

**QUEENSLAND PARTY DRUG  
TRENDS  
2001**



**FINDINGS OF THE  
ILLICIT DRUG REPORTING SYSTEM  
(IDRS) – PARTY DRUGS MODULE**

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Queensland Police Drug Squad  
Surfers Paradise Police Service

## **ABBREVIATIONS**

ABCI	Australian Bureau of Criminal Intelligence
ABS	Australian Bureau of Statistics
ADIS	Alcohol and Drug Information Service
AFDL	Australian Forensic Drug Laboratory
AIHW	Australian Institute of Health and Welfare
ASTI	Aborigine or Torres Strait Islander
ATODS	Alcohol, Tobacco, and Other Drugs Services, Queensland Health
BYS	Brisbane Youth Service
CBD	Central Business District
CDHA	Commonwealth Department of Health and Aging
GHB	gamma-hydroxy-butyrate
ICD	International Classification of Disease
IDRS	Illicit Drug Reporting System
IDU	Injecting Drug User
IV	Intravenous
MDA	methylenedioxyamphetamine
MDMA	3,4-methylenedioxymethamphetamine
NA	Narcotics Anonymous
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NDARC	National Drug and Alcohol Research Centre
NDLERF	National Drug Law Enforcement Research Fund
NDSHS	National Drug Strategy Household Survey
NSP	Needle and Syringe Program
PMA	para-methoxyamphetamine
QADREC	Queensland Alcohol and Drug Research and Education Centre
QCC	Queensland Crime Commission
QNSP	Queensland Needle Availability and Support Program
QuIVAA	Queensland Intravenous Aids Association
QPS	Queensland Police Service

## TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY .....</b>	<b>12</b>
<b>1.0 INTRODUCTION.....</b>	<b>13</b>
1.1 <i>Background.....</i>	13
1.2 <i>'Party drugs' module of IDRS .....</i>	13
1.3 <i>Study aims .....</i>	14
1.4 <i>Additional methamphetamine module.....</i>	14
<b>2.0 METHOD .....</b>	<b>16</b>
2.1 <i>Survey of ecstasy user population.....</i>	16
2.2 <i>Survey of key informants.....</i>	17
2.3 <i>Data analysis .....</i>	18
2.4 <i>Issues of concern.....</i>	18
<b>3.0 DEMOGRAPHIC CHARACTERISTICS .....</b>	<b>20</b>
3.1 <i>Age .....</i>	20
3.2 <i>Comparing participants' age over the duration of the study.....</i>	20
3.3 <i>Gender.....</i>	20
3.4 <i>ATSI identification .....</i>	20
3.5 <i>Education .....</i>	20
3.6 <i>Employment status .....</i>	21
3.7 <i>Drug treatment.....</i>	21
3.8 <i>Sexual identity.....</i>	22
3.9 <i>Prison and/or Criminal history.....</i>	22
3.10 <i>Summary of Demographics.....</i>	22
<b>4.0. ECSTASY .....</b>	<b>23</b>
4.1 <i>Routes of administration of ecstasy .....</i>	23
4.2 <i>Injecting drug use and ecstasy.....</i>	24
4.3 <i>Ecstasy views and usage patterns .....</i>	24

<b>5.0</b>	<b>PRICE OF PARTY DRUGS.....</b>	<b>26</b>
5.1	<i>Ecstasy .....</i>	26
5.2	<i>Other' party drugs' .....</i>	26
<b>6.0</b>	<b>PURITY OF ECSTASY .....</b>	<b>28</b>
6.1	<i>Current purity .....</i>	28
6.2	<i>Change in purity .....</i>	28
<b>7.0</b>	<b>AVAILABILITY OF ECSTASY .....</b>	<b>29</b>
7.1	<i>Current availability.....</i>	29
7.2	<i>Change in availability.....</i>	29
7.3	<i>Sources of obtaining ecstasy.....</i>	29
<b>8.0</b>	<b>PATTERNS OF SUBSTANCE USE AMONG ECSTASY USERS.....</b>	<b>31</b>
8.1	<i>Ecstasy, MDA, LSD, Ketamine and GHB.....</i>	32
8.2	<i>Alcohol, cannabis and tobacco .....</i>	32
8.3	<i>Amphetamine, Methamphetamine and Ice/Shabu.....</i>	32
8.4	<i>Cocaine and Heroin.....</i>	33
8.5	<i>Benzodiazepines and antidepressants.....</i>	33
8.6	<i>Continuity of use and dependency .....</i>	33
8.7	<i>Polydrug (multiple drug) use .....</i>	33
8.8	<i>Frequency of use over the past six months and addictive behaviour .....</i>	34
<b>9.0</b>	<b>CRIMINAL ACTIVITY .....</b>	<b>36</b>
<b>10.0</b>	<b>HEALTH ISSUES RELATED TO CONSUMPTION OF PARTY DRUGS</b>	<b>38</b>
10.1	<i>Physical health problems.....</i>	38
10.2	<i>Psychological symptoms associated with the use of ecstasy .....</i>	39
10.3	<i>Quantities of various party drugs used.....</i>	39
10.4	<i>Social problems related to ecstasy use .....</i>	41
<b>11.0</b>	<b>KEY INFORMANT COMMENTS ON DEMOGRAPHY OF USERS.....</b>	<b>42</b>
11.1	<i>Age and gender .....</i>	42

11.2	<i>Cultural background</i> .....	42
11.3	<i>Geographic areas</i> .....	42
11.4	<i>Education and work status</i> .....	43
11.5	<i>Currently in treatment</i> .....	43
11.6	<i>Criminal activity</i> .....	43
11.7	<i>Conclusion of demographics</i> .....	43
<b>12.0</b>	<b>KEY INFORMANT COMMENTS ON PRICE OF ECSTASY</b> .....	<b>44</b>
<b>13.0</b>	<b>KEY INFORMANT COMMENTS ON TRENDS IN ECSTASY USE</b> .....	<b>45</b>
13.1	<i>Usage patterns</i> .....	45
13.2	<i>Typical session</i> .....	45
13.3	<i>Polydrug use</i> .....	45
13.4	<i>Recovery</i> .....	46
13.5	<i>Responsible use</i> .....	46
<b>14.0</b>	<b>KEY INFORMANT COMMENTS ON PURITY OF ECSTASY</b> .....	<b>47</b>
<b>15.0</b>	<b>KEY INFORMANT COMMENTS ON SOURCES OF SUPPLY OF ECSTASY</b> .....	<b>48</b>
<b>16.0</b>	<b>KEY INFORMANT COMMENTS ABOUT CRIME</b> .....	<b>49</b>
<b>17.0</b>	<b>KEY INFORMANT COMMENTS ABOUT HEALTH ISSUES</b> .....	<b>50</b>
17.1	<i>Problems experienced by users</i> .....	50
17.2	<i>Public safety issues</i> .....	50
17.3	<i>Treatment issues</i> .....	50
<b>18.0</b>	<b>THE METHAMPHETAMINE MODULE</b> .....	<b>51</b>
18.1	<i>Base</i> .....	51
18.2	<i>Pure</i> .....	52
18.3	<i>Ice</i> .....	53
18.4	<i>Shabu</i> .....	54
<b>19.0</b>	<b>SEIZURE DATA FOR QUEENSLAND</b> .....	<b>55</b>

19.1	<i>Queensland Health Scientific Services</i> .....	55
19.2	<i>Queensland Police</i> .....	57
<b>20.0</b>	<b>SUPPLY OF ECSTASY</b> .....	<b>58</b>
20.1	<i>Manufacture of ecstasy</i> .....	58
20.2	<i>Importation of ecstasy</i> .....	58
20.3	<i>Purity levels of seizures of ecstasy</i> .....	58
<b>21.0</b>	<b>SEIZURES OF AMPHETAMINES AND CRIMINAL ACTIVITY</b> .....	<b>60</b>
21.1	<i>Laboratory seizures</i> .....	60
21.2	<i>Queensland Crime Commission (QCC) newsletter</i> .....	60
21.3	<i>Other crime</i> .....	60
<b>22.0</b>	<b>OTHER HEALTH RELATED ISSUES</b> .....	<b>61</b>
22.1	<i>Outreach teams working in nightclubs and rave venues</i> .....	61
22.2	<i>Factors predicting adverse symptoms of ecstasy use</i> .....	62
<b>23.0</b>	<b>QUALITATIVE COMMENTS BY ECSTASY USERS ABOUT WHY THEY USE PARTY DRUGS</b> .....	<b>63</b>
23.1	<i>Self-identity – change – transition – acting out a role</i> .....	63
23.2	<i>Political participants in a political activity</i> .....	64
23.3	<i>Ecstasy access issues</i> .....	64
23.4	<i>Hedonism and indulgence</i> .....	64
23.5	<i>Normalisation, individualism and market qua market principles</i> .....	65
23.6	<i>Views on use and management</i> .....	66
23.7	<i>Ecstasy user concerns</i> .....	67
23.8	<i>Comments about the survey</i> .....	67
23.9	<i>Conclusion on qualitative comments</i> .....	68
<b>24.0</b>	<b>SUMMARY</b> .....	<b>69</b>
24.1	<i>Demographics</i> .....	69
24.2	<i>Patterns of substance use</i> .....	69
24.3	<i>Ecstasy use</i> .....	69



24.4	<i>Methamphetamine Use</i> .....	69
24.5	<i>Price, purity and availability</i> .....	69
24.6	<i>Study limitations</i> .....	70
<b>25.0</b>	<b>CONCLUSION</b> .....	<b>71</b>
<b>26.0</b>	<b>REFERENCES</b> .....	<b>72</b>

## LOCATION OF TABLES

Table 1:	Key informants' contact with ecstasy users by gender of informant, 2001..	18
Table 2:	Key informant contact with ecstasy user groups, 2001. ....	18
Table 3:	Years of secondary education completed, by gender, 2001.....	20
Table 4:	Level of tertiary education completed, by gender, 2001. ....	21
Table 5:	Employment status of ecstasy users, by gender, 2001.....	21
Table 6:	Sexual identity of ecstasy users, by gender, 2001. ....	22
Table 7:	Routes of administration of ecstasy, 2001 .....	23
Table 8:	Median price (\$) of other 'party drugs', 1997, 2000 and 2001*.....	26
Table 9:	Perceptions on the purity of ecstasy, 2001.....	28
Table 10:	Perceptions on the availability of ecstasy, 2001. ....	29
Table 11:	Source and location of scoring ecstasy - 1997, 2000 and 2001.....	30
Table 12:	Use of various substances, 2001. ....	31
Table 13:	Level of use of substances over the previous six months, 2001.* .....	35
Table 14:	Self-reported criminal activity, 2000 and 2001. ....	37
Table 15:	Physical symptoms associated with ecstasy use, 2001.....	38
Table 16:	Psychological symptoms attributed to ecstasy use, 2001. ....	39
Table 17:	Quantities of party drugs used, 2000 and 2001. *.....	40
Table 18:	T-test for quantity of drug used in a 'typical episode', 2000 and 2001.....	40
Table 19:	Social problems related to use of ecstasy, 2001. * .....	41
Table 20:	Base - opinions of what type of drug it is, 2001.....	51
Table 21:	Forms of base, 2001.....	52
Table 22:	Pure - opinions on what type of drug it is, 2001.....	53
Table 23:	Analysis of ecstasy samples, 1999-2000 and 2000-2001. ....	55
Table 24:	Analysis of methamphetamine* samples, 1999-2000 and 2000-2001. ....	56
Table 25:	Analysis of amphetamine samples, 1999-2000 and 2000-2001. ....	56

Table 26:	Average purity of amphetamine seizures by Qld police, 2000-2001.....	57
Table 27:	Ecstasy purity levels (%) – Qld & NSW, 1996-1997 to 1999-2000.....	59
Table 28:	One Brisbane outreach team's interventions at major rave venues.....	61
Table 29:	RaveSafe interventions in Queensland, 2001* .....	62

### **LOCATION OF FIGURES**

Figure 1:	Drug injection patterns among ecstasy users, 2001.....	24
Figure 2:	Patterns of ecstasy use, 2000 (n=50) and 2001 (n=117).....	25
Figure 3:	Continuity of use of various substances, 2001.....	34
Figure 4:	Comparison of ecstasy user samples, 2000 and 2001.....	35

## **Executive Summary**

### **Demographics**

The age of ecstasy users appears to be declining. Ecstasy use was more common among males than females. Aboriginal and Torres Strait Islander users were identified for the first time. Most of the sample appeared to be functioning at least sufficiently to be employed part time.

### **Ecstasy Use Patterns**

Ecstasy was used for a median number of 15 days in the six months preceding the survey. A high percentage of ecstasy users also smoked tobacco and cannabis and drank alcohol regularly. The most popular route of administration of ecstasy was by mouth. Bingeing on ecstasy was becoming more popular with Recovery venues opening early in the mornings to attract users after nightclubs have closed. Polydrug (multiple drug) use was also common, with high consumption of amphetamine and methamphetamine.

### **Price of ecstasy**

There appeared to be a slight drop in the price of ecstasy in 2001.

### **Purity of ecstasy**

Respondents stated that the purity of ecstasy fluctuated. Purity of seizures remained stable at about 33%.

### **Availability of ecstasy**

Respondents on the whole stated it was very easy to obtain ecstasy and that this situation was stable.

### **Criminal activity**

This sample did not appear to be heavily involved in criminal activity. However, seizures of amphetamines had increased.

### **Health Issues**

Between 33% and 85% of respondents reported physical symptoms associated with their ecstasy use. Between 25% and 85% reported psychological symptoms; and 77% reported problems with relationships and financial hardships. More people seem to be seeking treatment for problem ecstasy use than in previous years.

### **The Methamphetamine Module**

Sixty-two users also participated in the Methamphetamine sub-study module.

### **Qualitative comments**

The report finishes with an analysis of the qualitative comments made by ecstasy users. These identify some of the social and cultural aspects of ecstasy use and assist in understanding why users use. They also identify strategies, which serve to facilitate harm minimisation and health promotion.

# ILLICIT DRUG REPORTING SYSTEM (IDRS) – PARTY DRUG MODULE

## 1.0 Introduction

### 1.1 Background

The Illicit Drug Reporting system (IDRS) is an ongoing project funded by the Commonwealth Department of Health and Aging (CDHA). The IDRS has been conducted on an annual basis in NSW since 1996 and in all States and Territories of Australia since 1999. To date, the purpose of the IDRS has been to provide a coordinated national monitoring of the use of illicit drugs, in particular, amphetamines, cannabis, cocaine and heroin. It is intended to serve as a strategic early warning system - identifying emerging trends of local and national concern in various illicit drug markets. The study is designed to be sensitive to changing trends and to provide data in a timely fashion. It is intended to serve as “front line” data - and as a basis for more detailed data collection on specific issues.

The IDRS data collection consists of three components: interviews with illicit drug users; interviews with individuals who have frequent contact with illicit drug users; and indicator or secondary data sources, such as national drug use household surveys, ABCI (Australian Bureau of Criminal Intelligence) seizure data, customs data and arrest data.

### 1.2 ‘Party drugs’ module of IDRS

In June 2000, the National Drug Law Enforcement Research Fund (NDLERF), administered by the Australasian Centre for Policing Research (ACPR), funded a two-year, two-State trial of the feasibility of monitoring emerging trends in the markets for ecstasy and other ‘party drugs’ using the extant IDRS methodology. For the purposes of the IDRS - the term ‘party drug’ is considered to include any drugs that are routinely used in the context of entertainment venues such as nightclubs or dance parties. These include drugs such as ecstasy, LSD, ketamine, MDA and GHB.

Ecstasy is a relatively new drug in Australia, having been widely used for only a decade. It has been closely tied to the rave and dance scenes. It has been used as a recreational drug throughout Australia since the mid 1980s and in Queensland since Expo 88 (1988).

The two sites chosen for the ‘party drug’ component of the IDRS were New South Wales and Queensland. The Drug and Alcohol Services Council of South Australia (DASC) provided funding to allow the trial to also proceed in that State. It was decided that consistency should be maintained between the main IDRS and the ‘party drugs’ component wherever possible. Therefore, like the main IDRS, the focus of the ‘party drugs’ component was on the capital cities of each participating state, as new trends in illicit drug markets are more likely to emerge in large cities rather than regional centres or rural areas. For Queensland, this region includes the southeast corner of the state. For the 2001 study, the IDRS included for the first time, ecstasy users and key informants from the Gold Coast.

This report summarises the trends in ecstasy and other ‘party drug’ use identified in southeast Queensland in 2001. These trends have been extrapolated from three data sources:

- face-to-face interviews with 117 ecstasy users in Brisbane and the Gold Coast;
- face-to-face interviews with 30 key informants who, through the nature of their work, had been in regular contact with ecstasy users in Brisbane and the Gold Coast during the six months preceding the survey;
- indicator data sources such as those from seizures of ecstasy made in Queensland.

Where possible, data from 1997 and 2000 are used for comparative purposes. The 1997 data are from a Brisbane study on Ecstasy users, conducted by the National Drug and Alcohol Research Centre (NDARC) and funded by the (then) Commonwealth Department of Health and Family Services (Kinner, 1997; Topp *et al.*, 1998). The 2000 data are from the ‘Party Drugs’ Module of the IDRS study for that year (McAllister, Topp, Dawes, Watt and Shuttlewood, 2001). Comparisons are made between the three samples (2001: n = 126; 2000: n = 50; 1997: n = 60).

State comparisons of the 2001 ‘party drug’ data are forthcoming in the NDARC report later this year. Also, a national overview of trends in other illicit drug markets will be presented in the Australian Drug Trends Report 2001 (Topp and Darke, 2001).

### 1.3 *Study aims*

The aims of the ‘party drug’ module of the Queensland IDRS 2001 were to:

- investigate the feasibility of adding ecstasy and other party drugs to the list of drug classes monitored by the IDRS using the extant IDRS methodology;
- describe the characteristics of a sample of ecstasy users in Brisbane;
- examine the patterns of ecstasy and other drug use among a sample of current ecstasy users;
- document the current price, purity and availability of ecstasy and other party drugs in Brisbane and the Gold Coast;
- describe and examine ecstasy users’ perceptions of the incidence and nature of ecstasy-related harms, including physical, psychological, financial, occupational, social and legal harms;
- identify emerging trends in the party drug market that require further investigation;
- compare key findings of the present study with Queensland findings from the 1997 and the 2000 ecstasy user survey, as reported by Kinner and Roche (1997), Topp (1998) and McAllister *et al.* (2001).

### 1.4 *Additional methamphetamine module*

There is evidence of a high level of amphetamine use in Queensland. This information usually comes from Needle Syringe Program (NSP) clients. For example, a one-week study conducted at NSPs in each State and Territory in October 2000, with NSP clients (Queensland sample n = 750 who voluntarily participated) revealed that, of the last drug injected, 38% had injected

amphetamine (NDARC, 2001). In the 2001 survey, the IDRS team were instructed to complete an additional 'Methamphetamine Module' if the respondents were taking forms of amphetamine other than ecstasy. Sixty-two respondents were eligible to complete this module.

## 2.0 Method

### 2.1 Survey of ecstasy user population

#### 2.1.1 Sample selection

The selection of a sample of regular ecstasy users was based on set criteria. Eligible participants had to:

- be at least 16 years of age; and
- have used ecstasy at least once per month during the previous six months; and
- have resided in the southeast corner of Queensland for at least 12 months preceding contact.

#### 2.1.2 Recruitment

Initially, 126 ecstasy users were selected for interview. Nine (9) of these did not satisfy the eligibility criteria because they had entered rehabilitation by the time of interview and so were removed from the sample, bringing the number of participants down to 117.

Participants were recruited through a purposive sampling strategy (Kerlinger, 1986), which included advertisements in entertainment newspapers, gay newspapers, flyers left in tattoo parlours, piercing parlours, at nightclubs, interviewer contacts and 'snowball' procedures (Biernacki and Waldorf, 1981). 'Snowballing' is a means of sampling 'hidden' populations which relies on peer referral and is widely used to access illicit drug users both in Australian (e.g., Boys, Lenton and Alorcoss, 1997; Ovendon and Loxley, 1996; Solowij, Hall and Lee, 1992) and international (e.g., Dalgarno and Shewan, 1996; Forsyth, 1996; Peters, Davies and Richardson, 1997) studies. While this form of sampling cannot be argued to constitute a representative sample, it does enable contact with at least a cross section of users.

#### 2.1.3 Procedure

Participants contacted the researchers by telephone and were screened for eligibility. Participants were assured that all information provided was strictly confidential and anonymous. The nature and purpose of the study was explained to participants before informed consent was obtained.

Survey data were collected via face-to face interviews, conducted by trained interviewers. Interviews were held between April and September 2001 and ranged from 45 minutes to one-hour duration. Interviews were held in various locations, including offices at the Queensland Alcohol and Drug Research and Education Centre (QADREC), offices on the Gold Coast, coffee shops and parks. All participants were volunteers and were reimbursed AUD\$20 for their participation.

#### 2.1.4 Measures

Participants were administered a structured interview schedule based on a national study of ecstasy users conducted by NDARC in 1997 (Topp *et al.*, 1998; 1999), which in turn had incorporated items from a number of previous NDARC studies of ecstasy (Solowij *et al.*, 1992) and amphetamine users (Darke *et al.*, 1994; Hando *et al.*, 1993; Hando, Topp and Hall, 1997).



The time period for most questions focussed on the six months preceding the interview. The survey collected information on respondent characteristics; ecstasy and other drug use history (including frequency and quantity of use and routes of administration); physical and psychological side-effects of ecstasy; other ecstasy-related problems (i.e., relationship, financial, legal and occupational problems); price, purity and availability of a number of different 'party drugs'; and general trends within the party drugs market, such as new drug types, new drug users and police activity.

## 2.2 *Survey of key informants*

### 2.2.1 Sample selection

To maintain consistency with the main IDRS, the eligibility criterion for key informant participation was regular contact, in the course of employment, with a range of ecstasy users, during the preceding six months. It proved difficult, yet not impossible however, to recruit key informants who were able to comment on ecstasy as a result of their regular contact with ecstasy users through their work.

### 2.2.2 Recruitment

Health professions were considered a main source of contact for recruiting 'key informants'. It was also necessary to go beyond that sector, to the entertainment industry, specifically the dance music industry, in order to identify others who could be considered 'experts' on ecstasy and ecstasy users.

It was discovered that the title of the qualitative in-depth interview schedule – 'Ecstasy Key Informant' - proved problematic for negotiating interviews with those working in the fields of clubbing, raves and ecstasy use/dealing. In these fields, social relationships are based on the premise of trust and many participants expressed distaste for the label of "informant".

### 2.2.3 Procedure and method

Key informants were initially contacted by telephone, snowballing, or electronic mail and were then screened for their eligibility to participate. They represented a range of connections with ecstasy users, such as: Disc jockeys (DJs); law enforcement; night club operators; rehabilitation/drug service delivery; IT/fashion/research; and outreach workers. Outreach workers provide education, first aid and brief treatment interventions at entertainment venues such as raves, dance parties and outdoor events. Key informants reported that their mode of contact with users was either: through their work and social interactions; through their work only; or through personal contact.

Table 1 provides some details of the thirty key informants, who were from various parts of Brisbane, the Gold Coast and the Sunshine Coast and interviewed between June and September 2001.

Table 1: Key informants' contact with ecstasy users by gender of informant, 2001.

Connection	Male	Female
DJs	11	0
Law enforcement	3	1
Night club operators	2	1
Rehabilitation/drug service delivery	5	1
IT/fashion/research	2	1
Outreach	2	1
Total	25	5

Key informants reported a relatively high volume of recent contact with ecstasy users. In terms of the week prior to interview, ten key informants had contact with over 100 ecstasy users; eight had contact with 21-50 users; five had contact with 10-20 users; and four had contact with fewer than 10 users.

The user groups that key informants had contact with is outlined in Table 2. It shows that key informants were most likely to have contact with all the groups listed, rather than solely one specific user group. Of the thirty key informants interviewed, most (25) were certain of the accuracy of the information they provided, with the remaining five being either moderately certain (3) or a little unsure (2).

Table 2: Key informant contact with ecstasy user groups, 2001.

User group	Number of key informants who had contact with group
All groups	12
IDU	7
Gay	6
Women	8
Prisoners	5
Youth	7
NESB	4
Students	2

### 2.3 *Data analysis*

Quantitative data were analysed using SPSS for Windows, Version 10.0. In terms of the calculation of averages, the mean was used for normally distributed variables, otherwise medians were used. For the regression analyses, *t*-tests were used.

Qualitative data were coded, categorised and then constant comparisons made.

### 2.4 *Issues of concern*

In general, a number of nightclub operators and disc jockeys (DJs) were reluctant to participate in the study and hence the 'key informant' recruitment process was time consuming with broken appointments and 'no shows' to arranged

appointments. However, those who did participate appeared to have a keen interest in their industry, a genuine concern for their patrons and a respect for research in their field of interest.

It was also difficult to obtain a complete list of current rave venues in southeast Queensland, for a number of reasons. Liquor licensing records provided a list of some venues, however, other venues were not licensed and so records are incomplete. The actual number of venues appears to be quite volatile on a year-to-year basis. Qualitative comments and comparisons made reveal that the number of venues in the Brisbane metropolitan region had increased from around 5-7 in 2000 to 17-20 in 2001, with most of the additional venues being in the Fortitude Valley and the Gold Coast areas.

Another problem was that nightclub ownership seems to change on a regular basis and it is therefore difficult to maintain accurate records. This became evident when obtaining telephone numbers from directory assistance. Phone numbers recorded were either incorrect; the venue did not exist, or it had changed its name along with a change in ownership. Internet sources became the most reliable source of information to access the “rave” venue operator population.

The IDRS Designer Drug module was used on the Gold Coast for the first time in 2001 and research revealed an active nightclub/rave scene in the Surfers Paradise region.

### 3.0 Demographic characteristics

The demographic characteristics of the ecstasy users are presented below. Characteristics include age; Aboriginal and/or Torres Strait Islander (ATSI) identification, sexual identity, educational and employment status, drug treatment status and prison history. Where possible previous year's data are also used in order to assess the comparability of the samples.

#### 3.1 Age

The mean age of users was 25.2 years. For males it was 25.8 years and for females it was 24.2 years.

#### 3.2 Comparing participants' age over the duration of the study

The mean age for first use of ecstasy was 19.6 years, compared to 19.8 years in 2000 and 20.8 years in 1997. This suggests that the age of initiation into ecstasy use is getting younger.

This trend was also reflected in the age of Users when they began using ecstasy on a regular basis. In 2001, the mean age was 20.8 years, down from 21.4 years in 2000 and 22.1 in 1997.

The current study indicates that the age at which regular ecstasy Users started using and started using regularly is getting younger.

#### 3.3 Gender

A higher proportion of respondents were male (61%) than female (39%). This is consistent with 2000 (62% and 38% respectively).

#### 3.4 ATSI identification

Nine of all respondents (8%) identified as ATSI; 9% of males and 7% of females doing so. In the 2000 IDRS study no respondents identified as ATSI. This could be indicative of an increase in ecstasy use among this population, an increase in the propensity to identify as ATSI or the results could reflect nuances in sampling.

#### 3.5 Education

In terms of years of secondary education completed, 76% had completed year 12 and 24% had completed year 11 or under. As can be seen in Table 3, there was little difference between male and female respondents, with females being only slightly more likely to have completed year 12 than their male counterparts.

Table 3: Years of secondary education completed, by gender, 2001.

Secondary level	Females (n = 46) %	Males (n = 71) %
Year 11 and under	22	25
Year 12	78	75

In terms of education completed since leaving school, 44% had not completed any, 32% had completed a university/college course and 24% had completed a trade or technical course. Table 4 shows these results broken down by gender.

Females as a group were more likely to have either completed no post secondary education (50%) or have completed a university level course (39%); whereas for males as a group, their level of post-secondary education was more evenly spread between having completed none (40%), trade/technical (32%) or university/college level course (28%).

Table 4: Level of tertiary education completed, by gender, 2001.

Level completed	Females (n = 46) %	Males (n = 71) %
None	50	40
Trade/technical	11	32
University/college	39	28

### 3.6 *Employment status*

The vast majority of respondents were either in employment (31% fulltime and 24% part-time) or were fulltime students (17%). Twenty-three percent were unemployed.

Table 5 indicates fairly similar patterns of employment for males and females. In terms of those employed however, it is interesting to note that male respondents were more likely than the females to be in fulltime employment and conversely, females were likely than the males employed to be working only part-time.

Table 5: Employment status of ecstasy users, by gender, 2001.

Employment Status	Females (n = 46) %	Males (n = 71) %
Unemployed	22	24
Employed full-time	24	35
Employed part-time	31	20
Full-time student	20	16
Other	2	5

### 3.7 *Drug treatment*

Thirteen percent (13%) of respondents were currently receiving drug treatment. More females (22%) were in drug treatment than males (9%). Even though females comprise a smaller proportion of ecstasy users, they appear to be more likely to be seeking treatment.

While consumption of ecstasy has dramatically increased over the years (Queensland Crime Commission, 2001), users in the past have not presented for treatment, or to other agencies such as needle and syringe programs (NSP), as frequently as it is believed have users of other illicit drugs such as heroin or methamphetamines (COTSA Drug Treatment by State 2001).

### 3.8 Sexual identity

Most respondents identified themselves as being heterosexual (74%), followed by bisexual (12%), gay male (9%), lesbian (3%) and other (1%).

It is interesting to note that whilst national and international studies indicate that fewer than 10% of the population are gay, lesbian or bisexual, 24% of respondents in this study identified as such. This could be seen as an indication of subgroup being over-represented in the ecstasy using population of southeast Queensland.

Table 6 shows similar patterns of sexual identity for males and females. Whilst heterosexuality remained most common for both groups, 27% of males identified as being either gay or bisexual, compared to 22% of females.

Table 6: Sexual identity of ecstasy users, by gender, 2001.

Sexual Identity	Males n = 70 %	Females n = 46 %
Heterosexual	73	76
Gay male	16	-
Lesbian	-	9
Bisexual	11	13
Other	0	2

### 3.9 Prison and/or Criminal history

Seven percent (7%) of respondents reported they had a criminal or prison history.

### 3.10 Summary of Demographics

- \* The age at which ecstasy is used for the first time appears to be getting younger.
- \* Male ecstasy users are more common than female ecstasy users.
- \* The ecstasy-user sample identified Aboriginal and Torres Strait Islander people for the first time.
- \* Thirteen (13%) of the population of ecstasy users were in drug treatment of some kind.
- \* Most of the ecstasy-using sample appears to be functioning sufficiently to be employed at least part-time.

## 4.0. Ecstasy<sup>1</sup>

As mentioned in the Methodology section, respondents had used ecstasy at least six times in the previous six months and had lived in the southeastern region of Queensland for at least the past 12 months.

### 4.1 Routes of administration of ecstasy

By far the most common route of administration of ecstasy was to have swallowed it (96%), followed by snorted (32%); injected (9%); smoked (6%); and shelved and/or shafted<sup>2</sup> (4%) it. Three percent (3%) had swallowed half of the pill and shafted or shelved the other half. One percent (1%) had let the pill dissolve under their tongue.

Table 7 presents the propensity of respondents to use each of these routes of administration, in terms of both their recent use (last six months) and total use. It shows that swallowing ecstasy was by far the most popular route of administration used. A lower proportion of respondents had injected, smoked or snorted ecstasy in the last six months compared to ever having done so. For example, 56% had snorted ecstasy at some stage but only 32% had done so in the last six months.

Table 7: Routes of administration of ecstasy, 2001

Route of administration	Ever used %	Recent use %
Swallowed	99	96
Injected	19	9
Smoked	16	6
Snorted	56	32
Shelved/shafted	4	4

Key informants' comments assist in understanding these patterns. Firstly, those who smoke ecstasy usually mixed it with cannabis (called "snow-cones"). Secondly, people who take ecstasy for many years develop an irritated stomach that causes vomiting and cramps and for this reason many were resorting to shafting or shelving. Thirdly, it was becoming more common to split the pill three ways and swallow a third, inject a third and shelve or shaft the other third. The reason for splitting the pill three ways was to experience varying stages of the 'rush' of the pill's effect via the different routes of administration.

<sup>1</sup>The popular dance drug ecstasy is the chemical Methylendioxyamphetamine, or MDMA for short. It has a double life because it is a stimulant (a relative of speed) with hallucinogenic properties. Ecstasy is described as an empathogen because it releases mood-altering chemicals, such as serotonin and L-dopa, in the brain, and generates feelings of love, intimacy, friendliness and euphoria. Because it is also a hallucinogen, it induces a surreal, highly coloured and distorted view of one's environment. It is also known as E, Ecstasy, Love Doves, Disco Biscuits, Shamrocks, MDMA, X, XTC, The Hug Drug and The Love Drug (Stoppard, 2000:50).

<sup>2</sup>"Shelved" is placing the pill in a woman's vagina. "Shafting" is placing the pill in the rectum of the individual (male or female). At times the mucous membrane becomes inflamed in the area where the "pill" is placed, whether that be the mouth, the vagina or the rectum. Consequently some of the participants stated they wrap the "pill" in tissue paper or toilet paper to prevent this inflammation.

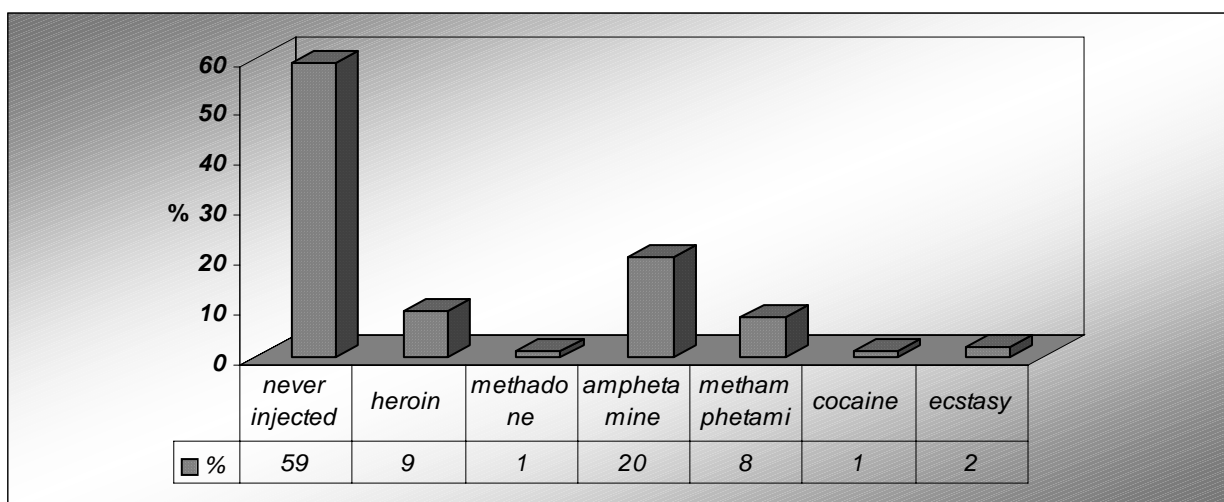
#### 4.2 *Injecting drug use and ecstasy*

As can be seen in Table 7, 19% of respondents had injected ecstasy at some stage and nine percent (9%) had done so in the last six months. These respondents had begun to inject from ages 15 to 38 with the median age at first injection being 22 years.

Figure 1 below shows that 59% of respondents stated that they had never injected any drug. Of those who had, the drug they first injected was amphetamine (20%), heroin (9%), methamphetamine (8%), ecstasy (2%), methadone (1%) or cocaine (1%).

Key informants stated that more people were becoming willing to inject ecstasy because tablets/capsules<sup>3</sup>/pills were becoming shorter acting than previously and the quality was not as high.

Figure 1: Drug injection patterns among ecstasy users, 2001.



#### 4.3 *Ecstasy views and usage patterns*

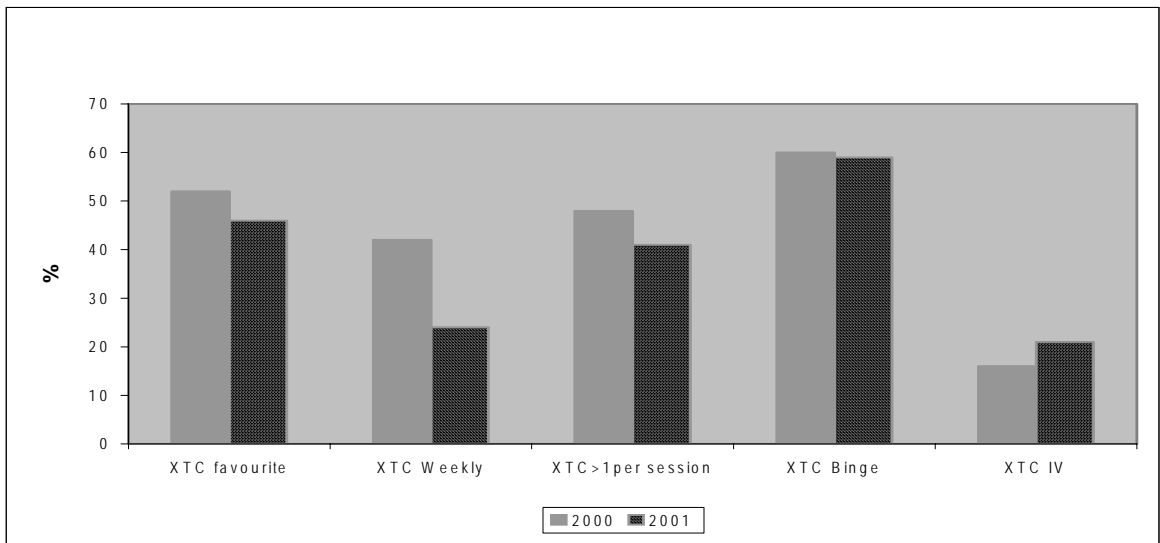
Almost half of respondents (46%) reported that ecstasy was their favourite drug. Twenty-four percent (24%) had used it at least once per week during the last six months; 41% typically used more than one tablet per session; and 59% had binged on it for more than 48 hours in the last six months.

Figure 2 graphically displays patterns of ecstasy use for 2000 and 2001. It shows there was little change in ecstasy being the favourite drug, or in bingeing behaviour, between 2000 and 2001. However, there was a notable reduction in the proportion that used ecstasy at least weekly in 2001 (24%) compared to 2000 (42%). There was also a slight increase in the proportion of respondents injecting the drug in 2001 (21%) compared to the previous year (16%).

<sup>3</sup>Capsules are not as popular as pills and tablets. They can be viewed as “dodgy.” Because they can be tampered with and other products included in the capsule.



Figure 2: Patterns of ecstasy use, 2000 (n=50) and 2001 (n=117).



## 5.0 Price of party drugs

Respondents were asked to comment on the price of ecstasy and other 'party drugs', in terms of their current price and price change over the six-month period January to June 2001.

### 5.1 Ecstasy

In terms of the current price of ecstasy, the median price reported was \$40 per tablet, with a range of \$15 and \$60.

It is worth noting that a majority of the respondents believed it to be cheaper to have a night out on ecstasy than on alcohol. Two factors contribute to this. Firstly, respondents said they did not generally drink alcohol when on ecstasy, buying water instead. Secondly, and subsequently, because they were not under the influence of alcohol, users could drive home without the added cost of a taxi fare.

In terms of price movements over the previous six months, 58% of respondents stated the price of ecstasy had been stable; 37% stated it had decreased; 11% said it had fluctuated; 3% said it had increased; and 8% of respondents did not know about change in price.

### 5.2 Other party drugs'

Table 8 shows the comparative median prices of other 'party drugs' for the 1997, 2000 and 2001.

Table 8: Median price (\$) of other 'party drugs', 1997, 2000 and 2001\*

Drug	1997		2000		2001	
	Price	Range	Price	Range	Price	Range
LSD (per tablet)	20	3-30	15	6-30	15	6-50
Ketamine (per gram)	70	60-120	50	6-30	142.5	35-250
GHB (per millilitre)	n.a.	n.a.	n.a.	n.a.	12	1-100
MDA (per tablet/capsule)	60	40-70	40	35-60	40	30-60
(Methamphetamine (Crystal "base") (per point)	n.a.	n.a.	30	15-80	30	13-120.
Ice (per point)	n.a.	n.a.	35	20-40	40.	10-60

\*Medians are used in this table because at times the mean might not reflect the true average because of a skew in the sample.

n.a. No data are available

For LSD and MDA, the same pattern of price occurred over the three periods. The relative prices for each of these drugs remained the same for 2000 and 2001, but had decreased from 1997. The price of base also remained constant between 2000 and 2001; however, there were no comparable data for 1997.

The price of ice was slightly more expensive in 2001 (\$40 per point) than it was the previous year (\$35). No comparable data were available for 1997.

GHB<sup>6</sup> sold for \$12 per millilitre in 2001, which was the first year its use was reported. Two respondents reported using GHB for injecting purposes.

The price for a gram of ketamine appeared to be quite volatile over the three years, but it must be stressed that the number of respondents reporting its use were consistently too small for any meaningful comparison.

## 6.0 Purity of ecstasy

Two aspects of the purity of ecstasy were examined - the current level of purity and the change in purity over the six month period January to June 2001. Table 9 shows the variation in opinion of both these purity aspects.

### 6.1 *Current purity*

In terms of current purity, half of the respondents indicated it to be of high (26%) or medium (24%) purity, with only seven percent (7%) believing it to be of low quality. However, forty-three percent (43%) considered the current stock of ecstasy to be too inconsistent to categorise. A key informant made comment that there is so much stock on the market presently that the type of pill and its purity changed almost daily.

### 6.2 *Change in purity*

In terms of change in purity over the previous six-month period, whilst 37% of respondents agreed that the purity had fluctuated, 28% felt that the purity of ecstasy had been stable. An equal percentage of respondents reported it to have increased or decreased (15% each) over this time.

Table 9: Perceptions on the purity of ecstasy, 2001.

Current level of purity	%
High	26
Medium	24
Low	7
Fluctuated	43
Don't know	1
Change in purity over the last six months	%
Increased	15
Stable	28
Decreased	15
Fluctuating	37
Don't know	6

## 7.0 Availability of ecstasy

Table 10 shows perceptions on the current availability of ecstasy in southeast Queensland, as well as the perceived changes to availability over the six (6) month period January to June 2001.

### 7.1 Current availability

Over half (59%) of respondents stated ecstasy was 'very easy' to procure; 13% stated it was 'easy' and 24% stated it was 'moderately easy' to procure.

### 7.2 Change in availability

Again, over half the respondents (57%) stated availability was stable while 28% stated that availability had become easier over the previous six months.

Table 10: Perceptions on the availability of ecstasy, 2001.

Current availability	
Very easy	59
Easy	13
Moderately easy	24
Difficult	4
Very difficult	-
Change in availability over last six months	
More difficult	9
Stable	57
Easier	28
Fluctuating	5
Don't know	1

### 7.3 Sources of obtaining ecstasy

As can be seen in Table 11, the most consistently popular source of obtaining ecstasy was through friends, with over 90% of respondents obtaining it this way over each of the three years.

This table also shows that the role of the 'dealer' as a source of ecstasy has reduced over time, from 70% in 1997 to 58% in 2001. Conversely, scoring ecstasy from acquaintances had become more popular, increasing from 23% in 1997 to 33% in 2001. These data suggest that obtaining ecstasy from within a close social network was becoming the favoured method of procuring ecstasy.

Table 11: Source and location of scoring ecstasy - 1997, 2000 and 2001.

	1997 (n = 60) %	2000 (n = 50) %	2001 (n = 117) %
<b>Source of scoring</b>			
Friends	93	94	94
Work colleagues	8	6	9
Dealers	70	56	58
Acquaintances	23	20	33
Unknown people	12	4	9
<b>Location of scoring</b>			
At own home	43	40	39
At dealer's home	45	46	43
Elsewhere	14	14	18

In terms of where respondents are when they score, patterns have been fairly constant over the three years with approximately equal percentages (40%) scoring at their own home or at their dealer's home.

## 8.0 Patterns of substance use among ecstasy users

Table 12 shows three aspects of the respondents' substance using history: proportion ever having used the substance; proportion who had used the substance in the previous six months; and of those who had used the drug in the last six months, the number of days it had been used.

Table 12: Use of various substances, 2001.

	Ever used (%)	Used in last six months (%)	Number of days used in last six months (Median)	(Range)
Ecstasy	100	100	15	6-100
Alcohol	98	94	36	1-180
Cannabis	97	88	65	1-180
Amphetamine	86	66	10	1-180
Tobacco	86	83	180	1-180
Methamphetamine	84	75	7	1-120
LSD	80	40	3	1-22
Nitrous oxide	70	40	7	1-72
Cocaine	69	43	3	1-90
Ice or shabu	67	55	5	1-120
Amyl nitrate	50	25	2	1-72
Benzodiazepines	50	38	6	1-180
MDA	40	27	3	1-100
Antidepressants	36	22	30	1-180
Heroin	33	16	30	1-180
Ketamine	27	11	2	1-90
GHB	27	15	2	1-70
Other opiates	20	7	8	1-60
Methadone	11	4	20	8-60

\* Includes only those participants who had used the drug/substance during the six months preceding the survey (maximum possible number of days used = 180).

Of the substances that respondents had ever used, ecstasy remained the only one used by everyone, followed closely by alcohol and cannabis.

Multiple drugs, or polydrug, use was the norm. As well as using ecstasy, the overwhelming majority of respondents had also used alcohol, cannabis and tobacco.

Examining the median number of days in the last six months that each substance had been consumed, tobacco was by far the most heavily used substance, followed by cannabis and alcohol. Ecstasy was only the sixth heaviest substance consumed during the reference period.

### 8.1 *Ecstasy, MDA,<sup>4</sup> LSD,<sup>5</sup> Ketamine<sup>6</sup> and GHB<sup>7</sup>*

As previously stated, all had used ecstasy within the last six months<sup>8</sup>, for the median number of 15 days (range 6-100 days).

Each of the other four substances used (MDA, LSD, ketamine and GHB), were less likely than ecstasy to have been ever used, with even lower percentages having used them in the previous six months (ranged from 11% to 40%). LSD was the substance used by most respondents (80%), with 40% having used it in the previous six months, for a median duration of three days.

### 8.2 *Alcohol, cannabis and tobacco*

Nearly all respondents had previously consumed alcohol (98%), cannabis (97%) and tobacco (97%), with very high percentages having done so in the previous six months (94%, 88% and 83% respectively). The median number of days these substances were consumed were the highest of all substances – tobacco being the highest (180 days), followed by cannabis (65 days) and then alcohol (36 days). So smoking tobacco was a daily occurrence for 83% of respondents. If regularity of consumption is used as an indicator of dependence, then tobacco is the most addictive product being consumed.

### 8.3 *Amphetamine<sup>9</sup>, Methamphetamine<sup>10</sup> and Ice/Shabu*

Of these three substances, amphetamine and methamphetamine were the most likely substances to ever have been used (86% and 84% respectively) and used in the last six months (66% and 75% respectively). Amphetamine was the most frequently used substance, with 10 days being the median usage in the reference period.

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<sup>4</sup>MDA methylenedioxyamphatamine, the parent drug, of MDMA shares the amphetamine-like effects of ecstasy, but is more hallucinogenic, more like acid and lasts longer (Stoppard, 2000:53).

<sup>5</sup>LSD is a powerful mind-altering drug, affecting the brain, causing hallucinations. Also known as Trips, Tabs, Blotters, Microdots (Stoppard, 2000:90).

<sup>6</sup>Ketamine is a “dissociative anaesthetic”, which means it detaches the mind from the body. It is used as a horse tranquilliser and is related to the veterinary anaesthetic PCP), also known as angel dust (Stoppard, 2000:56).

<sup>7</sup>GHB, gammahydroxybutyrate, is an anaesthetic used to sedate patients before an operation. This drug was implicated in the death of River Phoenix and has, more recently, become popular in clubs, particularly on the gay scene. Like Rohypnol, GHB is sometimes used to spike drinks. Other names for GHB are Grievous Bodily Harm, Liquid Ecstasy, Liquid X (Stoppard, 2000:58).

<sup>8</sup>Indicates that all participants in the study met the criteria of having used ecstasy within the last six months on at least six or more occasions.

<sup>9</sup>Amphetamine is short for AlphaMethylPHeneThylAMINE, a chemically made drug first created over 100 years ago. It is a powerful stimulant that triggers the central nervous system, making a person more alert and energetic (Stoppard, 2000:66).

<sup>10</sup>Methylamphetamine or methamphetamine is a chemically made stimulant. It is like amphetamine but much stronger. It is to amphetamine what crack is to cocaine - it can be 90-100% pure (Stoppard, 2000:72).



#### 8.4 *Cocaine<sup>11</sup> and Heroin<sup>12</sup>*

More than twice the percentages of respondents had used cocaine than heroin. However, heroin was used much more heavily than cocaine (30 days compared to 3 days). Key informants from the Gold Coast confided that cocaine was a popular nightclub drug in their jurisdiction and its use was increasing.

#### 8.5 *Benzodiazepines<sup>13</sup> and antidepressants*

A similar pattern as above emerged when comparing the use of benzodiazepines and antidepressants. Over the previous six months, a much higher proportion of respondents used benzodiazepines than antidepressants (38% and 22% respectively). However, antidepressants were used much more heavily than benzodiazepines (30 days and six days respectively).

#### 8.6 *Continuity of use and dependency*

It is interesting to reflect on the extent to which users who have tried a particular substance became regular users of that substance. Regularity of use is indicated by recent usage (used in last six months) and dependency is indicated by frequency of use in that period.

Continuity of use was highest for alcohol (94%); then cannabis (88%); tobacco (85%); methamphetamine (75%) and amphetamine (66%). Continuity of use for LSD (40%), nitrous oxide (40%) and cocaine (43%) were much lower, however, these substances were more likely to have availability difficulties associated with them which may explain their lower continuity of use.

Tobacco users appear to be the most dependent group. Ninety-seven percent (97%) of respondents had smoked recently, with the vast majority smoking on a regular daily basis.

While the sample was selected on the basis of their recent use of ecstasy, the regularity of which ecstasy was used was low, with users only doing so for 15 days in the last six months, or approximately once every twelve days. These low levels are not considered to be associated with dependence.

#### 8.7 *Polydrug (multiple drug) use*

As already discussed, most respondents have used a variety of drugs and continue to do so. Figure 3 displays the continuity of use of each of the 19 substances used by respondents. The mean number of drugs being used was eight. The

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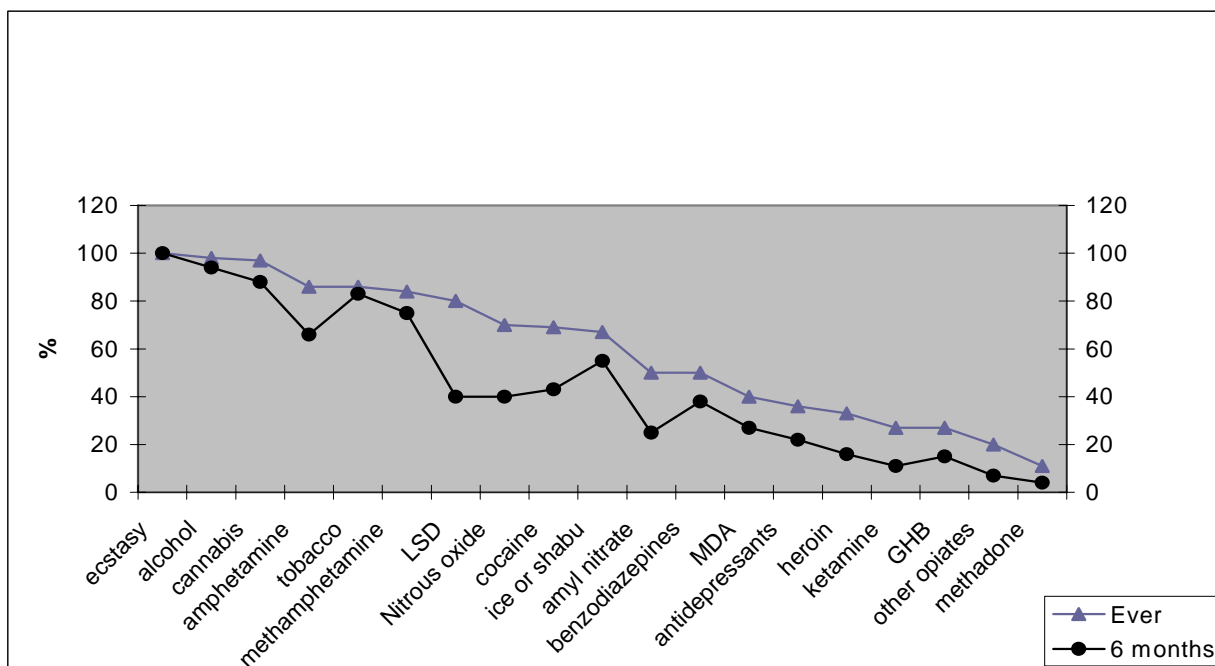
<sup>11</sup>The cocaine found on the streets appears to be a substance called cocaine hydrochloride. It is made by refining the leaves of the coca bush which grows mainly in Bolivia, Columbia and Peru. Cocaine is a powerful stimulant that has similar properties to amphetamine. It was used for medicinal purposes as an over-the-counter "tonic" until it was found to be a dangerous drug; many of the people who had taken it had become addicts (Stoppard, 2000:74).

<sup>12</sup>Heroin (diamorphine hydrochloride) is produced by processing raw opium, a natural substance found in oriental opium poppies. It is a depressant drug so its properties are basically the opposite of a stimulant drug, such as amphetamine. Heroin is a narcotic analgesic, it numbs the brain and body and diminishes pain (Stoppard, 2000:82).

<sup>13</sup>Benzodiazepines or tranquillisers are depressants which means they dull and slow down the central nervous system - the opposite of stimulants such as amphetamine and cocaine. Tranquillisers are prescribed for people who suffer from anxiety or those who have difficulty sleeping. Modern tranquillisers are based on the benzodiazepine group of drugs that largely replaced barbiturates in the 1950s (Stoppard, 2000:102).

respondents had used each of these substances in binge sessions in the previous six months.

Figure 3: Continuity of use of various substances, 2001.



Respondents reported that, to stay high for more than 24 hours, they also took base for endurance, whereas for just an evening out, say, that finished at around 5am, one to two ecstasy tablets would be all that was required.

As discussed previously, the additional substances used by the vast majority of ecstasy users, were alcohol, cannabis, tobacco, methamphetamine and amphetamine.

### 8.8 Frequency of use over the past six months and addictive behaviour

It is important to remember that this study used a selected sample of ecstasy users. Therefore, results for this group may differ from other user groups and the general population of ecstasy users. In terms of addictive behaviour, Table 13 shows that the vast majority of respondents used most listed substances only occasionally.

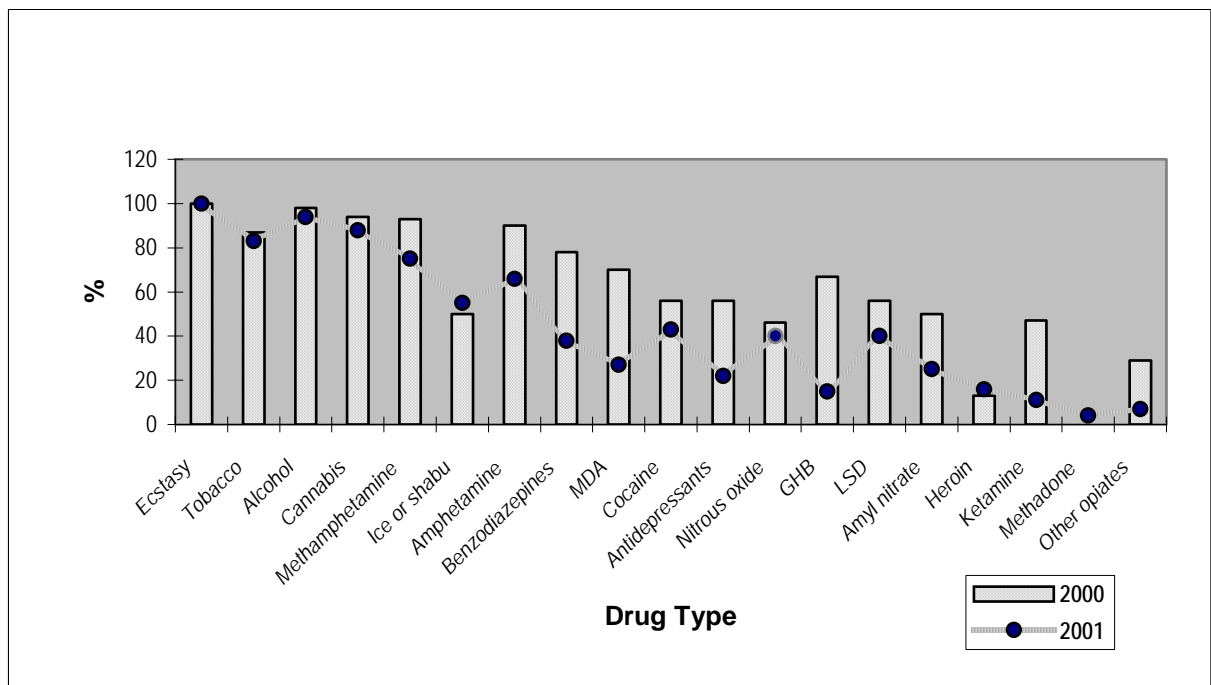
No respondent reported using ecstasy on a daily basis, hence none were considered to be addicted to it. Only 18% of respondents used ecstasy on a weekly basis. Much higher proportions of respondents used other substances on a regular basis, such as alcohol (52%); cannabis (33%); amphetamine (25%); tobacco (24%) and methamphetamine (23%). Six of the nineteen substances were taken at least daily by some respondents, those with the highest proportion of addictive use being tobacco (50%); cannabis (24%); and alcohol (14%).

Table 13: Level of use of substances over the previous six months, 2001. \*

Substance	Level of use (%)			
	Never	Occasional (1-21 days)	Regular (weekly: 22- 175 days)	Addicted (daily: 176-182 days)
Ecstasy	0	82	18	0
GHB	85	12	3	0
Ketamine	90	9	1	0
LSD	59	40	1	0
MDA	76	21	3	0
Alcohol	7	27	52	14
Cannabis	11	32	33	24
Tobacco	19	7	24	50
Amphetamine	35	40	25	0
Ice/shabu	44	39	17	0
Methamphetamine	25	52	23	0
Nitrous oxide	59	30	11	0
Amyl nitrate	74	22	4	0
Benzodiazepine	62	21	13	4
Antidepressant	77	9	10	4
Cocaine	58	39	3	0
Heroin	86	6	6	2
Other opiates	93	6	1	0

\*This table was developed firstly by dividing the number of days the substance was used in the previous six (6) months by 26 (26 weeks in six months) to give weekly use figures. Four categories were then created – never (0 times); occasional (having used substance at least once and up to 21 days); regular (having used weekly, i.e. on between 22 and 175 days); and addicted (have used daily, i.e. between 176-182 days)

Figure 4: Comparison of ecstasy user samples, 2000 and 2001.



This graph shows that with the exception of the tobacco, alcohol, cannabis and methamphetamine, there were lower levels of usage of most of the other drugs in 2001 than in 2000. Exceptions to this were ice/shabu, heroin and methadone which all showed increased use in 2001.

## **9.0 Criminal Activity**

Respondents were asked to self-report their criminal activity during the month preceding the survey. Table 14 presents the results.

Thirty-nine percent (39%) reported that they had sold drugs during this time. However, only nine percent (9%) reported having committed a crime during this time, perhaps indicating that selling drugs is not always considered to be a criminal offence.

The most common number of crimes admitted to was just one. Eight percent (8%) said they had been arrested in the last month, with use/possession of drugs being the most likely reason for arrest.

Some interesting comparisons can be made with 2000 data. Selling drugs remained the most common crime reported. Whilst the proportion of respondents selling drugs was much the same in both years, at around 40%, more were doing so on a weekly or daily basis in 2001 (18%) compared to 2000 (8%).

Less property crime was reported to have been committed in 2001 (3%) than in 2000 (14%). Fraud and violent crime both continued to be of low incidence, each at three (3%) or below, for both years.

Whilst a larger proportion of respondents commented on changes in police activity in 2001 (84%) than in 2000 (47%), the majority believed the situation to be stable (46%) with only a slightly higher proportion (36%) feeling such activity had increased compared to 2000 (31%). However in the 2001 survey, a much higher proportion (69%) felt police activity had made it hard to score over the last six months, compared to 2000 (18%). Perhaps as a result of the perceived increase in police activity and difficulties of scoring, it was also more common in 2001 to have had more friends busted (21%), than in 2000 (15%).

Table 14: Self-reported criminal activity, 2000 and 2001.

	2000 (n = 50) %	2001 (n = 117) %
Frequency of property crime committed		
Never	87	97
Less than once a week	12	2
Once a week	2	1
Frequency of having sold drugs		
Never	58	61
Less than once a week	25	18
Once a week	5	12
More than once a week	8	3
Daily	3	6
Frequency of fraud committed		
Never	97	99
Less than once a week	3	1
Frequency of violent crime committed		
Never	100	97
Less than once a week	0	2
Once a week	0	1
Number of crimes committed		
None	*	91
One	*	4
Two	*	2
Three	*	3
Four	*	1
Arrested in last month		
No	*	92
Yes	*	8
Reason for arrest in last month		
Not arrested	*	90
Use/possession	*	6
Property	*	2
Fraud	*	1
Other	*	1
Changes in police activities in last six months		
Don't know	53	16
Less activity	0	2
Stable	16	46
More activity	31	36
Police activity made it difficult to score in last six months		
Don't know	18	
No	64	31
Yes	18	69
More friends been busted in last six months		
Less	7	5
Stable	78	74
More	15	21

\*Data not available.

## 10.0 Health issues related to consumption of party drugs

### 10.1 Physical health problems

The table below summarises the physical symptoms experienced by respondents and their perceived association with ecstasy use.

Table 15: Physical symptoms associated with ecstasy use, 2001.

Symptom	Experienced in last six months (%)	Median length of worst case*	Solely attributed to ecstasy* use (%)
Trouble sleeping	76	12 hours	69
Blurred vision	68	2 hours	85
Numbness or tingling	62	2 hours	84
Weight loss	62	3 days	60
Hot or cold flushes	60	2 hours	83
Loss of energy	59	2 days	59
Tremors or shakes	59	2 hours	73
Muscular aches	58	2 days	49
Profuse sweating	56	4 hours	66
Joint pains or stiffness	55	2 days	48
Heart palpitations	51	10 hours	55
Dizziness	42	5 hours	71
Headaches	40	4 hours	62
Teeth problems	39	2 days	52
Shortness of breath	35	15 hour	42
Stomach pains	34	2 hours	60
Inability to urinate	31	3 hours	86
Vomiting	29	5 minutes	65
Chest pains	25	1 minute	38
Fainting or passing out	10	4 minutes	67
Fits or seizures	5	3 minutes	33

\* Of those reporting the symptom

Seventy-six percent (76%) of respondents reported having had trouble sleeping within the last six months and 69% of these related it solely to their use of ecstasy. Their inability to sleep lasted for a median number of 12 hours.

A further ten physical symptoms were experienced by more than half of respondents with the vast majority attributing each symptom to their ecstasy use. These symptoms were blurred vision; numbness/tingling; weight loss, hot and cold flushes; loss of energy; tremors/shakes, muscular aches; profuse sweating; joint pains and or stiffness; and heart palpitations.

The negative impact of ecstasy on the heart is well documented in Lester, Baggott, Welm *et al.* (2001). They noted that modest oral doses of MDMA increase heart rate, blood pressure, and myocardial oxygen consumption in a

magnitude similar to dobutamine.<sup>14</sup> The negative effects of taking ecstasy are also reported in Elk (1996) and these include elevated systolic/diastolic blood pressure, muscle hypertonicity, elevated heart rate, jaw clenching, transient nausea, insomnia, dehydration, hot/cold flashes and nystagmus.<sup>15</sup> Positive effects are also mentioned in this article i.e. increased energy levels, heightened sensory perception, desire to be in constant motion, appetite suppression and a high level of stimulation.

### 10.2 Psychological symptoms associated with the use of ecstasy

Table 16 displays the psychological symptoms reported and the perceived association with ecstasy use. Whilst the table is self-explanatory, it is of interest to note that the majority of respondents linked every one of their psychological symptoms to ecstasy use.

In terms of depression, Curran and Travill (1997) support this association and state that weekend use of MDMA may lead to depressed mood mid-week.

Table 16: Psychological symptoms attributed to ecstasy use, 2001.

Symptom	Experienced in last six months (%)	Median length of worst case*	Solely attributed to ecstasy* use (%)
Confusion		2 days	69
Irritability		2 days	60
Depression		2 days	72
Visual hallucinations		3 hours	83
Paranoia		3 hours	72
Memory lapse		4 hours	78
Anxiety		6 hours	73
Auditory hallucinations		60 minutes	76
Panic attacks		3 hours	85
Loss of sex urge		24 hours	73
Flashbacks		5 minutes	75
Suicidal thoughts		2 hours	53
Violent behaviour		45 minutes	60
Attempted suicide		-	25

\*Among those reporting that symptom.

### 10.3 Quantities of various party drugs used

The quantities of various party drugs used by participants are presented in Table 17 and includes 'typical use' and 'heaviest use' for both 2000 and 2001.

<sup>14</sup>Dobutamine hydrochloride is a direct acting inotropic agent whose primary activity results from stimulation of the B-receptors of the heart while producing comparatively mild chronotropic, hypertensive, arrhythmogenic and vasodilative effects. It does not cause the release of endogenous noradrenaline as does dopamine (MIMS, 2001).

<sup>15</sup>Eye-twitching.

Table 17: Quantities of party drugs used, 2000 and 2001. \*

Drug (measure)	Measure consumed during typical episode		Measure consumed during longest episode	
	2000	2001	2000	2001
Ecstasy (tablet)	49	110	50	111
LSD (tablet)	26	47	26	54
MDA (capsule)	11	22	11	24
Amphetamine powder (grams)	19	61	21	62
Methamphetamine (point = 0.1 gram)	39	71	39	73
Ice or shabu (point)	3	47	3	52
Cocaine (gram)	14	35	13	35
Amyl nitrate (snort)	14	23	14	24
Nitrous oxide (bulb) <sup>a</sup>	16	35	16	41
GBH (millilitre)	-	10	-	11
Ketamine (lines)	4	(n=4)*	4	(n=4)*
Ketamine (pills)	2	(n=2)*	2	(n=2)*

\* Sample too small to calculate the mean

\*\* Note: the data for this table was collected using the common form of dose i.e. tablet or gram. Quantities not presented in the most common measure were excluded.

With the exception of ketamine, the measure most frequently mentioned by participants who had used the drug during the six months preceding the survey is the measure reported. Data for participants who reported some other measure are not included.

<sup>a</sup>A 'bulb' of nitrous oxide refers to the small canister in which the gas is sold legally in supermarkets for insertion into an appliance used for whipping cream.

Table 18: T-test for quantity of drug used in a 'typical episode', 2000 and 2001.

Drug Type (measure)	2000	2001	T-test p-value
Ecstasy (tablet)	1.56	1.57	0.95
LSD (tablet)	0.91	1.23	0.25
MDA (capsule)	1.07	1.60	0.41
Amphetamine powder (gram)	0.73	0.70	0.84
Methamphetamine (point = 0.1 gram)	1.51	1.52	0.98
Ice or shabu (point)	1.33	1.08	0.64
Cocaine (gram)	0.41	0.86	0.02*
Amyl nitrate (snort)	3.79	4.52	0.47
Nitrous oxide (bulb) <sup>a</sup>	8.38	11.91	0.24

\*Significant



Table 18 shows the t-tests for quantity of drug used in a typical episode for both 2000 and 2001. It should be noted that the sample sizes were different for the years 2000 (n=50) and 2001 (n=117) and so p-values were calculated to confirm significant differences.

Cocaine was the only drug to show a statistically significant difference between 2000 and 2001. A typical dose of cocaine increased from 0.41 grams in 2000 to 0.86 grams in 2001.

#### 10.4 *Social problems related to ecstasy use*

Occupation/study problems were the most common (47%) social problem experienced by respondents, followed by relationship (43%) problems.

As shown in Table 19, each of the four problems were more likely to be experienced by females than males, even though females represent a smaller proportion of respondents.

Table 19: Social problems related to use of ecstasy, 2001. \*

Problem	Males (n = 71) %	Females (n = 46) %	Total (n = 117) %
Occupational	44	52	47
Relationship or other social problems	39	48	43
Financial problems	28	44	34
Legal police problems	4	7	5

\* A simple yes or no response was required to the question about relationship and social problems during the preceding 6 months.

## 11.0 Key Informant comments on demography of users

Much of the key informants' qualitative comments replicated the quantitative data collected from the survey of ecstasy users. There were also some other observations made by the key informants that are worth highlighting.

Before presenting these, it is important to note that another drug mentioned frequently by key informants, as well as by ecstasy users and which is relatively new to the scene in Queensland, was PMA.<sup>16</sup> There have been some reported incidences of cases at nightclubs where PMA use has been suspected. It is therefore recommended that PMA use be included in next year's study to ascertain the drug's prevalence.

### 11.1 Age and gender

On the whole, key informants identified ecstasy users as a young population. Those working in the entertainment industry stated that there were more male ecstasy users at the major rave events in general (estimated at 60%). This proportion sometimes increased even further, depending on the type of venue and the level of 'hardcore music' played.

Female users were generally younger than male users, perhaps because males tended to take ecstasy over a longer span of their lives than females. It seemed that, in general, female users in any given peer group were younger than their male counterparts and that initiation into ecstasy use was usually through an older boyfriend and/or peer

### 11.2 Cultural background

Many key informants had direct contact with users frequenting nightclubs. They stated there was increasing numbers of Asian and Far East Asian populations visiting nightclubs. They said that although one third of a nightclub population might be Asian, they were too difficult to recruit for this study.<sup>17</sup> They did not indicate ecstasy use by indigenous Australians as becoming an emerging trend.

### 11.3 Geographic areas

Areas involved in the heavy use of 'party drugs' included the Gold Coast, Brisbane's Fortitude Valley, the inner city of Brisbane, Elanora, Labrador, the

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<sup>16</sup>PMA (para-methoxyamphetamine) is like speed in its chemical make-up. PMA is amphetamine with a methoxy group at the fourth position on the aromatic ring. PMA is to amphetamine, what PMMA is to methylamphetamine. PMMA is less common than PMA. Although chemically similar, PMA and amphetamine have different target sites, i.e. they bind with different neurotransmitter receptors. Using PMA and PMMA can result in serious increases in body temperature, through actions on receptors in the hypothalamus. PMA in low doses may not give much of an E affect, so two or more may be consumed thinking it is a weak dose of MDMA. Most deaths have occurred when over 200mg has been consumed. Most people would not consciously take PMA, although many may do so thinking the substance is MDMA. There are however groups and individuals that prefer the effects of PMA and therefore choose it over MDMA. These people do so usually because of the powerful effects of the drug. One comment was that it "hammers you like no other"(key informant).

<sup>17</sup>Numerous attempts were made to recruit Asians but this population is still under-represented in the overall sample of ecstasy users, although some key informants/experts identified as Asian.

southern end of the Gold Coast, Surfers Paradise, Redland Bay, Maroochydore, Noosa, Mooloolaba and Brisbane's south and western suburbs.

The general pattern was for users to congregate in nightclubs in the more built up areas of the southeast corner of Queensland. A point worth mentioning is that the screening process and selection criteria necessitated the exclusion of about 20 backpackers. Since this region is a popular tourist destination it is likely that tourists are involved in the use of party drugs and as such perhaps should be included in future studies.

#### *11.4 Education and work status*

Key informants indicated that ecstasy users are found in a variety of employment areas, e.g. technology, entertainment, fashion and hospitality industries, retail and real estate; and work as doctors, lawyers, club owners and tradespeople.

#### *11.5 Currently in treatment*

Key informants reported that ecstasy users were generally not in drug treatment, although drug treatment workers said 'people came for related issues and disclosed their ecstasy use at the time of interview'. Drug rehabilitation workers stated that the demand for detoxification beds for problem ecstasy use was on the increase.

This pattern of seeking treatment is consistent with the QCC report (2001) which stated that ecstasy users in the past have not presented for treatment, or to other agencies such as needle and syringe programs (NSP), as frequently as it is believed have users of other illicit drugs such as heroin or methamphetamines (COTSA Drug Treatment by State 2001).

#### *11.6 Criminal activity*

Key informants stated that in general the ecstasy user population group displayed low levels of criminal activity.

#### *11.7 Conclusion of demographics*

An overall impression given by key informants was that the ecstasy-using group was high functioning, reasonably well educated, with high rates of employment or were studying. It was difficult to access people from non-English speaking backgrounds, due to different cultural mores and fear of exposure.

## **12.0 Key informant comments on price of ecstasy**

Twelve of the key informants believed the price of ecstasy to be stable, whilst three believed it had increased, six that it had decreased; and three that the price was in fluctuation. Capsules were generally sold for a cheaper price than pills (usually \$10 cheaper) as capsules could easily be tampered with.

Some key informants could give prices for larger quantities of ecstasy, i.e. 10 or more tablets cost approximately \$40 each; 20 or more cost approximately \$25 each; more than a hundred cost between \$15 to \$20 each. The quality of the drug would appear to be the major determinant of price.

## 13.0 Key informant comments on trends in ecstasy use

### 13.1 Usage patterns

Another trend observed by key informants was that while the age of the ecstasy user was getting younger, ecstasy was also being discovered by people older than 30 – and this was borne out in the data where the upper age of ecstasy users was 48 years.

Heavy use of ecstasy was seen to be associated with newer users. There seemed to be urban myths surrounding the effects of ecstasy and its impact on serotonin levels, with an increasing view that antidepressants enhanced the effects of ecstasy. Some informants stated that the Internet had become the major source of information about ecstasy.

Service providers stated that some clients were using ecstasy to induce weight loss because it was perceived as an appetite suppressant.

Ecstasy use was also said to be spreading from the party scene into mainstream society with some users stating that they had never been to a rave. Its use had moved into pubs, clubs, private parties, coffee lounges and private homes. Key informants believed there was a wider availability of ecstasy, which enabled users to obtain the substance prior to arriving at a venue.

### 13.2 Typical session

User comments about a typical ecstasy session involved:

*First night:* more emotionally in touch, discovers feelings about partner that they had not before realised, brings out emotions and feelings, leads to insights, difficulty sleeping, palpitations, dehydration problems, sense of euphoria, hallucinogen (visual and auditory). The pill's effect lasted for 2-3 hours. Sometimes an extra pill was taken in the evening or during the recovery period the next day.

*Day After:* come down, still difficult to sleep, negative feelings, difficult to come back to reality, physically tired, emotionally drained, depressed, anxious, muscle aches, emotionally fragile, misinterpret others as hostile, lack confidence

*Second Day:* depressed, feel terrible with body aches and tiredness, impatience, anger, frustration, increased use of benzodiazepines to assist with symptoms.

*Third day:* a day of depression and neurotic feelings

*Fourth day onwards:* seemingly feeling normal once again.

### 13.3 Polydrug use

Key informants reported high levels of amphetamine use with ecstasy. The general trend was to use ecstasy for an average night out and to use amphetamines for a big night. As ecstasy lasted only a few hours, other drugs were often used with it. Some people reported using LSD with ecstasy (known as 'candy flipping'). The larger the event the more likely it was to involve the use of multiple drugs. Ecstasy users stated that if they were wishing to keep going for

more than 24 hours, they took base and/or crystal and if it was a shorter evening out that finished at around 5 am, then one to two ecstasy tablets were all that were used.

It is of concern that there appears to be a tendency for users to take antidepressants during the week, with the perception that this would enhance the ecstasy 'effect' on the weekend. Others use antidepressants in conjunction with ingesting ecstasy, again, with the perception that it enhances the ecstasy 'effect'.

#### 13.4 *Recovery*<sup>18</sup>

For this report, the term 'recovery' is defined as the "continued state of drug taking to alleviate the symptoms of coming down from drug taking the night before and also includes other kinds of drugs used to assist with the come down effects that are experienced the day after."

Key informants reported an increasing number of 'recovery' events and entertainment venues that provided such facilities after nightclubs closed. They stated that big dance parties tended to bring out a lot of sporadic users whereas club nights tended to have more regular users. Many stated that on an average night out, people would take one to two ecstasy pills, often with amphetamine (base or crystal). At large parties, people often binge, taking between one and five ecstasy pills (or more) over a two to three day period. The availability of recovery parties/venues can determine whether people continue to top up with further drugs. If there is a party that continues throughout the next day, so too does the crowd. However, it is almost impossible to binge every weekend because there are not enough events.

#### 13.5 *Responsible use*

RaveSafe teams reported that over the previous six months, there had been an increased sense of awareness of using safely, among the ecstasy using population. Ecstasy users were taking advantage of the information on the Internet and there was a trend towards responsible use, such as planning the initiation phase; stage of ingestion; getting intoxicated; recovery period; and knowledge that it needed to be taken with friends in controlled settings.

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<sup>18</sup>Continued state of drug taking to alleviate the symptoms of coming down from the drug taking the night before and also includes other kinds of drugs used to assist with the come down effects that are experienced the day after

## **14.0 Key informant comments on purity of ecstasy**

There was disparity among the key informants in regard to purity, with nine stating it fluctuated, seven stating the strength was high, four stating it was of medium strength and two stating ecstasy was of low strength. Comments were made regarding 'bad batches' and ecstasy pills, which were 'speedy' or 'smacky'.

These comments supported the ABCI data that indicated that ecstasy was subject to fluctuating strengths as well as fluctuations in additives. A key informant stated that for ecstasy to have any effect there needed to be at least 60-80 mgs of ecstasy in the pill. Another key informant saw people trying to sell Panadol as ecstasy. Ecstasy can be cut with anything, giving unwanted effects and subsequent mental and physical health problems. Key informants stated that PMA, ketamine, cocaine, heroin, codeine, amphetamine, and methamphetamine were all components used in the development of ecstasy tablets for the Queensland market. The Australian Government of Analytical Laboratories in Queensland has reported that the majority of tablets received for analysis do not contain ecstasy (ABCI, 2001).

## **15.0 Key informant comments on sources of supply of ecstasy**

Reports on sources of supply included wealthy “yuppy” kids; Asian-looking speed dealers, opportunistic people, hardcore dealers, younger dealers, people dealing for nothing, white collar workers, security staff, DJs, one stop shopping for all substances dealers, dealers within a social network and people who were not dependent on ecstasy but were supporting other substance habits.

Key informant confirmed that ecstasy is predominantly distributed within the social network of friends and so the ‘dealer’ role changes constantly.

Interviews from the central Gold Coast region indicated that cocaine and ecstasy use were higher in the CBD where the bulk of the nightclubs were located. Gold Coast informants also said there was a higher use of cocaine and ecstasy by people from outer lying areas who visit the CBD, but because of the transient nature of the population in this region, it was difficult to police.



## 16.0 Key informant comments about crime

Key informants stated there had been police “blitzes in various geographical areas in the south-east region of Queensland especially in Fortitude Valley.”

A number of related comments were:

“CHOGM preparations and the ‘crack down’ by police have displaced a lot of the ravers from Fortitude Valley”;

“There was an increased presence of undercover police at the nightclubs”;

“police were more friendlier to ‘ravers’”;

“a lot of clubs were being raided”;

“heard of more dealers getting busted”;

“clubs are clamping down on dealing”;

“police are attending raves in uniform”;

“drinkers cause more trouble than we do”;

“sniffer dogs at dance parties.”

These comments suggest more police activity and presence in the rave/dance/recovery scene and support the notion of the Drug and Alcohol Coordination Unit of Queensland Police of placing emphasis on developing community and multi-agency responses to drug related problems (Department of Police, 2000).

Key informants reported a perceived increase in fraud (particularly credit card fraud), assault, motor vehicle theft and break and enter offences. There had been a number of incidences of aggression in the community associated with amphetamine use. For example, the Gold Coast Hospital reported a very high percentage of drug-related admissions to its Accident and Emergency Department (no actual figures available).

## **17.0 Key informant comments about health issues**

### *17.1 Problems experienced by users*

There was a range of comments from key informants about the problems associated with ecstasy use. These ranged from people having some difficulty communicating with parents and friends, through to having completely dysfunctional relationships.

Key informants stated that continued and regular use of ecstasy tended to lead to prolonged depression, paranoia and insecurities. Treatment centre workers stated that in the past six months younger people were presenting more frequently with ecstasy related problems. These problems were of a more complex nature and were problems, which would normally be seen, in a much older substance-using population. These included psychological, financial, legal and social problems.

Many users reported concern about the effects of ecstasy on their immune system.

### *17.2 Public safety issues*

A venue operator on the Gold Coast stated that the nightclub area was not safe for families to visit in the evenings. Another stated “it (the nightclub scene) looked like a war zone after 10pm with police, ambulances, people loudly partying and people who had “freaked-out.”

### *17.3 Treatment issues*

Reports from hospital accident and emergency departments and paramedics stated it was difficult to deal with people who were on stimulants because of their aggressive behaviour, which was directly associated with stimulant use. The opinion was expressed that user attendances to Accident and Emergency Departments and attendances made by Paramedics to stimulant related incidences was increasing. Figures are not yet available to confirm this comment.

## 18.0 The Methamphetamine module

Sixty-two people, or 53% of the total sample of ecstasy users, were also using some sort of amphetamine. A study of this sub-group was developed as part of the overall 2001 project, with an additional set of questions being asked of these respondents.

The purpose of this 'Methamphetamine module' was to assess the different types of stimulants available on the illicit drug market and the idiosyncrasies surrounding them. The types of methamphetamine identified and detailed below are base, pure, ice and shabu.

### 18.1 Base

#### 18.1.1 Types of Base<sup>19</sup>

Nearly all (98%) of this sub-group had used base. The common street names included 'pure', 'speed', 'goey', 'whizz', 'fast stuff', 'base', 'banger', 'flat-out', 'ox-blood' and 'crystal methamphetamine'.

Most users were under the impression that the drug acquired was either methamphetamine (43%) or crystal methamphetamine (24%), although 18% were unsure about the drug's content (see Table 20).

Table 20: Base - opinions of what type of drug it is, 2001.

Type of drug	% (n=62)
Dexamphetamine	2
Methamphetamine	43
Crystal methamphetamine	24
Mixture	2
Unsure	18
Pseudoephridine	2
None of the above	6
Dexamphetamine or methamphetamine	2
Crystal methamphetamine or methamphetamine	2

<sup>19</sup>Amphetamine comes as a white powder that looks like salt or, sometimes, as a pill or paste. The powder usually comes in a folded paper envelope called a "wrap" that contains about a gram of powder. Most wraps contain only about 5 mgs of actual amphetamine as it has often been "cut" with other substances to pad it out. The padding can harm, especially if snorted or injected. The effects on the body and mind are to speed everything up. Everything seems urgent. Users feel they are capable of doing things beyond their ability, such as driving at high speed. There is often a sense of feeling pumped up that lasts for hours. People stay awake for long periods and dance non-stop. Others become very talkative believing that they make sense but most probably talking gibberish. Amphetamine raises body temperature, so there is a real risk of overheating which can be dangerous especially if taken with alcohol or ecstasy (Stoppard, 2000:66-67).

The most common quantity of the drug purchased by this group was a point (70%) or a gram (22%). The rest bought amphetamine in millilitres (2%); rock (2%) or they had been given the drug free of charge (4%).

#### 18.1.2 Cost of base

The mean cost for a 'point' or an 'eight-ball' ranged from \$20 to \$50. A gram cost between \$198 and \$350.

#### 18.1.3 Forms of base available

The most common forms of base available were crystal (30%), powder (20%) and a mixture of powder and crystal (20%) as shown in the table below.

Table 21: Forms of base, 2001.

Form	% (n=62)
Crystal	30
Powder	20
Paste	12
Liquid	2
Rocks	2
Syrup	2
Mixture – powder and crystal	20
Mixture – crystal and paste	14

Fifty percent (50%) of users stated the drug had been cut, a further 38% stated it had not been cut and 10% were unsure. The most common cutting agent mentioned by respondents was glucose (38%), followed by Epsom salts (11%) and bicarbonate of soda (7%).

#### 18.1.4 Routes of administration of base and its effects

The routes of administration of base were swallowing (61%); injecting (31%); snorting (18%); drinking (8%); and smoking (4%). The subjective effects were many and varied and these ranged from nothing at all, to scattered thoughts, anxiety, depression, paranoia, aggression and violence.

### 18.2 Pure

#### 18.2.1 Types of pure

Fifty-seven percent (57%) of the sub-group had used pure. The most common names given for this substance were 'base', 'whiz', 'goey', 'gopher', 'white' and 'rock'. There appears to be a blurring of the boundaries between what is called 'base' and what is called 'pure', with one user stating that it is difficult to know what the drug was because "it could not be regulated in the legal sense."

Table 22 shows that one-third (33%) of users believed the drug was crystal methamphetamine, another 25% believed it to be methamphetamine and 17% pure amphetamine.

Table 22: Pure - opinions on what type of drug it is, 2001.

Type of drug	n = 62 %
Methamphetamine	25
Crystal methamphetamine	33
None of the above	17
Unsure	8
Pure amphetamine	17

### 18.2.2 Cost of pure

Users stated that the cost of pure was generally between \$55 and \$150 per point and between \$200 and \$350 per gram.

### 18.2.3 Forms of pure available

Pure was reported to come in a number of forms. These included crystal (58%); powder (8%); a mixture of crystals and powder (25%); and a mixture of crystal and glue like substance (8%).

Three-quarters of users (75%) believed the pure they obtained was not mixed or cut with anything, whilst the remaining 25% were not sure.

### 18.2.4 Routes of administration of pure and its effects

The most common routes of administration were injection (42%) and snorting (25%). Other methods included swallowing (8%); drinking (8%); a combination of injecting and swallowing (8%); and a combination of snorting and swallowing (8%).

Most users reported experiencing both positive and negative effects of the drug. The positive effects reported were that of increased energy levels and that it had a stronger effect than base. Negative effects included exhaustion; tiredness the next day; and fatigue, with the perception that the increased energy expelled during use of the drug left them drained the next day.

## 18.3 *Ice*<sup>20</sup>

### 18.3.1 Types of Ice

Seventy percent (70%) of the sub-group had used ice. Common street names were 'crystal meth', 'meth' and 'shabu'. A new street name identified was 'putih', meaning white. The vast majority of users (83%) believed the drug they had bought as ice was crystal methamphetamine.

### 18.3.2 Cost of ice

The price of a ice was generally between \$25 and \$140 per point, or between \$100 and \$300 per gram. Most had bought ice in points (46%) or grams (42%), while others had bought it as rocks (4%) or been given it free of charge (8%).

<sup>20</sup>Ice is a strong form of methamphetamine and its side effects may harm. There is a risk of a stroke or a heart attack. It also raises body temperature, which can lead to heatstroke, especially if in a club and taken with other drugs. Tolerance builds up quickly with continuous use. Eventually dangerous amounts are required to obtain the original effect. The potential for overdose is high, with even a small amount leading to convulsions, unconsciousness and even death (Stoppard, 2000:73).

### 18.3.3 Forms of ice available

The most common form the drug came in was crystal (83%). Other forms included powder (4%), a mixture of powder and crystals (8%), and rocks (4%). Fifty-four percent (54%) believed that the drug was uncut; 4% that it had been cut with glucose; 4% with Bicarbonate of soda; 4% with Epsom salts; 4% with codeine; 8% with cocaine; 4% with vitamin B; and 17% were unsure.

### 18.3.4 Routes of administration of ice and its effects

A variety of routes of administration were used with ice. The most common were swallowing (46%) or smoking (21%); others included injecting (8%), drinking (4%), a combination of swallowing and snorting (8%), rubbing on gums or teeth (4%), dissolving under tongue (4%) and a combination of injecting and swallowing (4%).

In terms of the effects of ice, most users reported depression as a major negative effect, whilst its positive effects were reported as being better than base.

## 18.4 *Shabu*

### 18.4.1 Types of shabu

Twenty-one percent (21%) of the sub-group had used shabu.

Dealers were reported to have told users the drug was either a mixture of cocaine and amphetamine (33%); a form of amphetamine (33%); or ice (33%). Most users were either unsure of what the drug actually was (67%) or were convinced that it was cut speed (33%).

### 18.4.2 Price, purity and potency of shabu

Most points cost between \$25 and \$50 and came in powder form. Many users (67%) stated the dealer sold them shabu with an extra bag of glucose for cutting.

## 19.0 Seizure data for Queensland

### 19.1 Queensland Health Scientific Services

Seizure data examined by Queensland Health Scientific Services shows the number of samples analysed; the weight of samples; and the content per gram of ecstasy, methamphetamine and amphetamine.

#### 19.1.1 Ecstasy sample analysis

As shown in Table 23, the number of ecstasy samples analysed in 2000-2001 was 68, with the majority of these (75%) falling within the 20-59.9% purity ranges. In 1999-2000, there were more cases analysed (103), with the majority (76%) falling within the narrower purity ranges of 20-39.9%.

Table 23: Analysis of ecstasy samples, 1999-2000 and 2000-2001.

Purity range (%)	Number of samples		Total sample weight (grams)		Total ecstasy content per gram	
	1999-2000	2000-2001	1999-2000	2000-2001	1999-2000	2000-2001
0 - 9.99	4	6	117	11	1	0
10.0 – 19.9	5	5	19	9	3	1
20.0 – 29.9	21	23	312	71	70	17
30.0 – 39.9	57	13	388	88	139	28
40.0 – 49.9	8	15	50	316	23	130
50.0 –59.9	6	1	13	13	7	7
60.0 – 69.9	0	2	0	6	0	4
70.0 – 79.9	2	1	3	1	3	1
80.0 and over	0	2	0	1	0	1
<b>Total</b>	<b>103</b>	<b>68</b>	<b>902</b>	<b>517</b>	<b>246</b>	<b>189</b>

Source: Queensland Health Scientific Services.

### 19.1.2 Methamphetamine sample analysis

Table 24 shows that the number of methamphetamine samples analysed in 1999-2000 were 2413, compared to 1753 in 2000-2001.

The purity of the samples varied considerably both within and between each of these years.

Table 24: Analysis of methamphetamine\* samples, 1999-2000 and 2000-2001.

Purity range (%)	Number of samples		Total sample weight (grams)		Total methamphetamine content per gram	
	1999-2000	2000-2001	1999-2000	2000-2001	1999-2000	2000-2001
0.0 – 9.99	750	389	3819	3970	392	98
10.0 – 19.99	267	211	2107	807	307	132
20.0 – 29.99	377	327	2088	1166	568	295
30.0 – 39.99	292	301	928	1137	326	395
40.0 – 49.99	283	213	825	836	374	376
50.0 – 59.99	223	155	1218	1596	686	870
60.0 – 69.99	104	70	477	1923	294	1186
70.0 - 79.99	114	84	244	89	180	67
80.0 and over	3	3	4	4	3	3
<b>Total</b>	<b>2413</b>	<b>1753</b>	<b>11710</b>	<b>11528</b>	<b>3130</b>	<b>3422</b>

\*Methamphetamine Samples 1999-2000 = 998; 2000-2001 = 708.

Source: Queensland Health Scientific Services.

### 19.1.3 Amphetamine sample analysis

In 2000-2001, the number of amphetamine samples analysed was 53, whereas in 1999 to 2000 there were 64, as can be seen in Table 25.

The strength of the sample varied and the difference between the years demonstrated that the strength of amphetamine was weak.

Table 25: Analysis of amphetamine samples, 1999-2000 and 2000-2001.

Purity range (%)	Number of samples		Total weight of sample (grams)		Total amphetamine content per gram	
	1999-2000	2000-2001	1999-2000	2000-2001	1999-2000	2000-2001
0.0 – 9.99	57	51	5066	242	32	5
10.0 – 19.99	5	1	28	595	4	67
20.0 – 29.99	1	0	<1	0	<1	0
30.0 – 39.99	0	1	0	14	0	5
40.0 – 49.99	1	0	15	0	6	0
50.0 and over	0	0	0	0	0	0
<b>Total</b>	<b>64</b>	<b>53</b>	<b>5109</b>	<b>851</b>	<b>42</b>	<b>77</b>

Source: Queensland Health Scientific Services.



## 19.2 Queensland Police

Table 26 presents the number and purity levels of amphetamine seizures by Queensland Police, for each quarter of 2000-2001. Out of 12 cases of amphetamine seizures under two grams the average purity was 4%. Of those seizures over two grams (26 cases) the average purity was 3%. It can also be seen that almost half of the year's total seizures (14 out of 30) were in the July-September quarter and that the purity of these seizures, at an average of 4.7%, were also higher than the other three quarters.

Table 26: Average purity of amphetamine seizures by Qld police, 2000-2001.

	Cases (no.)	Purity (%)	Cases (no.)	Purity (%)	Cases (no.)	Purity (%)	Cases (no.)	Purity (%)	Cases (no.)	Purity (%)
Seizure weight (grams)	July to September 2000		October to December 2000		January to March 2001		April to June 2001		Total 2000-2001	
Under 2	8	4.3	0	0	4	3	0	0	12	4
2 and over	6	3.8	6	3	5	3	1	2	26	3
Total	14	4.7	6	3	5	3	1	2	26	4

## 20.0 Supply of ecstasy

Demand for ecstasy in southeast Queensland seems to be increasing, access improving and the price decreasing. This trend will probably continue for as long as there is a thriving rave and dance culture scene.

Given that price is a function of supply and demand, there is little doubt a high demand for ecstasy. Demand is increased by the attraction of the Gold Coast and Sunshine Coast as tourist destinations, which promise good weather and plenty of recreational activities. Also, tourist organisations in Brisbane, Gold Coast and Sunshine Coast aggressively recruit clients from southern States for the 'schoolies weeks', thus further increasing potential demand.

Queensland's high level of tourism potentially increases importation of ecstasy from other States, which subsequently boosts the level of dealing and use of this drug. It is therefore possible that supply and demand fluctuate more in Queensland than in other States.

Some reported there had been an ecstasy drought during December 2000 to January 2001, but that the market had been flooded since then, with new batches appearing on the streets on a daily basis.

The QCC (August 2001:3) estimate the market value of ecstasy to be between \$10 to \$50 million per annum.<sup>21</sup>

### 20.1 *Manufacture of ecstasy*

As reported by ABCI (2001), most ecstasy available in Queensland is not manufactured locally. This is probably due to the difficulty in procuring precursor chemicals and a lack of expertise. However, key informants in this years study reported that while ecstasy pills are arriving from destinations such as the US, UK, Europe, China and Holland, they are then being re-manufactured in a weaker quality by Australian manufacturers in other States. Key informants believe that imported ecstasy is difficult to cut or restamp, consequently most was manufactured elsewhere. Cutting agents included PMA, MDA, GHB, crack cocaine, cocaine, speed, ketamine, lactose, sassafras oil and ordinary kitchen oil.

### 20.2 *Importation of ecstasy*

Key informants reported that ecstasy came into Australia arrived via all the normal routes i.e., by plane, boat, air passenger, air cargo and sea cargo routes. The ABCI (2001) also reported a trend towards commercial quantity importations.

### 20.3 *Purity levels of seizures of ecstasy*

Table 28 shows that there has been little change in purity levels over time or between that seized in Queensland or NSW. In 1999-2000, for the first time, two laboratories were seized in Queensland, indicating that local manufacture of ecstasy may be increasing. This is supported by key informant comments about pure ecstasy being imported and reconstituted by local manufacturers.

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<sup>21</sup>Based on an estimated 38,000 users with an estimated intake of 1 tablet per use from 6 to 36 times per year at an average price of \$42 per tablet (extrapolated from NDARC data)

Table 27: Ecstasy purity levels (%) – Qld & NSW, 1996-1997 to 1999-2000.

Year	Qld %	NSW %
1999-2000	33	37
1998-1999	33	32
1997-1998	31	32
1996-1997	34	26

*Source: ABCI (1997, 1998, 1999, 2000).*

## **21.0 Seizures of amphetamines and criminal activity**

### *21.1 Laboratory seizures*

Over the years 1995-96 to 1998-99, Queensland continually had a high proportion of Australia's total amphetamine laboratory seizures (between 74% and 93%). This can be seen as a reflection of market size in Queensland and/or a statewide program by Queensland Police to increase police awareness of clandestine laboratories (Department of Police, 2000). As yet, no comparable data are available for the years 1999-2000 and 2000-2001.

### *21.2 Queensland Crime Commission (QCC) newsletter*

In QCC's November 2000 newsletter, the following points were made about amphetamine offences:

- The number of consumer arrests has at least tripled - 358 in 1995 to 1284 in 1998-99. This is an exaggerated result because the QPS arrest statistics for 1995-96 are lower than actually reported.
- The consumer arrest rate per 100,000 people has risen at a fairly steady rate over the four-year period.
- The rate of provider arrests slowed after 1996-97 and has remained relatively steady.
- Total amphetamine arrests (combined consumer and provider arrests) have more than tripled - 560 in 1995-1996 to 1814 in 1998-1999.

nb: consumer arrests will always be considerably higher than provider arrests given there will always be more consumers than providers. Other arrest figures relating to the Qld amphetamine market can be found in the Queensland Crime Commission's November Newsletter (2000:6) *The Amphetamine Market in Queensland*.

### *21.3 Other crime*

In Queensland, 303,000 offences against property were reported in the 1999-2000 period, representing an 8% increase over 1998-99 (Dept of Police, 2000). The Department of Police reported that the greatest increases were recorded in respect of unlawful entry, other property damage, motor vehicle theft and other theft.

On the Gold Coast, it is drug users who are primarily responsible for property-related crime. As a consequence "Operation Clean-Up" was implemented and resulted in 1,173 drug-related charges (Department of Police, 2000).

## 22.0 Other health related issues

### 22.1 Outreach teams working in nightclubs and rave venues

There are now a number of rave-safe teams of workers employed by either Queensland Health (QH) or Non-Government Organisations (NGOs) working in Queensland. Workers from these groups report an increasing availability and use of ecstasy. These teams offer a range of interventions at the following levels:

- 1 - contact with ecstasy users;
- 2 - issuing resources;
- 3 - one-on-one counselling;
- 4 - referral;
- 5 - critical incidents.

There are also a number of independent rave-safe operators who offer assistance to users, either on site or over the Internet.

#### 22.1.1 Outreach service provision figures for NGO

Figures from one NGO service are shown in Table 29. It shows the number and level of interventions undertaken by one Brisbane outreach team from October 2000 to March 2001. As can be seen, the number of interventions is subject to fluctuation depending on the time of year and when large-scale rock festivals are held. Rock festivals such as 'Livid' in October, 'The Big Day Out' in January', Home Bake, 'Adventure'; and 'Schoolies' weeks in November/December are important venues for such interventions.

Table 28: One Brisbane outreach team's interventions at major rave venues

Level of intervention	Number of interventions	
	October to December 2000	January to March 2001
Contacted	5881	1610
Resource issued	4721	1306
One-on-one counselling	370	322
Referral	109	36
Intervention required included CPR	7	0

Key informants from these programs believed that ecstasy use was increasing, based on the number of drug interventions recorded at their outreach programs. However, an increase in the number of interventions could be also be a reflection of the type of events attended by the outreach teams, where ecstasy is the preferred drug. For example, outreach workers at a club may see more ecstasy related cases, a bush rave may see more LSD related cases, whereas the Big Day Out sees more alcohol related interventions.

### 22.1.2 RaveSafe Queensland

This team categorises incidents as follows:

*Category 1:* RaveSafe team in attendance  
 availability of water spray for cooling  
 availability of sunburn cream  
 availability of pamphlets  
 availability of drinking water  
 availability of web site;

*Category 2:* Incidents requiring one-on-one assistance but not requiring referral to emergency personnel; and

*Category 3:* Referral to emergency personnel.

At the four (4) events listed in Table 29, the RaveSafe team provided interventions to 587 people, 70% of which were drug use related.

Table 29: RaveSafe interventions in Queensland, 2001\*

Event	Estimated attendance	Number contacted by RaveSafe Team	% contacts that were drug use related	Number of multiple drug users
Adven*jah	7,000	44	71	5
Big Day Out	35,000	264	64	22
Livid	15,000	185	79	4
Exodus	n.a.	94	94	3
Total	n.a.	587	70	34

\*Adapted from tables supplied by Queensland Health.  
 n.a. Data not available.

The team reported that at these four events, there were almost 200,000 category one incidents; 566 category 2 and 20 category three incidents. So it can be seen that one person may require a number of interventions by the RaveSafe team at these events.

### 22.2 Factors predicting adverse symptoms of ecstasy use

Multiple regressions were performed to predict the extent of physical and psychological symptoms related to ecstasy. The following predictors were included: age; gender; number of days ecstasy used in the last six months; quantity of ecstasy typically used; whether ecstasy had been injected in the last six months; whether any other drug had been injected in the last six months; number of different drugs used in the last six months (i.e., extent of multiple drug use).

Age and gender were significantly related to physical symptomatology, with males on average reporting more physical symptoms than females. Males also reported more psychological symptoms than females. Extent of psychological symptomatology was positively related to the number of ecstasy tablets used in a session and to the number of drugs used in the last 6 months.

## 23.0 Qualitative comments by ecstasy users about why they use party drugs

Respondents were asked to comment on their reasons for using ecstasy and were given the opportunity to record anything else about their habit they wished to share. Eighty-four of the 117 respondents made comments about their ecstasy use.

These comments, as summarised below, are relevant to Australia's policy of Harm Minimisation which has been the cornerstone of Australia's response to drug-use issues including alcohol and blood-borne viruses.

They are presented to assist us in understanding why users use and the meanings they place on their use. We suggest that supply reduction requires the simultaneous consideration of both demand reduction and harm reduction. Below we examine the priorities of a normal consumer of ecstasy, the high level of compulsion, the cause of this compulsion; their concerns and how they are manifested.

### 23.1 *Self-identity – change – transition – acting out a role*

The move from adolescence to adulthood requires adjustment. Jane<sup>22</sup>, attempted to make sense of these changes and justify her use of ecstasy by associating it with healthy adult practices and said

“Ecstasy can be used wisely if you are responsible and plan your night properly. If you are sensible and control your use, eat properly, exercise, etc., then ecstasy shouldn't give you any problems” (Jane).

Tim also advocated for the use of ecstasy, he stated:

“Ecstasy is a drug that makes me feel comfortable, being able to open up and be confident within myself and around others. I believe it should be decriminalised. I feel very well informed about the effects of ecstasy and we should give it to all the world leaders”

Jeoff's identity is tied to ecstasy. He stated, “Ecstasy has allowed me to throw off the shackle which is the male ego dominated society oppressing one's ability to show affection towards my fellow man.”

In trying to come to terms with both his identity and his aggression, Jamie stated:

“Everything in moderation is OK. I'm a person who is nicer on drugs than on alcohol. I have more confidence now, not only when I'm on them but also when I'm off them. It's opened my eyes and I've had friends who have said the same thing. I was once against drugs but ...”

Jennifer uses ecstasy to reduce her feelings of insecurity. She stated “To make me feel good and the first time I've been able to look in the mirror and feel good about the way I look and gives you confidence” (Jennifer).

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<sup>22</sup>All names are pseudonyms.

### 23.2 *Political participants in a political activity*

Users are an interest group in the political process. James stated:

“Party drugs are becoming more accepted and taking the place of alcohol. Societal norms are changing – there is more use of ecstasy. Alcohol and tobacco now have more anti-social connotations.”

Kate stated “I don’t think people understand that it’s just like getting drunk – to me anyway. I don’t drink, so to have the drugs is something to take up that space.”

Brendan wishes to be involved more in the legalisation and control process and he stated, “Ecstasy use needs to be managed properly and drugs can be used safely.”

### 23.3 *Ecstasy access issues*

Access to ecstasy seems not to be a problem. Comments such as the following highlight the ease with which it is acquired.

“It is as easy to get ecstasy as going to the bottle shop to buy a beer” (Tim).

“Most people have jobs and just take it for fun” (Maree).

“E’s are very easily obtained. Usually I meet my dealer in a car on the street. Organise a place beforehand. My dealer sells everything – speed, E’s, cannabis. A one-stop shop” (Jacob).

For amphetamine one participant stated “It’s easier to get speed out here than it is to get petrol.”

### 23.4 *Hedonism and indulgence*

One thing to notice about sensory pleasure is its apparent heterogeneity. People enjoy pleasurable smells and pleasurable feelings of warmth. Hedonism, as some theorists state, has been expressed as “pleasure alone is intrinsically good” or “pleasure is the only thing worth seeking for its own sake” and pleasure is “The Good” (Feldman, 1997). It is not an unusual phenomenon to push these pleasurable feelings to their limits and this is what users said they are doing. Chris stated:

“‘It rocks!’ They always put in the bad info about it. Lots of positives. There are no beer drinking yobbo crowd. Lots of young people expressing themselves. I believe that my friends can relax in a comfortable environment. We always go to the XXXXX club.”

Jane wrote “Ecstasy is peaceful – as long as people are educated about use, it can be a harmless drug.”

Ben expresses the pleasure in terms of his life path “Ecstasy can do good things for your life if they are used properly.”



When combining various substances pleasure was said to be enhanced. Elissha stated, "...people are tending to drink alcohol more with pills."

From these comments it can be seen that ecstasy use is associated with the value users place on the pleasure that they get from the drugs. The pleasure may change depending on the situation of the user. Therefore harm minimisation strategies need to take into account the extent of the value users place on their use of ecstasy at a particular time in their lives.

### 23.5 *Normalisation, individualism and market qua<sup>23</sup> market principles*

Ecstasy users in the sample were given an opportunity to describe their recreational drug use patterns. On the whole, respondents seemed to view their recreational drug use as "normal." It appears that this sample group tended to exhibit addictive behaviour in respect to alcohol, tobacco and cannabis, whilst their ecstasy use was confined to occasional or intermittent use. It appears that the most confronting section of the questionnaire for respondents was the section related to health issues. For respondents, the questionnaire became a source of education. It made them aware that their symptoms may have been associated with ecstasy use.

The key features of normalization, for designer drug use in Queensland, seem to be related to the increasing availability of the designer drug. It is also related to the increasing view that ecstasy is a drug, which is used by well-behaved; middle class; and/or better-educated students, and therefore how could it be "bad" or "pathologised" and linked to failure? Ecstasy was seen as a "safe-drug," a view that appeared to cut across social stratification and culture. Addictive drug behaviour was high in this population, with daily use of alcohol, cigarettes and cannabis commonly recorded. The dance/club/rave/music lifestyle is widely embraced and designer drugs have consequently filtered into 'everyday' drug taking.

The view of the 'dealer' as the 'evil incarnate' no longer has credence; the 'dealer' is usually someone in the person's social network, a network based on friendship and trust. Comments recorded during the study show the extent to which ecstasy taking is regarded as normal behavior.

"We go out taking drugs but you don't see us getting into fights and passing out and abusing our friends like people who drink alcohol. Drugs make you more tolerant with other people. We don't get pissed and get into fights. We are more peaceful and friendly" (Thomas).

"Today's generation – my generation – everyone is doing it – I don't do it because of that – I probably know more people who take drugs than [who] don't take them" (Kerryanne).

Sometimes the complexities of drug use in the 21st Century are hidden by ideological and political dogma but most of all by the lack of understanding of the meanings users place on their substance use.

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<sup>23</sup>"Qua" – essence of the ultimate experience or the perfect example.

### 23.6 *Views on use and management*

Users manage their use according to the level of their knowledge and awareness. Jane encapsulates this concept by stating “E’s are safe as long as you look after yourself. You shouldn’t inject it. Taken orally it feels fine.”

Secondly, users are concerned about quality – the product they are getting. Don stated, “People need to be made aware that what they are taking is not real ecstasy. There needs to be more awareness in drug education at early age.”

Thirdly, users are well aware of the potential mental health problems but are not so aware of the potential physical health problems. Sue stated:

“Not taking them because your mind plays tricks on you and you feel you have to take them to have fun, in the last week since I’ve given up, I’ve noticed changes, I’ve noticed shakiness, feeling a little sick and the all round boredom because you are not high.”

They also know about health and welfare services. Shane, diagnosed with a mental health problem uses illicit substances as well as taking prescribed medication. He stated:

“Diagnosed with manic depression so I’m very aware of boundaries and medication requirements. I tell doctors about my drug use and doctors inform me of correct procedure to minimise harmful effects of drugs. I go off medication when taking party drugs.”

Helen, who is pregnant stated:

“I wish I had given them up sooner and I wish that it wasn’t just the pregnancy that made me give up. I wish that I had used my brains and it’s real hard, the longer you take them, the harder it is to give them up, it’s harder to go out with your friends.”

The need for more drug education is apparent in other comments as well. Thomas stated, “Some friends have started taking anti-depressants because of prolonged use of ecstasy taking and take ecstasy while on anti-depressants.”

Erica stated, “I think too much ecstasy will make you go crazy.”

Jason stated:

“People on e’s get really down afterwards – the next week and friends joke that our serotonin has been drained and we need to go out again the next week for that good feeling again – people using need to be provided with more information about what’s in each.”

Sean stated:

“Had some worrying effects the past six months. Don’t know if it is from the e’s or not. Sometimes up all night and other times needing to go to sleep. Not sure if this is related to pills or short-term memory loss. Now that is extreme with him and his friends.”

Fourthly, users are seeking knowledge about products and about quality control.

Adam stated, “People using need to be provided with more information about what’s in each pill/drug as people will always be used.”

### 23.7 *Ecstasy user concerns*

Some ecstasy users realised that they now had to deal with consequences of their past behaviour. Roy, a multiple drug user, stated:

“The money. You get in with some bad people. I used to go out four nights a week and I had a part time job and all my wages and more. I now owe more than I can pay.”

Jason, a cannabis and ecstasy user, considers the consequences of drug use.

“Some friends have started taking anti-depressants because of prolonged use of ecstasy and are now taking ecstasy while on antidepressants.”

Lisa, a multiple drug user, is experiencing the after effects of her ecstasy taking and is attempting to self-medicate her symptoms. She stated:

“St. John’s Wort helps to get your life back together after taking ecstasy. It increases your serotonin levels, and is a 5HTP – which is a herbal precursor to serotonin production.”

While Neil, an ecstasy user, assists us in understanding why users use and some of the emerging trends.

“The e’s are shorter acting. Two hours compared to around five hours a few years ago. The younger generation are taking e’s because they are just trying to ‘get out of it’ rather than experiencing the empathy type experiences people used to chase.”

Elaine, an ecstasy drug user, stated “They’re good while you’re on it, the after effects are not worth it but I still do it.”

Ray stated his concerns about the addictive nature of what he is doing. He wrote: “They’re addictive because of the fun you have with them rather than the physical addiction.”

These few comments reflect the fact that ecstasy users are largely aware of the consequences of their behaviour but do not fully appreciate the long-term effects of drug taking. Weighing up the chances of experiences being negative or positive seems to be the cost-benefit exercise that people undertake in the use of their ecstasy and party drug taking.

### 23.8 *Comments about the survey*

We conclude this section with some comments from respondents in the survey, which indicated that the study served as a vehicle to enhance harm minimisation, and has increased awareness about the consequence of drug use.

“Those health questions were pretty confronting. I didn’t realise that it was the ecstasy causing my symptoms. I’ll rethink my use” (Sandra).

“Great questionnaire. I think it is a really good idea and I don’t think you’ve missed out anything that is good. It made me think about giving up. You just can’t keep taking them. It is screwing up your body. I hope young people can give them up sooner than I did” (Elissa).

“Good survey. Enjoy doing survey to help. Questions are not too impersonal so it doesn’t worry me” (Thomas).

“Thought there would be more questions on interpretations of effects of drugs and what you can take away from the experience (for example relationships – positive experiences with friends on E.” (Tran).

### 23.9 *Conclusion on qualitative comments*

A suggested way to encourage the practice of harm reduction is to involve users in developing and practicing appropriate behaviour. That is, to co-opt users, DJs, venue operators and security in the practice and implementation of harm minimisation strategies.

The qualitative evidence shows us that the users are acutely aware of issues related to drug use. Users are consumers and it is important to understand the part ecstasy plays in their lives.

## 24.0 Summary

### 24.1 *Demographics*

The age of first use of ecstasy is getting younger. Male use is more common than female use. Most users appeared to be functioning well enough to be employed at least part-time. Females presented for treatment for ecstasy symptoms more frequently than males although males reported more related symptoms. This year's sample included indigenous users for the first time. Key informants identified more people of Asian, Far East Asian background at entertainment venues.

### 24.2 *Patterns of substance use*

Multiple drug use among respondents was the norm. However, an alarming trend is the high percentage of respondents using alcohol, cannabis, and tobacco on a daily basis. Tobacco was the most frequently used substance, followed by cannabis, then alcohol. There was an increasing trend to inject ecstasy and GHB. A new drug, PMA, not previously noted, appeared in this year's study. Use of cocaine, antidepressants, ice, shabu and methamphetamine had increased in the last six months. There was more injecting users this year and there were also more people presenting to treatment facilities for ecstasy problems alone.

### 24.3 *Ecstasy use*

Ecstasy was used for a median number of 15 days over the previous six months. Respondents were more likely to inject in 2001, but most used orally. Regular ecstasy use appeared to be less common than in previous years, however, 'bingeing' was still common. RaveSafe Teams working in the southeast Queensland reported an increased number of interventions; a higher number of rave venues; and that ecstasy use had moved beyond rave venues to private venues and the café arena. Heavy usage was associated with younger users. Ecstasy, methamphetamine, GHB, nitrous oxide and amyl nitrate seemed to be regarded as the party drugs of choice.

### 24.4 *Methamphetamine Use*

Sixty-two out of the 117 people who used ecstasy also used methamphetamine. Use was usually by swallowing, injecting and snorting.

### 24.5 *Price, purity and availability*

The price of ecstasy had decreased since the 2000 study. Most respondents said this price was either stable or decreasing. It was apparent that drug prices in general were decreasing.

The purity of ecstasy had fluctuated over the previous six months with new batches hitting the streets on a daily basis. Seizure data showed the purity level had generally increased. Availability for most drugs seemed to be stable or had become easier. Cocaine use, according to seizure data, was increasing.

## 24.6 *Study limitations*

This study attempted to address the limitations highlighted by McAllister, Topp, Dawes, Watt and Shuttlewood (2001). The study recruited heavily from the Gold Coast, Brisbane and the out-lying regions. Teams of interviewers conducted two days of interviews with users and key informants from the Gold Coast.

The larger total sample in 2001 was beneficial in that it enabled recruitment from a broader cross section of the population. It enabled analyses of relationships between patterns of ecstasy use and multiple-drug use, as well as the identification of patterns of addictive/daily use of cannabis, tobacco and alcohol amongst ecstasy users.

The inclusion of health service providers in the key informant profile provided an excellent forum for multidisciplinary research. It enabled the bringing together of a variety of data using triangulation and allowed cross-disciplinary links to occur between the areas of law, health, user, policy, practice, venues and research.

Another benefit of the expanded sampling was that we detected indigenous people using ecstasy for the first time. However, we did not recruit enough respondents from non-English speaking backgrounds. A recommendation for future studies would be that a research assistant with strong connections to this target group be recruited to conduct interviews.

It is, of course, not possible to know how representative the sample is, as the total population of drug users is not available. This issue needs to be addressed in subsequent studies.

## **25.0 Conclusion**

The dance/rave culture in Queensland is growing with a notable increase in dance clubs, warehouse parties, raves and festivals over the past five years and in particular over the past 12 months. The number of people attending these venues is also steadily increasing. People between the ages of 15 to 30 predominantly embrace dance culture and they come from a wide range of occupations and lifestyles.

Dance parties provide young people with an entertainment option. The increase in venues of this sort has also led to an increase in related dance culture magazines, dedicated dance music shows on radio and television and greatly increased retail sales of both dance-related electronic music and fashion. Illicit drugs are often linked to this trend, although young people themselves argue that not all people who attend raves are taking drugs.

Not only is the use of illicit drugs prominent in the dance culture but it is also evident in coffee lounges, private homes, and recovery sessions. Drugs are being taken before, during, and/or after events. Respondents believe that such drug taking adds significantly to their enjoyment of these events.

These findings have implications for health policy, liquor licensing mandates, law enforcement, entertainment policy and general occupational health and safety. Venue operators, while offering a drug-free venue, have no control over what has been taken before arrival at the venue and so there are issues pertaining to duty of care and accountability.

## 26.0 References

- Australian Institute of Health and Welfare and Queensland Health (1998), *1998 National Drug Strategy Household Survey: Queensland Results*. AIHW.
- Australian Institute of Health and Welfare (2000) *1998 National Drug Strategy Household Survey: Queensland Results* Drug Statistics Series Number 4. Canberra: AIHW.
- Biernacki, P. and Waldorf, D. (1981), Snowball sampling: problems, techniques and chain referral sampling. *Sociological Methods for Research*, 10, 141-163.
- Boys, A., Lenton, S. and Norcross, K. (1997), Polydrug use at raves by a Western Australian sample. *Drug and Alcohol Review*, 16, 227-234.
- Brisbane City Council (1999), *The Lord Mayor's Illicit Drug Taskforce Report 1999*. Brisbane: Brisbane City Council.
- Brisbane City Council (1999), *The Lord mayor's Illicit Drug Taskforce- Summary*. Brisbane: Brisbane City Council.
- Brisbane City Council (2000), *The Lord Mayor's Illicit Drug Taskforce- Summary*. Brisbane: Brisbane City Council.
- Broening, H., LaRonda, L., Morford, L., Sandra, L., Inman-Wood, Fukumura, M. and Vorhees, C. (2001), Methylendioxyamphetamine (ecstasy) - induced learning and memory impairments depend on the age of exposure during early development. *The Journal of Neuroscience*, 21 (9), 3228-3235.
- Cahill, A. (2001), *Indigenous Injecting Drug Use Project: Consultation Report*
- Clients of Treatment Service Agencies (2001). Report NDARC Sydney.
- Croft, R., Mackay, A, Mills, T. and Gruzelier, J. (2001), The relative contributions of ecstasy and cannabis to cognitive impairment. *Psychopharmacology*, 153, 373-379.
- Dalgarno, P.J. and Shewan, D. (1996), Illicit use of ketamine in Scotland. *Journal of Psychoactive Drugs*, 28, 191-199.
- Department of Police (1999-2000), *Annual Report: Embracing the New Millennium*. Brisbane: Queensland Police.
- Dunn, J., Pinheiro Ferri, C. and Laranjeira, R. (2001), Does multisite sampling improve patient heterogeneity in drug misuse research? *Drug and Alcohol Dependence*, 63, 79-85.
- Elk C. (1996), MDMA (ecstasy): useful information for health professionals involved in drug education programs. *Journal of Drug Education*, 26 (4), 349-356.
- Forsyth, A.J.M. (1996), Places and patterns of drug use in the Scottish dance scene. *Addiction*, 91, 511-521.



Indigenous Health Program, University of Queensland.

Kerlinger, F.N. (1986), *Foundations of Behavioral Research*, 3rd ed. Japan: CBS Publishing Limited.

Kinner, S. and Roche A. (1999), *Queensland Drug Trends: Findings from the Illicit Drug Reporting System (IDRS)*. NDARC Technical Report Number 87. Sydney: NDARC.

Lester, S., Baggott, M., Welm, S., Nelson, B., Schiller, B., Jones, R. *et al.* (2001), Cardiovascular effects of 3,4-Methylenedioxymethamphetamine: a double-blind, placebo-controlled trial. *Annals of Internal Medicine*, 133 (1), 69-73.

Liechti, M., Gamma Franz, A. and Vollenweider, X. (2001), Gendered differences in the subjective effects of MDMA. *Psychopharmacology*, 154, 161-168.

McAllister, R., Topp, L., Dawes, L., Watt, K. and Shuttlewood, G. (2001), *Queensland Party Drug Trends 2001: Findings from the Illicit Drug Reporting System (IDRS) Party Drugs Module*. NDARC Technical Report Number 114. Sydney: NDARC.

Ovendon, C. and Loxley, W. (1996), Bingeing on psychostimulants in Australia: do we know what it means (and does it matter)? *Addiction Research*, 4, 33-43.

Pacifica, R., Piergiorgio, Z., Lopez, C., Pichine, S., DiCarlo, S., Farre, M., Roset, N., Ortuno, J., Segura, J. and De La Torre, R. (2001), Acute effects of 3-4-Methylenedioxymetamphetamine alone and in combination with ethanol on the immune system in humans. *The Journal of Pharmacology and Experimental Therapeutics*, 296, 207-215.

Parker, H., Aldridge, J. and Measham, F. (1998), *Illegal Leisure: The Normalization of Adolescent Recreational Drug Use*. London: Routledge.

Peters, A., Davies, T. and Richardson, A. (1997), Increasing popularity of injection as the route of administration of amphetamine in Edinburgh. *Drug and Alcohol Dependence*, 48, 227-237.

Queensland Crime Commission (2000), *Annual Report 1999-2000*. Brisbane: QCC.

Queensland Crime Commission (2000), *The Amphetamine Market in Queensland No 2* November 2000. ISSN 1442-5815.

Queensland Crime Commission (2001), *The 'Ecstasy' Market in Queensland* No.3 August ISSN1442-5815, Brisbane.

Rodgers, J. (2000), Cognitive performance amongst recreational users of "ecstasy". *Psychopharmacology*, 151, 19-24.

Solowij, N., Hall, W. and Lee, N. (1992), Recreational MDMA use in Sydney: a profile of 'ecstasy' users and their experiences with the drug. *British Journal of Addiction*, 87, 1161-1172.

Stoppard, M. (2000), *Australian Drugs Infofile: From Alcohol and Tobacco to Ecstasy and Heroin*. Sydney: Drug and Alcohol Service.

Topp, L. and Darke, S. (2001), Findings of the Illicit Drug Reporting System (IDRS) Party Drugs Module. Technical Report XX. Sydney: NDARC.