EDRS

AUSTRALIAN CAPITAL TERRITORY DRUG TRENDS 2023

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

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

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ISSN 2981-9679

Suggested citation: Uporova J, Peacock A, & Sutherland R. Australian Capital Territory Drug Trends 2023: Key Findings from the Ecstasy and Related Drugs Reporting System (EDRS) Interviews. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney. 2023. DOI: 10.26190/hy4q-xv75

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

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

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Funding

In 2023, the Ecstasy and Related Drugs Reporting System (EDRS), falling within the Drug Trends program of work, was supported by funding from the Australian Government Department of Health and Aged Care under the Drug and Alcohol Program.

Research Team

The National Drug and Alcohol Research Centre (NDARC), University of New South Wales (UNSW) Sydney, coordinated the EDRS. The following researchers and research institutions contributed to the EDRS in 2023:

- 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;
- Joanna Wilson and Professor Paul Dietze, Burnet, Victoria;
- Sophie Radke, Lauren Stafford and Associate Professor Raimondo Bruno, School of Psychology, University of Tasmania, Tasmania;
- Dr Jodie Grigg and Professor Simon Lenton, National Drug Research Institute and enAble Institute, Curtin University, Western Australia; and
- Catherine Daly, Dr Jennifer Juckel, Dr Natalie Thomas and Associate Professor Caroline Salom, Institute for Social Science Research, The University of Queensland, Queensland.

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

Participants

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

Contributors

We thank all the individuals who contributed to questionnaire development and assisted with the collection and input of data at a jurisdictional and national level. In particular, we would like to thank Xin Wang, Dyah Ayu Kartika and Rachel Frost for conducting the Canberra, ACT EDRS interviews in 2023. We would also like to thank the Students for Sensible Drug Policy (SSDP) and the Drug Trends Advisory Committee for their contribution to the EDRS.

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

Abbreviations

1,4-BD	1,4-Butanediol
4-AcO-DMT	4-Acetoxy-N,N-dimethyltryptamine
4-FA	4-Fluoroamphetamine
5-MeO-DMT	5-methoxy-N,N-dimethyltryptamine
ACT	Australian Capital Territory
AIVL	Australian Injecting & Illicit Drug Users League
Alpha PVP	α-Pyrrolidinopentiophenone
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
LSA	*d*-lysergic acid amide
LSD	*d*-lysergic acid
MDA	3,4-methylenedioxyamphetamine
MDMA	3,4-methylendioxymethamphetamine
MDPV	Methylenedioxypyrovalerone
MXE	Methoxetamine
N (or n)	Number of participants
NBOMe	N-methoxybenzyl

NDARC	National Drug and Alcohol Research Centre
NPS	New psychoactive substances
NSP	Needle Syringe Program
OTC	Over-the-counter
PMA	Paramethoxyamphetamine
PMMA	Polymethyl methacrylate
PTSD	Post-traumatic stress disorder
REDCap	Research Electronic Data Capture
SD	Standard deviations
SDS	Severity of Dependence Scale
SSDP	Students for Sensible Drug Policy
STI	Sexually transmitted infection
THC	Tetrahydrocannabinol
UNSW	University of New South Wales
VIC	Victoria
WA	Western Australia
WHO	World Health Organization

Executive Summary

The Canberra, Australian Capital Territory (ACT) EDRS comprises a sentinel sample of people who regularly use ecstasy and/or other illicit stimulants recruited via social media, advertisements on websites and via word-of-mouth in Canberra, ACT. The results are not representative of all people who use illicit drugs, nor of use in the general population. **Data were collected in 2023 from April-June. Interviews from 2020 onwards were delivered face-to-face as well as via telephone, to reduce the risk of COVID-19 transmission; all interviews prior to 2020 were conducted face-to-face. This methodological change should be factored into all comparisons of data from the 2020-2023 samples, relative to previous years.**

Sample Characteristics

The 2023 EDRS sample (N=100) recruited from Canberra, ACT, were a significantly younger group compared to 2022 (median 22 years versus median 26 years in 2022; p=0.008), although resembled the age observed in 2021 and prior. Gender and sexual identity remained stable in 2023. There was a significant change in employment status between 2022 and 2023 (p<0.001), with fewer participants being unemployed (18%; 28% in 2022) and more employed part-time/casual (52%; 34% in 2022) and full-time (29%; 26% in 2022). Ecstasy was most commonly endorsed as the drug of choice (22%) followed by cannabis (15%). One third (33%) of participants reported that cannabis was the drug used most often in the last month, followed by 26% reporting alcohol.

Ecstasy

Recent use of any ecstasy significantly increased in 2023 (96%) relative to 2022 (87%; p=0.040), although frequency of use remained stable at a median of seven days, although remains lower compared to 2020 and prior years. Capsules remained the most commonly used form of ecstasy. In 2023, significantly more participants reported use of the powder form (32%) compared to 2022 (19%; p=0.038), although it remained the least commonly used form of ecstasy. The price of a pill increased from $25 in 2022 to $30 in 2023 ($p$=0.023) and the price of powder increased from $200 per gram to $225 ($p$=0.044). There was a significant change in the perceived availability of capsules (p=0.001) and crystal (p=0.003). More participants perceived both forms to be 'easy' or 'very easy' to obtain in 2023, relative to 2022.

Methamphetamine

Use of any methamphetamine has historically been declining. In 2023, significantly fewer participants reported recent use (23%) relative to 2022 (39%; p=0.024). This decrease was driven by the decline in the use of the crystal form (14% versus 31% in 2022; p=0.006). Frequency of use of any methamphetamine remained stable at a median of six days, although was higher for methamphetamine crystal (median 24 days). There was no change in the price, perceived purity or availability of methamphetamine powder or crystal in 2023, relative to 2022.

Non-Prescribed Pharmaceutical Stimulants

Half (51%) of the sample reported recent use of non-prescribed pharmaceutical stimulants, the highest percentage since monitoring commenced, although stable relative to 2022. Frequency of use also remained stable at a median of 10 days. The majority (88%) of those who had recently used non-prescribed pharmaceutical stimulants reported using dexamfetamine. Price and perceived availability remained stable relative to 2022.

Cocaine

In 2023, 78% reported recent cocaine use, stable relative to 2022 (76%). In 2023, participants reported using cocaine on a median of five days, a significant decrease from six days in 2022 (p=0.043). The median price for a gram of cocaine has remained stable since 2006 at $300. The perceived purity and perceived availability of cocaine remained stable between 2022 and 2023.

Cannabis and/or Cannabinoid-Related Products

At least three in four participants have reported any recent use of non-prescribed cannabis and/or cannabinoid-related products each year since monitoring commenced. In 2023, 80% reported recent use on a median of 55 days, stable from 2022. There were no significant changes in the price or perceived purity of hydroponic or bush cannabis. There was, however, a significant change in the perceived availability of hydroponic (p=0.036) and bush cannabis (p=0.011). More participants perceived both forms to be 'easy' or 'very easy' to obtain in 2023, relative to 2022.

Non-Prescribed Ketamine, LSD and DMT

Recent use of non-prescribed ketamine significantly increased to 56% in 2023 from 39% in 2022 (p=0.026), reaching the highest per cent since monitoring commenced. Frequency of use remained stable at a median of five days. There was no change in the price, perceived purity or perceived availability between 2022 and 2023. Recent use of LSD remained stable in 2023 (42%; 31% in 2022). Frequency of use remained low at a median of two days. There was a significant change in the perceived availability of LSD in 2023, relative to 2022 (p=0.001). More participants perceived LSD to be 'difficult' to obtain compared to 2022, and fewer participants perceived it to be 'very difficult'. Recent DMT use (13%) and frequency of use (median: 2 days) remained stable in 2023, relative to 2022.

New Psychoactive Substances (NPS)

Eighteen per cent reported recent use of at least one form of NPS (including plant-based NPS), stable relative to 9% in 2022. 2C substances have consistently been the most commonly used NPS with 8% reporting recent use in 2023, a significant increase relative to 2022 (n≤5; p=0.035).

Other Drugs

Half (49%) of the sample reported recent use of hallucinogenic mushrooms, the highest per cent since monitoring commenced, although stable relative to 2022. Seven per cent of the sample reported recent use of GHB/GBL/1,4-BD on a median of one day in the past six months. Recent use of alcohol (94%) and tobacco (70%) remained stable, although there was a significant decrease in median days of tobacco use from daily use (i.e., 180 days) in 2022 to twice weekly (i.e., 48 days; p<0.001) in 2023. Significantly more participants reported recent use of non-prescribed e-cigarettes in 2023 (72%; 57% in 2022; p=0.043), however, median days remained stable at 100 days. Recent use of nitrous oxide (53%) and amyl nitrite (46%) remained stable in 2023, relative to 2022.

Drug-Related Harms and Other Behaviours

- On the last occasion of ecstasy or related drug use, 86% of participants in 2023 reported concurrent use of two or more drugs.
- Significantly more participants reported having tested the contents of their illicit drugs in the 12 months preceding interview (53%; 29% in 2022; $p<0.001$).
- There was a significant increase in the mean AUDIT score in 2023 relative to 2022 (12.2 versus 11.6 in 2022; $p<0.001$).
- Seven per cent of the sample reported a non-fatal stimulant overdose and 15% a non-fatal depressant overdose (including alcohol) in the 12 months prior to interview, stable relative to 2022.
- Nearly three fifths (58%) reported that they had heard about naloxone.
- Reported past month injecting drug use remained low ($n\leq5$), as did current drug treatment engagement (6%).
- In 2023, 12% of those who reported recent ecstasy use obtained an SDS score of 3 or more, whilst 35% of participants reporting recent methamphetamine use obtained a score of 4 or more, indicating possible dependence on these substances.
- Three quarters (77%) of the sample reported engaging in some form of sexual activity in the past four weeks, of which 21% reported penetrative sex without a condom where they did not know the HIV status of their partner. One third (36%) of the sample reported having a HIV test in the six months preceding interview, and 34% reported having a sexual health check-up in the six months prior to interview.
- Mental health remained stable relative to 2022, with 58% (67% in 2022) reporting experiencing a mental health problem in the six months preceding interview, with anxiety (69%) and depression (67%) most commonly reported.
- One fifth (20%) of the sample reported very high psychological distress.
- Three in ten (30%) participants reported accessing any health service for alcohol and/or drug support in the six months preceding interview, and 29% of the sample reported experiencing stigma in any setting in the six months preceding interview.
- In 2023, two thirds (67%) had been tested for SARS-CoV-2 in the past 12 months, with 32% of participants testing positive to COVID-19 in the 12 months preceding interview.
- Amongst those who had recently driven, one third (32%) reported driving while over the perceived legal limit of alcohol and two fifths (41%) reported driving within three hours of consuming an illicit or non-prescribed drug in the prior six months.
- One third (33%) of the sample reported 'any' crime in the past month. Drug dealing and property crime were the main forms of criminal activity reported in 2023. Few participants reported having been arrested in the 12 months preceding interview, however 19% reported a drug-related encounter with police which did not result in charge or arrest.
- Face-to-face contact was the most popular means of participants arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview (74%; 68% in 2022). Most participants continued to report obtaining illicit drugs from a friend/relative/partner/colleague (84%; 83% in 2022).

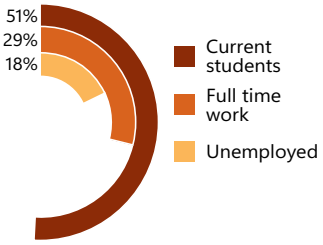
EDRS Ecstasy and Related Drugs Reporting System

2023 SAMPLE CHARACTERISTICS

In 2023, 100 participants, recruited from Canberra, ACT were interviewed.

22 years 63%

The median age in 2023 was 22, and 63% identified as male.

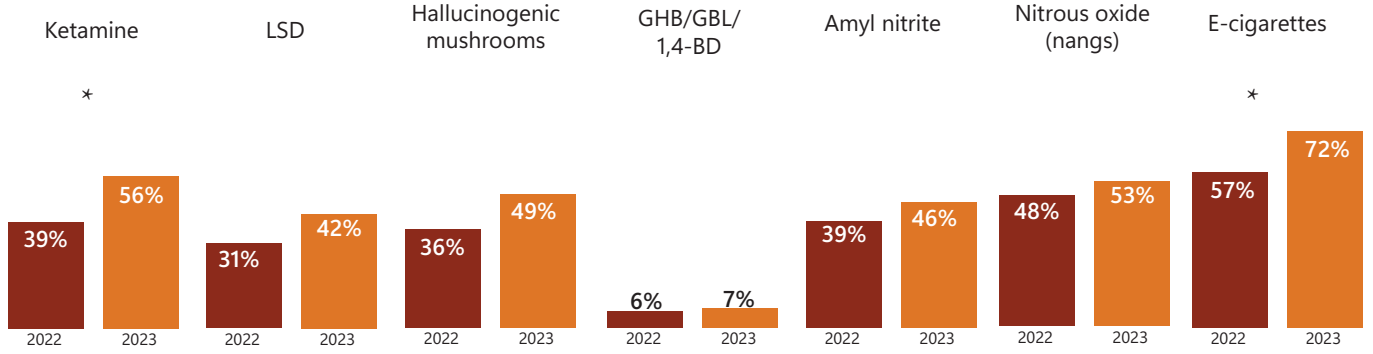


In the 2023 sample, 51% were current students, 29% were employed full time and 18% were unemployed.

- Ecstasy
- Cocaine
- Other stimulants

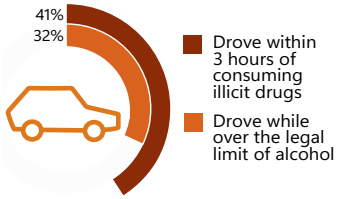
Participants were recruited on the basis that they had consumed ecstasy and/or other illicit stimulants at least monthly in the past 6 months.

PAST 6 MONTH USE OF OTHER DRUGS



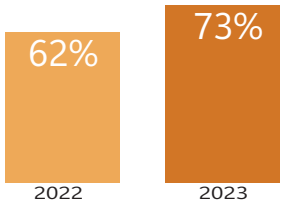
*p<0.050; **p<0.010; ***p<0.001

DRUG-RELATED HARMS AND RISKS

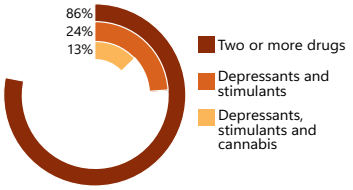


Among recent drivers, 41% reported driving a vehicle within 3 hours of consuming illicit drugs and 32% while over the legal limit of alcohol.

In the 2023 sample, 15% reported a non-fatal depressant overdose in the previous 12 months, and 7% reported a non-fatal stimulant overdose.

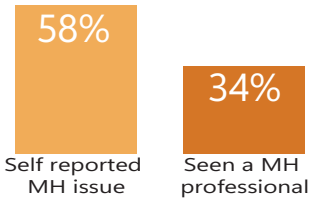


73% of the sample obtained an AUDIT score of eight or more, indicative of past year hazardous alcohol use (62% in 2022).

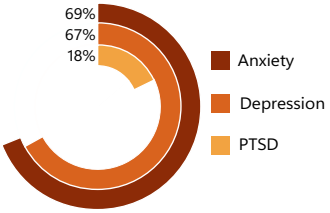


On the last occasion of ecstasy or related drug use, 86% used two or more drugs, 24% used both stimulants and depressants, and 13% used stimulants, depressants and cannabis.

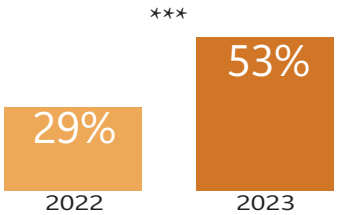
OTHER BEHAVIOURS



In the total sample, 58% self reported a mental health issue and 34% had seen a mental health professional in the past 6 months.



Of those who commented, the three most common mental health issues reported were anxiety (69%), depression (67%) and PTSD (18%).

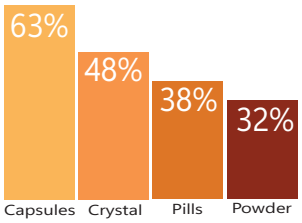


53% of the sample reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year.

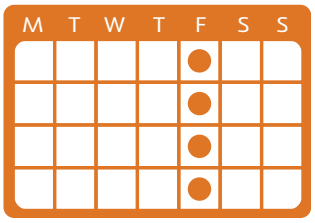
29% of the sample reported experiencing stigma because of their illicit drug use in the six months preceding interview, most commonly from police or a GP.

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

ECSTASY



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



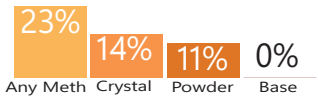
Of those who had recently consumed ecstasy, 11% used it weekly or more frequently.

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

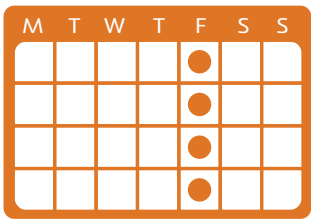
Median amounts of ecstasy consumed in a 'typical' session using each form.

In 2023, more participants perceived the availability of ecstasy crystal and capsules as 'easy' or 'very easy' relative to 2022.

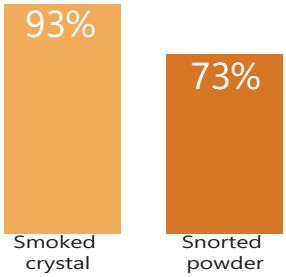
METHAMPHETAMINE



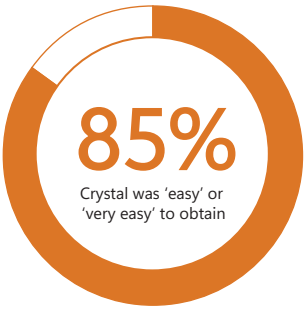
Past 6 month use of any methamphetamine, crystal, powder and base in 2023.



Of those who had recently consumed methamphetamine, 35% used it weekly or more frequently.

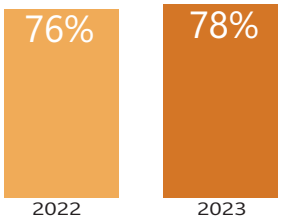


93% of participants who had recently used crystal smoked it. Of those who had recently used powder, 73% snorted it.

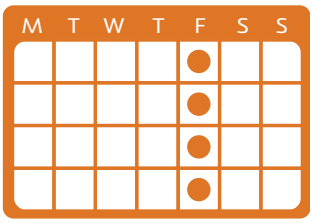


Of those who could comment 85% perceived crystal methamphetamine to be 'easy' or 'very easy' to obtain.

COCAINE

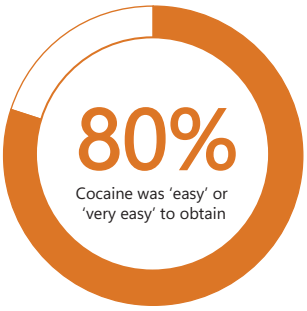


Past 6 month use of any cocaine remained stable between 2022 and 2023.



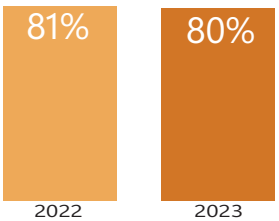
Of participants who had consumed cocaine recently, 10% reported weekly or more frequent use.

In 2023, the median price of a gram of cocaine was $300.

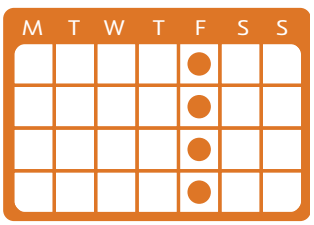


Of those who could comment 80% perceived cocaine to be 'easy' or 'very easy' to obtain.

CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS

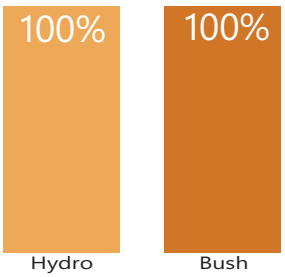


Past 6 month use of non-prescribed cannabis and/or cannabinoid-related products remained stable between 2022 and 2023.



Of those who had consumed non-prescribed cannabis recently, 69% reported weekly or more frequent use.

Of participants who had consumed cannabis in the last 6 months, 95% had smoked it (39% swallowed and n≤5 vaped it).



Of those who could comment, all participants 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/or other illicit 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 and/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 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.

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

2023 EDRS Sample

A total of 708 participants were recruited across capital cities nationally (April-July, 2023), with 100 participants interviewed in Canberra, ACT during April-June 2023 (N=100 in 2022). A total of 38 interviews (38%) were conducted via telephone in Canberra, ACT (68% in 2022); the remainder were conducted face-to-face.

Eight per cent of the 2023 Canberra sample completed the interview in 2022, and 11% of the 2022 sample completed the interview in 2021 (p=0.474). The recruitment methods in 2023 remained stable relative to 2022 (p=0.733), with most participants being recruited via the internet (e.g., Facebook and Instagram) (76%; 81% in 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 Canberra, Australian Capital Territory, and thus do not reflect trends in regional and remote areas. Further, the results are not representative of all people who consume illicit drugs, nor of illicit drug use in the general population, but rather are intended to provide evidence indicative of emerging issues that warrant further monitoring.

This report covers a subset of items asked of participants and does not include implications of findings. These findings should be interpreted alongside analyses of other data sources for a more complete profile of emerging trends in illicit drug use, market features, and harms in Canberra, ACT (see section on 'Additional Outputs' below for details of other outputs providing such profiles). **Differences in the methodology, and the events of 2020-2023, must be taken into consideration when comparing 2020-2023 data to previous years, and treated with caution.**

Additional Outputs

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

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

1

Sample Characteristics

In 2023, the Canberra EDRS sample had a median age of 22 years (IQR=20-26), significantly younger than the sample from 2022 (median 26 years; IQR=20-32; p=0.008), returning to levels seen in 2021 and prior (Table 1). Gender identity was similar to the 2022 sample (p=0.285), with more of the sample identifying as male (63%; 53% in 2022) than female (34%; 42% in 2022). Half (48%; 62% in 2022; p=0.067) of the sample reported having completed a post-school qualification(s) and half (51%; 39% in 2022; p=0.123) reported being current students. There was a significant change in current employment status between the 2022 and 2023 samples (p<0.001), with more reporting being employed part-time/casual (52%; 34% in 2022) and full-time (29%; 26% in 2022) and fewer being unemployed (18%; 28% in 2022). There was no significant change in participants' accommodation in the 2023 sample relative to the 2022 sample (p=0.622). Most participants reported residing in a rented house or flat (64%; 55% in 2022), followed by 16% who reported living at their parents'/family home (22% in 2022) (Table 1).

There was no significant change in the drug of choice nominated by participants between 2022 and 2023 (p=0.596). One fifth (22%) of the sample nominated ecstasy as their drug of choice (20% in 2022), followed by 15% nominating cannabis (21% in 2022) and one in ten reporting cocaine and alcohol (11% and 10%, respectively; 13%, respectively in 2022) (Figure 1).

The drug used most often in the past month also remained stable in 2023 compared to 2022 (p=0.917). One third (33%) of the sample reported that cannabis was the drug used most in the last month (33% in 2022), followed by one quarter (26%) reporting alcohol (25% in 2022). Further, one in ten participants reported consuming cocaine (9%) and ecstasy (8%) most often in the month preceding interview (11% and n≤5 in 2022, respectively) (Figure 2).

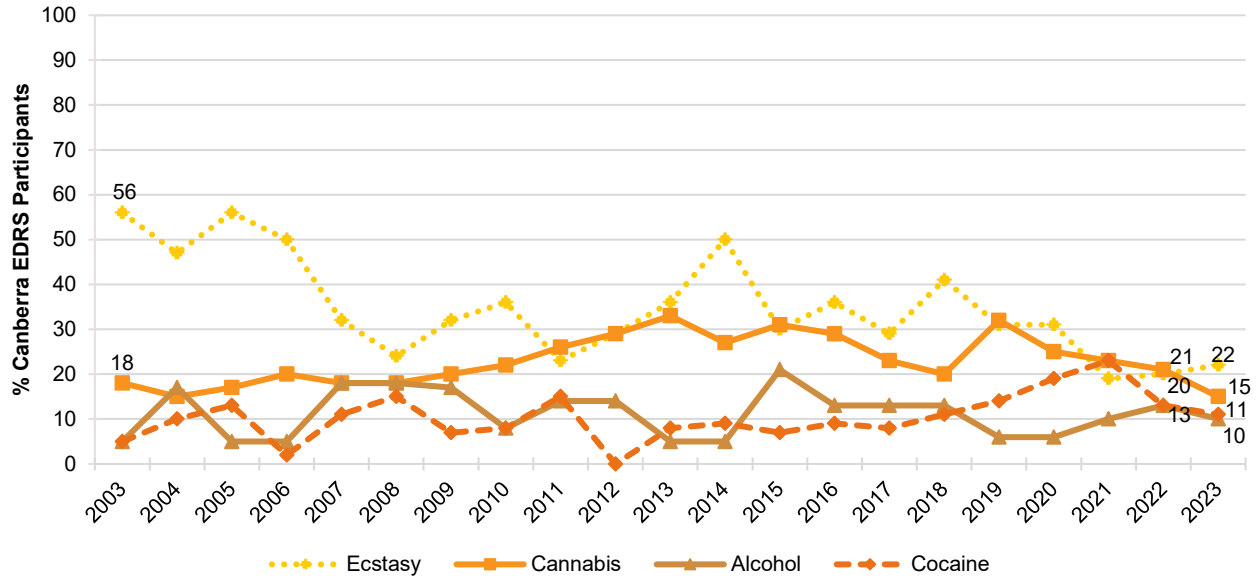
Weekly or more frequent use of cannabis (55%; 53% in 2022; p=0.884), ecstasy (10%; 12% in 2022; p=0.817), methamphetamine (8%; 18% in 2022; p=0.061) and cocaine (8%; 13% in 2022; p=0.353) remained stable in 2023, relative to 2022 (Figure 3).

Table 1: Demographic characteristics of the sample, nationally, 2023, and Canberra, ACT, 2017-2023

	Canberra, ACT							National
	2017 N=100	2018 N=100	2019 N=100	2020 N=101	2021 N=100	2022 N=100	2023 N=100	2023 N=708
Median age (years; IQR)	20 (19-22)	21 (19-24)	20 (19-23)	21 (20-24)	23 (21-29)	26 (20-32)	**22** (20-26)**	25 (21-32)
% Gender								
Female	34	50	37	44	34	42	**34**	40
Male	64	49	62	56	64	53	**63**	58
Non-binary	/	/	-	0	-	-	**-**	3
% Aboriginal and/or Torres Strait Islander	-	**-**	12	6	9	10	**6**	4
% Sexual identity								
Heterosexual	82	79	79	81	69	69	**71**	71
Homosexual	-	-	-	-	-	-	**8**	8
Bisexual	13	14	15	14	17	20	**19**	16
Queer	/	/	-	-	7	-	**-**	4
Different identity	-	-	-	-	-	-	**-**	1
Mean years of school education (range)	12 (12-12)	12 (11-12)	12 (11-12)	12 (8-12)	12 (8-12)	11 (6-12)	**12 (9-12)**	12 (5-12)
% Post-school qualification(s)^	27	40	40	48	55	62	**48**	62
Current Students#	17	27	44	55	45	39	**51**	36
% Current employment status							*******	
Employed full-time	12	23	23	34	27	26	**29**	38
Part time/ casual	55	30	49	32	39	34	**52**	39
Self-employed	/	/	-	-	10	11	**-**	4
Unemployed	13	19	22	31	24	28	**18**	19
Current median weekly income $ (IQR)	400 (250-638)	413 (244-800)	600 (300-900)	750 (496-1052)	588 (333-1081)	550 (336-1000)	**600 (379-1072)**	808 (450-1385)
% Current accommodation								
Own house/flat	-	7	-	-	8	10	**7**	9
Rented house/flat	58	44	39	54	64	55	**64**	58
Parents'/family home	32	42	46	36	15	22	**16**	26
Boarding house/hostel	-	0	-	-	-	-	**-**	2
Public Housing	/	-	-	-	-	-	**6**	3
No fixed address+	0	-	0	-	-	-	**-**	1
Other	-	-	0	0	-	-	**-**	1

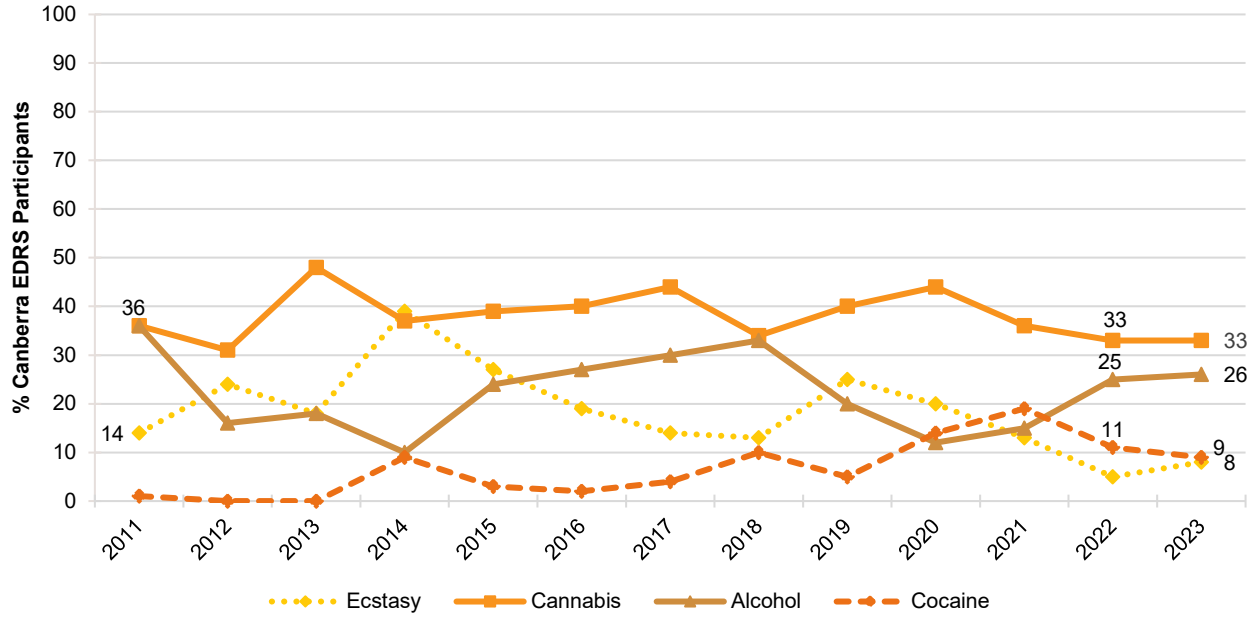
Note. ^Includes trade/technical and university qualifications. #'Current students' comprised participants who were currently studying for either trade/technical or university/college qualifications. / not asked. + No fixed address included 'couch surfing and rough sleeping or squatting. - Per cent suppressed 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 presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Figure 1: Drug of choice, Canberra, ACT, 2003-2023



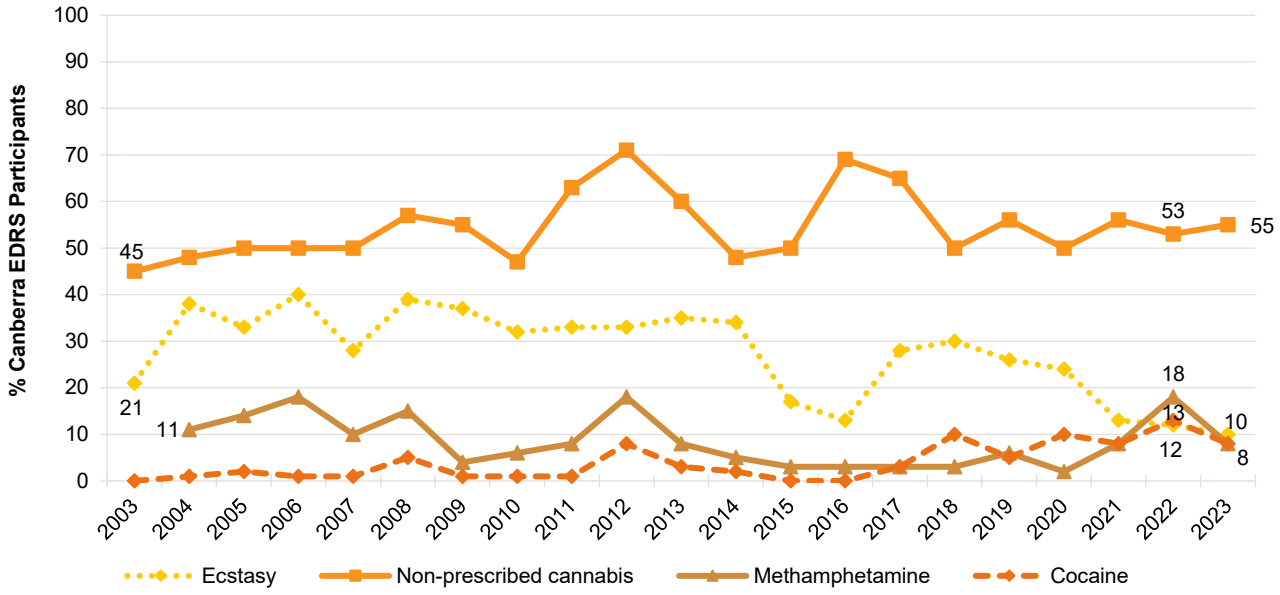
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; nominal percentages have endorsed other substances. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed 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, Canberra, ACT, 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, Canberra, ACT, 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. 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'. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

2

Ecstasy

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

Patterns of Consumption (any ecstasy)

Recent Use (past 6 months)

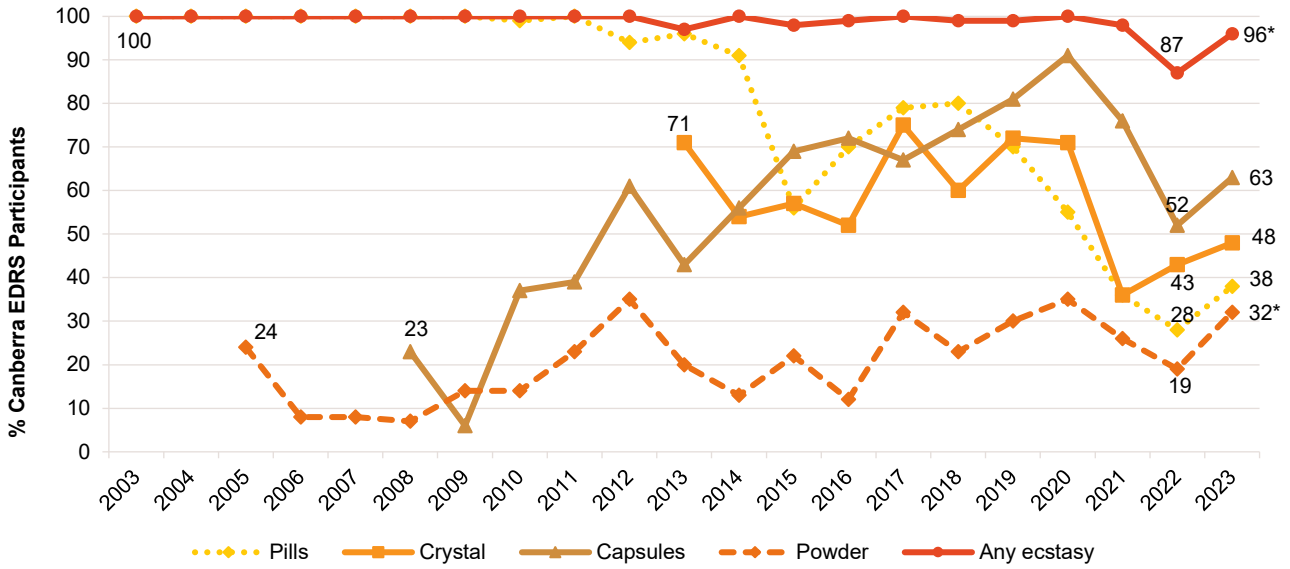
Over the course of monitoring, nearly all participants each year have reported recent ecstasy use. Past six month use decreased to a record low of 87% in 2022, however increased again in 2023 (96%; p=0.040), returning to levels observed historically (Figure 4).

From 2003-2014, pills dominated as the most common form of ecstasy used in the six months preceding interview. Between 2015-2019, pills competed with the crystal and capsule forms of ecstasy in terms of the per cent reporting recent use, with ecstasy capsules emerging as the most commonly used form of ecstasy from 2019 onwards. In 2023, capsules remained the most commonly used form of ecstasy (63%; 52% in 2022; p=0.150), followed by crystal (48% 43% in 2022; p=0.473) and pills (38%; 28% in 2022; p=0.134). The powder form significantly increased from 19% in 2022 to 32% in 2023 (p=0.038), although remains the least commonly used form of ecstasy (Figure 4).

Frequency of Use

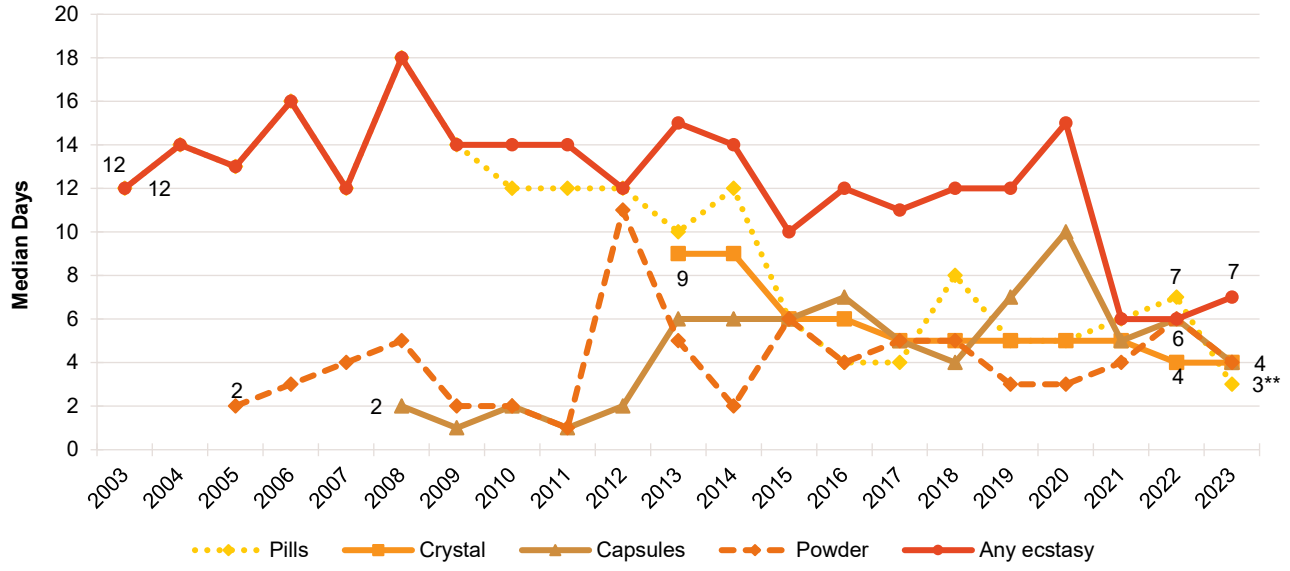
In 2023, participants reported using ecstasy (in any form) on a median of seven days (i.e., equivalent to monthly use; IQR=4-12; n=95), stable from 2022 (6 days; IQR=4-15; n=87; p=0.902) but remaining lower than what has historically been observed (10-18 days between 2003-2020) (Figure 5). Among those who reported recent ecstasy use in 2023, 11% reported weekly or more frequent use, stable relative from 2022 (14%; p=0.652).

Figure 4: Past six month use of any ecstasy, and ecstasy pills, powder, capsules, and crystal, Canberra, ACT, 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, Canberra, ACT, 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): Ecstasy pills dominated as the most common form of ecstasy used since monitoring commenced in 2003 until 2014, after which the most common form varied between pills, crystal and capsules until 2018. From 2019 onwards, pills have remained the third most commonly used form of ecstasy, with two fifths (38%) of the sample reporting recent use in 2023 (28% in 2022; p=0.134) (Figure 4).

Frequency of Use: Frequency of use of ecstasy pills significantly decreased, from a median of seven days in 2022 (IQR=4-12; n=28) to three days in 2023 (IQR=2-6; n=38; p=0.001) (Figure 5). Few participants reported weekly or more frequent use of ecstasy pills in 2023 (n≤5; n≤5 in 2022; p=0.389).

Routes of Administration: Swallowing remained the main route of administration among those who had recently used ecstasy pills (97%; 100% in 2022). Few participants (n≤5) nominated other routes of administration.

Quantity: In 2023, the median quantity used in a 'typical' session was two pills (IQR=1-2, n=38; 2 pills in 2022; n=28; IQR=2-3; p=0.120). The median maximum number of pills used remained stable at two pills (IQR=2-4, n=38; 3 pills in 2022; n=28; IQR=2-4; p=0.069).

Ecstasy Capsules

Recent Use (past 6 months): The per cent reporting recent use of ecstasy capsules has gradually increased over time, peaking at 91% in 2020, before subsequently declining. In 2023, nearly two thirds (63%) of the sample reported recent use, stable relative to 2022 (52%; p=0.150) and remaining as the most commonly used form of ecstasy since 2019 (Figure 4).

Frequency of Use: Participants reported consuming capsules on a median of four days in 2023 (IQR=2-8; n=62), stable relative to 2022 (6 days; IQR=3-10; n=52; p=0.086) (Figure 5). Of those who reported recent use of ecstasy capsules, few (n≤5) participants reported weekly or more frequent use in 2023 (n≤5 in 2022; p=0.243).

Routes of Administration: The main route of administration among those who had recently used capsules has consistently been swallowing (98%; 94% in 2022; p=0.330). Few participants (n≤5) reported other routes of administration.

Quantity: The median quantity used in a 'typical' session was two capsules in 2023 (IQR=1-2; n=62; 2 capsules in 2022; IQR=2-3; n=52; p=0.010) and the median maximum number of capsules used in a session was three (IQR=2-4; n=62; 3 capsules in 2022; IQR=2-5; n=52; p=0.034).

Ecstasy Crystal

Recent Use (past 6 months): Recent use of the crystal form of ecstasy was reported by half (48%) of the sample, stable relative to 43% in 2022 (p=0.473) (Figure 4).

Frequency of Use: Frequency of use among those who had recently used crystal remained stable at a median of four days (IQR=2-9; n=48; 4 days in 2022; IQR=2-8; n=43; p=0.851) (Figure 5). Few (n≤5) participants reported weekly or more frequent use (n≤5 in 2022).

Routes of Administration: Among those who had recently used crystal, the most common route of administration was swallowing (77%; 58% in 2022; p=0.075) and snorting (50%; 49% in 2022).

Quantity: The median amount of crystal used in a 'typical' session was 0.40 grams (IQR=0.20-

0.50; n=38; 0.40 grams in 2022; IQR=0.20-0.50; n=38; p=0.447) and the median maximum amount used was 0.60 grams (IQR=0.40-1.00; n=38; 0.60 grams in 2022; IQR=0.30-1.00; n=38; p=0.946).

Ecstasy Powder

Recent Use (past 6 months): With the exception of 2009, ecstasy powder has consistently been the least commonly endorsed form of ecstasy. In 2023, despite a significant increase in recent use (32%) relative to 2022 (19%; p=0.038), powder remained the least commonly used form of ecstasy (Figure 4).

Frequency of Use: Frequency of powder use remained stable at a median of four days in 2023 (IQR=3-8; n=32; 6 days in 2022; IQR=3-12; n=19; p=0.405) (Figure 5). Few (n≤5) participants reported weekly or more frequent use of ecstasy powder (n≤5 in 2022; p=0.623).

Routes of Administration: The main route of administration among those who had recently used powder has consistently been snorting (81%; 89% in 2022; p=0.694), followed by swallowing (41%; 47% in 2022; p=0.771).

Quantity: The median quantity used in a 'typical' session was 0.20 grams (IQR=0.10-0.50; n=23; 0.40 grams in 2022; IQR=0.20-0.50; n=16; p=0.140). The median maximum amount consumed in a session was 0.40 grams (IQR=0.20-0.70; n=23; 1.00 gram in 2022; IQR=0.40-2.00; n=17, p=0.028).

Price, Perceived Purity and Perceived Availability

Ecstasy Pills

Price: The reported median price of a pill was highest in the first four years of monitoring (2003-2006), after which it declined and then remained relatively stable at $25 between 2008 and 2022. However, in 2023, the median price of a pill significantly increased from $25 (IQR=21-25, n=10) in 2022 to $30 (IQR=25-40; n=17; p=0.023) (Figure 6).

Perceived Purity: No significant change was observed in 2023 compared to 2022 in relation to perceived purity of pills (p=0.226). Of those who responded in 2023 (n=40), 55% perceived pills to be of 'high' purity (33% in 2022), followed by one quarter (25%) reporting 'medium' purity (44% in 2022) (Figure 9).

Perceived Availability: The perceived availability of pills remained stable between 2022 and 2023 (p=0.118). Of those who responded in 2023 (n=41), nearly two fifths (37%) perceived pills to be 'difficult' to obtain (35% in 2022), the highest per cent since monitoring commenced. This was followed by 29% reporting perceived availability as 'easy' (23% in 2022) (Figure 13).

Ecstasy Capsules

Price: The median price per ecstasy capsule has fluctuated between $20-$30 since monitoring commenced. After declining to $20 in 2020 and 2021, the median price for capsules was $25 in 2023 (IQR=21-30; n=26), stable relative to 2022 ($25; IQR=20-29; n=14; p=0.269) (Figure 6).

Perceived Purity: No significant change was observed in 2023 compared to 2022 in relation to perceived purity of capsules (p=0.580). Among those who responded in 2023 (n=65), 43% perceived capsules to be of 'medium' purity (45% in 2022), followed by nearly one quarter (23%) reporting 'high' purity (25% in 2022) (Figure 10).

Perceived Availability: There was a significant change in the perceived availability of capsules between 2022 and 2023 (p=0.001). Of those who were able to comment in 2023 (n=66), more participants reported perceived

availability to be 'easy' (39%; 20% in 2022) and 'very easy' (33%; 16% in 2022), while fewer participants perceived it as being 'difficult' to obtain (23%; 52% in 2022) (Figure 14).

Ecstasy Crystal

Price: The median price of a gram of crystal was $250 in 2023 (IQR=200-250; n=27; $200 in 2022; IQR=200-300; n=24; *p*=0.938). Few participants reported the price of a point (n≤5; n≤5 in 2022; *p*=0.543) (Figure 7).

Perceived Purity: No significant change was observed in 2023 compared to 2022 in relation to perceived purity of crystal (*p*=0.086). Of those who responded in 2023 (n=52), 54% reported purity to be 'high' (35% in 2022), followed by one quarter (23%) reporting 'medium' purity (48% in 2022) (Figure 11).

Perceived Availability: There was a significant change in perceived availability between 2022 and 2023 (*p*=0.003). Among those who responded in 2023 (n=52), more participants reported perceived availability to be 'very easy' (42%; 15% in 2022) and 'easy' (29%; 23% in 2022), while fewer participants reported perceived availability as 'difficult' (21%; 42% in 2022) (Figure 15).

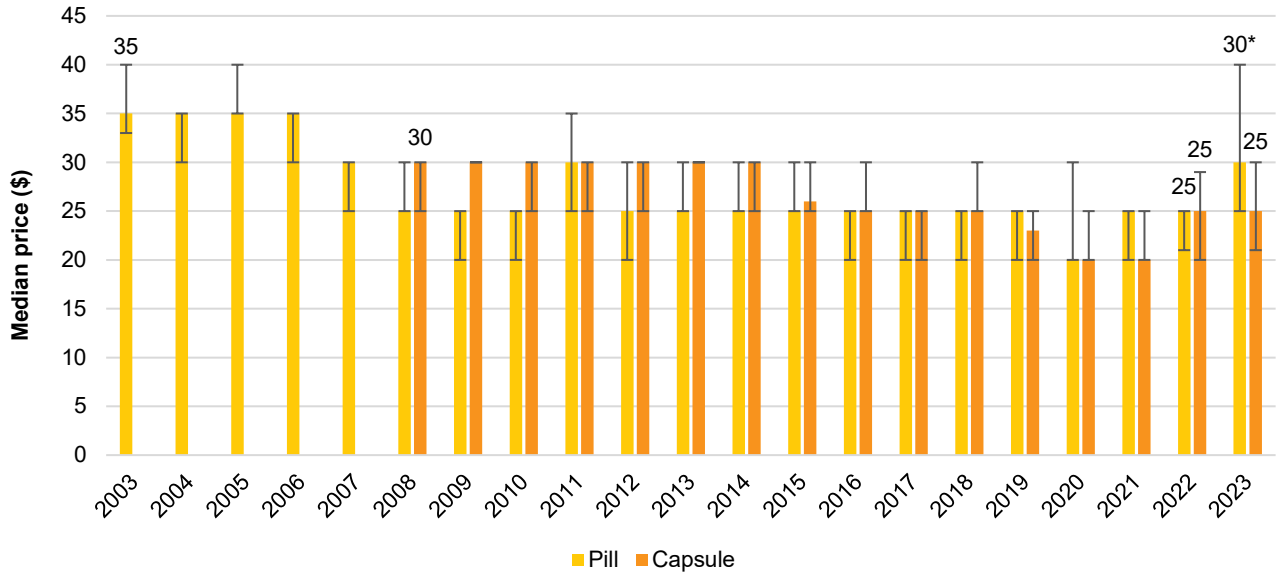
Ecstasy Powder

Price: The median price per gram of ecstasy powder significantly increased from $200 in 2022 (IQR=170-200; n=11) to $225 (IQR=200-250; n=13; *p*=0.044) in 2023. Few (n≤5) participants reported on the price for a point in 2023 (n≤5 in 2022) (Figure 8).

Perceived Purity: The perceived purity of powder remained stable between 2022 and 2023 (*p*=0.501). Among those who responded in 2023 (n=31), 45% perceived powder to be of 'medium' purity (61% in 2022), followed by one third (32%) perceiving it to be of 'high' purity (22% in 2022) (Figure 12).

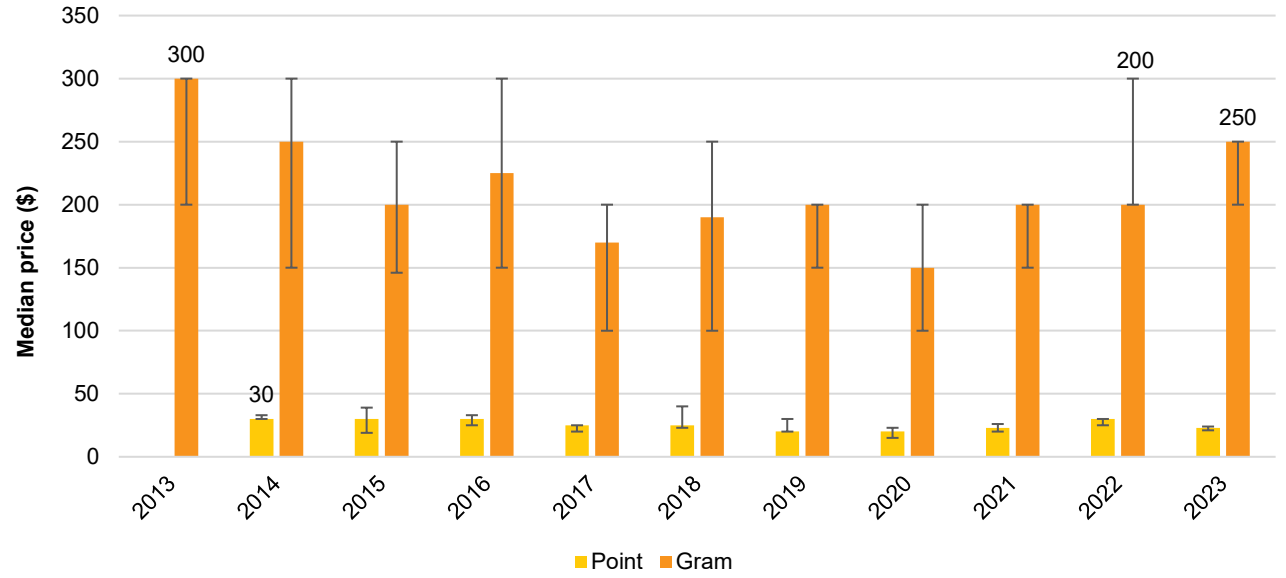
Perceived Availability: The perceived availability of ecstasy powder remained stable between 2022 and 2023 (*p*=0.420). Among those who responded in 2023 (n=32), two fifths (41%) reported that powder was 'easy' to obtain (25% in 2022), followed by 28% reporting that it was 'difficult' to obtain (40% in 2022) (Figure 16).

Figure 6: Median price of ecstasy pill and capsule, Canberra, ACT, 2003-2023



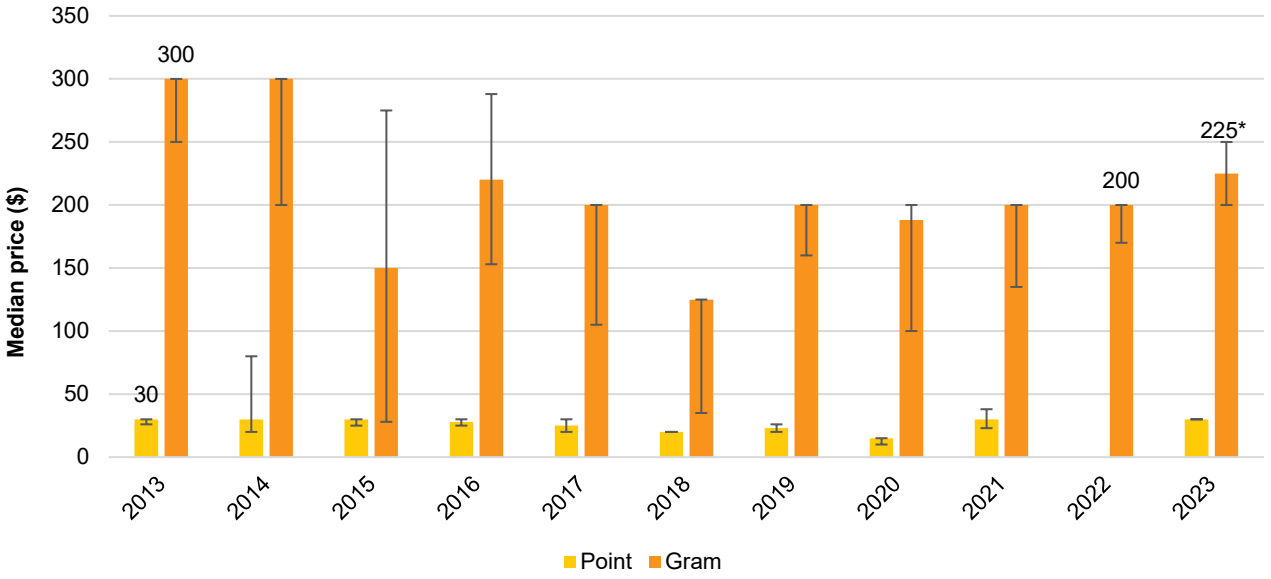
Note. Among those who commented. Data collection for price of ecstasy capsules started in 2008. Data labels are only provided for the first (2003/2008) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response 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, Canberra, ACT, 2013-2023



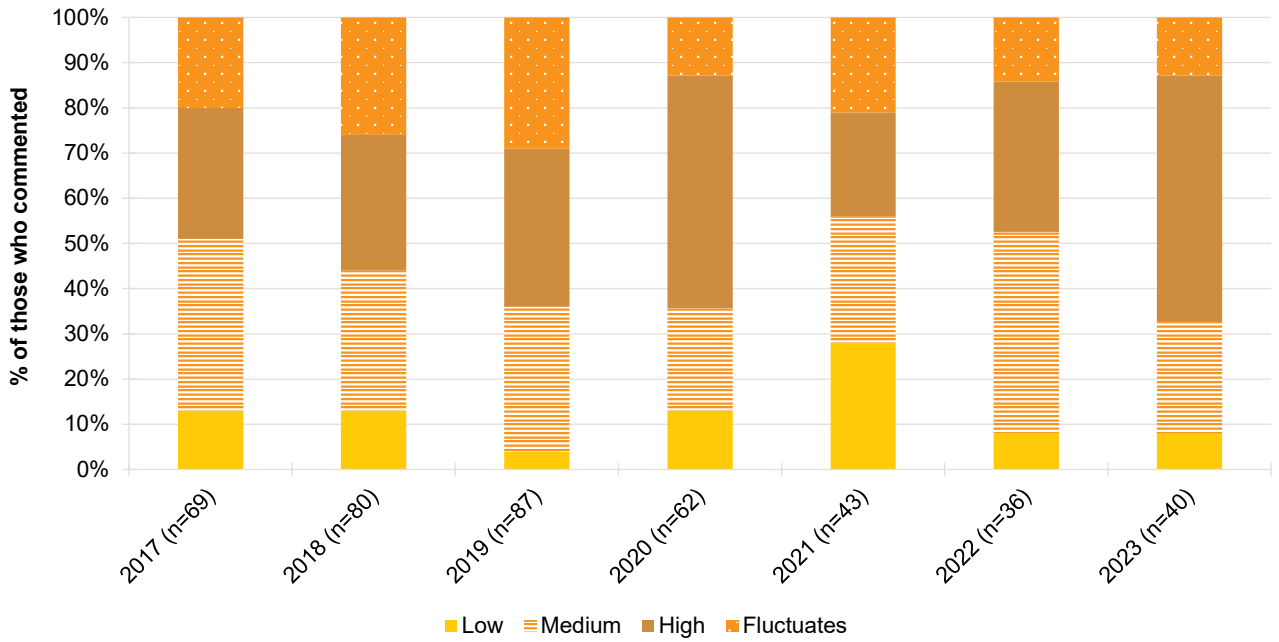
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) started in 2013. No participants reported price data for a 'point' of ecstasy crystal in 2013. Data labels are only provided for the first (2013/2014) and two most recent years (2022 and 2023) of monitoring, 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: Median price of ecstasy powder per point and gram, Canberra, ACT, 2013-2023



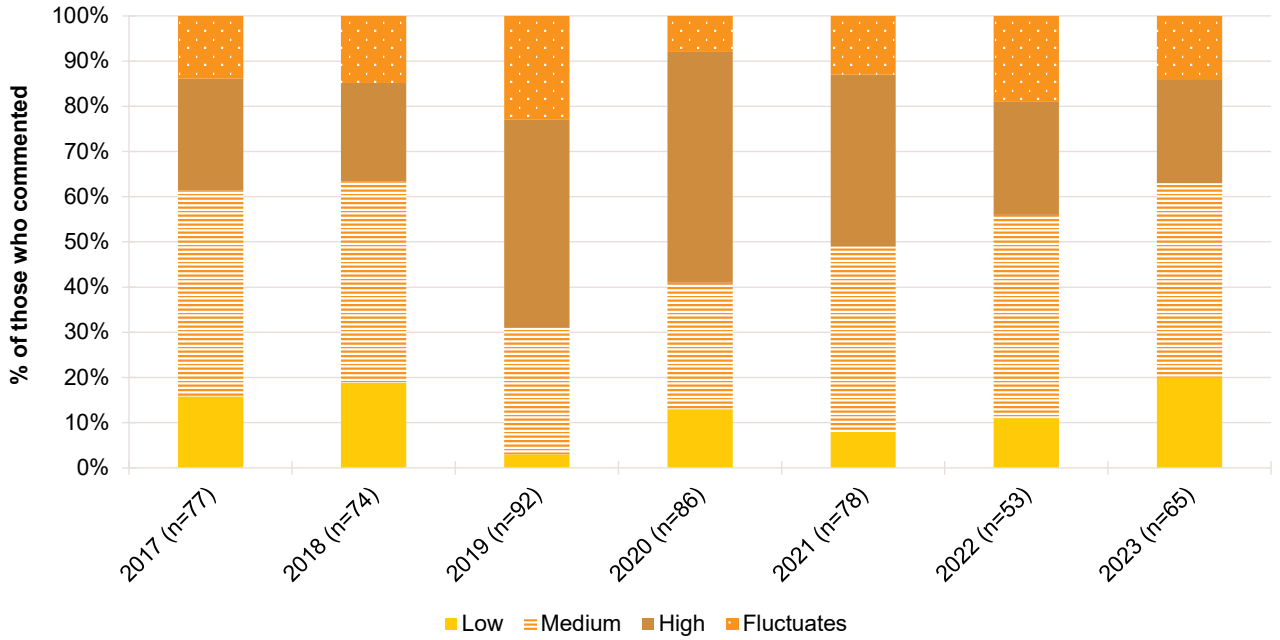
Note. Among those who commented. Data collection for price of ecstasy powder (gram and point) started in 2013. No participants reported price data for a 'point' of ecstasy powder in 2022. Data labels are only provided for the first (2013) and two most recent years (2022 and 2023) of monitoring, however 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 9: Current perceived purity of ecstasy pills, Canberra, ACT, 2017-2023



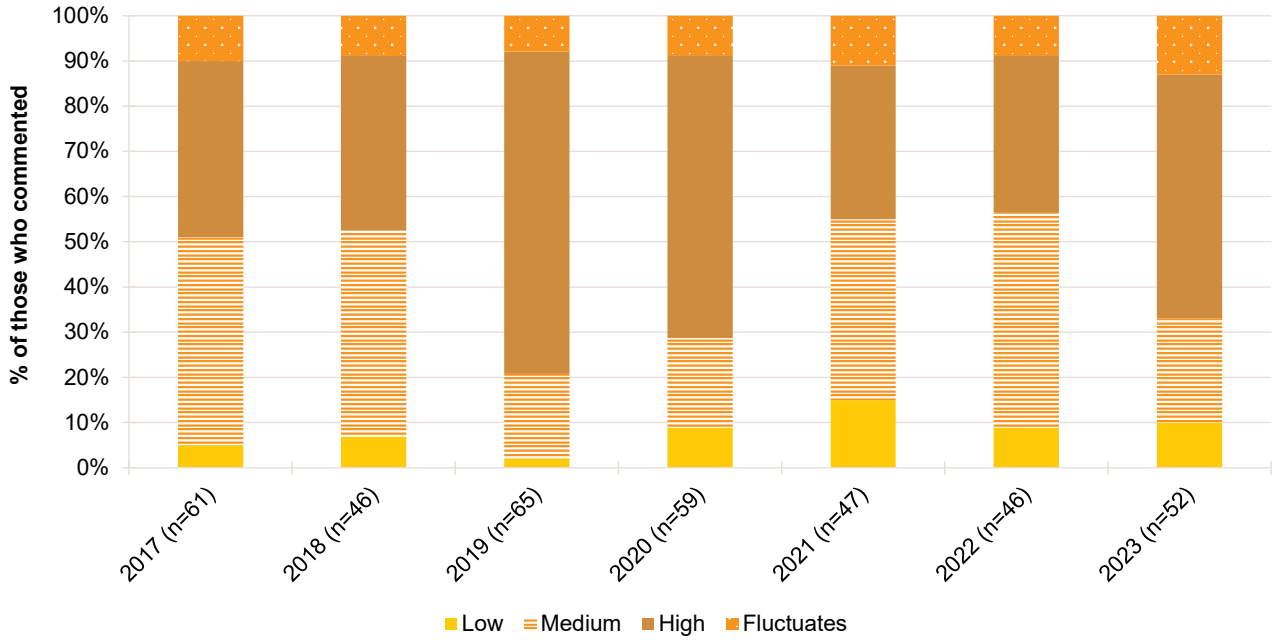
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and 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 capsules, Canberra, ACT, 2017-2023



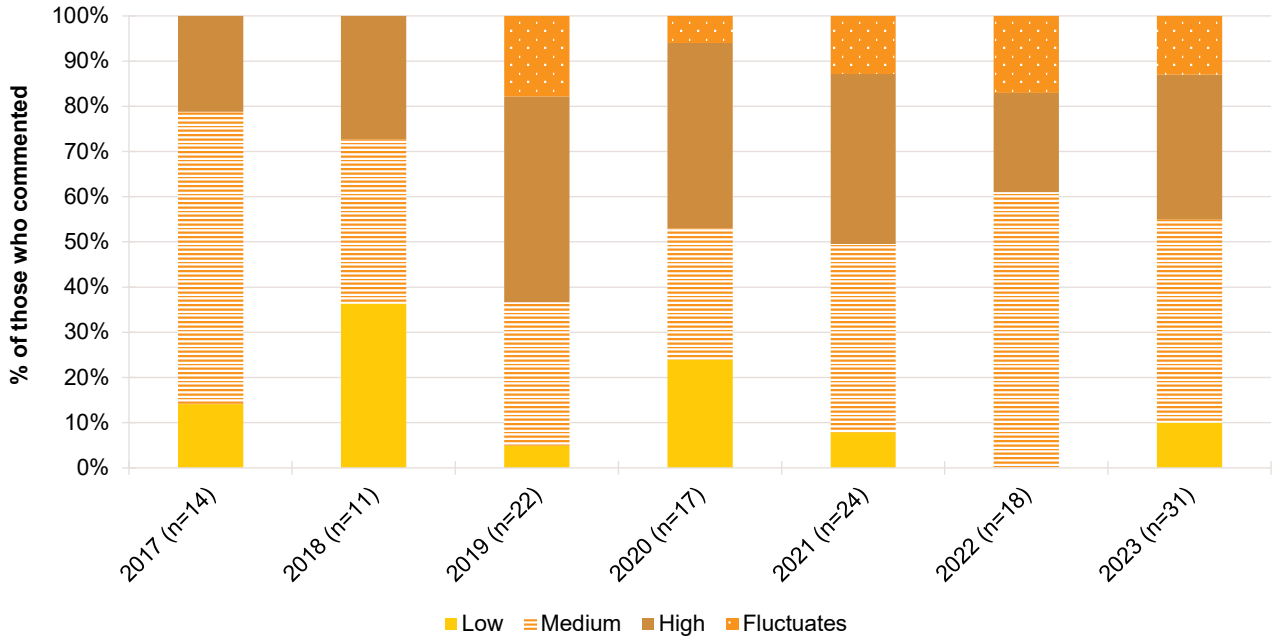
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and 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 crystal, Canberra, ACT, 2017-2023



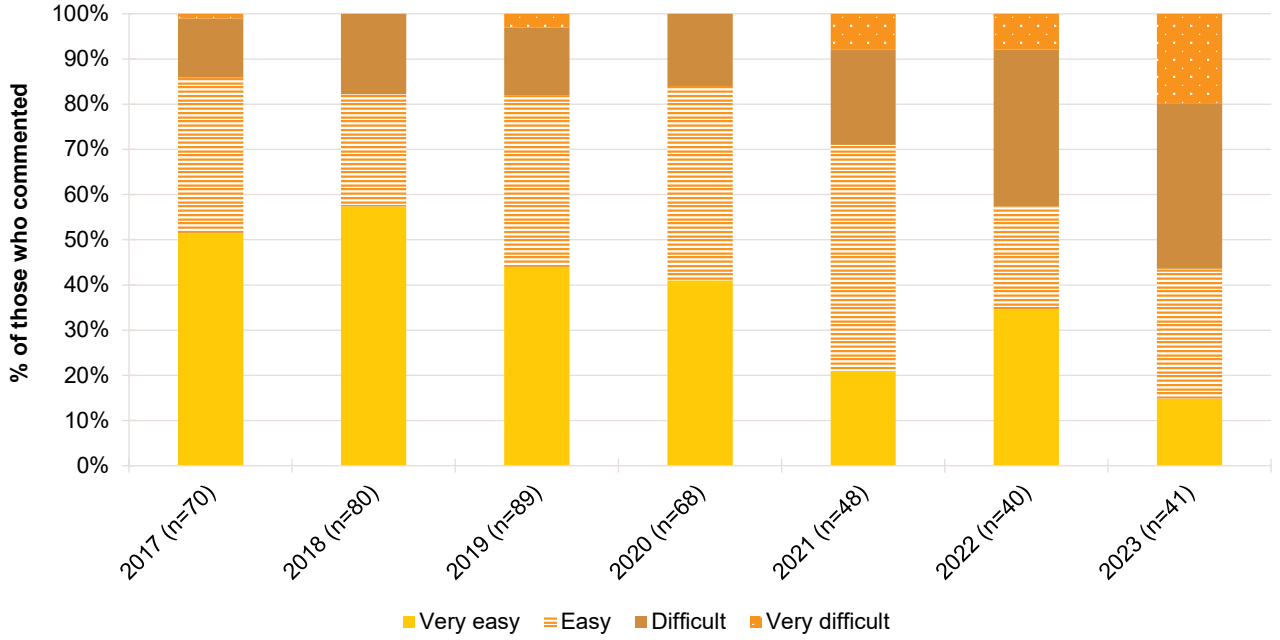
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and 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 purity of ecstasy powder, Canberra, ACT, 2017-2023



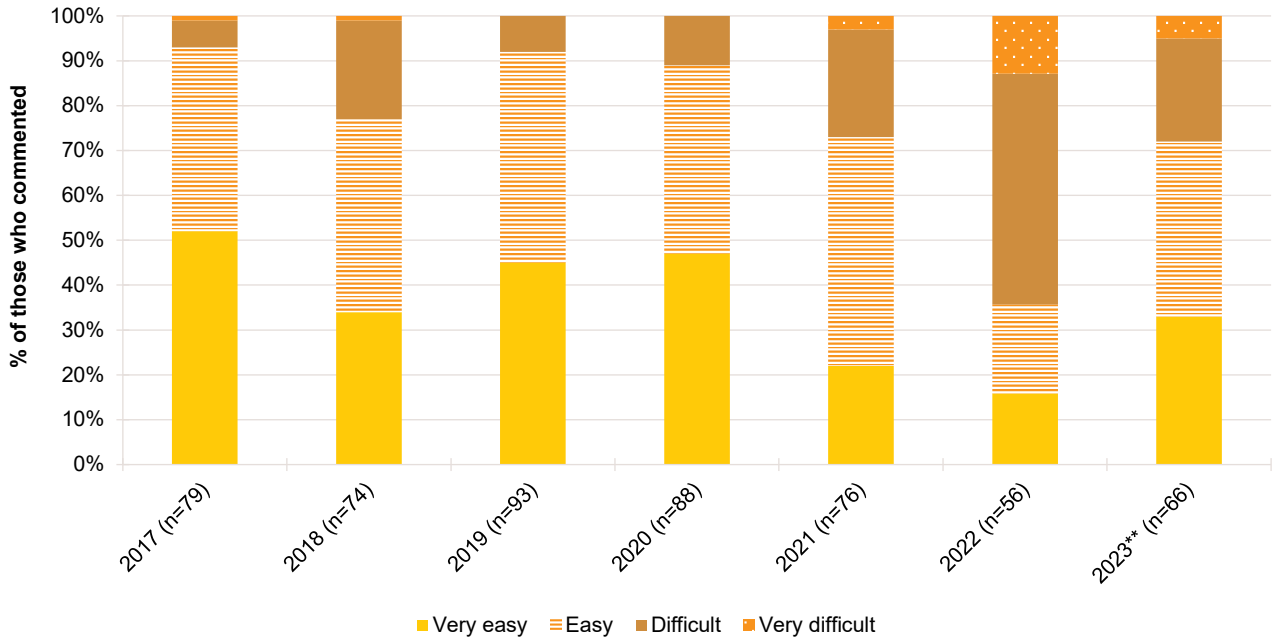
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and 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 pills, Canberra, ACT, 2017-2023



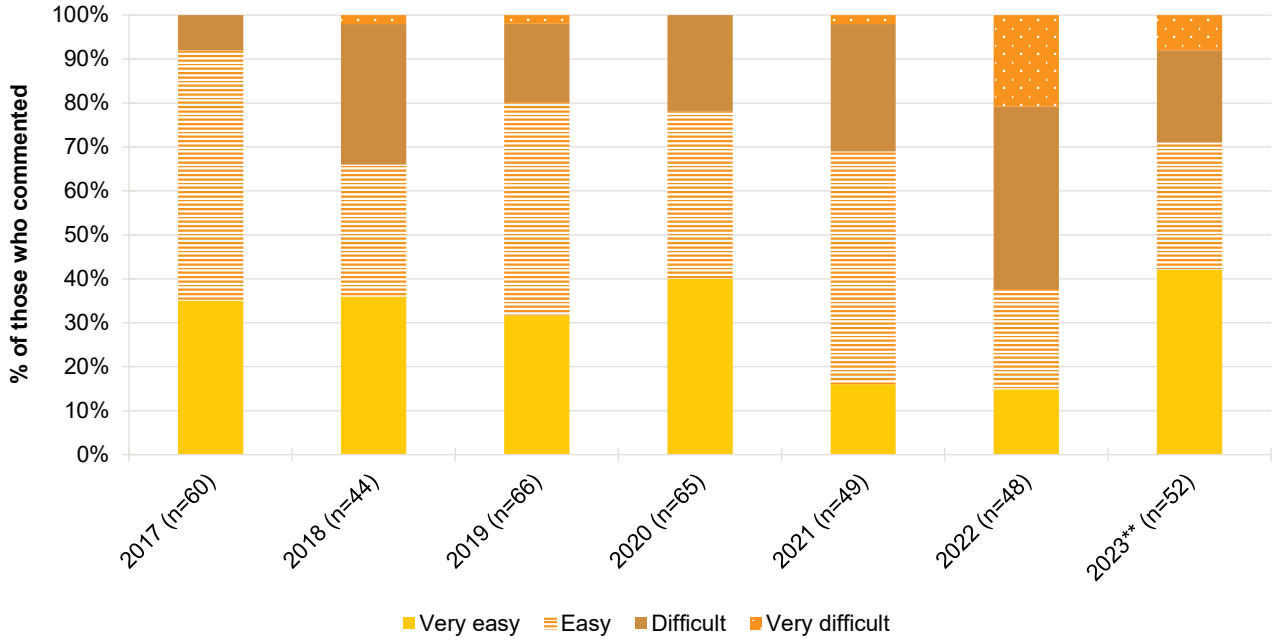
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and 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 capsules, Canberra, ACT, 2017-2023



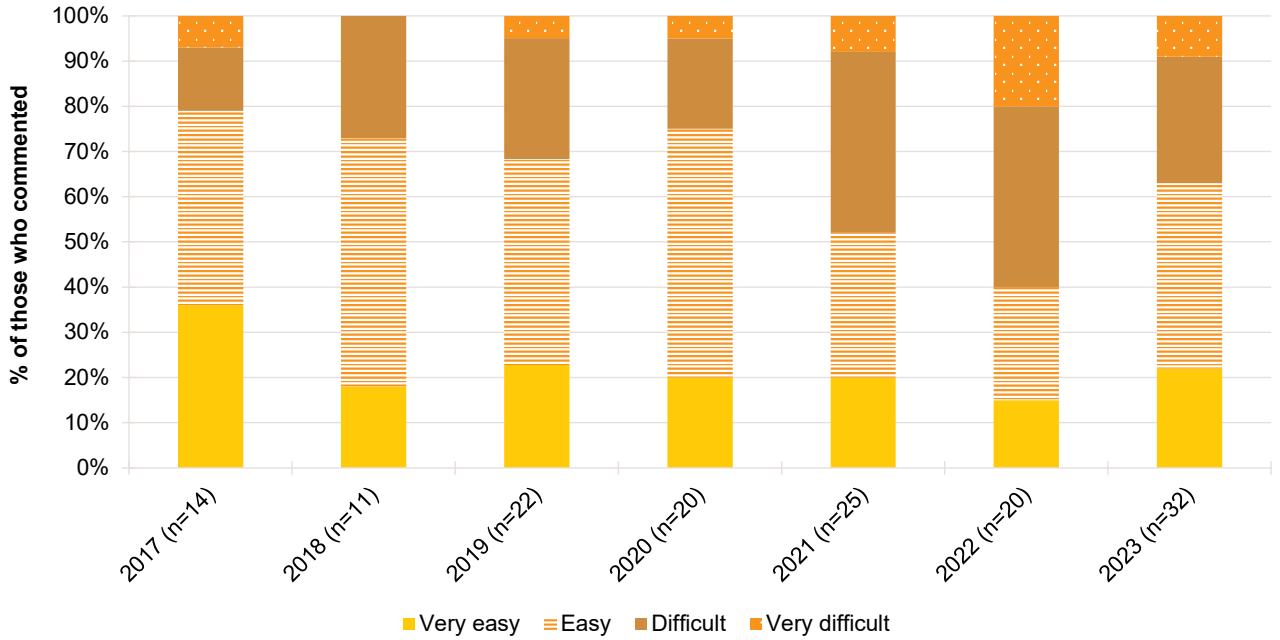
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and 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 crystal, Canberra, ACT, 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 16: Current perceived availability of ecstasy powder, Canberra, ACT, 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.

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 declined from four in five participants (79%) in 2003 to one in six participants in 2020 (15%), before increasing in 2021 and 2022. In 2023, nearly one quarter (23%) of the sample reported recent use, a significant decrease relative to 39% in 2022 (p=0.024) (Figure 17).

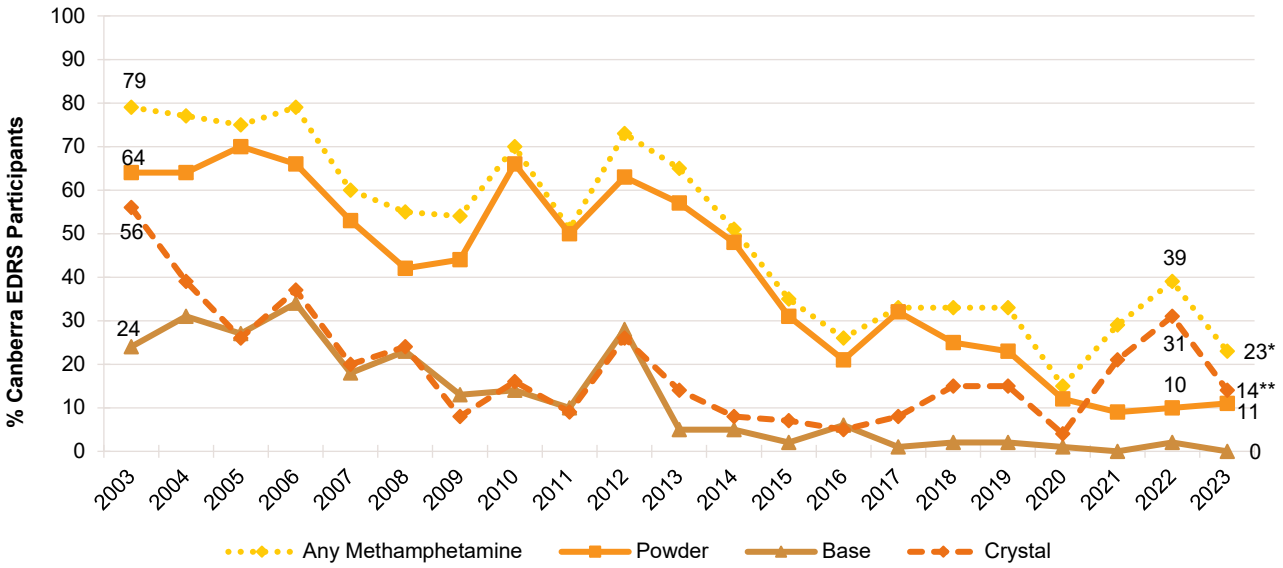
Frequency of Use

Use has historically been relatively infrequent over the course of monitoring, apart from a spike in 2022. In 2023, participants reported a median of six days of use (i.e., monthly use; IQR=2-37; n=23; 20 days in 2022; IQR=4-66; n=20; p=0.149) (Figure 18). Amongst participants who reported recent use of any methamphetamine (n=23), one third (35%) reported weekly or more frequent use (46% in 2022; p=0.433).

Forms Used

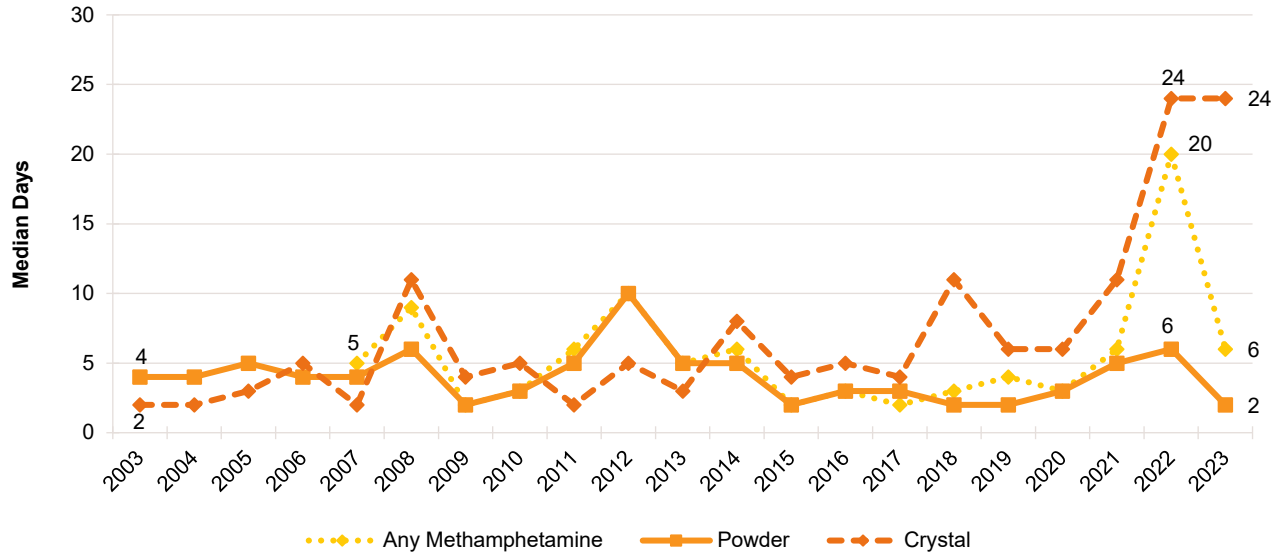
Of participants who had used methamphetamine in the six months preceding interview in 2023 (n=23), most had used crystal methamphetamine (61%; 79% in 2022; p=0.153), followed by powder (48%; 26% in 2022; p=0.105). No participants reported using base methamphetamine in 2023 (n≤5 in 2022; p=0.522).

Figure 17: Past six month use of any methamphetamine, powder, base, and crystal, Canberra, ACT, 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 18: Median days of any methamphetamine, powder, and crystal use in the past six months, Canberra, ACT, 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 30 days to improve visibility of trends. Data on base methamphetamine not provided due to low respondents historically. Data labels are only provided for the first (2003/2007) 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). 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): Powder was the most commonly used form of methamphetamine between 2003 and 2020, although the per recent reporting recent use declined substantially over this period. It was surpassed by the crystal form for the first time in 2021. In 2023, one in ten (11%) participants reported recent use of methamphetamine powder (10% in 2022) (Figure 17).

Frequency of Use: Frequency of use has fluctuated over the years, peaking at a median of 10 days in 2012. In 2023, participants reported using powder on a median of two days (IQR=1-3; n=11), the lowest frequency of use reported since monitoring commenced although stable from 2022 (6 days; IQR=1-9; n=10; *p*=0.102) (Figure 18).

Routes of Administration: Among participants who had recently used powder, the most common route of administration was snorting (73%; 70% in 2022).

Quantity: The median quantity used in a 'typical' session was 0.20 grams (IQR=0.10-0.40; n=6; 0.20 grams in 2022; IQR=0.10-0.50; n=10). The median maximum amount consumed in a session was 0.20 grams (IQR=0.10-0.40; n=6; 0.20 grams in 2022; IQR=0.10-0.50; n=10; *p*=0.782).

Methamphetamine Crystal

Recent Use (past 6 months): Recent use of crystal has fluctuated over the years, however crystal has been the most commonly used form of methamphetamine since 2021. In 2023, 14% of the sample reported recent use, a significant decrease relative to 2022 (31%; *p*=0.006) (Figure 17).

Frequency of Use: In 2023, participants reported using crystal methamphetamine once a week in the past six months (median 24 days; IQR=7-50; n=14; 24 days in 2022; IQR=5-72; n=31; *p*=0.844), the highest frequency of use reported since monitoring began (Figure 18).

Routes of Administration: Among participants who had recently used crystal, most reported smoking as a route of administration (93%; 94% in 2022).

Quantity: The median quantity used in a 'typical' session was 0.20 grams (IQR=0.10-0.50; n=13; 0.30 grams in 2022; IQR=0.20-0.50; n=30; *p*=0.546). The median maximum amount used in a session was 0.40 grams (IQR=0.20-1.20; n=12; 0.50 grams in 2022; IQR=0.40-1.00; n=30; *p*=0.644).

Methamphetamine Base

No participants reported recent use of base methamphetamine in 2023 and therefore further details are not reported. Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Due to the low number of respondents (n≤5), details regarding the price (Figure 19), perceived purity (Figure 21) and perceived availability (Figure 23) of methamphetamine powder will not be discussed.

Please refer to the 2023 EDRS National Report for national trends, or to the 2023 IDRS National Report or the 2023 IDRS ACT Report for trends amongst a sample of people who regularly injects illicit drugs. Alternatively, contact the Drug Trends team (drugtrends@unsw.edu.au) for further information.

Methamphetamine Crystal

Price: In 2023, few (n≤5) participants reported on the price of a gram (n≤5 in 2022; *p*=0.057) or a point ($70 in 2022; IQR=50-100; *p*=0.701) of methamphetamine crystal, therefore these data are suppressed (Figure 20).

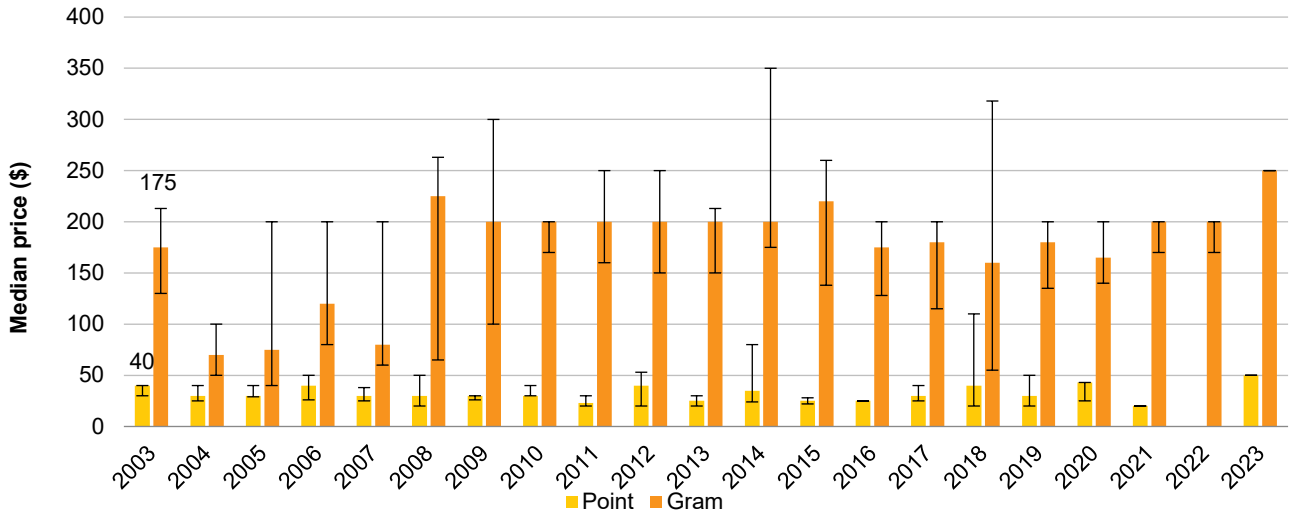
Perceived Purity: The perceived purity of crystal methamphetamine remained stable between 2022 and 2023 (*p*=0.172). Among those who responded in 2023 (n=14), two thirds (64%) perceived crystal methamphetamine to be of 'high' purity (47% in 2022) (Figure 22).

Perceived Availability: There was no significant change in the perceived availability of methamphetamine crystal between 2022 and 2023 (*p*=0.515). Of those who responded in 2023 (n=14), two thirds (64%) perceived the availability of crystal to be 'very easy' (63% in 2022) (Figure 24).

Methamphetamine Base

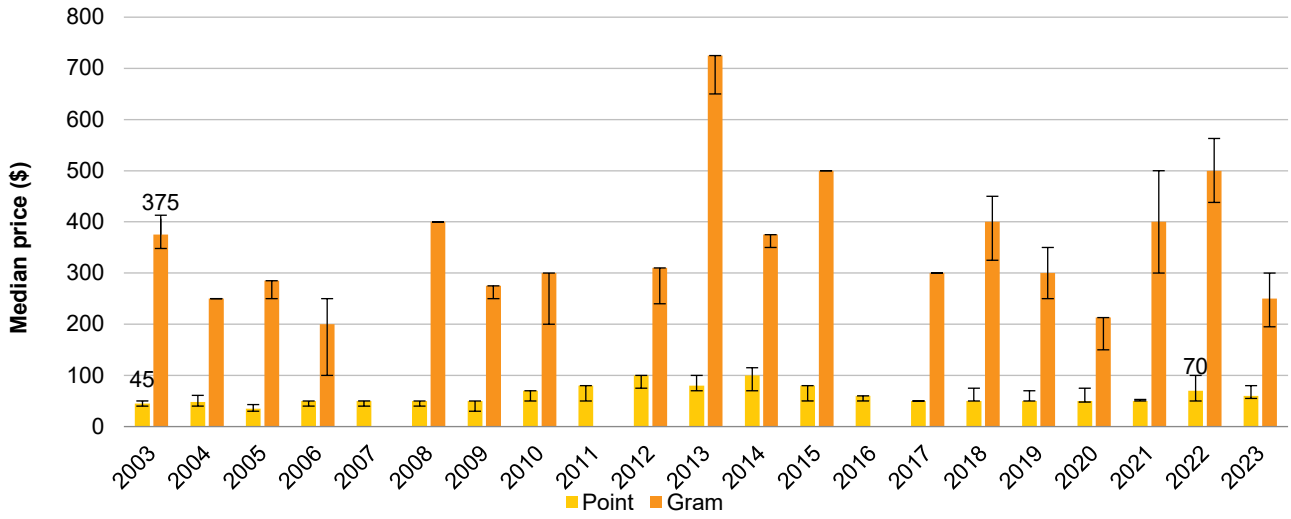
In 2023, no participants reported recent use of methamphetamine base, therefore data on the price, perceived purity and perceived availability of base methamphetamine are not reported. Please refer to the 2023 National EDRS Report for national trends, or to the 2023 IDRS National Report or the 2023 IDRS ACT Report for trends amongst a sample of people who regularly injects illicit drugs. Alternatively, contact the Drug Trends team (drugtrends@unsw.edu.au) for further information.

Figure 19: Median price of powder methamphetamine per point and gram, Canberra, ACT, 2003-2023



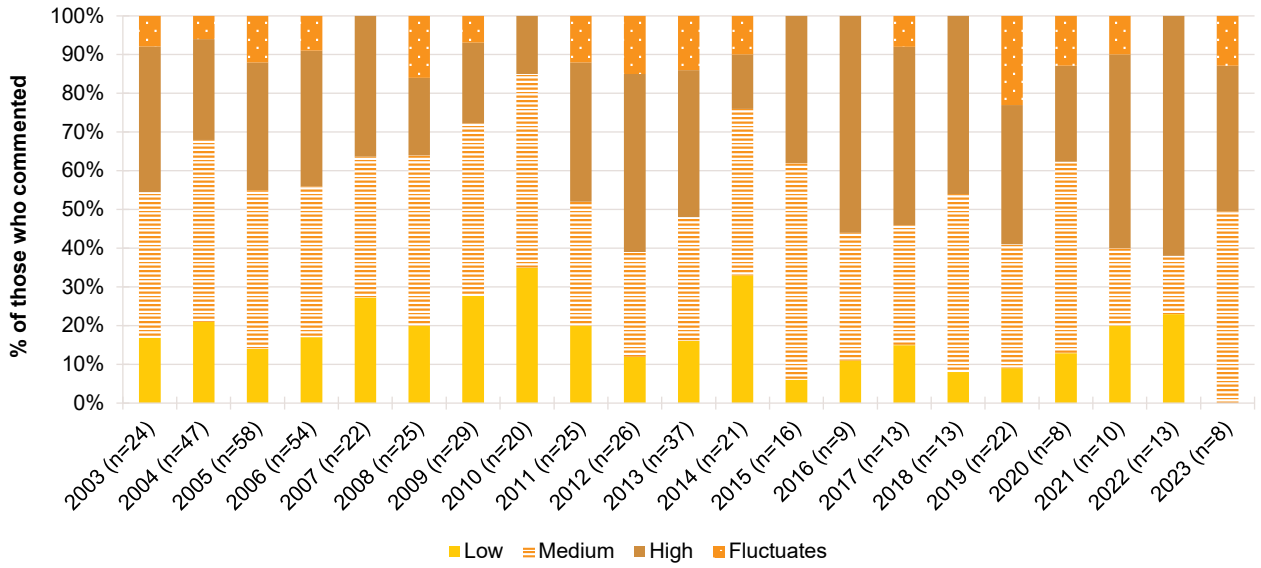
Note. Among those who commented. No participants reported purchasing a point of powder methamphetamine in 2022. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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 20: Median price of crystal methamphetamine per point and gram, Canberra, ACT, 2003-2023



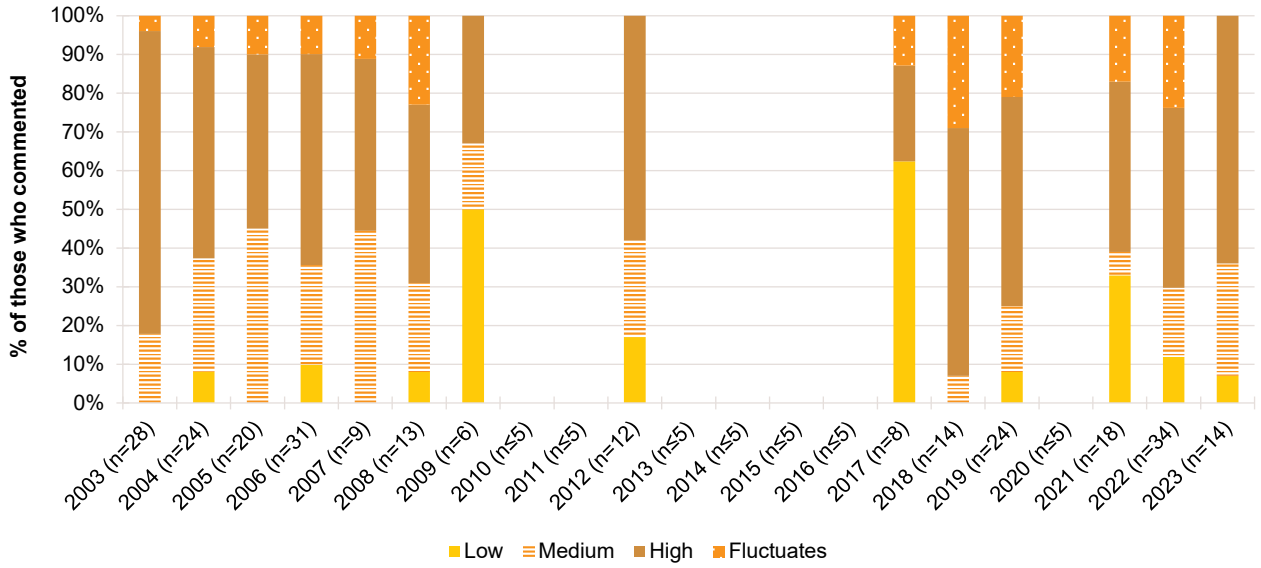
Note. Among those who commented. No participants reported purchasing a gram of crystal methamphetamine in 2007, 2011, 2016. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 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 21: Current perceived purity of powder methamphetamine, Canberra, ACT, 2003-2023



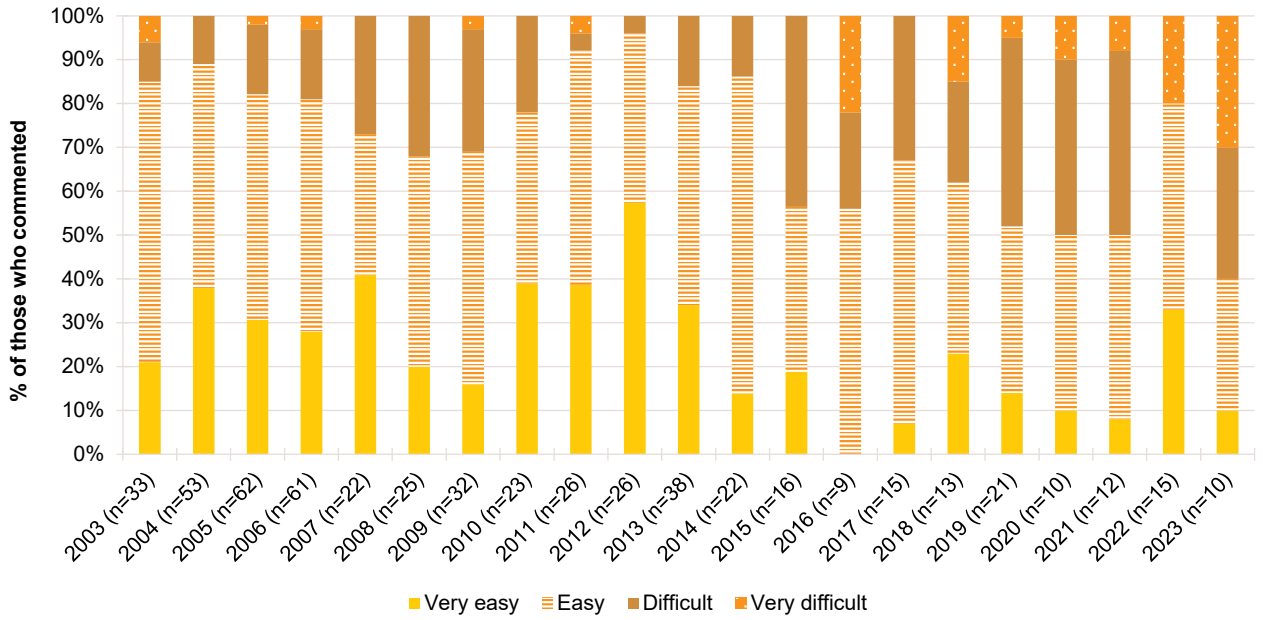
Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus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

Figure 22: Current perceived purity of crystal methamphetamine, Canberra, ACT, 2003-2023



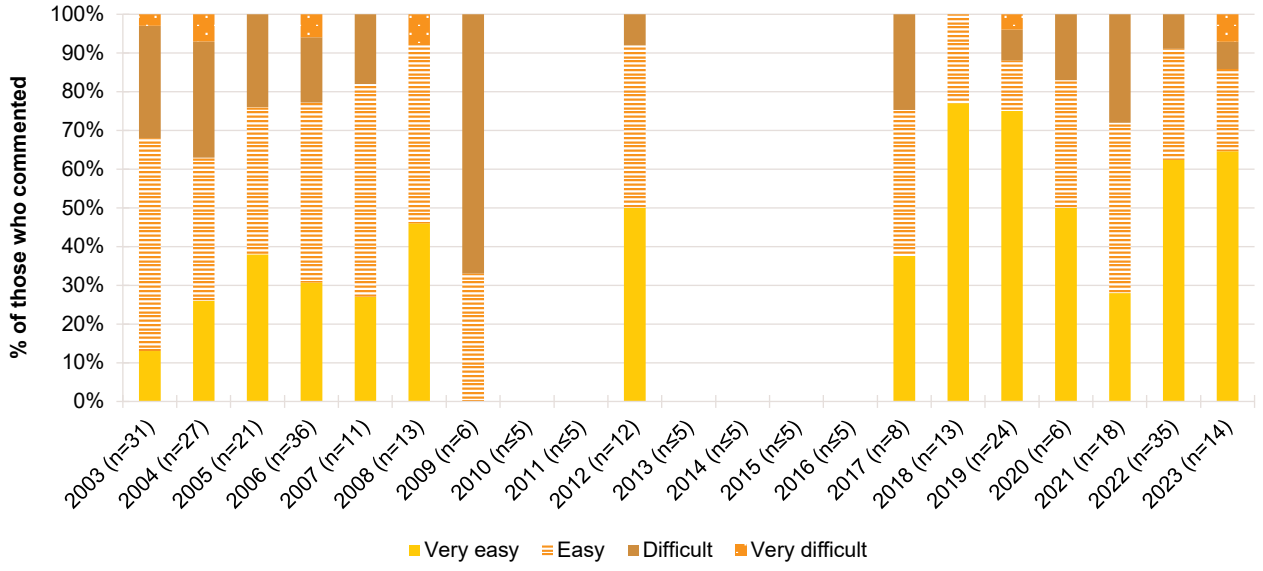
Note. The response 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022 versus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

Figure 23: Current perceived availability of powder methamphetamine, Canberra, ACT, 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 24: Current perceived availability of crystal methamphetamine, Canberra, ACT, 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.

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)

Recent non-prescribed use of pharmaceutical stimulants (e.g., dexamphetamine, methylphenidate, modafinil) has fluctuated over time. In 2023, half (51%) reported recent non-prescribed use, the highest per cent since monitoring commenced, although stable relative to 2022 (50%) (Figure 25).

Frequency of Use

Median days of non-prescribed use remained stable between 2022 and 2023 (10 days in 2023; IQR=3-20; n=51; 6 days in 2022; IQR=3-12, n=49; p=0.205) (Figure 25).

Routes of Administration

In 2023, the main route of administration among those who had recently used non-prescribed pharmaceutical stimulants was swallowing (94%; 90% in 2022; p=0.487), followed by snorting (27%; 34% in 2022; p=0.518).

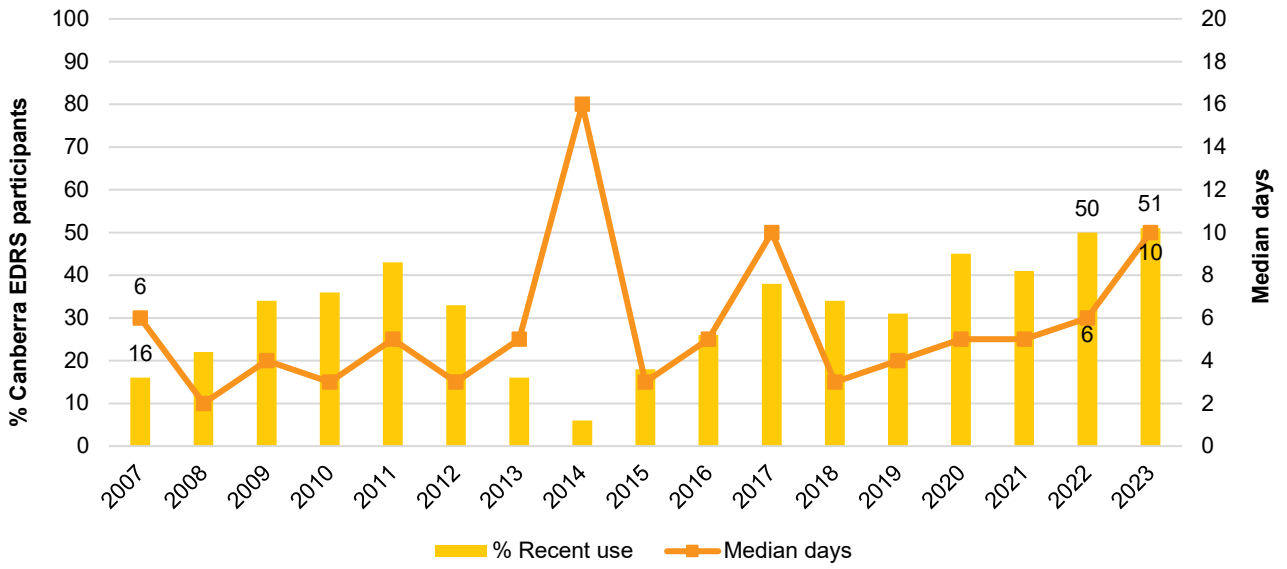
Quantity

The median quantity of non-prescribed pharmaceutical stimulants used in a 'typical' session in 2023 was two pills/tablets (IQR=1-3; n=46; 2 pills in 2022; IQR=1-4; n=46; p=0.764), and the median maximum amount used per session was three pills/tablets (IQR=2-4; n=45; 3 pills in 2022; IQR=2-5; n=47; p=0.831).

Forms Used

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=51), the majority reported using dexamfetamine (88%; 90% in 2022), with fewer participants reporting use of Ritalin® (55%; 48% in 2022; p=0.549) and lisdexamfetamine (22%; 12% in 2022; p=0.289).

Figure 25: Past six month use and frequency of use of non-prescribed stimulants, Canberra, ACT, 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. Secondary Y axis reduced to 20 days to improve visibility of trends. The response option 'Don't know' was excluded from analysis. 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. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Price and Perceived Availability

Price

Participants reported a median price of $5 per 5mg tablet in 2023 (IQR=5-11; n=8; $5 in 2022; IQR=3-5; n=19; p=0.168) and $5 per 10mg tablet (IQR=5-8; n=7; n≤5 in 2022; p=0.655).

Perceived Availability

Among those who responded in 2023 (n=44), the perceived availability of non-prescribed pharmaceutical stimulants was stable relative to 2022 (p=0.473). Three fifths (61%) of participants perceived availability to be 'very easy' to obtain (45% in 2022), followed by one quarter (27%) perceiving it to be 'easy' (33% 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 any cocaine has fluctuated over the years, from one quarter (26%) reporting use in 2003 to most participants reporting use in 2021 (91%). In 2023, nearly three fifths (78%) reported recent use, stable relative to 2022 (76%; p=0.864) (Figure 26).

Frequency of Use

Frequency of use has fluctuated between a median of one and six days over the course of monitoring. In 2023, the median days of use amongst participants who had recently used cocaine was five days (IQR=2-10; n=78), a significant decrease relative to 2022 (6 median days; IQR=3-12; n=76; p=0.043) (Figure 26). Of those who had recently consumed cocaine (n=78), one in ten (10%) reported weekly or more frequent use (17% in 2022; p=0.251).

Routes of Administration

In 2023, the main route of administration among those that had recently used cocaine was snorting (96%; 100% in 2022; p=0.245).

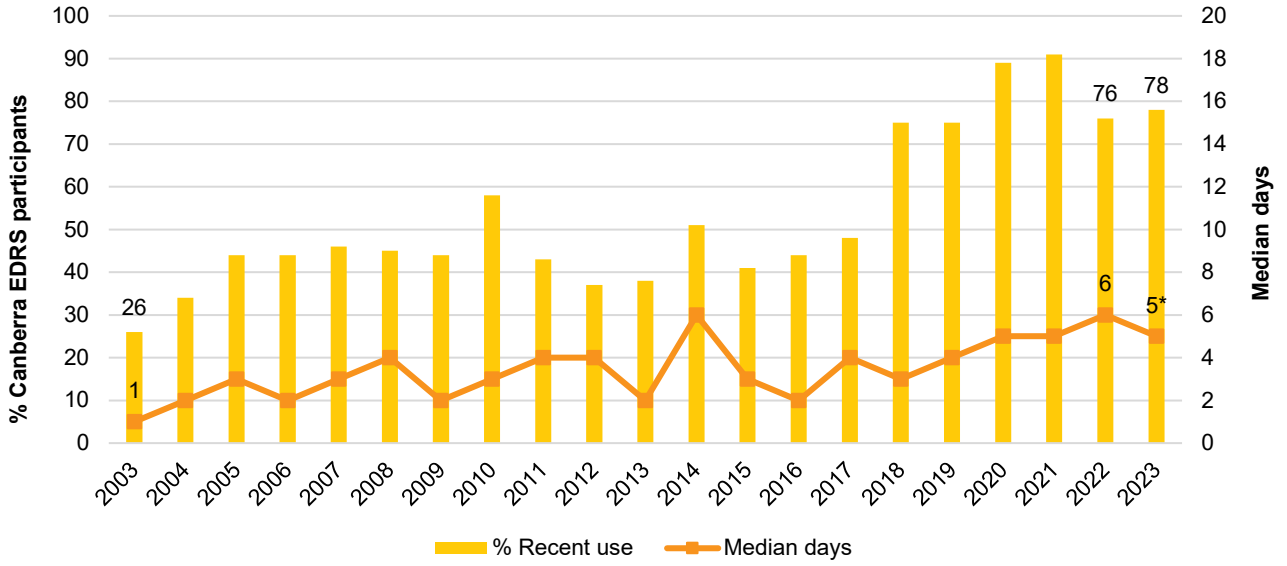
Quantity

The median intake in a 'typical' session was 0.50 grams (IQR=0.30-1.00; n=46; 0.50 grams in 2022; IQR=0.30-1.00; n=54; p=0.585) and the median maximum intake was 1.00 gram (IQR=0.50-2.50, n=47; 1.00 gram in 2022; IQR=0.50-2.00, n=53; p=0.822).

Forms used

Among participants who had recently consumed cocaine and commented (n=77), the vast majority reported using powder cocaine (97%; 93% in 2022; p=0.280), with fewer participants reporting use of cocaine in rock form (9%; 8% in 2022).

Figure 26: Past six month use and frequency of use of cocaine, Canberra, ACT, 2003-2023



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 20 days to improve visibility of trends for days of use. Data labels are only provided for the first (2003) and two most recent years (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

Consistent since 2006, the median price per gram of cocaine remained stable at $300 in 2023 (IQR=300-350; n=35; $300 in 2022; IQR=300-350, n=38; p=0.855) (Figure 27).

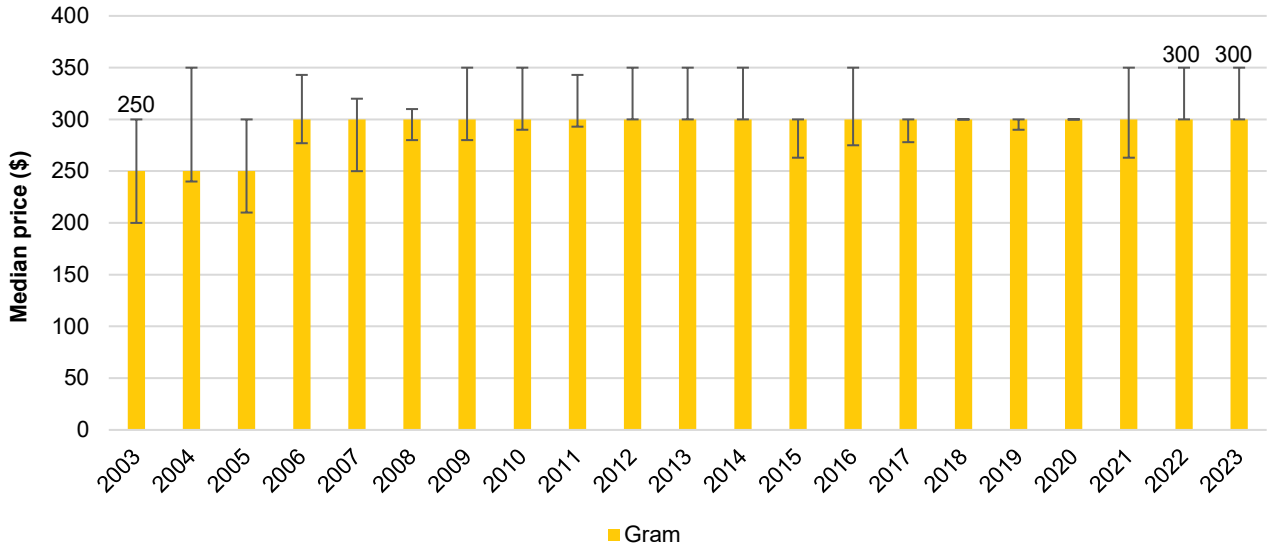
Perceived Purity

There were no significant changes in perceived purity between 2022 and 2023 (p=0.666). Among those able to comment in 2022 (n=72), one third (32%) perceived cocaine to be of 'medium' purity (42% in 2022), followed by 29% that perceived it to be of 'high' purity (25% in 2022) and one quarter (26%) reporting 'low' purity (22% in 2022) (Figure 28).

Perceived Availability

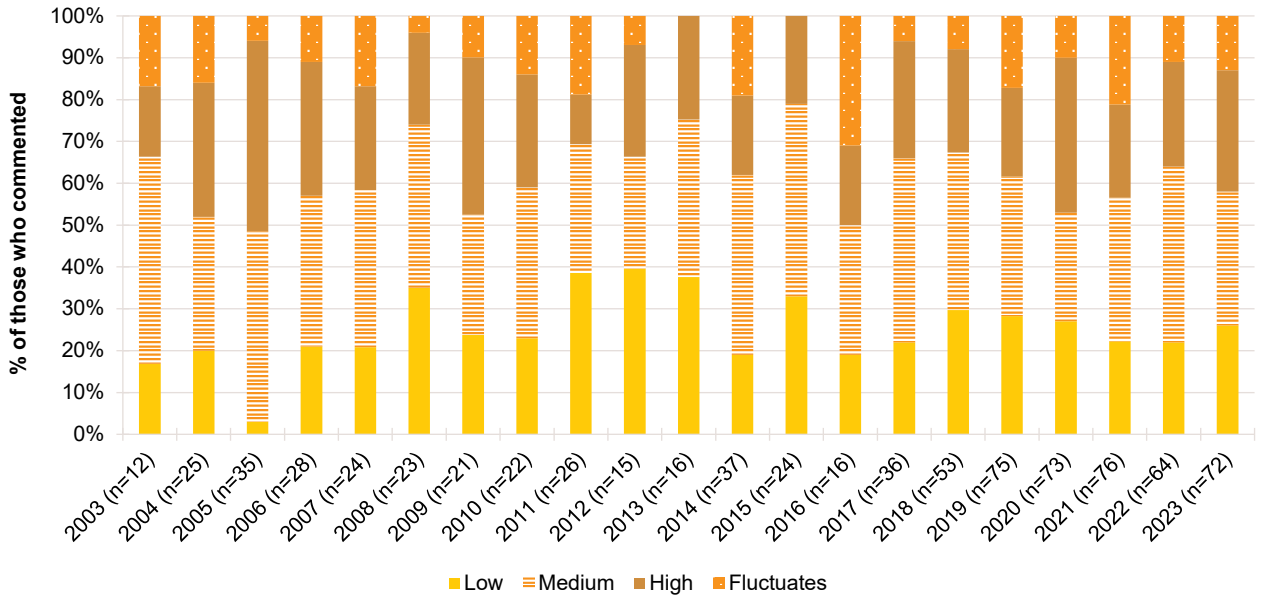
The perceived availability of cocaine remained stable in 2023 compared to 2022 (p=0.670). Among those able to comment in 2023 (n=70), two fifths (40%) perceived cocaine to be 'very easy' to obtain (42% in 2022), followed by another two fifths (40%) that perceived it to be 'easy' to obtain (39% in 2022) (Figure 29).

Figure 27: Median price of cocaine per gram, Canberra, ACT, 2003-2023



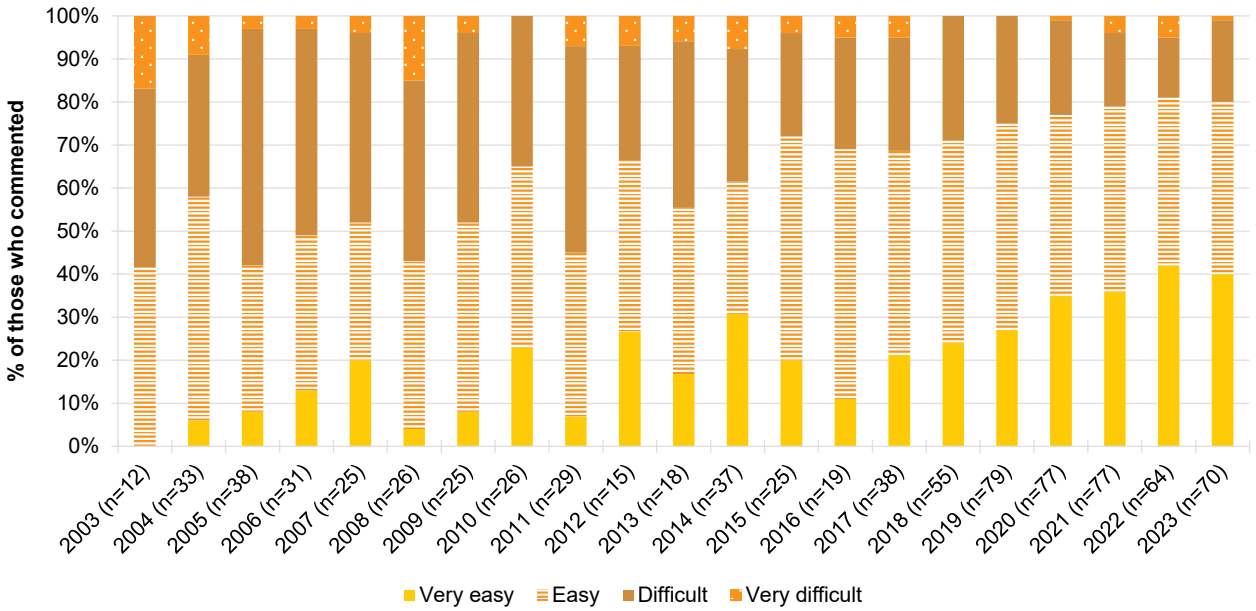
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent 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 28: Current perceived purity of cocaine, Canberra, ACT, 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 29: Current perceived availability of cocaine, Canberra, ACT, 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.

6

Cannabis and/or Cannabinoid-Related Products

Participants were asked about their recent (past six month) use of various forms of cannabis, including indoor-cultivated cannabis via a hydroponic system ('hydroponic'), outdoor-cultivated cannabis ('bush'), 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 between 2021 and 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)

Four fifths (80%) of the sample reported non-prescribed use of cannabis and/or cannabinoid-related products in 2023, stable relative to 2022 (81%) (Figure 30) and similar to estimates from earlier years. In 2023, few participants (n≤5) reported prescribed use in the six months preceding interview (n≤5 in 2022; p=0.683).

Frequency of Use

Frequency of use has varied between weekly and several times a week in the past six months over the course of monitoring (2023: median 55 days; IQR=17-165; n=80; 70 days in 2022; IQR=10-180; n=81; *p*=0.878) (Figure 30). Of those who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented (n=80), 69% reported weekly or more frequent use (65% in 2022; *p*=0.731) and one quarter (25%) reported daily use (31% in 2022; *p*=0.477).

Routes of Administration

Across all years, nearly all participants who reported recent use of non-prescribed cannabis and/or cannabinoid-related products reported smoking cannabis (95% in 2023; 93% in 2022; *p*=0.746). In 2023, two fifths (39%) reported swallowing (28% in 2022; *p*=0.195) and few (n≤5) participants reported inhaling/vaping non-prescribed cannabis and/or cannabinoid products (15% in 2022; *p*=0.122) in the past six months.

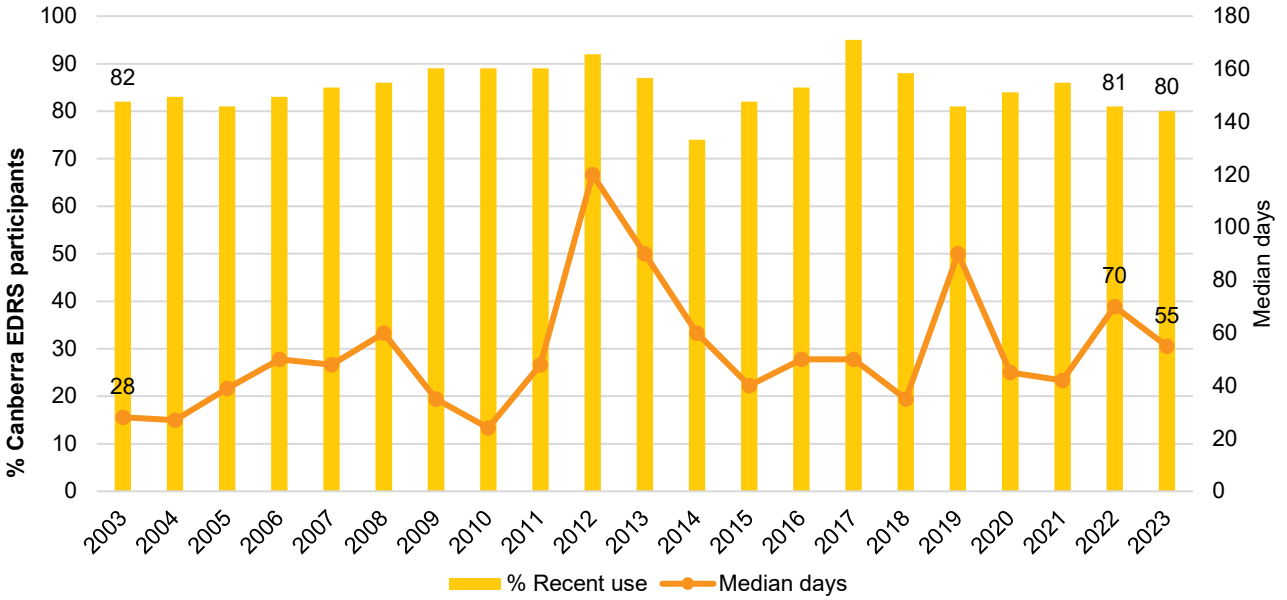
Quantity

Of those able to comment in 2023, the median amount used on the last occasion of use was one gram (IQR=0.40-2.00; n=34; 1 gram in 2022; IQR=0.50-1.00; n=27; *p*=0.835), two cones (IQR=1-3; n=25; 2 cones in 2022; IQR=1-4; n=32; *p*=0.229) or one joint (IQR=1-1; n=12; 1 joint in 2022; IQR=1-1; n=16; *p*=0.279) of non-prescribed cannabis and/or cannabinoid products.

Forms Used

Among participants that had recently used non-prescribed cannabis and/or cannabinoid-related products and responded (n=74), three fifths (61%) reported using outdoor-grown 'bush' cannabis (60% in 2022), followed by half (51%) reporting recent use of hydroponic cannabis in 2023 (66% in 2022; *p*=0.073). Few participants reported having used hashish (n≤5; n≤5 in 2022; *p*=0.742), hash oil (n≤5; n≤5 in 2022; *p*=0.489), THC extract (n≤5; 8% in 2022) or CBD extract (n≤5; n≤5 in 2022; *p*=0.443) in the preceding six months.

Figure 30: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid-related products, Canberra, ACT, 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 (in 2022 only few (n≤5) participants reported use of prescribed cannabis only). Further, from 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: In 2023, few (n≤5) participants reported on the price of an ounce ($300 in 2022; IQR=273-350; p=0.552) or a gram ($20 in 2022; IQR=20-20; p=0.555) of hydroponic cannabis, therefore these data are suppressed (Figure 31A).

Perceived Potency: The perceived potency of non-prescribed hydroponic cannabis remained stable between 2022 and 2023 (p=0.245). Of those able to comment in 2023 (n=32), most perceived hydroponic cannabis to be of 'high' potency (59%; 62% in 2022) (Figure 32A).

Perceived Availability: There was a significant change in the perceived availability of non-prescribed hydroponic cannabis between 2022 and 2023 (p=0.036). Of those able to comment in 2023 (n=32), all participants perceived availability to be 'easy' or 'very easy' (100%; 92% in 2022), the highest per cent since monitoring commenced (Figure 33A).

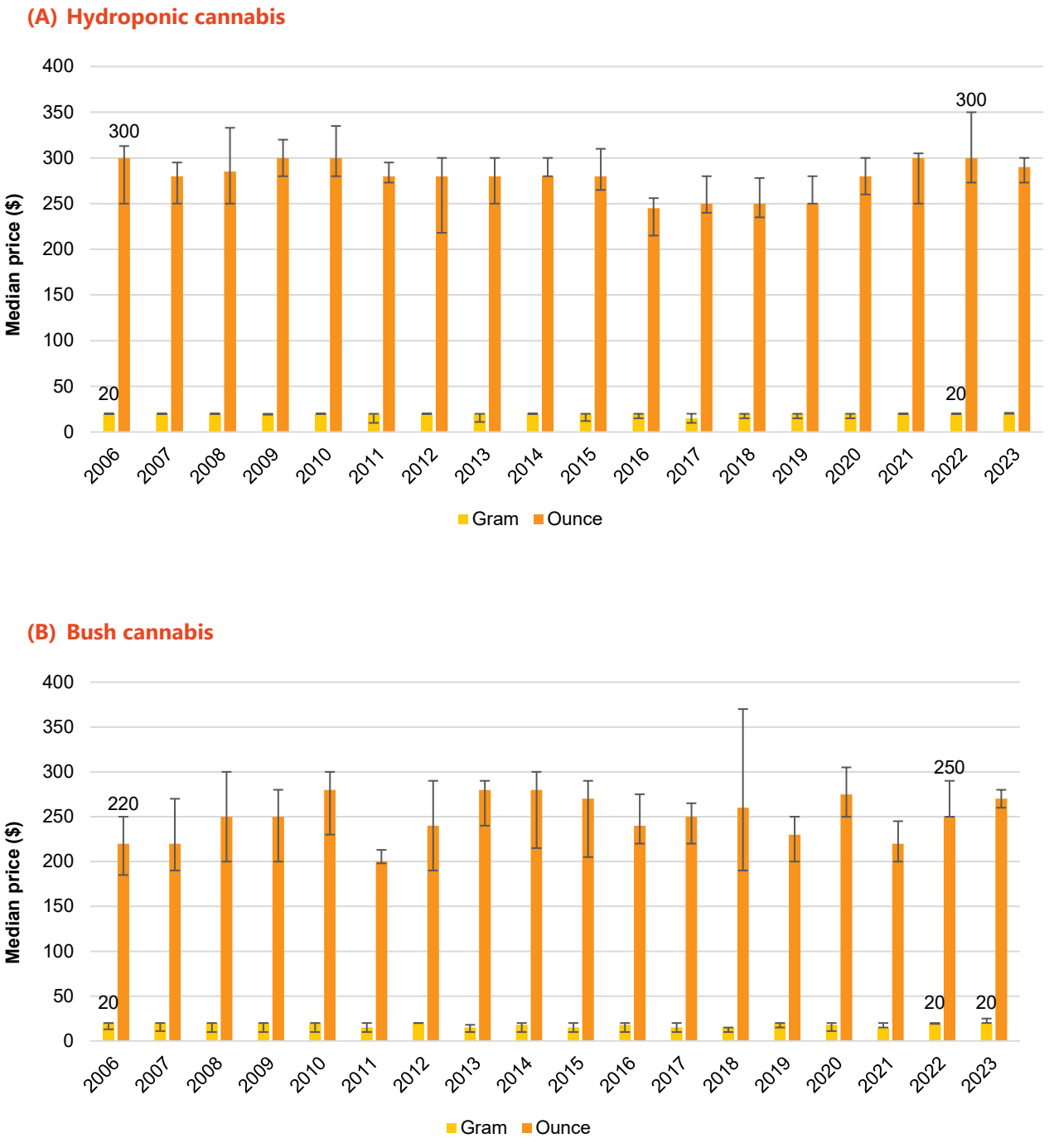
Bush Cannabis

Price: In 2023, few (n≤5) participants reported on the price of an ounce of bush cannabis ($250 in 2022; IQR=250-290; p=0.908). In 2023, one gram of bush cannabis was reported at $20 (IQR=20-25; n=9; $20 in 2022; IQR=19-20; n=12; p=0.324) (Figure 31B).

Perceived Potency: The perceived potency of non-prescribed bush cannabis remained stable between 2022 and 2023 (p=0.070). Among those able to comment in 2023 (n=41), half (49%) perceived bush cannabis to be of 'high' potency (43% in 2022), followed by one third (34%) reporting that potency was 'medium' (36% in 2022) (Figure 32B).

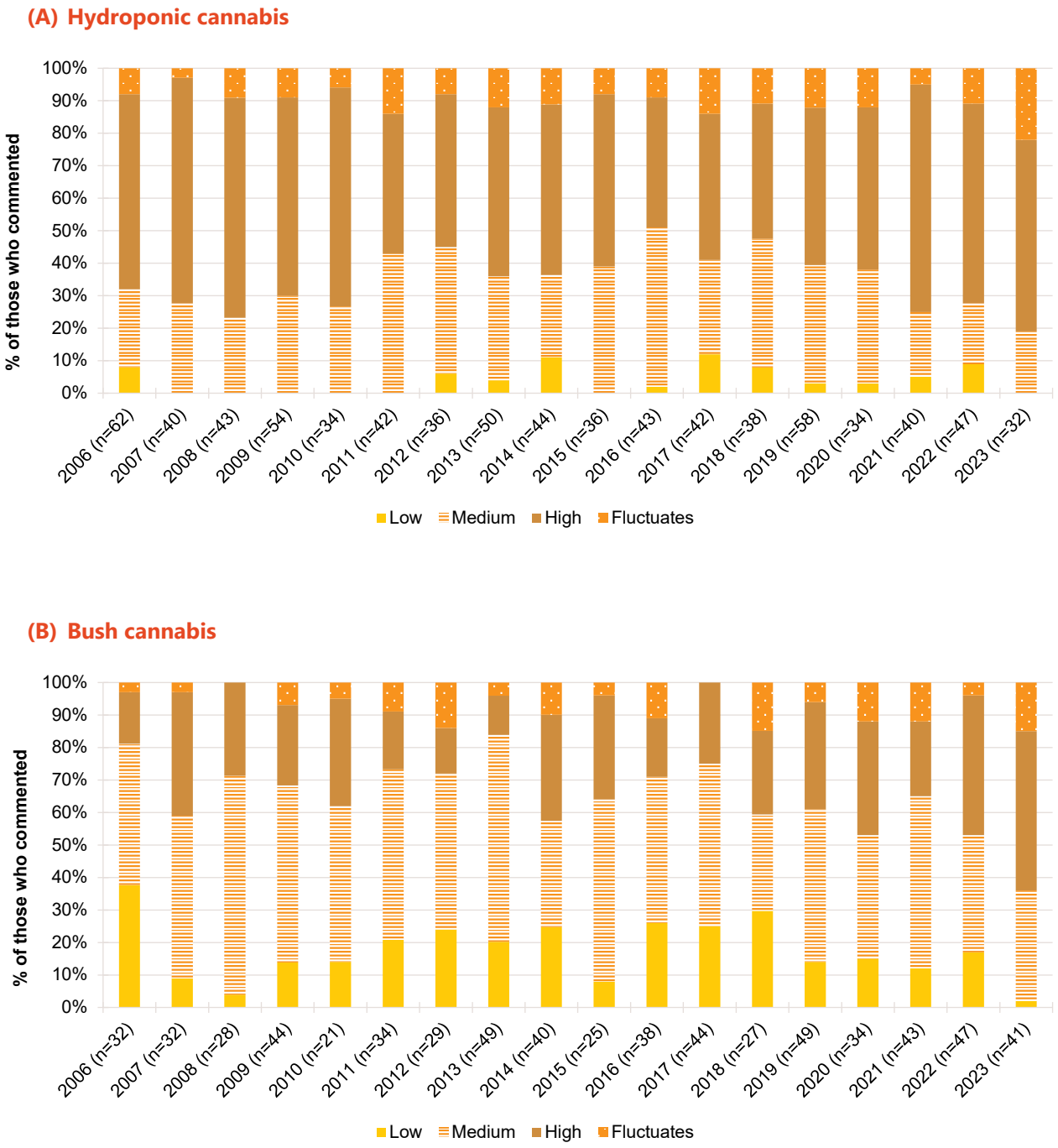
Perceived Availability: There was a significant change in the perceived availability of non-prescribed bush cannabis between 2022 and 2023 (p=0.011). Similar to hydroponic cannabis, among those able to comment in 2023 (n=42), all participants perceived the availability of bush to be 'easy' or 'very easy' (100%; 83% in 2022), the highest per cent since monitoring commenced (Figure 33B).

Figure 31: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Canberra, ACT, 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 32: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Canberra, ACT, 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 are reporting on the potency 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.

Figure 33: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Canberra, ACT, 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 are reporting on the availability 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.

7

Ketamine, LSD and DMT

Non-Prescribed Ketamine

Patterns of Consumption

Recent Use (past 6 months): Recent non-prescribed ketamine use has fluctuated over the period of monitoring but has been slowly increasing over time. In 2023, 56% of the sample reported recent use, the highest per cent since monitoring commenced and a significant increase relative to 2022 (39%; p=0.026) (Figure 34).

Frequency of Use: Frequency of use has historically been low, varying between a median of one and five days (2023: 5 days; IQR=2-10; n=56; 4 days in 2022; IQR=2-10; n=39; p=0.954) (Figure 34). Among participants who reported recent non-prescribed ketamine use, one tenth (11%) reported using weekly or more frequently in 2023 (n≤5 in 2022; p=0.464).

Routes of Administration: In 2023, the most common route of administration among participants who had recently used non-prescribed ketamine was snorting (96%; 97% in 2022).

Quantity: The median quantity used in a 'typical' session was 0.30 grams (IQR=0.10-0.40, n=33; 0.30 grams in 2022; IQR=0.10-0.90, n=26; p=0.938) and the median maximum amount used was 0.50 grams (IQR=0.20-1.00; n=34; 0.50 grams in 2022; IQR=0.20-1.00; n=26; p=0.886).

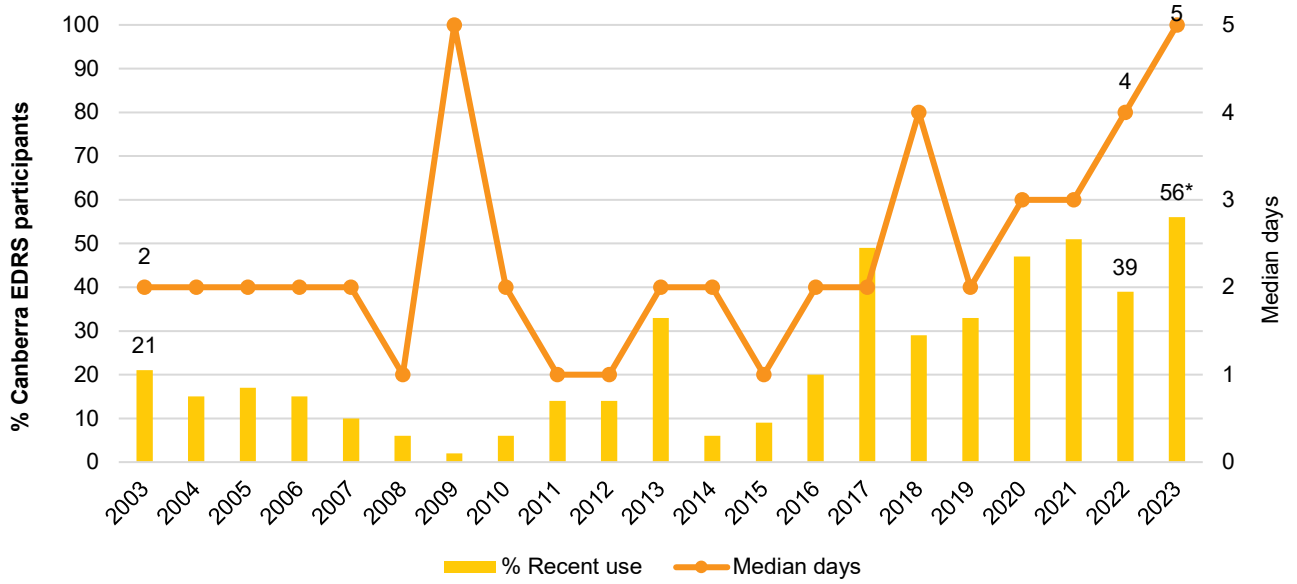
Price, Perceived Purity and Perceived Availability

Price: The reported median price for one gram of non-prescribed ketamine was $235 in 2023 (IQR=200-250; n=26; $200 in 2022; IQR=200-240; n=19; p=0.145) (Figure 35).

Perceived Purity: The perceived purity of non-prescribed ketamine remained stable between 2022 and 2023 (p=0.268). Of those who responded in 2023 (n=50), two thirds (68%) perceived the purity of ketamine to be 'high' (73% in 2022), followed by 16% perceiving it to be 'fluctuating' (n≤5 in 2022) (Figure 36).

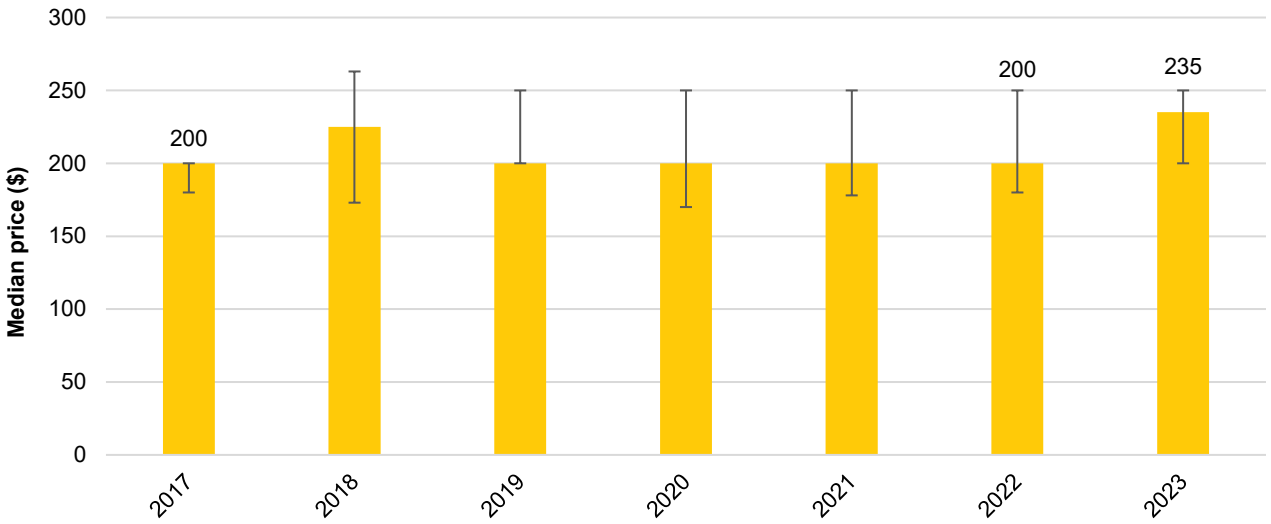
Perceived Availability: Perceived availability was also stable between 2022 and 2023 (p=0.779). Of those who commented in 2023 (n=50), two fifths (42%) reported non-prescribed ketamine to be 'easy' to obtain (31% in 2022), followed by 30% reporting it 'difficult' to obtain (34% in 2022) (Figure 37).

Figure 34: Past six month use and frequency of use of non-prescribed ketamine, Canberra, ACT, 2003-2023



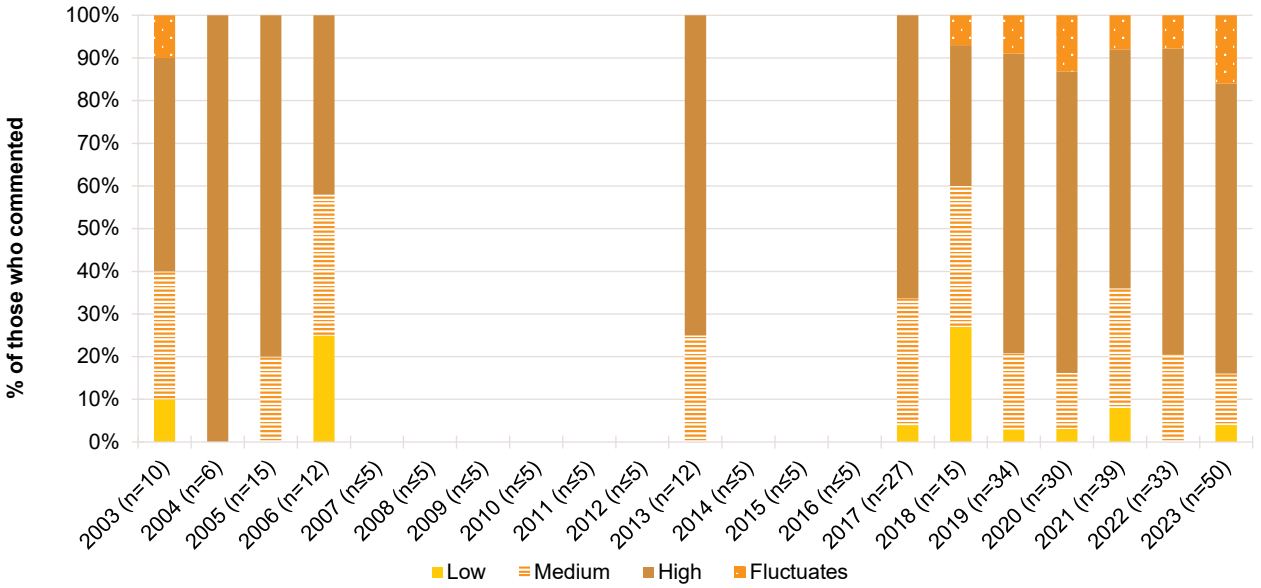
Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 5 days to improve visibility of trends. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been 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.

Figure 35: Median price of non-prescribed ketamine per gram, Canberra, ACT, 2017-2023



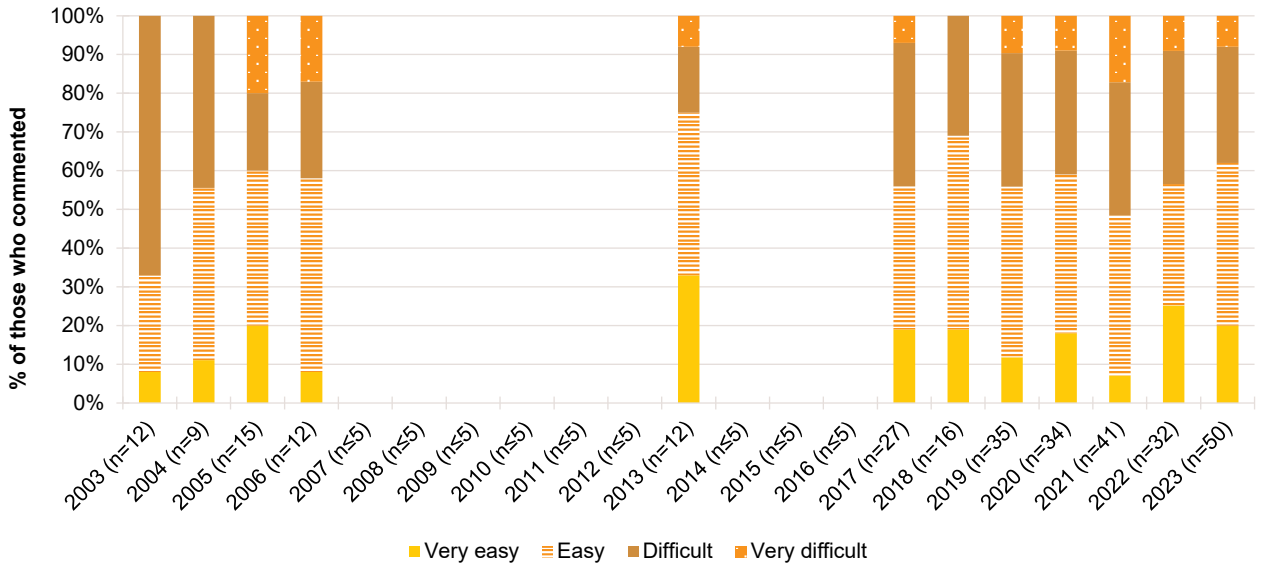
Note. Among those who commented. Data prior to 2017 not provided due to low respondents. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first (2017) and two most recent years (2022 and 2023) provided in the figure, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent the IQR. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 36: Current perceived purity of non-prescribed ketamine, Canberra, ACT, 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.

Figure 37: Current perceived availability of non-prescribed ketamine, Canberra, ACT, 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.

LSD

Patterns of Consumption

Recent Use (past 6 months): Recent use of LSD has fluctuated over the course of monitoring. In 2023, two fifths (42%) reported recent use (31% in 2022; p=0.142) (Figure 38).

Frequency of Use: Frequency of use has historically been low, varying between a median of one and five days. In 2023, participants who reported recent use of LSD reported using it on a median of two days (IQR=1-4; n=42; 2 days in 2022; IQR=1-3; n=31; p=0.858) (Figure 38). Few (n≤5) participants reported weekly or more frequent use of LSD in 2023 (n≤5 in 2022; p=0.571).

Routes of Administration: In 2023, all participants reporting recent use of LSD reported swallowing as a route of administration (100% in 2022).

Quantity: In 2023, the median quantity used in a 'typical' session was one tab (IQR=1-1; n=22; 1 tab in 2022; IQR=1-2; n=19; p=0.048). The median maximum number of tabs used was one (IQR=1-2; n=22; 2 tabs in 2022; IQR=1-2; n=19; p=0.056).

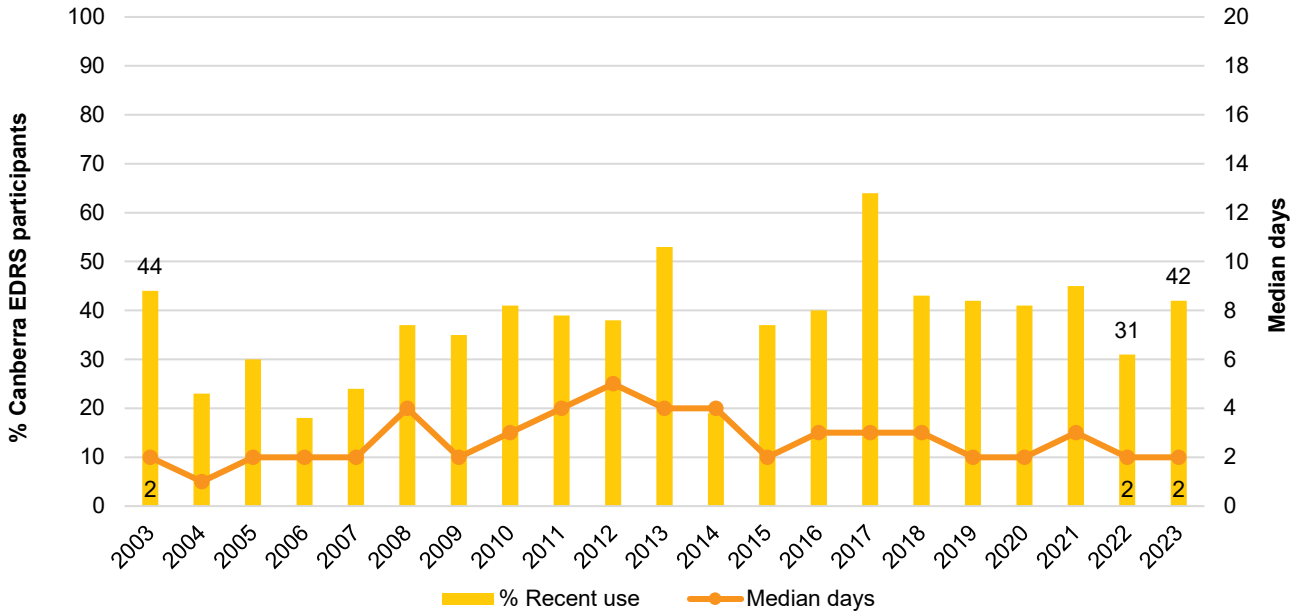
Price, Perceived Purity and Perceived Availability

Price: In 2023, the median price for one tab was $25 (IQR=25-30; n=23), stable compared to 2022 ($23; IQR=20-34; n=14; p=0.360) (Figure 39).

Perceived Purity: Perceived purity was stable between 2022 and 2023 (p=0.794). Of those who responded in 2023 (n=44), the majority perceived purity to be 'high' (68%; 63% in 2022), followed by 14% reporting 'medium' purity (22% in 2022) and 14% reporting 'fluctuating' purity (n≤5 in 2022) (Figure 40).

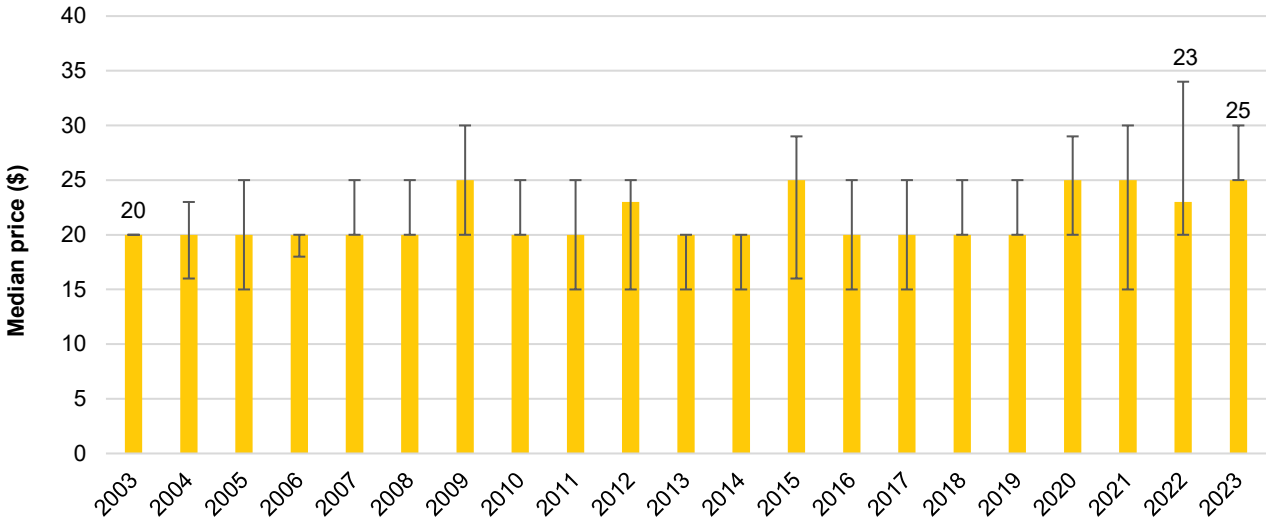
Perceived Availability: There was a significant change in perceived availability of LSD in 2023 relative to 2022 (p=0.001). Of those who responded in 2023 (n=44), more participants perceived LSD to be 'difficult' to obtain (43%; n≤5 in 2022), however, fewer participants perceived it to be 'very difficult' to obtain (n≤5; 22% in 2022) (Figure 41).

Figure 38: Past six month use and frequency of use of LSD, Canberra, ACT, 2003-2023



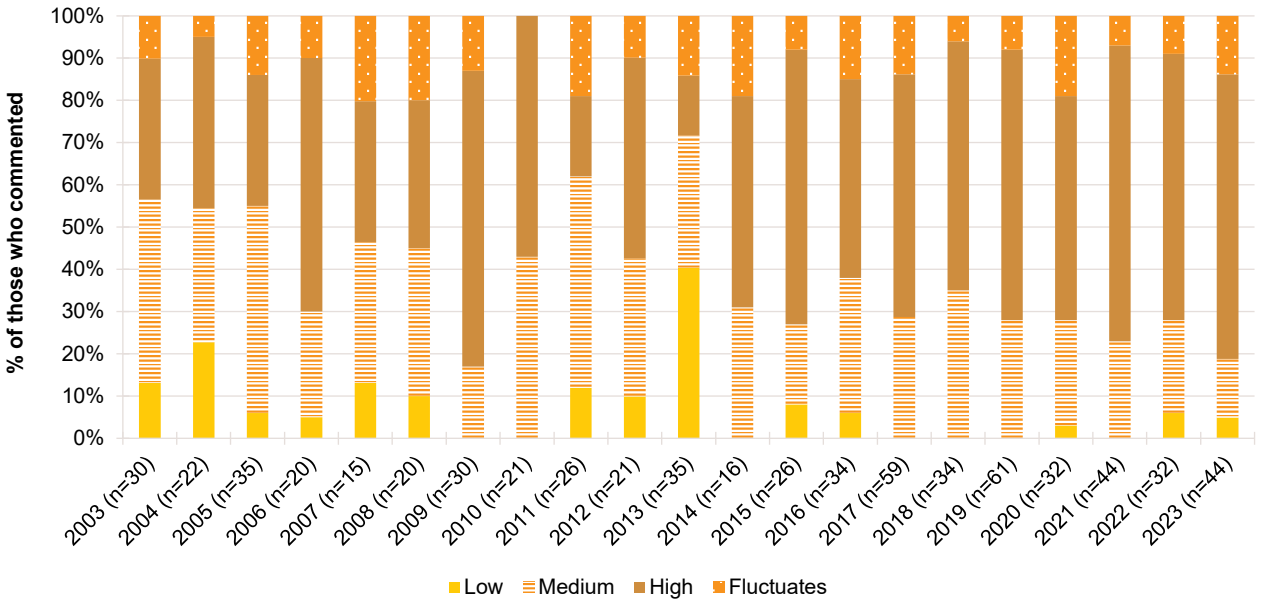
Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 20 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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 39: Median price of LSD per tab, Canberra, ACT, 2003-2023



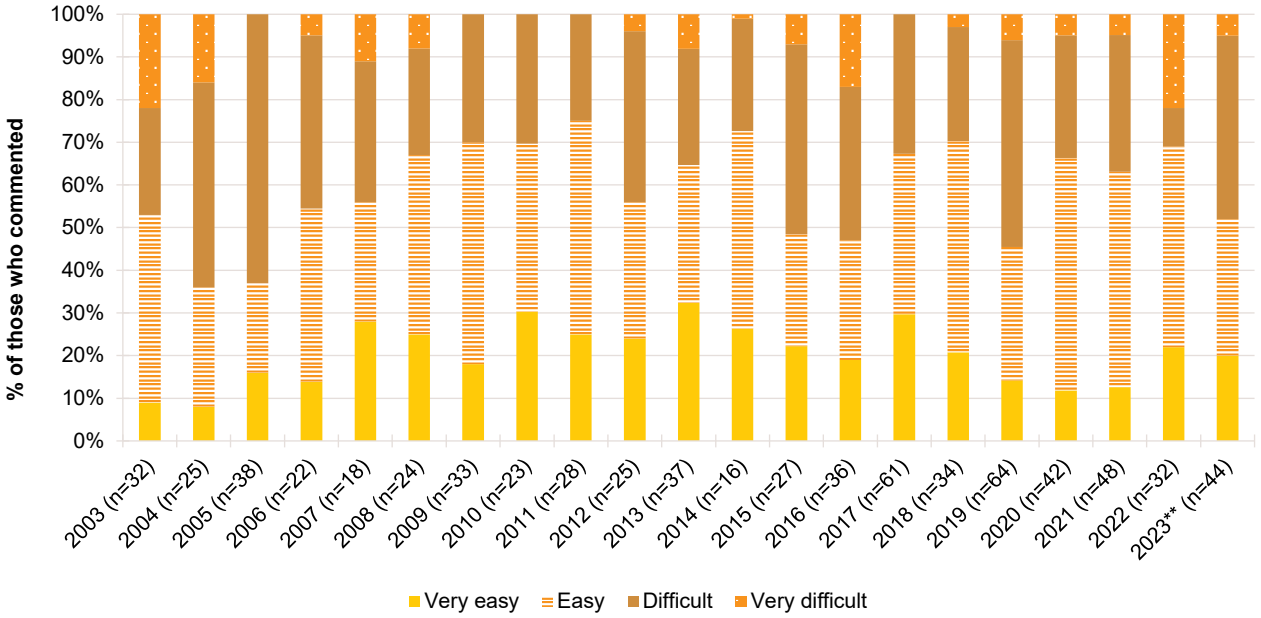
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent 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 40: Current perceived purity of LSD, Canberra, ACT, 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 41: Current perceived availability of LSD, Canberra, ACT, 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

Patterns of Consumption

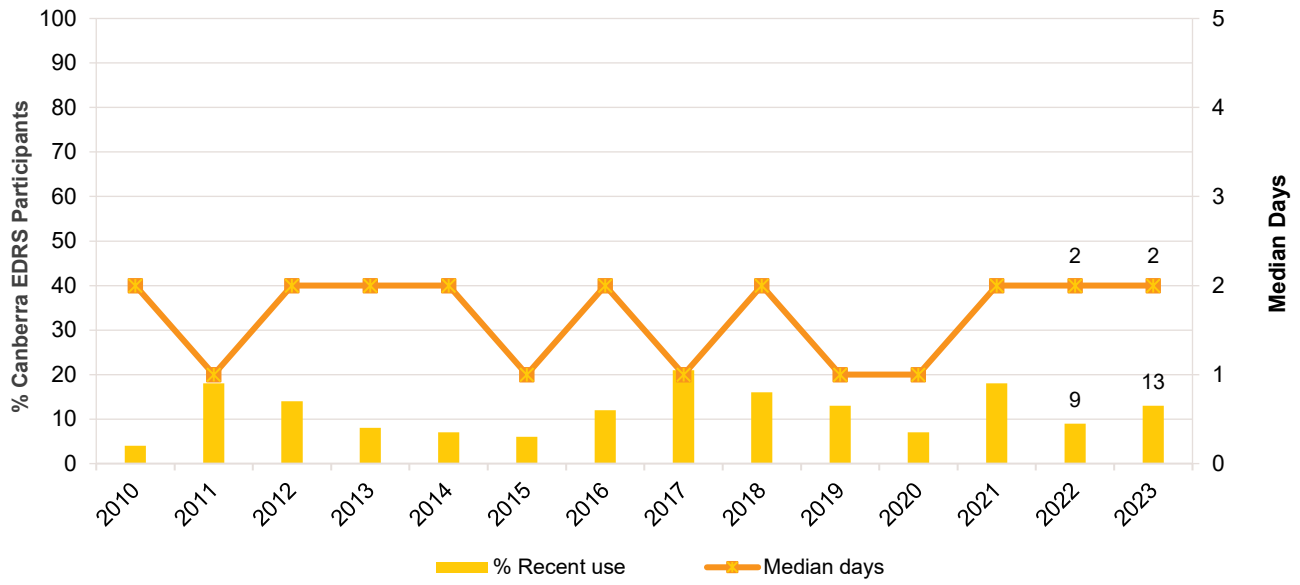
Recent Use (past 6 months): DMT use has fluctuated over the reporting period, with one in ten participants (13%) reporting recent use in 2023, stable compared to 2022 (9%; p=0.492) (Figure 42).

Frequency of Use: Use across the years has shown to be infrequent and stable, with a median of two days (IQR=1-4; n=13) of use in 2023 (2 days in 2022; IQR=2-4; n=9; p=0.490) (Figure 42).

Routes of Administration: Among participants who had recently consumed DMT, the main route of administration was smoking (100%; 89% in 2022; p=0.409).

Quantity: Few (n≤5) participants reported on the median quantity used in a 'typical' session and the maximum amount, hence no further information is provided for 2023 (n≤5 in 2022).

Figure 42: Past six month use and frequency of use of DMT, Canberra, ACT, 2010-2023



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Secondary Y axis reduced to 5 days to improve visibility of trends. Data labels are only provided for the first (2010) and two most recent years (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 the decision has been made to exclude them from this category from hereon-in. This means that the figures presented below for recent use of tryptamine, phenethylamine and any NPS will not align with those in our previous reports.

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

Patterns of Consumption

Recent Use (past 6 months)

Fifteen per cent of the Canberra sample reported recent use of NPS (including plant-based NPS) when monitoring of NPS commenced in 2010. This increased to 53% in 2012, before declining to 18% in 2023 (9% in 2022; p=0.100) (Table 2). Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 49% in 2012 and declining to 16% in 2023 (7% in 2022; p=0.080) (Table 2).

Forms Used

Participants are asked about a range of NPS each year, updated to reflect key emerging substances of interest. NPS use among the sample has fluctuated over time, however 2C substances have consistently been the most commonly used NPS, ranging from 21% reporting recent use in 2015 and 2013 to 8% in 2023 (n≤5 in 2022; p=0.035) (Table 3). Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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

	Canberra, ACT	
%	Excluding plant-based NPS	Including plant-based NPS
2010	15	15
2011	26	36
2012	49	53
2013	44	48
2014	17	17
2015	32	33
2016	24	27
2017	24	25
2018	18	20
2019	28	28
2020	11	13
2021	17	18
2022	7	9
2023	**16**	**18**

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, Canberra, ACT, 2010-2023

	2010 N=70 %	2011 N=80 %	2012 N=51 %	2013 N=77 %	2014 N=100 %	2015 N=99 %	2016 N=100 %	2017 N=100 %	2018 N=98 %	2019 N=100 %	2020 N=101 %	2021 N=100 %	2022 N=100 %	2023 N=100 %
Phenethylamines	8	9	13	19	12	21	16	16	7	8	-	8	-	**9**
Any 2C substance~	8	8	11	18	9	21	13	14	7	7	-	7	-	**8***
NBOMe	/	/	/	/	-	-	-	-	-	-	-	-	0	**-**
DO-x	0	0	0	0	0	0	0	0	0	0	0	0	-	**0**
4-FA	/	/	/	/	/	/	0	0	0	0	0	0	0	**0**
NBOH	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Tryptamines	-	-	-	-	0	0	-	-	-	-	-	-	0	**-**
5-MeO-DMT	-	-	-	-	0	0	-	-	-	-	-	-	0	**-**
4-AcO-DMT	/	/	/	/	/	/	0	0	/	/	/	/	/	**/**
Synthetic cathinones	-	-	13	-	-	9	-	-	-	11	0	0	-	**-**
Mephedrone	-	-	0	0	0	-	0	-	0	-	0	0	-	**-**
Methylone/bk MDMA	/	-	12	-	-	6	-	-	-	9	0	0	0	**0**
MDPV/Ivory wave	0	0	-	0	0	-	-	0	0	0	0	0	0	**0**
Alpha PVP	/	/	/	/	/	/	0	0	0	0	0	0	0	**0**
n-ethyl hexedrone	/	/	/	/	/	/	/	/	/	0	0	0	0	**0**
n-ethylpentylone	/	/	/	/	/	/	/	/	/	0	0	0	0	**0**
Other substituted cathinone	/	/	0	0	0	0	0	0	0	/	/	/	/	**/**
3-chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
4-chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
3-methylmethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	0	**-**
N, N-Dimethyl Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Piperazines	-	-	0	0	0	0	0	0	/	/	/	/	/	**/**
BZP	-	-	0	0	0	0	0	0	/	/	/	/	/	**/**
Dissociatives	/	/	-	/	/	-	-	0	0	-	0	-	0	**-**
Methoxetamine (MXE)	/	/	-	0	0	-	-	0	0	-	0	-	0	**0**
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	0	**-**
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**

3-HO-PCP/4-HO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
3-MeO-PCP/4- MeO-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Other drugs that mimic the effects of dissociatives like ketamine	/	/	/	/	/	/	/	/	/	/	0	-	0	**-**
Plant-based NPS	/	-	-	-	0	-	-	-	-	-	-	-	-	**-**
Ayahuasca	/	/	/	/	/	0	0	0	0	-	-	0	0	**0**
Salvia divinorum	/	-	-	-	0	-	-	-	-	0	-	-	0	**-**
Kratom	/	/	/	/	/	/	/	/	/	/	0	-	0	**-**
Mescaline	0	11	-	8	0	-	-	-	-	-	-	-	-	**0**
LSA	/	-	-	0	-	0	0	/	/	/	/	/	/	**/**
Datura	0	-	-	0	0	0	0	/	/	/	/	/	/	**/**
Benzodiazepines	/	/	/	/	/	/	0	-	-	-	0	-	-	**-**
Etizolam	/	/	/	/	/	/	0	-	0	-	0	-	0	**0**
8-Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Bromazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**-**
Clonazolam	/	/	/	/	/	/	/	/	/	/	/	/	-	**-**
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Other drugs that mimic the effect of benzodiazepines	/	/	/	/	/	/	/	/	0	0	0	0	0	**-**
Synthetic cannabinoids	/	-	16	-	-	0	-	-	-	-	-	-	-	**0**
Herbal high#	/	/	14	-	-	0	-	-	0	-	/	/	/	**/**
Phenibut	/	/	/	/	/	/	/	/	/	-	0	0	0	**0**
Other drugs that mimic the effect of opioids	/	/	/	/	/	/	/	/	-	0	0	0	0	**0**
Other drugs that mimic the effect of ecstasy	/	/	/	/	/	/	/	0	-	-	0	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 from 2021 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 from 2021 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.

9

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 1 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, 10% reported using any non-prescribed codeine (8% in 2022; p=0.801) (Figure 43).

Recent Use for Non-Pain Purposes (past 6 months): Four fifths (80%) of participants who had recently used codeine had used it for non-pain purposes (8% of the total sample; 6% in 2022; p=0.779).

Frequency of Use: Participants who had recently used any form of non-prescribed codeine (n=10) reported use on a median of three days (IQR=2-4) in the past six months (5 days in 2022; IQR=2-11; n=8; p=0.500).

Pharmaceutical Opioids

Recent Use (past 6 months): The per cent of participants reporting past six month use of non-prescribed pharmaceutical opioids (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl, excluding codeine) remained stable from 6% in 2022 to 8% in 2023 (p=0.779) (Figure 43).

Frequency of Use: Participants who had recently used non-prescribed pharmaceutical opioids reported use on a median of nine days (IQR=4-14; n=8) in the six months preceding interview (10 days in 2022; IQR=4-25; n=6; p=0.646).

Benzodiazepines

Recent Use (past 6 months): Recent use of non-prescribed benzodiazepines gradually increased between 2014 (9%) and 2020 (38%), before declining significantly in 2021 (23%). In 2023, recent use of any non-prescribed benzodiazepines was reported by almost one quarter of the sample (23%),

stable relative to 2022 (31%; p=0.265) (Figure 43). From 2019 onwards, we asked participants about non-prescribed alprazolam use versus non-prescribed 'other benzodiazepine' use, with 13% (23% in 2022; p=0.101) and 18% (17% in 2022) of the total sample reporting recent non-prescribed use in 2023, respectively.

Frequency of Use: Participants who had recently used non-prescribed alprazolam reported using it on a median of five days in the past six months (IQR=2-15; n=13; 3 days in 2022; IQR=2-25; n=23) while participants who had recently used non-prescribed 'other benzodiazepines' reported use on a median of six days (IQR=2-10; n=18; 5 days in 2022; IQR=2-20; n=17; p=0.727).

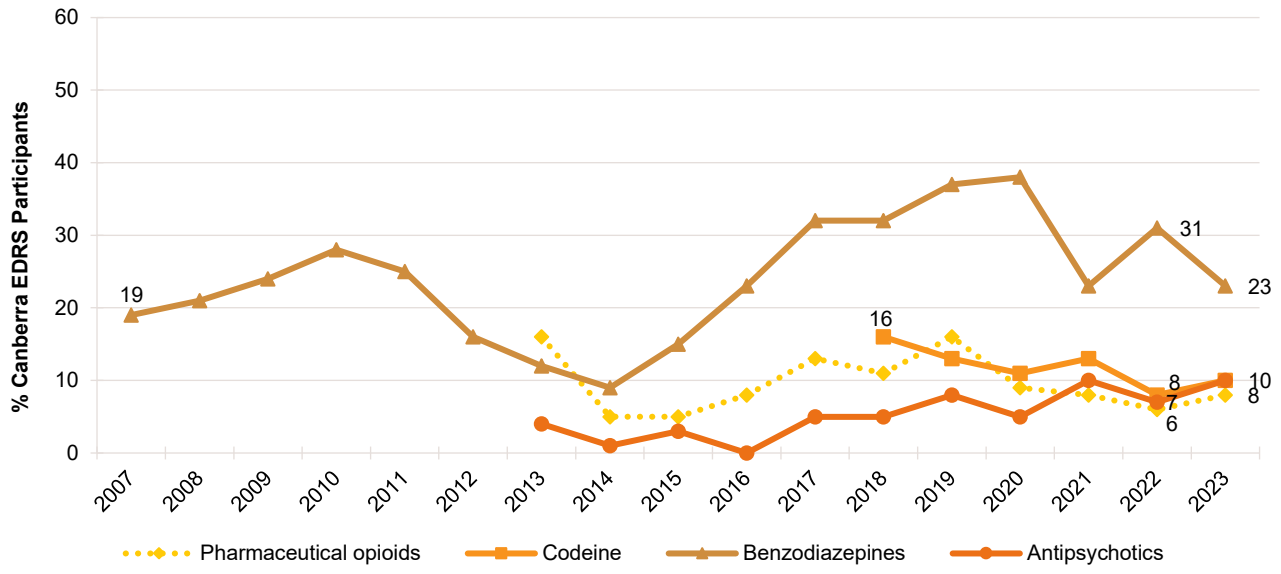
Forms Used: Few (n≤5) participants who had recently consumed non-prescribed benzodiazepines were able to comment on the main brand used in the six months preceding interview, therefore, further details are not reported. Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information

Antipsychotics

Recent Use (past 6 months): Historically, recent use of non-prescribed antipsychotics has remained low over the course of monitoring, with 10% of the sample reporting recent non-prescribed use in 2023 (7% in 2022; p=0.598) (Figure 43).

Frequency of Use: Participants who had recently used non-prescribed antipsychotics reported use on a median of six days in the past six months (IQR=3-44; n=10; 5 days in 2022; IQR=2-47; n=6; p=0.205).

Figure 43: Non-prescribed use of pharmaceutical drugs in the past six months, Canberra, ACT, 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): Recent use of hallucinogenic mushrooms has fluctuated over the course of monitoring. In 2023, half (49%) of participants reported recent use, the highest per cent since monitoring commenced, however, stable from 36% reporting recent use in 2022 (p=0.090) (Figure 44).

Frequency of Use: Recent use has typically been infrequent and stable, with participants reporting a median of three days of use in 2023 (IQR=1-4; n=49; 2 days in 2022; IQR=1-5; n=36; p=0.425).

MDA

Recent Use (past 6 months): Recent use of MDA has varied across the years and in 2023, few (n≤5) participants reported recent use, hence further information is not provided (n≤5 in 2022) (Figure 44). Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

Substance with Unknown Contents

Capsules (past 6 months): During the first three years of monitoring, low numbers reported recent use of 'capsules with unknown contents', rising to 45% in 2016. Since then, the percentage of participants reporting recent use has been gradually decreasing, with few (n≤5) participants reporting recent use in 2023 (n≤5 in 2022) (Figure 44).

Other Unknown Substances (past 6 months): From 2019 onwards, we asked participants about their use more broadly of substances with 'unknown contents'. These questions were asked by substance form, comprising capsules (as per previous years), pills, powder, crystal and 'other' form. In 2023, 10% reported recent use of any substance with 'unknown contents' (13% in 2022; p=0.643) on a median of two days (IQR=1-2; 2 days in 2022; IQR=1-4; p=0.379). Six per cent reported using powder with 'unknown contents' in the previous six months (6% in 2022). Few (n≤5) participants reported using pills and crystal with 'unknown' contents in 2023 (6%; p=0.118 and 0%; p=0.497 in 2022, respectively).

Quantity: From 2020 onwards, we asked participants about the average amount of pills and capsules used with 'unknown contents' in the last six months. Few (n≤5) participants reported on average use of capsules and pills with 'unknown contents' in 2023, therefore further information is not provided. Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

PMA

Recent Use (past 6 months): No participants reported recent use of PMA in 2023 (0% in 2022) (Figure 44). Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

PMMA

Recent Use (past 6 months): No participants reported recent use of PMMA in 2023 (0% in 2022) (Figure 44). Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

GHB/GBL/1,4-BD

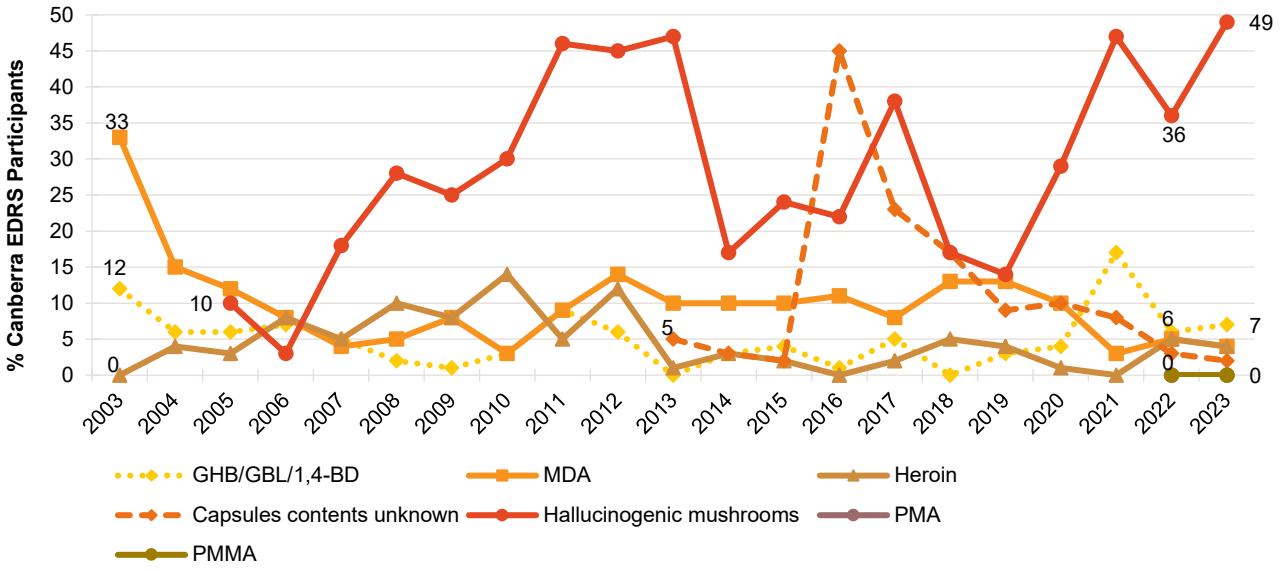
Recent Use (past 6 months): Historically, consistently small numbers have reported recent use of GHB/GBL/1,4-BD. In 2023, 7% of the sample reported past six month use, stable from 6% in 2022 (p=0.779) (Figure 44).

Frequency of Use: In 2023, participants reported use on a median of one day (IQR=1-9; n=7; 2 days in 2022; IQR=1-3; n=6; p=0.821).

Heroin

Recent Use (past 6 months): Few (n≤5) participants reported recent use of heroin in 2023 (n≤5 in 2022) (Figure 44). Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

Figure 44: Past six month use of other illicit drugs, Canberra, ACT, 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 and PMMA commenced in 2022. Y axis has been reduced to 50% to improve visibility of trends. Data labels are only provided for the first (2003/2005/2013) and two most recent years (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): Most of the sample has reported recent alcohol use across the period of monitoring (94% in 2023; 86% in 2022; p=0.101) (Figure 45).

Frequency of Use: In 2023, participants who reported recent alcohol use reported use on a median of 48 days in the past six months (i.e., equivalent to twice weekly; IQR=24-50; n=94; 48 days in 2022; IQR=24-72; n=86; p=0.292), with four fifths (79%) reporting weekly or more frequent use (76% in 2022; p=0.706) and 7% reporting daily use (n≤5 in 2022; p=0.335).

Tobacco

Recent Use (past 6 months): Recent tobacco use has fluctuated between 68% and 92% of the sample over the course of monitoring. In 2023, 70% of the sample reported recent tobacco use (68% in 2022; p=0.875) (Figure 45).

Frequency of Use: In 2023, participants reported using tobacco on a median of 48 days (i.e., equivalent to twice weekly; IQR=12-180; n=70), a significant decrease from 180 days in 2022 (IQR=56-180; n=68; p<0.001). Twenty-seven per cent of participants who reported recent use reported daily use, a significant decrease from 57% in 2022 (p<0.001).

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.

Recent Use (past 6 months): Recent e-cigarette use remained stable in the initial years of monitoring (2014-2018), however has since been mostly increasing. In 2023, nearly three quarters (72%) reported non-prescribed recent use, a significant increase relative to 2022 (57%; p=0.043) and the highest per cent since monitoring commenced (Figure 45). Few (n≤5) participants reported recent use of prescribed e-cigarettes in the last six months (n≤5 in 2022; p=0.331).

Frequency of Use: In 2023, median days of non-prescribed use remained stable relative to 2022 (100 days; IQR=30-180; n=71; 120 days in 2022; IQR=30-180; n=57; p=0.968). In 2023, two fifths (41%) of those who had recently used non-prescribed e-cigarettes reported daily use (33% in 2022; p=0.335).

Forms Used: Among those that reported recent non-prescribed e-cigarette use (n=72), most (99%) of the participants reported using e-cigarettes containing nicotine (100% in 2022) and few (n≤5) reported using e-cigarettes containing cannabis (n≤5 in 2022). Few participants (n≤5) reported using e-cigarettes that contained both cannabis and nicotine. Seventeen per cent reported using e-cigarettes that contained neither cannabis nor nicotine.

Reason for Use: Among participants who had recently consumed any (i.e., prescribed and non-prescribed) e-cigarettes in 2023, the majority (72%) reported that they did not use e-cigarettes as a smoking cessation tool (61% in 2022; p=0.275).

Nitrous Oxide

Recent Use (past 6 months): The per cent reporting recent use of nitrous oxide increased between 2014 and 2020, before subsequently stabilising. In 2023, half (53%) reported recent use, stable relative to 2022 (48%; *p*=0.571) (Figure 45).

Frequency of Use: Frequency of use remained stable at five days in 2023 (IQR=2-15; n=53; 11 days in 2022; IQR=3-24; n=48; *p*=0.081).

Quantity: Among those who commented in 2023 (n=52), the median amount of nitrous oxide used in a 'typical' session in the six months preceding interview was five bulbs (IQR=2-10; 9 bulbs in 2022; IQR=3-14; n=46; *p*=0.039). The median maximum amount used in a session was 10 bulbs (IQR=4-25; n=51; 16 bulbs in 2022; IQR=5-20; n=46; *p*=0.132).

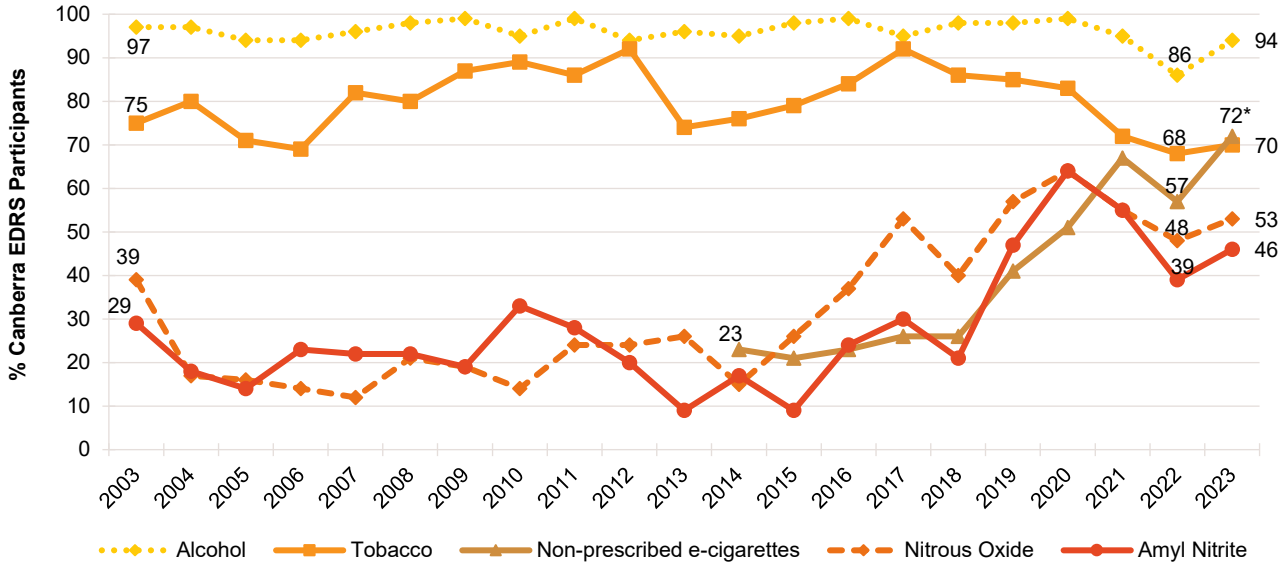
Amyl Nitrite

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

Recent Use (past 6 months): Use of amyl nitrite has varied over the course of monitoring. In 2023, recent use was reported by 46% of participants, stable relative to 2022 (39%; *p*=0.390) (Figure 45).

Frequency of Use: In 2023, participants who reported recent use of amyl nitrite reported use on a median of five days (IQR=2-12; n=46; 5 days in 2022; IQR=2-10; n=39; *p*=0.749).

Figure 45: Past six month use of licit and other drugs, Canberra, ACT, 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.

10

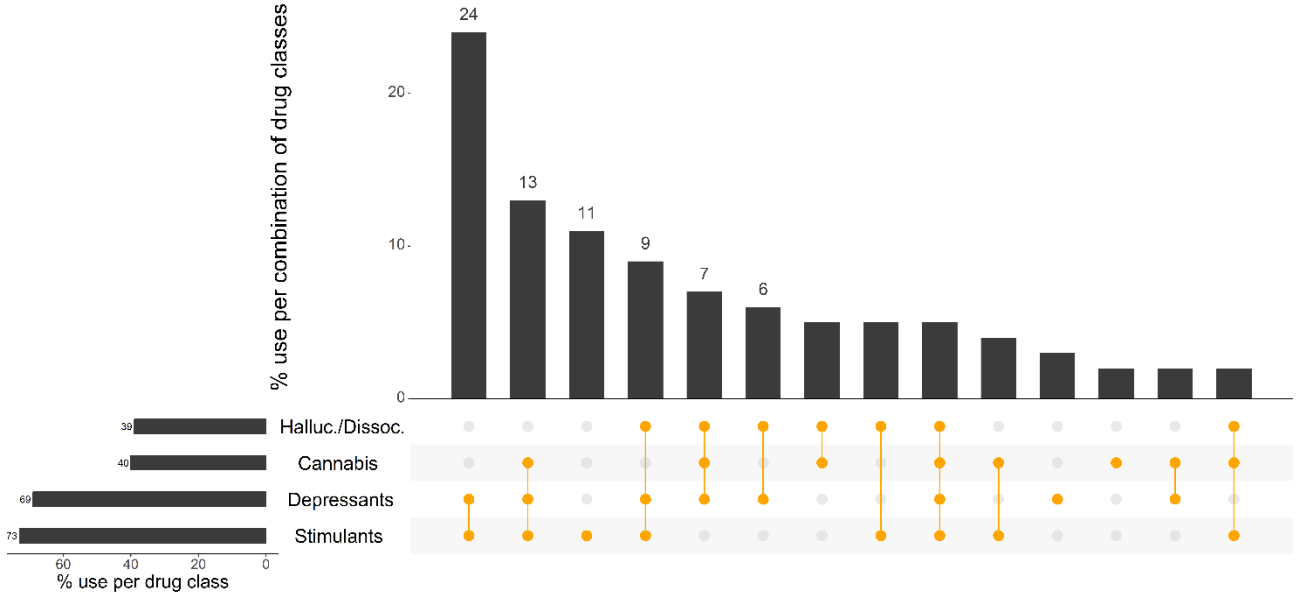
Drug-Related Harms and Other Behaviours

Polysubstance Use

On the last occasion of ecstasy or related drug use, the most commonly used substances were alcohol (65%), followed by cannabis (40%), ecstasy (40%), cocaine (25%), ketamine (23%), hallucinogenic mushrooms (11%) and pharmaceutical stimulants (11%).

The majority (86%) of the Canberra sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most common combinations of drug classes were stimulants and depressants (24%), followed by stimulants, depressants and cannabis (13%) and hallucinogenic/dissociatives, depressants and stimulants (9%). Eleven per cent of participants reported using stimulants alone on the last occasion of ecstasy and related drug use (Figure 46).

Figure 46: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Canberra, ACT, 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 30% to improve visibility of trends. Data labels are suppressed where there are small numbers (i.e., n≤5 but not 0).

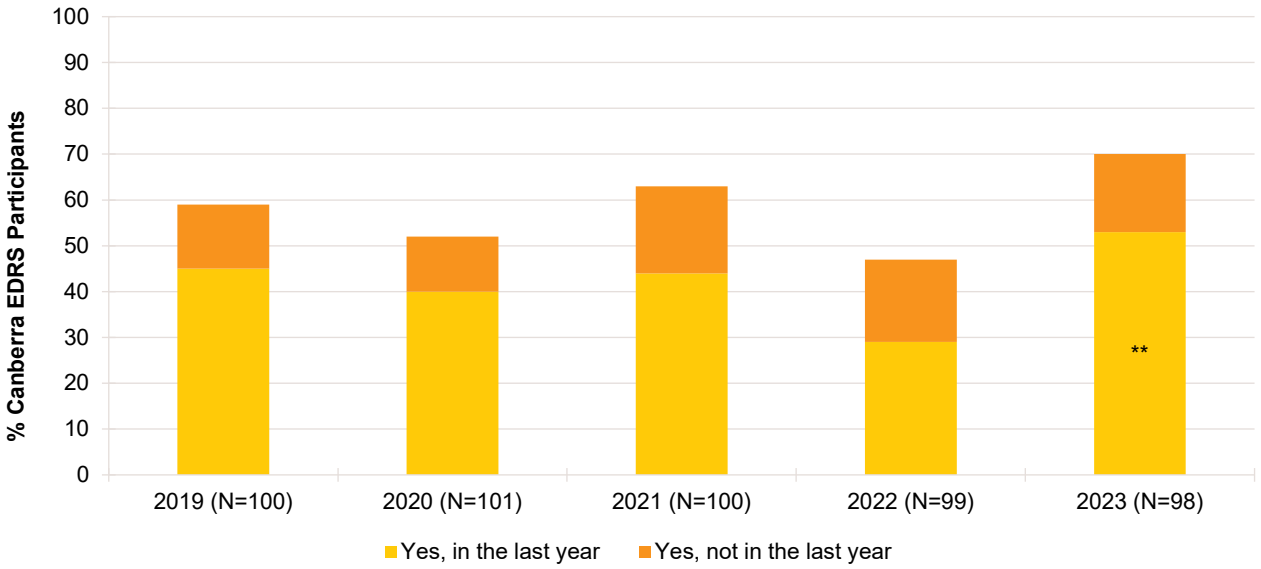
Drug Checking

Drug checking is a common strategy used to test the purity and contents of illicit drugs. 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 pilot fixed-site dug checking service in Canberra which has been operational since 17 July 2022.

In 2023, 53% of participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year, a significant increase relative to 2022 (29%; $p<0.001$). Of those who reported that they or someone else had tested their illicit drugs in the past year (n=52), half (54%) reported testing via professional testing equipment (e.g., Fourier Transform Infrared Spectroscopy), followed by 46% reporting using colorimetric reagent test kits, and 19% reported using testing strips.

Of those who reported that they or someone else had tested their illicit drugs in the past year (n=52), 44% reported having their drugs tested by a friend, followed by 27% reporting testing the drugs themselves.

Figure 47: Lifetime and past year engagement in drug checking, Canberra, ACT, 2019-2023



Note: 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; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Alcohol Use Disorders Identification Test

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

In 2023, the mean score on the AUDIT for the total sample (including people who had not consumed alcohol in the past 12 months) was 12.2 (SD 6.6), significantly higher than 11.6 in 2022 (SD 8.2; $p<0.001$) (Table 4). AUDIT scores are divided into four 'zones' which indicate risk level. Specifically, scores between 0-7 indicate low risk drinking or abstinence; scores between 8-15 indicate alcohol use in excess of low-risk guidelines; scores between 16-19 indicate harmful or hazardous drinking; and scores 20 or higher indicate possible alcohol dependence. There was a significant change in the per cent of the sample falling into each of these risk categories from 2022 to 2023 ($p=0.042$) (Table 6). In 2023, there were fewer (27%) participants that scored in the 0-7 category relative to 2022 (38%), and more who scored in the and 8-15 (41% versus 32% in 2022) and 16-19 (20% versus 10% in 2022) categories.

Three quarters (73%) of the sample obtained a score of 8 or more, indicative of hazardous use in 2023 (62% in 2022; $p=0.133$) (Table 4).

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

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
	N=71	N=79	N=49	N=75	N=97	N=97	N=99	N=98	N=90	N=99	N=100	N=99	N=100	N=100
Mean AUDIT total score (SD)	16.2 (7.4)	13.4 (6.2)	11.0 (7.0)	12.2 (5.8)	11.1 (5.6)	11.3 (4.7)	11.8 (6.8)	11.9 (6.1)	13.0 (7.3)	12.8 (6.2)	15.2 (6.7)	13.1 (7.7)	11.6 (8.2)	**12.2*** (6.6)**
Score 8 or above (%)	87	80	71	77	71	81	71	74	72	80	91	74	62	**73**
AUDIT zones:														
Score 0-7	13	20	29	23	29	18	29	26	28	20	9	26	38	***27**
Score 8-15	37	42	49	53	50	59	45	49	43	53	53	38	32	**41**
Score 16-19	17	22	14	13	12	17	11	13	19	14	16	16	10	**20**
Score 20 or higher	34	17	8	11	9	-	15	12	10	13	22	19	20	**12**

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 numbers (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Imputation used for missing scale scores. Statistical significance for 2022 versus 2023 presented in table; *$p<0.050$; **$p<0.010$; ***$p<0.001$.

Overdose Events

Non-Fatal Overdose

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

From 2019, changes were made to this module with participants asked about alcohol, stimulant and other drug overdose, prompted by the following definitions:

- **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 from 2020 onwards as few participants endorsed this behaviour.

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

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

Non-Fatal Stimulant Overdose

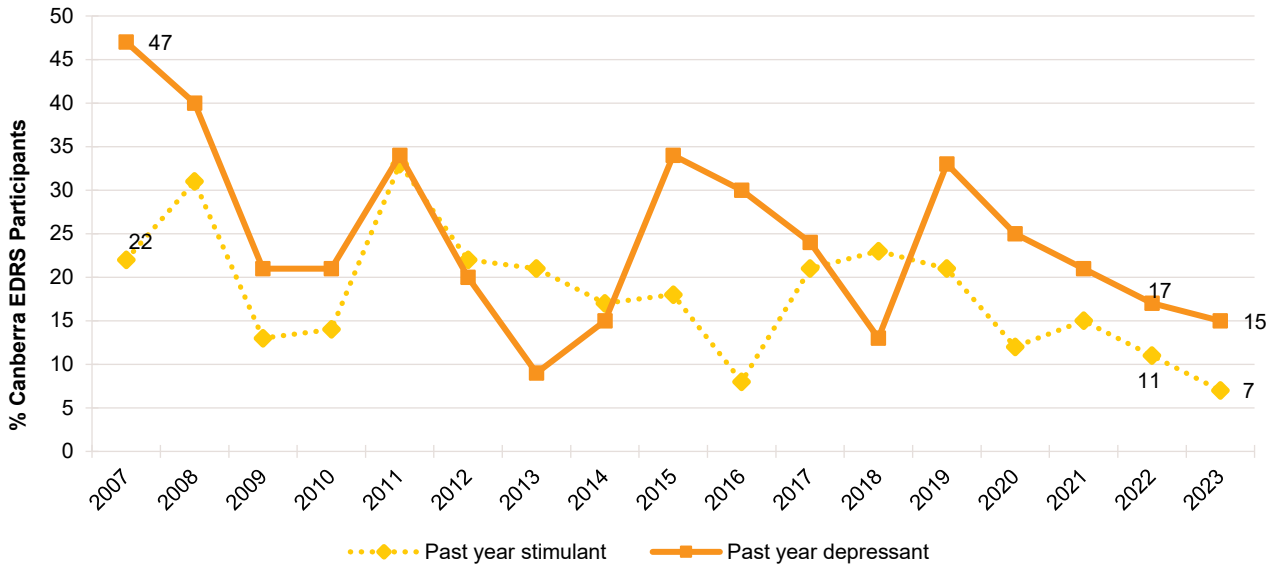
In 2023, almost one in ten participants (7%) reported a non-fatal stimulant overdose in the last 12 months (11% in 2022; p=0.337) (Figure 48). Due to low numbers reporting on the most common stimulants consumed during the most recent past 12 month non-fatal stimulant overdose (n≤5), please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information. Nearly all (86%) participants reported that they had consumed one or more additional drugs on the last occasion, however few (n≤5) participants reported on the additional drugs used and will therefore not be reported. On the last occasion of non-fatal stimulant overdose, few (n≤5) participants reported that they received treatment or assistance.

Non-Fatal Depressant Overdose

Alcohol: Fifteen per cent of the sample reported having experienced a non-fatal alcohol overdose in the past 12 months (12% in 2022; p=0.668) on a median of two occasions (IQR=1-4). Among those who had experienced an alcohol overdose in the past year (n=15), the majority (79%) reported not receiving treatment on the last occasion: the most common reason for not seeking treatment was that they decided it wasn't serious enough (54%).

Any Depressant (including alcohol): Past 12-month experience of any non-fatal depressant overdose has fluctuated over the course of monitoring. In 2023, 15% of the sample reported experiencing at least one non-fatal depressant overdose in the past 12 months (17% in 2022; p=0.845) (Figure 48). Of those who had experienced any depressant overdose in the last year (n=15), all participants reported alcohol as the drug being used prior to the event.

Figure 48: Past year non-fatal stimulant and depressant overdose, Canberra, ACT, 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. Y axis has been reduced to 50% to improve visibility of trends. Data labels are only provided for the first (2007) and two most recent years (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.

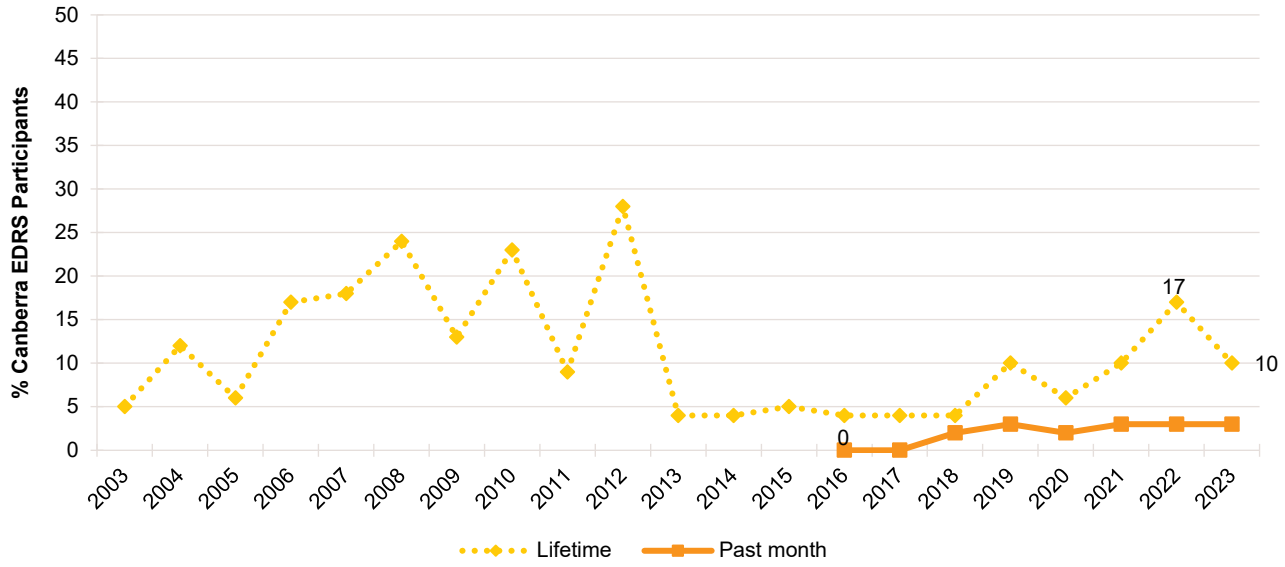
Awareness of Naloxone

In 2023, nearly three fifths (58%) reported that they had ever heard of naloxone (48% in 2022; p=0.203). Among those who had ever heard of naloxone and responded (n=57), 50% were able to correctly identify the purpose of naloxone (45% in 2022; p=0.557).

Injecting Drug Use and Associated Risk Behaviours

The per cent reporting injecting in their lifetime varied in earlier years of monitoring. In 2023, 10% reported lifetime injection (17% in 2022; p=0.221) (Figure 49). Few (n≤5) participants reported past month injection (n≤5 in 2022).

Figure 49: Lifetime and past month drug injection, Canberra, ACT, 2003-2023



Note. Items assessing whether participants had injected drugs in the past month were first asked in 2016. Y axis reduced to 50% to improve visibility of trends. Data labels are only provided for the first (2003/2016) and two most recent years (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

In 2023, 6% of participants reported that they were currently in drug treatment (9% in 2022; p=0.591). For national trends, please refer to the 2023 National EDRS Report, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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 measure the degree of 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, 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 had recently used ecstasy and responded (n=95), 12% recorded a score of three and above, stable from 16% in 2022 (p=0.393). Sixty-four per cent obtained a score of zero on the ecstasy SDS and a further 16% obtained a score of one on the scale, indicating that the majority of respondents reported no or few symptoms of dependence in relation to ecstasy use (Table 5).

To assess methamphetamine dependence in the past six months, the 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 had recently used methamphetamine and responded (n=23), 35% scored four or above, stable from 49% in 2022 (p=0.423). Half (52%) of the participants obtained a score of zero on the methamphetamine SDS, indicating that the majority of 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 particpants scoring above cut-off scores indicative of dependence, among those who reported past six month use, Canberra, ACT, 2017-2023

	2017	2018	2019	2020	2021	2022	2023
Ecstasy	**N=100**	**N=99**	**N=99**	**/**	**N=95**	**N=86**	**N=95**
Median total score (IQR)	1 (0-2)	1 (0-2)	0 (0-2)	/	0 (0-2)	0 (0-1)	**0 (0-1)**
% score 0	41	42	53	/	60	62	**64**
% score = 1	29	25	13	/	14	19	**16**
% score ≥ 3	19	19	22	/	15	16	**12**
Methamphetamine	**N=25**	**N=32**	**N=33**	**N=14**	**N=25**	**N=37**	**N=23**
Median total score (IQR)	**0 (0-2)**	**0 (0-2)**	**0 (0-2)**	**0 (0-0)**	**2 (0-6)**	**2 (0-6)**	**0 (0-5)**
% score 0	56	59	58	100	32	30	**52**
% score = 1	-	-	-	0	-	-	**-**
% score ≥ 4	-	-	-	0	40	49	**35**

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. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size (n≤5 but not 0). 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, 77% of the sample reported some form of sexual activity in the past four weeks, stable relative to 2022 (70%; *p*=0.334). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if conducted face-to-face).

Of those who had engaged in sexual activity in the past four weeks and who responded (n=71), 77% reported using alcohol and/or other drugs prior to or while engaging in sexual activity (84% in 2022; *p*=0.393) and few (n≤5) reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex, a significant decrease relative to 2022 (12%; *p*=0.015). Further, of those who had engaged in sexual activity in the past four weeks and who responded (n=72), one fifth (21%) reported penetrative sex without a condom where they did not know the HIV status of their partner in the past four weeks (28% in 2022; *p*=0.333) (Table 6).

Of those who commented (n=93), two thirds (66%) reported having a sexual health check-up in their lifetime (76% in 2022; *p*=0.160), including one third (34%) reporting having a sexual health check-up in the six months prior to interview (32% in 2022; *p*=0.753). Of the total sample and who responded (n=93), 18% had received a positive diagnosis for a sexually transmitted infection (STI) in their lifetime (23% in 2022; *p*=0.471) and 9% reported that they had received a positive diagnosis for a STI in the past six months in 2023 (n≤5 in 2022; *p*=0.241) (Table 6). The most common STI reported amongst participants who commented (n=8) was chlamydia (88%), with few participants (n≤5) reporting other STIs.

Of those who commented (n=94), 57% reported having a test for human immunodeficiency virus (HIV) in their lifetime (57% in 2022), including 36% who had done so in the six months prior to interview (23% in 2022; *p*=0.058). In 2023, no participants had been diagnosed with HIV in their lifetime (0% in 2022) (Table 6).

Table 6: Sexual health behaviours, Canberra, ACT, 2021-2023

	2021	2022	2023
Of those who responded#:	N=98	N=97	**N=94**
% Any sexual activity in the past four weeks (n)	84 (n=82)	70 (n=68)	**77 (n=94)**
Of those who responded# and reported any sexual activity in the past four weeks:	n=82	n=68	**n=71**
% Drugs and/or alcohol used prior to or while engaging in sexual activity	88	84	**77**
Of those who responded# and reported any sexual activity in the past four weeks:	n=82	n=67	**n=72**
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	7	12	**-***
Of those who responded# and reported any sexual activity in the past four weeks:	n=82	n=67	**n=72**
% Had penetrative sex without a condom and did not know HIV status of partner	27	28	**21**
Of those who responded#:	n=98	n=97	**n=94**
% Had a HIV test in the last six months	32	23	**36**
% Had a HIV test in their lifetime	61	57	**57**
Of those who responded#:	n=98	n=97	**n=94**
% Diagnosed with HIV in the last six months	0	0	**0**
% Diagnosed with HIV in their lifetime	0	0	**0**
Of those who responded#:	n=98	n=97	**n=93**
% Had a sexual health check in the last six months	45	32	**34**
% Had a sexual health check in their lifetime	76	76	**66**
Of those who responded#:	n=98	n=97	**n=93**
% Diagnosed with a sexually transmitted infection in the last six months	-	-	**9**
% Diagnosed with a sexually transmitted infection in their lifetime	26	23	**18**

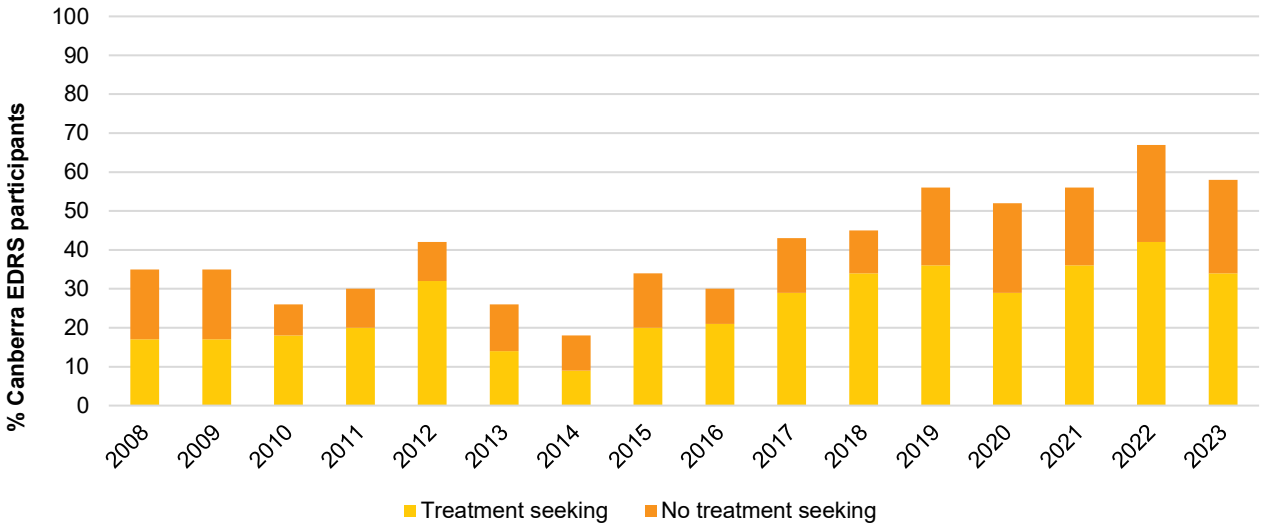
Note. #Due to the sensitive nature of these items there is missing data for some participants who chose not to respond. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size (n≤5 but not 0). Statistical significance for 2022 versus 2023 presented in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

Mental Health and Psychological Distress (K10)

Mental Health

Nearly three fifths (58%) of the sample self-reported that they had experienced a mental health problem in the preceding six months (other than drug dependence; 67% in 2022; p=0.192) (Figure 50). Of those who reported a mental health problem and who responded (n=55), the most common mental health problems were anxiety (69%; 64% in 2022; p=0.763) and depression (67%; 64% in 2022; p=0.156), followed by post-traumatic stress disorder (PTSD) (18%; 21% in 2022; p=0.039). Of those who reported a mental health problem, three fifths (60%; 34% of the total sample) reported seeing a mental health professional during the past six months (63% in 2022; p=0.848). Of this group (n=34), 56% reported being prescribed medication (79% in 2022; p=0.051).

Figure 50: Self-reported mental health problems and treatment seeking in the past six months, Canberra, ACT, 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. 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.

Psychological Distress (K10)

The Kessler Psychological Distress Scale 10 (K10) was administered to obtain a measure of psychological distress in the past four weeks. It 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 psychological 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 indicate 'low' psychological distress; scores between 16–21 indicate 'moderate' psychological distress; score 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 those who responded in 2023 (n=100), the per cent of participants scoring in each of the four K10 categories remained stable between 2022 and 2023 (p=0.335). In 2023, one fifth (20%) of the Canberra EDRS sample had a score of 30 or more (25% in 2022) (Figure 51).

The National Health Survey 2017-18 provides Australian population data for adult (≥18 years) K10 scores. EDRS participants in 2023 reported greater levels of 'high' and 'very high' distress compared to the general population (Figure 51).

Figure 51: K10 psychological distress scores, Canberra, ACT, 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 (EDRS only. 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 table; *p<0.050; **p<0.010; ***p<0.001.

Health Service Access

Three in ten (30%) participants reported accessing any health service for alcohol and/or drug (AOD) support in the six months preceding interview in 2023 (33% in 2022; p=0.759). The most common services reported by participants in 2023 included a drug and alcohol counsellor (11%; 15% in 2022), followed by a general practitioner (GP) (8%; 12% in 2022) and a medical tent (8%; n≤5 in 2022) (Table 7).

Nearly all (92%) of the sample reported accessing any health service in the six months preceding interview in 2023, a significant increase relative to 79% in 2022 (p=0.018). The most common services accessed by participants in 2023 were a GP (72%; 65% in 2022), followed by a dentist (45%; 24% in 2022) and a psychologist (36%; 23% in 2022) (Table 7).

Table 7: Health service access for alcohol and other drug reasons and for any reason in the past six months, Canberra, ACT, 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	33	**30**	**79**	**92***
Type of service accessed ***(participants could select multiple services)***	N=100	**N=100**	N=100	**N=100**
GP	12	**8**	65	**72**
Emergency department	-	**-**	17	**27**
Hospital admission (inpatient)	9	**-**	17	**11**
Medical tent (e.g., at a festival)	-	**8**	6	**10**
Drug and Alcohol counsellor	15	**11**	15	**11**
Hospital as an outpatient	-	**-**	-	**9**
Specialist doctor (not including a psychiatrist)	-	**0**	10	**21**
Dentist	-	**-**	24	**45**
Ambulance attendance	7	**-**	10	**8**
Other health professional (e.g., physiotherapist)	0	**-**	-	**9**
Psychiatrist	8	**-**	13	**15**
Psychologist	10	**7**	23	**36**
NSP	-	**-**	-	**-**
Peer based harm reduction service	-	**-**	-	**-**
Other harm reduction service	0	**0**	-	**-**

Note. 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.

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, 29% of the sample reported experiencing stigma because of their illicit drug use in any health/non-health care setting in the six months preceding interview.

Specifically, 6% of the sample reported experiencing stigma within specialist alcohol and other drug (AOD) services in the six months preceding interview (19% of those who had attended a specialist AOD service), stable relative to 2022 (8%; p=0.591). A larger percentage, however, reported experiencing stigma within general health care services in the six months preceding interview (20%; 23% of those who had attended general health care services), stable relative to 2022 (13%; p=0.250). Self-reported experiences of stigma while attending general health care services most commonly occurred while visiting a GP (8%) or the emergency department (7%). One fifth (21%) of participants reported experiencing stigma in non-health care settings, most commonly from police (17%; not asked in 2022) (Table 8).

Notably, 44% of participants reported engaging in some form of avoidance behaviour to avoid being treated negatively or differently by AOD specialist or general healthcare services. This most commonly involved not telling health workers about their drug use (31%) and delaying accessing health care (16%) (Table 8).

Table 8: Self-reported experiences of stigma due to illicit drug use in the past six months, Canberra, ACT, 2022-2023

	2022	2023
% Experienced stigma in specialist AOD service	N=99 8	**N=100** **6**
Needle and syringe program	/	**0**
Supervised injecting facility	/	**0**
Opioid treatment program	/	**-**
AOD counselling	/	**-**
Residential rehabilitation	/	**0**
Detoxification	/	**0**
Group therapy	/	**-**
Peer based harm reduction service	/	**0**
Other	/	**-**
% Experienced stigma in general health care service	N=99 13	**N=100** **20**
GP	/	**8**
Emergency department	/	**7**
Hospital admission (inpatient)	/	**-**
Medical tent	/	**0**
Dentist	/	**-**
Hospital outpatient	/	**-**
Specialist doctor	/	**-**
Ambulance	/	**0**
Psychiatrist	/	**-**
Psychologist	/	**-**
Other	/	**0**
% Experienced stigma in non-health care service	/	**N=99** **21**
Welfare and social service	/	**-**
Current or potential employer	/	**-**
School/uni/TAFE	/	**-**
Police	/	**17**
Other legal services	/	**-**
Housing and homelessness services	/	**-**
Other	/	**0**
% Experienced stigma in any of the above settings^	/	**29**
% Did any of the following to avoid being treated negatively or	/	**N=97** **44**

differently by AOD specialist or general healthcare services		
Delayed accessing healthcare	/	**16**
Did not tell health worker about drug use	/	**31**
Downplayed need for pain medication	/	**8**
Looked for different services	/	**10**
Did not attend follow-up appointment	/	**11**
Other	/	**-**

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. / Not asked. – 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.

COVID-19 Testing and Diagnosis

In 2023, the majority (98%) of the sample had ever been tested for SARS-CoV-2, with 67% having been tested in the 12 months preceding interview (96% in 2022; 56% in 2021; n≤5 in 2020). Four fifths (80%) of participants reported having ever been diagnosed with the virus (57% in 2022; 0% in 2021, 0% in 2020), with participants reporting a median of one infection (IQR=1-2). One third (32%) of the sample reported a positive COVID-19 test in the 12 months preceding interview.

At the time of interview, 94% reported that they had received at least one COVID-19 vaccine dose (91% in 2022), with participants receiving a median of three doses (IQR=2-3); few participants (n≤5) received one dose, 34% received two doses and 56% received three or more doses.

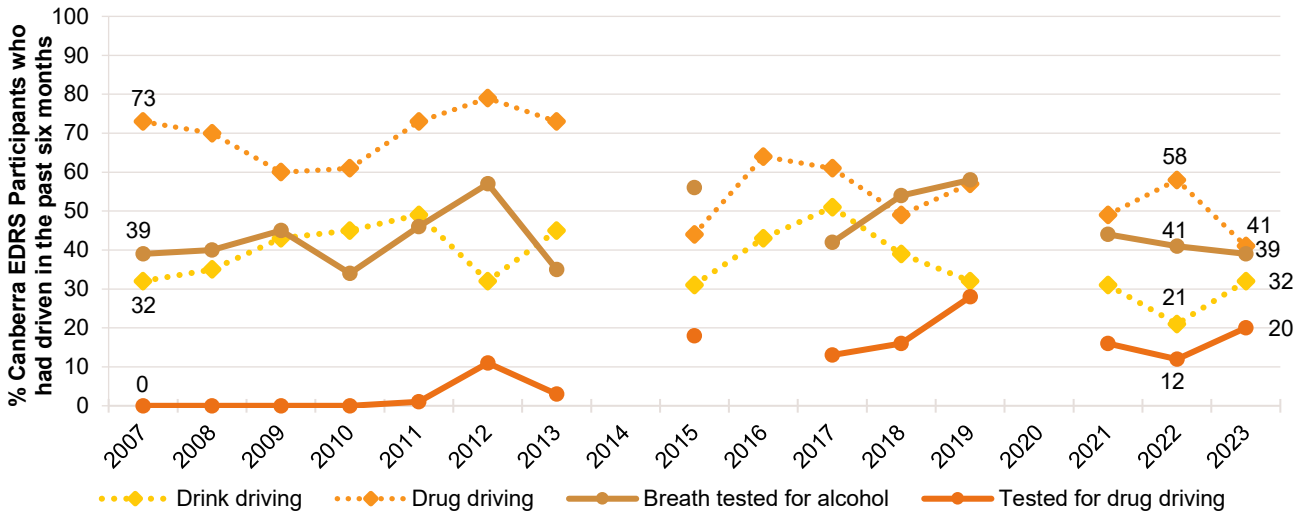
Driving

Seven in ten (70%) participants had driven a car, motorcycle or other vehicle in the last six months. Of those who had driven in the past six months and responded (n=69), 32% reported driving while over the (perceived) legal limit of alcohol (21% in 2022; p=0.186), and two fifths (41%) reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months (58% in 2022; p=0.069) (Figure 52).

Of those who had driven within three hours of consuming an illicit or non-prescribed drug in the last six months and responded (n=29), participants most commonly reported using cannabis (72%) prior to driving.

Among those who had driven in the past six months and commented (n=70), one fifth (20%) reported that they had been tested for drug driving by the police roadside drug testing service (12% in 2022), and 39% reported that they had been breath tested for alcohol by the police roadside testing service in the six months prior to interview (41% in 2022) (Figure 52).

Figure 52: Self-reported testing, and driving over the (perceived) legal limit for alcohol or three hours following illicit drug use, among those who had driven in the past six months, Canberra, ACT, 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.

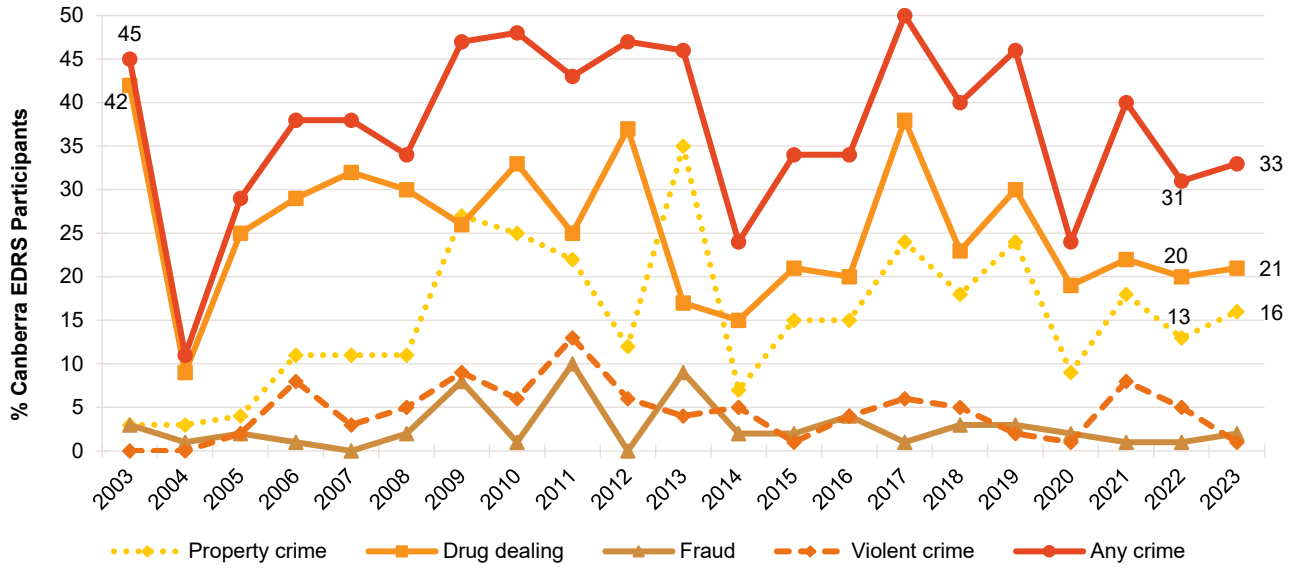
Experience of Crime and Engagement with the Criminal Justice System

The per cent reporting past month criminal activity has fluctuated over time, with drug dealing (21%; 20% in 2022) and property crime (16%; 13% in 2022; p=0.679) consistently being reported as the main forms of criminal activity (Figure 53). In 2023, one third (33%) of the sample reported 'any' criminal activity in the past month, stable relative to 2022 (31%; p=0.876). In 2023, 10% of the Canberra sample reported being the victim of a crime involving violence, stable relative to 2022 (15%; p=0.397) (Figure 54).

Few participants (n≤5) reported having been arrested in the 12 months preceding interview in 2023, stable relative to 2022 (n≤5; p=0.748), however one fifth (19%) reported a drug-related encounter in the last 12 months which did not result in charge or arrest (21% in 2022; p=0.855). This predominantly comprised being stopped and questioned (63%; 71% in 2022; p=0.745) and stopped and searched (63%; 48% in 2022; p=0.361). An additional 11% reported being stopped and issued a caution (33% in 2022; p=0.133).

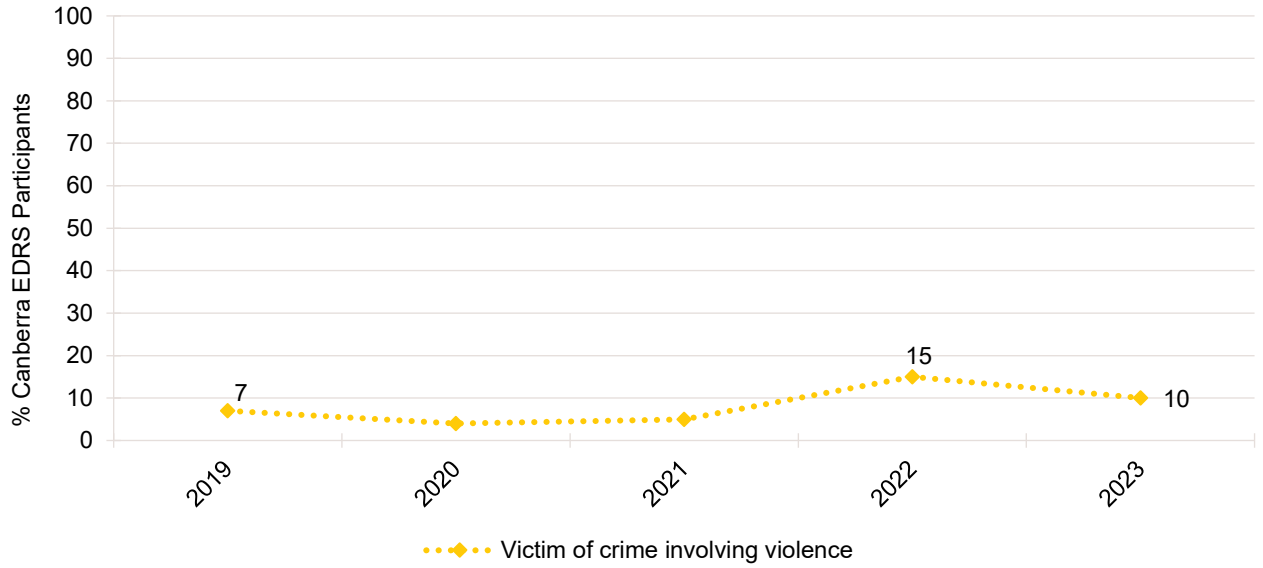
Few (n≤5) participants reported a lifetime history of imprisonment in 2023, a significant decrease relative to 2022 (11%; p=0.049).

Figure 53: Self-reported criminal activity in the past month, Canberra, ACT, 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. Y axis reduced to 50% to improve visibility of trends. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 54: Victim of crime involving violence in the past month, Canberra, ACT, 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 common means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was in person (74%; 68% in 2022; p=0.431) and via social networking applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (67%; 68% in 2022; p=0.877) (Table 9). It is important to re-iterate that this refers to people *arranging the purchase* of illicit or non-prescribed drugs. This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person.

Buying and Selling Drugs Online

Few (n≤5) participants reported obtaining drugs via the darknet (6% in 2022; p=0.765) or the surface web (n≤5 in 2022; p=0.274) in the past year. However, half (47%) of participants reported ever obtaining illicit drugs through someone who had purchased them on the surface or darknet, with one quarter (26%) having done so in the last 12 months (37% in 2022; p=0.179).

In 2023, few (n≤5) participants reported selling illicit/non-prescribed drugs via surface or darknet marketplaces in the 12 months preceding interview (n≤5 in 2022; p=0.318).

Source and Means of Obtaining Drugs

The majority of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2023 (84%; 83% in 2022; p=0.847), followed by two thirds (66%) reporting obtaining illicit drugs

from a known dealer/vendor (70% in 2022; p=0.651). Twenty-three per cent reported obtaining illicit drugs from an unknown dealer/vendor (23% in 2022) (Table 9).

When asked about how they had received illicit drugs on any occasion in the last 12 months, the majority of participants reported face-to-face (93%), stable relative to 2022 (97%; p=0.331), with fewer participants reporting receiving illicit drugs via post (16%; 15% in 2022) and via a collection point (defined as a predetermined location where a drug will be dropped for later collection; 11%; 12% in 2022; p=0.822) (Table 9).

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

	2019 n=98	2020 n=100	2021 n=100	2022 n=100	2023 n=100
% Purchasing approaches in the last 12 months^					
Face-to-face	81	49	63	68	**74**
Surface web	6	-	-	-	**-**
Darknet market	14	-	7	6	**-**
Social networking or messaging applications[#]	70	74	56	68	**67**
Text messaging	55	51	48	41	**35**
Phone call	54	27	33	30	**16***
Grew/ made my own	/	-	11	-	**7**
Other	0	-	0	0	**0**
% Means of obtaining drugs in the last 12 months^~	n=99	n=99	n=99	n=99	**n=100**
Face-to-face	99	97	86	97	**93**
Collection point	9	26	9	12	**11**
Post	13	8	8	15	**16**
% Sources of drugs in the last 12 months^	n=97	n=100	n=99	n=99	**n=100**
Friend/relative/partner/colleague	84	83	76	83	**84**
Known dealer/vendor	71	56	72	70	**66**
Unknown dealer/vendor	37	22	19	23	**23**

Note. - Per cent suppressed due to small numbers (n≤5 but not 0). ^ participants could endorse multiple responses. [#]This refers to people *arranging the purchase* of illicit or non-prescribed drugs. This captures participants who messaged friends or known dealers on Facebook Messenger or WhatsApp, for example, to organise the purchase of illicit or non-prescribed drugs, which may have then been picked up in person. ~ The face-to-face response option in 2021 was combined by those responding, 'I went and picked up the drugs', 'The drugs were dropped off to my house by someone' and/or 'Was opportunistic – I arranged and collected at the same time (e.g., at an event/club.)'. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in table; *p<0.050; **p<0.010; ***p<0.001.