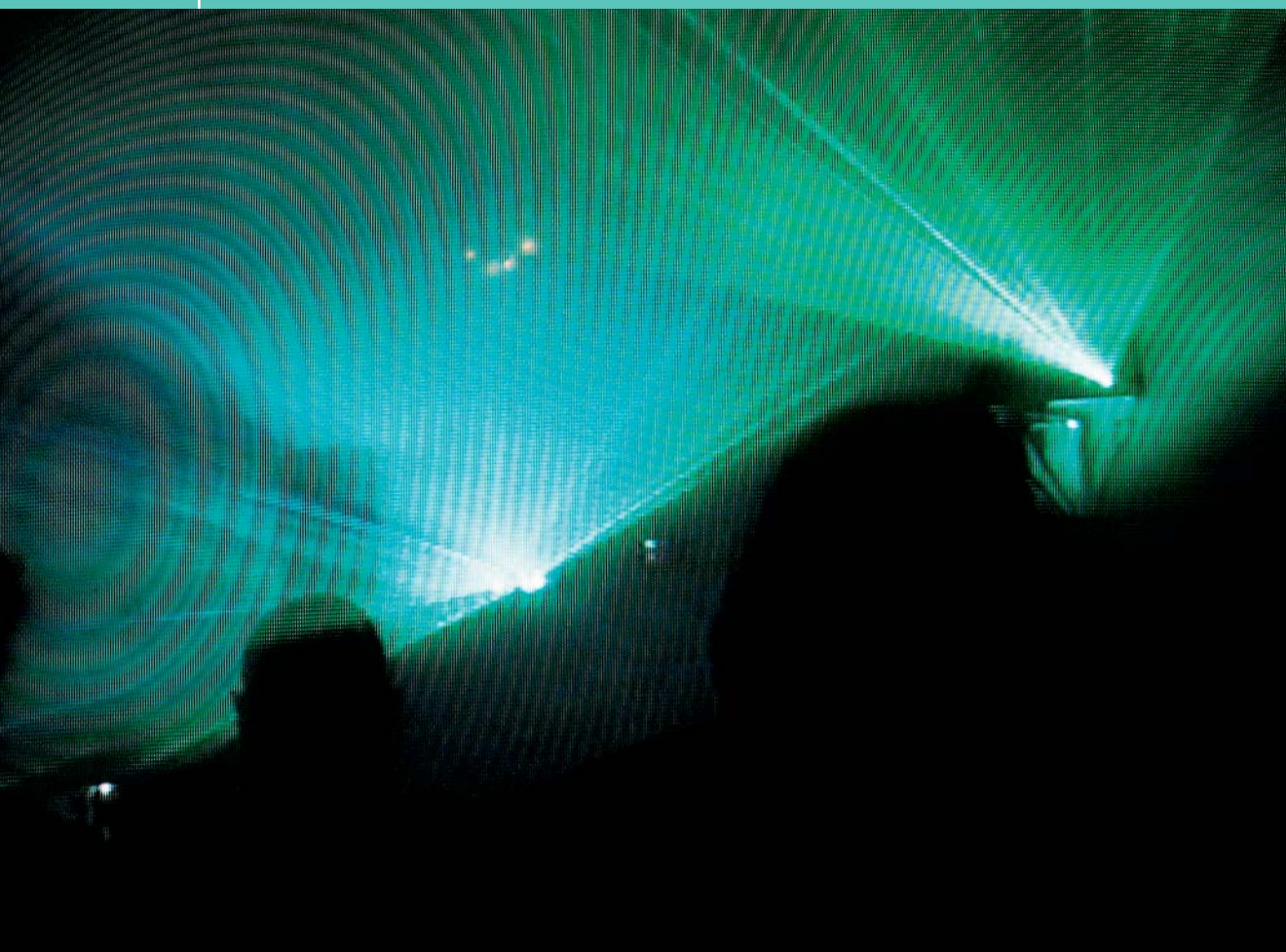




DRUGS AND
CRIME PREVENTION
COMMITTEE

INQUIRY INTO AMPHETAMINES AND 'PARTY DRUG' USE IN VICTORIA

DISCUSSION PAPER





PARLIAMENT OF VICTORIA
DRUGS AND CRIME PREVENTION COMMITTEE

**INQUIRY INTO AMPHETAMINE
AND 'PARTY DRUG' USE
IN VICTORIA**

September 2003

SUBMISSIONS ARE INVITED

The Committee welcomes written submissions in response to the issues raised in this Discussion Paper or on any matter related to the Terms of Reference of the Inquiry.

To assist interested parties in making submissions a number of questions have been posed throughout the Discussion Paper.

Details of how to make a Submission are included in the Insert. The Committee requires all submissions to be signed hard copy originals but would also appreciate an electronic copy.

Submissions should be sent by Monday 13 October 2003 to:

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Functions of the Drugs and Crime Prevention Committee

The Victorian Drugs and Crime Prevention Committee is constituted under the *Parliamentary Committees Act 1968*, as amended.

Parliamentary Committees Act 1968

Section 4 EF.

To inquire into, consider and report to the Parliament on any proposal, matter or thing concerned with the illicit use of drugs (including the manufacture, supply or distribution of drugs for such use) or the level or causes of crime or violent behaviour, if the Committee is required or permitted so to do by or under this Act.

Terms of Reference

15 April 2003

The Governor in Council, under section 4F of the *Parliamentary Committees Act 1968*, requests that the Drugs and Crime Prevention Committee of Parliament inquires into, considers and reports to Parliament on amphetamine and 'party drug' use in Victoria. In particular the Committee is required to:

- a) examine the nature, extent and culture of amphetamine and 'party drug' use;
- b) determine the demographic profile of users;
- c) examine the short and long-term consequences of amphetamine and 'party drug' use;
- d) examine the relationship of amphetamine and 'party drug' use to other forms of licit and illicit substance use;
- e) review the adequacy of existing strategies for dealing with amphetamine and 'party drug' use;
- f) consider best practice strategies to address the issue of amphetamine and 'party drug' use, including regulatory, law enforcement, education and treatment responses; and
- g) examine national and international legislation, reports and materials relevant to the issue.

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1. Introduction

The misuse of any drugs, licit or illicit, is bound to cause controversy and be subject to misinformation, leading to difficulties and confusion in the policymaking process. Drugs such as amphetamines and other psychostimulants are no exception. Indeed, in recent years there has been much publicity surrounding the use and abuse of 'ecstasy' (methyldioxymethamphetamine or MDMA) in particular. Some of this has been based on misinformation. This is one of the main reasons an Inquiry into the use of such drugs is timely.

Changes in the way certain drugs are now perceived are apparent in Australia and overseas. For example, early research in Australia and the United States documented relatively few problems associated with 'ecstasy' use. However, since the mid to late 1990s, many researchers have reassessed such views, particularly in the light of evidence that ecstasy is increasingly used via injection and that the purity of what purports to be ecstasy has been seriously compromised in recent years. In particular, researchers have been concerned about the growing number of deaths overseas and in Australia in which ecstasy has been implicated and the increasing evidence of some psychological morbidity associated with the drug.

Terms of Reference

The Governor in Council, acting under section 4F (1) of the *Parliamentary Committees Act 1968* required the Drugs and Crime Prevention Committee to inquire into and report to Parliament on the use of amphetamines and 'party drugs' in Victoria. In particular, the Committee is required to:

- a) examine the nature, extent and culture of amphetamine and 'party drug' use;
- b) determine the demographic profile of users;
- c) examine the short and long-term consequences of amphetamine and 'party drug' use;
- d) examine the relationship of amphetamine and 'party drug' use to other forms of licit and illicit substance use;

- e) review the adequacy of existing strategies for dealing with amphetamine and 'party drug' use;
- f) consider best practice strategies to address the issue of amphetamine and 'party drug' use, including regulatory, law enforcement, education and treatment responses; and
- g) examine national and international legislation, reports and materials relevant to the issue.

Background to the Inquiry

There are several reasons why it was thought that the inclusion of the amphetamine and the party drug components in the Terms of Reference was increasingly important.

First, and most important, it is now recognised that amphetamines are the most widely used of the illicit drugs after cannabis (Commonwealth Department of Health and Family Services 1996; Vincent, Allsop & Shoobridge 1996; Topp & Darke 1997; Vincent et al. 1999; Kamienicki et al. 1998; Makkai & McAllister 1998; Henry-Edwards & Ali 2000; Australian Institute of Health and Welfare 2002c). Indicators that substantiate this claim are readily found through the numbers of police and law enforcement seizures of amphetamines and the substantial increase in the number of amphetamine users attending clinical services (Vincent, Allsop & Shoobridge 1996). In South Australia, the problem and prevalence of amphetamine use was considered of such concern that a four-day drug summit, concentrating on amphetamines and 'designer drugs', was hosted by the South Australian government in June 2002 (see South Australia Drug Summit Communique 2002a).

Second, the use and abuse of a variety of amphetamine, methamphetamine and amphetamine derivatives such as ecstasy is increasing in Victoria, particularly among young people (Human Services Victoria 2001; National Drug and Alcohol Research Centre (NDARC) 2002a).

Third, in Australia the 'proportion of people presenting for treatment with a primary amphetamine problem has doubled in recent years' (Torres et al. 1996 cited in Topp & Darke 1997, p.113). Notwithstanding such concerns, the following comment by researchers Vincent et al. in 1999 is still, it would seem, largely accurate:

It is recognised that amphetamines are among the most widely used illicit drugs in Australia and there is a growing body of evidence regarding the harms associated with their use. However, effective interventions with this population are yet to be developed and evaluated and, until recently, there has been very little research which has addressed the characteristics of those who seek information, assistance or treatment (Vincent et al. 1999, p.64).

This increase in amphetamine use with the attendant health and social consequences is partly explained by the advent of the 'heroin drought' in Victoria and indeed the country as a whole in recent years.

Fourth, the treatment needs and options for amphetamine users have received very little examination (Burrows, Flaherty & MacAvoy 1993; Wickes 1993a, 1993b; Hall & Hando 1993, 1994; Huber et al. 1997; National Institute on Drug Abuse 1998; Wood 1998a; Richards et al. 1999; Anglin et al. 2000; Baker, Boggs & Lewin 2000; Turning Point Alcohol and Drug Centre 2001; Mundy 2001; NDARC 2001, 2002c; South Australian Drugs Summit Communique 2002a). Treatment for users of amphetamines and 'party drugs' is one of the areas that agencies and other concerned parties in the community have urged the Committee to include as part of its research brief. There is now considerable evidence that a number of physical, psychological and social harms may result from psychostimulant use. In particular, an amphetamine dependence syndrome comparable to alcohol and heroin use is noticeable (National Drug and Alcohol Research Centre (NDARC) 2002b).

Research into interventions to address amphetamine and party drug use (dependency) are extremely limited. Human Services Victoria (HSV) states that for some time now drug prevention education, information, treatment and policy has been geared towards the use of opioids.¹

This paucity of research applies not only to treatment interventions but also to more general demographic, statistical, epidemiological (who, where, how and why these drugs are being used) and social research. As with other areas of substance abuse the Drugs and Crime Prevention Committee has researched, only the provision of accurate, comprehensive and up-to-date data, information and research can inform useful policy development.

Which drugs to include?

It has not been easy deciding which drugs should be included for discussion under the rubric of amphetamines and 'party drugs'. After much deliberation it was decided that the major forms of amphetamine and methamphetamines would be included but not the psychostimulant cocaine.² The latter drug is excluded because, unlike Sydney, the use of cocaine is not particularly prevalent in Victoria, despite some recent increases in use. In its submission to the Drugs and Crime Prevention Committee, Turning Point, drawing from work done by Fry and Miller for the NDARC (2002), stated:

In general, recent evidence suggests that cocaine use remains infrequent amongst IDUs [injecting drug users] in Melbourne due to high prices and the

1 Submission of Human Services Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

2 For a discussion as to what is included under these groupings, see discussion of terminology in Chapter 2.

lack of availability in street based markets, as well as the ready availability of good quality methamphetamine.³

The Victorian Department of Human Services also stated that cocaine use in Victoria is low due to its prohibitive price compared to ecstasy and amphetamines (HSV 2002, p.14).

This situation has not changed with the advent of the so-called 'heroin drought' discussed in Chapter 2 of this Discussion Paper.⁴

As far as 'party drugs' are concerned, the major focus of this Inquiry will be on ecstasy (MDMA). Since approximately the mid 1990s much of what purports to be ecstasy is often not MDMA or is adulterated with other drugs. For this reason other party, dance or designer drugs must also be included. In particular, law enforcement seizures have shown that the derivative paramethoxyamphetamine (PMA) has been found in drugs passing as ecstasy (Australian Bureau of Criminal Intelligence (ACBI) 2002; Australian Crime Commission 2003). Many of the deaths associated with supposed ecstasy use both here and overseas have in fact been attributed to PMA. In effect, the taking of ecstasy at the present time can be a game of 'Russian roulette'. Given the growing prevalence and serious consequences of these 'substitutes', PMA, other amphetamine/methamphetamine derivatives, and other 'party drugs' such as gamma hydroxy butyrate (GHB), ketamine and methylene dioxy amphetamine (MDA), many of which have become popular in their own right, will also be studied as part of this proposed Inquiry.

A table listing the names, properties and intake methods of the most common amphetamines and 'party drugs' used is included in Chapter 2 of this Paper.

Work of the Committee

The Committee has embarked on an extensive research process in order to canvass the issues and receive input and information from a broad range of individuals, agencies and organisations with a stake or interest in the issues raised in the Terms of Reference.

To date the Committee has undertaken an extensive review of the literature on amphetamine and party drug use, has called for and received submissions from the community and spoken to some experts, key stakeholders and interested individuals in Melbourne, Sydney, Canberra and Brisbane.⁵

3 Excerpt from the confidential submission of Turning Point Alcohol and Drug Centre to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission and approval of Turning Point.

4 Research by the Turning Point Alcohol and Drug Agency in Victoria states that: '[f]ew participants in Melbourne reported purchasing cocaine, either regularly or as a result of changes in the heroin market. This situation contrasts with New South Wales where an active cocaine market has been reported amongst IDUs [Injecting Drug Users] interviewed for the IDRS...and other jurisdictions where problems with heroin supply have led to the development of the practice of cocaine injecting' (Turning Point 2001, p.16).

5 For a list of submissions received by the Committee see Appendix 1.
It should be noted that the interstate meetings were held after the draft of this Discussion

The Committee has also prepared this Discussion Paper to highlight the scope and complexity of issues to be addressed, provide an overview of the current law and regulations, policies and programmes in Victoria and other Australian and overseas jurisdictions, and raise specific questions that need to be addressed.

Structure of the Discussion Paper

One of the difficulties associated with the writing of this Paper has included the bifurcation apparent in the Inquiry title between amphetamines on the one hand and 'party drugs' on the other. Should, for example, different chapters be allocated to the discussion of 'party drugs' as opposed to amphetamines or should chapters and discussion be arranged thematically and according to content. For the most part, the Committee has decided to opt for the latter. Thus, for example, a chapter dealing with treatment options will contain discussion as to both treatments available (or not, as the case may be) for both groups of drug, although there may be separation within that chapter where appropriate. Such a schema recognises that there are no clear boundaries between the various drugs in question, but in fact much overlap. Terminology and nomenclature and the problems associated with these are discussed in Chapter 2.

Submissions are invited

The Committee welcomes written submissions in response to the issues raised in this Discussion Paper or on any matter related to the Terms of Reference of the Inquiry.

To assist interested parties in making submissions a number of questions have been posed throughout the Discussion Paper.

Details of how to make a submission are included in the insert. Note that the Committee requires all submissions to be signed hard copy originals and would also appreciate an electronic copy.

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Drugs and Crime Prevention Committee

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2. The Nature of Amphetamines and 'Party Drugs'

As indicated in the introductory chapter, the amorphous area of drug policy and drug studies, and drug practice, results in a difficulty of terminology and classification. For example, when we speak of amphetamines or psychostimulants or club or 'party drugs' what are we including? Are we discussing the same thing?⁶ The first section of this chapter discusses issues pertaining to nomenclature and sets some boundaries and parameters that will inform the rest of this Discussion Paper. For example, as discussed in further detail below, the use of the term 'club drugs' or 'dance drugs' in the context of this specific Inquiry is problematic. Club drugs certainly would include 'ecstasy', GHB, methamphetamine and possibly ketamine in its list, but one could also legitimately include such diverse substances as cocaine, LSD and rohypnol, which are not under review in this Discussion Paper.

The second part of this chapter will discuss the nature of those drugs or groups of drugs that have been selected as the focus of this Report. This will include an examination *inter alia* of:

- ◆ the pharmacological and chemical properties of the drug;
- ◆ how such drugs are used;
- ◆ the mode of administration; and
- ◆ a brief account of why some drugs may be seen as 'desirable' by their users.

An account of the physiological and toxicological consequences of taking various drugs, in addition to discussion of any psychological and behavioural effects, is analysed in Chapter 4.

6 The Illicit Drug Reporting System (IDRS) considers 'party drugs' to 'include any drugs that are frequently used in entertainment venues such as nightclubs or dance parties, but are not already monitored by the IDRS, including ecstasy, ketamine, LSD, MDA and GHB' (NDARC 2001, p.1).

Terminology and nomenclature

The planning of appropriate policy responses to the potential for an increase in psychostimulant related harms is currently hindered by the lack of clarity with respect to patterns of the use of these drugs, including terminology, the way in which the various forms are perceived to relate to each other, their appearance, their origin, purchase quantities, their price or the routes by which they are administered.⁷

As the above quote indicates, one of the difficulties pertaining to this Inquiry is that there are various taxonomic or classificatory systems associated with drug policy and particularly psychostimulant use. This can be problematic in deciding what counts as a 'party drug' or a 'dance drug'. Some of these drugs will cross boundaries of pharmacological or chemical groupings. For instance, hallucinogens may or may not be included as a 'party drug'.⁸

The terminology is constantly changing, as is the usage of the terms. For example, it would seem that when analysis is done of the drug that is being referred to as 'speed', it is for the most part composed of methamphetamine, rather than the amphetamine (sulfate) that it has historically referred to. Similarly, drugs being sold as MDMA or ecstasy have often been found on chemical analysis not to be methylenedioxymethylamphetamine, but may contain additives consisting of other drug types. In fact, an Australian Bureau of Criminal Intelligence (ABCI) report on illicit drug use has stated that drugs purported to be ecstasy can contain anything from benzodiazepines and caffeine to agricultural and veterinary drugs or even heroin and LSD (ABCI 2002). That street terms may not accurately reflect or refer to the actual drugs used is another problematic aspect of this type of inquiry.

Such distinctions are not merely semantic; they can have practical consequences. For example, Moore states that it can be difficult to aggregate overall figures for the use of any given drug, because of differing data collection categories: 'Some surveys target designer drugs, others examine stimulants, still others look at "psychostimulants"' (Moore 1992a, p.7).

Party or dance drugs

Another way of classifying a range of drugs is that based on the context in which they have commonly been used – in this case a range of drugs thought to be associated with dance clubs and parties, and raves. Such a classification is problematic not only for the wide range of drugs that may be included under this somewhat nebulous category (some of which are not included in the amphetamine 'family'), but also because there are distinct cultural and

7 Excerpt from the confidential submission of Turning Point Alcohol and Drug Centre to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission and approval of Turning Point.

8 Some drugs such as MDMA (ecstasy), while having chemical properties similar to amphetamines, may also be hallucinogens, thus adding to the confusion surrounding the classification of this drug.

contextual differences between different settings. For example, a traditional 'rave' may have a different culture of drug use than a more conventional dance club or disco (see the academic work of Lenton & Norcross 1997; Lenton & Davidson 1999).

Nonetheless, the types of drug often associated with dance and party cultures of one type or another have included:

- ◆ Amphetamines
- ◆ Methamphetamine
- ◆ Ecstasy (MDMA)
- ◆ Cocaine
- ◆ Ketamine (also known as Special K) – a veterinary anaesthetic
- ◆ GHB (gamma-hydroxy-butyrate), also somewhat erroneously referred to as 'Grievous Bodily Harm')
- ◆ Volatile nitrites (particularly in the gay party and club scene).

More problematically, in terms of this Inquiry, using this broader classification of 'party drugs' it is also possible to include cannabis/marijuana. There is a fairly high use of these latter drugs at 'rave parties' according to the literature. Synthetic hallucinogens such as LSD and even to a lesser, but increasing extent alcohol have also been used in conjunction with ecstasy. Certainly the phenomenon of poly drug use cannot be ignored at these settings.

The use of the term 'party drugs', although commonly referred to as a shorthand associated with clubs, raves and dance parties, is one that some groups feel is less appropriate as the boundary between club drug usage and street drug usage becomes blurred. For example, some commentators note that ecstasy, once a drug predominantly associated with the club, rave and party scene, is now, on occasion, being seen, distributed and sold on the streets. Moreover, studies such as those done by the Illicit Drug Reporting System (IDRS) report a *slight* increase in the numbers of people who are *injecting* ecstasy in Melbourne (NDARC 2002a). Such observations are a salutary reminder that drug use must always be contextualised.⁹ However, as will be discussed throughout this Discussion Paper, these numbers are still very small and not too much should be made, without further research, of this slight trend towards 'crossover' between party use and street use. Researchers from Turning Point warn that caution must be taken in interpreting these figures:

9 The factors of drug, set and setting, formulated by Zinberg are of utmost importance in this context. This concept is discussed below and in Chapter 5. For example, four settings where amphetamine/methamphetamine use can be discussed and problematised may include:

- Street trade and use
- Party, dance club and rave settings
- Truck drivers and the transport industry and in other occupational health and safety settings
- Amphetamine prescription for children with Attention Deficit Hyperactivity Disorder (ADHD).

Studies like the IDRS in Melbourne suggest that reported lifetime use of ecstasy by injecting drug users is increasing, along with signs that ecstasy injection is becoming more common in this group (as part of polydrug experimentation patterns). While this is indicative of a 'crossing-over' of illicit drug markets (and drug use subcultures) traditionally thought of as separate, further studies will be needed to explore this phenomenon. What is required is contact with different sentinel groups of drug users in addition to the injecting drug user target group (e.g. primary ecstasy users).¹⁰

Some other agencies in their submissions to this Inquiry have criticised the use of the term 'party drugs' in the original terms of reference. For example, the Catholic Education Office submits:

There is some concern that 'party drugs' may be a confusing description, especially as drugs that may be considered under this heading may not all be stimulants. The term also tends to give the impression that there are drugs that are a positive ingredient in enjoyable 'partying' and are without risk of doing harm.¹¹

This is a concern shared by the YWCA in its submission to the Inquiry:

In preparing this submission, there was much discussion about the term 'party drugs', and trying to determine what this included. In answering the question 'what *are* party drugs?' it seems to YWCA Victoria that the scope of this term is incredibly broad, as it can cover licit drugs including tobacco and alcohol, as well as illicit drugs such as ecstasy, LSD, heroin, amyl nitrate and marijuana.

YWCA Victoria is also concerned by the connection the Inquiry draws between amphetamines and 'party drugs'. The juxtaposition of amphetamines and 'party drugs' in this Inquiry can paint an inaccurate and incomplete picture of amphetamine use, by inferring that amphetamines are only used for 'partying' purposes. In the view of YWCA Victoria, the phrasing of the Inquiry's Terms of Reference unfairly focuses attention onto the actions of young people, and not on the activities of the whole community, by leaving out some significant issues relating to amphetamine usage.¹²

Victoria Police also have their reservations, particularly with the names given to and used for marketing of ecstasy or 'pseudo-ecstasy' tablets:

A real concern for Victoria Police is the marketing of these products to young people. The manufacturers use designer symbols and labels such as *Calvin Klein* and *DKNY* or have current cultural references such as *Bart Simpson* or *Banana Splits* to appeal to a young affluent market. Additionally, these tablets come in

10 Written communication from Turning Point Alcohol and Drug Centre to Committee staff, 18 July 2003.

11 Submission of the Catholic Education Office to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

12 Submission of YWCA Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

a variety of bright colours and can be easily swallowed. Users do not class themselves as traditional drug users such as intravenous users.¹³

Notwithstanding these reservations, most agencies have stated that 'party drug use' is an appropriate term or descriptor given the context in which much psychostimulant use – predominantly but not only MDMA – takes place.

Overarching classifications

One commonly used form of classification is the group of drugs termed 'amphetamine-type stimulants' (ATS). Such drugs, unlike cocaine, may have no botanical raw material but are fully synthetic derived. They include amphetamines, methamphetamines and a loose group of other central nervous system stimulants. Chawla gives a useful account as to the nomenclature of these drugs:

ATS include two sub groups with slightly different pharmacological properties: the amphetamine group and the ecstasy group. The former includes amphetamine, methamphetamine and methcathinone. Most of them were developed as therapeutic drugs: amphetamine in 1887; methamphetamine in 1919... The substance known commonly as 'ecstasy' (MDMA) has given its name to a whole range of related substances. They are sometimes called the hallucinogenic amphetamines because, in addition to the CNS stimulant effect, they produce effects of empathy, loquacity and serenity (Chawla 1998, pp.1–2).

The latter group of 'ecstasy' drugs may also be described as pure recreational drugs, as opposed to drugs used instrumentally (for example, amphetamines used by truck drivers or students to stay awake) (Chawla 1998). Moore (1992a) states that some Australian scholars have 'argued that to use the term "recreational" to describe illicit drug use may imply that it is "harm-free"'. However, Moore counters this argument by stating that:

...at least for some groups the term 'recreational' may accurately describe the orientation of drug use in that [these] drugs are primarily consumed in leisure contexts, e.g., at nightclubs or parties (Moore 1992a, p.10).

As Chawla indicates, the difficulty in describing the synthetic designer drugs¹⁴ is complicated by the fact that much of what is sold or passed off as 'ecstasy' is in fact not methylendioxyamphetamine (MDA). In discussing 'ecstasy' use

13 Excerpt from the confidential submission of Victoria Police (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission of Victoria Police.

14 Chesher argues that the term 'designer drug' can be misleading. Traditionally designer drugs (other than those 'designed' for licit purposes by pharmacologists) were those in which 'the psychoactive properties of an illegal drug have been retained, but the molecular structure has been altered in order to avoid prosecution' (Chesher 1990a, p.157). For example, in the United States drugs of abuse have been controlled by classifying, scheduling and proscribing certain compounds as illegal. Until such a process takes place no laws could apply. In recent years many western countries have changed legislation by making the analogues of scheduled drugs also subject to proscription. To the extent that the analogues are also caught by the legislative proscription they can no longer be called 'designer drugs' (see Shapiro 1989).

in Australia the NDARC stated that 'the term is now so widely used as to be considered virtually generic for any of the ring substituted amphetamine group' (NDARC 1998, p.1). This confusion as to terminology can have serious repercussions for research and data collection, as Gowing explains:

Identification of exactly which substances are involved when ecstasy use is reported is problematic because of the wide range of substances which are marketed as ecstasy and the fact that tablets may contain mixtures of different substances. In addition, classification of drugs varies from country to country and between studies. Ecstasy may be classified as an amphetamine-type stimulant, synthetic drug, designer drug, dance drug or be listed by name in different data sets... Even when one classification is used comparisons can be misleading. For example, amphetamine-type stimulant use is widespread in most regions of the world but amphetamine and methamphetamine predominate in some regions while ecstasy prevails in others (Gowing et al. 2001, p.4).

Ecstasy or purported ecstasy may contain a number of drugs in substitution to MDMA (aspirin, paracetamol, ketamine, caffeine) or may in fact be an amphetamine derivative that is chemically related or similar to MDMA, such as methylenedioxyamphetamine (MDA), methylenedioxyethylamphetamine (MDEA) or para methoxyamphetamine (PMA). In referring to 'ecstasy' throughout this Paper, at first instance the term will be used to refer to the drug as it is sold on the street unless the context otherwise specifies. If specific reference is required to the pharmacological compound known as 3,4-methyldioxymethamphetamine, the abbreviation MDMA shall be used.

In discussing amphetamines this Paper follows the lead of Burrows, Flaherty and MacAvoy (1993):

Amphetamine is used throughout this work to denote the sulphate salt of amphetamine [amphetamine sulfate] (the most common form of the drug in illicit use) while 'amphetamines' refers to the range of amphetamine-based psychostimulants (including dexamphetamine and methamphetamine, but excluding MDA and MDMA) (Burrows, Flaherty & MacAvoy 1993, p.1).¹⁵

In terms of referring to generic drug use for the drugs that are the subject of this Inquiry, the Committee has adopted the term used by the Victorian Turning Point Alcohol and Drug Centre. Its preferred classification as outlined in its submission to this Inquiry is 'psychostimulants'.

15 The NDARC (2002a) states that until the late 1980s the form of illicit amphetamine most available in Australia was amphetamine sulphate:

'Throughout the 1980s, the form of illicit amphetamine most available in Australia was amphetamine sulfate. During the 1990s, the proportion of amphetamine-type substance seizures that were methamphetamine (rather than amphetamine) steadily increased until methamphetamine clearly dominated the market. In Australia today, the powder traditionally known as 'speed' is almost exclusively methamphetamine rather than amphetamine. The more potent forms of this family of drugs, known by terms such as 'ice', 'shabu', 'base' and 'crystal meth', are also methamphetamine' (NDARC 2002a, p.28, footnote 1).

The wider classification of psychostimulants is used to reflect 'the diversity of changes to the illicit drug marketplace becoming apparent across Melbourne'.¹⁶ It also avoids some of the problems outlined by Turnbull in the following quote:

[I]n talking about amphetamines we are clearly faced with a diversity of both substances and users. My main concern here [is] with those stimulants known colloquially as speed – consisting predominantly of either methamphetamine or dexamphetamine. These drugs are used illicitly in Australia by groups ranging from street kids to truck drivers to business executives, and are variously taken as tablets, snorted or injected. It is important to keep in mind, however, that these drugs are closely linked to a range of common stimulants such as ephedrine on the one hand and designer drugs such as MDMA on the other.

The similarities and the popular confusion between these drugs and amphetamines is a significant factor to be considered in the framing of any strategy. In some cases it may actually be more effective to address amphetamines as part of a broader psychostimulants strategy (Turnbull 1993, p.98). (Committee emphasis)

In their classification of psychostimulants, Turning Point includes:

- ◆ Amphetamines and amphetamine-type substances
- ◆ Methamphetamine (including the powder traditionally known as 'speed' and methamphetamine drugs such as 'ice', 'shabu' (methylamphetamine hydrochloride), 'base' and 'crystal meth')
- ◆ Ecstasy (MDMA or its analogues).¹⁷

Cocaine is also included in this list. Although, as mentioned in Chapter 1, it is argued that:

In general, recent evidence suggests that cocaine use remains infrequent amongst IDUs [injecting drug users] in Melbourne due to high prices and the lack of availability in street based markets, as well as the ready availability of good quality methamphetamine.¹⁸

16 Ryder, Salmon and Walker are leading academics in the field of drug studies. In a recent book *Drug Use and Drug Related Harm* (2001) they also discuss the difficulties in classifying taxonomies of drugs and drug use. In relation to the more recent drugs that are being used in Victoria, they also prefer the use of the general category 'psychostimulants'. They define this category as those drugs that increase the activity of the central nervous system.

Their category of psychostimulants includes:

- Amphetamines
- Methamphetamine
- MDMA (ecstasy)
- Cocaine
- Nicotine
- Caffeine.

17 Excerpt from the confidential submission of Turning Point Alcohol and Drug Centre to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission and approval of Turning Point.

18 See NDARC 2002a pp.36-37 and Confidential Submission of Turning Point Alcohol and Drug Centre to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

Whatever form of classification is chosen, it is crucial to reiterate that the drugs will need to be studied in their contextual and cultural settings, each of which gives rise to different issues, problems and strategies. For example, the use of amphetamines by truck drivers to stay awake during long transport hauls will raise a different set of issues, risks, strategies and challenges to those facing young people who may use them while 'clubbing'.

The drugs and how they are used

Table 2.1 overleaf lists the names, properties and administration methods of the most common amphetamines and party drugs used. Detailed discussion of the drugs focussed on in this Inquiry follows the table.

Amphetamines and methamphetamines¹⁹

Amphetamines are one of the most widely used drugs in the western world. In Britain, for example, they have been cited as the second most popular form of illicit drug use, after marijuana (Griffin 1997, p.19). According to the United Nations Drug Control Programme (UNDCP), in Japan, Korea and the Philippines amphetamine-type stimulants (ATS) account for seven times as much use as heroin and cocaine combined (UNDCP cited in Henry-Edwards & Ali, in press). Amphetamine-type stimulants have been cited as the most commonly used illicit drug in Australia after cannabis. Indeed, the UNDCP is quoted as finding that Australia has the highest prevalence of ATS (primarily amphetamine and methamphetamine) use in the world (UNDCP cited in Henry Edwards & Ali, in press). Amphetamine use in Australia has also increased markedly since the advent of the so-called 'heroin drought', discussed later in this chapter. Further discussion of the prevalence of amphetamine use in Australia and Victoria is found in Chapter 3.

The term 'amphetamines' in general usage refers to a family of synthetic drugs that are all chemically related to amphetamine and all have similar effects. They are to be distinguished from the classical 'botanical' psychoactive drugs – heroin, cocaine and cannabis.²⁰ Amphetamines are psychostimulants. Stimulants act upon and increase the activity of the central nervous system and produce effects similar to the body's naturally occurring hormone, adrenalin.²¹

19 For basic factual and descriptive accounts of the various drugs in this section a variety of fact and information sheets produced from several drug and alcohol agencies are available. These include those of the National Drug and Alcohol Research Centre, the Australian Drug Foundation, 'Connexions', the United States Drug Enforcement Administration and Australian State Health Departments.

20 See Chawla 1998 for an account of the emergence and history of synthetic drugs.

21 For an account of the pharmacological properties of (meth)amphetamines, see Derlet and Heischouer 1990, pp.625ff.

Table 2.1: Table of drugs
Amphetamines

Common Name	Medical or Chemical Name	Other Street Names	Drug Action	Form	Route of Administration	Comments
SPEED	Amphetamine (Sulfate) Dexamphetamine	Goey or Go-ee Whizz Dexies	Stimulant	Powder, tablet or capsule, liquid	Snorted, swallowed, injected	Speed is often used as a generic name for a ‘family’ of amphetamine drugs that have been synthesised from approximately the late 19th century. In a general sense, the term amphetamines may also include ‘party drugs’ such as MDMA. More commonly, however, speed refers to the specific drug amphetamine sulphate and more recently it may also refer to methamphetamines and prescription drugs such as, ephedrine and pseudoephedrine.
METH	Methamphetamine or Methylamphetamine	Speed, Base	Stimulant	Powder, oil or paste (Base)	Snorted, swallowed, injected, smoked	
CRYSTAL METH	Methamphetamine Hydrochloride	Crystal, Ice, Shabu, Crank, Glass	Stimulant	Crystalline powder or crystals	Smoked, swallowed, injected, snorted	Scientists and pharmacists who use the term ‘ice’ may be referring to the chemical 4-methyl-aminorex. Street ice however is almost exclusively a strong, high purity form of methamphetamine.

Table 2.1: Table of drugs (cont.)
Party drugs

Common Name	Medical or Chemical Name	Other Street Names	Drug Action	Form	Route of Administration	Comments
ECSTASY (MDMA)	3,4 Methylene dioxy methamphetamine	E, Eckies, XTC, Dills, Eggs. Others too numerous to mention	Stimulant (but with hallucinogenic properties) sometimes known as a 'psychedelic amphetamine'.	Pills or tablets Less commonly capsules or powder	Predominantly swallowed. Some trends towards injectable use.	While 'ecstasy' is traditionally associated with the drug MDMA, in recent years analysis has shown what purports to be MDMA may in fact be adulterated or even substituted with other substances – including PMA, methamphetamine, caffeine and/or paracetamol.
GHB	Gamma Hydroxybutyrate Gamma Butyrolactone (GBL) – an analogue of GHB	Liquid E GBH Grievous Bodily Harm Blue Nitro Fantasy Easy Lay	Depressant/ Anaesthetic with sedative properties	Liquid (usually in small vials) Sometimes in bright blue liquid form known as 'blue nitro'	Usually orally, but with some reports of injection	Often used to 'spike' liquids and drinks in order to render victim vulnerable to sexual assault.
KETAMINE	Ketamine Hydrochloride	K, Special K	Hallucinogenic/ Anaesthetic	Tablet or pill, Powder	Swallowed, injected, sniffed	
PMA	Para methoxyamphetamine		Stimulant	Tablets (often purported to be MDMA or 'ecstasy'), Capsules	Swallowed	Not known as a drug of choice, as much as an additive put in tablets purporting to be MDMA.
COCAINE	Cocaine Hydrochloride	Coke, Charlie, Nose Candy, Snow, Charlie, Blow, White Dust	Stimulant	Powder	Snorted, injected,	Cocaine Hydrochloride cannot be smoked as the drug is destroyed at high temperature.
CRACK COCAINE	Cocaine (Freebase)	Crack	Stimulant		smoked	Crack is a freebase cocaine converted to alkaloid form so it can be smoked.

History

Amphetamine (amphetamine sulphate) was originally synthesised in 1887 by German chemists, but only studied and developed to any degree in the 1930s.

It was first used in the 1920s as a decongestant and to treat obesity and depression. Because of its effects in bronchial passage dilation, it was also used in the 1930s as a nasal spray for treating asthma:

Subsequent studies showed that the drug was also helpful in providing relief from narcolepsy, reducing activity in hyperactive children, suppressing appetite and enabling individuals (such as students and truck drivers) to stay awake for extended periods of time. In the 1930s and 1940s, amphetamine was used in treating a variety of other conditions and disorders including schizophrenia, morphine addiction, tobacco smoking, low blood pressure, radiation sickness, and even persistent hiccups (Anglin et al. 2000, p.138).

During World War II and the Korean and Vietnam Wars, soldiers on all sides of the conflicts were given amphetamine to keep them awake, to give them more energy and to suppress their appetites.²² It was also used for the same reasons by the American space programme (Grinspoon & Hedblom 1975).

Amphetamine was readily available without a prescription in the United States until the early 1950s, and amphetamine inhalers were available over the counter until 1960. Prescriptions for amphetamine tablets were one of the major ways of treating obesity and depression during the 1960s. It was only by the 1970s that:

[t]he dangers associated with the use of amphetamine were better understood, and additional restrictions were placed on the amount that could be legally produced and how it could be distributed. Increased levels of illicit production ensued, originally limited to motorcycle gangs and other independent

22 This practice is not apparently restricted to these previous wars if recent newspaper articles are accurate. During January, investigations of American Airforce pilots who had mistakenly dropped bombs on Canadian forces stationed in Afghanistan, revealed that amphetamines allegedly were and continue to be quite commonly prescribed to air force pilots to prevent fatigue. An *Age* article based on a *Los Angeles Times* report states:

'As two pilots face a possible court-martial, the air force says 'go pills' kept tired pilots alive in Afghanistan... As a hearing investigating two American fliers who bombed Canadian forces in Afghanistan entered a third day on Thursday, the air force summoned reporters to hear a pilot-surgeon extol the virtues of the practice of prescribing amphetamines for tired pilots.

"It is the gold standard for anti-fatigue", [said] Colonel Peter Demitry, chief of the US Air Force Surgeon General's science and technology division..."We know that fatigue in aviation kills... This is a life and death insurance policy that saves lives."

Lawyers [for the pilots] have said the pilots' judgment was impaired by amphetamines routinely prescribed by air force doctors...

Colonel Demitry [however] insisted that the drug Dexedrine – called 'go pills' by pilots – "has never been associated with a proven adverse outcome in a military operation. This is a common, legal, ethical, moral and correct application" (Lianne Hart, 'Air Force rushes to defend amphetamine use in 'friendly fire' case', *The Age*, 18 January 2003, p.25).

See also: 'US scientists seek formula to create 'super-soldiers'', *The Age*, 6 January 2003, p.10, (No author).

Andrew Masterson, 'More than once were warriors out of their tiny minds', 'The Culture' (Supplement), *The Age*, 21 January 2003, p.1.

groups... At the same time, the typical user population changed from white, blue-collar workers to include college students, young professionals, minorities, and women (Anglin et al. 2000, p.138).

Methamphetamine was first synthesised from ephedrine, itself a form of amphetamine, in Japan in 1893:

Methamphetamine did not become widely used until World War Two when Japan, Germany and the United States provided the drug to military personnel to increase endurance and performance... [it] was also used in Japan to improve productivity of civilian factory workers in military support industries. Beginning in 1941, methamphetamine was sold over the counter [and] advertised as a product 'to fight sleepiness and enhance vitality'. Widespread abuse occurred only after the war when methamphetamine from surplus army stocks flooded the market leading [in Japan] to the so-called 'First Epidemic' (Anglin et al. 2000, p.138).

It was estimated that at the peak of this 'epidemic' 1.5 million Japanese were injecting methamphetamine (Grinspoon & Hedblom 1975). In a review of the history of amphetamine abuse, Hall and Hando state that similar epidemics of amphetamine and methamphetamine use occurred in Sweden in the 1940s, 1950s and 1960s, the United States in the late 1960s and early 1970s, Japan again in the 1970s to the present day (the 'Second Epidemic'), and the United Kingdom in the late 1950s and the late 1960s (Hall & Hando 1993):

There are indications that there was a smaller epidemic of amphetamine use in Australia in the middle and late 1960s. During this time there was a large increase in the prescription of amphetamines by general practitioners, increased use of amphetamines among young offenders and young adults attending psychiatric hospitals...and an increase in the prevalence of persons diagnosed with amphetamine psychoses (Hall & Hando 1993, p.59).

By the 1960s the market in amphetamines and methamphetamines had changed from being predominantly licit to illicit. The black market consisted first of the diversion of supplies from pharmaceutical companies, chemists and doctors then developed into the synthesis, manufacture and distribution of amphetamines and methamphetamines by motor cycle gangs and other criminal gangs and syndicates, particularly on the Pacific Coast of the United States. Clandestine laboratories in California and Mexico are now the primary sources of methamphetamine available in the United States (Anglin et al. 2000).

In Australia, as in Britain, Europe and to a lesser extent the United States:

[a]mphetamine use was fuelled by a combination of ready availability and perceived safety by users and the medical profession (Hall & Hando 1993, p.60).

It was only when the medical profession began noticing links between heavy amphetamine use and an increase in paranoid psychoses (and to a lesser extent

violence)²³ that questions were raised about the advisability of prescribing amphetamines in a relatively unregulated way:

Once the abuse potential of amphetamines was recognised...their availability on medical prescription was severely restricted. This had two main consequences. First, the existence of a large market of users provided the incentive for the illicit manufacture and distribution of amphetamines, with a result that many of the later epidemics were supplied by the black market. Second, the development of a black market in turn changed the characteristics of the users. The proportion of amphetamine users who were middle class, middle aged women who used oral amphetamine declined while the proportion of younger male users correspondingly increased. The latter were primarily recruited from the drug subculture, where injection, the most hazardous form of administration, was the preferred route.²⁴ In this way the changes in the pattern of amphetamine use, and in the characteristics of users, mirrored that which occurred earlier in the century with morphine and heroin use (Hall & Hando 1993, p.60).

Despite such developments, amphetamine abuse in Australia was never as much of a concern, at least in the public realm, as drug issues pertaining to heroin and to a lesser extent cocaine.

However, during the 1990s, national Australian drug law enforcement and policy moved away from an emphasis on cocaine to one concentrating on psychostimulants such as amphetamines and MDMA. Burrows, Flaherty and MacAvoy (1993) state that by 1990:

[t]here was general agreement that the use of cocaine remained at a low level in Australia and that the social and economic conditions which have made cocaine such a major problem in the United States do not exist in Australia and are unlikely to develop here in the foreseeable future [and that] ...the use of amphetamines currently represented a larger potential problem for health, welfare and law enforcement authorities in Australia (1993, p.2).

Hall and Hando argue that one of the reasons there was so little known about amphetamines use in Australia was in fact attributable to the fears in the mid to late 1980s of a major cocaine epidemic in Australia. These fears turned out to be largely unfounded and 'distracted attention from an emerging home grown amphetamine epidemic' (Hall & Hando 1993 cited in Burrows, Flaherty & MacAvoy 1993, p.61).

As a consequence, most of what is known about amphetamine use in Australia has been gathered *en passant* in the course of research on the use of

23 For a discussion of the (somewhat tenuous) links between amphetamine use and violent behaviour, see Chapter 4.

24 This was not helped by the fact that a liquid form of methamphetamine was being used in the 1960s as a treatment for heroin addiction and 'quickly contributed to a new abuse pattern involving injections of methamphetamine, either alone or with heroin' (Ray & Ksir 1996 cited in Anglin et al. 2000, p.138).

cocaine...or on the risks of HIV transmission among injecting drug users (Hall & Hando 1993 cited in Burrows, Flaherty & MacAvoy 1993, p.61).

Consequently, in 1991 the national Ministerial Council on Drug Strategy endorsed a National Action Plan on Problems Associated with Amphetamine Use. Under the plan, research into the extent, nature, use and treatment of amphetamines and amphetamine-related problems became a priority.

The IDRS describes the change in traditional amphetamine markets in Australia as follows:

The amphetamines are a class of drugs that, in chemical terms are closely related. This family of drugs includes amphetamine sulfate, dexamphetamine, and methamphetamine (also known as methylamphetamine). Throughout the 1980s, the form of illicit amphetamine most available in Australia was amphetamine sulfate. Following the legislative controls introduced in the early 1990s on the distribution of the chemicals used to make amphetamine, illicit manufacturers were forced to rely on different recipes for 'cooking' the drugs. As a result, throughout the 1990s the proportion of amphetamine seizures that were methamphetamine (rather than amphetamine sulfate) steadily increased, until methamphetamine clearly dominated the market. In the financial year 2000/01, 91% of all seizures of amphetamines were of methamphetamines. Most methamphetamine manufactured in Australia is based on the precursor chemical pseudoephedrine²⁵ (IDRS 2002, p.2).

By the mid 1990s the use of methamphetamines and other ATS was being viewed with growing concern from a global perspective. In 1996 the UNDCP convened two expert meetings to consider ATS use and related problems. As a consequence, a number of regional and global Action Plans dealing with supply and demand reduction of ATS and designer drugs, including 'ecstasy', were developed (see Henry-Edwards & Ali 2000).

The source of amphetamines in Australia

Other than the clandestine manufacture of amphetamine in underground laboratories, which will be discussed separately in Chapter 7, amphetamines, and particularly methamphetamine, are imported into Australia from East Asia and Southeast Asia and the United States. An account of the sourcing, importation and border control of amphetamines can be found in Chapter 6 of this Discussion Paper and the latest *Illicit Drug Report* produced by the Australian Crime Commission (2003).

Form and composition

Amphetamines were commonly referred to by the street name of 'speed'. Other street names for amphetamines include 'goey' or 'go-ee', 'billy' and 'whizz'. Amphetamine as a generic term (including methamphetamines and 'ice') are also known by names such as uppers, dexies, 'buzz', 'rev', 'crystal', 'meth',

25 See Chapter 7 for a discussion of amphetamine manufacture.

'crystal meth', 'base', 'pure', 'ice', 'shabu', 'ox blood' and 'ice'. Amphetamine sulfate can often be adulterated with similar coloured off-white powders such as talc, paracetamol and in some rare cases strychnine (Connolly 2000, p.7).

Today what passes as speed is more likely to be a form of methamphetamine, and to a lesser extent dexamphetamine (a drug sometimes used legitimately to treat Attention Deficit Hyperactivity Disorder (ADHD)). Methamphetamines are similar to amphetamine sulfate in both chemical structure and effects. In addition to the term 'speed', methamphetamines are sometimes referred to as 'meth' and in the United States 'chalk'.²⁶ Amphetamines and methamphetamines come in many different forms, sizes, colours and shapes. Most amphetamine used for illicit purposes is made in clandestine laboratories by amateur 'chemists'.

A particularly potent form of methamphetamine comes in crystalline form and is colloquially known as 'crystal meth', 'shabu' or 'ice'. This will be discussed further below. Most forms of amphetamine, however, still come in powder form varying from pure white to brown and even orange or purple:

No matter what form it comes in, almost all the speed available in Australia today is methamphetamine. Methamphetamine is slightly different in chemical terms to amphetamine, but the two have very similar effects. Although the availability and use of crystalline forms of methamphetamine are increasing, most of the speed available in Australia these days still comes in the form of powder. Speed powder can vary in texture from very fine to more coarse and crystalline, and can also vary in colour from white to yellow, pink or brownish. All these variations occur because the purifying process involved in the manufacture of amphetamine is quite tricky and most of the people who make the drug don't have the chemical expertise to do it properly.

This means that, although they're all making speed, they end up with a wide range of products at the end of the manufacturing process which look different and contain different impurities (NDARC 2003, p.1).

Methamphetamine abuse has long been viewed as a problem in Hawaii and California but in recent years has also become a substantial problem in other areas of the south, south-west and mid-west of the United States and in big cities such as Denver and San Francisco. By contrast, methamphetamine abuse is seen relatively infrequently in the eastern United States (National Institute on Drug Abuse (USA) (NIDA) 1998, p.3).²⁷

26 In Britain, however, although the use of methamphetamines is increasing, amphetamine sulfate remains the most consistently used form of amphetamine.

27 In the controversial and contentious book *Fast Food Nation*, author Eric Schlosser discusses the increasing 'occupational' use of methamphetamines in various sectors of American industry. This is most graphically described in an examination of the meatpacking and abattoir industries:

'The unrelenting pressure of trying to keep up with the [processing] line has encouraged widespread methamphetamine use among meatpackers. Workers taking 'crank' feel charged and self confident, ready for anything. Supervisors have been known to sell crank to their workers or to supply it free in return for certain favours such as working a second shift.

Route of administration

The NDARC states that most Australians who use speed powder either snort or swallow it, although some people choose to inject it.²⁸ It can also be added to drinks and swallowed or dabbed from the fingers to the mouth. Some of the people who use the crystalline forms known as ice or shabu smoke it in a special glass pipe. Injecting and smoking of speed are generally viewed as a more harmful route of administration than oral use.²⁹

The route of administration and the general rituals and culture of amphetamine use will clearly be dependent on the situation and setting.³⁰ Those who use amphetamines experimentally or only occasionally are less likely to inject than heavy, dependent or dysfunctional users (see Wickes 1993b, p.2). Such differences may also apply to those who use them for 'functional' purposes such as truck driving, exam performance, weight loss or sports competition.

Hall and Hando completed a survey of 231 Australian amphetamine users in 1994, half of whom injected the drug. They concluded that side effects and adverse symptoms and outcomes were generally greater in the injecting cohort:³¹

[A]mong heavy chronic users there is a risk of developing a dependence syndrome that is characterised by a prolonged withdrawal syndrome in which depression, lethargy and irritability contribute to a high rate of relapse to use after abstinence, making it difficult to treat. Secondly, there is a risk, especially among injectors who use large doses, of developing a paranoid psychosis in which loosening of associations, delusions and auditory hallucinations are the most common symptoms. More conjecturally, there is a risk of chronic heavy users committing violent offences, perhaps while in the thrall of delusional thinking... Amphetamine users need to be better informed about the potential adverse effects of amphetamine use, and about ways in which they can reduce their risks of experiencing these harms by avoiding injecting use, and the regular use of high doses of amphetamines (Hall & Hando 1994, p.277).

Such views are reiterated in more recent American studies. Dornier et al. also conducted a survey of 427 methamphetamine users in California, 13 per cent of whom were injecting users. Injecting methamphetamine users were found to

Workers who use methamphetamine may feel energised and invincible, but are actually putting themselves at much greater risk of having an accident. For obvious reasons a modern slaughterhouse is not a safe place to be high' (Schlosser 2002, p.174).

28 For a comparison of differences between injecting and non-injecting amphetamine users, see Moore 1992a, particularly at p.49. See also Dornier et al. 2000; Hall & Hando 1994.

29 For a comprehensive and interesting account of the manner of administering amphetamines, methamphetamines and ecstasy, including snorting, smoking, swallowing and 'blatting' (intravenous injection), see Moore 1992a, pp.45ff.

30 For a discussion of Zinberg's (1984) concept of the importance of drug, set and setting, ie: the context of drug use, see Chapter 5.

31 For a general discussion of the physical, psychological and social effects and results of using psychostimulants, see Chapter 4.

be more at risk of developing serious health and social problems, including HIV and other blood borne diseases. Interestingly, methamphetamine users themselves definitely had distinct views about differences between injecting and non-injecting users:

Overall, this study found several interesting differences based on the route of administration. When the participants were asked if they injected MA many of the non injectors responded adamantly in the negative. There seemed to be a stereotype present within the drug-using population that injectors were 'more dependent' or 'more severe' addicts than other users. This idea that injecting users are more dependent on the drug is growing (Dornier et al. 2000, p.231).³²

A 1996 survey study of 100 amphetamine users conducted in South Australia also made some interesting comparisons between injecting and non-injecting drug users. The findings showed that:

- Injection was the most commonly used method for administering amphetamine in the sample, with 77% reporting injecting in the 6 months prior to interview. Forty-three percent of the sample had not used any other method during that time. Fifty-four percent had snorted amphetamine in the 6 months prior to interview, and 37% had swallowed the drug in that time.
- Amphetamine was the first drug injected for 61% of the sample.
- Greater use of injecting as a form of amphetamine administration in the 6 months prior to interview was significantly associated with a lower level of education, a greater number of days on which tobacco and benzodiazepines were used, a more frequent use of amphetamines, greater quantity of the drug used in a day, a younger age at first use of the drug, a younger age at first injection of amphetamine, and a younger age at first injection of any drug. This variable was also associated with a decreased tendency to use condoms for anal sex, and a higher self-rating of concern about the risks of contracting HIV, hepatitis B, and hepatitis C.
- Significantly, over half of all of those who had injected amphetamines in the 6 months prior to interview (n=38) had experienced difficulty in obtaining sterile injecting equipment. The majority of these people (n=20) said that the lack of a needle exchange within easy access had been a problem for them, and 15 people said that the opening hours of these services were often an issue (Vincent, Allsop & Shoobridge, 1996, p.376).

32 Dornier et al. (2000) note that paying attention to the difference between injecting and non-injecting users of amphetamines and methamphetamines may have important implications for strategy development:

'Overall... there are characteristics of injecting users that make them uniquely different from users of other routes. Knowing about these differences can provide useful information for clinicians treating injection users. Possible topics to include or emphasise in an injector's treatment plan are HIV concerns, legal issues, and a greater focus on depression, suicide and hallucinations' (Dornier et al. 2000, p.232).

Thus the effects and dangers of psychostimulant use and misuse are very closely connected with how they are used:

The importance of the route of administration of the psychostimulants rests not only with the bioavailability of the drug (a term used to describe the proportion of the administered dose which reaches the bloodstream), but also with the rate of its delivery to the site of action in the brain (Chesher 1993, p.14).

Mundy states that as well as the physical act of administration the context is all-important in terms of the consumption of methamphetamines, as with all drug use. Discussing methamphetamine use in Sydney she states:

Methods of administration appear to be dependent on 'community norms'. For instance residents in the Sydney beach suburb of Manly who use this drug seem to prefer smoking it, whereas Kings Cross users are more likely to inject (Mundy 2001, p.2).

'Base'

Base is a form of methamphetamine that resembles an oily, sticky or waxy powder or paste, often of a yellow or brownish shade. It can also be colloquially referred to as 'wax', 'point', 'pure' or 'paste'. Unlike, the sophisticated chemistry knowledge needed to produce 'ice' (see next section) base can be and is produced in Australia by amateur 'chemists':

It is oily because the pseudoephedrine to methamphetamine conversion produces the base form of methamphetamine, which is oil. An oil is not highly marketable in illicit drug markets, because it cannot be easily injected or snorted. Therefore, manufacturers attempt to purify methamphetamine base (oil) into methamphetamine hydrochloride (crystal). To successfully complete this process requires considerable chemistry expertise, and few illicit manufacturers in Australia have such expertise. The result is an oily powder ...[with organic impurities]. These organic impurities, which would not be present if the conversion and purification were performed accurately, also prevent the substance from forming into the large translucent crystals typical of 'ice', so the appearance of these two forms of methamphetamine is quite different (IDRS 2002, p.3).

Base can be administered by swallowing, smoking snorting and injecting, although its oily consistency makes dissolving for injection difficult without the application of heat. According to the IDRS, the availability of base has increased in Australia in recent years but prices have remained relatively stable, with a point (0.1 gram) costing approximately \$50.00 in most Australian states (2002).³³

33 Interestingly, the price has been costed at only \$30.00 per gram in South Australia. See IDRS 2002, p.3; NDARC 2001, 2002c.

'Crystal meth' or 'ice'

'Ice' is a particularly strong methamphetamine, which in the past five years has become more widely available and used on the streets of Melbourne and other Australian cities. Generally the drug that is referred to as 'ice' is a high purity form of methamphetamine that comes in crystalline form and may also be called other names such as 'shabu', 'crystal', 'crystal meth', and 'crank' or 'glass' in the United States.³⁴

History

Methamphetamine, including 'ice', was developed in the early 20th century from the parent amphetamine drugs. It was used in licit form in nasal decongestants and bronchial inhalers (see Derlet & Heischouer 1990; Safe & Sager 1990).

Ice was once very popular in the United States gay communities, particularly in the dance scene, due to its ability to keep users awake for long periods and its sexual disinhibition effect. It spread quickly into mainstream cultures. Truck drivers and bikers have also been known to use meth and ice to keep awake on long journeys.³⁵

Most of the 'ice' in Australia is clandestinely manufactured in China and transported to Australia via other Asian countries such as the Philippines or Indonesia. The illicit importation of ice has grown in recent years. According to NDARC, in the 2000/01 financial year the Australian Customs Service seized more than 80 kilograms of ice at the Australian border:

When there is more good quality ice being imported, it puts pressure on the people who manufacture methamphetamine in Australia to produce a higher quality product, so the purity of methamphetamine powder ('speed') made here has been increasing over the last few years (NDARC 2003, Fact Sheet).

As indicated in the previous section, pure crystalline ice is rarely made in Australia as clandestine manufacturers do not have the necessary expertise. What is in fact produced is more likely to be 'base', as referred to in the previous section:

Sometimes people who make or sell speed in Australia will call their product ice or shabu to make it more attractive to buyers so they can charge a higher price. This only leads to confusion among users as to what they've actually bought. Real ice is a big colourless crystal, but often people buy white powder that they've been told is ice (NDARC 2003, Fact Sheet).

34 'Shabu' is a Japanese word that is used to refer to ice in the Philippines, where the use of ice has a long history. See NDARC 2003, Fact Sheet. For an account of the 'crank' trade and 'crank' use in the United States, see Kirn 1998.

35 For a discussion of amphetamine use among truck drivers, see Chapter 5.

Form and composition

Ice is described as having large, translucent to white crystals or being a crystal coarse powder. It can sometimes have a blue, green or pinkish tinge as a result of the manufacturing processes. Ice is usually sold in 'points' (0.1 gram) because it is so strong that only a tiny bit is used at a time. According to recent data from the IDRS, points cost approximately \$50.00 in most Australian jurisdictions.

Route of administration

Ice has traditionally been smoked in a glass pipe similar to the kinds of pipes that crack cocaine is smoked in. This has particularly been the case in countries where ice has had a long history of use, especially Japan, the Philippines and Hawaii (see NDARC 2003, Fact Sheet; Derlet & Heischouer 1990).

Some people who use ice in Australia smoke it through this kind of pipe, whereas others mix it with cannabis and smoke it through a bong ('sno cones'), or 'chase' (heat) it on aluminium foil and inhale the vapours. But many people who use ice in Australia inject it or swallow it, and some people also snort it. Snorting ice leads to nasal damage because the crystals are sharp and can cause nosebleeds (NDARC 2003, Fact Sheet).

Price, purity and availability of amphetamines and methamphetamines

The IDRS annually monitors emerging trends in illicit drug use in Australia. In particular it gauges trends in the use, price, purity and availability of major drugs such as heroin, methamphetamine and cannabis. To a lesser extent it also concentrates on 'ecstasy' and other 'party drugs'.³⁶

A key advantage of the IDRS study is that it replicates core methods across each state and territory. At the national level, this permits the identification of emerging jurisdictional differences with respect to the operation of illicit drug markets, and enhances the capacity of health and law enforcement sectors in all jurisdictions to develop proactive responses to illicit drug problems (NDARC 2002a, p.viii).

Nationally, with regard to methamphetamines, powder and base were considered easy to obtain and availability was stable. Crystal methamphetamine was more difficult to obtain in some jurisdictions. All forms of methamphetamine were cheapest in South Australia. The use of methamphetamines among injecting drug users (IDUs) has decreased or stabilised in most jurisdictions, possibly as a result of an increase in the

36 The methodology of the IDRS and its data collection methods are based on a threefold process. First, a survey of injecting drug users is undertaken. This is supported by a survey of key informants, expert professionals in the illicit drug field. Finally, existing indicator data on drug issues is analysed. These may include household and school surveys, law enforcement, hospital and ambulance databases, needle exchange programme data and other relevant secondary indicators. A triangulation of this data avoids the problems associated with relying on secondary indicators of themselves, most notably the fact that they are by their very nature *lag indicators*.

availability of heroin in most jurisdictions compared to 2001 and the 'worst' days of the 'heroin drought' (discussed later in this chapter). Cocaine use has decreased in prevalence and frequency in its traditional stronghold of New South Wales. In all other jurisdictions 'it remained relatively uncommon and infrequent' (IDRS 2002, p.1).³⁷

The median price for a gram of methamphetamine powder ranged in 2002 from \$A50.00 (SA) to \$A250.00 (WA). The median price for a point (0.1 gram) of 'base' ranged from \$25.00 (SA) to \$50.00 in most other states. A point of crystal methamphetamine varied from \$25.00 in South Australia to \$80.00 in the Northern Territory and \$50.00 in most other states.

The IDRS states that there is no clear trend to gauge the purity of various forms of methamphetamine.³⁸ However, the majority of IDRS respondents in all jurisdictions reported that it was easy or very easy to obtain and that, unlike heroin, availability was generally stable, with some variations in availability of crystal meth (more difficult to obtain in NSW, ACT, Vic and Tas).

This recent summary of trends (December 2002) contains very little specific information pertaining to Victoria. A separate paper prepared by Turning Point Alcohol and Drug Centre, which conducts the research for the Melbourne arm of the IDRS project, outlined its summary of 2001 trends. It found:

[t]he use of methamphetamines has moved from mainly recreational users to more frequent poly-drug users. There was a large increase in the reported price of 'amphetamines' in the past year from \$50.00 to \$200 per gram (\$800 to \$1075 per ounce), however the most likely explanation for this is that more 2001 respondents are actually reporting on methamphetamines. Reports for gram prices of methamphetamines range from \$60.00 to \$400.00, and the median price per 'point' is \$50.00 (range \$40.00–\$100.00) suggesting the emergence of a new market due to non-stable prices... Whilst the amphetamine market appears to be predominantly a non-street market (26% mobile dealers, 24% dealer house, 33% friends), there has been an apparent increase in street sourcing from 4% in 2000 to 15% in 2001.³⁹ It was reported that both amphetamines and methamphetamines were readily available (amphetamines, easy to very easy 92%; methamphetamines, easy to very easy 72%). Both were reported as becoming easier to obtain. These trends demonstrate a major shift in illicit drug use in Melbourne and require further research to understand the nature of this change (NDARC 2002a, pp.x–xi).

37 This statement, however, does at least in part seem to be contradicted in the full text of both the Australian Drug Trends and Victorian Drug Trends Reports for 2002. In each of these reports there were reports of a small but potentially significant rise in cocaine use in states other than New South Wales. It could be conjectured that this was as a result of the 'heroin drought'. Nonetheless, in Victoria at least it is still thought that cocaine is too expensive for it to become the drug of choice of most Victorian drug users (NDARC 2002a, pp.36ff, NDARC 2002b, pp.81ff).

38 In past years, purity has been noted as markedly increasing, particularly in Victoria (McKey 2001, p.17).

39 Possibly reflecting the effect of the heroin drought on injecting drug users.

Purity of the drugs for the period 2000/2001 was said to have increased since previous years. Seizures by Police and Customs officials in Victoria indicate that average purity had increased from five per cent in 1996/97 to 21 per cent in 2000/2001 (NDARC 2002a, pp.31–32).

The above trends provide valuable information but some caveats must be noted. First, as acknowledged by IDRS itself, '[t]he distinction between amphetamines and methamphetamines in Melbourne has become problematic and many of the respondents appeared unsure of the distinction' (2002, p.x). This confusion between amphetamine (sulfate) and various forms of methamphetamine has the potential to skew the data. Second, the above figures for Victoria have to be read subject to detailed new figures for 2002 being released.⁴⁰ In particular, the apparent 'relief' of the heroin drought will need to be factored. It may be that an increasing availability of heroin will impact upon the amount of amphetamine used.

It is timely here to discuss briefly the effect of the 'heroin drought' on the use of amphetamines and 'party drugs'.

A note on the 'heroin drought'

From approximately December 2000 a reduction in the availability of heroin in Australia, partly due to an edict forbidding opium cultivation in Afghanistan, has meant an increase nation-wide in the use of other illicit drugs, especially amphetamines and to some extent benzodiazepines, such as temazepam.

It may be that this phenomenon will be merely a 'historical curio', as anecdotal evidence suggests that increased amounts of heroin are being seen back on the streets of Australian cities. Nonetheless, this section will discuss the linkages between increased usage of ATS as a result of the 'heroin drought', as it appeared until approximately the end of 2002.⁴¹ In the most recent survey of illicit drug trends compiled by the ABCI, it was stated that:

Increased amphetamine-type stimulant use as a direct result of the lack of heroin has been particularly noted in the Australian Capital Territory, Queensland, South Australia, Western Australia and some areas of New South Wales. In particular, police in the Lake Illawarra, Shoalhaven and Monaro Local Area Commands of New South Wales noted increased usage of crystalline methylamphetamine amongst traditional long-term heroin users. This raises concerns because of the increased propensity towards violent behaviour associated with crystalline methylamphetamine use. There has also been a

40 This data will be included and analysed in the Final Report of this Committee.

41 The most recent Victorian Drug Trends Component of the IDRS (NDARC 2002a) indicates that at the time of the interviews of participating IDUs (June 2001) there may have been a slight shift in perceptions of availability:

'77% of respondents indicated that the availability of heroin had not yet returned to normal, while 20% reported that it had. Reports varied as to the timing of the return of heroin availability with 8%...suggesting that it had returned in June 2001' (NDARC 2002a, p.59).

significant increase in property offences in those areas, which is correlated with increased consumption of crystalline methylamphetamine.

Researchers from the National Drug and Alcohol Research Centre (NDARC) noted the increased prevalence of crystalline methylamphetamine being smoked by users in Sydney (NDARC 2001). This was also a trend noted in the Footscray area of Melbourne where traditional heroin smokers have turned to smoking crystalline methylamphetamine due to the reduced availability of heroin (Tregear 2001). NDARC also reported instances of methylamphetamine base being swallowed due to the difficulty of injection or intranasal use of the drug in that form (2001) (ABCI 2002, pp.46–47).

A study of the 'heroin drought' conducted through Turning Point Alcohol and Drug Centre by Miller, Fry & Dietze (2001) has stated that the 'impact of the reduced Australian heroin supply has been the most pronounced in the state of Victoria'. Turning Point states further that the consequences of the drought have been both positive and negative. A survey of drug-using participants reported:

- A decrease in the availability of heroin
- Increases in the price of heroin and amphetamine
- Decreases in the purity of heroin and amphetamine
- Few changes in the availability of amphetamine...
- Increases in the reported use and injection of pharmaceuticals (especially benzodiazepines) and amphetamines
- Increases in number of people reporting involvement in criminal activity (including both property and violent crime)
- Reports of a generalised increase in 'danger' for drug users (Turning Point Alcohol and Drug Centre 2001, pp.vi–vii).

The survey sample showed that for 55 per cent of the drug users interviewed, heroin was the drug most often injected. This was in stark contrast to the IDRS (2000) findings:

These findings suggest that the 'drought' is best understood as an interruption to the steady supply of heroin evident in Melbourne over the late 1990s (Fry and Miller 2001), rather than the absence of the drug from Melbourne drug markets. The change from the 2000 IDRS findings, where 92% reported heroin as the last drug injected prior to interview, was however dramatic (Turning Point Alcohol and Drug Centre 2001, p.11).

The most recent evaluation of Victorian Drug Trends by the NDARC supports the increasing use of amphetamine in Melbourne and other major Victorian centres:

Amphetamines and methamphetamines have...become the identified drug of choice for a group of people who were primary heroin users and there [has been] an increase in the number of people reporting injecting amphetamines from 50% from the previous year to 75% for the current study [2001]... It was

noted that both amphetamines and methamphetamines were readily available... Both were reported as becoming easier to obtain. These trends demonstrate a *major shift in illicit drug use* and require further research to understand the nature of this change (NDARC 2002a, p.xi). (Committee emphasis)

It is not only amphetamines that have been affected by the 'heroin drought'. Fry and Miller, reporting for the NDARC on the most recent Victorian illicit drug trends, state that:

Victoria Police key informants reported that ecstasy has become of greater interest since the previous IDRS and that greater resources are being allocated to its detection and seizure, particularly due to the heroin drought (NDARC 2002a, p.51).

Ecstasy (methylenedioxymethamphetamine – MDMA)

Ecstasy, often abbreviated to 'e' or 'eckies', is the street term for a number of substances that are 3, 4, methylenedioxymethamphetamine (MDMA)⁴² or closely related. Pharmacologically it belongs to a family of drugs called the phenethylamines, which also include MDA (3, 4 methylenedioxymethamphetamine) and MDEA (3, 4 methylenedioxyethylamphetamine).⁴³ The latter two drugs are often passed off as MDMA (see Cheshier 1990a).

Ecstasy/MDMA is also known as an *empathogen*, that is a drug that releases chemicals into the brain that inspire feelings of well being, love, friendship and euphoria. For that reason one of the colloquial names for ecstasy is the 'Love Drug'.

One highly significant fact associated with ecstasy is that, like any illegal drug, there is no 'quality control' during the manufacturing or importation process. Since the 1990s the purity of ecstasy has been highly variable. There is therefore no guarantee that the user is actually consuming MDMA when he or she purchases or otherwise obtains what purports to be methylenedioxymethamphetamine:

Some of the tablets sold as ecstasy in Australia today do not contain MDMA at all, and are more likely to contain methamphetamine, perhaps in combination with an hallucinogen such as ketamine, an anaesthetic used primarily in veterinary surgery. They might also contain illegal chemicals like MDA, PMA or MDEA, or substances like caffeine or paracetamol. Some of the ecstasy tested has contained no active stimulant at all (NDARC 2003, Fact Sheet).

42 Ecstasy can also be colloquially known as 'eccy', 'XTC', 'doves', 'eggs' and many more. For further discussion of the names and nicknames given to ecstasy/MDMA, see Chapter 5.

43 For an interesting account of the history of the pharmacology of designer drugs, see Cheshier 1990b; Chawla 1998. Cheshier makes the salient point that it is often from articles in scientific and medical journals, which follow years of painstaking research and clinical trials, that many 'street chemists' get their ideas for producing illicit designer drugs and analogues.

Of particular concern is the fact that in a number of jurisdictions, paramethoxyamphetamine or PMA has been known to substitute for MDMA. PMA is generally thought of as a more toxic phenethylamine derivative with more harmful complications than pure MDMA (see for example Byard et al. 1999; Byard et al. 2002; White, Bochner & Irvine 1997; Felgate et al. 1998; Moriarty 2001). Such complications, including death, will be discussed further in Chapter 4, which deals with the medical consequences of the drugs under discussion.

The IDRS reports that few clandestine laboratories or chemists in Australia have the capacity or expertise to make pure MDMA and:

[a]lmost every tablet that contains true MDMA is imported from manufacturing and distribution points in Europe and Asia. The Australian Bureau of Criminal Intelligence estimates that 80% of the tablets sold as 'ecstasy' in Australia today are actually locally manufactured methamphetamine tablets that are sometimes mixed with other drugs such as ketamine in an attempt to mimic the effects of MDMA. Illicit manufacturers use the reports posted on websites about 'good pills' [to produce] 'fake ecstasy' tablets that are the same weight and colour and have the same logo as real MDMA tablets... Many experienced 'ecstasy' users know that they are unlikely to get real MDMA these days, and sometimes use the term 'pills' in place of 'ecstasy', in a tacit acknowledgment that they don't really know what they are using (IDRS 2002, p.2).

History⁴⁴

Overseas origins

MDMA is generally believed to have first been synthesised by Merck Pharmaceuticals in Germany in 1912 and patented in 1914, originally as an appetite suppressant.⁴⁵ Gowing et al. (2001) state that at this time it was never commercially successful or viable and largely was forgotten or ignored until the 1950s:

[w]hen it was studied by the US Army as a potential agent in psychological warfare. In the late 1960s the drug was synthesised and used experimentally by [Dr] Alexander Shulgin in California, USA. In the 1970s it was increasingly being [legitimately] used in the USA as an adjunct to psychotherapy to help lower inhibitions in patients undergoing psychoanalysis... In 1977 the drug was prohibited in the UK, and in 1985 perceptions of increasing recreational use of MDMA and reports that MDA [a structurally similar analogue] had neurotoxic effects in animals, resulted in the USA Food and Drug

44 For good general accounts of the evolution, development and history of MDMA, see Solowij, Hall & Lee 1992; Forsyth 1995; Gowing et al. 2001; Grob 2000; Shannon 2002.

45 Gowing states that this account of its origins is disputed by some researchers. Milroy, for example, claims that it was discovered merely as 'an accidental intermediate chemical' (Milroy 1999 in Gowing et al. 2001, p.3).

Administration in 1985 classifying MDMA as Schedule 1 [drug] (no acceptable therapeutic use) (Gowing et al. 2001, p.3).⁴⁶

MDMA's psychotherapeutic benefit was grounded in its reputation as augmenting therapy 'reducing defensive barriers while enhancing communication and intimacy':

Hailed as a 'penicillin for the soul' MDMA was said to be useful in treating a wide range of conditions, including post-traumatic stress, phobias, psychosomatic disorders, depression, suicidality, drug addiction, relationship difficulties and the psychological distress of terminal illness (Grob 2000, p.551).

Psychotherapists were particularly impressed that MDMA had the ability to facilitate feelings of intimacy, introspection and communication without altering perceptions in body image and sense of self that were typical of LSD:

MDMA had neither the pharmacological profile nor the provocative reputation of LSD and, so they [psychotherapists] hoped, would not suffer the fate of political reaction and legal censure as the hallucinogens had in the late 1960s (Grob 2000, p.552).

In the early 1980s, 3,4, methylendioxyamphetamine (MDMA) was reputedly given the name 'ecstasy' by the Los Angeles manufacturer of what was still at that stage a legal drug (Forsyth 1995, p.194):

MDMA was named 'ecstasy' as a marketing ploy... The illicit producer who first used the term said he preferred the name 'empathy', as this word was more fitting with the drug's effects. He believed [however] that the name Ecstasy would sell better than empathy.⁴⁷ The name did and the media also 'bought' the story. Had the name of the drug remained MDMA or Adam (its first nickname) it may have been many more years before it came to the attention of the media, followed by the DEA (Drug Enforcement Administration) and made illegal in America (Forsyth 1995, p.194).

By the mid 1980s MDMA was no longer simply the province of a coterie of psychotherapists and psychiatrists. It had been discovered by the counterculture. DEA officials were particularly concerned at its over the bar sales in Texas nightclubs (Forsyth 1995, p.194).

Now popularly known as *Ecstasy*, MDMA had been appropriated by the youth culture for use as a recreational drug. Spurred by media accounts reporting on

46 This was despite the objections of many psychiatrists and psychotherapists who championed the drug's therapeutic benefit. For an account of the usefulness of MDMA for psychotherapy, see Riedlinger and Riedlinger 1994; Gowing et al. 2001, 2002. So incensed were some psychiatrists by the listing that they took legal action to rescind it. This action was ultimately unsuccessful and the ban remains. To date Gowing et al. claim: 'There have been no controlled studies of the effectiveness of MDMA as an adjunct to psychotherapy. Claims of effectiveness rely largely on testimonies from therapists and their clients' (Gowing et al. 2001, p.3).

47 Or as Eisner states 'How many people [would] know what it [empathy] means?' (Eisner 1989 in Grob 2000, p.553).

both its suggested role in treatment and its new reputation as a 'fun drug' among the young, use of MDMA spread. By the mid-1980s the inevitable political response began to take form. With the clear intention of tightening the federal regulatory controls of what was still a legal drug, the U.S. Drug Enforcement Administration (DEA) invoked the Emergency Scheduling Act and convened formal hearings in 1985 to determine the fate of MDMA. These highly publicized hearings, however, achieved the unintended effect of further raising public awareness of the new *Ecstasy* phenomenon, and led to marked increases in manufacturing and marketing of the drug. Media accounts polarized opinion, pitting enthusiastic claims of MDMA by proponents on the one hand, versus dire warnings of unknown dangers to the nation's youth on the other... With growing concerns over the dangers of new 'designer drugs', public discussion took an increasingly discordant tone (Beck & Morgan, 1986).

In the spring of 1985, a series of scheduling hearings on MDMA were conducted by the DEA in several U.S. cities where a collective of physicians, psychologists, researchers and lawyers gave testimony that MDMA's healing potential should not be lost to the therapeutic community. After hearing the duelling sentiments expressed by federal regulators and by those opposed to controls, the DEA administrative law judge presiding over the hearings determined on the weight of the evidence presented that there was in fact sufficient indication for the safe utilization of MDMA under medical supervision and recommended Schedule III status. Not obliged to follow the recommendations of his administrative law judge, however, and expressing grave concerns that MDMA's growing abuse liability posed a serious threat to public health and safety, the DEA director overruled the advisement and ordered that MDMA be placed in the most restrictive category, Schedule I. Since then, with the exception of a three month period in late 1987 and early 1988 when it was briefly unscheduled due to a court challenge, MDMA has remained classified as a Schedule I substance (Young 1986; Lawn 1986).

In the decade following the MDMA scheduling controversy, patterns of use experienced a marked shift. With the failure to establish official sanction for MDMA treatment, most psychotherapists who had used the drug adjunctively in their work ceased to do so, unwilling to violate the law and jeopardize their livelihood through the use of a now illegal drug. In the wake of the highly publicized scheduling hearings, however, use among young people escalated (Grob 2000, pp.553–554).

Once proscribed by the DEA, some MDMA manufacturers synthesised another similar substance – 3,4 methyldioxyethylamphetamine or MDEA – to circumvent the scheduling:

MDEA was given the brand name 'Eve' to MDMA's 'Adam'. MDEA was marketed as Ecstasy in an attempt to get round the law against MDMA. This debate was academic in the UK where any substance containing a dimethoxyamphetamine structure was already illegal. Therefore all three of the Ecstasy type drugs – MDMA, MDEA and MDA (methyldioxyamphetamine) –

were illegal in the UK before their use [in the UK] had become widespread (Forsyth 1995, p.194).

Because of the scheduling laws, most psychotherapists, however reluctantly, ceased to use the drugs as adjuncts to their practice. Conversely, despite such proscription, or maybe because of it, by the late 1980s ecstasy use was particularly prominent among young people in Britain. As Grob states, the pattern of ecstasy use therefore experienced a marked shift:

By the late 1980s, the *Ecstasy* scene had attained particular prominence among young people in the United Kingdom. Between 1990 and 1995, British authorities estimated that the use of *Ecstasy* increased by over 4,000 percent. Starting in small London dance clubs, word rapidly spread of the euphoric, mood altering properties induced by *Ecstasy*, leading to larger and larger events throughout the British Isles. Almost overnight an enormous black market for *Ecstasy* was created. Leisure patterns among the young began to change, with *Ecstasy* to an increasing degree replacing alcohol as a generational drug of choice. By the early 1990s, the economic and social certainties of the past in Great Britain had started to change. The free market boom pursued throughout the eighties by the Thatcher government had ended in recession, with increasing unemployment and constricting opportunities, particularly for young people. The freeing of inhibitions, the peer bonding and the sense of community engendered by *Ecstasy's* dance floor pharmacology provided a release from the oppressive social atmosphere and a sense that 'all could be made right in the world'. The *Ecstasy* scene had become, in the eyes of many observers, the largest youth cultural phenomenon that Great Britain had ever seen (Collin 1998 cited in Grob 2000, p.555).

One of the most profound results of this shift from being a drug used medically and instrumentally to an almost exclusive recreational drug was the diminution of the drug's purity and the adulteration of it with other substances:

With the rapid expansion of *Ecstasy* culture in the United Kingdom, criminal gangs began to sense the opportunity for amassing large profits and moved in on the developing drug scene, rapidly taking control of the manufacturing and marketing of *Ecstasy*. Motivated solely by financial return and disinterested in the 'purity' of the phenomenon, the quality of distributed *Ecstasy* began to erode (Grob 2000, p.555).

Introduction into Australia

Ecstasy entered the Australian scene in the mid 1980s, although it did not achieve the great popularity it had in Britain and Europe until the late 1980s to the early 1990s. In 1988 a survey conducted by the National Campaign Against Drug Abuse (NCADA) found that of 1,830 Australians surveyed with regard to substance use, three per cent had been offered 'ecstasy' (Commonwealth

Department of Community Services and Health 1989).⁴⁸ As Solowij, Hall and Lee noted, 'research into the precise nature of Ecstasy use and characteristics of users is greatly lacking' (1992, p.1161). The situation has improved only marginally since that statement was written.

Ecstasy in Australia was and is primarily associated with recreational drug use and the culture of dance parties and to a lesser extent 'raves'.⁴⁹ Despite this association with dance culture, the latest survey of the IDRS noted a definite, if small, crossover to ecstasy being used as a street drug, including by injecting drug users (NDARC 2002a).

By the mid 1990s 'ecstasy' and its analogues or substitutes were being viewed with major concern by international drug bodies. In the late 1990s the World Health Organisation's Programme on Substance Abuse developed a project entitled 'Strengthening strategic responses to the health and social consequences of amphetamine type stimulant use (with special reference to MDMA – "ecstasy")':

This project aimed to give effect to the recommendations of [a] meeting held in Geneva in 1996 and to respond to the priorities of [an] Action Plan relating to raising awareness of the problem of ATS [amphetamine-type stimulant] reducing demand for illicit ATS and providing accurate information on ATS. A further meeting of experts was held in November 1999 in Bangkok to review the nature, extent, context and consequences of ATS use, to further understand the trend of ATS problems worldwide, to create an international network of researchers and relevant partners and to discuss the development of a guide to the use of Rapid Assessment and Response Methods for ATS use (Henry-Edwards & Ali 2000, p.2).

Form and composition

Ecstasy is in the curious position of being classified as a stimulant with hallucinogenic properties. Its stimulant properties speed up the activity of the central nervous system, while its hallucinogenic aspects affect and distort perception and awareness. Marked hallucinogenic effects similar to psychedelic drugs such as LSD are not, however, common unless 'ecstasy' is taken in particularly high quantities.

It is usually sold as a tablet or pill, but is increasingly found in capsule or powder form. The tablets come in a variety of colours and sizes and may carry a branded design.⁵⁰ The NDARC states that:

48 In 1987 importing and trafficking in 'ecstasy' was made illegal in Australia under the Customs Act, see Chapter 6 for further discussion.

49 For a discussion of who uses 'ecstasy' and the culture of party drug use, see Chapter 5.

50 For a fascinating ethnographic discussion of the shapes, sizes and colours of ecstasy tablets, see Forsyth 1995. Forsyth argues that users of ecstasy have a distinct culture. See also further discussion in Chapter 5.

In recent times well-known brands such as Calvin Klein and Rolls Royce have been found stamped on ecstasy tablets. Despite this identification, there is no reliable method of determining the quality of the drug, since pills with the same stamp can vary widely in the content of MDMA and other substances (NDARC 2003, Fact Sheet).

The active oral dose of the (unadulterated) drug is approximately 75mgs, with most pills containing 80–120mgs (<www.urban75.com/Drugs/e_guide.html>)

A recent IDRS report notes that the availability of 'ecstasy' tablets '[h]as increased markedly over the last few years, and [it] is readily available in most jurisdictions' (IDRS 2002, p.3).

Route of administration⁵¹

The most common route for the administration of ecstasy is oral,⁵² by the swallowing of ecstasy tablets. Taken this way, the pharmacological effects of the drug become evident in 30–45 minutes and usually last 4–6 hours, although this may depend on the context in which the drug is taken.⁵³ Ecstasy tablets can also be crushed and snorted or inserted into the anus to be absorbed as a suppository. Such a practice is referred to as 'shelving' or 'shafting' and avoids causing irritation to the stomach lining. Another practice is that of 'stacking' whereby heavy users of 'ecstasy' may take up to four or five tablets a night as the effects of the previous tablet begin to wear off (see Webb 1998, p.87).⁵⁴ Of particular concern in recent years has been a noticeable trend in the use of 'ecstasy' by intravenous injection. This has attendant health consequences that will be discussed in Chapter 4.

Price, purity and availability of ecstasy

Sophisticated quantitative and qualitative data regarding ecstasy use is less readily obtainable than data for other illicit drugs such as heroin and amphetamines.⁵⁵ Nonetheless, the Victorian component of the IDRS survey has made some interesting findings.

51 For a comprehensive if 'historical' description of the various routes of administration used when taking ecstasy, see Moore 1992, pp.45ff.

52 The 2001 Melbourne IDRS survey noted that the primary route of administration of ecstasy for the group surveyed was oral (34%). However, 31% of the IDUs interviewed reported that they had injected ecstasy before (compared to 15% of the 2000 sample) and 21% had done so within the six months prior to the survey interview (compared to 8% of the 2000 sample) (NDARC 2002a).

53 See culture of use discussion in Chapter 5.

54 Average use of ecstasy tablets per session varies depending on the individual, context and setting. A 'neophyte' or novice may only take or need half a tablet to achieve the desired effect, whereas one or two tablets may be average for more 'seasoned' users. See Chapter 5 for further discussion.

55 In recent years, however, the importance of including MDMA and 'party drugs' in data collection and monitoring systems has been recognised. In 2000 the National Drug Law Enforcement Research Fund funded a two year trial in New South Wales and Queensland to 'examine the feasibility of monitoring trends in the market for party drugs using extant IDRS methodology' (NDARC 2002d; 2002e). In South Australia comprehensive monitoring and research into ecstasy use has also been undertaken. (See NDARC 2001, 2002c.) Other states, including Victoria, have now included party drugs such as ecstasy in their IDRS modules.

Informants to the survey (both users and professionals) note that 'ecstasy' use has increased and become more widespread in 2001. Despite some evidence of a crossover between traditionally separate 'rave' or dance club markets and street drug use, 'Ecstasy was still perceived to be more prevalent among younger people who were involved in the dance party or "rave" scenes' (NDARC 2002a, p.50).⁵⁶

It was reported that the price of ecstasy had decreased, that it was easy to obtain and had become easier. Key informants reported that one ecstasy tablet cost \$35.00–\$50.00 or \$300.00 for 10 tablets... It was also reported that the purity of ecstasy remained low, however the advent of testing kits (EZ-test) had improved knowledge of what drug was being purchased... Key informant reports on ecstasy prices were consistent with that available from ABCI (Australian Bureau of Criminal Intelligence) sources for 2000/2001 (NDARC 2002, p.51).⁵⁷

Other 'party drugs'

Gamma-hydroxybutyrate (GHB)

GHB is naturally produced in the body and is structurally aligned to gamma amino butyric acid (GABA). GHB was first synthesised in 1960 as a hypnotic agent and has been used legitimately as a pre-medication sedative or anaesthetic and as a treatment for sleep disorders such as insomnia and narcolepsy.⁵⁸ It has also been trialed as a treatment for alcohol and heroin withdrawal and addiction. Apart from such licit uses, the drug has found favour among discrete groups in the community. During the 1980s, bodybuilders used it for its supposed anabolic qualities.⁵⁹ It was (and is) seen as being able to stimulate a growth hormone, release of which aids in fat reduction and muscular development.⁶⁰ In some jurisdictions it could be purchased from health food stores and gymnasias.⁶¹ It is also relatively easy to purchase the drug via the Internet. From the mid to late 1990s it had moved into the club and party scene, because it was esteemed by young people for both its euphoric and

56 See Chapter 3 for more discussion of prevalence and quantitative data.

57 ABCI records of ecstasy seized by Australian Federal Police in Victoria show an average purity of 34% (range 11% to 49%) for the July 2000–June 2001 period (see NDARC 2002a).

58 Its role as a sedative was largely discarded 'because of its inability to reliably induce a deep enough sleep for surgery' (Centre for Addiction and Mental Health (CAMH) (Canada) 2002, p.1). This role was superseded by the use of the drug ketamine, later in itself abused for recreational purposes (see below).

59 For an account of how GHB may be 'homemade' by athletes and bodybuilders, see Sanguineti, Angelo and Frank (1997). The authors quoting from the *Underground Steroid Handbook for Men and Women* refer to a chapter titled 'GHB: A home brew', in which the writer Daniel Duchane gives detailed instructions 'on how to make GHB in your own kitchen' (1997, p.637).

60 Such claims, however, have been refuted by medical scientists. See Centre for Addiction and Mental Health (CAMH) (Canada) 2002.

61 In Britain it is known to be openly sold in sex shops. See www.urban75.com/Drugs/gbh.html

sedative effects and its reputation as a sexual enhancer and aphrodisiac. This was particularly true of the gay party scene.

GHB is a colourless, odourless drug that acts as a depressant on the central nervous system, unlike psychostimulant 'party drugs'.⁶² It also has anaesthetic and sedative properties. While usually found in liquid form, it has been produced as a powder and in capsule form. It is most usually taken in oral liquid form from small vials or bottles that can be added to water or other drinks. Although it has a salty taste, strong tasting beverages can disguise this.⁶³ Along with rohypnol, it has become known as the 'date rape drug' due to its disabling effect.⁶⁴ It may cause amnesia, impaired movement and speech, and drinks can be spiked without visible trace.⁶⁵ Media reports on the drug have largely focussed public attention on this date rape phenomenon (see Nicholson & Balster 2001, p.14).⁶⁶

Other names for GHB include 'Grievous Bodily Harm' (or GBH), 'Georgia Home Boy', 'Fantasy', 'Easy Lay', 'Liquid Ecstasy' or 'Liquid E'. When it comes in bright blue liquid form it is known as 'Blue Nitro' or 'Midnight Blue'. Because it is most often taken in liquid form, it is extremely difficult to gauge how strong, concentrated or toxic any given dose may be. In other words, it is a very fine line between what may be considered a 'safe' dose and one that may cause overdose or even death.⁶⁷

There is not a great deal known about GHB (or ketamine) use in Australia. The survey of South Australian 'party drug' trends found that respondents noted that both GHB and ketamine (discussed below) were reasonably easy to obtain in Adelaide and that availability was stable although price varied enormously depending on the source. Purity of both drugs was reputed to be high (NDARC 2001, 2002c).

In Victoria there has been very little research into GHB use. The need for a greater research profile on emerging 'party drugs' is canvassed further in Chapter 10.⁶⁸

62 For a comprehensive account of the pharmacological, neurochemical and biological activity of GHB, see Galloway et al. 1997; Nicholson and Balster 2001.

63 As a clear and colourless liquid it is also not particularly easy to detect for either medical or police personnel (see Asante 1999).

64 A British Home Office report in June 2000 questioned 123 victims of such drug-assisted assaults and found that 70% of the rapists were known to the victim, 12% were given the drug in their home and 10% on a university campus. One in five victims could not remember the assault while around 70% felt physically unable to resist (see www.urban75.com/Drugs/gbh.html and *The Guardian* 22 June 2000).

65 A discussion of harm reduction programmes aimed at preventing drink spiking and the harms that can thereby ensue is given in Chapter 8. See also Cannon 1999; McKey 2000, pp.21ff).

66 In March 2000, GHB became a Schedule 1 Controlled Substance in the United States (see Drug Enforcement Administration 2000.) For an account of the somewhat confusing way in which GHB is regulated at both state and federal levels in the United States, see Nicholson and Balster 2001, pp.14ff. The authors note that there is some uncertainty as to its use in legitimate clinical and medical trials as opposed to its abuse potential as a recreational drug.

67 See Chapter 4 for a discussion of short and long-term effects of GHB.

68 The issue of GHB use was, however, thought sufficiently serious for the Victorian Minister for Health, Mr John Thwaites, to issue a press release on the subject in July 2002 warning of the dangerousness of the drug following a spate of admissions to hospitals for GHB overdoses in July 2002 (Thwaites 2002).

Ketamine

Ketamine Hydrochloride was first synthesised in 1962 by Parke Davis Laboratories as a replacement for the unsatisfactory use of phencyclidine (PCP) as a surgical sedative and anaesthetic.⁶⁹ In the United States, in particular, ketamine has most commonly been used as a veterinary tranquilliser (see Jansen 1993; Dotson, Ackerman & West 1995; Cloud 2001; Dillon 2001). It was also used frequently as an anaesthetic in American field hospitals during the Vietnam War (Dillon 2001).

Ketamine is a *dissociative* anaesthetic, that is, it 'induces a lack of responsive awareness not only to pain but to the general environment, without a corresponding depression of autonomic reflexes and vital centres in the diacephelon' (Dotson, Ackerman & West 1995, p.751).⁷⁰ It also has few of the emergence problems associated with PCP.⁷¹ In the early 1970s ketamine appeared on the streets in the big cities of the United States in a manner similar to that of its precursor PCP in the 1960s.⁷²

It comes in a clear liquid and a white or off-white powder form. The liquid can be injected or consumed in beverages.⁷³ The powder can be injected once dissolved. It goes by the street names of 'Jet', 'Super Acid', 'Special K', 'Green', 'K', and 'Cat Valium'.

Along with the other 'party drugs', ketamine has become popular among young people at dance clubs and 'raves' in recent years.⁷⁴ It has been reputed to give the user a powerful 'rush', which may occur very quickly indeed depending on the mode of administration (within a few minutes if sniffed or injected or 20 minutes if taken as an oral pill). It has a relatively short duration of effect:

Recreational users usually administer ketamine intranasally, and this has an estimated duration of effect of up to one hour... In an evening, ketamine abusers will often self-administer several sequential doses of the drug in order to maintain psychotropic effects over time. The short half life of ketamine

69 The use of PCP as a surgical anaesthetic had been known to produce adverse effects such as delirium, hallucinations, confusion, irrationality and even violence (see Dotson, Ackerman & West 1995).

70 For a detailed account of the pharmacology of ketamine, see White and Ryan 1996; Curran and Morgan 2000.

71 Patients emerging from anaesthetic use of PCP had on occasion suffered some complications including delirium, hallucinations and catatonic or psychotic reactions. See for example, Smith, Wesson, Buxton, Seymour, Ross, Bishop and Zerkon 1982; White and Ryan 1996, Curran and Morgan 2000.

72 In a curious footnote to the drug's history, Dillon notes that in the 1976 film *Family Plot*, director Alfred Hitchcock 'depicted a kidnap victim sedated with a little-known drug called ketamine. At that time it would have been hard to imagine that more than 20 years later the same drug would be better known as Special K and have little connection with the breakfast cereal' (Dillon 2001, p.11).

73 Thus making it along with rohypnol and GHB a potential 'date rape' drug, particularly given its dissociative effect.

74 This is despite the fact that many educators and drug workers have identified the drug as totally inappropriate to use as a 'dance drug' (see Jansen 1993; Dalgarno & Shewan 1996; Dillon 2001; Dillon & Degenhardt 2001).

would mean it would be eliminated from the body within 24 hours (Curran & Monaghan 2001, p.750).

Use of ketamine can lead to powerful hallucinations and out of body or near death experiences. This is sometimes known as entering the 'K-hole':

A K-hole can be anything from going to hell and meeting Satan to going to heaven and meeting God (ketamine user, quoted in *Time Out* 2000, cited in Curran & Monaghan 2001, p.749).

Curran and Monaghan expand on this notion of the K-hole:

The diverse subjective experiences of ketamine are collectively termed the K-hole by users and commonly include: the sensation of light through the body; novel experiences concerning 'body consistency' (eg: being made of wood or rubber); grotesque distortion of shape or size of body parts; a sensation of floating or hovering in a weightless condition; absence of sense of time; visions, hallucinations; sudden insight into the riddles of existence and the self; the experience of being at one with the universe; sensations of melting together with people or things in the environment; and 'out of body' experiences (Curran & Monaghan 2001, pp.749–750).

The United States Drug Enforcement Administration (DEA) has commented that the only known source of ketamine for illicit or street use is via diversion of pharmaceutical products from pharmacies in Mexico (DEA 2003). American press reports have also indicated that a significant number of veterinary clinics are being robbed specifically for their ketamine stock (see <http://usdoj.gov/dea/concern/ghb.html>).

Recognising the dangers of recreational ketamine use, the United States listed the substance as a controlled substance in 1999.

The effects of ketamine and the other 'party drugs' will be discussed further in Chapter 4.

Conclusion

This brief summary of amphetamines and the club drugs has attempted to give an overview of the major substances other than alcohol, tobacco and heroin being used in both licit and illicit settings and contexts today. Although ecstasy (MDMA) or that which purports to be ecstasy is probably still the major club or party drug to be used by people recreationally, new drugs are being synthesised frequently or 'old' drugs such as ketamine are being discovered or rediscovered by new generations of party goers. As Topp stated in 2001 in the context of 'crystal meth':

It is important to acknowledge that these [methamphetamine drugs] are not new drugs; some people who have used drugs for decades will say that such drugs have been available, on and off, for years. The change appears not to be

the appearance of the drugs themselves, but rather, the recent rapid increase in their availability and use across the country (Topp 2001, p.3).

Nonetheless, it is also equally true for Dillon and Degenhardt to claim that for many drug and alcohol workers it is difficult to keep up with new trends and changes in club drug use: 'As new drugs are introduced to the scene, it is important to be aware of these substances and the harms associated with their use' (2001, p.11).

These harms and the medical and social short-term and long-term effects associated with amphetamines and 'party drug' use are examined in Chapter 4.

Questions for discussion

- ◆ What difficulties arise from pairing the investigation of amphetamines with that of 'party drugs'?
- ◆ What problems are there associated with using a term such as 'party drugs'?
- ◆ Are there more acceptable or suitable terms?
- ◆ What other problems or issues are associated with the terminology, classification or nomenclature attached to these drugs?
- ◆ What effect has the so-called 'heroin drought' had on patterns and types of amphetamine and party drug use? What responses should be made in relation to the 'drought'?
- ◆ If there has been a displacement effect because of the 'drought', what have been the substituted drugs of choice?
- ◆ If the drought has 'eased' in recent months, what effect is this having on the use of amphetamines and/or 'party drugs'?
- ◆ What routes of administration are users of amphetamines and/or 'party drugs' taking?
- ◆ Can the 'history' of amphetamine and party drug use tell us anything useful about the way these drugs are used today and how we should respond to them?
- ◆ Is there any further information that can be usefully provided about the 'newer' 'party drugs' such as ketamine and GHB?
- ◆ How can we best keep track of new drugs and emerging trends?

3. The Extent of Use

There is considerable evidence of an international trend towards the increasing use of amphetamines and ecstasy. Given that drug misuse is a global problem, it is perhaps of little surprise that these trends have also been noted in Australia and Victoria. This chapter seeks to gain an understanding of these trends and identify the extent to which amphetamines and 'party drugs' are used within Australia and, particularly, within Victoria.

A snapshot of international data

Sources and limitations of international data on illicit drug consumption

An analysis of international illicit drug trend data is most helpful in establishing basic orders of the magnitude of illicit drug use. It can also identify emerging trends of use, facilitate discussion, promote understanding and is also useful for assessing the effectiveness of different drugs policies throughout the world. However, it is important that caution be used in interpreting these trends. As the Australian Institute of Health and Welfare (AIHW) explains:

...comparative analyses of drug use in different countries are difficult due to cultural and political differences, and the legal framework of drug laws can differ greatly. In addition, each country has unique surveys and data collection methodologies, which make comparisons difficult (AIHW 2003, p.27).

The following section presents data from the United Nations Office for Drug Control Policy and Crime Prevention (UNODCCP). It reports on the use of amphetamines and 'party drugs' internationally and compares this data with Australian figures. The data are drawn from estimates provided by member states of the UNODCCP via a range of sources including annual reports questionnaires, government reports, population surveys and research results often collected by the UNODCCP's field officers.

There are numerous difficulties associated with these statistics, which are outlined in detail in the UNODCCP's Report *Global Illicit Drug Trends* (2002) (see page 282–283). As such, assessing the extent of amphetamine and ecstasy use is both extremely difficult and problematic. There are for example, no questions on ecstasy use in the Annual Reports Questionnaires (UN surveys for member states). The UNODCCP also relies on receiving voluntary information

in relation to the prevalence of this drug, which may not be comprehensive (UNODCCP 2002, p.260). Countries use different methods for collecting data, definitions may vary from country to country and 'in some cases, strongly differing results have been obtained from the same country' (UNODCCP 2002, p.282). However, despite these difficulties the UNODCCP believe that the data pooling techniques they use, standardisation of results and the extrapolations they have undertaken are such that 'it should be sufficient to arrive at reasonable orders about the likely extent of drug abuse in the general population' (UNODCCP 2002, p.283).

Significant findings of the United Nations report on illicit drug consumption

The UNODCCP estimated that approximately 185 million people consume illicit drugs globally each year: 147 million consume cannabis, 33 million consume amphetamines, 13 million consume cocaine, 13 million consume opiates of which nine million consume heroin, and seven million consume ecstasy. They reported that the strongest increases in use of illicit drugs in 2000 were in amphetamine-type stimulant (ATS) consumption (UNODCCP, 2002). Other findings included that:

- Abuse of amphetamines increased strongly in East and South East Asia and appeared to be stabilising, after years of increase, in West Europe, as well as in North America (UNODCCP 2002, p.9).
- Approximately two-thirds of the users of amphetamines are found in Asia, mostly in the countries of East and South East Asia, abusing methamphetamine. The Americas and Europe account for a quarter of global use of amphetamines (UNODCCP 2002, p.260).
- Supply of amphetamines in North America, Europe and Asia is largely from clandestine sources; consumption in South America and Africa is still supplied from licit channels where the dividing line between licit and illicit consumption is not always clear (UNODCCP 2002, p.265).
- While in Europe amphetamine is the ATS of choice, in South-East Asia it is methamphetamine which in general is more potent and carries more health risks than amphetamine (UNODCCP 2002, p.265).
- Ecstasy abuse increased in the Americas, South East Asia and some parts of Europe, and stabilised in other parts of Europe (UNODCCP 2002, p.9).

When a comparison is made between the prevalence of amphetamine and ecstasy use in the English-speaking countries of Australia, Canada, New Zealand, the United Kingdom and the United States it can be seen that the levels of illicit drug use vary considerably (see Table 3.1). Of particular interest to this Inquiry is that ecstasy use is most prevalent in Australia and amphetamine use is most prevalent in New Zealand, followed by Australia.

Table 3.1: Summary of illicit drug use in the past 12 months: Proportion of the population aged 15 years and over, selected countries, 2000–2001^(a)

Substance	Australia	Canada	New Zealand	United Kingdom ^(b)	United States
	per cent				
Marijuana/cannabis	15.0	8.9	20.0	9.4	9.3
Amphetamines	4.0	n.a.	5.0	1.9	1.1
Ecstasy	3.4	1.5	3.4	1.6	1.4
Opiates ^(c)	0.6	0.3	1.0	0.6	0.5

(a) Australia, New Zealand and United States 2001; Canada and United Kingdom 2000.

(b) United Kingdom figures for marijuana/cannabis, amphetamines and ecstasy relate to persons aged 16–59 years.

(c) Includes heroin, opium, morphine and synthetic opiates.

Source: Australian Institute of Health and Welfare (AIHW) 2003, *Statistics on Drug Use in Australia 2002* (Drug Statistics Series No. 12), AIHW, Canberra, p.32.

Prevalence of drug use in Australia and Victoria

It is important to again emphasise the need for caution when interpreting the figures cited in this chapter. The accurate measurement of drug use from national surveys, particularly regarding amphetamine and party drug use, is compromised by a number of methodological obstacles that are discussed below. Given the limitations of current measurement techniques, the figures contained within this chapter are, at best, an approximation of the extent of amphetamine and party drug use. Nonetheless, given the limitations of current research techniques, the data referred to below remain the best available indication of the levels of use within the community.

Measuring prevalence in Australia and in Victoria

Prevalence data is primarily based upon population surveys. Three surveys have been used in order to establish the prevalence of amphetamine and party drug use in Australia and Victoria:

- ◆ The National Drug Strategy Household Survey is the largest drug-related survey conducted in Australia. It has been repeated in a similar format every 2–3 years since 1985. In 2001, the survey was conducted by the AIHW and involved the participation of 27,000 people aged 14 years and over (AIHW 2002c). This represented a significant increase on the 10,030 participants who took part in the 1998 Household Survey (AIHW 1999).
- ◆ The Australian School Students Alcohol and Drugs (ASSAD) Survey conducted in 1996 was the first national survey of students to obtain data about illicit drugs. It was coordinated by Anti-Cancer Council of Victoria and asked questions of approximately 31,000 school students aged 12–17 years who were selected randomly from government and independent schools. A second survey was conducted with over 25,000

students in 1999. The results of this survey were published in June 2001 (Commonwealth Department of Health and Aged Care 2001).

- ◆ The Victorian School Students and Drug Use Surveys record Victorian students use of over-the-counter and illicit drugs. In 1996 and 1999 surveys were conducted by the Centre for Behavioural Research in Cancer, funded by the Anti-Cancer Council of Victoria and the Victorian Department of Human Services (DHS). Previous surveys in 1992, 1989 and 1985 were conducted by the Department of Human Services. In 1996 this involved 4,700 students who also took part in the 1996 ASSAD survey. In 1999, 4,286 students from Years 7–12 took part. These students were drawn from a representative sample of 67 secondary schools across Victoria (DHS 2001).

A further source of extremely useful information is the Illicit Drug Reporting System (IDRS). The IDRS is a national drug trend monitoring project which is coordinated by the National Drug and Alcohol Research Centre. The aims of this project are

1. To provide a reliable method of monitoring emerging jurisdictional trends in price, purity, availability and use of opiates, cannabis, cocaine, amphetamines and other drugs.
2. To inform health and law enforcement sector policy and program responses to illicit drugs, as well as to identify areas/issues requiring further investigation.⁷⁵

Data for this project are obtained from interviews with injecting drug users, interviews with experts and professionals who work in the field, other key informants and data routinely collected by other agencies. These data are triangulated and compared against previous years to determine new trends. According to Turning Point Alcohol and Drug Centre the 'key advantage of the IDRS system is that it replicates core methods across each state and territory, and has done so since 1997'.⁷⁶

Limitations of survey data

The measurement of drug activity

The measurement of drug activity will always present significant research difficulties. The use of population surveys as the primary means of measurement inevitably raises questions of validity and reliability. Such problems may arise as a consequence of false reporting or through respondents' misinterpretation of questions asked.

75 Excerpt from the confidential submission of Turning Point Alcohol and Drug Centre to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission and approval of Turning Point.

76 Excerpt from the confidential submission of Turning Point Alcohol and Drug Centre to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission and approval of Turning Point.

In addition, illicit drug users often go to elaborate lengths to keep their illegal activities hidden. They may, consequently, be unwilling to reveal the extent of these activities to an unknown researcher. Suspicion as to the identity and motives of researchers may further impact upon the accuracy of the research findings. In this respect, the researcher must be prepared to acknowledge that surveys record what respondents *say* about their drug use, and not what they actually *do* (Moore 1992b). It would be naïve to expect population surveys to generate data that are accurate beyond question (Bourgois, Lettiere & Quesada 1997).

A further concern is the serious doubt as to whether surveys are able to reach a representative sample of the population. Surveys are unlikely to reach those in the community who might be characterised as 'hidden.' The most active drug users and those most likely to suffer from a broad range of health problems would be included within this group (Hopkins & Frank 1991; Jacobs & Miller 1998). There are good reasons for believing that those young people who are more likely to use drugs are the same young people who will be more likely to be absent from school and consequently missed by school based surveys. Likewise, the homeless, the incarcerated, and those in special accommodation are all populations with disproportionately high reported rates of illicit drug use, and yet they will not be 'captured' by national household surveys, the traditional measure of illicit drug use in Australia.

In addition, the capacity for national surveys to provide regional data is restricted by the sample size of the sample population in any category. The base population used by National Household Surveys, for example, is not of a size that might allow state-wide distinctions to be drawn. Similarly, the small number of respondents in categories that address issues of ethnicity or self-identification as an Indigenous person limits the use of resulting data.

Another problem with survey techniques is that they are only able to provide a snapshot of drug use. They provide little information on patterns of use over time, which is an issue of particular importance when considering the increasing nature of amphetamine and party drug use. Similarly they can only provide a representation of past drug use and as such can not be used by themselves as indicative of present use or consumption patterns.

Each of these issues must be taken into consideration when interpreting the survey data reported within this section.

What the national data say

It is salutary to note at the outset that the 2001 National Drug Household Survey found a generally very low use of illicit drugs in the community, with less than four per cent using any illicit drug other than cannabis in the past 12 months, and 13 per cent using cannabis (AIHW 2003) (see Table 3.7 below).

In relation to amphetamine and ‘party drugs’, perhaps the most notable finding of the 2001 Survey was the general increase in the use of these drugs by Australians since 1991. Table 3.2 shows that in the category of ‘use in the last 12 months’, ecstasy/designer drug use increased from 1.1 per cent in 1991 to 2.9 per cent in 2001 and amphetamine use increased from 2.6 per cent in 1991 to 3.4 per cent in 2001. Findings by the Australian Crime Commission (ACC) in the *Australian Illicit Drug Report* supported this trend:

There is little to no evidence to suggest that amphetamine-type stimulant use in Australia will decrease in the near future. While arrests related to amphetamine-type stimulants remained relatively constant during 2001–2002, other indicators, such as the high availability and increasing quantities seized both at the border and domestically, indicate a continuing if not growing demand for amphetamine-type stimulants in Australia (ACC 2003, p.61).

Table 3.2: Summary of recent^(a) illicit drug use: Proportion of the population aged 14 years and over, by drug type, Australia, 1991–2001

Substance/behaviour	1991	1993	1995	1998	2001
	(per cent)				
Marijuana/cannabis	13.7	12.7	13.1	17.9	12.9
Pain-killers/analgesics ^(b)	n.a.	1.7	3.5	5.2	3.1
Tranquillisers/sleeping pills ^(b)	n.a.	0.9	0.6	3.0	1.1
Steroids ^(b)	n.a.	0.3	0.2	0.2	0.2
Barbiturates ^(b)	1.5	0.4	0.2	0.3	0.2
Inhalants	0.8	0.6	0.6	0.9	0.4
Heroin	0.4	0.2	0.4	0.8	0.2
Methadone ^(c)	n.a.	n.a.	n.a.	0.2	0.1
Other Opiates ^(b)	n.a.	n.a.	n.a.	n.a.	0.3
Amphetamines ^(b)	2.6	2.0	2.1	3.7	3.4
Cocaine	0.7	0.5	1.0	1.4	1.3
Hallucinogens	1.6	1.3	1.8	3.0	1.1
Ecstasy/designer drugs	1.1	1.2	0.9	2.4	2.9
Injected drugs	0.5	0.5	0.6	0.8	0.6
Any illicit drug	22.8	14.0	17.0	22.0	16.9
None of the above	77.2	86.0	83.0	78.0	83.1

(a) Used in the last 12 months.

(b) For non-medical purposes.

(c) For non-maintenance purposes.

Source: Australian Institute of Health and Welfare (AIHW) 2003, *Statistics on Drug Use in Australia 2002* (Drug Statistics Series No. 12), AIHW, Canberra, p.19.

Unpublished Australian Customs Service data provides further evidence that the prevalence of ecstasy (MDMA) is increasing in Australia. The data shows that in the period 1992–1993 to 2001–2002, border detections for ecstasy (MDMA) increased from six in 1992–1993 to 285 in 2001–2002. At the same time, the total weight of these detections increased from almost zero kilograms in 1992–1993 to 445 kilograms in 2001–2002 (AIHW 2003, p.62).

Table 3.3: Summary of illicit drug use in Australia, 2001

Substance/behaviour	Drugs ever used ^(a)	Drugs recently used ^(b) (per cent)	Mean age of initiation (years)
Marijuana/cannabis	33.1	12.9	18.5
Pain-killers/analgesics ^(c)	6.0	3.1	18.9
Tranquillisers/sleeping pills ^(c)	3.2	1.1	22.8
Steroids ^(c)	0.3	0.2	22.5
Barbiturates ^(c)	0.9	0.2	18.7
Inhalants	2.6	0.4	17.6
Heroin	1.6	0.2	20.7
Methadone ^(d)	0.3	0.1	21.8
Other opiates ^(c)	1.2	0.3	n.a.
Amphetamines ^(c)	8.9	3.4	20.4
Cocaine	4.4	1.3	22.6
Hallucinogens	7.6	1.1	19.1
Ecstasy/designer drugs	6.1	2.9	21.9
Injected drugs	1.8	0.6	20.2

(a) Used at least once in lifetime.

(b) Used in the last 12 months.

(c) For non-medical purposes.

(d) For non-maintenance purposes.

Source: Australian Institute of Health and Welfare (AIHW) 2003, *Statistics on Drug Use in Australia 2002* (Drug Statistics Series No. 12), AIHW, Canberra, p.17.

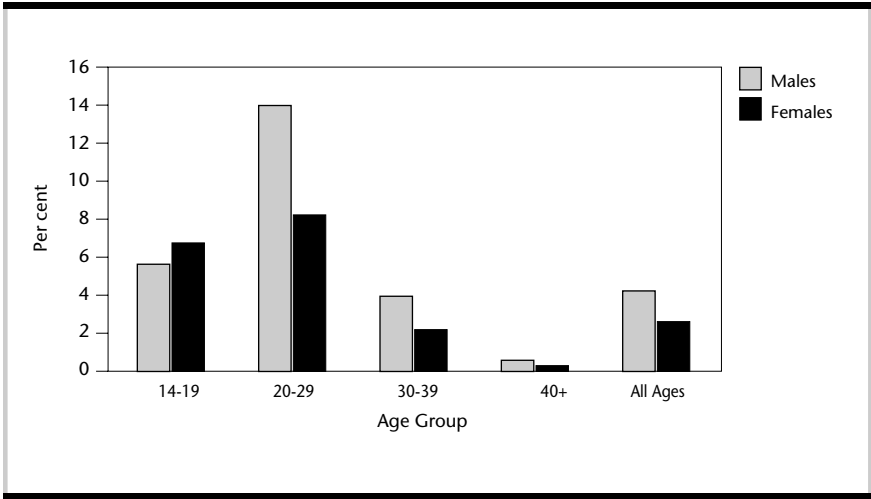
The following section gives specific data on amphetamine use in Australia and is followed by a corresponding section on party drug use.

Amphetamine use

According to the AIHW study, approximately 1.4 million Australians aged 14 and over had used amphetamines in their lifetime (AIHW 2002c). The study also revealed that amphetamine was the most widely used illicit drug after cannabis. Table 3.3 above shows that 8.9 per cent of the population aged 14 and over reported using amphetamines at some time, and around 3 per cent reported using amphetamines in the previous 12 months. The average age that people first used amphetamines was 20.4 years of age (see Table 3.3). Between 1995 and 2001 there has been little change in the age at which amphetamines were first used (see AIHW 2002a, p.5).

Figure 3.1 shows that males were more likely to have used amphetamines in the past 12 months. However, among the 14–19 year olds, females were more likely than males to have used. Those aged 20–29 years were more likely than those in other age groups to report ever using amphetamines (AIHW 2002c).

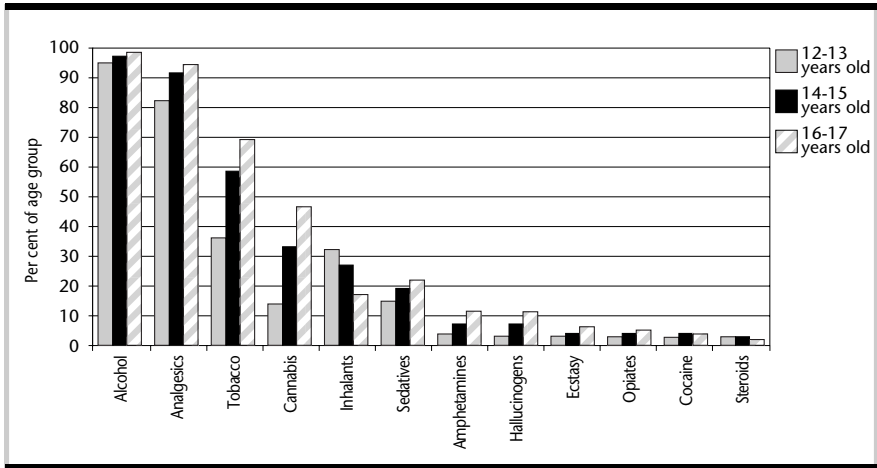
Figure 3.1: Percentage who have used amphetamines in the last 12 months in Australia, 2001



Source: Australian Institute of Health and Welfare (AIHW) 2002c, *2001 National Drug Strategy Household Survey: Detailed Findings* (Drug Statistics Series No. 11), AIHW, Canberra, p.62.

The 1999 Survey of Australian Secondary School Students also reported that young people were less likely to use amphetamines than other illicit drugs. However the results of that study did show that amphetamine use increased with age (see Figure 3.2).

Figure 3.2: Lifetime use of licit and illicit substances by Australian secondary school students, 1999



Source: Commonwealth Department of Health and Aged Care (National Drug Strategy Unit) 2001, *Australian Secondary Students' Use of Over-the-Counter and Illicit Substances in 1999*, Commonwealth Department of Health and Aged Care, Canberra, p.28.

Recent users of amphetamines indicated that they also used other drugs at the same time (at least on one occasion). Alcohol was most likely to be consumed at the same time as using amphetamines (87.7%), followed by

marijuana/cannabis (71%) (see Table 3.4). This finding certainly supports the academic literature, which suggests that poly drug use is quite common among amphetamine users. The issue of amphetamines and poly drug use is discussed in further detail in Chapter 4.

Table 3.4: Other drugs used with amphetamines, recent users aged 14 and over, by sex, Australia, 2001

Drug	Males	Females (per cent)	Persons
Alcohol	87.3	88.4	87.7
Marijuana/cannabis	75.0	65.6	71.5
Heroin	3.2	4.1	3.6
Cocaine	15.6	12.1	14.3
Tranquillisers/sleeping pills ^(a)	7.3	6.2	6.9
Anti-depressants ^(a)	2.8	4.1	3.3
Pain-killers/analgesics ^(a)	6.5	5.4	6.1
Barbiturates ^(a)	1.6	1.9	1.7
Ecstasy/designer drugs	43.4	43.2	43.3
Other	3.0	5.2	3.8
None of the above	0.8 *	1.4 *	1.0

(a) Used for medical purposes.

Notes

1. Base equals recent users.
 2. Respondents could select more than one response.
- * Relative standard error greater than 50%.

Source: Australian Institute of Health and Welfare (AIHW) 2002c, *2001 National Drug Strategy Household Survey: Detailed Findings* (Drug Statistics Series No. 11), AIHW, Canberra, p.65.

In relation to amphetamine use through injecting, the AIHW survey found that of those people who injected drugs the first drug injected was amphetamine (60.3%), followed by heroin (30.5%). Similarly, the most common drug recently injected by these users was amphetamine (77.1%), followed by heroin (22.9%).⁷⁷

Ecstasy use

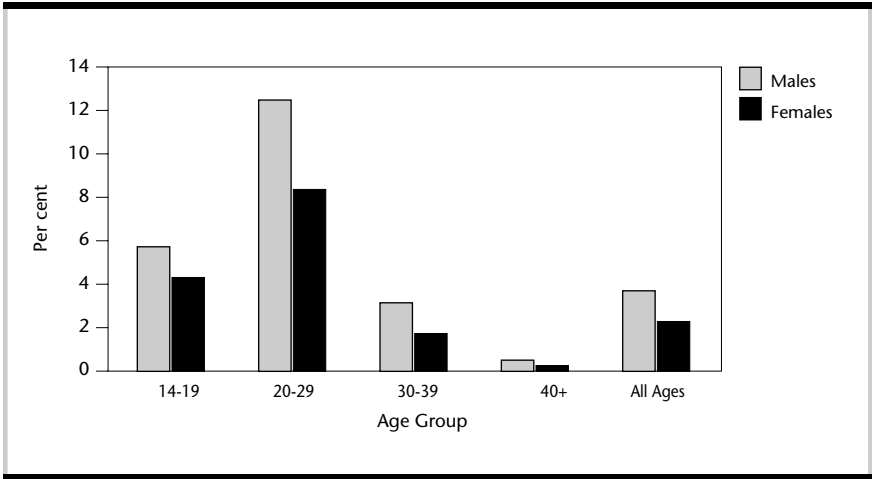
The AIHW survey reported that in 2001 almost '1 million (6.1%) Australians aged 14 years and over had used ecstasy/designer drugs in their lifetime' (AIHW 2002c, p.67). Ecstasy was reported as the fourth most widely used illicit drug ever used, after cannabis, amphetamines and hallucinogens and the fourth most recently used after cannabis, amphetamines and pain-killers/analgesics. On average, Australians first used ecstasy at 21.9 years of age (see Table 3.3 above). The age of initiation has remained relatively stable since 1995 (see AIHW 2002a, p.5).

As illustrated by Figure 3.3 below, the study shows that 10.4 per cent of people aged 20–29 years and five per cent of teenagers had used ecstasy in the past 12

77 See Table A in Appendix 2.

months. People in the 20–29 year age bracket were most likely to report ever using ecstasy/designer drugs. Males were more likely than females to have used ecstasy in the past 12 months in every age group; however, the recent use of ecstasy among females has increased significantly. Between 1998 and 2001, 'the recent use of ecstasy increased both overall and for those aged 20–29 years' but 'among females aged 40 years and over there was a significant decline in the recent use of ecstasy' (AIHW 2002a, p.29). The 1999 Survey of Australian Secondary School Students also reported that young people were less likely to use ecstasy/designer drugs than other licit and illicit drugs. However, the results of that study did show that ecstasy/designer use did increase with age (see Figure 3.2 above).

Figure 3.3: Percentage who have used ecstasy in the last 12 months in Australia, 2001



Source: Australian Institute of Health and Welfare (AIHW) 2002c, *2001 National Drug Strategy Household Survey: Detailed Findings* (Drug Statistics Series No. 11), AIHW, Canberra, p.67.

Recent users of ecstasy/designer drugs indicated that they also used other drugs at the same time (at least on one occasion). Alcohol was most likely to be consumed at the same time they used ecstasy/designer drugs (76.5%) followed by marijuana/cannabis (66.2%) (see Table 3.5). This seems to be a significantly different pattern of use from the earlier years of taking ecstasy, when alcohol was little in evidence. At least in the rave and dance cultures, the use of alcohol in conjunction with ecstasy was frowned upon because of the aggression that it could produce in users (see further discussion in Chapter 5). Commentators have noted with concern the increasing use of 'party drugs' and poly drug use. The issue of poly drug use will be discussed in Chapter 4.

Table 3.5: Other drugs used with ecstasy/designer drugs, recent users aged 14 years and over, by sex, Australia, 2001

Drug	Males	Females (per cent)	Persons
Alcohol	75.8	77.6	76.5
Marijuana/cannabis	70.6	59.4	66.2
Heroin	0.2 *	2.1	1.0 *
Cocaine/crack	24.1	16.2	21.0
Tranquillisers/sleeping pills ^(a)	8.9	5.9	7.7
Anti-depressants ^(a)	2.1	2.5	2.3
Pain-killers/analgesics ^(a)	4.2	3.5	3.9
Barbiturates ^(a)	1.7 *	0.7 *	1.3
Amphetamines/speed ^(a)	52.6	49.8	51.5
Other	3.4	3.3	3.3
None of the above	5.9	6.2	6.1

(a) Used for medical purposes.

Notes

1. Base equals recent users.

2. Respondents could select more than one response.

* Relative standard error greater than 50%.

Source: Australian Institute of Health and Welfare (AIHW) 2002c, *2001 National Drug Strategy Household Survey: Detailed Findings* (Drug Statistics Series No. 11), AIHW, Canberra, p.70.

Victorian drug use

Comparative data

When a comparison is made between all Australian states and territories in the AIHW study it can be seen that there was low consumption of illicit drugs generally, with 13 per cent using cannabis recently and only four per cent using any other illicit drug (see Table 3.6). The Northern Territory recorded the highest recent use for amphetamines followed by Western Australia, and Victoria recorded the second lowest. The ACT recorded the highest recent use of ecstasy followed by Western Australia. The study reported that nationally there was no significant increase of amphetamine use from 2000 to 2001.

Table 3.6: Recent^(a) illicit drug use summary: Proportion of the population aged 14 years and over, Australian States and Territories, 2001

Drug	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
	(per cent)								
Marijuana/cannabis	11.9	11.8	12.7	17.5	14.2	11.9	14.4	24.4	12.9
Amphetamines ^(b)	3.4	2.4	2.9	5.8	4.3	2.1	4.5	6.3	3.4
Pain-killers/analgesics ^(b)	2.5	3.2	3.4	3.9	3.1	2.2	3.3	3.8	3.1
Ecstasy/designer drugs	3.4	3.0	1.7	4.0	2.0	0.8	4.8	2.8	2.9
Cocaine	1.8	1.3	0.7	1.5	0.7	*0.2	1.5	*0.5	1.3
Tranquillisers/sleeping pills ^(b)	0.9	1.1	1.2	1.7	1.4	1.0	1.4	1.1	1.1
Hallucinogens	0.9	0.9	0.8	2.0	1.9	1.0	1.8	1.7	1.1
Injected drugs	0.3	0.4	0.6	1.3	0.8	1.0	*0.3	1.9	0.6
Inhalants	0.5	0.3	0.3	0.6	0.7	*0.2	0.5	*0.5	0.4
Other Opiates ^(b)	0.2	0.4	0.3	0.6	*0.3	0.7	0.6	0.8	0.3
Heroin	0.2	0.3	*0.2	0.3	*0.1	*0.3	*0.4	*0.1	0.2
Barbiturates ^(b)	*0.1	0.2	*0.1	0.2	*0.3	*0.1	*0.2	*0.1	0.2
Steroids ^(b)	*0.1	0.3	*0.1	*0.1	*0.3	*0.1	*0.1	*0.1	0.2
Methadone ^(c)	*0.1	*0.1	-	*0.1	*0.1	*0.1	-	*0.3	0.1
Any illicit	15.8	16.0	16.5	22.0	17.8	14.3	18.1	29.2	16.9

(a) Used in past 12 months.

(b) For non-medical purposes.

(c) For non-maintenance purposes.

* Relative standard error greater than 50%.

Source: Australian Institute of Health and Welfare (AIHW) 2003, *Statistics on Drug Use in Australia 2002* (Drug Statistics Series No. 12), AIHW, Canberra, p.8.

The findings from the Illicit Drug Reporting System (IDRS) provide further and more recent insights. The report found that 'substantial proportions of IDUs in all jurisdictions continue to use all forms of methamphetamine... [T]he frequency of methamphetamine use decreased from 2001 in all jurisdictions except NSW, VIC, and TAS where it remained stable' (IDRS 2002, p.81).

As discussed previously, the capacity for national surveys to provide state or regional data is restricted by the size of the sample population in any category. The base population used by National Household Surveys, for example, is not of a size that might allow state-wide distinctions to be drawn. The following discussion on amphetamine and party drug use in Victoria is drawn from a range of sources including the IDRS and DHS treatment statistics.

Amphetamines – Victorian data

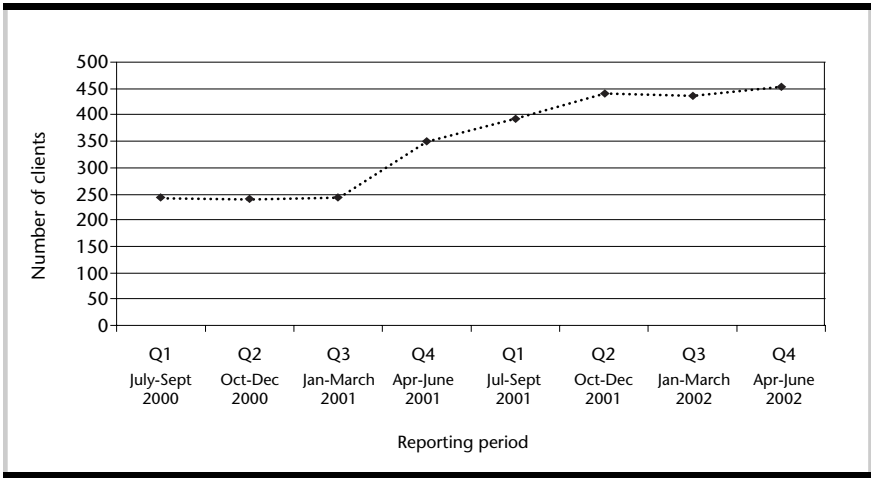
As discussed in Chapter 2, the 2001 IDRS study has commented about the volatile and changing nature of the amphetamine and methamphetamine markets in Melbourne and particularly the trend, at least in part because of the so-called 'heroin drought', towards increased amphetamine use. The 2002 IDRS study notes that this is a continuing trend with the levels of methamphetamine use among injecting users in Melbourne remaining quite high.

For example, the IDRS 2002 report suggested that in Melbourne the levels of methamphetamine use among injecting users is quite high:

The 2002 IDRS found that 73% had used some form of methamphetamine (either speed, base or ice) in the preceding six months, a proportion comparable to that of the 2001 IDRS (76%). Separating out forms of methamphetamine, 70% reported using speed, 19% reported using base and 26% reported using ice in the preceeding six months. The median number of days on which speed has been used in the preceeding 6 months was 24, while for base it was 10 and ice 6 days (IDRS 2002, p.78).

Human Services Victoria has confirmed this trend towards increasing amphetamine use through its monitoring of clients presenting for treatment across Victoria. Monitoring of clients is via an electronic data collection system – the Alcohol & Drug Information System (ADIS). This System records demographic details as well as some social details of individual clients. Between July 2000 and June 2002 the ADIS recorded the ‘primary drug use’ statistics which provided the data for Figure 3.4.

Figure 3.4: Clients accessing drug treatment services with primary drug amphetamines



Source: Alcohol and Drug Information System (ADIS) 2002, in the submission of Human Services Victoria to the Drugs and Crime Prevention Committee, September 2002.

The ADIS data collected by Human Services Victoria indicates that between July 2000 and June 2002 the percentage of clients naming amphetamines as their primary drug of choice almost doubled, although the number of clients presenting for treatment remained quite small.⁷⁸ The increase during this period is believed to be partly due to the decrease in availability of heroin:

78 Submission of Human Services Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and ‘Party Drugs’, September 2002.

Amphetamine/methamphetamines have also become the identified drug of choice for a group of people who were primary heroin users and there was an increase in the number of people reporting injecting amphetamines from 50% from the previous year to 75% from the current study (National Drug and Alcohol Research Centre (NDARC) 2002a).

There has also been anecdotal evidence indicating that amphetamine misuse is widespread within the rave party scene. Moreover, it is believed that amphetamines are being used by an increasingly younger age group. This evidence is reflected in the 1999 School Students and Drug Use Survey of over-the-counter and illicit substances among Victorian secondary school students.⁷⁹

Prevalence of amphetamines in heroin-related deaths

Further evidence that amphetamine use has become more prevalent in recent years can be found in statistics provided by the Victorian Institute of Forensic Medicine and Department of Forensic Medicine at Monash University, which reported an increase in heroin-related deaths involving amphetamine over the period 1997–2001 (see Table 3.7 below).

Table 3.7: Prevalence of amphetamine in heroin-related deaths

	1997	1998	1999	2000	2001	Overall
Morphine plus Amphetamines	7%	10%	6%	10%	22%	11%
Total Heroin Deaths	166	268	359	331	49	

Source: Wallington, J., Gerostamoulos, J. & Drummer, O. 2002, *Heroin Deaths in Victoria: 2001*, Victorian Institute of Forensic Medicine and Department of Forensic Medicine Monash University, Report No. 5, p.4.

While the total number of heroin deaths decreased by 89 per cent from 331 in 2000 to 49 in 2001, the percentage of heroin-related deaths involving amphetamines⁸⁰ increased in that year by 12 per cent.

The use of amphetamines has also increased in 2001 from the previous four years (1997–99) with 22% of all deaths now involving amphetamine use in addition to heroin (Wallington, Gerostamoulos & Drummer 2002, p.4).

The increase in heroin-related deaths involving amphetamines accords with other research that indicates amphetamine use is on the increase within the drug-using sector.

79 Submission of Human Services Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and ‘Party Drugs’, September 2002.
80 That is where toxicological analysis reveals amphetamine in the system in conjunction with heroin.

Ecstasy – Victorian data

Prevalence of use

In the NDARC research paper, *Victorian Drug Trends 2001 – Findings from the National Illicit Drug Reporting System (IDRS) Study*, Craig Fry and Peter Miller (NDARC 2002a) conducted interviews with 151 injecting drug users (IDUs) recruited in Melbourne between June and December 2001. The research identified a total of 39 per cent of respondents reporting ecstasy use within the last six months.

As indicated in Table 3.8 below, 65 per cent of IDUs stated they had used ecstasy at least once in their lifetime compared with 51 per cent in 2000 and 40 per cent in 1999. Twenty-one per-cent had injected ecstasy within the six months prior to interview compared with eight per cent in 2000 (NDARC 2002a).

Table 3.8: Trends in ecstasy use

	1999	2000	2001
Ecstasy – lifetime use	40%	51%	65%
Ecstasy injection in last 6 months		8%	21%

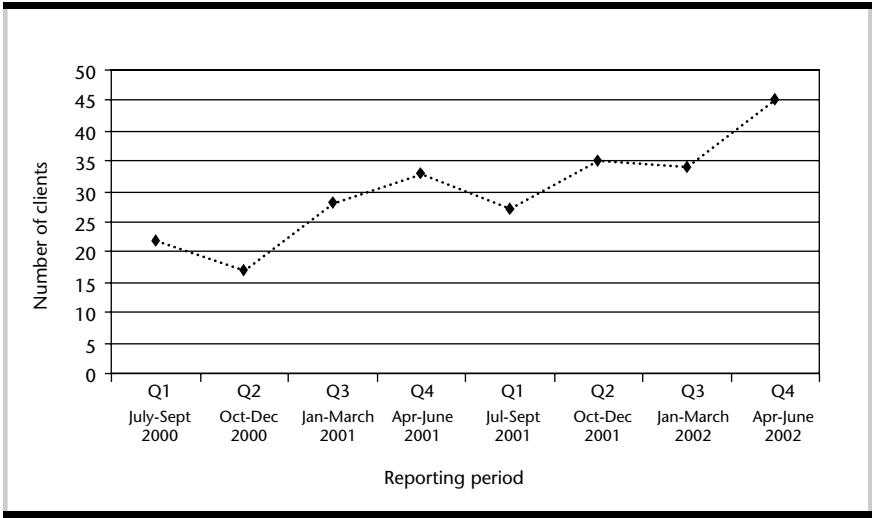
Source: National Drug and Alcohol Research Centre (NDARC) 2002a, *Victorian Drug Trends 2001: Findings from the Illicit Drug Reporting System (IDRS)*, by C. Fry & P. Miller, (NDARC Technical Report No. 129), NDARC, University of New South Wales, Sydney, p.50.

According to Human Services Victoria:

It has been apparent in Victoria for some time that there is an entrenched injecting drug culture, which seems to be on the increase with a steep rise in injection of ecstasy between 2000 and 2001. Injecting drugs, particularly those that were not designed to be injected, dramatically increases the risks of blood born viruses, Hep C and HIV, and can cause vein damage, ulcers and other medical complications.⁸¹

81 Submission of Human Services Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and ‘Party Drugs’, September 2002.

Figure 3.5: Clients accessing drug treatment services with primary drug ecstasy



Source: Alcohol and Drug Information System 2002, in the submission of Human Services Victoria to the Drugs and Crime Prevention Committee, September 2002.

As Figure 3.5 shows, the ADIS data identified a dramatic increase in the number of clients seeking treatment for problems related primarily to ecstasy use. While the numbers are small, they more than doubled during the research period (July 2000–June 2002), as was the case with amphetamines.

It would seem that the price and availability of ecstasy has been a factor in the increased ecstasy use. As Fry and Millar found:

It was reported that the price of ecstasy had decreased, that it was easy to obtain and had become easier. Key informants reported that one ecstasy tablet cost \$30–50 or \$300 for 10 tablets. It was also reported that purity of ecstasy remained low, however the advent of testing kits (EZ-test) had improved knowledge of what drug was being purchased (National Drug and Alcohol Research Centre 2002a, p.51)

Human Services Victoria also notes that as well as an increase in the number of ecstasy users there may be an increase in the amount taken by those who have been using ecstasy for some time, in order to achieve the desired effect. The Department is concerned that:

A consequence of this will be the increase in the level of contaminants and other drugs that they are ingesting, aggravating what could already be dangerous and certainly unpredictable poly drug use patterns.⁸²

Research and anecdotal evidence also indicates that ecstasy has moved into more traditional drug markets. Its use is also more widespread among intravenous drug users.

82 Submission of Human Services Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', September 2002.

There is also an increase among young people as the 2001 study shows:

In the Victorian Drug Trends 2001 study, key informants reported an age range of ecstasy users as between 12–30 years with an average age of 17. This is lower than previous IDRS studies.⁸³

Although the 1999 School Students and Drug Use Report 1999 reported that less than five per cent of students had 'ever used' ecstasy, and that use tended to be experimental, the decrease in the age of ecstasy users noted above supports anecdotal evidence within the rave and party scene that ecstasy is attracting younger people, as well as a more mainstream group of users.

Anecdotal evidence regarding current trends

The Committee has also received anecdotal evidence that suggests there has been an increase in the incidence of amphetamine and ecstasy use in Victoria during the past two to three years. While this evidence is not statistically based it has provided further insights into the issues and concerns surrounding the use of amphetamine and 'party drugs' in Victoria.

Many drug and alcohol agencies have noted that amphetamine use is not a major reason for their clients seeking treatment, however they note also that there is an increasing trend for amphetamine users to seek treatment.

Uniting Care Moreland Hall is an agency that has provided alcohol and other drug treatment services since 1969 to clients presenting with extensive drug use. In its submission to the Committee it stated that:

In the two year period from 1st July 2000 to 30th June 2002 there were 4770 treatment episodes across the range of UCMH programs. The primary drug which led people to present for these episodes were amphetamines for 6% of people and ecstasy for 0.5 % of people. Amphetamines were also used amongst a range of drugs (ie not the primary drug) for a further 14% of people, and ecstasy amongst a range of drugs for a further 3.5% of people.⁸⁴

This agency also noted that:

As the primary drug amphetamines have roughly doubled in the two-year period (3-4% to 6-8%), however it still remain less than 10% of the presenting primary drug to Moreland Hall. It can be seen that this increase has coincided with a significant reduction in heroin as the primary drug from the July–September 2001 quarter which is most likely due to the 'heroin drought' that has been impacting on the supply of heroin in Victoria since that time. Thus the increase in amphetamine as the primary drug (along with alcohol and cannabis) is likely to be the result of reduced access to heroin.⁸⁵

83 National Drug and Alcohol System 2002a, cited in the submission of Human Services Victoria to the Drugs and Crime Prevention Committee, September 2002.

84 Submission of Uniting Care Moreland Hall to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

85 Submission of Uniting Care Moreland Hall to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

In relation to heroin users also using amphetamines, the submission added:

For those people whose primary drug is heroin there has been an increase in them also using amphetamines. In the year 2000/2001, 53% of clients presenting at Moreland Hall had heroin as the primary drug with 14% of these also using amphetamines. In comparison, in the year 2001/2002, 26% of clients presenting had heroin as the primary drug and of these 27% were also using amphetamines. This may indicate increasing numbers of people whose primary drug is heroin using amphetamines when they are unable to access heroin.⁸⁶

Similarly, Open Family Australia, which provides 24-hour street-work services for street children, explained in its submission to the Committee that:

Illicit drug use has not been exclusive to the city as Open Family Street Outreach Workers in rural Victoria have noticed a considerable rise in the level of amphetamine use in the Hume region over the past couple of years. Staff are seeing an increasing number of young people, especially young women 14–21 years presenting with problematic amphetamine use. Some of the self rationalising perceptions for using amphetamines by young women in rural Victoria are seeing the drug as a social experience and not in any way like taking opiates which they see as 'using drugs'. Amphetamine use is also being used to lose weight and to keep up with social and school life and commitments.⁸⁷

These findings were not confined to drug and alcohol services. The City of Melbourne was also alerted to the increasing prevalence of amphetamines, as stated in its submission to the Committee:

However, very recently, Council has become aware of the increasing number of reports from services, police and government departments about the use of amphetamines, in particular, over the last 12 months. Some agencies have noted that this increase in amphetamines use is following a decrease in clients presenting with heroin as their principal drug. Recognising that there are distinctions in the patterns of drug use across and within drug types, amphetamine use is an example where there may be recreational use that differs from the chronic use of this substance... It is anticipated that the use of amphetamines will be identified as an emerging issue when the Drugs Action Plan is reviewed during 2003.⁸⁸

The experience of the City of Kingston was similar:

The research undertaken has not identified significant problems with regard to the use of amphetamines and 'party drugs' within the Kingston municipality. However, consultation with relevant service providers and community organisations does indicate an increase in the injecting of amphetamines and benzodiazepines amongst young people who have previously used heroin.

86 Submission of Uniting Care Moreland Hall to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

87 Submission of Open Family Australia to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

88 Submission of the City of Melbourne to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

Additionally there is evidence of some experimentation and recreational use of inhalants, hallucinogens, stimulants and designer drugs amongst young people.⁸⁹

Human Services Victoria also noted that:

There has been a recent escalation in Victoria in the misuse of amphetamines and methamphetamines, which has signalled the need for specific policy and program responses... The heroin drought in late 2000 saw an increase in poly-drug use including a perceptible increase in the use of amphetamines.⁹⁰

In addition, the Committee has received evidence that the use of both ketamine and GHB is also increasing. According to the submission from Human Services Victoria:

Vivids RaveSafe team advise that GHB 'made a huge appearance' at the New Years Eve Earthcore party 2000, that 'Ravers often use GHB as a "come down" drug after partying due to its depressant nature, as it purports to relax the mind and body'. It has continued to be prominent in the rave party scene since 2000.

Recently in Victoria 5 'life threatening' cases of 'fantasy' (GHB) overdoses were reported by the Alfred Hospital within 10 days, causing great concern that these might not be isolated incidents.⁹¹

According to Human Services Victoria there is also anecdotal evidence 'that indicates that currently ketamine is commonly being sold on the streets and in the party scene as ecstasy', and that:

Ravers have reported sporadically over the past 12 months that ketamine has been sold as ecstasy in pill form (Ravesafe, Safetime, 1999).⁹²

Unfortunately the Australian Institute of Health and Welfare study and the IDRS study do not monitor the prevalence of these drugs individually and there is, to the Committee's knowledge, no formal population survey that does. The Committee would be interested in receiving further anecdotal evidence on the prevalence of both ketamine and GHB as well as the research questions and projects that should be developed with respect to these drugs.

Conclusion

Clearly there are limitations in the accuracy of data on illicit drug use obtained through current research techniques, and therefore caution is needed when considering the available information. The research and anecdotal evidence

89 Submission of the City of Kingston to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

90 Submission of Human Services Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', September 2002.

91 Submission of Human Services Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', September 2002.

92 Cited in the submission of Human Services Victoria to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', September 2002.

does point to a trend towards increased use of amphetamines and ecstasy internationally, nationally and within Victoria.

Available data and anecdotal evidence also suggest that both amphetamines and ecstasy are being used by a wider demographic, and while most users are within the 20–29 year age group there appears to be an increase in the number of younger people using, which is concerning. Also of concern is the indication of an increase in these drugs being part of poly drug use patterns.

The phenomenon of a so-called 'heroin drought' has been briefly discussed in Chapter 2. It has been suggested, however, that the 'heroin drought' was a significant factor in the increased use of other illicit drugs, and that perhaps this increase will level out as heroin availability increases. Further research is essential for more accurate assessment of current trends in the use of amphetamines and ecstasy, as well as other 'party drugs' such as ketamine and GHB.

Questions for discussion

- ◆ How useful are current data collections for understanding the nature and extent of amphetamine and party drug use?
- ◆ To what extent are these data collections used to inform policy and practice?
- ◆ What additional statistics and other data should be collected pertaining to amphetamine and party drug use?
- ◆ How can such data be better coordinated and most efficiently disseminated?
- ◆ What research questions and projects are currently being developed with regard to amphetamine and party drug use?
- ◆ What research questions and projects should be developed with regard to amphetamine and party drug use?
- ◆ To what extent is international data on amphetamine and ecstasy use helpful in Australia?
- ◆ Are there recent data that demonstrate that as heroin use increases after the 'drought' amphetamine use decreases?

4. Effects of Amphetamines and ‘Party Drugs’ – Physical, Psychological and Social Consequences

This chapter begins with a detailed analysis of the medical, physical and psychological consequences or effects of using amphetamines and ‘party drugs’. It then looks at the social consequences pertaining to the use of the drugs. For example, is there a link between amphetamines, amphetamine psychosis and violence?

The general (and short-term) effects of the amphetamines, and indeed most of the psychostimulant drugs, can be divided into two basic categories. They provide:

- ♦ A sense of euphoria, confidence and well being, and
- ♦ Increased energy, often to the point of hyperactivity. This will depend on the amount. Such an outcome is of particular importance to consumers who are using them for instrumental reasons such as long-distance driving or studying.

Physical and psychological consequences – Amphetamines⁹³

A detailed medical, toxicological and pharmacological account of amphetamines (and ‘party drugs’) is beyond either the scope or the expertise of this Discussion Paper. There are also numerous learned journals and texts that the interested and expert reader can consult.⁹⁴ What follows is a relatively simplified version of the main medical and physical effects associated with taking amphetamines, methamphetamines and their analogues and

93 For a list of the toxicological effects of the drugs in question in table form and their interactions with other drugs, see the tables in Appendix 3 (taken from Kong 2000). For an excellent, if technical, account of the medical complications associated with amphetamine, particularly methamphetamine use, see Albertson, Derlet and Van Hoosen (1999). This account covers inter alia complications pertaining to the cardiovascular system, the central nervous system, infectious diseases, respiratory system, dermatologic toxicity, renal and hepatic disorders.

94 For example, see Kong (2000) and in the context of ‘ecstasy’ and other ‘designer drugs’ see Hando, Topp & Dillon 1998 and the references listed therein; Gowing et al. 2001 and the references listed therein.

derivatives. It should also be noted that there is not always consensus, even among medical experts, as to either the existence of these effects or the severity of the consequences. This is particularly true of 'ecstasy'/MDMA. For example, in a relatively early symposium on psychostimulant use in Australia⁹⁵ many of the presenters believed that the effects of psychostimulant abuse had been exaggerated. Chesher for example:

[c]oncludes that most users of amphetamines and cocaine control their use of these drugs and do not progress to dangerous use patterns... In agreement with Chesher, [Dr] Wickes states that, contrary to the impressions gained from the media or medical literature, many psychostimulant users do not suffer any adverse consequences from their use of these drugs. Even when individuals do present to accident and emergency services, few require either pharmacologic treatment or admission (in Burrows, Flaherty & Macavoy 1993, pp.4, 5).⁹⁶

Clearly the effects of the drug(s) will be dependent on a number of factors, which will vary depending on the individual. These may include the person's size, weight, general and mental health, the amount of the drug taken and whether it is consumed with alcohol or other drugs. Whether the person is a 'neophyte' or experienced user of the drug in question may also have a bearing on its possible effects. The 'dangerousness' or otherwise of using amphetamines may also vary depending on the mode of administration used. As noted in Chapter 2, the general consensus of medical opinion is that those who administer amphetamines through intravenous injection generally run the potential risk of adverse health outcomes associated with that particular form of administration, most notably HIV or hepatitis infection but also abscesses and other serious medical conditions (see Loxley & Macdonald 1990 in Moore 1992a; Hall & Hando 1993; Vincent, Allsop & Shoobridge 1996; Vincent et al. 1999; Hando, Topp & Hall 1997).

Yet even oral use of amphetamines has its risks. The National Drug and Alcohol Research Centre (NDARC) lists some of the most common effects of amphetamine use as follows:

Short-term effects

- ◆ euphoria and well being
- ◆ increased energy and hyperactivity
- ◆ talkativeness
- ◆ reduction of appetite
- ◆ dry mouth

95 Despite the various papers presented at the symposium being ten years old, this research collection is still regarded as a key benchmark reference in this area.

96 Chesher had earlier stated: 'If amphetamines are correctly manufactured, if they are adulterated...with safe substances, and if they are taken orally...the potential for harm cannot be described as serious' (Chesher cited in Moore 1992a).

- ◆ increased blood pressure and heart rate
- ◆ nausea
- ◆ headaches.

And in large quantities:

- ◆ Stomach cramps
- ◆ Restlessness
- ◆ Irregular breathing
- ◆ Sweating
- ◆ Loss of coordination.⁹⁷

Symptoms such as tension, aggression (even to the point of violence), panic attacks, mood swings, depression and exhaustion may be particularly noticeable during the 'coming down' stage when the (pleasurable) effects of the drug are wearing off. The Australian Drug Council (ADC) noted that to combat such effects, users of amphetamines may also use benzodiazepines, cannabis, opiates and/or alcohol.⁹⁸ Regular users of amphetamines may also use such drugs to counteract long-term consequences of their use, such as insomnia (ADC 2002, p.2).

One mode of amphetamine use that is documented as being the most potentially dangerous pattern of use is that of 'bingeing' (see Churchill 1991; Chesher 1993; Hando & Hall 1993; Ovenden & Loxley 1996). Bingeing on psychostimulants is usually characterised as 'repeated use over several days involving the administration of high doses by injection' (Ovenden & Loxley 1996, p.33). Bingeing is considered particularly hazardous as it can result in increased dysphoria and toxicity 'potentially producing both behavioural and cardiovascular [adverse] effects' (Chesher 1993).⁹⁹

Long-term effects

The long-term effects of using amphetamine may include:

- sleep problems
- extreme mood swings
- compulsive repetition of actions
- paranoia
- depression and anxiety
- panic attacks
- seizures

97 This list of short-term effects of amphetamine use was compiled mainly from the Australian Drug Foundation 'Fact Sheet on Amphetamines' (2002) and the NDARC 'Fact Sheet – Amphetamines' (2003) as well as other fact sheets and information services.

98 The use of such drugs, particularly cannabis and alcohol is a common way of 'chilling out' during the comedown period of MDMA (ecstasy) use. See discussion below.

99 An account of 'bingeing' from a cultural and psychosocial perspective is given in Chapter 5.

- social and financial problems (NDARC 2002a, p.2).

To this list one could add:

- Cardiac arrhythmias
- Headaches
- Joint pains
- Malnutrition and weight loss (often one reason why amphetamines are used for functional purposes – ie. deliberate weight reduction)
- Aggression
- High blood pressure
- Reduced resistance to infection, poor immune system functioning (NDARC 2003).

The NDARC also suggests that, '[o]ne of the greatest problems experienced by amphetamine users is amphetamine-induced psychosis or "speed psychosis"'.

The extent to which 'speed psychosis' is manifested by amphetamine users is a matter of contention, although it is generally agreed to exist (see discussion below). The symptoms of speed psychosis are similar to those of paranoid schizophrenia, and may include:

- hallucinations
- paranoid delusions
- uncontrolled violent behaviour (NDARC 2002a, p.2).

This state usually disappears after the drug has been eliminated from the body, although the user remains vulnerable to further episodes. If the drug is used again, the psychosis may recur (NDARC 2002a, p.2).

Finally, in terms of general side effects and symptomology, a comprehensive survey of amphetamine and methamphetamine users in South Australia is instructive for the variety of responses it produced. One hundred users of these drugs were surveyed in 1995 and 1996. This wide-ranging survey elicited responses to a number of questions concerning adverse effects of taking amphetamines. These findings are worth repeating at length. The results showed that:

- Forty percent of the sample reported having experienced health problems which they thought may have been related to their use of amphetamines in the 12 months prior to interview. The most commonly reported problem was an increased susceptibility to infections (such as colds) due to reduced immunity (14%). Others had experienced a variety of problems such as stomach cramps, skin problems, and reduced fitness.
- Thirty percent of participants were taking prescribed medication for health problems at the time of interview. However, younger users were significantly less likely to be on such medication than older users.

- Mental health problems such as anxiety, panic attacks, depression, attempted suicide, mood swings, aggression, hallucinations, and paranoia were extremely prevalent in the sample (ranging from 17% for attempted suicide to 61% for depression). Although participants reported a high rate of these problems before they began using amphetamines, more people had experienced them since starting to use the drug.
- Younger users (aged 24 or less) were more likely than older users to report that they had experienced panic attacks, mood swings, and hallucinations before they started using amphetamines. There was also a greater self-reported prevalence of mood swings since using amphetamines in the younger group.
- Thirty-seven percent of participants had seen a psychiatrist or a psychologist for problems other than drug use in the past. Eight percent of participants said that this was due to behavioural problems while at school, while the remainder had been seen for a variety of problems including depression, eating disorders, agoraphobia, and post traumatic stress.
- Just under half of the women who had been pregnant in the sample had used amphetamines during pregnancy (n=11). Four women said that they had used the drug while breast feeding, and two had actually breast fed their baby while intoxicated with the drug.
- The mean score for the sample on the Severity of Dependence Scale (SDS) was 4.9 (S.D. = 3.7). Using a score of 4 or more as the criterion for dependence, 60% of the sample were classified as dependent on amphetamines.
- There were no differences between the young amphetamine users (aged 24 or less) and the older users (25+) on the SDS. Both groups had a mean SDS score of 4.9.
- Compared to non-dependent amphetamine users, dependent users had significantly less education, used alcohol, tobacco, and amphetamines on more days in the 6 months prior to interview, used a greater variety of other drugs, used more amphetamine in an average day, had a lower age at first injection of any drug, were more concerned about their risk of catching blood borne diseases, were more likely to inject amphetamines, had experienced more problems from injecting, and had poorer health on all sub-scales of the SF36 (with the exception of 'bodily pain').
- Increasing Severity of Dependence (SDS) scores were associated with a greater likelihood of having shared injecting equipment, having experienced recent health problems related to amphetamine use, being on medication for health problems at the time of interview, and having experienced anxiety, panic attacks, depression, mood swings, hallucinations, paranoia and violent outbursts since starting to use

amphetamines. Increasing SDS was also associated with a greater likelihood of having been involved in crime since using amphetamines, as well as a greater likelihood of having experienced other legal problems resulting from amphetamine use. In addition, those with higher levels of dependence were more likely to have been in treatment for their amphetamine use, to have thought about seeking treatment, and to believe that they needed treatment at the time of interview.

- Sixty-one percent of participants had driven a motor vehicle while intoxicated with amphetamines in the month prior to interview, with 45% of these people stating that they had also been drinking alcohol on some or all of these occasions.
- Seventy percent of participants had been involved in some form of criminal activity (not including dealing drugs amongst their friends) since they began using amphetamines. However, 57 of these people had also been involved in crime beforehand. Fifty-one percent of participants had carried out a crime or crimes whilst intoxicated with amphetamines (Vincent, Allsop & Shoobridge 1996, pp.379–380).

Issues pertaining to criminal activity, including driving a motor vehicle while intoxicated, are discussed later in this chapter.

Risk taking

The results of the Vincent survey are concerning in as much as they indicate a willingness to engage in risk-taking behaviour, notwithstanding the side effects that many of the respondents had experienced. The particular risk-taking behaviour manifested by the respondents to the Vincent study is shown in the following findings:

- Twenty-two percent of participants had shared a needle with at least one other person in the month preceding the interview. Of these, 3 participants had only received used injecting equipment from someone else, 9 had only given their used injecting equipment to someone else, and 10 had both given and received used injecting equipment.
- There was no significant difference between the number of young injecting amphetamine users (aged 24 or less) who had shared needles in the month prior to interview, and the number of older users (25+) who had shared (44% and 56% of those who had injected in the month prior to interview respectively).
- Ten percent of the sample had shared injecting equipment with their regular sexual partner, 9% had shared with a friend, 3% had shared with a relative, 3% had shared with an acquaintance, and 2% had shared with a casual sexual partner.
- Fifty percent of the sample said that they had shared injecting equipment with another person on at least one occasion in their drug using career, and almost 80% (n=39) of these people had used a needle

after someone else had used it. 38% of the sharers (n=19) said that they had done so because they did not have any new injecting equipment.

- Forty-seven percent of the sample said that they were in a steady relationship, although the length of these ranged from 2 weeks to 20 years (median = 18 months). Sixty percent of those in a steady relationship (n=28) said that they did not use condoms at all.
- Ninety-one percent of the sample had sex at least once in the 6 months prior to interview, and 82% had sex in the month preceding the interview. Fifty-two percent of participants had done so with only one person, and 19% had two sexual partners. Eleven percent had sex with 3 or more people in the month preceding interview. Only half of those who had sex with two or more people in the month preceding interview had used a condom on every occasion.
- A quarter of participants (n=25) had anal sex at least once in the six months preceding interview. Seven of these people were homosexual males, 13 were heterosexual, and 5 were bisexual. Only half of these participants had used a condom for every occasion of anal sex, and 32% (n=8) said that they never used a condom for anal sex. The remainder said that they used them occasionally. There were no significant differences between younger and older users either in the prevalence or frequency of anal sex, or in the use of condoms for anal sex (Vincent, Allsop & Shoobridge 1996, pp.377–378).

Such findings would seem to indicate the importance of tailoring comprehensive harm reduction strategies to the particular group subject to the intervention. This is a subject that will be discussed further in Chapter 8.

Tolerance and dependence

As with many drugs, it is possible for people, particularly regular or dependent users of amphetamines, to develop a tolerance to the drug whereby increasing amounts are needed to get the same effect that a lesser amount achieved originally. As the ADF states: 'The quantity taken can reach a stage at which no further increase in the amount taken will produce the desired effect' (ADF 2002, p.4).

Topp and her colleagues (2002) have also referred to 'the existence and destructive nature of an amphetamine dependence syndrome, comparable to that which exists for alcohol and heroin'.¹⁰⁰

Such a contention has been posited for some years now. In an early paper on amphetamine use among heavy and chronic users in Sydney, Hall and Hando state:

First, among heavy chronic users there is a risk of developing a dependence syndrome that is characterised by a prolonged withdrawal syndrome in which

100 See NDARC 2002b.

depression, lethargy and irritability contribute to a high relapse to use after abstinence, making it difficult to treat. Secondly, there is a risk, especially among injectors who use large doses, of developing a paranoid psychosis in which loosening of associations, delusions and auditory hallucinations are the most common symptoms. More conjecturally, there is a risk of chronic heavy users committing violent offences, perhaps while in the thrall of delusional thinking (Hall & Hando 1994, pp.277–278).

Hall and Hando followed up this study with another research project whereby 301 Sydney based amphetamine users were interviewed about their psychological symptoms prior to, and subsequent to, their initiation of amphetamine use:

The main findings of the study were: that there was a high prevalence of psychological morbidity among a sample of amphetamine users; that the prevalence of most psychological symptoms reportedly increased after the initiation of amphetamine use; and that the severity of these symptoms was related to the frequency of amphetamine use and injection as the usual route of administration. Just under half the sample (44%) showed psychological morbidity suggestive of a psychiatric diagnosis... These results confirm our earlier finding that a transition to injecting is correlated with serious psychological symptoms in amphetamine users (Hall & Hando 1996, p.85).

The academic literature has in more recent years continued discussing and debating such a phenomenon (see Churchill 1991; Hall & Hando 1994, 1996; Topp & Darke 1997; Hall et al. 1996; NDARC 2002b; Turning Point Alcohol and Drug Centre 2002 Confidential Submission).¹⁰¹ As with many drugs, such dependence may be physical, psychological or both.¹⁰² Withdrawal symptoms on cessation of use may include fatigue, depression, anxiety or panic and sleep disturbance, including nightmares. Burrows, Flaherty and Macavoy, drawing from the work of Wickes, note that the use of a small amount of amphetamine, particularly after a long period of abstinence, may result in a recurrence of psychotic symptoms or behaviour:

Amphetamines and cocaine can produce a psychosis clinically similar to that which occurs in paranoid schizophrenia. The psychosis may be preceded by pseudo-hallucinations of a persecutory nature, known to be unreal by the user. True hallucinations – usually auditory or visual, but sometimes olfactory or

101 For a relatively early account of an amphetamine dependence syndrome, see Churchill 1991. Churchill based his research on a sample of 101 amphetamine-dependent clients at what was then the Pleasant View Centre in Melbourne and looked at the ways in which the opiate dependence concept could be extended to the amphetamines. Churchill observed that many psychiatric hospital admissions are due to amphetamine induced psychosis and often mimic the symptoms of schizophrenia (Churchill 1991, p.72).

102 Topp and Darke's review of the dependency literature posits that an amphetamine dependency syndrome similar to that proposed by Edwards and Gross for alcohol and developed into the diagnosis of substance dependence in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (DSM IV, American Psychiatric Association 1994) exists and meets that criteria. In such cases: '[p]hysiological, behavioural and psychological components are all important in defining such problematic patterns of use' (Topp & Darke 1997, p.117).

tactile – may follow. Behaviour may be meaningless and repeated for long periods, and violent outbursts may occur. Once a methamphetamine induced psychosis has occurred, a single small dose after a prolonged period of abstinence may precipitate another psychotic episode. Also psychotic symptoms can last over several years in some methamphetamine users (Burrows, Flaherty & Macavoy 1993, p.5).

Yui et al. have more recently also documented accounts of spontaneous recurrences of amphetamine or methamphetamine induced paranoid hallucinatory states (flashbacks) which may on occasion occur in response to stress (Yui et al. 2000).

Notwithstanding such views, in the past there has been some doubt expressed as to whether and to what extent an amphetamine dependence syndrome exists. Dr Nick Lintzeris, formerly Senior Medical Officer at Turning Point Alcohol and Drug Centre, expressed the following cautious view in an interview given in 1997. It is worth reproducing in full:

“There’s a lot of evidence to suggest that amphetamine users do experience problems. But these are not always necessarily caused by their amphetamine use,” he says.

“I think that’s one of the unfortunate things to come out of some of the research – you go and ask an amphetamine user, ‘have you ever had problems with ...?’, and you assume that any problems must be because of their amphetamine use. But that’s not necessarily the case at all.”

He asks how often, in the harms described, could amphetamine use actually be a form of self-medication?

“Are the reported suicidal feelings and depression, for example, caused by amphetamine use, or are they actually using amphetamine because they’ve been feeling so lousy?”

“As well, because symptoms are vague and amphetamine users commonly use other drugs, withdrawal symptoms could be due to dependence on any of a number of drugs”, he says.

Dr Lintzeris says that linking harm with dependence is wrong, and that the evidence for an amphetamine dependence syndrome is actually “somewhat shaky”. “It comes from applying models of dependence that were developed for alcohol and heroin to amphetamine”, he says. While such measures may show speed dependence, “that’s not necessarily the best way of describing it.”

Despite the difficulties in determining dependence, Dr Lintzeris is convinced that some people do experience quite specific symptoms related to stopping amphetamine use. However, the level and duration of use required before such symptoms manifest is unknown.

In fact, withdrawal from amphetamine is generally poorly understood...

He described a series of symptoms associated with stopping speed use, the most common of which he called the ‘crash’ phase. This occurred from day

one to three, and symptoms were exhaustion, increased sleep and depression. Following this could come a proper withdrawal period peaking at 7 to 14 days but lasting up to 3 months, during which users may experience decreasing episodic cravings, mood swings, sleep disturbance and increasing appetite.

"Most people who use a lot of amphetamines will experience that crash phase – but that's not withdrawal. How many people experience full-blown withdrawal syndromes? I think it's a minority of people, but the bottom line is that we don't know" (Dr Nick Lintzeris quoted in Wood 1998a, pp.21–22).

Expert researchers in this area, Hall and Hando, are also cautious about making too much of an amphetamine dependence syndrome in cases where the user is neither an injector nor a regular user:

Amphetamines are not the benign drugs many users believe them to be, especially when injected on a regular basis. For those who continue to use amphetamines our advice would be: if you wish to reduce the risks of developing dependence or symptoms of a paranoid psychosis, avoid injection or regular use (say more than once a week), and do not use more than half a 'street' gram by any route. Beware of the increased risks that intoxication with amphetamine and alcohol together poses for motor vehicle and other accidents... If amphetamine use is detected in young adults...practitioners should give factual information about the risks of injecting amphetamine, while being careful to avoid overstating the dangers of intermittent oral use (which may have the unintended consequence of increasing scepticism among illicit drug users about the veracity of all health information about amphetamine). Those users who indicate that they intend to continue to use the drug should be given simple advice on less harmful methods of administration and frequency of use, along the lines indicated above (Hall & Hando 1993, pp.643, 644).¹⁰³

Given that there is still some uncertainty as to the nature and extent of an independent amphetamine dependency syndrome, it is timely and useful that local authors Morefield et al.,¹⁰⁴ based at the Drug and Alcohol Services Council (DASC) (South Australia), are conducting the Australian component of the World Health Organisation Multi Centre Project on Methamphetamine Induced Psychosis. Similar research is being conducted simultaneously in Japan, Thailand and the Philippines. The authors explain the study in a submission to this Inquiry:

The major element of this research comprises the interviews that were conducted with 50 inpatients diagnosed with methamphetamine psychosis, recruited from psychiatric facilities within the South Australian Metropolitan area. These interviews investigated patients' past and recent substance use patterns, their experiences relating to methamphetamine use, and their

103 For further discussion of 'harm reduction' techniques, advice and programmes, see Chapter 8.

104 Attached to a confidential submission given to the Drugs and Crime Prevention Committee for this Inquiry by the Turning Point Alcohol and Drug Centre, August 2002.

psychiatric symptoms. Secondary data sources were also employed in this research. The treatment provided to the interviewed patients was investigated and the medical records of patients discharged from treating institutions...with a diagnosis of methamphetamine psychosis were also reviewed...¹⁰⁵

The Committee awaits with interest the final findings of the research project.

Cognitive functioning

The ability to which a person's cognitive abilities are affected by the use, particularly long-term use, of amphetamines is also an area of debate. Turning Point refers to recent research by Topp et al. that suggests:

[h]eavy amphetamine use has been associated with neuropsychological deficits that could not be accounted for by premorbid intelligence, concurrent polydrug use or acute intoxication. This deficit is related specifically to the inability among heavy users to focus attention in relevant stimuli, leading to an increased load on limited attentional resources (NDARC 2002b, p.131).¹⁰⁶

Simon et al. undertook one of the few studies of cognitive impairment in individuals who are *currently* using methamphetamines. This 1999 study of 65 self-reporting methamphetamine users in San Bernadino, California, noted that methamphetamine users were significantly more impaired than non-users in a variety of cognitive functioning tests, including recall and memory tasks and the manipulation of information. Although the sample was small, the findings were an important 'first step in elucidating the consequences of methamphetamine use' (Simon et al. 2000, p.230). The authors also make the salutary observation that:

It is important to distinguish between the 'the effects of long term use' and the 'long term effects' of methamphetamines. The former which are the topic of this study are the cognitive effects of using methamphetamines over a long period of time. The 'long term effects' of methamphetamines are the effects of using methamphetamines that persist over a period of time (Simon et al. 2000, p.222).

With regard to the latter phenomenon, clearly more longitudinal research needs to be done with ex-users of amphetamines and methamphetamines.

Research by McKetin and Mattick (1997) examined attention, memory and cognitive functioning in a group of illicit amphetamine users (N= 78) in Sydney, Australia. Based on the outcomes of that study and a review of earlier research, the authors state that:

Dependence on amphetamine has been associated with poor psychological health, especially in younger individuals who frequently use large amounts of amphetamine... Psychological problems reported by amphetamine users

105 Submission of the DASC to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

106 And see discussion below for possible links between brain damage, reduced cognitive functioning and the consumption of MDMA ('ecstasy').

included feeling scattered, vague, distracted and problems with concentration that impeded work performance or study. Most previous investigations of neuropsychological functioning in amphetamine users have examined the impact of amphetamine use in the context of poly drug use... The low number of heavy amphetamine users in these studies makes it difficult to infer the neuropsychological impact of amphetamine use per se.... [However] The results of this study show that severely dependent amphetamine users suffer from poor memory and concentration, performing from half to one standard deviation worse on WMS-R indices than less dependent amphetamine users. This study also found preliminary evidence that a history of heavy amphetamine use, particularly injecting more than 3–4 days per week, was associated with impairment of visual memory tasks (McKetin & Mattick 1997, pp.235, 240).

The research into the effect of amphetamines, ecstasy and indeed many illicit drugs on brain functioning and related issues of neurotoxicity is still relatively embryonic. This, as shall be discussed later in the chapter, is particularly problematic in the context of MDMA (ecstasy). At a conference in Chicago in 1998, some of the best academic and scientific thinking on the relationship between psychostimulants and brain functioning and brain behaviour was presented (see the summaries in Battaglia & Napier 1998). In particular, the contributors noted:

With respect to psychostimulant induced neurotoxicity, the evidence indicates that the amphetamines may produce long term, possibly irreversible, neurotic changes in both dopaminergic and serotonergic neurons, and that the readily observed biochemical changes appear to have a functional counterpart (Emanuele in Battaglia & Napier 1998, p.47).

The Chicago conference also discussed the possibility of amphetamine-related foetal and pre-natal exposure and possible consequent harms, particularly on the foetal brain:¹⁰⁷

[c]onferring on off-spring potential 'neurochemical handicaps' that may render them more vulnerable to developing clinical disorders or patterns of drug abuse during their lifetime (Emanuele in Battaglia & Napier 1998, p.47):

It is salutary, however, to point out, as the Chicago presenters do themselves, that while these possible connections are serious and plausible they need to be addressed by much further research.

Impure drug combinations

The ADF also counsels the need to be aware of the health consequences of using amphetamines that are of impure quality:

Most amphetamines sold illegally contain a mixture of pure amphetamines and other substances such as sugar, glucose, bicarbonate of soda and

107 For further discussion of the links between psychostimulant use and pregnancy, see Wickes 1992, pp.18ff; Wickes 1993, pp.40ff and the references cited therein.

ephedrine. These additives can be highly poisonous. They can cause collapsed veins, tetanus, abscesses and damage to the heart, lungs, liver and brain. And because the user doesn't know whether they are using five per cent or 50 per cent pure amphetamines, it is easy to overdose by accident... Due to the unknown strength and mix of street amphetamines, some users have overdosed and experienced strokes, heart failure, seizures and high body temperature. Some have died as a result. Injecting runs a greater risk of overdosing due to large amounts of the drug entering the bloodstream and quick travelling to the brain (ADF 2002, p.3).

Psychostimulants and medication interactions

One particular problem associated with drug and medical interactions concerns those people who may take medication related to HIV infection, such as antivirals, and simultaneously take recreational drugs. The relatively common use of amphetamines and 'party drugs' at gay dance parties may make gay men with HIV particularly vulnerable. Such a combination is acknowledged to be dangerous and unpredictable, and can have especially damaging results on liver functioning.¹⁰⁸ In general terms, there has been concern expressed, particularly in the United States, about the connection between high risk sexual behaviour and HIV infection among gay and bisexual male methamphetamine users. Research conducted by Frosch et al. (1996) states that:

Gay and bisexual men represent one group in which the connection between methamphetamine abuse and high risk sexual behaviour appears most pronounced. One study that examined the correspondence between HIV risk behaviours and drug use among gay and bisexual men found increased instances of reported unprotected high risk sex for those men who admitted to drug use, most strikingly those who used amphetamines.

Clinically, urban gay and bisexual males often report that they use methamphetamine to 'intensify' their emotions and sensations, particularly sexual ones...¹⁰⁹ and that methamphetamine is often consumed in highly charged sexual contexts such as bathhouses, sex clubs, and sex work situations. Chronic methamphetamine abuse can result in a specific sexual dysfunction known among users as 'crystal dick', a condition in which men are unable to achieve a full penile erection. Because of this, methamphetamine has been described as a drug that creates 'instant bottoms' [i.e.] increased libido due to methamphetamine abuse, coupled with an inability to achieve a full erection, can lead to multiple episodes of anal receptive sex with anonymous partners and little or no concern about condom use. Some users further

108 For an account of such interactions and some harm minimisation measures to reduce the risks, see Ryan and Keen 2001, p.4.

109 For further discussion of amphetamine and other drug use in gay and bisexual men and its connection to HIV and other health outcomes, see Heischouer and Miller 1991; Paul, Stall and Davis 1993; and in the Australian context, Hando and Hall 1994 ('Study of amphetamine use and HIV risk taking among young Sydney adults'); Murnane et al. 2000.

increase their particularly high risk for HIV transmission by administering methamphetamine intravenously, which corresponds to dramatically increased HIV seropositivity rates (Frosch et al. 1996, p.484).

Similar cause for concern has been documented with regard to MDMA/ecstasy use among gay and bisexual males. For convenience sake this aspect of ecstasy use is discussed in this section. In a recent study of gay and bisexual men who use MDMA in New York City it was found that:

MDMA users were found to be younger, less educated, to have had more male partners, more one night stands with men, more visits to bars or clubs and sex clubs or bathhouses, to have unprotected anal sex with a male, to be likely to have been the victim of physical domestic violence... MDMA users thus constitute a group at risk for sexually transmitted diseases, including HIV and other problems. The data suggest that MDMA use is associated with being more 'out', which may be advantageous in helping gay men deal with harmful psychological effects of stigma, but may place individuals in settings that expose them to MDMA...

Media reports suggest that MDMA use is particularly prevalent in the gay community... Indeed in a prior study we found that among the 169 gay and bisexual men recruited from three dance clubs in New York City, 34% had used MDMA in the past month. About half (52%) had used MDMA in the past year, and those MDMA users were 2.8 times more likely than non users to have had unprotected anal sex in the past year (Klitzmann et al. 2000). In fact among recreational drugs, only MDMA was found to be associated with unsafe sex in this sample (Klitzmann et al. 2002, pp.115, 116).

Of course the experiences of a sample in New York cannot necessarily be extrapolated to the Australian context. However, a comprehensive survey of drug use in the gay, bisexual and lesbian communities of Melbourne suggests that the parallels and circumstances are, at least in part, similar (Murnane et al. 2000). Certainly, both Australian and overseas data suggests, as discussed in Chapter 2, that if the mode of amphetamine administration is via intravenous injection the health-related risks and consequences, including HIV infection, are far greater¹¹⁰ (Hall & Hando 1994; Vincent, Allsop & Shooobridge, 1996; Vincent et al. 1999; NDARC 2002b). An examination of the patterns of use and the culture of drug taking among local gay and lesbian communities is found in Chapter 5.

110 Another possible cause for concern arises from some anecdotal evidence that some dance drug users, including gay men, are combining Viagra with stimulants and MDMA to facilitate and prolong sex after dance parties. The side effects of using Viagra in such circumstances may include 'dramatic drops in blood pressure, fainting, blackouts and coma' (see NDARC 'Viagra: the new party drug?' www.med.unsw.edu.au/ndarc/questions/jjjviagra.htm).

Physical and psychological consequences – Ecstasy (MDMA)

In Australia and the United States early research documented relatively few problems associated with ecstasy use. For example, comprehensive survey research undertaken by Solowij (Solowij et al. 1992; Solowij 1993) found the most common adverse effects of ecstasy use were relatively minor. These included loss of appetite and a dry mouth. In a recent monograph on ecstasy use produced by the NDARC, Topp et al. summarised some of the academic and medical views towards ecstasy as follows:

The results of the [Solowij] study confirmed those of early studies conducted in the United States (Beck, 1990; Beck and Rosenbaum 1994; Downing 1996; Petrouka 1990; Petrouka, Newman and Harris 1988). They provided support for suggestions that while the pattern of ecstasy use remained one of intermittent oral use, there was little cause for concern because use was usually self-limited and there were few extreme reactions or severe problems among users (Beck and Rosenbaum 1994; Chesher 1990; Solowij 1993). Such results seemed to confirm the prevailing view that ecstasy was a relatively benign substance with few associated problems (NDARC 1998, p.1).

Since the mid to late 1990s, many such researchers, including Solowij, have reassessed such views, particularly in the light of evidence that ecstasy is increasingly been used via injection and that the purity of what purports to be MDMA (ecstasy) has been seriously compromised in recent years.

It would seem that the 'jury is still out' regarding the extent to which serious medical consequences may follow the ingestion of MDMA (ecstasy). A recent international symposium on MDMA use world-wide summed up the dilemmas for the researcher:

The capacity for analysis of the health consequences of MDMA is limited by the lack of epidemiological studies. The only current source of information is case reports. Analysis of case reports is problematic as firstly, there is no way to determine whether reported cases are representative of the population of MDMA users and, secondly, there is likely to be significant publication bias, with 'novel' and severe cases being preferred for publication. Furthermore, there tends to be variability in the nature of data collected and reported and outcomes assessed for each case report, often reflecting whatever theme is being debated through scientific and medical literature at the time.

Another limitation is variability in information on drug use preceding the episode. Quantification of drugs in blood and urine samples is not always undertaken, and differing intervals between drug use and presentation for treatment influence the possibility and interpretation of testing. The extent and accuracy of reporting of drug use by the patient or observers, and on medical history prior to the adverse event is also variable (and often limited in cases with fatal outcomes).

A further difficulty in attributing causality of the adverse event to 'ecstasy' is variability in the purity of the ingested substance, together with the tendency for MDMA to be used in conjunction with other drugs (Gowing et al. 2001, p.25 and references cited therein).

Notwithstanding such limitations, some general factors and indications can be given for both the short and long-term health consequences of MDMA ecstasy use.¹¹¹

Short-term effects

These may include:

- euphoria and a feeling of well-being
- feelings of increased closeness with others
- increased self-confidence
- lack of inhibitions
- tongue and cheek chewing
- teeth grinding (bruxism)¹¹²
- dry mouth
- increased body temperature
- nausea and anxiety
- sweating
- inability to sleep (NDARC 2002a, p.2).

A number of surveys and research reports have canvassed the short-term effects of ecstasy use, including both during the 'high' and 'come down' stages.¹¹³ Such surveys are complicated, however, by the fact that many of those surveyed were using other drugs in addition to ecstasy, such as benzodiazepenes, opiates, cocaine and/or methamphetamines. It is sometimes difficult to know whether a side effect or adverse consequence can be isolated to one particular drug or an interaction or combination of a number of drugs (see Williamson et al. 1997). Nonetheless, some adverse effects common to ecstasy use have been

111 For an excellent, if technical, account of some of the major short and long-term effects of MDMA use, see Gowing et al. 2001, pp.25ff. This comprehensive examination includes a discussion inter alia of:

Hyperthermia
Hyponatraemia (excessive fluid)
Central nervous system disturbances
Cardiac factors
Cerebrovascular concerns
Respiratory factors
Trauma
Ophthalmic conditions
Liver and kidney damage
Psychiatric sequelae.

112 For a discussion of the links between regular use of MDMA and the excessive wear of the teeth and tooth damage, see Redfearn, Agrawal and Mair 1998.

113 See for example, Moore 1992a; Williamson et al. 1997.

frequently noted in such surveys. For example, in a British survey of 158 drug users, subjects were presented with a list of ten adverse effects and asked to rate them in terms of severity when applied to a number of drugs. With regards to ecstasy the authors note:

Many of the users reported adverse effects after having taken Ecstasy. The frequency with which adverse effects were reported varied from 21% for panic attacks to 79% for loss of appetite. In terms of severity, the majority of effects associated with use of Ecstasy were classed as mild by respondents. Trouble sleeping and loss of appetite scored most highly in severity...along with mood swings and lethargy...(Williamson et al. 1997, p.91).

The severity of the side effects is variable and, as stated by Moore (1992a), is shaped by the quality, quantity and purity of the drug and the individual's reaction to the drug. One might add that the frequency of use, the setting of use and whether or not the drug is used in combination with other substances all have a bearing on the extent or severity of any adverse effects.

It is also important to note that not all such side-effects will be experienced with each drug episode. For many episodes, few will be experienced; for some episodes several will be experienced; and, on rare occasions, a drug user might experience many of the reported effects. The following then are aggregations of the multiple possibilities.

When taken orally or intranasally, speed and Ecstasy share similar side-effects – excessive sweating, jaw-grinding or clenching, intermittent paranoia, general fatigue (when coming down,) loss of appetite, occasional bouts of nausea and vomiting, skin rashes, anxiety, and blurred or 'glassy' vision (in the case of Ecstasy). Side-effects resulting from trips include 'a bad trip' – an inability to interact coherently with others and to deal with the sometimes disorienting visual and/or mental hallucinations – 'flashbacks' to the tripping state (such as seeing colours or objects moving, although this seems to be a characteristic of people who have used trips with greater frequency), paranoia, painful introspection, and generally unpredictable behaviour.

Injecting speed, Ecstasy or trips may produce bruising at the injection site, the possibility of 'dirty tastes' (from adulterants or unhygienic injecting conditions), 'missing' (when the needle tip slips through or out of a vein leading to injection of the drug into the flesh), and 'trackmarks' (scarred veins), collapsed veins or acute pain (when injecting) from frequent injection in the same site. Such consequences stem from intoxication or manner of administration and are usually considered relatively minor by drug users. Unless they become frequent, regular, or painful or detract greatly from the drug experience, they are not generally considered detrimental enough to cease drug use altogether, but may lead to a reduction in frequency or attempts to remain abstinent for a period. For instance, attending a nightclub under the influence of speed may lead to sweating, jaw-grinding and a loss of appetite which, in this setting, will not be considered overly vexatious (Moore 1992a, pp.62–63).

An international symposium on MDMA also pointed to the complex clinical issues pertaining to determining the effect of MDMA on its users:

MDMA and other similar drugs based on the structure of amphetamine, have been shown to be toxic in animals and humans. It appears, however, that the type and severity of toxicity is influenced by many factors, such as ambient temperature, exercise, concurrent administration of other drugs and hydration... These variables when added to the large number of chemical species sold as 'ecstasy', or found as contaminants of street 'ecstasy' provide a very complex problem for scientists and clinicians alike (Gowing et al. 2001, p.20).

Some of the worst of the side effects reported by drug users are associated with the 'coming down' period immediately following intoxication. Such a period with regard to ecstasy may last from a few hours to a few days. The ecstasy come down is usually not viewed as anywhere near as severe as that associated with amphetamines or LSD (Moore 1992a). Moore describes the experience as follows:

Except when used in large quantities for long periods or with other drugs such as speed and/or trips, Ecstasy is distinctive for its gentle 'comedown' (relative at least to speed or trips), particularly after a single dose. Those who have been using it constantly for several days (usually in conjunction with other drugs) may experience unpleasant effects, although it is hard to fathom which drug is responsible for these. After finally going to sleep in the early hours of the morning, those individuals who have used Ecstasy report sleeping well (often with vivid and sometimes pleasant dreams) and waking with a positive outlook on the next day. Ecstasy is held to contribute to a general feeling of well-being which may last several days after the experience. Even those who do experience some 'comedown' from heavy Ecstasy use describe it as being less traumatic than that induced by trips or speed.

The negative effects of 'coming down' are exacerbated by the sometimes massive consumption of alcohol made possible by (in particular) speed, trips and Ecstasy (the number of drinks required to reach a subjective feeling of intoxication is greatly increased), and by the mixing of large quantities of various drugs. For example, one person told me that she consumed Ecstasy twenty-seven times in one week and that this was in addition to the speed and trips she has also used. Needless to say, she experienced a severe 'comedown' when consumption ended (Moore 1992a, p.62).

Another significant factor that needs to be taken into account, as noted above in the context of amphetamine use, is the possibility that ingestion of MDMA ecstasy may result in a readiness to take risks with regard to sexual behaviour. Klitzmann et al., for example, have noted the potential for greater HIV risk-taking behaviour when gay men in particular have ingested MDMA.¹¹⁴

114 See Klitzmann et al. 2002. See also the discussion in Frosch 1996; Moore 1992a, p.66.

Two of the most significant of the adverse effects of taking ecstasy are hyperthermia and hyponatraemia. These are discussed in the section below pertaining to ecstasy-related deaths.

Finally, in this brief discussion of the short-term side effects of ecstasy use it is worth examining the result of one of the most comprehensive survey of ecstasy users done in recent times – the South Australian Party Drug Trends study (2001) by Longo et al., auspiced by the Illicit Drug Reporting System (IDRS) for the NDARC (cited as NDARC 2002c). This survey of 70 South Australian ecstasy users questioned the participants as to physical and psychological side effects associated with ecstasy use and the social and legal problems associated with the drug.¹¹⁵ The results make for interesting reading.

The mean number of total side-effects reported in the previous six months was 16.5 (SD4.5; range 9–29). Subjects reported a mean of 10.8 physical side-effects (SD 3.1; range 4–20). The most common were teeth problems (caused by teeth grinding and jaw clenching), loss of appetite, muscular aches, loss of energy, trouble sleeping and numbness/tingling. Many subjects also reported blurred vision, heart palpitations, profuse sweating, hot/cold flushes, tremors/shakes and joint pains/stiffness. A mean of 5.7 psychological side-effects were reported (SD 2.2; range 2–11), most commonly confusion (disorientation, short-term memory loss and vagueness), depression, irritability, visual hallucinations and anxiety. Many subjects also reported paranoia and auditory hallucinations.

There were 22 subjects who reported additional effects they had experienced while taking ecstasy over the previous six months. The most common was a feeling of closeness to others, which included bonding, sharing and connecting, and an increase in tactile and demonstrative behaviour (n=7). Three subjects reported a general feeling of well-being, such as feeling confident, secure and safe, and two reported an increase in energy. Three subjects reported feeling nauseous, and two had experienced distortions in their perception of time.

Males reported a mean number of 10.9 physical side effects and 5.8 psychological side-effects, and females reported a mean number of 10.8 physical side effects and 5.6 psychological side-effects. The number of side-effects was thus very similar between males and females. A comparison was also made between the number of side-effects in subjects aged under 25 years, and those aged 25 years or more. The younger subjects reported a mean number of 11.1 physical side effects and 6 psychological side-effects. In comparison, the older subjects reported a mean number of 9.9 physical side effects and 4.5 psychological side-effects. Although there was no statistically significant difference in the number of physical side-effects according to age, the younger users reported a significantly higher number of psychological side-effects...

115 This aspect of the survey is dealt with later in this chapter.

The number of side-effects reported by subjects were also compared according to whether they had injected ecstasy either recently or in the past, or whether they had ever injected a drug. There were no significant differences found, with one exception. Subjects who had injected ecstasy in the previous six months reported a significantly higher mean number of psychological side-effects compared with those who had not...

Many of the physical side-effects experienced by subjects were attributed to ecstasy use. The physical side-effects that were attributed *solely* to ecstasy use by more than 70% of those who reported them included blurred vision, vomiting, tremors or shakes, numbness or tingling, hot/cold flushes, inability to urinate and loss of appetite. Moreover, side-effects such as dizziness, loss of energy, difficulty sleeping, headaches, heart palpitations, stomach pains and teeth problems as a result of grinding and jaw clenching were attributed solely to ecstasy by 50–70% of subjects who reported them... Although muscular aches and pains were experienced by 80% of subjects, only 12.5% attributed this solely to ecstasy use, saying that these effects were predominantly due to the excessive activity and energy that occurs in the environment where ecstasy is often taken, that is dancing at raves and clubs.

In contrast, all of the psychological side-effects were attributed solely to ecstasy use by at least 50% of those who reported them, and in most cases by over 70% of subjects. The side-effects attributed to ecstasy by at least three-quarters of subjects included depression, confusion, irritability, memory lapses, visual and auditory hallucinations, flashbacks and violent behaviour (NDARC 2002c, pp.37–39). (Author's emphasis)

Despite these myriad side effects being reported, the authors of the study were most concerned about the concurrent use by the respondents of a wide range of drugs in addition to ecstasy and the unpredictable health risks flowing from this. Such concern accords with that noted by Topp et al. in a 1999 study of 329 ecstasy users in three Australian cities (Sydney, Brisbane and Melbourne) where:

A broad range of ecstasy users were interviewed, but on the whole, the sample was young, relatively well educated and most were employed or students. Patterns of use were varied, although extensive polydrug use was the norm. High rates of intravenous drug use were recorded, which may relate to an over representation of chaotic intravenous polydrug users (Topp et al. 1999, p.105).

Long-term effects

It was noted in Chapter 2 that when ecstasy first arrived on the scene both in Australia and overseas it gave little cause for concern in terms of its potential for abuse and any deleterious medical or other consequences emanating from its use, particularly in the long term (see Fitzgerald 1991; Solowij, Hall & Lee 1992; Solowij 1993; Hando, Topp & Dillon 1998; Topp et al. 1999. And the references listed therein).

By the late 1990s, however, ecstasy was no longer seen as so benign. There were two main reasons for this, both related to each other. First, a number of deaths had been reported that were attributed to the use of ecstasy or what purported to be ecstasy. Second, according to some commentators, the media was taking a closer and sometimes prurient and irresponsible look at the drug and its associated culture (see Solowij, Hall & Lee 1992; O'Neill 1996; Sweet 1997; Saunders 1998; Lumby 2000; Luckman 2000; Teece & Makkai 2000). The media speculation and hyperbole, always inimical to the development of good public policy, reached its most intense pitch with the death of 15-year-old Sydney schoolgirl, Anna Wood, following on as it did from equally sensationalised accounts of ecstasy deaths in Britain and the United States. The issue of 'party drugs' and the media, including the death of Anna Wood, will be discussed further in Chapter 8.¹¹⁶ However, it is worth stating here that many media accounts at this time were not helpful in giving an accurate picture of just how dangerous or not the drug MDMA or its analogues in fact was and is. For example, Libby Topp, a researcher with the National Drug and Alcohol Research Centre, found in her interviews with ecstasy users that many young people who take ecstasy were dismissive about legitimate health issues pertaining to ecstasy because of the hype surrounding Anna Wood's death:

She adds that many ravers call a good night out an 'Anna Wood' night, as an expression of their frustration at ecstasy myths. "We really need to get off the idea that everyone who has an ecstasy is going to die" she says, citing a recent European review estimating the risk of dying from taking one ecstasy tablet at one in 3.4 million compared with a risk of one in 84,500 of dying from skydiving... Dr Andrew Byrne, a Redfern GP specialising in drug and alcohol treatment adds: "I get about three calls a year about ecstasy, compared with three calls a day about heroin and cocaine". It is difficult to escape comparisons with alcohol, which contributes to so many traffic and work accidents and to so much ugly violence, apart from not being terribly good for many of our vital organs (Topp quoted in Sweet 1997, p.6).

Certainly medical and research opinion was becoming less sanguine regarding the possible medical side effects of ecstasy by the late 1990s. It should be stressed, however, that much of the concern was and is not so much with regard to pure methylendioxyamphetamine (MDMA), the ostensible compound that makes up ecstasy. Rather, it was centred on what was being sold or traded as ecstasy and in fact is another drug altogether or is adulterated with more dangerous substances. Samples of ecstasy analysed in earlier years may have been relatively free of contaminants and therefore masked or at least confounded any possible adverse side effects (Fitzgerald 1991). Hando, Topp and Dillon track this change in professional thinking on the subject:

116 A detailed discussion of the role of the media with regard to amphetamines and 'party drugs' may be included in the Final Report for this Inquiry. The Committee welcomes input by way of submission from parties with experience or an interest in this area.

It was suggested that while the pattern of 'ecstasy' use remained one of intermittent oral use, there was little cause for concern because the use was usually self-limited and there were few extreme reactions or severe problems among users (Solowij 1993).

However, in recent years there has been a growing number of deaths in which 'ecstasy' has been implicated, both in Australia and overseas... Deaths have most often been attributed to heat stroke resulting from the circumstances in which 'ecstasy' is used, such as dance parties. It appears that a combination of sustained physical exertion, high ambient temperatures and inadequate fluid replacement compound a direct pharmacological effect of 'ecstasy' on thermo-regulatory mechanisms, leading to fulminant hyperthermia. This effect is in part a result of 'ecstasy's' neurotoxic effects on serotonergic nerve terminals, but such extreme reactions are idiosyncratic for reasons as yet unknown. On the other hand, some deaths have been attributed to excessive water consumption.

Other risks stem from the consumption of large doses of 'ecstasy' (acute or cumulative), a history of psychiatric disturbance or pre-existing disease... Research has also noted significant psychological morbidity associated with the use of 'ecstasy'.

Little systematic research on 'ecstasy' related harms has been conducted since the early 1990s. There is also little information about the intervention preferences of 'ecstasy' users necessary for the develop [sic] of public policy (Hando, Topp & Dillon 1998, pp.33–34).

It is still true to state that a paucity of research in this area has resulted in the long-term effects of ecstasy being clouded in uncertainty. It is equally true that there is still a certain amount of disagreement both within and outside the research community as to how dangerous in fact ecstasy is.¹¹⁷ This is particularly the case with regard to the effect of ecstasy on the brain and brain and cognitive functioning (see for example, Saunders 1998; Concar 2002). Very recent Australian research has explored the impact of regular use of ecstasy on memory function (Simon & Mattick 2002). Another Australian study found a reduction in memory retention and performance in ecstasy users compared to non-users (Dr Jeff Ward and his research team at the Australian National University). This was still the case even for those users who had not taken the drug for two years (quoted in *Youth Studies Australia* 2002, p.15). Such research is, for the most part, still at an embryonic stage.

Despite the doubts of some scientists as to the effect on brain function of ecstasy and other amphetamine analogues, after a comprehensive review of the

117 Saunders argues that both media reporting of and research into drug use generally, and MDMA specifically, is biased:

'Research into drug use is...biased through the grant application process. Funding to study negative effects of illicit drugs is available, while funding to study possible benefits is not. Publication of results is frequently biased, even respected journals reporting negative results of illicit drug use without evidence' (Saunders 1998, p.98).

medical evidence a recent international symposium on ecstasy felt confident enough to state:

Thus, there is continuing mounting evidence, by a number of independent research groups, supporting the concept of brain damage as a result of recreational use of MDMA. It appears that the most common functional deficit, so far revealed, is in short term memory... Overall, on the basis of animal and human data, it would appear that brain damage is largely irreversible and does not depend on an extensive history of MDMA use. Hence it is likely that the incidence of this irreversible neurotoxicity will be high in all users of MDMA. As this population ages, and normal brain function naturally declines, the effects of previous MDMA brain damage may present itself as a range of neurological and/or cognitive disorders... (Gowing et al. 2001, pp.23, 24).¹¹⁸

Long-term effects are also difficult to track and detect because many MDMA users may also be poly drug users (Beck 1989 in Fitzgerald 1991). Nonetheless, there is a general acceptance, as stated above, that long-term use, frequent use and particularly taking large amounts may have an effect on neurotoxicity,¹¹⁹ memory and cognition problems, and possibly depression.

MDMA and psychiatric morbidity

Other than problems pertaining to cognition and memory outlined above, depression and low mood 'is reported by users as relatively common in the week following ecstasy use' (Gowing et al. 2001, p.33). Gowing et al. review the published literature on psychiatric sequelae attributed to ecstasy use and find that there are definite connections of varying severity in three groups: altered mental state associated with intoxication; persistent or chronic sequelae; and in a very small number of cases, suicide. They summarise the research as follows:

Overall, these reports indicate a clear association between ecstasy use and subsequent short-term mood changes. More severe psychiatric sequelae, including depression, panic disorders, psychoses and anxiety, may occur but probably only in those individuals made vulnerable by personal or family history of psychiatric disturbance, by stress or by concurrent use of other drugs (Gowing et al. 2001, p.34).

A British study comparing 12 heavy recreational users of ecstasy, 16 light users and 22 non-ecstasy user controls with group mean ages of 21 was conducted in 2000 (Parrott, Sisk & Turner 2000). The study found that:

Heavy Ecstasy users reported significantly higher scores than controls on the following SCL-90 factors: paranoid ideation, psychoticism, Somatisation,

118 For specific accounts of MDMA and its links with cognitive functioning, including memory deficits, see Wareing, Fisk and Murphy 2000; Black, Farrell and McGuire 1992. The latter relatively early article questions whether MDMA has the potential to induce psychiatric illness that otherwise may not occur or merely exacerbates it in people already susceptible.

119 Boot, McGregor and Hall state that a review of MDMA studies suggests that 'MDMA can be neurotoxic with those who use two or more doses of MDMA at a time, who inject it, or use it frequently' (2000, p.1818).

obsessionality, anxiety, hostility, phobic anxiety, altered appetite and restless sleep, together with greater IVE impulsiveness. Light ecstasy users generally produced intermediate scores, with significantly higher scores than controls on two factors and significantly lower scores than heavy ecstasy users on another two. Previous reports have described various psychiatric and psychobiological disorders in recreational ecstasy users, but it is not known how typical they are, being mainly based on individual case studies. This is the first study to describe psychological problems in a non clinical sample of young recreational ecstasy users. However, our ecstasy users were polydrug users, with both groups showing significantly greater usage of amphetamine, LSD and cocaine than the controls. These other illicit drugs probably contributed to their adverse psychobiological profiles, while there is also the possibility of pre-existing differences between ecstasy users and non users. However, since repeated MDMA can cause serotonergic neurotoxicity in laboratory animals and man, these problems may reflect reduced serotonin activity induced by regular ecstasy use (Parrott, Sisk & Turner 2000, p.105).

The concern with regard to poly drug use among ecstasy users is similar to that found in the South Australian ecstasy use study cited earlier (NDARC 2002c). The psychological and psychiatric side effects experienced by the respondents to that study were profiled for convenience earlier in this chapter (in the section pertaining to physical health consequences of ecstasy use).

In short, it would seem that while there are clearly some minor psychological consequences of using ecstasy observable (predominantly low mood, shifting mood), further research is required into the psychiatric sequelae consequent to frequent, heavy or long-term use of ecstasy, particularly when used in combination with other drugs.

MDMA and mortality

In a recent comprehensive review of the health effects of ecstasy Linda Gowing and her colleagues at the Drug and Alcohol Services Council of South Australia state that although:

[t]he incidence of serious acute adverse events related to ecstasy is low [i]t is the unpredictability of those adverse effects and the risk of mortality and substantial morbidity that makes the health consequences of ecstasy significant (Gowing et al. 2001, p.53).

Hyperthermia and hyponatraemia (with consequent cerebral oedema)¹²⁰ are

120 Concar, drawing from the research of toxicologist and MDMA expert John Henry of St Mary's Hospital, London, explains the relationship between MDMA ingestion and hyponatraemia: 'Henry has discovered that MDMA makes the brain's hypothalamus secrete a substance known as antidiuretic hormone, which stops the kidney producing urine and makes it hard for MDMA users to pass water even if they are drinking pints of it. If they do drink excessively...in rare cases, the blood thins and the brain swells, creating a pressure that in extreme cases pushes the brainstem down the spine where it can no longer support breathing, (Concar 20002, p.31).

For further discussions of the link between MDMA use, hyperthermia and hyponatraemia, see Matthai et al. 1996; Cook 1996; Wilkins 1996; Parr, Low and Botterill 1997; Gowing et al. 2001.

the most potentially life threatening of the conditions associated with MDMA use. Their manifestation or at least the severity of the outcomes may be in large part dependent on the setting:

Some MDMA-related complications, such as cardiac arrhythmias and cerebral infarctions, are related to the acute pharmacological properties of MDMA that are shared by a number of amphetamine-type stimulants. Other complications, such as severe hyperthermia with rhabdomyolysis, renal failure and disseminated intravascular coagulation, are more probably related to the use of MDMA in 'raves' and dance parties, where individuals participate in extreme physical activity for prolonged periods in a hot crowded setting (Henry 1992; McCann *et al* 1996). MDMA can produce hyperthermia in quiet surroundings, when taken in sufficient quantity (Green *et al* 1995) but in the setting of 'raves' or dance parties, the toxicity appears to be enhanced; it is probably a combination of direct effects of MDMA and the high ambient temperature, sustained physical activity and inadequate fluid replacement, all reducing heat loss and potentiating the direct effect of MDMA on thermoregulatory mechanisms, that creates the greatest toxicity (Gowing *et al*. 2001, p.25).

Jones (1998) explains in somewhat distressing detail the ways in which hyperthermia and heatstroke can contribute to MDMA related deaths. While acknowledging that fatalities associated with ecstasy are low in number, they can have severe and dramatic manifestations:

When MDMA produces problems, they are frequently severe and unpredictable. Generally speaking, the course of events seems to be:

- The victims are out in a nightclub, rave party or concert;
- They faint or fit;
- They are taken to hospital where their limbs may be twisted and rigid;
- Their temperature is recorded at 40–42 degrees Celsius;
- They bruise easily and drip sites start to bleed;
- They start to bleed profusely;
- Death supervenes even where there are multiple infusions of donated blood and clotting factors.

What causes this bleeding to occur? The leading theory is that Ecstasy deaths are the result of the drug and of the setting in which the drug is used. Ecstasy has the tendency, as do many stimulant drugs (Jones & Owens 1996), to alter the body's internal thermostat and incline the body to overheat in hot, ambient atmospheres. In this condition, clubbers dance the night away without the insight of a 'normal' person into their own internal environment. Nightclubs are often damp, hot places where the high humidity may make sweat evaporation impossible. Add to this the dehydration caused by vigorous dancing, and several conditions coexist:

- Loss of body heat regulation

- Creation of more and more body heat
- Loss of ability to dissipate the heat.

This creates a rising core body temperature. Beyond a certain point, the rise in temperature causes problems to develop. The first body system to react is the central nervous system, which is very sensitive to abnormalities in temperature. High temperature caused by Ecstasy-induced heatstroke causes fainting and/or fitting in the victim. Other problems associated with high core temperature (and reported by medical staff caring for Ecstasy victims) include liver and kidney problems, but mainly disorders of the body's clotting system. This involves a condition called DIC (disseminated intravascular coagulation) (Clowes & O'Donnell 1974, Oh 1990), which involves inappropriate formulation of small blood clots across a wide area of the body's blood vessels, causing those components of blood usually reserved for plugging holes to be activated and attracted to areas of clot formation. These clotting promoters are used up faster than they can be produced, causing a depletion of clotting material in the circulating bloodstream. Without clotting material, the patient will bleed spontaneously from nose, mouth and gastrointestinal tract, and in severe cases, will bleed to death. There are blood tests that will reveal that this process is under way.

Certainly the theory that these fatalities are caused by heatstroke could explain the deaths by pointing to variations in the amount of dancing, fluid intake and so on, though it has to be said that, to the writer's knowledge, no empirical study of these variables has been conducted: Did the victim dance a lot? Did the victim drink enough? Was the club hot that night? etc. (Jones 1998, pp.95–96).

The emergence of hyponatraemia as a factor contributing to MDMA associated mortality suggests that well meaning advice with regard to fluid consumption when ingesting ecstasy needs to be modified or at least tailored to the setting in question. An examination of harm reduction techniques with regard to MDMA is given in Chapter 8. Suffice to state in this context that the message 'Drink lots of fluids' may not be useful and could be actually bad advice in cases where there is a potential for water overload. As Parr, Low and Botterill state:

Among the many adverse reactions [to ecstasy] we must now include life threatening hyponatraemia, which may have the same symptoms and signs as MDMA intoxication. To avoid adverse reactions, individuals using MDMA at dance parties are often advised to rest, avoid overheating, wear loose clothing and drink plenty of cool drinks. However, there is no evidence that this prevents adverse reactions. Furthermore, because of the possibility of hyponatraemia, this advice should be modified to suggest ingesting only moderate amounts of liquids (Parr, Low & Botterill 1997, p.137).

As indicated earlier, another way in which ecstasy use has been associated with death has been when what has been purported to be MDMA has, on analysis,

turned out to be a different more toxic drug. The other drug most usually associated in these circumstances is paramethoxyamphetamine (PMA). Paramethoxyamphetamine is viewed as having 'much more serious adverse effects than other ring derivative amphetamines' (Byard et al. 2002, p.496). Byard et al. state: 'A knowledge of the higher rate of complications occurring with PMA ingestion by users is reflected in...its street name – "death"...' (Byard et al. 1999, p.139). In 1998, six cases of death due to PMA were reported in South Australia (see Felgate et al. 1998; Byard et al. 2002, p.496). The pathologists associated with the cases have subsequently commented:

In 1998, our group warned that although PMA substitution for MDMA appeared at the time to be a local Australian problem, there was a possibility that the manufacture and sale of PMA could occur in other countries. Unfortunately, this prediction has proved accurate, with recent reports of PMA related deaths in the United States, Europe and Canada (Byard et al. 1999, p.139).

Felgate's analysis of the six South Australian deaths in 1998 indicates that PMA is certainly available in localised areas and is of particular concern: 'It is routinely sold as "ecstasy" but would appear to be more toxic than MDMA' (Felgate et al. 1998, p.171). It was thought that in most, if not all, of the PMA deaths reported in Australia the drug users thought they were taking MDMA, when in fact PMA was present as a contaminant (White, Bochner & Irvine 1997, p.117).

Such a development gives rise to concern by drug and alcohol workers that taking ecstasy is becoming part of a 'lucky dip' (see for example, Moriarty 2001, p.8).¹²¹

Gowing et al. (2001) reviewed a number of cases of MDMA-related mortality in which PMA was involved:

It is possible to conclude from these data that, although a number of cases of acute adverse effects involved other drugs instead of or in addition to MDMA, MDMA alone can produce adverse effects. Of the 35 cases in which only MDMA was detected, 21 involved hyperthermia and 10 of these (48%) were fatal. A further eight cases involved disturbances of sodium or fluid balance, with three (38%) fatal. The remaining six cases involved cardiac factors (1 fatal), a cerebral haemorrhage (1 non-fatal), respiratory factors (1 fatal), a sudden collapse (fatal), and trauma whilst intoxicated (2 fatal). Given that hyperthermia and disturbances of sodium or fluid balance generally occur when MDMA is used in nightclub or dance party settings, these data suggest that the acute adverse effects of MDMA arise from the way it is used, rather than solely an inherent toxic effect of the drug.

121 For a stark, if at times somewhat sensationalist, account of a young man's death as a result of PMA ingestion, see 'Timeline of a PMA death', *Drugs in Society*, June 2001, p.9.

This may not be the case with PMA (para methoxyamphetamine). There are two major clusters of deaths associated with PMA: nine cases in Ontario, Canada in 1973 (Cimbura 1974) and six cases in South Australia between 1995 and 1998 (Byard *et al* 1998; Byard *et al* 1999). Media reports (New York Times, 30 September 2000, USA Today, 6 October 2000) indicate that a further cluster of PMA-related deaths occurred in Florida, USA and Ontario, Canada in the first half of 2000. Of the 16 published case reports involving PMA, seven involved hyperthermia, five involved seizures, one a cerebral haemorrhage, and three were classed as miscellaneous, largely because of insufficient information. It is notable that in one of the cases reported by Byard *et al*, 'ecstasy' use occurred in a home setting over a 12 hour period and a maximum body temperature of 46.1 was recorded on admission to hospital. This case, together with several others involving ingestion of PMA in home settings, suggest that the adverse effects of PMA may be related more to the action of the drug rather than the way it is used. The higher incidence of seizures associated with PMA is suggestive of a more powerful central nervous system effect.

This makes it impossible to determine whether the apparently high mortality rate associated with PMA reflects the administration of high doses, or whether PMA is inherently more toxic than MDMA (Gowing *et al*. 2001, pp.30–31).

Whatever, the precise linkages between PMA, MDMA and adverse health consequences are, clearly more research is necessary to get a picture of the interaction of these drugs.

An MDMA dependence syndrome?

There is no reliable, or at least comprehensive, evidence that the use of MDMA is addictive or even with prolonged use can lead to a 'dependence syndrome' similar to that found with opiates, alcohol and some forms of amphetamine (as discussed above). One of the reasons that this may have been the case, at least until recently, is that 'there are simply no reports on individuals who take frequent and large amounts of MDMA for an extended period of time' (Petrouka 1990 in Jansen 1999, p.121). However, Jansen (1999) has noted some case studies where it could be stated that criteria for dependence has now been met:

MDMA is described as non-addictive, as was amphetamine itself earlier this century... However, there are now reports of individuals who have used large quantities for extended periods... These reports usually focus on adverse effects and rarely consider dependence as a specific issue. [This report describes] ...three cases [that] indicated MDMA can be addictive in certain cases. Identification and treatment is important as there is some evidence to suggest that high intensity MDMA use may cause lasting changes to serotonergic nerve terminals...

A dependence syndrome requires at least three of the following: a strong desire to take the drug; difficulties controlling the behaviour; a withdrawal state;

tolerance, progressive neglect of alternative pleasures; and persisting with use despite evidence of harm (WHO, 1992). These features occurred in all three cases who considered themselves harmed in various ways, made attempts to stop but yielded to a compelling desire to re-use, and listed fatigue, low mood, anxiety and sleep disturbance as withdrawal phenomena. One case was also amphetamine dependent, one was also dependent on benzodiazepines and opioids with a relatively high regular alcohol intake, and one also had a high daily alcohol intake verging on dependence (Jansen 1999, pp.121, 123).

While Jansen's studies are interesting and not without merit, it would seem that far more research needs to be undertaken and similar cases documented for the medical and academic community to be able to pronounce with any certainty that such a syndrome does in fact exist.

Physical and psychological consequences – Other 'party drugs'

GHB and ketamine

Most of the side effects associated with the use of these drugs have been outlined in the previous chapter, however some of the more salient points are repeated in this context.

GHB

A small amount of GHB can produce feelings of exhilaration, euphoria and well being. It may also heighten libido or cause sexual disinhibition contributing to its reputation as a 'date rape' drug. Higher doses can lead to disorientation, nausea, blackouts, headaches, seizures, a numbing of the muscles or muscle spasms, loss of consciousness, hypoventilation and vomiting:

After long term use at high doses, there may be a withdrawal reaction – rapid heartbeat, tremor, insomnia, anxiety and occasionally hallucinations that last a few days to a week. According to the Drug Enforcement Administration [USA], the use of GHB has been associated with 5,700 reported overdoses and 66 deaths over the years, mainly from respiratory depression. The danger seems to come mostly from mixtures with alcohol or opiates (Harvard Mental Health Letter 2001, p.19).

Galloway et al. state that the effects of GHB appear to be 'highly dose dependent':

The dose response curve for GHB is steep and exceeding the recommended or intoxicating dose can result in severe adverse effects. Effects of GHB in humans include somnolence leading to arousable sleep at 40–50mg/kg and at 60–70 mg/kg, coma for 1–2 hours... The lethal dose has been estimated at 5–15 times that inducing coma (Galloway et al. 1997, p.91).

Particular concern has been expressed regarding the interaction of GHB with other central nervous system depressants, in particular alcohol or MDMA and

methamphetamines (Galloway et al. 1997). Again such a mixture makes unsuspecting people, particularly women, vulnerable to assault (Nicholson & Balster 2001).

Sanguineti, Angelo and Frank (1997) also point to the dangers of perceiving GHB as a relatively safe drug when taken in the context of body building or a context outside of recreational drug use. Using a case study of a bodybuilder presenting with visual and auditory hallucinations in addition to depression and anxiety they state:

The case shows...how misinformation and mislabeling are a main source of the problem with products such as GHB. An athlete or bodybuilder like Mr J who already has a tendency to use illicit safe compounds like anabolic steroids, is lulled into a false sense of security by the way the information is given... The athlete is therefore encouraged to consider these effects as minor irritants from an otherwise natural product and is prone to ingest higher doses than recommended as it appears these doses may otherwise be safe. Symptoms are therefore underreported or unreported (Sanguineti, Angelo & Frank 1997, p.638).

The authors state that this false sense of security is particularly heightened when GHB is marketed in terms of a 'tonic' or 'health stuff':

Given today's abundance of alternative medical ingredients and the explosion of health stores rich in arcane concoctions, it may be easy for the physician not to recognise the relatively obscure mention of GHB (Sanguineti, Angelo & Frank 1997, p.638).

McDaniel and Miotto have documented five case studies that tend to indicate there is a discrete withdrawal syndrome for GHB use with concomitant dependence on the drug:

The most common signs and symptoms include anxiety, tremor, insomnia, episodes of tachycardia, affective lability, confusion, paranoia, agitation, delirium, and hallucinations... The observed withdrawal syndrome in these five patients lasted from three to 13 days. In all cases the initial symptoms of anxiety, tremor and insomnia manifested within two to eight hours of last reported dose. Tachycardia was seen within 12 hours of last dosing. In cases of severe withdrawal, psychosis and delirium developed within 48 hours of last use.

The development of addiction in this sample was rapid and unexpected. Patients initially considered GHB or GBL [an analogue] a safe supplement and none expected to transition from short term use to long term dependence (McDaniel & Miotto 2001, pp.146–147).

Given that GHB is a relatively new drug on the scene, the issue of a GHB dependence and withdrawal syndrome, as with many other issues pertaining to the drug, need to be researched much more comprehensively.

Ketamine

There is very little known about the long-term effects of taking ketamine regularly as a recreational drug. Because of its anaesthetic qualities, people have been known to hurt themselves after having taken the drug and not realise until the following day. Ketamine, as with GHB, MDMA and other psychostimulants, should not be taken with respiratory depressants, primarily alcohol, or benzodiazepines because of the potentially lethal consequences of interaction. Large doses could induce unconsciousness, which could lead to cardiovascular failure. Although not physically addictive, some users have developed a strong habit (Drug Enforcement Administration 2003).

Use of the drug can cause delirium, amnesia, depression, and long-term memory and cognitive difficulties (see Jansen 1993; Dotson, Ackerman & West 1995; Curran & Morgan 2000; Dillon & Degenhardt 2001).

Of particular concern is the dissociative symptomology associated with the drug. The out of consciousness or K-hole effect (see Chapter 2) can have dangerous consequences. The physical dangers associated with the drug may, as Dillon and Degenhardt comment, stem not so much from the drug itself as from the context of its use. Jansen explains this further:

As ketamine has a good physical safety profile and an established place in medicine, within current indications what are the reasons for concern about its non-medical use? The first and most important reason is that ketamine can readily induce a state of virtual helplessness, within the dose range normally taken by users, to a far greater extent than most other substances of abuse. The dissociation can be very dramatic, such that awareness of the environment is completely lost while the user experiences a 'separate reality', a marked reduction in sensory input in all modalities, and difficulty with movement. This is almost never the case with substances such as 3,4-methylenedioxymethamphetamine. The helplessness of the dissociative state may not be a problem for a patient in a protected setting, but at a large social gathering the chances that a disconnected person experiencing incoordination and analgesia may come to harm are substantially increased.

A further cause for concern is that ketamine can sometimes result in a state where the users are unconcerned whether they live or die. This is not a depressive or suicidal phenomenon but is related to the particular effect of the dissociative state upon the mind. "If you have a full-blown experience of K, you can never believe there is death, or that death can possibly influence who you are." Again, this may not be a problem in a protected setting but is cause for concern in a public place.

In some people ketamine has the potential for compulsive, repeated use; cases of self administered injections several times daily over prolonged periods have been reported. Long term use of high doses of ketamine has the potential to interfere with memory, learning, and attentional mechanisms due to blockade of the N-methyl-D-aspartate receptor, although there is no clear evidence of

this at present. Ketamine has been associated with recurring phenomena ('flashbacks') although whether these result from drug induced physiological changes or are a functional response to anxiety in predisposed personalities is still unclear. (In these cases flashbacks may involve little more than a 'graininess' of vision under anxiety provoking circumstances) (Jansen 1993, p.601).

Given the paucity of information associated with ketamine, this Committee welcomes receiving any information about the drug, particularly pertaining to the local use and abuse of it.

Social consequences of amphetamines and party drug use

As with any discussion of drugs and the way they impact upon society, *who* is taking the drug and the use to which it is being put will have a decided bearing on the consequences for the community at large. For example, the truck driver who regularly uses amphetamines to maintain tight delivery schedules may 'cost' the community in terms of road accidents or trauma. For the methamphetamine 'addict' who steals to maintain his or her habit, there is the obvious cost of crime in the community. The examples could be replicated depending on the drug and the reason the person is taking it. This brief section discusses some of the more common and serious social consequences of amphetamine and party drug use. In particular, it will concentrate on any possible links between the use of these drugs (particularly amphetamines) and the manifestation of crime or violent behaviour. Often such violent behaviour is linked to mental health disturbance, particularly paranoia and the amphetamine psychosis discussed earlier.

This section also examines the links between the use of these drugs and road trauma, including but not exclusive to the use of amphetamines by long-distance drivers.

Violence, crime and (meth)amphetamine use

It is a truism but nonetheless accurate to state that not all people who abuse drugs turn to crime, just as not all criminals are drug-dependent. Thus the following discussion is very much centred on a particular subset of amphetamine user. This discussion does not canvass an examination of crime and violence related to MDMA use or its analogues. Nearly all of the profiles done of ecstasy users fail to reveal any links between such use and criminal behaviour (other than the 'scoring' of the drug itself).¹²² At most, ecstasy users may generally deal on a small scale to cover the costs of purchase. Often this will be a case of sales to friends and associates and rarely result in any profit (see Moore 1992a, p.630). Party drug users on the whole seem to be law-abiding and non-violent. This is especially the case given that most ecstasy use

122 One area where there is cause for concern regarding a link between crime and 'party drugs' is the use of the 'date rape' drugs GHB and rohypnol. Ostensibly these drugs are surreptitiously slipped into unsuspecting people's drinks for the purposes of taking advantage of them sexually (see McKey 2000 and discussion in Chapter 2 and Chapter 8, footnote 23).

is primarily experimental and social. 'Most users adopt[ed] patterns and dosages that fail[ed] to produce dependence and significant psychopathology' (Siegel 1986 in Moore 1992a, p.9). This may change of course, as suggested by reports of an increasing trend to injecting ecstasy and a perceptible, if slight as yet, shift from ecstasy being used as a party drug to a street drug.¹²³

It is thought, not surprisingly, that the heavier the use of amphetamine and methamphetamines the greater the potential for using crime or its proceeds to obtain the drugs. But criminal behaviour serves not only such 'functional' purposes (that is, drug acquisition), it can also be a lifestyle by-product of the violent and even psychotic behaviour associated with some, particularly heavy, amphetamine use. The following quote from Wood (1998a) draws on comments by drugs researcher Nick Lintzeris:

During his work at Victoria's Pleasant View Centre, a treatment service for substance misuse, Dr Lintzeris saw a significant group of heavy users who were involved in crime.

'These people were using loads of amphetamine – it was definitely their primary drug – and were engaged in quite a lot of serious crime. Their amphetamine use was most certainly a cultural, lifestyle thing. These were heavy dudes, and it wasn't "let's take some speed and go and have fun" [unlike ecstasy] ...speed was not a fun drug for this group' (Lintzeris quoted in Wood 1998a, p.21).

Both the 'functional' and lifestyle links with crime can be seen in the association between amphetamine use, manufacture and trafficking and certain motorcycle gangs in the United States, Australia and Europe, particularly during the 1970s and 1980s. One social cost of amphetamine use, manufacture and trafficking that is often overlooked is the danger and public health consequences to not only those who manufacture the substances but also to police and emergency personnel who are investigating or otherwise responding to emergency events at clandestine laboratories. Such injuries may be caused either by explosions, fires or the caustic, corrosive, toxic or volatile nature of the chemicals associated with the manufacturing process (see, for example, *Journal of the American Medical Association* 2000). A discussion of amphetamine manufacture, including its links to such gangs, is found in Chapter 7 of this Discussion Paper.

Research data on links to violence and crime

There has not been a great amount of research investigating any link between (meth)amphetamine use, crime or violent behaviour. The following studies, however, do make some pertinent and useful observations.

123 See Chapter 5 for a discussion of profiles of drug use.

University of California study 1996–1997

A comprehensive survey of methamphetamine abuse and emergency department utilisation was conducted in a California teaching hospital during 1996–1997. This six-month study examined all admissions to the hospital where patients presented positive to a methamphetamine urine toxicology screen (N = 461). This public hospital (University of California/Davis Medical Centre) 'provides health care for a high proportion of uninsured patients and for those patients brought in by police from the street or jail' (Richards et al. 1999). Thus the findings have to be read subject to this knowledge.¹²⁴ The data of the methamphetamine users were compared against a non-using control of all other emergency department admissions for the period. The study concluded that there were significant social and economic costs to the user and the community from methamphetamine use. This included the costs associated with crime and violence, emergency department utilisation, hospital stays, police, ambulance and mental health transportation, costs of care in gaol and mental health facilities and costs associated with road trauma and accidents.¹²⁵ The occurrence of such behaviours seems to escalate when individuals have been 'bingeing' over a period of several days. The authors of the study state that:

Methamphetamine (MAP) is now the most common drug of abuse presenting to emergency departments (ED) in the western United States. Intoxicated MAP patients often present with agitation, violence and loss of self-control and represent a threat to themselves and caregivers. Chronic MAP users often develop paranoia and lasting psychosis as well as deterioration of judgment and fine motor skills, which may predispose them to injury from moving vehicle accidents... Criminal and violent behaviour associated with MAP may lead to blunt and penetrating traumatic injury... Inevitably, increasing MAP abuse translates into more frequent ED visits by this population... Our data suggest MAP users utilise prehospital and hospital resources at levels higher than the average ED population. Based on the current trends, we can expect more ED visits by MAP users in the future... (Richards et al. 1999, p.198).

This survey outlined a variety of serious trauma-related complaints for which emergency treatment was required. Thirty-seven per cent of MAP users as compared to 21 per cent of non-users required such treatment:

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- 124 Sixty-nine per cent of the methamphetamine users (MAU) used ambulance transport to attend the emergency room. This was significantly higher than for non-methamphetamine users (NMAU), 22 per cent of whom used ambulances for transport. Twelve per cent of MAU were brought in by police and four per cent by mental health facility transfer. Fifty-eight per cent of the MAU were admitted to the hospital proper from the emergency treatment (compared to 22% of NMAU). Fourteen per cent of MAU were admitted to an in-patient psychiatric facility and 9 per cent to jail. Significantly 386 of the 461 MAU patients had two or more emergency department visits within the previous 12 months (Richards et al. 1999).
 - 125 Very few of the MAU had medical insurance. The economic costs to the hospital and community were therefore great. This of course reflects a major difference in the American and Australian health care systems, universal health cover such as Medicare not being available in the United States.

A remarkable association between MAP use and injury from trauma existed in this study. Interpersonal trauma, including gunshot wounds, stabbings and assaults, was responsible for a large number of ED visits... The predisposition for violence and suicide from MAP abuse may account for the large proportion of these cases. This association has been investigated in previous studies. Kratofil and colleagues described self-injury and mutilation by MAP users. Logan reported a correlation between MAP and violent behaviour in drivers arrested for driving under the influence of alcohol. In another series by the same author, 146 deaths involving MAP were reviewed on autopsy, and 27% resulted from homicidal and 15% from suicidal violence. A similar study from Spain also found a high percentage of violent deaths in MAP positive autopsies. Bailey and co-workers reported MAP presence in almost one third of homicides and accidental overdoses in San Diego County. In the subculture of MAP users, in which paranoia, poor judgement, predisposition for violence and access to weapons coexist, any potential misunderstanding or disagreement, however insignificant, may lead to interpersonal violence¹²⁶ (Richards et al. 1999, p.201. See also the references cited therein).

South Australia Survey 1995–1996

A South Australian survey of 100 amphetamine users conducted in 1995–1996 across the Adelaide metropolitan region also revealed a relatively strong link between amphetamine use, criminal behaviour and other social problems. Such findings include:

- Sixty-one percent of participants had driven a motor vehicle while intoxicated with amphetamines in the month prior to interview, with 45% of these people stating that they had also been drinking alcohol on some or all of these occasions.
- Seventy percent of participants had been involved in some form of criminal activity (not including dealing drugs amongst their friends) since they began using amphetamines. However, 57 of these people had also been involved in crime beforehand. Fifty-one percent of participants had carried out a crime or crimes whilst intoxicated with amphetamines.
- Eighty-two percent of the sample reported having had some form of social problem in the six months prior to interview, which they believed had been caused by their use of amphetamines. Forty-two percent of the sample reported that they had experienced problems with friends, 40% reported problems with their partner, 18% said that they had had problems at work, 9% said that their amphetamine use had caused an accident, and 2% had dropped out of their studies because of their amphetamine use.
- Seventy-five percent of participants said that their use of amphetamines had caused them to have financial problems in the 6 months prior to

126 This may particularly be the case with 'crystal meth' or 'ice'. See Derlet and Heischouer (1990).

interview (Vincent, Allsop & Shoobridge 1997, pp.378–379. See also Vincent et al. 1999).

While the authors acknowledge that further and more detailed research into the social problems surrounding amphetamine abuse and the links to crime is required, their findings do suggest a nexus between dependence on amphetamines and poorer social functioning.

South Australia Drugs Summit 2002

A recent summit on amphetamine and psychostimulant use hosted by the government of South Australia discussed inter alia the social costs of such drug use. Some of the topics included the community loss due to criminal activity, law enforcement and judicial costs and the loss of quality of life for users and their families. The conference communique summed up the links between amphetamine and other drug use and criminal activity as follows:

In many circumstances drug use and criminal behaviour are linked, but the relationship is complicated. There are three aspects: users committing crime to obtain money to purchase drugs; crime committed under the influence of drugs; and an overlap between the factors associated with the development of criminal behaviour and factors associated with the initiation of illicit drug use. Whatever the basis of criminal behaviour, it is clear that heroin use results in a significant increase in the frequency of offending. The extent of involvement in property crime among illicit drug users is about 10 times higher than among non-users... Amphetamine use is also associated with higher levels of violent and bizarre behaviour than either opioids or cannabis (South Australia Drugs Summit Communique – Health Maintenance and Treatment 2002a, p.3).

Turning Point Alcohol and Drug Centre Report 2001

Of interest is the fact that the recent 'heroin drought' has resulted in an apparent increase in drug-related crime in Melbourne. The Victorian Drug Availability Monitoring Project (DAMP), authored by Miller, Fry and Dietze from the Turning Point Alcohol and Drug Centre, compared a range of drug use statistics from their own survey work conducted in March/April 2001 with samples from Illicit Drug Reporting System (IDRS) data reported for May/June 2000. While this report has already been discussed in Chapter 2, in this context the findings are of great interest:

[P]articipants' reports of involvement in any crime were roughly equivalent to the 2000 IDRS with just over half of the sample reporting involvement in any crime. However, the proportion reporting property and/or violent crime since Christmas 2000...was higher than the proportion reporting such crime in the 6 months prior to the 2000 IDRS survey. Given that the timeframe considered in the DAMP study was some 2–3 months less than the timeframe considered in the IDRS, the increase in reported crime involvement is important (Turning Point Alcohol and Drug Centre 2001, p.22).

Fourteen per cent of the DAMP sample reported an increase in the amount of property crime that *they* had committed during the 'drought'. However, 73 per cent of the sample reported that there had been an increase in *other* people committing property crime (Committee emphasis). Fifteen per cent of the sample reported that their dealing of drugs had increased. Moreover, 30 per cent of those sampled who admitted to dealing in drugs reported that they had changed the drugs dealt during the 'drought'. Other relevant data from the survey included the following:

Respondents were asked a number of questions regarding their perceptions of changes in police activity during the heroin 'drought' and whether these changes had an impact. Most of the respondents (80%) believed that there had been an increase in police activity over the 'drought' period, and over half (53%) reported that more of their friends had been arrested. Over half (58%) of the study participants reported that police activity had contributed to the heroin 'drought'...

The participants in the current study were asked about what other effects they had observed as a result of the heroin 'drought'. Most respondents believed that the 'drought' had led to an increase in the amount of violent crime (68%), property crime (55%), bad deals (68%) and a large minority (38%) believed there had been a significant increase in fraud. Other general impression [sic] reported by the sample included: an increase in sex work (12%), less people using heroin (6%) and an increase in begging (Turning Point Alcohol and Drug Centre 2001, p.22).

What is unclear, or at least can only be the subject of conjecture on the basis of anecdotal evidence, is how much of the increase in crime or violent behaviour reported or perceived to be committed in the sample is due to a switch to amphetamine use in addition to or as a substitution for heroin.

NSW study 1998

Although there is not a strong link established between ecstasy use and crime or violence this does not mean that the use of ecstasy and other 'party drugs' has not resulted in a variety of social problems, particularly when these drugs are used on a regular basis or in large amounts.¹²⁷ A number of Australian surveys have examined a range of social problems associated with ecstasy in addition to the medical and psychological consequences of the drug. A study of 213 ecstasy users in Sydney in 1998 found that a large number of those surveyed reported relationship, financial, legal and employment problems associated with their ecstasy use:

Almost half (47%) had experienced a relationship/social problem during the past six months with a partner, friend or relative. Most of these (80%) involved relatively minor problems such as arguments, mistrust or anxiety. Minorities

127 See also Hando and Hall 1997.

reported more serious problems such as ending a relationship (18%) or violence (2%).

Just under half (46%) of the sample reported a financial problem from their use of 'ecstasy', the most common of which was a lack of money for recreational activities (47%). Minorities reported being in debt (27%) or having no money for essentials such as food and rent (26%).

Occupational problems were reported by 47% of the sample. Females were significantly more likely than males to report work/study problems... Most of the reported problems (58%) involved trouble concentrating, reduced work performance or feeling unmotivated. Twenty-nine percent reported having to take sick leave or not attending classes. A minority (13%) reported very serious problems such as being sacked, quitting their job or study or not being able to find a job due to their 'ecstasy' use.

Seven subjects reported legal problems from their use of 'ecstasy' in the past six months, most having received a caution from police. Two subjects had been arrested (Hando, Topp & Dillon 1998 p.38).

South Australia study 2002

Similar findings were noted in a recent study of 70 ecstasy users in Adelaide, South Australia (NDARC 2002c):

In 79% of cases subjects reported at least one problem in the previous six months which they perceived as related, at least in part, to their use of ecstasy. This included relationship and social problems, financial problems, work or study problems, and legal or police problems.

The most common problems were related to occupation or study, with nearly 63% of the sample experiencing them.... More than half of these problems (52%) involved taking sick leave or not attending classes, and a further 43% involved trouble concentrating (16%), reduced work performance (14%) or feeling unmotivated (14%). A minority (5%) was more serious, such as being dismissed from or quitting a job, or inability to obtain employment.

The use of ecstasy caused financial problems for 39% of subjects in the previous six months. These subjects specified the most serious financial problem they had dealt with. In 56% of cases the problem was minor, with subjects having no money for recreation or luxuries. In 26% of cases the problem was more serious, with subjects being in debt or owing money to people. In the remaining 19% of cases the problem was extremely serious, with subjects not having enough money to pay for food or rent.

The use of ecstasy caused relationship or social problems for 36% of subjects in the previous six months. These subjects also specified the most serious relationship problem they had dealt with. In 80% of cases the problem was relatively minor, such as arguments and the development of mistrust or anxiety in the relationship. In the remaining 20% of cases the relationship actually ended as a result of ecstasy use, and in one case this resulted in violence. Three

of these subjects also reported conflict within the family as a result of their ecstasy use, including arguments with parents and siblings.

Only four subjects (6%) reported any legal or police problems related to their use of ecstasy in the previous six months. In one case the person was arrested by police, another had their car searched by police, and the remaining two reported feeling like they were being followed or were under police surveillance.

A variety of other problems caused by ecstasy in the previous six months were reported by 19 subjects (27%). Eight experienced problems with their general physical health for several days after taking ecstasy, as well as feeling confused, anxious, paranoid and depressed. Three subjects who had experienced a relationship breakdown due to their ecstasy use also reported conflicts with their family. Two spoke of their increased sexual risk-taking behaviour, saying they have unprotected sex while on ecstasy and "don't care about the consequences". Two reported feeling uncomfortable and alienated in social situations when not on ecstasy, that they have trouble interacting and dealing with people.

There were no gender differences in the number or type of ecstasy-related problems experienced by subjects. Overall, 82% of females had experienced at least one problem in the previous six months, compared with 76% of males. Similarly, there was no significant difference according to age. Overall, 80% of subjects aged less than 25 years had experienced at least one problem, compared with 67% of subjects aged 25 years or more.

There were also no statistically significant differences in the number and type of ecstasy-related problems experienced by subjects according to whether they had ever injected a drug. Eighty percent of subjects who had ever injected any drug reported at least one problem, compared with 78% of those who had never injected any drug. Although a higher percentage of subjects who had injected drugs reported financial problems (60% versus 33%), the difference did not quite reach statistical significance Similarly, a higher percentage of subjects who had injected drugs reported relationship or social problems (47% versus 33%) and legal or police problems (13% versus 4%), but again the differences were not statistically significant (Longo et al. 2002, pp.41–42).

Summary

While it cannot be said that the social problems related to ecstasy use are as numerous or as severe as those associated with other drugs such as heroin, amphetamines or alcohol, they are not insignificant. They require specific strategies and interventions that are tailored to the particular culture associated with ecstasy use. These interventions will be discussed in Chapter 8.

Road trauma, drugs and driving

One particular problem associated with the use of both amphetamines and 'party drugs' is their use while driving or in control of a motor vehicle. This may

be for instrumental reasons, for example the use of amphetamines by truck drivers to stay awake while maintaining punishing delivery schedules, or as a consequence of recreational use, for example getting home from a 'rave' or dance party when there is no public transport available. The user profiles of both amphetamine using transport workers and party drug use by 'ravers' and 'clubbers' will be discussed in Chapter 5. Nonetheless, it is appropriate at this instance to examine briefly some of the problematic aspects of drug use as it pertains to driving while intoxicated.

Driving under the influence of amphetamines is unfortunately an all too common practice of transport workers (see Mabbott & Hartley 1999). Tight deadlines and turnaround schedules, penalties for late delivery and products requiring urgent delivery have resulted in the use of 'speed' and both illegal and prescription stimulants by relatively many truck drivers, particularly long-distance or interstate drivers. These are used for staying awake and indeed 'energising' the driver. This can often result in speeding (in both senses of the word) and dangerous driving. Moreover, the abuse of amphetamines, particularly methamphetamines, while driving is not restricted to transport workers. The aforementioned American study of emergency room admissions related to methamphetamine abuse found a clear relationship between methamphetamine use and injury from road trauma. Such injuries may have been sustained by the user, a fellow passenger, bystander or by occupants of other vehicles:

The deleterious effect of methamphetamines (MAP) on psychomotor and cognitive skills has been well documented. The most notable consequence of this effect is an increased incidence of moving vehicle accidents and falls. In a series of moving vehicle accidents described by Logan et al. poor coordination and judgement was responsible for the majority of crashes, and typical driving behaviours included drifting out of the lane of travel, erratic driving, weaving, speeding, drifting off the road, and high speed collisions. The majority of MAP patients with blunt trauma in our study were involved in car crashes and other moving vehicles, including two MAP users who were riding bicycles and crashed into each other... Crouch and co-workers investigated fatal truck crashes over a one year period and found that an alarmingly high percentage tested positive for MAP postmortem. Although MAP does significantly extend periods of wakefulness, this benefit is quickly negated by poor task functioning. Wiegmann and his colleagues studied the effect of MAP on cognitive processing which deteriorated considerably with extended periods of wakefulness induced by MAP (Richards et al. 1999, p. 201).

The practice of driving under the influence of 'party drugs' used for recreational purposes is a problem which is not so well documented.

Of particular concern are the findings of a recent British study (Akram & Forsyth 2000) indicating that, unlike depressant drugs such as alcohol, dance

drugs are often perceived (mistakenly) to enhance driving and motor skills.¹²⁸ The authors acknowledge that attitudes towards drink driving have changed dramatically in the past few decades but add that 'it is not known to what extent this attitude extends towards drug driving'. A lack of police roadside testing for drug driving, in addition to the perceptions (partly true) that controlling a car while under the influence of dance drugs is less difficult than when intoxicated by alcohol, has contributed to a false sense of security about 'clubbers' being able to drive safely after having taken ecstasy and/or other 'party drugs':

The UK dance scene because of its conception in deserted warehouses and outdoor parties may have inadvertently encouraged the practice of dance drug driving. In the early days, party goers would meet at secret rendezvous...in an effort to confuse the authorities as to the whereabouts of the party. This would ultimately result in the return journey, for some, being undertaken whilst under the influence of drugs. Driving therefore became as much a part of the adventure as actually being there. For many, driving under the influence of dance drugs was the only real way of being part of the culture.

Although illegal warehouse and outdoor parties have largely been replaced by town nightclub venues, it is unlikely that this will have stopped the practice of drug driving. One study investigating dance drugs and safety awareness amongst users (Akram 1997) found that 62% of the sample (n = 135) had driven a motor vehicle whilst under the influence of dance drugs. This would suggest that dance drug driving does occur quite frequently (Akram & Forsyth 2000, p.266).

Moreover, Akram and Forsyth state that dance drug driving is not confined to clubs and raves in Britain but is also noticeable in travelling to and from outdoor music festivals:

The remote rural location of these festivals pose limitations on the availability and accessibility of public transport, resulting in a number of festival goers taking their own transport... It is likely that some festival goers are also under the influence of dance drugs as they drive to and from these sites (Akram & Forsyth 2000, p.267).

Although the culture of 'raving' is arguably not as pronounced in Australia as it is in Britain, there are definite parallels to be noted at a local level. Academic Simon Lenton has done a number of qualitative studies of ecstasy users in Perth, Western Australia, particularly in the context of 'raves'. One study of 83 'ravers' noted that a substantial minority of respondents 'described travelling to or from raves with drivers who were drug affected' (Lenton & Davidson 1999,

128 One study (Headen 1994) did show that drug driving was dangerous not only for the driver and any passengers but also to other road users:

'Co-ordination tests on Headen's volunteers showed that driving became considerably more aggressive under the influence of cocaine and ecstasy and judgement of distances between objects (eg. traffic cones) impaired (Headen 1994). Driving skills in general deteriorated especially driving under the influence of ecstasy' (in Akram & Forsyth 2000, p.267).

p.153). Of the 66 respondents in the Lenton study who either drove or were driven to a rave in a motor car, just under half (42%) felt the driver was under the influence of a drug. Twenty-seven per cent of respondents stated they were not concerned whether the driver had taken drugs or not:

Eight (12%) respondents mentioned taking drugs in the car on the way to their last rave, often in order to reduce the perceived risk of being arrested at, or outside, the rave.

Two respondents expressed the belief that driving under the influence of drugs was less likely to result in being apprehended by police because of the difficulty of roadside detection and four believed that driving under the influence of drugs was safer than driving drunk. *Amphetamines and cannabis in particular were believed to be associated with relatively safe driving.*

Some of the same respondents also mentioned the ease of getting away with driving under the influence of drugs even if pulled over by the police. The view was that as long as the driver could maintain a rational conversation and was not weaving all over the road, the police had no way of testing for the presence of non-alcoholic intoxicants at the roadside (Lenton & Davidson 1999, p.159). (Committee emphasis)

The authors view such misconceptions with concern. Of equal concern is the practice whereby some of the respondents who drove after consuming drugs assumed they would reach their destination prior to the effects of the drugs taking hold:

Individual differences, the unknown composition and potency of illicit substances, the possibility of the journey being longer than expected (due to getting lost or police roadblocks near the venue) are just some of the factors which could lead to the driver having to drive while drug affected. Police practices such as road blocks and car searches, which are likely to result in people consuming their drugs to avoid detection and forcing people to drive when events have shut down early, ought to be discouraged (Lenton & Davidson 1999, p.161).

Such findings and responses have significant implications for policy development, education and in particular harm reduction interventions.¹²⁹ These factors are discussed in detail in Chapter 8.

129 These academic findings are matched by data produced by Victoria Police that also raise concerns with regard to drug driving. The Victoria Institute of Forensic Medicine study of Victorian drivers either fatally injured or otherwise impaired found that in 2001, 2.6% of fatally injured [n = 274] and 23% of impaired when apprehended drivers [n = 57] had methamphetamines detected in their system (cited in excerpt from the confidential Victoria Police submission to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002). Quoted with the kind permission of Victoria Police.

Poly drug use

Throughout this Discussion Paper it has been noted that users of amphetamines and 'party drugs' rarely use only those substances exclusively (Darke & Hall 1995; Vincent, Allsop & Shoobridge 1996; Boys, Lenton & Norcross 1997; Hando, Topp & Dillon 1998; Kamienicki et al. 1998; Shewan, Dalgarno & Reith 2000; Gowing et al. 2001; Hansen, Maycock & Lower 2001; NDARC 1998, 2001, 2002a, 2002b, 2002c; Henry-Edwards 2002; Von Sydow et al. 2002). In other words, poly drug use is common among these groups, and indeed most illicit drug users. A submission to this Inquiry from the Victorian Department of Human Services makes the following comment:

There is much evidence that a range of drugs are used in conjunction with psychostimulants. Nearly all illicit drug users use a variety of drugs at the same time. Most drug users are aware there are risks associated with poly drug use but believe they are far outweighed by the gains. A concern is that many may have no idea of the unintended consequences of this risky behaviour. Drugs used regularly include heroin, LSD, cannabis, alcohol, amyl nitrate and tobacco. Users are known to use GHB, cannabis, alcohol and even heroin when withdrawing from amphetamine.

In Victoria multi or poly drug use is a major problem as highlighted in the Victorian Institute of Forensic Medicine Report No 5...

It is well documented that using many drugs together can cause serious health problems and precipitate drug overdose. The issue is that we do not know the wide-ranging effects of combining a variety of illicit and licit drugs and a range of unknown substances on individuals with very different physical and psychological makeups.¹³⁰

When it comes to 'party drugs', the relatively recent study conducted by the National Drug and Alcohol Research Centre (NDARC) of 213 Sydney based ecstasy users confirmed:

[w]hat any dance party patron has known for a long time: that ecstasy users are by and large, experienced and concurrent users of many other drugs (Review of the NDARC study by Wood 1998b, p.17).

The NDARC study, conducted by experienced researchers Libby Topp, Julie Hando and Paul Dillon, found that their sample:

[h]ad experimented with an average of 10.4 drugs, most frequently alcohol, cannabis, LSD, amphetamine, tobacco and amyl nitrate. In the preceding six months, the sample had used a mean of 8.1 drugs.

The study found that almost all the subjects (96.2%) typically used other drugs, both in combination with ecstasy and during the 'come down' period after using ecstasy. While using ecstasy, the average number of other drugs

130 Submission of the Department of Human Services (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

used was 2.4. The most common were tobacco (67.7%), cannabis (43.4%), alcohol (40.4%), amyl nitrate (11.7%) and LSD (10.3%).

'Of those that typically drank alcohol while using ecstasy, 45.0% typically consumed more than five standard drinks in an episode. A mean of 1.8 drugs were typically used while coming down from ecstasy, most commonly cannabis (63.4%), tobacco (61.5%), alcohol (19.7%), benzodiazepines (12.7%) and amphetamines', the authors wrote.

The study shows a marked increase in polydrug use among ecstasy users compared with Solowij et al's earlier study. While in the 1992 study 47% of subjects had used ecstasy with marijuana, 41% with amphetamines, 19% with LSD and smaller proportions of the sample with other drugs, the authors found that 24% of users had never taken any other drug together with ecstasy (Discussed and quoted in Wood 1998b, p.17).

Discussing the NDARC survey, Wood comments further:

It's clear from the studies that many users choose particular drugs to use in certain contexts and for certain effects.

Topp et al report that other drugs were often used deliberately to alleviate the effects of the 'come-down' period after using ecstasy. Most respondents reported doing this (88.7%), using cannabis, alcohol and benzodiazepines for this purpose.

'The rates of depressant use among a primarily party drug-using sample were surprisingly high, and suggest that ecstasy users are adept at obtaining drugs which help them to self medicate the aversive physical and psychological effects of an ecstasy (and other drug) use episode,' the study states.

The researchers were surprised at the high level of benzodiazepine use – 60% of the sample had used this drug. Twenty-eight percent had also used heroin (a figure of prevalence that the researchers attributed to its availability, particularly in south-west Sydney where subjects reported smoking it for relaxing or to aid with the side effects of stimulant use), 36% had used other opiates and 20% had used anti-depressants...

Topp et al emphasise the need for better education on the risks of polydrug use.

'Moreover, half of those who drank alcohol with ecstasy typically did so at binge drinking levels', they wrote.

'This is a hazardous pattern of alcohol consumption in itself, let alone in combination with a drug known to cause dehydration.'

'Remarkably high rates of party drug use were also reported, further highlighting the need for a better understanding of the patterns and correlates of such drug use.'

Almost all subjects in this sample had used LSD and amphetamine; over 80% had used amyl nitrate, and more than half had used cocaine, nitrous oxide and MDA, the study states.

'Given our lack of understanding of these drugs, urgent attention must be given to the possible harms associated with such use' (Discussed and quoted in Wood 1998b, pp.18–19).

Wood also reviews a study of poly drug use in the Perth dance party scene conducted by Boys, Lenton and Norcross (1997):

The Perth study found that 80% of its 83 respondents had used a combination of at least two 'dance drugs' – nominated as ecstasy, amphetamines or LSD – during their most recent rave.

'The most common drug used in addition to ecstasy was cannabis (69.2%), followed by amphetamines (34.6%) and inhalants (34.6%). LSD was used by 26.9% of those who used ecstasy, 19.2% used alcohol and 7.7% reported that they had used tranquillisers of some sort before, during or after the rave', the authors wrote...

Boys et al in Perth found particular patterns of drug use that differed before, during and after a rave.

'For example, amphetamines were used by many more respondents before or during the rave than after it. Ecstasy and LSD were both used by more people during the rave than either before or afterwards. Cannabis was used by more people before and after the last rave than it was during the event and tranquillisers were mainly used afterwards. As well as choosing combinations of different drugs, the Perth respondents also reported buying tablets reputed to have already been mixed with other drugs, such as opiates, LSD and amphetamines, sold as 'Smack-E', 'Trippy E' and 'Coke-E' respectively (Wood 1998b, pp.18–19).

Both of the studies reviewed by Wood note that 'polydrug use is normal behaviour for ecstasy users' (p.19) and comment that very little is known about the possible harmful effects of interacting drugs.

The authors of the Perth study point to the fact that there is little research on interactions between illicit drugs, and that the many possible specific combinations will continue to make research difficult...

One thing is clear from both studies, far more research is needed before the implications of such polydrug use can be understood or addressed (Wood 1998, p.19).

For ecstasy and party drug users, other drugs such as marijuana and alcohol can be used as a form of 'self-medication' during the comedown stage. As was discussed in Chapter 2, heroin users have been known to use amphetamines and increasingly benzodiazepines in an effort to self-medicate, particularly during the 'heroin drought'. Amphetamine users are also known to use tranquillisers in an effort to self-medicate (see also Vincent, Allsop & Shoobridge 1996; Turning Point 2001; Baker, Boggs & Lewin 2001). This has dangers not only because of the potentially toxic interactions between the drugs, but also because the amounts consumed are far in excess of safe

levels.¹³¹ Moore's study of psychostimulant users in Perth found that males in particular consumed enormous amounts of alcohol when under the influence of amphetamines and to a lesser extent ecstasy:

These drugs seem to suppress feelings of intoxication from alcohol and allow the drug user to drink far in excess of his normal capabilities and tolerance. Consequently, drinking anywhere between ten and twenty standard drinks per outing...is not uncommon. In an average week, one might attend nightclubs on two or three separate occasions which put the weekly consumption figure somewhere between thirty and sixty standard drinks (Moore 1992a, p.57).

Such studies, however, have been contradicted by others which find that users of ecstasy are inclined not to take it in conjunction with alcohol (at least not during the active phase of the drug) as it counteracts or deadens the effect of ecstasy and may result in unpleasant side-effects (Solowij, Hall & Lee 1992; see also Hansen, Maycock & Lower 2001; Lenton & Davidson 1999).¹³² It would seem, however, according to recent and current research, that alcohol use in conjunction with 'ecstasy' is increasingly common, particularly among young people. The Committee is interested in any input as to why this may be the case.¹³³

There has also been speculation as to ecstasy's potential to act as a 'gateway drug'; that is, initiating ecstasy or other party drug users to so-called harder drugs such as heroin or amphetamines (see Hansen, Maycock & Lower 2001; Von Sydow et al. 2002 and the references listed therein).¹³⁴ Research conducted by Pedersen and Skrondal suggests that such speculation is unfounded.

Hansen, Maycock and Lower suggest rather that:

Perhaps more significant than ecstasy's potential as a gateway drug [is] the general trend towards polydrug use. Previous studies have suggested that the 'pure' ecstasy user is a rarity, citing significant polydrug consumption

131 Williamson et al. conducted a study in Britain of illicit drug users that used stimulants alone and those who used them in conjunction with depressant drugs such as opiates and benzodiazepines. The study found that:

'The stimulant and depressant users were more likely than the stimulants-only users to use stimulants by injection and more likely to report adverse effects associated with stimulant use. The stimulant and depressant users were also more likely to have been treated for a drug problem' (Williamson et al. 1997, p.87).

Henry-Edwards has also noted that the effects of other drugs in conjunction with amphetamine use are marked. In particular, the effects of amphetamine on aggression are accelerated when the user is also affected by opioids and opioid withdrawal (Henry-Edwards 2002, p.3).

132 The Committee would be very interested, for example, in the findings of the 'party drugs' and psychostimulants module study being currently undertaken by researchers from the Turning Point Alcohol and Drug Centre in Melbourne.

133 As discussed in Chapter 5 of this Paper, much of the earlier sociological and ethnographic survey literature on ecstasy use comments that ecstasy users prefer raves precisely because to a large extent they are alcohol free and thereby non-violent and without the 'sleaze factor'.

134 Von Sydow et al. argue that 'it is important to evaluate if ex-ecstasy users who have stopped taking the drug compensate their ecstasy abstinence with an increased consumption of other licit or illicit drugs' (Von Sydow et al. 2002, p.148).

patterns... Initiates and inexperienced users tended [in this survey] to use ecstasy in isolation from other drugs, with the exception of alcohol, which was typically consumed in moderation or not at all. It was universal that as users became more experienced, they exhibited a pattern of use that included the consumption of greater amounts of ecstasy and an increasing combination of other drugs. Whether this pattern is a result of physical or psychological tolerance, or simply an experiential expansion along the drug use continuum, is difficult to say without further research (Hansen, Maycock & Lower 2001, p.189).¹³⁵

Grob is concerned about the relatively recent trend for ecstasy to be combined with other psychoactive drugs such as ketamine. This has been particularly noticeable in Britain. Commenting on the work of British researcher Valerie Curran, Grob states:

Curran's work and those of her counterparts in the United Kingdom, have highlighted the degree to which the Ecstasy scene has been pervaded with polydrug abuse. In Curran's study, less than two per cent of her ecstasy subjects were not polydrug users. An added factor has been the surge in popularity of the dissociative anaesthetic ketamine...ketamine use has increased significantly among Ecstasy using ravers... Excessive use of a variety of powerful psychoactive substances, taken at all night raves under conditions of nutritional and sleep deprivation, were all common histories for the ecstasy users recruited into the British studies...

...To fully appreciate the degree of public health risk, it is essential for investigators to acknowledge the polydrug context of Ecstasy culture. To mistake the cumulative consequences of multiple drug use for the effects of MDMA alone obfuscates our understanding of this complex phenomenon (Grob 2000, pp.573–574, 578–579).

A drug cocktail (whether because of using other drugs in addition to amphetamines at the same time or proximate in time as the administration of amphetamine or because of the variability in purity or quality of the amphetamines itself) can result in particular health problems. For example, the use of amphetamines or methamphetamines with alcohol can cause increased cardiac and psychological effects.¹³⁶ Similarly, 'speedballing' (or the use of amphetamines simultaneously with opiates such as heroin) can increase toxicity (Albertson, Derlet & Van Hoozen 1999, p.215).

135 For a discussion of the types of drugs commonly used before, during and after 'raves' in conjunction with ecstasy, see the survey of young ecstasy users in Perth done by Lenton, Boys and Norcross 1997; Lenton and Davidson 1999.

136 A survey by Australian drug researchers Hall and Hando found that:
'An unanticipated health risk among these [Sydney based survey] users was a high rate of concurrent alcohol and amphetamine intoxication. Just over half reported consuming five or more standard drinks when using amphetamines and one fifth reported using amphetamine because it enabled them to drink more alcohol without feeling or appearing to be intoxicated' (Hall & Hando 1993, p.643).

Conclusion

This chapter has endeavoured to examine, however cursorily, some of the main physical, psychological and social consequences of using amphetamines and ‘party drugs’. Given the wide range of drugs and substances that come under the rubric of both these broad classifications, such a task is bound to result in some generalisations.

Nonetheless, the chapter has examined a variety of consequences flowing from the use of the main drugs in these categories, particularly methamphetamine and ecstasy. These consequences range from the relatively minor to life threatening.

There are still, however, many ‘unknowns’ in this particular area of drug knowledge. For example: What are the effects of taking other drugs in association with amphetamines or ecstasy? What effect do amphetamines have on cognitive functioning?

The psychiatric and psychological consequences of amphetamines and ecstasy are still uncertain. For example, is there an ecstasy dependence syndrome? This is one of the many key scientific issues still being debated.

This chapter also examined some of the ‘newer’ ‘party drugs’ and their potential for deleterious outcomes. In particular, it noted the alarming trend to use drugs such as GHB as a means for committing sexual assault – that is, as a so-called ‘date rape’ drug.

Finally, the chapter discussed some of the social consequences of using these various drugs, including links between amphetamines, crime and violence and the effect of amphetamines and ecstasy on driving and road trauma.

Clearly one of the main factors to arise from the discussion in this chapter is that more research of both a qualitative and quantitative nature is needed to address some of these unresolved issues and questions. The need to prioritise research in this area will be discussed in detail in Chapter 10 of this Discussion Paper.

Questions for discussion
<ul style="list-style-type: none">◆ What are the long-term effects and/or dangers associated with amphetamine use?◆ What are the long-term effects and/or dangers associated with MDMA use?◆ What factors are contributing to deaths associated with MDMA use?◆ What are the long-term effects and/or dangers associated with ketamine, GHB and other party drug use?◆ What effects and consequences does the ‘bingeing’ of psychostimulants have on the user? Is bingeing a common occurrence? Does it occur in the context of ‘party drugs’?

- ◆ Is there enough evidence to substantiate the existence of a 'speed psychosis'? If so, how is it manifested?
- ◆ What is the relationship between MDMA and psychiatric morbidity? Is there any research proposed that will investigate this relationship?
- ◆ What forms of risk taking are amphetamine and party drug users commonly taking during the course of their drug taking?
- ◆ Is there an amphetamine dependence syndrome? If so, how is that dependence manifested?
- ◆ Is there an MDMA dependence syndrome?
- ◆ What effects does amphetamine and/or party drug use have on cognitive functioning?
- ◆ How prevalent is amphetamine use with co-morbid mental illness?
- ◆ What consequences do impure drug combinations have on those using amphetamines and 'party drugs' (such as 'fake ecstasy')?
- ◆ What consequences can occur when taking amphetamines and/or 'party drugs' simultaneously with medications?
- ◆ Are amphetamines and/or 'party drugs' being used as a form of self-medication?
- ◆ What is the association between amphetamines and crime or violence? Is it one of cause and effect?
- ◆ Is there any research being currently undertaken or proposed that will investigate any possible links between the use of amphetamines, ecstasy and the manifestation of criminal, violent and/or anti-social behaviour?
- ◆ What effect does the ingestion of amphetamines and/or party drug have on driving and control? What measures should be put in place to minimise any risks?
- ◆ What other social problems or consequences are related to or can be attributed to amphetamine and/or party drug use?
- ◆ What are the problems associated with and the issues that arise in relation to poly drug use and amphetamines and/or 'party drugs'?
- ◆ What other drugs are used in association with amphetamines and/or 'party drugs'?
- ◆ Anecdotal evidence suggests that alcohol is being used more commonly with ecstasy and other 'party drugs' than used to be the case. Is this the case? If so, why is this occurring? What are the harms associated, if any, with this combination?

5. The Culture and Patterns of Use

This chapter recognises that there is no one profile of a drug user or drug abuser. This is true of all drugs, be they licit such as alcohol or illicit such as amphetamines and 'party drugs'. The following sections of this chapter examine a variety of user profiles of discrete groups that use amphetamines and 'party drugs' and the reasons for such use. These range from transport drivers who rely on 'speed' and/or prescription drugs to maintain punishing delivery schedules, to 'ravers' who may use 'ecstasy' recreationally at dance parties and clubs to enhance the experience. Often there may be a certain amount of overlap between those groups. For example, a long-distance transport driver may use amphetamines in order to stay awake to meet deadlines but also may use them or indeed other drugs for recreational purposes. This also reflects the reality that poly drug use is a prevalent feature of much drug-taking in recent years, as discussed in Chapter 4.

'Street' users of amphetamines, as a separate class of user, are not examined in detail in this chapter. There is, however, strong anecdotal evidence of a significant change in the use patterns of and trade in amphetamines, particularly since the advent of the 'heroin drought'. This has resulted in a 'street culture' of use. One should be careful, however, in assuming that a street culture of amphetamine use is necessarily the same as that of heroin or other drug use. The manifestation of a street culture of amphetamine use is an area about which the Committee would particularly like further information. It welcomes submissions to that effect.

It should be observed from the outset that there is a notable dearth of good qualitative and ethnographic research detailing the cultural and sub-cultural aspects of drug use, particularly amphetamine use. While there has been some excellent ethnographic work conducted in the United Kingdom (Forsyth 1995; Shewan, Dalgarno & Reith 2000; McElrath & McEvoy 2001) there has been very little of this type of research undertaken in Australia. One of the few comprehensive qualitative studies is Moore's ethnographic observation of networks of young recreational drug users in Perth. Although ten years old, the following observation is both salient and salutary:

There appear to be two worlds of illicit drug use – the world of the clinic and the world of the general community with the latter category receiving

increased attention in recent years. One of the many terms used to describe drug use within the community is 'recreational'. Anecdotal evidence suggests that recreational drug use, particularly of psychostimulants such as amphetamines and Ecstasy, is on the increase. Yet information on the nature, meaning, expressive styles, extent, cost, routes of administration, and overall circumstances of recreational drug use is sparse. The paucity of research data on drug use in natural social settings precludes both the conceptualisation of a clear framework for understanding its nature and the development of appropriate harm reduction strategies (Moore 1992a, p.1).

Defining a culture

When one speaks of a culture or sub-culture of drug use, in a sense one is referring to membership of a group that is mainly distinguished by the narrow focus of drug use. As will be discussed in greater depth later in this chapter, this may be less true of a drug such as ecstasy which, at least in some contexts, may be seen as one aspect of a cultural phenomenon or as a means to an end. For example, in terms of 'rave use' it may be seen as an adjunct or contributor to a total transcendental experience which usually includes music, dance, visual images, lighting etc (see Melechi 1993; Moore 1995; Nolan 1998). Siokou states that: 'Although ravers may be viewed as a subculture, they are not a homogenous group and come from diversified backgrounds' (2002, p.12).

Conversely, at least in a 'traditional' rave context (for example large, often open-air, dance parties) other drugs such as alcohol may not be tolerated as it is associated with aggressive behaviour not conducive to the feelings of 'communality' expected of the 'love drug' (see Nolan 1998). Rather than speak of a culture or sub-culture of drug use, Moore's valuable study of amphetamine and ecstasy use in Western Australia prefers to refer to 'situationally specific shared understandings' or 'a sort of sub sub-culture':

These are the specific understandings shared by a small set of people about a particular activity in which they engage regularly with one another in particular social situations and which has relative little impact on their membership of other social scenes (Moore 1992a, p.31).

Moore and his colleagues observed a close network of young drug users in Perth over a 12-month period. The social contexts of their drug use showed that many of their 'subjects' had very diverse backgrounds and 'share few common understandings other than those pertaining to the particular focus of network activity'. Moore continues:

On subjects such as politics, the importance of money, the intrinsic value of material objects such as cars or fashion clothing labels, sexuality and a number of other social issues, there was little or no consensus amongst the recreational users I studied. Some did not appear particularly impressed with material things while others were; some held conservative political views, others were more radical and others still virtually apolitical; and so on. To some extent this

variety was reflected in their membership of other sets of people outside the narrow focus of drug use (Moore 1992a, p.31).

When it came to their drug use, however, the network shared a very marked set of specific shared understandings about such use:

[For example] Most were familiar with the idea of 'taxing' drugs (removing a small amount for one's personal consumption before passing it on to the buyer) either as a buyer or a seller, whatever they thought of such a practice. What was meant by the term 'junkie' was another oft-discussed theme. Some felt themselves to be junkies, others viewed it as a term of abuse, others felt it did not apply to them. Definitions of the term also changed over time. The point is that within a particular set of shared understandings, themes such as taxing and junkie-ness were commonly discussed and accepted as part of 'the way we use drugs' (Moore 1992a, p.31).

In a different paper presented at an Australian symposium on psychostimulant use, Moore again outlines the importance of understanding the 'social world' of the drug user, particularly for policy development:

Drug use occurs within specific social contexts and social networks which are constantly evolving, competing, collapsing, interacting and expanding. Drug users are embedded in ever changing social networks which do not consist solely of other, like drug users. The social world of a drug user is also likely to include employers or employees, workmates, partners, relatives, clients and sporting associates, some of whom use the same illicit drugs, others who use different illicit drugs and some who do not use illicit drugs at all. It is within these fluid social settings that individuals, as members of social groups, interact with one another and interpret, construct and negotiate the *shared* cultural means underlying their drug use.

If one accepts the principle that to reduce drug-related harm we must first understand the 'insider' view of drug use, then ethnographers must locate themselves within the specific social contexts in which drug use occurs. They are then ideally positioned to describe and interpret the social processes which underlie drug use, the social meanings of drug use fashioned during social interaction and the harm minimisation practices currently employed by drug users to reduce drug related harm.

Many aspects of psychostimulant use are...understandable with reference to broader themes in social life. The importance of social relationships and their management, the ways in which some individuals seek to assert their superiority within social groups, the processes by which individuals maintain their membership of these groups and the importance of the social context are all hallmarks of much human activity, drug related or otherwise. We should always pause to consider these complexities before resorting to simplistic explanations for drug use and before implementing simplistic policies (Moore 1993, p.88). (Author's emphasis)

Thus the reasons for using different drugs will be as varied as and as inextricably related to the cultures or sub-cultures of which they are part. These reasons are discussed at appropriate points throughout this chapter. However, an initial comment is that the reasons why people take amphetamines or 'party drugs' are of course as diverse and varied as the reasons people take any form of drug, substance or stimulant.

The reasons why a drug is taken may be instrumental or functional as much as recreational. It may even be a mixture of both motivations. Similarly, some drugs such as ketamine or nitrous oxide may have functional purposes (anaesthesia) or be used to get 'high', often by those very persons responsible for administering the drug in a legitimate setting, for example doctors and nurses.

One of the most formative and influential theorists to discuss drug use from a social context perspective was Zinberg (1979, 1984). Zinberg noted that policy development in the field of drugs had to take into account the variables 'drug, set and setting'. The concept of 'drug', 'set' and 'setting' is of primary importance in determining why different 'classes' of user may administer a particular substance.

d'Abbs and MacLean (2000) summarise Zinberg's approach well:

By these [concepts] Zinberg means: the pharmacological-toxicological properties of the substance (drug); the attributes of persons using the substance, such as personality and physical health (set); and aspects of the social and physical environment in which consumption occurs (setting). No intervention strategy is likely to ameliorate [volatile substance abuse] and the problems associated with it unless it addresses each of these factors, and the interrelated effects engendered by them. This does not mean that a single program must attempt to bring about change in all three domains, even if it could do so. However, it does mean that any intervention strategy, of which particular programs will form a part, must begin by identifying the factors in each of these domains that shape the usage patterns and consequences [of substance abuse and drug taking] (d'Abbs & MacLean 2000, p.v).

Amphetamine users in general

It is erroneous to speak of a 'typical' amphetamine user as it is to speak of a typical drug user per se. However, Kamienicki et al. note that while it is true that amphetamine users are not a homogenous group:

[r]esearch has shown that regular psychostimulant users (and particularly amphetamine users) have a number of common characteristics. Namely:

- They tend to exhibit a wider range of polydrug use than opioid users (Darke and Hall 1995);
- They tend to be younger than opioid users (Darke and Hall 1995; Loxley, Marsh and Lo 1991);

- They may exhibit a wide range of psychopathology associated with their amphetamine use (Hall et al 1996; Hando 1996; Klee et al 1995; Vincent et al 1996);
- They are generally highly socially orientated (Hando 1996; Klee and Morris 1994; Vincent et al 1996);
- They tend to see themselves as different from opioid users, and often won't enter existing treatment services because of the perceived stigma (Klee and Morris 1994; Vincent et al 1997);
- They are less likely to have experienced treatment for drug use than opioid users (Hall et al 1993), and those who have done so tend to have a more fragile connection with treatment services (Klee et al 1995);
- Many tend to seek assistance for problems associated with their drug use from a general practitioner in the first instance (Hando 1996; Klee et al 1995; Ross and Miller 1994; Vincent et al 1996). (Kamienicki et al. 1998, pp.7–8).

Despite such factors, it is generally true that one cannot speak of an amphetamine or psychostimulant class of user. One of the reasons why psychostimulant users cannot be readily compared is because amphetamines are a 'family' of drugs rather than one discrete drug and can vary from the prescription medications used to treat attention deficit disorder to weight loss formulae.

Because of this variation in compounds and the use to which they are put, it is very difficult to target programmes to meet the particular needs of any particular user, unlike targeting needs in the areas of alcohol and heroin use (Griffin 1997).¹³⁷ Exploratory research from southern Queensland conducted by Dennis for the Logan Youth Health Service (LYHS) confirms the difficulties involved in obtaining specific information necessary for targeting programmes:

Brett Cutting from the LYHS said finding information about amphetamine users was a hard task, which was why the service was forced to conduct its own research.

'There is little if any discussion about amphetamines at conferences, workshops and seminars.' [Our] study reinforced what we already knew. That amphetamine is on the rise and it is virtually impossible to get it on the agenda at professional level (Dennis 2000, p.12).

However, some distinctions can be made. Although Professor Hilary Klee of the Centre for Social Research on Health and Substance Abuse makes comment on the absolute dearth of research into social profiles of amphetamine users, referring to them as 'this hidden population', she has constructed a typology of what she views as the five main patterns and profiles of use occurring in Britain today. The typology consists of:

137 See Chapter 9 for an account of the difficulties associated with treating amphetamine-related problems.

- Ravers – young adolescents or people in their early to mid-20s. They used low doses for dancing and partying to capture the ambience of the rave scene and partly because it was cheaper than alcohol
- Drinkers – young men who regularly went out drinking with mates and took speed so they could appear to hold their liquor better
- Young mothers – women who had children at a young age and were working part time. They were rarely injecting users and took speed to give them energy to look after the kids, do the housework and work
- Young experimenters – male adolescents who took a variety of drugs ‘in a spirit of adventure’ to experience their effects
- Poly drug users – somewhat older than other user groups (Klee cited in Griffin 1997 pp.19–20).

Both research and programme development need to be better attuned to who is using amphetamines and what their specific needs are. In particular:

...Prof Klee nominated certain groups as being particularly hard to reach in campaigns and programmes – ‘women with young children, young criminals and any groups that believe that performance is superior if the drug is used’ (Griffin 1997, p.19).

There has been insufficient research to state categorically that such a typology can be extrapolated to the Australian context. Nonetheless, anecdotal accounts and some exploratory social research suggest that such comparisons are not without merit.

The LYHS study, although not academically based, did provide some useful information in a poorly researched area. For example, it found that those who used amphetamines were largely uninterested in accessing health and harm reduction information:

[b]ecause it was viewed as being more relevant to ‘junkies’ or heroin users. They were classifying speed as a softer drug. They did not see themselves as ‘junkies’ (Dennis 2000, p.12).

The authors of the report suggested that this ‘ignorance’ could be combated by an appropriate media campaign:

An intensive media campaign has been suggested as one solution, as there are often reports about alcohol, tobacco and heroin related health risks. Speed is rarely mentioned and this may be contributing to an almost false sense of security amongst some speed users (Dennis 2000, p.14).

The service found that most of their young amphetamine users commenced their use from curiosity:

[b]ut other reasons included ‘the ability to have the energy to get things done’, ‘the ability to feel in control’, ‘the ability to lose weight’ and most disturbing was that speed let one user ‘escape the reality of my poverty’ (Dennis 2000, p.13).

Of particular concern are some suggestions coming from the Logan survey that some young people may be using amphetamines to 'self-medicate' their pain:

From the information obtained it has been hard to establish whether amphetamines are causing problems or whether they are being used to deal with problems or a combination of the two. The only thing that really helped people to stop using seems to be the high cost of obtaining speed. Fifty-eight per cent of respondents reported that financial cost was the single hardest aspect of continuing to use amphetamines (Dennis 2000, p.14).

To Klee's typology one could also add sportspeople (see Chesher 1990 in the context of 'designer drugs' and amphetamines) and 'bingers' (Ovenden & Loxley 1996).¹³⁸ Bingeing on amphetamines, particularly when associated with injectable drug use, has been characterised as one of the hazardous patterns of psychostimulant abuse (Chesher 1993; Ovenden & Loxley 1996). Studies of binge use of amphetamines show that it is not uncommon for (young) people to use amphetamines repeatedly or continuously over a period of three to four days. In their qualitative survey of binge culture Ovenden and Loxley argue that an ethnographic understanding of bingeing is important in order to develop appropriate harm reduction strategies (1996, pp.33–34 ff). An interesting finding of their research is that those who inject amphetamines are more likely to binge for longer periods than those who do not inject. Of equal concern is the fact that bingeing has been associated with quite serious poly drug use (Ovenden & Loxley 1996).

Unfortunately, there is very little research material available of either a qualitative or quantitative nature in the context of sportspeople and bingers. Nor is there comprehensive research that examines the use of these drugs among women, people living in regional and rural Victoria, or people from non-English-speaking backgrounds.¹³⁹ The Committee welcomes any information on these or other groups that can be of use in writing its Final Report for this Inquiry. The rest of this chapter focuses primarily on the discrete groups of transport personnel who use amphetamines, and ecstasy and party drug use within rave and dance club culture, including drug use within the gay community.

138 A general typology of use could conceivably include licit forms of amphetamine use such as children with attention deficit type disorders and people using the drugs in order to lose weight. Neither of these groups will be discussed in any great detail.

139 A submission from the welfare agency 'Open Family', gives anecdotal evidence that problematic amphetamine use is rising among young women in rural Victoria: It states: 'Illicit drug use has not been exclusive to the city as Open Family Street Outreach Workers in rural Victoria have noticed a considerable rise in the level of amphetamine use in the Hume region over the past couple of years. Staff are seeing an increasing number of young people, especially young women 14–21 years presenting with problematic amphetamine use. Some of the self rationalising perceptions for using amphetamines by young women in rural Victoria are seeing the drug as a social experience *and not in any way like taking opiates which they see as "using drugs"*. Amphetamine use is also being used to lose weight and to keep up with social and school life and commitments' (Submission of Open Family Australia to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and Party Dugs, August 2002). (Committee emphasis)

Amphetamine use in the transport industry

The occupational use of psychostimulants including amphetamines by long-distance and other drivers has been of concern to Australian governments for some time. Early survey research cited by Hall and Hando (1993) suggested that in both Australia and the United States – countries with huge amounts of territory covered by road transport – between 40 and 60 per cent of long-distance truck drivers had taken stimulants (particularly ephedrine) to remain awake. More recent research reported prevalence figures varying between 20 and 50 per cent, although the higher figures tend to be based on anecdotal evidence (see studies and evidence cited in Mabbott & Hartley 1999, p.117).

A submission to this Inquiry by Victoria Police notes that the number of transport industry drivers charged with amphetamine offences, while relatively low in absolute terms, has been steadily increasing over the last five-year period.¹⁴⁰ Victoria Police state further:

Traditionally, transport industry truck drivers are not recreational drug users. They may use alcohol and tobacco, but the use of amphetamine away from the work place is not widespread. Fatigue, due to demanding schedules, is a major issue within the transport industry and illegal drugs are often being used to address it.

In 2000 the percentage of truck drivers at fault in fatal collisions was 28%. However, toxicology data shows that 20% of truck drivers' blood tested following a fatal collision was found to contain stimulant drugs. This figure is tenfold higher than for the drivers of motor cars. In 2001 this figure rose to 25%...

While numbers are low, there appears to be an increase in the detection rate for transport industry drivers using amphetamines over the above five-year period. These figures reflect only amphetamine possession and do not include any other stimulants or prescription drugs.¹⁴¹

The medical and other consequences of using psychostimulants for these reasons have already been commented on in Chapter 4. However, another major concern of governments and the community alike is the personal and economic costs associated with some fairly horrendous motor vehicle accidents involving heavy transport vehicles in which the drivers were found often to be using excessive amounts of psychostimulants.

An extensive study by Mabbot and Harley aimed to more systematically ascertain the prevalence and nature of psychostimulant use and abuse in the

140 From 12 offenders in 1997 to 19 in 2001 and 22 as of May 2002 (Confidential Submission of Victoria Police to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002). Quoted with the kind permission of Victoria Police.

141 Confidential Submission of Victoria Police to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Referred to with approval of Victoria Police.

transport industry of Western Australia. One of the more concerning issues outlined by the authors was that since a crackdown on illegal prescription drugs had made such drugs harder to obtain there had been an increase in the amount of illegal street amphetamines being used by drivers. The authors summarised their research as follows:

In July 1997, 236 truck drivers were interviewed at three truck stops in Western Australia. The interviews collected information on driver fatigue and stimulant drug taking as a fatigue countermeasure. Drivers have become more aware of fatigue as a problem within the industry over the last two years, however 27% of drivers reported using stimulant drugs to combat driver fatigue. Interstate drivers use more prescription and illicit stimulant drugs to keep awake while intrastate drivers use more over the counter stimulants. Over the counter stimulants are not perceived as drugs by intrastate drivers because they are easily and legally obtainable and this is reflected in many of their responses.

The most frequent way that drivers obtained stimulant drugs was through a chemist or illegal prescription. Anecdotal evidence from the drivers suggests that increasing pressure from the public and the media to eliminate illegally prescribed stimulant use by drivers has made them harder to obtain. Therefore, without fatigue issues within the industry being addressed, an increase in street purchases of illicit stimulants may occur. Prohibition of stimulant drug use without changing industry practices eliminates a fatigue countermeasure and could lead to a serious increase in fatigue related crashes (Mabbott & Harley 1999, p.115).

Of the illicit substances nominated by the surveyed drivers, amphetamine was the most common substance used. Prescription drugs were often obtained from partners or friends who had obtained them from doctors for weight problems. Illicit amphetamines were acquired from the black market and drug dealers, 'with some responses suggesting bike gangs, hotels and "off the street"' (Mabbott & Harley 1999, p.122).

Many factors contribute to fatigue being a major problem within the road transport industry.¹⁴² These include structural factors within the industry and problems pertinent to individual drivers. Some of these factors include:

- ◆ Extended driving periods;
- ◆ Tight delivery schedules;
- ◆ Penalties for late delivery;
- ◆ Lack of rest or sleep prior to commencing long hauls;
- ◆ Monotonous scenery;

142 American studies have also testified to quite serious cases of amphetamine abuse by pilots and other aviation personnel, particularly in the United States. Drug and Alcohol Testing of personnel by the US Federal Aviation Administration from 1995–2000 demonstrates that people working in safety sensitive workplace occupations such as aviation are being found positive to substance abuse. See for example Canfield et al. 2000.

- ◆ Job competition (or taking on more than one job or contract);
- ◆ Related to the previous point is undercutting of rates with some operators willing to offer a faster service for the same price or less; and
- ◆ Products requiring urgent delivery (such as livestock).

In addition to such factors, it is disturbing that Mabbot and Harley's study reveals that: 'It is clear from driver responses that little is known about the side effects of stimulant use' (p.127).

Indeed, 81.65 per cent of surveyed drivers knew of fewer than three side effects of listed psychostimulant drugs. As the authors remark, in addition to structural change within the industry (for example, regulated driving schedules etc) there is 'a need for education within the road transport industry on the risk of harmful effects from stimulant drug use' (Mabbot & Harley 1999, p.127).

Psychostimulant use and abuse in the transport industry is by no means a problem restricted to Western Australia. The very nature of interstate road transport and its dependence on long-distance driving make this a nation-wide problem. A submission from the Victorian Department of Human Services is testament to the seriousness with which they view the use of psychostimulants by heavy vehicle drivers and other motorists. They cite recent work done in this area outlining their concerns:

Heavy Vehicle drivers also continue to be at high risk. Vic Roads safety expert Phillip Swann stated at a recent road safety conference that drugged-out drivers were more dangerous than drunk drivers. Phillip Swann cited a 10 year study by the Victorian Institute of Forensic Medicine, which showed that psychoactive drugs outstripped alcohol among some road-user groups. The Victorian road safety report also cited in the paper 'Psychostimulants in Australia' (Henry Edwards 2001) indicated that stimulants were found in 21% of dead truck drivers compared with 3.9% of all dead drivers. This would seem to indicate an urgent need for harm reduction strategies to address this continuing problem.¹⁴³

Researchers and writers such as Mabbot and Harley recognise that driver education, particularly with regard to the side effects of psychostimulants, is very important. It is also suggested that prohibition of some psychostimulants may have positive effects (or conversely push drivers into seeking the drugs underground). However, neither of these measures will, according to the authors, prove effective in reducing fatigue-related crashes without a change to industry practices.

143 Submission of Human Services Victoria (Drug Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', September 2002.

Rave and club culture and its relationship to ecstasy use

As discussed in Chapter 2, ecstasy has been described as an 'atypical' drug that does not fit within traditional pharmacological groupings, as it possesses both hallucinogenic and stimulant properties. Nor are ecstasy users necessarily 'typical' or at least stereotypical of 'drug users'. The recent survey of ecstasy users in Adelaide, South Australia conducted by the National Drug and Alcohol Research Centre found that they:

[t]end on the whole to be young, well educated, heterosexual, from English speaking backgrounds and likely to be employed or engaged in studies. Most subjects had not had contact with police or other social authorities and did not come from socially deprived backgrounds, and few engaged in crime other than drug dealing. None were currently in treatment for a drug-related problem, and only one had a criminal conviction (NDARC 2001, p.vii).

The 'double' effects of ecstasy – that is, as both stimulant and euphoric producing but 'controlled' hallucinogen – seem to be one of the reasons that ecstasy is such an attractive drug for its users. Solowij et al's early research on ecstasy use in Sydney found that:

Ecstasy is an appealing drug to recreational drug users in that it provides an 'added bonus'. That is, for those seeking primarily stimulant effects it also induces the positive mood, euphoric and intimacy effects; for those seeking an enlightened experience or perhaps emotional therapy and insight it provides feelings of intimacy and closeness to others plus the stimulant-like alertness, talkativeness and energy.

Further, it is a drug experience in which one feels that one can remain in control of one's thoughts and actions rather than the drug being in control... Shulgin and Nichol's described [the controlled altered state of consciousness] as an 'easily controlled altered state of consciousness, with emotional and sensual overtones' and this was apparent in the responses of a large proportion of this sample, often being given as a reason for preferring Ecstasy over more 'mind bending drugs' (Solowij et al. 1992, pp.1169–1170).

A relatively recent study of ecstasy use in Australia (NDARC 1998) produced similar findings to the earlier survey work done of Sydney ecstasy users (Solowij et al. 1992) as to the reasons young people in particular use ecstasy:

A range of motivations for ecstasy use were reported, many consistent with those reported in the Solowij et al. (1992) study. In both studies, participants reported that a combination of curiosity, availability and having friends who used encouraged them to experiment with ecstasy. Ecstasy-induced euphoria was the overwhelming reason for continued use. Other reported reasons for continuing to use reinforced the nature of ecstasy as both a stimulant and an hallucinogen, as well as an 'entactogen' or 'touchy drug' (Hermle, Spitzer, Borchardt & Kovar, 1993; Solowij et al., 1992). Thus, energy, confidence, heightened sensations, the group experience of warmth and friendship,

improved communication and empathy, and insight and clarity of thought, were all important reasons for continued use in the present sample. Further, these effects of ecstasy were most often described as the best things about the drug.

These effects also relate to the activities undertaken while intoxicated, which were more extensive and varied than just dancing at clubs or raves (Henry, 1992; Forsyth, 1996). They included socialising and meeting new people, feeling emphatic and close to friends, touching, relaxing, 'hanging out' at home, having sex and thinking. Its enhancement of social events makes ecstasy conducive to use in many situations, ranging from using at home with a partner for empathy and intimacy, using during the day with friends to go shopping or to the beach, to taking small doses before the cinema or dinner parties. Although the social effects of ecstasy, in combination with the hallucinogenic and stimulant effects, made dancing in an aurally and visually stimulating environment a favourite activity for many participants there were many participants who had never used the drug in a dance environment.

Ecstasy is a drug used within a particular context. Few participants in either sample reported that they used it alone, with their dealer or acquaintances. Most used with small groups of friends, larger groups of friends or partners. Participants described extensive networks of friends who used the drug, with a majority of both samples indicating that most of the people they spent time with currently used ecstasy. The majority of those in the present study with regular partners reported that their partners also used. The social nature of ecstasy use also relates to the sources from which the drug is obtained; almost all participants (91%) usually obtained ecstasy from their friends (NDARC 1998, pp.35–36).

The Victorian Department of Human Services is concerned about the reasons young people use ecstasy and their lack of understanding of potential harms, as stated in its submission to this Inquiry:

Ecstasy has always been associated with the rave and dance party scene, which seems to attract young people from all cultures and socio-economic backgrounds, apparently with plenty of money to spend on drugs. In the main however, people who attend rave parties are well educated, employed or involved in studies, extremely sociable young people most likely from the middle and upper classes. They have not usually had involvement with the criminal justice or the drug treatment system. The drugs are considered as much a part of the rave party culture as the music and the clothes.

"Many young people in the rave subculture are coming into contact with drugs for the first time. This becomes more apparent as the rave subculture grows in numbers and many more people under the age of 18 join the scene. People younger and younger are having to make decisions about whether or not they are going to take drugs" (RaveSafe Safetime 1999).

"Ecstasy is very much a social drug that decreases inhibitions, enhances social experience and allows people to share emotions together" (RaveSafe Safetime 1999).

It is evident that impressionable young people with little experience or knowledge of drugs are becoming involved in a culture of which they have little understanding and are introduced to drugs purporting to be ecstasy, which may contain a harmful cocktail of other drugs and substances.¹⁴⁴

The NDARC Topp survey found that contrary to popular opinion:

[e]cstasy was used in a wide variety of situations, rather than being exclusively a dance drug. Ecstasy appears to have become a 'mainstream' drug in Australia, used by a demographically diverse range of people in a variety of contexts, not all dance oriented (NDARC 1998, p.viii).

Nonetheless, ecstasy is still very much a drug to be found and used at raves and dance parties and these are the contexts with which it is most associated. It is to this context that this section now turns.

The rave and club scene

In Australia, the emergence in the late 1980s of 'raves', often open-air or 'secret' dance parties associated with acid house music,¹⁴⁵ often brought with it, at least in the public and media mind, a concomitant use in 'party drugs', particularly MDMA (ecstasy) (Ryder, Salmon & Walker 2001, pp.242–243). By the 1990s a shift was observed whereby ecstasy use was more associated with a music and dance scene located in mainstream night clubs, discos and licensed premises (Fitzgerald 1992; Lenton & Davidson 1999; Boys, Lenton & Norcross 1997). Such a shift was not restricted to Australia but was also noticeable, somewhat earlier, in the United Kingdom and to a lesser extent the United States.¹⁴⁶

144 Submission of Human Services Victoria (Drug Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', September 2002.

145 Acid House is an eclectic music style originating in the United Kingdom. It draws from and incorporates modern and cool jazz, 1970s funk, house or dance music, soul, hip-hop, fusion and reggae. It became popular in the underground, rave and dance scenes in London, soon spreading to most other (western) music and dance scenes in the 1980s.

146 Lenton, Boys and Norcross (1997) note the suggestion that since the rave/dance culture has become located in more mainstream settings there is a danger that particularly younger users may not heed the 'safe' drug use messages adhered to by some members of a more 'traditional' rave culture:

'[t]he risk of harm has increased due to ill-informed, inexperienced users who do not have the knowledge informally held within a more entrenched drug culture. Many new ravers were found to have romantic, positive beliefs about effects of ecstasy, LSD and speed and were effectively blind to the more negative effects including needle sharing and risky sex. There is also a risk that novice ecstasy users, unaware that the drug can take an hour or so to take effect, may think that they had bought a 'dud' and go in search of alcohol or some other drug with serious interactive effects' (1997, pp.1328–1329).

A discussion of harm reduction campaigns as they apply to rave and party goers is given in Chapter 8.

Ecstasy use and club dance culture appears to be part of an international (youth) trend and 'while there are some exceptions, descriptions of ecstasy users in the literature are remarkably similar between countries and regions' (Gowing et al. 2001, p.11)

A recent global survey of ecstasy use auspiced by the United Nations makes the following comments:

Ecstasy users tend to be middle class, socially well integrated, well educated, are more likely to be employed than other drug users and less likely to have a criminal record. In Australia, the Netherlands, the USA, and Canada, ecstasy users are predominantly white, although use is increasing among other ethnic groups in the USA (Anonymous 1998; Anonymous 1999d; Forsyth 1996; Gamella 1999; Luna 1999; Smart 1999; Topp *et al* 1997b). In the Philippines, users predominantly come from wealthy families or are professional entertainers (Sunga 1999). Associations between ecstasy use and sex workers are reported in a number of countries including China (UNDCP Regional Centre for East Asia and the Pacific 2000), Spain (Gamella 1999) and the USA (Luna 1999). In spite of these trends, ecstasy use is found across the whole range of socioeconomic backgrounds and unemployed youth are considered to be at high risk (Henry-Edwards & Ali 1999; Liu 1999; Luna 1999)...

Ecstasy originally became popular as a party drug in association with so-called 'raves' at which large groups of young people gathered to listen to specific types of music and dance all night (Milroy 1999). This association has continued and rave attenders have the highest reported prevalence of ecstasy use. Ecstasy has also spread into regular nightclubs, discos and parties although prevalence of use in these settings tends to be lower (Anonymous 1999f; Anonymous 1999d; European Monitoring Centre for Drugs and Drug Addiction 1999; Forsyth 1996; Gamella 1999; Handy *et al* 1998; Klee 1999; Liu 1999; Luna 1999; Moskalewicz *et al* 1999; Smart 1999; Sunga 1999; Topp *et al* 1997b). Some users also use at home and in other venues but use seldom occurs alone (Handy *et al* 1998; Topp *et al* 1997b). (Quote and all references therein cited in Gowing et al. 2001, p.11.)

While it certainly seems that much of the club culture surrounding ecstasy use has to a certain extent become commercial and mainstream, Lenton's research suggests that, at least in the west, there is a move back to the 'rave experience' by ravers who are disillusioned with the commercialisation of the nightclub scene:

In Western Australia, as disenchantment grew with what many in the scene experienced as commercialisation and exploitation, a movement back to underground and unregulated events occurred with those in the scene reclaiming the scene by running their own events. These became known as 'Doofs', onomatopoeic for the heavy bass of music heard while approaching a rave held in a, usually clandestine, outdoor setting (Lenton & Davidson 1999, p.154).

Motivations for attending raves

The motivations for attending raves and the attraction of the rave (and club) scene centre on a combination of music, dancing, lighting and the pleasurable and euphoric feelings produced by the drugs taken, particularly 'ecstasy', although similar descriptions have been attributed to ketamine at raves (see for example, Dotson, Ackerman & West 1995).

Champness (2000) describes the compelling nature of a (Victorian) rave in the following terms:

The thumping tribal beats at rave dance parties, which attract the dedicated music fans, provide more than a good excuse to dance. There's an inherent sense of community, of being taken away from reality to another dimension, an altered state of being where the surreal becomes truth.

At a rave, the DJ is shaman, controlling psychic musical voyages by manipulating music and working beats and samples into a mind bending tapestry of sensory overload.

Together with visual stimuli, and more often than not, drugs, the experience elevates one to an altered state of physical or psychological existence (Champness 2000, p.50).

Gowing's international survey of ecstasy use reflects similar observations:

Sociability is a major characteristic of ecstasy use. It is almost exclusively taken in a social setting with partners or groups of friends. Users particularly seek the feelings of empathy and closeness with others, which result from ecstasy use, to foster a group identity and sense of belonging (Anonymous 1998; Gamella 1999; Klee 1999). Friends have a major influence on ecstasy use with the majority of users reporting that they were introduced to ecstasy by friends, and decided to try it because friends were using. A significant proportion report that they continue to use because their friends are using (Gamella 1999; Sherlock & Conner 1999; Topp *et al* 1997b).

There is a strong influence of youth culture, lifestyle and fashion trends on these social networks and groups of friends. Ecstasy is associated with a variety of specific cultural trends in particular networks where the importance of the group is emphasised. These groups have been likened to tribes which go out together, share the same taste in music or dance and develop the same norms (Anonymous 1998; Luna 1999). There is fairly universal acceptance of drugs as a component of the music and dance scene among these groups (Gamella 1999; Klee 1999). The gay club and party scene and the 'techno' music scene are two examples of particular subcultures in which ecstasy use is popular (Gamella 1999; Luna 1999; Anonymous 1998). In the UK, there are large differences in drug use at nightclubs and parties depending on the type of music played, with 'rave' and 'techno' music most associated with ecstasy use (Anonymous 1999f; Forsyth *et al* 1997; Klee 1999). In spite of the significance of drug use within the club and party scene, users in the UK rate drug use as

only the fifth most pleasant experience after music, socialising, atmosphere and dancing (Klee 1999) (Quote from Gowing et al. 2001, pp.11–12).

One of the perceived attractions of the rave for those who attend, particularly women, is the lack of a 'sleaze factor' and a generally non-violent ambience. This is partially attributed to far fewer people being intoxicated by alcohol than at other types of venues such as bars, nightclubs and pubs:

People who go are all going to have a good time, and very rarely are they drinking, and I think that helps to keep away people [who are] being really sleazy, really aggressive. So people are generally really friendly to everyone, really social, no one gets aggro, everyone is very accepting of different people, colour, sex, size, age, whatever they're like, because its such a broad angle of people going to raves (Male aged 19, quoted in Lenton & Davidson 1999, p.154).

Siokou (2002) researched ecstasy use in the Melbourne rave scene and also found among her respondents that one of the main attractions of the rave culture was a 'sense of feeling free and safe':

Over 90% of interviewees stated that they felt safe at raves and had never been harassed by anyone. One female interviewee, Anna (aged 26), stated: "I feel safe at raves even if I come alone and I have never been hassled by anyone. I would be too scared to go to a nightclub alone" ...There is a low level of consumption of alcohol at raves and combined with a focus on the music and dancing rather than 'picking up' this clearly creates a feeling of safety for participants that they do not experience in other forms of night time entertainment (Siokou 2002, p.14).

Raves were also seen as not creating a homophobic atmosphere. Even at dance parties which were not exclusively gay or lesbian, same sex couples were not frowned upon. Conversely, at dance parties and raves catering for homosexual people in particular, there tended to be a relatively high percentage of heterosexual people in attendance. This phenomenon testified to the fluidity of a youth culture predominantly based on music, fashion, books and dance rather than sexuality per se.¹⁴⁷ The move to rave parties enhanced by the use of 'party drugs' indicates a cultural swing that reflects a change from pub-based hard rock to acid house and techno dance parties. Dr John Fitzgerald of Melbourne University's Politics Department has stated that all things being equal, ecstasy can be seen as a relatively constructive social development for young people at least compared to alcohol and the 'suburban beer barns and meat market clubs' (quoted in Sweet 1997):

'What we've got is a generation of young people who've experienced social relations where a lot of the gender based distinctions are overturned', he says. At dance parties, men don't stand around awkwardly, waiting until they're plastered, to hit the dance floor (Sweet 1997, p.11).

147 For a discussion of amphetamine and ecstasy use in the gay community, see below.

Webb states that ecstasy use explains why:

[S]ocial drugs have become appropriated into mainstream youth culture, where they operate as both coping devices and ready-made identity badges... As one reviewer [United Nations Drug Control Programme] has commented: "On the one hand they offer possibilities for coping with today's performance-oriented society and social pressure on adolescents. On the other hand, they are used as representations of integration and socialisation, of a fashionable lifestyle and collective identification" (Webb 1998, p.92).

Communality and unity

Lenton and Davidson's survey research of 83 people who attended raves in Perth found that over a quarter of the sample (27%) described a 'sense of community' as being one of the chief attractions of the rave scene:

Everyone's, it's like a big family sort of thing...you get to know everyone from the raves, when you get to see them every single rave and that. You feel like you're somebody, you feel like you belong somewhere (Female aged 17, quoted in Lenton & Davidson 1999, p.155).

Ecstasy in particular is seen as promoting group solidarity and togetherness:

Ecstasy is the classic, because it enhances that group atmosphere, lots of people I know talk about the 'mass breathe' where everybody's almost breathing as one, it's one of the things with Ecstasy, it makes your respiratory system go mad. You can be in a crowd of 1000 people, feel like you're all taking in the same breath sort of thing (Male aged 22, quoted in Lenton & Davidson 1999, p.157).

This is what Nolan in her study of rave culture in Townsville, Queensland calls 'communality': 'Communality can be defined as a sense of unity or oneness with other rave participants' (Nolan 1998, p.7). Moore also observes this sense of collective consciousness among his sample of psychostimulant users in Perth (Moore 1992a):

An individual basking in the euphoric glow of Ecstasy, experiencing the kaleidoscopic sensory whirl of a trip, or internally racing under the influence of half a gram of speed, may positively vibrate to the pumping sound of contemporary dance music, the pulsating lighting displays and the mass of thrusting, sweating bodies in such close physical proximity. Any minor physical side effects such as sweating, jaw grinding or mild nausea will be largely ignored in such contexts.

One pharmacological property of stimulants well suited to nightclubbing is the ability to remain awake and 'up' for several hours. After injecting half a gram of speed, or dropping a trip or an 'Eckie' mid evening (say 10pm), one is likely to be still awake at dawn or even later the next morning. The afternoon is then used to rest or alternatively, phone calls are made, prices and quantities are agreed and arrangements made for procuring further drug supplies for the

coming evening. If there are few demands from the 'straight' (non drug using) world, such as an employment incompatible with little sleep or a social appointment with non using friends or relatives, sleep may be dispensed with altogether for several days, until one's money, source of drugs, desire to consume further or stamina run out (Moore 1992a, p.52).

Some of the most interesting qualitative research on ecstasy use in Australia comes out of Western Australia (Moore 1992a; Lenton & Davidson 1997). A relatively recent survey of users of ecstasy in Perth (Hansen, Maycock & Lower 2001) stresses the importance of friendship networks to the casual user of ecstasy:

A range of factors was important when making the decision to use, however the friendship groups and social support network were revealed to be of particular importance. All participants initiated their use in the company of close friends, partners or a relative. These friends were either fellow initiates or they were previously experienced and thus were accorded the role of guide and mentor. In this role they were responsible for reducing feelings of anxiety, monitoring the effects (physical and psychological) and enhancing the experience of the new user. Feeling comfortable, relaxed and secure were universally reported as essential to ensuring a positive introductory experience. The presence of friends in itself did not, however, serve to meet those needs. Typically, the initiate sought out information concerning the effects, risk of adverse events and strategies to minimise those risks from experienced acquaintances prior to making the decision to use. This was either done directly, by asking experienced individuals, or through observation of users in situ.

The appeal for ecstasy users appears to be controlled freedom, a loss of inhibitions, affirmation of friendships and...a range of sensory sensations linked to enjoyment and pleasure. Ecstasy is the drug of choice because it provides the fun, confidence and companionship that the users seek without the negative consequences associated with other recreational drugs. In fact, a significant proportion viewed ecstasy as an alternative to alcohol and preferred its effects. The preferred effects included the lack of aggression (physical and sexual), the sense of retaining control, the absence of a hangover, the positive feelings experienced during the ecstasy high, the loss of inhibitions (in particular dance-related inhibitions for men), the sense of intimacy and the desire to dance. Essential to the popularity of ecstasy is the sense of control that the users maintain, as the following quote highlights:

I don't like being not in control. I've always whenever I've had stuff before I've always been able to control what I'm doing. With 'e's you always know what you're doing. You can always remember what you did' (A.J., aged 23) (Hansen, Maycock & Lower 2001, p.187).

An even more fascinating study of the communality found among ecstasy users is that of McElrath and McEvoy (2001). The authors conducted in-depth

interviews with 50 users of ecstasy in Northern Ireland. Their paper explores the folklore of ecstasy use 'as it relates to the social relationships of drug user lifestyles' (p.1). Of particular interest is the fact that the communality produced by 'ecstasy', 'the loved-up drug', at least for the duration of the time it is being used, crosses sectarian boundaries of religion, culture and class in 'socially estranged' (and highly demarcated) communities such as Belfast. In other words, according to some of the study's respondents, the use of 'E' and the dance/rave scene has a positive impact on intercommunity relations between Protestant and Catholic. Take some of the following responses for instance:

'I think Ecstasy has had a very positive effect. I have to say living where I do which would be perceived as a Protestant loyalist area, I hadn't had much dealings with Catholics you know. I have to say I have made a couple of good friendships through it [Ecstasy] and it doesn't matter to me now whereas before I would have put my flag out on the twelfth and this sort of craic. Now I don't bother putting my flag out.'

'I'm a Catholic myself, I used to fight with the Protestants out in the park like but since we've took drugs like we don't give a fuck and people we used to scrap with, we go out and party with.'

'[Ecstasy] greatly changed my socializing. Before, I wasn't much into religious mixing ... you would have known and talked to people but you wouldn't have gone out with somebody from the other religion and [Ecstasy] changed your perspective, you meet people you realize it's not all everybody's been saying, you know, talk to them. I know some guys I knew turned from being in bands and being staunch loyalists into mellow people who started having Catholic girlfriends and all.'

'Ecstasy has bridged that gap socially... You would have had Catholics and Protestants but you would [also] have had loyalists and some republicans and to have them housed in one place was amazing like, you know? And they couldn't have done that unless they were off their faces, you know?' (All respondents quoted in McElrath & McEvoy 2001, pp.13–14).

Siokou (2002) has examined the rave culture in Melbourne, Victoria. Drawing from earlier work by Hopkins (1996), she explores the concept of collective and multiple identities and a sense of unity as it applies to rave culture:

Rave parties are events at which participants enter a fantasy world, which is dominated by loud techno music and utterly different to their everyday lives. There is a paucity of academic studies of raves...this paper focuses on theoretical issues to do with the construction of identity by the participants in raves... These questions about unity and identity are significant in the context of raves. Many ravers I have met during the past six years have asked me, "Has the party got the vibe?" as a way of asking whether the crowd is feeling unified and emotionally part of something larger than themselves (Siokou 2002, p.11).

Siokou, as with many of the commentators on ecstasy and the rave scene, stresses the importance of music to the overall collective experience:

Music played at raves is generally provided by a DJ. It is very loud, electronic and has minimal vocals. The ravers all dance facing the DJ...rather than each other, which is more often the case at clubs. Malbon's (1999) comment that music "provides us with an intensely subjective sense of being sociable...it both articulates and offers the immediate experience of collective identity" may be applied to the Melbourne rave scene. Many of my interview respondents stated that through the experience of dancing to electronic music at a rave, 'the vibe' or collective identity is created among the crowd. This is exemplified when a classic or anthem song is played (Siokou 2002, p.13).¹⁴⁸

In Siokou's study of the Melbourne rave scene, 75 per cent of her respondents had taken ecstasy and 60 per cent had taken some form of amphetamines and marijuana. Alcohol use was rare and there was little or no use of heroin or cocaine. Siokou writes:

Many ravers described drugs such as ecstasy and amphetamines as enhancing their appreciation of the music and their ability to dance, so that they literally 'feel' the music through their bodies. Ecstasy enhances empathy and lowers social inhibitions. Sheila Henderson (1997) notes that "it is curious that a drug which can increase emotional closeness, enhances receptivity to being sexual and would be chosen as a sexual enhancer, does not increase the desire to initiate sex" (Siokou 2002, p.15).

While drugs such as ecstasy are undeniably used at raves and dance clubs, according to Lenton and Davidson (1999) and contrary to much popular and media belief raves are not 'drug supermarkets'.

Perhaps surprisingly only 17 per cent of the Lenton and Davidson sample mentioned drugs as one of the attractive aspects of the rave scene, despite the fact that it was believed the majority of attendees used drugs at the rave. Many of the respondents commented on the synergy produced between the drug and its effects, the music, dancing and lighting:

Techno [is the] sort of music to listen to on drugs because it just sort of goes with it. The whole thing, little things just add up, like the lights and the

148 Siokou states that the Melbourne rave scene is bound to change once warehouse or 'dock' parties cease at the Melbourne Docklands due to redevelopment :

'The location shift will alter the Melbourne rave scene because many of the raves will be subsequently held at licensed nightclubs, which have a different atmosphere compared to dock parties which are held at huge warehouses colourfully decorated, with a DJ pumping extremely loud music through the speaker systems. "Chill out rooms" with quieter music and comfortable seats and cushions provide space for a break from dancing and offer people a chance to recuperate and talk.

The atmosphere at dock parties may be considered more underground compared to nightclubs which are generally smaller and more restrained. Furthermore, alcohol is not generally sold at the Docklands, whereas it is the main commodity at nightclubs' (Siokou 2002, p.13).

atmosphere, a hypey atmosphere hypes you up and gets you going, and that sort of like relates to the drugs, what the drugs do to you anyway, they sort of hype you up, but that sort of adds to it (Male aged 20, quoted in Lenton & Davidson 1999, p.157).

As the authors state, however, it is not that drug use is seen as a necessary part of the rave experience as much as the rave experience is viewed as being enhanced by the use of drugs, particularly ecstasy.¹⁴⁹

I've been to raves straight and I've been to raves off my face as well. The connection is well, you can have a good time if you're there and you're not under the influence of any drugs, but if you are, you have a better time because the lights are three times more brilliant, and the music is more impressive, you get disorientated and you've got a challenge to try and get your orientation back. I suppose it's...an environment conducive to taking drugs. You don't have to, but it is definitely a better time if you do (Female aged 21, quoted in Lenton & Davidson 1999, p.157).

Preparing for the rave

Southgate suggests that preparing for a drug experience is reflective of a phenomenon called 'folk pharmacology':

Folk pharmacology she explains involves a range of knowledge and practices from how to score drugs to how to reduce harm. Strategies include having support networks around if taking a new kind of drug, injecting or taking large quantities of a substance (Southgate quoted in Haire 1999, p.19).¹⁵⁰

149 A different paper produced by the authors based on the same sample noted that 'poly drug use' was prevalent among the sample, including amphetamines, ketamine, cocaine and nitrites. Poly drug use is discussed in Chapter 4. See also Dotson, Ackerman and West 1995; Von Sydow et al. 2002.

150 Moore's survey of ecstasy users in Perth also implicitly draws upon this notion of 'folk pharmacology', outlining a whole set of behaviours that reflect a particular culture of drug use, including the purchasing or scoring of the drugs, the relationship of buyer to seller, the distinction between a casual ecstasy user and a junkie, the process of ingesting the drug and the rituals of preparation (less complex with ecstasy which usually need only be swallowed). A full discussion of these fascinating rituals is beyond the scope of this Discussion Paper. The following discussion of how ecstasy and other psychostimulant users may view 'junkies' is, however, an interesting insight into the folk culture of a particular set of drug users:

'While members of this set viewed becoming a "junkie" or dependent on drugs with some trepidation, there was also a certain degree of admiration for what was seen as a sinister yet sometimes attractive status. Being a "junkie" or at least an injecting drug user was to claim membership of a dark, esoteric, subterranean world which involved deception, risk and a certain degree of glamour. Such feelings contrasted sharply with equally strongly-felt notions of uncontrollable drug use which characterised descriptions of the "junkie".'

Thus attitudes to the various adverse consequences of drug use display a marked ambivalence. Although "coming down", physical side-effects and becoming a "junkie" are recognised as drawbacks to or hazards of drug use, they may also be reinterpreted in a more favourable light in future discussions. When stories about particular events (and their negative consequences) are told and re-told, such drawbacks may become integral parts of an incident or period being remembered, in much the same way as hangovers, so often regarded in surveys as an "alcohol related problem", may become part of drinking legend amongst social networks of participating individuals. *Drug related harm and problems may become part of the folklore of drug use*' (Moore 1993, pp.64–65). (Committee emphasis)

In various qualitative surveys on ecstasy use, many respondents who do take drugs at raves testified to the importance of *preparing* for a big rave or gig in terms of taking drugs. This accords with much of the international literature on 'scoring' ecstasy (see Rosenbaum 1989; Forsyth 1995; Shewan, Dalgarno & Reith 2000). Sixty-one per cent of the sample profiled by Lenton and Davidson (1997) preferred to arrange their scoring or drug acquisition days ahead of the rave, and sometimes weeks ahead. Not to do so could result in missing out, paying excessive amounts for the drugs or risk an increased chance of being arrested for drug possession if the 'score' was done at the venue itself. It would seem that most people who score ecstasy do so from friends who in turn may purchase from an 'informal' dealer who may or may not be dealing for profit. Often the purchase is made on behalf of a group of friends who then share the drug. In other words, ecstasy acquisition is far less likely to be scored off the street than other illicit substances. Moreover, drug distributors, those who pass on or facilitate the deal, are less likely to do so for profit (other than cheaper or free drugs) (Lenton & Davidson 1999, p.158).

According to Moore's 1993 study of urban users in Perth, the financing of ecstasy use is much more likely to be from licit sources such as salaries, savings or unemployment benefits than illegal methods such as burglaries or stealing. This may well reflect the view that for the most part ecstasy is perceived as a non-addictive drug with planned use which does not result in the desperation surrounding scoring associated with drugs such as heroin. As Moore states: 'Funds expended on drugs [such as ecstasy] can be compared to those spent by non drug users on consumable items such as clothes, compact discs, alcohol or books' (1993, p.42). Solowij's earlier study of Sydney ecstasy users found that Friday and Saturday nights were chosen as the best times to take ecstasy '[s]upporting the notion of ecstasy as a recreational drug suited to a working lifestyle' (*Connexions* 1991, p.6).

More recent survey evidence of Western Australian ecstasy users shows that meticulous preparation for a 'big ecstasy night' is still common. Hansen, Maycock and Lower comment on the experiences of recreational ecstasy users in Perth:

The whole ecstasy experience is made up of events that surround the drug. Beginning with the decision to purchase; 'scoring' (the purchase of the drug); preparations for use; 'popping the tab'; the comedown and the inevitable 'eckkie blues' (the recovery phase that often includes mild to moderate, and in some individuals, intense, feelings of depression). The phases involved specific rituals that culminated in the actual use event. Each served to heighten user anticipation and expectations, which combined to create the overall ecstasy experience. These rituals included purchasing chubba chubbs/lollipops (to reduce the effects of gum chewing), mints, menthol drops or nasal sprays (to heighten the experience) and marijuana (for the comedown), organising music (specific to each stage), co-ordinating consumption and monitoring the group's progress.

The phases themselves were often spread out over a period of time, sometimes weeks and even months, while for spontaneous use events the phases were completed within a very short time frame. This appeared to have some effect on the experiential outcome. The physical setting (club, pub, home, beach) also tended to affect the organisational process and the various rituals involved, and therefore significantly affected the end experience...

The participants attempted to exert control over set (expectation, risk perception, mood) and setting (physical surroundings), and although it was impossible to control for the drug, they adopted measures such as using a regular supplier and having pre-taste tests as methods of semi control. New users were initiated into the ecstasy-using experience by more experienced users who helped the new initiates to interpret the symptoms they experienced during the drug use. The data revealed evidence of user folklore and myths that served to define and influence the overall drug experience. Users came to accept certain 'norms' about the effects, benefits and harms associated with their use of ecstasy. Using this knowledge they become more expert at manipulating drug, set and setting to maximise the experience and reduce the potential risks. Thus, despite the evidence of occasions of unplanned and spontaneous use, the participants revealed highly ritualised and largely controlled behaviour in relation to their ecstasy use (Hansen, Maycock & Lower 2001, pp.194–195, 197).

Siokou also reports that ravers regularly use drugs in planning the 'coming down' phase, most commonly marijuana. Marijuana is used predominantly to counter the depressive feelings associated with 'Blue Tuesday':

The energy that speed and ecstasy provide is only gradually sapped from the body so many ravers do not tire until two or three days later when they experience an effect commonly known as 'Blue Tuesday'. Symptoms of Blue Tuesday include moodiness, exhaustion and/or depression. Marijuana is also used to bring back the feelings induced by ecstasy tablets when its effects are wearing off or, alternatively, for putting the person to sleep. Some interviewees also use sleeping tablets to cure their insomnia. This behaviour supports Collin's argument that young people: '[b]ecome expert manipulators of mood, choosing exactly what to take in each situation to produce specific psychopharmaceutical responses, applying sophisticated cost benefit analyses to each substance' (Siokou 2002, pp.16–17).

A study based on the questioning of a focus group of 42 ecstasy users in Scotland tested the assumption:

[t]hat drug users are by definition reckless with regard to drug-related risk. A common assumption made of drug use is that it is a necessarily chaotic, relatively unplanned, impulsive event (Shewan, Dalgarno & Reith 2000, p.431).

Acknowledging the dearth of information available about the social and behavioural characteristics of ecstasy users and recognising that this prevents

informed policy, programme and harm reduction development, the authors explain their use of focus group methodology as follows:

The advantage of a focus group is that it allows the researcher to interact with the participants directly, clarifying issues and also observe non verbal behaviour that may contradict verbal response... One purpose of using a focus group, as opposed to individual interviews for example, is that this method offers data which includes negotiation of meaning between participants and allows the identification of subtle differences in meaning between focus groups (Shewan, Dalgarno & Reith 2000, pp.432–433).

The following response, for example, of one of the participants was fairly typical of the focus group as a whole:

Oh yes, the majority of times when I'm using drugs I plan it in advance, just to fit in with my lifestyle. If you're going to work on Tuesday, then at weekends you know you cannot be too many miles from home, and not have recovered fully by the time you are back in class, so pretty much it's planned (Shewan, Dalgarno & Reith 2000, p.445).

Just as with Siokou's study of Melbourne ecstasy users, so too in Scotland did this meticulous planning extend to the 'coming down' phase, as indicated by the following comments from participants in the focus groups:

'Planning a night, aye. Organise the evening, get hash in, get booze in for later. I like to make sure I've nothing to do the next day as well. That's a definite.'

'It's nice to have some things organised for a good night. It's good to have some hash at home and some drink maybe, even if I don't actually go home, it's good to know it's there. Also I like to know I've got the day off. I also like to have company too, when I'm coming down.'

'The next night I like to have a few joints and a few beers and chill [relax]. It just takes off the rough edges.'

'That's true, the comedown can be a bit nasty, and a wee drink can smooth it all off for you.'

'Yeah, it's like being prepared, you know? It's like the more you do it the more you become...'

'You know what to expect.'

'...yeah, and you know what's going to make you feel *most comfortable*, 'cos that's basically what everyone wants, is to feel as comfortable as possible, before, during and after. I mean the only hassle for us is if we've got to go somewhere, who's going to drive, that's a hassle sometimes' (Shewan, Dalgarno & Reith 2000, p.447). (Authors' emphasis)

This fascinating exercise in ethnography is summed up in the words of one of the participants: 'Drug taking *has* to have rules' (Shewan, Dalgarno & Reith 2000, p.447). (Authors' emphasis)

Drug, set and settings

Similar to surveys of ecstasy use in Australia, the Scottish focus groups of Shewan, Dalgarno and Reith showed that planning extended beyond the scoring of the drug to being in the right emotional mood when taking the drug; that is, the 'set' must be right. The consensus of the groups was that 'ecstasy was not a drug that should be taken when experiencing psychological difficulties of some sort' (2000, p.442). As one participant commented:

It's [ecstasy] definitely something I wouldn't take if I was feeling down or depressed. It's definitely not something I would take to get out of that...there's only one drug I'd bother with and that's alcohol, you know, to get yourself through a bad patch (quoted in Shewan, Dalgarno & Reith 2000, p.442).¹⁵¹

When it comes to considering the *drug* ecstasy, another Scottish survey from the mid 1990s has revealed some fascinating results. Forsyth (1995) states that the pattern of ecstasy use (in Glasgow) deviates from all other drugs in as much as the sub-culture has grown up around several brand names, designs, forms, sizes and colours of ecstasy pills, tablets and capsules. A survey of 135 users of ecstasy in the Glasgow area who were part of the rave scene were interviewed about their experiences of dance drugs. Among other findings, respondents were able to identify over 300 forms of substance being marketed as ecstasy, each with their own peculiar characteristics, shapes, colours, names etc. A physical description and an account of the subjective effects of these different types were given by each respondent. Brand names seem to be commonly ascribed to a particular feature of the drug, for example form (liquid E, bayer E); content (Saddam Hussein, Madwoman); shape (snowball, rusk, brown burger); colour (pink and white, manchester united, ie. red as per their guernseys); effect (smacky E, speedy E) and so on. Forsyth argues that a definite 'consumerist' culture has been built up around ecstasy acquisition:

There is an interesting parallel here between users' beliefs about the dance drug ecstasy and dance drug music; both are mixed. Perhaps Ecstasy can be seen as representative of a wider youth culture of conspicuous consumption, rather than simply being another drug used by drug users. From the point of view of the user, the importance of ecstasy lies in its place as part of a wider lifestyle, not merely as a drug, important for only its pharmacological effects.

151 Shewan, Dalgarno and Reith ground their research in Zinberg's framework of drug, set and setting referred to earlier, and previous work done by Weil (1972).

"Drug" is particularly relevant in the context of this study due to the variability in the amount of MDMA present in a tablet, and the presence of other psychoactive drugs such as MDA, ketamine or MDE.

"Set" is defined by Weil as a person's expectation of what a drug will do, considered in the context of a whole personality.

"Setting" is defined as the physical and social environment in which a drug is taken. As both Weil and Cohen have pointed out, the possible interactions of these components are equally as important as determinants of a drug experience as are the components individually' (Shewan, Dalgarno & Reith 2000, p.438).

When buying Ecstasy, the user is buying a feature of a lifestyle not a substance (Forsyth 1995, p.207).

In other words, unlike or to a lesser extent than drugs such as heroin and methamphetamines, ecstasy is part of an overall package in which the chemical properties or the rush of the drug is only one, albeit a significant, aspect. Despite some recent evidence that ecstasy may be crossing over to become an injectable street drug,¹⁵² it is still largely inseparable from other aspects of the youth culture such as music and dance.

When it came to a discussion of *setting*, participants were of the opinion that while ecstasy was most often taken in the context of a rave or dance club, and often to the beat of loud music, other settings had been (sometimes inappropriately) used:

I sat in a Jacuzzi with big bags under my eyes...it was quite a scary experience, 'cos with my dilated pupils, looking around and seeing the Sunday morning hangover faces, plus the overheating effect of the water, I suddenly felt very sick and out of place on my drug [ecstasy] (quoted in Shewan, Dalgarno & Reith 2000, p.444).

On the other hand, participants said taking ecstasy in atypical settings such as the home could also be pleasurable:

'I've taken E sitting in the house, and I enjoyed it.'

'A couple of my friends took it at home just sitting in the living room and the two kids had got up during the night, and this was about two in the morning, and they said it was one of the best times they'd ever had...E'd out of their heads with two kids, playing: how relaxing can you get?' (quoted in Shewan, Dalgarno & Reith 2000, p.444).

Moore's study of ecstasy users in Perth also comments on the use of the drug in 'mellow' domestic settings. Similar feelings of 'pleasant euphoria' expressed by those in the Scottish focus studies were experienced by the Perth respondents:

Yet, Ecstasy users also describe the experience as one of clarity. There is no fuzzing or distorting of the senses; just heightened appreciation of sensory messages and a supreme sense of well being. The experience in these quieter settings is not as intense as those where the drug user is bombarded with stimulus (like the nightclub). People report being able to drive a car, conduct conversations and generally conduct themselves without loss of control under its influence (Moore 1992a, p.56).

Luckman (2000) contrasts the experience of the raves as outlined by Lenton and Davidson with the ecstasy tripping that takes place in nightclubs,

152 A study conducted by the National Drug and Alcohol Research Centre (1998) found that 16% of a sample of young ecstasy users from Victoria, New South Wales and Queensland (n = 329) had injected ecstasy and 10% had injected ecstasy within the six months preceding the interview (NDARC 1998, p.8)

particularly in the big cities of Australia. According to Luckman, the death of Anna Wood resulted in a regulatory framework for clubs that was aimed at providing information to (young) people on the dangers of ecstasy and ways in which to reduce the harms associated with it. This is compared to the relatively ad hoc raves that still take place in usually rural settings around Australia:

[t]he release of governmental guidelines regulating the conduct of dance parties/raves has brought little joy to those for whom dance music cultures are more a personal cultural (or political) commitment than simply a money making strategy. Put together largely by police authorities, in consultation with various other governmental agencies, community groups and commercial entrepreneurs, the final documents privilege forms of organising dance party entertainment that are only possible where financial capital already exists. However...small scale operations continue, especially in places outside the eyes of the law (of which there can be many in a place as large and thinly populated as Australia). More DIY and counter hegemonically motivated corners of the scene which remain strong and active, particularly in places such as the North Coast of New South Wales [sic]. Since the sixties, this lush and climatically agreeable part of the country has been a haven for counter cultures, and with the tourist mecca of Byron Bay not too far away... While there are some suitable indoor venues, given the generally pleasant year round weather, most events in this region and in the Brisbane hinterland are conducted outdoors.

It is these sites that highlight more than anything else the limits of official regulatory regimes...bush raves are frequently organised in a clandestine fashion with ticket holders having to follow, telephone, checkpoint or online directions to get to the final –unadvertised – venue or site. A further variable in the Australian scene is the difficulty, and to an extent the pointlessness, of spending significant resources on policing raves and dance parties given the nation's vast open spaces. In the UK and Continental Europe community complaints have commonly been the impetus behind police crackdowns on events. This has also been true of events held in urban Australia, with sometimes violent police closures of free parties in Sydney an example. But in the open and relatively unpopulated spaces of rural Australia this is less of a concern (Luckman 2000, pp.221–222).

Most of the studies of ecstasy use and rave/dance culture examined in this setting have directly or indirectly referred to the importance of drug, set and setting. The following comments that apply specifically to the Scottish focus studies of Shewan, Dalgarno and Reith (2000) could no doubt be applied to all of these across the board:

The...data indicate participants' awareness of drug, set and setting which can lead to both adverse and positive effects when using ecstasy. The general trend within these data is not only recognition of these factors, but also a pattern of use which was aimed towards minimising harm, while maximising enjoyment.

The data...indicate participants' general awareness of the application of drug, set and setting in combination and particularly the benefits of planning and preparing for an ecstasy taking episode on the basis of these three principles (Shewan, Dalgarno & Reith 2000, p.445).¹⁵³

In the context of beliefs about ecstasy use and harm reduction knowledge in the rave scene, Boys, Lenton and Norcross state that :

Information campaigns targeted at people in the rave and dance party scene appear to have been well received. However, much of the harm reduction material targeting dance drugs has tended to focus on the effects of taking an individual drug in isolation. There seems to be little information about the possible effects of combining drugs, possibly because the research needed to support such information is scarce (1997, p.228).

Harm reduction principles and practices in the context of the culture of use will be discussed further in Chapter 8.

'Party drugs' in the gay and lesbian community

Drug use at dance clubs and parties is not of course an issue restricted to gay culture, but it is definitely *part* of that culture.¹⁵⁴ Gay raves and dance parties are seen as safe venues where gay men and lesbians can be themselves, free of homophobic threats.

Ryan and Keen explain the attractions of the gay party scene:

The [gay] dance party scene has developed along with post-Stonewall gay culture. Many of the bigger parties in Australian cities have grown out of gay and lesbian community events. Some gay and lesbian dance parties are part of a lineage of mass celebrations where people come together to participate in a life-affirming expression of communal identity and beliefs...

Such celebrations are often characterised by ecstatic, orgiastic release; extreme and unusual behaviour is allowed and things are generally turned on their heads. They are a time out of time. They simultaneously provide space for self expression, and participation in a collective articulation and affirmation of a shared identity...

Many modern gay and lesbian dance parties contain elements which are similar to ancient events: spaces are constructed to exclude the (real) outside world and create a new, artificial world – partygoers step into different identities and roles through costume; normal states of consciousness and perception are disturbed through drug use; and people dance all night instead of going to bed (Ryan & Keen 2001 (1999), p.4).

153 See in particular Lewis and Ross 1995 for a detailed discussion of the gay dance party culture and its relationship to drug use.

154 The use of the drug, set and setting framework as an adjunct for harm reduction policies is discussed in Chapter 8.

In a survey of recreational drug use, with a focus on ecstasy use in Perth, Moore (1993) comments on the experience of young gay men with whom he conducted several interviews. To a certain extent their party drug use was very much a product of their feelings about being gay and their experience of 'straight' society:

[these men] ...describe and understand drug use in terms of 'altered states', of experimentation, and of rejecting 'straight' society in favour of a coherent, well organised alternative value system in which their sexuality is not a mark of derision or exclusion. In their shared understandings about drugs, themes such as sharing the experience with friends, of grasping new perspectives on their lives while under the influence of drugs, and of thumbing their noses at the conservative, homophobic majority appear frequently (Moore 1992a, p.32).

The sense of 'other worldliness' testified to by Ryan and Keen, while one of the attractions of the gay dance scene and the taking of 'party drugs', also:

[c]reates an interesting dilemma for partygoers, promoters, and health educators: when everyone is trying as hard as they can to go beyond and outside their normal selves, how can everyday concerns – such as safe sex, safe using and adherence to HIV therapies – be properly incorporated in people's party planning and experience? (Ryan & Keen 2001 (1999), p.4).

Despite the 'liberating' aspects of much gay dance and party culture, concerns have been raised as to the extent, type and level of drugs being used at dance parties and nightclubs within the gay, particularly male homosexual, community. More importantly, such concerns have been expressed by members of that community. Drug and Alcohol Researcher, Paul Dillon, writes:

Recent studies have found that particular drugs are used by a sizeable percentage of homosexually active men, with men who identify with the lifestyle of the gay community far more likely to report recreational drug use than those who are not involved in that community.

However, experts believe that it is difficult to quantify how rates of drug use among gay men compare with those among the heterosexual population.

Research examining gay men has identified that their potential alcohol and drug abuse may be due to a number of factors including drinking styles, stress or the cultural importance of bars.

Gay men's involvement with the nightclub and dance party scene and the influence this has on increasing levels of drug use has also been examined. Dance parties have become increasingly popular in gay communities around the world, while nightclubs and bars have been long associated with gay culture (Dillon 2000, p.10).

Dillon comments that 'ecstasy' would appear to be far the most popular dance club drug associated with gay men, but amphetamines, LSD and ketamine have all appeared on the scene. In more recent years GHB has proven particularly popular in gay circles, at least in part due to its reputation as a sexual enhancer.

A recent survey of drug and alcohol use in the Victorian gay and lesbian community (see Murnane et al. 2000) attests to the central role of drug use in some parts of the gay community and culture:

Historically in both Australia and other developed countries, drug use has been at the centre of the establishment and the 'coming out' of the gay and lesbian community as a whole. Initially, sympathetic bars and clubs were the sole places where gay men and lesbians could socialise. Later Mardi Gras and a variety of dance parties became a way of celebrating the community and developing a sense of unity and strength. MacEwan and Kinder (1991) described a 'tripartite family system' made up of family of origin, an intimate partner and a close network of gay and lesbian friends, the latter being 'the major support for identity formation and maintenance'. Whilst not all gays and lesbians frequent pubs and nightclubs, it appears that such venues play a different role than in the general community. A qualitative investigation of the gay dance party phenomenon in Sydney identified a number of themes: that drug use is prominent at such events, there are established etiquettes and rituals around drug taking at these events, people in the age range 14–46 years attend the parties, attending the events and taking drugs has strong meanings for both individuals and the communities around belonging, defining and celebrating community (Lewis & Ross 1995 in Murnane et al. 2000, p.11).

Just as research on drug use among the heterosexual population reflects concerns about the relationship between drug use and unsafe practices, certainly, international studies have expressed dismay at the relatively high correlation between drug use and high risk behaviours within the homosexual population. Much of this research has concerned injectable drug use, unsafe sex and HIV risk but more recent studies have examined links between the use of 'party drugs' and high risk behaviours. For example, Klitzmann et al. (2002) examined the patterns of use of 733 gay men using MDMA/ecstasy in New York City. MDMA use, particularly at night and dance clubs, was found to be directly associated with unsafe and unprotected sex. The authors state:

...MDMA users are a group at risk that are young, are engaging in high risk sexual behaviours that may expose them to HIV or other STDs, ...and are using MDMA which may cause neurotoxicity. MDMA users as a group thus may face several important threats to their health. Part of the public health problem may lie in the fact that MDMA may be perceived as being safe because it is non addicting. Clearly, there is a need to research perceptions of the drug as safe or unsafe and in what ways it is or is not seen as posing risks.

MDMA use presents particular challenges in terms of possible interventions. MSM [Men who have sex with men] users [of MDMA] are more out and involved in the gay community than MSM non-users. Being 'out' can thus be psychologically advantageous in terms of dealing with stigma, but may also place individuals in settings where MDMA is used. Indeed, for many men,

MDMA use may be a part of a process of entry and socialisation into gay culture itself (Klitzmann et al. 2002, p.124).

Community forums have been held by various AIDS Councils and also by the Sydney Gay and Lesbian Mardi Gras to discuss drug use among the community. (Haire 1999; Dillon 2000). Although there has not been a great deal of research into the drug patterns, and particularly party drug use, in the Australian gay community, research by Erica Southgate at the University of New South Wales indicates there is a high rate of recreational drug use in the gay community:

...[t]he Sydney Men and Sexual Health Report showed that 78% of men surveyed had used illicit drugs in the last six months, and 12% had injected drugs ... "From [Drug Use in Gay Men, a qualitative study], we've identified patterns of drug use within the gay community. The most prominent pattern is around partying – dance parties or clubbing" said Southgate...(quoted in Haire 1999, p.19. See also Knox et al. 1999).

Despite this fairly high figure, Southgate believes that most members of the gay and lesbian community adhere to harm reduction practices (including the use of needles to inject drugs) and have 'a commitment to controlled drug use' (Haire 1999, p.19).

Although most of the Australian research focuses on gay men, the University of New South Wales is broadening its research profile to study the drug use of lesbians and women attached to the gay community.

A major research project on drug and alcohol use among gay and lesbian communities in Victoria was conducted recently.¹⁵⁵ This study developed a project to identify patterns of drug use and associated harms within the gay community and the consequent development of appropriate harm minimisation strategies.¹⁵⁶ A detailed analysis of the findings is beyond the scope of this Discussion Paper, however some general findings give an important insight into the role drugs and alcohol, and in particular 'ecstasy', plays in certain gay, lesbian and queer communities. In 1998 a questionnaire survey of 518 members of the Victorian gay and lesbian community established that:

- Overall the alcohol and other drug use within the GLBQ [Gay, Lesbian, Bisexual, and Queer] communities is two to four fold higher than in the general community [compared to figures in the National Household Survey 1998];
- Many respondents referred to past drug and alcohol problems. These were often associated with low self-esteem, depression, anxiety,

155 See *Beyond Perceptions: A Report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria* (Murnane et al. 2000)

156 Conducted jointly in partnership with the Australian Drug Foundation (Centre for Youth Drug Studies), the ALSO Foundation and VicHealth.

paranoia, confusion around sexuality, and the stress of 'coming out' to family, friends and work colleagues;

- Alcohol and other drug use was associated with particular subcultures or contexts, for example ecstasy, amphetamines and LSD were strongly associated with the 'dance party scene'. Poly drug use was common with different drugs used to achieve different effects;
- Illegal drugs are normalised to such a degree for some members of the GLBQ communities that their illicit nature is barely recognised;
- For some respondents drugs were seen as integral to creating and celebrating a sense of community and belonging. Some described it as a 'rite of passage'...(Murnane et al. 2000, p.7).

When examining ecstasy use in particular, the survey found that 65 per cent of men in the age group 20–29 had ever used the drug (23.9% in the last month prior to completing the survey) compared to 13 per cent of men aged over 50 (1.8% in the last month) (see Tables 5.1 and 5.2). This compared to 36 per cent of women having ever used ecstasy in the age group 20–29 and 7.1 per cent in the over 50 age group. Generally men were twice as likely as women to have used drugs of any type (except ketamine where gay men were six times more likely to have used this drug compared to women).

Table 5.1: Percentage of respondents ever having used ecstasy

	National Household Survey 1998			GLBQ	
	Age	Women % by age	Men % by age	Women % by age	Men % by age
Ecstasy/ Designer Drugs	20-29	11.9	19.1	36.0	65.2
	30-39	3.7	9.5	24.6	59.1
	40-49	0.0	0.0	2.3	36.7
	50+	1.6	1.9	7.1	12.7

Note: Men in the 20–29yr age group were four times more likely to have ever used ecstasy or designer drugs at 65% compared to men 50+, 13%. This percentage was considerably higher than the proportion of young men in the National Household Survey (NHS) sample (19% for 20–29) and 2% for 50+.

The percentages decreased from 36% of women (20–29) to 25% (30–39) then dropped substantially to 2.3% (40–49) and rose again to 7% (50+) with respect to ever having used ecstasy. It is difficult to explain this rise in the older age group. It did not occur in the male data. The difference in proportions between women in the Gay, Lesbian, Bisexual and Queer (GLBQ) sample and the NHS is considerable with 36% compared to 12% for women (20–29). The difference for men is also substantial, particularly within the 20–29yr old group, with 65% in the GLBQ sample compared to 19% in NHS. The difference continues in the 30–39yr, 40–49yr and 50+ groups.

Source: (including Note commentary): Adapted from Murnane et al. 2000, *Beyond Perceptions: A report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria*, The ALSO Foundation, Centre for Youth Drug Studies, Vic Health, Melbourne, p.36.

Table 5.2: Percentage of respondents using ecstasy in the last month

National Household Survey 1998				GLBQ	
	Age	Women % by age	Men % by age	Women % by age	Men % by age
Ecstasy	20-29	1.6	1.6	4.0	23.9
	30-39	0.0	0.5	0.0	13.6
	40-49	0.0	0.0	0.0	3.8
	50+	0.7	0.0	0.0	1.8

Note: For men in this GLBQ sample, ecstasy use ranged from 24% (20–29), 14% (30–39), 4% (40–49) and 2% (50+). Ecstasy use was only reported by 4% of women in the 20–29 age group and not by any women in other age groups. This is supported by the qualitative data, which indicated that ecstasy use is associated with the commercial and dance party scene, in which the greatest participants are gay men (although young women seem to be starting to become more involved in this in recent years). In comparison to the NHS the highest percentage was 1.6%, found for young women and men (20–29), which again could be associated with their involvement in the rave culture.

Source (including Note commentary): Adapted from Murnane et al. 2000, *Beyond Perceptions: A report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria*, The ALSO Foundation, Centre for Youth Drug Studies, Vic Health, Melbourne, p.44.

The percentage of gay men using ecstasy, particularly in the age group 20–29, was far higher than that for the heterosexual cohort based on the National Household Survey (NHS) (19% for the 20–29 age group and 2% for the over 50 age group).

With regard to ketamine, 24 per cent of the 20–29 year age group of young men had ever taken ketamine compared to 1.9 per cent of the over 50 group. Only four per cent of lesbians in the 20–29 year age group took ketamine and no women over that age took ketamine (see Table 5.3). In the last month, 2.2 per cent of gay men aged 20–29 and 1.1 per cent of women aged 30–39 had taken the drug. No men in the higher age bracket and no women at all had used ketamine in the last month (see Table 5.4). There were no figures available for NHS data (Murnane et al. 2000, pp.36–37).

Table 5.3: Percentage of respondents ever having used ketamine

National Household Survey 1998				GLBQ	
	Age	Women % by age	Men % by age	Women % by age	Men % by age
Ketamine	20-29			4.0	23.9
	30-39			0.0	20.5
	40-49			0.0	11.4
	50+			0.0	1.9

Note: In this GLBQ sample approximately a quarter of the (20–29) males reported having used ketamine and this then decreases to 21% (30–39), 11% (40–49) and 2% (50+). This exhibits a very different pattern to women’s where the only use of ketamine reported is in the 20–29yr group at 4%. In the qualitative data references are made to the effects of ketamine as, ‘get so blotto’ and ‘you loose [sic] your perception of time’. Although not mentioned in the qualitative data, ketamine is now being identified in some of the tablets sold as ecstasy. There are no data available for NHS comparison.

Source (including Note commentary): Adapted from Murnane et al. 2000, *Beyond Perceptions: A report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria*, The ALSO Foundation, Centre for Youth Drug Studies, Vic Health, Melbourne, p.37.

Table 5.4: Percentage of respondents using ketamine in the last month

National Household Survey 1998					GLBQ	
Age		Women % by age	Men % by age	Women % by age	Men % by age	
Ketamine	20-29			0.0	2.2	
	30-39			0.0	1.1	
	40-49			0.0	0.0	
	50-59			0.0	0.0	

Note: Use of ketamine was only reported by 2.2% by men (20–29) and 1.1% (30–39). This indicates that although the drug is used rarely its use is specific to the gay male community. No comparison with NHS is available.

Source (including Note commentary): Adapted from Murnane et al. 2000, *Beyond Perceptions: A report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria*, The ALSO Foundation, Centre for Youth Drug Studies, Vic Health, Melbourne, p.45.

Finally, with regard to amphetamines (methamphetamine) gay men in the sample were much more likely to have used amphetamines than those in the National Household Survey (76% of the GLBQ survey compared to 20% of the NHS cohort for the 20–29 year old age group). The percentage of lesbians having ever used amphetamines (48% in the 20–29 year old age group) was also substantially higher than the NHS sample (18% of women aged 20–29). It was noted that for both men and women in the GLBQ sample amphetamine use was likely to decrease with age (see Table 5.5).

Table 5.5: Percentage of respondents ever having used amphetamines

National Household Survey 1998				GLBQ	
	Age	Women % by age	Men % by age	Women % by age	Men % by age
Amphetamines	20-29	18.4	20.7	48.0	76.1
	30-39	10.3	21.9	44.9	64.8
	40-49	4.3	7.0	17.4	50.6
	50+	1.6	1.9	7.1	14.5

Note: The number of respondents reporting ever having used amphetamines decreased with age. Thus young men at 76% in the 20–29yr age group were five times more likely to report using amphetamines compared to 15% for (50+). Further, the proportion of 76% (20–29yrs) for this GLBQ sample of males is much higher than the 20% reported in the NHS. At 15% for (50+) this percentage can still be considered notable for men in this age group when compared to the NHS sample of 2%.

In comparison, women's reports of ever having used amphetamines were generally lower than men's, with 48% of women 20–29yrs compared to 76% of men (20–29). This percentage is still considerable however, with almost half of the women respondents having used. This percentage is also substantially higher than the NHS figure of 18% for women (20–29yrs).

These data are supported by numerous references in the qualitative data to widespread use of amphetamines, along with other drugs, typically at nightclubs and dance parties. Mention was made by a number of respondents of the difficulty individuals experience when trying to withdraw from amphetamines.

Source (including Note commentary): Adapted from Murnane et al. 2000, *Beyond Perceptions: A report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria*, The ALSO Foundation, Centre for Youth Drug Studies, Vic Health, Melbourne, p.35.

In the last month, 17 per cent of gay men compared to two per cent of the National Household Survey sample in the 20–29 year old group had taken amphetamines. While lesbians took amphetamines far less frequently than gay men, their use was still high compared to the women in the National Household Survey. Eight per cent of women in the 20–29 year old GLBQ group compared to one per cent of women in the National Household Survey took amphetamines in the last month (see Table 5.6).

Table 5.6: Percentage of respondents using amphetamines in the last month

National Household Survey 1998				GLBQ	
	Age	Women % by age	Men % by age	Women % by age	Men % by age
Amphetamines	20-29	1.2	1.6	8.0	17.4
	30-39	0.0	0.5	2.9	14.8
	40-49	0.0	0.0	0.0	2.5
	50+	0.0	0.0	0.0	1.8

Note: 17% of men in the 20–29 yr in this GLBQ sample compared to 2% of the NHS survey used amphetamines in the last month. The percentages for women were lower than men, at 8%, but still substantially higher than women of the same age in the NHS, at 1%. Interestingly, 2% of men in the 50+ age group had used within the last month compared to nil in all the other groups of that age.

Source (including Note commentary): Adapted from Murnane et al. 2000, *Beyond Perceptions: A report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria*, The ALSO Foundation, Centre for Youth Drug Studies, Vic Health, Melbourne, p.43.

The survey makes some interesting comparisons with the data collected and what is known from an ethnographic and social perspective about the gay community and dance culture, particularly as it applies to age:

The reports of ever having used most drugs declined very rapidly with age. Thus among men, those aged 50 or more were five times less likely to report ever having used amphetamines, four times less likely to report ever having used ecstasy or designer drugs, and three times less likely to ever report ever having used cocaine. Similar patterns were apparent among women. This suggests that the use of such drugs has become much more common within the communities within the last 30 years, the period of major development of the commercial lesbian and gay worlds (Murnane et al. 2000, p.32).

The Murnane survey is a useful document that shows how a mix of qualitative and quantitative data and methodologies can point the way to informed policy development with regard to drugs and particular harm reduction programmes, be they used in the gay and lesbian or wider communities. Harm reduction, education projects and associated policies will be discussed in greater detail in Chapter 8. Some of the techniques being currently implemented by gay communities, however, do have implications for mainstream Victoria. As Dillon states, ‘many of the drug trends identified within the gay dance scene

eventually emerge in the general community' (2000, p.11). They are therefore worth paying close attention to.

Middle-class professionals and ecstasy use

Early studies by Rosenbaum, Morgan and Beck (1989) examine a different cultural profile of ecstasy use, namely the middle-class professional who does not fit into the stereotype of 'junkie' or 'raver'. During the course of their research the authors noted that several middle and upper middle-class professionals used ecstasy on a regular basis:

This group, we discovered, has been able to integrate drug use into their busy lives, scheduling it in much like any other appointment or activity. It is, in the words of one respondent, 'controlled hedonism' for the ability to choose selectively where, when and how one experiences a...moment of 'time out' behaviour with drug induced altered states of consciousness (Rosenbaum, Morgan & Beck 1989, p.17).

Like the ravers in Lenton and Davidson's study (1999) and that of Shewan, Dalgarno and Reith (2000) these respondents testified to the importance of planning the drug experience. The acquisition, use of and aftermath of these professionals' ecstasy use was meticulously planned to the last detail.

The motivation in using ecstasy for these professionals was the reward it gave for a punishing and hectic work schedule. It was also contrasted with other drugs such as heroin, which were not seen as conducive to a busy professional lifestyle:

To me this is time out behaviour. My life is very full and I have lots of responsibility. I've got a lot of work that I need to do, I have a lot of deadlines. So to me it's like time out...it's like taking a vacation to Mexico for a week, only I'm going to do it in a day, because that's all I've got (Female aged 38, quoted in Rosenbaum, Morgan & Beck 1989, p.17).

Ecstasy was also viewed as part of the 'good life' in much the same way as good movie, a fancy dinner party or a ballgame. It also was seen as a way of 'depress[ing] time and accelerating interpersonal processes'. This point was particularly important for those whose workloads did not allow for frequent socialisation:

In addition to making you open, it seems to depress time and the ability to cover a lot of ground in this flurry of experience that you might take quite a long time to or may not get to without it. I think the world we live in right now seems too busy with our lives (Male aged 30, quoted in Rosenbaum, Morgan & Beck 1989, p.17).

For other members of the sample, ecstasy had a therapeutic benefit which allowed them to do 'two years of therapy in one afternoon' (Rosenbaum, Morgan & Beck 1989, p.17). The demographic of these users is clearly different to those in the rave or club samples. For instance, they are on average much

older, usually in their 30s and 40s, having already completed tertiary education and built up professional careers. The importance of their careers is highlighted in the meticulous preparation put into arranging an 'ecstasy weekend':

When a professional is planning his or her [first] trip, much research on the drug and its effects is done. These individuals have a healthy respect for the power of drugs, and want to know exactly what to expect. They tend not to like surprises and do not want to lose control. Consequently, they attempt to learn as much as possible about the drug before taking it (Rosenbaum, Morgan & Beck 1989, p.17).

Moreover, a combination of hectic schedules and the need for recovery time militates against having more than a handful of 'trips' in a given year:

[b]usy professionals do not have the time necessary to do more than three or four trips per year. They are too busy, too discriminating and a bit too old. Professionals cannot afford to lose sleep. Thus although it is understood that a 'trip' technically lasts four hours, with boosters of more MDMA or marijuana, it can be extended to eight or ten hours. Thus people very often take ecstasy early in the day, often between noon and 4.00pm and rarely later than 6 or 7pm.¹⁵⁷ This requires scheduling a whole day and night, rather than just an evening. Given that many of these people, aside from having demanding jobs, also have children, finding a mutually acceptable day and night can be quite a task. They report that usually five or six appointment books have to be consulted in order to find a date that works. And then numerous arrangements have to be made, clearing of calendars, procurement of babysitters, hotel accommodations if the group is going away for the trip...

...Often trips are planned in three day increments, so that the first day can be spent 'resting', the second for the actual trip, and the third for recovery and gearing up for the following week's work... (Rosenbaum, Morgan & Beck 1989, p.17).

Some of the respondents to the Rosenbaum, Morgan and Beck survey note that the planning can even extend to goals and objectives pertaining to relationship issues that can be 'worked through' while under the influence of ecstasy. In this respect ecstasy has an instrumental purpose that goes beyond merely getting 'high'.

If the professional is planning an Ecstasy trip for specific goals such as personal growth, awareness or building or patching up a relationship/friendship/marriage, often lists are made of items to address. Many professional couples, for example, use this opportunity to explore issues and/or problems in their relationship (Rosenbaum, Morgan & Beck 1989, p.18).

Thus the profile of user and the reasons for taking ecstasy are somewhat different when comparing the professional and the raver or clubber. The

157 Which is a major difference from the patterns of use of the young person who uses ecstasy as a club or rave drug.

professional user is much more likely to use ecstasy as an adjunct to inward reflection than the clubber. As such it may be used in conjunction with ambient music, a beautiful setting such as a beach and/or talking with friends or loved ones (Rosenbaum, Morgan & Beck 1989, p.18).

It should be noted that Rosenbaum's research is over ten years old and the debates surrounding ecstasy have changed in the intervening period. For example, as has been noted in a previous chapter, ecstasy, particularly if it is not pure MDMA, is not viewed as the benign drug that it was hitherto. Nor can the American experience be simplistically extrapolated to the scene in Australia.¹⁵⁸

Nonetheless, it still remains true that the sample of users profiled by Rosenbaum is testament to the importance of drug, set and setting (Zinberg). The dangers associated with using ecstasy in a calm and peaceful environment may be of a different order than that used in an overheated nightclub while dancing in an energetic manner. Moreover, a United Nations report on ecstasy in the mid 1990s found that a high proportion of recreational use of ecstasy was by people in the middle and upper classes (UNDCP 1996). Often price may be seen as the main determinant of who uses the drug. For example:

Whereas Ecstasy sells on the street for less than 20 pounds per tab in the United Kingdom and approximately A\$50.00 per tab in Australia, the average street price for a single tab of Ecstasy in New Zealand is around NZ \$90.00. This is outside the discretionary buying power of many people, particularly young people (Webb 1998, p.88).

The Committee would certainly welcome any information about this 'hidden population' of middle-class professional users of ecstasy in Victoria.

158 Solowij et al. in their earlier survey of ecstasy use in Sydney compared their own survey findings to that of an American survey (Beck et al. 1989). While many of the respective findings were comparable, an account of user profiles and 'culture' of use was in some ways quite different:

'While the study of Beck et al and the present study approached the subject matter from differing theoretical perspectives, a number of factors regarding the recreational use of Ecstasy have emerged consistently in both studies, and thus in both cultures. These include the motivations for use, patterns of use, mode and context of use, the nature of the experience itself (including effects, side effects and residual effects), abuse potential and issues of tolerance. Perhaps the only area on which the Australia and American samples differ is the hierarchies of user typologies. This may in part be due to this Australian sample being primarily an inner city one, while the American one was somewhat broader. In this Sydney sample at least, the most predominant users of Ecstasy were the dance party crowd and recreational drug users in general whose main reason for using ecstasy is to have "fun". It appears that Ecstasy has not penetrated the social world of the "New Age" spiritualists to the same extent in Australia as it has in the United States. While Australian users do seek the therapeutic effects of Ecstasy, it is in a way more akin to a "fortuitous therapy" user group with therapeutic effects being the secondary bonus rather than the primary reason for taking the drug' (Solowij et al. 1992, p.1169).

There is nothing substantial in the literature to suggest that this difference in user profiles has changed to any extent in the ten years since Solowij et al. conducted their study. In other words, ecstasy is still not used to any great extent as a primary therapeutic or 'New Age' drug.

Conclusion

The use, patterns and profiles of ecstasy and amphetamine use are constantly changing. Recent qualitative evidence, for example, suggests that at least in Australia the social demographic of ecstasy users is getting younger:

[The evidence] indicates that the age of Ecstasy users may be dropping, and the proportion of female users may be increasing. On the whole, the sample [of Sydney ecstasy users] was young and well educated. Ecstasy was reported to be used in a variety of social contexts. It was often linked to dance events such as nightclubs or dance parties, but was also used at pubs, friends' houses and at home. Most of the Sydney sample emphasised that Ecstasy users were just ordinary people who were not necessarily part of any particular 'scene' (Webb 1998, p.88).

Similarly some of the most recent research surveys of ecstasy use in Australia (NDARC 1998; Hansen, Maycock & Lower 2001) have also found that the patterns of ecstasy use are changing.¹⁵⁹ While ecstasy is still highly, even primarily, associated with dance parties and to a lesser extent 'raves', at least in the public eye, the authors note that it has also moved in recent years into the mainstream, being used by a much more diverse range of people.¹⁶⁰

As noted in Chapter 2, there has also been a slight but apparent shift from oral recreational use of ecstasy to injectable street use:

[Survey] Participants were asked to nominate a 'type' of ecstasy user with which they most identified. This proved a somewhat ambitious undertaking as some participants were reluctant to categorise or 'pigeon-hole' themselves, and some were unable to name a single scene or type with which they identified. While many participants identified with various dance scenes, the item provided a flavour of the wide range of ecstasy users in Australia and

159 'Data from recent Australian research suggested that ecstasy was increasingly being consumed by a more demographically diverse group of people than has been previously recorded (NDARC 1998). This trend was also evident in data taken from Western Australia (Australian Institute of Health and Welfare 1999; National Drug Strategy Household Survey 2000). The majority of self-reported ecstasy users were aged between 20–29 years of age; however, a significant number of users were aged 30 years and above, with approximately 11% of users belonging to the 40+ age group (National Drug Strategy Household Survey, 2000). All age groups, except the 30–39 years group, revealed little to no variation in the number who reported having ever used and having used in the past year. This suggests that there is a small but dedicated number of "older" (40+) ecstasy users within the Perth community. Despite this evidence, much of the research and many of the intervention programs have focussed on the rave/dance music scene and youth, thus ignoring a significant "hidden" population of ecstasy users. This study purposively selected a sample of ecstasy users to represent the pattern of age use in Western Australia, with the intention of broadening the current understanding of popular recreational ecstasy use in community settings' (Hansen, Maycock & Lower 2001, p.182).

160 A comprehensive survey of international ecstasy use also attested to this change in patterns of use and demographics of use:

'There is evidence from a number of countries that ecstasy has spread beyond the rave culture and is also used in a variety of other situations: European Monitoring Centre for Drugs and Drug Addiction 1999; Forsyth 1996; Gamella 1999; Handy et al. 1998; Klee 1999; Liu 1999; Luna 1999; Moskawiecz et al. 1999; Smart 1999; Topp et al. 1997, (all citations quoted in Gowing et al. 2001, p.10).

refuted the common view that ecstasy is *exclusively* a dance drug. Participants identified with a broad range of 'types' or 'scenes' of ecstasy use, although the validity of such a 'typology' cannot be evaluated using survey methodology. Ethnographic research would be preferable to develop a typology of ecstasy users, similar to that described for amphetamine users [developed by] Klee 1997 (NDARC 1998, p.33). (Authors' emphasis)

As discussed earlier in this chapter, Klee's typology on amphetamine use is supported by little grounded research that gives much useful information about profiles of those who use amphetamines. The paucity of research, both qualitative and quantitative, for both amphetamines and 'party drugs' is the subject of detailed comment in Chapter 10.

Questions for discussion

- ◆ What is the culture or cultures of street use of amphetamines in Victoria?
- ◆ What other cultures of amphetamine use are apparent in Victoria?
- ◆ Have these changed in any degree since the advent of the 'heroin drought'?
- ◆ Are there any industrial, professional or occupational groups particularly affected by amphetamine or party drug use?
- ◆ What problems or risks does the use of amphetamines pose for transport workers and the community?
- ◆ How can this issue be best addressed?
- ◆ What is the cultural profile or attributes of those who use 'party drugs' in Victoria?
- ◆ What are the 'settings' of those who use 'party drugs'? Of what relevance is Zinberg's concept of drug, set and setting to your understanding of and work in the area of amphetamine and party drug use?
- ◆ What role does music play in the various party drug cultures?
- ◆ What are the motivations for using 'party drugs' among various users? Do these vary between different 'cultures'?
- ◆ What is the 'folk pharmacology' of party drug use?
- ◆ What evidence, if any, is there that raves are 'drug supermarkets'?
- ◆ Is there still a strong 'underground' rave scene in Victoria? How does this differ from the dance scene in nightclubs?
- ◆ Is party drug use restricted to the club/dance scene or has it broadened out to other sectors of the community?
- ◆ Is there much 'street' or injectable use of ecstasy?
- ◆ The literature on party drug use often mentions the importance of 'preparation' and 'planning' with regard to attending a rave and, particularly using drugs there. What sort of preparations are used or observed before,

during or after a rave or dance party? For example, what is done to ensure a relatively 'smooth' come down period?

- ◆ How is the culture or cultures of amphetamine and party drug use differentiated according to:
 - gender?
 - age?
 - sexuality?
 - ethnicity?
- ◆ Are there any other variables that need to be taken into account in differentiating the cultures of use?
- ◆ To what extent is amphetamine and 'party drug' use a problem in regional and rural Victoria?
- ◆ To what extent, if any, is amphetamine and 'party drug' use a problem amongst Indigenous communities in Victoria?
- ◆ How prevalent is party drug use in gay and lesbian dance or party culture?
- ◆ What types of drugs are being used in this 'scene'?
- ◆ What other, if any, 'cultures' of use and users should be addressed?

6. Law, Law Enforcement, Policing and Supply Control

This chapter examines a variety of issues that impact upon the way the legal and criminal justice systems deal with the issue of amphetamines and 'party drugs'.

The chapter commences with a brief discussion of the law, both domestic and international, as it applies to these drugs. It then discusses ways in which the police and other law enforcement agencies have addressed tackling the problems associated with amphetamines and 'party drugs'.

The law pertaining to amphetamines and 'party drugs'

International provisions

International law pertaining to the control of illicit drugs, including amphetamines and MDMA/ecstasy is governed by a number of conventions to which Australia is a signatory. These include:

- ◆ The United Nations Single Convention on Narcotic Drugs (1961);
- ◆ The United Nations Convention on Psychotropic Substances (1971); and
- ◆ The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).¹⁶¹

161 These various conventions are summarised by the Australian Institute of Criminology as follows:

'The Single Convention on Narcotic Drugs (1961)

This Convention aims to combat drug abuse by coordinated international action. There are two forms of intervention and control that work together. First, it seeks to limit the possession, use, trade, distribution, import, export, manufacture and production of drugs exclusively for medical purposes. Second, it combats drug trafficking through international cooperation to deter and discourage drug traffickers. The 1975 Protocol Amending the Single Convention on Narcotic Drugs highlights the need for treatment and rehabilitation of drug addicts. As of 1999, 168 States are parties to the Single Convention or are parties to the Convention as amended by the 1972 Protocol.

The Convention on Psychotropic Substances (1971)

This Convention establishes an international control system for psychotropic substances. It responded to the diversification and expansion of the spectrum of drugs of abuse and introduced controls over a number of synthetic drugs according to their abuse potential on

Subject to the 1971 convention, drugs are scheduled depending on their public health risk or therapeutic potential. Four schedules classify the drugs, with those in Schedule One having the greatest public health risk and those in Schedule Four having the most therapeutic potential.

Schedule One drugs are generally outlawed for general consumption. Amphetamines and 'Party Drugs' are usually placed in the first schedule. Schedule Four drugs, however, because of their perceived therapeutic benefits, will often be available under licence or prescription.

Signatories to the convention then adopt these schedules and their content in their own domestic legislation. However, according to Sandeep Chawla, Senior Research Coordinator with the United Nations Drug Control Programme (UNCDP), the system is far from ideal:

The present control system...is simply inadequate for controlling illicit markets...[t]he scheduling process is slow and cumbersome; individual substances rather than chemically, or pharmacologically-related classes of drugs, are put under control. New individual substances with no therapeutic potential, structurally different though pharmacologically similar (the ATS analogues) perpetually appear on illicit markets. They cannot be scheduled fast enough. The control regime is thus bound to lag behind illicit innovation (Chawla 1998, p.35).

Of particular importance in the area of amphetamines and amphetamine manufacture is the last mentioned of these United Nations conventions. Subject to the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, an international control regime has been established to prevent precursor chemicals being used to make illicit amphetamines. Such chemicals may include diversions of licit pharmaceuticals or chemicals used in industry, but Chawla is equally sceptical about the effectiveness of these measures in preventing the manufacture of illicit drugs:

Controlling the supply of synthetic drugs is difficult, because there are neither any easily identifiable botanical raw materials to target nor any long trafficking routes linking production and consumption areas to interdict... The precursor control regime is still young... In any case, it is not feasible to put all possible precursors for amphetamine type stimulants under international control because they have a vast amount of licit industrial uses (Chawla 1998, p.35).

the one hand and their therapeutic value on the other. As of 1999, 159 States were parties to the Convention.

United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)

This Convention provides comprehensive measures against drug trafficking, including provisions against money laundering and the diversion of precursor chemicals. It provides for international cooperation through, for example, extradition of drug traffickers, controlled deliveries and transfer of proceedings. As of 1999, 153 States were parties to the Convention, (Australian Institute of Criminology 2003, to be found at the AIC's Illicit Drug website: <http://www.aic.gov.au/research/drugs/context/international.html>).

Similar reservations have been expressed in Australia:

Internationally, the success or otherwise of these strategies will depend on the number of countries which participate in them and the level of control exercised. A major problem with such regulatory regimes is that they are administratively burdensome to implement. There are many companies involved in the commerce of precursors and the chemicals themselves cannot be restricted too much because they are essential to many legitimate manufacturing processes. This means that some countries will not have the regulatory infrastructure or the financial resources necessary to conduct an effective level of supervision. The complexity of the system also allows for numerous loopholes to be exploited. Finally, some nations are not concerned enough about the problem or convinced of the efficacy of this approach to ensure their commitment (Wardlaw 1993, pp.96–97).

Further information with regard to precursor synthesis is given in the following sections.

Subject to the international conventions, the Commonwealth has enacted the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act* 1990. This will be discussed below under the section pertaining to federal law.

Domestic law

In the Final Report of this Inquiry, a chapter will be devoted to comparing interstate law and practice with regard to the laws pertaining to amphetamines and ‘party drugs’. This Discussion Paper, however, will confine itself to an examination of the federal and Victorian state laws only. The Committee welcomes any information with regard to law and practice in this area, particularly from interstate jurisdictions, by way of submission to this Inquiry.

Australian law concerning drugs is divided between state and federal jurisdictions. The relevant federal legislation is the *Customs Act* 1901. In Victoria, most state drug provisions and penalties are found in the *Drugs, Poisons and Controlled Substances Act* 1981 (as amended).

Subject to the United Nations treaties outlined above, particularly the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, amphetamine, amphetamine analogues and derivatives and most ‘party drugs’, including methylene dioxy methamphetamine (MDMA or ‘ecstasy’), have been scheduled as prohibited drugs under domestic legislation.¹⁶²

Federal law

Customs Act 1901

The most important criminal offences under federal law are those found in section 233B of the *Customs Act*. This section prohibits the importation of

162 For Victoria, see Schedule Eleven of the *Drugs, Poisons and Controlled Substances Act* 1981.

certain goods, including 'narcotic goods'. Narcotic goods are listed in Column A of Schedule Six and include cocaine, codeine, heroin, MDMA, LSD, methamphetamine and analogues or derivatives of these drugs.¹⁶³

There are also offences relating to aiding and abetting importation (and exportation) of (narcotic) goods and conspiring with another person to so import (or export). It should be noted that with regard to these provisions there is a *reverse onus of proof*. Once certain matters of proof are led by the prosecution, particularly that the accused knew or was aware of the existence of the goods brought into Australia and in his or her possession, the accused then has to prove his or her innocence on the balance of probabilities.¹⁶⁴

There is no specific provision for *trafficking* per se in the *Customs Act*. Rather, 'What it does instead is to provide heavier penalties for people convicted of being in possession of stated quantities of a drug (thus inferring trafficking)' (Smith 2002, p.614).

Penalties for importation or putative 'trafficking' are found in Section 235. This section creates a set of 'sentencing ranges' depending on a number of variables, including the amount of the drug seized.

If both prosecution and defence agree, the matter may be heard summarily in a Magistrate's Court where the maximum penalty imposed is \$2000 or two years imprisonment (Section 235(7)). Otherwise the trial will proceed by indictment in the County Court where the penalties are much higher.

Penalties are prescribed depending on whether the amount in question is less than a *traffickable quantity*, a *traffickable quantity* or a *commercial quantity*. These quantities for each particular type of drug are listed in the Sixth Schedule of the Act.

If the amount is less than a *traffickable quantity* the maximum penalty is \$2000 and/or two years imprisonment. A *traffickable quantity* of drugs, other than cannabis, incurs maximum penalties of \$100,000 or ten years imprisonment or both, unless the defendant has prior convictions for possessing traffickable quantities in which case the penalties are greater.¹⁶⁵ If the defendant has no prior convictions for offences relating to traffickable quantities *and* the court is satisfied the traffickable quantity is *not* related to any *commercial dealing* then the maximum penalty shall only be \$2000 and/or two years imprisonment.

Finally, a person may be charged with importation of a *commercial quantity* as specified in the Sixth Schedule of the Act for each drug. A defendant charged with being in possession of, or any other offence concerning this quantity of drug, is liable to a maximum sentence of life imprisonment or such sentence as the court deems appropriate.

163 Schedule Six of the *Customs Act* is reproduced as Table E in Appendix 4.

164 For a discussion of the defences available to the defendant, see Smith 2002.

165 In such circumstances, the court may impose a penalty of life imprisonment. See Sec 235(2)(c).

Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990

As stated above, the Commonwealth has enacted the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* pursuant to its obligations under United Nations drug treaties. This Act needs to be read in conjunction with the *Customs Act*. This Act is wider in scope than the importation of drugs, although it does include such provisions. Its main offences concern 'dealing in drugs' (Section 6). It covers the possession of equipment (for example laboratory equipment used to synthesise drugs); the manufacture, extraction, preparation, distribution or transportation of narcotics and psychotropic substances; and the sale, supply or possession of narcotic drugs or psychotropic substances.

Different penalties apply to the act engaged in (for example, extraction, manufacture, separation etc) and the quantities involved. As with the *Customs Act*, penalties vary depending on whether amounts are *traffickable* or *commercial* with the latter attracting more serious penalties.

Victorian law

The Victorian *Drugs, Poisons and Controlled Substances Act 1981* covers mostly drug offences occurring within the jurisdictional boundaries of Victoria. These include offences pertaining to:

- ◆ Use
- ◆ Possession
- ◆ Cultivation
- ◆ Trafficking

Use

The use of a drug of dependence other than cannabis provides for a maximum penalty of \$3000 or imprisonment of one year or both (Section 75(b) *Drugs, Poisons and Controlled Substances Act 1981*). A variety of diversion programmes are available for people charged with non-violent drugs offences who can show that they have a 'drug problem'. These include the Court Referral and Evaluation for Drug Intervention and Treatment Program (CREDIT) and Drug Treatment Orders under the new Drug Courts. A discussion of these programmes is beyond the scope of this Paper (for further information, see Smith 2002).

Possession

Possession is an indictable offence under Section 73 of the Act. Smith explains the relevant law as follows:

Under common law, a person is in possession of a drug if he or she has physical control or custody of the drug to the exclusion of others not acting with the person. The prosecution must prove knowledge by the person of the presence of the drug and an intention by the person to possess the drug. In many cases, custody of a drug may supply sufficient evidence of possession, including the

necessary mental element. This is because the inference of knowledge may often be drawn from the surrounding circumstances.

As well as its common law meaning, possession has an extended meaning under the *Drugs, Poisons and Controlled Substances Act 1981*: section 5 states that a person is in possession of drugs if he or she is in possession of drugs that are:

- On any land or premises occupied by the person; or
- Used, enjoyed or controlled by the person in any place whatsoever, unless the person satisfies the court to the contrary (Smith 2002, p.605).

With the exception of cannabis, the penalties relating to possession of a drug that is not related to trafficking is \$3000 and/or one year's imprisonment (Section 73(1)(b)).

Trafficking

The law of trafficking is complex. In simple terms, if the prosecution proves the following matters:

- ♦ the accused was in possession
- ♦ of a scheduled drug
- ♦ of a quantity that is a *traffickable quantity*,

then this will be *prima facie* evidence of the crime of trafficking in the particular drug. Similar to the Customs Act, a traffickable amount is determined by reference to a prescribed weight listed for that drug in the Eleventh Schedule of the *Drugs, Poisons and Controlled Substances Act 1981*. Under Section 70(1) of the Act, the definition of trafficking has been extended to include preparing or manufacturing a drug of dependence for trafficking, in addition to sale or possession for sale of the drug. Thus the manufacture or 'cooking' of methamphetamine may constitute trafficking even though no actual trafficking has yet occurred as long as it can be proven that the manufacture was intended to be for the ultimate purpose of trafficking. Of particular importance is the fact that at state level the traffickable amount of the drug is no longer weighed as pure amounts: 'The relevant weight is now the weight of the whole mixture, including substances other than the drug' (Smith 2002, p.607). Thus, for example, the traffickable amount of MDMA, currently listed as 3.0g, could in appropriate circumstances include a compound mixed of pure MDMA and talcum powder, baking soda, or sugar. The same would apply to the traffickable amount of amphetamine (currently 6.0 grams).

In addition to traffickable quantities, as with the federal law, a person may also be convicted of the more serious crime of trafficking in a *commercial quantity*. Commercial quantities and large commercial quantities for drugs of dependence are also found in Schedule Eleven of the Act.

These categories are still differentiated between pure amounts of the drug and where the drug may be mixed with other compounds or additives. The current *commercial quantity* of amphetamine is 250 gms (pure amount) and 1.25 kgs

(mixed amount). The current *large commercial quantity* of amphetamine is 750 gms (pure) and 2.50 kgs (mixed amount). The current *commercial quantity* of MDMA is 100 gms (pure amount) and 500 gms (mixed amount) respectively. The *large commercial quantity* of MDMA is currently 750 gms for pure amounts and 1 kg for mixed amounts.¹⁶⁶

Trafficking offences of non-commercial amounts attract a maximum penalty of 15 years imprisonment and/or a fine of \$100,000. These sentences increase to 20 years imprisonment and \$250,000 when the person is convicted of trafficking to a person under the age of 18.¹⁶⁷

A conviction for trafficking in a commercial quantity results in a maximum penalty of 25 years imprisonment. If the person is convicted of trafficking in a *large commercial quantity*, the penalties are even more severe – maxima of life imprisonment and *in addition* up to \$500,000 fine.¹⁶⁸

Trafficking also extends to manufacture. Under Section 71A of the *Drugs, Poisons and Controlled Substances Act*:

A person who, without being authorised by or licensed under this Act or the regulations to do so, possesses a substance, material, document containing instructions relating to the preparation, cultivation or manufacture of a drug of dependence or equipment with the intention of using the substance, material, document or equipment for the purpose of trafficking in a drug of dependence is guilty of an indictable offence and liable to level 5 imprisonment (10 years maximum).

In a submission to this Inquiry, representatives of Victoria Police have expressed reservations about the Victorian legislative framework pertaining to amphetamines and ‘party drugs’. In particular, they have concerns about the operation of Section 71A of the *Drugs, Poisons and Controlled Substances Act* as outlined above:

The definition of trafficking under the Act includes manufacture. The issue with this section of legislation is proving the intent of the person possessing the materials to traffick (manufacture). Investigators have found this problematic in prosecutions. For a prosecution to succeed under the current legislation police must first prove that a defendant found in possession of certain materials has done so in the knowledge that the materials are for the illicit manufacture of drugs. Under this section usually prosecutions only succeed where the accused makes admissions as to their intent. It is suggested to overcome the issue of proving intent that a person found in possession of any items listed in section 71A has a reverse onus applied to them.

166 See Schedule Eleven, Part Three

167 See Table F in Appendix 5 for a full list of penalties.

168 For figures of arrests and prosecutions for a variety of federal drug-related crimes, including amphetamines, MDMA and other ‘designer drugs’ for the period 2000–2001, see the *Australian Illicit Drug Report 2000–2001* (ABCI 2002). For an interesting analysis of criminal investigation pertaining to amphetamine and ecstasy control in Queensland, see Queensland Crime Commission 2000, 2001.

It is rare for a single individual in a criminal syndicate to possess all the precursors and equipment used in the manufacturing process. Usually the chemicals and other materials required in the process are deliberately stored separately. It is only when the actual manufacturing process is in progress and all the chemicals and materials are present that the difficulty of proving intent is lessened.¹⁶⁹

As such, Victoria Police have made the following recommendation to the Committee:

The amendment of Section 71A of the Drugs, Poisons and Controlled Substances Act 1981 to create a reverse onus provision on persons possessing certain materials with the intent to traffick (manufacture).¹⁷⁰

Problems in policing from a Victoria Police perspective

In its submission to this Inquiry the Victoria Police (Drug and Alcohol Policy Coordination Unit) outlined a number of specific difficulties associated with the policing of amphetamines and 'party drugs'.

The first of these is danger to personnel as a result of the state of the person on the drugs:

When a person uses an ATS [amphetamine-type stimulant] the effects include arousal, increased temperature and blood pressure. When intoxicated by these drugs, particularly through extended use, users can experience aggression, paranoia, hallucinations and delusions (psychosis). When coming down and during withdrawal, users can experience depression, suicidal tendencies, bizarre thoughts and mood swings.

Advice from the Victoria Police Negotiator Coordinator indicates that police members are experiencing greater numbers of critical incidents with people with amphetamine related drug induced psychosis.

These critical incidents include violent behaviour in domestic situations, sieges, threats, assaults, suicides and unintentional self-harm that may lead to death or serious injury to themselves or others. The behaviour of these people at such incidents are further complicated and exacerbated through polydrug use.

For many dependent users, particularly those that inject, the immediate and long term harms can be quite significant. Dependent users experience a range of harms associated with long term heavy use. These harms not only relate to the acquisition and administration of these illicit substances, but also the intoxicated behaviour as a result of their use.

Harms associated with injecting drug use not only relate to the users but also to other persons who have contact with them such as the emergency services.

169 Excerpt from the confidential submission of Victoria Police (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission of Victoria Police.

170 Excerpt from the confidential submission of Victoria Police (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission of Victoria Police.

For example there has been an increase in the number of needlestick injuries received by Victoria Police members. These injuries expose members to the risks of blood borne viruses including Hepatitis B and C, and HIV/AIDS. Notwithstanding the potential infection, there is the psychological trauma of undergoing testing.¹⁷¹

There are also problems associated with policing the venues themselves, particularly with regard to 'party drugs':

As the majority of ATS dealing and trafficking at 'street level' occurs in and around nightclubs and rave parties, this can be a difficult environment to police. Plain clothes police do attend and covertly patrol various rave and dance venues, however due to the subculture and the environment the plain clothes police presence is often obvious to the patrons.

Police members are also attempting to detect small tablets often stored in inoffensive containers such as breath mint containers in dark, noisy and crowded environments. This makes detection of offences problematic for police.¹⁷²

But these problems are relatively less difficult than the enormous problems of policing the import, manufacture and supply of these drugs on a national level.

Policing and supply control

Amphetamines

Australian drug control policies are based on a three-tiered approach that equally emphasises (in theory) supply, demand and harm reduction policies. Different emphases will be apparent in other jurisdictions:

In countries such as the Netherlands, for example, relatively more emphasis is placed on demand reduction measures. In the United States, supply reduction strategies attract the majority of funding, public and media attention, and political support. Australia, through its National Campaign Against Drug Abuse (NCADA), has consciously attempted to integrate demand and supply reduction philosophies, seeking to find a balance which is appropriate for its circumstances (Wardlaw 1993, p.91).

Demand and harm reduction policies will be discussed in more detail in Chapter 8. The focus for the rest of this section is on supply control.

Wardlaw states that amphetamines and other psychostimulants pose particular problems for law enforcement and supply control. One reason for this, of course, is the fact that much amphetamine is manufactured in Australia. Source control measures that take place overseas, for example crop substitution, are for

171 Excerpt from the confidential submission of Victoria Police (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission of Victoria Police.

172 Excerpt from the confidential submission of Victoria Police (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission of Victoria Police.

the most part irrelevant in this case. The most obvious methods of supply control with regard to amphetamine are border interdiction, targeting distributors, the destruction of clandestine laboratories and the restriction of the supply of essential ingredients – precursor control.

Border interdiction

While much, if not most, of the amphetamine available in Australia is manufactured locally, significant amounts are imported from overseas. However ecstasy, as will be discussed, is mainly imported into the country, particularly from the Netherlands and other European countries. Border interdiction is therefore still important.

Detection of illicit drug imports and exports is primarily the joint responsibility of the Australian Federal Police and the Australian Customs Service. After initial detection of illicit drugs, Customs will usually notify the Federal Police for follow-up investigation.

According to the Australian Bureau of Criminal Intelligence (ABCI)¹⁷³ the principal amphetamine-type stimulant imported into Australia during 2000–2001 was methamphetamine. The Bureau states:

Concerns that East Asian methylamphetamine would become a greater threat to Australia appear to have been well founded. The year saw a typical background level of small seizures from parcel-post and air passengers. Superimposed on this background was a 79.1 kilogram seizure of high purity crystalline methylamphetamine in November 2000 from a shipping container which arrived in Sydney from China. The seizure fits a pattern increasingly being seen around the world in which large quantities of multiple illicit drug commodities are shipped together. In addition to the 79.1 kilograms of methylamphetamine, approximately 184 kilograms of heroin also were detected.

In January 2001, Thai naval forces intercepted a fishing vessel in the Andaman Sea carrying 116 kilograms of heroin and 7.8 million methylamphetamine tablets. A route has been established for Golden Triangle drugs to be taken overland south through Myanmar, by sea to ports in Thailand or further south and east, then to consumer markets. Particularly threatening to Australia is the production of heroin and methylamphetamine as tablets and high purity powder occurring in this nearby region.

The seizure in early January 2001 of 142 kilograms of crystal methylamphetamine in Port Klang, Malaysia, illustrates the significant place of China in the amphetamine-type stimulant trade in the region. The drug had been smuggled from China by a group with connections in Hong Kong,

173 At the time of writing the draft of this Discussion Paper, the new Illicit Drug Report (2001–2002) had not yet been released. However, some subsequent writing has incorporated some of the most important addenda. In the past, as for 2000–2001, the Illicit Drug Reports have been compiled and written by the Australian Bureau of Criminal Intelligence (ABCI). ABCI is no longer in 'existence'. It has been merged with the National Crime Authority and the Office of Strategic Crime Assessments to form the new Australian Crime Commission (ACC).

Singapore, Malaysia and Australia. This seizure was a result of international cooperation in an investigation of a group using Malaysia as a transit area for trafficking methylamphetamine and ecstasy in the Asia-Pacific region. Other phases of the operation included the seizure of 37 kilograms of precursors and 113 kilograms of other methylamphetamine; the activities of drug traffickers who had been of long-term interest to law enforcement agencies in Australia and Southeast Asia were disrupted. This operation was enabled by the Australian Federal Police Law Enforcement Cooperation Programs assistance with training and equipment (ABCI 2002, p.39).

In 2001–2002 the ACC reported that:

During 2001–02, the Australian Customs Service (Customs) detected a record quantity of 428.3 kilograms of amphetamine-type stimulants excluding MDMA. This included the largest detection of amphetamine-type stimulants at the border to date: 168.5 kilograms of methylamphetamine, 152.2 kilograms of crystalline methylamphetamine and 90.7 kilograms of mixed amphetamine-type stimulant tablets (as well as 1.6 kilograms of MDMA) on a small craft in Queensland in July 2001.

The total weight of methylamphetamine (including crystalline methylamphetamine) detected increased from 83.4 kilograms in 2000–01 to a record 324.1 kilograms in 2001–02. There were 203 detections, a significant increase on the 49 in 2000–01. The average weight of detections rose from 1.7 kilograms in 2000–01 to 2.1 kilograms in 2001–02. All but one of the 203 detections involved importation. The single export detection was 8.7 grams of amphetamine tablets in a mail article destined for Japan.

In 2001–02 crystalline methylamphetamine accounted for 154.3 kilograms in 30 detections. Between 1997–98 and 2001–02, detections of crystalline methylamphetamine increased from less than one kilogram to more than 154 kilograms (Australian Crime Commission (ACC) 2003, pp.52–53).

Importation of illicit drugs is most commonly done by one of three ways – through the post, by sea cargo and shipment or through air passengers:

The most commonly detected method of importing amphetamine-type stimulants was through the post. Of the 202 amphetamine-type stimulant import detections made by Customs in 2001–02, 161 (79.7 per cent) used this method. Detections in air cargo accounted for 7.9 per cent of amphetamine-type stimulant detections, with a total weight of 10.5 kilograms.

In 2001–02, small watercraft accounted for 96.1 per cent of imported amphetamine-type stimulants by weight due to the record detection of amphetamine-type stimulants in July 2001.

During 2001–02 there were 44 detected importations from the United States (21.8 per cent of detections), 32 from the United Kingdom (15.8 per cent) and 23 from the Philippines (11.4 per cent).

Of the 203 detections of amphetamine-type stimulants at the border in 2001–02, 105 were in New South Wales, 60 in Victoria, 18 in Western

Australia, 17 in Queensland and three in South Australia. Although Queensland accounted for 8.4 per cent of the number of detections, it accounted for 96.2 per cent of the weight of amphetamine-type stimulants detected because of the significant small craft detection (ACC 2003, p.53).

Despite the relative success of these methods there are obvious limitations to curtailing the importation of illicit drugs:

The obvious difficulty facing Customs is in identifying likely drug shipments or couriers in the huge flow of cargo and people entering Australia each year. The majority of drug seizures (although not the majority of the bulk by weight) take place during examination of mail items. Items are diverted for examination following alerts by drug detector dogs and according to the system of indicators based on the characteristics of items previously found to include drugs, but the task of finding all the contraband among the hundreds of millions of pieces of mail coming through the system each year is too large to expect great success.

Similar problems are posed by other means of entry. An increasing trend is for large importations of drugs to be made concealed in cargo inside shipping containers... With nearly three-quarters of a million containers entering Australia each year and the fact that it takes a team of officers a number of hours to search each one thoroughly, it is obvious that it is impossible to screen containers generally...

As with other supply reduction strategies, border interdiction cannot be expected to stop the flow of illegal drugs. Even with more resources, the size of the problem, the opportunities for evasion and the realities of commerce and human rights which limit the application of many possible tactics (such as strip searching every passenger) all conspire to ensure that Customs can only limit some supplies and make the jobs of the criminals more difficult (and the drugs, consequently, more expensive). Even if Customs could substantially strangle importation the fact is that most stimulants (with the exception of cocaine) are produced locally and even those that are imported could be manufactured domestically (Wardlaw 1993, pp.98–99).

While there have been definite improvements in the intervening period since the above statement was written, the basic problem regarding the searching of both cargo and individuals still remains – resources are arguably, and understandably given budget constraints, never as ample as they ideally could be.

Targeting trafficking and distribution

Other supply reduction strategies that take place once the drugs have reached the country are those that seek to disrupt the market by targeting distributors and their profits. Much national and state law enforcement activity in the area of drugs has this as its focus. Agencies such as the Australian Crime Commission (ACC) and the New South Wales and Queensland Crime

Commissions spend much of their energy and funds investigating high level 'drug players' and their associated criminal activity.¹⁷⁴

For example, in 2001 in the Hunter Region of New South Wales one of the biggest busts ever witnessed in Australia saw \$60 million worth of amphetamine seized by New South Wales police in 'Operation Sibret'. The operation focused on outlawed motor cycle gangs' (OMCG) involvement in:

- The large scale manufacture and distribution of amphetamines;
- Firearm trafficking;
- The rebirthing of heavy duty motor vehicles and earth moving equipment (Stas 2001, p.5).

The investigation and subsequent raids were a collective effort of NSW Police, the ABCI and cross-border cooperation with the Queensland Police Service, reflecting the latter state's high level of amphetamine manufacture and trafficking:

Police involved in Strike Force Sibret shut down seven clandestine drug laboratories and seized \$60 million worth of amphetamine, as well as a large amount of firearms and explosives from OMCG members and associates on the state's north coast...

Officer in charge, Det Insp Wayne Gordon...said 20 people had been charged as part of the investigation, with more expected.

"The principal offenders were charged with the manufacture and supply of large commercial quantities of amphetamine..."

Investigators have frozen more than \$7 million worth of assets, including Harley Davidson motorcycles, cars, trucks and earthmoving equipment.

Det Insp Gordon said 'voluminous amounts' of prohibited weapons were also located by police, including machine guns, sniper rifles, other long arms with telescopic sights, automatic pistols, revolvers, explosives, detonators and detonator cords.

"It's considered to be the most successful incursion into the organised crime activities of OMCGs in the Commonwealth of Australia," he said (Stas 2001, pp.4-5).

Financial transactions legislation allowing the seizure of profits from the proceeds of (drug) crime are also in place in most jurisdictions and are a beneficial adjunct to target distributors.

The Australian Transaction Reports and Analysis Centre (AUSTRAC), formerly the National Cash Transaction Reports Agency (CTRA), also enables law enforcement agents to detect, trace and investigate instances of money laundering and transactions associated with criminal income.

171 The ACC was formed in January 2003 as a result of a merger between the Australian Bureau of Criminal Intelligence (ABCI), the National Crime Authority (NCA) and the Office of Strategic Crime Assessments (OSCA). The ACC has taken over the role of the former ABCI in producing the annual Australian Illicit Drug Report.

Such measures apply to all types of illicit drugs, however they may be less effective when it comes to combating the amphetamine and party drug trades. The following comments by Wardlaw, although somewhat dated, are still relevant:

In the case of amphetamines, high level investigations may be of less importance in Australia... Although traditionally a significant share of the market has been dominated by a number of motorcycle gangs, in recent years the production mix has become more varied, with a large number of manufacturers at various levels of sophistication and size. It is now doubtful if it is possible to identify a small group of manufacturers or distributors whose removal would have a long term disrupting effect on the market (Wardlaw 1993, p.100).

Law enforcement that targets high level distributors, usually through state police forces, also targets street level distributors. Clearly there are heated debates about the merit and appropriateness of using law enforcement strategies to target the 'small fry' dealer or distributor, particularly when that distributor is also a user and/or addict. These debates have been aired in numerous fora and are readily available (see for instance Dorn, Murji & South 1991; Bagnall 1997; Saunders 1993).¹⁷⁵ This Paper does not seek to 'rehash' these debates in any significant way. In any case, many of these enforcement strategies are geared towards heroin and heroin use. Although the 'heroin drought' has seen some displacement to the use of street market amphetamine and to a lesser extent ecstasy, much amphetamine is still distributed in more private and discreet networks that are far more difficult to intercept. This is certainly the case for 'middle-class' users of ecstasy and other 'party drugs':

Furthermore, for most people, use of stimulants is not compulsive and there is no need to buy at a particular time or with any great frequency. This means that most users can be more circumspect about their drug purchasers and need to purchase less frequently than do, for example, heroin users.

Finally, a significant number of stimulant users do not buy drugs themselves, but rely on friends to do so for them and share with them in a social setting. All of these factors reduce the number and public nature of drug transactions and so reduce the opportunities for vigorous street-level enforcement strategies to take place and have a major impact (Wardlaw 1993, pp.101–102).

175 For example, an interesting, if somewhat unsophisticated, article by O'Neill (1996) compares the prohibition of ecstasy with the ready availability of the anti-depressant drug Prozac. He argues that the biological and pharmacological effects of both drugs are remarkably similar, yet for a range of social, historical and political reasons one is banned while the other is prescribed. He contrasts the case of rock guitarist Richard Simpson being charged with the manufacture of MDMA:

'Another drug has a similar effect. It is used by several lawyers I know and could be taken legally by judges. But its manufacturers do not face charges; at worst they get the odd complaint that they are making excessive profits. The drug which could send Simpson to jail, MDMA, is best known by the name Ecstasy. The drug which comforts lawyers and millions of others is fluoxetine, marketed as Prozac, (1996, p.26).

Although the above remarks are probably less true today of amphetamine, particularly methamphetamine use, where the profile of the user is probably more akin to that of the person using heroin, they certainly would apply to those who may sporadically take and buy ecstasy or other 'party drugs'.¹⁷⁶

Policing manufacture

The manufacture of amphetamine in clandestine laboratories will be commented upon further in Chapter 7. As stated in that chapter, 201 such laboratories were located throughout the country in 2000–2001.

When it comes to controlling the supply of amphetamines and to a lesser extent ecstasy, a number of specialist initiatives have been put in place across Australia. In Queensland, where most of the synthetic laboratories are now located,¹⁷⁷ the Queensland Police has set up an Illicit Laboratory Investigation Task Force (ILITF) specifically given the task to investigate 'clan labs' (clandestine laboratories):

This Task Force is contained within the State Drug Investigation Squad and is headed by a Detective Senior Sergeant, with 11 other officers. Each of these officers has undergone an intensive training course relating to the latest methods used in the manufacture of drugs such as 'speed', 'ecstasy', 'home bake heroin' and other drugs. A large part of the course is also dedicated to instruction on the safe handling of chemicals, Workplace Health and Safety Issues, and the use of self-contained breathing apparatuses (Sheldon 1997, p.17).

While many of the laboratories 'processed' by the ILITF have been the result of planned raids and intelligence, a growing number have also been located through non-specialist police officers performing routine duties:

By way of example, 'clan lab' seizures have often been a result of such things as: police searching premises, attending normal complaints, attending fire scenes and on at least three occasions, have even been as a result of attending the scenes of traffic accidents.

If recent trends are any indication of the general increase in the number of 'clan labs' in [Queensland], it has now reached the stage where *operational police officers are more likely than not to come into contact with a 'clan lab' in the course of their duties* (Sheldon 1997, p.17). (Author's emphasis)

The former ABCI has also stated that, at least in south-eastern Queensland:

176 See discussion in Chapter 5 with regard to the profiles of ecstasy users and how they 'score' their drugs.

177 This differs from the position a decade ago when it was claimed that Victoria had the highest number of manufacturing laboratories (Australian Federal Police 1991; Wardlaw 1993). Recent figures for the period 2000–2001 show that 138 laboratories were located in Queensland and 32 in New South Wales. Victoria had the third highest total with 24 laboratories, not much more than South Australia and Western Australia (20 and 22 respectively) (ACC 2003, p.47).

See Table 7.1 reproduced in Chapter 7.

[m]any clandestine laboratories are detected as a result of calls for service or through information received from hotel/motel proprietors. In Brisbane, the Wynnum District of the Queensland Hoteliers Association has established an information exchange mechanism for the reporting of unusual odours or suspect persons staying in accommodation. Police in the Metropolitan North Region of Queensland are trying to establish a similar network with other hoteliers in Brisbane (ABCI 2002, p.47).

In Victoria, the Major Drug Investigation Division of the Victoria Police has been active in investigating clandestine laboratories:

Specifically, MDID operates a clandestine laboratory investigation unit, which has training for police members in the detection and safety management of clandestine laboratory sites. All investigators attending a clandestine laboratory site must wear protective clothing and abide by strict policy and procedures.

MDID also operates a chemical diversion desk which is a liaison point for the chemical and pharmaceutical industry to report suspect chemical purchases or potential purchases. Advice is also given regarding security.¹⁷⁸

While such proactive measures are obviously to be encouraged, one of the most effective ways of curtailing the work of clandestine laboratories is to stop, restrict or reduce the amounts of essential ingredients available to the 'cooks' – that is, limit the precursor chemicals in circulation.

Precursor control

Control of precursor chemicals as a law enforcement measure was first systematically used comprehensively by the United States:

In extending the reach of earlier attempts at precursor control, the *Chemical Diversion and Trafficking Act* of 1988 included provisions to regulate the distribution of chemicals used to produce illicit drugs. The Act requires chemical companies to keep records of sales and purchases of regulated chemicals, to report any transactions of an extraordinary quantity, and to give notice to the Drug Enforcement Administration (DEA) of uncommon methods of payment and any excessive loss or disappearance of a listed chemical. By analysing these records, the DEA identifies suspicious buyers and thus locates illicit manufacturers.

The precursor monitoring or restricting approach has attracted international interest and action. The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances provides (in article 12) for measures to monitor and control the international movement of precursor chemicals, including those used in the manufacture of amphetamines and cocaine. In 1990, the United States was instrumental in establishing a Chemical Action Task Force, of which Australia is a member, to further examine strategies for precursor control (Wardlaw 1993, p.96).

178 Excerpt from the confidential submission of Victoria Police (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission of Victoria Police.

Precursor control in Australia has taken two main forms; first, as discussed earlier, increased domestic controls over the availability of substances such as ephedrine and pseudoephedrine, and second, increased efforts over the last five years to target illicit importation of precursor chemicals into Australia.

Domestic controls

Precursor monitoring became part of the national drug agenda in 1990. A Working Party on Amphetamine Control established by the Australian Police Ministers Council recommended that ways should be examined to schedule and monitor certain amphetamine precursors under state and federal legislation. Since that date, regulations implemented in most state legislation have resulted in certain substances being restricted or in transactions over a certain amount being notified to police authorities.¹⁷⁹ Victoria has been at the forefront of many of these initiatives:

The Victoria Police Chemical Diversion Desk is involved in identifying potential alternative sources of chemicals for inclusion in the national precursors Code of Conduct and providing education on suspect purchase reporting, to identify illicit drug manufacturers. Overseas sourcing of precursor chemicals for illicit drug manufacture, particularly from China, has been identified as a particular concern requiring increased cooperation between law enforcement agencies.

Victoria Police Crime Prevention Officers are working closely with the Victorian Department of Human Services (Public Health Division) and the Pharmacy Society on an initiative called Pharmacy Watch. Pharmacy Watch aims to provide advice to pharmacies on issues such as security, to reduce the incidence of burglaries and thefts of cold-and-flu preparations – for use in illicit drug manufacture – and other prescription drugs such as benzodiazepines. The program works with the Victoria Police Chemical Diversion Desk to develop ongoing strategies and training (ABCI 2002, p.47).¹⁸⁰

But the approach is not a uniform one across jurisdictions and this is sorely needed:

Australian jurisdictions are also working towards a unified response to criminalising precursor possession or establishing national systems to identify suspicious precursor purchases. Only New South Wales, Queensland and

179 See for example, *Poisons and Therapeutic Goods Act 1966* (NSW). In Victoria, Pseudoephedrine is a scheduled substance under schedule two of the *Drugs, Poisons and Controlled Substances Act 1981*.

180 This Working Party consists of representatives from Victoria Police, Department of Human Services, Pharmacy Board (Victoria), Pharmacy Guild (Victoria) and the Pharmaceutical Society (Victoria). It has been meeting since approximately the start of 2002 to address the illegal diversion of pharmaceuticals containing pseudoephedrine:

‘The working party has developed two posters: one for display in the rear of the pharmacy which advises the pharmacist and staff of the problem of pseudoephedrine sales and provides contact details to the MDID, and the other for public display advising that, due to the issue of illegal diversion, only one packet of pseudoephedrine based tablets will be sold per customer’ (excerpt from the confidential submission of Victoria Police (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and ‘Party Drugs’, August 2002).

Victoria have legislation that makes it an offence to be in possession of a precursor with the intention to manufacture or produce a prohibited drug. However, all States and Territories have adopted a National Code of Conduct that places voluntary restrictions on the sale of chemicals used for manufacturing methylamphetamine and other psychostimulants. The Code has existed since 1994 and is also a means of monitoring suspicious sales of precursors, essential chemicals and reagents as well as laboratory equipment (ABCI 2002, p.38).

Moreover, despite the Victorian initiatives outlined above, this state does not compel pharmacists to record details of the purchasers of pseudoephedrine, unlike New South Wales. In a submission to this Inquiry, Victoria Police stated that:

A working party consisting of Victoria Police, Department of Human Services and key stakeholders in the pharmacy retail profession has agreed that the rescheduling of pseudoephedrine based products would unduly hamper legitimate sales of these products without reducing their diversion into the illicit drug market. At this time there are no plans in Victoria to reschedule these products to bring them into line with New South Wales legislation.¹⁸¹

There have also been some cooperative and voluntary accords struck between the private sector and law enforcement agencies such as the Industry Code of Conduct:

In 1996 the then Drug Squad in partnership with the Plastics and Chemicals Industries Association and the Scientific Suppliers Association of Australia developed and published a 'Code of Conduct' for Australian chemical manufacturers, importers and distributors. This document was developed in an attempt to prevent the diversion of precursor chemicals used in the illicit manufacture of ATS.

The document includes categories of drugs and materials that have been used in the illicit manufacture of ATS and requires industry stakeholders to sell these chemicals to account customers only and complete an end user declaration. The document also includes a requirement to notify law enforcement agencies of suspicious orders or enquiries.

This document is a voluntary code of conduct only and there is nothing binding the industry stakeholders to adhere to it.¹⁸²

181 Excerpt from the confidential submission of Victoria Police (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission of Victoria Police.

182 Excerpt from the confidential submission of Victoria Police (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

The new Code was officially launched in June 2002:

'The Code provides guidelines for a voluntary "system of practice for Australian chemical manufacturers, importers and distributors and scientific equipment and instrument suppliers" to guard against the diversion of essential chemicals and scientific equipment (New South Wales Police 2002). Parties to the Code agree to report all suspicious enquiries or orders relating to:

- "all Category I chemical substances, Category II chemical substances and scientific

As well as such voluntary and regulatory measures, Customs and federal and state police are working cooperatively with science and industry to 'develop more effective blocking agents, or reformulation of the product, to prevent the extraction of pseudoephedrine by illicit operators' (ABCI 2002, p.38).

This cooperation has been even more noticeable in the last reporting year of the ACC:

The diversion of single entity pseudoephedrine-based tablets has become more difficult due to a number of law enforcement and industry initiatives. In November 2001, the New South Wales Government rescheduled single entity products from Schedule 2 to Schedule 3a (behind the counter) and introduced mandatory recording of these sales. However, there are limited legislative requirements placed upon pharmacies in most jurisdictions and the industry is largely self-regulating. For example, in Queensland and Western Australia most pharmacies treat the sale of such products as a Health (Drugs and Poisons) Regulation Schedule 3 substance requiring the customer to produce photographic identification and recording the individual's details. A relatively new initiative in Western Australia, it has been practised by pharmacies for a number of years in Queensland.

Another example of industry self-regulating is the introduction of a national *Code of Practice for Supply Diversion into Illicit Manufacture* which was prepared jointly by Australian law enforcement agencies, the Plastics and Chemicals Industries Association, and Science Industry Australia (New South Wales Police 2002 cited in ACC 2003, p.49).

However, as the ACC itself has noted:

There have been consequences from these initiatives. Several jurisdictions reported increasing thefts of precursor chemicals from warehouses, chemical companies, doctors' surgeries, chemists and factory yards, as well as the theft of laboratory equipment from schools. The establishment of false companies to provide a legitimate cover for the acquisition of pseudoephedrine continued to be a means of acquiring precursors during the reporting period. There was also a greater move towards Schedule 2 combination tablets for the production of methylamphetamine.

Another consequence of restricting the availability of single entity pseudoephedrine-base products in Australia has been attempts to source these or similar products overseas. Outlaw motor cycle gangs are establishing connections in Southeast Asia and are believed to be increasingly sourcing

apparatus when sold to non account customers"

- "Category III chemical substances and scientific apparatus when suspicious circumstances are indicated"
- "mixtures and compounds which contain Category I substances that can be extracted for the illicit manufacture of drugs"" (Australian Crime Commission 2003, p.49).

For further information with regard to the Code, see the Plastics and Chemicals Industries Association website: [www.pacia.org.au/Health/IllicitDrug Code.pdf](http://www.pacia.org.au/Health/IllicitDrug%20Code.pdf).

amphetamine-type stimulant precursors from Thailand and Vietnam. Southeast Asian groups have also emerged as illicit importers of pseudoephedrine from Asian countries. New South Wales Police reported at least two instances where offenders were caught attempting to bring Actifed® and Rambaxi® tablets into Australia from Vietnam. There have also been several reported instances of purchases of cold and flu preparations from overseas sources via the Internet (ACC 2003, p.50).

Importation control

It should be noted, however, that tougher restrictions on controlling precursors in the United States (and other countries) has meant that in some cases that clandestine production has simply been driven further underground. Such laboratories rely on the smuggling of the necessary chemicals from organised crime groups in Mexico where precursor controls are less stringent (Mundy 2001; ABCI 2002).

There is a risk of similar developments occurring in Australia:

Customs and the National Crime Authority have highlighted the possibility that increasing volumes of chemicals required for amphetamine-type stimulant manufacture may be imported by organised crime networks. Large precursor-producing industries already exist in China and India. Furthermore, due to regional instability, vulnerable states may become conduits in the future for the illicit supply of precursors for the Australian amphetamine-type stimulant market (ABCI 2002, p.38).

Federal law enforcement agencies have noticed a distinct relationship between the tightening up of domestic precursor controls and the attempted importation of large amounts of precursor chemicals:

During 2000–01 Customs detected 1159 attempted importations of amphetamine-type stimulant precursors: pseudoephedrine/ephedrine (1025) and ephedra (134). In the majority of cases, these imports involved small quantities of health-and-fitness, weight-loss or cold-and-flu preparations licitly available over-the-counter in the country of origin. While in most cases these products are not intended for use in amphetamine-type stimulant production, their diversion into such production remains a potential risk.

The sea-cargo seizure of 42 kilograms of pseudoephedrine-based cold-and-flu tablets concealed in furniture from Vietnam in November 2000 signified a major change in precursor importation. This sea cargo seizure indicates traffickers consider the importation of such tablets to be a viable strategy for sourcing precursors, given increased domestic precursor controls. In the same month Customs seized 12,000 tablets (approximately 11 kilograms) of ephedrine imported in an air cargo item from the United States.

On 12 September 2000, a Customs detection of 100 kilograms of ephedra (containing 4.6 per cent pseudoephedrine and 1.6 per cent ephedrine) in air cargo from the United States led to the detection of a clandestine

methylamphetamine laboratory in Manjimup, Western Australia during a joint Customs, Australian Federal Police and Western Australian Police Service operation. This amount of ephedra could produce approximately four kilograms of methylamphetamine or around 47 kilograms of five per cent pure methylamphetamine tablets.

Reflecting the wide-scale licit availability of these substances over-the-counter, the United States was the embarkation point for 885 detections of amphetamine-type stimulant precursors in 2000–01, accounting for 76 per cent of the number of detections. Other significant embarkation points included Indonesia (52), China and Canada (34 each).

The most commonly detected method of importing amphetamine-type stimulant precursors during 2000–01 was the postal stream with 84 per cent of detections (978), which accounted for 4.2 per cent of the total weight. Air passengers accounted for a further 10.7 per cent of precursor detections and 28 per cent of the total weight.

There were several significant passenger detections of amphetamine-type stimulant precursors, including the seizure of over 13,000 cold-and-flu tablets from the baggage of a passenger from Vietnam.

The forms of amphetamine-type stimulant precursors detected by Customs in 2000–01 included capsules, caplets, tablets, powder, plasters, tea bags, injections, ampoules and soft gel (ABCI 2002, pp.41–42).

This trend has continued in 2001–2002, as noted in the most recent Illicit Drug Report (ACC 2003, pp.54–56).

Both domestic controls on the use of precursor chemicals and more stringent detection of their importation have led to some major supply control ‘successes’. Paradoxically however, as has been discussed, increased control over the first may result in greater importation. This is not the only problem associated with such control. In some cases, the chemicals used by illicit manufacturers are also used by legitimate industries, businesses and consumers:

A major problem with such [precursor control] regulatory regimes is that they are administratively burdensome to implement. There are many companies involved in the commerce of precursors and the chemicals themselves cannot be restricted too much because they are essential to many legitimate manufacturing processes...

The most obvious difficulty for any precursor control regime is that the precursors themselves may often be manufactured from yet other widely available and unmonitored chemicals. Regulations such as those passed in New South Wales allow for the list of monitored substances to be varied as needed. Obviously there is a point, however, beyond which additions cannot be made without the scheme becoming too cumbersome for police to administer and too onerous on the chemical sellers... This is particularly so because of the very wide range of drugs which could be manufactured. If

amphetamine production is restricted by this scheme, there is a likelihood of illicit manufacturers simply turning to new sorts of drugs involving entirely different sets of precursors. Indeed this is likely to occur anyway as trends and fashions of drug use change over time. Further, a successful monitoring scheme could encourage an increase in theft of precursors and in importation either of precursors or, more likely, of finished drugs (Wardlaw 1993, p.97).

Moreover, strong precursor control, if it is to work properly, requires uniform cooperation at an international level. If one country has a strict regime but another does not, illicit producers will simply turn to the countries with the lax control systems. The importation of precursors from Mexico to the United States and beyond is a salutary case in point.

Particular law enforcement issues pertaining to ecstasy

Many of the general comments pertaining to supply control of amphetamines will apply equally to ecstasy and therefore are not repeated here. This section comments solely on those issues unique to ecstasy importation and control.

In a recent comprehensive survey of the global proliferation of ecstasy, Yacoubian (2001) notes that the international community has not tackled the problem of MDMA, its analogues or other 'party drugs' anywhere near as systemically as they have approached heroin, [meth]amphetamines, cocaine or even marijuana:

While a comprehensive understanding of the drug phenomenon has been developed based on the concept of shared responsibility and respect for the fundamental principles in international law, as evidenced by successful interdiction efforts against cocaine, marijuana, and heroin...the focus should now turn to ecstasy. The global magnitude of the ecstasy problem makes it imperative that international co-operation be strengthened so as to respond adequately to new trends and modalities confronted by the countries in their anti-ecstasy efforts (Yacoubian 2001, p.133).

It is certainly true that distribution and subsequent control of ecstasy in Australia lagged somewhat behind other western countries, particularly the United States. MDMA/ecstasy was first noticed in Australia in approximately 1984, but it would seem that until the late 1980s few law enforcement officials, including Customs Officers and various state and federal police forces, were aware of its existence or the networks used to manufacture or distribute it (Leser 1988).

The most recent analysis of illicit drugs by the ACC makes the following general observations regarding the phenethylamine group of drugs, of which MDMA/ecstasy is part:

- Although little evidence of MDMA ('ecstasy') production in Australia was found during 2001–02, the production of 'fake ecstasy' continued.
- While MDMA production remains focused in Western and Eastern Europe, there was a significant increase in detections of phenethylamines transhipped via Asian countries.

- The total weight of seized phenethylamine importations increased from 338.4 kilograms in 2000–01 to 445 kilograms in 2001–02.
- The popularity of MDMA among users continued to increase in 2001–02. Availability of MDMA also increased during the period, specifically sourced from friends, acquaintances and lower level dealers (ACC 2003, p.69).

There were no confirmed detections of MDMA-producing clandestine laboratories in 2001–2002. This is the same as for previous reporting years.

However, while there is little evidence of clandestine manufacture of MDMA similar to that of methamphetamine, as indicated by the ABCI, tablets are being produced locally with a variety of drugs and chemicals being on-sold as ecstasy.¹⁸³ The great dangers associated with these tablets have already been discussed. It remains the case, however, that manufacture of MDMA takes place predominantly offshore:

Western and Eastern Europe continue to be the main centres of MDMA manufacture, with a large amount of ecstasy produced in clandestine laboratories in the Netherlands (BINLEA 2001; INCB 2002; UNODCCP 2001). The Netherlands, as a central player in the international chemical industry, is an ideal location for the acquisition of precursor chemicals vital to the production of MDAM and other drugs (BINLEA 2001). The Australian Federal Police regard the Netherlands as the most significant MDMA production country, although they report that less MDMA was seized in 2001–02 than 2000–01. The quantities of MDMA seized in countries with established production links to the Netherlands continued to increase.

MDMA manufacturing sites have been discovered in Belgium, Germany, Poland and the Czech Republic. The majority of countries identify the Netherlands and Belgium as the main sources of their ecstasy imports (UNODCCP 2001). The under-employment of chemists and chemical engineers in Central and Eastern European countries, particularly Poland and the former Czechoslovakia, may be linked to the increase in production of MDMA and other amphetamine-type stimulants in these countries. Due to differences in how jurisdictions report drug seizures, it is difficult to produce a reliable estimation of global data figures. United Nations figures for hallucinogens seized globally – excluding LSD but including ecstasy – show an increasing trend since 1998.

The use of MDMA has only recently become popular in China's growing urban areas (USDEA 2002B). China's industrialised southeast has also seen the addition of MDMA to the well-established high purity methylamphetamine trade. There are reports that clandestine manufacturers in Southeast Asia may

183 The ACC comments that the majority of fake MDMA is most probably produced in Australia: 'Fake MDMA is likely to be cheaper to supply than real MDMA and gives dealers a greater profit margin. New South Wales Police report that precursors used for the manufacture of MDMA and MDA are scarce and extremely difficult to obtain, primarily due to their limited legitimate use. As a consequence, the production of substances such as MDMA in Australia is difficult, (ACC 2003, p.72).

soon be producing MDMA comparable to the quality presently being imported from Europe (UNODCCP 2001). The Australian Federal Police reported high purity MDMA is being sent north from Malaysia to Thailand in exchange for heroin. And in a further example of the convergence of drug markets, an MDMA laboratory was detected in May 2002 in Cali, Columbia (ACC 2003, pp.72–73).

The major entry points for MDMA in Australia are through Sydney, Brisbane, Perth and Melbourne (ABCI 2002, p.56). Even more so than with methamphetamine however, few discrete groups or networks have been associated with MDMA distribution:

Distribution networks continue to be flexible and diverse, and may include involvement by individuals who may not be members of a criminal syndicate. Several groups, however, play a significant role in the importation and distribution of MDMA. Established Southeast Asian organised crime groups are involved in all aspects of the importation and distribution of MDMA in Australia. There are also links suggesting greater involvement of these crime groups in the production and distribution of domestically produced amphetamine-type stimulants, both independently as well as collaboratively with other crime groups. Western Australia and New South Wales police report the involvement of foreign students in distribution. A growing trend is distribution networks diversifying to handle a variety of illicit drugs, depending on availability and supply.

In the Australian Capital Territory, MDMA is believed to be sourced from Sydney to supplement locally produced methylamphetamine-based product. Ethnically-based crime groups as well as members and associates of outlaw motor cycle gangs are primarily involved in distribution

While some jurisdictions link MDMA distribution to outlaw motor cycle gangs, a number of these gangs are also closely associated with the production and distribution of methylamphetamine-based tablets. Involvement of outlaw motor cycle gangs in the entertainment/nightclub industry – from both a financial and a security perspective – provides these groups with ready access to major distribution opportunities for both imported and locally produced product (ABCI 2002, pp.55–56).¹⁸⁴

The 'micro-distribution' of MDMA and other drugs purporting to be ecstasy is fluid and diffuse. Most occasional users of the drug 'score' their tablets from friends, colleagues and acquaintances rather than through 'professional' dealers:

Micro-distribution remains similar to that of other amphetamine-type stimulants. Wholesalers sell bulk amounts of MDMA to known associates. However, further distribution to users occurs in a variety of ways, with delivery to personal residences or selling at nightclubs and dance parties continuing to

184 Bikies have also been associated with MDMA distribution in South Australia, see NDARC 2002c and the discussion above.

be common methods. There are increasing reports of the use of pre-paid SIM cards and mobile phone Short Message Services (SMS) to arrange delivery. The most prevalent form of supply, however, is through networks of friends (ABCI 2002, p.56).

Recent initiatives in MDMA control

As MDMA, mixtures of MDMA and other chemicals, and other 'party drugs' have become increasingly perceived as problematic, new initiatives, particularly through the Australian Federal Police, have been instigated to curtail their availability. Many of these initiatives have been cooperative ventures with the Netherlands. This is an acknowledgement of that country's primary role as a source of MDMA production. To this end the Australian Federal Police have opened a liaison office in The Hague as part of the Australian Federal Police Law Enforcement Cooperation Program (AFPLECP):

The value of having immediate contact with authorities in the Netherlands was quickly demonstrated. In a joint operation with the Australian Federal Police in early December 2000, Dutch drug law enforcement authorities arrested high-level traffickers and seized 200 000 MDMA tablets – some intended for Australia – and large quantities of cannabis products. The operation was developed from intelligence surrounding the seizure of 50.75 kilograms of MDMA in Australia on 15 January 2000 (ABCI 2002, p.53).

Other initiatives through the AFPLECP have included:

- Seminars presented in Perth, Melbourne, Brisbane, Sydney and Canberra by a team of representatives from the Dutch Synthetic Drugs Unit, the German Bundeskriminalamt, Europol and Interpol;
- An Israel–Middle East regional synthetic drug trafficking seminar;
- Short-term attachments of Australian Federal Police agents to Europol headquarters in The Hague, the Bundeskriminalamt in Wiesbaden and the Dutch Synthetic Drugs Unit in Eindhoven, focused on disrupting MDMA trafficking; and
- Inquiries in Europe following the seizure in Australia of 105 kilograms of MDMA concealed in wine cartons in a shipping container from France (ABCI 2002, p.58).

The Committee welcomes information pertaining to any other law enforcement strategies or initiatives, or problems faced in attempting to address control of ecstasy and other 'party drugs'.

The most recent Illicit Drugs Report notes that the Australian Customs Service:

[p]articipated in Operation Mercure, hosted by the Dutch Customs Service in March 2002. The operation was an exercise in the surveillance and control of air passengers from European participating countries to America, Canada and Australia, aimed at detecting passengers carrying synthetic drugs (ACC 2003, p.82).

Conclusion

Clearly the policing of any illicit drugs, let alone such a diverse range of substances known under the broad rubric of psychostimulants, amphetamines or 'party drugs' – each with their own user profiles, effects, source background and methods of distribution – is difficult and fraught with problems. Such policies are 'limited in [their] effectiveness by the reasonable restrictions which must be placed on law enforcement in a democratic society' (Wardlaw 1993, p.102; see also Henry-Edwards 2000, 2003 in press).

Nonetheless, law enforcement clearly has its place. And the efforts of under-resourced law enforcement officials, whether they are state police forces, Customs or other national authorities, are commendable in difficult circumstances. However, supply reduction cannot, as Wardlaw states, be seen as a 'quick fix' solution. This is arguably the way the problem is viewed in the United States. Supply reduction measures, whether internal as in the destruction of clandestine laboratories or external with the greater patrolling of our borders, needs to be but one of a series of measures. Such strategies must also examine ways to reduce the demand for psychostimulants and/or reduce the harms associated with taking these drugs. These areas of demand and harm reduction are part of the focus of Chapter 8.

Questions for discussion

- ◆ What types of problems do the following different types of drug pose for law enforcement officials?
 - (meth)amphetamines
 - MDMA (ecstasy)
 - gamma hydroxy-butyrate (GHB)
 - ketamine
 - other 'party drugs'
 - 'fake' MDMA.
- ◆ How effective are Victorian and Commonwealth laws in investigating, addressing and combating amphetamine and party drug use? Are there any changes that need to be made to current laws, particularly in Victoria, to achieve greater effectiveness?
- ◆ Are the current amounts [by weight] of drugs deemed to constitute sufficient quantities for various types of offences under Schedule Eleven of the *Drugs, Poisons and Controlled Substances Act 1981* appropriate? In particular, should the amount needed to constitute a 'commercial quantity' of MDMA be reduced? [Currently, 100gms pure drug, 500gms mixed compound]
- ◆ What, if any, harm reduction measures would the Victoria Police support in attempting to minimise the harms associated with party drug use in particular?

- ◆ What practical problems do police have in addressing 'party drug' use particularly in 'rave', nightclub and dance party contexts? How can a balance best be achieved between addressing drug use at such venues without unduly encroaching upon the ability of patrons to 'party'?
- ◆ What level of policing should exist in and around rave parties and associated venues?
- ◆ Should dance parties and 'raves' be subject to more stringent regulation? If so, of what type?
- ◆ Are there significant variations in patterns of use, trafficking and manufacture between the states?
- ◆ If so, what are these variations?
- ◆ How does the Australian Federal Police liaise with state, national and international agencies to combat the illicit drug trade in amphetamines and 'party drugs'?
- ◆ What collaborative programmes, if any, have been put in place to address amphetamine and party drug use?
- ◆ What problems, if any, does having seven separate state jurisdictions with regard to crime and policing in Australia pose for law enforcement officials attempting to combat the trade in amphetamines and 'party drugs'?
- ◆ Are there other national or cross-jurisdictional issues that have an impact on or concern Victoria (for example, inconsistent state laws, state border smuggling and control)?
- ◆ How can cross-border and cross jurisdictional issues be best addressed?
- ◆ To what extent is addressing the importation and distribution of amphetamines and 'party drugs' (not manufactured locally) a resource problem at Commonwealth and state levels? For example, are there sufficient searches of international freight by Customs? What could be done to address this problem?
- ◆ Should a reverse onus of proof apply in circumstances where a person is found in possession of a certain amount of drugs or precursor materials and it is reasonably suspected that such materials will be used for the illegal manufacture of illicit drugs?
- ◆ Should there be more stringent requirements with regard to the purchase, sale and regulation of pseudoephedrine and other commercially available compounds that are able to be used as precursors? If so, how should this be done? Should chemists and pharmacists maintain a register of sale with regard to these purchases? Should purchasers be required to provide identification and reasons when purchasing over a certain amount of these products?

7. The Manufacture and Distribution of Psychostimulants¹⁸⁵

Manufacturing psychostimulants

A recent report on illicit drug trends across Australia published by the Australian Bureau of Criminal Intelligence (ABCI)¹⁸⁶ stated:

The majority of amphetamine-type stimulants available on the Australian market during 2000–01 continued to be the result of domestic production in clandestine laboratories involving both sophisticated and rudimentary techniques and equipment. Illegal methylamphetamine producers, known as ‘cooks’, often contract their services out to various groups, though certain groups have their own resident ‘cook’. While there have been instances of qualified chemists taking part in the illegal production of methylamphetamine, the majority of ‘cooks’ are largely self-taught with little to no formal training in chemistry. A sharing of skills and an exchange of information on methods of extraction and manufacture take place, especially on the Internet (ABCI 2002, p.35).

There has also been a proliferation of laboratories, predominantly methamphetamine producing, established in the United States:

In 1999, the DEA [Drug Enforcement Administration] participated in the seizure of a record high 1,948 clan labs, the vast majority (99 percent) of which were meth labs. For comparison purposes this number was 306 in 1994 – representing a 537 percent increase in just five years. In addition, state and local law enforcement officers raided more than 4,400 such labs in 1999. In fiscal year 1999, DEA arrested 8,600 people for meth trafficking – a 113 percent increase over fiscal year 1996 arrests (Hargreaves 2000, p.2).

Where and how manufacture takes place

In Australia, amphetamine, and particularly methamphetamine, is widely manufactured illegally in these clandestine or underground ‘laboratories’ (commonly called ‘clan labs’).

185 A discussion of the sourcing of amphetamines from outside Australia has already been given in Chapter 6.

186 Now the Australian Crime Commission, see Chapter 6.

Recent figures compiled by the Australian Crime Commission (ACC) show that:¹⁸⁷

During 2001–02, 240 clandestine laboratories were located in Australia...[a] steadily increasing number discovered each year. The number of laboratories discovered in Queensland almost doubled in the reporting period (77 to 138). New South Wales recorded the next highest number (32). While no laboratories were detected in the Australian Capital Territory, the Australian Federal Police report indications of small scale production occurring but insufficient to significantly impact the Canberra market (ACC 2003, p.47).

Figures for the other states and territories can be seen in the following table. Of particular note is the fact that in Victoria during the reporting period 24 laboratories were discovered.

Table 7.1: Clandestine laboratory detections, by state and territory, per quarter, 2001–02

State/Territory	July-Sep 2001	Oct-Dec 2001	Jan-Mar 2002	Apr-June 2002	Total
New South Wales	9	7	4	12	32
Victoria	7	3	9	5	24
Queensland	42	28	29	39	138
South Australia	-	-	14	6	20
Western Australia	5	5	3	9	22
Tasmania	-	1	2	-	3
Northern Territory	1	-	-	-	1
Total	64	44	61	71	240

Note: 1. No clandestine laboratories were found in the Australian Capital Territory.
2. – signifies zero

Source: Taken from Table 4.2, Australian Crime Commission 2003, *Australian Illicit Drug Report 2001–2002*, Commonwealth of Australia, Canberra, p.47.

‘Ecstasy’, while mostly imported from countries in Europe, has also been known to be manufactured in ‘backyard labs’, although these are few in number, unlike amphetamines and methamphetamines labs. According to the *Australian Illicit Drug Report 2001–2002*, there have been no confirmed detection of MDMA producing laboratories in 2001–2002 (ACC 2003) and only two possible MDMA laboratories were detected in 2001–2002 (ABCI 2002). No clandestine MDMA laboratories have been located in Victoria according to Victoria Police sources.¹⁸⁸ However, ‘[d]ue to the presence of MDMA precursors, Victoria Police identified a laboratory that may have been used to produce MDMA [in 2001–2002]’ (ACC 2003, p.72).

While the production of pure MDMA is rare in Australia, largely because MDMA precursors are scarce and difficult to obtain, the production of fake MDMA tablets does take place in Australia. The production of fake MDMA is reputedly

¹⁸⁷ See also the discussion in Chapter 6.

¹⁸⁸ Confidential Submission of Victoria Police to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and ‘Party Drugs’, August 2002. Referred to with the kind permission of Victoria Police.

rising in Victoria (ACC 2003). It most often consists of methylamphetamine with adulterants of paracetamol, caffeine, ketamine or other unspecified additives.

A problem for law enforcement is the fact that these amphetamine-type stimulants, other than pure MDMA, are relatively inexpensive and easy to make:

All that is needed to manufacture it is a basic knowledge of chemistry, a recipe, and access to precursor chemicals, predominantly ephedrine and pseudoephedrine. Large scale production is dependent on ready access to bulk quantities of these chemicals. Being controlled substances, ephedrine and pseudoephedrine are difficult to obtain on their own. However, it is easy to obtain pseudoephedrine from pharmacies where it is sold in many over the counter medicines such as the cold remedy, Sudafed. Boxes of 60 and 90 Sudafed tablets are no longer available over the counter in at least one jurisdiction (NSW), while in Queensland it is necessary to have photo ID before purchasing over the counter. But despite these regulations it is still a relatively easy matter for organised rackets in all jurisdictions to do the rounds of the pharmacies (Mundy 2001, p.3).

The 'finished product' of the (meth)amphetamine may vary in appearance depending on the quality of the precursor chemicals and the skill of the 'cook' or chemist:

Methamphetamine in its pure hydrochloride salt form is colourless, however substances on the market often have different colouration, indicating different ingredients and manufacturing processes... 'Inexperienced' manufacturers may produce a substance that is wet or even gluggy – this is unpleasant to taste, is very toxic and burns the nose, so [it] is either wrapped in a cigarette paper and swallowed with water 'bombing' or mixed and injected (Mundy 2001, pp.3–4).

Illicit manufacture of (meth)amphetamines and to a lesser extent ecstasy may be done by large underworld outfits in relatively sophisticated clandestine laboratories, as well as by individuals 'cooking' their recipes with little more than high school chemistry sets. The information needed to cook the drugs, however unsafely, is available from a wide range of publications over the Internet. The Committee was surprised by the ease with which these formulae could be obtained. Type ecstasy or amphetamine (manufacture) into any web site and numerous responses arise. For example, a search of the amazon.com on line books and music store website came up with a reference to, among numerous others, *Secrets of Methamphetamine Manufacture: Including Recipes for MDA, Ecstasy, and other Psychedelic Amphetamines. Revised and Expanded Fifth Edition* by 'Uncle Fester'.¹⁸⁹

189 The entry comes complete with a set of reviews by satisfied (and unsatisfied) readers. Take for example, the following:

'I strongly recommend the purchase of this book. Geared towards the production of methamphetamine, the Uncle believes in hit and run tactics to avoid getting caught with a smoking gun in your hands...he also offers a range of psychedelic amphetamines that will no doubt appeal to the reader. The author was correct in saying that this is the best book in its genera [sic] ; no other book in this field matches up to it in its clarity and directness. This book was the pinnacle of the underground scene in the 20th century... Filled with hardcore synthesis Fester offers a diverse range of tactics to counteract the heat and thence avoid detection' (Source and date of review withheld).

In the United States, the 'recipes' for methamphetamine are relatively simple, relying on reduction of ephedrine/pseudoephedrine which in turn are produced from basic cold remedies:

Although the complete list of formulas, hazards and chemicals employed to produce meth remains extensive, the vast majority of meth laboratories seized today use a common ephedrine/pseudoephedrine reduction method of manufacturing. This method requires a chemical not produced in the United States; however, laboratory operators can find the precursor chemicals needed in many over the counter cold medicines. Some clan operators purchase dozens of bottles of these cold remedies in order to extract the ephedrine or pseudoephedrine from the tablets.

Meth cooks sometimes use a formula for production that uses two extremely dangerous and highly volatile chemicals – sodium metal and anhydrous ammonia. Sodium metal can ignite when it comes into contact with water and anhydrous ammonia is a deadly respiratory hazard. Some clan labs may even contain chemicals such as sodium cyanide, which if accidentally mixed with another type of chemical found in the same lab can produce a deadly hydrogen gas (Hargreaves 2000, p.4).

A report by the United Nations Drug Control Programme (UNDCP) explains the process of amphetamine and amphetamine-type stimulant synthesis in more sophisticated detail as follows:

One of the essential conditions for the clandestine manufacture of any synthetic substance is access to a chemical that serves as the key building block for the synthesis. This starting material – the precursor – has to fulfill a few basic conditions:

- It has to have in its chemical structure some essential parts of the final molecule, so that it is possible to build the amphetamine-type substance through a relatively simple process, in a few steps, requiring few and easily available additional chemicals and relatively simple technology;¹⁹⁰
- The starting material should be cheap and easily available. While the preceding criterion does have some technological limits in terms of convertibility and feasibility, price and accessibility seem to be very elastic;
- The chemical structure of the precursor should provide for some flexibility in the synthesis. The number of alternates that are available on legitimate chemical markets for a given precursor, the number of end-products that can easily be made from that precursor, as well as the number of synthetic pathways that exist, or are possible, from a given precursor to a given amphetamine-type substance, all contribute to the attraction of a starting material to clandestine operators (UNDCP 1996, p.50).¹⁹¹

190 As the UNDCP points out 'The relative quantities of chemical precursors required to produce a synthetic drug tend to be considerably less than the quantities of botanical raw material needed to produce a comparable amount of plant based narcotic drug' (UNDCP 1996, p.50).

191 For flow charts and diagrams outlining the synthesis of amphetamines and amphetamine type stimulants, see UNDCP 1996.

The manufacturing of amphetamines and amphetamine-type stimulants are attractive to backyard chemists from an economic perspective, as they are cheaper to produce than heroin or cocaine. The United Nations Drug Control Programme (UNDCP) states:

- The amphetamine-type end-products have a simple chemical structure, which makes them ideal for clandestine experimentation;
- Many simple chemicals can serve in the various synthesis processes, either as building blocks or as facilitators, and are cheap and widely available in most countries;
- A great number of simple synthesis methods and pathways have been developed, patented and/or published in the scientific literature, usually consisting of very few steps leading from a starting material (precursor) to the desired end-product;
- This information, and its availability, have been growing since the first quarter of the century;
- Ever-increasing technological awareness means that simple chemical conversion processes can today be performed by any amateur;
- Since ATS are very similar in chemical structure, they are ideal targets for minor structural modifications to obtain a different end-product;
- These modifications may be determined by the availability of the precursors or may be the result of a deliberate effort to circumvent legislation by manufacturing an ATS not covered by national law or international convention;
- The latter approach is similar to the molecular designing strategy in chemical and pharmaceutical research. This strategy is transposed, via the grey area between the licit and the illicit, into the manufacture of what are called 'designer drugs', 'designer amphetamines, or more accurately, controlled drug analogues;
- It is particularly revealing that over the last decade, at least 30 amphetamine-type substances of clandestine origin have appeared in different countries; most of them have never been tested clinically;
- Finally, from the perspective of the drug user, or abuser, the *substitutive* nature of the whole group of substances should be noted; though with individual differences, they all provide pharmacological assistance in achieving very similar ends or effects (United Nations Drug Control Programme 1996, p.126).

Chemical diversion or the use of precursors is relatively common in Australia with pseudoephedrine being the most popular of the compounds used:

Domestic sourcing of the pseudoephedrine required for methylamphetamine production can occur through a variety of means – one of the more popular being organised runs to purchase individual packets of pseudoephedrine-based preparations (such as Sudafed) from all pharmacies in a particular

geographical location. Other means include the purchase of chemicals from hardware stores, armed robberies of chemical companies, theft from warehouses and establishing false companies to provide a legitimate cover for the acquisition of pseudoephedrine. The increasing incidence of theft from pharmaceutical companies, particularly in New South Wales and Victoria, is of concern to law enforcement.

Methylamphetamine producers also sometimes assume the role of brokers of precursor chemicals. Groups based in Queensland's Gold Coast are known to have sourced precursors from associates in Melbourne before sending the finished product back to the same associate. In some cases, there is a division of labour occurring; associates in one jurisdiction are responsible for acquiring the precursors, while others are involved in some or all parts of the production and distribution process.

The use of 'extraction houses' for the conversion of tablets to pseudoephedrine continued to be reported in New South Wales. The National Crime Authority reports that the product of a number of these houses has been used by groups for large-scale methylamphetamine production. In the Northern Territory, precursor chemicals are primarily sourced from interstate suppliers, though smaller manufacturers who are not affiliated with outlaw motor cycle gangs tend to source precursors from local chemical companies.

The 2000–01 period has seen a move away from the sole use of Sudafed as a precursor to wider sourcing of pseudoephedrine-based products such as Logicin, Demazin, Actifed and generic brand decongestants. This has been a direct result of the increased restrictions on the sale of Sudafed as well as greater national awareness of its potential for use in the manufacture of methylamphetamine (ABCI 2002, pp.37–38).

Distribution and distribution networks are discussed separately later in this chapter, although with regard to amphetamines these are often part of the same groups or syndicates as the manufacturer. According to the ABCI:

Most jurisdictions reported outlaw motor cycle gangs continue to play a dominant role in methylamphetamine manufacture and distribution, although Victoria Police and the Queensland Crime Commission reported that the level of involvement is not as significant as it has been in the past. There is also increasing evidence of outlaw motor cycle gangs aligning with Southeast Asian organised crime groups and other established criminal networks to produce methylamphetamine. Some Southeast Asian groups were actively supplying and distributing methylamphetamine on their own or in association with other Southeast Asian or other ethnic groups.

All jurisdictions reported either direct or indirect links between outlaw motor cycle gangs and methylamphetamine manufacture (ABCI 2002, p.36).

The gangs and syndicates are most often associated with the large-scale laboratories, particularly in the Logan area of south-east Queensland. A newer phenomenon is the 'boxed lab':

A number of jurisdictions also identified an increased involvement of independent manufacturers operating small-scale, often mobile and decentralised laboratories. These laboratories are also referred to as 'boxed labs' because they can be easily packaged and moved. They present particular challenges and risks to law enforcement because they can be relocated quickly to avoid detection, collectively are capable of producing large amounts of methylamphetamine, and often contained highly flammable and explosive materials (ABCI 2002, p.36).

Although the majority of clandestine laboratories are located at the residence of the producer, following overseas trends, mobile laboratories are increasingly being detected in hotel rooms, rented premises including high-rise apartments, self-storage units and vehicles.¹⁹² Often units or flats are only rented for the duration of the manufacture process. Clandestine laboratories are also located on rural and semi-rural properties – Western Australia Police report the majority of detected production sites in that state have been in regional areas (ABCI 2002, p.36).

Dangers associated with manufacture

As indicated, there are serious dangers associated with the manufacture of amphetamines. These affect the 'chemist' or manufacturer and his or her associates, the police and investigative officials who raid the laboratories, and the ultimate consumer.

The manufacturing process is potentially dangerous, with the chemicals involved being extremely volatile. The major risks are from exposure to toxic fumes and explosions during processing. Indeed, law enforcement discovery of a number of clandestine laboratories has been occasioned by explosion or fire and by the characteristic odours which accompany the manufacture of amphetamines (Wardlaw 1993, p.96).

The dangers faced by law enforcement officials have been well documented (Sheldon 1997; Macdonald 1998; Hargreaves 2000; *Journal of the American Medical Association* 2000). Such dangers faced by 'first responders' (police, firefighters, specialist investigators) can range from inhalation of toxic fumes to death or injuries sustained by booby-trapped laboratories (for example, bombs set to go off should a raid take place). The latter have occurred predominantly in the United States (Sheldon 1997).

The American Hazardous Substances Emergency Events Surveillance system (HSEES) has investigated injuries sustained by first responders caused by exposure to chemicals while investigating clandestine methamphetamine laboratories:

192 The ACC notes that for the most recent reporting period:

'Queensland was the only jurisdiction to report the use of hotels for the production of methylamphetamine. Offenders will stay for several days to do the cooking and often use the premises as a base from which to distribute the drug (ACC 2003, p.48).

Hazardous substances released during and after an event usually enter the body by inhalation and skin absorption; acute exposures may result in cough, headache, chest pain, burns, pulmonary oedema, respiratory failure, coma and death. Of the types of responders usually on site first, police officers had the greatest number of injuries because they were present during and immediately after a release. Emergency medical technicians sustained most injuries through onsite exposure or direct contact with the clothing or skin of contaminated persons. Firefighters, the least often injured on site first responders, were likely to be wearing personal protective equipment during events... Standard uniforms worn by police officers, emergency medical technicians, and hospital personnel provided little or no chemical/respiratory protection. During some events, turn out gear worn by firefighters offered only limited protection (*Journal of the American Medical Association* 2000, p.2716).

In Australia these dangers have also been highlighted. Macdonald, Wilkins and Sheldon (1998) state that the instability of both the environment in which the drugs are manufactured and the manufacturers themselves add to the dangers:

The reasons for stringent safety procedures become evident when the methods of making amphetamine, and the people involved in this lucrative industry, are examined.

Virtually all methods of clandestine amphetamine production involve the heating of different types of chemicals, such as acetone and other solvents. The danger of this activity is increased when primitive items like camp stoves with open flames are used.

This creates enormous potential for an explosion of stored chemicals and glass equipment – a highly hazardous scenario.

If this is not dangerous enough, the process of heating some chemicals gives off explosive and/or poisonous gases, such as hydrogen iodide or phosphene gas. Some of these poisonous gases are odourless but will cause death in a matter of minutes.

Add to this that the offender is often an addicted, intravenous drug user who, as part of the symptoms of amphetamine addiction, suffers from paranoia.

When the paranoia of discovery by police is realised, this person is located in his or her clan lab, surrounded by dangerous chemicals and pieces of apparatus that could easily become weapons and be used against, or thrown at, investigating police (Macdonald, Wilkins & Sheldon 1998, p.24).

It is little wonder, given the above facts, that Hargreaves states: 'Raiding a clandestine drug laboratory...has become one of the most dangerous operations a law enforcement officer can undertake' (Hargreaves 2000, p.1).¹⁹³

193 Hargreaves also notes the risks posed to the environment from illicit amphetamine manufacture, particularly chemical contamination from the lab's hazardous wastes:

'Each pound of meth manufactured in a clan lab generates up to 5 or more pounds of toxic waste. Clan lab operators routinely dump such waste into local streams, rivers and sewage systems in order to cover up evidence of their illegal operations... The average clan lab costs

Finally, amphetamine manufacture also has clear dangers for the ultimate consumer of the drug. Prescription drugs are usually produced under strict quality controls. Consumers of ecstasy or methamphetamine may be taking a pill produced in unhygienic circumstances and with possible toxic adulterations.

This is particularly the case with synthesising what purports to be MDMA. The most common starter chemicals used to manufacture 'pure' MDMA are piperonal, isoafrole, safrole and piperonylacetone (Gowing et al. 2001, p.3). However, accessibility to these chemicals, particularly since greater restrictions have been placed on their availability in recent years, has sometimes proven difficult. This results in the final product frequently containing a toxic or non-toxic mixture of chemical compounds that are often not related to each other (2001, p.3). As was noted in Chapter 4, these admixtures can often result in serious medical complications, including death. Pure MDMA is mostly imported, partly as it takes more chemical expertise to synthesise. MDMA is also more expensive to produce in its pure form. Therefore the labs that do purport to be making ecstasy are often manufacturing dangerous compound mixtures:

According to the [Australian Bureau of Criminal Intelligence's] intelligence officer Troy Kaizik, the reasons for this practice are largely economical:

"There is a fair difference in price between an amphetamine tablet and an ecstasy tablet... So what people are doing is they are producing amphetamine and basically pressing it into tablet form and selling it off as ecstasy, so they are making that much more profit."

Put \$10.00 worth of amphetamine through a pill press and you have \$50.00 worth of ecstasy.

Throughout the 1990s, most of the ecstasy available on the Australian market was manufactured overseas. The imported product was generally inexpensive and of high quality so demand for domestic product was minimal. But in recent years, as demand for ecstasy has increased, so too has the circulation of the fabricated pills.

It's a bit like moc-croc manufacturers cashing in on the popularity of real crocodile leather. Like fake fur. Like fake Rolexes. The culture of cheap

\$3000 to clean up. However, large production labs, because of the significant quantities of toxic chemicals and higher hazardous waste disposal charges can result in clean up costs exceeding \$100,000. Annually, the overall cleanup of these labs costs the DEA and other government agencies millions of dollars' (2000, p.4).

The ACC has noted that the manufacture of methylamphetamine in Australia:

'[p]roduces toxic waste in a ration of ten to one – for every 100 grams of methylamphetamine illegally produced, a kilogram of of highly dangerous waste is produced and illegally buried or dumped in waterways, (ACC 2003, p.67).

According to the (former) ABCI, spoliation of the environment through illicit drug manufacturing waste is particularly noticeable in Queensland. In an effort to address this:

'The Queensland Health Scientific Services has sought to minimise the amount of chemical waste and enhance workplace health and safety by the on-site destruction of chemicals and equipment discovered at clandestine laboratory sites, (ABCI 2002, p.47).

imitations is universal – even in the drug world.

The analysis of ecstasy tablets seized by police in the last few years has reflected this evolution from real to fabricated ecstasy:

“In 1999 almost everything was MDMA and then there was a consistent introduction of other materials to the point now where something like maybe two in three pills aren’t ecstasy. We’ve only had probably two, three or four serious attempts...of making MDMA as opposed to methamphetamine...” [Peter Valley, Queensland Government Chief Chemical Analyst].

This assertion is backed up by official statistics...¹⁹⁴ And according to Mr Kaizik it’s not just a case of the police not finding the labs. The fact is that most of the drugs marketed as ecstasy come out of ordinary amphetamine laboratories. Real ecstasy labs are few and far between.

And with so much fabricated ecstasy on the market, there appears to be more at stake for users than just fifty bucks. According to Mr Valley, the stakes can be as high as human life:

“There are a couple of extremely toxic substances that appear in tablets from time to time, PMA being the one that springs to mind. If you take one of these other materials thinking it is MDMA, and you’re familiar with the onset and the effect of MDMA, and these other materials have a slower onset, the tendency would be to think ‘Well the tablet I bought had a particularly low level (of MDMA) I’ll just drop another one’.

And suddenly you’re in a situation where you’ve taken what is well within the toxic range and by the time the problems start to manifest themselves, it’s far too late to really do anything about it” (all quotes in Moriarty 2001, p.9).

Distribution

Amphetamines

In the 2000–2001 summary of the Australian Illicit Drug Report a number of key points were made with regard to the law enforcement of the amphetamine and ecstasy networks. Among other issues it was stated that:

- Outlaw motor cycle gangs continue to play a role in manufacture and distribution with evidence suggesting alignments with other criminal networks.
- The production trend towards smaller scale mobile laboratories in a number of jurisdictions continue to pose risks and challenges to law enforcement.

194 This is indeed the case. For example, the ABCI note:

‘The trend, noted over the past two to three years, for methylamphetamine produced in clandestine laboratories in Australia to be incorporated into tablets continued during 2000–01. There have been instances of methylamphetamine being mixed with ephedrine, ketamine, caffeine, LSD or heroin, then made into tablets and imprinted with logos matching imported product and passed as ecstasy; thus attracting a higher price (ABCI 2002, pp.36–37).

- Tighter domestic restrictions on the sale of precursor chemicals are resulting in increasing thefts from pharmaceutical companies and chemists, as well as increased attempts at importation.
- A wider range of pseudoephedrine-based products is being used as precursors for amphetamine-type stimulant production during 2000–2001.
- While the number of border detections dropped during 2000–01, the average weight of detections increased from 358 grams to 1.7 kilograms; the postal stream remained the most common method of importation.
- Increased availability and use of crystalline methylamphetamine hydrochloride or 'ice' has been noted in most States and Territories.
- Use of amphetamine-type stimulants has increased partially due to an Australia-wide heroin shortage; specifically in the Australian Capital Territory, Queensland, South Australia, Western Australia and some regions of New South Wales (ABCI 2002, p.34).

To take the first point, there has long been an association, at least in the public mind, between amphetamine markets and distribution and outlawed motor cycle gangs. The reality is not too far from the public perception. 'Bikie' gangs are involved in amphetamine distribution markets (and as was discussed above, clandestine manufacture) and other forms of organised drug crime.¹⁹⁵ The following summary from the 2000–2001 Illicit Drug Report is still an accurate reflection of the current situation:

Methods of distributing amphetamine-type stimulants across Australia remains diverse, varying between regions, States and Territories. Outlaw motor cycle gangs dominate the distribution market. They are involved particularly in the inter- and intra-state distribution of amphetamine-type stimulants, precursors, equipment and personnel. Information from a joint agency report suggests over 50 per cent of clandestine laboratories they seized in 2000–01 had involved members of outlaw motor cycle gangs or their associates.

National Crime Authority Task Force information suggests the distribution role of outlaw motor cycle gangs in and across jurisdictions varies from involvement by a whole group to just individuals within a group. Outlaw motor cycle gangs involved in amphetamine-type stimulant distribution are continuing to expand their collaboration with European and South-east Asian organised-crime groups based in Australia. However, links between traditional and other larger players in the amphetamine-type stimulant market are quite fluid.

¹⁹⁵ In Adelaide, bikie gangs have also been associated with ecstasy distribution. The NDARC study by Longo et al. comments with regard to the survey of ecstasy users in South Australia that:

'There was agreement that there are two main sources of ecstasy distribution in Adelaide: bikies, and people involved in the rave and clubbing scene, with the quality of the ecstasy available from the bikies markedly higher' (NDARC 2002c, p.25).

Distribution and supply of amphetamine-type stimulants are characterised by a great deal of fluidity within networks, particularly at the smaller end of the market where groups may come together to produce and distribute amphetamine-type stimulants and then dissipate. Often distributors are either connected in some other way or are known to each other (ABCI 2002, p.42).

More recently, the ACC comments that there has, however, been some dynamic shifts in the illicit amphetamine market due to the links between 'traditional' and emerging players on the scene:

The role of outlaw motor cycle gangs in the distribution of amphetamine-type stimulants varied within and across the jurisdictions, ranging from involvement of the whole group to individuals within a group. Gangs and individuals involved in amphetamine-type stimulant distribution continue to expand their collaboration with ethnic-based organised crime groups in Australia. It would appear that associations are being driven increasingly by business interests rather than race-based considerations. New South Wales Police reported that while outlaw motor cycle gang nominees and new members may be involved in distribution, users, prostitutes and other gang associates are more likely to be used to distribute the drugs. This broadening of the supply network not only enables outlaw motor cycle gangs to control the market in an area but also allows members to distance themselves from the actual distribution and associated police attention (ACC 2003, p.55).

The former ABCI states that due to the highly localised nature of methamphetamine production, there are no major or significant distribution centres feeding interstate markets:

A sizeable portion of the interstate distribution that does occur, however, is believed to be facilitated through individuals in the trucking industry. Several jurisdictions reported that some interstate truck drivers are believed to be acting as methamphetamine couriers for various distribution networks. The predominant method of importing amphetamines into the Northern Territory is by vehicle, often through the road transport industry. Outlaw motor cycle gangs in the Northern Territory have well established, close associations with the trucking industry, including local, regional and interstate movement of freight. Likewise, Far Northern Queensland police reported amphetamines were being couriered into the region by vehicle from other parts of Queensland, including central Queensland where several established outlaw motor cycle gang chapters are located.

Other modes of transport used by interstate distribution networks include the postal system, commercial aircraft, commercial coaches and rail. Inter- and intra-state distribution by air has become increasingly prevalent in New South Wales (ABCI 2002, p.43).

At the 'micro level' of the spectrum, depending on the user group:

Low-level distribution varied between the states and territories. However, hotels, bars, nightclubs and dance parties continued to feature significantly. Several jurisdictions reported dealers were using mobile phones more frequently to prearrange meeting points for the delivery of amphetamine-type stimulants. Meeting points included public places such as car parks, take-away food outlets, public phone boxes and railway stations. Supply through the residential premises of the dealer was also common – particularly in New South Wales – with some dealers delivering the product personally to regular customers. In Queensland, hotels and motels are being used increasingly as production and distribution points.

Relationships at the lower level of the distribution chain are best characterised as opportunistic. Most low-level suppliers are on-selling amphetamine-type stimulants to support their quantities of less than one gram. According to New South Wales Police, while many low-level suppliers operate semi-autonomously – sourcing amphetamine-type stimulants from single or multiple mid-level suppliers – a number are also members of networks which share a common middle or upper-level supplier. Consistent with the findings of the Drug Use Monitoring in Australia program, New South Wales Police reported that most amphetamine-type stimulant purchases were paid for in cash, with some instances of product being exchanged for stolen goods (Freeman & Fitzgerald 2002). Suppliers in the Campbelltown area of Sydney often use third parties as couriers to transport drugs. Juveniles are preferred as they are perceived to be less likely to receive custodial sentences (ACC 2003, p.55).

Conclusion

Problems associated with the manufacture, importation and distribution of amphetamines and 'party drugs' are serious, although not insurmountable. Some of the difficulties for law enforcement agencies stem from the fact that the various drugs subject of this Inquiry come from different sources. MDMA/ecstasy is usually imported from Europe, particularly the Netherlands, but 'fake' MDMA can be produced in clandestine Australian laboratories. Amphetamines and methamphetamines are both imported into the country and manufactured locally. Legitimate users and producers of precursor chemicals such as pseudoephedrine may feel aggrieved at tighter controls on the production of these substances. Therefore different strategies and more resources are required to tackle the control and eradication of these drugs.

There are also jurisdictional issues pertaining to the control of these drugs. Responsibility for law enforcement ranges across not only a variety of federal agencies (Federal Police, Customs, the Australian Crime Commission) but also a number of state based agencies including local Crime Commissions and state police forces who play a vital role in drug control and investigation at local level.

While the Committee has no responsibility for recommending policy at a federal level, it does welcome submissions from all or any of these bodies as to how state and federal bodies can best work together in producing best outcomes with regard to supply control of amphetamines and party drugs.

Questions for discussion

- ◆ How much of these drugs are imported into Victoria and how much is manufactured in clandestine laboratories? How much of these drugs are imported into Australia and how much is manufactured in clandestine laboratories?
- ◆ One of the big problems, it would seem, in addressing the clandestine manufacture of amphetamines is curtailing the accessibility and availability of precursor drugs. Could more be done in this area, and if so, what?
- ◆ In NSW, purchasers of pseudoephedrine based substances must have their details recorded by pharmacists at the point of purchase. Is this an effective system? Are there problems associated with it? Should a scheduling/notification system similar to NSW be adopted in Victoria?
- ◆ If not, how should pseudoephedrine and other precursors best be regulated or controlled?
- ◆ What are the associated dangers for law enforcement officials in investigating clandestine laboratories?
- ◆ How can police services best address the emerging trend for the manufacturing of amphetamines by smaller groups of 'Internet cooks'?

8. Education, Information and Harm Reduction Issues Pertaining to Amphetamines and 'Party Drugs'

Introduction

As various Drugs and Crime Prevention Committees have observed on numerous occasions and through several Inquiries, the concept of drug education is one that is fraught with difficulty. This chapter discusses some of the questions surrounding the provision of information pertaining to the drugs subject of this Inquiry, why such information is deemed to be necessary, the forms such information should take and the best ways in which this can be undertaken. The second part of this chapter examines the controversial issue of harm minimisation, or harm reduction as it is sometimes known, and in particular its application to amphetamines and 'party drugs'. Although it could be said that harm minimisation programmes are a form of strategy rather than an education initiative per se, it is thought that many of the issues and controversies pertaining to these practices are most usefully located in the debates surrounding drug education.

Drug education – General

Theory and practice

The Drugs and Crime Prevention Committee of the 54th Parliament has extensively canvassed the debates with regard to drug education in its *Final Report – Inquiry into the Inhalation of Volatile Substances*. Rather than 'reinvent the wheel', this Committee has reproduced some of that information in this section as it is equally timely and applicable to the current Inquiry.

Drug education, particularly as it applies to amphetamines and 'party drugs', takes different forms depending on the drug in question and the audience being addressed. Strategies that may be suitable for school students may not be appropriate if targeted at young adults, users of these drugs, party-goers, families of users or indeed professionals working in the field such as police, drug and alcohol workers and/or medical staff. Accordingly, drug educators

realise different models need to be developed to meet the needs of these discrete groups.

Moreover, despite some commonalities across substances, drug education may have to be targeted in particular ways for different types of drugs.¹⁹⁶ Health Educator J.T. Lee poses a number of questions that should be asked in tailoring drug education strategies to particular substances:

The questions are:

- How much information?
- How relevant is the information?
- When is the information best considered?
- How is it to be offered?
- Is the information to be given by imposition or is it generated through sharing the knowledge offered by the teacher? (Lee 1989, p.332).

Often, whether one is addressing school students, young adults or drug users of more mature years, a didactic approach is taken that does not draw from the valuable knowledge of the recipient. This applies, as shall be discussed later, equally to the knowledge of those who use the drug:

Too often knowledge is offered as if to fill the empty vessel, the learner. Yet with drugs, as with most other topics of concern, [young] people may possess a great deal of knowledge and experience, often more than the teacher... Education is about people, and drug education needs to consider people and their ability to cope in a drug-oriented society and not just to see drugs in terms of 'problems'. Schools [for example] offer a marvellous opportunity to consider the areas of knowledge, attitudes and skills and self esteem, for it is there that young people can learn, share, discuss, practise, refine and adapt these attributes (Lee 1989, p.332).

With regard to school-based education, researchers from the National Drug Research Institute (NDRI) based at Curtin University, Perth, also agree that schools can, at least in theory, make useful contributions to drug prevention strategies through education. This has been reflected in a number of federal and state drug education programmes.¹⁹⁷ Midford, McBride and Farrington argue that school based drug education is an attractive option for governments 'because it offers the potential to stop the next generation from experiencing drug problems' (1999, p.4). Given that schools are places of learning, 'there is a certain logical appeal to using school based drug education as a means of changing behaviour' (Midford, McBride & Farrington 1999, p.4). Moreover:

196 For example, the 54th Drugs and Crime Prevention Committee became aware quickly that the approach to educating young people about volatile substance abuse needed to be quite different to models tailored for illicit drugs. See Drugs and Crime Prevention Committee, *Final Report – Inquiry into the Inhalation of Volatile Substances*, 2002.

197 For example, the National Drug Strategy 1993–1997; National School Drug Education Strategy; National Initiatives in Drug Education 1995–1997; Prime Minister's National Illicit Drug Strategy 1999; School Drug Education Project 1997 (W.A.); and Turning the Tide (Victoria) 1996–1997.

Drinking and other drug taking usually starts during youth. Most young people go to school and are a 'captive audience'. Most schools are places of learning; ipso facto, use schools to educate young people about the pitfalls of using alcohol and other drugs and thus keep them from harm. Despite this seemingly inherent logic, drug education has not been greatly successful, which a number of researchers put down to the emphasis of abstinence as the only acceptable programme goal. If the state programme objective is non-use, then any use, no matter how little, constitutes a programme failure (Midford, McBride & Munro 1998, p.319).

Problems in drug education

Experts in drug education, however, do see some problems in how drug education principles are applied in Australia. One area of concern has been an over-reliance on American literature on drug education and a lack of critical analysis about the applicability of this to Australian settings (Midford, McBride & Munro 1998; Midford, McBride & Farrington 1999).¹⁹⁸

Second, notwithstanding some national frameworks in the past, there is no consistency in how drug education is supported and applied at state level:

The infrastructure for drug education, as opposed to one off funding strategies or initiatives...are extensive in some Australia states and limited in others. Commitment to ongoing funding and long-term infrastructure seems to be somewhat cyclical and is determined by departmental priorities, political ideology and community demands based on reactions to drug use incidents. Currently New South Wales has the most extensive and long standing infrastructure which incorporates drug education support staff in each region of the state. Consequently there is a relatively high support staff to teacher ratio. Queensland, by comparison, has recently downgraded its in-house support of drug education...replaced in the main by individual schools purchasing drug education support from the community (Midford, McBride & Munro 1998, p.323).

Third, Australian educators drawing from British research agree that too often drug education and health promotion is inadequately supported by theory and that it too often ignores the social and cultural contexts of health and well being. Those who support social-cultural bases for drug education argue that too often such approaches are eclipsed by more conventional psychological theories of drug use, such as self-esteem deficits.¹⁹⁹ A recent report on Drug

198 For an interesting analysis of the difference between British and American approaches to drug education in the context of [volatile substance abuse], see Ives 1994. Ives believes that American education approaches (at least up until 1994) were more focussed on the general harm to health that [volatile substances] pose, whereas British strategies were based more on preventing deaths (Ives 1994, p.44).

199 For a critique of such theories including self-esteem deficits, see Coggans et al. 1991; Health Education Board of Scotland (HEBS) 2002.

A report of the HEBS in 1991 states:

'An assumption underlying much drug education is that young people experiment with drugs because they are in some way lacking in self esteem or are socially inadequate. While there is

Education by the Health Education Board of Scotland (HEBS 2002) comments on the importance of understanding the drug user in his or her cultural, social and historical milieu:

Yet within drug education relatively little attention is given to the consideration of cultural factors in shaping and determining individual action. This is a crucial omission in developing effective interventions... In particular, there has been almost no systematic investigation of drug use that is perceived by the user or other individuals as a taken for granted aspect of everyday life. For example, investigation might consider the socialisation of drug use and the way which it manifests itself in youth culture (HEBS 2002, p.1).

This accords with d'Abbs and MacLean's exhortation that drug interventions and strategies, including education initiatives, must take account of Zinberg's analysis of 'drug, set and setting' discussed earlier. It is pertinent to repeat their discussion of this here:

Successful strategies involve the use of a range of concurrent interventions addressing three variables labelled by Zinberg (1979, 1984) as 'drug, set and setting'. By these Zinberg means: the pharmacological-toxicological properties of the substance (drug); the attributes of persons using the substance, such as personality and physical health (set); and aspects of the social and physical environment in which consumption occurs (setting). No intervention strategy is likely to ameliorate...[substance abuse] and the problems associated with it unless it addresses each of these factors, and the interrelated effects engendered by them (d'Abbs & MacLean 2000, p.v).

In the classroom such an approach might involve drawing upon the student's understanding and experience of drug use as referred to previously by Lee. On the dance floor or at the nightclub, outreach workers and peer educators may be able to tap into some of the knowledge that ravers and clubbers have about their own drug use and the ways they try to minimise harms associated with it.

Such an approach is in part premised on the idea that drug education should 'work with rather than against popular culture' (Backett & Davidson 1992, p.55).

Fourth, and aligned to the previous point, much drug education material produced in Australia tends to be of the factual information provision type. As will be discussed later in this chapter, this didactic approach may be viewed in some circumstances as counter-productive among those people who do not

some evidence that people with positive health practices have higher self esteem, positive health practices or high self esteem do not necessarily preclude use of drugs' (Coggans et al. 1991, p.11).

Eleven years later HEBS reinforced this message:

'Self esteem theories...which focus on a presumed lack of self esteem provide a less than complex explanation for drug use... A recent review of the relationship between self esteem and use identified a number of methodological and statistical problems with the body of research, including deficiencies in measurement, invalid drawing of inferences from correlational studies and misrepresentation of data. The authors concluded that the evidence relating self esteem to drug use was insufficient to justify esteem enhancement as the basis for drug prevention interventions' (HEBS 2002, p.5).

consider themselves 'drug users or abusers', particularly those who take MDMA/'ecstasy'. As important as accurate factual information is there has been very little education material that explores 'issues involved in decision making' about drug use (Midford, McBride & Farringdon 1999, p.6).

Fifth, a problem with some approaches to drug education is that they do not differentiate between different groups of children or adolescents:

One of the reasons that drug education has been so ineffective may be that only a small proportion of those targeted are likely to progress beyond experimentation with drugs or low levels of recreational misuse. On the other hand, problematic drug users (those with physical, psychological or legal problems arising from their drug use) are likely to be beyond the limited potential of most drug education interventions aimed at adolescents. There appears to be a need to develop variable and targeted interventions which account for the needs of different groups. The educational needs of most young people who may or may not pass through a phase of 'normative' use will differ from the needs of those who have the potential to develop drug use problems. On a continuum of drug use from no use, through experimental and recreational use to problematic use, it is possible to view normative users as those whose experimental or recreational misuse does not result in perceived physical, psychological, economic or legal problems. It is important to note there is often a significant disparity of views between young people and adults (health/social care professionals, legal authorities and policy makers) as to what constitutes misuse. The difficulty here is to have any degree of confidence in being able to distinguish, at an early enough age for proactive interventions, between those likely to be non-users and normative users, on the one hand, and problematic users, on the other (HEBS 2002, p.10).

Finally, some Australian researchers have bemoaned the lack of sophisticated evaluation studies of drug education programmes in this country, particularly those which are schools based. Midford, McBride and Farringdon state:

Despite commitments of tens of millions of dollars for the provision of illicit drug education, there is currently no research being undertaken in Australia as to what constitutes the best approach and how that can be translated into routine practice (Midford, McBride & Farringdon 1999, p.6).

Drug education, particularly in schools, is therefore clearly a complex matter. This chapter now examines education and information provision relating to the specific context of amphetamines and 'party drugs'.

Drug education, prevention and information provision – 'Party drugs' and amphetamines

Much of what has been stated in the previous section is generally applicable to the specific drugs which are the subject of this Inquiry. This section examines some of the issues and problems pertaining to drug education and prevention programmes as applied to amphetamines and 'party drugs'.

At the outset it should be stated that one of the concerns some groups have with regard to drug education is that by providing information about drugs, one runs the risk of enticing, encouraging or condoning drug use. These concerns are particularly felt and expressed with regard to the contentious issue of harm minimisation and harm reduction, an area that will be discussed in detail later in this chapter.

Ecstasy and other 'party drugs'

A recent comprehensive international review of ecstasy and its effects included an analysis of education and prevention programmes (Gowing et al. 2001). After an extensive review of the international literature it concluded that the underlying principles supporting effective education programmes were premised on the fact that 'drug use is part of wider social problems and is a health problem with multiple antecedents'. Moreover:

While no individual strategy has been found to be effective in the long term there is considerable consistency in the identification of the criteria for effective programmes (Gowing et al. 2001, p.37).

Some of these criteria are:

- Programmes should target specific settings and cultures;
- Strategies should be carefully tailored to clearly defined target groups;
- Include multiple components addressing individuals, families, school, media, community organisations and health providers;
- Ensure that components are well integrated and messages are consistent;
- Use an evidence based approach incorporating research at all stages of the design, implementation and evaluation of the programme;
- Involve the community and target groups in defining the problem and finding solutions;
- Target groups at higher risk require higher intensity interventions;
- Strategies applied early in life are more effective for children at higher risk;
- Longer term programmes have a longer lasting impact (Gowing et al. 2001, p.37).

In the specific context of ecstasy, Gowing et al. (2001) state that prevention programmes need to take into account the reasons (young) people *give* for using

ecstasy and 'acknowledge the personal and social functions which ecstasy *serves* for young people' (p.37, Committee emphasis). This is as true of amphetamines and other drugs as it is of ecstasy.

The importance of function in terms of prevention strategies cannot be overestimated according to Annabel Boys and her academic colleagues at the National Addiction Centre (London). Negative messages with regard to substance use, including ecstasy and amphetamines, were found to have limited effect on the respondents to a cross-sectional survey on substance use among young people (Boys et al. 1999). Moreover:

Statistically significant associations were observed between the reported frequency of taking substances and the perceived social/contextual and/or mood altering functions cited for their consumption... If these findings are confirmed in larger studies, educational and preventative efforts may need to acknowledge the positive personal and social functions which different substances serve for young people (Boys et al. 1999, p.1043).

The authors continue:

A common approach in drug prevention in the UK has been to highlight the potential negative effects from use. However, we found that in our sample correlations between the life time experience of negative effects and the frequency and intensity of substance use were low. It appears for this group of young people, negative experiences arising from substance use had not been sufficient to discourage future consumption. The implications from these data are that education and prevention programmes may be strengthened by using new approaches to deter use...

From the results of our regression analyses it appears that the perceived likelihood of taking a substance in the future may be understood in terms of the functions served by its use. For cannabis and alcohol, perceived mood alteration and social/contextual functions, together with the extent of peer involvement predicted intentions to use. For amphetamines and ecstasy, our analyses suggested that there may be a tendency for social/contextual but not mood altering functions to be more influential on future use.

Overall, our findings support the recommendation that educators and prevention programme planners should recognise the complexity of the reasons behind substance use and then encourage young people to seek alternative ways of fulfilling them (Boys et al. 1999, pp.1048-1049).

Other international surveys cited by Gowing et al. have also shown that the positive reasons for using ecstasy 'appear to be more influential in decisions to initiate or continue use than knowledge or experience of negative effects' (Gowing et al. 2001, p.37). For example, the research surveys of Italian youth by Schifano (2000, cited in Gowing et al. 2001) found that 31 per cent of the 2107 young people sampled did not think of ecstasy as a drug of abuse and 33 per cent emphasised its positive effects.

The Gowing et al. review indicates that across the world:

Social context, fashion and peer group norms appear to be significant influences on the initiation and maintenance of ecstasy use... Prevention programmes [therefore] targeted at influencing these factors, such as peer interventions and the promotion of alternative trends and fashions to provide group identity, may be of benefit in preventing ecstasy use (Gowing et al. 2001, p.37).

In the United States there have been concerns expressed about the apparent exclusion of education and information with regard to MDMA/ecstasy in drug education curricula at both high school and college level. Although this has changed to some degree in recent years, there is still a noticeable emphasis on heroin, marijuana and amphetamines to the exclusion of MDMA and 'party drugs'. The following remarks by Elk are still pertinent:

The absence of apparent immediate negative or debilitating effects of this drug coupled with the lack of information being taught to students in drug education programs where other frequently encountered drugs are discussed may encourage students not to question initial or subsequent use of MDMA. By excluding discussions of MDMA within such programs, awareness of its potential dangers may be minimised if students perceive this drug not worthy of discussion or that it is of minimal risk or danger compared to other drugs that are included in the curriculum. If anything, the lack of information about the use of MDMA should be interpreted and portrayed to students as an even greater danger in itself. Therefore, including discussion of some of the consistent data gathered thus far can only assist students in becoming more aware of the dangers of taking such a drug and possibly deter their initial or future use of it (Elk 1996, p.355).

This concern with regard to a lack of information about ecstasy and its effects is not restricted to America. Drug researchers and workers in Australia have also stated that there is not enough information available about ecstasy. For example:

The Alcohol and other Drugs Council of Australia (ADCA) says there should be more education programmes for younger people on the health risks of using ecstasy. They also say that these programmes should not exaggerate the risks for people who occasionally have small doses of ecstasy, but talk more about the risks of larger and more frequent doses of the drug (Shannon 2002, p.25).

This information particularly needs to be supplied while young people are still at school. The comprehensive research done by Simon Lenton and his colleagues from the National Drug Research Institute in Perth is testament to this need. Lenton's study of ecstasy and party drug use among young people at dance and rave parties in Perth revealed that to a large extent the use of dance drugs by young people began while they were enrolled at school. As Lenton states, this 'potentially [has] implications for the content of drug education offered in school' (Lenton, Boys & Norcross 1997, p.1329).

The authors continue:

That [drug education] which focuses exclusively on 'saying no' to drugs and resisting 'peer pressure' will not help young people like these to minimise their drug related harm once they begin using these drugs. While the study was not designed to be representative of the school population, substantial numbers were in school and smaller numbers were in other education. Although there are often hurdles, such as school policy and perceived parental or community concerns about providing information to students about strategies other than 'abstinence only' messages regarding illicit drug use, this issue is too important to avoid. Appropriate, credible harm reduction orientated drug education on a range of drugs, including cannabis and the 'dance drugs', should be provided in secondary school. This should be relevant to those who are currently using the drugs or may do so at some time in the future. Perhaps if community outrage about the death of young people associated with the use of dance drugs such as ecstasy²⁰⁰ can be channelled into support for sensible and workable harm prevention strategies, school based harm reduction drug education about the use of these drugs will gain more support (Lenton, Boys & Norcross 1997, p.1335).

One of the problems about supplying credible information about ecstasy lies in the fact that there is still so much about the drug that even medical researchers and drug workers do not know. Such problems are compounded when the media might exaggerate or over-dramatise its risks and effects:

The problem Ecstasy poses for drug and alcohol workers is to provide information about the very real hazards associated with use of a drug which is much safer than many other drugs. The difficulty is to provide credible, accurate information about a drug which has killed some people and made others very ill, but which produces no discernible ill effects in the vast majority of users. The challenge is risk communication [but] communicating the risks of Ecstasy use is something that has so far not been done particularly well. Much of the information spread about Ecstasy is 'folkloric and distorted to the point of legend'... In many parts of the media, Ecstasy has been portrayed as a highly lethal drug, while many occasional users consider it completely harmless (Griffin 1996, p.9).

While the article from which the above quote is taken is somewhat dated, its message is not. As will be discussed in detail in Chapter 10, much research, medical and social, quantitative and qualitative, is still needed regarding the use of and effects of 'party drugs' and amphetamines. Moreover, education and information provision, particularly from a harm reduction focus, needs to be targeted not only at users but also at general medical practitioners, nurses, police and teachers.²⁰¹ It is still at least partly true to state that:

200 The Anna Wood case being the prime example, see Chapter 4.

201 This is particularly the case, given that many users of amphetamines may not access specialist drug and alcohol treatment services but prefer to seek advice from general practitioners. Many of these may be ill-equipped to deal with the problems associated with amphetamine abuse (see Wickes 1993a; Vincent, Allsop & Shoobridge 1996; Hando, Topp & Hall 1997; Gowing et al. 2001 and the discussion in Chapter 9).

[f]or a drug that seems to be so widely used, there are a surprising number of things we don't know about ecstasy. We don't know exactly what's in the ecstasy tabs sold on our streets. We are not sure how many people in Australia now take it. We don't know [for certain] what the long term effects of use are (Griffin 1996, p.10).

Amphetamines

Similar concerns have been expressed about information provision and programmes targeting amphetamine use (Griffin 1997; Wood 1998a). Professor Klee, drug expert on amphetamine use, makes the following comments in the British context:

'Existing [education] programs are not well targeted' Prof Klee said. 'In fact there is very little targeted at British amphetamine users at all – which itself gives out a message to them that there is little to be concerned about' (quoted in Griffin 1997, p.18).

A study of British amphetamine users conducted by Klee found:

[t]hat while some negative aspects of amphetamine were of major concern to users, other aspects were tolerated and ignored. A key finding was that providing information on physical and health effects is ineffective as a deterrent... Prof Klee said the study showed 'you could forget about most physical damage' as a deterrent to continued use.

Information and services perceived as being for heroin users were also ignored by amphetamine users, who saw themselves as a very different group to 'smackheads', and therefore regarded services targeting heroin users as inappropriate for their needs (Griffin 1997, p.18).

One of the difficulties in targeting education and harm minimisation strategies for amphetamine users (as opposed to 'party drugs') is in fact the multiplicity of substances that can come under that rubric. As Malcolm Turnbull argues:

[I]n talking about amphetamines we are clearly faced with a diversity of both substances and users. My main concern [is] with those stimulants known colloquially as 'speed' – consisting predominantly of either methamphetamine or dexamphetamine. These drugs are used illicitly in Australia by groups ranging from street kids to truck drivers to business executives, and are variously taken as tablets, snorted or injected. It is important to keep in mind, however, that these drugs are closely linked with a range of common stimulants such as ephedrine, on the one hand and with designer drugs such as MDMA, on the other. The similarities and the popular confusion between these drugs and amphetamines is a significant factor to be considered in the framing of any strategy. In some cases it may actually be more effective to address amphetamines as part of a broader psychostimulants strategy (Turnbull 1992, p.98).

The problem with such an approach however, does lie in the fact that there *are* such a diversity of profiles of users of amphetamine-type drugs or psychostimulants, as was discussed in Chapter 5. For example, a harm reduction programme for truck drivers who use 'speed' to stay awake may involve something as complex as structural changes to the transport industry. This approach may be very different to harm reduction measures aimed at dance party-goers.

Moreover, ethnographic researcher David Moore states that, at least in the context of amphetamines and ecstasy, much useful information and services seems only to be utilised by those 'at the harmful/heavily dependent end of the drug using spectrum' (Moore 1992a, p.85). Turnbull states that:

This is of particular concern because the majority of amphetamine users are casual recreational users who may only use a few times a month and are not linked to harm reduction services established for intravenous users (Turnbull 1992, p.99).

As Turnbull states, amphetamines do bridge the gap between recreational, occupational and dependent use, at least in the broadest sense of the term. Recreational users, particularly those using 'party drugs', may rarely avail themselves of such information. Moreover, as Klee indicates in the earlier quote, recreational users may differentiate between themselves and 'smackheads' or 'heavy drug' users. Moore studied recreational use of amphetamines and ecstasy among young people in Perth. He argues that it is particularly difficult to get harm reduction information across to those who use amphetamines intravenously:

Why does such information, devised with the best of intentions, fail to penetrate the various small worlds of recreational drug use? There are a number of reasons. Loxley and Davidson (1991) identify a common fear which also troubled some of my drug-using contacts – the fear of being identified by police (or by any agency or person) as an intravenous drug user should needle exchanges be under surveillance for any reason. This fear of identification as a 'drug user' also extended to those whose route of administration did not necessarily require 'picks' (needles).

Some occasional intravenous users perceived educational material as targeted at 'junkies' or at least not at themselves...(Moore 1992a, p.85).

Turnbull's research makes similar findings:

Evidence from surveys suggests that young people, in particular, tend not to regard amphetamines as dangerous and even many who inject themselves with the drug do not identify as intravenous drug users and are actually very critical of heroin users. The first challenge for a harm reduction strategy [is] clearly to get the users themselves to recognise that they are at risk and to break down speed's image as a clean drug (Turnbull 1992, p.100).

How appropriate is the educational information provided?

This reluctance to seek information or services similarly extended to those of Moore's sample who were not necessarily using drugs intravenously. The reasons for this reluctance or resistance often rested in the culture of drug use:

Much of the information available on [harm reduction] is cold, calculated, detailed and informative. It is 'clean' and impersonal and somehow doesn't fit the reality of the social worlds of recreational drug use. Worse still, in the long run, much information is not seen as credible but rather as scare or 'cry wolf' tactics and regarded with suspicion... Such impersonal and/or discredited information is incorporated into such networks very slowly, if at all (Moore 1992a, p.86).

Moore argues that at least part of the answer with regard to information provision is to be found in an understanding of ethnography: understanding the value of the drug user's networks and the culture within which drug use takes place.

Those working in public health have recognised the implausibility of solely individually-based health promotion and have proceeded to the general community level, with messages about healthy behaviour. But they have missed an intermediate level, that of social contexts, within which all individuals interact and exist. Unlike public health and its research arm, epidemiology, ethnography provides very detailed rich material about actors within specific social contexts. To say this is not, of course, to suggest that mass promotion techniques [such as media campaigns] are necessarily redundant. Smaller scale measures are not intended to replace such initiatives but to complement them. It means mediating the monolithic messages of such broad based campaigns and translating them into messages (and media) more appropriate to the numerous and overlapping social worlds which make up modern pluralistic societies (Moore 1992a, p.89).

Moore argues that a focus on the networks and bonds apparent in groups of young people who may use drugs can give clues to how health promotion material can best be disseminated. Personal networks and contacts have an instrumental function in addition to their expressive or emotional ties:

[p]ersonal contact is highly valued...and information from a personal source rather than a booklet, other printed material or some other 'official' source is more likely to be understood and assimilated. For these reasons, most knowledge about using drugs is almost exclusively derived from other drug users (Moore 1992a, p.87).

How can a knowledge of these cultural networks be best used to provide appropriate information with regard to drug use and its potential dangers? Moore argues that detached or outreach street work and outreach methodologies are the best ways of connecting with (young) people who may otherwise be resistant to receiving such messages. The use of 'peer educators' to

disseminate non-judgmental drug information has also been utilised in a number of government and non-government programmes. This would seem to be a useful and worthwhile addition to education models, although further evaluation needs to be undertaken.

Youth workers, street outreach workers and indeed ethnographers all have a part to play in providing non-judgemental, accurate and impartial advice about drug use. Importantly, such advice may be given in a setting or context where the user is comfortable – a rave party, dance club or gay sauna for example.²⁰² Moore compares outreach methodologies with other secondary prevention strategies such as mass media campaigns, finding the latter less effective, at least with regard to those who may already be using:

Although mass media campaigns might reach much larger audiences, outreach networks will reach drug users *in an effective and culturally resonant way*. Outreach strategies build on a cultural emphasis that most information comes from other drug users in face to face interaction and in this way outreach does not seek to alter social and cultural processes but to make use of existing ones. Perhaps most importantly, outreach programmes may provide the kind of dialectical forum in which input from both drug expert and drug user may be combined to construct a much-needed middle ground (Moore 1992a, p.88). (Author's emphasis)

Recent national, state and local information programmes

Notwithstanding the above criticisms, in recent years there have been a number of national, state and local programmes that have endeavoured to provide information and educational materials with regard to amphetamine and ecstasy use that target audiences such as young people, ravers, clubbers and school students. Apart from fact and information sheets compiled, written and/or distributed by various drug resource and information groups, other projects have drawn from the ethnographic methodologies referred to by researchers such as Moore. For example, not only does the Australian Drug Foundation, the peak drug information body, produce standard resources such as Information Sheets, conduct research and maintain a library and information clearing-house, but it also hosts and manages a youth website called 'Somazone'.²⁰³

This website was developed *by* young people for young people. A key feature of the site is the question and answer section where young people can submit questions which are answered by people with expertise on the relevant issue.

202 The dissemination of material or equipment or the giving of advice at venues or places at which the recipient is comfortable avoids the problems discussed by Moore (1992a) with regard to the criminal nature of the user's behaviour. For example, Moore argues that some users may be disinclined to attend needle exchanges or specialist drug agencies for fear that they may be under police surveillance. Others may be reluctant to go to such venues because they may be perceived as 'junkies', a label that does not accord with either their self-image or their sense of their own drug-taking behaviour (see Moore 1992a, p.85).

203 www.somazone.com.au

The drug related questions are answered by ADF staff members. The questions and answers are posted on the site so that the information is available to all who visit the site. Currently there are 25 questions with answers listed for amphetamines, 13 for ecstasy, and 8 for hallucinogens. However it is the type of questions which young people are asking about these drugs which is enlightening, giving some indication of the level of knowledge (and ignorance) that exists about these drugs, attitudes to their use and actual practice.²⁰⁴

An early national initiative to try and make young clubbers aware of the potential dangers of ecstasy and other 'party drugs' was *project e*. This was an education kit produced for dance party patrons funded by the Commonwealth government and developed jointly by drug and alcohol agencies in Queensland, New South Wales and South Australia. The kit had four elements:

- A booklet for venue operators that suggests initiatives which encourage the safe organisation and management of dance parties. It addresses issues such as first aid requirements, provision of chill out areas, access to water, security arrangements and liaison with emergency services;
- An educational brochure about the effects of ecstasy, explaining the drug and its effects, safety risks, water consumption and how and when to seek medical assistance;
- Four wallet sized cards summarising the effects of ecstasy and what actions are necessary if someone is suffering the effects of taking ecstasy;²⁰⁵
- Two educational A4 sized poster for display in venue toilets (reproduced in Wood 1998a, p.19).

As with many such projects, whether they are dealing with ecstasy or alcohol, much of their effectiveness depends on the willingness of venue managements to fully participate in their implementation. This is not always forthcoming. Another criticism of the *project e* material was that it did not to any extent focus on or draw attention to the very real dangers of poly drug use in conjunction with ecstasy or it did so in very generalised ways. For example, messages such as 'It is dangerous to take ecstasy when using other drugs' are not very helpful if the types of drug interactions and their consequences are not spelt out. As Wood, quoting from leading drug educators, states in this context:

'If concurrent use of more than one drug is a common practice among users of dance drugs, the effectiveness of harm reduction messages advising users not to mix their drugs could be questioned'... But in fairness to drug educators, what else can they do in light of the dearth of research into drug combinations? (Wood 1998a, p.19).

204 Submission of the Australian Drug Foundation to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. (Committee emphasis)

205 The cards included messages with regard to safe water consumption, the effects of over-heating and how to prevent it or address it, and other medical advice to use during an emergency (see Webb 1998).

Programmes in schools

Many of the education and information provision projects that are being run in local areas concern various harm minimisation and reduction strategies aimed at reducing, if not eliminating, the deleterious effects associated with amphetamine and ecstasy use. Several school based programmes incorporate both peer education strategies as well as information sharing with parents and parent groups with regard to drug issues, including amphetamines and ecstasy.²⁰⁶ Many Victorian schools are involved in planning drug education programmes and policies through the Individual School Drug Education Strategy.

Nonetheless, there have been criticisms that schools could be doing more and doing it differently. In a submission to this Committee, the Victorian Catholic Education Office states, 'There is a need for schools to be...responsive to new situations and to adopt new approaches that promise to be effective.'²⁰⁷ It continues:

Schools should do more to provide age appropriate drug education for students in the senior secondary years (Years 11 and 12). Because of the pressures on students and schools to succeed academically in the VCE and other senior secondary programs, schools have difficulty in finding time in the teaching programs for such matters as drug education and drug related student welfare programs...

In addressing safety issues for young people using amphetamines and 'party drugs', especially in combination with alcohol, young people need to be encouraged to act on their feelings of friendship and care that they have in their groups, to support each other and seek help when needed. Schools should continue to build supportive environments for their students, so that at all levels young people experience connectedness and support. This should foster a readiness to seek advice and to talk to those who can provide advice and help.²⁰⁸

206 For example, the City of Monash's Parent Drug Education Program 'seeks to educate parents of secondary aged young people regarding drug and alcohol issues, as well as providing drug and alcohol service delivery information and encouraging parents to communicate with young people about substance abuse' (Submission of the City of Monash to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002).

207 Submission of the Catholic Education Office to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

208 Submission of the Catholic Education Office to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. This submission also makes reference to the hitherto mentioned 'Celebrating Safely – 'The Later Years Project':

'This project is designed to examine the approaches used by schools to prepare their students to make wise decisions about alcohol and drug use at key celebrations, particularly those associated with the end of Year 12. The project involves working with a small number of schools, conducting focus groups with students, surveying teachers and parents, identifying good practice and collating useful information and making it available to schools'.

The Celebrating Safety project is federally funded and applies to all Australian schools, state and private.

Many drug, youth and community agencies agree that interventions with regard to ecstasy and 'party drugs', and amphetamines used in the party context, need to be focussed differently compared to traditional drug education contexts. This is particularly the case given that young people who take ecstasy do not necessarily view themselves as 'taking drugs' and are therefore unlikely to appear at specialist drug services.²⁰⁹

The Drugs and Alcohol Services Council of South Australia makes the salutary point that those who use 'party drugs' are a population that are very hard to reach, particularly once they have left home and/or school and school/youth networks:

As the dance club scene has developed so has the increase in availability and the consumption of recreational dance drugs such as ecstasy and amphetamines. This has led to a 'normalisation' of recreational drug use within contemporary youth culture with the consequence of a potential increase in drug related harm. One of the key issues in providing harm reduction and prevention information to ecstasy and other party drug users is accessing the target group. This target group is quite different to other licit or illicit drug users and difficult to access through traditional, mainstream media outlets. Previous studies have found that most users are in their early 20s and can not be accessed through other program areas, such as the Clean Needle Program, as most have never injected drugs.²¹⁰

The Committee has received submissions from a variety of groups, which are often local government based, outlining many such projects. These projects and initiatives are most conveniently dealt with in the following section pertaining to the issue of harm minimisation.

Harm reduction and harm minimisation – General strategies and initiatives

The sometimes controversial issue of harm minimisation was thoroughly canvassed by the Drugs and Crime Prevention Committee in its recent Inquiry into the Inhalation of Volatile Substances. The interested reader is referred to the *Final Report* of that Inquiry for a detailed account of the theoretical and practical debates surrounding this contentious issue. However, there are some basic concepts from that Report that bear repeating at this stage prior to

209 This is certainly the view of Uniting Church drug agency Moreland Hall based in Melbourne. They have recently embarked on a project to develop a 'Big Book on "Party Drugs"', similar to their highly successful *Big Book on Drugs*. The aim is to distribute accessible and non-judgemental information on 'party drugs' to young people and students through school and youth networks across Victoria. See, Submission of Moreland Hall to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

210 Submission of the Drugs and Alcohol Services Council of South Australia to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

examining the issues as they specifically apply to the area of amphetamines and 'party drugs'.

Harm minimisation as defined by the Commonwealth Government refers to:

Policies and programmes designed to reduce drug-related harm. Harm minimisation aims to improve health, social and economic outcomes for both the community and the individual and encompasses a wide range of approaches, including

- Supply-reduction strategies designed to disrupt the production and supply of [illicit] drugs;
- Demand-reduction strategies designed to prevent the production and supply of [illicit] drugs;
- A range of targeted harm-reduction strategies designed to reduce drug-related harm for individuals and communities (Commonwealth Department of Health 1999, pp.15–16).

Harm minimisation is not necessarily a consistent policy. It takes different forms depending on the drug in question and the group that is being targeted. Harm minimisation is also often used interchangeably, and sometimes confusingly, with harm reduction. For the purposes of this discussion, harm reduction will be examined as one specific form or 'subset' of harm minimisation.²¹¹

The broader concept of harm minimisation has an extensive literature.²¹² The rationale for harm minimisation is based on the view that:

Neither law enforcement (prohibitionist) policies nor prevention through information and education strategies have succeeded in curbing either the supply of drugs or the demand for them, and many treatment responses have met with only modest success. This has led to the emergence over the past decade of a new way of thinking about drugs: harm minimisation. Harm minimisation tries to assess the actual harm associated with any particular drug use and asks how this harm could be minimised or reduced. This approach accepts that:

- Psychoactive substances are and will continue to be part of our society;
- Their eradication is impossible; and

211 For example, as stated earlier, the Commonwealth government definition of harm minimisation would also include demand and supply reduction principles. These have been considered separately in Chapter 6 of this Paper.

212 There is a wealth of literature explaining the concept of harm minimisation and the related principles of risk reduction. In an Occasional Paper produced by this Committee in 1998 these principles are thoroughly outlined (Drugs and Crime Prevention Committee 1998). There are also many good secondary references on the subject that can be consulted. In particular the text by Hamilton, Kellehear & Rumbold (1998) offers an excellent overview. A recent worthwhile publication is that of Ryder, Salmon & Walker (2001). See also Erickson 1995; Hawks & Lenton 1998; Lenton & Midford 1996; Midford, McBride & Munro 1998; Single 1995; Strang & Farrell 1992.

- The continuation of attempts to eradicate them may result in maximising net harms for society.

The objectives of the harm minimisation model are:

- The identification of the harmful consequences for individuals, those around them and the community overall; and
- The implementation of strategies to minimise this harm (Hamilton, Kellehear & Rumbold 1998, pp.135, 136).

Conceptually, Erikson et al. (1997, quoted in Hamilton, Kellehear & Rumbold 1998) identify the following elements as being part of harm minimisation strategies:

- A value-neutral view of drug use;
- A value-neutral view of users;
- A focus on problems or harmful consequences resulting from use;
- An acceptance that abstinence is irrelevant;
- A belief that the user has and should continue to have an active role in making choices and taking action about their own drug use (Erikson et al. quoted in Hamilton, Kellehear & Rumbold 1998, p.137).

These conceptual elements ideally produce practical strategies that:

- Seek to maximise those strategies that lead to harm reduction;
- Support pragmatic programmes that can be eclectic and flexible;
- Incorporate any scheme that will assist in net harm reduction;
- Aim to be user-centred, including users in planning;
- Emphasise choice, taking account of the users' own interests and the responsibilities they retain in their societal context (Hamilton, Kellehear & Rumbold 1998, p.137).

While acknowledging that there are people in the community who use drugs, harm minimisation policies neither condone nor encourage drug use.

In current drug policy, needle exchange programmes are a clear example of harm minimisation to reduce the transfer of blood-borne diseases. With regard to amphetamine use, a common harm minimisation approach is to attempt to persuade users not to use amphetamines intravenously or if they do to only use new and sterile needles.

Much of the misunderstanding concerning harm minimisation seems to stem from the fact that harm minimisation would appear to mean different things to different people. It also runs the risk of being loaded down with ideological meanings across the political spectrum that have little to do with what the term or the concept actually means. A worker from the Youth Substance Abuse Service giving evidence at the Inquiry into the Inhalation of Volatile Substances exhorted the former Drugs and Crime Prevention Committee to be clear as to what the concept does and does not mean. It is worth reproducing this

statement as it is an extremely lucid and clear exposition on the nature of harm minimisation:

It is important to look at the philosophical underpinnings of harm minimisation. Harm minimisation is actually a goal rather than a strategy or set of policies, so it is a position a worker in the field might adopt when trying to provide care for a young person.²¹³ It is absolutely essential to mention that the only method to divine whether an activity is harm minimisation is by the observation of the consequences – does it reduce harm? A lot of people seek to put zero tolerance at one end of the continuum and say that harm minimisation or harm reduction is at the other end of the continuum. In fact harm minimisation is a goal that is off that continuum altogether. If you could show or demonstrate that zero tolerance was able to reduce harm, you could embrace that as a harm-minimisation strategy or approach.

People often say that harm reduction or harm minimisation does not work for adolescents, which in some ways is a ludicrous thing to say because what would be the alternative – maximising harm for adolescents because it is a goal? What they are often talking about is that adolescents have a need for structuring and nurturing containment, as well as that need to take risks, bust out and find their own identity. People often react to that need for some sort of containment. Young people are often involved in very chaotic behaviour that can be very harmful, and so people will often seek a response like zero tolerance, which is an extreme response...

For harm minimisation strategies to work, you need to get as much information or evidence as possible about the circumstances presenting in front of you, whether that is at a broader policy level, around how the media responds, or from a youth worker with a young person in front of them who engages or has engaged in volatile substance inhalation. Secondly, all the needs of affected individuals and groups need to be considered. It is not just looking at the actual individual but at other stakeholders and other people involved.

Also, we need to deal with the unique specific circumstances that present. Given that we are looking at a goal rather than a set of strategies, one strategy that reduces harm in one circumstance may actually increase it in another, so we should not adopt strategies holus-bolus because of their effectiveness in one context.

Last is the importance of monitoring and evaluation, and that is in the short and long term. To come up with an effective harm-minimisation strategy you would need to consider all those factors. I contend that is the most responsible measured approach because it focuses particularly on the needs, the health and wellbeing of the person who is involved in the act of volatile substance inhalation and not just on the drug use itself. One of the problems with a lot

213 This idea of harm minimisation as a *goal* rather than a policy per se is echoed in the academic literature, in particular in the work of Midford, McBride & Munro (1998) and Midford, McBride & Farrington (1999) discussed below.

of policies and strategies that are implemented is that they focus on the use regardless of the consequences for the individual or the other stakeholders involved.²¹⁴

Moreover, the development of rational drugs policy is sometimes compromised by the sending of conflicting or contradictory messages and/or misinformation, exaggeration and hyperbole. This has certainly been the case in recent years with regard to ecstasy. For example, in the United States, Concar alludes to the mixed messages being sent to the community when different agencies, often within government, take opposing approaches to addressing drug use. He describes a project approved by the US Food and Drug Administration in which victims of trauma and violent crime are given ecstasy under controlled conditions as part of a trial to determine the effect of the drug as an anti-anxiety medication. Such experiments are not looked upon with favour by the US Drug Enforcement Agency:

In other words, while bona fide doctors supported by one US government agency get ready to dole out 'E' as medicine, other agencies are doing their utmost to warn teenagers off the drug. It's all very confusing. And you will find equally mixed messages elsewhere. Take Britain, last year the government introduced a tough new law making it a crime for club owners to permit the use of ecstasy on the premises. This year it issued a booklet telling the same club owners to lay on chill out rooms treatment areas and plentiful supplies of water (Concar 2002, p.27).

These 'mixed signals' are inimical to good policymaking, particularly policies that incorporate harm reduction messages.

How relevant are harm minimisation and reduction principles in the context of amphetamines and particularly 'party drugs'? The next section will discuss these issues in detail.

Harm reduction – Amphetamines and 'party drugs'

A variety of harm reduction measures have been established across the Australian states (and internationally) over the last ten years to minimise the dangers associated with using 'party drugs' and to a lesser extent other amphetamines. According to Lenton, Boys and Norcross (1997) these have taken three main forms:

- ◆ Safe rave or safe dance party guidelines aimed at club owners and rave promoters
- ◆ Outreach workers to provide support and assistance to those who use 'party drugs' [often located at raves and venues]
- ◆ Testing Stations or kits for party drug pills and tablets.

214 Mr Andrew Bruin, YSAS. Evidence given at the Public Hearing of the Drugs and Crime Prevention Committee, Inquiry into the Inhalation of Volatile Substances, 9 April 2002.

Mass media campaigns with regard to ecstasy and amphetamines have also been utilised in a number of jurisdictions both within Australia and overseas but these are generally viewed as less effective, particularly if accompanied by 'scare tactics' (Gowing et al. 2001, p.43). Indeed one of the problems facing drug educators is that media reports exaggerating the consequences of taking drugs such as ecstasy run the risk of making users blasé about the legitimate concerns held about the drug. For example Libby Topp, researcher with the National Drug and Alcohol Research Centre, states:

[t]hat many ravers call a good night out an 'Anna Wood'²¹⁵ night, as an expression of their frustration at ecstasy myths. "We really need to get off the idea that everyone who has ecstasy is going to die" she says (Topp quoted in Sweet 1997, p.6).

There is also the fact that harm minimisation projects such as *project e* are viewed by some members of the community as signalling a green light for drug abuse or at least condoning it. For example, in the context of *project e*, pharmacologist Greg Chesher states:

What I found was very, very sad was Mr Wood [Tony, father of Anna] saying project e is encouraging drug use...the very sad thing is that if his daughter had this information she would very likely still be alive today (quoted in Sweet 1997, p.6).

There are also ways in which users themselves self-regulate their use or utilise their own harm reduction measures, often drawing from the advice of friends and fellow users or the 'folkloric knowledge' alluded to by Moore and discussed above.

These tactics and strategies will be looked at in turn.

Dance/rave guidelines and outreach

Using guidelines to making 'partying' safer and employing outreach staff at such parties are attempts to use the environments in which young people congregate to make them more informed about the choices they are making. It is argued that this is a far more effective measure to get across messages with regard to the dangers of drug use than banning the activities in which the drug use is seen to flourish.²¹⁶ As Lenton, Boys and Norcross comment:

215 A 15 year old Sydney schoolgirl who tragically died as a result of complications after having taken ecstasy. For an account of the Anna Wood tragedy from the perspective of her parents and the police attached to the case, see Messenger 1998.

216 It is interesting that in the relatively early days of MDMA, some commentators had called for the drug to be legalised as a harm minimisation measure. For example, the following comments by Fitzgerald reflect a time in which MDMA was viewed pharmacologically as a benign substance, 'relatively free of contaminants':

'The arguments to change the legal status of MDMA are: firstly, that at the current use levels, MDMA poses a low health risk to the user; secondly, users may be suffering because of the illegal status of the drug; thirdly that there may be costs to society because of its illegal status; and finally, that MDMA may have significant therapeutic value' (Fitzgerald 1991, p.1).

Since the above comments were written, many if not all of the above factors have been if not disproved at least resiled from to a significant degree.

Raves and other venues where people in the scene go (such as certain nightclubs, music and clothing stores), provide channels for distributing harm reduction information materials to this population. Banning raves, or making the regulations which apply to them so restrictive that they are unworkable, could result in events being driven more underground rather than reducing drug use. Such actions are more likely to undermine cooperative alliances between people in the scene, health workers and event promoters to institute workable harm reduction strategies (1997, p.1336).

It is only relatively recently that clubs and venues in Australia have introduced guidelines and safety measures, often in conjunction with government health promotion units, to minimise and reduce harms associated with amphetamines and party drug use. In Britain such measures have been in use for much longer. As early as 1991 a variety of approaches were being used by club owners in consultation with drug agency workers and educators. Some of the advice given to club owners included the following:

- Safety: rave organisers need to provide more than the legal minimum, and this probably extends to crush barriers, better ventilation, chill zones and rest areas;
- Security: trained bouncers, chosen in consultation with the police;
- Silence: minimise public nuisance by staggering raves away from residential areas, supplying good maps, transport and parking;
- Supply: permitting supply of illegal drugs on the premises is illegal and neither this nor promotion of drugs should be tolerated;
- Sense: pass health information to ravers to help minimise harm...
- Site: for drug workers nothing beats working on site, where bouncers and other rave staff can be persuaded to become part of an informal paramedical team capable of dealing with all incidents (Pearson et al. 1991, p.11).

In Australia, research conducted by Hando et al. (1997 cited in Webb 1998) led, at least in part, to a series of formal and informal protocols being established to maintain a safe environment for dance clubs and venues.²¹⁷

217 Some harm minimisation projects indirectly associated with club drugs, particularly GHB, have been recently developed to combat the practice of drink spiking, usually of young women's drinks. For example, the Whitsunday Spiked Drink Awareness Program is a Queensland programme based in the Whitsunday Islands that was a result of the concerns of local police and health workers regarding the numbers of sexual assaults on young women, ostensibly as a result of disinhibiting drugs such as GHB being put in unattended drinks of young women, often tourists and backpackers. With the backing of local licensees and funding from the Queensland government the project aims to give information on the dangers of drink spiking through the placement of posters and other informative material in pubs, clubs, toilets and bars. The information in the posters included:

- 'What drink spiking is
- Harms associated with the practice, such as assault, rape, unsafe sex and robbery
- The physical effects of various drugs associated with drink spiking, particularly rohypnol and GHB
- Appropriate contacts to seek assistance or further information' (McKey 2000, p.23).

Drink Spiking Harm Reduction Programmes in Queensland are now co-ordinated and

Hando's research found that venues where ecstasy was being consumed 'were typically too crowded, noisy, smoky and hot':

The study's authors concluded that there was an urgent need for health and safety information about venue organisation and facilities to be distributed to venue operators and dance party promoters. The researchers recommended that such information should cover:

- Provision of adequate water;
- Toilet conditions;
- Ventilation and air conditioning;
- Crowd control;
- First aid procedures;
- "Chill out" areas which are quieter, cooler and less active; and
- Regular monitoring of patrons (Webb 1998, p.96).²¹⁸

Many of the Hando recommendations were incorporated into the *National Protocols on Conducting Safer Dance Parties* developed by the National Drug Strategy Committee (NDSC) (1997 cited in Wood 1998a). Other suggestions that have been incorporated into such guidelines include the provision of entertainment other than dancing at venues, for example computer games etc to encourage patrons to take breaks from continuous dancing, and encouraging the wearing of loose clothing at dance parties. It has also been suggested that the provision of water at dance venues should be *free of charge* (Gowing et al. 2001).²¹⁹

Specific projects in South Australia and Victoria

South Australian projects

South Australia has been one of the most proactive states in addressing amphetamines and 'party drugs' from a harm reduction perspective. In a

implemented by a Drink Spiking Working Party established by Queensland Health in conjunction with the Queensland Police Service, Liquor Licensing and a variety of Queensland community agencies (Personal communication to the Committee by Detective Senior Constable Fiona Hinshelwood, Queensland Police Service, 27 June 2003).

Similar projects and programmes have been established throughout Australia. See, for example, the 'Keep your eyes open' drink spiking campaign promoted by the Bendigo Safe City Forum in Bendigo, Central Victoria:

'The program is a six month pilot with an evaluative component that targets females, potential and actual perpetrators and bar staff in nightclubs. Program material consists of three A4 messages with take away information that are displayed in the toilet environments. The objectives of the program are to reinforce drink spiking as a criminal offence, recognise that nightclub staff have a duty of care, and provide behavioural practices to protect people from drink spiking' (Submission of the City of Greater Bendigo to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', July 2002).

218 For other information on the use of guidelines for the conduct of dance parties, see Fromberg 1998; Kamienicki et al. 1998 and Spruit 1999.

219 Sometimes this advice may change as more information about the drug and its effects is ascertained. For example, recent harm minimisation advice with regard to ecstasy/party drug use and water consumption stresses that 'water is the "antidote" to dancing, not ecstasy. That is, drink 250ml of water every hour if *not* dancing, increasing to 500ml every hour if dancing' (Kong 2000, p.420).

submission to this Inquiry the Drugs and Alcohol Services Council (DASC) of South Australia outlines the following strategies designed to 'address the prevention of uptake of 'party drugs' as well as reducing the harms associated with party drug use'.²²⁰

Illicit Drugs and Licensed Premises Project

The Drug and Alcohol Services Council is currently working in partnership with the Office of the Liquor and Gambling Commissioner, Australian Hotels Association (SA Branch), Clubs SA, Royal Adelaide Hospital and SA Police to develop a health promotion strategy addressing psychostimulant use by young people within South Australia.

The aim of the project is to decrease the harms associated with illicit drug use in and around licensed premises. This aim will be met by improving the capability of licensees to address illicit drug use issues through:

- developing and implementing education strategies for licenses; and,
- broadly disseminating clear, credible and accurate harm reduction and prevention information to patrons of licensed premises relating to illicit drug use.

Specific resources developed by the project will include social marketing tools, including posters and stickers, together with a licensee education kit which will be integrated within current licensee education and training sessions. The project will be piloted within three licensed premises in August 2002, with the project resources on offer to approximately 200 licensed premises by December 2002.²²¹

Community Enhancement Initiative

The Drug and Alcohol Services Council has developed an initiative which focuses on the youth 'dance club' culture to prevent the uptake of psychostimulant use, reduce harm among users, and encourage users to access the primary health care system. Specific initiatives include:

- Enhancing the capacity of Rave Safe, a local volunteer organisation, to promote health and reduce harm by providing training to their volunteers, support for strategies to recruit volunteers, and support for marketing their services to rave promoters.
- Working with Fresh FM (the most prominent dance music radio station within South Australia) to provide staff training, develop editorial for information distributed and broadcast by Fresh FM, promote the Alcohol and Drug Information Service and treatment options, provide brief on-air interviews

220 Submission of the Drug and Alcohol Services Council (DASC) (South Australia) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

221 Since the submission was received the Committee has been informed that this project has commenced with the relevant information kits being sent out to targeted licensed premises in December 2002 (Personal communication between Ms Kelly, DASC and Committee staff member, 14 May 2003).

with alcohol and other drug experts and have two way communication with the audience through surveys, phone-ins and chat rooms.

- Working with *Onion Magazine* (the dominant print publication for the dance music scene within this state) to advise on accuracy and validity of stories covering alcohol and other drugs, provide appropriate editorial content to this magazine, advertise the Alcohol and Drug Information Service and treatment options, and expand education opportunities.
- Developing, testing, distributing and maintaining up to date education resources targeting ecstasy and other 'party drugs', including information to be inserted on tickets to raves, information to be utilised by specific CD retailers focusing on dance music, information for licensed premises (e.g coasters, signage in toilet areas), and posters for licensed venues, CD retailers and health services.
- Developing web-based communication strategies, providing appropriate alcohol and other drug information and links for use on the DASC, Fresh FM, Rave Safe and other relevant web-sites.

Community Education

The Harm Reduction Unit of the Drug and Alcohol Services Council provides expert advice, education, training and information services to the South Australian community. Specific initiatives in response to amphetamine and 'party drug' use include:

- Information sessions on 'party drug' use in response to requests from individual organisations and agencies.
- The incorporation of amphetamine use scenarios in the training provided to all participants in the Clean Needle Program training, in particular a hands-on 'Safe Injecting' game.²²²

Victorian projects

Victoria has also been developing a variety of strategies and programmes relating to amphetamine and party drug use. These are outlined in the submission of the Drugs Policy and Services Branch of the Department of Human Services to this Inquiry. These include:

222 Submission of the Drugs and Alcohol Services Council (South Australia) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

RaveSafe

RaveSafe, a peer education initiative, targeting high-risk illicit drug users who frequent rave parties. RaveSafe, which has been funded by the Drug Policy Unit since 1996/97, is auspiced by Victorian Drug User Group (Vivids). RaveSafe, which consists of a team of trained peer educators, has been extremely successful in educating thousands of people who frequent the rave scene about safe drug use practices in a way relevant and acceptable to the culture. In 2000, 30 volunteers also received training and assisted RaveSafe at rave parties.

Party Safe Workshops

In 2001 RaveSafe also conducted Peer Education Workshops aimed at young people who are involved in or likely to be involved in the rave scene. The messages in the workshops included planning for a safe night, look after your mates, seeking assistance and first aid, harm reduction and 'party drugs', 'party drugs' and their effects. Workshops were held at RMIT Health Services, Southern School of Natural Therapies, NMIT Collingwood and Preston Campuses, Monash University and at Vivids. Party Safe Workshops will be expanded and continued in the current financial year.

Illicit Drug Harm Prevention Project for IDUs

The Drug Policy and Services Branch are currently working with Vivids targeting injecting drug users at high risk of drug overdose through peer education and information workshops. The project was initially aimed at the prevention of heroin overdose but re-designed in order to provide a response to current trends in drug use including the misuse of psychostimulants.

The Diversion of Pseudoephedrine Strategy

The Drug Policy and Services Branch of the Victoria Police, Pharmacy Board of Victoria, the Pharmacy Guild of Australia, and the Pharmaceutical Society of Australia have worked together to develop strategies to address the diversion of pseudoephedrine products (used as a precursor in the illicit manufacture of amphetamine in clandestine laboratories) from pharmacies. Strategies include:

- a letter to all pharmacists advising of the problem;
- a poster for pharmacists and staff providing strategies to assist in limiting the diversion of pseudoephedrine products; and
- a poster advising customers of the prevention strategy.²²³

Future strategies of the Department based on harm reduction principles include the distribution of *Guidelines for Running Safer Dance Parties* aimed at promoters and the dance party industry; a *Party Survival Guide* aimed at party goers 'with

223 Submission of Human Services Victoria (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

harm minimization tips, before, during and after rave parties'; a wallet card for party goers warning of the risks associated with amphetamines and 'party drugs'; and an education and information kit to be developed for general practitioners regarding the effects and misuse of psychostimulants.²²⁴

Local government and community recommendations

Harm minimisation strategies have also been promoted and endorsed at a local government and community level, as evidenced in many submissions to this Inquiry.²²⁵ Community workers recognise that in this particular area of drug education, dissemination and promotion of harm minimisation and prevention material can be difficult. For example, Doutta Galla Community Health Services based in the inner north of Melbourne argues that one of the difficulties in getting drug education messages across to party drug users is the fact that these people rarely associate themselves with 'drug users':

This creates a challenge when packaging educational resources. The resource must be presented in a format that is conducive to the users' way of thinking – ie does not identify them as 'illicit drug users' – and it is recommended that it is presented by peers from the dance party scene.

This also highlights the limited services available to party users when drug use becomes an issue; they would be unlikely to consult drug and alcohol services and be more likely to go to their local General Practitioner (GP). Identifying the drug use may be difficult for the GP as the symptoms of lack of appetite, sleep deprivation may be diagnosed as depression. There is limited study into the effects when anti depressants and ecstasy are combined. Some evidence suggests that it can have an adverse reaction.²²⁶

Numerous submissions have made a number of recommendations to the Committee with regard to safe guidelines for dance parties and clubbing. Doutta Galla, for example, makes the following suggestions:

Harm reduction policy is the best policy response to party drug use.

Safe partying guidelines should be designed and implemented. These guidelines should include:

1. All dance events should have access to free clean water
2. There must be a recognised first aid team available
3. Bar staff should have first aid training.

224 Submission of Human Services Victoria (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

225 See for example the submissions of: City of Greater Bendigo; City of Melbourne; City of Monash; Uniting Care, Moreland Hall; Youth Substance Abuse Service (YSAS); Doutta Galla Community Health Service; St Kilda Community Legal Service; YWCA Victoria (all the above submissions dated August 2002).

226 Submission of Doutta Galla Community Health Services to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

4. There should be an adequate quiet location for people to withdraw from the party
5. All fire exits must be cleared
6. Safe and appropriate syringe disposal facilities must be available
7. Clean syringes should be available during the party or at all clubs
8. Condoms should be available during the party or at all clubs
9. Drug education should be available during the party and at all clubs
10. Cars should not be allowed to enter an event.²²⁷

Such an approach is endorsed by the YWCA, which recommends similar measures in its submission to this Inquiry:

Harm minimisation and harm reduction practices can be implemented simply and effectively in relation to drug use in 'party' scenarios and in the community generally. These include:

- The easy and free availability of sharps, and extensive distribution of safe sharps disposal units in acknowledgement that amphetamines are used as an intravenous drug
- The availability of free water in licensed premises and at dance parties so that people are not discouraged from re-hydrating their bodies
- Extensive security camera coverage in licensed premises and at dance parties to monitor activity and assess drug related emergency situations
- The provision of 'chill-out' spaces for people who need to cool down and relax
- The availability of drug testing kits or facilities for people to test the purity and relative safety of the drugs they have purchased
- Compulsory training of staff to deal with drug related emergencies
- The availability of confidential support and assistance for decreased drug dependency in various languages
- Integrating harm reduction strategies into other areas such as primary health care and community participation
- Confidential first-aid assistance, unless hospitalisation is necessary.²²⁸

A submission to this Inquiry from the Victorian Youth Substance Abuse Service endorses greater resources for secondary prevention. They cite the work of drug researcher Russell Newcombe who:

[a]rgues that it is too late to apply 'primary prevention' – education to prevent people taking drugs – to the present generation of drug users. In general terms, primary prevention has failed. However, it has been shown that education can slow the development of the more problematic forms of drug

227 Submission of Doutta Galla Community Health Service to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

228 Submission of the YWCA to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

use, while leading to an increase in safer forms of drug use. This suggests that it would be prudent to divert some resources towards 'secondary prevention' or 'harm reduction' – preventing overdosing, accidents and infections that result from ignorance.²²⁹

In the context of MDMA and dance parties, YSAS makes the following recommendations to this Inquiry:

1. It is crucial that AOD workers be able to provide users with accurate and relevant information in relation to effects, avoiding hazards, obtaining help when needed, and methods of controlling mental states of critical importance. Such a harm minimisation approach is in accordance with Australia's official National Drug Strategy and HIV/AIDS policy framework.
2. One of the hazards associated with MDMA/ecstasy use is the unknown content of the pills. On-site testing facilities at venues in Holland enable the provision of accurate information to users and medical support staff in relation to the contents of pills submitted for testing, and potentially prevent adverse reactions. The provision of testing facilities has also been found to reduce the incidence of substance use (van de Wijngaart, et al). The ability for users in Victoria to be able to quickly test and verify any substances being sold as MDMA/ecstasy would also reduce the risks associated with 'party drug' use. This approach would certainly be consistent with a harm minimisation approach.
3. As discussed above, mandating the appropriate management of temperature, provision of chill-out spaces, the availability of isotonic drinks and free water, and the availability of trained first-aid staff at venues could potentially prevent adverse reactions, and would be in accordance with harm minimisation principles.²³⁰

229 Submission of the YSAS to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

230 Submission of the YSAS to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs' August 2002.

Specifically, YSAS gives the following pointers with regard to reducing the harms associated with MDMA use, particularly in the context of dance parties:

'If in doubt, always ring an ambulance.

How much water you should drink depends on the context in which you are taking MDMA/ecstasy. While MDMA/ecstasy will tend to raise your temperature, particularly when the external ambient temperature is high, you are going to get hotter in some situations than in others.

If you are dancing for hours on end in a hot and sweaty club or party, then you should aim to drink about a 500ml bottle of water to which one teaspoon of salt has been added every hour. Alternatively, consume isotonic drinks which will replace the salts and minerals lost through sweating, or eat a salty snack such as crisps or peanuts. MDMA/ecstasy increases body temperature, and water should be drunk when taking it to avoid overheating and dehydration. However, it must be emphasized that *water is not an antidote to the chemical effects of ecstasy*.

Drinks should be sipped rather than gulped.

Relying on drinking water to reduce body temperature is insufficient – taking breaks from dancing, spending time in specially designated chill-out spaces are also important interventions. In some venues, volunteers spray dancers with water.

Endeavour to urinate, even if it's difficult.

A move away from primary prevention is contentious. Indeed, harm minimisation material and information that concerns drugs and is aimed at young people, particularly if the material seemingly condones 'safe drug use', is bound to be controversial, as the earlier theoretical discussion suggests. Youth and outreach workers tread a fine line between promoting measures that will hopefully minimise adverse outcomes associated with taking the drug and promoting the drug itself.

Sometimes harm reduction advice is clearly not going to be palatable to some members of the community, least of all the popular media.²³¹ Any distaste may be as much for the way the advice is expressed and the language used as for the content of the message.

Another aspect of harm minimisation that is bound to be viewed as controversial is that of the testing of psychostimulants such as ecstasy, a form of 'quality control' for which there are both committed supporters and trenchant detractors. This is discussed in the next section.

The Committee welcomes receiving further submissions and material outlining any current community or local government strategies and initiatives to address amphetamine and party drug use.²³²

Testing

The testing of psychostimulant drugs, either through 'testing kits' used by the consumer²³³ or at testing stations conducted at dance venues is a development fraught with controversy:

Club situations are not the only concern. The need to drink enough water and not to get too hot is just as vital when taking MDMA outdoors on summer days (at music festivals, for example) or if hiking in the bush' (Submission of the YSAS to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002).

231 A submission from the Eastern Drug and Alcohol Service argues: 'that the scare mongering that occurs in the media inhibits the development of appropriate harm minimisation strategies that would foster a pragmatic approach to reducing the harms associated with use. For instance environmental changes in clubs and dance venues' (Submission of the Eastern Drug and Alcohol Service to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002).

232 For an account of four previously implemented preventive and harm reduction campaigns pertaining to psychostimulant use, see Kamienicki et al. 1998, pp.19–24. The authors discuss the development, execution and evaluation of the following programmes:

- Speed Wise Speed Safe (Amphetamines – Australian)
- Rave Safe Project ('Party Drugs' – New South Wales)
- Chill Out ('Party Drugs' – Liverpool, England)
- Factline '91 ('Party Drugs' – Brighton, England).

233 Such testing kits have been available in Australia for some time, often sold in music and record or clothing stores for approximately \$25.00. For example, a test called 'E – a Quick and Simple Test' was developed in 2001 by a consortium of Melbourne chemists called Chemical Generation (see *User News* 2001, p.3). Other testing kits including those produced by Dance Safe are purchasable from the United States and Holland via the internet (Shannon 2002, p.24).

A Sydney based group called 'Enlighten' also provides free substance testing at dance events and sells test kits:

'Enlighten is a volunteer organisation dedicated to raising safety awareness in the dance community. It is an organisation founded and run by "people like you" [users/clubbers]... [This] grassroots organisation provides data sheets on ecstasy, GHB, LSD and substance test

You want a good night out, the people running the rave or nightclub don't want you swallowing anything really nasty. So here's the deal. You provide a crumb or two of your ecstasy pills for the checkers to inspect and test. They tell you what they think the pills contain and what the risks of swallowing them might be.

Depending on who you talk to, it's either a pragmatic way to curb the harm ecstasy tablets can do or a dubious step toward quality control for illicit drugs that can only create more users (Ainsworth 2002, p.32).

In some countries (Spain, Holland, Austria, France and Germany) drug screening at raves, clubs and venues, if not approved by the state, is at least unofficially sanctioned in the interests of preventing fatalities and casualties caused through the use of adulterated tablets.²³⁴ Even in the United States the private sector organisation 'Dance Safe' has worked in collaboration with law enforcement authorities to ensure clubbers who produce pills for testing are not arrested for possession. Dance Safe is fairly typical of testing organisations. It is based in Berkeley, California and present in at least eight major American cities:

Dance Safe sets up tables at raves, where users can get information about drugs and also have ecstasy pills tested... A Dance Safe worker shaves off a sliver of the tablet and drops a solution on to it; if it doesn't turn black quickly, it's not MDMA.

The organisation has found that as much as 20% of the so-called ecstasy sold at raves contains something other than MDMA. Dance Safe also tests pills for anonymous users who send in samples from around the nation; it has found that 40% of those pills are fake. Late last year, Dance Safe workers attended a 'massive'...rave in Oakland, Calif. Nine people were taken from the rave in ambulances, but Dance Safe confirmed that eight of the nine had taken pills that weren't MDMA (Cloud 2000, p.52).

Not all commentators are as enthused by either the testing kits or drug screening conducted at dance parties. Claims are made that these tests can be imprecise and create a dangerous and false sense of security among users:

The commonest method, called the 'Marquis test', involves scraping some of the pill into a colourless reagent containing sulphuric acid and formaldehyde. MDMA turns the reagent violet/purple and then slowly blue/black. The problem is that some ingredients in fake ecstasy pills trigger the same colour changes. Others, such as PMA, cause no colour change at all. So tablets made

kits. Knowledge about responsible substance testing is absolutely key information...' (Thomas 2003, p.10).

234 In 2001 the Drugs and Crime Prevention Committee of the 54th Parliament visited the Vienna Social Projects Association. Since 1997 the Association has operated an innovative project 'Check it!' In addition to testing drug substances in an on-site laboratory during 'raves', the project has a strong prevention component. Street workers offer information and counselling to the ravers on ecstasy and other drugs. In the tent where samples are handed in, information and counselling is provided, as well as seats, drinking water and a 'relaxation zone'.

of these will pass the test provided they contain a trace of MDMA (Ainsworth 2000, p.32).

To circumvent these uncertainties, the Netherlands has utilised more sophisticated testing methods:

While stopping ad hoc chemical testing in nightclubs, it runs an official pill testing service at 23 drug prevention and treatment centres. Dutch ecstasy users can take their pills to any of these centres, where trained employees note down the pills' colour, dimensions and logo, and run a Marquis test. They then log on to a database that holds details of all the pills tested more rigorously by an independent lab service in the previous six weeks. If the pill doesn't match any of the known profiles, it can be sent off for rigorous testing and added to the database. Any evidence about potentially dangerous pills is available to clubbers within days (Ainsworth 2000, p.32).

Drug testing, particularly that which is given the imprimatur by the state, is clearly contentious. Its advocates cite the number of lives saved through alerting users to adulterated drugs, particularly those containing PMA. According to Gowing et al., a further benefit is that such programmes have 'the opportunity to monitor trends in supply and rapidly respond to changes in the market' (2001, p.38). Its detractors view such schemes as simply a back-door method of decriminalising such drugs. Notwithstanding these somewhat polarised views, it would seem that testing can never of itself be seen as an adequate harm minimisation strategy. Gowing et al. state that if testing is used it should always '[b]e accompanied by secondary preventive education' (2001, p.38).

The Committee welcomes receiving community views as to the desirability or otherwise of utilising such schemes in Victoria.

Self-regulation

In the previous section and in previous chapters the Committee examined the ethnographic work of David Moore and his study of party drug users in Perth. Moore argues that his set of recreational drug users employed a number of social controls to 'minimise the legal, financial, social and health costs associated with their illicit drug use and to maximise the benefits' (1992a, p.69). Moore states that some of these controls can be readily articulated but most 'remain part of their "taken for granted" reality' (p.69).

Some of the controls – of which several almost achieve the status of rules – observed in Moore's fascinating study include:

- Drug purchases should be conducted through a known dealer or dealers [As was observed in Chapter 5 at least in the case of ecstasy, users most often bought their tablets from friends or known acquaintances];
- Do not use drugs during the week;
- Do not use drugs with strangers (unless perhaps introduced by, or accompanying, a trusted friend);

- Seek advice from experienced drug users when in doubt;
- Do not carry drugs in public in case of arrest (although this sanction was obviously waived by those involved in drug-dealing);
- Consume drugs...in a comfortable, safe and hygienic place;
- Do not use drugs above a certain frequency (although rules concerning frequency are particularly fuzzy and vary considerably even within small drug using sets) (Moore 1992a, pp.70–71).

Moore states that while these controls/rules are sometimes broken:

[t]hey serve to set general limits on what is, and is not, broadly acceptable. When an individual does not follow them, he or she must usually offer some justification as to why this should be so (Moore 1992a, p.71).

In the specific context of ecstasy there are similar rules or extensions thereof. For example, on the advice of more experienced users, novice users of the drug may use only half the regular dose of an ecstasy tablet compared to regular users. The advice of more experienced, often older, drug 'mentors' is viewed as invaluable for the neophyte²³⁵ (see for example Forsyth 1995; Shewan, Dalgarno & Reith 2000; McElrath & McEvoy 2001). Other sources of information from which the novice user may draw can include isolated news reports, dance/music magazines and the Internet (see Webb 1998).

Shewan's ethnographic study of ecstasy use in Scotland also showed that ecstasy users consciously made efforts to minimise the harms associated with the adverse consequences of ecstasy use. Of paramount importance to this group was the preparation and planning of the 'big night out' discussed in Chapter 5 of this Paper. Members of this group adhered to a number of precepts about drug taking that seemed to be well known within the group. For example, not taking ecstasy when experiencing psychological difficulties such as depression, or ensuring that the drug was taken in the presence of supportive friends in case any of the batches were adulterated. Although the users would not rationalise it in such terms, their behaviour very much incorporates testing for the factors of drug, set and setting discussed in Chapter 5:

It is the case that these ecstasy users paid heed to existing guidelines in most UK harm reduction drug information (e.g. Lifeline, 1992; Scottish Drugs Forum, 1996). Becker (1953, 1963, 1967) has described how drug knowledge, including learning the appropriate way to use a drug, is communicated among groups of drug users and this type of 'social learning' may be a feature of the patterns of drug use described here. The principles of drug, set, and setting drawn from Zinberg's work have been used in this study to analyse drug using and related risk behaviour among ecstasy users (Zinberg, 1984). McDermott et al. (1993) have described using Zinberg's principle of controlled drug use as

235 This also seems to be true of amphetamines where advice is sought from within the peer group networks, see for example, Vincent et al. 1999.

the starting point for a health promotion initiative. It may be that the principles of drug, set and setting could be successfully implemented in future initiatives.

Almost by definition, taking a drug involves an element of risk: after this decision has been made a continuum of risk becomes apparent. The users described here, on the whole, seemed to feel that observing a number of basic harm reduction principles provided them with what they felt were acceptable safeguards. For this group, this is an element of safer drug use, which they did not see as impinging on the more hedonistic aspects of their ecstasy use.

The ecstasy-related risks which were, subjectively, most salient to this group, and which appear to have most influence on their behaviour are largely short-term negative experiences while taking ecstasy. In this context, the preparations which the group reported add an element of rational planning to the drug-taking episode. In terms of risk discourse (Douglas, 1986; Giddens, 1991; Beck 1992; Douglas, 1992; Furedi, 1997; Reith, 1999), this could be described as 'conservative' behaviour, rather than 'true risk taking' behaviour. In the short-term, surprisingly little is left to chance by this group when taking ecstasy, to the extent that events are under participants' control. For example, when buying ecstasy tablets there is always an element of doubt as to the actual content of the pill: that said, participants did seem to try and find out about the type of experience associated with particular designs (see Forsyth, 1995). An element of impulsive behaviour is reported verbally by some of the group, but typically this is contradicted by descriptions of actual behaviour.

Furedi (1997) has argued that the greater one's perception of risk, the more conservative one's behaviour will be. This would appear to be confirmed in relation to the perceived short-term risk of the sample described here, in terms of planning, preparation and monitoring of the ecstasy experience. Indeed this pattern could be described as archetypal harm reduction drug using behaviour, both in terms of the safer drug use messages given in harm reduction leaflets, and in terms of the provision of adequate safety facilities within clubs (Shewan, Dalgarno & Reith 2000, pp.450, 451).

Similar findings were noticeable in a more recent qualitative survey of ecstasy users conducted in Perth, Western Australia, by Hansen, Maycock and Lower (2001). This study found that participants applied a 'cost benefit analysis' to their use of ecstasy. As long as the positive effects of using the drug outweighed any negative benefits (experienced or perceived) then they would continue to use:

A number of strategies were adopted to minimise the potential for negative or adverse outcomes. These included controlling for the factors of drug, set and setting...the participants used the notion of 'acceptable safeguards'...or steps that provide an acceptable level of protection. For example, using only when with friends; using only after someone else has tried it; using a regular supplier; controlling the amount consumed; controlling the amount of other drugs consumed; monitoring others (for physical and psychological harm); guiding

initiates; limiting one's supply and use; and using only when in a positive mood (Hansen, Maycock & Lower 2001, pp.191–192).

The authors also state that:

The participants attempted to exert control over set (expectation, risk perception, mood) and setting (physical surroundings), and although it was impossible to control for the drug, they adopted measures such as using a regular supplier and having pre-taste tests as methods of semi-control. New users were initiated into the ecstasy-using experience by more experienced users who helped the new initiates to interpret the symptoms they experienced during the drug use. The data revealed evidence of user folklore and myths that served to define and influence the overall drug experience. Users came to accept certain 'norms' about the effects, benefits and harms associated with their use of ecstasy. Using this knowledge they become more expert at manipulating drug, set and setting to maximise the experience and reduce the potential risks. Thus despite the evidence of occasions of unplanned and spontaneous use, the participants revealed highly ritualised and largely controlled behaviour in relation to their ecstasy use (Hansen, Maycock & Lower 2001, p.197).

The degree and type of harm minimisation 'strategies' employed by users will also depend on the perception of risk the user has about the drug. Several surveys have included questions or discussions gauging risk perception with regard to 'party drugs' (see Hansen, Maycock & Lower 2001; Hando, Topp & Dillon 1998; NDARC 1998). For example, subjects in the Hando, Topp and Dillon survey on average tended to place ecstasy as a drug 'mid way' (5) on a risk scale (where cannabis was placed at 0, no or low risk, and heroin at 10, high risk). Such subjects tended to have reasonable knowledge about the physical effects of ecstasy; the risks posed by impurities in the drug and the unknown long-term effects of use. Accordingly, they took 'precautions', such as 'scoring' the drug from known acquaintances or monitoring their water/fluid intake, particularly after dancing (Hando, Topp & Dillon 1998, pp.36ff).²³⁶ Moreover, in a British survey comparing amphetamine, cocaine and ecstasy use, it was found that given knowledge (or experience) of adverse effects and consequences associated with their drug use, some users may modify their drug-taking behaviour in light of those effects. In this survey (Williamson et al. 1997) more than half of the sample modified the way they used their drugs, with half of that number reducing the amount taken, in response to experiencing or becoming aware of adverse effects associated with use. As the authors conclude:

If stimulant users in the community are able to modify their drug taking behaviour in the light of experience, then this should encourage the

236 Notwithstanding such perceptions of risk, in this survey:

'[M]ost subjects perceived their own use of ecstasy to be moderately (31%), quite (39%) or very safe (24%), with only 5% believing that ecstasy use was quite to very risky' (Hando, Topp & Dillon 1998, p.36).

development of health education strategies aimed at non treatment populations (Williamson et al. 1997, p.94).

More worrying, however, are indications that over time, and as users became more 'experienced', some of these safeguards may have been followed less stringently. Sometimes the behaviour of participants revealed 'a disparity between what they claimed to do and what they recognised as safe and what they were actually doing' (Hansen, Maycock & Lower 2001, p.192). The study conducted by Hansen, Maycock and Lower revealed that:

Though users identified a wide range of harm reduction strategies, the application of these strategies was inconsistent, with a large number of the sample indulging in occasional binges, spontaneous purchases, polydrug use and purchasing from unknown individuals in clubs/pubs. As users become more experienced, their perception of the risks associated with use tended to diminish and they exhibited greater risk taking behaviour. The majority of participants indicated an intention for prolonged future use; however, they recognised that changes to life circumstances could serve to alter their use patterns. This suggests that the cost-benefit analysis conducted by the users is a constant process and one that is periodically reviewed. It may be that interventions could be developed that alter the cost-benefit analysis so as to increase the costs while decreasing the benefits.

Although aware of some of the potential long-term adverse health effects, the participants did not perceive these risks as particularly salient. These data imply that the evidence linking use to long-term negative outcomes has had little impact upon levels of use. This suggests that greater emphasis on the negative short-term effects of use is required if changes to use patterns are to be achieved. Future interventions could adopt strategies similar to recent Western Australian programs directed towards the reduction of smoking and consumption of alcohol, which focused upon adverse short-term effects (Hansen, Maycock & Lower 2001, p.197).

Despite such 'lapses', the authors state that the participants did make conscious efforts to control any harms associated with their ecstasy use. Nonetheless, further research is crucial, particularly with regard to why some harm reduction techniques or measures may be utilised and others not:

The study points to other aspects associated with ecstasy use that need further research and careful consideration with regard to intervention programs. The socialization associated with use has potential to be used as an intervention route; however, it would be necessary for individuals to be able to distinguish between signs of ecstasy consumption and consumption of a product that could cause even more harm. The inconsistent application of the identified harm reduction strategies would require further research to investigate the efficacy of peer-led harm reduction interventions. The disparity between expressed harm reduction strategies and the observed action of the users

reinforces the need for multiple data collection methods and the need for constant comparison between data sets.

Further research is required to identify optimum intervention methods. For example, this study found evidence that as users became more experienced they appeared to be willing to engage in behaviour that they had previously identified as being risky. This has implications for the salience of intervention methods (Hansen, Maycock & Lower 2001, p.198).

Clearly, such research is important and needs to be undertaken as a matter of priority.²³⁷ Notwithstanding much useful information coming from valuable qualitative and ethnographic research projects such as that undertaken by Moore (1992a) and by Hansen, Maycock and Lower (2001) in Australia and Forsyth (1995), Shewan, Dalgarno and Reith (2000) and McElrath and McEvoy (2001) in Europe, there is still much to be done. Moore acknowledges that there is still a great deal of knowledge to be gained about psychostimulant use in non-captive settings:

There is [also] little known about the degree of penetration of harm reduction messages...into non clinical populations of drug users, the perceived relevance and extent of adoption of such messages, and whether there are alternative sources of information. How do drug users gain information about unsafe behaviour? Whom do they trust for such information? Which source or type of information do they act on? (Moore 1992, p.9).

It is equally important that research projects, particularly those exploring issues of risk perception and self-harm reduction measures, draw from the folklore and knowledge of users themselves.

Conclusion

Harm reduction approaches are not based on a 'one size fits all' strategy. Clearly, what works in some contexts and for some drugs may not necessarily be appropriate for others. Naturally information needs to be provided for users but should this be through didactic pamphlets and information sheets or via the use of outreach and peer networks. In addition to providing appropriate material for users, it is equally important that venue owners, bouncers, support staff, medical officers, including general practitioners, and police receive

237 One such research project that might yield some valuable information is currently being proposed between the Melbourne Parks Trust (MPT) and the Centre for Youth Drug Studies. The MPT manages large sports venues such as the Rod Laver arena that host large-scale dance parties six to eight times per year. The MPT has approached the Australian Drug Foundation for assistance in identifying issues of importance in conducting these parties and disseminating appropriate education messages with regard to party drug use:

'The Centre for Youth Drug Studies is currently working with the Trust to develop a research project to identify the key issues and messages which will have relevance with this target group. This project will provide valuable access to this particular target group (18–25 year olds who attend large dance parties) and the findings should greatly expand our knowledge of the drug knowledge, attitudes and practices among this group of young people' (Quoted in the submission of the Australian Drug Foundation to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002).

appropriate training and information. Dance party guidelines and practical measures such as the provision of water at venues (and information as to correct water consumption) are essential. The efficacy of tablet testing to ascertain their content and 'safety' has yet to be determined. Such a measure is highly contentious. It would certainly seem, however, that such a practice should never be implemented as a stand alone measure. Further research on all manner of aspects pertaining to the use of amphetamines and party drug use is crucial, as will be discussed in Chapter 10. Mass media campaigns might only be effective if complemented by grassroots community based initiatives.

Harm reduction measures such as those discussed in this chapter are not always universally popular. There is a tension apparent between trying to minimise the harms associated with drug use while not giving the message that such behaviour is approved of or even condoned. There are also, as many commentators have pointed out, tensions to be reconciled between strict law enforcement of illicit drug use and health promotion that incorporates harm minimisation techniques and strategies. Webb argues that:

The concept of harm minimisation need not be incompatible with modern policing practices if law enforcement officers are given appropriate training... Law enforcement personnel need to be trained about the health risks and consequences of amphetamine type stimulants and other drug use, so that their work does not conflict with that of health workers using harm minimisation approaches... Effective liaison between the Police and primary care workers is especially important when dealing with first time drug offenders (Webb 1998, p.97).

While such comments generally fit in with the approach taken in most Australian jurisdictions with regard to the issue of harm minimisation, the Committee nonetheless welcomes further contributions to this somewhat vexed and controversial area, particularly in the context of amphetamines and 'party drugs'.

Questions for discussion

- ◆ What education measures should be targeted at:
 - amphetamine users (including transport and other industry workers)?
 - party drug users?
- ◆ At which groups or individuals should they be targeted?
- ◆ Are there any problems associated with current drug education theories, policies or programmes in dealing with amphetamines and 'party drugs'?
- ◆ Should the positive aspects associated with party drug use by young people (for example, communality, friendship, the 'vibe', the music) be incorporated into drug education and intervention programmes? If so, how can this be done without encouraging or glamorising the use of these drugs?
- ◆ What approaches should schools take to 'party drugs' (and amphetamines)?
- ◆ How appropriate is the current educational material provided?
- ◆ What useful programmes and intervention strategies have been developed in Victoria and the other states and territories with regard to party drug and amphetamine use?
- ◆ How can the dangers of poly drug use best be addressed through education initiatives?
- ◆ Are there any practices by venue operators, staff or owners that could be said to be counter-productive to harm reduction measures?
- ◆ Are drug testing kits or 'official' drug testing stations at dance parties etc an appropriate harm reduction measure? How effective are they? What problems do they pose?
- ◆ How effective are dance party guidelines, codes and similar harm reduction measures? Should there be more stringent regulation in this area?
- ◆ What role has local government to play with regard to drug education programmes in this area?
- ◆ How can the knowledge of 'clubbers', users and young people generally best be utilised to provide education and interventions in this area?
- ◆ How effective are peer group initiatives in this area?
- ◆ What other harm reduction strategies or programmes could be utilised to minimise the harms associated with this form of drug use?

9. Treatment Issues Pertaining to Amphetamine and 'Party Drug' Use

This chapter raises ongoing points for discussion and probably asks more questions than it solves. It discusses the area of treatment of amphetamine and 'party drug' associated problems and conditions. It also examines the provision of treatment services (or lack thereof) for such conditions. In particular, it examines whether there are specific treatment regimes for amphetamine-related conditions and if there are not, should there be? A key aspect of the discussion will concern the apparent lack of treatment services specifically catering to the users of amphetamines and 'party drugs'.

A constant refrain throughout the academic literature and the submissions received by the Committee has been that users of amphetamines rarely use these drugs exclusively. The last section of the chapter looks at how poly drug use compounds the issue of treatment as it pertains to amphetamines and 'party drugs'.

Overview of treatment issues regarding psychostimulants

Research into treatment options for drug use is predominantly geared towards opioids such as heroin. There are few, if any, specialist drug and alcohol services in Australia catering exclusively for problematic, dependent or heavy users of amphetamines (South Australian Drugs Summit Communique 2002a; Mundy 2001). Moreover, research that is undertaken into treatment for psychostimulant-related conditions tends to be focussed on cocaine, despite the fact that amphetamine use is far more prevalent in Australia than cocaine use (South Australian Drugs Summit 2002b, p.15).

One of the few comprehensive studies and literature reviews of treatment options (or lack thereof) for psychostimulant users conducted in Australia comments:

Much of the intervention literature for psychostimulant users has come from the United States and has primarily involved cocaine users. The hundreds of treatment studies for cocaine users comprise an estimated 90% or more of the total psychostimulant intervention literature. Despite the great deal of effort

that has been expended in devising effective treatments for cocaine users, there is no consensus regarding effective treatment. The same is true of amphetamine users (Kamienicki et al. 1998, p.vii).²³⁸

Of further concern is the fact that many of the treatment interventions that are being used for illicit drug management are extrapolated from opioid and alcohol programmes. It has been suggested that many users of psychostimulants may not be willing to avail themselves of such measures because of the stigma associated with heroin use. Moreover:

The lack of [specific] pharmacotherapies for amphetamine users is probably one reason underlying the low number of users (compared to heroin users) who seek treatment from drug and alcohol services (South Australian Drugs Summit 2002b, p.15).

Whether or not there should be separate treatment regimes for psychostimulant abuse, particularly amphetamines and methamphetamines, is a debated issue and one that will be canvassed later in this chapter. The next section will examine some of the general issues associated with treating amphetamine-related problems. It will be followed by a section outlining the difficulties in accessing specific treatments for amphetamine use.

Treatment issues regarding amphetamines and methamphetamines

The harms associated with amphetamine use, particularly chronic use, are well documented.²³⁹ Despite this, an Australian study of amphetamine users in Newcastle, conducted as recently as 2001, comments that:

Despite the popularity of amphetamine and its associated problems, there is a paucity of information concerning the characteristics of regular users of the drug and their readiness for treatment (Baker, Boggs & Lewin 2001, p.50).

There is also still concern among medical practitioners, scientists and researchers about the lack of tailored treatment models for (meth)amphetamine users:

The number of people presenting to drug and alcohol services with primary amphetamine problems is increasing (Darke et al 1996; Torres et al 1996) but there are no specific services for amphetamine users. All current available treatments are abstinence based. This approach unfortunately appears unattractive to a considerable number of problematic users. There are currently no recognised pharmacotherapies for amphetamine users in Australia or overseas. Amphetamine users can attend general hospital emergency, general

238 This report comments further:

'Hundreds of empirical intervention studies have been conducted with cocaine users; the number of published and unpublished empirical intervention studies with amphetamine users is approximately 20' (National Centre for Education and Training on Addiction 1998, p.16).

329 See Kamieniecki et al. 1998 for a convenient summary, the discussion in Chapter 4 of this paper and the references listed therein.

practitioners, psychiatric services, drug counselling services, detoxification and rehabilitation services, therapeutic communities and self-help groups such as Narcotics Anonymous. Amphetamine users rarely contact these treatment services, which they perceive to be targeted at people with alcohol and opiate problems. ...This low level of engagement with treatment services is reflected in several studies which have reported between 7 and 12% of long term amphetamine users in treatment other than methadone maintenance (Hando et al 1997; Darke et al 1998; Ross et al 1994) (cited in National Drug and Alcohol Research Centre (NDARC) 1999, p.3).

There are a number of other issues associated with treating amphetamine and methamphetamine dependence which are still problematic, largely because they have been so under-researched. Some of the general areas that need to be examined in greater detail, as gleaned from the literature, include:

- ◆ Toxic complications from amphetamine use;²⁴⁰
- ◆ Withdrawal management for amphetamine use;
- ◆ Appropriate pharmacological interventions for psychostimulant treatment, including drugs to decrease discomfort, blocking drugs, aversive agents, and substitution therapies (see Kamienicki et al. 1998);²⁴¹
- ◆ The treatment of amphetamine use in conjunction with other forms of drug use (poly drug use);
- ◆ The treatment of amphetamine use in conjunction with co-morbid psychiatric disorders;
- ◆ Inpatient versus outpatient treatment;²⁴²

240 Psychostimulant intoxication is usually dealt with in hospital emergency departments (see Kamienicki et al. 1998, p.16).

241 Dr Nick Lintzeris, formerly of Turning Point Alcohol and Drug Centre in Melbourne, has commented that an effective medication to deal with amphetamine withdrawal and use is sorely needed to complement other methods:

'We're going to get many, many more people presenting for treatment and if we can give them a medication that actually works...because lots of these people will think "why bother going to treatment if all you're going to get is a bit of a talking to?", particularly when the talking to isn't even very good, and not amphetamine oriented. It will be good when we have an effective medication to link with psychotherapeutic approaches' (quoted in Wood 1998, p.22).

242 As early as 1993 these options were being canvassed by Wickes. Ten years later there is still uncertainty as to the appropriateness of one as opposed to the other. Wickes stated in 1993: 'The value of outpatient treatment programs is supported by studies of cocaine users in the United States where 30–90% of those who remained in outpatient treatment of various modalities ceased use. Outpatient programs are also more cost effective than inpatient programs and the problem of generalisation from the inpatient to the outpatient environment does not exist.

Inpatient treatment is, however, thought to be warranted in the following instances:

- Polydrug dependence;
- Where severe withdrawal is anticipated;
- Medical complications requiring close observation or treatment;
- Psychiatric complications...;
- Absence of social supports;
- Undesirable living conditions;

- ◆ Brief versus intensive treatment (Kamienicki et al. 1998; Wickes 1993a, 1993b);
- ◆ Non-pharmacological treatment interventions²⁴³ (including behavioural, cognitive, family oriented and supportive therapies);
- ◆ The suitability of natural therapies;
- ◆ The value of self-help groups and therapeutic communities; and
- ◆ Harm reduction measures.

This Discussion Paper does not seek to discuss each of the above factors in any great detail at this stage, although it is interested in seeking the views of experts within the field about such issues.²⁴⁴ However, it is important to canvass some general issues pertaining to amphetamine treatment that may in turn result in some useful submissions and input from the public. One of the important questions to ask is: What interventions do users themselves seek for their (problematic) amphetamine use?

Accessing treatment

Hando, Topp and Hall (1997) surveyed 200 regular and problematic amphetamine users in Sydney. The survey sought to determine the treatment issues and preferences of the sample. In doing so, the international literature on the increasing number of people presenting to drug treatment services with a *primary* amphetamine problem was reviewed. Most of these Australian, American and British studies showed that primary treatment programmes were either non-existent or perceived as inappropriate by users. Such views were also expressed by the sample in the Sydney study. Moreover, if 'treatment' was sought it was more often for the behavioural effects of the amphetamine use rather than any physiological or pharmacological problems (see, for example, the British study of Klee & Morris 1994, discussed in Hando, Topp & Hall 1997, p.106). In a more recent British study also conducted by Professor Klee, preliminary findings indicated that amphetamine users presenting for treatment 'tend to do so because of a feeling that their lives are out of control and because of social isolation and psychological symptoms' (noted in Griffin 1997, p.19). Moreover, because seeking intervention may be predicated on the occurrence of a crisis:

-
- Failed outpatient treatment' (Wickes 1993b, p.11).

Anglin et al. have more reservations about outpatient treatment for methamphetamine users, at least in the American context:

'For MA abusers being treated as outpatients, the easy availability of the drug and the allure of its long action often lead to resumption of MA early in treatment. The consequence is usually patient dropout from all forms of treatment before the onset of any effects of therapeutic medication or psychotherapy' (Anglin et al. 2000, p.140).

243 Kamienicki et al. define 'non-pharmacological interventions' as '[t]he treatment of psychostimulant users utilising non drug procedures with a view to decreasing/eliminating drug consumption or reducing the harms associated with continued use' (1998, p.16).

244 In particular, see Kamienicki et al. 1998; Wickes 1993a and 1993b; Anglin et al. 2000.

The motivation for treatment provided by a crisis is frequently short-lived; most users of illicit drugs are ambivalent about entering treatment and particularly about ceasing their drug use. Hence, unless a treatment response is provided quickly, the impact of the motivating factor is likely to decline, resulting in the risk of dropout from treatment (South Australian Drugs Summit Issues Paper 2002b, p.12).

An Australian study of amphetamine users also found that:

The best independent predictors of feeling the need for treatment were greater time spent unemployed, poor general health and the development of aggression since using amphetamine... Since psychological symptoms associated with amphetamine use have been found to be far more disturbing to users than physical health problems, psychological morbidity – and in particular the development of aggression – may be an important factor in precipitating treatment seeking in amphetamine users (Vincent et al. 1999, p.71).²⁴⁵

Clearly, the links between pre-existing psychological morbidity, co-morbidity and amphetamine use are ones that need to be examined in much greater detail.²⁴⁶ A more detailed discussion of this issue is beyond the scope of this Paper, but it must be stated that this is a much neglected area of research:

The treatment of psychostimulant users with co-morbid psychiatric disorders has largely been neglected in the literature. Only a handful of pharmacotherapeutic intervention studies have been conducted on psychostimulant users with co-morbid psychiatric disorders. Moreover, all of these studies have included very small sample sizes and most have been uncontrolled. The results from these studies need to be replicated in larger, controlled studies (Kamienicki et al. 1998, p.viii).²⁴⁷

Of particular concern to some clinicians is the fact that there appear to have been some efforts by amphetamine users to self-treat any medical problems associated with the drug. One Australian study reported that amphetamine users were using benzodiazepines to assist with amphetamine-related problems and even using heroin as a form of 'self-medication' (NDARC 1997).

What measures did the clients surveyed in this NDARC 1997 study by Hando, Topp and Hall consider most appropriate to deal with this issue?

Twelve per cent of the sample (n=24) were interested in receiving drug counselling, especially counselling which was amphetamine specific, non-

245 For a comprehensive review of the literature as to the reason why amphetamine users may (or may not) seek treatment or intervention, see Kamienicki et al. 1998, p.7.

246 See in particular Kamienicki et al. 1998; Baker, Boggs and Lewin 2000.

247 This paucity of treatment research studies is despite the fact that:

'Several studies have attested to the fact that very large numbers of amphetamine and cocaine users experience at least some psychiatric symptomatology (Gawin and Ellinwood 1988; Hall and Hando 1994; Hall et al. 1996; Hando 1996; Harrison 1994; Vincent et al. 1997). Not only do many users have some psychiatric symptomatology, many also have full blown psychiatric disorders (Gawin and Ellinwood 1988; Regier et al. 1990). This has been found to be especially true of those presenting to treatment services' (Kamienicki et al. 1998, p.18).

judgemental and allowed a variety of goals, including abstinence and controlled use. Of the sample, 12% (n = 24) were interested in receiving natural therapies, such as acupuncture, herbal remedies and massage. A total of ten subjects were interested in participating in a detoxification program, especially home detoxification programs and programs which were amphetamine specific. Those interested in NA [Narcotics Anonymous] and TCs [Therapeutic Communities] also wanted programs that focused on amphetamine use. Six subjects wanted assistance from a GP, four subjects wanted assistance from a psychiatrist and eight subjects desired greater support from family and friends (NDARC 1997, p.110).

Natural therapies and self-help and social support were viewed as valuable adjuncts by users. However, by far the most popular treatment option from the client or subject perspective was 'amphetamine substitution'.²⁴⁸ This topic is discussed further in a later section of this chapter.

The NDARC study by Hando, Topp and Hall concluded from their respondents' replies that:

The results of the present study confirm a growing need for treatment among regular amphetamine users. However, there are few treatment alternatives available specifically for amphetamine-related problems and none have been rigorously evaluated... In Australia, amphetamine users can attend general hospital accident and emergency departments, drug counselling, consultation with a GP, psychiatric services, detoxification services, therapeutic communities and self-help groups. Traditionally these services have most often dealt with primary alcohol and opiate problems; it is still being relatively uncommon for primary amphetamine users to present for treatment (Torres et al 1996). Preliminary results from a UK study found that help-seeking amphetamine users tended to avoid drug clinics as they were seen as oriented towards heroin users. [Conversely] Drug workers considered amphetamine clients 'hard work' and believed that there were fewer incentives (such as prescribed drugs) for amphetamine users to attend (Institute for Drug Dependence 1996; Myles 1997). Most users interested in receiving treatment in the present study also recommended that it focus on amphetamine-specific issues and be relevant to them (NDARC 1997, p.110).

A lack of services

It has been six years since the Hando, Topp and Hall study was undertaken. Nonetheless, there still seem to be few specific amphetamine treatment modalities. As recently as September 2002 Dr Nicole Lee, senior research fellow at Victoria's Turning Point Alcohol and Drug Centre, stated that:

[t]here are very few treatments specifically for speed users and little research is conducted in Australia.

248 This treatment option was requested by 18% of the subjects (see Hando, Topp & Hall 1997, p.110).

'There is an acknowledgement within alcohol and drug services that current treatment is not meeting client needs, staff need more training, and services need to become more amphetamine-user friendly' Nicole says (Turning Point Alcohol and Drug Centre 2002, p.1).

The submission from the Turning Point Alcohol and Drug Centre to this Inquiry was equally concerned about the ability of Victorian services to cater for this population:

Turning Point has experienced a significant increase in amphetamine use among our existing clients and also an increase in the number of clients presenting for treatment. However, [there are] very few interventions and services oriented towards recruiting and retaining amphetamine users in treatment...

Clinically, amphetamine users have different needs to other drug users. This is partly due to the pattern and context of use. Amphetamine is generally used as part of a social context and usually in a 'binge' pattern, intensely over short periods of time. Our traditional notions of what constitutes use, abuse and dependence do not always apply to this group. Typically, treatment seeking users present for short periods of time and are often in need of acute intervention. In general, they do not access traditional treatment centres, partly because of the focus on opiates and/or alcohol. Therefore treatment services require a reorientation and culture shift to increase 'user-friendliness' for this group.

In short our treatment services are not well equipped to deal with this ever increasing group – in either staff expertise nor specific treatments that staff could be trained in. This process of reorienting services will involve developing and trialing new interventions specifically designed for this group and to provide training and support for staff to implement these interventions. Supporting staff by providing tested best practice interventions will increase their confidence in addressing amphetamine use and assist in creating a culture shift to engage these clients more assertively.

In addition, amphetamine use tends to be accompanied by more severe mental health and other sequelae than other drug use (Nutting, Lee, Jenner & Saunders 2002). Co-morbidity creates a significant challenge for treatment providers. It has been widely recommended that treatments for co-morbid substance use and mental health problems should address both disorders at the treatment agency to which they present (Jenner et al., 1998; Pennebaker et al., 2001). Yet, there are few programs specifically designed for amphetamine users within alcohol and drug or mental health services. Much of the recent research in co-morbidity has been undertaken within mental health services, for people with severe mental illness, such as schizophrenia and bipolar affective disorder. However, research suggests that depression, anxiety and anger/irritability/paranoia are more commonly associated

249 Excerpt from the confidential submission of Turning Point Alcohol and Drug Centre to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission and approval of Turning Point.

with amphetamine use – problems that are often subclinical and are excluded from public mental health services.²⁴⁹

This lack of services has been felt even more since the rise of amphetamine use due to the 'heroin drought' (see Chapter 2). Miller, Fry and Dietze comment that it is natural to expect that as the heroin supply decreased, more demand for amphetamine and subsequent amphetamine-related problems would result in an increased need for treatment interventions:

This study provided evidence of increased amphetamine use as a result of the 'drought'. However, unlike benzodiazepines that frequently cause acute drug-related harms (eg. ambulance attendances), amphetamines only rarely appear involved in current monitoring systems for drug related harm. Nevertheless, stimulants such as amphetamines do present long-term harms for which treatment may be required. In this regard only a small proportion of clients of specialist drug agencies present with stimulants as their primary drug problem...and it is reasonable to expect an increase in demand for stimulant-related treatment if problems with heroin supply continue in the longer term. Typically, persons with stimulant-related problems have been characterised as difficult to manage (Lintzeris, Holgate and Dunlop 1996). Therefore the public health hazard presented by increases in amphetamine usage (as reported amongst the current sample) requires a response directed toward developing the capacity of treatment service providers (including General Practitioners) to respond to issues around amphetamine dependence. Moreover, this capacity development needs to go further than treatment service providers to include others who may come into contact with stimulant dependent persons (eg agents of law enforcement agencies) to ensure humane management of these people... Finally, it is important to sustain current monitoring efforts around amphetamine-related harms in order to document any rise in amphetamine-related harm that may emerge as a result of the heroin drought (Turning Point Alcohol and Drug Centre 2001, pp.28–29).

Moreover:

[m]any agencies were unprepared for the increased numbers and behaviour of amphetamine users who sought treatment when heroin became scarce (Turning Point Alcohol and Drug Centre 2002, p.1).

The comprehensive literature review of treatment interventions for psychostimulant users written by Kamienicki et al. raises pertinent issues pertaining to service provision for these groups of drug users:

The majority of existing drug treatment services in Australia have been designed to manage alcohol intoxication or withdrawal from opiates and alcohol. Staff within treatment services, both in Australia and overseas, have reported feeling frustrated by their inability to adequately manage withdrawal from amphetamines. This has resulted from their lack of knowledge about the amphetamine withdrawal syndrome and appropriate management strategies, and because the lack of resources within services places strain on agencies

since amphetamine users appear to require more time and effort than opioid users in withdrawal (Klee et al. 1995; Vincent et al. 1997).

Many amphetamine users have reported that they have found it extremely difficult to enter traditional drug treatment services because of the perceived stigma attached to being associated with opioid users... In addition, many services have long waiting lists, which may 'penalise the amphetamine user disproportionately as their connection with the agency ...[may be]...more fragile and they would prefer to opt out if they could' (Klee et al. 1995 cited in Kamienicki et al. 1998, p.60).

In the United States, pharmacological treatments until very recently have borrowed:

[f]rom treatment with cocaine dependence. Unfortunately, this approach has not met with much success since no single agent has proven efficacious in controlled clinical studies. Antidepressant medications [however] are helpful in combating the depressive symptoms frequently seen in methamphetamine users who recently have become abstinent.

There are [also] some established protocols that emergency room physicians use to treat individuals who have had a methamphetamine overdose. Because hyperthermia and convulsions are common and often fatal complications of such overdoses, emergency room treatment focuses on the immediate physical symptoms. Overdose patients are cooled off in ice baths, and anti-convulsant drugs may be administered also (National Institute on Drug Abuse 1998, p.7).

But as indicated above, such measures are more geared towards dealing with the ancillary symptoms or 'by-products' of amphetamine use, not the dependence itself.²⁵⁰ If, as seems to be the case from the discussion in Chapter 4 of this Paper, a discrete amphetamine dependence syndrome exists, then tailored interventions may indeed be necessary to treat the physical and psychological consequences of this condition.²⁵¹

250 In the United States, the extensive use of methamphetamine results in the users frequently accessing ambulance, emergency room and other hospital services and the resources associated with these services. However, the presentations largely concern trauma and violence associated with the use of the drug, such as stabbings, shootings, assaults and motor accidents. See Richards et al. 1999 and Chapter 4 of this Paper for further discussion of this issue.

251 This much was recognised by Huber and her colleagues in a 1997 study of possible research approaches needed for methamphetamine abuse. This study suggested that the development and application of novel pharmacotherapies for such abuse presupposed that medical science understood the clinical syndrome resulting from chronic methamphetamine abuse. This, at least in 1997, was not necessarily the case and much further research was (and is) required (see Huber et al. 1997).

252 For a comprehensive discussion of British studies on amphetamine substitution treatment, going as far back as the 1960s, see Kamienicki et al. 1998, pp.34ff. This includes a review of the *Cornwall Community Study*, an amphetamine substitution study with the largest treatment cohort in the world (as of 1998). In particular, the Cornwall study found that 'only those who had a history of psychotic episodes prior to the study experienced psychotic symptomatology during treatment' (Kamienicki et al. 1998, p.38).

Amphetamine substitution

As indicated above, the most popular treatment intervention sought by amphetamine users who responded to the survey of Hando, Topp and Hall (1997) was substitution therapy. The substitution therapy most often noted for treatment of problematic or dependent amphetamine users has been the controlled administration under clinical conditions of (oral) dexamphetamine substituting for street amphetamine. Substitution therapy has been available for a number of years in the United Kingdom²⁵² (see Strang et al. 1994) but has only been relatively recently considered as a method of treating amphetamine use and amphetamine dependence in Australia.²⁵³

Much of the interest in substitution therapy arises out of a concern with the increasing number of people using amphetamines intravenously during the 1980s and 1990s:

The rationale for the provision of amphetamine substitution is similar to that for heroin substitution programs. The potential benefits of such programs embody major public health goals including: prevention of transmission of blood borne viruses such as HIV and hepatitis B and hepatitis C by means of sharing of injecting equipment; improvements in the health and social functioning of drug users; reduced illicit drug use; and reductions in the associated criminal behaviour undertaken to fund drug use (Ward et al. 1998; Fleming 1998, cited in NDARC 1999, p.3).

One of the main objections to substitution schemes has been the risk that the use of dexamphetamine or other substitutes may in itself lead to dependence and/or providing dexamphetamine substitution therapy may result in the development of psychotic symptoms or episodes in the users. However, a study conducted by Shearer et al. at a primary health care centre in Kings Cross, Sydney, found that the risk of either of these complications arising was low (NDARC 1999). This study also reviewed the extensive British literature and studies on dexamphetamine substitution therapy which also found the benefits outweighed the low risk of any negative outcomes:²⁵⁴

It has been argued that public health benefits may outweigh risks associated with the prescribing of substitution drugs (Fleming and Roberts 1994; Pates et al 1996; Charnaud and Griffiths 1998). Oral dexamphetamine substitution may allow stabilisation of some patients on a dose which causes neither withdrawal or craving and which may thereafter allow gradual reduction and eventual cessation (Bradbeer et al 1998; Sherman 1990). In a discussion of the

253 The Committee welcomes any information about amphetamine substitution programmes, if any, currently operating in Australia.

254 Shearer et al. note that a survey of 149 medical drug and alcohol specialists in England and Wales:

'[f]ound that 46% of respondents were currently prescribing amphetamine and 60% saw a role for this therapy (Bradbeer et al 1998). [However] [A]lthough the practice of amphetamine prescription was found to be widespread, little scientific evidence was available to evaluate the efficacy or safety of the approach' (NDARC 1999, p.5).

role of substitution therapy for amphetamine users, Mattick and Darke (1995) identified four criteria of appropriateness of a maintenance treatment program. These were: i) regular frequent use (usually daily); ii) clear evidence of dependence; iii) continued use representing severe adverse complications for the user; and iv) the harms associated with illicit use exceed the risks associated with the use of legal substitute drug (NDARC 1999, p.4).

In a literature review of treatment options for amphetamine users, Kamienicki et al. summarise the arguments of the proponents of substitution therapy as follows:

These proponents argue that:

1. as current treatment programs are irrelevant to the needs of amphetamine users (ie: they are primarily orientated toward opioid users or rely on abrupt withdrawal) there is a need for appropriate interventions for amphetamine users;
2. amphetamine prescribing attracts users to treatment services;
3. having amphetamine users attending treatment services gives health practitioners the opportunity to distribute accurate harm minimisation and safer sex information;
4. amphetamine prescribing leads to a reduction in injecting activity;
5. the prescription of amphetamine will eliminate criminal activity associated with obtaining the drug;
6. the provision of dexamphetamine may stabilise patients on a dose which does not cause withdrawal or craving, and may subsequently lead to a reduction in dosage and eventual cessation of the drug; and
7. the high risk of contracting blood borne diseases as a result of needle sharing among intravenous amphetamine users outweighs the risks associated with prescribing amphetamines (Kamienicki et al. 1998, pp.35–36, reviewing the available literature).

Of particular importance, according to Shearer et al. (NDARC 1999) are the studies that suggest users who attend substitution programmes may also benefit from ancillary services often provided at the same clinic or treatment centre. These may include general information and advice, counselling and harm reduction measures such as needle exchange.

One barrier to treatment participation, however, noted at the recent South Australian Drugs Summit, was the cost of substitute medication. Although this was discussed particularly in the context of heroin and alcohol abuse (the cost of medications such as methadone, buprenorphine and naltrexone) the same point would apply to any existing or subsequently developed medications to treat amphetamine dependence. The Treatment Working Group at the Summit stated:

The cost of [such] medications...should not expose the individual to financial hardship arising from their participation in treatment. This has been identified

as a significant barrier to retention in treatment. The benefits associated with continued treatment are such that measures to overcome this barrier is considered by the working group to be highly desirable (South Australian Drugs Summit Communiqué 2002a, p.11).

As a result the Working Group recommended the introduction of a co-payment system for clients where 'the fee burden is shared between the individual and the state' (p.11). The Committee makes no comment as to the desirability or otherwise of such a system at this stage. It does, however, welcome comment as to both the merits of substitution treatment and how it may be financed.

Problems with substitution therapy?

Not all commentators have supported amphetamine substitution treatment or indeed separate treatment regimes for amphetamine users. The Treatment Working Party of the South Australian Summit sounded a cautionary note about relying too heavily on new pharmacotherapies to address problematic amphetamine use:

The inordinate amount of research effort that has been directed at pharmacological interventions for cocaine [and amphetamine] users has been to the detriment of psychosocial interventions which have good potential. Commentators in the field have recommended that further research on pharmacotherapies for cocaine and amphetamines factor in complementary psychological therapies, and be directed to determining whether specific pharmacotherapies add to overall treatment effectiveness. Because the safety of stimulant use is unpredictable and rates of retention in treatment tend to be poor, caution should be exercised when investigating new medications because of the possibility of additive negative effects of the trial drug and the stimulant. Indeed, it is desirable that selection of pharmacotherapies be undertaken on the basis of neurophysiological theory – the impression gained by reviewing research on pharmacotherapies for cocaine dependence is that of a scattergun approach in the hope that something interesting will emerge. Increased understanding of mechanisms of action of cocaine and amphetamines, and selection of appropriately targeted pharmacotherapies, would seem to be a more efficient approach (South Australian Drugs Summit Issues Paper 2002b, pp.15–16).

There have also been concerns expressed about the quality of the research conducted with regard to amphetamine substitution, including some of the older British studies that have been relied upon.

Mattick and Darke, for example, have sounded a note of caution, arguing that many of the analyses and studies upon which support of amphetamine substitution rely lack methodological rigour. The true efficacy of amphetamine prescribing can only be known when sufficient random and case-controlled trials are conducted (Mattick & Darke 1995). White argues that without such trials 'there is no way of knowing whether clients who cease injecting would

not have done so anyway without a prescription' (White 1996, cited in Kamienicki 1998, pp.38–39).²⁵⁵

On balance, however, substitution programmes do seem to have benefit,²⁵⁶ although there have not been sufficient evaluative studies undertaken to make this claim with complete confidence. Clearly such objective evidence is required. It should be noted that the Victorian Department of Human Services is currently considering conducting a trial with regard to the prescription of oral amphetamine (dexamphetamine) as a substitute treatment for dependent injecting amphetamine users:

This trial is expected to evaluate the safety and efficacy of prescribed oral dexamphetamine for amphetamine dependence. It will measure whether street amphetamine use decreases and if treatment retention, HIV/HCV risk behaviour, psychological and social adjustment, criminal behaviour and general health improve under this trial. It is expected that the trial will be completed by the end of 2003.²⁵⁷

The fact that such measures seem to be popular among users themselves also needs to be taken into consideration.²⁵⁸ Evaluation of these and other treatment measures are an important overall part of research involving amphetamines and 'party drugs'. This general issue will be discussed in the following chapter.

The importance of non-specialists

One of the constant themes coming from the literature is the place of non-specialist medical officers in addressing issues pertaining to (meth)amphetamine and to a lesser extent ecstasy use. Dr Nick Lintzeris, formerly medical officer with the Turning Point Alcohol and Drug Centre, stated that doctors and nurses *outside* the drug and alcohol field see more amphetamine users than do drug and alcohol counsellors:

Certain GPs in certain areas see a lot of amphetamine use. For example, in one or two community health centres in Melbourne the doctors who work there are saying 'I've thought about becoming a methadone prescriber but there's

255 Lintzeris, Holgate and Dunlop have established comprehensive guidelines for the establishment of an Amphetamine Prescription Program and a controlled amphetamine prescription study. These bear paying attention to. See Lintzeris, Holgate and Dunlop (1996).

256 See Table G in Appendix 6 for a summary of the positive outcomes associated with amphetamine substitution therapies.

257 Submission of the Department of Human Services (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

As of the time of writing (July 2003), the proposed trials have not yet commenced. A feasibility study is in progress and it is envisaged that the trials will commence in the later part of the year (Personal communication from the Drugs and Policy Services Branch, Human Services Victoria to the Drugs and Crime Prevention Committee, 7 July 2003).

258 As stated previously, Hando, Topp and Hall's survey found that substitution therapy was the most popular of the treatment options with 18% of the subjects requesting it.

However, it should be noted, if somewhat cynically, that not all users of amphetamines who have requested substitution therapies may have done so with treatment or 'recovery' uppermost in mind.

no point – I'd see one heroin user for every 20 amphetamine users' (quoted in Wood 1998, pp.20–21).

Many studies, both in Australia and overseas, have stressed the importance of having *well trained* general practitioners as a front line source of information and assistance for amphetamine users.²⁵⁹

Vincent et al. state it may therefore be:

[i]mportant to ensure that these professionals are equipped to respond appropriately to their needs. However, it has been noted that most health practitioners are largely unfamiliar with the management of amphetamine-related problems, and so require education and training on the issues. Another option may be the development of a system of 'shared care' between treatment services and general practitioners in the community. Such a system has been implemented in Britain, and although under resourced has been highly successful in many instances, particularly where services have been more pro-active in forging links with GPs (Vincent et al. 1999, pp.71–72).

Of particular concern is the need for emergency personnel to be aware of issues pertaining to amphetamine use. As Kamienicki et al. state:

The emergency services are often the first point of contact psychostimulant users have with the health system. This occurs when medical or psychiatric complications result from psychostimulant use. Individuals may not have had previous contact with a drug and alcohol service as they may not have believed their drug use to be problematic or may not have perceived such services as attractive and/or accessible. Accident and emergency staff are ill equipped to respond to the needs of psychostimulant users. They generally lack knowledge about psychostimulant use, have limited skills in identifying psychostimulant related harm, and limited skills in responding to and managing intoxicated behaviour. It is also important that referral pathways and processes are identified for accident and emergency staff (Kamienicki et al. 1998, pp.66–67).

Nonetheless, it is to general health services that amphetamine users, at least at first instance, may go to for assistance with any direct or indirect complications associated with the use of the drug. Yet as Kamienicki et al. also comment:

Psychostimulant users may be reluctant to access mainstream health services due to uncertainty about the reaction of staff to their use of illicit drugs. Thus, the response they may receive initially may have an impact on compliance with treatment and future utilisation of health services. More informed service providers/clinicians are likely to be more confident in managing psychostimulant users. This may result in more positive experiences for these clients through more effective management of their problem, which, in turn, results in more effective reduction of harm.

259 See Klee and Morris 1994; Klee et al. 1995; Hando, Topp and Hall 1997; Kamienicki et al. 1998; Vincent et al. 1999; Baker, Boggs and Lewin 2001.

Staff in general health services should be trained to consult with clients to link them in with drug and alcohol services for assessment and on-going management beyond the acute problems, if this is required (Kamienicki et al. 1998, p.67).

The need for well informed general practitioners and ancillary health personnel is similarly crucial when addressing health interventions and assistance with regard to MDMA/ecstasy, the subject of the next section of this chapter.

Treatment issues regarding MDMA/ecstasy and other 'party drugs'²⁶⁰

If there is little information with regard to the treatment of (meth)amphetamine use and dependence, this is even more the case for the use of MDMA (ecstasy). This is of course partly attributable to the very real doubts as to whether an 'Ecstasy Withdrawal Syndrome' exists (see discussion in Chapter 4 of this Discussion Paper).

It is also even more the case that MDMA users, even those who take it on a regular basis, do not present for treatment, although the Victorian Department of Human Services has notified the Committee that their Alcohol and Drug Information System (ADIS) data has recently:

...identifie[d] a dramatic increase in clients in treatment services with problems primarily related to ecstasy. Although the numbers presenting are small they more than doubled between July 2000 and December 2001.²⁶¹

Such an increase is a cause for concern.

Nonetheless, it would seem to be generally true that, as Longo et al. remark:

By their very nature, ecstasy users are highly functioning members of society who are likely to be employed or engaged in studies. They are less likely to present for treatment, to have major legal problems, or to die from drug related complications. In general, they are a much less 'visible' population of illicit drug users... (NDARC 2001, p.40).

Exceptions to this general rule of not presenting for treatment are usually medical emergencies, such as hyperthermia,²⁶² or when there have been medical complications as a result of taking other drugs or alcohol in association with the drug (see Gowing et al. 2001). Most interventions for the

260 While the discussion in this section will focus predominantly on 'party drugs', many of the issues and concerns will apply equally to substances such as GHB or ketamine.

261 Submission of the Department of Human Services (Drugs Policy and Services Branch) to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002.

262 There is some inconclusive evidence that a drug called 'dantrolene' may be of benefit in the treatment of hyperthermia induced by MDMA consumption. See White, Irvine and Bochner 1996; Denborough and Hopkinson 1996; Kamienicki et al. 1998.

users of 'party drugs' have been preventive in nature and often of the harm reduction type (see discussion in Chapter 8 of this Paper):

Moreover, there have been very few preventive interventions specifically targeted at users of MDMA; most have been aimed at users of 'party drugs' [in addition to MDMA]. Only one preventive intervention for the users of 'party drugs' has been evaluated (Kamienicki et al. 1998, p.17).

Most interventions for problematic or acute ecstasy or party drug use (including 'fake' ecstasy) have been similar to those applicable to other forms of psychostimulant.²⁶³

Wickes has provided guidelines for the management of acute amphetamine and cocaine intoxication. The medical management of acute MDMA intoxication is the same...with treatment of the symptom complexes as they emerge. The recommendations provided by Wickes are based on extensive clinical experience and have not been tested empirically to date (Kamienicki et al. 1998, p.28).

Similarly, the same types of intervention that are applicable to intravenous amphetamine (and heroin) users to minimise the spread of blood borne diseases will be applicable to those (few) groups of users who inject ecstasy.

However, treatment modules for other psychostimulant users cannot be extrapolated to party drug use exclusively and without qualification. As Gowing et al. state:

While cocaine and amphetamines are related to MDMA, it should be noted that there are substantial differences in the context and patterns of use, as well as pharmacology. Furthermore, it is now generally accepted that cocaine and amphetamine use can progress to a dependence syndrome, while the existence of ecstasy dependence remains questionable (2001, p.39).

There is also doubt as to whether pharmacotherapeutic measures have any relevance to the 'treatment' of ecstasy and other party drug use:

Considerable research effort has been directed towards the identification of effective pharmacotherapies for cocaine users. To date these efforts have been largely unsuccessful and even if an effective pharmacotherapy were found, any transfer to the treatment of ecstasy is questionable because of the differing pharmacology of the drugs... Hence pharmacotherapies for ecstasy users should be innovative and specific to the action of MDMA (Gowing et al. 2001, p.39).

Given the fact that users of 'party drugs' may not consider themselves to be taking 'drugs' per se, it is even more important that general practitioners and ancillary health personnel are aware of the nature of the drugs and the dangers associated with use (Wodak 1996; Gowing et al. 2001). It is equally necessary that emergency personnel, including ambulance officers, have the knowledge to effectively respond to acute episodes of ecstasy, 'fake ecstasy' and other 'party drug' use.

263 See generally, Wickes 1993a, 1993b; Kamienicki et al. 1998; Gowing et al. 2001.

Brief interventions

The concept of 'brief intervention' may be particularly appropriate for ecstasy users prior to the development of any problematic use. As Gowing et al. argue:

Brief interventions aim to investigate a potential problem and motivate an individual to begin to do something about their substance use. The basic goal of a brief intervention is to reduce the risk of harm that could result from continued substance use. Brief interventions on their own can promote behaviour change, or they can act as the first stage of more intense treatment. Furthermore, brief interventions are applicable to individuals from a wide range of cultures and backgrounds, and they can be used in a variety of settings, both opportunistic or within specialised substance abuse treatment.

Potential settings for opportunistic use of brief interventions to address ecstasy use include emergency departments of hospitals, subsequent to attendance for acute adverse effects; support services at major events such as dance parties; primary health care (doctors or dentists may detect ecstasy use in the context of other consultations); law enforcement settings (subsequent to being found in possession of an illicit drug); and computer based applications (the target group is likely to be high level internet users).

These strengths identify the potential value of brief interventions in addressing ecstasy use, but brief interventions need to be structured and much of the evidence of their effectiveness relates to alcohol abuse. It is desirable for there to be development and evaluation, through structured research, of brief interventions appropriate to ecstasy users and the various contexts for the delivery of the interventions (Gowing et al. 2001, p.40).

Baker, Boggs and Lewin also extol the benefits of tailored brief interventions:

[t]he data show that regular amphetamine users are a diverse group of people for whom interventions need to be specifically targeted. Brief interventions should be provided for people at early stages of change within primary care settings and needle and syringe exchange schemes. Interventions for amphetamine use should be provided within methadone maintenance treatment programmes and in community settings. Services should offer assistance with amphetamine-related problems. Clearly, services need to adopt a harm reduction approach as few users wish to reduce or abstain from all drug classes. Treatment in regional areas needs to address lifestyle issues in the likelihood of long term employment. Women may need to be targeted for early intervention with the aim of preventing transition to regular amphetamine use. Among people with a longer duration of amphetamine use, tranquilliser use and risk taking behaviour need to be specifically addressed (Baker, Boggs & Lewin 2001, p.55).

Whatever the problems or deficits that apply to the treatment of those who use amphetamines or 'party drugs', it is often the case, particularly with (meth)amphetamine users, that these will not be the only drugs they are

taking. The issue of treatment and intervention therefore is complicated by the issue of poly drug use; the topic of the following section.

Complicating treatment: Amphetamines, 'party drugs' and poly drug use

Poly drug use clearly has significant implications for treatment, both in terms of dealing with an emergency or acute episode (what drugs have been consumed) and with regard to long-term rehabilitation (in what context should the interventions focus upon; the treatment interventions for a problematic alcohol user may be very different to those dependent on methamphetamine). The problems are even more intractable when the amphetamine user may also have psychiatric co-morbidity or when heroin is used in association with amphetamines. With regard to this last issue, Baker, Boggs and Lewin state:

It is apparent that many people who inject drugs use amphetamine and heroin, often in combination with other drugs. Clearly interventions for amphetamine use are indicated among people who use amphetamine and heroin. In particular methadone maintenance treatment units could offer amphetamine focused interventions to users enrolled in MMT programmes. Interventions for amphetamine users not enrolled in MMT also need to be available... Interventions for people who are ready to reduce their use of amphetamine need to be accepting of polydrug use, as it is evident from the present study that polydrug use is common and readiness to change may vary between drug categories (Baker, Boggs & Lewin 2001, p.55).

It would therefore seem that interventions need to be developed that cater specifically for particular forms and combinations of poly drug abuse and that flexibility should be the key word. As Hando, Topp and Hall state:

The issue of polydrug use must [also] be considered. Given that most amphetamine users are polydrug users...is there a need for amphetamine specific treatment? Characteristics of the present [survey] sample clearly highlight an amphetamine dependence syndrome and a group of users who request treatment specifically for these problems... However, there is a need to assess polydrug dependence and to address it in the treatment plan (Hando, Topp & Hall 1997, pp.111–112).

Clearly further research, both medical and sociological or ethnographic, is needed on specific and general drug interactions. What Solowij, Hall and Lee stated in one of the earliest Australian studies on ecstasy is equally true today:

It is...clear that recreational drug users are likely to experiment with various 'cocktails' or mixtures of substances, whether it be premeditated or opportunistic experimentation. Further research is needed to explore the various drug interactions, licit and illicit, before the consequences of these can be fully understood (Solowij, Hall & Lee 1992, p.1168).

The need for further and better resourced research and policy development appears to be crucial. This will be the topic of the next and final chapter.

Questions for discussion

- ◆ Are there any specific treatment regimes for amphetamine-related conditions, and if not, should there be?
- ◆ How does poly drug use compound the issue of treatment as it relates to amphetamines and poly drug use?
- ◆ Are there any specialist drug and alcohol services in Australia catering exclusively for dependent or heavy use of amphetamines?
- ◆ How appropriate is it to extrapolate cocaine studies and regimens to amphetamines?
- ◆ What, if any pharmacotherapeutic regimes are available for amphetamine use?
- ◆ Should amphetamine substitution programmes be available in Australia?
- ◆ Why won't amphetamine users access treatment? What would make users access treatment?
- ◆ What are the medical and non-medical issues pertaining to treatment that need to be addressed?
- ◆ How does the existence of co-morbid psychiatric conditions affect the treatment of amphetamine use?
- ◆ What services should be provided with regard to amphetamine treatment?
- ◆ Should medical services be provided at rave parties, dance clubs and other venues where amphetamines and 'party drugs' may be consumed?

10. The Need for Further Research: Concluding Remarks

This Discussion Paper has not been easy to write. The topic of the Inquiry has canvassed two discrete types of drugs: amphetamines and 'party drugs'. Each of these categories contains differences in pharmacology, effects, consequences, culture and ways of addressing problems associated with the use of the drug. There are also similar differences within a grouping such as 'party drugs'. As such, as was noted in Chapter 2, it is problematic to couple these drugs in a research Paper such as this.

Nonetheless, there are some commonalities that have arisen through the course of the Inquiry that can apply to both types of drug. For example, whether addressing the issue of amphetamines or 'party drugs', it is clear that focusing on one narrow target of intervention is insufficient. There must, as has been recognised in Australian drugs policy for some years, be a three-pronged attack that incorporates supply reduction, demand reduction and harm reduction or minimisation. Destroying or intercepting drugs at their point of entry, for example, is necessary but not sufficient in dealing with the 'drugs menace'. Such interdiction will not of itself result in a lesser demand for drugs. As has been seen in the context of the 'heroin drought', it may simply serve to focus on a new drug of 'choice', such as amphetamines.

Another common theme that has arisen throughout the Inquiry is the paucity of research being undertaken into the areas of amphetamines and 'party drugs'.

This lack of research applies not only to medical research pertaining to treatment but also more general quantitative and epidemiological studies, qualitative and ethnographic research projects. Such a lack of inquiry and consequent policy development is felt not only in Australia but also at an international level (Yacoubian 2001). A need for a greater research effort with regard to these drugs is the topic of the following section.

The need for greater research

In 1993, at a symposium on psychostimulant use in Australia, drug researchers Julie Hando and Wayne Hall identified three areas of research priority:

First, we need much better information about what forms of amphetamines are being used. What are the major modes of administration? What are the typical doses used? What impurities do illicitly manufactured amphetamines contain?

Second, we need to be better informed about existing patterns of amphetamine use to make better educated guesses about the likelihood that amphetamine use will spread. What are the major routes of administration and why do different users choose them?

Third, we need to look more systematically at the potential health and social problems associated with amphetamine use by each of the major routes of administration. What are the adverse effects of acute oral and injected amphetamine use? What are the health hazards of chronic use? (Hall & Hando 1993, p.65).

Notwithstanding a range of state, federal and university funded projects over the ten years since these exhortations were made, it could still be argued that Hall and Hando's comments are as applicable today. This is as true of the international situation as it is in Australia. In an excellent literature review pertaining to global ecstasy use, Yacoubian makes the following pertinent comment:

Despite its history, and the major physiological and psychological problems associated with its ingestion, ecstasy has received relatively little attention in periodicals devoted to the social sciences... [O]nly 35 empirical studies have been published on ecstasy in peer reviewed periodicals devoted to the social sciences. Of these 28 (80 per cent) were conducted outside of the United States (Yacoubian 2001, p.128).

Medical and clinical research

In the area of clinical research there are still many gaps in what we know about psychostimulants and particularly MDMA/ecstasy. Much of what has been learned about (meth)amphetamine use and ecstasy has been extrapolated, not always appropriately, from research into cocaine. This has been partly attributed to an expected jump in cocaine use in Australia during the 1980s that in fact never eventuated (Baker in Wood 1998, p.19).

With ecstasy use in particular there is still a range of unanswered questions that need to be explored. In the medical/clinical area one of the key debates still focuses on the (relative) safety (or otherwise) of 'pure' MDMA:

In scientific as well as in popular texts there is a great controversy if ecstasy is a relatively benign (and even psychotherapeutically effective) substance (Szukaj 1994) or a dangerous neurotoxin (McCann et al. 1998).

There is also a lack of knowledge concerning the incidence and prevalence of ecstasy use and use disorders in the general population. Research deficits are mainly due to the fact that ecstasy studies mostly have highly selected samples...usually do not have prospective longitudinal designs, do not use

specified diagnostic criteria for clinically relevant abuse or dependence patterns and focus on the initiation of ecstasy use, not on its reduction or cessation (Von Sydow et al. 2002, p.147).

Such clinical issues tend to be mixed up with (or alternatively are part and parcel of) political ones, often generated by the media. (For an account of the 'politicisation' of the research agenda as it applies to amphetamines, ecstasy and drugs research more generally, see Burrows, Flaherty & MacAvoy 1993, at pp.105–106; Saunders 1998; Grob 2000; and Concar 2002).²⁶⁴ Grob's article particularly concerns the controversy over the neurotoxicity or otherwise of ecstasy. Political agendas aside, this is an issue which has vexed clinicians for many years. In their global review of the MDMA literature Gowing et al. 2001 make the following salient points:

This report identifies the absence of controlled epidemiological studies and the consequent difficulties in quantifying risks of ecstasy. It is recommended that such studies be designed and initiated to establish prevalence of harms associated with ecstasy use, and particularly to assess long term functional consequences of ecstasy use.

Another area where our knowledge is currently limited relates to the capacity of ecstasy to produce dependence. Furthermore, if ecstasy dependence does exist what are the central features, how should it be assessed, and does it have any diagnostic significance. That is, does it predict risk of adverse effects or appropriate treatment responses?

Although animal and cellular studies have contributed much to our understanding of the effects of amphetamine derivatives, there is still much to do. Due to the unpredictability of adverse effects of these drugs and the very large number of possible chemical manipulations that can be made by illicit chemists, we are still not capable of predicting the outcome of administration in individuals... Further cellular and animal studies are essential if we are to gain sufficient knowledge of the mechanisms of action of these drugs to predict the likely adverse effects in a given situation. This indicates the importance of continued basic research in the area.

Our general understanding of the pharmacology of MDMA and related amphetamine derivatives should continue to be developed... Data reviewed also indicates that a wide range of drugs are [sic] commonly used in conjunction with ecstasy. Improved understanding of the potential for interaction between these drugs may help to avert or respond to other possible interactions. Further analysis of toxicological data in fatal and non fatal cases of adverse effects would also help to determine relative toxicity of various amphetamine derivatives (Gowing et al. 2001, p.44).

264 Concar's article is particularly interesting for its account of the debates surrounding the views of Professor George Ricaurte of Johns Hopkins University in Baltimore. Ricaurte has been long advocating the view that ecstasy use, particularly if used regularly and over a long period of time, can have serious and damaging effects on brain function, a view to which not all in the research or medical communities subscribe (Concar 2002).

Gowing et al. also note that better systems of drug monitoring need to be implemented to give data on current drug patterns and usage. This should be done particularly in emergency room situations where patients are brought suffering the effects of overdoses and other adverse effects associated with the drug and/or drug interactions.²⁶⁵ The Turning Point Alcohol and Drug Centre also has called for more clear data on psychostimulant use in Victoria. In its submission to this Inquiry it states:

Given the significant demonstrated potential for health and other harms associated with psychostimulant abuse, there is an imperative for broadening existing drug trend monitoring systems to facilitate a more sensitive mechanism for detecting trends in this area. This may be achieved by extending current monitoring methods to new sentinel groups including gay and lesbian, dance/rave attendees and others (and also through the development of new methodologies). The value of such monitoring is that it may serve as a more sensitive early warning mechanism for emergent psychostimulant trends, and thereby highlight possible areas of focus for future public health response (policy, program and research).²⁶⁶

One encouraging development is the Psychostimulant Monitoring Project which aims to monitor psychostimulant market trends in Melbourne. In 2003, researchers at Turning Point Alcohol & Drug Centre commenced a study designed to identify and monitor emerging trends in psychostimulant (including 'party drugs') use and harms in Melbourne. The Party Drugs and Psychostimulant Monitoring Project is an example of integrated drug trend monitoring. The research is gathering primary data from current users, secondary data from available indicator sources and interviews with key informant experts across Victoria. Turning Point's research on this issue extends the drug trend monitoring model it has applied annually since 1997 in the conduct of the Melbourne arm of the national Illicit Drug Reporting System (IDRS) study. The challenge in developing an ongoing monitoring capacity for psychostimulant trends is to access new sentinel groups via novel research methods. To meet this challenge the Party Drugs and Psychostimulant Monitoring Project is exploring the feasibility of internet recruitment and surveys and computer assisted telephone interviews (CATI).

The methodology design includes a specific focus on cocaine, methamphetamines, ecstasy and other designer drugs, and will target people other than needle exchange programme clients (eg. dance/rave scene

265 Gowing et al. view the United States Drug Abuse Warning Network (DAWN) as a useful model:

'An added advantage of this sort of system is that it also has the capacity to identify emerging patterns of drug use and related problems. For example, data from DAWN indicates the significance of mixing drugs, and recent increases in GHB-related problems in parallel with MDMA. Data [also] shows the young age of users experiencing adverse effects' (Gowing et al. 2001, p.43).

266 Excerpt from the confidential submission of Turning Point Alcohol and Drug Centre to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission and approval of Turning Point.

participants, gay/lesbian groups). Data sources will be triangulated against each other in order to minimise the weaknesses inherent in each one and to ensure that only reliable and valid emerging trends are documented

In its submission to this Inquiry, Turning Point outlined the aims and methods of the project as follows:

1. To improve monitoring of the patterns and characteristics of psychostimulant use in Melbourne, including an increased focus upon target groups other than injecting drug users (e.g. rave/dance scene, gay/lesbian target groups).
2. To commence strategic early warning around psychostimulant trends across Melbourne, and serve as a mechanism for supporting drug trend monitoring over time.
3. To consider the implications of emerging psychostimulant trends for health and law enforcement sector responses.²⁶⁷

The Committee awaits the results of this project with interest.

There are a variety of other clinical research needs outlined in a research symposium on amphetamine use in Australia that still have relevance and still are worthy of attention today (see Burrows, Flaherty & MacAvoy 1993). For example, Wickes' (1993a) call for research into the effects of psychostimulants on pregnancy is still timely. Chesher's (1993) advocacy of research into the transition from oral use of amphetamines to injecting them may be equally applicable to the slight but nonetheless noticeable use of ecstasy intravenously. More generally, better research into the epidemiology of psychostimulant use, particularly with regard to ecstasy use, is clearly required. A specific area needing such research is the use of so-called 'party drugs' outside of the party or dance environment.

One other important issue to bear in mind in considering research agendas is the relationship between psychostimulant use, of whatever type, with other conditions. This, as has been observed in Chapter 4, is particularly important with regard to co-morbid mental illness. The Youth Substance Abuse Service based in Melbourne, which sees many young clients who present with co-morbid mental illness, makes the following points regarding research into psychostimulants:

[m]uch of the current research relates cause and effect conclusions that are not justified by the data presented. Some of the confounding variables include:

- Amphetamine or MDMA use is associated with the symptoms rather than being the cause of the symptoms.
- The probability of a chance association. Of the large group of drug users within the general population, a proportion will have mental health issues regardless of any drug use. Depression and anxiety are common conditions

267 Excerpt from the confidential submission of Turning Point Alcohol and Drug Centre to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission and approval of Turning Point

in the general population. According to the Australian National Survey of Mental Health and Wellbeing 2000, depression and anxiety affect up to one in five Australian adolescents – three times higher than 10 years ago (reported in *Sad statistics: the scourge that's scarring our young* The Age 7th July 2002). It is a statistical certainty that many users of amphetamines or MDMA will develop depression regardless of their drug use.

- Poor pre-morbid adjustment (a poor adjustment to life circumstances) is associated with an increased likelihood of any drug use. As such, a person's drug use in the form of self-medication of distress may be a symptom of impending or actual mental illness, or an indication of impaired judgement. Pre-existing mental illness and a family history of mental illness is common in people who develop psychiatric illness in apparent association with drug use.
- Some people with schizophrenia or bi-polar disorder may also use amphetamines or MDMA. The peak age of onset of schizophrenia is 20–30, an age group in which experimentation with drugs is relatively common. It is unknown whether amphetamines or MDMA can specifically induce a relapse of pre-existing schizophrenia or bi-polar disorder, beyond the increased risk of relapse attached to any emotional stressor.
- Demanding subjects abstain from all drugs before tests of function are undertaken can result in a mild withdrawal syndrome that could confound tests conducted during this withdrawal period. For example, ceasing regular coffee intake can result in headaches, fatigue and impaired function.
- Adequate control group monitoring. It is particularly important to carefully match for the use of *all* other drugs in order to avoid the possibility of bias for the control group to have used fewer drugs and to be higher functioning than the subjects are.²⁶⁸

The Committee welcomes responses by those researching into amphetamines and 'party drugs' with regard to the reservations expressed by YSAS in the preceding quote.

Finally, as has been noted in great detail in the last chapter, there is a great deficit in treatment options and treatment research for psychostimulant users. This lack applies to both pharmacological and behavioural interventions. Recent Australian reviews (Gowing, Proudfoot, Henry-Edwards & Teeson 2001; Baker & Lee, in prep):

[c]learly highlight the lack of well conducted research with psychostimulant users and the need to undertake research that suits the Australian treatment context. There is a great deal more research required into best practice treatment options for this group.²⁶⁹

268 Submission of Youth Substance Abuse Service to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. (Emphasis in the original)

269 Excerpt from the confidential submission of Turning Point Alcohol and Drug Centre to the Drugs and Crime Prevention Committee, Inquiry into the Use of Amphetamines and 'Party Drugs', August 2002. Quoted with the kind permission and approval of Turning Point.

Despite the clear need for greater research into epidemiological and clinical aspects of psychostimulant use, it would seem that it is equally important to continue and expand qualitative research into this area of drug studies. Such research should include social and ethnographic models.

Social research

In Australia there is a dearth of research into the 'social worlds' of psychostimulant users. This is particularly the case for those who use ecstasy. Conventional approaches in psychological, behavioural and psychosocial research clearly have an important role to play in the qualitative research programme (South Australian Drugs Summit Communique 2002a). However, one of the key areas of qualitative research that has been utilised in Europe, but to some extent ignored in Australia, is ethnography. Why is ethnography important in the area of drug studies? Australian ethnographer David Moore argues that:

[e]thnography has the ability to provide research insights, fill important gaps in our knowledge, and complement more quantitative methods. One of the main strengths of the method is the ability to get 'inside' a group and therefore to gain a fuller understanding of the social processes involved in drug use. This process in turn may generate hypotheses which might be later tested using more quantitative methods. With respect to drugs such as Ecstasy (and amphetamines), where our baseline information is poor, data collected via ethnography allow the planning of appropriate health promotion and harm reduction programmes by gaining an understanding of the origins of drug use, the maintenance of particular drug using patterns and the social meanings of such patterns

...Ethnographers claim to paint a picture of drug use which accords more closely with the various social contexts in which drug use occurs. The multitude of social worlds in modern pluralistic society means that simplistic messages which might be relevant to one set of people may hold little relevance for others. The challenge for health promotion and policy is to devise strategies which take into account these cultural and social differences (Moore 1992a, pp.13, 83).

Many ethnographical studies on drug use draws, either explicitly or implicitly, from Zinberg's analysis of 'drug, set and setting' referred to earlier. In other words, qualitative or social research into drug use should not concentrate only on the pharmacology of the drug (drug) or the individual psychology of the use (set) but should also examine the social context within which these two variables are located and the values, beliefs and sanctions that are brought to drug use by various individuals and social groups (the setting). It is the interaction between the drug taken, the individual psychology of the user and the cultural or social milieu in which it is taken that is crucial in attempting to understand drug use and thus formulate appropriate interventions. Much ethnographic research, particularly that which is based on participant

observation, also takes place in the natural settings of the user, the dance club or the rave, rather than a clinic or institution. Such a method would not concentrate exclusively on the negatives, problems or harm of drug use. This is not to condone, encourage or lionise drug use. It is simply to acknowledge that researchers, educators and policymakers need to understand the social world of the drug user in formulating effective interventions to reduce the harms that *are* associated with the drug. As Moore states:

Researchers spend many hours devising ways of measuring drug-related harm but there is a noticeable absence of ways of quantifying the benefits of drug use. If the majority of drug users experience little in the way of negative effects, this aspect must be incorporated into our approach however difficult we might feel this to be (Moore 1992a, p.83).

In short, ethnography promotes the 'insider' view of drug use as understood by the users themselves. Moore states that:

Various types of drug experts, policymakers and law enforcement personnel all contribute to the formation of policy and practice but drug users, who are presumably entitled to some say in policy which effects them, do not. Their view is labelled 'anecdotal' and given little intellectual, political or social weight (Moore 1992a, pp.82–83).

The recent comprehensive review into psychostimulant treatment and interventions by Kamienicki and his colleagues endorsed such an approach. It also recognised that:

[c]onsumer input into research, service development, provision and evaluation, should be recognised as vitally important. User groups, established in all states and territories, and which are tasked and assisted to access psychostimulant users from a range of subcultures, would be in a key position to provide such informed input based on local needs.

Psychostimulant users have useful information on their experience of, and beliefs about, drug treatment, which may facilitate treatment services attracting clients, making treatment more effective, and assist in defining measurable and achievable treatment goals which may have not been considered by service providers but which are of value to the client group. For example, while it may not result in abstinence, the interruption to an escalating binge cycle provided by a short term stay in an in-patient withdrawal service may provide important 'time out' from drug-using peers and environment and may facilitate re-establishing control over use. Thus, users of psychostimulants have a great deal to offer service providers in determining how existing services could be modified. They can also provide input into how new services, and other interventions, could be designed to better meet the needs of this group.

Within the heterogenous group of psychostimulant users, there appear to be distinct sub-cultures with different social norms and drug using practices

(Berg 1994, Hando & Hall 1993, National Task Force on Psychostimulants 1995, Vincent et al. 1997). Examples include transport industry and shift workers, users of 'party drugs' in the rave and dance music scene, and regular amphetamine injectors who may also inject opioids. Treatment services which target acute and chronic amphetamine associated harm are more likely to be attractive and acceptable to potential clients if they consult with representatives of a variety of identifiable client sub-groups (Kamienicki et al. 2002, p.63).

As with any area of health policy it is essential that *all* forms of research be undertaken that is relevant to the area of investigation. It is axiomatic that quantitative data is needed to understand the dimensions of any given drug 'problem'. But such data needs to be complemented by qualitative techniques including the more 'peripheral' studies in ethnography and social research.²⁷⁰

Evaluative research

Any programme or intervention that is designed or implemented should in the view of the Committee have an in-built requirement for evaluation. This is particularly important for harm reduction programmes and strategies. Evaluative research of both a process and outcome nature is an essential component of developing good, effective and relevant policy in this area. It is a crucial aspect of determining not only what works but what doesn't work or what at least could be improved upon.

Conclusion

Drug use of either a licit or illicit nature is a dynamic and constantly evolving phenomenon. The types of drugs used and the pattern of their use continually change. For example, although the amount of heroin appearing on Australian city streets now seems to be increasing, it is true that during the years of the 'heroin drought' there was a marked increase in the usage of amphetamines and other drugs such as benzodiazepines. As Miller and Fry state:

270 One research technique that seems to have produced some excellent results in amphetamine and other drug studies, is that of Rapid Assessment Research. This method, for example, was utilised by Vincent, Allsop and Shoobridge (1996) in their study of amphetamine users in South Australia. They describe the process as follows:

'Rapid assessment procedures consist mainly of research tools which have been adapted from anthropological investigation methods so that they can be applied within a rapid time frame, and can generate relevant information at relatively low cost. They are designed to be used in circumscribed geographical areas.

There is no single method of rapid assessment. Various combinations of research tools have been developed and utilised. These have generally included identification, examination, and analysis of existing quantitative data, "key informant" or consultant interviews, direct observation, and focus group discussions. Focused quantitative surveys, transcripts of informal conversations, personal diary entries, and other forms of qualitative and quantitative data have also been utilised. Exactly which tools are used depends on the nature and focus of the research problem, the time available for the assessment and the availability of funds... Researchers conducting rapid assessments need to be flexible in adopting techniques which are suitable to the particular situation' (Vincent, Allsop & Shoobridge 1996, p.370).

[The] reduction in supply of heroin to Melbourne's illicit drug markets provides a salient example of the sensitivity of these markets to change, and a reminder of the need for systematic monitoring research around trends in illicit drug markets in developing timely public health responses to the harms associated with drug use (Turning Point Alcohol and Drug Centre 2001, p.25).

Increasingly, a wide variety of substances are being used by drug users, either in substitution for their drug of choice or, more worryingly, in addition to it. Poly drug use would seem to be the norm rather than the exception. Policy development, treatment, research and education strategies need to take this into account in the development of any interventions to address drug use.

Drug use is of course a global phenomenon. The use of amphetamines and ecstasy is no exception to this rule. International cooperation through the framework of the relevant United Nations treaties is essential, particularly as the magnitude of the global 'ecstasy problem' becomes apparent (Yacoubian 2001, p.133).

Yet obviously much needs to be done on the local front, both at a national, state and community level. The complex area of drugs policy, particularly with regard to amphetamines and 'party drugs', needs to be approached from a creative multi-disciplinary focus. Health workers, law enforcement officials, teachers, researchers and users themselves all have a part to play.

On the basis of the information received to date, the Committee believes that any strategies, interventions or policies aimed at addressing amphetamine and party drug use must be based on the best available evidence and/or best practice. The Committee welcomes further consultation with the public to achieve this end and encourages people to read this Discussion Paper, think about the issues raised and send it submissions that address the 'Questions for discussion' at the end of each chapter. In particular, the Committee would like to receive more information about how amphetamine and 'party drug' use impacts differently on discrete sections of the community such as women, people from non-English-speaking backgrounds, prisoners and Indigenous Victorians, to name but a few.

At the end of last year's South Australian Drugs Summit the following closing statement was made:

The Summit urged participants to think creatively and to seek out innovative solutions. The challenge was to take what we know in terms of best practice and to marry it with innovation and a strong sense of pragmatism and humanitarianism.

It was recognised that the challenges confronting us are very complex and that complex problems require comprehensive strategies – not quick one-off solutions. Researchers, clinicians, drug treatment experts and criminal justice representatives came together in a spirit of good will and shared their collective knowledge and experience. Their perspectives were blended with the equally important and valid views of families, members of user groups, treatment

services, religious and spiritual groups and indigenous community members (South Australian Drugs Summit Communique 2002a).

This is an approach that Victoria could do well to emulate in its efforts to address the problems associated with drug use in general and amphetamines and 'party drugs' in particular.

Questions for discussion
<ul style="list-style-type: none">◆ What types of research and research projects should be conducted with respect to amphetamines and 'party drugs'?◆ What research projects are being currently conducted with regard to amphetamines and 'party drugs'?◆ Are there any specific problems in undertaking research into amphetamines and 'party drugs'?

Appendices

Appendix 1: List of Submissions Received

Submission Number	Name of Individual/Organisation	Date Received
1	Mr Simon Lenton, Senior Research Fellow – Curtin University of Technology	8 July, 2002
2	Mr Alan Benzley	11 July, 2002
3	Mr Kevin W. Walsh, Managing Director – Bio-Mediq DPC Pty Ltd	15 July, 2002
4	Confidential Submission	2 August, 2002
5	Mr Mark Young, Community Networks Manager – Open Family Australia	5 August, 2002
6	Mr David Risstrom, Councillor – City of Melbourne	5 August, 2002
7	Confidential Submission	6 August, 2002
8	Mr Mike Hill, Executive Officer – Victorian Local Governance Association	7 August, 2002
9	Mr Brendan Ball, Monash Drug and Alcohol Project – Monash City Council	7 August, 2002
10	Ms Janet Farrow, Executive Director – Uniting Care, Moreland Hall	7 August, 2002
11	Mr Andrew Paul, Chief Executive Officer – City of Greater Bendigo	7 August, 2002
12	Mr Rob Skinner, Chief Executive Officer – Kingston City Council	7 August, 2002
13	Mr David Murray, Chief Executive Officer – Youth Substance Abuse Service (YSAS)	7 August, 2002
14	Confidential Submission	7 August, 2002
15	Ms Rosemary McClean, Manager, Strategic Planning – Australian Drug Foundation	7 August, 2002
16	Ms Jacinta Maloney, Community Lawyer and Education Worker – St Kilda Legal Service	7 August, 2002
17	Mr Graham Strathearn, Chief Executive Officer – Drug and Alcohol Services Council	8 August, 2002
18	Ms Nancy Di Santo, Community Health and Safe City Planner – Hume City Council	8 August, 2002
19	Ms Noelene Duff, Chief Executive Officer – City of Whitehorse	9 August, 2002

Submission Number	Name of Individual/Organisation	Date Received
20	Ms Carmel Fox, Team Leader Eastern Drug & Alcohol Service – Monash Link Community Health Service	7 August, 2002
21	Helen Fraser, Project Worker, Drug and Health Issues – Doutta Galla Community Health Service	16 August, 2002
22	Michelle McDonald, Manager, Membership and Policy – YWCA Victoria	19 August, 2002
23	Rev Mgr T. M. Doyle, Director of Catholic Education	23 August, 2002
24	Kerrie Peters, Community Development Officer – Northern Grampians Shire Council	29 August, 2002
25	Gail Price, Community Development Officer – Mornington Peninsula Shire Council	28 August, 2002
26	Hon. John Thwaites, MP, Minister for Health – for Human Services Victoria, Drug Policy and Services Branch	16 September, 2002

Appendix 2: Injecting Drug Use

Table A: Injecting drug use: First and recent^(a) illicit drugs injected, proportion of ever/recent injecting drug users aged 14 years and over, by sex, Australia 2001

Drug	(Per cent)					
	First Injected ^(b)			Recently Injected ^(c)		
	Males	Females	Persons	Males	Females	Persons
Heroin	30.0	31.3	30.5	18.8	30.2	22.9
Methadone	0.0	0.3	0.1	9.1	5.0	7.6
Other opiates	3.0	3.2	3.1	15.8	22.7	18.3
Amphetamines	59.8	61.2	60.3	76.4	78.3	77.1
Cocaine	2.4	1.9	2.3	11.3	18.0	13.6
Hallucinogens	0.7	0.2	0.5	3.4	0.8	2.5
Ecstasy	0.0	1.6	0.6	14.8	11.4	13.6
Steroids	4.1	0.2	2.7	5.6	4.9	5.4
Benzodiazepines	-	-	-	2.2	4.4	3.0
Other drugs	-	-	-	3.9	6.9	4.9

(a) Used in the last 12 months

(b) Answered by respondents who have ever injected

(c) Answered by respondents who have injected in the last 12 months

Source: Australian Institute of Health and Welfare (AIHW) 2002a, *National Drug Strategy Household Survey: First Results*, AIHW, Canberra, p.39.

Appendix 3: Toxicological Effects of Amphetamines and Other Illicit Drugs

Table B: Toxicological effects of illicit drugs

Illicit Drug	Toxicity
Amphetamine	Vasoconstriction resulting in coronary spasm, MI, cardiomyopathy, cardiomegaly, pulmonary oedema, hypotension or hypertension, tachycardia or bradycardia, tachyarrhythmia, metabolic acidosis, seizure, intracranial haemorrhage (ICH), ischaemic stroke, rhabdomyolysis (v. high doses), hallucination, confusion, suicidal ideations.
Ecstasy and PMA	Marked hyperthermia, DIC, acute renal failure, rhabdomyolysis, arrhythmia, seizures, ICH, MI.
Gamma-Hydroxybutyric acid (GHB)	See Table D

Table C: Potential drug interactions with amphetamine

Drug	Interaction
Alcohol	Complex. Bioavailability of alcohol <i>slightly</i> increases. Amphetamine can potentially ‘reverse’ some of the ‘euphoric’ effects of alcohol.
Monoamine oxidase inhibitors (MAOI), including selegiline and Hypericum perforatum (St Johns Wort)	Accumulation of large amounts of noradrenaline in the brain and blood vessels. Amphetamines (and related compounds) release accumulated noradrenaline → massive over stimulation and hypertensive crisis. Clinical effects include neck stiffness, flushing, sweating, nausea, vomiting, increased muscle tone, intracranial bleed, arrhythmia, and cardiac arrest.
Tricyclic antidepressant (TCA)	Increase effects of amphetamine especially TCA with more serotonergic effects (e.g., clomipramine)
Chlorpromazine	Amphetamines may inhibit antipsychotic effect of chlorpromazine. Chlorpromazine may inhibit <i>anorectic</i> effect of amphetamines*
Selective Serotonin Reuptake Inhibitors (SSRIs), especially fluoxetine and paroxetine	Enhanced effects of amphetamine (↑ levels of amphetamine) ↓ metabolism of amphetamine by hepatic CYP2D6 isoenzyme. Potential serotonin syndrome.
Lithium	↓ effects of amphetamine in presence of lithium.
Dextromethorphan and L-tryptophan	Serotonergic. Possible serotonin syndrome

*Chlorpromazine can be useful in amphetamine overdose management.

Table D: Toxicology of GHB

Organ system	Toxicity
Central Nervous System (CNS)	Anaesthetic induction: Random clonic movements of face and extremities. Aggressive behaviour, combativeness Seizure-like activity (no epileptiform EEG changes) Seizures in overdose Mild toxicity: nystagmus, ataxia, sedation Severe toxicity: coma, respiratory depression, apnoea.
Cardiovascular	Bradycardia Arrhythmia (direct effect on K ⁺ ion balance). This can occur in the presence of normal serum potassium.
Other	Reduced tissue oxygenation demands and protects cells during hypoxic and shock states Inflammatory mediator: reduced ulcer formation by indomethacin and stress Improves visual acuity in glaucoma Hypothermia (~35°C) Respiratory depression, mild respiratory acidosis.

Source of Tables B, C, D: Adapted from Kong, Fabian 2000, 'Illicit drugs: Minimising spread of a lethal cocktail', *Australian Pharmacist*, vol.19, no. 7, August, pp.419–421.

Appendix 4: Customs Act 1901 (Cth), Schedule Six

Table E: Schedule Six – List of scheduled and prohibited drugs, trafficable and commercial quantities

Substance quantity	Trafficable quantity (grams)	Commerc (kilograms)
ACETORPHINE	2.000	
ACETYL-ALPHA-METHYLFENTANYL	0.005	0.005
ACETYLCODEINE	2.0	
ACETYLDIHYDROCODEINE	2.0	
ACETYLMETHADOL	2.0	
ALLYLPRODINE	2.0	
ALPHACETYLMETHADOL	10.0	
ALPHAMEPRODINE	0.2	
ALPHAMETHADOL	0.2	
ALPHA-METHYLFENTANYL	0.005	0.005
ALPHA-METHYLTHIOFENTANYL	0.005	0.005
ALPHAPRODINE	25.0	
AMPHECOLORAL	2.0	
3- (2-AMINOPROPYL) INDOLE	2.0	
AMPHETAMINE	2.0	
ANILERIDINE	25.0	
BARBITURATES	50.0	
BENZETHIDINE	10.0	
BENZYLMORPHINE	5.0	
BETACETYLMETHADOL	5.0	
BETA-HYDROXYFENTANYL	0.005	0.005
BETA-HYDROXY-3-METHYLFENTANYL	0.005	0.005
BETAMEPRODINE	5.0	
BETAMETHADOL	5.0	
BETAPRODINE	5.0	
BEZITRAMIDE	5.0	
4-BROMO-2, 5-DIMETHOXYAMPHETAMINE	0.5	
BUFOTENINE	2.0	
CANNABINOIDS	2.0	
CANNABIS	100.0	100.0
CANNABIS RESIN	20.0	50.0
CHLORPHENTERMINE	2.0	
CLONITAZENE	5.0	
COCAINE	2.0	2.0
CODEINE	10.0	
CODEINE-N-OXIDE	10.0	
CODOXIME	10.0	
DESOMORPHINE	2.0	
DIAMPROMIDE	5.0	
DIETHYLPROPION	5.0	
DIETHYLTHIAMBUTENE	5.0	
N, N-DIETHYLTRYPTAMINE	2.0	
DIHYDROCODEINE	10.0	
DIHYDROMORPHINE	10.0	
DIMENOXADOL	10.0	
DIMEPHEPTANOL	10.0	
2, 5-DIMETHOXY-4-METHYLAMPHETAMINE	2.0	

Substance quantity	Trafficable quantity (grams)	Commerc (kilograms)
DIMETHYLTHIAMBUTENE	20.0	
N, N-DIMETHYLTRYPTAMINE	2.0	
DIOXAPHETYL BUTYRATE	2.0	
DIPHENOXYLATE	2.0	
DIPIANONE	10.0	
ECGONINE	10.0	
ETHYLMETHYLTHIAMBUTENE	10.0	
ETHYLMORPHINE	2.0	
ETONITAZENE	5.0	
ETORPHINE	5.0	
ETOXERIDINE	5.0	
FENTANYL	0.005	
FURETHIDINE	1.0	
HARMALINE	2.0	
HARMINE	2.0	
HEROIN	2.0	1.5
HYDROCODONE	2.0	
HYDROMORPHINOL	2.0	
HYDROMORPHONE	2.0	
HYDROXYAMPHETAMINE	2.0	
HYDROXPETHIDINE	5.0	
KETOBEMIDONE	2.0	
LEVORPHANOL	1.0	
LYSERGAMIDE	0.1	
LYSERGIC ACID	0.002	0.002
LYSERGIDE	0.002	0.002
MESCALINE	7.5	
METAZOCINE	7.0	
METHADONE	2.0	
METHAQUALONE	50.0	
METHORPHAN	2.0	
METHYLAMPHETAMINE	2.0	
3, 4-METHYLENEDIOXYAMPHETAMINE	0.5	
3, 4-METHYLENEDIOXYMETHAMPHETAMINE	0.50	0.50
METHYLDESORPHINE	2.0	
METHYLDIHYDROMORPHINE	2.0	
3-METHYLFENTANYL	0.005	0.005
METHYLPHENIDATE	2.0	
1-METHYL-4-PHENYL-4-PROPIONOXYPIPERIDINE (MPPP)	2.0	2.0
3-METHYLTHIOFENTANYL	0.005	0.005
METOPON	2.0	
MONOACETYLMORPHINES	2.0	
MORAMIDE	2.0	
MORPHERIDINE	2.0	
MORPHINE	2.0	1.5
MORPHINE-N-OXIDE	2.0	
MYROPHINE	20.0	
NICOCODINE	2.0	
NICODICODINE	2.0	
NICOMORPHINE	2.0	
NORACYMETHADOL	2.0	
NORCODEINE	2.0	
NORLEVORPHANOL	2.0	
NORMETHADONE	5.0	
NORMORPHINE	20.0	
NORPIANONE	10.0	

Substance	Trafficable quantity (grams)	Commercial quantity (kilograms)
OPIUM	20.0	20.0
OXYCODONE	5.0	
OXYMORPHONE	2.0	
PARA-FLUOROFENTANYL	0.005	0.005
PENTAZOCINE	20.0	
PETHIDINE	10.0	
PHENADOXONE	10.0	
PHENAMPROMIDE	10.0	
PHENAZOCINE	1.0	
PHENDIMETRAZINE	5.0	
PHENMETRAZINE	5.0	
PHENOMORPHAN	5.0	
PHENOPERIDINE	1.0	
1-PHENYLETHYL-4-PHENYL-4-ACETOXYPIPERI- DINE (PEPAP)	2.0	2.0
PHOLCODINE	5.0	
PIMINODINE	10.0	
PIPRADROL	1.0	
PIRITRAMIDE	1.0	
PROHEPTAZINE	1.0	
PROPERIDINE	25.0	
PSILOCIN	0.1	
PSILOCYBIN	0.1	
TETRAHYDROCANNABINOLS	2.0	5.0
THEBACON	2.0	
THEBAINE	2.0	
THIOFENTANYL	0.005	0.005
TRIMEPERIDINE	10.0	

A substance ("drug analogue") which is, in relation to another substance (being a substance specified elsewhere in this Schedule, or a stereoisomer, a structural isomer (with the same constituent groups) or an alkaloid of such a substance):

- (a) a stereoisomer; or
- (b) a structural isomer having the same constituent groups; or
- (c) an alkaloid; or
- (d) a structural modification obtained in 1 or more of the following ways:
 - (i) by the replacement of up to 2 carbocyclic or heterocyclic ring structures with different carbocyclic or heterocyclic ring structures;
 - (ii) by the addition of hydrogen atoms to 1 or more unsaturated bonds;
 - (iii) by the addition of 1 or more of the following groups, namely alkoxy, cyclic diether, acyl, acyloxy, mono-amino and dialkylamino groups with up to 6 carbon atoms in any alkyl residue; alkyl, alkenyl and alkynyl groups with up to 6 carbon atoms in the group, where the group is attached to oxygen (for example, an ester or an ether group), nitrogen, sulphur or carbon; and halogen, hydroxy, nitro and amino groups;
 - (iv) by the replacement of 1 or more of the groups specified in subparagraph (iii) with another such group or groups;
 - (v) by the conversion of a carboxyl or an ester group into an amide group; or
- (e) otherwise an homologue, analogue, chemical derivative or substance substantially similar in chemical structure; however obtained, except where the drug analogue is separately specified in this Schedule.

The minimum trafficable quantity of:

- (a) that other substance in relation to which the substance is a drug analogue; or
- (b) if there is more than 1 such other substance—that other substance having the least minimum trafficable quantity.

The minimum commercial quantity, if any, of:

- (a) that other substance in relation to which the substance is a drug analogue; or
- (b) if there is more than 1 such other substance— that other substance having the least minimum commercial quantity.

Appendix 5: Penalties for Drug Offences

Table F: List of penalties for drug offences, based on *Drugs, Poisons and Controlled Substances Act 1981 (Vic)*

Offence	Jurisdiction	Penalty Section	Imprisonment (years)	Fine (penalty units: 1 unit = \$100)
Trafficking				
(1) Commercial Quantity	Indictable or summary	71(1)(a)	25	2500
(2) Other quantity	As above	71(2)		
(3) Supply of drug of dependence to a child	As above	72(1)(b)	15	1000
(4) Trafficking to a child of a non-commercial quantity of a drug	As above	71B	15	1000
(5) Possession of substance, material, documents or equipment for trafficking in a drug of dependence	As above	71(1)(ab)	20	2400
				10
		71A		
Cultivation				
(1) Not related to trafficking	As above	72(1)(a)	1	20
(2) Other	As above	72(1)(b)	15	1000
(3) Commercial quantity	As above	72(1)(ab)	25	2500
Possession				
(1) Small quantity of cannabis not related to trafficking	As above	73(1)(a)		5
(2) Not related to trafficking	As above	73(1)(b)	1	30
(3) Other	As above	73(1)(c)	5	400
Use				
(1) Cannabis	Summary	75(1)	-	5
(2) Other drug	As above	75(b)	1	30
Conspiracy to:				
(1) Traffic	Indictable or summary	79(1)	As for trafficking	
(2) Cultivate	As above	79(1)	As for cultivation	
(3) Possess	As above	79(1)	As for possession	
(4) Use	Summary			
(5) Introduce drug etc.	As above			
(6) Forge etc.	As above			
(7) False representation	As above			
Introduction of a drug into the body of another	Summary	74	1	30
Forge, alter, or utter prescription	Summary	78	1	20
False representation to obtain drug, injection or prescription	Summary	78	1	20

Note: As with conspiracy, the offences of 'aid' and 'abet' carry the same maximum penalties as the substantive offence. For example, conspiracy to traffick a commercial quantity of heroin has a maximum penalty of 25 years of imprisonment and a fine of up to \$250,000.

Source: Smith, G. 2002, 'Drug offences', in *The Law Handbook*, ed. K. Harper, Fitzroy, Victoria, pp.612–613.

Appendix 6: Positive Benefits of Amphetamine Substitution Programmes

Table G: Positive benefits of amphetamine substitution programmes – From a review of the studies by Shearer et al. for the National Drug and Alcohol Research Centre 1999

Benefit	Author, Year
Reduced injecting behaviour	Fleming & Roberts, 1994; McBride et al., 1997; White, 1996; Pates et al., 1996; Charnaud & Griffiths, 1998
Reduced sharing of injecting equipment	McBride et al., 1997
Improved retention in treatment	McBride et al., 1997
Reduced use of illicit amphetamine	McBride et al., 1997; White, 1996; Sherman, 1990; Pates et al., 1996; Charnaud & Griffiths, 1998
Improved social functioning (reduced crime, stable housing employment)	Fleming & Roberts, 1994; Pates et al., 1996; McBride et al., 1997
Reduced cravings	Sherman, 1990

Source: National Drug and Alcohol Research Centre (NDARC) 1999, *A randomised controlled trial of the feasibility of monitoring controlled prescribing of dexamphetamine*, by J. Shearer, A. Wodak, R.P. Mattick, I van Beek, J. Lewis, W. Hall, & K. Dolan, (NDARC Technical Report No. 75), NDARC, University of New South Wales, Sydney, p.5.

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