

Queensland

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QUEENSLAND TRENDS IN ECSTASY AND RELATED DRUG MARKETS 2012
Findings from the Ecstasy and Related Drugs Reporting System (EDRS)

Australian Drug Trend Series No. 108

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Queensland Alcohol and Drug Research and Education Centre

Australian Drug Trends Series No. 108

**ISBN978-0-7334-3251-4
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Suggested citation: Hickey, S., McIlwraith, F. and Alati, R. (2013). Queensland Trends in Ecstasy and Related Drug Markets 2012: Findings from the Ecstasy and Related Drugs Reporting System (EDRS). *Australian Drug Trend Series No. 108*. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.

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ACKNOWLEDGEMENTS

In 2012, the Ecstasy and Related Drugs Reporting System (EDRS) was supported by funding from the Australian Government under the substance Misuse Prevention and Service Improvement Grants Fund, and was coordinated by the National Drug and Alcohol Research Centre (NDARC). The EDRS team would like to thank Mr Chris Milton, Dr Robyn Davies and Mr Joe Upston of the AGDH&A for their continued assistance and support of the EDRS.

The EDRS is coordinated by the National Drug and Alcohol Research Centre (NDARC) in Sydney, and sincere thanks to our colleagues at NDARC:

- chief investigator: Dr Lucy Burns
- national coordinators: Natasha Sindicich and Jennifer Stafford
- Emma Black - previous national co-ordinator
- Amanda Roxburgh - for her help with access and analysis of indicator data

The success of the Queensland EDRS essentially depends upon the ongoing support and cooperation of a large number of stakeholders each year. In particular, we acknowledge and thank the following individuals and organisations:

- the 2012 EDRS participants for generously sharing their perceptions and experiences with us
- Caroline Salom as an additional EDRS interviewer
- the individuals from the health and law enforcement sectors who freely provided their time and knowledge to participate as key experts
- the health and law enforcement agencies that kindly provided indicator data.

ABBREVIATIONS

ACC	Australian Crime Commission
ACS	Australian Customs Service
ACT	Australian Capital Territory
ADIS	Alcohol and Drug Information Service
AFP	Australian Federal Police
AGDHA	Australian Government Department of Health and Ageing
AIHW	Australian Institute of Health and Welfare
ATS	amphetamine-type stimulant
ATSI	Aboriginal and Torres Strait Islander
CPR	cardiopulmonary resuscitation
DMT	dimethyltryptamine
DUMA	Drug Use Monitoring Australia
ED	emergency department
EDRS	Ecstasy and Related Drugs Reporting System
EPS	emerging psychoactive substances
GHB	gamma hydroxybutyrate acid ('fantasy')
GP	general practitioner
HPV	human papilloma virus
IDRS	Illicit Drug Reporting System
KE	key expert
K10	Kessler Psychological Distress Scale
LSD	lysergic acid diethylamide
MDA	3,4-methylenedioxyamphetamine
MDMA	3, 4-methylenedioxymethylamphetamine ('ecstasy')
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NSP	Needle and Syringe Program
NSW	New South Wales
NT	Northern Territory
PDI	Party Drugs Initiative
PMA	paramethoxyamphetamine
QADREC	Queensland Alcohol and Drug Research and Education Centre
QLD	Queensland
QPS	Queensland Police Service
RBT	random breath testing
ROA	route of administration
SD	standard deviation
WA	Western Australia
WHO	World Health Organization
2CB	4-bromo-2,5-dimethoxyphenethylamine
µg	microgram, 1/1000 of a milligram

GLOSSARY OF TERMS

Binge	Use over 48 hours without sleep
Eightball	3.5 grams
Halfweight	0.5 gram
Illicit	Describes pharmaceuticals obtained from a prescription in someone else's name, e.g. through buying them from a dealer or obtaining them from a friend or partner
Indicator data	Sources of secondary data used in the EDRS (see <i>Method</i> section for further details)
Key expert	A person who participated in the Key Expert Survey component of the EDRS (see <i>Method</i> section for further details)
Licit	Describes pharmaceuticals (e.g. benzodiazepines, antidepressants and opioids such as methadone, buprenorphine, morphine and oxycodone) obtained by a prescription in the user's name. This definition does not take account of 'doctor shopping' practices; however, it differentiates between prescriptions for self as opposed to pharmaceuticals bought on the street or those prescribed to a friend or partner
Lifetime injection	Injection (typically intravenous) on at least one occasion in the participant's lifetime
Lifetime use	Use on at least one occasion in the participant's lifetime via one or more of the following routes of administration: injecting, smoking, snorting, shelving/shafting and/or swallowing
Opiates	Opiates are derived directly from the opium poppy by departing and purifying the various chemicals in the poppy
Opioids	Opioids include all opiates but also include chemicals that have been synthesised in some way, e.g. heroin is an opioid but not an opiate, morphine is both an opiate and opioid
Participant	A person who participated in the Queensland ecstasy use survey component of the EDRS (does not refer to key expert participants unless stated otherwise)
Point	0.1 gram; although may also be used as a term referring to an amount for one injection
Recent injection	Injection (typically intravenous) in the six months preceding interview
Recent use	Use in the six months preceding interview via one or more of the following routes of administration: injecting, smoking, snorting, shelving/shafting and/or swallowing
Shelving/shafting	Use via insertion into vagina (shelving) or the rectum (shafting)
Use	Use via one or more of the following routes of administration: injecting, smoking, snorting, shelving/shafting and/or swallowing

Guide to days of use/injection in preceding six months

180 days	daily
90 days	every second day
24 days	weekly
12 days	fortnightly
6 days	monthly

EXECUTIVE SUMMARY

The Ecstasy and Related Drugs Reporting System (EDRS) is an on-going study of regular ecstasy users and is conducted annually in the capital city of every state and territory in Australia. It is designed to identify emerging trends among a sentinel group of drug users, and to inform the health and law enforcement sectors on current drug use consumption patterns, relevant health issues and other special areas of interest.

The demographic characteristics of the 2012 sample of regular ecstasy users in Queensland were similar to previous years. Typically they were in their mid-twenties, male, heterosexual, and engaged in work and/or study.

Consumption trends

Current drug use

A lower proportion of respondents reported recent use of cocaine, LSD, and cannabis ($p < 0.05$) compared with 2011. For the first time cocaine tied with ecstasy as the most commonly reported drug of choice.

Use of ecstasy and related drugs was most commonly fortnightly (32%) or weekly (27%). There was a significant increase in the proportion using these drugs more than once per week from 6% in 2011 to 24% in 2012 ($p < 0.05$).

Ecstasy use

Ecstasy use was similar to 2011. The mean age of first ecstasy use was 18 years, and participants typically swallowed two ecstasy pills per session once a fortnight. Approximately one-third of participants reported having recently binged on ecstasy. Ecstasy continued to be taken with other drugs, primarily alcohol at greater than five standard drinks. Over half of participants (53%) reported that all or most of their friends and acquaintances used ecstasy.

Methamphetamine use

Just over three-quarters of participants (76%) had used one or more forms of methamphetamine within the last six months. Use of methamphetamine powder (speed) and crystalline methamphetamine (ice) continued to rise. For all forms of methamphetamine, amounts used in a regular session were stable; however, amounts used in heavy sessions were higher than in 2011.

Cocaine use

Recent use of cocaine decreased in 2012 to 34% of participants (52% in 2011, $p < 0.05$). Use occurred on a median of 4 days, and the number of grams used in both a regular session and a heavy session was stable at 0.75 and 1 gram respectively.

Ketamine use

Although 36% of participants had a history of using ketamine at least once in their lifetime, only 7% had used it recently and then on one occasion only.

GHB use

GHB had been used by 44% of participants, with 10% having used it in the previous six months on a median of 1.5 days.

Hallucinogen use

Nearly three-quarters (74%) of participants had used LSD in their lifetime. Recent use decreased from 52% in 2011 to 34% ($p < 0.05$). Two-thirds of participants had used mushrooms in their lifetime, with 15% having used recently.

Cannabis use

Cannabis remains one of the most consumed illicit drugs in Australia. Nearly all participants had used cannabis at least once in their lifetime, with four in five participants (81%) having recently used on a median of 48 days, representing three to four days a week during the previous six months. Cones were more commonly used than joints.

Other drug use

Recent use of MDA was reported by 13%, but use was infrequent. Most participants had used alcohol in the previous six months, with use occurring on a median of 48 days. Tobacco use remained stable, with 84% reporting recent use and two-thirds smoking daily.

There were no reports of illicit anti-depressant use in the preceding six months, although 11% had recently used anti-depressants prescribed for them. Use of illicit benzodiazepines remained stable with 32% reporting recent use. Amyl nitrate had been recently used by 16%, but most had only used it once. Nitrous oxide had been recently used by 18% on a median of five days.

Heroin was rarely used (one participant recently); but 7% had recently used buprenorphine with 5% injecting it. Morphine had been recently used by 15%, with 3% injecting it. Nearly one in five (19%) had recently used illicit pharmaceutical stimulants. Over the counter codeine had been recently used for non-pain purposes by 18% of participants. DMT (dimethyltryptamine) was the most commonly used emerging psychoactive drug, with 34% using it in their lifetime and 15% in the previous six months.

Drug market: price, purity, availability and supply

Ecstasy market

The price of an ecstasy tablet/ capsule remained stable at \$25. Rating of ecstasy purity was mixed; although about half rated it as low, 18% rated it as high. There was an increase in the proportion rating availability of ecstasy as very high (57% in 2012 versus 36% in 2011, $p < 0.05$), with changes in availability commonly rated as stable (63%) or easier (23%). Ecstasy was mostly obtained from a friend (65%), with the most common venue being a friend's house (34%).

Methamphetamine market

It was unclear whether the price of speed and base had changed due to low numbers commenting, but the median price of one point of crystal/ice was \$95 compared with \$75 in 2011. Purity of all forms of methamphetamine rated highly, particularly ice/crystal purity which was rated as high by four in five participants. All forms of methamphetamines were generally considered to be readily available: friends were the most common source person, followed by a known dealer.

Cocaine market

The median price of cocaine was \$300 per gram, with price mostly reported as stable. The proportion rating cocaine purity as high increased from 12% in 2011 to 57% in 2012 ($p < 0.05$). Two-thirds (65%) reported cocaine was easy or very easy to obtain. Most of those reporting on cocaine scored from a friend (70%); and a friend's home was the most common location (60%).

Cocaine was consumed at a variety of venues, the most common being a friend's home.

Ketamine market

No participants were able to comment on the ketamine market. Key experts advised that ketamine use was uncommon. They explained that people tended to try it but not use it regularly.

GHB market

Only four participants commented on the GHB market, preventing meaningful analysis.

LSD market

Price of LSD was stable at a median of \$20 per tab. Purity was generally rated as medium (46%) or high (31%). Ratings of availability were mixed, with 46% rating it as easy but 37% rating it as difficult.

Cannabis market

Most participants rated the price of hydro and bush as stable. Hydro was mostly rated as high or medium strength, and bush as medium. Hydro was readily available but bush appeared to be becoming more difficult to access. A friend was the most common source person for both hydro and bush. Hashish and hashish oil were rarely used.

Health-related trends associated with ecstasy and related drug use

Regarding accidental overdoses in the previous 12 months, 18% experienced a stimulant overdose and 31% a depressant overdose. Help was sought by 16% of participants about a specific drug-related problem (e.g. dependence, legal issues) from a service or health professional. A very small proportion of participants (5%) were currently in drug treatment.

Drugs were reported as contributing to recurrent problems in four spheres: increased risky behaviour (52%), difficulty meeting responsibilities (41%), social relationships (29%), and legal (9%). Alcohol, cannabis, ice/crystal and ecstasy were the drugs most commonly reported as the main contributors to recurrent problems.

About three-quarters (74%) of participants recorded moderate to very high distress on the Kessler Psychological Distress Scale (K10). Thirty-six per cent reported a mental health problem in the previous six months, with depression and anxiety being the most common problems.

Risk behaviour

The proportion of participants who had injected in the previous six months remained at 16%. Just under half (46%) of participants had been vaccinated for hepatitis B, 48% reported being tested for hepatitis C, and 59% for HIV. Two in five participants reported having had a sexual health check-up in the last year.

Of those who drove a vehicle in the previous six months, 50% reported driving while over the alcohol limit and 65% reported driving soon after taking illicit drugs.

The majority of participants (83%) were drinking alcohol at levels which may be harmful to their health.

Law enforcement-related trends associated with ecstasy and related drug use

In the previous 12 months, 19% of participants had been arrested; and in the previous month, 48% had been involved in criminal activity (other than illicit drug use), with 39% having sold drugs for profit. Over a quarter of participants (27%) believed that police activity towards regular ecstasy users had increased. Nearly all participants were aware that if charged for possession of drugs, the quantity of drugs would affect the charge being brought against them.

Special topics of interest

Nearly a quarter (23%) of daily smokers scored high to very high nicotine dependence on the Fagerstrom test. The majority of respondents reported no or few symptoms of ecstasy dependence, with 78% responding that it would not be difficult to stop or go without.

In regard to neurological history, 38% of participants had experienced a traumatic brain injury. Of these ($n = 22$), 33% had been under the influence of alcohol at the time and 25% under the influence of illicit drugs.

Attitudes towards drug policy varied, with the strongest support being for Needle and Syringe Programs (NSP) and methadone treatment programs. There was strong support for the legalisation of cannabis for personal use, and very little support for increasing the penalties for its sale or supply.

In regard to body image, 23% reported using illicit psychostimulants for weight management, most commonly methamphetamines and ecstasy.

1 INTRODUCTION

The Ecstasy and Related Drugs Reporting System (EDRS) is an annual, national study supported by funding from the Australian Government under the Substance Misuse Prevention and Service Improvement Grants Fund. It is coordinated nationally by the National Drug and Alcohol Research Centre (NDARC), University of New South Wales. The Queensland component is undertaken by the Queensland Alcohol and Drug Research and Education Centre (QADREC) in the School of Population Health, University of Queensland.

QADREC participated in the 2000 and 2001 trial of the EDRS (then called the Party Drugs Initiative or PDI). The purpose of the trial was to determine the feasibility of monitoring emerging trends in ecstasy and related drug markets using the same methodology of the Illicit Drug Reporting System (IDRS). The Party Drugs Initiative commenced as a national study in 2003 and was re-named the Ecstasy and Related Drugs Reporting System in 2006. The current report presents the findings of the eleventh year of data collection for the EDRS in Queensland (no data was collected in 2002).

1.1 Study aims

The EDRS monitors the use, price, purity and availability of ecstasy, amphetamines and other illicit drugs. It is designed to provide a snapshot of emerging trends across all Australian jurisdictions and over time.

The annual EDRS national, state and territory reports:

- describe the demographic characteristics of current, regular ecstasy users in Australian capital cities
- examine patterns of ecstasy and other drug use among these samples
- identify current trends in the price, purity and availability of a range of illicit drug classes
- indicate the nature and incidence of drug-related harms
- identify emerging trends in ecstasy and related drug markets that may represent areas of research need.

2 METHODS

The EDRS uses a triangulation method to combine information collected from:

- quantitative interviews with regular and current ecstasy users (participants), who are considered a population likely to be aware of new drug trends
- qualitative interviews with 'key experts' who have current regular contact with people who are using ecstasy
- existing data on population trends in illicit drug use, and health and law enforcement data.

2.1 Survey of regular ecstasy users

The market for ecstasy (tablets that are alleged to contain 3, 4-methylenedioxymethamphetamine; MDMA) in Australia has existed for more than two decades. According to the 2010 National Drug Strategy Household Survey (NDSHS), ecstasy is the second most commonly used illicit drug alongside pain-killers/analgesics (used for non-medical purposes). In 2010, recent use of ecstasy (last 12 months) was reported by 3% of the population aged 14 years and over; this is a reduction from the peak of 3.5% in 2007.

For the purposes of the present study, the sentinel population consisted of regular users of tablets sold as 'ecstasy'. From April to June 2012, 62 current, regular ecstasy users were recruited from the greater Brisbane and Gold Coast regions (South East Queensland). They were interviewed on topics relating to their illicit drug use including prices paid for illicit drugs; perceptions of drug purity and availability; risk and help-seeking behaviours; health; law enforcement trends associated with drug use; drug-policy attitudes; and neurological history.

2.1.1 Recruitment of participants

Participants were recruited from advertisements placed in South East Queensland street press, web sites (e.g. pillreports.ru), posters, and word of mouth.

Advertisements explained that current regular ecstasy users were being recruited to undertake a face-to-face survey of approximately 60 minutes duration, and the respondents would be reimbursed \$40 for their time and expenses in completing the questionnaire. On completion of the interview, participants were asked to mention the study to friends who might be willing and able to participate. This is a method often used to access illicit drug user populations (Dalgarno, 1996; Ovendon & Loxley, 1996).

Selection criteria for participation in the EDRS were:

- aged 17 years or over
- resided in South East Queensland continuously for the past 12 months
- used ecstasy at least once a month for the past six months (six times or more).

In 2012, the Queensland EDRS team experienced difficulty with recruitment as did some of the smaller jurisdictions (i.e. WA and NT). These jurisdictions broadened the recruitment criteria to include regular use of any psychostimulant in the previous six months. Queensland kept to the criteria of use of ecstasy at least six times in the previous six months; but four participants who reported recently using six times when screened, but then reported using five times in the interview, were retained in the sample because they met the expanded criteria of use of any psychostimulant on six separate occasions. All other eligibility criteria were identical to previous years. Thus the Queensland EDRS team recruited 58 REU using the old criteria as well as 4 using the broader criteria of regular psychostimulants use, making a total of 62 participants.

2.1.2 Procedure

Enquiries about participating were made by telephone or email and, if the individual met the selection criteria, an interview was then scheduled at a coffee shop in one of five strategic localities. It was explained that participation was voluntary and anonymous, and information gathered would remain confidential with the de-identification of questionnaires. The nature and purpose of the study was explained to participants before consent was obtained.

2.1.3 Measures

Participants were asked a range of questions about their demographics, drug use history and characteristics of recent use - particularly ecstasy; price, purity and availability of various illicit drugs; risk behaviours; and perceptions of police activity. A dummy drug named 'canthezine' was included in the drug use section as a method of identifying over-reporting of drug use by participants. No participant identified themselves as having used canthezine.

2.1.4 Data analysis

Data were entered into an Access database and then transferred into IBM® SPSS® Statistics, version 21.0 for Windows. Data analyses were mostly descriptive and concerned with lifetime and recent patterns of use (in the previous six months) and participant reports of the price, purity and availability of a range of illicit drugs. Some significance testing was undertaken to compare differences in proportions between 2011 and 2012, and when found to be significant at the <0.05 level (using Excel spreadsheet available at <http://www.cebm.net/index.aspx?o=1023>), this was stated within the report. Other proportional differences observed between 2011 and 2012 may represent sampling variability only.

2.2 Survey of key experts

During August and September, 12 key experts who had knowledge of ecstasy users and/or the ecstasy market were recruited throughout South East Queensland. Key experts were drawn from the health sector, law enforcement/forensic sector and peers.

2.2.1 Recruitment

Key experts were recruited from appropriate organisations using the professional networks of project staff, and recommendations and referrals from colleagues and other key experts.

2.2.2 Procedure

Interviews with key experts occurred over the telephone or face-to-face in their work environment or at a convenient location. Interviews took on average 30 minutes to complete.

2.2.3 Measures

Key experts were interviewed on topics related to patterns of illicit drug use among people using ecstasy who they had contact with in the past six months. These topics included perceptions of price, purity and availability of ecstasy and other related drugs, emerging features of drug use, issues related to health, and perceptions of crime and police activity.

2.3 Other indicators

Secondary data sources from external health, research and law enforcement sources were collected and included to complement the data collected from participants and key experts. In 2012, the following data were obtained for the EDRS:

- Australian Crime Commission (ACC) — number and purity of drug seizures from Queensland Police Service and the Australian Federal Police
- Australian Customs Service (ACS) — number and weight of drug seizures
- Australian Institute of Health and Welfare (AIHW) — National Drug Strategy Household Surveys (NDSHS)
- Queensland Health — Alcohol and Drug Information Service (ADIS)
- Queensland Police Service (QPS) — clandestine laboratory seizures, drug-related arrests.

3 DEMOGRAPHICS

3.1 Overview of the EDRS sample

As in previous years, participants were typically in their mid-twenties, male, heterosexual, and engaged in work and/or study (Table 1).

Most participants lived in rental accommodation (68%), followed by family or parental home (21%). In 2012, there were similar rates of high school completion among participants compared to 2011 and similar completion of tertiary studies.

The mean weekly income was \$424 (range \$100–\$1,600). When asked about their main source of income in the month preceding the interview, 48% reported receiving it from a wage or salary, and 45% from a government pension, allowance or benefit. Other main sources of income included criminal activity (3%) and parental allowance (3%).

Table 1: Demographic characteristics, 2011 and 2012

	2011 (N = 103)	2012 (N = 62)
Mean age (range)	25 (18–43)	26 (17–51)
% Male	70	69
% English speaking background	97	98
% Aboriginal and/or Torres Strait Islander	-	5
% Sexual orientation		
Heterosexual	88	89
Gay male	5	3
Lesbian female	-	2
Bisexual	6	5
Other	1	2
% Relationship status		
Married/de facto	11	8
Regular partner	34	37
Single	54	55
Divorced/separated/widowed	1	-
% Accommodation		
Own house/flat	1	5
Rented house/flat	73	68
Parents'/family home	22	21
Boarding house/hostel	4	2
No fixed address	1	5
Education		
Mean years of school education	12	12
% Completed Year 12 or equivalent	73	73
% University/college qualifications	20	17
% Trade/technical qualifications	22	35
% Employment status		
Not employed	15	19
Full time	26	27
Part time/casual	18	11
Full time student	12	26
Part time student	-	3
Work and study	28	8
Other ^a	-	5
Income		
Mean weekly income	\$541	\$424

^aOther includes self-employed (3)

Source: QLD EDRS participant interviews

4 CONSUMPTION PATTERN RESULTS

Key Points

- Compared with 2011, a lower proportion of respondents in 2012 reported recent use of cocaine, LSD, and cannabis ($p < 0.05$).
- Cocaine tied with ecstasy as the most commonly reported drug of choice.
- Use of ecstasy and related drugs was most commonly fortnightly (32%) or weekly (27%). There was a significant increase in the proportion using these drugs more than once per week from 6% in 2011 to 24% in 2012 ($p < 0.05$).

4.1 Drug use history and current drug use

4.1.1 Drug history

Table 2 shows participants' lifetime and recent use (i.e. in the previous six months) of different drug types and includes age of first use, route of administration (ROA), and frequency of use.

Compared to 2011, a lower proportion of respondents in 2012 reported recent use of cocaine, LSD, and cannabis ($p < 0.05$). There also appeared to be a significant decrease in use of over-the-counter codeine but because the wording of the question was refined to include '*non pain use only*', an accurate comparison cannot be made. While shelving/shafting was included as a route of administration on the questionnaire, it has not been reported in Table 2 due to the rarity of this method (i.e. one participant reported recently shelving/shafting ecstasy pills and one participant reported recently shelving/shafting over-the-counter codeine).

Table 2: Drug use history, 2012

Form of drug	Use				Mode of administration %							
	Ever %	Mean age first used ^a	Recent ^b %	Days ^c	Injected		Smoked		Snorted		Swallowed	
					Ever	Recent ^b	Ever	Recent ^b	Ever	Recent ^b	Ever	Recent ^b
Ecstasy pills	100	19	95	18	16	5	16	3	86	59	100	94
Ecstasy powder	61	21	31	4	5	2	16	5	47	18	52	24
Ecstasy capsules	82	21	52	6	8	3	2	-	48	33	79	49
Methamphetamine powder	86	19	58	6	21	11	36	26	50	26	63	44
Methamphetamine base	45	22	19	4	18	2	20	10	8	2	30	16
Methamphetamine crystal	66	22	40	6	18	10	52	32	13	5	32	15
Pharmaceutical stimulants –licit	15	13	2	180	-	-	-	-	3	-	15	2
Pharmaceutical stimulants –illicit	60	19	19	3	2	-	-	-	18	5	57	19
Cocaine	79	21	34	4	13	-	8	2	68	32	19	10
LSD	74	19	34	2	2	2	2	-	2	-	74	32

^a Calculated for those who reported lifetime use

^b In the preceding six months

^c Median days in the preceding six months (180 days)

Note: Responses are for the name given to the drug when it was obtained (i.e. regardless of actual content).

Source: QLD EDRS participant interviews.

Table 2: Drug use history, 2012 (cont'd)

Form of drug	Use				Mode of administration %							
	Ever %	Mean age first used ^a	Recent ^b %	Days ^c	Injected		Smoked		Snorted		Swallowed	
					Ever	Recent ^b	Ever	Recent ^b	Ever	Recent ^b	Ever	Recent ^b
MDA	31	21	13	2	2	-	2	-	11	7	27	11
Ketamine	36	21	7	1	3	2	2	-	10	-	25	5
GHB ^d	44	22	10	2	3	-					42	10
Amyl nitrate	55	21	16	1								
Nitrous oxide	61	18	18	5								
Cannabis	98	15	81	48			98	81			81	18
Alcohol	98	14	90	48	2	-					98	89
Heroin	23	21	2	40	19	2	8	-	7	-	5	-
Methadone	13	21	-	-	5	-	-	-	-	-	11	-
Buprenorphine	10	21	7	133	5	5	-	-	-	-	10	7
Other opioids–licit	31	22	15	12	7	-	3	-	2	-	24	13
Other opioids–illicit	32	20	15	3	8	3	2	-	7	5	19	7

^a Calculated for those who reported lifetime use

^b In the preceding six months

^c Median days in the preceding six months (180 days)

^d Includes GBL, 1,4B, 9GBH, 'liquid e', and 'fantasy'.

Note: Responses are for the name given to the drug when it was obtained (i.e. regardless of actual content).

Source: QLD EDRS participant interviews

Table 2: Drug use history, 2012 (cont'd)

Form of drug	Use				Mode of administration %							
	Ever %	Mean age first used ^a	Recent ^b %	Days ^c	Injected		Smoked		Snorted		Swallowed	
					Ever	Recent ^b	Ever	Recent ^b	Ever	Recent ^b	Ever	Recent ^b
Over the counter codeine ^e	28	18	18	6	-	-	-	-	3	-	26	18
Tobacco	92	14	84	180			92	84				
Antidepressants –licit	40	18	11	180	-	-	-	-	-	-	37	11
Anti-depressants –illicit	5	19	-	-	-	-	-	-	-	-	2	-
Benzodiazepines –licit	29	23	19	177	3	-	-	-	-	-	29	19
Benzodiazepines –illicit	65	21	32	6	2	-	3	-	7	2	65	32
Mushrooms	67	19	15	1	-	-	-	-	-	-	67	15
Over the counter stimulants	25	22	8	6	-	-	-	-	3	3	23	8
Steroids	3	21	3	64	2	2	-	-	-	-	2	2

^a Calculated for those who reported lifetime use

^b In the preceding six months

^c Median days in the preceding six months (180 days)

^e Other than for pain relief.

Note: Responses are for the name given to the drug when it was obtained (i.e. regardless of actual content).

Source: QLD EDRS participant interviews

4.1.2 Drug of choice

In 2012, cocaine tied with ecstasy as the most commonly reported drug of choice among participants. The proportion nominating ecstasy as the preferred drug has been dropping ever since peaking at 53% in 2003.

Table 3: Drug of choice, 2011 and 2012

Drug of choice	2011 (N = 103) %	2012 (N = 62) %
Ecstasy	28	21
Cocaine	13	21
Cannabis	19	19
Speed	9	13
Alcohol	8	8
LSD	9	5
Heroin	5	2
Ice/crystal	2	2
Other	3	9

Note: Other includes 'nitrous oxide', 'can't specify'

Source: QLD EDRS participant interviews

The nine participants, who used a drug other than their drug of choice more frequently, gave a variety of reasons including price and health effects.

4.1.2 Prevalence of ecstasy and related drug use

In the preceding month, most participants reported using ecstasy and related drugs (e.g. methamphetamine, cocaine, GHB, LSD, mushrooms, etc.) fortnightly, followed by weekly (Table 4). There was a significant increase in the proportion using more than once per week from 6% in 2011 to 24% in 2012.

Table 4: Frequency of ecstasy and related drug use during previous month, 2011 and 2012

	2011 (N = 103) %	2012 (N = 62) %
Not in the last month	2	5
Monthly	21	10
Fortnightly	37	32
Weekly	34	27
More than once per week	6	24*
Once a day	-	2

*Significant at $p < 0.05$

Source: QLD EDRS participant interviews

4.2 Ecstasy use

Key Points

- The mean age of first use of ecstasy was 18 years (range 14–43).
- As in previous years, participants typically reported using two tablets in a session once a fortnight.
- Swallowing pills remained the most common form of ecstasy use.
- About one-third of participants had recently binged on ecstasy.
- Alcohol (>5 standard drinks) was commonly combined with ecstasy.
- 57% used other drugs to come down from ecstasy.
- Over half of participants (53%) reported that all or most of their friends and acquaintances used ecstasy.

4.2.1 Patterns of ecstasy use among regular ecstasy users

As in previous years, participants typically reported using two tablets once a fortnight (Table 5). There were no significant differences in patterns of ecstasy use from 2011 to 2012.

Table 5: Patterns of ecstasy use, 2003 to 2012

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	N=136	N=161	N=101	N=100	N=101	N=108	N=88	N=101	N=103	N=62
Mean age first used	20.7	21.3	19.2	18.0	18.6	19.0	18.0	18.5	18.0	18.6
Median days used last 6 months	24	24	17	14	12	12	13	12	12	18
% Use weekly or more	24	41	31	29	24	23	31	10	24	37
Median pills in 'typical' session	1.5	2	2	2	2	2	2	2	2	2
% Typically use >1 pill	57	75	77	63	69	73	78	82	84	86
% favourite drug	53	46	55	40	45	31	39	43	28	21
% Ever injected ecstasy	13	21	5	11	6	4	14	9	11	29
% Mainly swallowed ecstasy last 6 mths	91	83	92	97	87	96	87	91	90	89
% Mainly snorted ecstasy last 6 mths	5	7	5	3	10	3	9	9	7	8
% Mainly injected ecstasy last 6 mths	3	6	2	0	1	1	4	0	1	3
% Recently binged on ecstasy ^a	43	37	42	38	26	21	34	27	33	34
% Use other drugs with ecstasy	85	89	92	95	96	94	97	93	91	87
% Use other drugs to 'come down' from ecstasy	79	75	81	85	86	78	75	44	65	57

^a>48 hours without sleep

Source: QLD EDRS participant interviews

Participants were asked what proportion of their friends and acquaintances used ecstasy: 5% reported 'all', 48% 'most', 17% 'about half', and 30% 'a few'.

4.2.2 Forms and administration of ecstasy use

In the previous six months, 89% of participants reported that swallowing was the most usual route of administration of ecstasy, with 8% reporting snorting and 3% reporting injecting.

Ecstasy pills continued to be the most used form of ecstasy among participants, with all participants having used pills in their lifetime and 95% in the preceding six months. Ecstasy capsules were the second most popular form (82% ever; 52% recent), followed by powder (61% ever; 31% recent).

4.2.3 Poly-drug use of regular ecstasy users

In 2012, 87% of participants reported using other drugs in combination with ecstasy in the preceding six months (compared with 91% in 2011). Alcohol was most commonly combined with ecstasy, followed by tobacco (Table 6). In 2012, 57% reported using another drug while coming down from ecstasy (compared with 65% in 2011), with cannabis being the most common drug used.

Table 6: Use of other drugs with and to come down from ecstasy, 2012

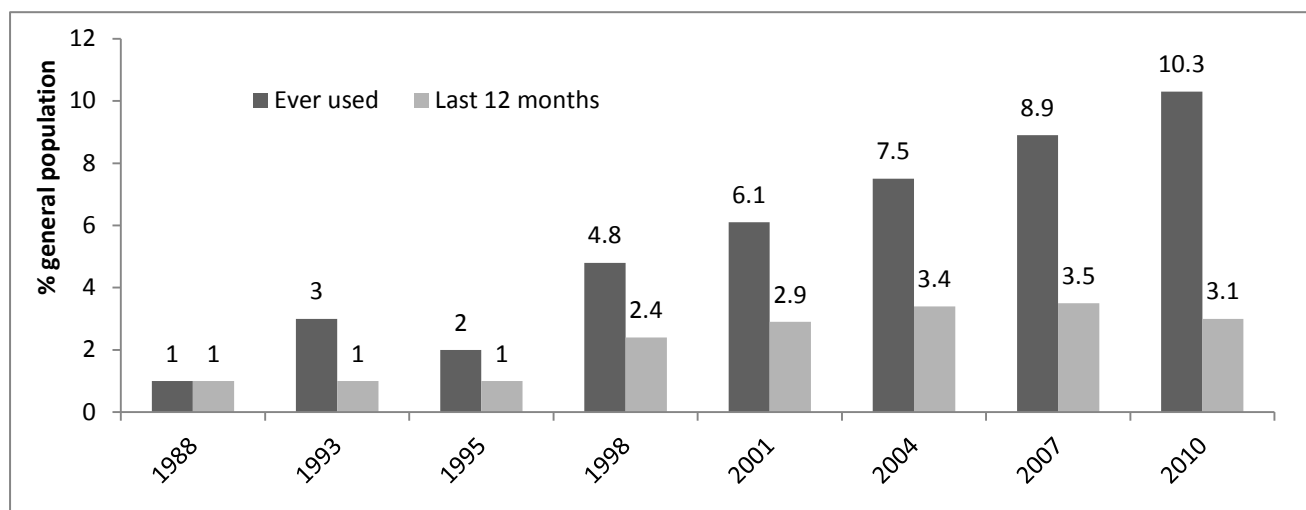
	Use with ecstasy	Use when coming down from ecstasy
	N ≈ 62 %	N ≈ 62 %
Methamphetamine powder (speed)	13	2
Ice/crystal	13	-
Cocaine	7	2
LSD	2	-
GHB	2	2
Nitrous oxide	2	-
Cannabis	38	31
Alcohol <5 standard drinks	10	3
Alcohol >5 standard drinks	56	5
Tobacco	51	3
Energy drinks	10	-
Benzodiazepines	7	21
Over the counter codeine	-	2
Buprenorphine	-	2

Source: QLD EDRS participant interviews

4.2.4 Ecstasy use in the general population

The 2010 National Drug Strategy Household Survey report (AIHW 2011) shows that from 2007 to 2010 the proportion having ever used ecstasy increased, but the proportion who had used ecstasy in the previous 12 months declined (Figure 1).

Figure 1: Prevalence of ecstasy use among the population aged 14 years and over in Australia, 1988 to 2010



Source: NDSHS 1988–2010 (AIHW, 2011)

4.2.5 Comments from key experts on ecstasy use

Key experts reported less frequent use of ecstasy overall, and this was consistent with our difficulty in recruiting regular users. One key expert related that although use of ecstasy appeared to be sporadic amongst the young people with whom they came in contact, there was also a small group of males in their late teens and early twenties with extremely frequent use. Some key experts also reported increased quantities of ecstasy pills being consumed in a session, and they linked this to the low effects experienced and the poor reputation for purity in recent years. These same key experts highlighted the increased risk when quantities of pills of unknown content are consumed.

Key experts pointed out that ecstasy was often used as a term for any pressed tablet with a distinctive motif. It was noted that there was some limited use of crystal ecstasy. Snorting of ecstasy was also reported, but swallowing was considered to remain the most common mode of consumption. Poly drug use in a session was regarded as common; ecstasy was not only consumed with alcohol, but it was also reported to be used in combination with a number of different drugs including methamphetamines and benzodiazepines. There were some reports of tripstacy (MDMA combined with LSD) use, but it was considered to be only used by a small minority. Key experts also noted that cannabis was a common drug used for coming down from ecstasy.

4.3 Methamphetamine use

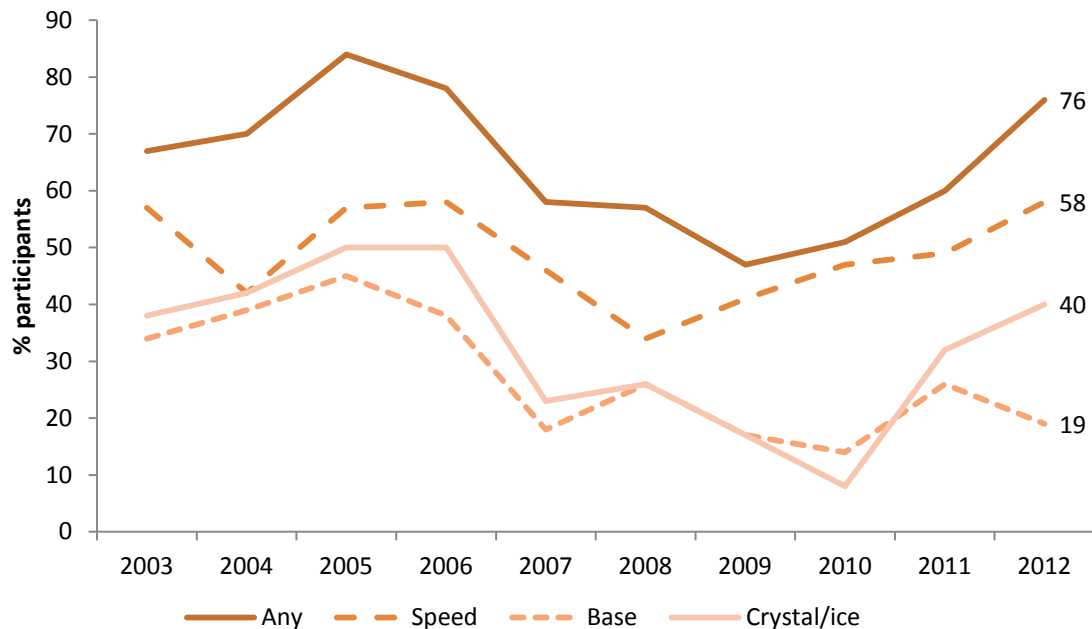
Key Points

- 76% of participants had used one or more forms of methamphetamine within the last six months.
- Use of methamphetamine powder (speed) and crystalline methamphetamine (ice) continued to rise.
- For all forms of methamphetamine, amounts used in a regular session were stable; however, amounts used in heavy sessions were higher than in 2011.

4.3.1 Patterns of methamphetamine use among regular ecstasy users

Figure 2 shows the change in patterns of methamphetamine use among participants since 2003. After a peak in 2005, use of methamphetamines had been declining but is now rising again, with 51% of participants reporting use of any form of methamphetamine in 2010, 60% in 2011, and 76% in 2012.

Figure 2: Patterns of methamphetamine use according to type (powder (speed), base and ice/crystal) in the previous six months, 2003 to 2012

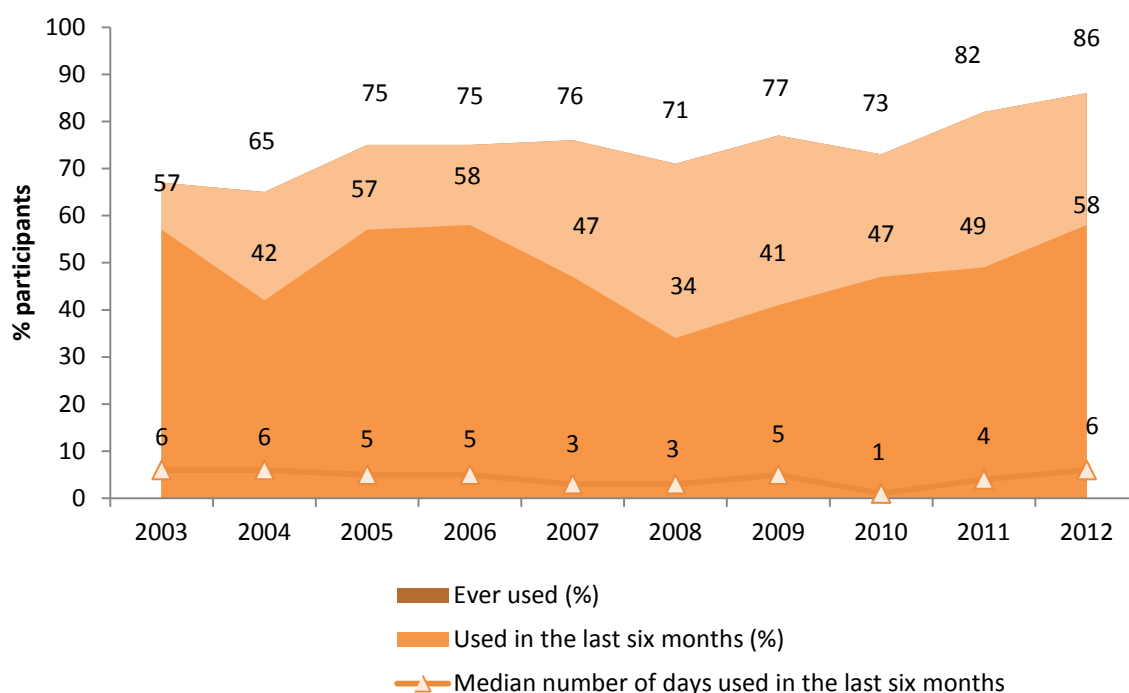


Source: QLD EDRS participant interviews

4.3.2 Speed methamphetamine use

In 2012, the percentage of lifetime use and recent use of methamphetamine powder (speed) was similar to 2011 (Figure 3). The median number of days that participants used ecstasy rose from 4 days in 2011 to 6 days in 2012, representing monthly use (range 1–180 days).

Figure 3: Patterns of methamphetamine powder (speed) use, 2003 to 2012



Source: QLD EDRS participant interviews

The typical median amount of methamphetamine powder (speed) used in a session remained consistent with previous years, at half a gram (Table 7). The reported median amount used in a heavy session was one gram per session.

Table 7: Median grams of methamphetamine powder (speed) used in a session in the last six months, 2003 to 2012

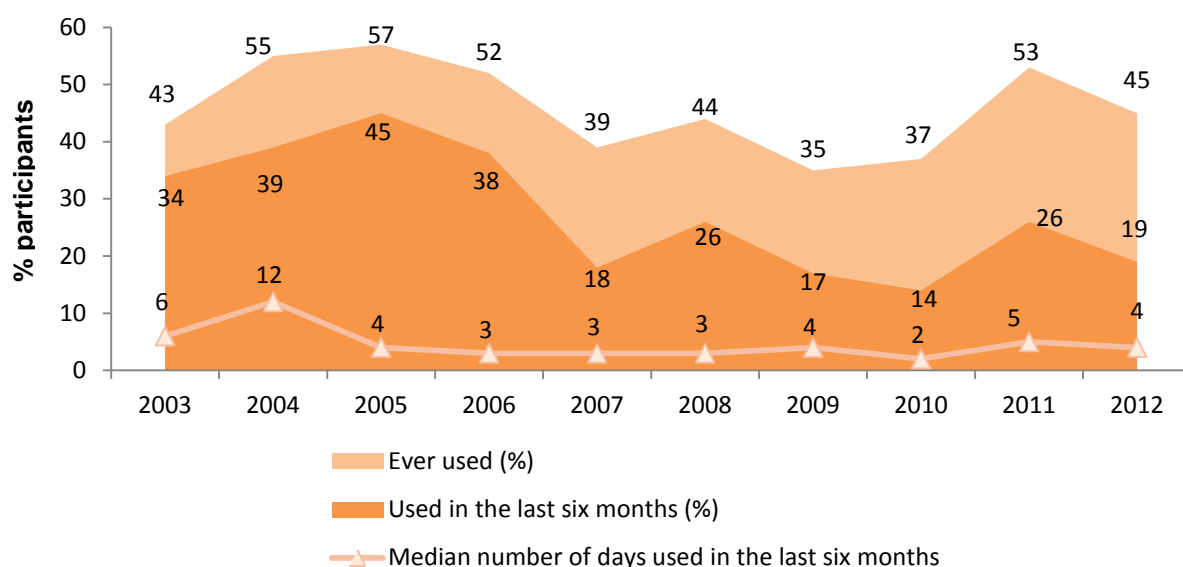
Session	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Typical (range)	0.5 (0.1-1.5)	0.5 (0.2-4)	0.5 (0.6-6)	0.5 (0-5)	0.5 (0.1-2)	0.5 (0.25-1.5)	0.5 (0.5-2)	0.5 (0.13-3.5)	0.5 (0.2-2)	0.5 (0.3-2.0)
Heavy (range)	1.0 (0.1-4)	1.0 (0.3-6)	1.0 (0.5-8)	0.5 (0.1-10)	0.5 (0.1-10)	1.0 (0.25-2)	1.0 (0.5-3.5)	0.63 (0.13-4)	0.88 (0.2-3)	1.0 (0.5-5.0)

Source: QLD EDRS participant interviews

4.3.3 Base methamphetamine use

Reports of lifetime and recent use of base methamphetamine were similar in 2012 to 2011 (Figure 4). Medium number of days used in the previous six months remained low.

Figure 4: Patterns of base methamphetamine use, 2003 to 2012



Source: QLD EDRS participant interviews

Since 2003, the median number of points used in a typical session has been between 1 and 3 points, and between 1 and 5 points for heavy use (Table 8). In 2012 the number of points used in a typical session was the same as in 2011 but was slightly higher for a heavy session.

Table 8: Median points of base methamphetamine used in a session in the preceding six months, 2003 to 2012

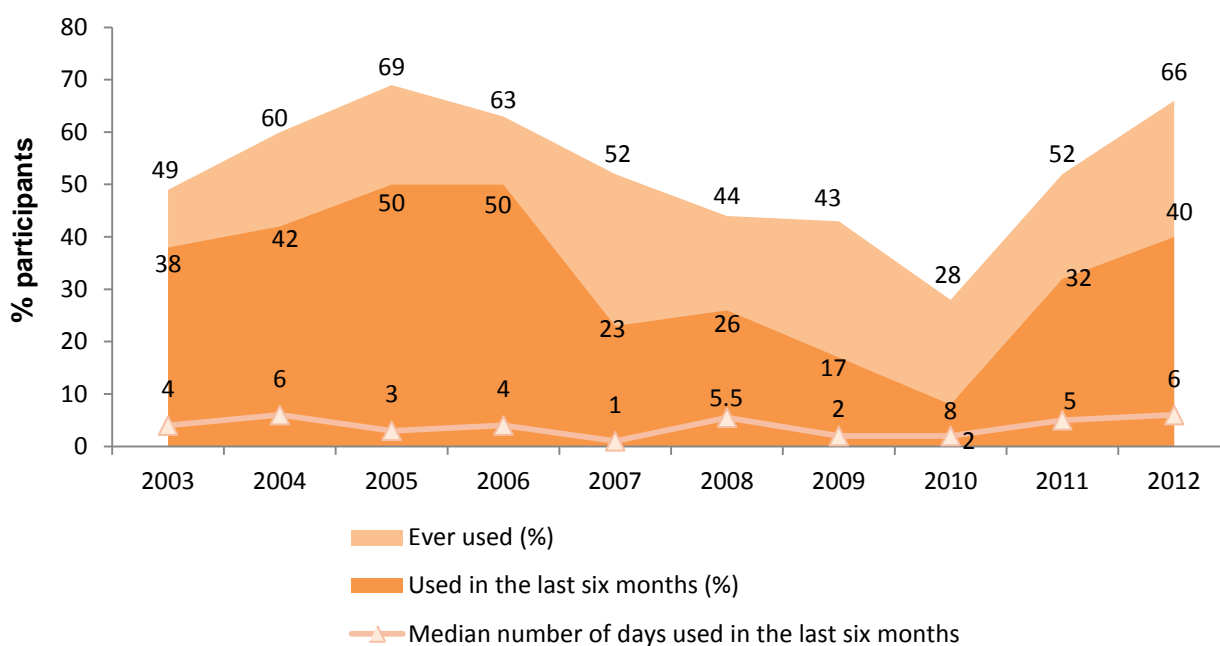
Session	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Typical (range)	1 (0.1-5)	2 (0.2-20)	1 (0.5-5)	2 (0.5-10)	1 (0.5-10)	2 (0.5-6)	2 (0.5-10)	3 (0.3-8)	2 (0.5-5)	2 (1-4)
Heavy (range)	2 (0.1-25)	3 (0.5-40)	2 (0.5-8)	2 (0.5-10)	2 (0.5-10)	2 (0.5-10)	5 (0.5-12)	3 (0.3-14)	2 (0.5-5)	2.5 (2-5)

Source: QLD EDRS participant interviews

4.3.4 Crystalline methamphetamine (ice/crystal) use

Following a drop in use of ice/crystal in 2010, use has continued to climb with 40% reporting recent use compared with 32% in 2011 (Figure 5). The median number of days of ice/crystal use was 6 days, corresponding to monthly use (range 1–120 days).

Figure 5: Patterns of crystalline methamphetamine (ice/crystal) use, 2003 to 2012



Source: QLD EDRS participant interviews

In 2012, the median number of points of ice/crystal used in a typical session remained at 2 points, and the median for heavy use was 2.3 points (Table 9).

Table 9: Median points of crystalline methamphetamine used in a session in the preceding six months, 2003 to 2012

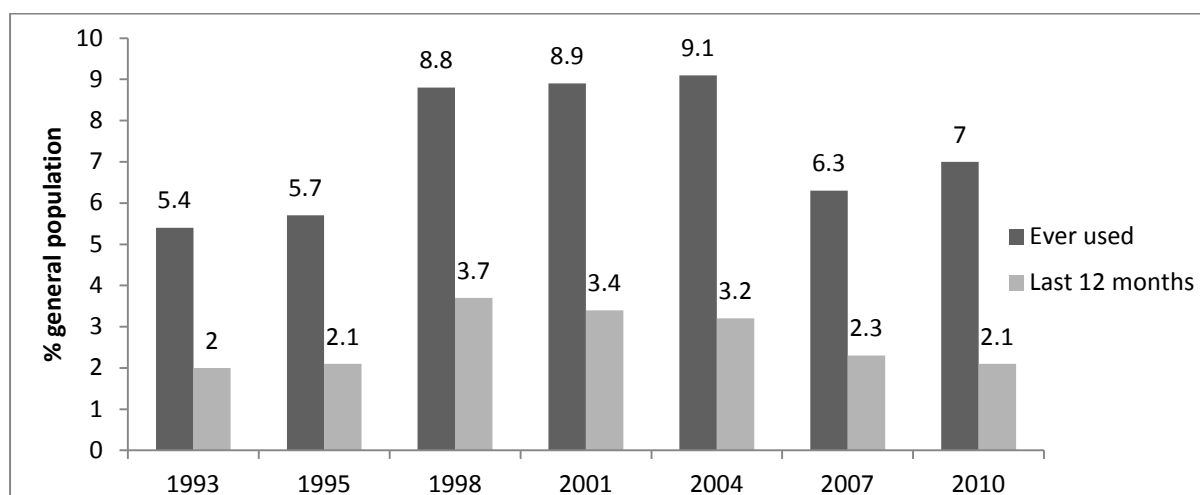
Session	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Typical (range)	1.0 (0.3-4)	1.5 (0.2-10)	1.0 (0.3-8)	2.0 (0.1-5)	1.3 (0.5-5)	1.5 (0.25-7)	2.0 (0.5-5)	2.0 (1-5)	2.0 (1-5)	2.0 (0.5-5)
Heavy (range)	1.0 (0.3-5)	3.0 (0.3-30)	2.0 (0.3-10)	2.0 (0.2-8)	1.5 (0.5-10)	2.0 (0.25-7)	5.0 (1-20)	2.0 (1-4)	2.0 (0.5-10)	2.3 (0.5-5)

Source: QLD EDRS participant interviews

4.3.5 Prevalence of methamphetamine use in the general population

According to the 2010 National Drug Strategy Household Survey report (AIHW, 2011), methamphetamine use in the previous 12 months has slightly declined from 2007 to 2010 in the general population of those 14 years and older (Figure 6).

Figure 6: Prevalence of meth/amphetamine use among the Australian population aged 14 years and over, 1993 to 2010



Source: NDSHS 1988-2010 (AIHW, 2011)

4.3.6 Comments from key experts on methamphetamine use

There was agreement amongst key experts that crystal was becoming the preferred form of methamphetamines; and that it was being marketed as a superior or premium product. There were mixed reports as to whether use of speed powder and base had declined. As one key expert explained ‘People have favourites [forms] but will use whatever they can get’.

4.4 Cocaine use

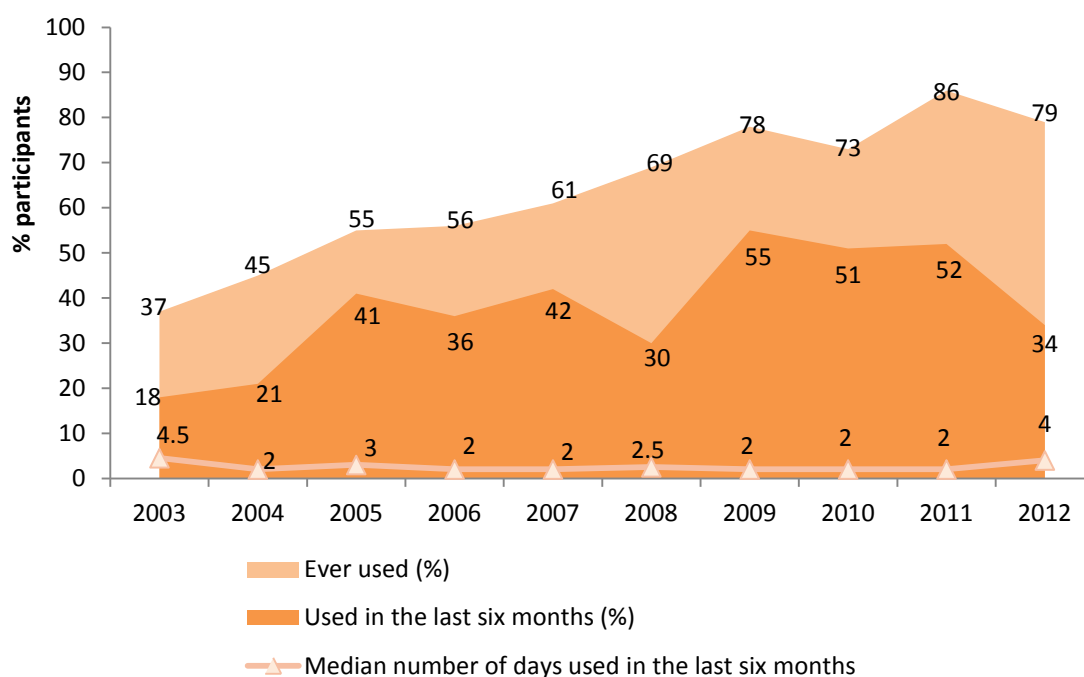
Key Points

- Recent use of cocaine decreased in 2012 to 34% of participants compared with 52% in 2011 ($p < 0.05$).
- The median number of days used in the preceding six months was four.
- Quantity used was similar to 2011 at a median of 0.75 grams in a regular session and a median of 1 gram in a heavy session.

4.4.1 Patterns of cocaine use among regular ecstasy users

The proportion of participants reporting lifetime use of cocaine was 79% in 2012 compared with 86% in 2011 (Figure 7). Recent use of cocaine decreased to 34% from 52% in 2011 ($p < 0.05$). The median number of days of cocaine use in the preceding six months rose from 2 days in 2011 to 4 days (range 1–100; $n = 21$).

Figure 7: Patterns of cocaine use, 2003 to 2012



Source: QLD EDRS participant interviews

The reported median number of grams of cocaine used in a session remained similar to 2011, at 0.75 grams for a typical session and 1 gram for a heavy session (Table 10).

Table 10: Median grams of cocaine used in a session in the preceding six months, 2003 to 2012

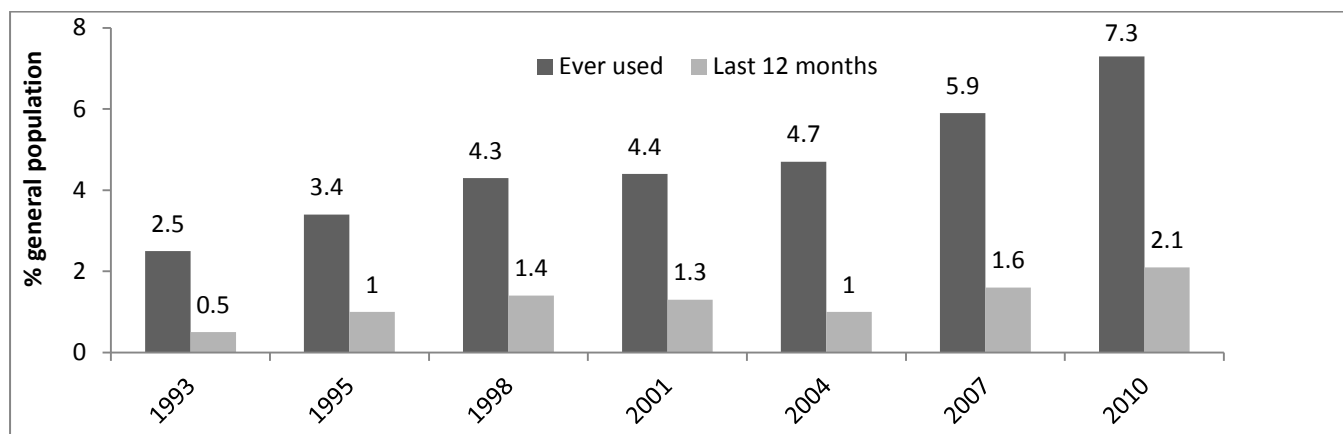
Session	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Typical	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.78	0.75
(range)	(0.3-2)	(0.1-3.5)	(0.1-4)	(0.1-4)	(0.1-3)	(0.08-3)	(0.1-2)	(0.17-2)	(0.2-6)	(0.4-1)
Heavy	1.0	1.0	1.0	0.7	0.5	1.0	1.0	0.5	1.0	1.0
(range)	(0.3-7)	(0.2-10)	(0.1-4)	(0.1-7)	(0.1-5)	(0.08-9)	(0.1-4)	(0.17-4)	(0.25-6)	(0.40-3)

Source: QLD EDRS participant interviews

4.4.2 Prevalence of cocaine use in the general population

According to the 2010 National Drug Strategy Household Survey report (AIHW, 2011), there is an upward trend in cocaine use within the Australian population aged over 14 years (Figure 8).

Figure 8: Prevalence of cocaine use among the Australian population aged 14 years and over, 1993 to 2010



Source: 2010 NDSHS (AIHW, 2011)

4.4.3 Comments from key experts about cocaine use

Cocaine use was reported as stable by key experts; used occasionally if at all by those who regularly use ecstasy. Use was seen as opportunistic or for special occasions, with reports that use increased during summer, particularly around the Christmas–New Year period. It was generally considered that people who regularly use cocaine are a different sub-population to those who regularly use ecstasy.

4.5 Ketamine use

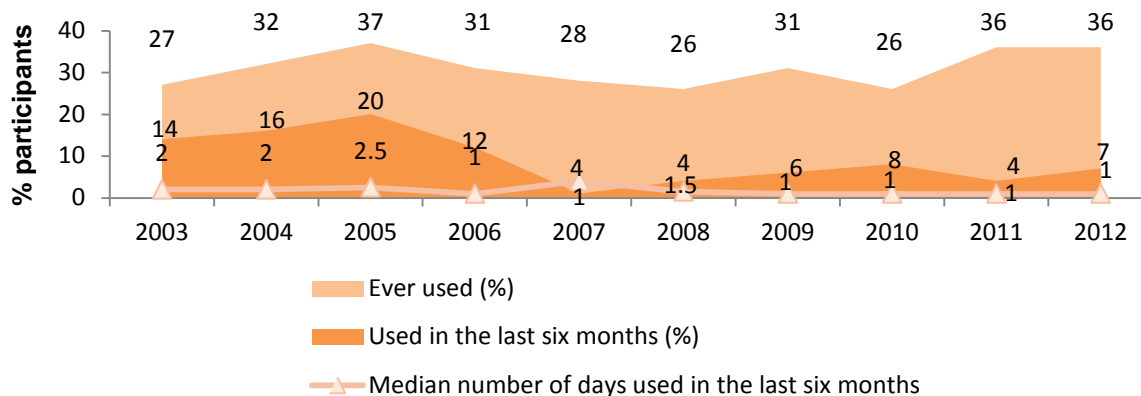
Key Points

- 36% of participants had used ketamine in their lifetime, and 7% recently; but on one day only.

4.5.1 Patterns of ketamine use among regular ecstasy users

In 2012, 36% of participants reported lifetime use of ketamine, and this was consistent with 2011 (Figure 9). Recent ketamine use was reported by 7% of participants. Participants who had recently used ketamine had used only once in the last six months.

Figure 9: Patterns of ketamine use, 2003 to 2012



Source: QLD EDRS participant interviews

4.5.2 Ketamine use in the general population

According to the 2010 National Household Drug Strategy Household Survey report (AIHW, 2011), the use of ketamine has remained relatively stable since 2004, with 2% of the national population (over 14 years of age) reporting its use in the previous 12 months.

4.5.3 Comments from key experts about ketamine use

Key experts advised that ketamine use was uncommon. They explained that people tended to try it but not use it regularly. One key expert noted that recently there was increased talk about ketamine. A ketamine analogue, MXE (methoxetamine) was reported as attracting a lot of interest.

4.6 GHB use

Key Points

- 44% of participants reported ever having used GHB.
- 10% had used in the preceding six months on a median of 1.5 days.

4.6.1 Patterns of GHB use among regular ecstasy users

In 2012, 44% of participants reported ever having used GHB/liquid E/fantasy compared with 28% in 2011. Use in the previous six months was 10% (7% in 2011). The median number of recent days of use was 1.5.

The small number of participants commenting on the amount used in sessions prevents meaningful comparisons over time (Table 11).

Table 11: Median millilitres of GHB used in a session in the last six months, 2003 to 2012

Session	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Typical (range)	4.0 (2-10)	4.0 (0.5-100)	7.5 (1-25)	3.5 (2.6-5)	3.3 (1.5-5)	3.0 ^a (3-3)	5.0 ^a (4-6)	5.25 (2.5-8)	2.5 ^b (0.5-10)	2.5^c (1-7)
Heavy (range)	6.0 (5-40)	8.8 (0.5-100)	7.5 (2-40)	5.0 (5-15)	5.0 (5-7)	3.0 ^a (3-3)	13.0 ^a (5-20)	21.5 (8-35)	5.0 ^b (0.5-12)	2.5^c (1-10)

^abased on responses of one participant

^bbased on responses of five participants

^cbased on responses of four people

Source: QLD EDRS participant interviews

4.6.2 GHB use in the general population

According to the 2010 National Household Drug Strategy Household Survey report (AIHW, 2011), the use of GHB has remained stable since 2004, with 0.1% of both the national and Queensland population (over 14 years of age) reporting its use in the previous 12 months.

4.6.3 Comments from key experts about GHB use

The consensus amongst key experts was that GHB (fantasy) use comes and goes in waves; although in the Gold Coast region there was a reported increase in use for both 2011 and 2012. Some key experts reported that GHB was not considered a ‘serious drug’ even though there are potentially serious health effects if a slightly too generous dose is taken.

4.7 Hallucinogen use

Key Points

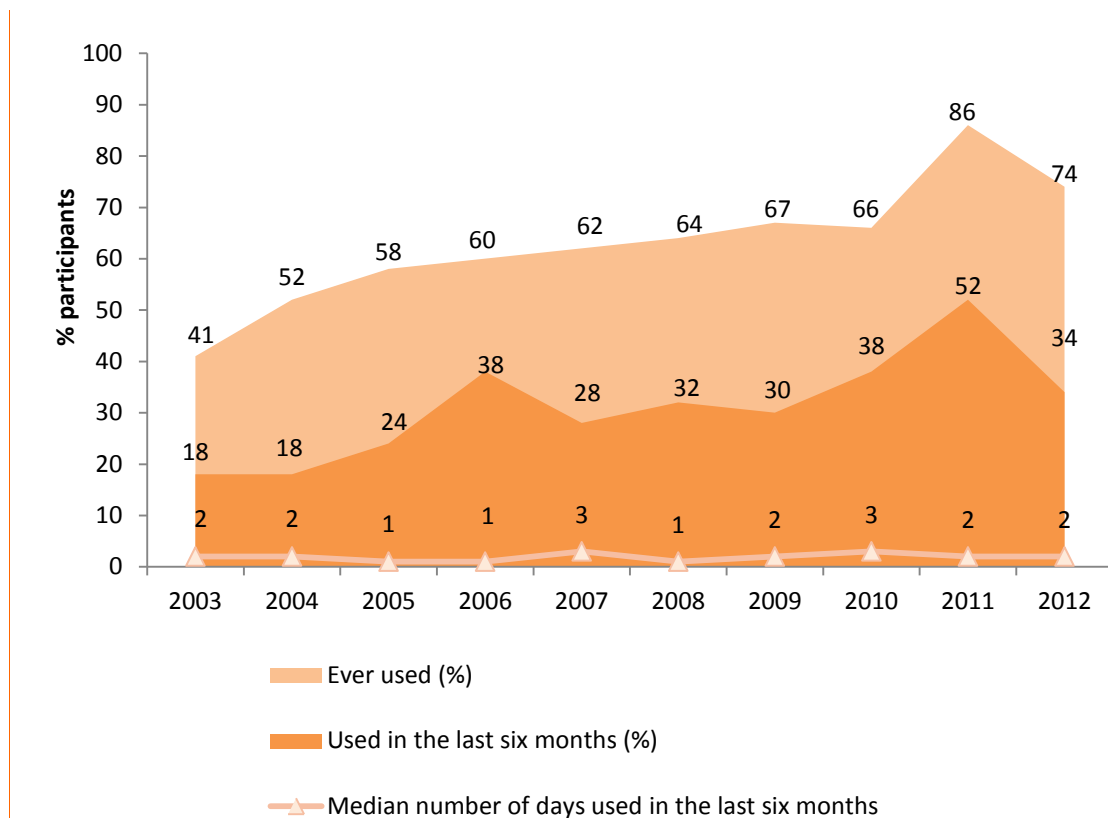
- 74% of participants reported having used LSD in their lifetime.
- Recent use was reported by 34%; a decrease from 52% in 2011 ($p < 0.05$).
- Two-thirds had used mushrooms in their lifetime, with 15% having used recently.

Participants were questioned about their use of LSD and mushrooms.

4.7.1 Patterns of LSD use among regular ecstasy users

Almost three-quarters (74%) of participants reported lifetime use of LSD (Figure 10). In 2012 about one-third (34%) reported use in the previous six months which was a significant decrease from 52% in 2011.

Figure 10: Patterns of LSD use, 2003 to 2012



Source: QLD EDRS participant interviews

Table 12 shows that participants reported using a median of 2 LSD tabs in both a typical session and a heavy session (n = 18).

Table 12: Median tabs of LSD used in a session in the last six months, 2003 to 2012

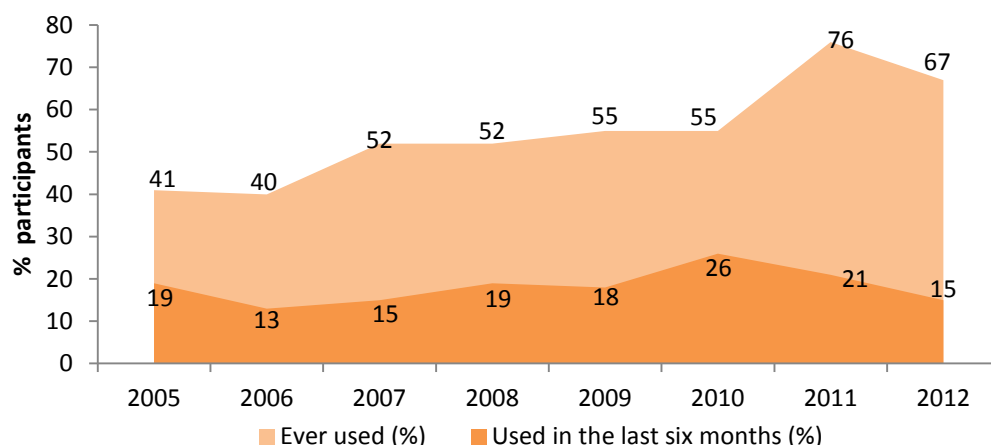
LSD	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Typical (range)	1.0 (0.5-3)	1.0 (0.5-4)	1.0 (0.3-3)	1.3 (1-1.5)	1.0 (0.5-5)	1.0 (0.5-3.5)	1.0 (0.5-4)	1.0 (1-5)	1.0 (0.5-3)	2.0 (1-4)
Heavy (range)	2.0 (1-5)	1.5 (0.5-4)	1.0 (0.5-4)	1.3 (1-1.5)	1.0 (0.5-6)	1.0 (0.5-4)	1.0 (1-4)	2.0 (1-11)	1.0 (0.5-5)	2.0 (1-4)

Source: QLD EDRS participant interviews

4.7.2 Mushroom use

Figure 11 shows that two-thirds of participants reported lifetime use of mushrooms compared with just over three-quarters in 2011, and 15% used in the previous six months compared with 21% in 2011. Among those who had used, the median frequency of use was once in the previous six months (range 1–8 days; n = 9).

Figure 11: Patterns of mushroom use, 2005 to 2012



Source: QLD EDRS participant interviews

4.7.3 Hallucinogen use in the general population

Findings from the 2010 National Drug Strategy Household Survey show that 8.8% of the population over fourteen years of age had ever used hallucinogens, and 1.4% of the population had consumed them in the previous 12 months which is a statistically significant rise from 0.6% in 2007 (AIHW, 2011).

4.7.4 Comments from key experts about hallucinogen use

In general LSD was reported as being used by a small minority and generally infrequently. As one key expert said: *'It is a situational drug; not for regular use but for use at places like a bush doof or festival'*. Accordingly, it tends to be used more often around Christmas and New Year which is a popular time for festivals. LSD was also reported as waxing and waning from year to year: *'there are spikes of use; fades, then after a while people start using it*

again'. There was disagreement around the use of LSD: some key experts thought it had decreased since last year, one key expert felt that use was continuing to increase. There were also reports of combinations of LSD and MDMA (tripstasy and candy flipping) being used. A derivative of the phenethylamine psychedelic 2C-1, NBOMe, has been reported as being sold as LSD. There were no reports about use of mushrooms.

4.8 Cannabis use

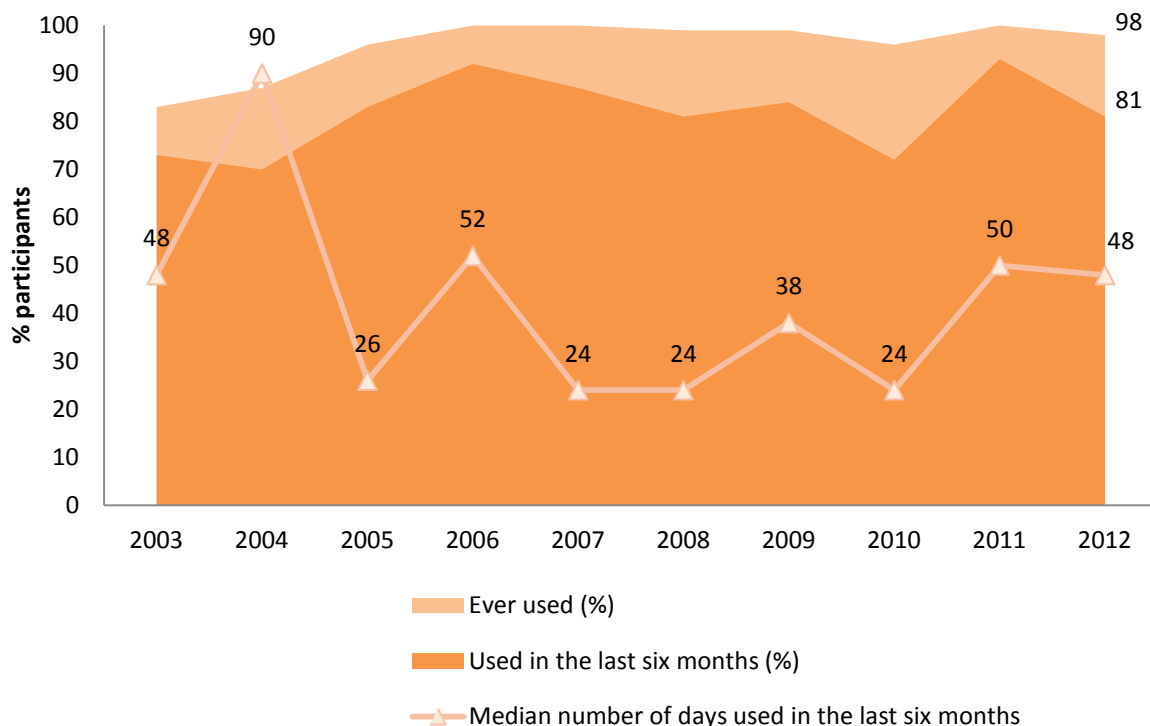
Key Points

- 81% of participants had recently used cannabis.
- Cannabis was used on a median of 48 days in the previous six months, representing three to four days a week.
- 61% used cones the most recent time of use.

4.8.1 Patterns of cannabis use among regular ecstasy users

In 2012, 98% of participants reported having ever used cannabis, with 81% reporting recent use (Figure 12). Cannabis was used on a median of 48 days in the previous six months (range 1–180 days, n = 50), representing three to four times a week. The average age participants first used cannabis was 15 years.

Figure 12: Patterns of cannabis use, 2003 to 2012



Source: QLD EDRS participant interviews

Table 13: Frequency of cannabis use in the last six months, 2003 to 2012

	2003 (n=99) %	2004 (n=112) %	2005 (n=84) %	2006 (n=92) %	2007 (n=88) %	2008 (n=87) %	2009 (n=74) %	2010 (n=73) %	2011 (n=101) %	2012 (n=50) %
Daily (180 days)	32	38	13	23	21	22	24	14	20	26
More than weekly (25 to 179 days)	28	33	39	35	26	23	28	29	33	32
Weekly (24 days)	6	4	0	1	7	12	8	14	6	8
Less than weekly (1-23 days)	34	25	48	42	46	44	39	44	41	34

Source: QLD EDRS participant interviews

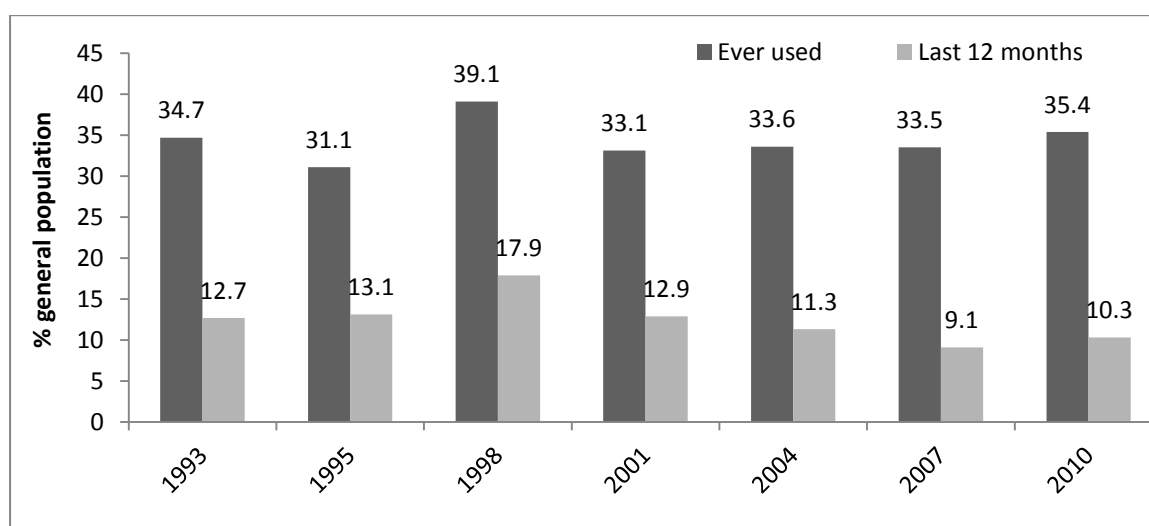
Note: Based on participants who used cannabis in the previous six months

Of those who used cannabis in the previous six months, 61% used cones, 35% joints, and 4% other.

4.8.2 Cannabis use in the general population

Findings from the 2010 National Drug Strategy Household Survey (AIHW, 2011) show that nationally 35% of people aged 14 or older had used cannabis in their lifetime, and that 10% had used cannabis within the previous 12 months (Figure 13). These findings were similar to survey findings for 2004 and 2007. Within Queensland 11% of the population 14 years and older had used cannabis in the previous 12 months.

Figure 13: Prevalence of cannabis use among the Australian population aged 14 years and over, 1993 to 2010



Source: NDSHS 1993-2011 (AIHW, 2011)

4.8.5 Comments from key experts about cannabis use

Although key experts report cannabis use as relatively stable, changes in use have been identified. Bongs and buckets have become the most common way of using; synthetic cannabis has also become popular. Key experts believe that some young people regard synthetic cannabis as a safer alternative to high strength hydroponic cannabis, and that many may also believe that it is legal. Hydroponic cannabis is considered to be the most common form used, with older people tending to prefer bush. It has also been pointed out that hydro is not as easy as bush for young people to initiate into because of its high strength.

Key experts report that cannabis is used for a variety of reasons including as a relaxant, to help cope, to assist with sleep, for pain relief, and to come down from other drugs. There are reports of substantial, high frequency use by a small minority.

4.9 Other drugs use

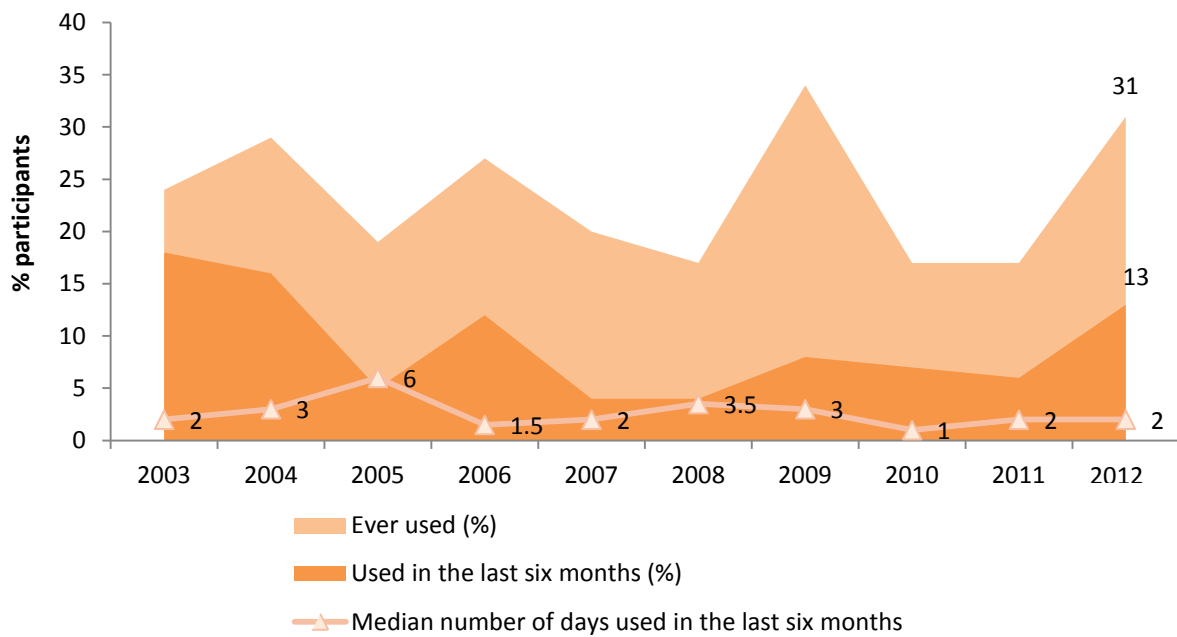
Key Points

- 13% of participants had recently used MDA, but use was infrequent.
- Recent use of alcohol occurred on a median of 48 days compared with 72 in 2011.
- 84% had smoked in the previous six months, with 67% of all participants being daily smokers.
- No use of illicit anti-depressants in previous six months; though 11% had recently used anti-depressants prescribed for them.
- 32% had recently used illicit benzodiazepines. Main brands were Xanax[®] and Valium[®].
- 16% had recently used amyl nitrate, with use being mostly on one occasion in the previous six months.
- 18% had recently used nitrous oxide on a median of 5 days.
- Heroin was rarely used (one participant in previous six months).
- 7% recently used buprenorphine, with 5% injecting it.
- 15% recently used morphine (main brand Oxycontin[®]), with 3% injecting it.
- 19% recently used illicit pharmaceutical stimulants.
- 18% recently used over the counter codeine for non-pain use.
- DMT was the most commonly used emerging psychoactive drug, with 34% having ever used it and 15% having used it in the previous six months.

4.9.1 MDA use

Figure 14 shows that in 2012, 31% of participants reported lifetime use of MDA compared with 17% in 2011, and 13% reporting recent use compared with 6% in 2011 (Figure 14). The median number of days of MDA use remained at twice in the previous six months (range 1–9 days; n = 7).

Figure 14: Patterns of MDA use, 2003 to 2012

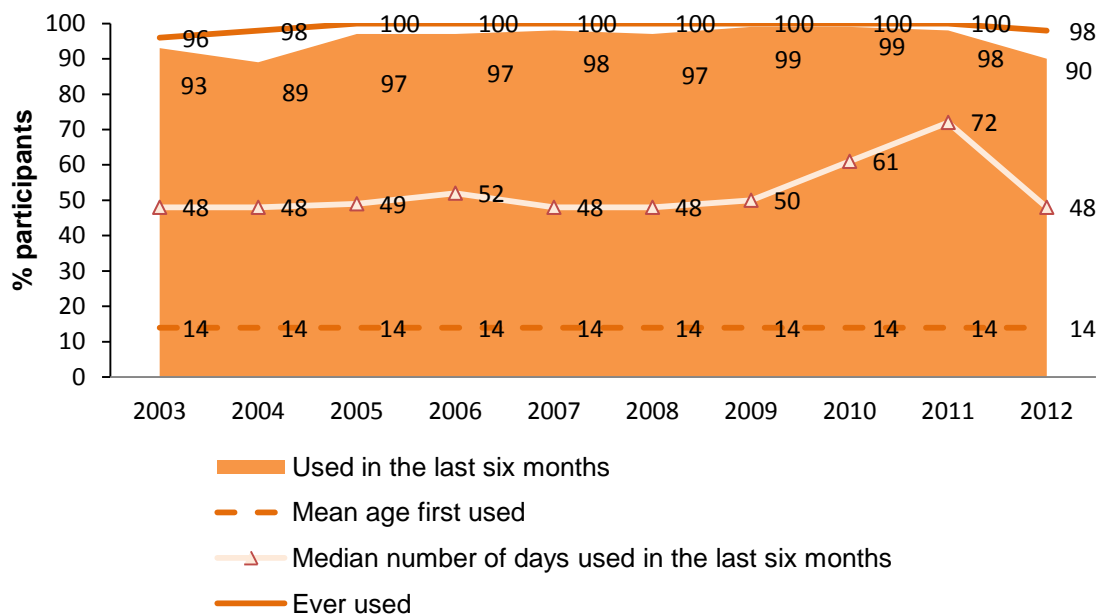


Source: QLD EDRS participant interviews

4.9.2 Alcohol

In 2012, 98% of participants reported lifetime use of alcohol, with 90% reporting recent use (Figure 15). The median number of days using alcohol in the previous six months was 48 compared with 72 in 2011 (range 1–180 days; n = 56). The mean age participants reported to have first used alcohol was 14 years, which has remained constant since 2003.

Figure 15: Patterns of alcohol use, 2003 to 2012



Source: QLD EDRS participant interviews

Two-thirds of participants drank alcohol while using ecstasy, with 56% of participants drinking ≥ 5 standard drinks.

Alcohol use in the general population

According to the 2010 National Drug Strategy Household Survey report (AIHW, 2011), in 2010 there was a decrease in the frequency of alcohol consumption within the population aged 14 years and over, with daily use dropping from 8.1% to 7.2% (Table 14).

Table 14: Alcohol drinking status of the Australian population 14 years and older (%), 1991 to 2010

	1991	1993	1995	1998	2001	2004	2007	2010
Daily	10.2	8.5	8.8	8.5	8.3	8.9	8.1	7.2
Weekly	41.0	39.9	35.2	40.1	39.5	41.2	41.3	39.5
Less than weekly	30.4	29.5	34.3	31.9	34.6	33.5	33.5	33.8
Ex-drinker	12.0	9.0	9.5	10.0	8.0	7.1	7.0	7.4
Never a full serve	6.5	13.0	12.2	9.4	9.6	9.3	10.1	12.1

Source: NDSHS 1991-2010 (AIHW 2011)

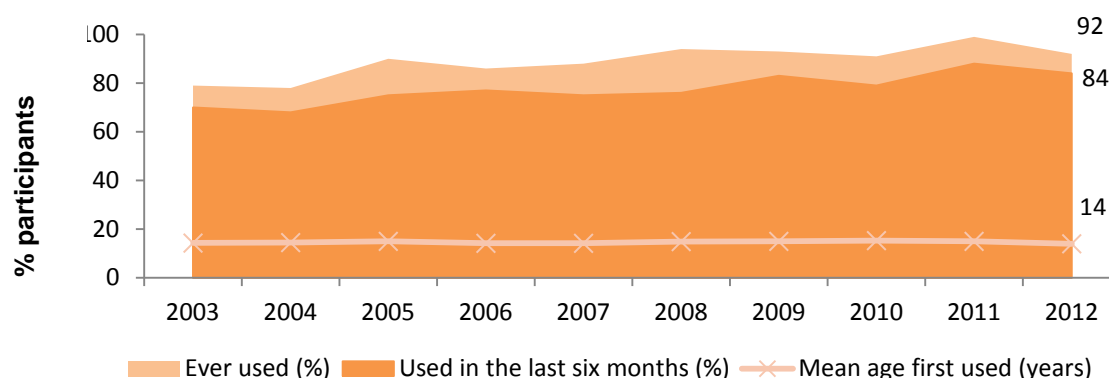
Comments from key experts about alcohol use

Key experts reported alcohol as being highly problematic. There was concern about the high level of bingeing which often involved pre-loading with drinks before attending nightclubs and parties. Key experts spoke about the problems arising from combining alcohol with other substances. They pointed out that intoxication often resulted in less accurate decision-making and consequently heavier use of illicit drugs. Drinking alcohol with medications which are prescribed but where alcohol is contra-indicated was seen as a growing problem, as was the combination of alcohol and energy drinks because of the masking effects of energy drinks enabling larger quantities of alcohol to be consumed.

4.9.3 Tobacco

Use of tobacco was consistent with previous years, with 92% of participants reporting lifetime use and 84% recent use (Figure 16). Among those who reported recent use, 67% reported to be daily smokers. The mean age of first tobacco use has remained relatively stable at 14 years.

Figure 16: Patterns of tobacco use, 2003 to 2012



Source: QLD EDRS participant interviews

Tobacco use in the general Australian population

Findings from the 2010 National Drug Strategy Household Survey (AIHW, 2011) revealed a continued decline in tobacco use among those aged 14 and above, with daily use reducing from 16.6 in 2007 to 15.1 in 2010 (Table 15). The proportion having never smoked has been steadily increasing (i.e. from 49% in 1991 to 57.8% in 2010).

Table 15: Smoking status, proportion of the Australian population 14 years and older, 1991 to 2010

	1991	1993	1995	1998	2001	2004	2007	2010
Daily	24.3	25.0	23.8	21.8	19.5	17.4	16.6	15.1
Weekly	2.8	2.3	1.6	1.8	1.6	1.6	1.3	1.5
Less than weekly	2.4	1.8	1.8	1.3	2.0	1.6	1.5	1.4
Ex-smoker ^a	21.4	21.7	20.2	25.9	26.2	26.4	25.1	24.1
Never smoked ^b	49.0	49.1	52.6	49.2	50.6	52.9	55.4	57.8

^a smoked at least 100 cigarettes in lifetime and no longer smoke

^b never smoked more than 100 cigarettes in lifetime

Source: NDSHS (AIHW, 2011)

4.9.4 Anti-depressants

In 2012, 40% of respondents reported having ever used anti-depressants prescribed to them (licit), with 11% reporting recent licit use. Among those who reported recent use of licit antidepressants, the median number of days used was 180, corresponding to daily use (range 2–180 days; n = 7). The brands recently used included Lexapro[®] (escitalopram), Endep[®] (amitriptyline), citalopram (generic), Prozac[®] (fluoxetine), Zoloft[®] (sertraline), and generic (unspecified). The mean age of first use of licit anti-depressants was 18 years (range 8–31 years; n = 25).

In 2012, 5% of participants reported having ever used illicit anti-depressants (i.e. not prescribed to them), though no one reported using them in the previous six months. The mean age of first use of illicit anti-depressants was 19 years old (range 18–22 years; n = 3).

4.9.5 Benzodiazepines

In 2012, 29% of participants reported having used licit (i.e. prescribed) benzodiazepines, with 19% reporting recent use. This is very similar to 2011 (28% and 19% respectively). The mean age of first use was 23 years (range 14–49 years; n = 17). The median number of days of recent licit benzodiazepine use was reported to be 177, corresponding to near daily use (range 3–180 days; n = 12). Among those who had used in the previous six months, the most popular brand was Xanax[®] (alprazolam), taken by 42%, followed by Valium[®] (diazepam) (33%). Other brands used include flunitrazepam (generic), Serepax[®] (oxazepam), and Stilnox[®] (zolpidem).

Sixty-five per cent of respondents reported having ever used illicit benzodiazepines, with 32% reporting recent use (compared to 60% and 36% last year). The mean age of first use was reported to be 21 years (range 14–50 years; n = 40). The reported median number of days of illicit benzodiazepine use was six, corresponding to monthly use (range 1–74 days; n = 20). Among those who had recently used, the brands reported to have been most used in the previous six months were Xanax[®] (alprazolam) (30%) and Valium[®] (diazepam) (30%), followed by rohypnol (15%) and temazepam (generic) (10%). Serepax[®] (oxazepam), oxazepam (generic), and diazepam (generic) were also reported to have been recently used.

Comments from key experts about benzodiazepine use

Benzodiazepine use was considered to be widespread, with Valium[®] reported as particularly easy to access whether licit or illicit. There were mixed reports about the use of Xanax[®], with one key expert reporting it was harder to obtain while others noted that its use was continuing to be problematic. Key experts noted a growing trend for people to become dependent on benzodiazepines after being initially prescribed them following an injury.

4.9.6 Inhalant use

Inhalant use was similar to 2011 with over half of participants (55%) having ever used amyl nitrate (57% in 2011), and 16% using in the previous six months (22% in 2011). The median number of days used was once in the previous six months (range 1–48 days; n = 10).

Three in five participants (61%) reported ever using nitrous oxide (55% in 2011), with 18% reporting recent use (16% in 2011). The median number of days used recently was five in the previous six months (1–100 days; n = 11). The mean number of bulbs reported to be used in a 'typical' session was 18 (range 2–50 bulbs; n = 11), while the mean of the most used in one session was 44 bulbs (range 2–150 bulbs; n = 11).

4.9.7 Heroin and other opiates

In 2012:

- 23% of participants reported ever using **heroin**, with one participant reporting recent use (which was injected and used 40 out of 180 days in the previous six months).
- 13% of participants reported ever using **methadone**, though there were no reports of recent use.
- 10% of participants reported ever using **buprenorphine**, with 7% reporting recent use, and 5% injecting buprenorphine in the previous six months. Among those who had used recently, the median number of days used was 133 days (range 1–180; n = 4)

- 31% of participants reported ever using **other licit opiates** (e.g. morphine), with 15% reporting recent use, with no reports of injecting in the previous six months. The median number of days of use was 12 (range 1–180 days; n = 9), corresponding to twice a month. The main brands used recently include Endone[®], Oxycontin[®], MS Contin[®], and Fentanyl.
- 32% of participants reported ever using **other illicit opiates**, with 15% reporting recent use, with 3% reporting injecting them recently. The median number of days of use was 3 days (range 1–6; n = 9). The most common main brand used recently was Oxycontin[®] followed by Oxycodone (generic). Endone[®] and MS Contin[®] were also used.
- The median number of days of the use of any opiates (whether licit or illicit) in the previous six months was 3 days (range 1–180 days; n = 15), corresponding to every two months.

Comments from key experts about pharmaceutical opiates

Key experts report that there is high use of pharmaceutical opioids, and in particular oxycodone (most commonly Oxycontin[®]). One key expert in the health sector said that his young clients had ‘a *buzz about oxy; there is excitement about it*’. This key expert considered that there was a ‘*low fear in giving it a go*’ because it was a pharmaceutical pill and not an illegal drug, and this point was made by other key experts as well. Key experts noted that Oxycontin[®] appeared to be readily available and pointed out the ease of obtaining it online, and also the apparent increase in prescribing. A number of key experts considered that for some people use of non-prescribed pharmaceutical opioids occurred after being initially prescribed them.

4.9.8 Pharmaceutical stimulants

With regards to pharmaceutical stimulants like dexamphetamines and Ritalin[®], 15% of participants reported having used prescribed pharmaceutical stimulants, but only one participant had used them in the previous six months.

Lifetime illicit pharmaceutical stimulant use was reported among 60% of participants, with 19% using in the previous six months. The median number of days used was 2.5 days (range 1–90; n = 12).

The median number of days of any pharmaceutical stimulant was 3 days (range 1–180; n = 13).

In 2012, 25% of participants reported having ever used over the counter pharmaceutical stimulants (e.g. cold and flu drugs) for ‘non-medicinal/recreational use’, with 8% reporting recent use. The median number of days of illicit pharmaceutical stimulant use was six in the previous six months (range 2–14 days; n = 5), corresponding to monthly use. Brands used include Codral and Sudafed.

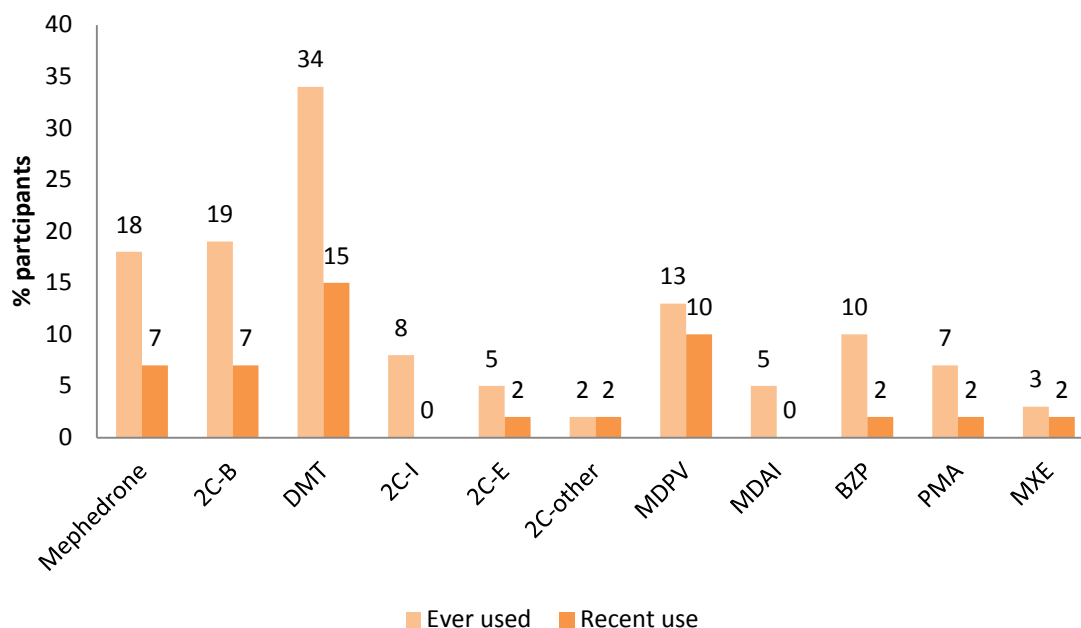
4.9.9 Over-the-counter (OTC) codeine for non-pain use

In 2012, 28% of participants reported having ever used over-the-counter codeine for non-pain use, with 18% using it in the previous six months. The mean age of first use for non-pain purposes was 18 years (range 12–24; n = 17).

4.10 Emerging psychoactive substance (EPS) use

In 2012, participants were asked about their use of emerging psychoactive substances (EPS), including analogues and research chemicals (Figure 17). The hallucinogenic drug DMT (Dimethyltryptamine) was the most reported EPS, with a lifetime use of 34% compared with 22% in 2011, and recent use of 15% compared with 6% in 2011. Use of the psychedelic phenethylamine 2C-B was similar to 2011, with 19% lifetime use and 7% recent use (20% lifetime and 10% recent use in 2011). Reports of lifetime use of mephedrone were similar to 2011 (18% in 2012 versus 17% in 2011), though recent use in 2012 was 7% compared with 13% in 2011. There was an increase in lifetime use of MDPV (also known as ‘ivory wave’), from 2% in 2011 to 13% in 2012 ($p < 0.05$). Recent use was 10% compared with 2% in 2011.

Figure 17: Use of emerging psychoactive substances, 2012



Source: QLD EDRS participant interviews

Comments from key experts about emerging psychoactive substance use

Key experts advised that use of emerging psychoactive substances was limited. They reported that MDPV (3,4-methylenedioxypropylvalerone, also sold as “bath salts”) had gained some prominence and there were small pockets of use. Another substance reported as increasing in use was DMT, which is a synthetic hallucinogenic tryptamine. An increasing interest in hallucinogens has been observed. Key experts also explained that there was a large range of substances with similar effects: some names became popular, and thus a variety of substances with different chemical structures might be called whatever name is currently popular. As expected, the use of plant-type substances such as Datura were reported to be seasonal.

5 DRUG MARKET: PRICE, PURITY, AVAILABILITY & SUPPLY

5.1 Ecstasy

Key Points

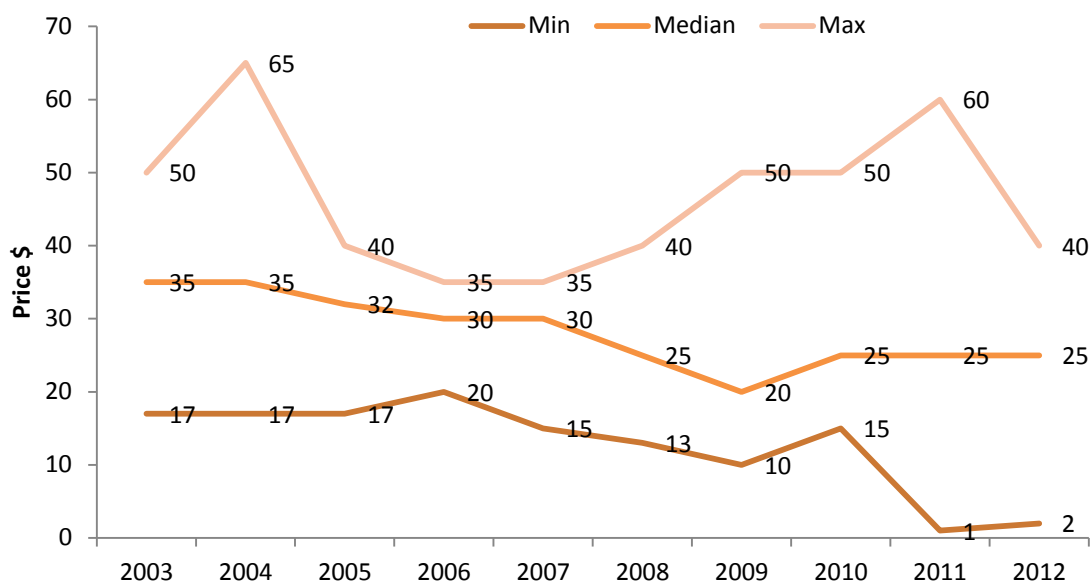
- Price of ecstasy tablet stable at \$25.
- Rating of ecstasy purity was mixed, with about half describing it as low but 18% as high.
- There was an increase in the proportion rating availability of ecstasy as very high (57% in 2012 versus 36% in 2011, $p < 0.05$), with changes in availability commonly rated as stable (63%) or easier (23%).
- Ecstasy was most commonly obtained from a friend (65%), with the most common venue being a friend's house (34%).

Responses in this section are reported from all participants in the Queensland sample.

5.1.1 Price

As in previous years, participants reported that ecstasy was most commonly purchased in pill form, though it was also available in capsule or powder form. Price has been stable in recent years, with a median price of \$25 per pill (range \$2–40; $n = 57$), and \$25 per capsule (range \$20–\$40; $n = 7$) (Figure 18).

Figure 18: Price of ecstasy per tablet, Queensland, 2003 to 2012



Source: QLD EDRS participant interviews

As in previous years, the median price per ecstasy pill tended to decrease if purchased in larger quantities (Table 16). Bulk prices were similar to 2011.

Table 16: Price of ecstasy pills according to quantity purchased, 2011 and 2012

Quantity	2011	2012
	Median (Range)	Median (Range)
1	\$25 (\$15-\$40)	\$25 (\$15-\$50)
10	\$20 (\$12-\$70)	\$20 (\$5-\$25)
20	\$18 (\$11-\$25)	\$18 (\$10-\$23)
50	\$16 (\$10-\$25)	\$15 (\$8-\$22)
100	\$14 (\$7-\$25)	\$13 (\$5-\$16)

Source: QLD EDRS participant interviews

Both in 2011 and 2012, EDRS data shows a lower minimum in the price ranges compared to Australian Crime Commission data (ACC, 2012) but in general prices are similar (Table 17).

Table 17: ACC reported price per unit of ecstasy in Queensland, 2010-11

Weight	Price per unit
1 tablet/capsule	\$25-50
100-999 tablets/capsules	\$18-25
1000+ tablets/capsules	\$12-18

Source: Australian Crime Commission (ACC, 2012)

Similar to 2011, the majority of participants (69%) reported that the price of ecstasy had remained stable over the previous six months (Table 18).

Table 18: Changes in recent price of ecstasy, 2011 and 2012

Price Change	2011	2012
	(n = 103) %	(n = 55) %
Increasing	25	15
Stable	61	69
Decreasing	3	6
Fluctuating	11	11

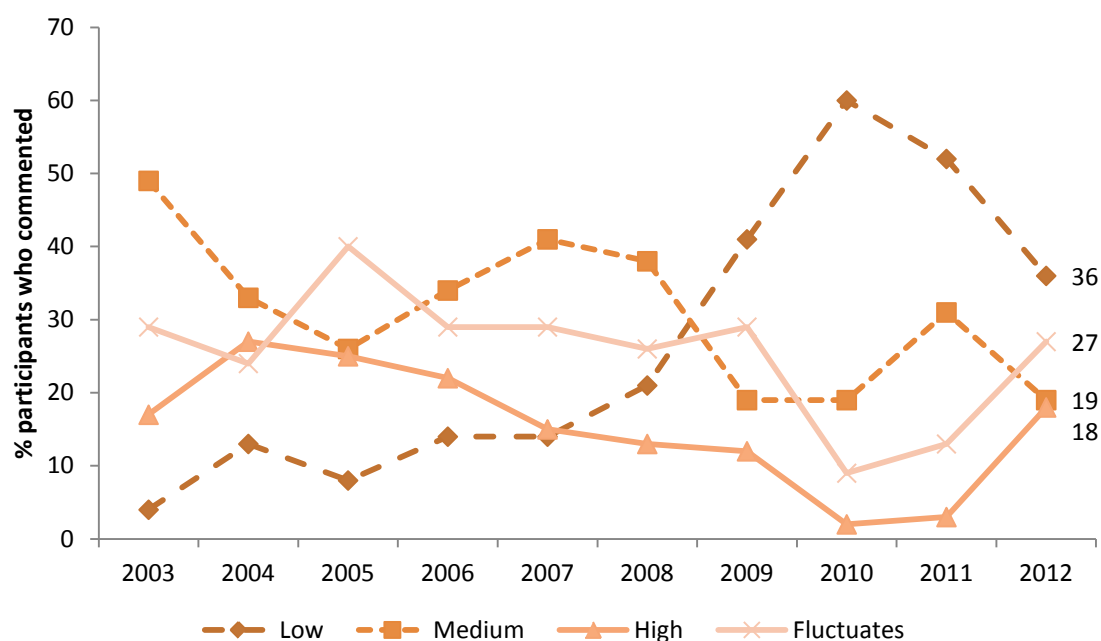
Note: Those choosing 'don't know' were excluded from analyses

Source: QLD EDRS participant interviews

5.1.2 Purity

As shown in Figure 19, 36% of participants rated ecstasy purity in the previous six months as low (52% in 2011), 19% as medium (31% in 2011), 18% as high (3% in 2011), and 27% as fluctuating (13% in 2011). This suggests some higher purity ecstasy may be obtainable.

Figure 19: Perception of ecstasy purity, 2003 to 2012



Source: QLD EDRS participant interviews

In 2012, more participants reported the purity of ecstasy to be fluctuating or increasing than in 2011 (Table 19).

Table 19: Perceived changes in recent ecstasy purity, 2003 to 2012

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	%	%	%	%	%	%	%	%	%	%
Decreasing	10	15	13	23	16	22	42	60	43	29
Stable	39	28	31	36	33	30	27	15	20	25
Increasing	18	9	14	11	4	6	6	3	9	15
Fluctuating	31	42	38	28	41	35	25	22	25	31

Note: Those choosing 'don't know' were excluded from analyses

Source: QLD EDRS participant interviews

The Queensland Health Forensic and Scientific Services reported recent presentations as containing between 10% and 26% of MDMA.

5.1.3 Availability

In 2012, 88% of participants reported ecstasy to be either easy or very easy to access in the previous six months (Table 20). More participants in 2012 reported that ecstasy was very easy to obtain compared with the previous year ($p < 0.05$) and, in keeping with this, fewer participants reported availability as more difficult ($p < 0.05$).

Table 20: Ease of access and reported change in availability of ecstasy in the previous six months, 2011 and 2012

	2011 %	2012 %
Ease of access to ecstasy	(N = 103)	(N = 62)
Very easy	36	57*
Easy	38	31
Difficult	24	11
Very difficult	1	2
Change in availability	(N = 103)	(n = 60)
Stable	50	63
Easier	18	23
More difficult	24	8*
Fluctuating	6	5

Note: Those choosing 'don't know' were excluded from analyses

*Significant at $p < 0.05$ level

Source: QLD EDRS participant interviews

5.1.4 Purchasing patterns and locations of use

Participants were asked about their ecstasy purchasing patterns in the previous six months (Table 21). Results were comparable to those given in 2011.

Table 21: Patterns of purchasing ecstasy in last six months, 2011 and 2012

	2011 (N = 103)	2012 (N = 62)
Number of people purchased from		
Median (range)	3 (0-15)	3 (1-10)
Number of ecstasy tablets purchased most recent occasion		
Median (range)	5 (1-500)	8 (1-700)
% Purchased for		
Self only	38	26
Self and others	61	69
Others only	0	2
Did not buy	1	3
% Number times purchased		
Monthly or less (1–6 times)	49	38
Fortnightly or less (7–12 times)	32	37
Weekly or less (13–24 times)	17	23
Three times a week or less (25+ times)	2	2

Source: QLD EDRS participant interviews

As in 2011, ecstasy was most commonly obtained from a friend, with the most common venue being a friend's house (Table 22).

Table 22: Source and location of most recent ecstasy purchase, 2011 and 2012

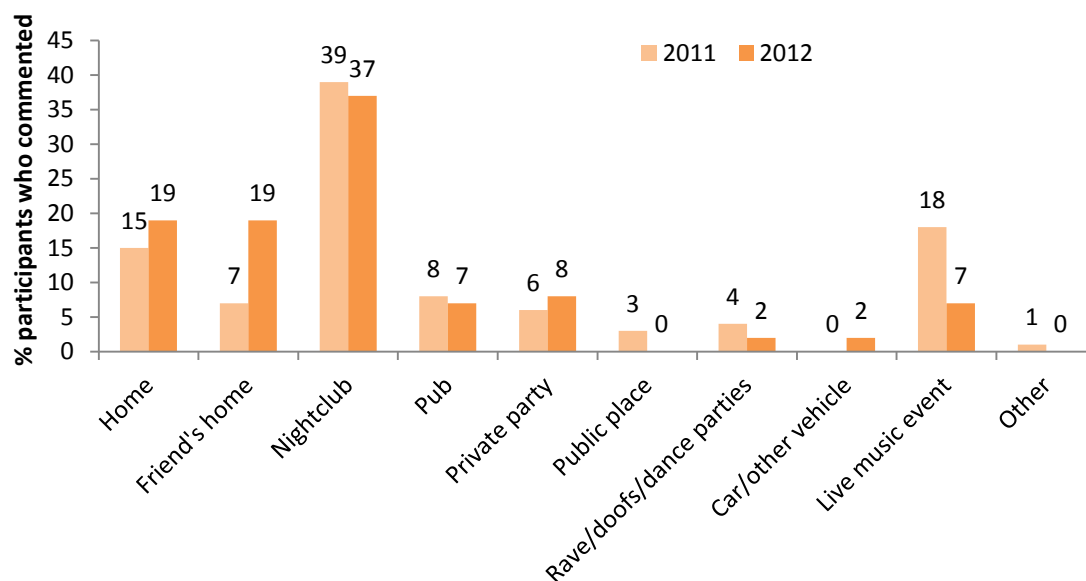
	2011 (N = 103) %	2012 (N = 62) %
Persons scored from		
Friends	58	65
Known dealers	21	13
Acquaintances	11	11
Work colleagues	0	2
Unknown dealers	9	7
Online	n/a	3
Other	2	-
Venues scored from		
Own home	13	21
Friend's home	34	34
Dealer's home	14	5
Nightclub	13	7
Pubs	6	2
Raves/dance parties	1	-
Street	2	-
Agreed public location	8	16
Work	-	2
Live music event	5	3
Acquaintance's home	3	2
Private party	2	7
Online	-	3

Note: Those responding 'used not scored' were excluded from analyses

Source: QLD EDRS participant interviews

Figure 20 shows that nightclubs remained the most popular venues while using ecstasy (37%), followed by one's home (19%) or a friend's house (19%).

Figure 20: Venue for most recent ecstasy use, 2011 and 2012



Source: QLD EDRS participant interviews

5.1.6 Comments from key experts

Consistent with participant rating of ecstasy's purity, purity was generally considered to be mainly low, with some medium quality ecstasy available as well as small quantities of quite high quality. Availability of higher quality ecstasy was reported as increasing. Cost was considered to vary according to location of purchase, with the highest cost being at nightclub-type venues. Festivals were considered to be a popular venue for using ecstasy. There were conflicting reports about price at festivals. One key expert said price was relatively low (e.g. \$20 a pill); while another said they were: '*super expensive at festivals, for all the trouble the dealers have to go through to conceal through security/sniffer dogs*'. It was noted that the very high quality ecstasy attracted a higher price.

5.2 Methamphetamine

Key Points

- The median price of one point of crystal/ice was \$95 compared with \$75 in 2011.
- 53% of participants rated speed purity as high compared with 26% in 2011.
- Four in five participants rated the purity of ice/crystal as high.
- All forms of methamphetamines were generally considered to be readily available.
- For all forms of methamphetamine, friends were the most common source person, followed by a known dealer.

The methamphetamine market consists of three forms: speed, base, and ice/crystal. Of the total sample, 20 participants felt they were confident enough to answer questions about speed, 5 participants about base, and 17 about ice/crystal. Responses in this section are reported from these sub-samples and when numbers are low caution is needed when interpreting changes.

5.2.1 Price

Numbers commenting on the price of speed and base were too low for meaningful comparison with last year; however, the price of crystal/ice was \$95 per point as compared with \$75 in 2011 (Table 23).

Table 23: Median price (range) of most recent methamphetamine purchase, 2011 and 2012

	2011	2012
Speed - Gram (1g)	\$200 (100-600)	\$200 (\$200; n = 2)
Base - Point (0.1g)	\$40 (6-50)	\$65 (\$50-80; n = 2)
Ice - Point (0.1g)	\$75 (45-100)	\$95 (50-150; n = 10)

Source: QLD EDRS participant interviews

Compared to 2011, more participants rated the price of speed as increasing in the previous six months ($p < 0.05$) (Table 24), with 21% reporting the price fluctuates. Too few participants commented on the price change of base for meaningful analysis. With crystal/ice, however, significantly fewer participants rated the price as increasing ($p < 0.05$).

Table 24: Perceived price changes for methamphetamines purchased in previous six months, 2011 and 2012

	Speed %		Base %		Crystal %	
	2011 (n = 39)	2012 (n = 14)	2011 (n = 12)	2012 (n = 4)	2011 (n = 16)	2012 (n = 14)
Increasing	15	64	33	25	56	14
Stable	67	14	42	25	33	71
Decreasing	5	-	8	-	-	-
Fluctuating	5	21	8	50	-	14

Note: Those choosing 'don't know' were excluded from analyses

Source: QLD EDRS participant interviews

Table 25 shows that the price range reported by the Australian Crime Commission for a point of crystal/ice is identical to the range reported by EDRS study participants.

Table 25: ACC reported methylamphetamine (crystal form) prices in Queensland, 2010-11

Weight	Price per unit
1 point (0.1 gram)	\$50-150
1 gram / 'weight'	\$300-1,000
1/8 ounce (3.5 grams) / 'eight ball'	\$750-1,800
1 ounce (28 grams) street deal	\$13,000-15,00
1 ounce (28 grams)	\$6,700-14,000
1 pound (454 grams)	\$70,000-120,000

Source: Australian Crime Commission (ACC, 2012)

Overall the Australian Crime Commission's prices are similar to those reported by the EDRS participants. However, it is worth noting the Commission reports the price of speed and base combined, so a direct comparison with the EDRS data is difficult (Table 26).

Table 26: ACC reported methylamphetamine (non-crystal form) prices in Queensland, 2010-11

Weight	Price per unit
1 point	\$50-150
1 gram 'weight'	\$250-1,000
1/8 ounce (3.5 grams) / 'eight ball'	\$600-1,100
1 ounce (28 grams)	\$4,000-18,000
1 pound (454 grams)	\$45,000-90,000

Source: Australian Crime Commission (ACC, 2012)

5.2.2 Purity

In 2012, over half (53%) of participants reported speed to be of high purity in the previous six months. compared with 26% in 2011 (Table 27).The purity of ice/crystal was reported as high by four in five participants.

Table 27: Perception of methamphetamine purity in previous six months, 2011 and 2012

	Speed %		Base %		Crystal %	
	2011 (n = 39)	2012 (n = 19)	2011 (n = 12)	2012 (n = 4)	2011 (n = 18)	2012 (n = 15)
Low	13	16	-	-	0	-
Medium	53	16	50	-	22	20
High	26	53	50	100	61	80
Fluctuates	8	16	-	-	17	-

Note: Those choosing 'don't know' were excluded from analyses

Source: QLD EDRS participant interviews

Purity was generally considered to be fluctuating or stable for speed and crystal/ice (Table 28).

Table 28: Perceived changes in purity of methamphetamine, 2011 and 2012

	Speed %		Base %		Crystal %	
	2011 (n = 39)	2012 (n = 19)	2011 (n = 12)	2012 (n = 4)	2011 (n = 18)	2012 (n = 15)
Increasing	8	5	9	50	17	13
Stable	35	37	46	25	28	53
Decreasing	16	21	9	-	17	-
Fluctuating	41	37	36	25	39	33

Note: Those choosing 'don't know' were excluded from analyses

Source: QLD EDRS participant interviews

Table 29 shows that in 2010–11 Queensland Police Service (QPS) made 56 seizures of low purity in the financial year 2010–11: whereas the Australian Federal Police (AFP) made fewer seizures but of higher purity (ACC, 2012).

Table 29: Median purity of amphetamine seizures analysed in Queensland by police, 200708 to 2010–11

	2007–08		2008–09		2009–10		2010–11	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
QPS	22	5.7	38	2.0	20	1.2	56	0.8
AFP	5	8.7	6	7.8	2	18.6	5	14.3

Source: Australian Crime Commission (ACC, 2012)

Table 30 shows the purity of methylamphetamine seizures by QPS was 13.9% (Range 0.1-82.1%) in the financial year 2010-11. The three AFP seizures ranged in purity from 11.1% to 73.6% (ACC, 2012).

Table 30: Median purity of methylamphetamine seizures analysed in Queensland by police, 2007–08 to 2010–11

	2007–08		2008–09		2009–10		2010–11	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
QPS	1,649	11.9	2,002	11.9	1,568	6.8	1,884	13.9
AFP	0	0	0	0	1	18.8	3	31.7

Source: Australian Crime Commission (ACC, 2012)

5.2.3 Availability

In 2012, speed was reported to be easy or very easy to obtain by 84% of those who commented; with over half reporting the availability of speed had remained stable in the previous six months (Table 31). Base appears to be readily available, although the small numbers commenting precludes reliable interpretation. The availability of crystal appeared similar to 2011.

Table 31: Availability of methamphetamine, 2011 and 2012

	Speed %		Base %		Crystal %	
	2011 (n = 38)	2012 (n = 19)	2011 (n = 12)	2012 (n = 4)	2011 (n = 18)	2012 (n = 16)
Current availability						
Very easy	37	26	42	75	39	29
Easy	42	58	25	-	56	53
Difficult	21	11	25	25	6	18
Very difficult	-	5	8	-	-	-
Change in availability						
More difficult	16	22	18	-	11	6
Stable	61	56	46	25	72	75
Easier	18	-	9	75	6	13
Fluctuating	5	22	27	-	11	6

Source: QLD EDRS participant interviews

5.2.4 Source and locations of use

For all forms of methamphetamine, friends were the most common source person, followed by a known dealer (Table 32). For speed, the most common source location was at a friend's house, yet for base and crystal it was at the participant's home.

Table 32: Most recent source person and location for methamphetamine obtained in the preceding six months, 2011 and 2012

	Speed %		Base %		Crystal %	
	2011 (n = 38)	2012 (n = 18)	2011 (n = 12)	2012 (n = 5)	2011 (n = 18)	2012 (n = 17)
Source person						
Friend	45	67	67	40	56	82
Known dealer	37	28	33	20	33	6
Workmate	3	-	-	-	6	-
Acquaintance	3	6	-	40	-	6
Unknown dealer	3	-	-	-	-	-
Other	1	-	-	-	6	6
Source location						
Home	16	22	8	40	28	53
Friend's house	35	44	50	20	33	35
Dealer's house	19	17	25	20	17	6
Nightclub	3	6	8	-	11	-
Private party	5	11	-	-	6	-
Agreed public location	5	-	8	-	6	6
Pub	3	-	-	-	-	-
Other	5	-	-	20	-	-

Note: Those choosing 'don't know' were excluded from analysis

Source: QLD EDRS participant interviews

The most recent time participants used speed, they reported being at home, (32%), at a friend's house (21%) or at a nightclub (16%) (Table 33). Crystal was most used at a friend's house (44%) or at home (38%).

Table 33: Location of most recent methamphetamine use, 2011 and 2012

	Speed %		Base %		Crystal %	
	2011 (n = 37)	2012 (n = 19)	2011 (n = 12)	2012 (n = 5)	2011 (n = 18)	2012 (n = 16)
Home	8	32	8	20	33	38
Friend's house	14	21	25	20	22	44
Dealer's house	-	-	-	-	-	6
Nightclub	27	21	8	20	6	-
Private party	5	16	17	-	-	-
Pub	16	-	8	-	11	6
Live music festival	11	11	-	-	-	-
Outdoors	3	-	-	-	-	-
Work	-	-	-	20	6	6
Other	3	-	8	20	11	-

Source: QLD EDRS participant interviews

5.2.5 Comments from key experts

There were no reports of differences in the speed and base markets. Crystal was, however, considered to be more readily available. The demand for crystal was reported to have increased and this was thought to be a consequence of marketing as well as the high purity levels. The Illicit Drug Group (Forensic Chemistry, Queensland Health) explained that there was more crystal being tested from seizures that was in the 60-100% purity band: more high purity, less low purity. Some key experts reported that the increase in purity had enabled dealers to ask for a higher price, but one key expert considered that the wider availability of crystal also meant that it was becoming cheaper.

5.3 Cocaine

Key Points

- Median price of cocaine was \$300 per gram, with price mostly reported as stable.
- 57% rated cocaine purity as high, an increase from 12% in 2011 ($p < 0.05$).
- Two-thirds (65%) reported cocaine was easy or very easy to obtain.
- Most of those reporting on cocaine scored from a friend (70%), and a friend's home was the most common location (60%).
- Cocaine was consumed at a variety of venues, the most common being a friend's home.

Of the total sample, 17 participants (27%) were able to answer questions about the cocaine market. Caution is needed when interpreting these data because of these low numbers.

5.3.1 Price

In 2012, the median price of the most recent cocaine purchase was \$300 per gram (range \$100–\$350; $n = 12$), compared with \$325 (\$120–\$500; $n = 30$) in 2011.

The price of cocaine in the preceding six months was mostly rated as stable (Table 34).

Table 34: Changes in prices of cocaine in preceding six months, 2011 and 2012

	2011 ($n = 26$) %	2012 ($n = 13$) %
Increasing	27	23
Stable	54	62
Decreasing	4	-
Fluctuating	15	15

Note: Those choosing 'don't know' were excluded from analysis

Source: EDRS QLD participant interviews

The Australian Crime Commission (ACC, 2012) reported that in 2010–11 the price of one gram of cocaine was \$450–\$500 which is considerably higher than what was reported by our study participants.

5.3.2 Purity

In 2012, more participants reported that cocaine was of 'high' purity (57%) compared with 2011 (12%, $p < 0.05$), yet 46% of participants who commented reported the level of purity of cocaine had fluctuated in the previous six months (Table 35).

Table 35: Perception of cocaine purity in previous six months, 2011 and 2012

	2011 (n = 32) %	2012 (n = 14) %
Current purity		
Low	33	29
Medium	42	14
High	12	57
Fluctuates	9	-
Change in purity		n = 13
Increasing	6	15
Stable	27	38
Decreasing	15	-
Fluctuating	33	46

Note: Those choosing 'don't know' were excluded from analyses

Source: QLD EDRS participant interviews

Although the purity of cocaine seized by the Australian Federal Police in Queensland had a median purity of 76.2%, seizures by the Queensland Police Service that were analysed had a median purity of 19.8% (Table 36).

Table 36: Median purity of cocaine seizures analysed in Queensland, 2007–08 to 2010–11

	2007–08		2008–09		2009–10		2010–11	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
QPS	133	35.2	214	28.1	257	30.1	126	19.8
AFP	6	84.6	6	41.7	3	53.7	21	76.2

Note: Figures do not represent purity of all cocaine seizures, but only of those submitted for analysis

Source: Australian Crime Commission (ACC, 2012)

5.3.3 Availability

In 2012, 65% of participants who commented on the cocaine market reported cocaine to be either easy or very easy to obtain in the previous six months, compared with 38% in 2011. Just over half (53%) reported that ease of access to cocaine had remained stable (Table 37).

Table 37: Availability of cocaine in previous six months, 2011 and 2012

	2011 %	2012 %
Current availability	(n = 32)	(n = 14)
Very easy	16	29
Easy	22	36
Difficult	53	29
Very difficult	3	7
Change of ease of access	(n = 32)	(n = 15)
More difficult	25	27
Stable	47	53
Easier	16	7
Fluctuates	6	13

Note: Those choosing 'don't know' were excluded from analyses.

Source: QLD EDRS participant interviews

5.3.4 Source, source location and location of use

Almost three-quarters (73%) of participants reported they had obtained cocaine from a friend the most recent occasion they used it in the previous six months (Table 38). The source location was most likely to be at a friend's house.

Table 38: Most recent source and location for obtaining cocaine, 2011 and 2012

	2011 (n = 32) %	2012 (n = 15) %
Persons scored from		
Friends	38	73
Dealers (known/unknown)	34	20
Acquaintances	13	7
Work colleagues	3	7
Location scored from		
Own home	13	20
Friend's home	28	60
Nightclub	13	-
Agreed public location	9	7
Pubs	6	13
Work	6	-
Dealer's home	3	-
Private party	3	-
Acquaintance's home	3	-
Other	3	-

Source: QLD EDRS participant interviews

Most participants reported using cocaine in a residential setting (e.g. at a friend's home or at home), and less rarely at a pub or nightclub (Figure 21).

Figure 21: Location of most recent cocaine use, 2011 and 2012

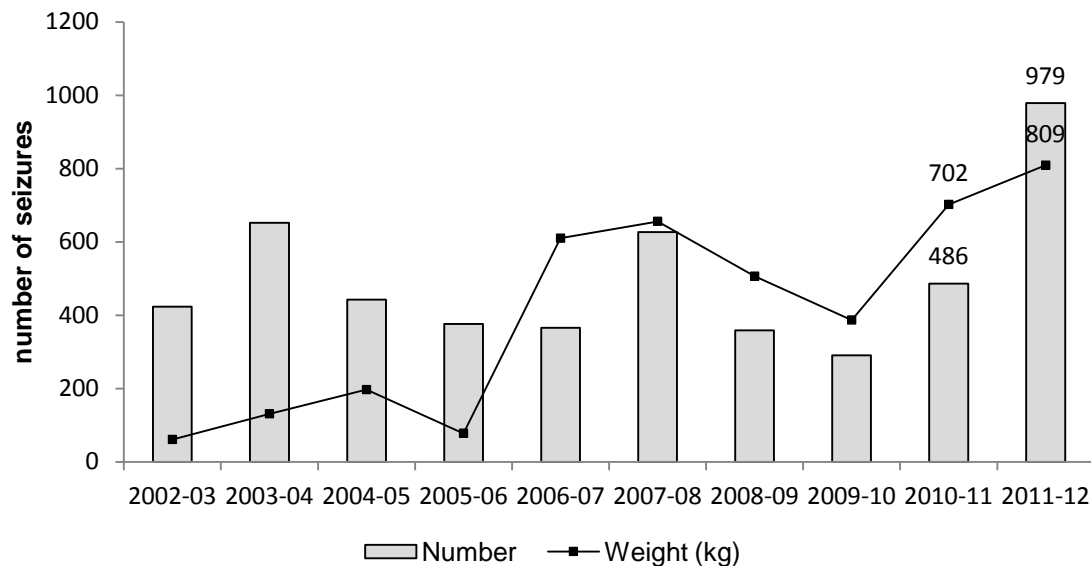


Source: QLD EDRS participants interviews

5.3.5 Cocaine seizures

Weight and number of cocaine detections by the Australian Customs Service at the Australian border are presented in Figure 22 with reports from earlier years. In 2011–12 the number of seizure rose to 979 from 486 in 2010–11; although the rise in the total weight of seizures from 2010–11 to 2011–12 was far less pronounced.

Figure 22: Number and weight of cocaine detections at the Australian border, 2002–03 to 2010–11



Source: Australian Customs and Border Protection Service (ACS)

5.3.6 Comments from key experts

Key experts reported that availability of cocaine tended to be ad hoc and not always reliable. Price was considered to be a barrier for many regular ecstasy users. Purity was reported to be low and this was in keeping with the results from testing cocaine seizures (Illicit Drug Group, Forensic Chemistry, Queensland Health), though spikes in purity levels of seized cocaine were also identified.

5.4 Ketamine

No participants were able to comment on the ketamine market.

Comments from key experts

Key experts advised that ketamine use was uncommon. They explained that people tended to try it but not use it regularly. One key expert noted that recently there was increased talk about ketamine. A ketamine analogue, MXE (methoxetamine) was reported as attracting a lot of interest.

5.5 GHB

In 2012, four participants were able to comment on the GHB market.

5.5.1 Price, purity and availability

The median price of GHB was reported to be \$6/ml (range \$5–\$15; n = 4), similar to 2011. Purity was reported to fluctuate, and availability was reported to be limited.

5.5.2 Source and locations of use

GHB was obtained from friends, at home, at a dealer's home or at a private party, and was used at home.

5.5.3 Comments from key experts

There was no information from key experts directly about markets; but key experts from the law advised that there were indications that GHB was being manufactured locally.

5.6 LSD

Key Points

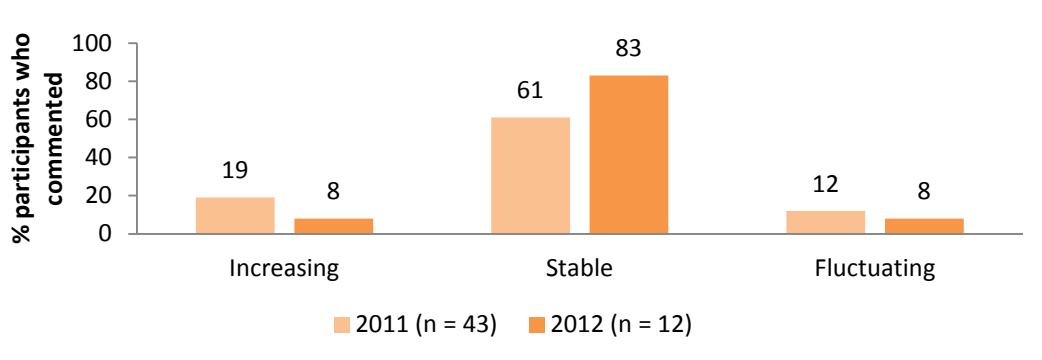
- Price of LSD was stable at a median of \$20 per tab.
- Purity was generally rated as medium (46%) or high (31%).
- Ratings of availability were mixed, with 46% rating it as easy and 37% rating it as difficult.

Of the total sample, 13 participants (21%) were able to answer questions about the LSD market.

5.6.1 Price

The median price per tab for the most recent purchase was similar to 2011 at \$20 (range \$15–\$30; n = 12). Most participants who commented (83%) reported the price to have remained stable in the previous six months (Figure 23).

Figure 23: Change in price of LSD in preceding six months, 2011 and 2012



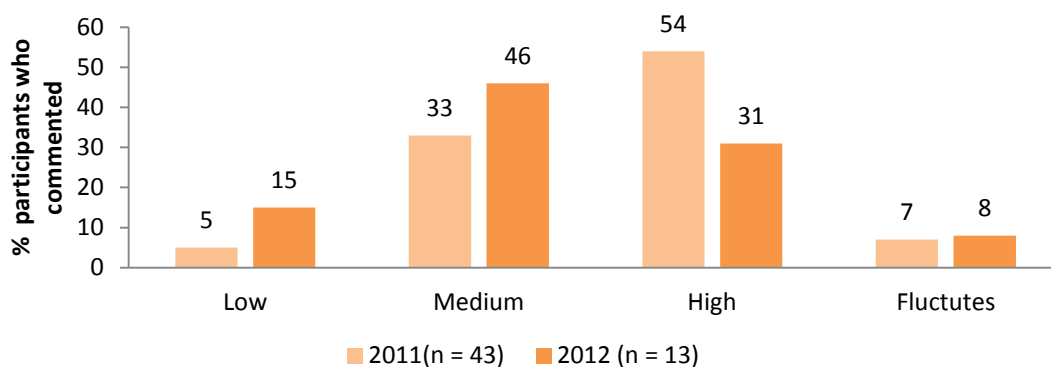
Note: Those choosing 'don't know' were excluded from analyses

Source: QLD EDRS participant interviews

5.6.2 Purity

The strength of LSD in 2012 was rated high by 31% compared with 54% in 2011 (Figure 24). Changes in purity over the previous six months were considered stable by over half who commented, with 27% reporting that it fluctuates (Figure 25).

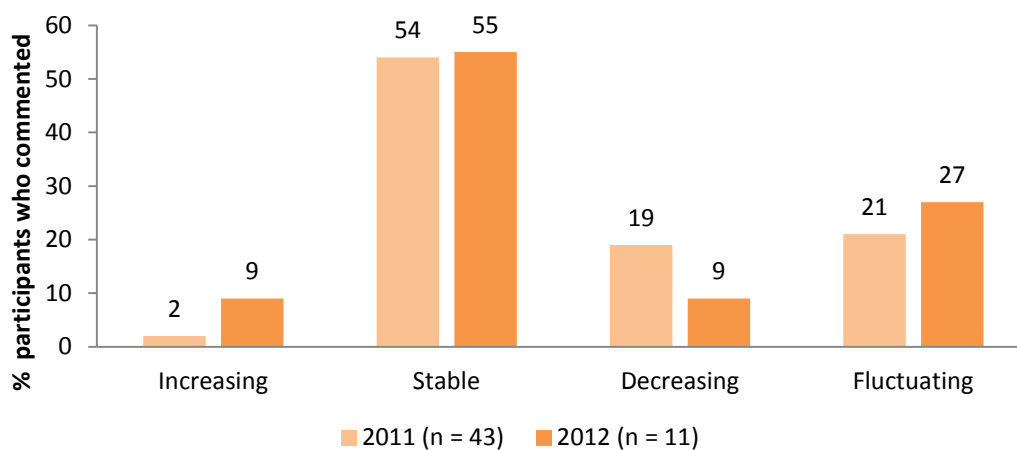
Figure 24: Purity/strength of LSD in preceding six months, 2011 and 2012



Note: Those choosing 'don't know' were excluded from analyses

Source: QLD EDRS participant interviews

Figure 25: Changes in purity/strength of LSD in preceding six months, 2011 and 2012

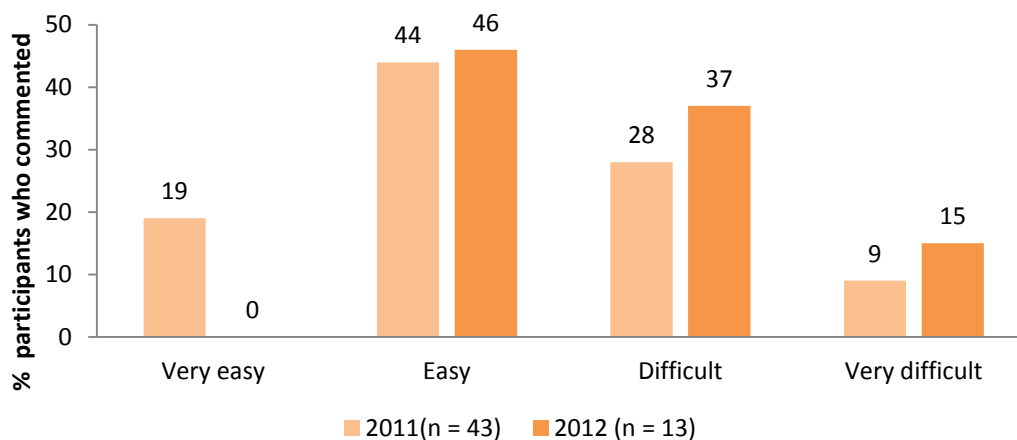


Note: Those choosing 'don't know' were excluded from analyses
 Source: QLD EDRS participant interviews

5.6.3 Availability

Although nearly half of participants who commented rated LSD easy to access, the remainder rated it as difficult or very difficult, with none rating it as very easy (Figure 26).

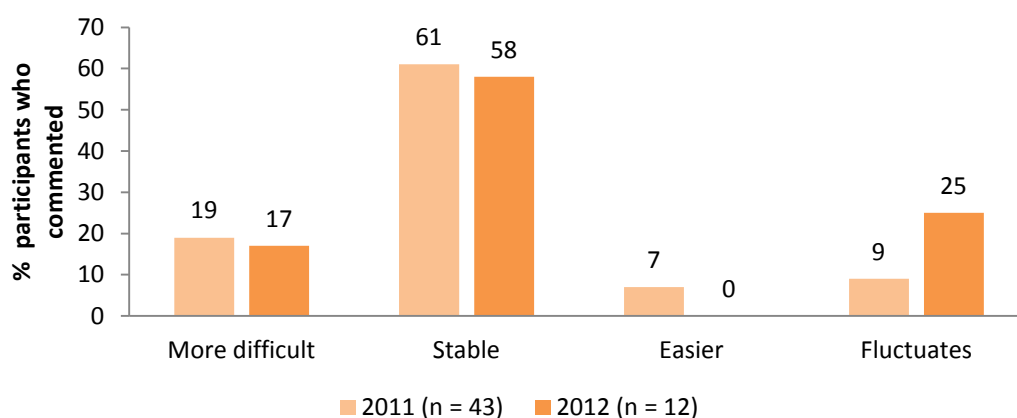
Figure 26: Availability of LSD in preceding six months, 2011 and 2012



Source: QLD EDRS participant interviews
 Note: Those choosing 'don't know' were excluded from analyses

Most participants reported that the availability of LSD remained stable in the previous six months, though one-quarter reported that it fluctuates (Figure 27).

Figure 27: Changes in availability of LSD in preceding six months, 2011 and 2012



Note: Those choosing 'don't know' were excluded from analyses
 Source: QLD EDRS participant interviews

5.6.4 Source and locations of use

Similar to previous years, friends were the most common source person the most recent time participants obtained LSD (Table 39). A friend's home was the most common source location.

Table 39: Source person and location for obtaining LSD most recent time, 2011 and 2012

	2011 (n = 43) %	2012 (n = 12) %
Source person		
Friends	72	58
Dealers (known/unknown)	14	33
Acquaintances	5	-
Other	9	8
Location sourced from		
Own home	19	-
Friend's home	42	58
Nightclub	-	8
Agreed public location	7	-
Pubs	2	-
Work	-	-
Dealer's home	7	17
Private party	9	-
Acquaintance's home	2	-
Other	12	17

Note: Those choosing 'don't know' were excluded from analyses
 Source: QLD EDRS participant interviews

One-third of participants who commented reported they were at home the more recent time they used LSD, while one-quarter reported they had been at a friend's home, and 17% at a nightclub (Figure 29).

Figure 28: Location of most recent LSD intoxication, 2011 and 2012



Source: QLD EDRS participant interviews

5.6.5 Comments from key experts

Key experts advised that LSD was not easy to access overall; but that it was being sold online by domestic sellers and delivered by the postal service. Key experts also explained that it was difficult to manufacture. The price for a card impregnated with LSD was reported as being \$20.

5.7 Cannabis

Key Points

- Hashish and hashish oil were rarely used.
- Most participants rated the price of hydro and bush as stable.
- Hydro was mostly rated as high or medium strength, and bush as medium.
- Hydro was readily available but bush appeared to be becoming more difficult to access.
- A friend was the most common source person for both hydro and bush.

In 2012, 41 participants responded that they could distinguish between bush and hydro cannabis, with 41 participants able to comment on the hydro market, and 24 on bush cannabis.

Only one participant was able to comment on hash oil, and no one was able to comment on hashish.

5.7.1 Price

Hash oil was reported to be \$25 per cap (n = 1), though no participant reported purchasing it in the previous six months.

The price of both bush and hydro cannabis appears to have remained stable, with the median price of hydro at \$280 an ounce, and bush at \$250 an ounce (Table 40).

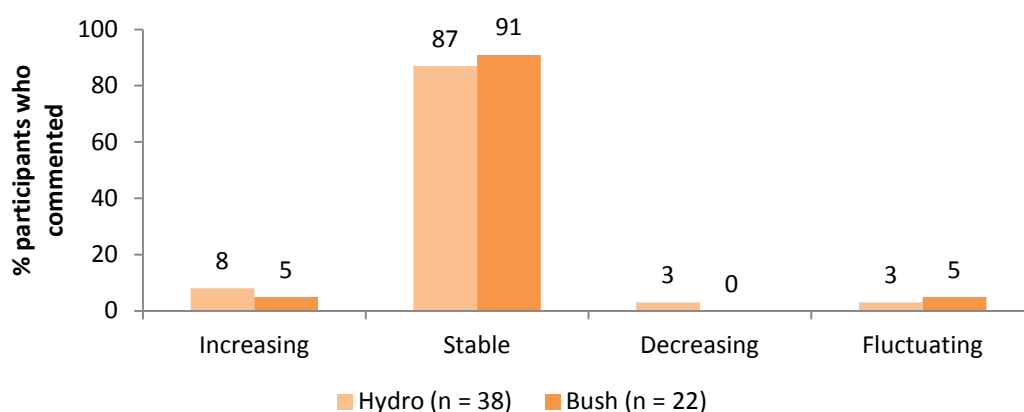
Table 40: Cannabis prices according to type and amount recently purchased, 2011 and 2012

	2011 Median (range)	2012 Median (range)
Hydro		
Gram	\$20 (12.50-25)	\$20 (10-20)
Quarter ounce	\$90 (25-125)	\$90 (70-100)
Ounce	\$300 (130-350)	\$280 (80-450)
Bush		
Gram	\$20 (10-20)	\$10 (n = 1)
Quarter ounce	\$80 (50-100)	\$80 (70-90)
Ounce	\$250 (130-400)	\$250 (60-300)

Source: QLD EDRS participant interviews

Most participants rated the price of hydro and bush as stable (Figure 29).

Figure 29: Price changes of cannabis in preceding six months, 2012



Note: Those choosing 'don't know' were excluded from analyses

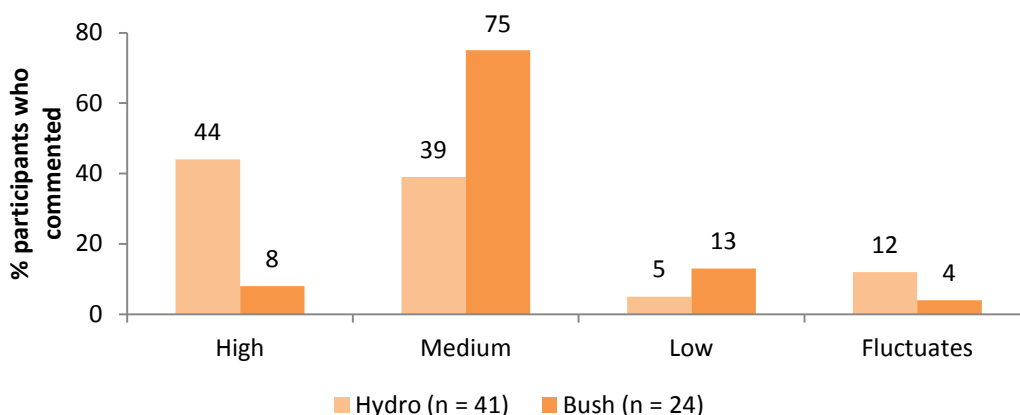
Source: QLD EDRS participant interviews

5.7.2 Purity

Hydro was perceived to be of high strength by 44% of participants who commented, (compared with 64% in 2011), and of medium strength by 39% (24% in 2011) (Figure 30).

Bush was reported to be of medium strength by three-quarters of participants (compared with 49% in 2011), high by 8% (14% in 2011) and low by 13% (20% in 2011).

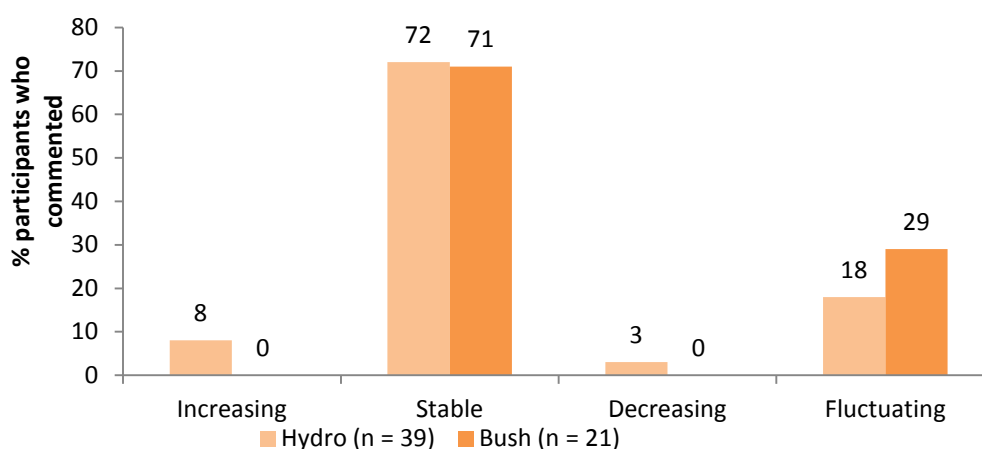
Figure 30: Perception of cannabis purity in preceding six months, 2012



Note: Those choosing 'don't know' were excluded from analyses
 Source: QLD EDRS participant interviews

As shown in Figure 31, reports of change in the recent purity of cannabis were similar to 2011, with 72% reporting hydro has remained stable (compared with 73% in 2011) and 71% reporting bush has remained stable (69% in 2011).

Figure 31: Perceived change in recent purity of cannabis, 2012



Note: Those choosing 'don't know' were excluded from analyses
 Source: QLD EDRS participant interviews

5.7.3 Availability

In 2012, bush appears to have been slightly more difficult to obtain, though the availability of hydro remained similar to reports in 2011 (Table 41).

Table 41: Availability of cannabis in preceding six months, 2011 and 2012

	Hydro		Bush	
	2011 (n=63) %	2012 (n = 41) %	2011 (n = 61) %	2012 (n = 24) %
Current ease of access				
Very easy	68	73	29	13
Easy	22	20	28	25
Difficult	10	7	39	50
Very difficult	-	-	4	13
Change in availability in last six months				
	(n = 63)	(n = 39)	(n = 61)	(n = 23)
More difficult	5	17	12	26
Stable	86	71	77	48
Easier	5	7	6	4
Fluctuates	3	5	2	22

Note: Those choosing 'don't know' were excluded from analyses
Source: QLD EDRS participant interviews

5.7.4 Source and locations of use

Friends remained the most common source person for both hydro and bush, followed by dealers, with residential dwellings (i.e. friend's home, at home, dealer's home) being the most common score location for the most recent cannabis purchase (Table 42).

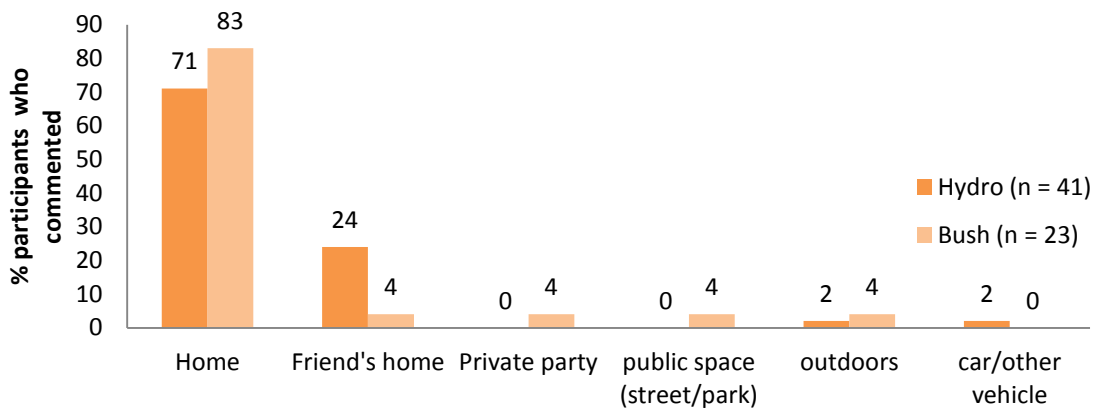
Table 42: Source person and location of most recent cannabis purchase, 2011 and 2012

	Hydro		Bush	
	2011 (n = 62) %	2012 (n = 41) %	2011 (n = 50) %	2012 (n = 23) %
Score person				
Friend	60	66	52	74
Known dealer	29	27	16	17
Acquaintances	7	7	6	9
Unknown dealer	5	-	10	4
Street dealer	-	-	10	-
Other	-	-	4	-
Score location				
Home	32	20	16	26
Dealer's home	23	20	16	9
Friend's home	39	46	41	48
Agreed public location	5	5	2	4
Work	-	-	2	-
Street market	-	-	14	4
Live music event	-	-	4	-
Other	1	2	2	4

Note: Those choosing 'don't know' were excluded from analyses
Source: QLD EDRS participant interviews

The participant's home remained the most common venue of intoxication on the most recent occasion cannabis was used (Figure 32).

Figure 32: Venue of most recent cannabis intoxication, 2012



Note: The category 'haven't used' is omitted.
Source: QLD EDRS participant interviews

5.7.5 Comments from key experts

Hydro and synthetic cannabis were reported as being widely available, with both of these sometimes being highly potent.

6 HEALTH-RELATED TRENDS ASSOCIATED WITH ECSTASY AND RELATED DRUG USE

Key Points

- 18% of participants experienced an accidental stimulant overdose in the previous 12 months.
- 27% reported not taking precautions to avoid bad effects of ecstasy-type pills.
- 31% experienced an accidental depressant overdose in the previous 12 months.
- 16% reported recently seeking help about a specific drug-related problem (e.g. dependence, legal issues) from a service or health professional.
- 5% of participants were currently in drug treatment.
- Drugs were reported as contributing to recurrent problems in four spheres: increased risky behaviour (52%), difficulty meeting responsibilities (41%), social relationships (29%), and legal problems (9%).
- Alcohol, cannabis, ice/crystal and ecstasy were the drugs most commonly reported as the main contributors to recurrent problems.
- About three-quarters (74%) of participants recorded moderate to very high distress on the Kessler Psychological Distress Scale (K10).

6.1 Overdose and drug-related fatalities

6.1.1 Non-fatal stimulant overdose

In 2012, one-third of respondents reported having ever overdosed on any stimulant drug in their lifetime. The median number of times a participant had overdosed was 1.5 times (range 1-10 times).

Of those who had ever experienced a stimulant overdose (n = 20), 55% had done so in the previous 12 months, corresponding to 18% of the total sample. Ecstasy remained the most common drug attributed to the most recent accidental stimulant overdose (Table 43).

Table 43: Primary and secondary drugs attributed to most recent accidental stimulant overdose in past year, and location, 2012

	2012 (n = 11) Count
Main drug attributed to the overdose	
Ecstasy	5
LSD	2
Meth powder	-
Meth base	1
Crystal meth/ice	1
GHB	-
Cocaine	-
Mushrooms	1
Unknown capsule	1
Other drugs taken (multiple responses permitted)	
No other drugs were taken	6
Alcohol	5
Cannabis	3
Ecstasy	-
Meth powder	1
Ice/crystal	-
Cocaine	-
Benzodiazepines	-
Methadone	-
Antidepressants	-
Energy drinks	-
Pharmaceutical stimulants	1
Buprenorphine	1
Location	
Home	4
Friend's home	2
Nightclub	1
Pub	1
Live music event	1
Private party	1
Work	1
Other	1

* Multiple responses permitted

Source: QLD EDRS participant interviews

Of those who had experienced a non-fatal stimulant overdose in the previous 12 months (n = 11), 55% reported it had occurred during a 'heavy' drug use session, compared with 45% who reported it had been a 'normal night out'.

Symptoms experienced most in recent stimulant overdose

There was a variety of primary symptoms experienced during the most recent stimulant overdose (e.g. passing out and delirium). The most common secondary symptoms (multiple answers permitted) were panic, visual hallucinations, dizziness, and muscle twitches.

Treatment of stimulant overdose

Of the people who reported experiencing a stimulant overdose in the previous 12 months (n = 11), 64% reported that there was no one sober present to assist them. Thus the friends who had monitored/watched over six participants (55%) (Table 44) may not necessarily have been sober. Two participants (18%) reported they had not received any treatment or monitoring at all.

Table 44: Treatment received most recent stimulant overdose in past year, 2012

	2012 (n = 11) Count
Immediate treatment	
Did not receive treatment	2
Monitored/watched by friends	6
Ambulance attendance	2
Hospital emergency department	-
Phone information service	-
Help from emergency tent at music festival	1

Note: Multiple responses permitted

Source: QLD EDRS participant interviews

After the overdose experience, three participants reported seeking out or getting treatment or information about the overdose or their drug use in general. This included seeing a psychologist and searching the internet/visiting a website.

Precautions taken to avoid bad effects

In 2012, questions were added about whether participants generally took precautions 'to avoid bad effects from ecstasy-type pills' in the previous six months. Of those who responded, 27% reported they had not used any precautions. The most popular reported precaution was obtaining ecstasy from a trusted source (58%), followed by starting with one pill or less (24%) (Table 45).

Table 45: Precaution taken when using ecstasy, 2012

	2012 (n = 45) %
None	27
Got from a trusted source	58
Pill reputation	16
Drug use website	16
Testing kit	7
Started session with one pill or less	24
Observed others	13
Drank water	7
Use with friends (around for help)	7
Other	7

Note: multiple answers permitted

Other: 'has friend in testing lab', 'monitors serotonin levels as influences drug effect' and 'supplement nutrition, maintain blood sugar levels'.

Source: QLD EDRS participant interviews

6.1.2 Non-fatal depressant overdose

In 2012, 16 participants reported that they had experienced at least one non-fatal depressant overdose in their lifetime. The median number of times this had occurred was twice (range 1–10 times; n = 16). Five participants (31% of the survey sample) reported experiencing a depressant overdose in the previous 12 months.

Of those who experienced a non-fatal overdose in the past year, two participants reported alcohol was the main contributing drug, while other participants reported GHB, ketamine and prescribed anti-depressants. Two participants reported that cannabis and ecstasy may have contributed as secondary drugs to their overdose.

Two participants reported the overdose had occurred at home, while others reported it happened at a dealer's house, at a friend's house or at a nightclub.

Symptoms experienced in most recent accidental depressant overdose

Losing consciousness was the most common symptom attributed to the depressant overdose. Other symptoms included suppressed breathing (1) and stomach pain/weakness (1).

Treatment received in most recent accidental depressant overdose

Two participants reported receiving immediate treatment for the most recent depressant overdose: one was attended to by an ambulance and the other was monitored by friends.

After overdosing, one participant reporting going to drug rehabilitation, one used the internet to find information about overdoses, and another one discussed with their mother to obtain advice/information.

6.1.3 Queensland Ambulance Service

Table 46 presents the number of attendances during the 2010–11 and 2011–12 financial years by the Queensland Ambulance Service to people who were coded as having a drug overdose and the primary drug was recorded. The total number of cases was similar for both

years with 8,863 in 2011–12 and 8,357 in 2010–11. As in 2010–11, alcohol was by far the most common primary drug followed by anti-depressants, benzodiazepines, and heroin; however, there were 265 amphetamine cases compared with 149 in 2010–11. Also there were 80 inhalant cases in 2010–11 but 136 in 2011–12.

Table 46: Overdose cases attended by Queensland Ambulance Service where primary substance was recorded, 2010–11 and 2011–12

Primary drug	2010–11	2011–12
Alcohol	3,813	3,950
Anti-depressants	661	641
Benzodiazepines	490	554
Heroin	285	281
Amphetamines	149	265
Antipsychotics	208	221
Cannabis	198	227
Ecstasy	107	137
Inhalants	80	136
GHB	32	53
Methadone	34	32
Cocaine	28	26
Buprenorphine	2	3

Source: Queensland Ambulance Service

These data are conservative for several reasons, and cannot be considered a definitive record of the number of overdoses attended by the service in the specified time period. Queensland Ambulance Service data do not include formal diagnoses, as these are not made until the patient has received treatment at a hospital emergency department. Also the ambulance service may have attended people who had overdosed without an overdose code being assigned, thus excluding them from the data shown.

Moreover, the 'drug type' field is optional as it is not always possible for paramedics to establish the drug type involved. Only the primary drug is recorded so the data does not capture the range of different illicit drugs that may be involved in each overdose case. Finally, these data relate only to cases where the primary case nature was coded as overdose. Any overdose cases where the overdose was coded as secondary to the primary problem are not included (e.g. cardiac arrest due to drug overdose, trauma, and/or psychiatric cases).

6.2 Help-seeking behaviour

Participants were asked whether they had sought help from a service or health professional in the last six months for any issues related to their drug and/or alcohol use. Of those who had not accessed a health service in relation to their drug use in the previous six months (n=47), 19% reported they had thought about doing so. When asked why they had not attended, reasons included: cost, embarrassment, no time, and could not be bothered.

Participants who sought help were asked to nominate the main issue. Of the 10 who responded, three nominated dependence/addiction and two nominated legal reasons (i.e. arrested or court order). Other reasons included psychosis, immediate anxiety, and long term depression/anxiety.

Among those who had visited a health service in the previous six months, the main health professions accessed were a counsellor (n = 3) or psychologist (n = 3), followed by a drug and alcohol worker (n = 2). One participant was admitted to hospital and one participant visited a GP.

Cannabis was reported to be the main drug involved for half of the participants who responded (n = 4), with ecstasy, methamphetamine base, alcohol, and other opiates also reported as the main drug.

Patterns of calls to the Alcohol and Drug Information Service (ADIS), which is a 24-hour information and counselling service provided by Queensland Health, were similar to the previous financial year. The majority of calls to ADIS were about alcohol, with only a very small proportion about ecstasy (Table 47).

Table 47: Number of calls to Alcohol and Drug Information Service (ADIS) according to drug type, 2010–11 to 2011–12

Drug type	Calls	
	2010–11	2011–12
Alcohol	5,871 (48%)	5,975 (42%)
Cannabis	2,363 (19%)	2,456 (17%)
Amphetamines	1,543 (13%)	1,913 (13%)
Licit opioids	1,487 (12%)	1,752 (12%)
Illicit opioids	849 (7%)	1,069 (7.5%)
Benzodiazepines	845 (7%)	1,008 (7%)
Cocaine	99 (1%)	80 (1%)
Ecstasy	126 (1%)	120 (1%)
Hallucinogens	48 (<1%)	44 (<1%)
Other	2,831 (23%)	3,090 (22%)

Source: Alcohol and Drug Information Service

As seen in Table 48, callers were most likely to be in the 25 to 34 year age groups for all drug types except alcohol (35 to 44 age group) and hallucinogens (18 to 24 age group).

Table 48: Number of calls to Alcohol and Drug Information Service (ADIS) by drug type and age, Queensland 2011–12

	0–17	18–24	25–34	35–44	45–54	55>	Total
Alcohol	137	425	1272	1701	995	577	5107
Cannabis	328	564	738	444	129	31	2234
Amphetamine	67	442	748	380	54	16	1705
Opioids illicit	4	88	355	260	66	4	777
Opioids licit	6	81	450	395	132	96	1160
Benzodiazepine	5	71	227	192	120	284	899
Cocaine	4	20	23	9	2	0	67
Ecstasy	11	59	31	4	1	0	106
Hallucinogens	5	19	9	3	1	0	37
Other	149	341	540	400	223	449	2855

Note: This represents the number of calls about each drug where there was a person with a drug history and information is known (as opposed to a call for information for assignments, etc). More than one drug may be mentioned on each call

Source: Alcohol and Drug Information Service

6.3 Drug treatment

As in previous years, only a small proportion of participants reported currently attending any form of drug treatment (5%). One participant reported being prescribed buprenorphine, while type of treatment was not specified for the other two participants.

6.4 Other self-reported problems associated with ecstasy and related drug use

In 2012, 58 participants answered questions about recurrent drug-related problems they may have experienced in the previous six months, with over half (52%) reporting increased risky behaviour, 41% reporting having difficulties meeting responsibilities, 29% reporting social problem and 9% reporting legal issues. Alcohol, cannabis, ice/crystal and ecstasy were the drugs most commonly reported as contributing to the recurrent problems (Table 49).

Table 49: Primary drug contributing to recurrent problems within previous six months, 2012

Main drug	Recurrent problems			
	Social/ relationship	Legal	Increased risky behaviour	Difficulty meeting responsibilities
	(n = 17) %	(n = 5) %	(n = 30) %	(n = 24) %
Ecstasy	6	-	13	25
Methamphetamine powder	12	-	-	4
Methamphetamine base	6	-	3	4
Methamphetamine crystal	6	40	7	13
Cannabis	53	20	13	29
Alcohol	18	20	53	17
Other	-	20	10	4

Other includes LSD, GHB, buprenorphine and 'combination of drugs in general' (one count each)
Source: QLD EDRS participant interviews

6.5 Hospital admissions

Data was unavailable at the time of publication.

6.6 Mental health problems

6.6.1 Mental health problems and psychological distress (K10)

The Kessler Psychological Distress Scale (K10) (Kessler & Mroczek, 1994) was designed as a screening tool for measuring psychological distress. It has well-established psychometric properties and validity for identifying anxiety and affective disorders (Andrews & Slade, 2001). The K10 comprises 10 questions used to assess symptoms which respondents may have experienced during the previous four weeks.

A 5-point Likert scale is used for responses, which range from 'all of the time' to 'none of the time' with a maximum possible score of 50. K10 scores provide a risk assessment which is categorised into the following: 'low', likely to be well (scores 10–15); 'moderate', may have a mild mental disorder (scores 16–21); 'high', likely to have a moderate mental disorder (scores 22–29); 'very high', likely to have a severe mental disorder (scores 30–50).

In 2012, about three-quarters (74%) of participants reported experiencing moderate to very high levels of distress in the previous month (Table 50).

Table 50: K10 level of distress, 2011 and 2012

	2011 (N = 103) %	2012 (N = 61) %
Low to no distress (10–15)	30	26
Moderate distress (16–21)	34	38
High distress (22–29)	25	21
Very high distress (30–50)	11	15

Source: QLD EDRS participant interviews

6.6.2 Self-reported mental problems and medication

In 2012, 36% of participants self-reported having a mental health problem in the previous six months, with depression and anxiety being the most common (Table 51).

Table 51: Self-identified recent mental health problems, 2009 to 2012

	2009 (n = 33) %	2010 (n = 32) %	2011 (n = 39) %	2012 (n = 22) %
Depression	67	60	80	68
Anxiety	42	78	62	45
Panic	9	3	21	14
Paranoia	21	6	18	18
OCD	3	3	8	9
Schizophrenia	9	6	8	9
Any personality disorder	-	-	5	9
Manic depression/bipolar disorder	18	9	5	9
Drug-induced psychosis	15	3	3	14
Other	-	25	10	18

Note: Multiple responses permitted. In 2010, 'other' category includes PTSD, ADHD, chronic fatigue, lethargy, night terrors, sleeping disorder and 'slight anger issues'. In 2011, 'other' category includes anorexia nervosa, insomnia, short-term memory loss, sleeping disorder and 'anger problems'. In 2012, 'other' category includes 'phobias' and 'gender identity disorder/severe mood disorder'

Source: EDRS QLD participant interviews

Nineteen participants reported visiting a health professional for a mental health problem in the previous six months. Of these, 32% were prescribed medication (anti-depressants, anti-psychotics, and benzodiazepines).

7 RISK BEHAVIOUR

Key Points

- 16% of participants reported recently injecting.
- 46% of participants had been vaccinated for hepatitis B, 48% tested for hepatitis C, and 59% tested for HIV.
- 40% reported having had a sexual health check-up in the last year.
- Of those who drove a vehicle in the previous six months, 50% reported driving while over the alcohol limit and 65% reported driving soon after taking illicit drugs.
- The majority of participants (83%) were drinking at levels which may harm their health.

7.1 Injecting risk behaviour

Participants who reported injecting drugs were asked a series of questions about their injecting drug use behaviour.

7.1.1 Lifetime injectors

In 2012, 29% of all participants reported injecting any drug at least once in their lifetime, with 16% reporting that they had injected in the previous six months (Table 52).

Table 52: Injecting risk behaviour, 2008 to 2012

	2008 (N = 108)	2009 (N = 88)	2010 (N = 101)	2011 (N = 103)	2012 (N = 62)
Ever injected (%)	13	22	17	24	29
Median age first injected (range)	18 (15-43)	19 (14-30)	20 (14-29)	18 (14-28)	19 (13-43)
Injected last 6 months (%)	7	13	11	16	16

Source: EDRS QLD participant interviews

7.1.2 Recent injectors

Among those who had recently injected, the median number of times injected was reported to be 117 times in previous six months (1–180 times; n = 8). Three participants injected ecstasy, two injected ice/crystal, two injected Subutex[®], and one injected a combination of cocaine and heroin. All who reported the venue of their most recent injection answered 'at home' (n = 7).

Half of participants who injected drugs in the previous six months (n = 10) reported obtaining their needles from a NSP, 40% from a hospital, 20% from a chemist, and 20% from a friend (multiple responses permitted).

Two participants reported using a needle after someone else had used it in the previous six months. No sharing of other equipment (e.g. spoons, mixing containers, filters, tourniquets, water and swabs) was reported.

Among those who had recently injected (n = 7), three reported that they usually injected with their regular sex partner, two with close friends, and one with acquaintances.

7.1.3 Injecting drug use in the general population

According to the 2010 National Drug Strategy Household Survey, 1.8% of Australians aged 14 and over had injected a drug other than that prescribed to them at least once in their lifetime. In the previous 12 months, 0.4% of Australians reported having injected illegally (AIHW, 2011).

Queensland Needle and Syringe Programs (NSP) dispensed a total of 7,924,015 needles in the 2011-12 financial year (7,374,360 in 2010–11).

7.2 Blood-borne viral infections (BBVI) and sexually transmitted infections (STI)

In 2012, participants had the option of self-completing a series of questions on testing and vaccinating against blood-borne viruses.

7.2.1 Testing among participants

Among those who responded, 46% of participants could recall being vaccinated for hepatitis B (Table 53), with the most common reason being 'vaccinated as a child'.

One-third reported having been tested for hepatitis C in the previous year, with 15% having been tested more than a year ago, leaving about half who had never been tested. Three participants reported testing positive to hepatitis C the most recent time they were tested.

Table 53: Testing and vaccination for hepatitis, 2011 and 2012

	2011 %	2012 %
Vaccinated for hepatitis B	(n = 72)	(n = 54)
No	36	22
Yes, didn't complete	7	9
Yes, completed	57	46
Don't know	-	22
Main reason for hepatitis B vaccination	(n = 44)	(n = 30)
At risk, injecting drug user	2	3
At risk, sexual transmission	11	3
Going overseas	32	17
Vaccinated as a child	30	27
Work	18	17
Other ^a	7	17
Don't know/can't remember	-	17
Tested for hepatitis C	(n = 83)	(n = 46)
No	42	52
Yes, in the last year	40	33
Yes, more than one year ago	18	15
Hepatitis C positive (if tested)	(n = 48)	(n = 22)
Yes	6	14
No	94	86

^aOther main reason for hepatitis B vaccination included 'other treatment and illness', 'parents', 'prison induction', and 'protection'.

Source: EDRS QLD participant interviews

Table 54 shows that among participants who responded (n = 53), 40% replied they had been tested for HIV in the past year, and 42% replied they had never been tested for HIV. No participants reported being HIV positive in 2012.

Two in five participants reported having a sexual health check-up in the previous year, with two participants reporting having been diagnosed with an STI. In 2012, 82% of participants who responded reported they had never been diagnosed with an STI.

Table 54: HIV and other sexual health check-ups, 2011 and 2012

	2011 %	2012 %
Tested for HIV	(n = 93)	(n = 53)
No	41	42
Yes, in the last year	38	40
Yes, more than one year ago	22	19
HIV positive^a	(n = 55)	(n = 31)
Yes	4	-
No	96	100
Other sexual health check-ups	(n = 99)	(n = 53)
No	28	26
Yes, in the last year	58	40
Yes, more than one year ago	14	34
Ever diagnosed with STI^b	(n = 71)	(n = 54)
No	69	82
Yes, in the last year	7	4
Yes, more than one year ago	24	15
STI diagnosis^c	(n = 22)	(n = 10)
Gonorrhoea	14	10
Chlamydia	68	60
Syphilis	0	-
HPV (genital warts)	9	-
Other	23	30

^aamong those who were tested

^bamong those who had a sexual health check-up

^camong those ever diagnosed with an STI

Source: EDRS QLD participant interviews

7.2.3 The National Notifiable Diseases Surveillance System

Notifications for blood-borne diseases and sexually transmitted disease among the general Queensland population were similar to 2011 (Table 55).

Table 55: Registered cases of blood-borne viruses and sexually transmitted diseases in Queensland, 2009 to 2012

Disease	2009	2010	2011	2012
Hepatitis B (newly acquired)	49	56	46	53
Hepatitis B (unspecified)	1,003	1,057	846	806
Hepatitis C (unspecified)	2,647	2,697	2,429	2,380
Syphilis - congenital	-	2	3	1
Syphilis < 2 years	191	195	275	321
Syphilis >2 years	294	178	201	232
Chlamydial infection	16,695	19,217	18,648	18,805
Gonococcal infection	1,786	2,299	2,959	2,689

Source: National Notifiable Diseases Surveillance System, 2009–2011 (NNDSS, 2012). Available at: http://www9.health.gov.au/cda/source/Rpt_2.cfm?RequestTimeout=500

7.3 Sexual risk behaviour

In 2012, 52 participants responded to the optional self-complete section on sexual risk behaviour.

7.3.1 Casual sex partners

Among participants who responded ($n = 52$), 71% reported they engaged in penetrative sex with at least one casual partner in the previous six months, while 29% did not (this includes people who may have a regular sex partner). Of those who did report recently engaging in penetrative sex with a casual partner, 41% reported they did so with one person, 19% with two people, 30% with 3–5 people, 5% with 6–10 people, and 5% with more than 10 people.

Among those who reported engaging in penetrative sex with a casual sex partner in the previous six months ($n = 37$), 92% reported they had done so while under the influence of drugs or alcohol. On the most recent occasion, the most commonly reported substance was ecstasy (68%), followed by cannabis (50%). Other substances used included ice/crystal (24%), meth power (18%), alcohol (18%), cocaine (9%), nitrous oxide (3%), meth base (3%) and benzodiazepines (3%)—multiple responses were permitted.

Among participants who had sex with a casual sex partner while under the influence of drugs or alcohol in the previous six months ($n = 33$), 27% reported never using a barrier (i.e. condom, gloves), while 42% reported always using one (12% often, 12% sometimes, 6% rarely).

In addition, participants were asked if they had used a barrier the most recent occasion they had sex with a casual partner in the previous six months. Among those who responded ($n = 34$), 56% replied that they had, while 44% had not. The most common reason for not using a barrier was not wishing to use ($n = 5$), followed by agreeing not to, using contraceptive pill, using implanon, partner not wishing to use, and being too intoxicated.

Among those who reported having sex with a casual sex partner while they were sober (i.e. *not* under the influence of drugs or alcohol) in the previous six months ($n = 34$), 68% reported they had used a barrier on the most recent occasion, while 32% reported they had not. When asked why they had not used a barrier on the most recent occasion they had sex

with a casual partner while sober, the most common reason was not wishing to use (n = 4), followed by agreeing not to, using contraceptive pill, and using implanon.

7.4 Driving risk behaviour

Among those who commented (n = 56), 71% of participants reported driving a vehicle in the previous six months (79% in 2011). Among those who had driven (n = 40), 60% reported driving under the influence of alcohol in the previous six months, with 50% driving over the limit. The median number of times driving while over the limit was twice in the previous six months (n = 24; range 1–10).

Among participants who reported driving a vehicle in the previous six months (n=40), 65% reported driving soon after taking illicit drugs, with a median of doing this 18 times, corresponding to three times a month (n = 26; range 1–180 times).

Cannabis and ecstasy were the most commonly reported illicit drugs taken prior to driving in the previous six months (Table 56).

Table 56: Drugs taken prior to driving in previous six months, 2011 and 2012

	2011 (n = 45) %	2012 (n = 26) %
Drugs taken prior to driving in preceding six months		
Cannabis	76	85
Ecstasy	51	65
Ice/crystal	16	8
Cocaine	13	-
LSD	11	15
Methamphetamine base	9	4
Heroin	9	-
Methamphetamine powder	7	23
Mushrooms	4	4
Pharmaceutical stimulants	2	-
Ketamine	2	-
Methadone	2	-
Other opiates	2	-
Benzodiazepines	2	-
GHB	2	-
Drugs taken most recent time prior to driving		
Cannabis	67	77
Ecstasy	20	42
Methamphetamine powder	4	8
Ice/crystal	11	4
Mushrooms	2	4
LSD	4	-
GHB	2	-
Cocaine	9	-
Heroin	7	-
Pharmaceutical stimulants	2	-
Meth base	-	4

Note: Multiple responses permitted
Source: EDRS QLD participant interviews

Participants were asked how impaired they believed their driving had been the most recent occasion they drove while under the influence of illicit drugs in the previous six months: 12%

reported their driving had been quite impaired, 42% slightly impaired, 23% no impact, and 23% slightly improved.

Two participants reported being tested for drug driving, though not in the previous six months.

7.5 The Alcohol Use Disorder Identification Test (AUDIT)

Questions were asked to identify participants with alcohol problems using the Alcohol Use Disorder Identification Test (AUDIT) (Saunders, Aasland, Babor, De La Fuente, & Grant, 1993). The AUDIT is a 10-item scale and respondents' total score places them into one of four 'zones' or risk levels. A total score of eight or more is an indication of being in one of three at-risk zones ranged according to severity. Intervention strategies are suggested for each zone (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). Table 57 indicates the majority of participants who completed the audit (83%) were drinking at levels which may be harmful to their health.

Table 57: AUDIT results and recommended intervention, 2011 and 2012

Zone (Score)	2011 (N = 103) %	2012 (n = 53) %	Intervention recommended
At risk (≥ 8)	86	83	-
Zone			
I (0-7)	14	17	Alcohol education
II (8-15)	36	40	Simple advice
III (16-19)	19	13	Simple advice plus brief counselling and continued monitoring
IV (20-40)	30	30	Referral to specialist for diagnosis and treatment

Source: EDRS QLD participant interviews

8 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH ECSTASY AND RELATED DRUG USE

Key Points

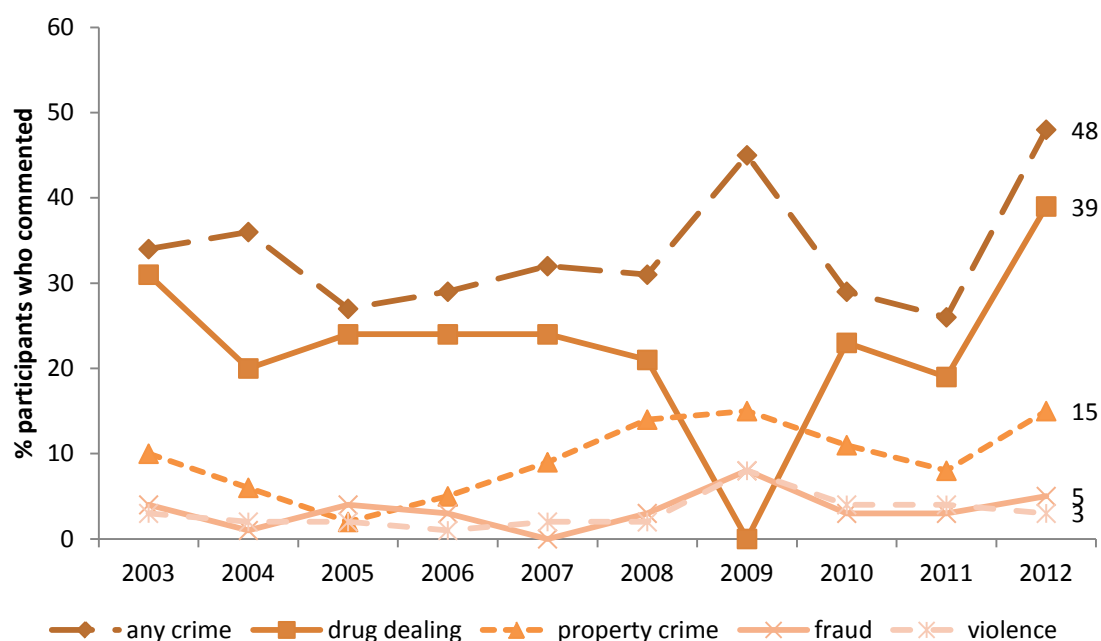
- 19% of participants had been arrested in the previous 12 months.
- 48% had been involved in criminal activity, with 39% having sold drugs for profit.
- Over a quarter of participants (27%) believed that police activity towards regular ecstasy users had increased.
- Nearly all participants were aware that if charged for possession of drugs, the quantity of drugs would affect the charge being brought against them.

8.1 Reports of criminal activity among participants

In 2012, participants responded to questions about their involvement in crime-related activity. Among the sample (N = 62), 11% participants reported ever going to prison, while 19% reported they had been arrested in the previous 12 months. Reasons given for the arrests included public order/drunk and disorderly (n = 3), use/possession drugs (n = 2), drug dealing/trafficking (n = 2), failure to dispose of needles (n = 2), violent crime (n = 2), use/possession of weapons (n = 1), drunk driving (n = 1), failure to dispose of cannabis (n = 1), and 'sleeping' (n = 1).

Figure 33 shows reports of criminal activity among participants in the previous month. Nearly half (48%) of participants reported being involved in some type of crime in the previous month: up from 26% in 2011 ($p < 0.05$). This overall increase is mainly accounted for by the increase in the proportion having sold drugs for profit at least once (39%) from 19% in 2011 ($p < 0.05$).

Figure 33: Criminal activity in the last month, 2003 to 2012



Source: EDRS QLD participant interviews

8.2 Perceptions of police activity towards regular ecstasy users

The majority of participants who commented perceived police activity towards ecstasy users to have remained stable in the previous six months (Table 58).

Table 58: Perceptions of changes in police activity towards ecstasy users over the preceding six months, 2009 to 2012

	2009 (n = 63) %	2010 (n = 65) %	2011 (n = 60) %	2012 (n = 34) %
Less activity	5	5	3	3
Stable	44	58	62	71
More activity	51	37	35	27

Note: Those choosing 'don't know' were excluded from analyses

Source: EDRS QLD participant interviews

8.3 Arrests

Table 59: Drug-related arrests by drug type, Queensland 2010–11

Type of drug	Consumer	Provider	Total
Amphetamine-type stimulants	2,213	898	3,111
Cannabis	14,397	1,880	16,277
Cocaine	120	25	145
Steroids	185	46	231
Hallucinogens	116	29	145

Note: Consumers= use, possession or administering for their own use; providers = importation, trafficking, selling, cultivation and manufacture

Source: Australian Crime Commission (ACC, 2012)

8.4 Perceptions and knowledge about drug law thresholds

Drug trafficking thresholds are used throughout every state and territory in Australia and often reverse the onus of proof onto users who exceed the nominated threshold quantity to prove they do not possess drugs for the purpose of trafficking. For the first time in 2012, participants were asked questions relating to drug trafficking thresholds/possession laws. The aim of these questions was to find out whether regular ecstasy users were aware of the existence of drug trafficking thresholds. Among the sample (N = 62), 89% correctly believed that the quantity of drugs that you have on you at the time you are caught by the police affects the type of charge you get.

9 SPECIAL TOPICS OF INTEREST

Key Points

- 23% of daily smokers scored high to very high nicotine dependence on the Fagerstrom test.
- The majority of respondents reported no or few symptoms of ecstasy dependence, with 78% responding that it would not be difficult to stop or go without.
- 38% of participants had experienced a traumatic brain injury. A third of these had been under the influence of alcohol at the time and nearly a quarter under the influence of illicit drugs.
- Drug policy questions elicited the strongest support for Needle and Syringe Programs (NSP) and methadone treatment programs. There was strong support for the legalisation of cannabis for personal use, and very little support for increasing the penalties for its sale or supply.
- In regard to body image, 23% reported using illicit psychostimulants for weight management. The most commonly used drugs for weight loss were methamphetamines and ecstasy.

9.1 Fagerstrom test for nicotine dependence

Participants who smoked daily (n = 35) were asked questions comprising the Fagerstrom test for nicotine dependence. This test includes six questions relating to daily cigarette smoking. The sum of the scores was computed and a cut-off score of more than 5 was used to indicate high to very high nicotine dependency (Heatherston et al., 1991).

As seen in Table 60, one in five of daily smokers reported smoking their first cigarette within five minutes of waking, and one-third between five to 30 minutes of waking. Most daily smokers did not find it difficult to refrain from smoking in smoke free areas. Thirty-eight per cent reported they would find the first cigarette in the morning the most difficult to give up. The majority of participants (77%) reported smoking less than 20 cigarettes per day. A minority (14%) reported that they smoke more in the morning, and 43% reported that they still smoke while sick in bed. The mean FTND score was 3.6. Twenty-three per cent of daily smokers scored above five, indicating high to very high nicotine dependence.

Table 60: Fagerstrom test for nicotine dependence, Queensland, 2012

	2012 (n = 35) %
Time for first cigarette after waking	
Within 5 minutes	20
5–30 mins	34
31–60 mins	20
60+ mins	26
Difficulty in refraining from smoking in forbidden places	
Yes	29
What cigarette would you hate to give up	
First in the morning	38
Other	62
Number of cigarettes smoked a day	
10 or less cigarettes	40
11–20 cigarettes	37
21–30 cigarettes	17
31 or more cigarettes	6
Smoke more frequently in the morning	
Yes	14
Smoke in bed even when sick	
Yes	43
High dependence	
(%)	23
Mean score	3.6

^a score of 6 and above

Source: QLD EDRS participant interviews

9.2 Ecstasy dependence

The question as to whether it is possible to be dependent on ecstasy is a controversial one. Currently, in the DSM-IV-TR, it is possible to be diagnosed with ecstasy dependence (coded as either amphetamine dependence or hallucinogen dependence), and there are clear case studies in the literature of people who are dependent on ecstasy. Animal models have demonstrated that dependence on ecstasy is biologically plausible. However, findings in relation to ecstasy dependence should be interpreted with caution due to limited research of this syndrome (see (Degenhardt, Bruno, & Topp, 2010; Topp & Mattick, 1997).

To date, internationally, there have been a small number of studies of rates of dependence in ecstasy users. Studies from the US household survey suggest a prevalence rate of past-year dependence in approximately 3.6–3.8% of ecstasy users in the general population. An early NDARC study suggests a lifetime prevalence rate of 64% in similar types of regular ecstasy users interviewed in the EDRS.

In 2012, the participants in the EDRS were asked questions from the Severity of Dependence Scale (SDS) adapted to investigate ecstasy 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. The SDS appears to be a reliable measure of the dependence construct. It has demonstrated good psychometric properties with heroin, cocaine, amphetamine, and methadone maintenance patients across five

samples in Sydney and London (Dawe, Loxton, Hides, Kavanagh, & Mattick, 2002). A total score was created by summing responses to each of the five questions. Possible scores range from 0 to 15.

Two cut-off scores are presented below of three or more and four or more. A cut-off score of three or more was used as these scores have been recently found in the literature to be a good balance between sensitivity and specificity for identifying problematic dependent ecstasy use (Bruno, et al., 2009).

In 2012, 24% of participants scored three or above. The cut off of four and above is a more conservative estimate which has been used previously in the literature as a validated cut-off for methamphetamine dependence (Bruno, et al., 2009; Topp & Mattick, 1997). Twenty-three per cent of EDRS participants scored four or above.

The median SDS score was 1 (n = 62; range = 0–8). In 2012, 48% of participants obtained a score of zero on the ecstasy SDS, and one in five (19%) obtained a score of one on the scale: thus, the majority of respondents reported no or few symptoms of dependence in relation to ecstasy use.

These findings are supported by the majority of participants (73%) responding 'never or almost never' to the question about whether they thought their use of ecstasy was out of control (Table 61), and 78% reporting that they would find it 'not difficult to stop or miss a prospective dose of ecstasy' (Table 62).

Table 61: Feelings about ecstasy use in the past six months, 2011 and 2012

	2011 (N = 102) %	2012 (N = 62) %
Ever think use of ecstasy was out of control		
Never/almost never	79	73
Sometimes	17	22
Often	2	5
Always/nearly always	2	-
Prospect of missing a dose makes you feel anxious or worried		
Never/almost never	79	78
Sometimes	16	19
Often	3	3
Always/nearly always	2	-
Worry about your use of ecstasy		
Never/almost never	56	59
Sometimes	38	41
Often	5	-
Always/nearly always	1	-
Wish you could stop		
Never/almost never	80	73
Sometimes	13	14
Often	4	7
Always/nearly always	3	7

Source: QLD EDRS participant interviews

The majority (78%) of participants reported that it would not be difficult to stop or go without using ecstasy (Table 62).

Table 62: Perception of difficulty stopping or going without ecstasy, 2011 and 2012

	2011 (N = 102) %	2012 (N = 62) %
Not difficult	79	78
Quite difficult	17	17
Very difficult	2	5
Impossible	2	-

Source: QLD EDRS participant interviews

Results were similar to 2011.

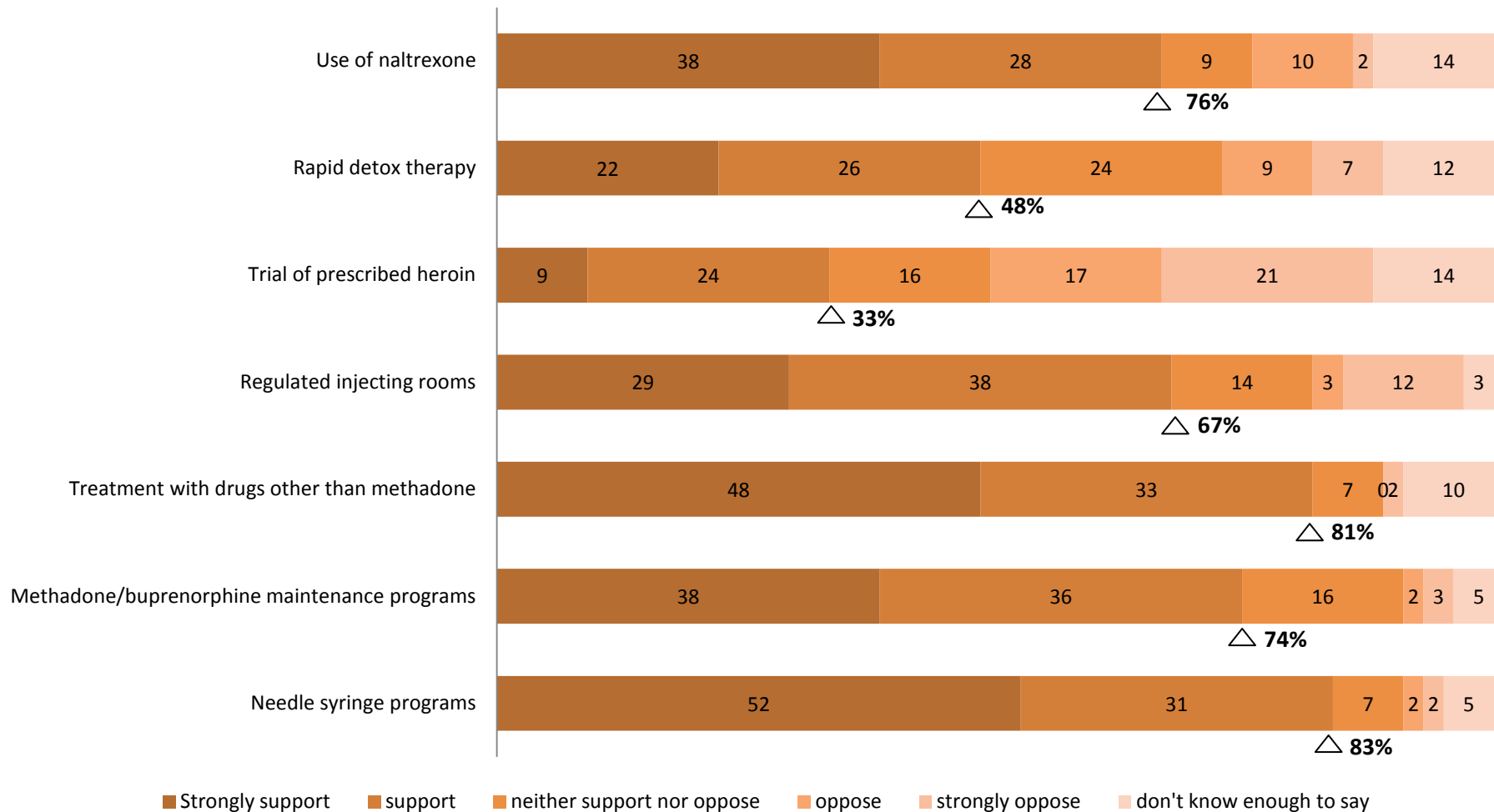
9.3 Drug policy attitudes

Public opinion can play an important role in determining social policy and informing political processes (Matthew-Simmons, Love, & Ritter, 2008). However, the vast majority of public opinion data regarding attitudes to drug policy in Australia is collected at the broader population level. In 2012, questions were added to find out how those who regularly use

ecstasy perceive Australian drug policy. The questions have been drawn from the National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2008) to ensure comparability with general population responses.

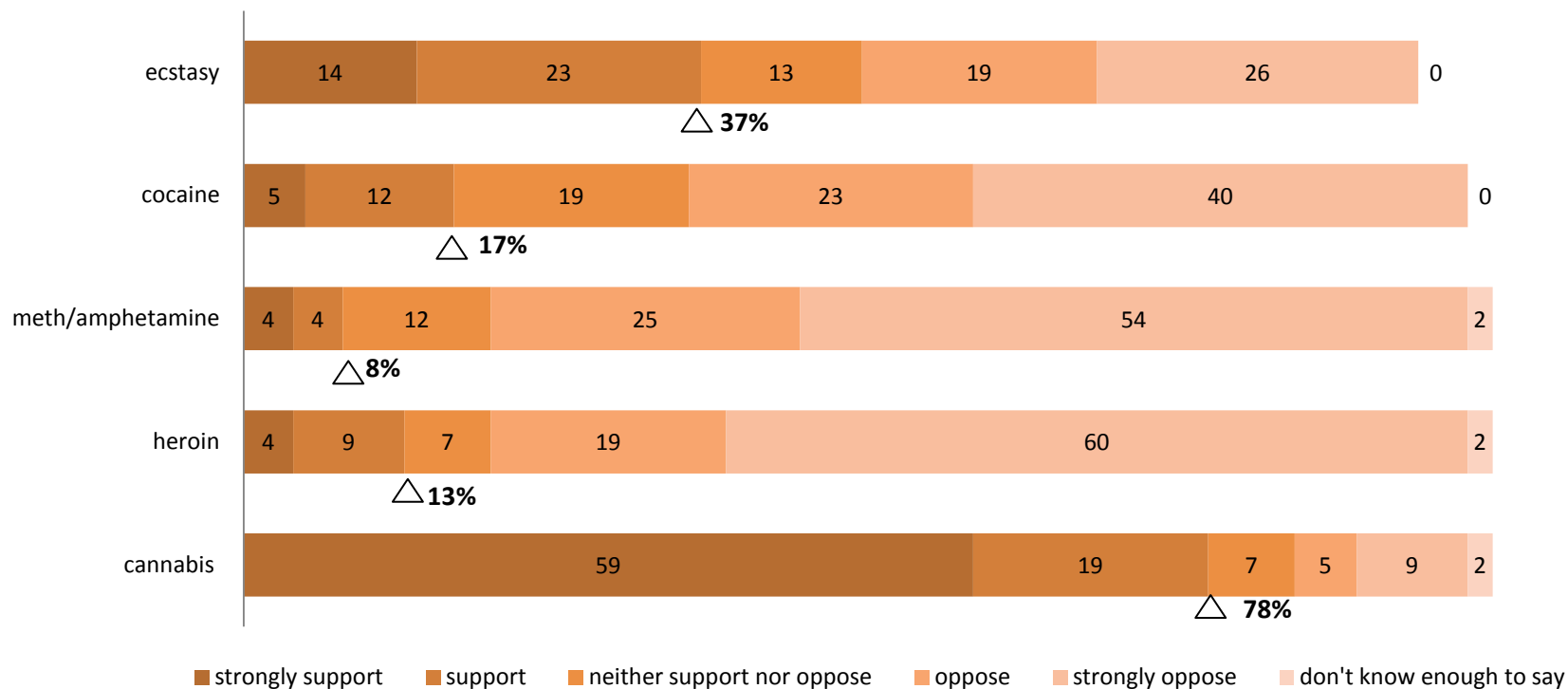
Needle and Syringe Programs (NSP) and methadone treatment programs were popular measures among the participants, with 83% and 81% of participants either strongly supporting or supporting the measures, respectively (Figure 34). There was less support for a trial of prescribed heroin for existing heroin users (only 33% supported or strongly supported) and rapid detox therapy (48%).

Figure 34: Participant reports of support or opposition to certain drug policy measures with regards to problems associated with heroin use



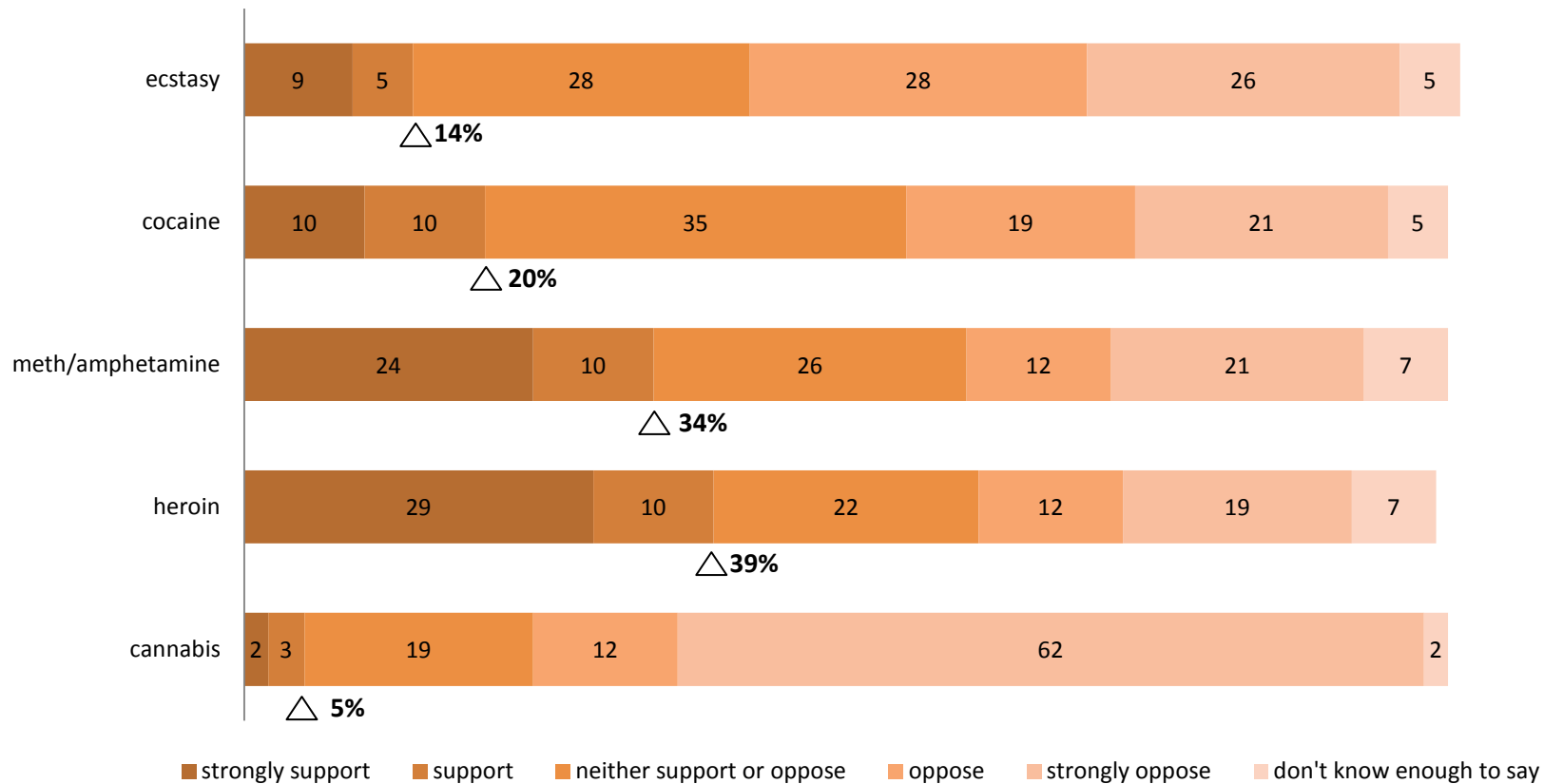
There was strong support for the legalisation of cannabis for personal use among participants (Figure 35) and moderate support for ecstasy though more opposition towards legalising methamphetamine, heroin and cocaine.

Figure 35: Participant reports of support or opposition to the legalisation of certain drugs for personal use



Participants reported very little support for increasing the penalties for the sale or supply of cannabis (Figure 36), though some for heroin and methamphetamines.

Figure 36: Participant reports of support or opposition to increased penalties for sale or supply of certain drugs



9.4 Neurological history

People with a neurological illness or injury may be at greater risk of experiencing adverse effects associated with drug use. Existing research indicates that there is an association between traumatic brain injury and drug use (Corrigan, Bogner, & Holloman, 2012). This may be due to greater exposure to violence, mental illness, poor nutrition and poor sleep among other factors. Traumatic brain injury is a major cause of morbidity and mortality in developed countries (Bruns & Hauser, 2003) and can result in long term physical and cognitive impairments, as well as negatively impact upon psychological wellbeing, social and occupational outcomes (Tait, Anstey, & Butterworth, 2010). The cognitive, emotional and functional impairments associated with drug use could potentially compound those associated with traumatic brain injury (Kelly, Johnson, Knoller, Drubach, & Winslow, 1997). In 2012, the prevalence of selected neurological illnesses and also traumatic brain injury was examined. A history of neurological illness was rare, but 38% had experienced a traumatic brain injury (Table 63).

Table 63: Incidence of selected neurological conditions among participants, 2012

	2012 (n = 58) %
Epilepsy	5
Stroke	-
Hypoxia	2
Traumatic brain injury	38

Source: QLD EDRS participant interviews

Among those who experienced a traumatic brain injury (n = 22), the median number of times this occurred was twice (range 1–20).

For the most severe injury, the median length of time that participants lost consciousness was 1 minute (range 0–30). The median age was 19 years (range 6–27).

One-third (33%) reported they had been under the influence of alcohol when the most severe injury occurred, and nearly one-quarter (24%) reported they had been under the influence of illicit drugs.

Among those who commented on the after-effects of their most severe traumatic brain injury (n = 19), 79% experienced at least one of the following effects: neurological, cognitive, behavioural or psychiatric. As Table 64 shows, the most common effect was poor concentration which was experienced by three in five.

Table 64: Immediate effects experienced at the time of traumatic brain injury among participants, 2012

	2012 (n = 19) %
Experienced any effects^a following the injury	79
	n = 15
Poor concentration	60
Functional weakness	53
Poor coordination/ balance	40
Memory loss	40
Word finding problems	27
Mood/Anxiety issues	27
Personality change	7

^a neurological, cognitive, behavioural or psychiatric
Source: QLD EDRS participant interviews

Effects that were reported to continue after the injury included ongoing weakness, ongoing concentration problems, ongoing speaking problems, and ongoing memory problems.

9.5 Body image

Research has highlighted a link between psychostimulant use and body image, suggesting that adolescent girls and young women with negative weight perceptions are more likely to engage in both licit and illicit substance use (Leventhal, 1983; Nieri, Kulis, Keith & Hurdle, 2005; Weathers & Billingsley, 1982). Negative weight perceptions are of particular concern for psychostimulant users because, in addition to acting as mood enhancers, psychostimulant drugs suppress the appetite. Other studies have found that female stimulant users exhibit higher levels of body image distortions and disordered eating behaviours than non-users (Curran & Robjant, 2006; Parkes, Saewyc, Cox & MacKay, 2008), and that some young women report using these drugs specifically to lose weight (Boys, Marsden & Strang, 2001). For example, a recent Australian case report found that ice/crystal use was associated with the onset of disordered eating and used as an efficient weight losing behaviour in an established eating disorder (Neale, Abraham & Russell, 2009). The aim of this module is to enhance understanding of the relationship between illicit psychostimulant drug use and body image.

Of the 56 participants who responded to this module, 23% reported using illicit psychostimulants for weight management. These 13 participants comprised 18% of the males who responded (n = 39) and 35% of the females who responded (n = 17). All except one recorded a normal BMI. The most commonly used drugs for weight loss were methamphetamine and ecstasy.

Of the 58 participants who responded to questions using illicit psychostimulant drugs for weight control, 14% reported they were concerned they had lost too much weight because of their illicit psychostimulant use, while 22% reported they were concerned about gaining weight if they stopped using illicit psychostimulants. Fourteen per cent considered that weight gain would be a desirable outcome if they ceased or stopped using illicit psychostimulants.

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