EDRS

SOUTH AUSTRALIAN DRUG TRENDS 2023

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

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

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

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

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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.

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Participants

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

Contributors

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

Abbreviations

1,4-BD	1,4-Butanediol
2C-B	4-bromo-2,5-dimethoxyphenethylamine
4-AcO-DMT	4-Acetoxy-N,N-dimethyltryptamine
4-FA	4-Fluoroamphetamine
5-MeO-DMT	5-methoxy-N,N-dimethyltryptamine
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	Lysergic Acid Amide
LSD	*d*-lysergic acid
MDA	3,4-methylenedioxyamphetamine
MDMA	3,4-methylenedioxymethamphetamine
MDPV	Methylenedioxypyrovalerone
MXE	Methoxetamine
N (or n)	Number of participants
NBOME	N-methoxybenzyl
NDARC	National Drug and Alcohol Research Centre
NHS	National Health Service
NPS	New psychoactive substances
NSP	Needle Syringe Program
NSW	New South Wales
OTC	Over-the-counter
PMA	Paramethoxyamphetamine
PMMA	Polymethyl methacrylate
PTSD	Post-Traumatic Stress Disorder
REDCAP	Research Electronic Data Capture

SA	South Australia
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SD	Standard deviation
SDS	Severity of Dependence Scale
SSDP	Students for Sensible Drug Policy
STI	Sexually Transmitted Infection
THC	Tetrahydrocannabinol
UNSW	University of New South Wales
WA	Western Australia
WHO	World Health Organization

Executive Summary

The Adelaide South Australia (SA) EDRS comprises a sentinel sample of people who regularly use ecstasy and/or other illicit stimulants, recruited via social media and word-of mouth in Adelaide, SA. 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-May. 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 EDRS sample (N=101) recruited from Adelaide was similar to the sample in 2022 and in previous years. Gender remained stable between 2022 and 2023, with half (52%) identifying as male (50% in 2022), and participants had a median age of 26 years. Significantly fewer participants reported being current students in 2023 (29%; 44% in 2022; p=0.033), though most participants held tertiary qualifications (62%). One-quarter (27%) of the sample reported full-time employment and 37% reported part time/casual employment. Accommodation remained stable relative to 2022, with over half the sample (52%; 50% in 2022) living in a rental house/flat or residing with their parents/at their family home (32%; 28% in 2022) at the time of interview. Drug of choice and drug used most often remained stable between 2022 and 2023, with one-quarter (26%) nominating cannabis as their drug of choice (31% in 2022), and one quarter (26%) nominating alcohol as the drug used most often in the month preceding interview (33% in 2022).

Ecstasy

Recent use of any ecstasy in the six months prior to interview remained stable in 2023, relative to 2022 (84%; 74% in 2022; p=0.092). Capsules (53%) and pills (52%) remained the most commonly used forms of ecstasy, although recent use of ecstasy crystal increased significantly from 22% in 2022 to 39% in 2023 (p=0.017). Frequency of use remained stable for all four forms of ecstasy. The perceived availability of ecstasy crystal significantly changed between 2022 and 2023 (p=0.022), with almost two-fifths (38%) reporting that crystal was 'very easy' to obtain, an increase from 32% in 2022 and no participants reporting that crystal was 'very difficult' to obtain, a decrease from 20% reporting so in 2022. The perceived availability of ecstasy pills, capsules and powder remained stable in 2023, relative to 2022, as did the perceived purity of all forms of ecstasy.

Methamphetamine

Forty-six per cent of the Adelaide sample reported recent use of any methamphetamine, stable compared to 2022 (36%). Frequency of use also remained stable, with participants reporting a median of 24 days in 2023 (14 days in 2022). Whilst availability remained stable between 2022 and 2023 for both powder and crystal, the perceived purity of methamphetamine crystal changed significantly ($p<0.001$), with 56% reporting 'medium' purity in 2023, an increase from 10% in 2022.

Non-Prescribed Pharmaceutical Stimulants

The per cent of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has steadily increased since the commencement of monitoring, from 15% in 2007 to 42% in 2023

(41% in 2022), signifying the second highest percentage of use since monitoring commenced.

Cocaine

Recent use of cocaine has increased over the years of monitoring, with the second largest per cent reporting any recent use in 2023 (77%). Twelve per cent of those who had recently used cocaine reported weekly or more frequent use. Perceived purity and perceived availability for cocaine largely remained stable between 2022 and 2023.

Cannabis and/or Cannabinoid-Related Products

At least seven in ten participants have reported any recent use of non-prescribed cannabis and/or cannabinoid-related products each year since 2003 (noting some changes in question wording over time). In 2023, 70% of the Adelaide sample reported recent use of non-prescribed cannabis and/or cannabinoid-related products, the lowest percentage since monitoring commenced, albeit stable from 2022 (75%). The majority of those who had recently used non-prescribed cannabis and/or cannabinoid-related products reported use of outdoor grown 'bush' cannabis (65%), with a decline in those reporting recent use of hydroponic cannabis (60%; 78% in 2022; p=0.038). Market characteristics of non-prescribed hydroponic and bush cannabis remained stable between 2022 and 2023.

Non-Prescribed Ketamine, LSD and DMT

Recent use of non-prescribed ketamine (37%; 29% in 2022), LSD (33%; 30% in 2022) and DMT (12%; 6% in 2022) remained stable in 2023, relative to 2022, as did frequency of use. Whilst market characteristics of ketamine and LSD remained stable between 2022 and 2023, the median price for one tab of LSD was the highest median price for the second year running at $25 per tab.

New Psychoactive Substances (NPS)

Any NPS use, including plant-based NPS, has fluctuated over time, with 10% reporting recent use in 2023, stable from 2022 (12%). A similar percentage was observed for any NPS use, excluding plant-based NPS (9%; 7% in 2022). In 2023, the lowest percentages of use were observed since monitoring of NPS first commenced in 2010, with few participants ($n \leq 5$) reporting use of any individual NPS, with the exception of any 2C substance (7%; $n \leq 5$ in 2022).

Other Drugs

Participants who had recently used non-prescribed other benzodiazepines (25%) reported a median of nine days of use in 2023, a significant increase from four days of use in 2022 (p=0.007). One fifth (20%) of the Adelaide sample reported recent use of GHB/GBL/1,4-BD in the six months prior to interview, a significant increase from 7% in 2022 (p=0.009), and the highest percentage reporting recent use since the commencement of monitoring. Two thirds (67%) of the Adelaide sample had used non-prescribed e-cigarettes in the six months preceding interview (62% in 2022), also the highest percentage observed since the commencement of monitoring. A median frequency of 180 days of non-prescribed e-cigarette use was reported in the six months prior to interview in 2023, a significant increase from 75 days in 2022 (p=0.013). Further, 51% of participants who had recently used non-prescribed e-cigarettes reported daily use, also a significant increase from 19% reporting daily use in 2022 (p<0.001).

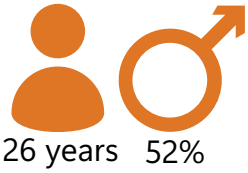
Drug-Related Harms and Other Behaviours

- Almost four fifths (79%; n=80) of the Adelaide sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes).
- Thirty-six per cent 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 from 22% in 2022 (p=0.032).
- Sixty per cent of participants obtained a score of eight or more on the AUDIT, indicative of hazardous use.
- Past year non-fatal stimulant overdose (17%; 16% in 2022) and non-fatal depressant overdose (23%; 23% in 2022) remained stable in 2023, relative to 2022.
- In 2023, almost three fifths (57%) reported that they had ever heard of naloxone, a significant increase relative to 2022 (36%; p=0.001), of which 91% were able to correctly identify the purpose of naloxone (92% in 2022).
- Reported past month injecting drug use remained low (n≤5), as did current drug treatment engagement (6%).
- In 2023, 18% of those who reported recent ecstasy use obtained an SDS score of 3 or more, whilst 52% of participants reporting recent methamphetamine use obtained a score of 4 or more, indicating possible dependence on these substances.
- Almost three-quarters (74%) of the sample reported engaging in some form of sexual activity in the past four weeks, of which 22% reported penetrative sex without a condom where they did not know the HIV status of their partner. One-fifth (22%) of the sample reported having a HIV test in the six months preceding interview, and 35% reported having a sexual health check-up in the six months prior to interview.
- Mental health remained stable relative to 2022, with 67% (61% in 2022) reporting experiencing a mental health problem in the six months preceding interview, with depression (64%) and anxiety (62%) most commonly reported.
- One quarter (27%) of the sample reported very high psychological distress.
- One third (34%) of 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, 79% had been tested for SARS-CoV-2 in the past 12 months, with one third (35%) 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 49% reported driving within three hours of consuming an illicit or non-prescribed drug in the prior six months.
- Thirty-six per cent of the sample reported 'any' crime in the past month. Drug dealing was the main form of criminal activity reported in 2023 and significantly increased, from 15% in 2022 to 27% (p=0.046). Eleven per cent of the sample reported having been arrested in the 12 months preceding interview, and 22% reported a drug-related encounter with police which did not result in charge or arrest.
- Face-to-face was the most common way in which participants arranged the purchase of illicit or non-prescribed drugs in the 12 months preceding interview, which significantly increased from 72% in 2022 to 85% in 2023 (p=0.031). The majority (88%) of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2023, stable from 2022 (89%).

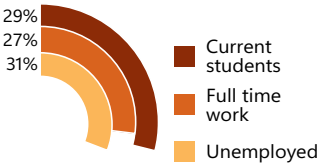
EDRS Ecstasy and Related Drugs Reporting System

2023 SAMPLE CHARACTERISTICS

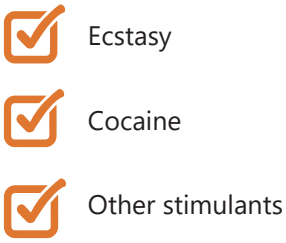
In 2023, 101 participants, recruited from Adelaide, SA were interviewed.



The median age in 2023 was 26, and 52% identified as male.

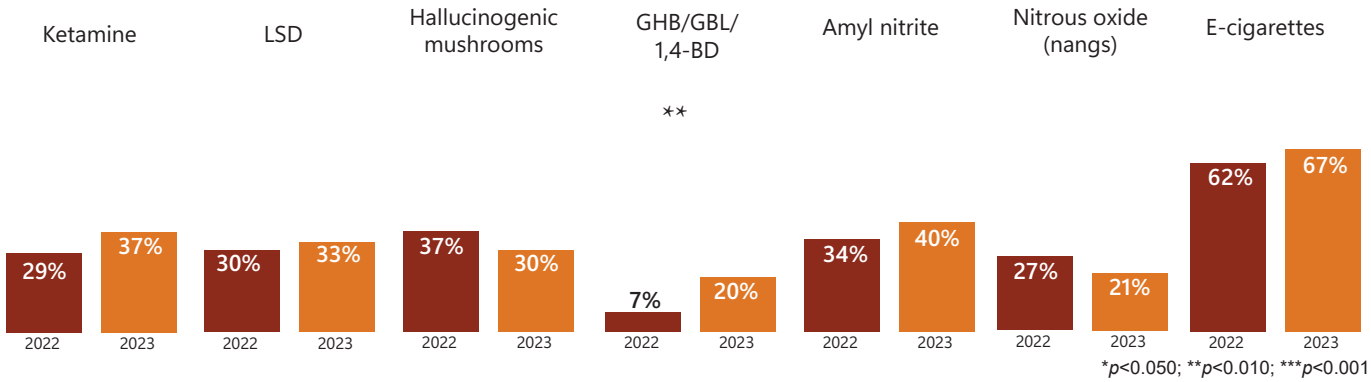


In the 2023 sample, 29% were current students, 27% were employed full time and 31% were unemployed.



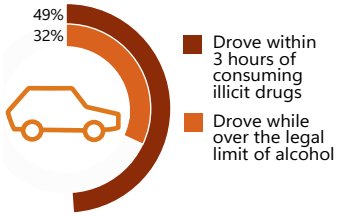
Participants were recruited on the basis that they had consumed ecstasy and/or other illicit stimulants at least monthly in the past 6 months.

PAST 6 MONTH USE OF OTHER DRUGS

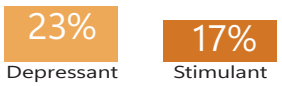


*p<0.050; **p<0.010; ***p<0.001

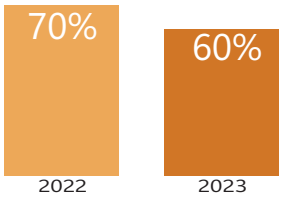
DRUG-RELATED HARMS AND RISKS



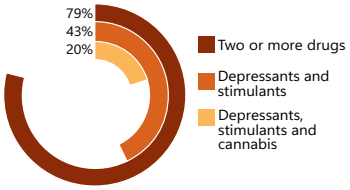
Among recent drivers, 49% reported driving a vehicle within 3 hours of consuming illicit drugs and 32% while over the legal limit of alcohol.



In the 2023 sample, 23% reported a non-fatal depressant overdose in the previous 12 months, and 17% reported a non-fatal stimulant overdose.

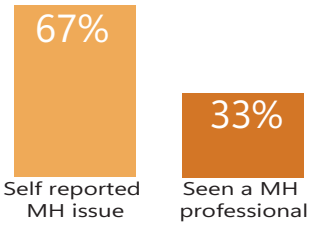


60% of the sample obtained an AUDIT score of eight or more, indicative of past year hazardous alcohol use (70% in 2022).

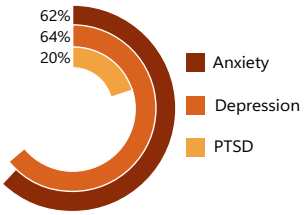


On the last occasion of ecstasy or related drug use, 79% used two or more drugs, 43% used both stimulants and depressants, and 20% used stimulants, depressants and cannabis.

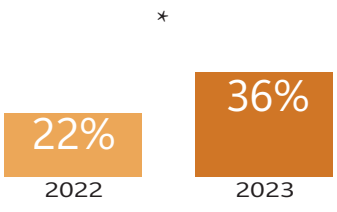
OTHER BEHAVIOURS



In the total sample, 67% self reported a mental health issue and 33% had seen a mental health professional in the past 6 months.



Of those who commented, the three most common mental health issues reported were depression (64%), anxiety (62%) and PTSD (20%).

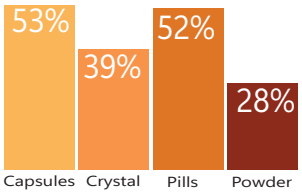


36% of the sample reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year.

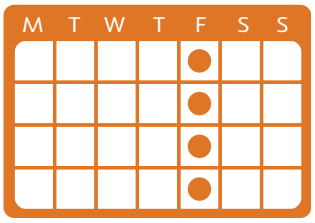
29% of the sample reported experiencing stigma because of their illicit drug use in the six months preceding interview, most commonly from police or a GP.

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

ECSTASY



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



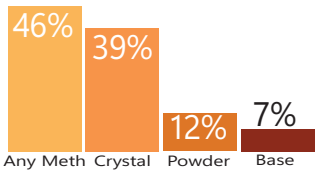
Of those who had recently consumed ecstasy, 15% used it weekly or more frequently.

2 Capsules
2 Pills
0.30 grams of crystal
0.50 grams of powder

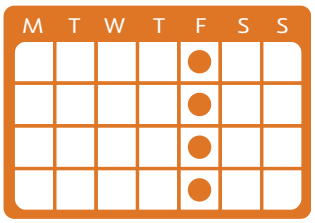
Median amounts of ecstasy consumed in a 'typical' session using each form.

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

METHAMPHETAMINE

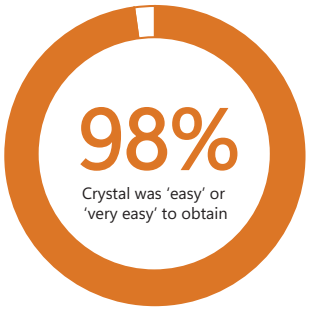


Past 6 month use of any methamphetamine, crystal, powder and base in 2023.



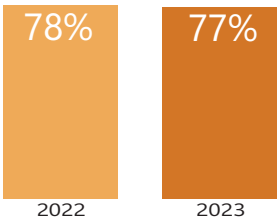
Of those who had recently consumed methamphetamine, 54% used it weekly or more frequently.

92% of participants who had recently used crystal smoked it.

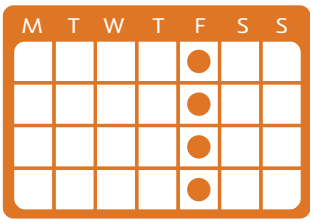


Of those who could comment 98% perceived crystal methamphetamine to be 'easy' or 'very easy' to obtain.

COCAINE

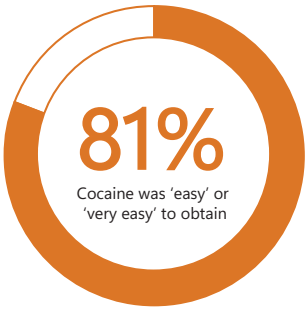


Past 6 month use of any cocaine remained stable between 2022 and 2023.



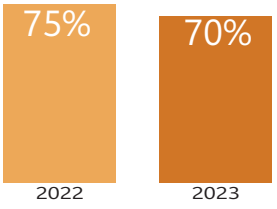
Of participants who had consumed cocaine recently, 12% reported weekly or more frequent use.

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

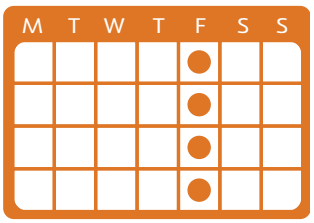


Of those who could comment 81% perceived cocaine to be 'easy' or 'very easy' to obtain.

CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS

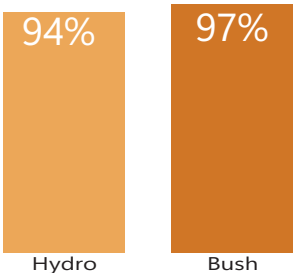


Past 6 month use of non-prescribed cannabis and/or cannabinoid-related products remained stable between 2022 and 2023.



Of those who had consumed non-prescribed cannabis recently, 66% reported weekly or more frequent use.

Of participants who had consumed cannabis in the last 6 months, 96% had smoked it (35% swallowed and 20% vaped it).



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

Background

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

The EDRS is designed to be sensitive to emerging trends, providing data in a timely manner rather than describing issues in extensive detail. It does this by studying a range of data sources, including data from annual interviews with people who regularly use ecstasy and/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 used to collect data on laptops or tablets. Following provision of written informed consent and completion of a structured interview, participants were reimbursed $40 cash for their time and expenses incurred.

EDRS 2020-2023: COVID-19 Impacts on Recruitment and Data Collection

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

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

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

2023 EDRS Sample

A total of 708 participants were recruited across capital cities nationally (April-July, 2023), with 101 participants interviewed in Adelaide, SA between 13 April and 8 May 2023 (n=104 in 2022). A total of 34 interviews (34%) were conducted via telephone (n=41 in 2022; 39%), the remainder were conducted face-to-face.

Thirteen per cent of the 2023 Adelaide sample completed the interview in 2022, and 16% of the 2022 Adelaide sample completed the interview in 2021 (p=0.691). There was a significant change in recruitment methods compared to 2022 (p=0.001), with more participants being recruited via the internet (e.g., Facebook and Instagram) (61%; 38% in 2022), and fewer via word-of-mouth (35%; 44% in 2022). Few (n≤5) responded 'other' (17% 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 Adelaide, South Australia, 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 Adelaide, SA (see section on 'Additional Outputs' below for details of other outputs providing such profiles).

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

Additional Outputs

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

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

1

Sample Characteristics

In 2023, the Adelaide EDRS sample was mostly similar to the sample in 2022 and in previous years (Table 1).

Gender remained stable between 2022 and 2023 (p=0.124), with half (52%) of the sample identifying as male (50% in 2022). The median age of the sample was 26 years (IQR=22-35), stable relative to 2022 (26 years; IQR=22-31; p=0.517).

Accommodation remained stable (p=0.060), with half (52%) of the sample reporting that they resided in a rented house/flat (50% in 2022), and most of the remaining participants living with their parents/in their family house (32%; 28% in 2022).

Participants reported a mean of 11 years of school in 2023 (range: 7-12; 11 years in 2022; range: 9-12; p=0.046) and 29% were current students, a significant decrease relative to 2022 (44%; p=0.033). Three fifths (62%) had obtained a post-school qualification(s) (69% in 2022; p=0.314).

Current employment status remained stable between 2022 and 2023 (p=0.548). Specifically, one quarter (27%) reported being employed full-time at the time of interview (21% in 2022), 37% reported being employed on a part time/casual basis (42% in 2022), and almost one third (31%) reported being unemployed at the time of interview (27% in 2022).

Table 1: Demographic characteristics of the sample, nationally, 2023, and Adelaide, SA, 2017-2023

	Adelaide, SA							National
	2017	2018	2019	2020	2021	2022	2023	2023
	(N=100)	(N=100)	(N=100)	(N=101)	(N=100)	(N=104)	(N=101)	(N=708)
Median age (years; IQR)	20 (19-22)	21 (18-28)	22 (19-25)	23 (19-27)	25 (21-32)	26 (22-31)	**26 (22-35)**	25 (21-32)
% Gender								
Female	40	29	28	37	42	50	**44**	40
Male	60	70	69	63	57	50	**52**	58
Non-binary	/	/	-	0	-	0	**-**	3
% Aboriginal and/or Torres Strait Islander	-	7	-	-	-	7	**-**	4
% Sexual identity								
Heterosexual	87	84	81	84	70	74	**70**	71
Homosexual	-	0	6	0	-	-	**7**	8
Bisexual	11	10	10	11	23	17	**16**	16

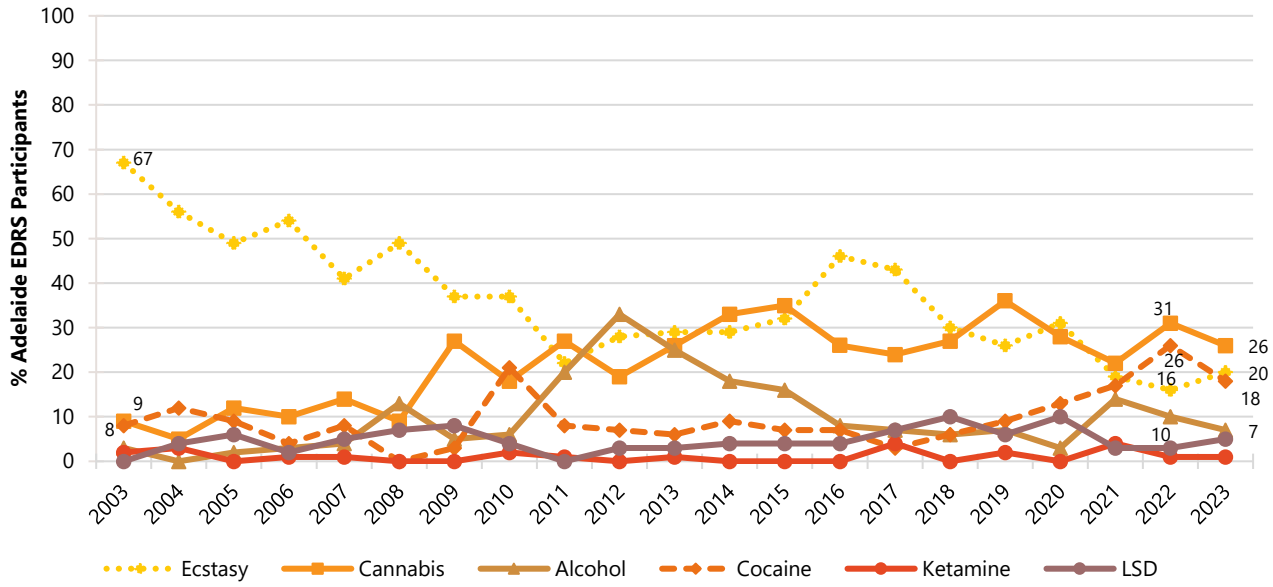
	Adelaide, SA							National
	2017	2018	2019	2020	2021	2022	2023	2023
Queer	/	/	-	-	-	-	**-**	4
Different identity	0	-	-	-	-	-	**-**	1
Mean years of school education (range)	12 (7-12)	11 (8-12)	11 (8-12)	12 (9-12)	12 (6-12)	11 (9-12)	**11 (7-12)***	12 (5-12)
% Post-school qualification(s)^	40	53	62	60	62	69	**62**	62
% Current students#	52	8	36	32	41	44	**29***	36
% Current employment status								
Employed full-time	18	21	22	20	20	21	**27**	38
Part time/casual	/	/	/	30	47	42	**37**	39
Self-employed	/	/	/	8	-	10	**6**	4
Unemployed	7	30	38	43	29	27	**31**	19
Current median weekly income $ (IQR)	$625 (370-1075)	$552 (358-800)	$460 (250-750)	$550 (348-800)	$500 (332-850)	$550 (350-900)	**$600 (400-1000)**	$808 (450-1385)
% Current accommodation								
Own house/flat	-	-	-	9	-	16	**-**	9
Rented house/flat	39	41	46	49	49	50	**52**	58
Parents'/family home	53	47	48	40	40	28	**32**	26
Boarding house/hostel	0	-	0	0	-	-	**-**	2
Public housing	/	-	-	-	-	-	**-**	3
No fixed address+	0	-	-	-	-	-	**-**	1
Other	-	0	0	0	0	0	**-**	1

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

Drug of choice remained stable between 2022 and 2023 (p=0.182), with one quarter (26%) nominating cannabis as their drug of choice in 2023 (31% in 2022), followed by one fifth (20%) nominating ecstasy as their drug of choice (16% in 2022) and 18% nominating cocaine (26% in 2022) (Figure 1). The drug used most often in the past month also remained stable between 2022 and 2023 (p=0.169), with one quarter reporting alcohol (26%) and cannabis (25%) as the drugs used most often (33% and 31% in 2022, respectively) (Figure 2).

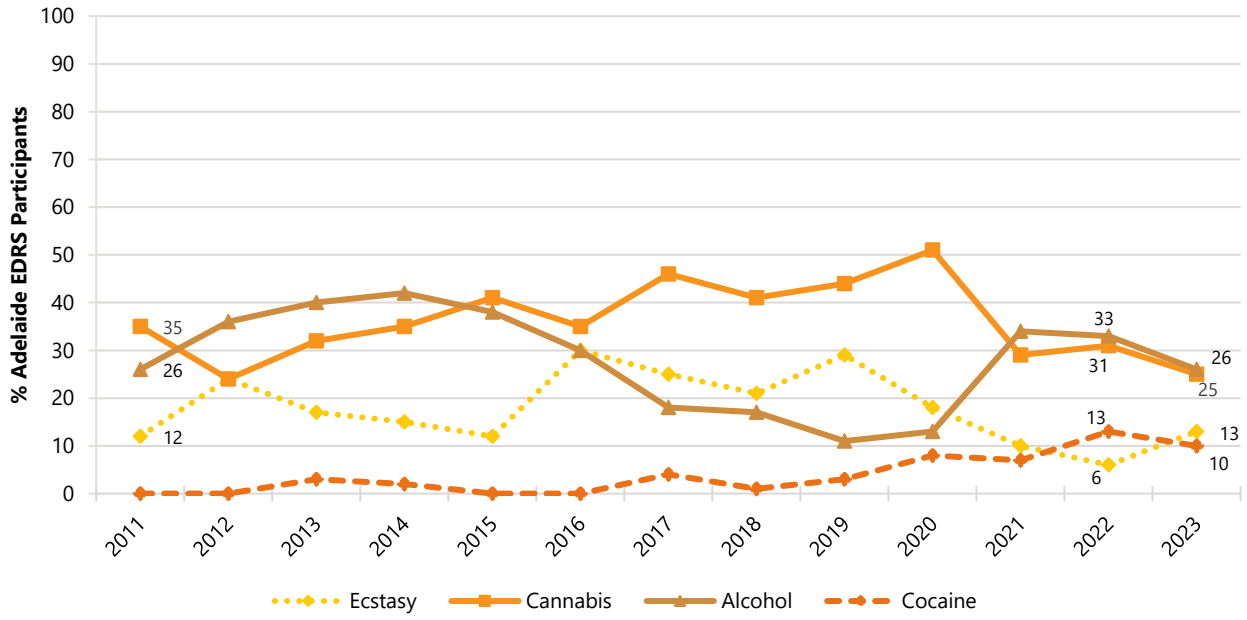
Weekly or more frequent use of various drugs remained stable between 2022 and 2023. Specifically, almost half (47%) of the Adelaide sample reported weekly or more frequent cannabis use (50% in 2022; p=0.676) and one quarter (25%) reported weekly or more frequent methamphetamine use (15% in 2022; p=0.121). Thirteen per cent reported weekly or more frequent use of ecstasy (13% in 2022) and 9% reported weekly or more frequent use of cocaine (11% in 2022; p=0.809) (Figure 3).

Figure 1: Drug of choice, Adelaide, SA, 2003-2023



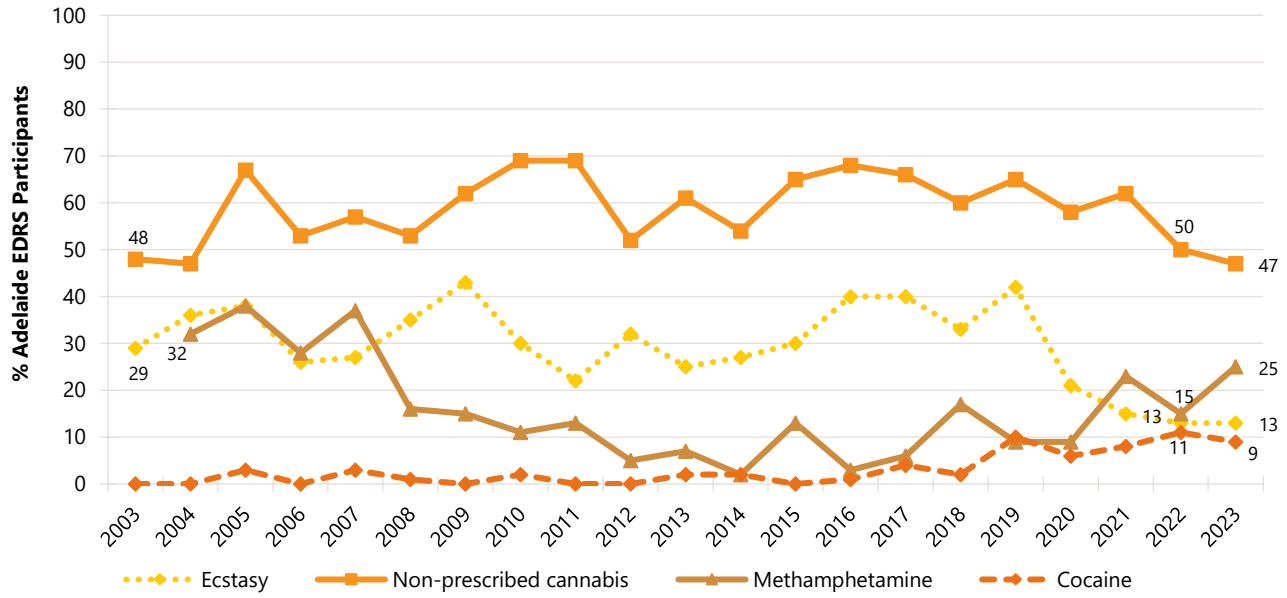
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; smaller percentages have endorsed other substances. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed 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, Adelaide, SA, 2011-2023



Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; smaller 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, Adelaide, SA, 2003-2023



Note. Computed from the entire sample regardless of whether they had used the substance in the past six months. 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'. Data labels are only provided for the first (2003/2004) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

2

Ecstasy

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

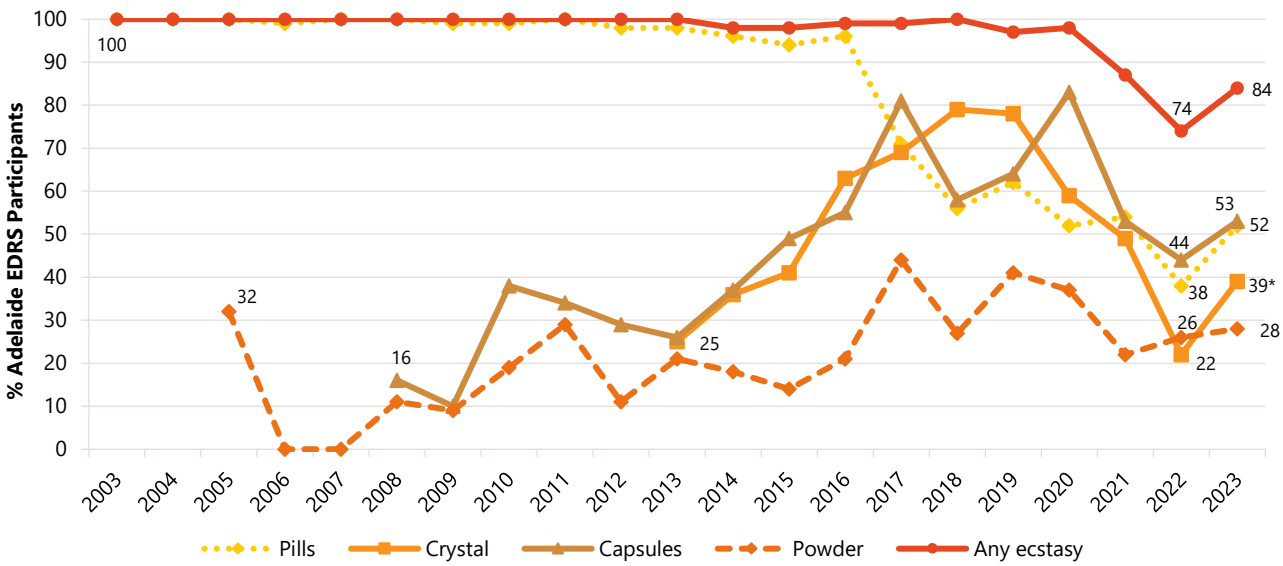
Recent Use (past 6 months)

Recent use of any ecstasy in the six months prior to interview remained stable in 2023, relative to 2022 (84%; 74% in 2022; p=0.092) (Figure 4). Consistent with the previous few years, capsules (53%; 44% in 2022; p=0.215) and pills (52%; 38% in 2022; p=0.054) were the most commonly used forms of ecstasy in the six months preceding interview in 2023, followed by crystal (39%; 22% in 2022; p=0.017). Powder remained the least commonly used form of ecstasy (28%; 26% in 2022; p=0.872), consistent with almost the entirety of the reporting period.

Frequency of Use

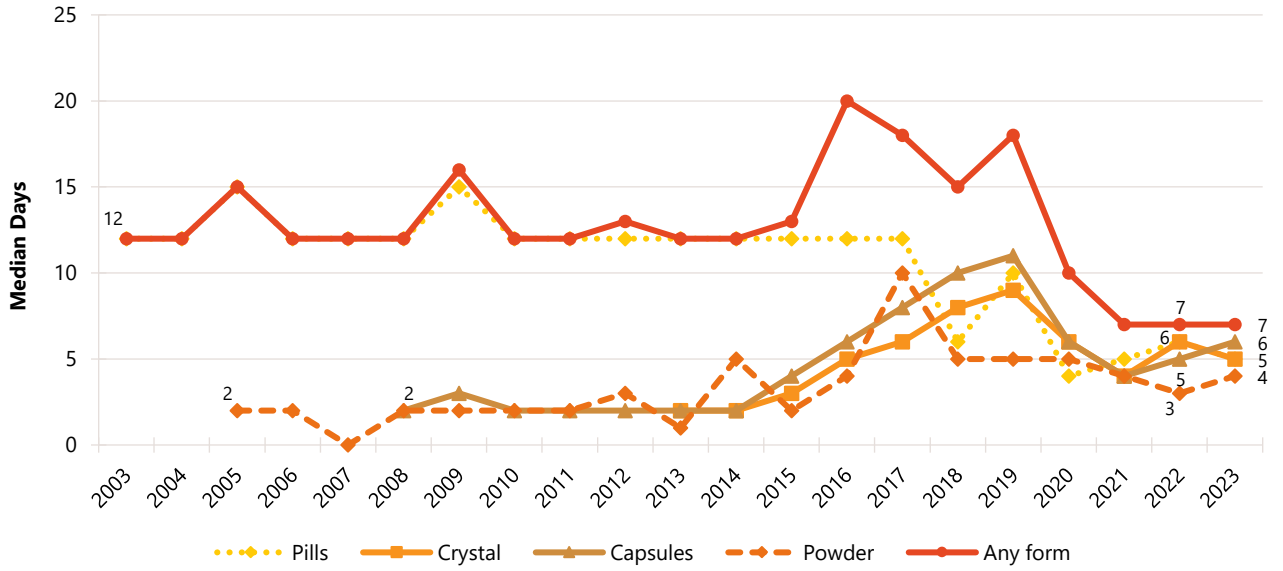
Among those who reported recent use of any ecstasy and commented (n=84), participants reported using ecstasy (in any form) on a median of seven days (IQR=4-13) in 2023, equivalent to monthly use in the preceding six months, and remaining stable, relative to 2022 (7 days; IQR=3-12; n=77; p=0.551) (Figure 5). Among those who had recently used any ecstasy and commented (n=84), weekly or more frequent use of any form of ecstasy remained stable, relative to 2022 (15%; 17% in 2022; p=0.829).

Figure 4: Past six month use of any ecstasy, and ecstasy pills, powder, capsules and crystal, Adelaide, SA, 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, Adelaide, SA, 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 25 days to improve visibility of trends. Data labels are only provided for the first (2003/2005/2008/2013) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Patterns of Consumption (by form)

Ecstasy Pills

Recent Use (past 6 months): Recent use of ecstasy pills has declined considerably since the commencement of monitoring. While 96%-100% of participants reported recent use from 2003-2016, 52% of participants reported recent use in 2023 (38% in 2022; p=0.054) (Figure 4).

Frequency of Use: Of those who had recently consumed ecstasy pills and commented (n=53), ecstasy pills were used on a median of five days (IQR=2-12) in the six months preceding interview in 2023, stable from 2022 (6 days; IQR=2-12; n=40; p=0.679) (Figure 5). One fifth (21%) of those who had recently consumed ecstasy pills reported weekly or more frequent use in 2023, stable relative to 2022 (n≤5; p=0.088).

Routes of Administration: Among participants who had recently consumed ecstasy pills and commented (n=53), the most common route of administration in 2023 was swallowing (91%; 98% in 2022; p=0.231), followed by snorting (26%; 15% in 2022; p=0.216), consistent with previous years. Few participants (n≤5) reported recent smoking and shelving/shafting, respectively.

Quantity: Of those who reported recent use and responded (n=53), the median number of pills used in a 'typical' session was two (IQR=2-3; 2 pills in 2022; IQR=1-3; n=40; p=0.428). Of those who reported recent use and responded (n=53), the median maximum number of pills used in a session was three (IQR=2-5; 3 pills in 2022; IQR=1.5-4; n=40; p=0.261).

Ecstasy Capsules

Recent Use (past 6 months): Fifty-three per cent of participants reported recent use of ecstasy capsules, stable from 44% in 2022 (p=0.215) (Figure 4).

Frequency of Use: Among those who reported recent use and commented (n=54), participants reported consuming capsules on a median of six days in 2023 (IQR=3-10), stable from 2022 (5 days; IQR=2-10; n=46; p=0.287) (Figure 5). Few participants (n≤5) who had recently consumed ecstasy capsules reported weekly or more frequent use in 2023 (n≤5 in 2022).

Routes of Administration: Among those who had recently consumed ecstasy capsules and commented (n=54), the vast majority (94%) of participants reported swallowing (100% in 2022; p=0.247). One quarter (28%) reported snorting, a significant increase relative to 2022 (n≤5; p=0.021). No participants reported recent smoking (0% in 2022), nor shelving/shafting (n≤5 in 2022; p=0.460).

Quantity: Of those who reported recent use and responded (n=54), the median number of capsules used in a 'typical' session was two (IQR=2-3; 2 capsules in 2022; IQR=1-2; n=46; p=0.013). Of those who reported recent use and responded (n=53), the median maximum number of capsules used in a session was three (IQR=2-5; 2 capsules in 2022; IQR=1-4; n=46; p=0.014).

Ecstasy Crystal

Recent Use (past 6 months): Thirty-nine per cent of participants reported recent use of ecstasy crystal, a significant increase from 2022 (22%; p=0.017) (Figure 4).

Frequency of Use: Among those who reported recent use and commented (n=39), participants reported using crystal on a median of five days (IQR=3-11) in 2023, stable from six days in 2022 (IQR=3-10; n=23; p=0.708) (Figure 5). Few participants (n≤5) who had recently consumed crystal reported weekly or more frequent use in 2023 (n≤5 in 2022; p=0.398).

Routes of Administration: Among participants who had recently consumed ecstasy crystal and commented (n=39), almost two thirds (64%) reported swallowing (65% in 2022), while 56% reported snorting (43% in 2022; *p*=0.431). Few (n≤5) participants reported recent smoking (n≤5 in 2022) and no participants reported recent shelving/shafting (0% in 2022).

Quantity: Of those who reported recent use and responded (n=37), the median amount of crystal used in a 'typical' session was 0.30 grams (IQR=0.20-0.50; 0.40 grams in 2022; IQR=0.20-0.50; n=19; *p*=0.944). Of those who reported recent use and responded (n=36), the median maximum amount of crystal used in a session was 0.50 grams (IQR=0.30-1.00; 0.50 grams in 2022; IQR=0.30-1.00; n=19; *p*=0.886).

Ecstasy Powder

Recent Use (past 6 months): Recent use of ecstasy powder remained stable, relative to 2022 (28%; 26% in 2022; *p*=0.872) (Figure 4).

Frequency of Use: Amongst those who reported recent use and commented (n=28), participants reported consuming powder on a median of four days (IQR=2-8) in 2023, stable from three days in 2022 (IQR=2-6; n=27; *p*=0.460) (Figure 5). Few (n≤5) participants who had recently consumed powder reported weekly or more frequent use in 2023 (0% in 2022; *p*=0.111).

Routes of Administration: Among participants who had recently consumed ecstasy powder and commented (n=28), almost four fifths (79%) reported snorting (85% in 2022; *p*=0.729), followed by two fifths (43%) who reported swallowing (26% in 2022; *p*=0.263).

Quantity: Of those who reported recent use and responded (n=23), the median amount of powder used in a 'typical' session was 0.50 grams (IQR=0.20-1.00; 0.30 grams in 2022; IQR=0.20-0.50; n=19; *p*=0.591). Of those who reported recent use and responded (n=22), the median maximum amount of powder used in a session was 0.50 grams (IQR=0.20-1.10; 0.40 grams in 2022; IQR=0.30-0.80; n=19; *p*=0.598).

Price, Perceived Purity and Perceived Availability

Ecstasy Pills

Price: The median price of a pill remained stable, recorded at $30 in 2023 (IQR=25-35; n=33) and $28 in 2022 (IQR=20-36; n=24; *p*=0.305) (Figure 6).

Perceived Purity: The perceived purity of ecstasy pills remained stable between 2022 and 2023 (*p*=0.492). Among those who responded in 2023 (n=54), almost two fifths (37%) reported purity as being 'medium' (29% in 2022), with a further 22% reporting purity to be 'high' (21% in 2022). 'Low' purity was reported by one fifth (20%) of participants (34% in 2022) (Figure 8).

Perceived Availability: The perceived availability of ecstasy pills remained stable between 2022 and 2023 (*p*=0.276). Among those who were able to comment in 2023 (n=56), almost two fifths (38%) reported that pills were 'easy' to obtain (23% in 2022), with a further 30% reporting 'very easy' obtainment (33% in 2022). On the other hand, one quarter (27%) reported pills as being 'difficult' to obtain (28% in 2022) (Figure 12).

Ecstasy Capsules

Price: The reported median price of an ecstasy capsule was $25 in 2023 (IQR=20-30; n=34), stable relative to $25 in 2022 (IQR=16-25; n=18; *p*=0.100) (Figure 6).

Perceived Purity: The perceived purity of ecstasy capsules remained relatively stable

between 2022 and 2023 (p=0.063). Among those who were able to comment in 2023 (n=56), almost two fifths (38%) perceived purity to be 'medium' (27% in 2022) and 36% perceived purity to be 'high' (20% in 2022). In contrast, 11% perceived purity to be 'low' (24% in 2022) and a further 16% perceived purity to be 'fluctuating' (29% in 2022) (Figure 9).

Perceived Availability: The perceived availability of ecstasy capsules remained relatively stable between 2022 and 2023 (p=0.052). Among those who responded in 2023 (n=56), almost half (48%) reported that capsules were 'easy' to obtain (36% in 2022), whereas 16% reported that capsules were 'difficult' to obtain (33% in 2022) (Figure 13).

Ecstasy Crystal

Price: The median price of a gram of crystal remained stable in 2023 at $200 (IQR=190-220; n=15; $150 in 2022; IQR=138-210; n=7; p=0.588) (Figure 7). The median price of a point of crystal also remained stable in 2023 ($25; IQR=25-33; n=9), relative to 2022 (n≤5; p=0.860).

Perceived Purity: The perceived purity of ecstasy crystal remained stable between 2022 and 2023 (p=0.926). Among those who responded in 2023 (n=39), 44% perceived the purity of crystal to be 'high' (42% in 2022) and 28% perceived purity to be 'medium' (33% in 2022) (Figure 10).

Perceived Availability: The perceived availability of ecstasy crystal significantly changed between 2022 and 2023 (p=0.022). Among those who were able to comment in 2023 (n=39), almost two fifths (38%) reported that crystal was 'very easy' to obtain, an increase from 32% in 2022. In contrast, no participants reported that crystal was 'very difficult' to obtain, a decrease from 20% in 2022 (Figure 14).

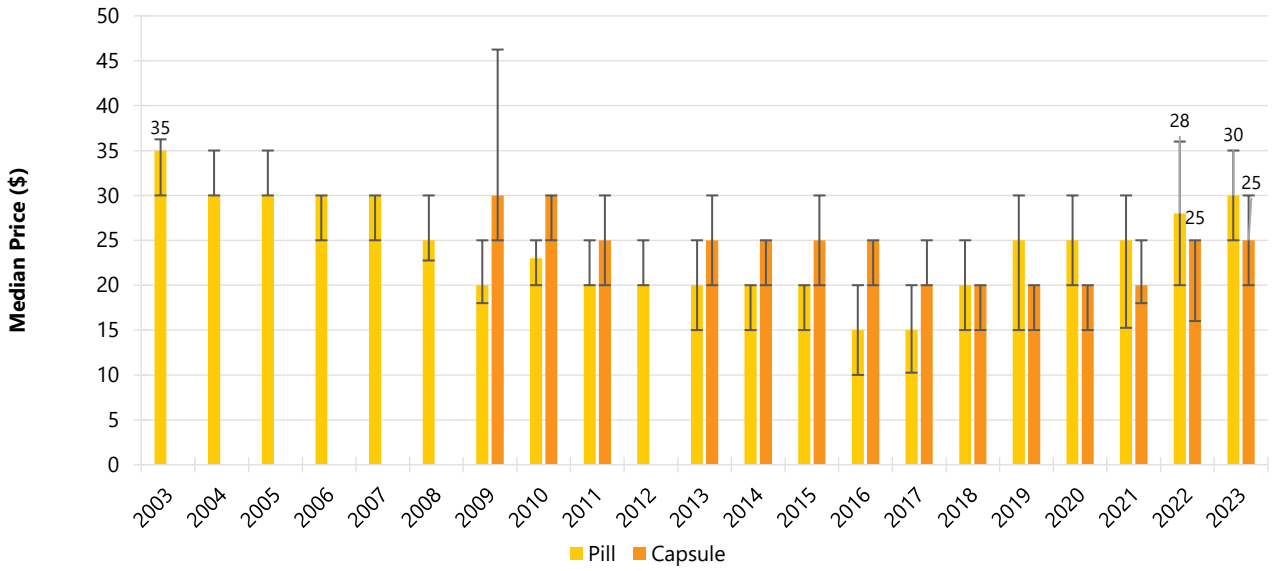
Ecstasy Powder

Price: The median price of a gram of powder remained stable in 2023 ($175; IQR=96-215; n=10; n≤5 in 2022; p=0.804), though few participants (n≤5) were able to report on the median price of a point of powder in 2023 (n≤5 in 2022; p=0.277) (Figure 7).

Perceived Purity: The perceived purity of ecstasy powder remained stable between 2022 and 2023 (p=0.189). Among those who were able to comment in 2023 (n=25), two fifths (40%) perceived purity to be 'high' (n≤5 in 2022), and almost one third (32%) perceived purity to be 'medium' (42% in 2022) (Figure 11).

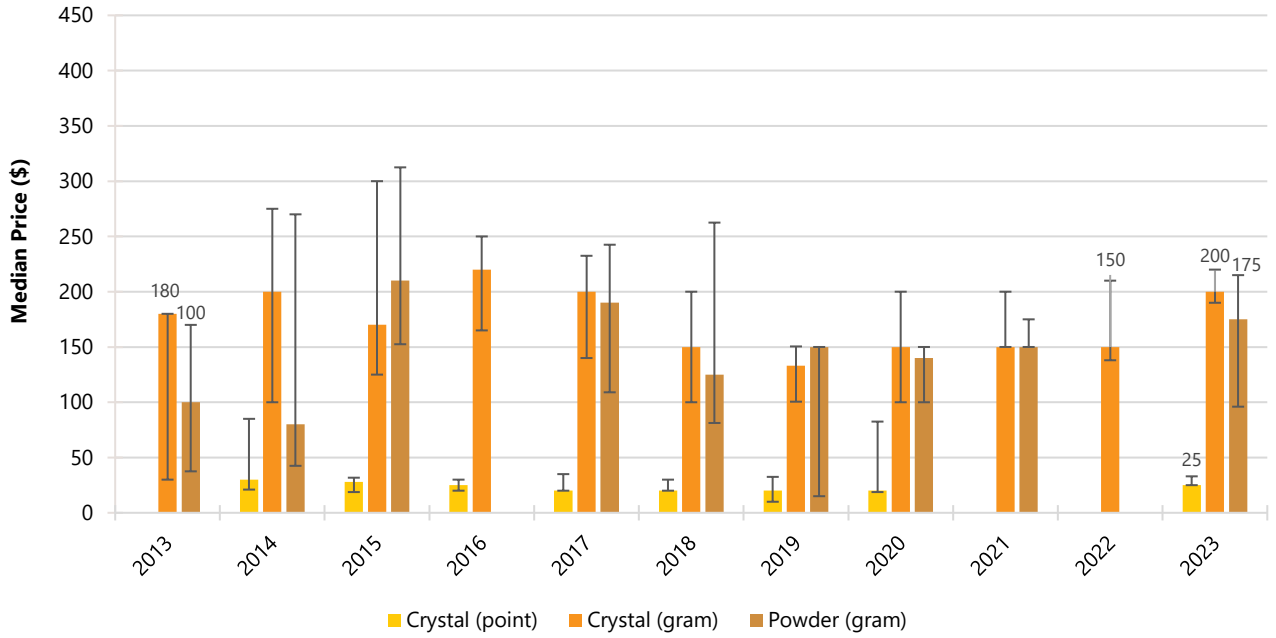
Perceived Availability: The perceived availability of ecstasy powder remained stable between 2022 and 2023 (p=0.688). Among those who were able to respond in 2023 (n=25), two fifths (40%) reported powder as being 'easy' to obtain (n≤5 in 2022), and a further 36% perceived powder as being 'difficult' to obtain (33% in 2022) (Figure 15).

Figure 6: Median price of ecstasy pill and capsule, Adelaide, SA, 2003-2023



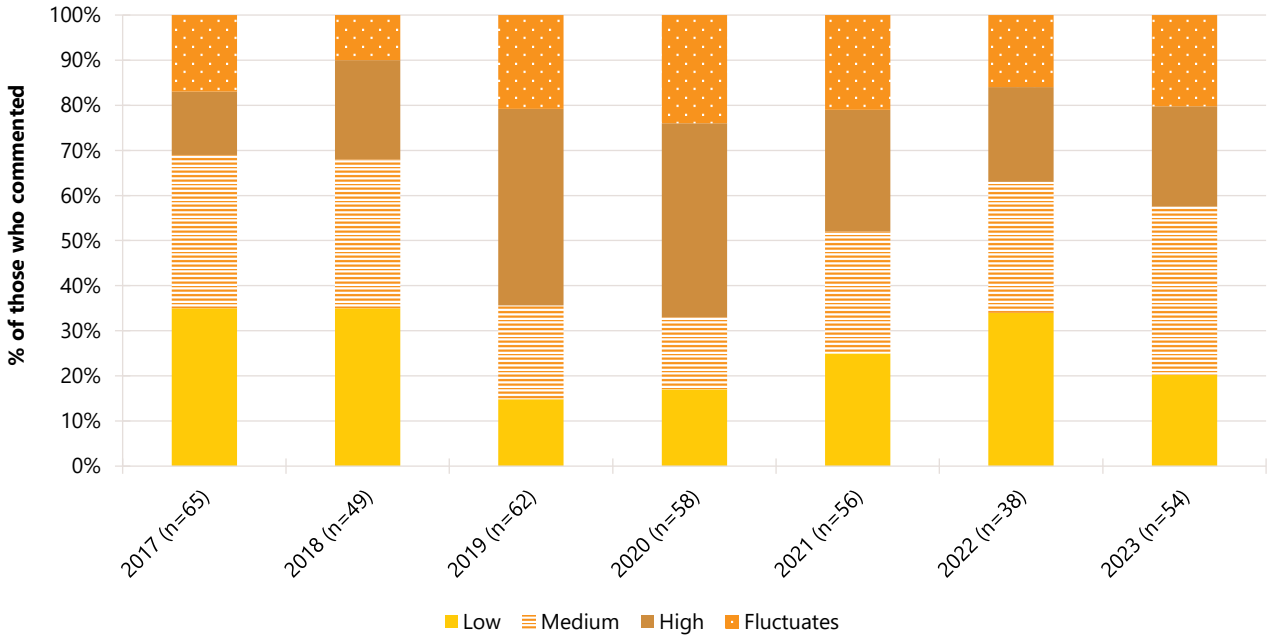
Note. Among those who commented. Data collection for price of ecstasy capsules started in 2008. Data labels are only provided for the first (2003/2008) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Data are suppressed in the figure and data tables where n≤5 responded to the item. The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. The error bars represent the IQR. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 7: Median price of ecstasy crystal (per point and gram) and powder (per gram only), Adelaide, SA, 2013-2023



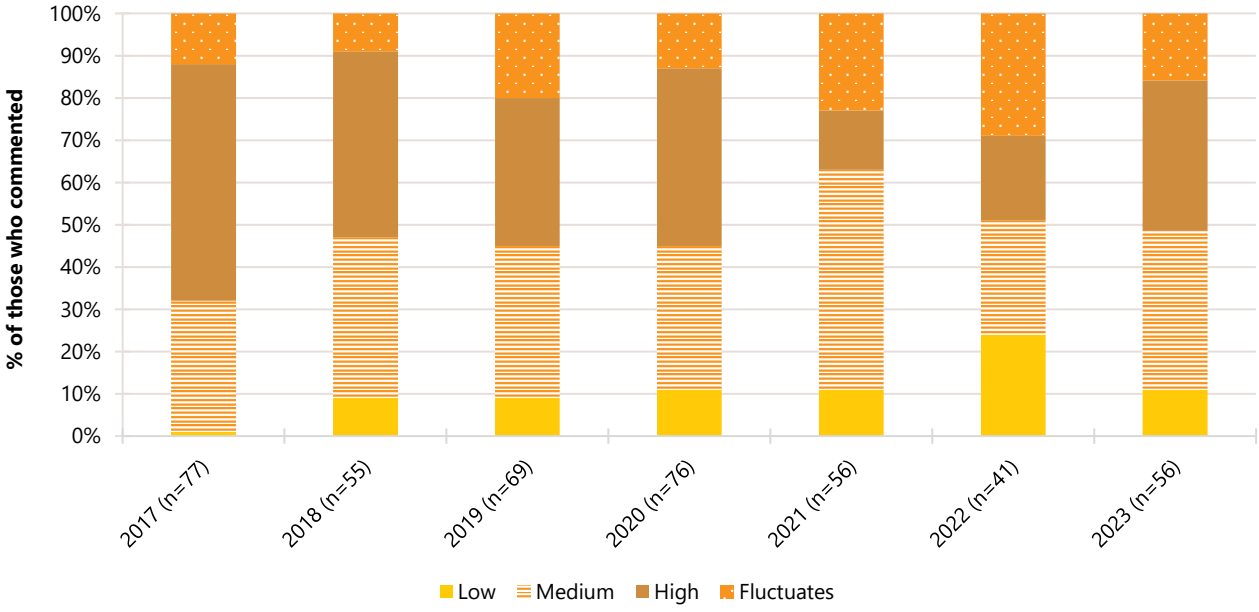
Note. Among those who commented. Data collection for price of ecstasy crystal (gram and point) and ecstasy powder (gram) started in 2013. No participants reported price data for a 'point' of ecstasy crystal in 2013 or 2021. Data labels are only provided for the first (2013) and two most recent years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

Figure 8: Current perceived purity of ecstasy pills, Adelaide, SA, 2017-2023



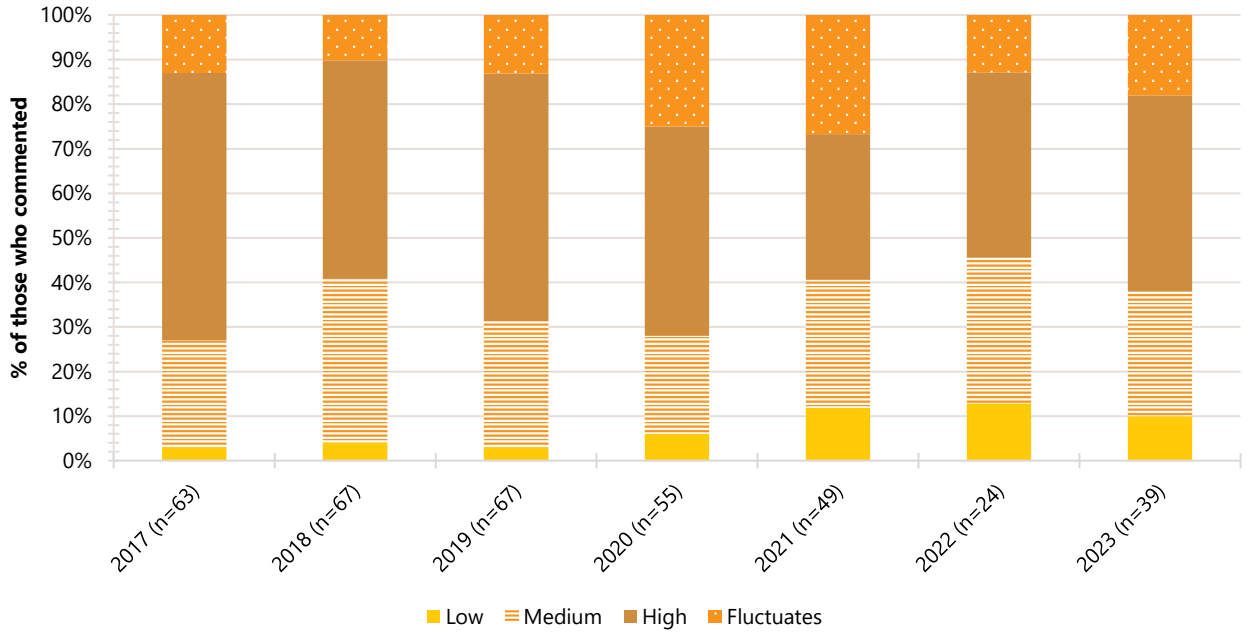
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and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

Figure 9: Current perceived purity of ecstasy capsules, Adelaide, SA, 2017-2023



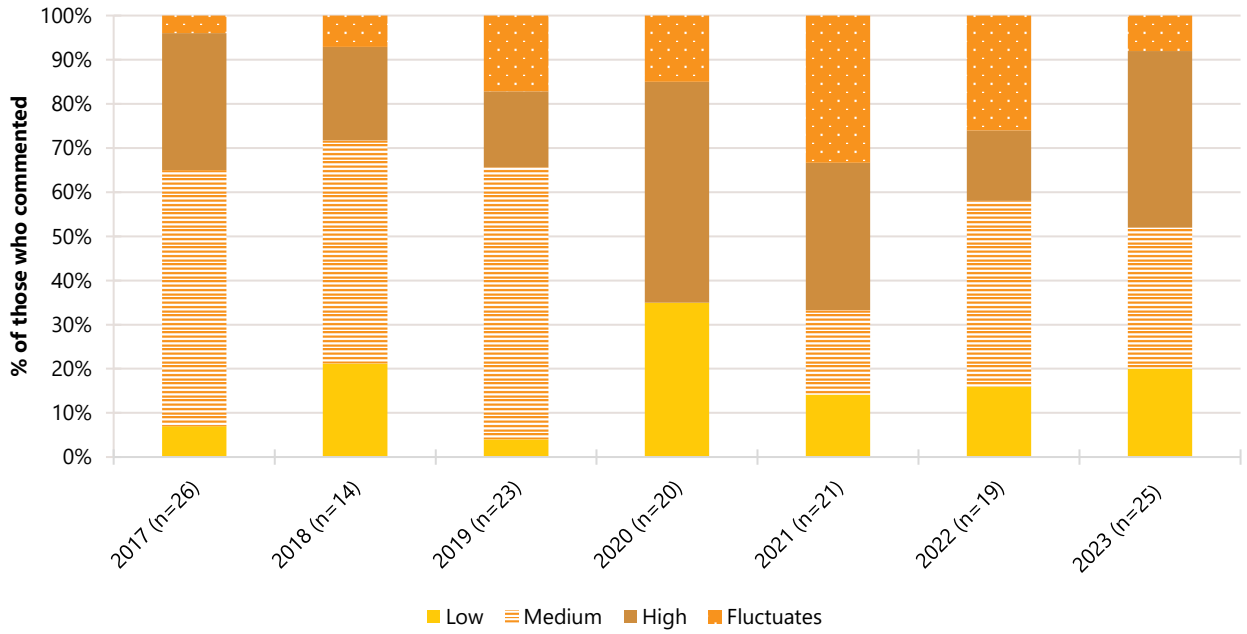
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and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

Figure 10: Current perceived purity of ecstasy crystal, Adelaide, SA, 2017-2023



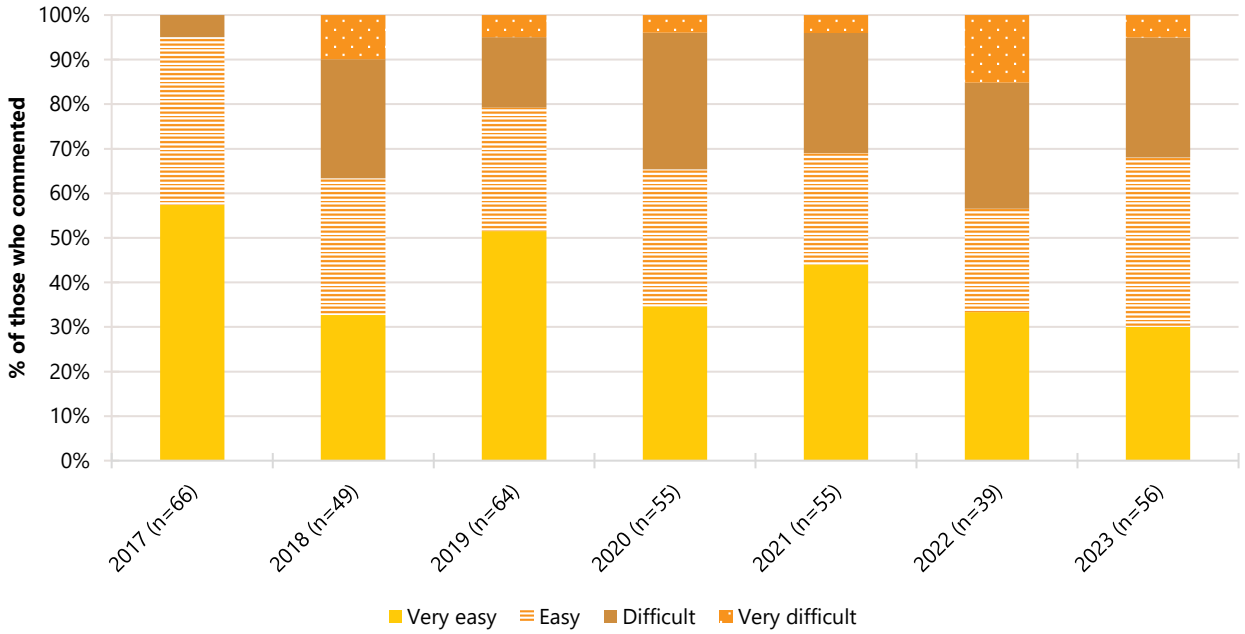
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and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

Figure 11: Current perceived purity of ecstasy powder, Adelaide, SA, 2017-2023



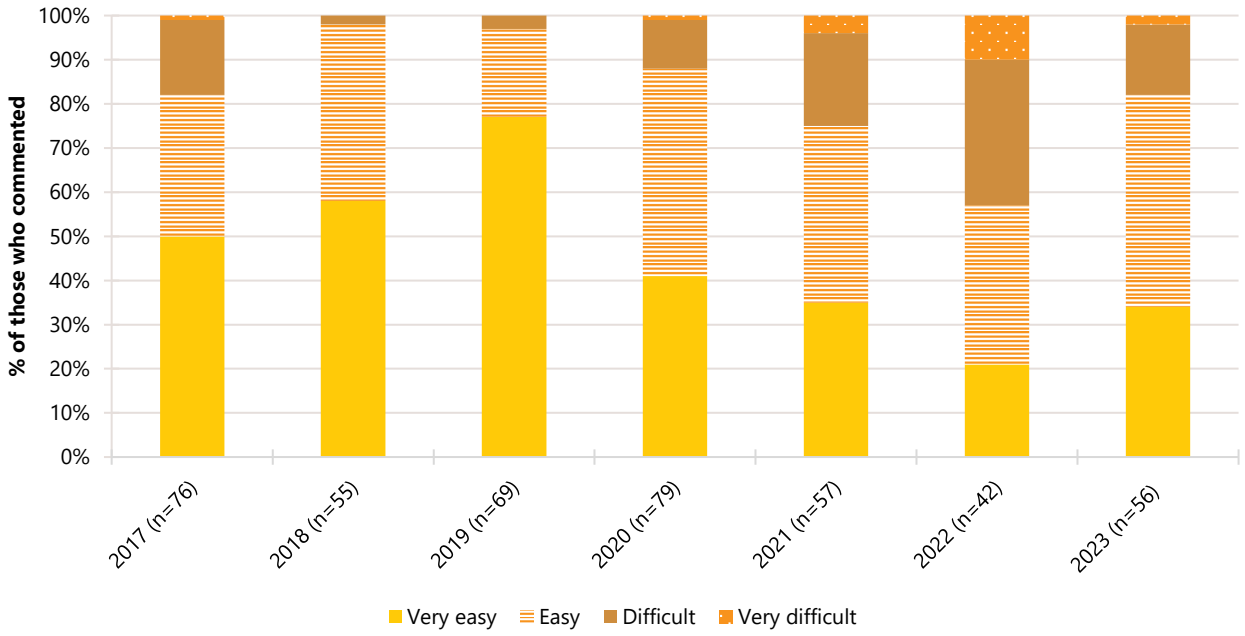
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and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

Figure 12: Current perceived availability of ecstasy pills, Adelaide, SA, 2017-2023



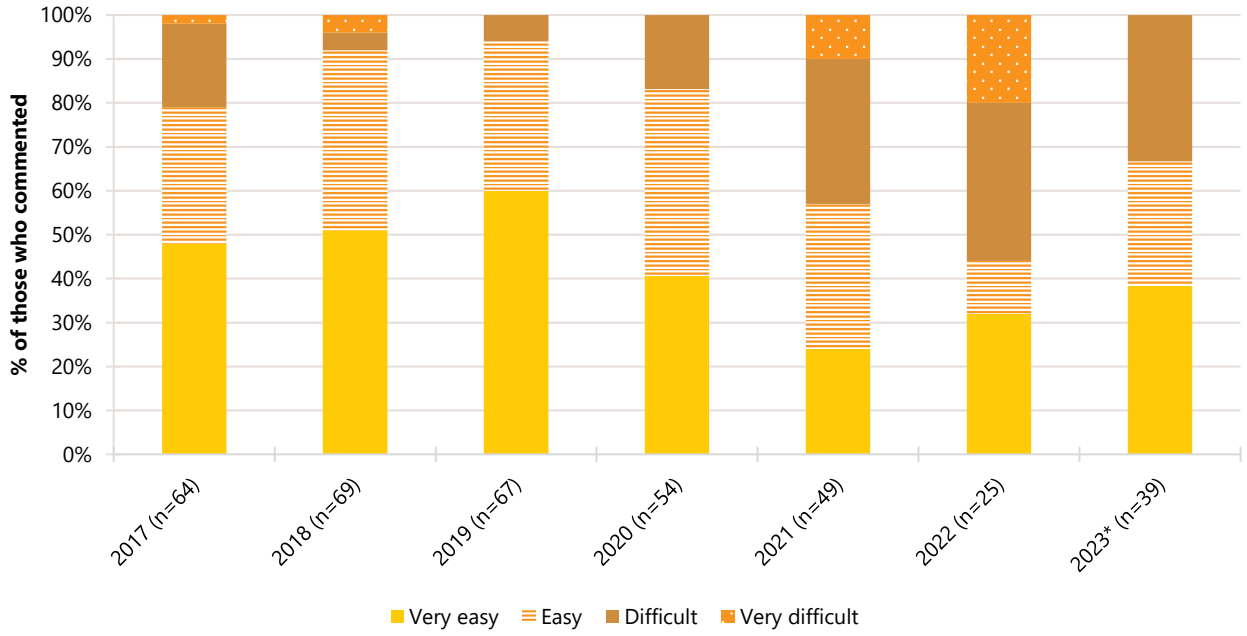
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and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

Figure 13: Current perceived availability of ecstasy capsules, Adelaide, SA, 2017-2023



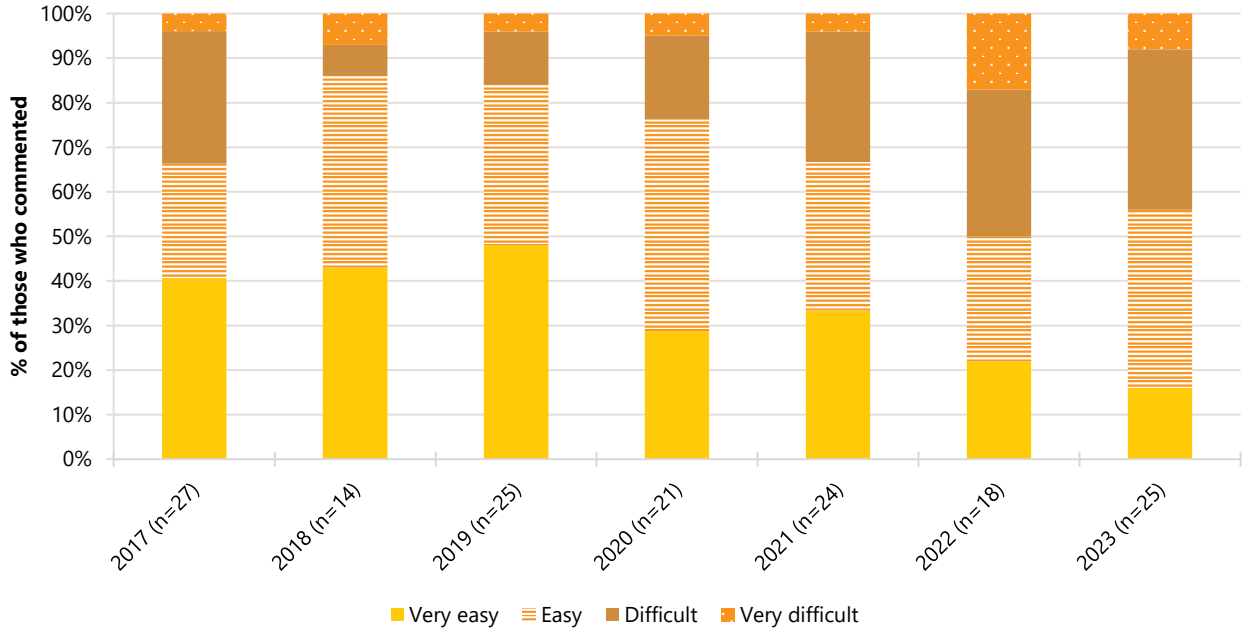
Note. The response option 'Don't know' was excluded from analysis. Market questions were only asked for all forms of ecstasy from 2017 onwards. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and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

Figure 14: Current perceived availability of ecstasy crystal, Adelaide, SA, 2017-2023



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

Figure 15: Current perceived availability of ecstasy powder, Adelaide, SA, 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 has largely declined since monitoring commenced (Figure 16), from more than nine in ten participants reporting recent use in 2003 (92%), down to 26% in 2020. Nevertheless, an upward trend has been observed from 2021, with 46% reporting recent use in 2023, stable relative to 2022 (36%; p=0.157)

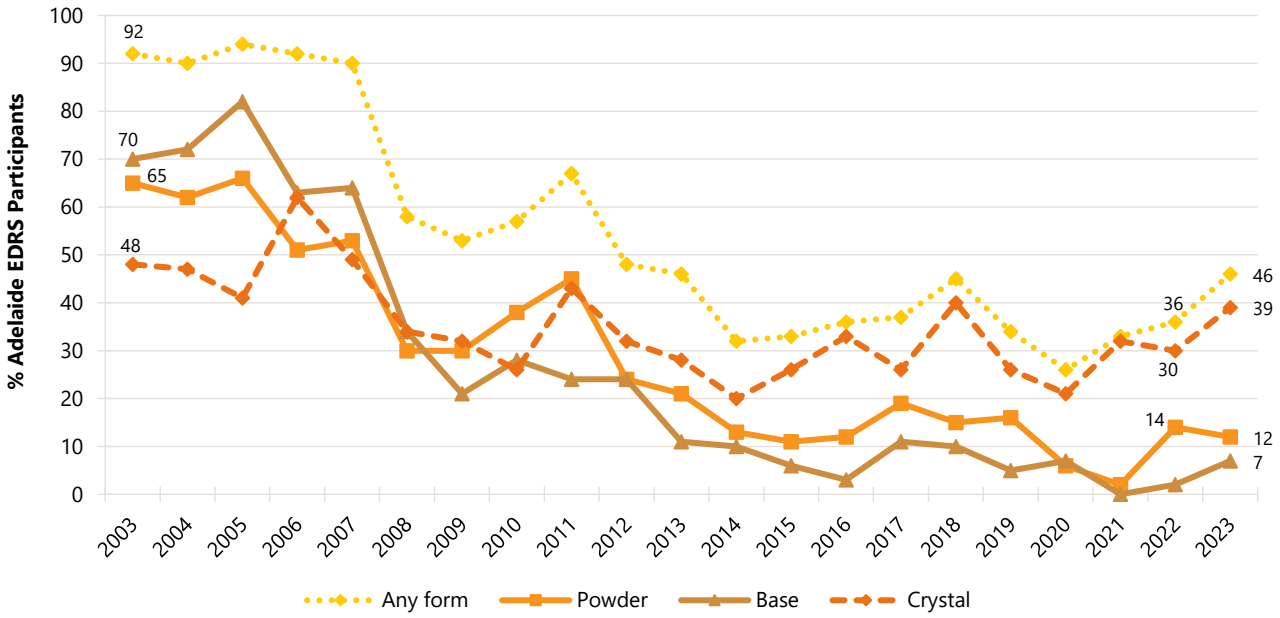
Frequency of Use

Median frequency of use reported by participants in the past six months was 24 days (IQR=4-95; n=46) in 2023, stable relative to 14 days in 2022 (IQR=2-48; n=37; p=0.363) (Figure 17). Fifty-four per cent of those who had recently used methamphetamine and commented reported using methamphetamine weekly or more frequently, stable relative to 2022 (43%; p=0.375).

Forms Used

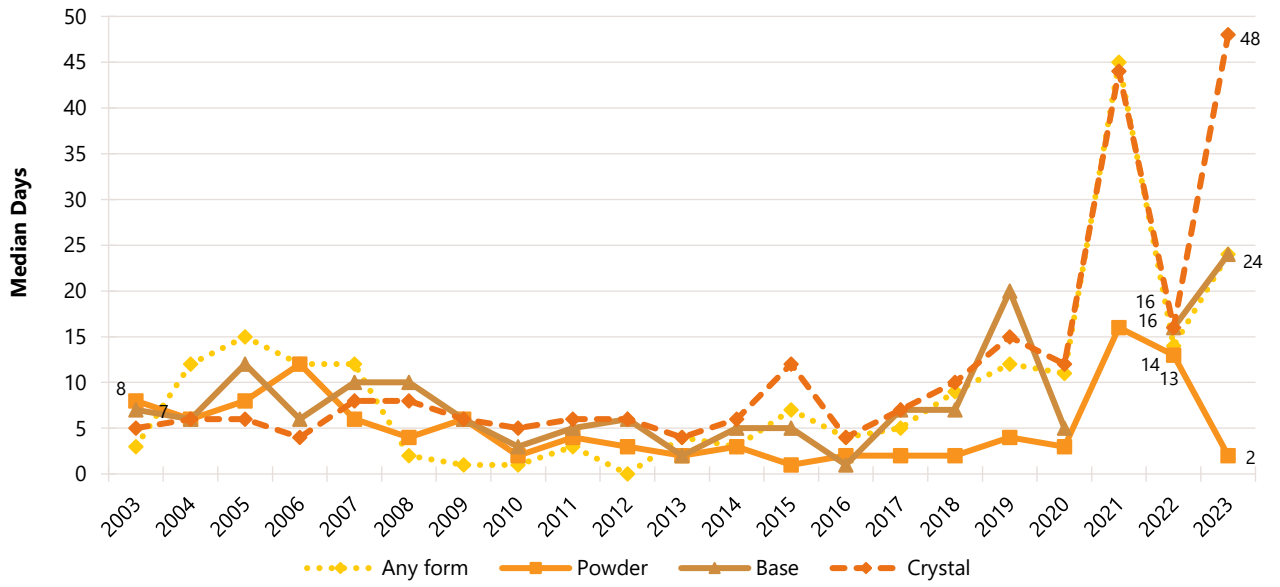
All forms of methamphetamine have decreased since the start of monitoring. Of participants who had used methamphetamine in the six months preceding interview in 2023 (n=46), most had used crystal methamphetamine (85%; 84% in 2022), followed by powder (26%; 41% in 2022; p=0.244) and base (15%; n≤5 in 2022; p=0.292).

Figure 16: Past six month use of any methamphetamine, powder, base, and crystal, Adelaide, SA, 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 17: Median days of any methamphetamine, powder, base, and crystal use in the past six months, Adelaide, SA, 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 50 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Patterns of Consumption (by form)

Methamphetamine Powder

Recent Use (past 6 months): Recent use of powder has declined over the course of monitoring, though remained stable in 2023 at 14% (12% in 2022; *p*=0.682) (Figure 16).

Frequency of Use: Amongst those who had recently consumed powder and commented (n=12), participants reported use on a median of two days (IQR=1-7) in 2023, stable relative to 2022 (13 days; IQR=2-24; n=14; *p*=0.100) (Figure 17). Few participants (n≤5) reported weekly or more frequent use of powder in 2023 (n≤5 in 2022; *p*=0.391).

Routes of Administration: Among participants who had recently consumed methamphetamine powder and commented (n=12), smoking was the most common route of administration, with 50% reporting this method in 2023 (53% in 2022). Few participants (n≤5) were able to comment on further routes of administration.

Quantity: Of those who reported recent use and responded (n=11), the median amount of powder used in a 'typical' session was 0.50 grams (IQR=0.20-1.00; 0.20 grams in 2022; IQR=0.10-0.30; n=11; *p*=0.204). Of those who reported recent use and responded (n=11), the median maximum amount of powder used in a session was 0.50 grams (IQR=0.20-1.00; 0.50 grams in 2022 (IQR=0.30-0.80; n=11; *p*=0.815).

Methamphetamine Crystal

Recent Use (past 6 months): Since 2012, crystal has consistently been the main form of methamphetamine used. Almost two fifths (39%) of participants reported recent use of crystal in 2023, stable relative to 2022 (30%; *p*=0.192) (Figure 16).

Frequency of Use: Of those who had recently consumed crystal and commented (n=39), participants reported use on a median of 48 days (IQR=6-93) in 2023, compared to 16 days in 2022 (IQR=4-54; n=31; *p*=0.119) (Figure 17). Three fifths (62%) of participants who had recently used crystal reported weekly or greater use in 2023, stable relative to 2022 (45%; *p*=0.233).

Routes of Administration: Among participants who had recently consumed methamphetamine crystal and commented (n=39), smoking remained the most common route of administration, with 92% reporting this method in 2023, stable from 87% in 2022 (*p*=0.692). Few participants (n≤5) reported swallowing crystal in 2023 (19% in 2022; *p*=0.520).

Quantity: Of those who reported recent use and responded (n=38), the median amount of crystal used in a 'typical' session was 0.30 grams (IQR=0.10-0.50; 0.20 grams in 2022; IQR=0.20-0.30; n=29; *p*=0.529). Of those who reported recent use and responded (n=37), the median maximum amount of crystal used in a session was 0.50 grams (IQR=0.30-1.00; 0.30 grams in 2022; IQR=0.20-0.50; n=28; *p*=0.080).

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Due to low numbers reporting (n≤5), further details are not reported on price (Figure 18), perceived purity (Figure 20) and perceived availability (Figure 22) for methamphetamine powder. Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

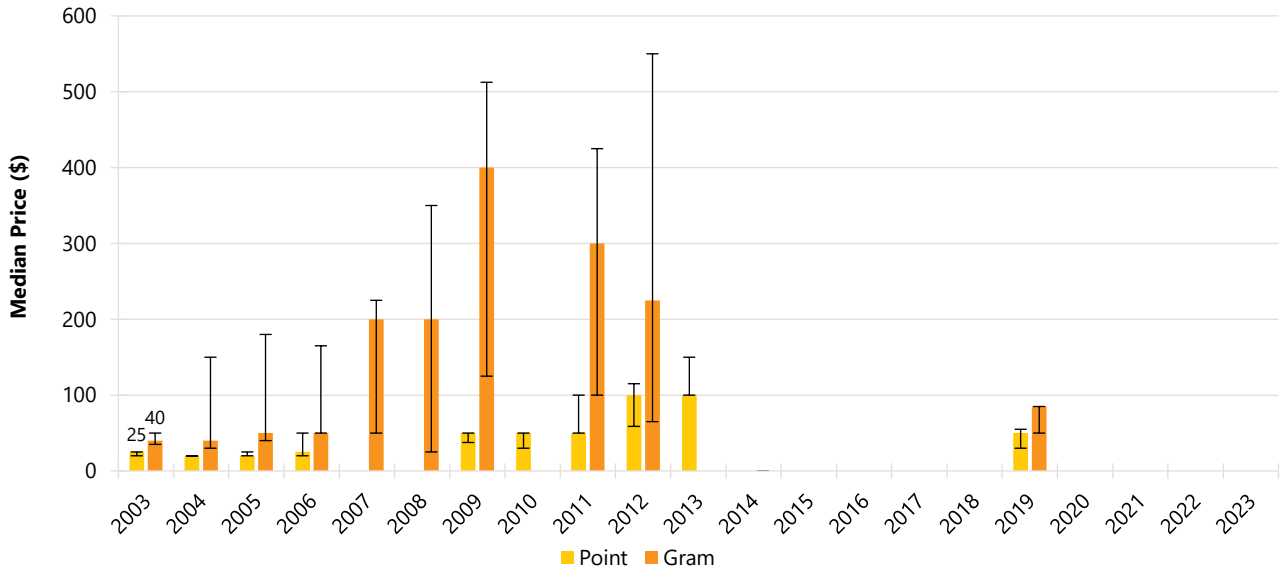
Methamphetamine Crystal

Price: Participants reported a median price of $50 per point (IQR=41-50; n=18; $50 in 2022; IQR=50-60; n=12; p=0.006), and $300 per gram (IQR=200-300; n=9; n≤5 in 2022; p=0.346) in 2023 (Figure 19).

Perceived Purity: The perceived purity of methamphetamine crystal changed significantly between 2022 and 2023 (p<0.001). Among those who were able to comment in 2023 (n=41), the greatest per cent reported purity to be 'medium' (56%), an increase from 10% in 2022. A further one quarter (24%) reported purity as 'high', a decrease from 31% in 2022 (Figure 21).

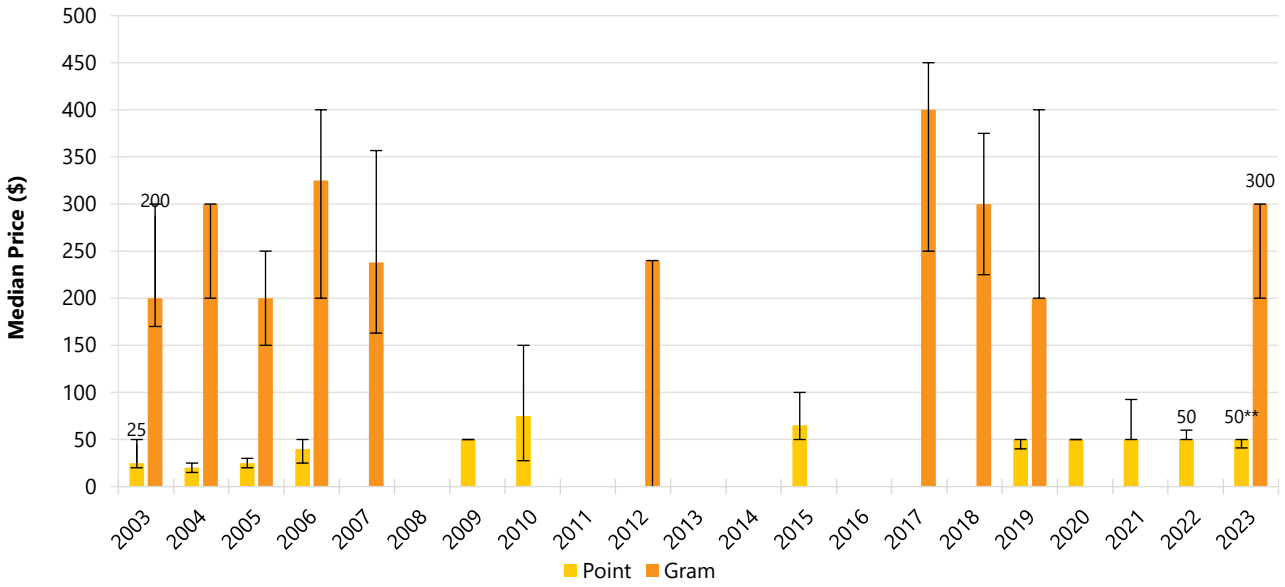
Perceived Availability: The perceived availability of methamphetamine crystal remained stable between 2022 and 2023 (p=0.898). Among those who were able to respond in 2023 (n=42), 62% reported availability as 'very easy' (67% in 2022), with a further 36% reporting it as 'easy' (30% in 2022) (Figure 23).

Figure 18: Median price of powder methamphetamine per point and gram, Adelaide, SA, 2003-2023



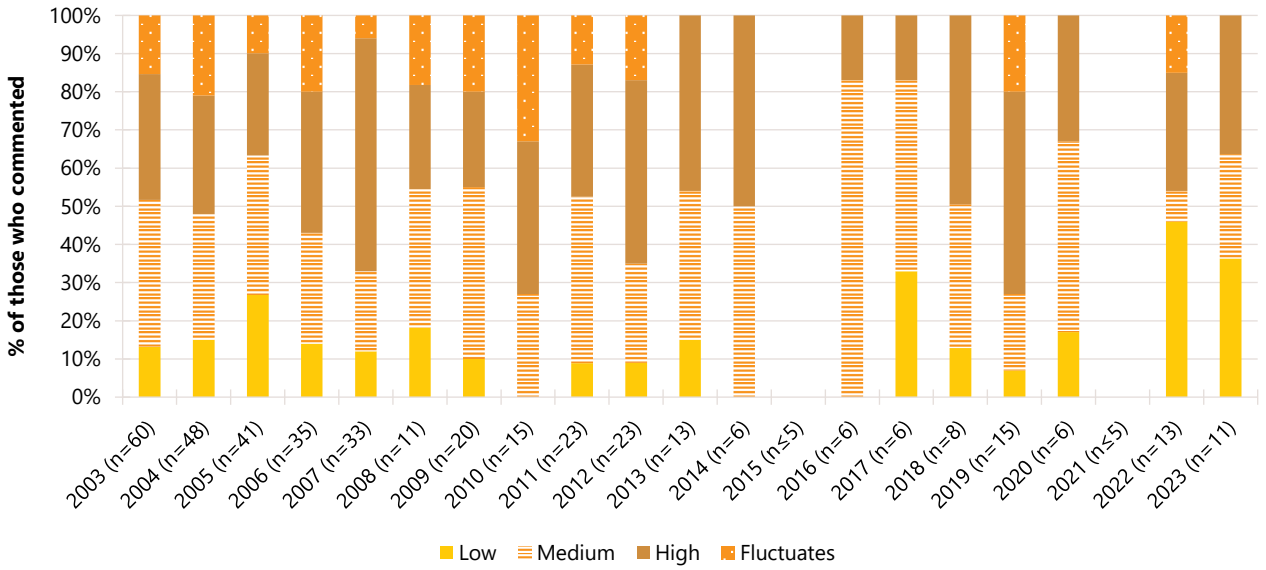
Note. Among those who commented. No participants reported purchasing a gram of powder methamphetamine in 2014, 2020 and 2021. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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. 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 19: Median price of crystal methamphetamine per point and gram, Adelaide, SA, 2003-2023



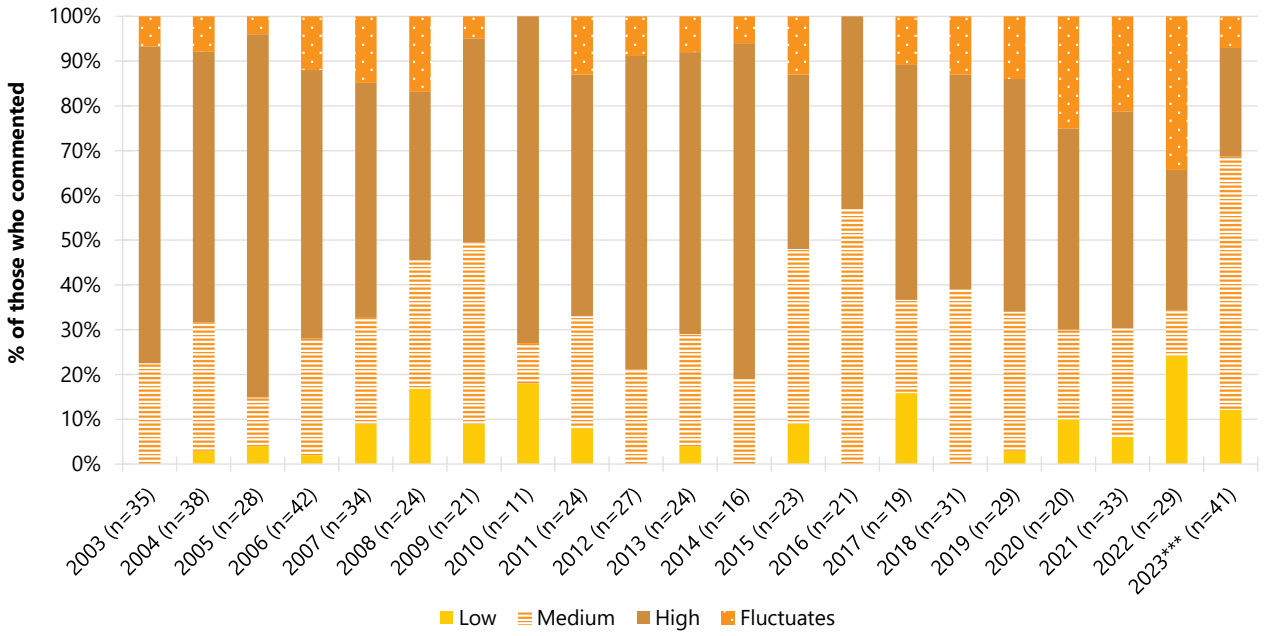
Note. Among those who commented. No participants reported purchasing a gram of crystal methamphetamine in 2011. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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. 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: Current perceived purity of powder methamphetamine, Adelaide, SA, 2003-2023



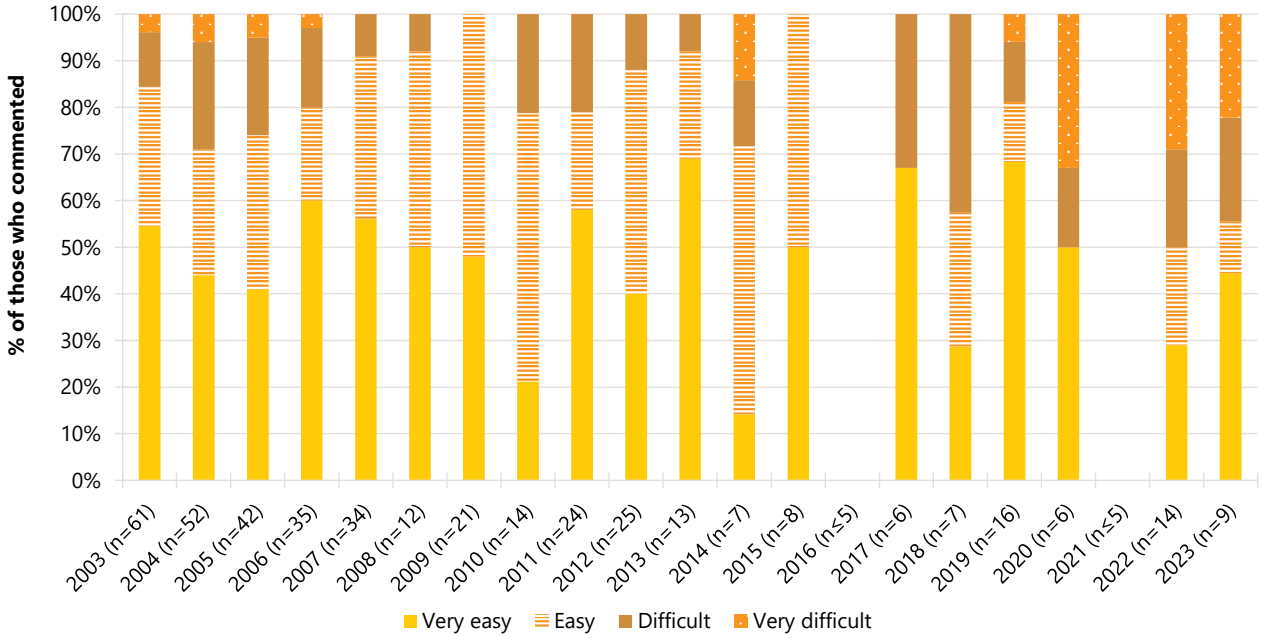
Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022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

Figure 21: Current perceived purity of crystal methamphetamine, Adelaide, SA, 2003-2023



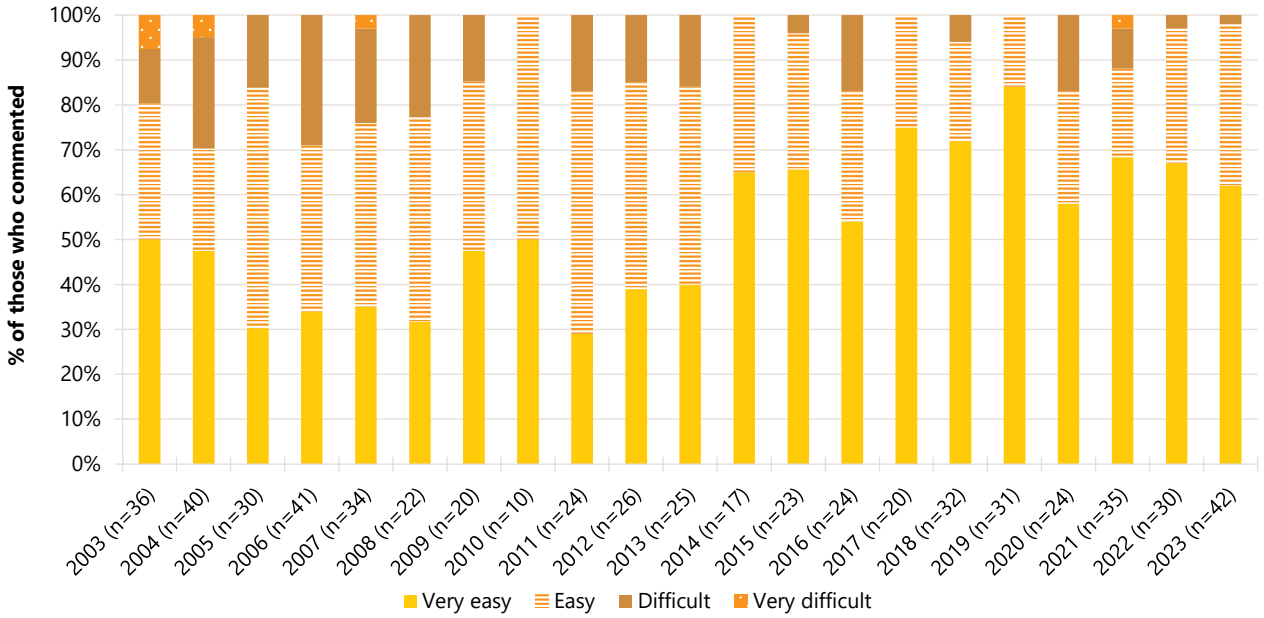
Note. The response option 'Don't know' was excluded from analysis. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Statistical significance for 2022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

Figure 22: Current perceived availability of powder methamphetamine, Adelaide, SA, 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 crystal methamphetamine, Adelaide, SA, 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)

The per cent of participants reporting any recent non-prescribed pharmaceutical stimulant (e.g., dexamphetamine, methylphenidate, modafinil) use has steadily increased since the commencement of monitoring, from 15% in 2007 to 42% in 2023 (41% in 2022), signifying the second highest percentage of use since monitoring commenced (Figure 24).

Frequency of Use

Frequency of use remained stable in 2023, at a median of four days in the six months prior to interview (IQR=1-10; n=42; 4 days in 2022; IQR=2-11; n=41; p=0.613) (Figure 24).

Routes of Administration

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=42), the vast majority reported swallowing as a route of administration (93%; 84% in 2022; p=0.313), with fewer participants reporting snorting (21%; 33% in 2022; p=0.333).

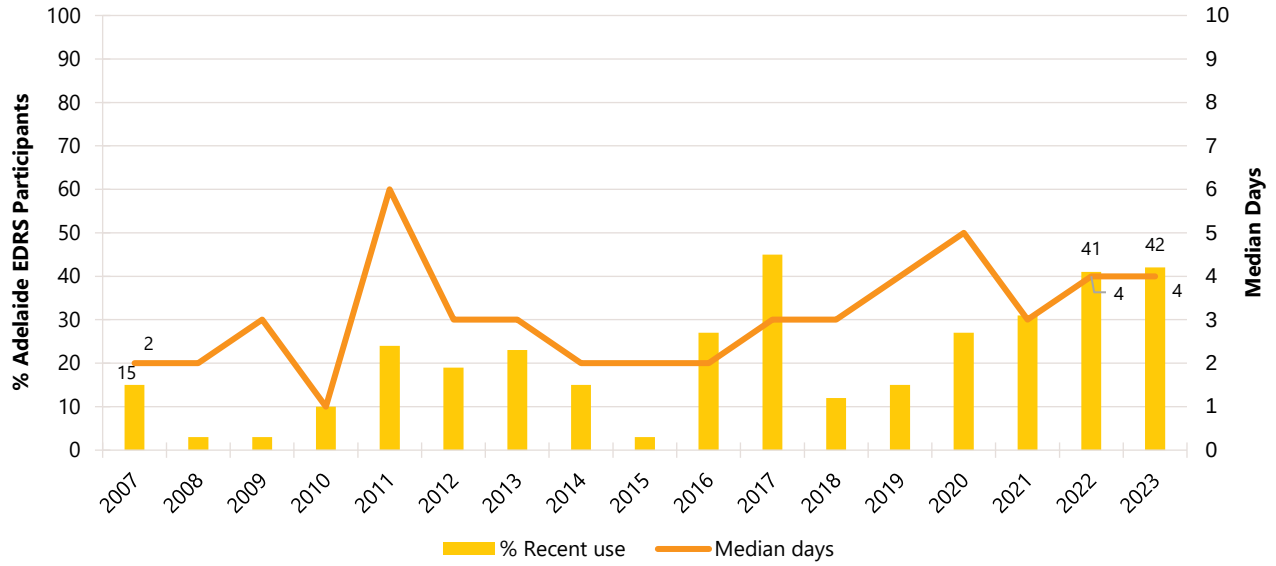
Quantity

Among those who reported recent use and responded (n=36), the median amount used in a 'typical' session was two pills/tablets (IQR=1-3; 2 pills/tablets in 2022; IQR=1-3; p=0.283). Of those who reported recent use and responded (n=36), the median maximum amount used in a session was two and a half pills/tablets (IQR=2–5; 2 pills/tablets in 2022; IQR=2-4; p=0.407).

Forms Used

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=42), the majority reported using dexamfetamine (81%; 72% in 2022; p=0.439), and almost one third (31%) reported using methylphenidate (37% in 2022; p=0.650).

Figure 24: Past six month use and frequency of use of non-prescribed pharmaceutical stimulants, Adelaide, SA, 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 10 days to improve visibility of trends. The response option 'Don't know' was excluded from analysis. Data labels are only provided for the first (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 and availability data for non-prescribed pharmaceutical stimulants were collected from 2022.

Price

Participants reported a median price of $10 per 10mg tablet in 2023 (IQR=6-10; n=6; n≤5 in 2022; p=0.885).

Perceived Availability

Among those who responded in 2023 (n=27), the perceived availability of non-prescribed pharmaceutical stimulants remained stable, relative to 2022 (p=0.218). In 2023, almost half (48%) perceived non-prescribed pharmaceutical stimulants to be 'very easy' (30% in 2022) to obtain, with a further 37% perceiving availability as '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)

Since 2015, the per cent reporting any recent cocaine use has gradually increased. In 2023, 77% of the Adelaide sample reported recent use, stable relative to 78% in 2022 (Figure 25).

Frequency of Use

Frequency of use has gradually increased from 2014 onwards. Of those who had recently consumed cocaine and commented (n=78), participants reported a median of six days (IQR=3-12) of use in 2023, stable from six days in 2022 (IQR=3-12; n=81; p=0.667) (Figure 25), equating to monthly use. Twelve per cent of those who had recently used cocaine reported weekly or more frequent use, stable relative to 2022 (14%; p=0.806).

Routes of Administration

Among participants who had recently consumed cocaine and commented (n=78), 95% of participants reported snorting cocaine, stable relative to 2022 (99%; p=0.204).

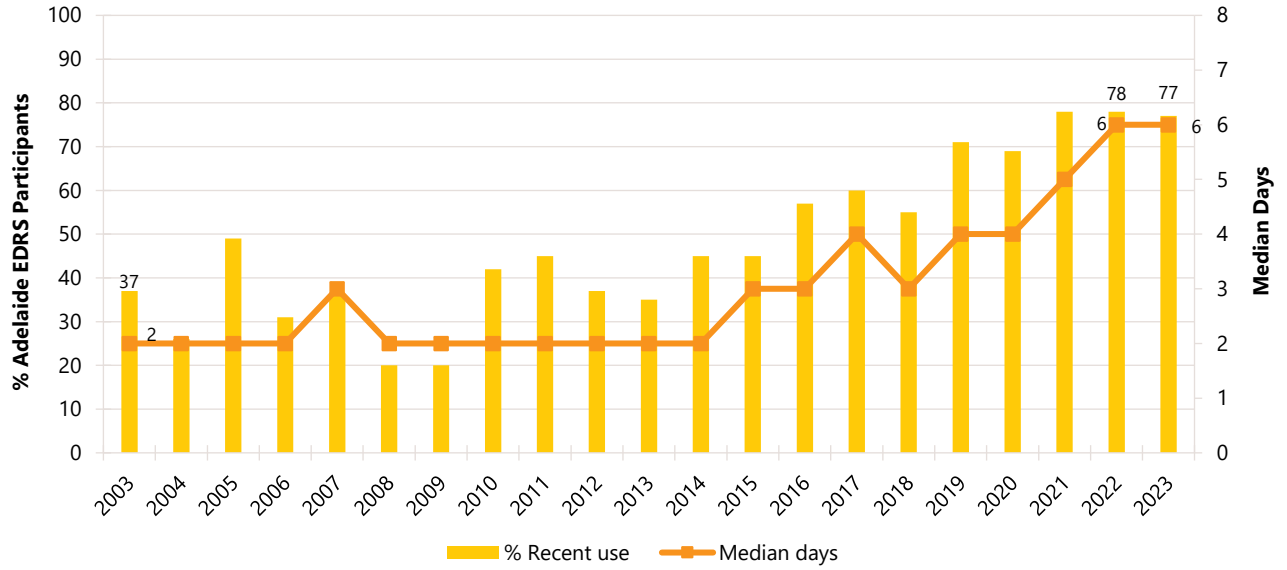
Quantity

Of those who reported recent use and responded (n=53), the median amount of cocaine used in a 'typical' session was 0.50 grams (IQR=0.50-1.00; 0.50 grams in 2022; IQR=0.50-1.00; n=55; p=0.766). Of those who reported recent use and responded (n=57), the median maximum amount of cocaine used in a session was one gram (IQR=0.50-2.00; 1.00 gram in 2022; IQR=0.50-2.00; n=57; p=0.641).

Forms Used

Among participants who had recently consumed cocaine and commented (n=78), the majority reported using powder cocaine (86%; 89% in 2022; p=0.634), with fewer participants reporting recent use of rock cocaine (19%; 15% in 2022; p=0.527). No participants reported using crack cocaine in 2022 or 2023.

Figure 25: Past six month use and frequency of use of cocaine, Adelaide, SA, 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 8 days to improve visibility of trends for days of use. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). The response option 'Don't know' was excluded from analysis. For historical numbers, please refer to the data tables. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Price, Perceived Purity and Perceived Availability

Price

The median price per gram of cocaine was $350 in 2023 (IQR=350-400; n=36; $350 in 2022; IQR=300-350; n=39; p=0.029) (Figure 26).

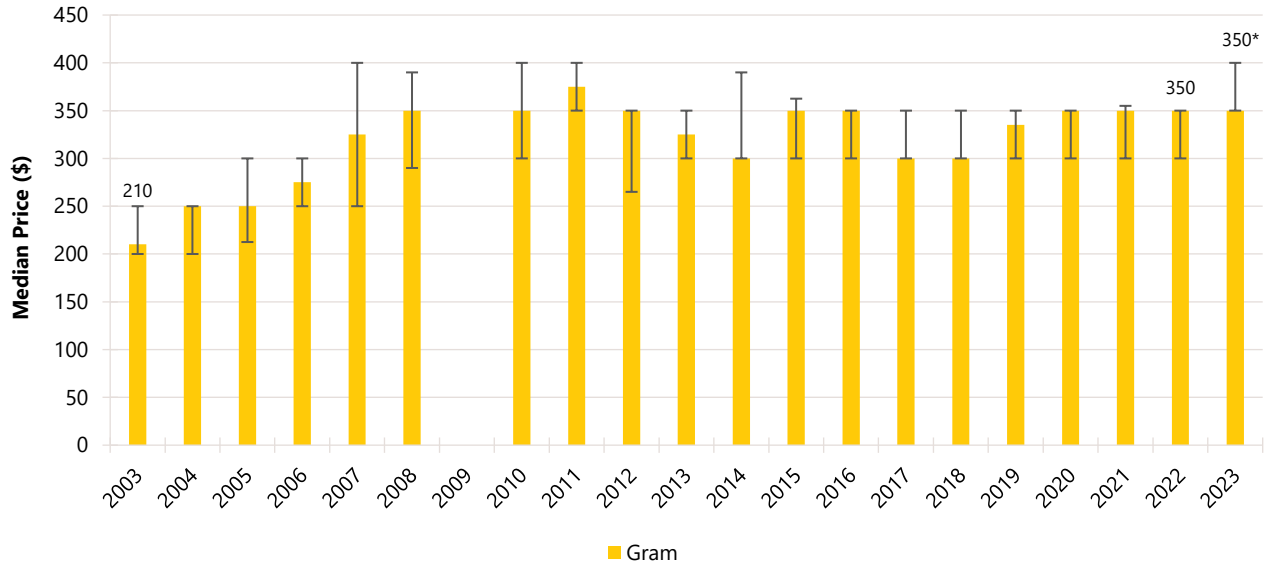
Perceived Purity

The perceived purity of cocaine remained stable between 2022 and 2023 (p=0.192). Among those who were able to respond in 2023 (n=72), equal percentages reported purity to be 'high' (31%; 22% in 2022) or 'medium' (31%; 28% in 2022). One fifth (22%) perceived purity to be 'low' (18% in 2022) and a further 17% perceived purity to be 'fluctuating' (32% in 2022) (Figure 27).

Perceived Availability

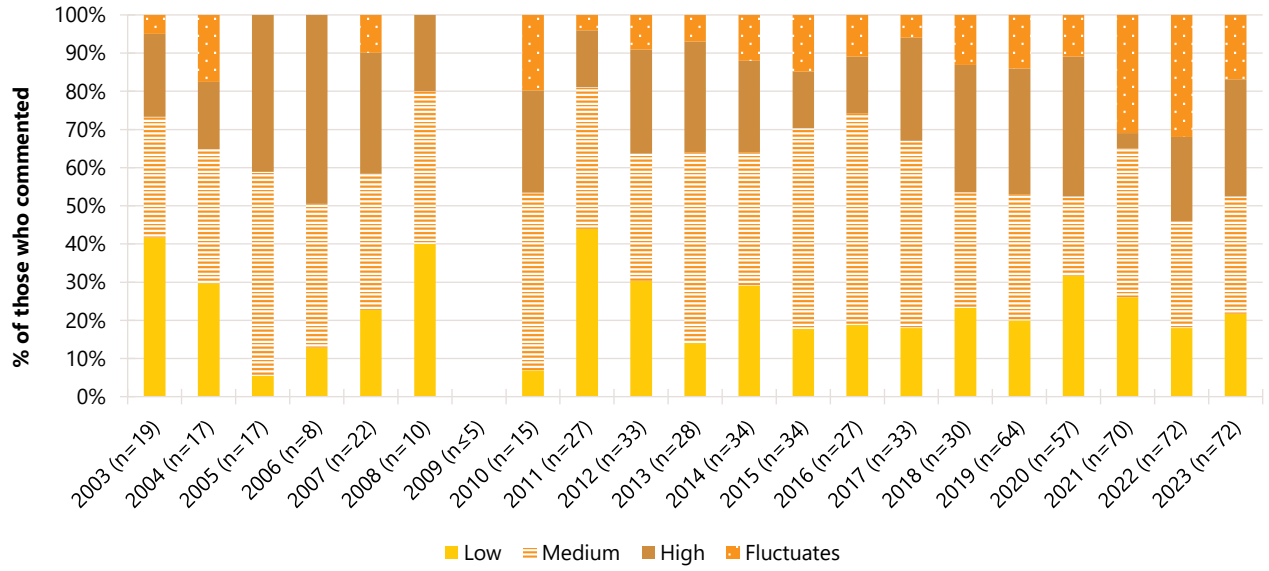
The perceived availability of cocaine remained stable between 2022 and 2023 (p=0.121). Among those who were able to respond in 2023 (n=74), 45% reported cocaine to be 'easy' to obtain (63% in 2022). A further 36% reported cocaine to be 'very easy' to obtain (22% in 2022). Almost one fifth (18%) perceived cocaine to be 'difficult' to obtain in 2023 (14% in 2022) (Figure 28).

Figure 26: Median price of cocaine per gram, Adelaide, SA, 2003-2023



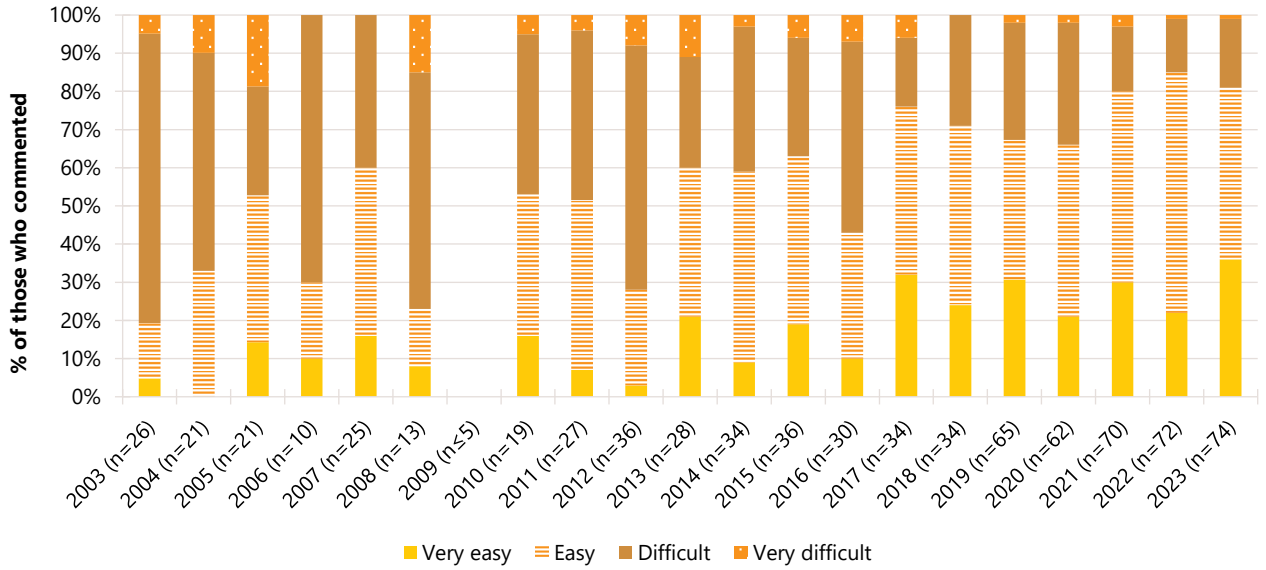
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Data are suppressed in the figure and data tables where n≤5 responded to the item. 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 27: Current perceived purity of cocaine, Adelaide, SA, 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 28: Current perceived availability of cocaine, Adelaide, SA, 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 from 2021-2023, and from 2003-2016, refers to non-prescribed cannabis use only, while data from 2017-2020 refers to 'any' cannabis use (including hydroponic and bush cannabis, hash and hash oil). While comparison between 2021-2023 and previous years should be treated with caution, the relatively recent legalisation of medicinal cannabis in Australia and the small percentage reporting prescribed use in 2022 and 2023 lends confidence that estimates are relatively comparable.

Recent Use (past 6 months)

Seventy per cent of the Adelaide sample reported recent use of non-prescribed cannabis and/or cannabinoid-related products in 2023. Whilst this remained stable relative to 2022 (75%; p=0.527), this represents the lowest percentage reporting recent use since the commencement of monitoring (Figure 29). Few (n≤5) participants in Adelaide reported prescribed use in the six months preceding interview (0% in 2022; p=0.118).

Frequency of Use

Median frequency of use has varied between at least once per week to up to four days per week over the course of monitoring. Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented (n=71), participants reported a median of 90 days

(IQR=8-180) of use in 2023, stable relative to 2022 (70 days; IQR=10-179; n=78; *p*=0.469) (Figure 29). Two thirds (66%) of those who had recently used non-prescribed cannabis and/or cannabinoid-related products reported weekly or more frequent use (67% in 2022), including almost two fifths (37%) who reported daily use (26% in 2022; *p*=0.160).

Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented (n=71), the vast majority (96%) reported smoking, stable relative to 2022 (90%; *p*=0.215). One third (35%) reported swallowing (37% in 2022; *p*=0.861) and one fifth (20%) reported inhaling/vaporising, a significant decrease from 41% in 2022 (*p*=0.010).

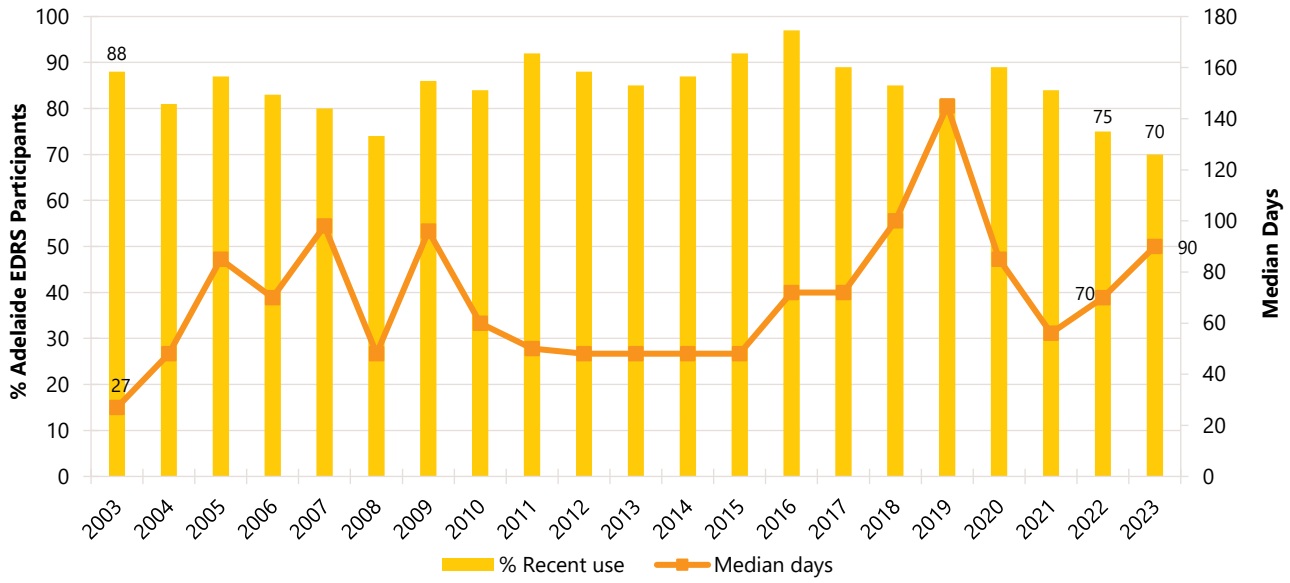
Quantity

Of those who reported recent non-prescribed use and responded, the median amount of non-prescribed cannabis and/or cannabinoid-related products used on the last occasion of use was two cones (IQR=1-4; n=28; 1 cone in 2022; IQR=1-2; n=28; *p*=0.104) or one gram (IQR=1.00-2.00; n=15; 2.50 grams in 2022; IQR=1.10-3.00; n=22; *p*=0.083) or one joint (IQR=1-1; n=21; 1 joint in 2022; IQR=1-2; n=16; *p*=0.430).

Forms Used

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and responded (n=62), the majority reported recent use of outdoor grown 'bush' cannabis (65%; 75% in 2022; *p*=0.253). This was closely followed by hydroponic cannabis, with 60% reporting recent use, a significant decrease from 78% in 2022 (*p*=0.038). Fewer participants reported having used hashish (16%; 19% in 2022; *p*=0.809) and hash oil (11%; 13% in 2022) in the preceding six months. Eighteen per cent of participants reported recent use of THC extract, which remained stable from 2022 (14%; *p*=0.626), and few (n≤5) participants reported recent use of (non-prescribed) CBD extract (6% in 2022).

Figure 29: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid-related products, Adelaide, SA, 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, no participants reported use of prescribed cannabis only). Further, from 2022 onwards, 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: The median price per ounce of non-prescribed hydroponic cannabis has fluctuated over the course of monitoring. In 2023, participants paid a median of $220 per ounce (IQR=220-240; n=18), stable relative to 2022 ($235; IQR=220-240; n=10; p=0.574) (Figure 30a). The median price per gram of non-prescribed hydroponic cannabis was $10 (IQR=10-10; n=7; $10 in 2022; IQR=10-10; n=7).

Perceived Potency: The perceived potency of non-prescribed hydroponic cannabis remained stable between 2022 and 2023 (p=0.469). Among those who were able to respond in 2023 (n=33), two thirds (67%) perceived non-prescribed hydroponic cannabis to be of 'high' potency (63% in 2022), and almost one fifth (18%) perceived potency to be 'medium (25% in 2022) (Figure 31a).

Perceived Availability: The perceived availability of non-prescribed hydroponic cannabis remained stable between 2022 and 2023 (p=0.320). Among those who were able to respond in 2023 (n=33), four fifths (82%) perceived non-prescribed hydroponic cannabis to be 'very easy' to obtain (67% in 2022) (Figure 32a).

Bush Cannabis

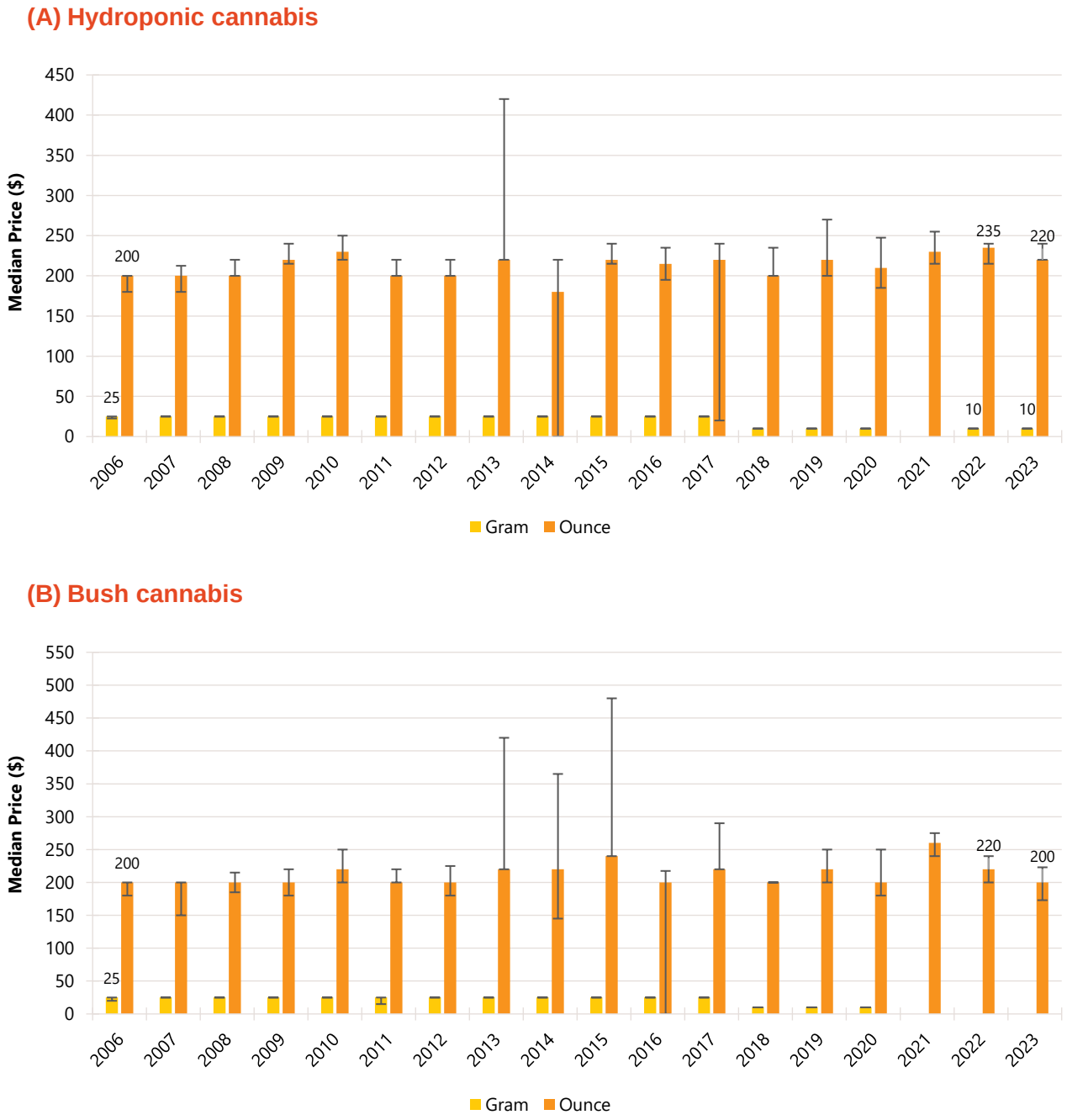
Price: The median price per ounce of non-prescribed bush cannabis remained stable, from $220 (IQR=210-240; n=9) in 2022 to $200 (IQR=173-223; n=12; p=0.315) in 2023 (Figure 30b). Few

participants (n≤5) reported on the price of a gram in 2022 and 2023; therefore, further details are not reported.

Perceived Potency: The perceived potency of non-prescribed bush cannabis remained stable between 2022 and 2023 (p=0.666). Among those who were able to respond in 2023 (n=32), half (50%) perceived the potency of non-prescribed bush cannabis to be 'high' (48% in 2022), with a further 38% perceiving potency to be 'medium' (29% in 2022) (Figure 31b).

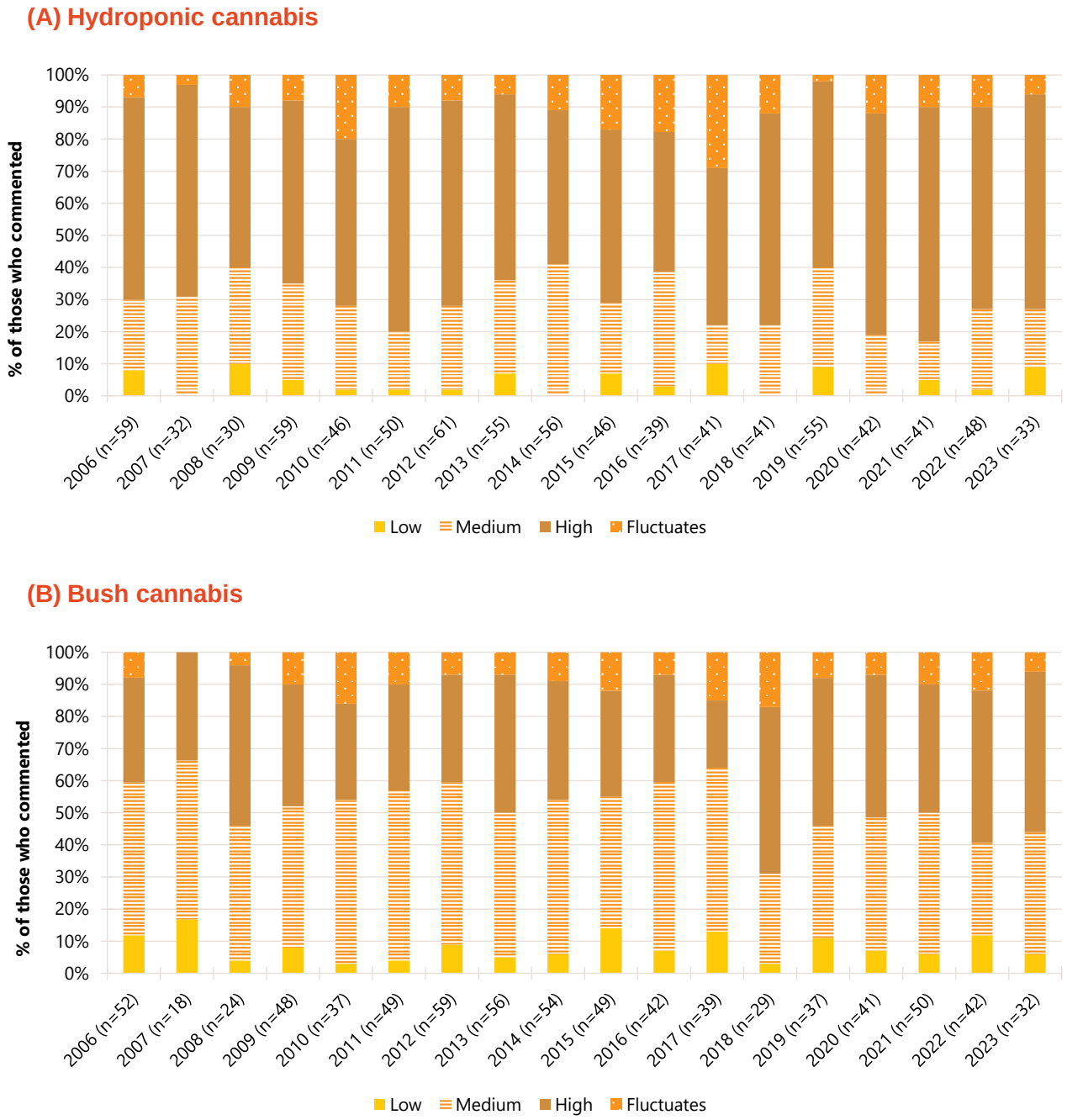
Perceived Availability: The perceived availability of non-prescribed bush cannabis remained relatively stable between 2022 and 2023 (p=0.055). Among those who were able to respond in 2023 (n=31), the largest per cent (84%) perceived non-prescribed bush cannabis to be 'very easy' to obtain (58% in 2022) (Figure 32b).

Figure 30: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Adelaide, SA, 2006-2023



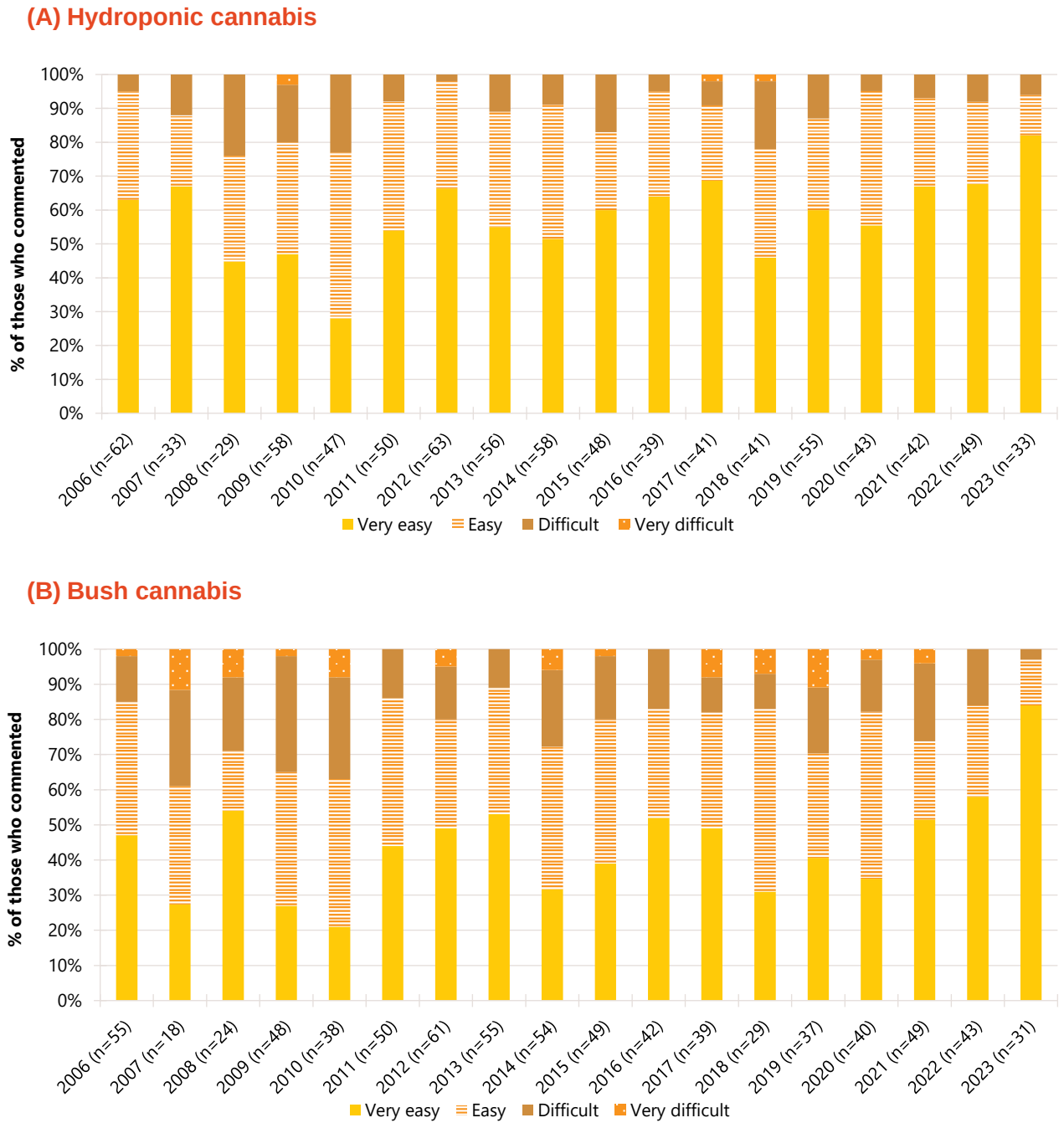
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants 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). Data are suppressed in the figure and data tables where n≤5 responded to the item. 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 31: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Adelaide, SA, 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 perceived 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 32: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Adelaide, SA, 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 perceived 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

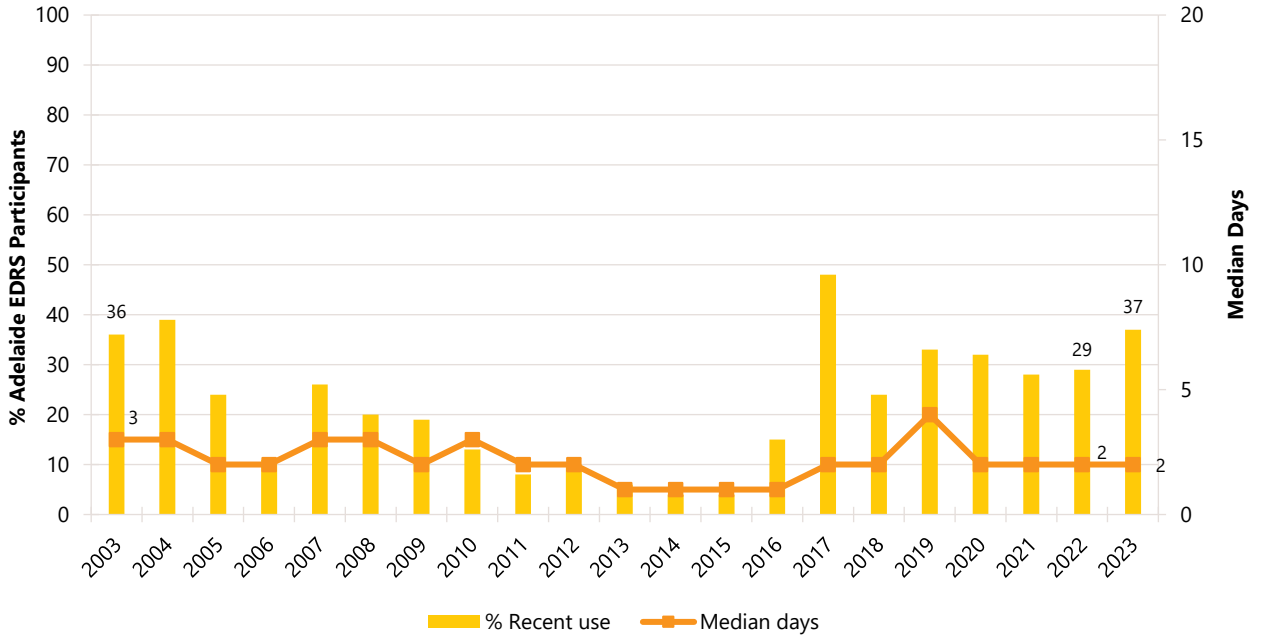
Recent Use (past 6 months): Almost two fifths (37%) of the Adelaide sample reported using non-prescribed ketamine in the six months prior to interview. This remained stable from 29% in 2022 (p=0.304) (Figure 33).

Frequency of Use: Of those who had recently consumed non-prescribed ketamine and commented (n=37), median days of use remained low and stable in 2023 (2 days; IQR=1-4), relative to 2022 (2 days; IQR=1-4; n=30; p=0.749) (Figure 33). Few participants (n≤5) reported weekly or more frequent use in 2023, therefore, these data are suppressed (0% in 2022).

Routes of Administration: Among participants who had recently consumed non-prescribed ketamine and commented (n=37), all (100%) participants reported snorting in 2023, stable from 2022 (100%).

Quantity: Of those who reported recent use and responded (n=22), the median amount of non-prescribed ketamine used in a 'typical' session was 0.40 grams (IQR=0.20-0.50; 0.20 grams in 2022; IQR=0.10-0.50; n=14; p=0.554). Of those who reported recent use and responded (n=21), the median maximum amount of non-prescribed ketamine used in a session was 0.50 grams (IQR=0.20-1.00; 0.30 grams in 2022; IQR=0.30-1.00; n=13; p=0.830).

Figure 33: Past six month use and frequency of use of non-prescribed ketamine, Adelaide, SA, 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 from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only became available via prescription, for treatment resistant depression, in 2021). Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

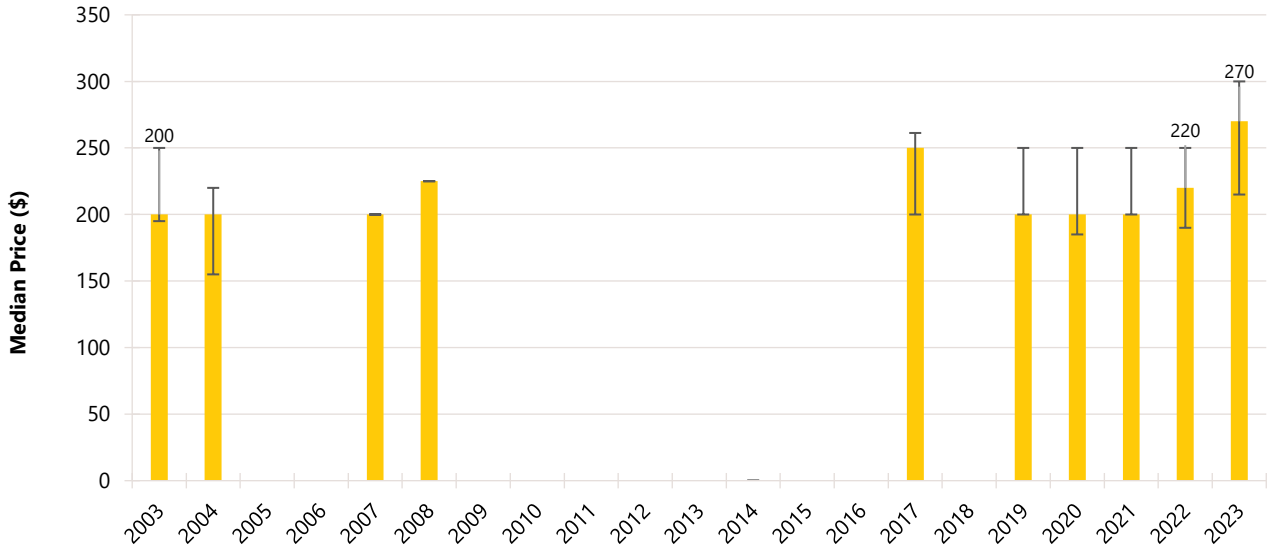
Price, Perceived Purity and Perceived Availability

Price: The median reported price of non-prescribed ketamine has fluctuated somewhat since the commencement of monitoring. The median price per gram of ketamine in 2023 was $270 (IQR=215-300; n=16; $220 in 2022; IQR=190-250; n=11; p=0.069), which represented the highest median price reported since 2007 (Figure 34).

Perceived Purity: The perceived purity of non-prescribed ketamine remained relatively stable between 2022 and 2023 (p=0.084). Among those who were able to respond in 2023 (n=31), the highest percentage (84%) perceived the purity of ketamine to be 'high' (63% in 2022) (Figure 35).

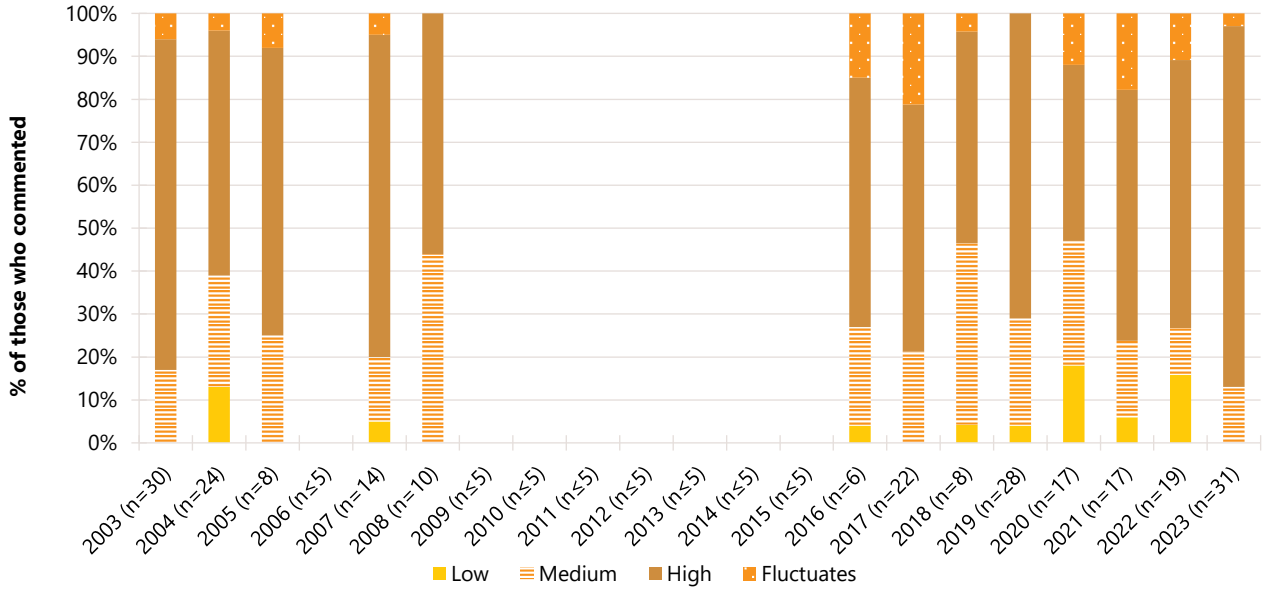
Perceived Availability: The perceived availability of non-prescribed ketamine remained stable between 2022 and 2023 (p=0.423). Of those who were able to respond in 2023 (n=30), two fifths (40%) reported ketamine to be 'difficult' to obtain (47% in 2022), with a further 20% perceiving it to be 'very difficult' to obtain (n≤5 in 2021). In contrast, almost one quarter (23%) perceived ketamine to be 'easy' to obtain (37% in 2022) (Figure 36).

Figure 34: Median price of non-prescribed ketamine per gram, Adelaide, SA, 2003-2023



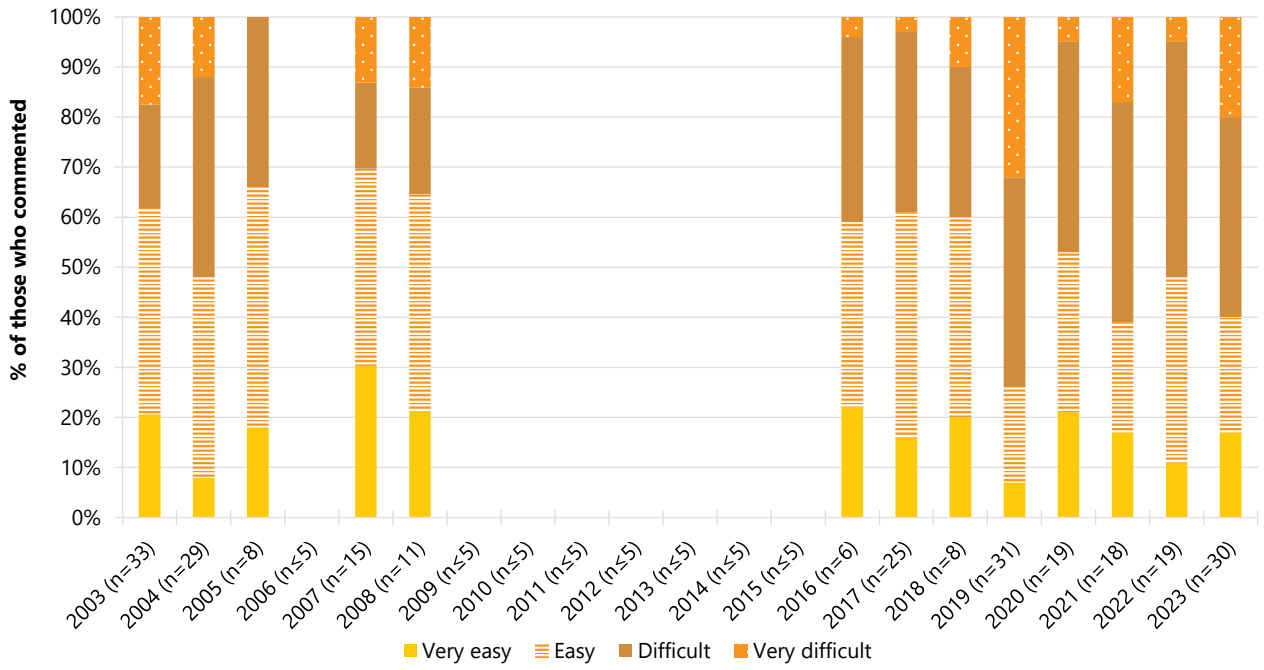
Note. Among those who commented. No participants reported purchasing ketamine in 2014 and 2015. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only became available via prescription, for treatment resistant 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). Data are suppressed in the figure and data tables where n≤5 responded to the item. 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 35: Current perceived purity of non-precribed ketamine, Adelaide, SA, 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 became available via prescription, for treatment resistant depression, in 2021). Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Figure 36: Current perceived availability of non-prescribed ketamine, Adelaide, SA, 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 became 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

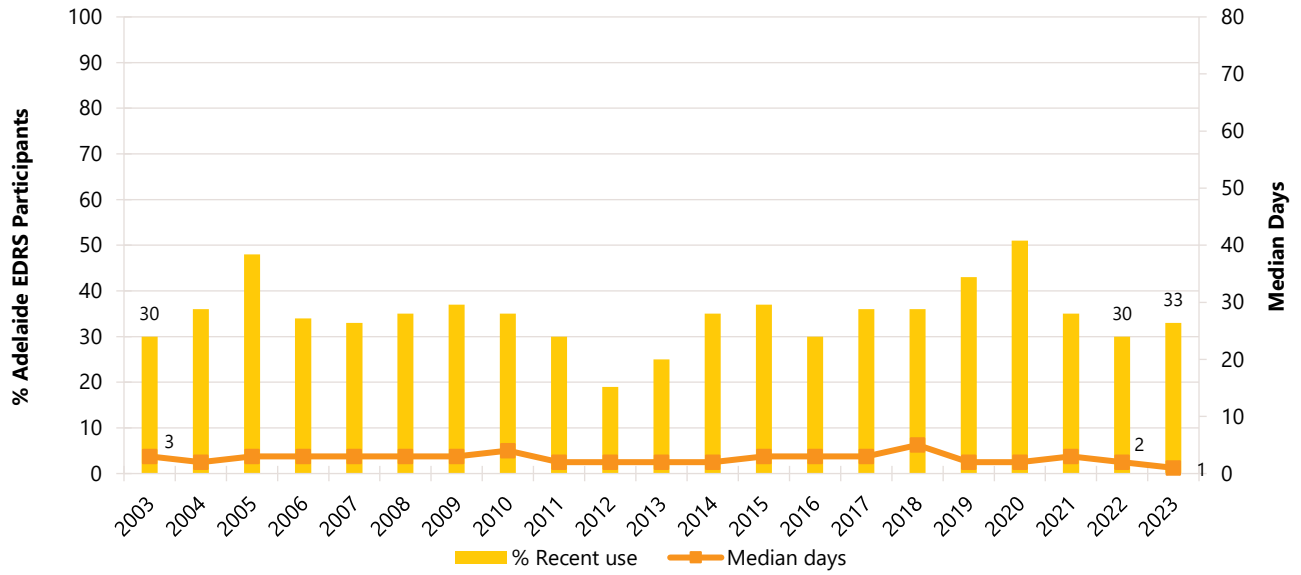
Recent Use (past 6 months): One third (33%) of the Adelaide sample had used LSD in the six months preceding interview, stable relative to 2022 (30%; p=0.762) (Figure 37).

Frequency of Use: Median days of LSD use over the years has remained low. Of those who had recently consumed LSD in 2023 and commented (n=33), frequency of use remained stable at one day (IQR=1-2; 2 days in 2022; IQR=1-4; n=31; p=0.226) (Figure 37). No participants who had recently consumed LSD reported weekly or more frequent use in 2023 (0% in 2022).

Routes of Administration: Among participants who had recently consumed LSD and commented (n=33), all participants (100%) reported swallowing LSD in 2023, stable from 2022 (97%; p=0.484).

Quantity: Of those who reported recent use and responded (n=17), the median amount of LSD used in a 'typical' session was one tab (IQR=1-2; 1 tab in 2022; IQR=1-1; n=15; p=0.140). Of those who reported recent use and responded (n=17), the median maximum amount of LSD used in a session was one tab (IQR=1-2; 1 tab in 2022; IQR=1-2; n=15; p=0.558).

Figure 37: Past six month use and frequency of use of LSD, Adelaide, SA, 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 80 days to improve visibility of trends. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

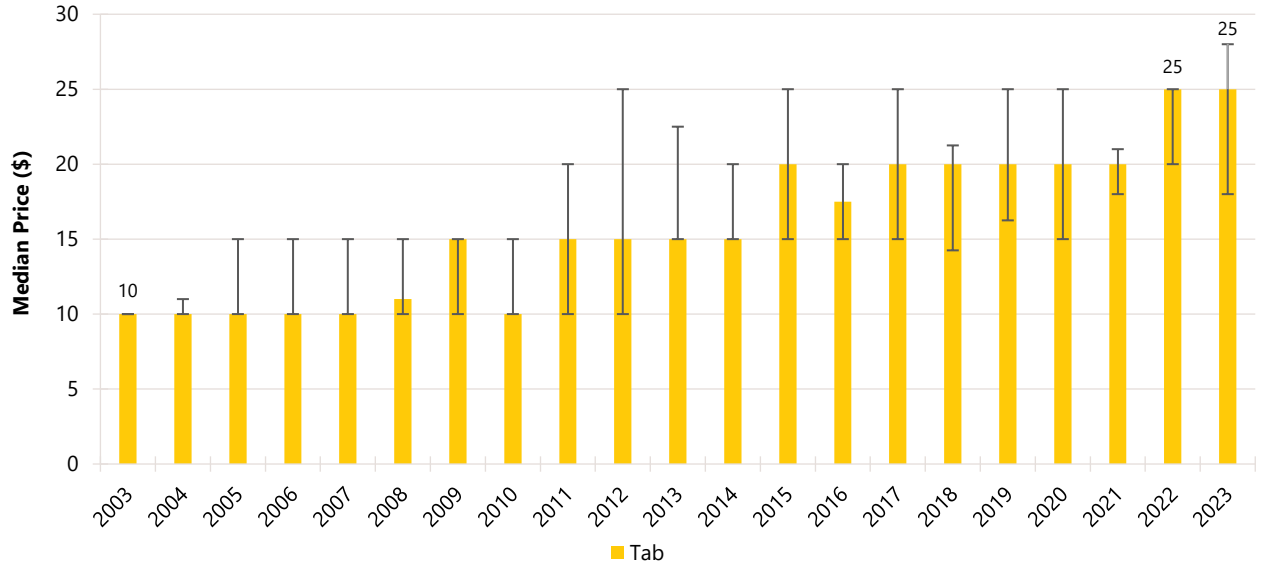
Price, Perceived Purity and Perceived Availability

Price: The median price for one tab of LSD has doubled since the start of monitoring. In 2023, the median price remained stable at $25 (IQR=18-28; n=15; $25 in 2022; IQR=20-25; n=14; p=0.720). For the second year running, this is the highest median price observed across the monitoring period (Figure 38).

Perceived Purity: The perceived purity of LSD remained stable between 2022 and 2023 (p=0.899). Among those who were able to respond in 2023 (n=31), three fifths (61%) perceived the purity of LSD to be 'high' (59% in 2022), followed by almost one third (32%) who reported the purity to be 'medium' (30% in 2022) (Figure 39).

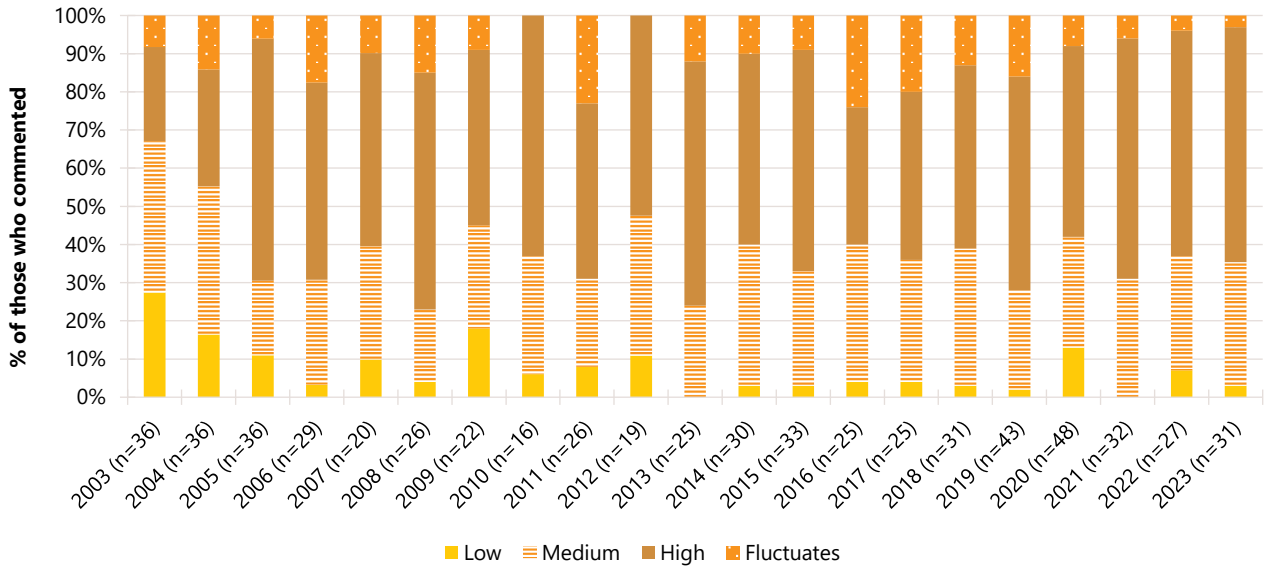
Perceived Availability: The perceived availability of LSD remained stable between 2022 and 2023 (p=0.439). Of those able to comment in 2023 (n=30), two fifths (40%) reported LSD as being 'difficult' to obtain (29% in 2022). In contrast, one third (33%) reported LSD as being 'very easy' to obtain (32% in 2022) (Figure 40).

Figure 38: Median price of LSD per tab, Adelaide, SA, 2003-2023



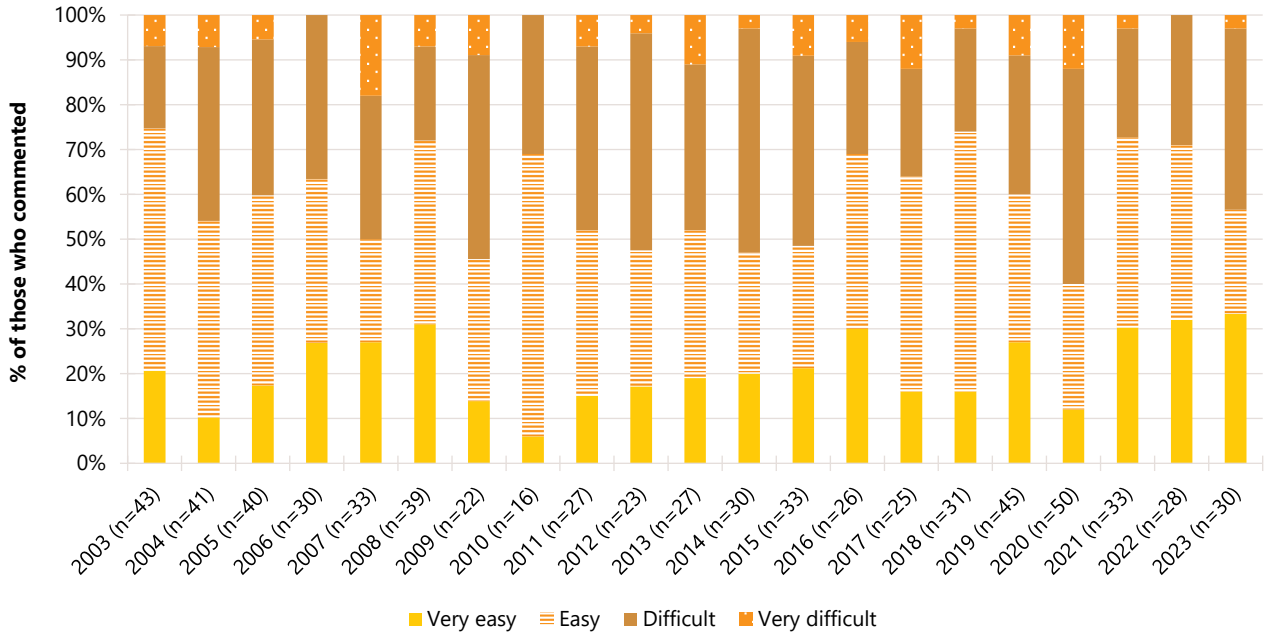
Note. Among those who commented. Data labels are only provided for the first (2003) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The error bars represent 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 39: Current perceived purity of LSD, Adelaide, SA, 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 40: Current perceived availability of LSD, Adelaide, SA, 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

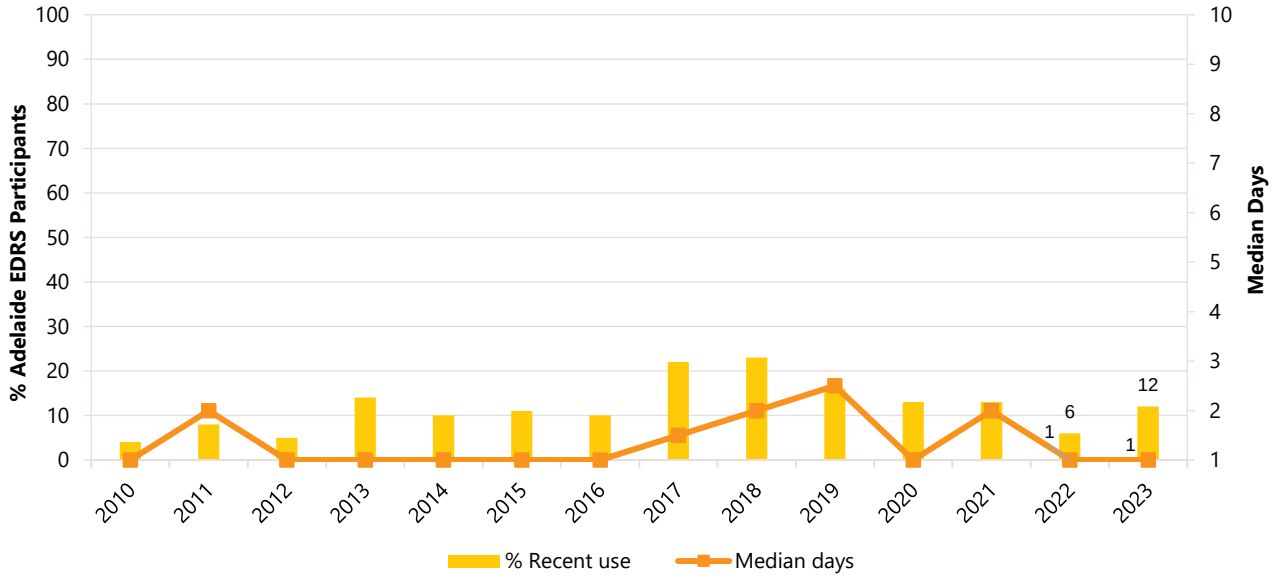
Recent Use (past 6 months): DMT use has fluctuated over the reporting period, with 12% reporting recent use in 2023, stable relative to 6% in 2022 (p=0.144) (Figure 41).

Frequency of Use: Median days of DMT use across the years has been infrequent and stable, with a median of one day of use (IQR=1-2; n=12) reported in 2023 (1 day in 2022; IQR=1-2; n=6; p=0.955) (Figure 41).

Routes of Administration: Among participants who had recently consumed DMT and commented (n=12), route of administration remained stable, with 92% reporting smoking (100% in 2022).

Quantity: Few participants (n≤5) reported on the 'typical' and maximum quantity of DMT used in a 'typical' session in 2023, therefore, further details are not reported (n≤5 in 2022).

Figure 41: Past six month use and frequency of use of DMT, Adelaide, SA, 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 10 days to improve visibility of trends. Data labels are only provided for the first (2010) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

8

New Psychoactive Substances

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

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

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

Recent Use (past 6 months)

Any NPS use, including plant-based NPS, has fluctuated over time, peaking at 49% in 2011 and 2015 and declining to 10% in 2023 (12% in 2022; p=0.817) (Table 2).

Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 47% in 2011 and declining to 9% in 2023 (7% in 2022; p=0.608) (Table 2).

Forms Used

Participants are asked about a range of NPS, updated each year to reflect key emerging substances of interest. NPS use among the Adelaide sample has fluctuated over time, although 2023 observed the lowest percentages of use since monitoring of NPS first commenced in 2010, with few participants (n≤5) reporting use of any individual NPS (Table 3), with the exception of any 2C substance (7%; n≤5 in 2022; p=0.065). Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

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

	Adelaide, SA	
%	Excluding plant-based NPS	Including plant-based NPS
2010	22	23
2011	47	49
2012	37	43
2013	36	38
2014	35	38
2015	44	49
2016	25	28
2017	25	31
2018	26	29
2019	24	27
2020	12	17
2021	8	10
2022	7	12
2023	**9**	**10**

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, Adelaide, SA, 2010-2023

	2010 (N=92)	2011 (N=76)	2012 (N=92)	2013 (N=100)	2014 (N=100)	2015 (N=100)	2016 (N=100)	2017 (N=100)	2018 (N=100)	2019 (N=100)	2020 (N=100)	2021 (N=100)	2022 (N=104)	2023 (N=101)
% Phenethylamines ^	13	42	11	20	26	36	14	15	12	14	7	-	-	**7**
Any 2C substance~	11	18	10	19	15	29	9	9	12	14	7	-	-	**7**
NBOMe	/	/	/	/	16	18	9	8	-	-	0	0	-	**0**
DO-x	-	7	0	-	0	0	0	-	0	-	0	0	0	**0**
4-FA	/	/	/	/	/	/	0	0	0	0	0	0	0	**-**
NBOH	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
% Tryptamines^^	-	-	-	-	0	0	0	-	-	-	-	-	0	**-**
5-MeO-DMT	-	-	-	-	0	0	0	0	-	-	-	-	0	**-**
4-AcO-DMT	/	/	/	/	/	/	0	-	/	/	/	/	/	**/**
% Synthetic cathinones	9	10	10	-	-	-	-	-	7	8	-	-		**-**
Mephedrone	9	8	-	-	-	0	0	0	-	-	-	-	0	**0**
Methylone/bk MDMA	/	-	-	-	-	-	-	-	7	-	0	-	0	**0**
MDPV/Ivory wave	-	-	-	-	0	-	0	0	0	0	0	0	0	**0**
Alpha PVP	/	/	/	/	/	/	0	0	-	0	0	0	0	**0**
Other substituted cathinone	/	/	0	0	0	0	0	0	0	/	/	/	/	**/**
N-ethylhexedrone	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
N-ethylpentylone	/	/	/	/	/	/	/	/	/	/	0	0	0	**0**
N-ethylbutylone	/	/	/	/	/	/	/	/	/	/	/	0	0	**0**
3-chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
4-chloromethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	/	**0**
3-methylmethcathinone	/	/	/	/	/	/	/	/	/	/	/	/	0	**-**
Alpha PHP	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Dimethylpentylone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
N, N-Dimethyl Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Pentylone	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
% Piperazines	0	-	-	0	0	0	0	0	/	/	/	/	/	**/**
BZP	0	-	-	0	0	0	0	0	/	/	/	/	/	**/**
% Dissociatives	/	/	0	/	/	0	0	-	-	0	-	0	0	**0**
Methoxetamine (MXE)	/	/	0	/	/	0	0	-	-	0	-	0	0	**0**
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**

	2010 (N=92)	2011 (N=76)	2012 (N=92)	2013 (N=100)	2014 (N=100)	2015 (N=100)	2016 (N=100)	2017 (N=100)	2018 (N=100)	2019 (N=100)	2020 (N=100)	2021 (N=100)	2022 (N=104)	2023 (N=101)
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	0	**0**
% Plant-based NPS	-	-	12	8	-	8	9	10	-	8	7	-	7	**-**
Ayahuasca	/	/	/	/	/	0	-	-	0	-	0	-	0	**-**
Mescaline	-	-	-	-	-	-	6	6	-	-	-	-	6	**0***
Salvia divinorum	/	-	-	-	0	-	-	-	-	-	-	0	0	**0**
Kratom	/	/	/	/	/	/	/	/	/	/	-	-	-	**-**
LSA	/	-	11	-	0	-	-	/	/	/	/	/	/	**/**
Datura	-	-	0	-	0	0	0	/	/	/	/	/	/	**/**
% Benzodiazepines	/	/	/	/	/	/	0	-	-	-	-	-	0	**-**
Etizolam	/	/	/	/	/	/	0	-	-	-	-	-	0	**0**
8-Aminoclonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Bromazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Clonazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**-**
Flualprazolam	/	/	/	/	/	/	/	/	/	/	/	/	0	**0**
Other drugs that mimic the effect of benzodiazepines	/	/	/	/	/	/	/	/	0	0	0	-	0	**0**
% Synthetic cannabinoids	0	0	10	/	/	0	/	/	/	-	-	0	-	**-**
% Herbal high#	/	/	17	10	6	7	-	-	-	-	/	/	/	**/**
Phenibut	/	/	/	/	/	/	/	/	/	/	0	-	0	**-**
% Other drugs that mimic the effect of opioids	/	/	/	/	/	/	/	/	-	0	0	0	0	**0**
% Other drugs that mimic the effect of ecstasy	/	/	/	/	/	/	/	0	-	-	-	-	-	**0**
% Other drugs that mimic the effect of amphetamine or cocaine	/	/	/	/	/	/	/	-	-	-	-	0	0	**0**
% Other drugs that mimic the effect of psychedelic drugs like LSD	/	/	/	/	/	/	/	0	0	-	-	0	-	**0**

Note. NPS first asked about in 2010. / not asked. ^In previous EDRS reports, PMA was included as a NPS under 'phenethylamines' and mescaline was included under both 'phenethylamines' and 'plant-based NPS'. In 2021, the decision was made to remove PMA from the NPS category altogether, while mescaline was removed from 'phenethylamines' and is now only coded under 'plant-based NPS'. This means that the percentages reported for any phenethylamine NPS use in the 2021-2023 EDRS reports will not align with those presented in earlier (2010-2020) reports. ^^In previous (2010-2020) EDRS reports, DMT was included as a NPS under 'tryptamines', however, was removed from the NPS category in 2021 (refer to Chapter 7 for further information on DMT use among the sample). This means that the percentages reported for any tryptamine NPS use in the 2021-2023 EDRS reports will not align with those presented in earlier (2010-2020) reports. # The terms 'herbal highs' and 'legal highs' appear to be used interchangeably to mean drugs that have similar effects to illicit drugs like cocaine or cannabis but are not

covered by current drug law scheduling or legislation. ~ In 2010 and between 2017-2019, three forms of 2C were asked about whereas between 2011-2016 four forms were asked about. From 2020 onwards, 'any' 2C use is captured. - Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in table; *p<0.050; **p<0.010; ***p<0.001.

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 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 onwards, 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, 12% reported using any non-prescribed codeine in the past six months, stable relative to 2022 (13% in 2022; p=0.830) (Figure 42).

Recent Use for Non-Pain Purposes: Six per cent of the Adelaide sample reported using non-prescribed codeine for non-pain purposes in 2023 (6% in 2022; p=0.779) (50% of participants who had recently used non-prescribed codeine; 57% in 2022).

Frequency of Use: Participants who had recently used non-prescribed codeine and commented (n=12) reported use on a median of two days (IQR=1-8) in the past six months, stable relative to 2022 (7 days; IQR=4-10; n=14; p=0.139).

Pharmaceutical Opioids

Recent Use (past 6 months): Six per cent of the Adelaide sample had recently used non-prescribed pharmaceutical opioids in 2023, excluding codeine (e.g., methadone, buprenorphine, morphine, oxycodone, fentanyl), stable from 8% in 2022 (p=0.779) (Figure 42).

Frequency of Use: Participants who had recently used non-prescribed pharmaceutical opioids reported use on a median of two days (IQR=1-23; n=6) in the six months preceding interview (6 days in 2022; IQR=4-11; n=8; p=0.472).

Benzodiazepines

Recent Use (past 6 months): Recent use of non-prescribed benzodiazepines has fluctuated considerably over the course of monitoring, with one third (34%) of the Adelaide sample reporting recent use in 2023, stable relative to 2022 (29%; p=0.545) (Figure 42).

From 2019, participants were asked about non-prescribed alprazolam use versus 'other' non-prescribed benzodiazepine use. One fifth (22%) of participants reported recent use of non-prescribed alprazolam, stable relative to 13% in 2022 (p=0.100). Recent use of non-prescribed 'other' benzodiazepines also remained stable, with one quarter (25%) reporting recent use in 2023 (23% in 2022; p=0.868).

Frequency of Use: Participants who reported recent non-prescribed use of alprazolam reported a median of three days (IQR=1-12; n=22; 3 days in 2022; IQR=2-5; n=13) of use in 2023. Participants reported a median of nine days (IQR=5-35; n=24) of other benzodiazepine use in 2023, a significant increase from four days (IQR=2-6; n=24) of use in 2022 (p=0.007).

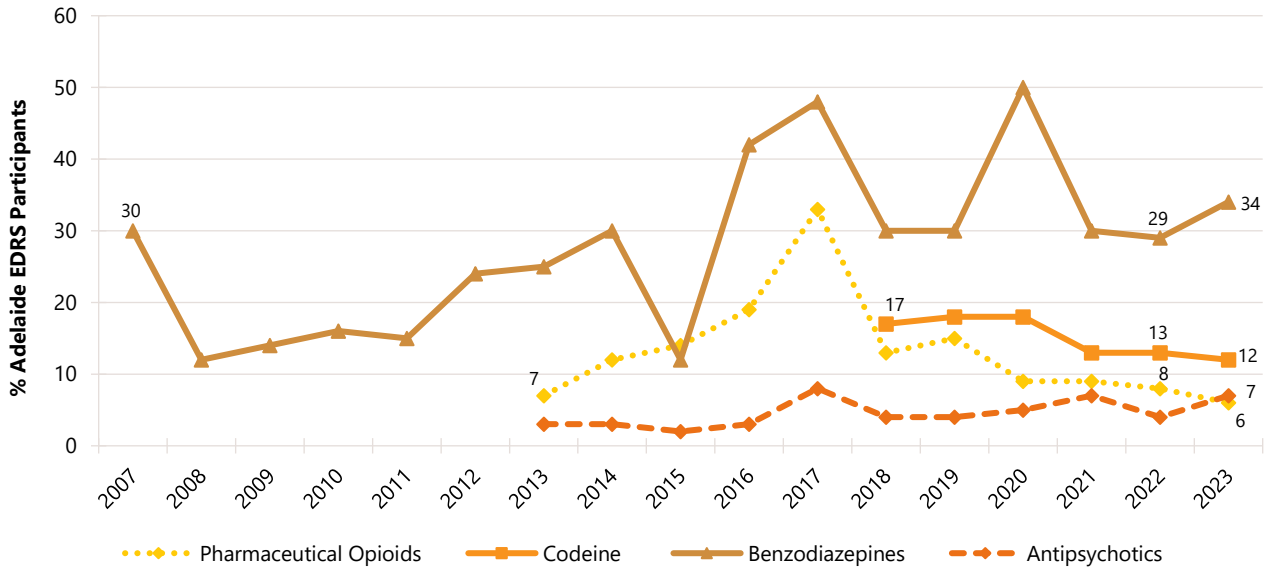
Forms Used: Few (n≤5) participants who had recently consumed non-prescribed benzodiazepines were able to comment on the main brand used in the six months preceding interview, therefore, further details are not reported. Please refer to the 2023 National EDRS Report for national trends, or contact the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

Antipsychotics

Recent Use (past 6 months): Seven per cent of the Adelaide sample had recently used non-prescribed antipsychotics in 2023, stable relative to 2022 (n≤5; p=0.369) (Figure 42).

Frequency of Use: Participants who had recently used non-prescribed antipsychotics and commented (n=7) reported use on a median of six days (IQR=1-35) in the six months preceding interview (n≤5 in 2022; p=0.613).

Figure 42: Non-prescribed use of pharmaceutical medicines in the past six months, Adelaide, SA, 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): In 2023, almost one third (30%) of the Adelaide sample reported recent use of hallucinogenic mushrooms in the six months prior to the interview, stable relative to 37% in 2022 (p=0.311) (Figure 43).

Frequency of Use: A median of three days of hallucinogenic mushroom use (IQR=2-5; n=30) was reported in the six months prior to interview in 2023 (2 days in 2022; IQR=2-3; n=38; p=0.333).

MDA

Due to low numbers reporting recent use of MDA, further details are not reported (n≤5 in 2022 and 2023; p=0.207) (Figure 43). 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: Few (n≤5) participants reported recent use of capsules with 'unknown contents' in 2023, therefore, further details are not reported (n≤5 in 2022) (Figure 43). Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

Other Unknown Substances: From 2019, we asked participants about their use more broadly of substances with 'unknown contents'. Eleven per cent of participants reported use of any substance with 'unknown contents' in 2023 (13% in 2022; p=0.824) on a median of two days (IQR=1-5; n=10), a significant increase from one day in 2022 (IQR=1-1; n=13; p=0.044).

When broken down by substance form, 9% of participants reported recent use of pills with 'unknown content' (8% in 2022; p=0.800). Few (n≤5) participants reported recent use of powder and crystal with 'unknown contents' in 2023, 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.

Quantity: From 2020, we asked participants about the average amount of pills and capsules used with 'unknown contents' in the six months preceding interview. Of those who reported recent use and responded (n=8), the median number of pills with 'unknown contents' used in a 'typical' session was one (IQR=1-2; 1 pill in 2022; IQR=1-1; n=8; p=0.481). Few (n≤5) participants were able to answer questions regarding the median quantity of capsules used in a 'typical' session in 2023, 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.

PMA

No participants reported recent use of PMA in 2023 (0% in 2022) (Figure 43). Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

PMMA

No participants reported recent use of PMMA in 2023 (0% in 2022) (Figure 43). Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

Heroin

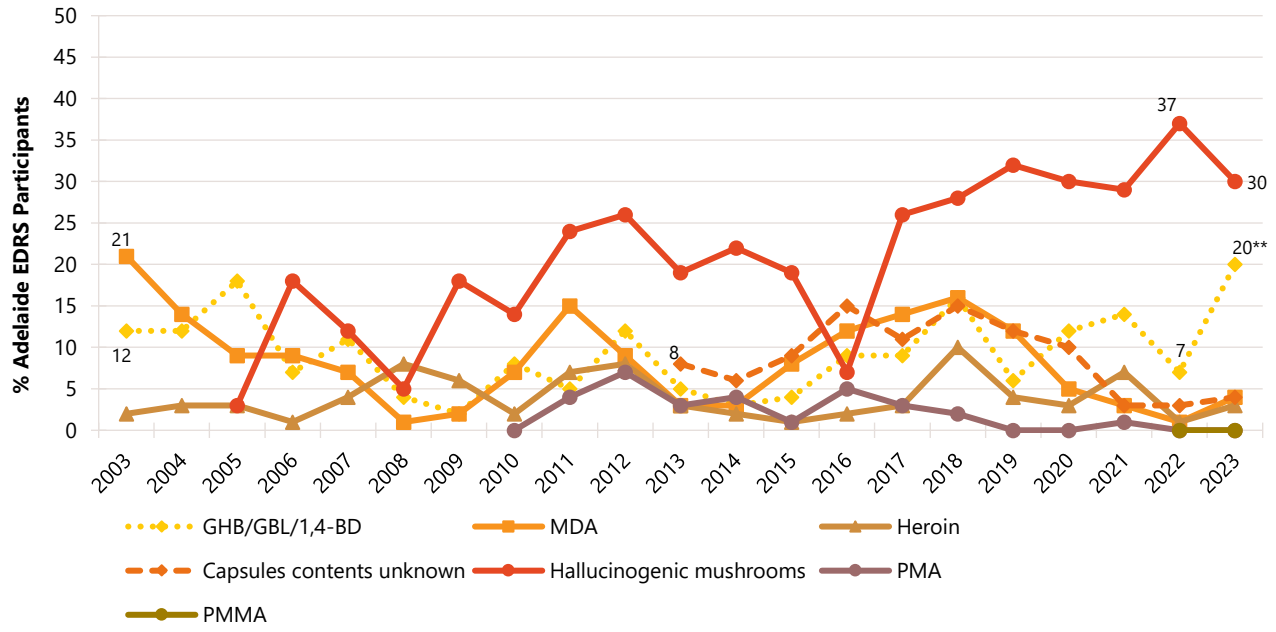
Few (n≤5) participants reported recent use of heroin in 2023, therefore, further details are not reported (n≤5 in 2022; *p*=0.364) (Figure 43). Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

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

Recent Use (past 6 months): In 2023, one fifth (20%) of the Adelaide sample reported recent use of GHB/GBL/1,4-BD in the six months prior to the interview, a significant increase from 7% in 2022 (*p*=0.009) (Figure 43), and the highest percentage reporting recent use since the commencement of monitoring.

Frequency of Use: A median of 12 days of GHB/GBL/1,4-BD use (IQR=2-22; n=19) was reported in the six months prior to interview in 2023 (20 days in 2022; IQR=3-60; n=7; *p*=0.450).

Figure 43: Past six month use of other illicit drugs, Adelaide, SA, 2003-2023



Note. Monitoring of hallucinogenic mushrooms commenced in 2005. Monitoring of capsules 'contents unknown' commenced in 2013; note that in 2019, participants were asked more broadly about 'substances contents unknown' (with further ascertainment by form) which may have impacted the estimate for 'capsules contents unknown'. Monitoring of PMA commenced in 2010 and monitoring of PMMA commenced in 2022. Y axis has been reduced to 50% to improve visibility of trends. Data labels are only provided for the first (2003/2005/2010/2013) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Licit and Other Drugs

Alcohol

Recent Use (past 6 months): The majority of the Adelaide sample continued to report recent use of alcohol in 2023 (91%), stable relative to 2022 (93%; *p*=0.610) (Figure 44).

Frequency of Use: A median of 30 days of alcohol use in the past six months (IQR=13-60; n=92) was reported in 2023 (28 days in 2022; IQR=18-72; n=97; *p*=0.409). Almost two thirds (65%) of those who

recently consumed alcohol had done so on a weekly or more frequent basis in 2023, stable from 2022 (72%; *p*=0.348). Few (n≤5) participants reported daily use of alcohol in 2022 (n≤5 in 2022).

Tobacco

Recent Use (past 6 months): Almost three quarters (73%) of the Adelaide sample reported recent tobacco use in 2023, which remained stable from 80% reporting recent use in 2022 (*p*=0.328) (Figure 44).

Frequency of Use: Participants reported using tobacco on a median of 180 days in 2023 (IQR=33-180; n=74; 140 days in 2022; IQR=13-180; n=82; *p*=0.485), with 51% of participants who had recently used tobacco reporting daily use (48% in 2022; *p*=0.740).

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): Two thirds (67%) of the 2023 Adelaide sample had used non-prescribed e-cigarettes in the six months preceding interview (62% in 2022; *p*=0.460) (Figure 44), the highest percentage observed since the commencement of monitoring. Few participants (n≤5) in Adelaide reported recent use of prescribed e-cigarettes in 2023 (n≤5 in 2022).

Frequency of Use: A median frequency of 180 days of non-prescribed use was reported in the past six months in 2023 (IQR=48-180; n=68), a significant increase from 75 days in 2022 (IQR=17-180; n=64; *p*=0.013). Half (51%) of participants who had recently used non-prescribed e-cigarettes reported daily use, also a significant increase from 2022 (19%; *p*<0.001).

Forms Used: Among participants who had recently used non-prescribed e-cigarettes and responded (n=68), the majority (93%) reported using e-cigarettes containing nicotine, whereas 9% reported using e-cigarettes containing cannabis, and a further 9% reported using e-cigarettes containing both cannabis and nicotine. One third (34%) reported using e-cigarettes which did not contain nicotine nor cannabis.

Reason for Use: Of those who reported any (i.e., prescribed and non-prescribed) e-cigarette use and responded (n=68), 53% of the Adelaide sample reported that they did not use e-cigarettes as a smoking cessation tool in 2023, a significant decrease relative to 2022 (72%; *p*=0.038).

Nitrous Oxide

Recent Use (past 6 months): One fifth (21%) of the Adelaide sample reported recent use of nitrous oxide in 2023, stable relative to 2022 (27%; *p*=0.333) (Figure 44).

Frequency of Use: Frequency of use remained stable at a median of three days (IQR=2-6; n=21) in 2023 (3 days in 2022; IQR=2-8; n=28; *p*=0.750).

Quantity: Among those who reported recent use and responded (n=16), the median amount used in a 'typical' session was 10 bulbs (IQR=5-21; 10 bulbs in 2022; IQR=4-20; n=27; *p*=0.960). Of those who reported recent use and responded (n=16), the median maximum amount used was 18 bulbs (IQR=6-35; 20 bulbs in 2022; IQR=5-30; n=27; *p*=0.930).

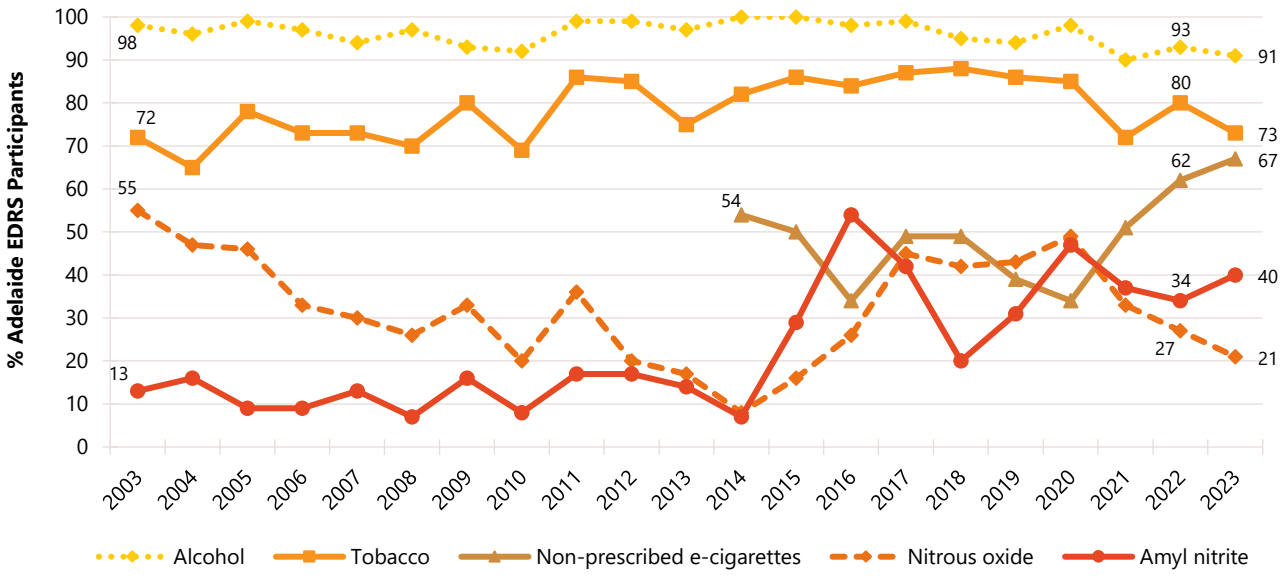
Amyl Nitrite

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

Recent Use (past 6 months): After considerable fluctuation over the course of monitoring, two fifths (40%) of the Adelaide sample reported recent use of amyl nitrite in 2023, stable relative to 2022 (34%; p=0.389) (Figure 44).

Frequency of Use: A median of four days of use was reported in 2023 (IQR=2-12; n=40; 4 days in 2022; IQR=2-6; n=35; p=0.407).

Figure 44: Licit and other drugs used in the past six months, Adelaide, SA, 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

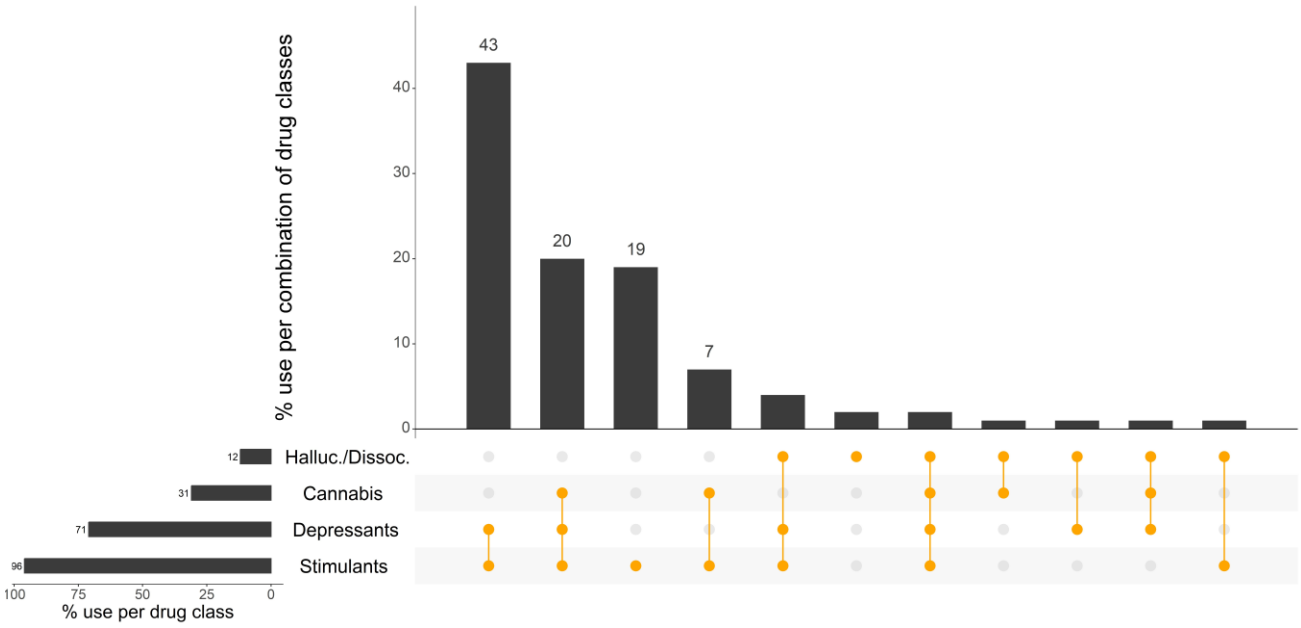
Drug-Related Harms and Other Behaviours

Polysubstance Use

On the last occasion of ecstasy or related drug use and among those who responded (n=101), the most commonly used substances were alcohol (66%) and ecstasy (38%), followed by cocaine (34%) and cannabis (31%).

Almost four fifths (79%; n=80) of the Adelaide sample reported concurrent use of two or more drugs on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes). The most commonly used combinations of drug classes were stimulants and depressants (43%), followed by stimulants, depressants, and cannabis (20%). Seven per cent reported using stimulants and cannabis, whilst 19% reported using stimulants alone (Figure 45).

Figure 45: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Adelaide, SA, 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 50% to improve visibility of trends.

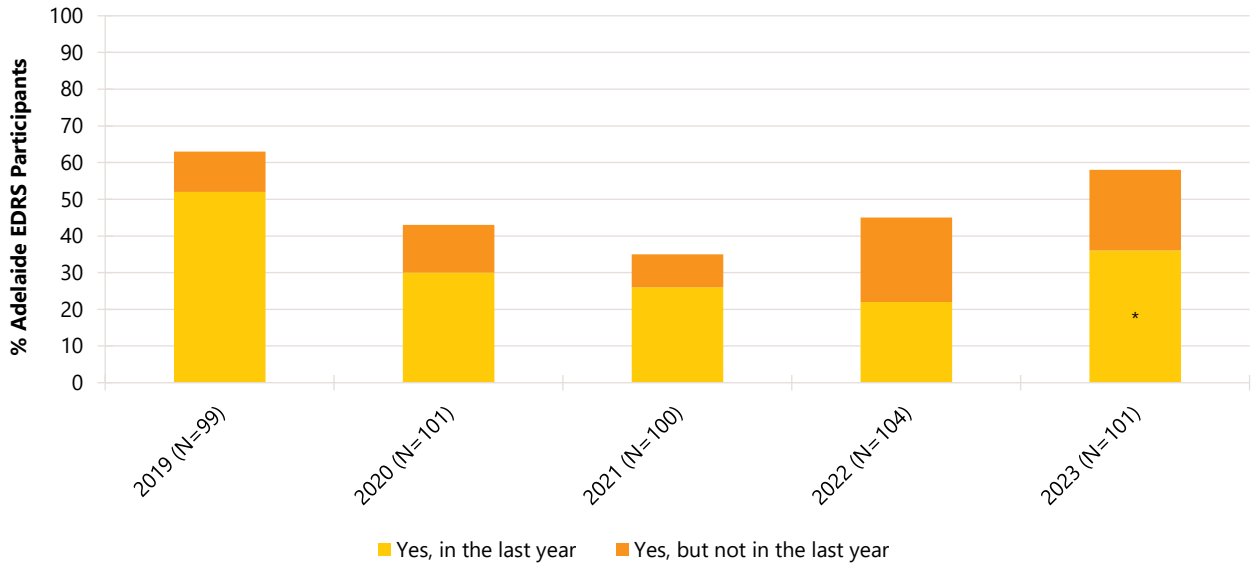
Drug Checking

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 fixed-site drug checking service in Canberra which has been operational since 17 July 2022.

In 2023, 36% 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 from 22% in 2022 (p=0.032) (Figure 46). Of those who reported that they or someone else had tested their illicit drugs in the past year (n=36), 75% reported using colorimetric reagent test kits, and 17% reported having their drugs tested via testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips). Few participants (n≤5) reported testing via professional testing equipment (e.g., Fourier Transform Infrared Spectroscopy).

Of those who reported that they or someone else had tested their illicit drugs in the past year (n=36), the majority (64%) reported having their drugs tested by a friend, followed by 50% who reported testing the drugs themselves. One quarter (25%) reported having their drugs tested by a dealer.

Figure 46: Lifetime and past year engagement in drug checking, Adelaide, SA, 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.

The mean score on the AUDIT for the total Adelaide sample (including people who had not consumed alcohol in the past 12 months) was 12.0 (SD 8.0) in 2023, a significant decrease from 12.9 (SD 7.9) in

2022 (p<0.001). AUDIT scores are divided into four 'zones' which indicate risk level. Specifically, scores between 0-7 indicate low risk drinking or abstinence; scores between 8-15 indicate alcohol use in excess of low-risk guidelines; scores between 16-19 indicate harmful or hazardous drinking; and scores 20 or higher indicate possible alcohol dependence. There was no significant change in the per cent of the sample falling into each of these risk categories from 2022 to 2023 (p=0.255) (Table 4). Three fifths (60%) of the sample obtained a score of eight or more (70% in 2022; p=0.154), indicative of hazardous use (Table 4).

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

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
	N=84	N=75	N=89	N=97	N=100	N=100	N=99	N=99	N=100	N=99	N=101	N=100	N=104	N=101
Mean AUDIT total score (SD)	14.9 (6.8)	18 (6.5)	16.5 (6.6)	15.2 (6.5)	14.7 (6.2)	13.1 (5.3)	11.3 (5.6)	12.9 (6.1)	14.6 (7.6)	13.5 (7.7)	12.8 (7.4)	12.1 (7.0)	12.9 (7.9)	**12.0 (8.0) *****
Score 8 or above (%)	86	99	89	88	89	81	75	84	84	74	77	72	70	**60**
AUDIT zones:														
Score 0-7	14	-	11	12	11	19	25	16	16	26	23	28	30	**40**
Score 8-15	42	41	34	44	44	48	52	52	40	38	46	43	32	**25**
Score 16-19	19	17	21	21	25	23	13	18	20	16	12	15	19	**13**
Score 20 or higher	25	40	34	23	20	10	10	14	24	19	20	14	19	**23**

Note. Monitoring of AUDIT first commenced in 2010. Computed from the entire sample regardless of whether they had consumed alcohol in the past twelve months. Total AUDIT score range is 0-40, with higher scores indicating greater likelihood of hazardous and harmful drinking. – Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in table; *p<0.050; **p<0.010; ***p<0.001. Imputation used for missing scale scores.

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 in 2020 as few participants endorsed this behaviour.

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

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

Non-Fatal Stimulant Overdose

In 2023, 17% of the Adelaide sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview, stable relative to 2022 (16%) (Figure 47).

The most common stimulants reported during the most recent non-fatal stimulant overdose in the past 12 months comprised any form of ecstasy (47%; individual numbers for ecstasy forms too low to report (n≤5 participants)) and any form of methamphetamine (35%; individual numbers for methamphetamine forms too low to report (n≤5 participants)). Among those who experienced a recent non-fatal stimulant overdose, 88% (n=15) reported that they had also consumed one or more additional drugs on the last occasion, most notably, alcohol (76%; ≥5 standard drinks: 53%; ≤5 standard drinks; n≤5 participants), tobacco (47%), e-cigarettes (41%) and cannabis (35%). Due to low numbers reporting on forms of treatment on the last occasion of experiencing a 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.

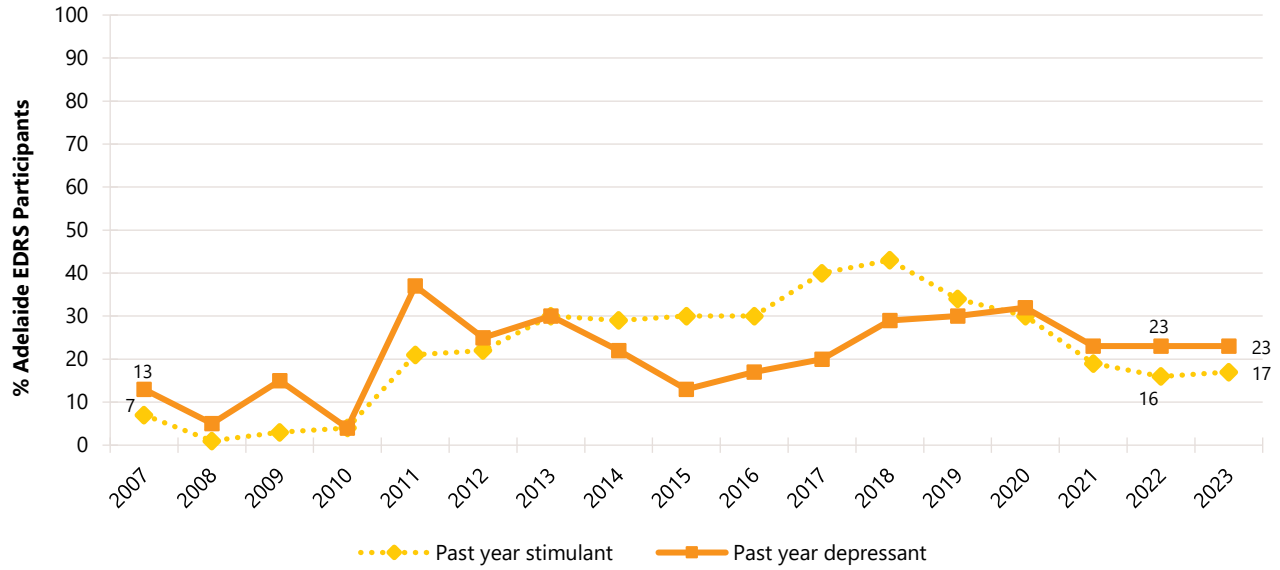
Non-Fatal Depressant Overdose

Alcohol: One fifth (21%) of the Adelaide sample reported a non-fatal alcohol overdose in the 12 months preceding interview (20% in 2022) on a median of two occasions (IQR=1-3). Of those who had experienced an alcohol overdose in the past year (n=21), the majority (90%) reported not receiving treatment on the last occasion. Due to low numbers reporting that they had received treatment or assistance (n≤5), please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

Any depressant (including alcohol): In 2023, almost one quarter (23%) of participants reported that they had experienced a non-fatal depressant overdose in the past 12 months, stable relative to 2022 (23%) (Figure 47).

Of those who had experienced any depressant overdose in the past 12 months (n=23), the majority (91%) of participants reported alcohol as the most common depressant drug. Few participants (n≤5) reported a non-fatal depressant overdose due to other drugs, therefore, these data are suppressed. Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

Figure 47: Past 12 month non-fatal stimulant and depressant overdose, Adelaide, SA, 2007-2023



Note. Past year stimulant and depressant overdose was first asked about in 2007. In 2019, items about overdose were revised, and changes relative to 2018 may be a function of greater nuance in capturing depressant events. Data labels are only provided for the first (2007) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

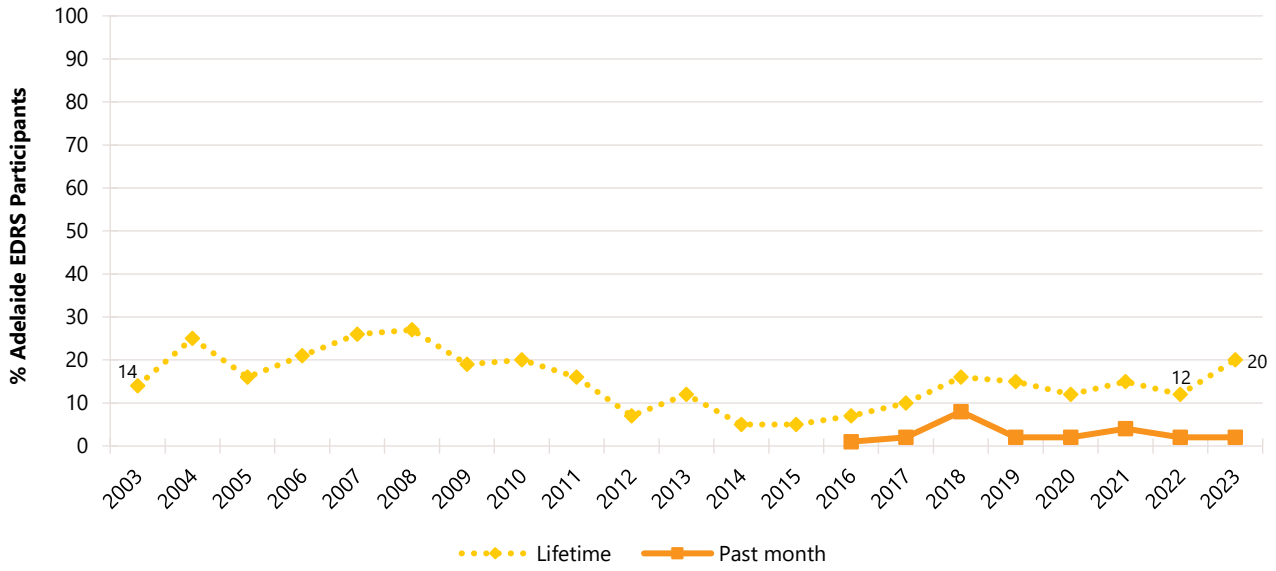
Awareness of Naloxone

In 2023, almost three fifths (57%) reported that they had ever heard of naloxone, a significant increase relative to 2022 (36%; p=0.001). Among those who had ever heard of naloxone and responded (n=57), 91% were able to correctly identify the purpose of naloxone, stable from 92% reporting so in 2022.

Injecting Drug Use and Associated Risk Behaviours

For the past several years, at least one in ten participants have reported ever injecting drugs, with 20% reporting lifetime injection in 2023 (12% in 2022; p=0.124). The per cent who reported injecting drugs in the past month remained low in 2023 (n≤5; n≤5 in 2022) (Figure 48), 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.

Figure 48: Lifetime and past month drug injection, Adelaide, SA, 2003-2023



Note. Items assessing whether participants had injected drugs in the past month were first asked in 2016. Data labels are only provided for the first (2003/2016) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Drug Treatment

In 2023, six per cent of the Adelaide sample reported currently receiving drug treatment (6% in 2022). Due to low numbers reporting on the forms of treatment received (n≤5), please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

Ecstasy and Methamphetamine Dependence

From 2017, participants were asked questions from the Severity of Dependence Scale (SDS) adapted to investigate ecstasy and methamphetamine dependence. The SDS is a five-item 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 in the past six months, a cut-off score of three or more was used, as this has been found to be a good balance between sensitivity and specificity for identifying problematic dependent ecstasy use. Among those who reported recent ecstasy use and commented (n=85), almost one-fifth (18%) recorded a score of three or above, stable relative to 2022 (8%; p=0.102). The median ecstasy SDS score was zero (IQR=0-2). Three fifths (62%) of participants obtained a score of zero on the ecstasy SDS and an additional 9% 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 the 44 participants who reported recent methamphetamine use and completed this section, 52% scored four or above, stable relative to 2022 (51%). The median methamphetamine SDS score was four (IQR=0-7). In 2023, one quarter (27%) of participants obtained a score of zero on the methamphetamine SDS and few participants (n≤5) obtained a score of one on the scale. The majority (52%) of participants obtained a score of four or above, indicating possible dependence in relation to methamphetamine use (Table 5).

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

	2017	2018	2019	2020	2021	2022	2023
Ecstasy	**(N=98)**	**(N=100)**	**(N=97)**	**/**	**(N=85)**	**(N=77)**	**(N=85)**
Median total score (IQR)	1 (0-2)	1 (0-3)	1 (0-3)	/	0 (0-2)	0 (0-1)	**0 (0-2)**
% score 0	42	46	42	/	59	70	**62**
% score =1	22	20	14	/	13	17	**9**
% score ≥3	24	27	32	/	20	8	**18**
Methamphetamine	**(N=31)**	**(N=41)**	**(N=34)**	**(N=26)**	**(N=32)**	**(N=37)**	**(N=44)**
Median total score (IQR)	2 (0-6)	3 (0-6)	4 (0-7)	4 (1-9)	5 (2-8)	4 (0-8)	**4 (0-7)**
% score 0	32	37	26	–	19	27	**27**
% score =1	–	–	–	23	–	–	–
% score ≥4	39	46	59	54	69	51	**52**

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 Scale was not asked of participants in 2020. – Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. Imputed values used for missing scale scores. Statistical significance for 2022 versus 2023 presented in table; *p<0.050; **p<0.010; ***p<0.001.

Sexual Health Behaviours

In 2023, almost three quarters (74%) of the sample reported some form of sexual activity in the past four weeks (69% in 2022; p=0.532). Given the sensitive nature of these questions, participants were given the option of self-completing this section of the interview (if the interview was undertaken face-to-face).

Of those who had engaged in sexual activity in the past four weeks and who responded (n=72), 86% reported using alcohol and/or other drugs prior to or while engaging in sexual activity, stable relative to 2022 (83%; p=0.630). Of those who had engaged in sexual activity in the past four weeks and responded (n=72), 14% reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex (10% in 2022; p=0.604). Furthermore, of those who had engaged in sexual activity in the past four weeks and who responded (n=72), one fifth (22%) reported penetrative sex without a condom where they did not know the HIV status of their partner (29% in 2022; p=0.343) (Table 6).

Of those who commented (n=99), one third (35%) reported having a sexual health check-up in the six months prior to interview (31% in 2022; p=0.549), whilst 82% had done so in their lifetime (76% in 2022; p=0.384). Of the total sample who responded (n=99), few participants (n≤5) reported that they had received a positive diagnosis for a sexually transmitted infection (STI) in the past six months in 2023 (0% in 2022; p=0.059), though 30% had received a positive diagnosis in their lifetime, a significant increase from 14% in 2022 (p=0.005) (Table 6). Due to low numbers reporting on the specific types of STIs diagnosed (n≤5), please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

Of those who commented (n=99), one fifth (22%) of the sample reported having a test for human immunodeficiency virus (HIV) in the six months prior to interview (20% in 2022; p=0.712), whilst 74% had done so in their lifetime, a significant increase from 51% in 2022 (p=0.001). In 2023, few (n≤5) participants had been diagnosed with HIV in the past six months (0% in 2022) or within their lifetime (0% in 2022) (Table 6).

Table 6: Sexual health behaviours, Adelaide, SA, 2021-2023

	2021	2022	2023
Of those who responded[#]:	**(N=88)**	**(N=100)**	**(N=99)**
% Any sexual activity in the past four weeks (n)	82 (n=72)	69 (n=69)	**74 (n=73)**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=70	n=69	**n=72**
% Drugs and/or alcohol used prior to or while engaging in sexual activity	84	83	**86**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=70	n=68	**n=72**
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	10	10	**14**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=73	n=68	**n=72**
% Had penetrative sex without a condom and did not know HIV status of partner	16	29	**22**
Of those who responded[#]:	n=93	n=96	**n=99**
% Had a HIV test in the last six months	25	20	**22**
% Had a HIV test in their lifetime	53	51	**74****
Of those who responded[#]:	n=94	n=100	**n=99**
% Diagnosed with HIV in the last six months	0	0	**-**
% Diagnosed with HIV in their lifetime	0	0	**-**
Of those who responded[#]:	n=94	n=100	**n=99**
% Had a sexual health check in the last six months	33	31	**35**
% Had a sexual health check in their lifetime	73	76	**82**
Of those who responded[#]:	n=94	n=100	**n=99**
% Diagnosed with a sexually transmitted infection in the last six months	–	0	**-**
% Diagnosed with a sexually transmitted infection in their lifetime	20	14	**30****

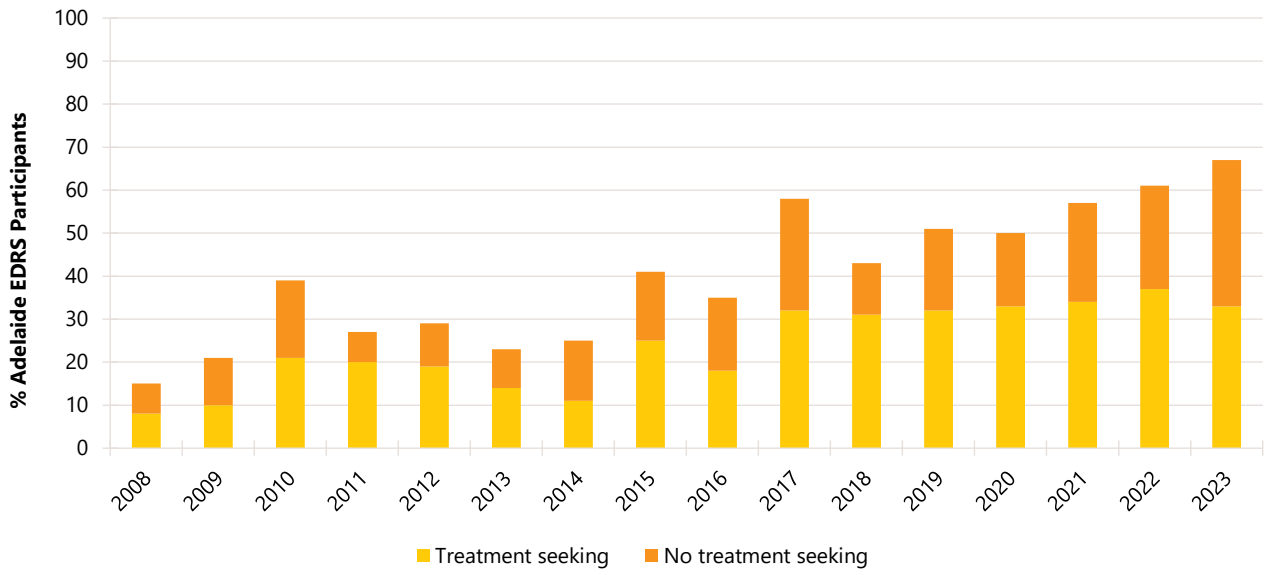
Note. [#] Due to the sensitive nature of these items, there is missing data for some participants who chose not to respond. The response option 'Don't know' was excluded from analysis. – Per cent suppressed due to small cell size (n≤5 but not 0). Statistical significance for 2022 versus 2023 presented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

Mental Health and Psychological Distress (K10)

Mental Health

Two thirds (67%) of the Adelaide sample self-reported that they had experienced a mental health problem in the preceding six months (other than drug dependence), stable relative to 2022 (61%; p=0.383). Of those who reported a mental health problem in 2023 and commented (n=66), the most common mental health problem reported was depression (64%; 65% in 2022; p=0.669), followed by anxiety (62%; 58% in 2022; p=0.389) and post-traumatic stress disorder (PTSD) (20%; 16% in 2022; p=0.504). Of those who reported experiencing a mental health problem (n=67), almost half (48%) reported seeing a mental health professional during the past six months (61% in 2022; p=0.164) (33% of the total sample) (Figure 49). Of those who reported seeing a mental health professional in 2023 (n=33), three fifths (61%) of the sample reported being prescribed medication for their mental health problem (47% in 2022; p=0.342).

Figure 49: Self-reported mental health problems and treatment seeking in the past six months, Adelaide, SA, 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. 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.

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 and 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 are considered to indicate 'low' psychological distress; scores between 16–21 indicate 'moderate' psychological distress; scores between 22–29 indicate 'high' psychological distress; and scores between 30–50 indicate 'very high' psychological distress. Among the general population, scores of 30 or more have been demonstrated to indicate a high likelihood of having a mental health problem, and possibly requiring clinical assistance.

Among those who responded in 2023 (n=101), the per cent of participants scoring in each of the four K10 categories remained stable between 2022 and 2023 (p=0.496). In 2023, 27% of the Adelaide EDRS sample had a score of 30 or more (22% in 2022) (Figure 50).

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 50).

Figure 50: K10 psychological distress scores, Adelaide, SA, 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). 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 table; *p<0.050; **p<0.010; ***p<0.001.

Health Service Access

One third (34%) of participants in the Adelaide sample reported accessing any health service for alcohol and/or drug support (AOD) in the six months preceding interview, stable relative to 2022 (34%). The most common services reported by participants in 2023 included a general practitioner (GP) (15%; 14% in 2022), followed by a drug and alcohol counsellor (10%; 9% in 2022) and a psychologist (10%; 18% in 2022) (Table 7).

The majority (89%) of participants reported accessing any health service for any reason in the six months preceding interview in 2023, stable from 92% in 2022 (p=0.471). The most common services accessed by participants in 2023 was a GP (71%; 76% in 2022), followed by a dentist (37%; 37% in 2022) and a psychologist (28%; 38% in 2022) (Table 7).

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

	AOD support		Any reason	
	2022 (N=104)	2023 (N=101)	2022 (N=104)	2023 (N=101)
% accessed a health service in the past 6 months	34	**34**	92	**89**
Type of service accessed ***(participants could select multiple services)***	N=104	**N=101**	N=104	**N=101**
GP	14	**15**	76	**71**
Emergency department	-	**8**	16	**18**
Hospital admission (inpatient)	-	**8**	11	**14**
Medical tent (e.g., at a festival)	-	**-**	-	**-**
Drug and Alcohol counsellor	9	**10**	9	**10**
Hospital as an outpatient	-	**-**	6	**7**
Specialist doctor (not including a psychiatrist)	0	**-**	12	**15**
Dentist	0	**0**	37	**37**
Ambulance attendance	-	**-**	6	**13**
Other health professional (e.g., physiotherapist)	-	**-**	28	**22**
Psychiatrist	-	**-**	9	**8**
Psychologist	18	**10**	38	**28**
NSP	6	**-**	6	**-**
Peer based harm reduction service	-	**-**	-	**-**
Other harm reduction service	-	**-**	-	**-**

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

Stigma

Questions regarding stigma were derived from the Stigma Indicators Monitoring Project, with stigma defined as people 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 (Table 8).

Few participants (n≤5) reported experiencing stigma within specialist alcohol and other drug (AOD) services in the six months preceding interview, stable relative to 7% in 2022 (p=0.537). A larger percentage, however, reported experiencing stigma within general health care services in the six months preceding interview (16%; 18% of those who had attended general health care services), stable relative to 2022 (19% in 2022; p=0.580). Self-reported experiences of stigma whilst attending general health care services most commonly occurred when visiting a GP (9%). One fifth (22%) of participants reported experiencing stigma in non-health care settings, most commonly from police (13%), followed by a current/potential employer (8%; not asked in 2022) (Table 8).

Notably, two fifths (38%) 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 (23%), followed by delaying accessing health care (12%) and not attending follow-up appointments (11%).

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

	2022	2023
% Experienced stigma in specialist AOD service	N=101 7	**N=101** **-**
% Experienced stigma in general health care service	N=104 19	**N=101** **16**
% Experienced stigma in non-health care service	/	**N=99** **22**
% Experienced stigma in any of the above settings^	/	**29**
% Did any of the following to avoid being treated negatively or differently by AOD specialist or general healthcare services	/	**n=98** **38**
Delayed accessing healthcare	/	**12**
Did not tell health worker about drug use	/	**23**
Downplayed need for pain medication	/	**7**
Looked for different services	/	**6**
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. – Per cent suppressed due to small cell size (n≤5 but not 0). The response option 'Don't know' was excluded from analysis. / Not asked. Statistical significance for 2022 versus 2023 presented in table; *p<0.050; **p<0.010; ***p<0.001.

COVID-19 Testing and Diagnosis

In 2023, the majority (97%) of the Adelaide EDRS sample had ever been tested for SARS-CoV-2, with 79% having been tested in the 12 months preceding interview (95% in 2022; 49% in 2021; 9% in 2020). Two thirds (67%) of participants reported having ever been diagnosed with the virus (59% in 2022; 0% in 2021; 0% in 2020), with participants reporting a median of one infection (IQR=1-2). One third (35%) of the sample reported a positive COVID-19 test in the 12 months preceding interview.

At the time of interview, 84% reported that they had received at least one COVID-19 vaccine dose (86% in 2022), with participants receiving a median of two doses (IQR=2-3); few participants (n≤5) received one dose, 41% received two doses and 39% received three or more doses.

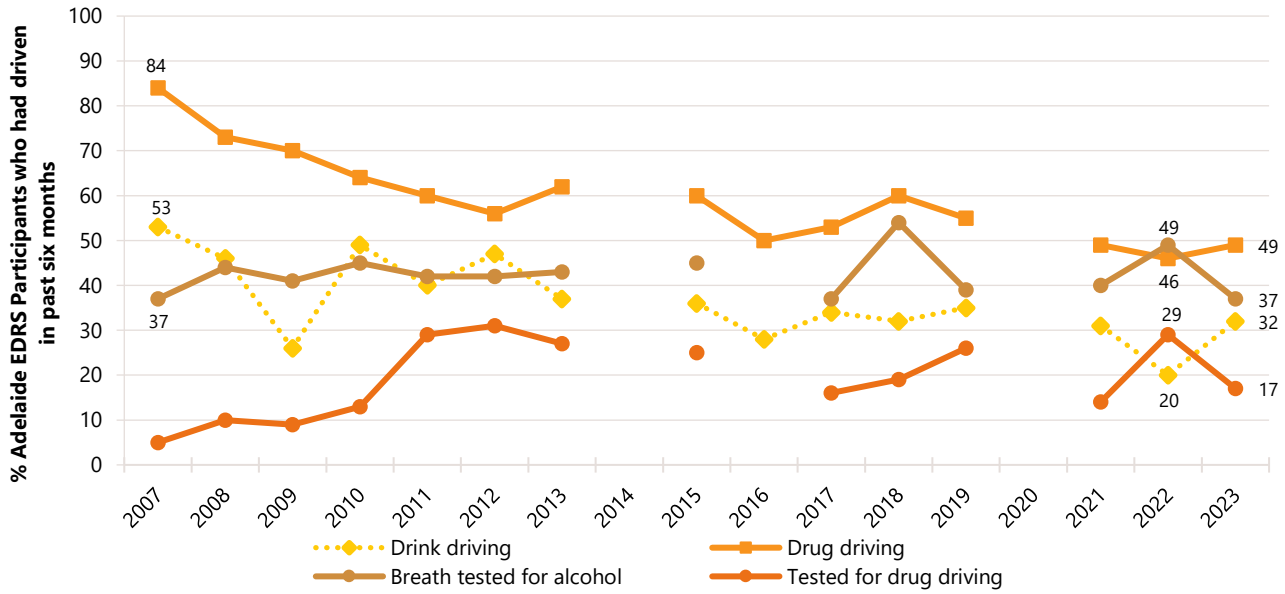
Driving

In 2023, 77% of the Adelaide sample 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=73), almost one third (32%) reported driving while over the (perceived) legal limit of alcohol (20% in 2022; p=0.184).

Of those who had driven in the past six months and responded (n=77), almost half (49%) reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months (46% in 2022; p=0.744) (Figure 51). Participants most commonly reported using cannabis (63%) prior to driving in the last six months, followed by methamphetamine crystal (45%) and cocaine (21%).

Among those who had driven in the past six months (n=78), almost one fifth (17%) reported that they had been tested for drug driving by the police roadside drug testing service (29% in 2022), and 37% reported that they had been breath tested for alcohol by the police roadside testing service in the six months prior to interview (49% in 2022) (Figure 51).

Figure 51: 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, Adelaide, SA, 2007-2023



Note. Computed of those who had driven a vehicle in the past six months. Questions about driving behaviour were first asked about in 2007. Questions about driving behaviour not asked in 2014 or 2020; questions about alcohol and drug driving testing were not asked in 2016. Data labels are only provided for the first (2007) and two most recent years (2022 and 2023) of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). For historical numbers, please refer to the data tables. The response option 'Don't know' was excluded from analysis. Statistical significance for 2022 versus 2023 presented in figure; *p<0.050; **p<0.010; ***p<0.001.

Experience of Crime and Engagement with the Criminal Justice System

In 2023, 36% of the Adelaide sample reported 'any' crime in the past month (30% in 2022; p=0.372), with drug dealing (27%; 15% in 2022; p=0.046) and property crime (17%; 15% in 2022; p=0.846) being the two main forms of criminal activity in 2023 (Figure 52).

In 2023, 6% of the Adelaide sample reported being the victim of a crime involving violence, stable relative to 2022 (8%; p=0.780) (Figure 53).

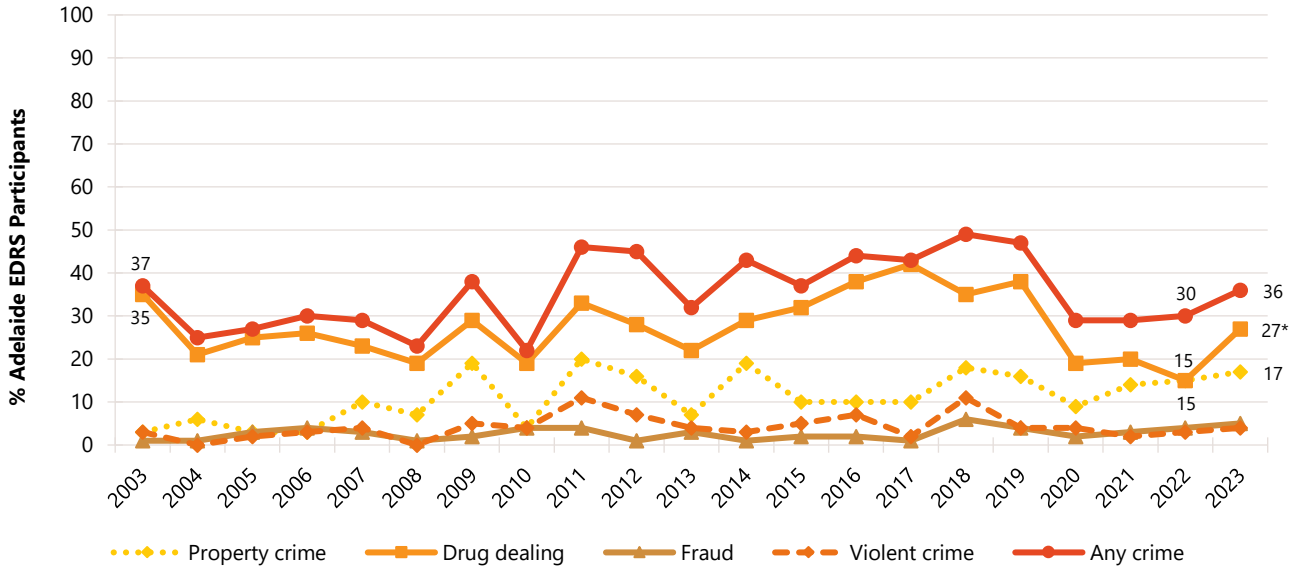
Eleven per cent of the 2023 sample reported having been arrested in the 12 months preceding interview (8% in 2022; p=0.470). Few participants (n≤5) reported reasons for arrest; therefore, further

details are not reported. Please refer to the 2023 National EDRS Report for national trends, or contact the Drug Trends team for further information.

One fifth (22%) of participants (17% in 2022; p=0.483) reported a drug-related encounter with police which did not result in charge or arrest in the past 12 months. This predominantly comprised being stopped for questioning (73%; 28% in 2022; p=0.010), followed by being stopped and searched (59%; 61% in 2022).

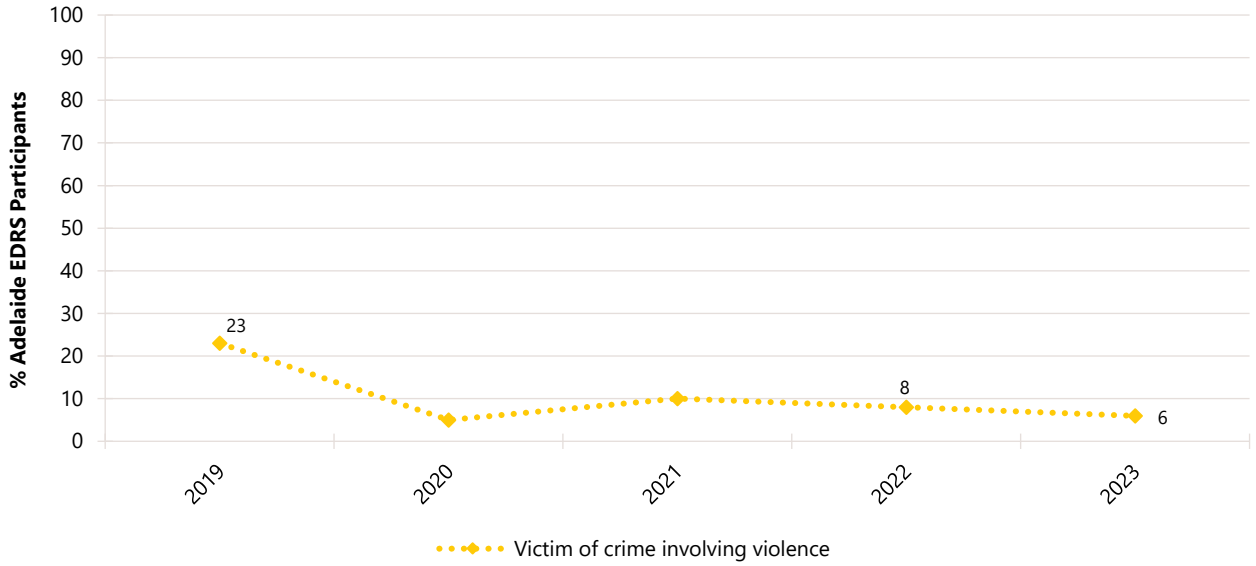
Eleven per cent reported having ever been in prison in 2023, stable relative to 2022 (13%; p=0.824).

Figure 52: Self-reported criminal activity in the past month, Adelaide, SA, 2003-2023



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

Figure 53: Victim of crime involving violence in the past month, Adelaide, SA, 2019-2023



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

Modes of Purchasing Illicit or Non-Prescribed Drugs

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

Purchasing Approaches

In 2023, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was in person (85%; 72% in 2022; p=0.031) and via social networking or messaging applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (76%; 72% in 2022; p=0.530) (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 participants (n≤5) reported obtaining drugs via the darknet (n≤5 in 2022) or the surface web (n≤5 in 2022; p=0.275) in the past year. However, almost half (48%) of participants reported ever obtaining illicit drugs through someone who had purchased them on the surface web or darknet, with 30% having done so in the last 12 months (32% in 2022; p=0.861).

In 2023, few participants (n≤5) reported selling illicit/non-prescribed drugs via surface or darknet marketplaces in the 12 months preceding interview (n≤5 in 2022; p=0.616).

Source and Means of Obtaining Drugs

The majority of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2023 (88%; 89% in 2022; p=0.820), followed by 67% reporting obtaining it from a known

dealer/vendor (70% in 2022; p=0.655). Almost one third (32%) reported obtaining illicit drugs from an unknown dealer/vendor (38% in 2022; p=0.456) (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 (98%; 94% in 2022; p=0.280), followed by a collection point (defined as a predetermined location where a drug will be dropped for later collection; 20%; 24% in 2022; p=0.497), and fewer participants reporting receiving illicit drugs via post (7%; 7% in 2022) (Table 9).

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

	2019 (N=100)	2020 (N=101)	2021 (N=100)	2022 (N=104)	2023 (N=101)
% Purchasing approaches in the last 12 months^	(n=100)	(n=99)	(n=98)	(n=104)	**(n=101)**
Face-to-face	79	72	83	72	**85***
Surface web	-	-	-	-	**-**
Darknet market	8	6	9	-	**-**
Social networking or messaging applications#	74	81	72	72	**76**
Text messaging	44	43	54	52	**60**
Phone call	37	34	35	39	**50**
Grew/made my own	0	-	-	-	**7**
Other	-	0	0	-	**-**
% Means of obtaining drugs in the last 12 months^~	(n=100)	(n=101)	(n=98)	(n=104)	**(n=100)**
Face-to-face	0	0	96	94	**98**
Collection point	12	25	20	24	**20**
Post	10	14	6	7	**7**
% Source of drugs in the last 12 months^	(n=100)	(n=100)	(n=98)	(n=104)	**(n=100)**
Friend/relative/partner/colleague	91	86	89	89	**88**
Known dealer/vendor	75	78	78	70	**67**
Unknown dealer/vendor	50	50	33	38	**32**

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