

# Queensland

S. Hickey, F. McIlwraith and R. Alati

**QUEENSLAND TRENDS IN ECSTASY AND RELATED DRUG MARKETS 2013**  
Findings from the Ecstasy and Related Drugs Reporting System (EDRS)

Australian Drug Trend Series No. 126



# **QUEENSLAND TRENDS IN ECSTASY AND RELATED DRUG MARKETS 2013**



## **Findings from the Ecstasy and Related Drugs Reporting System (EDRS)**

**Sophie Hickey, Fairlie McIlwraith  
and Rosa Alati**

**Queensland Alcohol and Drug Research and Education Centre**

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- the health and law enforcement agencies that kindly provided indicator data.

## ABBREVIATIONS

ACC	Australian Crime Commission
ACS	Australian Customs and Border Protection 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
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-methylenedioxymphetamine
MDMA	3,4-methylenedioxymethylamphetamine ('ecstasy')
NPS	new psychoactive substances
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
SHS	Severity of Dependence Scale
WA	Western Australia
WHO	World Health Organization
2CB	4-bromo-2,5-dimethoxyphenethylamine
2CC	2,5-dimethoxy-4-chlorophenethylamine
µg	microgram, 1/1000 of a milligram

## GLOSSARY OF TERMS

Binge	Use over 48 hours without sleep
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 Method section for further details)
Key expert	A person who participated in the Key Expert Survey component of the EDRS (see Method 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 and 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 a continuing study of people who regularly use ecstasy 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 about current drug use consumption patterns, relevant health issues, and other special areas of interest.

Characteristics of the 2013 sample (N=88) were largely similar to previous years (i.e. typically male, heterosexual, and engaged in work and/or study), except for one important characteristic. The mean age of the sample was 22 years compared with 26 years in 2012. This significant decrease in mean age may be associated with some important differences between the 2012 and 2013 samples.

### Consumption trends

#### *Current drug use*

Ecstasy was the drug of choice for nearly half of the sample. However, only a quarter reported that it was the drug most often used in the previous month; cannabis was the most commonly used, followed by alcohol. Consumption patterns of ecstasy and related drugs remained stable with most using fortnightly.

#### *Ecstasy use*

Although pills remained the most commonly used form of ecstasy, 67% had used capsules, 36% powder, and 23% crystals. Two pills once a fortnight was the typical pattern of consumption. There was an increase in snorting, and 36% had recently binged on ecstasy. Ecstasy was commonly taken in conjunction with alcohol, and 48% of the sample used other drugs to come-down from ecstasy, generally cannabis.

#### *Methamphetamine use*

Use of methamphetamines was lower than in 2012, with 41% reporting recent use of speed powder, 9% base, and 21% crystal/ice. All forms were generally used infrequently.

#### *Cocaine use*

Cocaine use was stable, with 67% of participants having ever used and 40% having used in the previous six months. Recent use was generally occasional (median of two days in past six months).

#### *Ketamine use*

Ketamine use continued to be low: 27% had used ketamine in their lifetime with 13% having used in the previous six months. Recent use occurred only once or twice.

#### *GHB use*

GHB was not commonly used, with 13% reporting use in their life time and 6% in the previous six months.

#### *Hallucinogen use*

Although two in five reported recent LSD use, it was only used on a median of two days. Recent use of mushrooms significantly increased from 15% in 2012 to 38% in 2013 ( $p<0.05$ ).

### ***Cannabis use***

Cannabis had been used in the previous six months by 84% of participants. Median days used was 48 corresponding to twice a week.

### ***Other drug use***

MDA use was stable, with 16% reporting recent use. Almost all participants had recently used alcohol, with median use being two times a week. Tobacco use remained high, with 83% reporting recent use and half of these using daily.

Anti-depressant use was low, with 7% reporting illicit use and 9% licit use (i.e. prescribed to them). About one third of participants had recently used illicit benzodiazepines, mainly Xanax<sup>®</sup> and Valium<sup>®</sup>, and 9% licit.

Only a few participants (8%) had recently used amyl nitrate, and use was occasional. Nitrous oxide was used by 28% on a median of 5 days in the past six months.

Heroin use was rare, with only 7% reporting ever having used and 3% reporting use in the previous six months.

Recent use of other opiates (e.g. morphine, oxycodone) was also low, with 7% reporting licit use and 11% reporting illicit use.

### ***New psychoactive substances***

New psychoactive substances (NPS) were used by 38% in the past six months, and the most commonly used were 2CB (15%), DMT (14%), and Kronic (13%). Fifteen per cent of participants reported recently taking a capsule of unknown content.

## **Drug market: price, purity, availability and supply**

### ***Ecstasy market***

Overall, the ecstasy market was stable, with median price of an ecstasy tablet being \$25 and a capsule \$30. Purity was most commonly rated as medium (40%) or fluctuating (30%).

Ecstasy was generally reported as being easy or very easy to obtain; although 21% reported that availability had become more difficult. Ecstasy was mostly purchased with other people. Source person was commonly a friend and the transaction undertaken at a friend's home or own home.

### ***Methamphetamine market***

The median price of one point of crystal/ice was \$100 and speed powder was \$65. Base was excluded from analysis because of insufficient responses. There were mixed reports on purity and availability. Half rated the purity of both speed and crystal/ice as high. Crystal/ice was readily available but reports were mixed for speed, with a third of respondents rating availability as difficult. The most common source for obtaining methamphetamines was a friend or known dealer.

### ***Cocaine market***

Price of cocaine remained stable at \$300 per gram, and purity was generally rated as medium. There were inconsistent reports about the availability of cocaine, with just over half reporting it as difficult or very difficult to obtain. Cocaine was commonly sourced from a friend at a friend's home, and generally consumed at a private venue.



### ***Ketamine market***

Only two participants responded, preventing meaningful analysis.

### ***GHB market***

Only one participant responded, preventing meaningful analysis.

### ***LSD market***

The price of LSD was generally considered to be stable, with a tab having a median price of \$22.50. Purity was mostly rated as medium or low; and two-thirds reported availability as easy or very easy.

### ***Cannabis market***

The cannabis market was considered stable, with hydro costing a median of \$25 per gram and bush costing \$10 per gram. The strength of both hydro and bush was generally rated as medium or high. Cannabis was commonly sourced from a friend or known dealer at their home.

## **Health-related trends associated with ecstasy and related drug use**

An accidental stimulant-drug overdose was reported by 21% in their lifetime with 9% having overdosed in the previous twelve months. Similarly, 18% reported an accidental depressant drug overdose with 9% having overdosed in the previous twelve months.

Most participants (83%) had recently accessed a health service and three quarters of these accessed a GP. Help with drug and/or alcohol use was sought by 13% of participants, mostly from a GP. Only a few participants (6%) were currently in drug treatment.

Drugs were reported as contributing to recurrent problems in four areas: increased risky behaviour (36%), difficulty meeting responsibilities (36%), social relationships (20%) and legal problems (9%). The drugs most often implicated were cannabis, alcohol, and ecstasy.

Almost two-thirds of participants recorded moderate to very high distress on the Kessler Psychological Distress Scale (K10).

## **Risk behaviour**

Fewer participants had ever injected a drug (14% compared with 29% in 2012), and 7% had injected in the previous six months.

Three quarters of participants reported having penetrative sex with casual partner/s in the past six months. In the last year, 43% had not had a sexual health check-up; and 10% had been diagnosed with a sexually transmitted disease.

Of those who drove a vehicle in the last six months, 31% reported driving while over the alcohol limit, and 46% reported driving soon after taking illicit drugs.

Most participants (84%) were drinking alcohol at a level that was risky to health.

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

One third of all participants reported involvement in criminal activity (mainly drug dealing) in the past month, with 9% having been arrested in the previous twelve months.

## **Special topics of interest**

Responses to questions about injecting revealed that 61% of participants had friends who had injected drugs; 28% had been offered drugs to inject in the previous twelve months; and among those who had never injected any drugs (n=76), 13% were seriously considering it.

The majority of participants reported very few or no symptoms of ecstasy dependence.

## 1 INTRODUCTION

The Ecstasy and Related Drugs Reporting System (EDRS) is an annual, national study funded by the Australian Government Department of Health and coordinated 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 twelfth 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 changes 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 psychostimulant users

The market for ecstasy (tablets that are alleged to contain 3, 4-methylenedioxymethylamphetamine; 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) (AIHW, 2011). NDSHS results show that, recent use of ecstasy (last twelve 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 (AIHW, 2011).

For the purposes of the present study, the sentinel population consisted of regular users of substances sold as 'ecstasy' or other psychostimulants. From April to June 2013, 88 current, regular ecstasy and other psychostimulants 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 twelve months
- used ecstasy or other psychostimulant at least once a month for the past six months (six times or more).

In 2013, a total 88 participants were recruited in Queensland. The majority of participants were recruited using the traditional criteria of using ecstasy at least once a month in the past six months, while seven participants were recruited with the new criteria of using a combination of ecstasy and other psychostimulants at least once a month.

### **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 2012 and 2013, 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 2012 and 2013 may represent sampling variability only.

## **2.2 Survey of key experts**

During August and September, 16 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 2013, 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; Queensland clandestine laboratory seizures and drug-related arrests
- Australian Customs and Border Protection 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)
- National Notifiable Diseases Surveillance System— registered cases of blood-borne viruses and sexually transmitted diseases.

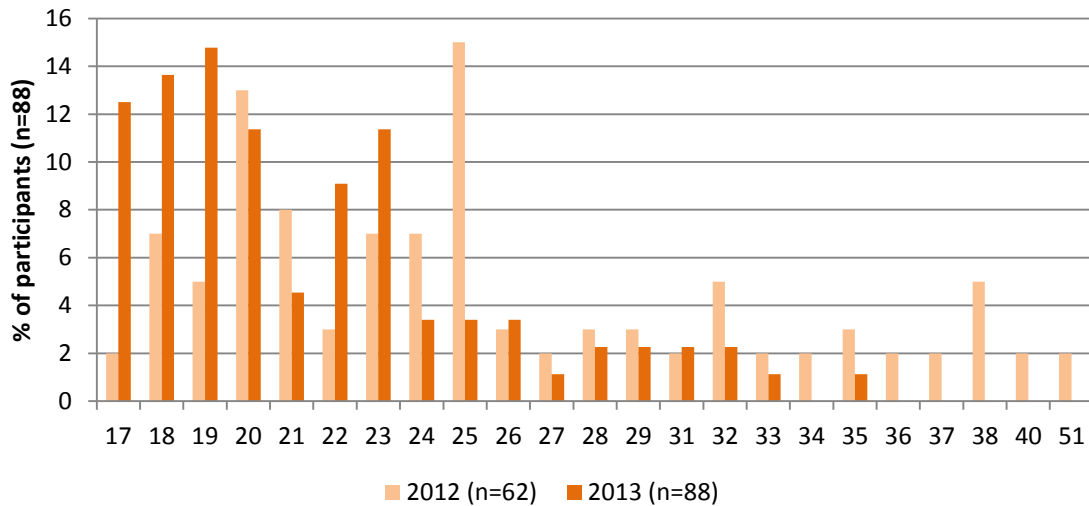
## **3 DEMOGRAPHICS**

### **3.1 Overview of the EDRS sample**

In 2013, the sample was significantly younger than the previous year, with a mean age of 22 years, compared with 26 years in 2012 ( $p < 0.05$ ). This corresponds to 81% of participants in 2013 being under the age of 25 years, compared with only 50% of participants in 2012 ( $p < 0.05$ ). Age distributions for 2012 and 2013 are presented below in Figure 1. The differences in the two distributions may contribute to differences in drug use and related behaviour between 2012 and 2013, particularly as younger users may have a shorter drug-using history. Because of this, a selection of variables with significant differences between 2012 and 2013 have been additionally tested comparing those aged 17–24 years with those 25 years or more, using

combined data from 2012 and 2013. More information about the age differences is available in the Appendix.

**Figure 1: Distribution of participant age, 2012 and 2013**



Source: QLD EDRS participant interviews

Other sample characteristics were largely similar to previous years, with participants typically male, heterosexual, and engaged in work and/or study (Table 1). Eighty percent of participants reported being born in Australia, and 96% reported coming from an English speaking background. Only one person reported being of Aboriginal and/or Torres Strait Islander descent.

Most participants lived in rental accommodation (58%), followed by family or parental home (32%). In 2013, there were similar rates of high school completion among participants compared with 2012 and similar completion of tertiary studies.

The mean weekly income was \$420 (range \$50–\$2,500). When asked about their main source of income in the month preceding the interview, 55% reported receiving it from a wage or salary, and 28% from a government pension, allowance or benefit. Other main sources of income included parental allowance (11%), savings (2%), and criminal activity (1%).

As in previous years, few reported currently being in drug treatment (6%) and only one had a prison history.

**Table 1: Demographic characteristics, 2012 and 2013**

	2012 (N=62)	2013 (N=88)
Mean age (range)	26 (17–51)	22 (17–35)↓
% Male	69	64
% English speaking background	98	96
% Aboriginal and/or Torres Strait Islander	5	1
<b>% Sexual orientation</b>		
Heterosexual	89	92
Gay male	3	2
Lesbian female	2	-
Bisexual	5	6
Other	2	-
<b>% Relationship status</b>		
Married/de facto	8	3
Regular partner	37	33
Single	55	61
Divorced/separated/widowed	-	2
<b>% Accommodation</b>		
Own house/flat	5	7
Rented house/flat	68	58
Parents' family home	21	32
Boarding house/hostel	2	3
No fixed address	5	-
<b>Education</b>		
Mean years of school education	12	12
% Completed Year 12 or equivalent	73	84
% University/college qualifications	17	16
% Trade/technical qualifications	35	18↓
<b>% Employment status</b>		
Not employed	19	8
Full time	27	15
Part time/casual	11	19
Full time student	26	30
Part time student	3	1
Work and study	8	25
Other	5	2
<b>Income</b>		
Mean weekly income	\$424	\$420

Note: Arrow symbol signifies a significant difference  $p < 0.05$

Totals may not add to 100% because of rounding

Source: QLD EDRS participant interviews

## 4 CONSUMPTION PATTERN RESULTS

### Key Points

- Increase in participants nominating ecstasy as drug of choice, from 21% in 2012 to 46% in 2013.
- The two most commonly used drugs in the previous month were cannabis (36%) followed by alcohol (26%).
- Ecstasy and related drugs were generally used fortnightly (44%), with a decrease from 2012 in the proportion using more often than fortnightly.

### 4.1 Drug use history and current drug use

#### 4.1.1 Drug history

Lifetime and recent (i.e. in the previous six months) drug use among participants is shown in Table 2, including age of initiation, route of administration (ROA), and frequency of use.

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. 5% reported shelving or shafting ecstasy pills in their lifetime, 1% reported shelving or shafting ecstasy powder in their lifetime, and there were no reports of recent shelving or shafting).



**Table 2: Drug use history, 2013**

Form of drug	Use				Route of administration %							
	Ever %	Mean age first used <sup>a</sup>	Recent <sup>b</sup> %	Days <sup>c</sup>	Injected		Smoked		Snorted		Swallowed	
					Ever	Recent <sup>b</sup>	Ever	Recent <sup>b</sup>	Ever	Recent <sup>b</sup>	Ever	Recent <sup>b</sup>
Ecstasy pills	100	17	99	12	3	-	7	-	76	61	99	97
Ecstasy powder	50	20	36	3	-	-	1	1	42	27	25	19
Ecstasy capsules	89	19	67	3	-	-	-	-	39	24	78	59
MDMA crystals	40	20	23	2	-	-	5	3	24	10	26	14
Methamphetamine powder	65	19	41	3	8	2	16	9	39	17	40	27
Methamphetamine base	18	19	9	2	3	2	6	6	6	1	13	3
Methamphetamine crystal	26	20	21	4	5	3	21	16	5	1	10	5
Pharmaceutical stimulants –licit	2	22	2	58	-	-	-	-	2	2	2	2
Pharmaceutical stimulants –illicit	61	20	41	4	-	-	3	2	22	15	56	38
Cocaine	67	19	40	2	2	1	1	-	64	38	9	7
LSD	63	18	41	2	1	-	-	-	-	-	63	41

<sup>a</sup>Calculated for those who reported lifetime use

<sup>b</sup>In the preceding six months

<sup>c</sup>Median days in the preceding six months (180 days) among those who did use

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, 2013 (continued)**

Form of drug	Use				Route of administration %							
	Ever %	Mean age first used <sup>a</sup>	Recent <sup>b</sup> %	Days <sup>c</sup>	Ever	Recent <sup>b</sup>	Ever	Recent <sup>b</sup>	Ever	Recent <sup>b</sup>	Ever	Recent <sup>b</sup>
MDA	24	21	16	3	-	-	-	-	6	5	24	16
Ketamine	27	20	13	1	-	-	-	-	17	7	13	7
GHB <sup>d</sup>	13	21	6	1	-	-					13	6
Amyl nitrate	35	19	8	2								
Nitrous oxide	49	18	28	5								
Cannabis	98	15	84	48			97	84			68	41
Alcohol	100	14	99	48	1	-					100	99
Heroin	7	18	3	4	3	1	5	2	-	-	-	-
Methadone	2	20	-	-	1	-	1	-	-	-	-	-
Buprenorphine	2	21	1	180	-	-	-	-	-	-	2	1
Other opioids–licit	11	20	7	13	1	-	-	-	-	-	10	7
Other opioids–illicit	23	21	11	2	2	-	3	2	6	4	18	10

<sup>a</sup>Calculated for those who reported lifetime use

<sup>b</sup>In the preceding six months

<sup>c</sup>Median days in the preceding six months (180 days) among those who did use

<sup>d</sup>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, 2013 (cont'd)**

Form of drug	Use				Route of administration %							
	Ever %	Mean age first used <sup>a</sup>	Recent <sup>b</sup> %	Days <sup>c</sup>	Injected		Smoked		Snorted		Swallowed	
					Ever	Recent <sup>b</sup>	Ever	Recent <sup>b</sup>	Ever	Recent <sup>b</sup>	Ever	Recent <sup>b</sup>
Over the counter codeine <sup>e</sup>	32	19	17	2	-	-	1	-	1	-	32	17
Tobacco	91	15	83	180								
Antidepressants –licit	21	19	9	180	-	-	-	-	-	-	21	9
Anti-depressants –illicit	14	21	7	1	-	-	-	-	2	-	12	7
Benzodiazepines –licit	19	20	9	16	1	-	-	-	-	-	19	9
Benzodiazepines –illicit	52	20	32	6	1	-	1	-	5	3	52	32
Mushrooms	61	19	38	2	-	-	-	-	-	-	61	38
Over the counter stimulants	16	21	6	2	-	-	-	-	-	-	16	6
Steroids	5	21	2	36	5	2	-	-	-	-	1	-

<sup>a</sup>Calculated for those who reported lifetime use

<sup>b</sup>In the preceding six months

<sup>c</sup>Median days in the preceding six months (180 days) among those who did use

<sup>e</sup>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 and drug most used

Ecstasy was the most commonly chosen drug of choice among participants in 2013, with a significant increase in those choosing ecstasy from 2012 ( $p < 0.05$ ) (Table 3). Cannabis was the second most common drug of choice among participants, while the popularity of speed significantly decreased ( $p < 0.05$ ).

**Table 3: Drug of choice, 2012 and 2013**

Drug of choice	2012 (N=62) %	2013 (N=88) %
Ecstasy	21	<b>46↑</b>
Cannabis	19	<b>19</b>
Cocaine	21	<b>10</b>
Alcohol	8	<b>10</b>
LSD	5	<b>6</b>
Speed	13	<b>2↓</b>
Heroin	2	<b>2</b>
Crystal/ice	2	<b>2</b>
Other	9	<b>2</b>

Note: Arrow symbol signifies a significant difference  $p < 0.05$

Source: QLD EDRS participant interviews

In 2013, 51% reported that the drug they used most often in the previous month was not their first drug of choice. When asked about the drug used most often in the previous month, cannabis was the most common (36%), followed by alcohol (26%), then ecstasy (24%). Other drugs reported to be the primary drug in the previous month included LSD, mushrooms, speed, cocaine, nitrous oxide, benzodiazepines, 2CB and 2CC. Reasons given for differences in use between drug of choice and drug most used included price, availability, health effects and the social context of use.

#### 4.1.3 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 monthly and weekly (Table 4). Fewer participants used more than once per week in 2013 compared with 2012 ( $p < 0.05$ ).

**Table 4: Frequency of ecstasy and related drug use during previous month, 2012 and 2013**

	2012 (N=62) %	2013 (N=88) %
Not in the last month	5	<b>8</b>
Monthly	10	<b>22</b>
Fortnightly	32	<b>44</b>
Weekly	27	<b>17</b>
More than once per week	24	<b>8↓</b>
Once a day	2	<b>1</b>

Note: Arrow symbol signifies a significant difference  $p < 0.05$

Source: QLD EDRS participant interviews

## 4.2 Ecstasy use

### Key Points

- Mean age for first use of ecstasy was 17 years.
- Ecstasy was used in the form of pills (99%), capsules (67%), powder (36%), and crystals (23%).
- Typical use of ecstasy continued to be two pills once a fortnight.
- 25% had recently snorted ecstasy.
- Over one third of participants had recently binged on ecstasy.
- Ecstasy was commonly combined with alcohol (mostly >5 standard drinks).
- About half the sample used other drugs to come-down from ecstasy, most commonly cannabis.

### 4.2.1 Patterns of ecstasy use among regular ecstasy users

Table 5 presents patterns of ecstasy use among participants. In 2013, the mean age of first use of ecstasy was 17 years, down from 2012 ( $p < 0.05$ ). Compared with 2012, there was an increase in the proportion of participants reporting ecstasy as their favourite drug of choice, an increase in recent snorting of ecstasy, but a decrease in injecting ecstasy ( $p < 0.05$ ).

Three-quarters reported typically using two or more ecstasy pills in one session, with the majority of participants using fortnightly.

**Table 5: Patterns of ecstasy use, 2003 to 2012**

	2003 N=136	2004 N=161	2005 N=101	2006 N=100	2007 N=101	2008 N=108	2009 N=88	2010 N=101	2011 N=103	2012 N=62	2013 N=88
Mean age first used	20.7	21.3	19.2	18.0	18.6	19.0	18.0	18.5	18.0	18.6	<b>17.3 ↓</b>
Median days used last 6 months	24	24	17	14	12	12	13	12	12	18	<b>14</b>
% Use weekly or more	24	41	31	29	24	23	31	10	24	37	<b>33</b>
Median pills in 'typical' session	1.5	2	2	2	2	2	2	2	2	2	<b>2</b>
% Typically use >1 pill	57	75	77	63	69	73	78	82	84	86	<b>83</b>
% favourite drug	53	46	55	40	45	31	39	43	28	21	<b>46 ↑</b>
% Ever injected ecstasy	13	21	5	11	6	4	14	9	11	9	<b>3</b>
% Mainly swallowed ecstasy last 6 mths	91	83	92	97	87	96	87	91	90	89	<b>75</b>
% Mainly snorted ecstasy last 6 mths	5	7	5	3	10	3	9	9	7	8	<b>25 ↑</b>
% Mainly injected ecstasy last 6 mths	3	6	2	0	1	1	4	0	1	3	<b>0</b>
% Recently binged on ecstasy <sup>a</sup>	43	37	42	38	26	21	34	27	33	34	<b>36</b>
% Used other drugs with ecstasy	85	89	92	95	96	94	97	93	91	87	<b>92</b>
% Used other drugs to 'come down' from ecstasy	79	75	81	85	86	78	75	44	65	57	<b>48</b>

<sup>a</sup>>48 hours without sleep

Note: Arrow symbol signifies a significant difference p<0.05

Source: QLD EDRS participant interviews

#### **4.2.2 Forms and administration of ecstasy use**

Swallowing remained the most common route of administration for ecstasy in the previous six months, though the proportion of participants who mainly snorted significantly increased from 2012 ( $p < 0.05$ ).

Pills were the most common form of ecstasy used, with 99% of participants having used ecstasy pills in the previous six months. Other forms of ecstasy recently used were capsules (67%), powder (36%) and crystals (23%).

Questions specifically about MDMA crystals were asked for the first time in 2013.

#### **4.2.3 Poly-drug use of regular ecstasy users**

Similar to previous years, participants commonly reported engaging in polydrug use (Table 6).

In 2013, 92% reported using other drugs with ecstasy on the most recent occasion they used ecstasy in the previous six months. Among these participants alcohol was the most common other drug, followed by tobacco and cannabis.

Also on the most recent occasion participants used ecstasy, 47% reported using other drugs while coming down from ecstasy. The drug most commonly used to come-down was cannabis.

Bingeing was common, with 46% of participants using stimulants or related drugs for 48 hours or more, continuously without sleep. During these binges, the most commonly used drugs were alcohol, ecstasy, tobacco and cannabis.

**Table 6: Polydrug use among participants who reported using other drugs most recent time using ecstasy, and drugs used during bingeing session, 2013**

	Used with ecstasy most recent time	Used while coming down from ecstasy most recent time	Used while bingeing
	n=81 %	n=42 %	n=40 %
Ecstasy	n/a	n/a	80
Alcohol >5 standard drinks	78	7	85
Alcohol <5 standard drinks	14	-	5
Tobacco	62	17	63
Cannabis	52	93	63
Energy drinks	10	-	23
Cocaine	7	2	18
Benzodiazepines	6	12	13
Pharmaceutical stimulants	4	-	13
Crystal/ice	4	-	25
Methamphetamine powder (speed)	3	-	23
Nitrous oxide	1	2	3
MDA	1	-	3
LSD	-	-	13
OTC codeine	-	2	5
Other	4	2	-

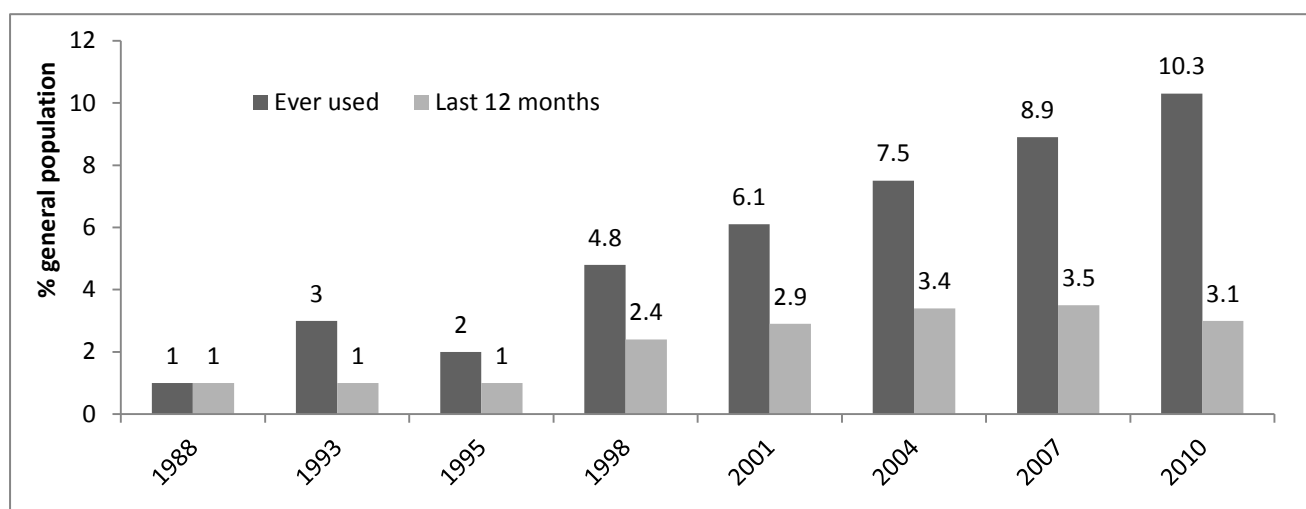
Source: QLD EDRS participant interviews

#### **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 twelve months declined (Figure 2).



**Figure 2: 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

‘Ecstasy’ or ‘pills’ continue to be the generalised terms used for psychostimulants in tablet form. Use of high quality MDMA has been reported, but this appears to be inconsistent. One key expert reported that when ‘good’ MDMA is available, large quantities are taken: ‘*They come in saying they haven’t slept for a couple of days as have been partying for two to three days*’. However, another key expert pointed out that two pills per session was the norm for ecstasy use; and that ecstasy users tend to only use ecstasy regularly for a period of time before their use declines or ceases altogether. Ecstasy use was seen as being closely aligned to a social milieu favoured by young people in their late teens and early twenties. Key experts reported that most ecstasy users were not distinguishable by their education level or employment.

MDMA was reported as being used in conjunction with Ice. Key experts in the health sector reported hearing about crystal MDMA from their clients but in general MDMA was not identified by clients as causing them concern.

### 4.3 Methamphetamine use

#### Key Points

- Fewer participants reported methamphetamine use than in 2012.
- 48% had recently used methamphetamines: 41% speed powder, 9% base, and 21% crystal/ice.
- Frequent use was low.

### 4.3.1 Patterns of methamphetamine use among regular ecstasy users

The proportion of participants using crystal/ice significantly decreased from 40% in 2012 to 21% in 2013 ( $p < 0.05$ ), contributing to an overall significant decrease in methamphetamine use (Figure 3).

**Figure 3: Patterns of methamphetamine use according to type (powder (speed), base and crystal/ice) in the previous six months, 2003 to 2013**

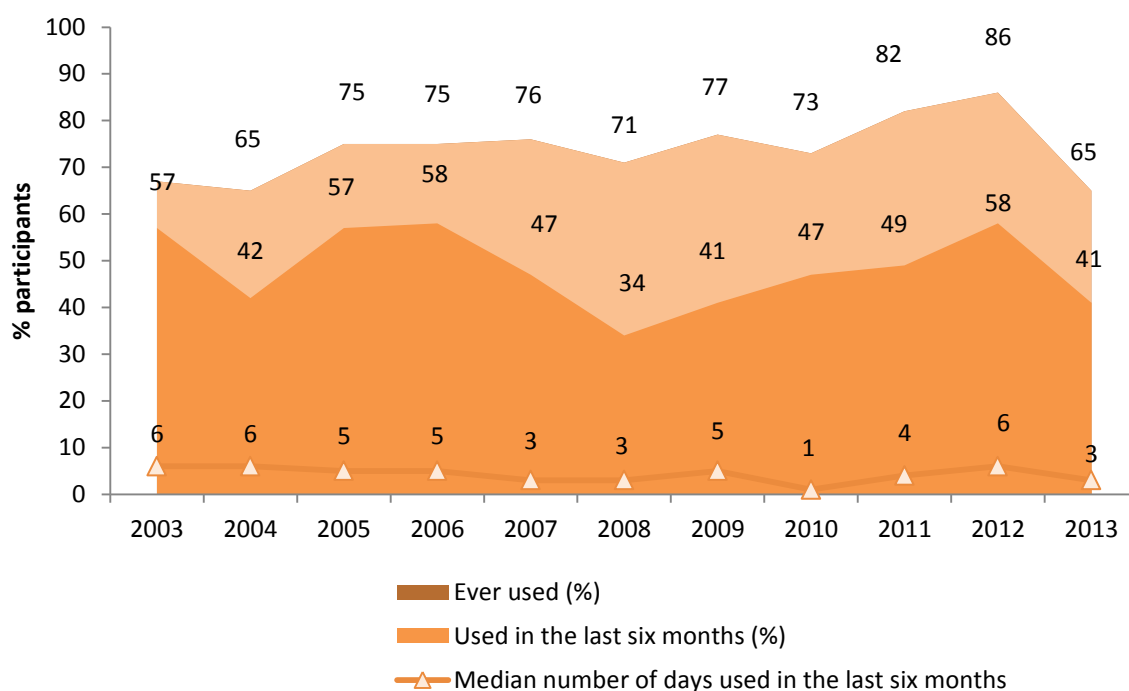


Source: QLD EDRS participant interviews

### 4.3.2 Speed methamphetamine use

There was a significant decrease in lifetime use of methamphetamine powder from 2012 to 2013 ( $p < 0.05$ ), and recent use was 58% in 2012 and 41% in 2013 (Figure 4). The median number of days used in the previous six months was three days ( $n=36$ , range 1–36 days).

**Figure 4: Patterns of methamphetamine powder (speed) use, 2003 to 2013**



Source: QLD EDRS participant interviews

Among those who reported recent use of methamphetamine powder in grams, the median amount used in a ‘typical’ session was reported to be half a gram (n=7, range 0.05–1 gram). This is the same for previous years (Table 7). The median amount used in a ‘heavy session’ was half a gram – down from previous years.

**Table 7: Median grams of methamphetamine powder (speed) used in a session in the last six months, 2003 to 2013**

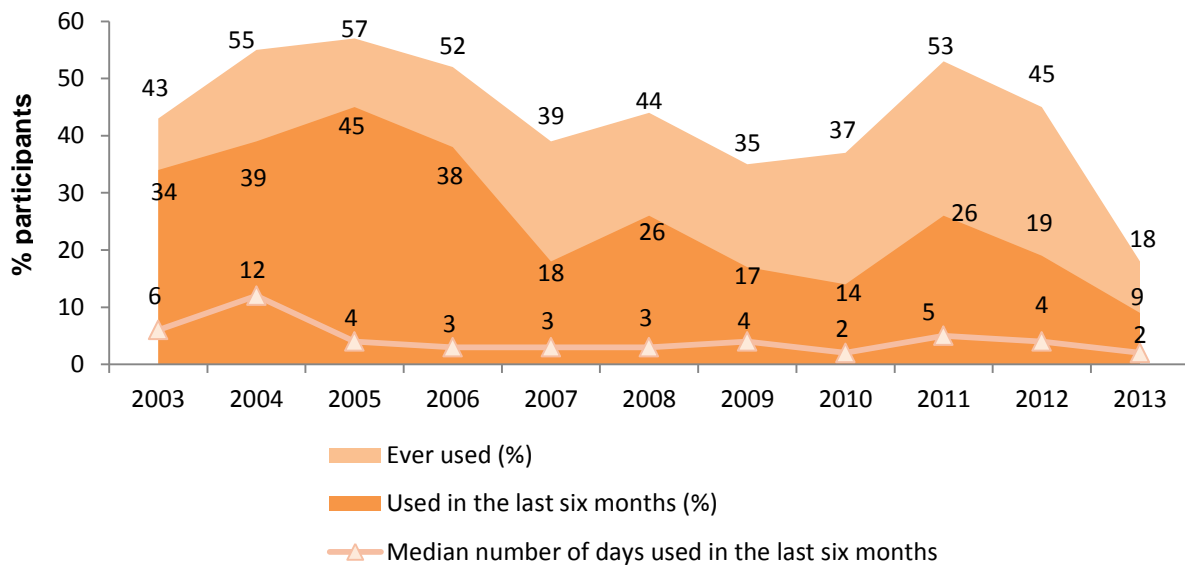
Session	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
<b>Typical</b>	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	<b>0.5</b>
(range)	(0.1–1.5)	(0.2–4)	(0.6–6)	(0–5)	(0.1–2)	(0.25–1.5)	(0.5–2)	(0.13–3.5)	(0.2–2)	(0.3–2.0)	<b>(0.05–1)</b>
<b>Heavy</b>	1.0	1.0	1.0	0.5	0.5	1.0	1.0	0.63	0.88	1.0	<b>0.5</b>
(range)	(0.1–4)	(0.3–6)	(0.5–8)	(0.1–10)	(0.1–10)	(0.25–2)	(0.5–3.5)	(0.13–4)	(0.2–3)	(0.5–5.0)	<b>(0.01–1)</b>

Source: QLD EDRS participant interviews

#### 4.3.3 Base methamphetamine use

In 2013, there was a significant decrease in the proportion of participants reporting lifetime use of base methamphetamine ( $p < 0.05$ ) (Figure 5). Numbers were too low to analyse additional patterns of use.

**Figure 5: Patterns of base methamphetamine use, 2003 to 2013**

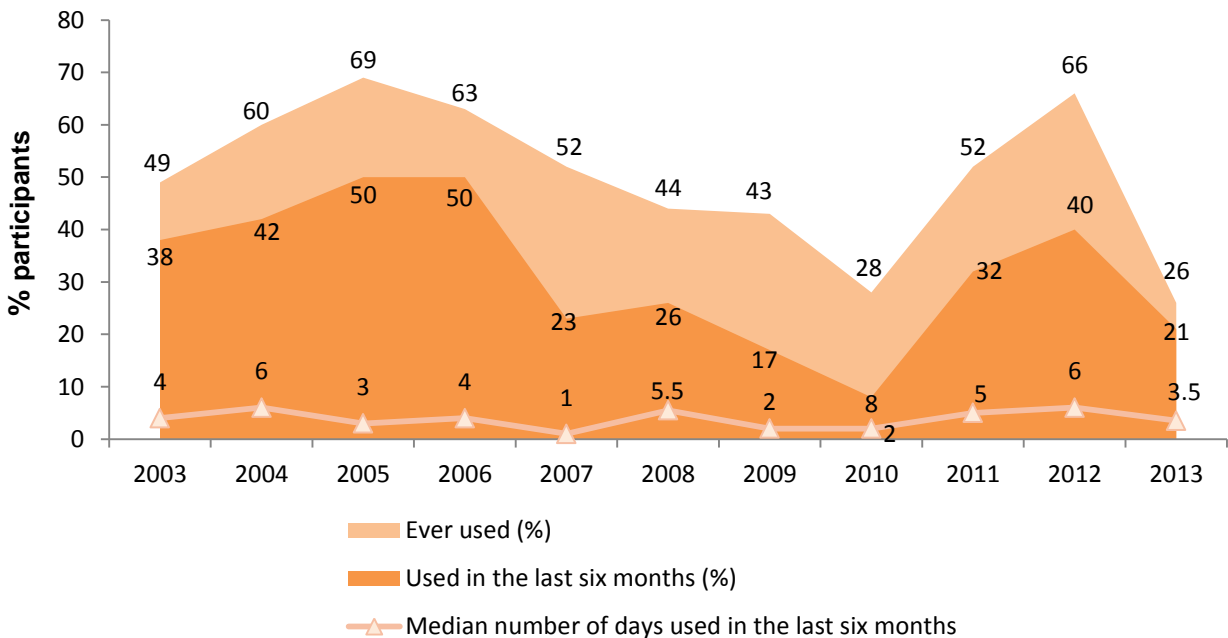


Source: QLD EDRS participant interviews

#### 4.3.4 Crystalline methamphetamine (crystal/ice) use

There was a significant decrease in lifetime and recent use of crystal/ice methamphetamine in 2013 from 2012 ( $p < 0.05$ ) (Figure 6). The median number of days used in the previous six months remained low at 3.5 days ( $n = 18$ , range 1–80 days).

**Figure 6: Patterns of crystalline methamphetamine (crystal/ice) use, 2003 to 2013**



Source: QLD EDRS participant interviews

In 2013, the median number of points of crystalline methamphetamine used in a typical session was one, and the median number of points used in a heavy session was two (Table 8).

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

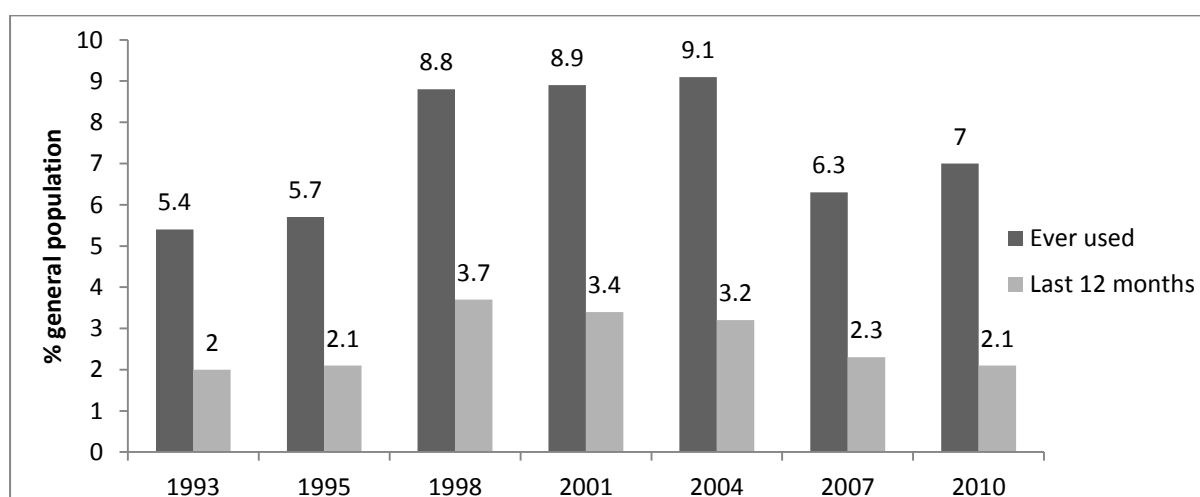
Session	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
<b>Typical (range)</b>	1.0 (0.3–4)	1.5 (0.2–10)	1.0 (0.3–8)	2.0 (0.1–5)	1.3 (0.5–5)	1.5 (0.25–7)	2.0 (0.5–5)	2.0 (1–5)	2.0 (1–5)	2.0 (0.5–5)	<b>1.0</b> <b>(0.25–3)</b>
<b>Heavy (range)</b>	1.0 (0.3–5)	3.0 (0.3–30)	2.0 (0.3–10)	2.0 (0.2–8)	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)	<b>2.0</b> <b>(0.5–5)</b>

Source: QLD EDRS participant interviews

#### 4.3.5 Prevalence of methamphetamine use in the general population

According to the most recent National Drug Strategy Household Survey report (AIHW, 2011), methamphetamine use in the previous twelve months has slightly declined from 2007 to 2010 in the general population of those 14 years and over (Figure 7).

**Figure 7: 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

Key experts confirmed our findings that crystal/ice is more commonly used than speed or base. Ice is seen as a premium option by consumers and is marketed as such. There is some scepticism amongst key experts as to the accuracy of the name (i.e. what is sold as ice is not necessarily crystallised methylamphetamine). Ice was reported as being commonly smoked; however, one key expert noted: *‘Younger people smoke ice but once injected don’t go back’*. Key experts reported that the age of those using methamphetamines generally spanned from late teens into the forties. Older users were observed to be predominantly male, whereas younger users tended to be both females and males. It was reported that younger people mainly used together within their peer group.

It was noted that there were geographical differences in the extent of ice use, with service providers in the northern Brisbane suburbs seeing an increase in use amongst young people.

Methamphetamines, and specifically crystal/ice, were seen as problematic because of the heightened state of arousal that users exhibited and their inability to realise the extent of their intoxication. There were also reports of bingeing for up to four days. Key experts reported that cannabis, Valium®, and Seroquel® were commonly used to come down from ice. Key experts spoke about the cyclical use of ‘uppers’ and ‘downers’ and how use of amphetamines was linked to the use of other drugs.

## 4.4 Cocaine use

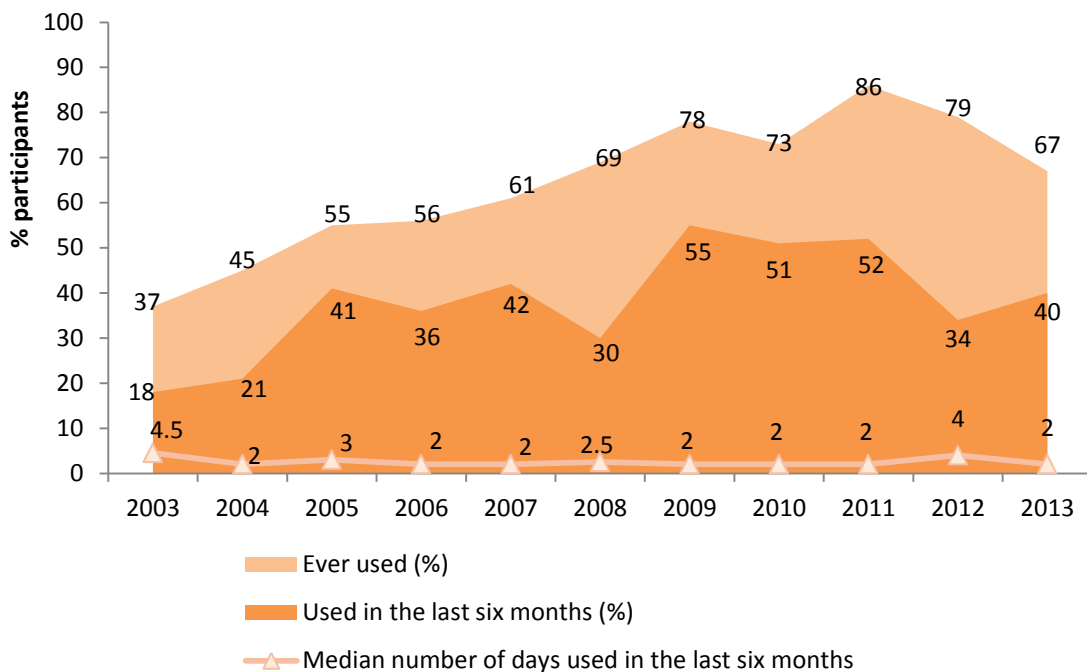
### Key Points

- Cocaine use stable, with two-thirds of participants having ever used and two in five having used in the previous six months.
- Use was generally occasional (median of two days in past six months).

#### 4.4.1 Patterns of cocaine use among regular ecstasy users

In 2013, lifetime and recent use of cocaine remained similar to previous years (Figure 8). The median number of days used in the previous six months was low at two days (n=35, range 1–12).

Figure 8: Patterns of cocaine use, 2003 to 2013



Source: QLD EDRS participant interviews

The reported median number of grams of cocaine used in a session remained similar to 2012, with one gram used in both a typical and heavy session (Table 9).

**Table 9: Median grams of cocaine used in a session in the preceding six months, 2003 to 2013**

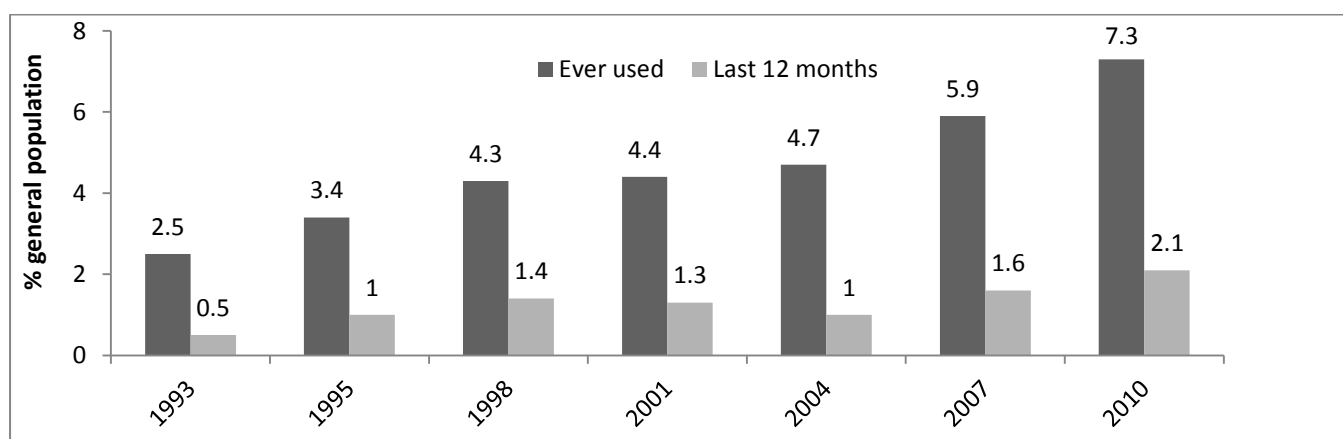
Session	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
<b>Typical (range)</b>	0.5 (0.3–2)	0.5 (0.1–3.5)	0.5 (0.1–4)	0.5 (0.1–4)	0.5 (0.1–3)	0.5 (0.08–3)	0.5 (0.1–2)	0.5 (0.17–2)	0.78 (0.2–6)	0.75 (0.4–1)	<b>1.0</b> <b>(0.25–3)</b>
<b>Heavy (range)</b>	1.0 (0.3–7)	1.0 (0.2–10)	1.0 (0.1–4)	0.7 (0.1–7)	0.5 (0.1–5)	1.0 (0.08–9)	1.0 (0.1–4)	0.5 (0.17–4)	1.0 (0.25–6)	1.0 (0.40–3)	<b>1.0</b> <b>(0.25–4)</b>

Source: QLD EDRS participant interviews

#### 4.4.2 Prevalence of cocaine use in the general population

According to the most recent National Drug Strategy Household Survey report (AIHW, 2011), there is an upward trend in cocaine use within the Australian population aged 14 years and over (Figure 9).

**Figure 9: 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

According to key experts, cocaine use continues to be an ‘aspirational’ drug for young people who regularly use pills, in the sense that it is greatly desired but one must be ambitious to obtain it. It was also reported that cocaine was more likely to be consumed during the ‘festival months’ (summer period). Key experts noted that although more people appeared to have tried cocaine than in the past, use was infrequent and opportunistic. Key experts also noted that problems associated with its use remain hidden because use tends to occur in relatively private venues and health problems tend to be treated in the private sector.

## 4.5 Ketamine use

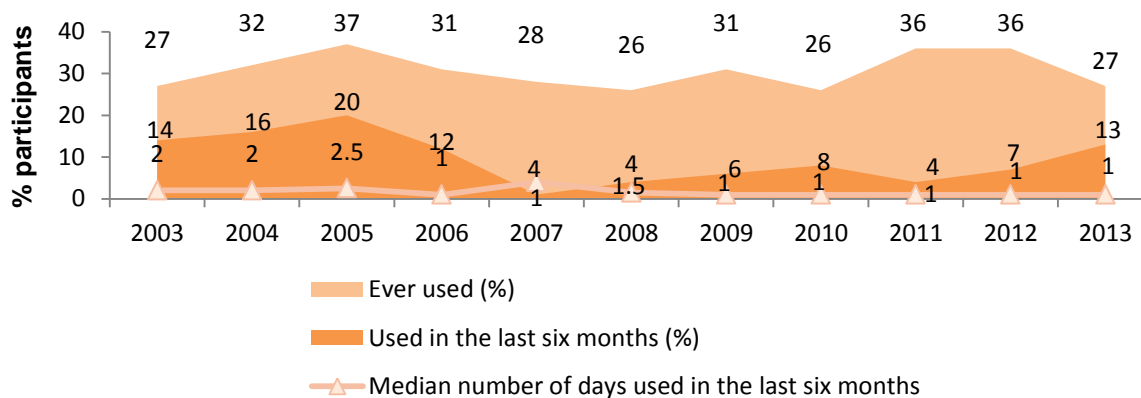
### Key Points

- Ketamine use continued to be low: 27% had ever used and 13% had recently used.
- Use in previous six months was limited to one or two occasions.

### 4.5.1 Patterns of ketamine use among regular ecstasy users

As in previous years, ketamine use remained low among this sample (Figure 10). The median number of days used among those who used in the previous six months was one (n=11, range 1–2 days).

Figure 10: Patterns of ketamine use, 2003 to 2013



Source: QLD EDRS participant interviews

### 4.5.2 Ketamine use in the general population

According to the most recent 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 twelve months.

### 4.5.3 Comments from key experts about ketamine use

Key experts reported very little use of ketamine. One key expert commented that 'a lot of people like ketamine but it is not very accessible'. However, forensic experts reported an increase in substances containing ketamine, often combined with methamphetamine.

## 4.6 GHB use

### Key Points

- There was a significant decrease in lifetime use of GHB in 2013 (13% compared with 44% in 2012).
- 6% had used GHB recently, with most reporting only using it once.



#### 4.6.1 Patterns of GHB use among regular ecstasy users

Similar to previous years, the use of GHB remained low. There was a decrease in lifetime use (13% in 2013 compared with 44% in 2012,  $p < 0.05$ ), though proportions of recent use remained similar (6% in 2013 compared with 10% in 2012). The median number of days used in the previous six months was one ( $n=11$ , range 1–2 days).

The small number of participants commenting on the amount used in sessions prevents meaningful comparisons over time (Table 10).

**Table 10: Median millilitres of GHB used in a session in the last six months, 2003 to 2013**

Session	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
<b>Typical (range)</b>	4 (2–10)	4 (.5–100)	7.5 (1–25)	3.5 (2.6–5)	3.3 (1.5–5)	3 <sup>a</sup> (3–3)	5 <sup>a</sup> (4–6)	5.3 (2.5–8)	2.5 <sup>b</sup> (.5–10)	2.5 <sup>c</sup> (1–7)	4 <sup>b</sup> (1–50)
<b>Heavy (range)</b>	6 (5–40)	8.8 (.5–100)	7.5 (2–40)	5 (5–15)	5 (5–7)	3 <sup>a</sup> (3–3)	13 <sup>a</sup> (5–20)	21.5 (8–35)	5 <sup>b</sup> (.5–12)	2.5 <sup>c</sup> (1–10)	4 <sup>b</sup> (1–50)

<sup>a</sup>based on responses of one participant

<sup>b</sup>based on responses of five participants

<sup>c</sup>based on responses of four participants

Source: QLD EDRS participant interviews

#### 4.6.2 GHB use in the general population

According to the most recent 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 twelve months.

#### 4.6.3 Comments from key experts about GHB use

Key experts believed that GHB is a drug that appears to have waves of popularity. As one key expert explained, it is often used by a peer group for a while until supply is halted or the group move on to something else. It appears to be a drug associated with the party scene, and what a key expert referred to as a ‘Friday night drug’ typically used by non-habitual users to relax. Because of its depressant qualities it has also been reported as a drug used to come down from methamphetamines. GHB is mainly swallowed and because it is colourless and odourless it is commonly consumed in alcoholic drinks.

### 4.7 Hallucinogen use

#### Key Points

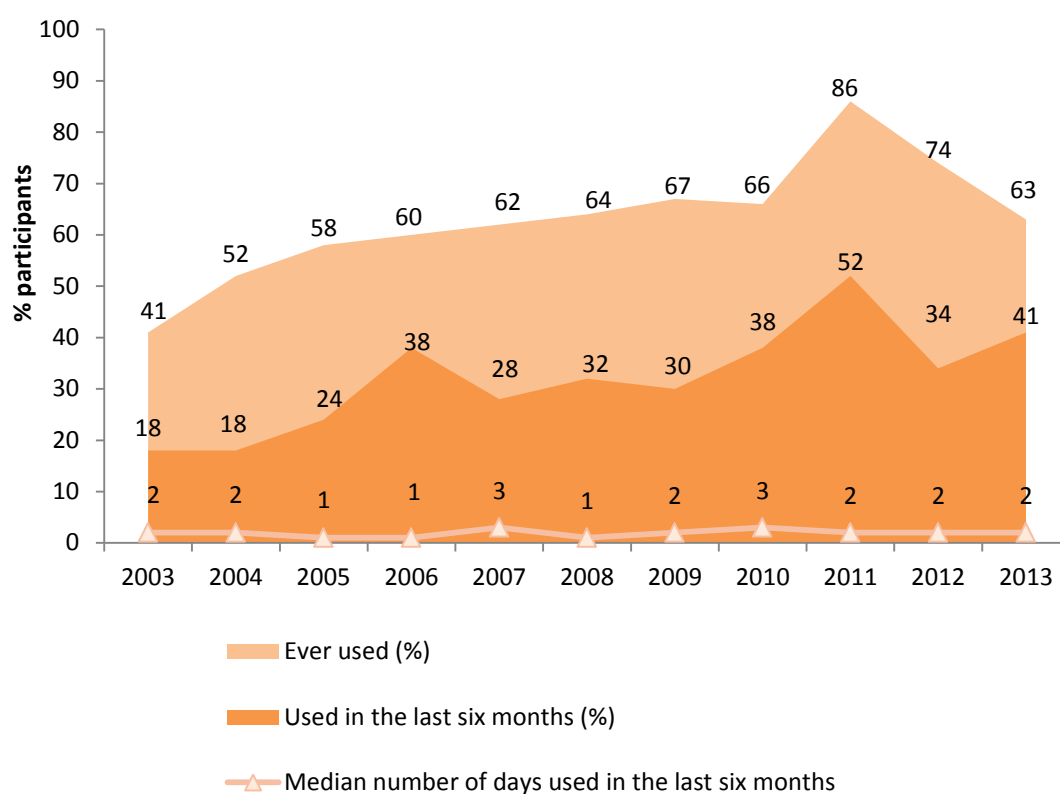
- 63% of participants had ever used LSD, with 41% reporting use in previous six months.
- LSD use was generally occasional.
- Significant increase in recent use of mushrooms from 15% in 2012 to 38% in 2013.

Participants were questioned about their use of LSD and mushrooms.

#### 4.7.1 Patterns of LSD use among regular ecstasy users

Figure 11 shows lifetime and recent use of LSD, which is not significantly different to 2012. The median number of days used in the previous six months remained low at two days (n=36, range 1–16 days).

**Figure 11: Patterns of LSD use, 2003 to 2013**



Source: QLD EDRS participant interviews

Among those who reported using LSD in the previous six months (n=36), participants reported a median of one tab used in a typical session, and 1.3 tabs in a heavy session (Table 11).

**Table 11: Median tabs of LSD used in a session in the last six months, 2003 to 2013**

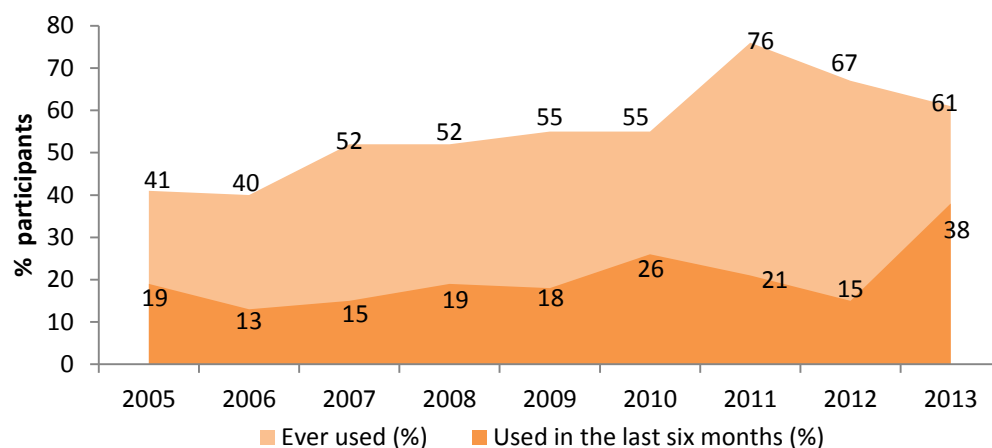
LSD	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
<b>Typical (range)</b>	1.0 (0.5–3)	1.0 (0.5–4)	1.0 (0.3–3)	1.3 (1–1.5)	1.0 (0.5–5)	1.0 (0.5–3.5)	1.0 (0.5–4)	1.0 (1–5)	1.0 (0.5–3)	2.0 (1–4)	<b>1.0 (0.5–6)</b>
<b>Heavy (range)</b>	2.0 (1–5)	1.5 (0.5–4)	1.0 (0.5–4)	1.3 (1–1.5)	1.0 (0.5–6)	1.0 (0.5–4)	1.0 (1–4)	2.0 (1–11)	1.0 (0.5–5)	2.0 (1–4)	<b>1.3 (0.5–12)</b>

Source: QLD EDRS participant interviews

### 4.7.2 Mushroom use

In 2013, recent use of hallucinogenic mushrooms significantly increased, ( $p < 0.05$ ) whereas lifetime use remained similar to 2012 (Figure 12). The median number of days used in the previous six months was two ( $n = 33$ , range 1–15 days).

Figure 12: Patterns of mushroom use, 2005 to 2013



Source: QLD EDRS participant interviews

### 4.7.3 Hallucinogen use in the general population

Findings from the most recent National Drug Strategy Household Survey show that 8.8% of the population over fourteen years of age had used hallucinogens in their lifetime, and 1.4% of the population had consumed them in the twelve months prior to the survey, a statistically significant rise from 0.6% in 2007 (AIHW, 2011).

### 4.7.4 Comments from key experts about hallucinogen use

There were reports of an increase in hallucinogens, particularly among young people. As one youth worker reported, '*Hallucinogens have become better known, more accepted. They are seen as something acceptable to experiment with.*' Young people appeared to be experimenting with hallucinogens, mostly LSD, on an opportunistic basis and as part of a group. Other key experts reported little change in the use of LSD which was generally infrequent. Use of mushrooms is reported as opportunistic and varies according to local availability (i.e. heavier use after a rainy period when mushrooms flourish).

## 4.8 Cannabis use

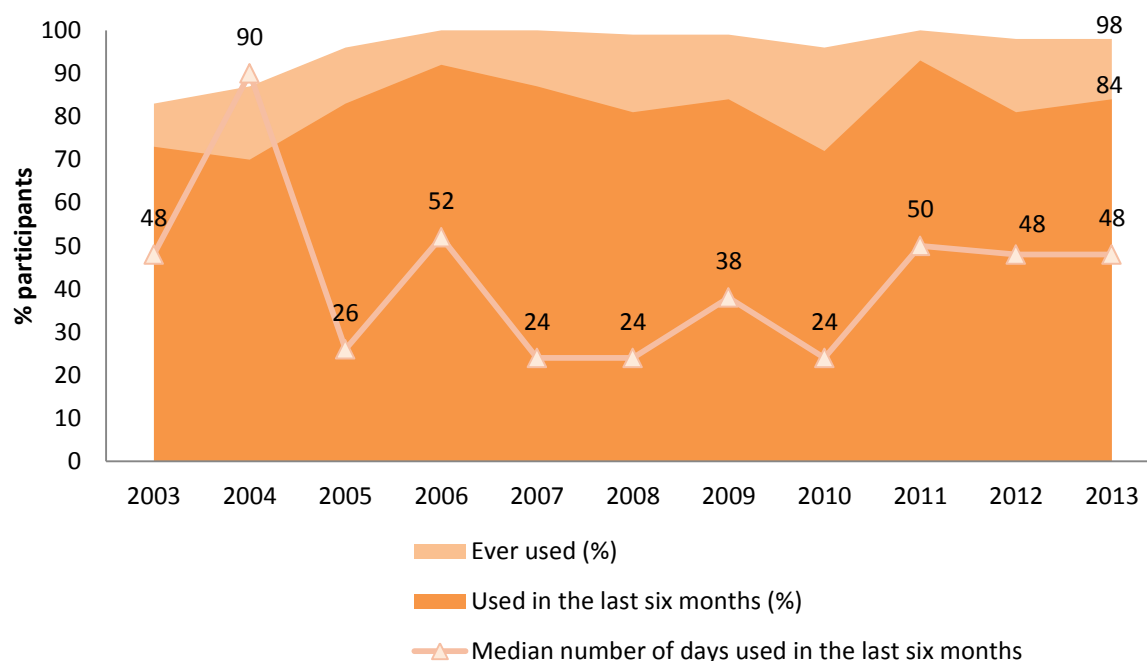
### Key Points

- Most participants (84%) had recently used cannabis.
- Nearly a quarter of participants used cannabis daily.

### 4.8.1 Patterns of cannabis use among regular ecstasy users

Lifetime and recent use of cannabis has remained high and stable, with the majority of the sample reporting use (Figure 13). The median number of days used in the previous six months was 48, corresponding to twice a week (n=74, range 1–180 days).

**Figure 13: Patterns of cannabis use, 2003 to 2012**



Source: QLD EDRS participant interviews

Among participants who reported recent use of cannabis (n=74), 23% reported using cannabis every day in the previous six months (Table 12).

**Table 12: Frequency of cannabis use in the last six months, 2003 to 2013**

	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) %	2013 (n= 74) %
Daily (180 days)	32	38	13	23	21	22	24	14	20	26	<b>23</b>
More than weekly (25 to 179 days)	28	33	39	35	26	23	28	29	33	32	<b>41</b>
Weekly (24 days)	6	4	0	1	7	12	8	14	6	8	<b>10</b>
Less than weekly (1–23 days)	34	25	48	42	46	44	39	44	41	34	<b>23</b>

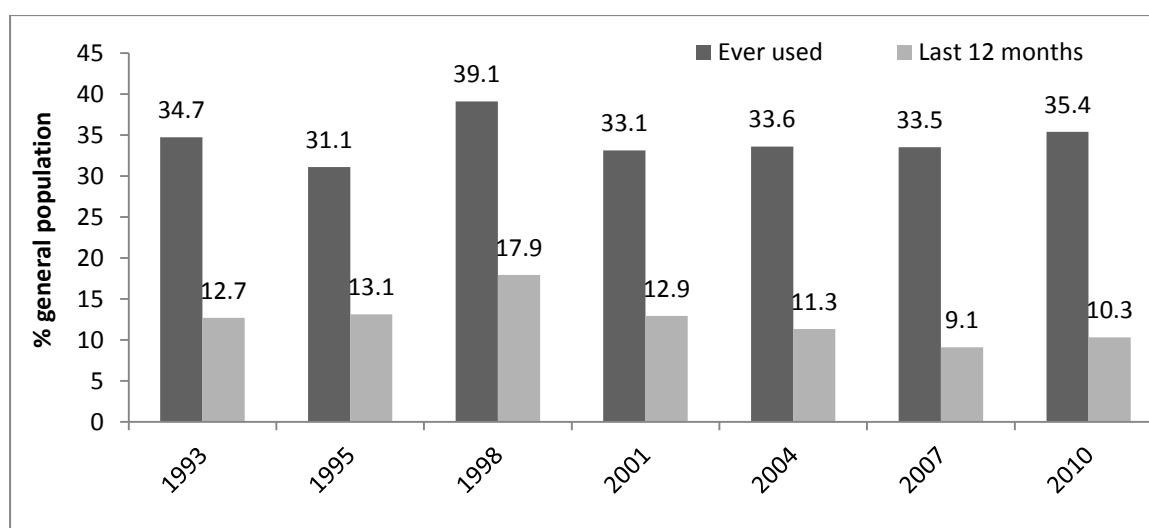
Note: Based on participants who used cannabis in the previous six months

Source: QLD EDRS participant interviews

#### 4.8.2 Cannabis use in the general population

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

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



Source: NDSHS 1993-2011 (AIHW, 2011)

#### 4.8.3 Comments from key experts about cannabis use

Cannabis was widely recognised as being used recreationally by many young people. Key experts pointed out that it was relatively inexpensive and readily available. Heavy regular use was identified as being problematic because of it impacting negatively on work and education, and the risk of contact with the law. Most key experts reported hearing very little about synthetic cannabis.

## 4.9 Other drugs use

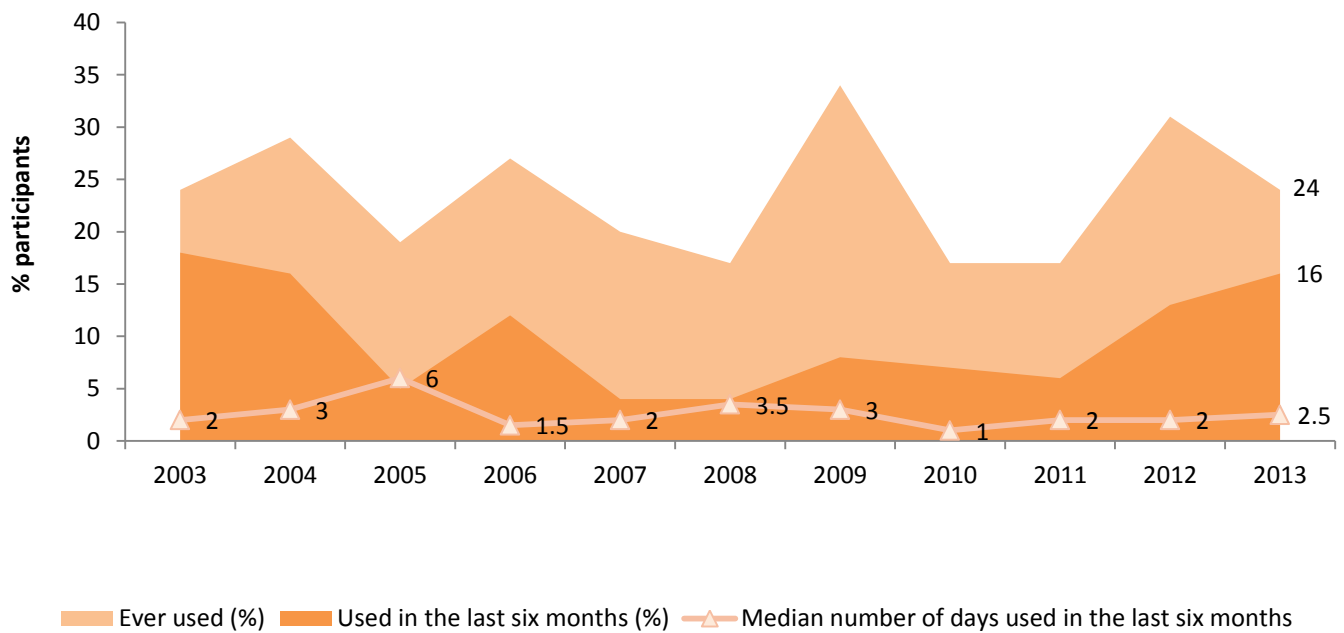
### Key Points

- Nearly a quarter of participants had used MDA in their lifetime, with 16% reporting recent use.
- Alcohol use was stable, with 99% of the sample using alcohol on a median of 48 days in the previous six months.
- The proportion of participants using tobacco continued to be high (83%), with about half smoking daily.
- 7% of participants had recently used illicit anti-depressants and 9% licit (prescribed to them).
- 32% of participants had recently used illicit benzodiazepines, mainly Xanax<sup>®</sup> and Valium<sup>®</sup>, and 9% licit.
- 8% had recently used amyl nitrate. Use was occasional.
- 28% had used nitrous oxide on a median of five days in the past six months.
- Heroin use was rare: 7% reported ever using and 3% recently using.
- Recent use of other opiates (e.g. morphine, oxycodone) was 7% licit and 11% illicit.
- Most commonly used new psychoactive substances (NPS) in the past six months were: 2CB (15%), DMT (14%), and Kronik (13%).
- 15% of participants reported recently taking a capsule of unknown content

### 4.9.1 MDA use

MDA use was similar to reports in 2012 (Figure 15). The median number of days used was 2.5 (n=14, range 1–30 days).

**Figure 15: Patterns of MDA use, 2003 to 2013**

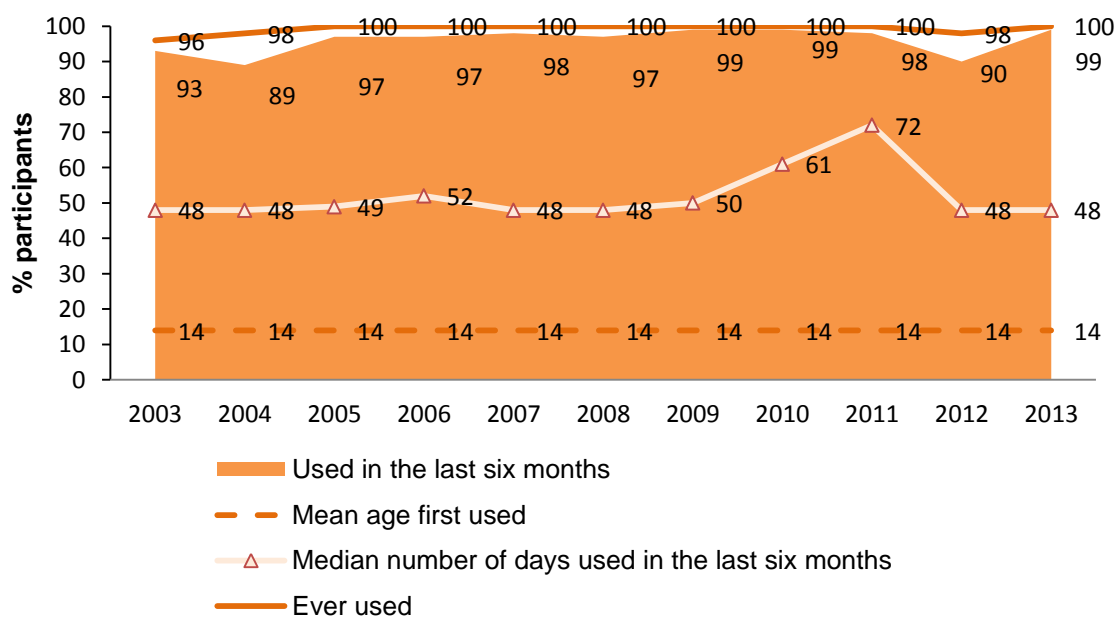


Source: QLD EDRS participant interviews

#### 4.9.2 Alcohol

Lifetime and recent use of alcohol remained high and constant (Figure 16). The median number of days used was 48, corresponding to twice a week (n=87, range 6–180 days). The mean age participants reported to have first used alcohol was 14 years, which has remained constant since 2003.

**Figure 16: Patterns of alcohol use, 2003 to 2013**



Source: QLD EDRS participant interviews

Among those who reported using other substances on the most recent occasion they used ecstasy (n=81), 14% reported they had consumed between one and five standard drinks, while 78% reported they had consumed more than five standard drinks.

### Alcohol use in the general population

According to the most recent 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 13).

**Table 13: Alcohol drinking status of the Australian population 14 years and older (%), 1991 to 2010**

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

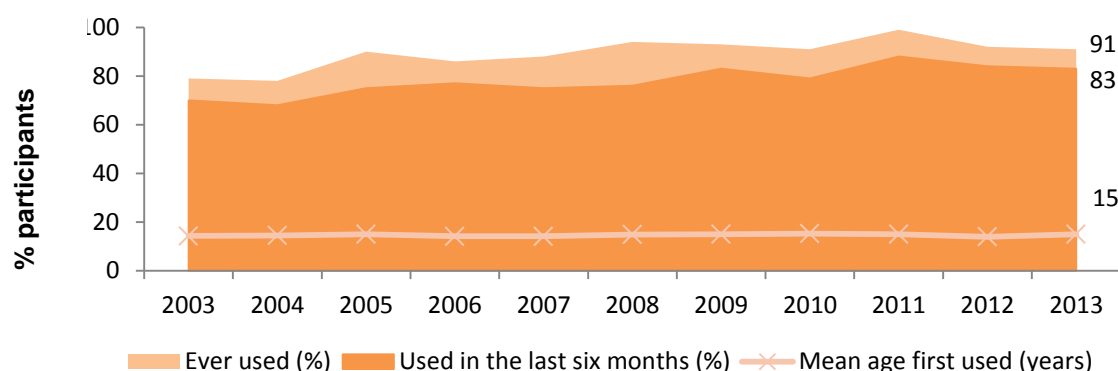
Alcohol is considered to be the most problematic drug by many key experts who work with young people. They note the damage caused from heavy alcohol use and bingeing. One key expert pointed out that some people increase the length of drinking sessions by also using stimulant drugs such as ecstasy. Key experts pointed to a 'booze culture' where illicit drugs like ecstasy were often additional to alcohol rather than the main substance for a night out. One key expert also commented that judgements about illicit drug use can become clouded in a social environment where large quantities of alcohol are being consumed.

### 4.9.3 Tobacco

The prevalence of tobacco use remains high and consistent (Figure 17). The median number of days smoked in the previous six months was 180, corresponding to daily use (n=73, range 1–180). Among those who smoked in the previous six months, 52% reported smoking daily. This equate to 43% of all participants in 2013. The mean age of first tobacco use has remained relatively stable at 15 years.



**Figure 17: Patterns of tobacco use, 2003 to 2013**



Source: QLD EDRS participant interviews

### Tobacco use in the general Australian population

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

**Table 14: Smoking status, proportion of the Australian population 14 years and over, 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 <sup>a</sup>	21.4	21.7	20.2	25.9	26.2	26.4	25.1	24.1
Never smoked <sup>b</sup>	49.0	49.1	52.6	49.2	50.6	52.9	55.4	57.8

<sup>a</sup> smoked at least 100 cigarettes in lifetime and no longer smoke

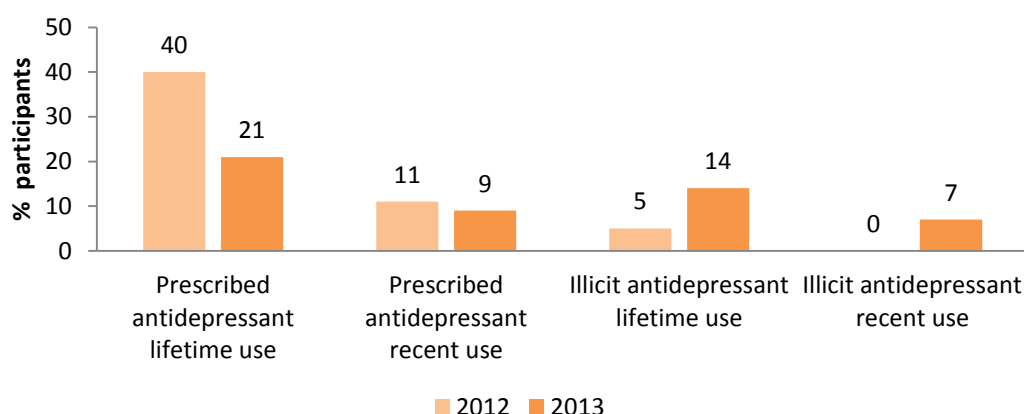
<sup>b</sup> never smoked more than 100 cigarettes in lifetime

Source: NDSHS 1991-2010 (AIHW, 2011)

#### 4.9.4 Anti-depressants

In 2013, there was a significant decrease in the proportion of participants reporting lifetime use of licit (prescribed) antidepressants ( $p < 0.05$ ) (Figure 18).

**Figure 18: Lifetime and recent use of antidepressants, 2012 and 2013**



Source: QLD EDRS participant interviews

Among those who used licit antidepressants in the previous six months, the median number of days used was 180, corresponding to daily use (n=8, range 10–180 days). The main brands used licitly in the previous six months were Lovan<sup>®</sup> (fluoxetine), Lexapro<sup>®</sup> (escitalopram), generic mirtazapine, and Pristiq<sup>®</sup> (desvenlafaxine).

Among those who used illicit antidepressants in the previous six months, the median number of days used was one (n=6, range 1–24 days). The main brands of antidepressants used in the previous six months were Endep<sup>®</sup> (amitriptyline) and Prozac<sup>®</sup> (fluoxetine).

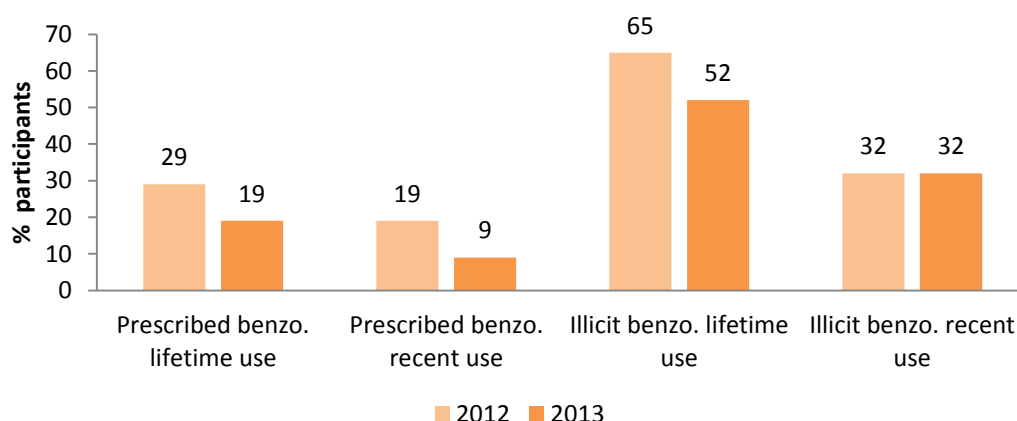
#### 4.9.5 Benzodiazepines

Figure 19 shows that lifetime and recent use of benzodiazepines in 2013 remained similar to proportions in 2012, though 9% had recently used prescribed benzodiazepines compared with 19% in 2012.

Among those who used prescription benzodiazepines in the previous six months, the median number of days used was 16 (n=8, range 2–180 days). The main prescribed brands used were Valium<sup>®</sup> (diazepam) and generic temazepam.

Among those who used benzodiazepines illicitly in the previous six months, the median number of days used was six (n=28, range 1–70 days). Xanax<sup>®</sup> (alprazolam) and Valium<sup>®</sup> were the main brands used: 46% mainly used Xanax<sup>®</sup>, which corresponds to 15% of all participants having used Xanax<sup>®</sup> illicitly in the previous six months; and 43% mainly used Valium<sup>®</sup>, which corresponds to 14% of all participants. Temazepam was also reported to have been used illicitly in the previous six months.

**Figure 19: Lifetime and recent use of benzodiazepines, 2012 and 2013**

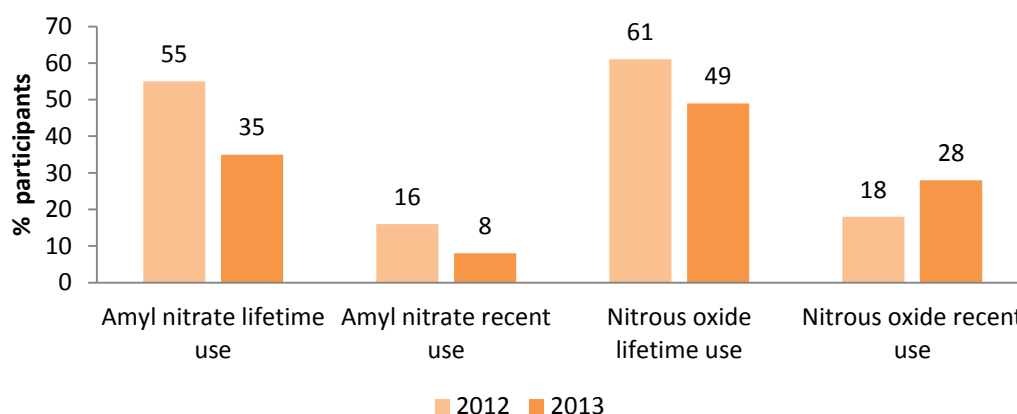


Source: QLD EDRS participant interviews

#### 4.9.6 Inhalant use

In 2013, lifetime use of amyl nitrate significantly decreased ( $p < 0.05$ ) from 2012 but there was no significant decrease for nitrous oxide (Figure 20).

**Figure 20: Lifetime and recent use of inhalants, 2012 and 2013**



Source: QLD EDRS participant interviews

Recent use of amyl nitrate remains low. Among those who recently used amyl nitrate, the median number of days used was two ( $n = 7$ , range 1–8).

Recent use of nitrous oxide was 28% compared with 18% in 2012. The median number of days used in the previous six months among those who recently used was five ( $n = 25$ , range 1–48 days).

#### 4.9.7 Heroin and other opioids

In 2013, participants were asked about their use of opioids, with 17% reporting recent use of any type of opioid. Among those who recently used opioids, the median number of days used was seven ( $n = 15$ , range 1–48 days).

There was a decline in reports of lifetime use of **heroin**, from 23% in 2012, to ~~only~~ 7% in 2013 ( $p < 0.05$ ). Only three participants reported recently using heroin, with one report of injecting. Use by these three participants was occasional (range 1–4 days).

Two participants reported ever using **methadone**, with none reporting use in the previous six months.

Two participants reported ever using **buprenorphine**, and one in the previous six months who swallowed prescribed buprenorphine every day.

In 2013, 11% of participants reported using **other licit opioids** (e.g. morphine, oxycodone) in their lifetime which was a significant decrease from 31% in 2012 ( $p < 0.05$ ). Recent use was reported by 7% which was not significantly different from 2012. The mean number of days used in the previous six months was 13 ( $n=6$ , range 4–15 days). The main brand used with a prescription was Endone<sup>®</sup>. No one reported injecting other licit opioids in the previous six months.

In 2013, 23% reported ever using **other illicit opioids**, with 11% reporting recent use. The median number of days used in the previous six months was between one and two days. The main brand used illicitly was Endone<sup>®</sup>. No one reported injecting other illicit opioids in the previous six months.

#### **4.9.8 Pharmaceutical stimulants**

In 2013, there was a significant decrease in the use of prescribed pharmaceutical stimulants. Only two participants (2%) reported ever using prescribed pharmaceutical stimulants such as dexamphetamines. This is a significant drop from 15% in 2012 ( $p < 0.05$ ). These two participants reported using in the previous six months.

Lifetime illicit use of pharmaceutical stimulants remained similar to previous years, with 60% of participants reporting lifetime use. However, recent use of illicit pharmaceutical stimulants significantly increased ( $p < 0.05$ ) from 19% in 2012 to 41% in 2013. Among those who used illicit pharmaceutical stimulants in the previous six months, the median number of days used was 3.5 ( $n=36$ , range 1–96 days).

The median number of days any pharmaceutical stimulant was used was four ( $n=37$ , range 1–124 days).

Participants were also asked about over the counter use of stimulants (e.g. cold and flu drugs) for 'non-medicinal/recreational use'. Lifetime use was reported by 16% and 6% reported recent use. The median number of days used was two in the previous six months ( $n=5$ , range 1–6 days). Brands used were Codral<sup>®</sup> and Dimetap<sup>®</sup>.

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

Similar to last year, in 2013, 32% of participants reported having used over-the-counter codeine for non-medical use in their lifetime, with 17% using it in the previous six months. The median number of days used in the previous six months was two ( $n=15$ , range 1–90 days).

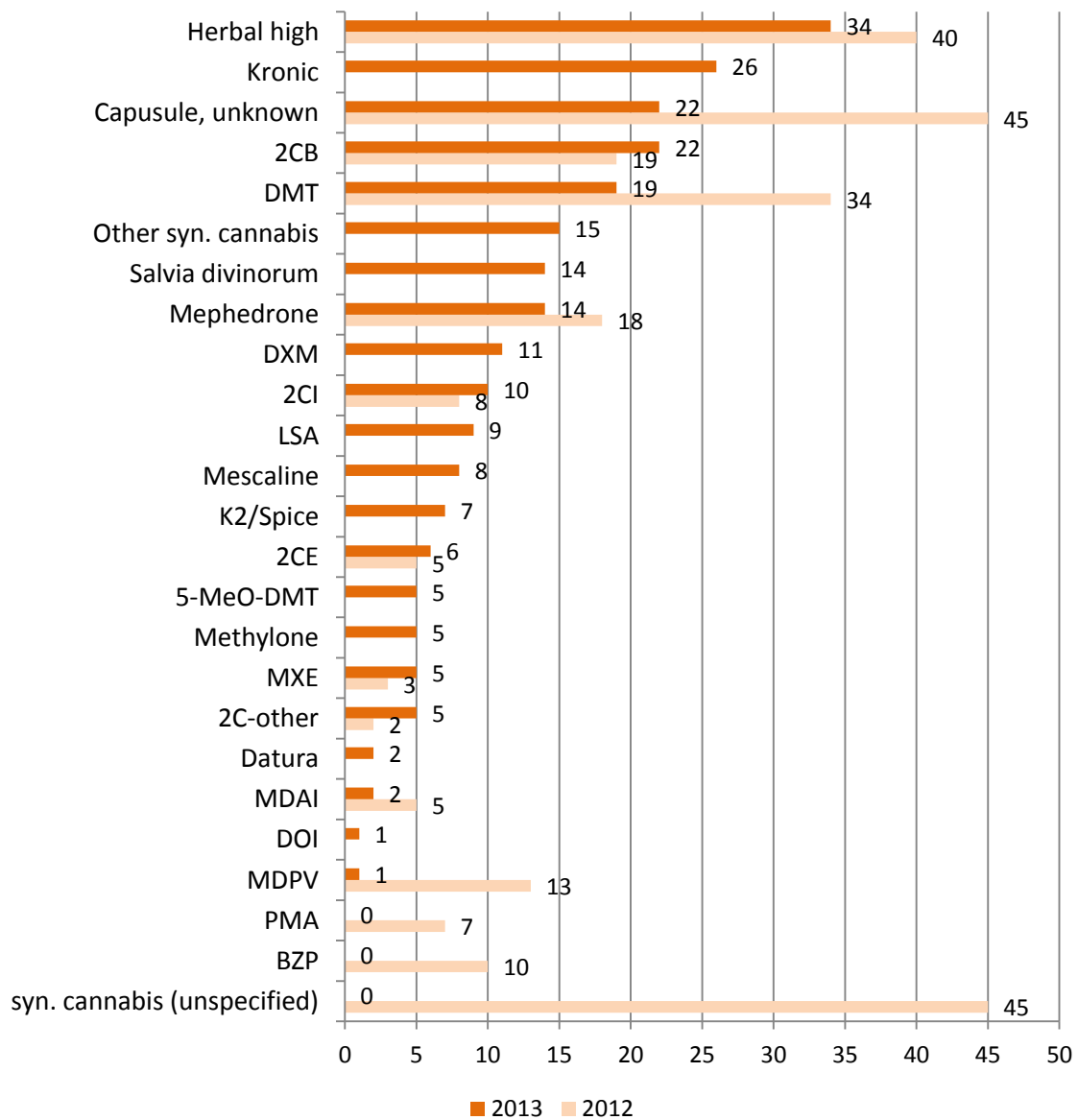
### **4.10 New psychoactive substance (NPS) use**

Participants were asked about their use of new psychoactive substances (NPS), including analogues and research chemicals (Figure 21, Figure 22).

In 2013, 38% of participants reported using a NPS in the previous six months, with 21% reporting recently using a synthetic cannabinoid. Altogether, just under half (49%) of all participants reported using either a NPS and/or a synthetic cannabinoid.

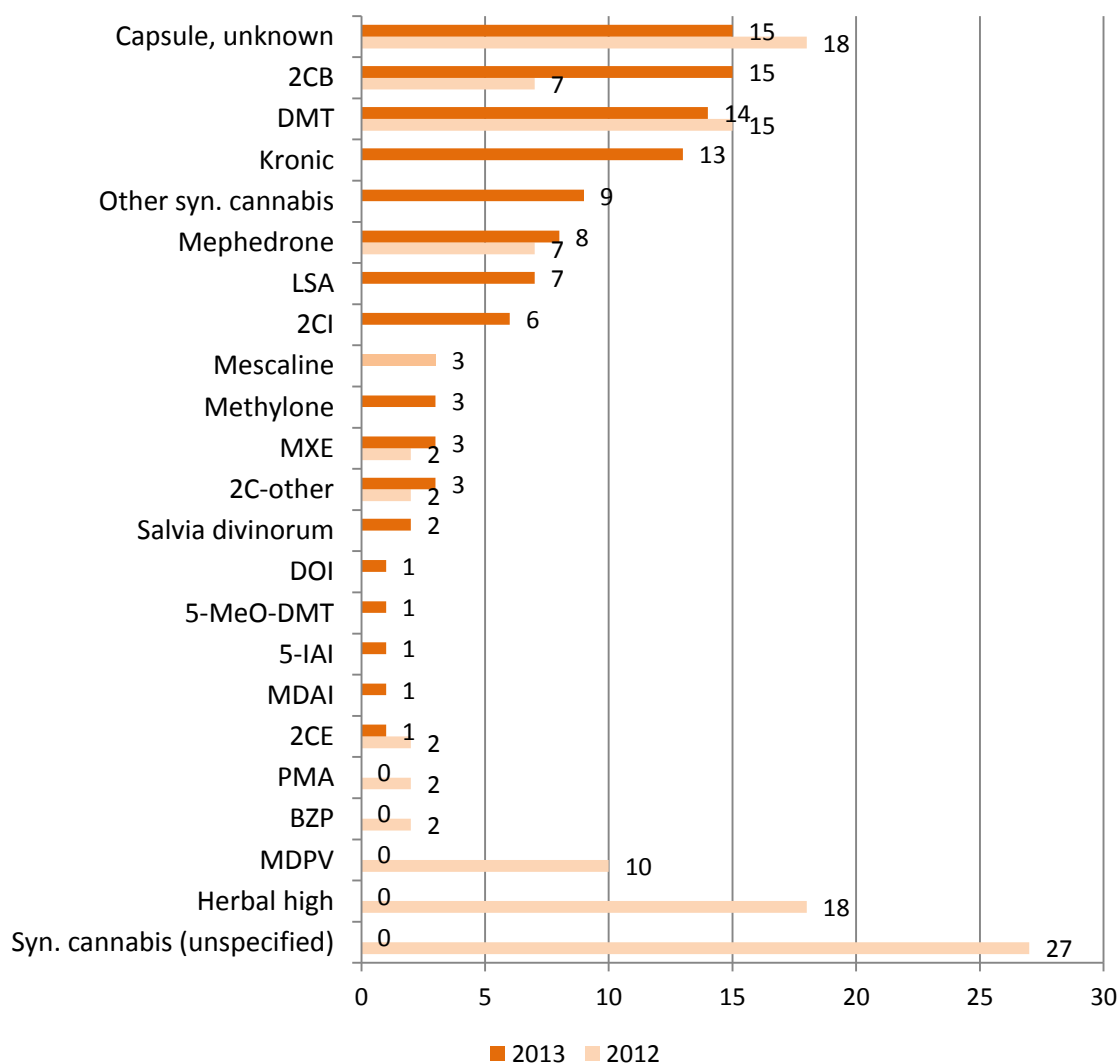
Participants reported different NPS lifetime and recent use in 2013 compared with 2012, and this partially relates to participants in 2012 being asked only about synthetic cannabis and not Kronic (synthetic cannabis) specifically. There are also low numbers for use of many of the NPS. NPS most commonly ever used were herbal highs, Kronic, 2CB and capsule of unknown content. Lifetime use of a capsule of unknown content significantly decreased ( $p < 0.05$ ) from 45% in 2012 to 22% in 2013.

**Figure 21: Lifetime use of new psychoactive substances, 2012 and 2013**



Source: QLD EDRS participant interviews

**Figure 22: Recent use of new psychoactive substances, 2012 and 2013**



Source: QLD EDRS participant interviews.

***Comments from key experts about new psychoactive substance use***

Key experts reported that there is a growing range of psychostimulant drugs, but they have limited popularity and are quickly superseded by the next new formula. For example, mephedrone which had become popular and received a lot of publicity approximately two years ago is no longer heard about. Key experts say that ‘pills’ is often the catchall name for new psychostimulant substances (NPS) whether in tablet or capsule form. There are key NPS names that sellers and the media use which do not necessarily reflect the actual content. Content is a concern as some formulas can be extremely toxic (e.g. NBOMBe). A number of different forms of NBOMBe have been found impregnated into cardboard tabs, replicating the way LSD has traditionally been sold in Australia. The uncertainty about content also relates to what is legal and what is illegal. This is particularly the case with ‘body image’ drugs but is also the case for psychostimulants.

Although there have been deaths and serious health problems associated with use of NPS, health and outreach services report that people are not presenting with problems associated with use.

## 5 DRUG MARKET: PRICE, PURITY, AVAILABILITY AND SUPPLY

### 5.1 Ecstasy

#### Key Points

- Median price of an ecstasy tablet was \$25 and a capsule \$30.
- Ecstasy purity was most commonly rated as medium (40%) or fluctuating (30%).
- Ecstasy was generally reported as readily available; although 21% reported that availability had become more difficult.
- Purchasing of ecstasy was generally undertaken with others. Source person was commonly a friend and the transaction undertaken at a friend's home or own home.

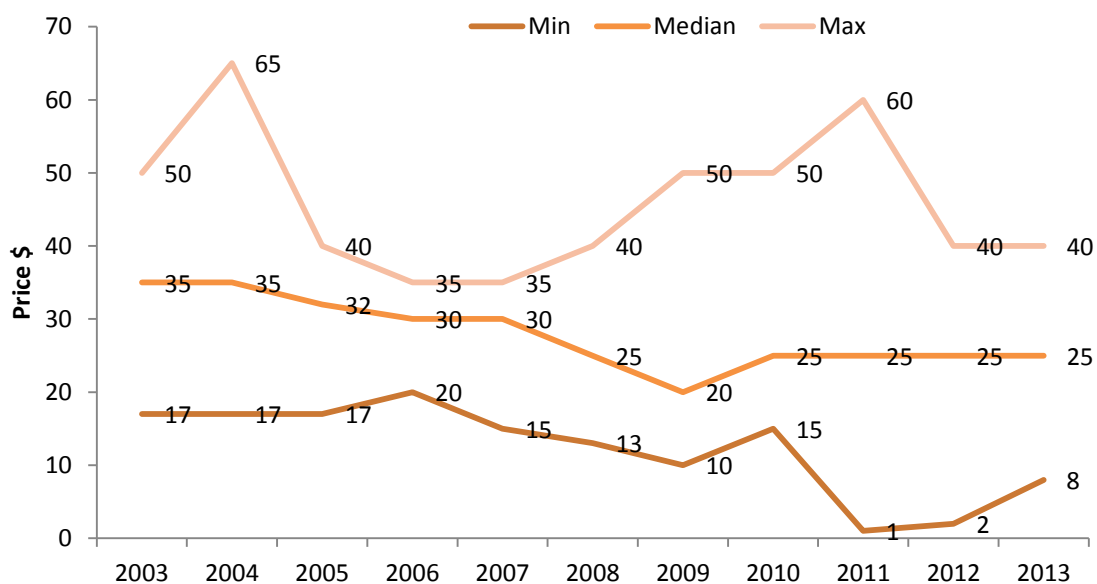
Responses in this section are reported from all participants in the Queensland sample.

#### 5.1.1 Price

As in previous years, participants reported that ecstasy was most commonly purchased in pill form. For the first time, participants in 2013 were asked about purchasing crystal MDMA. Ecstasy may also be obtained in capsule or powder form.

The median price per pill remained at \$25 (n=83, range \$8–40) (Figure 23) though the median price per capsule was reported to be \$30 (n=7, range \$25–40).

**Figure 23: Price of ecstasy per tablet, Queensland, 2003 to 2013**



Source: QLD EDRS participant interviews

Only two people commented on the price of MDMA crystals: one paid \$150 per gram and the other \$300 per gram.

As in previous years, the median price per ecstasy pill tended to decrease if purchased in larger quantities. While the median price for one pill was \$25 (n=60, range \$8–40), the median price per pill when purchasing 100 pills was \$12.5 (n=15, range \$5–18). Bulk prices were similar to 2012.

Prices were comparable to those reported by the Australian Crime Commission (ACC, 2013) for 2012. One tablet/capsule was reported by the ACC to be between \$20–50 and 100–999 tablets/capsules to be between \$8–20 per tablet/capsule.

Similar to 2012, the majority of participants (80%) reported that the price of ecstasy had remained stable over the previous six months (Table 15).

**Table 15: Changes in recent price of ecstasy, 2012 and 2013**

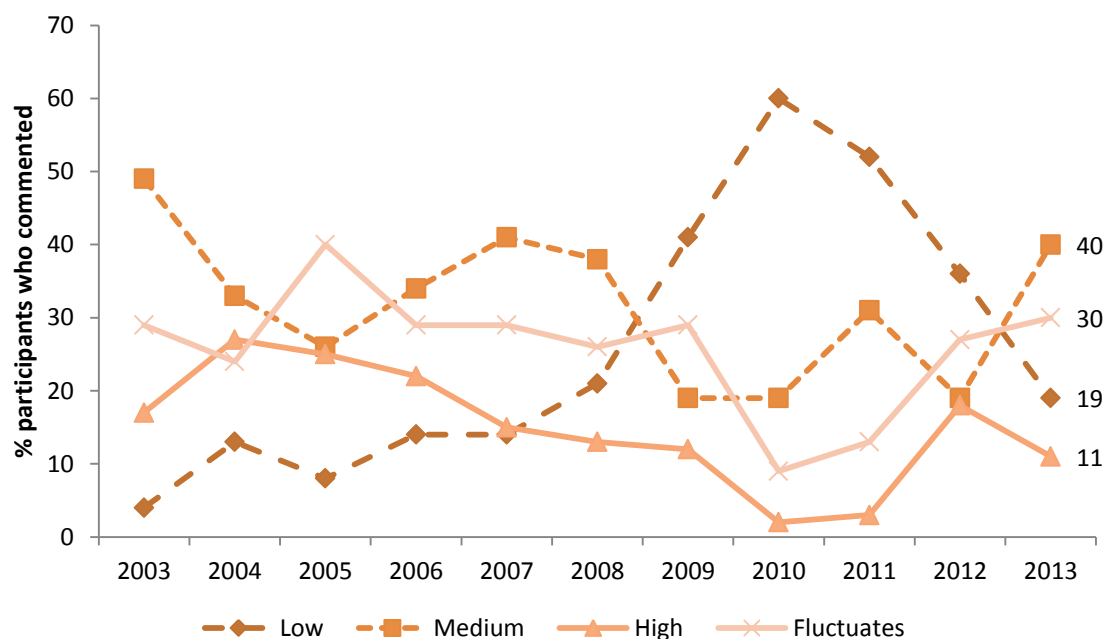
Price Change	2012 (n=55) %	2013 (n=84) %
Increasing	15	11
Stable	69	80
Decreasing	6	1
Fluctuating	11	8

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

### 5.1.2 Purity

In 2013, significantly fewer participants reported the purity of ecstasy to be of low strength and significantly more reported it to be of medium strength (p<0.05) (Figure 24).

**Figure 24: Perception of ecstasy purity, 2003 to 2013**



Source: QLD EDRS participant interviews



Reports of perceived changes in recent ecstasy purity were very similar to last year (Table 16).

**Table 16: Perceived changes in recent ecstasy purity, 2003 to 2013**

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
	%	%	%	%	%	%	%	%	%	%	%
Decreasing	10	15	13	23	16	22	42	60	43	29	<b>29</b>
Stable	39	28	31	36	33	30	27	15	20	25	<b>24</b>
Increasing	18	9	14	11	4	6	6	3	9	15	<b>13</b>
Fluctuating	31	42	38	28	41	35	25	22	25	31	<b>34</b>

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

Source: QLD EDRS participant interviews

### 5.1.3 Availability

In 2013, most participants reported access to be very easy or easy, and this was similar to 2012. About half reported that availability in the past six months was stable, but 21% found ecstasy more difficult to obtain compared with 8% in 2012 (Table 17).

**Table 17: Ease of access and reported change in availability of ecstasy in the previous six months, 2012 and 2013**

	2012	2013
	%	%
<b>Ease of access to ecstasy</b>	<b>(N=62)</b>	<b>(N=87)</b>
Very easy	57	<b>39</b>
Easy	31	<b>42</b>
Difficult	11	<b>18</b>
Very difficult	2	-
<b>Change in availability</b>	<b>(n=60)</b>	<b>(n=86)</b>
Stable	63	<b>51</b>
Easier	23	<b>17</b>
More difficult	8	<b>21</b>
Fluctuating	5	<b>10</b>

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

Totals may not add to 100% because of rounding

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. Responses were comparable to those given in 2012.

In 2013, participants reported purchasing ecstasy from a median of three different people in the previous six months (n=86, range 1–30 people). This is was the same as in previous years.

The median number of ecstasy pills purchased on the most recent occasion was four (n=73, range 1–200 pills). In 2012 the median number was eight (n=62, range 1–700).

When purchasing ecstasy in the previous six months, the majority of participants reported purchasing it for themselves and others (Table 18).

**Table 18: Usually purchased for whom in previous six months, 2012 and 2013**

	2012 (N=62) %	2013 (N=88) %
Self and others	69	<b>64</b>
Self only	26	<b>33</b>
Did not buy	3	<b>3</b>
Others only	2	-

Source: QLD EDRS participant interviews

About half of participants reported purchasing ecstasy fortnightly or less (Table 19). In 2013, participants were significantly less likely to report purchasing ecstasy three times a week or less compared with participants in 2012. The most common purchasing period was fortnightly or less.

**Table 19: Number times purchased ecstasy in the previous six months, 2012 and 2013**

	2012 (N=62) %	2013 (N=88) %
Monthly or less (1–6 times)	38	<b>37</b>
Fortnightly or less (7–12 times)	37	<b>51</b>
Weekly or less (13–24 times)	23	<b>13↓</b>
Three times a week or less (25+ times)	2	-

Note: Arrow symbol signifies a significant difference  $p < 0.05$

Source: QLD EDRS participant interviews

As in previous years, ecstasy was most commonly obtained from a friend, with the most common venue for 'scoring' being a friend's house (Table 20).

**Table 20: Source person and location of most recent ecstasy purchase, 2012 and 2013**

	2012 (n=62) %	2013 (n=87) %
<b>Source person</b>		
Friends	65	<b>62</b>
Known dealers	13	<b>24</b>
Acquaintances	11	<b>6</b>
Unknown dealers	7	<b>6</b>
Work colleagues	2	<b>1</b>
Relatives	-	<b>1</b>
Online	3	-
<b>Venue scored from</b>		
Friend's home	34	<b>39</b>
Own home	21	<b>21</b>
Dealer's home	5	<b>16</b>
Nightclub	7	<b>11</b>
Street	-	<b>3</b>
Private party	7	<b>3</b>
Agreed public location	16	<b>2</b>
Pubs	2	<b>1</b>
Live music event	3	<b>1</b>
Holiday rental	-	<b>1</b>
Work	2	-
Acquaintance's home	2	-
Online	3	-

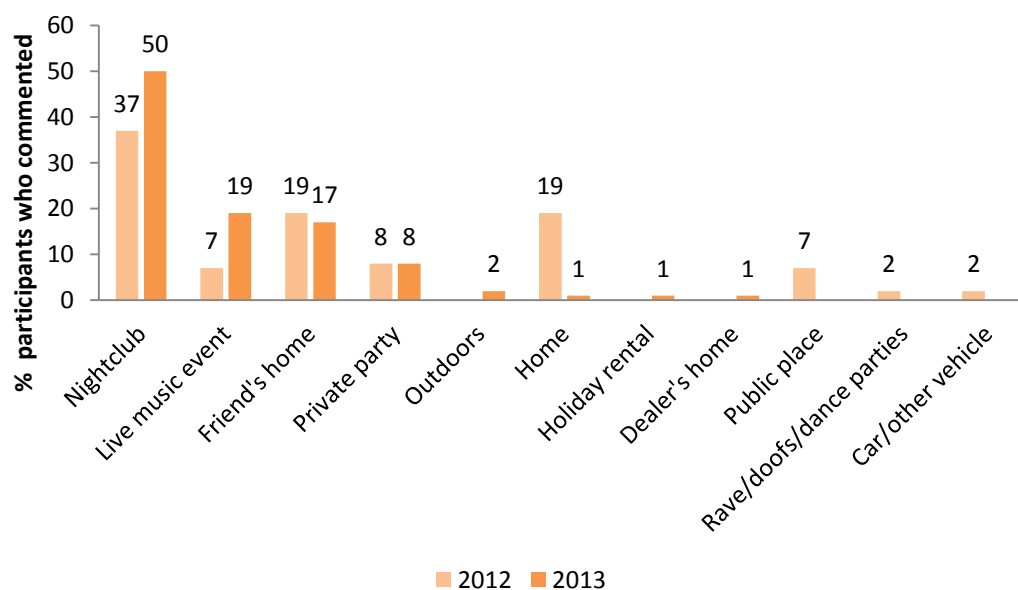
Note: Those responding 'used not scored' were excluded from analyses

Totals may not add to 100% because of rounding

Source: QLD EDRS participant interviews

Figure 25 shows that nightclubs remained the most popular venues to be while using ecstasy (50% in 2013 versus 37% in 2012), followed by live music events and at a friend's home. In 2013 none reported that their most recent use was at home. This was significantly different than 2012 when 19% reported using while at home ( $p < 0.05$ ).

**Figure 25: Venue for most recent ecstasy use, 2012 and 2013**



Source: QLD EDRS participant interviews

### 5.1.5 Comments from key experts

Pricing of MDMA appears to be stable with prices ranging from \$20 to \$30. Purchases were reported as being amongst friendship networks. Quality is seen as variable, with purity of crystals often being very high but less so for ecstasy in pill form. There has been evidence of pills containing both MDMA combined with methamphetamine. On balance, however, reports indicated an improvement in quality. With pills, some reports suggests that what was thought to be ecstasy was more like an acid trip. Ecstasy pills appeared to be readily available but there was little information on the availability of crystal MDMA.

## 5.2 Methamphetamine

### Key Points

- The median price of one point of crystal/ice was \$100 and speed powder was \$65. Base was excluded from analysis because of insufficient responses.
- Half of those who commented on the purity of speed and crystal/ice rated it as high.
- Crystal/ice was readily available and this was generally the case with speed; although a third rated availability as difficult.
- The most common source for methamphetamines was a friend or known dealer.

Reports about the methamphetamine market are about: speed powder, base, and crystal/ice.

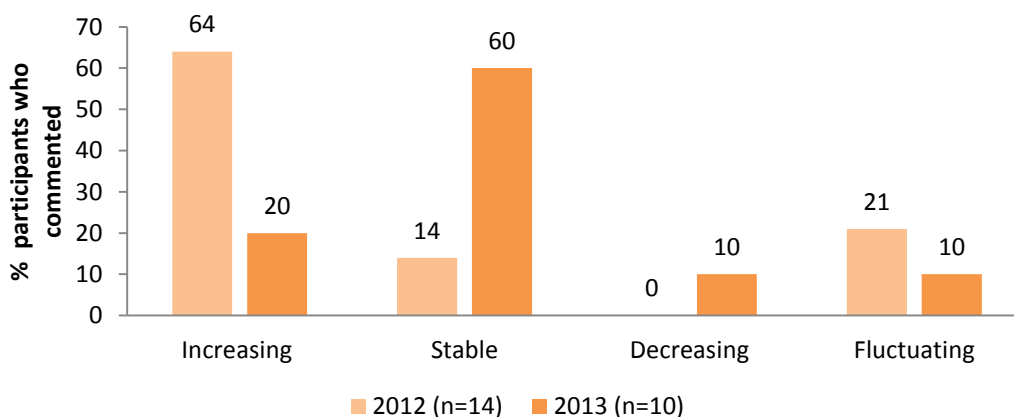
In 2013, 12 participants were able to comment on the market for speed powder, eight for crystal/ice, and only one for methamphetamine base. Accordingly, analysis of market trends for base has been excluded and caution is needed when interpreting results for crystal/ice.

### 5.2.1 Price

In 2013, the median price of the most recent methamphetamine purchase was similar to 2012; however, numbers are very low and findings must be treated with caution.

For speed powder, the median price for one point (0.1g) was \$65 (n=6, \$25-100). Three participants reported on price per gram: 2 x \$200 and 1 x \$100. (Figure 26).

**Figure 26: Perceived price changes for speed powder purchased in previous six months, 2012 and 2013**



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

The median price for one point (0.1g) of crystal/ice was \$100 (n=6, range \$90–120). Three participants provided a price for one gram: 2 x \$800 and 1 x \$1,000.

Seven people commented on the recent price changes for crystal/ice: three reported it was stable, two reported it was increasing, while one reported it had decreased and one reported it was fluctuating.

Table 21 shows that the price range reported by the Australian Crime Commission (ACC, 2013) for a point of crystal/ice in 2012 encompasses the narrower range reported by our study participants in 2013. The price range for a gram in 2012 was, however, lower than that reported by our three participants in 2013.

**Table 21: ACC reported methylamphetamine (crystal form) prices in Queensland, 2012**

Weight	Price per unit
1 point (0.1 gram)	\$50–150
1 gram / 'weight'	\$300–500
1/8 ounce (3.5 grams) / 'eight ball'	\$750–1,700
1 ounce (28 grams) street deal	\$3,300–8,000
1 ounce (28 grams)	\$13,000–15,000
1 pound (454 grams )	\$70,000–120,000

Source: Australian Crime Commission (ACC, 2013)

Overall the Australian Crime Commission's (ACC, 2013) prices are similar to those reported by the EDRS participants. However, the Commission reports the price of speed and base combined, so a direct comparison with the EDRS data is difficult (Table 22).

**Table 22: ACC reported methylamphetamine (non-crystal form) prices in Queensland, 2012**

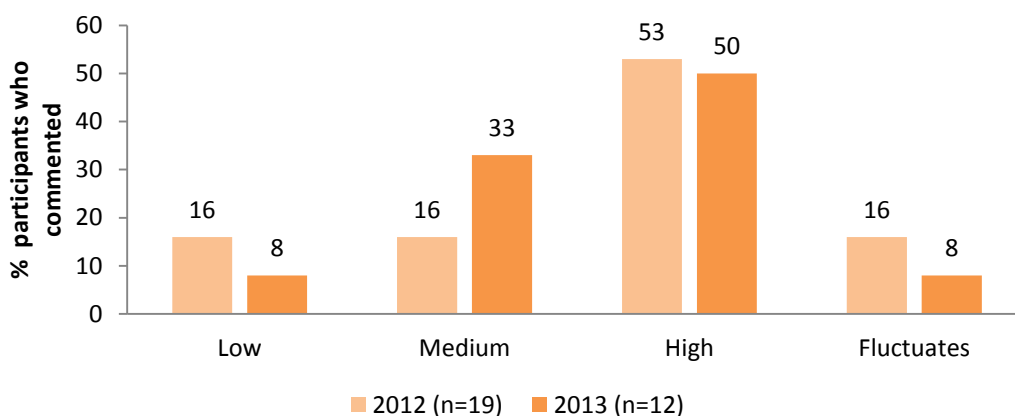
Weight	Price per unit
1 point	\$50–150
1 gram 'weight'	\$180–500
1/8 ounce (3.5 grams) / 'eight ball'	\$600–1,100
1 ounce (28 grams)	\$4,000
1 pound (454 grams )	\$45,000–90,000

Source: Australian Crime Commission (ACC, 2013)

### 5.2.2 Purity

Half of the participants who commented perceived speed powder to be of high purity in the previous six months, which is similar to reports in 2012 (Figure 27).

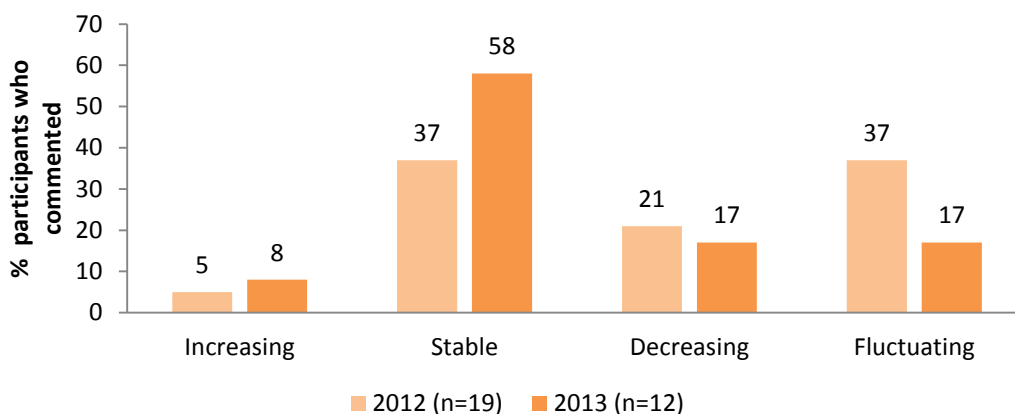
**Figure 27: Perception of speed powder purity in previous six months, 2012 and 2013**



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

The purity of speed powder was generally reported to be stable (Figure 28).

**Figure 28: Perceived changes in purity of speed powder, 2012 and 2013**



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

Crystal/ice was reported as being of high purity by half of those who commented (n=8). Reports about changes in purity during the previous six months were inconsistent (n=7).

Table 23 shows that in the financial year 2011–12 Queensland Police Service (QPS) made fourteen seizures of often low purity speed powder and base (range 0.2–38.5%); whereas the Australian Federal Police (AFP) made nine seizures but of higher purity (range 2.9–83.5%; ACC, 2013).

**Table 23: Median purity of amphetamine seizures analysed in Queensland by police, 2007–08 to 2011–12**

	2007–08		2008–09		2009–10		2010–11		2011–12	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
<b>QPS</b>	22	5.7	38	2.0	20	1.2	56	0.8	<b>14</b>	<b>1.5</b>
<b>AFP</b>	5	8.7	6	7.8	2	18.6	5	14.3	<b>9</b>	<b>69.1</b>

Source: Australian Crime Commission (ACC, 2013)

Table 24 shows the purity of the numerous methylamphetamine seizures by QPS was 34.2% (Range 0.1–79.3%) in the financial year 2011-12. The seven AFP seizures ranged in purity from 6.3% to 80.3% (ACC, 2013).

**Table 24: Median purity of methylamphetamine seizures analysed in Queensland by police, 2007–08 to 2010–11**

	2007–08		2008–09		2009–10		2010–11		2011–12	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
<b>QPS</b>	1,649	11.9	2,002	11.9	1,568	6.8	1,884	13.9	<b>1,694</b>	<b>34.2</b>
<b>AFP</b>	0	0	0	0	1	18.8	3	31.7	<b>7</b>	<b>76.2</b>

Source: Australian Crime Commission (ACC, 2013)

### 5.2.3 Availability

The availability of speed powder was commonly considered easy (as it was in 2012) but in 2013 a third considered it to be difficult (Table 25).

**Table 25: Availability of speed powder, 2012 and 2013**

	Speed powder %	
	2012 (n=19)	2013 (n=12)
<b>Current availability</b>		
Very easy	26	<b>8</b>
Easy	58	<b>58</b>
Difficult	11	<b>33</b>
Very difficult	5	-
<b>Change in availability</b>		
More difficult	22	<b>33</b>
Stable	56	<b>58</b>
Easier	-	<b>8</b>
Fluctuating	22	-

Note: Totals may not add to 100% because of rounding

Source: QLD EDRS participant interviews

Seven of the eight people who commented on the current availability of crystal/ice reported that it was readily available; the other participant reported it as very difficult. Availability was generally reported as stable.



#### 5.2.4 Source and locations of use

Table 26 presents information about the sourcing of speed powder. For all forms of methamphetamine, friends were the most common source person, followed by a known dealer. The most common source location was a dealer's house.

**Table 26: Most recent source person and location for speed powder obtained in the preceding six months, 2012 and 2013**

	Speed powder %	
	2012 (n=18)	2013 (n=11)
<b>Source person</b>		
Friend	67	55
Known dealer	28	36
Acquaintance	6	9
Unknown dealer	-	-
Other	-	-
<b>Source location</b>		
Home	22	18
Friend's house	44	18
Dealer's house	17	36
Nightclub	6	9
Private party	11	-
Agreed public location	-	9
Pub/bars	-	9

Note: Those choosing 'don't know' and 'haven't recently obtained' were excluded from analysis

Totals may not add to 100% because of rounding

Source: QLD EDRS participant interviews

The most popular venue where participants got intoxicated on the most recent occasion using speed powder was at a nightclub or pub/bar, while crystal/ice was most often used at a friend's house.

#### 5.2.5 Comments from key experts

Key experts generally confirmed that the price for a point of crystal/ice was \$100. There was less consensus about the price of a gram with key experts providing ranges within \$400–\$1000. Speed was considered by some key experts to be sold more cheaply than ice (i.e. between \$50 and \$80 point). There were no reports about the price of base. Group buying was reported as common and that this occurred person-to-person rather than buying from the web. Forensic experts reported that about a third of methylamphetamine seizures were high quality crystals with only a small proportion being low quality.

## 5.3 Cocaine

### Key Points

- Price of cocaine remained stable at \$300 per gram.
- Most (73%) rated cocaine purity as medium.
- Mixed reports about availability of cocaine, with just over half reporting it as difficult or very difficult to obtain.
- Cocaine was commonly sourced from a friend at a friend's home, and generally consumed in a home environment.

In 2013, 13 participants answered questions about the cocaine market. Caution is needed when interpreting these data because of these low numbers.

#### 5.3.1 Price

When asked the price of cocaine on the most recent purchase, the median price for one gram of cocaine was reported to be \$300 (n=8, range \$250–300). This is similar to previous years. The median price per point of cocaine was reported to be \$70 (n=3, range \$70–100).

In 2013, as in 2012, the price of cocaine in the preceding six months was mostly rated as stable (Table 27).

**Table 27: Changes in prices of cocaine in preceding six months, 2012 and 2013**

	2012 (n=13) %	2013 (n=11) %
Increasing	23	9
Stable	62	73
Decreasing	-	9
Fluctuating	15	9

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

Source: EDRS QLD participant interviews

Reports on price were in keeping with prices reported by the Australian Crime Commission (ACC, 2013) for 2011–12. The ACC (2013) reported that one gram of cocaine was \$300–\$400.

#### 5.3.2 Purity

The current purity of cocaine was commonly rated at medium strength (Table 28).

**Table 28: Perception of cocaine purity in previous six months, 2012 and 2013**

	2012 (n=14) %	2013 (n=11) %
<b>Current purity</b>		
Low	29	<b>18</b>
Medium	14	<b>73↑</b>
High	57	<b>9</b>
Fluctuates	-	-
<b>Change in purity</b>	n=13	n=9
Increasing	15	-
Stable	38	<b>33^</b>
Decreasing	-	<b>22^</b>
Fluctuating	46	<b>44^</b>

^ Small numbers reported; interpret with caution (n<10)

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

Totals may not add to 100% because of rounding

Source: QLD EDRS participant interviews

The purity of cocaine seized in Queensland and analysed is presented in Table 29. Queensland Police Service (QPS) seizures ranged in purity from 0.7–83.3%, and Australian Federal Police (AFP) seizures ranged from 26.2 to 82.3% (ACC, 2013).

**Table 29: Median purity of cocaine seizures analysed in Queensland, 2007–08 to 2011–12**

	2007–08		2008–09		2009–10		2010–11		2011–12	
	n	%	n	%	n	%	n	%	n	%
<b>QPS</b>	133	35.2	214	28.1	257	30.1	126	19.8	<b>125</b>	<b>18.7</b>
<b>AFP</b>	6	84.6	6	41.7	3	53.7	21	76.2	<b>9</b>	<b>66.0</b>

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

Recent availability of cocaine appears to be similar to last year (Table 30). About 50% respondents considered availability to have been stable in the previous six months.

**Table 30: Availability of cocaine in previous six months, 2012 and 2013**

	2012 %	2013 %
<b>Current availability</b>	<b>(n=14)</b>	<b>(n=13)</b>
Very easy	29	15
Easy	36	31
Difficult	29	46
Very difficult	7	8
<b>Change of ease of access</b>	<b>(n=15)</b>	<b>(n=11)</b>
More difficult	27	-
Stable	53	55
Easier	7	27
Fluctuates	13	18

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

Friends remained the most common source person for cocaine on the most recent occasion participants used, and the most common source location was at a friend's house (Table 31).

**Table 31: Most recent source and location for obtaining cocaine, 2012 and 2013**

	2012 (n=15) %	2013 (n=12) %
<b>Persons scored from</b>		
Friends	73	58
Known dealers	20	17
Acquaintances	7	25
Work colleagues	7	-
<b>Location scored from</b>		
Own home	20	25
Friend's home	60	50
Nightclub	-	8
Agreed public location	7	8
Pub/bar	13	-
Dealer's home	-	8

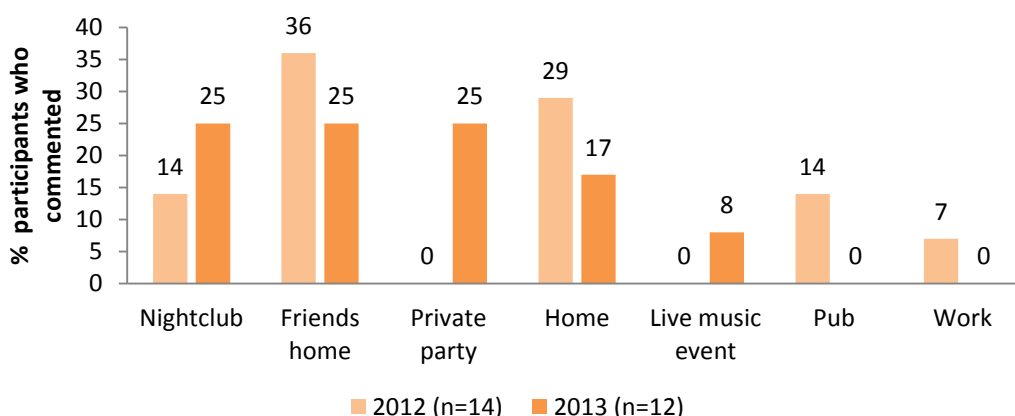
Note: Those choosing 'haven't recently obtained' were excluded from analysis

Totals may not add to 100% because of rounding

Source: QLD EDRS participant interviews

Participants were most likely to report using cocaine at a nightclub, a friend's home or at a private party on the most recent occasion they used cocaine in the previous six months (Figure 29).

**Figure 29: Location of most recent cocaine use, 2012 and 2013**

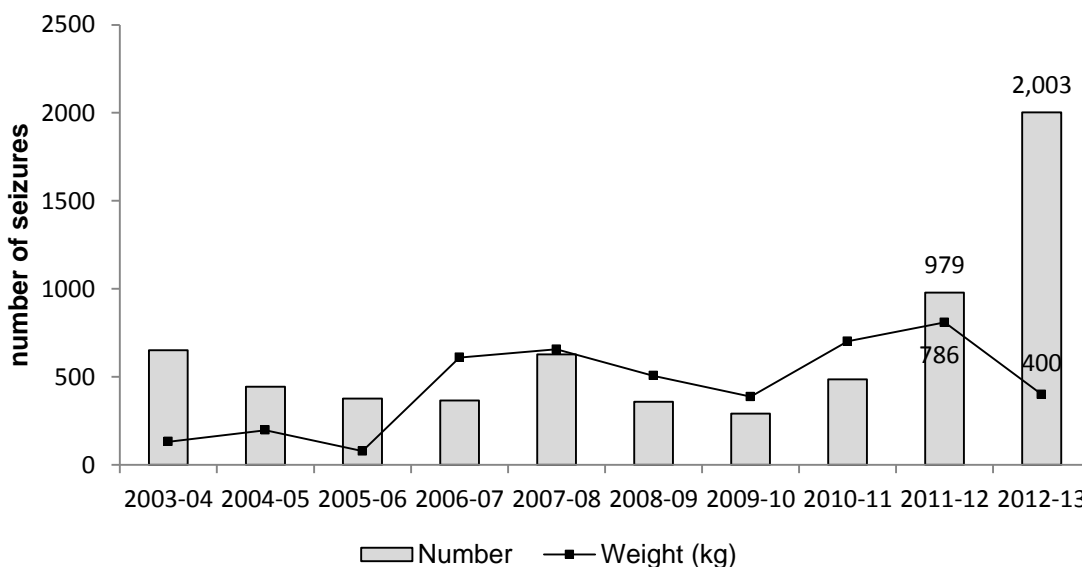


Source: QLD EDRS participants interviews

### 5.3.5 Cocaine seizures

Figure 30 shows the weight and number of cocaine detections by the Australian Customs and Border Protection Service at the Australian border over the last decade. In 2012–13 the number of seizures was double the previous year; however, the total weight of seizures was 400 kg compared with 786 kg in 2011–12.

**Figure 30: Number and weight of cocaine detections at the Australian border, 2003–04 to 2012–13**



Source: Australian Customs and Border Protection Service (ACS) Annual Report 2012–13

## 5.4 Ketamine

In 2013, two participants answered questions on the price and purity of ketamine. One gave the most recent price paid as \$150 per gram and the other \$180 per gram. Both rated purity as high.

## 5.5 GHB

In 2013, only one participant reported on the GHB market. The most recent price paid was \$5 per ml, which is similar to previous years.

## 5.6 LSD

### Key Points

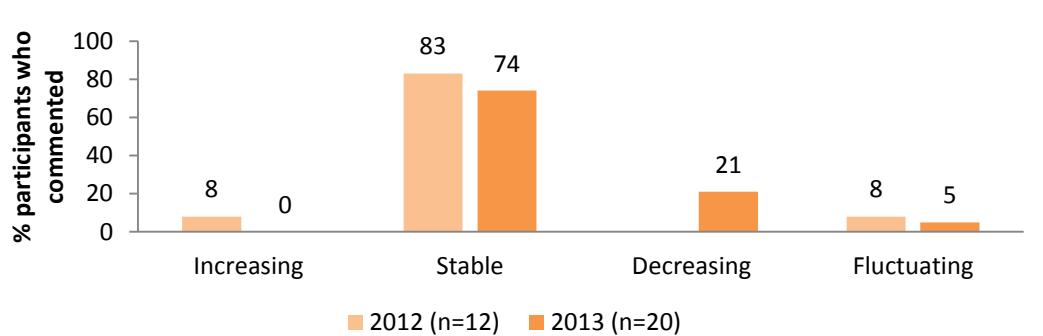
- Median price per tab of LSD was \$22.50, with most rating price as stable.
- Four in five rated LSD purity as medium or low.
- Two-thirds reported availability as easy or very easy.

Of the total sample, 20 participants (23%) were able to answer questions about the LSD market.

### 5.6.1 Price

In 2013, the median price per tab of LSD was \$22.5 which was similar to previous years (n=20, range \$8–30). Price was generally reported as stable (Figure 31).

**Figure 31: Change in price of LSD in preceding six months, 2012 and 2013**

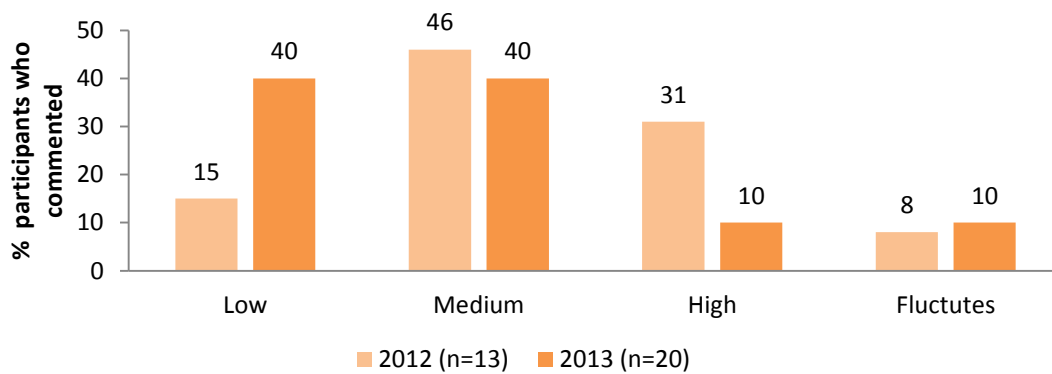


Note: Those choosing 'don't know' were excluded from analyses  
Source: QLD EDRS participant interviews

### 5.6.2 Purity

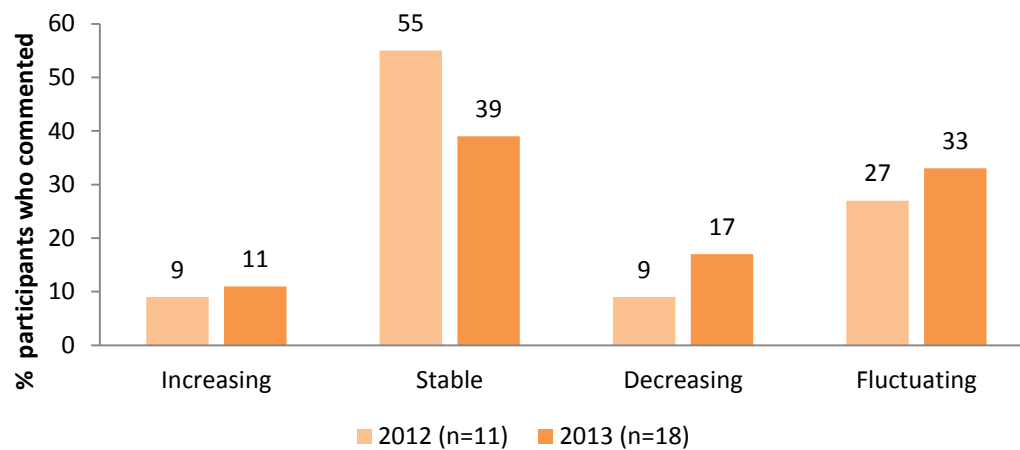
The purity of LSD was mostly rated low or medium by participants (Figure 32), with no clear consensus about recent changes (Figure 33).

**Figure 32: Purity/strength of LSD in preceding six months, 2012 and 2013**



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

**Figure 33: Changes in purity/strength of LSD in preceding six months, 2012 and 2013**

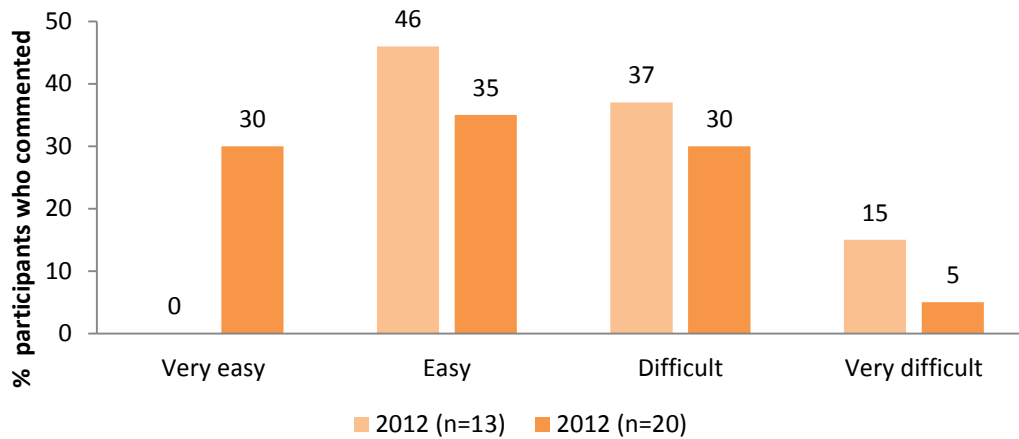


Note: Those choosing 'don't know' were excluded from analyses  
 Source: QLD EDRS participant interviews

### 5.6.3 Availability

Availability of LSD appears to have increased, with nearly a third reporting it was very easy to obtain compared with none in 2012 (Figure 34).

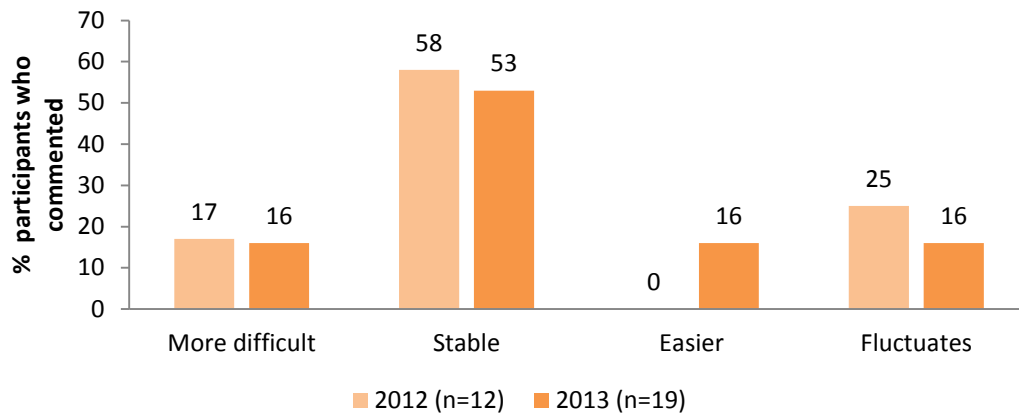
**Figure 34: Availability of LSD in preceding six months, 2012 and 2013**



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

Just over half considered that availability had recently been stable with the remainder varying in their response (Figure 35).

**Figure 35: Changes in availability of LSD in preceding six months, 2012 and 2013**



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

#### **5.6.4 Source and locations of use**

Friends remained the most common source person for obtaining LSD, and a friend's home was the most common source location (Table 32).



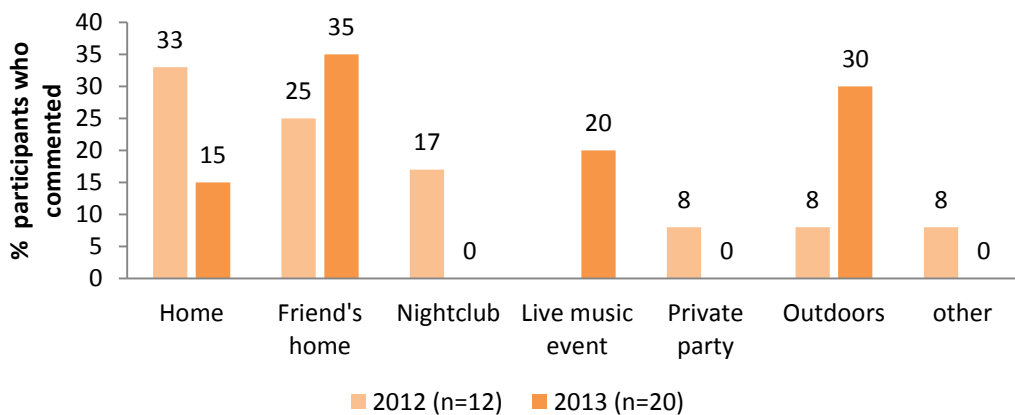
**Table 32: Source person and location for obtaining LSD most recent time, 2012 and 2013**

	2012 (n=12) %	2013 (n=20) %
<b>Source person</b>		
Friends	58	50
Dealers (known/unknown)	33	30
Acquaintances	-	20
Other	8	-
<b>Location sourced from</b>		
Own home	-	5
Friend's home	58	40
Nightclub	8	-
Agreed public location	-	15
Dealer's home	17	25
Other	17	15

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

On the most recent occasion participants reported using LSD, the most common location where they were intoxicated was at a friend's home followed by outdoors (Figure 36).

**Figure 36: Location of most recent LSD intoxication, 2012 and 2013**



Source: QLD EDRS participant interviews

### 5.6.5 Comments from key experts on the hallucinogen market

Forensic experts reported that strength of LSD was increasing following a number of years when strength was very low.

## 5.7 Cannabis

### Key Points

- The price of hydro and bush was reported as stable, with a gram of hydro costing a median of \$25 and bush \$10.
- The strength of both hydro and bush was generally rated as medium or high.
- Cannabis was generally sourced from a friend or known dealer at their home.

In 2013, 63% participants reported they could distinguish between bush and hydro cannabis, with 56% reporting they were able to comment on the hydro market and 45% reporting they could comment on the bush cannabis market. Three participants were able to answer about the price of hash, and no one was able to comment on hash oil.

### 5.7.1 Price

In 2013, only three participants reported purchasing hash in the previous six months. Prices per gram were diverse (\$30, \$50, \$100).

The price of both hydro and bush cannabis appear to have remained stable, with hydro continuing to be a little more expensive than bush with a median price of \$268 per ounce for most recent purchase, compared with \$235 per ounce of bush (Table 33 and Figure 37).

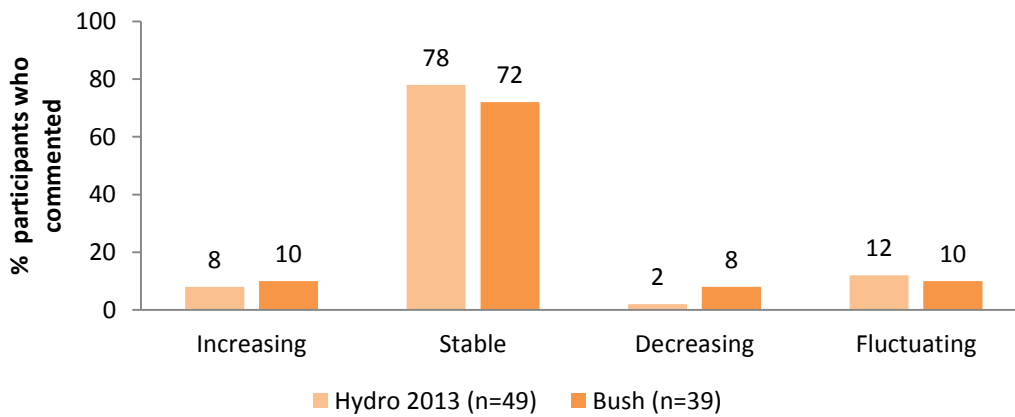
**Table 33: Cannabis prices according to type and amount recently purchased, 2012 and 2013**

	2012 Median (range)	2013 Median (range)
<b>Hydro</b>		
Gram	\$20 (10–20)	<b>\$25 (15–40)</b>
Quarter ounce	\$90 (70–100)	<b>\$90 (30–100)</b>
Ounce	\$280 (80–450)	<b>\$268 (150–320)</b>
<b>Bush</b>		
Gram	\$10 ^	<b>\$10 (10–15) ^</b>
Quarter ounce	\$80 (70–90)	<b>\$75 (30–90)</b>
Ounce	\$250 (60–300)	<b>\$235 (130–285)</b>

Note: ^ denotes that <10 participants commented, hence findings must be interpreted with caution

Source: QLD EDRS participant interviews

**Figure 37: Price changes of cannabis in preceding six months, 2013**

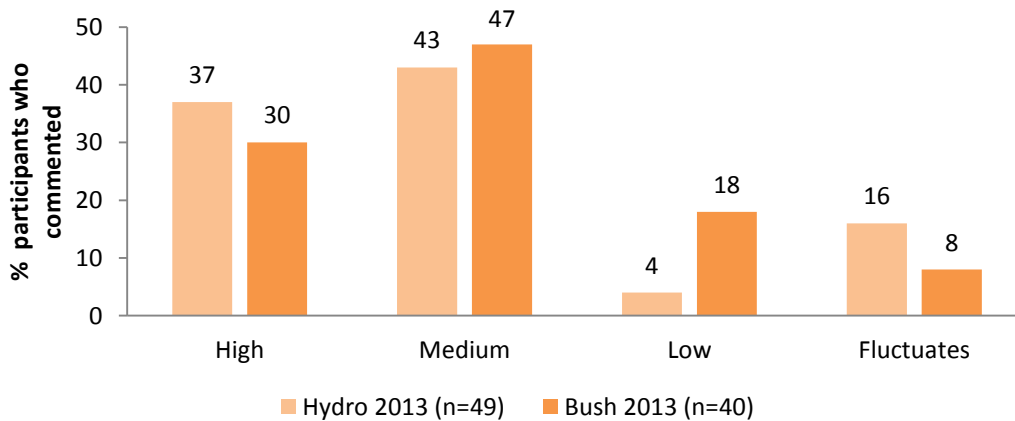


Note: Those choosing 'don't know' were excluded from analyses  
 Source: QLD EDRS participant interviews

### 5.7.2 Purity

Figure 38 shows that the perceived purity/strength of both hydro and bush cannabis was largely medium or high as was the case in 2012.

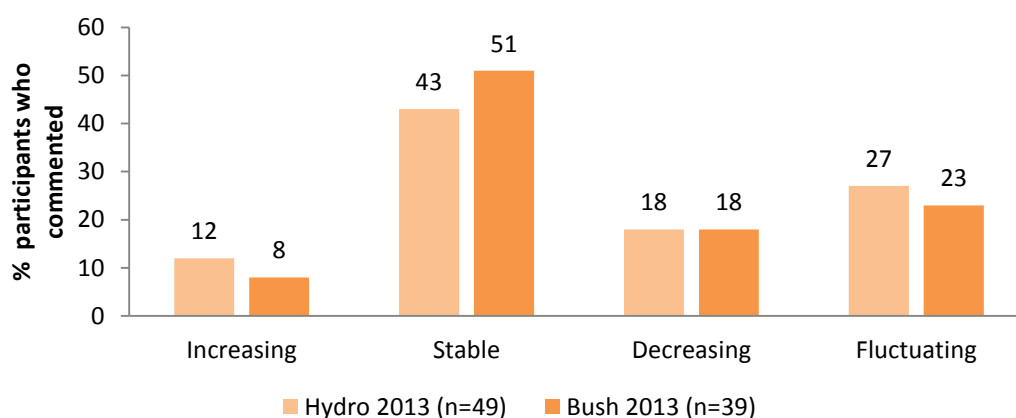
**Figure 38: Perception of cannabis purity in preceding six months, 2013**



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

Figure 39 shows that the purity of cannabis was most commonly reported as stable but a sizeable proportion reported it as fluctuating for both hydro and bush.

**Figure 39: Perceived change in recent purity of cannabis, 2013**



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

### 5.7.3 Availability

In 2013, bush cannabis was more likely to be reported as very easy to obtain than in 2012 ( $p < 0.05$ ), while hydro was less likely to be reported as very easy to obtain ( $p < 0.05$ ) (Table 34).

**Table 34: Availability of cannabis in preceding six months, 2012 and 2013**

	Hydro		Bush	
	2012 (n=41) %	2013 (n=49) %	2012 (n=24) %	2013 (n=40) %
<b>Current ease of access</b>				
Very easy	73	<b>47</b> ↓	13	<b>50</b> ↑
Easy	20	<b>39</b>	25	<b>33</b>
Difficult	7	<b>14</b>	50	<b>18</b> ↓
Very difficult	-	-	13	-
<b>Change in availability in last six months</b>				
	(n=39)	(n=48)	(n=23)	(n=40)
More difficult	17	<b>33</b>	26	<b>15</b>
Stable	71	<b>52</b>	48	<b>68</b>
Easier	7	<b>2</b>	4	<b>8</b>
Fluctuates	5	<b>13</b>	22	<b>10</b>

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

Arrow symbol signifies a significant difference  $p < 0.05$

Totals may not add to 100% because of rounding

Source: QLD EDRS participant interviews

### 5.7.4 Source and locations of use

Friends remained the most likely 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 35).

**Table 35: Source person and location of most recent cannabis purchase, 2012 and 2013**

	Hydro		Bush	
	2012 (n=41) %	2013 (n=48) %	2012 (n=23) %	2013 (n=40) %
<b>Score person</b>				
Friend	66	<b>48</b>	74	<b>50</b>
Known dealer	27	<b>46</b>	17	<b>33</b>
Acquaintances	7	<b>4</b>	9	<b>5</b>
Unknown dealer	-	<b>2</b>	4	<b>5</b>
Street dealer	-	-	-	<b>5</b>
Relative	-	-	-	<b>3</b>
<b>Score location</b>				
Home	20	<b>23</b>	26	<b>18</b>
Dealer's home	20	<b>40</b>	9	<b>35</b>
Friend's home	46	<b>31</b>	48	<b>33</b>
Agreed public location	5	<b>2</b>	4	<b>3</b>
Acquaintance's home	-	<b>2</b>	-	<b>3</b>
Street market	-	<b>2</b>	4	<b>8</b>
Other	2	-	4	<b>3</b>

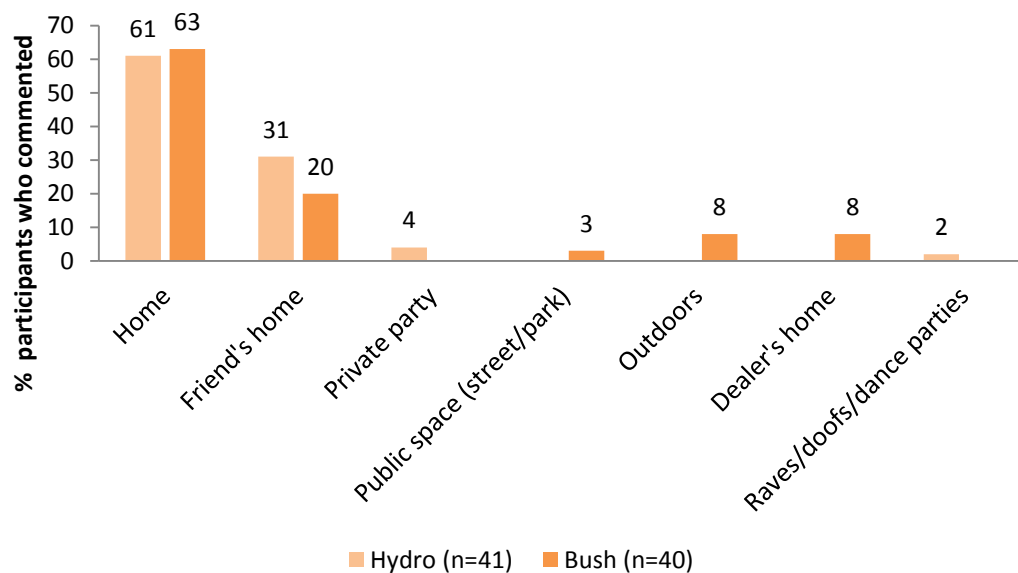
Note: Those choosing 'haven't obtained' were excluded from analyses

Totals may not add to 100% because of rounding

Source: QLD EDRS participant interviews

The participant's home remained the most common venue where both hydro and bush cannabis were used (Figure 40).

**Figure 40: Venue of most recent cannabis use, 2013**



Note: The category 'haven't used' is omitted

Source: QLD EDRS participant interviews

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

### Key Points

- 21% of participants had experienced an accidental stimulant-drug overdose in their lifetime, with 9% having overdosed in the previous twelve months.
- 18% experienced an accidental depressant-drug overdose in their lifetime, and 9% of these had overdosed in the previous twelve months.
- 83% had recently accessed a health service and three quarters of these accessed a GP
- 13% of all participants reported seeking help specifically about their drug and/or alcohol use: most had accessed a GP.
- 6% were currently in drug treatment.
- Drugs were reported as contributing to recurrent problems in four areas: increased risky behaviour (36%), difficulty meeting responsibilities (36%), social relationships (20%) and legal problems (9%).
- Drugs most often implicated in recurrent problems were cannabis, alcohol, and ecstasy.
- Almost two-thirds of participants recorded moderate to very high.

### 6.1 Overdose and drug-related fatalities

#### 6.1.1 *Non-fatal stimulant overdose*

In 2013, 21% of participants reported overdosing on a stimulant drug. The median number of times a participant reported overdosing in their lifetime was once (n=18, range 1–15 times).

Eight participants reported a non-fatal stimulant overdose in the previous twelve months. These participants were then asked about their most recent overdose. The venues where the overdose occurred included nightclubs, outdoors and live music events, followed by at home and at a restaurant/cafe. Half reported having a sober person present to assist them.

Reasons given for the overdose included consuming too much, and/or consuming a bad or adulterated pill. The main drug attributed to the overdose were: ecstasy, crystal meth, MDA, speed powder, 2CE, ketamine, legal high, and an adulterated pill used in conjunction with LSD.

The median number of hours participants reported partying before the overdose was three (n=8, 1–24 hours). Five out of the eight participants reported that the overdose had occurred on a particularly ‘heavy night out’ compared to a ‘normal night out’.

### **6.1.2 Non-fatal depressant overdose**

In 2013, 18% of participants reported experiencing at least one non-fatal depressant overdose in their lifetime. The median number of times this had occurred was 2.5 times (n=16, range 1–30 times).

Six participants reported a non-fatal depressant overdose in the previous twelve months, and were then asked about the most recent overdose. Four reported that alcohol was the main drug attributable to the overdose; one attributed it to benzodiazepines and the other to cannabis.

Half reported being at a friend’s house when they overdosed. The others sites were at home, at a private party, and in a car. Five of the six participants reported a sober person was present to assist them.

The most common main symptom experienced was loss of consciousness, followed by suppressed breathing and memory loss.

The median number of hours participants reported partying prior to the overdose was 10 (n=6, range 2–48 hours). Three out of the six participants reported that the overdose occurred on a ‘heavy night out’ compared to a ‘normal night out’.

### **6.1.3 Queensland Ambulance Service**

Figures from the Queensland Ambulance Service (2013) are shown for people coded as having a drug overdose and where the primary drug was recorded in Table 36.

In the 2012–13 financial year, 9,616 people were attended to for a drug overdose. As in previous years, the most common drug attributed to the overdose was alcohol, making up 43% of cases. Medications, antidepressants and benzodiazepines were the next most common.

**Table 36: Overdose cases attended by Queensland Ambulance Service where primary substance was recorded, 2009–10 to 2012–13**

Primary drug	2009–10	2010–11	2011–12	2012–13
Alcohol	3,629	3,813	3,950	<b>4,151</b>
Other medications	1,060	1,000	992	<b>1,026</b>
Antidepressants	766	661	641	<b>720</b>
Benzodiazepines	467	490	554	<b>613</b>
Unknown substance	322	320	351	<b>369</b>
Amphetamines	132	149	265	<b>282</b>
Cannabis	182	198	227	<b>251</b>
Heroin	242	285	281	<b>217</b>
Antipsychotics	228	208	221	<b>216</b>
Ecstasy	166	107	137	<b>212</b>
Inhalants	74	80	136	<b>180</b>
Other opiates (excl. heroin)	110	148	131	<b>179</b>
GHB	38	32	53	<b>119</b>
Cocaine	33	28	26	<b>42</b>
Methadone	39	34	32	<b>31</b>
Buprenorphine	5	2	3	<b>7</b>
Naltrexone	3	3	3	<b>1</b>
Other	880	799	860	<b>1,000</b>
<b>Total</b>	<b>8,376</b>	<b>8,357</b>	<b>8,863</b>	<b>9,616</b>

Source: Queensland Ambulance Service, 2013

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 previous six months for any issues related to their drug and/or alcohol use.

In 2013, the majority of participants (88%) reported not recently seeking help from a service or health professional in relation 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=77), 16% reported they had thought of doing so.

The reasons the 12 participants gave for not accessing services or professionals varied with two not wanting to stop drug use, and the remainder giving a range of individual reasons such as working it out on one's own, not having time, and fear of approaching a service.

In 2013, 13% of participants reported seeking help from a service or health professional for their drug and/or alcohol use in the previous six months. This was generally a GP, other doctors or a psychologist. The main drug participants were seeking help for was alcohol, followed by ecstasy and cannabis, as well as pharmaceutical stimulants, LSD, mushrooms and buprenorphine.

Among all participants, 83% reported accessing a service or health professional for any reason in the previous six months. Table 37 shows the main services accessed in the previous six months.

**Table 37: Main service accessed for any reason in the previous six months, 2013**

	2013 (n=73) %
GP (for any reason)	75
Emergency department	4
Outpatient hospital	1
Specialist doctor (not psychiatrists)	3
Dentist	6
Psychiatrist	1
Psychologist	3
Social/Welfare worker	1
Other doctors	4

Source: QLD EDRS participant interviews

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 (ADIS, 2013). The majority of calls to ADIS were about alcohol, followed by cannabis and amphetamines, with only a very small proportion about ecstasy (Table 38).

**Table 38: Number of calls to Alcohol and Drug Information Service (ADIS) according to drug type, 2010–11 to 2012–13**

Drug type	Calls		
	2010–11	2011–12	2012–13
Alcohol	5,871 (48%)	5,975 (42%)	<b>5,166 (32%)</b>
Cannabis	2,363 (19%)	2,456 (17%)	<b>2,167 (13%)</b>
Amphetamines	1,543 (13%)	1,913 (13%)	<b>2,020 (12%)</b>
Licit opioids	1,487 (12%)	1,752 (12%)	<b>1,503 (9%)</b>
Illicit opioids	849 (7%)	1,069 (7.5%)	<b>756 (5%)</b>
Benzodiazepines	845 (7%)	1,008 (7%)	<b>971 (6%)</b>
Cocaine	99 (1%)	80 (1%)	<b>134 (1%)</b>
Ecstasy	126 (1%)	120 (1%)	<b>76 (&lt;1%)</b>
Hallucinogens	48 (<1%)	44 (<1%)	<b>50 (&lt;1%)</b>
Other	2,831 (23%)	3,090 (22%)	<b>3,430 (21%)</b>

Note: This represents the number and percentage 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, 2013

When separated by age, the 25 to 34 year-old age group made the most number of calls for any drug. (Table 39). The age group most likely to make calls about ecstasy and hallucinogens was the 18 to 24 age group. Calls about alcohol were most common in the 35 to 44 year-old age group, whereas calls about benzodiazepines were most common among the 55 to 64 year-old age group.

**Table 39: Number of calls to Alcohol and Drug Information Service (ADIS) by drug type and age, Queensland 2012–13**

	0–17	18–24	25–34	35–44	45–54	55–64	≥65	Total
Alcohol	114	359	1096	1498	842	397	148	5,166
Cannabis	330	548	652	351	117	21	0	2,167
Amphetamines illicit	71	487	741	382	68	9	1	1,918
Amphetamines licit	4	23	36	20	7	0	0	102
Opioids illicit	13	60	260	195	46	6	1	756
Opioids licit	6	88	397	363	114	70	16	1,503
Benzodiazepine	15	67	204	197	114	245	35	971
Cocaine	4	16	25	17	9	0	0	76
Ecstasy	17	62	38	12	3	0	0	134
Hallucinogens	10	22	12	5	0	0	0	50
Other	85	395	673	494	259	851	40	3,430
<b>Total</b>	<b>740</b>	<b>2,127</b>	<b>4,134</b>	<b>3,534</b>	<b>1,579</b>	<b>1,311</b>	<b>257</b>	<b>16,273</b>

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, 2013

### 6.3 Drug treatment

Similar to previous years, only a small proportion of participants reported currently attending any form of drug treatment in 2013 (6%). Types of treatments included being prescribed buprenorphine, visiting a psychologist, quitting smoking, a probation course for cannabis diversion and being prescribed temazepam.

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

Participants were asked questions about recurrent drug-related problems they may have experienced in the previous six months.

In 2013, 36% reported having increased risky behaviour because of their drug use, and 36% reported having difficulty meeting responsibilities. Additionally, 20% reported a drug-related social problem and 9% reported having a drug related legal problem.

Alcohol, cannabis and ecstasy were the most likely drugs attributed to these recurrent problems (Table 40).

**Table 40: Primary drug contributing to recurrent problems within previous six months, 2013**

Main drug	Recurrent problems			
	Social/ relationship (n=26) %	Legal (n=8) %	Increased risky behaviour (n=32) %	Difficulty meeting responsibilities (n=32) %
Alcohol	23	25	43	28
Cannabis	50	63	11	28
Cocaine	4	-	7	-
Ecstasy	12	-	32	22
LSD	4	-	-	13
Speed powder	4	-	-	6
Other	4	13	8	3

'Other' includes MDA, 'other opiates' and 'other drug'

Source: QLD EDRS participant interviews

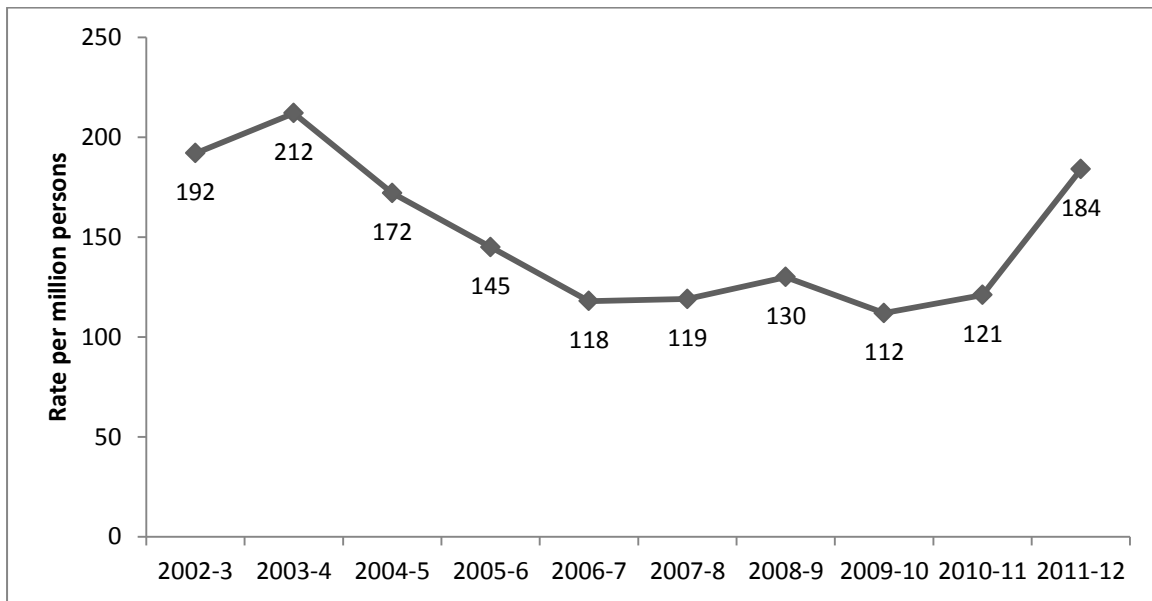
### 6.5 Hospital admissions

Data for hospital admissions was unavailable for 2012–13.

#### 6.5.1 Methamphetamine

In 2011–12, the number of inpatient hospital admissions in Queensland where the principal diagnosis related to methamphetamines was 466 for persons aged 15–54 years (i.e. 184 per million persons). As Figure 41 shows, the number of inpatient hospital admissions per million persons has risen from preceding years.

**Figure 41: Number of principal methamphetamine-related hospital admissions per million persons among people aged 15–54 years, Queensland, 2002–03 to 2011–12**

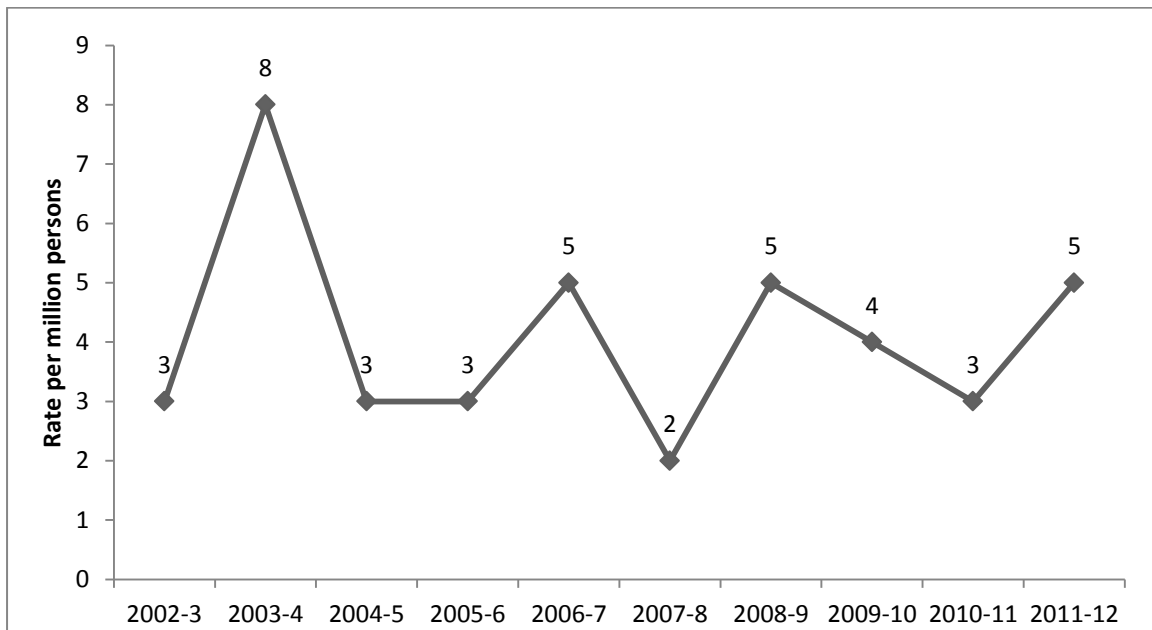


Source: Roxburgh and Burns, in press

### 6.5.2 Cocaine

Figure 42 shows the number of inpatient hospital admissions per million persons with a principal diagnosis relating to cocaine over the last decade. The number of admissions has remained consistently low.

**Figure 42: Number of principal cocaine-related hospital admissions per million persons among people aged 15–54 years, Queensland, 2002–03 to 2011–12**

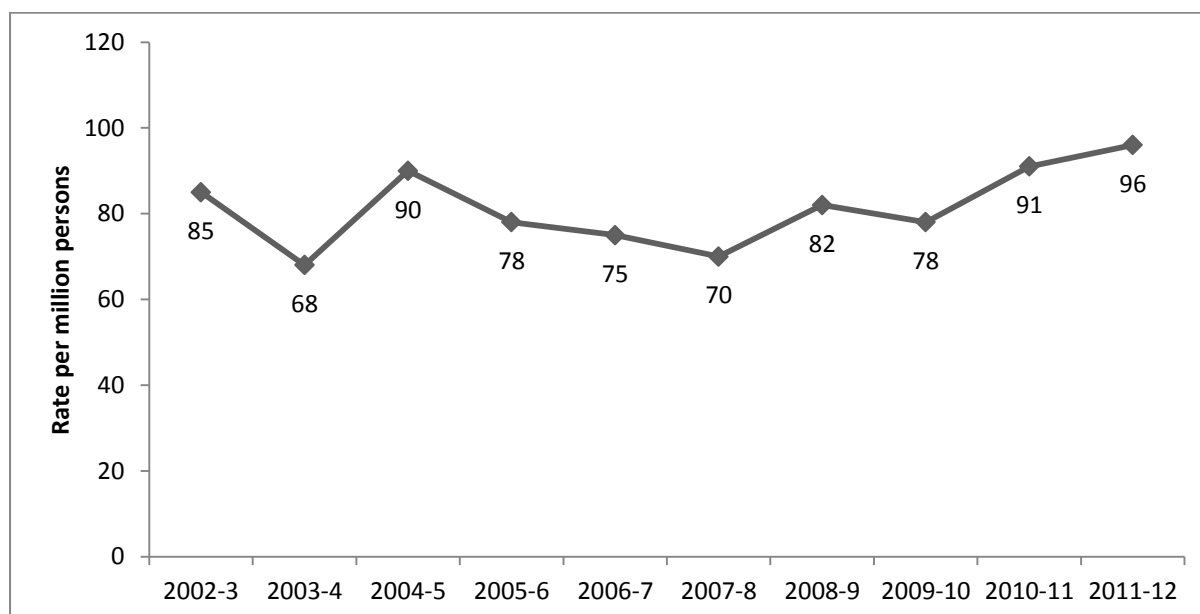


Source: Roxburgh and Burns, in press

### 6.5.3 Cannabis

In 2011–12, there were 243 inpatient hospital admissions in Queensland for those aged 15–54 years where the principal diagnosis related to cannabis. This equates to 96 inpatient hospital admissions per million persons (Figure 43). Admission numbers appear to be trending upwards.

**Figure 43: Number of principal cannabis-related hospital admissions per million persons among people aged 15–54 years, 2002–03 to 2011–12**



Source: Roxburgh and Burns, in press

## 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).

Less than two-thirds (63%) of participants who commented reported experiencing moderate to very high levels of distress in the previous month in 2013, compared to about three-quarters (74%) in 2012, though this difference was not statistically significant (Table 41).

**Table 41: K10 level of distress, 2012 and 2013**

	2012 (n=61) %	2013 (n=81) %
Low to no distress (0–15)	26	<b>37</b>
Moderate distress (16–21)	38	<b>27</b>
High distress (22–29)	21	<b>27</b>
Very high distress (30–50)	15	<b>9</b>

Source: QLD EDRS participant interviews

### 6.6.2 Self-reported mental problems and medication

In 2013 32% of participants reported having a mental health problem in the previous six months. Similar to previous years, depression and anxiety were the most common self-reported mental health problems (Table 42).

**Table 42: Self-reported recent mental health problems, 2009 to 2013**

	2009 (n=33) %	2010 (n=32) %	2011 (n=39) %	2012 (n=22) %	2013 (n=38) %
Depression	67	60	80	68	<b>61</b>
Anxiety	42	78	62	45	<b>61</b>
Panic	9	3	21	14	<b>18</b>
OCD	3	3	8	9	<b>11</b>
Manic depression/bipolar disorder	18	9	5	9	<b>8</b>
Paranoia	21	6	18	18	<b>4</b>
Drug-induced psychosis	15	3	3	14	<b>4</b>
Schizophrenia	9	6	8	9	-
Any personality disorder	-	-	5	9	-
Other	-	25	10	18	<b>20</b>

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'. In 2013, 'other' category includes 'other psychosis' and PTSD

Source: EDRS QLD participant interviews

Among those who self-reported recently having a mental health problem (n=28), half attended a health service or professional for this in the previous six month.

Of the fourteen participants who attended a health service or professional for a mental health problem in the previous six months, nine were prescribed medication (i.e. anti-depressants, antipsychotic, benzodiazepines, mood stabilisers).

## 7 RISK BEHAVIOUR

### Key Points

- 14% of participants had ever injected a drug, and 7% had injected in the last six months.
- Three quarters of participants reported having penetrative sex with casual partner/s in the past six months.
- 43% had not had a sexual health check-up in the last year.
- 10% had been diagnosed with a sexually transmitted disease during the past year.
- Of those who drove a vehicle in the last six months, 31% reported driving while over the alcohol limit, and 46% reported driving soon after taking illicit drugs.

### 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 2013, twelve participants reported ever injecting any drug at least once in their lifetime; this corresponds to 14% of the total sample. This is a significant decrease ( $p < 0.05$ ) from 29% in 2012 (Table 43).

**Table 43: Injecting risk behaviour, 2008 to 2013**

	2008 (N=108)	2009 (N=88)	2010 (N=101)	2011 (N=103)	2012 (N=62)	2013 (N=88)
Ever injected (%)	13	22	17	24	29	<b>14↓</b>
Median age first injected (range)	18 (15–43)	19 (14–30)	20 (14–29)	18 (14–28)	19 (13–43)	<b>18 (15–26)</b>
Injected last 6 months (%)	7	13	11	16	16	<b>7</b>

Source: EDRS QLD participant interviews

Participants reported first injecting a drug at a median age of 18 years which is similar to previous years.

Half of those who had ever injected used speed the first time. Others used steroids, cocaine, methamphetamine base, crystal/ice or adrenaline for their first injection.

### 7.1.2 Recent injectors

In 2013, six participants (7%) from the total sample reported injecting a drug in the previous six months, compared with 16% in 2012. Two had injected crystal/ice the most recent time, two steroids, one cocaine, and one speed. Four of the six had undertaken the injection in their own home, and two at a friend's home

Participants mostly reported injecting with close friends, with one person reporting usually injecting alone and another with acquaintances.

Needles were obtained from chemists, needle and syringe programs, and friends.

### 7.1.3 Injecting drug use in the general population

According to the most recent 2010 National Drug Strategy Household Survey (NDHS), 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 twelve months, 0.4% of Australians reported having injected illegally (AIHW, 2011).

Queensland Health Needle and Syringe Program supplied 8,221,400 syringes to their programs in the financial year 2012–13.

## 7.3 Sexual risk behaviour

### 7.3.1 Casual sex partners

Participants were asked whether they engaged in sexual behaviour with a casual sex partner. In 2013, 87 participants completed this section; of these 74% reported having had penetrative sex with at least one casual sex partner at least once in the previous six months. About two-thirds reported having one to two casual partners (Table 44).



**Table 44: Number of casual partners participants reported to have had penetrative sex with in previous six months, 2013**

	2013 (n=64) %
One person	36
Two people	31
3–5 people	25
6–10 people	3
More than 10 people	5

Source: EDRS QLD participant interviews

Of those who reported having penetrative sex with a casual sex partner in the previous six months (n=65), 89% reported having done so while under the influence of drugs. Table 45 shows that three-quarter of these participants reported doing so three times or more in the previous six months.

**Table 45: Reported number of times participants had penetrative sex with a casual sex partner while under the influence of any drug in the previous six months, 2013**

	2013 (n=58) %
Once	12
Twice	12
3–5 times	38
6–10 times	12
More than 10 times	26

Source: EDRS QLD participant interviews

Among those who had penetrative sex while under the influence of drugs (n=58), the most commonly reported drugs involved were ecstasy (62%), cannabis (52%) and alcohol (38%). Other drugs used were cocaine (21%), speed powder (10%), LSD (9%), amyl nitrate (3%), crystal/ice (3%), pharmaceutical stimulants (3%), mushrooms (3%), and nitrous oxide (2%).

When asked how often participants used condoms or other barriers when having sex with casual sex partners while under the influence of drugs, only 26% reported doing so every time (Table 46).

**Table 46: Frequency of condom or barrier use when having penetrative sex with a casual sex partner while under the influence of drugs, 2013**

	2013 (n=58) %
Every time	26
Often	21
Sometimes	12
Rarely	12
Never	29

Source: EDRS QLD participant interviews

When asked whether they had used a condom or barrier on the most recent occasion they had penetrative sex with a casual sex partner, 45% reported they had.

The most common reasons given for not using a condom or barrier on the most recent occasion were 'it wasn't mentioned' and 'using contraceptive pill'. Responses also included 'I didn't wish to use', 'we agreed not to', 'lack of availability' and 'other'.

### 7.3.2 Sexually transmitted infections

Among participants who commented, 42% reported having a sexual health check-up in the previous year, with 10% reporting they were diagnosed with an STI (Table 47). Among those who had been diagnosed with an STI (n=8), the most common diagnosis was chlamydia (7), with one diagnosis of a urinary tract infection and one of HPV genital warts.

**Table 47: STI check-ups, 2012 and 2013**

	2012 %	2013 %
<b>Had sexual health check-ups</b>	<b>(n=53)</b>	<b>(n=83)</b>
No	26	43
Yes, in the last year	40	42
Yes, more than one year ago	34	14
<b>Ever diagnosed with STI<sup>a</sup></b>	<b>(n=54)</b>	<b>(n=82)</b>
No	82	85
Yes, in the last year	4	10
Yes, more than one year ago	15	5

<sup>a</sup>among those who had a sexual health check-up

Note: Those who reported 'don't know' were excluded from the analysis

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 follow a similar pattern to previous years (Table 48).

**Table 48: Registered cases of blood-borne viruses and sexually transmitted diseases in Queensland, 2009 to 2013**

<b>Disease</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
Hepatitis B (newly acquired)	52	58	46	55	<b>43</b>
Hepatitis B (unspecified)	1,000	1,054	846	808	<b>900</b>
Hepatitis C (unspecified)	2,627	2,668	2,413	2,376	<b>2,503</b>
Syphilis — congenital	0	2	4	0	<b>1</b>
Syphilis <2 years	215	251	323	349	<b>259</b>
Syphilis >2 years	303	199	225	246	<b>278</b>
Chlamydial infection	16,695	19,217	18,645	18,852	<b>19,427</b>
Gonococcal infection	1,787	2,383	2,952	2,700	<b>2,727</b>

Source: National Notifiable Diseases Surveillance System (NNDSS), 2013

## 7.4 Driving risk behaviour

In 2013, 74% of participants reported driving a vehicle in the previous six months. Among these (n=65), 31% reported driving while over the limit of alcohol in the previous six months.

Among those who recently drove while over the limit (n=20), the mean number of times was three (range 1–10).

Among those who drove in the previous six months (n=65), 46% reported being randomly breath tested in the previous six months. Of these, two participants were over the limit when they were tested.

Among those who drove in the previous six months (n=65), 49% reported recently driving soon after taking any drug. The mean number of times was 20. The most common drug taken before driving was cannabis (72%), followed by ecstasy (38%). LSD, speed powder, cocaine, crystal/ice, mushrooms, and nitrous oxide were also used.

On the most recent occasion participants drove while under the influence of illicit drugs (n=32), most people reported using cannabis (69%), followed by ecstasy (22%), with smaller proportions using speed powder, cocaine, mushrooms, LSD, and nitrous oxide.

Among participants who drove while under the influence of illicit drugs in the previous six months (n=32), 40% reported they believed their driving was either quite or slightly impaired, while 29% reported it had been slightly or quite improved, with 31% reporting no impact.

In 2013, five participants reported being ever tested for drug driving, with two reporting being tested in the previous six months. One participant reported receiving a positive result from a roadside drug test.

Participants who drove in the previous six months were asked how many people would be caught out of the next 100 people who drove soon after taking illicit drugs. The median response was five people (n=63, range 0–90), with 18% responding that no one would get caught.

They were then asked how many times they thought they would drive after taking illicit drugs in the following six months (n=63), and 57% replied they would not. Among those who

replied that they would most probably drive after taking illicit drugs (n=28), the median number of times they expected to do this was five (range 1–180).

## 7.4 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).

Similar to the previous year, in 2013, 84% of participants had a score equal to or greater than 8, corresponding to drinking at levels which may be harmful to their health (Table 49). The mean score for the AUDIT was 16, corresponding to Zone II. There was no significant difference in AUDIT mean scores between males and females.

**Table 49: AUDIT results and recommended intervention, 2012 and 2013**

Zone (Score)	2012 (n=53) %	2013 (n=88) %	Intervention recommended
At risk (≥ 8)	83	84	-
<b>Zone</b>			
<b>I</b> (0–7)	17	16	Alcohol education
<b>II</b> (8–15)	40	35	Simple advice
<b>III</b> (16–19)	13	19	Simple advice plus brief counselling and continued monitoring
<b>IV</b> (20–40)	30	29	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

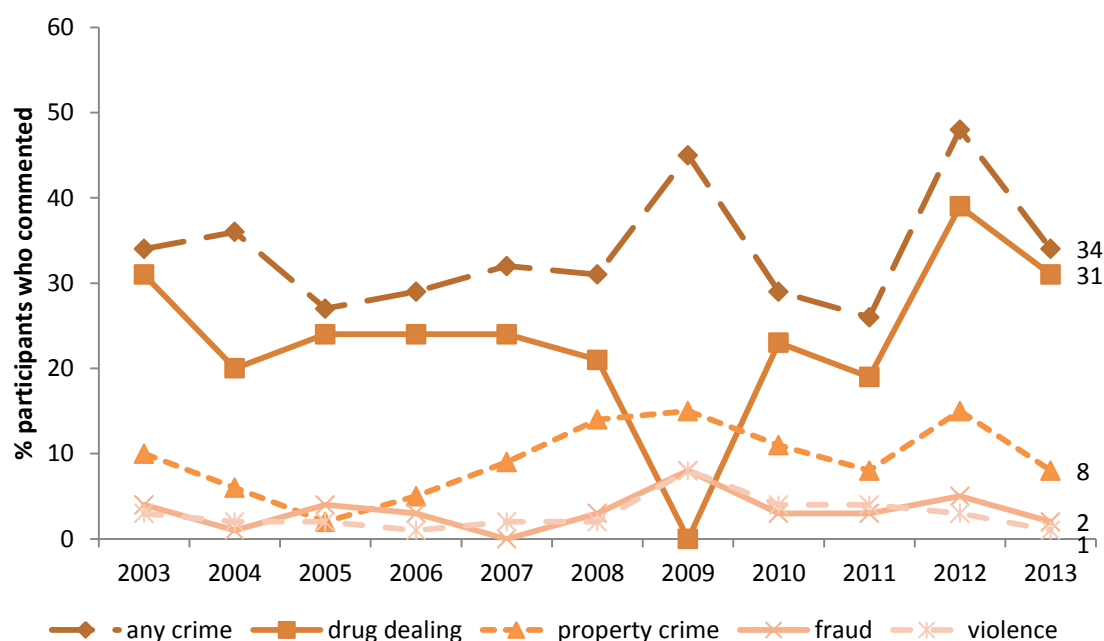
- One-third of all participants reported involvement in criminal activity (mainly drug dealing) in the past month.
- 9% had been arrested in the previous twelve months.

### 8.1 Reports of criminal activity among participants

Participants were asked questions about their recent involvement in criminal activity. In 2013, only one participant reported having been to prison in the previous twelve months. Eight participants reported having been arrested. The most common reason for arrest was a public order (drunk and disorderly) (n=5), followed by possession of drugs (n=2). Other reasons included dealing and trafficking of drugs (n=1) and driving under the influence of alcohol (n=1).

In 2013, 34% of all participants reported being involved in some form of criminal activity in the previous month (Figure 44). The most common type of crime was drug dealing (31% of all participants).

**Figure 44: Criminal activity in the last month, 2003 to 2013**



Source: EDRS QLD participant interviews

## 8.2 Arrests

Police data from the 2011–12 financial year shows that there was a total of 26,463 drug related arrests, with cannabis being the most common drug attributed to the arrest (Table 50).

**Table 50: Drug-related arrests by Queensland Police Service by drug type, 2011–12**

	Consumer	Provider	Total
Cannabis	15,690	2,043	17,773
Amphetamine type stimulants	3,671	517	4,188
Other and unknown	2,901	657	3,558
Heroin and other opioids	248	66	314
Steroids	236	60	296
Cocaine	163	19	182
Hallucinogens	156	38	192
<b>Total</b>	<b>23,065</b>	<b>3,398</b>	<b>26,463</b>

Note: Consumer = use, possession or administering for own use; Provider = importation, trafficking, selling, cultivation and manufacture.

Source: Australian Crime Commission, 2013

Table 51 shows the number and type of drug seizures by state and federal police. Cannabis continues to be the most seized drug, both in number and weight.

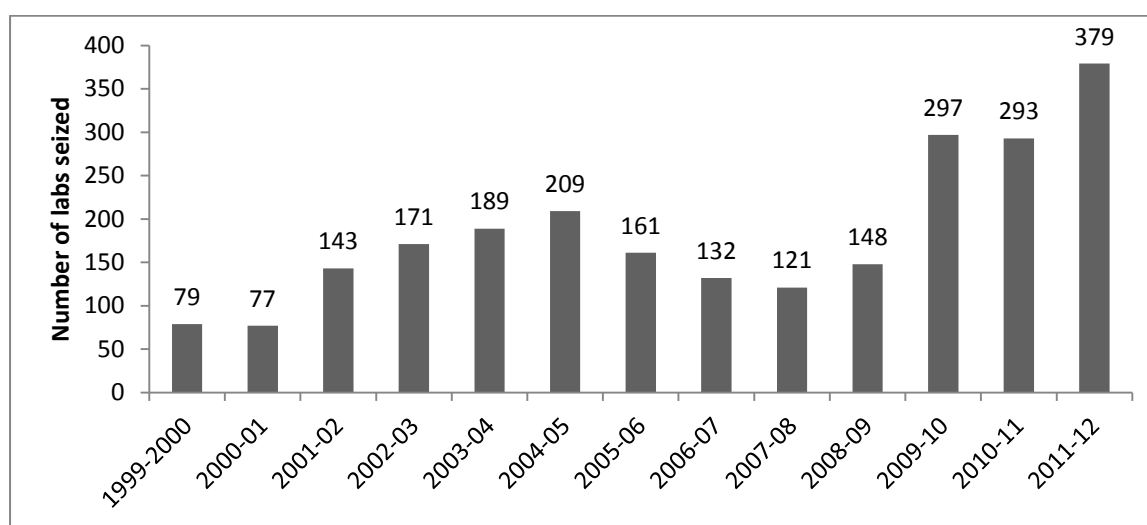
**Table 51: Queensland drug seizures by police service and drug type, 2011–12**

	Police Force	No of seizures	Weight (grams)
Cannabis	QPS	18,205	802,618
	AFP	81	5,735
Amphetamine type stimulant	QPS	3,307	25,217
	AFP	43	16,049
Heroin	QPS	223	927
	AFP	4	62
Other opioids	QPS	6	5
	AFP	0	0
Cocaine	QPS	154	8,442
	AFP	17	286,321
Steroids	QPS	26	65
	AFP	2	151
Hallucinogens	QPS	16	176
	AFP	5	45
Other and unknown drugs	QPS	1,158	105,296
	AFP	34	29,981

Note: Includes only those seizures for which a drug weight was recorded. No adjustment has been made for double counting data from joint operations between the Australian Federal Police and Queensland Police Service  
Source: Australian Crime Commission, 2013

Nationally, a total of 809 clandestine labs were detected in the 2011–12 financial year. In Queensland there were 379 detections, the highest number detected in a financial year, and the highest number across all states and territories (Figure 45). However the Australian Crime Commission (ACC) reported that about 90% of detections in Queensland were addict-based labs. Data for 2012–13 was unavailable at the time of publication.

**Figure 45: Clandestine labs seized in Queensland from 1999–2000 to 2011–12**



Source: Australian Crime Commission, 2013

## 9 SPECIAL TOPICS OF INTEREST

### Key Points

- 61% of all participants had friends who had injected drugs.
- 28% had been offered drugs to inject in the previous 12 months.
- Among those who had never injected any drugs (n=76), 13% were seriously considering it.
- The majority of participants reported no or very few symptoms of ecstasy dependence.

### 9.1 Exposure to injecting

Interviews with key experts, conducted as part of the 2012 EDRS, identified that there could be an increasing number of young people injecting as a route of administration. Key experts reported that they have noticed an increasing number of young people presenting to emergency services with injection-related problems, indicating that in addition to an increase in young people injecting, there could be a lack of awareness around safe injecting practices. While rates of injecting drug use among EDRS samples have traditionally been extremely low, identifying risk of injecting could have important harm reduction implications, particularly in relation to education around blood-borne viruses and safe injecting practices.

The aim of this module was to investigate the risk of injecting drug use among people who regularly use ecstasy-type substances by: (a) identifying the level of exposure to injecting; (b) investigating attitudes toward the practice of injecting drugs; and (c) investigating beliefs around the likelihood of injecting a drug in the future.

Participants were asked what proportion of their friends had ever injected any drugs: 61% reported they knew 'a few' friends had injected drugs, with 36% reporting having no friends who had ever injected drugs.

Among participants who reported knowing at least one person who had ever injected any drug (n=55), most reported that this was a friend or acquaintance (87%), with few reporting it was a family member (6%) or partner (4%); 44% reported that a friend had injected around them at least once in their lifetime.

In 2013, 28% of all participants reported being offered drugs to inject in the previous twelve months.

Among participants who had never injected any drug (n=76), 13% reported seriously considering doing so, and 87% never seriously considering it. When asked why they had not considered injecting any drug, the main reasons given were concerns about dependence, having a fear of needles, and injecting not being their preferred route of administration. Other reasons included the social stigma around injecting, using non-injectable drugs, concerns about blood-borne viruses, and not knowing how to inject.



Among participants who had never injected any drugs (n=76), the main reason participants would consider injecting drugs was out of curiosity, to get high/have fun, and to get a stronger effect; though 71% reported they believed there was no reason for them to consider ever injecting any drug.

Participants were asked to rate how likely they would be to inject drugs in the future on a scale of one to ten (1=extremely unlikely, 10=extremely likely). Among those who had never injected any drug (n=76), 80% reported it would be extremely unlikely for them to inject drugs in the future, with only 1% indicating that it would be extremely likely.

## 9.2 New psychoactive substances (NPS) health module

In 2013, participants were asked about the health effects of NPS however numbers were too low in the Queensland sample for any meaningful analysis. Please see the national report for more details.

## 9.3 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 (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 2013, participants 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 2013, 22% of participants scored three or more (24% in 2012).

When using the more conservative estimate of four or more, which has been used previously in the literature as a validated cut-off for methamphetamine dependence (Bruno, et al., 2009; Topp & Mattick, 1997), only 9% of participants scored four or more, which was significantly lower than the 23% in 2012 ( $p < 0.05$ ).

In 2013, 42% of participants had a score of zero, corresponding to no symptoms of ecstasy dependence. Cumulatively, 60% obtained a score of one or less. The median SDS score was 1 (n=88; range 0–8). Thus, the majority of participants report very few or no symptoms of ecstasy dependence (Table 52).

**Table 52: Symptoms of ecstasy dependence in previous six months, 2012 and 2013**

	2012 (N=62) %	2013 (N=88) %
<b>Ever think use of ecstasy was out of control</b>		
Never/almost never	73	71
Sometimes	22	24
Often	5	5
Always/nearly always	-	1
<b>Prospect of missing a dose makes you feel anxious or worried</b>		
Never/almost never	78	80
Sometimes	19	18
Often	3	2
Always/nearly always	-	-
<b>Worry about your use of ecstasy</b>		
Never/almost never	59	55
Sometimes	41	44
Often	-	1
Always/nearly always	-	-
<b>Wish you could stop</b>		
Never/almost never	73	85
Sometimes	14	10
Often	7	5
Always/nearly always	7	-
<b>How difficult to stop or go without</b>		
Not difficult	78	88
Quite difficult	17	13
Very difficult	5	-
Impossible	-	-

Source: QLD EDRS participant interviews

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## APPENDIX

Due to the significant age difference between 2012 and 2013 in the QLD EDRS samples, additional analysis was conducted on a selection of drug consumption patterns that were found to be significantly different between 2012 and 2013. Data from 2012 and 2013 was combined to increase numbers, and was tested for age differences, using a 25 year age cut-off. The findings are presented below.

### Appendix 1: Summary of significant age differences in drug consumption patterns for 2012 and 2013 combined.

	Under 25 years (n=102)	25 years and over (n=48)	
Ecstasy as main drug of choice (%)	41	23	p<0.05
Speed as main drug of choice (%)	3	15	p<0.05
Mean age of first ecstasy use (years)	17	20	p<0.05
Ever injected any drug (%)	10	42	p<0.05
Ever used heroin (%)	6	29	p<0.05
Ever used 'other' licit opioids (%)	13	33	p<0.05
Ever used crystal/ice (%)	31	67	p<0.05
Recent use of crystal/ice (%)	21	46	p<0.05
Ever used speed powder (%)	66	90	p<0.05
Ever used base methamphetamine (%)	17	56	p<0.05
Recent use of mushrooms (%)	36	10	p<0.05
Ever used prescribed antidepressants (%)	24	40	p<0.05
Ever used amyl nitrate (%)	36	58	p<0.05
Ever used nitrous oxide (%)	53	56	NS
Ever used licit pharmaceutical stimulants (%)	5	13	NS
Recent use of illicit pharmaceutical stimulants (%)	37	21	p<0.05

Source: QLD EDRS participant interviews