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

NDARC Technical Report No. 281

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

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ABBREVIATIONS

ABCI	Australian Bureau of Criminal Intelligence
ACC	Australian Crime Commission
ADF	Australian Drug Foundation
ADIS	Alcohol and Drug Information Service
AFP	Australian Federal Police
AIHW	Australian Institute of Health and Welfare
A&TSI	Aboriginal and/or Torres Strait Islander
AUDIT	Alcohol Use Disorders Identification Test
BBVI	blood-borne viral infections
DHHS	Department of Health and Human Services
DXM	dextromethorphan
EDRS	Ecstasy and related Drugs Reporting System
ERD	ecstasy and related drugs
GHB	gamma-hydroxy-butyrate
GLBT	gay lesbian bisexual transgender
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IDRS	Illicit Drug Reporting System
IDU	injecting drug user
KE	key expert(s) (previously 'key informant')
KI	key informant
LSD	*d*-lysergic acid
M	mean
MAOI	monoamine oxidase inhibitor
MDA	3,4-methylenedioxyamphetamine
MDEA	3,4-methylenedioxyethamphetamine
MDMA	3,4-methylenedioxymethamphetamine
N	(or n) Number of participants
NAP	Needle Availability Program
NDARC	National Drug and Alcohol Research Centre
NDLERF	National Drug Law Enforcement Research Fund
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NSP	Needle and Syringe Program
PCP	phencyclidine
PDI	Party Drugs Initiative
REU	regular ecstasy user(s) (previously 'party drug user')
SD	standard deviation
SIS	State Intelligence Services, Tasmania Police
SPSS	Statistical Package for the Social Sciences
SSRI	specific serotonin reuptake inhibitor
TAS	Tasmania
TASPOL	Tasmania Police
TCA	tricyclic antidepressant

EXECUTIVE SUMMARY

Demographic characteristics of REU

The sample of 100 regular ecstasy users (REU) interviewed in 2006 were typically young, with ages ranging from 18 to 61 years and the majority in their early- to mid-twenties. Participants were generally well educated and either employed on a full- or part-time/casual basis or currently engaged in full-time study. Few participants had come into contact with the criminal justice system or drug treatment agencies. These demographic characteristics are generally consistent with those reported among REU in the previous three years of the study. However, there was less recent injecting drug use, involvement in current drug treatment, and recent use of methadone and heroin among the most recent three cohorts relative to 2003, possibly reflecting less overlap between the IDU and REU populations in the latter three years of the study.

Patterns of polydrug use

While the participants were selected on the basis of regular use of ecstasy, and over half nominated ecstasy as their drug of choice, polydrug use was the norm among the REU interviewed. Recent use of alcohol, cannabis, tobacco, and methamphetamine (powder, base and crystal) was common, and over half had recently used psychedelic mushrooms. Between one-third and one-quarter had recently used nitrous oxide, cocaine, benzodiazepines, LSD, or 2CI. Around one-tenth had recently used opiates other than heroin or methadone, pharmaceutical stimulants, amyl nitrite, or antidepressants and the recent use of ketamine, methadone, MDA, GHB, buprenorphine, and heroin was uncommon. There was no recent use of 1,4B or GBL among the current sample.

Over the four years of the study there have been trends in the use of some drug types. Between 2003 and 2006 there has been a steady decrease in the recent use of ketamine, MDA, and amyl nitrite, and an increase in the use of cocaine. Relative to the 2005 sample, there was a slight decrease in the recent use of methamphetamine powder (62% vs. 77%) and a slight increase in the use of methamphetamine base (23% vs. 40%) and crystal methamphetamine (10% vs. 27%) in 2006. However, the highest recent use of crystal methamphetamine was observed among the 2003 sample (52%). One-quarter of the 2006 sample (23%) had recently used the hallucinogen 2CI among the 2006 cohort compared to less than one-twentieth of previous cohorts. Stable trends were observed in the use of most other drug types.

Ecstasy

Data from the National Drug Strategy Household Survey (NDSHS) suggest a steady increase in the national prevalence of ecstasy use in Australia between 1995 and 2004, where 7.5% of the population are estimated as ever trying the drug, and 3.4% were estimated as using the drug in the preceding 12 month period. The prevalence of recent ecstasy use among the Tasmanian sample has remained at least half that of the national estimate during this time, and it is unclear whether there has been any substantial change in the prevalence of ecstasy use in Tasmania over this time.

The participants interviewed in the present study had first started to use ecstasy on a regular basis at 20 years on average and a large majority of the sample had been using ecstasy for two years or more. The entire sample had recently used ecstasy in tablet form while a minority had recently used ecstasy capsules or powder. There was a wide variation in the frequency of ecstasy use among the sample, ranging from monthly to several times a week. On average, ecstasy had been used fortnightly with a median of two tablets taken in a typical session. Although ecstasy was typically swallowed, snorting of ecstasy was also common, with three-quarters of the sample recently snorting the drug. This may be an issue of concern due to potential damage to mucous

membranes, a steeper dose-response curve, and the increased risk of blood-borne viral infections. A minority of the sample had also recently shelved/shafted (anal/vaginal administration), smoked, or injected ecstasy.

There were some concerning patterns of use among the sample. One-fifth (22%) had used ecstasy on a weekly basis or more frequently, three-quarters (79%) usually used more than one tablet in a typical session of use, and one-third (37%) had recently used ecstasy in a 'binge session' (a continuous 48 hour period of drug use without sleep). Relative to 2005, slightly greater proportions of the sample had usually used more than one tablet in a typical session, or had recently 'binged' on ecstasy, but the median frequency of ecstasy use overall was slightly lower. Whereas the long-term effects and risks of extended ecstasy use are largely unknown, evidence from toxicology studies in rats and neuropsychological studies in humans indicate that the safest pattern of use is to use the drug infrequently and in small amounts. Thus, those using the drug frequently or in large amounts for extended periods of time may be at a greater risk for neurological and neuropsychological harm.

Ecstasy was typically consumed in combination with other drugs. Alcohol, cannabis, and tobacco were commonly used in a typical session of ecstasy use. Just over one-tenth (15%) typically used methamphetamine when under the influence of ecstasy, similar to the proportion in 2005 (17%), marking a sustained reduction from the rates in the 2003 (25%) and 2004 cohorts (25%). The use of cannabis both under the influence and when 'coming down' from ecstasy and the use of benzodiazepines when coming down from ecstasy has also decreased slightly over the past four years.

The majority of participants (79%) reported drinking alcohol when under the influence of ecstasy and two-thirds (66%) typically consumed more than five standard drinks. Although the proportion reporting 'binge drinking' when under the influence and coming down from ecstasy had slightly declined from the high rates amongst the 2004 and 2005 cohorts, the high level of coincident binge alcohol and ecstasy use is still an issue of concern. There is an increased risk of dehydration when alcohol is combined with ecstasy and larger quantities of alcohol can be consumed when under the influence of psycho-stimulants without experiencing immediate effects of intoxication; however, the harms associated with this use still occur. Additionally, most of the overdose episodes reported by the REU in the current study involved alcohol and/or polydrug use.

Close to half (49%) of the REU sample had recently experienced no or few psychological symptoms of dependence in relation to their ecstasy use as measured by the Severity of Dependence Scale (SDS) for ecstasy. However, almost one-fifth (19%) reported experiencing significant symptoms of dependence in relation to ecstasy. High ecstasy SDS scores were associated with greater frequency and quantity of ecstasy use, binge drug use, and high levels of methamphetamine dependence and psychological distress scores.

Ecstasy was typically used at music-related venues including dance parties, nightclubs and live music events but was also used at a range of other locations including private parties and private residences. REU reports and anecdotal comments of KE suggest an increase in the use of ecstasy at locations other than dance/events and nightclubs, in particular at private residences and public bars. Qualitative comments of both KE and REU suggest that the use of ecstasy has become more 'mainstream' and less restricted to dance-related events and nightclubs. There were anecdotal reports of a broadening demographic of people consuming the drug locally, including the use of ecstasy by younger and older people as well as an increase in the social acceptability of the drug. Ecstasy appears to have become enmeshed in drinking culture and is likely to be used in combination with binge alcohol drinking.

The majority of participants perceived both benefits and risks to be associated with their ecstasy use. Perceived benefits were generally associated with having a fun and enjoyable time, social benefits such as enhanced closeness and enhanced communication with others, the enhanced appreciation of music/dance as well as acute drug effects such as enhanced mood and increased energy. The greatest risks perceived were the unknown contaminants/cutting agents in pills, legal/police problems, damage to brain function, and depression, among other psychological, neuropsychological, and physical risks. A minority considered acute physical problems such as vomiting, headaches, dehydration, overdose, and body temperature regulation, or the acute effects of intoxication, such as risk-taking behaviours, to be major risks of ecstasy use.

Price, purity and availability of ecstasy

Whereas there was evidence for an expanding ecstasy market in 2004, marked by decreased price, increased purity, and increased availability relative to 2003, in 2005 the market appeared to have tightened slightly, with a slight increase in price and decreased purity and availability relative to 2004. In 2006, a slight decrease in price and purity was observed, while availability remained relatively stable.

The median price reported by REU for one tablet of ecstasy was $40, which is slightly lower then the price of $45 reported in 2005. Over one-half indicated that this price had remained stable during the preceding six months, but one-quarter indicated that there had been a recent decrease in price. The median price reported by KE was also $40 and over half of those that commented (n=7) indicated that the price of ecstasy had recently decreased.

REU typically reported that ecstasy was 'medium' or 'fluctuating' in purity, with a smaller proportion reporting that ecstasy was 'high' in purity relative to previous years. REU typically indicated that this purity had remained stable or had fluctuated during the six months preceding the interview. KE indicated that the purity of ecstasy typically fluctuated or was 'low' to 'medium', with four out of eight KE reporting a recent decrease in the purity of ecstasy. There have been limited forensic analyses of the purity of ecstasy tablets seized by Tasmania Police. The median purity of the 33 seizures analysed during the 2003/04 reporting period was 26.0% and ranged from 10.4% to 44.5%. There were no analyses of ecstasy purity reported by Tasmania Police in the 2004/05 reporting period and the 2005/06 data was unavailable at the time of publication.

Both KE and REU indicated that ecstasy is 'easy' or 'very easy' to obtain and that recent availability had remained stable.

There was a substantial increase in the number of ecstasy tablets seized by Tasmania Police in the 2003/04 financial year, and the number of tablets seized has remained relatively stable since this time. Whereas this has had minimal impact on the number of arrests made in relation to ecstasy, there were a greater number of consumer (5) and provider (7) arrests reported in the 2004/05 reporting period relative to previous years (although these numbers remain low). Data for the 2005/06 financial year were unavailable at the time of publication.

Ecstasy markets and patterns of purchasing

Consistent with previous years, ecstasy was typically purchased from friends and obtained from friends' homes. Over one-half (54%) indicated that when they purchased ecstasy, they typically purchased the drug both for themselves and others, while the remainder (44%) typically purchased ecstasy only for themselves. Although the ecstasy market is predominantly based on individuals sourcing the drug for other friends while making no cash profit, those that purchase ecstasy in larger quantities may be putting themselves at greater risk of being arrested as a provider rather

than a consumer of the drug. While two-fifths (43%) of the sample perceived that getting tablets for friends carried a heavier penalty than getting tablets for themselves, the remainder of the sample did not perceive that there was a distinction. Almost half of the cohort (46%) were aware of some possible consequences of being charged with supplying ecstasy (although the suggested consequences were not necessarily technically correct in terms of the legislated legal sanctions), and the remainder were not able to confidently comment.

Under Tasmanian legislation, the offences of possession, supply, and trafficking of a controlled substance are based on various factors including 'intent' and are not necessarily determined by the quantity of the seized substance. However, the offence of trafficking, which carries the largest penalty, may be determined by possession of a traffickable amount of a controlled substance. For ecstasy (MDMA), this traffickable amount is 10g.

Methamphetamine

Consistent with previous years, use of methamphetamine was common among REU in 2006. Over three-quarters (78%) had used some form of methamphetamine in the preceding six months. Methamphetamine was typically swallowed or snorted and was used on a median of six times during this period (approximately monthly) in small quantities (0.1g). The proportion reporting recent use of any form of methamphetamine and the frequency of methamphetamine use has remained relatively stable since 2003.

Recent use of methamphetamine powder was most common (62%) followed by methamphetamine base (40%), and crystal methamphetamine (27%). Relative to 2005, the proportion that had recently used powder was lower (62% vs. 77%) and the proportion that had recently used base (40% vs. 23%) and crystal (27% vs. 10%) was higher in the 2006 cohort. The frequency of methamphetamine powder use has decreased slightly over the past three years of the study. In 2006, the quantity of methamphetamine base used in a typical session was greater (~0.2g) relative to previous years (0.1g), and relative to the other methamphetamine forms. The increase in the recent use of crystal methamphetamine was largely attributable to an increase in those who reported smoking the drug.

Over half of recent methamphetamine users (52%) had experienced no symptoms of psychological dependence as measured by the methamphetamine SDS. However, almost one-fifth (19%) had experienced significant symptoms of dependence. High SDS scores were associated with greater frequency of methamphetamine use, use of methamphetamine in combination with ecstasy, recent binge drug use, recent injecting drug use, and elevated levels of psychological distress.

The median price for one 'point' (0.1g) of methamphetamine powder and methamphetamine base was $40, and the median price for one 'point' of crystal was higher at $50. The price of methamphetamine base was $10 less in comparison to 2005.

Methamphetamine powder and base were reported to be 'medium' to 'high' purity, whereas crystal methamphetamine was reported to be 'high' in purity. Subjective reports of REU suggest decreased purity of methamphetamine base relative to 2005.

Methamphetamine powder and base were considered to be 'easy' or 'very easy' to obtain, and crystal methamphetamine was typically considered to be 'difficult' or 'very difficult' to obtain. The availability of methamphetamine base appears to have increased relative to 2005. Those that commented on crystal methamphetamine indicated that it had become more difficult to obtain in the last six months.

The overall use of methamphetamine among REU in Tasmania has remained stable, but there have been some recent shifts in the use and market characteristics of each form. The recent use of powder is slightly lower than 2005 and there has been a gradual decrease in frequency of use since 2003. The recent use, frequency of use, and availability of base has increased relative to 2005, and the price has decreased. While the recent use of crystal has also increased relative to 2005, it is still half of that reported in 2003, and prices have remained stable, and availability low.

Cocaine

The lifetime and recent use of cocaine has steadily increased among the REU interviewed in Tasmania since 2003. One-third (33%) had recently used cocaine in 2006, compared to one-fifth (20%) in 2005, and one-tenth among the 2004 (10%) and 2003 (7%) samples.

Cocaine was typically snorted and was used on a median frequency of two days (range 1-6 days) in the six months preceding the interview, with an average of 0.2 to 0.5 grams used in a typical session.

The median price for one gram of cocaine was $350 (range $250-500) and the price for one point (0.1g) of cocaine was $50 (range $35-50). These prices were typically reported to have remained stable during the six months preceding the interview, though one-quarter of those who commented indicated a recent decrease in the price of cocaine.

Cocaine was typically considered to be 'medium', 'low', or 'fluctuating' in purity, and to have recently remained 'stable' or 'fluctuated' in purity during the six months preceding the interview.

REU reports on the availability of cocaine were mixed, with half indicating that it was 'easy' or 'very easy' to obtain and half indicating that it was 'difficult' or 'very difficult' to obtain. Although a majority indicated that the availability of cocaine had remained stable during the six months preceding the interview, one-third indicated a recent increase in the availability of cocaine. KE comments also indicated a recent increase in the use and availability of cocaine among REU in Hobart.

Ketamine

The lifetime and recent use of ketamine has decreased among the Tasmanian EDRS sample since 2003. Less than one-tenth (6%) of REU interviewed had used ketamine during the six months preceding the interview. Ketamine had been used on an average of two occasions in the preceding six months in relatively small amounts. This, along with anecdotal reports of key experts, suggests predominately experimental use by a small number of people amongst this regular ecstasy-consuming cohort. Ketamine was typically swallowed or snorted and had been purchased in powder form.

Consistent with the relatively low use of ketamine among the 2006 REU sample, few participants were able to comment on the price, purity and availability of the drug and these estimates should therefore be interpreted with caution. One participant indicated that the price for one gram of ketamine was $180 and another indicated that they had purchased one point of ketamine for $40 during the six months preceding the interview. The purity of ketamine was considered to be high or medium and to have remained stable in recent months. The comments of KE and the patterns of use among REU both indicate relatively low availability of ketamine in Tasmania.

GHB

Consistent with the low levels of use reported among the Tasmanian REU sample in previous years, less than one-tenth (9%) of the REU sample had ever used GHB, and only three participants (3%) had used GHB during the six months preceding the interview. GHB was taken orally in liquid form on a median of 2 days (range 1-3 days) during this time. There was no lifetime or recent use of GHB-like substances such as 1,4B or GBL among the 2006 REU cohort.

Only two participants commented on the price, purity, and availability of GHB in Tasmania, making it difficult to delineate clear trends. Patterns of use among REU and anecdotal comments of key experts indicate low availability of GHB in Tasmania and predominantly experimental use by few people. However, considering the potentially harmful nature of GHB, future monitoring of GHB markets in Tasmania is important.

LSD and other psychedelics

Over half of the 2005 REU sample had used LSD at some stage of their lives and almost one-third had used LSD in the six months preceding the interview. A significantly greater proportion of males had ever and recently used LSD in comparison to the proportion of females. One tab or drop of liquid LSD was taken orally in a typical session of use, and LSD had been used on a median of 2 days in the preceding six months. Whereas LSD was most typically used at private residences, the use of LSD at dance-related events, nightclubs, and private parties was slightly higher in 2006 relative to previous years.

The median price for one tab of LSD was $20 (range $10-40) and this price was considered to have remained stable in the last six months. The purity of LSD was perceived by REU to be 'medium' or 'high' and stable during the six months preceding the interview. Two-thirds of the sample reported that LSD was 'easy' or 'very easy' to obtain, and the remainder reported that it was currently 'difficult' or 'very difficult' to obtain. Subjective reports of REU indicate a gradual increase in the availability of LSD since 2003, but levels of use have remained stable in successive EDRS cohorts during this time.

Almost three-quarters of respondents had ever used psychedelic mushrooms and over half had used mushrooms during the six months preceding the interview, which is an increase relative to previous years. A greater proportion of males had ever and recently used mushrooms in comparison to females. Mushrooms had been used on a median of three days in the preceding six months, approximately every two months. Both REU and KE noted a recent increase in the use of mushrooms at the time of the interview that was attributed to the seasonal increase in their availability. Almost two-thirds of the sample, and a greater proportion of males than females, had used some form of psychedelic (either LSD or mushrooms) in the last six months.

In 2006, almost one-quarter of the REU sample (23%) had recently used the experimental research chemical 2CI, which is a substantial increase relative to the small proportions that had recently used the drug in 2004 (5%) and 2005 (1%). Whereas this indicates an increase in the availability of 2CI locally, the frequency of use was relatively low, indicative of predominantly experimental use.

MDA

The lifetime and recent use of MDA among the Tasmania REU sample has decreased gradually from 32% and 21% respectively in 2003, to 14% and 3% respectively in 2006. MDA had been purchased in capsule form and had been swallowed or snorted on single occasions during the six months preceding the interview. Few respondents were able to confidently comment on the price, purity or availability of MDA and thus it is difficult to delineate clear trends. However, based on

the decline in the use of MDA since 2003, and the comments of several KE, the local availability of MDA in Tasmania appears to be low.

Cannabis

The entire REU sample had used cannabis at some stage of their life, and a majority (82%) had used cannabis during the six months preceding the interview. Cannabis had been used approximately weekly on average during the six months preceding the interview, and this frequency of use tended to be greater for males relative to females (30 vs. 12 days), and for older relative to younger participants (72 vs. 12 days).

Participants were asked about the price, purity, and availability of hydroponically-grown ('hydro') and bush-grown ('bush') cannabis for the first time in 2006. Bush was typically cheaper than hydro, particularly when bought in larger amounts. The median last purchase price for one gram of cannabis was $15 for both bush and hydro (range $10-$25). The median last purchase price for one-quarter of an ounce was $85 ($70-$100) and $65 ($40-$80) for hydro and bush respectively, and the median price for one ounce of hydro was $250 (range $200-300) compared to $200 ($50-350) for bush. The purity of hydro was reported to be high and stable, and the purity of bush was reported to be medium and stable. Both bush and hydro were reported to be 'easy' or 'very easy' to obtain and availability was reported to have remained stable during the six months preceding the interview.

Patterns of other drug use

The majority of REU had recently consumed alcohol on an average of two days per week in the six months preceding the interview. A large majority (78%) of the 2006 EDRS REU sample had used alcohol at least weekly during the six months preceding the interview, which is substantially higher than both the Tasmanian (39.4%) and national (41.2%) estimates of prevalence for the general population, and among those aged 20-29 nationally (56.7%), from the 2004 National Drug Strategy Household Survey. A large majority of REU (85%) scored 8 or more on the alcohol use disorders identification test (AUDIT), suggestive of hazardous and harmful alcohol use and the possibility of alcohol dependence.

Tobacco had recently been used by four-fifths of the sample and over half the sample had smoked tobacco on a daily basis in the last six months, with others smoking tobacco less frequently. The proportion of daily smokers among REU interviewed in the present study (63%) is greater in comparison to both national (23.5%) and Tasmanian (27.7%) estimates of prevalence among those aged 20-29 from the 2004 National Drug Strategy Household Survey.

There has been a reduction among REU in the recent use of amyl nitrite from two-fifths (43%) in 2003 to less than one-tenth (16%) in 2006. The majority (90%) of those that had inhaled amyl nitrite had done so less than once a month during the last 6 months. The proportion of the sample reporting recent use of nitrous oxide has increased from one-quarter (25%) to two-fifths in 2005 (43%), and 2006 (39%). On average, nitrous oxide had been used less than monthly.

One-third of the sample had recently used benzodiazepines, on a median of five days in the last six months. One-tenth of the sample had recently used antidepressants, with one-third of these using them on a daily basis during the six months preceding the interview.

The use of other pharmaceuticals and opioid drugs was relatively rare among the regular ecstasy users interviewed in the current study, and those that had recently used these drugs had generally done so infrequently. Twelve percent had recently used pharmaceutical stimulants (such as

dexamphetamine or methylphenidate), with a median frequency of approximately once every three months. Only small proportions of the sample had recently used methadone (5%), heroin (2%), and buprenorphine (1%). The recent use of other opiates (pharmaceuticals and alkaloid poppy derivatives) was slightly more common (14%) but relatively infrequent at once every two months.

Drug information-seeking behaviour

Two-thirds (66%) of the REU sample indicated that they had 'sometimes' bought a drug and it turned out to have different effects than they expected in the last six months, and two-thirds (63%) indicated that they did not know what was in the pills that they took. Whereas one-third (34%) of the REU interviewed in 2006 actively sought information about the content/purity of 'batches' of ecstasy pills, the remainder did so half the time or less (37%) or 'never' (27%). Participants typically obtained this information from friends, dealers, and other people as well as websites, personal experience, and pill testing kits. Ten participants reported recent use of pill testing kits, and one-half of these were aware of some limitations of testing kits.

The majority of REU were receptive to harm-reduction information. Three-quarters (72%) indicated that they would find pill testing kits personally useful if available locally. Other information resources that were considered useful by REU were information pamphlets, a local website, health outreach workers at events, and posters. Participants generally indicated that the result of pill testing would influence their decision to take a pill. For example, many would not take a pill if testing indicated that it contained potentially harmful substances such as PMA and DXM.

Several REU commented on the lack of information available to them on the effects of drugs and ways in which to consume them more safely. In 2005, REU indicated that they were particularly interested in finding out more information about the long-term effects of drug use (physical, psychological, neuropsychological, and neurological) and also considered it to be important that new consumers were aware of the acute effects of drug use and ways in which to use drugs more safely.

Risk behaviour

Less than one in ten regular ecstasy users (9%) had recently used substances intravenously, consistent with the proportion of recent injectors amongst the preceding two EDRS cohorts. Methamphetamine was typically the first drug ever injected and the most common drug ever and recently injected. The sharing of needles was relatively rare; however, two out of five had recently shared other injecting equipment such as spoons, tourniquets, and water. One-tenth of these recent injectors had always required others to inject them in the last six months. The majority of recent injectors had obtained injecting equipment from NSP outlets in the preceding six months and none reported difficulty in obtaining needles during this time.

A large majority (94%) of REU had been sexually active during the six months preceding the interview and most of these (87%) reported recent penetrative sex under the influence of ecstasy and related drugs. Participants were generally more likely to report some use of protective barriers with a casual partner than with a regular partner. Participants were slightly less likely to use protective barriers with a regular partner when under the influence of party drugs (60% vs. 49%). When having sex with a casual partner, participants were more likely to use protective barriers (82% vs. 91%) when under the influence of party drugs, but the proportion that 'always' used barriers declined when under the influence of drugs (47% vs. 34%). Whereas two-fifths of participants (40%) had been for a sexual health check up in the last year, one-third (37%) had

never had a sexual health check up. Three-fifths of the sample had never been tested for hepatitis C or HIV. Three participants reported testing positive for hepatitis C.

Of those that had driven a car, one-half (48%) reported driving at a time when they perceived themselves to be over the legal alcohol limit during the last six months, compared to three-fifths (58%) in 2005. Three-quarters (78%) reported driving within an hour of taking ERDs in the last 6 months, compared to one-half (55%) in 2005. Most commonly, participants reported driving under the influence of ecstasy, cannabis or methamphetamine. Those that had recently driven under the influence of drugs were older, less likely to be students, and more likely to be full-time workers than those that had not. They were also more likely to have recently binged on ERDs and had recently used ecstasy more frequently and in larger amounts.

Almost one-half (46%) had recently 'binged' on ecstasy and related drugs (a continuous period of use for more than 48 hours without sleep). Substances most commonly used in a binge session of use were ecstasy, cannabis, alcohol, and methamphetamine. Those who had recently 'binged' had first started using ecstasy at an earlier age, had experimented with a greater number of drugs, and had recently used ecstasy more frequently and in larger amounts. They were also more likely to report recent injecting drug use, recent methamphetamine use, and to have typically used methamphetamine in combination with ecstasy during this time. They also reported higher psychological dependence scores for ecstasy and methamphetamine as measured by the SDS.

Health-related issues

Less than one-tenth of the sample (8%) reported that they had overdosed (passed out or fallen into a coma) on any drug in the six months preceding the interview. The main drugs involved in recent overdoses were ecstasy (43%), ketamine (14%), GHB (14%), methadone (14%), and Phenergan (14%). The majority of overdose episodes (86%) were associated with the use of more than one drug, most typically alcohol (43%), and cannabis (43%).

One-fifth (22%) of the 2006 REU sample had accessed health services in relation to drug use in the preceding six months. The most commonly accessed service was a GP (n=10), followed by ambulance (n=6), first aid (n=5), emergency (n=4), counsellor (n=3), hospitalisation (n=3), drug and alcohol worker (n=3), psychologist (n=3), and psychiatrist (n=2). Participants were most likely to access services in relation to the use of alcohol (n=10), ecstasy (n=9), methamphetamine (n=9), or cannabis (n=7) use, the drugs most commonly used among this cohort. A greater proportion of younger participants had accessed health services in comparison to older participants.

Mean scores on the Kessler psychological distress scale (K10) and the proportion with 'high' scores (25 or more) were higher among the current sample of REU relative to estimates among the general Australian population. One in ten REU (13%) had 'high' K10 scores indicative of high levels of psychological distress and a possible diagnosis of a mood disorder. Those with this high level of psychological distress were more likely to be unemployed, to be GLBT, to have recently injected, to have recently 'binged' on stimulants, to have 'high' methamphetamine dependence scores, and to have recently accessed health services. However, more than two-fifths of those with 'high' K10 scores had not accessed any health services in relation to their psychological distress in the preceding six months.

One half of the sample (55%) had recently experienced work/study problems in relation to drug use, two-fifths had recently experienced financial (45%) and social/relationship (44%) problems, and less than one-tenth (5%) had recently experienced legal/police problems in relation to drug use. Problems were most commonly attributed to ecstasy, methamphetamine, or cannabis. Whereas the majority of these problems were relatively minor, small proportions experienced

more serious problems such as ending a relationship, being kicked out of home, leaving school, being sacked/quitting work, or having no money to pay for food or rent.

Criminal activity, policing and market changes

Consistent with previous years, the self-reported criminal activity among the 2006 REU sample was relatively low. With the exception of dealing drugs, only 8% of the REU interviewed had committed criminal offences during the one month preceding the interview, and 8% had been arrested during the preceding 12 months. Key experts generally indicated that there was no or little crime among the group of REU that they were familiar with.

Almost one-third of the REU sample (30%) and several key experts perceived that there had been an increase in police activity towards ecstasy users in the last six months; however, the majority of regular ecstasy users indicated that police activity had not recently made it more difficult for them to obtain drugs.

Conclusion

The REU interviewed for the current study were generally young, employed or studying, and not currently in drug treatment or legal trouble. While ecstasy was the preferred drug of most, polydrug use was the norm and the use of alcohol, cannabis, tobacco and methamphetamine common. The current harm-reduction messages in regard to ecstasy suggest that use of the drug infrequently and in small amounts may assist in minimising the risk of neurological and neuropsychological harm. This is concerning as a notable proportion of those interviewed were using ecstasy more than weekly, using multiple tablets on an occasion of use, and using for extended periods (more than 48 hours) without sleep. Moreover, the rate of binge alcohol consumption in combination with ecstasy is concerning and may also exacerbate health harms.

There was a subset of this cohort that experienced notable symptoms of dependence to both ecstasy and methamphetamine and were more likely to be involved in multiple risky health behaviours (injection, more frequent use, binge use) and to experience clinically significant levels of psychological distress. However, the level of harm experienced by the majority of participants was relatively low, with few recent overdose episodes, few people accessing health services in relation to drug use, only relatively minor work/study, financial, and social problems experienced by most users, and most not experiencing significant symptoms of dependence in relation to either ecstasy or methamphetamine, or high levels of psychological distress.

Only a minority of the cohort had accessed health services in relation to drug use, and this point of contact was most likely to be a general medical practitioner. While many consumers actively sought harm-reduction information about the risks and effects of the drugs that they chose to use, these messages were not necessarily reaching other consumers, and more proactive health programs to this demographic are clearly warranted.

Implications

It is important to remember that the aim of the EDRS is to investigate the patterns of drug use, drug markets and associated risks and harms among a sentinel group of participants that use ecstasy on a regular basis; as such, this population is not necessarily representative of all consumers of ecstasy and related drugs and the prevalence of ecstasy and other drug use can not be directly inferred. However, the study is designed to identify emerging trends and important issues, and the findings of the 2006 EDRS suggest five key areas for future policy:

1. Funding of specific health programs to meet the needs of local consumers

There are currently no services that specifically cater to users of ecstasy and related drugs in Hobart, and aside from volunteer organisations at predominantly large-scale events there is currently very little dissemination of harm-reduction information to these populations. This indicates a clear need for funding and a proactive response in terms of the implementation of harm-reduction strategies. Although approximately half of the REU interviewed in the current study were actively seeking harm-reduction information in relation to the substances that they chose to use, these messages were not necessarily reaching other consumers. Despite this, the majority of REU were receptive to such information. Considering that drug information was typically sought from peers or peer-run organisations, and the fact that REU do not typically come into contact with traditional health services, it is likely that harm-reduction programs will attain maximum impact if delivered through peer-based organisations and mediums appropriate to the target group such as internet sites and outreach workers or information at events. Such a peer-led service would be extremely well-placed to target the following specific risk behaviours identified in the current study: polydrug and binge drug use, binge drinking, unsafe sex, and sharing of injecting equipment. By contrast, illicit-drug education campaigns based around 'fear arousal' have been shown to be ineffective or to even have contradictory effects (Ashton, 1999; Skiba, Monroe & Wodarski, 2004; West & O'Neal, 2004), and these programs, and associated sensationalised reporting of drug use in the media, run the real risk of undermining the potential for successfully reducing health harms amongst this population.

Consistent with this recommendation, a recent parliamentary inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs (AOSD) in Australia recommended that harm-reduction strategies and programs receive more attention and resources in the execution of the National Drug Strategy (Commonwealth of Australia, 2007). The committee also recommended that that public education and demand-reduction campaigns for illicit drugs be factual, informative and appropriately targeted, seek input from young people and take account of user's experiences. (Secretariat of the Parliamentary Joint Committee on the Australian Crime Commission, 2007).

2. Focused interventions to reduce the harm associated with binge drinking in combination with ecstasy

The majority of participants (79%) reported drinking alcohol when under the influence of ecstasy and two-thirds of these (66%) typically consumed more than five standard drinks. Although the proportion reporting 'binge drinking' when under the influence and coming down from ecstasy had slightly declined from the high rates amongst the 2004 and 2005 cohorts, the high level of coincident binge alcohol and ecstasy use is still an issue of concern. There is an increased risk of dehydration when alcohol is combined with ecstasy. Additionally, larger quantities of alcohol can be consumed when under the influence of psychostimulants without experiencing the immediate effects of intoxication; however, the harms associated with this use still occur. A large majority (78%) of the 2006 EDRS REU sample had used alcohol at least weekly during the six months preceding the interview, which is substantially higher than both the Tasmanian (39.4%) and national (41.2%) estimates of prevalence for the general population, and among those aged 20-29 nationally (56.7%). A large majority of REU (85%) scored 8 or more on the alcohol use disorders identification test (AUDIT), suggestive of hazardous and harmful alcohol use and the possibility of alcohol dependence. Additionally, most of the overdose episodes reported by REU in the current study involved alcohol and/or polydrug use.

3. The provision of pill testing kits

While there are some limitations to the use of commercially available ecstasy 'testing kits', currently there is often very little information available to consumers in regard to the substances contained within the tablets that are sold on the local market, and two-thirds of the participants in the current study indicated that they had sometimes bought a drug and it turned out to have different effects than expected. Limitations aside, use of these kits may allow consumers to be more informed about the tablets that they choose to use, and it was apparent that the consumers interviewed would act on information from testing kits – not taking a pill if it appeared to have an unexpected content such as potentially harmful substances such as PMA or DXM (see also Johnston et al., 2006). Testing kits can be purchased via the internet but are currently not available from any local source. There may be some benefit in making these available locally on a not-for-profit or cost-recovery basis, or facilitating provision of testing at dance and related events. The use and/or supply of testing kits under these circumstances would also allow for the limitations of these kits to be conveyed more effectively to consumers.

While noting some concerns about the potential limitations of pill testing kits, the recent parliamentary inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs (AOSD) in Australia noted that a feasibility study an illicit tablet monitoring service is underway in Victoria, and that the results of the evaluation of this study will be informative for future policy decisions in relation to pill testing (Secretariat of the Parliamentary Joint Committee on the Australian Crime Commission, 2007).. The authors of this report concur with this view and would encourage Tasmanian services and consumers to support this feasibility study wherever possible.

4. Increased awareness among local consumers of legislation with regard to possession, supply, and trafficking of controlled substances

Although the ecstasy market is predominantly based on individuals sourcing the drug for other friends while making no cash profit, those that purchase ecstasy in larger quantities may be putting themselves at greater risk of being arrested as a provider rather than a consumer of the drug. Over one-half (54%) indicated that when they purchased ecstasy, they typically purchased the drug both for themselves and others, while the minority (44%) typically purchased ecstasy only for themselves. Over half of the 2006 REU sample was not aware of the distinction between purchasing for themselves and others in terms of the law. Further, over half were not explicitly aware of the consequences with being charged with the supply of ecstasy. This indicates a need for increased awareness among REU in Tasmania of the risks associated with supplying ecstasy to friends, so that they are able to make informed choices with regard to this.

5. Consideration of the potential consequences of legislation surrounding smoking devices such as ice/crystal pipes

Although the use of crystal methamphetamine had increased slightly among the REU interviewed in Tasmania relative to 2005, the overall use of methamphetamine (all forms) has remained stable among the cohort, and the recent use of crystal remains half that of the recent use observed among the 2003 cohort. Among the 2005 sample, the small number of people that had recently used crystal methamphetamine had typically injected the drug. In 2006, the increase seen in the recent use of crystal was among those smoking the drug. There has been some recent suggestion nationally that legislation should be enacted to ban the sale of smoking devices such as ice/crystal pipes. The possible dangers of such legislation are that consumers will turn to other potentially harmful routes of administration such as injection, or the use of 'home made' devices that are potentially less safe (e.g. broken light globes). These issues should be considered with regard to the introduction of such legislation, and the EDRS aims to examine the possible impact of such legislation in 2007. While the behavioural responses to such a policy change are not yet known,

and risks to the health of consumers and the population more broadly are high (given the potential harm should a substantial proportion of smokers make the transition to injecting use), any such policy changes should be limited to discrete regions and their consequences carefully evaluated before wider enactment.

6. Monitoring and dissemination of party drug trend information

Over the last four years, the findings of the EDRS have revealed some important trends in drug use among regular ecstasy-consuming cohorts in Tasmania. The use and availability of substances such as ketamine and MDA has decreased among the REU cohort since 2003, and the use of potentially harmful substances such as GHB is currently relatively low in Tasmania. There has been a gradual increase in the use and availability of cocaine and psychedelic mushrooms and a more recent increase in the use of the research chemical 2CI, though the frequency of use for these drugs remain relatively low. Although the overall use of methamphetamine has remained stable among the REU interviewed in Tasmania, there have been some shifts in the use of particular methamphetamine forms, notably a recent increase in the use of methamphetamine base and crystal methamphetamine among the sample in 2006. While there has been some recent concern nationally about the use of crystal methamphetamine, the use of the drug among REU interviewed in Tasmania in 2006 was still substantially lower than the level of use first reported in 2003. It is imperative that emerging trends in illicit drug markets are continually monitored so policy responses, emergency service workers, service providers and consumers are well informed to ensure the best outcome for the health of our community.

1.0 INTRODUCTION

The Ecstasy and Related Drugs Reporting System (EDRS, formerly the Party Drugs Initiative or PDI) is a companion project to the Illicit Drug Reporting System (IDRS). The IDRS has been conducted in every Australian state and territory annually since 1999, following successful trials in 1996 and 1997. The IDRS is currently funded by the Australian Government Department of Health and Ageing and was designed to monitor trends and emerging issues in illicit drug use in order to provide a timely early warning system for health and law enforcement services, to provide direction for subsequent further research, and to inform policy where appropriate. The IDRS focuses on drugs such as methamphetamine, opioids, cannabis, and cocaine, and issues that pertain particularly to the intravenous use of drugs in Australia. The methodology of the IDRS involves the triangulation of three data sources including a survey of people who regularly inject illicit drugs, a survey of 'key experts' (KE) who have regular contact with injecting drug users, and an examination of 'indicator data' or available existing data sources.

The EDRS uses the same triangulated methodology as the IDRS, but aims to examine emerging trends in the use, price, purity and availability of 'ecstasy and related drugs' (ERD) in Australia. For the purpose of the present study, ERDs are defined as drugs commonly used recreationally in the context of venues such as nightclubs and dance- or music-related events. These drugs primarily include ecstasy, methamphetamine, cocaine, LSD, ketamine, MDA, and GHB. The feasibility of the EDRS was assessed with a two-state trial funded by NDLERF in 2000 (Breen, Topp, & Longo, 2002). It was clear from the feasibility study that the EDRS could adequately capture the emerging population of ecstasy and related drug users in Australia, a demographic which was largely distinct from that accessed within the methods of the IDRS, and NDLERF provided additional funding for a two year project in every Australian state and territory beginning in 2003. The EDRS was funded by the Australian Government Department of Health and Ageing and the Ministerial Council on Drug Strategy as a project under the cost-shared funding arrangement in 2005 and by the Australian Government Department of Health and Ageing in 2006. The current report contains data collected in 2006. Tasmanian trends in 2003 (Bruno & McLean, 2004b), 2004 (Matthews & Bruno, 2005) and 2005 (Matthews & Bruno, 2006) and jurisdictional comparisons (Breen et al., 2004; Stafford et al., 2005, 2006) are available as technical reports from the National Drug and Alcohol Research Centre, University of New South Wales.

1.1 Aims

The aims of 2006 EDRS were: to describe the demographic characteristics and patterns of ecstasy and other drug use among a sample of regular ecstasy users (REU) in Hobart and surrounding areas in 2006; to examine and identify trends in the price, purity, and availability of ERDs in Hobart; to examine perceptions of the incidence of the risks and benefits of ecstasy use; to examine the nature and incidence of risk behaviours among the group of REU (e.g. injecting drug use, driving risk, sexual risk, blood-borne viral infections and vaccination); to examine health-related harms associated with ERD use including overdose, help-seeking behaviour, dependence, psychological distress and other potential problems (occupational, social, financial, legal); to investigate emerging trends in local ERD markets that may warrant further investigation or monitoring; to examine the incidence of drug information-seeking behaviour; and to identify issues that are pertinent to developing harm-reduction strategies in Hobart. An overarching aim is to, where possible, incorporate converging data from KE and indicator data and to identify emerging trends through comparison with EDRS data collected in Hobart in 2003 (Bruno & McLean, 2004b), 2004 (Matthews & Bruno, 2005) and 2005 (Matthews & Bruno, 2006).

2.0 METHODS

The EDRS uses a convergent validity methodology involving the triangulation of three different sources. The three components include a survey of regular ecstasy users (REU) in Hobart, a survey of key experts (KE) who have regular contact with ecstasy users in Hobart through the nature of their work or role in the community, and an examination of existing data sources that pertain to ecstasy and related drugs in Tasmania. Focusing on convergent trends among the three data sources allows the validity of each data set to be established. Specific information about the three data sources used in the present study is outlined below.

2.1 Survey of regular ecstasy users (REU)

2.1.1 Recruitment

One hundred regular ecstasy users were interviewed using a structured face-to-face interview between May and July 2006. Interviews were conducted at locations such as cafes, bars, the University of Tasmania, and private residences such as participants' and interviewers' homes where appropriate. Inclusion criteria for the study included at least monthly use of ecstasy in the last six months and having resided in the greater Hobart area for at least twelve months prior to the interview. Participants were recruited through posters and flyers distributed in the Hobart area at various locations (cafes, bars, nightclubs, clothing stores, music stores, universities, youth services, hairdressers), internet forums, and through snowball methods (word of mouth and recruitment through friends and associates).

2.1.2 Procedure

Participants contacted the researchers through voicemail, email, or SMS to leave their contact details and were subsequently contacted by one of the interviewers. Upon initial contact, participants were asked questions to establish their eligibility for the study and were provided with information about the aims and rationale for the study, the interview content and process, and the confidentiality and anonymity of the information that they may provide. Following informal consent to participate, interviewers arranged to meet participants at a mutually acceptable time and place. Prior to commencing the interview, participants were given further information about the study through a written information sheet describing the study and the interview content and process in more detail. Participants were also informed that the information they gave was strictly confidential, that they could not be personally identified in any way, and that they were free to withdraw at any time without prejudice, or decline to answer any questions. Participants signed a consent form to indicate that they had read and understood the information given to them and that any questions had been answered to their satisfaction. Interviews generally took between 45 to 60 minutes to complete and participants were reimbursed a sum of $30 for their travel and out of pocket expenses.

2.1.3 Measures

The structured interview focused on the six month period preceding the interview and assessed information in regard to demographic characteristics; patterns of ecstasy and other drug use including frequency, quantity and routes of administration; the price, purity, and availability of different drugs; patterns of purchasing; the perceived benefits and risks associated with ecstasy use; symptoms of dependence; risk behaviours such as injecting drug use, overdose, driving under the influence and safe sex; other problems associated with ecstasy use such as work/study, financial, social and legal problems; psychological distress; self-reported criminal activity and perceptions of police activity; and general trends in party drug markets.

2.1.4 Data analysis

Differences between the means of continuous normally distributed variables were analysed using t-tests. The non-parametric Mann-Whitney *U* test was used to analyse differences on continuous variables that did not follow a normal distribution. Chi-square tests were used to analyse categorical variables. A categorical variable for age was created using a median split for age, resulting in a 'younger' group (aged 23 and below, n=50) and an 'older' group (aged over 23 years, n=50). All statistical analyses were conducted using SPSS 12.0.1 for Windows (SPSS Inc., 2003).

2.2 Survey of key experts (KE)

Key experts (KE) who had regular contact with ecstasy users in the six months preceding the interview were eligible to participate in the study. Twenty-two key experts participated in semi-structured face-to-face interviews at either their place of work, private residences, locations such as coffee shops or bars or over the phone between May and August 2006. Half of the KE were familiar with ecstasy users through both work and social/personal contact (n=11), others through only work (n=8). Key experts had contact with regular ecstasy users on a median of 4 days a week during the preceding six months, ranging from once a week to daily (n=17). Most KE (n=10) had meaningful contact with over twenty regular ecstasy users during this time, with all but two having contact with more than ten users. KE indicated that the information that they provided was sourced through contact with users (n=13) as well as observation (n=5), talking with colleagues (n=4), and the media (n=2). Key experts included youth/health promotion workers (n=4), law enforcement personnel (n=4), ambulance/emergency workers (n=3), alcohol and drug counsellors/workers/psychologists (n=4), venue/event owners or managers (n=2), and DJs/party promoters (n=5). Fourteen of the key experts were male and eight were female. Several KE indicated that they had regular contact with special populations including youth (n=7), GLBT (n=2), drug users (n=4), and women (n=1).

The semi-structured key expert interview included sections on demographic characteristics, drug use patterns and price/purity/availability of ecstasy and other drugs, criminal behaviour and health issues, and was particularly focused on indicating any recent changes in these areas. Interviews took approximately 60 minutes to complete. Questions were generally open-ended and interviewers wrote verbatim responses at the time of the interview. Interviews were later transcribed in full and recurring themes were identified using Excel and are included in the text of the report. Information from a single KE was also included in the report where deemed reliable by the interviewer and/or pertinent to the explanation of particular trends. Some closed-ended questions were asked in relation to the price/purity/availability of ecstasy and analysed using SPSS 12.0.1 for Windows (SPSS Inc., 2003).

2.3 Other indicators

Data from existing sources such as survey, health and law enforcement data were collated to provide contextual information and to complement and validate the data obtained from the survey of both regular ecstasy users and key experts. The pilot study for the IDRS (Hando et al., 1997) recommended that such data should be available at least annually; include 50 or more cases; provide brief details of illicit drug use; be collected in the main study site (Hobart or Tasmania for the current study); and include details on the main illicit drugs under investigation. However, due to the relatively small size of the illicit drug-using population in Tasmania (in comparison to other jurisdictions involved in the EDRS), and a paucity of available data, the above recommendations have been used as a guide only. Indicators not meeting the above criteria should be interpreted with due caution and attention is drawn to relevant limitations in the text.

Data sources that fulfil the majority of these criteria and have been included in this report are as follows:

National Drug Strategy Household Surveys (1998, 2001, 2004)
The National Drug Strategy Household Survey aimed to determine the prevalence of the use of illicit drugs such as cannabis, methamphetamine, hallucinogens, cocaine, and ecstasy/designer drugs among the general community. Tasmanian participants were English-speaking individuals, over the age of fourteen, who lived in private residences in Tasmania during 1998 (n=1,031), 2001 (n=1,349), 2004 (n=1,208) (Australian Institute of Health and Welfare, 1999, 2002, 2005). Participants were asked to indicate whether they had used each type of illicit drug at some stage in their life or during the 12 months preceding the interview.

Telephone Advisory Services Data
Tasmania has two 24-hour alcohol- and drug-related telephone information services. In mid-May 2000, Turning Point Alcohol and Drug Centre in Victoria took over responsibility for administration of the Tasmanian Alcohol and Drug Information Service (ADIS), a confidential drug and alcohol counselling, information and referral service. Turning Point systematically record data for each call received, which comprised 2,208 calls during the 2000/01 financial year; 2,129 in 2001/02; 1,984 calls in 2002/03; 1,554 during 2003/04; 1,332 calls during 2004/05 and 1,469 calls in the 2005/06 financial year.

Police data
Information on drug seizures, charges, price and purity were obtained from Australian Illicit Drug Reports (1997/98, 1998/99, 1999/00, 2000/01, 2001/02) produced by the Australian Bureau of Criminal Intelligence (ABCI) and Illicit Drug Data Reports (2002/03, 2003/04, 2004/05) provided by the Australian Crime Commission (ACC). The Tasmanian data in these reports are provided by Tasmania Police State Intelligence Services. The ABCI and ACC reports do not necessarily report seizure and arrest data separately for drugs such as ecstasy, and the 2005/06 data was unavailable at the time of publication. Data on the purity of drugs seized are also provided through the ACC; however, drugs are only analysed by Tasmania Police Forensic Services in seizures where the person involved denies that the seizure in question contains illicit substances. Hence, a very small number of drug seizures were analysed for purity. Further, ACC purity data for the 2005/06 financial year was unavailable at the time of publication.

Public hospital admission data – Australian Institute of Health and Welfare
The Australian Institute of Health and Welfare has provided hospital morbidity data for 'principal' and 'additional' diagnoses in relation to drug use from the year 1999/00 to 2004/05. These data relate to public hospital admissions, for individuals aged between 15 and 54 years. Diagnoses were coded based on the International Classification of Diseases (ICD) 10, second edition. A 'principal diagnosis' refers to the instance where it is established upon examination that the drug was principally responsible for the patient's episode in hospital. An 'additional diagnosis' refers to the case where the condition or complaint is either co-morbid with the principal diagnosis or arises during the course of the episode in hospital. It is important to note that data from Tasmania's only public detoxification centre were included only from June 2002 onwards. Hospital admissions are reported separately for amphetamines, opioids, cannabis, and alcohol and are included in the text of the report where appropriate.

3.0 OVERVIEW OF REGULAR ECSTASY USERS

3.1 Demographic characteristics of the REU sample

Table 1 shows the demographic characteristics of the sample of 100 regular ecstasy users interviewed for the EDRS in 2006. Over half of the sample was male (58%). The mean age of the sample was 25 years (range 18-61 years, SD=5.7 yrs), and there was no significant difference between the mean age of males (25.5 years) and females (23.7 years) ($p>.05$). All but one participant spoke English as their main language (99%), and a minority (2%) were of Aboriginal and/or Torres Strait Island (A&TSI) descent. The majority (91%) of participants nominated their sexual identity as heterosexual, although gay males (2%), lesbians (1%), and bisexuals (6%) were also represented. Participants resided in a number of different suburbs across the greater Hobart area. A great majority lived in the inner Hobart suburbs (including North, South, West Hobart and Sandy Bay) (86%), with smaller proportions living in northern suburbs (4%), on the eastern shore (5%), or in suburbs surrounding Kingston (4%) or Sorrell (1%). The majority lived in their own (owned or rented) accommodation (80%) and the remainder lived in their parents' or family's home (19%), or a boarding house/hostel.

The mean number of years of school education completed by participants was 12 (range 9-12 years, SD = 0.66 years), and the majority of participants (83%) had completed year 12. Over half of the sample (47%) had completed courses after school, two-fifths had completed a university degree (19%) and one-quarter (28%) had completed a trade or technical qualification. One-third of participants were employed on a full-time basis (33%), one-third (32%) were currently full-time students, and one-fifth were employed on a part-time/casual basis (21%). One-tenth of the sample was currently unemployed (14%), which is slightly greater than the proportion of the 2004 (8%) and 2005 (5%) samples, but similar to the proportion reported in 2003 (14%). Only small proportions of the sample were currently receiving drug treatment (2%) or had received a custodial sentence for a previous criminal conviction (3%). These demographic characteristics are generally similar to those reported amongst the 2003, 2004, and 2005 cohorts. However, there were substantially lower levels of current drug treatment among the latter samples in comparison to 2003. Two-fifths of the sample (22%) had had previously participated in the EDRS, either in 2005 (21%), 2004 (5%), or 2003 (2%), and four participants had previously participated in the IDRS study.

Demographics of regular ecstasy consumers described by KE

Key expert descriptions of the ecstasy users with whom they had regular recent contact were consistent with the characteristics of the REU sample. Most experts described groups as being predominately (60-70%) male (n=6) or of an even gender balance (n=4). Key experts estimated that the age of these groups ranged between 12 and 50 years, with most being in their late-teens to mid-20s. Most KEs described the groups as being from English-speaking backgrounds, and to be mainly heterosexual. KEs noted contact with individuals from a wide range of suburbs but in particular inner city suburbs and surrounding areas. Key experts noted that the majority of ecstasy users that they were familiar with were well educated and either employed or currently studying at university. Two KE noted that the group that they had regular contact with were generally unemployed, probably reflecting the nature of their role within government health services rather than being characteristic of REU per se. Three KE noted that a large number of the REU that they were familiar with were in the hospitality industry. Few KE were aware of any drug treatment among the groups that they were familiar with, though one KE with a role in health services noted that a large proportion of the group was currently in drug treatment. The majority of KE indicated low levels of criminal activity among the group that they were familiar with, with two KE noting that a small proportion of the groups that they were familiar with had come into contact with the criminal justice system.

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

	2003 n=100	2004 n=100	2005 n=100	**2006 n=100**
Mean age (years)	24 (18-45)	23 (18-32)	24 (18-44)	**25 (18-61)**
Sex (% male)	61	61	55	**58**
English speaking background (%)	100	100	100	**99**
A&TSI (%)	6	2	2	**2**
Accommodation				
Own accomm. (includes rented) (%)	75	82	73	**80**
Live with parents/family (%)	22	17	27	**19**
Boarding house/hostel (%)	2	1	-	**1**
Refuge (%)	1	-	-	**-**
Location of residence				
Inner Hobart suburbs (%)	70	87	79	**86**
Northern suburbs (%)	12	2	11	**4**
Eastern shore (%)	7	11	6	**5**
Kingston area (%)	6	0	2	**4**
Sorrell area (%)	4	1	2	**1**
No fixed address (%)	1	0	0	**0**
Education				
Mean number school years* (range)	12 (8-12)	12 (10-12)	12 (10-12)	**12 (9-12)**
Trade/technical qualifications (%)	23	21	25	**28**
University qualifications (%)	21	35	26	**19**
Employment				
Full-time employment (%)	27	28	41	**33**
Part-time/casual employment (%)	17	26	19	**21**
Full-time student (%)	40	37	31	**32**
Part-time student (%)	0	1	2	**-**
Home duties (%)	-	-	2	**-**
Not employed (%)	16	8	5	**14**
Sexual identity				
Heterosexual (%)	85	93	94	**91**
Gay male (%)	2	2	1	**2**
Lesbian (%)	-	-	-	**1**
Bisexual (%)	13	5	5	**6**
Current drug treatment (%)	10	1	2	**2**
Previous prison conviction (%)	3	1	3	**3**

Source: EDRS Regular ecstasy user interviews 2003-2006

*question changed from 'How many years of school did you complete?' to 'What grade of school did you complete?'

3.2 Drug use history and current drug use

Ecstasy was the preferred or favourite drug for almost two-thirds of the participants (59%). Smaller proportions preferred alcohol (10%), or cannabis (10%), followed by methamphetamine (base 4%, crystal 3%, powder 1%), cocaine (6%), LSD (3%), heroin (2%), benzodiazepines (1%) and mushrooms (1%). The sample of regular ecstasy users were asked about the types of drugs that they had used in their lifetime and during the six months preceding the interview (see Table 2). Less than one-fifth (18%) of the sample had injected any drug at some stage of their life, which is similar to the proportion reported in 2005 (19%) and 2004 (15%), but fewer in comparison to the 2003 sample (26%). One-tenth of the sample (9%) had injected a drug in the six months preceding the interview, which is similar to the proportion reported in 2005 (8%) and 2004 (9%), but is fewer in comparison to the 2003 sample (22%).

The majority of REU had used alcohol (100%), cannabis (100%), and tobacco (94%) and methamphetamine powder (83%) at some stage of their lives and over two-thirds had ever used psychedelic mushrooms (74%) and nitrous oxide (69%). Substantial proportions had ever used cocaine (55%), LSD (52%), pharmaceutical stimulants (50%), methamphetamine base (49%), benzodiazepines (48%), crystal methamphetamine (42%), amyl nitrite (41%) or opiates other than heroin, methadone or buprenorphine (33%). One-quarter or less had ever used 2CI (25%), ketamine (23%), or antidepressants (20%), and smaller proportions had ever used MDA (14%), heroin (10%), GHB (9%), methadone (9%), and buprenorphine (3%). There were no reports of lifetime use of GBL or 1,4B.

In the six months preceding the interview, a majority of the REU interviewed had used alcohol (95%), cannabis (82%), and tobacco (81%), two-thirds had used methamphetamine powder (62%), and over half had used psychedelic mushrooms (55%). One-third or more had recently used methamphetamine base (40%), nitrous oxide (39%), cocaine (33%), and benzodiazepines (33%), followed by LSD (29%), crystal methamphetamine (27%) and 2CI (23%). Around one-tenth had recently used other opiates (14%), pharmaceutical stimulants (12%), amyl nitrite (10%), antidepressants (9%), and smaller proportions had recently used ketamine (6%), methadone (5%), MDA (3%), GHB (3%) buprenorphine (2%) and heroin (2%). None of the participants had recently used 1,4B or GBL.

Relative to the last two years of the study, there was a slight decrease in the recent use of methamphetamine powder (62% in 2006 vs. 77% in 2005 and 68% in 2004) and slight increases in the recent use of methamphetamine base (40% vs. 23% and 20% respectively) and crystal (27% vs. 10% and 16%). However, it should be noted that the recent use of crystal methamphetamine was greatest among the 2003 cohort (52%) relative to all other cohorts. Over the last three years there has been a steady increase in the use of cocaine from less than one-tenth (10%) in 2004 to one-third (33%) in 2006. There was an increase in both the lifetime (25%) and recent use (23%) of the hallucinogen 2CI in 2006, compared to less than one-tenth of the sample among the sample in previous years. The recent use of psychedelic mushrooms was also greater among the 2006 cohort (55%) relative to the 2005 cohort (40%), but the recent use of LSD has remained stable over the years at around 30% of each cohort. The recent use of ketamine and MDA decreased from two-fifths of the sample in 2003 (24% and 21% respectively) to less than one-tenth in 2006 (6% and 3% respectively). Similarly the recent use of amyl nitrate has decreased from two-fifths in 2003 (43%) to one-tenth (10%) in 2006. Compared to the 2003 sample which included a higher proportion of IDU, there has been less recent use of heroin and methadone among the latter three cohorts.

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

Variable	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever inject any drug (%)	26	15	19	**18**
Injected any drug in last 6 mths (%)	22	9	8	**9**
Alcohol				
Ever used (%)	100	100	100	**100**
Used last 6 months (%)	98	98	98	**95**
Cannabis				
Ever used (%)	100	98	100	**100**
Used last 6 months (%)	90	91	89	**82**
Tobacco				
Ever used (%)	96	89	89	**94**
Used last 6 months (%)	81	77	83	**81**
Methamphetamine powder (speed)				
Ever used (%)	90	82	89	**83**
Used last 6 months (%)	67	68	77	**62**
Methamphetamine base (base)				
Ever used (%)	36	32	35	**49**
Used last 6 months (%)	24	20	23	**40**
Crystal methamphetamine (crystal)				
Ever used (%)	58	36	29	**42**
Used last 6 months (%)	52	16	10	**27**
Pharmaceutical stimulants[#]				
Ever used (%)	n/a	39	44	**50**
Used last 6 months (%)	n/a	14	16	**12**
Cocaine				
Ever used (%)	44	32	43	**55**
Used last 6 months (%)	7	10	20	**33**
LSD				
Ever used (%)	62	51	54	**52**
Used last 6 months (%)	24	32	31	**29**
MDA				
Ever used (%)	32	20	8	**14**
Used last 6 months (%)	21	15	3	**3**
Ketamine				
Ever used (%)	38	23	24	**23**
Used last 6 months (%)	24	5	11	**6**
GHB				
Ever used (%)	10	7	7	**9**
Used last 6 months (%)	6	3	2	**3**
1,4B				
Ever used (%)	2	-	-	**-**
Used last 6 months (%)	1	-	-	**-**
GBL				
Ever used (%)	-	-	-	**-**
Used last 6 months (%)	-	-	-	**-**

Source: EDRS Regular ecstasy user interviews 2003-2006

[#] Pharmaceutical stimulants were not included prior to 2004

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

Variable	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Amyl nitrite				
Ever used (%)	78	52	49	**41**
Used last 6 months (%)	43	23	16	**10**
Nitrous oxide				
Ever used (%)	47	57	69	**69**
Used last 6 months (%)	25	34	41	**39**
Benzodiazepines				
Ever used (%)	52	34	40	**48**
Used last 6 months (%)	35	23	25	**33**
Antidepressants				
Ever used (%)	32	14	21	**20**
Used last 6 months (%)	14	4	12	**9**
Heroin				
Ever used (%)	20	4	8	**10**
Used last 6 months (%)	6	0	-	**2**
Methadone				
Ever used (%)	14	2	5	**9**
Used last 6 months (%)	13	2	1	**5**
Buprenorphine				
Ever used (%)	5	-	2	**3**
Used last 6 months (%)	3	-	1	**2**
Other opiates				
Ever used (%)	35	19	25	**33**
Used last 6 months (%)	13	8	13	**14**
Psychedelic mushrooms				
Ever used (%)	54	60	63	**74**
Used last 6 months (%)	38	41	40	**55**
2CI				
Ever used (%)	-	5	2	**25**
Used last 6 months (%)	-	5	1	**23**

Source: EDRS Regular ecstasy user interviews 2003-2006

3.3 Summary of polydrug use trends in REU

- The sample of 100 regular ecstasy users interviewed in 2006 were typically in their early- to mid-twenties, with ages ranging from 18 to 61 years. There were slightly more males than females (58%). Most of the participants were well educated, with the majority having completed year 12, and one-half (48%) having completed tertiary qualifications (university or trade/technical). Over one-half (54%) were employed either full-time or part-time/casual and one-third (32%) were full-time students. Few participants had come into contact with the criminal justice system or drug treatment agencies.
- Polydrug use was the norm among the REU interviewed, with most having used a range of drug classes in the preceding six months. Recent use of alcohol, cannabis, and methamphetamine powder was common, and over half had recently used psychedelic mushrooms. Between one-third and one-quarter had recently used methamphetamine base, nitrous oxide, cocaine, benzodiazepines, LSD, crystal methamphetamine, and 2CI. Around one-tenth had recently used other opiates, pharmaceutical stimulants, amyl nitrite, or antidepressants and the recent use of ketamine, methadone, MDA, GHB, buprenorphine and heroin was low. There was no recent use of 1,4B, and GBL among the current sample.
- Between 2003 and 2006 there has been a steady decrease in the recent use of ketamine, MDA, and amyl nitrite, and an increase in the use of cocaine. Relative to the 2005 sample, there was a slight decrease in the recent use of methamphetamine powder (62% vs. 77%) and a slight increase in the use of methamphetamine base (23% vs. 40%) and crystal (10% vs. 27%) in 2006. However, the highest recent use of crystal methamphetamine was observed among the 2003 sample (52%). One-quarter of the 2006 sample (23%) had recently used the hallucinogen 2CI among the 2006 cohort compared to less than one-twentieth of previous cohorts. Stable trends were observed in the use of most other drug types.
- There was less recent injecting drug use, involvement in current drug treatment, and recent use of heroin or methadone among the latter three cohorts relative to 2003, possibly reflecting lower levels of overlap between the IDU and REU samples in the latter three years of the study.

4.0 ECSTASY

Over a half of the regular ecstasy users (59%) indicated that ecstasy was their drug of choice. The mean age of first ecstasy use was 20 years (range 14-55, SD=4.7). There was no significant difference between the mean age of first use for females (19.3 years, SD=2.2) and for males (20.4 years, SD=5.8). The median age at which participants had first started to use ecstasy on a regular (at least monthly) basis was 21 years (range 14-59, SD=5.1) and there were no significant sex differences. Ecstasy had been used by this group for a median of 4 years (range 0-19 years). The majority of the sample (87%) had been using ecstasy for two years or more and there was no significant difference in the length of ecstasy use for males (M=5.1, SD=3.5) and females (M=5.1, SD=3.5).

The entire 2006 REU sample (100%) had ever used ecstasy in tablet form, over one-half (51%) had ever used ecstasy capsules and one-quarter (28%) had ever used ecstasy powder. Lifetime use of ecstasy capsules (51% vs. 28%) and powder (28% vs. 18%) was greater in 2006 than 2005. In terms of lifetime consumption, ecstasy tablets had typically been swallowed (100%) or snorted (90%) and smaller proportions had ever shelved/shafted (17%), smoked (13%), or injected (10%) ecstasy tablets. Ecstasy powder had typically been snorted (68%) or swallowed (79%) and a small proportion had ever injected (14%, n=4) or smoked (11%, n=3) ecstasy powder. Ecstasy capsules had typically been swallowed (98%) or snorted (35%), and a small proportion had ever injected (8%, n=4), smoked (4%, n=2), or shelved/shafted (2%, n=1) ecstasy capsules.

4.1 Ecstasy use among REU

When REU were asked which form they had mainly used in the preceding six months, the entire sample had predominantly used ecstasy tablets (100%) and none reported that they mainly used ecstasy capsules or powder. Consistent with this, all of the participants had recently used ecstasy in tablet form (100%), and between one-fifth and one-tenth had recently used ecstasy capsules (19%) or ecstasy powder (13%). Of the thirteen participants that had recently used ecstasy powder, this had been snorted (77%) or swallowed (62%) on a median of two days (range 1-6) during the six months preceding the interview. Of the 19 participants recently using ecstasy capsules, this had been used orally (100%) or snorted (95%) on a median of 2 days (range 1-20) during the last six months. Ecstasy tablets had recently been swallowed (99%) or snorted (83%) and smaller proportions had recently shafted/shelved (12%), smoked (4%) or injected (5%) ecstasy tablets. Ecstasy tablets had been used on a median of 12 days (range 7-72) or approximately fortnightly.

The comments of key experts were generally consistent with reports of REU. The majority of KE who commented noted that ecstasy was typically used in tablet form by consumers (n=16). However, some KE noted infrequent use of ecstasy in either capsule form (n=2) or powder form (n=2). The majority of KE who commented (n=16) indicated that ecstasy was typically swallowed. It was noted that some proportion of the groups that KE were familiar with snort ecstasy (10%-40%, n=7), and that smaller proportions use ecstasy intravenously (1%-2%, n=2), or shelve/shaft (n=3) the drug. While there were some anecdotal indications of an increase in the amount of REU shelving/shafting ecstasy among the 2004 and 2005 samples, there were no indications from KE of recent changes in this route of administration in 2006.

Ecstasy (tablets, powder, capsules) had been used by REU on a median of 12 days (range 6-78 days), or fortnightly in the six months preceding the interview. There was no significant difference between the frequency of use for males and females in the current cohort. Over

one-fifth of the sample (22%) had used ecstasy weekly or more frequently in the six months preceding the interview. The remainder of the sample had used ecstasy either less than weekly to fortnightly (40%), or less than fortnightly to monthly (38%).

The median number of ecstasy tablets consumed in a typical session of use in the past six months was 2 tablets (range 1-6), which is similar to the median number reported in 2005 (2 tablets), 2004 (2 tablets) and 2003 (1.5 tablets). There was no significant sex difference in the median number of tablets used in a typical session in 2006, though males reported using greater quantities than females among the 2005 sample, with a similar trend observed in 2004. Almost four-fifths of the sample (79%) typically used more than one tablet per session in 2006, which is greater in comparison to the 2005 (67%) 2004 (69%) and 2003 (54%) cohorts.

The median number of ecstasy tablets consumed in the heaviest session of use in the past six months was 4 tablets (range 1-20), which is similar to that reported in 2005 (4 tablets) but slightly greater than the median of 3 tablets observed in 2003 and 2004. Half of the sample (47%) typically used 4 or more tablets in the heaviest session of use in 2006. There was no significant sex difference in the number of tablets used in the biggest session of use in 2006, though males reported using greater quantities than females among the 2005 sample. Over two-fifths of the sample (43%) had recently 'binged' on ecstasy (used ecstasy for more than 48 hours continuously without sleep), which is slightly greater to the proportion that had recently binged on ecstasy in 2005 (37%) and 2004 (34%), but similar in comparison to 2003 (41%).

Key expert comments on the frequency of ecstasy use were varied and ranged from 2-3 times a week to sporadic use restricted to special occasions, but several KE indicated that the majority of these groups use ecstasy on a weekly (n=8), fortnightly (n=6) or monthly (n=5) basis. Estimates of the amount of ecstasy used in a typical session of use were also varied, but typically ranged from 1-3 tablets on average (n=10). Binge use of ecstasy among some proportion of REU (5-20%, n=2) was also noted by several KE. One KE noted that it was not uncommon for people to have ½-1 pill on 'normal' drinking nights for an 'extra lift'. Another noted an increase in frequency but a decrease in the quantity used among the group that they were familiar with.

REU participants were asked to comment on the locations that they had usually taken ecstasy to be under the influence of the drug (i.e. the location of use rather than the location of ingestion). Table 3 shows that ecstasy was most commonly used at dance- or music-related venues such as raves/doofs/dance parties (81%), nightclubs (77%), live music events (66%) and public bars (46%). Ecstasy use was also common at private residences including private parties (75%), at a friend's home (86%), the consumer's own home (59%), or an acquaintance's home (15%). Other locations included outdoors (32%), dealer's home (14%), public place (11%), car (10%), work (3%), day club (2%), or restaurant/café (1%). The last location of ecstasy use was relatively consistent with the usual locations used. One-fifth of the sample each reported last using ecstasy at a nightclub (18%), a dance related event (18%), a friend's home (22%) or their own home (20%). Smaller proportions reported last using ecstasy at a private party (14%), outdoors (2%), at a live music event (2%), dealer's home (1%) or other location (1%).

Over the last four years of the study, there are trends among REU for increased use at a consumer's own home, a friend's home, private parties and public bars. This finding is consistent with the comments of two KE, who noted more use in homes, public places and private parties rather than just dance event/nightclub-based use. Two REU also noted anecdotally that there had been a recent increase in the use of ecstasy at private residences and private parties.

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

Variable	2003 n=100	2004 n=100	2005 n=100	**2006 (n=100)**
Mean age first used ecstasy (range)	20 years (14-40)	20 years (15-32)	20 years (14-42)	**20 years (14-55)**
Ecstasy drug of choice (%)	50	58	52	**59**
Frequency of use				
Median days used ecstasy last 6 months#	14	12	15	**12**
Use ecstasy weekly or more frequently (%)	38	24	29	**22**
Dose				
Median ecstasy tablets in 'typical' session (range)	1.5 (0.5-7.5)	2 (0.5-12)	2 (1-6)	**2 (1-6)**
Typically use > one tablet per session (%)	54	69	67	**79**
Recently binged on ecstasy* (%)	41	34	37	**43**
Median ecstasy tablets in 'biggest' session (range)	3 (1-60)	3 (1-30)	4 (1-15)	**4 (1-20)**
Main route of administration in last 6 mths				
Swallowed (%)	89	94	96	**95**
Snorted (%)	6	6	3	**4**
Injected (%)	5	-	1	**1**
Shelved/shafted (%)	n/a	-	-	**-**
Main form used last 6 mths (%)				
Tablets (pills)	n/a	n/a	98	**100**
Powder	n/a	n/a	-	**-**
Capsules	n/a	n/a	2	**-**
Injecting drug use				
Ever injected any drug (%)	26	15	19	**18**
Ever injected ecstasy (%)	18	6	9	**10**
Injected ecstasy in the last 6 months (%)	11	1	4	**5**
Locations typically used ecstasy in the last 6 mths				
Home (%)	30	39	48	**59**
Dealer's home (%)	5	7	5	**14**
Friend's home (%)	29	56	58	**86**
Raves/doofs/dance parties	82	89	81	**81**
Nightclub (%)	73	82	86	**77**
Pub (%)	10	21	32	**46**
Restaurant/cafe	n/a	6	-	**1**
Private party (%)	32	64	60	**75**
Public place (street/park) (%)	5	5	7	**11**
Outdoors (%)	n/a	17	13	**32**
Car (%)	5	7	3	**10**
Live music event (%)	n/a	53	54	**66**
Work (%)	-	-	4	**3**
Acquaintance's home (%)	n/a	n/a	3	**15**
Day club (%)	n/a	n/a	n/a	**2**

Source: EDRS interviews

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

Includes pills, powder and capsules

Table 3: Patterns of ecstasy use among REU, 2003-2006 (continued)

Variable	2003 n=100	2004 n=100	2005 n=100	**2006 (n=100)**
Location last used ecstasy in the last 6 months				
Home (%)	8	10	13	**20**
Dealer's home (%)	3	-	-	**1**
Friend's home (%)	11	15	13	**22**
Rave/doof/dance party	33	37	16	**18**
Nightclub (%)	37	22	40	**18**
Pub (%)	4	2	3	**-**
Private party (%)	4	10	8	**14**
Outdoors (%)	-	1	1	**2**
Live music event (%)	n/a	1	4	**2**
Other (%)	-	2	2	**1**

Source: EDRS Regular ecstasy user interviews 2003-2006

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

Includes pills, powder and capsules

Polydrug use among REU

Table 4 shows that the majority of the REU sample had typically used other drugs when under the influence of ecstasy (94%) and when 'coming down' from ecstasy (73%) during the six months preceding the interview. Drugs most commonly used when under the influence of ecstasy were alcohol (79%), tobacco (66%) and cannabis (38%). Just over one-tenth (15%) had typically used methamphetamine (powder, base, or ice/crystal) in combination with ecstasy and smaller proportions had typically used amyl nitrite (3%), nitrous oxide (6%), pharmaceutical stimulants (2%), methadone (1%), mushrooms (1%), buprenorphine (1%), other opiates (1%), antidepressants (1%), benzodiazepines (1%), and 2CI (1%). The drugs most commonly used when coming down from ecstasy were tobacco (55%), cannabis (44%), and alcohol (41%). Smaller proportions had typically used benzodiazepines (6%), nitrous oxide (5%), methamphetamine (powder, base or ice/crystal, 4%), opiates other than heroin (3%), and antidepressants (2%).

There was less use of methamphetamine in combination with ecstasy in 2005 (17%) and 2006 (15%) compared to the 2004 (26%) and 2003 (31%) cohorts. There was also slightly less use of cannabis both under the influence and when coming down and less use of benzodiazepines when coming down in the latter two years of the study.

The proportion of participants that usually drink alcohol when under the influence of ecstasy was greater among the 2004 and 2005 samples compared to the 2003 sample (93% and 90% vs. 72%). In 2006, this proportion was slightly lower (79%) than the previous two years. Three-quarters of those who usually drank when under the influence of ecstasy in 2004 (76%) and 2005 (78%) reported that they typically consumed more than five standard drinks when under the influence of ecstasy, compared to less than half (45%) among the 2003 cohort. This proportion was also slightly lower among the 2006 sample (66%).

Several KE indicated that polydrug use was common among the group of regular ecstasy users that they had recent regular contact with. Typical drug combinations included the use of ecstasy with alcohol, cannabis and methamphetamine, which is consistent with the patterns of use of the REU interviewed in the present study. Consistent with the high levels of binge drinking in combination with ecstasy among the REU sample, several KE commented on the use of alcohol in combination with ecstasy (n=4). One KE indicated that REU consider having a pill to be similar to having a beer, and another commented that using ecstasy is part of the 'binge drinking routine'.

Table 4: Polydrug use among REU, 2003-2006

%	Drugs typically used with ecstasy in last six mths (%)				Drugs typically used to come down from ecstasy in last six mths (%)			
	2003 n=100	2004 n=100	2005 n=100	**2006 n=100**	2003 n=100	2004 n=100	2005 n=100	**2006 n=100**
None	2	1	1	**6**	11	11	15	**27**
Meth. (any form)	31	26	17	**15**	6	2	3	**4**
Pharm. stimulants	1	-	1	**2**	-	-	1	**-**
Cocaine	-	-	-	**-**	-	-	-	**-**
LSD	2	1	-	**-**	-	-	-	**-**
Ketamine	3	-	-		2	-	-	**-**
Amyl nitrate	12	6	2	**3**	2	2	-	**-**
Nitrous oxide	4	4	2	**6**	1	2	4	**5**
Cannabis	44	41	35	**38**	63	62	52	**44**
Alcohol								
Usually drink	72	93	90	**79**	39	57	54	**41**
> 5 std drinks	45	71	78	**66**	23	39	46	**28**
Methadone	4	1	1	**1**	4	1	1	**-**
Buprenorphine	-	-	-	**1**	-	-	-	**-**
Other opiates	5	1	-	**1**	10	1	1	**3**
Tobacco	72	66	73	**66**	56	51	67	**55**
Antidepressants	1	-	4	**1**	1	-	4	**2**
Benzodiazepines	2	-	-	**1**	17	13	3	**6**
Mushrooms	-	1	1	**-**	-	-	-	**-**
2CI	-	-	-	**1**	-	-	-	**-**

Source: EDRS Regular ecstasy interviews 2003-2006

4.1.1 Self-reported symptoms of ecstasy dependence

REU were asked about how they had felt about their ecstasy use during the 12 months preceding the interview using a version of the Severity of Dependence Scale (SDS) adapted for ecstasy use. The scale consisted of 5 multiple choice questions that were rated on a scale of 0 to 3, resulting in a range of possible scores from 0-15 where high scores suggest greater psychological dependence. Participants were asked if they thought that their ecstasy use was out of control, if the prospect of missing a dose made them feel anxious or worried, if they had worried about their ecstasy use, if they had wished they could have stopped, and if they would find it difficult to stop, or go without ecstasy. Findings in relation to ecstasy dependence should be interpreted with caution due to the fact that the SDS scale does not have demonstrated reliability or validity in relation to ecstasy use and due to the lack of research in the area of ecstasy dependence (see Topp, Hall & Hando, 1997). Another issue that should be considered is the fact that many ecstasy pills also include methamphetamine as well as or instead of MDMA, and there is well documented evidence that methamphetamine is associated with symptoms of dependence.

Two-fifths of participants (21%) obtained a score of zero on the ecstasy SDS, and just over one-quarter (28%) obtained a score of one on the scale: thus, close to half of respondents

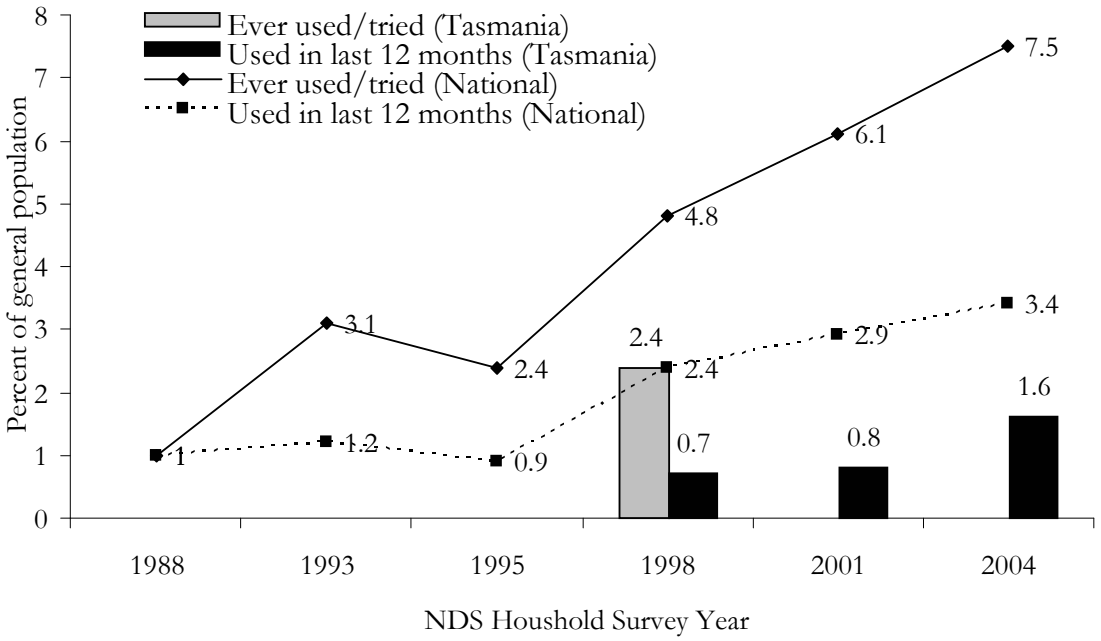
reported none or few symptoms of dependence in relation to ecstasy use. This is consistent with the comments of one KE, a youth worker, who commented that ecstasy use is typically recreational and not usually associated with dependence. The median ecstasy SDS score was 2 (range 0-10) compared to a median score of 2 (0-10) among the 2005 sample, and a median of 1 (range 0-7) among the 2004 sample. There was no significant difference between the ecstasy SDS scores of males and females or 'younger' and 'older' participants (based on a median split for age). A score of four on the SDS is considered a reasonable cut-off for predicting DSM-III-R diagnosis of severe amphetamine dependence, and thus the cut-off of five selected in the present study is a more conservative estimate (Topp & Mattick, 1997). Almost one-fifth of the 2006 REU sample (19%) had a score of 5 or above on the ecstasy SDS compared to 14% in 2005 and 11% in 2004. The following analyses, examining differences between those with high and low methamphetamine SDS scores, should be interpreted with caution due to small and uneven sample sizes.

There was no significant difference in the proportion of males (17%) and females (21%) or 'younger' (22%) and 'older' (16%) participants (based on a median split for age) that had a score of 5 or more on the ecstasy SDS. On average, those with a high ecstasy SDS score had used ecstasy on a significantly greater number of days (16 vs. 12 days or weekly vs. fortnightly, Mann-Whitney U=469.00, p<.01), used a greater number of tablets in a typical session (3 vs. 2 tablets, Mann-Whitney U=480.0, p<.05), had used a significantly greater number of tablets in the biggest session of use (7 vs. 4 tablets, Mann-Whitney U=452.0, p<.01), and had used a greater number of drug types in the last six months (8 vs. 6, from a list of 20 possible drug types, Mann-Whitney U=195.5, p<.001), compared to those with low ecstasy SDS scores. Those with high ecstasy SDS scores were more likely to have recently binged on ERDs (used for 48 hours without sleep), (79% vs. 38%, χ^2=10.35, p<.01), and were less likely to have completed year 12 (63% vs. 88%, χ^2=6.55, p<.05), compared to those with low scores. Those with high scores were also more likely to have a 'high' score (five or more) on the methamphetamine SDS (37% vs. 10%, χ^2=8.78, p<.01). Thus, over one-third (37%) of those with a high dependence score on the ecstasy SDS also had a high dependence score on the methamphetamine SDS. They also had significantly higher average scores on the Kessler scale of psychological distress (16 vs. 22, Mann-Whitney U=429.5, p<.05), but there was no difference in the proportion that had 'high' scores (25 or more, the cut-off for clinical concern of possible presence of mood disorders) on the Kessler scale.

4.2 Use of ecstasy in the general population

Figure 1 shows the prevalence of lifetime and recent ecstasy use in the general population and in Tasmania based on data collected by the National Drug Strategy Household Survey (NDSHS) between 1988 and 2004 (Australian Institute of Health and Welfare, 1999, 2002a, 2002b, 2005a, 2005b). The lifetime prevalence of ecstasy use among the general population has increased from 1% in 1988 to 7.5% in 2004. The proportion of the national sample that had used ecstasy in the preceding 12 months has also increased from 1% in 1988 to 3.4% in 2005. The proportion of the Tasmanian sample reporting lifetime use of ecstasy was not included in the 2001 and 2004 reports due to a change in the way this question was asked between surveys, which may have influenced its reporting. The proportion reporting recent use of ecstasy among the 2004 Tasmanian sample was 1.6% which is was lower than that seen nationally (3.4%). Although the estimated prevalence of recent ecstasy use in Tasmania appears to have increased from 0.7% in 1998 to 1.6% in 2004, this change is within the bounds of error measurement for the survey. Thus it is not possible to infer that this suggests an increased prevalence of ecstasy use locally.

Figure 1: Prevalence of ecstasy use in Australia and Tasmania among those aged 14 years and over, 1988-2004



Source: National Drug Strategy Household Survey 1988-2004

4.3 Other trends and features of ecstasy use

Ecstasy use was common among the social networks of the regular ecstasy users who participated in the study. Three-fifths of the REU interviewed (65%) indicated that most of their friends use ecstasy, and two-fifths (21%) indicated that about half of their friends use ecstasy. Smaller proportions indicated that only a few (9%) or all (5%) of their friends used ecstasy. Two fifths of the respondents (44%) indicated that there had been some recent change in drug use among themselves or friends. Key experts were asked to comment on any changes or trends in ecstasy and other drug use among the group of users they were familiar with. The qualitative comments of both REU and KE in relation to recent changes and trends in ecstasy use are discussed below.

Whereas the present study is not designed to provide indications of the prevalence of ecstasy use among the population, there is anecdotal evidence from both REU and KE for changes in the types and number of people that use ecstasy in Hobart. Several KE (n=3) and REU (n=1) indicated a perception that the use of ecstasy had become more 'normalised', 'socially acceptable' or 'mainstream' in society and less 'underground'. KE noted that there had been a general increase in the number of people using ecstasy (n=6) and that there had been a broadening of the demographic of users (n=5) including an increase in use among people of lower (n=2) and higher (n=2) socio-economic status (SES), and a broadening of the age range of users (n=2), including an increase in the number of 'younger' (n=5) and 'older' users (n=1). REU comments on the changes in the use of ecstasy among themselves and their friends were varied. Whereas some REU noted increases in the number of people using ecstasy (n=6), others noted less use of ecstasy (n=2) among themselves or their friends. One REU also perceived an increase in 'younger' users, and that consumers didn't necessarily match the stereotype of 'drug users' – noting that *"people are taking ecstasy that you wouldn't expect to take it"*.

4.4 Summary of patterns of ecstasy use

- Most participants had first used ecstasy at around 20 years of age and a large majority (87%) had been using ecstasy for two years or more.
- The entire sample had recently used ecstasy in tablet form while a minority had recently used ecstasy in capsule (19%) or powder form (13%). Ecstasy tablets were typically swallowed, but snorting of ecstasy was also common and small proportions had recently shelved/shafted, smoked, or injected ecstasy.
- On average, ecstasy had been used fortnightly with an average of two tablets taken orally in a typical session. One-quarter (22%) had used ecstasy on a weekly basis or more frequently. Almost four-fifths (79%) usually used more than one tablet in a typical session of use, which is greater than the proportion reported in previous years (54-69%). Over two-fifths (43%) had recently used ecstasy in a 'binge session' (a continuous 48 hour period of drug use without sleep), which is slightly higher relative to the 2004 (34%) and 2005 (37%) samples.
- Ecstasy was typically used at music-related venues including dance parties, nightclubs and live music events but was also used at a range of other locations including private parties and private residences. REU reports and anecdotal comments of KE suggest an increase in the use of ecstasy at locations other than dance/events and nightclubs, in particular at private residences and public bars.
- The majority of REU had typically used other drugs when under the influence (94%) and when coming down from ecstasy (73%). Alcohol, cannabis, and tobacco were the drugs most commonly used. Just over one-seventh (15%) typically used methamphetamine when under the influence of ecstasy – similar to the proportion in 2005 (17%), marking a sustained reduction from the rates in the 2003 (25%) and 2004 (25%) cohorts. The use of cannabis both under the influence and when coming down from ecstasy and the use of benzodiazepines when coming down from ecstasy has also decreased slightly over the past four years.
- Four-fifths (79%) reported drinking alcohol when under the influence of ecstasy and two-thirds of these (66%) typically consumed more than five standard drinks. The proportion reporting binge drinking when under the influence and coming down from ecstasy had slightly declined from the rates amongst the 2004 and 2005 cohorts.
- Close to half (49%) of the REU sample had recently experienced none or few psychological symptoms of dependence in relation to their ecstasy use as measured by the Severity of Dependence Scale (SDS) for ecstasy. However, almost one-fifth (19%) reported experiencing significant symptoms of dependence in relation to ecstasy. High ecstasy SDS scores were associated with greater frequency and quantity of ecstasy use, binge drug use, and high levels of methamphetamine dependence and psychological distress scores.
- Qualitative comments of both KE and REU suggest that the use of ecstasy has become more 'mainstream' and less restricted to dance-related events and nightclubs. There were anecdotal reports of a broadening demographic of people consuming the drug locally.
- Data from the NDSHS suggests a steady increase in the national prevalence of ecstasy use in Australia between 1995 and 2004. The prevalence of recent ecstasy use among the Tasmanian sample has remained at least half that of the national estimate during this time.

4.5 Price

Table 5 shows ecstasy prices reported by REU from 2003 to 2006. The median market price for one ecstasy tablet was $40 (range $30-60) in 2006, which is less in comparison to 2005 ($45), but the same as that reported in 2004 ($40). In 2006, the median price of the last ecstasy tablet purchased was $35 (range $20-50), which is less than the last price reported in 2005 ($40), 2004 ($40), and 2003 ($45). Two participants indicated that the price for 10 ecstasy tablets was $350. Over one-half (54%) of the 2006 cohort indicated that the price of ecstasy had been stable in the six months preceding the interview, one-quarter (28%) indicated that the price of ecstasy had decreased, and smaller proportions indicated that the price of ecstasy had either fluctuated (13%), or increased (5%). The proportion indicating that the price of ecstasy had decreased in 2006 (28%) was greater relative to the 2005 (10%), 2004 (15%), and 2003 (15%) samples.

Table 5: Price of ecstasy purchased by REU and price variations, 2003-2006

Variable	2003 n=100	2004 n=100	2005 n=100	**2006 n=100**
Median price per ecstasy tablet (range)	$50 ($30-$50) n=65	$40 ($30-50) n=100	$45 ($35-50) n=100	**$40 ($30-60) n=100**
Median price of last tablets purchased (range)	$45 ($15-68) n=98	$40 ($30-50) n=100	$40 ($20-50) n=95	**$35 ($20-50) n=97**
Price change				
Don't know (%)	-	2	-	**-**
Increased (%)	5	6	7	**5**
Stable (%)	72	64	67	**54**
Decreased (%)	15	15	10	**28**
Fluctuated (%)	8	13	16	**13**

Source: EDRS Regular ecstasy user interviews 2003-2006

Key experts' comments on the price of ecstasy were generally consistent with those of regular ecstasy users. The median price for one ecstasy pill was reported to be $40 (n=9), or to range from $20-70 (n=9). Four KE noted that the price per pill was less when bought in larger quantities, with a median of $300 reported for ten pills/tablets. Fourteen KE commented on changes in the price of ecstasy in the preceding six months. One-half (50%) indicated that the price of ecstasy had recently decreased, and over one-fifth indicated that the price of ecstasy had remained stable (21%) or did not know of any recent price changes (29%).

The price of ecstasy reported by Tasmania Police (based on reports from informants) has varied from $60-80 in 1997/98 down to $15-25 in the following two years up to $50-60 and $50-70 respectively in the 2000/01 and 2001/02 reporting periods. The price of $30-70 per tablet in 2002/03 and 2003/04 indicates a decrease in the lower price range in comparison to the previous two years. Further, during the last quarter of the 2002/03 period, a price range of $30-50 was reported. In the 2004/05 financial year, a price range of $40-50 was reported by Tasmania Police, which is reasonably commensurate with the prices reported by REU and KE above. At the time of publication, data was not available for the 2005/06 financial year.

Table 6: Price of ecstasy reported by Tasmania Police 1997/98-2004/05

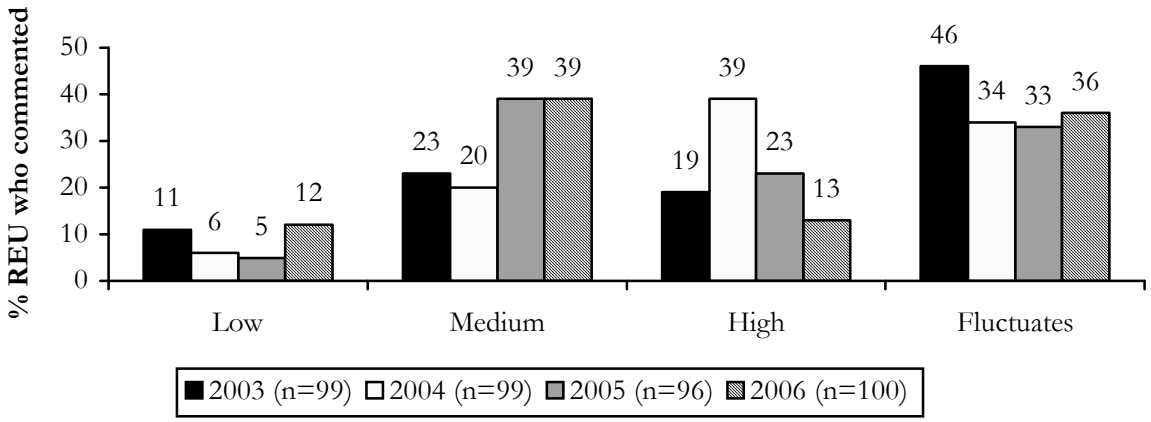
	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05
Price per tablet	$60-80	$15-25	$15-25	$50-60	$50-70	$30-70	$30-70	$40-50

Source: Australian Bureau of Criminal Intelligence (1998, 1999, 2000, 2001, 2002); Australian Crime Commission (2003, 2004, 2005, 2006)

4.6 Purity

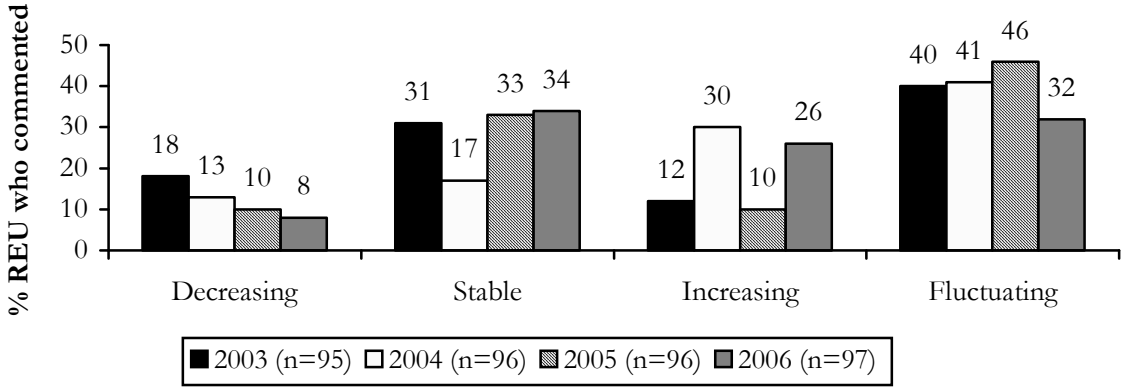
Regular ecstasy users were asked to estimate the purity of ecstasy in the six months preceding the interview (Figure 2). Over one-third of the 2006 sample indicated that ecstasy was medium in purity (39%), one-third indicated that it had fluctuated in purity (36%), and one-tenth indicated that ecstasy was either high in purity (13%), or low in purity (12%). The proportion of REU who reported that ecstasy was high in purity was greater among the 2004 sample (39%) and has steadily declined amongst subsequent cohorts (23% in 2005; 13% in 2006). Regular ecstasy users were also asked if there had been any changes in the purity of ecstasy in the six months preceding the interview (Figure 3). One-third of respondents indicated that ecstasy had either fluctuated (32%) or was stable (34%) in purity during this time. One-quarter (26%) reported that the drug had increased in purity, and less than one-tenth (8%) indicated that the purity of ecstasy had decreased. In summary, ecstasy was typically considered to be medium or fluctuating in purity. Although the proportion reporting that ecstasy was high in purity has decreased over the last two years of the study, one-quarter of the 2006 sample indicated that the purity had recently increased.

Figure 2: REU reports of current ecstasy purity, 2003-2006



Source: EDRS Regular ecstasy user interviews 2003-2006

Figure 3: REU reports of change in purity of ecstasy in the preceding six months, 2003-2006



Source: EDRS Regular ecstasy user interviews 2003-2006

Nine KE commented on the purity of ecstasy within the preceding six months. Over one-half (55%) commented that the purity of ecstasy had fluctuated (n=5) and smaller proportions indicated that ecstasy was medium (n=2), or low (n=2) in purity. Out of the eight KE who commented on recent changes in the purity of ecstasy, one-half indicated that purity had fluctuated in the last six months, and one half indicated that the purity of ecstasy had recently decreased. One KE commented that fluctuations in the purity of pills was possibly due to fluctuations in the cutting agents used to make them.

There is little objective data on the purity of phenethylamines (the class of drugs that ecstasy, or MDMA, and drugs such as MDA, MDEA and mescaline belong to) from Tasmania Police, due to the small number of ecstasy seizures, and particularly those in which a formal laboratory analysis was conducted to establish the content of the drug seized. Only seizures in which the illicit nature of the drug is contested are formally analysed in Tasmania. Table 7 shows the median purity and number of phenethylamine seizures analysed, reported by Tasmania Police from 1999/00 to 2003/04. From this data it would appear that median purity of these seizures had remained relatively stable between 2001/02 to 2003/04, ranging from 22.9% to 26%. The purity of the 33 samples analysed during the 2003/04 period ranged from 10.4% to 44.5% with a median purity of 26.0%. There were no purity estimates reported by Tasmania Police in the 2004/05 reporting period, and the data for the 2005/06 reporting period was not available at the time of publication.

Table 7: Median purity of phenethylamine* seizures 1990/00 to 2004/05

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05
Median % purity	n/a	3.4 n=1	22.9 n=1	28.5 n=3	26.0 n=33	n/a

Source: Australian Bureau of Criminal Intelligence (2001, 2002); Australian Crime Commission (2003, 2004, 2005, 2006)

4.7 Availability

The sample of regular ecstasy users were asked how easy it had been to obtain ecstasy and whether there had been any changes in the availability of ecstasy in the six months preceding the interview (Table 8). Over half of the 2005 sample (52%) indicated that ecstasy was 'very easy' to obtain and close to one-half (46%) indicated that it was 'easy' to obtain. A small proportion (2%) indicated that ecstasy was 'difficult' to obtain. Over two-thirds of the 2006 cohort (70%) indicated that the availability of ecstasy had remained stable in the preceding six months, with smaller proportions indicating that ecstasy had recently become more difficult (13%), or easier (13%) to obtain, or had fluctuated (3%) in availability. Fewer respondents reported that ecstasy had recently become easier to obtain among the 2006 sample relative to previous years of the study.

Fourteen KE commented on the current availability of ecstasy, with all indicating that ecstasy was currently 'easy' (n=8), or 'very easy' (n=6) to obtain. Of the fifteen KE who commented on changes in the availability of ecstasy during the six months preceding the interview, over one-half (n=8) indicated that availability had remained stable and smaller proportions indicated that availability had increased (n=3) or fluctuated (n=2) during this time. One KE noted an increase in the availability of ecstasy pills in non-urban areas.

The sample of REU was asked who they had obtained ecstasy from and at which locations they had typically obtained the drug in the six months preceding the interview. A large majority indicated that they typically obtained ecstasy from friends (91%), followed by dealers (63%), and acquaintances (40%). Smaller proportions typically purchased ecstasy from unknown people (11%) or workmates (11%). Ecstasy was typically obtained from a friend's home (80%) followed by dance-related events (57%), nightclubs (49%), the consumer's own home (42%), private parties (39%), a dealer's home (38%) or at a public bar (21%). Smaller proportions obtained ecstasy from an agreed public location (12%), an acquaintance's house (9%), the street (4%), or at their work place (3%). These findings are relatively consistent with the data from previous years. However, relative to the 2005 sample, fewer participants reported obtaining ecstasy from nightclubs (49% vs. 59%) in 2006.

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

Ecstasy	2003	2004	2005	2006
Ease of obtaining ecstasy	n=100	n=100	n=100	**n=99**
Very easy (%)	43	68	57	**52**
Easy (%)	29	25	40	**46**
Moderately easy (%)	26	n/a	n/a	**n/a**
Difficult (%)	2	7	3	**2**
Very difficult (%)	-	-	-	**-**
Changes in availability in the last six months	n=99	n=97	n=98	**n=97**
Stable (%)	53	44	50	**70**
Easier (%)	20	35	25	**13**
More difficult (%)	19	10	14	**13**
Fluctuates (%)	7	10	9	**3**

Source: EDRS interviews

*changed from dealers to known dealers in 2004 **question asked for the first time in 2004

participants able to give more than one answer

Table 8: REU reports of availability of ecstasy in the preceding six months, 2003-2006 (continued)

Ecstasy	2003	2004	2005	2006
Persons scored from in the last six months #	n=100	n=100	n=100	**n=99**
Used not scored (%)	n/a	1	-	**3**
Friends (%)	90	92	95	**91**
Known dealers* (%)	66	62	63	**63**
Acquaintances (%)	34	34	39	**40**
Workmates (%)	12	12	17	**11**
Unknown people (%)	7	19	19	**11**
Mainland contact/dealer (%)	9	n/a	n/a	**n/a**
Locations scored from in the last six months #	n=100	n=100	n=99	**n=100**
Used not scored (%)				
Friend's home (%)	n/a	1	-	**3**
Dealer's home (%)	56	77	73	**80**
At own home (%)	47	35	37	**38**
Nightclub (%)	30	44	38	**42**
Rave/doof/dance party	40	53	59	**49**
Private party (%)	37	59	57	**57**
Pub (%)	n/a	n/a	36	**39**
Street (%)	15	15	22	**21**
Agreed public location (%)	7	3	1	**4**
Work (%)	-	17	20	**12**
Educational institute (%)	-	10	7	**3**
Acquaintance's house (%)	n/a	n/a	-	**1**
Other (%)	n/a	n/a	11	**9**
	-	2	1	**1**

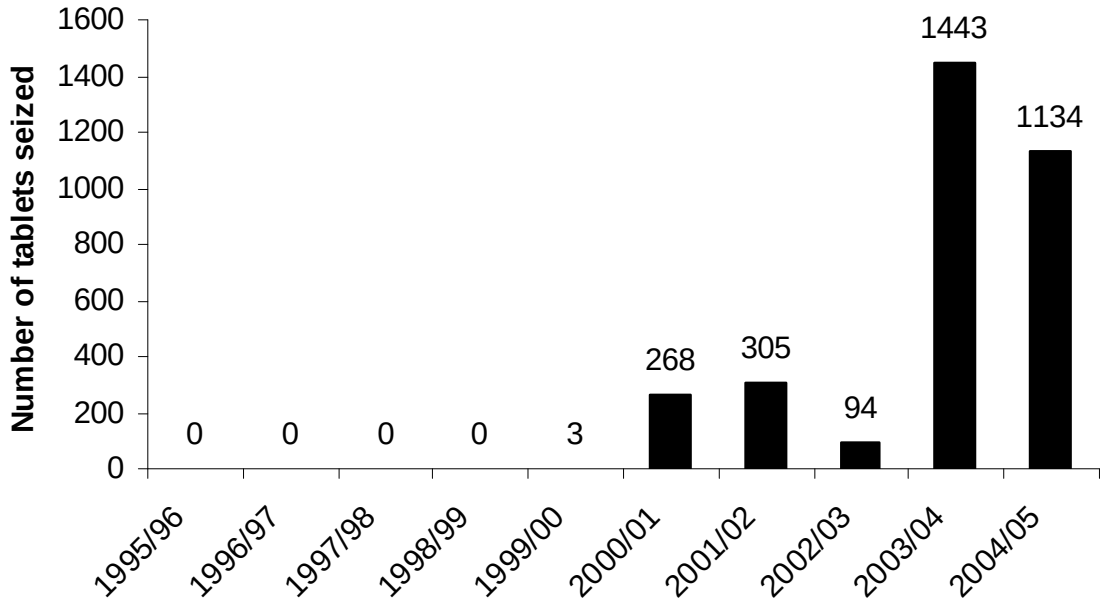
Source: EDRS interviews

*changed from dealers to known dealers in 2004 **question asked for the first time in 2004

participants able to give more than one answer

Figure 4 shows that there were no ecstasy tablets seized by Tasmania Police prior to the 1997/00 financial year. Since this time the number of tablets has increased, with a considerable increase observed in the 2003/04 reporting period in comparison to the previous three years. In 2004/05, this number was slightly reduced but still considerably higher than the years prior to 2003/04. However, it should be noted that the number of tablets seized depends on the size and number of individual seizures, and the 2004/05 data are based on a greater number of seizures. For example, the 2002/03 reporting period data are based on four seizures, three of which were less than 5 tablets. The 2003/04 data are based on 16 seizures, two of which were over 500 tablets and six of which were less than two tablets. The 2004/05 data are based on 20 seizures, 5 of which were over 50 tablets, and nine of which were under 10 tablets. While seizure data for 2005/06 was not available at the time of reporting, two law enforcement professionals interviewed for the current study noted a recent increase in the number of ecstasy seizures.

Figure 4: Number of seizures of tablets suspected to contain ecstasy by Tasmania Police, 1995/96-2004/05



Source: Tasmania Police

4.8 Ecstasy markets and patterns of purchasing ecstasy

REU interviewed in the 2006 study reported purchasing ecstasy from a median of 4 people (range 1-30 people) in the preceding six months (Table 9). Over half of the 2006 sample (54%) indicated that they typically purchased ecstasy for themself and others, two-fifths (44%) typically purchased ecstasy only for themselves, and 2% did not purchase ecstasy during the 6 months preceding the interview. The number of times that ecstasy was purchased in the preceding six months ranged from monthly or less (43%), fortnightly to monthly (42%), weekly to fortnightly (10%) or more than weekly (4%). The median number of tablets typically purchased in a single transaction was 3 (range 1-100).

Two-thirds of the sample (66%) were able to obtain other drugs from the person they had most often purchased ecstasy from in the last six months. Among those who could purchase other drugs from their main ecstasy source, the most commonly available drugs were cannabis (62%), methamphetamine powder (53%), cocaine (40%), methamphetamine base (35%), LSD (33%) and crystal methamphetamine (30%). Other drugs included mushrooms (17%), ketamine (13%), 2CI (11%), GHB (8%), pharmaceutical stimulants (6%), MDA (5%), heroin (2%), benzodiazepines (2%), and methadone (2%). Relative to previous years, a greater proportion were able to purchase methamphetamine base, crystal methamphetamine, and cocaine, and a smaller proportion were able to purchase cannabis and methamphetamine powder.

Table 9: Patterns of purchasing ecstasy, 2004-2006

	2004 n=100	2005 n=100	**2006 n=100**
Median no. of people purchased from (range)	4 (1-15)	4 (1-25)	**4 (1-30)**
Purchased for (%)			
Didn't purchase	n/a	-	**2**
Self only		34	**44**
Self and others		66	**54**
Others only		-	**-**
No. of times purchased in the last 6 months (%)			
1-6	n/a	38	**43**
7-12		36	**42**
13-24		25	**10**
25 +		-	**4**
Median no. of ecstasy tablets purchased (range)		3 (1-100)	**3 (1-100)**
Able to purchase other drugs from main dealer (%)	74	54	**66**
Drugs able to purchase*	n=74	n=54	**n=66**
Cannabis	64	80	**62**
Speed	70	69	**53**
Base	8	17	**35**
Ice/Crystal	4	7	**30**
Cocaine	11	22	**40**
LSD	26	37	**33**
Ketamine	5	13	**8**
Pharmaceutical stimulants	1	7	**6**
GHB	1	-	**8**
MDA	1	2	**5**
Heroin	9	-	**2**
Opium	3	6	**-**
Morphine	1	2	**-**
Benzodiazepines	-	-	**2**
Methadone	-	-	**2**
Mushrooms	-	-	**17**
2CI	1	-	**11**

Source: EDRS Regular ecstasy user interviews 2004-2006

* among those who reported they had been able to purchase other drugs from main dealer

In 2006, REU were asked if they were aware of the quantity of ecstasy that would qualify for a 'supply-type' offence if they were to be found in possession of the drug by police. One-third (34%) indicated that they knew how many tablets qualified as 'supply'. The median number of tablets thought to qualify as supply was 10 (range 1-100 tablets). The majority of REU (91%) thought that this was for tablets sold as ecstasy regardless of MDMA purity. Almost half of the REU interviewed (46%) reported that they knew what the consequences were for being convicted with supplying ecstasy. These consequences included a fine (33%), a caution (26%), a prison sentence (74%), community service (17%), and suspended sentence (9%). Several REU noted that the consequences depended on factors such as the amount of ecstasy caught with, prior criminal history, and police discretion (13%). REU were asked if there was a difference between purchasing tablets for personal use or for friends in the eyes of the police. Two-fifths of the sample (43%) perceived that there was a difference and indicated that there was a heavier penalty for obtaining ecstasy for friends than for themselves.

Under Tasmanian legislation (*Misuse of Drugs Act, 2001*), possession of a controlled substance carries a penalty of a fine not exceeding 50 penalty points ($5000) or imprisonment for a term

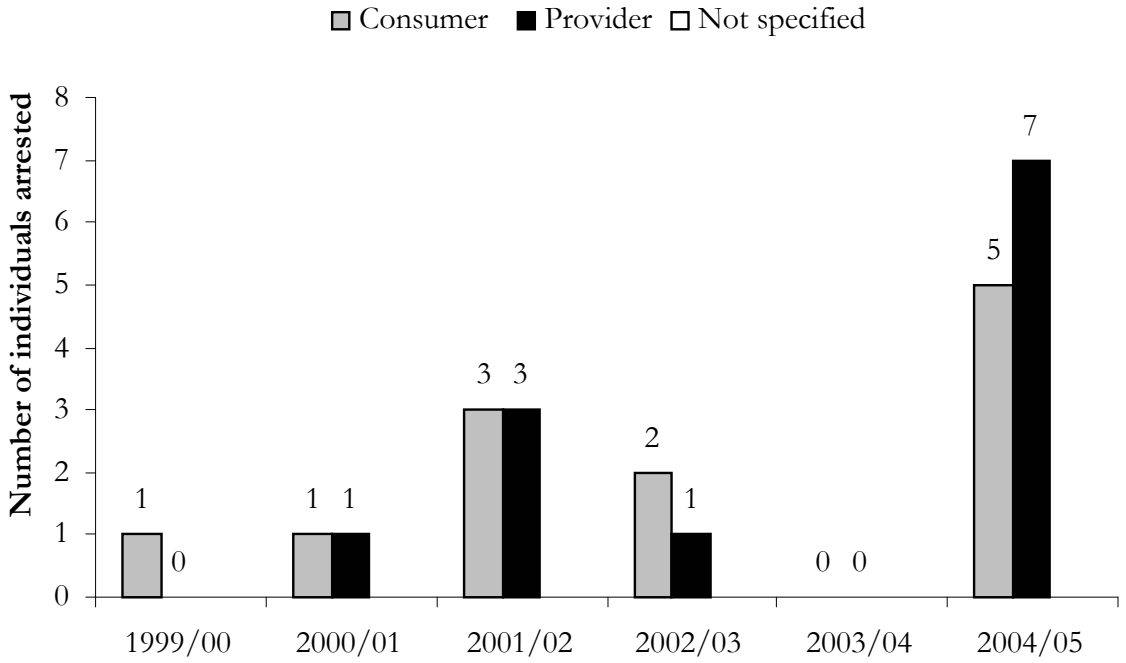
not exceeding two years, and selling or supplying a controlled drug carries a penalty of a fine not exceeding 100 penalty units ($10,000) or imprisonment for a term not exceeding four years. Under this legislation, possession and supply charges are not necessarily determined by the quantity of the substance. However, the offence of 'trafficking' is determined based on a number of factors, one of which is possession of a trafficable quantity of a controlled substance. Under Tasmanian legislation, the trafficable quantity for ecstasy or MDMA is 10g, and trafficking in a controlled substance carries a penalty of imprisonment for a term not exceeding 21 years.

4.9 Ecstasy-related harms

4.9.1 Law enforcement

Figure 5 shows the number of police incidents recorded by Tasmania Police for ecstasy possession and use (consumers) and for dealing or trafficking of ecstasy (providers) from 1999/00 to 2004/05. Consistent with the small number of regular ecstasy users that report coming into contact with the criminal justice system, there were few ecstasy-related police incidents between the 1999/00 and 2003/04 financial years. Despite the fact that at least 16 seizures were made during the 2003/04 period (see Figure 4 above), there were no arrests reported by Tasmania Police during this time. It is possible that this discrepancy reflects matters that were still before the courts, offences that were recorded as pertaining to 'amphetamine-type stimulants' if multiple drugs were seized, or that those involved in seizures received diversionary sentences or cautions. A considerable increase in the number of ecstasy-related arrests can be seen during the 2004/05 financial year relative to previous years. However, it is possible that some of these were arrests still before the court from the previous year. Data relating to arrests in 2005/06 were not available at the time of publication.

Figure 5: Number of police incidents recorded for ecstasy possession/use (consumers) and deal/traffic (providers), 1999/00-2004/05



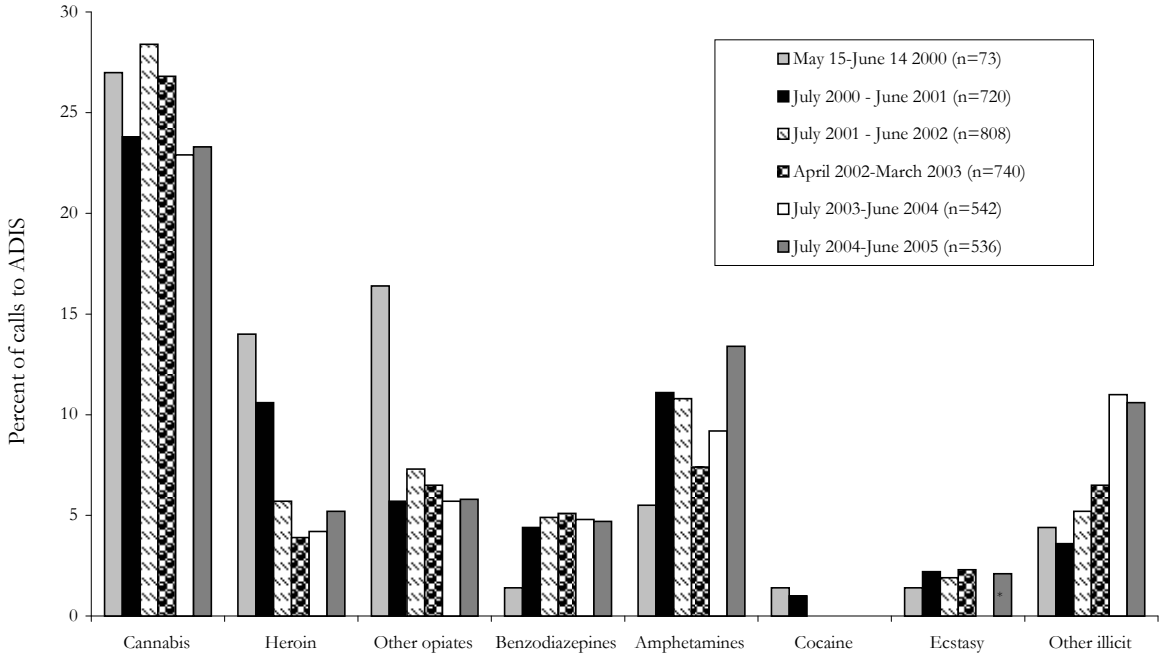
Source: Tasmania Police

4.9.2 Health

Alcohol and Drug Information Service data

The Tasmanian Alcohol and Drug Information Service (ADIS) is a telephone information and referral service that is administered by Turning Point Alcohol and Drug Centre in Victoria. A small but consistent number of calls have been recorded in relation to ecstasy during the 2000/01 (16 calls), 2001/02 (15 calls), 2002/03 (17 calls), and 2004/05 (11 calls) reporting periods[1]. Figures 6 and 7 show that calls in relation to ecstasy account for a small percentage (between 1.9% and 2.3%) of the total calls made to the service, particularly when compared to drugs such as cannabis, opiates and methamphetamine. It should also be noted that calls pertaining to ecstasy use were not specified in the 2003/04 period, and this information (along with cocaine and hallucinogens) may have been collapsed into the apparently increased 'other illicits' category. For the 2005/06 reporting period, data for each drug type was not available at the time of publication. However, 47% of all calls related to alcohol, 31% to cannabis and 13% to amphetamines, a pattern in keeping with the overall trends in previous years (ADIS & DACAS annual report, 2005/06).

Figure 6: Percentage of inquiries to ADIS with regard to each drug type, May 2000-June 2005.

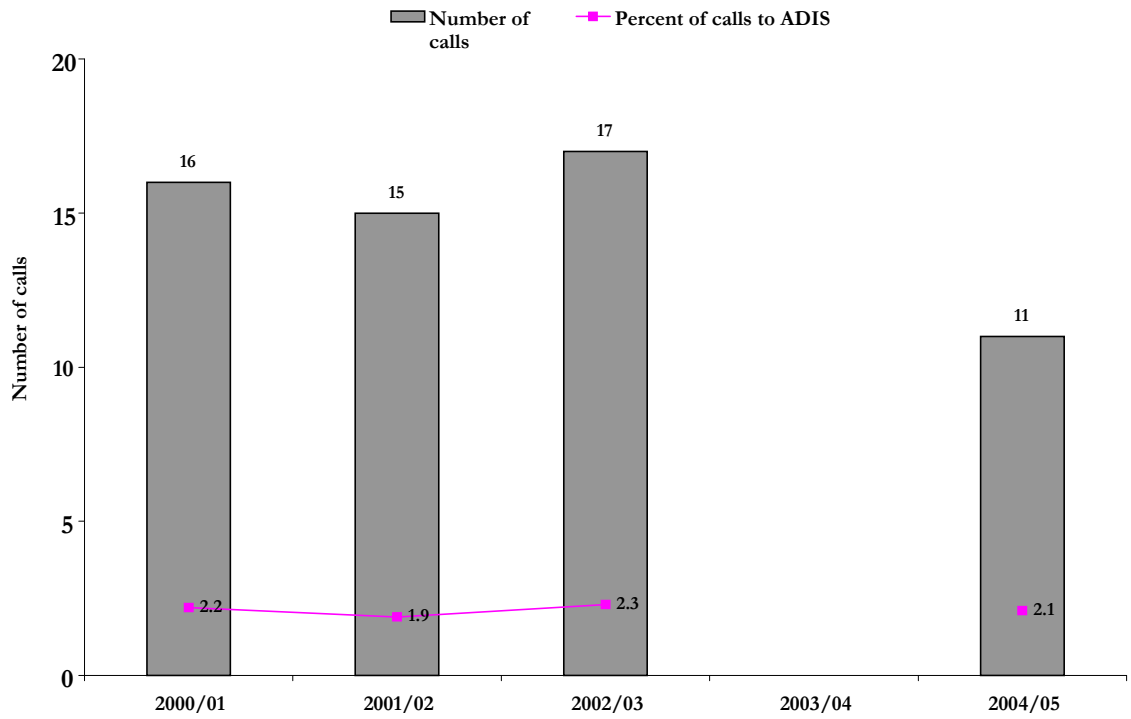


Source: ADIS Tasmania reports, Turning Point Alcohol and Drug Centre

Note: calls referring to ecstasy were not specified in the 2004 report, and may have been collapsed into the 'other' column.

[1] Data from calls made to the Turning Point-administered ADIS has been reported over differing time periods due to the requirements of the Department of Health and Human Services; however, for comparative purposes (and since this annual data are the only information available to the authors), these slightly differing reporting periods were each treated as financial year periods. There were 2,422 calls made to ADIS between May 15, 2000 and June 30, 2001; 2,208 in the 2000/01 financial year; 1,827 in 2001/02; 1984 during the period April 2002-March 2003; 1,837 during 2003/04 and 1,498 in 2004/05.

Figure 7: Percentage of inquiries to ADIS with regard to ecstasy, May 2000-June 2005.



Source: ADIS Tasmania reports, Turning Point Alcohol and Drug Centre
Note: calls referring to ecstasy were not specified in the 2004 report, and may have been collapsed into the 'other' column.

4.10 Benefit and risk perception

4.10.1 Perceived benefits

The sample of regular ecstasy users were asked to name the three biggest benefits associated with their own ecstasy use (see Table 10). A large majority of the sample (93%) indicated that there were benefits associated with taking ecstasy. The biggest social benefits of ecstasy use were perceived to be enhanced closeness with others (47%), having fun (enjoyable night or good time) (50%), and enhanced communication (40%). Sensory benefits such as enhanced appreciation of music/dance (23%) were also commonly reported as were acute effects of ecstasy such as enhanced mood (37%), experiencing a high/rush/buzz (22%), increased energy (18%), and other drug effects (10%). Other benefits included the relax/escape/release (14%), increased confidence/decreased inhibitions (12%), a favourable experience in comparison to alcohol (6%), feeling in control/focused (2%) and enhanced sexual experience (1%).

Table 10: Perceived benefits of ecstasy use among REU, 2004-2006

Benefit	2004 n=100	2005 n=98	**2006 n=93**
Fun (enjoyable night/good time) (%)	50	46	**50**
Enhanced closeness/bonding/empathy with others (%)	39	56	**47**
Enhanced mood (euphoria/wellbeing/happiness) (%)	39	37	**37**
Enhanced appreciation of music/dance (%)	36	31	**23**
Enhanced communication/talkative/more social (%)	33	18	**40**
Increased energy/stay awake (%)	29	24	**18**
The high/rush/buzz (%)	28	36	**22**
Relax/escape/release (%)	13	17	**14**
Drug effects (e.g. hallucinations/insight/creativity/heightened senses) (%)	10	8	**10**
Different to alcohol (e.g. non-violent/safer environment/no hangover) (%)	8	8	**6**
Increased confidence/decreased inhibitions (%)	4	9	**12**
Feeling in control/focused (%)	4	1	**2**
Enhanced sexual experience (%)	4	4	**1**
Other benefit (%)	-	3	**1**

Source: EDRS Regular ecstasy user interviews 2004-2006
Note: participants could report up to three perceived benefits

4.10.2 Perceived risks

Participants were asked to name the three biggest risks associated with their own ecstasy use (Table 11). The majority of the sample (97%) perceived that there were some risks associated with ecstasy use. The greatest risks were unknown contaminants/cutting agents (29%), legal/police problems (27%), damage to brain function (26%), and depression (24%). Other perceived psychological risks included addiction/dependence (15%), lack of motivation (6%), psychosis (4%), anxiety/panic (4%), a general lack of emotional wellbeing (4%), paranoia (3%), and feeling bad during comedown (1%). Other perceived neuropsychological risks included memory impairment (14%), general cognitive impairment (4%) and other harms related to the illicit status of ecstasy including unknown drug strength and purity (9%). The greatest physical harms were perceived to be dehydration (15%), fatal overdose (13%), long-term physical problems (12%) and acute physical harms (10%), followed by non-fatal overdose (5%), and body temperature dysregulation (2%). One-tenth or less considered effects of intoxication such as impaired decision-making/risk-taking (11%), increased vulnerability (3%), sexual risk (3%), driving risk (1%), aggression/violent behaviour (1%), taking more than intended (1%) and accidents (1%) to be major risks. Similarly, less than one-tenth perceived financial problems (8%), work/study problems (2%), social/relationship problems (2%), unknown long-term harm (2%) and lack of knowledge (2%) to be major risks.

Table 11: Perceived risks of ecstasy use among REU, 2004-2006

Risk	2004* n=95	2005 n=97	**2006 n=97**
Psychological harms			
Depression (%)	32	35	**24**
Anxiety/panic (%)	13	10	**4**
Addiction/dependence (%)	11	12	**15**
Lack of motivation (%)	12	20	**6**
Paranoia (%)	6	4	**3**
Psychosis (%)	2	4	**4**
General lack of emotional wellbeing (%)	2	-	**4**
Personality changes (%)	2	1	**-**
Feeling bad during comedown (%)	1	1	**1**
Other psychological harm	5	7	**1**
Neuropsychological harms			
Damage to brain function (brain cells/neurological damage) (%)	36	31	**26**
Memory impairment (%)	13	21	**14**
Cognitive impairment (%)	4	10	**4**
Physical harms			
Acute physical harms (e.g. vomiting/headache/sleeplessness/weight loss) (%)	18	9	**10**
Long-term physical problems (e.g. cardiac/lungs/respiratory/nasal) (%)	16	22	**12**
Dehydration (%)	11	7	**15**
Body temperature regulation (%)	8	3	**2**
Over-hydration (%)	2	-	**-**
Fatal OD (death) (%)	4	6	**13**
Non-fatal OD (passing out, coma) (%)	2	3	**5**
Other physical harm (%)	4	9	**1**
Harms related to illicit status			
Unknown drug strength/purity	18	9	**12**
Unknown drug contaminants cutting agents	12	20	**29**
Effects of intoxication			
Impaired decision-making/risk-taking (%)	9	8	**11**
Increased vulnerability (%)	-	1	**3**
Aggression/violent behaviour (%)	-	1	**1**
Driving risk (%)	3	2	**1**
Sexual risk (%)	-	1	**3**
Taking more than intended (%)	3	-	**1**
Accidents (%)	-	1	**1**
Combined effects of polydrug use (%)	3	-	**-**
Other harms			
Legal/police problems (%)	23	11	**27**
Financial problems (%)	14	8	**8**
Unknown long-term harm (%)	7	10	**2**
Work/study problems (%)	2	4	**2**
Relationship/social problems (%)	1	4	**2**
Lack of knowledge (%)	-	1	**2**
Other harm (general) (%)	15	4	**3**

Source: EDRS Regular ecstasy user interviews 2004-2006

Note: participants could report up to three perceived risks

* 2004 data differ to that reported by Matthews and Bruno (2005) as percentage of those that commented is reported in 2005.

4.11 Summary of ecstasy trends

- The median price reported by REU for one tablet of ecstasy was $40, which is slightly lower then the price of $45 reported in 2005. Over one-half indicated that this price had remained stable during the preceding six months, but one-quarter indicated that their had been a recent decrease in price. The median price reported by KE was also $40 and over half of those that commented (n=7) indicated that the price of ecstasy had recently decreased.
- REU typically reported that ecstasy was medium (39%) or fluctuating (36%) in purity, with a smaller proportion (13%) reporting that ecstasy was high in purity relative to previous years. REU typically indicated that this purity had remained stable (34%) or had fluctuated (32%) during the six months preceding the interview. KE indicated that the purity of ecstasy typically fluctuated or was low to medium, with four out of eight KE reporting a recent decrease in the purity of ecstasy.
- Both key experts and REU indicated that ecstasy is 'easy' or 'very easy' to obtain and that recent availability had remained stable.
- Whereas there was evidence for an expanding ecstasy market in 2004 - marked by decreased price, increased purity, and increased availability relative to 2003 - in 2005 the market appeared to have tightened slightly, with a slight increase in price and decreased purity and availability relative to 2004. In 2006, a slight increase in price and decrease in purity was observed, while availability remained relatively stable.
- Ecstasy was typically purchased from friends and obtained from friends' homes. Over one-half (54%) indicated that when they purchased ecstasy they typically purchased the drug both for themselves and others, while the remainder (44%) typically purchased ecstasy only for themselves. Although two-fifths (43%) of the sample perceived that getting tablets for friends carried a heavier penalty than getting tablets for themselves, the remainder of the sample did not perceive that there was a distinction. Almost half of the sample (46%) was aware of some possible consequences of supplying ecstasy, and the remainder were not able to confidently comment.
- There was a substantial increase in the number of ecstasy tablets seized by Tasmania Police in the 2003/04 financial year, and the number of tablets seized has remained relatively stable since this time. Whereas this has had minimal impact on the number of arrests made in relation to ecstasy, there were a greater number of arrests reported in the 2004/05 reporting period relative to previous years.
- While a small and consistent number of calls have been made to the Tasmanian Alcohol and Drug Information Service over the last few years in relation to ecstasy, these account for a small percentage of the calls made to this service, particularly when compared to the percentage of calls that relate to cannabis and amphetamines.

5.0 METHAMPHETAMINE

Throughout the 1980s, the form of illicit amphetamine most available in Australia was amphetamine sulphate (Chesher, 1993). Following the legislative controls introduced in the early 1990s on the distribution of the main precursor chemicals for the production of amphetamine sulphate (Wardlaw, 1993), illicit manufacturers were forced to rely on different procedures for the preparation of amphetamine. Throughout the 1990s, the proportion of amphetamine-type substance seizures that were methamphetamine[2] (rather than amphetamine) steadily increased until methamphetamine clearly dominated the market (ABCI, 1999, 2000, 2001). Across Australia today, the powder traditionally known as 'speed' is almost exclusively methamphetamine rather than amphetamine. For example, in the 2003/04 financial year, of the 4,182 seizures of (non-phenethylamine) amphetamine-type seizures analysed for purity in Australia, 94.5% (by number) were methamphetamine rather than amphetamine (ACC, 2005).

As methamphetamine markets across the country have expanded over the past few years, it has become apparent that there is a diversity of forms of methamphetamine sold in the Australian illicit drug market. These more potent forms may be known by terms such as ice, shabu, base, paste and crystal meth, but they are all methamphetamine in basis. While there is some disagreement among both users and researchers as to the nature of these forms, it is clear that these are marketed differently to IDU and REU, and often sold on differing price scales. As such, trends in regard to each of these forms will be discussed separately where appropriate, and the term methamphetamine will be used in the EDRS to refer to the drugs available in this class

With the exception of amphetamine-based tablets marketed as 'ecstasy', and pharmaceutical stimulants such as dexamphetamine and methylphenidate, it appears that there are three dominant 'preparations' of methamphetamine used within the Tasmanian (and Australian) drug market – each falling at three points along a continuum of form, but all of which are essentially the same substance.

Powder form methamphetamine[3] is the presentation of the drug which has traditionally been available in Australia. This is commonly a powder that can range from fine to more crystalline or coarse, and may take different colours (commonly white, yellow, brown, orange or pink), depending on the chemical process used in its production and the quality of that process. It is produced within Australia, most commonly in small, portable 'laboratories', and is usually based on pharmaceutical pseudoephedrine (extracted from, for example, Sudafed tablets). Because of its powder form, it is fairly easy to 'cut' (dilute) and is commonly sold at fairly low purity/potency (although this can vary substantially). Consumers interviewed for the 2005 IDRS survey commonly reported that methamphetamine powder was often 'claggy', a little 'wet' in appearance and sometimes contained small crystals amongst the powder, ranging from clear to white, pink or brown in colour (Bruno, 2006).

The two other 'forms' of methamphetamine are traditionally higher in potency (due to being more difficult to 'cut') and have been increasing in availability across all Australian jurisdictions in the past few years (Topp et al., 2002). The first, referred to in some jurisdictions as 'base' or 'paste', is commonly a gluggy, oily, 'wet' powder. This form of the drug appears oily because the conversion process from pseudoephedrine to methamphetamine produces the alkaline (base) form of methamphetamine, which is 'oily'. To convert this to a more easily injectable form (methamphetamine hydrochloride crystals, which may take the appearance of powder, or, when no impurities are present, and carefully crystallised, may take the form of the 'ice'

[2] Methamphetamine is an abbreviation of the name methylamphetamine, and, as such, both terms are interchangeable.
[3] Powder form methamphetamine is also referred to in national and other jurisdiction IDRS reports as 'speed'.

crystals discussed below) requires a high level of skill, and, when not completed correctly, the result of this process is an oily powder that often has a yellow or brownish tinge due to the presence of iodine and other impurities (Topp & Churchill, 2002). In the 2005 IDRS survey, participants that had recently purchased this form of the drug locally commonly described it as 'milky', 'sticky', 'waxy' and 'wet' in appearance, with specific examples of it as 'clear, jelly-like', 'brown, like soggy brown sugar' or 'golden syrup', or 'pinky', like wet fairy floss' (Bruno, 2006).

The final form of methamphetamine, often referred to as 'ice' or 'crystal meth(amphetamine)' is the product of a careful production process, and is believed to chiefly be imported into Australia from Asian countries (Topp & Churchill, 2002), although there are also indications of local production in recent years (ACC, 2003). It commonly appears as clear crystals, and, as such, is difficult to 'cut' (dilute), resulting in a relatively high-purity/potency product. Consumers in previous IDRS studies have commonly described this form as white/clear crystals or rocks, looking like crushed glass or rock salt (with crystals commonly larger than sugar crystals).

For the purposes of the EDRS, regular ecstasy users were asked to differentiate between methamphetamine powder, 'base/paste' and ice/crystal methamphetamine.

5.1 Methamphetamine use among REU

A large majority of the regular ecstasy users interviewed in 2006 (94%) had used methamphetamine at some stage during their lives. A significantly greater proportion of males (98%) had ever used methamphetamine in comparison to females (88%), $\chi^2=4.48$, $p<.05$, but there was no significant difference between the proportion of 'younger' (92%) or 'older' (96%) participants (based on a median split for age). Over three-quarters of the sample (78%) had used some form of methamphetamine in the six months preceding the interview. There was no significant difference in the proportion of males (83%) and females (71%) that had recently used any form of methamphetamine and no significant difference between the proportion of 'older' (82%) and 'younger' (74%) participants that had recently used methamphetamine. The median frequency of use of any methamphetamine form over the last six months was 6 days (range 1-156), or approximately once a month, and there was no difference between the median frequency of use amongst males (6 days) and females (5 days). Of those that had recently used any form of methamphetamine, the most common route of administration in the last six months was swallowing (91%), followed by snorting (50%), smoking (27%), injecting (12%) and shelving/shafting (1%). Just over one-tenth of the 2006 REU sample (14%) had ever injected some form of methamphetamine, and less than one-tenth (9%) had injected any form of methamphetamine in the last six months.

5.1.1 Methamphetamine powder (speed)

The majority of regular ecstasy users interviewed in 2006 (83%) had used methamphetamine powder at some stage of their lives, which is similar to the proportion among the 2003 (90%), 2004 (82%), and 2005 (89%) samples. There was no significant difference between the proportion of males (86%) and females (79%) that had ever used methamphetamine powder. There was a trend for a greater proportion of 'older' relative to 'younger' participants (based on a median split for age) to have ever used methamphetamine powder (90% vs. 76%), $\chi^2=3.47$, $p=.062$. However, this failed to reach conventional levels of statistical significance. The median age of first use was 20 years (range 15-60 years, SD=5.1), and there was no significant difference between the age of first use for males and females. The majority of those who had ever used methamphetamine powder had swallowed (88%) or snorted (74%) the

drug, and smaller proportions had ever injected (17%), smoked (16%) or shelved/shafted (1%) the drug.

Three-fifths of the 2006 REU sample (62%) had used methamphetamine powder in the six months preceding the interview, which is less in comparison to the 2005 sample (77%), and slightly less relative to the 2003 (67%), and 2004 (68%) samples. There was no significant difference between the proportion of males (66%) and females (57%), or the proportion of 'older' (68%) and 'younger' (56%) participants (based on a median split for age) reporting recent use of methamphetamine powder. The majority of those who had recently used methamphetamine powder had swallowed (88%) or snorted (63%) the drug during the six months preceding the interview, and smaller proportions reported injecting (8%), smoking (8%) or shelving/shafting (2%, n=1) the drug during this time. Those that had injected methamphetamine had done so on a median of 10 days (range 2-30, n=5) during the six months preceding the interview.

The median frequency of methamphetamine powder use was 3 days (range 1-48 days), or once every two months, during the six months preceding the interview (Table 12). The median frequency of use for males (3.5 days) was similar to the median frequency of use for females (3 days), and there was no significant difference in the median frequency of use of 'older' and 'younger' participants. The median frequency of methamphetamine powder use has decreased slightly over the last three years (5 days vs. 4 days vs. 3 days across the past three cohorts respectively). Four-fifths (81%) of those that had recently used methamphetamine powder had done so once monthly or less, compared to over three-quarters in 2005 (78%) and two-thirds in 2004 (66%), suggesting a lower frequency of use among the sample in 2005 and 2006 relative to 2004. The remainder had used the drug more than monthly but less than weekly (10%), or weekly or more often (10%) in the six months preceding the interview. The typical amount of methamphetamine powder used by REU was a median of one point (0.1 of gram) in a typical session (range 0.25-4.5 points), and 2 points (range 0.13-6 points) in the biggest session of use in the last six months.

The majority of key experts were able to comment on the use of methamphetamine powder among the regular ecstasy users that they were familiar with. Estimates of the proportion of the groups that used methamphetamine powder ranged from 'none' (n=2), 'a few' (n=8), 'half' (n=4), and 'all' (n=2). Three KE noted a recent decrease in the use of methamphetamine powder, two of whom commented that this was related to an increase in the availability of other methamphetamine forms.

Table 12: Patterns of methamphetamine powder (speed) use among REU, 2003-2006

Methamphetamine powder	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	90	82	89	**83**
Median age of first use (range)	19 years (16-31)	20 years (15-27)	20 years (13-44)	**20 years (15-60)**
Used in last six months (%)	67	68	77	**62**
Of those who had used in last 6 mths				
Median days used last 6 mths (range)	4 (1-120)	5 (1-48)	4 (1-90)	**3 (1-48)**
Route of administration in last 6 mths				
Smoked (%)	4	4	8	**8**
Snorted (%)	63	63	56	**63**
Swallowed (%)	79	85	86	**89**
Injected (%)	16	9	6	**8**
Shafted/shelved (%)	-	-	-	**2**
Median quantities used in last 6 mths (range)	1 (0.5-5)	1 (.25-3)	1 (0.2-5)	**1 (0.25-4.5)**
Points used typical session	1 (0.5-40)	1 (.25-6)	1.5 (0.2-5)	**2 (0.13-6)**
Points used biggest session				

Source: EDRS Regular ecstasy user interviews 2003-2006

5.1.2 Methamphetamine base

Table 13 shows that almost one-half of the 2006 sample (49%) had used methamphetamine base at some stage of their lives, which is greater relative to the proportion reporting lifetime use among the 2003 (36%) and 2004 (32%) cohorts. A greater proportion of the male sample (57%) reported lifetime use of methamphetamine base in comparison to the female sample (38%), χ^2=3.45, p=.063, though this did not reach conventional levels of statistical significance. A significantly greater proportion of 'older' (62%) consumers had ever used methamphetamine base in comparison to 'younger' participants (based on a median split for age), χ^2=6.76, p<.01. The median age of first use of methamphetamine base was 21 years (range 15-32 years, SD=3.24) and there was no significant difference of the average age of first use for males and females. The majority of those that had ever used methamphetamine base had swallowed the drug (90%), and smaller proportions reported ever snorting (20%), injecting (22%), smoking (8%) or shelving/shafting (2%) the drug.

Two-fifths of the 2006 sample (40%) had used methamphetamine base in the six months preceding the interview, which is greater to the proportion of the sample that reported recent use of methamphetamine base among the 2003 (24%), 2004 (20%), and 2005 (23%) samples. A greater proportion of males (48%) had recently used methamphetamine base in comparison to the proportion of females (29%), χ^2=3.94, p<.05. There was no significant difference between the proportion of 'older' (48%) and 'younger' (32%) participants that had recently used methamphetamine base. The majority of those who had recently used methamphetamine base had swallowed the drug (88%), and smaller proportions had injected (20%), snorted (15%) or smoked (3%) the drug. The median frequency of use in the six months preceding the interview was four days (range 1-150), or just over once every two months during this time. There was no significant difference between the median frequency of use for males and females or for 'older' and 'younger' participants. Almost three-quarters of those who had recently used methamphetamine base (73%) had used the drug less than monthly in the preceding six months, and the remainder had used the drug between monthly and weekly (15%) or more frequently (13%). Of those that had recently injected methamphetamine base,

the median frequency of injection was 27 days (range 1-150) during the six months preceding the interview. The median quantity of methamphetamine base used in the preceding six months was 2 points (0.2 of a gram) in both a typical session of use (range 0.5-3 points) and in the biggest session of use (range 0.5-10 points), which is greater than the median quantity of one point reported in previous years. There were no significant sex differences in the median number of points used in a typical session. Based on a median split for age, the median number of points used in a typical session was significantly greater for 'older' (2 points, range 0.5-3) in comparison to 'younger' participants (1 point, range 0.5-3), Mann-Whitney U=61.0, p<.05.

KE that were able to comment on the use of methamphetamine base among the group of REU that they had regular contact with indicated that methamphetamine base was generally not used (n=6), or that 'a few' (n=7), or 'half' (n=2) of the group used methamphetamine base. One KE noted a recent increase in the use of base among REU.

Table 13: Patterns of methamphetamine base use among REU, 2003-2006

Methamphetamine base	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	36	32	35	**49**
Median age of first use (range)	21 years (16-31)	22 years (16-29)	20 years (17-29)	**21 years (15-32)**
Used in last six months (%)	24	20	23	**40**
Of those who had used in last 6 mths				
Median days used last 6 mths (range)	3 (1-96)	3 (1-24)	4 (1-70)	**4 (1-150)**
Route of administration in last 6 mths				
Smoked (%)	-	5	-	**3**
Snorted (%)	50	15	39	**15**
Swallowed (%)	71	85	91	**88**
Injected (%)	38	30	22	**20**
Shafted/shelved (%)	-	-	4	**-**
Median quantities used last 6 mths (points)				
Points used typical session	1 (0.5-5)	1 (0.25-2.5)	1 (0.25-5)	**2 (0.5-3)**
Points used biggest session	1 (1-40)	1 (0.25-2.5)	1 (0.25-10)	**2 (0.5-10)**

Source: EDRS Regular ecstasy user interviews 2003-2006

5.1.3 Crystal methamphetamine

Table 14 shows that two-fifths (42%) of the REU interviewed in 2006 had ever used crystal methamphetamine which is a greater proportion relative to the 2004 (36%) and 2005 (29%) samples but smaller relative to the 2003 sample (58%). There was no significant difference in the proportion of males (47%) and females (36%) reporting lifetime use of crystal methamphetamine. Based on a median split for age, a significantly greater proportion of 'older' (52%) participants had ever used crystal methamphetamine in comparison to the proportion of 'younger' participants (32%), χ^2=4.12, p<.05. The median age of first use of crystal methamphetamine was 23 years (range 15-34 years), and there was no significant difference between males and females in terms of the age of first use. The majority of those who had ever used crystal methamphetamine had smoked (81%) or swallowed (52%) the drug, and smaller proportions had ever injected (29%) or snorted (19%) the drug.

Over one-quarter (27%) of the 2006 REU sample had recently used crystal methamphetamine which is greater relative to the 2004 (16%) and 2005 (10%) samples but fewer relative to the

2003 sample (52%). A significantly greater proportion of the male sample (36%) had recently used crystal methamphetamine in comparison to the proportion of the female sample (14%), $\chi^2=5.94$, $p<.05$. The majority of those that had recently used crystal methamphetamine had smoked the drug (78%), almost one-half (48%) had recently swallowed the drug, and smaller proportions had recently injected (22%) or snorted (15%) the drug. Whereas smoking was the most common route of administration among the 2003 and 2004 samples, injection was more common than smoking among the few people (n=10) that had used the drug among the 2005 sample. This indicates that the increase in the number of people reporting recent use is due to an increase in those that smoke crystal methamphetamine.

The median frequency of crystal methamphetamine use in the preceding six months was 5 days (range 1-50) which is greater than the median frequency of 1 to 3.5 days reported among the samples between 2003 and 2005 (see Table 14). There was no significant difference between the median frequency of use for males and females or for 'older' and 'younger' participants. Three-fifths (59%) of those that had recently used methamphetamine had used the drug monthly or less during this time. The remainder had used the drug between monthly to weekly (19%), or more than weekly (22%). The average quantity used in a typical session of use in the six months preceding the interview was one point or 0.1 of a gram (range 0.5-3.5 points). In the biggest session of use, the median amount used was 2 points (range 0.5-10). These quantities are relatively similar to those reported by the REU samples between 2003 and 2005. There was no significant difference between the average number of points used in a typical session for males and females or for 'older' and 'younger' participants.

Some key experts that commented on the use of crystal methamphetamine indicated that there was no use of the drug among the REU group that they were familiar with (n=5). However, other KE indicated that that 'a few' (n=9) REU used crystal methamphetamine, with three KE noting a recent increase in the use of the drug. Several REU (n=5) also commented anecdotally on a recent increase in the use of crystal methamphetamine among themselves or their friends.

Table 14: Patterns of crystal methamphetamine use among REU, 2003-2006

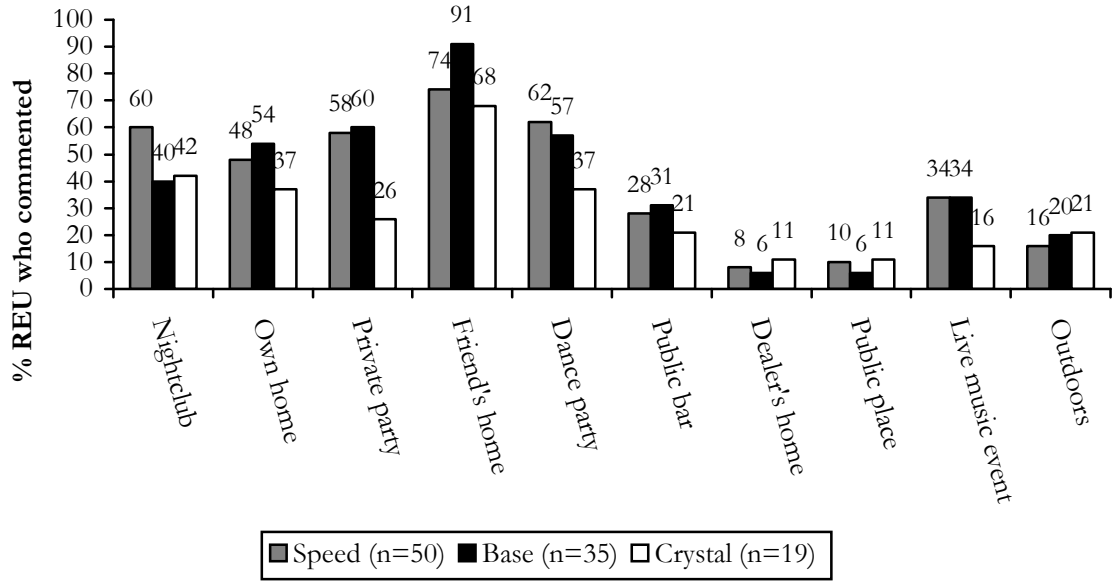
Crystal methamphetamine	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	58	36	29	**42**
Median age of first use (range)	22 years (17-45)	22 years (16-29)	23 years (15-29)	**23 years (15-34)**
Used in last six months (%)	52	16	10	**27**
Of those who had used in last 6 mths				
Median days used last 6 mths (range)	3 (1-72)	1 (1-18)	3.5 (1-30)	**5 (1-50)**
Route of administration in last 6 mths				
Smoked (%)	62	69	20	**78**
Snorted (%)	14	13	20	**15**
Swallowed (%)	38	31	40	**48**
Injected (%)	25	6	50	**22**
Shafted/shelved (%)	-	-	-	**-**
Median quantities used in last 6 mths (range)				
Points used typical session (range)	0.5 (0.2-2)	1 (0.25-2)	1 (0.5-3)	**1 (0.5-3.5)**
Points used biggest session (range)	1 (0.25-10)	1 (0.25-2.5)	1 (0.5-10)	**2 (0.5-10)**

Source: EDRS Regular ecstasy user interviews 2003-2006

Regular ecstasy users were asked to comment on the locations that they had typically used each form of methamphetamine to be under the drug's influence (rather than the place of ingestion) during the last six months preceding the interview (see Figure 8). Methamphetamine powder was typically used at private residences such as a friend's home (74%), their own home (60%), or private parties (58%), as well as at venues such as dance events (62%), nightclubs (60%), live music events (34%), or pubs (28%). Methamphetamine base was most commonly used at private residences such as a friend's home (91%), the respondent's own home (54%), and private parties (60%), as well as dance parties (57%), nightclubs (40%), live music events (34%), and public bars (31%). Crystal methamphetamine was typically used at private residences such as a friend's home (58%), the consumer's own home (37%), and private parties (26%) as well as venues such as nightclubs (42%), dance parties (37%), public bars (21%), and live music events (16%). In comparison to reports in 2005, there was more use of crystal methamphetamine at locations such as dance parties and nightclubs in 2006

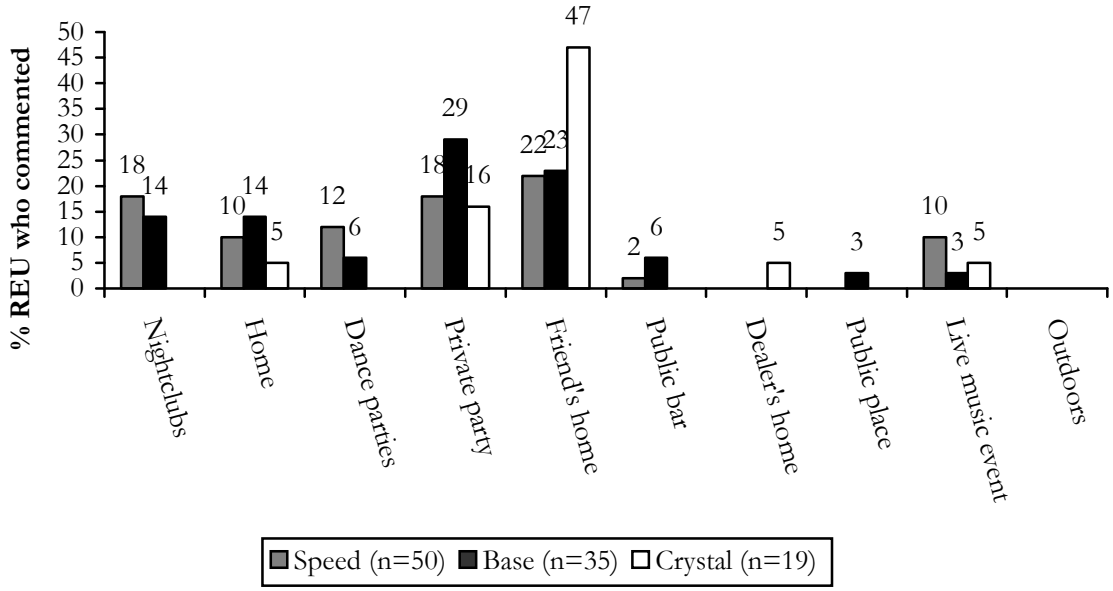
The last location of methamphetamine use was generally consistent with the usual locations of use (see Figure 9). Methamphetamine powder was most commonly last used at a friend's home (22%), private parties (18%), nightclubs (18%), and dance events (12%), followed by own home (10%), live music event (10%) and public bar (2%). Methamphetamine base was most commonly used last at private parties (29%), a friend's home (23%), own home (14%), and nightclub, followed by dance party (6%), public bar (6%), public place (3%) and live music event (3%). In contrast, crystal methamphetamine was most commonly last used at a friend's home (47%) and private parties (16%), own home (5%), and dealer's home (5%), rather than nightclubs (0%) and dance parties (0%).

Figure 8: Location of usual methamphetamine use by form, 2006



Source: EDRS Regular ecstasy user interviews 2006

Figure 9: Location of most recent methamphetamine use by form, 2006



Source: EDRS Regular ecstasy user interviews 2006

5.1.4 Self-reported symptoms of methamphetamine dependence

REU that had used methamphetamine during the six months preceding the interview (n=77) were asked about how they felt about their use of this drug in the last 12 months, using the Severity of Dependence Scale (SDS). The scale consisted of 5 multiple choice questions that were rated on a scale of 0-3, resulting in a range of possible scores from 0-15, where higher scores suggest greater psychological dependence. Participants were asked if they thought that their methamphetamine use was out of control, if the prospect of missing a dose had made them feel anxious or worried, if they had worried about their methamphetamine use, if they had wished they could have stopped, and if they would find it difficult to stop or go without methamphetamine. Of those who completed the methamphetamine SDS, two-fifths (43%) were referring to methamphetamine powder, one-quarter (26%, n=15) were referring to methamphetamine base, less than one-tenth were referring to crystal methamphetamine (8%, n=6) and almost one-third (29%) were not referring to any particular form of methamphetamine.

The median SDS score for those who had used methamphetamine in the preceding six months was 0 (range 0-13, n=77). Over half of those who completed the methamphetamine SDS received a score of zero (52%, n=40), indicating no symptoms of dependence. There was no significant difference between the median methamphetamine SDS scores of male and female respondents. However, based on a median split for age, 'older' participants had a higher median methamphetamine SDS score in comparison to 'younger' participants (2 vs. 0; Mann-Whitney U=549.5, $p<.001$). A score of four on the SDS in relation to methamphetamine use is considered a reasonable cut-off for predicting DSM-III-R diagnosis of severe amphetamine dependence (Topp & Mattick, 1997). A more conservative cut-off of five was employed in the present analyses. Almost one-fifth of those who completed the methamphetamine SDS (19%, n=15) had a score of 5 or more on the methamphetamine SDS, and it is reasonable to assume that some proportion of these people had experienced significant psychological symptoms of dependence.

The following analyses examining differences between those with high and low methamphetamine SDS scores should be interpreted with caution due to small and uneven sample sizes. There was no significant difference in the proportion of males (23%) and females (13%) or 'older' (20%) and 'younger' (19%) participants that had a score of 5 or more on the methamphetamine SDS. Those with a high methamphetamine SDS score (n=15) had used a greater number of drug types (out of a list of 20 drug classes) in the last six months (9 vs. 7: Mann-Whitney U=195.5, p<.001), and had used methamphetamine (any form) on a significantly greater number of days (37 vs. 4:, Mann-Whitney U=97.5.0, p<.001), in comparison to those with a low methamphetamine SDS score. Those with a high methamphetamine SDS score were more likely to be unemployed (33% vs. 11%, χ^2=4.60, p<.05), to have recently used drugs intravenously (40% vs. 5%, χ^2=14.74, p<.001), to have recently binged on ERDs (used for more than 48hrs without sleep) (80% vs. 44%, χ^2=6.16, p<.05), and to typically use methamphetamine in combination with ecstasy (47% vs. 13%, χ^2=9.0, p<.01), compared to those with a 'low' methamphetamine SDS score. Those with a 'high' methamphetamine SDS score were more likely to have a 'high' ecstasy SDS score (a score of 5 or more on the SDS for ecstasy: 47% vs. 13%: χ^2=9.0, p<.01). They also had significantly higher scores on the Kessler scale of psychological distress on average (16 vs. 22: Mann-Whitney U=203.5, p<.01), and were more likely to have a 'high' score (25 or more) on the Kessler psychological distress scale (33% vs. 9%: χ^2=7.06, p<.01), than those with a 'low' methamphetamine SDS score. Thus, one-third (33%) of those with high levels of methamphetamine dependence also had clinically significant levels of psychological distress.

5.2 Price

Regular ecstasy users were asked to indicate the market price and the price of last purchase for the three major forms of methamphetamine (see Table 15). A greater number of respondents were able to report confidently on the price of methamphetamine powder, in comparison to methamphetamine base and crystal methamphetamine. As such the prices reported for the latter two methamphetamine forms should be interpreted with caution.

The median market price and last purchase price for one point (0.1 of a gram) of methamphetamine powder was $40 (range $30-50), which is consistent with the prices reported in 2005 ($40, range $25-45), and 2004 ($40, range $25-$50), but is $10 less in comparison to the market price reported by the 2003 REU sample ($50, range $40-$50). The market price and last purchase price for a gram of methamphetamine powder was $325 (range $45-400) and $350 (range $150-400) respectively. One KE noted that the price for one point of methamphetamine powder ranged between $40-70.

The median market price and last purchase price for one point of methamphetamine base was $40 (range $30-300) and $40 (range $10-300) respectively, which is consistent with the last reported price among the 2005 participants. The median market price and last purchase price for one gram of methamphetamine base was $300 (range $300-$350) and $350 (range $45-400) respectively. Whereas these figures are largely consistent with previous years of the study, they are all based on relatively small sample sizes and should be interpreted with caution.

The median reported market price and last purchase price of one point (0.1g) of crystal methamphetamine was $50 (range $1-50) and $50 (range $40-50) respectively in 2006, which is $10 greater than the other methamphetamine forms. Whereas these prices are consistent with the figures reported in 2003, 2004, and 2005, it should be noted that few REU were able to confidently comment on the price of crystal methamphetamine in 2004, 2005, and 2006 relative to the 2003 sample. The median market price for one gram of crystal methamphetamine was $350 (range $150-450). A single participant had last purchased one

gram of crystal methamphetamine for $150. Changes in the price of crystal methamphetamine across time should be interpreted with caution due to small sample sizes.

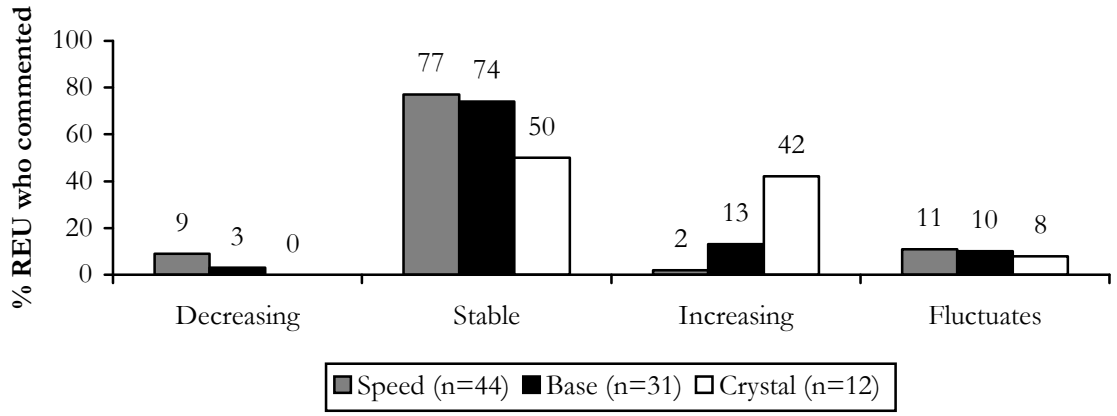
Table 15: Price of various methamphetamine forms purchased by REU, 2003-2006

Median price ($)	2003	2004	2005	**2006**
Speed				
Point	$50 (40-50) n=41	$40 (25-55) n=49	$40 (25-50) n=37	**$40 (30-50) n=31**
Gram	$200 (30-300) n=11	$300 (50-400) n=18	$325 (200-400) n=22	**$325 (45-400) n=28**
Base				
Point	$50 (35-300) n=16	$50 (40-200) n=14	$50 (40-60) n=11	**$40 (30-300) n=26**
Gram	$300 (250-375) n=5	$300 (50-350) n=7	$350 (300-400) n=3	**$300 (300-350) n=9**
Crystal				
Point	$50 (35-100) n=31	$50 (40-75) n=11	$50 (50-60) n=3	**$50 (35-50) n=7**
Gram	$400 (300-500) n=8	$350 (250-400) n=4	$400 (350-500) n=3	**$350 (150-450) n=11**
Last purchase price ($)				
Speed				
Point	$40 (3-65) n=47	$40 (20-50) n=41	$40 (25-50) n=36	**$40 (30-50) n=27**
Gram	$300 (30-320) n=9	$300 (50-400) n=11	$300 (200-400) n=14	**$350 (45-400) n=11**
Base				
Point	$40 (20-50) n=14	$50 (30-55) n=14	$45 (30-50) n=8	**$40 (10-300) n=25**
Gram	$275 (200-300) n=4	$300 (250-350) n=3	$300 (250-400) n=3	**$350 (300-350)n=7**
Crystal				
Point	$50 (35-100) n=22	$50 (40-50) n=6	$50 (50-60) n=3	**$50 (40-50) n=8**
Gram	$450 (400-450) n=3	$350 (350-350) n=2	$375 (350-400) n=2	**$150 n=1**

Source: EDRS Regular ecstasy user interviews 2003-2006

Figure 10 shows that a greater proportion of the REU sample was able to comment on recent price changes of methamphetamine powder (44%) and methamphetamine base (31%) in comparison to crystal methamphetamine (12%). Three-quarters of those who commented on methamphetamine powder (77%) and methamphetamine base (74%) in the preceding six months indicated that the price had remained stable. Whereas one-half (50%) of those that commented on crystal methamphetamine indicated that the price of the drug had remained stable during the six months preceding the interview, a further two-fifths (42%) indicated that the price of crystal methamphetamine had recently increased.

Figure 10: Recent changes in price of various methamphetamine forms purchased by REU, 2006



Source: EDRS Regular ecstasy user interviews 2006

Tasmania Police area drug bureaux gather regular information regarding current prices of illicit drugs, both through informant reports and covert drug purchases. Since July 1999, this has been provided to the authors through the Tasmanian Police State Intelligence Services and, prior to this, such information has been attained through the Australian Bureau of Criminal Intelligence (ABCI, now the Australian Crime Commission). During the 2004/05 financial year, Tasmania Police reported prices as being $50 per 'point' (0.1g) of methamphetamine, $400-500 per two grams, and $5000 per ounce (Table 16). While consumers did not typically purchase methamphetamine in large amounts, the prices reported by police for 'street deal' purchases (0.1g) were consistent with REU and KE reports of prices in the current survey – although over a longer time period – providing support for REU and KE suggestions that the price of methamphetamine had remained stable in the preceding six months. It should be noted that the prices reported in Table 16 for the 2003/04 financial year are substantially greater than those reported for the 2001/02 financial year. It is likely that this change is due to a shift in focus in that the earlier reported prices were primarily reflective of the prices of methamphetamine powder, which was the form that Tasmania Police were primarily identifying at this time. Data for the 2005/06 reporting period was unavailable at the time of publication.

Table 16: Methamphetamine prices in Tasmania reported by the Tasmania Police drug bureaux, 1996-2005

	Point (~0.1g)	Street gram (0.6-0.8g)	Full gram (1.0g)	Ounce (28g)
July-Sept 1996	*price not reported*	$50-80	$100-120	$1400
Oct-Dec 1996	*price not reported*	$50-80	$100-120	$1400
Jan-Mar 1997	*price not reported*	$50-80	$100-120	$1400
April-June 1997	*price not reported*	$70-80	$100-120	$1400
July-Sept 1997	*price not reported*	$50	$100-120	$1200-1400
Oct-Dec 1997	*price not reported*	$50	$100-120	$1400-1600
Jan-Mar 1998	*price not reported*	$50	$70-100	$1400-1600
April-June 1998	*price not reported*	$50	$70	$1400-1600
July-Sept 1998	*price not reported*	*price not reported*	*price not reported*	*price not reported*
Oct-Dec 1998	*price not reported*	$50	$70-80	$1200-1400
Jan-Mar 1999	*price not reported*	$50	$70-80	$1200-1400
April-June 1999	*price not reported*	$50	$70-80	$1200-1400
July-Sept 1999	$50	*price not reported*	*price not reported*	*price not reported*
Oct-Dec 1999	$50	$50	$70-80	$1200-1400
Jan-Mar 2000	$40-50	$40-50	$70-80	$1200-1400
April-June 2000	$40-50	$40-50	$70-80	$1200-1400
July-Sept 2000	$40-50	$40-50	$70-80	$1200-1400
Oct-Dec 2000	*price not reported*	$40-50	$70-80	$1200-1400
Jan-Mar 2001	$40-50	$40-50	$70-80	$1200-1400
April-June 2001	$40-50	$40-50	$70-80	$1200-1400
July-Sept 2001	$40-50	$40-50	$70-80	$1200-1400
Oct-Dec 2001	$40-50	$40-50	$70-80	$1200-1400
Jan-Mar 2002	$40-70	$40-50	$70-80	$1200-1400
April-June 2002	$40-70	$40-50	$70-80	$1200-1400
July-Sept 2002	$50-60	*price not reported*	*price not reported*	*price not reported*
Oct-Dec 2002	$50-60	*price not reported*	*price not reported*	$3500-5000
Jan-Mar 2003	$50	$100-300	$200-300	$5000
April-June 2003	$50	$150	$400	$5000-6000
July-Sept 2003	$50-70*	$100-300	$300-600*	$3000-10000*
Oct-Dec 2003	$50-70*	$100-300	$300-600*	$3000-10000*
Jan-Mar 2004	$50-70*	$100-300	$300-600*	$3000-10000*
April-June 2004	$50-70*	$100-300	$300-600*	$3000-10000*
July-Sept 2004	$50†	*price not reported*	*price not reported*	$5000
Oct-Dec 2004	$50†	*price not reported*	*price not reported*	$5000
Jan-Mar 2005	$50†	*price not reported*	*price not reported*	$5000
April-June 2005	$50†	*price not reported*	*price not reported*	$5000

Source: Australian Crime Commission; Tasmania Police State Intelligence Services

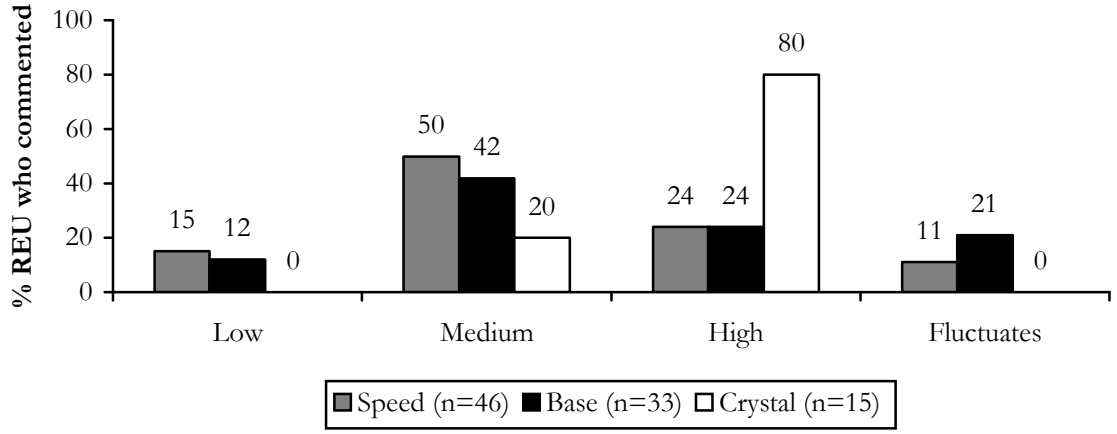
*****Note: these prices are those reported by Tasmania Police State Intelligence Services. For this period, the Australian Crime Commission reported the following prices: $50-60 per 0.1g; $200-400 per 1.0g; $3500-6000 per ounce. †Note: in the 2004/05 report, financial year prices only were reported, but are displayed in the above table in quarters for consistency with previous years. Additionally, in the 2004/05 financial year period, the Australian Crime Commission reported the following prices not included in the table: $400-500 per 2 grams; $800 per 3.5 grams; $1600 per 7 grams.

5.3 Purity

Figure 11 shows that a greater proportion of the REU sample was able to comment on the strength or purity of methamphetamine powder (46%) and methamphetamine base (33%) in comparison to crystal methamphetamine (15%). As such, the purity estimates of the latter form should be interpreted with caution. One-half (50%) of those who commented on the purity of methamphetamine powder indicated that it was medium in purity, with smaller proportions reporting that it was high (24%), low (15%), or that it fluctuated (11%) in purity in recent months. Similarly, two-fifths (42%) of those who commented on the purity of methamphetamine base perceived it to be medium in purity with a smaller proportion indicating that it was high (24%), low (12%) or fluctuating (21%) in purity. This is in contrast to 2005, when one-half (54%) reported that base was high in purity (see Matthews & Bruno, 2006). A majority (80%) of those who commented on crystal methamphetamine indicated that it was high in purity and one-fifth (20%) indicated that it was medium in purity. One KE also commented that crystal methamphetamine was often high in purity.

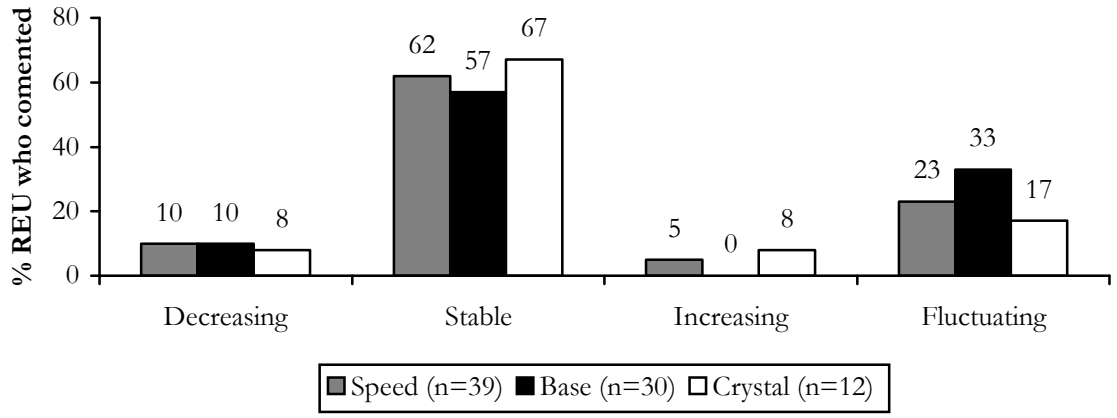
Figure 12 shows that a greater proportion of REU respondents were able to comment on changes in the purity of methamphetamine powder (39%) and methamphetamine base (30%) in comparison to crystal methamphetamine (12%). Methamphetamine powder was considered to be stable (62%) or fluctuating (23%) in purity, with smaller proportions indicating that it had recently decreased (10%) or increased (5%) in purity during the six months preceding the interview. Methamphetamine base was reported to be stable (57%) or fluctuating (33%) in purity, and a small proportion (10%) noted a recent decrease in purity. Crystal methamphetamine was reported to be stable (67%) or fluctuating (17%) in purity with smaller proportions noting a recent decrease (8%) or increase (8%) in purity (Figure 12).

Figure 11: User reports of current methamphetamine purity, 2006



Source: EDRS Regular ecstasy user interviews 2006

Figure 12: User reports of changes in methamphetamine purity in the past six months, 2006



Source: EDRS Regular ecstasy user interviews 2006

Data for purity of methamphetamine received at police analytical laboratories have been provided for the 1997/98 to 2004/05 financial years (Table 17, Table 18). Data for the 2005/06 financial period was not available at the time of publication. All amphetamine-type stimulants tested for purity during 2003/04 and 2004/05 were methylamphetamine rather than amphetamine. Drugs seized by Tasmania Police are only tested for composition and purity if the alleged offender pleads not guilty to the associated charge. Hence, purity data for drug seizures in the state are minimal. This very restricted sample size renders it difficult to make inferences about trends in purity of methamphetamine. However, the data do seem to suggest that the level of purity of consumer-type amounts of methamphetamine seized in Tasmania had remained relatively stable over the period 1997/98 to 2000/01. The apparent sharp 'jump' in purity of analysed methamphetamine samples between 2000/01 and 2001/02 related to samples analysed in the October-December 2001 and January-March 2002 period (Table 18). This increase in purity may have simply reflected the analysis of a more representative sampling of methamphetamine seizures (afforded by the greater sample size) rather than being indicative of changes in market purity, particularly given the decline in both number and purity of analysed seizures in subsequent months (Table 17).

Overall purity data in 2004/05 represent an increase in purity (32.3%) when compared to those analysed in the previous year (16.9%: Table 17), and are in line with REU reports of 'medium' purity levels overall for methamphetamine powder, the most commonly used form of the drug. This is tempered, however, by the analysis of a very small number (n=10) of seizures in 2004/05 (n=10), and that they were all small seizures of the drug (two grams or less), which have, in previous years, been higher in purity than seizures of larger amounts (purity range of 2-81% for seizures of 2 grams or less, and 4-22% for larger seizures analysed in 2003/04). While, again, it is difficult to make inferences from such a small number of analysed seizures, it is notable that the purity range of analysed seizures, which has been steadily increasing in recent years (0.5-50% in 2000/01; 0.1-70.6% in 2001/02; 1.9-78.5% in 2002/03; 2.4-80.5% in 2003/04) had declined in 2004/05 (18.5-35.5%). The particularly high-

purity seizures in previous years are uncommon by national standards (ACC, 2005) and may reflect the selection of particularly unusual seizures of the drug for analysis by police[4].

Table 17: Purity of seizures of methamphetamine made by Tasmania Police received for laboratory testing, 1997/98-2004/05

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05
≤2g								
n	*4*	*31*	*9*	*10*	*20*	*30*	*9*	*10*
Avg % purity	5 %	5 %	7.4 %	10.4%	26.6%	12.7%	25.6%	32.3%
> 2g								
n	*2*	*8*	*11*	*14*	*28*	*13*	*14*	-
Avg % purity	7 %	21 %	6.6 %	3.6 %	19.2%	11.2%	9.8%	-
Total								
n	*6*	*39*	*20*	*24*	*48*	*43*	*23*	*10*
Avg % purity	**6 %**	**8 %**	**7 %**	**6.4 %**	**22.2%**	**12.2%**	**16.9%**	**32.3%**
Range in % purity	3-8%	2-59%	2-26%	0.5-50%	0.1-70.6%	1.9-78.5%	2.4-80.5%	18.5-35.5%

Source: Australian Bureau of Criminal Intelligence; Australian Crime Commission; Tasmania Police State Intelligence Services. Note: No seizures made by the Australian Federal Police in the state were analysed during this period. All analysed seizures of amphetamines in this period revealed methylamphetamine rather than amphetamine.

[4]Anecdotal reports from Tasmania Police in previous IDRS surveys have suggested that these particularly high-purity samples may have been seizures of small amounts of crystal methamphetamine.

Table 18: Purity of Tasmanian seizures of methamphetamine made by Tasmania Police received for laboratory testing, by quarter, Jan 2001-June 2005

	Jan-Mar 2001	Apr-Jun 2001	Jul-Sep 2001	Oct-Dec 2001	Jan-Mar 2002	Apr-Jun 2002	Jul-Sep 2002	Oct-Dec 2002	Jan-Mar 2003	Apr-Jun 2003	Jul-Sep 2003	Oct-Dec 2003	Jan-Mar 2004	Apr-Jun 2004	Jul-Sep 2004	Oct-Dec 2004	Jan-Mar 2005	Apr-Jun 2005
<=2 g																		
n	*9*	*1*	*1*	*6*	*12*	*1*	*3*	*4*	*4*	*19*	*2*	*2*	*4*	*1*	*10*	-	-	-
Median % purity	3.2%	5.2%	9.0%	31.1 %	26.0 %	6.7%	6.4%	5.9%	13.1 %	13.1 %	40.0 %	28.4 %	50.6 %	16.9 %	32.3 %	-	-	-
> 2g																		
n	*12*	*2*	*6*	*7*	*13*	*2*	*1*	*4*	*7*	*1*	*8*	*1*	*5*	-	-	-	-	-
Median % purity	3.8%	3.1%	5.5%	30.1 %	20.0 %	18.5 %	6.3%	10.4 %	12.8 %	7.6%	17.4 %	15.4 %	4.1%	-	-	-	-	-
Total																		
n	*21*	*3*	*7*	*13*	*25*	*3*	*4*	*8*	*11*	*20*	*10*	*3*	*9*	*1*	*10*	-	-	-
avg % purity	3.4%	4.3%	6.8%	30.1 %	24.9 %	6.7%	6.4%	10.4 %	12.8 %	13.0 %	17.4 %	25.6 %	4.1%	16.9 %	32.3 %	-	-	-

Source: Australian Bureau of Criminal Intelligence; Australian Crime Commission; Tasmania Police State Intelligence Services. Note: No seizures made by the Australian Federal Police in Tasmania were submitted for purity testing in this period. All analysed seizures of amphetamines in this period revealed methylamphetamine rather than amphetamine. Figures represent the purity of seizures received at the laboratory within the relevant quarter, and the interim between the date of seizure by police and the date of receipt at the laboratory may vary between one day and several months.

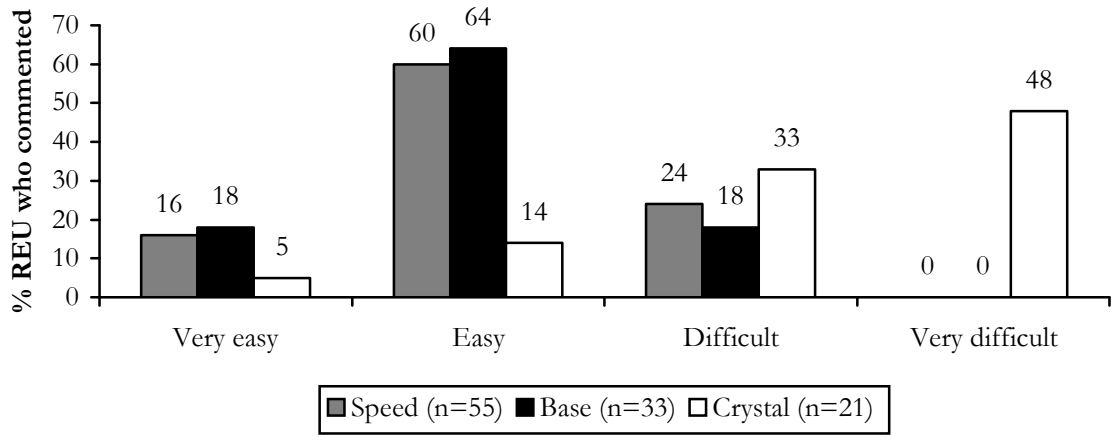
5.4 Availability

Figure 13 shows that a greater proportion of the REU sample was able to comment on the availability of methamphetamine powder (55%), followed by methamphetamine base (33%) and crystal methamphetamine (21%). The majority of those who commented on methamphetamine powder indicated that it was 'easy' (60%) or 'very easy' (16%) to obtain, and one-quarter (24%) reported that it was 'difficult' to obtain. Similarly, methamphetamine base was reported to be 'easy' (64%) or 'very easy' (18%) to obtain, with one-fifth (18%) indicating it was currently 'difficult' to obtain. A greater proportion indicated that base was 'easy' to obtain in 2006 (64%) relative to the 2005 sample (31%), and a smaller proportion indicated that base was 'difficult' to obtain (18% vs. 38%) (see Matthews & Bruno, 2006). In contrast, crystal methamphetamine was reported to be 'difficult' (33%) or 'very difficult' (48%) to obtain, with only small proportions indicating that it was currently 'very easy' (5%) or 'easy' (14%) to obtain.

Figure 14 shows REU comments on changes in the availability of methamphetamine in the six months preceding the interview. Over half of those who commented on changes in the availability of methamphetamine powder indicated that it had remained 'stable' (64%), while smaller proportions indicated that the drug had become 'more difficult' (19%), or 'easier' (10%) to obtain or had 'fluctuated' (6%) in availability during the preceding six months. Similarly, three-quarters of those who commented on the availability of methamphetamine base (78%) indicated that it had recently remained 'stable', while smaller proportions indicated that the drug had become 'more difficult' (13%), or 'easier' (3%) to obtain or had 'fluctuated' (6%) in availability. In contrast, four-fifths (81%) of those who commented on changes in the availability of crystal methamphetamine indicated that it had recently become 'more difficult' to obtain the drug, and only small proportions indicated that the availability of crystal was 'stable' or that it had recently become 'easier' to obtain (10%).

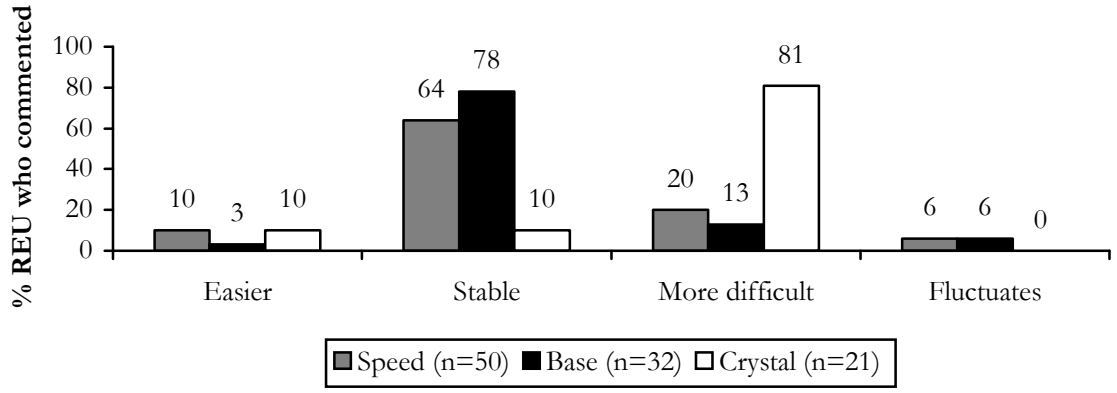
The comments of KE on the availability of each methamphetamine form were varied. Three KE commented that the availability of methamphetamine powder had increased and one KE commented that the availability of powder had decreased. Whereas one KE indicated that the availability of base was currently low in Hobart, another commented that base was the most readily available form in Hobart. Similarly, whereas two KE noted that the availability of crystal was currently low, three KE commented that that there had been a recent increase in the availability of crystal, and four KE noted that there had been a recent decrease in availability.

Figure 13: Current availability of methamphetamine forms, 2006



Source: EDRS Regular ecstasy user interviews 2006

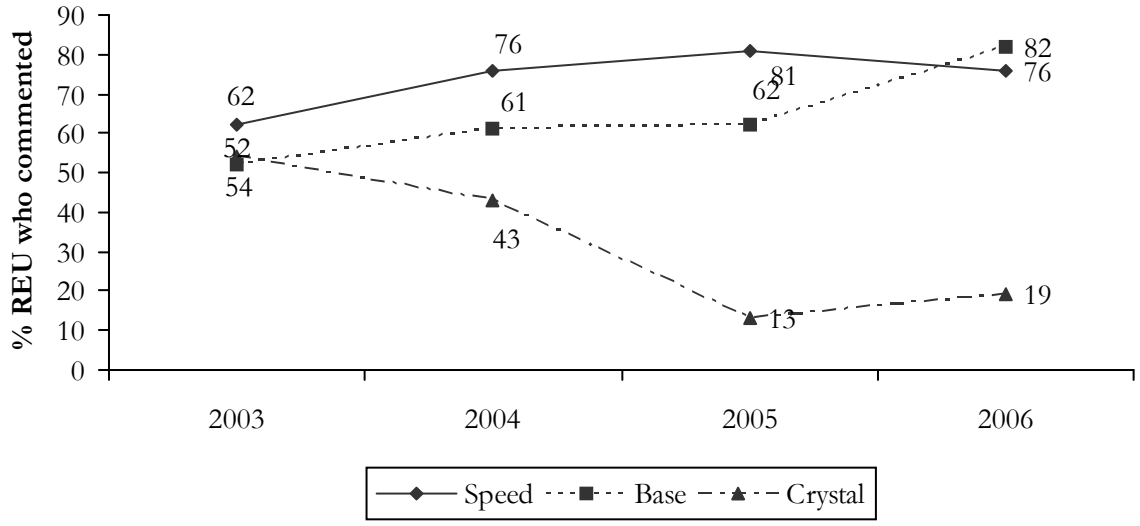
Figure 14: Change in the availability of various forms of methamphetamine in the preceding six months, 2006



Source: EDRS Regular ecstasy user interviews 2006

Figure 15 shows the proportion of the REU sample who indicated that each methamphetamine form was 'very easy' or 'easy' to obtain across the four years of the study. The proportion of the sample that indicated that methamphetamine powder was 'very easy/easy' to obtain increased from 62% to 76% between 2003 and 2004 but has remained relatively stable across the latter three cohorts (76%, 81%, and 76%). The availability of methamphetamine base increased from 52% in 2003 to 61% in 2004, was stable at 62% in 2005, rising to 81% in 2006. The reported availability of crystal methamphetamine was at it highest in 2003 (54%), decreasing to 43% in 2004, and 13% in 2005, remaining relatively stable in 2006 at 19%. However, it should be noted that a greater number of participants were able to comment on methamphetamine base (33 vs. 16) and crystal methamphetamine (21 vs. 8) in 2006 relative to 2005.

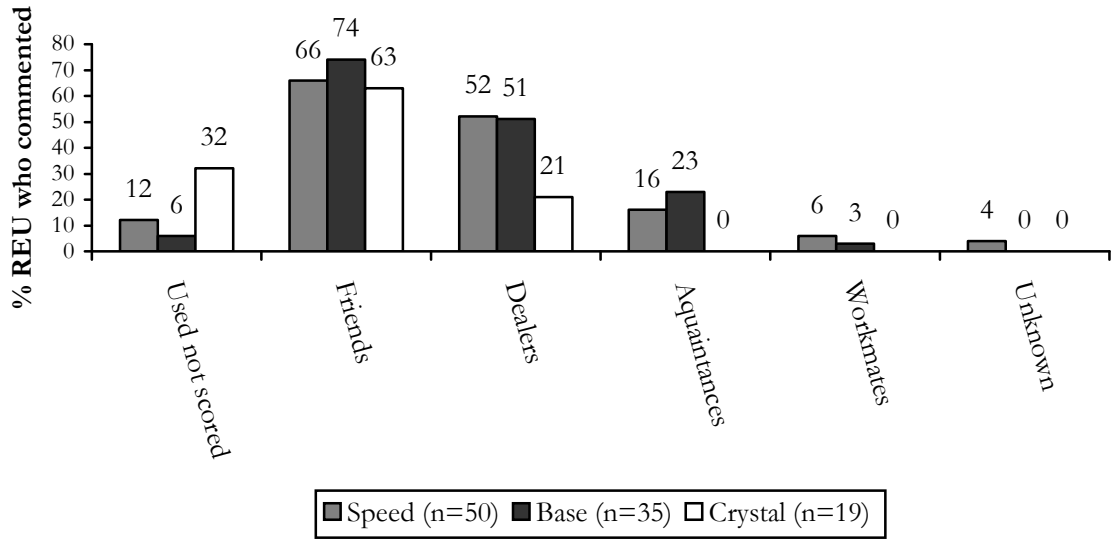
Figure 15: Changes to current availability over time: proportion of REU who report various forms of methamphetamine as 'very easy' or 'easy' to obtain in the six months preceding interview, 2003-2006



Source: EDRS Regular ecstasy user interviews 2006

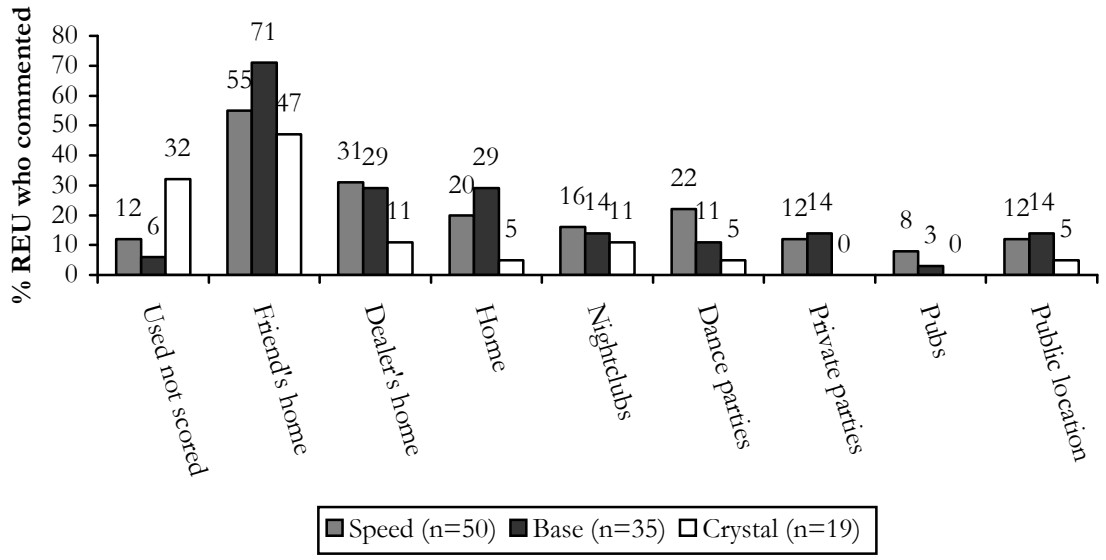
REU were asked who they had obtained each methamphetamine form in the last six months and at which locations they had normally obtained the drug (see Figure 16 and Figure 17). Methamphetamine powder was typically obtained from friends (66%), dealers (52%) or acquaintances (16%), followed by workmates (6%) and unknown dealers (4%). Consistent with this, methamphetamine powder was typically obtained from private residences such as a friend's home (55%), the consumer's own home (20%), or a dealer's home (31%), with smaller proportions obtaining the drug at nightclubs (16%), dance-related events (22%), private parties (12%), public locations (12%) or public bars (8%). Methamphetamine base was typically obtained from friends (74%), and dealers (51%), followed by acquaintances (23%), workmates (6%), and unknown dealers (4%). Methamphetamine base was typically obtained at a friend's home (71%), dealer's home (29%), or the consumer's own home (29%), with smaller proportions obtaining the drug at nightclubs (14%), private parties (14%), public locations (14%), dance parties (11%) and public bars (3%). Crystal methamphetamine was most commonly obtained from dealers (21%), followed by friends (63%) or had not been 'scored' directly by the consumer (32%). Crystal methamphetamine was typically obtained at a dealer's home (11%), friend's home (47%), nightclub (11%) or dance party (5%), followed by own home (5%) or a public location (5%).

Figure 16: People from whom methamphetamine powder, base and crystal were purchased in the preceding six months, 2006



Source: EDRS Regular ecstasy user interviews 2006

Figure 17: Locations where methamphetamine powder, base and crystal were purchased in the preceding six months, 2006



Source: EDRS Regular ecstasy user interviews 2006

Tasmania Police seizures (Table 19) of drugs suspected to be methamphetamine have varied somewhat in recent years, following a reasonably stable level of seizures in the 2000/01 and 2001/02 financial years (3,303g and 3,041g respectively), falling to 2,022g in 2002/03 and 1,182g in 2003/04, but increasing again in 2004/05 to 2,283g[5]. There has been a more steady increase in the number of tablets seized believed to be methamphetamine (or pharmaceutical stimulants) in recent years, increasing from 23 in 2000/01, 44 in 2001/02, 70 in 2002/03, 192 in 2003/04 and 261 in 2004/05 (Table 21). Data for the 2005/06 financial year was not available at the time of publication.

[5] Data reported by the Australian Crime Commission (ACC) differs to that provided by Tasmania Police State Intelligence Services (SIS), with the ACC reporting 109 seizures, totalling 1,737g of 'amphetamine-type stimulants' made in Tasmania during the 2003/04 financial year. As the other data reported in Table 21 represent SIS figures, SIS figures for 2003/04 and 2004/05 are reported for consistency.

Table 19: Tasmania Police data for methamphetamine: July 2000-June 2005

	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004	Jul-Dec 2004	Jan-Jun 2005
*Methamphetamine powder seized (g)**										
South	1113	330	469	1077	882	457	96	495	489	1472
North	17	86	70	1	196	27	23	44	36	114
West	1073	411	822	602	144	316	469	55	9	163
Total	2203g	827g	1361g	1680g	1222g	800g	588g	594g	534g	1749g
% within southern region	*51%*	*40%*	*34%*	*64%*	*72%*	*57%*	*16%*	*83%*	*92%*	*84%*
Methamphetamine tablets seized										
South	2	0	1	1	24	21	146	0	0	8
North	4	17	0	0	13	11	43	3	12	206
West	0	0	0	42	1	0	0	0	0	35
Total	6	17	1	43	38	32	189	3	12	249
% within southern region	*33%*	*0%*	*100%*	*2%*	*63%*	*66%*	*77%*	*100%*	*0%*	*3%*

Source: Tasmania Police State Intelligence Services

*This row includes powder seized and verified as containing methamphetamine, and unknown powder seized, believed to be methamphetamine.

5.5 Methamphetamine-related harms

5.5.1 Law enforcement

Arrest data for methamphetamine-related offences indicate a marked increase in the number of arrests between 1998/99 and 2000/01, with this upward trend sustained into 2001/02 (Table 20). The main increase over this period related to those charged with 'consumer'-type offences (such as use and possession), consistent with reports of increased availability and use of methamphetamines, although there was a concomitant, albeit less marked, increase in the number of supply-type arrests in this period. The 2002/03 financial year saw a decline in the number of arrests, with this reduction relating to a decline in the number of arrests for consumer-type offences rather than that of providers. In the 2003/04 financial year there was a continued reduction in the numbers of methamphetamine-related arrests, with both consumer- and provider arrest rates affected; however, arrest rates increased in the 2004/05 financial year for both offence types. While there have been some slight variations in the number of arrests in recent years, it is clearly apparent that there has been a marked and sustained increase in arrests in relation to methamphetamine in recent years, with arrest rates for both consumer and provider offences being substantially greater than those seen prior to 2000/01. Data for the 2005/06 financial year was unavailable at the time of publication.

Table 20: Consumer and provider arrests for methamphetamine and related substances, 1996/97-2004/05

	1996 /97 n	1997 /98 n	1998 /99 n	1999 /00 n	2000 /01 n	2001 /02 n	2002 /03 n	2003 /04 n	2004 /05 n
Consumers									
Female	3	5	0	4	9	18	8	10	20
Male	15	9	4	14	51	53	34	21	57
Unknown	0	1	2	2	0	0	0	0	0
Total	18	15	6	20	60	71	42	31	77
Providers									
Female	0	0	0	0	1	6	2	1	2
Male	2	0	1	7	9	12	17	7	27
Unknown	0	0	0	1	0	0	0	0	0
Total	2	0	1	8	10	18	19	8	29
Total Arrests	20	15	7	28	70	89	66	39	124*

Source: Australian Crime Commission (previously the Australian Bureau of Criminal Intelligence) and State Intelligence Services, Tasmania Police

Note: 'Consumer' refers to persons charged with use-type offences (e.g. possession, administration), while 'provider' refers to persons charged with supply-type offences (e.g. supply, cultivation or manufacture). Where a person has been charged with multiple offences within a category, that person is only counted once in these statistics.

*includes 18 cases related to methamphetamine or related drugs (dexamphetamine, pseudoephedrine) where consumer/provider status and gender was not recorded

5.5.2 Health

Alcohol and Drug Information Service data

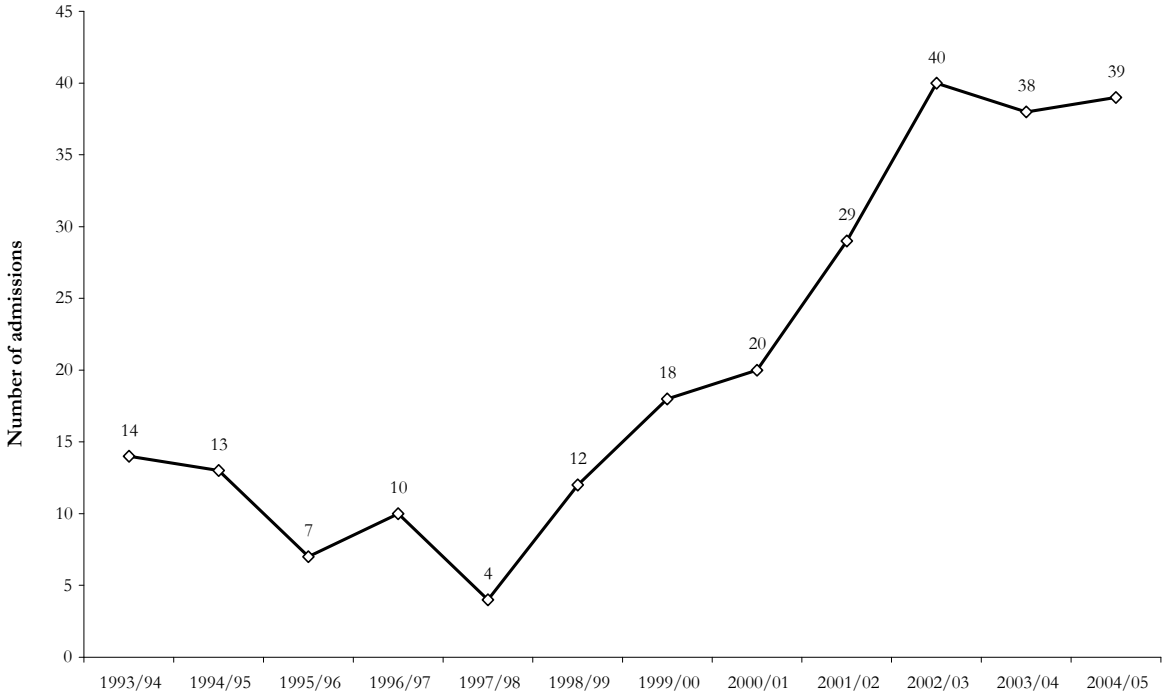
The Tasmanian Alcohol and Drug Information Service (ADIS) is a telephone information and referral service that is administered by Turning Point Alcohol and Drug Centre in Victoria. Figure 6 in Section 4.7.2 shows that calls in relation to amphetamine account for between 6% and 13.4% of all calls made to the service between the 2000/01 and 2004/05 reporting periods. The percentage of calls peaked at 13.4% in the 2004/04 financial year. Full data for the 2005/06 reporting period was not available at the time of publication, but the proportion of calls made in relation to amphetamines remained stable at 13% (ADIS & DACAS Annual Report, 2005/06)

Hospital admissions

Hospital morbidity data in relation to use of drugs have been provided by the Australian Institute of Health and Welfare for the 1993/04 to 2004/05 financial year periods (Roxburgh & Degenhardt, 2006). These data relate to Tasmanian public hospital admissions, for individuals aged between 15 and 54 years, where methamphetamine use was recorded as the 'principal diagnosis' – namely, where the effect of methamphetamine was established, after study, to be chiefly responsible for occasioning the patient's episode of care in hospital (with the exception of admissions for psychosis and withdrawal). These figures were based on diagnoses coded according to the International Classification of Diseases (ICD) 10, second edition. It is also important to note that data from the state's single public specialist detoxification centre are only included in this dataset from June 2002.

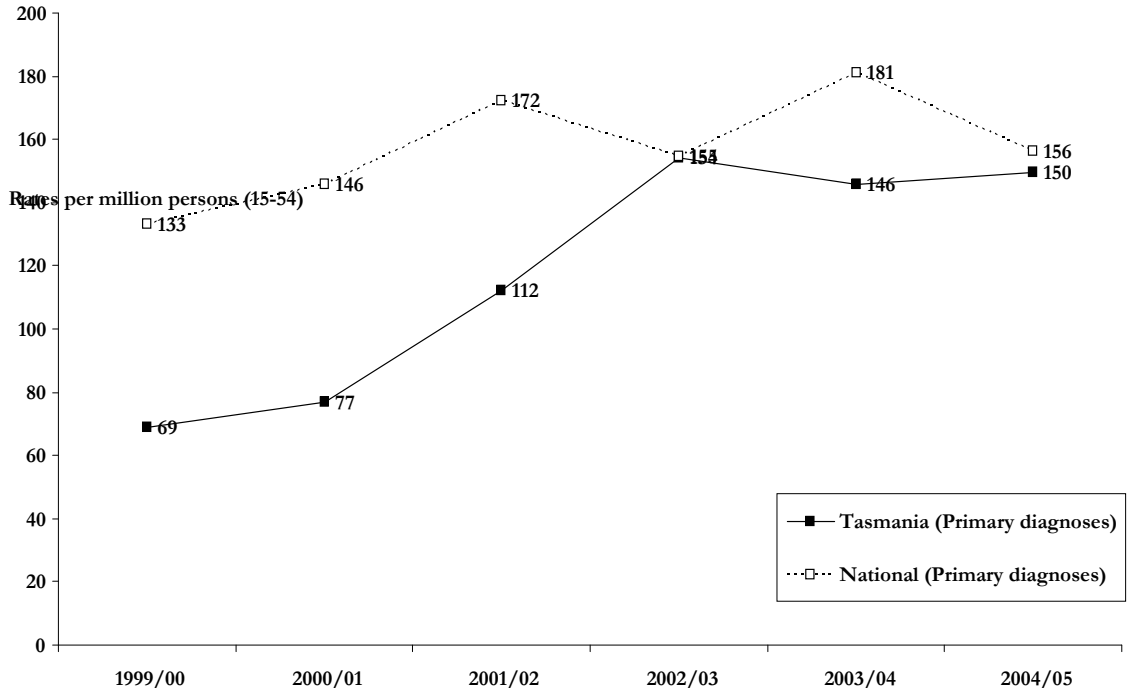
Tasmanian public hospital admissions where methamphetamine use was noted as the principal diagnosis are presented in Figure 18 below. It is clear that, following a relatively stable period between 1993/94 and 1998/99, where there were less than 15 such cases per annum, the number of admissions where methamphetamine use was the principal diagnosis steadily increased between 1999/00 and 2002/03, approximately doubling during this period, with rates appearing to stabilise between 2002/03 and 2004/05. When the population-adjusted rates of Tasmanian admissions are compared with those nationally (Figure 19), two trends are notable: firstly, that both local and national admission rates were increasing steadily between 1999/00 and 2001/02, although local population-adjusted rates were substantially lower than the national figures during this period (with Tasmanian admission rates half that of the national figures in 1999/00 and 2000/01, and two-thirds of the national level in 2001/02). Secondly, the national admission rates for methamphetamine-related primary diagnoses began to plateau after steady increases in previous years in 2001/02, a trend which occurred in the Tasmanian context a year later (possibly reflective of the inclusion of data from the detoxification service for the first time in 2002/03). As such, in the 2002/03, 2003/04, and 2005/06 periods, the local admission rates have been very similar to those seen nationally, and Tasmanian rates of admission have remained relatively stable.

Figure 18: Public hospital admissions amongst persons aged 15-54 in Tasmania where methamphetamine use was noted as the primary factor contributing to admission, 1993/04-2004/05



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

Figure 19: Public hospital admissions among persons aged 15-54 where methamphetamine was noted as the primary factor contributing to admission, rates per million population for Tasmania and Australia 1999/00-2004/05



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

5.6 Summary of methamphetamine trends

- Consistent with previous years, use of methamphetamine was common among REU in 2006. Over three-quarters (78%) had used some form of methamphetamine in the preceding six months. Methamphetamine was typically swallowed or snorted and was used on a median of six times during this period (approximately monthly).
- Recent use of methamphetamine powder was most common (62%) followed by methamphetamine base (40%) and crystal methamphetamine (27%). Relative to 2005, the proportion that had recently used powder was lower (62% vs. 77%) and the proportion that had recently used base (40% vs. 23%) and crystal (27% vs. 10%) was higher in the 2006 cohort.
- Methamphetamine powder was typically swallowed or snorted, and used once every two months in small amounts (0.1g). The frequency of methamphetamine powder use has decreased slightly over the last three years.
- Methamphetamine base was typically swallowed, and was used on a median of 4 days during the six months preceding the interview. A median of two 'points' (~0.2g) of base were used in a typical session compared to a median of one 'point' (~0.1g) in previous years. Males were more likely to have recently used base in comparison to females.
- Crystal methamphetamine was typically smoked or swallowed, and a greater proportion reported smoking the drug in 2006 relative to 2005. Crystal had been used on a median frequency of 5 days in the preceding six months, with a median of one 'point' used in a typical session of use. Males were more likely to have recently used crystal in comparison to females.
- Over half of recent methamphetamine users (52%) had experienced no symptoms of psychological dependence on the methamphetamine SDS. However, almost one-fifth (19%) had experienced significant symptoms of dependence. High SDS scores were associated with greater frequency of methamphetamine use, use of methamphetamine with ecstasy, recent binge drug use, recent injecting drug use, and high ecstasy dependence and psychological distress scores.
- The median price for one 'point' (0.1g) of methamphetamine powder and methamphetamine base was $40, and the median price for one 'point' of crystal was $50. The price of methamphetamine base was $10 less in comparison to 2005.
- Methamphetamine powder and base were reported to be 'medium' to 'high' purity, whereas crystal methamphetamine was reported to be 'high' in purity. Subjective reports of REU suggest decreased purity of methamphetamine base relative to 2005.
- Methamphetamine powder and base were considered to be 'easy' or 'very easy' to obtain, and crystal methamphetamine was typically considered to be 'difficult' or 'very difficult' to obtain. The availability of methamphetamine base appears to have increased relative to 2005. Those that commented on crystal methamphetamine indicated that it had become more difficult to obtain in the last six months.
- The overall use of methamphetamine among REU in Tasmania has remained stable, but there have been some recent shifts in the use and market characteristics of each form.
- The recent use of powder is slightly lower than 2005 and there has been a gradual decrease in frequency of use since 2003.
- The recent use, frequency of use, and availability of base has increased relative to 2005, and the price has decreased.
- While the recent use of crystal has also increased relative to 2005, it is still half of that reported in 2003, and prices have remained stable, and availability low.

6.0 COCAINE

According to the findings of the 1998 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 1999) 2.4% of surveyed Tasmanian residents (n=29) reported ever trying cocaine, while 0.1% (n=3) had used it in the 12 months prior to interview. Findings of the 2001 survey (Australian Institute of Health and Welfare, 2002) were very similar, with 0.2% of those sampled in Tasmania reporting using the drug in the preceding year, compared to 1.3% nationally. In the 2004 National Drug Strategy Household Survey, it was similarly estimated (from the sample of 1,208 participants) that approximately 0.2% of Tasmanians had used cocaine in the year prior to interview, compared with 1.0% of Australians nationally (Australian Institute of Health and Welfare, 2005).

6.1 Cocaine use among REU

The lifetime use of cocaine has steadily increased among successive Tasmanian REU cohorts since 2003. Among the 2006 REU sample, over one-half (55%) had ever used cocaine, compared to two-fifths in 2005 (43%), one-third in 2004 (32%) and two-fifths in 2003 (44%) (see Table 21). There was no significant difference in the proportion of the male (53%) and female (57%) samples that had ever used cocaine. There was no significant difference in the mean age of those that had (M=25.3, SD=4.2) or hadn't (M=24.0, SD=7.0) ever used cocaine. However, based on a median split for age, a significantly greater proportion of 'older' participants had ever used cocaine in comparison to 'younger' participants (66% vs. 44%); χ^2=4.89, p<.05. The median age of first use of cocaine was 22 years (range 17-30 years) and there was no significant difference between the average age of first use for females (M=22.0, SD=2.6) and males (M=22.5, SD=2.7). Amongst the 2006 cohort, the majority of those who had ever used cocaine had snorted the drug (87%), and smaller proportions reported swallowing (46%), smoking (15%), and injecting (9%, n=5) the drug.

One-third of the 2006 REU sample had used cocaine during the six months preceding the interview compared to one-fifth (20%) in 2005 and one-tenth or less in 2004 (10%) and 2003 (7%) (see Table 21). There was no significant difference in the proportion of males (33%) and females (33%) that had recently used cocaine and no significant age differences. The median frequency of cocaine use was 2 days (range 1-6 days) in the preceding six months compared to a median of 1 day (range 1-5 days) in 2005 and a median of 2 days among the 2003 and 2004 samples. One-third (30%) of those that had recently used cocaine had done so on only one occasion in the preceding six months compared to over one-half among the 2005 sample. There was no significant difference between the median frequency of use for males (2 days, range 1-6) and females (1 day, range 1-6), or that of 'younger' or 'older' participants. Those that had recently used cocaine reported using a median of 0.5 grams (range 0.2-2 gram) or a median of 2 'points' (1-5 points) in a typical session, and 1 gram (range 0.2-4 grams) or 2 'points' (range 1-7) in the biggest session of use in the six months preceding the interview. The majority of those who had used cocaine in the preceding six months had snorted the drug (94%), with smaller proportions reporting that they had swallowed (39%) or injected (6%) the drug.

Those who had recently used cocaine were asked about the locations that they had typically used the drug (to be under the influence of its effects). Cocaine was most commonly used at private residences such as a friend's home (48%), the consumer's own home (33%) or private parties (33%), followed by nightclubs (29%), dance-related events (14%), a dealer's home (14%), pub (10%), outdoors (10%), car (10%), live music event (5%), public place (5%), or acquaintance's house (5%). The most common locations for last use of cocaine were at a friend's home (33%), the consumer's own home (19%), a nightclub (19%), pub (18%), private party (14%), outdoors (5%), or a dealer's home (5%). Locations of cocaine use are relatively

consistent with those observed between 2003 and 2005; however, sample sizes have been too small in previous years to make meaningful comparisons.

Table 21: Patterns of cocaine use among REU, 2003-2006

Cocaine	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	44	32	43	**55**
Median age first used cocaine (range)	21 (15-30)	21 (16-32)	20 (15-30)	**22 (17-30)**
Used preceding six months (%)	7	10	20	**33**
Of those who had used last 6 mths				
Median days used last 6 mths (range)	2 (1-10)*	2 (1-20)	1 (1-5)	**2 (1-6)**
Route of administration in last 6 mths				
Smoked (%)	14	-	15	**-**
Snorted (%)	71	70	90	**94**
Swallowed (%)	14	30	10	**39**
Injected (%)	-	10	-	**6**
Shafted/shelved (%)	-	-	-	**-**
Median quantities used in last 6 mths				
Median grams used typical session	0.1 (0.1-0.5)*	0.5 (0.5-1.5)*	0.5 (0.5-1)*	**0.5 (0.2-2.0)**
Median grams used biggest session	0.5 (0.1-0.5) *	1.0 (0.5-5.0)*	0.5 (0.5-1)*	**1 (0.2-4.0)**
Median points used typical session	-	1.0 (0.5-2) *	2 (0.25-3)	**2 (1-5)**
Median points used biggest session	-	0.75 (0.5-1) *	2 (0.25-4)	**2 (1-7)**
Locations typically used in last 6 mths	n=7	n=6	n=11	**n=21**
Home (%)	14	17	36	**33**
Dealer's home (%)	-	-	9	**14**
Friend's home (%)	28	67	9	**48**
Raves/doofs/dance parties	29	17	9	**14**
Nightclub (%)	42	50	36	**29**
Pub (%)	-	33	18	**10**
Restaurant/cafe	-	17	-	**-**
Private party (%)	14	17	9	**33**
Public place (street/park) (%)	-	-	9	**5**
Outdoors (%)	-	17	-	**10**
Car (%)	-	-	-	**10**
Live music event (%)	n/a	50	-	**5**
Work (%)	-	-	9	**-**
Acquaintance's house (%)	-	-	-	**5**
Other (%)	-	-	-	**5**

Source: EDRS Regular ecstasy user interviews 2003-2006

* n<10

Table 21: Patterns of cocaine use among REU, 2003-2006 (continued)

Cocaine	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Location last used cocaine	n=5	n=6	n=11	**n=21**
Home (%)	20	17	18	**19**
Dealer's home (%)	-	-	-	**5**
Friend's home (%)	40	33	9	**33**
Rave/doof/dance party	20	17	9	**-**
Nightclub (%)	20	33	18	**19**
Pub (%)	-	-	18	**-**
Private party (%)	-	-	-	**14**
Outdoors (%)	-	-	-	**5**
Live music event (%)	-	-	-	**-**
Public place (%)	-	-	9	**-**
Work (%)	-	-	9	**-**
Other	-	-	9	**5**

Source: EDRS Regular ecstasy user interviews 2003-2006

* n<10

Seven KE (n=7) indicated that they were not aware of cocaine use among the regular ecstasy users that they were familiar with. However, multiple KE (n=11) indicated that 'a few' of the regular ecstasy-using group also use cocaine, which is much greater than in previous years. Two KE indicated that there had been a recent increase in the use of cocaine among the group of REU that they were familiar with. Several REU (n=7) also noted anecdotally that there had been a recent increase in the use and availability of cocaine among themselves and their friends.

6.2 Price

Table 22 shows median prices and price variations reported by REU for cocaine between 2003 and 2006. The median price for one gram of cocaine in 2006 was $350 (range $250-300) which is consistent with the median prices reported in 2005 ($350, range $220-500) and 2004 ($325, range $200-400). The median price for the last purchase of one gram of cocaine was slightly lower at $310 (range $250-400) compared to $350 (range $180-400) in 2005. The median price for one point (0.1 of a gram) of cocaine was $50 (range $35-50) which is lower than the median price reported in 2005, $65 (range $60-70). Similarly, the median price for the last purchase of one point of cocaine was $45 (range $40-50) compared to $65 (range $60-70) in 2005. Two participants reported that they had purchased a 'line' of cocaine for between $50 and $60. Although the median price and last purchase price for one point of cocaine has decreased relative to previous years, these estimates are based on small sample sizes (n<10) and should be interpreted with caution. Three out of the four participants who commented (73%) indicated that the price of cocaine had remained stable in the six months preceding the interview and one-quarter (27%) indicated that the price had recently decreased.

Table 22: Price of cocaine purchased by REU and price variations 2003-2006

Median Price	2003	2004	2005	**2006**
Point (0.1 gram)	$65 (50-80)*	$70*	$65 (60-70) *	**$50 (35-50)** *
Half gram				**$225 (200-250)** *
Gram	$250 (200-400) *	$325 (200-400) *	$350 (220-500) *	**$350 (250-500)**
Last purchase price				
Point (0.1 gram)	$60*	-	$65 (60-70) *	**$45 (40-50)** *
Half gram	$125*	-	$180*	**$250***
Gram	$270 (200-400) *	$300 (200-400) *	$350 (180-400) *	**$310 (250-400)**
Price change last 6 mths	n=10	n=8	n=4	**n=11**
Increased (%)	10	13	25	**-**
Stable (%)	50	75	75	**73**
Decreased (%)	10	-	-	**27**
Fluctuated (%)	30	13	-	**-**

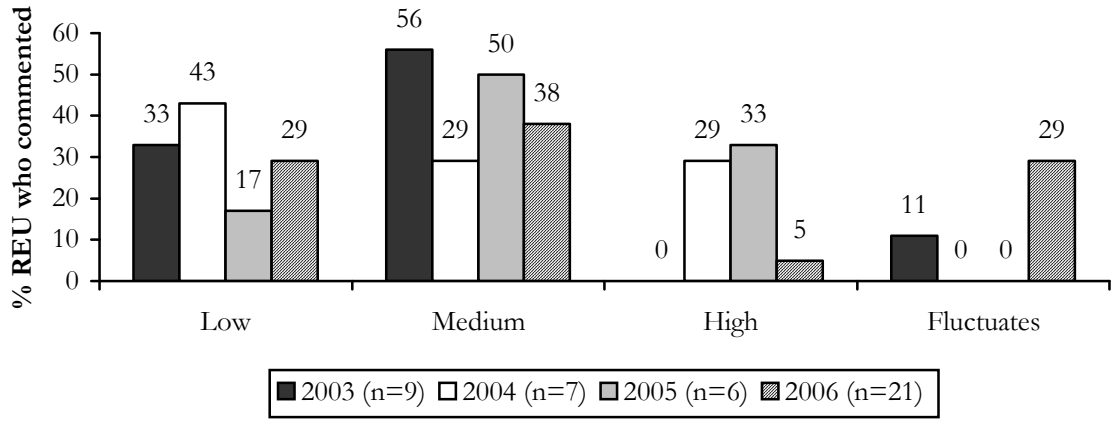
Source: EDRS Regular ecstasy user interviews 2003-2006
* n<10

Tasmania Police had been unable to report prices of cocaine from either informant reports or covert bust operations between 1995/96 and 1999/00; however, in 2001 Southern Drug Investigation Services estimated the price of cocaine as $250 per gram, on the basis of an informant report, and the price reported by Tasmania Police remained stable during the remainder of the 2001/02 financial year. Price information for cocaine has not been provided to the Australian Crime Commission between 2002/03 and 2004/05, reflecting the lack of a local market of the drug. Data for the 2005/06 financial year was unavailable at the time of publication.

6.3 Purity

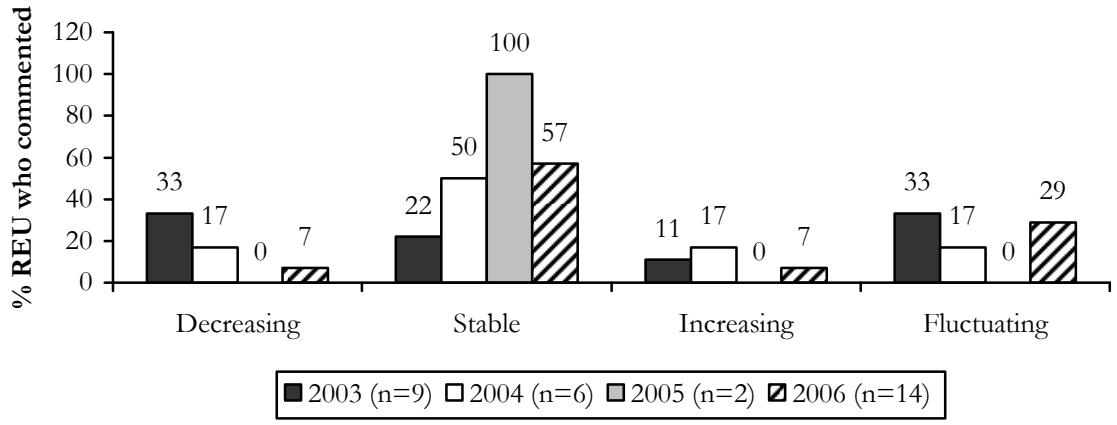
A greater number of REU were able to comment on the purity of cocaine in 2006 relative to previous years of the study (see Figures 20-21). Cocaine was reported to be medium (38%), low (29%) or fluctuating (29%) in purity and few respondents (5%) reported that cocaine was high in purity (Figure 20). Those that commented on changes in the purity of cocaine in the last six months indicated that it had remained stable (57%) or had fluctuated (29%), with few participants indicating that it had recently decreased (7%) or increased (Figure 21). It is not possible to compare trends in the purity of cocaine across time due to the small number of people able to comment in previous years of the study.

Figure 20: User reports of current purity of cocaine, 2003-2006



Source: EDRS Regular ecstasy user interviews 2003-2006

Figure 21: User reports of changes in cocaine purity in the past six months, 2003-2006



Source: EDRS Regular ecstasy user interviews 2003-2006

Three KE indicated that there had been a recent increase in the purity of cocaine in Tasmania.

The last analysed sample of cocaine seized within the state by Tasmania Police was from the first quarter of 2001. This was an amount of less than two grams, and was analysed during the first quarter of 2002 at 44.0% purity. Data for the 2005/06 financial year was unavailable at the time of publication.

6.4 Availability

Around one-quarter (n=24) of the REU sample was able to comment on the current availability of cocaine in 2006 (see Table 23). One-half of those who commented indicated that cocaine was currently 'easy' (38%) or 'very easy' (13%) to obtain and one-half indicated that cocaine was currently 'difficult' (33%) or 'very difficult' (17%) to obtain. Three-fifths (61%) indicated that the availability of cocaine had remained stable in the last six months, one-third (33%) indicated that the availability of cocaine had recently increased, and a small proportion (6%) indicated that it had fluctuated. Cocaine had typically been purchased from friends (48%), dealers (43%), and acquaintances (10%), or had not been scored directly by the

consumer (29%). Cocaine had typically been accessed at a dealer's home (48%), friend's home (33%) or had not been scored directly by the consumer (29%). Small proportions had scored cocaine at locations such as a nightclub (10%), an agreed public location (10%), a public bar (5%), at their own home (5%), a dance-related event (5%), private party (5%), or an acquaintance's home (5%).

Two KE indicated that the availability of cocaine is relatively low in Hobart, and six KE (n=6) commented that there had been a recent increase in the availability of the drug.

Table 23: REU reports of availability of cocaine in the preceding six months, 2003-2006

Cocaine	2003	2004	2005	**2006**
Ease of obtaining cocaine	n=32	n=9	n=13	**n=24**
Very easy (%)	3	11	-	**13**
Easy (%)	3	-	23	**38**
Moderately easy (%)	16	n/a	n/a	**n/a**
Difficult (%)	34	44	31	**33**
Very difficult (%)	44	44	46	**17**
Changes in availability in last 6 months	n=23	n=8	n=10	**n=18**
Stable (%)	83	63	90	**61**
Easier (%)	4	13	-	**33**
More difficult (%)	9	25	10	**-**
Fluctuates (%)	4	-	-	**6**
Persons scored from in last 6 months	n=5	n=6	n=11	**n=21**
Used not scored (%)	-	33	36	**29**
Friends (%)	80	67	18	**48**
Dealers (%)	40	17	27	**43**
Acquaintances (%)	-	-	9	**10**
Unknown dealers (%)	-	-	9	**-**
Locations scored from in last 6 months	n=5	n=6	n=11	**n=21**
Used not scored (%)	-	33	36	**29**
Own home (%)	-	17	-	**5**
Friend's home (%)	80	67	18	**33**
Dealers' home (%)	20	17	-	**48**
Raves/doofs/dance parties (%)	-	-	9	**5**
Nightclubs (%)	-	-	9	**10**
Pubs (%)	-	-	9	**5**
Private party (%)	-	-	-	**5**
Agreed public location (%)	-	-	9	**10**
Work (%)	-	-	9	**-**
Acquaintance's house (%)	-	-	-	**5**
Other (%)	-	-	9	**-**

Source: EDRS Regular ecstasy user interviews 2003-2006

6.5 Cocaine-related harms

6.5.1 Law enforcement

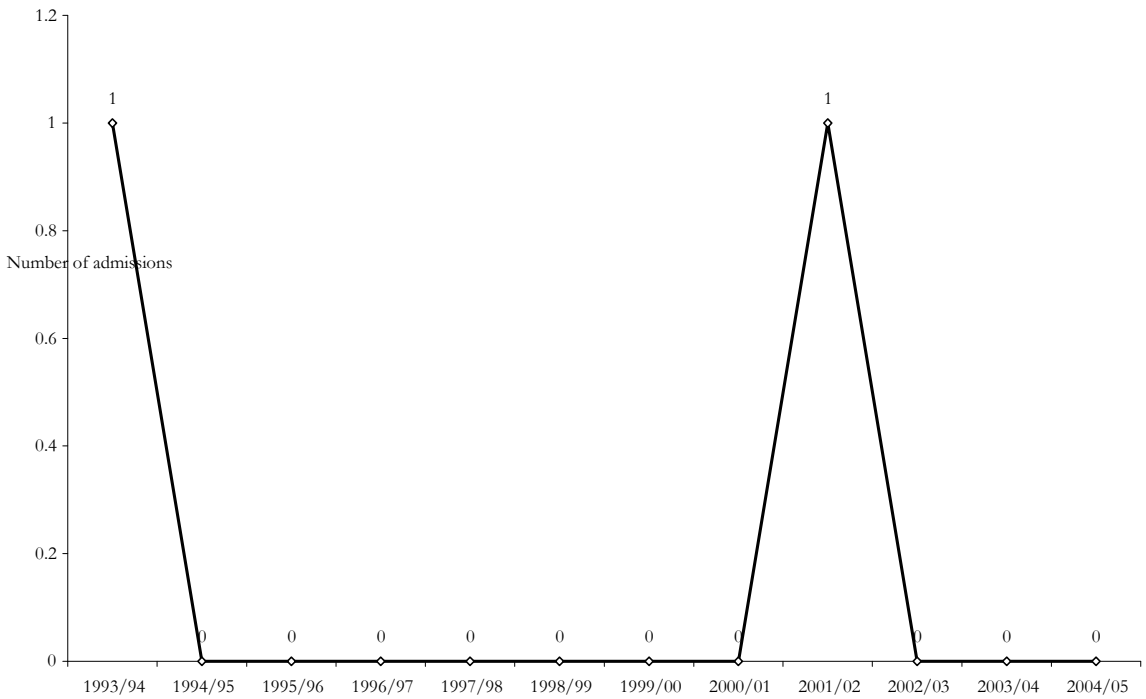
Tasmania Police have reported few seizures or arrests in relation to cocaine between the 1995/96 and 2003/04 financial years apart from two consumer arrests made during the 2000/01 period and one recorded seizure of 1g. (ABCI, 1996, 1997, 1998, 1999, 2000, 2001, 2002; ACC, 2003, 2004, 2005, 2006).

6.5.2 Health

There is little objective data available on mortality or access to treatment providers in relation to cocaine in Tasmania. However, the Australian Institute of Health and Welfare has provided hospital morbidity data in relation to drug use for the 1993/94 to 2004/05 financial year periods (Roxburgh & Degenhardt, 2006). Diagnoses were coded based on the International Classification of Diseases (ICD) 10, second edition. These data are based on Tasmanian public hospital admissions in which cocaine was recorded as the 'principal diagnosis'. A 'principal diagnosis' refers to the instance where it is established upon examination that the drug was principally responsible for the patient's episode in hospital. It is important to note that data from Tasmania's only public detoxification centre were included from only June 2002 onwards.

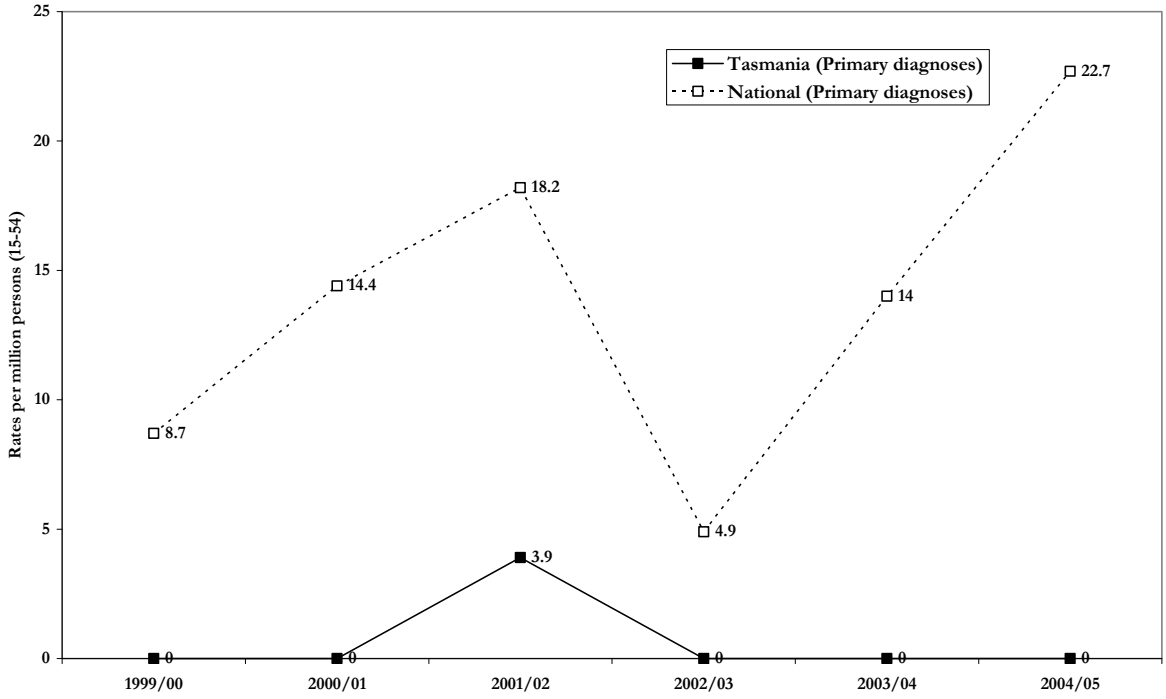
Consistent with the relatively low level of availability and use of cocaine locally, cocaine-related hospital admissions in Tasmania are very low (see Figure 22) with only two instances of admission where cocaine was the principal diagnosis between 1993/04 and 2004/05. Further, the rate of cocaine-related hospital admissions (per million of population) in Tasmania has been consistently and substantially lower in comparison to the national rate between 1999/00 and 2004/05 (Figure 22).

Figure 22: Public hospital admissions among persons aged 15-54 where cocaine use was noted as the primary factor contributing to admission in Tasmania, 1993/04-2004/05



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

Figure 23: Public hospital admissions among persons aged 15-54 where cocaine was noted as the primary factor contributing to admission, rates per million population for Tasmania and Australia, 1999/00-2004/05



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

6.6 Summary of cocaine trends

- The lifetime and recent use of cocaine has increased among the REU cohort since 2003. In 2006, over one-half (55%) of the REU sample had ever used cocaine, compared to two-fifths (43%) in 2005. One-third (33%) had used cocaine during the six months preceding the interview in 2006, compared to one-fifth (20%) in 2005, and one-tenth among the 2004 (10%) and 2003 (7%) samples. There were no significant sex differences in use.
- Cocaine was typically snorted and was used on a median frequency of two days (range 1-6 days) in the six months preceding the interview, with an average of 0.2 to 0.5 grams used in a typical session. Cocaine was typically used at private residences or nightclubs.
- Consistent with increased use of cocaine among REU, a greater number of participants were able to comment on the price, purity and availability of the drug relative to previous years.
- The median price for one gram of cocaine was $350 (range $250-500) and the price for one point of cocaine was $50 (range $35-50). Three-quarters of those that commented (73%) indicated that the price of cocaine had remained stable in the preceding six months, and one-quarter (27%) indicated that the price of cocaine had recently decreased.
- Cocaine was typically considered to be 'medium' to 'low', or 'fluctuating' in purity, and to have recently remained 'stable' or 'fluctuated' in purity during the six months preceding the interview.
- REU reports on the availability of cocaine were mixed, with one-half of those who commented indicating that it was 'easy' or 'very easy' to obtain and one-half indicating that it was 'difficult' or 'very difficult' to obtain. Three-fifths (61%) indicated that the availability of cocaine had remained stable during the six months preceding the interview, but one-third (33%) indicated a recent increase in availability.
- KE comments also indicated a recent increase in the use and availability of cocaine among REU in Hobart. This appears to be a distinct trend amongst REU demographic groups, as there had been no change apparent in use or availability of cocaine among regular injecting consumers in the 2006 Tasmanian IDRS (de Graaff & Bruno, 2007).
- Cocaine had typically been purchased from friends or dealers, but almost one-third of those that had used cocaine (29%) had not scored the drug themselves.
- Whereas the lifetime and recent use and the reported availability of cocaine is greater among the 2006 sample than previous cohorts, the median frequency of cocaine use is still relatively low and there have been no recent changes in the low-levels of cocaine-related harms in Tasmania.

7.0 KETAMINE

7.1 Ketamine use among REU

Almost one-quarter of the 2006 REU sample (23%) had used ketamine at some stage of their life compared to a similar proportion in 2005 (24%), less than one-fifth (18%) in 2004, and over one-third in 2003 (38%) (Table 24). A greater proportion of the male sample (29%) had ever used ketamine in comparison to the proportion of the female sample (14%), χ^2= 3.12, p=.078. However, this failed to reach conventional levels of statistical significance. A greater proportion of 'older' participants (32%) had ever used ketamine compared to 'younger' participants (14%), χ^2= 4.57, p<.05 (based on a median split for age). The median age of first use was 22 years (range 19-30 years, SD=3.1 years), and there was no significant difference between the average age of first use for males and females. The majority of those that had ever used ketamine had swallowed (57%) or snorted (44%) the drug, and smaller proportions had ever injected (13%, n=3), or smoked (4%, n=1) the drug.

Less than one-tenth of the REU sample (6%) had used ketamine in the six months preceding the interview in 2006, compared to 11% in 2005, 5% in 2004, and almost one-quarter (24%) of the 2003 sample (see Table 24). There was no significant difference between the proportion of males (9%) and females (2%) that had recently used ketamine or between the proportions of 'older' or 'younger' participants. Those that had recently used ketamine reported either swallowing (50%) or snorting (50%) the drug.

The median frequency of ketamine use was 2 days (range 1-3 days) in the six months preceding the interview or approximately once every three months. There were no significant sex or age differences in the median frequency of ketamine use. Those who had recently used ketamine reported using a median of 1 'bump'[6] (range 1-10) in a typical session of use and a median of 1 bump in the biggest session of use in the preceding six months. Whereas these quantities are relatively consistent with data from 2004 and 2005, these figures should be interpreted with caution due to the small number of participants reporting ketamine use during this time. A single respondent commented that they had used ketamine at a friend's home during the six months preceding the interview.

Seven of the key experts interviewed (n=7) were aware of some use of ketamine among the group of regular ecstasy users that they were familiar with. Three KE indicated that a use of ketamine is typically experimental and, whereas people may have tried it, use of the drug has never really become popular locally. One KE who worked in ambulance/emergency services noted one recent overdose episode associated with ketamine.

[6] Ketamine powder may be used in devices known as 'bump bottles' that facilitate snorting in small amounts of the drug. A single snort, or 'bump', is difficult to quantify, but may approximate 0.05-0.2g.

Table 24: Patterns of ketamine use among REU, 2003-2006

Ketamine	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	38	18	24	**23**
Median age of first ketamine use (range)	21 years (15-36)	21 years (18-24)	22 years (16-28)	**22 years (19-30)**
Used preceding six months (%)	24	5	11	**6**
Of those who had used in preceding 6 mths				
Median days used last 6 mths (range)	2.5 (1-24)	2 (1-5)*	3 (1-5)	**2 (1-3)***
Route of administration in last 6 months				
Snorted (%)	63	60	45	**50**
Swallowed (%)	67	80	91	**50**
Injected (%)	17	-	-	**-**
Median quantities used in last 6 mths (range)				
Median bumps used typical session	5 (2-5)*	1 (1-1)*	1 (1-2)*	**1 (1-10)***
Median pills used typical session	1.25 (0.5-2)*	1 (1-1)*	2 (2-2)*	**-**
Median bumps used biggest session	10 (2-20)*	3 (1-5)*	2 (2-2)*	**1 (1-20)***
Median pills used biggest session	5 (2-8)*	1.25 (1-1.5)*	2 (2-2)*	**-**
Locations typically used ketamine in last 6 mths	n=21	n=4	n=8	**n=1**
Home (%)	19	75	38	**-**
Dealer's home (%)	14	-	-	**-**
Friend's home (%)	29	50	75	**100**
Raves/doofs/dance parties	19	50	-	**-**
Nightclub (%)	48	25	-	**-**
Pub (%)	5	25	-	**-**
Restaurant/cafe	-	-	-	**-**
Private party (%)	14	25	25	**-**
Public place (street/park) (%)	-	-	-	**-**
Outdoors (%)	n/a	-	-	**-**
Car (%)	-	-	-	**-**
Live music event (%)	n/a	25	-	**-**
Other (%)	-	-	25	**-**
Location last used ketamine	n=21	n=4	n=8	**n=1**
Home (%)	19	50	13	**-**
Dealer's home (%)	5	-	-	**-**
Friend's home (%)	24	50	50	**100**
Rave/doof/dance party	10	-	-	**-**
Nightclub (%)	25	-	-	**-**
Pub (%)	-	-	-	**-**
Private party (%)	14	-	13	**-**
Outdoors (%)	n/a	-	-	**-**
Live music event (%)	n/a	-	-	**-**
Other (%)	-	-	25	**-**

Source: EDRS Regular ecstasy user interviews 2003-2006

7.2 Price

Regular ecstasy users were asked to estimate the market price of ketamine (Table 25). A single respondent indicated that one gram of ketamine was $180 which is relatively consistent with the median price of $190 ($180-280) reported in 2005. A single participant indicated that they had last purchased one point of ketamine for $40. A single participant indicated that the price of ketamine had remained stable in the six months preceding the interview. Due to small sample sizes, price estimates for ketamine and comparisons with previous years should be interpreted with caution.

Table 25: Price of ketamine purchased by REU, 2003-2006

Median Price	2003	2004	2005	**2006**
Tablet	$45 ($25-50)	$27.50 ($25-30) *	$20 ($20-35) *	**-**
Point (0.1 gram)	$50 ($25-60) *	$50*	-	**-**
Gram	$100 ($50-150) *	$50*	$190 ($180-280) *	**$180 n=1**
Vial	-	$300*	-	**-**
Vial (100ml)	-	$150*	-	**-**
Last purchase price				
Tablet	$47.50 ($25-50) *	$25*	$20 ($20-35) *	**-**
Point (0.1 gram)	-	-	-	**$40 n=1**
Half gram	-	-	-	**-**
Gram	-	-	$200 ($180-280) *	**-**
Vial	$60 (50-120) *	-	-	**-**
Vial (100ml)	-	$150*	-	**-**
Price change	n=14	n=3	n=5	**n=1**
Increased (%)	7	-	20	**-**
Stable (%)	79	100	80	**100**
Decreased (%)	7	-	-	**-**
Fluctuated (%)	7	-	-	**-**

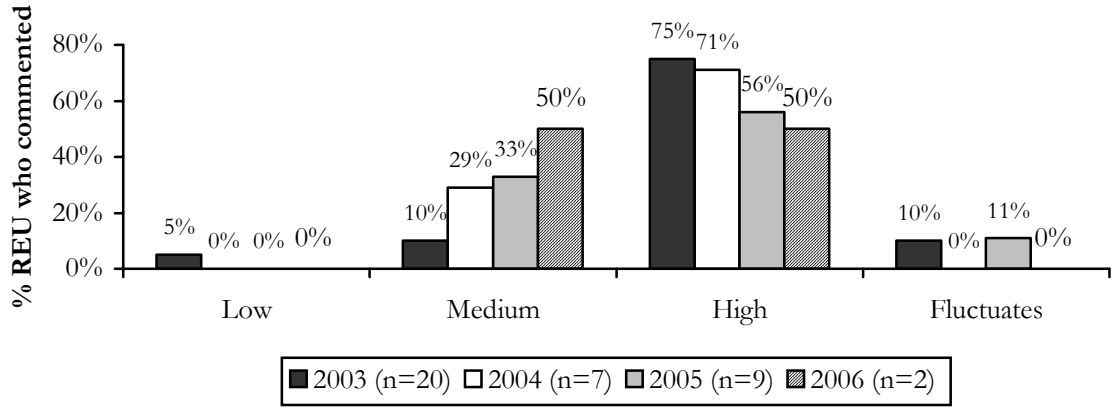
Source: EDRS Regular ecstasy user interviews 2003-2006

* n<10

7.3 Purity

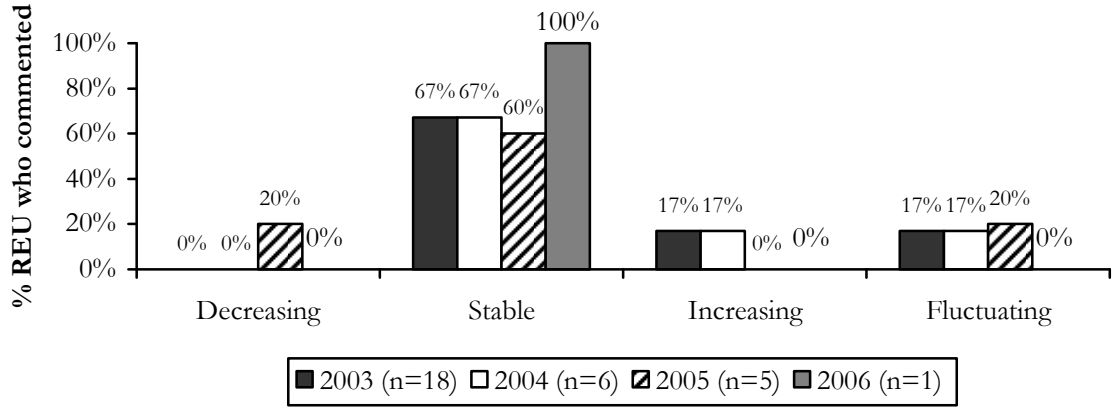
REU were asked to comment on the current purity of ketamine (Figure 24) and any changes in purity during the six months preceding the interview (Figure 25). Only two participants were able to comment on the purity of ketamine. One participant indicated that ketamine was high in purity and the other indicated that ketamine was medium in purity. Both participants reported that the purity of ketamine had remained stable during the six months preceding the interview. Estimates of purity for ketamine should be interpreted with caution due to small sample sizes.

Figure 24: User reports of current purity of ketamine, 2003-2006



Source: EDRS Regular ecstasy user interviews 2003-2006

Figure 25: User reports of changes in ketamine purity in the past six months, 2003-2006



Source: EDRS Regular ecstasy user interviews 2003-2006

7.4 Availability

Only two REU were able to comment on the availability of ketamine in 2006 (see Table 26). One participant indicated that ketamine was 'easy' to obtain and another indicated that ketamine was 'difficult' to obtain. The single respondent who commented on changes in the availability of ketamine in the preceding six months indicated that availability had remained stable during this time. A single respondent indicated that they had obtained ketamine from friends or dealers in the last six months and had scored the drug at their own home, a dealer's home, nightclubs and agreed public locations during this time.

Table 26: REU reports of availability of ketamine in the preceding six months, 2003-2006

Ketamine	2003	2004	2005	**2006**
Ease of obtaining ketamine	n=24	n=8	n=9	**n=2**
Very easy (%)	8	13	-	**-**
Easy (%)	29	25	11	**50**
Moderately easy (%)	46	n/a	n/a	**n/a**
Difficult (%)	17	50	78	**50**
Very difficult (%)	-	13	11	**-**
Changes in availability in last 6 months	n=24	n=6	n=6	**n=1**
Stable (%)	67	67	50	**-**
Easier (%)	21	-	-	**100**
More difficult (%)	5	33	33	**-**
Fluctuates (%)	-	-	17	**-**
Persons scored from in last 6 months	n=25	n=4	n=8	**n=1**
Used not scored (%)	-	25	13	**-**
Friends (%)	56	50	38	**100**
Dealers (%)	52	25	38	**100**
Workmates (%)	4	-	-	**-**
Acquaintances (%)	-	25	13	**-**
Unknown persons (%)	-	-	13	**-**
Locations scored from in last 6 months	n=25	n=4	n=8	**n=1**
Used not scored (%)	-	25	13	**-**
Home (%)	20	25	13	**100**
Friend's home (%)	36	50	38	**-**
Dealer's home (%)	40	25	50	**100**
Rave/doof/dance party (%)	16	-	-	**-**
Nightclub (%)	24	-	-	**100**
Pub (%)	4	-	-	**-**
Agreed public location (%)	-	-	13	**100**
Other (%)	-	-	13	**-**

Source: EDRS Regular ecstasy user interviews 2003-2006

7.5 Ketamine-related harms

7.5.1 Law enforcement

There are few objective data on seizures and arrests in relation to ketamine in Tasmania as it is not listed as a separate drug in the illicit drug data reports (Australian Crime Commission, 2004, 2005, 2006). However, drug-specific data provided by Tasmania Police suggests no ketamine seizures or arrests were made during the 2003/04 or 2004/05 reporting periods. Data for the 2005/06 financial year was not available at the time of publication.

7.5.2 Health

There are no objective data on hospital admissions, or access to treatment providers, in relation to ketamine in Tasmania.

7.6 Summary of ketamine trends

- One-quarter of the 2006 REU sample (24%) had ever used ketamine, and less than one-tenth (6%) had used ketamine during the six months preceding the interview. The lifetime and recent use of ketamine has decreased among the Tasmanian EDRS sample since 2003.
- Ketamine had been used on an average of two occasions in the preceding six months in relatively small amounts. This, along with anecdotal reports of key experts, suggests predominately experimental use by a small number of people amongst this regular ecstasy-consuming cohort. Ketamine was typically swallowed or snorted and had been purchased in powder form.
- Consistent with the relatively low use of ketamine among the 2006 REU sample, few participants were able to comment on the price, purity and availability of the drug and these estimates should therefore be interpreted with caution.
- One participant indicated that the price for one gram of ketamine was $180 and another indicated that they had purchased one point of ketamine for $40 during the six months preceding the interview. The purity of ketamine was considered to be high or medium and to have remained stable in recent months.
- The comments of KE and the patterns of use among REU both indicate relatively low availability of ketamine in Tasmania.

8.0 GHB

GHB (gamma-hydroxybutyrate) was initially developed for use as an anaesthetic, and has also been utilised in the treatment of sleep disorders and trialled as a treatment for alcohol and opioid withdrawal. GHB was commonly used in the 1980s by bodybuilders in order to promote growth hormone release and has since become popular as a recreational drug in the dance/club scene in a number of countries. In Australia, GHB may also known as 'GBH', 'grievous bodily harm', 'fantasy', 'liquid ecstasy', 'liquid E' and 'blue nitro'. GHB has received unfavourable mentions in the media due to its suspected use in the facilitation of sexual assaults and an anecdotal increase in the number of GHB-related deaths and overdose. A study investigating GHB overdose (Degenhardt, Darke, & Dillon, 2003), found that over half of GHB users interviewed had overdosed at some stage, and that frequency of use and use of alcohol and other drugs in combination with GHB were significant risk factors in GHB overdose. A recent retrospective study of GHB-related deaths in Australasia from 2000 to 2003 (Caldicott, Chow, Burns, Felgate & Byard, 2004) reported ten confirmed GHB-related deaths during this period. Whereas GHB is considered to be particularly dangerous in combination with alcohol, only two GHB-related deaths in this study were also associated with use of alcohol.

8.1 GHB use among REU

Less than one-tenth (9%) of the 2006 REU sample had used GHB at some stage of their lives, which is similar to the proportion reported among the 2003 (10%), 2004 (7%) and 2005 (7%) cohorts (Table 27). There was no significant difference between the proportion of males (12%) and females (5%) that had ever used GHB. A significantly greater proportion of 'older' participants (16%) had ever used GHB in comparison to 'younger' participants (2%) χ^2= 5.98, p<.05. Those that had recently used GHB had been using ecstasy for significantly longer than those that had not (3 years vs. 1 year), Mann-Whitney *U*=43, p<.05. All of those who had ever used GHB had swallowed the drug. The median age of first use of GHB was 23 years (range 21-31 years), and there was no significant sex difference in the age of first use. Several substances such as GBL (gamma-butyrolactone) and 1,4B (1,4 butanediol) are metabolised to GHB following ingestion and may be used as substitutes for GHB (Australian Crime Commission, 2003). There were no reports of use of 1,4B or GBL among the 2004, 2005, or 2006 samples, and a single participant had recently used 1,4B and two had ever tried the drug among the 2003 sample (Bruno & McLean, 2004b).

Among the 2006 sample, only three REU (3%) reported use of GHB in the six months preceding the interview, which is similar to the proportion that had recently used the drug among the 2005 (2%) and 2004 (3%) samples (Table 27). All of those who reported recent use of GHB had swallowed the drug, on a median of 2 days (range 1-3) during the preceding six months. None of the respondents who had recently used GHB were able to confidently comment on the quantities of the drug they had used in the preceding six months. Two respondents reported using GHB at a range of locations (see Table 27) and both had last used GHB at a friend's home.

The majority of key experts did not comment or were not aware of use of GHB among the group of REU that they were familiar with. Five KE commented that a small proportion of the group of REU used GHB. One KE noted a recent increase in the use of GHB among the group that they were familiar with.

Table 27: Patterns of GHB use among REU, 2003-2006

GHB	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	10	7	7	**9**
Median age of first use of GHB	22 years (16-27)	20 years (17-32)	21 years (18-30)	**23 years (21-31)**
Used in last 6 months (%)	6	3	2	**3**
Of those that had used in last 6 mths				
Median days used last 6 mths (range)	1 (1-1)	1 (1-3)	2 (2-2)	**2 (1-3)**
Route of administration in the last 6 months				
Swallowed (%)	100	100	100	**100**
Median quantities used in last 6 mths (ml)		n=1	n=1	
Typical session	-	300ml	25 ml	**-**
Biggest session	-	300ml	50 ml	**-**
Locations typically used GHB in last 6 months	n=4	n=1	n=2	**n=2**
Home (%)	-	100 (n=1)	-	**50**
Dealer's home (%)	-	-	-	**50**
Friend's home (%)	50 (n=2)	-	50 (n=1)	**100**
Rave/doof/dance party (%)	25 (n=1)	-	-	**50**
Nightclub (%)	-	-	-	**50**
Private party (%)	25 (n=1)	-	-	**50**
Car (%)	-	-	50 (n=1)	**-**
Restaurant/café (%)	-	-	-	**50**
Location last used GHB	n=4	n=1	n=2	**n=2**
Home (%)	-	100 (n=1)	-	**-**
Dealer's home (%)	-	-	-	**-**
Friend's home (%)	25 (n=1)	-	50 (n=1)	**100**
Rave/doof/dance party (%)	50 (n=2)	-	-	**-**
Nightclub (%)	-	-	-	**-**
Private party (%)	25 (n=1	-	-	**-**
Car (%)	-	-	50 (n=1)	**-**

Source: EDRS Regular ecstasy user interviews 2003-2006

8.2 Price

Two respondents reported that the price of GHB was $3 per ml and one of these respondents reported purchasing 7mls of GHB for $21. Only one respondent reported on price changes in the six months preceding the interview, indicating that the price had remained stable during this time. Due to small sample sizes, price estimates of GHB across the four years of the study should be interpreted with caution.

Table 28: Price of GHB purchased by REU, 2001-2006

Median price	2003	2004	2005	**2006**
100 ml solution	-	$5* n=1	-	**-**
75 ml solution	-	-	$150* n=1	**-**
30 ml solution	$10* n=1	-	-	**-**
7 ml solution	-	-	-	**$21* n=1**
Price per ml	-	-	-	**$3 n=2**
Price change	n=1			**n=1**
Increased (%)	-	-	-	**-**
Stable (%)	100*	-	-	**100***
Decreased (%)	-	-	-	**-**
Fluctuated (%)	-	-	-	**-**

Source: EDRS Regular ecstasy user interviews 2003-2006
*n=1

8.3 Purity

Only two REU among the 2005 sample were able to confidently comment on the purity of GHB. Both participants indicated that GHB was high in purity and that the purity of GHB had increased in the six months preceding the interview.

8.4 Availability

Only two REU were able to confidently comment on the availability of GHB. Both participants indicated that GHB was currently 'difficult' to obtain. One of these participants indicated that the availability of GHB had remained stable during the six months preceding the interview and the other indicated that availability of GHB had recently increased. Participants that had recently used GHB were asked from whom they had typically obtained the drug. The two respondents that commented indicated that they had 'used but not scored' the drug. Small proportions of the REU sample have reported recent use and have been able to comment on the price, purity, and availability of GHB over the four years of the study. This indicates that the availability of GHB has remained low in Tasmania during this time.

8.5 GHB-related harms

8.5.1 Law enforcement

There are no objective data on seizures and arrests in relation to GHB in Tasmania, as it is not listed as a separate drug in the illicit drug data reports (Australian Crime Commission, 2004, 2005). However, between 2004 and 2006 single law enforcement KE have noted recent seizures and/or information on the drug.

8.5.2 Health

There are no objective data on hospital admissions, or access to treatment providers, specifically in relation to GHB in Tasmania.

8.6 Summary of GHB trends

- Less than one in ten (9%) of the REU sample had ever used GHB, and only three participants (3%) had used GHB during the six months preceding the interview. This is consistent with the low levels of use reported among the Tasmanian REU sample in previous years.
- Amongst those three participants that had recently used the drug, GHB was taken orally, in liquid form, on a median of 2 days (range 1-3 days) during this time.
- There was no lifetime or recent use of GHB-like substances such as 1,4B or GBL among the 2006 REU cohort.
- Only two participants commented on the price, purity, and availability of GHB in Tasmania, and therefore these estimates should be interpreted with caution.
- Patterns of use among REU and anecdotal comments of key experts indicate low availability of GHB in Tasmania and predominantly experimental use by few people. However, considering the potentially harmful nature of GHB, future monitoring of GHB markets in Tasmania is important.

9.0 LSD

In the 2004 National Drug Strategy Household Survey, it was estimated (from the sample of 1,208 participants) that approximately 0.6% of Tasmanians had used hallucinogens in the year prior to interview, compared with 0.7% Australians nationally (Australian Institute of Health and Welfare, 2005).

9.1 LSD use among REU

Table 29 shows that half of the 2006 REU sample (52%) had used LSD at some stage of their lives, which is similar to the proportion among the 2005 (54%) and 2004 (51%) samples. A significantly greater proportion of the male sample (64%) had ever used LSD in comparison to the proportion of the female sample (46%), $\chi^2=7.70$, $p<.01$, and, based on a median split for age, a significantly greater proportion of 'older' participants (72%) had ever used LSD in comparison to 'younger' participants (32%), $\chi^2=16.03$, $p<.001$. All of those who had ever used LSD had ingested the drug and small proportions had ever injected (10%), snorted (8%) or smoked (4%) LSD. The median age of first use was 19 years (range 14-35 years, SD=3.7 years), and there was no significant difference between the age of first use for males (19 years, range 15-31) and females (18 years, range 15-24).

Almost one-third (29%) of the 2006 REU sample had used LSD during the six months preceding the interview, compared to a similar proportion among the 2005 (31%) and 2004 (32%) samples (Table 29). A significantly greater proportion of the male sample (38%) had recently used LSD in comparison to the proportion of the female sample (17%), $\chi^2=5.35$, $p<.05$. There was no significant difference between the proportions of 'younger' (36%) and 'older' (24%) participants that had recently used LSD (based on a median split for age). All of those who had recently used LSD had taken the drug orally, and small proportions had recently smoked (3%) or snorted (3%) the drug.

Of those who had recently used LSD, the median frequency of use was 2 days (range 1-15 days), which is similar to the relatively low frequency of use reported among the REU sample in previous years. Males had a significantly higher median frequency of use in comparison to females (3 days vs. 1 day), Mann-Whitney $U=33.0$, $p<.05$. The median number of tabs/drops of LSD used in a typical session was 1 (range 1-3), which is similar to the median quantity observed among the 2003, 2004, and 2005 cohorts. The number of tabs/drops used in the biggest session of use in the preceding six months was 2 (range 1-16).

REU were asked which locations they had typically used LSD (to be under the influence of the drug though not necessarily the location of ingestion) during the 6 months preceding the interview (Table 29). LSD was typically used at private residences such as the consumer's own home (52%), a friend's home (44%), private parties (41%) as well as dance-related events (56%), outdoor locations (37%), nightclubs (33%), live music events (19%), public places (11%), cars (7%), or a dealer's home (7%). The most commonly reported location of last use included: dance-related events (31%), the consumer's own home (23%), a friend's home (15%), outdoor locations (12%), a live music event (12%), nightclub (4%), or public place (4%). These findings are relatively consistent with the locations of use reported among the 2003-2005 cohorts. However, greater proportions reported typically using LSD at dance-related events, nightclubs, and private parties in 2006 relative to previous years.

KE who commented on the use of LSD in the group of regular ecstasy users that they were familiar with noted that a small proportion of REU used LSD (n=10), with only two KE indicating that 'half' (n=1) or 'most' (n=1) of the REU group used LSD. The majority of those who commented indicated that the paper form of the drug ('tabs') was most often used (n=5),

but three KE commented that liquid LSD was also used. KE were asked to comment on any changes in the use of LSD in the six months preceding the interview. Two KE commented that there had been a decrease in the availability of LSD (n=2) in the preceding six months, and two KE noted that the use of LSD had decreased as psychedelic mushrooms were a similar and cheap alternative. However, although the use of mushrooms has increased among the Tasmanian EDRS sample (see Section 12.7), the use of LSD has remained relatively stable over the years.

Table 29: Patterns of LSD use among REU, 2003-2006

LSD	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	62	51	54	**52**
Median age of first use of LSD (range)	18 years (14-25)	19 years (14-32)	18 years (15-31)	**19 years (14-35)**
Used in last six months (%)	24	32	31	**29**
Of those who had used in last 6 mths				
Median days used last 6 mths (range)	1 (1-15)	2.5 (1-12)	1 (1-15)	**2 (1-15)**
Route of administration in last 6 months				
Smoked (%)	-	3	-	**3**
Snorted (%)	-	-	-	**3**
Swallowed (%)	100	100	100	**100**
Injected (%)	-	-	-	**-**
Median tabs/drops used in last 6 mths				
Typical session (range)	1.25 (1-2)	1 (0.25-2.5)	1 (0.5-3)	**1 (1-3)**
Biggest session (range)	3 (1-4)	1.25 (0.25-3.0)	1 (0.5-6)	**2 (1-16)**
Locations usually used LSD in last 6 months	n=27	n=30	n=30	**n=27**
Home (%)	28	43	33	**52**
Dealer's home (%)	-	3	-	**7**
Friend's home (%)	24	40	50	**44**
Raves/doofs/dance parties	33	40	23	**56**
Nightclub (%)	-	17	17	**33**
Pub (%)	-	3	-	**-**
Restaurant/café (%)	-	3	-	**-**
Private party (%)	21	13	13	**41**
Public place (street/park) (%)	7	3	10	**11**
Outdoors (%)	n/a	30	23	**37**
Car (%)	3	-	-	**7**
Live music event (%)	n/a	17	13	**19**
Other (%)	-	3	-	**-**
Location last used LSD	n=27	n=30	n=30	**n=26**
Home (%)	22	17	13	**23**
Dealer's home (%)	4	-	-	**-**
Friend's home (%)	19	17	40	**15**
Rave/doof/dance party	22	17	10	**31**
Nightclub (%)	26	17	13	**4**
Pub (%)	-	3	-	**-**
Restaurant/café (%)	-	3	-	**-**
Private party (%)	7	3	-	**12**
Outdoors (%)	n/a	13	10	**12**
Live music event (%)	n/a	7	7	**-**
Public place (%)	-	-	3	**4**
Other (%)	-	3	-	**-**

Source: EDRS Regular ecstasy user interviews 2003-2006

9.2 Price

The estimated market price for one tab of LSD and perceived price changes over the six months preceding the interview are shown in Table 30. The median market price and last purchase price for one tab of LSD was $20 (range $10-40) and $20 (range $10-50) respectively. This price is lower than the median price of $25 reported in 2005, but the same as median price of $20 reported among both the 2003 and 2004 REU samples. Three respondents reported that the median price for one microdot (small tablet) of LSD was $20 (range $15-25). A single participant indicated that they had last purchased a microdot of LSD for $20. Two KE also commented on a recent increase in the availability of microdots. Over one-half (53%) of those who commented on the price of LSD in 2006 indicated and that it had remained stable during the six months preceding the interview, with smaller proportions reporting that the price had fluctuated (23%), increased (10%), or decreased (13%) during this time.

Table 30: Prices of LSD purchased by REU, 2003-2006

LSD	2003	2004	2005	**2006**
Median market price				
Tab (range)	$20 (5-50) n=39	$20 (10-50) n=40	$25 (15-40) n=36	**$20 (10-40) n=32**
Microdot (range)	-	-	-	**$20 (15-25) n=3**
Median last price				
Tab (range)	$20 (2-40) n=21	$20 (5-40) n=24	$25 (10-40) n=30	**$20 (10-50) n=29**
Drop (range)	$20 (10-20) n=6	-	-	**-**
Microdot (range)	-	-	-	**$20 n=1**
Price change	n=39	n=31	n=31	**n=30**
Increased (%)	13	10	13	**10**
Stable (%)	79	77	68	**53**
Decreased (%)	-	3	10	**13**
Fluctuated (%)	8	10	10	**23**

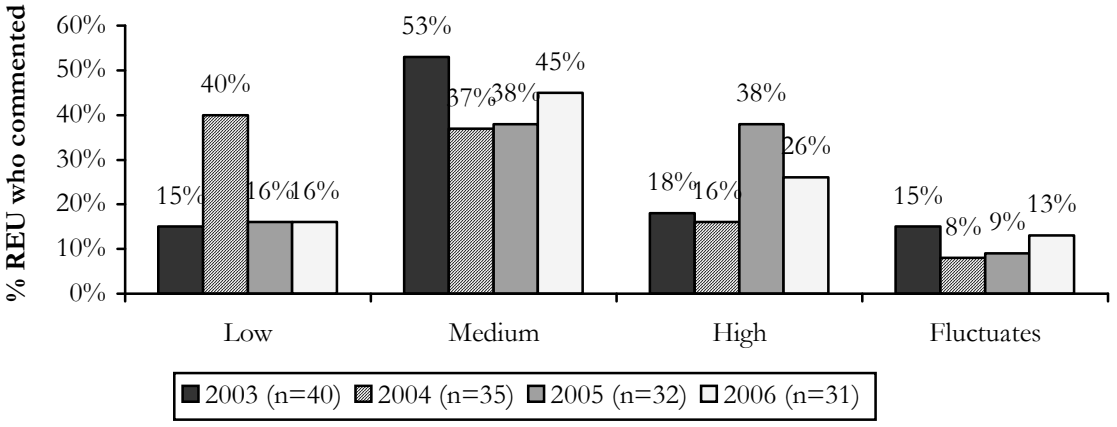
Source: EDRS Regular ecstasy user interviews 2003-2006

Tasmania Police reported prices of LSD tabs as $20-$25 during the 2001/02 and 2000/01 financial years, a potential decrease on the $15-$30 reported during 1999/00 (ABCI, 2001, 2002; ACC, 2003). Price information in regard to LSD is no longer reported by the ACC in their annual reports.

9.3 Purity

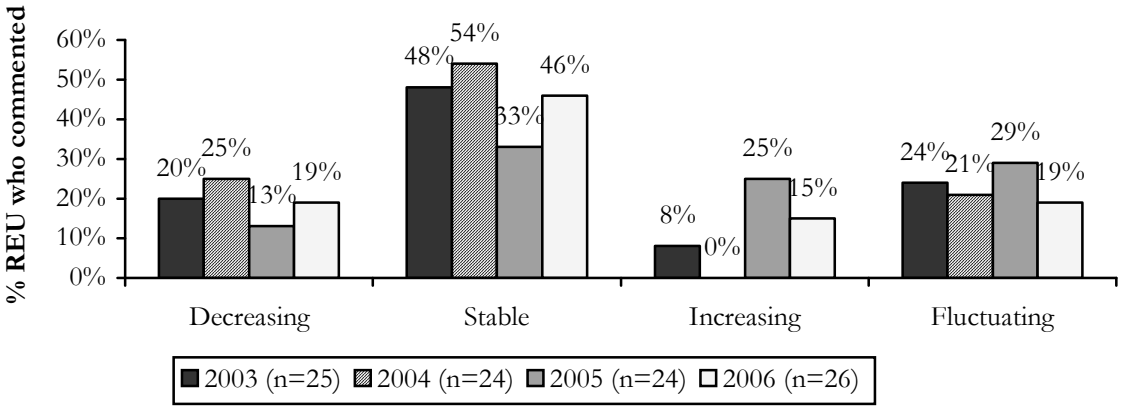
One-third of the 2006 sample (n=31) was able to comment on the purity of LSD in the six months preceding the interview (see Figure 26). Two-fifths (45%) of those who commented indicated that LSD was medium in purity and smaller proportions indicated that LSD was high (26%), low (16%), or fluctuating (13%) in purity. One-quarter of the 2006 sample (n=26) were able to comment on changes in the purity of LSD in the last six months (see Figure 27). Close to one-half (46%) indicated that the purity of LSD had remained stable during the six months preceding the interview, and smaller proportions indicated that the purity of LSD had recently decreased (19%), increased (15%) or fluctuated (19%) during this time.

Figure 26: Current purity of LSD, 2003-2006



Source: EDRS Regular ecstasy user interviews 2003-2006

Figure 27: Recent change in purity of LSD, 2003-2006



Source: EDRS Regular ecstasy user interviews 2003-2006

9.4 Availability

One-third of the 2006 REU sample were able to comment on the availability (n=31) and changes in availability (n=30) of LSD in the six months preceding the interview (see Table 31). Two-thirds of those that commented indicated that LSD was currently 'easy' (42%) or 'very easy' (26%) to obtain, and one-third indicated that LSD was currently 'difficult' (26%) or 'very difficult' (7%) to obtain. The proportion of the REU sample reporting that LSD is 'easy' or 'very easy' to obtain has increased gradually since 2003. Two-fifths (41%) of those who commented on changes in the availability of LSD in 2006 indicated that availability had remained 'stable', two-fifths indicated that LSD had recently become easier to obtain (23%) and smaller proportions indicated that LSD had recently become more difficult to obtain (17%) or had fluctuated (7%) in availability.

The persons and locations from which LSD was obtained are shown in Table 31. LSD was typically obtained from friends (78%), or known dealers (41%), followed by workmates (11%) and acquaintances (7%). LSD was typically obtained from a friend's home (52%), a dealer's home (26%), the consumer's own home (19%), or from a dance-related event (37%), nightclub (11%), private party (15%), public location (11%), or public bar (4%). A greater proportion

had scored LSD from a dance-related event in 2006 (37%), relative to previous years (8%-17%).

Table 31: REU reports of availability of LSD in the preceding six months, 2003-2006

LSD	2003	2004	2005	**2006**
Ease of obtaining LSD	n=54	n=38	n=35	**n=31**
Very easy (%)	4	18	20	**26**
Easy (%)	13	29	49	**42**
Moderately easy (%)	24	n/a	n/a	**n/a**
Difficult (%)	46	40	29	**26**
Very difficult (%)	13	13	3	**7**
Change in availability in last six months	n=45	n=31	n=29	**n=30**
Stable (%)	49	58	41	**53**
Easier (%)	7	13	38	**23**
More difficult (%)	36	23	17	**17**
Fluctuates (%)	9	6	3	**7**
Persons scored from in last six months	n=27	n=30	n=30	**n=27**
Used not scored (%)	-	10	3	**7**
Friends (%)	74	67	80	**78**
Dealers (%)	30	33	40	**41**
Workmates (%)	4	-	3	**11**
Acquaintances (%)	11	23	10	**7**
Unknown persons (%)	-	7	-	**-**
Locations scored from in last six months	n=22	n=30	n=30	**n=27**
Used not scored (%)	-	10	3	**7**
Home (%)	20	23	20	**19**
Friend's home (%)	36	53	43	**52**
Dealer's home (%)	40	20	23	**26**
Rave/doof/dance party (%)	8	17	17	**37**
Nightclub (%)	24	-	13	**11**
Pub (%)	4	-	-	**4**
Street (%)	-	7	-	**-**
Agreed public location (%)	-	3	3	**11**
Private party (%)	-	-	10	**15**
Acquaintance's home (%)	-	-	3	**-**
Other (%)	-	3	-	**-**

Source: EDRS Regular ecstasy user interviews 2003-2006

9.5 LSD-related harms

9.5.1 Law enforcement

Tasmania Police seized 5 tabs of LSD during 2001/02 (all during December, 2001), and 8 tabs during 2000/01 (all during August 2000), compared to 109 tabs during the 1999/00 financial year, all during the summer October-December 1999 quarter. During 2002/03, Tasmania Police (Western District) seized 488 tabs believed to be LSD (and sold as such by the 'dealer') but forensic tests of the seized tabs indicated negative results for any drug. During 2003/04, 31 tabs of LSD, 10.5 grams of psychedelic mushrooms (psilocybin) and 6 'tablets' defined as hallucinogenic were seized by Tasmania Police. In 2004/05, 1,289 tabs of LSD and 565 grams of psychedelic mushrooms were seized. The quantities seized are so variable that it is difficult to infer any clear trends in availability for this class of drugs from these figures. Data for the 2005/06 financial year was not available at the time of publication.

9.5.2 Health

There are no objective data in terms of hospital admissions, mortality, or access to treatment providers specifically in relation to LSD in Tasmania.

9.6 Summary of LSD trends

- Over half (52%) of the 2006 REU sample had used LSD at some stage of their lives and almost one-third (29%) had used LSD in the six months preceding the interview.
- A significantly greater proportion of males had ever and recently used LSD in comparison to the proportion of females.
- One tab or one drop of liquid LSD (range 1-3) was taken orally in a typical session of use and LSD had been used on a median of 2 days (range 1-15 days) in the preceding six months.
- LSD was typically used at private residences such as the consumer's own home, a friend's home, or a private party, as well as dance-related events, outdoor locations and nightclubs. The proportion reporting recent use of LSD at dance-related events, nightclubs, and private parties was greater in 2006 relative to previous years.
- The median price for one tab of LSD in 2006 was $20 (range $10-40), which is consistent with the price reported in 2003 and 2004, but less than the price of $25 reported in 2005. The price of LSD was considered to have remained stable in the last six months.
- The purity of LSD was considered by REU to be 'medium' (45%) to 'high' (26%) and stable during the six months preceding the interview.
- Two-thirds of those who commented on the availability of LSD reported that LSD was 'easy' or 'very easy' to obtain, and the remainder reported that it was currently 'difficult' or 'very difficult' to obtain. Subjective reports of REU indicate a gradual increase in the availability of LSD since 2003, but the proportion of each cohort reporting recent use has remained stable, and the frequency of this use has remained stable, during this time.
- LSD was typically obtained from friends or dealers and was typically scored from a friend's home, a dealer's home or dance-related event.

10.0 MDA

10.1 MDA use among REU

Just over one-tenth (14%) of the 2006 REU sample had ever used MDA which is similar to the proportion among the 2005 sample (8%) and smaller relative to 2004 (20%) and 2003 (32%) (Table 32). There was a trend indicating that a greater proportion of the male sample (19%) had ever used MDA in comparison to the proportion of the female sample (7%) in 2006, χ^2=2.82, p=.093, but this did not reach conventional levels of statistical significance. There was no significant difference between the proportion of 'older' and 'younger' participants that had ever used MDA (based on a median split for age). The median age of first use was 22 years (range 15-30, SD=3 years), and there was no significant difference between the age of first use for males and females. Most of those that had ever used MDA had swallowed the drug (92%), two-fifths had ever snorted (21%), or injected (21%) MDA, and a single participant had ever shelved MDA (7%).

Two male and one female participants among the 2006 REU sample (3%) had used MDA during the six months preceding the interview, compared to the same proportion in 2005 (3%) and larger proportions among the 2004 (15%) and 2005 (21%) samples (Table 32). Two participants had recently swallowed MDA and one participant had recently snorted MDA. All three participants had used one capsule of MDA on a single occasion during the six months preceding the interview. A single participant indicated that they had used MDA at a friend's home during this time.

The majority of key experts indicated that there was no (n=9) or very little use (n=5) of MDA among the group of ecstasy users that they were familiar with. Three KE indicated that MDA was currently difficult to obtain in Tasmania.

Table 32: Patterns of MDA use among REU, 2003-2006

MDA	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2003 (n=100)**
Ever used (%)	32	20	8	**14**
Median age first used MDA (range)	20 years (16-32)	20 years (16-21)	23 years (17-28)	**22 years (15-30)**
Used in last 6 months (%)	21	15	3	**3**
Of those who had used in the last 6 mths				
Median days used last 6 mths (range)	2 (1-20)	2 (1-4)	2 (1-2)	**1 (1-1)**
Route of administration in last 6 months				
Smoked (%)	-	-	-	**-**
Snorted (%)	43	20	-	**33**
Swallowed (%)	95	100	100	**67**
Injected (%)	-	-	-	**-**
Median capsules used in preceding 6 mths				
Typical session (range)	0.5 (0.5-1)	1 (1-5)	1 (1-1)	**1 (1-1)**
Biggest session (range)	1.25 (0.5-2)	1.5 (1-8)	1.5 (1-2)	**1 (1-1)**

Source: EDRS Regular ecstasy user interviews 2003-2006

Table 32: Patterns of MDA use among REU, 2003-2006 (continued)

MDA	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2003 (n=100)**
Locations usually used MDA in last 6 months	n=21	n=7	n=2	**n=1**
Home (%)	14	71	-	**-**
Dealer's home (%)	5	-	-	**-**
Friend's home (%)	24	43	-	**100**
Raves/doofs/dance parties	71	57	50	**-**
Nightclub (%)	43	14	50	**-**
Pub (%)	-	14	-	**-**
Restaurant/cafe	-	-	-	**-**
Private party (%)	14	43	-	**-**
Public place (street/park) (%)	-	-	-	**-**
Car (%)	-	-	-	**-**
Live music event (%)	n/a	14	-	**-**
Location last used MDA	n=21	n=7	n=2	**n=1**
Home (%)	14	14	-	**-**
Dealer's home (%)	-	-	-	**-**
Friend's home (%)	10	29	-	**100**
Rave/doof/dance party	48	57	50	**-**
Nightclub (%)	19	-	50	**-**
Pub (%)	-	-	-	**-**
Private party (%)	5	-	-	**-**
Public place (street/park) (%)	5	-	-	**-**
Live music event (%)	-	-	-	**-**

Source: EDRS Regular ecstasy user interviews 2003-2006

10.2 Price

A single respondent among the 2006 REU sample indicated that the price for one MDA capsule had remained stable at $40 which is relatively consistent with prices reported among the 2005 ($45), 2004 ($40) and 2003 ($50) samples (see Table 33). One participant indicated that the current price for one gram of MDA was $350, and that this price had fluctuated in the last six months. These price estimates should be interpreted with caution due to the small number of individuals able to report prices of MDA in recent years.

Table 33: Price of MDA purchased by REU, 2003-2006

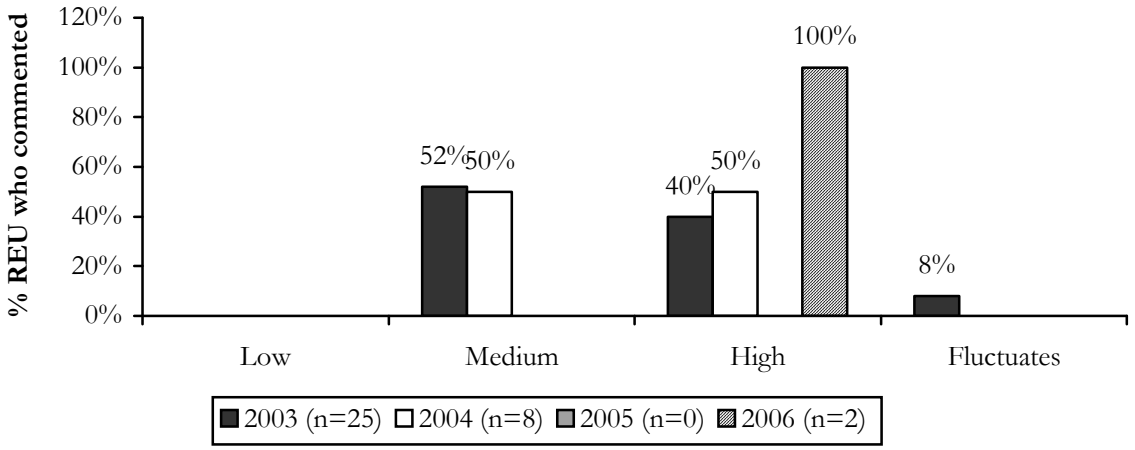
MDA	2003	2004	2005	**2006**
Median market price	n=15	n=9	n=1	**n=1**
Capsule	$50 ($35-60)	$40 ($35-60)	$45	**$40**
Last purchase price	n=11	n=7	n=0	**n=1**
Capsule	$50 ($40-50)	$40 ($40-50)	-	**$40**
Price change	n=20	n=9	n=0	**n=2**
Increased (%)	-	-	-	**-**
Stable (%)	100	100	-	**50**
Decreased (%)	-	-	-	**-**
Fluctuated (%)	-	-	-	**50**

Source: EDRS Regular ecstasy user interviews 2003-2006

10.3 Purity

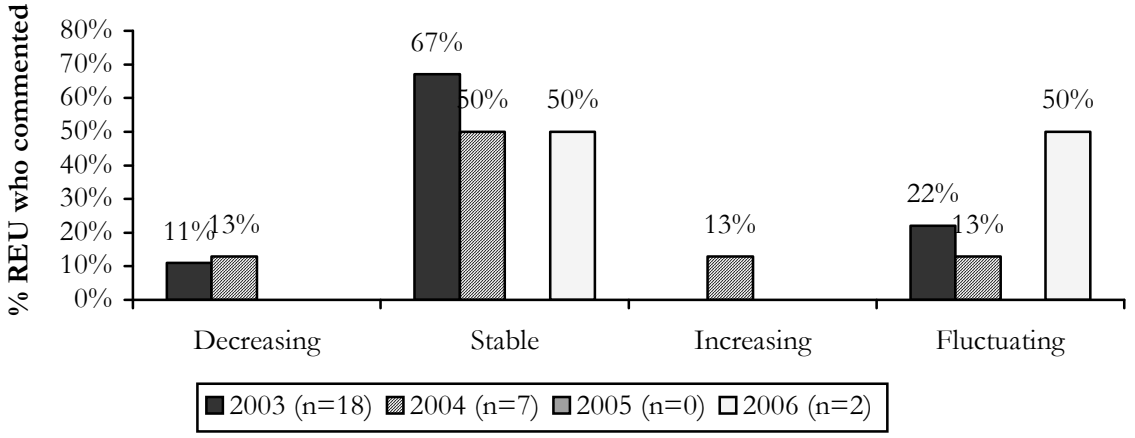
Figures 28 and 29 show current purity and changes in purity of MDA reported between 2003 and 2006. Two participants commented on the purity of MDA in 2006; both indicated that MDA was currently high in purity, and that the purity of MDA had either remained stable or fluctuated during the six months preceding the interview.

Figure 28: Current purity of MDA, 2003-2006



Source: EDRS Regular ecstasy user interviews 2003-2006

Figure 29: Recent change in purity of MDA, 2003-2006



Source: EDRS Regular ecstasy user interviews 2003-2006

10.4 Availability

Only two participants were able to confidently comment on the current availability of MDA (Table 34). One participant indicated that MDA was currently very difficult to obtain and that this had remained stable in the preceding six months. The other participant indicated that MDA was difficult to obtain and had recently become more difficult. A single participant indicated that they had obtained MDA from a dealer at a dealer's home in the six months preceding the interview. The small number of participants able to comment on the availability of MDA since 2003 suggests a decrease in the availability of MDA in Hobart since this time.

Table 34: REU reports of availability of MDA in the preceding six months, 2003-2006

MDA variable	2003	2004	2005	**2006**
Ease of obtaining MDA	n=24	n=9	n=1	**n=2**
Very easy (%)	8	-	-	**-**
Easy (%)	25	56	-	**-**
Moderately easy (%)	29	n/a	n/a	**n/a**
Difficult (%)	38	44	100	**50**
Very difficult (%)	-	-	-	**50**
Changes in availability last 6 months	n=19	n=7	n=1	**n=2**
Stable (%)	95	100	100	**50**
Easier (%)	-	-	-	**-**
More difficult (%)	-	-	-	**50**
Fluctuates (%)	5	-	-	**-**
Persons scored from in last 6 months	n=21	n=7	n=2	**n=1**
Used not scored (%)	-	-	50	**-**
Friends (%)	71	86	50	**-**
Dealers (%)	57	43	-	**100**
Workmates (%)	-	-	-	**-**
Acquaintances (%)	10	-	-	**-**
Unknown persons (%)	-	14	-	**-**
Locations scored from in last 6 months	n=21	n=7	n=2	**n=1**
Used not scored (%)	-	-	50	**-**
Home (%)	24	29	-	**100**
Friend's home (%)	48	86	-	**100**
Dealer's home (%)	48	-	-	**-**
Rave/doof/dance party (%)	24	14	-	**-**
Nightclub (%)	10	-	50	**-**
Pub (%)	-	-	-	**-**
Street (%)	5	-	-	**-**
Agreed public location (%)	-	-	-	**-**

Source: EDRS Regular ecstasy user interviews 2003-2006

10.5 MDA-related harms

10.5.1 Law enforcement

The Australian Crime commission reports seizures and arrests for drugs classed as phenethylamines which includes MDMA (ecstasy) as well as 3,4-methylendioxyethylamphetamine (MDEA), 3,4-methylendioxyamphetamine (MDA) and paramethoxyamphetamine (PMA). Thus, there are no data from Tasmania Police that relates specifically to MDA, though it is possible that some MDA-related seizures and arrests are inadvertently reported in Section 4.7.1 in relation to ecstasy.

10.5.2 Health

There are no objective data available in terms of hospital admissions, mortality, or access to treatment providers specifically in relation to MDA in Tasmania.

10.6 Summary of MDA trends

- The lifetime and recent use of MDA among the Tasmania REU sample has been decreasing since 2003. Just over one-tenth (14%) of the 2006 REU sample had used MDA at some stage of their lives and only two male and one female participants (3%) had recently used MDA.
- MDA had been purchased in capsule form and had been swallowed or snorted on single occasions during the six months preceding the interview.
- Few respondents were able to confidently comment on the price, purity or availability of MDA and thus it is difficult to delineate clear trends. However, based on the decline in the use of MDA since 2003, and the comments of several KE, the local availability of MDA in Tasmania appears to be relatively low.

11.0 CANNABIS

In the 2004 National Drug Strategy Household Survey, it was estimated (from the sample of 1,208 participants) that approximately 10.9% of Tasmanians (aged 14 years and over) had used cannabis in the year prior to interview, compared with 11.3% Australians nationally (AIHW, 2005). These figures are relatively similar to those reported in the 2001 NDSHS (11.9% of Tasmanians vs. 12.9% nationally) and slightly lower than those reported in the 1998 NDSHS survey (15.9% vs. 17.9%).

11.1 Cannabis use among REU

The entire sample of regular ecstasy users surveyed in 2006 had used cannabis at some stage of their lives (Table 35). All participants (100%) had smoked cannabis at some stage of their lives and a large majority (87%) had ever used cannabis orally. The median age of first cannabis use was 15 years (range 8-27 years, SD=2.4), and the median age of first use tended to be lower for males in comparison to females, t(98)=3.82, p=.053. A majority of respondents (82%) had used cannabis during the six months preceding the interview. A greater proportion of males (88%) had recently used cannabis in comparison to the proportion of females (74%), χ^2=3.29, p=.07. However, this trend failed to reach conventional levels of statistical significance. There was no significant difference in the proportion of 'younger' and 'older' participants that had recently used cannabis. All participants had recently smoked cannabis and one-third (38%) had recently ingested cannabis. Those that had recently used cannabis had first started using ecstasy at a younger age than those that had not (19 vs. 20 years), Mann-Whitney *U*=520.5, p<.05. The median frequency of cannabis use during this six month period was 25 days (range 1-180 days), or approximately once a week. The median frequency of cannabis use tended to be greater for males in comparison to females (30 vs. 12 days) in the preceding six months; Mann-Whitney *U* = 599.0, p=066. The median frequency of cannabis use was significantly greater for 'older' in comparison to 'younger' participants (72 vs. 12 days) in the preceding six months; Mann-Whitney *U* = 512.0, p<.01.

Table 35: Patterns of cannabis use of REU, 2003-2006

Cannabis	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	100	98	100	**100**
Median age first used cannabis (range)	15 years (9-26)	15 years (9-22)	15 years (10-21)	**15 years (8-27)**
Used preceding six months (%)	99	91	89	**82**
Of those who had used in last 6 mths				
Median days used last 6 mths (range)	48 (1-180)	24 (1-180)	24 (1-180)	**25 (1-180)**

Source: EDRS Regular ecstasy user interviews 2003-2006

KE typically commented that a large proportion of the REU that they had regular contact with used cannabis, with several KE indicating that 'a few' (n=2), 'half' (n=6), 'most' (n=8), or 'all' (n=1) of REU used cannabis. One KE noted a recent increase in the number of people smoking 'bush' rather than hydroponically-grown cannabis. However, two KE who were involved in law enforcement suggested that there was relatively more hydroponically-grown cannabis available at the time of the interview in comparison to outdoor-cultivated or 'bush' cannabis. Two KE who worked in ambulance and/or emergency services perceived that the use of cannabis was related to psychological issues such as depression and psychosis. Those that commented on the price, purity or availability of cannabis (n=2) reported that there were no recent changes.

11.2 Price

For the first time in 2006, REU were asked to comment on the price, purity and availability of both hydroponically-grown ('hydro') and bush-grown ('bush') cannabis. Table 36 shows the median prices reported by REU in 2006. The median market price for hydroponically-grown cannabis was reported to be $20 per gram (range $10-25) or $290 per ounce (range $200-375). The median last purchase price for 'hydro' was $15 for one gram (range $10-25), $25 for two grams (range $20-50), $50 for three grams (range $30-50), $85 for a quarter of an ounce (range $70-100), $155 for half an ounce (range $140-180), and $250 for one ounce (range $200-300). The majority (81%) who commented on recent price changes indicated that the price of hydro had recently remained stable and smaller proportions indicated that the price of hydro had recently decreased (6%), increased (4%), or fluctuated (8%).

The median market price for 'bush' cannabis was reported to be $15 per gram (range $10-25) or $200 per ounce (range $200-375). The median last purchase price for 'bush' was $15 for one gram (range $10-25), $25 for two grams (range $10-40), $45 for three grams (range $25-50), $65 for a quarter of an ounce (range $40-80), $100 for half an ounce (range $70-150), and $200 for one ounce (range $50-350). The majority (81%) who commented on recent price changes indicated that the price of bush had recently remained stable and smaller proportions indicated that the price of bush had recently decreased (8%), or fluctuated (11%).

Eight REU were able to comment on the price of hashish. The median price for one gram of 'hash' was $25 (range $15-50, n=6), and two participants indicated that the price for one cap of hash oil was $50. One participant indicated that they had bought one block of hash for $25 and another indicated that they had bought a block of hash for $50.

Table 36: Price of cannabis purchased by REU, 2006

Cannabis	Hydro	Bush
Median market price		
Per gram (range)	$20 ($10-25) n=14	$15 ($10-25) n=13
Per ounce (range)	$290 ($200-375) n=38	$200 ($100-300) n=38
Last purchase price		
One gram (range)	$15 ($10-25) n=4	$15 ($10-25) n=9
Two grams (range)	$25 ($20-50) n=9	$25 ($10-40) n=7
Three grams (range)	$50 ($30-50) n=10	$45 ($25-50) n=9
Quarter ounce (range)	$85 ($70-100) n=23	$65 ($40-80) n=15
Half ounce (range)	$155 ($140-180) n=8	$100 ($70-150) n=8
One ounce (range)	$250 ($200-300) n=19	$200 ($50-350) n=17
Price change	n=48	n=53
Increased (%)	4	-
Stable (%)	81	81
Decreased (%)	6	8
Fluctuated (%)	8	11

Source: EDRS Regular ecstasy user interviews 2006

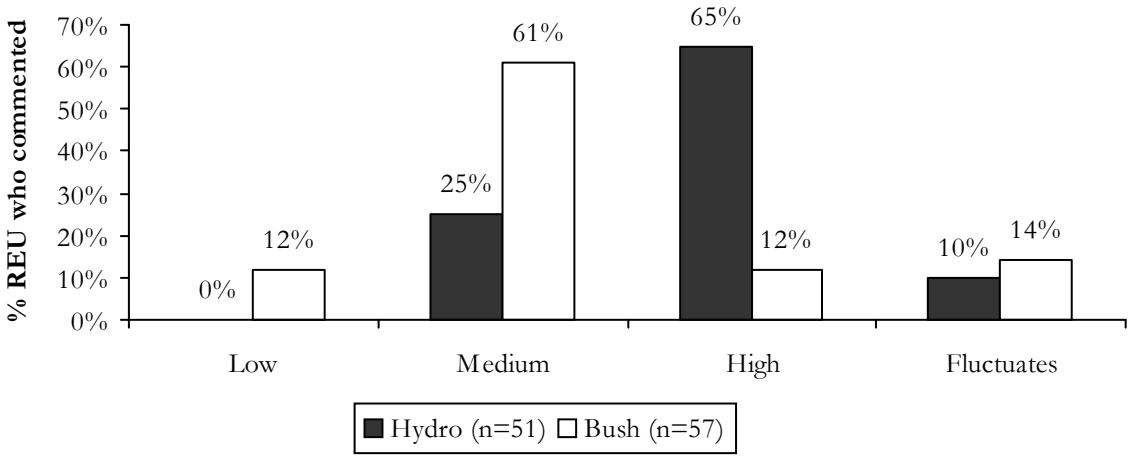
Tasmania Police provide quarterly figures on the price of covert drug purchases. According to prices reported to the ABCI (now the ACC) in 2004/05, one gram of cannabis costs $20-25, one quarter-ounce $70-100 and one ounce $150-300 (outdoor) and $300-350 (indoor/hydroponic). While price data for the 2005/06 financial year were not available at the time of publication, the figures for 2004/05 are similar to the purchase prices nominated by REU in the current study (Table 36). Consistent with the reports of REU, Tasmania Police report the price of one gram of cannabis hash/resin to be $25 in the 2004/05 financial year.

11.3 Purity

Participants were asked to comment on the current purity of hydroponic and bush cannabis (Figure 30) and changes in their purity during the six months preceding the interview (Figure 29). Almost two-thirds (65%) of those who commented indicated that hydroponically-grown cannabis was currently 'high' in purity, with smaller proportions indicating that it was 'medium' (25%) or 'fluctuating' (10%) in purity. Three-fifths of those who commented (63%) indicated that the purity of hydro had remained 'stable' in the six months preceding the interview, and smaller proportions indicated that that it had 'increased' (15%), 'decreased' (4%) or 'fluctuated' (19%) in puriety during this time (Figure 31).

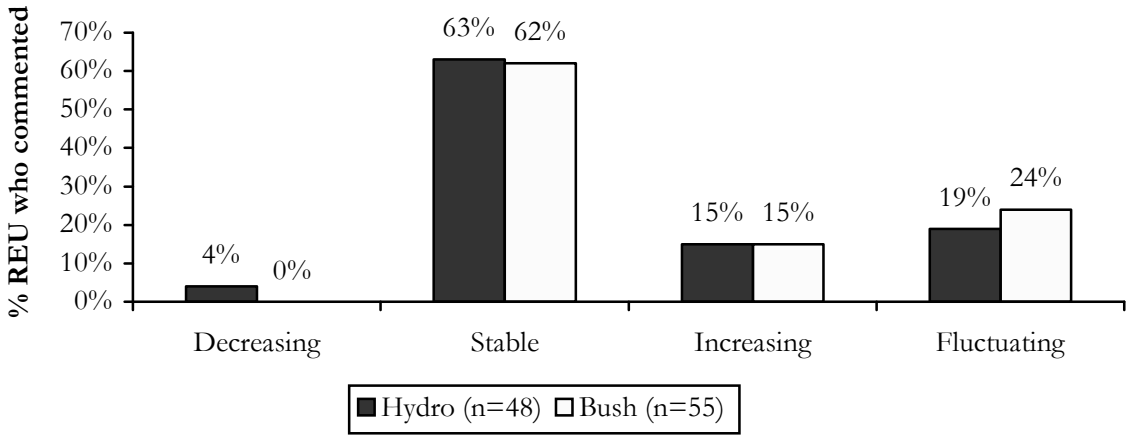
In contrast, three-fifths (61%) of those that commented indicated that bush was currently 'medium' in purity with smaller proportions indicating that bush was currently 'low' (12%), 'high' (12%) or 'fluctuating' (14%) in purity. Three-fifths (62%) of those who commented indicated that the purity of bush had remained 'stable' during the six months preceding the interview, and smaller proportions indicated that bush had 'increased' (15%) or 'fluctuated' (24%) during this time.

Figure 30: Current purity of cannabis, 2006



Source: EDRS Regular ecstasy user interviews 2006

Figure 31: Recent change in purity of cannabis, 2006



Source: EDRS Regular ecstasy user interviews 2006

In 2001, Tasmania Police reported an increasing trend toward hydroponic, or indoor[7], cultivation of cannabis, and this was supported by an increase in the proportion of Indian Hemp plant seizures being of indoor crops between 1999/00 and 2001/02 (from 16% in 1999/00 to 41% in 2001/02[8]). However, Tasmania Police officers interviewed in 2005 noted that the preference among both consumers and producers may be shifting back toward outdoor-cultivated cannabis. In 2006, law enforcement officers reported that indoor-cultivated cannabis was the predominant form used (n=3), with one report that this may be due, in part, to outdoor-cultivated cannabis being out of season at the time of the interview.

11.4 Availability

REU were asked to comment on the current availability of 'hydro' and 'bush' cannabis and changes in this availability during the six months preceding the interview (Table 37). A majority of those that commented on the current availability of 'hydro' indicated that it was currently 'very easy' (50%) or 'easy' (41%) to obtain, and a small proportion (9%) indicated that it was currently 'difficult' to obtain. Almost three-quarters (74%) of those who commented indicated that this availability had remained 'stable' during the six months preceding the interview and smaller proportions indicated that it had recently become 'easier' (15%), 'more difficult' (6%) or had 'fluctuated' in availability.

A majority of those that commented on the current availability of 'bush' indicated that it was currently 'very easy' (46%) or 'easy' (43%) to obtain, and a small proportion (11%) indicated that it was currently 'difficult' to obtain. Two-thirds (69%) of those who commented indicated that this availability had remained 'stable' during the six months preceding the interview, one-quarter (27%) indicated that it had recently become 'easier' to obtain and smaller proportions indicated that it had recently become 'more difficult' (6%) or had 'fluctuated' in availability.

REU were asked who they had typically obtained cannabis from, and the locations that they had typically scored the drug in the preceding six months (Table 37). 'Hydro' was most commonly obtained through purchases from friends (87%) or gifts from friends (37%), followed by purchases from dealers (39%), workmates (15%), acquaintances (15%), unknown persons (6%), or street dealers (2%). The locations that 'hydro' was typically obtained from included at a friend's home (73%), through 'home delivery' (45%), or at a dealer's home (33%), followed by an acquaintance's home (8%), mobile dealer (8%), agreed public location (8%), street market (4%), or work (2%). REU were asked about the production source of the hydroponically-grown cannabis that they had last used. The majority of those that commented indicated that it had come from a small-time/backyard user/grower (45%) or did not know the production source (33%). Smaller proportions indicated that it had come from a large-scale cultivator/supplier (14%) or had grown their own (8%).

'Bush' was most commonly purchased from friends (83%) or received as a gift from friends (41%), with smaller proportions purchasing the drug from dealers (29%), workmates (12%), acquaintances (3%), or street dealers (2%). The locations that 'bush' was typically obtained from included a friend's home (79%), through 'home delivery' (38%), at a dealer's home (28%), followed by acquaintance's home (10%), mobile dealer (9%), agreed public location (3%), street market (2%), and work (2%). REU were asked about the production source of the 'bush' grown cannabis that they had last used. The majority of those that commented indicated that it had come from a small-time/backyard user/grower (47%) or did not know the production source (33%). Smaller proportions had grown their own (17%) or indicated that it had come from a large-scale cultivator/supplier (3%).

[7] For the purpose of reporting, Tasmania Police record all cannabis plants seized that had been grown indoors as hydroponically cultivated, rather than just those plants that are grown without the use of soil.

[8] Cannabis seizures after 2001/02 were not divided according to cultivation type due to inconsistencies in recording on exhibit sheets.

Table 37: REU reports of availability of cannabis in the preceding six months, 2006

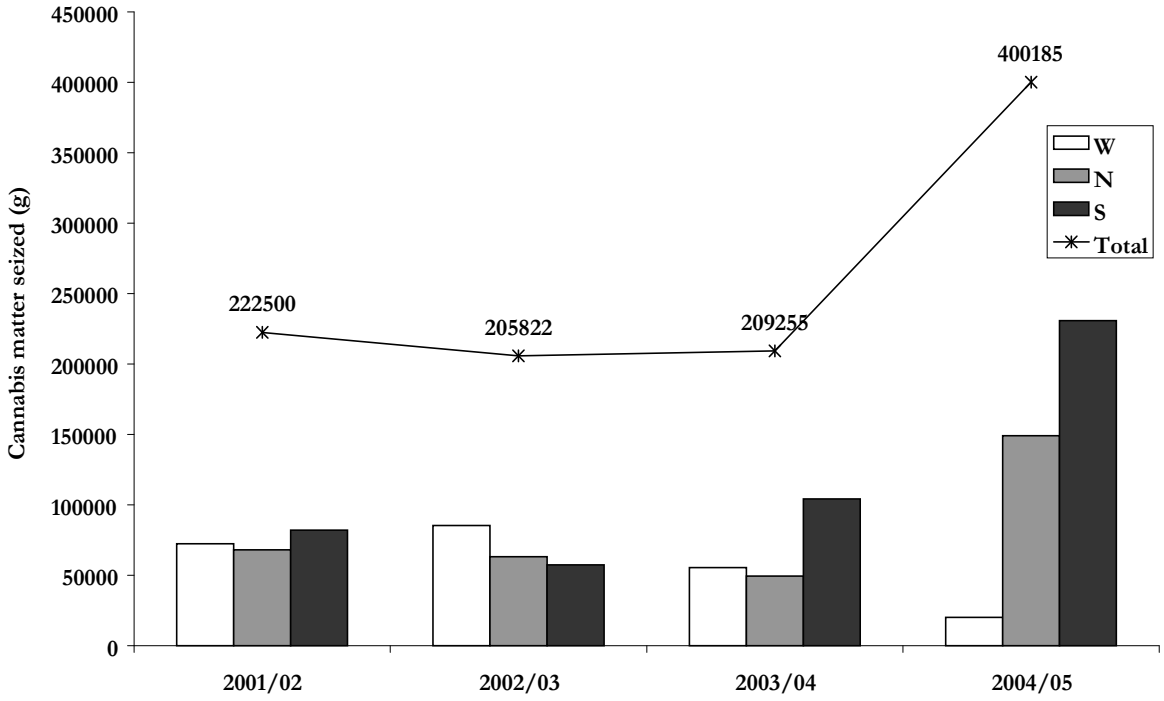
Cannabis variable	Hydro	Bush
Ease of obtaining cannabis	n=54	n=63
Very easy (%)	50	46
Easy (%)	41	43
Difficult (%)	9	11
Very difficult (%)	-	-
Changes in availability last 6 months	n=53	n=59
Stable (%)	74	69
Easier (%)	15	27
More difficult (%)	6	2
Fluctuates (%)	6	2
Persons scored from in last 6 months	n=52	n=59
Used not scored (%)	2	3
Street dealer (%)	2	2
Gift from friends (%)	37	41
Friends (%)	87	83
Dealers (%)	39	29
Workmates (%)	15	12
Acquaintances (%)	15	3
Unknown persons (%)	6	-
Locations scored from in last 6 months	n=51	n=58
Used not scored (%)	2	3
Home delivery (%)	45	38
Friend's home (%)	73	79
Dealer's home (%)	33	28
Acquaintance's home (%)	8	10
Mobile dealer (%)	8	9
Street market (%)	4	2
Agreed public location (%)	8	3
Work (%)	2	2

Source: EDRS Regular ecstasy user interviews 2006

Cannabis seizures made by Tasmania Police[9] suggest a substantial increase in the weight of seizures of cannabis leaf or head 'vegetable matter' between 2003/04 and 2004/05, with a concomitant substantial decrease in the number of cannabis plants or seedlings seized. As such, this change in seizures is likely to be primarily reflective of changes in the coding practices adopted by Tasmania Police, and it is difficult to determine the extent of any change in seizure patterns that may have occurred in this time.

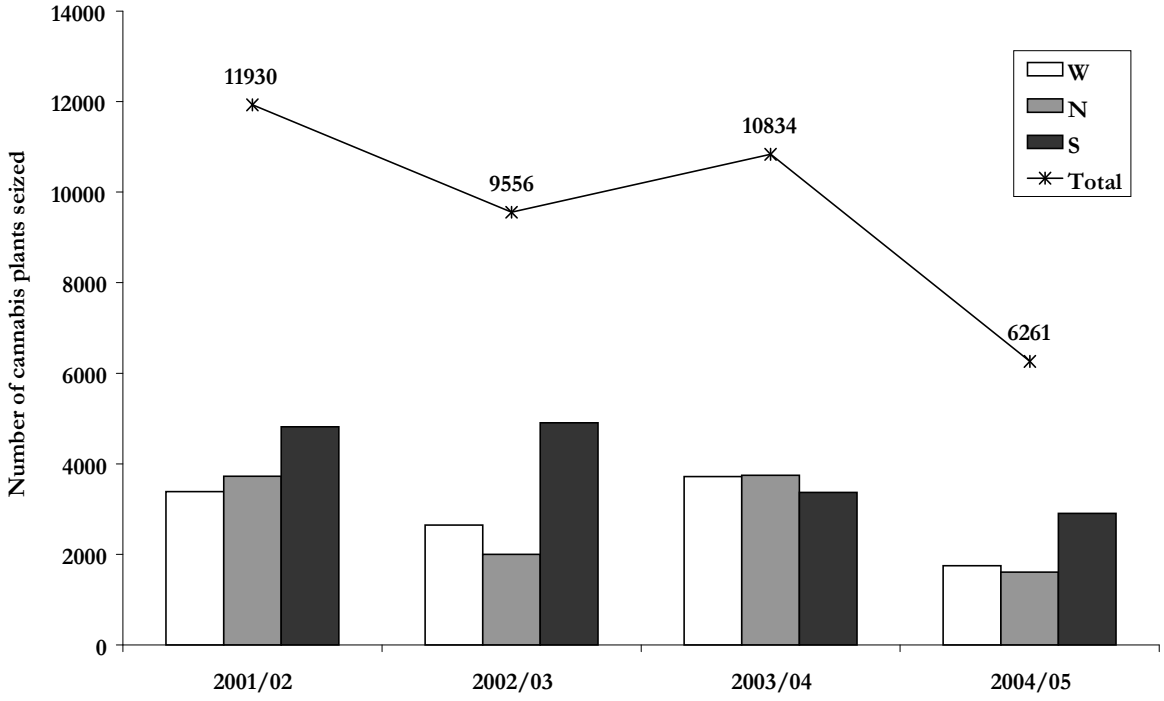
[9] Data reported in this paragraph has been provided by Tasmania Police State Intelligence Services. Data reported in the Australian Crime Commission annual report does not specify whether cannabis seized related to head/leaf or whole plant, and indicates that Tasmania Police made 1,854 seizures of cannabis, at a total weight of 449,341g in the 2004/05 financial year.

Figure 32: Seizures of cannabis (leaf and head) by Tasmania Police district drug bureaux, 2001/02-2004/05



Source: Tasmania Police State Intelligence Services

Figure 33: Seizures of cannabis plants (and seedlings) by Tasmania Police district drug bureaux, 2001/02-2004/05



Source: Tasmania Police State Intelligence Services

11.5 Cannabis-related harms

11.5.1 Law enforcement

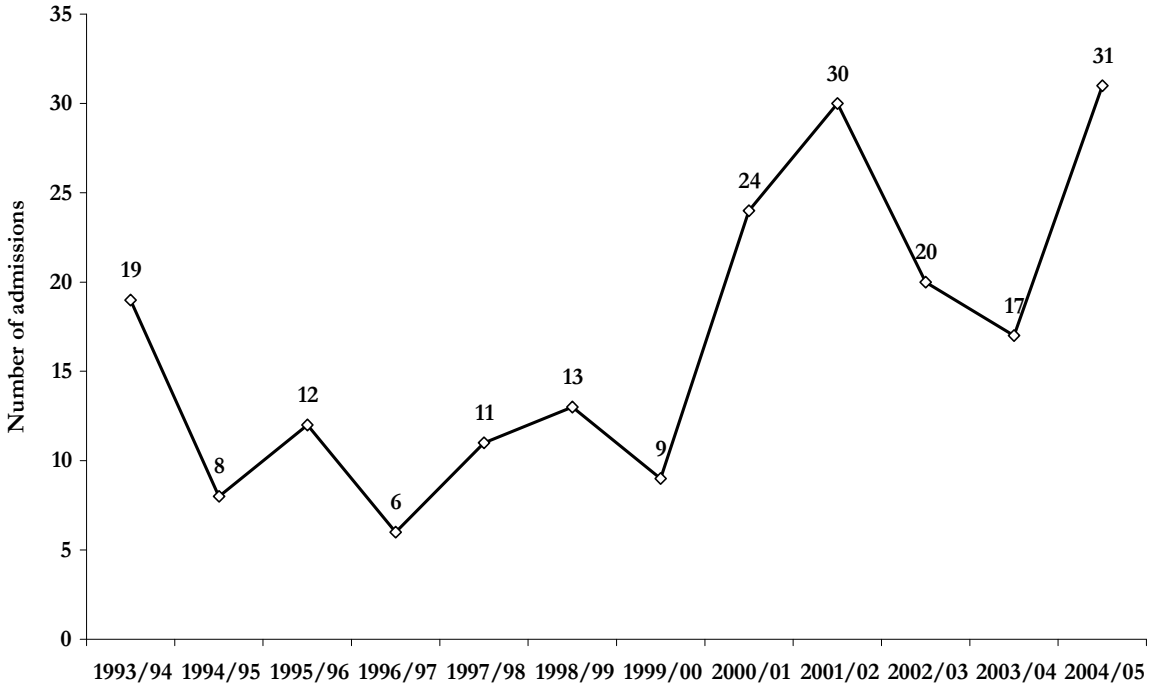
Details of cannabis-related consumer and provider arrests are in Section 15.3 (Data for 2005/06 was not available at the time of publication). Since the implementation of the Cannabis Cautioning Program (which evolved into the Illicit Drug Diversion Initiative), cautions and arrests relating to cannabis increased steadily from 736 in 1998/99 to 1,830 in 2002/03. This trend, however, reversed in 2003/04, declining to 1,638 cases, and 1,474 cases in 2004/05. The bulk of these cases (92% in 2003/04 and 86% in 2004/05) related to consumer-type offences.

11.5.2 Health

Hospital morbidity data in relation to use of drugs have been provided by the Australian Institute of Health and Welfare for the 1993/04 to 2004/05 financial year periods. These data relate to Tasmanian public hospital admissions for individuals aged between 15 and 54 years, where cannabis use was recorded as the 'principal diagnosis'; namely, where the effect of cannabis was established, after study, to be chiefly responsible for occasioning the patient's episode of care in hospital (with the exception of admissions for psychosis and withdrawal). These figures were based on diagnoses coded according to the International Classification of Diseases (ICD) 10, second edition. It is also important to note that data from the state's single public specialist detoxification centre are only included in this dataset from June 2002.

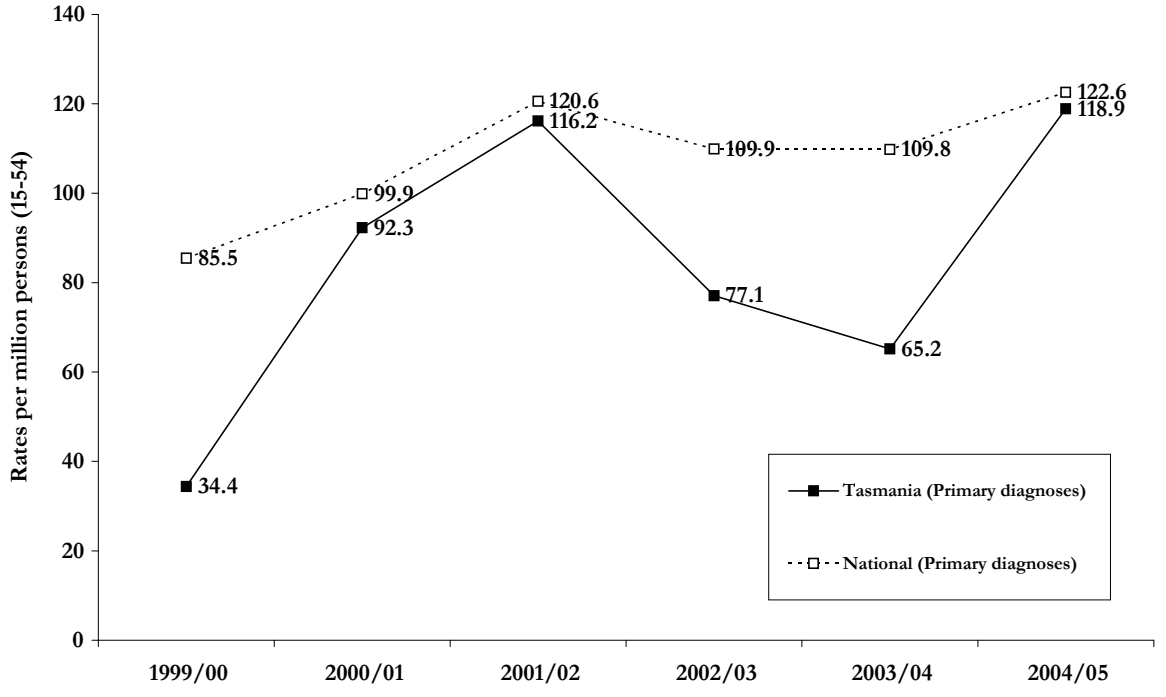
Tasmanian public hospital admissions where cannabis use was noted as the principal diagnosis are presented in Figure 34 below. Examining these figures, it appears that the number of cases per annum has increased in recent years: between 1993/04 and 1999/00 there were around 11 cases per annum (6-19) but this has doubled to an average of 24 cases per annum between 2000/01 and 2004/05 (range 24-31). When the population-adjusted rates of Tasmanian admissions are compared with those nationally (Figure 35), it is clear that Tasmanian admission rates in 2004/05 are comparable with those nationally, with the rate around 97% of the national average, at 119 admissions per million population. This marks a return to nationally-consistent admission rates after lower levels of admissions in Tasmania during 2002/03 and 2004/05, where local admission rates were 70% and 59% of the national average respectively.

Figure 34: Public hospital admissions amongst persons aged 15-54 in Tasmania where cannabis use was noted as the primary factor contributing to admission, 1993/94-2004/05



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

Figure 35: Public hospital admissions among persons aged 15-54 where cannabis was noted as the primary factor contributing to admission, rates per million population for Tasmania and Australia, 1999/00-2004/05



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

11.6 Summary of cannabis trends

- The entire REU sample had used cannabis at some stage of their life, and a majority (82%) had used cannabis during the six months preceding the interview. There was a trend for a greater proportion of males (88%) relative to females (74%) to have recently used cannabis. Cannabis had typically been smoked, and over one-third had recently swallowed the drug.
- The median frequency of cannabis use was 25 days (range 1-180) or approximately weekly, and this tended to be greater for males relative to females (30 vs. 12 days), and for older relative to younger participants (72 vs. 12 days).
- Participants were asked about the price, purity, and availability of hydroponically -grown ('hydro') and bush-grown ('bush') cannabis for the first time in 2006.
- The median last purchase price for one gram of cannabis was $15 for both 'bush' and 'hydro' (range $10-$25). The median last purchase price for one quarter of an ounce was $85 ($70-$100) and $65 ($40-$80) for 'hydro' and 'bush' respectively, and the median price for one ounce of 'hydro' was $250 (range $200-300) compared to $200 ($50-350) for 'bush'.
- The purity of 'hydro' was reported to be high and stable, and the purity of 'bush' was reported to be medium and stable in the preceding six months.
- Both 'bush' and 'hydro' were reported to be 'easy' or 'very easy' to obtain, and this level of availability was perceived as remaining stable during the six months preceding the interview. Cannabis was typically purchased or received as gifts from friends at friend's homes.
- The numbers of arrests and cautions made by Tasmania police increased steadily between 1998/99 and 2002/03, and have decreased slightly between 2003/04 and 2004/05. The number of Tasmanian hospital admissions in relation to cannabis increased between 2003/04 and 2004/05, but is at a level comparable to the rate nationally.

12.0 OTHER DRUGS

12.1 Alcohol

The entire sample of REU interviewed in 2005 had used alcohol at some stage in their lives (see Table 38). The median age that respondents had first used alcohol was 15 years (range 4-19 years, SD=2.1) and there was no difference in the mean age of first use for males and females. A large majority of the sample (95%) had used alcohol during the six months preceding the interview and there was no difference between the proportion of males (97%) and females (93%) or 'older' (92%) and 'younger' (98%) participants that had used alcohol. The median frequency of alcohol use was 48 days (range 2-180 days, SD=39.1), or approximately twice a week, during the six months preceding the interview. There was no significant difference in the median frequency of use for 'older' and 'younger' participants. Almost three-quarters of those that had recently used alcohol (74%) had done so twice a week or more during the preceding six months.

In the 2004 National Drug Strategy Household Survey, it was estimated (from the sample of 1,208 participants) that approximately 39.4% of Tasmanians had used alcohol on a weekly basis in the year prior to interview, compared with 41.2% Australians nationally (AIHW, 2005). The proportion of the Tasmanian sample that had used alcohol daily in the year prior to interview was slightly lower in comparison to the national estimate (6.3% vs. 8.9%). Among the national sample, 56.7% of those aged between 20-29 had used alcohol on a weekly basis. A large majority (78%) of the 2006 EDRS REU sample had used alcohol at least weekly during the six months preceding the interview, which is substantially higher than both the Tasmanian (39.4%) and national (41.2%) estimates of prevalence for the general population, and among those aged 20-29 nationally. However, the proportion reporting recent daily use of alcohol (4%) is slightly lower than both the Tasmanian (6.2%) and national (8.3%) estimates of prevalence, and similar to the estimate among those aged 20-29 among the national sample.

Table 38: Patterns of alcohol use of REU, 2003-2006

Alcohol	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	100	100	100	**100**
Median age first used alcohol (range)	15 years (10-18)	14 years (7-18)	14 years (8-18)	**15 years (4-19)**
Used preceding six months (%)	98	98	98	**95**
Of those who had used in preceding 6 mths				
Median days used last 6 mths (range)	48 (1-180)	48 (6-180)	49 (2-180)	**48 (2-180)**

Source: EDRS Regular ecstasy user interviews 2003-2006

Those key experts that commented on alcohol use indicated that 'half', (n=3) 'most' (n=9) or 'all' (n=3) of the group of REU that they were familiar with drank alcohol. The majority of these (n=7) indicated that there had been no recent changes in the use of alcohol. Two KE indicated that there had been a recent increase in the use of alcohol in combination with ecstasy. Another KE indicated that the use of alcohol had recently decreased among 'older' users and increased among 'younger' users. One KE that worked in emergency services indicated that a large majority of presentations to their services were associated with the use of alcohol rather than the use of illicit drugs such as ecstasy, cannabis, or methamphetamine and that this had been slowly but steadily increasing in recent years.

12.1.1 Alcohol Use Disorders Identification Test (AUDIT)

In 2006, REU completed the Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aaslad, Babor & de la Fuente, 1993). The AUDIT was designed by the World Health Organization as a brief screening scale to identify individuals with alcohol problems, including those in early stages. It is a 10-item scale, designed to assess three conceptual domains: alcohol intake, dependence, and adverse consequences (Reinert & Allen, 2002).

Total scores of 8 or more are recommended as indicators of hazardous and harmful alcohol use, as well as possible alcohol dependence (Babor, Higgins-Biddle, Saunders & Monteiro, 2001). Higher scores indicate greater likelihood of hazardous and harmful drinking; such scores may also reflect greater severity of alcohol problems and dependence, as well as a greater need for more intensive treatment (Babor, Higgins-Biddle, Saunders & Monteiro, 2001).

The overall mean score on the AUDIT was 13.3 (median=13; range 0-29, SD=5.9). The mean AUDIT score was significantly greater for males (M=14.8, SD=5.8) in comparison to females (M=11.4, SD=5.4), t(93)=-2.9, p>0.01. There was no significant difference in the mean AUDIT scores of 'older' and 'younger' participants, or in the proportion that scored 8 or more on the scale (based on a median split for age).

Of those REU that completed the AUDIT (n=95), eighty-five percent (85%) scored 8 or more, a level at which alcohol intake may be considered hazardous. A greater proportion of males (91%) scored 8 or more on the AUDIT in comparison to the proportion of females (78%), χ^2=3.31, p=.069. However, this failed to reach conventional levels of statistical significance. There was no significant difference between the proportion of 'older' (88%) and 'younger' (83%) participants who scored eight or more on the AUDIT.

The total AUDIT score places respondents into one of four 'zones', or risk levels. Just fifteen percent (15%) of the REU that completed the AUDIT scored in zone 1 (low-risk drinking or abstinence). Over one-half (52%) scored in zone 2 (alcohol use in excess of low-risk guidelines), a further 18% scored in zone 3 (harmful or hazardous drinking) and 15% scored in zone 4 (those in this zone may be referred to evaluation and possible treatment for alcohol dependence).

12.2 Tobacco

A large proportion (94%) of the REU sample in 2005 had smoked tobacco at some stage in their lives (Table 39), and this proportion was similar for males (97%) and females (91%). The median age that tobacco was first used was 15 years (range 7-23 years, SD=2.9 years) and there was no significant difference between the age of first use for males and females. Four-fifths (81%) of the sample had smoked tobacco during the six months preceding the interview, and there was no significant difference in the proportion of males (79%) and females (83%) or 'older' (80%) and 'younger' (82%) participants. Those that had recently used tobacco had first started using ecstasy at a younger age than those that had not (19 vs. 21 years), Mann-Whitney U=545.5, p<.05

Almost two-thirds (63%) of those who had recently smoked, and over half (51%) of the sample, reported smoking tobacco on a daily basis during the six months preceding the interview. Two-fifths (19%) of those that had recently smoked tobacco (15% of the entire sample) had smoked tobacco once a week or less during the six months preceding the interview. There was no significant difference between males or females or 'older' and 'younger' participants in terms of the number of days that they had smoked tobacco in the preceding six months, or the proportion that had smoked on a daily basis. The proportion that

reported smoking tobacco on a daily basis was greater among the 2005 (51%) and 2006 (51%) samples in comparison to the 2003 (44%) and 2004 (40%) samples.

In the 2004 National Drug Strategy Household Survey, it was estimated (from the sample of 1,208 participants) that approximately 21.5% of Tasmanians (aged 14 years and over) smoked tobacco on a daily basis in the year prior to interview, compared with 17.4% Australians nationally (Australian Institute of Health and Welfare, 2005). Among those aged 20-29, 27.7% of Tasmanians had smoked tobacco on a daily basis, compared to 23.5% nationally. Almost two-thirds (63%) of the 2006 REU sample had smoked on a daily basis in the current study, which is substantially greater than the estimate of prevalence among the general population both nationally and in Tasmania.

Table 39: Patterns of tobacco use of REU, 2003-2006

Tobacco	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	96	89	89	**94**
Median age first used tobacco	15 years (3-23)	14 years (7-22)	15 years (8-20)	**15 years (7-23)**
Used preceding six months (%)	81	77	83	**81**
Used on a daily basis in the last six months (%)	44	40	51	**51**
Of those who had used in the preceding 6 mths	n=81	n=77	n=83	**n=81**
Used on a daily basis (%)	54	57	61	**63**
Used once a week or less (%)	22	25	18	**19**

Source: EDRS Regular ecstasy user interviews 2003-2006

Most key experts noted recent tobacco use among the group of regular ecstasy users that they were familiar with. Estimates of the proportion of these groups that used tobacco ranged from 'a few' (n=5), 'half' (n=5), 'most' (n=4) to 'all' (n=1). While six KE indicated that there had been no recent changes in the use of tobacco among REU, three KE indicated that there had been a recent reduction in the use of tobacco. Two of these KE suggested that the reduction in tobacco smoking was related to changes in legislation regarding smoking in bars and nightclubs in Tasmania. However, there is no indication of a reduction in tobacco smoking among the 2006 EDRS sample.

12.3 Benzodiazepines

Of the Tasmanians surveyed in the 1998 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 1999), 7.9% (n=75) indicated that they had ever tried benzodiazepines for non-medical purposes, and 2.9% (n=28) reported use in the year prior to the survey. However, in the 2001 National Drug Household Survey (n=1,349: Australian Institute of Health and Welfare, 2002), only 1.0% (n=13) of respondents reported use of benzodiazepines for non-medical purposes in the year prior to interview. In the 2004 survey, just 0.7% (n=8) of the 1,208 local participants sampled (Australian Institute of Health and Welfare, 2005) reported using benzodiazepines (referred to as 'tranquilizers/sleeping pills' in the study) in the year prior to interview. While these are low base rates of reported benzodiazepine use, this does seem to indicate a slight reduction in the prevalence of benzodiazepine (mis)use among the general Tasmanian population between the 1998 and 2001/2004 studies.

Almost one-half (48%) of the 2005 REU sample had used benzodiazepines at some stage of their life (Table 40). There was no difference between the proportion of males (52%) and

females (43%) or 'older' (52%) and 'younger' (44%) participants that had ever used benzodiazepines. The median age that respondents had first used benzodiazepines was 21 years (range 14-35 years, SD=3.9 years) and there was no significant difference between the age of first use for males (19 years) and females (21 years). The majority of those that had ever used benzodiazepines had swallowed the drug (98%) and smaller proportions had ever injected (8%), snorted (6%) or shelved (2%) the drug.

One-third (33%) of the of the 2006 REU sample had used benzodiazepines during the six months preceding the interview, which is slightly greater than proportion that had recently used benzodiazepines among the 2005 sample (25%). There was no significant difference between the proportion of the male (33%) and female (33%) or 'older' and 'younger' groups that had recently used benzodiazepines. The majority (97%) of those that had recently used benzodiazepines had swallowed the drug and a single participant had recently shelved benzodiazepines. The median frequency of recent benzodiazepine use was 5 days (range 1-180 days, SD=34 days) during the six months preceding the interview. Three-quarters (73%) of those who had recently used benzodiazepines had done so on six or less occasions in the six months preceding the interview, or less than once a month. There was no difference in the frequency of recent benzodiazepine use for males and females or 'older' and 'younger' participants. A single participant had recently used benzodiazepines daily during the six months preceding the interview.

Table 40: Patterns of benzodiazepine use of REU, 2003-2006

Benzodiazepines	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	52	34	40	**48**
Ever injected (%)	7	2	3	**4**
Median age first used benzodiazepines (range)	20 years (10-40)	20 years (8-24)	19 years (10-28)	**21 years (14-35)**
Used preceding six months (%)	35	23	25	**33**
Injected in preceding six months (%)	2	1	-	**-**
Of those who had used in preceding 6 mths				
Median days used last 6 mths (range)	6 (1-180)	6 (1-96)	3 (1-50)	**5 (1-180)**

Source: EDRS Regular ecstasy user interviews 2003-2006

Whereas seven KE indicated that there was no use of benzodiazepines among the REU that they were familiar with, eight KE noted that a small proportion of REU use benzodiazepines and seven of these indicated that there had been no recent changes in the use of benzodiazepines among this population. One KE indicated that use of benzodiazepines was typically licit (used as prescribed for a genuine medical condition). In contrast, another KE commented that benzodiazepines were often used to 'come down' or to 'get to sleep' following a session of ecstasy use. However, among the 2006 REU sample, only 6 out of the 33 respondents that had recently used benzodiazepines reported that they typically used benzodiazepines when coming down from ecstasy (see Table 4, Section 4.1).

12.4 Antidepressants

Two-fifths (20%) of the 2006 REU sample had used antidepressants at some stage of their life (Table 41). The median age of first use was 20 years (range 14-35 years, SD=5.5 years). All of those who had used antidepressants had taken them orally. There were no sex differences in the proportion of males (19%) and females (21%) who had ever used antidepressants, or the

age of first use. There was no significant difference in the proportion of 'older' (20%) and 'younger' (20%) participants that had ever used antidepressants.

One-tenth of the 2005 REU sample (9%) had recently used antidepressants and there was no significant difference in the proportion of males (9%) and females (10%) or 'older' (8%) and 'younger' (10%) participants. All of those that had used antidepressants among the 2006 sample had taken them orally. The median frequency of antidepressant use was 34 days (range 3-180 days) in the preceding six months. One-third (33%, n=3) of those that had recently used antidepressants had used them on a daily basis. There were no significant sex or age differences in terms of the median frequency of use.

Table 41: Patterns of antidepressant use of REU, 2003-2006

Antidepressants	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	32	14	21	**20**
Median age first used antidepressants (range)	18 years (13-44)	20 years (17-23)	18 years (16-27)	**20 years (14-35)**
Used preceding six months (%)	14	4	12	**9**
Of those who had used in preceding 6 mths				
Median days used last 6 mths (range)*	90 (14-180)	6 (1-180)	180 (1-180)	**34 (3-180)**

Source: EDRS Regular ecstasy user interviews 2003-2006

Several KE (n=10) reported that they were aware that 'a few' REU took antidepressants, and six of these commented that use of antidepressants among this population was usually licit or as prescribed. One KE noted an increase in the use of prescribed antidepressants among the REU that they were familiar with.

12.5 Inhalants

Amyl nitrite

Two-fifths (41%) of the 2006 REU sample had ever used amyl nitrite compared to approximately one-half among the 2004 (52%) and 2005 (49%) samples, and a much larger proportion (78%) among the sample in 2003 (Table 42). There was no significant difference in the proportion of males (47%) and females (33%) that had ever used amyl nitrite. A greater proportion of 'older' participants (62%) had ever used amyl nitrite in comparison to the proportion of the 'younger' participants (20%), χ^2=18.233, p<.001, and those that had recently used amyl nitrite were significantly older than those that had not (28 vs. 23 years), t(98)=24.3, p<.001. The median age of first use was 20 years (range 14-55 years, SD=3.3 years) and there was no difference between the first age of use for males and females.

One-tenth of the 2006 sample (10%) had recently used amyl nitrite. The recent use of amyl nitrite among the REU sample has decreased gradually over the four years of the study. A greater proportion of females had recently used amyl nitrite in comparison to males, χ^2=3.58, p=.059. However, this failed to reach conventional levels of statistical significance. There was no significant difference between the proportion of 'older' (12%) and 'younger' (8%) participants that had recently used amyl nitrite. However, those that had recently used amyl nitrite were significantly older than those that had not recently used the drug (29 vs. 24 years), t(98)=6.71, p<.05. The median frequency of use was 3 days (range 1-10, SD=5), or approximately once every two months. The majority (90%) of those that had recently used amyl nitrite had done so on six occasions or less, or less than once a month. The median

number of snorts used in a typical session was 8 (range 4-15 snorts) and the median number of snorts in a heavy session of use was 8 (range 4-25 snorts). There were no sex or age differences in the frequency or quantity of recent amyl nitrite use.

Table 42: Patterns of amyl nitrite use of REU, 2003-2006

Amyl nitrite	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	78	52	49	**41**
Median age first used amyl nitrite (range)	20 years (16-43)	20 years (14-31)	19 years (14-25)	**20 years (14-55)**
Used preceding six months (%)	43	23	16	**10**
Of those who had used in the preceding 6 mths				
Median days used last 6 mths (range)	3 (1-72)	5 (1-120)	3.5 (1-20)	**3 (1-10)**
Snorts used typical session in last 6 mths	5 (1-40)	3 (1-10)	5 (1-30)	**6 (4-15)**
Snorts used biggest session in last 6 mths	5 (1-300)	5 (1-20)	10 (1-50)	**8 (4-25)**

Source: EDRS Regular ecstasy user interviews 2003-2006

Nitrous oxide

Two-thirds of the 2006 REU sample (69%) had ever used nitrous oxide compared to the same proportion among the 2005 sample and smaller proportions among the 2003 (47%) and 2004 (57%) samples (Table 43). A greater proportion of the male sample (79%) had ever used nitrous oxide in comparison to the proportion of the female sample (55%), χ^2=6.86, p<.01. There was no significant difference in the proportion of or 'older' (72%) and 'younger' (66%) participants that had ever used amyl nitrite. The median age of first use was 19 years (range 11-30 years, SD=3.3 years).

Two-fifths of the 2006 sample (39%) had used nitrous oxide during the six months preceding the interview compared to a similar proportion among the 2005 sample (41%) and smaller proportions among the 2003 (25%) and 2004 (34%) samples. The median frequency of use during this time was 5 days (range 1-30, SD=9.4 days), or less than once a month. Over two-thirds of those who had recently used nitrous oxide (72%) had done so less than monthly in the preceding six months. Then median frequency of use was significantly greater for males in comparison to females (5 days vs. 1 day), Mann-Whitney U=102.0, p<.05. There were no significant sex or age differences in the proportion reporting recent nitrous oxide use or age differences in the median frequency of use. The median number of bulbs used in a typical session was 5 (range 1-40 bulbs) and the median number used in a heavy session of use was 10 (range 1-140 bulbs). There were no age or sex differences in terms of the median number of bulbs used in a typical session.

Table 43: Patterns of nitrous oxide use of REU, 2003-2006

Nitrous oxide	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	47	57	69	**69**
Median age first used nitrous oxide (range)	19 years (12-30)	19 years (12-28)	18 years (15-29)	**19 years (11-30)**
Used preceding six months (%)	25	34	41	**39**
Of those who had used in preceding 6 mths				
Median days used last 6 mths (range)	4 (1-50)	3 (1-24)	5 (1-24)	**5 (1-30)**
Number of bulbs used in a typical session (range)	6 (1-12)	4 (1-50)	7 (1-40)	**5 (1-40)**
Number of bulbs used in biggest session (range)	10 (1-24)	6 (1-20)	9 (1-60)	**10 (1-140)**

Source: EDRS Regular ecstasy user interviews 2003-2006

Few key experts commented on the use of inhalants among the group of REU that they had regular contact with. Two KE indicated that 'a few' of the REU that they were familiar with used amyl nitrite, and two KE indicated that 'a few' of REU that they were familiar with used nitrous oxide.

12.6 Pharmaceutical stimulants

One-half of the 2006 REU sample (50%) had ever used pharmaceutical stimulants, which is slightly greater than the proportion that had ever used among the 2004 (39%) and 2005 (44%) samples (Table 44). A significantly greater proportion of males (60%) had ever used pharmaceutical stimulants in comparison to females (36%), $\chi^2=5.91$, $p<.05$. A significantly greater proportion of 'older' in comparison to 'younger' participants had ever used pharmaceutical stimulants, $\chi^2=58.91$, $p<.05$. The median age of first use was 19 years (range 11-31 years, SD=4.0), and there was no significant difference between the age of first use for males (20 years) and females (19 years). The majority of those that had ever used pharmaceutical stimulants had swallowed the drug (98%), and smaller proportions had ever snorted (24%), smoked (12%) or injected (12%) these drugs.

More than one-tenth of the 2006 REU sample (12%) had used pharmaceutical stimulants in the six months preceding the interview, compared to similar proportions among the 2004 (14%) and 2005 (16%) samples (Table 44). There was no significant difference in the proportion of the males (16%) and females (7%) or the proportion of 'older' (14%) and 'younger' (10%) participants that had recently used pharmaceutical stimulants. The majority of those who had recently used pharmaceutical stimulants had taken the drug orally (92%), and a single participant (8%, n=1) had recently injected pharmaceutical stimulants on five occasions in the preceding six months. The median frequency of use was 2 days (range 1-60) in the six months preceding the interview. The median number of tablets used in a typical session was 5 (range 1-8 tablets) and the median number used in a heavy session of use was 6 (range 1-32 tablets). There was no significant sex or age difference in terms of the median frequency of use or the number of tablets used in a typical session.

Key experts were not specifically asked about the use of pharmaceutical stimulants, and there were no comments in relation to these drugs.

Table 44: Patterns of pharmaceutical stimulant use of REU, 2004-2006

Pharmaceutical stimulants	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	39	44	**50**
Median age of first use (range)	19 years (7-31)	19 years (15-28)	**19 years (11-31)**
Used preceding six months (%)	14	16	**12**
Injected in the preceding six months (%)	2	1	**1**
Of those who had used in the preceding 6 mths			
Median days used last 6 mths (range)	3 (1-180)	3.5 (1-30)	**2 (1-60)**
Median tablets used in a typical session (range)	4 (1-15)	4 (2-10)	**5 (1-8)**
Median tablets used in biggest session (range)	4 (1-15)	6 (2-25)	**6 (1-32)**

Source: EDRS Regular ecstasy user interviews 2004-2006

12.7 Psychedelic mushrooms

Almost three-quarters (74%) of the 2006 REU sample had ever used psychedelic mushrooms which is greater than the proportion among the 2005 (63%), 2004 (60%), and 2003 (58%) samples (see Table 45). There was a trend for a greater proportion of the male sample (81%) to have ever used psychedelic mushrooms in comparison to the female sample (64%), χ^2=3.55, p=.059. A significantly greater proportion of 'older' (84%) in comparison to 'younger' (64%) participants had ever used mushrooms, χ^2=5.20, p<.05. The median age of first use for mushrooms was 20 years (range 11-29 years, SD=3.0 years), and this was the same for males (20 years) and females (20 years). The majority of those who had ever used psychedelic mushrooms had used them orally (97%) and smaller proportions had ever smoked (16%), snorted (3%), or shelved (1%) mushroom preparations.

Over one-half of the 2006 sample (55%) had used mushrooms in the preceding six months, which is greater than the proportion among the 2005 (40%), 2004 (41%), and 2003 (38%) samples (Table 45). A significantly greater proportion of males (66%) in comparison to females (41%) had recently used psychedelic mushrooms, χ^2=6.17, p<.05. There was no significant difference in the proportion of 'older' and 'younger' participants who had recently used mushrooms. A majority (96%) of those that had recently used mushrooms had ingested them, and smaller proportions had recently smoked (7%), snorted (2%, n=1) or shelved/shafted (2%, n=1) mushroom preparations. The median frequency of mushroom use was 3 days (range 1-19 days, SD=3.6) in the preceding 6 months, or approximately once every two months. Males tended to have a greater median frequency of mushroom use in comparison to females (3 vs. 2 days), Mann-Whitney *U*=223.5, *p*=.065.

It is noteworthy that the proportion of the sample reporting recent mushroom use (55%) is greater than the proportion reporting recent use of LSD (29%) (see Table 29). Two-fifths (21%) of the sample had recently used both LSD and mushrooms and almost two-thirds (63%) had recently used some form of psychedelic (either LSD or mushrooms). A significantly greater proportion of males (33%) had recently used both LSD and mushrooms in comparison to females (5%), χ^2=11.51, p<.01. Although the use of psychedelics appears to have increased over the last four years of the study, this largely reflects an increase in the use of mushrooms, whereas the use of LSD has remained relatively stable (see Section 9.0).

Several key experts (n=5) commented on recent use of psychedelic mushrooms among the group of REU that they had regular contact with. One KE commented that the use of mushrooms is generally seasonal and two KE indicated that mushrooms are often used instead

as LSD as they are free and have similar effects. Several REU (n=5) also noted an anecdotal increase in the seasonal use of mushrooms among themselves or their friends.

Table 45: Patterns of psychedelic mushroom use of REU, 2003-2006

Psychedelic mushrooms	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	58	60	63	**74**
Median age of first use (range)	20 years (14-37)	20 years (14-25)	20 years (14-28)	**20 years (11-29)**
Used preceding six months (%)	38	41	40	**55**
Injected in the preceding six months (%)	-	-	-	**-**
Used both LSD and mushrooms last 6 mths (%)	13	17	16	**21**
Used either LSD or mushrooms last 6 mths (%)	49	56	55	**63**
Of those who had used in last 6 mths	n=38	n=41	n=40	**n=55**
Median days used last 6 mths (range)	3 (1-180)	3 (1-48)	3 (1-12)	**3 (1-19)**

Source: EDRS Regular ecstasy user interviews 2003-2006

12.8 Heroin

One-tenth (10%) of the 2006 REU sample had ever used heroin, and there was no significant difference between the proportion of males (12%) and females (7%) that had ever used the drug (Table 46). A greater proportion of 'older' (16%) participants had ever used heroin in comparison to 'younger' (4%) participants, $\chi^2=4.00$, $p<.05$. A majority of those that had ever used heroin (90%) had injected the drug and smaller proportions had ever smoked (50%), snorted (20%), or swallowed (10%) the drug. The median age of first heroin use was 18 years (range 15-32 years, SD=5.6). In the 2006 cohorts, two male participants had used heroin during the six months preceding the interview, while there was no recent use noted amongst the 2004 and 2005 cohorts. Both participants had injected heroin and one participant had smoked heroin during this time. One participant had injected heroin on three occasions and the other had injected heroin on 10 occasions and had also smoked the drug during this time.

The majority of key experts were not aware of any heroin use among REU that they were familiar with and two key experts commented that heroin is currently difficult to obtain in Hobart. Only three key experts were aware of heroin use among a small proportion of the REU that they had regular contact with. The low reported use and availability of heroin among REU in Hobart is consistent with data reported in the Tasmanian IDRS in relation to injecting drug users (see Bruno, 2005, 2006; de Graaff & Bruno, 2007).

Table 46: Patterns of heroin use of REU, 2003-2006

Heroin	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	20	4	8	**10**
Median age of first use (range)	19 years (14-30)	20 years (16-26)	22 years (16-26)	**18 years (15-32)**
Used preceding six months (%)	6	-	-	**2**
Injected in the preceding six months (%)	6	-	-	**2**
Of those who had used in last 6 mths Median days used last 6 mths (range)	16 (3-48)	-	-	**7 (3-10)**

Source: EDRS Regular ecstasy user interviews 2003-2006

12.9 Methadone

Less than one-tenth (9%) of the 2006 REU sample (4 females, 5 males) had ever used methadone, which is slightly greater than the proportion reporting lifetime use among the 2004 (2%) and 2005 (5%) samples and slightly less than the proportion among the 2003 (14%) sample (Table 47). The median age of first methadone use was 21 years (range 16-34, SD=5.7). Those reporting lifetime use of methadone had either swallowed (100%, n=9) or injected (56%, n=5) the drug. Five participants (5%, 4 females, 1 male) had used methadone during the six months preceding the interview. Those that had recently used methadone had either swallowed (60%) or injected (60%) the drug. The median frequency of use was 20 days (range 1-180) during the six months preceding the interview. A single participant had used methadone on a daily basis and the remainder had used the drug weekly or less during this time.

The majority of key experts were not aware of any use of methadone among the group of REU that they had regular contact with. Three key experts commented that a small proportion of the regular ecstasy users that they were familiar with used methadone. Two KE commented that the use of methadone was more common among a minority of older rather than younger users.

Table 47: Patterns of methadone use of REU, 2003-2006

Methadone	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	14	2	5	**9**
Median age of first use (range)	22 years (16-36)	18 years (17-19)	20 years (16-22)	**21 years (16-34)**
Used preceding six months (%)	13	2	1	**5**
Injected in the preceding six months (%)	11	2	1	**3**
Of those who had used in last 6 mths Median days used last 6 mths (range)	10 (1-24)	(2-180)	180	**20 (1-180)**

Source: EDRS Regular ecstasy user interviews 2003-2006

12.10 Buprenorphine

Three REU (3%, 2 female, 1 male) among the 2006 sample had ever used buprenorphine, compared to none among the 2005 and 2004 samples, and five participants among the 2003 sample (Table 48). The median age of first use was 32 years (range 22-35). Among the 2006 cohort, all three participants reporting use had swallowed buprenorphine and a single participant had ever injected the drug. A single female participant had used buprenorphine orally on a daily basis during the six months preceding the interview. Consistent with the low levels of buprenorphine use among the REU sample, a single KE indicated that one REU that they had recently had contact with used buprenorphine.

Table 48: Patterns of buprenorphine use of REU, 2003-2006

Buprenorphine	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	5	-	2	**3**
Median age of first use (range)	25 (22-37)	-	21 (20-22)	**32 (22-35)**
Used preceding six months (%)	3	-	1	**1**
Injected in the preceding six months (%)	2	-	-	**-**
Of those who had used in last 6 mths				
Median days used last 6 mths (range)	30 (2-180)	-	6	**180**

Source: EDRS Regular ecstasy user interviews 2003-2006

12.11 Other opiates

'Other opiates' comprised a broad drug class including over-the-counter pharmaceuticals such as codeine, restricted pharmaceuticals such as morphine, and alkaloid poppy plant derivatives such as opium or 'poppy wash'. Table 49 shows that one-third (33%) of the 2006 REU sample had ever used 'other opiates', compared to one-quarter (25%) in 2005, one-fifth (19%) in 2004, and one-third (35%) among the 2003 sample. A greater proportion of the male sample (45%) had ever used other opiates in comparison to the proportion of the female sample (17%), χ^2=8.74, p<.01. Lifetime use of 'other opiates' also tended to be more common among 'older' relative to 'younger' participants, χ^2=3.66, p=.056. The median age of first 'other opiate' use was 20 years (14-29 years, SD=4.0), and this was similar for males (20 years) and females (19 years). The most common route of administration was swallowing (76%) and smoking (70%), followed by injection (24%), snorting (9%) and shelving/shafting (3%, n=1).

Just over one-tenth of the 2006 REU sample (14%) had recently used 'other opiates', which is similar to the proportion reporting recent use among the 2003 (13%), 2004 (8%), and 2005 (13%) samples. A significantly greater proportion of males (21%) had recently used 'other opiates' in comparison to females (5%), χ^2=5.13, p<.05. The median frequency of 'other opiate' use was 3 days (range 1-121) during the six months preceding the interview, or approximately once every two months which is lower than the frequency of use reported in previous years (range 6-11 days). There were no significant sex or age differences in the median frequency of 'other opiate' use. For those that had recently used 'other opiates', the most common route of administration was swallowing (100%), followed by smoking (29%), injecting (29%), snorting (7%, n=1) and shelving/shafting (7%, n=1).

Table 49: Patterns of other opiate use of REU, 2003-2006

Other opiates	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever used (%)	35	19	25	**33**
Median age of first use (range)	20 years (14-44)	19 years (16-27)	18 years (16-27)	**20 years (14-29)**
Used preceding six months (%)	13	8	13	**14**
Injected in the preceding six months (%)	8	-	-	**4**
Of those who had used in last 6 mths	n=13	n=8	n=13	**n=14**
Median days used last 6 mths (range)	6 (1-120)	11 (3-48)	8 (1-48)	**3 (1-121)**

Source: EDRS Regular ecstasy user interviews 2003-2006

Some KE also noted occasional use of morphine (n=2) and seasonal use of poppy derivatives such as opium (n=1) among the REU that they were familiar with.

12.12 Other drugs

There was increased use of the research chemical 2CI (2, 5-dimethoxy-4-iodophenethylamine) among the participants interviewed in 2006. Research chemicals or 'experimental chemicals' refer to relatively new substances that have not necessarily been formally studied or are still being researched. As such, very little is known about the effects and risks of using these drugs and there have been few animal or human toxicology studies or studies looking at issues such as long-term problems, side effects, addiction/dependence, allergic reactions, acute overdose, and interactions with other drugs. In many countries, research chemicals are not controlled substances and can often be purchased through chemical supply companies for 'research' purposes (Erowid, 2005). 2CI has only been available as a research chemical since 2002. It belongs to the phenethylamine class of drugs and is structurally related and has similar effects to 2CB, but may be more potent. As with MDMA, 2CI should not be taken with MAOI antidepressants. 2CI was not listed as a controlled substance in Tasmania until an amendment was made to the Misuse of Drugs Act in 2006.

Five participants among the 2004 REU cohort had recently used 2CI and there were anecdotal reports by both REU and KE of an increase in the use and availability of the drug in 2004. Among the 2005 sample, two respondents had ever used the drug and a single respondent had used the drug on one occasion during the six months preceding the interview. In 2006, one quarter (25%) of the REU sample had ever used 2CI and 23% had used the drug during the six months preceding the interview, representing a substantial increase in the use and availability of the drug. The median age of first use was 22 years (range 20-37). All of those that had ever and recently used 2CI had swallowed the drug and three participants had ever and recently snorted the drug. The median frequency of use in the last six months was 2 days (range 1-7). Almost half of those that had recently used 2CI (44%) had done so on single occasions in the last 6 months, indicating predominantly experimental use.

Some KE also commented on a recent increase in the use (n=4) and availability (n=1) of 2CI, with another commenting that the drug was readily available about ten months prior to interview in September 2005. Many REU (n=18) also commented anecdotally on the recent increase in the use and availability of 2CI and four REU commented that there had been a recent increase in the availability of 2C-E, although none of the REU reported using 2C-E during the six months preceding the interview. One KE noted that use of 2CI is mainly experimental and that often people do not want to try it again.

2CB is a synthetic chemical in that is related structurally to mescaline and distantly to MDMA. 2CB first gained popularity as a legal ecstasy replacement in the US in the mid-1980s. It is generally considered to provide a psychedelic experience which is somewhat 'gentler' than LSD or mushrooms, being less prone to producing 'bad trips' or anxiety at recreational use levels (Erowid, 2005). One participant reported lifetime use of 2CB among the 2006 sample, but had not used the drug during the six months preceding the interview. Two participants reported lifetime use of 2CB among the 2005 REU sample and a single participant had snorted and swallowed the drug on one occasion during the six months preceding the interview (Matthews & Bruno, 2006). There was also some use of 2CB among the 2003 and 2004 samples, with single participants having recently used the drug (Bruno & McLean, 2004b; Matthews & Bruno, 2005).

Single participants indicated lifetime use of BZP, DXM, DMT and mescaline among the 2006 REU sample, and BZP and DMT had been used on single occasions during the six months preceding the interview.

Three KE commented on the recent increased use of BZP in the form of 'funk pills' that could be purchased by mail order from New Zealand where they are legal. BZP was also legal in Tasmania until an amendment to the Misuse of Drugs Act was made in 2006 to list the drug as a controlled substance. A single REU also commented anecdotally on a recent use of 'funk pills' among REU.

12.13 Summary of other drug use

- The majority of REU had recently consumed alcohol on an average of two days per week in the six months preceding the interview. A large majority (78%) of the 2006 EDRS REU sample had used alcohol at least weekly during the six months preceding the interview, which is substantially higher than both the Tasmanian (39.4%) and national (41.2%) estimates of prevalence for the general population from the 2004 NDSHS, and among those aged 20-29 nationally (56.7%). A large majority of REU (85%) scored 8 or more on the Alcohol Use Disorders Identification Test (AUDIT), suggestive of hazardous and harmful alcohol use and the possibility of alcohol dependence.
- Tobacco had recently been used by four-fifths (81%) of the sample. Over half had smoked tobacco on a daily basis in the last six months, and others had smoked tobacco less frequently. The proportion of daily smokers among REU interviewed in the present study (63%) is greater in comparison to both national (23.5%) and Tasmanian (27.7%) estimates of prevalence among those aged 20-29 (a comparable age group to the current REU cohort).
- One-third of the sample had recently used benzodiazepines, with the drug used on a median of five days in the last six months. However, only 6% reported using benzodiazepines when 'coming down' from ecstasy.
- One-tenth of the sample (9%) had recently used antidepressants, with one-third of these using them on a daily basis.
- There has been a reduction among REU in the recent use of amyl nitrite from two-fifths (43%) in 2003 to one-tenth (10%) in 2006. The majority (90%) of those that had inhaled amyl nitrite had done so less than once a month during the last 6 months.
- The proportion of the sample reporting recent use of nitrous oxide has increased from one-quarter (25%) to two-fifths in 2005 (43%), and 2006 (39%). On average, nitrous oxide had been used less than monthly.
- Twelve percent had recently used pharmaceutical stimulants (such as dexamphetamine or methylphenidate), at a median frequency of approximately once every three months.
- Only small proportions of the sample had recently used methadone (5%), heroin (2%), and buprenorphine (1%). The recent use of other opiates (pharmaceuticals and alkaloid poppy derivatives) was slightly more common (14%) but relatively infrequent at once every two months.
- Over one-half (55%) of the sample had recently used psychedelic mushrooms, which is an increase relative to previous years. Mushrooms had been used on a median of once every two months during the last six months Both REU and KE indicated a recent increase in the use of mushrooms due to seasonal increase in availability at the time of the interviews. Over three-fifths of the sample (63%) had recently used some form of psychedelic drug (either LSD and/or mushrooms) in the last six months.
- Almost one-quarter of the 2006 REU sample (23%) had recently used the hallucinogenic research chemical 2CI, which is a substantial increase relative to previous years. Whereas this indicates an increase in the availability of 2CI locally, the frequency of use was relatively low, indicative of predominantly experimental use. There was also an anecdotal increase in the availability of 2C-E

13.0 DRUG INFORMATION-SEEKING BEHAVIOUR

The regular ecstasy users interviewed in the present study were asked how often they found out about the content or purity of batches of ecstasy pills (Table 50). One-quarter of the sample (25%) indicated that they 'never' found out about the content/purity of ecstasy tablets before they took them. The remaining participants either 'sometimes' (34%), 'about half the time' (7%), 'most times' (19%) or 'always' (15%) found out about the content/purity of ecstasy tablets prior to taking them. This information was typically through friends (93%), dealers (61%), websites (36%), other people (31%), and personal experience (23%). Of those that had accessed websites, the most commonly accessed website was www.pillreports.com (63%). Other websites included www.ravesafe.org, www.erowid.org, www.enlighten.org.au, www.bluelight.ru, and www.shroomery.net.

Two-thirds of the 2005 REU sample (66%) indicated that they had 'sometimes' bought a drug in the last six months and it had turned out to have a different content or purity than they expected. Two-fifths indicated that this had 'never' occurred and smaller proportions indicated that this had occurred 'about half the time' (8%), 'most times' (2%), or always (1%).

Participants were asked about their perceptions of ecstasy pills and ecstasy markets (Table 50). When asked whether pill logos are a good indication of what a pill will be like, over two-thirds 'disagreed' (43%) or 'strongly disagreed' (25%), and only one-quarter 'agreed' (24%) or 'strongly agreed' (3%). When participants were asked if they knew what was in the pills that they consumed, only 20% agreed that they did know what active drug/s were in the pills that they took, and three fifths (63%) indicated that they did not know what was in the pills that they took.

The REU sample was asked which information resources they would find personally useful if available locally (Table 50). Information sources considered most useful were testing kits (72%), a local website (62%), and information pamphlets (57%), followed by outreach workers at events (28%), posters (24%), video/DVDs (10%), postcards (10%), and music CDs (9%).

Ten participants (13%) reported using testing kits in the preceding six months, compared to five among the 2005 sample. Of those that had used testing kits, one-half (50%, n=5) only 'sometimes' used testing kits, a single participant (10%, n=1) used them 'half the time', and four participants (40%) used them 'most times'. Five out of the ten REU that had recently used testing kits indicated that they were aware of their limitations (such as that testing only indicates the dominant ingredient contained in the pill or that testing kits can go out of date).

Table 50: Content and testing of ecstasy tablets, 2005-2006

	2005 n=100	**2006 n=100**
Find out the content/purity of ecstasy (%)		
Never	27	**25**
Sometimes	28	**34**
Half the time	9	**7**
Most times	27	**19**
Always	9	**15**
Find out content/purity of ecstasy via (%)	n=73	**n=75**
Friends	88	**93**
Dealers	45	**61**
Other people	38	**31**
Personal experience	41	**23**
Testing kits	7	**13**
Information pamphlets	1	**-**
Websites	45	**36**
Ecstasy different content/purity than expected (%)		
Never	27	**23**
Sometimes	67	**66**
Half the time	5	**8**
Most times	1	**2**
Always	-	**1**
I know what is in the pills I take (%)	n/a	
Strongly agree		**2**
Agree		**18**
Neutral		**17**
Disagree		**46**
Strongly disagree		**17**
Logo believed to be a good indication of what pill is like (%)	n/a	
Strongly agree		**3**
Agree		**24**
Neutral		**5**
Disagree		**43**
Strongly disagree		**25**
Information resources believed to be personally useful (%)		
None	10	**7**
Pamphlets	53	**57**
Posters	18	**24**
Postcards	8	**10**
Music CDs	7	**9**
Video/DVDs	10	**10**
Local website	50	**62**
Testing kits	72	**72**
Outreach worker	23	**28**
Other	3	**4**
Use testing kits* (%)	n=5	**n=10**
Always	20	**-**
Sometimes	80	**50**
Half the time	-	**10**
Most times	-	**40**
Are aware of limitations of testing kits* (%)	**60**	**50**

Source: EDRS Regular ecstasy user interviews 2005-2006

* among those who used testing kits

REU were asked whether they would still take a pill if testing indicated that it contained a particular substance (Table 51). Participants were only encouraged to answer if they had some knowledge of the drug in question. As such, fewer people were able to answer confidently in relation to substances such as 2CB/2CI, PMA and DXM. The majority of those who commented indicated that they would still take a pill if testing indicated that it contained an ecstasy-like (100%), or amphetamine (97%) substance. One-half would still take a pill if testing indicated ketamine (57%), opiates (51%) or showed no reaction (47%). Only one-third would still take the pill if it contained DXM (35%) or 2CB/2CI (30%), and one-tenth (11%) would still take a pill if testing indicated that it contained PMA. This indicates that participants typically believed that pill testing would influence their decision to take a pill, particularly in the case of potentially harmful substances such as DXM and PMA.

Table 51: Use of pill testing kits and decision to take pill, 2006

	n	%
Would still take pill if contained* (%)		
Ecstasy-like substance	73	**100**
Amphetamine substance	73	**97**
Ketamine substance	70	**57**
Opiates	72	**51**
2CB/2CI	66	**30**
PMA	55	**11**
DXM	57	**35**
No reaction	70	**47**

Source: EDRS Regular ecstasy user interviews 2006

Some REU also made spontaneous qualitative comments in relation to harm-reduction information. Three REU commented on the need for more information on the effects of drugs, and three REU commented on the problem of not knowing what is contained in pills.

13.1 Summary of drug information-seeking behaviour

- Whereas one-third (34%) of the regular ecstasy users interviewed in 2006 actively and regularly sought information about the content/purity of 'batches' of ecstasy pills, the remainder did so half the time or less (37%) or 'never' (27%).
- Participants typically obtained this information from friends, dealers, and other people, as well as websites, personal experience and pill testing kits. Ten participants reported recent use of pill testing kits, and one-half of these were aware of some limitations of testing kits.
- Two-thirds of the sample (66%) indicated that they had 'sometimes' bought a drug and it turned out to have different effects than they expected in the last six months, and two-thirds (63%) indicated that they did not know what was in the pills that they took.
- The majority of the REU sample was receptive to harm-reduction information. Three-quarters (72%) indicated that they would find pill testing kits personally useful if available locally. Other information resources that were considered useful by REU were information pamphlets, a local website, outreach workers at events, and posters.
- Participants generally indicated that the result of pill testing would influence their decision to take a pill. For example, many would not take a pill if testing indicated that it contained potentially harmful substances such as PMA and DXM.
- Several REU commented on the lack of information available to them on drug-related effects and ways to use drugs more safely.

14.0 RISK BEHAVIOUR

14.1 Injecting drug use

Close to one-fifth of the 2005 REU sample (18%) had used substances intravenously at some stage of their lives, which is similar to the proportion of the 2005 (19%) and 2004 (15%) samples and fewer compared to 2003 (26%) (Table 52). There was no significant difference in the proportion of males (22%) and females (12%) that had ever injected. The mean age of lifetime injectors (28 years, SD=7.2) was significantly greater than those that had never injected (24 years, SD=5.0; $t(98)=-2.86$, $p<.01$), and based on a median split for age, a significantly greater proportion of 'older' users had ever injected in comparison to 'younger' users (26% vs. 10%; $\chi^2=4.34$, $p<.05$.

Less than one-tenth (9%) of the 2005 sample had used substances intravenously during the six months preceding the interview, compared to a similar proportion among the 2005 (8%) and 2004 (9%) samples and a greater proportion among the 2003 sample (22%). There was no significant difference in the proportion of males (10%) and females (7%) that had recently injected. The mean age of recent injectors was significantly greater than those that had not recently injected (28 vs. 24 years; $t(98)=-2.04$, $p<.05$), and, based on a median split for age, the proportion of 'older' users that had recently injected tended to be greater than the proportion of 'younger users' (14% vs. 4%; $\chi^2=3.05$, $p=.081$). Recent injectors were less likely to have completed year 12 (44% vs. 87%; $\chi^2=10.42$, $p<.01$), more likely to be unemployed (67% vs. 9%; $\chi^2=22.8$, $p<.001$), and none of the recent injectors were full-time students or currently in full-time work.

Those who had recently injected had used a significantly greater number of drug types in the last six months (10 vs. 6, from a list of 20 drug classes; Mann-Whitney $U=99.0$, $p<.001$), and were more likely to have recently binged on methamphetamine (78% vs. 30%; $\chi^2=8.45$, $p<.01$), to typically use methamphetamine with ecstasy (56% vs. 11%, $\chi^2=12.76$, $p<.001$), and have a high methamphetamine dependence score (67% vs. 10%; $\chi^2=20.71$, $p<.001$), compared to those that had not. This is not surprising considering that a majority of recent injectors had recently injected methamphetamine (see below). However, there was no difference in the frequency or quantity of ecstasy use, and none of the recent injectors had 'high' scores on the ecstasy symptoms of dependence scale. Further, recent injectors were less likely to binge drink in combination with ecstasy (22% vs. 70%; $\chi^2=8.45$, $p<.01$), and were less likely to have a 'high' score on the alcohol use disorders identification test (AUDIT) (56% vs. 84%; $\chi^2=4.16$, $p<.05$). Relative to non-injectors, recent injectors had a significantly higher scores on the Kessler psychological distress scale (18 vs. 17, Mann-Whitney $U=288.5$, $p<.05$), and were more likely to have a 'high' score (25 or more) on the Kessler scale (44% vs. 9%; $\chi^2=9.27$, $p<.01$), indicating greater likelihood of a mental disorder.

Table 52: Injecting risk behaviour among REU, 2003-2006

	2003 (n=100)	2004 (n=100)	2005 (n=100)	**2006 (n=100)**
Ever injected (%)	26	15	19	**18**
Injected last 6 months*	22	9	8	**9**

Source: EDRS Regular ecstasy user interviews 2003-2006

14.1.1 Lifetime injectors

Patterns of injecting drug use

Table 53 shows that those drugs that had ever been injected (n=18) were methamphetamine (78% powder, 61% base, 67% crystal), ecstasy pills (56%) and powder (22%), 'other opiates' (44%), heroin (50%), pharmaceutical stimulants (33%), LSD (28%), methadone (28%), cocaine (28%), benzodiazepines (22%), MDA (17%), ketamine (17%), buprenorphine (6%), and alcohol (6%).

Context of initiation to injecting

Over one-half of those who had ever injected had first injected methamphetamine (39% powder, 11% base, 6% crystal), followed by ecstasy pills (17%), heroin (17%), and other opiates (11%) (Table 53). Two-fifths (39%, n=7) of those who had ever injected were under the influence of other drugs the first time that they had injected. The drug types used preceding first injection were cannabis (28%, n=5), alcohol (22%, n=4), methamphetamine powder (6%, n=1), or LSD (6%, n=1). Participants were asked how they learnt to inject. The majority of those that had ever injected had learnt to inject from a friend/partner (61%) or other user (17%), followed by a needle exchange (6%, n=1), a website (6%, n=1), and information pamphlet (6%, n=1). Two-fifths indicated that they did not inject themselves (22%).

Table 53: Injecting drug use history among REU injectors, 2006

	Ever injected (%) (n=18)	First drug injected (%) (n=18)
Methamphetamine powder	78	39
Methamphetamine base	61	11
Crystal methamphetamine	67	6
Pharmaceutical stimulants	33	-
Ecstasy pills	56	17
Ecstasy powder	22	-
Heroin	50	17
Methadone	28	-
Buprenorphine	6	-
Cocaine	28	-
LSD	28	-
Ketamine	17	-
MDA	17	-
Other opiates*	44	11
Benzodiazepines	22	-
Alcohol	6	-

Source: EDRS Regular ecstasy user interviews 2006

* Includes codeine, Physeptone tablets, morphine, and pethidine.

14.1.2 Recent injectors

Patterns of injecting drug use

Less than a tenth of the sample (9%) had injected a drug in the six months prior to the interview. Table 54 shows that the most frequently injected drug in the last six months was methamphetamine (56% powder, 89% base, 67% crystal), followed by ecstasy (56%), 'other opiates' (44%), methadone (33%), cocaine (22%), heroin (22%), or pharmaceutical stimulants (11%). Over three-quarters of those who had recently injected (89%) had last injected methamphetamine (11% powder, 67% base, 11% crystal), followed by 'other opiates' (11%).

The frequency of injection for each drug was variable and ranged from single occasions to five times a week within the preceding six months. Overall, recent injectors had injected any drug a median of 120 times (range 1-400 times) in the six months preceding the interview, or approximately five times a week (Table 54).

Table 54: Recent injecting drug use patterns (recent injectors) among REU, 2006

	% injected last 6 months n=9	Median days injected last 6 months* (range)	Last drug injected n=8
Methamphetamine powder (%)	56	10 (2-30)	11
Methamphetamine base (%)	89	27 (1-60)	67
Crystal methamphetamine (%)	67	10 (2-30)	11
Ecstasy (%)	56	20 (2-24)	-
Methadone (%)	33	72 (72-72)	-
Pharmaceutical stimulants (%)	11	5 (5-5)	-
Cocaine (%)	22	3 (2-4)	-
Heroin (%)	22	6.5 (3-10)	-
Other opiates (%)	44	28.5 (1-120)	11

Source: EDRS Regular ecstasy user interviews 2006
* Of those who had injected in the preceding six months

Context of injecting

Of those that had injected drugs in the preceding six months, the majority (78%, n=7) had always injected themselves in this time. A small proportion had injected themselves 'often' (11%), or always required others to inject them during this period of time (11%) (Table 55). Recent injectors had typically injected with close friends (44%), a regular sex partner (33%), or acquaintances (22%), a casual sex partner (11%) or relatives (11%). The majority of those that had recently injected had done so at private residences including their own home (78%), a friend's home (78%) and dealer's home (33%). Other locations included a car (56%), a public toilet (33%), venue (nightclub) toilet (22%) and street (22%).

Table 55: Context and patterns of recent injection among REU, 2004-2006

	2004 (n=9)	2005 (n=8)	**2006 (n=9)**
Frequency of self-injection			
Every time (%)	56	63	**78**
Often (%)	11	13	**11**
Sometimes (%)	-	-	**-**
Rarely (%)	-	-	**-**
Never (%)	33	25	**11**
People usually inject with*			
Close friends (%)	56	63	**44**
Regular sex partner (%)	11	38	**33**
Casual sex partner (%)	11	-	**11**
Acquaintances (%)	11	13	**22**
No one (%)	11	13	**-**
Relative (%)	-	-	**11**
Locations injected in last six months*			
Own home (%)	89	75	**78**
Friend's home (%)	76	50	**78**
Car (%)	33	38	**56**
Dealer's home (%)	11	63	**33**
Street (%)	-	-	**22**
Public toilet (%)	-	38	**33**
Venue toilet (%)	11	25	**22**
Work (%)	2	-	**-**

Source: EDRS Regular ecstasy user interviews 2004-2006
*could nominate more than one response

Injecting risk behaviour

Overall, recent injectors (n=8) had injected any drug a median of 120 times (range 1-400 times) in the six months preceding the interview, or approximately five times a week (Table 56). Two participants had injected less than once a week during this time, three participants had injected more than weekly but less than daily, and the remaining three participants had injected more than daily during this time.

None of the recent injectors had used a needle after someone else in the last month or in the last six months and a single participant indicated that someone had used a needle after them in the last six months (Table 56). Sharing of other injecting equipment was more common, with two-fifths (44%) of recent injectors reporting sharing of equipment during the last six months. Equipment that was shared during this time included tourniquets (33%, n=3), spoons/mixing containers (22%, n=2), and water (11%, n=1). This is of concern as sharing equipment increases the risk of exposure to blood-borne viral infections.

Obtaining needles

The majority of recent injecting drug users (89%, n=8) had obtained needles from NSP outlets during the last six months and smaller proportions had obtained needles from a chemist (56%, n=5), a friend (44%, n=4), dealer (22%, n=2) or partner (11%, n=1). None of those that had recently injected reported difficulty in obtaining needles in the last six months.

Table 56: Injecting risk behaviour of recent injectors, 2004-2006

	2004 (n=9)	2005 (n=8)	**2006 (n=9)**
Median times injected any drug last 6 mths (range)	20 (1-72)	58 (1-350)	**120 (1-400)**
Injected under the influence of ERD (%)	-	13	**-**
Injected while coming down from ERD (%)	-	13	**33**
Injecting while under the influence and coming down (%)	67	50	**56**
Median times injected under the influence last 6 mths (range)*	n=6 5 (2-13)	n=6 5 (2-120)	**n=8** **8 (2-120)**
Used needle after someone in last month (%)	-	13 (n=1)	**-**
Used needle after someone in last 6 months (%)	11 (n=1)	13 (n=1)	**-**
Used needle before someone in last 6 months (%)	-	13 (n=1)	**11 (n=1)**
Shared other injecting equipment			
None (%)	44	38	**56**
Spoons/mixing containers (%)	44	13	**22**
Tourniquets (%)	33	38	**33**
Filters (%)	22	-	**-**
Water (%)	11	38	**11**

Source: EDRS Regular ecstasy user interviews 2004-2006
* Of those that had injected under the influence

14.2 Blood-borne viral infections (BBVI)

Two-fifths of the 2005 REU sample (44%) had been vaccinated for hepatitis B and the rate of vaccination was higher among recent injectors (66%) (Table 57). Among the 2006 REU sample, the main reason for hepatitis B vaccination was overseas travel (59%), followed by work requirements (12%), sexual risk (7%), advice of a relative (5%), childhood vaccination (5%), working in a health setting (2%), precautionary (2%), or injecting risk (2%).

Two-fifths of the 2006 REU sample (40%) had been tested for hepatitis C, compared to one-third (30%) in 2005, and 17% of the sample had been tested in the last year. Among recent injectors a large majority (89%) had been tested for hepatitis C. Three participants reported testing positive to hepatitis C (two of whom were recent injectors) and two participants who were recent injectors did not know or did not obtain the result of the test.

Two-fifths of participants (40%) had been tested for HIV at some stage, and 20% of the sample had been tested during the last year. Among recent injectors, three-quarters (89%) had been tested for HIV. None of the participants indicated that the result of the HIV test was positive.

Whereas two-fifths of this group (40%) had been for a sexual health check up in the last year, one-third (51%) had never had a sexual health check up. The majority of the sample (90%) had never been diagnosed with an STI and small proportions had been diagnosed with an STI in the last year (6%) or more than a year ago (4%). Among recent injectors, similar proportions had a sexual health check in the last year (44%) or had never been diagnosed with an STI (89%).

Table 57: BBVI vaccination, testing and self-reported status, 2004-2006

	REU sample 2004	REU sample 2005	**REU sample 2006**	**Recent Injectors 2006**
HBV vaccination (%)	n=96	n=99	**n=97**	**n=9**
No	44	41	**44**	**33**
Yes (didn't complete schedule)	10	14	**6**	**11**
Yes (completed schedule)	44	30	**38**	**56**
Don't know	2	14	**11**	**-**
If yes, reason for vaccination (%)	n=51	n=42	**n=41**	**n=5**
Risk (sexual)	2	12	**7**	**-**
Risk (IDU)	2	-	**2**	**-**
Going overseas	33	67	**59**	**40**
Vaccinated as a child	14	5	**5**	**-**
Don't know/can't remember	12	5	**2**	**20**
Working in a health setting	11	-	**2**	**-**
Work requirement	26	5	**12**	**-**
Relative's advice	16	7	**5**	**20**
GP's advice	11	-	**-**	**-**
Precautionary	26	-	**2**	**20**
Other	11	5	**-**	**-**
HCV test last year (%)	n=96	n=99	**n=97**	**n=8**
No	67	62	**57**	**11**
Yes (in the last year)	18	18	**17**	**33**
Yes (more than one year ago)	16	12	**23**	**56**
Don't know	-	8	**4**	**-**
If yes, what was the result (%)	n=32	n=29	**n=36**	**n=8**
Positive	-	3 (n=1)	**8 (n=3)**	**25 (n=2)**
Negative	97	90	**86**	**50**
Don't know	3 (n=1)	7	**6 (n=2)**	**25 (n=2)**
HIV test last year (%)	n=96	n=99	**n=97**	**n=9**
No	64	65	**60**	**11**
Yes (in the last year)	22	19	**20**	**56**
Yes (more than one year ago)	15	15	**20**	**33**
Don't know	-	1	**1**	**-**
If yes, what was the result (%)	n=35	n=33	**n=37**	**n=8**
Positive	3 (n=1)	-	**-**	**-**
Negative	97	94	**100**	**100**
Don't know	-	6	**-**	**-**
Ever had a sexual health check up (%)	n=96	n=100	**n=95**	**n=8**
No	53	51	**37**	**22**
Yes (in the last year)	33	32	**40**	**44**
Yes (more than one year ago)	14	17	**22**	**33**
Don't know	-	-	**1**	**-**
Ever diagnosed with STI (%)		n=98	**n=95**	**n=9**
No	n/a	92	**90**	**89**
Yes (in the last year)	n/a	5	**6**	**-**
Yes (more than one year ago)	n/a	2	**4**	**11 (n=1)**
Don't know	n/a	1	**-**	**-**

Source: EDRS Regular ecstasy user interviews 2004-2006

14.3 Sexual risk behaviour

A large majority of the regular ecstasy-using sample (94%) reported having penetrative sex during the six months preceding the interview (Table 58). Penetrative sex was defined as the penetration of the penis/hand in the vagina/anus. Participants were given the option of self-completing this section of the report due to the sensitive nature of the questions.

Recent sexual activity

Of those who had penetrative sex in the preceding six months, the number of sexual partners varied between one (54%), two (18%), three to five (20%), six to ten (5%), and more than ten (2%) partners. Of those that had recently had penetrative sex, three-quarters (73%) reported having sex with a regular partner and less than half (69%) reported having sex with a casual partner during this time. Participants were asked about their use of protective barriers (condoms, dams, gloves) during the preceding six months. Of those who had sex with a regular partner in the preceding six months, three-fifths (41%) reported some use of protective barriers, one-fifth (19%) had used protective barriers every time, and two-fifths (40%) had never used protective barriers. Participants were more likely to use protection when having sex with a casual partner, with a majority (82%) reporting some use of protective barriers. Almost half (47%) of those that had sex with a casual partner used protective barriers 'every time' and one-tenth (11%) 'never' used protective barriers.

Recent sexual activity while under the influence of drugs

A large majority of the participants that had been sexually active in the six months preceding the interview (87%) had engaged in penetrative sex under the influence of ecstasy and related drugs during this time (Table 59). Of those that had recently engaged in penetrative sex under the influence of ERDs, the number of occasions varied from once (9%), twice (24%), three to five times (37%), six to ten times (8%) to more than ten times (16%). These respondents most commonly reported having sex under the influence of ecstasy (87%), alcohol (59%), cannabis (37%), and/or methamphetamine powder (11%), base (11%) or crystal (1%). Smaller proportions reported having had sex under the influence of LSD (3%), other opiates (2%), pharmaceutical stimulants (2%), 2CI (2%), amyl nitrite (1%), nitrous oxide (1%), mushrooms (1%), and methadone (1%).

Of those who had sex under the influence of ERDs with a regular partner in the preceding six months (n=63), one-half (49%) reported some use of protective barriers, less than one-fifth used protective barriers 'every time' (14%) and one-half (51%) never used protective barriers. Participants were more likely to use protective barriers with a casual partner. Of those who had sex under the influence of ERDs with a casual partner in the preceding six months, a large majority (91%) reported some use of protective barriers, one-third had always used protective barriers (34%), and one-tenth (9%) never used protective barriers.

Those who had sex with a regular partner were slightly less likely to use protection under the influence of drugs (Table 59) compared to when having sex generally (Table 56). For example, 60% reported some use of protective barriers generally and 49% reported use of protective barriers when under the influence of ERDs. Those who had sex with a casual partner were more likely to use some protection when they under the influence of drugs. For example, 82% reported some use of protective barriers generally and 91% reported some use of protective barriers when under the influence of drugs. However, the proportion that always used protective barriers was slightly lower (34%) when under the influence of drugs, compared to generally (47%).

Table 58: Prevalence of sexual activity and protective barrier use in the preceding six months, 2004-2006

	2004 n=100	2005 n=100	**2006** **n=100**
Penetrative sex in last six months (%)	92	97	**94**
Number of sexual partners in the last six months*	n=92	n=97	**n=94**
One partner (%)	44	38	**54**
Two partners (%)	16	26	**18**
Three to five partners (%)	34	30	**20**
Six to ten partners (%)	5	6	**5**
More than ten partners (%)	1	-	**2**
Sex with regular partner(s) (%)*	85	76	**73**
Use protective barriers with regular partner	n=78	n=74	**n=73**
Always use protective barrier (%)	21	18	**19**
Never use protective barrier (%)	12	32	**40**
Any protective barrier use (%)	88	68	**60**
Sex with casual partner(s) (%)*	61	69	**45**
Use protective barriers with casual partner	n=56	n=67	**n=45**
Always use protective barrier (%)	36	45	**47**
Never use protective barrier (%)	7	19	**11**
Any protective barrier use (%)	93	81	**82**

Source: EDRS Regular ecstasy user interviews 2004-2006

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

Table 59: Sexual activity and protective barrier use under the influence of drugs in the preceding six months, 2004-2006

	2004	2005	**2006**
Of those who had penetrative sex in last six months	n=92	n=97	**n=94**
Penetrative sex while on drugs in last 6 months (%)	80	83	**87**
Of those who had sex under the influence of drugs	n=74	n=80	**n=87**
No. times had sex under the influence			
Once (%)	19	14	**9**
Twice (%)	22	15	**24**
Three-five times (%)	24	29	**37**
Six-ten times (%)	19	19	**8**
More than ten times (%)	16	24	**16**
Drugs used under the influence			
Ecstasy (%)	93	88	**87**
Cannabis (%)	42	33	**37**
Alcohol (%)	64	69	**59**
Methamphetamine powder (%)	26	19	**11**
Methamphetamine base (%)	5	4	**11**
Crystal methamphetamine (%)	1	-	**1**
Cocaine (%)	4	1	**-**
LSD (%)	3	4	**3**
Amyl nitrite (%)	5	1	**1**
Nitrous oxide (%)	3	3	**1**
Methadone (%)	1	1	**1**
Other opiates (%)	3	3	**2**
Benzodiazepines (%)	3	-	**4**
Psychedelic mushrooms (%)	1	-	**1**
Pharmaceutical stimulants (%)	1	1	**2**
2CI	-	-	**2**
Of those who had sex with regular partner(s) under influence of drugs	n=60	n=57	**n=63**
Always use protective barriers (%)	18	18	**14**
Never use protective barriers (%)	20	42	**51**
Any protective barrier use (%)	80	58	**49**
Of those who had sex with casual partner(s) under influence of drugs	n=43	n=48	**n=32**
Always use protective barriers (%)	35	44	**34**
Never use protective barriers (%)	12	19	**9**
Any protective barrier use (%)	88	81	**91**

Source: EDRS Regular ecstasy user interviews 2004-2006

14.4 Driving risk behaviour

Eighty-one out of the 100 REU interviewed in 2006 had driven a car during the six months preceding the interview (Table 60). Almost one-half of these (48%) had driven while they perceived themselves to be over the legal alcohol limit during this time, compared to over one-half (58%) among the 2005 sample. The median frequency of driving over the limit was 3 times (range 1-60) in the last six months, or once every two months. Over half (51%) had been random breath tested (once or more) during this time, and of these 35% (n=7) were found to be over the legal blood alcohol limit.

Three-quarters of those that had recently driven a car (78%) had driven soon after (within an hour of) taking a drug in the last six months, compared to one-half (55%) among the 2005 sample. Of those that had driven under the influence of drugs, the median number of times in

the last six months was 5 times (range 1-180) or slightly less than once a month. Three participants who had recently driven under the influence of drugs had been tested for drug driving by police during this time. None of these participants had tested positive for drugs. Of those that had driven under the influence, the drugs most commonly used were ecstasy (89%), cannabis (52%), and methamphetamine (27% powder, 24% base, 10% crystal), followed by mushrooms (8%), nitrous oxide (5%), cocaine (6%), benzodiazepines (5%), LSD (2%), pharmaceutical stimulants (2%), GHB (2%), methadone (2%) and 2CI (2%).

Of those that had driven under the influence of ecstasy, the median number of times in the last six months was 3 times (range 1-48) or once every two months. Those that had last driven under the influence of ecstasy had driven a median of 2 hours (range 0-8 hours) after taking the drug. One-quarter (28%) of those that had last driven under the influence of ecstasy perceived that their driving was 'not at all impaired', half (50%) perceived that it was 'slightly impaired', and the remainder thought that their driving was 'moderately' (20%) or 'substantially' (3%) impaired.

Those that had last driven under the influence of cannabis had driven a median of 0.5 hours (range 0-5 hours) after taking the drug. Almost two-fifths (38%) of those that had last driven under the influence of cannabis, perceived that their driving was 'not at all impaired', two-fifths (38%) perceived that it was 'slightly impaired', and the remainder thought that their driving was 'moderately' (21%) or 'substantially' (4%) impaired.

There were no sex differences between those that had or had not recently driven under the influence of drugs. However, based on a median split for age, a greater proportion of 'older' participants (57%) had recently driven under the influence of drugs in comparison to the proportion of 'younger' participants (43%; χ^2=6.83, p<.01). Those that had recently driven under the influence of drugs were less likely to be a student (27% vs. 61%; χ^2=7.21, p<.01), more likely to be employed full-time (41% vs. 17%; χ^2=3.69, p=.055), and more likely to have recently binged (used continuously for 48 hours or more) on ERDs (48% vs. 18%; χ^2=5.18, p<.05). On average, those that had recently driven under the influence of drugs were significantly older (25 vs. 22 years; t(79)=-2.0, p<.05), had recently used ecstasy on a greater number of days (15 vs. 8 days; Mann-Whitney U = 275.50, p<.01), had used a greater number of tablets in a typical session (2 vs. 1 tablet; Mann-Whitney U = 336.50, p<.01), compared to those that hadn't recently driven under the influence of drugs.

Table 60: Driving under the influence of drugs among REU, 2004-2006

Variable	2004* n=100	2005 n=80	**2006 n=81**
Driven while over the legal alcohol limit in last 6 mths (%)#	n/a	58	**48**
Of those that had driven over the legal alcohol limit		n=46	**n=39**
Median number of times in last six months (range)	n/a	4 (1-24)	**3 (1-60)**
Random breath tested in the last 6 mths (%)	n/a	n/a	**51**
Of those breath tested, over legal limit (once or more) (%)	n/a	n/a	**35 (n=7)**
Driven soon after (within an hour of) taking a drug (%)#	n/a	55	**78**
Of those that had driven soon after taking drugs			**n=63**
Median number of times in last six months (range)	n/a	n/a	**5 (1-180)**
Tested for drug driving in the last 6 mths (%)	n/a	n/a	**5 (n=3)**
Of those that had been drug tested, tested positive (%)	n/a	n/a	**-**
Of those who'd driven soon after, drugs used (%)	n=59	n=44	**n=63**
Cannabis	85	68	**52**
Ecstasy	76	91	**89**
Methamphetamine powder	75	34	**27**
Methamphetamine base	10	9	**24**
Crystal methamphetamine	-	2	**10**
Benzodiazepines	10	2	**5**
Psychedelic mushrooms	8	-	**8**
LSD	7	5	**2**
Amyl nitrite	8	2	**-**
Nitrous oxide	5	16	**5**
Cocaine	2	5	**6**
Ketamine	2	2	**-**
MDA	2	-	**-**
Other opiates	2	-	**-**
Pharmaceutical stimulants	-	-	**2**
GHB	-	2	**2**
Methadone	-	-	**2**
2CI	-	-	**2**
Of those who had driven soon after taking ecstasy		n=40	**n=47**
Median number of times in last 6 mths (range)	n/a	3.5 (1-24)	**3 (1-48)**
Of those who had last driven soon after taking ecstasy	n/a	n/a	**n=40**
How long driven after taking ecstasy (hours)			**2 (0-8)**
Perceived level of impairment			
Not at all impaired			**28**
Slightly impaired			**50**
Moderately impaired			**20**
Substantially impaired			**3**
Of those who had last driven soon after taking cannabis	n/a	n/a	**n=24** **0.5 (0-5)**
How long driven after taking cannabis (hours)			
Perceived level of impairment			
Not at all impaired			**38**
Slightly impaired			**38**
Moderately impaired			**21**
Substantially impaired			**4**

Source: EDRS Regular ecstasy user interviews 2004-2006

* not restricted to those that had recently driven in 2003

# of those who had driven a car in the last 6 months

REU were asked about their perceptions of the risks associated with driving under the influence of particular drug types (Table 61). Two-thirds (67%) of those who commented considered driving under the influence of alcohol to be 'high risk', and one-third (30%) considered it to be a 'moderate risk', followed by 'low risk' (3%). Driving under the influence of ecstasy was considered by half (50%) to be moderate risk, followed by 'high risk' (30%), 'low risk' (14%), and 'no risk' (3%). Perceptions about the risk of driving under the influence of methamphetamine were mixed, with close to one-third each perceiving this to be 'high risk' (32%), 'moderate risk' (35%) and 'low risk' (26%), followed by 'no risk' (1%) or 'don't know/unsure' (6%). Close to half of those who commented (46%) perceived that driving under the influence of cannabis was 'low risk', and one-tenth (10%) considered it to be 'no risk'. The remainder considered driving under the influence of cannabis to be a 'moderate' (24%) or 'high' risk (18%).

Table 61: Perceptions of risk associated with driving under the influence of drugs among REU, 2005-2006

Perceptions of the risk associated with driving under the influence of the following drugs:	2005 n=78	**2006 n=91**
Over legal blood alcohol limit		
Don't know (%)	-	-
No risk (%)	-	-
Low risk (%)	4	3
Moderate risk (%)	27	30
High risk (%)	69	67
Ecstasy		
Don't know (%)	1	-
No risk (%)	-	3
Low risk (%)	19	14
Moderate risk (%)	54	50
High risk (%)	24	33
Methamphetamine		
Don't know (%)	6	6
No risk (%)	1	1
Low risk (%)	24	26
Moderate risk (%)	47	35
High risk (%)	21	32
Cannabis		
Don't know (%)	-	2
No risk (%)	14	10
Low risk (%)	56	46
Moderate risk (%)	22	24
High risk (%)	7	18

Source: EDRS Regular ecstasy user interviews 2005-2006

14.5 Binge drug use

Table 62 shows that almost one-half of the 2006 REU sample (46%) had recently 'binged' on ERDs (used for more than 48 hours continuously without sleep), compared to a slightly lower proportion among the 2004 (35%) and 2005 (35%) samples, and a similar proportion (45%) in 2003. Those that had recently binged had done so on a median of 3 occasions (range 1-24) during the six months preceding the interview. The median length of the longest period of continuous use during this time was 2.5 days (range 2-6 days).

Of those that had recently 'binged', the substances used most commonly during a binge session of use were ecstasy (93%), cannabis (53%), alcohol (60%), methamphetamine (49% powder, 36% base, 36% crystal), followed by cocaine (27%), mushrooms (27%), LSD (16%),

nitrous oxide (20%), 2CI (11%), GHB (4%), amyl nitrite (2%), and pharmaceutical stimulants (2%). Relative to 2005, a greater proportion reported binging on cocaine, mushrooms, 2CI, base and crystal, and fewer reported binging on methamphetamine powder, LSD, alcohol and cannabis.

There were no age or sex differences in terms of those that had or had not recently 'binged' on drugs. Those that had recently 'binged' had first started using ecstasy at a younger age (19 vs. 20 years: Mann-Whitney U=881.0, p<.05), had used a significantly greater number of drug types in the last six months (8 vs. 6 drug types, from a list of 20 drug classes; Mann-Whitney U = 462.0, p<.001), had used ecstasy more frequently in the last six months (16 vs. 10 days; Mann-Whitney U = 515.5, p<.001), and had used greater numbers of ecstasy tablets in a typical session (3 vs. 2 tablets; Mann-Whitney U = 506.5, p<.001), and largest recent session of use (6 vs. 3 tablets; Mann-Whitney U = 443, p<.001), in the last six months. Those that had recently 'binged' were more likely to be unemployed (22% vs. 8%; χ^2=4.28, p<.05), more likely to be recent injectors (16% vs. 3%; χ^2=4.05, p<.05), more likely to have recently used methamphetamine (86% vs. 70%; χ^2=3.97, p<.05), and to typically use methamphetamine with ecstasy (27% vs. 4%; χ^2=10.42, p<.01). They were also more likely to have a 'high' SDS score (greater than 5) for ecstasy (33% vs. 8%; χ^2= 10.35, p<.01), and methamphetamine (27% vs. 6%; χ^2=8.28, p<.01), suggestive of greater psychological symptoms of dependence on these drugs. On average, they also had significantly higher scores on the Kessler psychological distress scale (18 vs. 16, Mann-Whitney U = 649.5, p<.01), and were more likely to have a 'high' score (25 or more) on the Kessler scale (44% vs. 9%; χ^2=9.27, p<.01, indicating greater likelihood of psychological distress.

Table 62: Binge drug use among REU, 2003-2006

Variable	2003 n=100	2004 n=100	2005 n=80	**2006 n=98**
Binged on any drug in the last six months (%)#	45	35	39	**46**
Median number of times binged in last six months (range)	n/a	n/a	n/a	**3 (1-24)**
Median length (days) of biggest binge in last six mths (range)	2.5 (2-8)	2.5 (2-5)	2.5 (2-5)	**2.5 (2-6)**
Of those that had recently binged (%)				
Ecstasy	91	97	95	**93**
Methamphetamine powder	53	71	64	**49**
Methamphetamine base	21	-	23	**36**
Crystal methamphetamine	36	11	13	**36**
Pharmaceutical stimulants	-	3*	5	**2**
Cocaine	2	3*	13	**27**
LSD	9	20	26	**16**
Ketamine	11	-	10	**-**
MDA	7	6	-	**-**
GHB	-	-	3*	**4**
Amyl nitrite	25	9	10	**2**
Nitrous oxide	11	20	18	**20**
Cannabis	62	54	79	**53**
Alcohol	62	80	77	**60**
Benzodiazepines	2	3	-	**-**
Psychedelic mushrooms	4	11	3*	**27**
2CI	-	-	-	**11**

Source: EDRS Regular ecstasy user interviews 2003-2006

14.6 Summary of risk behaviour

Injecting drug use

- Less than one in ten of the 2005 REU sample (9%) had recently used substances intravenously, similar rates to that in recent cohorts: 9% in 2004 and 8% in 2005. Methamphetamine was typically the first drug ever injected and the most common drug ever and recently injected. The sharing of needles was relatively rare; however, two out of five had recently shared other injecting equipment such as spoons, tourniquets, and water. One-tenth of recent injectors had always required others to inject them in the last six months. The majority of recent injectors had obtained injecting equipment from NSP outlets in the preceding six months and none reported difficulty in obtaining needles during this time.

Sexual risk behaviours

- A large majority (94%) of REU had been sexually active during the six months preceding the interview and most of these (87%) reported recent penetrative sex under the influence of ecstasy and related drugs. Participants were generally more likely to report some use of protective barriers with a casual partner than with a regular partner. Participa nts were slightly less likely to use protective barriers with a regular partner when under the influence of party drugs (60% vs. 49%). When having sex with a casual partner, participants were more likely to use protective barriers with a casual partner (82% vs. 91%) when under the influence of party drugs, but the proportion that 'always used barriers' dropped slightly when under the influence of drugs (47% vs. 34%). Whereas two-fifths of participants (40%) had been for a sexual health check up in the last year, almost an equal proportion (37%) had never had a sexual health check up. Three-fifths of the sample had never been tested for hepatitis C or HIV.

Drug driving

- Of those that had driven a car, one-half (48%) reported driving at a time when they perceived themselves to be over the legal alcohol limit during the last six months, compared to three-fifths (58%) in 2005. Three-quarters of those that had recently driven (78%) reported driving within an hour of taking ERDs in the last 6 months, compared to one-half (55%) in 2005. Most commonly, participants reported driving under the influence of ecstasy, cannabis and/or methamphetamine. Those that had recently driven under the influence of a drug were older, less likely to be students and more likely to be full-time workers than those that had not. They were also more likely to have recently binged on ERDs and had recently used ecstasy more frequently and in larger amounts. On average, the risks associated with drug driving were considered by REU to be 'low' for cannabis, 'moderate' to 'high' for ecstasy, varied ('low' to 'moderate' to 'high') for methamphetamine, and 'high' for alcohol.

Binge drug use

- Almost one-half (46%) had recently 'binged' on ecstasy and related drugs (a continuous period of use for more than 48 hours without sleep). Substances most commonly used in a binge session of use were ecstasy, cannabis, alcohol, and methamphetamine. Those who had recently 'binged' had first started using ecstasy at an earlier age, had experimented with a greater number of drugs, and had recently used ecstasy more frequently and in larger amounts. They were also more likely to report recent injecting drug use, recent methamphetamine use, and to have typically used methamphetamine in combination with ecstasy during this time. They also reported higher psychological dependence scores for ecstasy and methamphetamine as measured by the SDS, and higher levels of psychological distress as measured by Kessler Psychological Distress Scale.

15.0 HEALTH-RELATED ISSUES

15.1 Overdose

The REU sample was asked if they had overdosed on any drug at some stage of their life and during the six moths preceding the interview (Table 63). The definition of overdose included passing out or falling into a coma, but does not necessarily indicate that the participant accessed a health service or experienced acute physical problems in relation to overdose. Of the twenty-four participants that had ever overdosed on any drug, the median number of times that they had overdosed was 1 (range 1-5). Less than one-tenth of the 2006 REU sample (8%) had overdosed on a drug in the preceding six months, which is fewer in comparison to the proportion of the sample in 2004 (18%) and 2005 (16%).

Participants were asked to comment on the last overdose episode in the preceding six months. In the last overdose episode in the preceding six months, the 'main drugs' involved ecstasy (43%, n=3), ketamine (14%, n=1), GHB (14%, n=1), methadone (14%, n=1) and Phenergan (an antihistamine/sedative) (14%, n=1). In six out of seven overdose episodes, participants were under the influence of other drugs. Other drugs included alcohol (43%, n=3), cannabis (43%, n=3), ecstasy (14%, n=1), base (14%, n=1), other opiates (14%, n=1) and benzodiazepines (14%, n=1).

In the last overdose episode in the preceding six months, participants had been partying for a median of 10.5 hours (range 0.5-48) prior to the overdose episode, and it had been a median of 9 hours (range 0.5-24) since their last meal. Three-quarters were at private residences at the time of overdose (50% friend's home, 25% own home), and single participants were at a nightclub (13%) or live music event (13%). While a single participant received no treatment (14%), others were monitored by friends (29%), received on-site help (14%), were attended on-site by ambulance (14%), taken to hospital by friends/family (14%), or were taken to hospital by ambulance (14%).

There were no significant age or sex differences between those who had and had not recently overdosed. Due to the small number of participants that had overdosed, no other demographic analyses were conducted. However, two of the eight participants that had recently overdosed (25%) were recent injecting drug users.

Three KE who worked in the hospitality industry were aware of single overdose episodes in the last six months (n=2) or had heard rumours about overdose episodes. However, no recent changes in the frequency and/or severity of such episodes were reported. KE that worked in emergency and ambulance services (n=3) typically reported low levels of overdose among ERD consumers. Two of these also noted that these episodes were typically associated with mixing ecstasy with alcohol or other drugs. This is consistent with the overdose episodes reported among the REU interviewed in the present study.

Table 63: Overdose among REU, 2004-2006

	2004 n=100	2005 n=99	**2006 n=100**
Ever overdosed on any drug (%)	n/a	30	**24**
Median number of times ever overdosed (range)	n/a	2 (1-50)	**1 (1-5)**
Overdosed on any drug in last 6 months (%)	18	16	**8**
Main drug involved in overdose (%)*	n=18	n=16	**n=7**
Ecstasy	11	13	**43**
Cannabis	6	25	**-**
Alcohol	72	25	**-**
Speed	6	6	**-**
Ice/Crystal	-	-	**-**
Ketamine	-	-	**14 (n=1)**
GHB	-	-	**14 (n=1)**
LSD	-	6	**-**
Nitrous oxide	6	6	**-**
Benzodiazepines	-	19	**-**
Methadone	-	-	**14 (n=1)**
Phenergan	-	-	**14 (n=1)**
Other drug involved in overdose (%)*	n/a	n=16	**n=7**
None		19	**14 (n=1)**
Ecstasy		25	**14 (n=1)**
Methamphetamine powder		13	**-**
Methamphetamine base		-	**14 (n=1)**
Cannabis		50	**43**
Alcohol		63	**43**
Other opiates		6 (n=1)	**14 (n=1)**
Benzodiazepines		-	**14 (n=1)**
Cocaine		6 (n=1)	**-**
Amyl nitrite		6 (n=1)	**-**
Nitrous oxide		6 (n=1)	**-**
Mushrooms		6 (n=1)	**-**
Median number of months since last overdose (range)*	n/a	n/a	**4 (0.5-5)**
Median number of hours partying before overdose (range)*	n/a	n/a	**10.5 (0.5-48)**
Median number of hours since last meal prior to overdose (range)*	n/a	n/a	**9 (0.5-24)**
Location of last overdose (%)*	n/a	n/a	**n=8**
Own home			**25**
Friend's home			**50**
Nightclub			**13 (n=1)**
Live music event			**13 (n=1)**
Treatment received last overdose (%)*	n/a	n/a	**n=7**
None			**14 (n=1)**
On-site help			**14 (n=1)**
Attended on-site ambulance			**14 (n=1)**
Taken to hospital by friends/family			**14 (n=1)**
Taken to hospital by ambulance			**14 (n=1)**
Monitored by friends			**29**

Source: EDRS Regular ecstasy user interviews 2004-2006
* of those reporting overdose episode in last 6 months

15.2 Help-seeking behaviour

One-fifth (22%) of the 2006 REU sample had accessed a health or medical service in relation to their drug use in the six months preceding interview (Table 64), compared to 17% among the sample in 2005 (Matthews & Bruno, 2006), and 10% in 2004 (Matthews & Bruno, 2005). Those that had recently accessed health services were significantly younger (22 vs. 25 years; t(98)=2.35, p>.05), and had been using ecstasy for a shorter period of time (2.5 vs. 4 years; Mann-Whitney U =615.5, p<.05), relative to those that had not accessed health services. There was no significant difference in the proportion of the female (19%) and male (24%) sample that had recently accessed a health service. A significantly greater proportion of 'younger' (32%) in comparison to 'older' (12%) participants had recently accessed health services in relation to their drug use (χ^2=5.83, p<.05). They were also less likely to have finished year 12 (68% vs. 87%; χ^2=4.39, p<.05), more likely to be unemployed (36% vs. 7%; χ^2=11.72, p<.01) and more likely to be recent injectors (22% vs. 5%; χ^2=6.49, p<.05), compared to those that had not accessed health services. However, there were no differences in the frequency or quantity of recent ecstasy use for these groups. Those that had recently accessed health services had significantly higher scores on the Kessler psychological distress scale on average (22 vs. 17; Mann-Whitney U =472.0, p<.01), and were more likely to have a 'high' score (25 or more) on the scale (33% vs. 7%; χ^2=10.67, p<.01) than those that had not accessed health services, indicating greater likelihood of the presence of a mood or affective disorder. This is not surprising considering that health services were often accessed in relation to mental health problems such as addiction/dependence and depression (see below).

The most commonly accessed service was a GP (n=10), followed by ambulance (n=6), first aid (n=5), emergency (n=4), counsellor (n=3), hospitalisation (n=3), drug and alcohol worker (n=3), psychologist (n=3), or psychiatrist (n=2). Some participants had accessed more than one service during this time. Participants that had accessed health services in relation to their drug use in the last six months were asked to specify the main drug and the main issue involved. Services had typically been accessed in relation to alcohol (n=10), ecstasy (n=9), methamphetamine (n=9), or cannabis (n=7). Services such as emergency, hospitalisation, ambulance, and first aid were accessed in relation to acute physical problems (n=10), overdose (n=4), or injury (n=2). A general practitioner had typically been accessed in relation to issues such as dependence/addiction (n=3), depression (n=2), acute physical problems (n=2), anxiety (n=1), information/advice (n=1), and blood testing (n=1). A counsellor had been accessed in relation to dependence/addiction (n=2) and information/advice on drug effects (n=1). A drug and alcohol worker had been accessed in relation to dependence/addiction (n=2) and acute physical problems (n=1). A psychologist had been accessed in relation to dependence/addiction (n=1), depression (n=1), and social/relationship issues (n=1). A psychiatrist had been accessed in relation to psychosis (n=1) and medication prescription (n=1).

Table 64: Proportion of REU who accessed health services by main drug type, 2006

Service	Any drug	Ecstasy	Alcohol	Metha-done	Cannabis	Meth. powder	Meth. base	Polydrug
GP	**n=10**	n=2	n=1		n=4	n=2	n=1	
Counsellor	**n=3**		n=1	n=1		n=1		
Hospitalisation	**n=3**	n=1	n=2					
Emergency	**n=4**	n=1	n=1	n=1				n=1
Ambulance	**n=6**	n=1	n=3	n=1	n=1			
First aid	**n=5**	n=3	n=2					
D&A worker	**n=3**				n=2		n=1	
Psychologist	**n=3**	n=1				n=1	n=1	
Psychiatrist	**n=2**					n=2		

Source: EDRS Regular ecstasy user interviews 2006

15.3 Mental health problems

For the first time in 2006, participants completed the Kessler Psychological Distress Scale (K10). This ten item questionnaire was designed to measure the level of distress and severity associated with psychological symptoms in population surveys and has been shown to be a marker for possible clinical diagnosis of anxiety or affective disorders (Andrews & Slade, 2001). Participants were asked to rate the extent to which they had experienced particular psychological symptoms (e.g. How often did you feel depressed?) in the preceding month on a five-point Likert scale. Among a normative Australian population sample, the mean K10 score was 14.2, and the median was 12 (range 0-50) (Andrews & Slade, 2001). Among the REU interviewed in 2006, the mean K10 score was slightly higher at 18.3 (SD=5.72) and the median score was 17 (range 10-36) out of a possible score of 50.

Furukawa, Kessler, Slade & Andrews (2003) assessed the efficiency of the K10 in detecting mood disorders. Scores between 25 and 50 were found to be significant predictor of a possible clinical diagnosis. Among an Australian normative sample, one in twenty (5%) had a score greater than 25 on the K10, and three-fifths (59%) of these people currently met the criteria for a clinical diagnosis. In the current sample, more than one in ten REU (13%) had a score of 25 and above, possibly indicating higher levels of psychological distress relative to the general population. However, the K10 is also sensitive to the diagnosis of substance disorders which may have elevated the scores among the current population. The following analyses were conducted to determine the characteristics of those with a 'high' K10 score (25 or more) compared to those with a 'low' K10 score (less than 25) among the 2006 REU cohort.

There were no significant age or sex differences between those with 'high' or 'low' scores. Those with 'high' K10 scores tended to have first started using ecstasy (on a regular basis) at an earlier age relative to those with 'low' K10 scores (21 vs. 19; Mann-Whitney U=334.0, p=.057). Those with 'high' K10 scores were more likely to be unemployed (50% vs10%; χ^2=13.81, p<.001), less likely to be in full-time work (0% vs. 39%; χ^2=7.18, p<.01), more likely to be GLBT (33% vs. 6%; χ^2=9.27, p<.01), more likely to be recent injecting drug users (33% vs. 6%; χ^2=9.27, p<.01), more likely to have recently binged on stimulants (used for more than 48 hours continuously without sleep: 75% vs. 42; χ^2=4.74, p<.05), and more likely to have a 'high' methamphetamine dependence score on the SDS (42% vs. 12%; χ^2=7.06, p<.01). Similar to recent injecting drug users generally (see Section 13.1), those with high K10 scores were less likely to have recently used alcohol (83% vs. 96%; χ^2=3.65, p=.056), to typically use alcohol in combination with ecstasy (42% vs. 70%; χ^2=3.86, p=.05), and less likely to have a high score on the alcohol use disorders identification test (AUDIT) (58% vs. 87%; χ^2=6.17, p<.01). As previously mentioned in Section 14.2, those with 'high' scores were more likely to have

recently accessed health services (58% vs. 17%, χ^2=6.17, p<.01). However, two-fifths (42%) of those with 'high' K10 scores had not accessed any services in the six months preceding the interview.

Few KE commented on mental health problems among REU. However, several KE in health professions commented that some clients presented with depression (n=2) and anxiety and/or sleeping problems during the days following ecstasy use, and one KE commented that long-term use was associated with endogenous depression. Other KE noted that REU typically presented to health services with polydrug issues (n=2) and/or multiple complex issues (n=1) rather than for problems specific to ecstasy use. One KE noted that there had been an increase in REU presenting to their service for support.

15.4 Other problems

The sample of regular ecstasy users were asked if their drug use had caused any problems during the six months preceding the interview (Table 65). Over one-half of the sample (55%) indicated that their drug use had recently caused work/study problems, and two-fifths had recently experienced financial (45%) and relationship/social problems (44%). Consistent with low levels of criminal activity and number of arrests in this group, only five participants (5%) reported that their drug use had caused recent legal/police problems. These figures are relatively consistent with those observed in previous years, though the proportion reporting a recent occupational/study problem is slightly lower relative to 2004 and 2005.

Table 65: Self-reported drug-related problems, 2003-2006

	2003 n=100	2004 n=100	2005 n=100	**2006 n=100**
Occupational/study problems (%)	47	66	68	**55**
Financial problems (%)	47	40	43	**45**
Relationship/social problems (%)	40	37	43	**44**
Legal/police problems (%)	5	2	6	**5**

Source: EDRS Regular ecstasy user interviews 2003-2006

Table 66 shows the main drug attributed to the problems experienced by REU during the six months preceding the interview. Whereas the majority of participants attributed drug-related problems to ecstasy use, this is likely to reflect the purposive sampling of participants that regularly use ecstasy in the present study, rather than indicating that ecstasy has a greater impact in comparison to other drugs. Other drugs in which participants typically attributed problems to included methamphetamine, cannabis, and alcohol. Those that had recently experienced work/study problems (55% of the sample) mostly attributed them to ecstasy use (71%), followed by methamphetamine (6% powder, 4% base, 2% crystal), cannabis (9%), alcohol (4%), 2CI (4%), and LSD (2%). Of those experiencing recent work/study problems, the majority of problems were relatively minor, including lack of motivation (40%), trouble concentrating (22%), and reduced work performance (13%). Two-fifths (22%) had taken sick leave or did not attend classes due to drug use and a single participant had been sacked/quit (2%). There was no significant difference in the proportion of males (53%) and females (47%) or 'older' (47%) and 'younger' participants (53%) that had recently experienced occupational/study problems in relation to drug use. Those that had experienced work/study problems were more likely to binge drink in combination with ecstasy (78% vs. 51%; χ^2=8.08, p<.01), and to have recently binged on ecstasy (53% vs. 30%; χ^2=4.99, p<.05). However, there were no significant differences in the frequency of ecstasy use or the quantities used in a typical session.

Of the forty-five participants that had experienced financial problems, two-thirds attributed these to ecstasy use (64%), followed by cannabis (11%), methamphetamine (4% powder, 9% base), alcohol (4%), cocaine (2%), LSD (2%), and polydrug use (2%). Close to half of those who had experienced financial problems (49%) had recently had no money for recreation or luxuries and one-third (31%) reported being in debt or owing money. Almost one-fifth had experienced more serious financial problems such as having no money for food or rent (18%). There were no sex or age differences between those that had or had not recently experienced financial problems in relation to drug use. Those that had recently experienced financial problems were less likely to have a tertiary degree (9% vs. 27%; χ^2=5.44, p<.05), and more likely to have recently binged on ERDs (62% vs. 32%, χ^2=8.91, p<.01), compared to those that had not experienced financial problems in relation to their drug use. On average they had first started using ecstasy at an earlier age (19 vs. 20 years; Mann-Whitney U = 911.0, p<.05), and had used ecstasy more frequently in the last six months (16 vs. 12 days; Mann-Whitney U = 784.0, p<.01). Those that had experienced financial problems also had higher average scores on the Kessler psychological distress scale (Mann-Whitney U = 679.0, p<.01), but there was no difference in the proportion that had a 'high' score (25 or more) on the scale.

Of the forty-three participants that had recently experienced relationship/social problems attributed to drug use, half attributed these problems to ecstasy use (48%), followed by methamphetamine (14% powder, 9% base, 7% crystal), cannabis (14%), alcohol (5%), mushrooms (2%), and polydrug use (2%). The relationship/social problems experienced by REU were relatively minor, with the majority reporting arguments (48%), or mistrust/anxiety (30%), as well as not keeping in touch with friends (2%) or family (2%), straining relationships (2%) and not fulfilling obligations (2%). Smaller proportions reported more serious relationship/social problems such as ending a relationship (7%), violence (2%), or being kicked out of home (2%). There were no sex differences between those that had or had not recently experienced social problems in relation to drug use. Those that had experienced social/relationship problems tended to be younger (24 vs. 26 years; t(98)=1.94, p=.056), to have recently used a greater number of drug types (7 vs. 6 types, from a list of 20 drug classes; Mann-Whitney U = 958.0, p=.055), and reported a significantly higher frequency of ecstasy use (15 vs. 12 days; Mann-Whitney U = 916.0, p<.05), compared to those that had not. They were also more likely to have a 'high' SDS score (greater than 5) for ecstasy (32% vs. 9%; χ^2= 8.39, p<.01), and methamphetamine (25% vs. 7%; χ^2=6.16, p<.01), suggestive of greater psychological symptoms of dependence on these drugs, and tended to have higher average scores on the Kessler psychological distress scale (18 vs. 16; Mann-Whitney U =874.0, p=.06). However, there was no difference in the proportion that had 'high' scores on the Kessler psychological distress scale (scores of 25 or more).

Of the five male participants that had experienced legal/police problems due to drug use, two participants each attributed these problems to cannabis and alcohol and a single participant attributed these problems to methamphetamine base. A single participant had been arrested in relation to drug use, three participants had been cautioned by police and a single participant felt they were under surveillance. Due to the small number of respondents that had recently experienced legal/police problems, demographic analyses were not carried out on these data.

Table 66: Main drug attributed to problems experienced in the last six months, 2006.

	Work/study problems %	Financial problems %	Social problems %	Legal problems %
Any drug	n=55	n=45	n=43	n=6
Ecstasy	71	64	48	-
Methamphetamine powder	6	4	14	-
Methamphetamine base	4	9	9	20
Crystal methamphetamine	2*	-	7	40
Cannabis	9	11	14	-
Alcohol	4	4	5	40
Cocaine	-	2*	-	-
LSD	2*	2*	-	-
Polydrug use	-	2*	-	-
Mushrooms	-	-	2*	-
2CI	4	-	-	-

Source: EDRS Regular ecstasy user interviews 2006
*** n=1**

15.5 Summary of health-related issues

- Less than one-tenth of the sample (8%) reported that they had overdosed (passed out or fallen into a coma) on any drug in the six months preceding the interview. The main drugs involved in recent overdoses were ecstasy (43%), ketamine (14%), GHB (14%), methadone (14%), and Phenergan (14%). The majority of overdose episodes (86%) were associated with the use of more than one drug, most typically alcohol (43%) and cannabis (43%).
- One-fifth (22%) of the 2006 REU sample had accessed health services in relation to drug use in the preceding six months. The most commonly accessed service was a GP (n=10), followed by ambulance (n=6), first aid (n=5), emergency (n=4), counsellor (n=3), hospitalisation (n=3), drug and alcohol worker (n=3), psychologist (n=3), or psychiatrist (n=2). Participants were most likely to access services in relation to the use of alcohol (n=10), ecstasy (n=9), methamphetamine (n=9), or cannabis (n=7). A greater proportion of younger participants had accessed health services in comparison to older participants.
- Mean scores on the Kessler psychological distress scale (K10) and the proportion with 'high' scores (twenty five or more) were slightly higher among the current sample of REU relative to estimates among the general Australian population. More than one in ten REU (13%) had 'high' K10 scores indicative of high levels of psychological distress and the possible presence of a mood or affective disorder, double the rate of that seen in the Australian normative sample. Those with this high level of psychological distress were more likely to be unemployed, to be GLBT, to have recently injected, to have recently 'binged' on stimulants, to have 'high' methamphetamine dependence scores, and to have recently accessed health services. However, more than two-fifths of those with 'high' K10 scores had not accessed any health services in the preceding six months.
- One-half of the sample (55%) had recently experienced work/study problems in relation to drug use, two-fifths had recently experienced financial (45%) and social/relationship (44%) problems, and one-twentieth (5%) had recently experienced legal/police problems in relation to drug use. Problems were most commonly attributed to ecstasy, methamphetamine, or cannabis. Whereas the majority of these problems were relatively minor, small proportions experienced more serious problems such as ending a relationship, being kicked out of home, leaving school, being sacked/quitting work, or having no money to pay for food or rent.

16.0 CRIMINAL ACTIVITY, POLICING AND MARKET CHANGES

16.1 Reports of criminal activity among REU

Almost one-quarter (26%) of the 2006 REU sample had committed a crime within the last month compared to 15% in 2005, 19% in 2004, and 30% among the 2003 sample (see Table 67). Consistent with previous years, the most common crime was drug dealing, with one-fifth (21%) reporting dealing drugs for cash profit in the last month. The majority of REU that reported drug dealing for cash profit had done so less than weekly in the last month (n=13) and others had done so at least once a week (n=4), or more than once a week but less than daily (n=4).

With the exception of drug dealing, only 8% of the 2006 REU sample had committed a crime during the month preceding the interview. Small proportions reported committing property crime (5%), fraud (3%), and violent crime (1%) during the last month. All of those that had recently committed property crime had done so less than weekly in the preceding month. Two participants had committed fraud once a week (n=1) or less (n=1) in the last month and a single participant reported committing fraud more than once a week but less than daily. The single participant that had committed violent crime had done so less than weekly in the last month.

Less than one-tenth of the 2005 sample (8%) had been arrested during the 12 months preceding the interview. These participants had been arrested for a variety of offences (see Table 67), with only small proportions having been arrested for drug-related offences including use/possession (1%), dealing/trafficking (1%). Small proportions reported that they had received a drug caution or diversion either more than 12 months ago (6%) or in the last 12 months (2%), which is similar to the proportion among the 2005 sample (6% and 3% respectively).

The majority of KE did not know or were not aware of any crime among the group of regular ecstasy users that they were familiar with. One key expert noted that there was some property crime among this group and one KE noted that property crime was generally more common among primary methamphetamine or pharmaceutical users rather than ecstasy users. Other KE noted that violent crime among this group was typically associated with methamphetamine use (n=2), and one KE noted a recent increase in assaults among this group. Some KE noted an increase in the amount of drug dealing during the six months preceding the interview (n=3), an increase in the number of younger people dealing drugs (n=3), and an increase in dealing in nightclubs (n=1). Others noted a recent broadening of the demographic of drug dealers (n=3), and another KE noted a recent increase in the local manufacture of low quality pills.

Table 67: Criminal activity reported by REU, 2003-2006

Criminal activity in the last month	2003 n=100	2004 n=100	2005 n=100	**2006 n=100**
Any crime	30	19	15	**26**
Drug dealing	25	16	8	**21**
Property crime	4	6	4	**5**
Fraud	1	-	3	**3**
Violent crime	-	-	2	**1**
Arrested in the preceding 12 mths	6	3	9	**8**
Arrested for property crime	1	3	1	**1**
Arrested for use/possession	-	-	1	**1**
Arrested for violent crime	-	-	1	**1**
Arrested for dealing/trafficking	-	-	2	**-**
Arrested for driving offence	1	-	-	**-**
Arrested for alcohol and driving	2	-	2	**2**
Arrested for drugs and driving	-	-	1	**-**
Arrested for other reason	1	-	2	**2**
Received drug caution/diversion				
More than 12 months ago*	n/a	n/a	6	**6**
In the last 12 months*	n/a	n/a	3	**2**

Source: EDRS Regular ecstasy user interviews 2003-2006
* Not recorded prior to 2004
# No distinction made between dealing for cash profit and ecstasy profit prior to 2004

16.2 Perceptions of police activity towards REU

REU were asked if there had been any changes in police activity towards ecstasy users during the six months preceding the interview. Two-fifths of the sample (45%) did not know whether there had been any recent changes in police activity, one-quarter (24%) thought that police activity had been stable, one-third thought that police activity had increased (30%), and only a small proportion (1%) thought that police activity had decreased during this time. Those that commented on increased police activity typically noted an increased number of 'busts' of both ecstasy users and dealers (n=16). Other comments included a perception of generally increased police presence (n=2), increased undercover police presence at nightclubs/venues (n=7), increased police presence both at (n=3) and outside nightclubs/venues (n=3), and an increase in the number of searches conducted outside nightclubs (n=1). Other participants commented on the recent introduction of roadside drug testing (n=4). A large majority of the REU sample (85%) indicated that police activity had not made it more difficult for them to score drugs during the six months preceding the interview. Few participants agreed that using or selling of ecstasy should be legal, with over half disagreeing with these statements (see Table 68).

Table 68: Perceptions of police activity by REU, 2003-2006

Perception	2003 n=100	2004 n=100	2005 n=100	**2006 n=100**
Recent changes in police activity:				
Decreased	1	4	1	**1**
Stable	24	35	43	**24**
Increased	55	31	27	**30**
Don't know	20	30	29	**45**
Has police activity made it more difficult for you to score drugs recently?				
Yes	28	17	15	**15**
No	73	83	85	**85**
Don't know	-	-	-	**-**
Using 'ecstasy' should be legal (%)	n/a	n/a	n/a	
Strongly agree				9
Agree				13
Neutral				20
Disagree				48
Strongly disagree				10
Selling 'ecstasy' should be legal (%)	n/a	n/a	n/a	
Strongly agree				5
Agree				7
Neutral				16
Disagree				52
Strongly disagree				20

Source: EDRS Regular ecstasy user interviews 2003-2006

The majority of KE did not comment or did not know of any recent changes in police activity towards ecstasy users. Consistent with user reports, some KE noted an increase in visible police activity (n=6), an increase in undercover police presence at nightclubs and events (n=2), and a general increase in police presence (n=1). Single KE noted a recent increase in police monitoring of events and in the number of searches conducted outside nightclubs. Four law enforcement KE noted a recent increase in the number of seizures and arrests made in relation to ecstasy, with all commenting that this was due to a recent change in police focus.

16.3 REU responses to police sniffer dogs

For the first time in 2006, REU were asked about their responses to police sniffer dogs at events. Sniffer dogs are not currently used at events in Tasmania, thus REU responses are likely to be related to their experiences in other states of Australia. Four REU had seen sniffer dogs at events on single occasions in the six months preceding the interview. When asked what precautions they took when they know/hear that sniffer dogs are going to be at an event, these participants responded that they decide not to take drugs to an event (n=2) or hide drugs better (n=1). One participant indicated that they had had drugs with them on an occasion when sniffer dogs were present at an event, and that they had not changed their behaviour in response as they did not expect to get caught.

16.4 Arrests made by Tasmania police in relation to drug use

In July 1998, Tasmania Police introduced a Cannabis Cautioning Program, which gave police officers the discretion to caution first-time minor cannabis offenders. Following a successful

trial of the program, the eligibility criteria for cautioning were expanded to include consideration of non-first time offenders (ABCI, 2001). In March 2000, under a series of initiatives funded by the Council of Australian Governments, the program was further adapted within the Tasmanian Early Intervention and Diversion Framework. This current diversion model now extends to cover individuals who have been apprehended for no more than three offences in the past ten years, and follows a three-tiered approach to diversion.

Individuals with a first minor cannabis offence are cautioned and provided with health and legal information, as well as contact details of referral and treatment services, and do not receive any criminal record. Second-time offenders are cautioned and diverted into a brief face-to-face intervention with a health professional. Again, there is no criminal conviction; however, if they fail to attend the brief intervention the individual is prosecuted for the drug offence. Third-time offenders are cautioned and diverted directly to assessment and treatment through the Department of Health and Human Services Alcohol and Drugs Service. Charges are not pursued providing attendance and compliance with the requirements of treatment as assessed. In the case of a first offence with an illicit drug other than cannabis, individuals are immediately diverted to the third tier of diversion (as per third-time cannabis offenders). This initiative has been well supported by police, with approximately 1000 diversions made per annum between 2001/02 and 2004/05. However, this has decreased in 2005/06, with 595 diversions being made (Table 69). The number of second- and third-level diversions (to health interventions), which have fluctuated in recent years, have declined proportionally (from 365 cases in 2004/05 to 236 cases in 2005/06: Table 69).

Table 69: Drug diversions or cautions issued by Tasmania Police, 2000/01-2005/06

	2000 /01	2001 /02	2002 /03	2003 /04	2004 /05	2005 /06*
Number of cautions/diversions state-wide	764	978	990	977	977	595
% diversions in Southern District	95	79	78	n/r	53	33
Number diverted to health intervention state-wide	151	n/a	263	179	365	236
% health intervention diversions in South	86	n/a	86	90	57	44

Source: Tasmania Police State Intelligence Services State-wide Illicit Drug Reports; Alcohol and Drug Service

Note: These figures may differ from data submitted to the Australian Crime Commission if the decision to charge persons was altered to a caution after the figures were forwarded to State Intelligence Services. *These figures are also included within the Alcohol and Other Drug Treatment Services Minimum Dataset statistics. 'n/a' refers to cases where the relevant data were not provided to the authors

Data pertaining to drug-related arrests in Tasmania between 1995/96 and 2004/05 are shown below in Table 70 (Data for 2005/06 was not available at the time of publication). These data illustrate a marked increase in arrests for methamphetamine-related offences for 2000/01 and 2001/02 in comparison to previous years (7 arrests in 1998/99 to 89 in 2001/02). While these arrests decreased between 2001/02 and 2003/04 (89 in 2001/02, 66 in 2003/04 and 39 in 2003/04), these again increased in 2004/05 (rising to 72 arrests in that financial year). Cannabis-related arrests appear to have doubled between 1999/00 and 2004/05 (from 736 in 1999/00 to 1,474 in 2004/05). As this increasing trend coincides with the implementation of the Cannabis Cautioning Program, and subsequently the Illicit Drug Diversion Initiative, it is likely that much of this increase may simply reflect the increase in utilisation of 'official' cautions and diversions by Tasmania Police (which are included in these statistics) over 'unofficial' warnings, which would not be recorded in these statistics in preceding years.

Arrests for opioids have remained low in the past 9 years, and arrests for cocaine have remained almost non-existent in that time.

Table 70: Number of arrests (including cautions and diversions) for cannabis-methamphetamine- opioid- and cocaine-related offences in Tasmania, 1996/97-2004/05

Type of offence	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05
Cannabis	1079	1196	736	799	1050	1540	1830	1638	1474
Methamphetamine	20	15	7	28	70	89	66	39	72
Opioids	28	16	25	9	9	34	9	10	16
Cocaine	0	0	0	0	4	1	0	0	0

Source: Australian Illicit Drug Reports 1995/96-2000/01, Australian Bureau of Criminal Intelligence (now the Australian Crime Commission), and Tasmania Police State Intelligence Services State-wide Illicit Drug Reports Note: 2001/02 data are based on data provided to State Intelligence Services, which may differ from official statistics and counting rules used by the Australian Crime Commission (formerly ABCI); similarly, data for 2004/05 is State Intelligence Service Data, reported for consistency with data presented earlier in this report. ACC figures for 2004/05 differ only slightly from those reported here (cannabis: n=1353; methamphetamine: n=69; opioids: n=10; cocaine: n=0). Data for 2005/06 was not available at the time of publication.

Table 71 below indicates the proportion of arrests for offences relating to the possession or use of illicit drugs (consumer offences) as opposed to supply-type (provider) offences between 1996/97 and 2004/05. During this period, the proportion of arrests relating to consumer-type offences has been variable without particular trend for both cannabis and opioid arrests (Table 71). Arrests relating to methamphetamine, however, have followed a variable but identifiable trend toward a lower proportion of consumer-type arrests (Table 71), which is reflective of Tasmania Police's focus toward suppliers.

Table 71: Consumer arrests (including cautions and diversions) for cannabis-, methamphetamine- and opioid-related offences as a proportion of all drug-related arrests in Tasmania, 1996/97-2004/05

Drug Type	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05
Cannabis	49	76	93	88	96	72	90	92	82
Methamphetamine	90	100	86	71	86	79	63	79	61
Opioids	86	94	96	78	89	68	88	100	81

Source: Australian Illicit Drug Reports 1995/96-2000/01, Australian Bureau of Criminal Intelligence (now the Australian Crime Commission), and Tasmania Police State Intelligence Services State-wide Illicit Drug Reports Note: 2001/02 data are based on data provided to State Intelligence Services, which may differ from official statistics and counting rules used by the Australian Crime Commission (formerly ABCI). Similarly, 2004/05 data are based on SIS reporting, for consistency with data presented earlier in this report; however, figures reported by the ACC are consistent with these: cannabis – 83% consumers; methamphetamine – 62% consumers; opioids – 80% consumers. Note: Data for 2005/06 was not available at the time of publication.

As shown in Table 72, the number of individuals before the Supreme Court for selling or trafficking in drugs has increased slightly in the past decade, from 22 individuals in 1996/97 to 33 in 2004/05 (data from 2005/06 was not available to the authors in time for inclusion in this report). As part of the context of these increases, the *Misuse of Drugs Act 2001* implemented changes to the existing law and may have expanded the number of prosecutions appropriate for presentation to the Supreme Court. The act was further amended in 2004. It is thus likely that the recent apparent increase in charges (from 20 in 2003/04 to 33 in 2004/05) may largely relate to such legal changes (the full effect of the enactment of the *Misuse of Drugs Act 2001*

together with several prosecutions being withheld while amendments effected in 2004 were being expected, and then were the subject of a reference to the Court of Criminal Appeal to determine if there were any retrospective effect: T. Ellis SC, Personal Communication, 2005), rather than necessarily reflective of substantial changes in the rate of such offences. In 2003/04 and 2004/05, the majority of relevant charges before the Supreme Court related to trafficking in a controlled substance (16 individuals in 2003/04 and 19 in 2004/05) and cultivating a controlled plant for sale (3 individuals in 2003/04 and 10 in 2004/05).

The number of individuals before the Magistrates Court for drug-related matters has stabilised somewhat in the past three financial years following marked increases in the number of cases in 1999/00 (Table 72, Figure 36). In particular, the number of individuals before the court dealing and trafficking in drugs (23 individuals in 1999/00 and 106 in 2005/06) has markedly increased. It is noteworthy that the number of cases in relation to possession or use declined in 1999/00 in comparison to previous years, possibly reflecting the impact of the Cannabis Cautioning trial; however, these cases have steadily increased since this time (195 individuals in 1999/00 and 422 in 2005/06), and in recent financial years these cases had returned to a level similar to that prior to the implementation of the diversion programs. The number of cases relating to importing and/or exporting of drugs heard by the Magistrates Court has remained low and stable in recent years. In contrast, the number of cases for manufacturing or growing of drugs has declined in recent years following an earlier increase (with 101 individuals before the court for this charge in 1999/00, rising to 186 in 2002/03, and declining to 93 in 2005/06).

Table 72: Number of individuals before Tasmanian courts or imprisoned on drug charges, 1996-2006

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
SUPREME COURT OF TASMANIA										
Number of individuals convicted of selling or trafficking in dangerous drugs	22	18	22	27	14	15	30	20^	33~	**
HOBART MAGISTRATES COURT										
Number of individuals before the court for:										
dealing and trafficking in drugs	*n/p*	30 *(40)*	28 *(33)*	23 *(28)*	42 *(47)*	39 *(48)*	159 *(180)*	120 *(138)*	123 *(130)*	106 (118)
importing /exporting of drugs	*n/p*	4 *(5)*	7 *(8)*	5 *(8)*	2 *(2)*	0 *(0)*	1 *(1)*	1 *(1)*	0 *(0)*	2 (3)
manufacturing/growing of drugs	*n/p*	201 *(260)*	164 *(189)*	101*(124)*	144 *(163)*	142 *(194)*	186 *(202)*	102 *(105)*	80 *(81)*	93 (96)
possession and/or use of drugs	*n/p*	469 *(928)*	342 *(654)*	195*(428)*	263*(544)*	277 *(542)*	438 *(896)*	414 *(829)*	414 *(800)*	422 (823)
other drug offences	*n/p*	229 *(284)*	178 *(251)*	105*(169)*	113*(155)*	102 *(104)*	34 *(38)*	4 *(6)*	1 *(1)*	1 (1)
(alleged number of offences in parentheses)										
HOBART PRISON*										
Number of individuals incarcerated	21	42	26	29	*n/p*	16	35	36	55	57
Number of offences among those incarcerated	33	77	50	44	25	27	78	83	101	112
Offence breakdown										
Grow prohibited plant/substance	3	6	3	4	0	2	6	5	13	13
Possession/use	16	30	20	22	13	18	44	51	66	67
Prescription offences	3	7	6	0	0	0	4	1	0	6
Sell/supply narcotic substance	1	1	1	2	0	1	5	1	2	0
Sell/supply prohibited substance	1	6	4	0	6	4	5	8	10	6
Traffic in narcotic substance	1	1	1	6	1	1	3	1	0	3
Traffic prohibited substance	4	7	2	4	1	1	7	7	7	6
Traffic prohibited plant	0	5	4	2	1	0	3	4	1	6
Other	4	14	9	5	3	0	0	4	1	5

Sources: Department of Public Prosecutions (Supreme Court data); Magistrates Court (Magistrates Court Data); Corrective Services (Prison data), Department of Justice and Industrial Relations

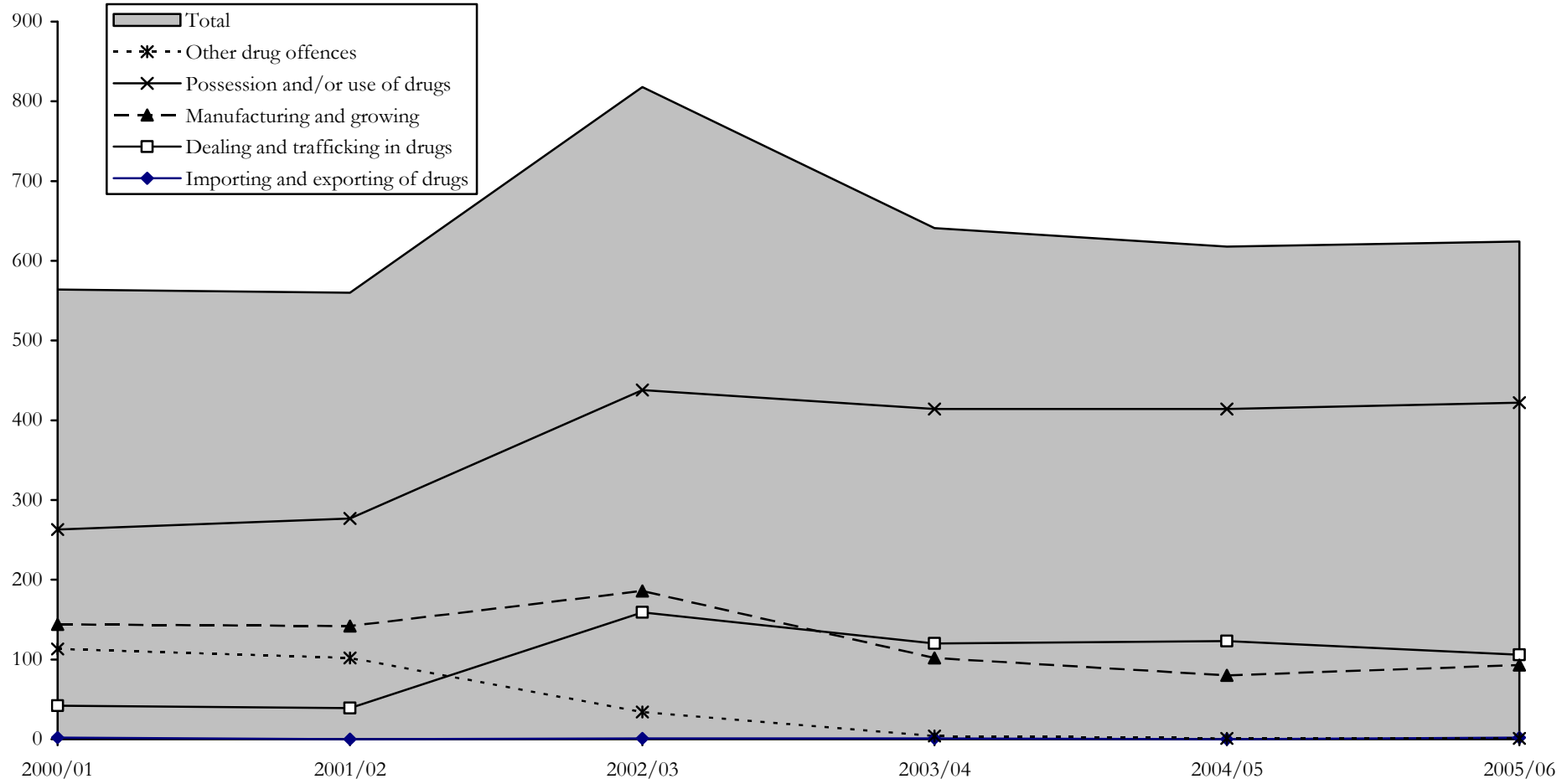
*Note that numbers of incarcerations refer to cases presented before both the Supreme and Magistrates courts; 'n/p' refers to cases where data were not provided to the authors.

^ Note: this includes the following offences: cultivating a controlled plant for sale (3); posses a thing intended for the use in manufacturing drugs for sale (1); selling a narcotic substance (1); trafficking in a controlled substance (16);

~ Note that this includes the following offences (most serious offences only recorded): trafficking in a controlled substance (19); trafficking in a prohibited substance (1); cultivating a controlled plant for sale (10); possess thing intended to use for cultivating a controlled plant for sale (2).

**Note: Data for 2005/06 not available at the time of publication.

Figure 36: Number of individuals before the Hobart Magistrates Court for drug-related offences, 2000/01-2005/06



Source: Hobart Magistrates Court

16.5 Summary of criminal and police activity

- The self-reported criminal activity among the 2006 REU sample was relatively low. With the exception of dealing drugs, only 8% of the REU interviewed had committed criminal offences during the one month preceding the interview and 8% had been arrested during the preceding 12 months. Key experts generally indicated that there was no or little crime among the group of REU that they were familiar with.
- Almost one-third of the REU sample (30%) and several key experts perceived that there had been an increase in police activity towards ecstasy users in the last six months; however, the majority of regular ecstasy users indicated that police activity had not recently made it more difficult for them to obtain drugs.

17.0 SUMMARY

17.1 Demographic characteristics of REU

The sample of 100 regular ecstasy users (REU) interviewed in 2006 were typically young, with ages ranging from 18 to 61 years and the majority in their early- to mid-twenties. Participants were generally well educated and either employed on a full- or part-time/casual basis or currently engaged in full-time study. Few participants had come into contact with the criminal justice system or drug treatment agencies. These demographic characteristics are generally consistent with those reported among REU in the previous three years of the study. However, there was less recent injecting drug use, involvement in current drug treatment, and recent use of methadone and heroin among the most recent three cohorts relative to 2003, possibly reflecting less overlap between the IDU and REU populations in the latter three years of the study.

17.2 Patterns of polydrug use

While the participants were selected on the basis of regular use of ecstasy, and over half nominated ecstasy as their drug of choice, polydrug use was the norm among the REU interviewed. Recent use of alcohol, cannabis, tobacco, and methamphetamine (powder, base and crystal) was common, and over half had recently used psychedelic mushrooms. Between one-third and one-quarter had recently used nitrous oxide, cocaine, benzodiazepines, LSD, or 2CI. Around one-tenth had recently used opiates other than heroin or methadone, pharmaceutical stimulants, amyl nitrite, or antidepressants and the recent use of ketamine, methadone, MDA, GHB, buprenorphine, and heroin was uncommon. There was no recent use of 1,4B or GBL among the current sample.

Over the four years of the study there have been trends in the use of some drug types. Between 2003 and 2006 there has been a steady decrease in the recent use of ketamine, MDA, and amyl nitrite, and an increase in the use of cocaine. Relative to the 2005 sample, there was a slight decrease in the recent use of methamphetamine powder (62% vs. 77%) and a slight increase in the use of methamphetamine base (23% vs. 40%) and crystal methamphetamine (10% vs. 27%) in 2006. However, the highest recent use of crystal methamphetamine was observed among the 2003 sample (52%). One-quarter of the 2006 sample (23%) had recently used the hallucinogen 2CI among the 2006 cohort compared to less than one-twentieth of previous cohorts. Stable trends were observed in the use of most other drug types.

17.3 Ecstasy

Data from the National Drug Strategy Household Survey (NDSHS) suggest a steady increase in the national prevalence of ecstasy use in Australia between 1995 and 2004, where 7.5% of the population are estimated as ever trying the drug, and 3.4% were estimated as using the drug in the preceding 12 month period. The prevalence of recent ecstasy use among the Tasmanian sample has remained at least half that of the national estimate during this time, and it is unclear whether there has been any substantial change in the prevalence of ecstasy use in Tasmania over this time.

The participants interviewed in the present study had first started to use ecstasy on a regular basis at 20 years on average and a large majority of the sample had been using ecstasy for two years or more. The entire sample had recently used ecstasy in tablet form while a minority had recently used ecstasy capsules or powder. There was a wide variation in the frequency of ecstasy use among the sample, ranging from monthly to several times a week. On average, ecstasy had been used fortnightly with a median of two tablets taken in a typical session. Although ecstasy was typically

swallowed, snorting of ecstasy was also common, with three-quarters of the sample recently snorting the drug. This may be an issue of concern due to potential damage to mucous membranes, a steeper dose-response curve, and the increased risk of blood-borne viral infections. A minority of the sample had also recently shelved/shafted, smoked, or injected ecstasy.

There were some concerning patterns of use among the sample. One-fifth (22%) had used ecstasy on a weekly basis or more frequently, three-quarters (79%) usually used more than one tablet in a typical session of use, and one-third (37%) had recently used ecstasy in a 'binge session' (a continuous 48 hour period of drug use without sleep). Relative to 2005, slightly greater proportions of the sample had usually used more than one tablet in a typical session, or had recently 'binged' on ecstasy, but the median frequency of ecstasy use overall was slightly lower. Whereas the long-term effects and risks of extended ecstasy use are largely unknown, evidence from toxicology studies in rats and neuropsychological studies in humans indicate that the safest pattern of use is to use the drug infrequently and in small amounts. Thus, those using the drug frequently or in large amounts for extended periods of time may be at a greater risk for neurological and neuropsychological harm.

Ecstasy was typically consumed in combination with other drugs. Alcohol, cannabis, and tobacco were commonly used in a typical session of ecstasy use. Just over one-tenth (15%) typically used methamphetamine when under the influence of ecstasy – similar to the proportion in 2005 (17%), marking a sustained reduction from the rates in the 2003 (25%) and 2004 cohorts (25%). The use of cannabis both under the influence of and when coming down from ecstasy .and the use of benzodiazepines when coming down from ecstasy, has also decreased slightly over the past four years.

The majority of participants (79%) reported drinking alcohol when under the influence of ecstasy and two-thirds (66%) typically consumed more than five standard drinks. Although the proportion reporting 'binge drinking' when under the influence of and coming down from ecstasy had slightly declined from the high rates amongst the 2004 and 2005 cohorts, the high level of coincident binge alcohol and ecstasy use is still an issue of concern. There is an increased risk of dehydration when alcohol is combined with ecstasy and larger quantities of alcohol can be consumed when under the influence of psycho-stimulants without experiencing immediate effects of intoxication; however, the harms associated with this use still occur. Additionally, most of the overdose episodes reported by the REU in the current study involved alcohol and/or polydrug use.

Close to half (49%) of the REU sample had recently experienced no or few psychological symptoms of dependence in relation to their ecstasy use as measured by the Severity of Dependence Scale (SDS) for ecstasy. However, almost one-fifth (19%) reported experiencing significant symptoms of dependence in relation to ecstasy. High ecstasy SDS scores were associated with greater frequency and quantity of ecstasy use, binge drug use, and high levels of methamphetamine dependence and psychological distress scores.

Ecstasy was typically used at music-related venues including dance parties, nightclubs and live music events but was also used at a range of other locations including private parties and private residences. REU reports and anecdotal comments of KE suggest an increase in the use of ecstasy at locations other than dance/events and nightclubs, in particular at private residences and public bars. Qualitative comments of both KE and REU suggest that the use of ecstasy has become more 'mainstream' and less restricted to dance-related events and nightclubs. There were anecdotal reports of a broadening demographic of people consuming the drug locally, including the use of ecstasy by younger and older people as well as an increase in the social acceptability of the drug.

Ecstasy appears to have become enmeshed in drinking culture and is likely to be used in combination with binge alcohol drinking.

The majority of participants perceived both benefits and risks to be associated with their ecstasy use. Perceived benefits were generally associated with having a fun and enjoyable time, social benefits such as enhanced closeness and enhanced communication with others, the enhanced appreciation of music/dance as well as acute drug effects such as enhanced mood and increased energy. The greatest risks perceived were the unknown contaminants/cutting agents in pills, legal/police problems, damage to brain function, and depression, among other psychological, neuropsychological, and physical risks. A minority considered acute physical problems such as vomiting, headaches, dehydration, overdose, and body temperature regulation, or the acute effects of intoxication, such as risk-taking behaviours, to be major risks of ecstasy use.

17.3.1 Price, purity and availability of ecstasy

Whereas there was evidence for an expanding ecstasy market in 2004, marked by decreased price, increased purity, and increased availability relative to 2003, in 2005 the market appeared to have tightened slightly, with a slight increase in price and decreased purity and availability relative to 2004. In 2006, a slight decrease in price and purity was observed, while availability remained relatively stable.

The median price reported by REU for one tablet of ecstasy was $40, which is slightly lower then the price of $45 reported in 2005. Over one-half indicated that this price had remained stable during the preceding six months, but one-quarter indicated that there had been a recent decrease in price. The median price reported by KE was also $40 and over half of those that commented (n=7) indicated that the price of ecstasy had recently decreased.

REU typically reported that ecstasy was 'medium' or 'fluctuating' in purity, with a smaller proportion reporting that ecstasy was 'high' in purity relative to previous years. REU typically indicated that this purity had remained stable or had fluctuated during the six months preceding the interview. KE indicated that the purity of ecstasy typically fluctuated or was 'low' to 'medium', with four out of eight KE reporting a recent decrease in the purity of ecstasy. There have been limited forensic analyses of the purity of ecstasy tablets seized by Tasmania Police. The median purity of the 33 seizures analysed during the 2003/04 reporting period was 26.0% and ranged from 10.4% to 44.5%. There were no analyses of ecstasy purity reported by Tasmania Police in the 2004/05 reporting period and the 2005/06 data was unavailable at the time of publication.

Both KE and REU indicated that ecstasy is 'easy' or 'very easy' to obtain and that recent availability had remained stable.

There was a substantial increase in the number of ecstasy tablets seized by Tasmania Police in the 2003/04 financial year, and the number of tablets seized has remained relatively stable since this time. Whereas this has had minimal impact on the number of arrests made in relation to ecstasy, there were a greater number of consumer (5) and provider (7) arrests reported in the 2004/05 reporting period relative to previous years (although these numbers remain low). Data for the 2005/06 financial year were unavailable at the time of publication.

17.3.2 Ecstasy markets and patterns of purchasing

Consistent with previous years, ecstasy was typically purchased from friends and obtained from friends' homes. Over one-half (54%) indicated that when they purchased ecstasy they typically

purchased the drug both for themselves and others, while the remainder (44%) typically purchased ecstasy only for themselves. Although the ecstasy market is predominantly based on individuals sourcing the drug for other friends while making no cash profit, those that purchase ecstasy in larger quantities may be putting themselves at greater risk of being arrested as a provider rather than a consumer of the drug. While two-fifths (43%) of the sample perceived that getting tablets for friends carried a heavier penalty than getting tablets for themselves, the remainder of the sample did not perceive that there was a distinction. Almost half of the cohort (46%) were aware of some possible consequences of being charged with supplying ecstasy (although the suggested consequences were not necessarily technically correct in terms of the legislated legal sanctions), and the remainder were not able to confidently comment.

Under Tasmanian legislation, the offences of possession, supply, and trafficking of a controlled substance are based on various factors including 'intent' and are not necessarily determined by the quantity of the seized substance. However, the offence of trafficking, which carries the largest penalty, may be determined by possession of a trafficable amount of a controlled substance. For ecstasy (MDMA), this trafficable amount is 10g.

17.4 Methamphetamine

Consistent with previous years, use of methamphetamine was common among REU in 2006. Over three-quarters (78%) had used some form of methamphetamine in the preceding six months. Methamphetamine was typically swallowed or snorted and was used on a median of six times during this period (approximately monthly) in small quantities (0.1g). The proportion reporting recent use of any form of methamphetamine and the frequency of methamphetamine use has remained relatively stable since 2003.

Recent use of methamphetamine powder was most common (62%) followed by methamphetamine base (40%), and crystal methamphetamine (27%). Relative to 2005, the proportion that had recently used powder was lower (62% vs. 77%) and the proportion that had recently used base (40% vs. 23%) and crystal (27% vs. 10%) was higher in the 2006 cohort. The frequency of methamphetamine powder use has decreased slightly over the past three years of the study. In 2006, the quantity of methamphetamine base used in a typical session was greater (~0.2g) relative to previous years (0.1g), and relative to the other methamphetamine forms. The increase in the recent use of crystal methamphetamine was largely attributable to an increase in those who reported smoking the drug.

Over half of recent methamphetamine users (52%) had experienced no symptoms of psychological dependence as measured by the methamphetamine SDS. However, almost one-fifth (19%) had experienced significant symptoms of dependence. High SDS scores were associated with greater frequency of methamphetamine use, use of methamphetamine in combination with ecstasy, recent binge drug use, recent injecting drug use, and elevated levels of psychological distress.

The median price for one 'point' (0.1g) of methamphetamine powder and methamphetamine base was $40, and the median price for one 'point' of crystal was higher at $50. The price of methamphetamine base was $10 less in comparison to 2005.

Methamphetamine powder and base were reported to be 'medium' to 'high' purity, whereas crystal methamphetamine was reported to be 'high' in purity. Subjective reports of REU suggest decreased purity of methamphetamine base relative to 2005.

Methamphetamine powder and base were considered to be 'easy' or 'very easy' to obtain, and crystal methamphetamine was typically considered to be 'difficult' or 'very difficult' to obtain. The availability of methamphetamine base appears to have increased relative to 2005. Those that commented on crystal methamphetamine indicated that it had become more difficult to obtain in the last six months.

The overall use of methamphetamine among REU in Tasmania has remained stable, but there have been some recent shifts in the use and market characteristics of each form. The recent use of powder is slightly lower than 2005 and there has been a gradual decrease in frequency of use since 2003. The recent use, frequency of use, and availability of base has increased relative to 2005, and the price has decreased. While the recent use of crystal has also increased relative to 2005, it is still half of that reported in 2003, and prices have remained stable, and availability low.

17.5 Cocaine

The lifetime and recent use of cocaine has steadily increased among the REU interviewed in Tasmania since 2003. One-third (33%) had recently used cocaine in 2006, compared to one-fifth (20%) in 2005, and one-tenth among the 2004 (10%) and 2003 (7%) samples.

Cocaine was typically snorted and was used on a median frequency of two days (range 1-6 days) in the six months preceding the interview, with an average of 0.2 to 0.5 grams used in a typical session.

The median price for one gram of cocaine was $350 (range $250-500) and the price for one point (0.1g) of cocaine was $50 (range $35-50). These prices were typically reported to have remained stable during the six months preceding the interview, though one-quarter of those who commented indicated a recent decrease in the price of cocaine.

Cocaine was typically considered to be 'medium', 'low', or 'fluctuating' in purity, and to have recently remained 'stable' or 'fluctuated' in purity during the six months preceding the interview.

REU reports on the availability of cocaine were mixed, with half indicating that it was 'easy' or 'very easy' to obtain and half indicating that it was 'difficult' or 'very difficult' to obtain. Although a majority indicated that the availability of cocaine had remained stable during the six months preceding the interview, one-third indicated a recent increase in availability of cocaine. KE comments also indicated a recent increase in the use and availability of cocaine among REU in Hobart.

17.6 Ketamine

The lifetime and recent use of ketamine has decreased among the Tasmanian EDRS sample since 2003. Less than one-tenth (6%) of REU interviewed had used ketamine during the six months preceding the interview. Ketamine had been used on an average of two occasions in the preceding six months in relatively small amounts. This, along with anecdotal reports of key experts, suggests predominately experimental use by a small number of people amongst this regular ecstasy-consuming cohort. Ketamine was typically swallowed or snorted and had been purchased in powder form.

Consistent with the relatively low use of ketamine among the 2006 REU sample, few participants were able to comment on the price, purity and availability of the drug and these estimates should therefore be interpreted with caution. One participant indicated that the price for one gram of

ketamine was $180 and another indicated that they had purchased one point of ketamine for $40 during the six months preceding the interview. The purity of ketamine was considered to be high or medium and to have remained stable in recent months. The comments of KE and the patterns of use among REU both indicate relatively low availability of ketamine in Tasmania.

17.7 GHB

Consistent with the low levels of use reported among the Tasmanian REU sample in previous years, less than one-tenth (9%) of the REU sample had ever used GHB, and only three participants (3%) had used GHB during the six months preceding the interview. GHB was taken orally in liquid form on a median of 2 days (range 1-3 days) during this time. There was no lifetime or recent use of GHB-like substances such as 1,4B or GBL among the 2006 REU cohort.

Only two participants commented on the price, purity, and availability of GHB in Tasmania making it difficult to delineate clear trends. Patterns of use among REU and anecdotal comments of key experts indicate low availability of GHB in Tasmania and predominantly experimental use by few people. However, considering the potentially harmful nature of GHB, future monitoring of GHB markets in Tasmania is important.

17.8 LSD and other psychedelics

Over half of the 2005 REU sample had used LSD at some stage of their lives and almost one-third had used LSD in the six months preceding the interview. A significantly greater proportion of males had ever and recently used LSD in comparison to the proportion of females. One tab or drop of liquid LSD was taken orally in a typical session of use, and LSD had been used on a median of 2 days in the preceding six months. Whereas LSD was most typically used at private residences, the use of LSD at dance-related events, nightclubs, and private parties was slightly higher in 2006 relative to previous years.

The median price for one tab of LSD was $20 (range $10-40) and this price was considered to have remained stable in the last six months. The purity of LSD was perceived by REU to be 'medium' or 'high' and stable during the six months preceding the interview. Two-thirds of the sample reported that LSD was 'easy' or 'very easy' to obtain, and the remainder reported that it was currently 'difficult' or 'very difficult' to obtain. Subjective reports of REU indicate a gradual increase in the availability of LSD since 2003, but levels of use have remained stable in successive EDRS cohorts during this time.

Almost three-quarters of respondents had ever used psychedelic mushrooms and over half had used mushrooms during the six months preceding the interview, which is an increase relative to previous years. A greater proportion of males had ever and recently used mushrooms in comparison to females. Mushrooms had been used on a median of three days in the preceding six months, approximately every two months. Both REU and KE noted a recent increase in the use of mushrooms at the time of the interview that was attributed to the seasonal increase in their availability. Almost two-thirds of the sample, and a greater proportion of males than females, had used some form of psychedelic (either LSD or mushrooms) in the last six months.

In 2006, almost one-quarter of the REU sample (23%) had recently used the experimental research chemical 2CI, which is a substantial increase relative to the small proportions that had recently used the drug in 2004 (5%) and 2005 (1%). Whereas this indicates an increase in the availability of 2CI locally, the frequency of use was relatively low, indicative of predominantly experimental use.

17.9 MDA

The lifetime and recent use of MDA among the Tasmania REU sample has decreased gradually from 32% and 21% respectively in 2003, to 14% and 3% respectively in 2006. MDA had been purchased in capsule form and had been swallowed or snorted on single occasions during the six months preceding the interview. Few respondents were able to confidently comment on the price, purity or availability of MDA and thus it is difficult to delineate clear trends. However, based on the decline in the use of MDA since 2003, and the comments of several KE, the local availability of MDA in Tasmania appears to be low.

17.10 Cannabis

The entire REU sample had used cannabis at some stage of their life, and a majority (82%) had used cannabis during the six months preceding the interview. Cannabis had been used approximately weekly on average during the six months preceding the interview, and this frequency of use tended to be greater for males relative to females (30 vs. 12 days), and for older relative to younger participants (72 vs. 12 days).

Participants were asked about the price, purity, and availability of hydroponically-grown ('hydro') and bush-grown ('bush') cannabis for the first time in 2006. Bush was typically cheaper than 'hydro', particularly when bought in larger amounts. The median last purchase price for one gram of cannabis was $15 for both bush and hydro (range $10-$25). The median last purchase price for one quarter of an ounce was $85 ($70-$100) and $65 ($40-$80) for hydro and bush respectively., and the median price for one ounce of hydro was $250 (range $200-300) compared to $200 ($50-350) for bush. The purity of hydro was reported to be high and stable, and the purity of bush was reported to be medium and stable. Both bush and hydro were reported to be 'easy' or 'very easy' to obtain and this availability was reported to have remained stable during the six months preceding the interview.

17.11 Patterns of other drug use

The majority of REU had recently consumed alcohol on an average of two days per week in the six months preceding the interview. A large majority (78%) of the 2006 EDRS REU sample had used alcohol at least weekly during the six months preceding the interview, which is substantially higher than both the Tasmanian (39.4%) and national (41.2%) estimates of prevalence for the general population, and among those aged 20-29 nationally (56.7%), from the 2004 National Drug Strategy Household Survey. A large majority of REU (85%) scored 8 or more on the alcohol use disorders identification test (AUDIT), suggestive of hazardous and harmful alcohol use and the possibility of alcohol dependence.

Tobacco had recently been used by four-fifths of the sample and over half the sample had smoked tobacco on a daily basis in the last six months, with others smoking tobacco less frequently. The proportion of daily smokers among REU interviewed in the present study (63%) is greater in comparison to both national (23.5%) and Tasmanian (27.7%) estimates of prevalence among those aged 20-29 from the 2004 National Drug Strategy Household Survey.

There has been a reduction among REU in the recent use of amyl nitrite from two-fifths (43%) in 2003 to less than one-tenth (16%) in 2006. The majority (90%) of those that had inhaled amyl nitrite had done so less than once a month during the last 6 months. The proportion of the sample reporting recent use of nitrous oxide has increased from one-quarter (25%) to two-fifths in 2005 (43%), and 2006 (39%). On average, nitrous oxide had been used less than monthly.

One-third of the sample had recently used benzodiazepines, on a median of five days in the last six months. One-tenth of the sample had recently used antidepressants, with one-third of these using them on a daily basis during the six months preceding the interview.

The use of other pharmaceuticals and opioid drugs was relatively rare among the regular ecstasy users interviewed in the current study, and those that had recently used these drugs had generally done so infrequently. Twelve percent had recently used pharmaceutical stimulants (such as dexamphetamine or methylphenidate), with a median frequency of approximately once every three months. Only small proportions of the sample had recently used methadone (5%), heroin (2%), and buprenorphine (1%). The recent use of other opiates (pharmaceuticals and alkaloid poppy derivatives) was slightly more common (14%) but relatively infrequent at once every two months.

17.12 Drug information-seeking behaviour

Two-thirds (66%) of the REU sample indicated that they had 'sometimes' bought a drug and it turned out to have different effects than they expected in the last six months, and two thirds (63%) indicated that they did not know what was in the pills that they took. Whereas one-third (34%) of the REU interviewed in 2006 actively sought information about the content/purity of 'batches' of ecstasy pills, the remainder did so half the time or less (37%) or 'never' (27%). Participants typically obtained this information from friends, dealers, and other people as well as websites, personal experience, and pill testing kits. Ten participants reported recent use of pill testing kits, and one-half of these were aware of some limitations of testing kits.

The majority of REU were receptive to harm-reduction information. Three-quarters (72%) indicated that they would find pill testing kits personally useful if available locally. Other information resources that were considered useful by REU were information pamphlets, a local website, health outreach workers at events, and posters. Participants generally indicated that the result of pill testing would influence their decision to take a pill. For example, many would not take a pill if testing indicated that it contained potentially harmful substances such as PMA and DXM.

Several REU commented on the lack of information available to them on the effects of drugs and ways in which to consume them more safely. In 2005, REU indicated that they were particularly interested in finding out more information about the long-term effects of drug use (physical, psychological, neuropsychological, and neurological) and also considered it to be important that new consumers were aware of the acute effects of drug use and ways in which to use drugs more safely.

17.13 Risk behaviour

Less than one in ten regular ecstasy users (9%) had recently used substances intravenously, consistent with the proportion of recent injectors amongst the preceding two EDRS cohorts. Methamphetamine was typically the first drug ever injected and the most common drug ever and recently injected. The sharing of needles was relatively rare; however, two out of five had recently shared other injecting equipment such as spoons, tourniquets, and water. One-tenth of these recent injectors had always required others to inject them in the last six months. The majority of recent injectors had obtained injecting equipment from NSP outlets in the preceding six months and none reported difficulty in obtaining needles during this time.

A large majority (94%) of REU had been sexually active during the six months preceding the interview and most of these (87%) reported recent penetrative sex under the influence of ecstasy

and related drugs. Participants were generally more likely to report some use of protective barriers with a casual partner than with a regular partner. Participants were slightly less likely to use protective barriers with a regular partner when under the influence of party drugs (60% vs. 49%). When having sex with a casual partner, participants were more likely to use protective barriers with a casual partner (82% vs. 91%) when under the influence of party drugs, but the proportion that 'always' used barriers declined when under the influence of drugs (47% vs. 34%). Whereas two-fifths of participants (40%) had been for a sexual health check up in the last year, one-third (37%) had never had a sexual health check up. Three-fifths of the sample had never been tested for hepatitis C or HIV. Three participants reported testing positive for hepatitis C.

Of those that had driven a car, one-half (48%) reported driving at a time when they perceived themselves to be over the legal alcohol limit during the last six months, compared to three-fifths (58%) in 2005. Three-quarters (78%) reported driving within an hour of taking ERDs in the last 6 months, compared to one-half (55%) in 2005. Most commonly, participants reported driving under the influence of ecstasy, cannabis or methamphetamine. Those that had recently driven under the influence of drugs were older, less likely to be students, and more likely to be full-time workers than those that had not. They were also more likely to have recently binged on ERDs and had recently used ecstasy more frequently and in larger amounts.

Almost one-half (46%) had recently 'binged' on ecstasy and related drugs (a continuous period of use for more than 48 hours without sleep). Substances most commonly used in a binge session of use were ecstasy, cannabis, alcohol, and methamphetamine. Those who had recently 'binged' had first started using ecstasy at an earlier age, had experimented with a greater number of drugs, and had recently used ecstasy more frequently and in larger amounts. They were also more likely to report recent injecting drug use, recent methamphetamine use, and to have typically used methamphetamine in combination with ecstasy during this time. They also reported higher psychological dependence scores for ecstasy and methamphetamine as measured by the SDS.

17.14 Health-related issues

Less than one-tenth of the sample (8%) reported that they had overdosed (passed out or fallen into a coma) on any drug in the six months preceding the interview. The main drugs involved in recent overdoses were ecstasy (43%), ketamine (14%), GHB (14%), methadone (14%), and Phenergan (14%). The majority of overdose episodes (86%) were associated with the use of more than one drug, most typically alcohol (43%), and cannabis (43%).

One-fifth (22%) of the 2006 REU sample had accessed health services in relation to drug use in the preceding six months. The most commonly accessed service was a GP (n=10), followed by ambulance (n=6), first aid (n=5), emergency (n=4), counsellor (n=3), hospitalisation (n=3), drug and alcohol worker (n=3), psychologist (n=3), and psychiatrist (n=2). Participants were most likely to access services in relation to the use of alcohol (n=10), ecstasy (n=9), methamphetamine (n=9), or cannabis (n=7) use, the drugs most commonly used among this cohort. A greater proportion of younger participants had accessed health services in comparison to older participants.

Mean scores on the Kessler psychological distress scale (K10) and the proportion with 'high' scores (25 or more) were higher among the current sample of REU relative to estimates among the general Australian population. One in ten REU (13%) had 'high' K10 scores indicative of high levels of psychological distress and a possible diagnosis of a mood disorder. Those with this high level of psychological distress were more likely to be unemployed, to be GLBT, to have recently injected, to have recently 'binged' on stimulants, to have 'high' methamphetamine dependence scores, and to have recently accessed health services. However, more than two-fifths of those with

'high' K10 scores had not accessed any health services in relation to their psychological distress in the preceding six months.

One-half of the sample (55%) had recently experienced work/study problems in relation to drug use, two-fifths had recently experienced financial (45%) and social/relationship (44%) problems, and less than one-tenth (5%) had recently experienced legal/police problems in relation to drug use. Problems were most commonly attributed to ecstasy, methamphetamine, or cannabis. Whereas the majority of these problems were relatively minor, small proportions experienced more serious problems such as ending a relationship, being kicked out of home, leaving school, being sacked/quitting work, or having no money to pay for food or rent.

17.15 Criminal activity, policing and market changes

Consistent with previous years, the self-reported criminal activity among the 2006 REU sample was relatively low. With the exception of dealing drugs, only 8% of the REU interviewed had committed criminal offences during the one month preceding the interview, and 8% had been arrested during the preceding 12 months. Key experts generally indicated that there was no or little crime among the group of REU that they were familiar with.

Almost one-third of the REU sample (30%) and several key experts perceived that there had been an increase in police activity towards ecstasy users in the last six months; however, the majority of regular ecstasy users indicated that police activity had not recently made it more difficult for them to obtain drugs.

18.0 IMPLICATIONS

It is important to remember that the aim of the EDRS is to investigate the patterns of drug use, drug markets and associated risks and harms among a sentinel group of participants that use ecstasy on a regular basis; as such, this population is not necessarily representative of all consumers of ecstasy and related drugs and the prevalence of ecstasy and other drug use can not be directly inferred. However, the study is designed to identify emerging trends and important issues, and the findings of the 2006 EDRS suggest five key areas for future policy:

1. Funding of specific health programs to meet the needs of local consumers

There are currently no services that specifically cater to users of ecstasy and related drugs in Hobart, and aside from volunteer organisations at predominantly large-scale events there is currently very little dissemination of harm-reduction information to these populations. This indicates a clear need for funding and a proactive response in terms of the implementation of harm-reduction strategies. Although approximately half of the REU interviewed in the current study were actively seeking harm-reduction information in relation to the substances that they chose to use, these messages were not necessarily reaching other consumers. Despite this, the majority of REU were receptive to such information. Considering that drug information was typically sought from peers or peer-run organisations, and the fact that REU do not typically come into contact with traditional health services, it is likely that harm-reduction programs will attain maximum impact if delivered through peer-based organisations and mediums appropriate to the target group such as internet sites and outreach workers or information at events. Such a peer-led service would be extremely well-placed to target the following specific risk behaviours identified in the current study: polydrug and binge drug use, binge drinking, unsafe sex, and sharing of injecting equipment. By contrast, illicit-drug education campaigns based around 'fear arousal' have been shown to be ineffective or to even have contradictory effects (Ashton, 1999; Skiba, Monroe & Wodarski, 2004; West & O'Neal, 2004), and these programs, and associated sensationalised reporting of drug use in the media, run the real risk of undermining the potential for successfully reducing health harms amongst this population.

Consistent with this recommendation, a recent parliamentary inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs (AOSD) in Australia recommended that harm-reduction strategies and programs receive more attention and resources in the execution of the National Drug Strategy (Commonwealth of Australia, 2007). The committee also recommended that that public education and demand-reduction campaigns for illicit drugs be factual, informative and appropriately targeted, seek input from young people and take account of user's experiences. (Secretariat of the Parliamentary Joint Committee on the Australian Crime Commission, 2007).

2. Focused interventions to reduce the harm associated with binge drinking in combination with ecstasy

The majority of participants (79%) reported drinking alcohol when under the influence of ecstasy and two-thirds of these (66%) typically consumed more than five standard drinks. Although the proportion reporting 'binge drinking' when under the influence and coming down from ecstasy had slightly declined from the high rates amongst the 2004 and 2005 cohorts, the high level of coincident binge alcohol and ecstasy use is still an issue of concern. There is an increased risk of dehydration when alcohol is combined with ecstasy. Additionally, larger quantities of alcohol can be consumed when under the influence of psychostimulants without experiencing the immediate

effects of intoxication; however, the harms associated with this use still occur. A large majority (78%) of the 2006 EDRS REU sample had used alcohol at least weekly during the six months preceding the interview, which is substantially higher than both the Tasmanian (39.4%) and national (41.2%) estimates of prevalence for the general population, and among those aged 20-29 nationally (56.7%). A large majority of REU (85%) scored 8 or more on the alcohol use disorders identification test (AUDIT), suggestive of hazardous and harmful alcohol use and the possibility of alcohol dependence. Additionally, most of the overdose episodes reported by REU in the current study involved alcohol and/or polydrug use.

3. The provision of pill testing kits

While there are some limitations to the use of commercially available ecstasy 'testing kits', currently there is often very little information available to consumers in regard to the substances contained within the tablets that are sold on the local market, and two-thirds of the participants in the current study indicated that they had sometimes bought a drug and it turned out to have different effects than expected. Limitations aside, use of these kits may allow consumers to be more informed about the tablets that they choose to use, and it was apparent that the consumers interviewed would act on information from testing kits – not taking a pill if it appeared to have an unexpected content such as potentially harmful substances such as PMA or DXM (see also Johnston et al., 2006). Testing kits can be purchased via the internet but are currently not available from any local source. There may be some benefit in making these available locally on a not-for-profit or cost-recovery basis, or facilitating provision of testing at dance and related events. The use and/or supply of testing kits under these circumstances would also allow for the limitations of these kits to be conveyed more effectively to consumers.

While noting some concerns about the potential limitations of pill testing kits, the recent parliamentary inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs (AOSD) in Australia noted that a feasibility study an illicit tablet monitoring service is underway in Victoria, and that the results of the evaluation of this study will be informative for future policy decisions in relation to pill testing (Secretariat of the Parliamentary Joint Committee on the Australian Crime Commission, 2007).. The authors of this report concur with this view and would encourage Tasmanian services and consumers to support this feasibility study wherever possible.

4. Increased awareness among local consumers of legislation with regard to possession, supply, and trafficking of controlled substances

Although the ecstasy market is predominantly based on individuals sourcing the drug for other friends while making no cash profit, those that purchase ecstasy in larger quantities may be putting themselves at greater risk of being arrested as a provider rather than a consumer of the drug. Over one-half (54%) indicated that when they purchased ecstasy, they typically purchased the drug both for themselves and others, while the minority (44%) typically purchased ecstasy only for themselves. Over half of the 2006 REU sample was not aware of the distinction between purchasing for themselves and others in terms of the law. Further, over half were not explicitly aware of the consequences with being charged with the supply of ecstasy. This indicates a need for increased awareness among REU in Tasmania of the risks associated with supplying ecstasy to friends, so that they are able to make informed choices with regard to this.

5. Consideration of the potential consequences of legislation surrounding smoking devices such as ice/crystal pipes

Although the use of crystal methamphetamine had increased slightly among the REU interviewed in Tasmania relative to 2005, the overall use of methamphetamine (all forms) has remained stable among the cohort, and the recent use of crystal remains half that of the recent use observed among the 2003 cohort. Among the 2005 sample, the small number of people that had recently used crystal methamphetamine had typically injected the drug. In 2006, the increase seen in the recent use of crystal was among those smoking the drug. There has been some recent suggestion nationally that legislation should be enacted to ban the sale of smoking devices such as ice/crystal pipes. The possible dangers of such legislation are that consumers will turn to other potentially harmful routes of administration such as injection, or the use of 'home made' devices that are potentially less safe (e.g. broken light globes). These issues should be considered with regard to the introduction of such legislation, and the EDRS aims to examine the possible impact of such legislation in 2007. While the behavioural responses to such a policy change are not yet known, and risks to the health of consumers and the population more broadly are high (given the potential harm should a substantial proportion of smokers make the transition to injecting use), any such policy changes should be limited to discrete regions and their consequences carefully evaluated before wider enactment.

6. Monitoring and dissemination of party drug trend information

Over the last four years, the findings of the EDRS have revealed some important trends in drug use among regular ecstasy-consuming cohorts in Tasmania. The use and availability of substances such as ketamine and MDA has decreased among the REU cohort since 2003, and the use of potentially harmful substances such as GHB is currently relatively low in Tasmania. There has been a gradual increase in the use and availability of cocaine and psychedelic mushrooms and a more recent increase in the use of the research chemical 2CI, though the frequency of use for these drugs remain relatively low. Although the overall use of methamphetamine has remained stable among the REU interviewed in Tasmania, there have been some shifts in the use of particular methamphetamine forms, notably a recent increase in the use of methamphetamine base and crystal methamphetamine among the sample in 2006. While there has been some recent concern nationally about the use of crystal methamphetamine, the use of the drug among REU interviewed in Tasmania in 2006 was still substantially lower than the level of use first reported in 2003. It is imperative that emerging trends in illicit drug markets are continually monitored so policy responses, emergency service workers, service providers and consumers are well informed to ensure the best outcome for the health of our community.

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