MDMA powder, pills and crystal: the persistence of ecstasy and the poverty of policy

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Abstract
Commonly known as ecstasy, MDMA has been central to the British acid house, rave and dance club scene over the last 20 years. Figures from the annual national British Crime Survey suggest that ecstasy use has declined since 2001. This apparent decline is considered here alongside the concurrent emergence of a 'new' form of ecstasy – MDMA powder or crystal – and the extent to which this can be seen as a successful rebranding of MDMA as a 'premium' product in the wake of user disenchantment with cheap and easily available but poor quality pills. These changes have occurred within a policy context, which in the last decade has increasingly prioritised the drugs–crime relationship through coercive treatment of problem drug users within criminal justice-based interventions, alongside a focus on binge drinking and alcohol-related harm. This has resulted in a significant reduction in the information, support and treatment available to ecstasy users since the height of dance drug harm reduction service provision pioneered by the *Safer Dancing* model in the mid-1990s.

Key words
Ecstasy, ecstasy pills, MDMA powder, MDMA crystal, harm reduction, *Safer Dancing*, recreational drug use, poly drug repertoires

Introduction
Since the emergence of the British acid house, rave and dance club scene 20 years ago, a variety of illicit drugs have been taken in order to enhance the music, dancing, and overall experience of raving and clubbing. Central to the phenomenon of rave, symbolically, socially and pharmacologically, has been the hallucinogenic stimulant or empathogen MDMA[1], commonly known as ecstasy. Not only has ecstasy been the drug with the highest

prevalence of use in dance club settings (eg. Deehan & Saville, 2003), it has also been reported by club goers as their 'favourite drug' (Release, 1997; Measham *et al*, 2001) and has come to be seen as the *'cultural signifier of a generation'* (Shapiro, 1999:23). Yet figures from the British Crime Survey, the most robust annual national household survey, suggest that self-reported consumption of ecstasy has declined. This paper addresses this apparent decline in ecstasy in the official statistics alongside the emergence of a 'new' form of ecstasy in recent years – known as MDMA powder or MDMA crystal – and considers the extent to which this can be seen as a successful recommodification or rebranding of ecstasy as a higher priced, higher quality product. Ecstasy users, notably in dance club contexts, may be switching to MDMA powder/crystal primarily as a result of growing disenchantment with cheap, easily available, but poor quality[2], less culturally appealing, ecstasy pills. However, caution is required here regarding the scale of this substitution of pills with powder/crystal; it would seem that MDMA powder/crystal is being added to some weekend poly drug repertoires and taken alongside ecstasy pills, rather than simply acting as a replacement.

Ecstasy trends – official and alternative sources

Self-reported past year 'ecstasy' use for 16–24 year olds peaked at 6.8% in 2000/1 in the British Crime Survey (BCS) and has fallen each year since then, with the most recent figures reporting 3.9% past year ecstasy use in this age group in 2007/8 (Kershaw *et al*, 2008:54). Among the general population aged 16–59, self-reported past year ecstasy use also fell from a peak of 2.2% in 2000/1 to 1.5% in 2007/8 (Kershaw *et al*, 2008:53). To date, the British Crime Survey does not distinguish between ecstasy pills and MDMA powder/crystal. What is not clear then, from British Crime Survey figures, is the extent to which this apparent decline in ecstasy use reflects at least in part a switch from the consumption of ecstasy in pill form to powder form. In earlier British Crime Surveys, respondents were asked if they had taken '*ecstasy or ecstasy type pills*'. While British Crime Survey terminology changed from '*ecstasy or ecstasy type pills*' to the general term 'ecstasy' at the turn of the century, it is unclear the extent to which, if at all, BCS respondents realise that MDMA powder/crystal is ecstasy, and the extent to which self-reported MDMA powder/crystal use reported as 'other', is then recoded within the generic term 'ecstasy'. The lack of clarity in the question format and the potential confusion among users means that official statistics on ecstasy use since the emergence of MDMA powder/crystal in the early 2000s need to be treated with caution.

In response to an apparent tailing off in ecstasy use first evident in the 2002/3 BCS, Measham (2004a) explored two possible explanations. First, significant changes in '*price, access and availability*' resulted in ecstasy pills falling in price from a standard £15–20 in the early acid house and rave scene to £1–2 per pill (cheaper than most alcoholic beverages) by the early 2000s. The cheapness and ubiquity of ecstasy pills thus resulted in a low profit margin and decreased financial motivation for suppliers disproportionate to their Class A status, coupled with a shift from '*subcultural iconic status as the "cultural signifier of a generation" (Shapiro, 1999:23) to a cheeky supplement to a night's drinking*' (2004a:313), and increased associations with younger teenagers. Indeed age remains an under-explored factor in dance club cultures generally, and ecstasy/MDMA powder/crystal consumption patterns specifically. The drop in the age of ecstasy initiation evident in recent schools surveys – from around 18–20 in the late 1990s (Measham *et al*, 2001; Shiner, 2003) – and a widening of use beyond the confines of the dance club scene illustrate the growing allure and availability of the drug to younger teenagers, a process also noted in relation to cocaine (McCrystal & Percy, 2009). Second, after 10–15 years of ecstasy having been firmly rooted in dance culture as the club drug of choice, it is perhaps not surprising that ecstasy pills may be falling out of favour with adults. After all, '*not only does each generation of young people want to make its own mark on the world (including the illicit world), subcultural value is not attached to certain style icons indefinitely*' (Measham, 2004a:312).

Thus, the rebranding of ecstasy as MDMA powder/crystal potentially offers both increased profit margins for suppliers, and, for adult users of recreational drugs, an apparently 'premium' product with which to distinguish themselves from teenage 'pillheads':

> *'Given that financial value is associated with cultural value in capitalist consumer society and that ecstasy powder is more expensive than pills, the higher cost of ecstasy powder is equated by some with higher quality and higher cultural credibility making ecstasy powder the perceived elite and mature alternative to the cheap, widely available and widely tried ecstasy pills across the UK'* (Measham, 2004a:314–5).

Therefore the apparent decline in ecstasy in the official statistics could be due in part to a switch from pills to powder among users, rather than a decline in overall ecstasy use:

> *'As yet, both the self-report British Crime Survey and the official statistics on drug seizures and offenders do not publish separate data on ecstasy powder and ecstasy pills. In the meantime, the dwindling profit margins for suppliers, alongside the dwindling status among young adult drug users, would support the early indicators from the most recent British Crime Survey and official statistics, which suggest that the tide may be turning for ecstasy pills'* (Measham, 2004a:315).

Hence, subcultural value may be shifting from ecstasy pills to MDMA powder/crystal as dance club culture enters its third decade and continues to retain its appeal among young and not so young adults (Goulding & Shankar, 2004). Equally, although powder cocaine appears to be retaining its position among 16–24 year olds in England and Wales as the most commonly used Class A drug – eg. 161,000 estimated last month cocaine users in 2007/8, compared to 88,000 last month 'ecstasy' users (HM Government, 2008a:21) – the relationship between use of powder cocaine, ecstasy pills and MDMA powder/crystal is currently ambiguous, with the possibility that as cocaine continues to drop in price and quality, and its cultural association with 'determined drunkenness' (Measham, 2006) escalates, MDMA powder/crystal may become more popular among those seeking 'determined drugged-ness' (Moore & Measham, 2008; Moore, 2009) within club cultures.

Five years after Measham (2004a), the continued lack of reliable national data on the prevalence of MDMA powder/crystal has implications for harm reduction advice and service provision. National survey findings inform current policy; therefore any inconsistencies between street evidence and national surveys means service provision is out of step with actual substance use, with services commissioned to undertake work in line with national priorities rather than local need. A further confusion is that some suppliers, users and drugs agencies use the terms 'MDMA powder' and 'MDMA crystal' interchangeably whereas others distinguish between the two. Furthermore, routes of ingestion have broadened from swallowing pills, to dabbing MDMA powder from packets with a moistened finger, making bombs out of cigarette papers and for some, snorting the powder either alone or mixed with other illegal drugs such as cocaine, amphetamines and ketamine in 'designer lines' (Measham, 2004a:315).

What is clear is that alongside this confusion surrounding different forms of ecstasy available on the illegal market, at a local level, drug researchers and street drug agency staff are increasingly noting the prevalence of MDMA powder/crystal through observations, referral meetings, contact with user groups, surveys and interviews. For example, an ongoing online survey hosted by Lancaster University[3] provides some evidence of the growing popularity of MDMA powder/crystal over and above ecstasy pills among club customers. The sample is self-selecting, with 90% considering clubbing to be either 'very important' or 'quite important' in their lives. Of the 109 respondents to date (December 2008), 57% reported that their favourite drug or combination of drugs to take in a club includes MDMA powder/crystal (both options were included in the survey) whereas 52% reported that their favourite combination of club drugs includes ecstasy pills. 21% of respondents reported that their favourite drug or combination of drugs to take at 'chill out' parties after clubbing includes MDMA powder/crystal compared with 15% including ecstasy pills. In terms of recent usage, 31% of respondents reported having had MDMA powder/crystal within the last month whereas 28% reported having had ecstasy pills.

Policy and practice implications

Since 1998 and the implementation of the first 10-year drugs strategy (HM Government, 1998) there has been a growing focus of policy and resources on criminal justice-based interventions for drug users and quasi-compulsory treatment for opiate and (predominantly crack) cocaine users, which the National Treatment Agency (NTA) defines as problem drug users (PDUs). The new 10-year drug strategy looks set to continue with the same focus on PDUs with local targets and outcomes being measured against the successful engagement and retention of PDUs in treatment (HM Government, 2008). Alongside this focus on PDUs, there has also been a focus on binge drinking, and more recently harmful and hazardous drinking and associated alcohol-related disorderly and antisocial behaviour (Strategy Unit, 2004; HM Government, 2007; Hadfield & Measham, 2009). The focus on both alcohol and PDU reflects a prioritisation of substance use, which is seen to result in the most significant health, crime and social problems for the individual user and

wider society. This has resulted in the so-called 'recreational' users of drugs[4] – who may or may not face problems resulting from their drug use – experiencing declining levels of drugs education, information, support, and treatment since the *Safer Dancing* harm reduction model at its height in the mid-1990s. So while drug use by young people has featured in policy in relation to services aimed at children and teenagers such as FRANK, services for young adult recreational drug users have fared badly in the last decade (Hunt & Stevens, 2004), with the primary government response being increased criminalisation dominated by 'war on drugs' and 'law and order' discourses (Measham & Moore, 2008).

Harm reduction for recreational drug use emerged from research undertaken by Newcombe and the Rave Research Bureau in the late 1980s and early 1990s (Newcombe, 1991, 1992, 1994; see Measham & Moore, 2006, for review). In 1991, the research led to collaborative work with Lifeline, a street-based drugs agency in Manchester, with the support of Manchester City Council, researching and producing pioneering and credible *Safer Dancing* harm reduction materials together both *with* and specifically *for* recreational drug users involved in the rave and dance club scene (Ashton, 1992). Dance club management and promoters generally welcomed the provision of such advice at their events with Lifeline's *Safer Dancing* materials proving popular among ravers and clubbers who perceived them as part of the scene rather than an (unwelcome) intervention from an outside agency. *Safer Dancing* and a similar 'Chill Out' harm reduction campaign by Mersey Drug Training and Information Centre (McDermott *et al*, 1992; see also Kilfoyle & Bellis, 2001), spread across the north west of England and beyond, inspiring such diverse harm reduction initiatives as Crew 2000, Dance Ambulance and the *Mixmag* dance magazine's tap water campaign. At a national level, the Home Office produced a *Safer Clubbing* manual (Webster *et al*, 2002), whose second edition more broadly covered *Safer Nightlife* (Webster, 2008). This broadening agenda characterised the shift in focus from dance clubs to the alcohol-oriented night-time economy, which expanded rapidly in the UK from the mid-1990s (Hobbs *et al*, 2003), with binge drinking continuing to dominate public debate (Herring *et al*, in press), despite evidence that frequency of drinking, drunkenness and binge drinking are all now falling among British youth and young adults (Hibell *et al*, 2004; Measham, 2008).

By the turn of the century, and in light of these new public health priorities, *Safer Dancing* initiatives waned, and harm reduction initiatives have become more 'mainstream', multi-agency initiatives, often with increasing involvement from criminal justice agencies[5]. For example, the emergence of the Frank campaign in 2003 saw the UK government producing standardised 'educational' drugs prevention messages aimed specifically at parents and children, messages that were seen as external to the dance club scene. Consultation with drug users indicated that the Frank messages were and still are perceived as being designed for children and their parents, with, for example, the recent anti-cocaine Frank campaign explicitly targeting 15–18 year olds (HM Government, 2008b:14).

As dance club-specific harm reduction initiatives fell out of favour, legislative changes around the responsibility of club owners in the use of drugs in their premises since the 1990s altered the atmosphere within clubland, making the assistance of club management and promoters less likely (Measham, 2004b). These changes included the use of the Antisocial Behaviour Act (2003) (specifically so-called 'crack house' closure laws) to shut dance clubs such as Brixton's The Fridge, as '*premises where drugs are being used unlawfully*'[6]. Most recently, the owner and the resident DJ of the Plymouth Dance Academy club were sentenced to nine years and five years respectively under Section 8 of the Misuse of Drugs Act for 'allowing' the sale of Class A drugs at their club (Drugscope, 2008).

The current policy agenda, including NTA and Drug Action Team targets, make it harder for drugs services to resource support and advice for recreational users of drugs such as ecstasy, whose use is characterised as non-daily, non-dependent and non-injecting, and therefore not associated with significant health or social problems, or drug-related acquisitive crime. Some services retain a commitment to provide support for non-NTA defined PDUs, but whereas providing 'young ravers' with advice and coping strategies for 'bad trips' were '*bread and butter issues for drug workers in the '90s*' (Gilman, 1992:21), there are now far fewer recreational drug users accessing support[7]. This suggests that there is a 'forgotten generation' of recreational drug users emerging in the 21st century for whom there is little targeted public health policy. This leaves this 'new chemical generation' hungry for credible information, as well as vulnerable to growing potential health risks from the new routes of ingestion of MDMA powder/crystal, along with the as-yet poorly researched consequences of

widening poly drug repertoires, for example, with reported increases in hospital emergency admissions for nasal problems and overdose related to snorting MDMA powder mistaken for cocaine (ACMD, 2009). Furthermore, a switch from pills to powder and the dabbing from shared packets of powder/crystal may result in individual users being less able to quantify their own consumption and keep within personal boundaries. A switch from ecstasy pills to MDMA powder/crystal may increase problems of dental decay, while also increasing opportunities for powder/crystal to be cut with adulterants and bulking agents at any stage along the supply chain, something not possible after the manufacturing stage with ecstasy in pill form. Finally, little is known about exactly when and where MDMA powder/crystal is being consumed, or whether users are experiencing problems when mixing MDMA powder/crystal with alcohol, given that the latter is now an entrenched feature of dance club culture.

Concluding thoughts

On the eve of the publication of the ACMD report reconsidering the potential harms of ecstasy and its Class A classification under the Misuse of Drugs Act, we need to be cautious in uncritically accepting the apparent decline in ecstasy use in national surveys such as the British Crime Survey. Our ongoing interviews with both suppliers and users suggest that MDMA powder/crystal in the late 2000s is being rebranded and sold as a 'premium' product whose appeal draws together experienced adult users of recreational drugs and club-goers in the mature, post rave dance club scene with a 'new chemical generation' in their late teens and early 20s attending live gigs, festivals and bars as well as clubs. Many of these new younger ecstasy users do not have the lay understanding of harm reduction pioneered in the north west of England in the 1990s and widely accessed by ecstasy users at that time. The lack of credible information combined with widening poly drug repertoires, emergent drugs and this rebranding of established drugs, together with the lack of a national, resourced 'recreational' drug policy for adults, means contemporary ecstasy users may also be the 'forgotten chemical generation'.

There remains cause for hope in light of emergent drug use trends highlighted here. Despite their image as risk-taking hedonists, recreational drug users do seek out and share lay harm reduction strategies, often being coupled with 'pleasure maximisation' strategies, the latter requiring greater consideration in drug research, policy and practice (Moore & Measham, 2006; 2008). For example, recreational drug users access internet-based resources such as http://www.erowid.org to obtain and exchange advice and information about their drugs of choice (Murguia *et al*, 2007), with experienced 'recreational' drug users frequently offering experiential 'knowledge' to young people new to dance club scenes (Tackett-Gibson, 2008). Helpfully, drug services themselves are keen to revive *Safer Dancing* initiatives, with recent interest expressed by adult and young people's services in both the north west and north east of England.

It would seem then that the time is ripe for a renewed focus on harm reduction initiatives aimed specifically at the weekend poly drug repertoires of young people frequenting the bars, pubs and clubs within the diverse and vibrant British night-time economy. Such initiatives will have their work cut out to tackle confusion around the risks, harms and pleasures of illegal drugs, exacerbated by recent changes to the Misuse of Drugs Act appearing to be more politically-driven than evidence-based. In addition, such harm reduction initiatives will need to overcome cynicism among drug-experienced young adults towards central government-driven health promotion and crime prevention campaigns, while working within the broader cultural context of individualism, commodification and 'consumer choice'. Of course, it remains to be seen whether ecstasy, in powder, pill, or crystal form, will retain its Class A classification under the Misuse of Drugs Act in the near future.

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Endnotes

[1] MDMA became a controlled drug in the UK in 1977 under the Misuse of Drugs Act (Modification) Order covering 'substituted amphetamines'. It has remained a Class A Schedule 1 controlled drug since then.

[2] According to a recent report by the UK's Serious and Organised Crime Agency (SOCA), the amount of active ingredient in ecstasy pills has fallen, from 100 milligrams per tablet in 2000, to 54 milligrams in 2007 (SOCA, 2008:34).

[3] See www.clubbingresearch.com for details.

[4] Whilst recognising the limitations of the 'recreational'–'problematic' dichotomy in terms of characterising patterns of drug use (eg. Simpson, 2003), we use the term 'recreational' here to describe non-daily, non-injecting and non-dependent use of drugs other than crack-cocaine and opiates taken predominantly in leisure and social settings, and distinguishable from problem drug use, rather than to imply that recreational drug use is in itself unproblematic.

[5] From 1995 to 2001 Manchester City Council provided Lifeline with an annual £10,000 *Safer Dancing* budget to attend events and produce two harm reduction leaflets for recreational drug users each year. Over the years, more stakeholders, (including the police) were keen to be involved in the initiative, each introducing elements of their own agenda. This began to shift the focus away from health promotion to criminal justice, ultimately quashing the initiative's original function. For example, see the Manchester Citysafe scheme (Strategy Unit, 2004:47).

[6] Antisocial Behaviour Act (2003) Chapter 38 available at http://www.opsi.gov.uk/acts/acts2003/ukpga_20030038_en_1

[7] Currently, statutory funding to provide advice and support around recreational drugs is generally allocated to young people's substance misuse services, which typically provide support to under 19s (in some cases, under 25s). The majority of their work deals with referrals through the criminal justice system or from parents, often focusing on heavy alcohol use, cannabis and increasingly cocaine. This, in most cases, does not allow much scope to develop and promote specific targeted harm reduction messages to young ecstasy users either in service or in an outreach capacity.