

J. Johnston, B. Quinn and R. Jenkinson

**VICTORIAN TRENDS IN ECSTASY AND
RELATED DRUG MARKETS 2006
Findings from the
Ecstasy and Related Drugs Reporting
System (EDRS)**

NDARC Technical Report No. 282

**VICTORIAN
TRENDS IN ECSTASY AND RELATED
DRUG MARKETS
2006**



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

Jennifer Johnston, Brendan Quinn and Rebecca Jenkinson

Turning Point Alcohol and Drug Centre

NDARC Technical Report No. 282

ISBN : 978 0 7334 2479 3

©NDARC 2006

This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or use within your organisation. All other rights are reserved. Requests and enquiries concerning reproduction and rights should be addressed to the information manager, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, NSW 2052, Australia.

TABLE OF CONTENTS

LIST OF TABLES	iv
LIST OF FIGURES	v
ACKNOWLEDGEMENTS.....	viii
ABBREVIATIONS.....	ix
EXECUTIVE SUMMARY	xi
1 INTRODUCTION	1
1.1 Aims.....	3
2 METHODS.....	4
2.1 Survey of regular ecstasy users (REU).....	4
2.2 Survey of key experts (KE).....	5
2.3 Other indicators.....	6
3 OVERVIEW OF REGULAR ECSTASY USERS (REU).....	8
3.1 Demographic characteristics of the REU sample	8
3.2 Drug use history and current drug use	10
3.3 Summary of demographic characteristics and drug use trends in REU	13
4 ECSTASY	14
4.1 Use of ecstasy in the general population	14
4.2 Ecstasy use among REU.....	15
4.3 Summary of patterns of ecstasy use	21
4.4 Price.....	21
4.5 Purity	22
4.6 Availability	24
4.7 Ecstasy markets and patterns of purchasing ecstasy	27
4.8 Ecstasy related harms.....	28
4.9 Benefit and risk perception	31
4.10 Summary of ecstasy trends.....	33
5 METHAMPHETAMINE	34
5.1 Methamphetamine use in the general population.....	34
5.2 Methamphetamine use among REU	34
5.3 Price.....	40
5.4 Purity	42
5.5 Availability	44
5.6 Methamphetamine related harms	48
5.7 Summary of methamphetamine trends.....	53
6 COCAINE	54
6.1 Cocaine use in the general population.....	54
6.2 Cocaine use among REU	54
6.3 Price.....	57
6.4 Purity	57
6.5 Availability	59
6.6 Cocaine related harms.....	61
6.7 Summary of cocaine trends	64
7 KETAMINE.....	65
7.1 Ketamine use in the general population	65
7.2 Ketamine use among REU	65

7.3	Price	67
7.4	Purity	68
7.5	Availability	69
7.6	Ketamine related harms	72
7.7	Summary of ketamine trends	73
8	GHB	74
8.1	GHB use among REU	74
8.2	Price	77
8.3	Purity	78
8.4	Availability	79
8.5	GHB related harms	81
8.6	Summary of GHB trends.....	83
9	LSD	84
9.1	LSD use among REU.....	84
9.2	Price.....	87
9.3	Purity	88
9.4	Availability	89
9.5	Hallucinogen related harms.....	91
9.6	Summary of LSD Trends.....	92
10	MDA	93
10.1	MDA use among REU	93
11	CANNABIS	94
11.1	Cannabis use in the general population.....	94
11.2	Cannabis use among REU	94
11.3	Price	95
11.4	Potency	96
11.5	Availability	97
11.6	Cannabis-related harms	99
11.7	Summary of cannabis trends	101
12	ALCOHOL	102
12.1	Alcohol use in the general population	102
12.2	Alcohol use among REU	102
12.3	Summary of other drug use	104
13	OTHER DRUGS	105
13.1	Tobacco	105
13.2	Psilocybin or ‘magic’ mushrooms.....	105
13.3	Benzodiazepines.....	105
13.4	Antidepressants	105
13.5	Inhalants	105
13.6	Heroin and other opiates	106
13.7	Other drugs.....	106
13.8	Summary of other drug use	106
14	DRUG INFORMATION SEEKING BEHAVIOUR	107
15	RISK BEHAVIOUR	109
15.1	Injecting and injecting-risk behaviour.....	109
15.2	Blood borne virus infection (BBVI) vaccination, testing and status.....	111
15.3	Sexual risk behaviour	112
15.4	Driving risk behaviour.....	115

16	HEALTH RELATED ISSUES.....	118
16.1	Overdose.....	118
16.2	Self reported symptoms of dependence	118
16.3	Measure of psychological distress.....	119
16.4	Help-seeking behaviour	119
16.5	Other problems.....	120
17	CRIMINAL ACTIVITY, POLICING AND MARKET CHANGES.....	121
17.1	Reports of criminal activity among REU.....	121
17.2	Perceptions of police activity towards REU	122
18	SUMMARY.....	124
18.1	Demographic characteristics of REU	124
18.2	Patterns of polydrug use.....	124
18.3	Ecstasy.....	124
18.4	Methamphetamine	124
18.5	Cocaine	124
18.6	Ketamine.....	125
18.7	GHB.....	125
18.8	LSD.....	125
18.9	MDA	125
18.10	Cannabis	125
18.11	Alcohol.....	125
18.12	Patterns of other drug use	126
18.13	Drug information seeking behaviour	126
18.14	Risk behaviour.....	126
18.15	Health related issues	127
18.16	Criminal activity, policing and market changes	127
19	IMPLICATIONS	128
	REFERENCES	130

LIST OF TABLES

Table 1: Demographic characteristics of REU sample, 2003–2006	8
Table 2: Lifetime and recent polydrug use of REU, 2003–2006.....	10
Table 3: Patterns of ecstasy use among REU, 2003–2006.....	17
Table 4: Price of ecstasy purchased by REU, 2003–2006	21
Table 5: Patterns of purchasing ecstasy, 2005–2006.....	28
Table 6: Perceived benefits of ecstasy use among those who commented, 2006.....	32
Table 7: Perceived risks of ecstasy use among those who commented, 2006.....	33
Table 8: Patterns of methamphetamine powder (speed) use among REU, 2003–2006.....	35
Table 9: Patterns of methamphetamine base use among REU, 2003–2006	37
Table 10: Patterns of crystal methamphetamine use among REU, 2003–2006.....	38
Table 11: Price of various methamphetamine forms purchased by REU, 2003–2006.....	41
Table 12: Amphetamine-type stimulants: consumer and provider arrests, Victoria and national, 2004/2005+	49
Table 13: Patterns of cocaine use among REU, 2003–2006.....	55
Table 14: Price of cocaine purchased by REU, 2003–2006.....	57
Table 15: Cocaine: consumer and provider arrests, Victoria and national, 2004/2005+	62
Table 16: Patterns of ketamine use among REU, 2003–2006	66
Table 17: Price of ketamine purchased by REU, 2003–2006	68
Table 18: Patterns of GHB use among REU, 2003–2006	74
Table 19: Price of GHB purchased by REU, 2003–2006	77
Table 20: Patterns of LSD use among REU, 2003–2006.....	85
Table 21: Prices of LSD purchased by REU, 2003–2006	87
Table 22: Hallucinogens: consumer and provider arrests, Victoria and national, 2004–2005+	91
Table 23: Patterns of MDA use among REU, 2003–2006.....	93
Table 24: Patterns of cannabis use among REU, 2003–2006.....	94
Table 25: Price of cannabis purchased by REU, 2006.....	95
Table 26: Cannabis: consumer and provider arrests, Victoria and national, 2004/2005+	99
Table 27: Patterns of alcohol use among REU, 2003–2006	102
Table 28: AUDIT scores and proportion of REU scoring above recommended levels indicative of hazardous alcohol, 2006	103
Table 29: Content and testing of ecstasy tablets by jurisdiction, 2005-2006.....	108
Table 30: Injecting behaviour among REU, 2005–2006	109
Table 31: Recent injecting drug use patterns (recent injectors) among REU, 2006.....	110
Table 32: Context and patterns of recent injection among REU, 2005–2006	111
Table 33: BBVI vaccination, testing and self reported status, 2006	112
Table 34: Prevalence of sexual activity and number of sexual partners in the preceding six months, 2005–2006.....	113
Table 35: Sex under the influence of drugs in the preceding six months, 2006	114
Table 36: Drug driving in the last six months among REU, 2004–2006.....	115
Table 37: Criminal activity reported by REU, 2003–2006	121
Table 38: Perceptions of police activity by REU, 2003–2006	122

LIST OF FIGURES

Figure 1: Prevalence of ecstasy use among the population aged 14 years and over in Australia, 1988–2004.....	14
Figure 2: Usual location of ecstasy use, 2003–2006.....	19
Figure 3: Location of most recent ecstasy use, 2003–2006.....	20
Figure 4: Recent changes in price of ecstasy purchased by REU, 2003–2006.....	22
Figure 5: REU reports of current ecstasy purity, 2003–2006.....	22
Figure 6: REU reports of change in purity of ecstasy in the preceding six months, 2003–2006.....	23
Figure 7: Purity of ecstasy seizures by Victorian law enforcement, July 2005–June 2006.....	24
Figure 8: REU reports of current availability of ecstasy in the preceding six months, 2003–2006.....	24
Figure 9: REU reports of changes in availability of ecstasy in the preceding six months, 2003–2006.....	25
Figure 10: People from whom ecstasy was purchased in the preceding six months, 2003–2006.....	26
Figure 11: Locations where ecstasy was purchased in the preceding six months, 2003–2006.....	27
Figure 12: DirectLine calls where drug of concern identified as ecstasy, 1999–2005.....	29
Figure 13: Monthly totals of ambulance attendance where ecstasy was mentioned in Melbourne, 2004–2005 (excluding June–July 2004).....	30
Figure 14: Location of usual methamphetamine use by form, 2006.....	39
Figure 15: Location of most recent methamphetamine use by form, 2006.....	40
Figure 16: Recent changes in price of various methamphetamine forms purchased by REU, 2006.....	42
Figure 17: User reports of current methamphetamine purity, 2006.....	42
Figure 18: User reports of changes in methamphetamine purity in the past six months, 2006.....	43
Figure 19: Average purity of methamphetamine seizures by Victorian law enforcement, July 2005–June 2006.....	44
Figure 20: Current availability of methamphetamine forms, 2006.....	45
Figure 21: Changes to current availability over time: proportion of REU who report various forms of methamphetamine as ‘very easy’ to obtain at the time of interview in Melbourne, 2003–2006.....	45
Figure 22: Change in the availability of three forms of methamphetamine in the preceding six months, 2006.....	46
Figure 23: People from whom methamphetamine powder, base and crystal was purchased in the preceding six months, 2006.....	47
Figure 24: Locations where methamphetamine purchased in the preceding six months, 2006.....	48
Figure 25: DirectLine calls where drug of concern identified as amphetamines and/or other stimulants, 1999–2005.....	50
Figure 26: Monthly totals of ambulance attendance where amphetamines were mentioned in Melbourne, 2004–2005 (excluding June–July 2004).....	51
Figure 27: Amphetamine-related hospital admissions, Victoria and National, 1999/00–2004/05.....	52
Figure 28: Usual location of cocaine use, 2003–2006.....	56
Figure 29: Location of most recent cocaine use, 2003–2006.....	56
Figure 30: Recent changes in price of cocaine purchased by REU, 2003–2006.....	57
Figure 31: User reports of current purity of cocaine, 2003–2006.....	58
Figure 32: User reports of changes in cocaine purity in the past six months, 2003–2006.....	58

Figure 33: Average purity of cocaine seizures by Victorian law enforcement, July 2005– June 2006.....	59
Figure 34: Current availability of cocaine, 2003–2006.....	60
Figure 35: Changes in cocaine availability in the preceding six months, 2003–2006.....	60
Figure 36: People from whom cocaine had been purchased the preceding six months, 2003–2006.....	61
Figure 37: Locations where cocaine had been purchased in the preceding six months, 2003–2006.....	61
Figure 38: DirectLine calls where drug of concern identified as cocaine, 1999–2005.....	63
Figure 39: Cocaine-related hospital admissions, Victoria and National, 1999/00–2004/05.....	64
Figure 40: Location of usual ketamine use, 2003–2006.....	66
Figure 41: Location of most recent ketamine use, 2003–2006.....	67
Figure 42: Recent changes in price of ketamine purchased by REU, 2003–2006.....	68
Figure 43: Current purity of ketamine, 2003–2006.....	69
Figure 44: Recent change in ketamine purity, 2003–2006.....	69
Figure 45: Current ketamine availability, 2003–2006.....	70
Figure 46: Changes in availability of ketamine over the past 6 months, 2003–2006.....	70
Figure 47: People from whom ketamine had been purchased from in the preceding six months, 2003–2006.....	71
Figure 48: Locations ketamine had been purchased from in the preceding six months, 2003–2006.....	72
Figure 49: Usual location of GHB use, 2003–2006.....	76
Figure 50: Location of most recent GHB use, 2003–2006.....	77
Figure 51: Recent changes in price of GHB purchased by REU, 2003–2006.....	78
Figure 52: REU reports of purity of GHB in the preceding six months, 2003–2006.....	78
Figure 53: REU reports of change in purity of GHB in the preceding six months, 2003–2006.....	79
Figure 54: Current availability of GHB, 2003–2006.....	79
Figure 55: Change in GHB availability in the preceding six months, 2003–2006.....	80
Figure 56: People from whom GHB had been purchased in the preceding six months, 2003–2006.....	80
Figure 57: Locations where GHB had been purchased in the preceding six months, 2003–2006.....	81
Figure 58: Monthly totals of ambulance attendance where GHB was mentioned in Melbourne, 2004–2005 (excluding June–July 2004).....	82
Figure 59: Usual location of LSD use, 2004–2006.....	86
Figure 60: Location of most recent LSD use, 2004–2006.....	86
Figure 61: Recent changes in price of LSD purchased by REU, 2003–2006.....	87
Figure 62: REU reports of purity of LSD in the preceding six months, 2003–2006.....	88
Figure 63: REU reports of change in purity of LSD in the preceding six months, 2003–2006.....	88
Figure 64: Current LSD availability, 2003–2006.....	89
Figure 65: Changes in availability of LSD, 2003–2006.....	90
Figure 66: People from whom LSD had been purchased in the preceding six months, 2004–2006.....	90
Figure 67: Locations LSD had been purchased from in the preceding six months, 2004–2006.....	91
Figure 68: Recent changes in price of hydroponic and bush cannabis purchased by REU, 2006.....	95
Figure 69: Reports of current hydroponic and bush cannabis potency by REU, 2006.....	96
Figure 70: Reports of changes in hydroponic and bush cannabis potency by REU, 2006.....	97

Figure 71: Current availability of hydroponic and bush cannabis, 2006	97
Figure 72: Recent changes in availability of hydroponic and bush cannabis, 2006	98
Figure 73: People from whom hydroponic and bush cannabis had been purchased in the preceding six months, 2006.....	98
Figure 74: Locations in which hydroponic and bush cannabis had been purchased from in the preceding six months, 2006.....	99
Figure 75: DirectLine calls where drug of concern identified as cannabis, 1999–2005.....	100
Figure 76: Cannabis-related hospital admissions, Victoria and National, 1999/00–2004/05	101
Figure 77: Degree of risk ascribed by REU to driving soon after taking drugs, 2006	116

ACKNOWLEDGEMENTS

The Ecstasy and Related Drugs Reporting System (EDRS) is funded by the Australian Government Department of Health and Ageing.

We thank the following individuals and organisations for assisting in access to and collation of indicator data:

- Mark Stoovè, Stefan Cvetkovski, Sharon Matthews and Susan Clemens, Turning Point Alcohol and Drug Centre;
- Rebecca Monahan and Cate Quinn from Victoria Police, Forensic Services Department; and
- Amanda Roxburgh, National Drug and Alcohol Research Centre.

We thank Bernadette McGrath, Robyn Dwyer, Dianne Beck and Annie Haines who provided advice and assisted in recruiting and interviewing study participants.

Thanks go to Paul McElwee from Turning Point Alcohol and Drug Centre for database development and assistance, and to Louisa Degenhardt, Jennifer Stafford, Susannah O'Brien, Emma Black and Matthew Dunn at National Drug and Research Centre (NDARC) for assistance as National Coordinators of the EDRS during 2006.

We are grateful to the key experts (KE) who generously donated their time and support to this study. As always, we acknowledge that studies of illicit drug users could not occur without the participation of the users themselves. We thank the 100 ecstasy users who gave their time and trust to provide us with the important information contained in this report.

ABBREVIATIONS

1,4B	1,4-Butanedoil
2CB/2CI	4-Bromo-2, 5-Dimethoxyphenthylamine
ACC	Australian Crime Commission
ADIS	Alcohol and Drug Information Service
ATSI	Aboriginal and Torres Strait Islander
BAC	Blood alcohol concentration
BBV	Blood borne viruses
BBVI	Blood borne virus infection
BZD	Benzodiazepine(s)
CNS	Central nervous system
DHS	Department of Human Service, Victorian Government
DMT	Dimethyltryptamine
DXM	Dextromethorphan
EDRS	Ecstasy and Related Drugs Reporting System
ERD	Ecstasy and related drugs
GBL	Gamma Butyrlactone
GHB	Gamma-hydroxy-butyrate
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
IDRS	Illicit Drug Reporting System
IDU	Injecting drug user(s)
K10	Kessler Psychological Distress Scale (10-item)
KE	Key Expert(s)
LSD	<i>d</i> -lysergic acid
MAS	Metropolitan Ambulance Service (Melbourne)
MAOI	Monoamine oxidase inhibitor(s)
MDA	3,4-methylenedioxyamphetamine
MDMA	3,4-methylenedioxymethamphetamine (ecstasy)
NDARC	National Drug and Alcohol Research Centre
NDLERF	National Drug Law Enforcement Research Fund
NDSHS	National Drug Strategy Household Survey
NHMD	National Hospital Morbidity Database
NSP	Needle syringe program(s)

NSW	New South Wales
REU	Regular Ecstasy User(s)
PADD	Passive Alert Drug Detection
PCR	Patient care record
PDI	Party Drug Initiative
PMA	Paramethoxyamphetamine
SDS	Severity Dependence Scale
SPSS	Statistical Package for the Social Sciences
VYADS	Victorian Youth Alcohol and Drug Survey

EXECUTIVE SUMMARY

This report presents the results from the fourth year of a study monitoring ecstasy and related drug (ERD) trends in Victoria. A feasibility trial of this research was conducted in 2000 and 2001 in NSW, QLD and SA, and in 2002 the study was continued in those jurisdictions. 2003 marked the first year of a two-year national trial of the study, with the addition of capital cities in Western Australia, the Northern Territory, the Australian Capital Territory, Tasmania and Victoria.

The demographic characteristics, patterns of drug use and perceptions of the price, purity and availability of ERD among a sample of regular ecstasy users (REU) are described in this report. Their severity of dependence on ecstasy and methamphetamines, perceptions of the effects of drug use (e.g. benefits and risks), health risk behaviours and criminal behaviour are also reported. These findings are triangulated with information from key expert (KE) and secondary indicator data sources in an attempt to minimise biases and weaknesses inherent to each source of data. These methods are employed to gain an understanding of the current ERD markets in Melbourne, Victoria. Where appropriate, 2006 findings are compared to findings from the previous three years and implications of the results and the nature and characteristics of ERD markets are discussed.

Demographic characteristics of regular ecstasy users (REU)

Reports from the 2006 Victorian REU sample and KE suggest that regular ecstasy users are equally likely to be male or female, to be aged in their early twenties, tend to be well-educated, either employed and/or studying and either living in rental accommodation or in the family home. The findings suggest that regular ecstasy users are unlikely to be involved in either the treatment or justice systems.

Patterns of drug use among REU

In addition to ecstasy, REU reported having ever and recently used a range of other drugs. The drugs used by the 2006 sample were comparable to previous years, with recent use of alcohol, cannabis, tobacco and speed commonly reported. Less than half the 2006 REU sample reported bingeing (defined as continuous use of drugs for more than 48 hours) on drugs in the six months prior to interview, most commonly on speed, ecstasy, alcohol and cannabis.

Ecstasy

The 2006 REU sample reported first use of ecstasy, on average, in their late teens, typically commencing regular use in their early twenties. Although there was a wide range of patterns of current ecstasy use reported by the 2006 REU sample, over half (53%) reported using ecstasy pills fortnightly or less frequently. The median number of ecstasy pills used in a session was reported as two, with a median of four used in a heavy session.

Ecstasy pills are most commonly used orally. Regular ecstasy users take ecstasy in a wide range of locations, most commonly nightclubs, dance parties/raves/doofs, private homes/parties and at live music events. The perceived (user defined) benefits of ecstasy use include fun, and enhanced bonding with others, mood and communication. The user-defined risks of ecstasy use include psychological/mental health concerns, physical harms and neuropsychological harms.

As in previous years, polydrug use was the norm among the 2006 EDRS participants, a pattern of use confirmed among ERD users more generally by the KE reports. Most of the 2006 REU

sample reported the use of other drugs in combination with ecstasy (82%), and during the ‘come down’ from ecstasy (82%).

The price of ecstasy appears to have remained stable over the last four years, with ecstasy typically costing \$30 per pill. The purity of ecstasy tends to be rated as medium or fluctuating. Ecstasy remains readily available, and is predominantly sourced from friends or known dealers in private residences and nightclubs.

Regular ecstasy users tend to have a number of people they can purchase ecstasy from and typically purchase for themselves. In addition to ecstasy, most regular ecstasy users can obtain a range of other drugs from the dealers, most commonly speed and cannabis.

Methamphetamine

Of the three forms of methamphetamine, speed is most widely used by regular ecstasy users (in terms of both lifetime and recent use), followed by crystal meth and then base. Regular ecstasy users commonly use speed in conjunction with ecstasy and during binges. Methamphetamines are used in a variety of locations, predominantly nightclubs and in private homes.

The price of methamphetamines has remained stable, with crystal meth (median of \$360 per gram) more expensive than speed (median of \$200 per gram). According to the REU reports, the purity of crystal meth is relatively high and stable, whereas the purity of speed is medium to high and less consistent. Speed remains readily available, with ease of access to crystal meth stable or declining. Both speed and crystal meth are most commonly acquired through friends and known dealers. Methamphetamine use has the potential to be associated with considerable harms (i.e. violence and mental and physical health problems).

Cocaine

Reports from the Victorian REU and KE suggest that a high proportion of regular ecstasy users have ever used cocaine, with a considerable number also reporting recent use. Those regular ecstasy users using cocaine tend to use it infrequently, typically snort it, and report using it in a wide range of locations, most commonly nightclubs, pubs and private homes.

Perhaps contributing to the relatively low frequency of recent use, cocaine is an expensive drug. The purity of cocaine is typically rated as medium, it is considered as readily available, with availability recently stable or increasing. Cocaine is commonly purchased from friends or known dealers in private homes.

Ketamine

Reports from the 2006 Victorian REU and KE reflect decreasing levels of both lifetime and recent ketamine use among regular ecstasy users since 2003. Those reporting recent ketamine use typically use it infrequently, in a range of public and private locations.

The purity of ketamine is generally reported as medium or high. Reports of ketamine availability are inconsistent, with a recent trend of stable availability. Ketamine is most commonly purchased from friends and known dealers in private homes and dance parties/raves/doofs.

GHB

Reports from the 2006 Victorian EDRS suggest moderate prevalence of lifetime and low prevalence of recent GHB use among regular ecstasy users. Indeed, fewer of the 2006 REU

sample reported recent GHB use than previous years. REU tend to use GBH infrequently across a wide range of locations, predominantly private homes, dance parties and nightclubs.

GHB remains inexpensive (median \$3 per ml) and is currently considered to be of medium purity. GHB also remains readily available, although this may have recently decreased. GHB tends to be purchased from friends in their homes. There remains concern regarding GHB among professionals working in a range of capacities with regular ecstasy users.

LSD

Evidence suggests a high prevalence of lifetime use of LSD with moderate levels of recent use among regular ecstasy users. Recent users report infrequent use of LSD across a wide range of locations, predominantly ‘outdoors’, live music events and dance parties.

LSD is relatively cheap (median \$12 per tab) and the price has remained stable. Current LSD purity is regarded as high, with purity described as stable. There is little consistency in the reported current availability of LSD, although availability tends to be reported as stable over the previous six months. Regular ecstasy users most commonly purchase LSD from dealers in private homes.

MDA

Reports suggest low prevalence of lifetime and recent use of MDA among regular ecstasy users. It is not possible to comment on trends in the price, purity and availability of MDA given the small number of respondents able to comment in 2006.

Cannabis

Evidence suggests high prevalence of both ‘lifetime’ and recent cannabis use among REU, with relatively frequent recent use common. Cannabis is commonly used during the comedown period from ecstasy and during ERD binges. Questions were asked about the markets for hydroponic and bush cannabis for the first time in 2006. According to REU reports, bush and hydroponic cannabis are of comparable and stable price, although hydroponic cannabis is perceived to have a higher potency than bush cannabis. Both hydroponic and bush cannabis are readily available and are purchased from friends and known dealers in private homes.

Alcohol

The findings suggest almost universal lifetime and recent use of alcohol by regular ecstasy users, and high prevalence of alcohol use in conjunction with, and during comedown from, ecstasy. Indeed, the findings suggest that considerable proportions of REU drink at levels which may cause acute and/or long terms harms.

Patterns of other drug use

Reports from the Victorian REU and KE suggest very high lifetime and recent use of tobacco, with many REU being daily smokers. There also appears to be relatively high prevalence of lifetime and recent use of magic mushrooms in this population, although low frequency of use is typical. Although there appears to be relatively high prevalence of lifetime and recent use of benzodiazepines with use approximately monthly, low levels of lifetime and recent use of antidepressants among REU were reported. Approximately half of REU report lifetime use of

inhalants and about one-quarter report low levels of recent use, and reports suggest low levels of lifetime and recent use of heroin and ‘other opiates’ among REU.

Drug information seeking behaviour

The 2006 REU sample were asked about their use of methods to determine the content and purity of ecstasy pills and other drugs, their knowledge of the limitations of available pill testing methods, and how pill test results would influence their drug use behaviour.

The majority of the Victorian sample reported attempting to find out the content and purity of ecstasy at least some of the time, most commonly asking friends who had taken it or asking dealers. Slightly less than one-third of the sample reported personal use of testing kits. There was a moderate level of awareness of the limitations of testing kits among those who reported having used them, with nearly two-thirds able to comment on the limitations. The findings suggest that the results of pill testing may influence the drug use behaviour of regular ecstasy users: over half of those participants reporting personal use of testing kits reported that they would not take a pill if test results indicated that it contained ketamine, and approximately three-quarters reported that they would not take a pill if test results indicated that it contained opiates, 4-bromo-2, 5-dimethoxyphenthylamine (2CB/2CI) or an ‘unknown’ pill (producing no reaction in a reagent test). The majority of respondents reported that they would not take a pill if test results indicated that it contained paramethoxyamphetamine (PMA) or dextromethorphan (DXM).

Participants were also asked what information sources they would find most useful if they were made locally available; with web sites, testing kits and venue outreach workers receiving the most support.

Risk behaviour

The findings of the 2006 EDRS suggest low levels of injecting drug use by regular ecstasy users. The findings suggest that the sharing of needles is rare among those regular ecstasy users reporting injecting, although the sharing of other injecting equipment (i.e. spoons or other mixing equipment, water and/or filters) is more common. This population appears not to experience difficulties in accessing injecting equipment, most commonly accessing equipment through needle syringe programs (NSP). Among regular ecstasy users reporting recent injection there appears to be low levels of Hepatitis B virus (HBV) vaccination and low levels of Hepatitis C virus (HCV) and human immunodeficiency virus (HIV) infection. These findings, however, need to be interpreted with caution, given the small numbers of participants reporting injection as a route of administration.

Regular ecstasy users appear to be a relatively sexually active group, among whom condom use with regular sex partners is infrequent, but with casual partners relatively frequent. Unsurprisingly, this group tends to report having sex while under the influence of drugs. A small proportion of those who had had casual sex under the influence in the past six months reported that they never used condoms when doing so.

The current study also suggests that risky driving practises are relatively common among regular ecstasy users: over two-thirds of the REU sample who reported having driven in the six months prior to interview reported having driven soon after (i.e. within one hour) of taking any illicit drug/s and more than one-third reported having driven under the influence of alcohol (i.e. over the legal limit). Those reporting driving after using illicit drugs most commonly did so following ecstasy, speed and/or cannabis use. Respondents were asked how impaired they felt the last time they drove soon after taking a drug, with the vast majority reporting they felt only slightly or not at all impaired. 2006 REU participants were also asked what degree of risk they associated with

driving after taking a range of drugs, with the highest degrees of risk associated with LSD (*d*-lysergic acid), ketamine and GHB (gamma-hydroxy-butyrate), as well as with driving over the legal blood alcohol concentration (BAC).

Health related issues

A range of potential harms associated with ERD use is examined as part of the EDRS, including the experience of overdose, dependence, psychological distress and the use of drug-related treatment services.

The findings suggest that overdose is only experienced by a small proportion of regular ecstasy users, although it is still considered a significant harm by some KE.

Although the majority of the REU sample tended not to have scores on the Severity Dependence Scale (SDS) indicative of amphetamine dependence, a small proportion did so. Similarly, only a small proportion of the sample scored in the high risk range on the measure of psychological distress.

The findings indicate that regular ecstasy users tend not to utilise health and treatment services for their ERD use. This appears to be a result of a number of factors including services not being necessary due to generally infrequent patterns of use and low levels of harms and, among those experiencing harms, a lack of recognition that such harms are associated with ERD use. GPs and counsellors appear to be the treatment types most commonly accessed by regular ecstasy users.

Consistent with previous years, the reports of the 2006 REU sample suggest that relatively high levels of non-health related problems are experienced by regular ecstasy users: participants reported high rates of occupational/study, financial and relationship/social problems due to their use of ERD in the six months preceding interview. It is important to note, however, that the majority of these problems are considered as relatively minor by users, and that few participants reported legal/police problems associated with their ERD use.

Criminal activity, policing and market changes

The evidence suggests that the majority of regular ecstasy users do not undertake criminal activities. Over one-quarter of the 2006 REU sample, however, had been involved in drug dealing in the month prior to interview. These relatively high levels of dealing were also corroborated by the KE.

Nearly one-half of the 2006 participants believed police activity had increased in the last six months, most frequently citing increased presence of sniffer dogs, increased police presence and drug-driving testing buses. Despite such perceived changes, however, the majority of participants reported that police activity had not made it more difficult to obtain ERD in the six months prior to interview.

Conclusions

The results reported here describe trends in the market for ecstasy and related drugs in Melbourne, Victoria, and provide comparisons with the findings of the 2003 to 2005 studies. Many characteristics of ERD use reported in the previous Victorian and national (e.g. Stafford et al., 2006) reports are confirmed in the current study, perhaps suggesting a level of stability in this illicit market. Regular ecstasy users are typically aged in their mid-twenties, are well educated and tend to be employed and/or students.

Polydrug use appears to be the norm among regular ecstasy users, with a range of drugs used in conjunction with, and during the comedown from, ecstasy. Bingeing on drugs also appears to be common by this population, although few engage in intravenous drug use.

Many of the drugs investigated in this research (i.e. ecstasy, speed) were identified as readily available, although some classes of drug (i.e. cocaine and crystal meth) appear more difficult to access or are highly variable in their availability. Similarly, there was a degree of variability in the frequency with which some drugs were used. Ecstasy, speed and cannabis were used regularly, whereas, cocaine was used infrequently and opportunistically.

In general, risk behaviours, health-related problems and criminal activity among REU were relatively uncommon. However, considerable proportions of REU reported driving soon after taking drugs (both ERD and alcohol) and participating in dealing. Problems associated with ERD use tend to involve work, study and social relationships, and were reported by a substantial proportion of participants.

Implications

This fourth consecutive year of the Victorian EDRS study has provided further indication of the patterns and characteristics of ERD use and related consequences in Melbourne. Patterns of polydrug use, binge drug use, the frequency and locations where some drugs are used, and the availability of many drugs have shown a degree of consistency across the four years of data collection. Other characteristics, such as the prevalence of recent GHB, cocaine use and crystal meth were inconsistent across time and warrant further exploration. The EDRS has also provided unique information on a range of issues of relevance to ERD using populations such as drug-driving behaviour.

With increasing community interest in the patterns and characteristics of ERD use, the Victorian EDRS represents a key knowledge base from which to further explore these local markets. The primary aim of the national EDRS was to provide a 'snapshot' of the characteristics of regular ecstasy use in Australia. Although the data collection methods described in this report have limitations, the findings provide information that can be used to inform other research with the capacity to target emergent questions relating to regular ecstasy use (see below).

The findings of the 2006 Victorian EDRS suggest the following recommendations:

1. Polydrug use by REU, associated harms, and explorations of harm reduction strategies used by REU warrant further investigation. In particular, the high levels of alcohol use reported by the REU sample, both in conjunction with ecstasy and during the comedown, as well as during binges, needs to be examined further, with new harm reduction messages targeting such behaviours potentially required.
2. The findings of the EDRS studies illustrate the wide range of settings in which ERD are used. Considering that harm reduction messages have traditionally been designed for and implemented in rave settings, such findings have implications for the development and implementation of harm reductions in a wider range of settings. For example, specific resources targeting home-based users and those using in nightclubs is also required (i.e. the expansion of the RaveSafe model of peer education to a equivalent nightclub based initiative).
3. More thorough and targeted research examining the extent and nature of injecting drug use in ecstasy-using populations is required. Although reports from the 2004, 2005 and 2006 Victorian REU suggest only low levels of injecting drug use, the sharing of injecting equipment other than needles (i.e. spoons or other mixing equipment, water and/or filters) is relatively common among those reporting injecting. Further, there appears to be

low levels of HBV vaccination among this group. Interventions specifically targeting this population and addressing these issues (i.e. risks of sharing ‘any’ injecting equipment and increasing awareness of HBV vaccination) may usefully be developed and potentially disseminated via NSP (the most commonly reported sources of injecting equipment). The findings and implications of the current research need to be interpreted with caution, however, given the small numbers, with further research clearly warranted.

4. Problems relating to financial, work/study and relationship/social outcomes need further exploration to provide a better understanding of the harms associated with regular ecstasy use. Increased understanding of such issues may have implications for the development of both prevention and harm reduction strategies, such as tools encouraging problem recognition and providing strategies to reduce and/or cease ERD use.
5. The findings of the 2005 Party Drug Initiative (PDI) suggest that a small proportion of regular ecstasy users experience dependence on methamphetamines. This needs to be explored further, in terms of the implications for such users, their perceptions of such dependence, and the utilisation of treatment services. Levels of dependence of this population on other drugs commonly used (i.e. cannabis) could also be usefully explored.
6. The findings of the 2005 Victorian PDI also provide evidence of low levels of treatment utilisation among regular ecstasy users. Although this may primarily be a result of low levels of harm and need of treatment among this group, there is also some evidence to suggest a lack of problem recognition and a reluctance to seek treatment among those regular ecstasy users experiencing harms. Barriers to treatment beyond lack of problem recognition (i.e. lack of knowledge of treatment options available, stigma associated with treatment utilisation) should be explored. Such research may usefully inform the development of a tool designed to increase recognition of problematic use and encourage treatment utilisation among those experiencing harms.
7. The high levels of driving under the influence of both alcohol and ERD reported by participants is a major concern. Targeted research is needed in this area, particularly in the context of Victoria’s new ‘drug-driving’ testing initiatives and the impact such initiatives have on behaviour. Attitudes towards these initiatives and drug-driving more generally need to be assessed to allow for education and awareness campaigns to be developed.
8. Although experienced by a minority of regular ecstasy users, overdose events are a significant concern. Little is known about the circumstances around overdose, hampering efforts to both prevent and treat such events. Further research examining such factors is a priority. Overdose events present potential opportunities to provide individuals with information about their overdose, harm minimisation strategies and general drug information. There is, however, a current lack of appropriate resources to provide such information.
9. Relatively high levels of dealing were reported by the 2006 REU sample. Issues such as the legal status of on-selling and dealing/supplying to friends need to be examined in greater detail, potentially informing the development of resources designed to raise awareness of such issues and the potential penalties of such behaviour.

1 INTRODUCTION

The Illicit Drug Reporting System (IDRS) is an annual study funded by the Australian Government Department of Health and Ageing. It has been conducted on an annual basis in NSW since 1996, Victoria since 1997 and in all states and territories of Australia since 1999.

The IDRS aims to provide a reliable method of monitoring emerging jurisdictional trends in the price, purity, availability and use of opiates, cannabis, cocaine, amphetamines and other drugs. 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 IDRS is designed to be sensitive to such trends, providing data in a timely fashion, rather than to describe phenomena in detail. The drug trends information obtained from this study is intended to inform health and law enforcement sector policy and program responses to illicit drugs, as well as to identify areas and issues requiring further investigation (Darke, Hall & Topp, 2000; Topp et al., 2002).

The IDRS data collection consists of three components: interviews with illicit drug users, KE interviews with individuals who work with illicit drug users, and the collection of secondary indicator data sources (such as surveys of drug use in the general population, data on drug seizures, arrest data, hospital accident and emergency data and so on). These three data sources are triangulated against each other in order to minimise the biases and weaknesses inherent in each one.

The IDRS, however, has historically not provided clear data on party drug use trends. This is because the sentinel group chosen for study purposes has been injecting drug users (IDU) recruited mostly through Needle and Syringe Programs. The majority of these IDU have been primary heroin users whose polydrug use extended to other opiates and central nervous system (CNS) depressants, but not to ecstasy and related drugs to the same extent (Breen et al., 2004; Breen, Topp & Longo, 2002).

Given the significant demonstrated potential for health and other harms associated with ERD misuse (Vincent et al., 1998; Williamson et al., 1997; Deehan & Saville, 2003; Degenhardt & Topp, 2003; Topp et al., 1999), there is an imperative for broadening existing drug trend monitoring systems to facilitate a more sensitive mechanism for detecting trends in this area. The greatest opportunity for achieving this is by extending current monitoring methods to new sentinel groups and settings. With increasing community interest in the patterns and characteristics of ERD, the Victorian Ecstasy and Related Drug Reporting System (EDRS) represents a timely move to gather information about these local markets.¹

In 2000, the National Drug Law Enforcement Fund (NDLERF) funded a two-year, two-state trial of the feasibility of monitoring emerging trends in ecstasy and other related drug markets using the extant IDRS methodology. For the purposes of the study, the term ‘ecstasy and related drugs’ is considered to include drugs that are routinely used in the context of entertainment venues such as nightclubs or dance parties. In addition to ecstasy (3,4-methylenedioxymethamphetamine (MDMA)), this includes drugs such as methamphetamine, cocaine, LSD, ketamine, MDA (3,4-methylenedioxyamphetamine) and GHB (gamma-hydroxybutyrate).² The findings of the two-year trial (Breen, Topp & Longo, 2002) are reported elsewhere.

The sentinel population examined in this report (as in the 2003, 2004 and 2005 reports) are regular ecstasy users. The findings in this report provide a summary of trends in ecstasy and related drug use detected in Melbourne, Victoria, in 2006 through the conduct of the fourth year

¹ See the Drugs & Crime Prevention Committee’s discussion paper “Inquiry into amphetamine and ‘party drug’ use in Victoria” as a good source for further reading.

² For further information about these and other party drugs see: www.adf.org.au; www.bluelight.nu; www.crowid.org

of the study, formerly known as the Party Drug Initiative (PDI). Comparisons are also made between results reported in the 2003, 2004 and 2005 studies. The trends described in this report have been extrapolated from the three data sources; interviews with current regular ecstasy users, interviews with individuals who have contact with ecstasy users through their work, and the collation of indicator data. As with the core IDRS, the data sources are triangulated in order to minimise the biases and weaknesses inherent to each. Consistency between the main IDRS and the EDRS was maintained where possible, as the IDRS has demonstrated success as a monitoring system (Shand et al., 2003; Topp et al., 2003; Topp et al., 2002; Topp et al., 2003). Consequently, the focus is on the capital city, as new trends in illicit drug markets are more likely to initially emerge in large cities rather than regional centres or rural areas.

1.1 Aims

The overall aim of the 2006 Victorian EDRS was to extend to a fourth year the routine monitoring of key ERD market indicators in Melbourne. The specific aims of the study were to:

1. describe the characteristics of a sample of current ecstasy users interviewed in Melbourne;
2. examine the patterns of ERD use of this sample;
3. document the current price, purity and availability of ERD in Melbourne;
4. examine participants' perceptions of the benefits of ERD;
5. examine participants' perceptions of the incidence and nature of ecstasy and other party drug-related harm, including physical, psychological, financial, occupational, social and legal harms;
6. identify emerging trends in the ERD market that may require further investigation; and
7. where appropriate, provide a comparison of 2006 findings with those reported in the 2003, 2004 and 2005 PDI reports.

2 METHODS

The 2006 Ecstasy and Related Drugs Reporting System (EDRS) used the methodology trialled in the feasibility study (Breen, Topp & Longo, 2002) to monitor trends in the markets for ecstasy and related drugs, and replicate the methods used in the 2003–2005 studies. The three main sources of information were used to document trends were:

1. face-to-face interviews with current regular ecstasy users;
2. telephone and face-to-face interviews with KE who, through their work, have regular contact with ecstasy users in Melbourne; and
3. indicator data sources such as ERD drug treatment episodes, the purity of seizures of ecstasy analysed in Victoria, and prevalence of use data drawn from the National Drug Strategy Household Surveys.

These three data sources were triangulated, so that different data sources were used to validate each other and provide a more reliable indication of emerging trends in drug use and party drug markets.

2.1 Survey of regular ecstasy users (REU)

As described above, a range of drugs are included in the category of ecstasy and related drugs. The sentinel population chosen to monitor trends in ERD markets consisted of people who reported regular use of tablets sold as ‘ecstasy’. This population was chosen for a number of reasons: ecstasy can be considered one of the main illicit drugs used in Australia. It is the second most widely used illicit drug after cannabis, with 3.4% of the Australian population aged 14 years and older estimated to have used it in the last 12 months (Australian Institute of Health and Welfare, 2005).

Further, a sample of this population was successfully recruited and interviewed for both the two-year feasibility trial (2000–2001) in NSW, QLD and SA as well as the subsequent implementation of the PDI in 2002 in these jurisdictions. The findings from these studies provide further evidence of the central role of ecstasy to the various party drug markets of Australia (White, Breen & Degenhardt, 2003). Therefore, regular ecstasy users, who were used in the 2003–2005 PDI studies, have again been used in the 2006 study to provide information on ERD markets.

For the purpose of this study ‘regular ecstasy use’ was defined as use of ecstasy at least once a month for the previous six months. Participants were also required to have resided in the Melbourne metropolitan area for the 12 months prior to the interview.

2.1.1 Recruitment

A total of 100 regular ecstasy users were interviewed for the Victorian 2006 EDRS. All of the participants resided in the Melbourne metropolitan region and were recruited through a purposive sampling strategy (Kerlinger 1986). This strategy included advertisements in entertainment street press and online forums, interviewer contacts, flyers at retail outlets (for example, music stores and clothing shops) and at bars and cafes, and ‘snowball’ procedures (Biernacki & 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 (Solowij, Hall & Lee, 1992; Ovendon & Loxley 1996; Boys, Lenton & Norcross, 1997) and international studies (Dalgarno & Shewan, 1996; Forsyth, 1996; Peters, Davies & Richardson, 1997). Accordingly, on completion of their interview, participants were asked if they would be willing to discuss the study with friends who might be willing and able to participate. Snowballing is also routinely employed as a recruitment method in the IDRS (Jenkinson & O’Keeffe, 2005).

2.1.2 Procedure

Participants contacted the researchers by telephone or via email and were screened for eligibility. To meet entry criteria, they had to be at least 16 years of age, have used ecstasy at least once a month for the last six months, and have been a resident of the Melbourne metropolitan region for the past 12 months. As in the main IDRS, the focus was on the capital city, as new trends in illicit drug markets are more likely to emerge in urban areas rather than in remote or regional areas.

Participants were informed that all information provided was strictly confidential and anonymous, and that the study would involve a face-to-face interview that would take approximately 60 minutes. All respondents were volunteers who were reimbursed \$30 for their participation. All interviews were undertaken at Turning Point Alcohol and Drug Centre and were conducted by trained researchers using a standardised interview schedule. The nature and purpose of the study was explained to participants before informed consent was obtained. Ethics approval for this study was obtained from the Victorian Department of Human Services, Human Research Ethics Committee.

2.1.3 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; Topp et al., 1999), which incorporated items from previous NDARC studies of users of ecstasy (Solowij et al., 1992) and powder meth/amphetamine (Hando & Hall, 1993; Darke et al., 1994; Hando, Topp & Hall, 1997). The interview schedule focused primarily on the preceding six months, and assessed demographic characteristics; patterns of ecstasy and other drug use, including frequency and quantity of use and routes of administration; the price, purity and availability of ecstasy and other related drugs; patterns of ecstasy purchasing; self-reported criminal activity; perceived physical and psychological side-effects of ecstasy; other ecstasy-related problems, including relationship, financial, legal and occupational problems; help-seeking behaviour; and general trends in party drug markets, such as new drug types, new drug users and perceptions of police activity.

2.1.4 Data analysis

Univariate descriptive analyses were conducted using Statistical Package for the Social Sciences (SPSS) for Windows Version 11.5.1.

2.2 Survey of key experts (KE)

The criterion for KE eligibility was regular contact, in the course of employment, with users of ecstasy and/or related drugs throughout the preceding six months. Twenty-nine KE provided information on the ecstasy users with whom they had contact in the 6 to 12 months preceding the interview. Most of the KE interviews were conducted face-to-face, with two conducted over the phone.

The twenty-nine KE interviewed in 2006 represented a range of occupations and organisations. Nine were alcohol and drug counsellors, psychologists and/or community development workers and five worked for medical services (private and public first aid and emergency management organisations, ambulance services and hospital accident and emergency departments). A further nine KE were from Victoria Police, including members of the Drug and Alcohol Strategy Unit, Major Drug Investigation Division, and Forensic Services Department, and one was from the Australian Customs Service. Two KE were health promotion/peer educator workers, with an additional KE from the Victorian Department of Human Services. Two party promoter and event organisers were also interviewed.

Just over one-third of KE (n=11) stated that they worked with one or more 'special population' groups. Five KE identified 'youth' as the sole 'special population' they worked with, however six

KE listed other populations, including injecting drug users (n=5), women (n=5), individuals from non-English speaking backgrounds (n=5), prisoners and/or parolees (n=4), youth (n=4), Indigenous Australians (n=3), gay men (n=2) and forensic clients (n=1). The majority of KE (n=18), however, did not report working with any 'special population' groups. Indeed, many KE reported that the demographics of the ecstasy users they had contact with were comparable to that of the general community.

In the six months preceding their interviews, nineteen KE had regular daily to weekly contact with ecstasy users. The remaining KE, for example senior police and policy-level government bureaucrats, had only little or indirect contact with users. Despite this, these KE were considered well positioned to comment on ecstasy and related drug use or associated drug markets as a result of their responsibilities and/or managerial roles. These KE gained information from sources such as colleagues (both peers and more junior staff with more hands-on roles), friends and acquaintances, data sets, surveys, research reports and websites. The majority of KE (n=26) obtained their knowledge solely through their work. Three KE stated that their information came from ecstasy users they knew through both their work and personal lives.

Of the KE who gained information via direct contact with users, all but one estimated having contact with at least 10 users in the previous six months. Two KE reported contact with more than 100 users. Several KE reported that their level of contact with users tended to fluctuate, either around a particular time of the week (i.e. weekends versus weekdays) and particular times of the year (i.e. summer and/or public holidays versus winter).

2.3 Other indicators

Primary information collected from the REU survey and KE interviews was supplemented by data obtained from a number of secondary indicator sources of illicit drug use and related morbidity and mortality. Where possible, data relating to trends for the 2005/2006 financial year are reported, unless otherwise indicated. For secondary indicators, where current data is not available, the most recently available data has been included.

Indicator data sources accessed for this study are described in the following sections:

Surveys reporting on illicit drug use prevalence in Victoria

- Data on the prevalence of drug use in the community is typically derived from large-scale population surveys. The most recent household surveys from which estimates of illicit drug use within the community are available include the 2004 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2005) and the 2004 Victorian Youth Alcohol and Drug Survey (Premier's Drug Prevention Council, 2005).

Drug seizure purity levels

- The Drug Analysis Branch of the Victoria Police Forensic Services Department conducts purity analyses for all drug seizures made by the Victoria Police. Since 2001, the Victoria Police Forensic Services Department has provided drug purity data for inclusion in the IDRS report. This report presents data for the 2005/2006 financial year.

Drug-related arrest data

- Information pertaining to drug-related arrests in Victoria has been obtained from the Australian Crime Commission (ACC). The Victoria Police and the Australian Federal Police provide arrest data to the ACC for the *Illicit Drug Data Report*. This report presents drug-related arrest data for the 2004/2005 financial year (2005/2006 data were not available at the time of publication).

Specialist drug treatment presentations

- The Victorian Department of Human Services funds community-based agencies to provide specialist alcohol and drug treatment services across the state. The collection of client information is a mandatory requirement and occurs via a formalised client data collection system called the Alcohol and Drug Information System (ADIS). The ADIS data presented in this report represents courses of treatment (not client numbers) for the period 2004/2005.
- DirectLine is a 24-hour specialist telephone service in Victoria (operated by Turning Point Alcohol & Drug Centre) that provides counselling, referral and advice about drug use and related issues. All calls to DirectLine are logged to an electronic database that can provide information about caller drugs of concern, calls from drug users and calls about drug users. This report presents data for the period 1999–2005.

Ambulance attendances at non-fatal drug overdoses and other episodes

- Turning Point Alcohol and Drug Centre manages an electronic drug-related ambulance attendance database, comprising information obtained from the Melbourne Metropolitan Ambulance Service (MAS) Patient Care Records (Dietze et al., 2000). Reliable data is available from June 1998 (with missing data for the periods May–July 2001, October 2002–February 2003, and June–July 2004). Although the database includes overdose-related calls for all types of drugs, the dataset is best suited to the monitoring of non-fatal heroin-related overdose, due to the availability of a biological marker of heroin involvement (i.e. the administration of Narcan and subsequent patient response). Data for the period January 2004–December 2005 are presented in this report.

NHMD (National Hospital Morbidity Database)

- The National Hospital Morbidity Database (NHMD) is compiled by the Australian Institute of Health and Welfare. It is a collection of electronic records for admitted patients in public and private hospitals in Australia. ‘Principal diagnosis’ (the diagnosis established after study to be chiefly responsible for occasioning the patient’s episode of care in hospital) has been reported. This report presents drug-related (opioid, amphetamine, cocaine and cannabis) hospital admissions for Victoria and Australia, 1999/00 - 2004/05 (Roxburgh & Degenhardt, 2006).

3 OVERVIEW OF REGULAR ECSTASY USERS (REU)

3.1 Demographic characteristics of the REU sample

Just over half (52%) of the 2006 REU sample were male (Table 1). The mean age of the sample was 24.4 years (SD 5.9; range 18–56). Most (91%) participants nominated their sexual identity as heterosexual, although bisexuals (7%) and homosexuals (2%) were also represented. Nearly all participants (94%) identified English as the main language spoken at home, and two participants identified themselves as Aboriginal or Torres Strait Islander (ATSI). Slightly more than half (52%) of the sample lived in rental accommodation and one-third (33%) lived in their parents' or family house. Seven participants reported owning their own home.

Table 1: Demographic characteristics of REU sample, 2003–2006

	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Mean age (years)	25.1	23.5	24.2	24.4
Male (%)	53	58	52	52
English speaking background (%)	99	96	94	94
ATSI (%)	6	0	2	2
Heterosexual (%)	81	87	86	91
Mean number school years*	12.5	11.6	11.7	11.7
Tertiary qualifications (%)	41	53	52	42
Employed full-time (%)	31	25	33	26
Full-time students (%)	18	23	17	16
Unemployed (%)	24	17	15	20
Previous conviction (%)	7	4	4	6
Current drug treatment (%)	6	6	0	4

Source: REU interviews, 2003–2006

*Question changed from 'How many years of school did you complete?' (2003) to 'What grade of school did you complete?' (2004–2006)

The mean number of years of school education completed by the sample was 11.7 (SD 0.9; range 7–12), and the majority of the participants (87%) had completed high school education. Forty-two percent of the sample had completed courses after school, with 21% possessing a trade or technical qualification and 21% having completed a university degree or college course. Sixteen percent of the sample were full-time students at the time of interview. Just less than two-thirds (62%) were currently employed; 26% on a full-time basis and 36% on a part-time or casual basis, and 20% were unemployed. Four participants reported being in drug treatment at the time of interview, most commonly methadone (n=2). Six participants had a previous criminal conviction for which they had served a custodial sentence.

The demographic characteristics of the REU samples over the four years of data collection are generally comparable, with those undertaking interviews tending to be aged in the early- to mid-

twenties, heterosexual and from English-speaking backgrounds. They also tend to be well educated and employed and/or studying at the time of interview. The 2006 sample, however, were slightly less likely to have completed a tertiary education than the 2004 and 2005 samples, slightly less likely to be employed on a full-time basis than the 2005 sample and slightly more likely to report being unemployed at the time of interview than the 2004 and 2005 samples.

Information gained from KE interviews indicates that diverse groups of people (in terms of differing age, gender, sexuality, geographic location) are part of the broad ERD-using population in Melbourne. Indeed, KE commented on the increasingly mainstream and widespread nature of ERD use, with one KE stating that *“if you go to a nightclub and you’re not drinking water, there’s something wrong with you”*.

Many KE indicated that the gender ratio of ERD users with whom they had contact tended to be relatively equal. Most KE from law enforcement, however, reported being in contact with more males than females. This was also the case for one KE who worked with drug diversion clients, and another service-based KE who stated that males constituted two-thirds of their client-base. In contrast, two KE from public first aid and emergency management organisations noted that female ERD clients were more common than males. As may be expected, one KE reporting on ERD use in Melbourne’s gay community (including male sex-on-premises venues) reported a client base of predominantly men.

KE reported a number of different age ranges of ERD users, typically approximately 17 to 35 years of age, with most in their early- to mid-twenties. One ambulance paramedic KE reported *“a good range”* of 14 to 40 years, noting that when individuals younger than fourteen consume ecstasy, it is usually accidental. Four KE reported that, in addition to ecstasy use becoming mainstream, ecstasy users are ‘getting younger’. One KE indicated that their primary ERD-using client base generally consisted of young individuals without a stable environment or ‘loving home’ to go to. This KE stated that these particular clients usually present with underlying issues, ranging from self-esteem issues and/or sexual abuse in the past, to *“coming to terms with the concept of being different”*.

Eight KE reported ERD users originating from a variety of ethnic backgrounds, with six indicating that the majority of ecstasy users with whom they had contact were of Anglo backgrounds. The remaining two KE reported users originating primarily from European backgrounds. One of these, an alcohol and drug counsellor at a private practice, indicated that user demographics could be influenced by the significant cost of treatment, in addition to the fact that European families are often ‘more supportive’ and proactive in seeking treatment for a drug-using member of the family.

Eight KE commented on the education histories or status of ERD users. Six of these KE reported that ERD users were relatively well educated. They indicated that ERD users had generally completed secondary education, with a significant number also university-educated (including a large proportion of current students). In contrast, two KE reported that ERD users were usually at school and not doing well, or had dropped out and found employment. One of these KE noted that a ‘small percentage’ of ERD users were university-educated.

With regard to employment, seven KE reported that the majority of ERD users were currently employed, representing a variety of skilled and unskilled professions and trades. KE specified that many individuals maintain casual and/or part-time employment whilst simultaneously completing either secondary or tertiary education. Four KE reported that employed ERD users are ‘not a lower socioeconomic group’ and usually have a high disposable income. In contrast, one KE specified that the majority of ERD users were unemployed, although admitted that it was possible that they were undertaking education at the time. This KE indicated that *“telemarketing is the main profession for these people”*, noting that most of the employed ERD users worked shifts, ranging from 10 to 50 hours per week.

Only a few KE (n=4) commented on the sexual preference of ERD users. Two KE suggested that ERD populations were ‘mixed’ with regard to heterosexual, homosexual and bisexual individuals, while another suggested that the number of homosexual ERD-using individuals had decreased during the previous twelve months, particularly because homosexuality had become less accepted in the ERD-using community. This KE noted that bisexuality was much more common, especially amongst female ERD users. Another KE working primarily with gay males at gay-orientated dance parties and sex-on-premises venues, primarily had contact with gay ERD users.

Most KE suggested that REU were unlikely to have had prior contact with the criminal justice system. One KE reported that even those with a criminal history were only guilty of minor offences. Law enforcement KE (n=5) commenting on the drug diversion program reported that the majority of REU detected by sniffer dogs were first time offenders possessing small quantities of drugs (under trafficable amounts, for example). These KE also noted the minimal number of repeat offenders detected by Passive Alert Drug Detection (PADD) dogs, arguing this as a measure of success for the program.

The treatment experiences of ERD users were clearly delineated along the background or current working experiences of the KE. Several KE did, however, indicate that drug treatment is not accessed by many ERD users. One KE suggested that there is a stigma attached to drug treatment, insisting that treatment is unpopular because it is associated with being a ‘junkie’, while another noted that if REU access treatment they usually “*drop off the face of the planet*” because they sever all ties with the scene. A KE working with drug diversion clients described ERD users as generally ‘high functioning’, and reported that approximately half of these individuals “*are just recreational party drug users with bad luck – it’s rare that they’ve got a full-on habit, mainly just social use*”. According to this KE, many ERD users do not benefit from the drug diversion program. Regardless, this KE noted that “*every now and then*” an individual who actually requires treatment, though has never accessed it before, is assigned to the drug diversion program and continues receiving treatment after completing the initial mandatory session(s).

3.2 Drug use history and current drug use

As in previous years, the 2006 REU sample were likely to have used a range of drugs in addition to ecstasy. The percentage of the sample reporting having ever and recently used each of the eighteen drugs asked about is presented in Table 2.

Table 2: Lifetime and recent polydrug use of REU, 2003–2006

	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Alcohol				
Ever used (%)	99	100	100	99
Used last 6 months (%)	87	94	97	97
Cannabis				
Ever used (%)	98	98	97	97
Used last 6 months (%)	82	78	87	79

Table 2: Lifetime and recent polydrug use of REU, 2003–2006 (continued)

Tobacco				
Ever used (%)	86	94	93	93
Used last 6 months (%)	73	83	78	78
*Ecstasy Powder				
Ever used (%)	--	--	55	66
Used last 6 months (%)	--	--	27	55
Methamphetamine powder (Speed)				
Ever used (%)	98	98	97	100
Used last 6 months (%)	89	92	85	91
Methamphetamine base (Base)				
Ever used (%)	50	45	34	32
Used last 6 months (%)	27	34	21	12
Crystal methamphetamine (Crystal meth)				
Ever used (%)	75	71	71	73
Used last 6 months (%)	62	52	42	49
Cocaine				
Ever used (%)	80	72	79	82
Used last 6 months (%)	35	48	63	55
LSD				
Ever used %	86	72	67	60
Used last 6 months %	48	39	38	37
MDA				
Ever used (%)	40	37	25	26
Used last 6 months (%)	19	16	8	8
Ketamine				
Ever used %	70	70	56	56
Used last 6 months %	51	45	35	29
GHB				
Ever used (%)	33	38	33	35
Used last 6 months (%)	18	27	16	14
Amyl nitrate				
Ever used (%)	70	52	49	42
Used last 6 months (%)	25	20	20	11

Table 2: Lifetime and recent polydrug use of REU, 2003–2006 (continued)

Nitrous oxide				
Ever used (%)	59	54	41	32
Used last 6 months (%)	22	27	17	14
*Psilocybin Mushrooms				
Ever used (%)	--	--	53	55
Used last 6 months (%)	--	--	19	32
Benzodiazepines				
Ever used (%)	61	58	54	51
Used last 6 months (%)	38	41	37	36
Antidepressants				
Ever used (%)	35	28	33	25
Used last 6 months (%)	11	12	14	10
Heroin				
Ever used (%)	39	18	18	23
Used last 6 months (%)	23	9	7	8
Methadone				
Ever used (%)	15	8	1	11
Used last 6 months (%)	6	2	0	6
Other opiates				
Ever used (%)	33	26	34	29
Used last 6 months (%)	9	13	18	16

Source: REU interviews, 2003-2006

*Question not asked prior to 2005

A small proportion of the 2006 sample reported having used drugs other than those listed in Table 2, with one participant reporting use of dimethyltryptamine (DMT) (compared to seven in 2005) and one reporting use of mescaline (compared to four in 2005).

For the purposes of this study, bingeing is defined as using drug(s) on a continuous basis for more than 48 hours without sleep (Ovendon & Loxley 1996). Less than half (44%) of the sample reported that they had binged on ERD in the six months preceding interview. The median length of the longest binge was 65.5 hours (range 50–312 hours) and those reporting bingeing in the last six months reported having done so a median of three times (range 1 to 24 times) during that period. Speed was the most commonly reported drug used during binges (91%), followed by ecstasy (89%), crystal meth (57%), alcohol (57%) and cannabis (50%). Cocaine (23%), LSD (21%) and ketamine (16%) were also relatively commonly used during binges, with smaller numbers reporting use of psilocybin mushrooms (9%), GHB (9%), base (7%), nitrous oxide (7%) and MDA (5%).

Over the four years that data has been collected in Melbourne, the drugs reported as being used have generally been comparable, with the use of alcohol, cannabis, tobacco and speed commonly

reported. Changes in the levels of use of specific drugs are discussed in the sections of this report pertaining to their use.

3.3 Summary of demographic characteristics and drug use trends in REU

Reports from the Victorian REU sample and KE suggest that regular ecstasy users:

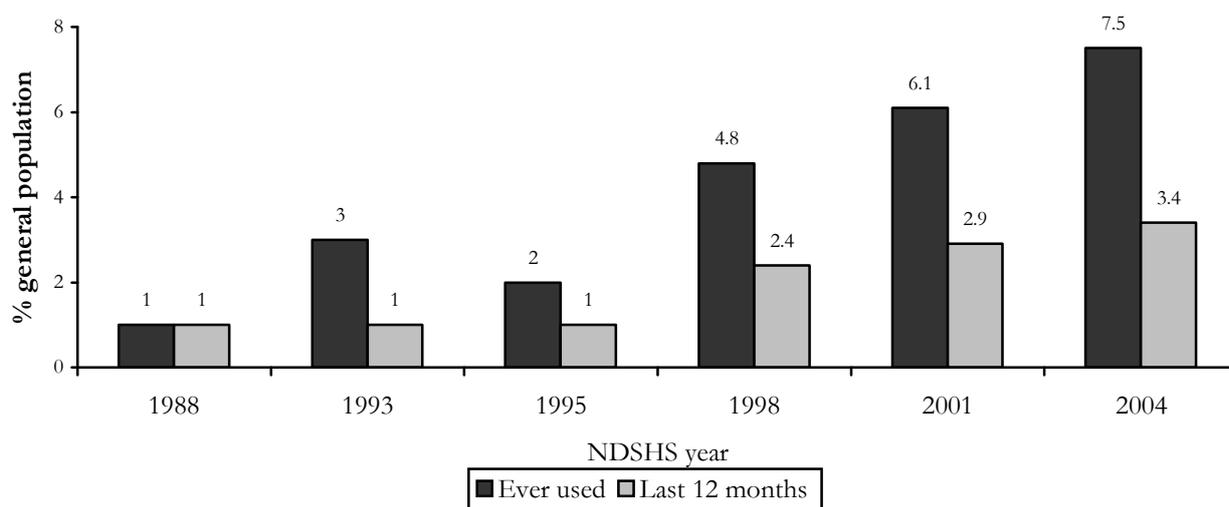
- ❖ are approximately equally likely to be male or female;
- ❖ are likely to be aged in their early twenties;
- ❖ are likely to have completed secondary school, with a substantial proportion continuing to tertiary education;
- ❖ are likely to be employed and/or studying;
- ❖ are unlikely to have been in prison;
- ❖ are unlikely to have used A&D treatment services in relation to their ED use;
- ❖ are very likely to have used a range of drugs in addition to ecstasy, most commonly alcohol, cannabis, speed and tobacco; and that
- ❖ bingeing on ERD is common among REU, with speed and ecstasy being the drugs most commonly used during a binge.

4 ECSTASY

4.1 Use of ecstasy in the general population

The 2004 National Drug Strategy Household Survey (NDSHS) provides the most recent national figures regarding the prevalence of ecstasy use in the general population. The results of this survey indicate that in 2004 three point four percent of the Australian population aged 14 years and over had recently (in the last 12 months) used ecstasy (Australian Institute of Health and Welfare, 2005). This represents a statistically significant increase from the previous NDSHS survey, which indicated that in 2001 two point nine percent of the general population aged 14 years and older had recently used ecstasy (Australian Institute of Health and Welfare, 2005) (see Figure 1). The most recent data available regarding the prevalence of ecstasy use in the general population of Victoria also comes from the 2004 NDSHS, according to which, in 2004 three point one percent of the Victorian population aged 14 years and above had used ecstasy within the past twelve months (Australian Institute of Health and Welfare, 2005).

Figure 1: Prevalence of ecstasy use among the population aged 14 years and over in Australia, 1988–2004



Source: 2004 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2005)

It is noteworthy that, nationally, the highest prevalence of both ‘lifetime’ (22.0%) and ‘recent’ (12.0%) ecstasy use was reported by the 20–29 year old age group (Australian Institute of Health and Welfare, 2005). Data from the most recent Victorian Youth Alcohol and Drug Survey (VYADS) (Premier’s Drug Prevention Council, 2005), provide further evidence of relatively high levels of ecstasy use among a young cohort: of the 16–24 year olds surveyed in 2004 (n=6,005), 18% reported having ever used ecstasy, 12% reported use in the 12 months prior to survey, 6% reported ecstasy use in the last month and 2% in the last week (Premier’s Drug Prevention Council, 2005). Of those who reported having used ecstasy in the 12 months prior to interview, however, frequency of use tended to be low: approximately one-third (34%) reported using it once a month or more often, just fewer than one-third (30% reported using it ‘every few months’, slightly less than one-quarter (24%) reported using it once of twice a year, and 12% had used ecstasy on one occasion (Premier’s Drug Prevention Council, 2005). The vast majority of respondents (97%) reported taking ecstasy in pill or tablet form (Premier’s Drug Prevention Council, 2005). Median age of first use for the participants in the VYADS was 17.4 years

(Premier's Drug Prevention Council, 2005), with data from the 2004 NDSHS indicating a median age of first use of 22.8 years (Australian Institute of Health and Welfare, 2005).

4.2 Ecstasy use among REU

The mean age at which participants first tried ecstasy was 19 years (SD = 4.6; range 12–52) and the mean age at which participants first started using ecstasy regularly (at least once a month) was 21 years (SD = 5.1; range 13–54; Table 3). Ecstasy was the drug of choice for slightly less than one-third (32%) of respondents.

In accordance with the eligibility criteria, all participants had been using ecstasy at least monthly for the six months prior to the interview. Participants were asked to differentiate their use in terms of ecstasy pills/tables and ecstasy powder. All of the participants reported use of ecstasy pills in the six months to interview and had used them on a median of 12 days in the preceding six months (range 6–75). Over half (53%) of the participants reported using ecstasy pills fortnightly or less frequently, 17% reported using them more than fortnightly but less than weekly and the remaining 30% reported using ecstasy pills at least once a week.

The median number of ecstasy pills taken in a 'typical' or 'average' use episode in the preceding six months was two (range 0.5–6), with a small proportion of the participants (13%) typically using four or more in a single 'typical' or 'average' episode. During their 'heaviest' use episode in the preceding six months, participants reported using a median of four pills (range 1–12), with 29% of the participants typically using six or more in a single 'heavy' episode.

The KE reported a wide variety of current ecstasy use patterns amongst the ecstasy users with whom they had contact. Although ecstasy use by REU was typically considered to be restricted to weekends (which two KE described as running from Friday to Monday), KE also commented on individuals who use less frequently and more sporadically, often 'saving' themselves and their ecstasy use for larger events (such as raves or music festivals) where they were reported to binge on ecstasy and/or engage in polydrug use.

KE generally reported that REU consume ecstasy one to two times per week. Two KE noted, however, that one 'session' might last for more than twenty-four hours, particularly if users are combining ecstasy with methamphetamines. One KE noted that frequency of ecstasy use had declined, stating that whereas in previous years younger REU were consuming ecstasy every weekend, a pattern of use which was associated with behavioural problems at school, these types of problems were not as prevalent in 2006. Four additional KE reported that, in addition to ecstasy use becoming increasingly mainstream, the age of REU is decreasing.

With regard to quantity of use, KE reported that weekly users generally consume smaller amounts per session (one KE estimated one to two pills, while another reported that users 'usually' consume approximately one pill, and sometimes two to three), whereas other individuals who use less often, such as those saving ERD use for special occasions, tend to binge on ecstasy and are more likely to engage in polydrug use. One KE differed from this view, reporting that REU ingest between 2 and 8 pills per weekend, depending on the individual. As previously mentioned, one KE reported that users generally avoid polydrug use at smaller weekly club events, as opposed to larger events such as a rave. One KE estimated that some people use up to 7 pills during a binge session, while another reported a maximum of ten. One KE reported that novice users generally start with half a pill or copy an experienced friend and use the same quantity. This KE mentioned that experienced, regular users ingest up to two ecstasy pills per session.

The REU sample was asked about their routes of administration. All but one of the 2006 REU participants reported swallowing ecstasy pills in the six months preceding the interview. In addition, participants reporting snorting (69%), shelving or shafting (10%), smoking (4%) and injecting (4%) ecstasy pills during this period. The majority (94%) of the sample reported swallowing as their main route of ecstasy administration in the previous six months.

Consistent with REU sample findings, KE all reported swallowing as the main route of ecstasy pill administration. Snorting crushed pills or ecstasy powder was described by two KE as the second most popular route of administration. These KE reported that shelving ecstasy was relatively rare, and was usually only an occasional or experimental method of ingesting ecstasy. One KE noted that people might choose to shelve ecstasy as a method of hiding drugs from sniffer dogs; this notion supports information provided by three law enforcement KE, who reported there is evidence that, in response to the presence of sniffer dogs at events, some ERD users attempt to hide drugs on different parts of their bodies.

While two KE reported not knowing of any ecstasy users who inject, two KE noted that ‘some’ people choose to engage in this practice. One KE in particular reported that injecting ecstasy is an acceptable practice amongst people looking for value for money, although noting that route of administration usually depends on context of use. For example, this KE suggested that injecting ecstasy might not be appropriate for people desiring lasting effects and wanting to dance all night. This KE also noted that injection is not a popular route of administration in the rave scene because it is seen as ‘crossing the line’. This KE reported hearing of anecdotal evidence of home-based ecstasy injectors, and noted that this population of REU is difficult to access for the provision of harm minimisation information, because they are ‘not the usual NSP crowd’.

Regarding the use of ecstasy powder, two-thirds (66%) of the 2006 REU sample reported having ever used it, with first use at a median of 20 years (SD = 4.3; range 13–37). Slightly more than one-third (35%) of the 2006 REU sample reported having used ecstasy powder in the six months prior to interview. Compared to ecstasy pills, ecstasy powder was used relatively infrequently, with those reporting recent use of ecstasy powder using it on a median of two days in the preceding six months (range 1–40). Indeed, the majority (86%) of recent users reported using ecstasy powder monthly or less frequently.

Recent ecstasy powder users (n=35) quantified their use in terms of capsules, points and lines and grams. Both recent ‘typical’ and ‘heavy’ use episodes were most often reported in terms of points, with participants (n=14) reporting using a median of 1.75 points in a ‘typical’ or ‘average’ use episode in the preceding six months (range 1–3). During their ‘heaviest’ use episode in the preceding six months, participants (n=12) reported using a median of two points (range 1–4). Recent ecstasy powder users (n=35) most commonly reported recently swallowing (71%) and snorting (66%) ecstasy powder, with small proportions reporting smoking (3%) and injecting (3%) ecstasy powder in the six months prior to interview.

In line with the relatively low prevalence of ecstasy powder use within the 2006 REU sample and the low frequency of use reported by recent users, the vast majority (98%) of the REU sample reported pills as the form of ecstasy they most often used in the six months prior to interview, with only two participants reporting mostly using ecstasy powder. KE also generally reported that pills are always, or the majority of the time, the form of ecstasy used. One KE, however, reported that ecstasy powder is ‘always’ around, although indicated that this form is not as common as pills. One other KE noted that powder is becoming increasingly available and more widely used.

One KE commented on the large variety of ecstasy pill colours and designs, describing this diversity as a marketing exercise. Essentially, if pills with a certain logo and/or of a specific colour develop a good reputation, ‘that’s what users go for’. This KE indicated that variety is important for both dealers and users, and that relevant and/or amusing logos with a good reputation are always common and important for both business and use.

Table 3: Patterns of ecstasy use among REU, 2003–2006

	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Mean age first used ecstasy (years)	19	19	19	19
Ecstasy 'favourite' drug (%)	44	47	45	32
Median days used ecstasy pills last 6 months*	15	15	13	14
Use ecstasy pills weekly or more (%)	36	21	33	31
Median ecstasy pills in 'typical' session	1.5	2	2	2
Typically use >1 pill (%)	55	77	72	75
Recently binged on ecstasy (%)*	55	42	51	39
Main route of administration of ecstasy pills in the last 6 months (%)				
Swallow	85	95	86	94
Snort	10	2	13	4
Inject	3	1	1	2
Ever injected ecstasy pills (%)	27	9	9	10
Main form used last 6 months (%)**	–	–	99	98
Tablets (Pills)	–	–	1	2
Powder	–	–	0	–
Capsules	–	–	–	–
Typically use other drugs in conjunction with ecstasy (%)	97	94	97	97
Typically use other drugs to 'come down' from ecstasy (%)	84	85	88	82

Source: PDI REU interviews, 2003–2006

* Binged defined as the use of drugs for more than 48 hours continuously without sleep

** Question not asked prior to 2005, and response options modified in 2006 to 'pills' and 'powder' only

Consistent with the high levels of drug use in addition to ecstasy reported by the REU sample (see Section 3.2), most participants 'typically' (defined as on two-thirds or more occasions of their ecstasy use in the preceding six months) used other drugs in combination with ecstasy (97%) and during the 'come down' (i.e. acute recovery period) following ecstasy use (82%). Participants using drugs in conjunction with ecstasy (n=97) most commonly reported using alcohol (76%), tobacco (72%), methamphetamine powder (69%), cannabis (38%), crystal methamphetamine (18%), LSD (16%), cocaine (16%) and ketamine (8%) at the same time as ecstasy. Of those who typically drank alcohol while using ecstasy, two-thirds (66%) usually consumed more than five standard drinks.

Participants reporting using drugs during the 'comedown' from ecstasy (n=82) reported the use of a range of drugs, most frequently tobacco (70%), cannabis (65%), alcohol (45%), benzodiazepines (21%) and methamphetamine powder (13%). Of those who typically drank

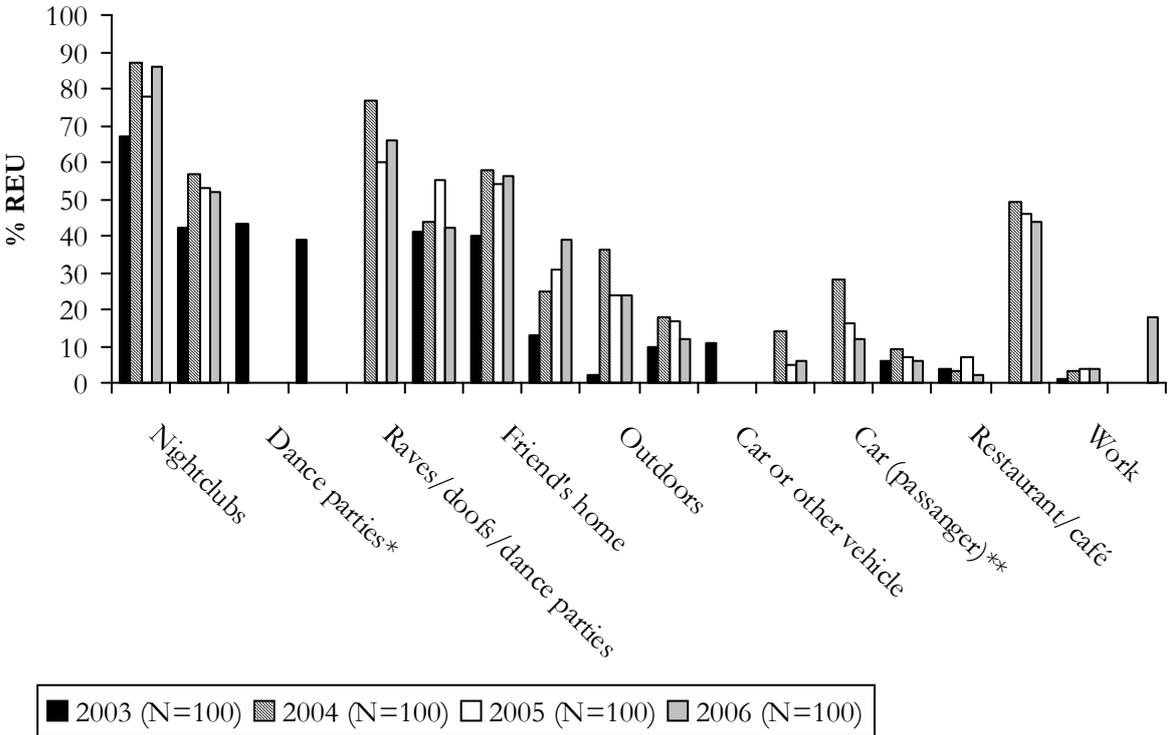
alcohol during the come down from ecstasy just over two-thirds (68%) reported usually consuming more than 5 standard drinks.

Consistent with REU sample findings, information from KE generally supported a high prevalence of polydrug use amongst ERD users. The majority of KE reported that (varying proportions) of ERD users combine ecstasy and legal (e.g. alcohol and tobacco) and/or illegal drugs (e.g. cannabis, methamphetamines). In particular, KE reported that the ecstasy users with whom they had contact commonly use cannabis, alcohol, tobacco and methamphetamine powder. KE also reported that smaller proportions of ecstasy users consume crystal meth, ketamine, GHB, LSD and cocaine. Two KE noted that some ERD users combine Viagra with ecstasy to enhance or initiate sexual experiences. Several KE reported that many users ingest drugs such as cannabis, benzodiazepines and even GHB to counter the effects of ecstasy during the comedown. ERD users in Melbourne's gay community were broadly described by one KE as being very meticulous and organised regarding the types of substances they use, how much they use, and when they consume each substance during a night out. For example, an individual may consume speed at home prior to leaving, then ingest alcohol and ecstasy when out at a nightclub, then smoke cannabis after arriving home.

One KE stated that polydrug use is more likely to occur at larger events (e.g. raves) than at smaller, weekly club events where people 'don't go as hard'. An ambulance paramedic KE highlighted the high prevalence of polydrug use amongst Melbourne's ERD-using population, stating that "*the only drug that people use in isolation is alcohol*". Finally, two KE indicated that ecstasy is often a precursor to an individual's future drug use. For example, one KE reported that an individual may try ecstasy initially, then move onto speed and possibly other substances such as ketamine, GHB and LSD.

The 2006 REU sample reported usually using ecstasy a wide range of places in the six months prior to interview (Figure 2). Consistent with previous years, the locations most commonly reported were nightclubs (86%), raves/doofs/dance parties (66%), friends' homes (56%), private parties (52%), at live music events (44%) and in their own homes (42%). 2006 REU participants also reported usually using ecstasy in pubs (39%), outdoors (24%), at day clubs (18%), in a car or other vehicle as a passenger (12%), in public places (12%) and in a car or other vehicle as a driver (6%).

Figure 2: Usual location of ecstasy use, 2003–2006



Source: REU interviews, 2003–2006

* ‘Rave’ and ‘dance party’ categories combined from 2004 onwards

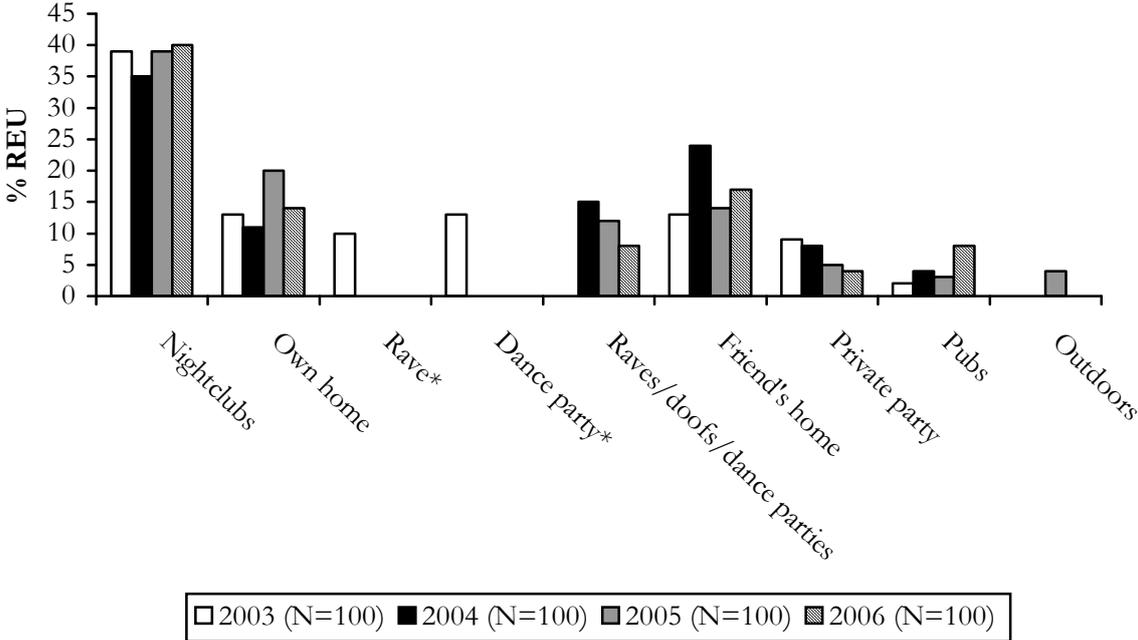
** Distinction between driver and passenger made from 2004 onwards

*** No ‘live music’ category in 2003 REU survey

**** ‘Day clubs’ category added in 2006

The 2006 REU sample most commonly reported nightclubs (40%), a friend’s home (17%) or their own home (14%) as the last venue where they used ecstasy (Figure 3). Raves/doofs/dance parties (8%), pubs (8%), private parties (4%), hotel rooms (3%) and live music events (2%) were nominated by smaller numbers of participants as the venue they last used ecstasy.

Figure 3: Location of most recent ecstasy use, 2003–2006



Source: REU interviews, 2003–2006

* 'Rave' and 'dance party' categories combined from 2004 onwards

As mentioned previously, a number of KE commented on the increasingly mainstream nature of ERD use. One KE indicated that there is no evidence of ecstasy use at major events other than raves, such as the Royal Melbourne Show or sports events where alcohol continues to be the primary drug consumed. Another KE reported that the Spring Racing Carnival is the only major event where people consume illicit drugs. Nevertheless, KE generally agreed that ecstasy use is becoming more widespread amongst the Victorian population. One law enforcement KE attributed this normalisation of ecstasy to the current cultural climate, stating that people now associate drug use with an enjoyable night out. However, two KE noted that many individuals do not go out to take ecstasy, often choosing to consume the drug at home outside the traditional ERD culture or scene. Further, one KE noted that consumption of ecstasy at house parties is not uncommon. Two KE raised concerns about people using ERD in private homes due to isolation from information about the use of these drugs, and having a lack of knowledge about harm reduction strategies.

4.3 Summary of patterns of ecstasy use

Reports from the Victorian REU and KE suggest that:

- ❖ ecstasy tends to be used for the first time during late-teens/early twenties;
- ❖ although there is a wide range of patterns of ecstasy reported by REU, ecstasy is commonly used less than weekly and most REU report using more than one tablet per episode;
- ❖ ecstasy is most commonly used orally;
- ❖ most ecstasy users use other drugs in combination with ecstasy and during ‘come down’ from ecstasy; and
- ❖ ecstasy is used in a wide range of locations, most commonly at nightclubs, dance parties/raves/doofs and private homes/parties.

4.4 Price

All but one of the 2006 REU sample were able to comment on the price of ecstasy in Melbourne during the six months preceding interview. The majority (96%) of the sample reported purchasing ecstasy in pills or tablet form, with a small number of respondents (n=9) reporting purchasing powder (in grams, points and capsules). Participants reported a median price of \$30 per ecstasy pill (range \$15–\$40; Table 4). Consistent with REU sample findings, KE cited prices for ecstasy within a \$15 to \$40 range with an average price of \$30. The price that the REU samples paid for ecstasy has remained remarkably consistent over the four years that the EDRS has been conducted in Melbourne.

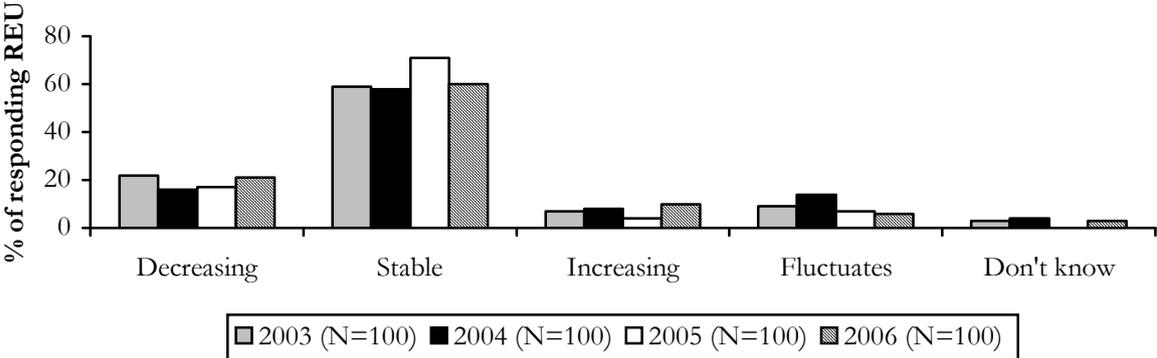
Table 4: Price of ecstasy purchased by REU, 2003–2006

	2003	2004	2005	2006
Median price per tablet (range)	\$30 (\$8-\$50)	\$30 (\$14-\$45)	\$30 (\$15-\$40)	\$30 (\$15-\$40)

Source: REU interviews, 2003–2006

Consistent with previous years, most of the 2006 REU sample reported that the price of ecstasy had remained stable in the six months prior to interview (60%), with smaller proportions reporting that the price had decreased (21%), increased (10%) and fluctuated (6%) over this time (Figure 4). The reports of the KE regarding recent price changes were comparable: three KE reported that the price of ecstasy had remained stable over the preceding 6 to 12 months, while two indicated that the price had decreased. One of these KE reported that the price of ecstasy is ‘always coming down’.

Figure 4: Recent changes in price of ecstasy purchased by REU, 2003–2006

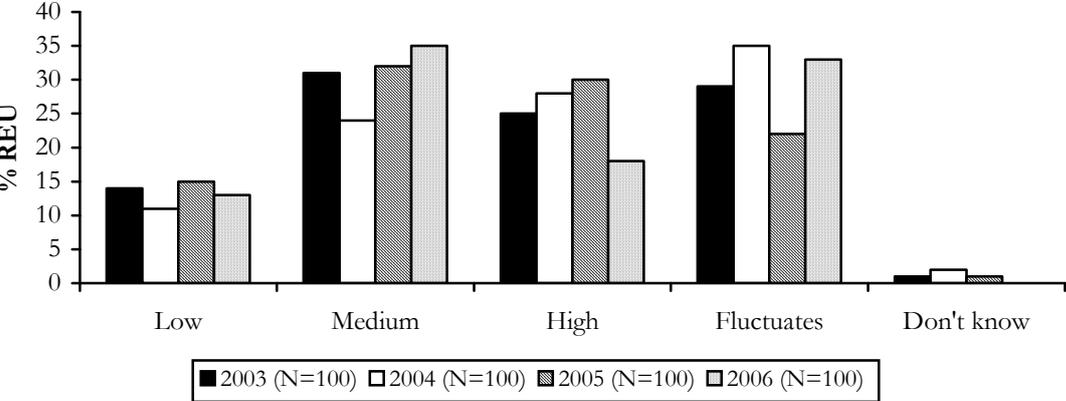


Source: REU interviews, 2003–2006

4.5 Purity

In comparison to the stability of reported ecstasy price, the purity of ecstasy is typically considered by REU as more variable. Consistent with previous years, the 2006 REU sample tended to rate the current purity of ecstasy as medium (35%) or fluctuating (33%). Only 18% reported the current purity of ecstasy as high and 13% as low (Figure 5).

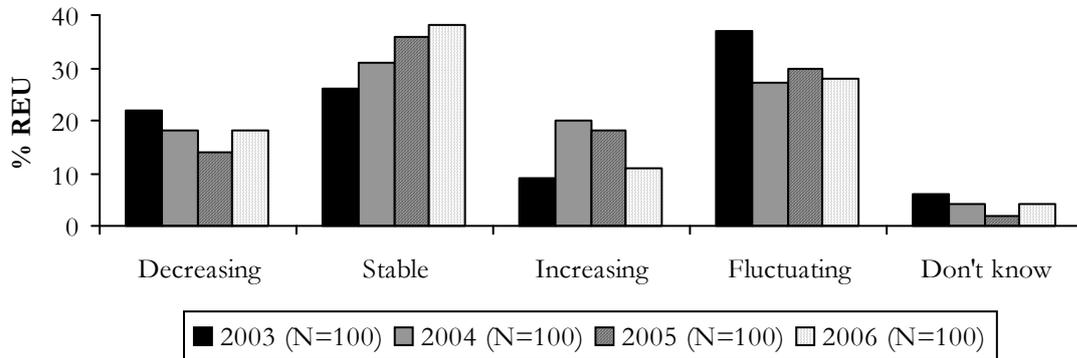
Figure 5: REU reports of current ecstasy purity, 2003–2006



Source: REU interviews, 2003–2006

As in previous years, the 2006 REU sample’s reports of changes in ecstasy purity in the preceding six months were inconsistent (Figure 6). Over one-third (38%) of the sample reported that the purity of ecstasy had remained stable over the preceding six months, with a further 28% reporting that the purity had fluctuated over this time. Smaller proportions reported that the purity had increased (11%) or decreased (18%).

Figure 6: REU reports of change in purity of ecstasy in the preceding six months, 2003–2006

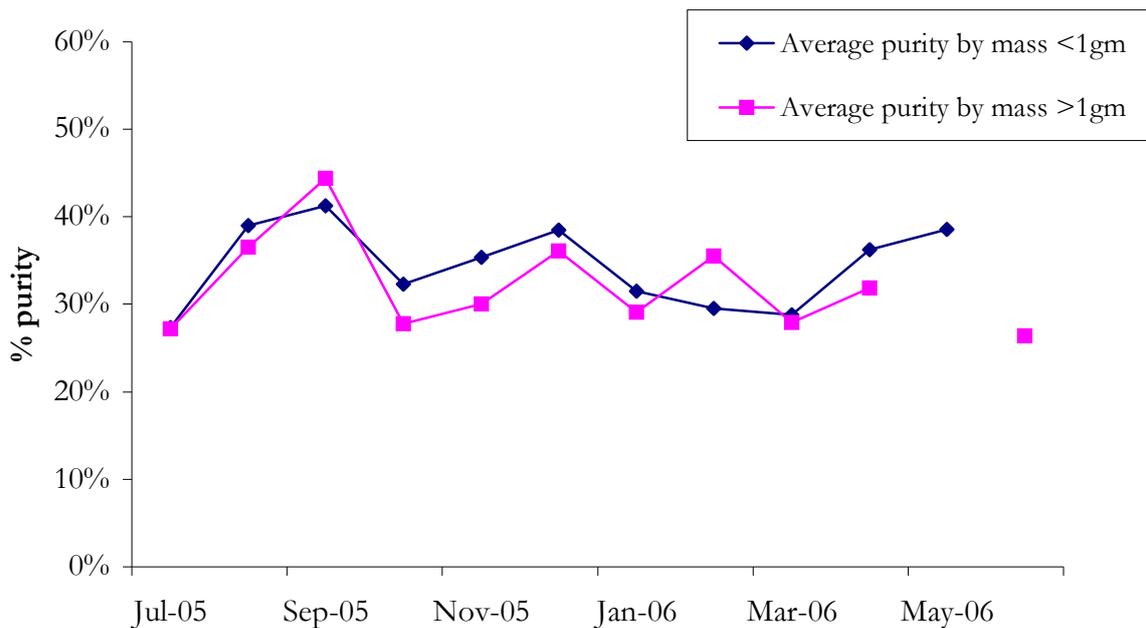


Source: REU interviews, 2003–2006

Reflecting REU sample findings, KE also provided a variable response regarding ecstasy purity. Three KE rated it as medium and stable, with another reporting it as high and fluctuating. Two KE reported that ecstasy purity had decreased despite being readily available. One law enforcement KE stated that ecstasy purity had remained relatively constant over the previous 5 to 6 years, however, demand had been so great that many fake pills had flooded the market. These fake pills were reported to contain cocktails of additional drugs or substances, including MDA, methamphetamines, ketamine and even caffeine, while some fake pills were reported to contain no MDMA whatsoever. This notion was supported by six other KE who reported that clients believed ecstasy purity to be low, forcing both KE and ecstasy users to question whether any MDMA was actually present in many so-called ecstasy pills. Nevertheless, the aforementioned law enforcement KE reported that the number of fake pills on the market was declining, with an increase in the proportion of pills containing MDMA. This KE reported that ecstasy pills usually weigh between 0.25 and 0.3 grams each, with pills currently containing between 80 and 100 mg of MDMA. This equates to a purity of approximately 30%.

The average purity level of ecstasy seizures analysed by law enforcement agencies in Victoria during the 2005/06 financial year was 33% (range 26%–44%) (see Figure 7). The average purity of ecstasy seizures was relatively stable during this 12 month period, and the overall average purity was similar to that recorded in the previous seven financial years: 30% in 2004/05, 32% in 2003/04, 30% in 2002/03, 31% in 2001/02, 31% in 2000/01, 34% in 1999/00, and 28% in 1998/99.

Figure 7: Purity of ecstasy seizures by Victorian law enforcement, July 2005–June 2006

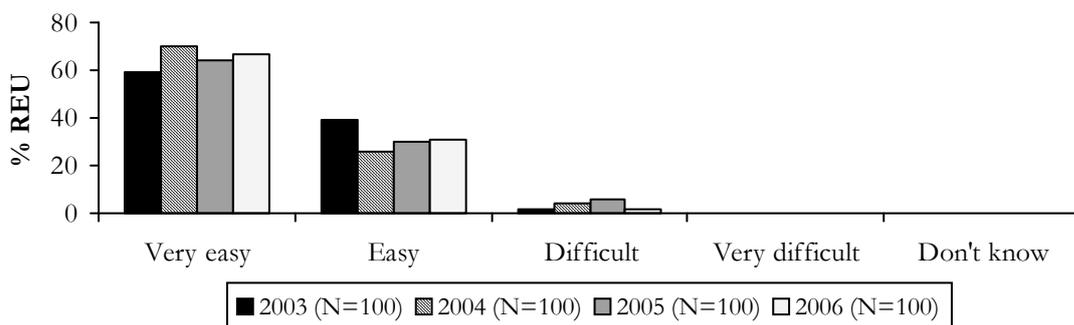


Source: Victoria Police Forensic Services Department

4.6 Availability

All but one of the 2006 REU sample were able to comment on the availability of ecstasy. Consistent with previous years, the vast majority reported that ecstasy was currently either ‘very easy’ (67%) or ‘easy’ (31%) to obtain, with only 2% reporting it as difficult to obtain (Figure 8).

Figure 8: REU reports of current availability of ecstasy in the preceding six months, 2003-2006

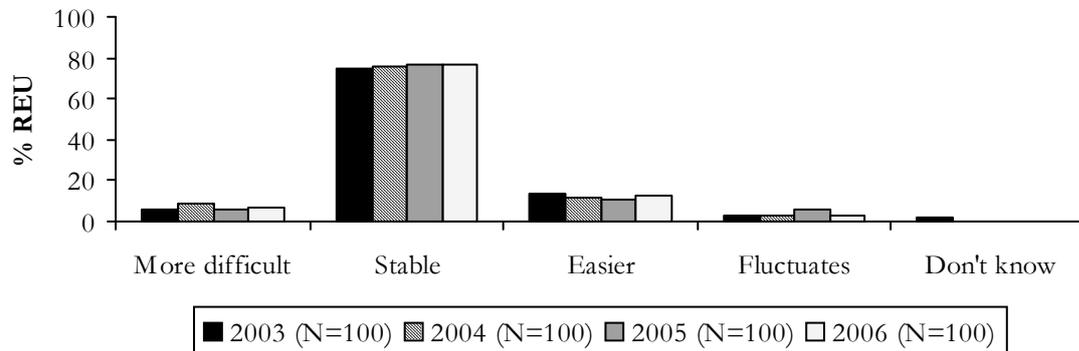


Source: REU interviews, 2003–2006

Note: The 2003 REU survey included a ‘moderately easy’ category, combined here with the ‘easy’ category

Over the last four years, the REU samples have consistently reported that the availability of ecstasy has been stable in the six-month period prior to interview: the majority of the 2006 sample reported that the availability of ecstasy had remained stable (77%) in the preceding six months and 13% reported that it had become easier to access (Figure 9).

Figure 9: REU reports of changes in availability of ecstasy in the preceding six months, 2003–2006



Source: REU interviews, 2003–2006

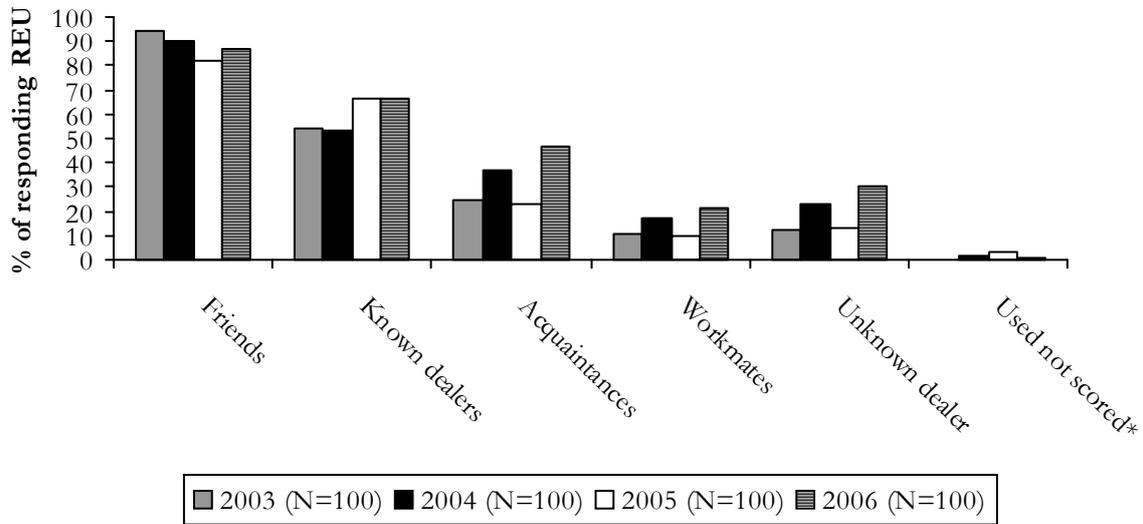
Consistent with REU sample findings, four KE reported that ecstasy pills were currently very easy to obtain. Three of these KE reported that availability had remained stable, while the fourth indicated that ecstasy had become easier to obtain during the previous 6 to 12 months. An additional law enforcement KE agreed that ecstasy availability had increased. Only one KE reported that the availability of ecstasy had decreased.

One KE from the Australian Customs Service reported that ecstasy is the main illicit drug smuggled into Australia, citing a move away from heroin importation to more ‘synthetic’ substances in recent times. Furthermore, a KE from law enforcement described the availability of ecstasy in Melbourne as ‘excellent’, emphasised by a continuing ‘insatiable demand’ for the drug in Melbourne, which was particularly demonstrated by previous seizures of ecstasy in very large quantities. This KE did, however, question whether these shipments were so sizeable simply because it might be more practical and/or economical to shift large loads. Nevertheless, an additional KE reported that a recent bust of 300 kg of ecstasy had no impact on the availability of the drug in Melbourne.

Three law enforcement KE reported that 9 out of 10 sniffer dog detections at raves are for what is generally believed to be ecstasy pills, further highlighting the high prevalence of the drug. They stated that detected drug types do differ between events (of a different genre, for example), however, ecstasy remains the most common seized drug – “*other substances pale in comparison*”. A KE working in first aid supported such reports, noting that ecstasy is usually the main drug consumed at these events. Finally, one KE reported that there is ‘plenty’ of ecstasy around, however noted that the ‘craze and hysteria’ surrounding the drug appears to have decreased in comparison to previous years.

As with previous years, the majority of 2006 REU sample reported that in the six months prior to interview they had obtained ecstasy from friends (87%) or known dealers (66%; Figure 10). Other people from whom ecstasy had recently been obtained included acquaintances (47%) and unknown dealers (30%).

Figure 10: People from whom ecstasy was purchased in the preceding six months, 2003-2006

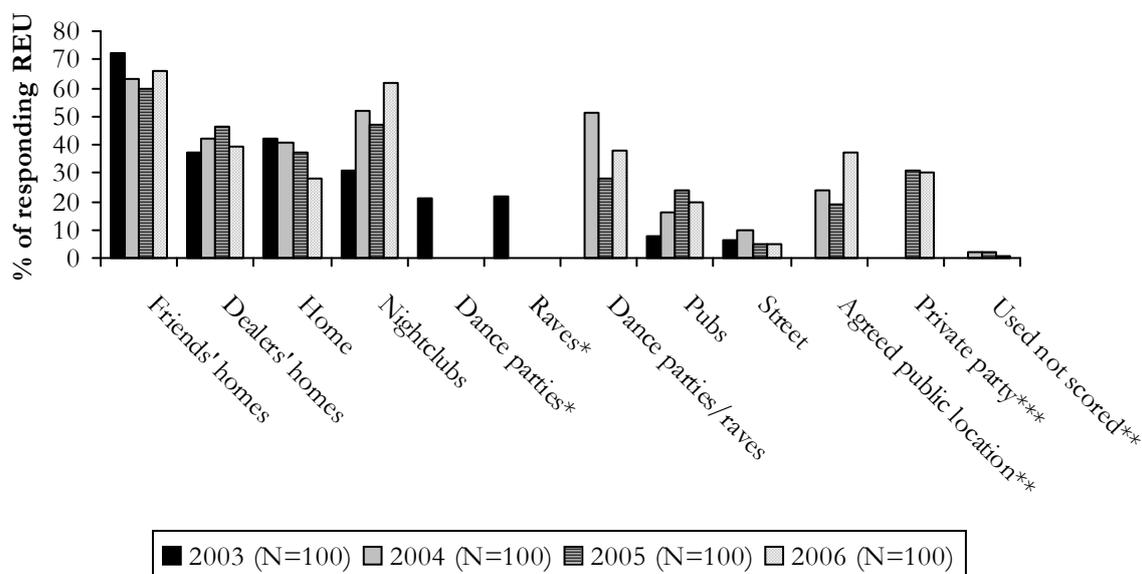


Source: REU interviews, 2003-2006

* Category not included in 2003 REU survey

The 2006 REU sample reported obtaining ecstasy in a wide range of locations, most often at friends' homes (66%), in nightclubs (62%), at dealers' homes (39%), raves/doofs/dance parties (38%), agreed public locations (37%), private parties (30%) and their own home (28%; Figure 11). Other purchase locations included pubs (20%), acquaintances' homes (13%), the street (5%), work (10%) and day clubs (9%).

Figure 11: Locations where ecstasy was purchased in the preceding six months, 2003-2006



Source: REU interviews, 2003–2006

* ‘Rave’ and ‘dance party’ categories combined from 2004 onwards

** Categories not included in 2003 REU survey

*** Day club category added in 2006

These reports, both in terms of who the REU sample purchase ecstasy from (i.e. friends and other social network members) and purchase locations (i.e. private homes), illustrate the central role that social networks play in ecstasy markets. Nevertheless, a higher proportion of the 2006 sample reported purchasing from acquaintances and unknown dealers than in previous years. This is consistent with changes in locations of most recent purchase, with nightclubs, dance parties and agree public locations more commonly reported in 2006 than in previous years.

4.7 Ecstasy markets and patterns of purchasing ecstasy

The 2006 REU sample reported that they had scored ecstasy from a median of three different people in the preceding six months. The majority (78%) of the sample reported typically purchasing ecstasy for themselves and others, and purchasing a median of six ecstasy pills (range 1–50) each occasion. One KE reported that ‘9 out of 10’ ERD users purchase from friends, and also buy ecstasy in bulk for friends.

When discussing ecstasy markets in relation to Melbourne’s gay community, one KE stated that dealing is present at gay-orientated dance parties, although it is not as prevalent as it is at mainstream events. This KE reported that people in the gay ERD-using community tend to be more organised, buying before they go out or attend an event, or simply ‘borrowing’ drugs from other people or friends when aware of a police presence. It was reported that people seeking to buy ERD at gay-orientated events are usually ‘out-of-towners’. In reference to the wider community, three law enforcement KE also reported that most people take their own drugs to events, with only some intending to buy drugs at the venue.

Over three-quarters (77%) of the REU sample reported being able to obtain other drugs from their main ecstasy dealer. Other drugs identified by these participants as being available from

their main dealer included methamphetamine powder (86%), cannabis (60%), crystal methamphetamine (36%), cocaine (33%), ketamine (21%) and LSD (21%).

Table 5: Patterns of purchasing ecstasy, 2005–2006

	2005 (N=100)	2006 (N=100)
Median no. of people purchased from	3	3
Purchased for (%)		
Self only	18	21
Self and others	80	78
Others only	1	0
No. of times purchased in the last 6 months (%)		
1-6	32	37
7-12	45	38
13-24	16	22
25 +	4	1
Median no. of ecstasy tablets purchased	5	6
Able to purchase other drugs from main dealer (%)	77	77
Drugs able to purchase (%)*		
Speed	87	86
Base	8	3
Ice	30	36
Pharmaceutical Stimulants	4	3
Cocaine	27	33
MDA	7	8
LSD	29	21
GHB	3	10
Ketamine	26	21
Cannabis	53	60
Heroin	3	1

Source: REU interviews, 2005–2006

* Among those who reported being able to purchase other drugs from main dealer

4.8 Ecstasy related harms

4.8.1 Law enforcement

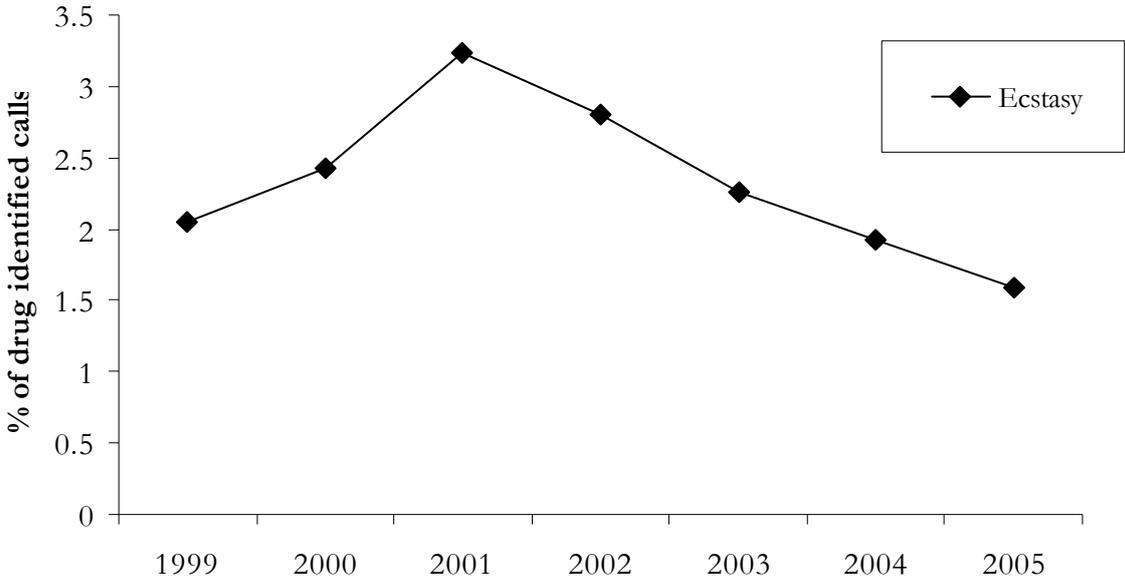
No Victorian ecstasy-specific law enforcement indicator data is available.

4.8.2 Health

DirectLine calls

During 2005, DirectLine responded to 401 calls where ecstasy was identified as a drug of concern. This represents less than two percent of all drug-identified calls to DirectLine in that year (Turning Point Alcohol and Drug Centre Inc., unpublished data). The proportion of drug-related calls where ecstasy was identified has steadily declined since 2001 (see Figure 12).

Figure 12: DirectLine calls where drug of concern identified as ecstasy, 1999–2005



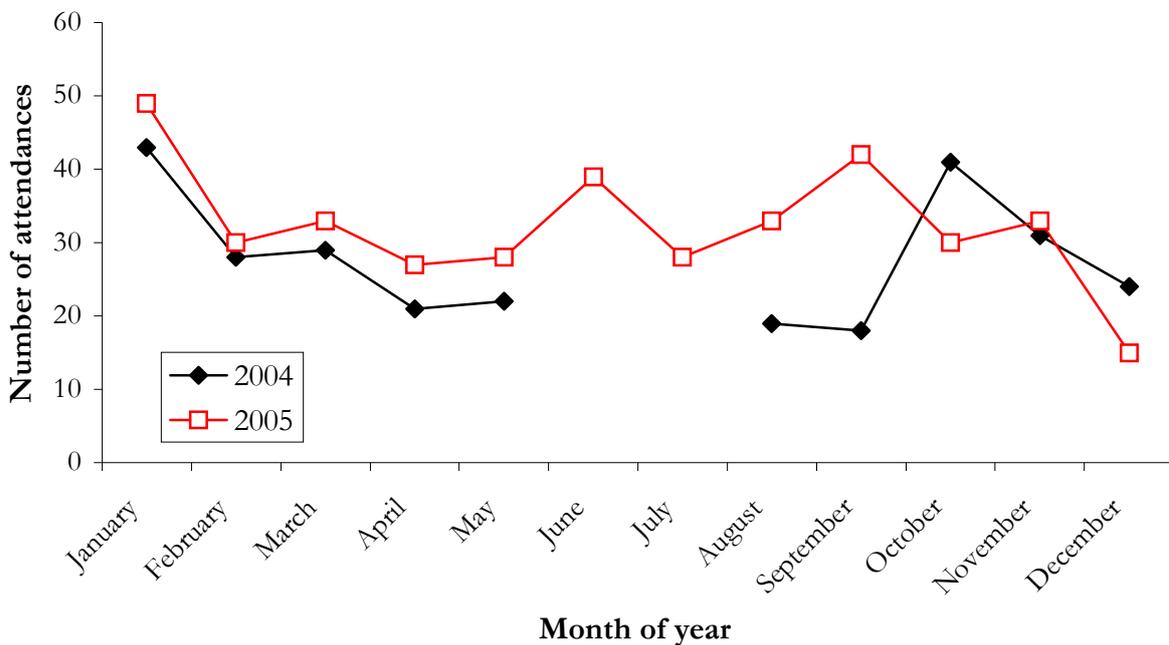
Source: DirectLine, Turning Point Alcohol and Drug Centre Inc (unpublished data).

Ecstasy-related events attended by ambulance

Figure 13 reports the monthly totals of ambulance attendances where ecstasy use was mentioned in Melbourne, 2004–2005 (excluding June–July 2004). Ambulance attendances where ecstasy use was recorded ranged between approximately 20–50 per month during 2004–2005, peaking in January each year.

In 2005 there were a total of 387 attendances where ecstasy use was mentioned, a larger number than in previous years (N=276 in 2004, N=191 in 2003, and N=174 in 2002). In 2005 the average estimated age of cases was 23 years, which is comparable to previous years (24 years in 2004 and 25 years in 2003) (analysis by S. Cvetkovski, Turning Point Alcohol and Drug Centre).

Figure 13: Monthly totals of ambulance attendance where ecstasy was mentioned in Melbourne, 2004–2005 (excluding June–July 2004)



Source: Metropolitan Ambulance Service and Turning Point Alcohol and Drug Centre

KE generally reported low levels of health problems amongst the ecstasy users they were aware of. Consistent with the nature of their work, however, those KE in first aid/treatment/clinical roles reported two broad categories of health problems associated with ERD use: acute health problems and general mental health concerns. Two first aid KE reported that drug-related presentations had increased, while a KE working in an accident and emergency department reported that ecstasy-related presentations had decreased. One of these first aid workers did indicate, however, that at large-scale music events or festivals, many people presenting with drug-related problems would have been transferred to hospital in the past, whereas now ‘most’ are treated onsite. It is possible that this accounts, at least in part, for the hospital worker’s perceived decrease in ecstasy-related presentations.

Those KE providing harm reduction, first aid or treatment services (n=5) for people attending events reported a wide range of concerns experienced by ecstasy users, from headaches/migraines and high blood pressure and pulse rates, to hypothermia, ‘bad trips’, nausea, vomiting, sore jaws, dehydration, palpitations and respiratory distress or arrest (i.e. patients are unconscious and/or unresponsive). One KE described the problem of hyponatremia, which is essentially an over-consumption of water leading to a loss of sodium in the body. This can produce symptoms including headaches, nausea, vomiting and convulsions, among others. Two KE mentioned the occurrence of problems not directly related to drug consumption, such as dance-related injuries, with one KE indicating that cuts and insect bites are also common at events particularly in rural settings that may run over multiple days. This KE also reported that ERD-using attendees of such music festivals often only get very small amounts of sleep while eating little to no food, which can result in both physical and mental harms. Another KE mentioned that the general health of REU gradually deteriorates with prolonged, regular ecstasy use, primarily due to a lack of awareness about looking after themselves. In addition to music festival attendees, this KE noted that diet is an issue of concern for REU, stating that when they

eat, they usually only eat junk food. KE indicated that overdoses resulting solely from ecstasy consumption were uncommon.

Some licensed venues were also criticised by KE for the lack of free or cheap water accessible to patrons. Three KE commented on this issue; all maintained that the current voluntary guidelines concerning free or cheap water are not effective in minimising harms associated with ERD use in club environments without an adequate supply of water. Two KE reported a need for mandatory guidelines to address the problem. In addition, one KE indicated that free or cheap water is essential at outdoor music events or festivals.

As previously mentioned, KE indicated that people are often more likely to binge and engage in polydrug use at larger events in comparison to smaller, weekly club events. Consequently, KE noted that harms tend to be more numerous and evident at these large-scale events, such as raves and music festivals. Polydrug use was described as particularly problematic by five KE, with harms ranging from sex risks to crime and mental health issues.

KE (n=14) also listed acute mental health issues resulting from the use of ERD, including hallucinations, paranoia, anxiety and drug-induced psychosis. One KE discussed the mental health issues experienced by REU in the aftermath of a drug-using session, such as depression and 'terrible Tuesdays'. This KE reported being asked 'a few questions' regarding the use of antidepressants to combat such effects, noting that people usually state that they are asking on behalf of a friend or simply to obtain 'general' information. An ambulance paramedic KE reported that they were beginning to see individuals with mental health issues using drugs, indicating that they were 'expanding' their existing problems. One KE reported treating people with hysteria following polydrug use, while another mentioned that people experiencing psychosis associated with polydrug use might engage in criminal activities and get into trouble with the law.

4.9 Benefit and risk perception

Participants were asked to describe the benefits and risks they perceived to be associated with their own use of ecstasy.

4.9.1 Perceived benefits

The vast majority of the 2006 REU sample (98%) reported that they perceive there are benefits associated with ecstasy use, with the remaining two participants reporting that they 'didn't know'. In general, the perceived benefits concerned enhanced social and interpersonal experiences and the emotional and physical effects of the drug (Table 6). The most commonly mentioned benefits were enhanced communication (40%), enhanced closeness/bonding/empathy with others (39%), fun (37%) and enhanced mood (such as euphoria, a sense of well-being and happiness; 30%).

Table 6: Perceived benefits of ecstasy use among those who commented, 2006

Benefit (%)	2006 (N=98)
Enhanced communication/talkativeness/more social	40
Fun	37
Enhanced mood	30
Increased confidence/decreased inhibitions	11
Enhanced closeness/bonding/empathy with others	39
Increased energy/stay awake	24
Relax/escape/release	11
Enhanced appreciation of music and/or dance	16
Enhanced sexual experience	7
The high/rush/buzz	12
Different to effects of alcohol	10
Drug effects	13
Feelings in control/focused	7
Cheap	0
Other	16
None	0

Source: REU interviews, 2006

4.9.2 Perceived risks

The majority (96%) of the 2006 REU sample also reported on risks they perceived to be associated with their own use of ecstasy. Equal proportions of participants (55%) listed physical and psychological harms as the most common risks. Physical harms specified by participants included unspecified physical harms (26%), dehydration (11%), and general acute physical harms, while psychological harms included depression (25%), unspecified psychological harms (11%), paranoia (6%), and anxiety/panic (5%; Table 7). Potential neuropsychological harms listed by participants included damage to brain function (17%), memory impairment (13%), and cognitive impairment (8%). Concerns about the contents of ecstasy tablets, such as unknown contaminants (22%) and unknown strength or purity (7%) were also mentioned as a potential source of harm. In addition, impaired decision making (including sex risk and consuming more drugs than intended) and fatal (7%) and non-fatal (15%) overdoses were also identified as risks associated with ecstasy use by participants.

Table 7: Perceived risks of ecstasy use among those who commented, 2006

Risk (%)	2006 (N=96)
Physical harm (effects on physical health)	55
Psychological harm (effects on mental health)	55
Neuropsychological harms	38
Harms related to illicit status (unknown purity/ contaminants)	29
Overdose (fatal or non-fatal)	22
None	0
Impaired decision making	20
Addiction/ dependence	2
Legal problems	6
Unknown long-term risks	3
Financial problems	4
Employment problems	4
Social/relationship problems	5
Driving risk	0
Increased vulnerability	2
Unsure	0
Aggression/violent behaviour	1
Other	15

Source: REU interviews, 2006

4.10 Summary of ecstasy trends

Reports from the Victorian REU and KE suggest that:

- ❖ ecstasy typically costs \$30 per pill;
- ❖ the price of ecstasy has remained stable since 2003;
- ❖ ecstasy is perceived by REU to be of medium or fluctuating purity;
- ❖ ecstasy remains readily available and is predominantly sourced from friends or known dealers in private residences and nightclubs;
- ❖ the majority of ecstasy users can purchase drugs other than ecstasy from their dealers, most commonly speed and cannabis;
- ❖ the perceived benefits of ecstasy use include enhanced communication/sociability and bonding and fun; and
- ❖ the perceived risks of ecstasy use include psychological/mental health concerns, physical harms and neuropsychological harms.

5 METHAMPHETAMINE

5.1 Methamphetamine use in the general population

The 2004 NDSHS provides the most recent national figures regarding the prevalence of methamphetamine use in the Australian general population. This survey indicates that in 2004 3.2% of the Australian population aged 14 years and over had recently (in the last 12 months) used methamphetamine (Australian Institute of Health and Welfare, 2005). The most recent data available regarding the prevalence of methamphetamine use in the general population of Victoria also comes from the 2004 NDSHS. According to the findings of this survey, 2.8% of the Victorian population aged 14 years and above had used methamphetamine within the twelve months prior to interview (Australian Institute of Health and Welfare, 2005).

It is noteworthy that, as with ecstasy use, nationally the highest prevalence of both 'lifetime' (21.1%) and 'recent' (10.7%) methamphetamine use was reported by the 20–29 year old age group (Australian Institute of Health and Welfare, 2005). Figures from the most recent Victorian Youth Alcohol and Drug Survey (Premier's Drug Prevention Council, 2005), are comparable with these findings: of the 16–24 year olds surveyed (n=6,005), 15% reported having ever used methamphetamine in their lifetime, and 10% reported use in the 12 months prior to survey. The VYADS provides evidence of the relatively infrequent use of methamphetamine among this younger age group: among recent methamphetamine users, just over one-third (35%) reported using approximately once a month or more frequently, just over a quarter (29%) reported using 'every few months', less than a quarter (22%) reported using once or twice a year and 14% reported having only used methamphetamine on one occasion (Premier's Drug Prevention Council, 2005). According to the VYADS, methamphetamine powder (87%) and crystal methamphetamine or ice (19%) were the most commonly used forms of methamphetamine by respondents, and were most commonly snorted (72%), swallowed (59%) or smoked (23%) (Premier's Drug Prevention Council, 2005). Evidence from the 2004 NDSHS suggests a median age of first methamphetamine use of 20.8 years (Australian Institute of Health and Welfare, 2005).

5.2 Methamphetamine use among REU

5.2.1 Methamphetamine Powder (Speed)

All the 2006 REU sample reported lifetime methamphetamine powder (speed) use and the majority (91%) had used speed in the preceding six months (Table 8). The median age of first use for speed was 18 years (range 12–35). Ten participants nominated speed as their drug of choice.

Those participants that reported speed use in the preceding six months (n=91) had used it on a median of 12 days (range 1–120), with over one-third (36%) using speed once a month or less, and nearly two-thirds (64%) using it fortnightly or less. Fifteen percent of recent speed users used speed more than fortnightly, but less than once per week and slightly more than one-fifth (21%) used it once per week or more.

Thirty-six participants reported their 'typical' or 'average' use episodes in terms of grams and fifty-one reported their 'heaviest' use episodes in the preceding six months in terms of grams: the median amount used in a 'typical' episode was 0.5 gram (range 0.25–1) and the median amount used in the 'heaviest' session was one gram (range 0.25–4).

Table 8: Patterns of methamphetamine powder (speed) use among REU, 2003–2006

Speed	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Ever used (%)	98	98	97	100
Used preceding six months (%)	89	92	85	91
Of those who had used				
Median days used last 6 months (range)	8 (1–170) (n=89)	7.5 (1–150) (n=92)	10 (1–80) (n=85)	12 (1–120) (n=91)
Median quantities used (grams)				
Typical (range)	0.5 (0.1–5) (n=23)	0.5 (0.13–1) (n=23)	0.5 (0.05–1) (n=35)	0.5 (0.25–1) (n=36)
Heavy (range)	1 (0.1–14) (n=43)	1 (0.25–4) (n=40)	1 (0.01–5) (n=48)	1 (0.25–4) (n=51)

Source: REU interviews, 2003–2006

The majority of participants who reported using speed in the past six months (n=91) said they snorted it (87%). Swallowing (67%), smoking (49%) and injecting (10%) were other routes of speed administration reported by the 2006 REU sample.

As may be expected given its stimulant effects, over two-thirds (69%) of those participants (n=97) who reported typically using drugs in conjunction with ecstasy reported that they usually used speed in conjunction with ecstasy, whereas only 13% of those reporting use of drugs during the comedown from ecstasy (n=82) reported usually using speed during this period. Further, the vast majority (91%) of those who reported bingeing (n=44) in the six months prior to interview, reported typically using speed when doing so.

Although the patterns of speed use were generally comparable over the four years of data collection, characterised by high prevalence of use and relatively high frequency of use, a considerably higher proportion of the 2005 and 2006 samples reported smoking speed (45% and 49%, respectively) than the 2003 (20%) and 2004 (6%) REU samples.

Twenty-one KE reported the use of speed by the REU of whom they were aware, reporting use by proportions ranging from ‘a few’ to ‘most’. One KE from law enforcement reported that speed powder is the most common form of methamphetamine used by ERD users. As some KE did not distinguish between the three forms of methamphetamine their comments concerning methamphetamines are included in this section of the report.

One KE reported an increase in the use of speed powder and attributed this largely to its increased availability, while another reported a decreased use of speed, insisting that although powder used to be the most common form of methamphetamine used, “*nobody wants it anymore*” due to an increased popularity of crystal methamphetamine or ‘ice’. Another KE acknowledged reports that REU have stopped using speed in favour of crystal meth, however dismissed this notion due to increased hype regarding crystal meth and the possibility that some users might be unable to distinguish between different forms of methamphetamine. Eight KE indicated that methamphetamine use had generally increased, while another KE working in an accident and emergency department reported that methamphetamine presentations had remained stable.

Only a few KE (n=5) commented on route of administration regarding speed, with one reporting that snorting was the most common route and another indicating that ‘a lot’ of ERD users preferred to smoke the substance. Indeed, five KE reported the use of ‘smokable’ speed, with

four reporting that use of this form of speed had increased. In contrast to the majority of the REU sample, two KE reported that their client bases consisted mostly of speed injectors, while another noted that most of their clients chose to inject with a significant proportion smoking speed. Two of these KE also commented on ‘smokable’ speed, however, distinguishing this route of administration from the ingestion of speed powder. An additional two KE remarked that methamphetamine use, in particular, crosses ‘population boundaries’ and is used by a variety of social groups, reflecting the different types of administration routes people use to consume speed.

KE reported that methamphetamine use was generally recreational, with one stating that bingeing on weekends is common. Two KE mentioned, however, that there is a group of methamphetamine users who consume the substance more frequently. This group was described by the KE as tending “*not to be highly functional socially*”, reflected by, for example, a failure to maintain long-term commitments, such as employment and relationships. Further, a KE working with drug diversion clients reported that approximately half of these individuals have a speed ‘habit’ to some degree, using the substance up to twice a week in some cases. However this KE asserted that such users are still able to maintain a ‘normal’ life, which may include employment and stable relationships.

5.2.2 Methamphetamine Base

Slightly fewer than one-third of the 2006 REU sample (32%) reported that they had ever used methamphetamine base (base) and only 12% reported using base in the preceding six months (Table 9). The median age of first use for base was 20 (range 17–36).

Those participants that reported using base in the preceding six months (n=12) had done so on a median of four days (range 1–15). Base was used relatively infrequently in the preceding six months, with most (75%) respondents reporting using it less than once a month. Base was only used by two of those participants that reported they typically used other drugs in conjunction with ecstasy (n=97), and none of those participants reporting use of the drug during comedown reported using base during this period (n=82). Of those who reported bingeing in the preceding six months (n=44), three participants had used base when doing so.

Of those who reported using base during the preceding six months, eight quantified their average and six quantified their heaviest episodes of use in terms of points. The median amount of base used in a ‘typical’ episode was two points (range 0.5–4) and the median amount used in the ‘heaviest’ session was two and a half points (range 0.5–8).

The majority (75%) of participants that reported using base in the preceding six months (n=12) had swallowed it. Over half (58%) reported snorting it, with 33% reporting smoking base and 8% reporting injecting it in the previous six months.

Table 9: Patterns of methamphetamine base use among REU, 2003–2006

Base	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Ever used (%)	50	45	34	32
Used last six months (%)	27	34	21	12
Of those who had used				
Median days used last 6 months (range)	4 (1–52)	2.5 (1–48)	3 (1–70)	4 (1–15)
Median quantities used (points)				
Typical (range)	1 (0.13–3) (n=15)	1 (0.25–5) (n=26)	1.25 (0.5–3) (n=14)	2 (0.5–4) (n=8)
Heavy (range)	1 (0.5–11) (n=16)	1 (0.5–5) (n=19)	2 (0.5–3) (n=13)	2.5 (0.5–8) (n=6)

Source: REU interviews, 2003–2006

The patterns of base use are comparable over the four years that data has been collected in Victoria, reflecting relatively low levels of lifetime and recent use in the REU samples, and low frequency of use by those reporting recent use.

Few KE (n=6) were able to comment on the use of methamphetamine base amongst Melbourne’s ERD-using population. One KE reported that ‘a lot’ of REU are smoking base. In contrast, another KE reported no current use by REU, while another stated that they were not aware of base being sold in Melbourne during the previous twelve months. Two law enforcement KE commenting on methamphetamine clandestine laboratories in Victoria reported ‘certainly’ seeing base, however, the indicated that the main form of methamphetamine at these laboratories was speed powder. Finally, one KE reported that some people are confused about the type of methamphetamine they are using, suggesting that individuals are using base and thinking that it is crystal meth.

5.2.3 Crystal Methamphetamine

Nearly three-quarters (73%) of the 2006 REU sample reported having ever used crystal methamphetamine (crystal meth) and just fewer than half (49%) reported using crystal meth in the preceding six months (Table 10). The median age of first use for crystal meth was 21 years (range 15–37). Six participants nominated crystal meth as their drug of choice.

Those participants that reported use of crystal meth in the preceding six months (n=49) had done so on a median of 5 days (range 1–48). Crystal meth was used relatively infrequently in the preceding six months, with most (69%) participants using it once a month or less, 8% more than once a month but less than fortnightly and 22% using crystal meth more than fortnightly. Eighteen percent of those participants reporting typically using other drugs in conjunction with ecstasy (n=97) reported usually using crystal meth with ecstasy and only five percent of those participants that reported typically using drugs during the comedown from ecstasy (n=82) reported typically using crystal meth during this period. Of those participants who reported bingeing in the preceding six months (n=44), over half (57%) reported that they had used crystal meth when doing so.

Of those who reported using crystal methamphetamine during the preceding six months, most quantified their average (n=32) and heaviest (n=26) use in terms of points. The median amount of crystal methamphetamine used in a ‘typical’ episode was 2 points (range 0.25–3). The median amount used in the ‘heaviest’ session was also 2 points (range 0.5–8; Table 10). Small numbers of participants also referred to the use of grams, lines, pipes and ‘burns’.

Most (84%) participants that reported using crystal methamphetamine in the preceding six months had smoked it. Slightly less than one-third (31%) reported snorting crystal methamphetamine, over one-quarter (29%) reported having swallowed it, 16% of recent users reported injecting crystal methamphetamine in the past six months and one participant reported shelving it.

Table 10: Patterns of crystal methamphetamine use among REU, 2003–2006

Crystal methamphetamine	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Ever used (%)	75	71	71	73
Used last six months (%)	62	52	42	49
Of those who had used				
Median days used last 6 mths (range)	6 (1–60) (n=62)	5.5 (1–96) (n=52)	4.5 (1–100) (n=42)	5 (1–48) (n=49)
Median quantities used (points)				
Typical (range)	1 (0.25–3) (n=42)	1 (0.5–5) (n=40)	1 (0.13–5) (n=28)	2 (0.25–3) (n=32)
Heavy (range)	2 (0.5–6) (n=33)	1 (0.5–4) (n=31)	2 (0.5–5) (n=26)	2 (0.5–8) (n=26)

Source: REU interviews, 2003–2006

Although ‘lifetime’ prevalence of use has been consistent across the four years of data collection, there has been some fluctuation in terms of prevalence of recent use: following a decrease from 2003 to 2005, there was a slight increase in 2006 levels of recent use, although not returning to 2003 levels. It is important to note, however, that the frequency of recent use has remained relatively stable and low across the four years.

Twenty KE commented on the use of crystal meth, or ‘ice’, amongst ERD users. Three KE reported that ‘a few’ REU use the substance, while two reported exclusively on users with crystal meth as their primary drug. Six KE indicated that use of crystal meth was increasing, with one suggesting that increased use might be a result of increased availability, while two KE reported that use of crystal meth remained stable.

Ten KE acknowledged that REU were reporting increased use of crystal meth, however, questioned whether these reports were entirely accurate. A significant amount of media coverage in 2006 caused some KE to wonder whether so-called ‘ice’ users were simply succumbing to the hype regarding the drug and using a ‘buzz word’, as described by one KE. Other KE questioned whether users were confusing crystal meth with other forms of methamphetamine (and vice versa); as previously mentioned, one KE suggested that people were using base and thinking it was crystal meth. An ambulance paramedic KE further questioned the idea of an ‘ice epidemic’, reporting that cases of the stereotypical, ‘true’ crystal meth user (a ‘house-destroying person’) were less common than the media suggested. An additional KE noted that many clients were

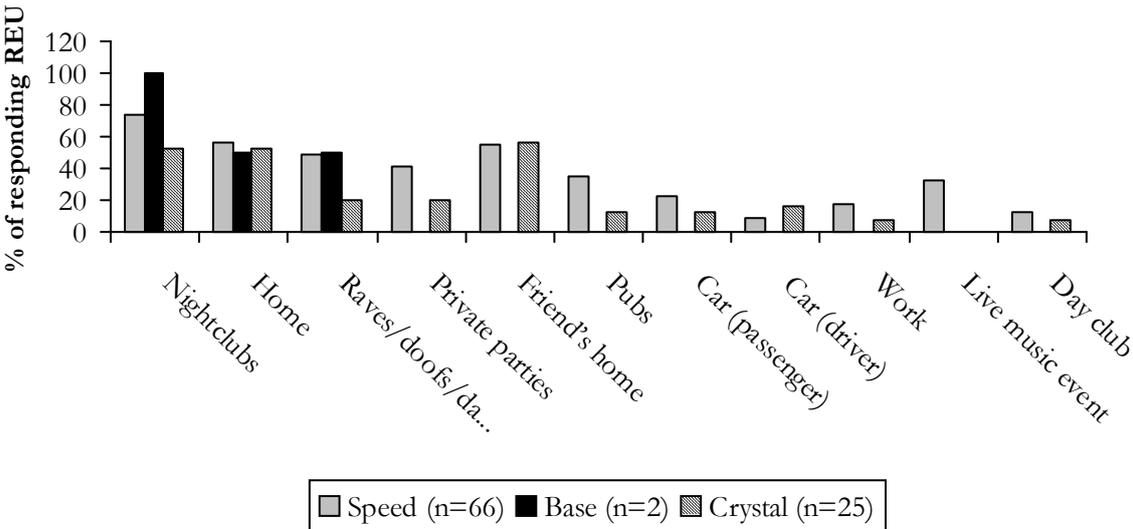
reporting the use of crystal meth, however, their behaviour was not representative of that associated with crystal meth use, which this KE described as typically volatile and violent.

Consistent with REU sample findings, smoking was the main route of ice administration reported by five KE, with three reporting that a small proportion of crystal meth users also injected, and one KE reporting that a minority chose to snort. Three law enforcement KE reported an increase in the detection of meth pipes at dance parties. As described below (see Section 5.6), KE reported a range of harms associated with the use of crystal methamphetamine.

5.2.4 Location of methamphetamine use

Participants reported using methamphetamines in a wide range of locations (Figure 14). Sixty-six participants reported on venues in which they had used speed in the six months prior to interview, most commonly reporting using it in nightclubs (74%), their own home (56%) and friends’ homes (55%). The use of speed at raves/doofs/dance parties (49%) and private parties (41%) was also commonly reported. Those participants reporting on their usual locations of crystal meth use (n=25) also commonly reported friend’s home (56%), their own home (52%), and nightclubs (52%). Only two participants commented on usual location of base use, with nightclubs being the only location that both participants reported.

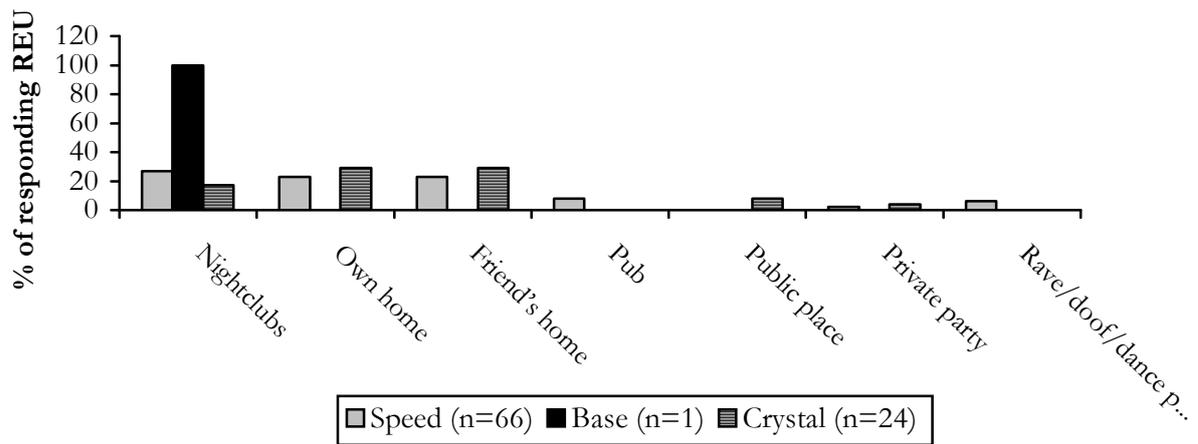
Figure 14: Location of usual methamphetamine use by form, 2006



Source: REU interviews, 2006

Consistent with the variability in reports of usual locations of use, the 2006 REU sample most commonly reported nightclubs (powder: 27%; base: 100%; crystal: 17%), their own home (powder: 23%; crystal: 29%) and friend’s home (powder: 23%; crystal: 29%; Figure 15). Please note that only one participant reported on their last location of base use. One KE commented on locations of crystal meth use and divided users into two groups: those who use crystal meth and go out clubbing all weekend, attending between five and ten clubs, and those who use crystal meth and ‘stay at home and have sex’.

Figure 15: Location of most recent methamphetamine use by form, 2006



Source: REU interviews, 2006

5.3 Price

Two-thirds (66%) of the 2006 REU sample was able to comment on the current price of speed (Table 11). Forty-five participants commented on the price of speed per gram, with a median of \$200 (range \$80–\$250) reported. The other commonly mentioned amount of speed was one point (n=19), with a median of \$20 (range \$20–\$60) reported.

Only two participants from the 2006 REU sample were able to comment on the price of base, and as such, these findings must be interpreted with caution. Both participants commented on the price of methamphetamine base in terms of grams, both reporting a price of \$250 per gram.

One-quarter (25%) of the sample were able to comment on the price of crystal meth. Twelve participants reported on the price of crystal meth per point, with a median of \$47.50 (range \$25–\$50). Thirteen participants reported the price of crystal meth in terms of grams, with a median price of \$360 (range \$200–\$400) per gram.

Table 11: Price of various methamphetamine forms purchased by REU, 2003–2006

Median price (\$)	2003	2004	2005	2006
Speed				
Point	\$30 (\$15–\$50) (n=30)	\$25 (\$15–\$50) (n=34)	\$30 (\$20–\$50) (n=16)	\$20 (\$20–\$60) (n=19)
Half gram	–	\$95 (\$80–\$120) (n=4)	\$100 (\$50–\$130) (n=11)	–
Gram	\$180 (\$30–\$300) (n=33)	\$180 (\$50–\$250) (n=34)	\$180 (\$100–\$280) (n=46)	\$200 (\$80–\$250) (n=45)
Ounce	–	–	\$1300 (n=1)	–
Base				
Point	\$32.50 (\$20–\$230) (n=10)	\$28.75 (\$25–\$50) (n=6)	\$22.50 (\$20–\$25) (n=2)	–
Half gram	–	\$110 (\$100–\$120) (n=2)	–	–
Gram	–	\$200 (\$160–\$270) (n=3)	\$200 (\$170–\$300) (n=4)	\$250 (n=2)
Crystal				
Point	\$40 (\$20–\$50) (n=29)	\$40 (\$25–\$50) (n=20)	\$40 (\$25–\$40) (n=5)	\$47.50 (\$25–\$50) (n=12)
Half gram	–	\$150 (\$125–\$180) (n=4)	\$120 (n=1) –	–
Gram	\$300 (\$200–\$400) (n=13)	\$290 (\$120–\$400) (n=11)	\$385 (\$200–\$550) (n=12)	\$360 (\$200–\$400) (n=13)
Quarter ounce	–	–	\$2,450 (n=1)	–

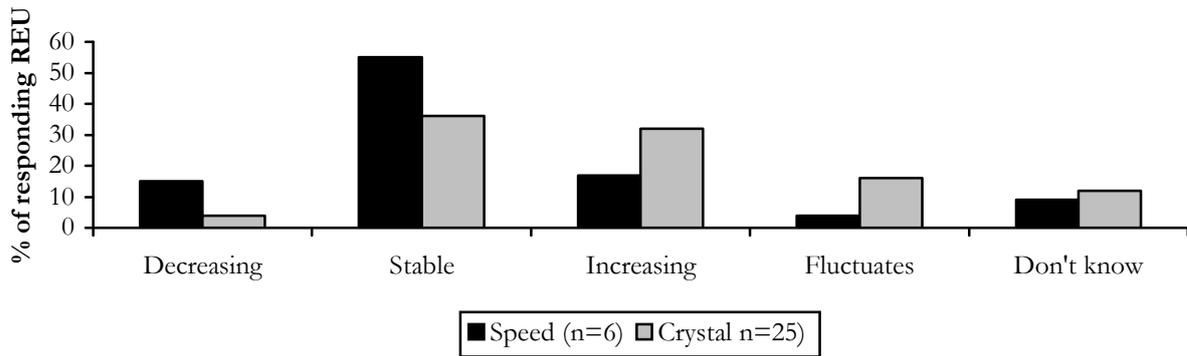
Source: REU interviews, 2003–2006

Of the 66 participants from the 2006 REU sample who commented on the price of speed over the preceding six months, over half (55%) reported that it had remained stable, 17% reported it had increased and 15% reported decreases in the price of speed (Figure 16). None of the 2006 REU sample were able to comment on the price of base over the preceding six months. Of the 25 participants who were able to comment on the price of crystal meth over the preceding six months, just over one-third (36%) reported the price of crystal meth had remained stable, with just less than one-third (32%) reporting that it had increased and 16% reporting that it had fluctuated.

One KE reported that the price of methamphetamines as a whole had fluctuated over the last 6 to 12 months. Three KE commented on the price of crystal meth. One reported a range of \$350 to \$500 for one gram, noting that price “*depends on who you know*”. This KE reported that a bump or point of crystal meth can cost \$10, although two other KE reported a range of \$50 to \$60 per point. These two KE noted that the price of crystal meth had remained stable over the last 6 to 12 months.

Two KE suggested that the popularity of crystal meth among some REU might be attributed to its price. One of these KE compared the price of ice and its effects to those of ecstasy, stating that one ecstasy pill might cost \$30 and last for 8 hours, whereas one point of crystal meth might cost \$50 and last for multiple days. This KE proposed, therefore, that people might be attracted to crystal meth because it demonstrates “*better value for money*”.

Figure 16: Recent changes in price of various methamphetamine forms purchased by REU, 2006

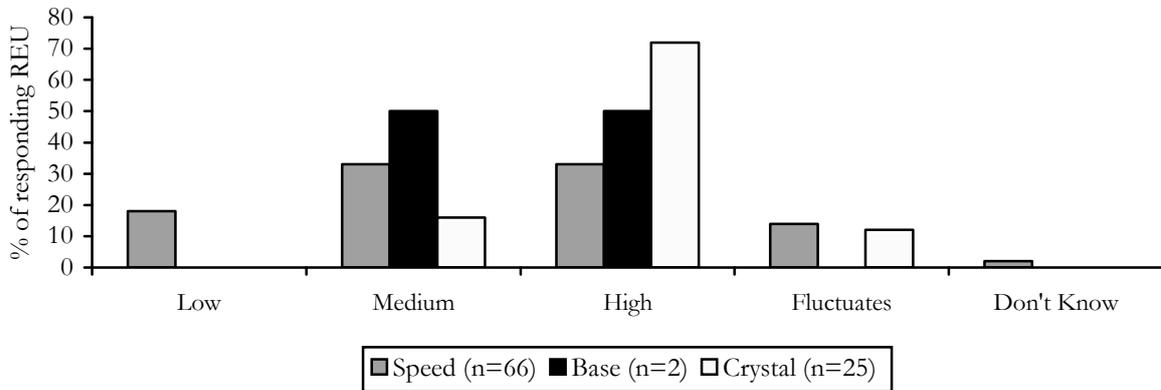


Source: REU interviews, 2006

5.4 Purity

Estimates of the purity of the three forms of methamphetamine varied (Figure 17). Of those participants able to comment (n=66), one-third (33%) reported the current purity of speed as high, one-third (33%) rated it as medium and 18% reported it as fluctuating. Only two participants commented on the current purity of base, with one reporting it as high and the other reporting it as medium. Given that only two participants responded, the reports regarding the purity of base need to be interpreted with caution. Of those who responded (n=25), the majority (72%) rated the current purity of crystal meth as high, with a further 16% rating it as medium.

Figure 17: User reports of current methamphetamine purity, 2006

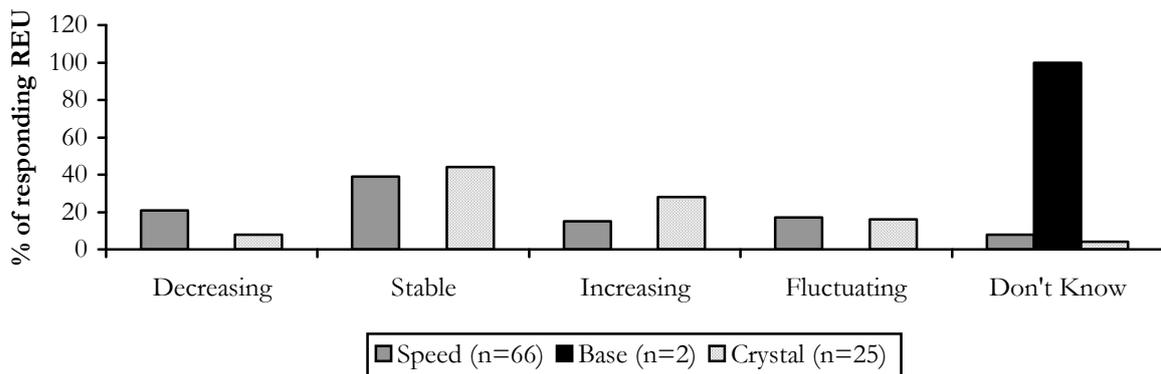


Source: REU interviews, 2006

The REU subjective reports regarding the purity of the three forms of methamphetamine are consistent with the KE reports, suggesting that the purity of crystal meth is higher than that of the other forms. One law enforcement KE reported that the purity of crystal meth seized was currently 50%, while another reported a range of 20% to 40%. This second KE also reported on purities of other forms of methamphetamines, stating that speed powder ranged from 15% to 20%, while methamphetamines in tablet form ranged from 1% to 5%. An additional law enforcement KE noted that purities of methamphetamines ranged between 3.5% and 5% at street level, to 70% in clandestine laboratories.

Over one-third (39%) of the 2006 REU sample able to comment on the purity of speed in the six months prior to interview (n=66) reported that it had been stable, 21% reported that it had decreased, 16% that it had fluctuated and 15% that it had increased (Figure 18). The two participants that commented on base reported that they did not know about the changes in purity over the preceding six months. Of the 25 respondents able to comment on changes in the purity of crystal methamphetamine, nearly half (44%) reported that it had been stable, 28% that it had increased and 16% that it had fluctuated.

Figure 18: User reports of changes in methamphetamine purity in the past six months, 2006



Source: REU interviews, 2006

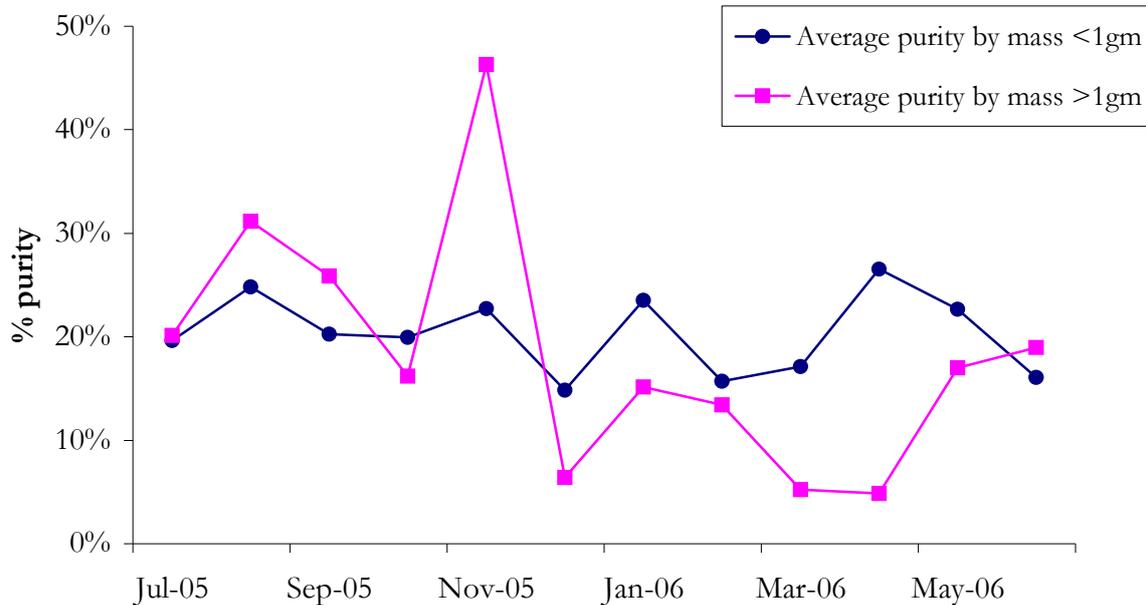
One KE reported that the purity of methamphetamines had generally remained stable. Four KE commented on purity changes regarding crystal meth. One reported that the purity of crystal meth had increased during the previous 6 to 12 months and was currently high, one indicated that the purity had remained stable, and a further two KE reported that the purity of crystal meth had decreased.

The mean purity of <1gm and >1gm methamphetamine seizures by law enforcement agencies in Victoria during 2005/2006 financial year is shown in Figure 19. All Victorian seizures are tested for purity. As shown in Figure 19, the average purity of smaller seizures (<1gm) was relatively stable over the 12-month period, while the average purity of the larger (>1gm) seizures was more variable.

The mean purity of all seizures of methamphetamine analysed in Victoria during the 2005/2006 financial year was 19% (range 5%–46%), compared to 21% reported in 2004/2005, 31% reported in 2003/2004, 33% reported in 2002/2003, 20% reported in 2001/2002 and 21% in 2000/2001 (Jenkinson & O’Keeffe, 2006).

There were very few amphetamine seizures (as opposed to methamphetamine seizures) made by law enforcement agencies in Victoria during 2005/2006 financial year. The purity of the small amount of amphetamine seized was generally very low (< 10%). (Victoria Police Forensic Services Department: unpublished data).

Figure 19: Average purity of methamphetamine seizures by Victorian law enforcement, July 2005–June 2006



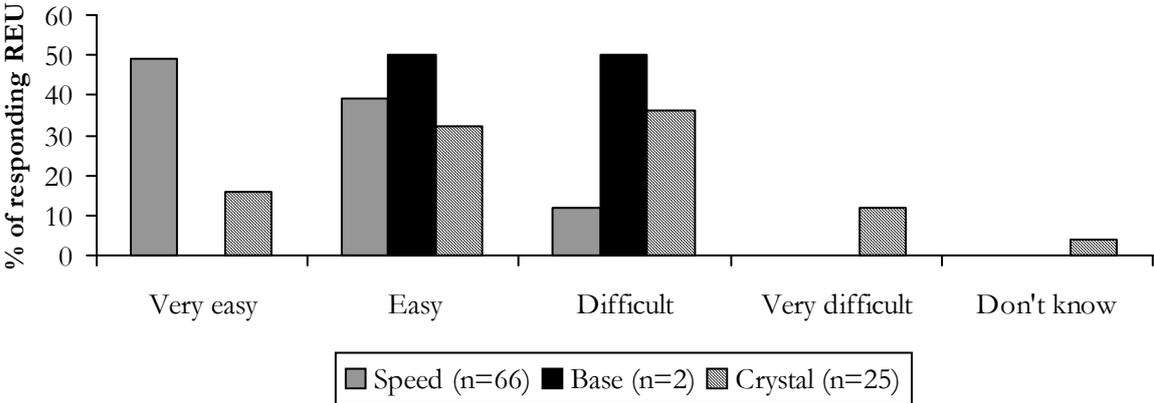
Source: Victoria Police Forensic Services Department

A number of KE (n=9, of which eight were from law enforcement) discussed the increasing prevalence of the substance dimethyl sulphone, a unique methamphetamine cutting agent that emerged on the scene in early 2006. KE theories concerning the exact properties and function(s) of the substance varied considerably (ranging from a substance used to give speed powder the appearance of ice, to a substance used to ‘hasten’ the effect(s) of the drug), however, all agreed that at the basic level dimethyl sulphone was simply a cutting agent, thereby decreasing the purity of methamphetamine.

5.5 Availability

The reported current availability varied across the three types of methamphetamines (Figure 20). Of those who commented on the availability of speed (n=66), the majority (88%) reported it as being ‘very easy’ (49%) or ‘easy’ (39%) to obtain. The reports of the two participants who commented on the availability of base (n=2) were inconsistent, with one reporting it as ‘easy’ and the other as ‘difficult’ to obtain. In contrast to the reported relative ease of availability of speed, of those who commented on the availability of crystal meth (n=25), slightly fewer than half (48%) reported it as ‘difficult’ (36%) or ‘very difficult’ (12%) to obtain, with the same proportion (48%) reporting crystal meth as ‘easy’ (32%) or ‘very easy’ (16%) to obtain. Comparing the availability of the different types of methamphetamine is problematic because of the variable and relatively small numbers of participants able to respond, particularly in relation to base. There does appear to be a trend, however, for speed to be more readily available than the other two forms of methamphetamine.

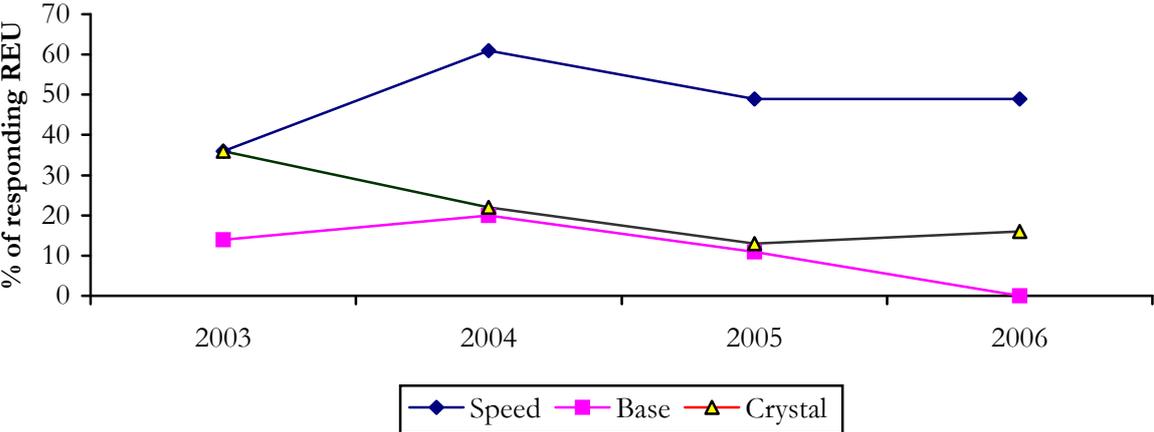
Figure 20: Current availability of methamphetamine forms, 2006



Source: REU interviews, 2006

Figure 21 presents the proportion of REU from the 2003 to 2006 samples that reported each of the three forms of methamphetamine as ‘very easy’ to obtain. Consistent with the patterns of recent use reported earlier (i.e. fluctuations in the prevalence of recent crystal meth use: see Table 10), the availability of crystal methamphetamine (as indicated by reports of ‘current availability’) appears to have declined between 2003 and 2005, with a slight increase in 2006 (Figure 21). Speed remains reportedly easier to obtain than other forms of methamphetamine (i.e. base and crystal).

Figure 21: Changes to current availability over time: proportion of REU who report various forms of methamphetamine as ‘very easy’ to obtain at the time of interview in Melbourne, 2003–2006

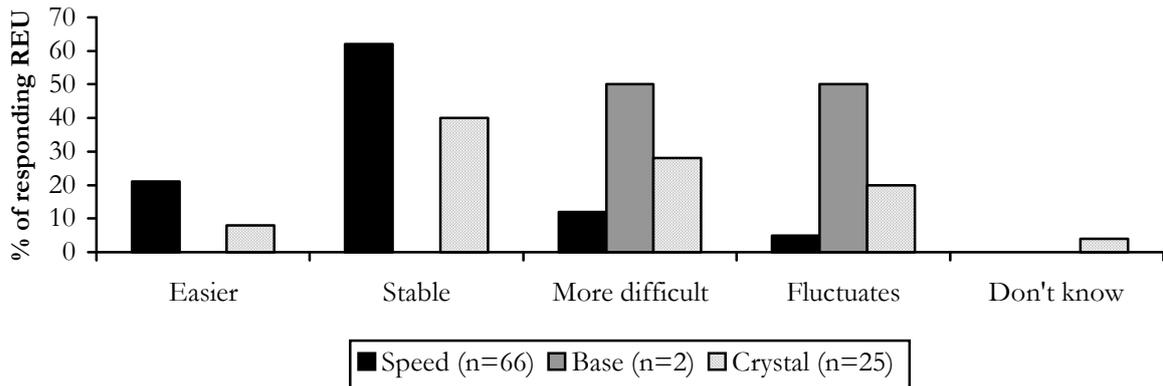


Source: REU interviews, 2003–2006

Of those able to comment (n=66), nearly two-thirds (62%) reported that the availability of speed had remained stable over the preceding six months, while nearly one-quarter (21%) reported it had become ‘easier’ obtain over that period of time (Figure 22). The reports of two participants that commented on the availability of base in the preceding six months were inconsistent, with

one reporting that it had become ‘more difficult’ and the other that availability had fluctuated. Participants’ (n=25) reports concerning the availability of crystal meth in the preceding six months also varied: 40% reported that it had remained stable, just over one-quarter (28%) reported it had become ‘more difficult’ and one-fifth (20%) reported that availability had fluctuated.

Figure 22: Change in the availability of three forms of methamphetamine in the preceding six months, 2006

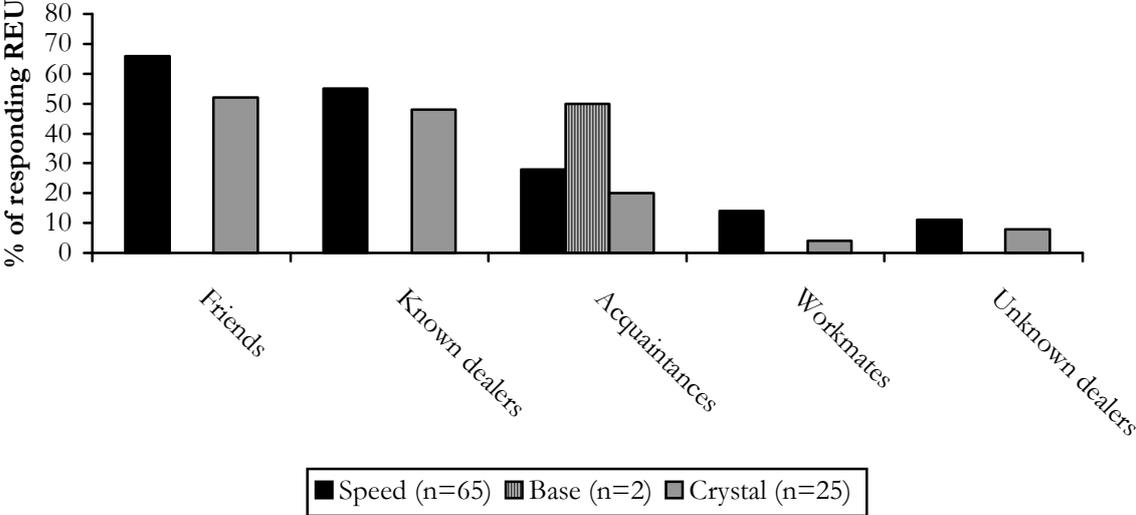


Source: REU interviews, 2006

Of those KE able to comment on methamphetamine availability, one reported that methamphetamines were ‘easy’ to obtain, another reported that their availability was currently ‘good’, and one KE noted that methamphetamine availability had remained stable during the previous 6 to 12 months. In reference to crystal meth, one KE stated that it was easy to obtain, while a second KE reported that ice was very easy to obtain and becoming easier.

Although participants reported purchasing speed and crystal meth from a range of people, friends (speed 66%; crystal meth 52%) and known dealers (speed 55%; crystal meth 48%) were most commonly reported (Figure 23). One participant reported that although they had used base in the preceding six months, they had not personally purchased it, and the other reported having purchased base from acquaintances. Given the small number of respondents, the findings regarding base must be interpreted with caution.

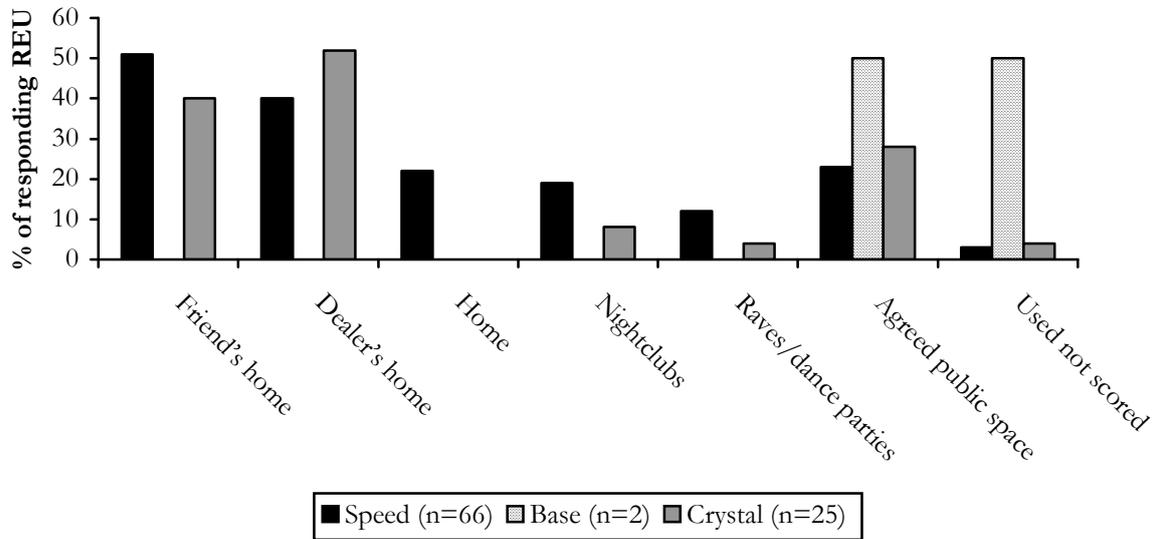
Figure 23: People from whom methamphetamine powder, base and crystal was purchased in the preceding six months, 2006



Source: REU interviews, 2006

The range of venues in which participants reported purchasing methamphetamines were consistent with the types of people from whom participants reported purchasing methamphetamines (Figure 24). Both speed and crystal meth were most commonly purchased at friends' homes (speed 51%; crystal meth 40%), dealers' homes (speed 40%; crystal meth 52%), and agreed public locations (speed 23%; crystal meth 28%). One KE reported that there is no street market for speed in Melbourne, insisting that the majority of it is sold in clubs. As reported above, of the two REU participants reporting on their purchasing patterns of base, one reported using but not personally scoring base, with the other reporting purchasing base in agreed public locations.

Figure 24: Locations where methamphetamine purchased in the preceding six months, 2006



Source: REU interviews, 2006

5.6 Methamphetamine related harms

5.6.1 Law enforcement

Table 12 details consumer (e.g. possession/use) and provider (e.g. trafficking/ manufacture) arrests for amphetamine-type stimulants, during 2004/2005 (in Victoria and Australia). During that financial year just over one-fifth (22%) of the arrests made in Australia for amphetamine-type stimulant offences occurred in Victoria (data provided by the Australian Crime Commission).³ In Victoria the total number of consumer and provider arrests for amphetamine-type stimulants remained relatively stable since 2003/2004 (N=2,240 in 2003/2004).

³ Proportions (%) should be interpreted with caution due to the lack of uniformity across states and territories in the recording and storing of data on illicit drug arrests.

Table 12: Amphetamine-type stimulants: consumer and provider arrests, Victoria and national, 2004/2005⁺

	Victoria (n)	Australia (n)	% of national arrests
Consumer	1,515	7,285	20.8
Provider	659	2,696	24.4
TOTAL*	2,174	10,056	21.6

Source: Australian Crime Commission

*Includes those offenders for whom consumer/provider status was not stated

+ 2005/2006 data not available at the time of publication

Seven law enforcement KE reported an increase in the number of methamphetamine clandestine laboratories discovered in Victoria in the last 12 months. KE noted that these labs were situated throughout the state in both rural and urban areas, though they noted that it is virtually impossible to provide any general demographics regarding specific locales and the type of people who create the labs, primarily due to the diverse range of locations they have been discovered in (both affluent and working-class suburbs, for example), and the variety of people responsible for them. Sizes of clan labs reportedly range from smaller, ‘Beavis and Butthead’ or ‘Mum and Pop’ laboratories, to much larger laboratories associated with organised crime. Most of these KE reported that speed powder was the primary type of methamphetamine produced/discovered at these laboratories, though crystal meth and base were sometimes present.

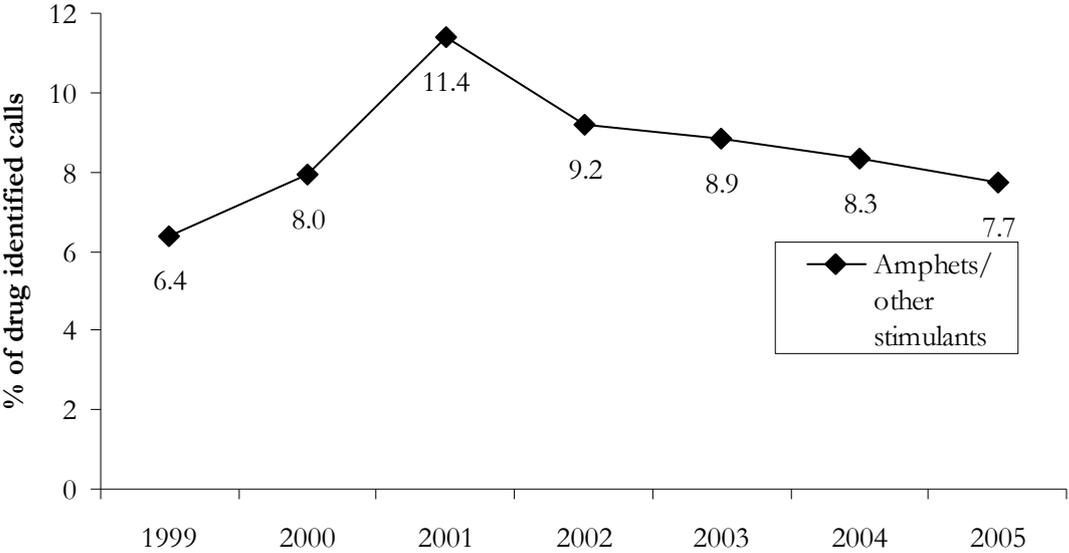
To counter the rising number of methamphetamine laboratories discovered in Victoria, one law enforcement KE reported that ‘Project Stop’, an initiative targeting pseudoephedrine diversion, is going to be implemented in Victoria in 2007. Project Stop is a collaboration between police and pharmacists which involves the monitoring and restriction of sales of precursor chemicals (primarily pseudoephedrine) in pharmacies. Project Stop is already operational in Queensland. In addition, legislation was introduced in January 2006 restricting the commercial sale of pseudoephedrine to packets containing less than 720mg of pseudoephedrine tablets in total (http://www.police.vic.gov.au/content.asp?Document_ID=6690, sourced 2 February 2007).

5.6.2 Health

DirectLine calls

During 2005 DirectLine responded to 1,942 calls where amphetamines and/or other stimulants were identified as a drug of concern. This represents eight percent of all drug-identified calls to DirectLine in that year (Turning Point Alcohol and Drug Centre Inc., unpublished data). The proportion of drug-related calls where amphetamines and/or other stimulants were identified has gradually declined since 2001 (see Figure 25).

Figure 25: DirectLine calls where drug of concern identified as amphetamines and/or other stimulants, 1999–2005



Source: DirectLine, Turning Point Alcohol and Drug Centre Inc (unpublished data)

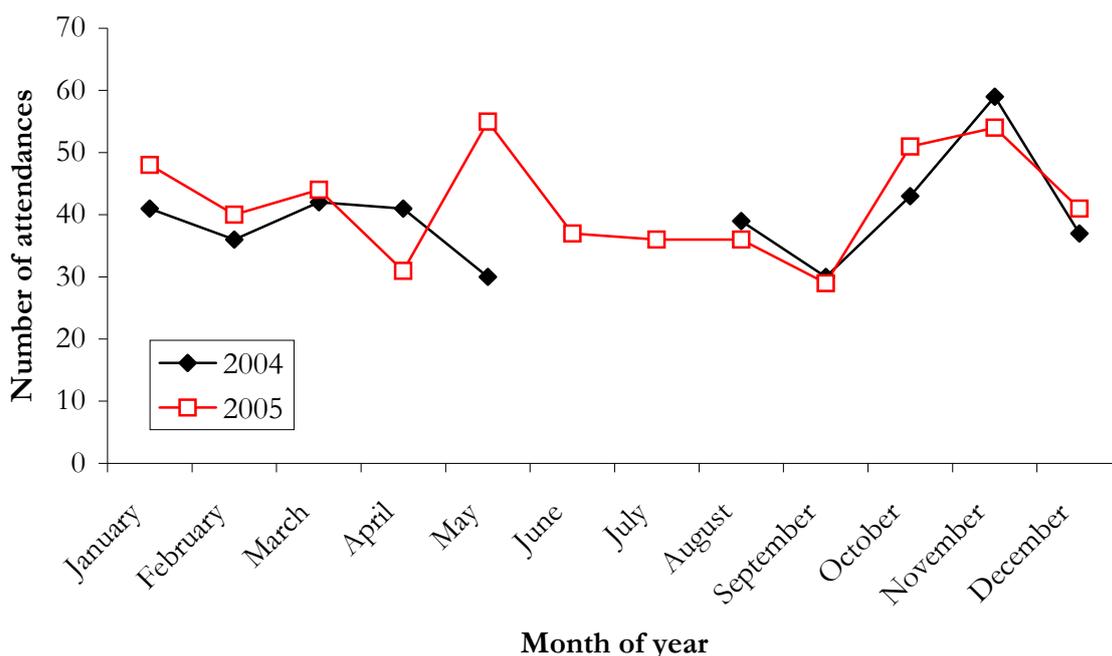
KE reported a number of concerns associated with methamphetamine use, particularly in relation to the use of crystal meth. Mental health issues were a primary concern for KE, ranging from users becoming slower, unmotivated and irrational following a weekend methamphetamine binge session, to drug-induced psychosis and increased violent and aggressive behaviours generally associated with frequent and/or prolonged methamphetamine use. One KE working with drug diversion clients reported an influx of methamphetamine users into involuntary treatment, while another KE reported an increase in shared case work with mental health organisations associated with increased methamphetamine use.

Additional problems associated with methamphetamine use were poor general health, eating disorders (“they’re all anorexic”), general skin problems (e.g. acne) and increased sex risks such as engaging in unprotected sex, thereby increasing the risk of contracting blood borne viruses (BBVs). One KE reported that methamphetamine users sometimes frequent gambling venues when intoxicated. This KE hypothesised that repetitive movements (citing the pokies as an example) might help with the drug effects and/or the comedown. An additional KE noted that some people were taking extreme measures to transport meth pipes into venues, describing the case of one individual who entered a venue with a glass pipe (inside a condom) up his rectum.

Amphetamine-related events attended by ambulance

The database maintained by Turning Point also records other drugs (in addition to heroin) that are mentioned in a patient care record (PCR). However, in contrast to heroin overdose, where there are definitive clinical symptoms of overdose (such as pinpoint pupils and a positive response to naloxone), these cases are only reported when the drug names are recorded by the ambulance officers on the PCR. Therefore, the figures reported here should only be interpreted as indicators and would significantly under-report the actual number of people seen by ambulance officers who had used these drugs.

Figure 26: Monthly totals of ambulance attendance where amphetamines were mentioned in Melbourne, 2004–2005 (excluding June–July 2004)



Source: Metropolitan Ambulance Service and Turning Point Alcohol and Drug Centre

Figure 26 reports the monthly totals of ambulance attendances where amphetamine use was mentioned in Melbourne, January 2004–December 2005 (excluding June–July 2004). Ambulance attendances where amphetamine use was recorded were relatively stable, ranging between approximately 30–60 per month during this time. In 2005 there were a total of 502 attendances where amphetamine use was mentioned, and in 2004 there were a total of 398. In 2005 the average estimated age of cases was 28 years and in 2004 it was 27 years (analysis by S. Cvetkovski, Turning Point Alcohol and Drug Centre).

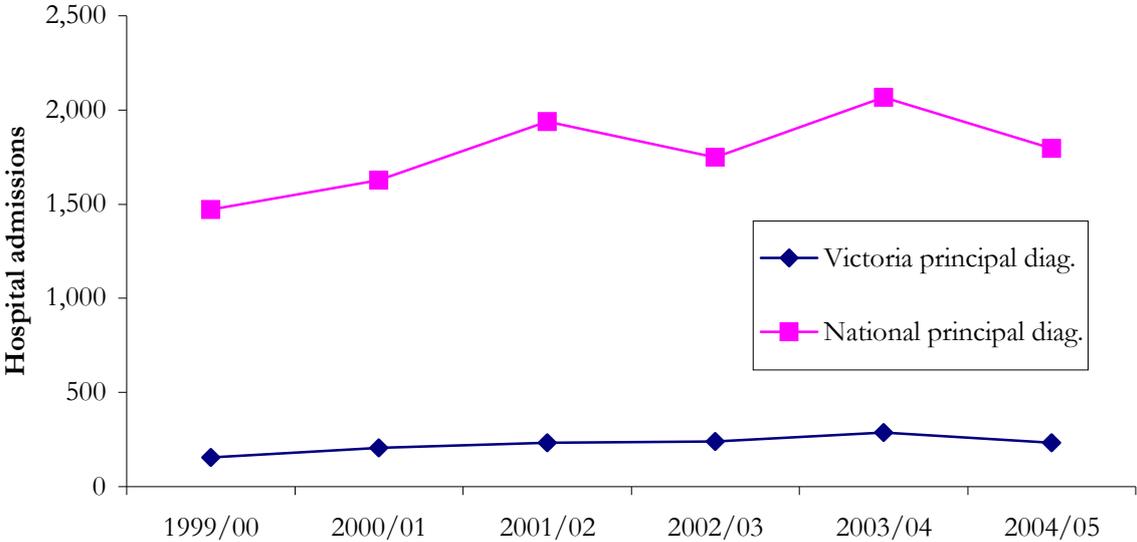
Ambulance paramedic KE listed a number of acute health problems associated with methamphetamine use. One KE reported generally seeing acute physical harms such as increased heart rate and blood pressure, sore jaws and hyponatremia, in addition to acute mental harms (usually associated with binge use) including paranoia, drug-induced psychosis and anxiety. Although not as common as the aforementioned health concerns, this KE noted that frequent methamphetamine users experience the greatest health risks, such as ‘meth mouth’ (with symptoms including a dry mouth, tooth decay, cracked teeth and gum disease) and a decline in social functioning. Another KE reported anecdotal evidence of an increase in the number of

people ‘freaking out’ as a result of methamphetamine use, adding that there has been a slight increase in methamphetamine-related events attended by ambulance personnel.

Hospital admissions

The National Hospital Morbidity Database (NHMD) is compiled by the Australian Institute of Health and Welfare. Amphetamine-related hospital admissions for Victoria and Australia (among persons aged 15–54 years) are presented in Figure 27. It is evident from this data that the number of amphetamine-related hospital admissions has generally been stable–increasing over the period of analysis, although a slight decrease was observed in 2004/05.

Figure 27: Amphetamine-related hospital admissions, Victoria and National, 1999/00–2004/05



Source: Roxburgh & Degenhardt (2006); Australian Institute of Health and Welfare

A KE from a Melbourne hospital accident and emergency department reported that while ‘a lot’ of people are using methamphetamines, there are not many methamphetamine-related presentations. This KE reported that the number of methamphetamine-related presentations had, in fact, remained stable throughout the preceding 6 to 12 months, with methamphetamine-using individuals usually only presenting after fights or car crashes. This KE stated that there is a lot of violence and irrational behaviour associated with methamphetamine users (particularly with recurrent users), however, this KE questioned whether such behaviour was directly related to methamphetamine use or to other factors, such as the type of people using methamphetamines and their lifestyles.

5.7 Summary of methamphetamine trends

Reports from the Victorian REU and KE suggest that:

- ❖ of the three forms of methamphetamine, speed is most widely used (in terms of both lifetime and recent use), followed by crystal meth and then base;
- ❖ speed is commonly used in conjunction with ecstasy and during binges;
- ❖ speed is mostly commonly snorted, whereas base is predominantly swallowed and crystal meth smoked;
- ❖ methamphetamines are used in a variety of locations, predominantly nightclubs and private homes;
- ❖ crystal meth is more expensive than speed and base (which are of comparable cost);
- ❖ the price of the three forms of methamphetamine has remained relatively stable since 2003;
- ❖ the purity of crystal meth is relatively high and stable, whereas the purity of speed is medium to high and less consistent;
- ❖ speed has remained readily available, with ease of access to crystal meth stable or declining. Both speed and crystal meth are most commonly acquired through friends and known dealers; and
- ❖ a number of KE identified significant problems associated with violence and health-related harms caused by methamphetamine use.

6 COCAINE

6.1 Cocaine use in the general population

The 2004 NDSHS provides the most recent national figures regarding the prevalence of cocaine use in the Australian general population. This survey indicates that in 2004 one percent of the Australian population aged 14 years and over had recently (in the last 12 months) used cocaine, a statistically significant decrease from the 2001 survey estimate of 1.3% (Australian Institute of Health and Welfare, 2005). The most recent data available regarding the prevalence of cocaine use in the general population of Victoria also comes from the 2004 NDSHS. According to the findings of this survey, 1.2% of the Victorian population aged 14 years and above had used cocaine within the twelve months prior to interview (Australian Institute of Health and Welfare, 2005).

As is the case with ecstasy and methamphetamine use, nationally the highest prevalence of both 'lifetime' (8.9%) and 'recent' (3.0%) cocaine use was reported by the 20–29 year old age group (Australian Institute of Health and Welfare, 2005). Figures from the most recent Victorian Youth Alcohol and Drug Survey (Premier's Drug Prevention Council, 2005), are comparable with these findings: of the 16–24 year olds surveyed (n=6,005), 6% reported having ever used cocaine in their lifetime, and 3% reported use in the 12 months prior to survey. The VYADS also provides indicators of the frequency of cocaine use among this younger age group: among recent cocaine users, 17% reported using cocaine once a month or more frequently, slightly less than one-quarter (22%) reported using cocaine 'every few months', approximately one-third (31%) reported using cocaine once or twice a year and 30% reported having only used cocaine on one occasion in the previous year (Premier's Drug Prevention Council, 2005). According to the VYADS, cocaine was most commonly used in powder form (95%), although a small proportion of recent users reported having used crack cocaine (smokeable crystals: 7%). The majority of respondents reported typically snorting cocaine (91%). The median age for first cocaine use was 18.5 years (Premier's Drug Prevention Council 2005), compared to a median age of 23.5 years suggested by the 2004 NDSHS (Australian Institute of Health and Welfare, 2005) (likely to be an artefact of the differing sampling frames of the two surveys).

6.2 Cocaine use among REU

The majority (82%) of the 2006 REU sample reported having ever used cocaine and over half (55%) reported use in the preceding six months (Table 13). The median age of first use for cocaine was 21 years (range 14–34).

The 55 participants that reported recent cocaine use had done so on a median of two days in the preceding six months (range 1–72). The majority of those who had used cocaine in the previous six months had done so infrequently, with 84% of the participants using it once a month or less frequently, 13% using it more than once a month but less than once a week and two participants (3%) reporting using cocaine more than once a week.

Approximately half of the recent cocaine users reported their recent use in terms of grams, with a median of one gram being used during a typical (range 0.1–3; n=27) occasion of use and a median of one gram being used during a heavy occasion (range 0.2–9; n=35) of use. Other participants reported their recent use cocaine in terms of points, with a median of two points used during a typical (range 0.5–3; n=18) occasion of use and a median of two points (range 0.5–5; n=11) being used during a heavy occasion of use. Of those participants who reported bingeing in the preceding six months (n=44), 23% reported using cocaine when doing so. Fifteen percent of those participants reporting typically using drugs in conjunction with ecstasy (n=97) reported usually using cocaine with ecstasy. Only a small proportion of those participants reporting typically using drugs during the comedown from ecstasy (n=82), however, reported using cocaine during this time (2%).

Most (98%) recent users reported snorting cocaine, with fewer participants swallowing cocaine (33%) and small proportions smoking (2%) and injecting (2%) cocaine. Reflecting REU sample reports, two KE noted that snorting is the most popular route of cocaine administration.

Although the prevalence of lifetime use has remained relatively stable over the four years, levels of recent use reported by the REU sample have fluctuated somewhat. Frequency of use, however, has remained relatively low, and quantity of use has also been stable.

Table 13: Patterns of cocaine use among REU, 2003–2006

Cocaine	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Ever used %	80	72	79	82
Used last six months%	35	48	63	55
Of those who had used				
Median days (range) used last 6 months	3 (1–30) (n=35)	1.5 (1–180) (n=48)	2 (1–50) (n=63)	2 (1–72) (n=55)
Median quantities used (grams)				
Typical (range)	0.5 (0.25–3) (n=13)	0.5 (0.13–2) (n=20)	0.5 (0.1–3) (n=31)	1 (0.1–3) (n=27)
Heavy (range)	1 (0.5–3.5) (n=16)	0.5 (0.13–4) (n=23)	1 (0.1–5) (n=33)	1 (0.2–9) (n=35)

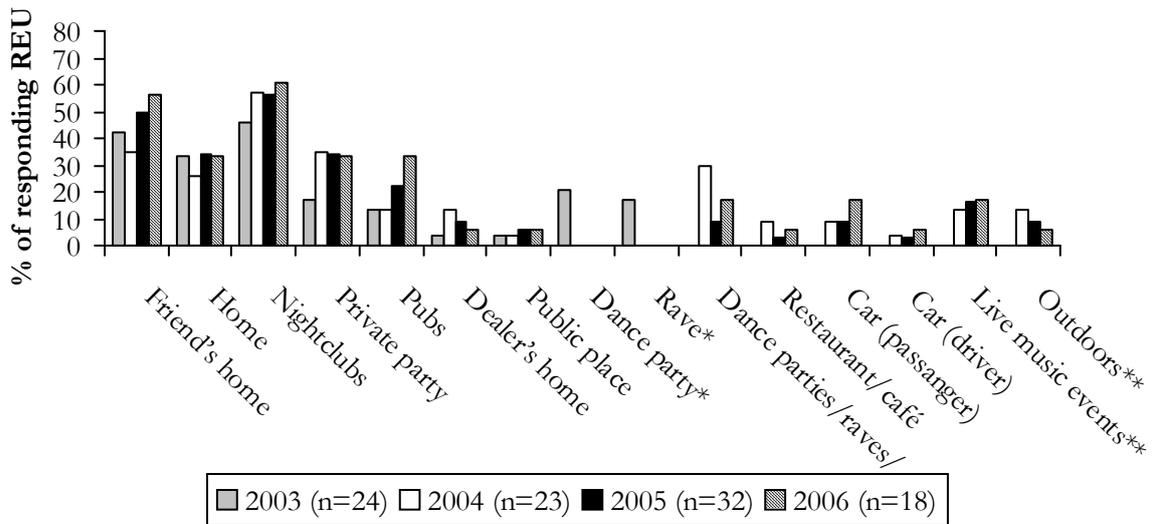
Source: REU interviews, 2003–2006

Fifteen KE reported that small numbers of REU use cocaine. Cocaine use was typically characterised as infrequent and recreational, with cocaine users described as ‘older’ people with ‘a better income’. In addition, two KE noted that ERD dealers are usually more likely to use cocaine as they are able to afford the high prices of the drug.

Four KE reported an increase in the prevalence of cocaine use during the previous 6 to 12 months, four reported no changes, and one KE reported a decrease in cocaine use amongst ERD users.

Recent cocaine users in the 2006 REU sample reported usually using cocaine in nightclubs (61%) and at friends’ homes (56%; Figure 28).

Figure 28: Usual location of cocaine use, 2003–2006



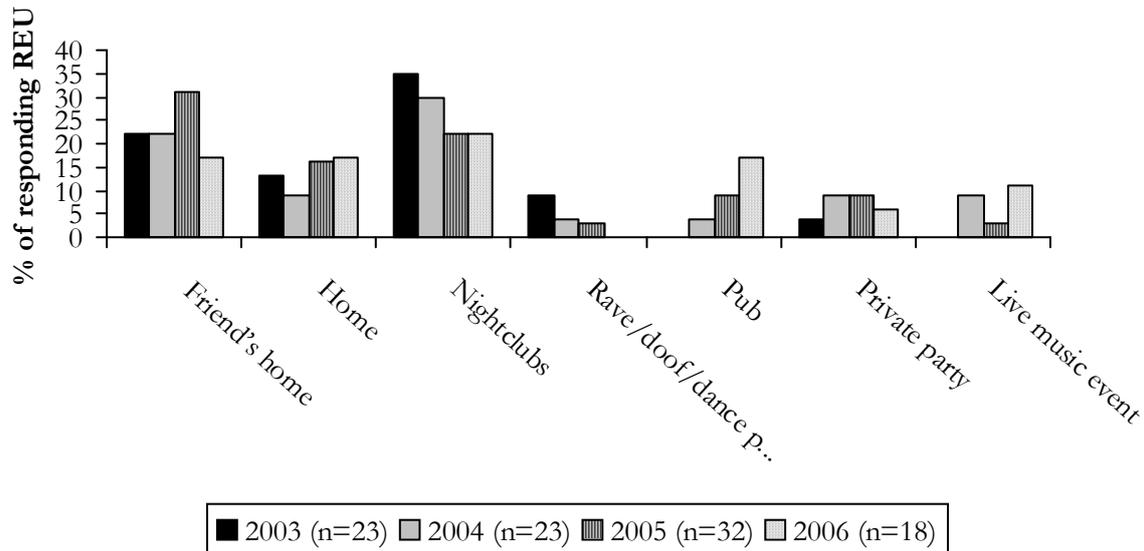
Source: REU interviews, 2003–2006

* 'Rave' and 'dance party' categories combined from 2004 onwards

** No 'live music' or 'outdoors' categories in 2003 REU survey

Consistent with reports of usual locations of cocaine use, the most common places of last use reported by the 2006 REU sample were nightclubs (22%), friends' homes (17%), own home (17%) and pub (17%; Figure 29).

Figure 29: Location of most recent cocaine use, 2003–2006



Source: REU interviews, 2003–2006

6.3 Price

Eighteen participants from the 2006 REU sample were able to comment on the current price, purity and availability of cocaine. All commented on the price of cocaine per gram, with a median of \$300 (range \$200–\$400) being reported (Table 14).

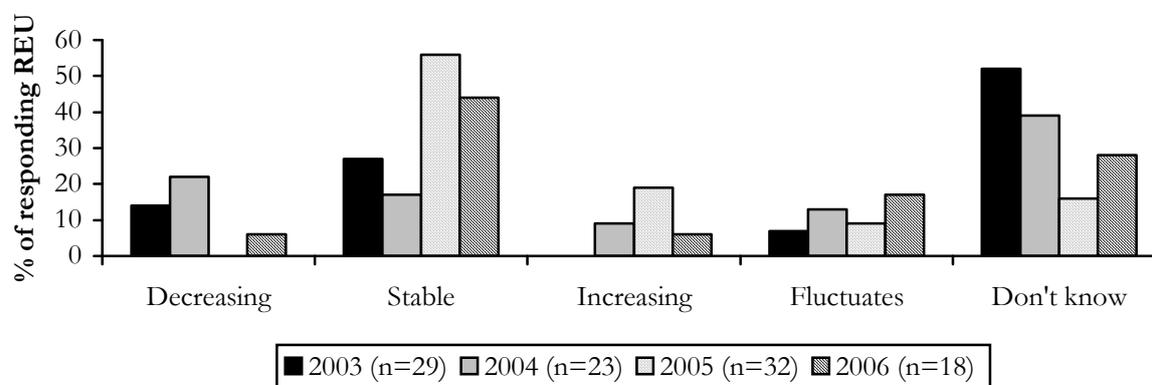
Table 14: Price of cocaine purchased by REU, 2003–2006

Variable	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Median price (range) per gram	\$250 (\$100–\$400) (n=14)	\$277.50 (\$100– \$400) (n=16)	\$300 (\$200–\$350) (n=29)	\$300 (\$200–\$400) (n=18)

Source: REU interviews, 2003–2006

Of the 18 participants able to comment on the price of cocaine in the six months prior to interview, less than half (44%) reported that the price had been stable, 17% that it had fluctuated, 6% reported that it had increased and 6% reported that it had decreased during this period of time, with a further 28% unable to comment (Figure 30).

Figure 30: Recent changes in price of cocaine purchased by REU, 2003–2006

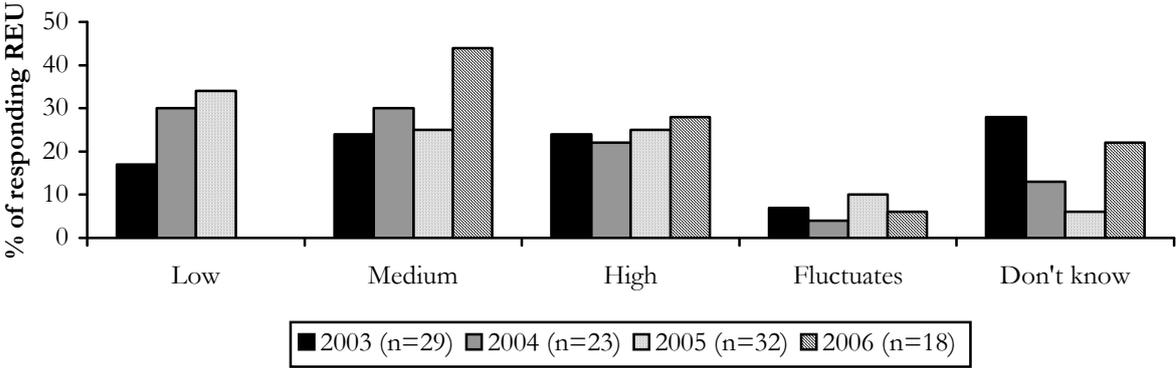


Source: REU interviews, 2003–2006

6.4 Purity

The reports of the current purity of cocaine by the 2006 REU sample were somewhat more consistent than in previous years, with one-quarter (44%) reporting it as medium, one-quarter (28%) as high purity and one participant (6%) reporting fluctuating cocaine purity (Figure 31).

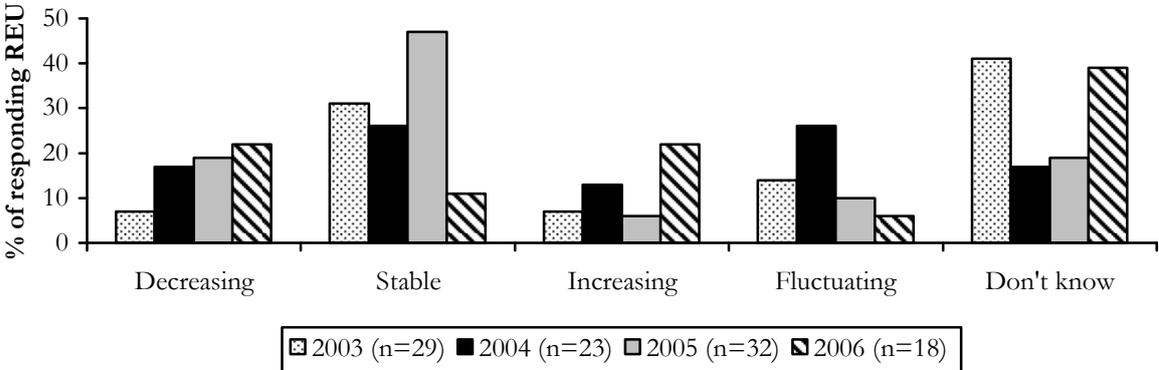
Figure 31: User reports of current purity of cocaine, 2003–2006



Source: REU interviews, 2003–2006

There was less consistency, however, in the reports of changes in the purity of cocaine over the preceding six months: nearly one-quarter of the 2006 REU participants able to comment reported the purity had increased (22%), with the same proportion reporting that it had decreased. Only 11% reported that it had been stable, with 39% unable to comment (Figure 32).

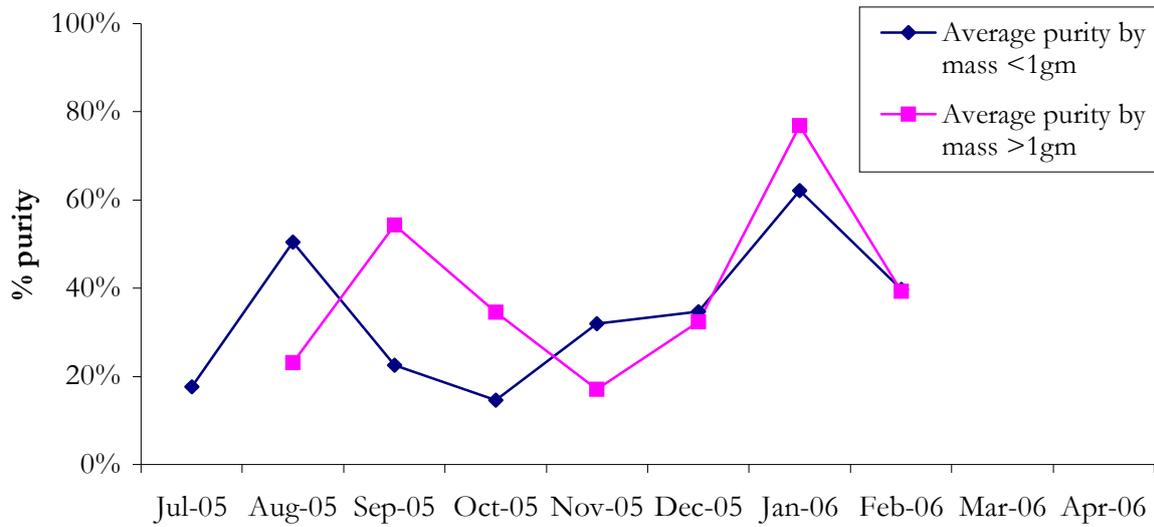
Figure 32: User reports of changes in cocaine purity in the past six months, 2003–2006



Source: REU interviews, 2003–2006

The mean purity levels of cocaine seizures analysed by law enforcement agencies in Victoria during the 2005/2006 financial year are shown in Figure 33. During the period March–June 2006 there were no seizures of cocaine.

Figure 33: Average purity of cocaine seizures by Victorian law enforcement, July 2005–June 2006



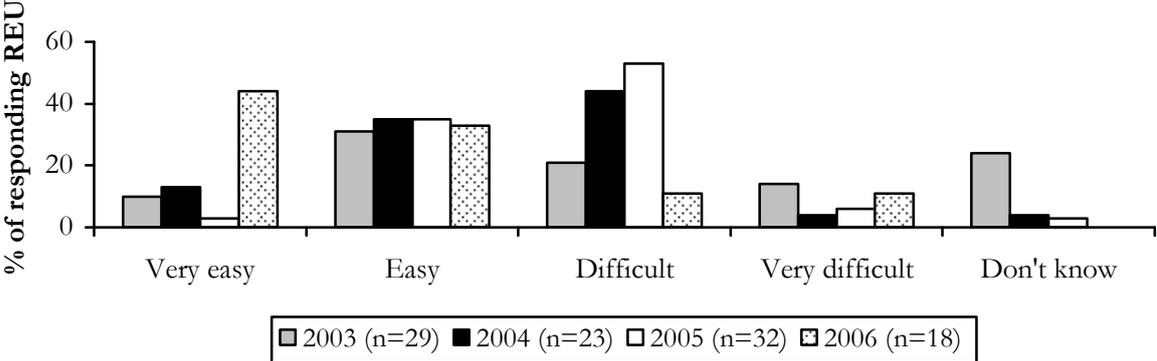
Source: Victoria Police Forensic Services Department

The mean purity of all seizures analysed during this period was 37% (range 15% to 77%), compared to 42% in 2004/05, 40% in 2003/04, 27% in 2002/03, 38% in 2001/02 and 40% in 2000/01. Hence, whilst there was some variability in the purity of cocaine seized by Victoria Police during 2005/06 (see Figure 23), the average purity of cocaine seizures in this jurisdiction has generally ranged from approximately 30–40% since 2000/01 (Jenkinson & O’Keeffe, 2006).

6.5 Availability

Of the 2006 REU participants that were able to comment on the current availability of cocaine (n=18), less than half (44%) reported it as currently being ‘very easy’ and one-third (33%) reported it as ‘easy’ to obtain. Smaller proportions reported that cocaine was ‘difficult’ (11%) or ‘very difficult’ (11%) to obtain (Figure 34). Thus, a considerably higher proportion of those able to comment from the 2006 sample reported cocaine as ‘very easy’ to obtain compared to previous years. The smaller number of respondents in 2006 should, however, be considered when interpreting these findings.

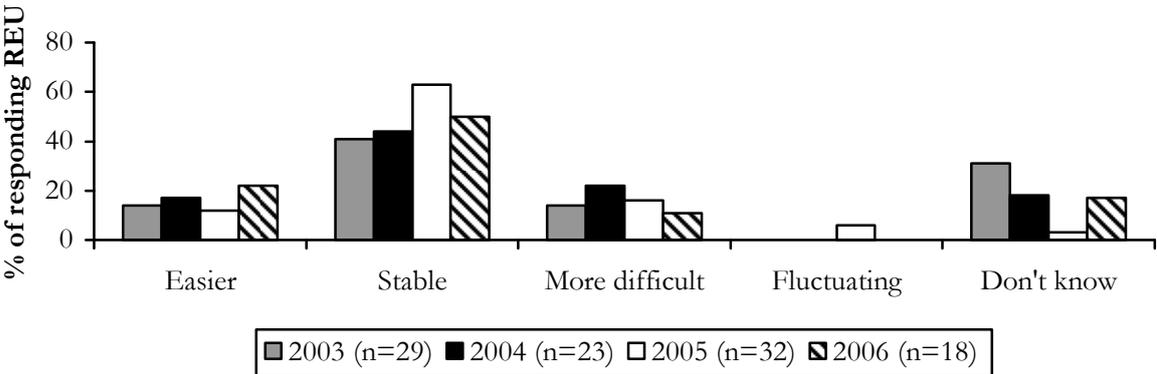
Figure 34: Current availability of cocaine, 2003–2006



Source: REU interviews, 2003–2006

As in previous years, cocaine availability tended to be reported by the REU samples as being stable (Figure 35). Half (50%) of those 2006 respondents able to comment (n=18) reported that during the preceding six months the availability of cocaine had remained stable, with 22% reporting it had become easier and 11% more difficult to obtain.

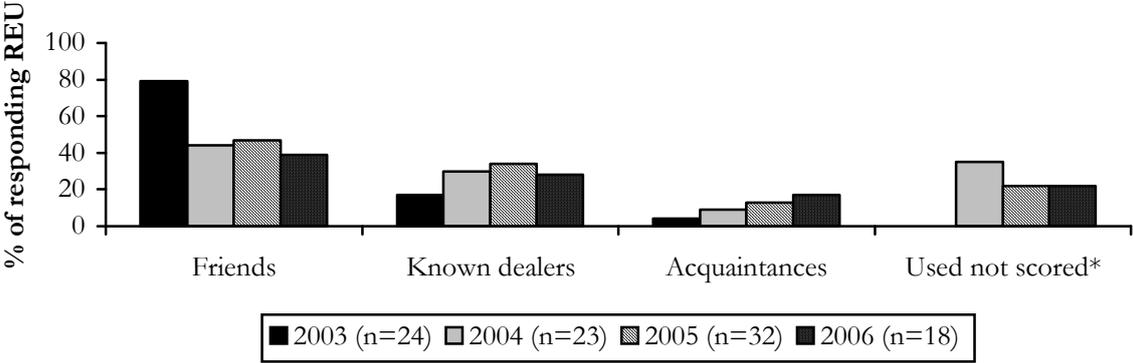
Figure 35: Changes in cocaine availability in the preceding six months, 2003–2006



Source: REU interviews, 2003–2006

Consistent with previous years, the 2006 REU sample reported that cocaine was primarily purchased from friends (39%) or known dealers (28%). In addition, 22% of recent cocaine users report using but not scoring cocaine (i.e. being ‘shouted’ it).

Figure 36: People from whom cocaine had been purchased the preceding six months, 2003–2006

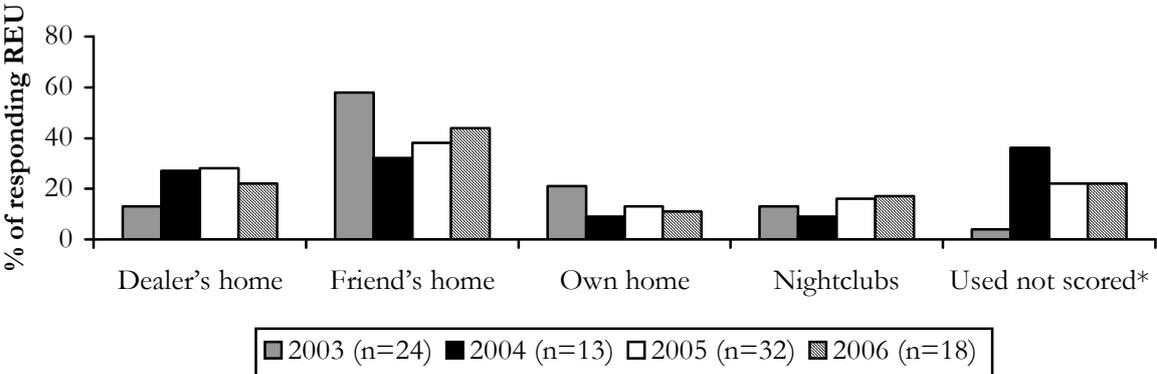


Source: REU interviews, 2003–2006

* ‘Used not scored’: option not included in 2003 survey

Consistent with reports of whom cocaine is purchased from, the 2006 sample most commonly reported scoring cocaine at friends’ homes (44%) and dealers’ homes (22%) (Figure 37). Indeed, across the four years that the Victorian PDI has been conducted, private homes, including participants’ own homes, friends’ homes and dealers’ homes, were the locations participants were most likely to report scoring cocaine.

Figure 37: Locations where cocaine had been purchased in the preceding six months, 2003–2006



Source: REU interviews, 2003–2006

* ‘Used not scored’: option not included in 2003 survey

6.6 Cocaine related harms

6.6.1 Law enforcement

Table 15 details consumer (e.g. possession/use) and provider (e.g. trafficking/ manufacture) arrests for cocaine during 2004/2005 (in Victoria and Australia). During that financial year approximately one-fifth (21%) of the arrests made in Australia for cocaine offences occurred in

Victoria (data provided by the Australian Crime Commission).⁴ In Victoria the total number of consumer and provider arrests for amphetamine-type stimulants have remained relatively stable since 2003/2004 (n=85 in 2003/2004).

Table 15: Cocaine: consumer and provider arrests, Victoria and national, 2004/2005⁺

	Victoria (n)	Australia (n)	% of national arrests
Consumer	54	257	21.0
Provider	37	164	22.6
TOTAL*	91	425	21.4

Source: Australian Crime Commission

*Includes those offenders for whom consumer/provider status was not stated

+ 2005/2006 data not available at the time of publication

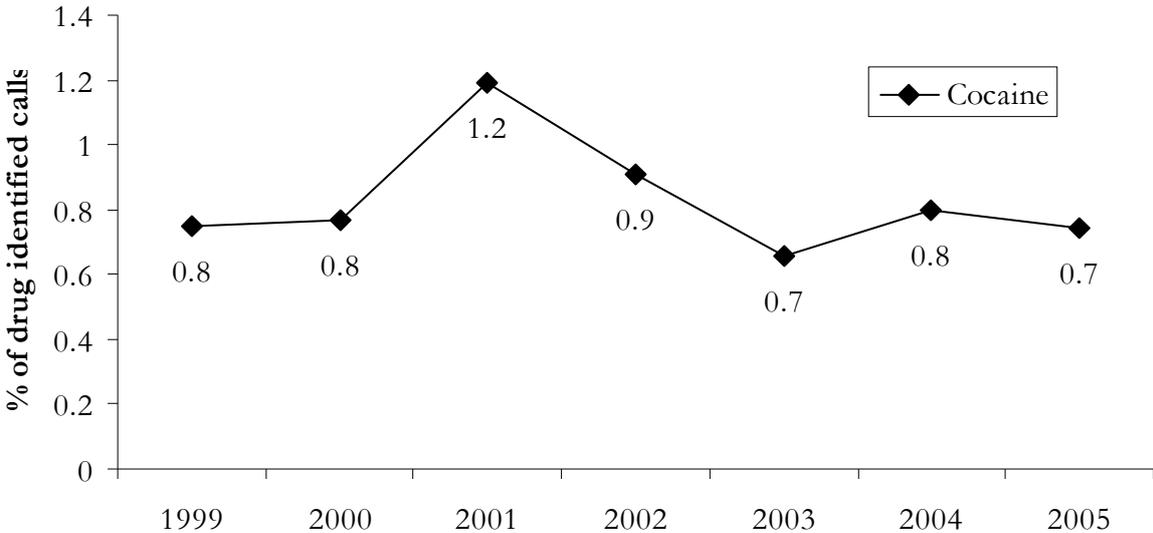
6.6.2 Health

DirectLine calls

During 2005 DirectLine responded to 186 calls where cocaine was identified as a drug of concern. This represents less than one percent of all calls made to DirectLine during that time where a drug of concern was cited (Turning Point Alcohol and Drug Centre Inc., unpublished data). The proportion of drug-related calls where cocaine was identified has remained very low ($\leq 1\%$) during the past seven years (see Figure 38).

⁴ Proportions (%) should be interpreted with caution due to the lack of uniformity across states and territories in the recording and storing of data on illicit drug arrests.

Figure 38: DirectLine calls where drug of concern identified as cocaine, 1999–2005



Source: DirectLine, Turning Point Alcohol and Drug Centre Inc (unpublished data)

Cocaine-related events attended by ambulance

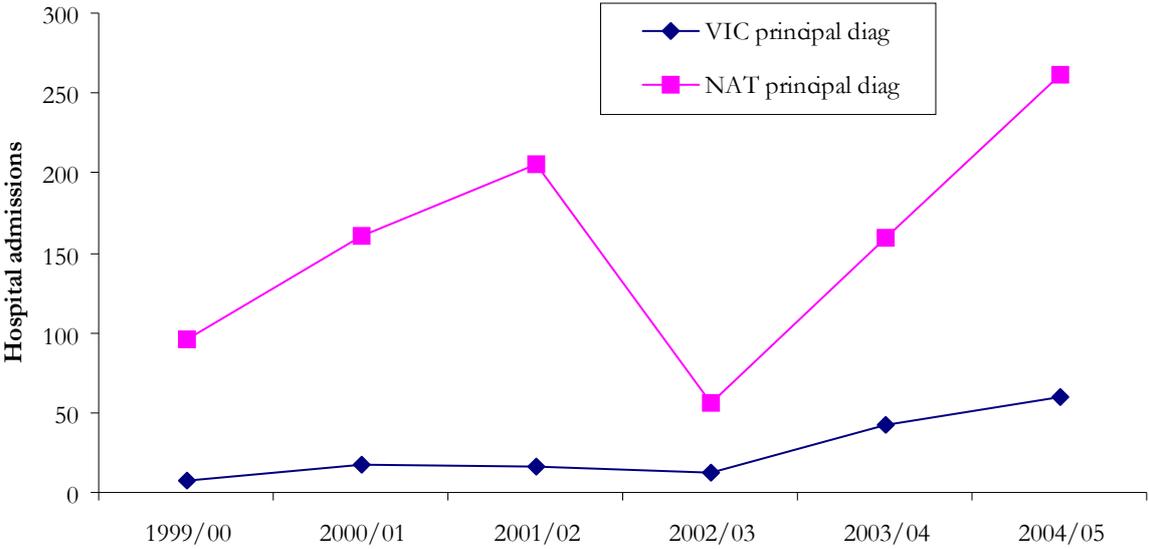
In 2005 there were a total of 48 ambulance attendances in Melbourne where cocaine use was mentioned (there were 26 in total in 2004 and 23 in 2003). The estimated average age of cases in 2005 was 28 years (which was similar to the 30 years reported in 2004 and 29 years in 2003) (analysis by S. Cvetkovski, Turning Point Alcohol and Drug Centre). As noted in previous years (Jenkinson & O’Keeffe, 2005 ; 2006; Jenkinson, Miller & Fry, 2004), these numbers are too small to provide clear trends, but generally indicate that people who are using cocaine in Melbourne are not coming into contact with the ambulance service.

One ambulance paramedic KE stated that cocaine was previously only consumed at big functions and special occasions, however, this KE now reported seeing it at clubs on weekends, primarily as a secondary substance. An additional first aid KE mentioned unexpectedly seeing a number of cocaine-using patients at the 2005 Spring Racing Carnival.

Hospital admissions

The National Hospital Morbidity Database (NHMD) is compiled by the Australian Institute of Health and Welfare. Cocaine-related hospital admissions for Victoria and Australia (among persons aged 15–54 years) are presented in Figure 39. It is evident from this data that the number of cocaine-related hospital admissions in Victoria was relatively stable between 1999/00–2002/03, but has since increased (in 2003/04 and 2004/05). Nationally, the number of cocaine-related hospital admissions increased between 1999/00 and 2001/02, then significantly decreased in 2003. Since that time the number of cocaine-related hospital admissions across Australia has again steadily increased (in both 2003/04 and 2004/05). The number of cocaine-related hospital admissions is much lower than for opioids or amphetamines.

Figure 39: Cocaine-related hospital admissions, Victoria and National, 1999/00–2004/05



Source: Roxburgh & Degenhardt (2006); Australian Institute of Health and Welfare

6.7 Summary of cocaine trends

Reports from the Victorian REU and KE suggest:

- ❖ relatively high prevalence of ‘lifetime use’ and recent use among REU;
- ❖ cocaine is typically used infrequently by REU;
- ❖ cocaine is typically snorted;
- ❖ cocaine is used across a wide range of locations, most commonly nightclubs, pubs and private homes;
- ❖ cocaine is a relatively expensive drug;
- ❖ cocaine is currently readily available, with recent availability stable or increasing;
- ❖ the purity of cocaine is medium and has been stable over the past six months; and
- ❖ cocaine is commonly purchased from friends or known dealers in private homes.

7 KETAMINE

7.1 Ketamine use in the general population

There is only a small amount of data available regarding the prevalence of ketamine use in the Australian general population as questions about its use were included for the first time in the 2004 NDSHS and it is not asked about in the VYADS. The available evidence suggests that 0.3% of the Australian population aged 14 years and older have used ketamine in the last 12 months, that 1.0% of the population have ever used it, and that the median age of first use is 23.7 (Australian Institute of Health and Welfare, 2005). The available Victorian data suggest comparable prevalence of ketamine use, with 0.3% of the Victorian population aged 14 years and older estimated to have used ketamine in the previous 12 months (Australian Institute of Health and Welfare, 2005).

7.2 Ketamine use among REU

Over half (56%) of the 2006 REU sample reported having ever used ketamine, with less than one-third (29%) the sample reporting recent use (Table 16). The median age of first use for ketamine was 20 (range 12–37).

The 29 participants that reported recent ketamine use had done so on a median of three days in the preceding six months (range 1–14). The majority (76%) used ketamine once a month or less, with the remaining 24% (n=7) using it more than monthly but less than weekly.

Recent ketamine users most commonly quantified their use in terms of points, and reported using a median of two points (range 0.5–4; n=18) during a typical episode of use and a median of two points (range 1–4; n=13) during a heavy episode of use. Of those participants who reported bingeing in the preceding six months (n=44), 16% reported using ketamine when doing so. Only a small proportion of those participants reporting typically using drugs in conjunction with ecstasy (n=97) reported using ketamine (8%). Similarly, only a small proportion of those participants reporting typically using drugs during the comedown from ecstasy (n=82) reported using ketamine during this time (9%).

Most recent ketamine users (n=29) reported snorting (90%) it in the six months prior to interview. Slightly more than one-quarter (28%) reported swallowing ketamine, with smaller proportions reporting injecting (7%; n=2) and smoking it (3%; n=1).

Levels of both 'lifetime' and recent ketamine use have decreased since 2003, with frequency of use reported by REU remaining relatively low.

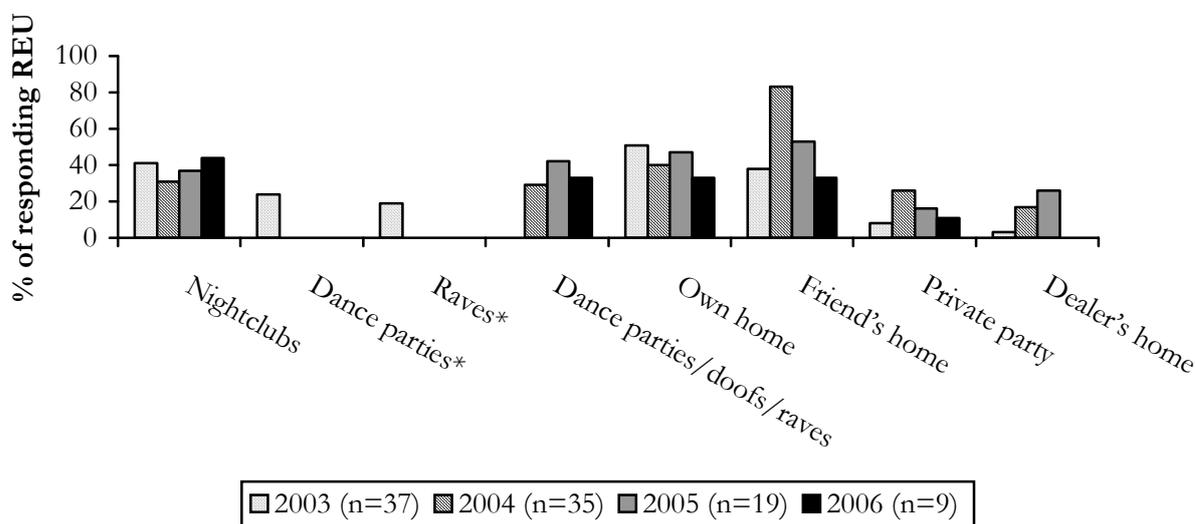
Table 16: Patterns of ketamine use among REU, 2003–2006

Ketamine	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Ever used (%)	70	70	56	56
Used last six months (%)	51	45	35	29
Of those who had used				
Median days used last 6 mths (range)	3.5 (1–104) (n=50)	3 (1–96) (n=45)	3 (1–72) (n=35)	3 (1–14) (n=29)
Median quantities used (points)				
Typical (range)	1 (0.5–5) (n=15)	1 (0.5–4) (n=21)	1.75 (0.5–3) (n=16)	2 (0.5–4) (n=18)
Heavy (range)	1 (0.5–4) (n=11)	1.5 (0.5–5) (n=16)	2 (1–4) (n=15)	2 (1–4) (n=13)

Source: REU interviews, 2003–2006

The locations of recent ketamine use most commonly reported by the 2006 participants were nightclubs (44%; n=4), raves/doofs/parties (44%; n=4), friend’s home (3%) and participants’ own homes (33%). These findings should be interpreted with caution, however, given the small number of respondents.

Figure 40: Location of usual ketamine use, 2003–2006

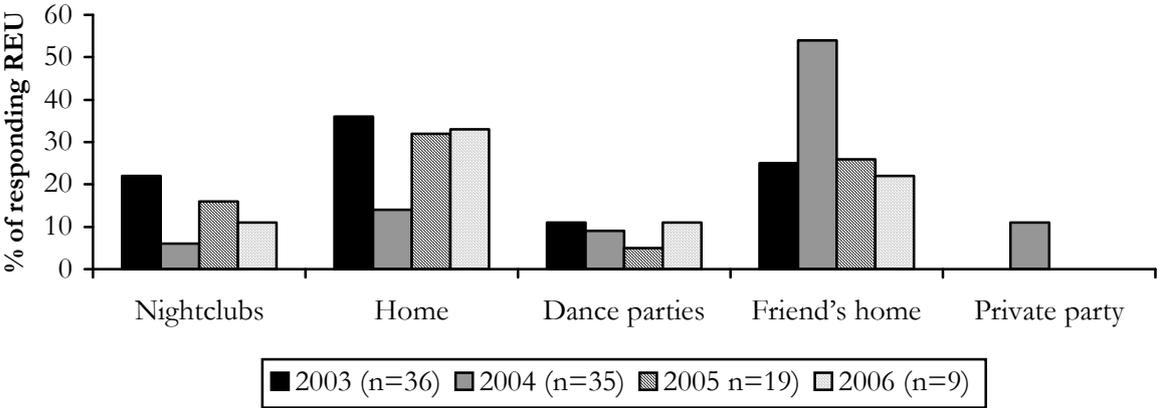


Source: REU interviews, 2003–2006

* ‘Rave’ and ‘dance party’ categories combined from 2004 onwards

The 2006 REU sample reported most recently using ketamine in private locations such as their own home (33%; n=3) and friend’s home (22%; n=2) (Figure 41). Again, these findings should be interpreted with caution, however, given the small number of respondents.

Figure 41: Location of most recent ketamine use, 2003–2006



Source: REU interviews, 2003–2006

Four KE reported on the prevalence of ketamine use amongst the ERD users with whom they had contact. One reported that ‘a few’ (approximately 40%) people used ketamine, though added that the number of people using the drug had decreased during the preceding six months. In contrast, another KE reported an increase in ketamine use from approximately one-half to two-thirds of ERD users in the previous year, suggesting that such an increase could be due to a belief that ketamine is undetectable by sniffer dogs. This KE also reported that with ERD use becoming increasingly mainstream, more ‘traditional rave drugs’, such as ketamine, are increasingly being noticed in clubs and smaller venues more frequently. One KE reported no changes to the ‘consistent small group’ of REU who use ketamine, stating that ketamine (and other hallucinogens) is usually not an individual’s primary drug, while another KE also reported that ketamine was more typically one of multiple substances used for polydrug use.

7.3 Price

Nine participants from the 2006 REU sample were able to comment on the current price, purity and availability of ketamine. Five participants reported on the price of ketamine per gram, with a median price of \$100 (range \$80–\$200) being reported (Table 17). One participant reported ketamine costing \$20 per point and another reported purchasing half a gram of ketamine for \$150.

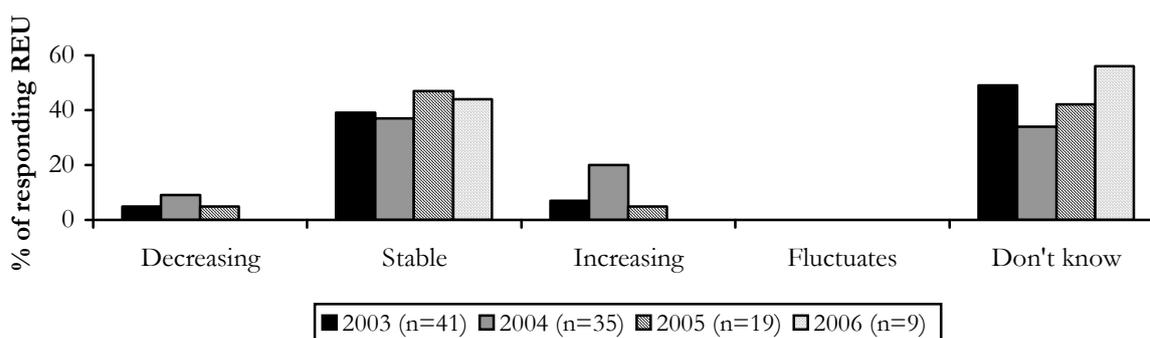
Table 17: Price of ketamine purchased by REU, 2003–2006

Ketamine	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Median price (\$)				
Point (range)	–	\$22.50 (\$15–\$40) (n=10)	\$25 (n=1)	\$20 (n=1)
Gram (range)	\$200 (\$100–200) (n=10)	\$195 (\$150–\$250) (n=10)	\$180 (\$150–\$250) (n=13)	\$100(\$80–\$200) (n=5)

Source: REU interviews, 2003–2006

Consistent with findings from previous years, of the nine 2006 REU participants able to comment on ketamine markets in Melbourne over the six months prior to interview, nearly half (44%; n=4) reported that the price had been stable in the preceding six months, with a substantial proportion (56%; n=5) unable to comment (Figure 42).

Figure 42: Recent changes in price of ketamine purchased by REU, 2003–2006

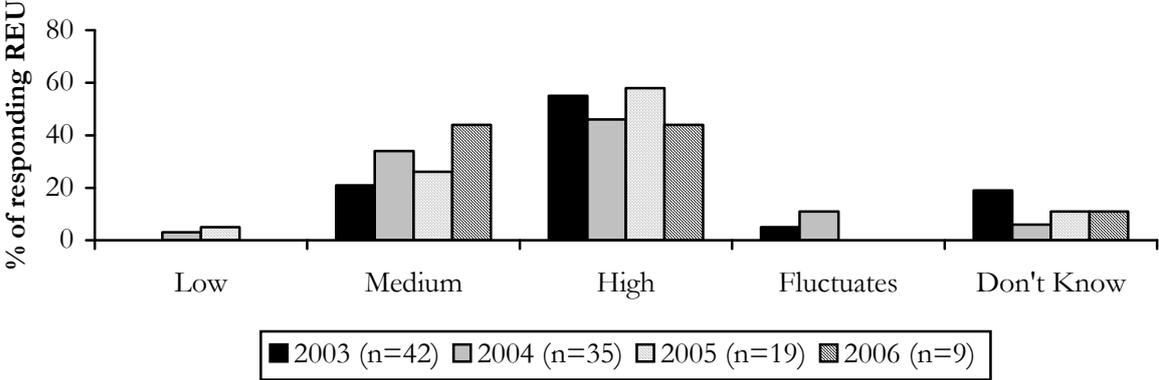


Source: REU interviews, 2003–2006

7.4 Purity

Consistent with previous years, the majority of those from the 2006 REU sample who were able to comment on ketamine markets (n=9) reported the current purity of ketamine as medium (44%) or high (44%; Figure 43).

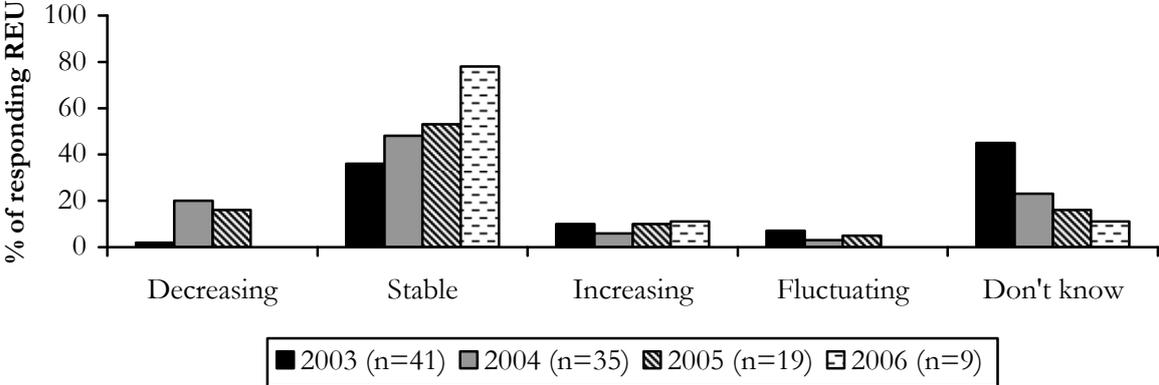
Figure 43: Current purity of ketamine, 2003–2006



Source: REU interviews, 2003–2006

The majority (78%; n=7) reported that the purity of ketamine had remained stable in the preceding six months (Figure 44).

Figure 44: Recent change in ketamine purity, 2003–2006

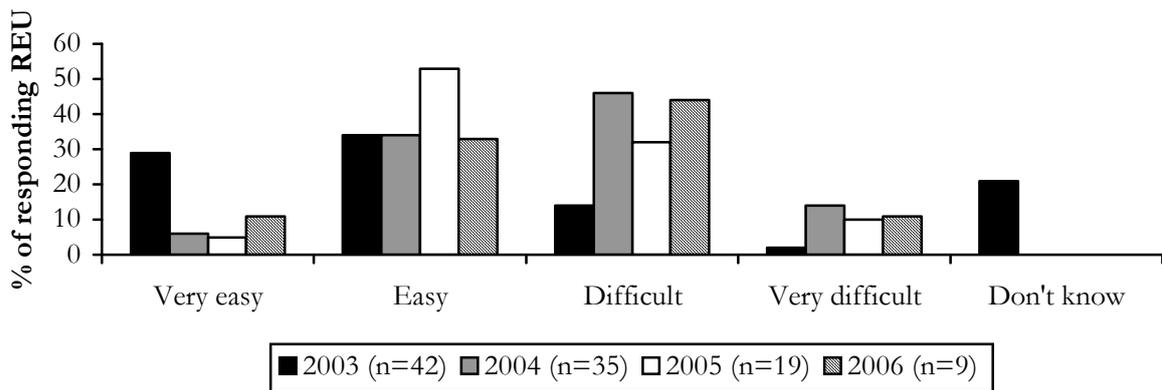


Source: REU interviews, 2003–2006

7.5 Availability

As with previous years, there was little consistency in the reports of the current availability of ketamine among the 2006 REU sample (Figure 45). Over half (55%) of those able to comment (n=9) reported that ketamine was currently either ‘difficult’ (44%) or ‘very difficult’ (11%) to obtain, a considerable proportion reported it as either ‘easy’ (33%) or ‘very easy’ (11%) to obtain. The small number of participants commenting on the current availability must be considered when interpreting these findings.

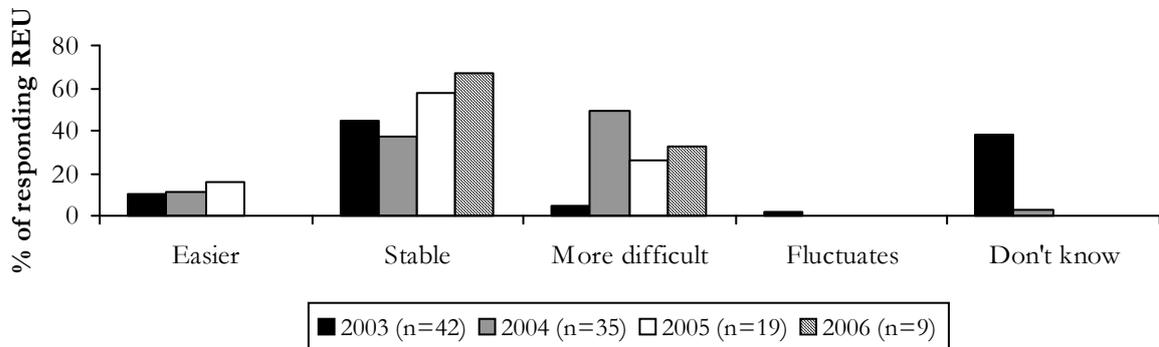
Figure 45: Current ketamine availability, 2003–2006



Source: REU interviews, 2003–2006

Of those from the 2006 REU sample who commented on changes in the availability of ketamine in the previous six months (n=9), two-thirds (67%) believed it had remained stable, while the remaining third (33%) reported it had become more difficult to obtain (Figure 46). Again, the small number of participants commenting on the current availability must be considered when interpreting these findings.

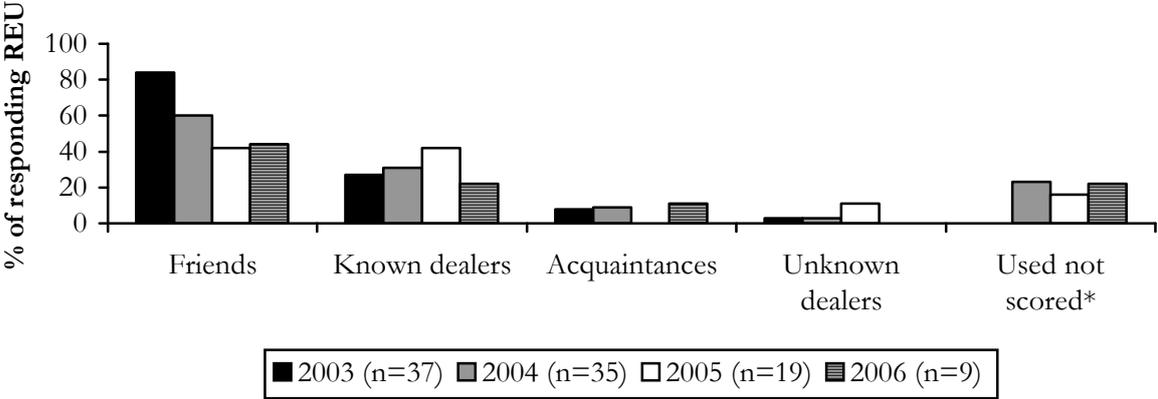
Figure 46: Changes in availability of ketamine over the past 6 months, 2003–2006



Source: REU interviews, 2003–2006

Consistent with previous years, ketamine was most commonly purchased from friends (44%; n=4) and known dealers (22%; n=2), with the same proportion (22%; n=2) reported using but not scoring ketamine (Figure 47).

Figure 47: People from whom ketamine had been purchased from in the preceding six months, 2003–2006

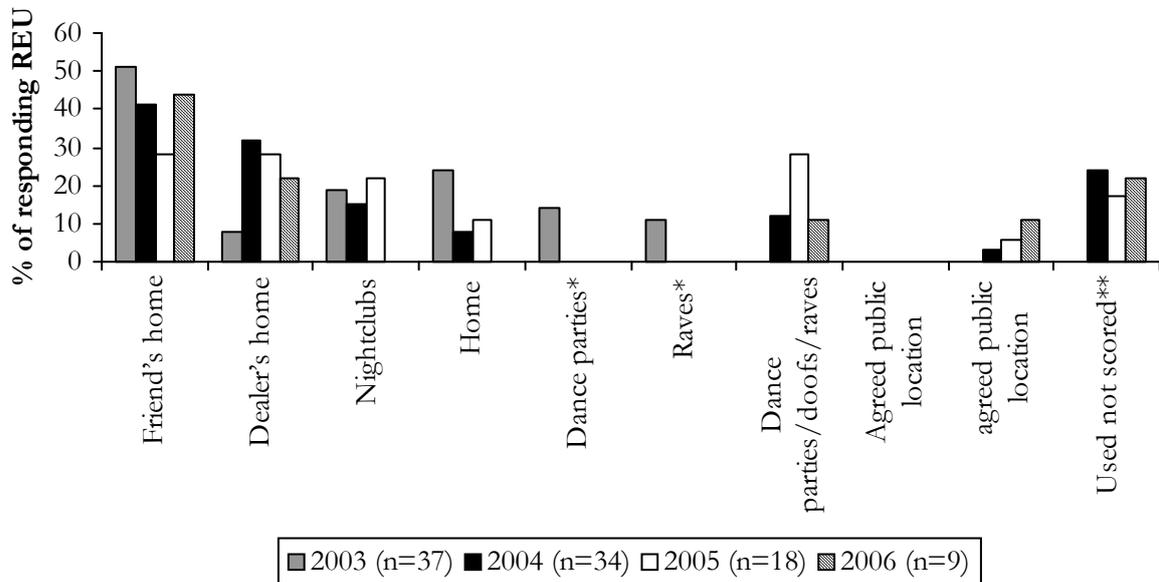


Source: REU interviews, 2003–2006

* ‘Used not scored’: option not included in 2003 REU survey

Consistent with their reports regarding who they purchased ketamine from, the 2006 REU participants (n=9) reported scoring ketamine predominately at friends’ (44%) or dealers’ (22%) homes (Figure 48).

Figure 48: Locations ketamine had been purchased from in the preceding six months, 2003–2006



Source: REU interviews, 2003–2006

* ‘Rave’ and ‘dance party’ categories combined from 2004 onwards

** ‘Used not scored’: option not included in 2003 REU survey

7.6 Ketamine related harms

7.6.1 Law enforcement

No Victorian ketamine-specific law enforcement indicator data is available. Two law enforcement KE noted a significant increase in the number of ketamine diversions from ‘legitimate industry’ during the previous two years, particularly from the veterinary industry. Three law enforcement KE also reported that ketamine is sometimes discovered at dance parties, though is much less frequently seized in comparison to drugs such as ecstasy and methamphetamines.

An additional law enforcement KE commented on the purity of ketamine seizures, ranging from 15% to 25% pure. This KE stated that ketamine is usually seized in tablet form, and – in addition to another law enforcement KE – listed ketamine as a substance sometimes present in ‘fake’ ecstasy pills.

7.6.2 Health

Mortality

No Victorian ketamine-related mortality data is available.

Treatment

No Victorian ketamine-related mortality data is available. KE (n=2) from first aid and ambulance services noted ketamine use was very infrequently, if ever, reported by those presenting to their services. One of these KE believed ketamine to have a similar subjective effect to ecstasy though suggested that it might be less harmful to people because it is a ‘cleaner’ drug. This KE reported that ketamine is usually a secondary substance, and is not the primary reason for the attendance of paramedics. Another first aid KE reported an increase in ketamine use at music festivals.

7.7 Summary of ketamine trends

Reports from the Victorian REU and KE suggest:

- ❖ decreasing levels of 'lifetime' and recent ketamine use reported since 2003;
- ❖ ketamine is typically infrequently used by REU, who use it in a range of public and private locations;
- ❖ the purity of ketamine is generally reported medium or high;
- ❖ reports of current ketamine availability are inconsistent, although generally reported as recently stable; and
- ❖ ketamine is most commonly purchased from friends and known dealers in private homes and dance parties/raves/doofs.

8 GHB

There is only a small amount of data available regarding the prevalence of GHB use in the Australian general population as questions about its use were included for the first time in the 2004 NDSHS and it is not asked about in the VYADS. The available evidence suggests that 0.1% of the Australian population aged 14 years and older have used GHB in the last 12 months, that 0.5% of the population have ever used it, and that the mean age of first use is 23.7 (Australian Institute of Health and Welfare, 2005). The available Victorian data suggest comparable prevalence of GHB use, with 0.2% of the Victorian population aged 14 years and older estimated to have used GHB in the previous 12 months (Australian Institute of Health and Welfare, 2005).

8.1 GHB use among REU

Slightly more than one-third (35%) of the 2006 REU sample reported having ever used GHB, with 14% of the sample reporting recent use (Table 18). The median age of first use for GHB was 20 (range 15–29).

The 14 participants that reported recent GHB use had done so on a median of 2.5 days in the preceding six months (range 1–20). Over half (57%) used GHB once every two months or less frequently, 36% (n=5) reported using GHB approximately once a fortnight and one participant reported using GHB approximately once a week.

Participants quantified amounts of GHB used in the preceding six months in terms of millilitres. A median of 5ml was used during a typical occasion (range 1.5–15; n=12) and a median of 10ml was used during a heavy occasion (range 2–25; n=11) of use. Of those participants who reported bingeing in the preceding six months (n=44), only 9% (n=4) reported using GHB when doing so. All of the participants that reported recent GHB use in 2006 had swallowed it, with no other routes of administration reported.

Table 18: Patterns of GHB use among REU, 2003–2006

GHB	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Ever used (%)	33	38	33	35
Used last six months (%)	18	27	16	14
Of those who had used				
Median days (range) used last 6 months	4 (1–72) (n=18)	3 (1–72) (n=27)	10 (1–100) (n=16)	2.5 (1–20) (n=14)
Median quantities used (ml)				
Typical (range)	14 (1–70) (n=13)	7.5 (1–75) (n=26)	10 (3–50) (n=15)	(1.5–15) (n=12)
Heavy (range)	22.5 (2–130) (n=14)	8 (2–150) (n=26)	20 (3–70) (n=15)	10 (2–25) (n=11)

Source: REU interviews, 2003–2006

Patterns of GHB use reported by the REU samples have varied over the four years of data collection. Although the proportion of REU reporting having ever used GHB has remained

stable over the four years of the study, levels of reported recent use have decreased. There has also been some fluctuations in terms of frequency of use, which peaked in 2005.

Twenty KE commented on patterns of GHB use with variable responses. Four KE reported that 'a few' (20% to 25%) REU used GHB, while one KE indicated that 50% were GHB users. Two additional KE reported that GHB use is common at events, whereas another stated that GHB-related overdoses were 'everywhere', both at small weekly club events and larger raves. One KE observed that, with ERD use becoming increasingly mainstream, 'traditional rave drugs' such as GHB and ketamine were being noticed in clubs and smaller venues more frequently. Four reported increased GHB use, four reported a decrease, and one KE reported that GHB use had remained stable throughout the preceding 6 to 12 months. One KE noted that, because his anti-GHB stance was well-known throughout the ERD-using community, very few people disclosed details of GHB use to him, making it difficult to determine any changes to the prevalence of GHB use. Four KE predicted that the number of GHB users may rise due to the increased use of sniffer dogs and the belief that GHB is one substance PADD dogs are unable to detect. One KE described this possibility as ironic, given their understanding that sniffer dogs were introduced in response to the high number of GHB-related overdoses at events in previous years.

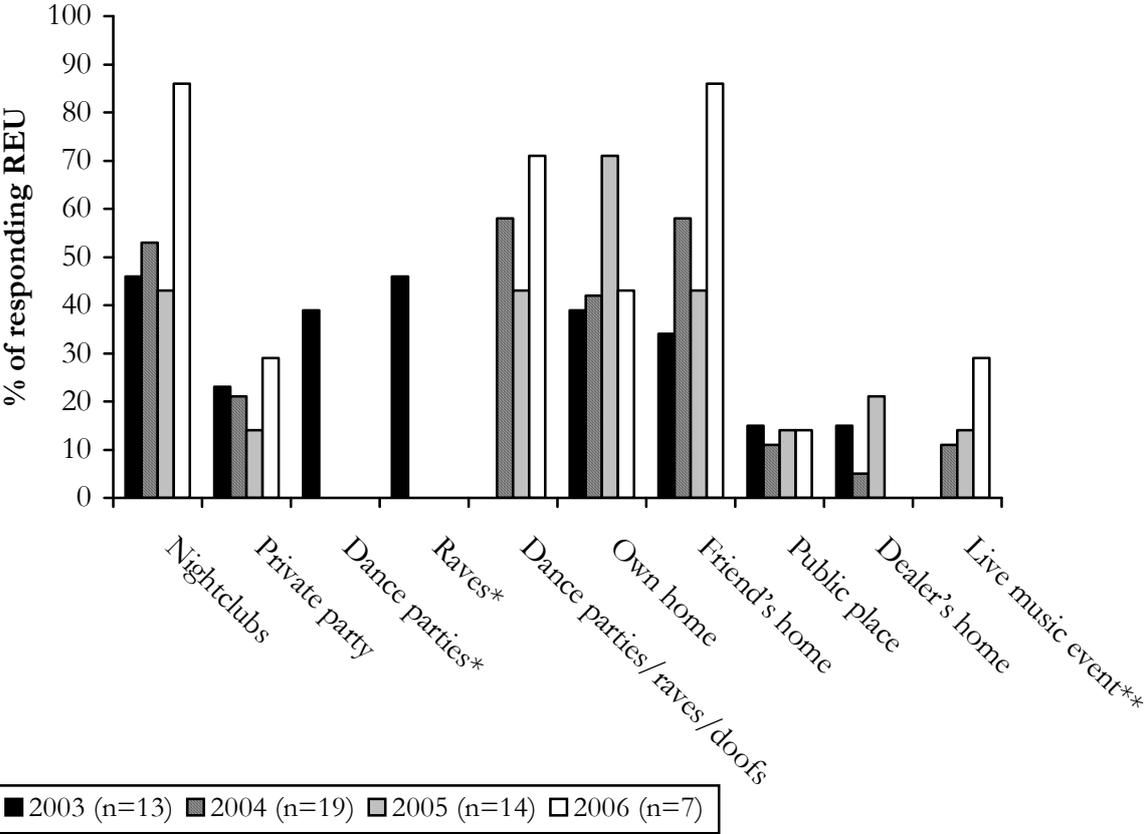
A small number of KE (n=5) noted that GHB is often a component of polydrug use patterns as a secondary substance. One KE working with drug diversion clients, however, reported the case of an individual using GHB 5 to 6 times per day in addition to methamphetamines. This person had been continuing this habit for several months at the time of the interview. The KE highlighted the very unusual nature of this case, and noted that as a result they experienced difficulty finding appropriate treatment options for the client.

A Victorian Government Department of Human Services (DHS)-initiated campaign, *Using G is never safe*, commenced in April 2005, with the support of a number of industry members. As part of this campaign, over 500 kits were distributed to a wide range of selected sites, including late-night entertainment venues, pubs and clubs, as well as alcohol and drug agencies, police, licensing authorities, promoters, and education institutions that conduct courses for promoters. In 2006, a KE noted that although this campaign had not been formally evaluated, DHS still received requests for campaign posters and brochures to be used at large-scale events, therefore, information was continually 'getting out there'. Another KE indicated that the campaign had produced positive results. This KE reported that GHB seemed to be the 'drug of choice' 2 to 3 years ago, however, since the campaign it became more of a secondary substance, if even used at all. An additional KE suggested that a decrease in GHB use might be a result of increased awareness of its harms, and education of ERD users.

A division between GHB users and users of other ERD was identified by two KE. One stated that many ecstasy users do not like to be put in the same drug-using category as GHB users, while the second KE reported anecdotal evidence of people using alcohol to hide the use of GHB from their friends; by slowly sipping beer, GHB users were able to attribute the effects of intoxication to alcohol rather than GHB. This KE noted that "*everyone knows people don't drink and use G, so it's 'proof' that they're not on G*".

Seven participants from the 2006 sample reported on their typical locations of recent GHB use, with nightclubs (86%), friends' homes (86%), dance parties/raves/doofs (71%) and participants' own homes (43%) most commonly reported (Figure 49). There was an increase in the proportion of recent GHB users reporting using GHB in public locations such as nightclubs and dance parties/raves/doofs, as well as friends' homes. These trends must be interpreted with caution, however, given the small number of participants responding.

Figure 49: Usual location of GHB use, 2003–2006



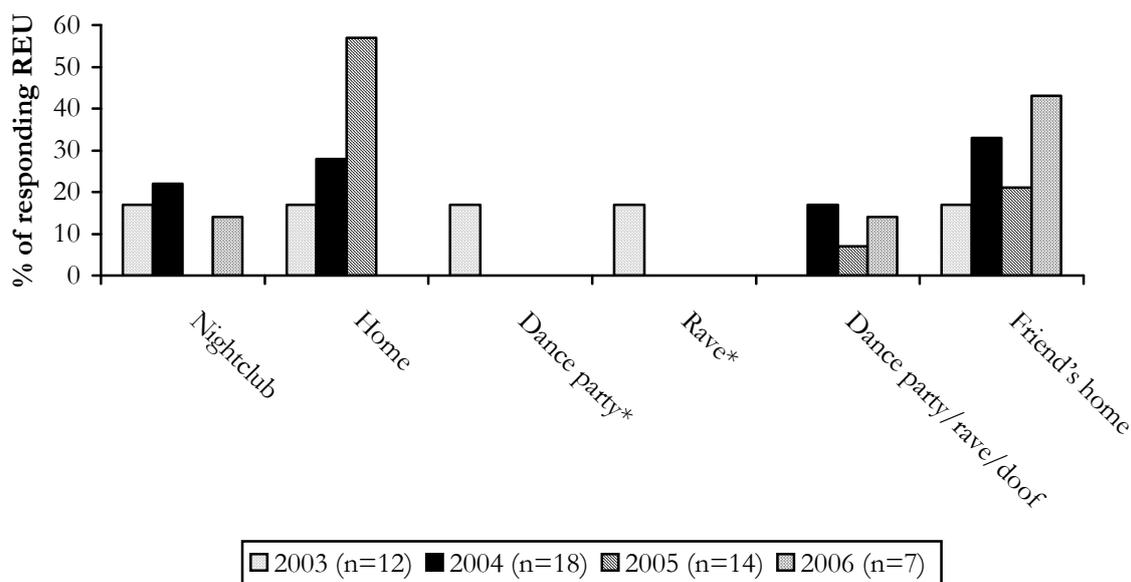
Source: REU interviews, 2003–2006

* 'Rave' and 'dance party' categories combined from 2004 onwards

** 'Live music event' not an response option in 2003 REU survey

The most frequently reported location of GHB use by recent users in the 2005 sample was friend's home (43%).

Figure 50: Location of most recent GHB use, 2003–2006



Source: REU interviews, 2003–2006

* 'Rave' and 'dance party' categories combined from 2004 onwards

8.2 Price

Seven participants from the 2006 REU sample were able to comment on the current price of GHB. Five participants reported on the price of GHB per ml, with a median price of \$3 (range \$1–\$3) being reported (Table 19). One participant described purchasing 20 ml quantities of GHB for \$50 and another participant reported purchasing 150 ml for \$100.

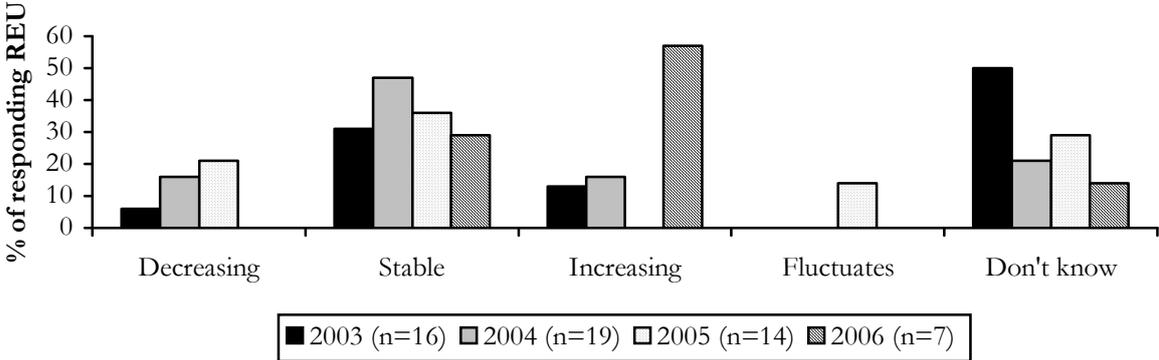
Table 19: Price of GHB purchased by REU, 2003–2006

GHB	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Median price (\$)				
ml (range)	\$3 (\$2.50–\$3) (n=5)	\$2.50 (\$2–\$8) (n=12)	\$2.50 (\$1–\$3) (n=12)	\$3 (\$1–\$3) (n=5)
3 ml (range)	–	–	\$3 (n=1)	–
20 ml (range)	–	–	\$35 (\$30–\$40) (n=2)	\$50 (n=1)
Vial 100ml (range)	\$25 (\$25–\$300) (n=3)	\$119 (\$38–\$200) (n=3)	–	–

Source: REU interviews, 2003–2006

Of the seven participants from the 2006 REU sample who responded, over half (57%) reported that the price of GHB had increased over the preceding six months, 29% reported it had been stable and 14% (n=1) were unable to comment (Figure 51).

Figure 51: Recent changes in price of GHB purchased by REU, 2003–2006

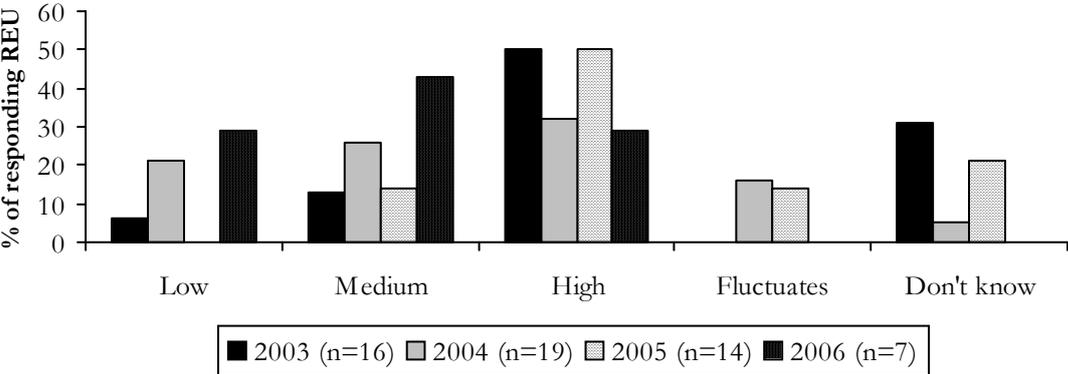


Source: REU interviews, 2003–2006

8.3 Purity

The seven participants from the 2006 REU sample able to comment on current GHB purity reported it as medium (43%) or higher (29%), although 29% reported it as low (Figure 52).

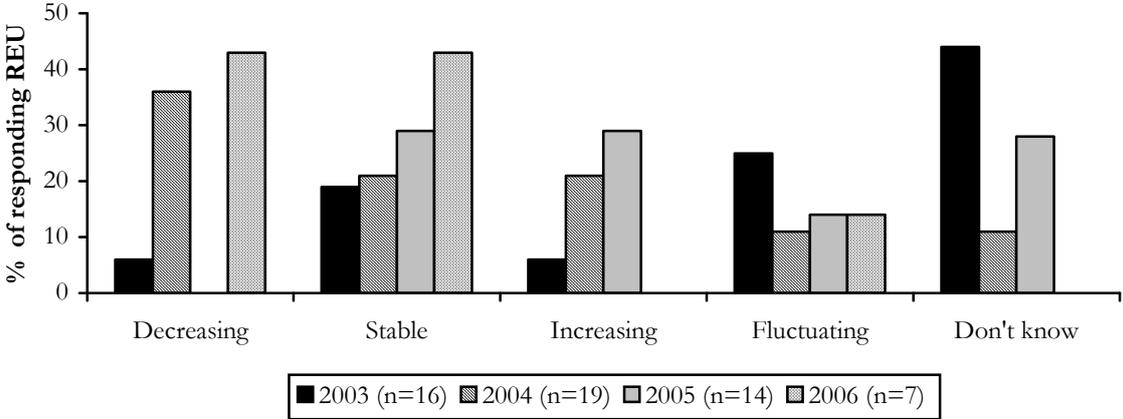
Figure 52: REU reports of purity of GHB in the preceding six months, 2003–2006



Source: REU interviews, 2003–2006

Reports concerning the purity of GHB in the six-month period prior to interview have been variable within each year that the study has been conducted in Melbourne. Again in 2006, the reports were inconsistent, with 43% of those able to respond reporting the purity as stable, 43% as decreasing and 14% (n=1) as fluctuating (Figure 53).

Figure 53: REU reports of change in purity of GHB in the preceding six months, 2003–2006

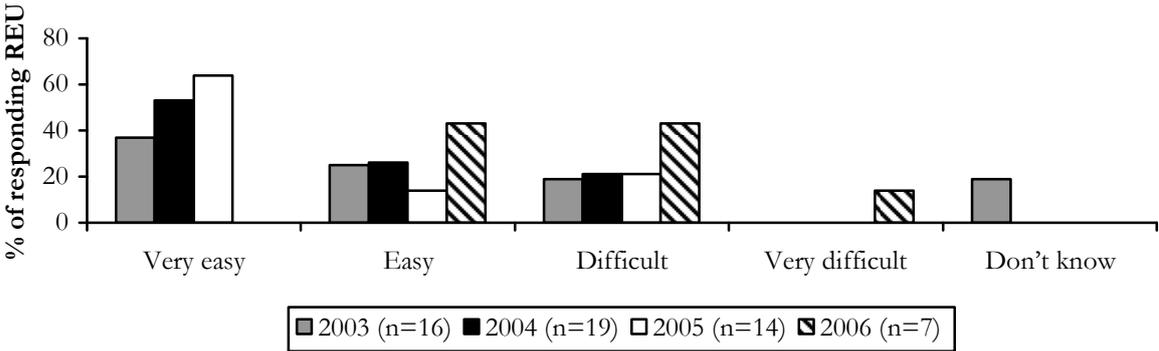


Source: REU interviews 2003–2006

8.4 Availability

Of the seven participants from the 2006 REU sample who were able to comment on the current availability of GHB, the majority (57%) responded that it was either ‘very difficult’ (14%) or ‘difficult’ (43%) to obtain, with the 43% reporting it as ‘easy’ to obtain (Figure 54). Over the previous years of the Victorian Party Drug Initiative (PDI), GHB has consistently been reported as being readily available by the REU samples, with a larger proportion of the 2006 respondents reporting it as either difficult or very difficult than in previous years.

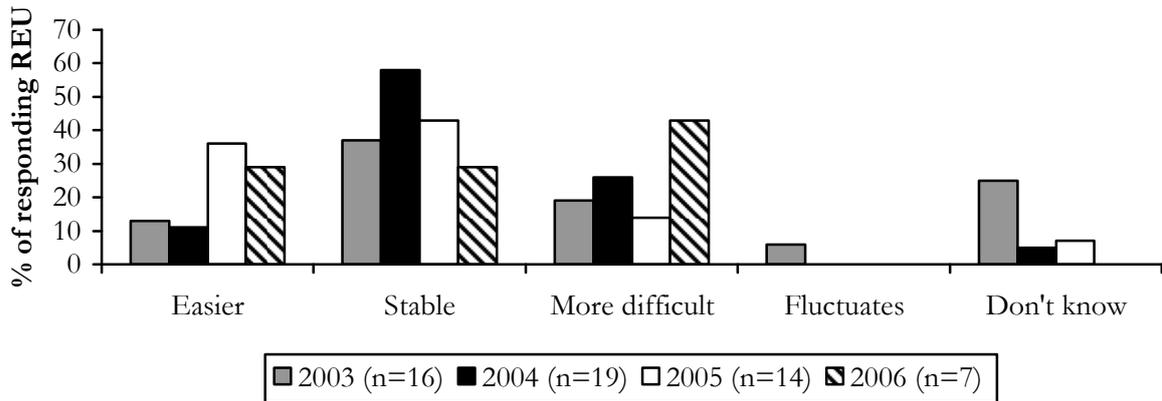
Figure 54: Current availability of GHB, 2003–2006



Source: REU interviews, 2003–2006

Most respondents (43%) of the 2006 REU sample who were able to comment indicated that GHB had become more difficult to access over the preceding six months, with 29% reporting that availability had remained stable and 29% that it had become easier to access (Figure 55). Indeed, a considerably larger proportion of 2006 participants reported that GHB had become more difficult to obtain than in previous samples.

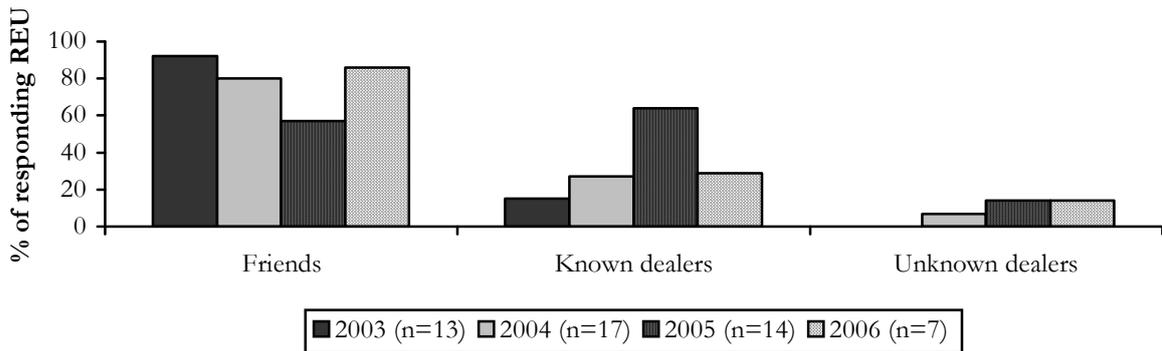
Figure 55: Change in GHB availability in the preceding six months, 2003–2006



Source: REU interviews 2003–2006

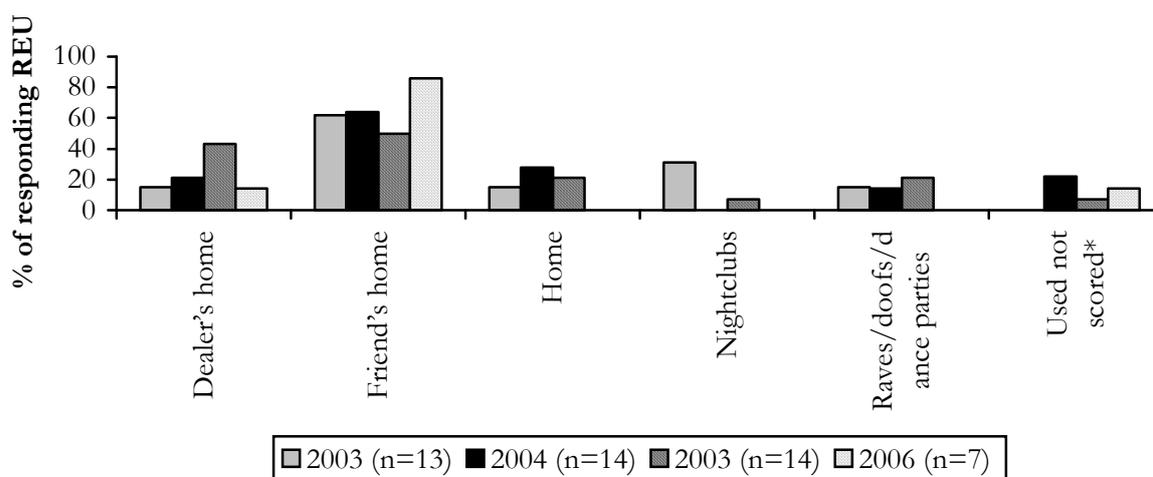
Consistent with previous years, GHB was reported to be predominately purchased from friends and known dealers (Figure 56) in friends’ homes (Figure 57).

Figure 56: People from whom GHB had been purchased in the preceding six months, 2003–2006



Source: REU interviews, 2003–2006

Figure 57: Locations where GHB had been purchased in the preceding six months, 2003–2006



Source: REU interviews, 2003–2006

- ‘Used not scored’: option not included in 2003 REU survey

One KE commented on the availability of GHB, noting that although it has become harder to purchase when at many venues, there remain certain venues where it can still easily be obtained. This KE also noted that the recipe for GHB can be easily found on the internet.

8.5 GHB related harms

8.5.1 Law enforcement

No Victorian GHB-specific law enforcement indicator data is available. Three law enforcement KE reported that ‘a lot’ of GHB was confiscated at a large music event in early 2006, noting that GHB users generally store the substance in 10ml bottles that are usually used for storing bubble mixture. Consequently, GHB is often more difficult to hide than other drugs that might be packaged more discretely and occupy less space. These law enforcement KE did report a reduction in GHB overdoses during the last 12 months, and suggested that because the substance is more difficult to hide when entering a venue, it is more frequently detected by police and less people are consuming it as a result.

However, these law enforcement KE also reported that the prevalence of GHB has increased since late 2004, and “*has been of increasing concern in 2006*”. One KE from Australian Customs Service reported that GHB was previously detected and seized “*fairly regularly*”, although there have been very few attempts to import GHB since Pelchat Labs (an internet-based GHB kit distributor) was shut down in Canada. This KE suggested that there is no need to import GHB considering it can easily be made in Australia.

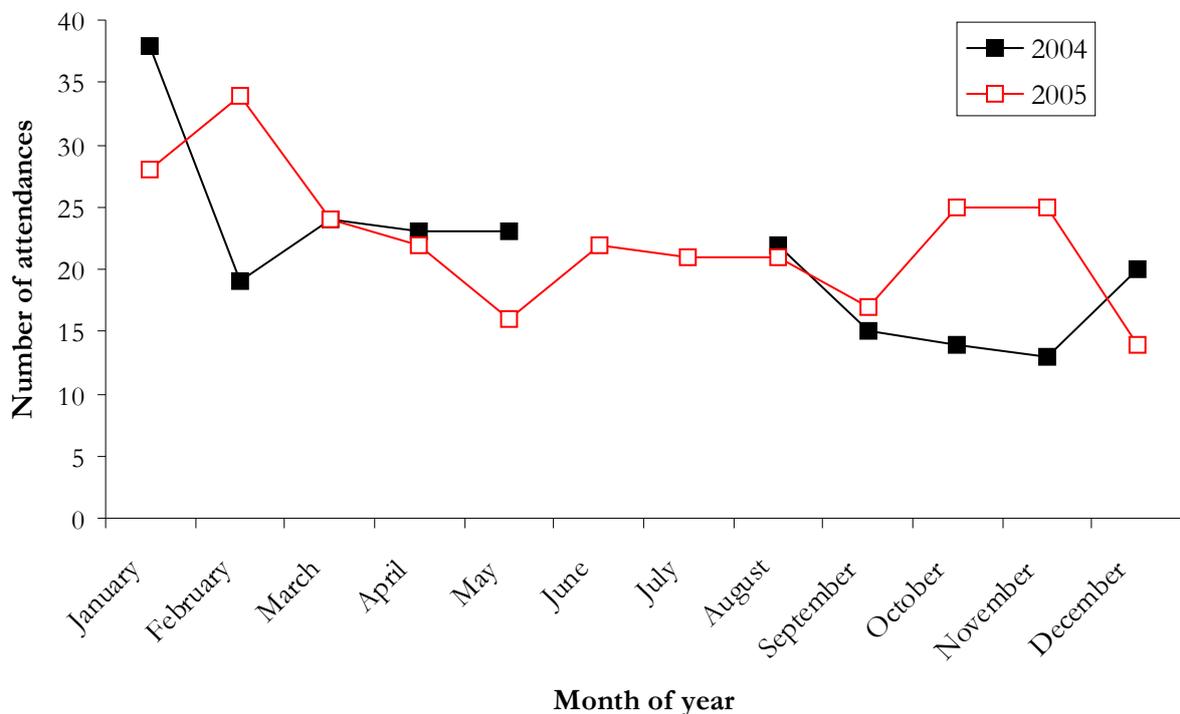
Several law enforcement KE also highlighted the increasing prevalence of 1,4-Butanediol (1,4-B) during the preceding 12 months. One law enforcement KE described 1,4-B as a substance that, once ingested, provides similar effects to those of GHB, with similar associated health risks. However, this KE did note that, unlike GHB, there is currently no legislation preventing the use or possession of 1,4-B, although the KE was unsure whether there were any legal implications if GHB was sold as 1,4-B. Although two law enforcement KE reported that increasing amounts of 1,4B were being imported into Australia, they were unable to specify which countries it was coming from.

8.5.2 Health

GHB-related events attended by ambulance

Figure 58 reports the monthly totals of ambulance attendances where GHB use was mentioned in Melbourne, January 2004–December 2005 (excluding June–July 2004). Ambulance attendances where GHB use was recorded ranged between 13–38 per month during this time. In 2005 there were a total of 269 attendances where GHB use was mentioned, compared to 211 in 2004 and 114 in 2003. In both years the average estimated age of cases was 23 years (analysis by S. Cvetkovski, Turning Point Alcohol and Drug Centre).

Figure 58: Monthly totals of ambulance attendance where GHB was mentioned in Melbourne, 2004–2005 (excluding June–July 2004)



Source: Metropolitan Ambulance Service and Turning Point Alcohol and Drug Centre

Two KE reported that there are venues in Melbourne that continue to have problems with GHB use and the detrimental effects of the drug. One of these KE reported that 2 to 8 ambulances are sent to one particular nightclub every Saturday night, “*particularly because of GHB blowouts*”. In addition, a first aid KE reported that out of every twenty people seen by first aid staff at a large-scale event, approximately two-thirds would be sent to the emergency department via ambulance, usually as a result of polydrug use involving GHB and/or ecstasy, or “*a particularly high dose of one drug, especially GHB*”. This contrasts the report of another first aid KE, who noted that, although GHB use is present at ‘most’ events and is a drug of concern, most cases are now treated on-site instead of being sent to the hospital via ambulance.

An ambulance paramedic KE reported the high prevalence of 1,4-B in Melbourne’s ERD-using scene, adding that ‘many’ users think they are simply consuming GHB. This KE highlighted one particular danger resulting from this misconception – an individual can receive anywhere between

1 to 4 times the expected dose of GHB, depending on how effective their body is at turning 1,4-B into GHB.

One KE providing hospital-based emergency treatment for GHB overdoses reported that presentations usually come ‘in waves’, suggesting that there might be 6 to 8 GHB cases presenting each weekend for 6 weeks, then a 3 month period might follow without any GHB-related cases. This KE hypothesised that although GHB-related cases were more prevalent in summer, the number and frequency of cases was more strongly associated with the production and availability of the substance as opposed to season.

The association between GHB and drink spiking was mentioned by three KE. One KE working in a hospital accident and emergency department reported that drink spike cases, although rare, were usually associated with GHB and were more common in the gay community. Another KE cited GHB as a drug that could possibly be used for the purposes of drink spiking, noting that as GHB remains in the body for only a short period of time it might not be detected by the time a potential drink spiking victim is able to be tested. This KE did acknowledge, however, that anecdotes such as this are “*easy to throw around*”. A law enforcement KE added that the issue of GHB used to spike drinks is being ‘overblown’, and suggested that some GHB-using individuals might use it as an excuse to explain intoxication or overdoses.

8.6 Summary of GHB trends

Reports from the Victorian REU and KE suggest:

- ❖ moderate prevalence of ‘lifetime’ and low prevalence of recent GHB use among REU;
- ❖ low frequency of use reported by recent users;
- ❖ GHB is used across a wide range of locations, predominantly private homes, dance parties and nightclubs;
- ❖ GHB remains very cheap;
- ❖ current GHB purity is regarded as medium, but there is little consensus about recent changes in purity;
- ❖ GHB remains readily available, although availability may have recently decreased;
- ❖ GHB tends to be purchased from friends in their homes; and
- ❖ KE continue to report concern for the health consequences associated with GHB use.

9 LSD

There is limited data available regarding the prevalence of LSD use in the Australian general population. A 'hallucinogen' category is included in the NDSHS, but this is a broad category encompassing the use of synthetic hallucinogens such as LSD, psilocybin and angel dust and naturally occurring hallucinogens such as magic mushrooms, and datura (Australian Institute of Health and Welfare, 2005). The most recent data from the 2004 NDSHS indicates that this category of drugs had been used by 0.7% of the general Australian population in the preceding twelve months, a statistically significant reduction on the 2001 estimate of 1.1% (Australian Institute of Health and Welfare, 2005). It is estimated that 7.5% of the general Australian population aged 14 years and older have ever used a 'hallucinogenic' substance (Australian Institute of Health and Welfare, 2005). The estimates of use within the Victorian general population are consistent with national figures, with 0.7% estimated to have recently used a hallucinogenic substance (Australian Institute of Health and Welfare, 2005). LSD is specifically asked about in VYADS, with estimates of used slightly higher in this younger cohort than the general Australian population: 5% having ever used LSD and 2% used LSD in the preceding 12 months (Premier's Drug Prevention Council 2005). Data from the 2004 VYADS suggest that hallucinogens tend to be infrequently used: 30% of recent users report using them once a month or more, 32% once or twice a year and 37% had only used on one occasion in the 12 months prior to interview (Premier's Drug Prevention Council 2005).

9.1 LSD use among REU

Less than two-thirds (60%) of the 2006 REU sample reported having ever used LSD, with over one-third (37%) reporting use of LSD in the preceding six months (Table 20). The median age of first use for LSD was 19 (range 13–32).

The thirty-seven recent LSD users in the 2006 sample reported using LSD a median of three days (range 1–20) in the six months preceding interview, with the majority (84%) reporting using LSD monthly or less frequently. Most respondents quantified LSD usage in terms of tabs (n=34), with a median number of one (range 0.5–3) reported as being taken in a 'typical' or 'average' use episode. During their 'heaviest' use episode in the preceding six months, a median of 1.75 tabs (range 0.5–10) was used. Twenty-one percent of participants who had recently binged (n=44) used LSD when doing so. All recent LSD users reported swallowing the drug.

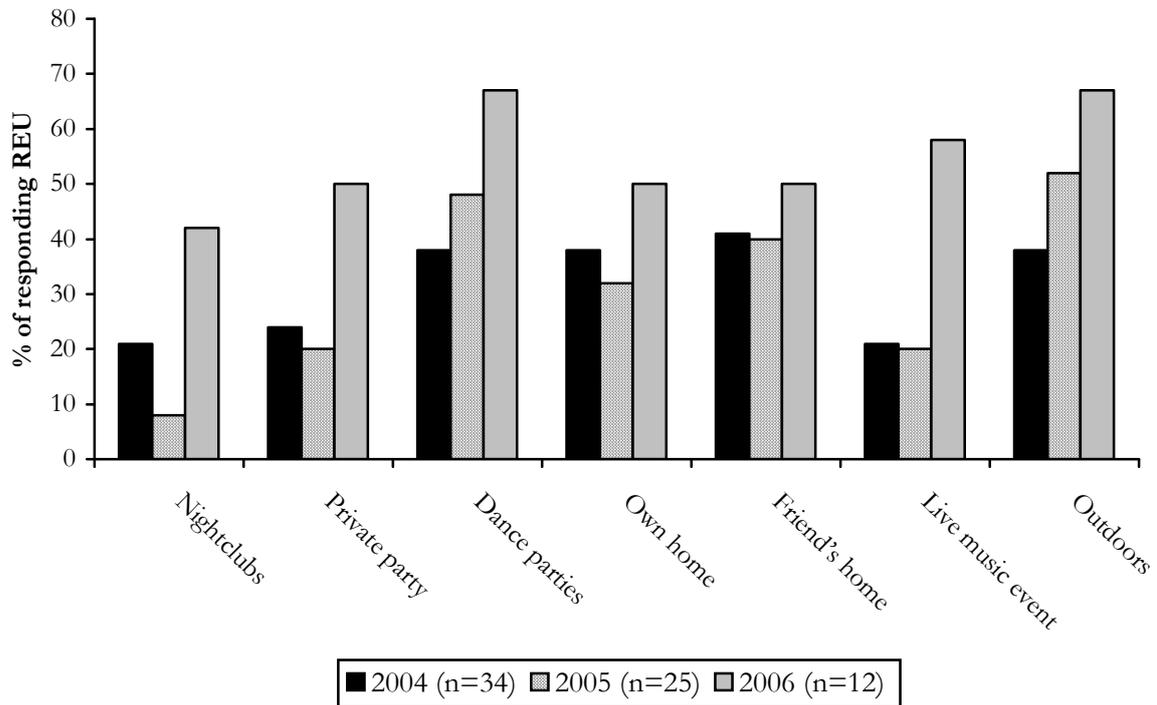
Table 20: Patterns of LSD use among REU, 2003–2006

LSD	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Ever used (%)	86	72	67	60
Used last six months (%)	48	40	38	37
Of those who had used				
Median days (range) used last 6 months	2 (1–70) (n=48)	2 (1–18) (n=39)	3 (1–30) (n=38)	3 (1–20) (n=37)
Median quantities used (tabs)				
Typical (range)	1 (0.5–3) (n=38)	1 (0.5–5) (n=30)	1 (0.5–3) (n=31)	1 (0.5–3) (n=34)
Heavy (range)	1 (0.5–15) (n=36)	2 (0.5–50) (n=29)	1.25 (0.5–10) (n=30)	1.75 (0.5–10) (n=34)

Source: REU interviews, 2003–2006

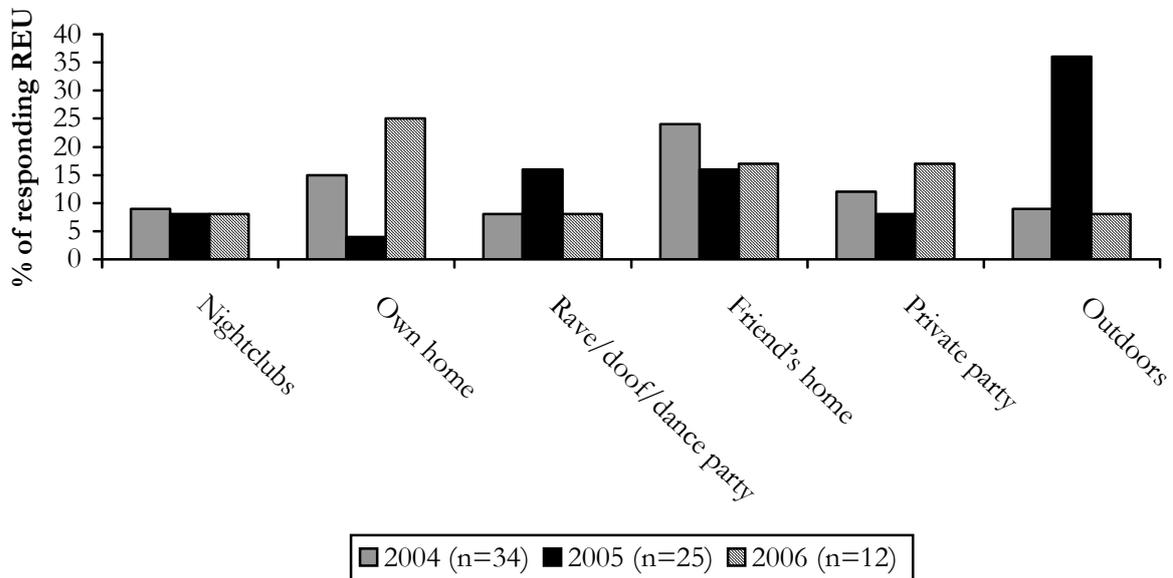
LSD was used across a wide variety of locations, predominantly outdoors (67%), at dance parties/raves/doofs (67%), in friends' homes (50%), participants' own homes (50%), private parties (50%) and live music events (58%; Figure 59). The most common location where participants last used LSD was their own homes (25%; Figure 60). Information regarding location of LSD use was not collected in the 2003 REU survey.

Figure 59: Usual location of LSD use, 2004–2006



Source: REU interviews, 2004–2006

Figure 60: Location of most recent LSD use, 2004–2006



Source: PDI REU interviews, 2004–2006

Twelve KE commented on the use of LSD, with six reporting that ‘a few’ ERD users consumed the substance. One KE indicated that the proportion of LSD users fluctuates, estimating that 70% of ERD users will try it, though following the initial use it is unknown how many people

continue to use it. This KE also described LSD use as “*more of an experimental thing*”. Another KE reported that some people try LSD after using ecstasy and possibly other substances such as speed, ketamine and/or GHB, whereas others view it as ‘hardcore’ and do not use the substance due to the fear of a ‘bad trip’. Four KE reported that levels of LSD use had remained stable throughout the previous 6 to 12 months, while two KE reported increased LSD use. Both attributed this increase, in part, to the belief that LSD is not detectable by PADD dogs. One of these KE also noted that LSD use may have increased due to the inexpensive nature of the substance. One KE noted that LSD is often a part of polydrug use, while three law enforcement KE reported seeing ‘a little bit’ of hallucinogens at dance parties.

9.2 Price

Only twelve participants in the 2006 sample were able to comment on the current price, purity and availability of LSD in Melbourne in the six months prior to interview. Eleven participants reported on the price of LSD per tab, with a median price of \$12 (range \$7.50–\$25) being reported (Table 21).

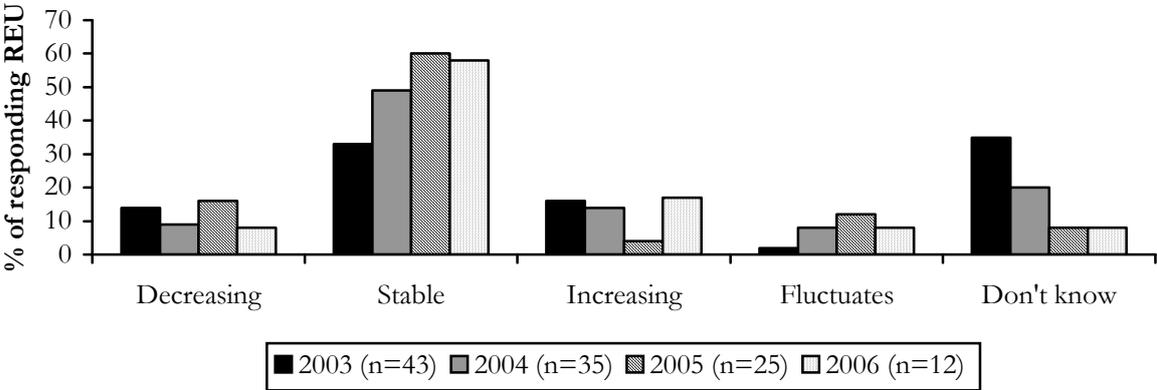
Table 21: Prices of LSD purchased by REU, 2003–2006

LSD	2003 (n=18)	2004 (n=33)	2005 (n=25)	2006 (n=11)
Median price (\$) Tab (range)	\$15 (\$6.50–\$25)	\$20 (\$4–\$40)	\$15 (\$5–\$30)	\$12 (\$7.50–\$25)

Source: REU interviews, 2003–2006

Of the twelve participants who responded, the majority (58%) reported that the price of LSD had been stable in the prior six months (Figure 61). Two (17%) reported that it had increased, and one participant each reported the price of LSD as recently decreasing and fluctuating. One participant (8%) was unable to comment on price variations in LSD in the six months prior to interview.

Figure 61: Recent changes in price of LSD purchased by REU, 2003–2006

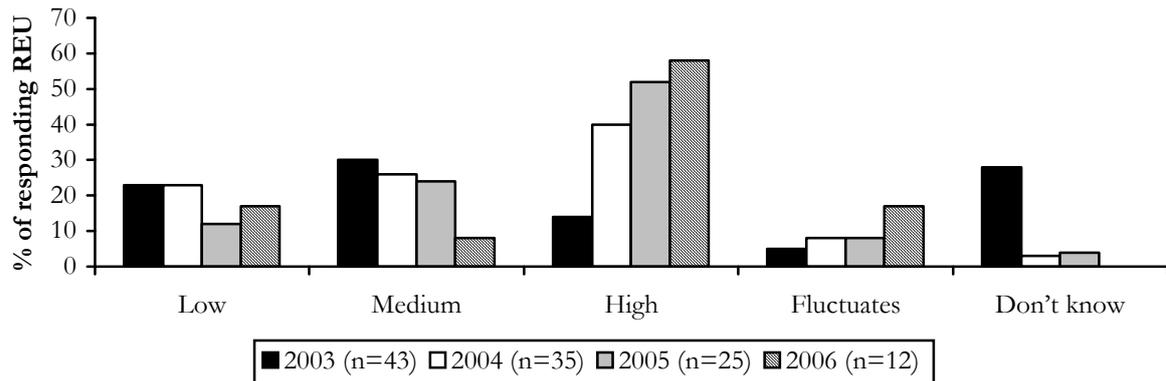


Source: REU interviews, 2003–2006

9.3 Purity

Of the twelve participants who commented on current LSD purity, over half (58%) reported the strength as high, 8% (n=1) as medium and 17% each reported it as low and fluctuating (Figure 62). The proportion of participants reporting the purity of LSD as high has increased since 2003, although given the small number of those commenting, the 2006 results must be interpreted with caution.

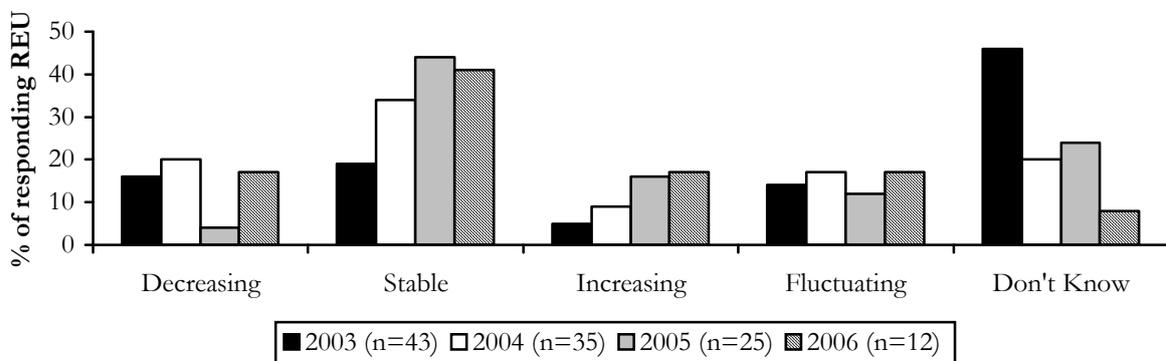
Figure 62: REU reports of purity of LSD in the preceding six months, 2003–2006



Source: REU interviews 2003–2006

Regarding changes in the purity of LSD in the preceding six months, although nearly half (41%) of 2006 REU sample able to comment (n=12) reported the purity had remained stable, the remaining reports were variable: 17% (n=2) each reported LSD purity as increasing, decreasing and fluctuating, with one participant unable to comment on changes in purity (Figure 63). A larger proportion of the 2005 and 2006 samples than previous years reported that the purity had been stable in the preceding six months.

Figure 63: REU reports of change in purity of LSD in the preceding six months, 2003–2006

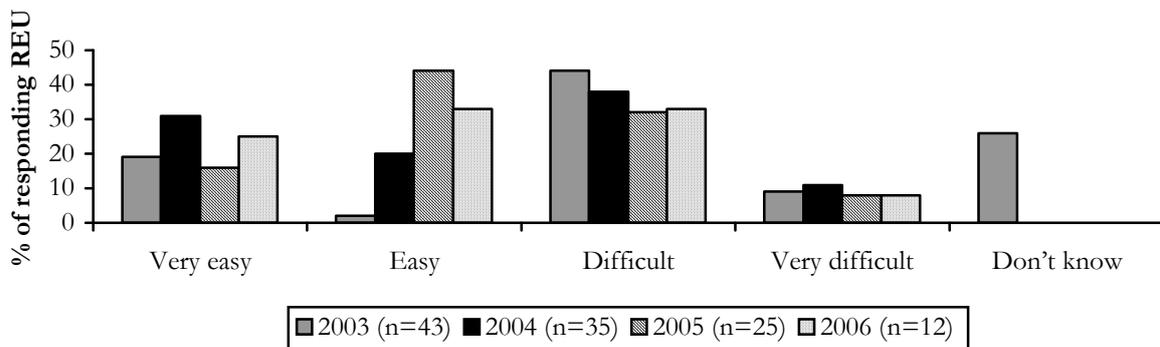


Source: REU interviews 2003–2006

9.4 Availability

There was little consistency in responses around the current availability of LSD (Figure 64). Of the 12 participants who were able to comment, over half (58%) reported that LSD was either ‘easy’ (33%) or ‘very easy’ (25%) to obtain. The remaining 41% reported LSD to either be ‘difficult’ (33%) or ‘very difficult’ (8%) to obtain.

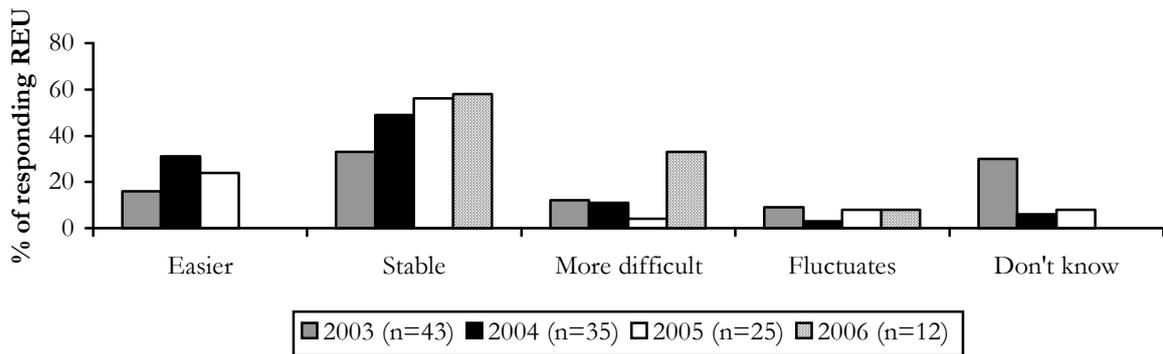
Figure 64: Current LSD availability, 2003–2006



Source: REU interviews 2003–2006

Although over half of respondents (58%) indicated that LSD availability had remained stable over the preceding six months, one-third (33%) reported that it was more difficult to access and one participant (8%) reported that availability had fluctuated (Figure 65). A larger proportion of the 2006 respondents reported that LSD had become more difficult to obtain in the six months prior to interview than those in previous years. The small number of respondents must be considered when interpreting these results.

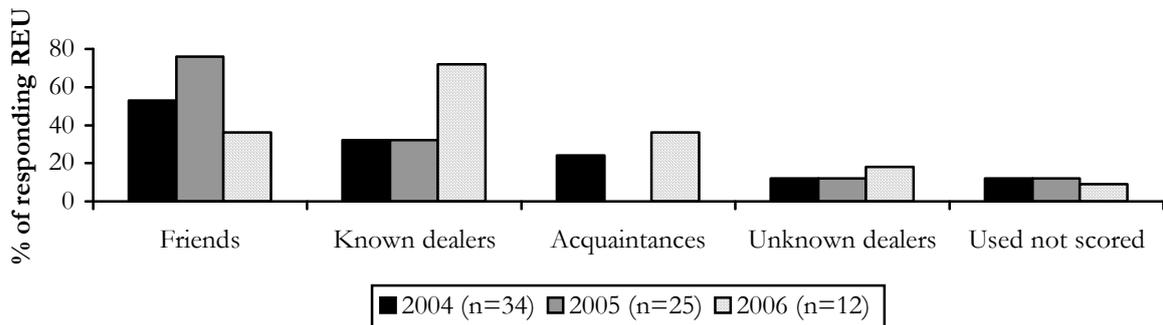
Figure 65: Changes in availability of LSD, 2003–2006



Source: REU interviews 2003–2006

Known dealers (72%), friends (36%) and acquaintances were the most common people from whom LSD had been purchased in the past six months (Figure 66). The 2006 sample were more likely to report purchasing LSD from known dealers than those from previous years, although again the small number of respondents must be considered when interpreting these results.

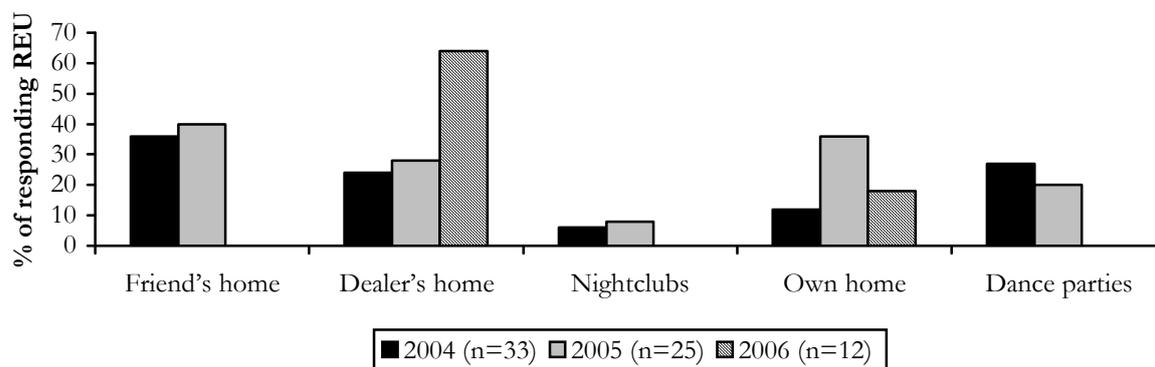
Figure 66: People from whom LSD had been purchased in the preceding six months, 2004–2006



Source: REU interviews 2004–2006

2006 participants reported purchasing LSD in fewer locations than those from previous years. Respondents reported purchasing LSD in dealers' (63%) and their own (18%) homes (Figure 67).

Figure 67: Locations LSD had been purchased from in the preceding six months, 2004–2006



Source: REU interviews 2004–2006

9.5 Hallucinogen related harms

9.5.1 Law enforcement

Table 22 details consumer (e.g. possession/use) and provider (e.g. trafficking/manufacture) arrests for hallucinogens, during 2004/05 (in Victoria and Australia). During that financial year 19% of the arrests made in Australia for hallucinogen offences (LSD or psilocybin mushrooms) occurred in Victoria (Australian Crime Commission, 2004).⁵ The number of consumer and provider arrests for hallucinogen offences remains very low.

Table 22: Hallucinogens: consumer and provider arrests, Victoria and national, 2004–2005+

	Victoria (n)	Australia (n)	% of national arrests
Consumer	19	89	21.3
Provider	4	30	13.3
TOTAL*	23	119	19.3

Source: Australian Crime Commission

*Includes those offenders for whom consumer/provider status was not stated

+ 2005/2006 data not available at the time of publication

⁵ Proportions (%) should be interpreted with caution due to the lack of uniformity across states and territories in the recording and storing of data on illicit drug arrests.

9.6 Summary of LSD Trends

Reports from the Victorian REU and KE suggest:

- ❖ high prevalence of lifetime use of LSD with moderate levels of recent use among REU;
- ❖ recent users report infrequent use of LSD;
- ❖ LSD is used across a wide range of locations, predominantly ‘outdoors’, live music events, and at dance parties;
- ❖ LSD is relatively cheap and the price has remained stable over the preceding six months;
- ❖ current LSD purity is regarded as high, with purity described as stable over the previous six months;
- ❖ there is little consistency in the reported current availability of LSD, although availability has remained stable over the previous six months; and
- ❖ LSD is most commonly purchased from known dealers in private homes.

10 MDA

10.1 MDA use among REU

Just over one-quarter of the sample (26%) reported having ever used MDA, with only 8% reporting use of MDA in the preceding six months (Table 23). The median age of first use for MDA was 21 (range 14–33).

Recent MDA users (n=8) reported using it on a median of one day (range 1–40) in the preceding six months. Of those who had used MDA in the preceding six months, the majority (75%) reported using only on one occasion.

MDA users quantified their usage in terms of a range of amounts, including capsules (n=3), with a median of one MDA cap taken during both ‘typical’ (range 1–3) use episodes and ‘heaviest’ (range 1–6) use episodes. Quantities of use were also reported in terms of lines (n=3), pills/tabs (n=1) and points (n=1). Two of the participants who had recently binged (n=44) had used MDA when doing so. Recent MDA users reported swallowing (63%) and snorting (38%) the drug.

Table 23: Patterns of MDA use among REU, 2003–2006

MDA	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Ever used (%)	40	37	25	26
Used last six months (%)	19	16	8	8
Of those who had used				
Median days (range) used last 6 mths	4 (1–72) (n=19)	2.5 (1–15) (n=16)	5.5 (1–24) (n=8)	1 (1–40) (n=8)
Median quantities used (capsules)				
Typical (range)	1 (0.5–2) (n=7)	1 (0.5–4) (n=14)	1 (n=2)	1 (1–3) (n=3)
Heavy (range)	1 (0.5–4) (n=8)	1.5 (0.5–8) (n=14)	1 (n=2)	1 (1–6) (n=3)

Source: REU interviews, 2003–2006

As only one participant from the 2006 sample reported on MDA markets in Melbourne in the six months prior to interview, this data is not presented. Further, no KE were able to comment on MDA use or markets, and no MDA indicator data is available.

11 CANNABIS

11.1 Cannabis use in the general population

The most recent survey of cannabis use within the general community of Victoria was undertaken within the 2004 National Drug Strategy Household Survey. The findings of this survey suggest that cannabis is the most commonly used illicit drug within the Victorian community, with 9.8% of the Victorian population aged 14 years and over reporting use of the drug within the past 12 months (Australian Institute of Health and Welfare, 1999).

Data from the 2004 Victorian Youth Alcohol and Drug Survey (Premier's Drug Prevention Council, 2002) show that cannabis is the most frequently, and widely used illicit drug by the 6,005 young people surveyed. Approximately half (48%) of the 16–24 year olds sampled reported lifetime use of cannabis, and over one-quarter of the sample (27%) reported use in the 12 months prior to the survey. Alcohol and tobacco were reported to be the drugs most commonly used at the same time as cannabis.

11.2 Cannabis use among REU

Nearly all (97%) of the 2006 REU reported having ever used cannabis and the majority (79%) had used cannabis in the preceding six months (Table 24). The median age of first use for cannabis was 15 (range 11–25). Cannabis was used on a median of 48 days (range 1–180) in the preceding six months. Of those who had used cannabis in the previous six months (n=79), only twenty percent (n=16) reported using it once a month or less frequently. In comparison, a substantial proportion (52%) reported using cannabis twice a week or more in the preceding six months, with 22% reporting using cannabis daily. Further, more than one-third (37%) of the sample reported typically using cannabis in conjunction with ecstasy and more than half (53%) during 'comedown' from ecstasy in the six months preceding the interview. Of those participants that reported bingeing in the six months prior to being interviewed (n=44), half (50%) reported using cannabis during a binge.

Table 24: Patterns of cannabis use among REU, 2003–2006

Cannabis	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Ever used %	98	98	97	97
Used last six months%	82	78	87	79
Of those who had used				
Median days (range) used last 6 months	55 (1–180)	24 (1–180)	20 (1–180)	48 (1–180)

Source: REU interviews, 2003–2006

Sixteen KE commented on the use of cannabis amongst ERD users. No changes regarding cannabis use were reported by any KE, while proportions of individuals using cannabis ranged from 'a few' to 'all' – 'everyone smokes pot' – with the majority of KE indicating that 'most' ERD users use the substance. Three KE highlighted the use of cannabis to counter the comedown effects of ecstasy and methamphetamines, while KE from first aid and treatment backgrounds reported that cannabis is rarely the 'principal reason' for individuals to present to a service. When cannabis use is reported by individuals presenting to treatment services, these KE

noted that it is usually an aspect of polydrug use. A few KE highlighted the predominantly social aspect of cannabis use, also noting that it is generally a secondary substance for REU.

11.3 Price

For the first time in 2006 questions related to the price, potency and availability of cannabis were asked. These questions were asked separately for hydroponic cannabis and bush/naturally grown cannabis. Prices paid by participants for hydroponic and bush/naturally grown cannabis in the six months prior to interview are presented in Table 25.

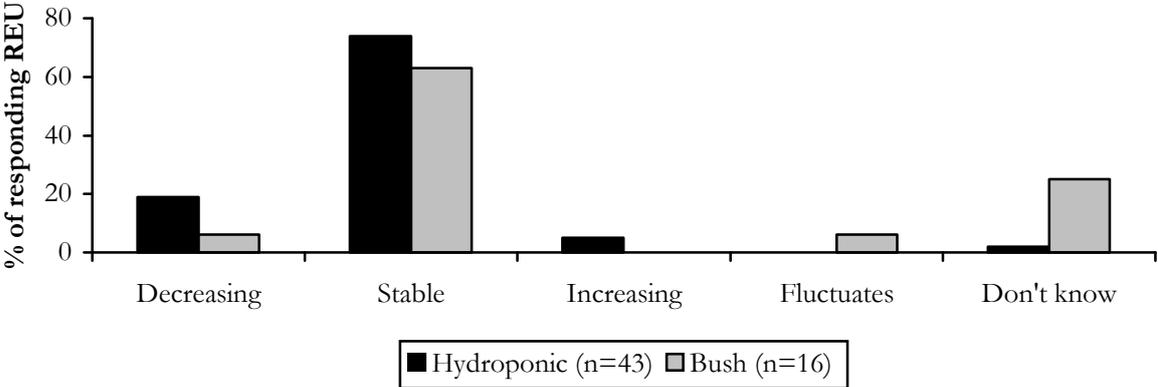
Table 25: Price of cannabis purchased by REU, 2006

Cannabis	2006 (N=100)
Median price (\$)	
Hydroponic	
- gram	\$15 (\$10–\$20) (n=35)
- ounce	\$220 (\$180–\$300) (n=28)
Bush	
- gram	\$15 (\$10–\$20) (n=11)
- ounce	\$200 (\$100–\$280) (n=11)

Source: REU interviews, 2006

Of the 43 participants who reported, the vast majority (74%) stated that the price of hydroponic cannabis had been stable in the prior six months. Eight (19%) reported that the price had decreased and two (5%) that it had increased (Figure 68). Of the sixteen participants who responded, slightly less than two-thirds (63%) reported that the price of bush cannabis had been stable in the prior six months. One participant each reported the price of bush cannabis as recently decreasing and fluctuating respectively, and four participants (25%) were unable to comment on price variations in bush cannabis in the six months prior to interview (Figure 68).

Figure 68: Recent changes in price of hydroponic and bush cannabis purchased by REU, 2006

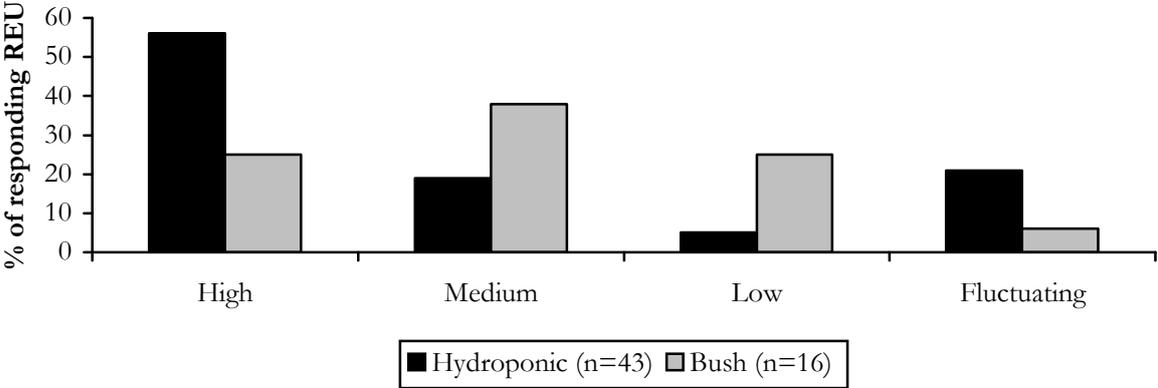


Source: REU interviews, 2006

11.4 Potency

Estimates of the potency of hydroponic and bush cannabis at the time of interview are presented in Figure 69. Of those participants who commented (n=43), over half (56%) reported the current potency of hydroponic cannabis as high. Eight participants (19%) reported it as fluctuating and nine (21%) as medium. In comparison, the reports regarding current potency of bush cannabis were more varied: of those participants who commented (n=16), one-quarter (25%) reported the current potency of as high. More than one-third (38%) reported it as medium and a further quarter (25%) reported the current purity of bush cannabis as low. These findings should be interpreted with caution, however, given the relatively small number of participants able to comment on bush cannabis.

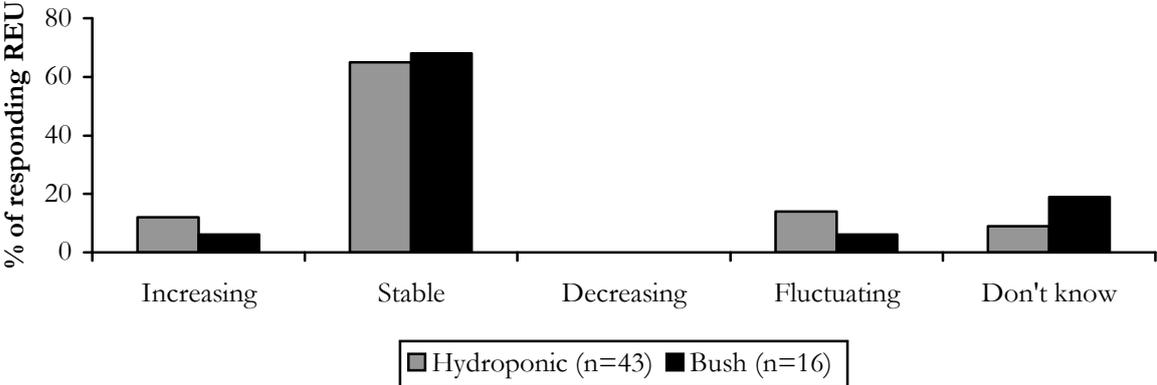
Figure 69: Reports of current hydroponic and bush cannabis potency by REU, 2006



Source: REU interviews, 2006

Reports regarding changes in the potency of hydroponic and bush cannabis during the six months prior to time of interview were comparable. Of those participants who commented (n=43), nearly two-thirds (65%) reported the potency of hydroponic cannabis had been stable. Six participants (14%) reported it had fluctuated and five (12%) that it had increased during this period of time (Figure 70). Similarly, the majority of those who commented (n=16), reported that the potency of bush cannabis had been stable over the six months prior to interview (Figure 70). One participant each reported it as increasing and fluctuating, and three (18%) were unable to comment.

Figure 70: Reports of changes in hydroponic and bush cannabis potency by REU, 2006

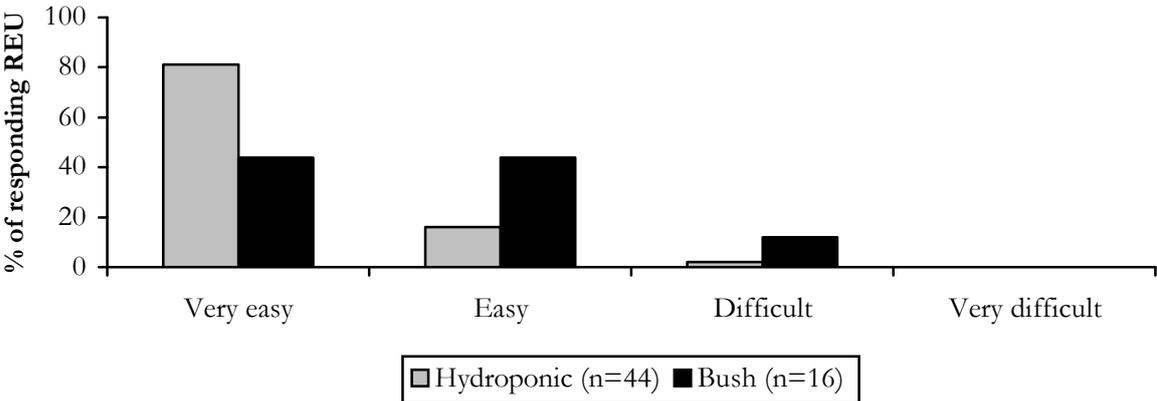


Source: REU interviews, 2006

11.5 Availability

The reported current availability was broadly comparable across the two forms of cannabis (Figure 71). Of those who commented on the availability of hydroponic cannabis (n=43), the majority (81%) reported it as being ‘very easy’ to obtain at the time of interview. A further seven participants (16%) reported it as being easy to obtain, with only one participant reporting it as difficult to obtain. Of the sixteen participants able to comment on ‘current’ availability of bush cannabis, the majority (88%) reported it as either being ‘very easy’ (44%) or ‘easy’ (44%) to obtain, with only two participants (12%) reporting it as ‘difficult’ to obtain.

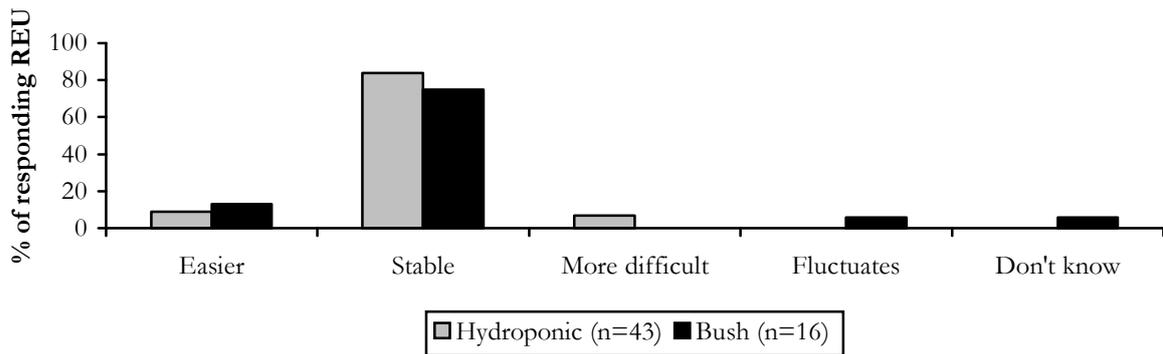
Figure 71: Current availability of hydroponic and bush cannabis, 2006



Source: REU interviews, 2006

The vast majority (84%) of respondents able to comment (n=43) indicated that hydroponic cannabis availability had remained stable over the preceding six months, with three participants (9%) reporting that it had become easier to obtain and three (7%) that it had become more difficult to obtain over this period of time (Figure 72). Similarly, the majority (75%) of those able to comment on the availability of bush cannabis over the preceding six months (n=16) reported it as stable, with 13% reporting it had become easier to obtain and one participant (6%) that it had fluctuated (Figure 72).

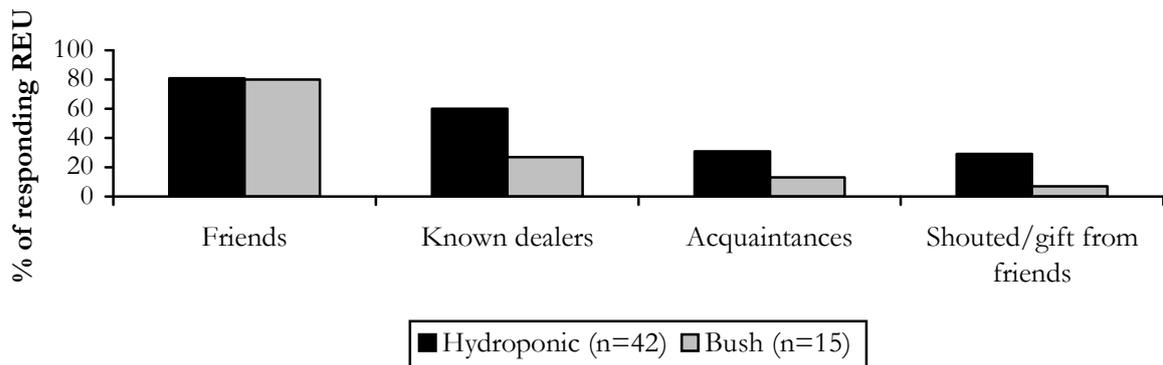
Figure 72: Recent changes in availability of hydroponic and bush cannabis, 2006



Source: REU interviews 2006

Friends (81% and 80%), known dealers (60% and 27%), and acquaintances (31% and 13%) were the most common people from whom both hydroponic and bush cannabis had been purchased in the past six months (Figure 73).

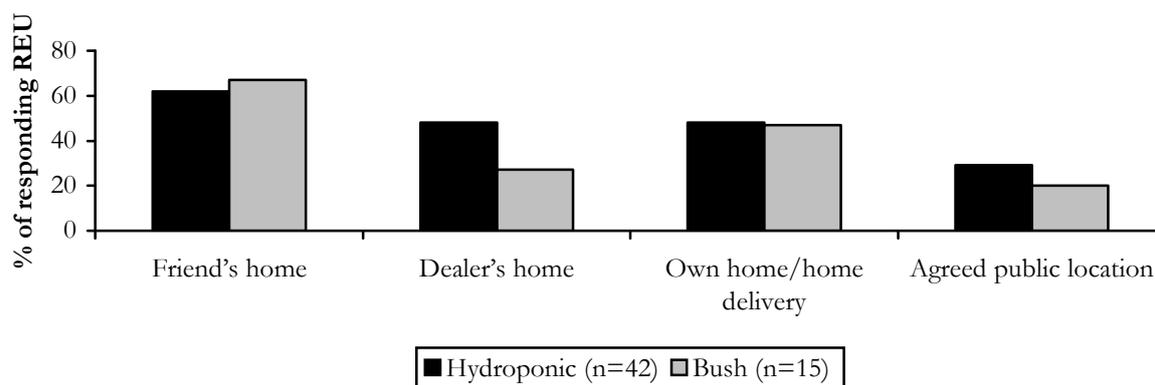
Figure 73: People from whom hydroponic and bush cannabis had been purchased in the preceding six months, 2006



Source: REU interviews, 2006

2006 participants predominately reported purchasing both hydroponic and bush cannabis in private locations, such as friends' homes (62% and 67%), dealers' homes (48% and 27%) and their own homes (48% and 47%), respectively (Figure 74).

Figure 74: Locations in which hydroponic and bush cannabis had been purchased from in the preceding six months, 2006



Source: REU interviews, 2006

11.6 Cannabis-related harms

11.6.1 Law enforcement

Table 26 details consumer (e.g. possession/use) and provider (e.g. trafficking/ manufacture) arrests for cannabis, during 2004/2005 (in Victoria and Australia). During that financial year 14% of the arrests made in Australia for cannabis offences occurred in Victoria (data provided by the Australian Crime Commission).⁶ In Victoria the total number of consumer and provider arrests for cannabis have remained relatively stable since 2003/2004 (N=7,620 in 2003/2004).

Table 26: Cannabis: consumer and provider arrests, Victoria and national, 2004/2005+

	Victoria (n)	Australia (n)	% of national arrests
Consumer	5,064	44,248	11.4
Provider	2,157	8,626	25.0
TOTAL*	7,221	53,053	13.6

Source: Australian Crime Commission

*Includes those offenders for whom consumer/provider status was not stated

+ 2005–2006 data not available at the time of publication

11.6.2 Health

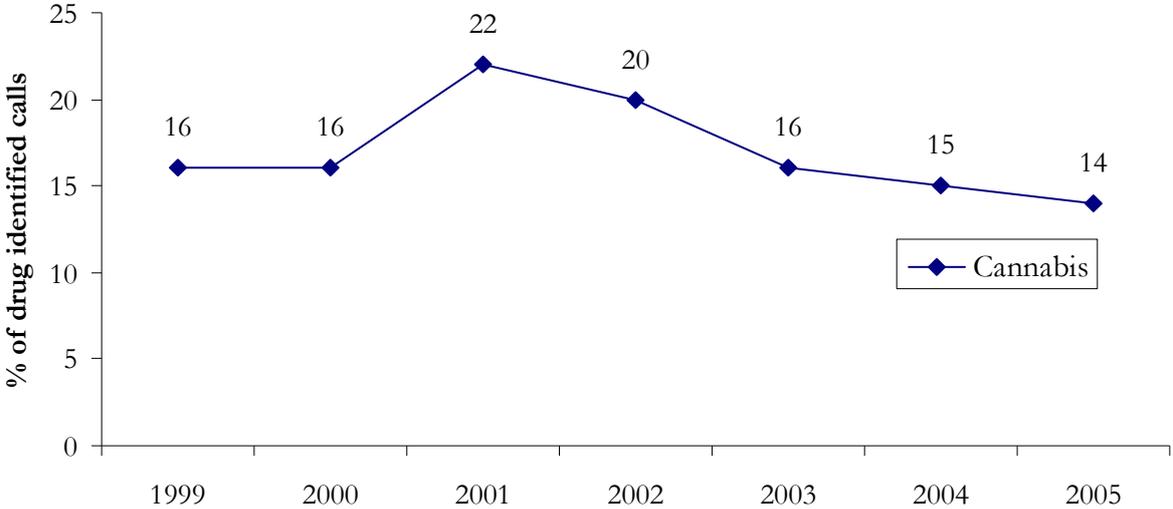
DirectLine calls

During 2005, DirectLine responded to 3,449 calls where cannabis was identified as a drug of concern. This represents 14% of all drug-identified calls to DirectLine during that year (Turning Point Alcohol and Drug Centre Inc., unpublished data). The proportion of drug-related calls

⁶ Proportions (%) should be interpreted with caution due to the lack of uniformity across states and territories in the recording and storing of data on illicit drug arrests.

where cannabis was identified has gradually decreased since 2001, when cannabis-related calls peaked at 22% (see Figure 75).

Figure 75: DirectLine calls where drug of concern identified as cannabis, 1999–2005

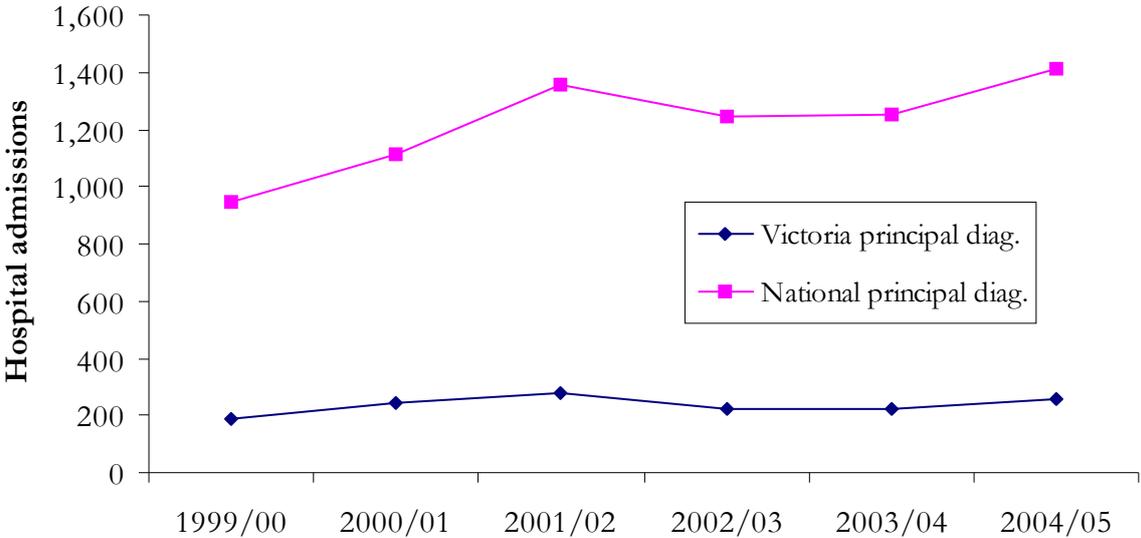


Source: DirectLine, Turning Point Alcohol and Drug Centre

Hospital admissions

The National Hospital Morbidity Database (NHMD) is compiled by the Australian Institute of Health and Welfare. Cannabis-related hospital admissions for Victoria and Australia (among persons aged 15–54 years) are presented in Figure 76. It is evident from this data that the number of cannabis-related hospital admissions in Victoria has been relatively stable over the period of analysis.

Figure 76: Cannabis-related hospital admissions, Victoria and National, 1999/00–2004/05



Source: Roxburgh & Degenhardt (2006); Australian Institute of Health and Welfare

11.7 Summary of cannabis trends

Reports from the Victorian REU and KE suggest:

- ❖ high prevalence of ‘lifetime’ and recent cannabis use among REU, with relatively frequent recent use common;
- ❖ cannabis is commonly used during the comedown period from ecstasy and during ERD binges;
- ❖ bush and hydroponic cannabis are of comparable and stable in price;
- ❖ hydroponic cannabis is perceived to have a higher potency than bush cannabis;
- ❖ both hydroponic and bush cannabis are readily available; and
- ❖ both hydroponic and bush cannabis are purchased from friends and known dealers in private homes

12 ALCOHOL

12.1 Alcohol use in the general population

Alcohol is the most widely used drug in Australia. Most recent estimates from the 2004 NDSHS indicate that approximately 90% of the Australian population aged 14 years and over have ever had an alcoholic drink and that over 80% have done so in the last 12 months (Australian Institute of Health and Welfare, 2005). Data from the NDSHS suggests that Australians tend to have their first drink at approximately 17 years of age (Australian Institute of Health and Welfare, 2005).

12.2 Alcohol use among REU

All 2006 REU participants, but one, reported that they had ever used alcohol, and nearly 97% reported recent alcohol use (Table 27). The median age of first alcohol use was 14 years (range 5–29). Alcohol was consumed on a median of 52 days (approximately twice a week) (range 1–180) in the preceding six months.

Nearly three-quarters (74%) of the 2006 REU sample reported usually (at least two-thirds of occasions of ecstasy use) drinking alcohol while using ecstasy, two-thirds (66%) of who reported consuming more than five standard drinks when doing so. Slightly more than one-third of the sample (37%) reported usually drinking alcohol during the comedown from ecstasy, over two-thirds (68%) of whom reported consuming more than five standard drinks when doing so. Of those participants that reported bingeing in the six months prior to being interviewed (n=44), over half (57%) reported drinking alcohol during a binge.

Table 27: Patterns of alcohol use among REU, 2003–2006

Alcohol	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Ever used %	99	100	100	99
Used last six months%	87	94	97	97
Usually drink alcohol while using ecstasy	57	62	73	74
Usually drink more than 5 standard drinks while using ecstasy*	79	57	60	66
Usually drink while coming down from ecstasy	29	25	35	37
Usually drink more than 5 standard drinks while coming down from ecstasy**	93	48	60	68
Drank alcohol during a ‘binge’***	48	33	45	57

Source: REU interviews, 2003–2006

* Of those who reported usually drinking alcohol while using ecstasy

** Of those who reported usually drinking alcohol while coming down from ecstasy

*** Of those who reported bingeing in the six months prior to interview

Fourteen KE commented on alcohol use amongst ERD users. Consistent with REU sample findings, KE indicated that ‘most’ use alcohol, with proportions ranging from 60% to 100%. One KE reported that REU do not usually drink alcohol to excess, primarily engaging in the activity for social purposes. KE from first aid and treatment backgrounds, however, named alcohol as

their primary drug of concern in many presentations, and also cited it as the main cause of violence. One ambulance paramedic KE listed direct harms resulting from alcohol use, such as vomiting and unconsciousness, and indirect harms such as falls and car accidents.

Despite the harms associated with ERD use, KE indicated that alcohol remains the substance that causes the most amount of drug-related harm. One KE reported that violence is a problem for ERD users when a venue is close to another that is primarily associated with alcohol (such as a pub), specifically when pub patrons initiate fights with dance venue patrons. This KE stated that alcohol is the main cause of violence and of people being ejected from venues. Furthermore, four KE highlighted the dangers of 24-Hour Liquor Licenses, stressing that it increases alcohol-related crime and encourages people to consume drugs and alcohol for a longer period of time, increasing the prevalence of drug-related harms.

12.2.1 Alcohol Use Disorders Identification Test (AUDIT)

Considerable proportions of the REU samples from the 2003–2005 studies reported both drinking alcohol in conjunction with ecstasy use and during the comedown period, and drinking more than five standard drinks during these times. To examine patterns of alcohol use and associated harms in more detail, the World Health Organisation’s Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993) was administered as part of the EDRS for the first time in 2006. The AUDIT is a reliable and simple screening tool used as a measure of risky and high risk (or hazardous and harmful) drinking. Its ten core questions cover the domains of alcohol consumption, drinking behaviour and dependence and the consequences or problems related to drinking, and were designed to assess three conceptual domains: alcohol intake or consumption, dependence, and adverse consequences (Reinert & Allen, 2002). The scores of the 96 participants from the 2006 study who completed the AUDIT scale are presented in Table 28.

Table 28: AUDIT scores and proportion of REU scoring above recommended levels indicative of hazardous alcohol, 2006

	Median score (range) (N=96)	Proportion scoring above recommended level (%) (N=96)
Consumption score	7.5 (1–12)	67
Dependence score	2 (0–11)	23
Adverse consequences score	4 (0–12)	86
Total AUDIT score	12.5 (2–30)	77

Source: REU interviews, 2006

The ‘consumption score’ is scored from the first three questions of the AUDIT:

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have six or more drinks on one occasion?

A score of 6 or 7 may indicate a risk of alcohol-related harm, particularly for those groups more susceptible to the effects of alcohol, such as young people, women, and people using other substances. Just over two-thirds (67%) of respondents scored six or more on these questions.

The ‘dependence score’ is scored from questions 4 to 6 of the AUDIT:

4. How often during the last year have you found that you were not able to stop drinking once you had started?
5. How often during the last year have you failed to do what is normally expected from you because of drinking?
6. How often during the last year have you needed a first drink in the morning to get yourself going, after a heavy drinking session?

A score of 4 or more indicates the possibility of alcohol dependence. The majority (n=74) of the REU respondents scored three or less on these questions, although the remaining 22 participants (23%) had scores of 4 or more, indicating the possibility of dependence.

The 'alcohol-related problems score' is derived from the final four questions, any scoring on which is considered to warrant further investigation to determine whether the problem is of current concern and requires intervention:

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been injured as a result of your drinking?
10. Has a relative or friend or doctor or other health workers been concerned about your drinking or suggested you cut down?

Thirteen participants scored zero on these questions, indicating that the remaining 74 warranted further investigation.

Finally, total AUDIT scores of 8 or more are recommended as indicators of hazardous and harmful alcohol use, as well as possible alcohol dependence (Babor et al., 2001). Seventy-seven percent of the respondents scored 8 or more, levels at which alcohol intake may be considered hazardous.

12.3 Summary of other drug use

Reports from the Victorian REU and KE suggest:

- ❖ **very high prevalence of both lifetime and recent use of alcohol**
- ❖ **high levels of alcohol use in conjunction with, and during comedown from ecstasy;**
- ❖ **considerable proportions of REU drink at levels which may cause acute and/or long terms harms**

13 OTHER DRUGS

13.1 Tobacco

Nearly all (92%) the sample reported having ever smoked tobacco and 78% had used tobacco in the six months preceding the interview. Of those participants who had smoked in the preceding six months, over half (56%) were daily smokers, with only 15% reporting smoking once a week or less frequently.

13.2 Psilocybin or ‘magic’ mushrooms

Over half (55%) of the 2006 sample reported having ever used mushroom, with a median age of 19 years (range 13–40) at first use. Slightly fewer than one-third (32%) of the sample reported having used mushrooms during the six months prior to interview, using them on a median two days (range 1–72) during this period of time. All of the recent mushroom users reported swallowing mushroom during the last six months. In addition, one participant reported snorting and two reported smoking mushrooms during this period of time.

Only a small number (n=4) of participants reported using mushrooms during binges, in conjunction with ecstasy (n=4) and during the comedown period (n=2).

Five KE commented on the use of magic mushrooms amongst ERD users. Two KE reported that mushroom use fluctuates depending on season, with one stating that mushroom use increases during the winter. Two KE also associated mushroom use primarily with the ‘doof’ music scene as opposed to raves, however, one reported that mushroom use was increasing in the rave scene. This KE also noted that some people use magic mushrooms to introduce themselves to other hallucinogens, such as LSD.

13.3 Benzodiazepines

Approximately half (51%) of the 2006 sample reported having ever used benzodiazepines (BZD) and 36% had used BZD in the six months preceding the interview. The median age of first use for BZD was 19 years (range 12–50). Those reporting recent use of BZD had done so on a median of 5.5 days in the preceding six months (range 1–180). About half (53%) of the recent users had used BZD once a month or less, with 36% (n=13) reporting using them once a week or more frequently, four of whom reported daily use. All recent BSD users reported swallowing as their only recent route of administration. Only four participants reported using BZD during binges in the six months prior to interview and three participants reported the use of BZD in conjunction with ecstasy. Their use during the comedown was more common, with 17 participants reporting doing so.

13.4 Antidepressants

One-quarter (25%) of the 2006 sample reported having ever used antidepressants, with 10% reporting use of them in the six months prior to interview. Median age of first use was 19 years (range 14–50). The recent users (n=10) used antidepressants on a median of 56 days (range 2–180) in the six months prior to interview, with swallowing the only route of administration reported during that time. Only one participant reported the use of antidepressants in conjunction with ecstasy and two during the comedown period.

13.5 Inhalants

Less than half (42%) of the sample had ever used amyl nitrate and 32% had used nitrous oxide. Ten participants had used amyl and fourteen had used nitrous oxide in the preceding six months. The median age of first use for amyl was 20 (range 13–32) and the median age of first use for nitrous oxide was 18.5 (range 13–33). Most (70%) recent users had used amyl only once in the previous six months, and 64% of recent users had used nitrous oxide three times or less in the

previous six months. Small proportions of the sample had used amyl (2%) and nitrous oxide (2%) in conjunction with ecstasy, and one participant had used nitrous oxide during the ‘comedown’ from ecstasy. Of the participants who reported bingeing in the previous six months (n=49), three (7%) used nitrous oxide, and one used amyl during binges.

13.6 Heroin and other opiates

Less than one-quarter (23%) of the 2006 sample reported having ever used heroin, with only 8% reporting heroin use in the previous six months. The median age of first use for heroin was 18 years (range 13–32). Participants tended to report relatively infrequent heroin use, with a median of 8.5 days (range 1–20) in the six months prior to interview. Most (88%; n=7) of the recent heroin users had injected it, with two reporting smoking it in the six months prior to interview. One participant reported usually using heroin in conjunction with ecstasy and three reported its use during the comedown from ecstasy. No participants reported using heroin during binges in the six months prior to interview.

Eleven participants reported having ever used methadone at a median age of 23 years (range 16–32) and six had used it in the last six months. Frequency of use varied widely: two participants had used it three or fewer times, and two participants reported daily methadone use in the six months prior to interview. Nine participants reported having ever used buprenorphine at a median age of 24 years (range 16–31). Of these, three reported using buprenorphine in the six months prior to interview, one approximately monthly and the remaining two five or more times a week. Participants reported swallowing (n=2) and injecting (n=1) buprenorphine in the six months prior to interview.

13.7 Other drugs

Fewer 2006 participants than in recent years reported the use of other drugs. One participant (compared to seven in 2005) reported having ever used dimethyltryptamine (DMT), “*a powerful, visual psychedelic which produces short-acting effects when smoked. It is used orally in combination with an monoamine oxidase inhibitor (MAOI), as in ayahuasca brews. It is naturally produced in the human brain and by many plants*” (<http://www.erowid.org/chemicals/dmt/dmt.shtml>, sourced 15 February 2006). This participant reported using DMT in the six months prior to interview.

One participant (compared to five in 2005) reported having ever used ‘cactus’ and/or mescaline, “*a naturally occurring psychedelic with a long history of human use. It is best known as the primary active chemical in the peyote cactus*” (<http://www.erowid.org/chemicals/mescaline/mescaline.shtml>, sourced 15 February 2006).

13.8 Summary of other drug use

Reports from the Victorian REU and KE suggest:

- ❖ very high lifetime and recent use of tobacco, with many REU daily tobacco smokers;
- ❖ relatively high prevalence of lifetime and recent use of magic mushrooms, although low frequency of use is typical;
- ❖ relatively high prevalence of lifetime and recent use of benzodiazepines, with approximately monthly use is typical;
- ❖ low levels of lifetime and recent use of antidepressants among REU;
- ❖ approximately half of REU report lifetime use of inhalants and about one-quarter report low levels of recent use; and
- ❖ low levels of lifetime and recent use of heroin and ‘other opiates’ among REU.

14 DRUG INFORMATION SEEKING BEHAVIOUR

For the first time in 2005, the REU sample asked about their use of methods to determine the content and purity of ecstasy pills and other drugs, their knowledge of the limitations of available pill testing methods, and how pill test results would influence their drug use behaviour. These questions, plus some additional ones, were asked in 2006.

The majority of the 2006 sample reported attempting to find out the content and purity of ecstasy at least some of the time (86%), most commonly asking friends who had taken it (78%) or asking dealers (71%: Table 29). Slightly less than one-third (30%) of the sample reported personal use of testing kits. There was a moderate level of awareness of the limitations of testing kits among those who reported having used them, with approximately (65%) able to comment on the limitations. Over half (54%) of those participants reporting personal use of testing kits reported that they would not take a pill if test results indicated that it contained ketamine, and over three-quarters (77%) reported that they would not take an 'unknown' pill (producing no reaction in a reagent test).

Participants were also asked what information sources they would find most useful if they were made locally available (Table 29). Consistent with the findings from 2005, web sites (74%) and testing kits (60%) received the most support from the 2006 REU sample. It is interesting to note the increase in support for venue outreach workers from 2005 to 2006.

Table 29: Content and testing of ecstasy tablets by jurisdiction, 2005-2006

	2005 (N=100)	2006 (N=100)
Find out the content/purity of other drugs (not including ecstasy)		
Always (%)	29	26
Most times (%)	19	13
Half the time (%)	7	10
Sometimes (%)	17	20
Never (%)	28	31
Find out the content/purity of ecstasy		
Always (%)	40	33
Most times (%)	27	27
Half the time (%)	8	5
Sometimes (%)	16	21
Never (%)	9	14
Find out content/purity via*		
Friends who have taken it (%)	79	78
Dealers (%)	63	71
Testing kits (%)	38	30
Websites (%)	58	59
Information pamphlets (%)	3	0
Personal experience (%)	31	48
Other people who have taken it (%)	20	38
Use testing kits**		
Always (%)	34	61
Most times (%)	19	17
Half the time (%)	13	9
Sometimes (%)	34	13
Are aware of limitations of testing kits** (%)	56	65
Would still take pill if contained**		
Ecstasy-like substance (%)	100	100
Amphetamine substance (%)	77	92
Ketamine substance (%)	38	46
Opiates (%)	–	23
2CB/2CI (%)	–	29
PMA (%)	–	17
DXM (%)	–	13
No reaction (%)	21	23
Information resources believed to be/would be useful		
Pamphlets (%)	41	46
Local website (%)	61	74
Testing kits (%)	60	61
Venue outreach worker (%)	38	61

Source: REU interviews, 2005–2006

* Among those who find out about the content/purity of ecstasy

** Among those who used testing kits (n=26)

15 RISK BEHAVIOUR

15.1 Injecting and injecting-risk behaviour

15.1.1 'Lifetime' injectors

Comparable to the levels of injecting reported by the 2005 REU sample, 18% of the 2006 sample reported ever injecting any drug, with a mean of 6.5 drug types injected (range 1–12: Table 30).

Speed (89%) was the drug most commonly ever injected by injectors in the 2006 sample, followed by heroin (83%), crystal methamphetamine (67%), ecstasy pills (56%), other opiates (56%), with smaller numbers reporting having ever injected BZD (39%), ecstasy powder (33%), methamphetamine base (33%) and cocaine (33%).

Table 30: Injecting behaviour among REU, 2005–2006

	2005 (N=100)	2006 (N=100)
Ever injected (%)	16	18
Median number of drugs ever injected (range)	4 (1–9) (n=16)	6.5 (1–12) (n=18)

Source: REU interviews, 2005–2006

Context of initiation to injecting

Of the eighteen participants from the 2006 sample who reported ever injecting drugs, over half (56%) reported injecting for the first time while they were under the influence of drugs, most commonly cannabis (60%) and/or alcohol (50%). Seventeen participants reported on the circumstances around their learning to inject, with over half (53%) being taught by a friend/partner, two being self-taught and four (24%) reporting that they had never injected themselves. Speed (44%) and heroin (39%) were most commonly reported as the drugs first injected.

15.1.2 Recent injectors

Patterns of recent injecting drug use

Twelve participants reported having injected a median of three drugs types (range 1–5) in the six months preceding interview. Speed was the drug most commonly injected by participants in the preceding six months, followed by crystal methamphetamine and heroin (Table 31). Further, of those who responded (n=10), three participants reported speed, and two reported heroin, as the drug they most recently injected. Overall, recent injectors (n=8) had injected any drug a median of 44.5 times (range 10–180) in the preceding six months.

Table 31: Recent injecting drug use patterns (recent injectors) among REU, 2006

	% injected past 6 months (n=12)	Median days injected last 6 months (range)*	% last drug injected (n=10)
Crystal	67	7 (1–12)	10
Speed	75	12 (1–26)	30
Base	8	3 (n=1)	0
Ecstasy (pills)	33	7.5 (3–20)	10**
Ecstasy (powder)	8	25 (n=1)	
Heroin	58	10 (2–20)	20
Ketamine	17	1.5 (1–2)	
Other opiates	33	37 (2–160)	20
Cocaine	8	1 (n=1)	0
Buprenorphine	8	7 (n=1)	10
Any drug	–	44.5 (10–180) (n=8)	–

Source: REU interviews, 2006

* Of those who had injected in the preceding six months

** Form of ecstasy (i.e. pills and powder) not asked

Injecting risk behaviour

All of the participants who responded (n=9) reported that they had not used a needle after anyone else in the previous six months. Six (of the eight who responded), however, reported that they had used other injecting equipment after others in the previous six months, namely spoons/mixing containers (n=5), water (n=2), tourniquets (n=2) and filters (n=1). Further, two respondents (of nine who responded) reported that someone had used a needle after them in the previous six months

Context of injecting

REU who had injected drugs in the past six months who commented (n=11) most commonly injected in their own home (73%; Table 32). Only one participant reported usually injecting alone, with close friends (78%) reported as the people users most commonly injecting with. All respondents, but one, reported injecting themselves every time, with the other respondent reporting being injected by a friend. All participants reported having injected either while coming down, or both under the influence of and coming down from, ecstasy and related drugs in the past six months.

Table 32: Context and patterns of recent injection among REU, 2005–2006

	2005 recent injectors (n=9)	2006 recent injectors (n=9)
Frequency of self-injection		
Every time (%)	56	89
Often (%)	22	0
Rarely (%)	11	0
Never (%)	11	11
People usually inject with*		
Close friends (%)	44	78
Regular sex partner (%)	33	11
Casual sex partner (%)	11	0
Acquaintances (%)	11	11
No one (%)	22	22
Locales where injected*		
Own home (%)	89	73
Friend's home (%)	44	55
Car (%)	0	55
Dealer's home (%)	11	18
Street, park (%)	22	46
Public toilet (%)	33	36
Venue toilet (%)	22	18
Sex venue (%)	11	0
Injected (only) under the influence (%)	11	0
Injected (only) while coming down (%)	11	44
Injected (both) while under the influence and coming down (%)	78	56
Median times injected any drug under the influence and/or coming down last 6 months (range)	5 (2–100)	10 (2–30)

Source: REU interviews, 2005–2006

* Could nominate more than one response

Obtaining needles

For those who had injected drugs in the past six months who responded (n=11), 82% obtained needles from NSP, 18% from chemists, 18% from friends, and 9% (n=1) from dealers. Only one participant had problems accessing clean needles because of restricted opening hours for dispensing outlets, noting it is particularly difficult to get them at night.

15.2 Blood borne virus infection (BBVI) vaccination, testing and status

Those participants who reported having ever injected were compared to those who reported having never injected on a range of BBV-related variables (Table 33). Two-thirds (67%) of 'ever injectors' had either not been vaccinated for Hepatitis B virus (HBV) (50%), had started but not completed a vaccination schedule (11%), or did not know of their HBV vaccination status (6%: Table 33). Comparable proportions of the 'ever injecting' and 'never injecting' groups reporting having completed a HBV vaccination schedule. All injectors had, however, been tested for Hepatitis C virus (HCV), with over half reporting that their most recent test results had been negative. The majority (89%) of the injectors had been tested for human immunodeficiency virus (HIV), with all reporting that their most recent test results had been negative.

Table 33: BBVI vaccination, testing and self reported status, 2006

	Never injectors (n=82)	Ever injectors (n=18)
HBV vaccination:		
No (%)	34	50
Schedule not completed (%)	10	11
Schedule completed (%)	34	33
Don't know (%)	23	6
HCV test:		
No (%)	61	0
Yes (in last year) (%)	13	50
Yes (more than a year ago) (%)	19	50
Don't know (%)	7	0
If tested, results:		
Negative (%)	100	56
Don't know (%)	0	44
HIV test:		
No (%)	55	11
Yes (in last year) (%)	16	50
Yes (more than a year ago) (%)	28	39
Don't know (%)	1	0
If tested, results:		
Negative (%)	100	100

Source: REU interviews, 2006

15.3 Sexual risk behaviour

15.3.1 Recent sexual activity

Of those participants who responded (n=99), the vast majority (94%; n=93) reported having had penetrative sex in the six months prior to interview (Table 34). Condoms were used infrequently with regular sex partners but more frequently with casual partners, although only approximately half of those who reported having had sex with casual partner/s in the six months prior to interview reported always using a condom (Table 34). Only a small proportion (17%) of REU reporting penetrative sex in the six months prior to interview reported having had anal sex.

Table 34: Prevalence of sexual activity and number of sexual partners in the preceding six months, 2005–2006

	2005 (n=94)	2006 (n=99)
Penetrative sex (%)	97	94
No. of sexual partners (%)*		
One person	47	40
Two people	15	16
3–5 people	23	33
6–10 people	9	5
10+ people	6	5
Sex with a regular partner (%)*	85 (n=77)	73 (n=68)
Always use protection (%)**	19	26
Never used a protective barrier (%)**	49	44
Sex with a casual partner (%)*	53 (n=48)	63 (n=58)
Always use a protective barrier (%)***	65	53
Never used a protective barrier (%)***	6	5
Anal sex (in last six months) (%)*	32 (n=29)	17 (n=16)
No. of times has anal sex****		
≤ Mthly (%)	87	88
Less than fortnightly, more than monthly (%)	3	6
Weekly or less, more than fortnightly (%)	3	6
More than weekly (%)	7	0

Source: REU interviews, 2005–2006

* Of those who had penetrative sex in the last 6 months

** Of those who had sex with a regular partner

*** Of those who had sex with a casual partner

**** Of those reporting anal sex

15.3.2 Drug use during sex

Of those who commented, most (84%) had had penetrative sex under the influence of ecstasy or other related drugs in the past six months. Ecstasy (68%) was the most common drug used during sex, followed by alcohol (40%) and speed (28%) and cannabis (24%). Although participants were more likely to report always using condoms with casual partners than regular partners when under the influence, nearly half (48%) of those participants who had sex with casual partners under the influence in the six months prior to interview reported not always using condoms or other protective barriers (Table 35).

Table 35: Sex under the influence of drugs in the preceding six months, 2006

	2006 (n=93)
Penetrative sex while on drugs* (%)	84
<i>Of those who had penetrative sex under the influence of drugs (n=77)</i>	
Number of times	
Once (%)	7
Twice (%)	20
3 –5 times (%)	32
6 – 10 times (%)	14
Ten or more times (%)	27
Drugs used	
Ecstasy (%)	82
Cannabis	29
Alcohol (%)	48
Speed (%)	34
Base (%)	0
Ice (%)	10
Cocaine (%)	14
Ketamine (%)	3
GHB (%)	5
LSD (%)	7
Sex with a regular partner (%)**	(n=57)
Always used a protective barrier (%)	19
Never used a protective barrier (%)	53
Sex with a casual partner (%)***	(n=48)
Always used a protective barrier %	52
Never used a protective barrier %	13

Source: REU interviews, 2006

* Of those who had penetrative sex under the influence of drugs in the last 6 months

** Of those who had penetrative sex with a regular partner under the influence of drugs in the last 6 months

*** Of those who had penetrative sex with a casual partner under the influence of drugs in the last 6 months

The primary sex risk specified by two KE was the simultaneous ingestion of Viagra with substances such as ecstasy and methamphetamines. KE also suggested that there are sex risks associated more generally with drug use, due to the decline of an individual's ability to assess risk once intoxicated. For example, two KE reported that ERD users might engage in unprotected sex and/or sex with multiple partners, potentially exposing them to blood borne virus infections. An additional KE stated that recent sexual assaults had been linked to the ERD scene in their local area.

15.4 Driving risk behaviour

Eighty-four participants from the 2006 REU sample reported having driven in the six months prior to being interviewed (Table 36). Of those driving during this time, more than one-third (39%) reported having driven under the influence of alcohol (i.e. over the legal limit) a median of two times (range 1–54) and over two-thirds (68%) having driven soon after (i.e. within one hour) of taking any illicit drug/s a median of six times (range 1–180). Those reporting driving after taking illicit drugs (n=56) did so after using ecstasy (82%), speed (64%), cannabis (57%), cocaine (23%) and crystal meth (21%). The drugs that the 2006 participants reported driving after using were comparable to those reported by the 2004 and 2005 REU samples.

Table 36: Drug driving in the last six months among REU, 2004–2006

	2004	2005	2006
Driven while over the limit of alcohol#	–	35	39
Driven soon after* taking a drug# (%)	63	58	68
<i>Of those who'd driven soon after,</i>			
Drug (%)			
Ecstasy	73	70	82
Cannabis	48	43	57
Speed	58	70	64
Cocaine	8	15	23
Crystal methamphetamine	22	24	21
Methamphetamine base	8	2	2
Ketamine	11	7	5
LSD	8	9	5
GHB	8	7	4
Other opiates	0	0	2
Benzodiazepines	6	2	4
MDA	0	2	2
Methadone	3	0	2
Amyl nitrate	0	0	2
Nitrate oxide	0	2	2
Heroin	6	0	5

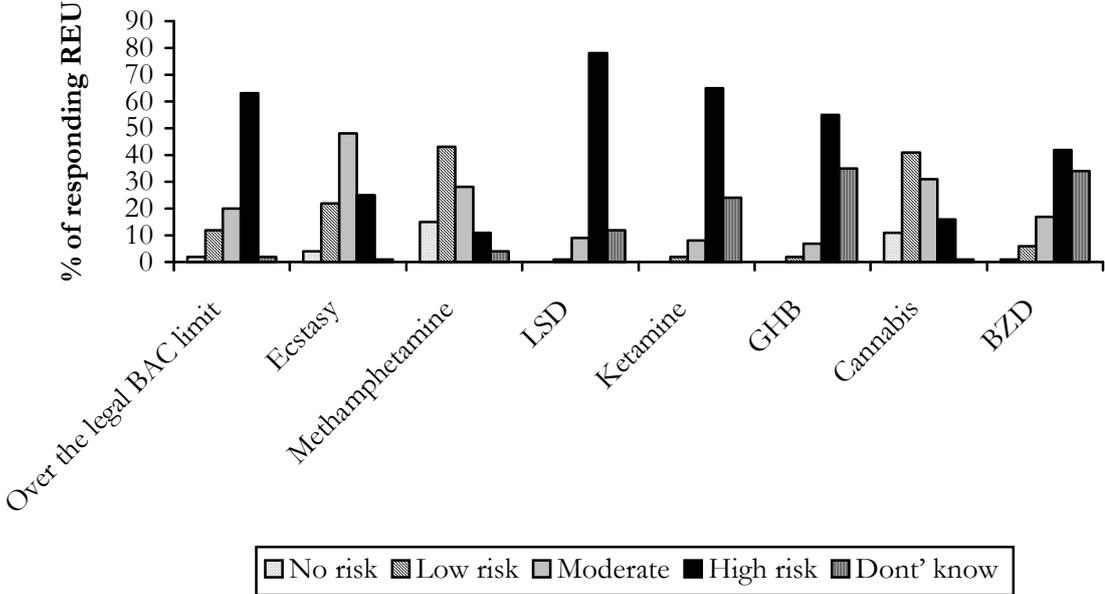
Source: REU interviews, 2004–2006

Of those who had driven a car in the last 6 months

* Within one hour of taking

For the first time in 2006, REU participants were asked what degree of risk they ascribed to driving soon after taking a range of drugs (Figure 77). The highest degrees of risk were associated to drugs with hallucinogenic and/or dissociative properties, such as LSD, ketamine and GHB, as well as to driving over the legal blood alcohol concentration (BAC).

Figure 77: Degree of risk ascribed by REU to driving soon after taking drugs, 2006



Source: REU interviews, 2006

Participants who reported driving after taking drugs (n=56) were asked how impaired they felt the last time they did this. Nearly half (48%) believed that they were not impaired, 43% that they were slightly impaired, 5% that they were moderately impaired and 2% each that they were substantially impaired and totally impaired.

Nine KE commented on driving risk behaviour (including the impact of the drug-testing buses) amongst Melbourne’s ERD-using population. One KE stated that the reporting of drug driving statistics resulting from use of the drug bus by Victoria Police was misleading, primarily because the statistics failed to indicate that police were targeting specific populations with the bus, namely truck drivers and ravers. This KE asserted that the statistics were consequently skewed, which led to an exaggeration of the drug driving problem in the general community. In addition, this KE stressed that little education was provided to the public regarding the implementation of the drug bus, such as appropriate periods of time individuals should wait to drive after consuming different drugs.

One KE reported that, at the time of the interview when only one drug-testing bus was in operation, people were aware of the drug bus, however, the issue had “*blown over now – people are back to ‘normal’ as if there was no bus at all*”. Nevertheless, five KE maintained that drug driving is still a significant issue to ERD users and the wider community. For example, one KE working in a hospital accident and emergency department reported that approximately one-third of people involved in vehicle accidents have at least one drug other than alcohol in their system, including benzodiazepines, ecstasy, methamphetamines and cannabis. Another KE reported an increase in the number of people driving while intoxicated, stating that ice users in particular are prone to driving under the influence because they feel ‘supercharged’, alert and ‘normal’.

As possible responses to the drug driving issue, one KE suggested that the implementation of 24-hour public transport in Melbourne would provide more transport options for drug-using individuals. Another KE suggested more severe punishments for drug drivers, such as complete loss of license, as opposed to temporary loss of license and/or a fine. Two KE also noted that road rules in the Prahran area had been changed in an attempt to “*curb the party scene in the area*”, such as restrictions preventing people from driving down particular streets after a certain time.

Finally, one law enforcement KE stated that the drug buses will continue in a targeted fashion. This KE acknowledged, however, that the detection rate for drug-using truck drivers is low because they have access to a radio so that other truck drivers can be warned. This KE reported that the detection rate for 'ravers', however, was approximately 1 in 70 at the time of the interview.

16 HEALTH RELATED ISSUES

16.1 Overdose

Nineteen participants reported that they had ever overdosed on any party drug(s), a median of two times (range 1–15). Three participants reported that they had overdosed on a party drug in the preceding six months, with the most recent overdose occurring a median of four months (range 3–4) prior to interview. Drugs reported by participants as being the main drug they last overdosed on were GHB (n=1), ecstasy (n=1) and alcohol (n=1). Other drugs used by participants prior to their most recent overdose were ecstasy (n=3), speed (n=2) and alcohol (n=1).

The KE reports pertaining to ERD-related overdoses have been presented elsewhere in this report, primarily in Sections 3.2 (Drug use history and current drug use), 4.8.2 (Ecstasy-related harms – Health), 8.1 (GHB use among REU), and 8.5.2 (GHB-related harms - Health). KE particularly characterised overdoses in the ERD-using population as generally associated with GHB and/or polydrug use. KE indicated that overdoses resulting solely from ecstasy use were uncommon.

Four KE reported on the issue of drink spiking, with all noting that genuine drink spike cases are uncommon. For example, an ambulance paramedic reported no genuine cases throughout the previous twelve months, whereas an accident and emergency department worker reported an average of only two genuine drink spike presentations per year in one particular hospital. This KE noted that genuine drink spike presentations were usually more common in the gay community, usually associated with GHB, and were generally reported by people who had been sexually assaulted.

These KE noted that drink spiking was increasingly used as an excuse for individuals attempting to forfeit responsibility for adverse consequences associated with excessive alcohol use. They stated that large proportions of people reporting drink spikes usually only had alcohol in their systems when tested, although it is possible that substances used to spike an individual's drink may have left their system before being tested. Three KE reported that when drink spiking did occur, it was usually in 'intimate' settings, such as amongst friends and/or in a private home, as opposed to public places and licensed venues. One law enforcement KE noted that it is important to put the issue of drink spiking into perspective to prevent panic, paranoia and misconceptions in the community.

One KE highlighted the problem of 'unrousable snoring'. Essentially, unrousable snorers are users of CNS depressants (such as GHB and alcohol) "*who appear to be asleep and snoring but are actually unconscious and dying*". Family members or friends might underestimate the seriousness of the situation, thinking that an individual is simply sleeping off the effects of the drug(s). This KE noted that DHS is considering implementing a campaign to raise awareness of the problem and the need to call an ambulance if the situation does occur.

16.2 Self reported symptoms of dependence

Participants were asked to complete the Severity of Dependence Scale (SDS) regarding their methamphetamine use. The SDS is a short, five-item scale designed to measure the level of dependence on a range of drugs. It was specifically designed as a research tool (Gossop et al., 1995) and is quick and easy to administer (it may be self-completed or interviewer administered). The SDS is explicitly concerned with the psychological components of dependence, with the items pertaining to impaired control over drug use, preoccupation and anxiety about drug use, and difficulty stopping (Gossop et al., 1995; Dawe et al., 2002). Each of the five items is scored on a four-point scale (0–3), resulting in a range of possible scores of 0–15. The SDS has been widely used to assess dependence on a range of drugs including heroin, amphetamines, cocaine,

cannabis and alcohol (Gossop et al., 1995; Ferri et al., 2000). A score of four or more is considered as indicative of amphetamine dependence (Topp & Mattick, 1997; Dawe et al., 2002).

Ninety participants from the Victorian sample completed the SDS in regards to their methamphetamine use: 59% regarding their speed use, 17% regarding their crystal meth use, and 23% not specifying a form of methamphetamine.

The majority (85%) of participants referring to their use of speed when completing the SDS (n=53) scored less than four, with the scores of the remaining small proportion (15%; n=8) indicating dependence (Topp & Mattick, 1997; Dawe et al., 2002). Although the majority (73%) of participants referring to their use of crystal meth when answering the SDS questions (n=15) scored four or less, over a quarter (27%; n=4) had scores indicative of dependence. The vast majority (91%) of those participants not specifying a form of methamphetamine (n=21) scored four or less, with the scores of only two participants indicating dependence.

16.3 Measure of psychological distress

For the first time in 2006, the EDRS included the 10-item Kessler Psychological Distress Scale (K10), a questionnaire designed to measure the level of distress and severity associated with psychological symptoms in population surveys (Kessler et al., 2002).

Ninety-nine participants from the 2006 REU sample completed the scale, with a mean score of 19 (range 10–40). Scores ranging from 10 to 15 are typically classified as ‘low’, 16 to 29 as ‘medium’ and 30 to 50 as ‘high’. According to this classification, 34% (n=34) were in the low range, 60% (n=59) in the medium range, and 6% (n=6) in the high range.

16.4 Help-seeking behaviour

Twenty-two 2006 REU participants had accessed a health or medical service in relation to their party drug use in the six months preceding interview. These participants reported most commonly accessing general practitioners (GP: 59%; n=13) and counsellors (20%; n=4). Other services accessed in the six months prior to interview included first aid services (n=3), drug and alcohol workers (n=3), ambulance (n=3), emergency departments (n=2), telephone counselling (n=2), social/welfare workers (n=1), psychologists (n=1), psychiatrist (n=1), inpatient detoxification (for alcohol; n=1) and NSP (n=1). Respondents reported accessing these services in relation to a range of drugs and issues. For example, those accessing GPs reported doing so in relation to heroin (n=3), ecstasy (n=2), crystal meth (n=2), cannabis (n=2) and BZD (n=2) for issues ranging from dependence and/or anxiety to acute medical problems.

Five KE noted that few ERD users receive treatment for ERD use. KE indicated that, compared to users of other drugs such as heroin, people seem less likely to seek help for their ERD use, with one noting it “*is not the nature of their drug use*”. Another KE noted that people are concerned about drug issues within the ERD-using community, but that they want to hear more about harm reduction information as opposed to being told that ‘drugs are bad’. One KE reported that the treatment of methamphetamine users in particular is problematic because it is often very difficult to engage this specific group of drug users. This KE specified that although there is treatment available for problematic methamphetamine users, it can be difficult getting users to recognise that they have a problem and require help. Another alcohol and drug counsellor KE supported this view, noting that many methamphetamine users only come into contact with treatment as a result of supportive families encouraging individuals to seek help.

Five KE (including four law enforcement KE) reported that the drug diversion program is useful because it can assist ERD individuals who would not otherwise access treatment. The usefulness of the drug diversion program was questioned by a number of KE. One noted that many see it as a way of avoiding court, with another noting that many drug diversion clients do not benefit from treatment. This KE did acknowledge, however, that a small proportion do.

16.5 Other problems

Participants reported relatively high rates of occupational/study (53%), financial (43%) and relationship/social (51%) problems due to ecstasy and related drugs in the six months preceding interview. The most commonly reported occupational/study problems reported by those participants reporting such problems (n=53) related to being unmotivated (34%) and trouble concentrating (30%). Occupational/study problems were most commonly attributed to ecstasy (45%) and cannabis (21%) use. The financial problems experienced most commonly related to not having money for recreation/luxuries (47%) and being in debt/owing money (28%). Financial problems were most commonly attributed to ecstasy (44%), cannabis (16%) and speed (12%) use. The two most commonly reported relationship problems were arguments (47%) and mistrust/anxiety (24%), with such problems most frequently attributed to ecstasy (39%), speed (20%) and cannabis (12%) use.

Relatively few participants (6%) reported legal/police problems associated with their party drug use. The legal/police problems reported by the 2006 sample were being arrested (n=5) and convicted of a crime (n=1). Legal problems were attributed to ecstasy (n=3), alcohol (n=2) and speed (n=1). The criminal activity of the REU sample and KE reports regarding this issue are discussed below in Chapter 17.

17 CRIMINAL ACTIVITY, POLICING AND MARKET CHANGES

17.1 Reports of criminal activity among REU

Twelve participants reported that they had been arrested in the twelve months preceding interview. Five arrests were alcohol-related: drunk in public (n=2), drunk and disorderly (n=2) and drink-driving (n=1). Other participants reported being arrested in the 12 months prior to interview for violent crime (n=2), use/possession (n=1) and property crime (n=1). In comparison to the low levels of arrest reported, over one-third (35%) of the 2006 REU respondents reported having committed at least one of the crimes listed in Table 37 in the month preceding interview, most commonly drug dealing (28%).

Table 37: Criminal activity reported by REU, 2003–2006

Criminal activity in the last month	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=98)
Any crime (%)	49	33	24	35
Drug dealing (%)	43	29	18	28
Property crime (%)	12	9	10	11
Fraud (%)	5	2	2	3
Violent crime (%)	4	2	1	4
Arrested in the preceding 12 months (%)*	–	17	10	12

Source: REU interviews, 2003–2006

* Not recorded prior to 2004

KE typically reported that REU rarely and infrequently involve themselves in criminal activities, other than the possession and use of illicit substances. A few KE (n=5), however, made reference to some ecstasy users undertaking low-level dealing of ERD. Three KE reported increased amounts of dealing, with one referring specifically to increased dealing of crystal meth and another KE stating that the prevalence of Vietnamese traffickers had increased in Melbourne's 'party-drug scene'. In contrast, two KE reported that dealing activity had remained stable among the REU they were aware of.

Two law enforcement KE reported that the organised crime element accompanying the ERD scene is most problematic for police, referring specifically to violence in nightclubs, in addition to 'heavy dealing' both in and close to venues, such as in parking lots and laneways. One of these KE noted that this ongoing 'gangster element' is a concern for the community, often receiving exaggerated media attention as a result. The second law enforcement KE indicated that many different types of people sell ecstasy, including university students, people of various nationalities, and nightclub bouncers, managers and owners. Another KE noted that, despite a constant turnover, there always remains a consistent number and type of people dealing ERD. One KE noted that REU usually purchase ERD from within their social group, estimating that 'nine out of ten' people purchase ERD from friends.

As previously mentioned, law enforcement KE also commented on the use of PADD dogs, reporting that most people detected with illicit substances are carrying less than trafficable amounts, and usually have no prior history with the criminal justice system. In addition, four law enforcement KE noted that detection of repeat offenders is uncommon. One KE from law enforcement asserted that, in response to the PADD dogs and the diversion program, the number of drug-related arrests had increased, although less people had been charged as a result of diversion. Four KE reported that violent crimes are rare in the ERD-using community, though one KE stated that ‘tensions’ had increased in venues because of increased use of crystal meth.

17.2 Perceptions of police activity towards REU

Nearly half (45%) of the 2006 participants believed police activity had increased in the last six months, whereas 26% believed police activity had remained stable. Sixty participants commented on their perceptions of recent changes in police activity, most frequently mentioning increased presence of sniffer dogs (n=21), increased police presence (both uniform and undercover: n=19) and drug-driving buses (n=17). Despite these perceived changes in police activity, the majority of participants (85%) said that police activity had not made it more difficult to obtain ecstasy and related drugs in the past six months (Table 38).

Table 38: Perceptions of police activity by REU, 2003–2006

Recent police activity:	2003 (N=100)	2004 (N=100)	2005 (N=100)	2006 (N=100)
Decreased (%)	3	1	1	0
Stable (%)	56	31	31	26
Increased (%)	19	58	52	45
Don't know (%)	22	10	16	28
Did not make scoring more difficult (%)	86	90	94	85

Source: REU interviews, 2003–2006

Several (n=7) non-law enforcement KE discussed the use of sniffer (PADD) dogs by Victoria Police, highlighting potential harms associated with their use. Four KE reported that people are turning to drugs other than ecstasy and methamphetamines, due to the belief that such substances cannot be detected by PADD dogs. These alternative substances listed by KE included acid/LSD, ketamine and GHB.

Three KE stated that, upon seeing the dogs or hearing that they will be at an event, people are ingesting all their drugs at once instead of spreading use over an extended period of time. KE indicated that this leads to dangers associated with polydrug use and increased levels of intoxication, such as a higher propensity to engage in risky behaviour (e.g. sex risks) and overdose. One KE stated that the presence of sniffer dogs at events is purely a symbolic gesture for both the media and the public, which simultaneously undermines harm reduction principles. An additional KE noted that there is a danger of exposing ‘low-key recreational users’ to the criminal justice system through the use of this policing strategy.

Representing an alternative view, three law enforcement KE highlighted their perceived success of the sniffer dogs and associated drug diversion program. They reported that, although a higher

number of users are detected by the dogs in comparison to dealers, the number of individuals detected more than once is minimal (arguing that this is evidence that people do not re-offend after their initial detection). In addition, these KE argued that this system actually diverts people away from the criminal justice system, as most people detected by the dogs do not receive a criminal conviction and also experience drug treatment when many would not normally have access to it. These KE stated that the drug diversion program should be national.

Finally, one law enforcement KE reported that a 'special taskforce' will be implemented along Chapel Street in Prahran in 2007 due to problems associated with the ERD-using scene in the area, specifically in relation to declining levels of community perceptions of safety. This KE also noted that police do not have the resources to adequately 'eradicate' the scene, so they are instead working with the Department of Human Services to develop health interventions in addition to law enforcement strategies.

18 SUMMARY

18.1 Demographic characteristics of REU

Reports from the 2006 Victorian REU sample and KE suggest that regular ecstasy users are equally likely to be male or female, to be aged in their early twenties, tend to be well-educated and either employed and/or studying. The findings suggest that regular ecstasy users are unlikely to be involved in either the treatment or justice systems.

18.2 Patterns of polydrug use

Reports from the 2006 Victorian REU sample and KE suggest that regular ecstasy users are polydrug users and are likely, in addition to ecstasy, to have recently used alcohol, cannabis, speed and tobacco. Bingeing on ERD is common among REU, with speed and ecstasy the drugs most commonly used during a binge, but few regular ecstasy users inject drugs.

18.3 Ecstasy

18.3.1 Price, purity and availability of ecstasy

Reports from the 2006 Victorian REU and KE suggest that the price of ecstasy has remained stable over the previous four years and that ecstasy typically costs \$30 per pill. The purity of ecstasy tends to be rated as medium or fluctuating. Ecstasy remains readily available and is predominantly sourced from friends or known dealers in private residences and nightclubs.

18.3.2 Ecstasy markets and patterns of purchasing

Reports from the 2006 Victorian REU suggest that regular ecstasy users tend to have a few people they can purchase ecstasy from, typically purchase for themselves and others. In addition to ecstasy, most regular ecstasy users can obtain a range of other drugs from the dealers, most commonly speed and cannabis.

18.4 Methamphetamine

Reports from the 2006 Victorian REU and KE suggest that of the three forms of methamphetamine, speed is most widely used (in terms of both lifetime and recent use), followed by crystal meth and then base. Regular ecstasy users commonly use speed in conjunction with ecstasy and during binges. Methamphetamines are used in a variety of locations, predominantly nightclubs and private homes.

The price of the three forms of methamphetamine has remained stable, with crystal meth more expensive than speed and base (which are of comparable cost). According to the REU reports, the purity of crystal meth is relatively high and stable, whereas the purity of speed is medium to high and less consistent. Speed remains readily available, with ease of access to crystal meth stable or declining. Both speed and crystal meth are most commonly acquired through friends and known dealers. Methamphetamine use has the potential to be associated with considerable harms (i.e. violence and mental and physical health problems).

18.5 Cocaine

Reports from the 2006 Victorian REU and KE suggest that a high proportion of regular ecstasy users have ever used cocaine, with a considerable number also reporting recent use. Those regular ecstasy users using cocaine tend to use it infrequently, typically snort it, and report using it in a wide range of locations, most commonly nightclubs, pubs and private homes.

Perhaps contributing to the relatively low frequency of recent use, cocaine is an expensive drug. The purity of cocaine is typically rated as medium, it is considered as readily available, with

availability recently stable or increasing. Cocaine is commonly purchased from friends or known dealers in private homes.

18.6 Ketamine

Reports from the 2006 Victorian REU and KE reflect decreasing levels of both lifetime and recent ketamine use among regular ecstasy users since 2003. Those reporting recent ketamine use typically use it infrequently, in a range of public and private locations.

The purity of ketamine is generally reported as medium or high. Reports of ketamine availability are inconsistent, with a recent trend of stable availability. Ketamine is most commonly purchased from friends and known dealers in private homes and dance parties/raves/doofs.

18.7 GHB

Reports from the 2006 Victorian PDI suggest moderate prevalence of lifetime and low prevalence of recent GHB use among regular ecstasy users. REU tend to use GHB infrequently across a wide range of locations, predominantly private homes, dance parties and nightclubs. GHB remains inexpensive and is currently considered to be of medium purity. GHB also remains readily available, although this may have recently decreased. GHB tends to be purchased from friends in their homes. KE continue to report concern about the acute health consequences associated with GHB.

18.8 LSD

Reports from the 2006 Victorian REU and KE suggest high prevalence of lifetime use of LSD with moderate levels of recent use among regular ecstasy users. Recent users report infrequent use of LSD across a wide range of locations, predominantly 'outdoors', live music events and dance parties.

LSD is relatively cheap and the price has remained stable. Current LSD purity is regarded as high, with purity described as recently stable. There is little consistency in the reported current availability of LSD, although availability tends to be reported as stable over the previous six months. Regular ecstasy users most commonly purchase LSD from dealers in private homes.

18.9 MDA

Reports suggest low prevalence of lifetime and recent use of MDA among regular ecstasy users. It is not possible to comment on trends in the price, purity and availability of MDA given the small number of respondents able to comment in 2006.

18.10 Cannabis

Reports from the 2006 Victorian REU and KE suggest high prevalence of both 'lifetime' and recent cannabis use among REU, with relatively frequent recent use common. Cannabis is commonly used during the comedown period from ecstasy and during ERD binges. Bush and hydroponic cannabis are of comparable and stable price, although hydroponic cannabis is perceived to have a higher potency than bush cannabis. Both hydroponic and bush cannabis are readily available and are purchased from friends and known dealers in private homes.

18.11 Alcohol

Reports from the 2006 Victorian REU and KE suggest almost universal lifetime and recent use of alcohol, and high prevalence of alcohol use in conjunction with, and during comedown from, ecstasy. Indeed, the findings suggest that considerable proportions of REU drink at levels which may cause acute and/or long terms harms.

18.12 Patterns of other drug use

Reports from the 2006 Victorian REU and KE suggest very high lifetime and recent use of tobacco, with many REU being daily smokers. There also appears to be relatively high prevalence of lifetime and recent use of magic mushrooms in this population, although low frequency of use is typical. Although there appears to be relatively high prevalence of lifetime and recent use of benzodiazepines, with use approximately monthly, low levels of lifetime and recent use of antidepressants among REU were reported. Approximately half of REU report lifetime use of inhalants and about one-quarter report low levels of recent use, and reports suggest low levels of lifetime and recent use of heroin and 'other opiates' among REU.

18.13 Drug information seeking behaviour

The 2006 REU were asked about their use of methods to determine the content and purity of ecstasy pills and other drugs, their knowledge of the limitations of available pill testing methods, and how pill test results would influence their drug use behaviour.

The majority of the Victorian sample reported attempting to find out the content and purity of ecstasy at least some of the time, most commonly asking friends who had taken it, or asking dealers. Slightly less than one-third of the sample reported personal use of testing kits. There was a moderate level of awareness of the limitations of testing kits among those who reported having used them, with nearly two-thirds able to comment on the limitations. The findings suggest that the results of pill testing may influence the drug use behaviour of regular ecstasy users: over half of those participants reporting personal use of testing kits reported that they would not take a pill if test results indicated that it contained ketamine, and approximately three-quarters reported that they would not take a pill if test results indicated that it contained opiates, 2CB/2CI or an 'unknown' pill (producing no reaction in a reagent test). The majority of respondents reported that they would not take a pill if test results indicated that it contained PMA or DXM.

Participants were also asked what information sources they would find most useful if they were made locally available, with web sites, testing kits and venue outreach workers receiving the most support.

18.14 Risk behaviour

Reports from the 2006 Victorian REU and KE suggest low levels of injecting drug use by regular ecstasy users. The findings suggest that the sharing of needles is rare among those regular ecstasy users reporting injecting, although the sharing of other injecting equipment (i.e. spoons or other mixing equipment, water and/or filters) is more common. This population appears not to experience difficulties in accessing injecting equipment, most commonly accessing equipment through NSP. Among regular ecstasy users reporting recent injection there appears to be low levels of HBV vaccination and low levels of HCV and HIV infection. These findings, however, need to be interpreted with caution, given the small numbers of participants reporting injection as a route of administration.

Regular ecstasy users appear to be a relatively sexually active group, among whom condom use with regular sex partners is infrequent but with casual partners relatively frequent. Unsurprisingly, this group tend to report having sex while under the influence of drugs. A small proportion of those who had had casual sex under the influence in the past six months reported that they never used condoms when doing so.

The current study also suggests that risky driving practises are relatively common among regular ecstasy users: over two-thirds of the REU sample who reported having driven in the six months prior to interview reported having driven soon after (i.e. within one hour) of taking any illicit drug/s and more than one-third reported having driven under the influence of alcohol (i.e. over the legal limit). Those reporting driving after using illicit drugs most commonly did so following ecstasy, speed and/or cannabis use. Respondents were asked how impaired they felt the last time

they drove soon after taking a drug, with the vast majority reporting they felt only slightly or not at all impaired. 2006 REU participants were also asked what degree of risk they associated with driving after taking a range of drugs, with the highest degrees of risk associated with LSD, ketamine and GHB, as well as with driving over the legal BAC.

18.15 Health related issues

Although not commonly reported by the 2006 REU sample, overdose is experienced by a small proportion of regular ecstasy users and is considered a significant harm by some KE.

Although the majority of the REU sample tended not to have scores on the SDS indicative of amphetamine dependence, a small proportion did. Similarly, only a small proportion on the sample scored in the high risk range on the measure of psychological distress.

Reports from the REU sample and KE indicate that regular ecstasy users tend not to utilise health and treatment services for their ERD use. This appears to be a result of a number of factors including services not being necessary due to generally infrequent patterns of use and low levels of harms, and, among those experiencing harms, a lack of recognition that such harms are associated with ERD use. GPs and counsellors appear to be the treatment types most commonly accessed by regular ecstasy users.

The reports of the 2006 REU sample suggest that relatively high levels of non-health related problems are experienced by regular ecstasy users: participants reported high rates of occupational/study, financial and relationship/social problems due to their use of ERD in the six months preceding interview. It is important to note, however, that the majority of these problems are considered as relatively minor by users, and that few participants reported legal/police problems associated with their ERD use.

18.16 Criminal activity, policing and market changes

The reports of the 2006 REU and KE suggest that the majority of regular ecstasy users do not undertake criminal activities. Over one-quarter of the sample, however, had been involved in drug dealing in the month prior to interview. These relatively high levels of dealing were also corroborated by the KE.

Nearly one-half of the 2006 participants believed police activity had increased in the last six months, most frequently citing increased presence of sniffer dogs, increased police presence and drug-driving buses. Despite such perceived changes, however, the majority of participants reported that police activity had not made it more difficult to obtain ERD in the six months prior to interview.

19 IMPLICATIONS

The results reported here describe trends in the market for ecstasy and related drugs in Victoria, and provide comparisons with the findings of the 2003 to 2005 studies. Many characteristics of ERD use reported in the previous Victorian and national (e.g. Stafford et al., 2006) reports are confirmed in the current study, perhaps suggesting a level of stability in this illicit market. Regular ecstasy users are typically aged in their mid-twenties, are well educated and tend to be employed and/or students.

Polydrug use appears to be the norm among regular ecstasy users, with a range of drugs used in conjunction with, and during the comedown from, ecstasy. Bingeing on drugs also appears to be common by this population, although few engage in intravenous drug use.

Many of the drugs investigated in this research (i.e. ecstasy, methamphetamine powder) were identified as readily available, although some classes of drug (i.e. cocaine and crystal meth) appear more difficult to access or highly variable in their availability. Similarly, there was a degree of variability in the frequency with which some drugs were used. Ecstasy, speed and cannabis were used regularly, whereas, cocaine was used infrequently.

In general, risk behaviours, health-related problems and criminal activity among REU were relatively uncommon. However, considerable proportions of REU reported driving soon after taking drugs (both ERD and alcohol) and participating in dealing. Problems associated with ERD use tend to involve work, study and social relationships, and were reported by a substantial proportion of participants.

The findings of the 2006 Victorian EDRS suggest the following recommendations.

1. Polydrug use by REU, associated harms, and explorations of harm reduction strategies used by REU warrant further investigation. In particular, the high levels of alcohol use reported by the REU sample both in conjunction with ecstasy and during the comedown, as well as during binges, needs to be examined further, with new harm reduction messages targeting such behaviours potentially required.
2. The findings of the EDRS studies illustrate the wide range of settings in which ERD are used. Considering that harm reduction messages have traditionally been designed for and implemented in rave settings, such findings have implications for the development and implementation of harm reductions in a wider range of settings. For example, specific resources targeting home-based users and those using in nightclubs is also required (i.e. the expansion of the RaveSafe model of peer education to a equivalent nightclub based initiative).
3. More thorough and targeted research examining the extent and nature of injecting drug use in ecstasy-using populations is required. Although reports from the 2004, 2005 and 2006 Victorian REU suggest low levels of injecting drug use, the sharing of injecting equipment other than needles (i.e. spoons or other mixing equipment, water and/or filters) is relatively common among those reporting injecting. Further, there appears to be low levels of HBV vaccination among this group. Interventions specifically targeting this population and addressing these issues (i.e. risks of sharing 'any' injecting equipment and increasing awareness of HBV vaccination) may usefully be developed, potentially disseminated via NSP (the most commonly reported sources of injecting equipment). The findings and implications of the current research need to be interpreted with caution, however, given the small numbers, with further research clearly warranted.
4. Problems related to financial, work/study and relationship/social outcomes need further exploration to provide a better understanding of the harms associated with

5. The findings of the 2005 PDI suggest that a small proportion of regular ecstasy users experience dependence on methamphetamines. This needs to be explored further, in terms of the implications for such users, their perceptions of such dependence, and the utilisation of treatment services. Levels of dependence of this population on other drugs commonly used (i.e. cannabis) could also be usefully explored.
6. The findings of the 2005 Victorian PDI also provide evidence of low levels of treatment utilisation among regular ecstasy users. Although this may primarily be a result of low levels of harm and need of treatment among this group, there is also some evidence to suggest a lack of problem recognition and a reluctance to seek treatment among those regular ecstasy users experiencing harms. Barriers to treatment beyond lack of problem recognition (i.e. lack of knowledge of treatment options available, stigma associated with treatment utilisation) should be explored. Such research may usefully inform the development of a tool designed to increase recognition of problematic use and encourage treatment utilisation among those experiencing harms.
7. The high levels of driving under the influence of both alcohol and ERD reported by participants is a major concern. Targeted research is needed in this area, particularly in the context of Victoria's new 'drug-driving' testing initiatives and the impact such initiatives have on behaviour. Attitudes towards these initiatives and drug driving more generally need to be assessed to allow for education and awareness campaigns to be developed.
8. Although experienced by a minority of regular ecstasy users, overdose events are a significant concern. Little is known about the circumstances around overdose, hampering efforts to both prevent and treat such events. Further research examining such factors is a priority. Overdose events present potential opportunities to provide individuals with information about their overdose, harm minimisation strategies and general drug information. There is, however, a current lack of appropriate resources to provide such information.
9. Relatively high levels of dealing were reported by the 2006 REU sample. Issues such as the legal status of on-selling and dealing/supplying to friends need to be examined in greater detail, potentially informing the development of resources designed to raise awareness of such issues and the potential penalties of such behaviour.

REFERENCES

- Australian Crime Commission (2004). *The Illicit Drug Data Report*. Canberra, Australian Crime Commission.
- Australian Institute of Health and Welfare (1999). *1998 National Drug Strategy Household Survey: First Results*. Canberra, Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare (2005). *2004 National Drug Strategy Household Survey*. Canberra, Australian Institute of Health and Welfare.
- Australian Institute of Health and Welfare (2005). *2004 National Drug Strategy Household Survey: State and territory supplement*. Canberra, Australian Institute of Health and Welfare.
- Babor T.F., Higgins-Biddle J.C., Saunders J.B., & Monteiro M.G. (2001). *AUDIT: The Alcohol Use Disorders Identification Test, Guidelines for Use in Primary Care*. Geneva, World Health Organization.
- Biernacki, P. & Waldorf, D. (1981). "Snowball sampling: Problems, techniques and chain referral sampling." *Sociological Methods for Research* **10**: 141–63.
- Boys, A., Lenton, S. & Norcross, K. (1997). "Polydrug use at raves by a Western Australian sample." *Drug and Alcohol Review* **16**: 227–34.
- Breen, C., Degenhardt, L., Roxburgh, A., Bruno, R., Fetherston, J., Jenkinson, R., Kinner, S., Moon, C., Proudfoot, P., Ward, J. & Weekley, J. (2004) *Australian Drug Trends 2003: Findings from the Illicit Drug Reporting System (IDRS)*. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
- Breen, C., Topp, L. & Longo, M. (2002). *Adapting the IDRS methodology to monitor trends in party drug markets: Findings of a two-year feasibility trial*. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
- Dalgarno, P. J. & Shewan, D. (1996). "Illicit use of ketamine in Scotland." *Journal of Psychoactive Drugs* **28**: 191–9.
- Darke, S., Cohen, J., Ross, J., Hando, J. & Hall, W. (1994). "Transitions between routes of administration of regular amphetamine users." *Addiction* **89**: 1683–90.
- Darke, S., Hall, W. & Topp, L. (2000) *The Illicit Drug Reporting System (IDRS): 1996-2000*. NDARC Technical Report Number 101. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
- Dawe, S., Loxton, N.J., Hides, L., Kavanagh, D.J. & Mattick, R.P. (2002). *Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders*. Canberra, Commonwealth Department of Health and Aging.
- Dietze, P., Cvetkovski, S., Rumbold, G. & Miller, P. (2000). "Ambulance attendance at heroin overdose in Melbourne: The establishment of a database of Ambulance Service records." *Drug and Alcohol Review* **19**(1): 27–33.

- Ferri, C. P., Marsden, J., de Araujo, M., Laranjeira, R.R. & Gossop, M. (2000). "Validity and reliability of the Severity of Dependence Scale (SDS) in a Brazilian sample of drug users." Drug & Alcohol Review **19**(4): 451–5.
- Forsyth, A. J. M. (1996). "Places and patterns of drug use in the Scottish dance scene." Addiction **91**: 511–21.
- Gossop, M., Darke, S., Griffiths, P., Hando, J., Powis, B., Hall, W. & Strang, J. (1995). "The Severity of Dependence Scale (SDS) – Psychometric Properties of the SDS in English and Austrian Samples of Heroin, Cocaine and Amphetamine Users." Addiction **90**(5): 607–14.
- Hando, J. & Hall, W. (1993). Amphetamine use among young adults in Sydney, Australia. Sydney, New South Wales Health Department.
- Hando, J., Topp, L. & Hall, W. (1997). "Amphetamine-related harms and treatment preferences of regular amphetamine users in Sydney, Australia." Drug and Alcohol Dependence **46**: 105–13.
- Jenkinson, R., Miller, P. & Fry, C. (2004). Victorian Drug Trends 2003: Findings from the Illicit Drug Reporting System (IDRS). NDARC Technical Report No. 175. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
- Jenkinson, R. & O'Keeffe, B. (2005). Victorian Drug trends 2004: Findings from the Illicit Drug Reporting System (IDRS). Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
- Jenkinson, R. & O'Keeffe, B. (2006). Victorian Drug trends 2005: Findings from the Illicit Drug Reporting System (IDRS). Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
- Kerlinger, F. N. (1986). Foundations of Behavioral Research. Japan, CBS Publishing Limited.
- Ovendon, C. & Loxley, W. (1996). "Bingeing on psychostimulants in Australia: Do we know what it means (and does it matter)?" Addiction Research **4**: 33–43.
- Peters, A., Davies, T. & Richardson, A. (1997). "Increasing popularity of injection as the route of administration of amphetamine in Edinburgh." Drug and Alcohol Dependence **48**: 227–37.
- Premier's Drug Prevention Council (2002). Victorian Youth Alcohol and Drugs Survey: Number 1, March 2002. Melbourne, Victorian Government Department of Human Services.
- Premier's Drug Prevention Council (2005). Victorian Youth Alcohol and Drug Survey 2004. Melbourne, Victorian Government Department of Human Services.
- Reinert, D.F. & Allen, J.P. (2002). "The Alcohol Use Disorders Identification Test (AUDIT): a review of recent research." Alcoholism, clinical and experimental research **26**(2): 279–9
- Roxburgh, A. & Degenhardt, L. (2006). Drug-related hospital stays in Australia 1993-2005. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.

- Shand F., Topp L., Darke S., Makkai T & Griffiths, P. (2003). "The monitoring of drug trends in Australia." Drug and Alcohol Review **22**(1): 3-6.
- Stafford, J., Degenhardt, L., Dunn, M., Fischer, J., George, J., Johnston, J., Matthews, A., Newman, J., Proudfoot, P. & Weekley, J. (2006). Australian Trends in Ecstasy and Related Drug Markets 2005: Findings from the Party Drugs Initiative (PDI). Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
- Solowij, N., Hall, W. & Lee, N. (1992). "Recreational MDMA use in Sydney: A profile of 'Ecstasy' users and their experiences with the drug." British Journal of Addiction **87**: 1161-72.
- Topp, L., Degenhardt, L., Day, C. & Collins, L. (2003). "Contemplating drug monitoring systems in the light of Australia's 'heroin shortage'." Drug Alcohol Review **22**(1): 3-6.
- Topp, L., Degenhardt, L., Kaye, S. & Darke, S. (2002). "The emergence of potent forms of methamphetamine in Sydney, Australia: A case study of the IDRS as a strategic early warning system." Drug and Alcohol Review, **21**: 341-49.
- Topp, L., Hando, J., Degenhardt, L., Dillon, P., Roche, A., & Solowij, N. (1998). Ecstasy Use in Australia. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
- Topp, L., Hando, J., Dillon, P., Roche, A. & Solowij, N. (1999). "Ecstasy use in Australia: Patterns of use and associated harms." Drug and Alcohol Dependence **55**: 105-15.
- Topp, L. & R. P. Mattick (1997). "Choosing a Cut-Off on the Severity of Dependence Scale (SDS) for Amphetamine Users." Addiction **92**(7): 839-45.
- White, B., Breen, C. & Degenhardt, L. (2003). NSW Party Drug Trends 2002: Findings of the Illicit Drug Reporting System (IDRS) Party Drugs Module. NDARC Technical Report Number 162. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.