EDRS

NORTHERN TERRITORY DRUG TRENDS 2024

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

NORTHERN TERRITORY DRUG TRENDS 2024: 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: h.tayeb@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 2024:

- Dr Rachel Sutherland, Antonia Karlsson, Julia Uporova, Olivia Price, Udesha Chandrasena, Haniene Tayeb, 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;
- Zachary Lloyd and Professor Paul Dietze, Burnet, Victoria;
- Sophie Radke and Associate Professor Raimondo Bruno, School of Psychology, University of Tasmania, Tasmania;
- Dr Jodie Grigg, Dr Sophie Haywood and Professor Simon Lenton, National Drug Research Institute and enAble Institute, Curtin University, Western Australia; and
- Catherine Daly, Dr Jennifer Juckel, Dr Natalie Thomas and Associate Professor Caroline Salom, Institute for Social Science Research, The University of Queensland, Queensland.

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

Participants

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

Contributors

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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
4-FA	4-Fluoroamphetamine
5-MeO-DMT	5-methoxy-N,N-dimethyltryptamine
ACT	Australian Capital Territory
ADHD	Attention-Deficit/Hyperactivity Disorder
Alpha PVP	α-Pyrrolidinopentiophenone
AOD	Alcohol and Other Drug
AUDIT	Alcohol Use Disorders Identification Test
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
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
NT	Northern Territory
OTC	Over-the-counter
PMA	Paramethoxyamphetamine
PMMA	Polymethyl methacrylate
REDCAP	Research Electronic Data Capture

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 Darwin, Northern Territory (NT) 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 Darwin, NT. The results are not representative of all people who use illicit drugs, nor of use in the general population. Historically, there have been difficulties recruiting people in Darwin who meet the eligibility criteria, likely due to its smaller, and highly transient, population. Data from 2010-2012 and 2022-23 are therefore suppressed due to small sample sizes (n<50). **In 2024, data were collected from April-July. 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 2020-2024 samples, relative to previous years.**

Sample Characteristics

Fifty-one participants were recruited from Darwin, Northern Territory (NT) in 2024. Almost half (49%) the sample identified as male, and participants had a median age of 27 years. Participants reported a mean of 11 years of school in 2024, and 59% reported holding post-school qualification(s). Half (51%) the sample reported full-time employment and 20% reported part time/casual employment. Participants most commonly reported living in a rented house/flat (61%), followed by their parents/family home (20%), at the time of interview. Almost one quarter (24%) of participants nominated cannabis as their drug of choice, closely followed by cocaine (22%) and ecstasy (20%). Ecstasy was reported as the drug used most often in the month prior to interview by 27% of the sample, followed by alcohol (20%). Two fifths (41%) of participants reported using cannabis on a weekly or more frequent basis in 2024.

Non-Prescribed Ecstasy

In 2024, 92% of the Darwin sample reported recent use of any non-prescribed ecstasy, the lowest percentage observed since monitoring commenced. Capsules were the most commonly used form of non-prescribed ecstasy in 2024 (55%), followed by crystal (49%), pills (39%) and powder (27%). The reported median price of an ecstasy capsule was $38. Perceived availability varied across the different forms, with the largest percentage of participants who responded reporting that ecstasy pills were 'difficult' to obtain (47%), whereas participants most commonly reported that ecstasy capsules (48%), crystal (37%) and powder (50%) were 'easy' to obtain.

Methamphetamine

Almost two fifths (39%) of the Darwin sample reported recent use of any methamphetamine in 2024, on a median of 11 days. This mostly comprised methamphetamine crystal, with 31% of participants reporting recent use, followed by powder (14%) and base (n≤5). Fifty per cent of participants who had recently used methamphetamine crystal reported weekly or more frequent use. The reported median price of a point of methamphetamine crystal was $100, with participants who responded most commonly reporting that methamphetamine crystal was 'very easy' to obtain in 2024 (44%).

Non-Prescribed Pharmaceutical Stimulants

Almost two fifths (39%) of the Darwin sample reported recent use of non-prescribed pharmaceutical stimulants (e.g., dexamphetamine, methylphenidate, modafinil) in 2024, signifying the highest percentage of use since monitoring commenced. Most

participants who reported recent use and commented reported using non-prescribed dexamfetamine (60%). Among those who commented, two fifths (40%) reported that non-prescribed pharmaceutical stimulants were 'difficult' to obtain.

Cocaine

In 2024, almost four fifths (78%) of the Darwin sample reported any recent use of cocaine, on a median of five days in the prior six months. Fifteen per cent of those who had recently used cocaine reported weekly or more frequent use. The majority of participants who had recently used cocaine reported using powder cocaine (93%), with few participants (n≤5) using crack/rock cocaine. The median price per gram of cocaine was $375. Among those who commented, one third of participants (31%) reported that cocaine was of 'medium' purity, and 39% perceived cocaine as being 'easy' to obtain.

Cannabis and/or Cannabinoid-Related Products

In 2024, two thirds (69%) of the Darwin sample reported recent use of non-prescribed cannabis and/or cannabinoid-related products in the prior six months on a median of 48 days. Three fifths (60%) of those who had recently used non-prescribed cannabis and/or cannabinoid-related products reported weekly or more frequent use, and 29% reported daily use. Hydroponic cannabis was the most commonly used form of non-prescribed cannabis in 2024 (58%), followed by bush cannabis (48%). Among those who commented, the majority of participants reported that non-prescribed hydroponic and bush cannabis were 'very easy' to obtain (62% and 60%, respectively).

Non-Prescribed Ketamine, LSD and DMT

In 2024, two fifths (41%) of the Darwin sample reported recent use of non-prescribed ketamine in the prior six months on a median of four days. Almost two fifths (39%) reported recent use of LSD, on a median of two days. Among those who commented, participants most commonly perceived the purity of non-prescribed ketamine and LSD as 'high' (67% and 55%, respectively), and the availability as 'easy' (59% and 45%, respectively). Few participants (n≤5) reported recent use of DMT in 2024.

New Psychoactive Substances (NPS)

In 2024, few participants (n≤5) reported any NPS use, both including and excluding plant-based NPS.

Other Drugs

In 2024, one fifth (22%) of the Darwin sample reported recent use of non-prescribed benzodiazepines, however non-prescribed use of other pharmaceutical drugs was low. One third (35%) reported recent use of hallucinogenic mushrooms/psilocybin, 16% reported recent use of any substance with 'unknown contents', and 12% reported recent use of GHB/GBL/1,4-BD. Alcohol was consumed by the majority of participants (96%) in the six months preceding interview, 67% reported recent use of non-prescribed e-cigarettes, and 65% reported recent use of tobacco. Almost one third (31%) reported recent use of nitrous oxide, and 16% reported recent use of amyl nitrite.

Drug-Related Harms and Other Behaviours

Polysubstance use and bingeing

Almost four fifths (78%) of the Darwin sample reported concurrent use of two or more drugs

on the last occasion of ecstasy or related drug use (excluding tobacco and e-cigarettes).

Forty-five per cent of participants reported using stimulants or related drugs for 48 hours or more continuously without sleep in the six months preceding interview.

Dependence, overdose and injecting

The majority (90%) of participants obtained an AUDIT score of ≥8, indicative of hazardous alcohol use. One fifth (21%) of those who reported recent ecstasy use obtained an SDS score of ≥3, whilst two fifths (40%) of participants reporting recent methamphetamine use obtained a score of ≥4, indicating possible dependence on these substances.

One fifth (20%) of participants reported a past year non-fatal stimulant overdose and 22% reported a past year non-fatal depressant overdose.

Few participants (n≤5) reported past month injecting drug use.

Drug checking and naloxone awareness

Almost one fifth (18%) of the Darwin sample reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year.

In 2024, 45% reported that they had ever heard of naloxone, of which the majority (91%) were able to correctly identify the purpose of naloxone. However, no participants reported ever obtaining naloxone.

Sexual activity, mental health and health service access

Almost four fifths (78%) of the Darwin sample reported engaging in sexual activity in the past four weeks, of which 88% reported using alcohol and/or other drugs prior to or while engaging in sexual activity. Two fifths (43%) of the sample reported having a sexual health check in the six months preceding interview, though no participants were diagnosed with a sexually transmitted infection.

In 2024, 51% of the Darwin sample reported experiencing a mental health problem in the six months preceding interview, with depression (52%) and anxiety (40%) most commonly reported. One fifth (20%) of the sample reported a score of ≥30 on the K10, indicating very high psychological distress.

Twenty-nine per cent of participants reported accessing any health service for alcohol and/or drug support in the six months preceding interview. Few participants (n≤5) reported current drug treatment engagement.

One quarter (27%) of the Darwin sample reported experiencing stigma because of their illicit drug use in any health/non-health care setting in the six months preceding interview.

Driving, contact with police and modes of purchasing drugs

Among recent drivers, 51% reported driving while over the perceived legal limit of alcohol, and 55% reported driving within three hours of consuming an illicit or non-prescribed drug in the six months preceding interview.

Almost one third (31%) of the Darwin sample reported any past month crime, most commonly drug dealing and property crime (22% and 14%, respectively). Few participants (n≤5) reported past year arrest, though 12% reported a drug-related encounter with police which did not result in charge or arrest.

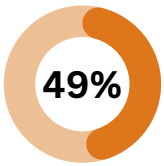
In 2024, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview was face-to-face (80%), followed by social networking or messaging applications (55%). Most participants reported obtaining illicit drugs from a friend/relative/partner/colleague (78%), followed by a known dealer/vendor (63%).

2024 SAMPLE CHARACTERISTICS

EDRS Ecstasy and Related Drugs Reporting System

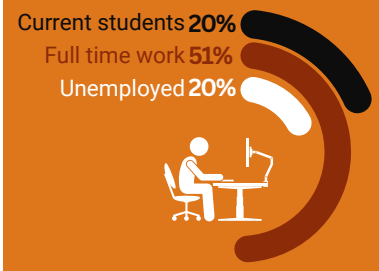
In 2024, 51 participants, recruited from Darwin, NT, were interviewed.

27 years



Male

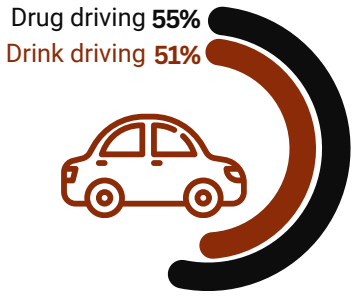
The median age in 2024 was 27 years, and 49% identified as male.



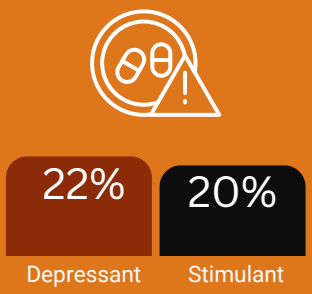
In the 2024 sample, 20% were current students, 51% were employed full time and 20% were unemployed.

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

DRUG-RELATED HARMS AND RISKS

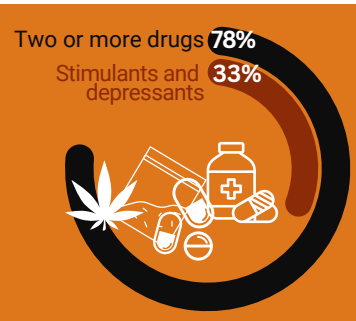


Among recent drivers, 55% reported driving a vehicle within 3 hours of consuming illicit drugs and 51% while over the legal limit of alcohol.



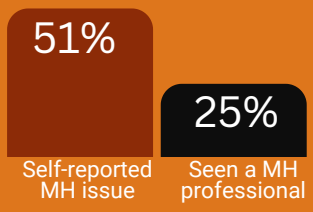
Percentage who reported past year non-fatal depressant and stimulant overdose.

Percentage who obtained an AUDIT score of eight or more in 2024, indicative of past year hazardous alcohol use.

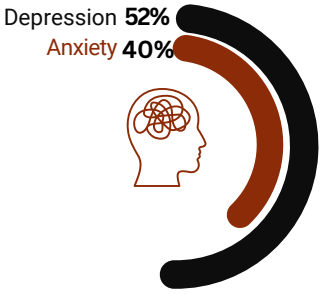


In 2024, 78% reported using two or more drugs on the last occasion of ecstasy or related drug use: the most commonly used combination of drug classes was stimulants and depressants (33%).

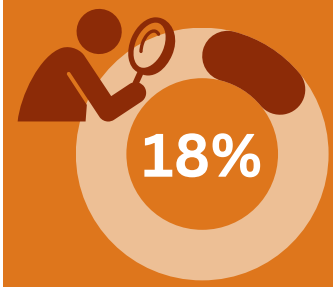
OTHER BEHAVIOURS



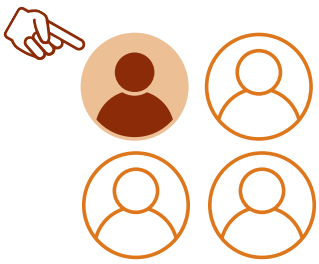
Percentage who self-reported mental health problems and treatment seeking in the six months preceding interview.



Among those who reported a mental health problem, the two most common mental health issues were depression and anxiety.

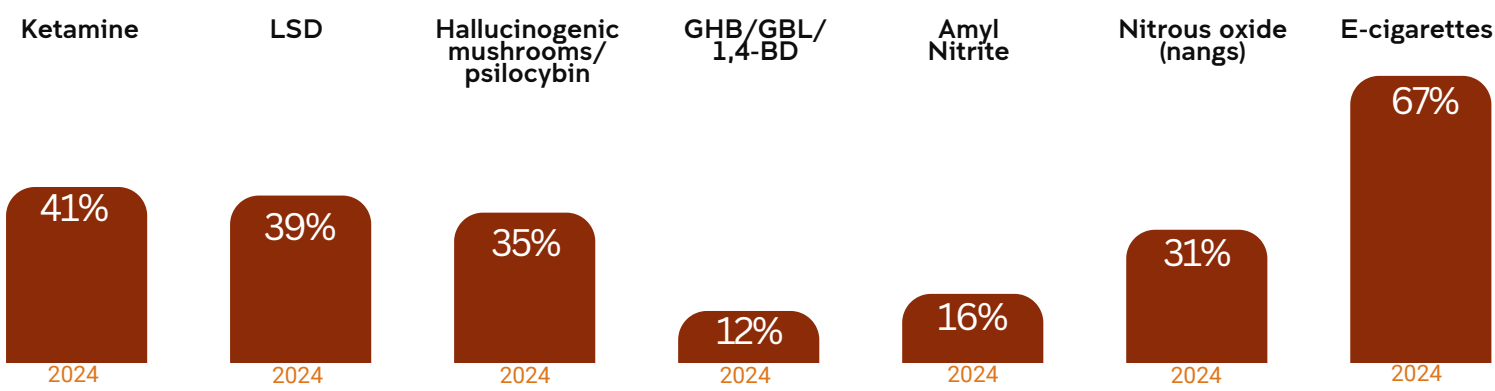


Percentage who reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year.



27% of the sample reported experiencing stigma because of their illicit drug use in the six months preceding interview, most commonly from police (12%).

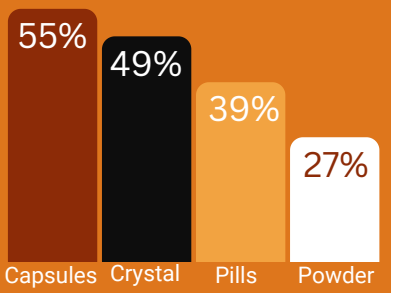
PAST 6 MONTH USE OF SELECT DRUGS



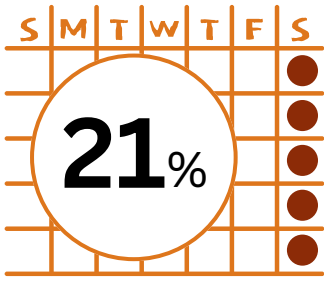
ECSTASY

EDRS Ecstasy and Related Drugs Reporting System

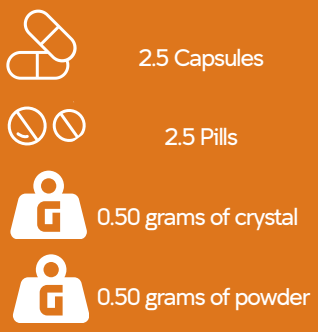
FORM of ecstasy



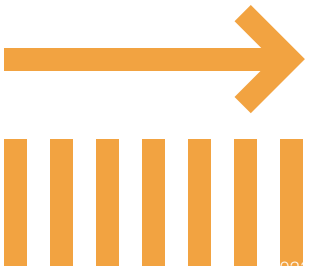
Past 6 month use of ecstasy capsules, crystal, pills and powder in 2024.



Of those who had recently used any ecstasy, 21% reported weekly or more frequent use.



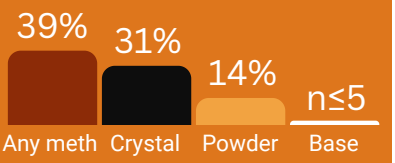
Median amounts of ecstasy consumed in a 'typical' session.



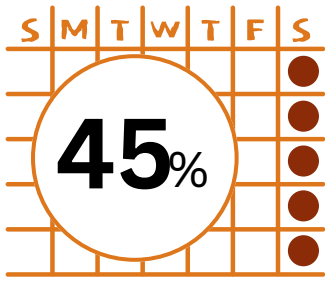
In 2024, participants perceived the availability of most forms of ecstasy as 'easy' or 'very easy'.

METHAMPHETAMINE

FORM of methamphetamine

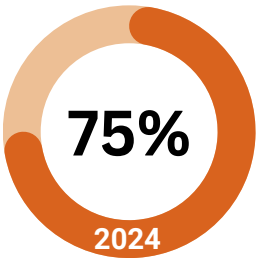


Past 6 month use of any methamphetamine, crystal, powder and base in 2024.



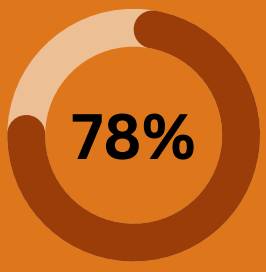
Of those who had recently used any methamphetamine, 45% reported weekly or more frequent use.

94% of participants who had recently used crystal smoked it.

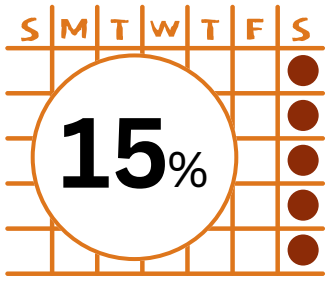


Percentage who perceived methamphetamine crystal as being 'easy' or 'very easy' to obtain.

COCAINE

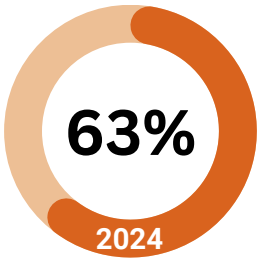


Past 6 month use of any cocaine in 2024.



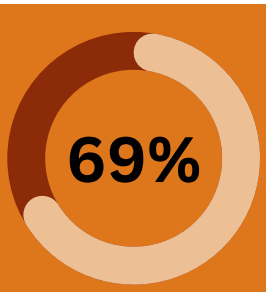
Of those who had recently consumed cocaine, 15% reported weekly or more frequent use.

The median reported price for a gram of cocaine in 2024.

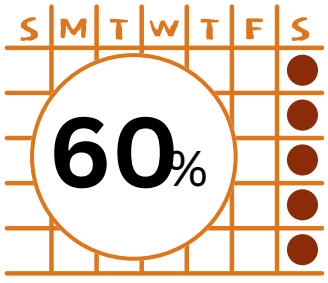


Percentage who perceived cocaine as being 'easy' or 'very easy' to obtain.

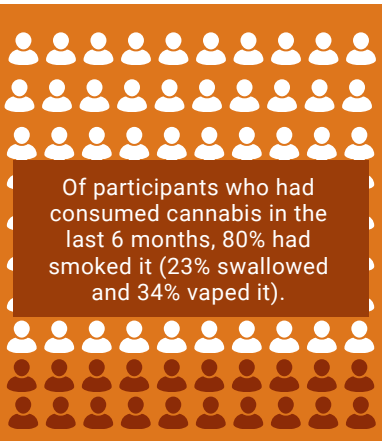
CANNABIS AND/OR CANNABINOID-RELATED PRODUCTS

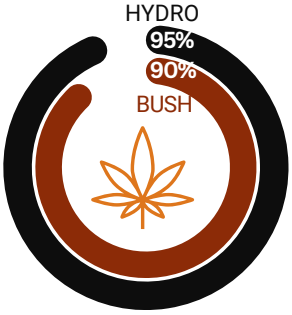


Past 6 month use of non-prescribed cannabis and/or cannabinoid-related products in 2024.



Of those who had recently used non-prescribed cannabis, 60% reported weekly or more frequent use.





Percentage who perceived cannabis and/or cannabinoid-related products as being '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) on at least six days 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 2020-2024: 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.

Historically, there have been difficulties recruiting people in Darwin who meet the eligibility criteria outlined above. This is largely thought to be due to the smaller population size of Darwin, as well as the highly transient nature of its population. **Due to the particularly small samples (n<50) recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution.**

2024 EDRS Sample

Between 9 April – 13 July 2024, a total of 740 participants were recruited across capital cities nationally, with 51 participants interviewed in Darwin, NT between 18 April and 13 July 2024. The majority of interviews (98%) were conducted via telephone, the remainder were conducted face-to-face.

Few participants (n≤5) among the 2024 Darwin sample completed the interview in 2023. Four fifths (80%) reported being recruited via the internet (e.g., Facebook and Instagram), with 14% recruited via word-of-mouth. Few participants (n≤5) reported 'other' means of recruitment.

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. Due to the small sample size in 2023 (n=40), data for 2023 is suppressed and no tests of statistical significance have been conducted between estimates for 2023 and 2024, 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. The response options 'Don't know' and 'Skip question', which were available to select throughout the interview, was excluded from analysis.

Guide to Table/Figure Notes

Table 1: Guide to Table/Figure Notes

Legend	
/	Question not asked in respective year (for tables)
~	Data not presented for Darwin in 2022 and 2023 due to small samples (n<50) recruited.
-	Per cent suppressed due to small cell size (n≤5 but not 0) (for tables)
	Missing data points indicate question not asked in respective year or n≤5 answered the question (for figures)

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 Darwin, Northern Territory, and thus do not reflect trends in regional and remote areas. Further, the results are not representative of all people who consume illicit drugs, nor of illicit drug use in the general population, but rather are intended to provide evidence indicative of emerging issues that warrant further monitoring.

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

Differences in the methodology, and the events of 2020-2024, must be taken into consideration when comparing 2020-2024 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 national reports, 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 2024, the Darwin EDRS sample had a median age of 27 years (IQR=23-38), with a gender distribution of 51% female and 49% male (Table 2). One quarter of the sample (25%) identified as Aboriginal and/or Torres Strait Islander. Eighty-four per cent of participants were Australian born, and the entire Darwin sample spoke English at home (100%).

Respondents reported a mean of 11 years of school at the time of interview (range: 7-12), with 59% holding post-school qualifications and 20% currently studying. One fifth (20%) of participants reported being unemployed at the time of interview, with the remainder reporting employment on a full-time (51%) or part time/casual (20%) basis. The median weekly income was $1115 (IQR=700-1548). Three fifths (61%) of the sample reported that they resided in a rented house/flat at the time of interview, and 20% lived at their parents/family home.

The drug/s of choice nominated by participants were mixed, with almost equal percentages nominating cannabis (24%), cocaine (22%) and ecstasy (20%) as their drug of choice in 2024 (Figure 1). Similarly, the drug/s used most often in the month preceding interview were mixed, with 27% reporting cannabis, 20% reporting alcohol and 16% reporting cannabis as the drug used most often. Fourteen per cent reported that cocaine was the drug they had used most often In the month prior to interview, the highest percentage observed since monitoring commenced (Figure 2).

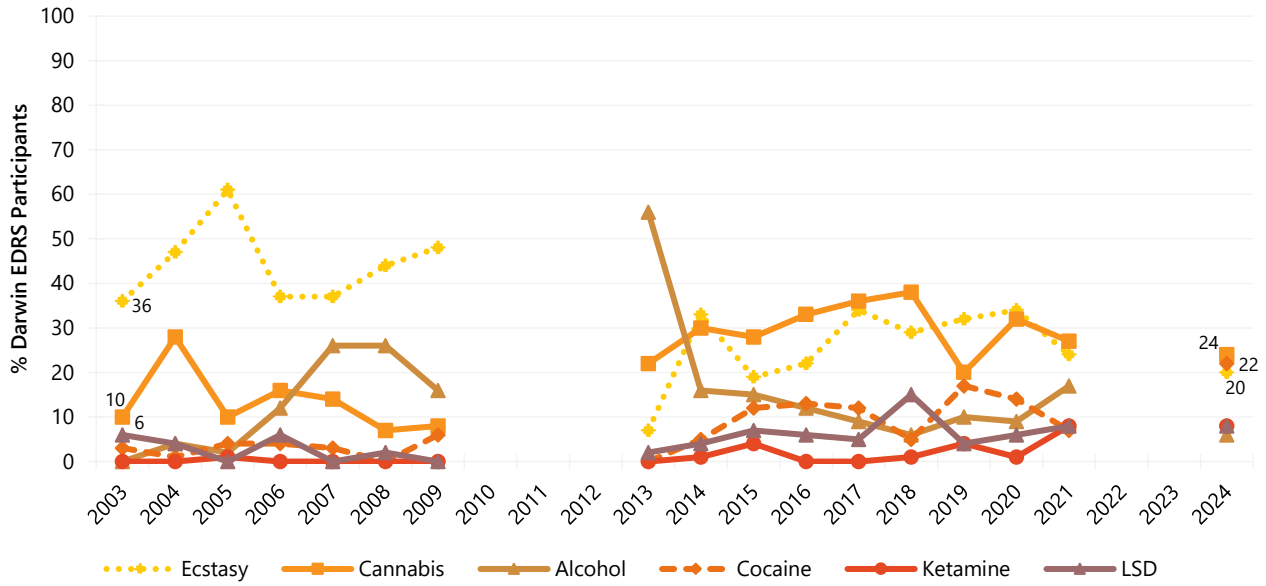
In 2024, two fifths of the sample (41%) reported weekly or more frequent use of non-prescribed cannabis in the six months preceding interview, while approximately one fifth reported weekly or more frequent use of ecstasy (20%) and methamphetamine (18%). One tenth (12%) reported weekly or more frequent use of cocaine (Figure 3).

Table 2: Demographic characteristics of the sample, nationally, 2024, and Darwin, NT, 2020-2024

	Darwin, NT					National
	2020	2021	2022	2023	2024	2024
	(N=100)	(N=100)			(N=51)	(N=740)
Median age (years; IQR)	23 (20-28)	25 (23-28)	~	~	**27 (23-38)**	23 (20-32)
% Gender						
Female	58	65	~	~	**51**	43
Male	42	34	~	~	**49**	55
Non-binary	0	-	~	~	**0**	3
% Aboriginal and/or Torres Strait Islander	-	-	~	~	**25**	9
% Born in Australia	/	/	~	~	**84**	84
% English primary language spoken at home	/	/	~	~	**100**	97
% Sexual identity						
Heterosexual	87	84	~	~	**84**	69
Homosexual	-	-	~	~	**0**	7
Bisexual	8	11	~	~	**12**	17
Queer	-	-	~	~	-	4
Other identity	-	-	~	~	-	3
Mean years of school education (range)	12 (7-12)	11 (7-12)	~	~	**11 (7-12)**	12 (7-12)
% Post-school qualification(s)^	47	70	~	~	**59**	56
% Current students#	40	22	~	~	**20**	39
% Current employment status						
Employed full-time	30	42	~	~	**51**	30
Part time/casual	33	34	~	~	**20**	42
Self-employed	-	-	~	~	-	5
Unemployed	31	21	~	~	**20**	23
Current median weekly income $ (IQR)	$696 (386-1000)	$1000 (700-1361)	~	~	**$1115 (700-1548)**	$700 (400-1200)
% Current accommodation						
Own house/flat	-	16	~	~	-	10
Rented house/flat	49	50	~	~	**61**	48
Parents'/family home	40	28	~	~	**20**	34
Boarding house/hostel	-	-	~	~	-	1
Public housing	-	-	~	~	-	3
No fixed address+	-	-	~	~	-	2
Other	0	0	~	~	-	1

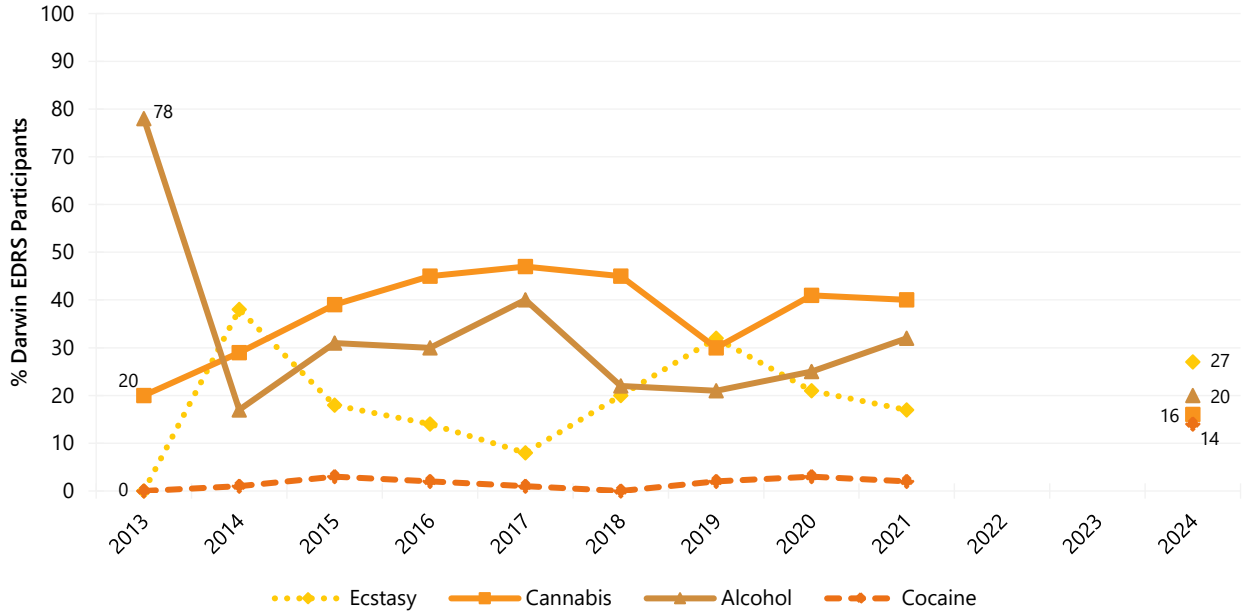
Note. ^ Includes trade/technical and university qualifications. #'Current students' comprised participants who were currently studying for either trade/technical or university/college qualifications. + No fixed address included couch surfing and rough sleeping or squatting. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Figure 1: Drug of choice, Darwin, NT, 2003-2024



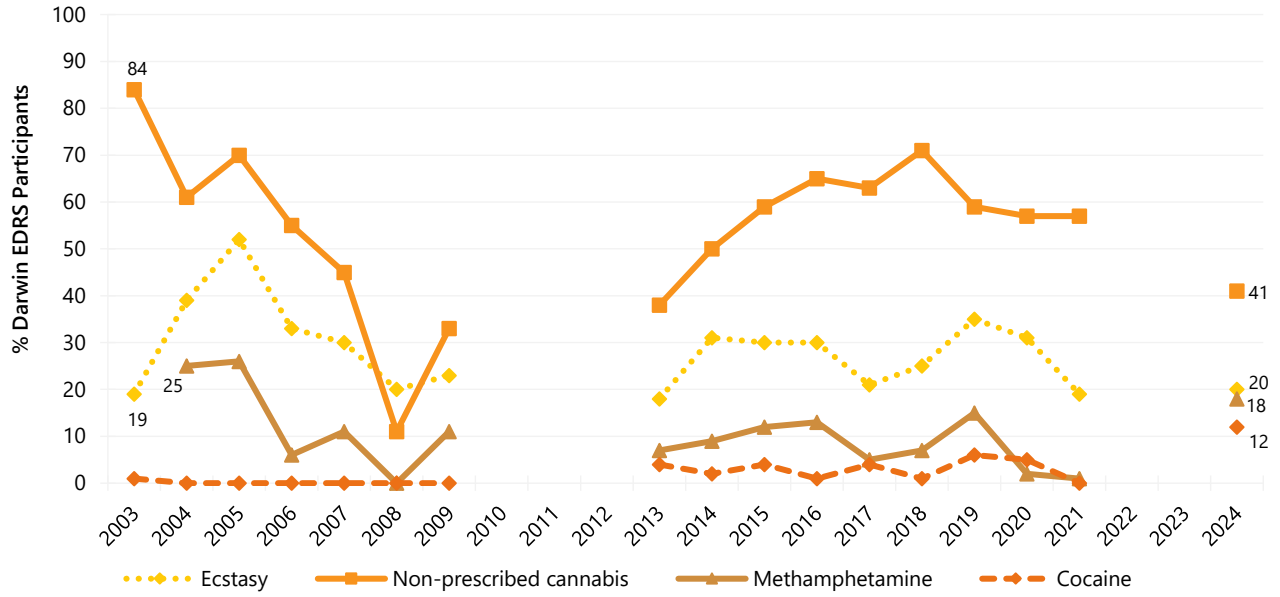
Note. Participants could only endorse one substance. Substances listed in this figure are the primary endorsed; smaller percentages have endorsed other substances. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 2: Drug used most often in the past month, Darwin, NT, 2013-2024



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 2013-2024 as this question was not asked in 2003-2010. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 3: Weekly or more frequent substance use in the past six months, Darwin, NT, 2003-2024



Note. Computed from the entire sample regardless of whether they had used the substance in the past six months. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. 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 and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

2

Non-Prescribed Ecstasy

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

Patterns of Consumption (Any Ecstasy)

Recent Use (past 6 months)

Ninety-two per cent of the 2024 Darwin sample reported recent use of non-prescribed ecstasy in any form in the six months preceding interview, representing the lowest percentage recorded since monitoring commenced (Figure 4). Capsules were the most commonly used form of non-prescribed ecstasy (55%), followed by crystal (49%) and pills (39%). Powder remained the least commonly used form of non-prescribed ecstasy (27%), consistent with the entirety of the reporting period.

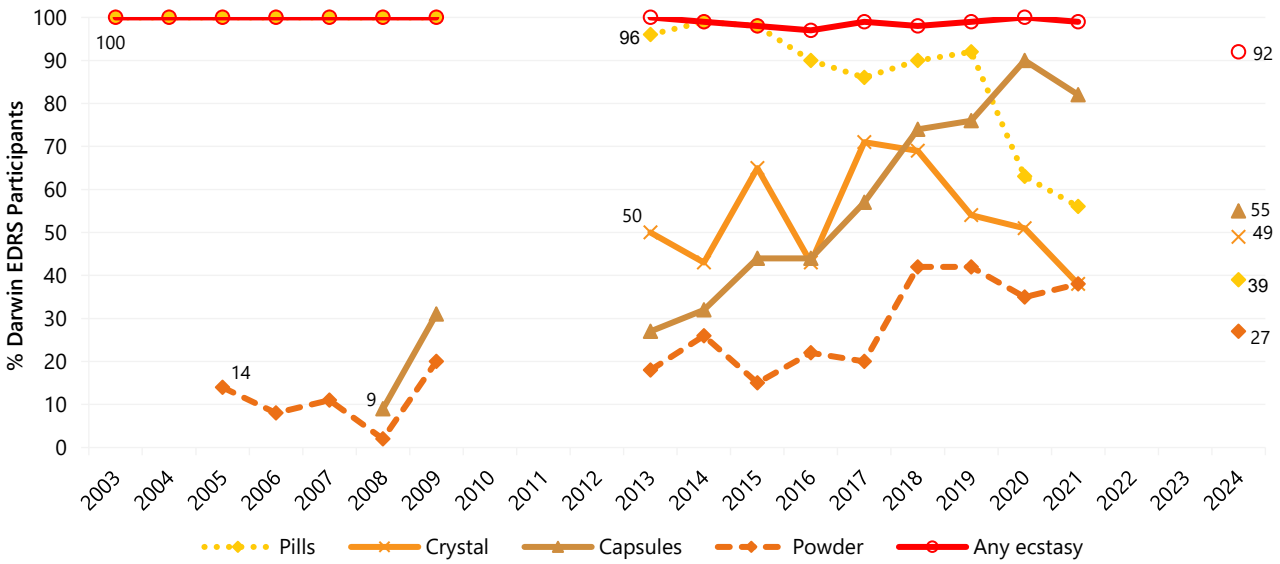
Frequency of Use

Among those who reported recent use of any non-prescribed ecstasy and commented (n=47), participants reported using ecstasy (in any form) on a median of nine days (IQR=5-21) in 2024 (Figure 5). One fifth (21%) of participants who had recently used any form of non-prescribed ecstasy reported weekly or more frequent use.

Number of Forms Used

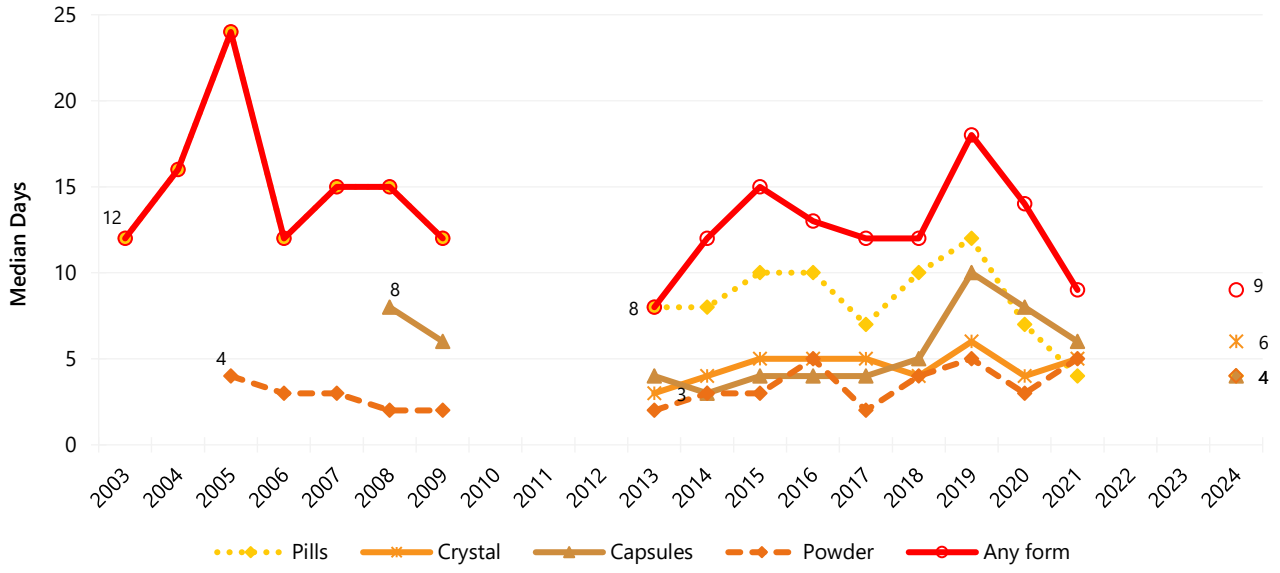
Among participants who had recently consumed non-prescribed ecstasy and commented (n=47), the median number of forms of ecstasy used was two (IQR=1-2).

Figure 4: Past six month use of any non-prescribed ecstasy, and non-prescribed ecstasy pills, powder, capsules, and crystal, Darwin, NT, 2003-2024



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 5: Median days of any non-presribed ecstasy use, and non-prescribed ecstasy pills, powder, capsules, and crystal use in the past six months, Darwin, NT, 2003-2024



Note. Up until 2012, participant eligibility was determined based on any recent ecstasy use; subsequently it has been expanded to broader illicit stimulant use. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Median days computed among those who reported past 6-month use (maximum 180 days). Median days rounded to the nearest whole number. Y axis reduced to 25 days to improve visibility of trends. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Patterns of Consumption (by form)

Non-Prescribed Ecstasy Pills

Recent Use (past 6 months): Recent use of non-prescribed ecstasy pills has declined since the commencement of monitoring. Whilst 96%-100% of participants reported recent use from 2003-2015, this gradually declined between 2015-2017, and then sharply declined from 2019 onwards. In 2024, 39% of participants reported recent use in the six months preceding interview, the lowest per cent observed since 2003 (Figure 4).

Frequency of Use: Of those who had recently consumed non-prescribed ecstasy pills and commented (n=20), participants reported use on a median of four days (IQR=2-9) in the six months preceding interview in 2024 (Figure 5). Few participants (n≤5) who had recently consumed non-prescribed ecstasy pills reported weekly or more frequent use.

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy pills and commented (n=20), the most common route of administration was swallowing (100%). Few participants (n≤5) reported smoking or snorting (n≤5).

Quantity: Of those who reported recent use and responded (n=20), the median number of non-prescribed ecstasy pills used in a 'typical' session was 2.5 (IQR=2-3). Of those who reported recent use and responded (n=19), the median maximum number of ecstasy pills used in a session was three (IQR=2-4).

Non-Prescribed Ecstasy Capsules

Recent Use (past 6 months): Recent use of non-prescribed ecstasy capsules increased sharply between 2008 (9%) and 2020 (90%), before subsequently declining. In 2024, 55% of participants reported recent use of non-prescribed ecstasy capsules in the six months preceding interview (Figure 4).

Frequency of Use: Among those who reported recent use of non-prescribed ecstasy capsules and commented (n=28), participants reported consuming capsules on a median of four days (IQR=2-11) (Figure 5). Few participants (n≤5) who had recently consumed capsules reported weekly or more frequent use.

Routes of Administration: Among those who had recently consumed non-prescribed ecstasy capsules and commented (n=28), 89% of participants reported swallowing and one fifth (21%) reported snorting. No participants reported recent smoking.

Quantity: Of those who reported recent use and responded (n=28), the median number of non-prescribed ecstasy capsules used in a 'typical' session was 2.5 (IQR=1-4.3). Of those who reported recent use and responded (n=28), the median maximum number of ecstasy capsules used in a session was four (IQR=2-5.3).

Non-Prescribed Ecstasy Crystal

Recent Use (past 6 months): Recent use of non-prescribed ecstasy crystal has fluctuated over the course of monitoring. In 2024, almost half (49%) of the Darwin sample reported recent use of non-prescribed ecstasy crystal (Figure 4).

Frequency of Use: Among those who reported recent use and commented (n=25), participants reported using non-prescribed ecstasy crystal on a median of six days (IQR=3-15) in 2024 (Figure 5). Few participants (n≤5) who had recently consumed crystal reported weekly or more frequent use.

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy crystal and commented (n=25), three quarters (76%) reported

swallowing, whilst 64% reported snorting. Few participants (n≤5) reported recent smoking.

Quantity: Of those who reported recent use and responded (n=17), the median amount of non-prescribed ecstasy crystal used in a 'typical' session was 0.50 grams (IQR=0.25-1.00). Of those who reported recent use and responded (n=16), the median maximum amount of ecstasy crystal used in a session was one gram (IQR=0.50-2.25).

Non-Prescribed Ecstasy Powder

Recent Use (past 6 months): One quarter (27%) of participants reported use of non-prescribed ecstasy powder in the six months preceding interview in 2024 (Figure 4).

Frequency of Use: Amongst those who reported recent use and commented (n=14), participants reported consuming non-prescribed ecstasy powder on a median of four days (IQR=3-9) in the six months preceding interview in 2024 (Figure 5). Few participants (n≤5) who had recently consumed powder reported weekly or more frequent use.

Routes of Administration: Among participants who had recently consumed non-prescribed ecstasy powder and commented (n=14), almost four fifths (79%) reported snorting, followed by 43% who reported swallowing. No participants reported recent smoking.

Quantity: Of those who reported recent use and responded (n=10), the median amount of non-prescribed ecstasy powder used in a 'typical' session was 0.50 grams (IQR=0.29-0.65). Of those who reported recent use and responded (n=9), the median maximum amount of ecstasy powder used in a session was 0.50 grams (IQR=0.20-1.00).

Price, Perceived Purity and Perceived Availability

Non-Prescribed Ecstasy Pills

Price: The median price of a non-prescribed ecstasy pill in 2024 was $40 (IQR=40-50; n=13), higher than observed in 2016-2020 ($30-35), though similar to the price observed in 2014-15 (Figure 6).

Perceived Purity: Among those who responded in 2024 (n=20), 35% perceived the purity of non-prescribed ecstasy pills as being 'high', while 30% reported purity to be 'low' (Figure 8).

Perceived Availability: Among those who were able to comment in 2024 (n=19), 47% reported that non-prescribed ecstasy pills were 'difficult' to obtain (Figure 12).

Non-Prescribed Ecstasy Capsules

Price: The reported median price of an ecstasy capsule was $38 in 2024 (IQR=30-40; n=26) (Figure 6).

Perceived Purity: Among those who were able to comment in 2024 (n=34), two fifths (41%) perceived the purity of non-prescribed ecstasy capsules to be 'fluctuating' and 29% perceived purity to be 'high'. In contrast, 18% perceived purity to be 'low' (Figure 9).

Perceived Availability: Among those who responded in 2024 (n=33), almost half (48%) reported that non-prescribed ecstasy capsules were 'easy' to obtain, with a further 21% reporting 'very easy' obtainment. On the other hand, one quarter (27%) of participants reported that non-prescribed ecstasy capsules were 'difficult' to obtain (Figure 13).

Non-Prescribed Ecstasy Crystal

Price: The median price of one gram of crystal in 2024 was $300 (IQR=250-350; n=15) (Figure

7). No participants were able to comment on the price of a point of crystal in 2024.

Perceived Purity: Among those who responded in 2024 (n=19), three fifths (58%) perceived the purity of non-prescribed ecstasy crystal to be 'high' (Figure 10).

Perceived Availability: Among those who were able to comment in 2024 (n=19), 37% perceived non-prescribed ecstasy capsules as being 'easy' to obtain. In contrast, 32% reported that non-prescribed ecstasy capsules were 'difficult' to obtain (Figure 14).

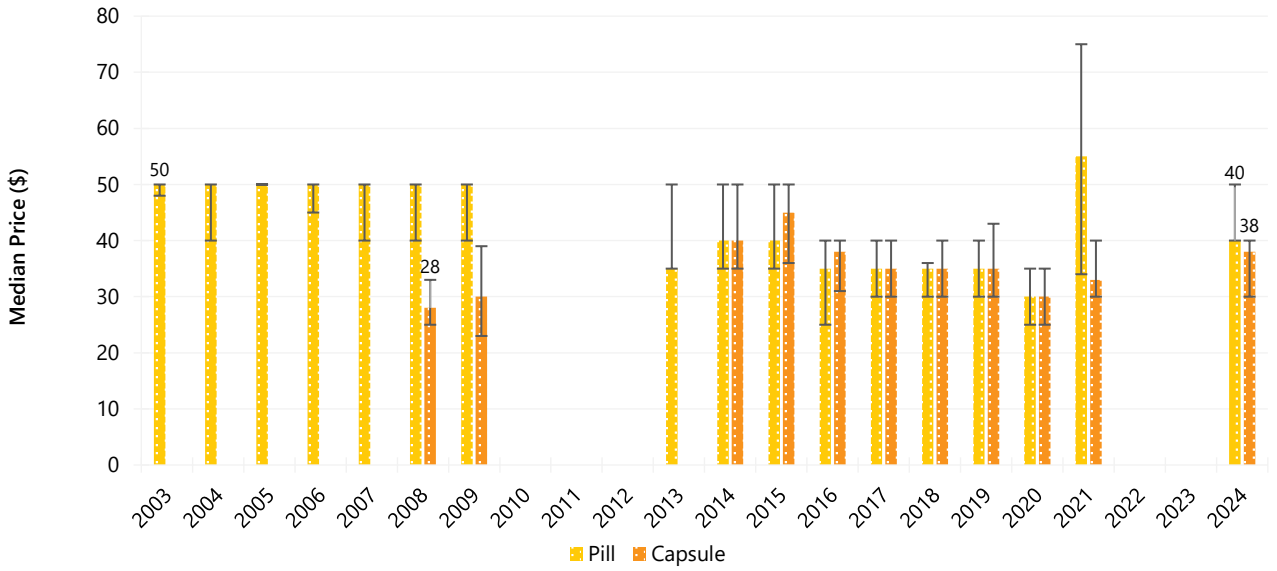
Non-Prescribed Ecstasy Powder

Price: The median price of a gram of non-prescribed ecstasy powder in 2024 was $300 (IQR=288-350; n=7). Few participants (n≤5) were able to report on the median price of a point of powder in 2024 (Figure 7).

Perceived Purity: Among those who were able to respond in 2024 (n=13), perceptions of purity were mixed (n≤5 for each of the response options) (Figure 11).

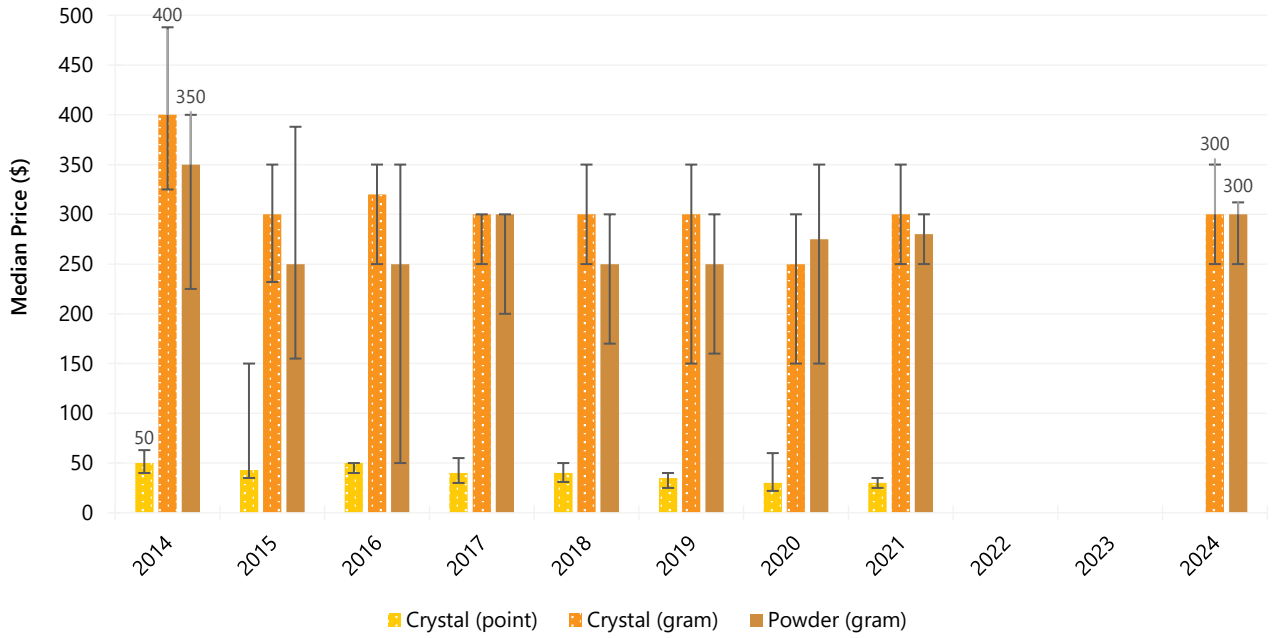
Perceived Availability: Among those who were able to respond in 2024 (n=12), half (50%) reported non-prescribed ecstasy powder as being 'easy' to obtain (Figure 15).

Figure 6: Median price of non-prescribed ecstasy pill and capsule, Darwin, NT, 2003-2024



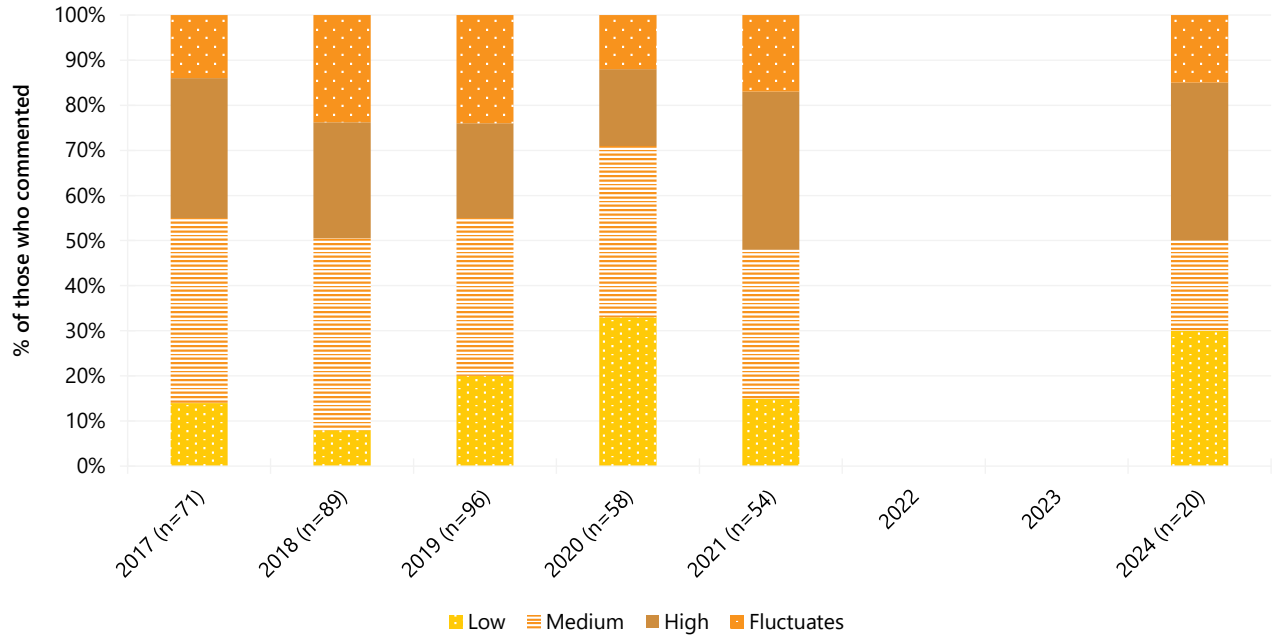
Note. Among those who commented. The error bars represent the IQR. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however data are suppressed in the figure and data tables where n≤5 responded. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Figure 7: Median price of non-prescribed ecstasy crystal (per point and gram) and powder (per gram only), Darwin, NT, 2014-2024



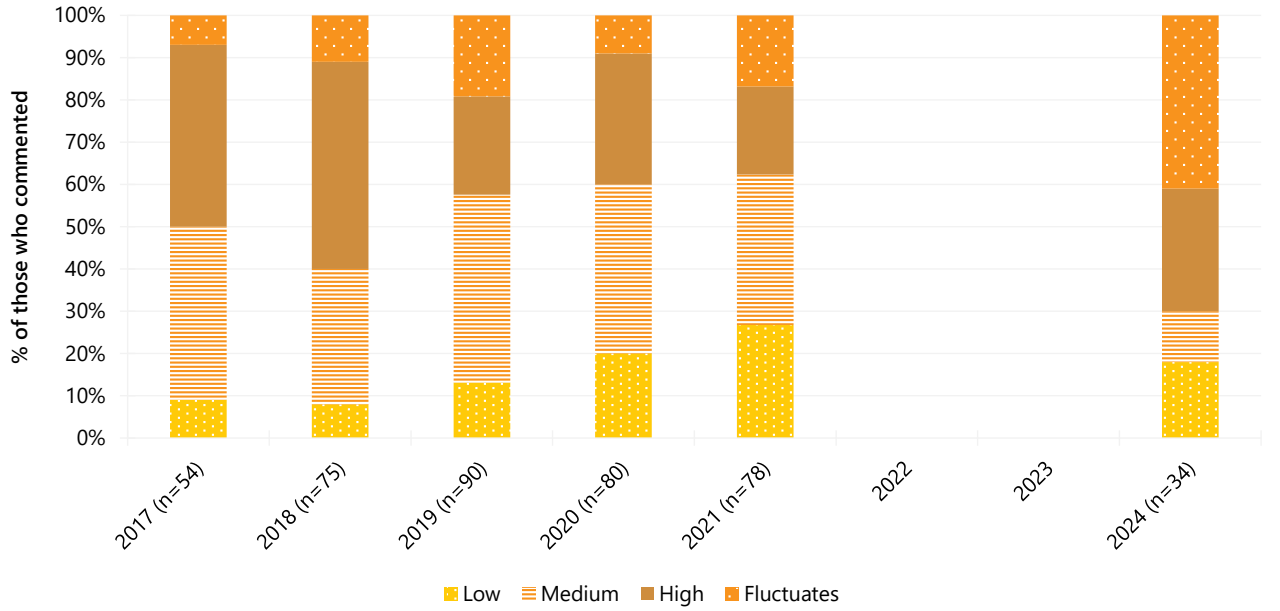
Note. Among those who commented. The error bars represent the IQR. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however data are suppressed in the figure and data tables where n≤5 responded. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Figure 8: Current perceived purity of non-prescribed ecstasy pills, Darwin, NT, 2017-2024



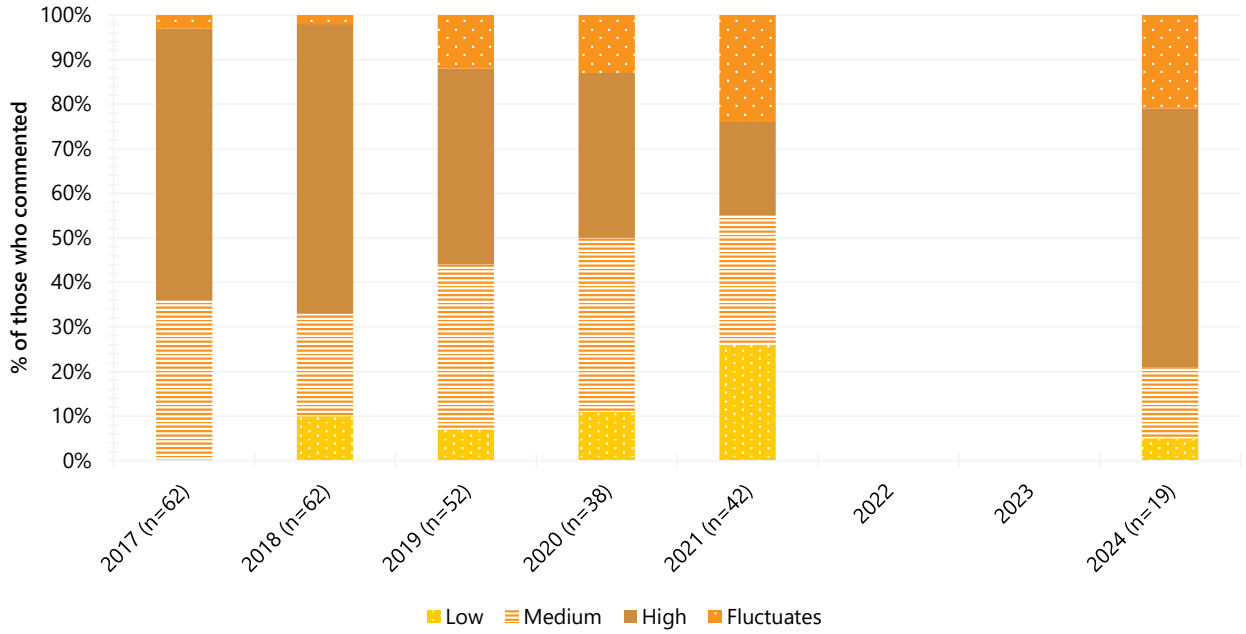
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data labels are not shown for any of 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 9: Current perceived purity of non-prescribed ecstasy capsules, Darwin, NT, 2017-2024



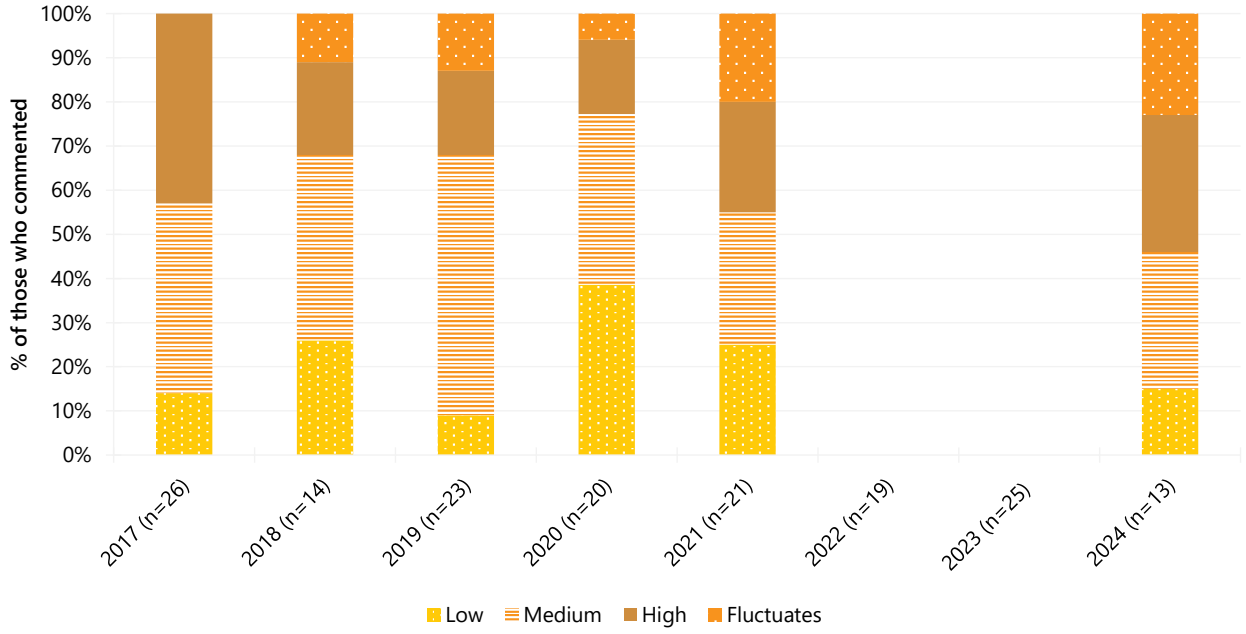
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data labels are not shown for any of 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 10: Current perceived purity of non-prescribed ecstasy crystal, Darwin, NT, 2017-2024



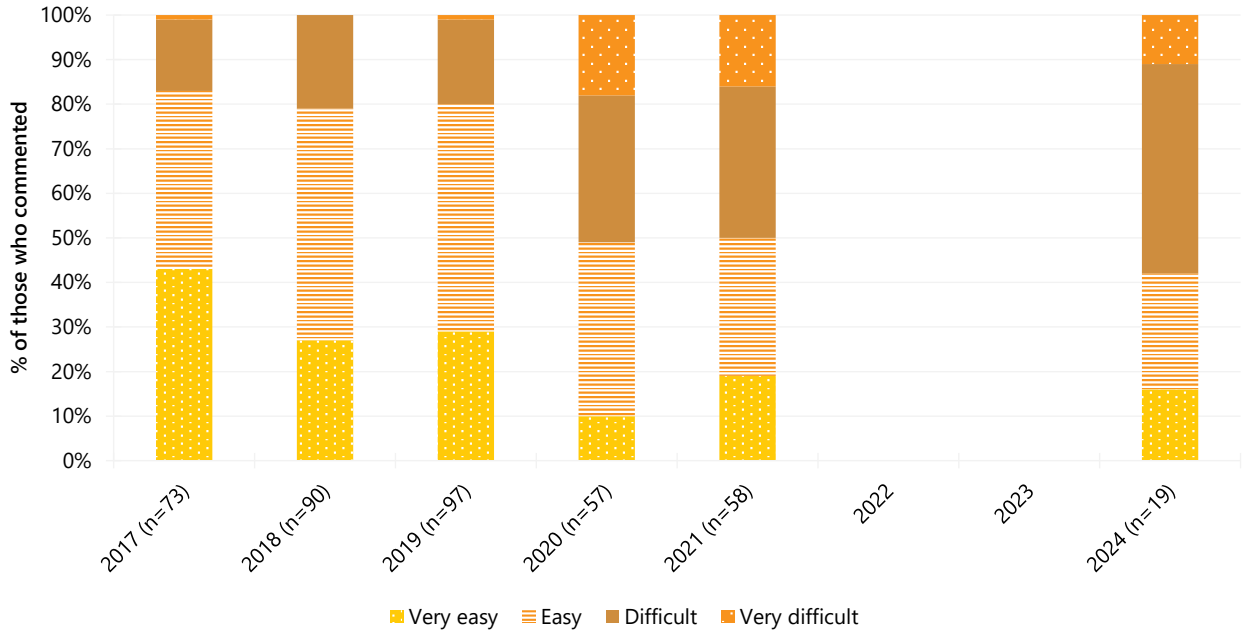
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data labels are not shown for any of 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 11: Current perceived purity of non-prescribed ecstasy powder, Darwin, NT, 2017-2024



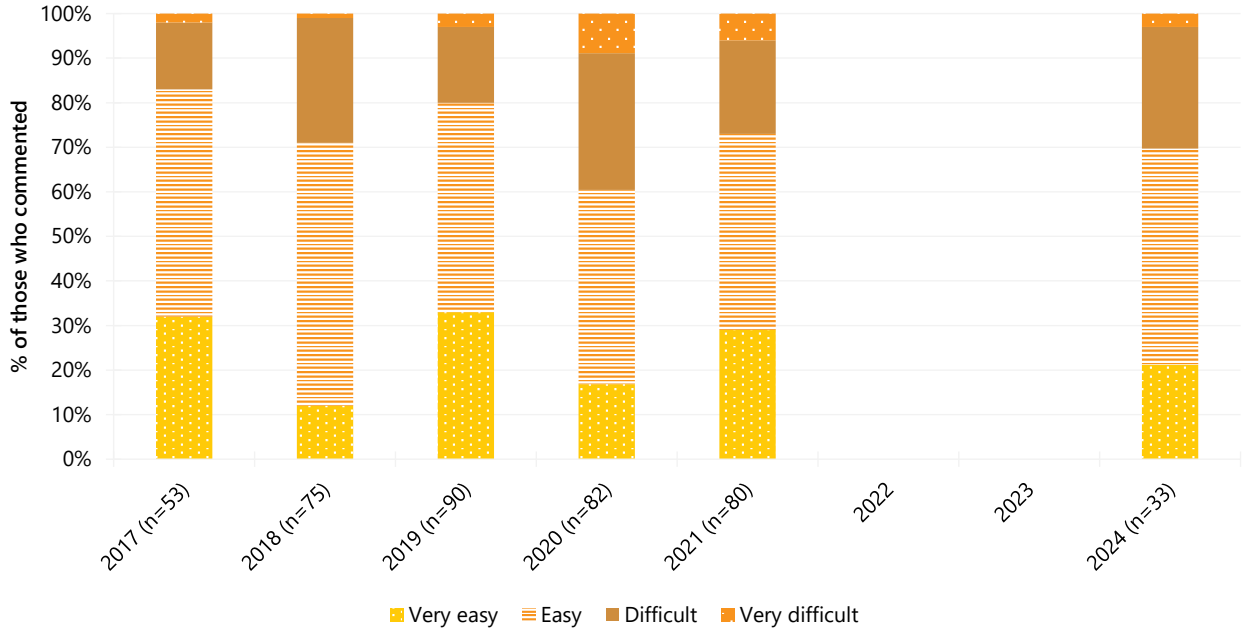
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data labels are not shown for any of 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 12: Current perceived availability of non-prescribed ecstasy pills, Darwin, NT, 2017-2024



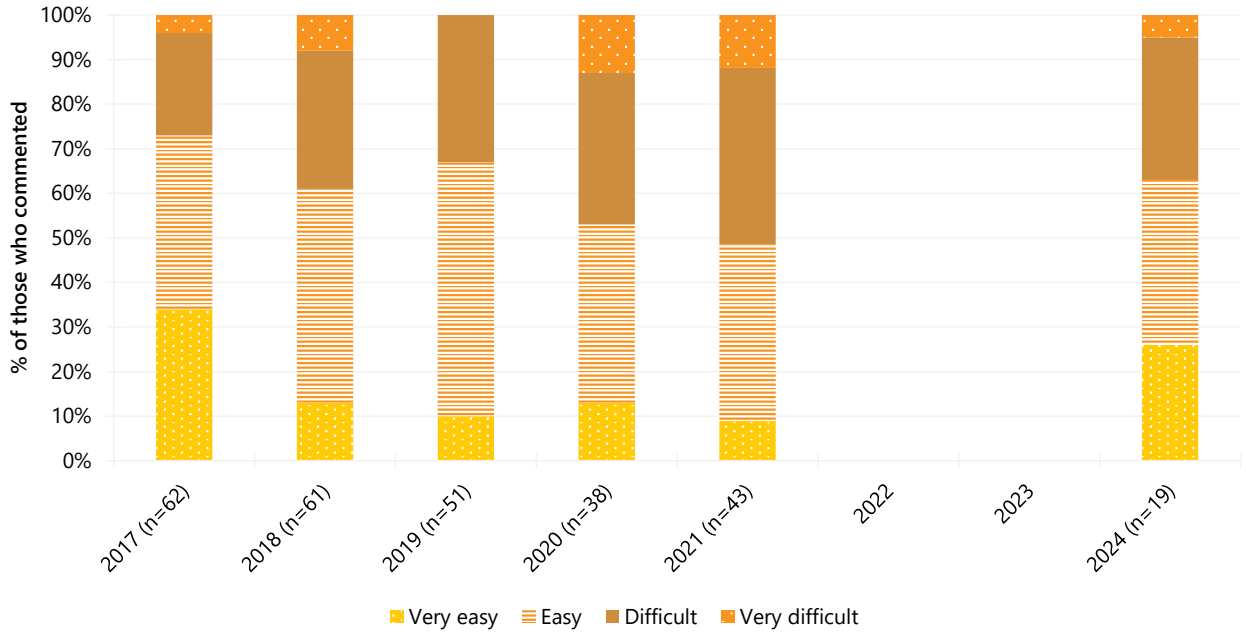
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data labels are not shown for any of 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 13: Current perceived availability of non-prescribed ecstasy capsules, Darwin, NT, 2017-2024



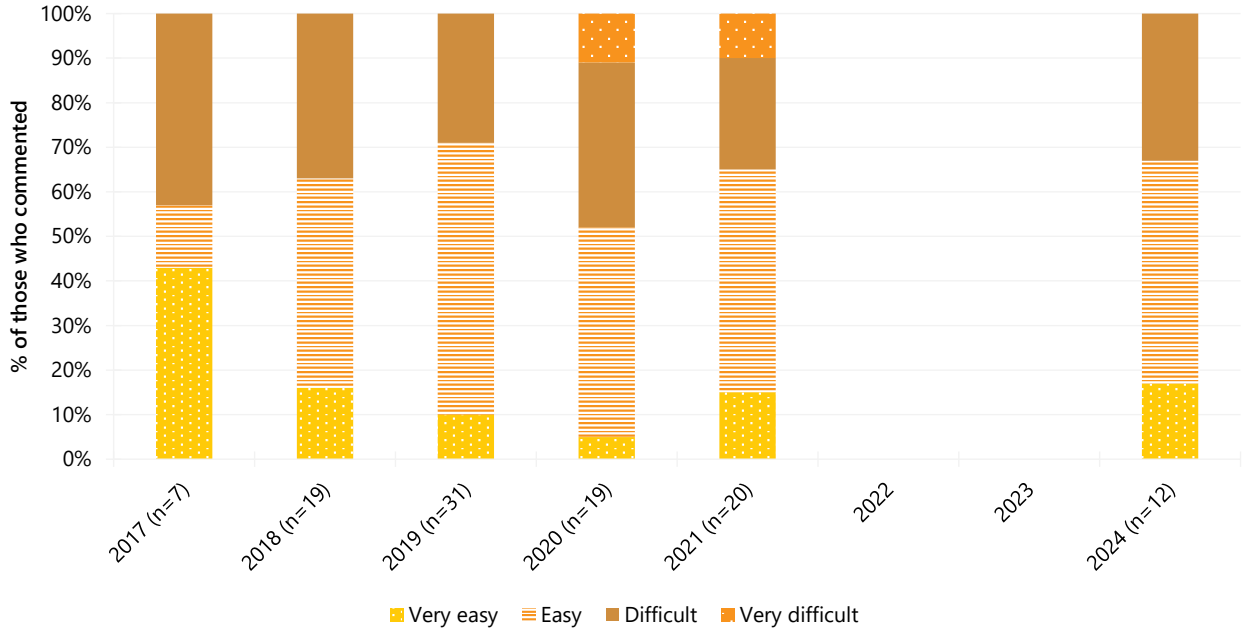
Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data labels are not shown for any of 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 14: Current perceived availability of non-prescribed ecstasy crystal, Darwin, NT, 2017-2024



Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 15: Current perceived availability of non-prescribed ecstasy powder, Darwin, NT, 2017-2024



Note. Market questions were only asked for all forms of ecstasy from 2017 onwards. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. 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. Please refer to Table 1 for a guide to table/figure notes.

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). Findings for base methamphetamine are not reported here due to small numbers reporting recent use. For further information on base methamphetamine, please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team (drugtrends@unsw.edu.au).

Patterns of Consumption (Any Methamphetamine)

Recent Use (past 6 months)

Recent use of any methamphetamine has declined since monitoring commenced (Figure 16), from more than four in five participants reporting recent use in 2003 (81%), down to one in ten (14%) in 2021. However, in 2024, two fifths (39%) of participants reported recent use of any methamphetamine in the six months preceding interview.

Frequency of Use

Median frequency of use reported by participants in the six months preceding interview was 11 days (IQR=4-72; n=20) in 2024 (Figure 17). Of those who had recently used any methamphetamine and commented (n=20), 45% reported using methamphetamine weekly or more frequently.

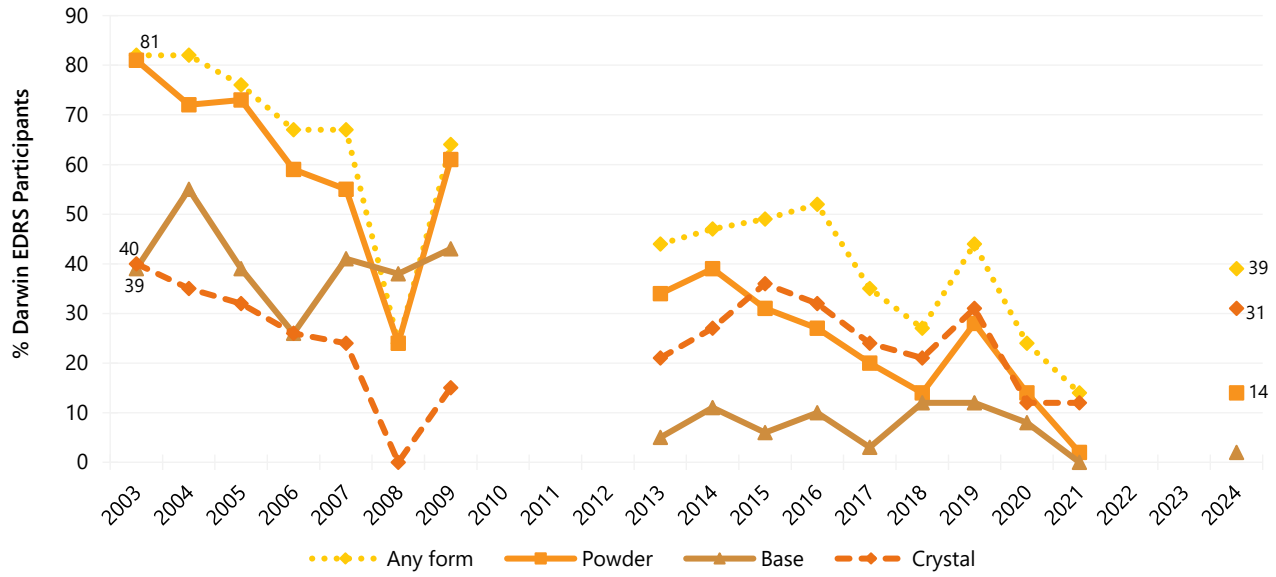
Forms Used

All forms of methamphetamine have decreased since the commencement of monitoring. Of participants who had used methamphetamine in the six months preceding interview in 2024 (n=20), most had used methamphetamine crystal (80%) followed by powder (35%). Few participants (n≤5) reported use of methamphetamine base.

Number of Forms Used

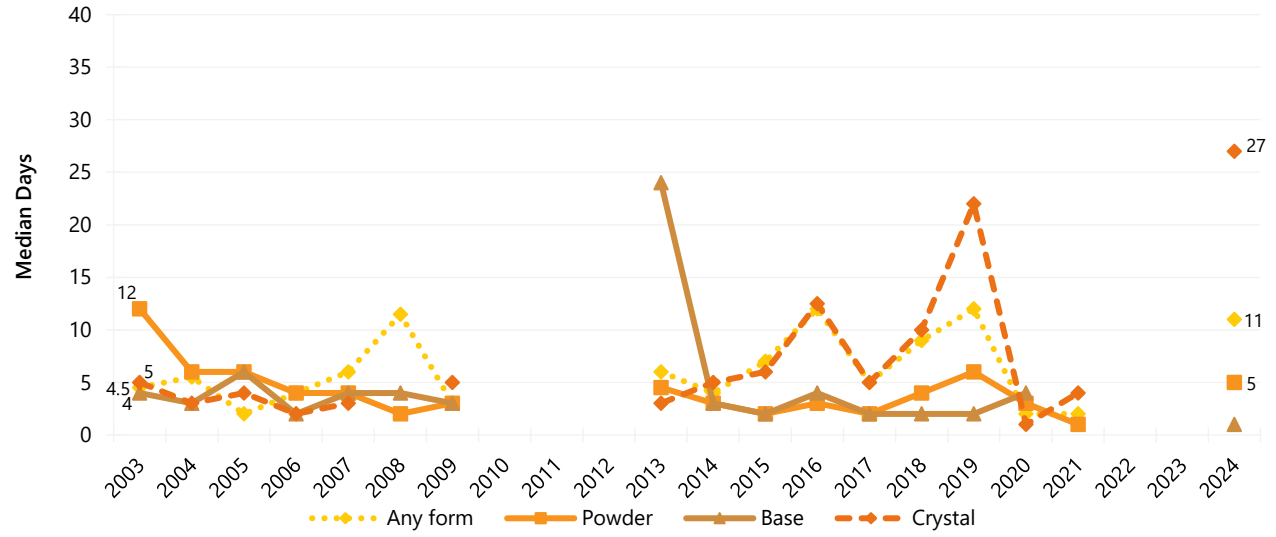
Among participants who had recently consumed any methamphetamine and commented (n=20), the median number of forms used was one (IQR=1-1).

Figure 16: Past six month use of any methamphetamine, and methamphetamine powder, base, and crystal, Darwin, NT, 2003-2024



Note. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Y axis reduced to 90% to improve visibility of trends. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Figure 17: Median days of any methamphetamine use, and methamphetamine, powder, base, and crystal use in the past six months, Darwin, NT, 2003-2024



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 40 days to improve visibility of trends. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Patterns of Consumption (by form)

Methamphetamine Powder

Recent Use (past 6 months): Fourteen per cent of participants reported recent use of methamphetamine powder in the six months preceding interview (Figure 16).

Frequency of Use: Among those who had recently consumed methamphetamine powder and commented (n=7), participants reported use on a median of five days (IQR=2-7) in 2024 (Figure 17). Few participants (n≤5) reported weekly or more frequent use of powder.

Routes of Administration: In 2024, few participants (n≤5) were able to comment on any specific route of administration.

Quantity: Few participants (n≤5) were able to report on the median amount of methamphetamine powder used in a 'typical' session, as well as the maximum amount of methamphetamine powder used in a session in 2024.

Methamphetamine Crystal

Recent Use (past 6 months): From 2015 to 2024, methamphetamine crystal has consistently been the most common form of methamphetamine reported by participants. In 2024, almost one third (31%) of participants reported use of methamphetamine crystal in the six months preceding interview (Figure 16).

Frequency of Use: Of those who had recently consumed crystal and commented (n=16), participants reported use on a median of 27 days (IQR=9-75) in 2024 (Figure 17). Half (50%) of participants who had recently used methamphetamine crystal reported weekly or more frequent use in 2024.

Routes of Administration: Among participants who had recently consumed methamphetamine crystal and commented (n=16), smoking remained the most common route of administration, with 94% reporting this method in 2024. Few participants (n≤5) reported swallowing, snorting or injecting methamphetamine crystal in 2024.

Quantity: Of those who reported recent use and responded (n=16), the median amount of methamphetamine crystal used in a 'typical' session was 0.18 grams (IQR=0.10-0.77). Of those who reported recent use and responded (n=16), the median maximum amount of methamphetamine crystal used in a session was 0.50 grams (IQR=0.10-1.10).

Price, Perceived Purity and Perceived Availability

Methamphetamine Powder

Due to low numbers reporting (n≤5), further details on the price (Figure 18), perceived purity (Figure 20) and perceived availability (Figure 22) of methamphetamine powder are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

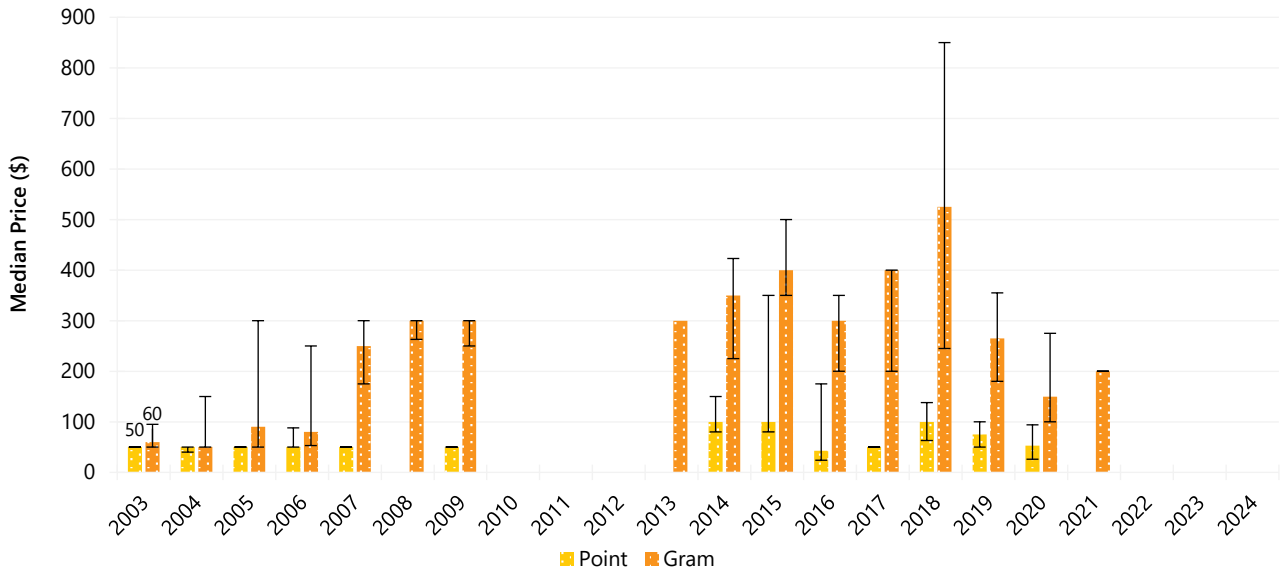
Methamphetamine Crystal

Price: The median price for one gram of methamphetamine crystal in 2024 was $600 (IQR=475-675; n=7), while the median price for a point was $100 (IQR=100-100; n=6) (Figure 19).

Perceived Purity: Among those who were able to comment in 2024 (n=15), two fifths (40%) reported purity as 'fluctuating' (Figure 21).

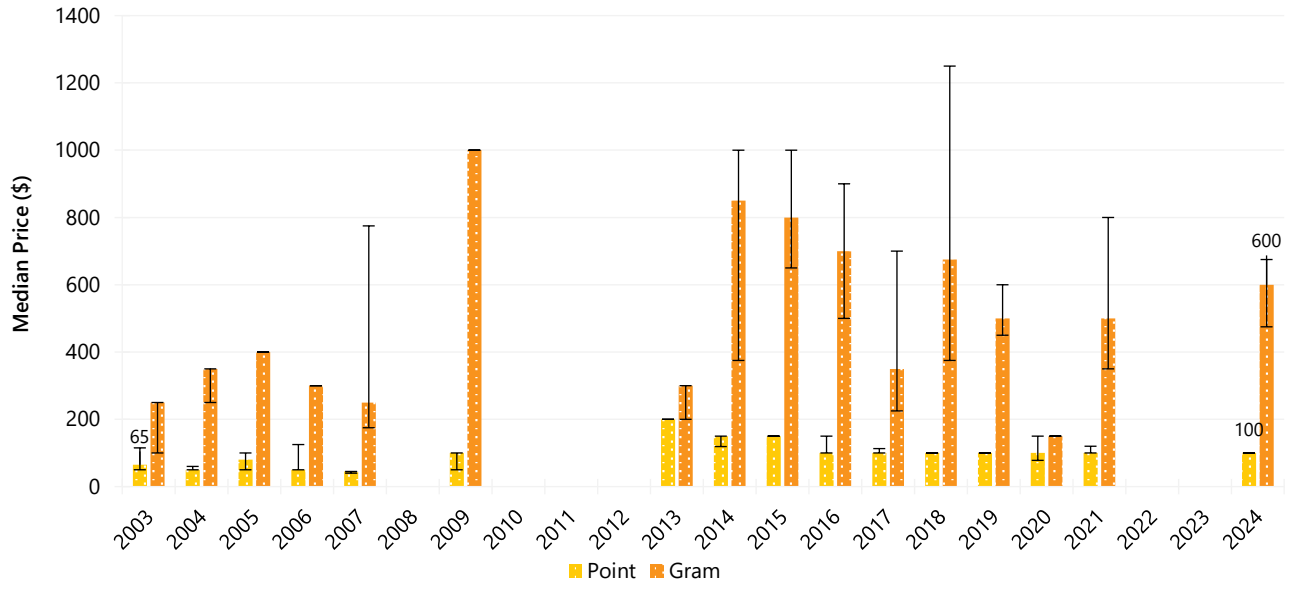
Perceived Availability: Among those who responded in 2024 (n=16), 44% reported availability as 'very easy' (Figure 23).

Figure 18: Median price of methamphetamine powder per point and gram, Darwin, NT, 2003-2024



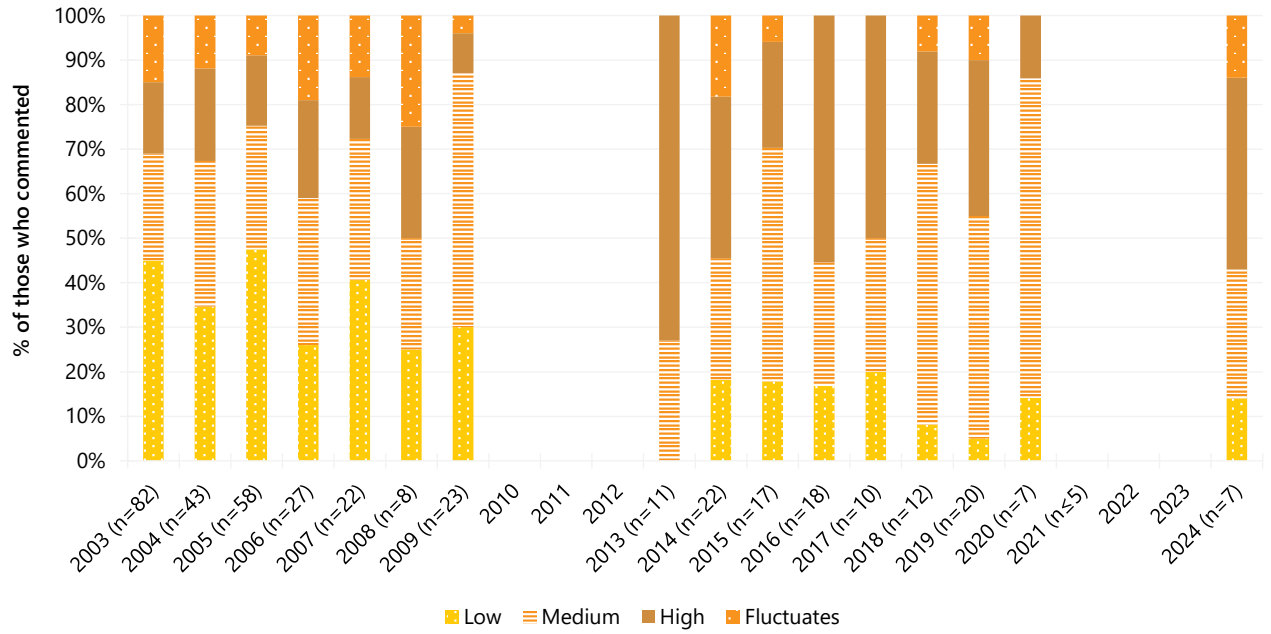
Note. Among those who commented. The error bars represent the IQR. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however data are suppressed in the figure and data tables where n≤5 responded. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Figure 19: Median price of methamphetamine crystal per point and gram, Darwin, NT, 2003-2024



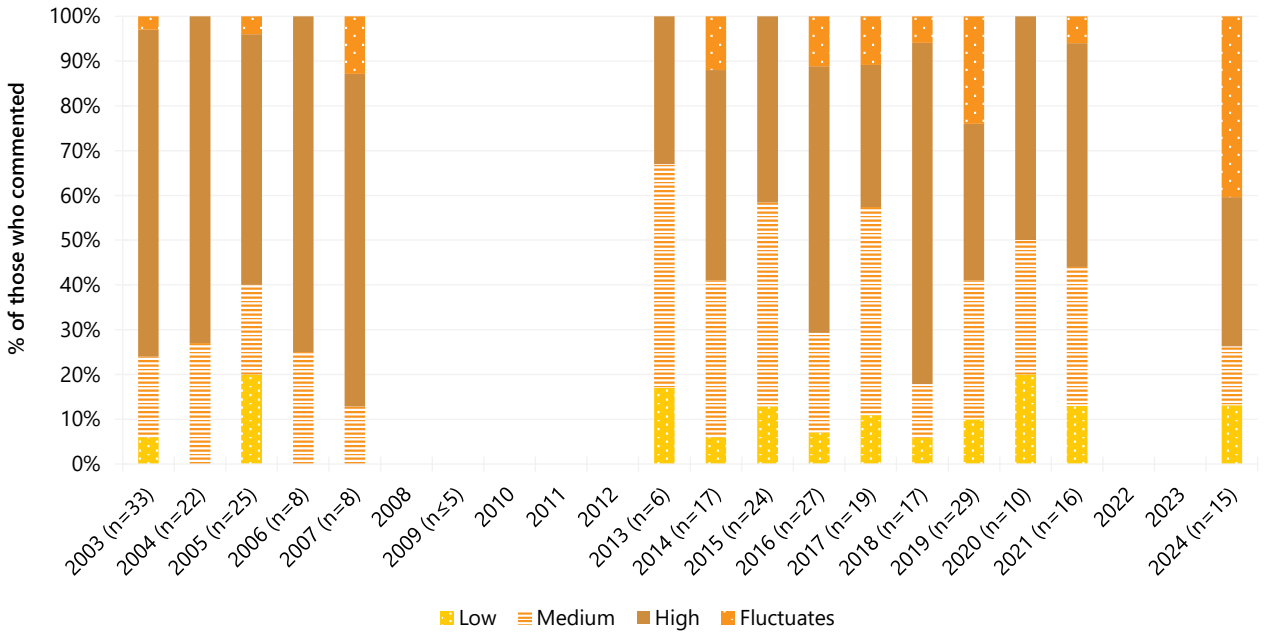
Note. Among those who commented. The error bars represent the IQR. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however data are suppressed in the figure and data tables where n≤5 responded. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Figure 20: Current perceived purity of methamphetamine powder, Darwin, NT, 2003-2024



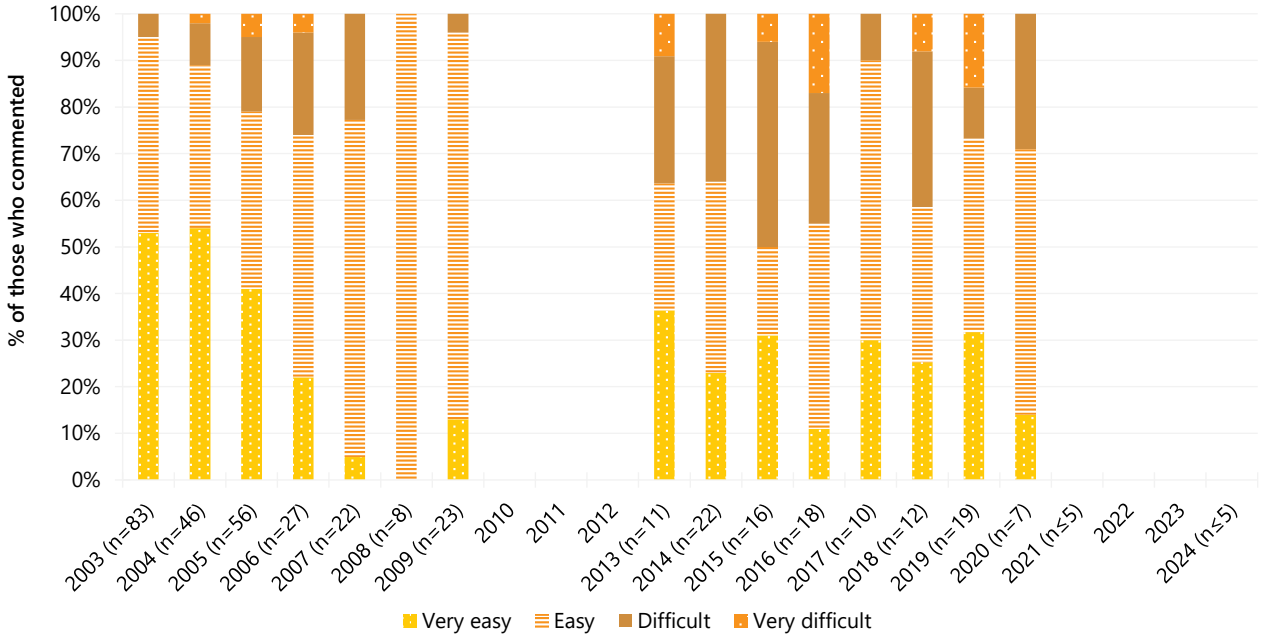
Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

Figure 21: Current perceived purity of methamphetamine crystal, Darwin, NT, 2003-2024



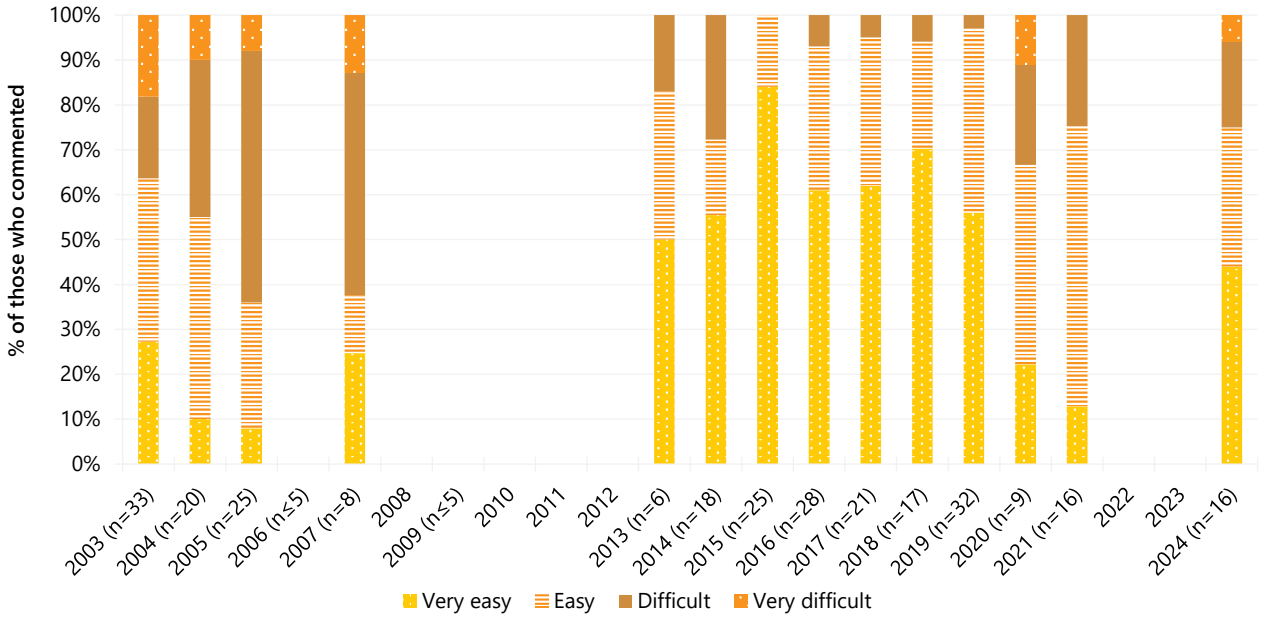
Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

Figure 22: Current perceived availability of methamphetamine powder, Darwin, NT, 2003-2024



Note. 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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

Figure 23: Current perceived availability of methamphetamine crystal, Darwin, NT, 2003-2024



Note. 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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

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 (ADHD) 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 8% in 2007 to 39% in 2024, signifying the highest percentage of use since monitoring commenced (Figure 24).

Frequency of Use

Frequency of use is also at its highest level since monitoring commenced, at a median of five days in the six months prior to interview in 2024 (IQR=3-13; n=20) (Figure 24).

Routes of Administration

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=20), the vast majority reported swallowing as a route of administration (95%), with few participants (n≤5) reporting snorting.

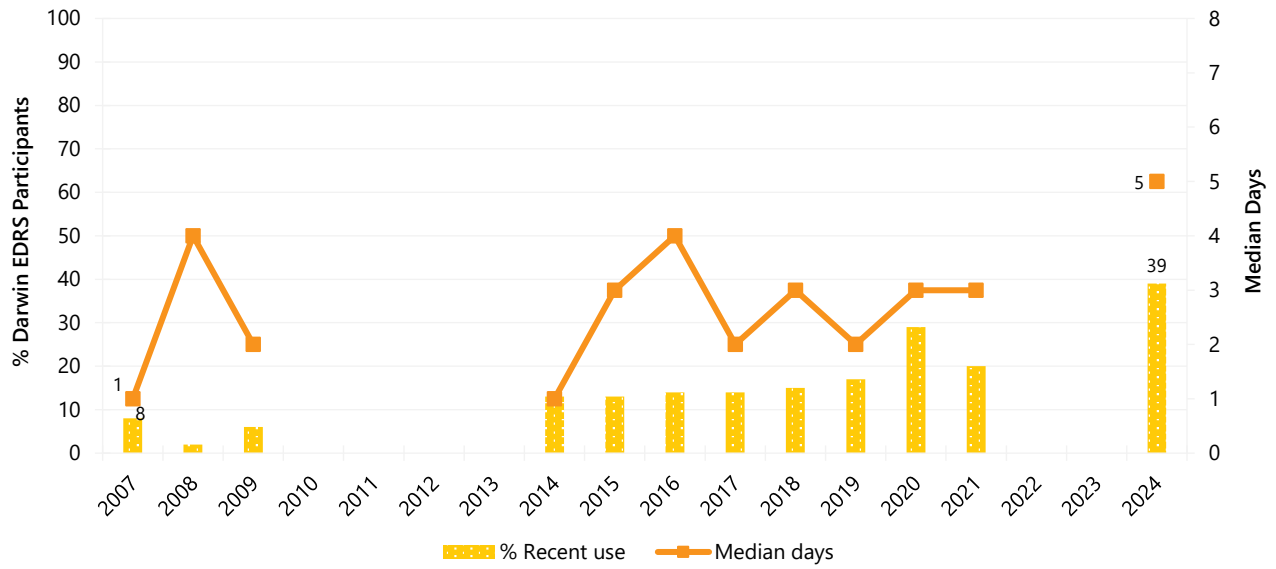
Quantity

Among those who reported recent use and responded (n=19), the median amount used in a 'typical' session was two pills/tablets (IQR=1.3-3.5). Of those who reported recent use and responded (n=19), the median maximum amount used in a session was two pills/tablets (IQR=2.0–3.5).

Forms Used

Among participants who had recently consumed non-prescribed pharmaceutical stimulants and commented (n=20), three fifths (60%) reported using dexamphetamine in 2024. Few participants (n≤5) reported use of other brands.

Figure 24: Past six month use and frequency of use of non-prescribed pharmaceutical stimulants, Darwin, NT, 2007-2024



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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Secondary Y axis reduced to 8 days to improve visibility of trends. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Price and Perceived Availability

Price and availability data for non-prescribed pharmaceutical stimulants have been collected from 2022 onwards.

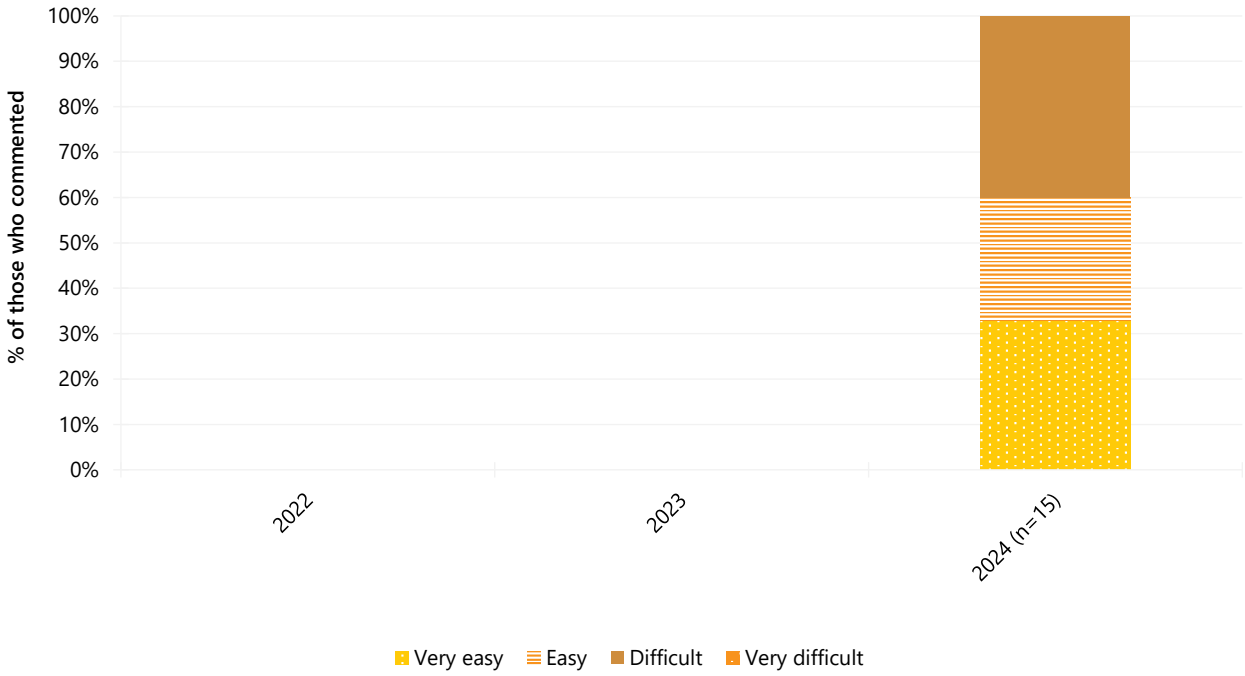
Price

Few participants (n≤5) were able to comment on the price per 5mg, 10mg or 20mg tablet.

Perceived Availability

Among those who responded in 2024 (n=15), two fifths (40%) perceived non-prescribed pharmaceutical stimulants to be 'difficult' to obtain (Figure 25).

Figure 25: Current perceived availability of non-prescribed pharmaceutical stimulants, Darwin, NT, 2022-2024



Note. 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. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

5

Cocaine

Participants were asked about their recent (past six month) use of various forms of cocaine, including powder and crack/rock 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)

The per cent reporting any recent cocaine use has increased, from few participants (n≤5) in 2003 to 78% in 2024, signifying the highest percentage of use since monitoring commenced (Figure 26).

Frequency of Use

Of those who had recently consumed cocaine and commented (n=40), participants reported a median of five days (IQR=3-12) of use in the six months preceding interview in 2024 (Figure 26). Fifteen per cent of those who had recently used cocaine reported weekly or more frequent use.

Routes of Administration

Among participants who had recently consumed cocaine and commented (n=40), 95% reported snorting as a route of administration, followed by 23% who reported swallowing. Few participants (n≤5) reported smoking.

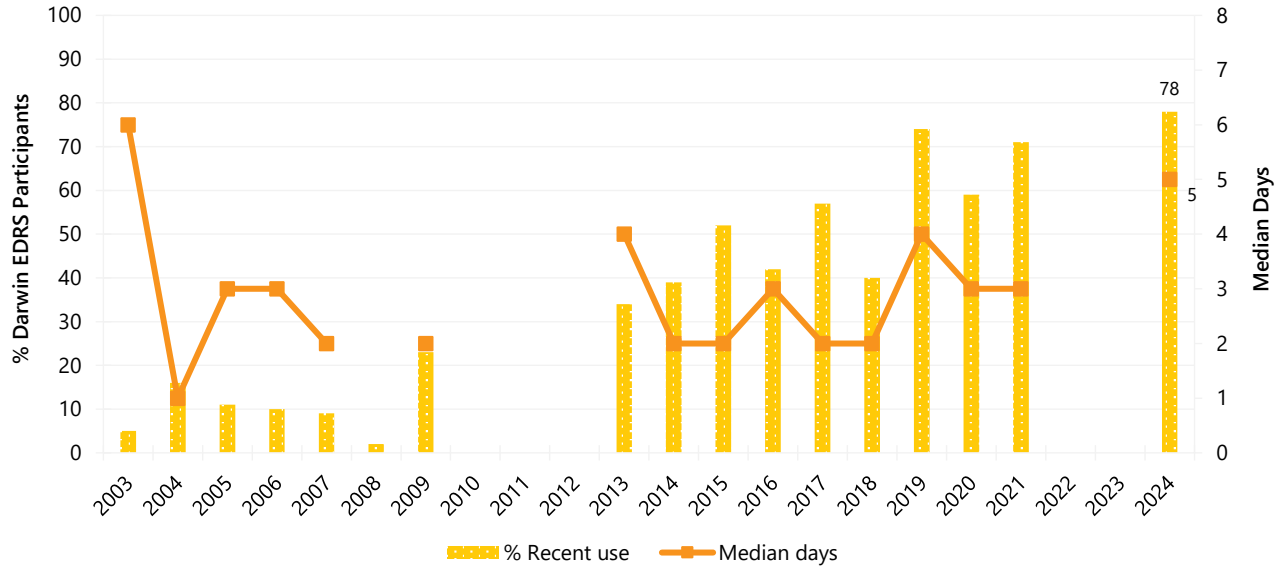
Quantity

Of those who reported recent use and responded (n=25), the median amount of cocaine used in a 'typical' session was 0.50 grams (IQR=0.40-1.00). Of those who reported recent use and responded (n=26), the median maximum amount of cocaine used in a session was one gram (IQR=0.50-2.75).

Forms Used

Among participants who had recently consumed cocaine and commented (n=40) the majority of participants reported using powder cocaine (93%). Few participants (n≤5) reported the use of crack/rock cocaine or other cocaine.

Figure 26: Past six month use and frequency of use of cocaine, Darwin, NT, 2003-2024



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Secondary Y axis reduced to 8 days to improve visibility of trends for days of use. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Price, Perceived Purity and Perceived Availability

Price

The median price per gram of cocaine was $375 in 2024 (IQR=350-400; n=22) (Figure 27).

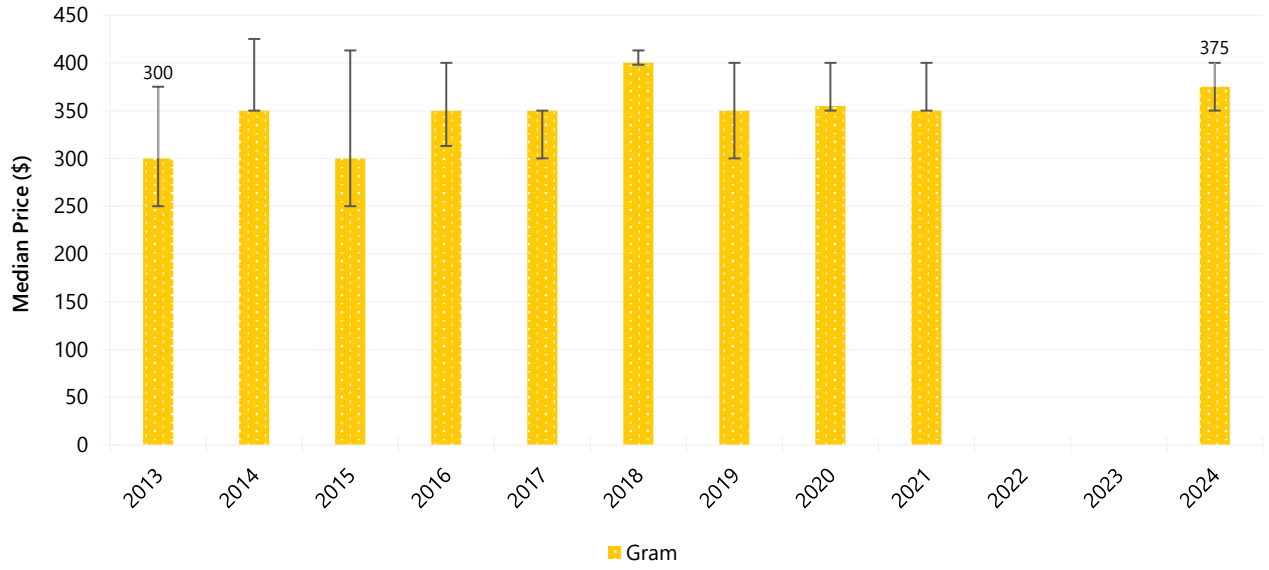
Perceived Purity

Among those who were able to respond in 2024 (n=35), almost one third (31%) perceived purity to be 'medium', whilst equal percentages reported purity to be 'low' or 'fluctuating' (29%, respectively) (Figure 28).

Perceived Availability

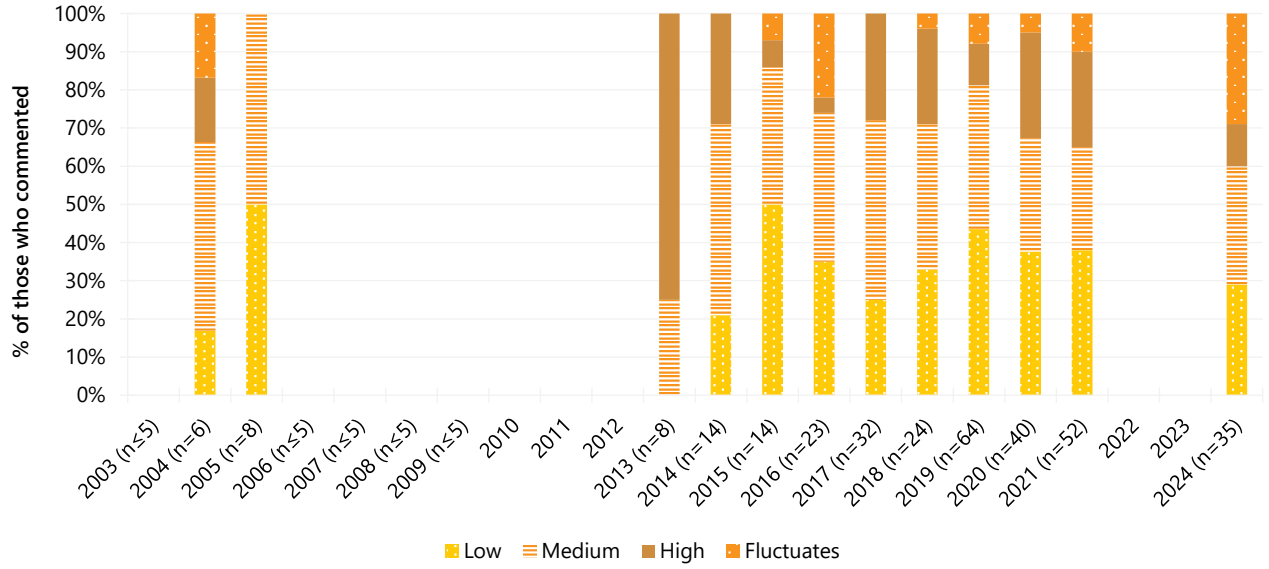
Among those who were able to comment in 2024 (n=33), 39% perceived cocaine to be 'easy' to obtain and a further one quarter (24%) of participants perceived cocaine to be 'very easy' to obtain. In contrast, 30% perceived cocaine to be 'difficult' to obtain (Figure 29).

Figure 27: Median price of cocaine per gram, Darwin, NT, 2013-2024



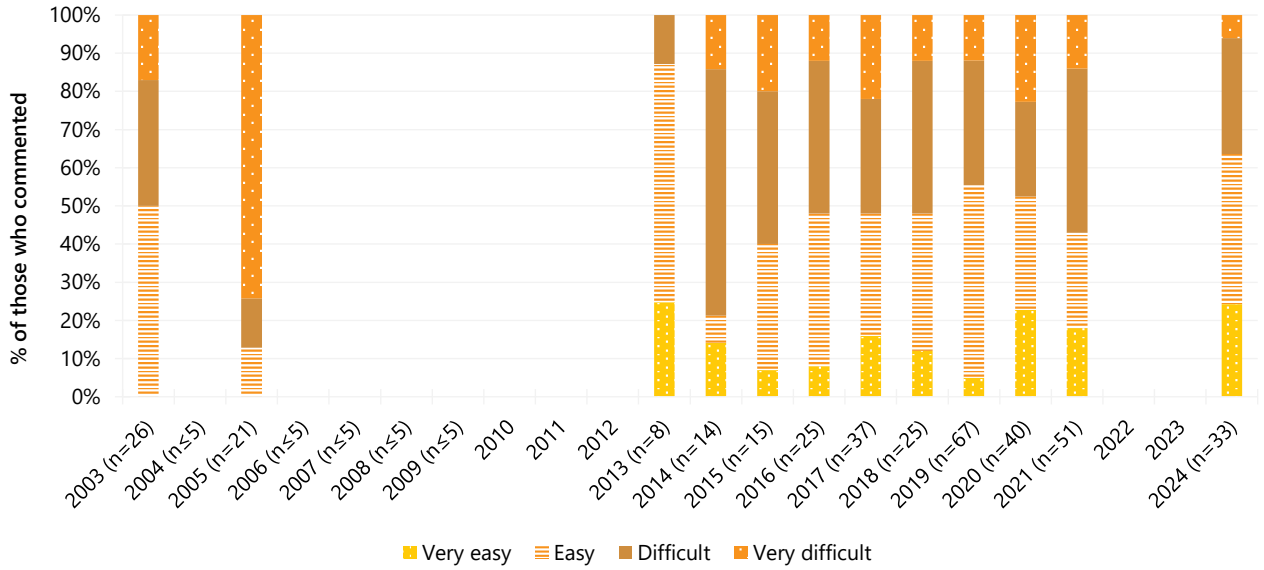
Note. Among those who commented. The error bars represent the IQR. Prices are not reported prior to 2013 due to small numbers commenting. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however data are suppressed in the figure and data tables where n≤5 responded. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Figure 28: Current perceived purity of cocaine, Darwin, NT, 2003-2024



Note. 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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

Figure 29: Current perceived availability of cocaine, Darwin, NT, 2003-2024



Note. 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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

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

Participants were asked about their use of both prescribed and non-prescribed cannabis and/or cannabinoid-related products. One fifth (22%) of the Darwin sample reported prescribed use in the six months preceding interview in 2024.

In the remainder of this chapter, data from 2021-2024, 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, hashish and hash oil). While comparison between 2021-2024 and previous years should be treated with caution, the relatively recent legalisation of medicinal cannabis in Australia lends confidence that estimates are relatively comparable.

Recent Use (past 6 months)

Two thirds (69%) of the Darwin sample reported recent use of non-prescribed cannabis and/or cannabinoid-related products in the six months preceding interview in 2024 (Figure 30).

Frequency of Use

Median frequency of use has fluctuated over the course of monitoring. Of those who had recently consumed non-prescribed cannabis and/or cannabinoid related products and commented (n=35), participants reported a median of 48 days (IQR=5-180) of use in the six months preceding interview (Figure 30). Three fifths (60%) of those who had recently used non-prescribed cannabis and/or cannabinoid-related products reported weekly or more frequent use, including 29% who reported daily use.

Routes of Administration

Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and commented (n=35), four fifths (80%) reported smoking, and one third (34%) reported inhaling/vaporising. A further one quarter (23%) reported swallowing.

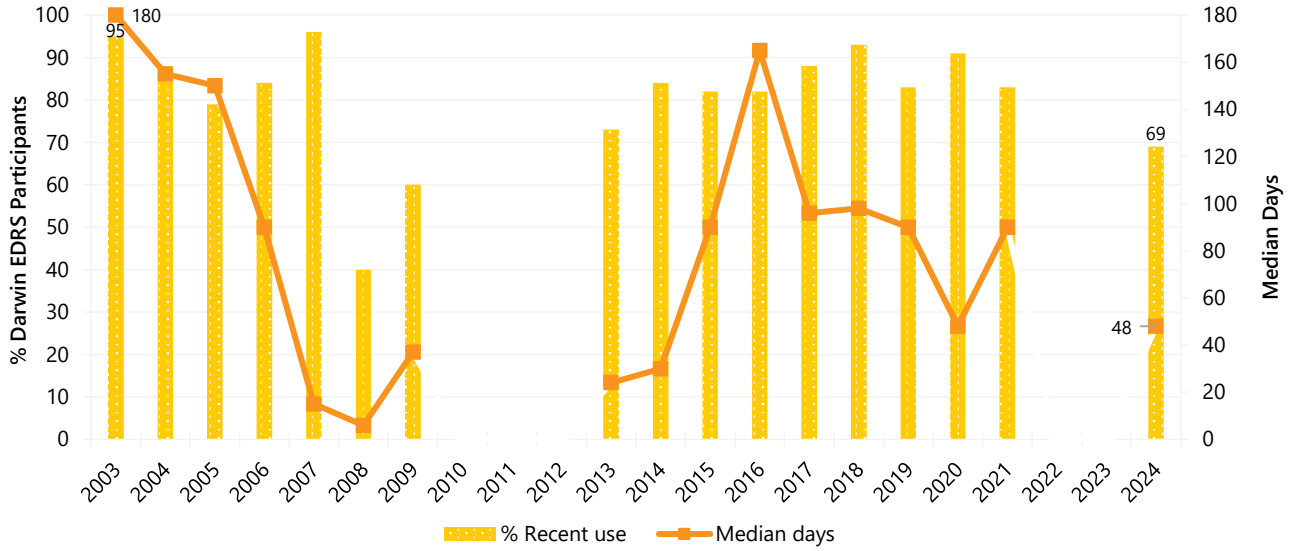
Quantity

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=1-3; n=13), one gram (IQR=1.00-3.25; n=6) or one joint (IQR=0.8-1; n=7).

Forms Used

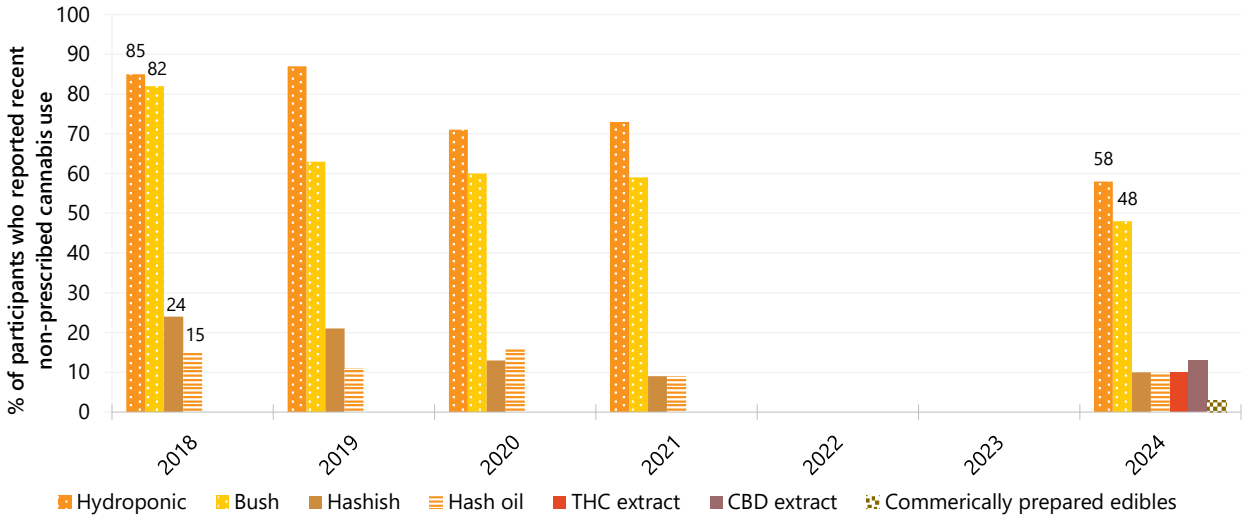
Among participants who had recently consumed non-prescribed cannabis and/or cannabinoid-related products and responded (n=31), the majority reported recent use of hydroponic cannabis (58%), followed by outdoor grown 'bush' cannabis (48%). Few participants (n≤5) reported recent use of other forms of cannabis and/or cannabinoid-related products, including hashish, hash oil, CBD extract, THC extract or commercially prepared edibles (Figure 31). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 30: Past six month use and frequency of use of non-prescribed cannabis and/or cannabinoid-related products, Darwin, NT, 2003-2024



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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 31: Past six month use of different forms of non-prescribed cannabis and/or cannabinoid-related products, among those who reported recent use, Darwin, NT, 2018-2024



Note. Prior to 2021, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2018-2020 figures include some participants who were using prescribed forms of cannabis (with medicinal cannabis first legalised in Australia in November 2016), although we anticipate these numbers would be very low. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data labels are only provided for the first and two most recent years 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. Please refer to Table 1 for a guide to table/figure notes.

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, however, few participants (n≤5) were able to comment in 2024. The median price per gram of non-prescribed hydroponic cannabis was $30 (IQR=25-30) (Figure 32A).

Perceived Potency: Among those who were able to respond in 2024 (n=22), 55% perceived non-prescribed hydroponic cannabis to be of 'high' potency (Figure 33A).

Perceived Availability: Among those who were able to respond in 2024 (n=21), three fifths (62%) perceived non-prescribed hydroponic cannabis to be 'very easy' to obtain and one third (33%) perceived it to be 'easy' to obtain (Figure 34A).

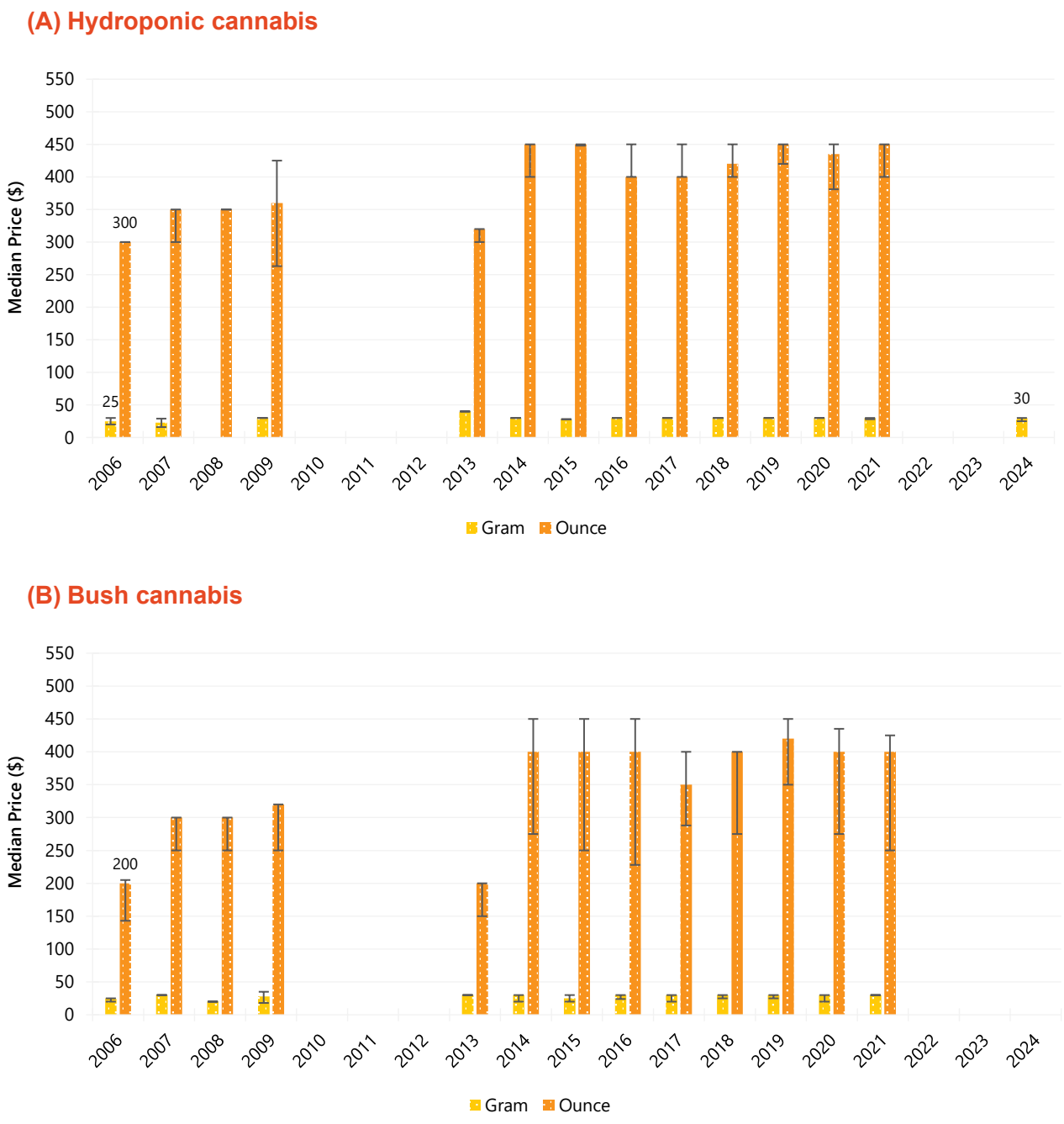
Bush Cannabis

Price: Due to low numbers reporting (n≤5), further details are not reported on the price per ounce or gram of non-prescribed bush cannabis (Figure 32B). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Perceived Potency: Among those who were able to respond in 2024 (n=11), perceptions of potency were mixed (n≤5 for each of the response options) (Figure 33B). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

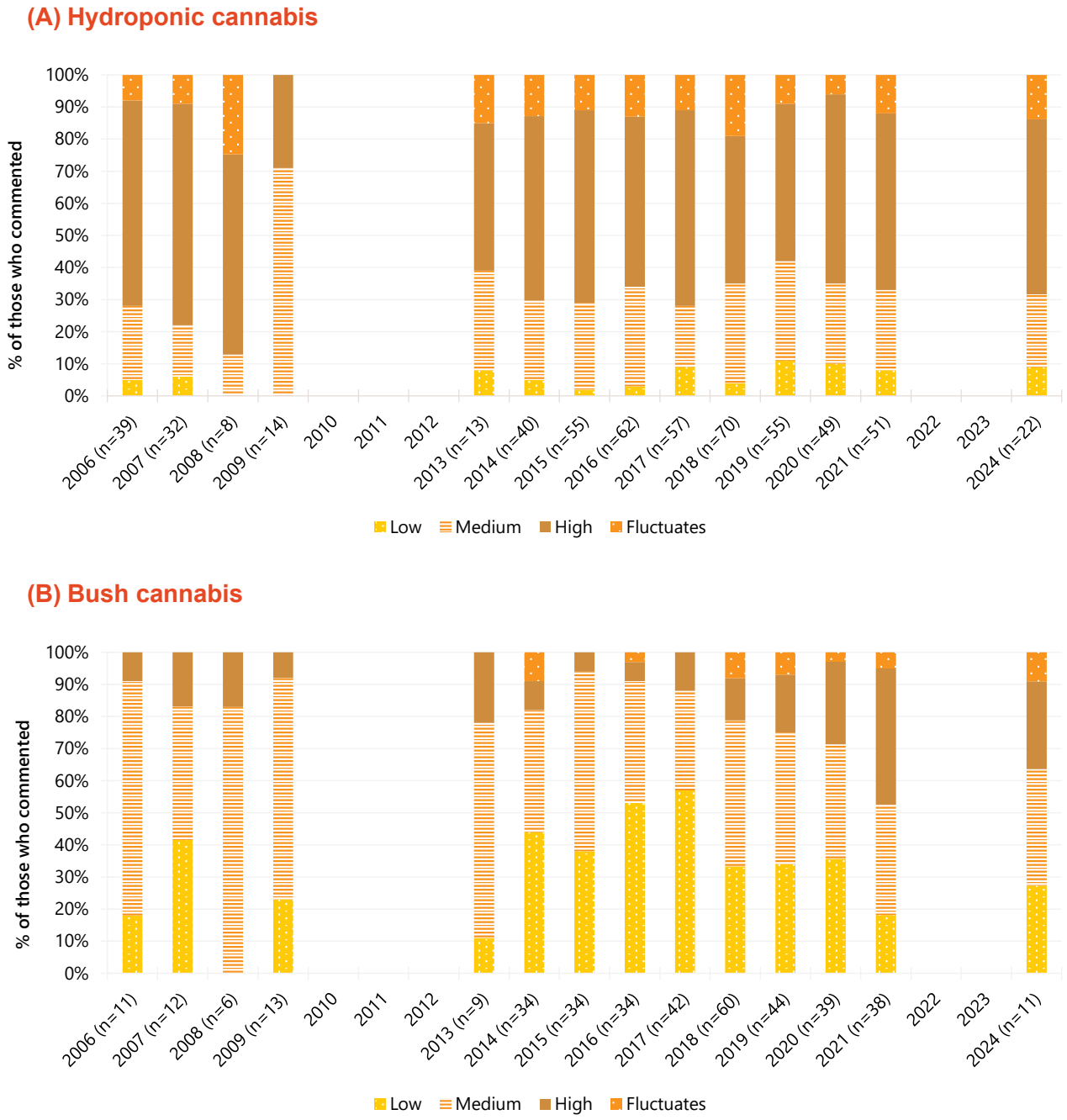
Perceived Availability: Among those who were able to respond in 2024 (n=10), three fifths (60%) perceived non-prescribed bush cannabis to be 'very easy' to obtain (Figure 34B).

Figure 32: Median price of non-prescribed hydroponic (A) and bush (B) cannabis per ounce and gram, Darwin, NT, 2006-2024



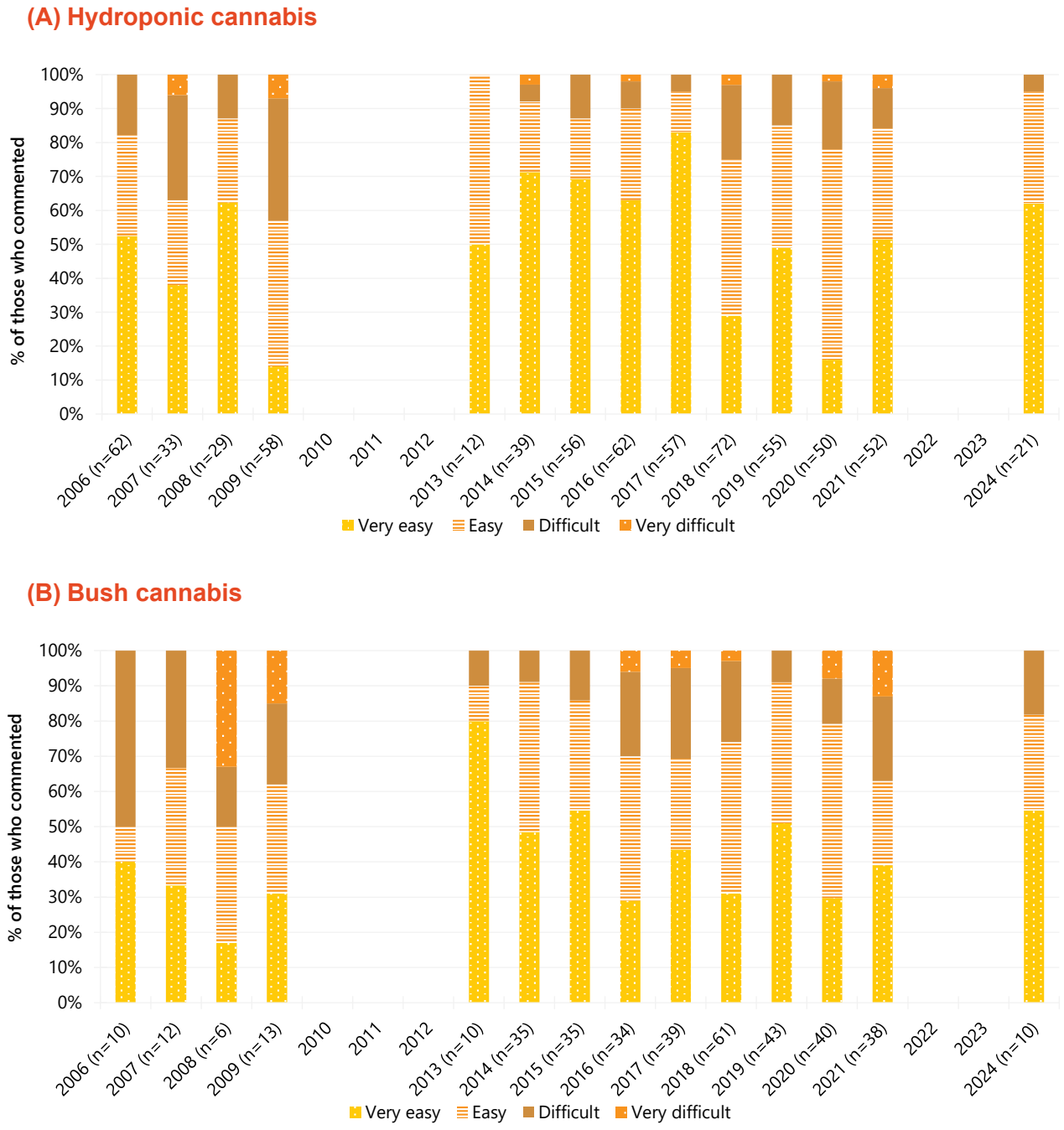
Note. From 2006 onwards hydroponic and bush cannabis data collected separately. Data from 2022 onwards refers to non-prescribed cannabis only; prior to 2022, we did not distinguish between prescribed and non-prescribed cannabis, and as such it is possible that 2017-2021 figures include some participants 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. The error bars represent the IQR. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however data are suppressed in the figure and data tables where n≤5 responded. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Figure 33: Current perceived potency of non-prescribed hydroponic (A) and bush (B) cannabis, Darwin, NT, 2006-2024



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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 34: Current perceived availability of non-prescribed hydroponic (A) and bush (B) cannabis, Darwin, NT, 2006-2024



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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. 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. Please refer to Table 1 for a guide to table/figure notes.

7

Ketamine, LSD and DMT

Non-Prescribed Ketamine

Patterns of Consumption

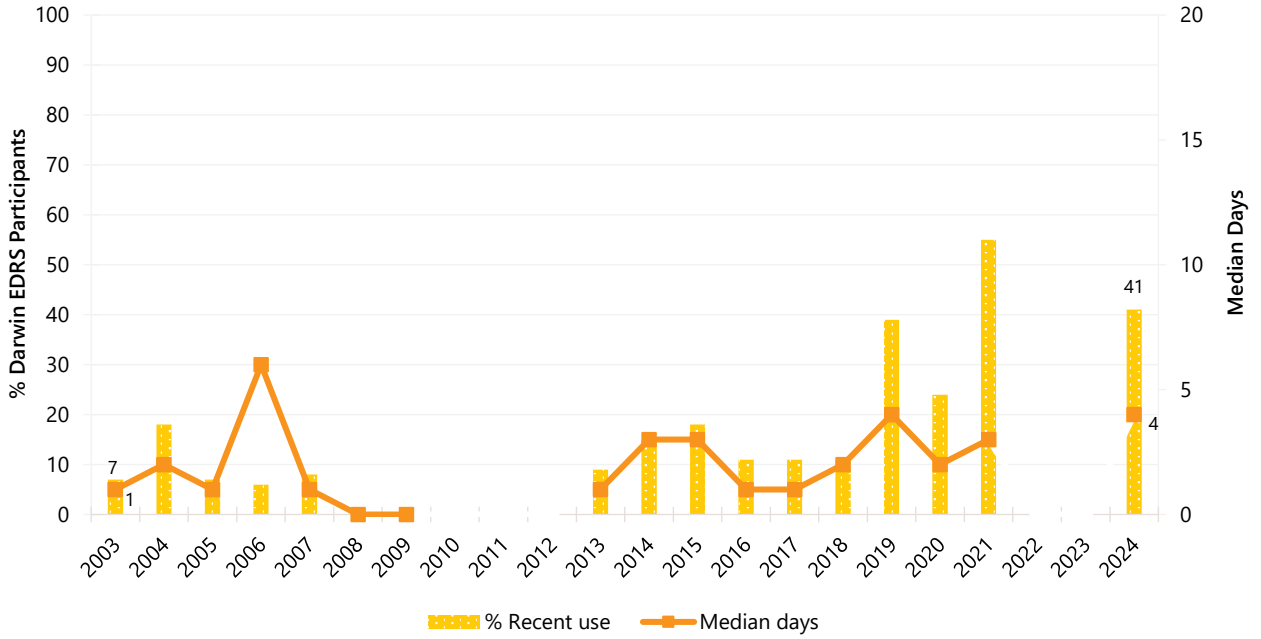
Recent Use (past 6 months): Two fifths (41%) of the Darwin sample reported using non-prescribed ketamine in the six months prior to interview in 2024 (Figure 35).

Frequency of Use: Of those who had recently consumed non-prescribed ketamine and commented (n=21), participants reported a median of four days (IQR=1-7) of use in the six months preceding interview (Figure 35). Few participants (n≤5) reported weekly or more frequent use in 2024.

Routes of Administration: Among participants who had recently consumed non-prescribed ketamine and commented (n=21), the majority (90%) of participants reported snorting.

Quantity: Of those who reported recent use and responded (n=14), the median amount of non-prescribed ketamine used in a 'typical' session was 0.45 grams (IQR=0.26-0.50). Of those who reported recent use and responded (n=14), the median maximum amount of non-prescribed ketamine used in a session was 0.50 grams (IQR=0.50-0.95).

Figure 35: Past six month use and frequency of use of non-prescribed ketamine, Darwin, NT, 2003-2024



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). 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 become available via prescription, for treatment resistant depression, in 2021). For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

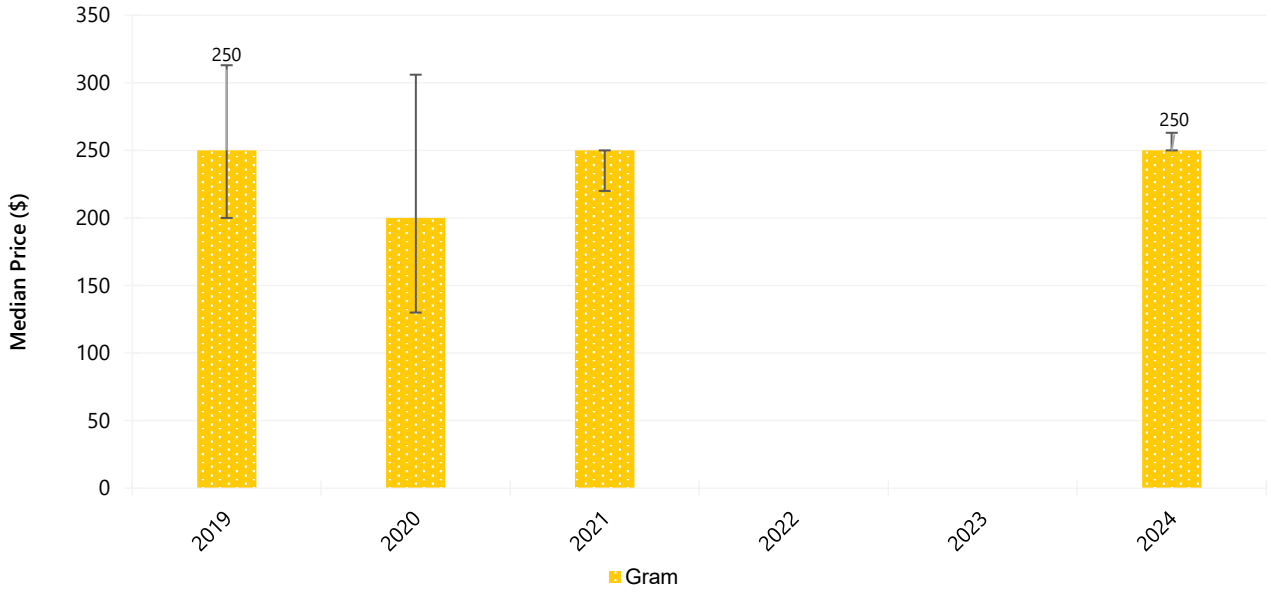
Price, Perceived Purity and Perceived Availability

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 the six months preceding interview in 2024 was $250 (IQR=250-263; n=12) (Figure 36).

Perceived Purity: Among those who were able to respond in 2024 (n=18), two thirds (67%) perceived the purity of ketamine to be 'high' (Figure 37).

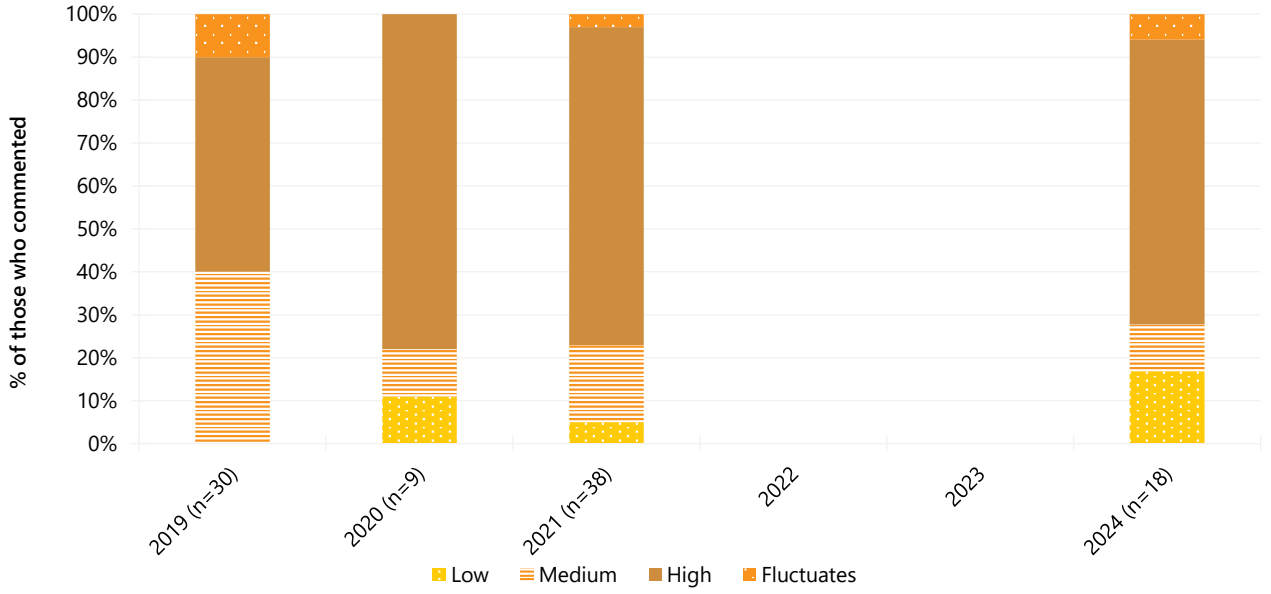
Perceived Availability: Of those who were able to respond in 2024 (n=17), almost three fifths (59%) reported ketamine to be 'easy' to obtain (Figure 38).

Figure 36: Median price of non-prescribed ketamine per gram, Darwin, NT, 2019-2024



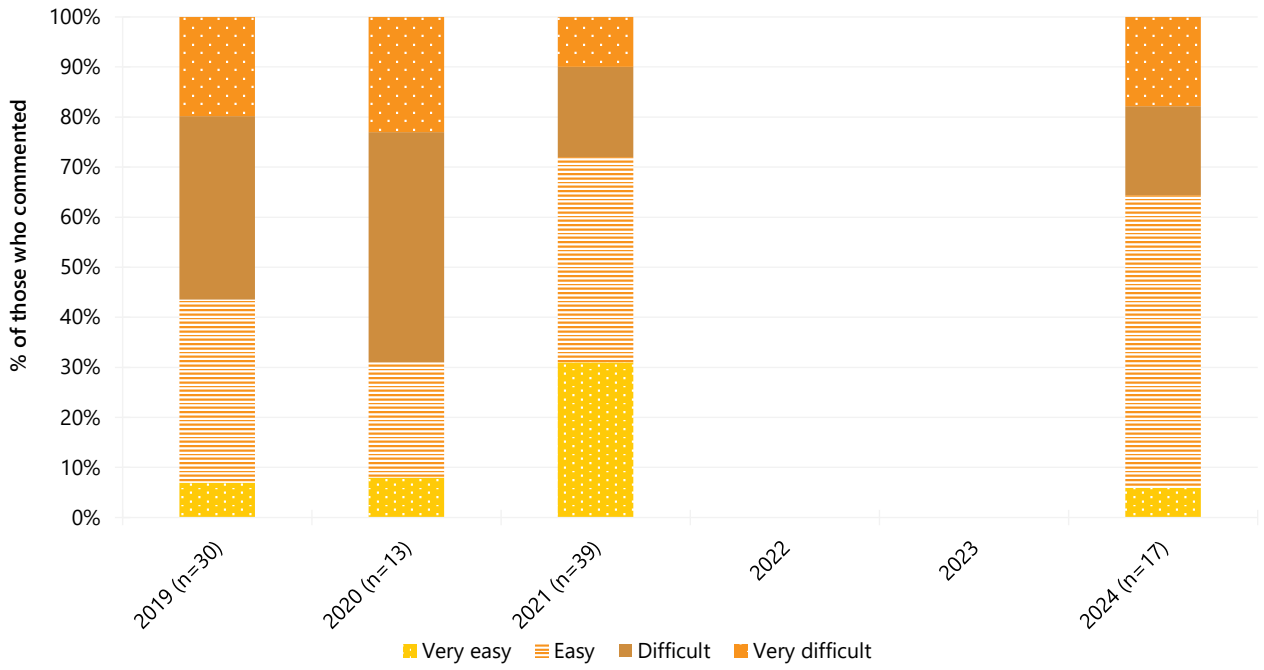
Note. Among those who commented. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). The error bars represent the IQR. Prices are not reported prior to 2019 due to small numbers commenting. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however data are suppressed in the figure and data tables where n≤5 responded. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Figure 37: Current perceived purity of non-precribed ketamine, Darwin, NT, 2019-2024



Note. 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. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Please refer to Table 1 for a guide to table/figure notes.

Figure 38: Current perceived availability of non-prescribed ketamine, Darwin, NT, 2019-2024



Note. 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 data tables where n≤5 responded to the item. Availability is not reported prior to 2019 due to small numbers commenting. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data from 2023 onwards refers to non-prescribed ketamine only (noting that although ketamine has been used as an anaesthetic for many years, it only become available via prescription, for treatment resistant depression, in 2021). Please refer to Table 1 for a guide to table/figure notes.

LSD

Patterns of Consumption

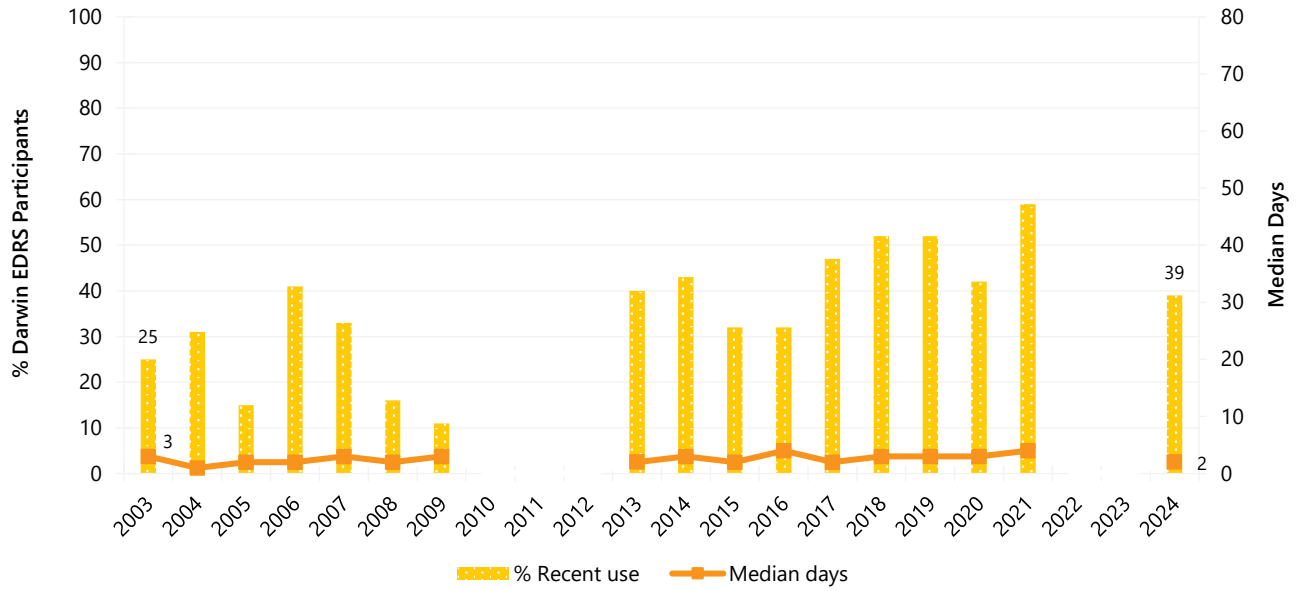
Recent Use (past 6 months): Almost two fifths (39%) of the Darwin sample had used LSD in the six months preceding interview in 2024 (Figure 39).

Frequency of Use: Median days of LSD use over the years has remained low. Of those who had recently consumed LSD in 2024 and commented (n=20), participants reported a median of two days of use (IQR=1-4) in the six months preceding interview (Figure 39). Few participants (n≤5) who had recently consumed LSD reported weekly or more frequent use in 2024.

Routes of Administration: Among participants who had recently consumed LSD and commented (n=20), all participants (100%) reported swallowing LSD.

Quantity: Of those who reported recent use and responded (n=16), the median amount of LSD used in a 'typical' session was one tab (IQR=1-2). Of those who reported recent use and responded (n=16), the median maximum amount of LSD used in a session was also one tab (IQR=1-2).

Figure 39: Past six month use and frequency of use of LSD, Darwin, NT, 2003-2024



Note. Median days computed among those who reported recent use (maximum 180 days). Median days rounded to the nearest whole number. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however labels are suppressed where there are small numbers (i.e., n≤5 but not 0). Secondary Y axis reduced to 80 days to improve visibility of trends. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

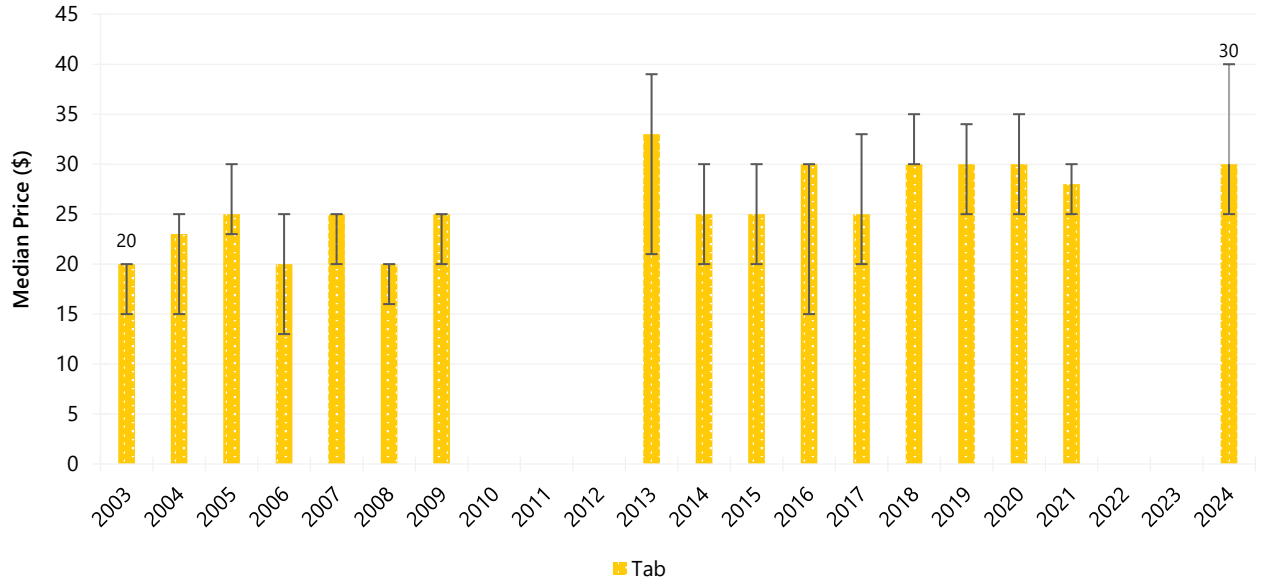
Price, Perceived Purity and Perceived Availability

Price: The median price for one tab of LSD has fluctuated since the commencement of monitoring. In 2024, participants reported a median price of $30 for one tab of LSD (IQR=25-40) (Figure 40).

Perceived Purity: Among those who were able to respond in 2024 (n=22), 55% perceived the purity of LSD to be 'high' (Figure 41).

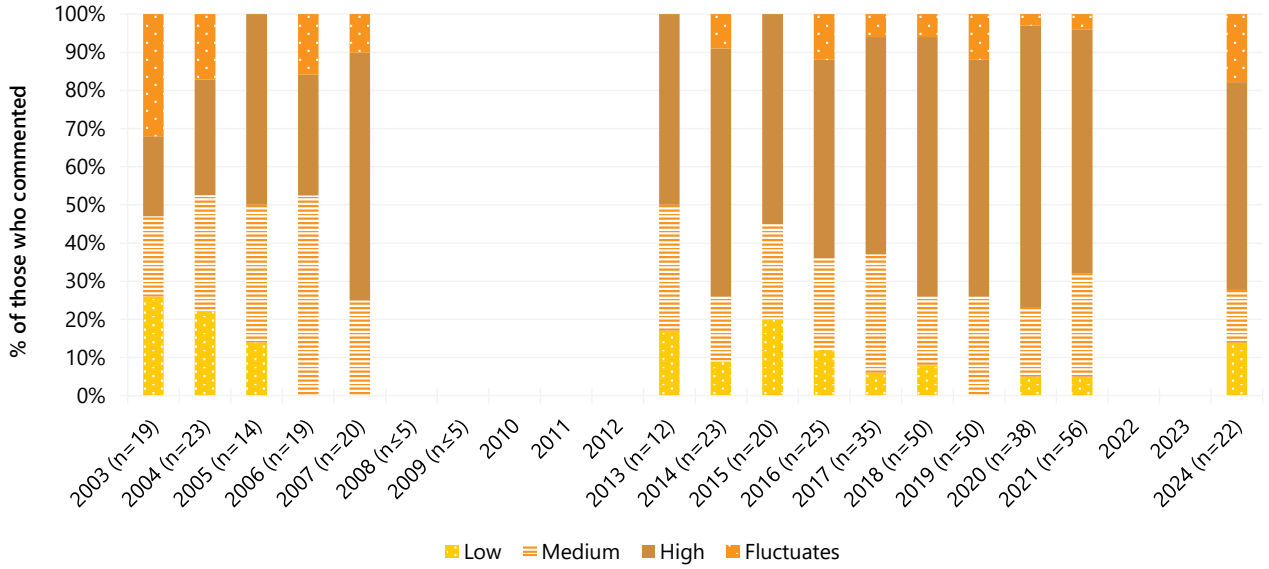
Perceived Availability: Of those able to comment in 2024 (n=22), 45% of participants reported that LSD was 'easy' to obtain. In contrast, one third (36%) perceived LSD as being 'difficult' to obtain (Figure 42).

Figure 40: Median price of LSD per tab, Darwin, NT, 2003-2024



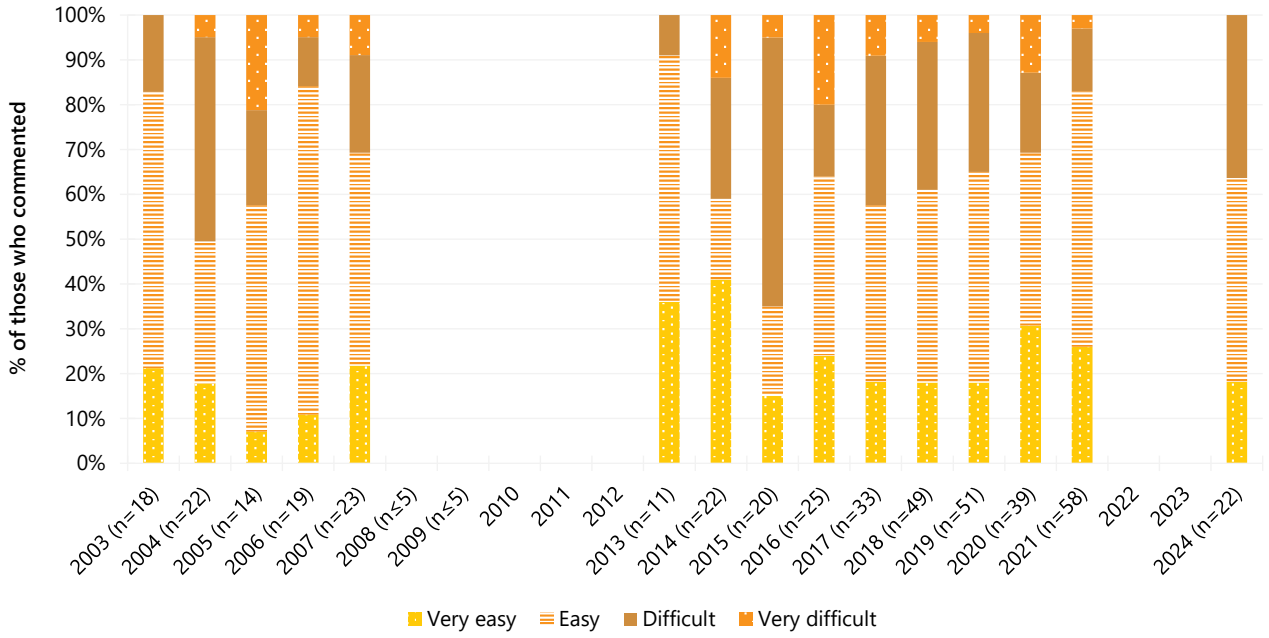
Note. Among those who commented. The error bars represent the IQR. Data labels are only provided for the first and most recent year of monitoring. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, however data are suppressed in the figure and data tables where n≤5 responded. For historical numbers, please refer to the data tables. Please refer to Table 1 for a guide to table/figure notes.

Figure 41: Current perceived purity of LSD, Darwin, NT, 2003-2024



Note. 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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

Figure 42: Current perceived availability of LSD, Darwin, NT, 2003-2024

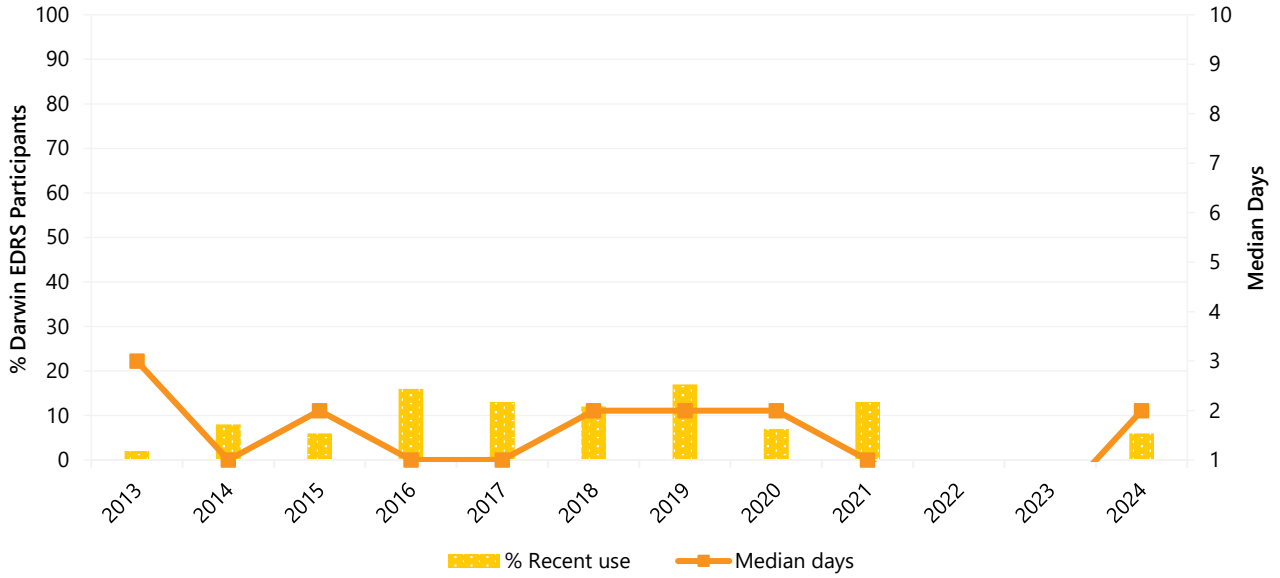


Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the figure and data tables where n≤5 responded to the item. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

DMT

Few participants (n≤5) reported using DMT in the six months prior to interview in 2024 (Figure 43) and therefore, no further reporting on patterns of use are included. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 43: Past six month use and frequency of use of DMT, Darwin, NT, 2013-2024



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. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

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 para*methoxyamphetamine* (PMA) were categorised as NPS. However, the classification of these substances as NPS is not universally accepted, and from 2021 onwards, 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 39% in 2015 and declining thereafter, with few participants (n≤5) reporting recent use in 2024 (Table 3).

Any NPS use, excluding plant-based NPS, has shown a similar trend, peaking at 44% in 2015 and subsequently declining, with few participants (n≤5) reporting recent use in 2024 (Table 3).

Forms Used

Participants are asked about a range of NPS, updated each year to reflect key emerging substances of interest. NPS use among the Darwin sample has fluctuated over time, although 2024 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 4). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information.

Table 3: Past six month use of NPS (including and excluding plant-based NPS), Darwin, NT, 2013-2024

%	Including plant-based NPS	Excluding plant-based NPS
2013	38	36
2014	25	35
2015	39	44
2016	25	25
2017	26	25
2018	17	26
2019	19	24
2020	13	12
2021	20	8
2022	~	~
2023	~	~
2024	-	-

Note. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2013 and 2024 should be interpreted with caution. 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. Please refer to Table 1 for a guide to table/figure notes.

Table 4: Past six month use of NPS by drug type, Darwin, NT, 2013-2024

	2013 (N=45)	2014 (N=100)	2015 (N=101)	2016 (N=100)	2017 (N=86)	2018 (N=99)	2019 (N=100)	2020 (N=99)	2021 (N=100)	2022	2023	2024 (N=51)
% Phenethylamines ^	-	7	14	-	-	6	-	-	-	~	~	**-**
Any 2C substance +	-	-	12	-	-	5	-	-	-	~	~	**-**
NBOMe	/	-	-	0	-	-	0	-	-	~	~	**0**
DO-x	0	0	0	0	0	0	0	-	0	~	~	**0**
Tuci	/	/	/	/	/	/	/	/	/	/	/	**0**
4-FA	/	/	/	0	0	0	0	0	0	~	~	**0**
NBOH	/	/	/	/	/	/	/	/	/	~	~	**0**
% Tryptamines^^	0	-	0	0	0	0	-	-	-	~	~	**-**
5-MeO-DMT	0	-	0	0	0	0	-	-	-	~	~	**-**
% Synthetic cathinones	-	-	9	-	-	-	10	0	-	~	~	**0**
Mephedrone	-	-	-	0	-	0	-	0	-	~	~	**0**
Methcathinone	/	/	/	/	/	/	/	/	/	/	/	**0**
Methylone/bk MDMA	-	-	-	-	-	-	6	0	0	~	~	**0**
MDPV/Ivory wave	-	0	-	-	0	0	-	0	-	~	~	**0**
Alpha PVP	/	/	/	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**
4-chloromethcathinone	/	/	/	/	/	/	/	/	/	/	~	**0**
3-methylmethcathinone	/	/	/	/	/	/	/	/	/	~	~	**0**
Alpha PHP	/	/	/	/	/	/	/	/	/	~	~	**0**
Dimethylpentylone	/	/	/	/	/	/	/	/	/	~	~	**0**
N, N-Dimethyl Pentylone	/	/	/	/	/	/	/	/	/	~	~	**0**
Pentylone	/	/	/	/	/	/	/	/	/	~	~	**0**
% Piperazines	0	0	0	-	0	/	/	/	/	/	/	**/**
% Dissociatives	0	0	0	-	0	0	-	-	-	~	~	**-**
Methoxetamine (MXE)	0	0	0	-	0	0	-	0	-	~	~	**0**
2F-2-oxo PCE	/	/	/	/	/	/	/	/	/	/	/	**-**
2-Fluorodeschloroketamine (2-FDCK)	/	/	/	/	/	/	/	/	/	~	~	**0**
3 CI-PCP/4CI-PCP	/	/	/	/	/	/	/	/	/	~	~	**0**
3F-2-oxo PCE	/	/	/	/	/	/	/	/	/	/	/	**0**

	2013 (N=45)	2014 (N=100)	2015 (N=101)	2016 (N=100)	2017 (N=86)	2018 (N=99)	2019 (N=100)	2020 (N=99)	2021 (N=100)	2022	2023	2024 (N=51)
3-HO-PCP/4-HO-PCP	/	/	/	/	/	/	/	/	/	~	~	**0**
3-MeO-PCP/4- MeO-PCP	/	/	/	/	/	/	/	/	/	~	~	**0**
Tiletamine	/	/	/	/	/	/	/	/	/	/	/	**0**
Other drugs that mimic the effects of dissociatives like ketamine	/	/	/	/	/	/	/	0	0	~	~	**0**
% Plant-based NPS	-	6	-	-	-	-	-	-	7	~	~	**-**
Ayahuasca	/	/	0	-	-	0	0	-	-	~	~	**0**
Mescaline	-	0	0	0	0	-	-	-	6	~	~	**0**
Salvia divinorum	-	-	-	0	0	0	-	-	0	~	~	**0**
Kratom/mitragynine	/	/	/	/	/	/	/	0	-	~	~	**-**
% Benzodiazepines	/	/	/	0	0	0	0	0	-	~	~	**0**
Etizolam	/	/	/	0	0	0	0	0	-	~	~	**0**
8-Aminoclonazolam	/	/	/	/	/	/	/	/	/	~	~	**0**
Bromazolam	/	/	/	/	/	/	/	/	/	~	~	**0**
Clonazolam	/	/	/	/	/	/	/	/	/	~	~	**0**
Flualprazolam	/	/	/	/	/	/	/	/	/	~	~	**0**
Flubromazepam	/	/	/	/	/	/	/	/	/	/	/	**0**
Phenazolam	/	/	/	/	/	/	/	/	/	/	/	**0**
Other drugs that mimic the effect of benzodiazepines	/	/	/	/	/	0	-	0	0	~	~	**0**
% Xylazine	/	/	/	/	/	/	/	/	/	/	/	**0**
% Synthetic cannabinoids (e.g., ADB-BUTINACA, 4F-MDMB-BUTICA, FUB-AM)	/	/	/	15	6	-	12	-	-	~	~	**0**
% Herbal high[#]	18	-	8	8	-	-	6	/	/	/	/	**/**
Phenibut	/	/	/	/	/	/	0	0	0	~	~	**0**
4F-phenibut	/	/	/	/	/	/	/	/	/	/	/	**0**
Glaucine	/	/	/	/	/	/	/	/	/	/	/	**0**
% Other drugs that mimic the effect of opioids (e.g., acetylfentanyl, nitazenes)	/	/	/	/	0	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	~	~	**-**

	2013 (N=45)	2014 (N=100)	2015 (N=101)	2016 (N=100)	2017 (N=86)	2018 (N=99)	2019 (N=100)	2020 (N=99)	2021 (N=100)	2022	2023	2024 (N=51)
% Other drugs that mimic the effect of psychedelic drugs like LSD	/	/	/	/	0	-	-	0	/	~	~	**0**
Other new and emerging psychoactive substances	-	0	-	-	-	-	0	0	0	~	~	**0**

Note. NPS first asked about in 2010. ^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 2021-2024 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. Please refer to Table 1 for a guide to table/figure notes.

9

Other Drugs

Non-Prescribed Pharmaceutical Drugs

Codeine

Before 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, participants were only asked about prescribed and non-prescribed codeine use, regardless of whether it was low- or high-dose.

Due to few participants (n≤5) reporting recent use of non-prescribed codeine in the six months prior to interview, further details are not reported (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Pharmaceutical Opioids

Due to few participants (n≤5) reporting recent use of non-prescribed pharmaceutical opioids in the six months preceding interview in 2024, further details are not reported (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Benzodiazepines

From 2019-2023, participants were asked about non-prescribed alprazolam use and non-prescribed use of 'other' benzodiazepines (e.g., diazepam). In 2024, the two forms were combined, such that participants were asked about non-prescribed use of any benzodiazepines.

Recent Use (past 6 months): Recent use of non-prescribed benzodiazepines (e.g., Valium, Diazepam, Xanax, Kalma) gradually increased between 2013 and 2019 before subsequently stabilising and then slightly declining. In 2024, one fifth (22%) of the Darwin sample reported use in the six months prior to interview (Figure 44).

Frequency of Use: Participants who reported recent non-prescribed use of benzodiazepines (e.g., Valium, Diazepam, Xanax, Kalma) reported a median of four days (IQR=1-13) of use.

Forms Used: Few participants (n≤5) were able to report on the forms of benzodiazepines used in the six months preceding interview, and therefore, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

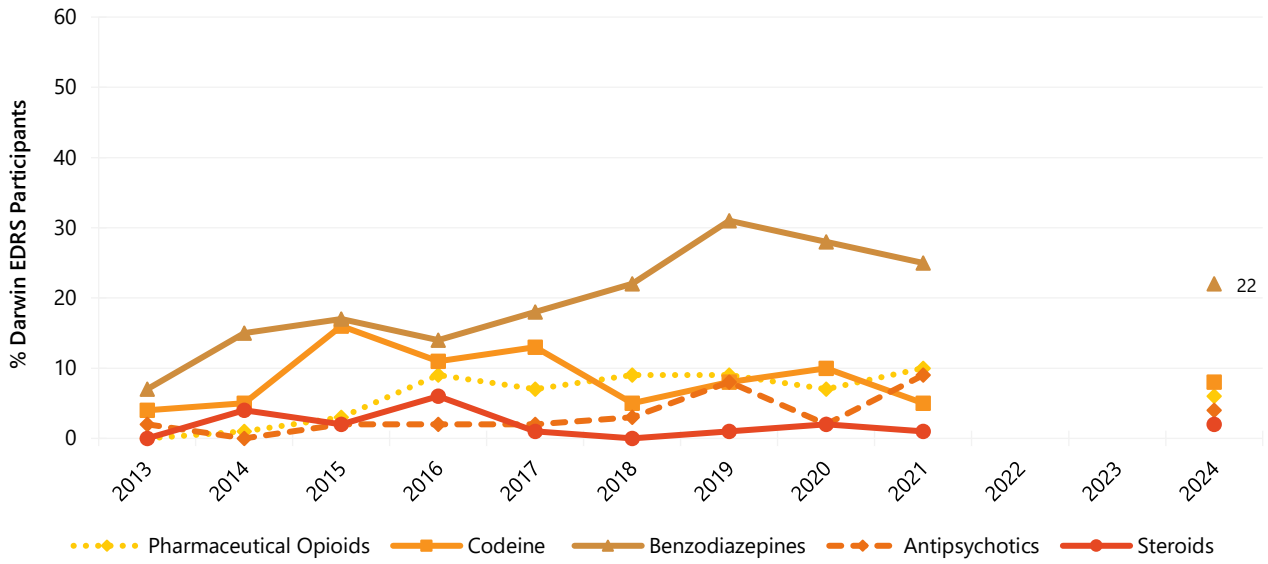
Steroids

Due to few participants (n≤5) reporting use of non-prescribed steroids in the six months prior to interview in 2024, further details are not reported (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Antipsychotics

Due to few participants (n≤5) reporting use of non-prescribed antipsychotics in the six months preceding interview in 2024, further details are not reported (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 44: Non-prescribed use of pharmaceutical medicines in the past six months, Darwin, NT, 2013-2024



Note. Non-prescribed use is reported for prescription medicines. 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 (2018-2024), with high-dose codeine excluded from pharmaceutical opioids from 2018. Between 2019 and 2023, participants were asked about 'alprazolam' and 'other benzodiazepines'. In 2024, 'alprazolam' and 'other benzodiazepines' were combined. Y axis has been reduced to 60% to improve visibility of trends. Monitoring of benzodiazepines first commenced in 2010, however due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Other Illicit Drugs

Non-Prescribed Hallucinogenic Mushrooms/Psilocybin

Recent Use (past 6 months): Recent use of non-prescribed hallucinogenic mushrooms/psilocybin has gradually increased since 2016, with one third (35%) of the Darwin sample reporting recent use in 2024, the highest percentage observed since monitoring commenced (Figure 45).

Frequency of Use: Participants who reported recent use of non-prescribed hallucinogenic mushroom/psilocybin (n=18) reported a median of two days of use (IQR=1-3).

Kava

Due to few participants (n≤5) reporting recent use of kava, further details are not reported (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

MDA

Due to few participants (n≤5) reporting recent use of MDA, further details are not reported (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Substance with Unknown Contents

Capsules: Due to few participants (n≤5) reporting recent use of capsules with 'unknown contents', further details are not reported (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Other Unknown Substances: From 2019, we asked participants about their use more broadly of substances with 'unknown contents'. Sixteen per cent of the Darwin sample reported recent use of any substance with 'unknown contents' in 2024 on a median of three days (IQR=1-4; n=8).

Due to few participants (n≤5) reporting recent use of pills, capsules, powder and crystal with 'unknown contents' in 2024, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Quantity: From 2020, we asked participants about the average amount of pills and capsules used with 'unknown contents' in the six months preceding interview. Few participants (n≤5) were able to answer questions regarding the median quantity of pills and/or capsules used in a 'typical' session in 2024, therefore, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

PMA

No participants reported recent use of PMA in the six months preceding interview in 2024 (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

PMMA

No participants reported recent use of PMMA in the six months preceding interview in 2024 (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Heroin

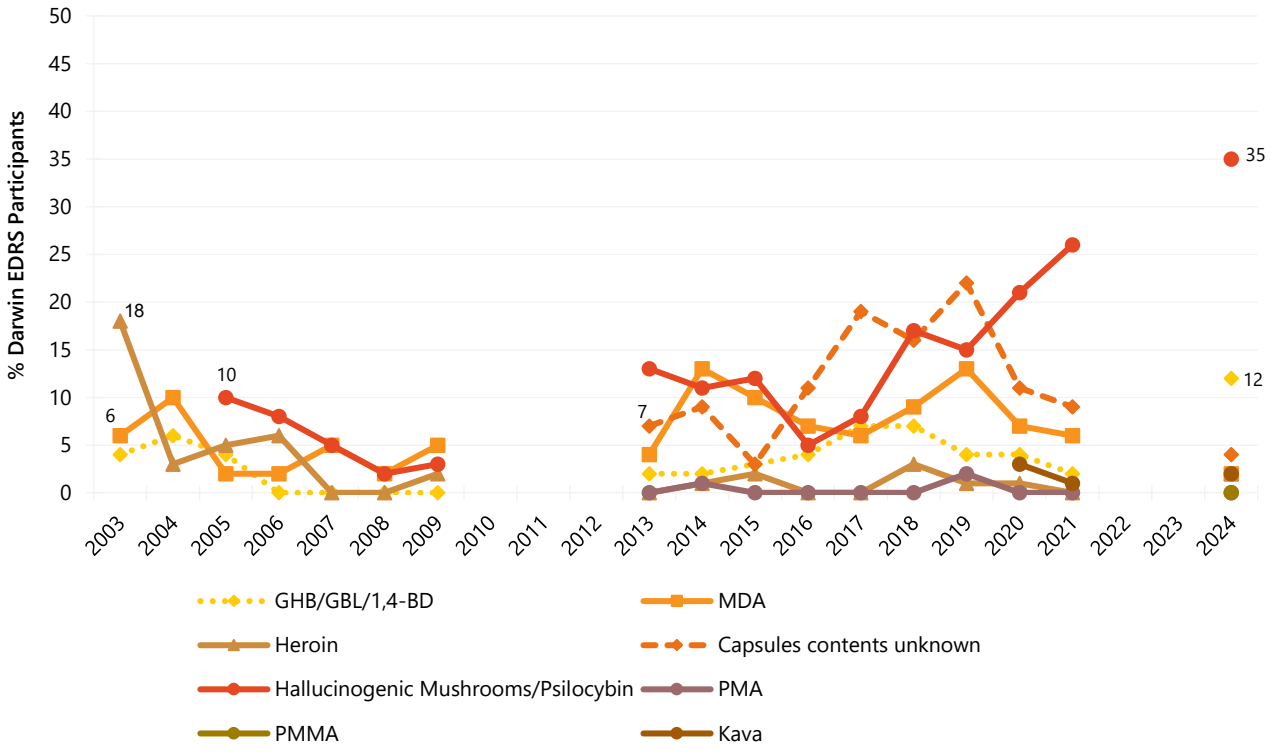
Due to few participants (n≤5) reporting recent use of heroin, further details are not reported (Figure 45). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

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

Recent Use (past 6 months): In 2024, 12% of the Darwin sample reported use of GHB/GBL/1,4-BD in the six months prior to interview (Figure 45).

Frequency of Use: Participants who reported recent use of GHB/GBL/1,4-BD (n=6) reported a median of six days of use (IQR=3-11).

Figure 45: Past six month use of other illicit drugs, Darwin, NT, 2003-2024



Note. 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'. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Y axis has been reduced to 50% to improve visibility of trends. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Licit and Other Drugs

Alcohol

Recent Use (past 6 months): The majority (96%) of the Darwin sample reported recent use of alcohol in the six months preceding interview in 2024 (Figure 46).

Frequency of Use: Participants reported using alcohol on a median of 48 days in the six months preceding interview (IQR=24-100; n=49) in 2024. Almost four fifths (78%) of those who had recently consumed alcohol had done so on a weekly or more frequent basis in 2024, with 12% reporting daily use of alcohol.

Tobacco

In 2024, for the first time, questions were included about illicit tobacco. This was defined as products sold illegally without the necessary taxes added to the price.

Recent Use (past 6 months): Almost two thirds (65%) of the Darwin sample reported tobacco use in the six months preceding interview in 2024 (Figure 46). Fourteen per cent reported recent use of smoked or non-smoked illicit tobacco products.

Frequency of Use: Participants reported using tobacco on a median of 173 days in the six months prior to interview in 2024 (IQR=48-180; n=33), with almost half (48%) of participants who had recently used tobacco reporting daily use.

E-cigarettes

From October 2021, Australians were required to have a prescription to legally access nicotine containing e-cigarette products for any purpose. In 2022, participants were asked for the first time about their use of both prescribed and non-prescribed e-cigarettes. No participants reported recent use of prescribed e-cigarettes in the six months preceding interview in 2024 (0%). Data below for 2024 refers only to non-prescribed e-cigarette use; data for 2021 and earlier refers to any e-cigarette use.

Recent Use (past 6 months): Two thirds (67%) of the Darwin sample reported use of non-prescribed e-cigarettes in the six months preceding interview in 2024 (Figure 46), the highest percentage observed since the commencement of monitoring.

Frequency of Use: Participants reported using non-prescribed e-cigarettes on a median of 150 days in the past six months in 2024 (IQR=51-180; n=34). Forty-four per cent of participants who had recently used non-prescribed e-cigarettes reported daily use.

Contents and Forms Used: Among participants who had recently used non-prescribed e-cigarettes and responded (n=32), all participants (100%) reported using e-cigarettes containing nicotine. Among participants who had recently used e-cigarettes and responded (n=34), participants most commonly reported using disposable devices (91%), followed by pods (21%).

Eighteen per cent of the sample reported vaping substances other than nicotine/vape juice. Among those who vaped substances other than nicotine/vape juice and commented (n=9), the most commonly vaped substance was cannabis (89%).

Reason for Use: Of those who reported non-prescribed e-cigarette use in the six months preceding interview and responded (n=34), 53% of the Darwin sample reported that they did not use e-cigarettes as a smoking cessation tool in 2024.

Nicotine Pouches

Due to few participants (n≤5) reporting recent use of nicotine pouches, further details are not reported (Figure 46). Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Nitrous Oxide

Recent Use (past 6 months): Almost one third (31%) of the Darwin sample reported use of nitrous oxide in the six months preceding interview in 2024 (Figure 46).

Frequency of Use: Participants reported a median of three days (IQR=2-7; n=16) of use in the six months prior to interview in 2024.

Quantity: Among those who reported recent use and responded (n=13), the median amount used in a 'typical' session was five bulbs (IQR=4-10). Of those who reported recent use and responded (n=12), the median maximum amount used was nine bulbs (IQR=6-21).

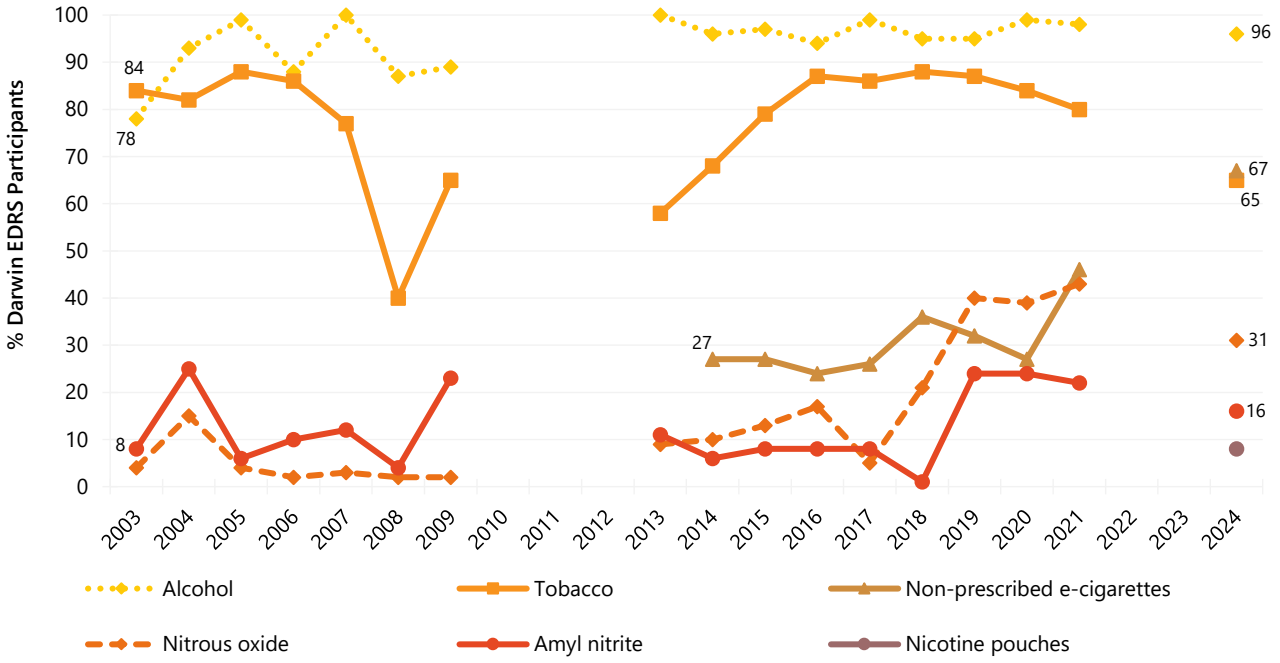
Amyl Nitrite

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, 16% of the Darwin sample reported use of amyl nitrite in the six months preceding interview in 2024.

Frequency of Use: Participants reported a median of four days of use in the six months prior to interview in 2024 (IQR=3-5; n=8).

Figure 46: Licit and other drugs used in the past six months, Darwin, NT, 2003-2024



Note. Regarding e-cigarettes, 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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

10

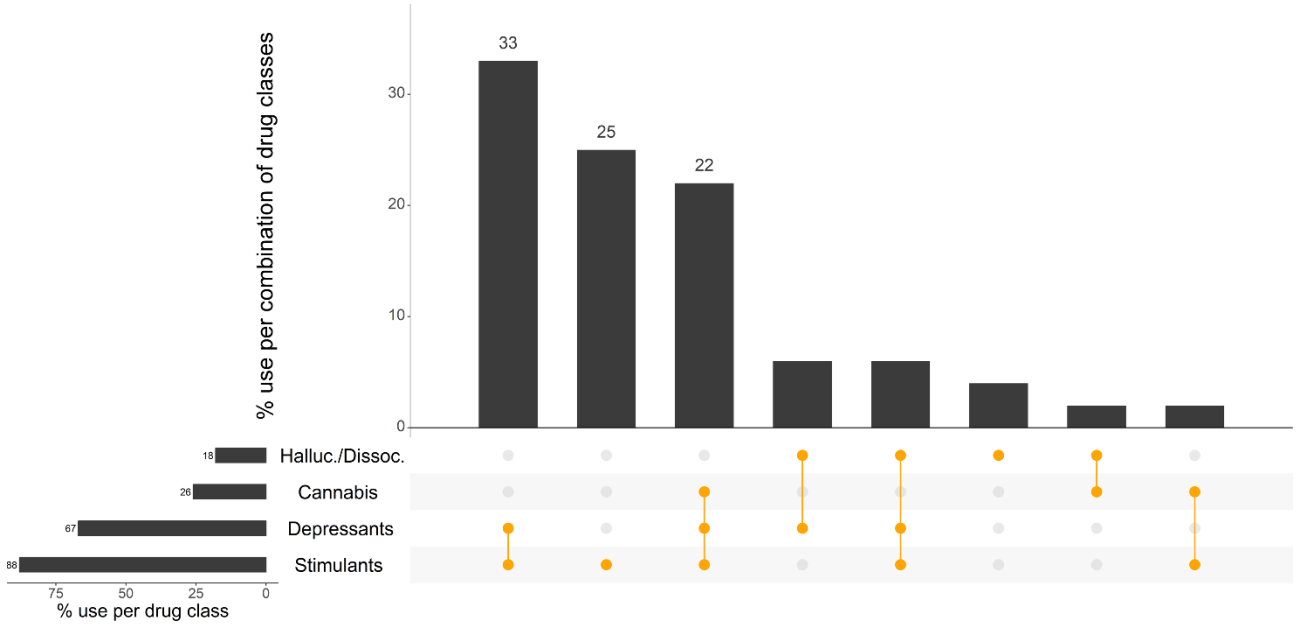
Drug-Related Harms and Other Behaviours

Polysubstance Use

Among those who responded (n=51), the most commonly used substances on the last occasion of ecstasy or related drug use were alcohol (65%) and ecstasy (47%), followed by cocaine (27%), tobacco (25%) and cannabis (25%).

Four fifths (78%; n=40) of the Darwin 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 combination of drug classes was stimulants and depressants (33%), followed by stimulants, depressants and cannabis (22%). One quarter (25%) reported using stimulants alone (Figure 47).

Figure 47: Use of depressants, stimulants, cannabis, hallucinogens and dissociatives on the last occasion of ecstasy or related drug use, Darwin, NT, 2024: Most common drug pattern profiles

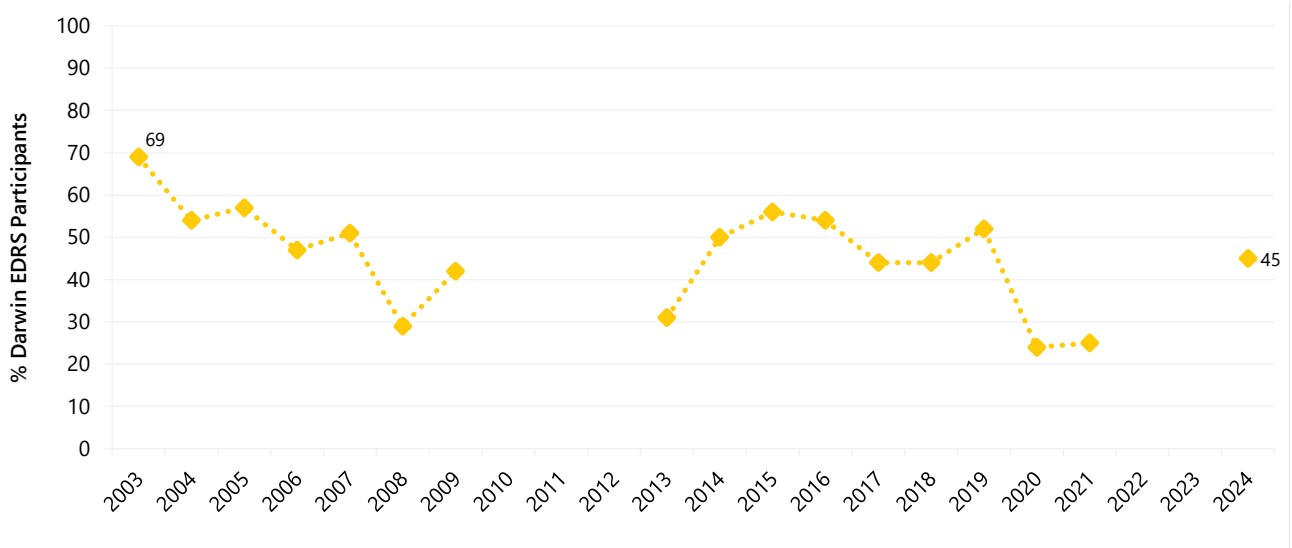


Note. % calculated out of total EDRS 2024 sample. The horizontal bars represent the per cent of participants who reported use of each substance on their last occasion of ecstasy or related drug use; the vertical columns represent the per cent of participants who used the combination of drug classes represented by the orange circles. Drug use pattern profiles reported by ≤5 participants or which did not include any of the four drug classes depicted are not shown in the figure but are counted in the denominator. Halluc./Dissoc = hallucinogens/dissociatives (LSD, hallucinogenic mushrooms, amyl nitrite, DMT, ketamine and/or nitrous oxide); depressants (alcohol, GHB/GBL,1,4-BD, kava, opioids and/or benzodiazepines); stimulants (cocaine, MDA, ecstasy, methamphetamine, and/or pharmaceutical stimulants). Use of benzodiazepines, opioids and stimulants could be prescribed or non-prescribed use. Note that participants may report use of multiple substances within a class. Y axis reduced to 40% to improve visibility of trends.

Binge Drug Use

Participants were asked whether they had used any stimulant or related drug for 48 hours or more continuously without sleep (i.e., binged) in the six months preceding interview. The per cent of the Darwin sample who have reported bingeing has fluctuated since the commencement of monitoring. In 2024, 45% of the sample had binged on one or more drugs in the preceding six months (Figure 48).

Figure 48: Past six month use of stimulants or related drugs for 48 hours or more continuously without sleep ('binge'), Darwin, NT, 2003-2024



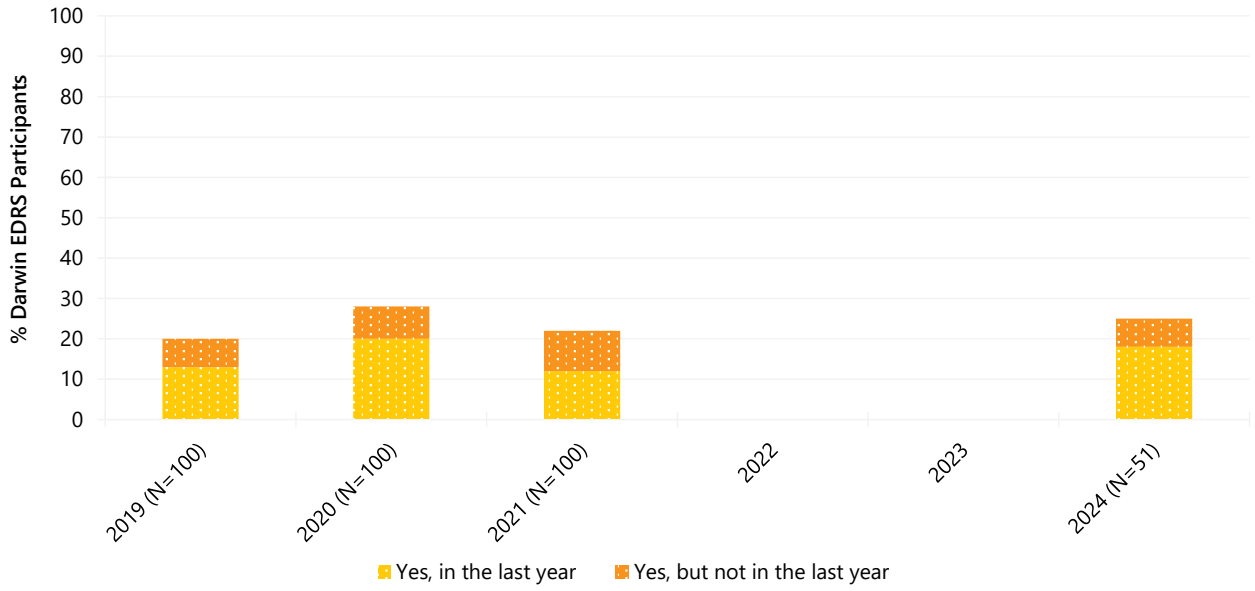
Note. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, 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. Please refer to Table 1 for a guide to table/figure notes.

Drug Checking

Drug checking is a common strategy used to test the purity and contents of illicit drugs. At the time interviewing commenced in 2024, 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 CanTEST, a pilot fixed-site dug checking service in Canberra which has been operational since 17 July 2022. Queensland's first fixed-site drug checking service, CheQpoint, opened its doors in Brisbane shortly after EDRS recruitment commenced (April 20, 2024), and a second service opened on the Gold Coast shortly after recruitment had finished (July 2024).

In 2024, 18% 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 (Figure 49). Of those who reported that they or someone else had tested their illicit drugs in the past year and commented (n=7), 86% reported using colorimetric reagent test kits. Few participants (n≤5) reported testing via testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips) and no participants reported professional testing equipment (e.g., Fourier Transform Infrared Spectroscopy).

Figure 49: Lifetime and past year engagement in drug checking, Darwin, NT, 2019-2024



Note. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

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 Darwin sample (including people who had not consumed alcohol in the past 12 months) was 16.5 (SD 7.9) in 2024. 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.

Ninety per cent of the sample obtained a score of eight or more, indicative of hazardous use, the highest per cent recorded since monitoring commenced (Table 5).

Table 5: AUDIT total scores and per cent of participants scoring above recommended levels, Darwin, NT, 2013-2024

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
	N=45	N=100	N=100	N=99	N=99	N=100	N=99	N=101	N=100			N=48
Mean AUDIT total score (SD)	14.7 (7.1)	14.8 (6.7)	15.4 (7.6)	13.3 (6.6)	13.1 (5.7)	11.6 (5.8)	15.9 (8.3)	13.9 (5.6)	14.2 (7.2)	~	~	**16.5 (7.9)**
Score 8 or above (%)	89	87	82	80	88	77	84	88	77	~	~	**90**
AUDIT zones:												
Score 0-7	-	13	18	20	12	23	16	12	23	~	~	**-**
Score 8-15	53	42	38	41	55	57	37	56	36	~	~	**38**
Score 16-19	19	19	12	19	17	13	19	17	19	~	~	**-**
Score 20 or higher	19	25	33	20	16	6	27	15	22	~	~	**46**

Note. Computed from the entire sample regardless of whether they had consumed alcohol in the past twelve months. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2013 and 2024 should be interpreted with caution. Total AUDIT score range is 0-40, with higher scores indicating greater likelihood of hazardous and harmful drinking. Imputation used for missing scale scores. Please refer to Table 1 for a guide to table/figure notes.

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 among the sample.

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 2024, one fifth (20%) of the Darwin sample reported experiencing a non-fatal stimulant overdose in the 12 months preceding interview (Figure 50).

The most common stimulant reported during the most recent non-fatal stimulant overdose in the past 12 months comprised any form of ecstasy (80%; individual numbers for ecstasy forms too low to report (n≤5 participants)). Among those who experienced a recent non-fatal stimulant overdose, 90% (n=9) reported that they had also consumed one or more additional drugs on the last occasion, most notably, alcohol (60%). Of those who had experienced an alcohol overdose in the past year (n=10), four fifths (80%) reported not receiving treatment on the last occasion. Due to few participants (n≤5) reporting that they had received treatment or assistance, please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

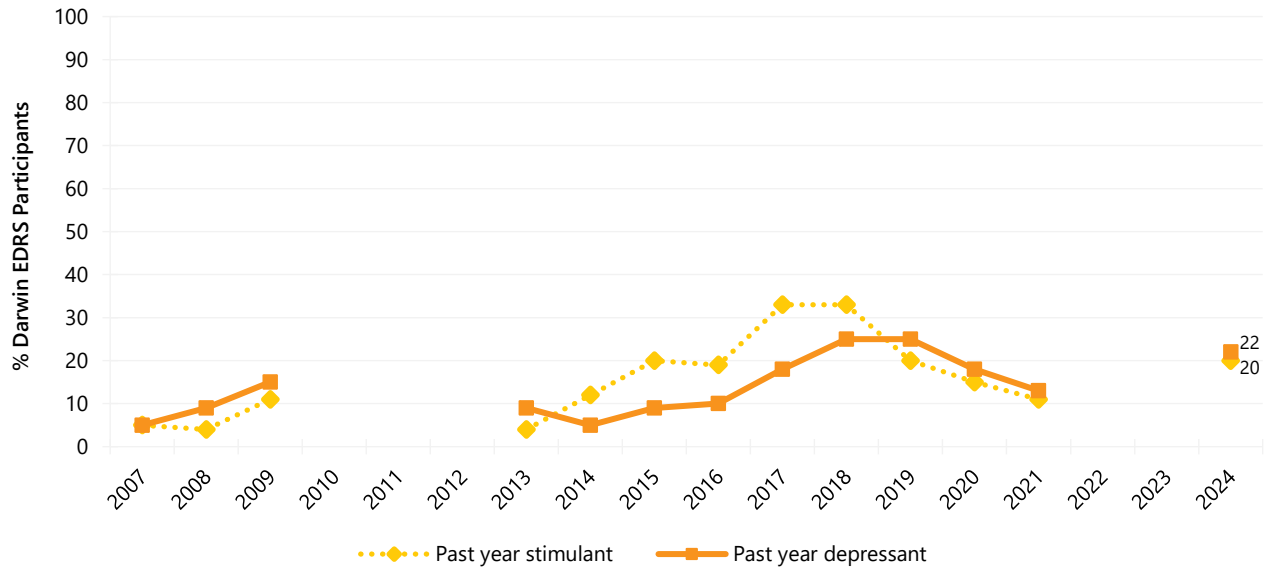
Non-Fatal Depressant Overdose

Alcohol: One fifth (20%) of the Darwin sample reported a non-fatal alcohol overdose in the 12 months preceding interview on a median of two occasions (IQR=1-4). Of those who had experienced an alcohol overdose in the past year (n=10), four fifths (80%) reported not receiving treatment on the last occasion. Due to few participants (n≤5) reporting that they had received treatment or assistance, please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Any depressant (including alcohol): In 2024, one fifth (22%) of participants reported that they had experienced a non-fatal depressant overdose in the past 12 months (Figure 50).

Of those who had experienced any depressant overdose in the past 12 months (n=11), 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 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 50: Past 12 month non-fatal stimulant and depressant overdose, Darwin, NT, 2007-2024



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. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

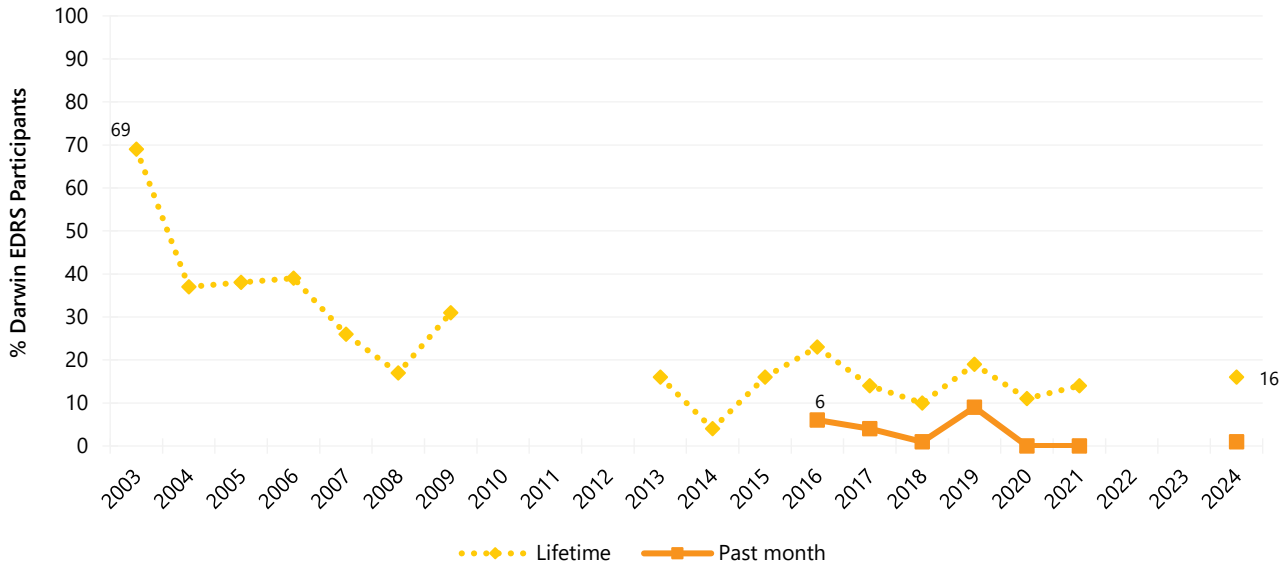
Awareness of Naloxone

In 2024, 45% of the Darwin sample reported that they had ever heard of naloxone. Among those who had ever heard of naloxone and responded (n=22), 91% were able to correctly identify the purpose of naloxone. No participants reported obtaining naloxone in the past year or in their lifetime. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Injecting Drug Use and Associated Risk Behaviours

Sixteen per cent reported lifetime injection in 2024 (Figure 51), however, few participants (n≤5) reported injecting drugs in the past month, therefore, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Figure 51: Lifetime and past month drug injection, Darwin, NT, 2003-2024



Note. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Drug Treatment

Few participants (n≤5) reported currently receiving drug treatment in 2024, therefore, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Ecstasy and Methamphetamine Dependence

From 2017, participants were asked questions from the Severity of Dependence Scale (SDS) adapted to investigate ecstasy and methamphetamine dependence. The SDS is a five-item 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=47), 21% recorded a score of three or above. The median ecstasy SDS score was zero (IQR=0-2). Sixty per cent of participants obtained a score of zero on the ecstasy SDS, indicating that three fifths of respondents reported no symptoms of dependence in relation to ecstasy use (Table 6).

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 20 participants who reported recent methamphetamine use

and completed this section, two fifths (40%) scored four or above. The median methamphetamine SDS score was two (IQR=0-4). Forty per cent of participants obtained a score of zero on the methamphetamine SDS, indicating that two fifths of respondents reported no symptoms of dependence in relation to methamphetamine use (Table 6).

Table 6: 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, Darwin, NT, 2017-2024

	2017	2018	2019	2020	2021	2022	2023	2024
Ecstasy	**(n=83)**	**(n=97)**	**(n=99)**	**/**	**(n=98)**			**(n=47)**
Median total score (IQR)	0 (0-2)	1 (0-1)	0 (0-2)	/	0 (0-1)	~	~	**0 (0-2)**
% score = 0	57	48	59	/	63	~	~	**60**
% score ≥3	17	13	15	/	16	~	~	**21**
Methamphetamine	**(n=26)**	**(n=24)**	**(n=43)**	**(n=24)**	**(n=13)**			**(n=20)**
Median total score (IQR)	0 (0-5)	1 (0-2)	1 (0-6)	0 (0-1)	3 (0-7)	~	~	**2 (0-4)**
% score = 0	58	46	40	67	-	~	~	**40**
% score ≥4	27	-	40	-	-	~	~	**40**

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. Imputed values used for missing scale scores. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

Sexual Health Behaviours

In 2024, 78% of the Darwin sample reported some form of sexual activity in the past four weeks (Table 7). 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=40), 88% reported using alcohol and/or other drugs prior to or while engaging in sexual activity. Few participants (n≤5) reported that their use of alcohol and/or other drugs had impaired their ability to negotiate their wishes during sex, whilst 43% reported that they had used alcohol and/or other drugs to enhance sexual activity or pleasure with another person. Few participants (n≤5) had engaged in sexual activity in exchange for money, drugs, or other goods or services (Table 7).

Of those who commented (n=51), 43% reported having a sexual health check-up in the six months prior to interview, whilst 84% had done so in their lifetime. Of the total sample who responded (n=51), no participants reported that they had received a positive diagnosis for a sexually transmitted infection (STI) in the past six months in 2024, whilst one quarter (25%) had received a positive diagnosis in their lifetime (Table 7). No participants reported on the specific types of STIs diagnosed, therefore, please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Of those who commented (n=50), 30% of the sample reported having a test for human immunodeficiency virus (HIV) in the six months prior to interview, whilst 58% had done so in their lifetime. In 2024, no participants had been diagnosed with HIV in the past six months, and few participants (n≤5) had been diagnosed within their lifetime (Table 7).

Table 7: Sexual health behaviours, Darwin, NT, 2021-2024

	2021	2022	2023	2024
Of those who responded[#]:	**N=98**			**N=51**
% Any sexual activity in the past four weeks (n)	90 (n=88)	~	~	**78 (n=40)**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=88			**n=40**
% Drugs and/or alcohol used prior to or while engaging in sexual activity	89	~	~	**88**
Of those who responded[#] and reported any sexual activity in the past four weeks:	n=77			**n=40**
% Drugs and/or alcohol impaired their ability to negotiate their wishes during sexual activity	17	~	~	**-**
% Drugs and/or alcohol used to enhance sexual activity or pleasure with another person	/	/	/	**43**
Of those who responded[#] and reported any sexual activity in the past four weeks:				**n=40**
% Engaged in sexual activity in exchange for money, drugs or other goods or services	/	/	/	**-**
Of those who responded[#]:	n=98			**n=50**
% Had a HIV test in the last six months	30	~	~	**30**
% Had a HIV test in their lifetime	72	~	~	**58**
Of those who responded[#]:	n=71			**n=50**
% Diagnosed with HIV in the last six months	0	~	~	**0**
% Diagnosed with HIV in their lifetime	0	~	~	**-**
Of those who responded[#]:	n=98			**n=51**
% Had a sexual health check in the last six months	45	~	~	**43**
% Had a sexual health check in their lifetime	89	~	~	**84**
Of those who responded[#]:	n=98			**n=51**
% Diagnosed with a sexually transmitted infection in the last six months	-	~	~	**0**
% Diagnosed with a sexually transmitted infection in their lifetime	28	~	~	**25**

Note. [#] Due to the sensitive nature of these items, there is missing data for some participants who chose not to respond. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

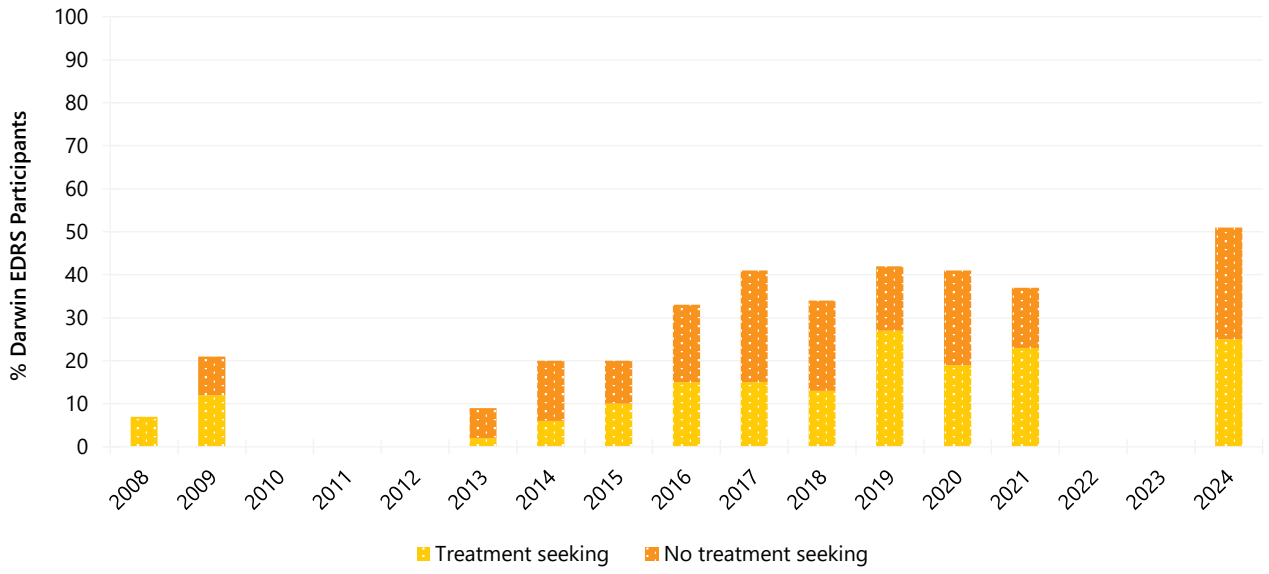
Mental Health and Psychological Distress (K10)

Mental Health

Half (51%) of the Darwin sample self-reported that they had experienced a mental health problem in the preceding six months (other than drug dependence). Of those who reported a mental health problem in 2024 and commented (n=25), the most common mental health problem reported was depression (52%) followed by anxiety (40%). Of those who reported experiencing a mental health problem (n=26), half (50%) (25% of the total sample) reported seeing a mental health professional during the six months preceding interview (Figure 52). Of those who reported seeing a mental health

professional in 2024 (n=13), three fifths (62%) reported being prescribed medication for their mental health problem.

Figure 52: Self-reported mental health problems and treatment seeking in the past six months, Darwin, NT, 2008-2024



Note. Questions about treatment seeking were first asked in 2008. The combination of the per cent who report treatment seeking and no treatment is the per cent who reported experiencing a mental health problem in the past six months. Data labels are not shown for any of the stacked bar charts in the jurisdictional reports; see data tables for values. Data are suppressed in the data tables where n≤5 responded to the item. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2008, 2013 and 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

Psychological Distress (K10)

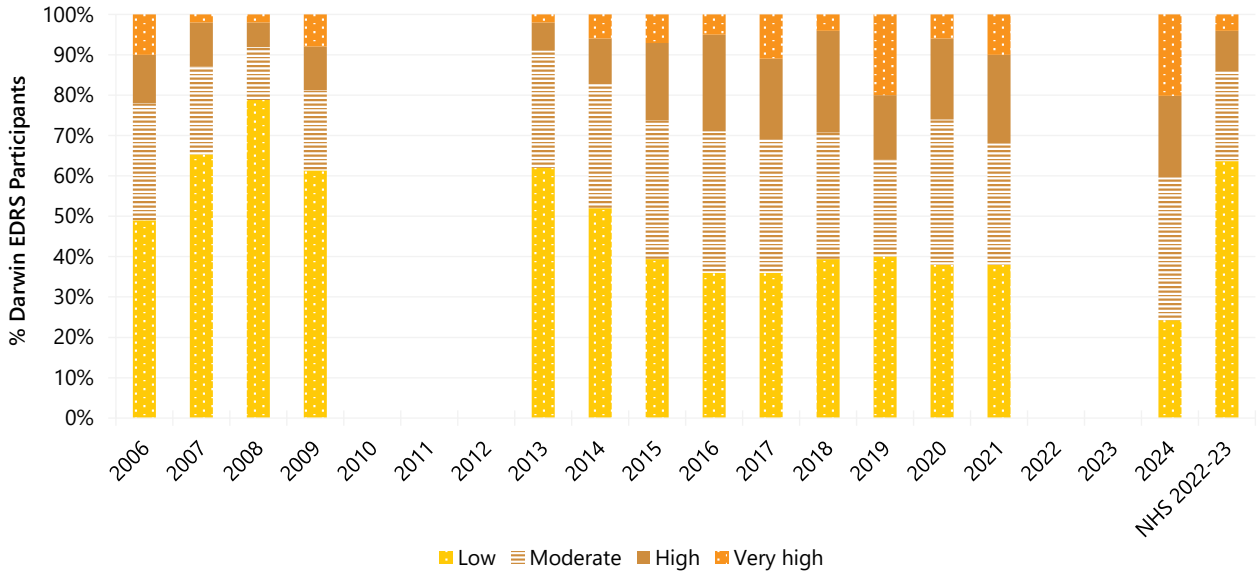
The Kessler Psychological Distress Scale 10 (K10) was administered to obtain a measure of psychological distress in the past four weeks. It is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured 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 2024 (n=49), one fifth (20%) of the Darwin EDRS sample had a score of 30 or more (Figure 53).

The National Health Survey 2022-23 provides Australian population data for adult (≥18 years) K10 scores. EDRS participants in 2024 reported greater levels of 'high' and 'very high' distress compared to the general population (Figure 53).

Figure 53: K10 psychological distress scores, Darwin, NT, 2006-2024 and among the general populatoin, 2022-2023



Note. Data from the National Health Survey are a national estimate from 2022-23 for adults 18 or older. Imputation used for missing scale scores (EDRS only). 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 data tables where n≤5 responded to the item. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

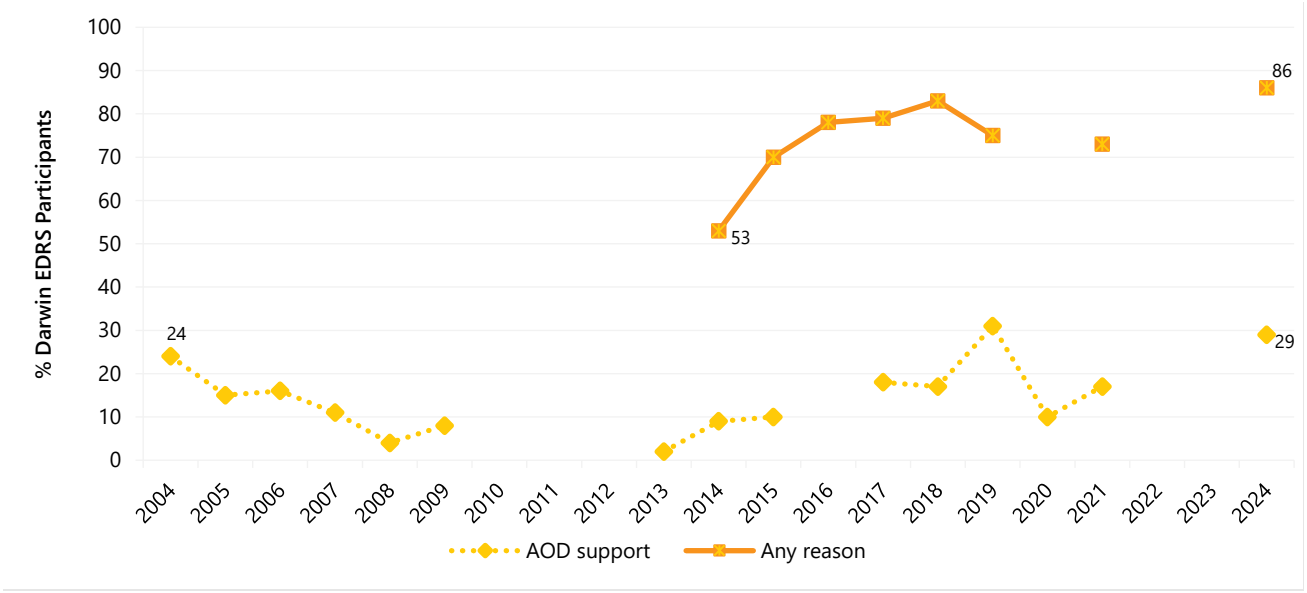
Health Service Access

In 2024, 29% of the Darwin sample reported accessing any health service for alcohol and/or drug support (AOD) in the six months preceding interview (Figure 54). Few participants (n≤5) reported access to each type of health service (Table 8), therefore, these data are suppressed. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

Eighty-six per cent of participants reported accessing any health service for any reason in the six months preceding interview in 2024 (Figure 54). The most common service accessed by participants in 2024 was a general practitioner (GP) (65%), followed by a pharmacy (49%) and a psychologist (31%) (Table 8).

Twenty-nine per cent of participants reported attending the emergency department in the past six months (for any reason), with the most common reason being injury (14%). Few participants (n≤5) reported being attended to by an ambulance in the past six months (for any reason), please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrend@unsw.edu.au).

Figure 54: Health service access for alcohol and other drug reasons, and for any reason in the past six months, Darwin, NT, 2004-2024



Note. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Table 8: Types of health services accessed for alcohol and other drug reasons and for any reason in the past six months, Darwin, NT, 2022-2024

	AOD support			Any reason		
	2022	2023	2024	2022	2023	2024
% accessing health services			**N=51 29**			**N=51 86**
GP	~	~	-	~	~	**65**
Emergency department	~	~	-	~	~	**29**
Hospital admission (inpatient)	~	~	-	~	~	**22**
Medical tent (e.g., at a festival)	~	~	-	~	~	-
Drug and Alcohol counsellor	~	~	-	~	~	-
Hospital as an outpatient	~	~	-	~	~	-
Specialist doctor (not including a psychiatrist)	~	~	-	~	~	**12**
Dentist	~	~	**0**	~	~	**29**
Ambulance attendance	~	~	-	~	~	-
Pharmacy	/	/	-	/	/	**49**
Other health professional (e.g., physiotherapist)	~	~	-	~	~	**20**
Psychiatrist	~	~	**0**	~	~	-
Psychologist	~	~	-	~	~	**31**
NSP	~	~	-	~	~	-
Peer based harm reduction service	~	~	-	~	~	-
Other harm reduction service	~	~	**0**	~	~	**0**

Note. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report. Data from 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

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 2024, one quarter (27%) of the Darwin sample reported experiencing stigma because of their illicit drug use in any health/non-health care setting in the six months preceding interview (Table 9).

No participants reported experiencing stigma within specialist AOD services in the six months preceding interview, however, 12% reported experiencing stigma within general health care services in the six months preceding interview. One fifth (20%) of participants reported experiencing stigma in non-health care settings, most commonly from police (12%) (Table 9).

Notably, one third (33%) of participants reported engaging in some form of avoidance behaviour to avoid being treated negatively or differently by an AOD specialist or general health care services. This most commonly involved not telling health workers about their drug use (22%).

Table 9: Self-reported experiences of stigma due to illicit drug use in the past six months, Darwin, NT, 2022-2024

	2022	2023	2024
% Experienced stigma in specialist AOD service	~	~	**N=51** **0**
% Experienced stigma in general health care service	~	~	**N=51** **12**
% Experienced stigma in non-health care service	/	~	**20**
Welfare and social service	/	~	**-**
Current or potential employer	/	~	**-**
School/uni/TAFE	/	~	**-**
Police	/	~	**12**
Other legal services	/	~	**-**
Housing and homelessness services	/	~	**0**
Other	/	~	**-**
% Experienced stigma in any of the above settings^	/	~	**27**
% Did any of the following to avoid being treated negatively or differently by AOD specialist or general healthcare services	/		**N=49** **33**
Delayed accessing healthcare	/	~	**-**
Did not tell health worker about drug use	/	~	**22**
Downplayed need for pain medication	/	~	**-**
Looked for different services	/	~	**-**
Did not attend follow-up appointment	/	~	**-**
Other	/	~	**0**

Note. N is the number who responded (denominator). ^Includes specialist AOD service, general health care service and non-health care services. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report. Data from 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.

Driving

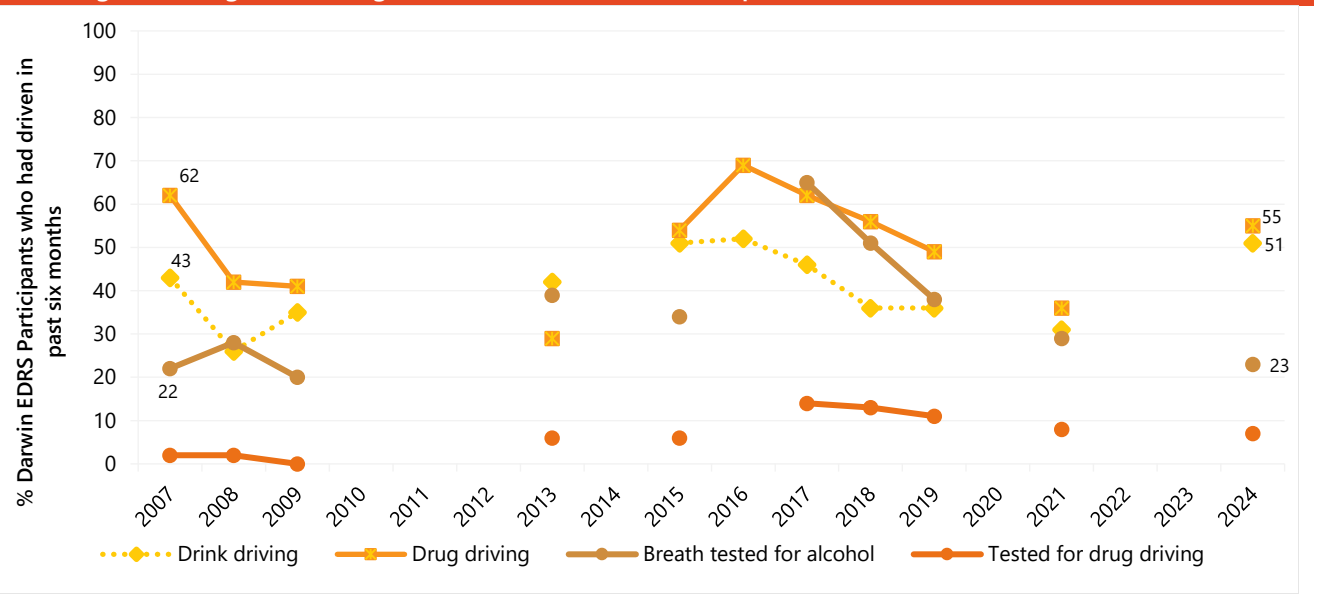
In 2024, 86% of the Darwin sample had driven a car, motorcycle, or other vehicle in the six months prior to interview. Of those who had driven in the past six months and responded (n=43), half (51%) reported driving while over the (perceived) legal limit of alcohol.

Of those who had driven in the past six months and responded (n=44), 55% reported driving within three hours of consuming an illicit or non-prescribed drug in the last six months (Figure 55). Participants most commonly reported using cannabis (63%) prior to driving in the six months preceding interview, followed by cocaine (38%), ecstasy capsules (33%) and methamphetamine crystal (25%).

Among those who had driven in the past six months (n=44), few participants (n≤5) reported that they had been tested for drug driving by the police roadside drug testing service, and 23% reported that

they had been breath tested for alcohol by the police roadside testing service in the six months prior to interview (Figure 55).

Figure 55: 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, Darwin, NT, 2007-2024



Note. Computed of those who had driven a vehicle in the past six months. Questions about driving behaviour were first asked about in 2007. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

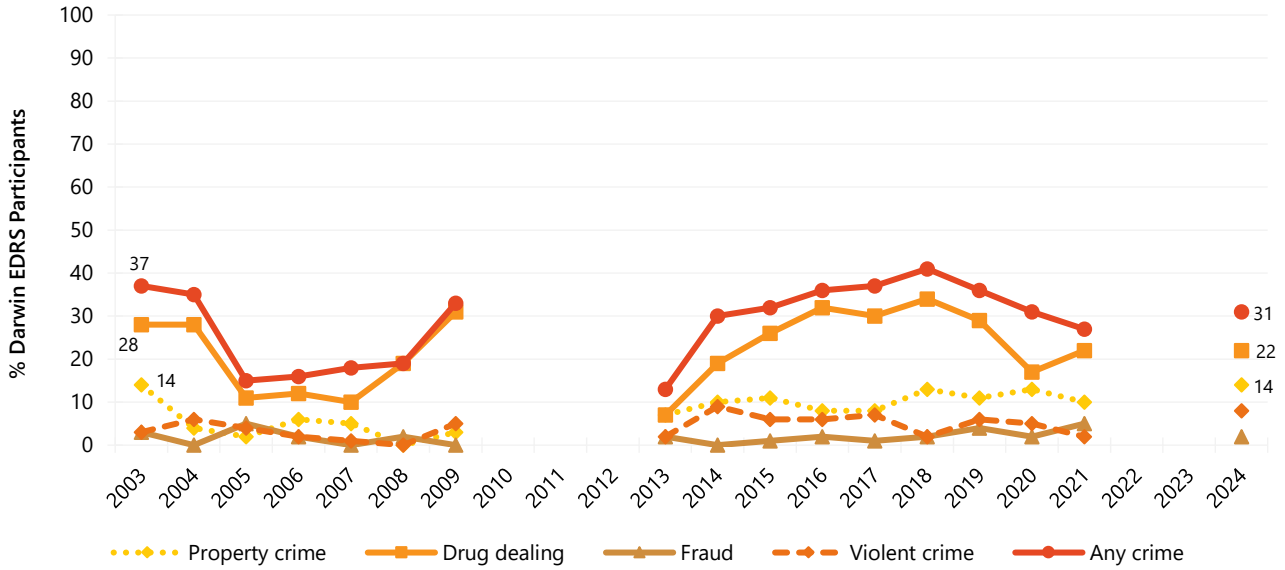
Experience of Crime and Engagement with the Criminal Justice System

In 2024, almost one third (31%) of the Darwin sample reported 'any' crime in the past month, with drug dealing (22%) and property crime (14%) being the two main forms of criminal activity in 2024 (Figure 56). Few participants (n≤5) reported being the victim of a crime involving violence; therefore, further details are not reported (Figure 57).

Twelve per cent reported having ever been in prison in 2024 (Figure 58). Few participants (n≤5) reported having been arrested in the 12 months preceding interview (Figure 58); therefore, further details are not reported. Please refer to the 2024 National EDRS Report for national trends, or contact the Drug Trends team for further information (drugtrends@unsw.edu.au).

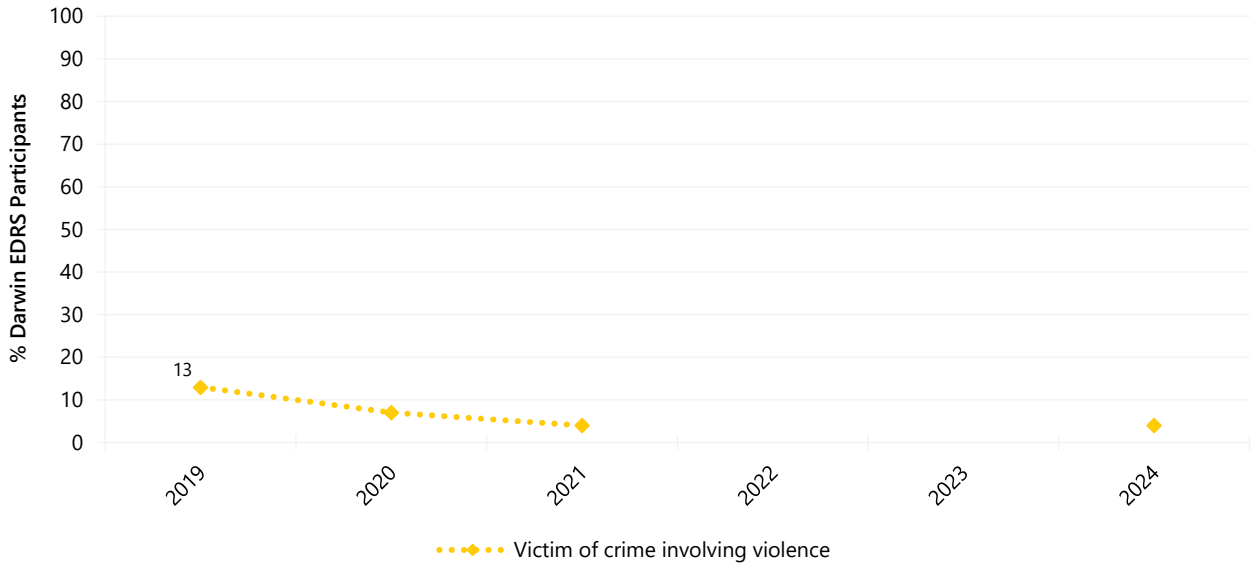
Twelve per cent of participants reported a drug-related encounter with police which did not result in charge or arrest in the past 12 months (Figure 58). Few participants (n≤5) were able to comment on the type of drug-related encounters.

Figure 56: Self-reported criminal activity in the past month, Darwin, NT, 2003-2024



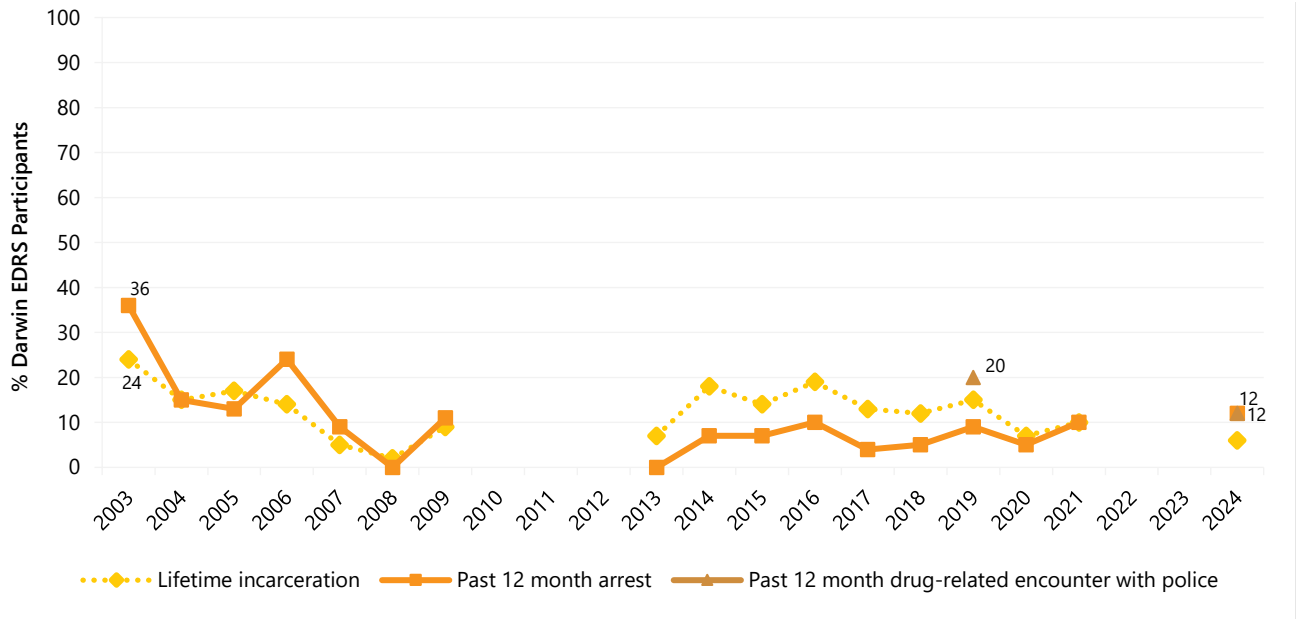
Note. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year of monitoring, 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 57: Victim of crime involving violence in the past month, Darwin, NT, 2019-2024



Note. Questions regarding being the victim of a crime involving violence were first asked in 2019. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report; furthermore, data from 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

Figure 58: Lifetime incarceration, and past 12 month arrest and drug-related encounters with police that did not result in arrest, Darwin, NT, 2003-2024



Note. Due to the particularly small samples recruited in 2010-2012 and 2022-2023, data from these years are not presented in this report; furthermore, data from 2006, 2008, 2013 and 2024 should be interpreted with caution. Data labels are only provided for the first and most recent year 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. Please refer to Table 1 for a guide to table/figure notes.

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 2024, the most popular means of arranging the purchase of illicit or non-prescribed drugs in the 12 months preceding interview were in person (80%), via social networking or messaging applications (e.g., Facebook, Wickr, WhatsApp, Snapchat, Grindr, Tinder) (55%) and via text messaging (53%) (Table 10). 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.

Among those who had used social networking or messaging applications to arrange the purchase of illicit or non-prescribed drugs in the 12 months preceding interview, the most commonly used social networking or messaging apps were Snapchat (63%), Facebook (48%) and Instagram (22%), with substances mostly obtained from a friend/relative/partner/colleague (70%), followed by a known dealer/vendor (59%). Among those who had used social networking or messaging apps to arrange the purchase of drugs in 2024 and responded (n=28), 43% reported that the person they had obtained drugs from advertised the sale of illicit drug/s via these platforms.

Buying and Selling Drugs Online

Few participants (n≤5) reported obtaining drugs via the darknet or the surface web in the past year. However, 44% of participants reported ever obtaining illicit drugs through someone who had

purchased them on the surface web or darknet, with 29% having done so in the last 12 months. In 2024, few participants (n≤5) reported selling illicit/non-prescribed drugs via surface or darknet marketplaces in the 12 months preceding interview.

Source and Means of Obtaining Drugs

Almost four fifths (78%) of participants reported obtaining illicit drugs from a friend/relative/partner/colleague in 2024, followed by almost two thirds (63%) reporting obtaining illicit drugs from a known dealer/vendor. One quarter (25%) reported obtaining illicit drugs from an unknown dealer/vendor (Table 10).

When asked about how they had received illicit drugs on any occasion in the last 12 months, almost all participants reported face-to-face (96%), followed by a collection point (defined as a predetermined location where a drug will be dropped for later collection; 22%), and fewer participants reporting receiving illicit drugs via post (16%) (Table 10).

Table 10: Means of purchasing and obtaining illicit drugs in the past 12 months, Darwin, NT, 2019-2024

	2019 (N=100)	2020 (N=100)	2021 (N=100)	2022	2023	2024 (N=51)
% Purchasing approaches in the last 12 months^	(n=100)	(n=100)	(n=99)			**(n=51)**
Face-to-face	90	69	86	~	~	**80**
Surface web	-	-	-	~	~	**-**
Darknet market	6	-	-	~	~	**-**
Social networking or messaging applications#	56	66	66	~	~	**55**
Text messaging	71	49	55	~	~	**53**
Phone call	54	37	40	~	~	**29**
Grew/made my own	/	-	-	~	~	**-**
Other	0	0	0	~	~	**0**
% Means of obtaining drugs in the last 12 months^*	(n=98)	(n=100)	(n=100)			**(n=51)**
Face-to-face	100	98	97	~	~	**96**
Collection point	15	27	10	~	~	**22**
Post	7	8	-	~	~	**16**
% Source of drugs in the last 12 months^	(n=99)	(n=99)	(n=100)			**(n=51)**
Friend/relative/partner/colleague	87	90	85	~	~	**78**
Known dealer/vendor	67	65	51	~	~	**63**
Unknown dealer/vendor	35	38	34	~	~	**25**

Note. ^ 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)'. Due to the particularly small samples recruited in 2022-2023, data from these years are not presented in this report. Furthermore, data from 2024 should be interpreted with caution. Please refer to Table 1 for a guide to table/figure notes.