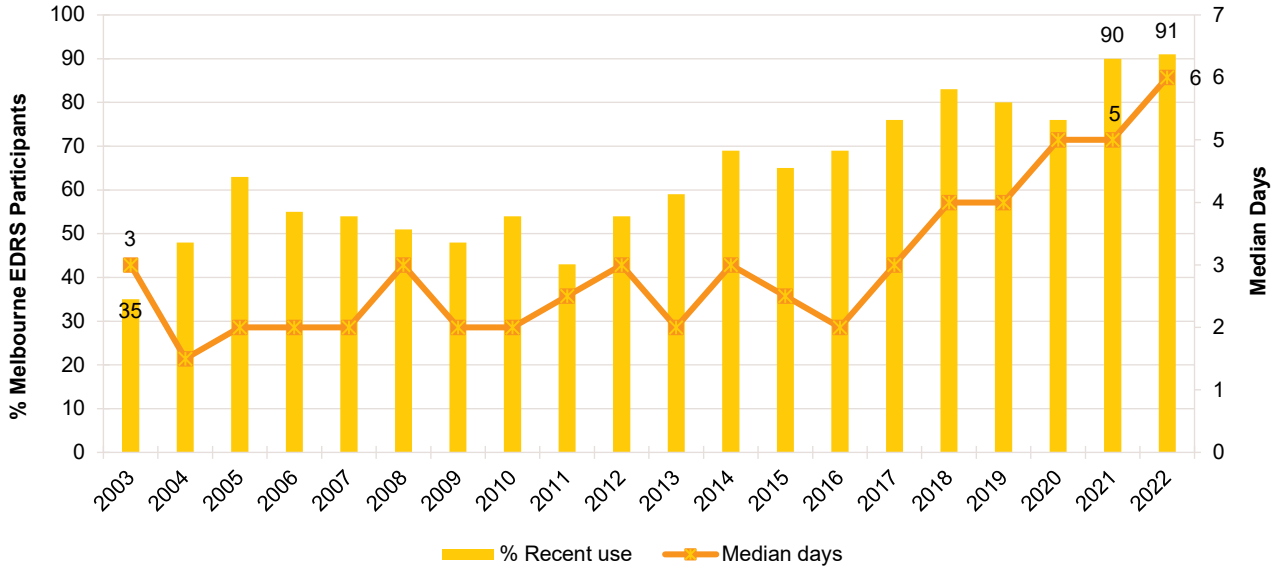
Quantity

Of those who reported recent cocaine use and responded (n=56), the median amount of cocaine reportedly used in a 'typical' session was 0.50 grams (IQR=0.30–1.00; 0.50 grams in 2021; IQR=0.30–0.50; *p*=0.490). Of those who reported recent use and responded (n=61), the median maximum amount used was 1.00 gram (IQR=0.50–1.00; 1.00 gram in 2021; IQR=0.50–1.00; *p*=0.585).

Forms Used

Among participants who reported recent cocaine use and commented (n=91), the vast majority reported using powder cocaine (98%; 96% in 2021; *p*=0.455), with few participants (n≤5) reporting use of crack (n≤5 in 2021) and rock cocaine (12% in 2021; *p*=0.032).

Figure 31: Past six month use and frequency of use of cocaine, Melbourne, VIC, 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 7 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, and are suppressed for 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 reported price per gram of cocaine was $350 (IQR=300–350; n=65) in 2022, relatively stable from $300 recorded in 2021 (IQR=300–350; n=53; p=0.086) (Figure 32).

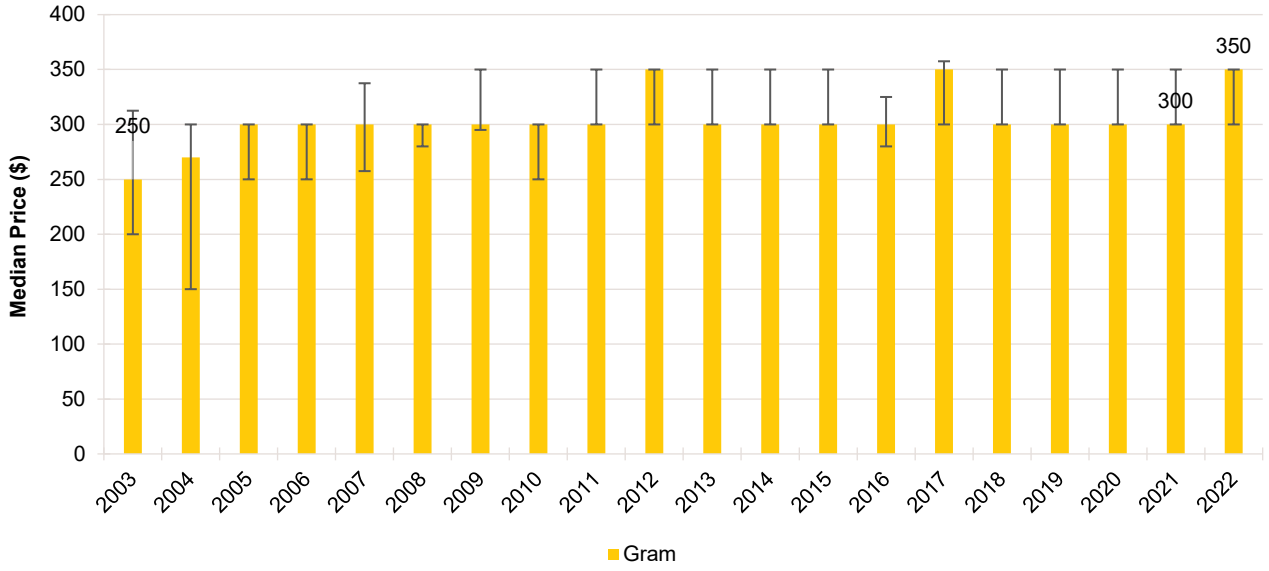
Perceived Purity

The perceived purity of cocaine remained stable between 2021 and 2022 (p=0.693). Among those who were able to respond in 2022 (n=73), the largest percentage of participants reported cocaine to be of 'medium' purity (37%; 38% in 2021), followed by 26% reporting 'low' purity (20% in 2021) and 23% reporting that purity 'fluctuates' (23% in 2021) (Figure 33).

Perceived Availability

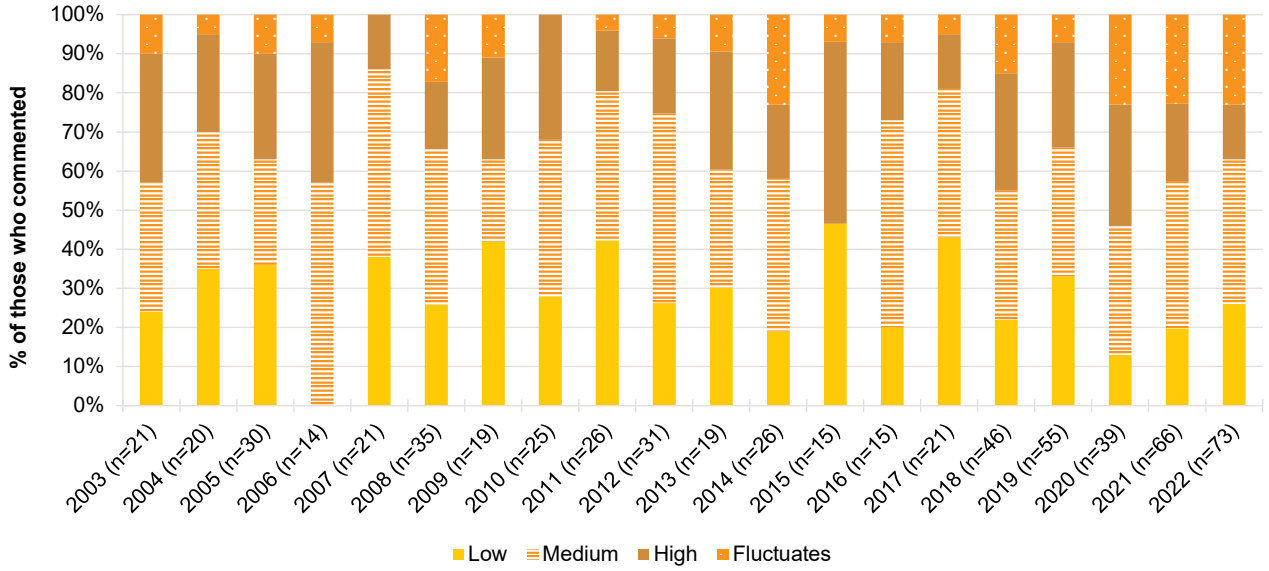
The perceived availability of cocaine remained stable between 2021 and 2022 (p=0.181). Among those who were able to respond in 2022 (n=75), half (52%) reported cocaine to be 'easy' to obtain (38% in 2021), 35% reported it to be 'very easy' (50% in 2021), and 12% perceived it to be 'difficult' to obtain (13% in 2021) (Figure 34).

Figure 32: Median price of cocaine per gram, Melbourne, VIC, 2003-2022



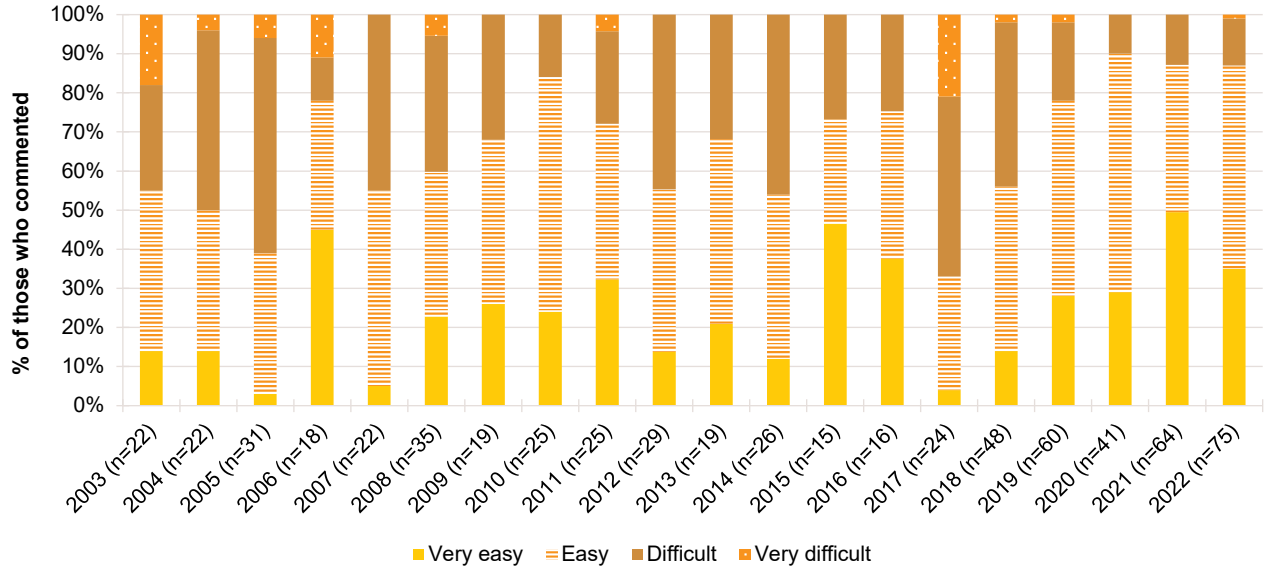
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, and are suppressed for small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent the IQR. The response 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 33: Current perceived purity of cocaine, Melbourne, VIC, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 34: Current perceived availability of cocaine, Melbourne, VIC, 2003-2022



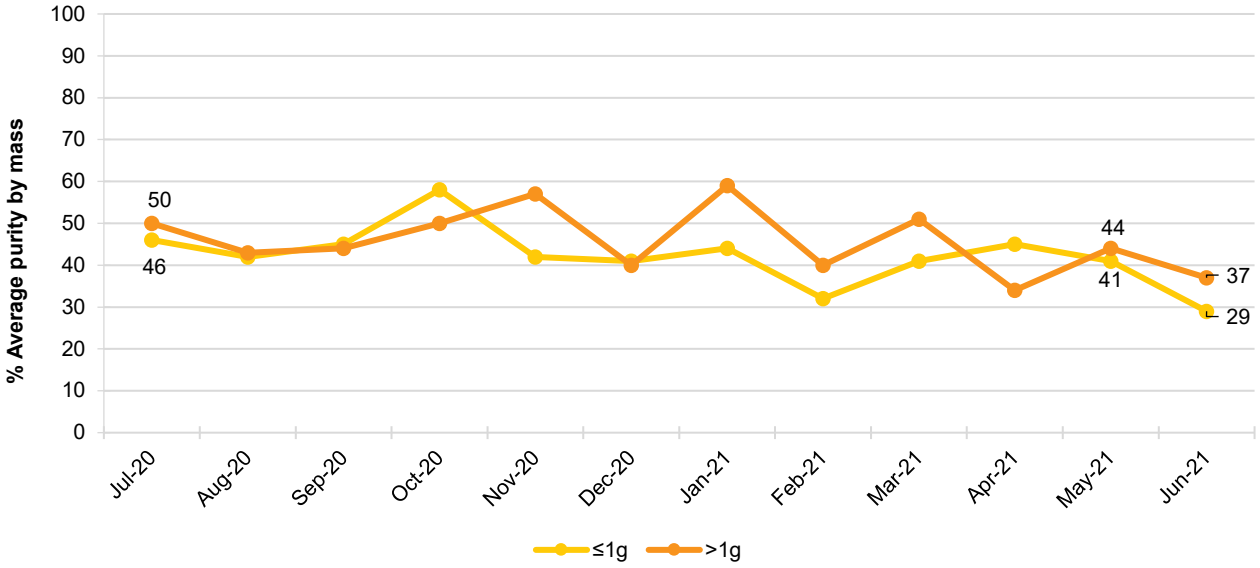
Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. For historical numbers, please refer to the data tables. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Routinely Collected Data

Victoria Police Seizure Purity

Cocaine seizures analysed by the Victoria Police Forensic Services Department during the 2020/21 financial year averaged 42% purity in those weighing one gram or less (IQR=41–45, range=29–58) and 46% in those weighing over one gram (IQR=40–50, range=34–59) (Figure 35).

Figure 35: Purity of cocaine seizures by Victorian law enforcement, July 2020–June 2021

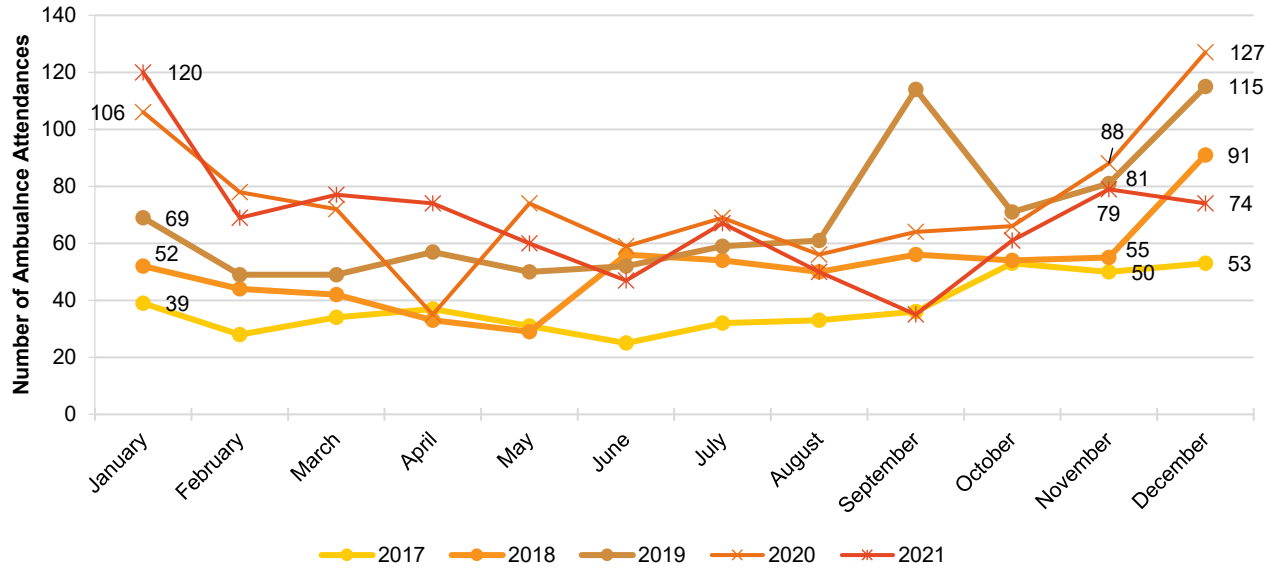


Note. May not include every drug seized, as not all seized drugs undergo purity analysis. Data labels are only provided for the first (July 2020) and two most recent months (May and June 2021) of monitoring.

Ambulance Attendances at Non-Fatal Drug Events

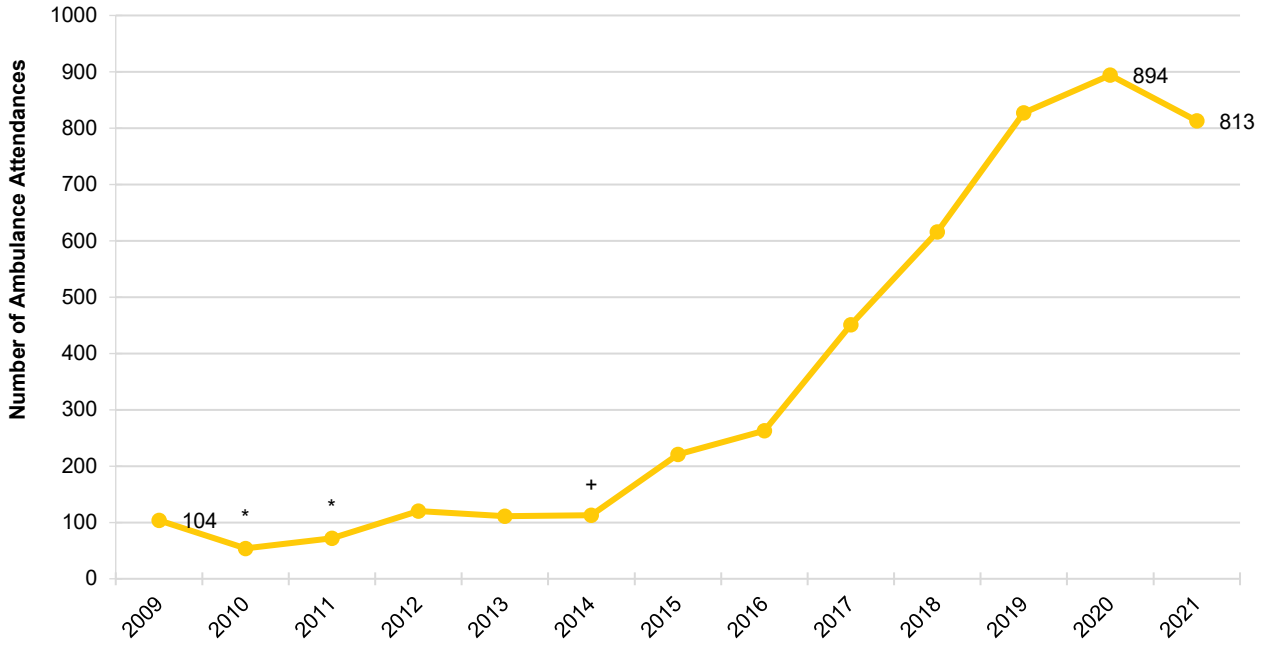
The number of cocaine-related ambulance attendances in metropolitan Melbourne ranged between 25 and 127 per month during 2017–2021 (Figure 36). The annual number of cocaine-related attendances has risen steadily since 2015, when 221 attendances were recorded. In 2021 there were 813 attendances, down slightly from 2020 (Figure 37). The median age of patients in 2021 was 26 years (range=122–32), consistent with previous years.

Figure 36: Number of cocaine-related events attended by Ambulance Victoria, Melbourne, 2017–2021



Source: Turning Point. Data labels are only provided for the first (January) and last two months (November and December) of monitoring in each year.

Figure 37: Number of cocaine-related events attended by Ambulance Victoria, Melbourne, 2009-2021



Note. * = Some months excluded due to small numbers (≤5). + = Data missing from October-December due to industrial action. Source: Turning Point. Data labels are only provided for the first (2009) and two most recent years (2020 and 2021) of monitoring.

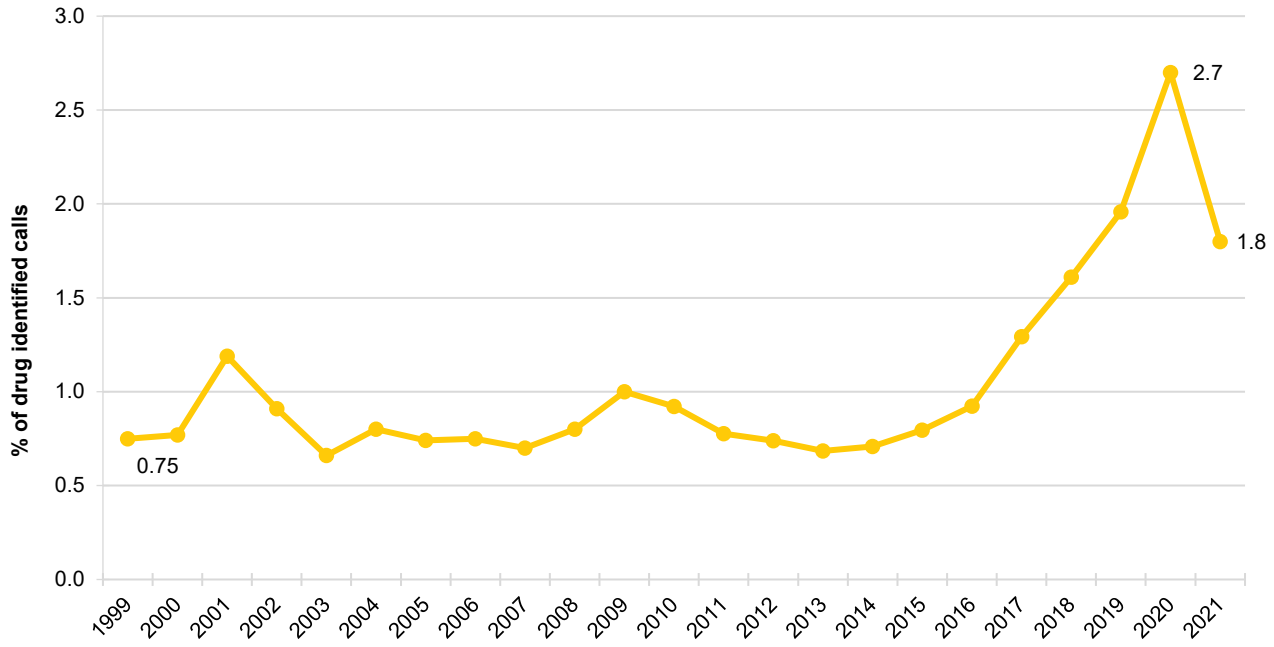
ADIS\VADC

In 2020/2021, 376 courses of treatment were delivered to 297 clients for cocaine, equivalent to 0.7% and 0.9% of the total courses delivered and clients treated. This represents a decrease of 5.1% and 8.3% in courses delivered and clients treated from 2019/20 (396 and 324, respectively).

DirectLine

During 2021, DirectLine received 276 calls in which cocaine was identified as the drug of concern, representing 1.8% of all drug-identified calls to DirectLine in that year, a reduction from 2020 (Figure 38).

Figure 38: Percentage of calls to DirectLine in which cocaine was identified as drug of concern, Victoria 1999–2021



Source: DirectLine, Turning Point. Data labels are only provided for the first (1999) and two most recent years (2020 and 2021) of monitoring

5

Cannabis and/or Cannabinoid Related Products

Participants were asked about their recent (past six month) use of indoor-cultivated cannabis grown using a hydroponic system ('hydro') and outdoor-cultivated cannabis ('bush'), as well as hashish, hash oil and CBD and tetrahydrocannabinol (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 and THC extract); few participants (n≤5) in Melbourne 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 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)

Around 80% of participants have reported any recent use of non-prescribed cannabis and/or cannabinoid related products each year since 2003. The majority (82%) reported recent use of non-prescribed cannabis and/or cannabinoid related products in 2022, stable from 2021 (84%; p=0.847) (Figure 39).

Frequency of Use

Typical frequency of reported cannabis use has varied between fortnightly and several times per week over the course of monitoring. In 2022, of those who reported recent non-prescribed cannabis and/or cannabinoid related product consumption and commented (n=82), the median reported number of days of use was 33 days (IQR=7–99) in the past six months, stable from 2021 (28 days; IQR=6–92; p=0.787) (Figure 39). Three-fifths (60%) reported using non-prescribed cannabis and/or cannabinoid related products weekly or more frequently (57% in 2021; p=0.743), including 15% who reported using cannabis daily (13% in 2021; p=0.818).

Routes of Administration

Among participants who reported recent non-prescribed cannabis and/or cannabinoid related product consumption and commented (n=82), most participants (91%) reported smoking, stable from 2021

(94%; *p*=0.563). Half (52%) reported swallowing, a significant increase from 32% in 2021 (*p*=0.016), while 16% reported inhaling/vaporising (15% in 2021).

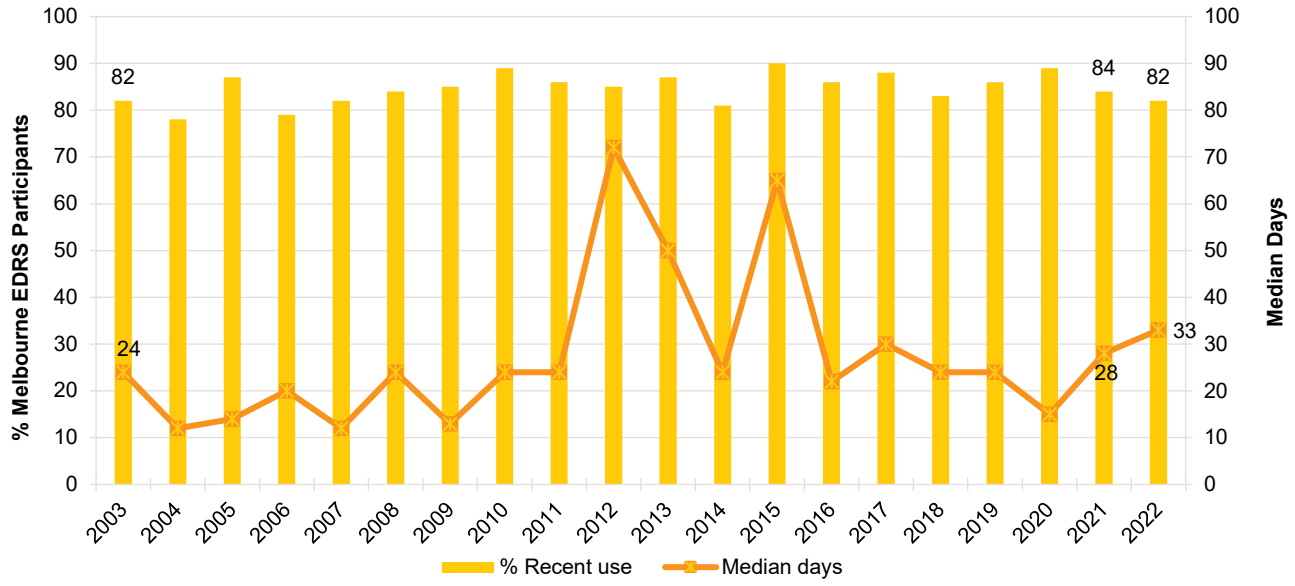
Quantity

Among those who reported recent non-prescribed use and responded (n=28), the median amount of cannabis reportedly used on the last occasion of use was one gram (IQR= 0.50–1.10; n=32; 0.70 in 2021; IQR=0.50-1.00; *p*=0.746), one joint (IQR=0.50–1.00; n=26; 1.00 in 2021; IQR=0.50-1.00; *p*=0.441) or 2.5 cones (IQR=1.00–4.00; n=6; 2.50 in 2021; IQR=1.00-5.00; *p*=0.829).

Forms Used

Among participants who reported recent non-prescribed cannabis and/or cannabinoid related product consumption and responded (n=68), 65% reported recent use of hydroponic cannabis (75% in 2021; *p*=0.258), followed by 37% reporting recent use of outdoor-grown 'bush' cannabis, a significant decrease from 63% in 2021 (*p*=0.003). Few participants (n≤5) reported having used hashish (n≤5 in 2021) or hash oil (no participants in 2021) in the preceding six months. One-tenth (12%) of participants reported recent use of (non-prescribed) CBD extract in 2022 (n≤5 reported having used CBD oil in 2021), and 21% reported use of THC extract (not asked in 2021).

Figure 39: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid related products, Melbourne, VIC, 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. Y axis reduced to 100 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, and are suppressed for 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 reported price per ounce of non-prescribed hydroponic cannabis was $250 (IQR=250–288; n=6) in 2022, stable from $280 in 2021 (IQR=250–290; *p*=0.768), and $15 per gram (IQR=13–15; n=7; n≤5 in 2021) (Figure 40a).

Perceived Potency: The perceived potency of non-prescribed hydroponic cannabis remained stable between 2021 and 2022. Among those who were able to respond in 2022 (n=26), most (62%)

perceived non-prescribed hydroponic cannabis to be of 'high' potency (62% in 2021), followed by 27% reporting 'medium' potency (24% in 2021) (Figure 41a).

Perceived Availability: The perceived availability of non-prescribed hydroponic cannabis remained stable between 2021 and 2022. Among those who were able to respond in 2022 (n=27), 56% perceived non-prescribed hydroponic cannabis to be 'very easy' to obtain (53% in 2021), with a further 41% perceiving non-prescribed hydroponic cannabis to be 'easy' to obtain (44% in 2021) (Figure 42a).

Bush Cannabis

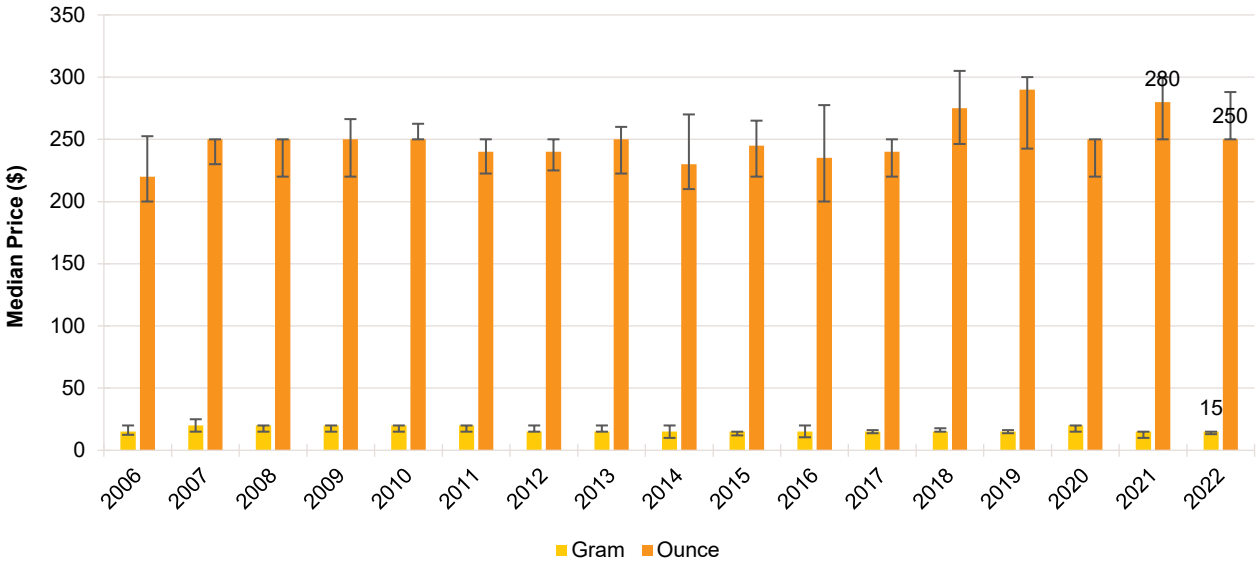
Price: The median reported price per gram of non-prescribed bush cannabis was $13 (IQR=10–15; n=6) in 2022 (n≤5 in 2021) (Figure 40b). Few participants (n≤5) reported on the price of an ounce in 2022; therefore, these data are suppressed (n≤5 in 2021).

Perceived Potency: The perceived potency of non-prescribed bush cannabis remained stable between 2021 and 2022. Among those who were able to respond in 2022 (n=14), 43% perceived the potency of non-prescribed bush cannabis to be 'medium' (45% in 2021) (Figure 41b).

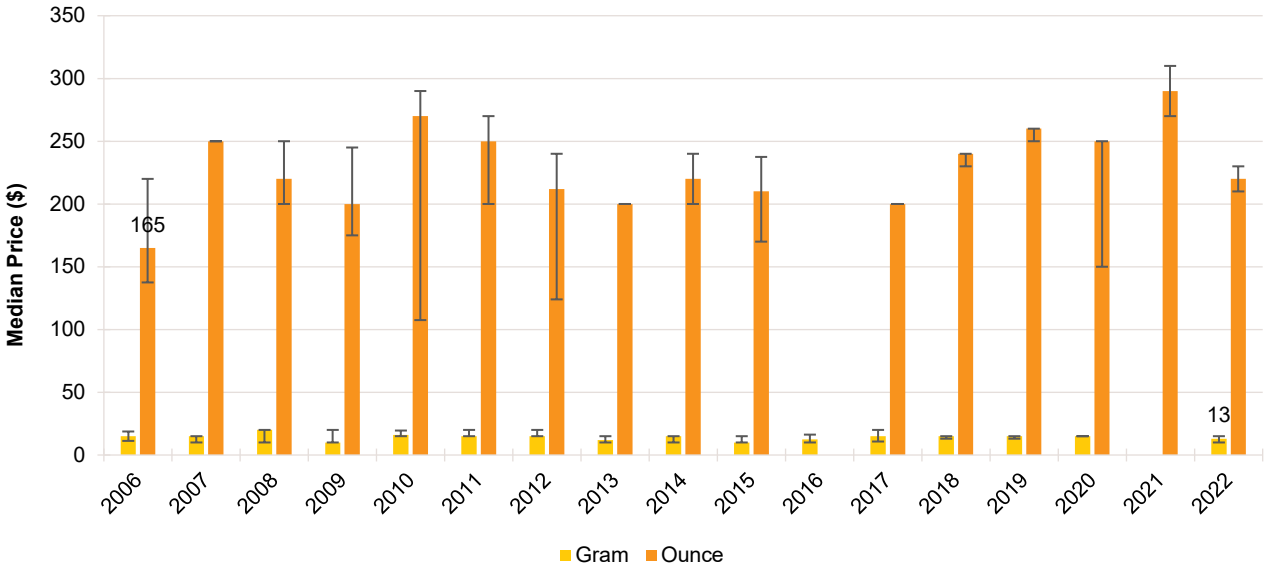
Perceived Availability: The perceived availability of non-prescribed bush cannabis remained stable between 2021 and 2022 (p=0.326). Among those who were able to respond in 2022 (n=14), most (64%) perceived non-prescribed bush cannabis to be 'very easy' to obtain (55% in 2021) (Figure 42b).

Figure 40: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Melbourne, VIC, 2006-2022

(A) Hydroponic cannabis



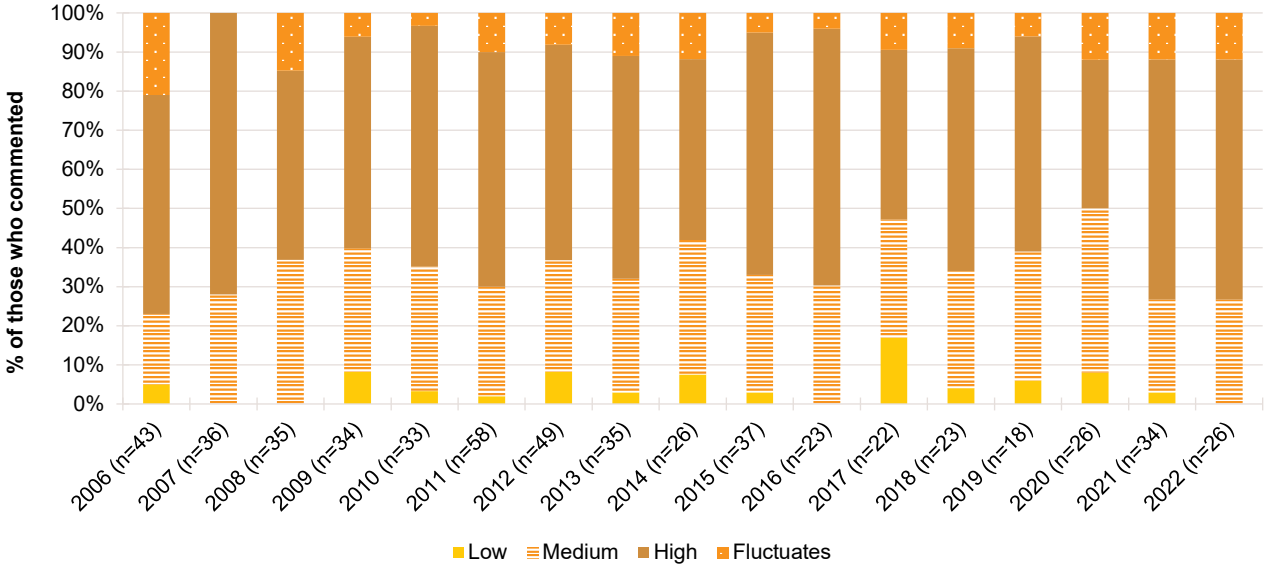
(B) Bush cannabis



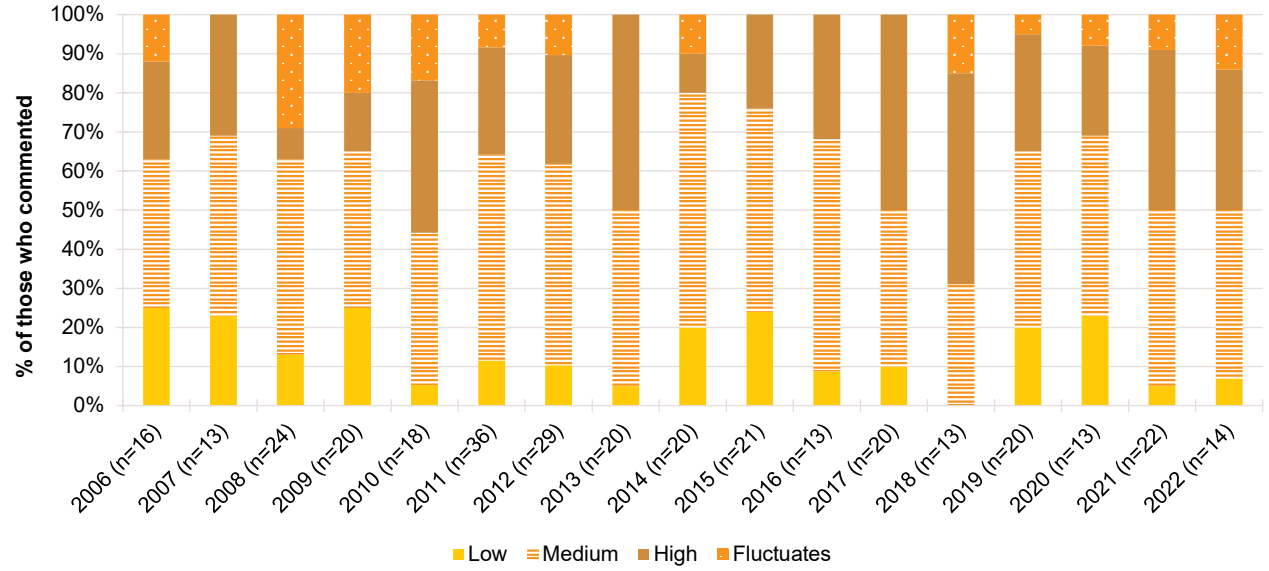
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels are only provided for the first (2006) and two most recent years (2021 and 2022) of monitoring, and are suppressed for small numbers (i.e., n≤5 but 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 41: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Melbourne, VIC, 2006-2022

(A) Hydroponic cannabis



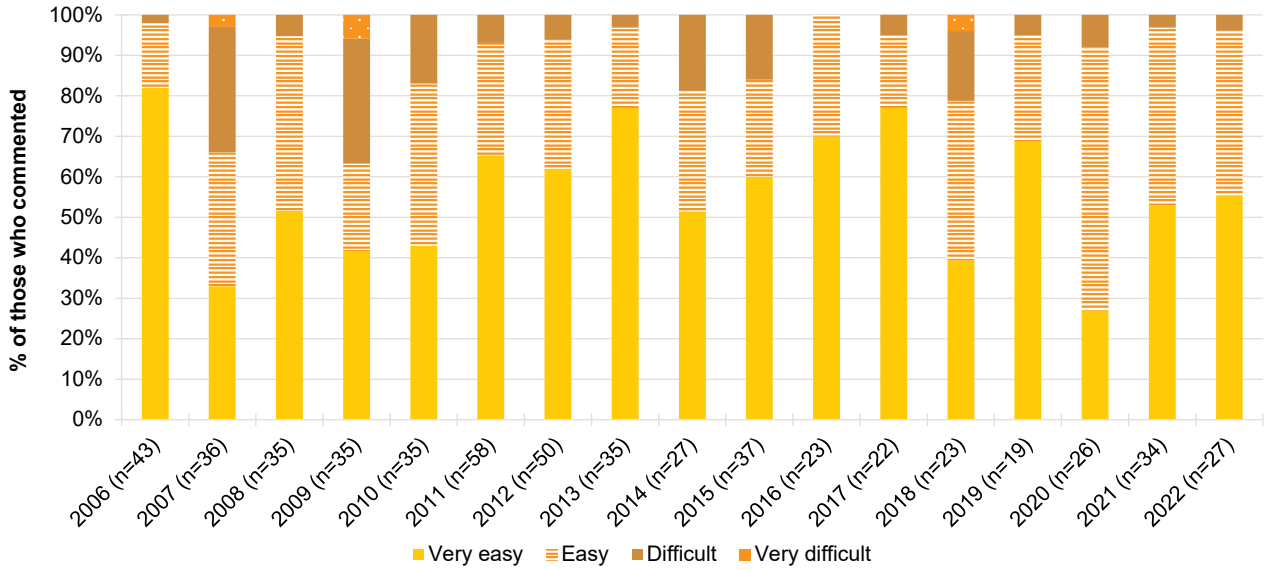
(B) Bush cannabis



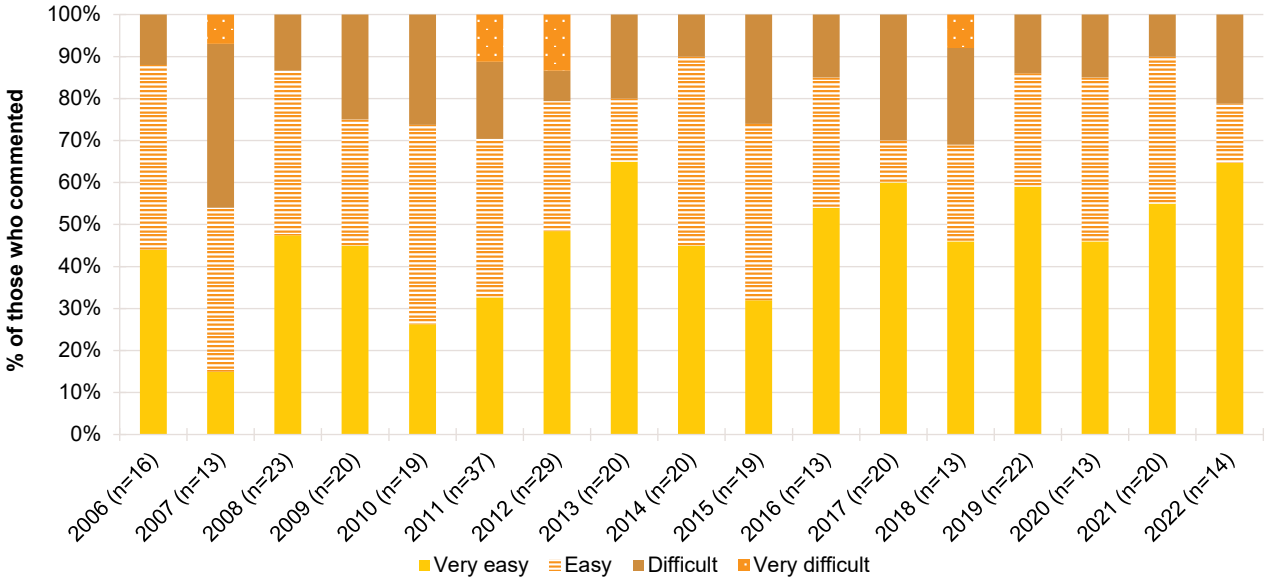
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 42: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Melbourne, VIC, 2006-2022

(A) Hydroponic cannabis



(B) Bush cannabis



Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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.

Routinely Collected Data

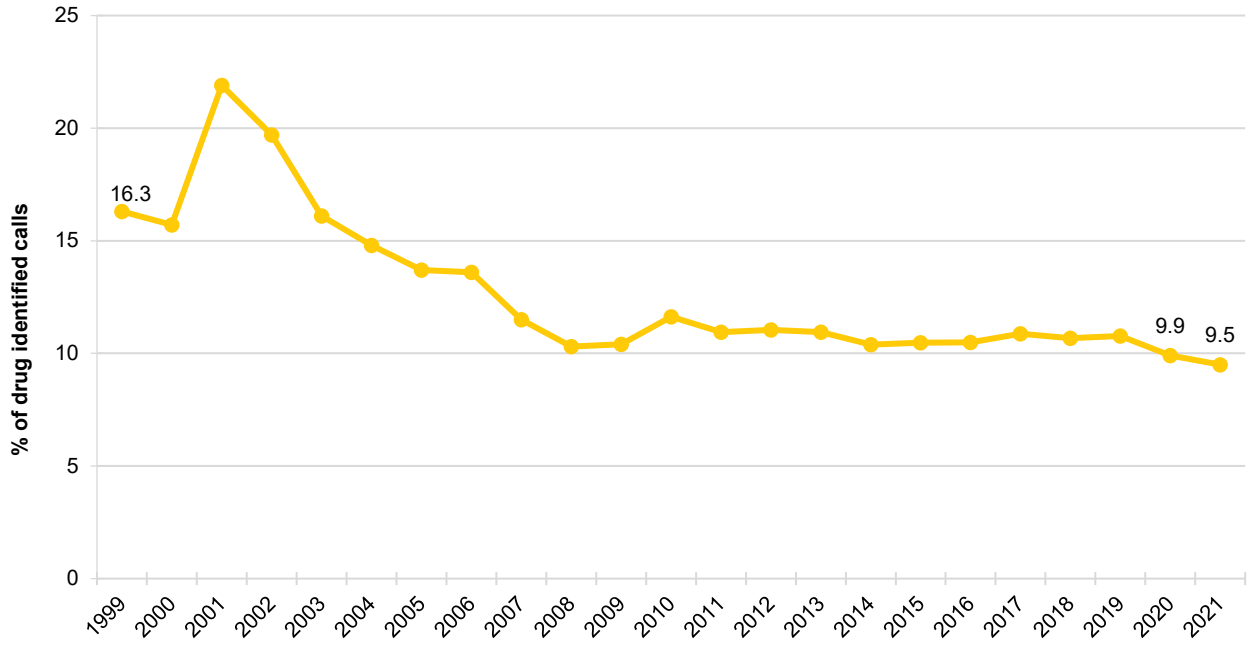
ADIS\VADC

In 2020/21, 8,260 courses of treatment were delivered to 4,564 clients for cannabis, equivalent to 14.2% and 13.7% of the total courses delivered and clients treated. These were 14.5% and 5.7% increases from courses delivered and clients treated in 2019/20 (7,212 and 4,317, respectively).

DirectLine

During 2021, DirectLine received 1,445 calls in which cannabis was identified as the drug of concern – 9.5% of all drug-identified calls to DirectLine in that year. The percentage of drug-related calls in which cannabis was identified as the drug of concern has been consistent since 2008 (Figure 43).

Figure 43: Percentage of calls to DirectLine in which cannabis was identified as drug of concern, Victoria 1999–2021



Source: DirectLine, Turning Point. Data labels provided are only provided for the first (1999) and the two most recent years (2020 and 2021) of monitoring.

6

Ketamine, LSD and DMT

Ketamine

Patterns of Consumption

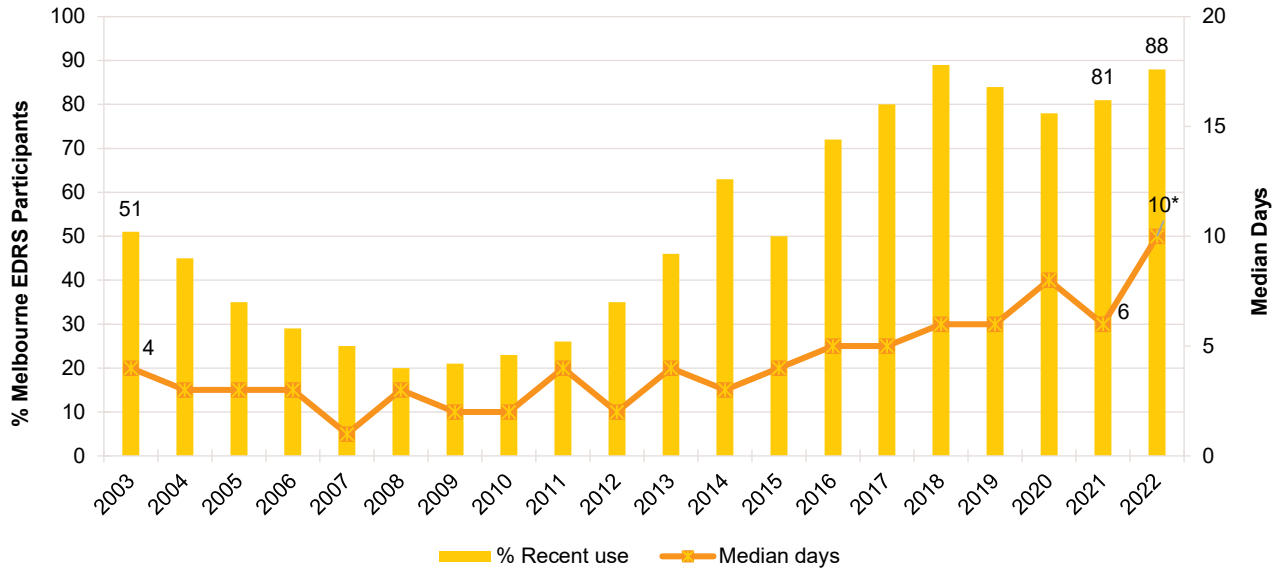
Recent Use (past 6 months): Reported recent use of ketamine has increased steadily over the period of monitoring, and then stabilised from 2017. The majority (88%) of the sample reported using ketamine in the six months prior to interview in 2022, stable relative to 2021 (81% ;*p*=0.244) (Figure 44).

Frequency of Use: In 2022, of those who reported recent ketamine consumption and commented (n=88), frequency of reported use significantly increased from six days (IQR=3–12) in 2021 to a median of 10 days (IQR=5–15) in the past six months and equivalent to nearly fortnightly use (*p*=0.020) (Figure 44). Fourteen per cent of participants reported weekly or more frequent ketamine use in 2022, stable from 11% in 2021 (*p*=0.636).

Routes of Administration: Among participants who reported recent ketamine consumption and commented (n=88), almost all (99%) reported snorting in 2022, as was the same in 2021 (99%).

Quantity: Of those who reported recent ketamine consumption and responded (n=54), the median amount of ketamine reportedly used in a 'typical' session was 0.40 grams (IQR=0.30–0.50; 0.30 grams in 2021; IQR=0.20–0.50; *p*=0.277). Of those who reported recent use and responded (n=59), the median maximum amount reportedly used was 0.80 grams (IQR=0.40–1.00; 0.50 grams in 2021; IQR=0.30–1.00; *p*=0.435).

Figure 44: Past six month use and frequency of use of ketamine, Melbourne, VIC, 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, and are suppressed for 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.

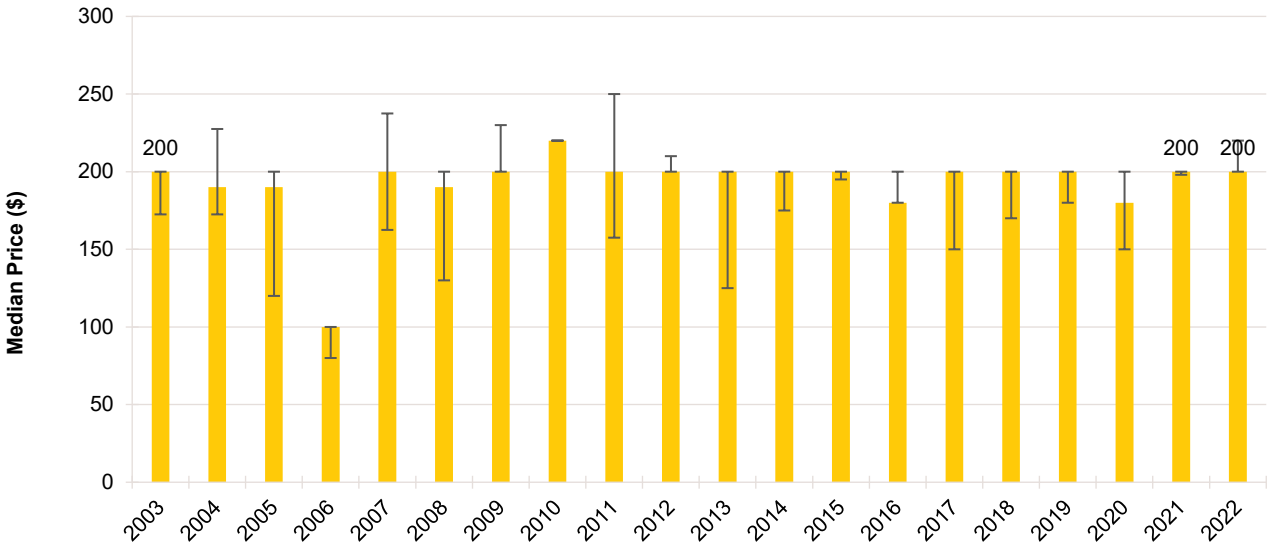
Price, Perceived Purity and Perceived Availability

Price: In 2022, the median reported price per gram of ketamine was $200 (IQR=200–220; n=55), stable compared to 2021 ($200; IQR=198–200; n=36; p=0.449) (Figure 45).

Perceived Purity: The perceived purity of ketamine remained stable between 2021 and 2022 (p=0.339). Among those who were able to respond in 2022 (n=75), 40% perceived the purity of ketamine to be 'high' (48% in 2021), with 27% reporting 'medium' purity (26% in 2021) and a further 27% reporting that purity 'fluctuates' (15% in 2021) (Figure 46).

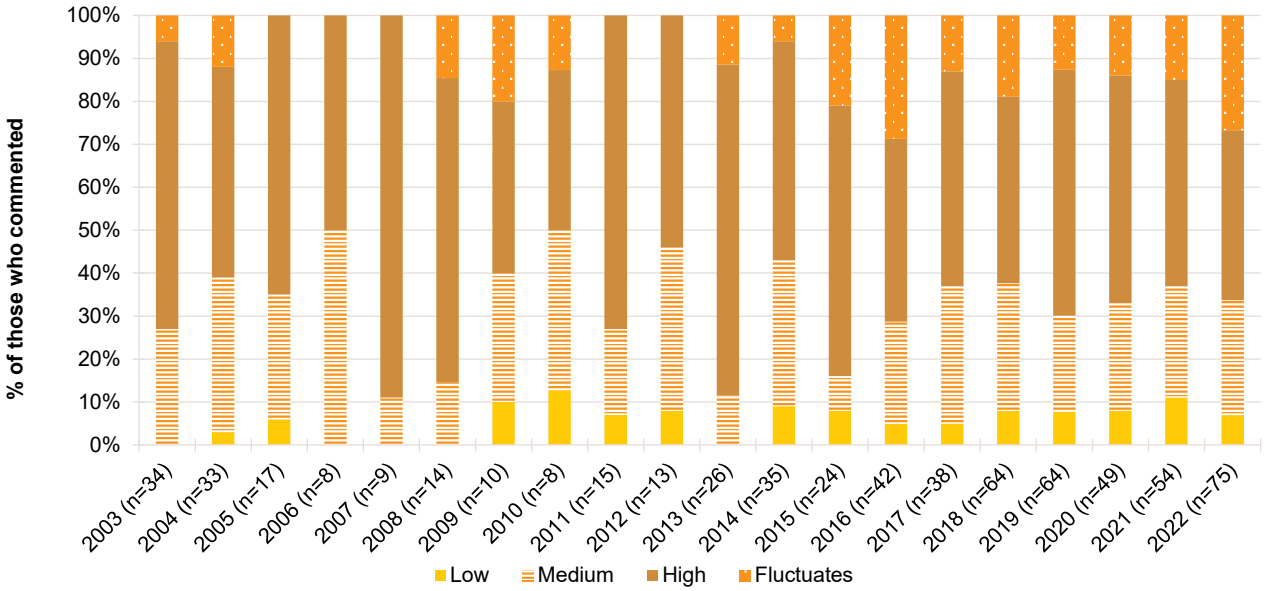
Perceived Availability: There was a significant difference in the perceived availability of ketamine between 2021 and 2022 (p<0.001). Of those who were able to respond in 2022 (n=79), 54% perceived ketamine to be 'easy' to obtain, an increase from 34% in 2021, with fewer participants reporting it to be 'very easy' to obtain (15%; 52% in 2021) (Figure 47).

Figure 45: Median price of ketamine per gram, Melbourne, VIC, 2003-2022



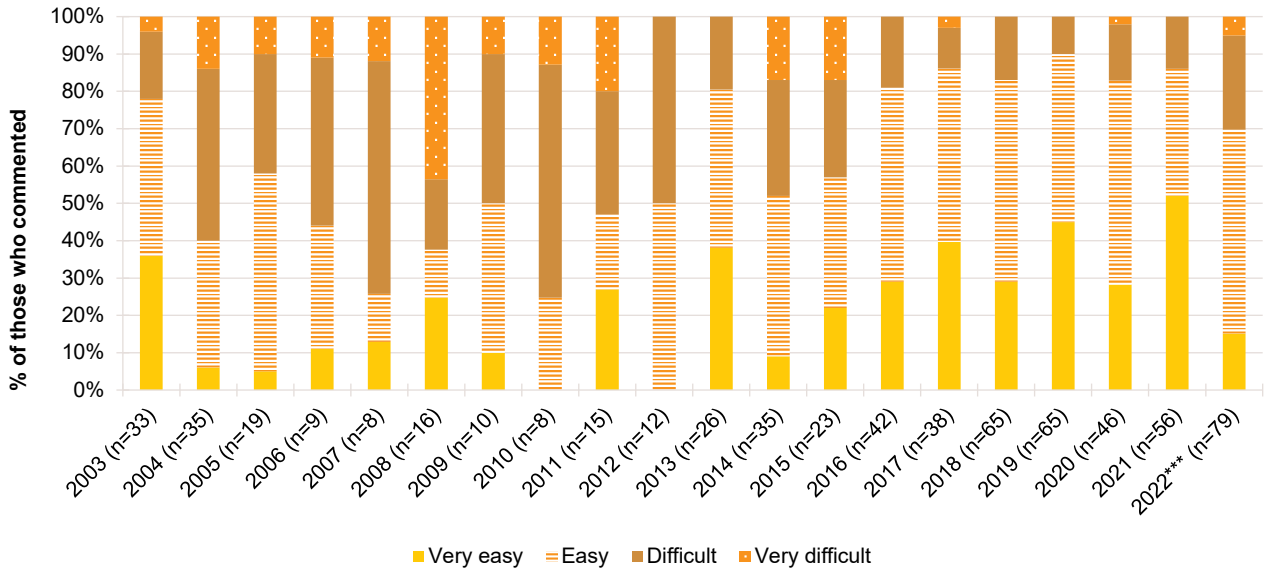
Note. Among those who commented. No participants reported purchasing ketamine in 2014 and 2015. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, and are suppressed for small numbers (i.e., n≤5 but not 0). For historical numbers, please refer 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 46: Current perceived purity of ketamine, Melbourne, VIC, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 47: Current perceived availability of ketamine, Melbourne, VIC, 2003-2022



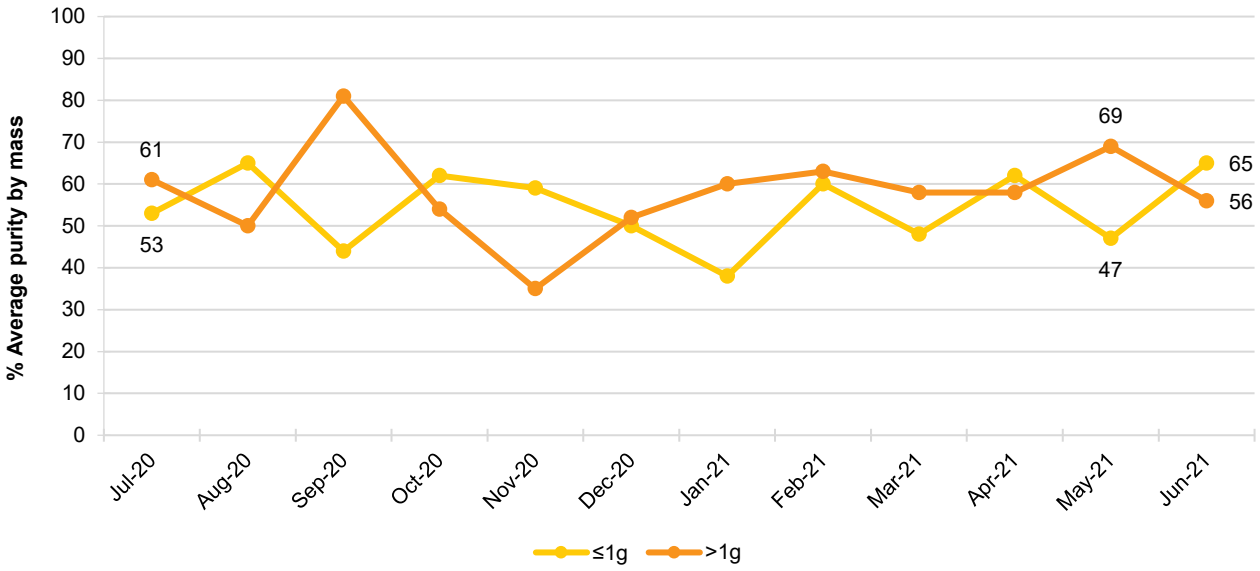
Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. For historical numbers, please refer to the data tables. Statistical significance for 2021 versus 2022 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Routinely Collected Data

Victoria Police Seizure Purity

Ketamine seizures analysed by the Victoria Police Forensic Services Department during the 2020/21 financial year averaged 54% purity in samples weighing one gram or less (IQR=48–62, range=38–65) and 58% in samples weighing over one gram (IQR=54–62, range=35–81) (Figure 48).

Figure 48: Purity of ketamine seizures by Victorian law enforcement, July 2020–June 2021



Note. May not include every drug seized, as not all seized drugs undergo purity analysis. Data labels are only provided for the first (July 2020) and the two most recent months (May and June 2021) of monitoring.

LSD

Patterns of Consumption

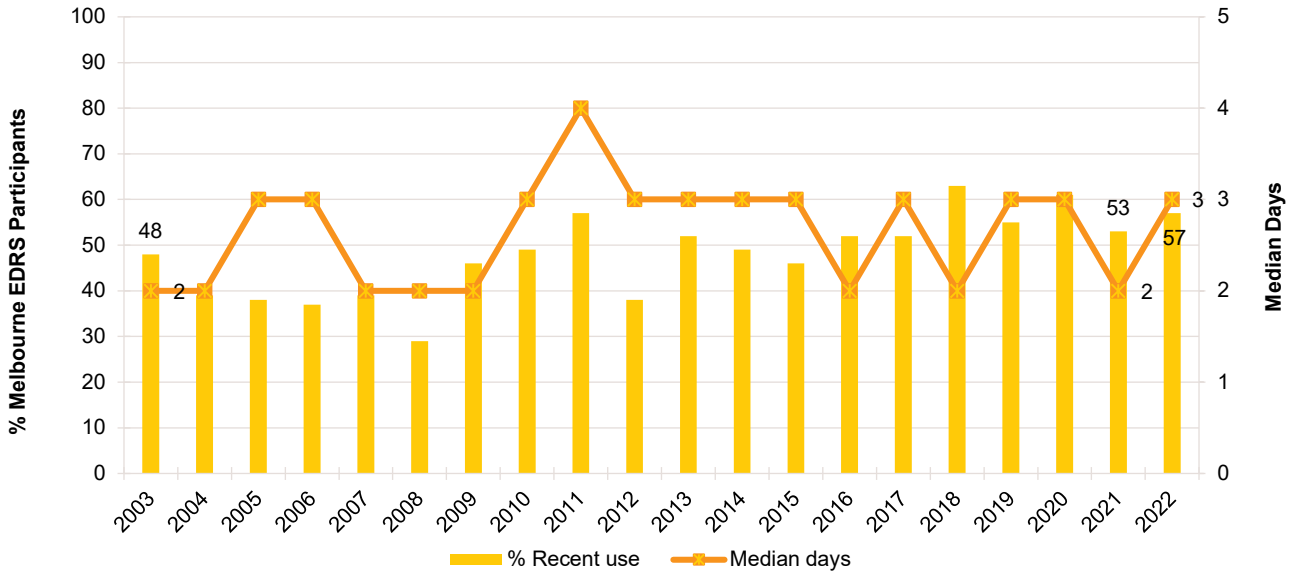
Recent Use (past 6 months): Almost three-fifths (57%) of the sample reported using LSD in the six months preceding interview, stable from 53% recorded in 2021 (p=0.670) (Figure 49).

Frequency of Use: Median days of use has fluctuated across the period of monitoring, although it remained stable in 2022 at three days (IQR=1–6) in the past six months (2 days in 2021; IQR=1–5; p=0.457) (Figure 49). Of those who reported recent LSD consumption, few participants (n≤5) reported weekly or more frequent use in 2022, therefore these data are suppressed (n≤5 in 2021).

Routes of Administration: Among those who reported recent LSD consumption and commented (n=57), all participants (100%) reported swallowing LSD in 2022 (100% in 2021).

Quantity: Of those who reported recent LSD consumption and responded (n=40), the median amount of LSD reportedly used in a 'typical' session was one tab (IQR=0.5–1; 1 tab in 2021; IQR=0.5–1; n=43; p=0.850). Of those who reported recent LSD consumption and responded (n=42), the median maximum amount used was one tab (IQR=1–2; 1 tab in 2021; IQR=1–1; p=0.301).

Figure 49: Past six month use and frequency of use of LSD, Melbourne, VIC, 2003-2022



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 5 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, and are suppressed for 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

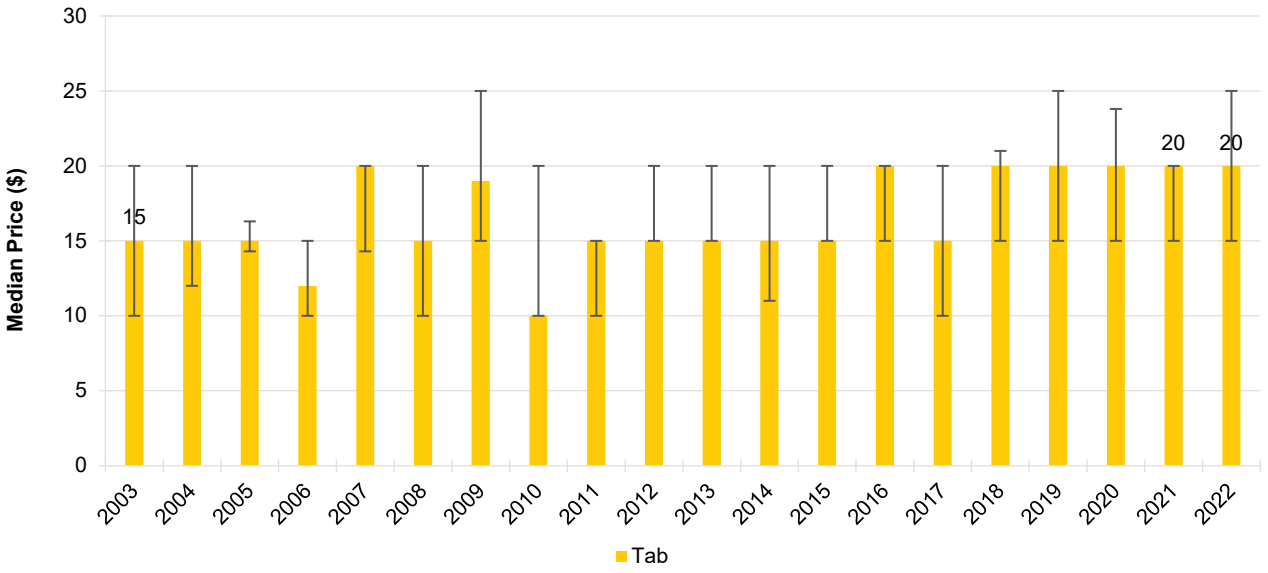
Price: The median reported price for one tab of LSD has remained relatively stable since 2011, ranging from $15 to $20. In 2022, participants reported a median of $20 per tab (IQR=15–25; n=36; $20 in 2021; IQR=15–20; n=29; p=0.188) (Figure 50).

Perceived Purity: The perceived purity of LSD remained stable between 2021 and 2022 (p=0.463). Among those who were able to respond in 2022 (n=49), 59% perceived the purity of LSD to be 'high' (54% in 2021), followed by 29% who reported the purity to be 'medium' (26% in 2021) (Figure 51).

Perceived Availability: The perceived availability of LSD remained stable in 2022 compared to 2021 (p=0.734). Among those who responded in 2022 (n=47), participants most commonly reported LSD

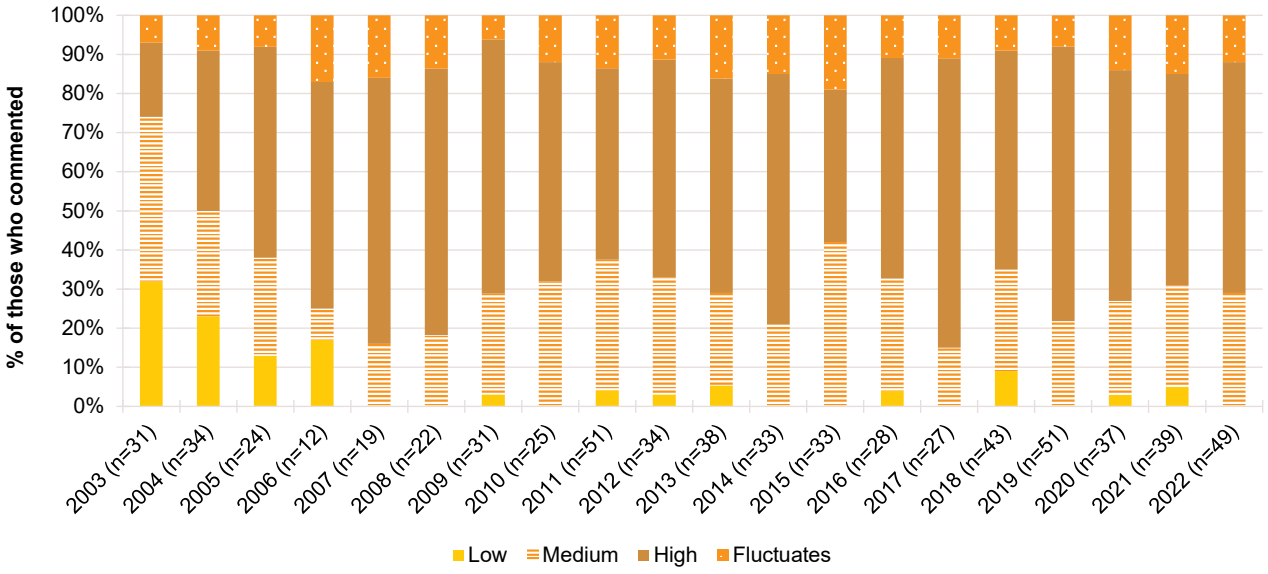
to be 'easy' to obtain (55%; 62% in 2021), although 26% reported it to be 'difficult' to obtain (18% in 2021) (Figure 52).

Figure 50: Median price of LSD per tab, Melbourne, VIC, 2003-2022



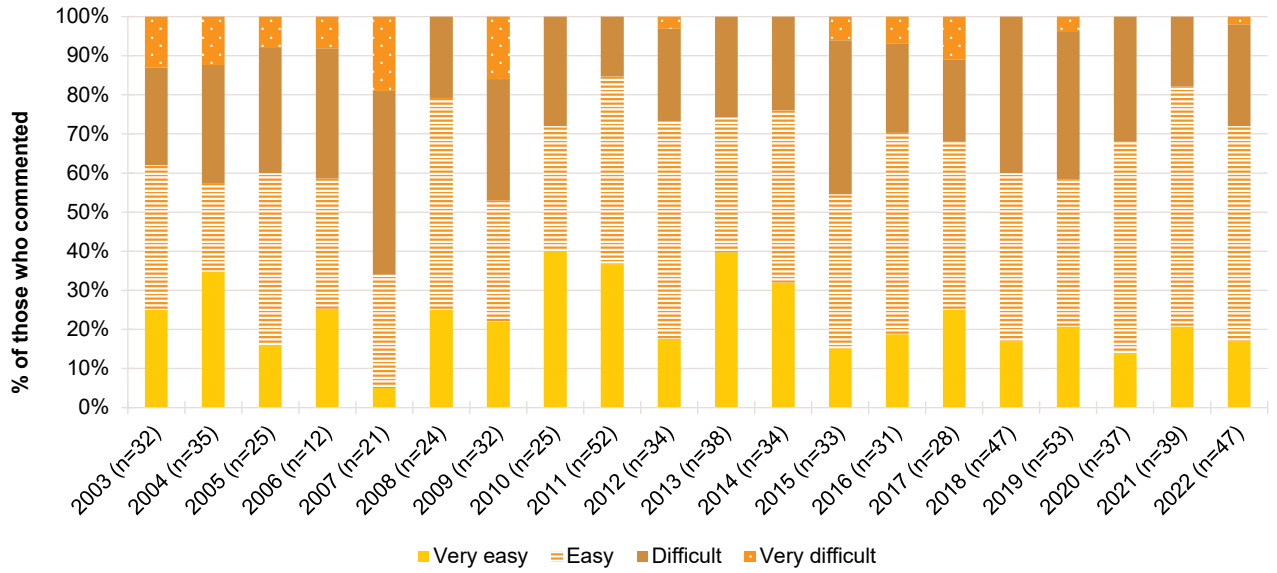
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, and are suppressed for small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent the IQR. The response 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 51: Current perceived purity of LSD, Melbourne, VIC, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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 52: Current perceived availability of LSD, Melbourne, VIC, 2003-2022



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for all stacked bar charts; see data tables for values. Data are not shown in the figure nor values in the data tables where n≤5 responded to the item. 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.

DMT

Patterns of Consumption

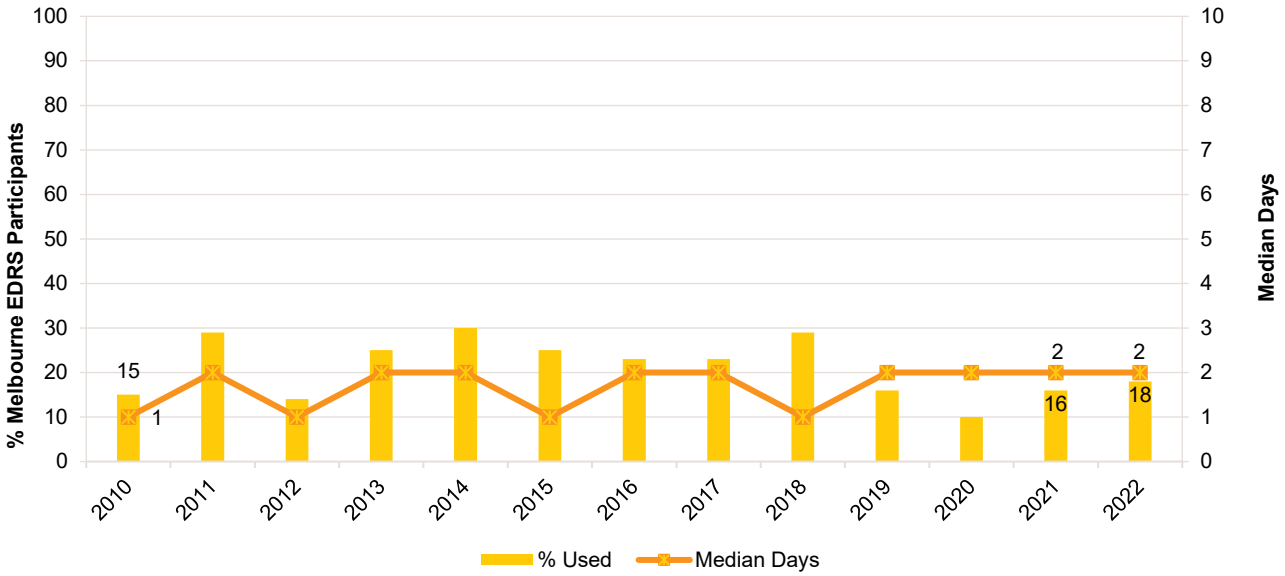
Recent Use (past 6 months): In 2022, 18% of the sample reported DMT consumption in the past six months, stable compared to 2021 (16%; p=0.847) (Figure 53).

Frequency of Use: Use of DMT was infrequent, reported on a median of two days (IQR: 1–3; stable relative to 2 days in 2021, IQR=1–2; p=0.377) (Figure 53).

Routes of Administration: Among those who reported recent DMT use and commented (n=18), smoking was the main route of administration in 2022 (100%; 100% in 2021), with few participants (n≤5) reporting snorting.

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 53: Past six month use and frequency of use of DMT, Melbourne, VIC, 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, and are suppressed for 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 were not collected.

7

New Psychoactive Substances

New psychoactive substances (NPS) are often defined as substances that do not fall under international drug control, but which may pose a public health threat. However, there is no universally accepted definition, and the term has come to include drugs that are not long 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. This means that the figures presented below for recent use of tryptamine, phenethylamine and any NPS do not align with those in our 2010-2020 reports.

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

Recent Use (past 6 months)

NPS use among the Melbourne sample has fluctuated over time. In 2022, 16% of participants reported recent use of any NPS, including plant-based NPS, in the past six months, stablefrom 2021 (23%; p=0.278) (Table 2). Fifteen per cent reported recent use of any NPS, excluding plant-based NPS, in the past six months, similar to 2021 (21%; p=0.359) (Table 3).

Forms Used

The NPS most frequently reported as having been consumed was 'any 2C substance', with 9% reporting recent use in 2022; comparable to 2021 (16%; p=0.202) (Table 4). Few participants (n≤5) reported use of any other NPS (Table 4).

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

%	National	Melbourne, VIC
2010	24	29
2011	36	40
2012	40	45
2013	44	45
2014	35	34
2015	37	36
2016	28	31
2017	26	29
2018	23	28
2019	20	17
2020	15	12
2021	16	23
2022	**11**	**16**

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

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

%	National	Melbourne, VIC
2010	24	28
2011	33	37
2012	37	40
2013	42	45
2014	34	34
2015	34	33
2016	27	29
2017	24	27
2018	21	27
2019	19	16
2020	12	12
2021	14	21
2022	**9**	**15**

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

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

	2010 N=100	2011 N=101	2012 N=100	2013 N=100	2014 N=100	2015 N=100	2016 N=100	2017 N=100	2018 N=100	2019 N=99	2020 N=99	2021 N=100	2022 N=100
% Phenethylamines ^	-	-	14	23	22	12	13	12	11	-	8	17	**11**
Any 2C substance~	-	-	10	20	16	7	12	9	8	-	8	16	**9**
NBOMe	/	/	/	/	8	7	0	-	-	-	0	0	**-**
DO-x	0	0	0	0	0	0	0	-	-	0	0	0	**0**
4-FA	/	/	/	/	/	/	0	-	0	0	0	-	**-**
NBOH	/	/	/	/	/	/	/	/	/	/	/	/	**0**
% Tryptamines^^	0	-	-	-	0	0	0	-	-	0	0	0	**0**
5-MeO-DMT	0	-	-	-	0	0	0	-	-	0	0	0	**0**
4-AcO-DMT	/	/	/	/	/	/	0	0	/	/	/	/	**/**
% Synthetic cathinones	29	42	14	18	11	11	-	-	-	-	0	-	**29**
Mephedrone	28	25	8	10	6	7	-	-	-	0	0	0	**28**
Methylone/bk MDMA	/	12	-	6	-	-	-	-	-	-	0	-	**/**
MDPV/Ivory wave	-	-	-	-	-	0	0	-	0	0	0	0	**-**
Alpha PVP	/	/	/	/	/	/	-	0	0	0	0	0	**/**
Other substituted cathinone	/	/	0	0	0	-	0	-	0	/	/	/	**/**
N-ethylhexedrone	/	/	/	/	/	/	/	/	/	0	0	0	**/**
N-ethylpentylone	/	/	/	/	/	/	/	/	/	0	0	-	**/**
N-ethylbutylone	/	/	/	/	/	/	/	/	/	/	/	0	**/**
3-chlorometh-cathinone	/	/	/	/	/	/	/	/	/	/	/	/	**0**
3 – Methylmeth-cathinone	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	**-**
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	**0**
N, N-Dimethyl Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	**0**
% Piperazines	-	-	-	-	0	0	0	0	/	/	/	/	**/**
BZP	-	-	-	-	0	0	0	0	/	/	/	/	**/**
% Dissociatives	/	/	-	6	/	10	9	-	6	-	-	6	**-**
Methoxetamine (MXE)	/	/	-	6	/	10	9	-	6	-	-	-	**-**
2-Fluorodeschloro-ketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	**0**
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	/	/	/	**0**
3-HO-PCP/4-HO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	**-**
3-MeO-PCP/4- MeO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	**0**

	2010 N=100	2011 N=101	2012 N=100	2013 N=100	2014 N=100	2015 N=100	2016 N=100	2017 N=100	2018 N=100	2019 N=99	2020 N=99	2021 N=100	2022 N=100
Other drugs that mimic the effects of dissociatives like ketamine	/	/	/	/	/	/	/	/	/	/	-	-	-
% Plant-based NPS	-	6	9	-	-	6	-	7	-	-	-	7	-
Ayahuasca	/	/	/	/	/	0	0	-	-	-	-	-	-
Mescaline	-	-	-	-	-	-	-	6	-	-	-	-	-
Salvia divinorum	/	-	-	0	-	-	-	0	0	0	0	-	**0**
Kratom	/	/	/	/	/	/	/	/	/	/	0	-	**0**
LSA	/	0	0	0	1	1	1	/	/	/	/	/	**/**
Datura	0	0	0	0	0	0	0	/	/	/	/	/	**/**
% Benzodiazepines	/	/	/	/	/	/	-	-	0	-	0	-	-
Etizolam	/	/	/	/	/	/	-	-	0	-	0	-	-
8-Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Bromazolam	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Clonazolam	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	**0**
Other drugs that mimic the effect of benzodiazepines	/	/	/	/	/	/	/	/	-	-	0	0	**0**
% Synthetic cannabinoids	/	-	16	18	9	8	-	-	-	0	0	-	-
% Herbal high[#]	/	/	7	7	-	-	-	-	0	-	/	/	**/**
Phenibut	/	/	/	/	/	/	/	/	/	/	-	-	**/**
% Other drugs that mimic the effect of opioids	/	/	/	/	/	/	/	/	0	0	0	0	**/**
% Other drugs that mimic the effect of ecstasy	/	/	/	/	/	/	/	0	0	-	0	0	**/**
% Other drugs that mimic the effect of amphetamine or cocaine	/	/	/	/	/	/	/	-	0	-	-	0	**/**
% Other drugs that mimic the effect of psychedelic drugs like LSD	/	/	/	/	/	/	/	-	-	-	-	0	**/**

Note. NPS first asked about in 2010. / not asked. ^In previous EDRS reports, PMA was included as a NPS under 'phenethylamines' and mescaline was included under both 'phenethylamines' and 'plant-based NPS'. This year, PMA has been deleted as a NPS altogether, while mescaline was removed from 'phenethylamines' and is now only coded under 'plant-based NPS' – this means that the percentages reported for any phenethylamine NPS use (2010-2020) will not align with those presented in previous EDRS reports. ^^In previous EDRS reports, DMT was included as a NPS under 'tryptamines'. This year, DMT has been removed as a NPS (refer to Chapter 7 for further information on DMT use among the sample), which means that the percentages reported for any tryptamine NPS use (2010-2020) will not align with those presented in previous EDRS reports. # The terms 'herbal highs' and 'legal highs' appear to be used interchangeably to mean drugs that have similar effects to illicit drugs like cocaine or cannabis but are not covered by current drug law scheduling or legislation. – not reported, due to small numbers (n≤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

in Australia, before 1 February 2018, people could purchase 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 1 February 2018, legislation changed so that all codeine products, low- and high-dose, require a prescription from a doctor to access.

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

Recent Use (past 6 months): In 2022, 11% reported using any non-prescribed codeine in the past six months (12% in 2021).

Recent Use for Non-Pain Purposes: Six per cent of the total sample reported using non-prescribed codeine for non-pain purposes in the past six months in 2022 (55% of participants who had recently consumed non-prescribed codeine) (Figure 54).

Frequency of Use: Median reported frequency of use among participants who had recently used non-prescribed codeine and commented (n=11) was two days (IQR=1–3) in the past six months (2 days in 2021; IQR=1–2; n=11; *p*=0.744).

Pharmaceutical Opioids

Recent Use (past 6 months): In 2022, one-tenth (11%) of the sample reported recent non-prescribed pharmaceutical opioid use (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl, excluding codeine) in the past six months, stable from 13% in 2021 (*p*=0.822) (Figure 54).

Frequency of Use: Participants who reported recent non-prescribed pharmaceutical opioid use and commented (n=10) reported use on a median of five days (IQR=1–7) in the six months preceding interview (2 days in 2021; IQR=2–4; n=10; *p*=0.395).

Pharmaceutical Stimulants

Recent Use (past 6 months): In 2022, 64% of the sample reported recent non-prescribed pharmaceutical stimulant use (e.g., dexamphetamine, methylphenidate, modafinil), stable relative to 2021 (66%; *p*=0.878) (Figure 54).

Frequency of Use: The median number of days of reported use of non-prescribed pharmaceutical stimulant use in the six months prior to interview was four (IQR=2–12; n=64) in 2022, stable from 2021 (6 days; IQR=3–12; n=65; *p*=0.176).

Quantity: Among those who reported recent use of non-prescribed pharmaceutical stimulants and responded (n=57), the median amount used in a 'typical' session was two pills/tablets (IQR=1–3), a significant increase from one pill/tablet in 2021 (IQR=1–2; *p*=0.009). Among those who reported

recent non-prescribed pharmaceutical stimulant use and responded (n=57), the median maximum amount reportedly used was two pills/tablets (IQR=1–4; 2 pills/tablets in 2021; IQR=1–4; *p*=0.136).

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): Reports of recent use of non-prescribed benzodiazepines has remained relatively stable in recent years, with 47% reporting recent use in 2022, similar to 2021 (54%; *p*=0.395) (Figure 54). From 2019, participants were asked about non-prescribed alprazolam versus other non-prescribed benzodiazepine use. Twenty-nine per cent of the sample reported recent non-prescribed use of alprazolam (28% in 2021), whereas 31% reported recent non-prescribed use of other benzodiazepines (41% in 2021; *p*=0.187).

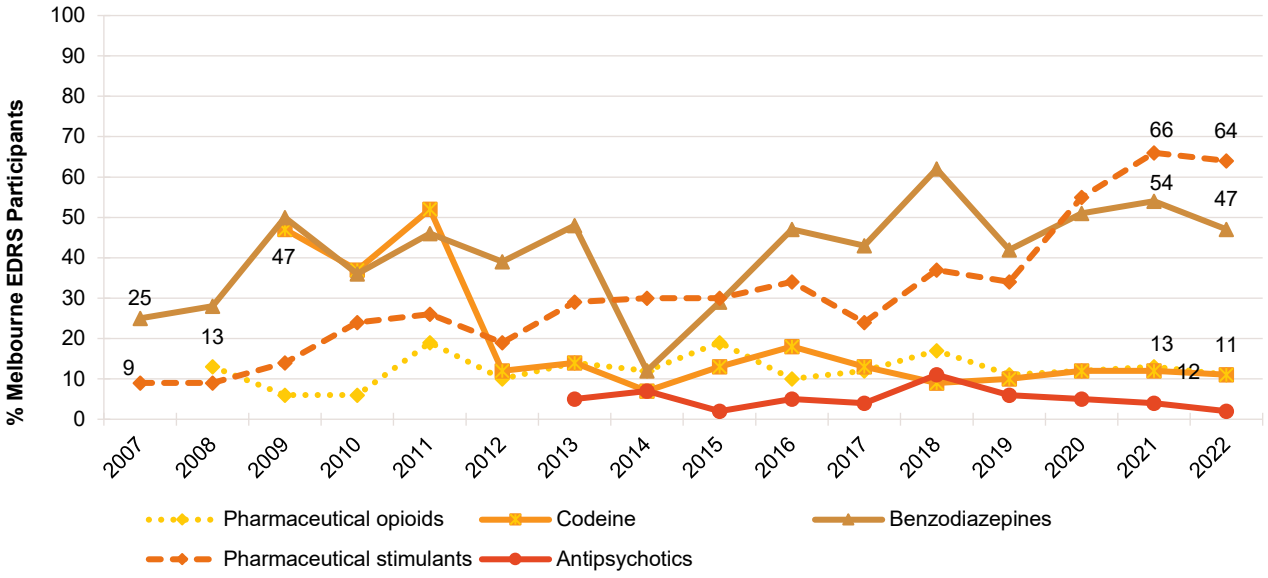
Frequency of Use: In 2022, participants who reported recent use did so on a median of three days (IQR=2–6; n=29; 3 days in 2021; IQR=2–5; n=28; *p*=0.871) and four days (IQR=2–9; n=31; 4 days in 2021; IQR=2–12; n=41; *p*=0.731) of non-prescribed alprazolam and other benzodiazepine use in the past six 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

Due to low numbers reporting on recent use of non-prescribed antipsychotics, numbers have been suppressed (Figure 54). For further information, please refer to the National EDRS report, or contact the Drug Trends team for further information.

Figure 54: Non-prescribed use of pharmaceutical drugs in the past six months, Melbourne, VIC, 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 OTC codeine (low-dose codeine) commenced in 2010, however, in February 2018, the scheduling for codeine changed such that low-dose codeine formerly available OTC was required to be obtained via a prescription. To allow for comparability of data, the time series here represents non-prescribed low- and high dose codeine (2018-2022), with high-dose codeine excluded from pharmaceutical opioids from 2018. Data labels are only provided for the first (2007/2008/2009/2013) and two most recent years (2021 and 2022) of monitoring, and are suppressed for 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): Reported hallucinogenic mushroom use has generally increased since 2005. In 2022, 64% of the sample reported recent use of hallucinogenic mushrooms in the past six months, comparable to 54% in 2021 (p=0.198) (Figure 55).

Frequency of Use: The median reported number of days of hallucinogenic mushroom use in the past six months was three (IQR=1–4; n=64) in 2022 (2 days in 2021; IQR=1–5; n=54; p=0.427).

MDA

Recent Use (past 6 months): In 2022, 7% of the sample reported recent use of MDA in the six months prior to the interview (n≤5 in 2021; p=0.101) (Figure 55).

Frequency of Use: The median number of reported days of MDA use was two (IQR=1–3; n=7) in the past six months in 2022 (n≤5 in 2021).

Substance with Unknown Contents

Capsules: Few (n≤5) participants reported recent use of capsules with unknown contents in 2022, therefore these data are suppressed (0% in 2021) (Figure 55). 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 of substances with 'unknown contents'. One-fifth (20%) of participants reported use of any substance with 'unknown contents' in 2022 (21% in 2021) on a median of one day (IQR=1–2; 1 day in 2021; IQR=1–1; p=0.264).

When broken down by substance form, 15% of participants reported use of powder with 'contents unknown' (21% in 2021; *p*=0.359). Few (n≤5) participants reported recent use of pills and crystal with unknown contents in 2022, therefore these data are suppressed.

Quantity: From 2020, we asked participants about the average amount of pills and capsules with unknown contents used in the past six months. Few (≤5) participants were able to answer these questions in 2022, therefore these data are suppressed. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

PMA

No participants reported recent use of PMA. For further information, please refer to the National EDRS report, or contact the Drug Trends team for further information.

PMMA

Due to low numbers reporting on recent use of PMMA, numbers have been suppressed (not asked in 2021). For further information, please refer to the National EDRS report, or contact the Drug Trends team for further information.

Heroin

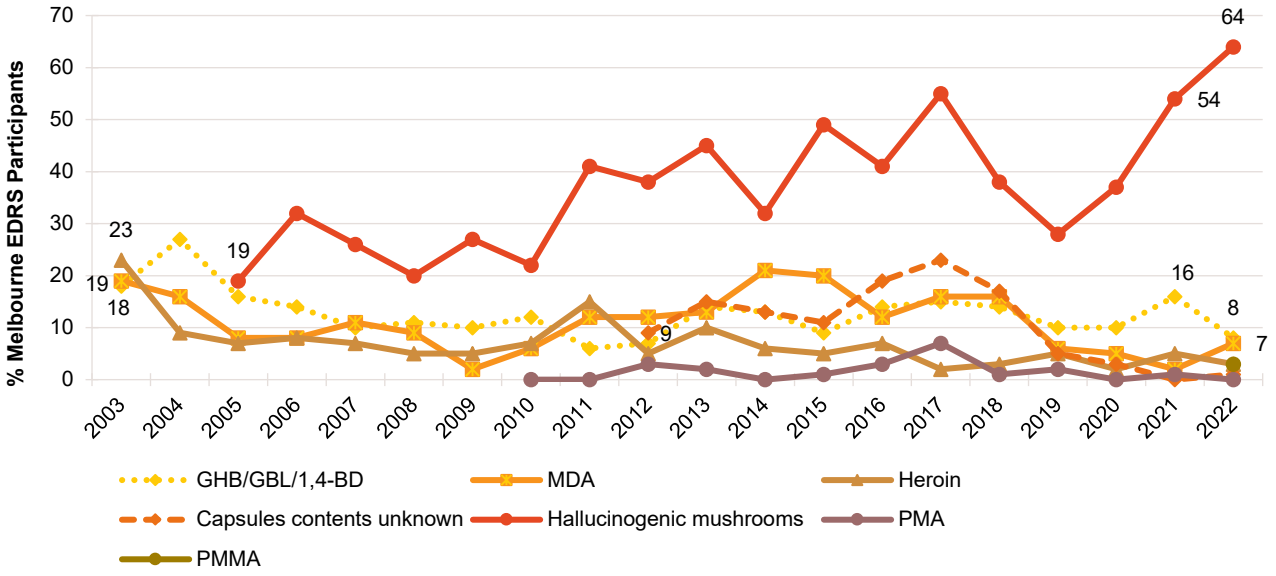
Due to low numbers reporting on recent use of heroin, numbers have been suppressed. For further information, please refer to the National EDRS report, or contact the Drug Trends team for further information.

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

Recent Use (past 6 months): In 2022, 8% of the sample reported recent use of GHB/GBL/1,4-BD in the past six months, stable relative to 2021 (16%; *p*=0.134) (Figure 55).

Frequency of Use: The median number of days of GHB/GBL/1,4-BD use reported in the past six months was four (IQR=1–12; n=8) in 2022 (2 days in 2021; IQR=1–3; n=16; *p*=0.728).

Figure 55: Past six month use of other illicit drugs, Melbourne, VIC, 2003-2022



Note. Monitoring of hallucinogenic mushrooms commenced in 2005. Monitoring of capsules contents unknown commenced in 2012; note that in 2019, participants were asked more broadly about 'substances contents unknown' (with further ascertainment by form) which may have impacted the estimate for 'capsules contents unknown'. Monitoring of PMA commenced in 2010 and monitoring of PMMA commenced in 2022. Y axis has been reduced to 70% to improve visibility of trends. Data labels are only provided for the first (2003/2005/2012) and two most recent years (2021 and 2022) of monitoring, and are suppressed for 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): Reported use of alcohol has remained stable since monitoring began. Most of the sample reported recent use of alcohol in 2022 (96%), stable from 96% in 2021 (Figure 56).

Frequency of Use: The median reported number of days of alcohol use in the past six months was 48 (IQR=24–72; n=96) in 2022 (48 days in 2021; IQR=24–72; n=96; p=0.816). Four-fifths (80%) of those who had recently consumed alcohol had done so on a weekly or more frequent basis in 2022, stable from 2021 (82%; p=0.849). Few (≤5) participants reported daily use of alcohol in 2022 (n≤5 in 2021).

Tobacco

Recent Use (past 6 months): Seventy-one per cent of the sample reported tobacco use in the past six months in 2022, stable from 67% in 2021 (p=0.647) (Figure 56).

Frequency of Use: The median reported number of days of tobacco use was 48 days in 2022 (IQR=6–143; n=70; 72 days in 2021; IQR=18–180; n=67; p=0.173), with 24% of these participants reporting daily use (30% in 2021; p=0.564).

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 Melbourne reported recent use of prescribed e-cigarettes in 2022 (n≤5).

Recent Use (past 6 months): Seventy-one per cent of the 2022 sample reported non-prescribed e-cigarette use in the past six months, a significant increase relative to 2021 (54%; *p*=0.020) (Figure 56).

Frequency of Use: The median frequency of non-prescribed e-cigarette use in the past six months was 35 days in 2022 (IQR=12–170; n=71), stable relative to 20 days of use in 2021 (IQR=4–137; n=54; *p*=0.116).

Forms Used: Among participants who responded (n=69), 91% reported using e-cigarettes containing nicotine, whereas 13% reported using e-cigarettes containing cannabis. A further 13% reported using e-cigarettes which did not contain nicotine or cannabis. Few participants (n≤5) reported using e-cigarettes containing both nicotine and cannabis, therefore, these data are supressed. 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=73), 19% reported that they used e-cigarettes as a smoking cessation tool in 2022.

Nitrous Oxide

Recent Use (past 6 months): Three-fifths (61%) of participants reported recent use of nitrous oxide in 2022, stable from 60% in 2021 (Figure 56).

Frequency of Use: In 2022, the frequency of reported nitrous oxide use remained stable at a median of four days (IQR=3–6; n=60) in the past six months (3 days in 2021; IQR=2–6; n=60; *p*=0.171).

Quantity: Among those who reported recent nitrous oxide use and responded (n=61), the median amount used in a 'typical' session was five bulbs (IQR=2–20; 5 bulbs in 2021; IQR=3–18; n=59; *p*=0.878). Of those who reported recent use and responded (n=60), the median maximum amount used was 10 bulbs (IQR=3–40; 10 bulbs in 2021; IQR=4–30; *p*=0.951).

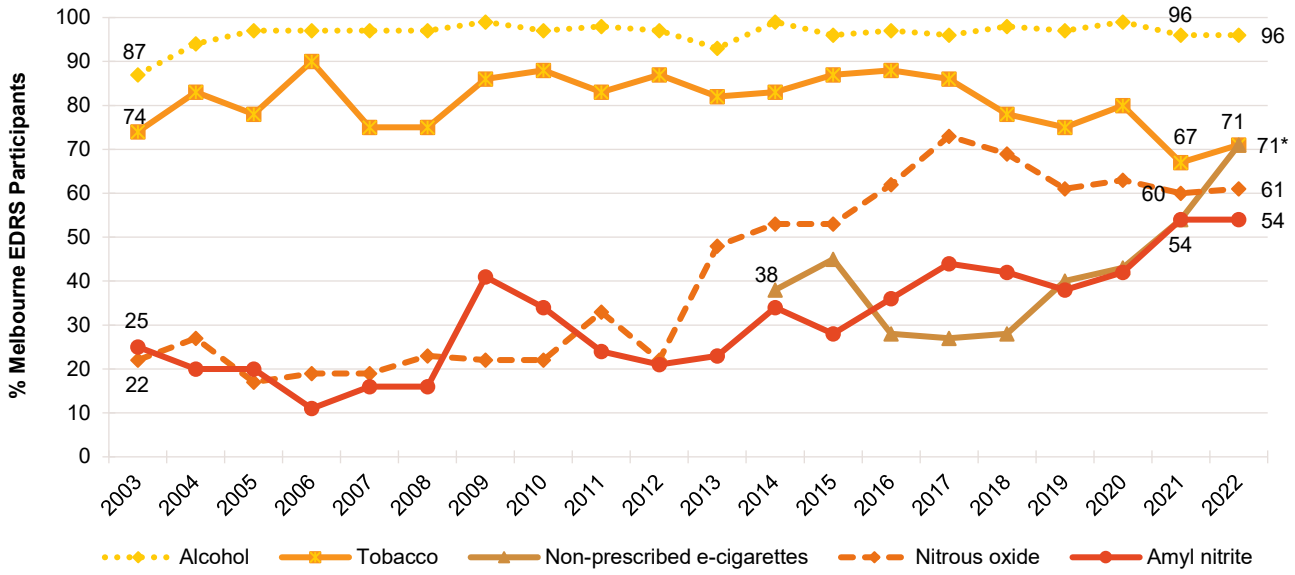
Amyl Nitrite

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

Recent Use (past 6 months): The per cent reporting recent use of amyl nitrite remained stable at 54% in 2022 (54% in 2021) (Figure 56).

Frequency of Use: The median frequency of use in the past six months was three days (IQR=2–5; n=54; 3 days in 2021; IQR=1–6; n=54; *p*=0.666).

Figure 56: Licit and other drugs used in the past six months, Melbourne, VIC, 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, and are suppressed for 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

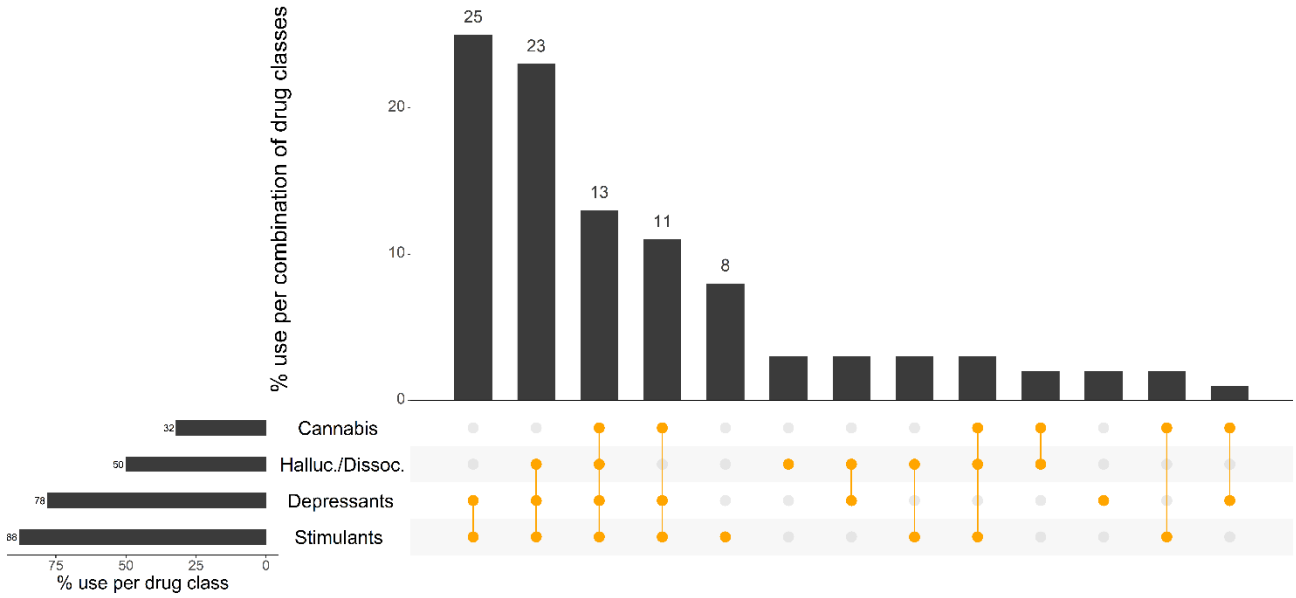
Drug-Related Harms and Other Behaviours

Polysubstance Use

On the last occasion of ecstasy or related drug use and among those who commented (n=95), the most commonly used substances were alcohol (75%) and ecstasy (54%), followed by ketamine (45%) and cocaine (36%) (Figure 57).

The majority (87%; n=83) of the sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most commonly reported combinations of drug classes were stimulants and depressants (25%), followed by stimulants, depressants, and hallucinogens/dissociatives (23%). Thirteen per cent of participants reported using stimulants, depressants, hallucinogens/dissociatives and cannabis, whilst 11% reported using stimulants, depressants, and cannabis, and 8% reported using stimulants alone (Figure 57).

Figure 57: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Melbourne, VIC, 2022: Most common drug pattern profiles



Note. % calculated using total EDRS 2022 sample. The horizontal bars represent the proportion of participants who reported use of each substance on their last occasion of ecstasy or related drug use; the vertical columns represent the proportion 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 25% to improve visibility of trends.

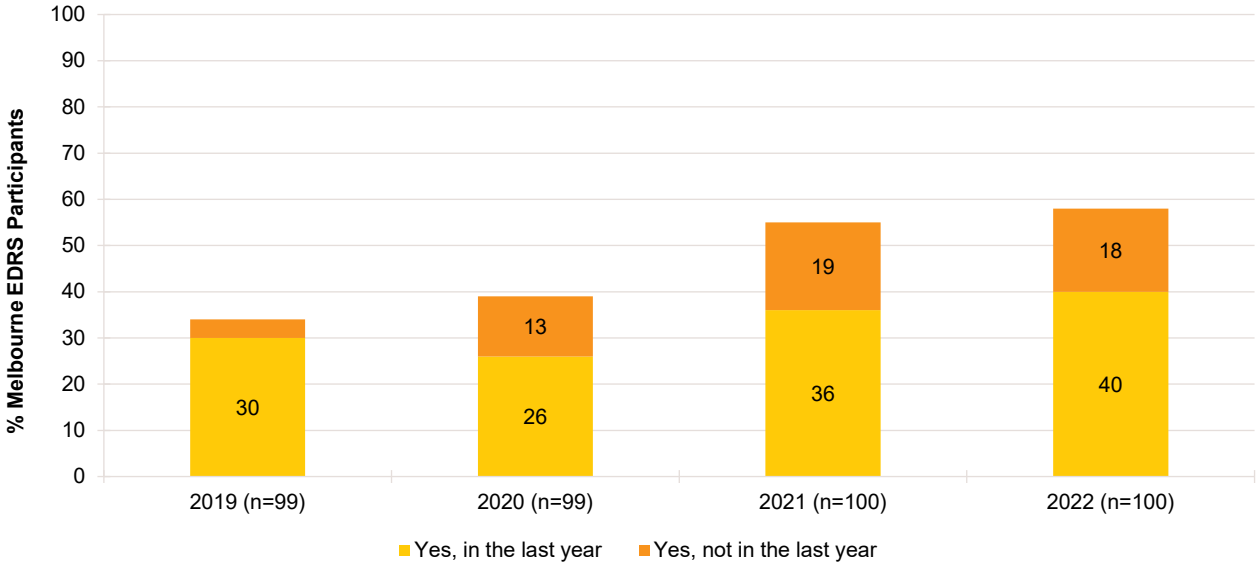
Drug Checking

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

In 2022, 40% 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*=0.664) (Figure 58). Of those who reported that they or someone else had tested their illicit drugs in the past year (n=40), 91% reported using colorimetric or reagent test kits, with few participants (n≤5) using testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips). No participants reported having their drugs tested via Fourier transform infrared spectroscopy or other methods of spectroscopy/ chromatography.

Of those who reported that they or someone else had tested their illicit drugs in the past year (n=40), 58% reported having their drugs tested by a friend, followed by 45% who reported testing the drugs themselves, and 23% by a dealer.

Figure 58: Lifetime and past year engagement in drug checking, Sydney, NSW, 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 World Health Organization designed the Alcohol Use Disorders Identification Test (AUDIT) as a brief screening scale to identify individuals with problematic alcohol use in the past 12 months.

The mean score on the AUDIT for the total sample (including people who had not consumed alcohol in the past six months) was 12.9 (SD= 7.2) in 2022, a significant increase from 12.1 (SD= 6.4) in 2021 (*p*<0.001). AUDIT scores are divided into four 'zones' that indicate risk level. Scores of 0–7 indicate low-risk drinking or abstinence, scores of 8–15 indicate alcohol use in excess of low-risk guidelines, scores of 16–19 indicate harmful or hazardous drinking, and scores 20 or higher indicate possible alcohol dependence. Three-quarters (76%) of the sample obtained a score of eight or more (73% in 2021; *p*=0.739), indicative of hazardous use (Table 5).

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

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
	N=97	N=98	N=97	N=96	N=100	N=97	N=97	N=97	N=98	N=98	N=98	N=100	N=98
Mean AUDIT total score (SD)	14.1 (7.1)	13.3 (7.2)	15 (7.5)	12.1 (6.8)	12 (6.1)	11.5 (6.3)	11.5 (6.6)	10.4 (6.6)	12.6 (6.2)	12 (7.5)	11.8 (5.4)	12.1 (6.4)	**12.9*** (7.2)**
Score 8 or above (%)	86	90	88	86	89	81	74	83	85	74	77	72	**76**
AUDIT zones:													
Score 0-7	22	19	18	30	22	29	34	38	19	26	18	27	**24**
Score 8-15	31	43	40	41	51	47	43	43	55	50	57	43	**44**
Score 16-19	24	22	12	10	13	12	12	7	12	7	15	18	**14**
Score 20 or higher	24	15	30	19	14	11	10	11	14	17	9	12	**17**

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

Overdose Events

Non-Fatal Overdose

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

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

- **Alcohol overdose:** experience of symptoms (e.g., reduced level of consciousness and collapsing) where professional assistance would have been helpful;
- **Stimulant overdose:** experience of symptoms (e.g., nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, seizure, extreme paranoia, extreme anxiety, panic, extreme agitation, hallucinations, excited delirium) where professional assistance would have been helpful; and
- **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 when a depressant (e.g., opioid, GHB/GBL/1,4-BD, benzodiazepines) was listed.

Non-Fatal Stimulant Overdose

In 2022, 12% of the sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview, stable from 2021 (15%; p=0.668) (Figure 59).

The most common stimulant reportedly used during the most recent non-fatal stimulant overdose in the past 12 months was any form of ecstasy (50%; individual numbers for forms too low to report).

Among those that experienced a recent non-fatal stimulant overdose, 92% (n=11) reported that they had also consumed one or more additional drugs on the last occasion, most notably, alcohol (67%; ≥5 standard drinks: 50%; ≤5 standard drinks: n≤5). On the last occasion of experiencing a non-fatal stimulant overdose, the majority (92%) reported that they did not receive treatment or assistance. Due to few participants 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.

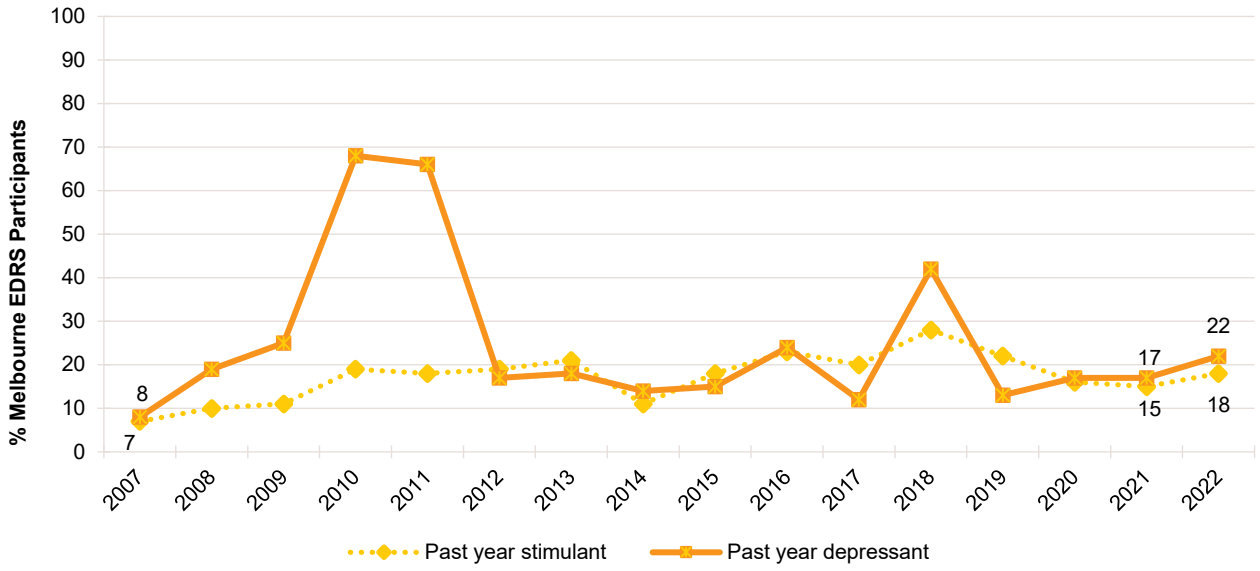
Non-Fatal Depressant Overdose

Alcohol: Eighteen per cent of the sample reported a non-fatal alcohol overdose in the 12 months preceding interview on a median of two occasions (IQR=1–4), similar to 14% in 2021 (p=0.451). Of those who reported experiencing an alcohol overdose in the past year (n=18), the majority (94%) reported not receiving treatment on the last occasion. Due to few participants 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, 22% of participants reported that they had experienced a non-fatal depressant overdose (including alcohol) in the past 12 months, similar to 2021 (17%; p=0.372) (Figure 59).

Of those who reported experiencing any depressant overdose in the past 12 months (n=22), 82% reported alcohol as the most common depressant drug. 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 59: Past 12 month non-fatal stimulant and depressant overdose, Melbourne, VIC, 2007-2022

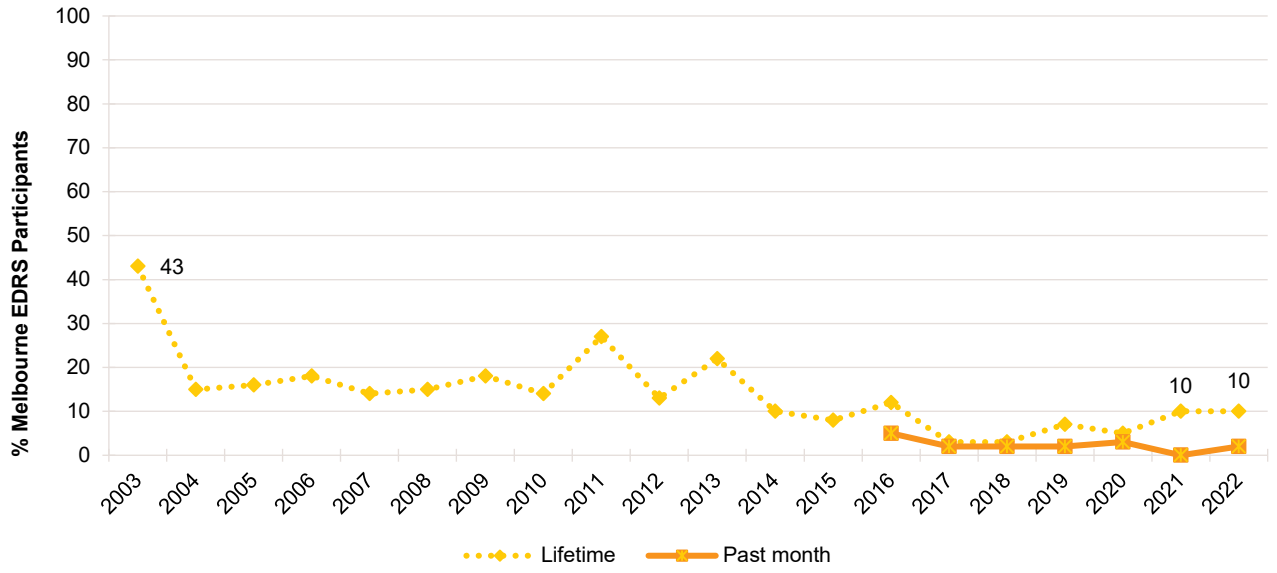


Note. Past year stimulant and depressant overdose was first asked about in 2007. In 2019, items about overdose were revised, and changes relative to 2018 may be a function of greater nuance in capturing depressant events. Data labels are only provided for the first (2007) and two most recent years (2021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

Ten per cent of participants reported lifetime injection in 2022 (10% in 2021) (Figure 60). Few participants (n≤5) reported injecting drugs in the past month (0% in 2021; *p*=0.497), therefore, these data are suppressed (Figure 60). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Figure 60: Lifetime and past month drug injection, Melbourne, VIC, 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, and are suppressed for 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 very small proportion of participants 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, 76% of the sample reported engaging in some form of sexual activity in the past four weeks (78% in 2021; *p*=0.864). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if undertaken face-to-face).

Of those who reported engaging in sexual activity in the past four weeks and who responded (n=76), 84% reported using alcohol and/or other drugs prior to or while engaging in sexual activity, a significant decrease from 95% in 2021 (*p*=0.036). Of those who reported engaging in sexual activity in the past four weeks and responded (n=76), 11% reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (n≤5 in 2021; *p*=0.243). Furthermore, of those who reported engaging in sexual activity in the past four weeks and who responded (n=76), 21% reported penetrative sex without a condom when they did not know the HIV status of their partner (14% in 2021; *p*=0.301) (Table 6).

Of the total sample who responded (n=99), 76% reported having had a sexual health check-up in their lifetime (83% in 2021; *p*=0.593), including 29% having done so in the past six months prior interview (39% in 2021; *p*=0.124). 24% had never had a sexual health check-up (17% in 2021). Of the total

sample who responded (n=99), 76% reported that they had never received a positive diagnosis for a sexually transmitted infection (STI; 80% in 2021); few (n≤5) participants had received a positive diagnosis in the past six months (n≤5 in 2021), therefore these data are suppressed; and 24% had received a positive diagnosis in their lifetime (20% in 2021; *p*=0.502).

Of the total sample (n=100), 65% reported having ever had a test for human immunodeficiency virus (HIV) (25% in the past six months; 40% more than six months ago). Small numbers (n≤5) reported ever having been diagnosed with HIV in their lifetime (n≤5 in 2021).

Table 6: Sexual health behaviours, Melbourne, VIC, 2021-2022

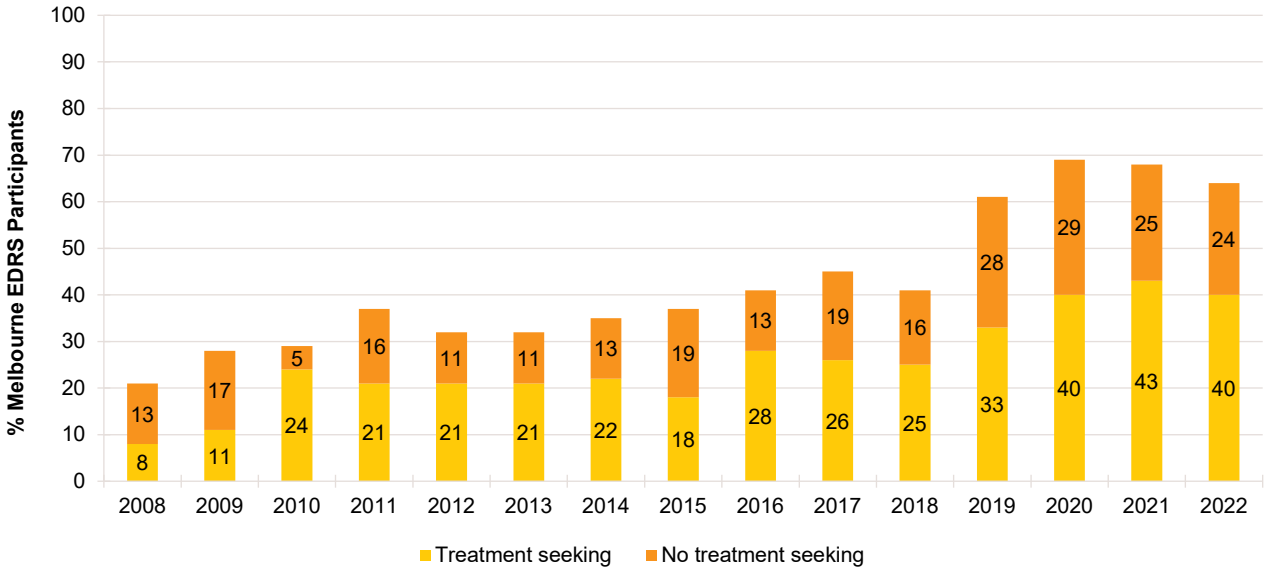
	2021	2022
Of those who responded:	N=100	**N=100**
% Any sexual activity in the past four weeks (n)	78 (n=78)	**76 (n=76)**
Of those who responded# and reported any sexual activity in the past four weeks	n=78	**n=76**
% Drugs and/or alcohol used prior to or while engaging in sexual activity	95	**84***
Of those who responded# and reported any sexual activity in the past four weeks:	n=78	**n=76**
% 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=78	**n=76**
% Had penetrative sex without a condom and did not know HIV status of partner	14	**21**
Of those who responded#:	n=100	**n=100**
% Had a HIV test in the last six months	32	**25**
% Diagnosed with HIV in their lifetime	-	**-**
Of those who responded#:	n=100	**n=99**
% Had a sexual health check in the last six months	39	**29**
% Had a sexual health check in their lifetime	83	**76**
Of those who responded#:	n=100	**n=99**
% Diagnosed with an STI in the last six months	-	**-**
% Diagnosed with an STI in their lifetime	20	**24**

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

The percentage of participants self-reporting mental health problems increased from 2008 through to 2020. In 2022, 64% of the sample self-reported that they had experienced a mental health problem in the past six months (other than drug dependence), similar to 2021 (68%; *p*=0.548). Of those who reported a mental health problem in 2022 and responded (n=63), the most common mental health problem noted was anxiety (71%), followed by depression (67%) and post-traumatic stress disorder (14%). Of those who reported experiencing a mental health problem (n=63), 63% reported seeing a mental health professional during the past six months (63% in 2021), equivalent to 40% of the total sample (Figure 61). Of these participants (n=40), 55% reported being prescribed medication for their mental health problem during this period (51% in 2021; *p*=0.820).

Figure 61: Self-reported mental health problems and treatment seeking in the past six months, Melbourne, VIC, 2008-2022

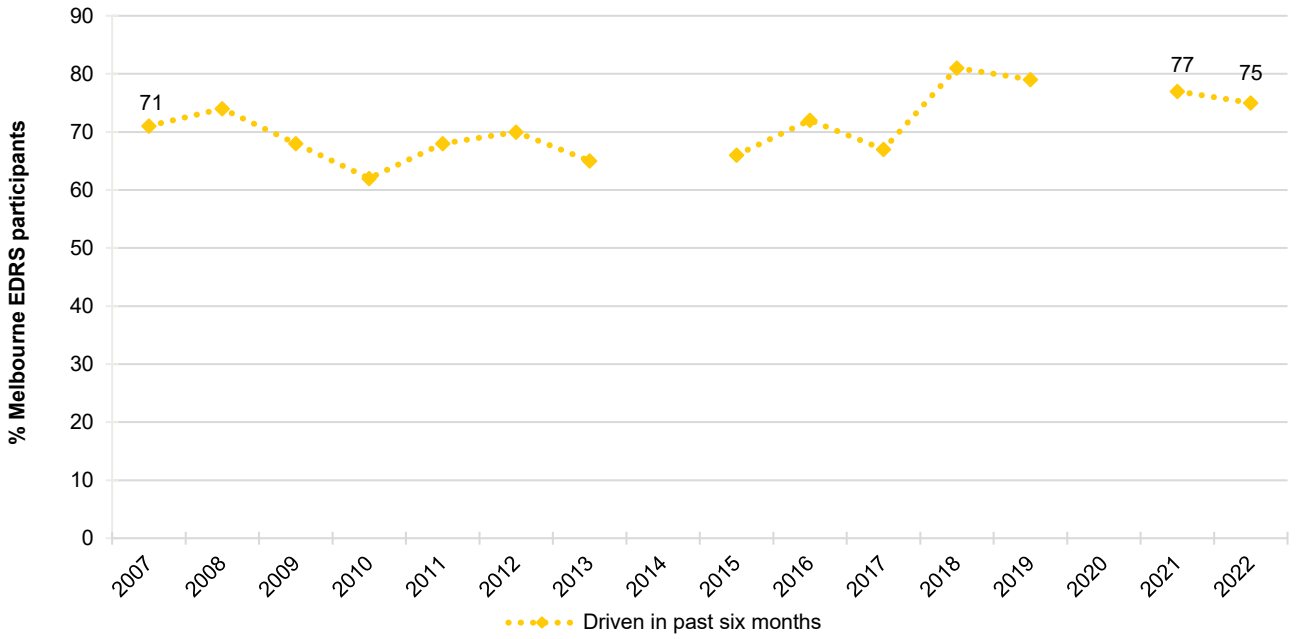


Note. The combination of the proportion who report treatment seeking and no treatment is the proportion who reported experiencing a mental health problem in the past six months. Data labels have been removed from figures with small cell size (i.e., n≤5 but not 0). The response option 'Don't know' was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

Driving

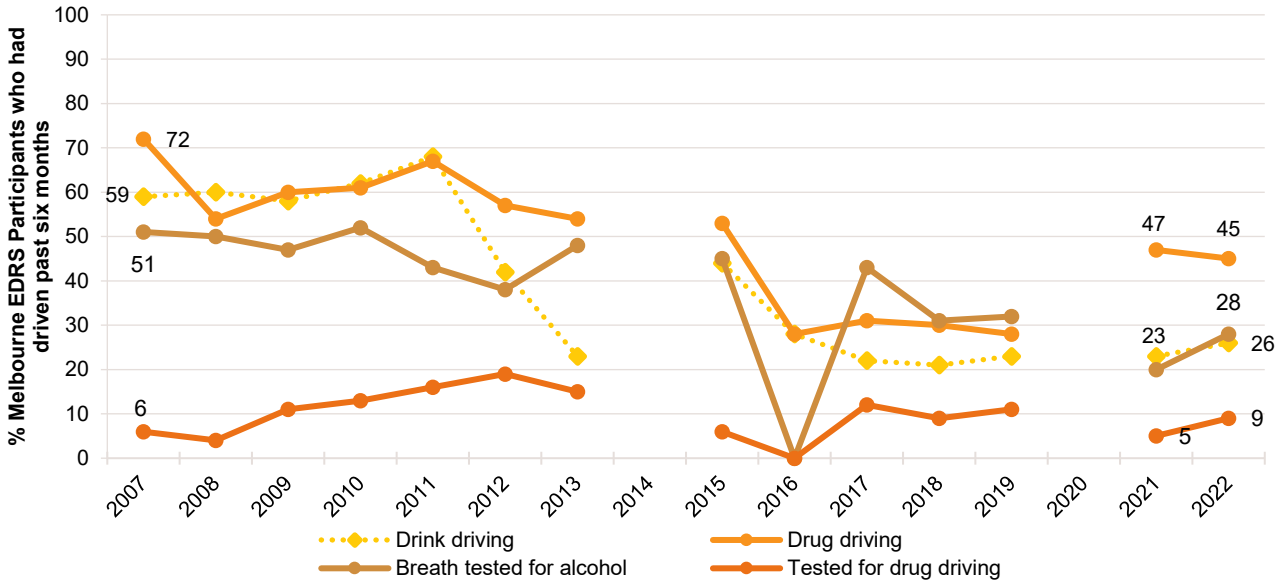
In 2022, 75% of the Melbourne sample had driven a car, motorcycle, or other motor vehicle in the past six months (Figure 62). Of those who had driven in the past six months and responded (n=70), 26% reported driving while over the (perceived) legal blood-alcohol limit (23% in 2021; p=0.843), and of those who responded (n=74), 45% reported driving within three hours of consuming an illicit or non-prescribed drug in the past six months (47% in 2021; p=0.868) (Figure 63). Among those who had driven in the past six months (n=75), 9% reported that they had been tested for drug driving by the police roadside drug testing service (5% in 2021; p=0.365), and 28% reported that they had been breath-tested for alcohol by the police roadside testing service in the past six months (19% in 2021; p=0.256) (Figure 63).

Figure 62: Self-reported driving in the past six months, Melbourne, VIC, 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, and are suppressed for 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 63: 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, Melbourne, VIC, 2007-2022



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

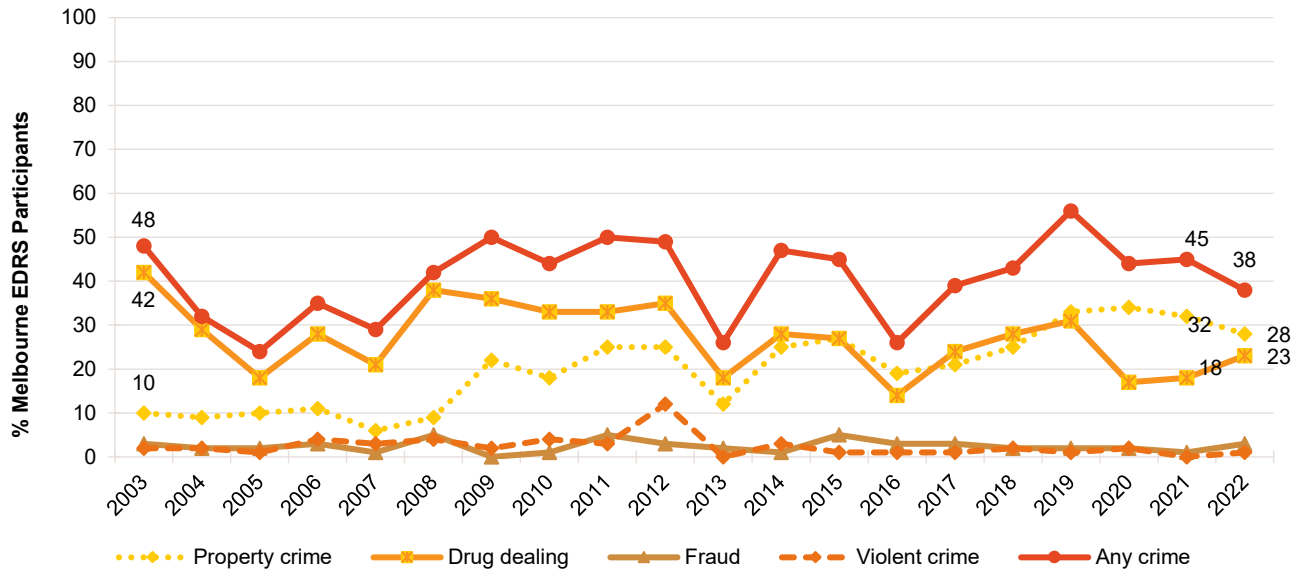
Experience of Crime and Engagement with the Criminal Justice System

In 2022, 38% of the sample reported 'any' crime in the past month (45% in 2021; *p*=0.389), with property crime (28%; 32% in 2021; *p*=0.641) and drug dealing (23%; 18% in 2021; *p*=0.487) being the two main forms of criminal activity reported in 2022 (Figure 64). In 2022, 6% of the sample reported being the victim of a crime involving violence (n≤5 in 2021).

Few participants (n≤5) reported being arrested in the 12 months preceding interview (10% in 2021; *p*=0.082), 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, 12% of the sample reported a drug-related encounter with law enforcement in the last 12 months that did not result in charge or arrest (data not collected in 2021).

Few participants (n≤5) reported having ever been in prison in 2022 (n≤5 in 2021), therefore these data are supressed. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Figure 64: Self-reported criminal activity in the past month, Melbourne, VIC, 2003-2022



Note. Data labels are only provided for the first (2003) and two most recent years (2021 and 2022) of monitoring, and are suppressed for 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.

In 2022, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was reported to be social networking applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder; 84%), similar to 2021 (88%; p=0.537). This was followed by face-to-face communication (56%; 52% in 2021; p=0.669). It is important to reiterate 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, 30% reported arranging the purchase of illicit or non-prescribed drugs via text messaging (20% in 2021; p=0.150), 14% arranged the purchase via a phone call (19% in 2021; p=0.448) and 12% arranged the purchase via the darknet market (6% in 2021; p=0.219), with the most common drug purchased being ecstasy crystal (25%), followed by benzodiazepines (19%) (Table 7).

In 2022, 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 acquisition (96%), similar to 2021 (94%; p=0.747). No significant change was observed between reports of participants receiving illicit drugs via post between 2022 and 2021 (15% and 10%, respectively; p=0.397). Few participants (n≤5) reported receiving illicit drugs via a collection point in 2022 (n≤5 in 2021; defined as a predetermined location where a drug will be left for later collection) (Table 7).

The majority of participants in 2022 reported obtaining illicit drugs from a friend/relative/partner/colleague (78%; 73% in 2021; p=0.415), followed by obtaining illicit drugs from a known dealer/vendor (78%; 75% in 2021; p=0.619), and 45% from an unknown dealer/vendor (33% in 2021; p=0.116) (Table 7).

In 2022, few (n≤5) participants reported that they had sold illicit drugs on the surface web or darknet market in the past 12 months (n≤5 in 2021; p=0.324). However, 60% reported they had ever obtained illicit drugs through someone who had purchased them on the surface web or darknet market, with 44% having done so in the past 12 months (48% in 2021; p=0.656).

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

	2019	2020	2021	2022
	n=99	n=100	n=99	**n=99**
% Purchasing approaches in the last 12 months^				
Face-to-face	82	68	52	**56**
Surface web	-	7	-	**-**
Darknet market	7	7	6	**12**
Social networking applications#	77	81	88	**84**
Text messaging	51	48	20	**30**
Phone call	34	36	19	**14**
Grew/made my own	/	-	0	**-**
Other	-	-	0	**-**
% Means of obtaining drugs in the last 12 months^~	n=99	n=100	n=99	**n=99**
Face-to-face	99	94	94	**96**
Collection point	-	18	-	**-**
Post	11	12	10	**15**
% Source of drugs in the last 12 months^	n=99	n=100	n=99	**n=100**
Friend/relative/partner/colleague	85	82	73	**78**
Known dealer/vendor	83	75	75	**78**
Unknown dealer/vendor	33	49	33	**45**

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.

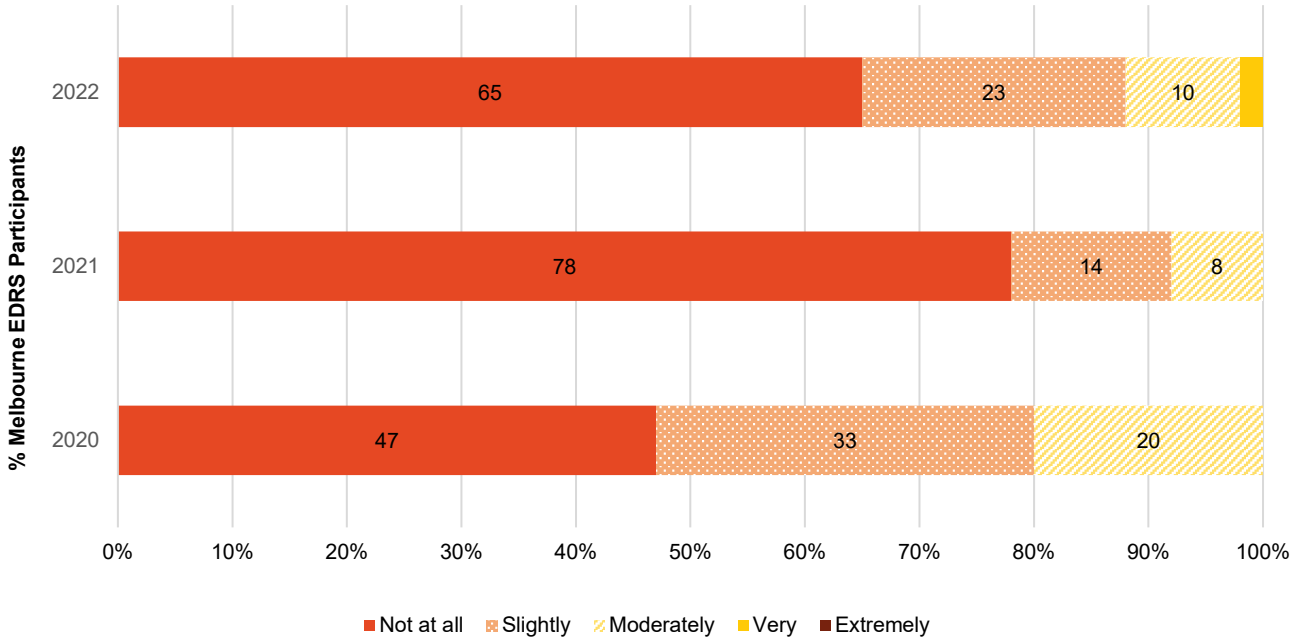
COVID-19 Testing and Diagnosis

In 2022, almost all (97%) of the sample reported having been tested for SARS-CoV-2 by the time of interview (76% in 2021; 7% in 2020), of whom 93% had received a PCR test and 91% a rapid antigen test. Almost four-fifths (79%) of participants reported having been diagnosed with the virus (no participants in 2021 and 2020).

In 2022, 86% of the sample reported quarantining for at least seven days due to a positive test or possible exposure in the past 12 months, with 16% quarantining in the month prior to interview and 76% in the six months prior to interview. At the time of interview, 98% reported that they had received at least one COVID-19 vaccine dose (median 3 doses: no participants received one dose, 28% received two doses, 70% received three or more doses).

When asked how worried they were currently about contracting COVID-19, 28% of participants reported some level of concern, with 23% responding that they were 'slightly' concerned, 10% reporting that they were 'moderately' concerned, and low numbers (n≤5) reporting that they were 'very' concerned, stable from 2021 (p=0.123). No participants reported that they were 'extremely' concerned (Figure 65). Furthermore, 43% of participants reported that they would be concerned about their health if they contracted COVID-19, with 33% reporting they would be 'slightly' concerned, 6% reporting 'moderately', and low numbers (n≤5) reporting 'very' or 'extremely' concerned.

Figure 65: Current concern related to contracting COVID-19, Melbourne, VIC, 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.