Queensland

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QUEENSLAND TRENDS IN ECSTASY AND RELATED DRUG MARKETS 2014
Findings from the Ecstasy and Related Drugs Reporting System (EDRS)

Australian Drug Trend Series No. 144

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Queensland Alcohol and Drug Research and Education Centre

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Please note that as with all statistical reports there is the potential for minor revisions to data in this report over its life. Please refer to the online version at www.ndarc.med.unsw.edu.au.

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ABBREVIATIONS

ACC	Australian Crime Commission
ACBPS	Australian Customs and Border Protection Service
ADIS	Alcohol and Drug Information Service
AFP	Australian Federal Police
AGDH	Australian Government Department of Health
AIHW	Australian Institute of Health and Welfare
AUDIT	Alcohol Use Disorder Identification Test
DMT	dimethyltryptamine
EDRS	Ecstasy and Related Drugs Reporting System
GHB	gamma hydroxybutyrate acid ('fantasy')
GP	general practitioner
HPV	human papiloma virus
IDRS	Illicit Drug Reporting System
K10	Kessler Psychological Distress Scale
LSD	lysergic acid diethylamide
MDA	3,4-methylenedioxyamphetamine
MDMA	3,4-methylenedioxymethylamphetamine ('ecstasy')
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NNDSS	National Notifiable Diseases Surveillance System
NPS	new psychoactive substances
NSP	Needle and Syringe Program
NSW	New South Wales
PDI	Party Drugs Initiative
PMA	paramethoxyamphetamine
QADREC	Queensland Alcohol and Drug Research and Education Centre
QLD	Queensland
QPS	Queensland Police Service
RPU	regular psychostimulant user
SDS	Severity of Dependence Scale
STI	sexually transmitted infection
WHO	World Health Organization
2CB	4-bromo-2,5-dimethoxyphenethylamine
2CC	2,5-dimethoxy-4-chlorophenethylamine
2CI	4-Iodo-2,5-dimethoxyphenethylamine

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 (i.e. a shot)
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 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 conducted every year in the capital city of every state and territory in Australia. Interviews are conducted with people from the general population who regularly use ecstasy and other illicit psychostimulant drugs. The EDRS is designed to identify emerging trends among a sentinel group of drug users, and to inform the health and law enforcement sectors about patterns of drug use, drug markets, relevant health issues, and other special areas of interest.

In 2014, 100 regular psychostimulant users (RPU) were recruited for the Queensland EDRS. Characteristics were largely similar to previous years (i.e. typically male, heterosexual, from an English-speaking background, and had completed secondary school). Although the mean age of the 2014 sample was older than in 2013 (25 years compared with 22 years in 2013; $p<0.001$), it was similar to earlier years (e.g. 26 years in 2012). There was also a significant increase in current unemployment (from 8% in 2013 to 21% in 2014; $p<0.05$), and an increase in participants with a trade/technical qualification (from 18% in 2013 to 32% in 2014; $p<0.05$).

Consumption trends

Current drug use

Ecstasy remained the drug of choice among participants, though there was a decrease in the proportion of participants reporting ecstasy as their drug of choice (from 46% in 2013 to 29% in 2014; $p<0.05$), with an increase in preference for LSD (from 6% in 2013 to 16% in 2014; $p<0.05$). Fewer participants reported alcohol as the drug most used in the previous six months (from 26% in 2013 to 9% in 2014; $p<0.05$). Aside from tobacco, the most common drugs used recently were alcohol, cannabis, ecstasy and LSD. Most participants reported using ecstasy and related drugs fortnightly, though one-third reported using weekly or more. Injecting remained rare among this sample. Binging behaviour (i.e. using drugs for 48 hours or more without sleep) was reported by 39% of all participants in the previous six months.

Ecstasy use

All participants reported using a form of ecstasy/MDMA at least once in their lifetime. The mean age of first ecstasy use increased from 17 years in 2013 to 19 years in 2014 ($p<0.05$).

Nearly all (94%) reported using some form of ecstasy/MDMA in the previous six months. The most common form was ecstasy pills (81%), with the proportion recently using pills significantly lower than in 2013 ($p<0.05$). However, there was an increase in recent MDMA crystal use (45% compared with 23% in 2013; $p<0.05$). Ecstasy was mainly swallowed, sometimes snorted, and rarely smoked, shelved/shafted or injected.

When last using ecstasy, three-quarters of participants also used another drug. The use of other drugs while coming down from ecstasy on the most recent occasion was reported by 57% of all participants. The most common drugs taken when coming down from ecstasy were cannabis and benzodiazepines. Among those who reported using drugs for 48 hours or more without sleep in the previous six months (n=39), 56% reported having used ecstasy on the most recent occasion.

Key experts reported very little change in ecstasy use.

Methamphetamine use

Almost three-quarters (72%) of all participants reported lifetime use of a form of methamphetamine, with 47% reporting recent use. Amphetamine powder (speed) remained the

type of methamphetamine most used in the previous six months, followed by crystalline methamphetamine (ice), and methamphetamine base. Lifetime and recent use of speed remained stable at 65% and 34% respectively. Lifetime use of base was reported by 24% of participants, with 8% reporting use in the previous six months. There was an increase in reports of lifetime use of ice from 26% in 2013 to 42% in 2014 ($p<0.05$). Recent use of ice remained stable at 26%. Frequency of use in the previous six months for ice increased from 3.5 days (i.e. less than monthly) in 2013 to 12 days (i.e. fortnightly) in 2014 ($p<0.05$).

Cocaine use

Lifetime and recent cocaine use remained stable at 75% and 42% respectively. Cocaine use remained low and occasional.

Ketamine use

Only 5% of participants had recently used ketamine and their use was infrequent. Lifetime use was reported by 29%.

GHB use

Lifetime use of GHB remained low, with only one-off use by three participants in the previous six months.

Hallucinogen use

There was an increase in the use of LSD. Lifetime use significantly increased from 63% in 2013 to 83% in 2014 ($p<0.05$). Recent use also increased from 41% in 2013 to 57% in 2014 ($p<0.05$). Frequency of use remained stable at a median of two days in the previous six months.
The median number of LSD tabs used in a typical session was one tab.

Over two-thirds reported lifetime use of hallucinogenic mushrooms, with one-quarter using them in the previous six months. Frequency of use remained occasional.

Cannabis use

The use of cannabis remained high and stable, with 87% reporting use in the previous six months. Frequency of use was estimated at twice a week. Cannabis was predominantly smoked, though it was also reported to be eaten and inhaled using a vaporiser.

Other drug use

The use of alcohol and tobacco remained high, frequent, and stable. MDA use was low and occasional. The prevalence of lifetime and recent use of licit and illicit anti-depressants remained stable. There was an increase in licit recent use of benzodiazepines, from 9% in 2013 to 21% in 2014 ($p<0.05$). Illicit use of benzodiazepines remained stable, as did the use of inhalants (i.e. amyl nitrate and nitrous oxide).

The use of heroin, methadone, buprenorphine and prescribed other opioids (e.g. morphine and oxycodone) remained low and stable, though there was an increase in illicit lifetime use of other opioids, with 42% reporting ever using other opioids not prescribed to them (i.e. illicit use) compared with 23% in 2014 ($p<0.05$).

There was an increase in licit lifetime use of pharmaceutical stimulants from 2% in 2013 to 12% in 2014 ($p<0.05$) whereas recent use of illicit pharmaceutical stimulants decreased, from 41% in 2013 to 22% in 2014 ($p<0.05$).

New psychoactive substances

In 2014, 58% reported using new psychoactive substances (NPS) and/or synthetic cannabis in the previous six months. The most common NPS used in the previous six months were NBOMe, 2CB and DMT. Lifetime and recent use of NBOMe has significantly increased from 2013, as well as lifetime use of 2CB, and DMT.

Drug market: Price, purity, availability and supply

Ecstasy market

Ecstasy pills remained the most common form of ecstasy/MDMA purchased in the previous six months. The median price per ecstasy pill remained stable at $25 per pill. Frequency of purchasing ecstasy decreased from fortnightly or less in 2013 to monthly or less in 2014. Almost half of participants who commented reported the purity (strength) of pills, powder and caps to be medium, with a significant decrease in reports that purity fluctuated (30% in 2013 compared with 12% in 2014; $p<0.05$). MDMA crystal was considered to be of much higher purity than pills, powder and caps. Ecstasy was most likely to have been bought from a friend at a friend's house the most recent time it was purchased.

Methamphetamine market

The price of speed remained stable at approximately $55 per point. It was rated to be of medium purity, and easy/very easy to obtain. The median price of base was estimated at $60 per point, and was perceived as difficult to access. A point of ice cost about $100 per point or $650 per gram. Ice was rated to be of medium/high purity and easy/very easy to obtain. Methamphetamine was most likely to have been sourced from a friend, at a friend's house.

Cocaine market

The median price of a gram of cocaine remained stable at $300. Among those who commented, 45% perceived cocaine as difficult/very difficult to obtain in the previous six months. A friend was the most common source person and a friend's house was the most common source location.

Ketamine market

Only one participant reported having purchased ketamine in the previous six months.

GHB market

Only one participant reported having purchased GHB in the previous six months.

LSD market

The price of LSD was reported as stable, with one tab of LSD costing approximately $20. There was an increase in those perceiving purity to be high (54% compared with only 10% in 2013; $p<0.05$). Three-quarters of participants who commented reported LSD to be easy or very easy to obtain, and that availability had remained stable. Participants were most likely to have obtained LSD from a friend at a friend's house.

Cannabis market

The median price for an ounce of hydro was $280, and $275 for bush, with prices perceived to have remained largely stable in the previous six months. Purity of both hydro and bush cannabis was rated at medium to high. Cannabis remained easy/very easy to obtain in the

previous six months. It was most often obtained from a friend, at a friend's house and was most often used at home.

Health-related trends associated with ecstasy and related drug use

In 2014, 27% reported overdosing on a stimulant drug at least once in their lifetime, with 15% reporting overdosing on a stimulant drug in the previous year. The most common stimulant drug attributed to an overdose in the previous year was ecstasy, followed by LSD.

A lifetime experience of an overdose on a depressant drug was reported by 24% of participants, with 9% experiencing a depressant overdose in the previous 12 months. The most common depressant drug attributed to an overdose in the previous year was alcohol.

The majority (86%) of participants reported not accessing a health service or professional related to their drug and/or alcohol use in the previous six months. Among those who did, the most common service accessed was a general practitioner (GP).

Drug treatment remained low in this sample with only 3% reporting they were currently in some form of treatment

Among all participants, 60% reported moderate to very high levels of psychological distress on the K10. Nearly a third (31%) self-reported a mental health problem in the previous six months. The most common mental health problems experienced were anxiety and depression, with 23% attending a health professional for mental health reasons in the previous six months.

Risk behaviour

There was a significant increase in reports of recent injecting, with 19% reporting injecting any drug in the previous six months compared with 7% in 2013 ($p<0.05$). The most common drug recently injected was ice, followed by speed and steroids.

Three in five participants reported having had penetrative sex with a casual sex partner in the previous six months. The most common drugs to have been used when having sex were alcohol and ecstasy, with alcohol use significantly increasing (from 38% in 2013 to 82% in 2014%; $p<0.05$) and cannabis use significantly decreasing (from 52% in 2013 to 32% in 2014; $p<0.05$).

Four out of five participants scored eight or higher on the Alcohol Use Disorder Identification Test (AUDIT), corresponding to drinking at levels which may be harmful to their health.

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

Prison history remained low (6%). Eighteen per cent of participants reported being arrested in the previous six months; the most common reasons for arrest were being in possession of drugs, followed by being a public nuisance. Drug dealing in the previous month was reported by 30% of participants.

Special topics of interest

In 2014, three extra modules were added to the EDRS.

The first module was about purchasing drugs online and using the dark web. Over two-thirds of participants (68%) reported they knew that at least a few friends had purchased drugs online,

with 22% reporting buying drugs online themselves. Online purchasing of drugs in the previous year was reported by 17% of participants. Silk Road was the most common online location for purchasing drugs, and the most common drugs purchased online were ecstasy, LSD and cannabis. Motivations for buying online were a cheaper price, higher quality of drugs and convenience.

The second module was about the health risks and harms of NPS, though numbers are too low to report on jurisdictional differences.

The third module included perceptions of the legality of certain NPS. Most participants perceived the possession of 2CB, 2CI, DMT and mephedrone to be illegal in Queensland (which it is), though there was a sizable proportion who were uncertain. The legal status of NPS was reported to not impact NPS use among the majority of participants. Motivations for using NPS were price, and high quality and purity of drugs compared with ecstasy and related drugs.

1 INTRODUCTION

The Ecstasy and Related Drugs Reporting System (EDRS) is an annual, national study funded by the Australian Government Department of Health and co-ordinated 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 PDI commenced as a national study in 2003 and was re-named the EDRS in 2006. The current report presents the findings of the 13th 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

A triangulation method was used to combine information collected from:

- quantitative interviews with current, regular ecstasy and other psychostimulant 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

In Australia, the ecstasy market has existed for over two decades. Throughout this report, 'ecstasy' refers to drugs that are alleged to contain 3, 4-methylenedioxymethylamphetamine (MDMA). Excluding the misuse of pharmaceutical drugs, ecstasy is the second most prevalent illicit drug after cannabis, with 2.5% of the Australian population aged 14 years and over having used ecstasy in the previous 12 months (AIHW, 2014).

Until 2013, EDRS participants were required to be regular ecstasy users; however, due to difficulty with recruitment in some of the smaller jurisdictions, the nationwide EDRS criteria were broadened to include regular psychostimulant users (i.e. people who had used any ecstasy or related drug on at least six separate occasions over the last six months). Participants are now termed regular psychostimulant users (RPU).

A sentinel sample of 100 current, regular users of substances sold as 'ecstasy' or other psychostimulants was recruited between April and June 2014 from the greater Brisbane, Gold Coast and Sunshine 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; and drug-policy.

2.1.1 Recruitment of participants

As in previous years, purposive sampling was used to recruit participants using advertisements in local street press, websites (e.g. pillreports.ru) and posters in public places (e.g. shops and universities). Snow-balling techniques (i.e. word-of-mouth) were also used.

Recruitment advertisements explained that current regular ecstasy users and other psychostimulant users were being recruited to undertake a face-to-face survey lasting approximately one hour. They were made aware that if eligible, they would be reimbursed $40 for their time and expenses in completing the questionnaire. Upon completion of the interview, participants were asked to mention the study to friends who might be willing and able to participate. This is a method often used to access illicit drug user populations (Dalgarno, 1996; Ovendon & Loxley, 1996).

Selection criteria for participation in the EDRS were:

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

The 2014 Queensland EDRS recruited a total of 100 participants. The majority of participants were recruited using the traditional criterion of using ecstasy at least once a month in the past

six months, while 26 participants were recruited with the new criterion of using any illicit psychostimulant at least six times in the previous six months (compared with seven in 2013).

2.1.2 Procedure

Interested individuals inquired about participating in the survey via telephone, SMS or email. 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 that responses would be de-identified to protect confidentiality. The nature and purpose of the study was explained to participants before consent was obtained.

2.1.3 Measures

Questions in the interview covered a range of topics including 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 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 2013 and 2014, and when found to be significant at the $p<0.05$ level (using Excel spreadsheet available at http://www.cebm.net/index.aspx?o=1023, or t-tests for comparison of means), this was stated within the report. Other proportional differences observed between 2013 and 2014 may represent sampling variability only.

2.2 Survey of key experts

During August and September, 11 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. The duration of the interviews ranged from 30 minutes to one hour.

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 2014, the following data were obtained for the EDRS:

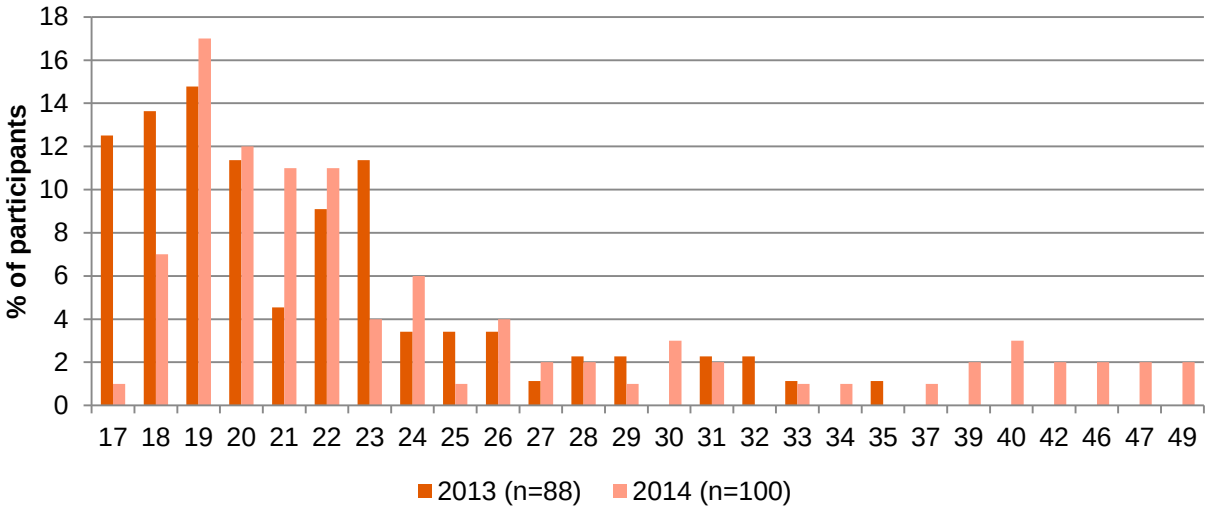
- Australian Crime Commission (ACC) — number and purity of drug seizures from Queensland Police Service (QPS) and the Australian Federal Police (AFP); Queensland clandestine laboratory seizures and drug-related arrests
- Australian Customs and Border Protection Service (ACBPS) — number and weight of 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 (NNDSS) — registered cases of blood-borne viruses (BBVI) and sexually transmitted infections (STIs).

3 DEMOGRAPHICS

3.1 Overview of the EDRS sample

The 2014 EDRS sample in Queensland was older than in 2013 (Figure 1). The mean age increased from 22 years in 2013 to 25 years in 2014 ($p<0.001$), which was similar to earlier years (26 years in 2012 and 25 years in 2011).

Figure 1: Distribution of participants' age, 2013 and 2014



Source: QLD EDRS participant interviews

Table 1 shows demographic characteristics of the 2014 sample. Compared with 2013, in 2014 there was a significant increase in the proportion of participants reporting current unemployment and having a trade/technical qualification ($p<0.05$). However, it is unknown whether these increases related to the older age of the sample. All other characteristics remained similar to previous years. Two-thirds of participants were male, and the majority were of English-speaking background, living in rental accommodation, and had completed year 12.

The mean weekly income was estimated at $451 (n=97, range $1.54–2000). In 2014, 52% of all participants reported their main source of income in the previous months was from a wage or salary, with 33% reporting it was from a government pension, allowance or benefit (i.e. Centrelink), and 11% reported it was from a parental allowance. Three participants reported they received no income in the previous months and one participant reported criminal activity was their main source of income.

Table 1: Demographic characteristics, 2013 and 2014

	2013 (N=88)	**2014 (N=100)**
Mean age (range)	22 (17–35)	**25 (17–49) ↑**
% Male	64	**67**
% English speaking background	96	**96**
% Aboriginal and/or Torres Strait Islander	1	**-**
% Sexual orientation		
Heterosexual	92	**82**
Gay male	2	**3**
Lesbian female	-	**2**
Bisexual	6	**11**
Other	-	**2**
% Relationship status		
Married/de facto	3	**10**
Regular partner	33	**41**
Single	61	**49**
Divorced/separated/widowed	2	**-**
% Accommodation		
Own house/flat	7	**5**
Rented house/flat	58	**66**
Parents'/family home	32	**27**
Boarding house/hostel	3	**-**
No fixed address	-	**1**
Education		
Mean years of school education	12	**12**
% Completed Year 12 or equivalent	84	**84**
% University/college qualifications	16	**17**
% Trade/technical qualifications	18	**32↑**
% Employment status		
Not employed	8	**21↑**
Full time	15	**17**
Part time/casual	19	**14**
Full time student	30	**17**
Part time student	1	**-**
Work and study	25	**31**
Other	2	**-**
Income		
Mean weekly income	$420	**$451**

Note: Arrow symbol signifies a significant difference between 2013 and 2014 ($p<0.05$). Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

4 CONSUMPTION PATTERN RESULTS

Key points

- Ecstasy remained the drug of choice among participants, although there was a decrease in reports of ecstasy as drug of choice, and an increase in preference for LSD.
- Fewer participants reported alcohol was the drug most used in previous six months.
- Alcohol, cannabis, ecstasy and LSD had the highest prevalence of recent use.
- Most reported using ecstasy and related drugs fortnightly, though one-third reported using weekly or more.
- Injecting remained rare among this sample.

4.1 Drug use history and current drug use

4.1.1 Drug history

Participants were asked about lifetime and recent use of drugs, as well as age of first use, frequency of use in the previous six months, and route of administration (ROA) (Table 2).

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. In 2014:

- 15 participants reported shelving/shafting ecstasy pills in their lifetime, with six in the previous six months
- two participants reported shelving/shafting MDMA crystal, speed, base and ice, but not in the previous six months
- one participant reported shelving/shafting pharmaceutical stimulants not prescribed to them in their lifetime but not in the previous six months
- one participant reported shelving/shafting over-the-counter codeine but not in the previous six months.

Table 2: Drug use history, 2014

Form of drug	Use				Route of administration %							
					Injected		Smoked		Snorted		Swallowed	
	Ever %	Mean age first used[a]	Recent[b] %	Days[c]	Ever	Recent[b]	Ever	Recent[b]	Ever	Recent[b]	Ever	Recent[b]
Ecstasy pills	97	19	81	6	9	1	11	1	60	34	96	80
Ecstasy powder	60	20	36	3	5	2	7	-	41	18	45	29
Ecstasy capsules	79	20	53	3	1	-	3	-	24	18	77	52
MDMA crystals	63	21	45	4	4	1	10	1	39	28	50	39
Amphetamine powder (speed)	65	19	34	5	14	9	14	7	40	13	46	19
Methamphetamine base	24	21	8	8	11	7	11	2	7	1	14	2
Crystalline methamphetamine (ice)	42	24	26	12	17	13	28	15	16	6	19	7
Pharmaceutical stimulants (licit)	12	18	3	8	2	-	2	-	3	1	10	2
Pharmaceutical stimulants (illicit)	57	21	22	2.5	4	1	1	-	13	8	53	19
Cocaine	77	21	42	2	11	6	6	3	72	40	13	5
LSD	83	19	57	2	3	-	-	-	1	-	83	57

[a] Calculated for those who reported lifetime use
[b] In the preceding six months
[c] 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, 2014 (continued)

Form of drug	Use				Route of administration %							
					Injected		Smoked		Snorted		Swallowed	
	Ever %	Mean age first used[a]	Recent[b] %	Days[c]	Ever	Recent[b]	Ever	Recent[b]	Ever	Recent[b]	Ever	Recent[b]
MDA	31	21	17	2	1	-	-	-	3	1	31	17
Ketamine	29	22	5	2	6	2	-	-	17	4	13	2
GHB[d]	16	29	3	1	-	-					16	3
Amyl nitrate	35	20	6	1.5								
Nitrous oxide	54	20	26	5								
Cannabis	98	16	87	48			97	86			76	33
Alcohol	98	14	97	48	4	-					95	95
Heroin	17	21	3	4	13	3	9	2	10	-	3	-
Methadone	10	23	2	6.5	8	1	-	-	-	-	9	2
Buprenorphine	8	26	2	26	4	1	1	-	-	-	4	-
Other opioids (licit)	15	34	10	12	3	2	2	1	1	-	15	8
Other opioids (illicit)	42	23	18	5.5	12	4	3	1	7	3	35	13

[a]Calculated for those who reported lifetime use
[b]In the preceding six months
[c]Median days in the preceding six months (180 days) among those who did use
[d]Includes GBL, 1,4B, 9GBH, 'liquid e', and 'fantasy'
Note: Responses are for the name given to the drug when it was obtained (i.e. regardless of actual content).
Source: QLD EDRS participant interviews

Table 2: Drug use history, 2014 (continued)

Form of drug	Use				Route of administration %							
					Injected		Smoked		Snorted		Swallowed	
	Ever %	Mean age first used[a]	Recent[b] %	Days[c]	Ever	Recent[b]	Ever	Recent[b]	Ever	Recent[b]	Ever	Recent[b]
Over-the-counter codeine[e]	31	20	13	6	-	-	-	-	1	-	31	13
Tobacco	89	15	71	180								
Antidepressants (licit)	29	23	12	180	-	-	-	-	1	1	28	11
Anti-depressants (illicit)	14	19	4	27	-	-	-	-	1	1	14	4
Benzodiazepines (licit)	29	26	21	44	2	-	-	-	1	-	29	21
Benzodiazepines (illicit)	62	22	37	5	4	-	-	-	2	1	61	37
Mushrooms	68	19	25	1	-	-	-	-	-	-	68	25
Over-the-counter stimulants (illicit)	17	22	1	10	-	-	-	-	1	-	17	1
Steroids	7	19	3	8	6	3	-	-	-	-	1	-

[a]Calculated for those who reported lifetime use
[b]In the preceding six months
[c]Median days in the preceding six months (180 days) among those who did use
[e]Other than for pain relief
Note: Responses are for the name given to the drug when it was obtained (i.e. regardless of actual content).
Source: QLD EDRS participant interviews

4.1.2 Drug of choice and drug most used

Compared with 2013, there was a significant decrease in participants reporting ecstasy as their main drug of choice in 2014, with an increase in participants selecting LSD (p<.05, Table 3).

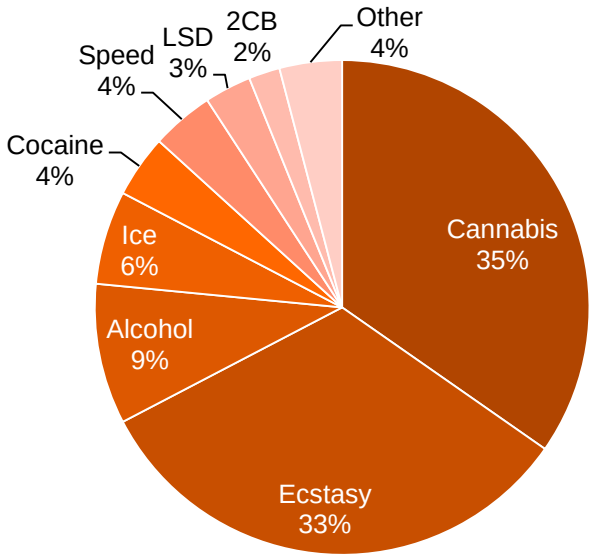
Table 3: Drug of choice, 2013 and 2014

Drug of choice	2013 (N=88) %	2014 (N=100) %
Ecstasy	46	**29↓**
Cannabis	19	**20**
Cocaine	10	**16**
Alcohol	10	**3**
LSD	6	**16↑**
Speed	2	**2**
Heroin	2	**4**
Crystalline methamphetamine (ice)	2	**3**
2CB	-	**2**
Other*	2	**5**

Note: 'Other' includes DMT, methamphetamine base, ketamine, pharmaceutical stimulants and oxycodone.
Arrow signifies a statistical difference between 2013 and 2014 (p<0.05).
Source: QLD EDRS participant interviews

Figure 2 shows that cannabis and ecstasy were the drugs used most often in the previous six months, followed by alcohol and crystalline methamphetamine (ice). Compared to 2013, there was a significant decrease in alcohol being reported as the drug most used (26% to 9%, p<0.05).

Figure 2: Drug used most often in previous six months, 2014



Note: 'Other' includes 'Adderall', benzodiazepines, nitrous oxide and methamphetamine base.
Source: QLD EDRS participant interviews

4.1.3 Prevalence of ecstasy and related drug use

Frequency of use of ecstasy and related drugs remained stable from 2013 (Table 4). In 2014, 34% reported using weekly or more often.

Table 4: Frequency of ecstasy and related drug use during previous month, 2013 and 2014

	2013 (N=88) %	**2014 (N=100) %**
Not in the last month	8	**8**
Monthly	22	**21**
Fortnightly	44	**37**
Weekly	17	**20**
More than once per week	8	**11**
Once a day	1	**1**
More than once a day	-	**2**

Source: QLD EDRS participant interviews

4.2 Ecstasy use

Key points

- Mean age of first ecstasy use increased to 18.3 years ($p<0.05$).
- Ecstasy as drug of choice decreased ($p<0.05$).
- Recent use of ecstasy in pill form decreased ($p<0.05$).
- MDMA crystal use increased, with 45% using it in the previous six months ($p<0.05$).
- Ecstasy was mainly swallowed, sometimes snorted, and rarely smoked or injected.
- The most recent time participants used ecstasy, three-quarters also used another drug.
- 57% reported using other drugs when coming down from ecstasy (e.g. cannabis and benzodiazepines).
- 39% reported using drugs for 48 hours or more without sleep in the previous six months.
- Key experts reported very little change in ecstasy use.

4.2.1 Patterns of ecstasy use among regular psychostimulant users

Table 5 presents reported patterns of ecstasy use among the 2014 sample.

All participants reported using some form of ecstasy at least once in their lifetime. The mean age of first use of ecstasy significantly increased from 17.3 years in 2013 to 18.5 years in 2014 ($p<0.05$), though this may be due to the significantly higher number of 17 year-old participants in the 2013 sample. Pills were the most common form of ecstasy ever used, with lifetime use reported by 97% of all participants. Lifetime use was reported as: ecstasy caps 79%, MDMA crystal 63%, and ecstasy powder 60%.

Most participants (94%) reported using some form of ecstasy in the previous six months. The most common form was ecstasy pills, used by 81% of all participants.

Compared with 2013, fewer participants reported ecstasy as their drug of choice in 2014 ($p<0.05$).

The median number of ecstasy pills used in a 'typical' session remained at two. Among those who reported using ecstasy pills in the previous six months (n=81), 23% reported using more than two pills in a usual session.

The frequency of using ecstasy pills was a median of six times in the previous six months (n=81, range 1–120). There was no significant difference to the median of fortnightly use in 2013.

The median frequency of use of other forms of ecstasy in the previous six months was less than once a monthly. The mean frequency for ecstasy powder and ecstasy capsules was three times a month; and for MDMA crystal it was four times a month.

Among those who reported using ecstasy pills in the previous six months (n=81), 22% reported using them at least weekly.

Table 5: Patterns of ecstasy use, 2010 to 2014

	2010 (N=101)	2011 (N=103)	2012 (N=62)	2013 (N=88)	**2014 (N=100)**
% ecstasy (any form) in last six months[a]	100	100	100	100	**94[a]**
Mean age first used ecstasy (any form)	18.5	18.0	18.6	17.3	**18.5↑**
Median days used any form in last six months[b]	12	12	18	14	**10**
% Use weekly or more in last six months[b]	10	24	37	33	**30**
Median pills in 'typical' session[b]	2	2	2	2	**2**
% Typically use >1 pill[b]	82	84	86	83	**78**
% favourite drug	43	28	21	46	**29↓**
% Ever injected ecstasy	9	11	9	3	**12**
% Mainly swallowed ecstasy recently[b]	91	90	89	75	**84**
% Mainly snorted ecstasy recently[b]	9	7	8	25	**13**
% Mainly injected ecstasy recently[b]	0	1	3	0	**2**
% Recently binged on ecstasy[b,c]	27	33	34	36	**23**
% Used other drugs with ecstasy[b]	93	91	87	92	**82**
% Used other drugs to 'come down' from ecstasy[b]	44	65	57	48	**63**

[a] Criteria for recruitment changed in 2013 from people who had used ecstasy six or more times in the previous six months (2005–2012) to include people who had used any psychostimulant six or more times in the previous six months.
[b] Among those who reported using ecstasy in the previous six months (n=94).
[c] >48 hours without sleep
Note: Arrow symbol signifies a significant difference between 2013 and 2014 ($p<0.05$).
Source: QLD EDRS participant interviews

4.2.2 Forms and administration of ecstasy use

Nearly all participants (94%) reported recent use of a form of ecstasy. Pills remained the most common form used, though recent use significantly decreased from 99% of all participants in 2013 to 81% in 2014 ($p<0.05$). There was a significant increase in the use of MDMA crystal, with 45% of all participants reporting use in the previous six months, compared with 23% in 2013 ($p<0.05$).

Swallowing remained the main route of administration for all forms of ecstasy, followed by snorting (Table 2). Injecting ecstasy remained rare among this sample, with only one participant reporting injecting was their main route of administration, and two reporting recently injecting any form of ecstasy. Similarly, smoking was only reported by one person as the main route of administration. Six participants reported shelving/shafting ecstasy pills in the previous six months, with one reporting this was their main route of administration.

4.2.3 Poly-drug use of regular ecstasy and other psychostimulant users

As in previous years, the majority of participants reported engaging in polydrug use (Table 6).

Eighty per cent of those who used ecstasy recently, reported that, on the most recent occasion they used ecstasy, they also used a least one other drug, most commonly alcohol, tobacco and cannabis.

Among those who reported using other drugs to come down from ecstasy the most recent time they used ecstasy (n=57), cannabis was the most common other drug (79%) followed by benzodiazepines (19%).

About two in five of all participants (39%) reported ‘bingeing’, that is, using drugs for more than 48 hours or more without sleep. Substances most often used during a ‘binge’ included alcohol (more than five standard drinks), ecstasy, tobacco, cannabis and crystalline methamphetamine (ice).

Table 6: Drugs used with ecstasy, coming down from ecstasy, and when binging, 2014

	Used with ecstasy most recent time (n=75) %	Used while coming down from ecstasy most recent time (n=57) %	Used while bingeing (n=39) %
Ecstasy	n/a	n/a	56
Alcohol >5 standard drinks	68	2	62
Tobacco	55	9	54
Cannabis	47	79	49
Cocaine	12	-	15
LSD	11	-	18
Alcohol <5 standard drinks	9	4	5
Ice	9	-	44
Nitrous oxide	7	-	3
Energy drinks	5	-	10
Speed	3	-	18
Base	3	-	8
Benzodiazepines	1	24	10
Pharmaceutical stimulants	1	-	5
MDA	1	-	8
Over-the-counter codeine	-	2	3
NBOMe	1	-	2
Other	1[a]	9[b]	18[c]

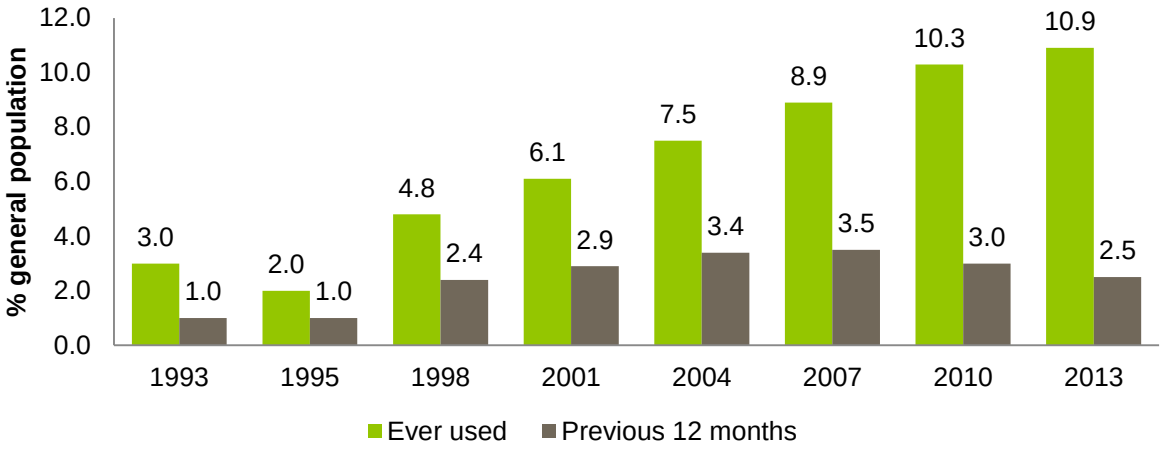
[a] 'Other' includes 'Amphetamine sulphate'.
[b] 'Other' includes 'Fentanyl', 'Fermugan', 'Heroin+Xanax', 'Heroin+methadone', 'panadol' and 'seroquel'.
[c] 'Other' includes 'caffeine pills', 'endone', 'herbal ecstasy, oxycodone and fentanyl', 'heroin', 'heroin+methadone', 'PMA powder' and 'valium, mogaclon and hamadol'.
Note: Multiple responses permitted.
Source: QLD EDRS participant interviews

4.2.4 Ecstasy use in the general population

The 2013 NDSHS shows a gradual increase in lifetime use of ecstasy among the Australian population aged 14 years and older, although use in the previous 12 months has been decreasing since 2007 (Figure 3).

Reported use of ecstasy in the previous 12 months was estimated at 2.5% of the general population, which is significantly less than 3% in 2010 (AIHW, 2014, Online Tables 5.2 and 5.3).

Figure 3: Prevalence of ecstasy use among the population aged 14 years and over in Australia, 1988 to 2013



Source: NDSHS 1988–2013 (AIHW, 2014)

4.2.5 Comments from key experts on ecstasy use

Key experts reported that ecstasy is usually used in combination with alcohol and/or other drugs. Use continues to be primarily recreational, generally within a group at a social setting. Ecstasy use was considered to be most common among young people in their twenties, with regularity of use tapering off as people approach their thirties. A typical trajectory is using ecstasy weekly or fortnightly, reducing over time to about monthly, and then once or twice a year before ceasing altogether. Reports of dependency are rare. Key experts in the health field reported that people may present with adverse symptoms due to ecstasy use but seldom identify that they have overdosed or that their use of ecstasy is problematic.

Pills appear to remain the most common form, with key experts noting that consumers tend to be suspicious of capsules, considering them more likely to have dubious content. There was a report of more ecstasy powder about, and that there was use of combined ecstasy powder and MDMA crystal. Only a few key experts reported knowledge of crystal MDMA use.

Overall, key experts reported very little change in ecstasy use.

4.3 Methamphetamine use

Key Points

- Lifetime and recent use of amphetamine powder remained stable.
- There was an increase in reports of lifetime use of ice ($p<0.05$), though no significant change in recent use.
- Frequency of ice use in the previous six months increased to fortnightly ($p<0.05$).

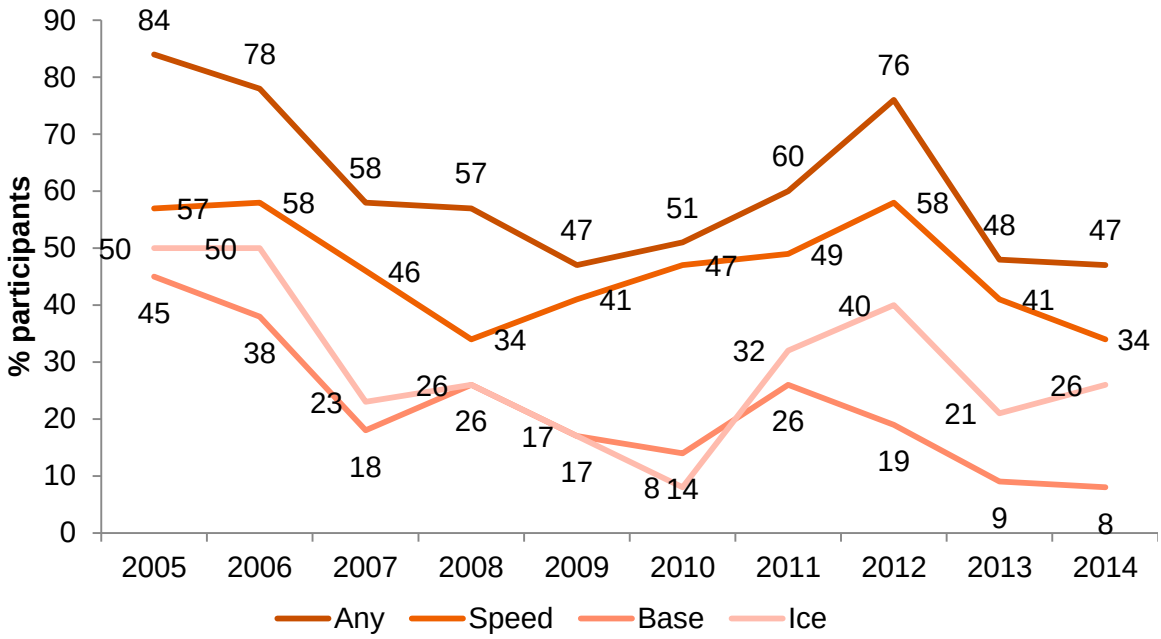
4.3.1 Patterns of methamphetamine use among regular psychostimulant users

Participants were asked about their consumption of methamphetamine in three different forms:

- Amphetamine powder (speed)
- Methamphetamine base
- Crystalline methamphetamine (ice).

In 2014, 72% of participants reported lifetime use of any form of methamphetamine, with 47% reporting recent use. Figure 4 presents trends of recent methamphetamine use among participants over the last decade. Speed remained the type of methamphetamine most used in the previous six months.

Figure 4: Patterns of recent methamphetamine use according to type, 2005 to 2014



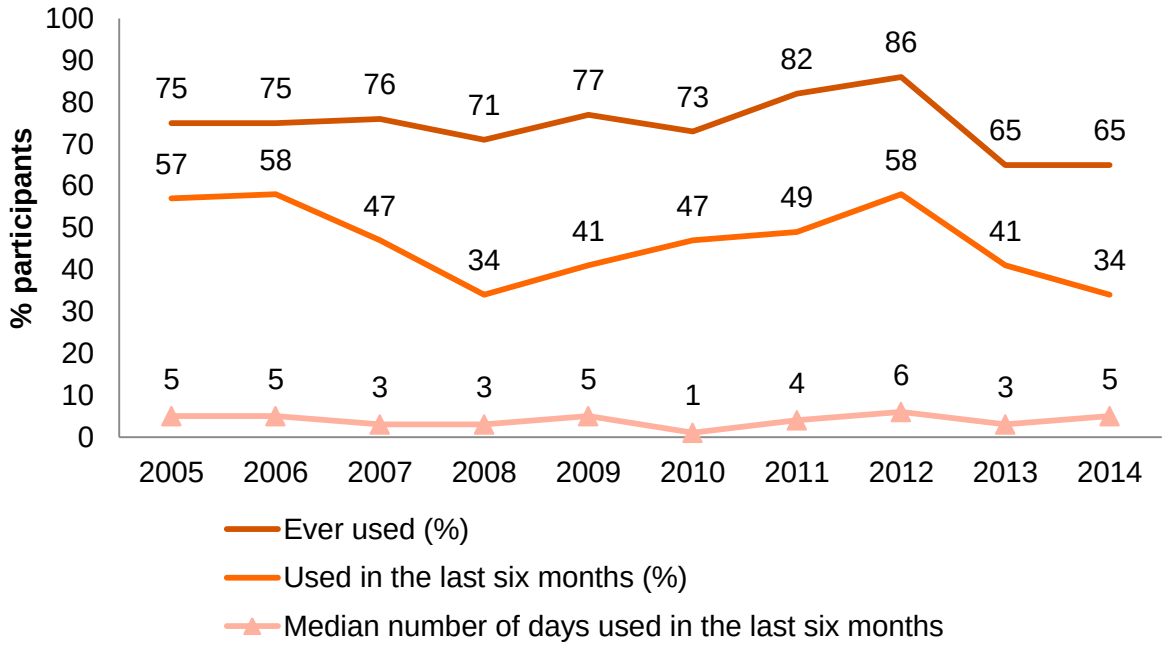
Source: QLD EDRS participant interviews

4.3.2 Speed use

Figure 5 shows that in 2014 the proportion of participants reporting lifetime use of speed was consistent with the previous year. There appears to be a downward trend in recent use but there was no significant difference between 2013 and 2014.

Frequency of use of speed in the previous six months was estimated at five days (n=33, range 1–120 days).

Figure 5: Patterns of amphetamine powder (speed) use, 2005 to 2014



Source: QLD EDRS participant interviews

Among those who reported in points (0.1g) and grams, the median number of points used in a typical session was one (n=25, range 0.5–20pts)[1]. For participants who responded in caps, one cap was the median amount used in typical session (n=7, range 1–2 caps).

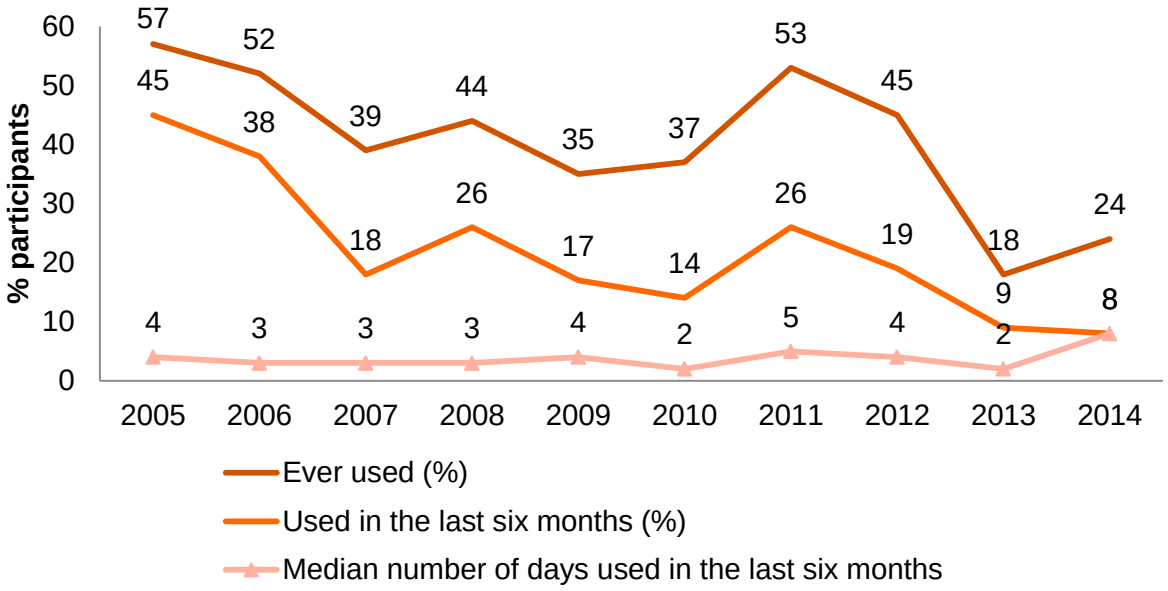
Participants were asked what was the largest amount of speed they had used in one session in the previous six months: among those who reported in points (0.1g) and grams, the median number of points used in their heaviest session was three (n=24, range 0.5–20pts)[2]. Among those who responded in caps, one cap was the median amount used in a heavy session (n=6, range 1–5 caps).

4.3.3 Methamphetamine base use

Lifetime and recent use of methamphetamine base was similar to reports in 2013 (Figure 6). The median number of days of base use was eight in the previous six months (n=8, range 1–30 days).

[1] For those who replied in grams, the median used in a typical session was 0.5g (n=6, range 0.1-2g), and for those who replied in points the median was one point (n=19, range 0.5-3pts).
[2] For those who replied in grams, the median used in a typical session was on gram (n=5, range 0.3-2g), and for those who replied in points the median was two points (n=20, range 0.5-8pts).

Figure 6: Patterns of methamphetamine base use, 2005 to 2014



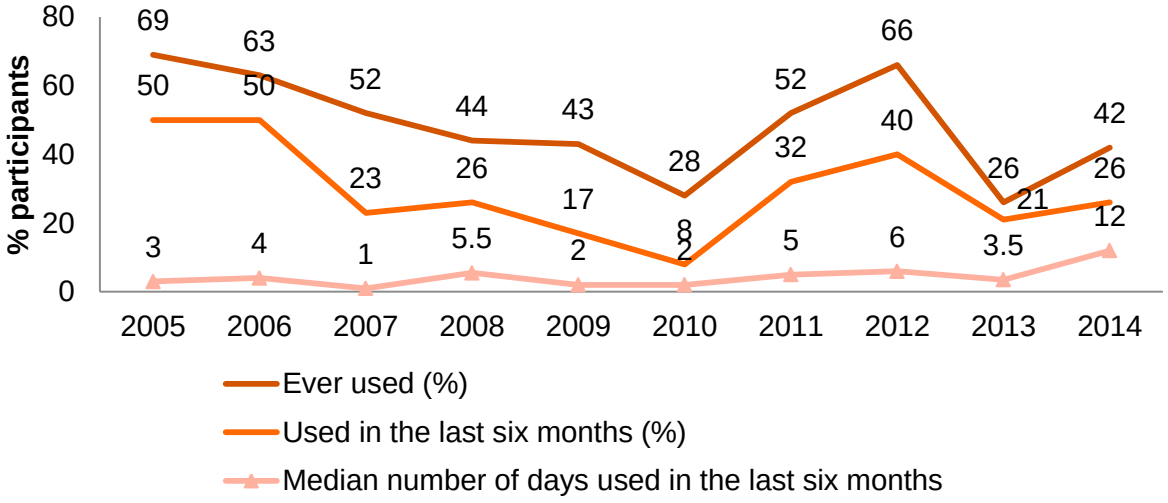
Source: QLD EDRS participant interviews

Among those who reported in points (0.1g) and grams, the median number of points used in a typical session was 2 (n=6, range 1.5–2.5pts)[3], and the median number of points used in a heavy session was 3.5 (n=6, range 1.5–5pts)[4].

4.3.4 Ice use

The proportion of participants who reported lifetime use of ice significantly increased to 42% from 26% in 2013 ($p<0.05$) (Figure 7). However, the proportion of participants reporting recent use remained stable, though the frequency of use increased from a median of 3.5 days in 2013 to 12 days in 2014, corresponding to fortnightly use ($p<0.05$).

Figure 7: Patterns of crystalline methamphetamine (ice) use, 2005 to 2014



Source: QLD EDRS participant interviews

Among those who responded in points (0.1g) and grams, the median number of points used in a typical session of ice was one (n=22, range 0.2–10pts)[5]. Among those who responded in

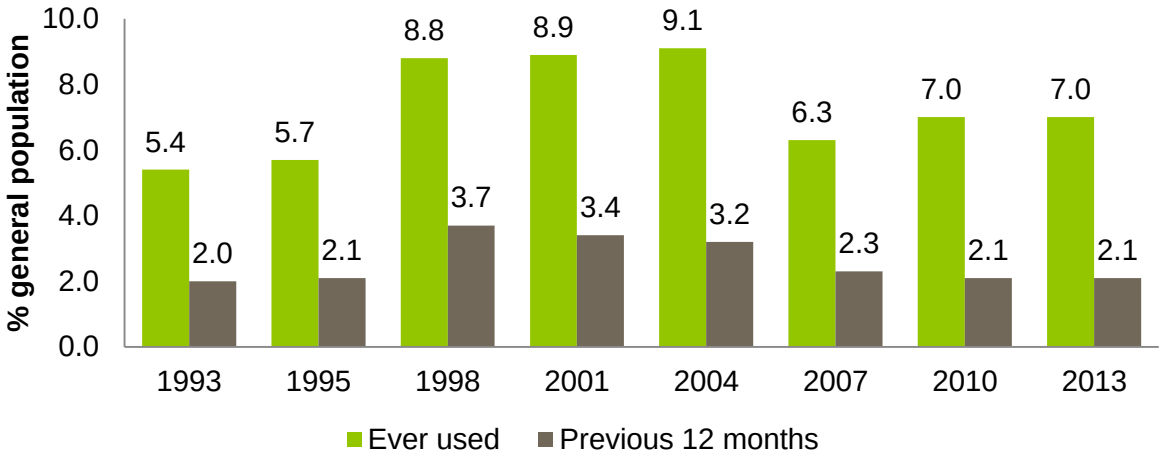
[3] Only one participant replied in grams (0.25g).
[4] Only one participant replied in grams (0.5g).

points (0.1g) and grams, the median number of points used in a heavy session was two points (n=19, range 0.5–20pts)[6].

4.3.5 Prevalence of methamphetamine use in the general population

Lifetime methamphetamine use in the general population is estimated at approximately 7%, with use in the previous year at 2.1% (Figure 8). This is similar to previous years (AIHW, 2014, Online Tables 5.2 and 5.3).

Figure 8: Prevalence of methamphetamine use among the Australian population aged 14 years and over, 1993 to 2013



Source: NDSHS 1993–2013 (AIHW, 2014)

4.3.6 Comments from key experts on methamphetamine use

Overall, methamphetamine use was reported as stable by key experts; however, there was concern that some people were using quite considerable amounts of methamphetamines over extended periods of time and becoming mentally unwell as a result. Some key experts singled out crystal/ice as being particularly problematic due to the aggressive and sometimes psychotic behaviour associated with its use. It was observed that people reached a high level of crisis after a very short period of using crystal/ice.

Use of other drugs in combination with methamphetamines was reported as common, and smoking was observed to be a popular method of use.

4.4 Cocaine use

Key points

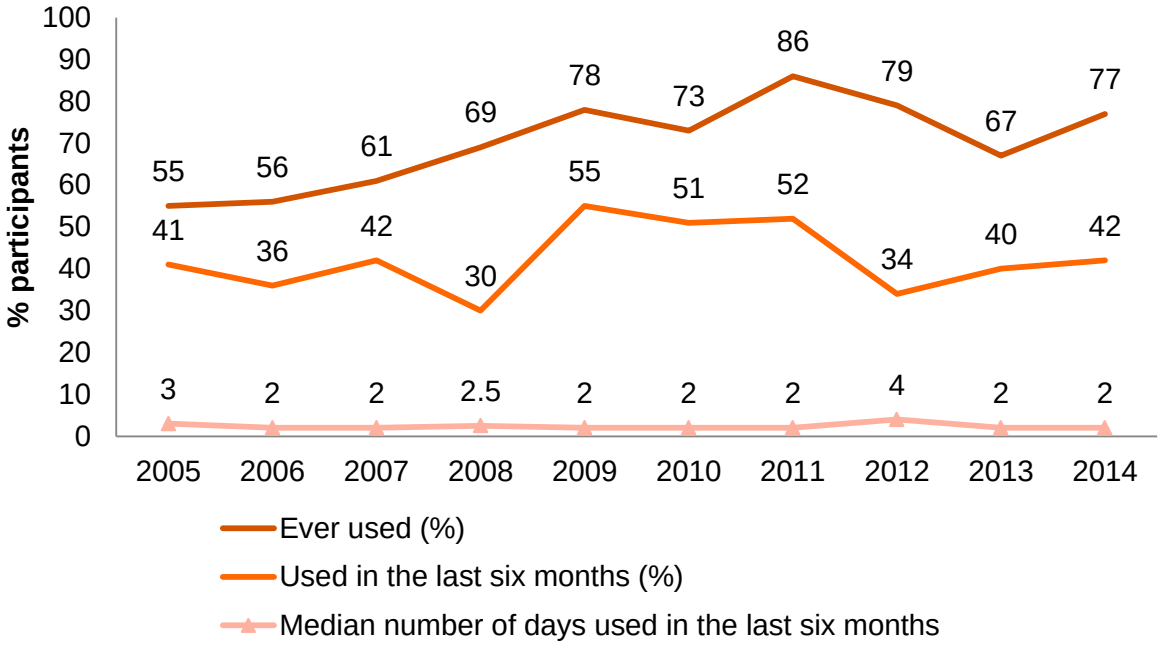
- Lifetime and recent cocaine use remained stable at 75% and 42% respectively.
- Frequency of use remained low and occasional.

[5] Two participants replied in grams (0.02g and 1g).
[6] Only one participant replied in grams (1g).

4.4.1 Patterns of cocaine use among regular psychostimulant users

Reports of lifetime and recent use of cocaine remained stable, with over three-quarters reporting having ever used, and 42% using in the previous six months (Figure 9). Frequency of use remained stable at two days in the previous six months, corresponding to occasional use.

Figure 9: Patterns of cocaine use, 2005 to 2014



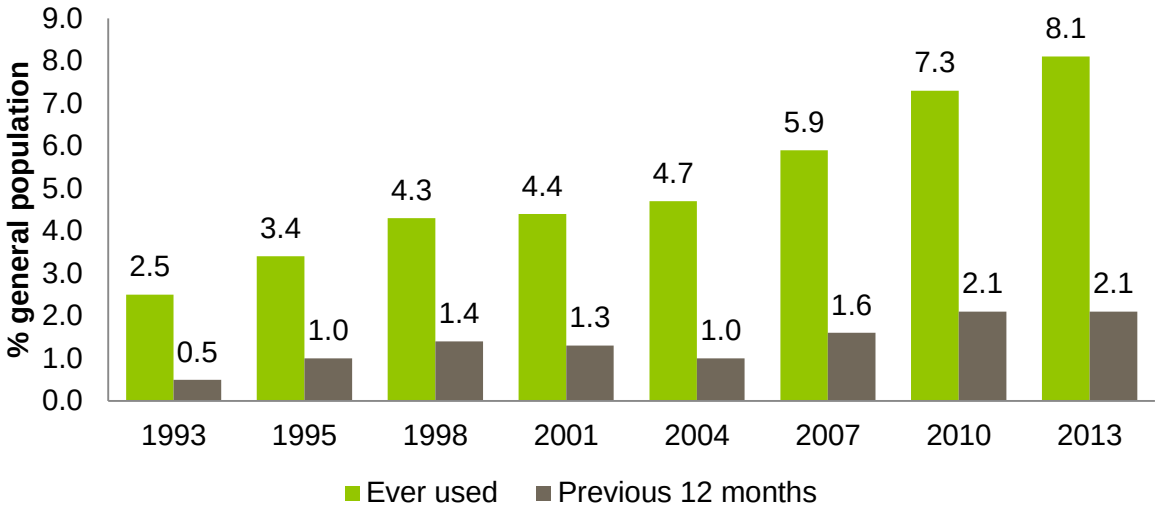
Source: QLD EDRS participant interviews

Among those who responded in grams, the median average amount used in a typical session was 1g (range 0.25–3.5g), and 2g for a heavy session (range 0.25–8g).

4.4.2 Prevalence of cocaine use in the general population

Figure 10 shows the upward trend of lifetime cocaine use estimated for the general population aged 14 years and older based on reports in the NDSHS. Cocaine use in the previous 12 months has remained stable at 2.1% (AIHW 2014, Online Tables 5.2 and 5.3).

Figure 10: Prevalence of cocaine use among the Australian population aged 14 years and over, 1993 to 2013



Source: NDSHS 1993–2013 (AIHW, 2014)

4.4.3 Comments from key experts about cocaine use

Key experts reported that cocaine use was becoming more common; although frequency of use remained low and opportunistic—'*generally a few times a year*'. One key expert explained that cocaine use was '*very recreational—associated more as a fun thing*'. There was agreement among key experts that use was most evident among people in their mid to late twenties: '*an older crowd—talking about 22–30 year olds'*. One key expert had observed that those who used cocaine tended to be heavy alcohol drinkers.

4.5 Ketamine use

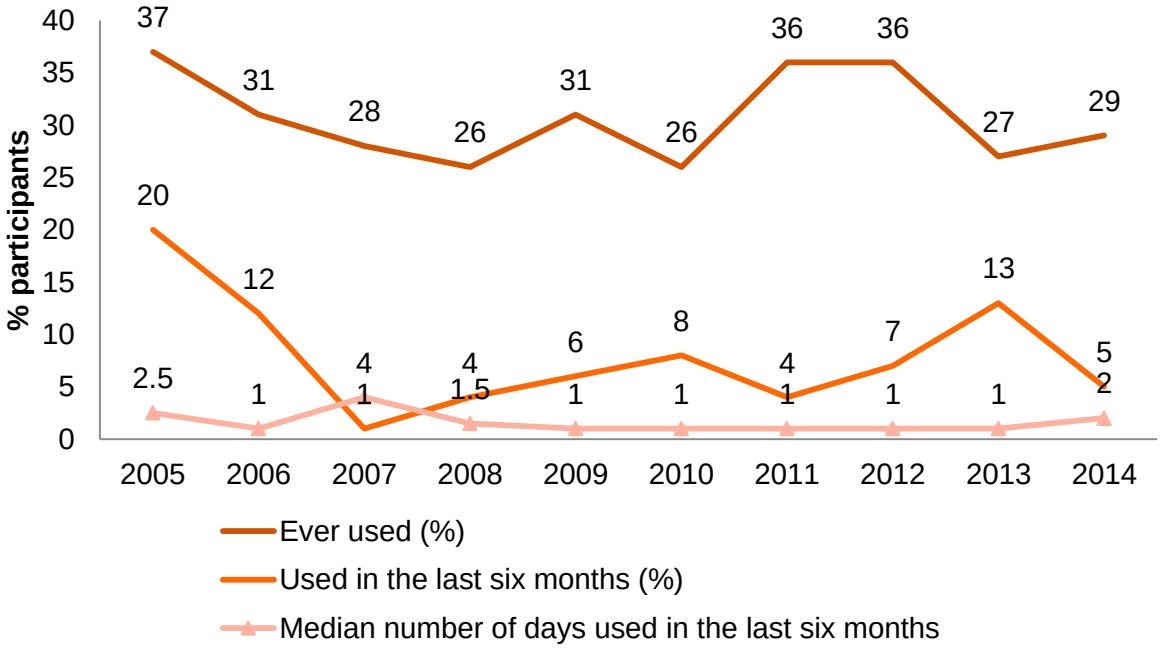
Key points

- Only a small proportion (5%) had recently used ketamine and frequency of use remained low.

4.5.1 Patterns of ketamine use among regular psychostimulant users

Although 29% of participants had used ketamine in their lifetime, only 5% reported recent use (Figure 11). As in previous years, the frequency of use has remained very low.

Figure 11: Patterns of ketamine use, 2005 to 2014



Source: QLD EDRS participant interviews

The median number of 'bumps' used in a typical and heavy session was 1.5 (n=4, range 1–2 bumps).

4.5.2 Ketamine use in the general population

The 2013 NDSHS (AIHW, 2014, Online Table 5.3) estimated the lifetime use of ketamine among the general population 14 years and older to be at 1.7% (which was significantly higher than 1.4% in 2010), with 0.3% reporting use in the previous 12 months. Use of ketamine has remained low over the past decade.

4.5.3 Comments from key experts about ketamine use

Key experts reported that use of ketamine appeared to be rare; although there was some evidence that it may be an ingredient in certain illicit drugs that have recently been available.

4.6 GHB use

Key points

- Lifetime use of GHB remained low, with only one-off use by three participants in the previous six months.

4.6.1 Patterns of GHB use among regular psychostimulant users

In 2014, 16% of participants reported ever using GHB, with only 3% reporting recent use, and this was only on one occasion for all three. This is similar to reports in 2013.

The amount of GHB used in a typical session was 3–4 ml, and 3–12ml for a heavy session.

4.6.2 GHB use in the general population

Among the general population aged 14 years and over, the NDSHS estimated that the lifetime use of GHB has remained low at less than 1% in the past decade (0.9% in 2013). Use in the previous 12 months was reported to be less than 0.1%, which was significantly lower than reports in 2010 (AIHW 2014, Online Tables 5.2 and 5.3).

4.6.3 Comments from key experts about GHB use

Key experts reported that GHB comes and goes in waves, and that in recent times there was very little indication of use. It was pointed out that it may be used more in regional areas than in Brisbane. GHB use is associated with venues like bars and nightclubs, and is not conspicuous due to it being easily camouflaged as a legal liquid and its depressive effect. Because of these characteristics, use can be undetected. Forensic experts reported an increase in submissions containing the GHB precursor 1,4-butanedial and an increase in GHB detections in blood specimens collected from drivers.

4.7 Hallucinogen use

Key Points

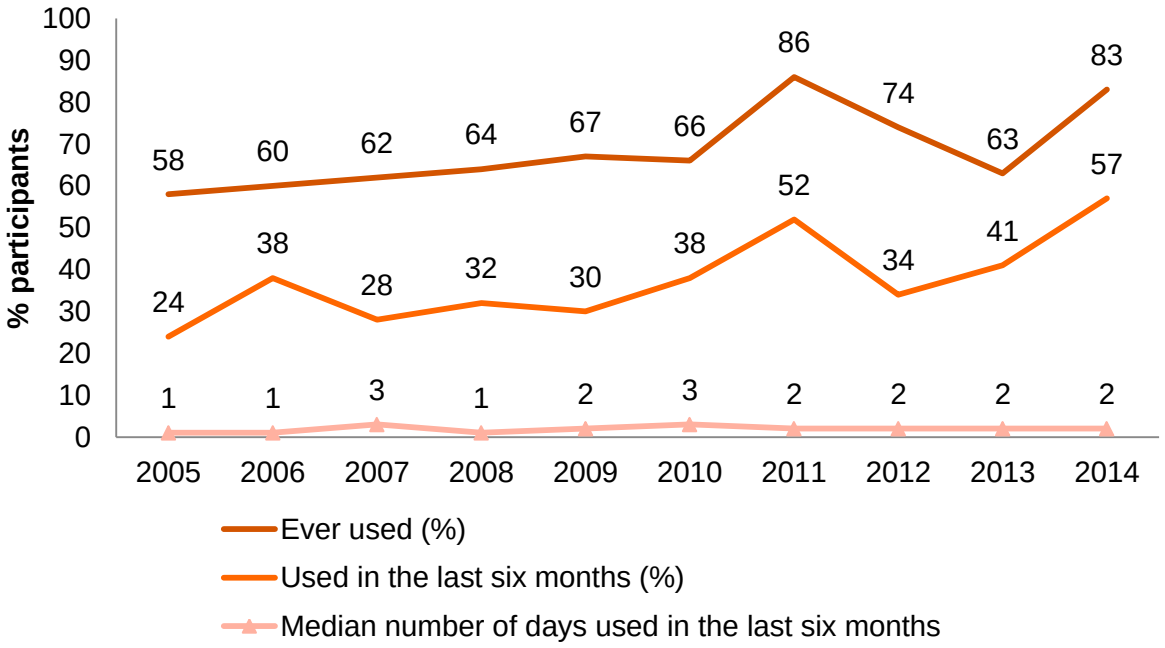
- Lifetime and recent use of LSD significantly increased from 2013, with 83% reporting having ever used and 57% reporting use in the previous six months.
- Frequency of LSD use remained stable, with median use being twice in the previous six months.
- One LSD tab was the median amount used in a typical session.
- Over two-thirds reported lifetime use of hallucinogenic mushrooms, with one-quarter having used them in the previous six months. Frequency of use was occasional.

In this section, participants were asked about their use of ‘traditional’ hallucinogens, LSD and mushrooms. Other drugs with hallucinogenic effects are reported in the NPS section.

4.7.1 Patterns of LSD use among regular psychostimulant users

Figure 12 shows that reported lifetime use of LSD significantly increased from 63% in 2013 to 83% in 2014 ($p<0.05$). Recent use also increased to 57% ($p<0.05$). Frequency of use remained stable at a median of two days in the previous six months.

Figure 12: Patterns of LSD use, 2005 to 2014



Source: QLD EDRS participant interviews

Table 7 shows the quantity of LSD tabs reported to have been used. In 2014, one tab was the median amount used in a typical session, with two tabs being the median amount used in a heavy session.

Table 7: Median tabs of LSD used in a session in the last six months, 2005 to 2014

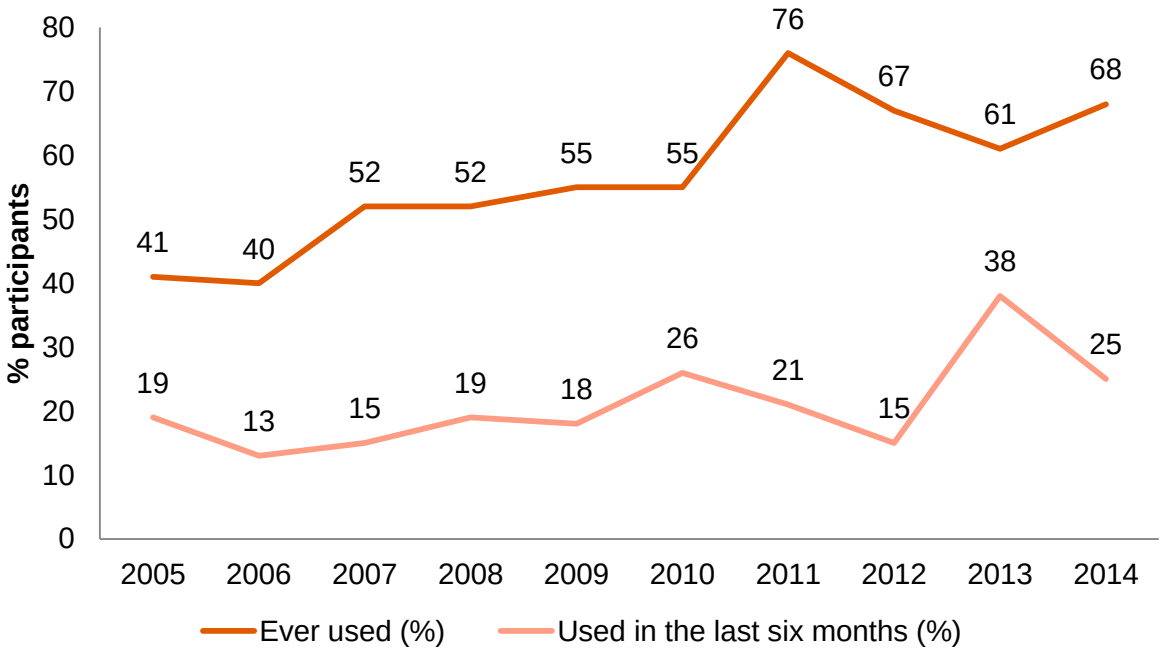
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Typical (range)	1.0 (.3–3)	1.3 (1–1.5)	1.0 (.5–5)	1.0 (.5–3.5)	1.0 (.5–4)	1.0 (1–5)	1.0 (.5–3)	2.0 (1–4)	1.0 (.5–6)	**1.0 (.3–5)**
Heavy (range)	1.0 (.5–4)	1.3 (1–1.5)	1.0 (.5–6)	1.0 (.5–4)	1.0 (1–4)	2.0 (1–11)	1.0 (.5–5)	2.0 (1–4)	1.3 (.5–12)	**2.0 (.5–8)**

Source: QLD EDRS participant interviews

4.7.2 Mushroom use

The lifetime and recent use of hallucinogenic mushrooms remained stable, with over two-thirds reporting lifetime use and one-quarter reporting use in the previous six months (Figure 13). Frequency of use was estimated at one day in the previous six months (n=25, range 1–5 days).

Figure 13: Patterns of mushroom use, 2005 to 2014



Source: QLD EDRS participant interviews

4.7.3 Hallucinogen use in the general population

The 2013 NDSHS estimated the lifetime use of hallucinogens among the general population aged 14 years and older to be at 9.4%, with use in the previous 12 months to be at 1.3% (AIHW, 2014, Online Table 5.4). This was similar to previous years.

4.7.4 Comments from key experts about hallucinogen use

Key experts were of the opinion that use of LSD was quite low. One commented that use was generally among '*a subculture of people who experiment with drugs*' and that it was used in a '*different context to going out and partying*'. Another key expert spoke of a '*bubble of use before Christmas*'. There was also a report of young people injecting liquid LSD.

It was noted that NPS such as the 25X-NBOMe drugs have been sold as LSD. Forensic experts report that a range of 25X-NBIMBe drugs have been in cardboard tabs which traditionally has been the distinctive form of LSD in Australia. Overall, LSD use was reported as small and relatively stable.

4.8 Cannabis use

Key points

- Use of cannabis has remained high and stable with 87% reporting use in the previous six months.
- Frequency of use was estimated at twice a week.
- Cannabis was predominantly smoked, though it was also eaten and inhaled.

4.8.1 Patterns of cannabis use among regular psychostimulant users

In 2014, use of cannabis remained high and stable, with almost all (98%) reporting lifetime use and 87% reporting use in the previous six months (Figure 14). As in previous years, the

median number of days used in the previous six months was 48, corresponding to twice a week (n=87, range 1–180).

Mean age of first use of cannabis was 15.6 years (n=98, range 8–23).

Among those who reported using cannabis in the previous six months (n=87), smoking remained the main route of administration (99%), followed by eating it (38%).

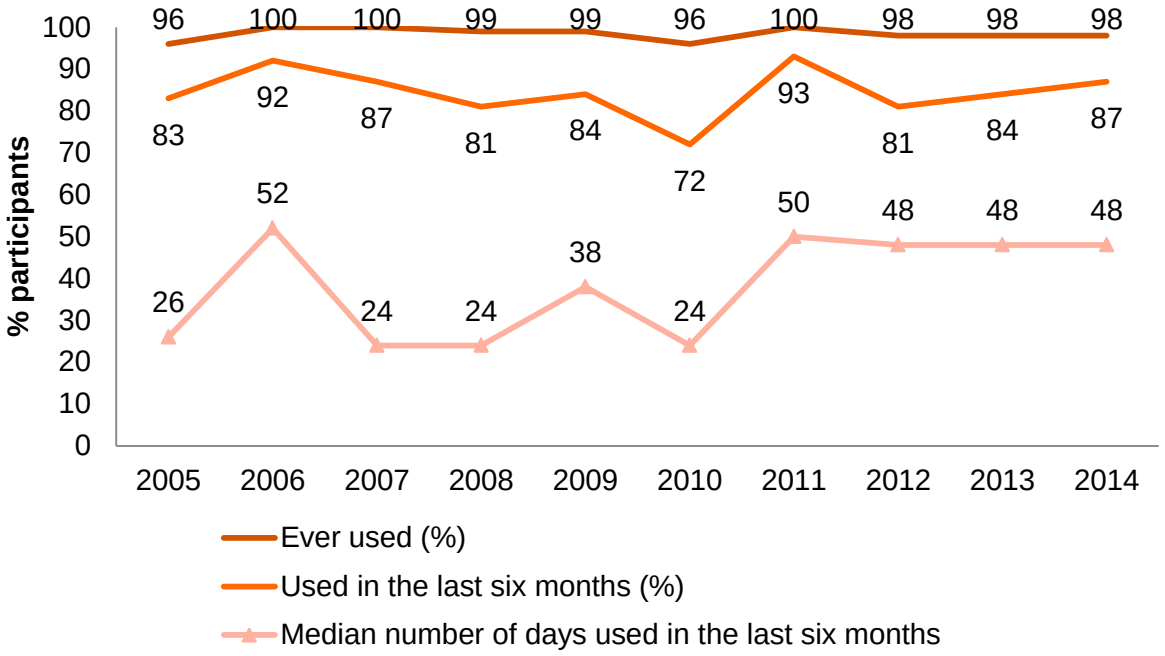
In 2014, inhaling with the use of a vaporiser was also included as a route of administration for cannabis, with 46% of all participants reporting lifetime inhalation, and 21% in the previous six months (i.e. 24% of those who recently used cannabis).

Participants were asked the amount of cannabis used on the most recent occasion in the previous six months. The median amount varied depending on the unit used:

- Joints: two (n=32, range 0.25–7g)
- Cones: three (n=46, range 1–50g)
- Grams: one (n=7, range 0.2–3g)

Among those who reported using another drug when coming down from ecstasy on the most recent occasion (n=57), cannabis was the drug most used (79%).

Figure 14: Patterns of cannabis use, 2005 to 2014



Source: QLD EDRS participant interviews

Among participants who reported recent use of cannabis (n=87), 18% reported using cannabis every day in the previous six months (Table 8). This has remained stable in recent years.

Table 8: Frequency of cannabis use in the last six months, 2005 to 2014

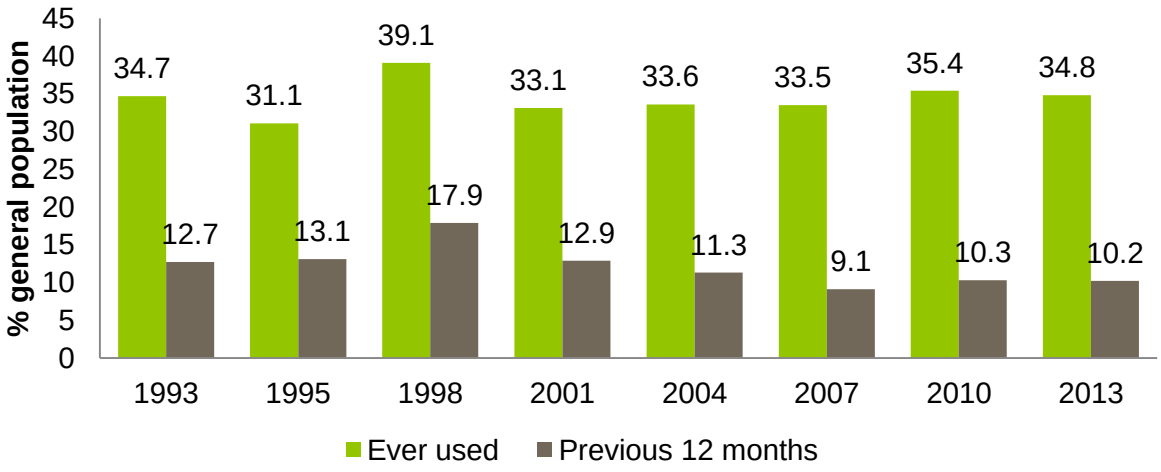
	2005 (n=84) %	2006 (n=92) %	2007 (n=88) %	2008 (n=87) %	2009 (n=74) %	2010 (n=73) %	2011 (n=101) %	2012 (n=50) %	2013 (n=74) %	2014 (n=87) %
Daily	13	23	21	22	24	14	20	26	23	**18**
More than weekly	39	35	26	23	28	29	33	32	41	**40**
Weekly	0	1	7	12	8	14	6	8	10	**7**
Less than weekly	48	42	46	44	39	44	41	34	23	**34**

Note: Based on participants who used cannabis in the previous six months. Daily=180 days; more than weekly=25–179 days; weekly=24 days; and less than weekly=1–23 days.
Source: QLD EDRS participant interviews

4.8.2 Cannabis use in the general population

The NDSHS report shows that lifetime and recent use of cannabis among the general population has remained stable over the past decade (Figure 15; AIHW, 2014, Online Tables 5.2 and 5.3).

Figure 15: Prevalence of cannabis use among the Australian population aged 14 years and over, 1993 to 2013



Source: NDSHS 1993–2013 (AIHW, 2014)

4.8.3 Comments from key experts about cannabis use

Cannabis use was reported as common among people who used amphetamine-type substances. As one key expert related, '*I hear people saying, "going home for a cone or joint". They smoke before going out and using, and then to come down*'. The use of cannabis to come down from stimulants and also to prolong euphoria was commented on by a number of key experts.

Key experts also expressed concern about the level of cannabis dependence, with some people using cannabis continually throughout each day. The use of synthetic cannabis was seen as particularly problematic because of panic and psychotic type symptoms. However, key experts reported that people tended to try synthetic cannabis but that it has not replaced

the use of hydro and bush. The novelty of synthetic cannabis was regarded as having passed.

4.9 Other drugs use

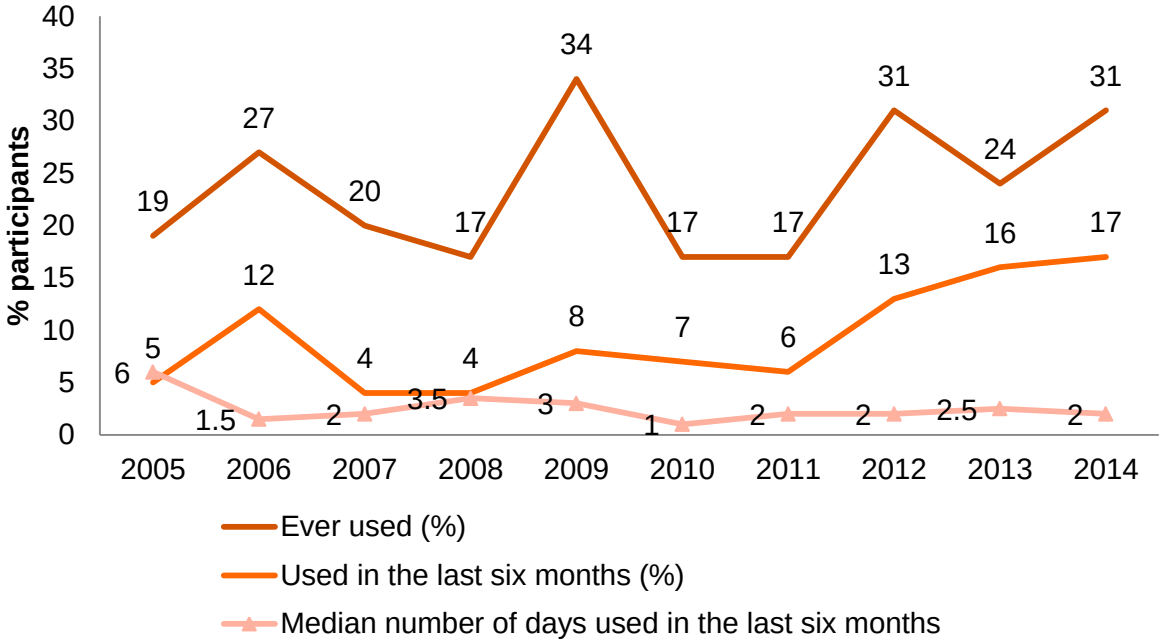
Key Points

- The use of alcohol and tobacco remained high, frequent, and stable.
- Use of MDA was low and occasional.
- There was an increase in recent use of licit benzodiazepines.
- There was an increase in illicit lifetime use of other opioids, with 42% reporting ever using other opioids not prescribed to them (illicit use), and 18% reporting doing so in the previous six months
- There was an increase in licit lifetime use of pharmaceutical stimulants, with a decrease in recent illicit use.

4.9.1 MDA use

In 2014, MDA use was low and occasional, similar to recent years (Figure 16). Lifetime use was reported by 31%, with 17% reporting use in the previous six months. The average amount used in a session was 1.5 caps (n=12, range 0.25–80 caps), with the most used in a single session in the previous six months estimated at two caps (n=11, range 1–80 caps).

Figure 16: Patterns of MDA use, 2005 to 2014



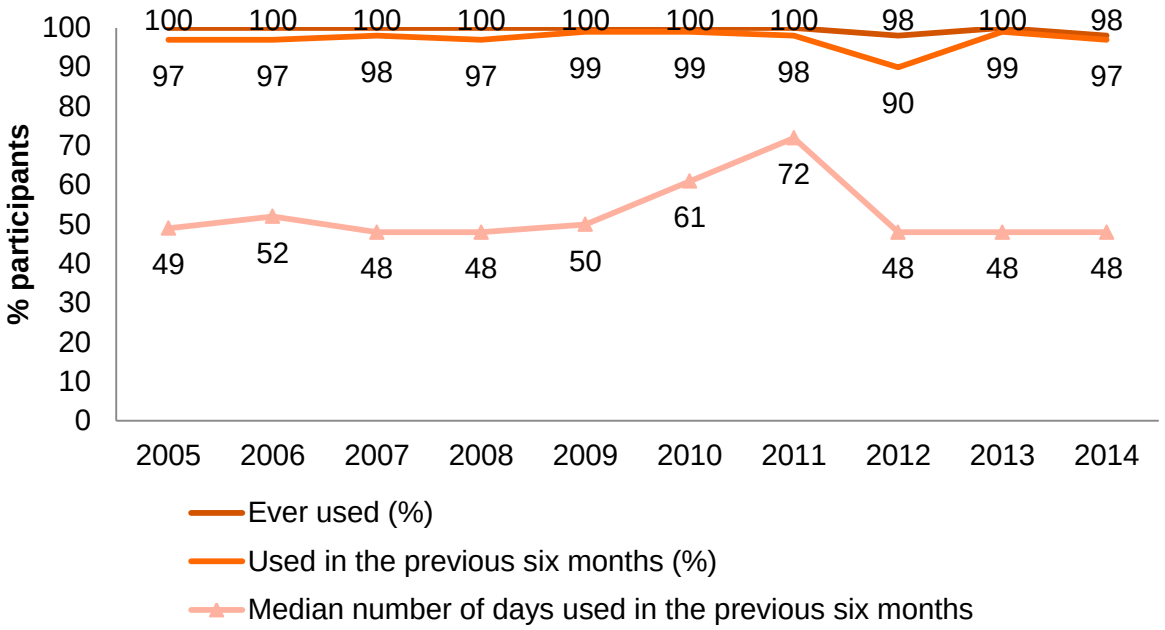
Source: QLD EDRS participant interviews

4.9.2 Alcohol

Similar to previous years, lifetime and recent use of alcohol remained high and frequent (Figure 17). Only two participants reported they had never used alcohol, and three had not

used it in the previous six months. Over the past decade, the mean age of first use has been stable at 14 years.

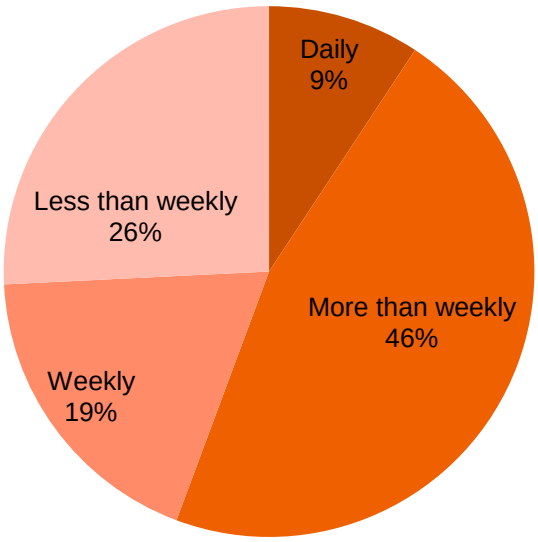
Figure 17: Patterns of alcohol use, 2003 to 2014



Source: QLD EDRS participant interviews

Figure 18 shows frequency of alcohol use reported in the previous six months. The median number of days used was 48, corresponding to twice a week (n=97, range 1–180 days).

Figure 18: Frequency of alcohol use, 2014



Note: Based on participants who used alcohol in the previous six months (n=97). Daily=180 days; more than weekly=25–179 days; weekly=24 days; and less than weekly=1–23 days.
Source: QLD EDRS participant interviews

Among those who reported using other substances on the most recent occasion they used ecstasy (n=75), 9% reported they had consumed between one and five standard drinks, while 68% reported they had consumed more than five standard drinks.

Alcohol use in the general population

Results from the recent NDSHS show the continued, significant decrease in frequency of alcohol consumption among the general population aged 14 years and older (Table 9).

Table 9: Alcohol drinking status of the Australian population 14 years and older (%), 1993 to 2013

	1993	1995	1998	2001	2004	2007	2010	2013
Daily	8.5	8.8	8.5	8.3	8.9	8.1	7.2	6.5*
Weekly	39.9	35.2	40.1	39.5	41.2	41.3	39.5	37.3*
Less than weekly	29.5	34.3	31.9	34.6	33.5	33.5	33.8	34.5
Ex-drinker	9.0	9.5	10.0	8.0	7.1	7.0	7.4	8.0*
Never a full serve	13.0	12.2	9.4	9.6	9.3	10.1	12.1	13.8*

* Statistically significant change between 2010 and 2013
Source: NDSHS 1993–2013 (AIHW, 2014, Online Table 4.1)

Comments from key experts about alcohol use

As in past years, many key experts regarded alcohol as the most problematic drug. Bingeing on alcohol continues to be prevalent along with alcohol in combination with illicit drugs, primarily amphetamine-type substances. It was also noted that high use of alcohol is often accompanied by cigarette smoking. No gender differences were identified, and although heavy alcohol use was reported across age groups, some key experts considered that high level use was more common among people in their early and mid-twenties.

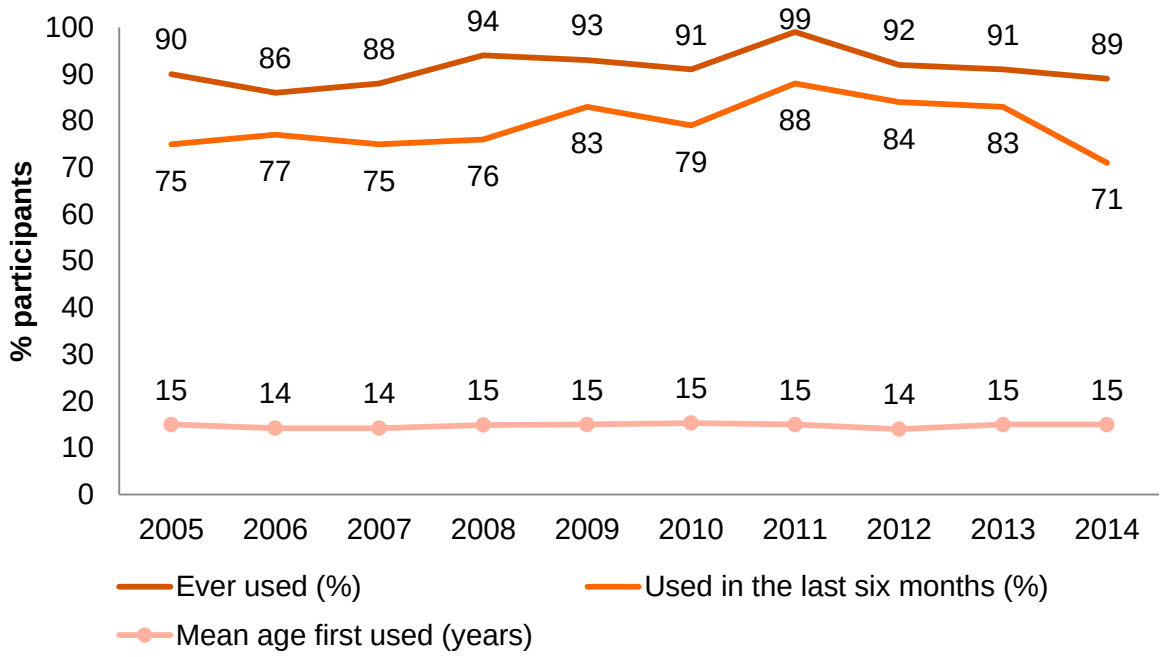
4.9.3 Tobacco

In 2014, tobacco use remained high among participants (Figure 19). While use appeared to be trending downwards, this was not significantly different to 2013.

Among those who reported using tobacco in the previous six months (n=71), 51% reported using daily. The median number of days of use has consistently been reported as 180 days, corresponding to daily use.

The mean age of initiation for tobacco was 15 years (n=89, range 5–25 years). This was similar to previous years.

Figure 19: Patterns of tobacco use, 2005 to 2014



Source: QLD EDRS participant interviews

Tobacco use in the general Australian population

The 2013 NDSHS report noted a decrease in daily smokers and an increase in lifetime abstinence of tobacco use among the general population aged 14 years and older since the previous survey in 2010 (AIHW, 2014, Online Table 3.1). This follows the continued decline of tobacco use over the past decade (Table 10).

Table 10: Smoking status, proportion of the Australian population 14 years and over, 1993 to 2013

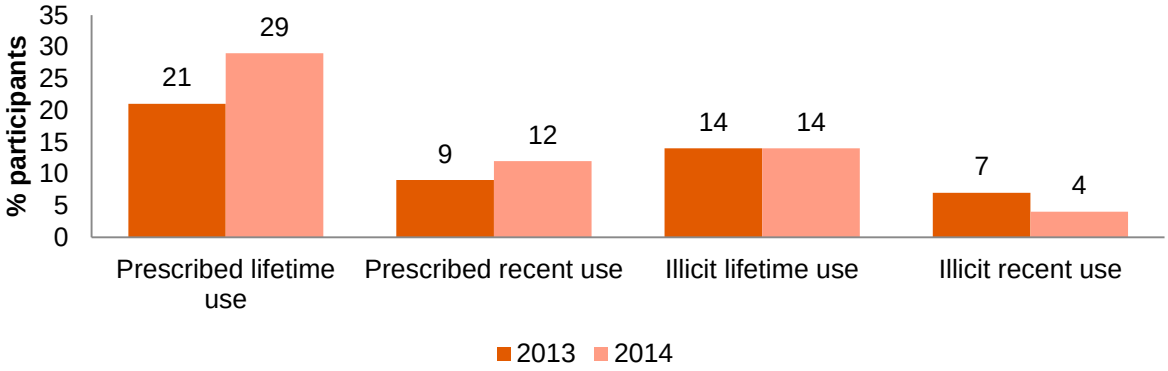
	1993	1995	1998	2001	2004	2007	2010	2013
Daily	25.0	23.8	21.8	19.5	17.4	16.6	15.1	12.8*
Weekly	2.3	1.6	1.8	1.6	1.6	1.3	1.5	1.4
Less than weekly	1.8	1.8	1.3	2.0	1.6	1.5	1.4	1.6
Ex-smoker[a]	21.7	20.2	25.9	26.2	26.4	25.1	24.1	24.0
Never smoked[b]	49.1	52.6	49.2	50.6	52.9	55.4	57.8	60.1*

* statistically significantly different between 2010 and 2013
[a] smoked at least 100 cigarettes in lifetime and no longer smoke
[b] never smoked more than 100 cigarettes in lifetime
Source: NDSHS 1993–2013 (AIHW, 2014)

4.9.4 Anti-depressants

The prevalence of lifetime and recent use of licit and illicit anti-depressants remained stable (Figure 20).

Figure 20: Lifetime and recent use of antidepressants, 2013 and 2014



Source: QLD EDRS participant interviews

In 2014, 12% of participants were using their own prescribed antidepressants in the previous six months. The median number of days used was 180 days (n=12, range 5–180 days), corresponding to daily use. The most common brand used licitly was Prozac (fluoxetine). Other brands also used included Lovan (fluoxetine), Lexapro (escitalopram), Avanza (mirtazapine), Zoloft (sertraline) and Pristiq (desvenlafaxine).

Only four participants reported illicit use of anti-depressants in the previous six months.

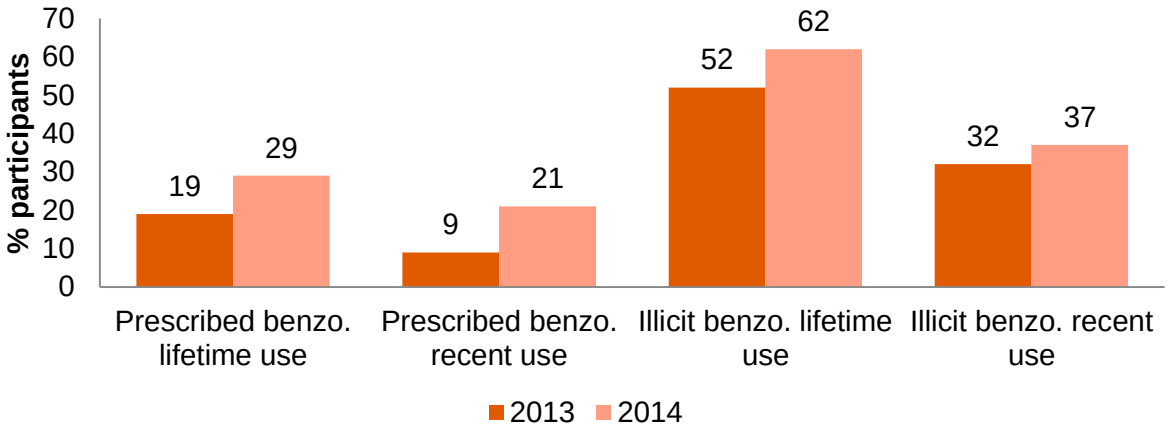
4.9.5 Benzodiazepines

While lifetime use of prescribed benzodiazepines remained stable in 2014, there was a significant increase in the recent use of prescribed benzodiazepines ($p<.05$), from 9% in 2013 to 21% in 2014 (Figure 21). The median number of days using prescribed benzodiazepines was 44 days (n=20, range 1–180 days), corresponding to nearly twice a week. Among those who used benzodiazepines in the previous six months that were prescribed to them, the main brand prescribed (60%) was Valium (diazepam); other brands were Xanax (alprazolam), generic diazepam, Temtabs (temazepam) and generic temazepam.

Lifetime and recent use of illicit benzodiazepines (i.e. not prescribed) remained stable with 37% of participants reporting illicit use. The median number of days using illicit benzodiazepines was five (n=37, range 1–50 days), corresponding to less than monthly use. Among those who reported illicit use of benzodiazepines in the previous six months (n=36), the brands most commonly used without a prescription were Valium (50%) (diazepam) and Xanax (36%) (alprazolam); other brands were generic diazepam, Serepax (oxazepam) and Temtabs (temazepam).

Among those who reported taking drugs when coming down from ecstasy in the previous six months (n=57), 19% reported using benzodiazepines on the most recent occasion.

Figure 21: Lifetime and recent use of benzodiazepines, 2013 and 2014

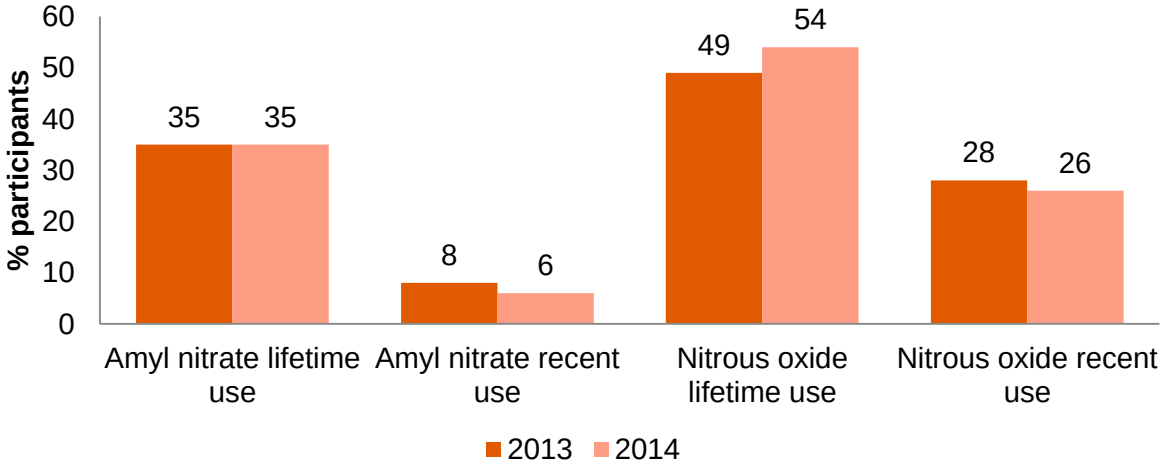


Source: QLD EDRS participant interviews

4.9.6 Inhalant use

Lifetime and recent use of amyl nitrate and nitrous oxide remained stable in 2014 (Figure 22).

Figure 22: Lifetime and recent use of inhalants, 2013 and 2014



Source: QLD EDRS participant interviews

4.9.7 Heroin and other opioids

Heroin

Similar to previous years, the use of heroin remained low among participants. In 2014, 17% participants reported lifetime use of heroin (compared with 7% in 2013), with 3% reporting use in the previous six months (consistent with 2013). The mean age of first use of heroin was 20.7 years (n=17, range 14–28). The median number of days used in the previous six months was four, corresponding to occasional use (less than monthly). Among those who used heroin in the previous six months, it was injected or smoked.

Methadone

Lifetime use of methadone was reported among 10% of participants, compared with 2% in 2013. Recent use was reported by two participants, with a median of 6.5 days use in the previous six months. The mean age of first use of methadone was reported to be 22.5 years (n=10, range 13–35).

Buprenorphine

In 2014, 8% of participants reported having ever used buprenorphine (compared with 2% in 2013), with only two participants reporting recent use.

Other licit opioids

Lifetime use of other opioids (e.g. morphine, oxycodone) obtained under participants' own prescriptions was reported by 15%, with 10% reporting recent use. The median number of days used was 12 days in the previous six months, corresponding to fortnightly used. Two participants reported injecting their own prescribed opioids. The main brands used were Endone (n=5) and OxyContin (n=4).

Other illicit opioids

In 2014, 42% of participants reported using other opioids not prescribed to them (illicit use), a significant increase from 23% in 2013 ($p<.05$). Recent illicit use of opioids was reported by 18%. The median number of days used in the previous six months was 5.5 days, corresponding to monthly use. Four participants reported injecting opioids in the previous six months. The main brands used were OxyContin (n=9) and Endone (n=4), with four participants reporting making a poppy seed tea reduction.

4.9.8 Pharmaceutical stimulants

The lifetime use of prescribed (licit) pharmaceutical stimulants (e.g. dexamphetamine) was reported by 12% of participants, which is a significant increase from 2% in 2013 ($p<0.05$), though it was a return to similar percentages in previous years. In 2014, recent use was reported by three participants (none in 2013).

In 2014, the reported lifetime illicit use of pharmaceutical stimulants was 57%, similar to 60% in 2013. Recent illicit use decreased from 41% in 2013 to 22% in 2014 ($p<0.05$), though this is similar to 19% in 2012. Frequency of use in the previous six months corresponded to bi-monthly use (2.5 days).

Lifetime use of over-the-counter stimulants (e.g. cold and flu drugs) for non-medical/recreational use was similar to previous years (17% in 2014 and 16% in 2013). Only one person reported using it in the previous six months.

4.9.9 Over-the-counter codeine

In 2014, 31% of participants reported ever using over-the-counter codeine for non-medical use, with 13% reporting recent use. This is similar to previous years (32% ever used and 17% recently used in 2013).

4.10 New psychoactive substance (NPS) use

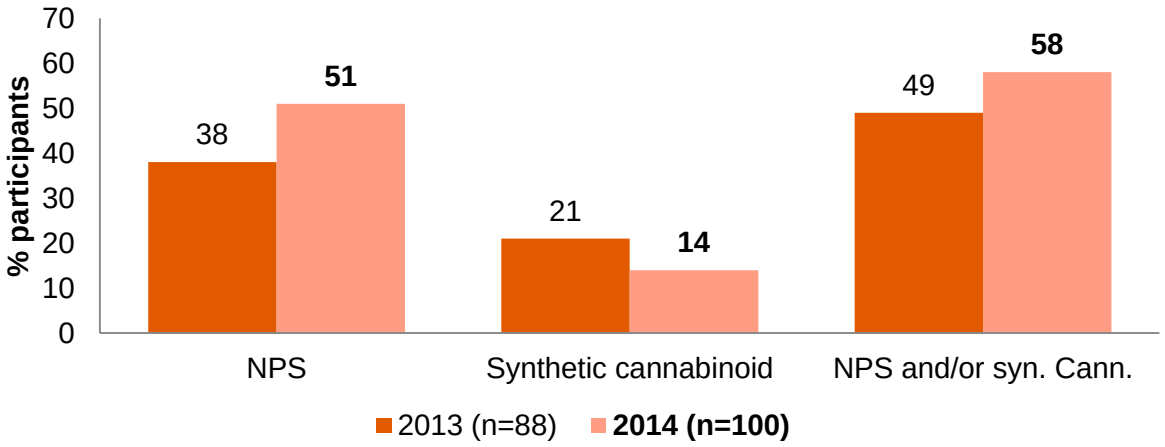
Key points

- 58% reported using NPS and/or synthetic cannabis in the previous six months.
- Lifetime and recent use of NBOMe has significantly increased, as well as lifetime use of 2CB, and DMT.

4.10.1 Patterns of use among regular psychostimulant users

In 2014, 58 participants reported using NPS and/or synthetic cannabinoids in the previous six months (Figure 23). There appears to have been an increase in use of NPS, though changes were not significantly different to 2013 (low numbers may affect statistical power for associations).

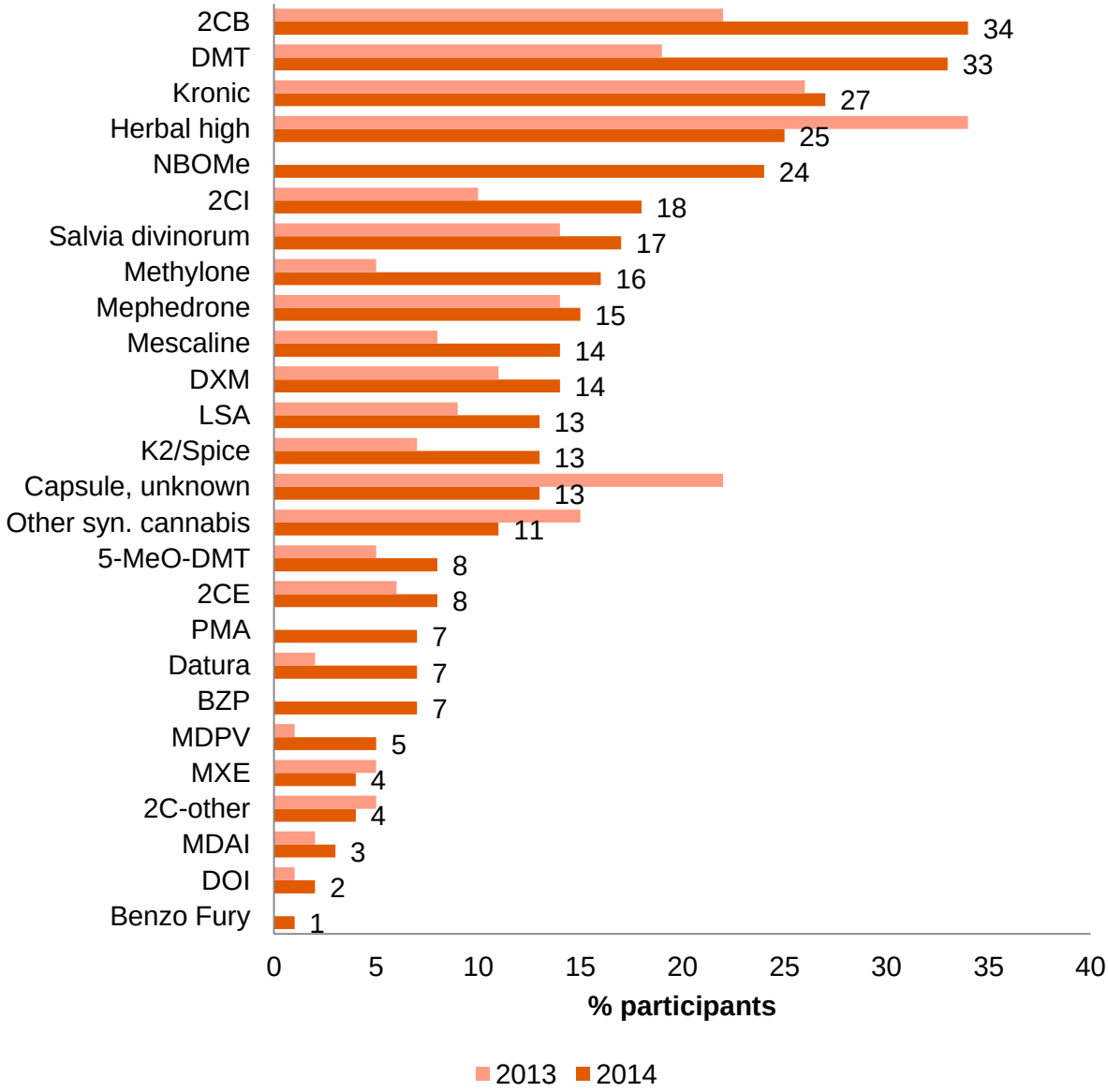
Figure 23: Recent use of any NPS and synthetic cannabinoid, 2013 and 2014



Source: QLD EDRS participant interviews

Figure 24 presents the proportion of participants reporting lifetime use of NPS and synthetic cannabinoids. Reports of lifetime use of DMT and NBOMe increased significantly from 2013 ($p<0.05$), and reported lifetime use of 2CB, Kronic and herbal highs remained high.

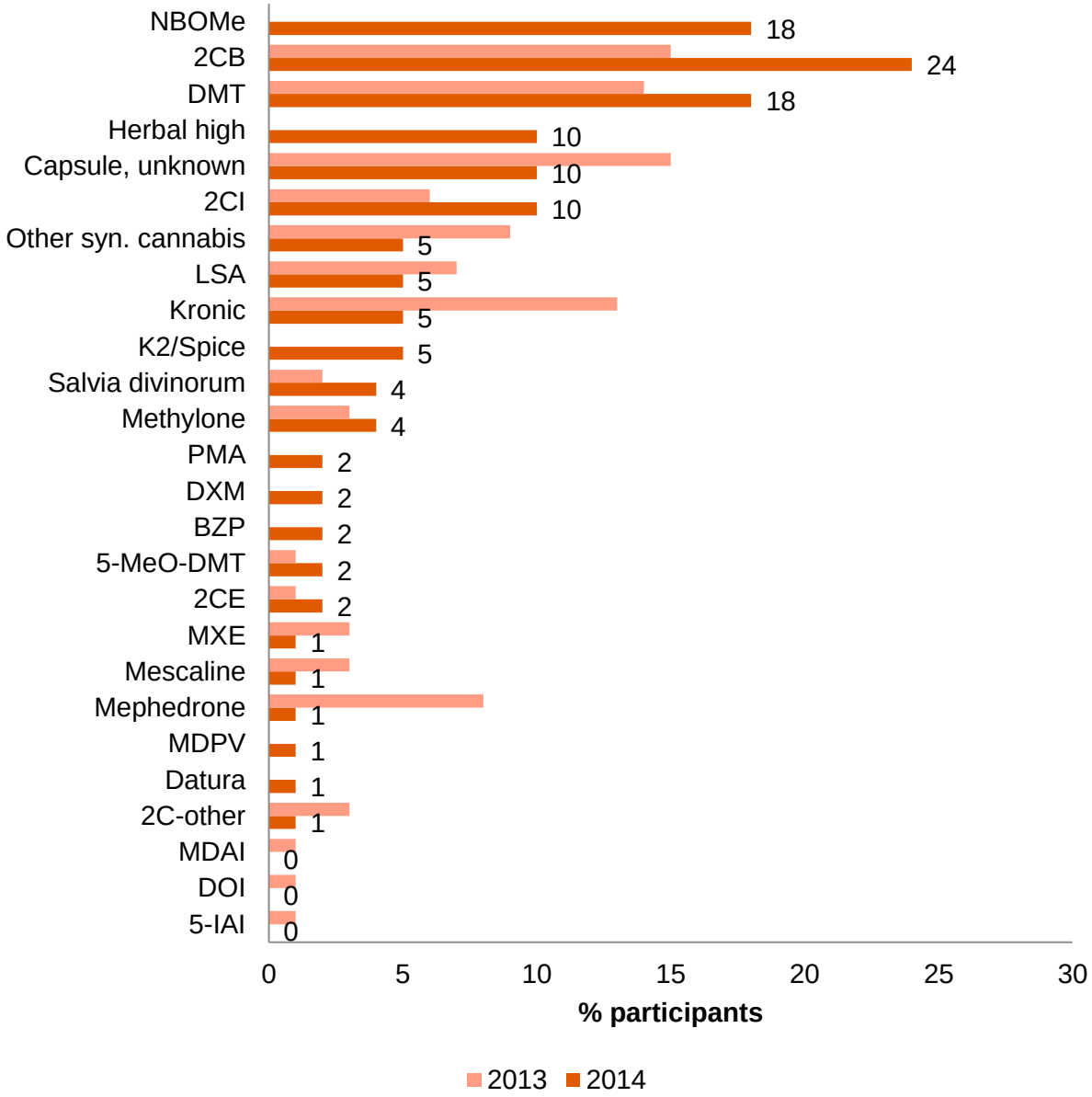
Figure 24: Lifetime use of NPS and synthetic cannabinoids, 2013 and 2014



Note: Multiple responses permitted.
Source: QLD EDRS participant interviews

Recent use of NBOMe has significantly increased from 2013 ($p<0.05$) (Figure 25), while 2CB, 2CI and DMT use has remained high.

Figure 25: Recent use of NPS and synthetic cannabinoids, 2013 and 2014



Note: Multiple responses permitted.
Source: QLD EDRS participant interviews.

4.10.2 NPS use in the general population

For the first time, in 2013 the NDSHS asked about the use of new and emerging psychoactive substances and synthetic cannabinoids. Both lifetime use and use in the previous 12 months of NPS was estimated at 0.4% among the general population aged 14 years and older (AIHW, 2014, Online Table 5.4). Lifetime use of synthetic cannabinoids was estimated at 1.3%, and use in the previous 12 months at 1.2%.

4.10.3 Comments from key experts about NPS use

NPS use was reported as sporadic. Some NPS (e.g. MDPV) seem to be used only when available in setting such as a musical festival. However, there was a report of MDPV being more regularly used via injection by people in their early twenties. A couple of key experts reported being aware of some MDA use. One key expert said, although people were trying 2CB, they had heard no positive reviews and that it was generally an '*awful experience*'. Key experts reported that NPS may be sampled but that there was a preference for more traditional drugs.

5 DRUG MARKET: PRICE, PURITY, AVAILABILITY AND SUPPLY

5.1 Ecstasy

Key points

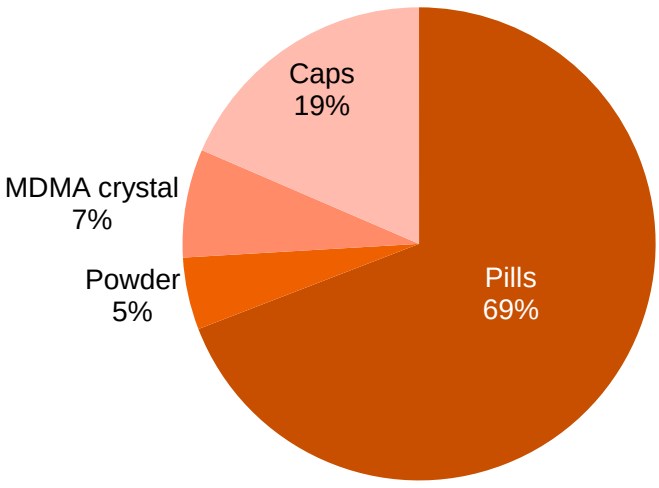
- Pills remained the most common form of ecstasy purchased.
- Price per ecstasy pill remained stable at $25.
- Frequency of purchasing ecstasy decreased to monthly or less.
- Almost half reported purity of pills, powder and caps to be medium, with a decrease in reports that purity fluctuated.
- MDMA crystal was considered to be of much higher purity than pills, powder and caps.
- Ecstasy was most likely to have been bought from a friend, at a friend's house.

New questions were added in 2014 about the market trends for MDMA crystal. Since MDMA crystal has been reported to have different price, purity and availability than ecstasy pills, powder and caps, this section has been split into two parts:

1. Ecstasy pills, powder and caps
2. MDMA crystal.

In 2014, 81% of participants reported using some form of ecstasy/MDMA in the previous six months. Ecstasy pills remained the most popular form of ecstasy purchased (Figure 26).

Figure 26: Form of ecstasy obtained at most recent purchase (n=81), 2014



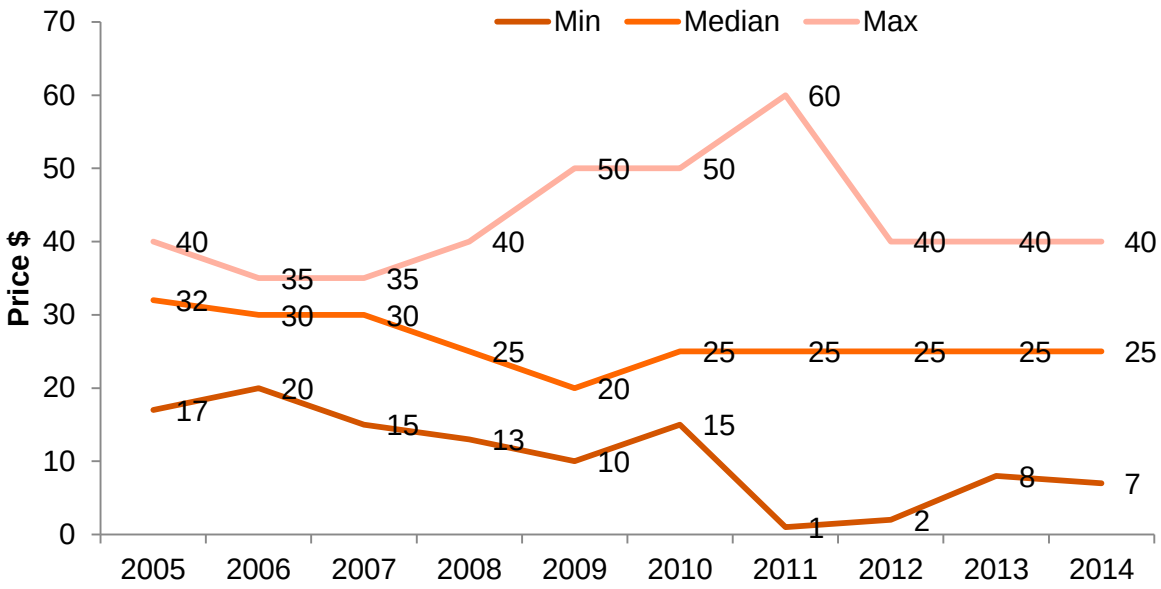
Source: QLD EDRS participant interviews

5.1.1 Price

Ecstasy pills, powder and caps

The price of ecstasy pills remained unchanged at $25 per pill (n=74, range $7–40) (Figure 27).

Figure 27: Price of ecstasy per tablet, 2005 to 2014



Source: QLD EDRS participant interviews

As in previous years, the median price per ecstasy pill tended to decrease if purchased in larger quantities. While an individual pill had a median price of $25 (n=52; range $15–30), the median price when purchasing ten pills decreased to $20 per pill (n=43; range $13–27), and decreased further to $15 when purchasing 100 pills (n=24; range $8–20).

Prices were comparable to those reported by the ACC (2014) for 2012–13. 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.

Table 11 shows that, similar to 2013, most participants who commented (73%) reported that the price of ecstasy had remained stable over the previous six months.

Table 11: Changes in recent price of ecstasy pills, powder and caps, 2013 and 2014

Price Change	2013 (n=84) %	2014 (n=81) %
Increasing	11	**15**
Stable	80	**73**
Decreasing	1	**3**
Fluctuating	8	**10**

Note: Those choosing 'don't know' were excluded from analyses. Percentages may not add up to 100 due to rounding.
Source: QLD EDRS participant interviews

MDMA crystal

In 2014, questions were asked about the price, purity and availability of MDMA crystal, with 37 reporting purchasing MDMA crystal in the previous six months.

The median price per gram of MDMA crystal was $300 (range $30–350).

The price of MDMA was perceived to have remained stable in the previous six months by 69% of participants who commented (Table 12).

Table 12: Perceptions in recent change of price of MDMA crystal, 2014

	2014 (n=36) %
Increasing	19
Stable	69
Decreasing	6
Fluctuating	6

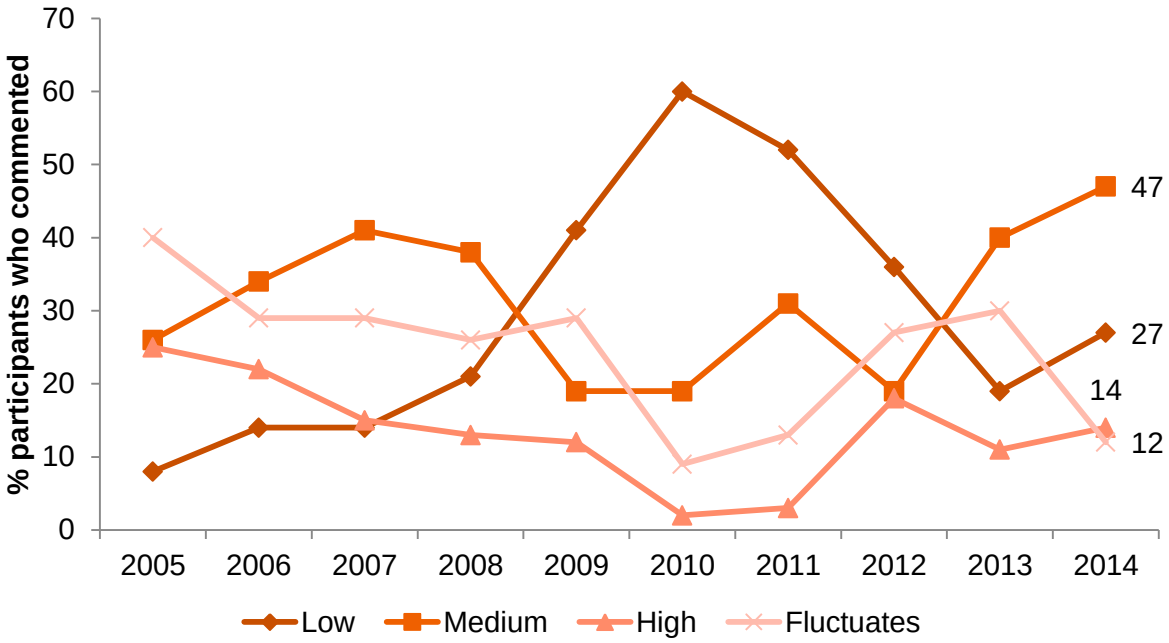
Source: QLD EDRS participant interviews

5.1.2 Purity

Ecstasy pills, powder and caps

Almost half of the sample reported the perceived purity of ecstasy pills, powder and caps to be medium (Figure 28). There was a significant decrease in participants reporting the purity of ecstasy to be fluctuating in the previous six months, from 30% in 2013 to 12% in 2014 ($p<0.05$).

Figure 28: Perception of purity for ecstasy pills, powder and caps, 2005 to 2014



Source: QLD EDRS participant interviews

While a greater proportion of participants than in recent years reported the purity of ecstasy pills, powder and caps had remained stable over the previous six months, there was little overall consensus (Table 13). Reports of changes in purity were not significantly different to 2013.

Table 13: Perceived changes in recent purity of ecstasy pills, powder and caps, 2005 to 2014

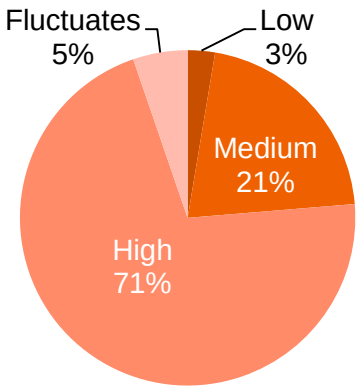
	2005 %	2006 %	2007 %	2008 %	2009 %	2010 %	2011 %	2012 %	2013 %	**2014 %**
Decreasing	13	23	16	22	42	60	43	29	29	**26**
Stable	31	36	33	30	27	15	20	25	24	**35**
Increasing	14	11	4	6	6	3	9	15	13	**11**
Fluctuating	38	28	41	35	25	22	25	31	34	**28**

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

MDMA crystal

Figure 29 shows that 71% of participants who commented on the purity of MDMA crystal reported it to be high (compared with 12% for ecstasy pills, powder, and caps). Very few reported it to be low.

Figure 29: Perceptions of recent purity of MDMA crystal (n=38), 2014



Source: QLD EDRS participant interviews

Participants were asked whether they believed there had been a change in the purity of MDMA crystal in the previous six months. Among those who commented (n=34), 68% reported it had remained stable, 15% reported it was decreasing, and the remainder reported it was increasing (9%) or fluctuating (9%).

5.1.3 Availability

Ecstasy pills, powder and caps

Similar to 2013, 81% of those who commented on the previous six months availability of ecstasy pills, powder and caps reported them to be easy or very easy to obtain (Table 14). When asked whether they believed ease of access had changed in the previous six months, over half (55%) reported it to have remained stable, with around one-quarter (26%) reporting it to have fluctuated.

Table 14: Ease of access and reported change in availability of ecstasy pills, powder and caps in the previous six months, 2013 and 2014

	2013 %	**2014 %**
Ease of access to ecstasy	(n=87)	**(n=85)**
Very easy	39	**29**
Easy	42	**52**
Difficult	18	**15**
Very difficult	-	**4**
Change in availability	(n=86)	**(n=82)**
Stable	51	**55**
Easier	17	**7**
More difficult	21	**22**
Fluctuating	10	**26**

Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

MDMA crystal

Among those who commented (n=38), the current ease of access and availability of MDMA crystal was reported to be easy (47%) or very easy (29%), though 24% reported it to be difficult to obtain.

When asked whether availability of MDMA crystal had changed (n=37), most (68%) reported it had remained stable, while 19% reported it was becoming more difficult to obtain, 8% reported it was easy, and 5% reported that it fluctuated.

5.1.4 Purchasing patterns and locations of use

Ecstasy pills, powder and caps

Five pills was the median number of ecstasy pills bought on the most recent occasion (n=56, range 1–60 pills). For those who had bought caps, the median number was two caps (n=15, range 1–140 caps).

Among those who reported purchasing ecstasy in the previous six months, nearly two-thirds (63%) reported buying it for themselves and others, with 37% reporting they bought it for themselves only. This was similar to 2013.

Purchases in the preceding six months were made from a median of three people (n=19, range 1–20 people). This was the same in 2013.

The frequency of purchasing ecstasy appears to have decreased in 2014. Two-thirds of participants reported purchasing ecstasy monthly or less, which was a significant increase from 2013 ($p<0.05$) (Table 15). Accordingly, there was a significant decrease in reports of purchasing ecstasy fortnightly or less ($p<0.05$).

Table 15: Number times purchased ecstasy in the previous six months, 2013 and 2014

	2013 (n=88) %	**2014 (n=81) %**
Monthly or less (1–6 times)	37	**67↑**
Fortnightly or less (7–12 times)	51	**17↓**
Weekly or less (13–24 times)	13	**15**
Three times a week or less (25+ times)	-	**1**

Note: Arrow symbol signifies a significant difference between 2013 and 2014 ($p<0.05$).
Source: QLD EDRS participant interviews

Friends remained the most common source person the most recent time ecstasy pills, powder and caps, were purchased (Table 16). The most common source location was a private home, primarily a friend's home.

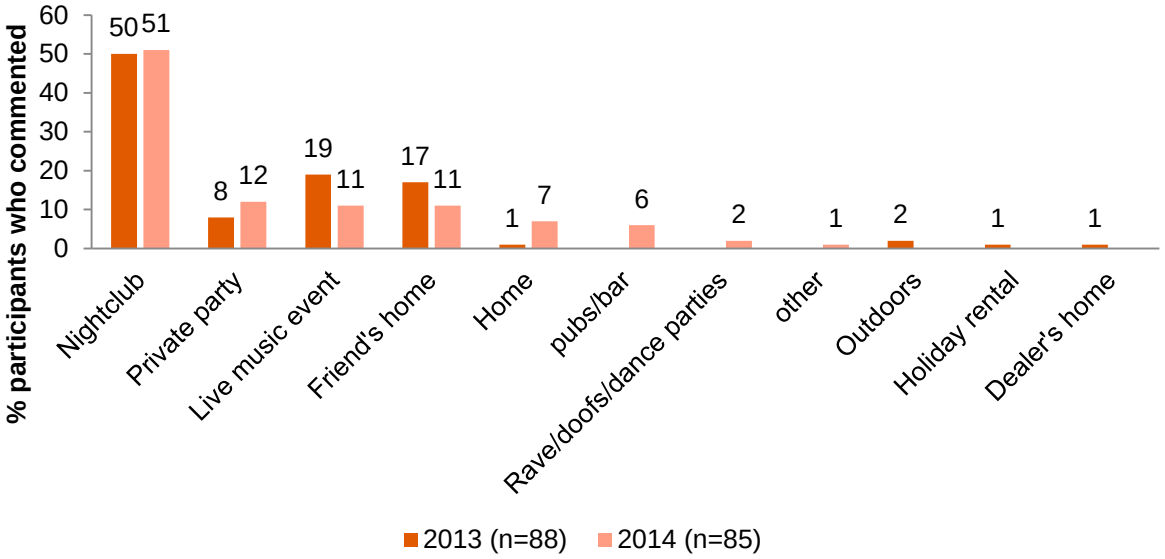
Table 16: Source person and location of most recent purchase of ecstasy pills, powder and caps, 2013 and 2014

	2013 (n=87) %	**2014 (n=85) %**
Source person		
Friends	62	**61**
Known dealers	24	**17**
Acquaintances	6	**9**
Unknown dealers	6	**9**
Work colleagues	1	**1**
Relatives	1	**-**
Online	-	**2**
Venue scored from		
Friend's home	39	**37**
Own home	21	**20**
Dealer's home	16	**12**
Nightclub	11	**12**
Agreed public location	2	**8**
Private party	3	**4**
Pubs/bar	1	**2**
Acquaintance's home	-	**2**
Online	-	**1**
Raves/doofs/dance parties	-	**1**
Street	3	**1**
Live music event	1	**-**
Holiday rental	1	**-**

Note: Those responding 'used not scored' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

Nightclubs remained the most popular venue for use of ecstasy pills, powder and caps (Figure 30).

Figure 30: Venue for most recent use of ecstasy pills, powder or caps, 2013 and 2014



Source: QLD EDRS participant interviews

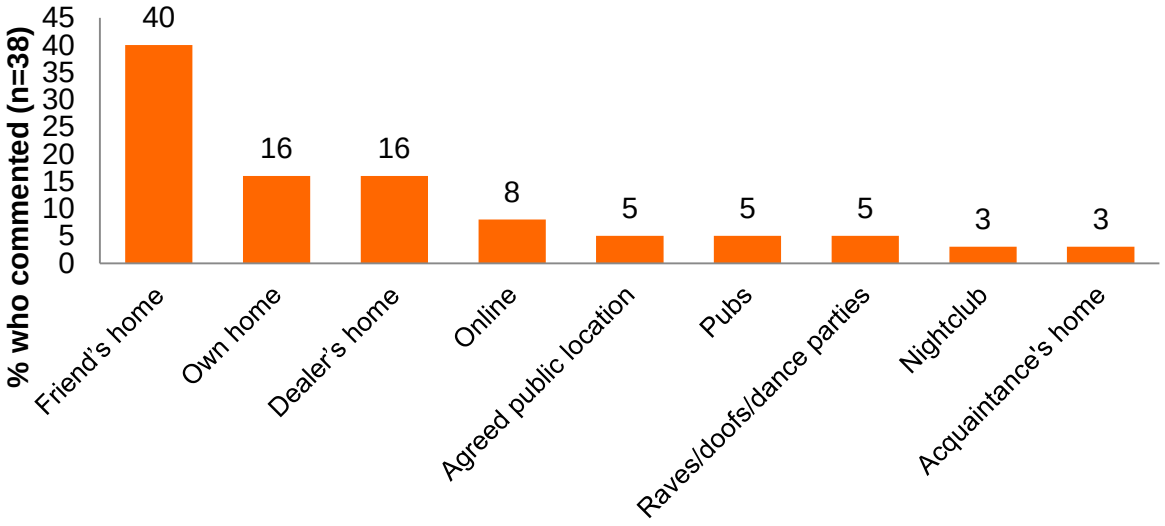
MDMA crystal

Among those who reported purchasing MDMA crystal in the previous six months (n=37), participants reported they made their most recent purchase from:

- Friend 46%
- Known dealer 30%
- Online 14%
- Unknown dealer 8%
- Acquaintance 3%

Figure 31 shows that a private home was the most common location for purchasing MDMA crystal, with 40% reporting buying it at a friend's home.

Figure 31: Location of most recent purchase of MDMA crystal, 2014



Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

Among those who commented (n=38), the location where the most time was spent under the influence of MDMA crystal the most recent time was:

- Nightclub 45%
- At home 16%
- Friend's home 13%
- Private party 11%
- Live music event 8%
- Rave/doof/dance party 5%
- Pub/bar 3%

5.1.5 Comments from key experts

Ecstasy pills were reported by key experts as being readily available, particularly at special events when it is common for people to be in groups. There was less information about the availability of MDMA crystal. Quality was reported as variable and dependent on regularity of use and context of use. Forensic experts reported some high purity levels, particularly in capsules and MDMA crystal. It was pointed out that two different-sized pills may have the same amount of MDMA because one may be a small pill with a high purity level and the other may be a large pill with a lower purity level (i.e. two different presentations of the same amount of a substance: one with a lot of filler and one with very little). Price was considered to be stable at $25 per pill and powder at $300–400 per gram.

5.2 Methamphetamine

Key points

- The price of speed remained stable at a median of $55 per point. Purity was generally rated as medium, and most reported that it was easy/very easy to obtain.
- Methamphetamine base cost a median of $60 per point, and was described as difficult to access.
- A point of ice cost a median of $100 per point, and $650 per gram. Purity was generally rated as medium/high, and accessibility as easy/very easy.
- Methamphetamine was most likely to have been sourced from a friend, at a friend's home.

In 2014, participants commented on the market trends for three forms of methamphetamine:

- Amphetamine powder (speed); n=14
- Methamphetamine base; n=8
- Crystalline methamphetamine (ice); n=17

Because numbers are low, findings should be treated with caution.

5.2.1 Price

Amphetamine powder (speed)

When asked how much speed cost the most recent time they purchased a point (0.1g), the median response was $55 (n=8, range $30–100). This appears lower than the median report of $65 per point in 2013 (n=6, range $25–100); however, this cannot be confirmed due to low numbers.

Four people reported buying one gram of speed in the previous six months. The prices paid were $300, $600 and 2 x $700 per gram. This appears to be more expensive than in 2013 (n=3, range $100–200), though numbers are too low for statistical comparison.

Of the 10 participants who were able to comment on the price of speed, seven reported that the price had remained stable in the previous six months, while three reported it was increasing. This is similar to 2013, though numbers are too low for meaningful comparison.

Methamphetamine base

The median price of one point of methamphetamine base at the most recent purchase was $60 (n=5, range $40–100). Of the six participants who commented on the price of base in the previous six months, three perceived it to have remained stable, two to have increased, and one to have decreased.

Crystalline methamphetamine (ice)

The median reported price per point of crystalline methamphetamine (ice) cost $100 (n=14, range $50–100), identical to 2013. One gram was a median of $650 (n=3, range $650–700).

Sixteen participants commented on the change in price of ice in the previous six months: 75% reported it to be stable, 19% as increasing, and 6% as decreasing.

Table 17 shows that the price ranges reported by the ACC (2014) for crystal/ice in 2012/13 encompasses the narrower range reported by our study participants in 2014.

Table 17: ACC reported methylamphetamine (crystal form) prices in Queensland, 2012–2013

Weight	Price per unit
1 point (0.1 gram)	$50–150
1 gram / ‘weight’	$500–1,000
¼ ounce (1.7 grams)	$5,800–8,000
1/8 ounce (3.5 grams) / ‘eight ball’	$750–1,700
1 ounce (28 grams)	$10,000–15,000
1 pound (454 grams)	$70,000–120,000

Source: ACC, 2014

Overall the ACC’s 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 18).

Table 18: ACC reported methylamphetamine (non-crystal form) prices in Queensland, 2012–13

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 pound (454 grams)	$45,000–90,000

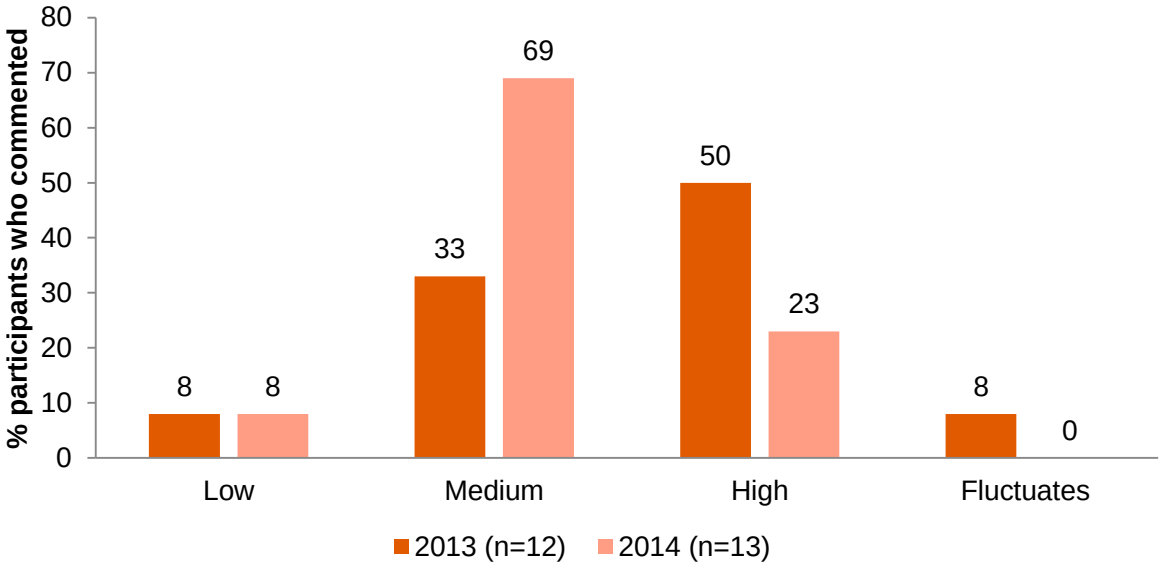
Source: ACC, 2014

5.2.2 Purity

Amphetamine powder (speed)

In 2014, 13 participants reported on their perception of purity of speed. Though there appeared to be a decrease in purity, with fewer people reporting it to be of high purity, and more as medium (Figure 32), this report is based on very low numbers and should therefore be treated with caution.

Figure 32: Perception of speed powder purity in previous six months, 2013 and 2014



Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

In 2014, only eight participants commented on perceived changes in purity of speed in the previous six months: three considered it to be decreasing, three as fluctuating, one as increasing, and one as stable. Low numbers prevent comparison with 2013.

Methamphetamine base

Six participants reported on perceived purity of methamphetamine base, though reports were not consistent.

Crystalline methamphetamine (ice)

In 2014, 17 participants were able to comment on the purity of ice. The responses were:

- high 47%
- medium 24%
- low 12%
- fluctuated 18%.

This is similar to 2013, though numbers are too low for statistical comparison.

Among those who reported on perceived changes in purity of ice in the previous six months (n=16), 38% reported it to have remained stable, 31% fluctuated, 19% decreased and 13% increased. This was similar to 2013.

Table 19 shows that in the financial year 2012/13 the QPS made 46 seizures of often low purity speed and base (range 0.4–25.5%): whereas the AFP made only one seizure of 13.7% purity (ACC, 2014).

Table 19: Median purity of amphetamine seizures analysed in Queensland by police, 2008–09 to 2012–13

	2008–09		2009–10		2010–11		2011–12		**2012–13**	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	***n***	***%***
QPS	38	2.0	20	1.2	56	0.8	14	1.5	**46**	**3.2**
AFP	6	7.8	2	18.6	5	14.3	9	69.1	**1**	**13.7**

Source: ACC, 2014

Table 20 shows the purity of the numerous methylamphetamine seizures by QPS was 52.6% (range 0.1–79.8%) in the financial year 2012–13. The 16 AFP seizures ranged in purity from 3.2% to 80.0% (median 71.1%) (ACC, 2014).

Table 20: Median purity of methylamphetamine seizures analysed in Queensland by police, 2008–09 to 2012–13

	2008–09		2009–10		2010–11		2011–12		**2012–13**	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	***n***	***%***
QPS	2,002	11.9	1,568	6.8	1,884	13.9	1,694	34.2	**1,763**	**52.6**
AFP	0	0	1	18.8	3	31.7	7	76.2	**16**	**71.1**

Source: ACC, 2014

5.2.3 Availability

In 2014, most participants who commented reported speed to be easy to very easy to obtain and that this had not changed in the previous six months (Table 21).

There was no consensus on the availability of base.

Ice was reported as easy or very easy to obtain, and availability was generally reported to have remained stable.

Table 21: Perceived availability by methamphetamine type, 2014

	Speed %	Base %	Ice %
Current availability	**(n=14)**	**(n=7)**	**(n=17)**
Very easy	21	43^	41
Easy	58	-	53
Difficult	21	43^	6
Very difficult	-	14^	-
Change in availability	**(n=13)**	**(n=7)**	**(n=16)**
More difficult	15	43^	6
Stable	62	57^	75
Easier	23	-	19

Note: ^ denotes small numbers reported; interpret with caution (n<10). Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

5.2.4 Source and locations of use

Amphetamine powder (speed)

Friends remained the most common source person for speed the most recent time it was obtained, with the most common source location being at a friend's home (Table 22). Unlike 2013, speed was not obtained from dealers, though statistical comparison was unwarranted due to low numbers.

Table 22: Most recent source person and location for amphetamine powder (speed) obtained in the previous six months, 2013 and 2014

	2013 (n=11) %	**2014 (n=14) %**
Source person		
Friend	55	**93**
Acquaintance	9	**7**
Known dealer	36	**-**
Source location		
Friend's home	18	**64**
Own home	18	**7**
Nightclub	9	**7**
Pub/bars	9	**7**
Other	-	**7**
Dealer's home	36	**-**
Agreed public location	9	**-**

Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

When asked where they had spent most of their time the most recent time they used speed (n=14), the most common location was at nightclubs (36%), followed by at a friend's home (29%), and then other locations such as at own home or in pubs/bars.

Methamphetamine base

Of the seven people who commented on their most recent methamphetamine base purchase in the previous six months, four sourced it from a friend, two from a known dealer and one from an acquaintance.

The most common location for obtaining base was at a friend's home. Other source locations included 'at own home', 'at a pub/bar' or 'at an agreed public location'.

The most common venue where participants reported spending most of their time while intoxicated on base was at their own home. Other venues included nightclubs, pubs/bar or live music events.

Crystalline methamphetamine (ice)

Among those who commented on the most recent time they purchased ice in the previous six months (n=16), 63% reported they had obtained it from a friend, 31% from a known dealer, and 6% from an acquaintance.

A friend's home was the most common source location for the most recent purchase of ice. Other source locations included at own home, at a dealer's home and at an agreed public location.

When asked where participants spend the majority of the time the most recent occasion they had used ice, most participants reported using it at their own home or at a friend's home. Other locations included nightclubs, outdoors, and live music events.

5.2.5 Comments from key experts

Key experts reported the market as stable with both speed and ice selling for between $70–100 per point and $1,000 per gram.

5.3 Cocaine

Key points

- The median price of a gram of cocaine remained stable at $300.
- 45% of participants who commented perceived cocaine as difficult/very difficult to obtain in the previous six months.
- A friend was the most common source person and a friend's home was the most common source location the most recent time cocaine was obtained in the previous six months.

In 2014, 23 participants answered questions about the cocaine market. Caution is needed when interpreting these data due to low numbers.

5.3.1 Price

The median price of a gram of cocaine was $300 the most recent time it was purchased in the previous six months (n=17, range $100–700). This was the same as in previous years.

Most reported the price to have remained stable in the previous six months (Table 23).

Table 23: Changes in prices of cocaine in previous six months, 2013 and 2014

	2013 (n=11) %	2014 (n=16) %
Increasing	9	31
Stable	73	63
Decreasing	9	-
Fluctuating	9	6

Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

Reports on price were in keeping with prices reported by the ACC (2014) for 2012–13. The ACC (2014) reported that one gram of cocaine was $300–$400.

5.3.2 Purity

The perceived purity of cocaine appears to have decreased, though there was not a statistically significant difference from 2013 (Table 24), but this may be due to the small sample size.

Table 24: Perception of cocaine purity in previous six months, 2013 and 2014

	2013 %	2014 %
Current purity	**(n=11)**	**(n=17)**
Low	18	**39**
Medium	73	**29**
High	9	**29**
Fluctuates	-	**5**
Change in purity	**(n=9)**	**(n=17)**
Increasing	-	**6**
Stable	33^	**53**
Decreasing	22^	**35**
Fluctuating	44^	**6**

Note: ^ denotes small numbers reported; interpret with caution (n<10). 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 25. In 2012–13, QPS seizures ranged in purity from 0.1–84.5% (median 27.8%), and AFP seizures ranged from 10.1–82.3% (median 65.5%) (ACC, 2014).

Table 25: Median purity of cocaine seizures analysed in Queensland, 2008–09 to 2012–13

	2008–09		2009–10		2010–11		2011–12		**2012–13**	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	***n***	***%***
QPS	214	28.1	257	30.1	126	19.8	125	18.7	178	27.8
AFP	6	41.7	3	53.7	21	76.2	9	66.0	11	65.5

Note: Figures do not represent purity of all cocaine seizures, but only of those submitted for analysis
Source: ACC, 2014

5.3.3 Availability

In 2014, 45% of participants who commented perceived cocaine as difficult/very difficult to obtain in the previous six months (Table 26), and that this had remained stable.

Table 26: Availability of cocaine in previous six months, 2013 and 2014

	2013 %	**2014 %**
Current availability	(n=13)	**(n=20)**
Very easy	15	**5**
Easy	31	**50**
Difficult	46	**35**
Very difficult	8	**10**
Change of ease of access	(n=11)	**(n=19)**
More difficult	-	**32**
Stable	55	**63**
Easier	27	**-**
Fluctuates	18	**5**

Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

5.3.4 Source and location of use

Similar to previous years, friends remained the most common source person for cocaine when last obtained, and the most common source location was at a friend's home (Table 27).

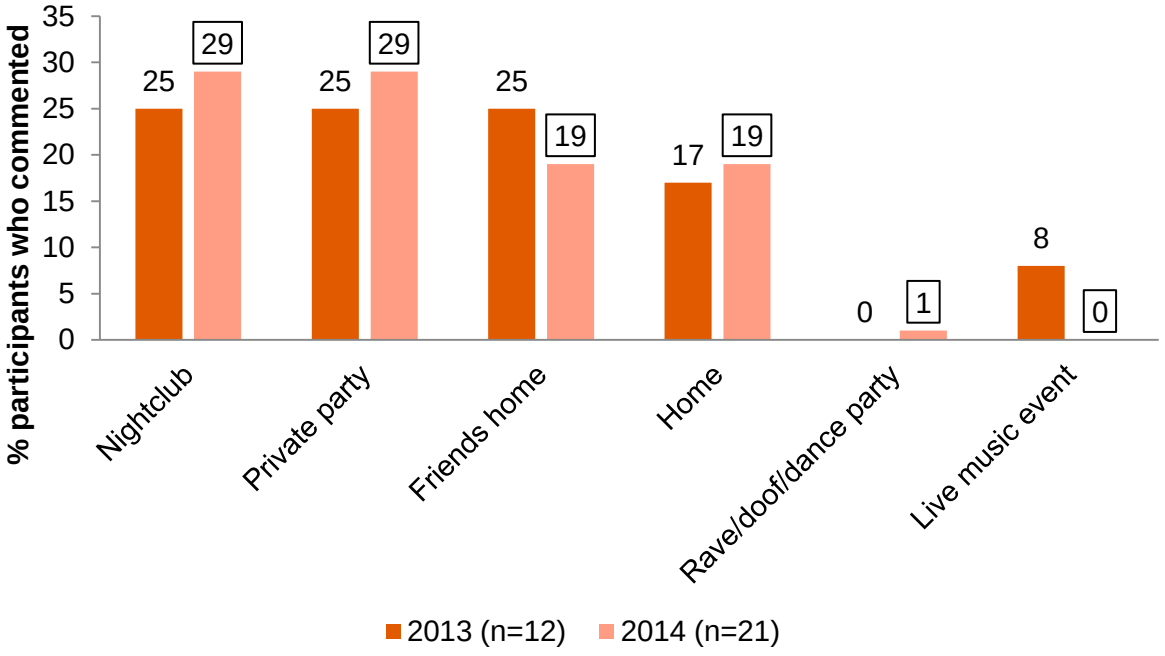
Table 27: Most recent source and location for obtaining cocaine, 2013 and 2014

	2013 (n=12) %	**2014 (n=21) %**
Persons scored from		
Friend	58	**67**
Known dealer	17	**33**
Acquaintance	25	**5**
Unknown dealer	-	**5**
Location scored from		
Friend's home	50	**52**
Dealer's home	8	**19**
Own home	25	**10**
Private party	-	**5**
Agreed public location	8	**5**
Nightclub	8	**-**

Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

Nightclubs and private parties were the most commonly reported locations for most recent use of cocaine (Figure 33).

Figure 33: Location of most recent cocaine use, 2013 and 2014

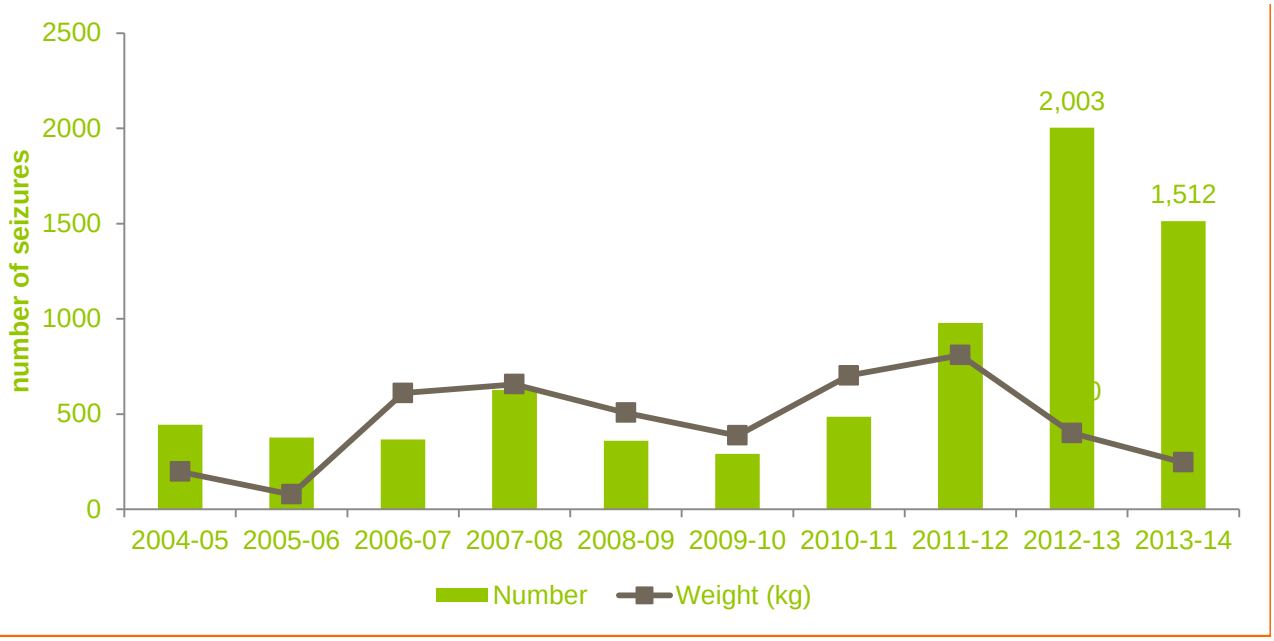


Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

5.3.5 Cocaine seizures

Figure 34 shows the weight and number of cocaine detections by the ACBPS at the Australian border over the last decade. In 2013–14 both the number and weight of seizures were lower than in 2012–13.

Figure 34: Number and weight of cocaine detections at the Australian border, 2004–05 to 2013–14



Source: ACBPS Annual Report 2013–14

5.3.6 Comments from key experts on cocaine market

According to key experts cocaine quality was variable as was price. Key experts reported ranges of $300–400 and $400–500 per gram.

5.4 Ketamine

Only one participant reported having purchased ketamine in the previous six months. The participant's most recent purchase of ketamine cost $250 per gram, was of medium strength and was easy to obtain. The ketamine was bought from a dealer, at a dealer's home and was used at a friend's home.

Due to low use, there was no information about the ketamine market from key experts.

5.5 GHB

Only one participant reported having purchased GHB in the previous six months. The most recent purchase cost $5 per ml from an unknown dealer in a public location and was used at home. The participant reported that price fluctuated, strength was high, and access and availability was difficult.

Key experts reported that GHB is fairly easy to obtain, particularly the precursors GBL and 1,4-butanedial. Key experts in the legal field reported that some drug labs in Queensland are dedicated to producing GHB.

5.6 LSD

Key points

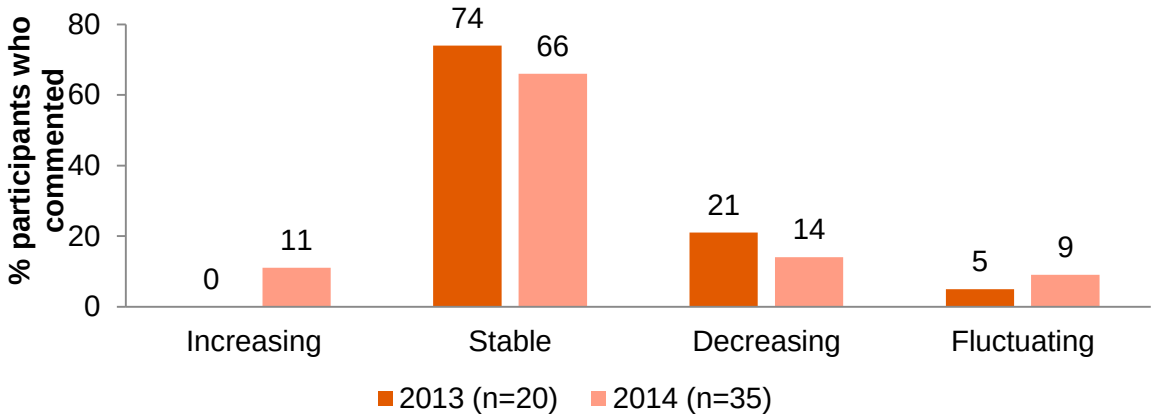
- One tab of LSD costs approximately $20; price is stable.
- Increase in perceived purity of LSD from 2013.
- Three-quarters reported LSD to be easy or very easy to obtain, and availability had remained stable.
- LSD was most likely to have been obtained from a friend at a friend's home.

In 2014, 42 participants were able to comment on the price, purity and availability of LSD in the previous six months.

5.6.1 Price

The median price for one tab of LSD was $20 (n=39, range $5–50), similar to previous years. Two-thirds reported the price had remained stable in the previous six months (Figure 35).

Figure 35: Change in price of LSD in previous six months, 2013 and 2014

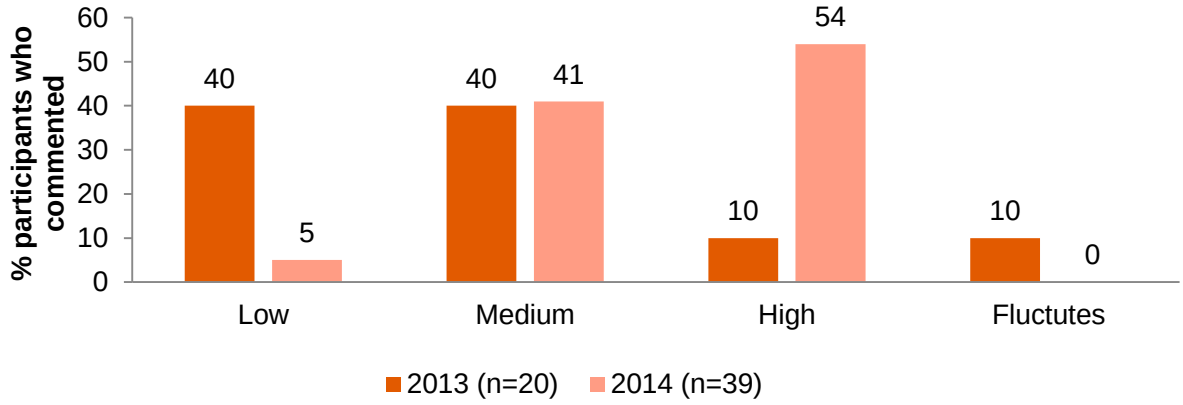


Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

5.6.2 Purity

In 2014, over half (54%) of participants reported the current purity of LSD as high, which is significantly more than 2013 ($p<0.05$) (Figure 36).

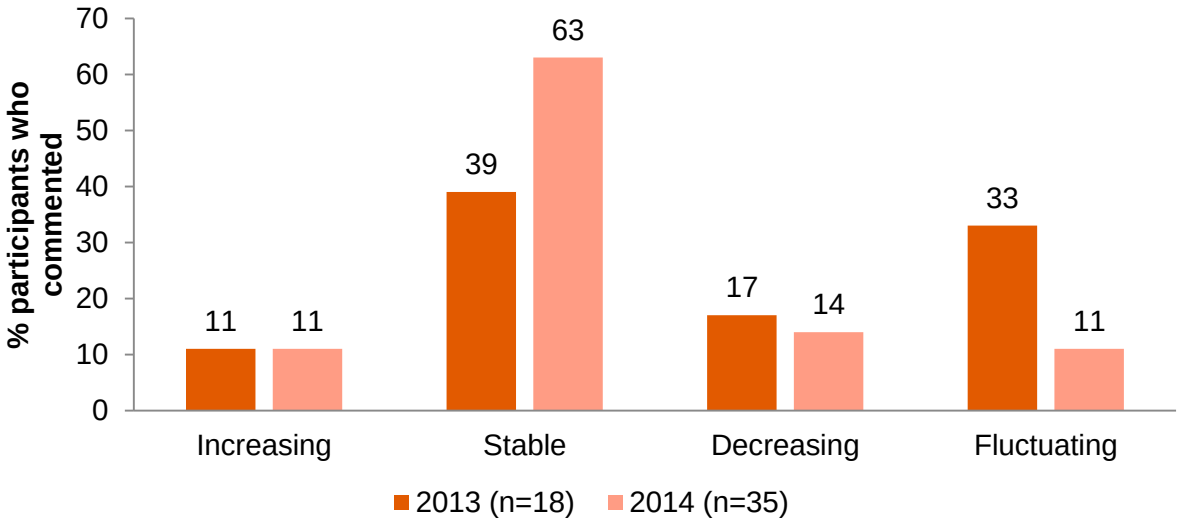
Figure 36: Purity of LSD in previous six months, 2013 and 2014



Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

Almost two-thirds perceived the purity of LSD had remained stable in the previous six months (Figure 37).

Figure 37: Changes in purity of LSD in previous six months, 2013 and 2014

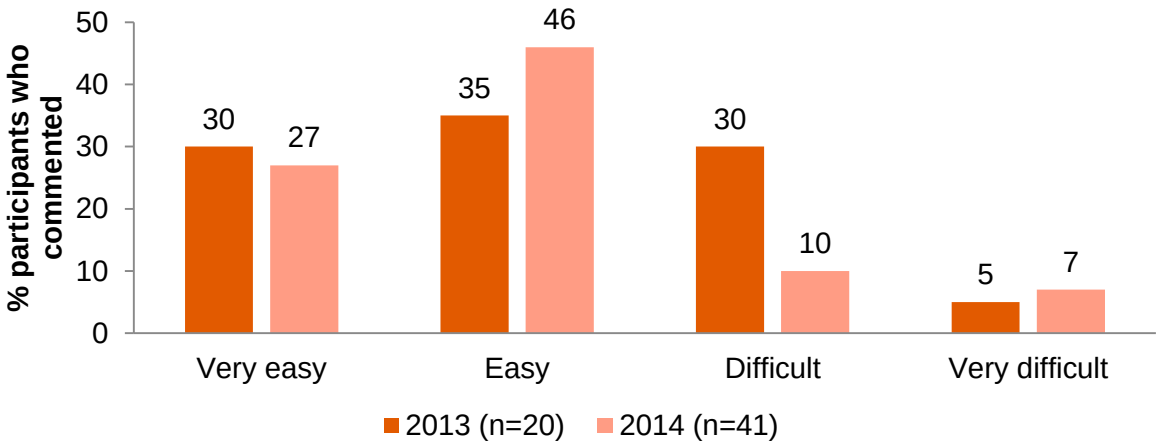


Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

5.6.3 Availability

Almost three-quarters reported LSD to be easy or very easy to obtain (Figure 38). Perceived availability was similar to 2013.

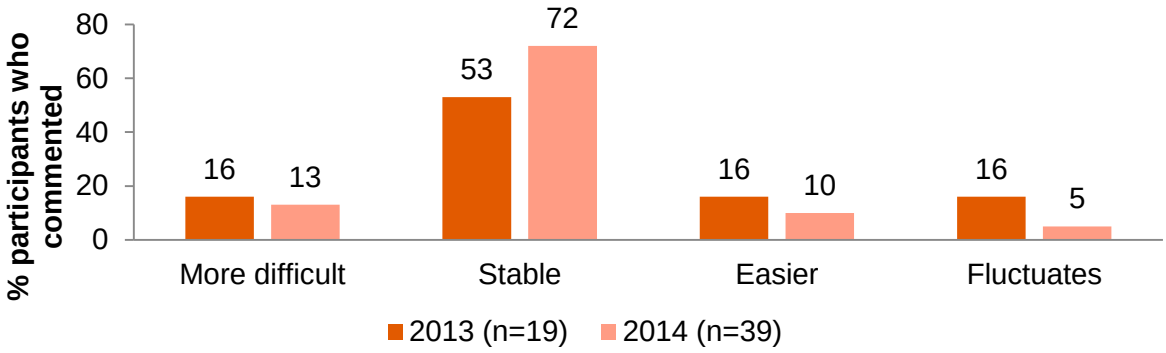
Figure 38: Availability of LSD in previous six months, 2013 and 2014



Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

Almost three-quarters reported the recent availability of LSD to be stable (Figure 39).

Figure 39: Changes in availability of LSD in previous six months, 2013 and 2014



Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

5.6.4 Source and locations of use

Friends remained the most common source person and a private home was the most common location when LSD was last obtained in the previous six months (Table 28).

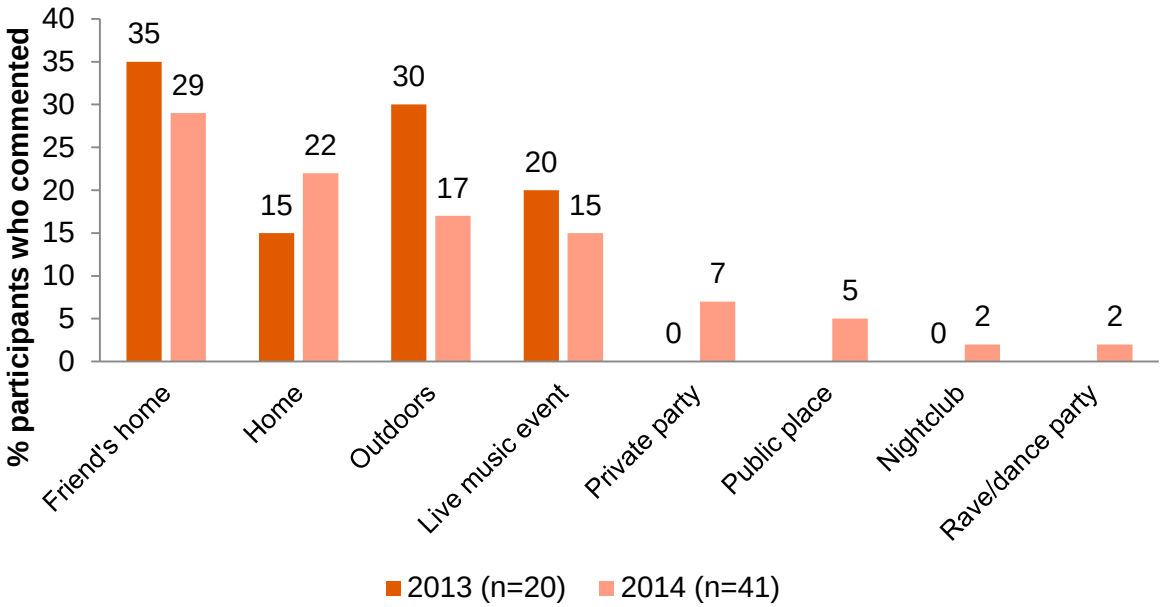
Table 28: Source person and location for obtaining LSD most recent time, 2013 and 2014

	2013 (n=20) %	**2014 (n=41) %**
Source person		
Friend	50	**61**
Dealer (known/unknown)	30	**20**
Acquaintances	20	**5**
Relative	-	**2**
Online	-	**10**
Other	-	**2**
Location sourced from		
Friend's home	40	**34**
Own home	5	**15**
Dealer's home	25	**7**
Online	-	**5**
Live music event	-	**5**
Agreed public location	15	**5**
Rave/doof/dance party	-	**2**
Acquaintance's house	-	**2**
Nightclub	-	**2**
Pub/bar	-	**2**
Private party	-	**2**
Other	15	**-**

Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

Figure 40 shows that a friend's home was the most common venue for using LSD the most recent occasion in the previous six months.

Figure 40: Location of most recent LSD intoxication, 2013 and 2014



Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

5.6.5 Comments from key experts on the hallucinogen market

It was noted that NPS such as the 25X-NBOMe drugs have been sold as LSD. Forensic experts reported that a range of 25X-NBIMBe drugs have been in cardboard tabs which traditionally has been the distinctive form of LSD in Australia.

5.7 Cannabis

Key points

- The median price for an ounce of hydro was $280, and $275 for bush, with prices perceived to have remained largely stable in the previous six months.
- The perceived purity of both hydro and bush cannabis was medium or high.
- Availability of cannabis remained easy/very easy.
- Cannabis was most often obtained from a friend, at a friend's home and was most often used at participants' own homes.

In 2014, 56 participants reported they were able to distinguish between hydro and bush cannabis. Forty-four participants were able to comment on hydro, and 34 were able to comment on the bush cannabis market. Two participants reported they were able to comment on the price of hash. No one was able to comment on the price of hash oil.

5.7.1 Price

In previous years, the price of hydro has been higher than bush. In 2014, however, the price of hydro and bush appeared similar though this may be influenced by low numbers: the median price of an ounce of hydro was $280 (n=12, range $250–300) and the median price of an ounce of bush was $275 (n=8, range $200–300).

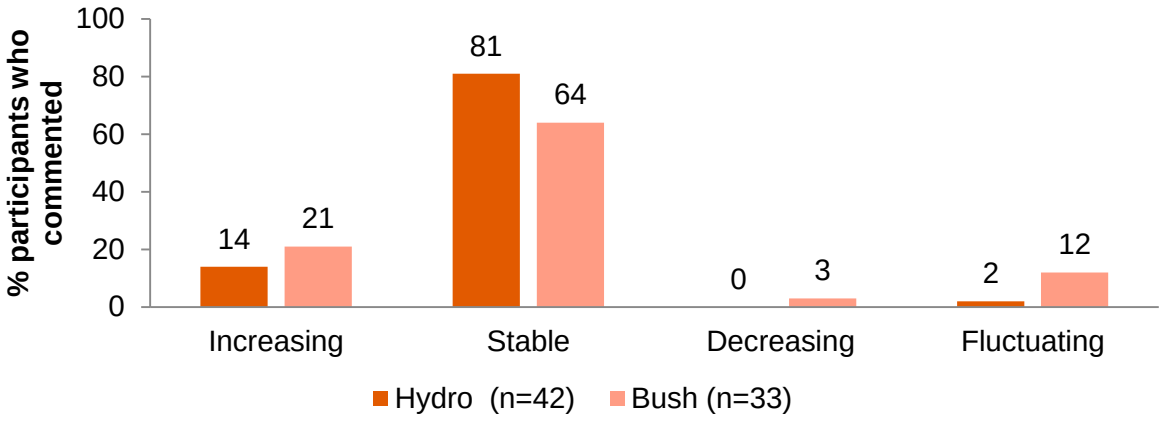
Table 29: Cannabis prices according to type and amount recently purchased, 2013 and 2014

	2013 Median (range)	2014 Median (range)
Hydro		
Gram	$25 (15–40)	**$11 (10–17)^**
Quarter ounce	$90 (30–100)	**$80 (70–90)**
Ounce	$268 (150–320)	**$280 (250–350)**
Bush		
Gram	$10 (10–15)^	**$15 (10–20)^**
Quarter ounce	$75 (30–90)	**$80 (70–180)**
Ounce	$235 (130–285)	**$275 (200–300)^**

Note: ^ denotes small numbers reported; interpret with caution (n<10).
Source: QLD EDRS participant interviews

Figure 41 shows that the price of both hydro and bush cannabis in the previous six months is perceived to have remained largely stable.

Figure 41: Price changes of cannabis in previous six months, 2014



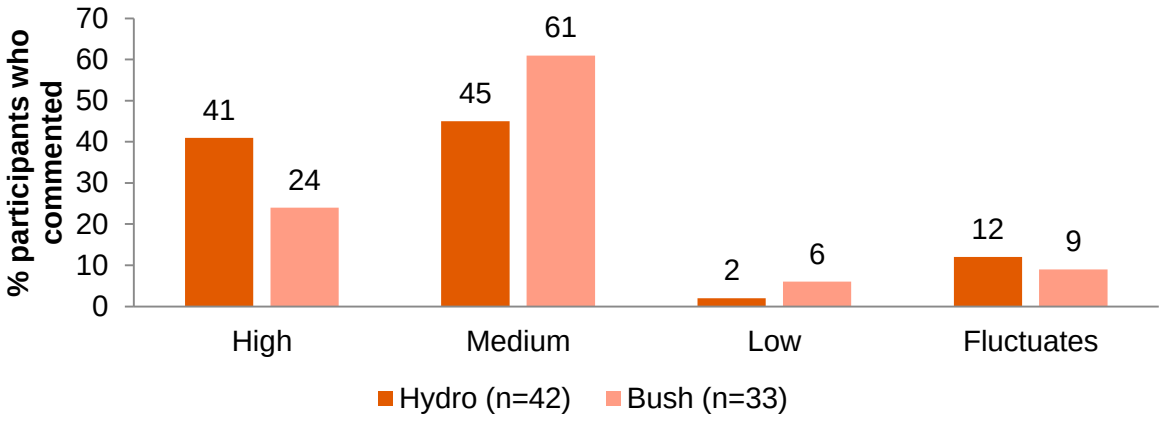
Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

Only two participants reported on the price of hash ($25 and $30 per gram).

5.7.2 Purity

Figure 42 shows that the perceived purity (i.e. strength) of both hydro and bush cannabis was largely medium or high as was the case in 2013.

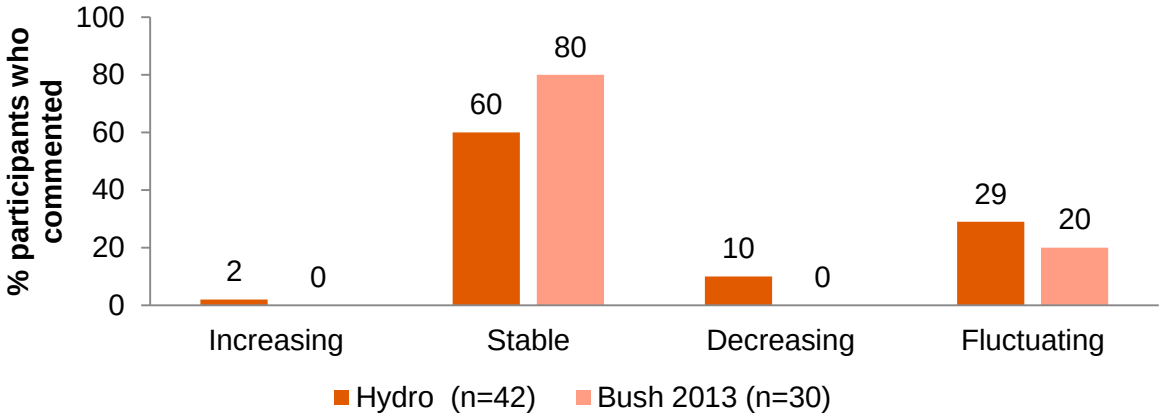
Figure 42: Perception of cannabis purity in previous six months, 2014



Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

Figure 43 shows that the purity of cannabis was most commonly reported as stable for both hydro and bush.

Figure 43: Perceived change in recent purity of cannabis, 2014



Note: Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

5.7.3 Availability

Similar to previous years, bush cannabis was perceived to be more difficult to obtain than hydro (Table 30).

Table 30: Availability of cannabis in preceding six months, 2013 and 2014

	Hydro		Bush	
	2013 %	**2014 %**	2013 %	**2014 %**
Current ease of access	**(n=49)**	**(n=42)**	**(n=40)**	**(n=33)**
Very easy	47	**52**	50	**30**
Easy	39	**38**	33	**46**
Difficult	14	**5**	18	**15**
Very difficult	-	**5**	-	**9**
Change in availability in previous six months	**(n=48)**	**(n=43)**	**(n=40)**	**(n=32)**
More difficult	33	**19**	15	**22**
Stable	52	**72**	68	**66**
Easier	2	**-**	8	**6**
Fluctuates	13	**9**	10	**6**

Note: Arrow symbol signifies a significant difference p<0.05. Those choosing 'don't know' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

5.7.4 Source and locations of use

The most common source person for purchasing either hydro or bush was a friend, followed by a dealer; and the most common location remained a friend's home (Table 31).

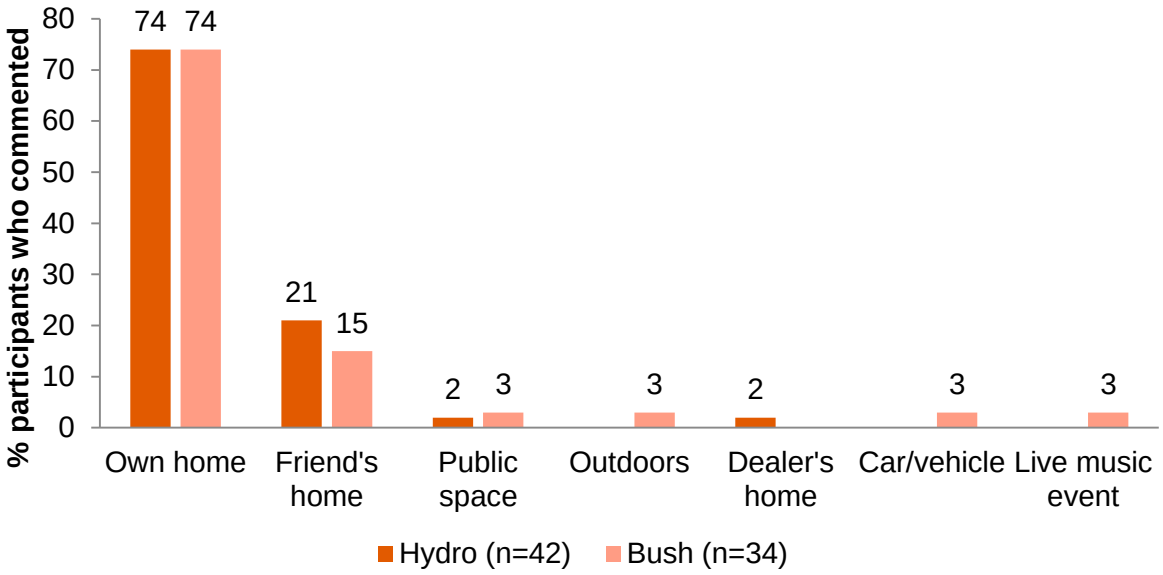
Table 31: Source person and location of most recent cannabis purchase, 2013 and 2014

	Hydro		Bush	
	2013 (n=48) %	**2014 (n=42) %**	2013 (n=40) %	**2013 (n=34) %**
Score person				
Friend	48	**51**	50	**59**
Known dealer	46	**30**	33	**18**
Unknown dealer	2	**2**	5	**12**
Acquaintances	4	**9**	5	**9**
Street dealer	-	**2**	5	**3**
Relative	-	**2**	3	**-**
Score location				
Friend's home	31	**42**	33	**47**
Dealer's home	40	**26**	35	**18**
Agreed public location	2	**5**	3	**15**
Own home	23	**21**	18	**12**
Other	-	**-**	3	**6**
Acquaintance's home	2	**5**	3	**3**
Street market	2	**-**	8	**-**

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 for using both hydro and bush cannabis (Figure 44).

Figure 44: Venue of most recent cannabis use, 2014



Note: Those choosing 'haven't obtained' were excluded from analyses. Totals may not add to 100% because of rounding.
Source: QLD EDRS participant interviews

5.7.5 Comments from key experts on cannabis market

Key experts reported that cannabis was readily available, particularly hydro as bush is more seasonal. Prices reported for cannabis were: hydro $350–400 per gram and bush $250–300 per gram.

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

Key points

- 27% reported a lifetime stimulant overdose, with 15% overdosing on a stimulant drug in the previous year. The most common stimulant drug attributed to causing an overdose in the previous year was ecstasy, followed by LSD.
- 24% reported experiencing an overdose on a depressant drug, with 9% doing so in the previous 12 months. The most common depressant drug attributed to causing an overdose in the previous year was alcohol.
- The majority (86%) of participants did not access a health service or professional about their drug and/or alcohol use in the previous six months.
- Among those who did access a health service or professional about their drug use in the previous six months, the most common service accessed was a general practitioner (GP).
- Drug treatment remained low in this sample, with only 3% reporting they were currently in some form of treatment.
- 60% scored moderate to very high levels of psychological distress on the K10.
- 31% self-reported having a mental health problem in the previous six months, most commonly anxiety and depression; and 23% attended a health professional for mental health reasons in the previous six months.

6.1 Overdose and drug-related fatalities

6.1.1 Non-fatal stimulant overdose

Twenty-seven per cent of participants reported experiencing a stimulant overdose in their lifetime. The median number of times this had ever happened was once (n=26, range 1–5 times). Fifteen per cent of all participants had experienced a stimulant overdose in the previous 12 months.

Among the participants who commented on their most recent stimulant overdose in the previous 12 months (n=14), the two drugs most commonly attributed to the overdose were ecstasy (50%), followed by LSD (29%). Additional use of alcohol occurred in nearly half of the overdoses (43%).

The most common location of the most recent stimulant overdose was at a friend's home (29%), followed by at a nightclub (21%). Other locations included at own home, at a hotel, at a live music event, and at a rave/doof/dance party.

The main symptom experienced was vomiting. Other symptoms included change in body temperature (hot and cold), increased heart rate, irregular breathing, sweating excessively, clenched/grinding jaw, depression, extreme anxiety, auditory and visual hallucinations, delirium/confusion and losing consciousness.

Most (79%) reported someone sober was present during the overdose to assist, and 71% reported that they were monitored by friends. One participant was taken to the hospital emergency department via ambulance and received oxygen. One-third (36%) received treatment/information after the overdose. Of these five participants, four used the internet (e.g. pillreports.com, wikipedia.org) and one visited a GP.

Eighty-six per cent reported the stimulant overdose had occurred during a particularly heavy session of drug use.

6.1.2 Non-fatal depressant overdose

Twenty-five per cent of participants reported experiencing an overdose on a depressant drug in their lifetime. The median number of depressant overdoses was twice (n=24, range 1–25).

Nine per cent of all participants had experienced a depressant overdose in the previous 12 months. Of these nine participants, seven attributed the overdose to alcohol (78%), one to heroin, and the other to fentanyl.

The most common location where the overdose occurred was at a nightclub. Other locations included at home, at a friend's house, or at a pub.

Main symptoms included vomiting, loss of consciousness, dizziness, memory loss, anxiety and liver failure.

Seven of the nine participants reported that a sober person was present who was able to assist, and five were monitored by friends. Two participants reported visiting the hospital emergency department, where one received oxygen. One person had to undergo three months in hospital and physical rehabilitation.

After the overdose, one participant reported visiting a GP, another a psychologist and one went to a user group/organisation. Two did not receive any type of treatment or assistance.

All reported that their depressant overdose had occurred during a particularly heavy session.

6.1.3 Queensland Ambulance Service

Figures from the Queensland Ambulance Service (2014) are shown In Table 32 for people coded as having a drug overdose and where the primary drug was recorded.

In the 2013–14 financial year, 8,136 people received attention for a drug overdose by the Queensland Ambulance Service. As in previous years, the most common drug attributed to the overdose was alcohol, making up 46% of cases. Medications, antidepressants and benzodiazepines were the next most common.

Table 32: Overdose cases attended by Queensland Ambulance Service where primary substance was recorded, 2009–10 to 2013–14

Primary drug	2009–10	2010–11	2011–12	2012–13	2013–14
Alcohol	3629	3813	3950	4,151	**3,750**
Other medications	1060	1000	992	1,026	**982**
Antidepressants	766	661	641	720	**454**
Benzodiazepines	467	490	554	613	**413**
Unknown substance	322	320	351	369	**307**
Amphetamines	132	149	265	282	**247**
Cannabis	182	198	227	251	**226**
Heroin	242	285	281	217	**190**
Other opiates	110	148	131	179	**186**
Antipsychotics	228	208	221	216	**155**
Inhalants	74	80	136	180	**135**
Ecstasy	166	107	137	212	**82**
Methadone	39	34	32	31	**37**
GHB	38	32	53	119	**29**
Cocaine	33	28	26	42	**27**
Buprenorphine	5	2	3	7	**8**
Naltrexone	3	3	3	1	**1**
Other	880	799	860	1,000	**907**
Total	8376	8357	8863	9,616	**8,136**

Source: Queensland Ambulance Service, 2014

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

6.2.1 Use of health services among participants

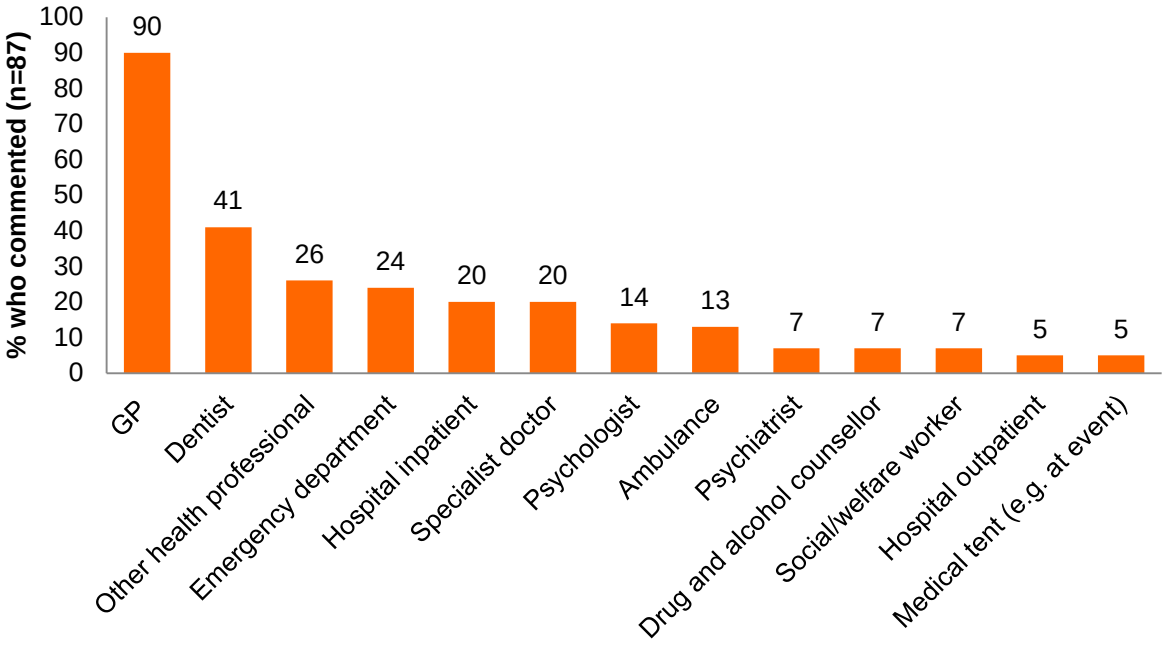
Similar to previous years, 86% of participants reported that they had not accessed a service or health professional about their drug and/or alcohol use in the previous six months.

Among those who had not recently accessed a service or health professional about drug and/or alcohol use in the previous six months (n=82), 16% had thought about doing so. Their reasoning for not seeking help, despite having thought about it (n=13) included: 'I worked it out on my own' (41%), 'not a priority' (23%), and 'couldn't be bothered' (15%).

Fourteen per cent of participants reported that they had sought help from a service or health professional for their drug and/or alcohol use in the previous six months. Of these 14 participants, 89% accessed a GP. Additional services accessed in relation to drug and/or alcohol use were: emergency department (43%), hospital as an inpatient (36%), psychologist (36%), drug and alcohol counsellor (29%), social/welfare worker (29%), hospital ambulance (14%), psychiatrist (14%), hospital as an outpatient (14%), and a specialist doctor (7%). The main drug of concern for seeking help was alcohol, followed by speed and ice. Other drugs of concern were LSD, cannabis and benzodiazepines. No participants reported accessing a service related to ecstasy use.

Eighty-seven per cent of all participants reported accessing at least one health service for any reason (i.e. not just related to drug and/or alcohol use) in the previous six months. Figure 45 shows the most common service accessed for any reason was a GP, followed by a dentist.

Figure 45: Main service accessed for any reason in the previous six months, 2014



Note: Multiple responses permitted.
Source: QLD EDRS participant interviews

6.2.2 Calls to drug-related telephone helplines among general population

The following data was obtained from the Queensland Alcohol and Drug Information Service (ADIS) which is a 24-hour information and counselling service provided by the Queensland Department of Health (Table 33). In the financial year 2013–14, the pattern of calls according to drug type was similar to previous years, with alcohol being the most common drug of concern, followed by amphetamines, licit opioids, and cannabis.

Table 33: Number of calls to ADIS according to drug type, 2011–12 to 2013–14

Drug type	Calls		
	2011–12	2012–13	**2013–14**
Alcohol	5,975	5,166	**5,923**
Amphetamines	1,913	2,020	**2,960**
Licit opioids	1,752	1,503	**2,675**
Cannabis	2,456	2,167	**2,464**
Benzodiazepines	1,008	971	**1,050**
Illicit opioids	1,069	756	**1,005**
Ecstasy	120	134	**117**
Cocaine	80	76	**116**
Hallucinogens	44	50	**55**
Other	3,090	3,430	**5,791**

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: ADIS

6.3 Drug treatment

Similar to previous years, drug treatment remained low among this sample. Only three participants reported currently being in some form of drug treatment. Types of current drug treatment were drug counselling, Narcotics Anonymous, and sessions with the psychosis team at a hospital.

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.

One-third of all participants (34%) reported drug use had increased risky behaviour in the previous six months, and 24% reported they believed it had impacted their social relationships. Legal problems related to drug use were reported by 9% of participants, and 21% reported having difficulty meeting responsibilities (e.g. work/study commitments, homework, etc.)

Table 34 shows that alcohol, cannabis and ecstasy were the most likely drugs attributed to these recurrent problems.

Table 34: Primary drug contributing to recurrent problems within previous six months, 2014

Main drug	Recurrent problems			
	Social/ relationship (n=24) %	Legal (n=9^) %	Increased risky behaviour (n=34) %	Difficulty meeting responsibilities (n=39) %
Alcohol	29	11	38	21
Cannabis	21	22	18	32
Cocaine	4	-	-	-
Ice	13	11	9	8
Ecstasy	4	22	6	13
Heroin	8	-	-	3
Methadone	4	11	3	3
LSD	-	-	15	
Speed	8	-	-	5
MDA	-	11	3	
Other	8	11	9	13

Note: ^ denotes small numbers reported; interpret with caution (n<10). 'Other' includes MDA, oxycodone, valium and 'E10'
Source: QLD EDRS participant interviews

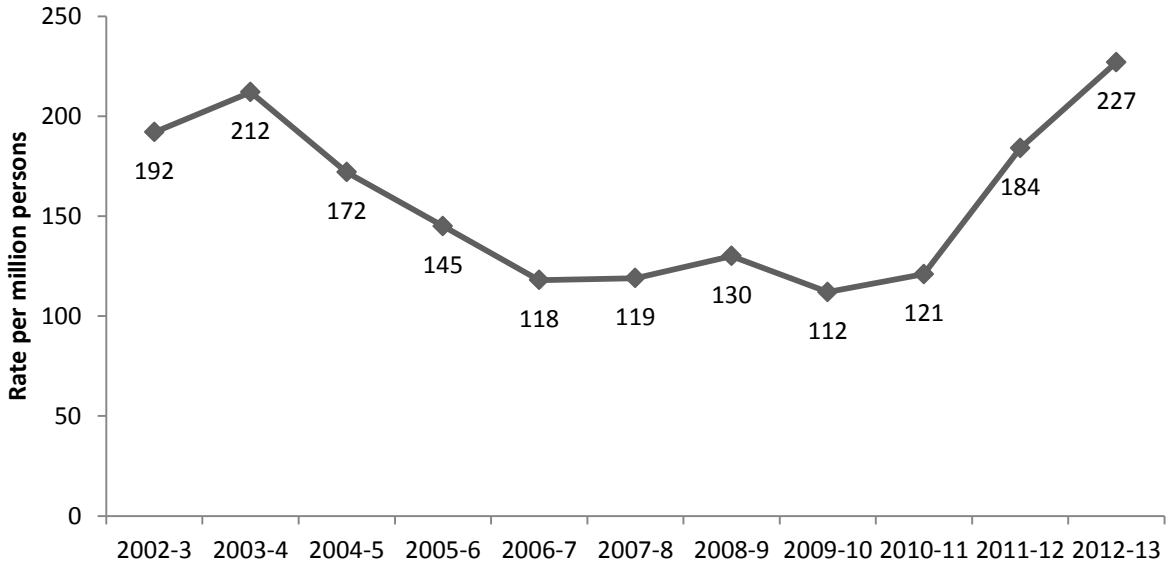
6.5 Hospital admissions

Data for hospital admissions is only available for 2012–13.

6.5.1 Methamphetamine

In 2012–13, the number of inpatient hospital admissions in Queensland where the principal diagnosis related to methamphetamines was 583 for persons aged 15–54 years. This equates to 227 per million persons. The national rate per million persons is 272. As Figure 46 shows, the number of inpatient hospital admissions per million persons has been trending upwards in recent years and is now the highest in the reporting period.

Figure 46: Number of principal methamphetamine-related hospital admissions per million persons among people aged 15–54 years, Queensland, 2002–03 to 2012–13

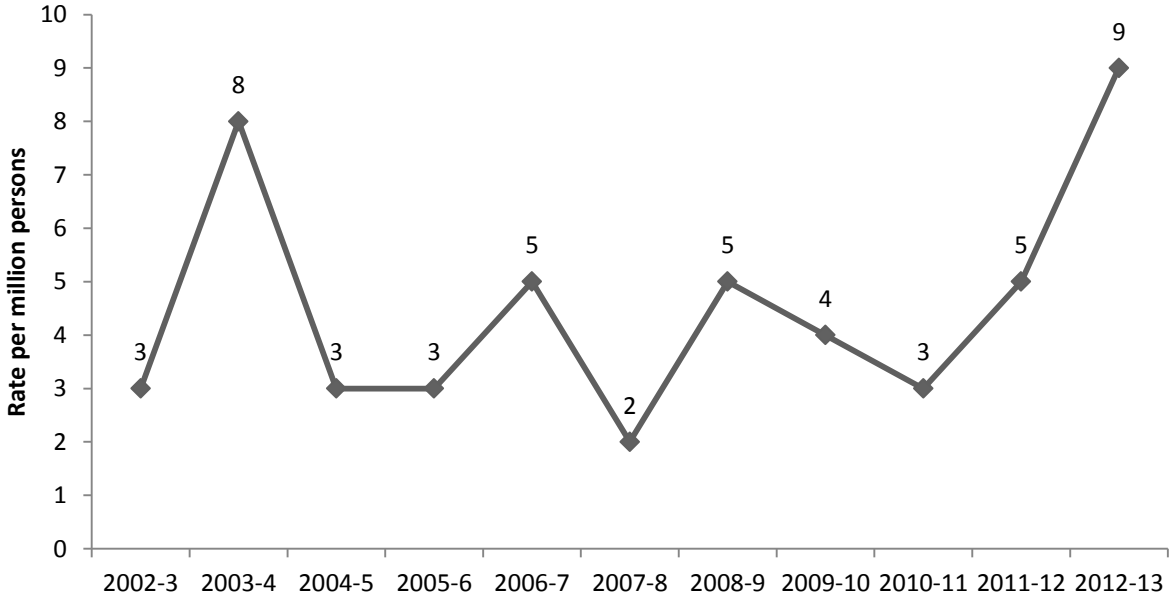


Source: Roxburgh and Burns, in press

6.5.2 Cocaine

Figure 47 shows the number of inpatient hospital admissions in Queensland per million persons with a principal diagnosis relating to cocaine over the last decade. The nine admissions per million persons is much lower than the national rate of 28, and equates to 22 admissions.

Figure 47: Number of principal cocaine-related hospital admissions per million persons among people aged 15–54 years, Queensland, 2002–03 to 2012–13



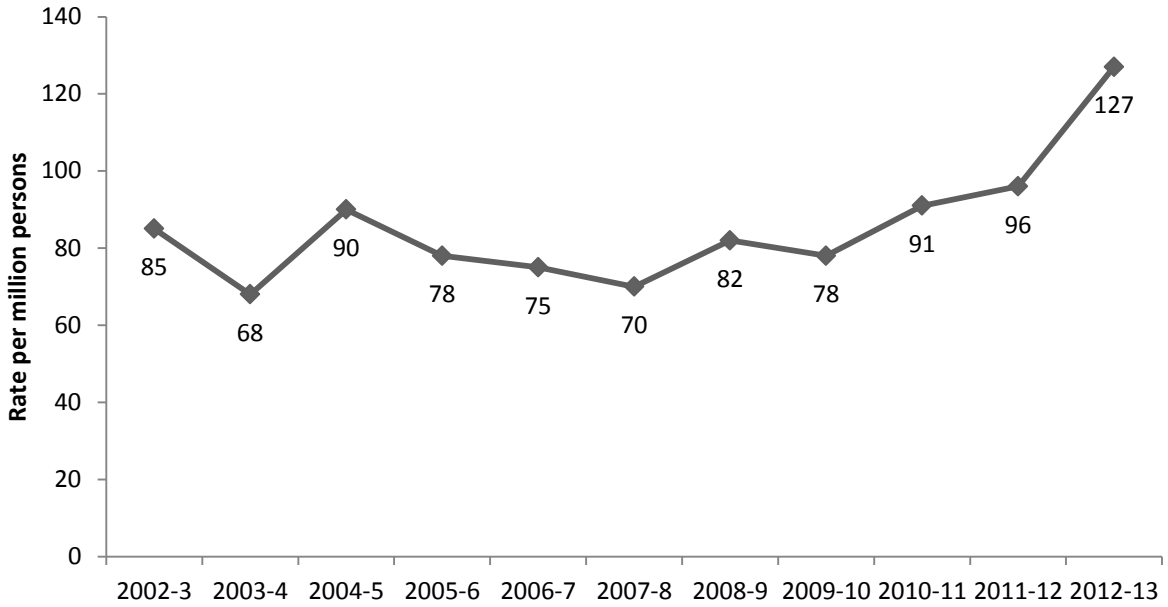
Source: Roxburgh and Burns, in press

6.5.3 Cannabis

In 2012–13, there were 326 inpatient hospital admissions in Queensland for those aged 15–54 years where the principal diagnosis related to cannabis. This equates to 127 inpatient

hospital admissions per million persons (Figure 48). Admission numbers are continuing to trend upwards. The national rate is 186.

Figure 48: Number of principal cannabis-related hospital admissions per million persons among people aged 15–54 years, 2002–03 to 2012–13



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).

In 2014, 60% of participants who commented reported experiencing moderate to very high levels of distress in the previous month (Table 35). This is similar to 2013.

Table 35: K10 level of distress, 2013 and 2014

	2013 (n=81) %	**2014 (n=93) %**
Low to no distress (0–15)	37	**40**
Moderate distress (16–21)	27	**31**
High distress (22–29)	27	**20**
Very high distress (30–50)	9	**9**

Source: QLD EDRS participant interviews

6.6.2 Self-reported mental problems and medication

In 2014, 31% of all participants reported having a mental health problem in the previous six months. Similar to previous years, anxiety and depression were the most common self-reported mental health problems (Table 36).

Table 36: Self-reported recent mental health problems, 2009 to 2014

	2009 (n=33) %	2010 (n=32) %	2011 (n=39) %	2012 (n=22) %	2013 (n=38) %	**2014 (n=30) %**
Anxiety	42	78	62	45	61	**70**
Depression	67	60	80	68	61	**63**
Panic	9	3	21	14	18	**17**
OCD	3	3	8	9	11	**13**
Manic depression/bipolar disorder	18	9	5	9	8	**7**
Drug-induced psychosis	15	3	3	14	4	**3**
Schizophrenia	9	6	8	9	-	**3**
Paranoia	21	6	18	18	4	**-**
Any personality disorder	-	-	5	9	-	**-**
Other	-	25	10	18	20	**23**

Note: Multiple responses permitted. In 2010, 'other' included PTSD, ADHD, chronic fatigue, lethargy, night terrors, sleeping disorder and 'slight anger issues'. In 2011, 'other' included anorexia nervosa, insomnia, short-term memory loss, sleeping disorder and 'anger problems'. In 2012, 'other' included 'phobias' and 'gender identity disorder/severe mood disorder'. In 2013, 'other' included 'other psychosis' and PTSD. In 2013, 'other' included 'phobia', PTSD, ADHD, eating disorder, panic attacks, nervous disorder, and 'dex'.
Source: QLD EDRS participant interviews

Nearly a quarter (23%) of all participants reported attending a health professional for a mental health problem in the previous six months. Of these (n=23), 57% were prescribed medication. These participants (n=13) were prescribed:

- anti-depressants (i.e. Prozac, Lexapro, Lovan, Pristiq, Efexor and Avanza) 92%
- benzodiazepines (i.e. Valium) 46%
- anti-psychotics (i.e. Seroquel and Zyprexa) 38%
- mood stabiliser 8%.

7 RISK BEHAVIOUR

Key Points

- Increase in reports of recent injecting, with 19% reporting injecting a drug in the previous six months.
- Most common recently-injected drug was ice, followed by speed and steroids.
- 60% reported having penetrative sex with a casual sex partner in the previous six months.
- Drug use when having penetrative sex with a casual partner differed from 2013 with more accompanying alcohol use and less cannabis use.
- 80% scored eight or higher on the AUDIT, corresponding to drinking at levels which may be harmful to their health.

7.1 Injecting risk behaviour

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

7.1.1 Lifetime injectors

Twenty-five participants reported having ever injected a drug. In 2014, there was a significant increase in the proportion of participants reporting recently injecting, with 19% of all participants reporting they had injected a drug in the previous six months ($p<0.05$) (Table 37).

Table 37: Injecting risk behaviour, 2008 to 2014

	2009 (N=88)	2010 (N=101)	2011 (N=103)	2012 (N=62)	2013 (N=88)	**2014 (N=100)**
Ever injected (%)	22	17	24	29	14	**25**
Median age first injected (range)	19 (14–30)	20 (14–29)	18 (14–28)	19 (13–43)	18 (15–26)	**21 (14–35)**
Injected last 6 months (%)	13	11	16	16	7	**19↑**

Note: Arrow symbol signifies a significant difference $p<0.05$.
Source: QLD EDRS participant interviews

The mean age of first injection was 21 years (n=25, range 14–35 years).

The most common drug first injected was speed, followed by heroin and steroids, then cocaine and ice. Other drugs included base, ketamine and 'other opiates'.

7.1.2 Recent injectors

In 2014, 19 participants reported injecting drugs in the previous six months, which was significantly more than 2013 ($p<0.05$). Ice was the most common drug injected on the most

recent occasion, followed by speed, then steroids. Base, cocaine, heroin, fentanyl, oxycodone and suboxone were also reported to have been injected the most recent time.

The most common location of the most recent injection was at own home, followed by at a friend's home. Other locations included at a dealer's home, in a motel room, and at a sex venue.

Ten per cent of participants reported that they usually injected alone. For those who reported they usually inject with others, this was usually a close friend, sex partner or acquaintance.

The majority of participants reported sourcing their needles in the previous six months from a needle and syringe program (NSP) or from a chemist. Other needle sources included an NSP vending machine, from their partner, and from a friend (multiple answers permitted).

7.1.3 Injecting drug use in the general population

According to the recent 2013 NDSHS, 1.5% of Australians aged 14 and over had injected a drug other than that prescribed to them at least once in their lifetime. In the previous 12 months, 0.3% of Australians reported having injected illegally (AIHW, 2014).

The Queensland Department of Health NSP supplied 8,662,985 syringes to their programs and 1,000650 to pharmacies in the financial year 2013–14.

7.2 Sexual risk behaviour

7.2.1 Casual sex partners

Participants were asked optional questions about whether they engaged in sexual behaviour with a casual sex partner. In 2014, 88 participants completed this section, with 60 participants reporting penetrative sex with at least one casual sex partner at least once in the previous six months (Table 38).

Table 38: Number of casual partners participants had penetrative sex with in previous six months, 2013 and 2014

	2013 (n=64) %	**2014 (n=60) %**
One person	36	**27**
Two people	31	**27**
3–5 people	25	**30**
6–10 people	3	**13**
More than 10 people	5	**3**

Source: QLD EDRS participant interviews

Among those who reported having penetrative sex with a casual sex partner in the previous six months (n=60), 92% reported having done so while under the influence of drugs. Table 39 shows that four in five did this more often than once.

Table 39: 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 and 2014

	2013 (n=58) %	2014 (n=54) %
Once	12	**20**
Twice	12	**24**
3–5 times	38	**22**
6–10 times	12	**22**
More than 10 times	26	**11**

Source: QLD EDRS participant interviews

In 2014, there was a significant increase from 2013 in participants reporting they had used alcohol the most recent time they had penetrative sex with a casual sex partner in the previous six months ($p<0.05$) (Table 40). There was also a significant decrease in reports of having used cannabis the most recent time ($p<0.05$).

Table 40: Drugs used most recent time had penetrative sex with a casual sex partner while under the influence, 2013 and 2014

	2013 (n=58) %	2014 (n=54) %
Alcohol	38	**82↑**
Ecstasy	62	**46**
Cannabis	52	**32↓**
Cocaine	21	**19**
LSD	9	**13**
Ice	3	**11**
Speed	10	**9**
MDA	-	**7**
Amyl nitrate	3	**4**
Benzodiazepines	-	**4**
Base	-	**2**
Nitrous oxide	2	**2**
Pharmaceutical stimulants	3	**2**
Mushrooms	3	**-**

Note: Multiple responses permitted. Arrow symbol signifies a significant difference ($p<0.05$).
Source: QLD EDRS interview participants

In 2014, 57% of those who had had penetrative sex while under the influence of drugs in the previous six months reported using a protective barrier (e.g. a condom) the most recent time, with 55% using a barrier the most recent time they had penetrative sex with a casual partner while sober.

When asked how often participants used condoms or other barriers when having sex with casual sex partners while under the influence of drugs, only 30% reported doing so every time (Table 41). This was similar to 2013.

Table 41: Frequency of condom or barrier use when having penetrative sex with a casual sex partner while under the influence of drugs, 2013 and 2014

	2013 (n=58) %	**2014 (n=53) %**
Every time	26	**30**
Often	21	**23**
Sometimes	12	**19**
Rarely	12	**6**
Never	29	**23**

Note: Those who reported 'don't know' have been excluded from analysis.
Source: QLD EDRS participant interviews

7.2.2 Sexually transmitted infections

In 2014, 84 participants responded to questions about their sexual health. Among these, 56% reported having a sexual health check-up in the previous 12 months, and 22% reported ever having an STI (Table 42). Among those who had an STI in the previous 12 months, the most common was HPV genital warts, followed by chlamydia.

Table 42: STI check-ups, 2013 and 2014

	2013 %	**2014 %**
Had sexual health check-ups	(n=83)	**(n=84)**
No	43	**36**
Yes, in the last year	42	**56**
Yes, more than one year ago	14	**8**
Ever diagnosed with STI[a]	(n=82)	**(n=84)**
No	85	**77**
Yes, in the last year	10	**4**
Yes, more than one year ago	5	**18**

[a]among those who had a sexual health check-up.
Note: Those who reported 'don't know' were excluded from the analysis.
Source: QLD EDRS 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 43).

Table 43: Registered cases of blood-borne viruses and sexually transmitted diseases in Queensland, 2009 to 2014

Disease	2009	2010	2011	2012	2013	2014
Hepatitis B (newly acquired)	52	58	46	55	43	**52**
Hepatitis B (unspecified)	1,000	1,054	846	808	900	**994**
Hepatitis C (unspecified)	2,627	2,668	2,413	2,376	2,503	**2,674**
Syphilis – congenital	0	2	4	0	1	**0**
Syphilis <2 years	215	251	323	349	259	**382**
Syphilis >2 years	303	199	225	246	278	**287**
Chlamydial infection	16,695	19,217	18,645	18,852	19,427	**20,317**
Gonococcal infection	1,787	2,383	2,952	2,700	2,727	**2,711**

Source: NNDSS, 2014

7.3 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 et al., 2001).

In 2014, 80% of participants scored eight or higher on the AUDIT, corresponding to drinking at levels which may be harmful to their health (Table 44). The mean score was 13, corresponding to Zone II. This was similar to 2013.

Table 44: AUDIT results and recommended intervention, 2013 and 2014

	2013 (n=88) %	**2014 (n=98) %**	**Intervention recommended**
Zone I (scores 0–7)	16	**20**	Alcohol education
Zone II (scores 8–15)	35	**47**	Simple advice
Zone III (scores 16–19)	19	**16**	Simple advice plus brief counselling and continued monitoring
Zone IV (scores 20–40)	29	**16**	Referral to specialist for diagnosis and treatment

Source: QLD EDRS participant interviews

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

Key Points

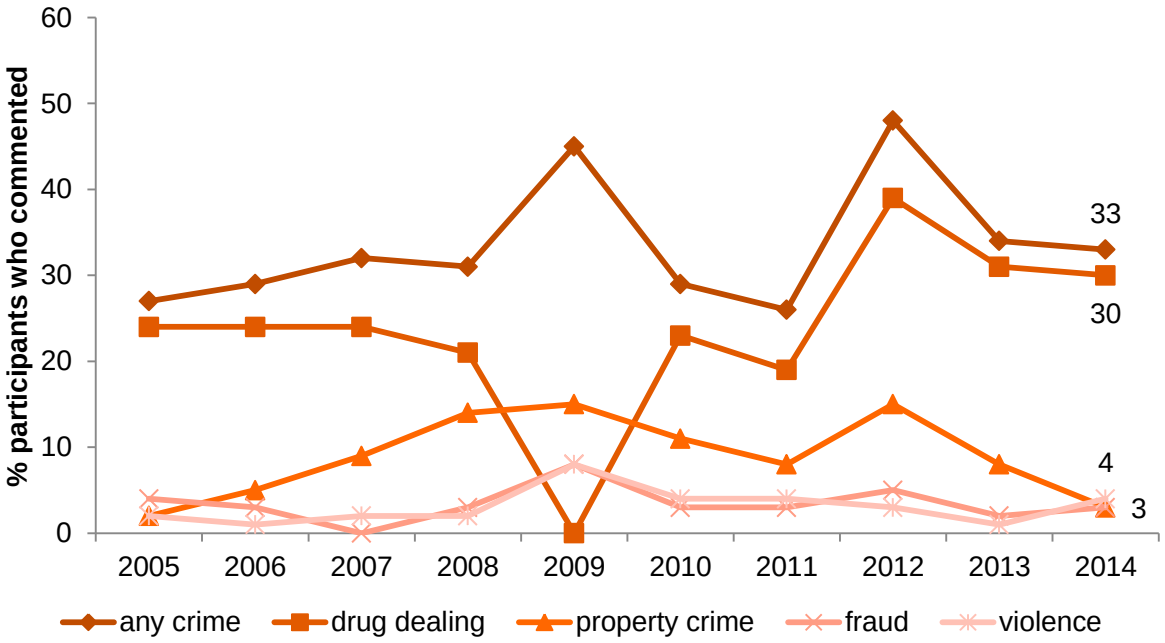
- Prison history remained low among participants (6%).
- 18% reported being arrested in the previous six months.
- 30% reported drug dealing in the previous month.

8.1 Reports of criminal activity among participants

Six per cent of participants reported having been to prison, with 18% reporting they had been arrested in the previous six months. The most common reason for arrest was possession of drugs, followed by being deemed a public nuisance. Other reasons for arrests included violent behaviour, property crime, possession of weapons, fraud, drink driving, and breach of an apprehended violence order (multiple responses permitted).

Similar to 2013, 33% of participants reported engaging in some form of criminal activity in the previous month (Figure 49). The most commonly reported crime was drug dealing, reported by 30% of the sample.

Figure 49: Criminal activity in the last month, 2005 to 2014



Source: QLD EDRS participant interviews

8.2 Arrests

Table 45 presents the most recent available data for drug-related arrests made by the QPS. In 2012–13 there was a similar pattern of arrests to 2011–12, with the majority of arrests related to cannabis (65%), followed by amphetamine-type stimulants (17%). There was a

total of 28,350 arrests compared with 26,463 in 2011–12. Data for 2013–14 was unavailable at the time of publication.

Table 45: Drug-related arrests by Queensland Police Service by drug type, 2012–13

	Consumer	Provider	Total
Cannabis	16,331	2,034	18,365
Amphetamine-type stimulants[a]	4,281	660	4,941
Other and unknown	3,280	665	3,945
Heroin and other opioids	249	42	291
Steroids	316	76	392
Cocaine	177	36	213
Hallucinogens	171	32	203
Total	**24,805**	**3,545**	**28,350**

[a] includes amphetamine, methylamphetamine, and phenethylamines
Note: consumer=use, possession or administering for own use; provider=importation, trafficking, selling, cultivation and manufacture.
Source: ACC, 2014

Table 46 shows the number of seizures by the QPS and the AFP for each drug type along with their weight. The total number of drug seizures in 2012–13 was similar to 2011–12 (23,979 and 23,281 respectively); however, the total weight of cocaine seizures was considerably lower in 2012–13 (4,503 grams compared with 294,763 grams in 2011–12) and the total weight of heroin seizures was considerably higher (128,818 grams compared with 989 grams in 2011–12). Data for 2013–14 was unavailable at the time of publication.

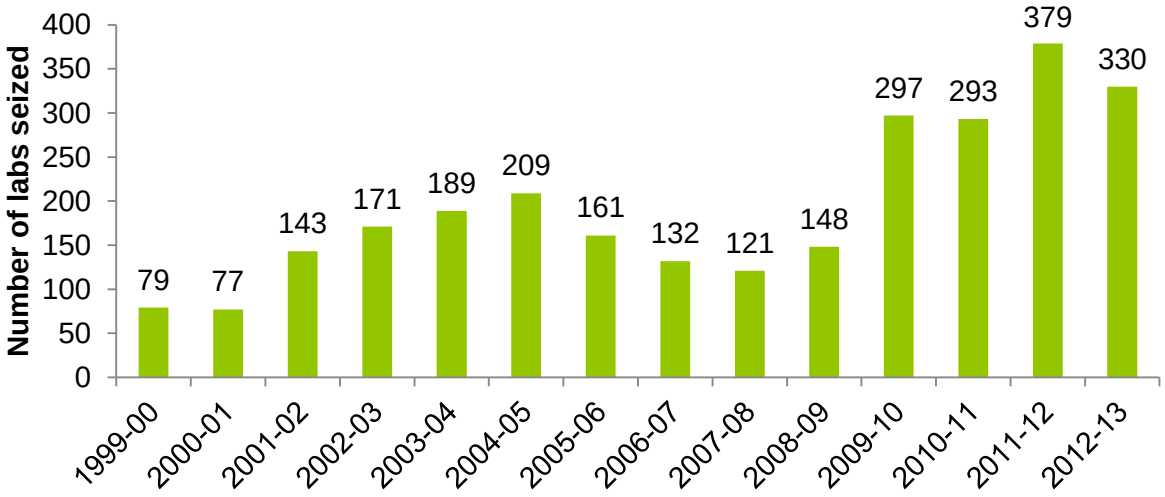
Table 46: Queensland drug seizures by police service and drug type, 2012–13

	Police force	No of seizures	Weight (grams)
Cannabis	QPS	17,741	810,499
	AFP	268	2,778
Amphetamine-type stimulant	QPS	3,900	34,257
	AFP	272	23,796
Heroin	QPS	185	1,380
	AFP	9	127,438
Other opioids	QPS	8	339
	AFP	8	46
Cocaine	QPS	174	1,361
	AFP	79	3,142
Steroids	QPS	46	4,066
	AFP	11	552
Hallucinogens	QPS	18	273
	AFP	2	5
Other and unknown drugs	QPS	1,107	450,845
	AFP	151	36,072

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 AFP and QPS.
Source: ACC, 2014

Nationally, a total of 757 clandestine labs were detected in the 2012–13 financial year (809 in 2011–12). In Queensland there were 379 detections, with 55% being amphetamine-type stimulants (excluding MDMA) labs (Figure 50). Most of the detections in Queensland were addict-based labs. Data for 2013–14 was unavailable at the time of publication.

Figure 50: Clandestine labs seized in Queensland from 1999/00 to 2012–13



Source: ACC, 2014

9 SPECIAL TOPICS OF INTEREST

Key Points

- 68% reported at least a few friends had ever purchased drugs online.
- 22% reported ever buying drugs online, with 17% doing so in the previous year.
- Silk Road was the most common online location for purchasing drugs.
- The most common drugs purchased online were ecstasy, LSD and cannabis.
- Motivations for buying online were price, quality and convenience.
- Most participants perceived 2CB, 2CI, DMT and mephedrone to be illegal in Queensland though there was uncertainty among respondents.
- Legal status of NPS would not impact NPS use among majority of participants.
- Motivations for using NPS were price, quality of high, and purity of drug compared with ecstasy and related drugs.

9.1 Purchasing drugs online and the use of dark web marketplaces

The rise of the internet as an integral part of daily life has globalised retail marketing. This extends to web stores offering a range of substances that mimic the effects of traditional illicit substances such as ecstasy, amphetamines and cannabis (termed here new psychoactive substances or NPS). This market is also highly dynamic, with websites closing or altering available stock as legislation changes (Bruno, Poesiat, & Matthews, 2013; Van Buskirk et al., 2014).

In addition to the surface web, readily accessible by search engines such as Google, new marketplaces have emerged located on the 'dark web', that offer a range of illicit and pharmaceutical drugs for sale (Van Buskirk et al., 2013). The 'dark web' refers to a collection of domains accessible only through an anonymous routed connection and specially configured browser. As such, these dark web marketplaces are not overt and are susceptible to closure due to changes in legislation (Barratt, 2012). The marketplaces on the dark web have proliferated in the past three years, retailing not only NPS, but also traditional illicit substances including cannabis and pharmaceuticals such as benzodiazepines prescription opioids (Van Buskirk et al., 2013). Silk Road is one such marketplace operating on the dark web that has received a large amount of attention from law enforcement, media and researchers. Until its closure on 2 October 2013, the Silk Road marketplace served to greatly expand the availability of both illicit and NPS online.

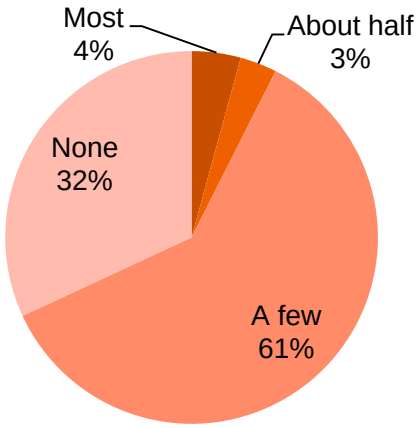
On both the dark web and the surface web, there exist both 'webstores' and 'online marketplaces' from which to purchase substances. Webstores refer to websites that sell products or services and typically have an online shopping cart. Online marketplaces, however, refer to a type of online community where products are traded by users of the website instead of being sold by the owner or moderator of the website. Products on online marketplaces are sold by retailers either based in Australia, or internationally. Prices from international retailers are typically lower but carry with them a greater risk of detection by law enforcement during importation (Van Buskirk et al., 2013).

While it is apparent that availability of illicit drugs and NPS has increased since the arrival of dark web marketplaces, it is not clear to what extent consumers use these marketplaces for the purchase of drugs. The aim of this model is, therefore, to ascertain how often EDRS participants use online marketplaces and webstores for the purchase of drugs, as well as

what substances are commonly bought and the positives and negatives of using these marketplaces and stores over traditional street markets.

In 2014, participants were asked to estimate what proportion of their friends had ever purchased a drug online. Figure 51 shows that 68% (n=94) knew at least a few friends who had bought drugs online.

Figure 51: Proportion of friends who had ever bought a drug online, 2014



Source: QLD EDRS participant interviews

Twenty-two per cent of participants reported they themselves had bought a drug online, and 17% reported doing so in the previous 12 months. The most common source location was Silk Road, using the dark web (Table 47).

Table 47: Location purchased drugs online in lifetime and previous 12 months, 2014

	Ever (n=22) %	Previous 12 months (n=17) %
Australian webstore (surface web)	14	12
International webstore (surface web)	14	6
Silk Road (dark web)	68	71
Other dark web marketplace	14	29
Other online marketplace (e.g. eBay, Gumtree)	5	-
Other*	5	-

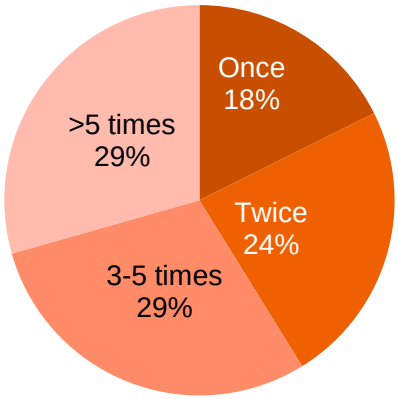
*i.e. 'in China'
Note: Multiple responses permitted.
Source: QLD EDRS participant interviews

Among those who reported having ever used the dark web (n=15), 40% reported it was from an Australian retailer only, 40% from an international retailer only, and 20% reported they had purchased from both Australian and international retailers on the dark web.

Among those who reported purchasing drugs online from the dark web in the previous 12 months (n=14), 36% reported it was from an Australian retailer, 43% from an international retailer and 21% reported both.

Frequency of online drug purchasing varied with most having made purchases more than once (Figure 52).

Figure 52: Frequency of online drug purchase in the previous 12 months (n=17), 2014



Source: QLD EDRS participant interviews

Among those who commented (n=16), the most common drug purchased online in the previous 12 months was ecstasy (any form), followed by LSD (Table 48). Three participants reported purchasing an NPS (salvia, NBOMe and 'amphetamine sulphate').

Table 48: Substances purchased online in the previous 12 months, 2014

	2014 (n=16) %
Ecstasy (any form)	69
LSD	44
Cannabis	25
Methamphetamine (any form)	13
Cocaine	13
Pharmaceutical stimulants	6
Mushrooms	6
Ketamine	6
Amyl nitrate	6
Benzodiazepines (e.g. valium/ serepax/xanax)	6
Steroids or PIEDs	6
Salvia divinorum	6
NBOMe (25I, 25B, 25C)	6
Other ('amphetamine sulphate')	6

Note: Multiple responses permitted.
Source: QLD EDRS participant interviews

Of those who purchased drugs online in the previous 12 months (n=17), 82% bought for themselves and others and 18% for themselves only.

All but one participant reported successfully receiving their most recent package in the previous 12 months.

Table 49 shows the motivating factors respondents gave for purchasing online, as well as the positives and negatives of purchasing online (multiple answers were permitted). Cheaper prices online and convenience were the most commonly reported positives, while packages not arriving and the slow, waiting process for deliveries were the most commonly reported negatives.

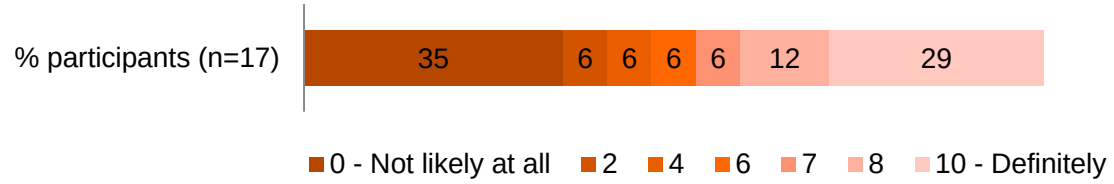
Table 49: Reasons and attitudes for purchasing drugs online, 2014

	2014 (n=17) %
Main motivation for purchasing online	
Curiosity	29
Drugs were cheaper online	24
Drugs I wanted weren't available on the street	12
Convenience	6
Drugs are better quality online	6
Other*	24
Positives of purchasing online	
No positives	6
Drugs were cheaper online	35
Convenience (including easier)	35
Drugs were better quality online	29
Avoided contact with dealers (including increased safety)	18
Accessed drugs I couldn't get on the street	6
Less legal risk buying online	6
Other**	18
Negatives of purchasing online	
No negatives	18
Packages didn't arrive	29
Slow process (including waiting)	24
More legal risk purchasing online	18
Difficult process	6
Poorer quality of drugs	6
Other**	12

*Other motivations include: 'everyone else had done it successfully', 'it's ideological, something supports. Safer than carrying on self, cheaper, do not have to deal with dealer', 'rating of systems and descriptions means you get better idea of what you are getting' and 'the fact that you can do it'
** Other positives include: 'feedback from other forum, feels more informative', 'people can talk about if do it right', 'reliability of delivery'
*** Other negatives include: 'setting up the money system' and 'it's trackable'
Note: Multiple responses permitted.
Source: QLD EDRS participant interviews

When asked to rate how likely they would be to purchase drugs online again in the future on a scale from 0 to 10 (n=17), 35% responded '0 – not likely at all', and 29% responded '10 – definitely' (Figure 53).

Figure 53: How likely to purchase drugs online again, 2014



Source: QLD EDRS participant interviews

9.2 NPS harm

The past 10 years has seen the emergence of a range of substances that mimic illicit stimulants and hallucinogens such as amphetamines, ecstasy and LSD (i.e. NPS). As they are designed to be structurally similar to their banned counterparts, without containing controlled substances, they do not fall readily under legislative control and some have been marketed as 'legal highs'. The promotion of these substances as 'legal highs', together with the fact that they can be bought over the internet, over the counter, and in shop fronts in Australia has made them accessible to people who may not have used illicit drugs previously, and also gives the illusion of safety. However, the safety or otherwise of these substances is unclear, and there is little evidence on which to base public policies relating to these substances. Indeed, the health and social consequences of these drugs remain poorly understood in Australia, and internationally. This module has therefore been included to improve our knowledge and understanding of the use and effects of the most commonly used NPS.

Participants were asked if they had experienced a particular effect whilst using NPS, and were then asked to rate the severity ('mild', 'moderate' or 'severe') of that experience. However, due to small numbers (n<10), jurisdictional findings will not be presented; for national findings please refer to Sindicich & Burns (2015).

9.3 NPS health policy

Drug policy and the legality of certain drugs differ between states and territories within Australia. This may influence opportunities and motivations to use certain drugs over others, particularly when NPS may be new analogues of similar existing drugs not specifically listed as illegal in some jurisdictions.

For a drug to be considered illegal in Queensland, it must be scheduled as a 'dangerous drug' by the parliament of Queensland according to the *Drugs Misuse Act 1986* and the *Drugs Misuse Regulation 1987*. In Queensland, individual NPS have been listed under Schedule II as 'Dangerous Drugs' (current as at 5 September 2014). The list includes N,N-Diethyltryptamine (DMT), Methcathinone (mephedrone), 4-Bromo-2,5-dimethoxyphenethylamine (2CB), and 4-Iodo-2,5-dimethoxyphenethylamine (2CI). This is different to NSW, where the *Drugs and Poisons Legislation Amendment (New Psychoactive and Other Substances) Act 2013* has resulted in the illegality of any new psychoactive substance other than those manufactured by licensed or authorised individuals as covered by the *Therapeutic Goods Act 1966*.

Participants were asked whether 2CB, 2CI, DMT and mephedrone were illegal in Queensland (which they are). These substances were selected as they were the most commonly reported in the 2013 EDRS.

Table 50 shows that most participants perceived 2CB, 2CI, DMT and mephedrone as illegal, though there was a substantial proportion of those uncertain.

Table 50: Participant knowledge of the legality, 2014

	2014 (n=95) %
2CB	
Legal	1
Illegal	62
Unsure	37
2CI	
Legal	2
Illegal	58
Unsure	40
DMT	
Legal	3
Illegal	67
Unsure	30
Mephedrone	
Legal	1
Illegal	63
Unsure	34

Source: QLD EDRS participant interviews

Participants were also asked if a change to the legality of all NPS in the future—making them all illegal—would impact on their use of those substances. Among those who commented (n=94), 89% said legal status would make no impact, while 11% reported they would stop or not start use.

The most common NPS used the last time was from the 2C* group, followed by DMT and NBOMe.

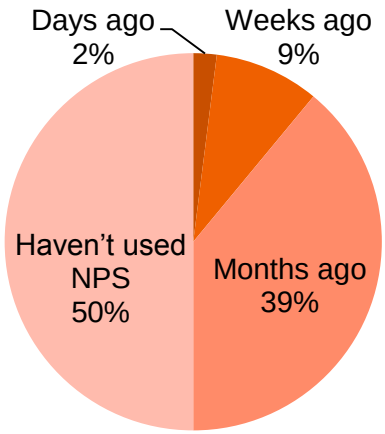
Table 51: Most recent NPS used, 2014

	2014 (n=44) %
2C* (e.g. 2CB, 2CI etc.)	46
DMT	23
NBOMe (25I, 25B, 25C)	23
Methylone/bk-MDMA	2
LSA (Hawaiian Baby Woodrose)	2
Synthetic Cannabis	2
'Capsule unknown'	1

Source: QLD EDRS participant interviews

Participants were asked how recently they last used an NPS (Figure 54).

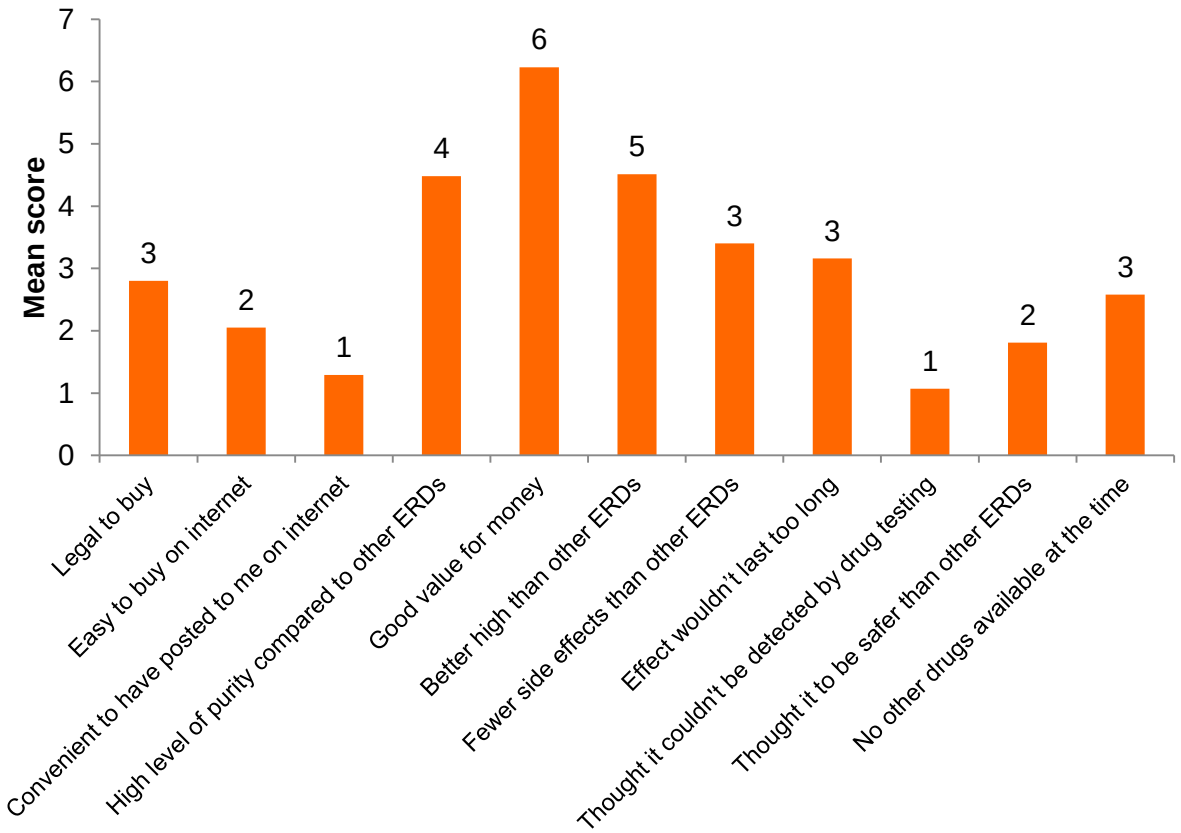
Figure 54: Most recent occasion used NPS (n=94), 2014



Source: QLD EDRS participant interviews

Participants who had used NPS were asked to rate the motivating factors for using NPS the most recent time. Figure 55 presents the mean scores for each factor (0=no influence to 10=maximum influence). The most highly rated motivations were 'good value for money', 'better high than ecstasy and related drugs' and 'high level of purity compared to ecstasy and related drugs'.

Figure 55: Mean score of motivating factors for using NPS, 2014



Source: QLD EDRS participant interviews

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