EDRS

VICTORIAN DRUG TRENDS 2023

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

VICTORIAN DRUG TRENDS 2023: KEY FINDINGS FROM THE ECSTASY AND RELATED DRUGS REPORTING SYSTEM (EDRS) INTERVIEWS

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This report was prepared by the National Drug and Alcohol Research Centre, UNSW Sydney. Please contact the following with any queries regarding this publication: e@burnet.edu.au or drugtrends@unsw.edu.au

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Research Team

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

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Abbreviations

1,4-BD	1,4-Butanediol
2C-B	4-bromo-2,5-dimethoxyphenethylamine
4-AcO-DMT	4-Acetoxy-N,N-dimethyltryptamine
4-FA	4-Fluoroamphetamine
5-MeO-DMT	5-methoxy-N,N-dimethyltryptamine
AIVL	Australian Injecting and Illicit Drug Users League
Alpha PVP	α-Pyrrolidinopentiophenone
AOD	Alcohol and Other Drug
AUDIT	Alcohol Use Disorders Identification Test
BZP	Benzylpiperazine
CBD	Cannabidiol
COVID-19	Coronavirus Disease 2019
DMT	Dimethyltryptamine
DO-x	4-Substituted-2,5-dimethoxyamphetamines
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDRS	Ecstasy and Related Drugs Reporting System
GBL	Gamma-butyrolactone
GHB	Gamma-hydroxybutyrate
GP	General Practitioner
HIV	Human immunodeficiency virus
IDRS	Illicit Drug Reporting System
IQR	Interquartile range
K10	Kessler Psychological Distress Scale 10
LSA	Lysergic Acid Amide
LSD	d-lysergic acid
MDA	3,4-methylenedioxyamphetamine
MDMA	3,4-methylenedioxymethamphetamine
MDPV	Methylenedioxypyrovalerone
MXE	Methoxetamine
N (or n)	Number of participants
NBOME	N-methoxybenzyl
NDARC	National Drug and Alcohol Research Centre
NHS	National Health Service
NPS	New psychoactive substances
NSP	Needle Syringe program
NSW	New South Wales
OTC	Over-the-counter
PCR	Polymerase Chain Reaction
PMA	Paramethoxyamphetamine

PMMA	Polymethyl methacrylate
PTSD	Post-Traumatic Stress Disorder
REDCAP	Research Electronic Data Capture
SA	South Australia
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SD	Standard deviation
SDS	Severity of Dependence Scale
SSDP	Students for Sensible Drug Policy
STI	Sexually transmitted infection
THC	Tetrahydrocannabinol
UNSW	University of New South Wales
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 word of mouth in Melbourne, VIC. The results are not representative of all people who use illicit drugs or drug use in the general population. **In 2023, data were collected from April to June. Interviews between 2020 and 2023 were delivered face-to-face as well as via telephone and video conference, 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 2020-2023 samples, relative to previous years.**

Sample Characteristics

The EDRS sample (N=100) recruited from Melbourne was similar to the sample in 2022 and in previous years. The gender distribution was similar in 2022 and 2023, with 54% identifying as male (52% in 2022), and participants had a median age of 29 years, a significant increase from 2022 (25 years; p=0.006). Significantly more participants (p=0.005) reported being in full-time employment in 2023 (51%; 29% in 2022), and fewer reported part time/casual employment (32%; 52% in 2022). Most participants held tertiary qualifications (71%; 62% in 2022). The distribution of participants' accommodation status was similar in 2023 and 2022, with 69% of the sample reporting living in a rental house/flat (69% in 2022) or residing with their parents/at their family home (19%; 26% in 2022) at the time of interview. There was a significant change in drug of choice between 2022 and 2023 (p=0.032), with more participants nominating ecstasy (32%; 18% in 2022). There was also a significant change in the drug used most often in the month preceding interview between 2022 and 2023 (p=0.004), with more participants (27%) nominating ecstasy (7% in 2022).

Ecstasy

In 2023, a significantly higher proportion of participants reported recent (in the six months prior to interview) use of any ecstasy (99%; 90% in 2022; p=0.010). Frequency of use increased for ecstasy capsules, from a median of three days in the previous six months (IQR=2–7) in 2022 to five days (IQR=3–10) in 2023 (p=0.041). The perceived availability of pills and capsules increased significantly between 2022 and 2023 (p=0.011 and p<0.001, respectively): more participants perceived availability to be 'very easy' in 2023 (28%; 9% in 2022, 40%; 10% in 2022, respectively). The median reported price of ecstasy capsules increased significantly from $25 (IQR=20–30) in 2022 to $30 (IQR=25–30) in 2023 ($p$=0.017).

Methamphetamine

Twenty-nine per cent of the Melbourne sample reported recent use of any methamphetamine, a significant decrease from 2022 (49%; p=0.008). Frequency of use remained stable at a median of two days use in the previous six months in 2023 (3 days in 2022). Recent use of methamphetamine powder significantly decreased from 45% in 2022 to 23% in 2023 (p=0.002). Thirteen per cent of the sample reported recent crystal methamphetamine use. Methamphetamine powder was largely reported to be 'very easy' to obtain (43%).

Non-Prescribed Pharmaceutical Stimulants

The percentage of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has increased since the commencement of monitoring, from

9% in 2007 to 47% in 2023, although the figure for 2023 represents a significant decrease from 64% in 2022 (p=0.022).

Cocaine

Reports of recent use of cocaine have increased over the years of monitoring, to 90% in 2023. Frequency of reported use remained similar to previous years, at five days in the previous six months. The median price of a gram of cocaine was reported as $350 in 2023, similar to previous years.

Cannabis and/or Cannabinoid Related Products

Sixty-seven per cent of the sample reported recent use of non-prescribed cannabis in 2023, a significant decrease from 2022 and the lowest recorded in the Melbourne EDRS (82% in 2022; p=0.021). Frequency of use also significantly decreased from a median of 33 days of use in the previous six months in 2022 to 24 days in 2023 (p=0.045). Weekly or more frequent use amongst those who reported recent non-prescribed cannabis use remained stable at 51%.

Non-prescribed Ketamine, LSD and DMT

Recent use of ketamine remained stable at 82% in 2023, although frequency of use in the previous six months significantly decreased from a median of 10 days in 2022 to six days in 2023 (p=0.003). There was a significant difference in the perceived availability of ketamine from 2022 to 2023 (p<0.001), with more participants reporting it to be 'very easy' to obtain (42%; 15% in 2022). Recent use of LSD remained stable, with 55% reporting recent use. There was a significant fall in the proportion of participants reporting LSD purity to be 'high' in 2023 (39%; 59% in 2022, p=0.049). The median frequency of use of LSD remained low in 2022 at two days. Few participants (n≤5) reported recent use of DMT in 2023, a significant decrease from 18% in 2022 (p=0.007).

New Psychoactive Substances (NPS)

Twelve per cent reported recent use of any NPS (including plant-based NPS) in 2022. Dissociatives were the most frequently reported NPS used in 2023 (7%).

Other Drugs

Reports of recent use of non-prescribed benzodiazepines significantly decreased from 47% in 2022 to 31% in 2023 (p=0.033). There was also a significant decrease in reported recent use of hallucinogenic mushrooms (49%; 64% in 2022; p=0.049). Recent use of tobacco also decreased significantly in 2023, to 56% (71% in 2022; p=0.044).

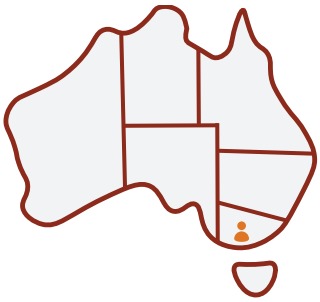
Drug-Related Harms and Other Behaviours

Most participants (86%) reported concurrent use of two or more drugs on the last occasion of ecstasy or other drug use, most commonly stimulants and depressants. Two-thirds (66%) of participants reported ever having tested the contents of their illicit drugs in Australia, with 51% reporting doing so in the past year, most commonly using colorimetric or reagent test kits (90%). Hazardous alcohol use remained common, with 74% of the sample scoring above the hazardous range in the Alcohol Use Disorders Identification Test (AUDIT). Fourteen per cent reported a non-fatal stimulant overdose, and 17% a non-fatal depressant overdose (including alcohol), in the past year. Few participants reported past month injecting drug use in 2023, and small numbers (n≤5) reported receiving drug treatment. Four-fifths (80%) reported engaging in some form of sexual activity in the past four weeks, of whom 82% reported use of alcohol/drugs before or during sexual activity, and 14% reported penetrative sex without a condom where they

did not know the HIV status of their partner. Half (52%) of the sample self-reported experiencing a mental health problem in the preceding six months. Of those participants, the most common problems identified were anxiety (71%) and depression (67%). Of those who had driven a motor vehicle in the past six months and commented (n=79), 16% reported driving while over (what they perceived to be) the legal blood alcohol concentration, while 30% reported driving within three hours of consuming an illicit or non-prescribed substance (most commonly cannabis). Twenty-nine per cent of participants reported 'any' crime in the past month in 2023, with property crime being the main form of self-reported criminal activity (23%), followed by drug dealing (15%). The most popular means of arranging the purchase of illicit drugs remained social networking applications (82%), followed by face-to-face (63%). Almost all (97%) participants reported obtaining illicit drugs face-to-face. Almost all (97%) of the sample reported having been tested for SARS-CoV-2 in the 12 months preceding interview in 2023, with 86% reporting having been diagnosed with COVID-19. All (100%) participants reported that they had received at least one dose of the COVID-19 vaccine (median of three doses).

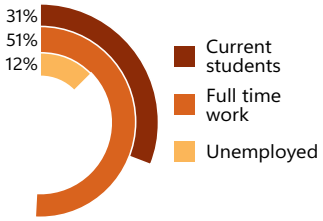
EDRS Ecstasy and Related Drugs Reporting System

2023 SAMPLE CHARACTERISTICS



In 2023, 100 participants, recruited from Melbourne, VIC were interviewed.

The median age in 2023 was 29, and 54% identified as male.

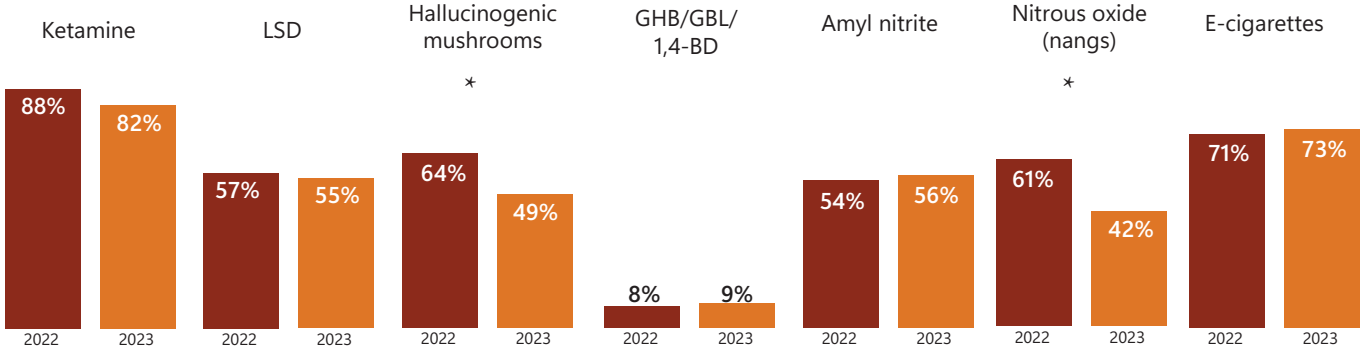


In the 2023 sample, 31% were current students, 51% were employed full time and 12% were unemployed.

- Ecstasy
- Cocaine
- Other stimulants

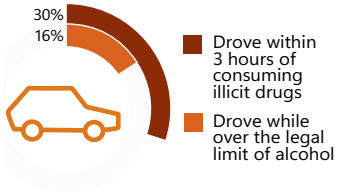
Participants were recruited on the basis that they had consumed ecstasy and/or other illicit stimulants at least monthly in the past 6 months.

PAST 6 MONTH USE OF OTHER DRUGS



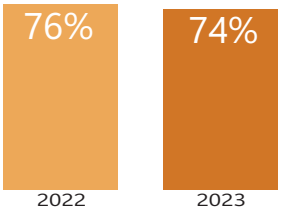
*$p<0.050$; **$p<0.010$; ***$p<0.001$

DRUG-RELATED HARMS AND RISKS

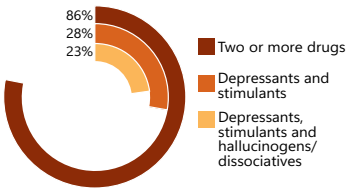


Among recent drivers, 30% reported driving a vehicle within 3 hours of consuming illicit drugs and 16% while over the legal limit of alcohol.

In the 2023 sample, 18% reported a non-fatal depressant overdose in the previous 12 months, and 14% reported a non-fatal stimulant overdose.

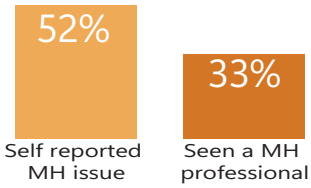


74% of the sample obtained an AUDIT score of eight or more, indicative of past year hazardous alcohol use (76% in 2022).

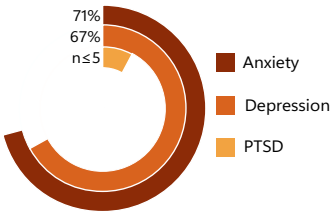


On the last occasion of ecstasy or related drug use, 86% used two or more drugs, 28% used both stimulants and depressants, and 23% used stimulants, depressants and hallucinogens/dissociatives.

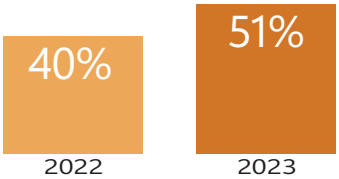
OTHER BEHAVIOURS



In the total sample, 52% self reported a mental health issue and 33% had seen a mental health professional in the past 6 months.



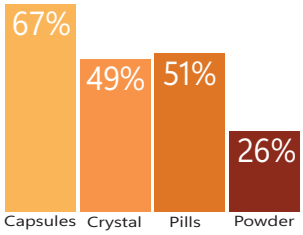
Of those who commented, the most common mental health issues reported were anxiety (71%) and depression (67%).



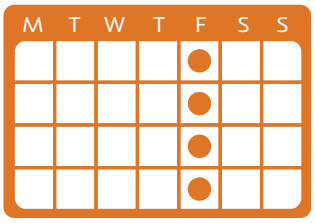
51% of the sample reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year.

14% of the sample reported experiencing stigma because of their illicit drug use in the six months preceding interview, most commonly from a GP.

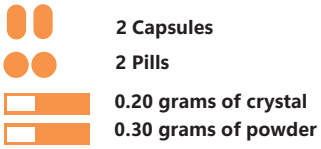
ECSTASY



Past 6 month use of ecstasy capsules, crystal, pills, and powder in 2023.



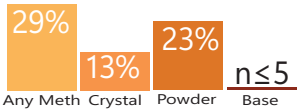
Of those who had recently consumed ecstasy, 9% used it weekly or more frequently.



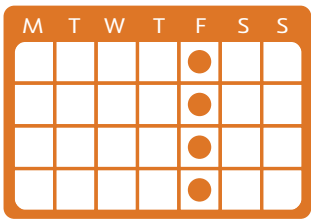
Median amounts of ecstasy consumed in a 'typical' session using each form.

In 2023, more participants perceived the availability of all forms of ecstasy as 'easy' or 'very easy' relative to 2022.

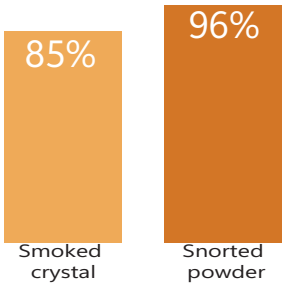
METHAMPHETAMINE



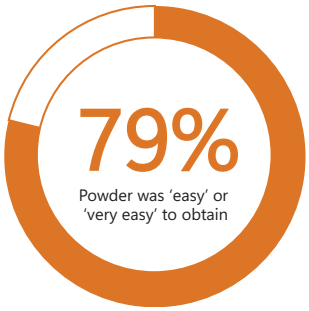
Past 6 month use of any methamphetamine, crystal, powder and base in 2023.



Of those who had recently consumed methamphetamine, few (n≤5) used it weekly or more frequently.

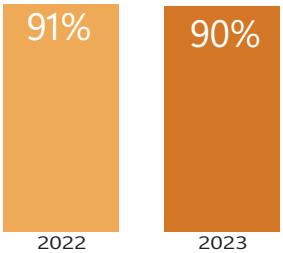


85% of participants who had recently used crystal smoked it. Of those who had recently used powder, 96% snorted it.

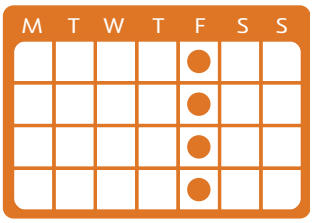


Of those who could comment 79% perceived powder methamphetamine to be 'easy' or 'very easy' to obtain.

COCAINE

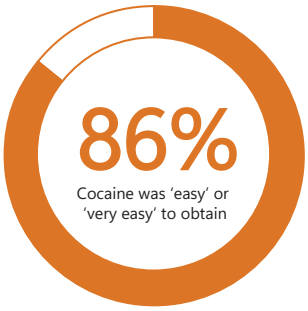


Past 6 month use of any cocaine remained stable between 2022 and 2023.



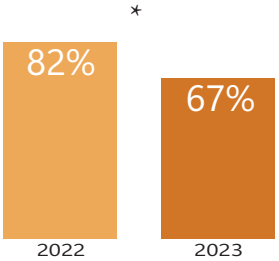
Of participants who had consumed cocaine recently, few (n≤5) reported weekly or more frequent use.

In 2023, the median price of a gram of cocaine was $350.

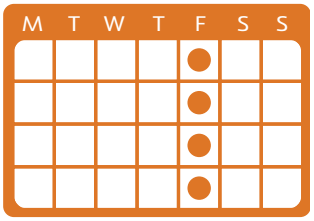


Of those who could comment 86% perceived cocaine to be 'easy' or 'very easy' to obtain.

CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS

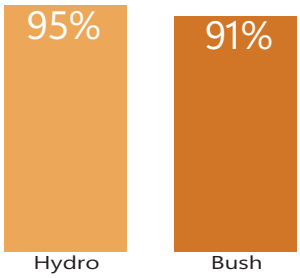


Past 6 month use of non-prescribed cannabis and/or cannabinoid-related products significantly decreased between 2022 and 2023.



Of those who had consumed non-prescribed cannabis recently, 51% reported weekly or more frequent use.

Of participants who had consumed cannabis in the last 6 months, 88% had smoked it (40% swallowed and 25% vaped it).



Of those who could comment, the majority perceived both hydro and bush to be 'easy' or 'very easy' to obtain.

Background

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

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

Methods

EDRS 2003-2019

Full details of the methods for the annual interviews are available for download. To briefly summarise, since the commencement of monitoring up until 2019, participants were recruited primarily via internet postings, print advertisements, interviewer contacts, and snowballing (i.e., peer referral). Participants had to: i) be at least 17 years of age (due to ethical constraints) (16 years of age in Perth, Western Australia (WA)), ii) have used ecstasy or other illicit stimulants (including: MDA, methamphetamine, cocaine, non-prescribed pharmaceutical stimulants, mephedrone or other stimulant NPS) at least six times during the preceding six months; and iii) have been a resident of the capital city in which the interview took place for ten of the past 12 months. Interviews took place in varied locations negotiated with participants (e.g., research institutions, coffee shops or parks), and in later years 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 2020-2023: COVID-19 Impacts on Recruitment and Data Collection

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

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

These changes were carried through between 2021 and 2023. A hybrid approach was used, with interviews conducted either face-to-face (whereby participants were reimbursed with cash) or via telephone/videoconference (with participants reimbursed via bank transfer or other electronic means). Face-to-face interviews were the preferred methodology, however telephone and video conference interviews were conducted when required (i.e., in accordance with government directives) or when requested by participants. Consent was collected verbally for all participants.

2023 EDRS Sample

A total of 708 participants were recruited across capital cities nationally (April–July, 2023), with 100 participants interviewed in Melbourne, VIC between 14th April and 16th June 2023 (n=100 in 2022). Forty-eight interviews (48%) were conducted via video conference (n=12 in 2022; 12%).

Four per cent of the 2023 Melbourne sample completed the interview in 2022, whereas 9% of the 2022 Melbourne sample completed the interview in 2021 (p=0.162). There was a significant change in recruitment methods since 2022 (p=0.007), with more participants being recruited via the internet (e.g., Facebook and Instagram) (88%; 72% in 2022), and fewer via word-of-mouth (11%; 28% in 2022).

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 2021/22 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 2022 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 were collected via the Alcohol and Drug Information System (ADIS), now called the Victorian Alcohol and Drug Collection (hereafter ADIS/VADC). During the 2021/22 financial year, 65,799 courses of treatment were delivered to 29,971 clients, compared to 58,219 courses of treatment delivered to 26,112 clients in the 2020/21 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 2022.

Data Analysis

For normally distributed continuous variables, means and standard deviations (SD) are reported; for skewed data (i.e., skewness > ±1 or kurtosis > ±3), medians and interquartile ranges (IQR) are reported. Tests of statistical significance have been conducted between estimates for 2022 and 2023, noting that no corrections for multiple comparisons have been made and thus comparisons should be treated with caution. References to significant differences throughout the report are where statistical testing has been conducted and where the *p*-value is less than 0.050. Values where cell sizes are ≤5 have been suppressed with corresponding notation (zero values are reported). References to 'recent' use and behaviours refers to the six months preceding interview.

Interpretation of Findings

Caveats to interpretation of findings are discussed more completely in the methods for the annual interviews but it should be noted that these data are from participants recruited in Melbourne, Victoria, and thus do not reflect trends in regional and remote areas. Further, the results are not representative of all people who consume illicit drugs, nor of illicit drug use in the general population, but rather are intended to provide evidence indicative of emerging issues that warrant further monitoring.

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

Differences in the methodology, and the events of 2020-2023, must be taken into consideration when comparing 2020-2023 data to previous years, and treated with caution.

Additional Outputs

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

Please contact the research team at drugtrends@unsw.edu.au 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 2023, the characteristics of the Melbourne EDRS sample were mostly similar to those of samples in 2022 and previous years (Table 1).

The gender distribution of the sample in 2023 (54% male) was comparable to 2022 (52%, p=0.910). The median age of the sample was 29 years (IQR= 23–33), a significant increase from 2022 (25 years; IQR= 22–28; p=0.006).

The distribution of participants' reported accommodation types was in 2023 was similar to that found in 2022 (p=0.130), with 69% of the sample reporting that they resided in a rented house/flat (69% in 2022), and most of the remaining participants living with their parents/in their family house (19%; 26% in 2022).

Around one-third (31%) of the sample were current students, a significant decrease from 50% in 2022 (p=0.010), and 71% had obtained a post-school qualification(s) (62% in 2022; p=0.236).

There was a significant change in participants' reported employment status between 2022 and 2023 (p=0.005). Specifically, half (51%) reported being employed full-time in 2023, a significant increase from 29% in 2022, one-third (32%) reported being employed on a part time/casual basis (52% in 2022), and 12% reported being unemployed at the time of interview (9% in 2022).

Median weekly income increased significantly, from $700 in 2022 (IQR=490–1154) to $1200 in 2023 (700–1737) (p<0.001).

Table 1: Demographic characteristics of the sample, nationally, 2023, and Melbourne, VIC, 2017-2023

	Melbourne, VIC							National
	2017	2018	2019	2020	2021	2022	2023	2023
	(N=100)	(N-=100)	(N=99)	(N=100)	(N=100)	(N=100)	(N=100)	(N=708)
Median age (years; IQR)	21 (19–23)	23 (20–25)	21 (17–26)	26 (22–30)	25 (23–28)	25 (22–28)	**29 (23–33)****	25 (21–32)
% Gender								
Female	43	41	48	38	26	43	**42**	40
Male	57	57	51	60	67	52	**54**	58
Non-binary	0	0	-	-	7	-	**-**	3
% Aboriginal and/or Torres Strait Islander	0	-	0	-	-	-	**-**	4
% Sexual identity					*			
Heterosexual	79	74	82	70	64	64	**61**	71
Homosexual	-	6	6	8	-	-	**13**	8

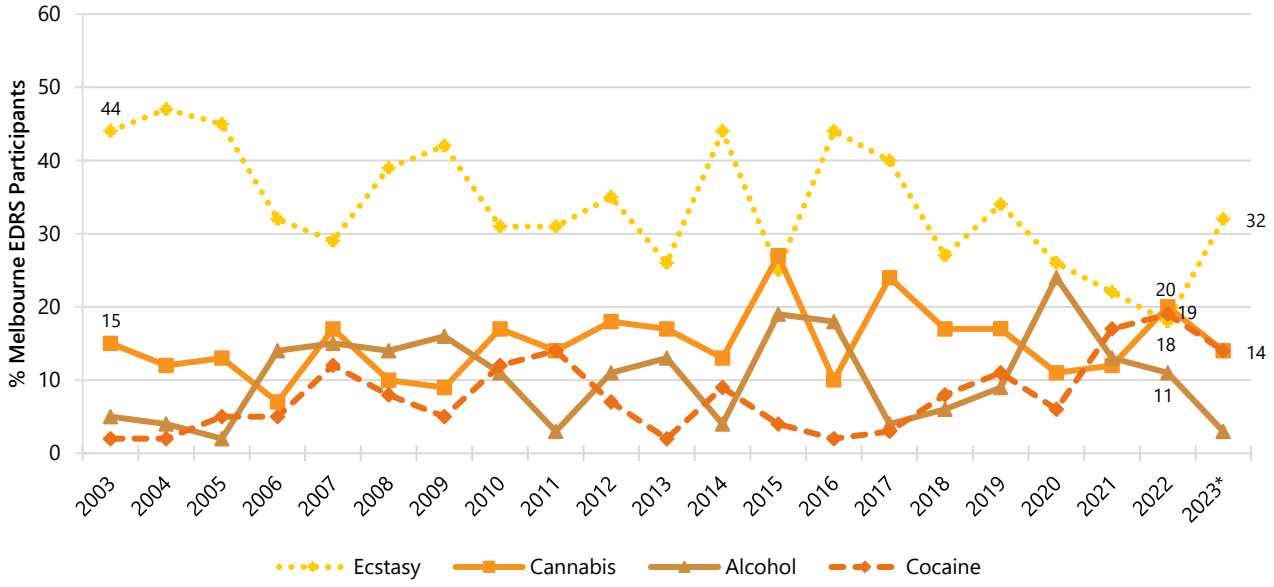
	Melbourne, VIC							National
	2017	2018	2019	2020	2021	2022	2023	2023
Bisexual	17	17	10	12	11	18	**15**	16
Queer	17	17	10	10	17	11	**9**	4
Different identity	0	-	-	0	6	-	**-**	1
Mean years of school education (range)	12 (9–12)	12 (9–12)	12 (8–12)	12 (8–12)	12 (8–12)	12 (9–12)	**12 (9–12)**	12 (5–12)
% Post-school qualification(s)^	42	32	57	64	69	62	**71**	62
% Current students#	-	8	51	40	42	50	**31***	36
% Current employment status							**	
Employed full-time	18	21	22	24	18	29	**51**	38
Part time/casual	/	/	/	37	51	52	**32**	39
Self-employed	/	/	/	-	8	10	**-**	4
Unemployed	17	14	25	34	23	9	**12**	19
Current median weekly income $ (IQR)	$300 (175–500)	$400 (250–760)	$450 (230–900)	$750 (441–963)	$540 (350–906)	$700 (490–1154)	**$1200 (700–1737)*** **	$808 (450–1385)
% Current accommodation								
Own house/flat	0	-	7	-	-	-	**11**	9
Rented house/flat	36	50	50	63	75	69	**69**	58
Parents'/family home	62	48	41	26	19	26	**19**	26
Boarding house/hostel	0	-	0	-	-	0	**-**	2
Public housing	/	-	-	-	0	-	**0**	3
No fixed address+	-	0	0	-	-	0	**0**	1
Other	-	0	-	0	0	0	**0**	1

Note. ^ Includes trade/technical and university qualifications. #'Current students' comprised participants who were currently studying for either trade/technical or university/college qualifications. / not asked. + No fixed address included 'couch surfing and rough sleeping or squatting. - Per cent suppressed due to small cell size (n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 (Melbourne) presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

The distribution of reported drug of choice changed significantly between 2022 and 2023 ($p=0.032$), with one-third (32%) nominating ecstasy as the drug of choice in 2023 (18% in 2022), followed by 14% nominating cocaine (19% in 2022) and 14% nominating cannabis (20% in 2022) (Figure 1). The distribution of reported drug used most often in the past month also changed significantly between 2022 and 2023 ($p=0.004$), with 27% reporting ecstasy as the drug they used most often (7% in 2022), followed by cannabis (22%; 22% in 2022) (Figure 2).

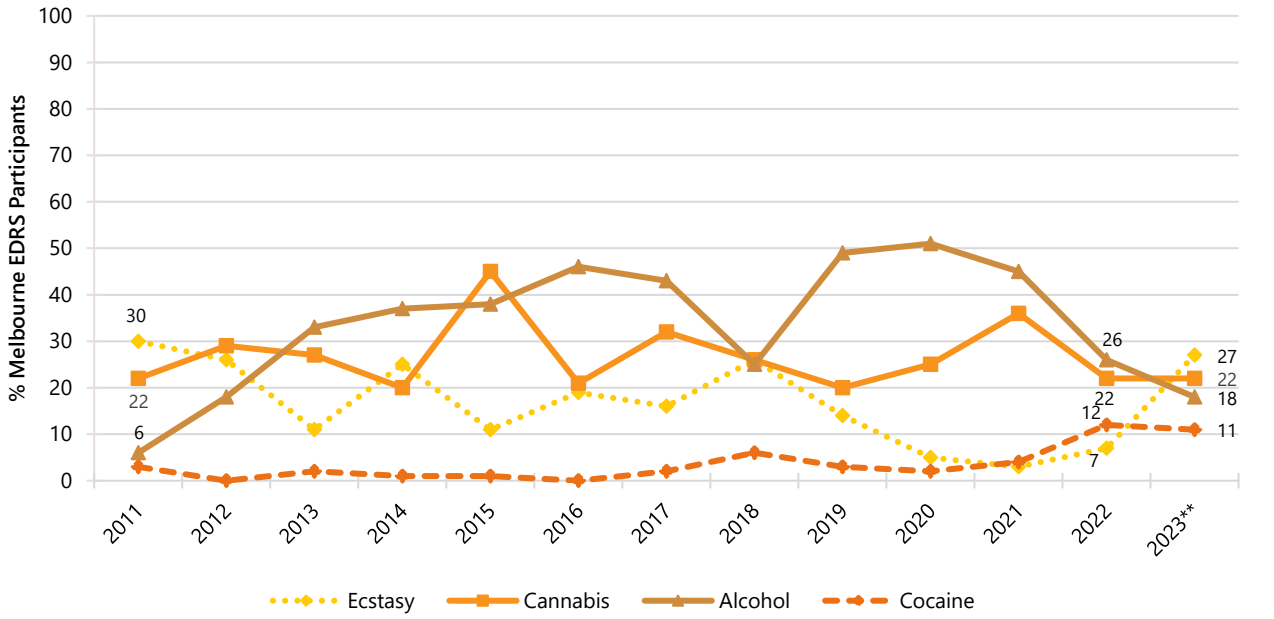
One-third (34%) of the Melbourne sample reported weekly or more frequent cannabis use, a significant decrease from 49% in 2022 ($p=0.047$), and 9% reported weekly or more frequent ecstasy use (11% in 2022; $p=0.645$).

Figure 1: Drug of choice, Melbourne, VIC, 2003-2023



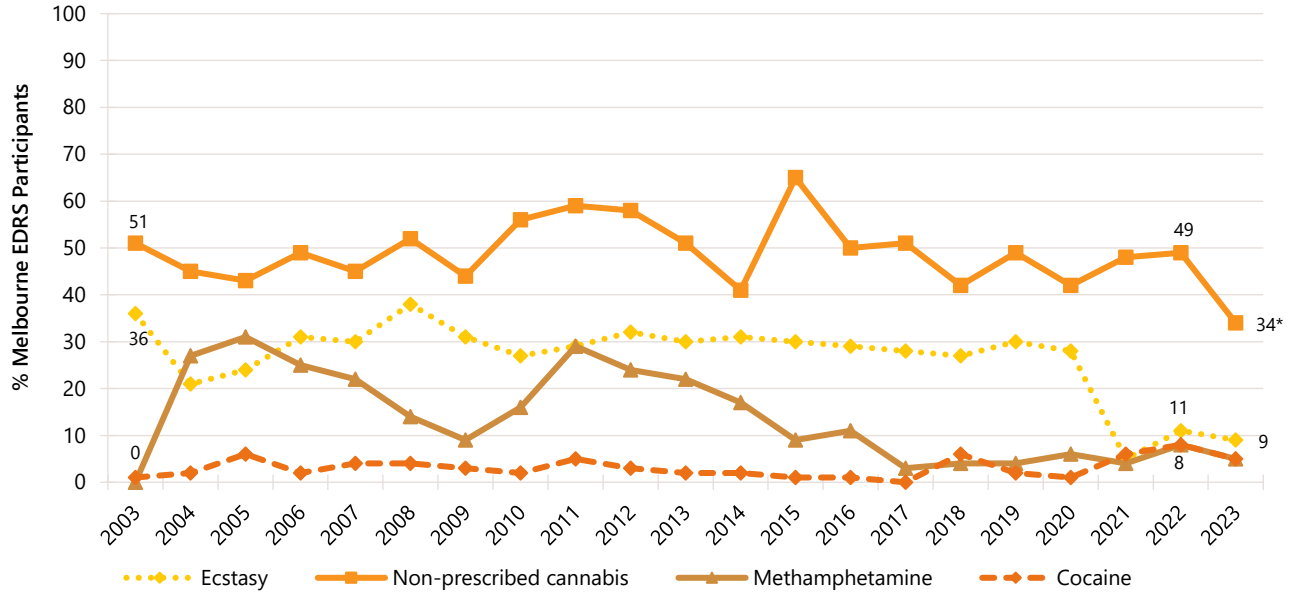
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 2: Drug used most often in the past month, Melbourne, VIC, 2011-2023



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 2011-2023 as this question was not asked in 2003-2010. Data labels are only provided for the first (2011) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 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, 2003-2023



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 (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001. 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, from 2022, we captured use of 'cannabis and/or cannabinoid-related products', while in previous years questions referred only to 'cannabis.'

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.

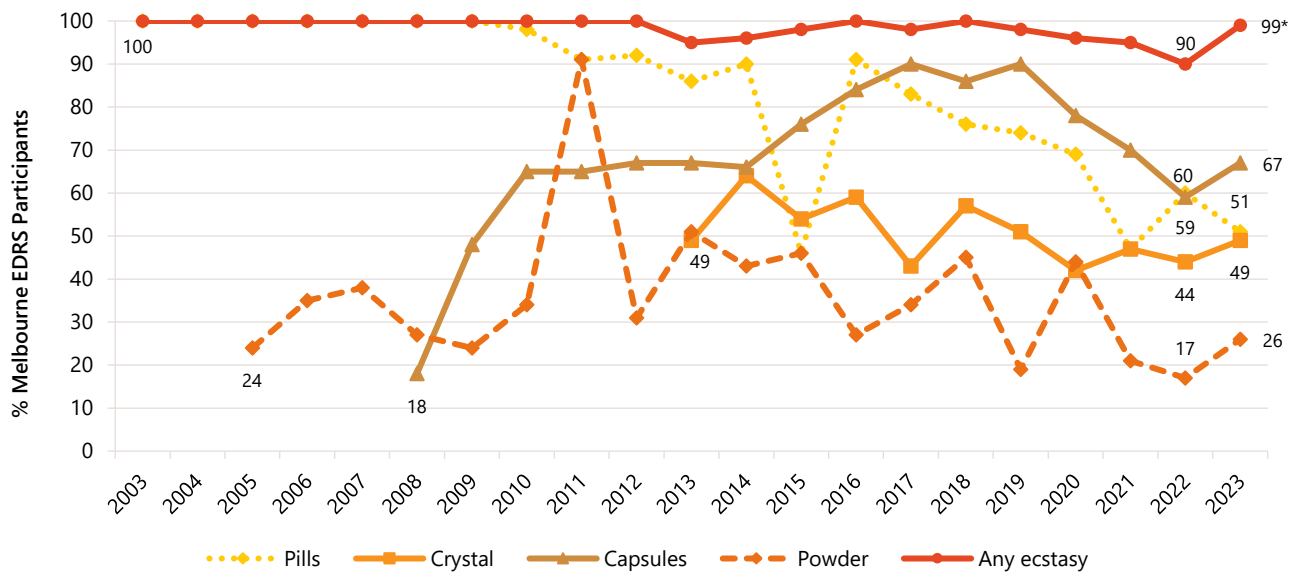
Recent Use (past 6 months)

Most participants (99%) reported use of any form of ecstasy in the past six months, a significant increase from 90% in 2022 (p=0.010) (Figure 4). There has been a shift over time to use of ecstasy capsules, which peaked in 2017 and 2019, 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

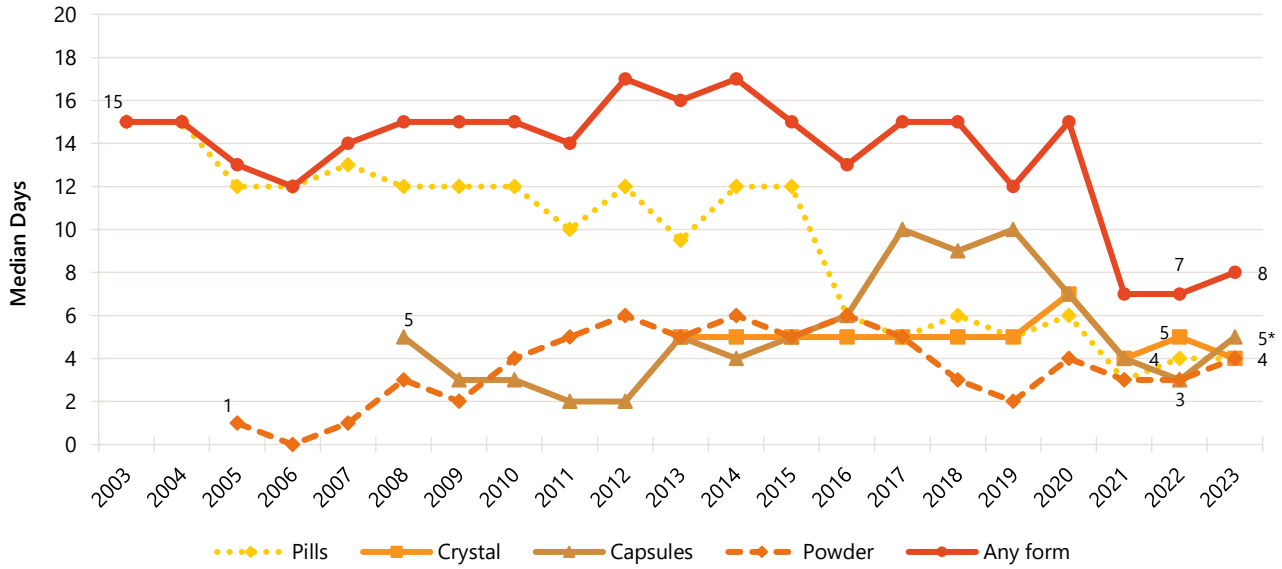
In 2023, among those who reported recent use of any ecstasy and commented (n=99), participants reported using ecstasy (in any form) on a median of eight days (IQR=6–13; 7 days in 2022; IQR=4–12; p=0.301). Weekly or more frequent use of any form of ecstasy remained stable (9%; 12% in 2022; p=0.482) (Figure 5).

Figure 4: Past six month use of any ecstasy, and ecstasy pills, powder, capsules, and crystal, Melbourne, VIC, 2003-2023



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 (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2022 versus 2023 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, 2003-2023



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Data collection for powder started in 2005, capsules in 2008 and crystal in 2013. Median days computed among those who reported past 6-month use (maximum 180 days). Median days rounded to the nearest whole number. The response option 'Don't know' was excluded from analysis. Y axis reduced to 20 days to improve visibility of trends. Data labels are only provided for the first (2003/2005/2008/2013) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2022 versus 2023 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 in 2023 (51%) was similar to that in 2022 (60%; *p*=0.261) (Figure 4).

Frequency of Use: Among those who reported recent use and commented (n=51), ecstasy pills were reportedly used on a median of four days (IQR=2–6) in the six months preceding interview in 2023, stable from 2022 (4 days; IQR=2–6; *p*=0.895) (Figure 5). Few participants (n≤5) who reported recent consumption of ecstasy pills reported weekly or more frequent use in 2023, therefore these data are suppressed (n≤5 in 2022).

Routes of Administration: The most commonly reported route of administration was swallowing (98%; 98% in 2022), followed by snorting (16%; 27% in 2022; *p*=0.181).

Quantity: Of those who reported recent use and responded (n=49), the median number of pills reportedly used in a 'typical' session was two (IQR=1–2.5; 2 pills in 2022; IQR=1–2; *p*=0.143). The median maximum number of pills reportedly used in a session was three (IQR=1–4; 2 pills in 2022; IQR=1–3; *p*=0.071).

Ecstasy Capsules

Recent Use (past 6 months): Recent use of ecstasy capsules was reported by 67% of participants in 2023, comparable to 2022 (59%; *p*=0.311) (Figure 4).

Frequency of Use: In 2023, among those who reported recent use and commented (n=67), participants reported consuming capsules on a median of five days in the past six months (IQR=3–10), a significant increase from 2022 (3 days; IQR=2–7; *p*=0.041) (Figure 5). Few participants (n≤5) who reported recent ecstasy capsule consumption reported weekly or more frequent use in 2023, therefore these data are suppressed (n≤5 in 2022, *p*=0.017).

Routes of Administration: In 2023, among participants who reported recent ecstasy capsule consumption and commented (n=67), 99% reported swallowing, comparable to 2022 (93%; *p*=0.185), and 15% reported snorting (19% in 2022; *p*=0.633).

Quantity: Of those who reported recent use and responded (n=67), the median number of capsules reportedly used in a 'typical' session was two (IQR=1–3), stable from 2022 (2 capsules; IQR=1–3; *p*=0.636). The median maximum number of capsules reportedly used per session was three (IQR=2–5; 3 capsules in 2022; IQR=2–4; *p*=0.346).

Ecstasy Crystal

Recent Use (past 6 months): Recent use of ecstasy crystal in 2023 was comparable to 2022 (49%; 44% in 2022; *p*=0.568) (Figure 4).

Frequency of Use: In 2023, among those who reported recent ecstasy crystal use and commented (n=49), participants reported using crystal on a median of four days in the previous six months (IQR=2–8), comparable to five days in 2022 (IQR=3–10; *p*=0.178) (Figure 5). A small number (n≤5) who reported recent ecstasy crystal consumption reported weekly or more frequent use in 2023; therefore, these data are suppressed (n≤5 in 2022, *p*=0.341).

Routes of Administration: Among participants who had reported recent ecstasy crystal consumption and commented (n=49), 88% reported swallowing (80% in 2022; *p*=0.395), while 41% reported snorting (57% in 2022; *p*=0.155).

Quantity: Of those who reported recent ecstasy crystal use and responded (n=39), the median amount of ecstasy crystal reportedly used in a 'typical' session was 0.20 grams (IQR=0.20–0.30; 0.30 grams in 2022; IQR=0.20–0.40; *p*=0.322). Of those who reported recent

use and responded (n=39), the median maximum amount of ecstasy crystal reportedly used in a session was 0.30 grams (IQR=0.20–0.60; 0.50 grams in 2022; IQR=0.30–0.50; *p*=0.432).

Ecstasy Powder

Recent Use (past 6 months): Reports of recent use of ecstasy powder in 2023 (26%) were comparable to 2022 (17%; *p*=0.176) (Figure 4).

Frequency of Use: In 2023, among those who reported recent ecstasy powder use and commented (n=26), ecstasy powder was reportedly consumed on a median of four days (IQR=2–7) in the past six months (3 days in 2022; IQR=2–6; *p*=0.832) (Figure 5).

Routes of Administration: Among participants who reported recently consuming ecstasy powder and commented (n=26), 69% reported snorting (71% in 2022), with 62% reporting swallowing (41% in 2022; *p*=0.226).

Quantity: Of those who reported recent ecstasy powder use and commented (n=18), the median amount of ecstasy powder used in a 'typical' session was 0.30 grams (IQR=0.20–0.40; 0.30 grams in 2022; IQR=0.20–0.50; *p*=0.531). Of those who reported recent ecstasy powder use and commented (n=18), the median maximum amount of powder used in a session was 0.50 grams (IQR=0.30–0.60; 0.50 grams in 2022; IQR=0.30–1.00; *p*=0.961).

Price, Perceived Purity and Perceived Availability

Ecstasy Pills

Price: The median price of a pill remained stable, recorded as $38 in 2023 (IQR=30–40; n=32) and $35 in 2022 (IQR=30–40; n=41; *p*=0.439) (Figure 6).

Perceived Purity: The perceived purity of ecstasy pills remained stable between 2022 and 2023 (*p*=0.357). Among those who responded in 2023 (n=46), one-third (33%) reported purity as being 'medium' (29% in 2022), with a further 26% reporting purity to be 'high' (18% in 2022). Around one-fifth (22%) reported purity to 'fluctuate' (38% in 2022), with the remaining 20% reporting it to be 'low' (16% in 2022) (Figure 8).

Perceived Availability: The perceived availability of ecstasy pills changed significantly between 2022 and 2023 (*p*=0.011). Among those who were able to comment in 2023 (n=47), more participants reported that pills were 'very easy' to obtain (28%; n≤5 in 2022), in 2022), with a corresponding decrease in those reporting pills to be 'difficult' to obtain (23%; 49% in 2022) (Figure 12).

Ecstasy Capsules

Price: The median reported price of an ecstasy capsule was $30 in 2023 (IQR=25–30; n=43), a significant increase from $25 in 2022 (IQR=20–30; n=40; *p*=0.017) (Figure 6).

Perceived Purity: The perceived purity of ecstasy capsules in 2023 was comparable to 2022 (*p*=0.051). Among those who were able to comment in 2023 (n=63), 37% perceived purity to be 'medium' (36% in 2022) and 32% perceived purity to be 'high' (18% in 2022), while 24% reported purity 'fluctuates' (21% in 2022) (Figure 9).

Perceived Availability: There was a significant difference in perceived availability of ecstasy capsules between 2022 and 2023 (*p*<0.001). Among those who responded in 2023 (n=62), more participants reported that capsules were 'easy' to obtain (44%; 34% in 2022). A corresponding decrease was observed in those

reporting capsules being 'difficult' to obtain (16%; 48% in 2022) (Figure 13).

Ecstasy Crystal

Price: The median reported price of a gram of ecstasy crystal in 2023 was $250 (IQR=200–250; n=28; $200 in 2022; IQR=179–250; n=38; *p*=0.415) (Figure 7). Few participants (n≤5) reported purchasing a point of ecstasy crystal in 2023, therefore, these data are supressed (n≤5 in 2022).

Perceived Purity: There was a significant difference in the perceived purity of ecstasy crystal between 2022 and 2023 (*p*=0.015). Among those who responded in 2023 (n=38), more participants perceived the purity of crystal to be 'high' (47%; 28% in 2022), with a corresponding decrease in the number perceiving purity to be 'medium' (21%; 33% in 2022) or 'low' (n≤5; 26% in 2022) (Figure 10).

Perceived Availability: The perceived availability of ecstasy crystal changed significantly between 2022 and 2023 (*p*<0.001). Among those who were able to comment in 2023 (n=39), more participants reported crystal as being 'easy' (44%; 33% in 2022), and 'very easy' to obtain (38%; 10% in 2022), with a corresponding decrease in in the number perceiving availability to be 'difficult' (18%; 42% in 2022) (Figure 14).

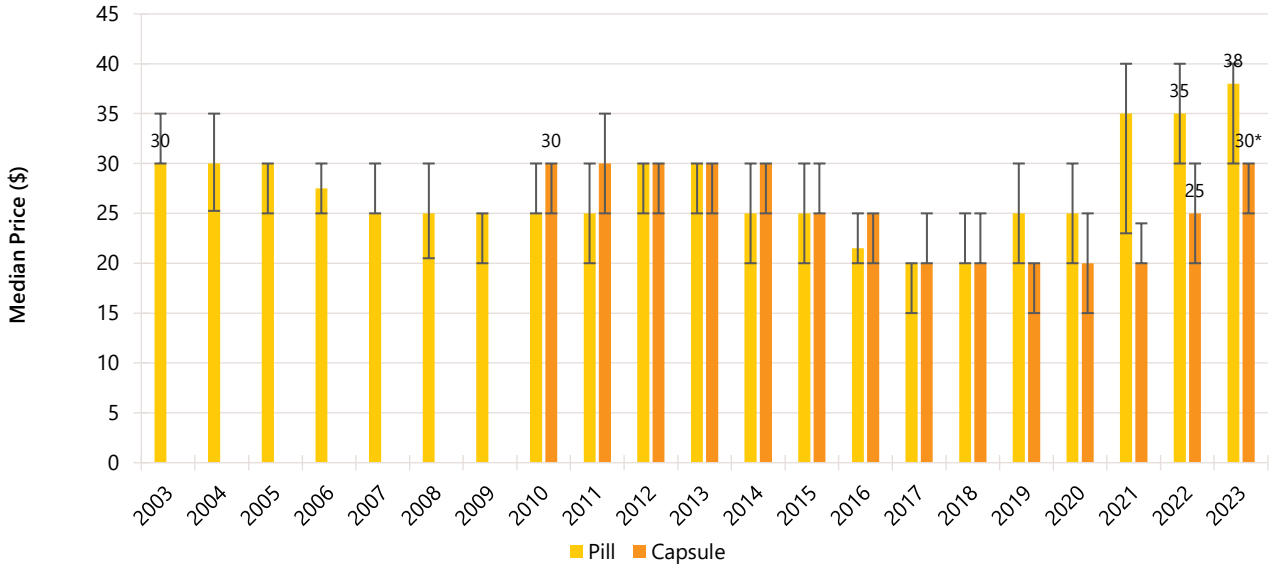
Ecstasy Powder

Price: The median price of a gram of ecstasy powder was $240 in 2023 (IQR=200–255; n=7), similar to the $250 recorded in 2022 (IQR=200–250; n=13; *p*=0.839) (Figure 7).

Perceived Purity: The perceived purity of ecstasy powder remained stable between 2022 and 2023 (*p*=0.230). Due to low numbers for each of the responses, further details have been supressed (Figure 11).

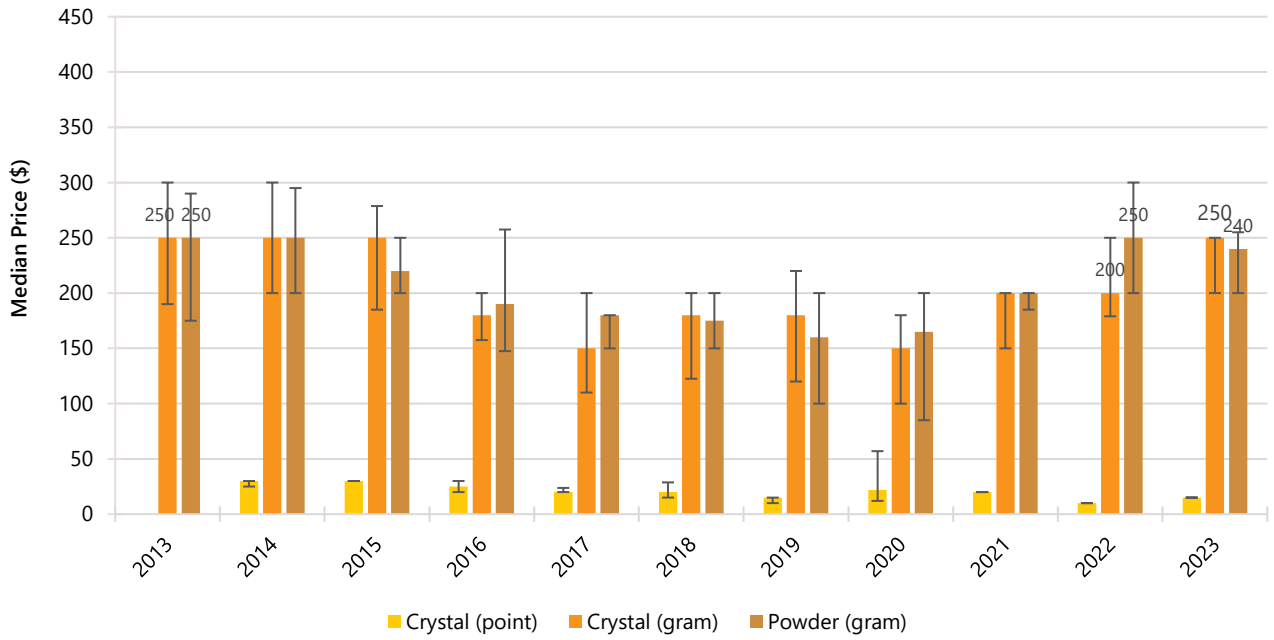
Perceived Availability: The perceived availability of ecstasy powder changed significantly between 2022 and 2023, with no participants reporting it to be 'difficult' or 'very difficult' to obtain in 2023 (38% and 38% in 2022, respectively; *p*=0.005). Due to low numbers for each of the responses, further details have been supressed (Figure 15).

Figure 6: Median price of ecstasy pill and capsule, Melbourne, VIC, 2003-2023



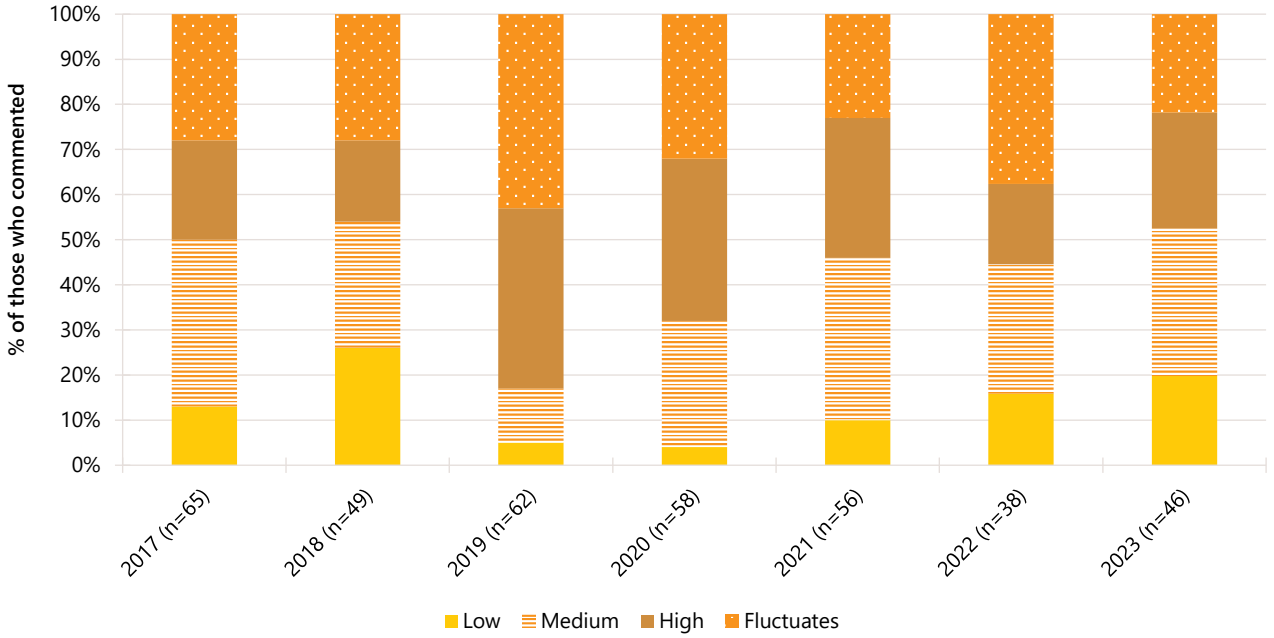
Note. Among those who commented. Data collection for price of ecstasy capsules started in 2008. Data labels are only provided for the first (2003/2008) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. The error bars represent the IQR. Statistical significance for 2022 versus 2023 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, 2013-2023



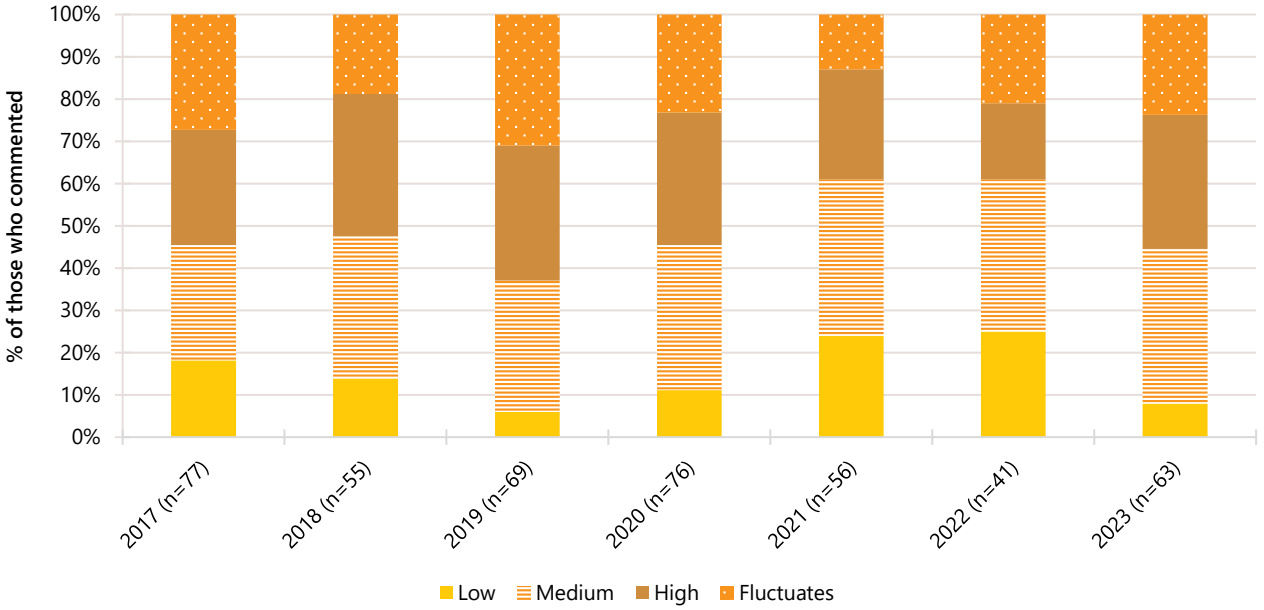
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) and ecstasy powder (gram) started in 2013. No participants reported price data for a 'point' of ecstasy crystal in 2013 or 2021. Data labels are only provided for the first (2013) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. The error bars represent the IQR. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Figure 8: Current perceived purity of ecstasy pills, Melbourne, VIC, 2017-2023



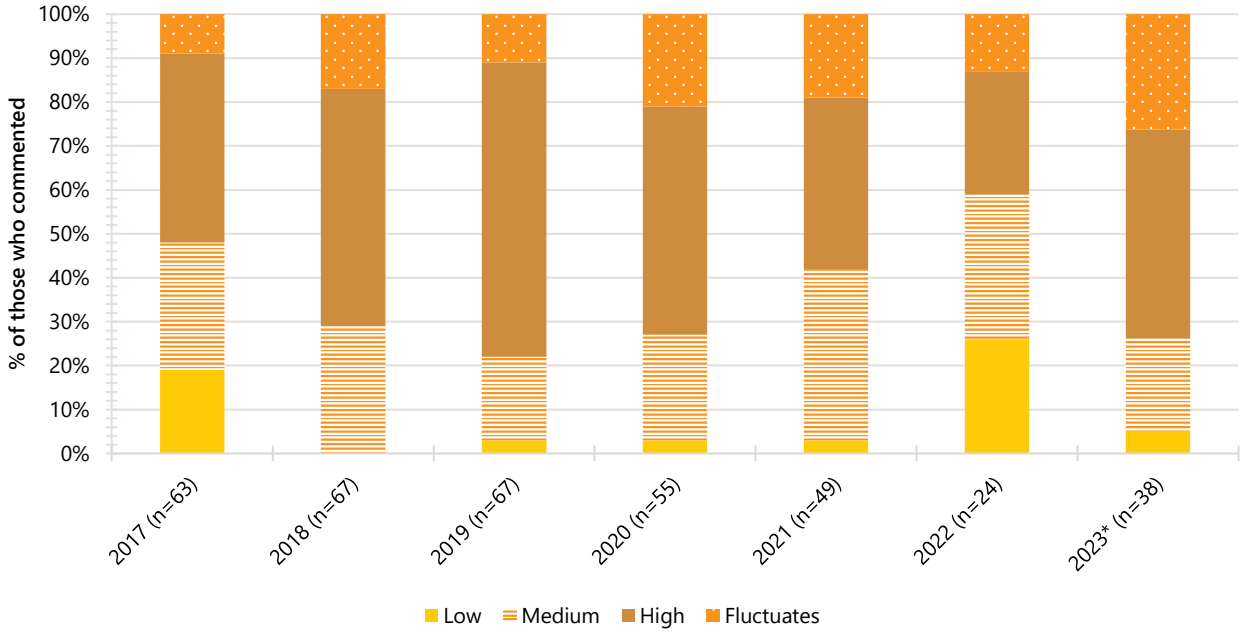
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Figure 9: Current perceived purity of ecstasy capsules, Melbourne, VIC, 2017-2023



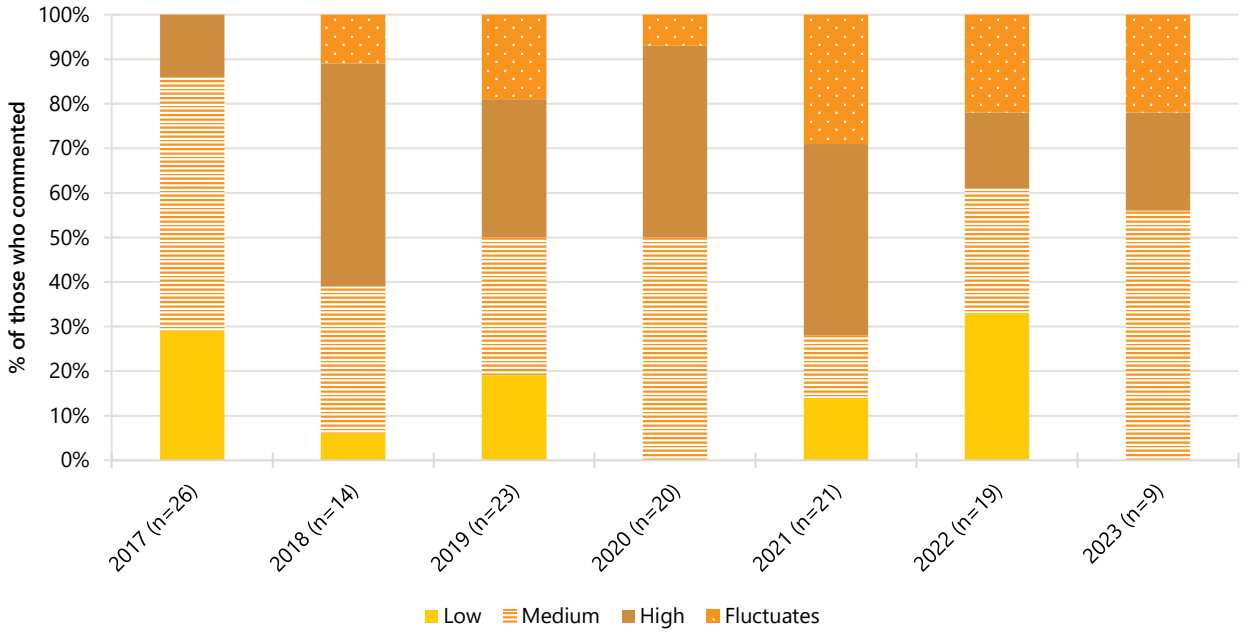
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Figure 10: Current perceived purity of ecstasy crystal, Melbourne, VIC, 2017-2023



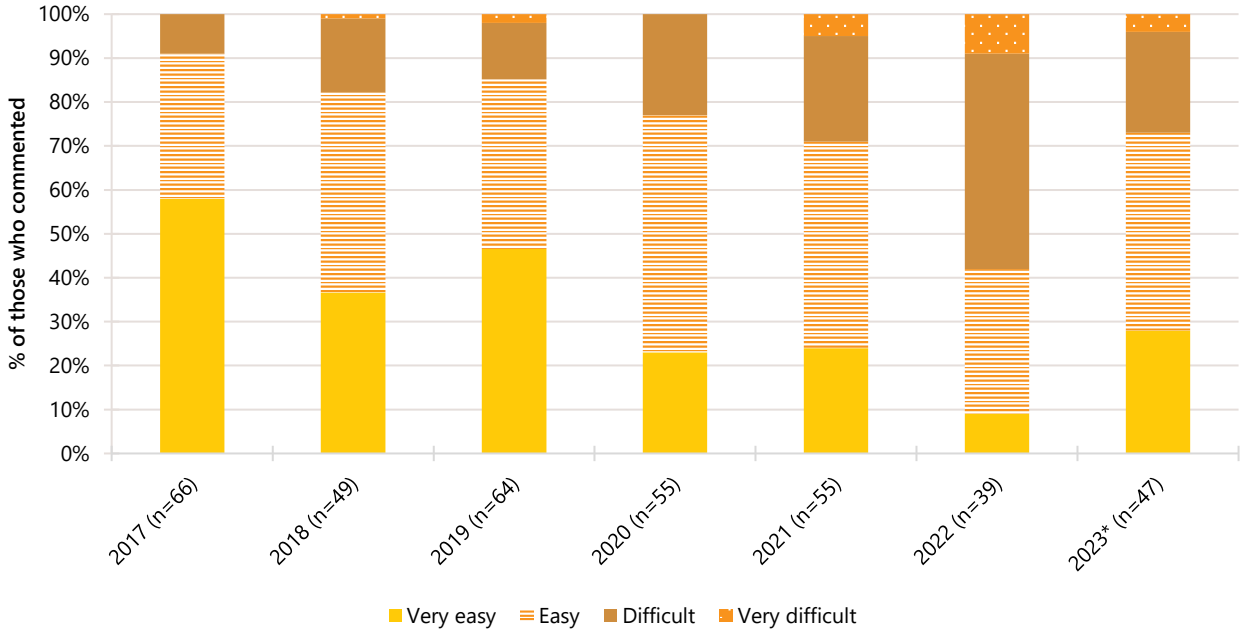
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 11: Current perceived purity of ecstasy powder, Melbourne, VIC, 2017-2023



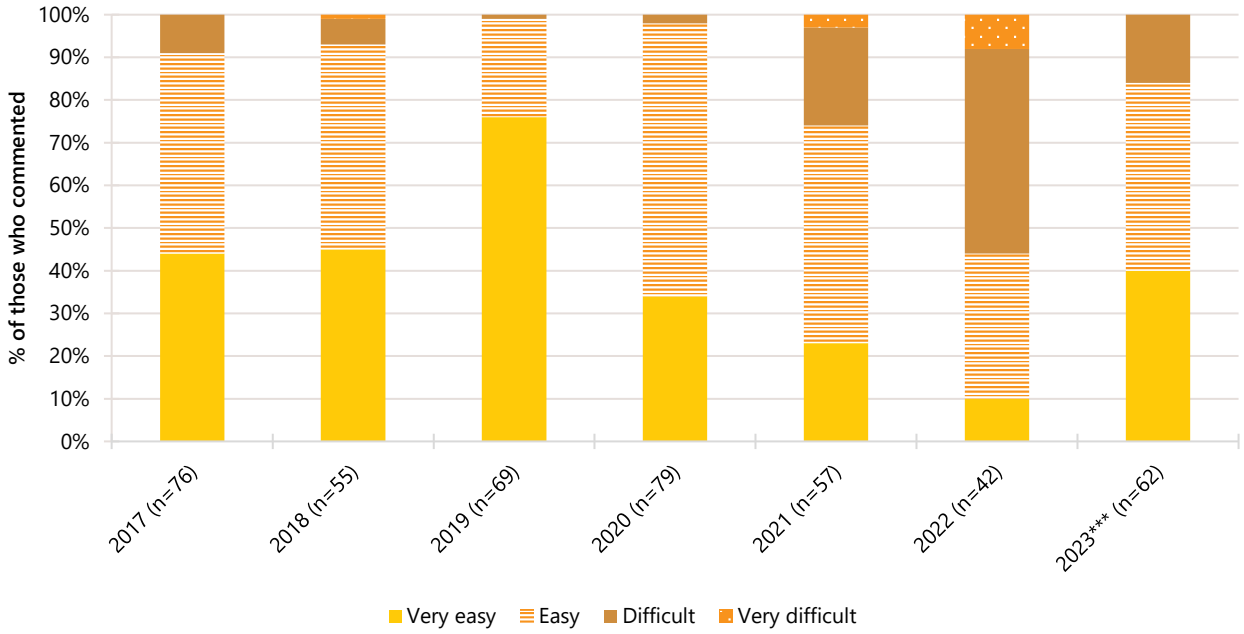
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 12: Current perceived availability of ecstasy pills, Melbourne, VIC, 2017-2023



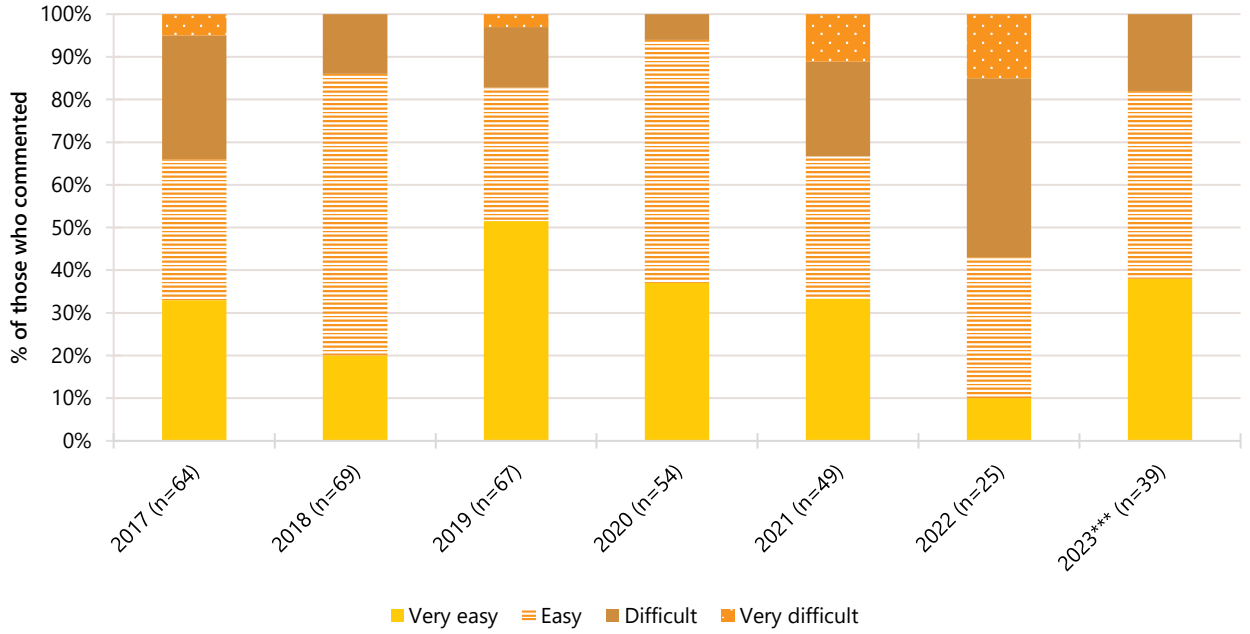
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 13: Current perceived availability of ecstasy capsules, Melbourne, VIC, 2017-2023



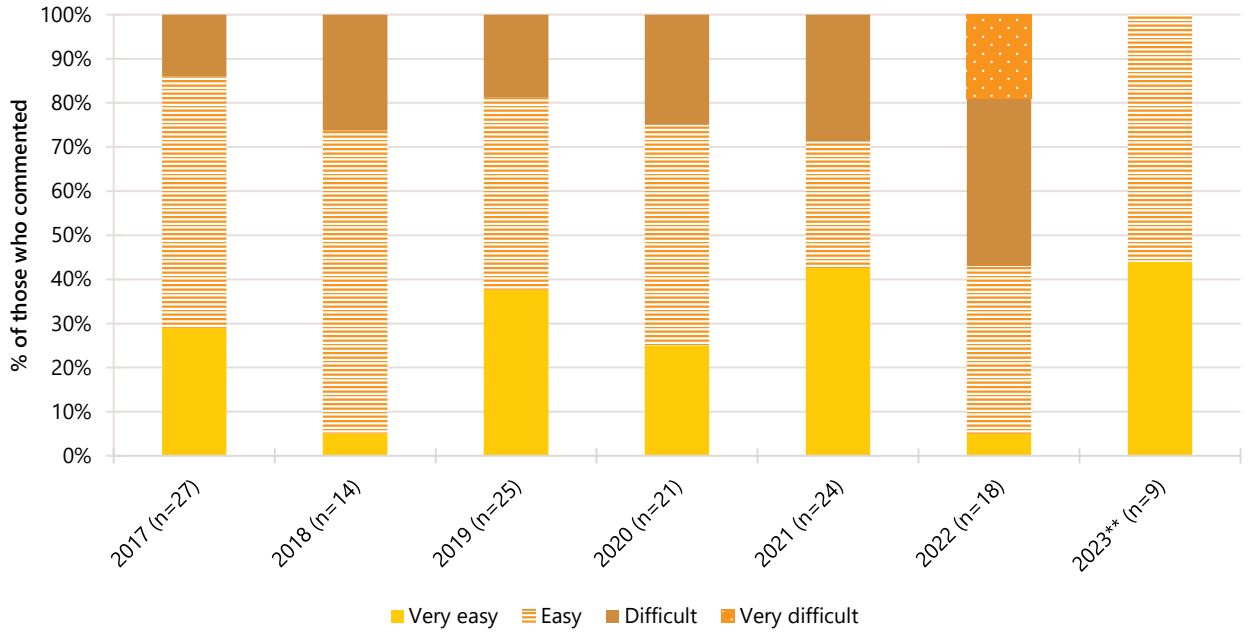
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 14: Current perceived availability of ecstasy crystal, Melbourne, VIC, 2017-2023



Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 15: Current perceived availability of ecstasy powder, Melbourne, VIC, 2017-2023



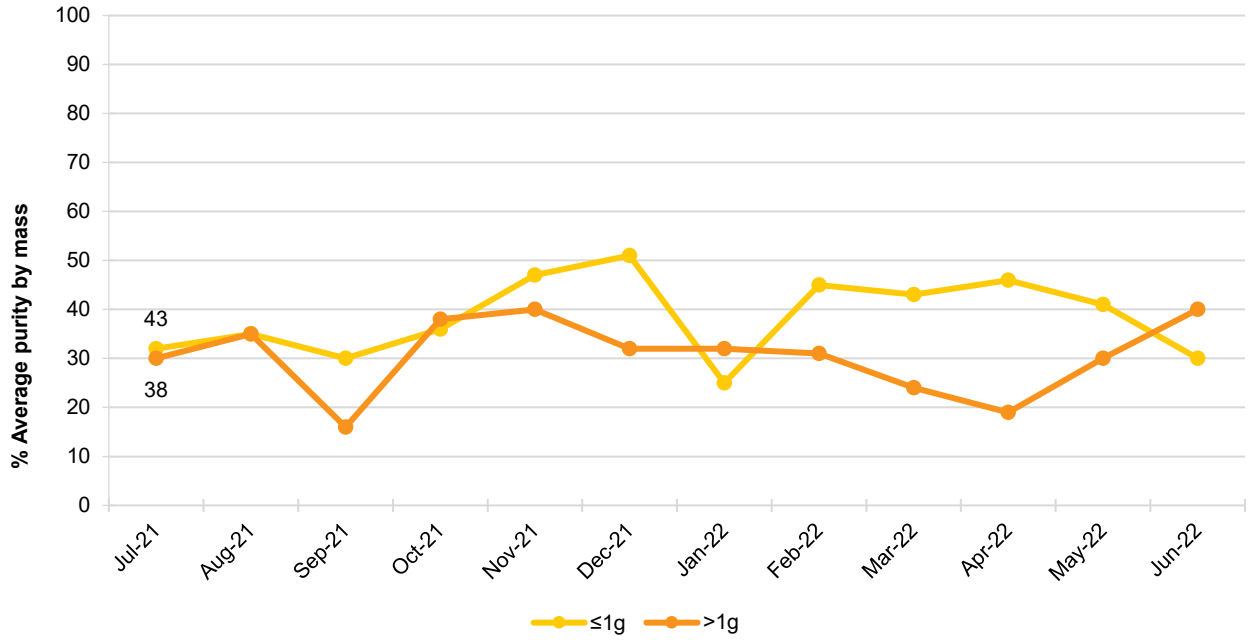
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 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 2021/22 financial year, weighing one gram or less and more than one gram, were on average 38% (IQR=32–45%, range=25–51) and 31% (IQR=29–36, range=24–40) pure, respectively (Figure 16).

Figure 16: Purity of ecstasy seizures (includes MDMA, MDEA and MDA) by Victorian law enforcement, July 2021–June 2022

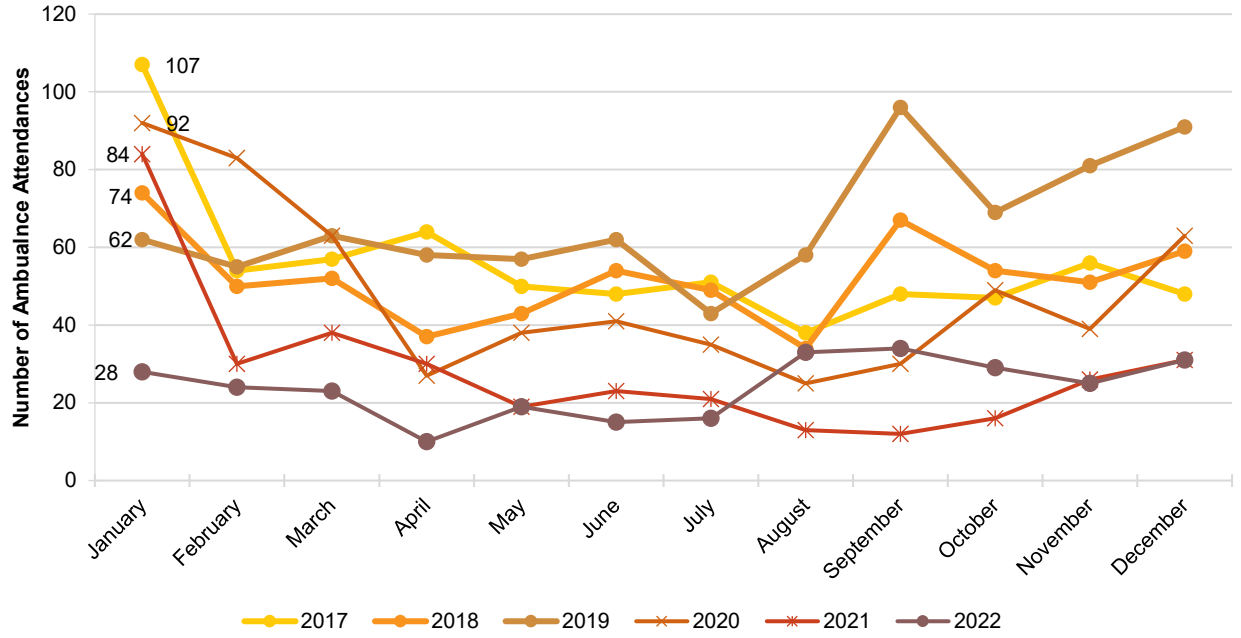


Note. Includes all forms (e.g., pill, capsule, powder and crystal) of MDMA, MDEA and MDA seized by Victoria Police. May not include every drug seized, because not all seized drugs undergo purity analysis. Data labels provided are only provided for the first (July 2021) month of monitoring.

Ambulance Attendances at Non-Fatal Drug Events

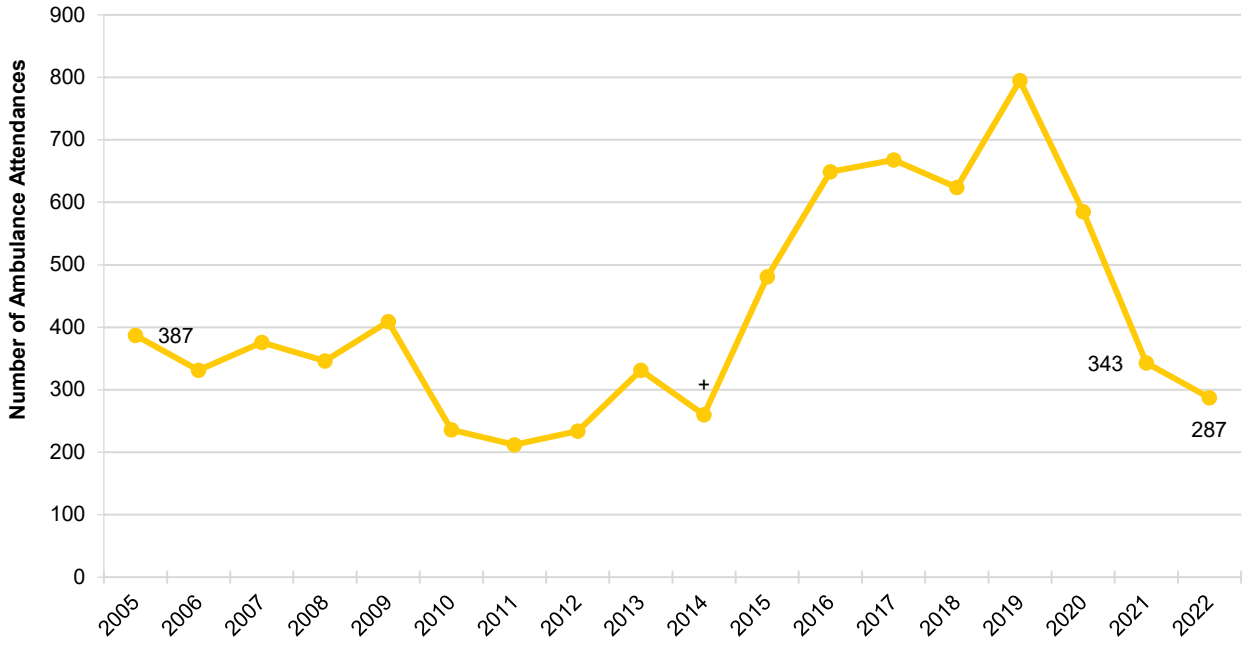
The number of ecstasy-related ambulance attendances in metropolitan Melbourne ranged between 10 and 107 per month during 2017–2022 (Figure 17). The total annual number of ecstasy-related attendance attendances rose steadily between 2014 and 2019 but has been declining in recent years. In 2022 there were 287 attendances, a reduction from 2021 (Figure 18). The median age of patients in Melbourne in 2022 was 24 years (range 20–29), consistent with previous years.

Figure 17: Number of ecstasy-related events attended by Ambulance Victoria, Melbourne, 2017–2022



Source: Turning Point. Data labels are only provided for the first (January) month 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 (2021 and 2022) of monitoring.

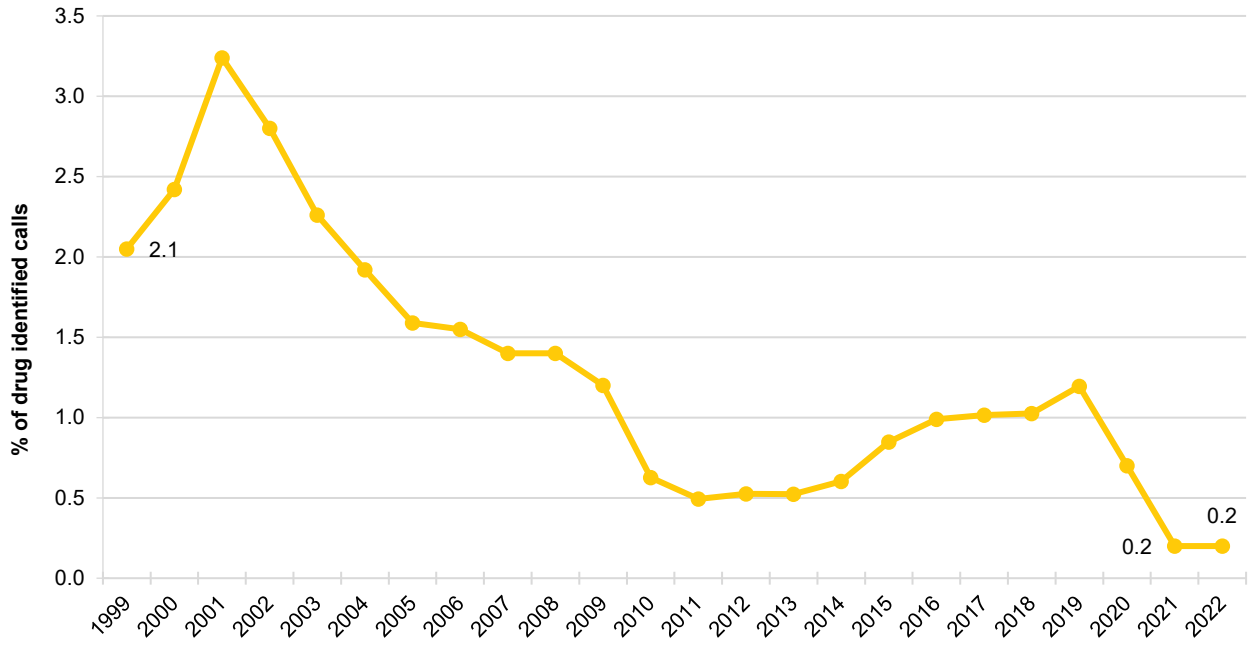
ADIS\VADC

In 2021/22, 170 courses of treatment were delivered to 142 clients for ecstasy, equivalent to 0.3% and 0.4% of the total courses delivered and clients treated. This represents an increase of 21.4% and 46.4% in courses delivered and clients treated from 2020/21 (140 and 97, respectively).

DirectLine

During 2022, DirectLine received 28 calls in which ecstasy was identified as the drug of concern, representing 0.2% of all drug-identified calls to DirectLine in that year, stable from 0.2% of drug-identified calls reported in 2021 (Figure 19).

Figure 19: Percentage of calls to DirectLine in which ecstasy was identified as drug of concern, Victoria 1999–2022



Source: DirectLine, Turning Point. Data labels provided are only provided for the first year (1999) and the two most recent years (2021 and 2022) 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).

Patterns of Consumption (Any Methamphetamine)

Recent Use (past 6 months)

Recent use of any methamphetamine has fluctuated since 2003 but declined gradually overall (Figure 20). In 2023, 29% of participants reported recent use of any form of methamphetamine, a significant decrease from 2022 (49%; p=0.008).

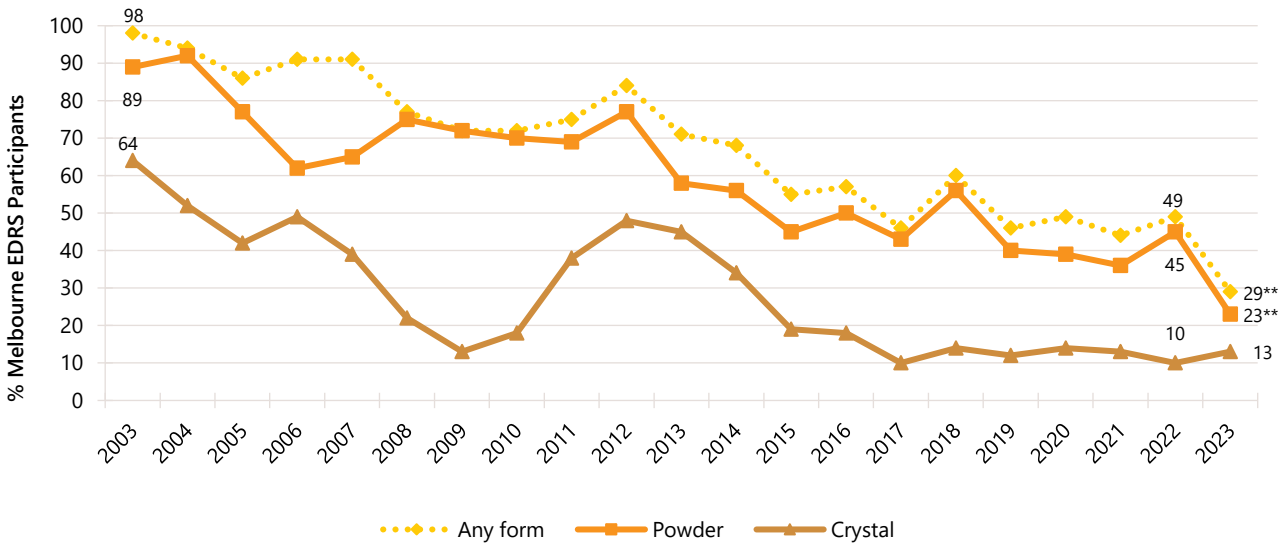
Frequency of Use

Median reported frequency of use remained stable in 2023, at two days in the past six months (IQR=1–12; 3 days in 2022; IQR=2–10; p=0.435) (Figure 21). Few participants (n≤5) reported using methamphetamine weekly or more frequently in 2023 (16% in 2022).

Forms Used

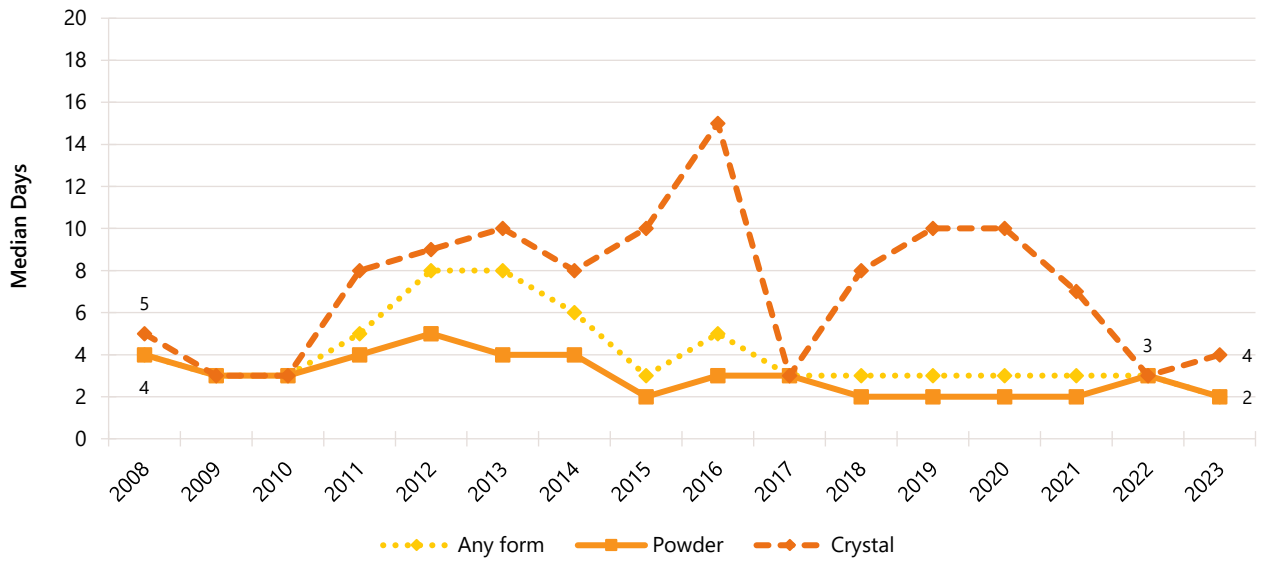
Use of all forms of methamphetamine has decreased since the start of monitoring, with 98% of participants reporting any use in 2003, decreasing to 29% in 2023 (Figure 20). Of participants who reported using methamphetamine in the six months preceding interview in 2023 (n=29), most reported using powder methamphetamine (79%; 92% in 2022; p=0.161), followed by crystal (45%; 20% in 2022; p=0.040). Few participants (n≤5) reported using base in 2023 (n≤5 in 2022, p=0.646).

Figure 20: Past six month use of any methamphetamine, powder, base, and crystal, Melbourne, VIC, 2003-2023



Note. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. Statistical significance for 2022 versus 2023 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, 2003-2023



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 (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. Statistical significance for 2022 versus 2023 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 reportedly used. Use has declined over the period of monitoring, with a significant decrease from 45% of the sample reporting recent use in 2022 to 23% in 2023 (p=0.002) (Figure 20).

Frequency of Use: In 2023, the median days of reported methamphetamine powder use remained stable at two days in the past six months (IQR=1–10; n=23; 3 days in 2022; IQR=2–5; n=45; p=0.580) (Figure 21). Among participants who reported recent use, few (n≤5) reported weekly or greater use of powder, comparable to 2022 (n≤5; p=0.474).

Routes of Administration: In 2023, the most common route of administration among participants who reported recent methamphetamine powder use continued to be snorting (96%; 87% in 2022; p=0.409), with few participants reporting swallowing (13% in 2022; p=0.707).

Quantity: The median amount of methamphetamine powder reportedly used in a 'typical' session was 0.40 grams (IQR=0.20–0.60; n=16), similar to 2022 (0.30 grams; IQR=0.20–0.50; n=22; p=0.798). The median 'maximum' amount reportedly used in a session was 0.70 grams (IQR=0.40–1.00; n=16), also similar to 2022 (0.50 grams; IQR=0.20–1.00; n=24; p=0.478).

Methamphetamine Crystal

Recent Use (past 6 months): Use of methamphetamine crystal has remained stable in recent years. In 2023, 13% of participants reported recent use of methamphetamine crystal, comparable to 2022 (10%; p=0.643) (Figure 20).

Frequency of Use: In 2023, of those who reported recent use of methamphetamine crystal and commented (n=13), frequency of reported use was a median of four days (IQR=2–12) in the past six months, comparable to three days (IQR=1–90) in 2022 (Figure 21). Few participants (n≤5) reported weekly or more frequent use of methamphetamine crystal, similar to 2022 (n≤5; p=0.341).

Routes of Administration: Among participants who reported recent methamphetamine crystal use and commented (n=13), smoking remained the most common route of administration, with 85% reporting this method in 2023 (90% in 2022).

Quantity: Of those who reported recent use and commented (n=10), the median amount of crystal reportedly used in a 'typical' session was 0.30 grams (IQR=0.20–0.40; 0.30 grams in 2022; IQR=0.10–0.90; p=0.701). Of those who reported recent use and commented (n=10), the median maximum amount of crystal reportedly used in a session was 0.70 grams (IQR=0.30–1.00; 0.40 grams in 2022; IQR=0.10–1.70; p=0.663).

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 of a gram of methamphetamine powder was $200 in 2023 (IQR=190–235; n=11), comparable to 2022 ($200; IQR=200–205; n=20) (Figure 22). No participants reported on the price of a point in 2023 and 2022.

Perceived Purity: The perceived purity of methamphetamine powder in 2023 was comparable to 2022 (p=0.339). Among those who commented in 2023 (n=13), 62% reported methamphetamine powder purity to be 'high' (33% in 2022) (Figure 23).

Perceived Availability: The perceived availability of methamphetamine powder in 2023 was comparable to 2022 (p=0.383). Among those who commented in 2023 (n=14), 43% reported methamphetamine powder to be 'very easy' to obtain (n≤5 in 2022) (Figure 25).

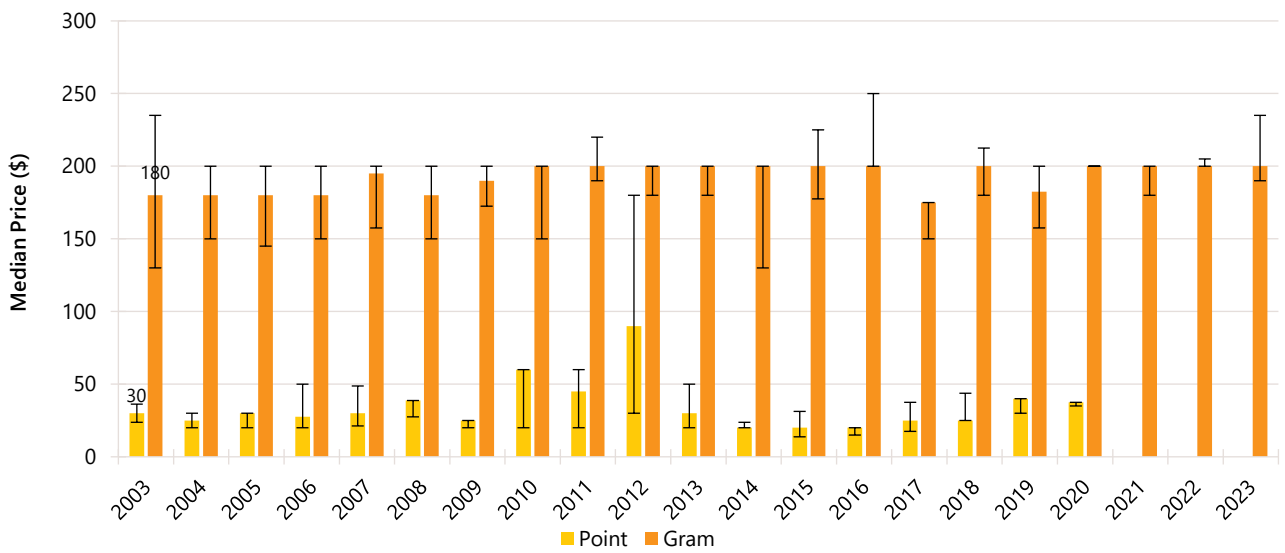
Methamphetamine Crystal

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 in 2023 was comparable to 2022 (*p*=0.530). Due to low numbers for each of the responses, further details have been suppressed (Figure 24).

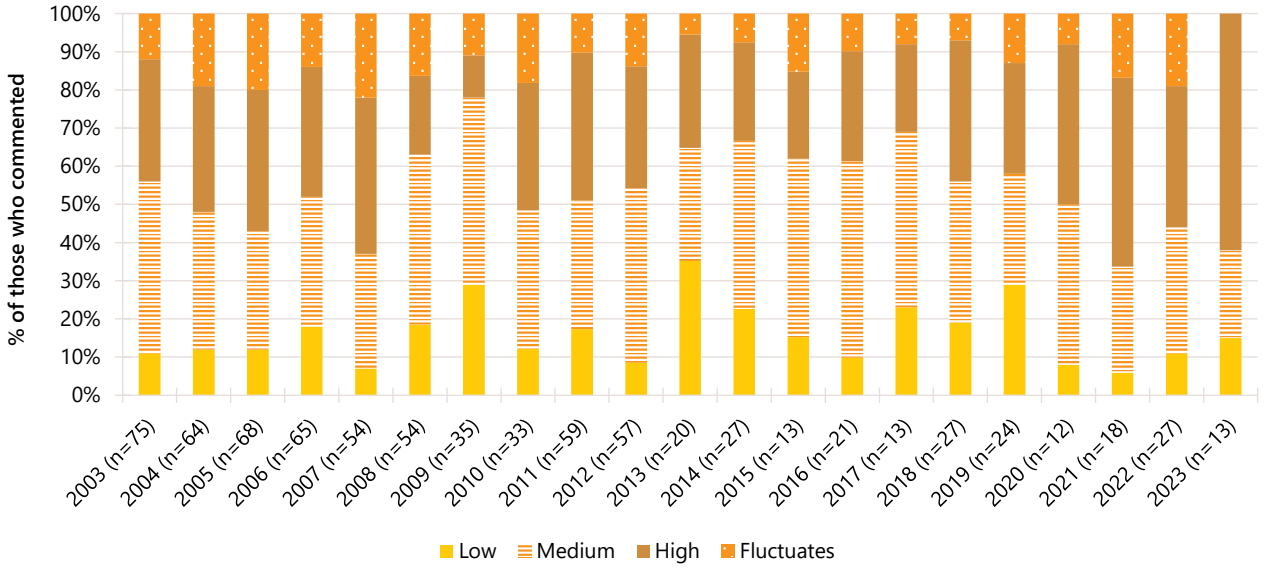
Perceived Availability: The perceived availability of methamphetamine crystal in 2023 was comparable to 2022 (*p*=0.530). Due to low numbers for each of the responses, further details have been suppressed (Figure 26).

Figure 22: Median price of powder methamphetamine per point and gram, Melbourne, VIC, 2003-2023



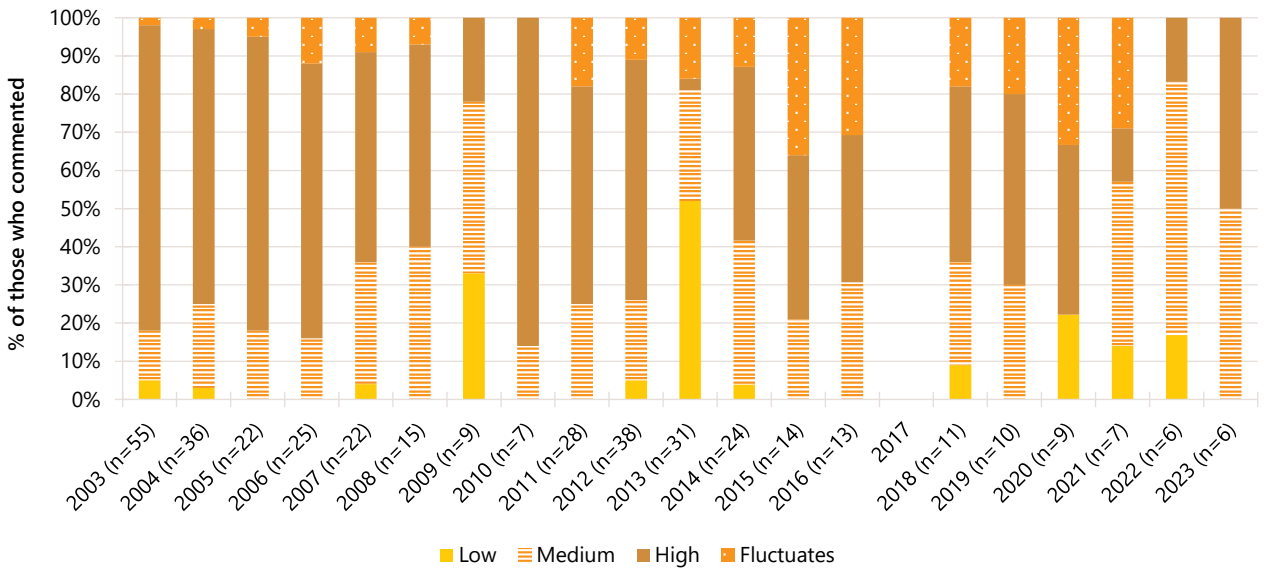
Note. Among those who commented. No participants reported purchasing a gram of powder methamphetamine in 2014, 2020 and 2021. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. The error bars represent the IQR. Statistical significance for 2022 versus 2023 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001.

Figure 23: Current perceived purity of powder methamphetamine, Melbourne, VIC, 2003-2023



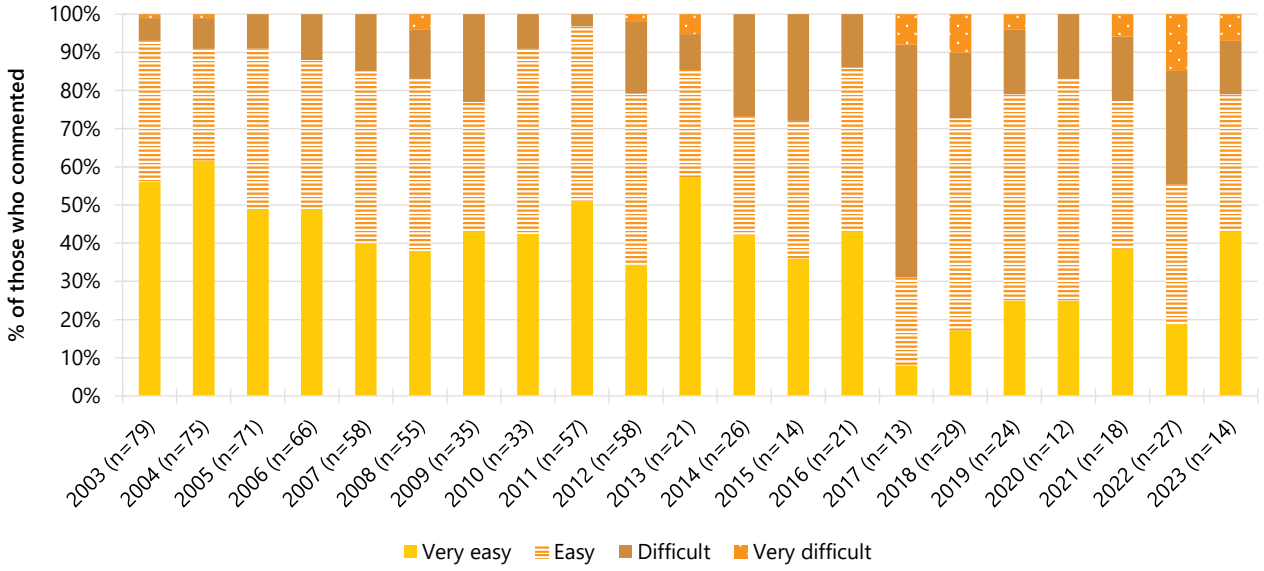
Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Figure 24: Current perceived purity of crystal methamphetamine, Melbourne, VIC, 2003-2023



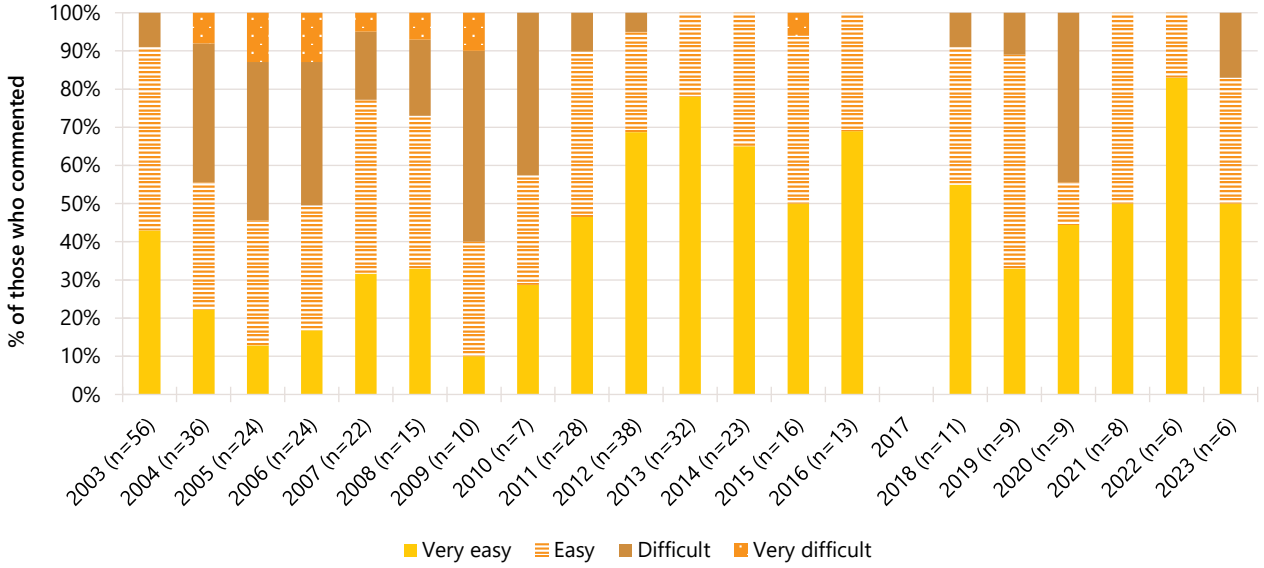
Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Figure 25: Current perceived availability of powder methamphetamine, Melbourne, VIC, 2003-2023



Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 26: Current perceived availability of crystal methamphetamine, Melbourne, VIC, 2003-2023



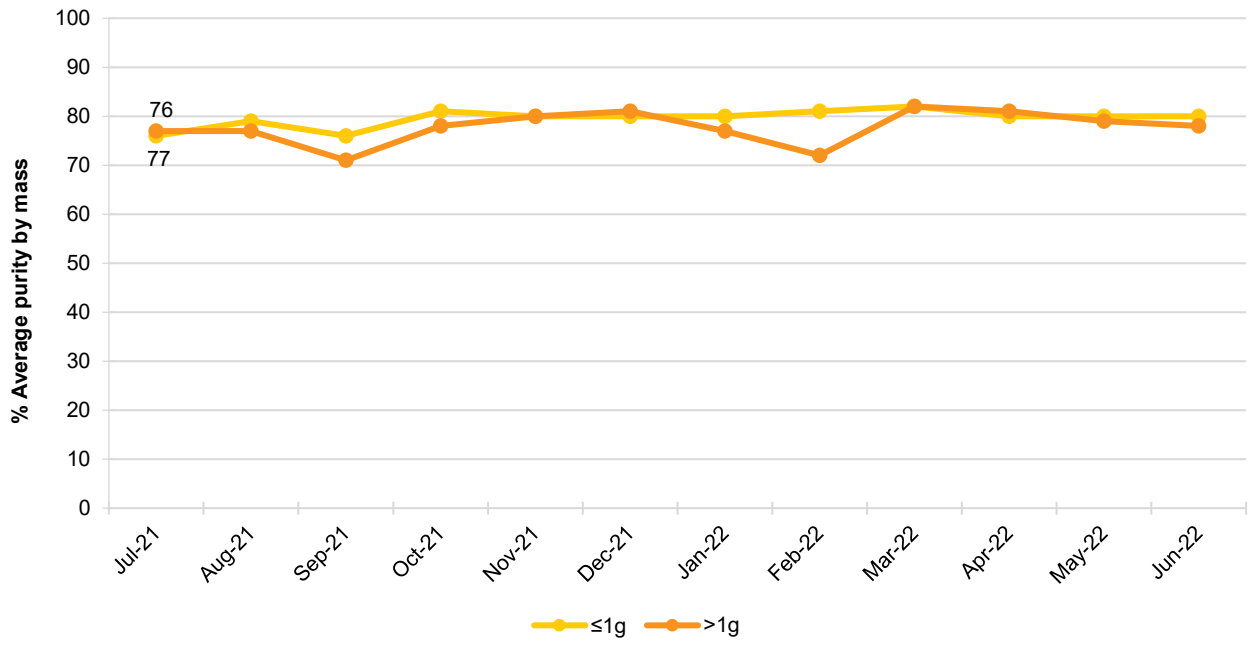
Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 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 2021/2022 financial year averaged 80% purity in those weighing one gram or less (IQR=80–80, range=76–82) and 78% in those weighing over one gram (IQR=77–80, range=71–82) (Figure 27).

Figure 27: Purity of methamphetamine seizures by Victorian law enforcement, July 2021–June 2022



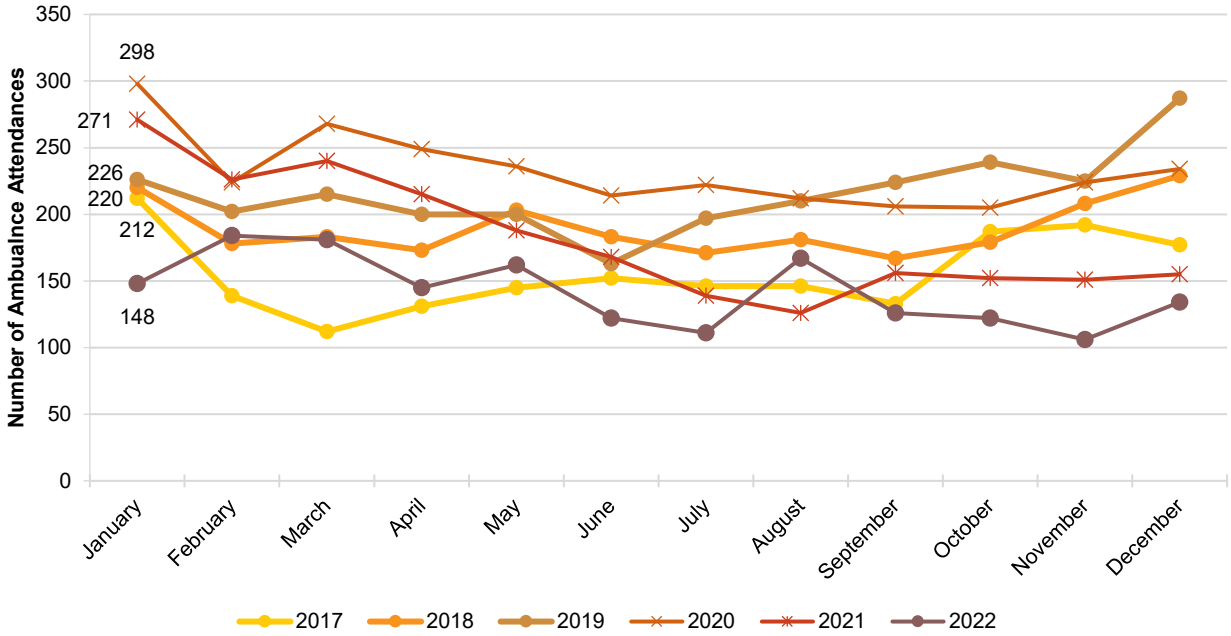
Note. Includes all forms (e.g., powder, base and crystal) of methamphetamine seized by Victoria Police. May not include every drug seized, as not all seized drugs undergo purity analysis. Data labels are only provided for first (July 2021) and two most recent months (May and June 2022) of monitoring.

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.

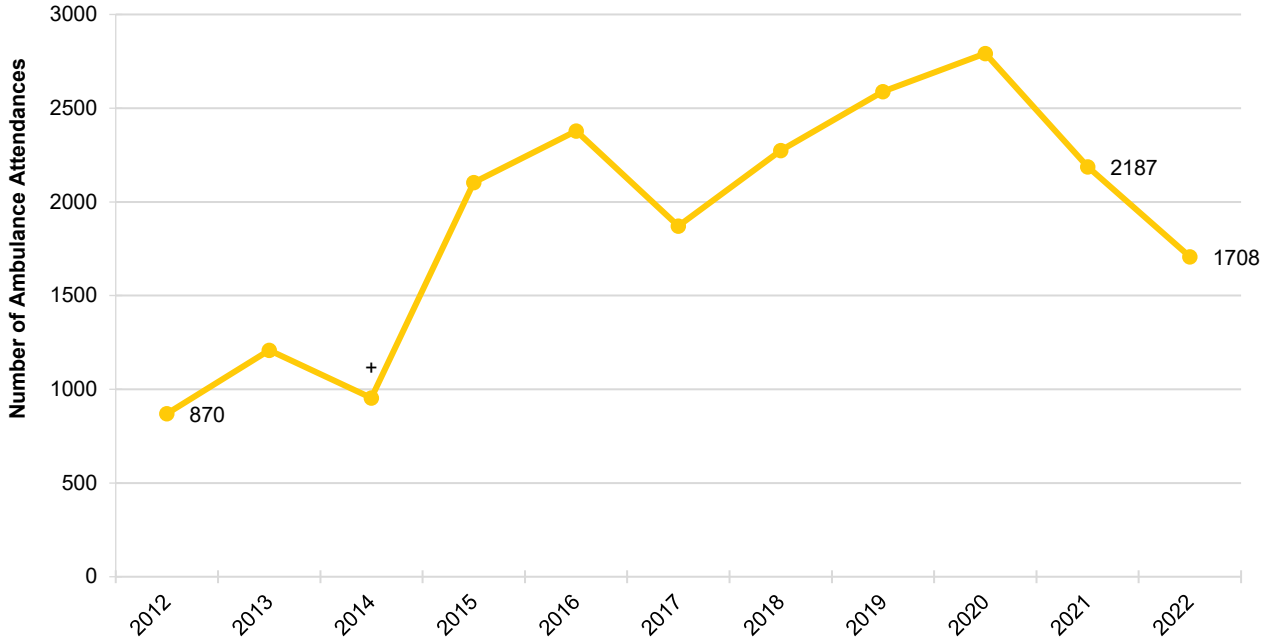
The number of methamphetamine-related ambulance attendances in metropolitan Melbourne ranged between 106 and 298 per month during 2017–2022 (Figure 28). The annual number of methamphetamine-related attendances rose steadily between 2012 and 2022. In 2022 there were 1708 attendances, a reduction from 2021 (Figure 29). The median age of patients in 2022 was 33 years (range 26–41), consistent with recent years.

Figure 28: Number of methamphetamine-related events attended by Ambulance Victoria, Melbourne, 2017–2022



Source: Turning Point. Data labels are only provided for the first (January) month of monitoring in each year.

Figure 29: Number of methamphetamine-related events attended by Ambulance Victoria, Melbourne, 2012–2022



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 (2021 and 2022) of monitoring.

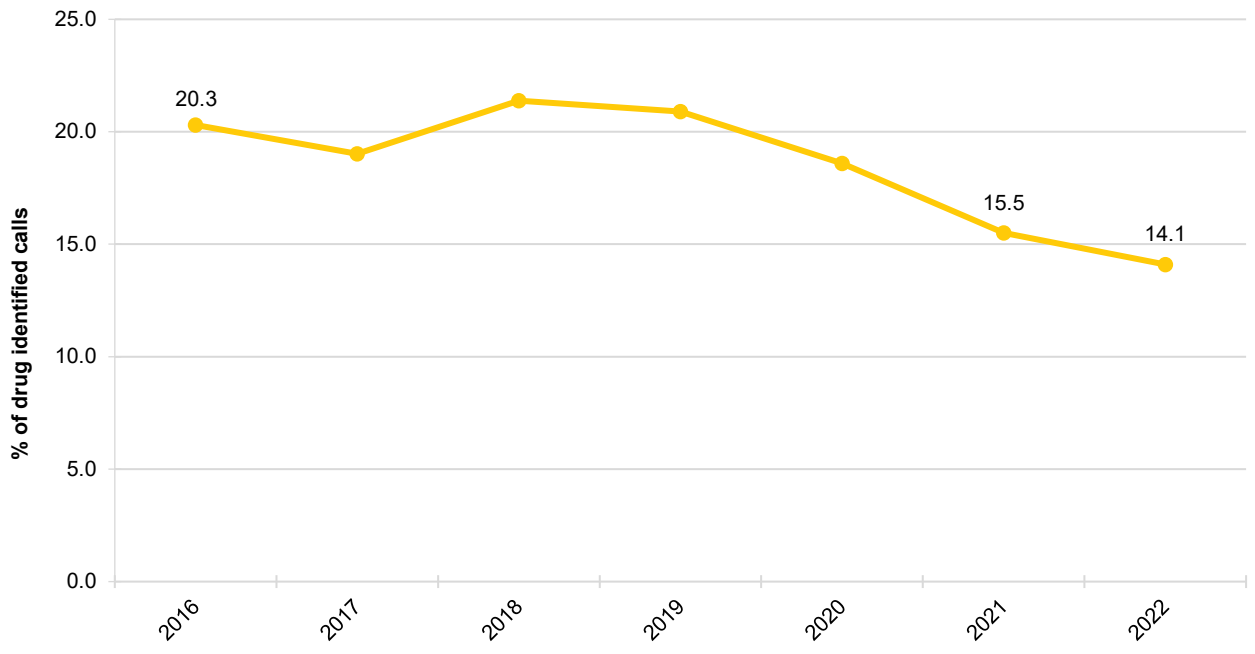
ADIS\VADC

In 2021/22, 12,145 courses of treatment were delivered to 7,723 clients for methamphetamine, equivalent to 18.5% and 19.4% of the total courses delivered and clients treated, respectively. This represents an increase of 36.8% and 49.6% in courses delivered and clients treated from 2020/21 (8,878 and 5,162, respectively).

DirectLine

During 2022, DirectLine received 2,122 calls in which methamphetamine was identified as the drug of concern, representing 14.1% 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 2016–2022



Source: DirectLine, Turning Point. Data labels are provided only for the first (2016) and two most recent years of monitoring (2021 and 2022).

4

Non-Prescribed Pharmaceutical Stimulants

Participants were asked about their recent (past six month) use of non-prescribed pharmaceutical stimulants, such as dexamfetamine, lisdexamfetamine (Vyvanse®), or methylphenidate (Concerta®, Ritalin®, Ritalin LA®). These substances are commonly prescribed to treat attention deficit hyperactivity disorder and narcolepsy.

Patterns of Consumption

Recent Use (past 6 months)

The proportion of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has increased since the commencement of monitoring, from 9% in 2007 to a peak of 64% in 2022. However, there was a significant decrease in recent use between 2023 and 2022 (47%; 64% in 2022; p=0.022) (Figure 31).

Frequency of Use

Reported frequency of use in 2023, at a median of five days in the six months prior to interview (IQR=2–12; n=47), was comparable to that in 2022 (4 days; IQR=2–12; n=64; p=0.843) (Figure 31).

Routes of Administration

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=47), the vast majority reported swallowing as a route of administration (94%; 95% in 2022; p=0.697), with fewer participants reporting snorting (21%; 17% in 2022; p=0.620).

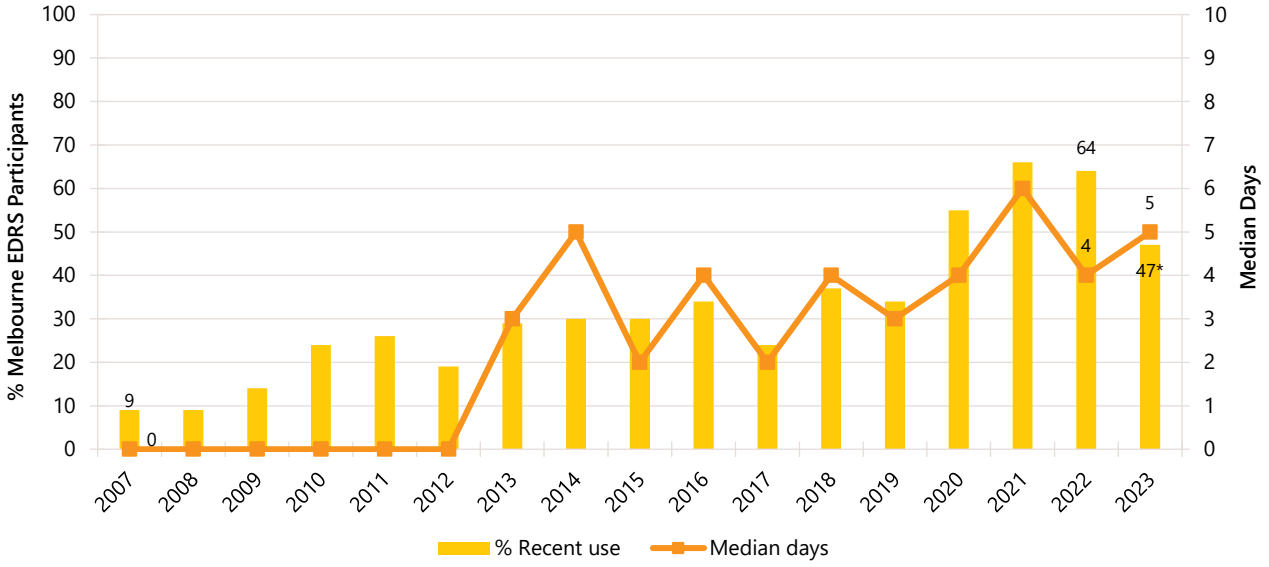
Quantity

Among those who reported recent use and commented (n=42), the median amount reportedly used in a 'typical' session in 2023 was one pill/tablet (IQR=1.00–2.00), a significant decrease from 2022 (2.00 pills/tablets; IQR=1.00–3.00; p=0.040). Of those who reported recent use and commented (n=39), the median maximum amount used in a session was two pills/tablets (IQR=1.00–3.00; 2.00 pills/tablets in 2022; IQR=1.00–4.00; p=0.345).

Forms Used

Among participants who reported recently consuming non-prescribed pharmaceutical stimulants and commented (n=47), most reported using dexamphetamine (77%; 73% in 2022; p=0.818), with fewer participants reporting use of Ritalin® (43%; 35% in 2022; p=0.438) and Modafinil (28%; 17% in 2022; p=0.251).

Figure 31: Past six month use and frequency of use of non-prescribed pharmaceutical stimulants, Melbourne, VIC, 2007-2023



Note. Monitoring of pharmaceutical stimulants commenced in 2007. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 10 days to improve visibility of trends. The response option 'Don't know' was excluded from analysis. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Price and Perceived Availability

Price and availability data for non-prescribed pharmaceutical stimulants were collected from 2022.

Price

Participants reported a median price of $10 per 5mg tablet in 2023 (IQR=5–15; n=11; $5 in 2022; IQR=5–10; n=16; p=0.097).

Perceived Availability

Among those who responded in 2023 (n=34), the perceived availability of non-prescribed pharmaceutical stimulants remained stable, relative to 2022 (p=0.968). In 2023, 26% perceived non-prescribed pharmaceutical stimulants to be 'very easy' (30% in 2022) to obtain, with a further 38% perceiving availability as 'easy' (40% in 2022).

5

Cocaine

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

Patterns of Consumption

Recent Use (past 6 months)

Recent use of cocaine has gradually increased since monitoring began but has since plateaued. In 2023, 90% of the sample reported recent use, comparable to 91% in 2022 (Figure 32).

Frequency of Use

Reported frequency of cocaine use has also increased gradually in recent years, with a median of five days (IQR=2–10) of use reported in 2023, a figure comparable to 2022 (6 days; IQR=3–10; p=0.125) (Figure 32). Of those who reported recent cocaine use (n=90), few (n≤5) reported weekly or more frequent use of cocaine (9% in 2022; p=0.567).

Routes of Administration

Among participants who reported recent cocaine use and commented (n=90), 100% of participants reported snorting cocaine, comparable to 2022 (99%).

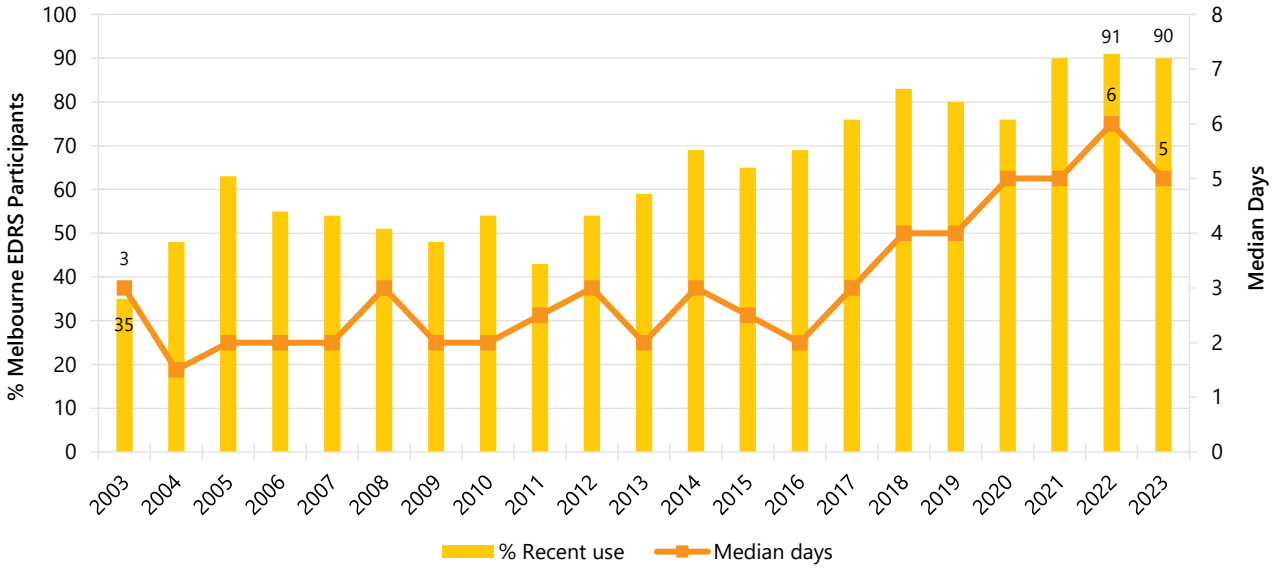
Quantity

Of those who reported recent cocaine use and commented (n=60), the median amount of cocaine reportedly used in a 'typical' session was 0.50 grams (IQR=0.30–0.50; 0.50 grams in 2022; IQR=0.30–1.00; p=0.438). Of those who reported recent use and commented (n=64), the median maximum amount used in a session was 0.80 gram (IQR=0.50–1.00; 1.00 gram in 2022; IQR=0.50–1.00; p=0.261).

Forms Used

Among participants who reported recent cocaine use and commented (n=90), 99% reported using powder cocaine (98% in 2022), with few participants (n≤5) reporting use of crack (n≤5 in 2022; p=0.621) or rock cocaine (n≤5 in 2022; p=0.720).

Figure 32: Past six month use and frequency of use of cocaine, Melbourne, VIC, 2003-2023



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 8 days to improve visibility of trends for days of use. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. Statistical significance for 2022 versus 2023 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=315–350; n=52) in 2023, comparable to 2022 ($350; IQR=300–350; n=65; *p*=0.164) (Figure 33).

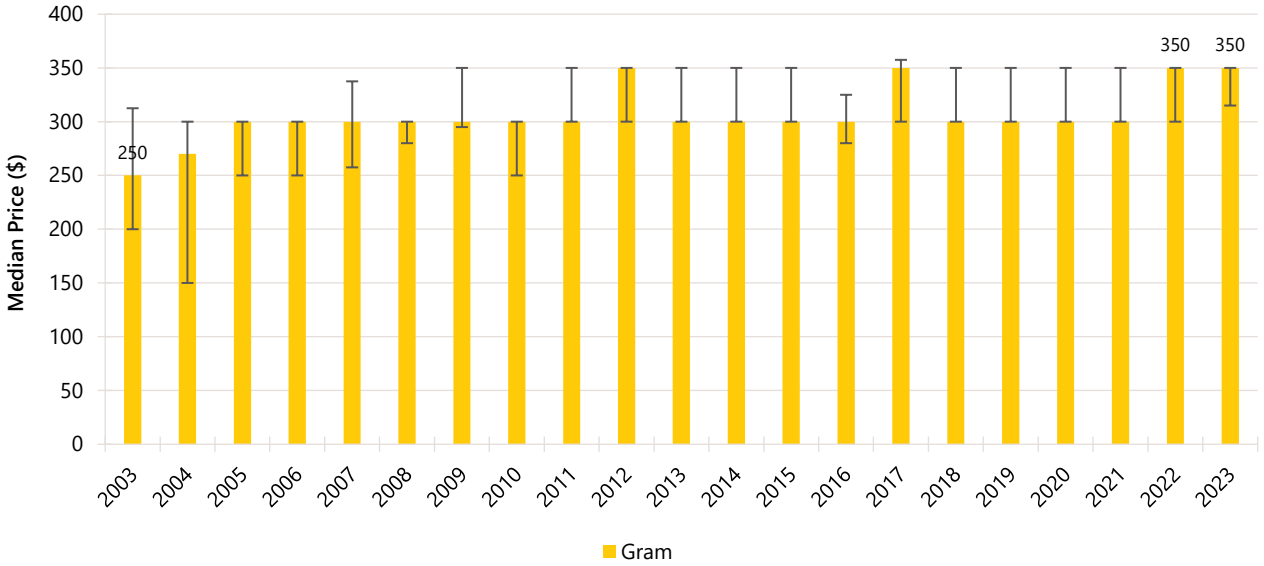
Perceived Purity

The perceived purity of cocaine remained stable between 2022 and 2023 (*p*=0.329). Among those who were able to comment in 2023 (n=71), the largest percentage of participants reported cocaine to be of 'low' purity (39%; 26% in 2022), followed by 27% reporting 'medium' purity (37% in 2022) and 20% reporting that purity 'fluctuates' (23% in 2022) (Figure 34).

Perceived Availability

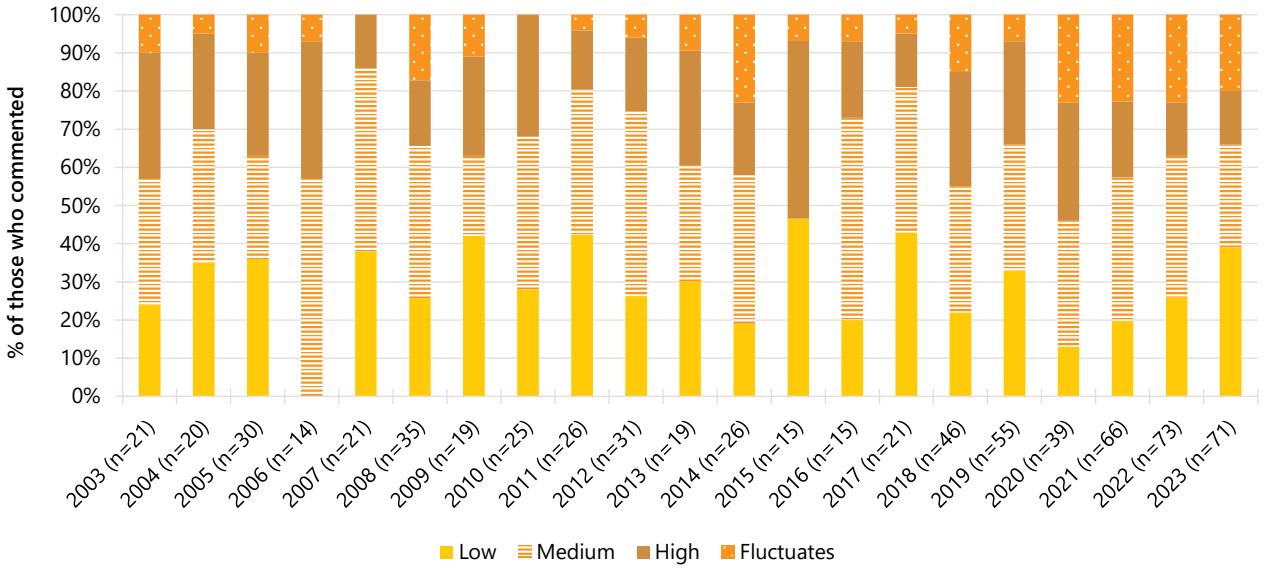
The perceived availability of cocaine remained stable between 2022 and 2023 (*p*=0.603). Among those who were able to comment in 2023 (n=70), 43% reported cocaine to be 'very easy' to obtain (35% in 2022), with a further 43% reporting it to be 'easy' (52% in 2022), while 11% perceived it to be 'difficult' to obtain (12% in 2022) (Figure 35).

Figure 33: Median price of cocaine per gram, Melbourne, VIC, 2003-2023



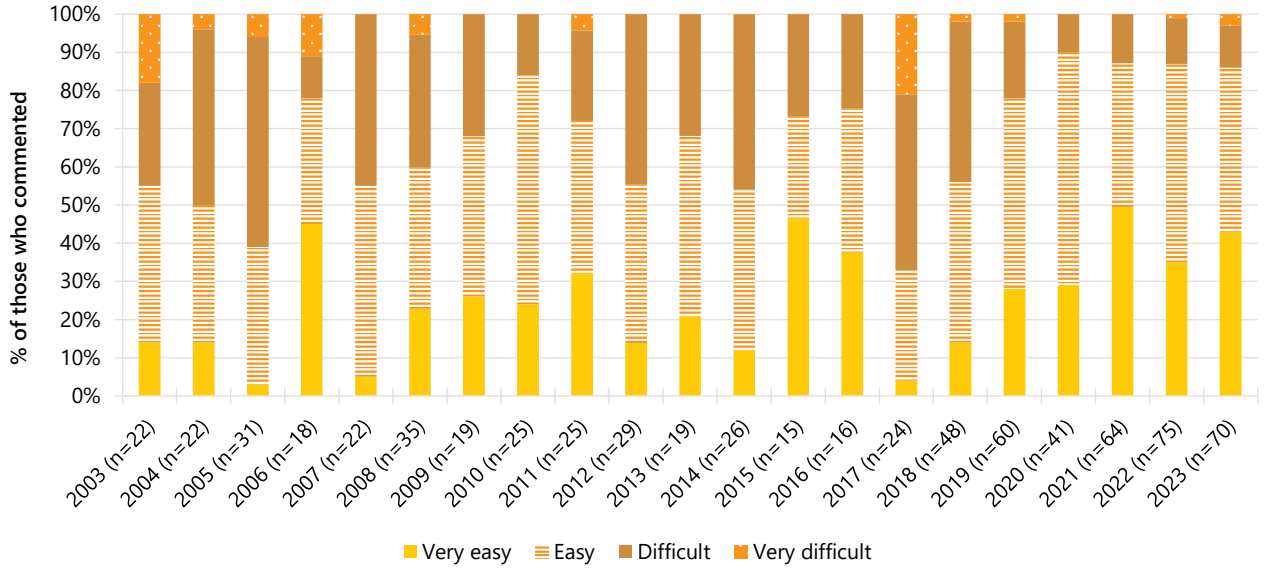
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 34: Current perceived purity of cocaine, Melbourne, VIC, 2003-2023



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 35: Current perceived availability of cocaine, Melbourne, VIC, 2003-2023



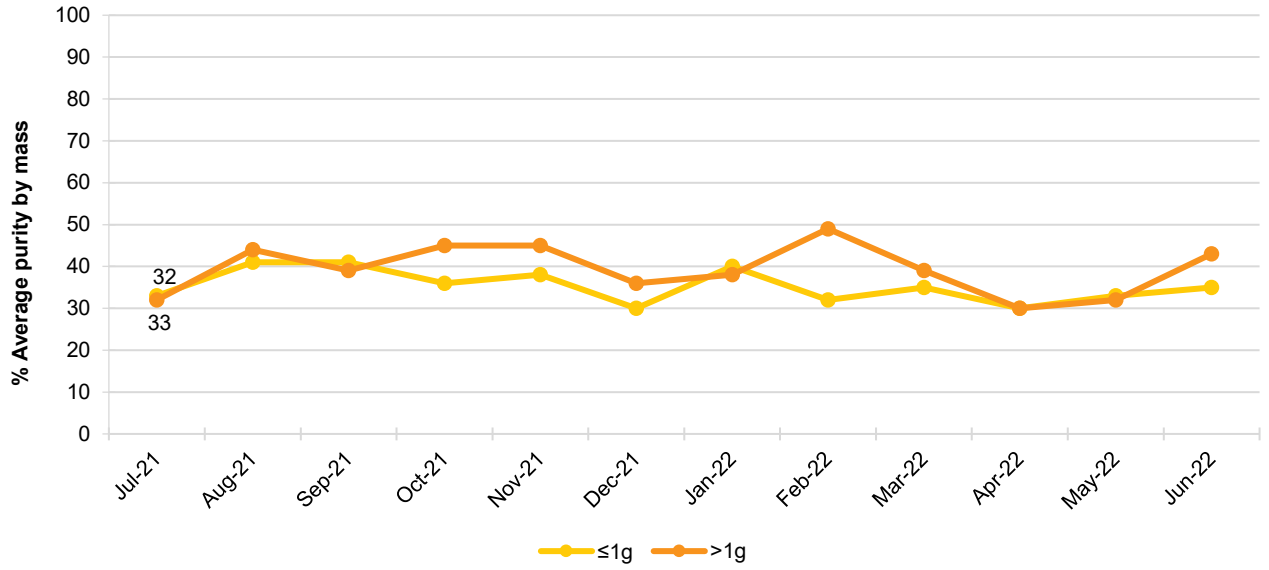
Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 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 2021/22 financial year averaged 35% purity in those weighing one gram or less (IQR=33–39, range=30–41) and 39% in those weighing over one gram (IQR=35–44, range=30–49) (Figure 36).

Figure 36: Purity of cocaine seizures by Victorian law enforcement, July 2021–June 2022

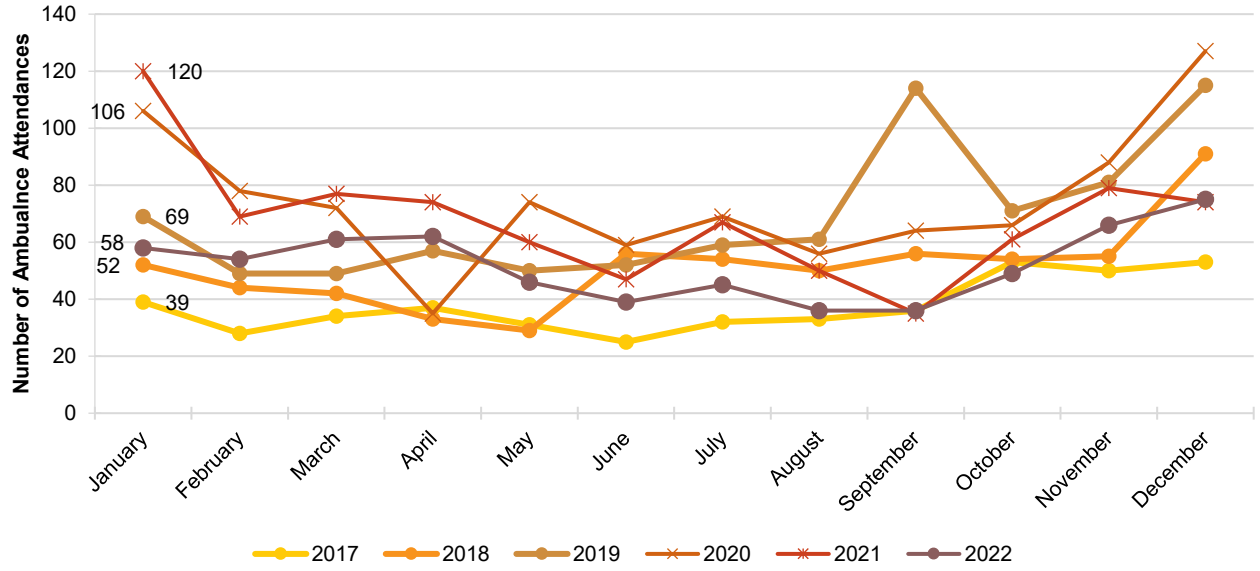


Note. May not include every drug seized, as not all seized drugs undergo purity analysis. Data labels are only provided for the first (July 2021) month of monitoring.

Ambulance Attendances at Non-Fatal Drug Events

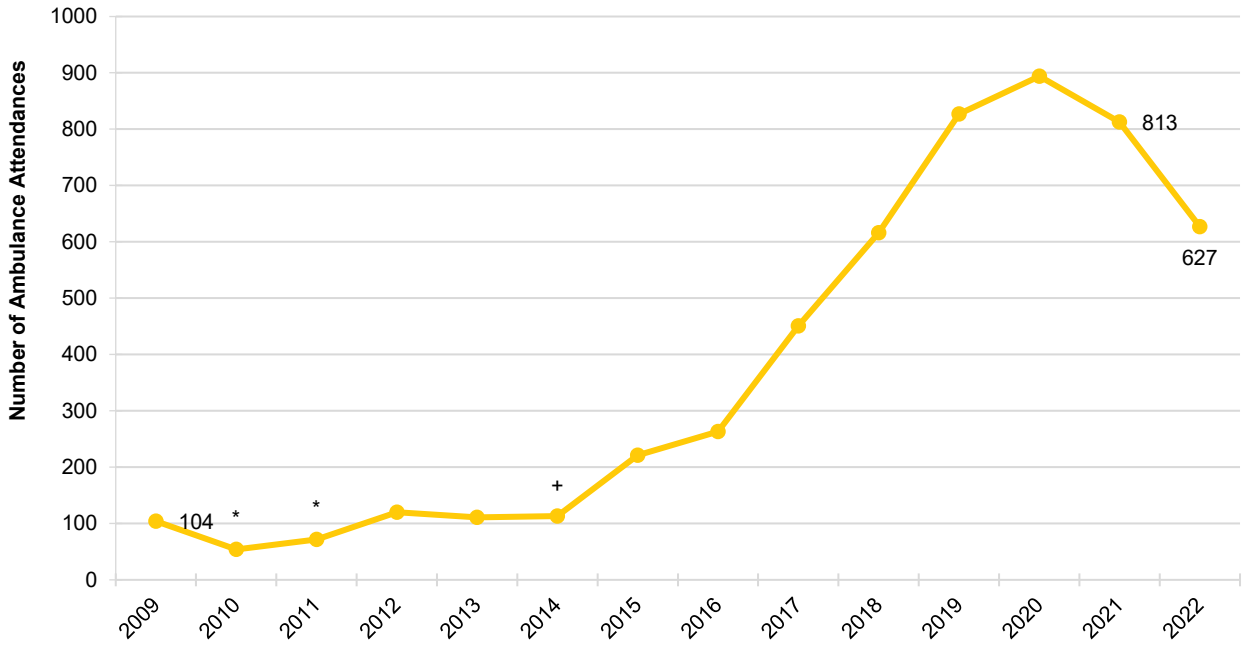
The number of cocaine-related ambulance attendances in metropolitan Melbourne ranged between 25 and 127 per month during 2017–2022 (Figure 37). The annual number of cocaine-related attendances rose steadily between 2015 and 2020. In 2022 there were 627 attendances, down from 2021 (Figure 38). The median age of patients in 2022 was 27 years (range=23–32), consistent with previous years.

Figure 37: Number of cocaine-related events attended by Ambulance Victoria, Melbourne, 2017–2022



Source: Turning Point. Data labels are only provided for the first (January) month of monitoring in each year.

Figure 38: Number of cocaine-related events attended by Ambulance Victoria, Melbourne, 2009-2022



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 (2021 and 2022) of monitoring.

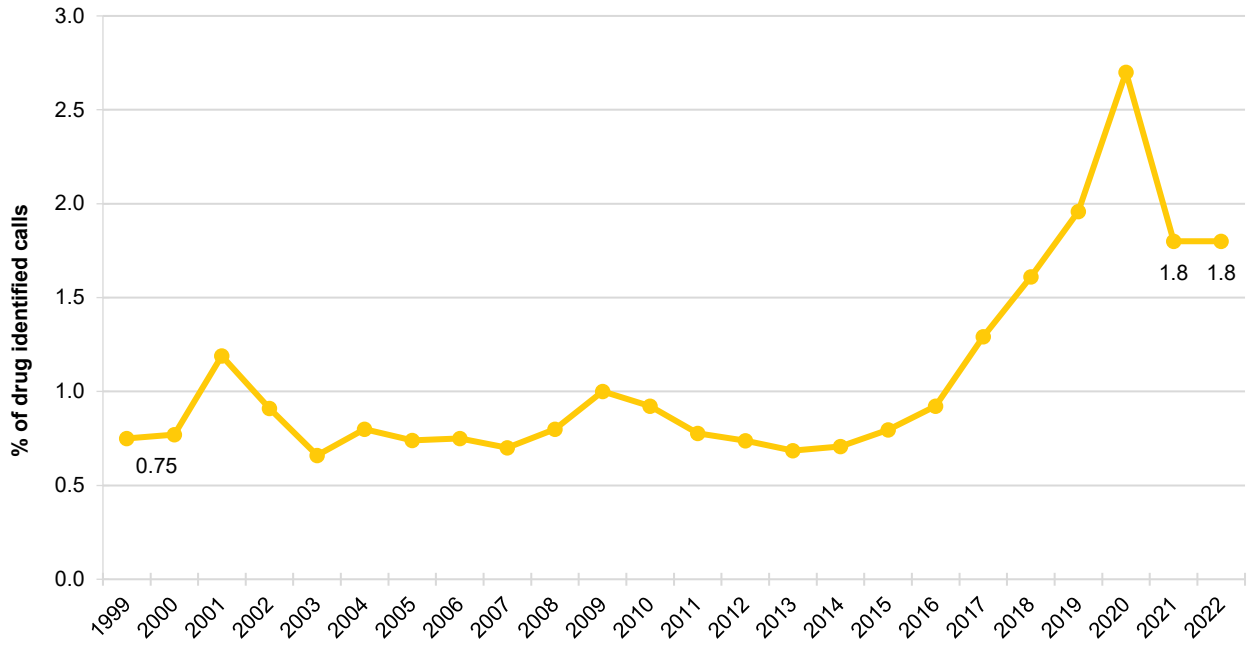
ADIS\VADC

In 2021/2022, 516 courses of treatment were delivered to 420 clients for cocaine, equivalent to 0.8% and 1.1% of the total courses delivered and clients treated. This represents an increase of 37.2% and 41.4% in courses delivered and clients treated from 2020/21 (376 and 297, respectively).

DirectLine

During 2022, DirectLine received 272 calls in which cocaine was identified as the drug of concern, representing 1.8% of all drug-identified calls to DirectLine in that year, comparable to 2021 (Figure 39).

Figure 39: Percentage of calls to DirectLine in which cocaine was identified as drug of concern, Victoria 1999–2022



Source: DirectLine, Turning Point. Data labels are only provided for the first (1999) and two most recent years (2021 and 2022) of monitoring.

6

Cannabis and/or Cannabinoid Related Products

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

Terminology throughout this chapter refers to:

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

Patterns of Consumption

In 2023, participants were asked about their use of both prescribed and non-prescribed cannabis and/or cannabinoid-related products.

In the remainder of this chapter, data from 2021-2023, 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 and hash oil). While comparison between 2021-2023 and previous years should be treated with caution, the relatively recent legalisation of medicinal cannabis in Australia and the small percentage reporting prescribed use in 2022 and 2023 lends confidence that estimates are relatively comparable.

Recent Use (past 6 months)

Sixty-seven per cent reported recent use of non-prescribed cannabis and/or cannabinoid related products in 2023, a significant decrease from 2022 (82%; p=0.021) (Figure 40).

Frequency of Use

Typical frequency of reported cannabis use has varied between fortnightly and several times per week over the course of monitoring. In 2023, of those who reported recent non-prescribed cannabis and/or cannabinoid-related product consumption and commented (n=67), the median reported number of days of use was 24 days (IQR=5–50) in the past six months, equivalent to weekly use, and a significant decrease from 2022 (33 days; IQR=7–99; p=0.045) (Figure 40). Around half (51%) reported using non-

prescribed cannabis and/or cannabinoid-related products weekly or more frequently (60% in 2022; p=0.327), while few participants (n≤5) reported using cannabis daily (15% in 2022; p=0.055).

Routes of Administration

Among participants who reported recent non-prescribed cannabis and/or cannabinoid-related product consumption and commented (n=67), most participants (88%) reported smoking, comparable to 2022 (91%; p=0.584). Forty per cent reported swallowing (52% in 2022; p=0.188), while a quarter (25%) reported inhaling/vaporising (16% in 2022; p=0.164).

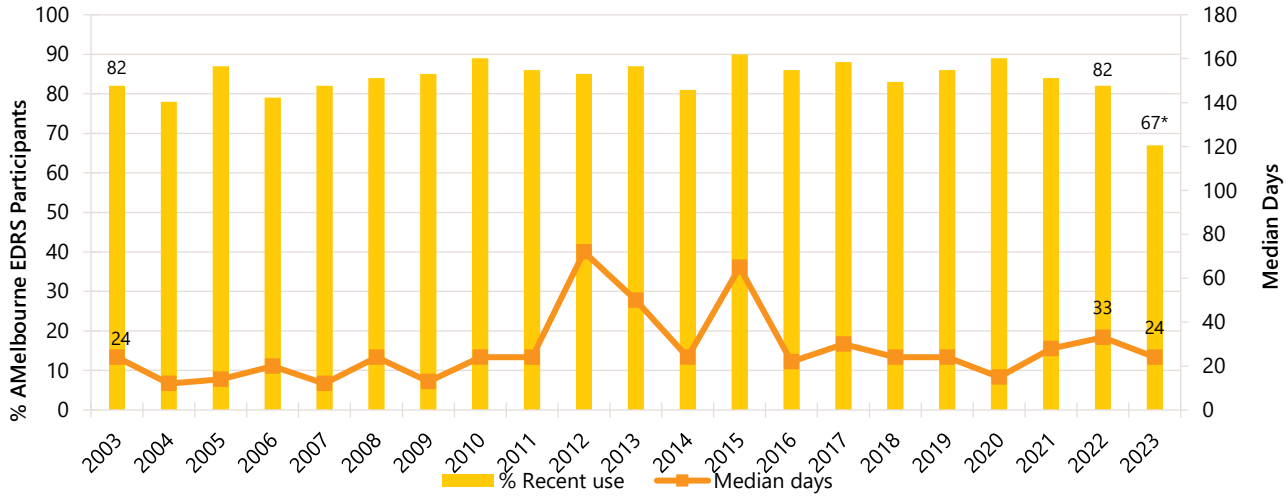
Quantity

Among those who reported recent non-prescribed use and commented (n=23), the median amount of cannabis reportedly used on the last occasion of use was 0.50 grams (IQR= 0.50–1.30; 1.00 in 2022; IQR=0.50–1.10; n=28; p=0.494), or one joint (IQR=0.50–1.00; n=22; 1.00 in 2022; IQR=0.50–1.00; n=26; p=0.973). Few participants (n≤5) reported using cones on the last occasion of use (2.5 cones in 2022; IQR=1.00–4.00; n=6; p=0.740).

Forms Used

Among participants who reported recent non-prescribed cannabis and/or cannabinoid-related product consumption and commented (n=52), half (50%) reported recent use of hydroponic cannabis (65% in 2022; p=0.143), followed by 46% reporting recent use of outdoor-grown 'bush' cannabis (37% in 2022; p=0.349). Few participants (n≤5) reported having used hashish (n≤5 in 2022), hash oil (n≤5 in 2022), or CBD extract (12% in 2022; p=0.550) in the preceding six months. Twenty-three per cent of participants reported recent use of (non-prescribed) THC extract (21% in 2022; p=0.817).

Figure 40: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid related products, Melbourne, VIC, 2003-2023



Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2020 figures include some participants who were using prescribed cannabis only (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Further, in 2022, we captured use of 'cannabis and/or cannabinoid related products', while in previous years questions referred only to 'cannabis'. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Price, Perceived Potency and Perceived Availability

Hydroponic Cannabis

Price: Few participants (n≤5) reported on the price of hydroponic cannabis in 2023; therefore, these data are supressed ($250 in 2022; IQR=250–288; n=6; *p*=0.600) (Figure 41a).

Perceived Potency: The perceived potency of non-prescribed hydroponic cannabis in 2023 was comparable to 2022. Among those who were able to respond in 2023 (n=18), 44% perceived non-prescribed hydroponic cannabis to be of 'high' potency (62% in 2022), followed by 39% reporting 'medium' potency (27% in 2022) (Figure 42a).

Perceived Availability: The perceived availability of non-prescribed hydroponic cannabis in 2023 was comparable to 2022. Among those who were able to respond in 2023 (n=18), 67% perceived non-prescribed hydroponic cannabis to be 'very easy' to obtain (56% in 2022) (Figure 43a).

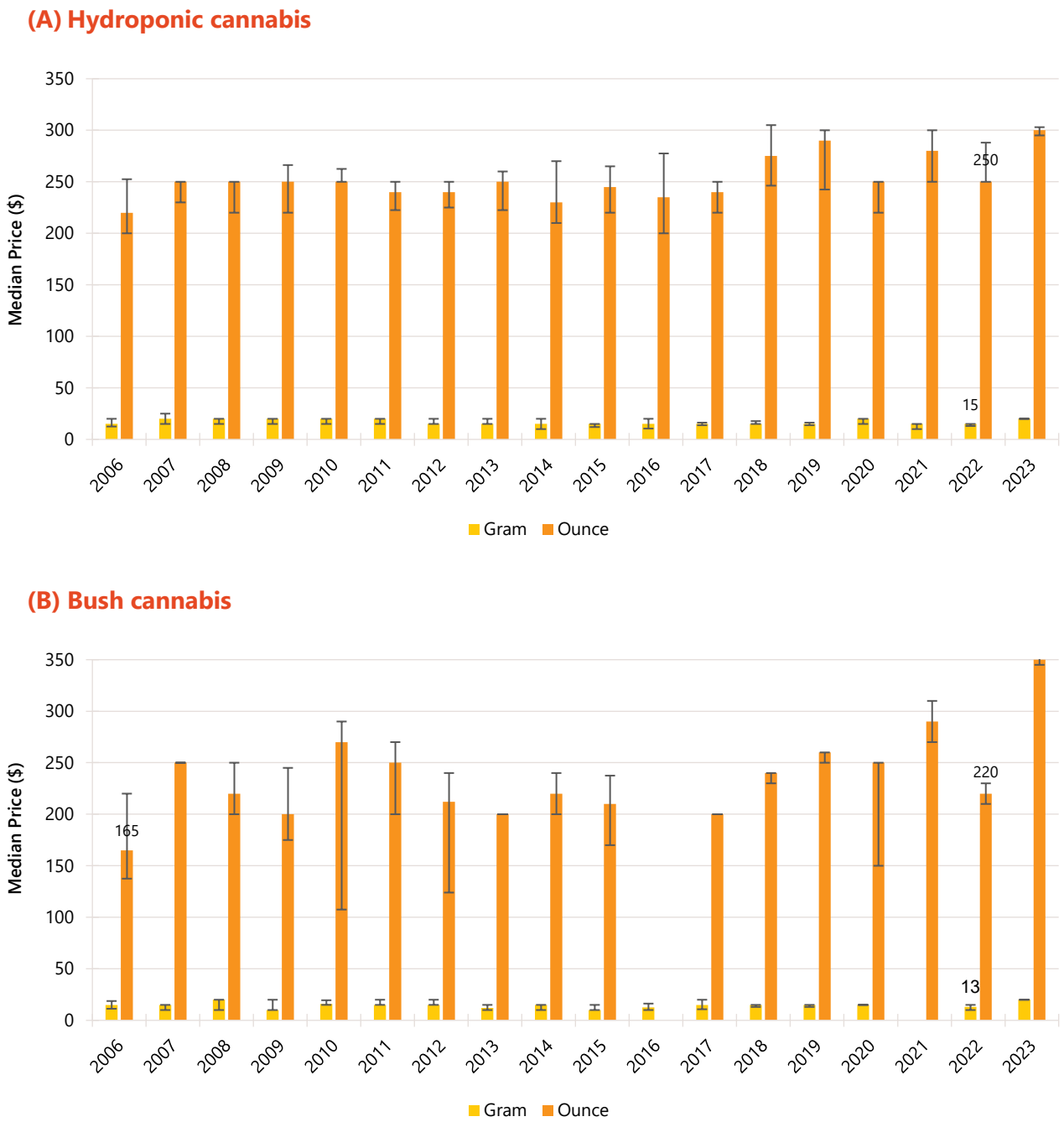
Bush Cannabis

Price: Few participants (n≤5) reported on the price of bush cannabis in 2023; therefore these data are supressed ($13 for a gram in 2022; IQR=10–15; n=6; *p*=0.290) (Figure 41b).

Perceived Potency: The perceived potency of non-prescribed bush cannabis in 2023 was comparable to 2022 (*p*=0.916). Among those who were able to respond in 2023 (n=11), 55% perceived the potency of non-prescribed bush cannabis to be 'high' (n≤5 in 2022) (Figure 42b).

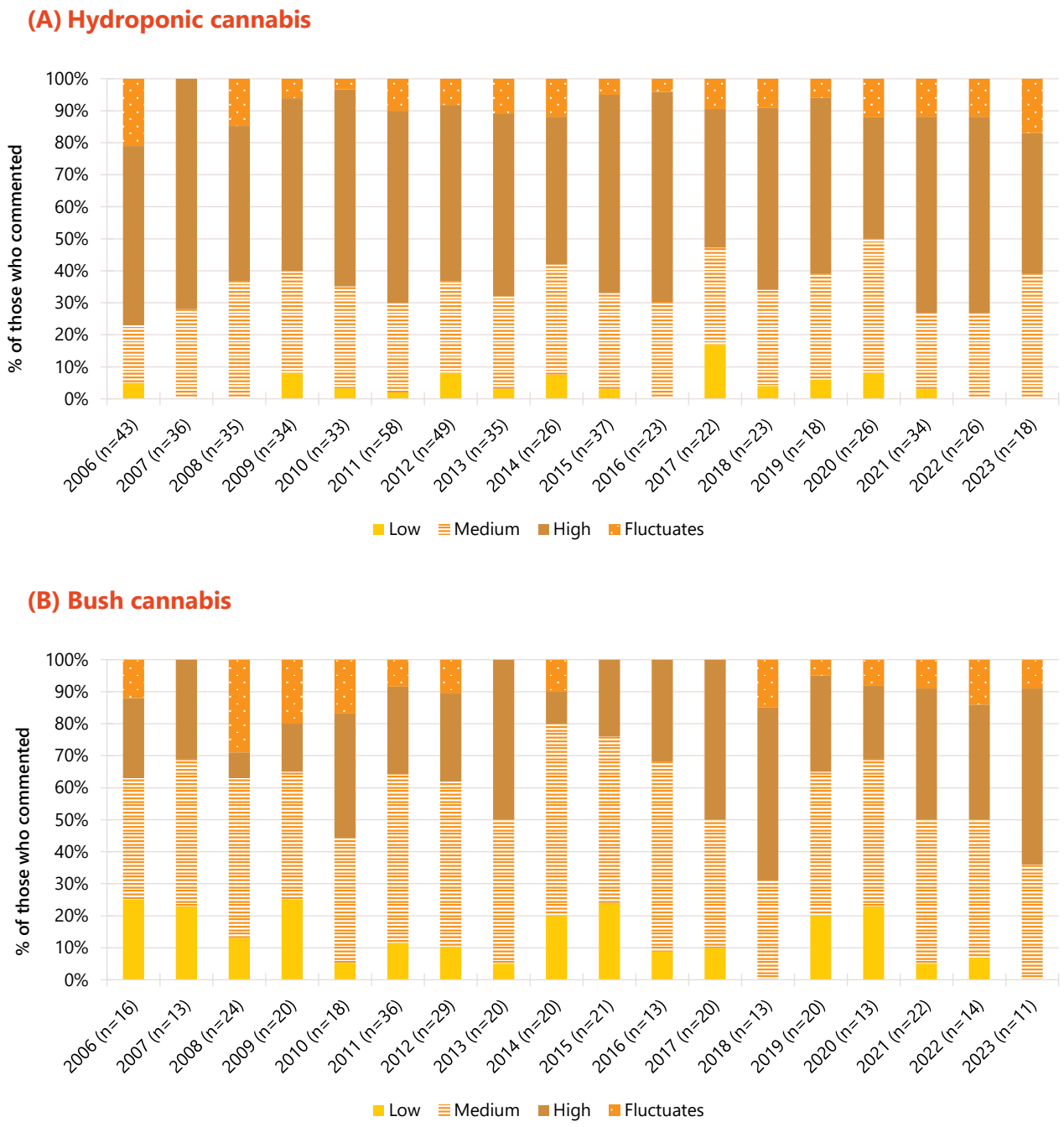
Perceived Availability: The perceived availability of non-prescribed bush cannabis in 2023 was comparable to 2022 (*p*=0.612). Among those who were able to respond in 2023 (n=11), most (64%) perceived non-prescribed bush cannabis to be 'very easy' to obtain (64% in 2022) (Figure 43b).

Figure 41: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Melbourne, VIC, 2006-2023



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 (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

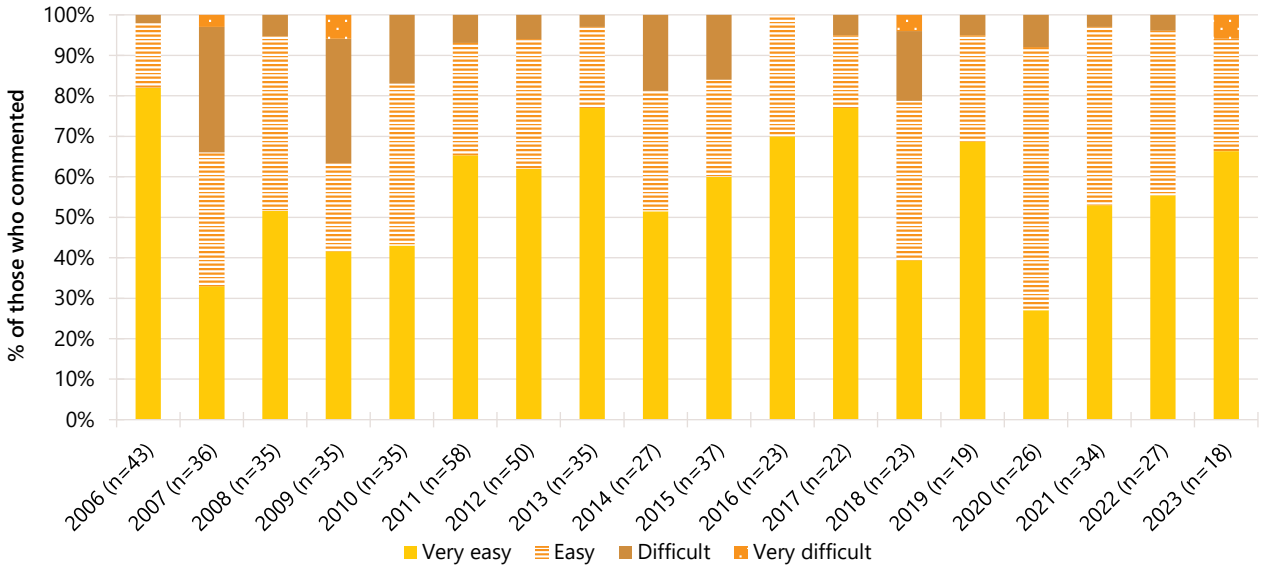
Figure 42: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Melbourne, VIC, 2006-2023



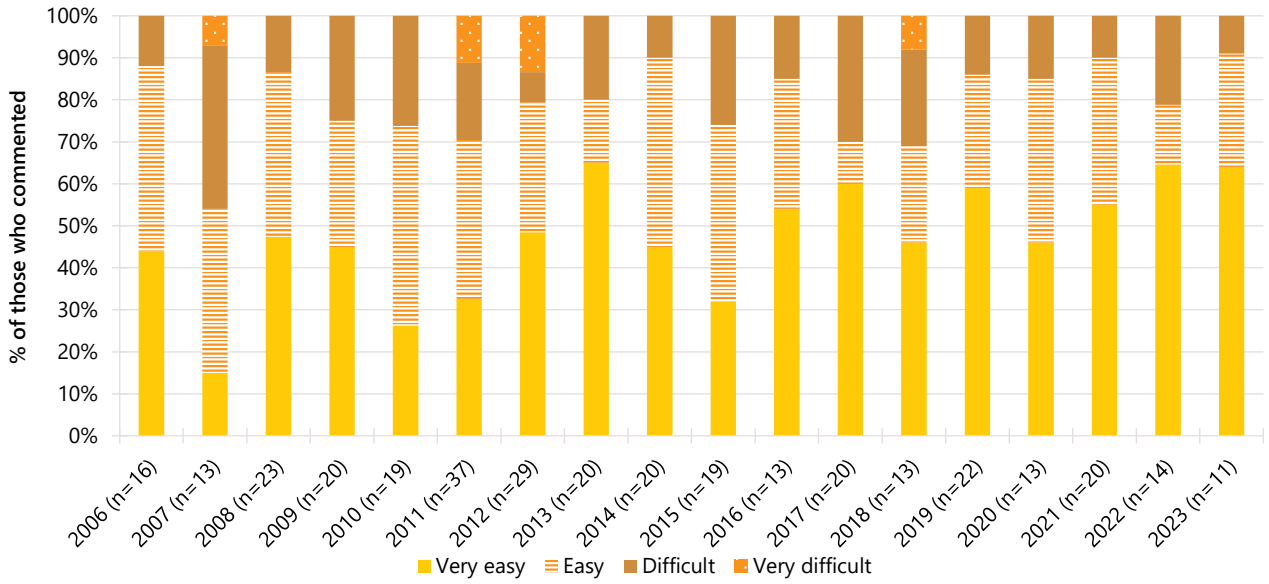
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the price of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are only provided for the first (2006) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Figure 43: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Melbourne, VIC, 2006-2023

(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; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants who reported on the price of prescribed cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Routinely Collected Data

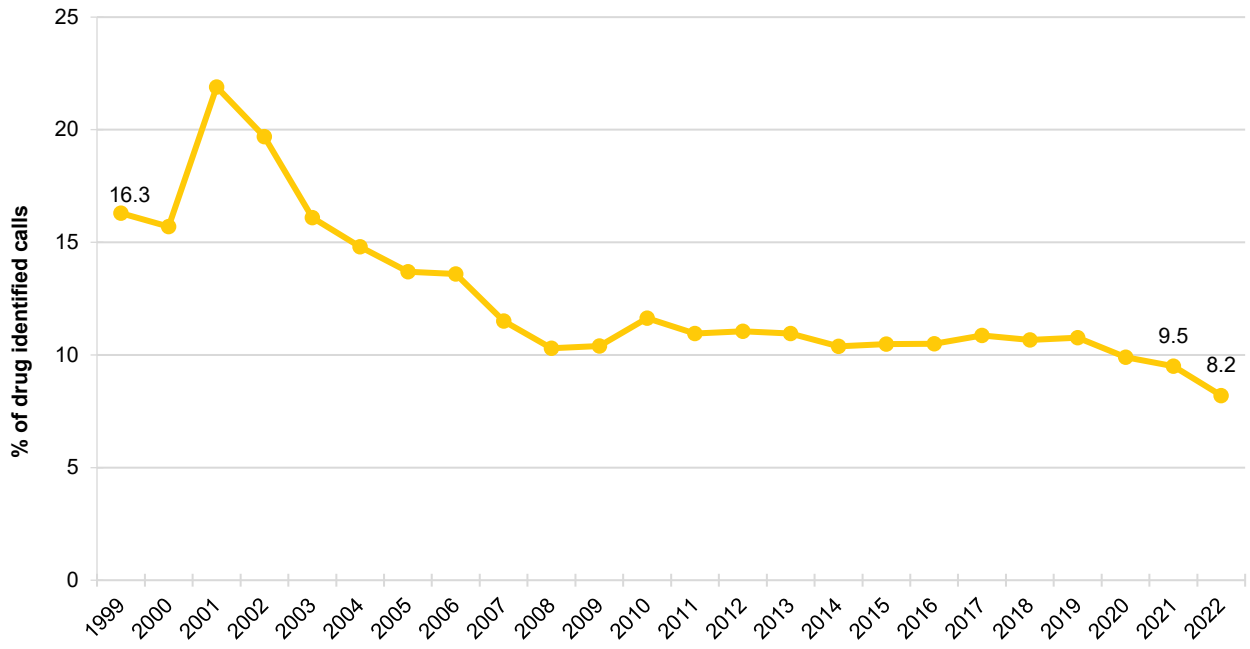
ADIS\VADC

In 2021/22, 9,356 courses of treatment were delivered to 5,316 clients for cannabis, equivalent to 14.2% and 13.4% of the total courses delivered and clients treated. These were 29.6% and 23.0% increases from courses delivered and clients treated in 2020/21 (7,218 and 4,322, respectively).

DirectLine

During 2022, DirectLine received 1,226 calls in which cannabis was identified as the drug of concern – 8.2% 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 largely consistent since 2008, but declining since 2019 (Figure 44).

Figure 44: Percentage of calls to DirectLine in which cannabis was identified as drug of concern, Victoria 1999–2022



Source: DirectLine, Turning Point. Data labels provided are only provided for the first (1999) and the two most recent years (2021 and 2022) of monitoring.

7

Ketamine, LSD and DMT

Non-Prescribed Ketamine

Patterns of Consumption

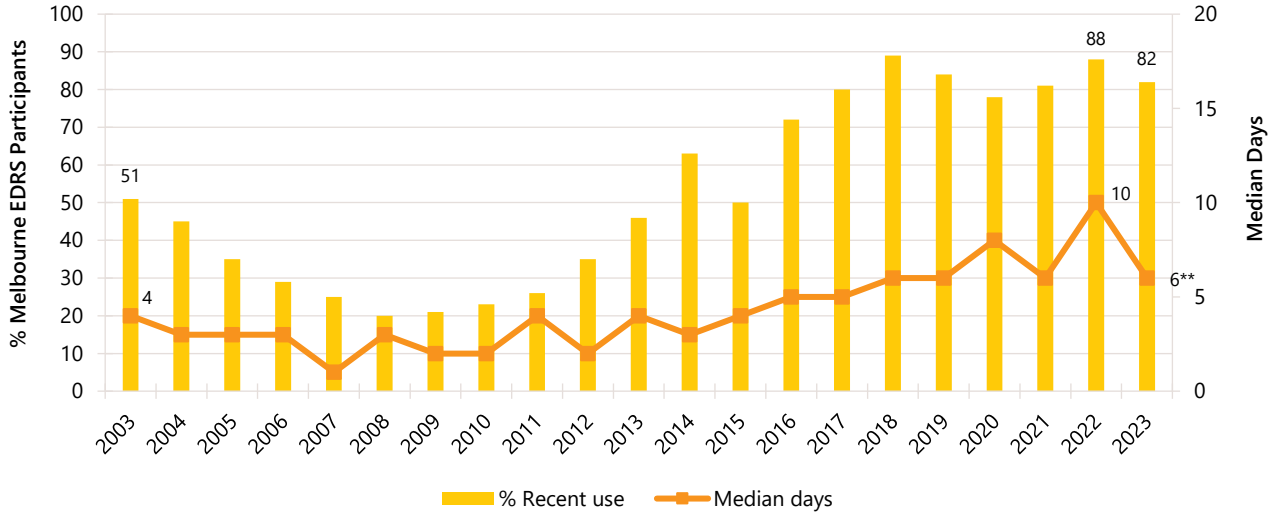
Recent Use (past 6 months): Reported recent use of ketamine increased steadily through to 2017 before plateauing. The majority (82%) of the sample reported using ketamine in the six months prior to interview in 2023, comparable to 2022 (88%; p=0.327) (Figure 45).

Frequency of Use: In 2023, of those who reported recent ketamine consumption and commented (n=82), frequency of reported use decreased significantly from 10 days (IQR=5–15) in 2022 to a median of six days (IQR=2–10) in the past six months and equivalent to nearly monthly use (p=0.003) (Figure 45). Eleven per cent of participants reported weekly or more frequent ketamine use in 2023, comparable to 14% in 2022 (p=0.648).

Routes of Administration: Among participants who reported recent ketamine consumption and commented (n=82), all (100%) reported snorting in 2023, comparable to 2022 (99%).

Quantity: Of those who reported recent ketamine consumption and commented (n=47), the median amount of ketamine reportedly used in a 'typical' session was 0.30 grams (IQR=0.20–0.40), a significant decrease from 2022 (0.40 grams; IQR=0.30–0.50; p=0.035). Of those who reported recent use and commented (n=49), the median maximum amount reportedly used in a session `was 0.50 grams (IQR=0.30–0.60), a significant decrease from 2022 (0.80 grams; IQR=0.40–1.00; p=0.016).

Figure 45: Past six month use and frequency of use of non-prescribed ketamine, Melbourne, VIC, 2003-2023



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 from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

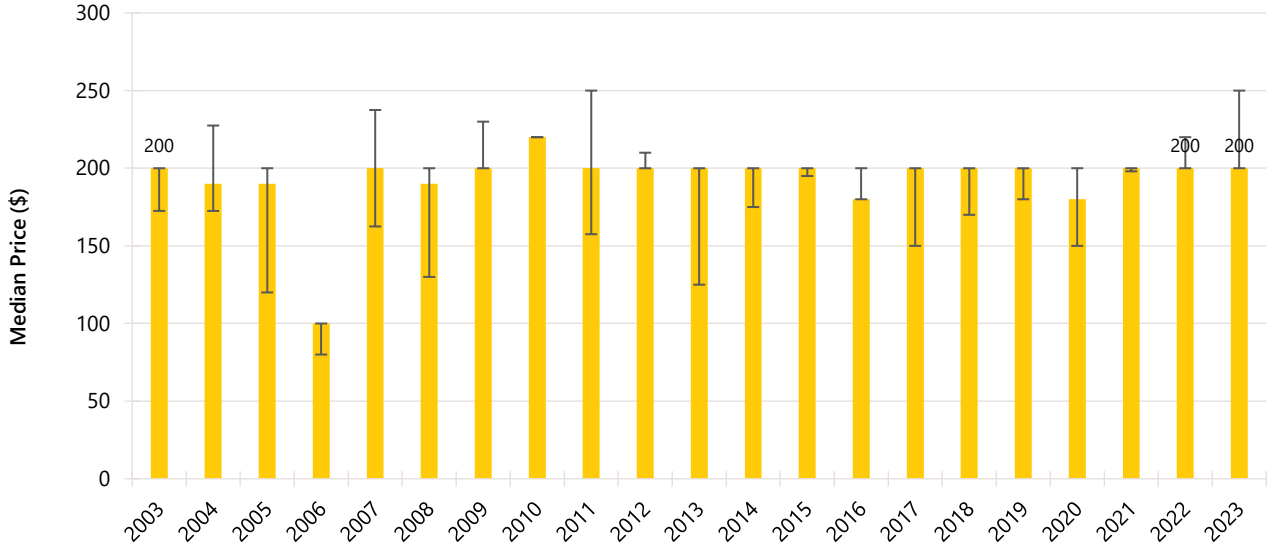
Price, Perceived Purity and Perceived Availability

Price: In 2022, the median reported price per gram of ketamine was $200 (IQR=200–250; n=41), comparable to 2022 ($200; IQR=200–220; n=55; p=0.073) (Figure 46).

Perceived Purity: The perceived purity of ketamine in 2023 was comparable to 2022 (p=0.200). Among those who were able to respond in 2023 (n=57), 58% perceived the purity of ketamine to be 'high' (40% in 2022), with 23% reporting 'medium' purity (27% in 2022) and a further 16% reporting that purity 'fluctuates' (27% in 2022) (Figure 47).

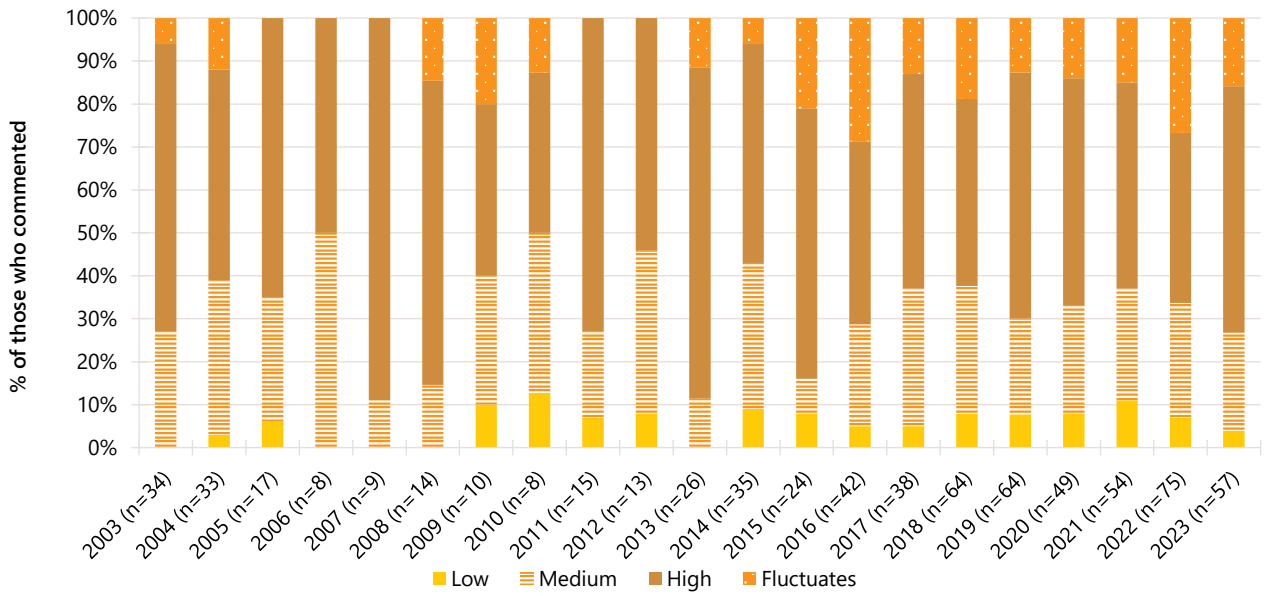
Perceived Availability: There was a significant difference in the perceived availability of ketamine between 2022 and 2023 (p<0.001). Of those who were able to respond in 2022 (n=57), half (49%) perceived ketamine to be 'easy' to obtain (54% in 2022), while a greater percentage (42%) reported it to be 'very easy' to obtain compared to 2022 (15%). Fewer participants reported it to be 'difficult' to obtain (n≤5; 25% in 2022) (Figure 48).

Figure 46: Median price of non-prescribed ketamine per gram, Melbourne, VIC, 2003-2023



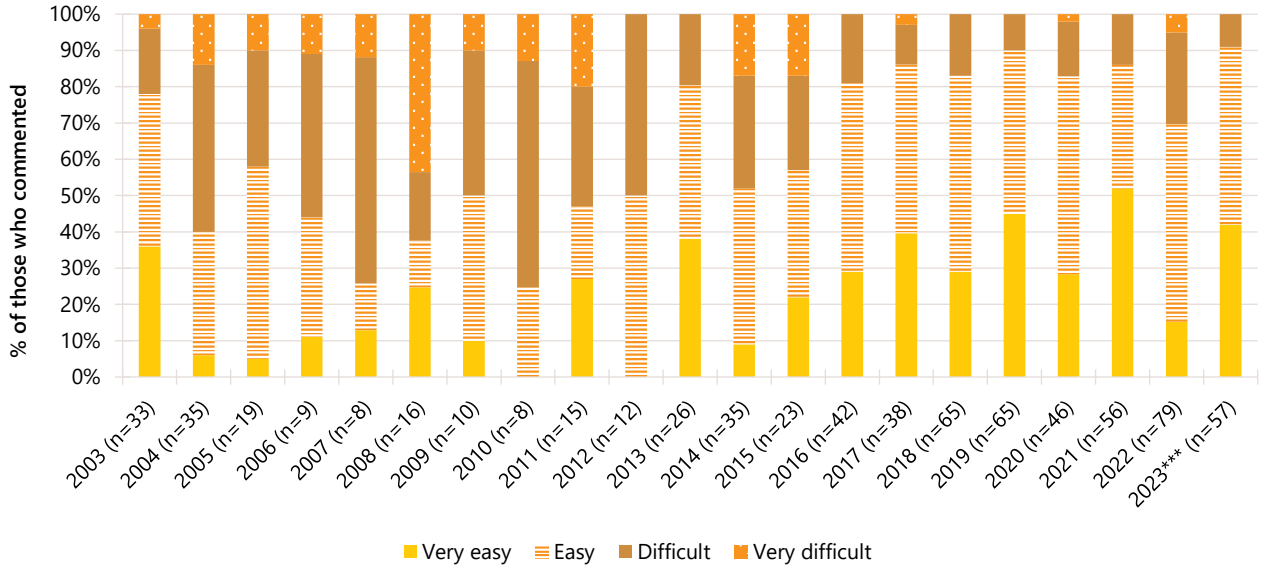
Note. Among those who commented. No participants reported purchasing ketamine in 2014 and 2015. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Figure 47: Current perceived purity of non-precribed ketamine, Melbourne, VIC, 2003-2023



Note. The response option 'Don't know' was excluded from analysis. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Figure 48: Current perceived availability of non-prescribed ketamine, Melbourne, VIC, 2003-2023



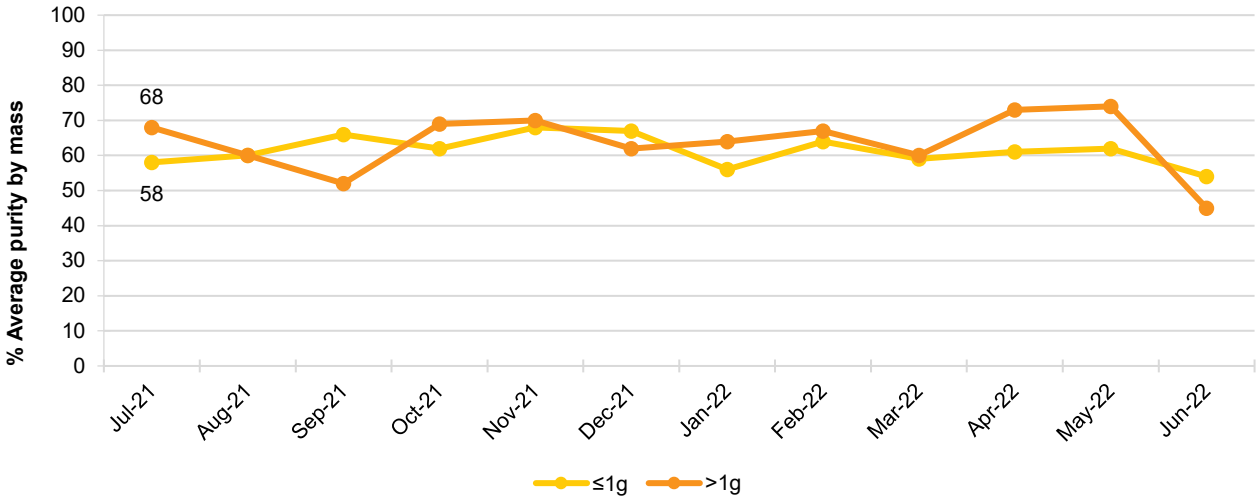
Note. The response option 'Don't know' was excluded from analysis. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 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 2021/22 financial year averaged 61% purity in samples weighing one gram or less (IQR=59–65, range=54–68) and 64% in samples weighing over one gram (IQR=60–69, range=45–74) (Figure 49).

Figure 49: Purity of ketamine seizures by Victorian law enforcement, July 2021–June 2022



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) month of monitoring.

LSD

Patterns of Consumption

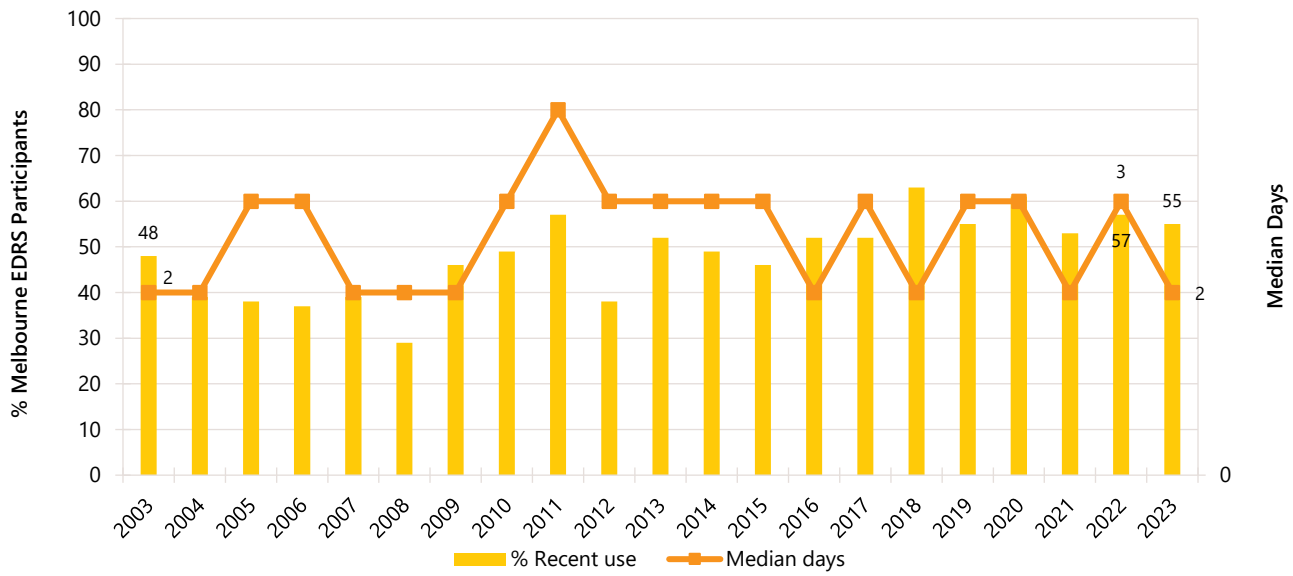
Recent Use (past 6 months): Fifty-five per cent of the sample reported using LSD in the six months preceding interview, comparable to 57% recorded in 2022 (p=0.883) (Figure 50).

Frequency of Use: Median days of reported use has fluctuated across the period of monitoring, although the frequency of two days (IQR=1–4) in the past six months was comparable to 2022 (3 days in 2022; IQR=1–6; p=0.248) (Figure 50). Of those who reported recent LSD consumption, few participants (n≤5) reported weekly or more frequent use in 2023, therefore these data are suppressed (n≤5 in 2022).

Routes of Administration: Among those who reported recent LSD consumption and commented (n=55), all participants (100%) reported swallowing LSD in 2023 (100% in 2022).

Quantity: Of those who reported recent LSD consumption and commented (n=44), the median amount of LSD reportedly used in a 'typical' session was one tab (IQR=0.5–1.0; 1 tab in 2022; IQR=0.5–1.0; n=40; p=0.803). Of those who reported recent LSD consumption and commented (n=44), the median maximum amount used in a session was one tab (IQR=0.7–2.0; 1 tab in 2022; IQR=0.8–2.0; p=0.872).

Figure 50: Past six month use and frequency of use of LSD, Melbourne, VIC, 2003-2023



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 80 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

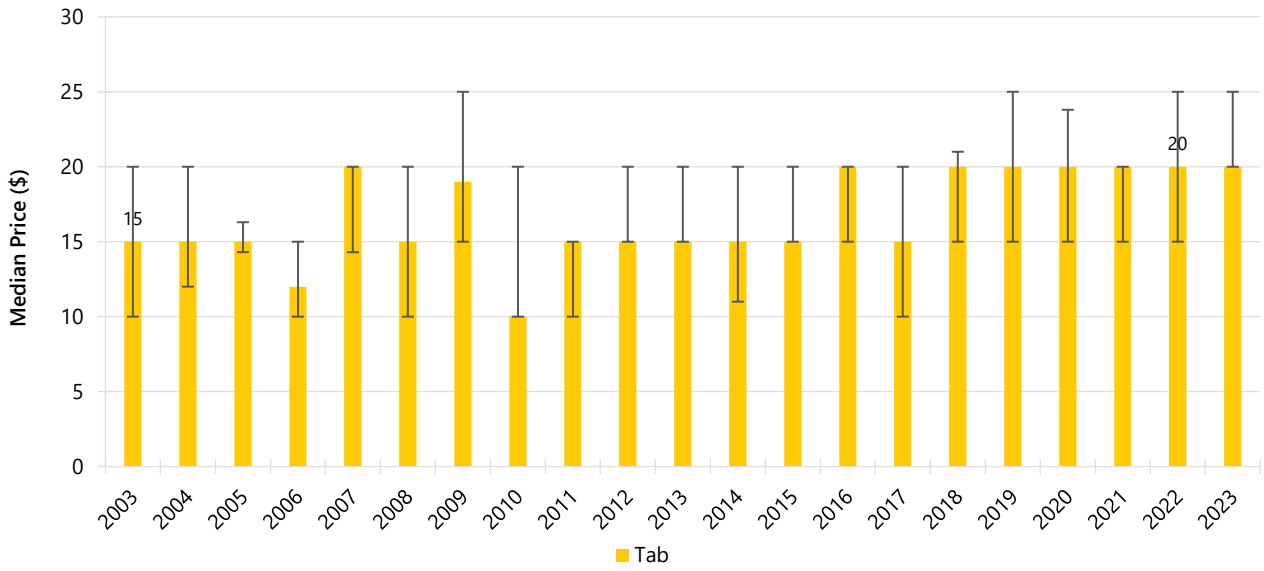
Price, Perceived Purity and Perceived Availability

Price: The median reported price for one tab of LSD has remained relatively stable since 2011, ranging from $15 to $20. In 2023, participants reported a median of $20 per tab (IQR=20–25; n=28; $20 in 2022; IQR=15–25; n=36; *p*=0.324) (Figure 51).

Perceived Purity: The perceived purity of LSD changed significantly between 2022 and 2023 (*p*=0.049). Among those who were able to respond in 2023 (n=36), more participants (44%) perceived the purity of LSD to be 'medium' (29% in 2022), with a corresponding decrease in those who reported the purity to be 'high' (39%; 59% in 2022) (Figure 52).

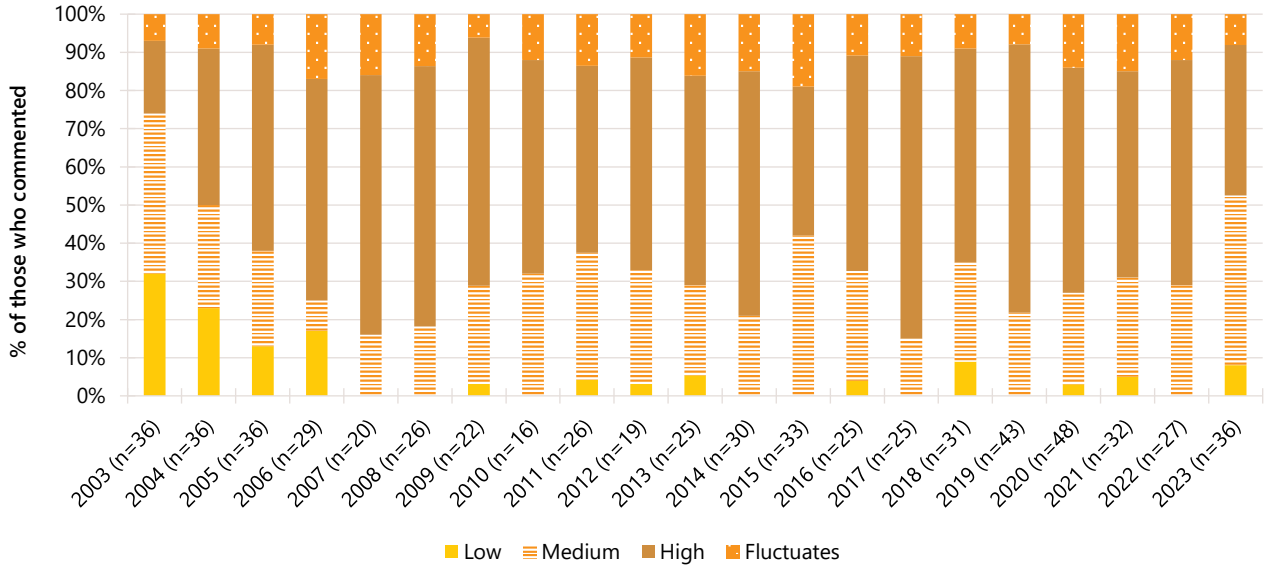
Perceived Availability: The perceived availability of LSD in 2023 was comparable to 2022 (*p*=0.124). Among those who responded in 2023 (n=40), participants most commonly reported LSD to be 'easy' to obtain (35%; 55% in 2022), with a further 33% reporting it to be 'very easy' to obtain (n≤5 in 2022), although 33% reported it to be 'difficult' to obtain (26% in 2022) (Figure 53).

Figure 51: Median price of LSD per tab, Melbourne, VIC, 2003-2023



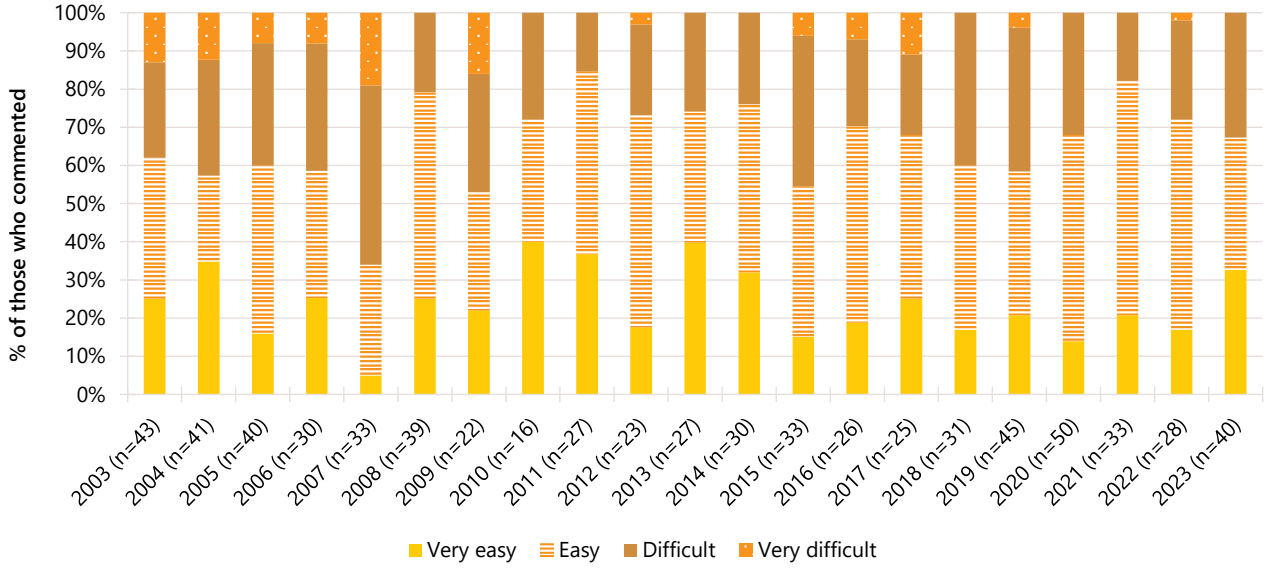
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; **p*<0.050; ***p*<0.010; ****p*<0.001.

Figure 52: Current perceived purity of LSD, Melbourne, VIC, 2003-2023



Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 53: Current perceived availability of LSD, Melbourne, VIC, 2003-2023

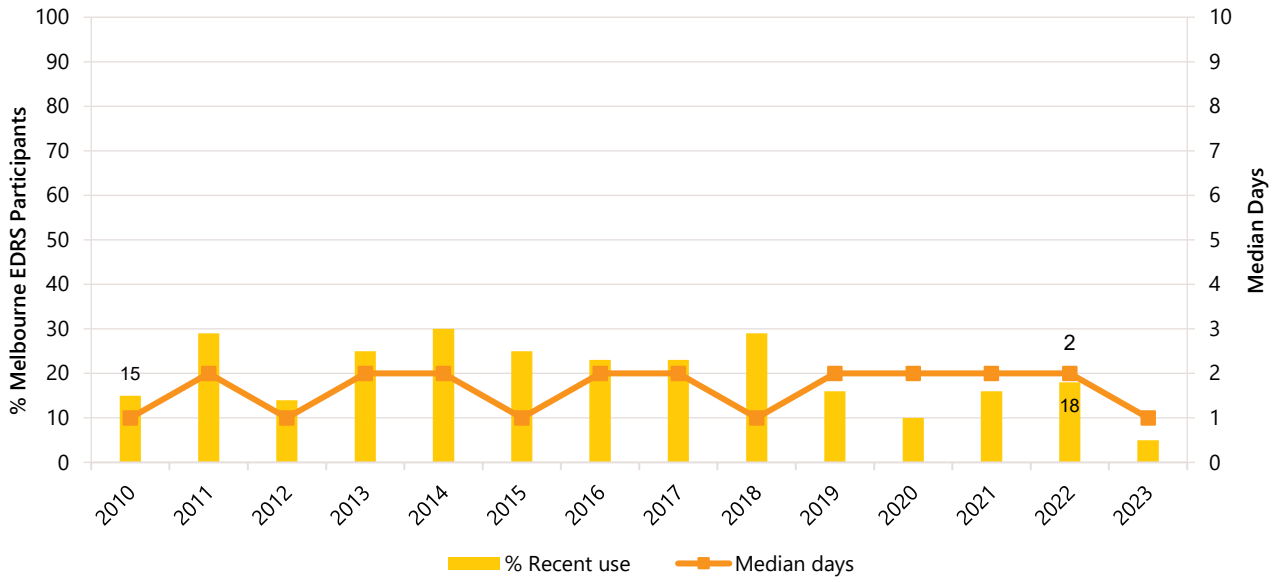


Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

DMT

Few (n≤5) participants reported recent use of DMT in 2023, therefore, further details are not reported (18% in 2022; p=0.007) (Figure 54). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Figure 54: Past six month use and frequency of use of DMT, Melbourne, VIC, 2010-2023



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 (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

8

New Psychoactive Substances

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

In previous (2010-2020) EDRS reports, DMT and paramethoxyamphetamine (PMA) were categorised as NPS. However, the classification of these substances as NPS is not universally accepted, and in 2021, the decision was made to exclude them from this category. This means that the figures presented below for recent use of tryptamine, phenethylamine and any NPS will not align with those in our 2010-2020 reports.

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

Recent Use (past 6 months)

NPS use among the Melbourne sample has fluctuated over time. In 2023, 12% of participants reported recent use of any NPS, including plant-based NPS, in the past six months, comparable to 2022 (16%; p=0.537) (Table 2). Twelve per cent reported recent use of any NPS, excluding plant-based NPS, in the past six months, similar to 2022 (15%; p=0.668) (Table 2).

Forms Used

The NPS most frequently reported as having been consumed was 'dissociatives', with 7% reporting recent use in 2023; comparable to 2022 (n≤5; p=0.537) (Table 3), followed by 6% reporting recent use of 'any 2C substance' (11% in 2022; p=0.306) and 6% reporting recent use of 'any phenethylamines' (9% in 2022; p=0.435). Few participants (n≤5) reported use of any other NPS.

Table 2: Past six month use of NPS (excluding and including plant-based NPS), Melbourne, VIC, 2010-2023

	Melbourne, VIC	
%	Excluding plant-based NPS	Including plant-based NPS
2010	28	29
2011	37	40
2012	40	45
2013	45	45
2014	34	34
2015	33	36
2016	29	31
2017	27	29
2018	27	28
2019	16	17
2020	12	12
2021	21	23
2022	15	16
2023	**12**	**12**

Note. Monitoring of NPS first commenced in 2010. In 2021, the decision was made to remove DMT and PMA from the NPS category, with these substances now presented in Chapter 7 and Chapter 9, respectively. This has had a substantial impact on the percentage of the sample reporting 'any' NPS use in the past six months and means that the figures presented above will not align with those presented in previous (2010-2020) EDRS reports. – 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 2022 versus 2023 presented in table; $^{*}p<0.050$; $^{**}p<0.010$; $^{***}p<0.001$.

Table 3: Past six month use of NPS by drug type, Melbourne, VIC, 2010-2023

	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=1(00)	2022 (N=100)	2023 (N=100)
% Phenethylamines ^	-	-	14	23	22	12	13	12	11	-	8	17	11	**6**
Any 2C substance~	-	-	10	20	16	7	12	9	8	-	8	16	9	**6**
NBOMe	/	/	/	/	8	7	0	-	-	-	0	0	-	**0**
DO-x	0	0	0	0	0	0	0	-	-	0	0	0	0	**0**
4-FA	/	/	/	/	/	/	0	-	0	0	0	-	-	**0**
NBOH	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
% Tryptamines^^	0	-	-	-	0	0	0	-	-	0	0	0	0	**0**
5-MeO-DMT	0	-	-	-	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	-	/	**0**
MDPV/Ivory wave	-	-	-	-	-	0	0	-	0	0	0	0	-	**0**
Alpha PVP	/	/	/	/	/	/	-	0	0	0	0	0	/	**0**
Other substituted cathinone	/	/	0	0	0	-	0	-	0	/	/	/	/	**0**
N-ethylhexedrone	/	/	/	/	/	/	/	/	/	0	0	0	/	**0**
N-ethylpentylone	/	/	/	/	/	/	/	/	/	0	0	-	/	**0**
N-ethylbutylone	/	/	/	/	/	/	/	/	/	/	/	0	/	**0**
3-chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
4-chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
3-methylmethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0	**-**
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	-	**0**
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
N, N-Dimethyl Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
% Piperazines	-	-	-	-	0	0	0	0	/	/	/	/	/	**/**
BZP	-	-	-	-	0	0	0	0	/	/	/	/	/	**/**
% Dissociatives	/	/	-	6	/	10	9	-	6	-	-	6	-	**7**
Methoxetamine (MXE)	/	/	-	6	/	10	9	-	6	-	-	-	-	**-**
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
3-HO-PCP/4-HO-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=1(00)	2022 (N=100)	2023 (N=100)
3-MeO-PCP/4-MeO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	**-**
Other drugs that mimic the effects of dissociatives like ketamine	/	/	/	/	/	/	/	/	/	/	-	-	-	**-**
% Plant-based NPS	-	6	9	-	-	6	-	7	-	-	-	7	-	**-**
Ayahuasca	/	/	/	/	/	0	0	-	-	-	-	-	-	**-**
Mescaline	-	-	-	-	-	-	-	6	-	-	-	-	-	**0**
Salvia divinorum	/	-	-	0	-	-	-	0	0	0	0	-	0	**0**
Kratom	/	/	/	/	/	/	/	/	/	/	0	-	0	**0**
LSA	/	0	0	0	1	1	1	/	/	/	/	/	/	**0**
Datura	0	0	0	0	0	0	0	/	/	/	/	/	/	**0**
% Benzodiazepines	/	/	/	/	/	/	-	-	0	-	0	-	-	**0**
Etizolam	/	/	/	/	/	/	-	-	0	-	0	-	-	**0**
8-Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Bromazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Clonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Other drugs that mimic the effect of benzodiazepines	/	/	/	/	/	/	/	/	-	-	0	0	0	**0**
% Synthetic cannabinoids	/	-	16	18	9	8	-	-	-	0	0	-	-	**-**
% Herbal high#	/	/	7	7	-	-	-	-	0	-	/	/	/	**/**
Phenibut	/	/	/	/	/	/	/	/	/	/	-	-	/	**0**
% Other drugs that mimic the effect of opioids	/	/	/	/	/	/	/	/	0	0	0	0	/	**0**
% Other drugs that mimic the effect of ecstasy	/	/	/	/	/	/	/	0	0	-	0	0	/	**0**
% Other drugs that mimic the effect of amphetamine or cocaine	/	/	/	/	/	/	/	-	0	-	-	0	/	**0**
% Other drugs that mimic the effect of psychedelic drugs like LSD	/	/	/	/	/	/	/	-	-	-	-	0	/	**0**

Note. NPS first asked about in 2010. / not asked. ^In previous EDRS reports, PMA was included as a NPS under 'phenethylamines' and mescaline was included under both 'phenethylamines' and 'plant-based NPS'. In 2021, the decision was made to remove PMA from the NPS category altogether, while mescaline was removed from 'phenethylamines' and is now only coded under 'plant-based NPS'. This means that the percentages reported for any phenethylamine NPS use in the 2021-2023 EDRS reports will not align with those presented in earlier (2010-2020) reports. ^^In previous (2010-2020) EDRS reports, DMT was included as a NPS under 'tryptamines', however, was removed from the NPS category in 2021 (refer to Chapter 7 for further information on DMT use among the sample). This means that the percentages reported for any tryptamine NPS use in the 2021-2023 EDRS reports will not align with those presented in earlier (2010-2020) reports. # The terms 'herbal highs' and 'legal highs' appear to be used interchangeably to mean drugs that have similar effects to illicit drugs like cocaine or cannabis but are not covered by current drug law scheduling or legislation. ~ In 2010 and between 2017-2019, three forms of 2C were asked about whereas between 2011-2016 four forms were asked about. From 2020 onwards, 'any' 2C use is captured. - Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Other Drugs

Non-Prescribed Pharmaceutical Drugs

Codeine

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

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

Recent Use (past 6 months): In 2023, 7% reported using any non-prescribed codeine in the past six months (11% in 2022; p=0.453) (Figure 55).

Recent Use for Non-Pain Purposes: Few participants (n≤5) reported using non-prescribed codeine for non-pain purposes in the past six months in 2023.

Frequency of Use: Median reported frequency of use among participants who had recently used non-prescribed codeine and commented (n=7) was one day (IQR=1–4) in the past six months (2 days in 2022; IQR=1–3; n=11; p=0.811).

Pharmaceutical Opioids

Recent Use (past 6 months): In 2023, 7% of the sample reported recent non-prescribed pharmaceutical opioid use (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl, excluding codeine) in the past six months, comparable to 11% in 2022 (p=0.453) (Figure 55).

Frequency of Use: Participants who reported recent non-prescribed pharmaceutical opioid use and commented (n=7) reported use on a median of two days (IQR=1–3) in the six months preceding interview (5 days in 2022; IQR=1–7; n=10; p=0.161).

Benzodiazepines

Recent Use (past 6 months): Reports of recent use of non-prescribed benzodiazepines decreased in 2023, with 31% reporting recent use (47% in 2022; p=0.033) (Figure 55). From 2019, participants were asked about non-prescribed alprazolam versus other non-prescribed benzodiazepine use. Eighteen per cent of the sample reported recent non-prescribed use of alprazolam (29% in 2022; p=0.100), whereas 20% reported recent non-prescribed use of other benzodiazepines (31% in 2022; p=0.109).

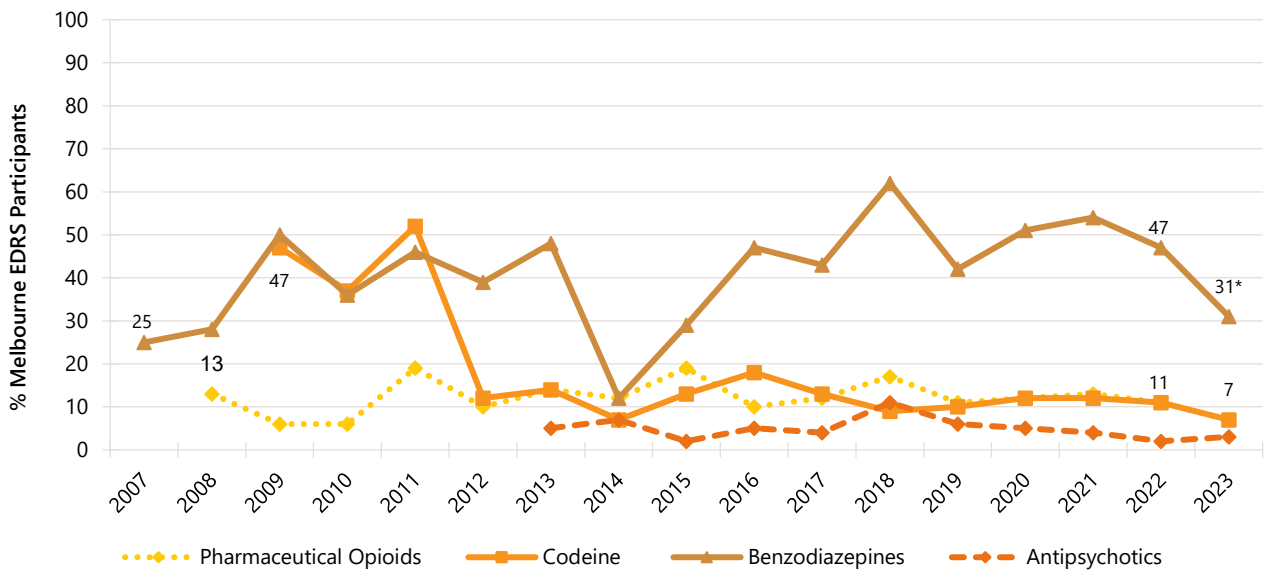
Frequency of Use: In 2023, participants who reported recent use did so on a median of five days (IQR=3–18; n=18; 3 days in 2022; IQR=2–6; n=29; p=0.067) and three days (IQR=2–5; n=20; 4 days in 2022; IQR=2–9; n=31; p=0.572) of non-prescribed alprazolam and other benzodiazepine use in the past six months, respectively.

Forms Used: There was a significant change in the form of benzodiazepines reportedly used among the sample in 2023 compared to 2022 (p=0.031). Among participants who had recently consumed non-prescribed benzodiazepines and commented (n=20), half (50%) of participants reported using clonazepam (n≤5 in 2022), with the remaining half (50%) reporting using diazepam (18% in 2022).

Antipsychotics

Few (n≤5) participants reported recent non-prescribed use of antipsychotics in 2023, therefore, further details are not reported (n≤5 in 2022) (Figure 55). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Figure 55: Non-prescribed use of pharmaceutical medicines in the past six months, Melbourne, VIC, 2007-2023



Note. Non-prescribed use is reported for prescription medicines. Monitoring of benzodiazepines commenced in 2007, and pharmaceutical opioids and antipsychotics in 2013. Monitoring of over-the-counter (OTC) codeine (low-dose codeine) commenced in 2010, however, in February 2018, the scheduling for codeine changed such that low-dose codeine formerly available OTC was required to be obtained via a prescription. To allow for comparability of data, the time series here represents non-prescribed low- and high dose codeine (2018-2023), with high-dose codeine excluded from pharmaceutical opioids from 2018. Y axis has been reduced to 60% to improve visibility of trends. Data labels are only provided for the first (2007/2013/2018) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 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, but there was a significant decrease from 2022 to 2023, with 49% of the sample reporting recent use in the past six months in 2023 (64% in 2022; p=0.049) (Figure 56).

Frequency of Use: The median reported number of days of hallucinogenic mushroom use in the past six months was two (IQR=1–3; n=49) in 2023 (3 days in 2022; IQR=1–4; n=64; p=0.113).

MDA

Due to low numbers (n≤5) reporting recent use of MDA, further details are not reported (7% in 2022; *p*=0.101) (Figure 56). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Substance with Unknown Contents

Capsules: Few (n≤5) participants reported recent use of capsules with unknown contents in 2023, therefore, further details are not reported (n≤5 in 2022) (Figure 56). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Other Unknown Substances: From 2019, we asked participants about their use more broadly of substances with 'unknown contents'. Fourteen per cent of participants reported use of any substance with 'unknown contents' in 2023 (20% in 2022; *p*=0.347) on a median of two days (IQR=1–2; 1 day in 2022; IQR=1–2; *p*=0.494).

When broken down by substance form, 14% of participants reported use of powder with 'contents unknown' (15% in 2022). Few (n≤5) participants reported recent use of pills with unknown contents in 2023, therefore these data are suppressed. No participants reported recent use of crystal with unknown contents in 2023 (n≤5 in 2022; *p*=0.497).

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 2023, 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 in 2022 (no participants in 2022) (Figure 56). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

PMMA

Due to low numbers (n≤5) reporting on recent use of PMMA, numbers have been suppressed (n≤5 in 2022). For further information, please refer to the National EDRS report, or contact the Drug Trends team for further information.

Heroin

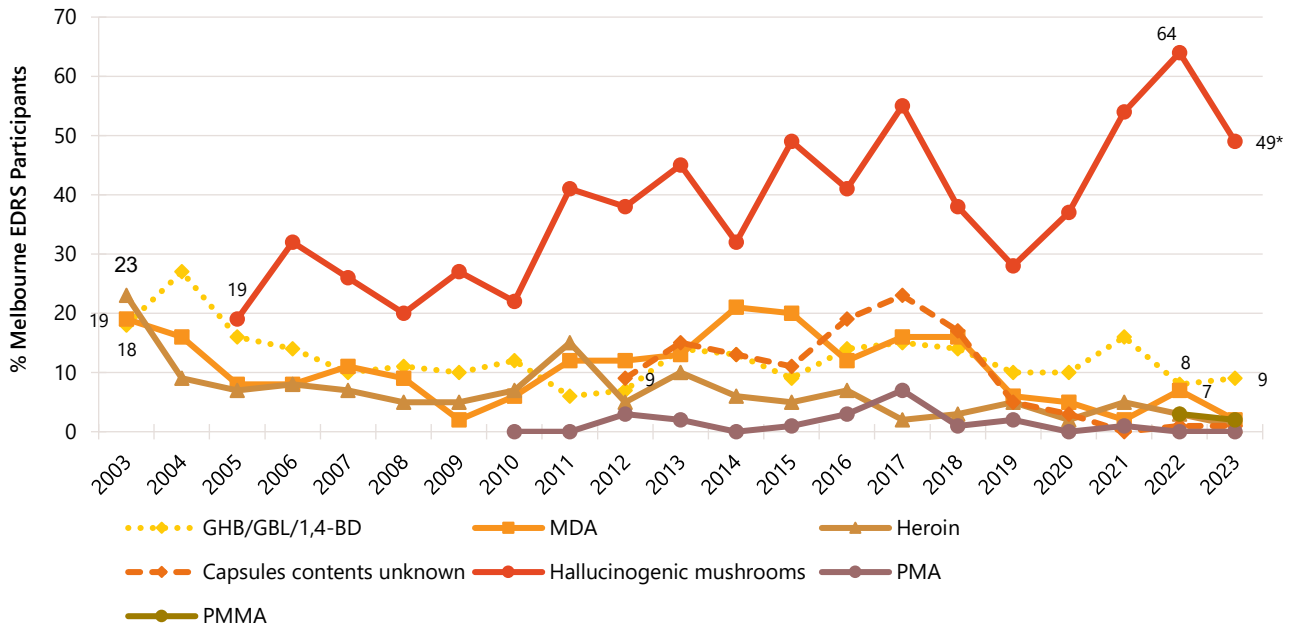
Few (n≤5) participants reported recent use of heroin in 2023, therefore, further details are not reported (n≤5 in 2022; *p*=0.621) (Figure 56). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

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

Recent Use (past 6 months): In 2022, 9% of the sample reported recent use of GHB/GBL/1,4-BD in the past six months, comparable to 2022 (8%) (Figure 56).

Frequency of Use: The median number of days of GHB/GBL/1,4-BD use reported in the past six months was one (IQR=1–1; n=9) in 2023 (4 days in 2022; IQR=1–12; n=8; *p*=0.284).

Figure 56: Past six month use of other illicit drugs, Melbourne, VIC, 2003-2023



Note. Monitoring of hallucinogenic mushrooms commenced in 2005. Monitoring of capsules contents unknown commenced in 2013; note that in 2019, participants were asked more broadly about 'substances contents unknown' (with further ascertainment by form) which may have impacted the estimate for 'capsules contents unknown'. Monitoring of PMA commenced in 2010 and monitoring of PMMA commenced in 2022. Y axis has been reduced to 70% to improve visibility of trends. Data labels are only provided for the first (2003/2005/2010/2013) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 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 (96%) reported recent use of alcohol in 2023, stable from 96% in 2022 (Figure 57).

Frequency of Use: The median reported number of days of alcohol use in the past six months was 48 (IQR=20–72; n=96) in 2023 (48 days in 2022; IQR=24–72; n=96; p=0.258). Seventy per cent of those who reported recent alcohol consumption reported having done so weekly or more frequently in 2023, comparable to 2022 (80%; p=0.307). Few (≤5) participants reported daily use of alcohol in 2023 (n≤5 in 2022).

Tobacco

Recent Use (past 6 months): Fifty-six per cent of the sample reported tobacco use in the past six months in 2023, a significant decrease from 71% in 2022 (p=0.044) (Figure 57).

Frequency of Use: The median reported number of days of tobacco use was 14 days in 2023 (IQR=5–100; n=56; 48 days in 2022; IQR=6–143; n=70; p=0.117), with 12% of these participants reporting daily use (24% in 2022; p=0.827).

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, from 2022, participants were asked about their use of both prescribed and non-prescribed e-cigarettes. No participants in Melbourne reported recent use of prescribed e-cigarettes in 2023.

Recent Use (past 6 months): Seventy-three per cent of the 2023 sample reported non-prescribed e-cigarette use in the past six months, comparable to 2022 (71%; p=0.872) (Figure 57). No participants reported use of prescribed e-cigarettes in the six months preceding interview in 2023 (n≤5 in 2022; p=0.497).

Frequency of Use: The median frequency of non-prescribed e-cigarette use in the past six months was 90 days in 2023 (IQR=20–180; n=73), comparable to 35 days of use in 2022 (IQR=12–170; n=71; p=0.052).

Forms Used: Among participants who responded (n=73), 96% reported using e-cigarettes containing nicotine, whereas 12% reported using e-cigarettes containing cannabis. A further 10% reported using e-cigarettes containing both nicotine and cannabis. Few participants (n≤5) reported using e-cigarettes that did not contain nicotine or cannabis; therefore, these data are supressed.

Reason for Use: Of those who reported any (i.e., prescribed and non-prescribed) e-cigarette use and commented (n=73), 26% reported that they used e-cigarettes as a smoking cessation tool in 2023 (19% in 2022), while 74% did not (81% in 2022; p=0.439).

Nitrous Oxide

Recent Use (past 6 months): Forty-two per cent of participants reported recent use of nitrous oxide in 2023, a significant decrease from 61% in 2022 (p=0.016) (Figure 57).

Frequency of Use: In 2023, the frequency of reported nitrous oxide use on a median of three days (IQR=1–7; n=42) in the past six months was comparable to 2022 (4 days; IQR=3–6; n=60; p=0.416).

Quantity: Among those who reported recent nitrous oxide use and commented (n=36), the median amount used in a 'typical' session was 4.5 bulbs (IQR=2–10; 5 bulbs in 2022; IQR=2–20; n=61; p=0.599). Of those who reported recent use and responded (n=36), the median maximum amount used in a session was 6.5 bulbs (IQR=2–20; 10 bulbs in 2022; IQR=2.8–40; n=60; p=0.269).

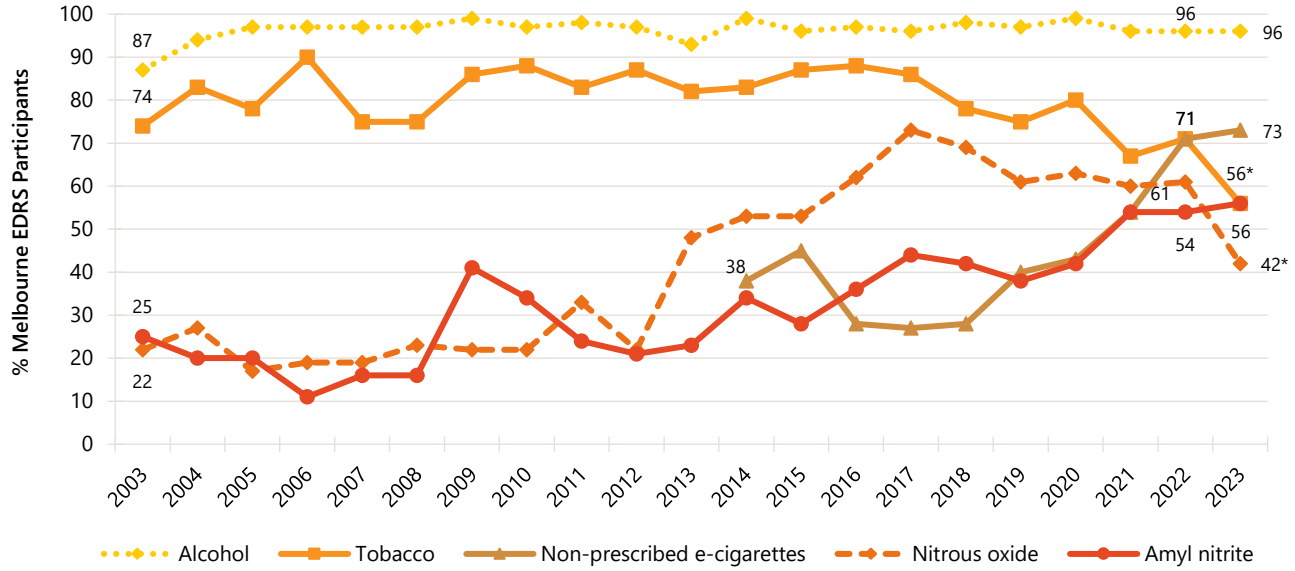
Amyl Nitrite

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

Recent Use (past 6 months): The proportion reporting recent use of amyl nitrite was 56% in 2023, comparable to 2022 (54%; p=0.883) (Figure 57).

Frequency of Use: The median frequency of use in the past six months was four days (IQR=2–13; n=56; 3 days in 2022; IQR=2–5; n=54; p=0.109).

Figure 57: Licit and other drugs used in the past six months, Melbourne, VIC, 2003-2023



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 (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

9

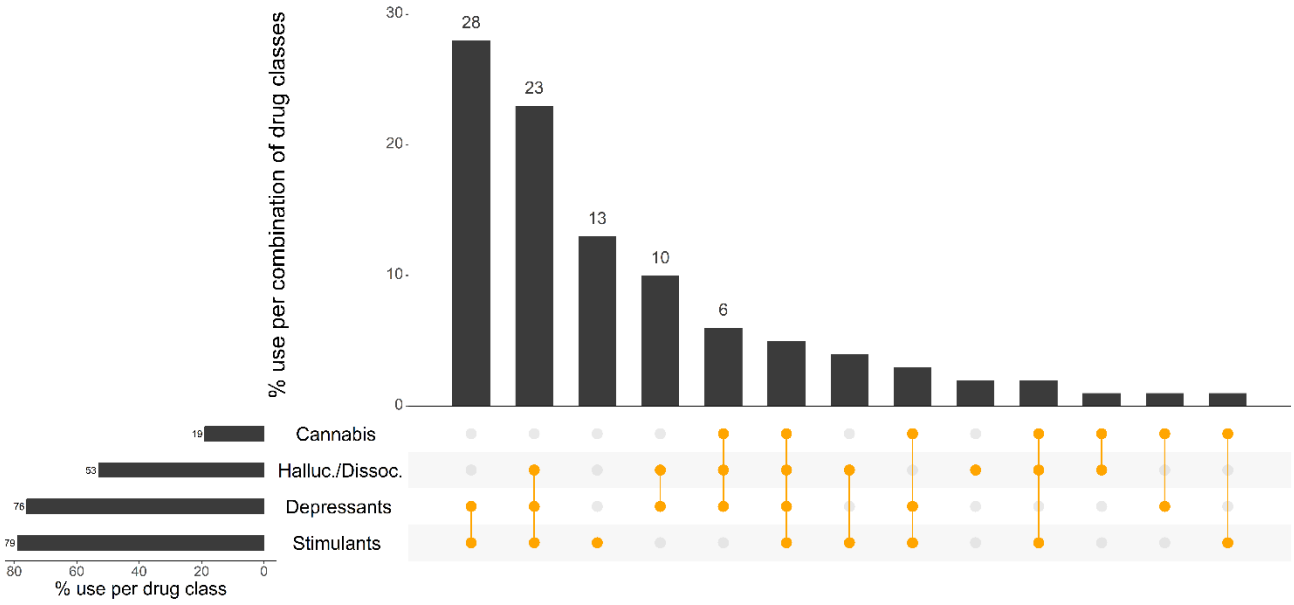
Drug-Related Harms and Other Behaviours

Polysubstance Use

On the last occasion of ecstasy or related drug use and among those who commented (n=99), the most commonly used substances were alcohol (74%) and ecstasy (54%), followed by ketamine (43%) and cocaine (26%).

The majority (86%; n=85) 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 (28%), followed by stimulants, depressants, and hallucinogens/dissociatives (23%). Thirteen per cent of participants reported using stimulants alone, 10% reported using depressants and hallucinogens/dissociatives, and 6% reported using depressants, hallucinogens/dissociatives and cannabis (Figure 58).

Figure 58: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Melbourne, VIC, 2023: Most common drug pattern profiles



Note. % calculated out of total EDRS 2023 sample. The horizontal bars represent the per cent of participants who reported use of each substance on their last occasion of ecstasy or related drug use; the vertical columns represent the per cent of participants who used the combination of drug classes represented by the orange circles. Drug use pattern profiles reported by ≤5 participants or which did not include any of the four drug classes depicted are not shown in the figure but are counted in the denominator. Halluc./Dissoc = hallucinogens/dissociatives (LSD, hallucinogenic mushrooms, amyl nitrite, DMT, ketamine and/or nitrous oxide); depressants (alcohol, GHB/GBL,1,4-BD, kava, opioids and/or benzodiazepines); stimulants (cocaine, MDA, ecstasy, methamphetamine, and/or pharmaceutical stimulants). Use of benzodiazepines, opioids and stimulants could be prescribed or non-prescribed use. Note that participants may report use of multiple substances within a class. Y axis reduced to 38% to improve visibility of trends.

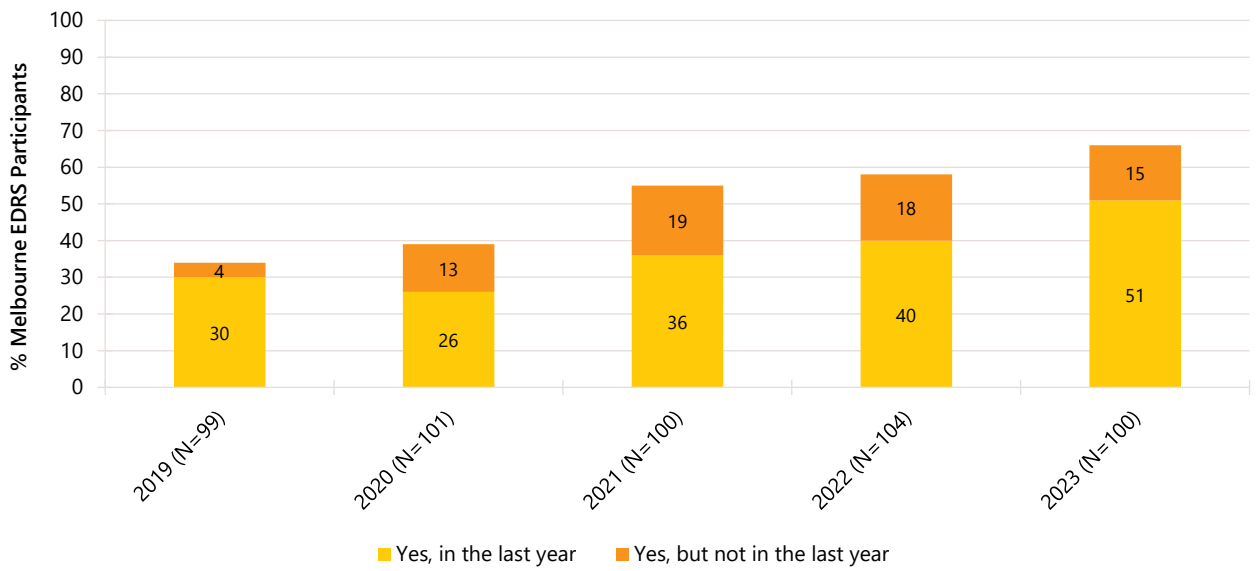
Drug Checking

Drug checking is a common strategy used to test the contents and purity of illicit drugs. At the time of interviewing in 2023, the only government-sanctioned drug checking services that had operated in Australia were at the Groovin the Moo festival in Canberra, ACT (2018, 2019) and at CanTEST, a fixed-site drug checking service in Canberra which has been operational since 17 July 2022.

In 2023, 51% 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 (40% in 2022; p=0.159) (Figure 59). Of those who reported that they or someone else had tested their illicit drugs in the past year (n=40), 90% 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) or 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=51), 41% reported having their drugs tested by a friend, followed by 37% who reported testing the drugs themselves, and 20% by a dealer.

Figure 59: Lifetime and past year engagement in drug checking, Melbourne, VIC, 2019-2023



Note: The response option 'Don't know' was excluded from analysis. Data labels are only provided for the first (2019) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2022 versus 2023 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 12.3 (SD= 7.3) in 2023, a significant decrease from 12.9 (SD= 7.2) in 2022

($p<0.001$). 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 (74%) of the sample obtained a score of eight or more (76% in 2022; $p=0.868$), indicative of hazardous use (Table 4).

Table 4: AUDIT total scores and per cent of participants scoring above recommended levels, Melbourne, VIC, 2010-2023

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
	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	N=100
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)	**12.3*** ** (7.3)**
Score 8 or above (%)	86	90	88	86	89	81	74	83	85	74	77	72	76	**74**
AUDIT zones:														
Score 0-7	22	19	18	30	22	29	34	38	19	26	18	27	24	**26**
Score 8-15	31	43	40	41	51	47	43	43	55	50	57	43	44	**43**
Score 16-19	24	22	12	10	13	12	12	7	12	7	15	18	14	**15**
Score 20 or higher	24	15	30	19	14	11	10	11	14	17	9	12	17	**16**

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. – Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$. Imputation used for missing scale scores. Computed from the entire sample regardless of whether they had consumed alcohol in the past six months.

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 survey module. Participants were asked about alcohol, stimulant and other drug overdose, prompted by the definitions provided:

- **Alcohol overdose:** experience of symptoms (e.g., reduced level of consciousness and collapsing) where professional assistance would have been helpful.
- **Stimulant overdose:** experience of symptoms (e.g., nausea, vomiting, chest pain, tremors, increased body temperature, increased heart rate, seizure, extreme paranoia, extreme anxiety,

panic, extreme agitation, hallucinations, excited delirium) where professional assistance would have been helpful.

- **Other drug overdose (not including alcohol or stimulant drugs):** similar definition to above. Note that in 2019, participants were prompted specifically for opioid overdose but this was removed in 2020 as few participants endorsed this behaviour.

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

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

Non-Fatal Stimulant Overdose

In 2023, 14% of the sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview, similar to 2022 (12%; p=0.829) (Figure 60).

The most common stimulant reportedly used during the most recent non-fatal stimulant overdose in the past 12 months was any form of ecstasy (71%; numbers for individual forms too low to report). Among those who experienced a recent non-fatal stimulant overdose, 93% (n=13) reported that they had also consumed one or more additional drugs on the last occasion, most notably, alcohol (71%; ≥5 standard drinks: n≤5; ≤5 standard drinks: n≤5). On the last occasion of experiencing a non-fatal stimulant overdose, no participants reported receiving treatment or assistance. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

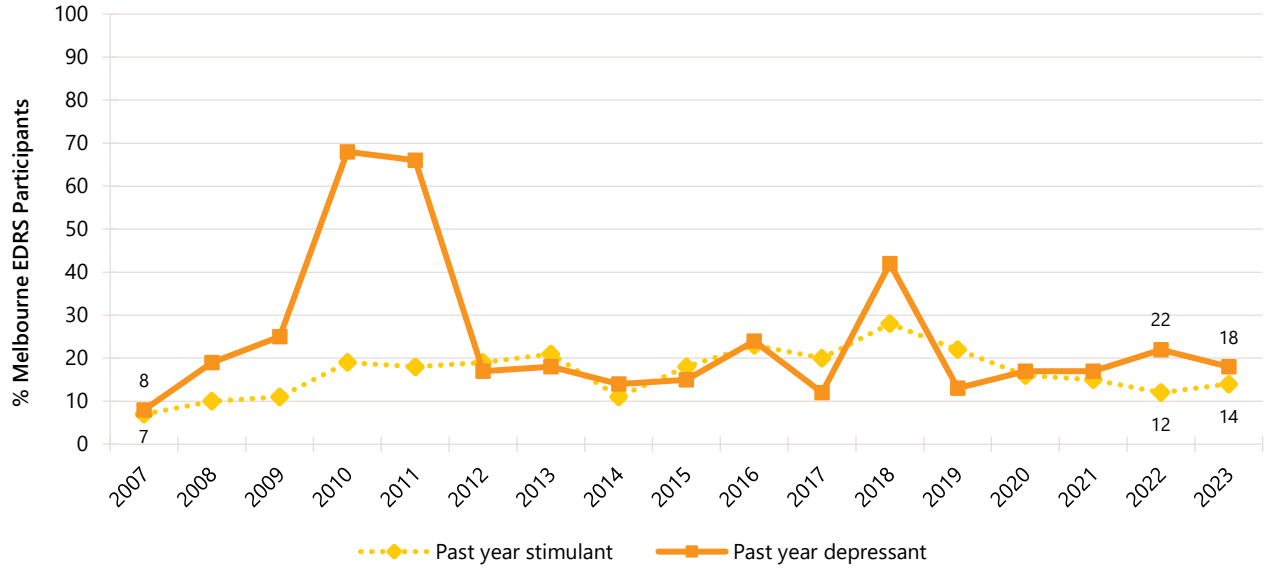
Non-Fatal Depressant Overdose

Alcohol: Seventeen per cent of the sample reported a non-fatal alcohol overdose in the 12 months preceding interview on a median of three occasions (IQR=1–4), stable from 18% in 2022 (p=0.849). Of those who reported experiencing an alcohol overdose in the past year and commented (n=16), 81% reported not receiving treatment on the last occasion. Due to few participants (n≤5) reporting that they had received treatment or assistance, please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Any depressant (including alcohol): In 2023, 18% of participants reported that they had experienced a non-fatal depressant overdose (including alcohol) in the past 12 months, similar to 2022 (22%; p=0.475) (Figure 60).

Of those who reported experiencing any depressant overdose in the past 12 months (n=18), 94% 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 60: Past 12 month non-fatal stimulant and depressant overdose, Melbourne, VIC, 2007-2023



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 (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

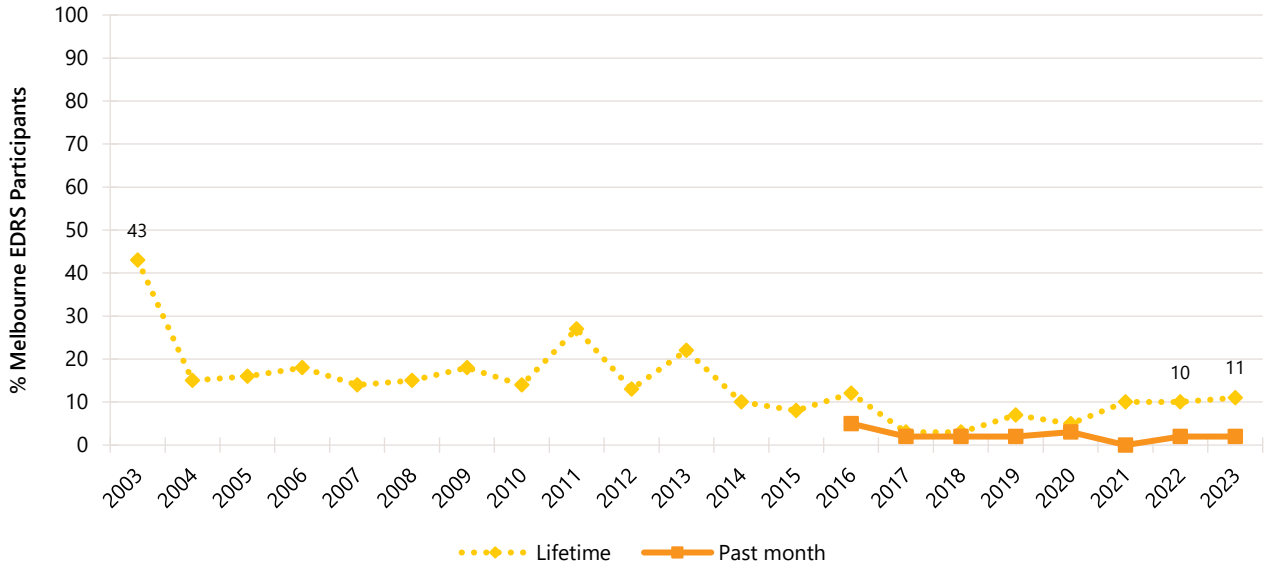
Awareness of Naloxone

In 2023, 60% of the sample reported that they had ever heard of naloxone (57% in 2022; $p=0.773$), of whom 93% were able to correctly identify the purpose for which naloxone is used (86% in 2022; $p=0.362$).

Injecting Drug Use and Associated Risk Behaviours

Eleven per cent of participants reported lifetime injection in 2023 (10% in 2022) (Figure 61). Few participants (n≤5) reported injecting drugs in the past month (n≤5 in 2022), therefore, these data are suppressed (Figure 61). Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Figure 61: Lifetime and past month drug injection, Melbourne, VIC, 2003-2023



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 (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 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.

Ecstasy and Methamphetamine Dependence

From 2017, participants were asked questions from the Severity of Dependence Scale (SDS) adapted to investigate ecstasy and methamphetamine dependence. The SDS is a five-item tool questionnaire designed to screen for potential dependence on a variety of drugs. The SDS focuses on the psychological aspects of dependence, including impaired control of drug use, and preoccupation with, and anxiety about, use. A total score was created by summing responses to each of the five questions. Possible scores range from 0 to 15.

To assess ecstasy dependence in the past six months, a cut-off score of three or more was used, as this has been found to be a good balance between sensitivity and specificity for identifying problematic dependent ecstasy use. Of those who reported recent use of ecstasy and responded (n=99), 9% recorded a score of three and above (n≤5 in 2022; p=0.418). The median ecstasy SDS score was zero (range: 0–9). Sixty-eight per cent obtained a score of zero on the ecstasy SDS and a further 15% obtained a score of one on the scale, indicating that most respondents reported no or few symptoms of dependence in relation to ecstasy use (Table 5).

To assess methamphetamine dependence, a cut-off of four and above, which is a more conservative estimate, has been used previously in the literature as a validated cut-off for methamphetamine dependence. Of those who reported recent use of methamphetamine and responded (n=29), 24%

scored four or above (11% in 2022; *p*=0.194). The median methamphetamine SDS score was zero (range: 0–12). Sixty-six per cent of these participants obtained a score of zero on the methamphetamine SDS and a further 7% obtained a score of one on the scale, indicating that most respondents reported no or few symptoms of dependence in relation to methamphetamine use (Table 5).

Table 5: Total ecstasy and methamphetamine SDS scores and per cent of participants scoring above cut-off scores indicative of dependence, among those who reported past six month use, Melbourne, VIC, 2017-2023

	2017	2018	2019	2020	2021	2022	2023
Ecstasy	**(N=97)**	**(N=98)**	**(N=97)**	**/**	**(N=95)**	**(N=88)**	**(N=99)**
Median total score (IQR)	1 (0–2)	1 (0–3)	1 (0–3)		0 (0–1)	0 (0–1)	**0 (0–1)**
% score 0	47	37	38		74	65	**68**
% score =1	22	22	28		12	17	**15**
% score ≥3	18	31	30		6	6	**9**
Methamphetamine	**(N=43)**	**(N=59)**	**(N=43)**	**(N=48)**	**(N=44)**	**(N=47)**	**(N=29)**
Median total score (IQR)	0 (0–0)	0 (0–0)	0 (0–1)	0 (0–0)	0 (0–0)	0 (0–0)	**0 (0–3)**
% score 0	86	76	72	85	75	79	**66**
% score =1	5	-	-	-	-	11	**7**
% score ≥4	7	10	12	8	11	11	**24**

Note. Severity of Dependence scores calculated out of those who used ecstasy/methamphetamine recently (past 6 months). A cut-off score of ≥3 and ≥4 is used to indicate screening positive for potential ecstasy and methamphetamine dependence, respectively. / Ecstasy Severity of Dependence was not asked of participants in 2020. – Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Imputed values used for missing scale scores. Statistical significance for 2022 versus 2023 presented in table; **p*<0.050; ***p*<0.010; ****p*<0.001.

Sexual Health Behaviours

In 2023, 80% of the sample reported engaging in some form of sexual activity in the past four weeks (76% in 2022; *p*=0.607). 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 responded (n=79), 82% reported using alcohol and/or other drugs prior to or while engaging in sexual activity, comparable to 84% in 2022 (*p*=0.826). Of those who reported engaging in sexual activity in the past four weeks and responded (n=79), 13% reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (11% in 2022; *p*=0.799). Furthermore, of those who reported engaging in sexual activity in the past four weeks and responded (n=78), 14% reported penetrative sex without a condom when they did not know the HIV status of their partner (21% in 2022; *p*=0.301) (Table 6).

Of those who responded (n=100), 82% reported ever having a sexual health check-up, stable from 76% in 2022 (p=0.297), with 39% having done so in the past six months (29% in 2022; p=0.184). Of those who responded (n=100), 29% reported that they had received a positive diagnosis for a sexually transmitted infection in their lifetime (STI; 24% in 2022, p=0.526), with 10% reporting that they had received a positive diagnosis in the past six months (n≤5 in 2022, p=0.033). The most common STI reported amongst participants who commented (n=10) was chlamydia (70%), with few participants (n≤5) reporting other STIs.

Of the total sample (n=100), 70% reported ever having a test for human immunodeficiency virus (HIV) (28% in the past six months; 42% more than six months ago). No participants reported having been diagnosed with HIV in their lifetime (n≤5 in 2022).

Table 6: Sexual health behaviours, Melbourne, VIC, 2021-2023

	2021	2022	2023
Of those who responded:	N=100	N=100	**N=100**
% Any sexual activity in the past four weeks (n)	78 (n=78)	76 (n=76)	**80 (n=80)**
Of those who responded# and reported any sexual activity in the past four weeks	n=78	n=76	**n=79**
% Drugs and/or alcohol used prior to or while engaging in sexual activity	95	84	**82**
Of those who responded# and reported any sexual activity in the past four weeks:	n=78	n=76	**n=79**
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	-	11	**13**
Of those who responded# and reported any sexual activity in the past four weeks:	n=78	n=76	**n=78**
% Had penetrative sex without a condom and did not know HIV status of partner	14	21	**14**
Of those who responded#:	n=100	n=100	**n=100**
% Had a HIV test in the last six months	32	25	**28**
% Had a HIV test in their lifetime		65	**70**
Of those who responded#:	n=100	n=100	**n=100**
% Diagnosed with HIV in the last six months	-	-	**0**
% Diagnosed with HIV in their lifetime	-	-	**0**
Of those who responded#:	n=100	n=99	**N=100**
% Had a sexual health check in the last six months	39	29	**39**
% Had a sexual health check in their lifetime	83	76	**82**
Of those who responded#:	n=100	n=99	**n=100**
% Diagnosed with a sexually transmitted infection in the last six months	-	-	**10**
% Diagnosed with a sexually transmitted infection in their lifetime	20	24	**29**

Note. # Due to the sensitive nature of these items, there is missing data for some participants who chose not to respond. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size (n≤5 but not 0). Statistical significance for 2022 versus 2023 presented in table; *p<0.050; **p<0.010; ***p<0.001.

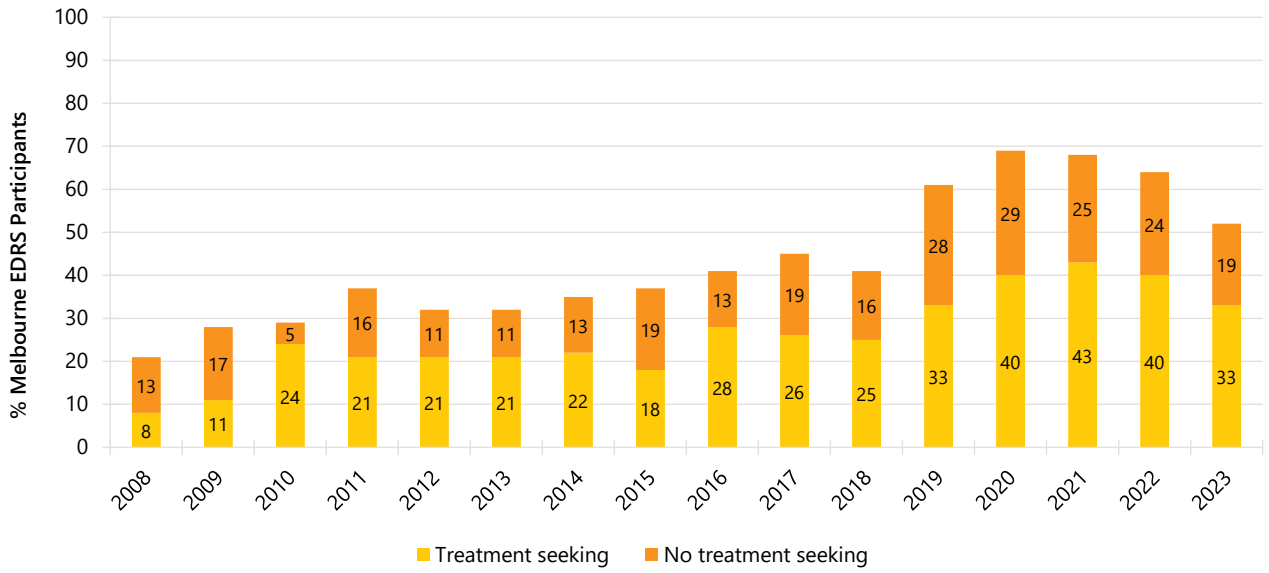
Mental Health and Psychological Distress (K10)

Mental Health

Half (52%) of the Melbourne sample self-reported that they had experienced a mental health problem (other than drug dependence) in the preceding six months, comparable to 2022 (64%; p=0.119). Of

those who reported a mental health problem in 2023 and commented (n=51), the most common problem was anxiety (71%, 71% in 2022), followed by depression (67%, 67% in 2022). Of those who reported experiencing a mental health problem (n=51), 65% reported seeing a mental health professional during the past six months (63% in 2022) (33% of the total sample) (Figure 62). Of those who reported seeing a mental health professional (n=33), 55% reported being prescribed medication for their mental health problem (55% in 2022).

Figure 62: Self-reported mental health problems and treatment seeking in the past six months, Melbourne, VIC, 2008-2023



Note. Questions about treatment seeking were first asked in 2008. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. Data labels are only provided for the first (2008) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Psychological Distress (K10)

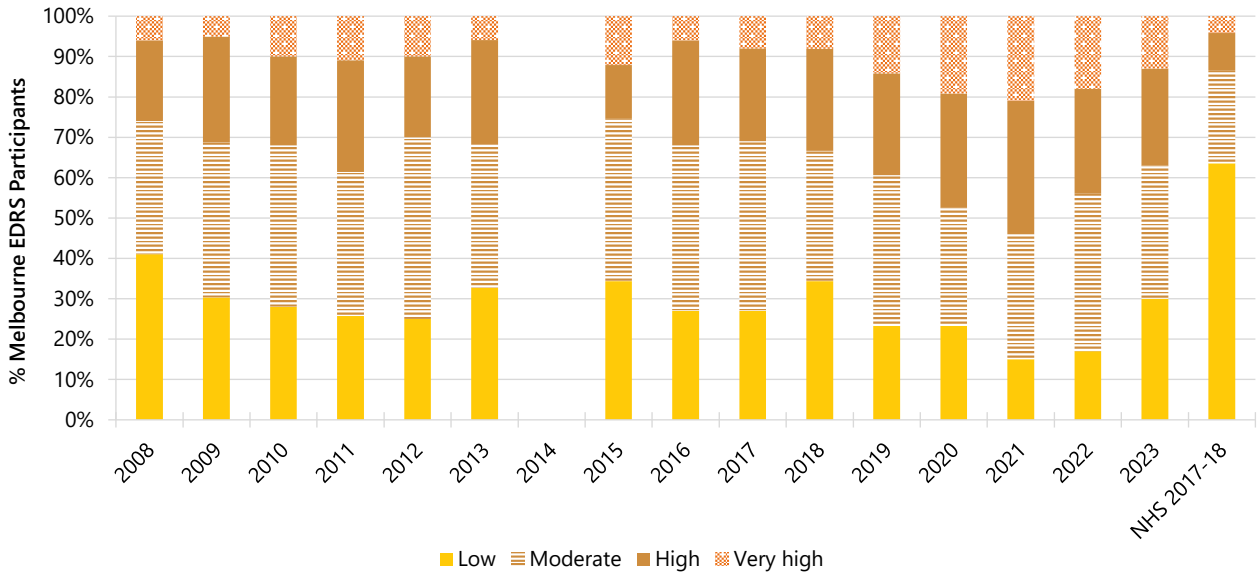
The Kessler Psychological Distress Scale 10 (K10) was administered to obtain a measure of psychological distress in the past four weeks. The K10 is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured by the Diagnostic and Statistical Manual of Mental Disorders/the Structured Clinical Interview for DSM disorders.

The minimum score is 10 (indicating no distress) and the maximum is 50 (indicating very high psychological distress). Scores can be coded into four categories to describe degrees of distress: scores from 10–15 are considered to indicate 'low' psychological distress; scores between 16–21 indicate 'moderate' psychological distress; scores between 22–29 indicate 'high' psychological distress; and scores between 30–50 indicate 'very high' psychological distress. Among the general population, scores of 30 or more have been demonstrated to indicate a high likelihood of having a mental health problem, and possibly requiring clinical assistance.

Among the general population, scores of 30 or more have been demonstrated to indicate a high likelihood of having a mental health problem. Among those who responded in 2023 (n=101), the per cent of participants scoring in each of the four K10 categories remained stable between 2022 and 2023 (p=0. 194). In 2023, 13% of the Melbourne EDRS participants had a score of 30 or more (18% in 2022) (Figure 63).

The National Health Survey 2017-18 provides Australian population data for adult (≥18 years). EDRS participants in 2023 reported greater levels of 'moderate', 'high' and 'very high' distress compared to the general population (Figure 63).

Figure 63: K10 psychological distress scores, Melbourne, VIC, 2006-2023 and NHS 2017-18



Note. Data from the National Health Survey are a national estimate from 2017-18 for adults 18 or older. Imputation used for missing scale scores. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in table; *p<0.050; **p<0.010; ***p<0.001.

Health Service Access

Sixteen per cent of participants reported accessing any health service for alcohol and/or drug support in the six months preceding interview in 2023 (23% in 2022; p=0.278). Low numbers (n≤5) reported accessing individual services (Table 7).

Eighty-eight per cent of participants reported accessing any health service in the six months preceding interview in 2023 (83% in 2022; p=0.431). Primary services reported by participants in 2023 were general practitioners (GPs) (74%; 76% in 2022), dentists (41%; 28% in 2022) and psychologists (34%; 30% in 2022) (Table 7).

Table 7: Health service access for alcohol and other drug reasons and for any reason in the past six months, Melbourne, VIC, 2022-2023

	AOD support		Any reason	
	2022 (N=100)	2023 (N=100)	2022 (N=100)	2023 (N=100)
% accessed a health service in the past 6 months	23	**16**	83	**88**
Type of service accessed ***(participants could select multiple services)***	N=100	**N=100**	N=100	**N=100**
GP	8	**-**	76	**74**
Emergency department	-	**-**	13	**19**
Hospital admission (inpatient)	-	**-**	9	**12**
Medical tent (e.g., at a festival)	-	**-**	-	**11**
Drug and Alcohol counsellor	7	**-**	6	**-**
Hospital as an outpatient	0	**0**	7	**9**
Specialist doctor (not including a psychiatrist)	-	**-**	15	**18**
Dentist	-	**-**	28	**41**
Ambulance attendance	0	**-**	-	**-**
Other health professional (e.g., physiotherapist)	0	**0**	23	**23**
Psychiatrist	-	**-**	14	**10**
Psychologist	7	**-**	30	**34**
NSP	0	**0**	0	**0**
Peer based harm reduction service	6	**-**	7	**9**
Other harm reduction service	0	**0**	-	**-**

Note. – Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Stigma

Questions regarding stigma were derived from the Stigma Indicators Monitoring Project, with stigma defined as being treated negatively or differently because of their illicit drug use. These questions have been asked, in part, since 2022.

In 2023, 14% of the sample reported experiencing stigma in any setting because of their illicit drug use in the six months preceding interview. These experiences of stigma most commonly occurred when visiting general health care services (11%; 20% in 2022; $p=0.154$) (Table 8).

Few participants (n≤5) reported experiencing stigma within specialist alcohol and other drug (AOD) services in the six months preceding interview, stable relative to 8% in 2022 ($p=0.082$). A larger percentage, however, reported experiencing stigma within general health care services in the six months preceding interview (10%; 11% of those who had attended general health care services), stable relative to 2022 (20% in 2022; $p=0.067$). Self-reported experiences of stigma whilst attending general health care services most commonly occurred when visiting a GP (6%). Six per cent of participants reported experiencing stigma in non-health care settings, most commonly from police (n≤5; not asked in 2022) (Table 8).

Table 8: Experience of stigma, Melbourne, VIC, 2022-2023

	2022	2023
% Experiencing stigma in specialist AOD service	N=84 8	**N=100** **-**
% Experiencing stigma in general health care service	N=86 20	**N=100** **11**
% Experienced stigma in non-health care service:	/	**6**
% Experienced stigma in any of the above settings^	/	**14**
% Did any of the following to avoid being treated negatively or differently by AOD specialist or general healthcare services	/	**n=99** **37**
Delayed accessing healthcare	/	**10**
Did not tell health worker about drug use	/	**31**
Downplayed need for pain medication	/	**-**
Looked for different services	/	**6**
Did not attend follow-up appointment	/	**8**
Other	/	**0**

Note. N is the number who responded (denominator). The response option 'Don't know' was excluded from analysis. ^Includes specialist AOD service, general health care service and non-health care services. – Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. / Not asked. Statistical significance for 2022 versus 2023 presented in table; *p<0.050; **p<0.010; ***p<0.001.

COVID-19 Testing and Diagnosis

In 2023, 98% of the Melbourne EDRS sample reported having ever been tested for SARS-CoV-2 by the time of interview, and 86% reported having been tested in the 12 months preceding interview (97% in 2022; 76% in 2021; 7% in 2020). Most (86%) participants reported having ever been diagnosed with the virus in 2023 (79% in 2022; no participants in 2021 and 2020, respectively), with participants reporting a median of two infections (IQR=1–2). Forty-four per cent of the sample reported a positive COVID-19 test in the 12 months preceding interview.

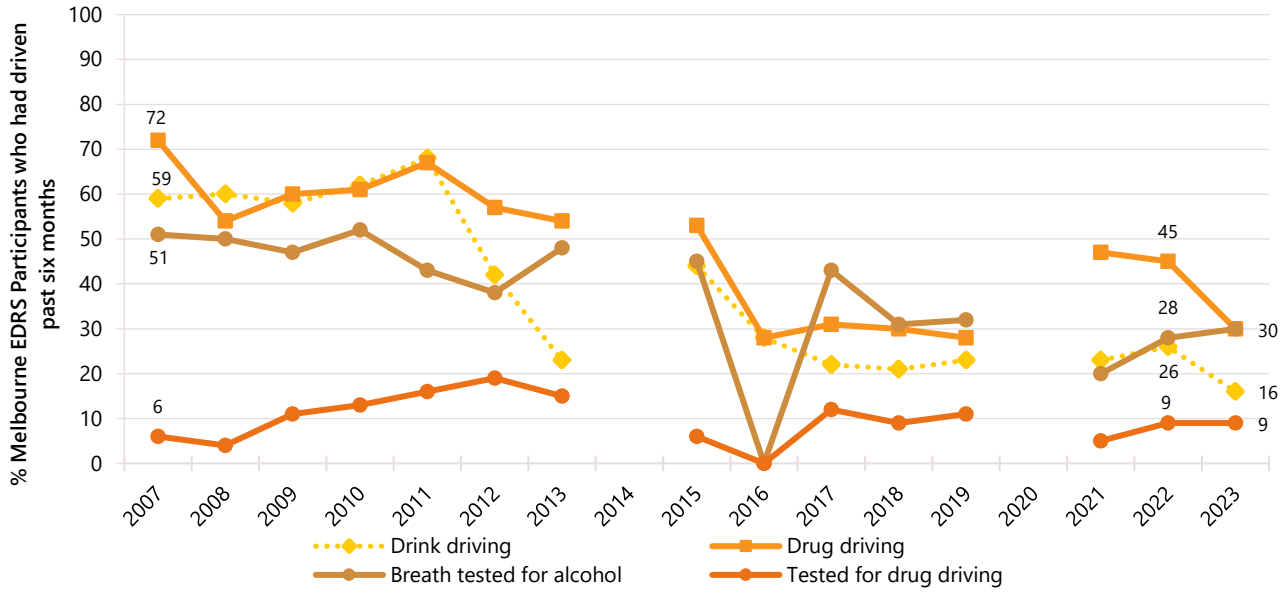
All (100%) participants reported that they had received at least one COVID-19 vaccine dose (98% in 2022), with participants receiving a median of three doses (IQR=2–3); n≤5 received one dose, 29% received two doses and 70% received three or more doses.

Driving

In 2023, 79% of the Melbourne sample reported having driven a car, motorcycle, or other motor vehicle in the past six months. Of those who reported driving in the past six months and responded (n=74), 16% reported driving while over the (perceived) legal blood-alcohol concentration (26% in 2022; p=0.221), and of those who responded (n=79), 30% reported driving within three hours of consuming an illicit or non-prescribed drug in the past six months (45% in 2022; p=0.099) (Figure 64). Participants most commonly reported using cannabis (50%) within three hours of driving in the previous six months. Among those who reported driving in the past six months (n=79), 9% reported that they had been tested for drug driving by the police roadside drug testing service (9% in 2022),

and 30% reported that they had been breath-tested for alcohol by the police roadside testing service in the previous six months (28% in 2022; p=0.854) (Figure 64).

Figure 64: 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, 2007-2023



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 2016. Data labels are only provided for the first (2007) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Experience of Crime and Engagement with the Criminal Justice System

In 2023, 29% of the sample reported engaging in 'any' crime in the past month (38% in 2022; p=0.236), with property crime (23%; 28% in 2022; p=0.521) and drug dealing (15%; 23% in 2022; p=0.159) being the two main forms of criminal activity reported in 2023 (Figure 65).

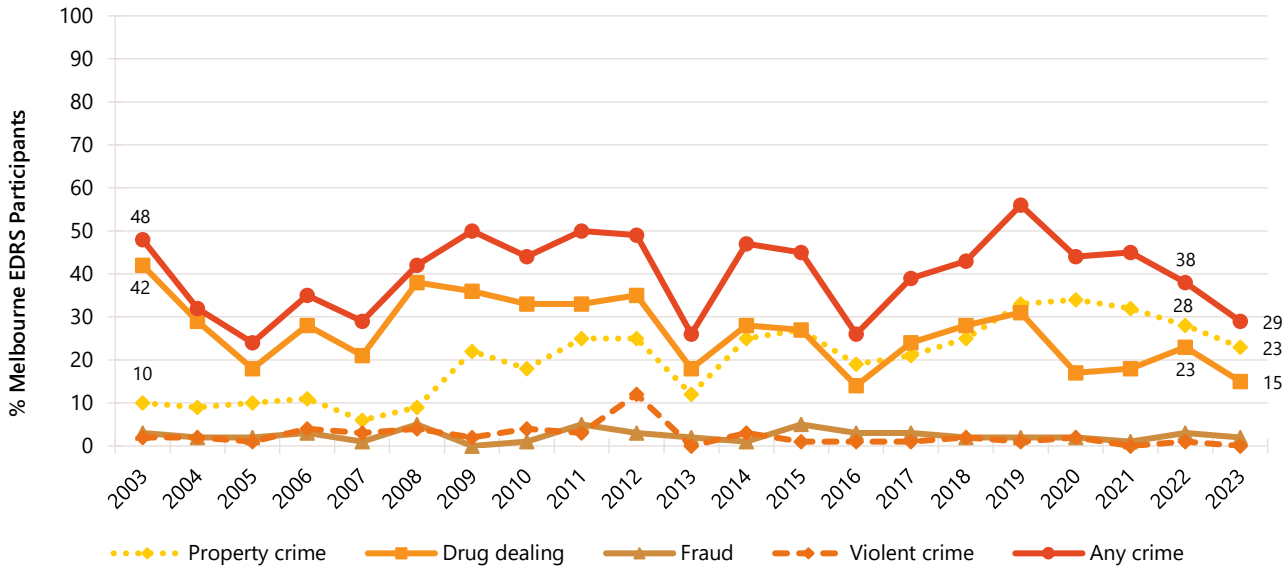
In 2023, few participants (n≤5) reported being the victim of a crime involving violence (6% in 2022) (Figure 66), therefore these data are suppressed. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Few participants (n≤5) reported being arrested in the 12 months preceding interview (n≤5 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.

In 2023, 8% of the sample reported a drug-related encounter with law enforcement in the last 12 months that did not result in charge or arrest, comparable to 2022 (12%; p=0.474).

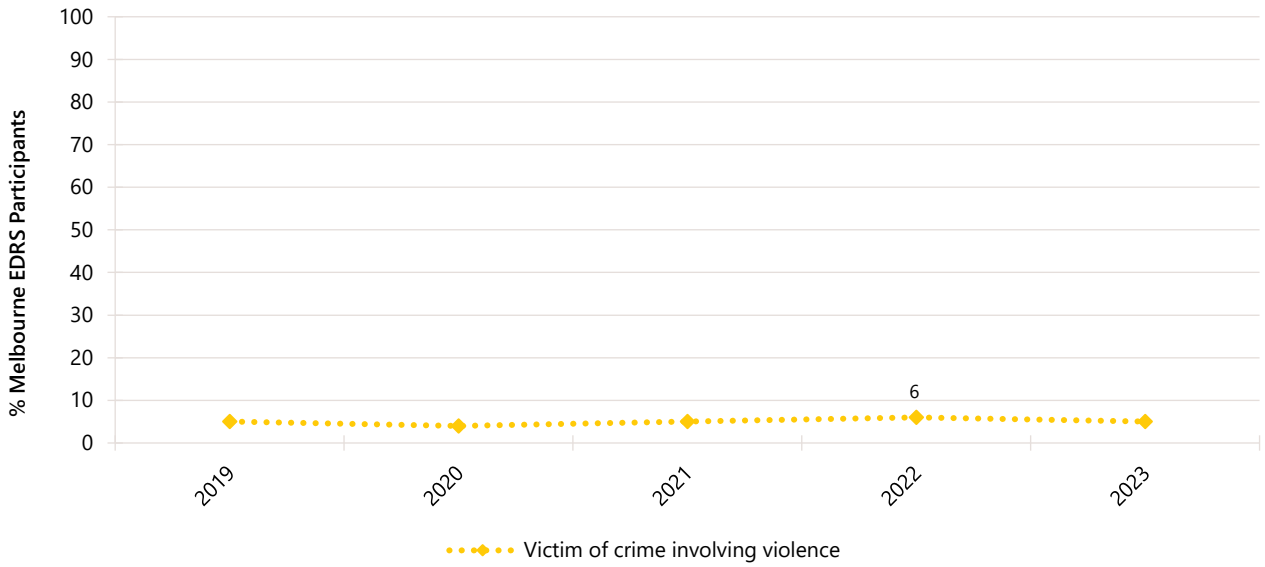
Few participants (n≤5) reported having ever been in prison in 2023 (n≤5 in 2022), therefore these data are supressed. Please refer to the National EDRS Report for national trends, or contact the Drug Trends team for further information.

Figure 65: Self-reported criminal activity in the past month, Melbourne, VIC, 2003-2023



Note. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 66: Victim of crime involving violence in the past month, Melbourne, VIC, 2019-2023



Note. Questions regarding being the victim of a crime involving violence were first asked in 2019. Data labels are only provided for the first (2019) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Modes of Purchasing Illicit or Non-Prescribed Drugs

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

Purchasing Approaches

In 2023, 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 or messaging applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder; 82%), similar to 2022 (84%; p=0.847) (Table 9). This was followed by face-to-face communication (63%; 56% in 2022; p=0.385). 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.

Buying and Selling Drugs Online

Six per cent of the sample reported obtaining drugs via the darknet in the past year (12% in 2022; p=0.219); and few (n≤5) reported purchasing drugs on the surface web (n≤5 in 2022). Half (50%) of participants reported ever obtaining illicit drugs through someone who had purchased them on the surface web or darknet, with 28% having done so in the last 12 months, a significant decrease from 2022 (44%; p=0.032).

In 2022, no participants reported selling illicit/non-prescribed drugs via surface or darknet marketplaces in the 12 months preceding interview (n≤5 in 2022; p=0.522).

Source and Means of Obtaining Drugs

Most participants reported obtaining illicit drugs from a known dealer/vendor in 2023 (74%; 78% in 2022; p=0.504), followed by 72% reporting obtaining them from a friend/relative/partner/colleague (78% in 2022; p=0.334). Around one quarter (23%) reported obtaining illicit drugs from an unknown dealer/vendor, a significant decrease from 2022 (45%; p=0.002) (Table 9).

When asked about how they had received illicit drugs on any occasion in the last 12 months, most participants reported face-to-face (97%; 96% in 2022; p=0.712), followed by a collection point (defined as a predetermined location where a drug will be dropped for later collection; 14%; n≤5 in 2022; p=0.009), with fewer participants reporting receiving illicit drugs via post (10%; 15% in 2022; p=0.299) (Table 9).

Table 9: Means of purchasing and obtaining illicit drugs in the past 12 months, Melbourne, VIC, 2019-2023

	2019	2020	2021	2022	2023
	(n=99)	(n=100)	(n=99)	(n=99)	**(n=99)**
% Purchasing approaches in the last 12 months^					
Face-to-face	82	68	52	56	**63**
Surface web	-	7	-	-	**-**
Darknet market	7	7	6	12	**6**
Social networking or messaging applications#	77	81	88	84	**82**
Text messaging	51	48	20	30	**26**
Phone call	34	36	19	14	**11**
Grew/made my own	/	-	0	-	**-**
Other	-	-	0	-	**-**
% Means of obtaining drugs in the last 12 months^~	n=99	n=100	n=99	n=99	**n=100**
Face-to-face	99	94	94	96	**97**
Collection point	-	18	-	-	**14****
Post	11	12	10	15	**10**
% Source of drugs in the last 12 months^	n=99	n=100	n=99	n=100	**n=99**
Friend/relative/partner/colleague	85	82	73	78	**72**
Known dealer/vendor	83	75	75	78	**74**
Unknown dealer/vendor	33	49	33	45	**23****

Note. - Per cent suppressed due to small cell size (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 from 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 2022 versus 2023 presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$.