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Reflections on a two-year national pilot study of the Party Drugs Initiative (PDI)

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Louisa Degenhardt, Jennifer Stafford, Stuart Kinner, Jennifer Johnston, Craig Fry, Raimondo Bruno & Maria Agaliotis

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[1] Please note that in 2005 the Drug and Alcohol Services Council of South Australia underwent a name change to become Drug and Alcohol Services of South Australia (DASSA) and will be referred to as such in future IDRS publications.

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- Australian Bureau of Statistics (ABS);

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LIST OF ABBREVIATIONS

ACON	AIDS Council of NSW
ACPR	Australasian Centre for Policing Research
ACT	Australian Capital Territory
ADIS	Alcohol and Drug Information Service
AFAO	Australian Federation of AIDS Organisations
AFP	Australian Federal Police
AGAL	Australian Government Analytical Laboratories
ATS	amphetamine-type stimulants
BBVI	blood-born viral infection
CDHA	Commonwealth Department of Health and Ageing
DASSA	Drug & Alcohol Services South Australia
ERD(s)	Ecstasy and related drug market(s)
GHB (GBH)	gamma-hydroxy-butyrate ('grievous bodily harm')
IDRS	Illicit Drug Reporting System
IDU(s)	Injecting drug user(s)
KE(s)	Key Expert(s)
LSD	*d*-lysergic acid
MDA	3,4-methylenedioxyamphetamine
MDMA	3,4-methylenedioxymethamphetamine
NDARC	National Drug and Alcohol Research Centre
NDLERF	National Drug Law Enforcement Research Fund
NDS	National Drug Strategy
NIDIP	National Illicit Drug Indicators Project
NSP	Needle and Syringe Program

NSW	New South Wales
NT	Northern Territory
Qld	Queensland
REU(s)	**r**egular ecstasy user(s)
SA	South Australia
TAS	Tasmania
Vic	Victoria
WA	Western Australia

EXECUTIVE SUMMARY

The PDI is a national monitoring system for ecstasy and related drugs that is intended to serve as a strategic early warning system, identifying emerging trends of local and national interest in ecstasy and related drug (ERD) markets. The PDI was conducted across Australia for the first time in 2003; monitoring of these markets has been undertaken since 2000 in NSW, SA and Qld.

The PDI is based on the IDRS methodology and consists of three components:

1. interviews with regular ecstasy users (REUs), considered a sentinel group of drug users who could comment on these drug markets;
2. interviews with key experts (KEs), professionals who have regular contact with REUs through their work; and
3. indicator data sources related to ERDs.

The PDI monitors the price, purity, availability and patterns of use of ecstasy, methamphetamine, cocaine, ketamine, GHB and other related drugs. It also monitors harms related to these drug types. It is designed to be sensitive to trends, providing data in a timely manner, rather than describing issues in extensive detail.

The results of the two-year national pilot PDI indicate that regular ecstasy users tend to be young, relatively well-educated, and likely to be employed or engaged in studies. Small proportions of participants in all years were currently in drug treatment or had previously been incarcerated. This is in strong contrast to the demographic profile of the regular injecting drug users (IDUs) accessed for the IDRS, who are typically older, unemployed, and with both drug treatment and incarceration histories.

Details about the harms, patterns of use and the price, purity and availability of ecstasy and related drugs can be obtained from the national and jurisdictional reports in 2003 and 2004, which can be ordered from NDARC or downloaded from the NDARC website: http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.national; and http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.state. Additionally, quarterly Bulletins have been produced from the PDI, which can be downloaded from: http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.erds.

Aims of this report

This report is an evaluation of the national pilot PDI study. The data from the jurisdictions that undertook the PDI prior to the national pilot is, however, included in the present report. This additional data provides a good illustration of the trends in use over time and the value of monitoring these markets over time. The questions asked in this report are as follows:

1. Was the PDI successfully conducted in all Australian jurisdictions?
2. What were the strengths and weaknesses of the method?
3. Did the data from the PDI provide a unique source of information about illicit drug markets in this country?
4. Did the PDI provide a data source of use for policymakers, health, law enforcement and researchers in their understanding of trends in ERD markets?

1. Conduct of the PDI around the country

The PDI was successfully conducted around the country. Due to the relatively hidden nature of these markets, considerable work was required in those jurisdictions that had not conducted the PDI previously.

This points to the fact that good links with appropriate groups related to these markets is important. Researchers need to maintain a flexible and innovative approach to accessing and maintaining links with users, key experts and relevant agencies involved in events or groups who have contact with such users.

2. Evaluation of the method

Although the prevalence of ecstasy use in most Australian jurisdictions is substantial and increasing, reliable and valid information about the patterns and context of use, related harms and, in particular, about the nature of the drug market is difficult to gather. The PDI attempts to overcome these limitations using the well-established triangulation approach, combining user surveys, interviews with key experts and collation of existing indicator data.

The PDI was successfully implemented in all jurisdictions and the information provided by the PDI received positive feedback with regard to its validity and usefulness (see below). The trial demonstrated that the methodology employed herein allows the successful monitoring of the market for ecstasy. It was possible to collect data related to ecstasy that was as comprehensive as the data collected in the IDRS to monitor trends in the ecstasy and related drug markets. Ecstasy is the most widely preferred and widely used of all the drugs that could be classed as 'party drugs', and can rightfully be considered one of Australia's main illicit drugs, along with cannabis, methamphetamine, cocaine and heroin. Given the demonstrations of the capacity of the IDRS to successfully monitor trends in the markets for these drugs (Darke, Kaye, & Topp, 2002; Darke, Topp, Kaye, & Hall, 2002; Darke, Topp, & Ross, 2002; Topp, Degenhardt, Kaye, & Darke, 2002), and its relatively limited capacity to monitor the market for ecstasy, it is consistent that the methodology can be adapted to allow the effective monitoring of trends in a fifth major illicit drug market.

The trial also suggested, however, that the methodology is unlikely to enable the rigorous monitoring of trends in the markets for other related drugs, such as ketamine, LSD or GHB. Even among those that do use the less common other drugs, patterns of use tend to be less frequent than ecstasy use. Much of the use of these drugs is opportunistic in nature, and there are much fewer dedicated users of these drugs than there are dedicated users of ecstasy. As a result, even among those who report the recent use of other drugs, the extent of knowledge relating to their price, purity and availability tends to be relatively limited.

There is considerable variation in the extent to which markets for different illegal drugs are hidden. One factor, likely to influence how 'hidden' a drug market is, is the perceived stigma or risk associated with use of the drug. In this respect, one might expect the ecstasy market to be relatively accessible to researchers, given growing evidence of decreasing stigma associated with recreational drug use in general, and ecstasy use in particular (Duff, 2003). Indeed, recruitment of REUs for the PDI project is reasonably straightforward in most capital cities, and samples recruited in this way are reasonably representative of REUs in Australia, at least in terms of demographics and patterns of drug use (2004).

Another factor likely to impact on the effectiveness of ongoing monitoring is the degree to which the market is open or closed to entry by consumers and to public view. Particularly from a law enforcement perspective, it is easier to gather information about drug use and supply when this occurs in open, accessible locations (e.g. the street, nightclubs), when it is relatively easy for naïve users to enter the market (i.e. purchase and consume the drug), and/or when users of the drug are easily identified because their behaviour makes them conspicuous. REUs typically have *not* had contact with either law enforcement or health professionals for their drug use, so they may be considered a more "hidden" group of illicit drug users. This means that routine data sources may not be as useful as self-reported data to inform us about changes in drug use and the harms that users are experiencing.

The collation of extant indicator data sources relating to ecstasy and related drugs was the most difficult element. There were difficulties in identifying and accessing extant data sources relevant to ecstasy and related drugs. Fewer relevant data sources exist for ecstasy and related drugs than for the other illicit drugs such as heroin (Kinner, Fowler, Fischer, Stafford, & Degenhardt, 2005). Ecstasy is a relatively new drug in Australia's illicit drug markets. Moreover, as we have argued above, users of ecstasy and related drugs are a less 'visible' population than users of other illicit drugs, and are less likely to come into contact with various government and non-government agencies. As a result, compared to the data sources that exist for the other illicit drugs (e.g. heroin), fewer data sources exist which could provide information about trends in ecstasy and related drug markets.

It would be of considerable use to examine ways in which routine data collection systems might be able to collect specific data on ecstasy and related drugs. One first step in this direction would be the separation of ecstasy from other amphetamine-type stimulants (ATS) in health and law enforcement operational information systems.

In the meantime, the difficulties with the availability and accuracy of appropriate indicator data ensure that both KE and REU reports are even more important for the unique information they are able to provide about trends in ERD markets.

3. Uniqueness of the PDI

There is currently no other system in place in Australia to monitor trends in ecstasy and related drug markets. Due to previous NDLERF funded research, data on these markets exists in NSW, SA and Qld from 2000, and since 2003 in the remaining jurisdictions. We have repeatedly been informed that this is a unique data source on a relatively hidden population both within Australia and internationally.

Available indicator data are currently very limited in scope and detail. Key expert data are valuable, but the low level of users' contact with health and law enforcement agencies also limits the detail KEs can provide. Even more than with the IDRS, the user survey forms the backbone of the PDI. In order to provide a more balanced 'triangulation' of data for the PDI in future, better use needs to be made of existing data collected routinely across Australia.

As well as providing the only data from ecstasy and other drug users on these drug markets in a timely manner, the project identified existing data sources to integrate available information. As the target population has limited contact with health and law enforcement agencies, the indicator data that are currently collected have not been well examined or integrated to date, and are at present of limited value in monitoring these markets.

4. Usefulness of the data

One of the most consistent messages we have received about the PDI is that the unique nature of the information collected in the PDI has proved useful to agencies, researchers, treatment centres and law enforcement around the country. Reports were received from a variety of agencies about the uses to which the PDI data were put.

Implications

The IDRS methodology was successfully adapted and implemented across the country to monitor ecstasy and related drug markets. This enabled the collection of information that is not obtained through the IDRS.

Both users and KEs in both years of the national trial reported that the number of people using ecstasy had recently increased and that, in recent years, ecstasy has become a mainstream drug firmly established in the illicit drug landscape in Australia. These reports by users and KEs are validated by the results of the 2004 NDSHS, which indicated that the prevalence of both lifetime and recent use of ecstasy in Australia continues to increase especially among young adults. Prevalence of use increased again in 2004, with ecstasy now established as the second most commonly used illicit drug in Australia among young adults. Indeed, a youth culture that revolves around the use of drugs like ecstasy and associated trends in music and fashion is evident not only in Australia but throughout the Western world (Griffiths et al., 1997).

To confidently determine trends in the market according to jurisdiction, data would need to be collected on an ongoing basis. In states where data has been collected for longer periods, there are some indications that suggest the quantity and frequency of ecstasy use among these samples of regular users may have increased. These quantitative self-report data obtained from users are supported by the impressions of some KEs across all jurisdictions, who reported increased use of ecstasy and other drug use among users with whom they had recent contact.

Continued monitoring of the market for this drug will ensure policymakers are able to respond to changes in the market or in the nature and extent of ecstasy-related harms in a timely fashion, as has been enabled through the routine conduct of the IDRS since 1996. It will also enable the regular collection of indicative data relating to the size of the markets for other drugs, such as GHB and ketamine, and will point to the need for research specific to such drugs as and when it arises.

1. Introduction

The PDI is a national monitoring system for ecstasy and related drugs that is intended to serve as a strategic early warning system, identifying emerging trends of local and national interest in ecstasy and related drug (ERD) markets.

In 2000-2001, the National Drug Law Enforcement Research Fund (NDLERF) funded a two year feasibility study for the examination of trends in ERD markets in New South Wales (NSW) and Queensland (Qld); a similar study was self-funded in South Australia (SA) (Breen, Topp, & Longo, 2002; Longo, Humeniuk, Topp, Christie, & Ali, 2002; Topp, Breen, Kaye, & Darke, 2004). The study was continued on a self-funded basis in 2002 in SA and NSW (White, Breen, & Degenhardt, 2003).

Following the review of this feasibility study (Breen et al., 2002; L. Topp, C. Breen et al., 2004), a two-year national pilot study was funded in 2003 and 2004 to monitor emerging trends in the markets for ERDs across the country (Breen et al., 2004; Stafford, Degenhardt, Agaliotis et al., 2005). The 2003 and 2004 PDI national reports are available from the NDARC website, namely: http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.national. Jurisdictional reports are available from http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.state. This report evaluates the national pilot study.

1.1. Aims of this report

This report is not designed to provide an overview of the data collected over the two years of the national pilot study. A considerable amount of information was collected on a jurisdictional and national level, which has been published in the 2003 and 2004 PDI *Drug Trends Reports* series. The reader is strongly encouraged to refer to these reports for full detail on the findings of the pilot in each state and territory.

We have, however, included a summary of some of the findings of the pilot study. This is to provide some context to the reader in which to consider the discussion of the methodological issues and usefulness of the PDI. The national and jurisdictional reports contain a large amount of information that we have summarised somewhat for the purposes of the current report.

This report is an evaluation of the pilot PDI study. The data from the states that undertook the PDI prior to the national pilot is, however, included in the present report. This additional data provides a good illustration of the trends in use over time and the value of monitoring these markets over time. The questions asked in this report are as follows:

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4. Did the PDI provide a data source of use for policymakers, health, law enforcement and researchers in their understanding of trends in ERD markets?

The report will briefly summarise the findings of the PDI before answering these questions.

2. Method

2.1. Method of the PDI

The PDI used the methodology trialled in the feasibility study (Breen et al., 2002; L. Topp, C. Breen et al., 2004) to monitor trends in the markets for ERDs. The three main sources of information used to document trends were:

1. face-to-face interviews with current regular ecstasy users (REUs) recruited in each capital city across Australia;

2. face-to-face and telephone interviews with key experts (KEs, formally known as key informants) who, through the nature of their work, have regular contact with REUs; and

3. indicator data sources such as the purity of seizures of ecstasy analysed and community prevalence of use data drawn from the National Drug Strategy Household Surveys.

These three data sources were triangulated to provide an indication of emerging trends in ERD markets.

2.1.1. Survey of regular ecstasy users

The sentinel population chosen to monitor trends in ecstasy and related drug markets consisted of people who engage in the regular use of the drug sold as 'ecstasy'. Although a range of drugs falls into the category 'ecstasy and related drugs', ecstasy is a drug that can be considered one of the main illicit drugs used in Australia. A growing market for ecstasy (mostly tablets, sold purporting to contain 3,4-methylenedioxymethamphetamine (MDMA) has existed in Australia for more than a decade. Indeed, ecstasy is the second most widely used illicit drug after cannabis, with one in eight (12.0%) 20-29 year olds and 4.3% of 14-19 year olds reporting recent ecstasy use in the 2004 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2002).

In contrast, other drugs that fall into the class of 'ecstasy and related drugs' have either a lower prevalence of use (e.g. LSD), fluctuate in availability (e.g. 3,4-methylenedixoyamphetamine (MDA), or are relatively new in the market and are not as widely used as ecstasy (e.g. ketamine and gamma-hydroxy-butyrate (GHB). It has been suggested that it would be difficult to identify a regular user of GHB or ketamine (Topp & Darke, 2001), who was not also an experienced user of ecstasy, whereas the reverse will often be the case. Further, ecstasy may be the first drug with which many young Australians who choose to use illicit drugs will experiment and a minority of these users will go on to experiment with the less common related drugs such as ketamine and GHB.

The entrenchment of ecstasy in Australia's illicit drug markets relative to other related drugs underpinned the decision that regular use of ecstasy would be used as the defining characteristic of the target population of the PDI (Topp & Darke, 2001). In addition, as there has been an indication of increases in use and controversy regarding the neurotoxicity of ecstasy, more information on ecstasy users was considered beneficial. A sample of this population was

successfully recruited and interviewed in the two-year feasibility trial. Therefore, REUs were used again in the national pilot study in 2003 and 2004 to provide information on ecstasy and related drug markets.

Recruitment

In the two-year national pilot study a total of 809 REUs were interviewed in 2003 (NSW, n=102; ACT, n=66; Vic, n=100; TAS, n=100; SA, n=101; WA, n=100; NT, n=104; Qld, n=136); and 852 REUs in 2004 (NSW, n= 104; Qld, n=161, ACT n=116, and 100 each from Vic, TAS, SA and WA and 71 from the NT).

The sample size was predetermined, with each state aiming to interview at least 100 REUs in both 2003 and 2004. Although the same recruitment strategies were employed in the NT in 2004 as in other jurisdictions, 100 eligible participants were not identified within the required timeframe. This may indicate a more hidden population, or reflect a smaller population of REUs in this jurisdiction.

In previous years a total of 194 REUs were interviewed for the 2000 PDI (NSW n=94; Qld n=50; SA n=50); 350 individuals were interviewed in 2001 (NSW n=163; Qld n=117; SA n=70). During 2002, NSW and SA self-funded the project to ensure consistency of the data series, recruiting a total of 156 REUs (NSW, n=88 and SA, n=68).

Participants were recruited through a purposive sampling strategy (Kerlinger, 1986), which included advertisements in entertainment and gay and lesbian newspapers, interviewer contacts, and 'snowball' procedures (Biernacki & Waldorf, 1981). 'Snowballing' is a means of sampling 'hidden' populations which relies on peer referral, and is widely used to access illicit drug users both in Australian (Boys, Lenton, & Norcoss, 1997; Ovendon & Loxley, 1996; Solowij, Hall, & Lee, 1992) and international (Dalgarno & Shewan, 1996; Forsyth, 1996; Peters, Davies, & Richardson, 1997) studies.

Initial contact was established through newspaper advertisements or interviewers' personal contacts. Following interviews, participants were asked if they would be willing to discuss the study with friends who might be able to provide the desired information.

Procedure

Participants contacted the researchers by telephone and were screened for eligibility. To meet entry criteria, they had to be at least 16 years of age (due to ethical constraints), have used ecstasy at least six times during the preceding six months, and have been a resident of the capital city in which the interview took place for the past year. As in the IDRS, the focus was on the capital city, as new trends in illicit drug markets are more likely to emerge in urban areas rather than in remote or regional areas.

All information provided was confidential and anonymous, and the study involved a face-to-face interview that would take approximately 45 minutes to complete. All respondents were volunteers who were reimbursed $30 for their participation. Interviews took place in varied locations, negotiated with participants, including the research institutions, coffee shops or parks, and were conducted by interviewers trained in the administration of the interview schedule. The nature and purpose of the study was explained to participants before informed consent was obtained.

Measures

Participants were administered a structured interview schedule based on a national study of ecstasy users conducted by NDARC in 1997 (Topp et al., 1998; Topp, Hando, Dillon, Roche, & Solowij, 2000), which incorporated items from a number of previous NDARC studies of users of ecstasy (Solowij et al., 1992) and powder amphetamine/methamphetamine (Darke, Cohen, Ross, Hando, & Hall, 1994; Hando & Hall, 1993; Hando, Topp, & Hall, 1997). The interview focused primarily on the preceding six months, and assessed demographic characteristics; patterns of ecstasy and related drug use, including frequency and quantity of use and routes of administration; the price, purity and availability of ecstasy and related drugs; risk behaviours (such as injecting, vaccinations, sexual behaviour, driving, tattooing and body piercing), self-reported symptoms of dependence, help seeking behaviour, and self-reported criminal activity; perceived physical and psychological side-effects of ecstasy; other ecstasy-related problems, including relationship, financial, legal and occupational problems; and general trends in ecstasy and related drug markets, such as new drug types, new drug users and perceptions of police activity.

Data analysis

In the 2003 and 2004 reports, for continuous, normally distributed variables, *t*-tests were employed and means reported. Where continuous variables were skewed, medians are reported and the Mann-Whitney *U*-test, a non-parametric analogue of the *t*-test (Siegel & Castellan, 1988), was employed. Categorical variables were analysed using χ^2. To investigate differences between states, dummy variables were created and an individual state was compared against all the others states combined. All analyses were conducted using SPSS for Windows, Version 12.0 (SPSS inc, 2004).

2.1.2. Survey of key experts

The eligibility criterion for key expert (KE) participation in the PDI was regular contact, in the course of employment, with a range of REUs throughout the preceding six months.

Interviews were primarily conducted face-to-face, except in NSW where most interviews were conducted over the telephone. The interview schedule was a semi-structured instrument that included sections on drug use patterns, drug availability, criminal behaviour, health issues and police activity. The majority of interviews took approximately 45 minutes to an hour to conduct. Notes were taken during the interview and the responses were analysed and sorted for recurring themes.

In 2000, a total of 46 KEs were interviewed. This increased to 63 KEs interviewed in 2001 and very few KEs were interviewed in 2002 (Approx. n=10). In the two-year pilot national study, a total of 143 KEs were interviewed in 2003 and 153 KEs in 2004.

Key experts were involved in a broad range of occupations including: involvement in the entertainment industry (DJs, party promoters, venue managers and events organisers); law enforcement (intelligence analysts, intelligence officers, commanders of local area commands and drug squad officers); and health professionals (drug treatment staff, medical officers, counsellors, health promotion officers and hospital emergency). Researchers, user group representatives and drug dealers also participated as KEs.

Many key experts reported they had contact with a range of REUs, although KEs also reported having contact with specific groups such as youth, women, injecting drug users, HIV+ people, and the gay and lesbian community.

Detailed reports of KE interviews may be found in each jurisdictional report available from the NDARC website at http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.erds

2.1.3. Other indicators

To complement and validate data collected from user surveys and KE interviews, a number of secondary data sources were examined. These included data from health, survey, research and law enforcement sources.

Data sources included:

- The National Drug Strategy Household Survey (NDSHS) (Australian Institute of Health and Welfare, 2002);
- Australian Crime Commission (formally the Australian Bureau of Criminal Intelligence and National Crime Authority) on the number and purity of seizures of ecstasy by state and federal law enforcement agencies analysed across sampling years, and on the number of drug-related arrests by drug type;
- Australian Customs Service; data on the number and weight of seizures of ecstasy, cocaine and methamphetamine made at the border;
- National Hospital Morbidity Database (NHMD) (Australian Institute of Health and Welfare);
- Alcohol and Other Drug Treatment Services-National Minimum Dataset (AODTS-NMDS) (Australian Institute of Health and Welfare);
- hospital emergency departments;
- cocaine and amphetamine-related overdose fatalities from the Australian Bureau of Statistics.

2.2. Approach taken to evaluate the PDI

This evaluation is an information evaluation by the PDI national co-ordinators, with contributions by a number of state collaborators. The evaluation was unfunded and as such this evaluation consists primarily of a discussion of the PDI methodology and outcomes, and their relevance to policy and practice. A summary of some of the PDI data collected over the last two years has been included to demonstrate the capacity of the PDI to monitor these ecstasy and related drug markets, and to illustrate that these markets are dynamic, and thus worthy of routine monitoring. Strengths and limitations of the PDI are also discussed, in the context of existing drug monitoring systems both nationally and internationally.

In addition, PDI research teams in each state were requested to provide some indication of how and where PDI findings have been of relevance to stakeholders in their jurisdiction. A comprehensive list of presentations and publications stemming from the PDI is also included, to support these jurisdictional reports.

3. Summary of PDI results

As previously mentioned, more detailed results are available from the individual national and state reports for each year from the NDARC website.

3.1. Ecstasy use in the general population

The lifetime prevalence of ecstasy use among the general population has increased from 1% in1988, to 4.8% in the 1998 survey (Appendix 1). In the 1998 survey, more than double the proportion of respondents reported ecstasy use in the preceding twelve months compared to the previous three surveys, in which reported recent use had remained stable at about 1% (Appendix 1). In 2004, 7.4% of respondents reported that they had used ecstasy at some point, with 3.4% reporting past year use[2] (Australian Institute of Health and Welfare, 2005).

Prevalence of ecstasy use varies slightly according to gender, although differences are modest compared to other drugs. In the 2004 NDSHS (Australian Institute of Health and Welfare, 2005), 6.0% of females and 9.1% of males reported ecstasy use at some point in time. Recent ecstasy use was reported by 4.4% of males and 2.4% of females in 2004. In the 2004 NDSHS, the prevalence of both lifetime and recent ecstasy use were most common among those aged 20-29 years. Approximately 26% of males and 18% of females in this age bracket reported lifetime ecstasy use, with 15% of males and 9% of females reporting having used ecstasy in the preceding 12 months (Australian Institute of Health and Welfare, 2005).

The availability of ecstasy has also increased in recent years, as indicated by the proportion of NDSHS respondents reporting having been offered ecstasy. In 1988, 4% of the population reported having been offered ecstasy at some point in their lives, compared to 7% in 1991 and 6% in 1993. In 1995, the focus of the questions in the survey changed from lifetime exposure to exposure in the preceding 12 months. In 1995, 3% of the sample reported past year exposure to ecstasy, compared to 8% in 2004 (Australian Institute of Health and Welfare, 2005). There was a particularly high prevalence of exposure among young adults. In 2001, 16.4% of 14-19 year olds and 24.1% of 20-29 year olds had had the opportunity to use ecstasy in the past 12 months.

[2] In the 2001 and 2004 survey, changes to the methodology of the NDSHS were implemented to make the 2001 survey more comparable with general population surveys conducted in the United States. Many people working in the field agree that the change in the wording of the question relating to lifetime use of drugs (from having ever 'tried' to having ever 'used') may have led to fewer people being willing to report that they had 'used' (as opposed to 'tried') illicit drugs. In general, the prevalence of use of most illicit drugs appeared to decrease between 1998 and 2004, which may reflect, at least in part, the change to the methodology. However, even in the face of the methodological change and the trend toward an apparent decrease in prevalence of illicit drug use in general, reported lifetime prevalence of ecstasy use still increased between 1998 and 2004, from 4.8% to 7.5% of the general population. Similarly, the proportion of the general population who reported that they had used ecstasy in the preceding 12 months also increased, from 2.4% in 1998 to 3.4% in 2004.

3.2. Demographics of regular ecstasy users

The results of the two-year national pilot PDI indicate that regular ecstasy users tend to be young, relatively well-educated, and likely to be employed or engaged in studies. A variety of cultural backgrounds were represented, with the majority of participants from English speaking backgrounds.

Small proportions of participants in all years were currently in drug treatment or had previously been incarcerated (Appendix 2). This is in strong contrast to the demographic profile of the regular injecting drug users (IDUs) accessed for the IDRS, who are typically older, unemployed, and with both drug treatment and incarceration histories (Stafford, Degenhardt, Black et al., 2005). It is also consistent with the conception that this group represent a relatively "hidden" group of illicit drug users, many of whom do not come to the obvious attention of health or law enforcement services.

Appendices 3 and 4 present demographic data for the 2003 and 2004 sample of REUs in each state. The demographic characteristics of REUs recruited were generally consistent across jurisdictions and years with small differences.

3.3. Patterns of ecstasy use

The REUs interviewed as part of the two-year national pilot study described a wide range of patterns of ecstasy and other drug use (Appendix 5). The median age at which participants first used ecstasy was 18 years. Participants in both years had all used ecstasy at least monthly at some time (reflecting eligibility criteria), using on a median of 12 days in 2003 and 18 days in 2004.

Fifty one percent of the 2003 sample and 46% of the 2004 sample had used ecstasy between monthly and fortnightly in the six months preceding interviews. Thirty four percent of the 2003 sample and 29% of the 2004 sample reported using between fortnightly and weekly, while 17% of the 2003 and 25% of the 2004 sample had used ecstasy more than one day per week. Around half of the sample in each year nominated ecstasy as their favourite or preferred drug. The next most commonly preferred drug was cannabis, followed by methamphetamine powder.

The median number of ecstasy tablets taken in a 'typical' or 'average' use episode in the preceding six months was 1.5 (range 0.5-15) in 2003 and 2 (range 0.5-21) in 2004. Over half of both samples reported that they typically used more than one tablet (57% in 2003, 69% in 2004). During their 'heaviest' use episode in the preceding six months, participants reported the use of a median of 3 tablets (range 0.5-60) in 2003 and 4 tablets (range 0.5-96) in 2004. It should be noted that an 'episode' of use does *not* mean one administration, but rather the period across which the person was consuming drugs (for example, many users report that they have taken drugs across a 48 hour period without sleeping or resting). The high number could, nevertheless, reflect some misreporting by participants.

Many REUs had binged on one or more drugs in the six months preceding interview. The most commonly reported drugs used in a binge were methamphetamine powder, crystal methamphetamine and methamphetamine base. This is consistent with the pharmacological effects of methamphetamine.

Most participants 'typically'[3] used other drugs in combination with ecstasy (91%, 93%) and in the 'comedown' (acute recovery period) following ecstasy use (83% and 78%, in 2003 and 2004 respectively). Alcohol and tobacco were the most commonly reported drugs used with ecstasy.

Swallowing ecstasy was the main route of administration reported by the majority in all stages and this has remained fairly stable over time. The consistencies between years regarding routes of administration are noteworthy (Appendix 8). In the six months preceding the interview, almost all participants had swallowed ecstasy. The majority of participants in both years nominated oral ingestion as their main route of ecstasy administration in the preceding six months.

Thirty percent of the 2003 sample and 23% of the 2004 sample reported they had injected a drug (Appendix 8) in their lifetime. A total of 17% of the 2003 sample and 13% of the 2004 sample had injected ecstasy at some time in their life. The median age of first injection of ecstasy was 22 years (range 12-46 years) in 2003 and 21 years (range 15-49 years) in 2004.

3.3.1. Jurisdictional patterns

To examine trends and confidently interpret changes in patterns of ecstasy use over time, data needs to be collected in all states in consecutive years. In all states the age of first ecstasy use has remained relatively stable over time (Appendix 6 and 7). Some indicators from the PDI are consistent, however, in suggesting that the quantity of ecstasy use among regular users may have increased in recent years. Comparing 2003 to 2004, the median number of days used ecstasy increased in NSW, the ACT, Vic, SA and the NT.

In NSW, the proportion of REUs who nominated ecstasy as their 'favourite' drug has gradually increased since 2000; this was the case in Vic, TAS and the NT since 2003.

In the majority of states the median number of tablets used in a `typical' session is around 2 tablets, with the number of people typically using greater than one tablet increasing between 2003 and 2004 in all states except in the ACT, where it decreased slightly. Recently binging on ecstasy (> 48 hours) decreased between 2003 and 2004 in all states except in SA.

3.4. Patterns of polydrug use and risk

PDI data in both years indicated that regular ecstasy users are typically polydrug users. In 2004 participants reported having used a mean of 9.5 drug types (range 1-19) in their lifetime, and a mean of 6.6 drug types (range 1-15) in the preceding six months[4]. Although regular ecstasy users across jurisdictions were polydrug users, the drugs used differed across jurisdictions. This may reflect variation in the preferences of ecstasy users across the country and/or variation in the availability of different drugs (Appendix 11 and 12).

The use of GHB was documented in all jurisdictions, although it appeared to be more common in the more populous States (Vic and NSW). Again, changes in use of GHB were most clearly documented for states in which this data collection had been conducted for a greater period of time (see below). The increase in the proportions of users reporting the use of 'crystal' and GHB

[3] Defined as on two-thirds or more occasions of ecstasy use in the preceding six months.
[4] Note: In 2003 the result is out of a possible 18 drug types and in 2004 19 drug types.

in 2001 was consistent with KE reports. Given concerns about the risks associated with the use of GHB, monitoring of trends in GHB use and availability is clearly warranted, particularly given the overdose risks with GHB, especially when combined with another depressant such as alcohol.

The level of use of methamphetamine powder ("speed") across jurisdictions appears to be remaining stable or somewhat reducing over time. This is in contrast to increases observed in "base" and "crystal" methamphetamine use, which have been documented in all jurisdictions. The increase in use of the more potent forms of methamphetamine is particularly clear for those jurisdictions for which there are more years of data (see below).

Close monitoring of the expanding methamphetamine market is required, particularly in terms of the use and impacts of crystal methamphetamine, as the availability of this more potent form of the drug appears to have increased in recent years. There is growing interest among health professionals in examining the use of this form of the drug and its potential impact on unsafe sex. The relationship between crystal methamphetamine and unsafe sex is likely to be a complex one, but the association (and the reasons for it) deserves greater attention (Degenhardt, McGuigan, & Clayton, 2005)

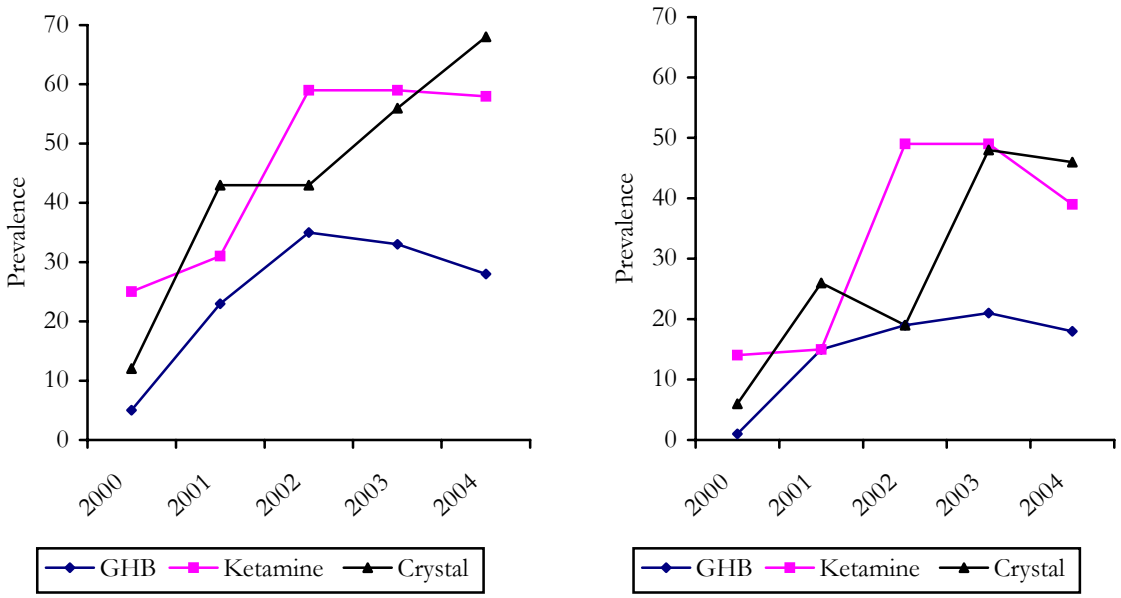
The use of ketamine among this group also appears to have increased over past years. Reported lifetime ketamine use was 40% in 2003 and 2004, while use in the last 6 months was reported by around one in four REUs in 2003 (26%) and 2004 (23%). In contrast, in states with monitoring of this group for longer time periods, this level of use seems to be higher than the levels recorded in 1997 (for NSW) and 2000 (NSW, SA and Qld; see below).

3.4.1. Jurisdictional patterns

The use of GHB and ketamine were more commonly reported in NSW, Vic and SA. In contrast, the use of psychedelic drugs was more common in TAS. Methamphetamine use patterns also differed across jurisdictions, with use of the stronger forms of methamphetamine higher among ecstasy users in WA and SA. Consistent with user reports of cocaine availability, the highest rates of cocaine use in the country were reported in NSW and Vic. The frequency of ecstasy use was highest in Qld (as it had been in 2003), suggesting that the potential risks of more frequent ecstasy use are a pertinent issue in this jurisdiction. The documentation of these different drug use patterns across the country clearly reinforced the utility of conducting the PDI across jurisdictions.

Since 2000, the lifetime use and recent use in the last six months of base, crystal, MDA and ketamine has increased in NSW and slightly in SA and Qld. NSW also documented an increase in the lifetime and recent use of GHB. The use of powder methamphetamine (speed) decreased in SA and Qld and remained stable in NSW since 2000 (Appendix 11 and 12). For illustrative purposes, NSW data from 2000 is presented below for crystal methamphetamine, GHB and ketamine (Figure 1).

Figure 1: Lifetime and 6-month prevalence of crystal methamphetamine, GHB and ketamine, NSW 2000-2004



Source: PDI regular ecstasy user interviews

In 2004, the ACT, Vic and TAS reported a decrease in recent use of a number of drugs, in particular crystal, LSD, MDA, amyl nitrate, nitrous oxide and ketamine, compared to the proportions reported in 2003. The ACT and TAS also reported a decrease in GHB use; however, Vic reported an increase. At the same time, in the NT (in 2004) the recent use of base, MDA, amyl nitrate, nitrous oxide, ketamine and GHB increased and recent crystal use remained stable. In WA, the use of most drugs remained stable between 2003 and 2004 (Appendix 11 and 12).

In those states where data have been collected since 2000, the recent use of cocaine has decreased. However, in those states where data have only been collected since 2003, recent cocaine use has increased, except in WA where it remained stable.

It was clear that regular ecstasy users are less likely to come into regular contact with either health or law enforcement agencies than other populations of illicit drug users such as injecting drug users. This is not to say that this group does not report (or experience) harms related to their illicit drug use: significant proportions report a range of risk behaviours, acute health harms, and a significant minority report engaging in drug dealing for cash profit. This places users at risk of interdiction by law enforcement in the short term, and of health harms in the longer term related to sex, injecting and other drug risk behaviours. Despite little access to drug treatment services, one third of the REUs reported being concerned about their ecstasy use, suggesting unmet treatment needs for this group.

3.5. Price, purity and availability of ecstasy

In 2003 and 2004, participants were asked 'How much does ecstasy cost at the moment?'. Nationally, the average price of a single ecstasy tablet was AUD$35 for both years. In NSW, SA, Qld and the ACT, the average price of a single ecstasy tablet has remained stable at $35 over the

last couple of years. Vic reported the cheapest average price of $30 in 2003 and 2004, while in WA and the NT the price of a single ecstasy tablet was $50 per tablet in 2004.

When asked if the price had changed in the last six months, the majority reported the price as stable (64% in 2003 and 60% in 2004). Substantial minorities reported the price as decreasing.

Participants were asked how they paid for ecstasy in the preceding six months. The two most common methods reported in 2003 and 2004 were using money from their paid employment (78%, 82% respectively) and being given ecstasy by friends (64% both years).

When asked about the purity of ecstasy in the last six months, in 2003 the majority reported the purity as medium (35%) and in 2004 the majority reported the purity as high (32%). Purity was reported as fluctuating over the last six months by about a third of participants in both years (35%, 34% respectively).

Data from the Australian Customs Service suggests an increase in the number and weight of seizures of ecstasy in recent years. It appears that the number of seizures of ecstasy tablets is gradually increasing, with 294 detections of MDMA at the Australian border in 2003/04 weighing a record 873 kg (Appendix 13). So-called 'real' ecstasy (MDMA) is generally thought to be imported through West Germany, Belgium, France and Holland, while locally produced tablets often do not contain MDMA (Australian Crime Commission, 2005). The possibility of increased supply of methamphetamine-based tablets sold as ecstasy, and produced in South East Asia, remains significant and should be closely monitored in coming years.

Tablets sold as ecstasy have remained readily available across the years of the PDI pilot, with the great majority of participants describing the drug as 'very easy' or 'easy' to obtain in 2003 and 2004. Availability was reported as stable over the last six months (64% both years). The majority of users across all states considered that ecstasy was either 'very easy' or 'easy' to obtain (Appendix 14 and 15), and similar proportions reported that the availability had either remained stable or increased in the preceding six months.

The majority of participants in 2003 and 2004 reported that in the six months preceding the interview they had obtained ecstasy from friends (86%, 82%) or dealers (62%, 57%). Other people from whom ecstasy had recently been obtained included acquaintances (reported by 31% in 2003 and 34% in 2004); people unknown to participants (usually dealers selling tablets in entertainment venues; 11% in 2003, 19% in 2004); and work colleagues (14% in 2003, 13% in 2004).

Ecstasy was most often *obtained* in private homes. Other purchase locations included nightclubs, raves/dance parties, and pubs. The usual venue participants reported *using* ecstasy included a nightclub, raves/dance parties, and private parties.

The increased use of ecstasy in venues other than the 'traditional' rave and dance parties is significant for a number of reasons, and also warrants close monitoring in coming years for a number of reasons:

(1) use in a specified cultural context is arguably safer, and use is more likely to be moderate in this context;
(2) use at private parties is arguably harder to monitor; and
(3) this trend may be related to increased law enforcement activity around raves and dance parties – monitoring of this trend will inform us regarding some indirect impacts of law enforcement demand reduction efforts.

In all jurisdictions, similar proportions of participants reported that they normally obtained ecstasy from friends and from work colleagues (Appendix 14 and 15). Substantial proportions of participants reported that they normally obtained ecstasy through dealers, acquaintances, or persons unknown to them.

It was common for participants to report that they obtained ecstasy at a dealer's home and on the street (from a known dealer). This may reflect the diversification of the low-level ecstasy supply market. The results may also reflect the increase in the number of dealers who are willing to make 'home deliveries' (a trend with all drugs), as well as an increase in the number of dealers who operate through a mobile phone, meeting customers in a designated meeting spot to exchange drugs and money. Relatively few REUs reported purchasing ecstasy from an unknown dealer on the street or any other public location.

In summary, these findings suggest that ecstasy supply and purchase occurs within a relatively social context at the consumer level. The increasing range of locations within which ecstasy is used may reflect the increasing spread of this drug into a range of social contexts in Australia, and may also carry with it unique issues related to the reduction of harm of an acute nature.

3.6. Price, purity and availability of drugs other than ecstasy

Smaller numbers of participants were able to comment on the price, purity and availability of drugs other than ecstasy, and, accordingly, these data should be interpreted cautiously. Indeed, the lack of data relating to these drugs suggests relatively limited recent exposure among this sample, and that they are not as widely available, or at least not as widely used as ecstasy in these populations.

Appendix 16 and 17 present results relating to the price of LSD, methamphetamine (speed, base and crystal), MDA, ketamine and cocaine in NSW, Qld and SA from 2000 to 2004 and in the other states for 2003 and 2004. No data are available for Qld in 2002. GHB is not presented in the tables, as very few participants were able to comment on price. Small numbers reported on the prices of ketamine and these results should be interpreted with caution.

With only a small number of participants reporting on the price of drugs such as GHB and ketamine, there is still some uncertainty on the price of quantities purchased. Initially it was thought that people were reporting purchasing GHB by the gram; however, after a study with GHB users (Degenhardt, Darke, & Dillon, 2002), it was thought to be more commonly purchased by the millilitre. Future studies could clarify this issue by determining the price and most common amount purchased with a dedicated sample of GHB users.

The relatively small numbers of participants who felt confident enough of their knowledge about other drugs (other than ecstasy) to comment on their price, purity and availability suggests limited exposure to such drugs among these samples. Although there appear to be small numbers of "dedicated" GHB and ketamine users, much of the use of these drugs appears to be opportunistic in nature, and therefore infrequent relative to the use of ecstasy. Whereas many participants who participated in this trial would be willing to expend considerable effort to obtain ecstasy, relatively few would place the same emphasis on obtaining LSD or GHB. Consequently, many people who report the recent use of such drugs may not deliberately seek them out, and hence are unfamiliar with market indicators such as changes in their price, purity and availability. The relatively low rate of exposure among the sample is in itself an indicator of

the smaller size of the markets for them. Ongoing monitoring would allow the detection of any expansion in the market.

3.7. Risk behaviours

In 2004, additional risk questions were incorporated into the questionnaire and presented in individual state reports. There was also more detailed examination of the following:

- Examination of injecting drug use, blood borne virus infection and risk behaviours;
- Examination of sexual activity and sex risk behaviours, with some consideration of the role of different drug types in risky sexual activity;
- Examination of the characteristics of persons reporting "binge" alcohol use when using ecstasy, in comparison with those reporting low level alcohol use and no alcohol use, with the aim of considering the association between binge alcohol use, risk and harm;
- Consideration of overdose and treatment seeking behaviours by regular ecstasy users, with the aim of identifying potential risk factors for both negative consequences of drug use and help seeking behaviours;
- Examination of the characteristics of person reporting smoking (insufflation) of crystal methamphetamine, and identification of changes in the prevalence of this behaviour;
- Examination of drug use patterns and risk behaviours of persons according to sexuality.

3.7.1. Injecting risk behaviours

One in five (22%) of the national sample reported having injected at some time in their lives and 69% of whom reported injecting in the six months preceding interview. A median of three drugs (range 1-13) had ever been injected while those who reported injecting in the preceding six months had injected a median of two (range 1-9) drugs during this period (Appendix 18). Those who reported injecting a drug at some time in their life first did so at a mean age of 21 years and had been injecting for a median of six years. Speed was the most common drug ever injected (75%), followed by base (62%), crystal (58%) and ecstasy (58%, Appendix 19). The drugs injected in the past six month were similar.

One third (32%) of lifetime injectors reported injecting for the first time while under the influence of drugs (mainly cannabis and alcohol). Of those that first injected while under the influence of drugs, the most common drug injected was speed (47%) followed by heroin (20%).

When lifetime injectors were asked to specify how they learned to inject, two thirds (66%) reported that a friend or partner showed them how. Around one in five lifetime injectors (17%) reported that they did not inject themselves and another 17% reported another user taught them. A further eight respondents each reported been taught by outreach workers, seven from an information pamphlet, six from a health professional, five were self taught, two people from a website and two from a sibling and one person reported from a book.

Needle sharing was uncommon among this group. Of those that injected in the preceding six months, only one percent reported using a needle after someone else in the month preceding interview. Ten percent (n=13) reported that someone had used a needle after them in the preceding six months. Nearly half (46%, n=60) of recent injectors reported using other injecting equipment after someone else, with spoons (28%) being most common. Tourniquets (21%) were other commonly reused paraphernalia followed by water (18%) and filters (15%).

Most (75%) recent injectors reported they injected themselves 'every time'. While two thirds (66%) of recent injectors reported usually injecting with close friends, one third (29%) reported usually injecting with a regular sex partner and a quarter (21%) typically injected alone (Appendix 21). The median number of times injected by recent injectors in the preceding six months was 30 times.

The majority of recent injectors reported injecting at home (79%) or friends' homes (66%) in the previous six months. A third reported injecting in a car (35%) or at dealers' homes (28%) and a further quarter reported injecting on the street (19%), or in a public toilet (18%) or venue toilet (15%; such as night clubs and pubs). A potentially risky behaviour engaged by the majority (76%) of recent injectors in the preceding six months was injecting while under the influence or coming down from the effects of drugs (Appendix 22).

The majority of recent injectors obtained needles from needle and syringe programs (NSPs) (67%) or chemists (38%) in the preceding six months. Nine participants (7%) reported difficulty obtaining needles in the preceding six months, the majority of whom reported opening hours of services to be the reason they were unable to obtain sterile injecting equipment.

3.7.2. BBVI

Blood-born viral infection (BBVI) vaccinations and testing may be considered a marker of awareness of the risks involved with injecting. Therefore, those who reported injecting in the preceding six months were compared to those who reported never having injected a drug, to investigate whether they were more likely to report hepatitis B virus (HBV) vaccination, hepatitis C virus (HCV) and human immunodeficiency virus (HIV) testing.

Forty two percent of the national sample reported that they have never been vaccinated for HBV. A further 40% reported that they had completed the vaccination schedule, 8% did not finish the vaccination schedule and 10% did not know if they have been vaccinated. There was no significance difference between participants who had injected at some stage in their life or in the preceding six months and had completed the three dose schedule of HBV vaccinations compared to those who never injected.

Participants were asked if they have been tested for HCV. Of the national sample 47% reported that they had never been tested for HCV, 26% had been tested in the last year, 17% were tested more than a year ago, and 4% either did not know or didn't get their result. Of those that had ever injected, 56% had been tested for HCV in the last year compared to 64% of those who had injected recently. Eight percent (n=28) of the national sample were positive for HCV; of this number 27 participants were lifetime injectors and 25 participants were recent injectors.

Thirty two percent of the national sample had been tested for HIV in the last year and a further 19% had been tested more than a year ago. Lifetime (86% vs. 40%, OR, 9.0; 95% CI 5.4-15.0) and past year (65% vs. 23%, OR, 6.3; 95% CI 4.2-9.4) HIV testing was also more likely to be reported by recent injectors compared to those who had never injected. Of the national sample eleven participants reported that they were HIV positive. No significant difference in HIV prevalence was found between recent injectors and those who had never injected.

3.7.3. Sexual risk behaviours

As expected among a sample of young adults, the majority (93%) of participants reported penetrative sex[5] in the six months preceding interview. Given the sensitive nature of these questions, participants were given the option of self-completing this section of the questionnaire.

Of those who reported penetrative sex in the past six months, the largest proportion (45%) reported one sexual partner during the preceding six months. One fifth (19%) of participants had had penetrative sex with two people, and just over a quarter (27%) reported sex with between three and five people. Of those who reported penetrative sex in the preceding six months, the majority (84%) reported having sex with a regular partner and half (59%) reported sex with a casual partner.

Participants were asked about the use of "protective barriers" which were defined as "condoms, dams or gloves" with each partner type. Consistent with population-based surveys, the prevalence of using any barrier *every time (always)* was higher with casual (56%) compared to regular (26%) partners. Nearly a quarter (20%) of those who reported penetrative sex in the preceding six months had had anal sex. The frequency of anal sex was relatively low, with the majority (71%) of those who reported it having had anal sex less than monthly (Appendix 23).

As may be expected among a group with high levels of polydrug use, the majority (79%) of those reporting recent penetrative sex reported using drugs during sex in the previous six months. The highest was reported in NSW (90%) and lowest in WA (67%). Drug use during sex was reportedly frequent, with the majority reporting that drug use during sex had occurred at least three to five times (29%) in the preceding six months, followed by ten or more times (25%). The most commonly used drugs during sex were ecstasy (84%), alcohol (46%) and cannabis (36%). This pattern continued across the different jurisdictions (Appendix 9). Similar to protective barrier use generally, the use of any barrier *every time (always)* during sex combined with drug use was more common with casual (57%) compared to regular (24%) partners.

3.7.4. Driving risk behaviour

The PDI asked participants for the first time in 2004 about driving soon after taking a drug. Of the national sample 60% had driven within one hour of taking a drug. The drug most commonly taken was ecstasy (69%) followed by cannabis (57%), alcohol (52%) and speed (41%). Ecstasy was the most commonly taken drug prior to driving in all jurisdictions except in the ACT and TAS, which reported alcohol (Appendix 24).

3.8. Health-related issues

3.8.1. Overdose

Routine data collection systems (such as emergency departments and ICD-coded mortality data) are *not* currently well suited to providing accurate data on trends in overdoses related to ecstasy, GHB and other drugs used by this group. This is for a number of reasons, which are discussed in more detail in the methodology evaluation section. However, the data that could be collected suggested that there have been increases in recent years in the number of persons admitted to emergency departments for "overdoses" related to psychostimulants and other drugs such as

[5] Penetrative sex was defined as "penetration of penis or fist of the vagina or anus".

GHB. More work needs to be done to better adapt routine data collection systems to capture this information.

Data were obtained during the PDI from ecstasy users on their experience of overdose. In 2003 and 2004, participants were asked if they had overdosed on ecstasy or related drugs. Overdose was defined as 'passed out or fallen into a coma'. Of the 2004 sample, 16% had "overdosed" on either ecstasy or related drugs. The highest overdose rate was reported in ACT (28%) and lowest in QLD and SA (10%). Of those that had overdosed, the main drug used was alcohol (36%) followed by ecstasy (23%). Alcohol was most commonly reported in TAS (72%) and ecstasy in NSW (58%).

3.8.2. Self-reported dependence symptoms

First for the first time in 2004 participants were asked questions from the severity of dependence scale (SDS) for both ecstasy and methamphetamine; previous research has suggested that a cut-off of four is indicative of dependence for methamphetamine users (Topp & Mattick, 1997).

The median SDS score for ecstasy was one (range 0-15). There were no significant differences between genders in SDS scores. Of those that had used methamphetamine, the median SDS score was one (range 0-15), with 21% scoring four or above, considered to be indicative of dependence (Topp & Mattick, 1997). Of those that scored above four on the SDS, 38% reported specifically using crystal methamphetamine, 32% speed, 16% base and 17% reported no specific methamphetamine.

3.8.3. Help seeking behaviour

Participants were asked in 2004 if they had accessed any medical or health services in relation to their ecstasy and related drug use in the last six months. Of the national sample, 17% had accessed either a medical or health service in the preceding six months of the interview. Of those who had accessed help, the majority accessed their general practitioner (GP, 44%), followed by a counsellor (28%), drug and alcohol worker (21%), emergency department (15%), psychologist (12%), first aid (11%), ambulance (10%), psychiatrist (9%), hospital (9%) or social worker (8%).

Appendix 25 presents the proportion of participants who accessed health help by main drug used. For those who saw a GP (n=59) 39% reported that the main drug involved was ecstasy, followed by crystal meth (14%) and the main issue of concern was depression. A counsellor (n=37) was the next most assessed service, where the main drug of concern was ecstasy (27%) and the main issue was for dependence.

3.8.4. Other problems

Appendix 26 presents data relating to 'other problems' including occupation/study problems, relationship/social problems, financial or legal/police problems that the participant may have experienced in the six months preceding interview that they attribute to their drug use.

Relationship or social problems attributed to ecstasy and related drug use were reported by over a third of participants. Financial problems were reported by over one third of REUs in both 2003 (40%) and 2004 (38%). A small proportion across the years reported legal/police problems.

3.9. Criminal activity

3.9.1. Self-reported criminal activity among REUs

Self-reported criminal activity in the last month among REUs appears to have reduced over time: any crime reduced from 57% in 2000 to 24% in 2004 (Appendix 27).

Drug dealing was the criminal activity participants were most likely to have recently committed (ranging from 42% in 2002 to 19% in 2004), having sold drugs at least once in the month preceding the interview. It should be noted that many of these 'dealers' would not identify themselves as such, buying drugs to distribute among their friends and making little (if any) profit. Property crime, fraud and violent crime was reported by a small proportion from 2000 to 2004.

The number of participants arrested in the last 12 months has remained fairly stable during 2000 to 2004, ranging from 6% in 2002 to 11% in 2003.

The proportion of participants reporting involvement in any crime in the last month varied over the years and jurisdictions. The most common self-reported crime was drug dealing in all jurisdictions in all years, reducing to the lowest levels reported in 2004, except in the NT where it remained stable (Appendix 28 and 29). Similarly low rates of property, fraud and violent crime in the preceding month were reported in all states for all years.

In NSW, compared to the 2004 sample, larger proportions of the 2000 to 2003 samples reported having engaged in any crime in the month preceding interview. Drug dealing and recent property crime had the largest reduction from 40% in 2000 to 12% in 2004 for drug dealing and from 11% in 2000 to 0.5% in 2004 for property crime. Qld and SA also experienced similar drops for drug dealing and property crime between 2000 and 2004. The other states reported a reduction in drug dealing between 2003 and 2004. Reports for fraud and violent crime remained low in all states in all years.

3.10. Perceptions of police activity

The majority of participants in both years reported that police activity had either increased (more activity) or remained stable in the six months preceding interview (Appendix 30). In all years the majority of participants also reported that police activity did not make it more difficult for them to obtain drugs. Between 2003 and 2004 police activity was reported as more active in all states (especially Vic).

An increase in the visibility of uniformed police and more undercover agents around venues and on the streets between venues was commonly reported. The emergence of drug detector (sniffer) dogs was the most common change noted by participants in NSW, with disapproval of the routine use of the dogs to detect illicit drugs carried by patrons waiting in the queues outside venues.

4. Evaluation of the pilot

This section evaluates the utility of the methodology in terms of the achievements of the trial, points to areas where improved data collection methods could in the future allow more comprehensive and rigorous monitoring of ERD markets, and discusses some of the methodological issues encountered during the conduct of the two-year trial. Key questions addressed by this evaluation are:

1. Could the PDI be successfully conducted in all Australian jurisdictions?
2. What were the strengths and weaknesses of the method?
3. Did the data from the PDI provide a unique data source of use for policymakers, health, law enforcement and researchers in their understanding of trends in ERD markets?

Although the prevalence of ecstasy use in most Australian jurisdictions is substantial and increasing, reliable and valid information about use and, in particular, about supply of the drug is very difficult to gather. The PDI attempts to overcome these limitations, using the well-established triangulation approach, combining user surveys, interviews with key experts and collation of existing indicator data.

There is considerable variation in the extent to which markets for different illegal drugs are hidden. One factor, likely to influence how 'hidden' a drug market is, is the perceived stigma or risk associated with use of the drug. In this respect, one might expect the ecstasy market to be relatively accessible to researchers, given growing evidence of decreasing stigma associated with recreational drug use in general, and ecstasy use in particular (Duff, 2003). Indeed, recruitment of REUs for the PDI project is reasonably straightforward in most capital cities, and Topp, Barker and Degenhardt (2004) have demonstrated that samples recruited in this way are reasonably representative of REUs in Australia, at least in terms of demographics and patterns of drug use.

Another factor likely to impact on the effectiveness of ongoing monitoring is the degree to which the market is open or closed to entry by consumers and to public view. Particularly from a law enforcement perspective, it is easier to gather information about drug use and supply when this occurs in open, accessible locations (e.g. the street, nightclubs), when it is relatively easy for naïve users to enter the market (i.e. purchase and consume the drug), and/or when users of the drug are easily identified because their behaviour makes them conspicuous.

Available indicator data are currently very limited in scope and detail, and although key expert data are valuable, the low level of users' contact with health and law enforcement agencies also limits them. Even more than with the IDRS, the user survey forms the backbone of the PDI. In order to provide a more balanced 'triangulation' of data for the PDI in future, better use needs to be made of existing data collected routinely across Australia.

It would be of considerable use to examine ways in which routine data collection systems might be able to collect specific data on ecstasy and related drugs. An important step in this direction would be the separation of ecstasy from other ATS in health and law enforcement operational information systems.

4.1. Successful conduct of the PDI

The PDI was successfully implemented in all jurisdictions. The trial demonstrated that the method employed allowed the successful monitoring of the market for ecstasy. Given the demonstrations of the capacity of the IDRS to successfully monitor trends in the markets for these drugs, such as heroin and cocaine (Darke, Kaye et al., 2002; Darke, Topp, Kaye et al., 2002; Darke, Topp, & Ross, 2002; Topp et al., 2002), and the relatively limited capacity of the IDRS to monitor the market for ecstasy, it is reassuring that the methodology can be adapted to allow the effective monitoring of trends in a fifth major illicit drug market (Breen et al., 2002). The PDI also proved important for the information it provided on the extent of (and changes in) the use of various forms of methamphetamine among this group.

The PDI trial also suggested, however, that the methodology is unlikely to enable the rigorous monitoring of trends in the markets for other drugs, such as ketamine, LSD or GHB. This is directly related to the size of the markets for these drugs relative to the size of the market for ecstasy, and the level of their use among REUs. The demand for other drugs is possibly not as great as the demand for ecstasy, and as a result the market is much smaller, and it seems fairly clear that committed groups of (for example) GHB users have not been tapped using ecstasy use as a criterion for interview in the PDI. Even among those that do use the less common other ecstasy-related drugs, patterns of use tend to be less frequent than ecstasy use. Much of the use of these drugs is opportunistic in nature, and there are many fewer dedicated users of these drugs than there are dedicated users of ecstasy. As a result, even among those who report recent use, the extent of knowledge relating to the price, purity and availability of LSD, ketamine and GHB tends to be relatively limited.

Given that, at least currently, these markets are relatively small, it may be difficult to justify the investment required to monitor them specifically. We recommend, therefore, that any future monitoring of trends in the markets for ecstasy and related drugs employ REUs as the target sentinel population. Although such methodology is unlikely to allow rigorous monitoring of trends in the markets for other drugs, it is likely to detect any sizeable changes in the size of these markets. If the results of such monitoring suggested that there had been a rapid or significant expansion of any of these markets, further examination and perhaps monitoring of those markets would be justified. In the meantime, however, it would seem that smaller studies to provide detail about users of these less common drugs would probably be sufficient.

It is appropriate to consider the issues facing comparisons between different samples across time. In survey research, inferences about the entire population are drawn from the results of samples of the population (Kerlinger, 1986). By definition, illicit drug use is a hidden and socially stigmatised activity, so it is difficult, if not impossible, to define the parameters of an illicit drug-using population, and therefore to obtain a random sample of that population. Although it is appropriate to draw comparisons across time between random samples drawn from the same population – because such samples can be considered to represent the entire population (Kerlinger, 1986) – it is more difficult to do so when the samples to be compared are not random, and it cannot be confidently ascertained that they represent the entire population from which they were drawn.

The REUs recruited for the PDI pilot were obtained through purposive sampling, characterised by the use of judgement and a deliberate effort to obtain representative samples by including presumably typical groups in the sample (Kerlinger, 1986), rather than the more desirable probability sampling, in which each sampling unit has a known probability of being selected such

that inferences about the population can be derived from the sample with a measurable degree of precision (Lilienfeld & Lilienfeld, 1980). Although efforts were made to recruit a wide cross-section of participants as possible across years, it is not possible to state with complete confidence that one or both samples represented the entire population of REUs. Therefore, caution must be exercised when interpreting differences between the two samples as indicative of changes in the ecstasy market over the intervening years.

However, supporting the notion that such comparisons are reasonable, it should also be noted that the methodology of the two studies was identical. Recruitment methods (street press, dance music publications, gay and lesbian 'niche' market publications) and entry criteria were the same in both studies. It is therefore considered that drawing comparisons between the samples is an appropriate strategy and that doing so provided valid information on changes in the ecstasy market across years.

4.2. Strengths and weaknesses

4.2.1. Survey of regular ecstasy users (REUs)

There is considerable variation in the extent to which markets for different illegal drugs are hidden. One factor, likely to influence how 'hidden' a drug market is, is the perceived stigma or risk associated with use of the drug. In this respect, one might expect the ecstasy market to be relatively accessible to researchers, given growing evidence of decreasing stigma associated with recreational drug use in general, and ecstasy use in particular (Duff, 2003). Indeed, recruitment of REUs for the PDI project is reasonably straightforward in most capital cities, and samples recruited in this way are reasonably representative of REUs in Australia, at least in terms of demographics and patterns of drug use (Topp, Barker, & Degenhardt, 2004).

Another factor likely to impact on the effectiveness of ongoing monitoring is the degree to which the market is open or closed to entry by consumers and to public view. Particularly from a law enforcement perspective, it is easier to gather information about drug use and supply when this occurs in open, accessible locations (e.g. the street, nightclubs), when it is relatively easy for naïve users to enter the market (i.e. purchase and consume the drug), and/or when users of the drug are easily identified because their behaviour makes them conspicuous.

Although many REUs use ecstasy in nightclubs and at raves, only a minority report usually purchasing their ecstasy in a nightclub, rave or street. In most cases, REUs purchase their ecstasy in private homes – either their own home (35%), a friend's home (62%) or a dealer's home (42%). In the 2004 PDI only about one in twenty REUs reported usually purchasing ecstasy 'on the street', which is indicative of planned rather than opportunistic purchasing patterns.

Although a significant and increasing proportion of young Australians report recent ecstasy use, entry into this market as a consumer is not as straightforward as it may seem. While use of the drug is becoming increasingly open and normalised, access to ecstasy supply is still restricted by a series of unspoken but rarely challenged rules of conduct, with pre-arranged transactions typically occurring in private locations among trusted persons. Indeed, the development of trust is a prerequisite for access to a supplier in the ecstasy subculture (Parker, Williams, & Aldridge, 2002).

The quantitative survey of regular REUs was successfully conducted in all jurisdictions, and the results validated our choice of this population as the appropriate sentinel group. Through the administration of the quantitative interview schedule to the samples of regular REUs, information was collected regarding demographic characteristics, self-reported patterns of drug use and experience of associated harms, criminal behaviour, the price, purity and availability, and general trends in ecstasy and related drug markets.

4.2.2. Survey of key experts (KE)

The qualitative survey of key experts (KE) was also successfully conducted, and the data thus collected were used to validate and contextualise the quantitative reports of the REUs. The nature of these KE differed fundamentally from the types of KE recruited for the IDRS. This is a direct consequence of the less 'visible' nature of regular ecstasy users compared to injecting drug users.

Accessing key experts was both time consuming and challenging, but networks could be established that aided the recruitment of relevant KEs. KE interviews require links to be established with people involved in ecstasy and related drug markets and the music industry, and include the traditional health and law enforcement KEs (such as accident and emergency workers, police, peer educators and AOD workers), but also DJs, club owners, party promoters and medical personnel at dance parties.

There are fewer professionals in the law enforcement, health and criminal justice sectors who are knowledgeable about regular ecstasy users than about other groups of illicit drug users such as IDU. Many KEs are from within the ecstasy and related drug subculture itself. In other words, although such KEs do have regular contact with REUs through the nature of their work, they do not necessarily discuss in detail with users their drug use and associated topics, as many KE who participate in the IDRS are likely to do. As a result, their knowledge of the population and its practices tended to be less systematic and specialist than among KEs recruited in the IDRS. Notwithstanding these differences, it is still considered that the KE component of this methodological trial was successful, and provided an important source of data relating to trends in illicit drug markets against which to triangulate others. These KEs can, however, tell us some things that most IDRS KEs cannot, such as cultural context, consumer attitudes and so on. Given that PDI KEs include dealers, DJs and other individuals more closely involved with these sub-cultures, they are able to provide both market participant and market observer perspectives.

4.2.3. Indicator data

The collation of extant indicator data sources relating to ecstasy and related drugs was the least successful methodological component of this trial. There were difficulties in identifying and accessing extant data sources relevant to ecstasy and related drugs. Fewer relevant data sources exist for ecstasy and related drugs than for the other illicit drugs (Kinner et al., 2005). Ecstasy is a relatively new drug in Australia's illicit drug markets. Moreover, as we have argued above, users of ecstasy and related drugs are a less 'visible' population than users of other illicit drugs, and are less likely to come into contact with various government and non-government agencies. As a result, compared to the data sources that exist for the other illicit drugs, fewer data sources exist which could provide information about trends in ecstasy and related drug markets.

It is useful to identify some of the limitations of routine data collection systems:

1. Misclassification of drug types

In some cases (particularly for drugs such as GHB), routine data collections (such as emergency department surveillance systems) do not include the drugs as a separate drug type (for example, MDMA and GHB are not separately recorded under the International Classification of Diseases coding system); in some jurisdictions MDMA is recorded in the same category as methamphetamine.

2. Frequency of occurrence

Despite an apparently high proportion of REUs experiencing problems that may be defined as "overdose" (see below), and a known high prevalence of use of drugs such as ecstasy in the general population, relatively few cases of "overdose" were recorded for psychostimulant drugs in hospitals. This could represent: a) a low rate of problems related to the use of these drugs; b) diagnostic confusion (with medical professionals unaware of the reasons for the symptoms with which users may present); c) under-utilisation of health services by REUs who are experiencing acute problems related to their use; d) users' perceptions of what constitutes an "overdose"; or e) a combination of these factors.

3. Reasons for presentation

Some ERD users may be presenting to emergency departments for reasons other than their ecstasy use. A recent study found that methamphetamine dependent users were more likely than non-dependent users to present to emergency departments, and that those who presented were more likely to be heroin users who were presenting for problems related to their heroin use (Kelly, McKetin, & McLaren, in press). Limited access to health services was determined to be an important issues of concern for methamphetamine dependent persons (Kelly et al., in press).

The National Illicit Drug Indicators Project (NIDIP) is currently being conducted by NDARC with a view to making some headway towards resolving these issues (http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.NIDIP). NIDIP aims to evaluate data sources and build a more comprehensive system of collection of indicator data around the country. The first step in this project is the identification of possible sources of indicator data that may reflect the use and problematic use of illicit drugs. These indicators will be evaluated to provide more information about what useful data is contained within routine data collection systems, and suggest directions on modifications or additions that may be made to the collection of indicator data around the country.

At a level even more fundamental than identifying and collating extant data sources, however, is the need for standardised data collection procedures. A consensus view of the way in which drugs should be classified would greatly increase the precision with which indicator data could inform our understandings of the market. For example, in some data collection systems, such as hospital separations, ecstasy and amphetamines are grouped into a single class known as 'amphetamine-type stimulants', whereas in other systems, such as those recording the purity of drug seizures, the two classes are considered separately.

Another way that our understanding of the market for ecstasy could be improved is the collection, where possible, of two sources of information about the specific drug involved. The first is information about the specific chemical compound confirmed by laboratory testing as being present (such as is conducted by forensic laboratories on seizures of illicit drugs, or by toxicological laboratories on biological samples obtained from drug users). The second is information collected about what the market considered the drug to be: in other words, what it was sold as or purchased as. The two sources of information are likely to be discrepant in many cases, such as when a tablet containing methamphetamine is sold as ecstasy. In other words, a comprehensive understanding of ecstasy and related drug markets might seek to determine not only what participants are actually using, but also what they think they are using.

The PDI trial has – consistent with the feasibility study before it – pointed to the need for improvements in the collection of data that could be used to monitor trends in ecstasy and related drug markets. Until these improvements are implemented, systems such as the PDI will continue to have a much greater reliance on the data obtained from sentinel groups of ecstasy and other drug users, as well as upon KE reports.

4.3. Uniqueness of the PDI as a data source

There is currently no other system in place in Australia to monitor trends in ecstasy and related drug markets. Due to previous NDLERF funded research for a feasibility study of the PDI, data on ERD markets exists in NSW, SA and QLD from 2000. We have repeatedly been informed that this is a unique data source on a relatively hidden population both within Australia and internationally.

Some of the major data collection systems that provide data on trends in drug use or drug related harms in Australia are listed below. Their capacity to provide information on trends in ecstasy and related drug markets is summarised.

4.3.1. Drug Use Monitoring of Arrestees (DUMA)

The PDI has shown that ecstasy users are rarely arrested. Rates of positive urines are low among persons taking part in DUMA.

4.3.2. Illicit Drug Reporting System (IDRS)

IDU have limited use of ecstasy and related drugs. In general, they have some limited experimentation with the drug and little use of other ERDs. KEs interviewed in the IDRS do not comment on many ERDs.

4.3.3. National Drug Strategy Household Survey (NDSHS)

Ecstasy data is collected in the NDSHS and is probably relatively reliable given the increasing prevalence of its use in this country. However, the survey is conducted on a triannual basis, making trends in use difficult to establish and making the data obviously too far apart in time to provide timely information.

The prevalence of other drug types such as ketamine and GHB, although now included in the survey (as a result of data provided by the PDI), suggests general population prevalence is very low. This limits the usefulness of this data source.

There is very limited data in this survey on harms related to the use of any of these drugs, since the survey is designed to provide information about community use and attitudes towards drugs.

4.3.4. Australian Bureau of Statistics Causes of Death database

This uses ICD-10 so cannot examine trends on any of these drugs with the exception of amphetamines.

4.3.5. National Coronial Information System

Will pick up deaths such as overdose from GHB (Caldicott, Chow, Burns, Felgate, & Byard, 2004) and ecstasy-related deaths. However, the numbers are very small, making it difficult to interpret trends over time.

4.3.6. National Hospital Morbidity Database (NHMD)

This data collection system uses ICD-10 classification codes, which means no data on ecstasy, GHB, ketamine or other drugs used by this population is specifically recorded. Data is recorded on cannabis, heroin, cocaine and amphetamines (Roxburgh & Degenhardt, in preparation).

4.3.7. National Minimum Dataset on Alcohol and Other Drug Treatment Services (NMDS-AODTS)

This data collection system records specific drug types, but the numbers in treatment for ecstasy and related drug types is relatively low, limiting the usefulness of this data source for monitoring *trends* in harms.

4.3.8. Australian Crime Commission Illicit Drug Data Report

This contains data on seizures and arrests related to ecstasy and related drugs. Data on the emerging drug types is variable and in some cases absent. The data suggest that ecstasy arrests have increased over the years. This report uses PDI data to provide context (Australian Crime Commission, 2005).

4.3.9. Jurisdictional health data collection systems

The characteristics of treatment and hospital data collection systems have been mentioned above.

Emergency departments constitute an important source of information about acute harms related to ecstasy and related drug use (such as overdose) but most emergency departments use ICD-9 classification systems, which means (as noted for the hospital databases above) no specific information on ecstasy and related drugs can be extracted.

4.3.10. Jurisdictional law enforcement data collection systems

The characteristics of arrests and seizure data have been broadly summarised above. Police have often commented that ecstasy users are a group which they have limited contact with and limited knowledge of.

4.4. Usefulness of PDI as a data source

One of the most consistent messages we have received about the PDI is that the unique nature of the information collected in the PDI has proved useful to agencies, researchers, treatment and law enforcement around the country. Below is an indication of the feedback and interest.

4.4.1. Jurisdiction feedback

Tasmania

In Tasmania, the reports go out to at least 50 individuals or agencies, including Tasmania Police (Drug Investigation Bureau, State Intelligence Services, Commissioner's Office, Analytical and Forensic Laboratory, Forensic Medical Services); Customs, Australian Federal Police; Tasmanian Government Departments and sub-sections (Justice, Executive, Community Corrections, Risdon prison, Magistrates Court, Director of Public Prosecutions; Health, Alcohol and Drug Services, Pharmaceutical Services, Royal Hobart Hospital, Public Health, Sexual Health); AG Health and Ageing (Population Health); Non-Government Agencies (Drug and Alcohol: The Link Youth Health Service, Anglicare Drug & Alcohol Service, Drug Education Network, Salvation Army Bridge Program; Youth: Youth ARC, Youth and Family Focus); Local Government Agencies (Hobart City Council Youth Arc, Clarence City Council, Clarence Plains community centre); Department of Education; Medical practitioners specialising in Alcohol and Drugs; and pharmacies engaged in pharmaceutical maintenance programs. Tasmania Police Southern Drug Investigation Services are, in particular, avid readers of both the IDRS and PDI reports and always request multiple copies.

The Tasmanian Council on Aids, Hepatitis and Related Diseases is the only organisation in the state to offer a specific harm reduction program for REU, and we worked closely with them in the development of their current project which was specifically targeted to address some of the recommendations raised in the TAS 2003 PDI report, which won funding from the Tasmanian Community Health Fund. The project officer is currently drafting a letter to NDARC in support of the PDI, as it is the only document providing any information on use of ecstasy and related drugs by Tasmanians.

In TAS, all the signs are there of a rapidly expanding ecstasy and related drug market: the price of ecstasy has dropped between 2003 and 2004, availability has increased, Tasmania Police are now focusing resources on this area in particular (which is a shift from previous years) and have exponentially increased their seizures (rising from 3 tablets seized during 1999/00, which were the first ever local seizures of ecstasy, to 1442.5 tablets during 2003/04). Moreover, there is a clear need for harm reduction health interventions with consumers: 70% reported usually binge drinking while consuming ecstasy (an increase in the already high levels seen during 2003) and a similar proportion reported usually using more than one tablet per occasion, and finally there are indications that consumers are becoming more complacent about their use, being less concerned about the effects of dehydration or the unknown contents of purchased pills (in comparison to those interviewed in 2003). Additionally, more than two-thirds reported recently driving within one hour of consuming a drug, typically alcohol, cannabis or ecstasy.

These consumers are not coming to the attention of traditional health services or police (and, apart from the TASCHARD project, for which funding will run out shortly, there are no health or outreach projects for ecstasy and related drug users in TAS), and, as such, outside of the PDI

system there is virtually no information concerning trends in ecstasy and related drug consumption.

The concerning changes in local consumption and the market for ecstasy and related drugs clearly points to a strong need to monitor trends in this demographic in Tasmania. If the PDI is discontinued in TAS, there will be no available data on trends in this population.

Queensland

Queensland disseminates PDI reports and bulletins to health, law enforcement and research agencies throughout the state, and provides a summary of the findings at a range of conferences, seminars and meetings. Feedback from stakeholders is uniformly positive. For example, strategic intelligence staff at the Crime and Misconduct Commission and in the Bureau of Criminal Intelligence, Queensland Police Service, are always very keen to receive our reports, and they cite them heavily in their own strategic intelligence documents. Each year we provide a targeted briefing to key staff from these agencies, and this also provides a forum for wider networking and information sharing among these agencies.

In addition to our established distribution list, PDI reports have been requested by staff from the following agencies: ATODS, within Queensland Health; Queensland Police Service in Brisbane, Gold Coast and Cairns; Queensland Crime and Misconduct Commission (staff from both Research and Prevention, and Strategic Intelligence divisions); Australian Crime Commission in Brisbane; Australian Customs Service in Brisbane; AFP in Brisbane and Canberra; Gold Coast Hospital Emergency Department. Reports are also provided to all key experts (which includes staff in the health and law enforcement sectors, nightclubs and dance industry) and to a small number of selected media personnel.

Qld researchers also have regular (every couple of months) contact with staff from the Bureau of Criminal Intelligence (BCI) within QPS, to share and discuss information about drug markets. At present, the PDI is regarded by these stakeholders as the only reliable source of information about the market for ecstasy and related drugs in Queensland.

South Australia

Within South Australia, the PDI is considered to be an extremely valuable tool used by drug and alcohol service providers, law enforcement agencies, health and allied health organisations, education groups and State Government departments. The PDI reports and bulletins are disseminated to a wide range of both government and non-government agencies and individuals, and this expanded further in 2004 following each seminar presentation (listed previously). In particular, in 2004 over 150 reports were distributed to over 30 different agencies, including the South Australian Police State Intelligence Branch, Department of Health Drug Programs and Policies Branch, The Second Story Youth Health Services, SA Ambulance Services, Life Education SA, and Ravesafe, to name a few.

Feedback indicates that PDI information and/or data is used for a wide variety of purposes. For example, within the justice and health areas, PDI results are applied to diverse uses including strategic planning, service delivery and statistical monitoring. Additional uses include professional training and education, monitoring and research/evaluation.

Requests for PDI information and feedback on its usefulness has been particularly strong from two diverse sectors: law enforcement and the entertainment industry. Specifically, the State Intelligence Branch and the Drug and Alcohol Policy Section of the South Australian Police

utilise the PDI to inform and assist in their monitoring, planning and training activities. To that end the PDI project officer has been asked to present at an upcoming South Australian Police information and strategic planning workshop on ecstasy and methamphetamine. In addition, promoters and entertainment industry representatives who attended a recent Community Stakeholders meeting hosted by the Drug and Alcohol Services Harm Reduction Unit gave strong and positive feedback on the usefulness of the PDI. They were particularly interested in trends in the use of ecstasy and related drugs, and harms associated with that use, and how this data could inform their practices to reduce harms at events and within entertainment venues.

The PDI is a unique information source providing valuable local information on the linkages between drugs and crime, health issues and needs, drug use trends amongst users and drugs in the community. The value of a multi-jurisdictional approach to the collection of information cannot be understated. While there are some consistencies across jurisdictions, the uncovering of unique patterns of drug use within each state has been an extremely useful finding attributable primarily to the PDI's existence. The provisions of state-specific information through the PDI allows state-based services to accurately tailor their prevention and education programs.

ACT

In the ACT, positive feedback has been received from ACT Police, who report using the PDI report as a resource to inform policing, operations and to inform police appearing in court. The ACT arm of the PDI has led to the enrolment of a young researcher in a program of doctoral research on the issue of ecstasy use, which is anticipated to lead to a number of novel papers examining ecstasy use, risk and expectancy.

Western Australia

The PDI mailing list in WA is currently extensive, with the reports being sent to over 90 agencies and individuals including: The WA Police Service (Alcohol and Drug Coordination Unit, Organised Crime Unit, and Crime Investigation Support Unit,) Sir Charles Gardiner Hospital (Emergency & Psychiatry Departments), King Edward Memorial Hospital, Health Department of WA (Drug and Alcohol Office, Sexual Health Branch), Crime Research Centre at University of Western Australia, Pharmaceutical Services at the Health Department of Western Australia, Department of Justice, Alcohol and Drug Information Service.

Recently the list has been expanded due to requests for copies of the reports by various members of the public and from different agencies for information concerning the PDI. For example, a symposium attendee requested resources on ecstasy and related drugs to be used in their outreach agency, and a member of a community drug service team asked to be added to the regular bulletin mail out. Reports have also been provided to other interested parties including a student studying in the area.

Additionally, data from the PDI was used in response to three media enquiries during the year: one on 'ecstasy and antidepressant use' and two on 'GHB'. These resulted in one newspaper article and two radio pieces.

The extent to which the WA PDI study could be disseminated to local agencies was adversely affected by the delay in approval of release of the final report. The data is most useful for local agencies if it is timely, and while almost 40 staff from relevant agencies attended a symposium held on the IDRS and PDI data in May 2004, the full report was not available for dissemination at that time.

Northern Territory

In the NT the PDI report has been distributed to participating key informants, 22 government and NGO AOD treatment agencies, selected officers in Dept of Health and Police, and has been requested by relevant researchers at Charles Darwin University. Hospitality venues that agreed to display advertising for the 2003 and 2004 REU survey all expressed an interest in the report and have been provided with copies. The 2003 PDI sparked an interest on the part of some NGO AOD services in ecstasy and related drug users as a group that is growing in Darwin and that may need services in the future but are currently being under-serviced. The relationships established as a part of the 2003 PDI, and reinforced by distributing that report, led directly to more and better informed key informants being available for the 2004 PDI.

Information in the report has been used by one of the researchers in a presentation to an AGM at a non-government AOD service attended by approximately 40 people. There was media interest in the results during the survey period, in a subsequent local ABC TV interview (*Stateline*) about 'Drugs in the NT' with one of the researchers drawing on IDRS and PDI data.

New South Wales

In addition to the conference presentations and information sessions already reported, the media and information officer at NDARC, Paul Dillon, has used slides presenting PDI data to describe patterns of recent ecstasy and related drug use in numerous talks around the country.

The NSW PDI report is distributed widely to a range of agencies. Law enforcement agencies include Local Area Commands, the Australian Crime Commission and the Australian Federal Police. State and national government agencies include the NSW Cabinet Office, the Department of Health, the Australian National Council on Drugs and the Australian Government Department of Health and Ageing. Other agencies include universities and research centres, drug analytical laboratories, university and public libraries, the Australian Bureau of Statistics, and of course drug and alcohol service providers around the state.

Further, several State Government departments made requests for specific PDI data or requested meetings with PDI researchers to discuss the information gathered as part of this monitoring system, including:

- The NSW Premiers department;
- The NSW Ombudsman Department for the *Review of the police powers (drug detection dogs) Act*;
- The Criminal Law Review Division, NSW Attorney General's Department (who were seeking advice on the amount of drugs that make up average use and street deal amounts) when considering revisions to the *Drug Misuse and Trafficking Act*.

Victoria

In Victoria the printed reports are distributed to approximately 60 individuals or agencies, including State Government departments, police, drug and alcohol services, the Australian Drug Foundation (ADF), and user groups (e.g. VIVAIDS). Requests for additional copies were also made from several A&D agencies and the ADF library.

Turning Point also conducted the Victorian Psychostimulant Monitoring Project (PMP). The PMP was funded by the Victorian Department of Human Services for one year as an extension of the PDI (extending the sentinel group of users to include regular methamphetamine and cocaine users). The PMP report usefully compared and combined the findings from the PDI and PMP.

The PDI findings have also been used to inform the Victorian Government's GHB prevention strategy, the recent National Illicit Drug Campaign development and production, and the Drugs and Crime Prevention Committee "Inquiry into Amphetamine and 'party drug' use in Victoria". The findings were the basis of a discussion at a Turning Point "Think Tank" (involving researchers, heads of Turning Point Units and Department of Health Services representatives), and have been presented in a number of forums including RaveSafe reference group meetings, Turning Point Clinic Training and Development workshops, as well as to Singapore Narcotic Agency representatives and the Victorian Customs Service.

The PDI findings have been used by the Education and Training Unit at Turning Point in their development of resources (for students, alcohol and other drug workers and GPs) and in their training and education curriculum. The PDI findings have also been reported widely in the media.

National

The national report is distributed to the state researchers to send to their mailing list with their individual state report. These mailing lists include people from a range of disciplines including health, law enforcement and people involved in the entertainment industry. In addition, the national report is sent to national organisations and government departments including Customs, Australian Federal Police, Australian Crime Commission, and the Australian Government Department of Health and Ageing. The reports are also sent to libraries and other research organisations.

There was a great deal of interest in the findings of the first year of the PDI. The National Coordinator and Chief Investigator receive numerous phone call enquiries about the PDI regarding questions on the 2003 data and reports. These calls included personnel from the NSW and Commonwealth Health Departments, Attorney General's Department and law enforcement. We have received calls from police enquiring about ecstasy and related drug prices when preparing for court and calls on recent use patterns of particular drugs (e.g. GHB and crystal methamphetamine). Personnel from Customs have called enquiring about the reported use of more obscure drugs or clarification of terms used for different drugs. PDI data and the reports from the PDI has been distributed to the Intergovernmental Committee on Drugs (IGCD) and Ministerial Council on Drug Strategy (MCDS). The PDI data has been used in media reports when information on recent trends in patterns of drug use is required.

Several articles have been and will continue to be produced for submission to peer reviewed publications using national PDI data, including:

- 'Alcohol use among regular ecstasy users' (Breen et al., in press);
- 'Drug use and risk among regular ecstasy users: does sexuality make a difference?' (Degenhardt, in press);
- 'The emergence of crystal smoking' is in preparation;
- 'Injecting risk behaviour among regular ecstasy users' (White, Day et al., in press);
- An editorial on the PDI is under review;
- 'Risk and benefit perceptions of ecstasy and related drug use' (White, Degenhardt et al., in press);
- 'Sexual risk behaviour of regular ecstasy users' is in preparation.

4.4.2. Dissemination

As a general comment, we note that we received many requests to present information at a range of events and to differing audiences.

Reports
The PDI reports have received considerable interest from around the country, and feedback from stakeholders has been very positive.

Bulletins
In addition to the December 2003 and April 2004 Party Drug Trends Bulletin, an additional two bulletins have been prepared. The June 2004 bulletin contained data on drug seizures, focusing on the illicit tablet market and was prepared in conjunction with Catherine Quinn, Victoria Police. The October 2004 bulletin presented gender differences from the 2003 PDI sample.

The December 2004 bulletin is in preparation and presents the preliminary findings of the 2004 PDI and will be forwarded to NDLERF for approval in the next two weeks. Following approval, the bulletins are disseminated via email lists and posting on the NDARC website.

The bulletins were approved by NDLERF prior to dissemination via email lists and posting on the NDARC website. There has been extensive interest in these bulletins, with regular requests from individuals to be included on mailing lists.

The PDI bulletins (along with IDRS bulletins) are the most commonly accessed page from the NDARC website, reaffirming the usefulness of this medium in disseminating findings from the study.

- Breen C., White B, Degenhardt, L and Pointer S. (2004). Examining differences between younger and party drug users (PDU) in the 2003 National PDI sample. *April Party Drug Trends Bulletin Sydney: National Drug and Alcohol Research Centre.*

- Quinn C. (2004). Illicit Tablet Market in Victoria. *June Party Drug Trends Bulletin Sydney: National Drug and Alcohol Research Centre.*

- White, B., Stafford, J., Breen, C. and Degenhardt, L (2004). Gender differences among party drug users in Australia. *October Party Drug Trends Bulletin Sydney: National Drug and Alcohol Research Centre.*

- Breen C., White B., Stafford, J. and Degenhardt, L (2004). A national overview of the 2004 Party Drugs Initiative. *December Party Drug Trends Bulletin Sydney: National Drug and Alcohol Research Centre.*

- Breen C., Degenhardt, L. and White B. (2003). The Party Drug Trends Bulletin. *December Party Drug Trends Bulletin Sydney: National Drug and Alcohol Research Centre.*

Drug Trends Conference
The state and national findings were presented at the Drug Trends Conference in November 2003 and 2004. In addition, a number of talks on areas of interest were given in 2004, which included the following:

- Phoebe Proudfoot (ANU), 'Risk taking and expectancy from the EEQ among ecstasy users'
- Bethany White (NDARC), 'Sex and BBVI Risk'
- Jane Fischer (QADREC), 'Smoking crystal methamphetamine'

Presentations

Club Health 2004 Conference, in Melbourne 18th-20th April 2004

- Louisa Degenhardt presented the 2003 national PDI findings at the Club Health 2004 Conference in Melbourne 18th -20th April.
- Courtney Breen (NDARC) presented the use of crystal methamphetamine at the same conference.
- Bethany White (NDARC) presented the perceived risks and benefits of ecstasy and related drug use.
- Jennifer Johnston (Turning Point – VIC) presented results from the Victorian arm of the PDI.
- Josephine Weekley (DASC – SA) presented on methamphetamine base use among ecstasy and related drug users in SA.

15th International Conference on the Reduction of Drug Related Harm, in Melbourne 20-24th April 2004

- Louisa Degenhardt also presented the 2003 national PDI findings at the 15th International Conference on the Reduction of Drug Related Harm in, Melbourne 20-24th April.
- Courtney Breen presented on the increases in the availability and use of crystal methamphetamine among IDU and ecstasy users in Australia.
- Bethany White (NDARC) presented the perceived risks and benefits of party drug use.

College of Problems of Drug Dependence (CPDD), San Juan Puerto Rico, June 2004.

- Courtney Breen (NDARC) presented on the emergence of crystalline methamphetamine in Australia: Findings of the Illicit Drug Reporting System and the Party Drugs Initiative.

The Australian Professional Society on Alcohol and other Drugs (APSAD) 2004 National Conference, in Fremantle, WA, 15-17th November

- Josephine Weekley (DASC) presented a poster: 'Responding to the evidence: The interface of research and harm-reduction strategy'.
- Jennifer Johnston (Turning Point) presented on 'The injection of "party drugs" in Victoria'.
- Bethany White (NDARC) presented a poster on 'Injecting and sex risk behaviour among regular ecstasy users' – results from the 2004 national PDI.

Occasional lectures, seminars and symposia

- J. Fischer & S. Kinner. 'Do Party Drugs Make You Happy?': Health and Wellbeing of Regular Party Drug Users, APSAD 2005.
- Jane Fischer & Stuart Kinner. Queensland Drug Trends 2005, Queensland Alcohol and Drug Research and Education Centre, Seminar Series.
- Weekley, J. Seminar presentation to the Office of Crime Statistics and Research: Overview of the PDI project and 2004 PDI Findings. April 2005.
- S. Kinner & J. Fischer (2004). QADREC seminar series, Brisbane, Dec 2004. Drugs in Queensland 2004: Preliminary Findings of the Party Drugs Initiative (PDI) and Illicit Drug Reporting System (IDRS).

- Weekley, J. Southern Division of General Practice, Party Drugs Seminar: Ecstasy and related drug use in SA. December, 2004.
- Fischer, Jane & Kinner, Stuart. Smoking Crystal Methamphetamine. Sunday 14th, November 2004, National Drug Trends Conference.
- Degenhardt, L. Crystal Methamphetamine. ACON Service Providers' Forum, Sydney, November 4th, 2004.
- Degenhardt, L. Crystal Methamphetamine. ACON Community Forum, Sydney, November 3rd, 2004.
- Bruno, R. IDRS steering committee meeting (Nov, 2004).
- White, B & Stafford, J. Ecstasy and related drugs. Family Drug Support, Sydney, 26 October 2004.
- Degenhardt, L. Crystal Methamphetamine and sex risk. ACON Special Interest Forum, Sydney, September 29th, 2004.
- Weekley, J. DASC Seminar Series (for various government and non-government agencies): SA Drug Trends 2003 – Findings from the PDI. September 2004.
- Fry, C. (2004). Party drug & psychostimulant trends in Melbourne. Drugs and Crime Prevention Committee, Research Forum on Party Drugs, Melbourne Town Hall, 16 August 2004.
- Fry, C. (2004). Party drug and psychostimulant trends in Melbourne. Premier's Drug Prevention Council 'Research Forum on Party Drugs', August 16, Melbourne.
- Bruno, R. Inter-Departmental Committee on Drugs (Tasmanian Government) (August 2004).
- Weekley, J. Party Drugs Seminar Series – Community Stakeholders (hosted by DASC's Harm Reduction Unit): SA Drug Trends 2003 – Findings from the PDI. August 2004.
- Weekley, J. Party Drugs Seminar Series – Researchers (hosted by DASC's Harm Reduction Unit): SA Drug Trends 2003 – Findings from the PDI. August 2004.
- Fischer Jane. Illicit drug trends: Can they readily inform policy and practice? 28 July 2004, ADTRU Seminar Series, Biala, Queensland Health.
- White B. Risk and benefit perception of party drug users. National Drug and Alcohol Research Centre Annual Symposium, Sydney, 29 July 2004,
- Fry, C. (2004). Integrated monitoring of illicit drug trends in Melbourne. Australian Customs Service, May 13, Melbourne.
- Richards J., Fry C., Laslett A.-M., Miller P. (2004). Enhanced integrated monitoring of party drug and psychostimulant trends in Melbourne, Victoria.Paper at the 3rd International Conference on Nightlife Substance Use and Related Health Issues. Club Health, 18-20 April, Melbourne, Australia.
- Bruno, R. Tasmanian Needle Availability Program Working Party (Feb 2004).
- Bruno, R. The Link Youth Health Service/Tasmanian Council of Aids, Hepatitis and Related Diseases/Anglicare Alcohol and Drug Service (Feb 2004).
- Bruno, R. Alcohol and Drug Service, Department of Health and Human Services (Jan 2004).
- Chanteloup, F. (2004). Public seminar hosted at NDRI: Patterns of Party Drug Use in Perth: findings from the 2003 Party Drugs Initiative.
- Jenkinson, R. (2004). Training and development workshop, Turning point Alcohol and Drug Centre. 'Findings from the Illicit Drug Reporting System (IDRS) and Party Drugs Initiative (PDI)'.
- Fry, C. (2004) Intergrated Monitoring of Illicit Drug Trends in Melbourne. Presented to Victorian Customs Service.

- Kinner, S. & Fischer, J. (2003). QADREC seminar series, Brisbane, Dec. 2003. Drugs in Queensland: What's Old, What's New?
- Bruno, R. IDRS steering committee meeting (Nov, 2003).
- Bruno, R. Illicit Drug Diversion Initiative Reference Group (Nov, 2003).
- Hamilton, M., Lee, N., Fry, C, & Richards, J (2003). From Anecdote to Answers: Drug Trend Monitoring, Party Drugs and Psychostimulants in Victoria – Drugs and Crime Prevention Committee, Inquiry into Amphetamines and Party Drugs. Public Hearings, Parliament of Victoria, Melbourne 27 October 2003.
- Weekley, J. Lecture to University of SA Pharmacy students: Drug Use Monitoring Systems – IDRS and PDI. October 2003.
- Breen, C. Party Drugs. St Johns Ambulance, September 2003.
- Kinner, S. (2003). Gold Coast Health District, Monthly Psychologists Meeting, 14 July 2003. Monitoring Illicit Drug Trends: Findings of the 2002 Queensland IDRS.
- Weekley, J. Presentation to Life Education SA: SA Drug Trends 2003 – Findings from the PDI. July 2004.
- Kinner, S. (2003). Alcohol and Drug Foundation, Queensland, 2003. Winter School in the Sun, 2 July 2003. What's the Deal in Queensland? llicit Drug Reporting System: Queensland Findings 2002.
- Fry C (2003). From Anecdote to Answers: Drug Trend Monitoring, Party Drugs and Pychostimulants in Victoria. The Victorian Alcohol and Drug Association, Inaugural Victorian Party Drugs Symposium. Beyond 'e': exploring the impact of party drugs on current day youth and culture. June 23, Melbourne, Australia.
- Kinner, S. (2003). Queensland Needle and Syringe Program (QNSP) Statewide Workshop, Brisbane, March 2003. The 2002 Queensland IDRS: Key findings.

In addition, state researchers have fed back the results locally to agencies that assisted with recruitment, provided indicator data and key informants that participated in the study. We have received phone calls and/or emails from law enforcement and other researchers enquiring regarding the study findings and to find out when the reports will be released.

4.5. Future iterations of the PDI

The PDI has been successful in gaining funding from the Australian Government Department of Health and Ageing (AGDH&A) and the Australian Ministerial Council on Drug Strategy (MCDS) for the 2005-2006 year period. This carries a number of benefits: a) including that year, there will be at least three years of data for all states and territories from this data collection system, and six years for some others; b) any decision regarding the future of the PDI may be made within the coming months without losing the collection of this year's data; and c) the capacity that has been built across the country to conduct work within these markets has been preserved.

It is useful at this point to reflect upon the different models upon which the PDI might run in future years, should a decision be made to continue its funding. The variations considered here attempt to consider the coverage, cost-effectiveness, feasibility, and quality of the data collection system. The PDI could be run on an annual or biannual basis, and it could be run in all states and territories, or in only a reduced number. There could also be some combination of these options. The implications of these are briefly discussed below.

4.5.1. Time periods for data collection

There are obvious cost savings to the collection of data for the PDI on a biannual basis. This would effectively halve the cost of running this monitoring system (for every two years that it would run). This may improve the chances of continuing the funding of the PDI in the future.

However, there are a number of negative consequences of this option:

(1) The ability of the PDI to detect emerging drug trends in a timely fashion would be reduced, since trends would not be detected in the intervening year;
(2) The feasibility of the PDI depends upon the development of ongoing links with both ecstasy users networks and with professionals who have relevant exposure to these groups. Given the relatively "hidden" nature of many of these networks, and the high turnover (even from one year to the next) of appropriate key experts, the challenges facing researchers attempting to run this system on a biannual basis may be increased;
(3) The capacity of research centres would be difficult to maintain, particularly in the smaller jurisdictions, since staff would need to move to other projects when the year's project had been completed. In many ways, the PDI is even more dependent upon the researchers' development of capacity than the IDRS, simply because the market is less overt than for injecting drug users that are the focus of the IDRS.

4.5.2. Jurisdictions for data collection

One element that could be considered is the conduct of the PDI on a geographically more limited basis. Again, this would mean that the costs of running the PDI would be substantially reduced each year (depending upon how many jurisdictions were funded to conduct data collection). Alternatively, it may be considered reasonable to fund the PDI on a biannual basis in some smaller jurisdictions, while collecting data annually in the larger ones. The benefit of this option is again the relative cost savings.

The negatives associated with this option are that emerging trends in some smaller markets may not be detected. It may not be the case that all trends documented in the larger jurisdictions are necessarily seen in the smaller ones. As we have seen in the IDRS, the smaller jurisdictions (especially the geographically isolated ones) may develop markets that are highly distinct from other jurisdictions, and findings from larger jurisdictions may not be generalisable to these jurisdictions. With these distinct markets come differing needs for law enforcement and harm reduction responses.

Second, in our years of monitoring through the IDRS, it has been clear that the spread of trends can be highly unpredictable: some trends that emerge in particular jurisdictions may not spread to others (e.g. cocaine use in NSW) whereas others are more generalised and slowly spread across regions (e.g. the rise, and fall, of heroin). The methodology applied in the PDI has demonstrated its usefulness in being able to be sensitive to these changes and the regular, frequent, whole-of-country approach (with timely reporting turnarounds) has proven to be an important part of the success of this.

5. Conclusions

Despite the continued efforts by Australian law enforcement to reduce the importation and local manufacture of ecstasy, it has remained readily available in recent years. The price of a tablet of ecstasy has decreased since 1997, seizures at the border have increased, domestic laboratories are now being detected, and the prevalence of use has increased across the community. All indications suggest that the use of ecstasy is increasing, in terms of the number of users, and the frequency and amounts used by current users.

The PDI was successfully trialled across Australia and appeared to provide information useful to a wide range of individuals and agencies. The PDI involved the collection of information that is not obtained through the IDRS or through other routine data collection that are in place in this country.

It remains the case that many REUs report a wide range of harms that they perceive as related to their use of the drug, and that some of these harms constitute significant disruptions to functioning. These harms do not appear to be easily captured in routine data collections systems.

Continued monitoring of the market for this drug will ensure policymakers are able to respond to changes in the market or in the nature and extent of ecstasy-related harms in a timely fashion, as has been enabled through the routine conduct of the IDRS since 1996. It will also enable the regular collection of indicative data relating to the size of the markets for other drugs, such as GHB and ketamine, and will point to the need for research specific to such drugs as and when it arises.

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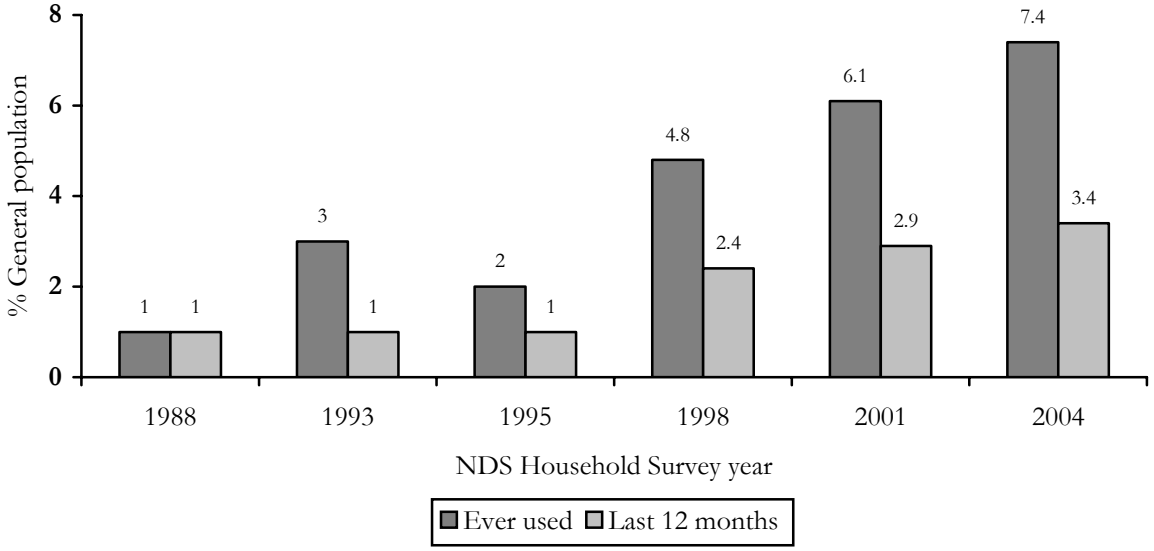
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APPENDICES

Appendix 1: Prevalence of ecstasy use in Australia, 1988-2004



Appendix 2: Demographic characteristics of REUs from 2000 to 2004

Variable	2000 (n=194)	2001 (n=350)	2002 (n=156)	2003 (n=809)	2004 (n=852)
Mean age (years)	24	24	22	25	24
% male	63	58	64	60	62
% English speaking background	96	96	99	98	98
% ATSI	3	5	1	7	4
% heterosexual	79	75	69	82	83
Mean number school years completed	12	12	12	12	12
% tertiary qualifications	61	52	54	46	50
% employed full-time	37	37	41	30	37
% full-time students	14	5	21	22	21
% unemployed	15	14	15	25	16
% previous prison history	4	4	3	8	7
% currently in drug treatment	0	5	5	6	3

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

Appendix 3: Demographic characteristics of REUs in NSW, ACT, VIC and TAS, 2000 to 2004

	NSW					ACT		VIC		TAS	
Variable	**2000 (n=94)**	**2001 (n=163)**	**2002 (n=88)**	**2003 (n=102)**	**2004 (n=104)**	**2003 (n=66)**	**2004 (n=116)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**
Mean age (years)	25	25	25	26	26	22	25	25	24	24	23
% male	69	58	67	63	60	73	70	53	58	61	61
% English speaking background	95	93	98	96	95	96	98	99	96	100	100
% ATSI	6	6	2	7	7	2	2	6	0	6	2
% heterosexual	78	68	63	69	69	96	90	81	87	85	93
Mean number school years	12	12	13	12	12	13	13	12	12	12	12
% tertiary qualifications	55	54	58	49	60	27	43	41	53	44	56
% employed full-time	33	48	47	35	44	30	41	32	25	27	28
% full-time students	12	20	26	26	23	33	30	18	23	40	37
% unemployed	21	9	11	22	8	10	12	25	17	16	8
% prison history	0	1	2	3	3	0	9	7	4	3	1
% current drug treatment	6	3	5	7	2	0	0	6	6	10	1

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004 n/a - data not collected

Appendix 4: Demographic characteristics of REUs in SA, WA, NT and QLD from 2000 to 2004

	SA					WA		NT		QLD				
Variable	**2000 (n=50)**	**2001 (n=70)**	**2002 (n=68)**	**2003 (n=101)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=104)**	**2004 (n=71)**	**2000 (n=50)**	**2001 (n=117)**	**2002**	**2003 (n=136)**	**2004 (n=161)**
Mean age (years)	23	22	23	24	24	21	22	33	24	25	25	n/a	25	26
% male	54	53	60	63	62	53	59	70	73	62	61	n/a	49	55
% English speaking background	98	99	100	95	98	99	97	98	100	96	100	n/a	98	98
% ATSI	0	0	0	1	0	9	1	20	11	0	8	n/a	5	10
% heterosexual	86	90	78	91	84	83	89	73	83	74	74	n/a	79	75
Mean number school years	13	12	11	12	12	12	12	10	11	12	12	n/a	11	11
% tertiary qualifications	54	41	50	46	46	48	49	56	46	80	56	n/a	50	47
% employed full-time	44	24	32	29	34	33	31	17	49	36	31	n/a	38	44
% full-time students	12	47	13	31	25	16	21	6	1	22	17	n/a	16	10
% unemployed	6	10	19	20	15	22	24	61	30	14	23	n/a	20	16
% prison history	0	0	3	1	5	4	16	36	16	0	13	n/a	4	7
% current drug treatment	2	0	4	1	1	5	6	13	1	2	7	n/a	2	3

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004 n/a - data not collected

Appendix 5: Patterns of ecstasy use from 2000 to 2004

Variable	2000 (n=194)	2001 (n=350)	2002 (n=156)	2003 (n=809)	2004 (*n*=852)
Median age first used ecstasy (years)	19	19	18	18	18
Median no. days used ecstasy last 6 months	15	15	20	12	18
% ecstasy 'favourite' drug	50	54	56	53	51
% use ecstasy weekly or more	31	26	40	33	37
Median no. ecstasy tablets in 'typical' session	1.5	1.5	2	1.5	2
% typically use >1 tablet	52	55	72	57	69
% recently binged on ecstasy (>48 hours)	51	56	62	46	38
% ever injected ecstasy	14	13	14	17	13
% mainly swallowed ecstasy last 6 months	93	92	89	90	93
% used ecstasy with other drugs	88	78	42	91	93
% used other drugs to come down from ecstasy	86	73	44	83	78

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

Appendix 6: Patterns of ecstasy use in NSW, ACT, VIC and TAS from 2000 to 2004

	NSW					ACT		VIC		TAS	
Variable	**2000 (n=94)**	**2001 (n=163)**	**2002 (n=88)**	**2003 (n=102)**	**2004 (n=104)**	**2003 (n=66)**	**2004 (n=116)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**
Age first used ecstasy (median years)	18	19	18	18	18	18	19	19	18	19	19
Days used ecstasy last 6 months (median)	12	20	20	12	20	12	18	15	18	14	12
% ecstasy 'favourite' drug	53	63	51	55	59	56	47	44	47	54	58
% use ecstasy weekly or more	34	29	42	22	42	21	38	36	36	38	24
Median no. ecstasy tablets in 'typical' session	1.5	1.5	2	2	2	2	2	1.5	2	1.5	2
% typically use >1 tablet	53	62	74	74	84	74	67	54	77	54	69
% recently binged on ecstasy (>48 hours)	44	58	55	35	28	46	32	55	42	41	34
% ever injected ecstasy	12	10	15	13	10	0	6	27	9	18	6
% mainly swallowed ecstasy last 6 months	89	98	92	90	93	97	96	85	95	89	94
% used ecstasy with other drugs	84	92	97	89	94	88	96	98	99	98	94
% used other drugs to come down from ecstasy	82	82	91	77	68	83	80	85	85	89	89

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004 n/a - data not collected

Appendix 7: Patterns of ecstasy use in SA, WA, NT and QLD from 2000 to 2004

	SA					WA		NT		QLD				
Variable	**2000 (n=50)**	**2001 (n=70)**	**2002 (n=68)**	**2003 (n=101)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=104)**	**2004 (n=71)**	**2000 (n=50)**	**2001 (n=117)**	**2002**	**2003 (n=136)**	**2004 (n=161)**
Age first used ecstasy (median years)	20	19	18	19	18	17	18	21	19	19	19	n/a	19	20
Days used ecstasy last 6 months (median)	18	13	19	12	16	12	12	12	20	18	15	n/a	24	24
% ecstasy 'favourite' drug	40	45	62	67	56	52	44	36	47	52	46	n/a	53	47
% use ecstasy weekly or more	34	20	37	29	36	25	21	19	39	42	31	n/a	60	53
Median no. ecstasy tablets in 'typical' session	1.5	2	2	2	2	1.5	2	1	2	1	1	n/a	1.5	2
% typically use >1 tablet	44	61	71	69	84	57	61	21	55	48	41	n/a	56	75
% recently binged on ecstasy (>48 hours)	54	49	72	40	47	53	38	55	44	60	59	n/a	43	37
% ever injected ecstasy	16	11	7	11	18	10	14	39	21	16	19	n/a	13	21
% mainly swallowed ecstasy last 6 months	94	83	82	95	91	91	93	77	89	98	88	n/a	91	83
% used ecstasy with other drugs	94	87	91	93	94	85	86	92	89	88	97	n/a	85	89
% used other drugs to come down from ecstasy	86	83	88	91	79	76	80	84	68	92	92	n/a	79	75

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004 n/a - data not collected

Appendix 8: Routes of administration among REUs from 2000 to 2004

Variable	2000 (n=194)	2001 (n=350)	2002 (n=156)	2003 (n=809)	2004 (n=852)
% injected any drug	26	27	30	30	23
First drug injected (%)*					
Methamphetamine	60	64	36	69	71
Heroin	24	18	9	19	16
Ecstasy	2	2	1	4	2
% ever injected ecstasy	14	13	14	17	13
Median age injected ecstasy (years)	21	21	n/a	22	21
In the six months prior to interview: (%)					
Swallowed ecstasy	99	98	100	98	99
Snorted ecstasy	44	41	64	59	60
Smoked ecstasy	8	6	9	6	6
Injected ecstasy	7	6	6	10	5
Main route of ecstasy administration:					
Swallowed	93	92	n/a	90	93
Snorted	3	1	n/a	5	5
Injected	2	2	n/a	4	2
Shelved/Shafted	2	1	n/a	1	<1
Could not specify	2	3	n/a	n/a	n/a

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

Appendix 9: Patterns of drug use for REUs from 2000 to 2004

	2000 (n=194)	2001 (n=350)	2002 (n=156)	2003 (n=809)	2004 (n=852)
Mean no. drug types ever used*	10.0 (3-16)	9.4 (3-17)	10.2 (5-17)	9.4 (1-18)	9.5 (1-19)
Mean no. drug types used in last 6 months*	7.1 (2-14)	7.0 (3-16)	7.9 (3-13)	6.7 (1-14)	6.6 (1-15)
Ecstasy					
Ever used (%)	100	100	100	100	100
Used last 6 months (%)	100	100	100	100	100
No. days used in last 6 months (median, range)	15 (1-117)	15 (6-100)	20 (6-78)	12 (6-105)	18 (6-180)
Alcohol					
Ever used (%)	99	99	99	98	99
Used last 6 months (%)	94	95	92	93	95
No. days used in last 6 months (median, range)	48 (1-180)	48 (1-180)	26 (1-180)	48 (1-180)	48 (1-180)
Cannabis					
Ever used (%)	98	95	91	96	96
Used last 6 months (%)	90	85	87	85	81
No. days used in last 6 months (median, range)	100 (1-180)	50 (1-180)	52 (1-180)	56 (1-180)	48 (1-180)
Methamphetamine powder (speed)					
Ever used (%)	99	94	97	87	85
Used last 6 months (%)	76	78	80	73	68
No. days used in last 6 months (median, range)	12 (1-180)	7 (1-180)	7 (1-104)	6 (1-180)	6 (1-180)
Tobacco					
Ever used (%)	86	81	85	87	87
Used last 6 months (%)	69	76	76	75	74
No. days used in last 6 months (median, range)	180 (1-180)	180 (1-180)	180 (1-180)	180 (1-180)	180 (1-180)
LSD					
Ever used (%)	85	77	83	65	60
Used last 6 months (%)	43	35	47	29	26
No. days used in last 6 months (median, range)	3 (1-74)	3 (1-70)	3 (1-100)	2 (1-72)	2 (1-50)
Cocaine					
Ever used (%)	70	69	71	54	54
Used last 6 months (%)	44	47	59	24	27
No. days used in last 6 months (median, range)	3 (1-90)	3 (1-96)	3 (1-48)	2 (1-90)	2 (1-180)
Amyl nitrate					
Ever used (%)	64	55	58	52	47
Used last 6 months (%)	29	29	33	20	20
No. days used in last 6 months (median, range)	4 (1-180)	5 (1-180)	2 (1-180)	3 (1-180)	3 (1-120)
Benzodiazepines					
Ever used (%)	57	45	51	47	43
Used last 6 months (%)	36	33	37	32	27
No. days used in last 6 months (median, range)	3 (1-180)	6 (1-180)	3 (1-180)	6 (1-180)	5 (1-180)

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

* Speed, base and ice categorised as one drug type. Results in 2000 and 2003 are out of a possible 18 drug types, in 2001 and 2002 a possible 17 drugs types and in 2004 a possible 19 drug types.

Appendix 10: Patterns of drug use for REUs from 2000 to 2004

	2000 (n=194)	2001 (n=350)	2002 (n=156)	2003 (n=809)	2004 (n=852)
Nitrous oxide					
Ever used (%)	72	59	62	52	53
Used last 6 months (%)	40	29	31	26	27
No. days used in last 6 months (median, range)	15 (1-95)	6 (1-104)	3 (1-90)	4 (1-90)	5 (1-100)
Methamphetamine base*					
Ever used (%)	62	56	71	51	53
Used last 6 months (%)	51	44	61	36	39
No. days used in last 6 months (median, range)	6 (1-150)	5 (1-130)	5 (1-104)	5 (1-180)	5 (1-180)
MDA					
Ever used (%)	39	38	42	33	32
Used last 6 months (%)	22	19	30	19	15
No. days used in last 6 months (median, range)	2 (1-30)	2 (1-100)	3 (1-20)	2 (1-72)	2 (1-100)
Heroin					
Ever used (%)	26	22	18	22	17
Used last 6 months (%)	10	9	6	9	6
No. days used in last 6 months (median, range)	1 (1-96)	12 (1-180)	10 (1-180)	12 (1-180)	6 (1-180)
Antidepressants					
Ever used (%)	34	27	33	29	26
Used last 6 months (%)	15	15	21	14	10
No. days used in last 6 months (median, range)	10 (2-180)	42 (1-180)	7 (1-180)	47 (1-180)	68 (1-180)
Ketamine					
Ever used (%)	26	27	48	40	40
Used last 6 months (%)	14	14	40	26	23
No. days used in last 6 months (median, range)	2 (1-30)	3 (1-90)	3 (1-30)	2 (1-104)	3 (1-96)
Other opiates					
Ever used (%)	24	13	21	29	23
Used last 6 months (%)	13	4	10	15	10
No. days used in last 6 months (median, range)	4 (2-35)	5 (1-60)	2 (1-30)	14 (1-180)	5 (1-180)
Ice (crystalline methamphetamine)*					
Ever used (%)	12	56	64	63	63
Used last 6 months (%)	6	42	49	52	45
No. days used in last 6 months (median, range)	1 (1-20)	4 (1-130)	6 (1-160)	5 (1-180)	5 (1-180)
Methadone					
Ever used (%)	4	5	8	12	6
Used last 6 months (%)	0	2	4	7	2
No. days used in last 6 months (median, range)	n/a	17.5 (3-60)	135 (1-180)	30 (1-180)	100 (1-180)
GHB					
Ever used (%)	16	24	41	22	23
Used last 6 months (%)	8	16	28	11	10
No. days used in last 6 months (median, range)	2(1-40)	2 (1-70)	3 (1-52)	2 (1-90)	2 (1-78)

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

* In 2000 'crystal meth' was coded under 'methamphetamine – crystal meth/base/paste/pure'. Ice or shabu was a separate category. In 2001 methamphetamine was base/paste/pure and crystal methamphetamine incorporated 'ice or shabu'.

Appendix 11: Patterns of polydrug use among REUs in NSW, ACT, VIC and TAS, 2000 to 2004

Variable	NSW					ACT		VIC		TAS	
	2000 (n=94)	2001 (n=163)	2002 (n=88)	2003 (n=102)	2004 (n=104)	2003 (n=66)	2004 (n=116)	2003 (n=100)	2004 (n=100)	2003 (n=100)	2004 (n=100)
Number drug types ever used (mean)*	10	10	12	10	10	10	10	11	11	10	8
Number drug types used last 6 months (mean)*	7	7	7	7	7	7	6	8	8	7	6
Cocaine											
% ever used	78	77	80	78	79	47	69	80	72	44	32
% used last 6 months	53	57	64	46	46	26	34	35	48	7	10
Methamphetamine powder											
% ever used	92	99	100	97	98	88	87	98	98	90	82
% used last 6 months	75	87	85	79	81	64	64	89	92	67	68
Methamphetamine base											
% ever used	36	34	59	63	64	30	43	51	45	36	32
% used last 6 months	22	20	44	42	39	24	31	28	34	24	20
Crystalline methamphetamine											
% ever used	12	43	43	56	68	71	62	77	71	58	36
% used last 6 months	6	26	19	48	46	56	39	64	52	52	16
LSD											
% ever used	80	74	73	66	61	59	62	86	72	62	51
% used last 6 months	37	23	33	27	20	44	23	48	39	24	32
MDA											
% ever used	36	43	56	56	54	56	41	40	37	32	20
% used last 6 months	16	14	35	35	30	33	15	19	16	21	15
Amyl nitrate											
% ever used	66	62	68	66	66	50	44	70	52	78	52
% used last 6 months	29	36	40	28	27	29	18	25	20	43	23
Nitrous oxide											
% ever used	54	48	50	44	40	56	52	59	54	47	52
% used last 6 months	22	11	14	8	14	39	17	22	27	25	34
Ketamine											
% ever used	25	31	59	59	58	49	36	70	70	38	18
% used last 6 months	14	15	49	49	39	21	15	51	45	24	5
Anti-depressants											
% ever used	31	22	31	27	21	11	24	35	28	32	14
% used last 6 months	14	9	15	11	3	6	6	11	12	14	4
GHB											
% ever used	5	23	35	33	28	17	23	33	38	10	7
% used last 6 months	<1	15	19	21	18	12	6	18	27	6	3

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004 n/a - data not collected

* out of a possible 19 drug types in 2002, 2003 and 2004

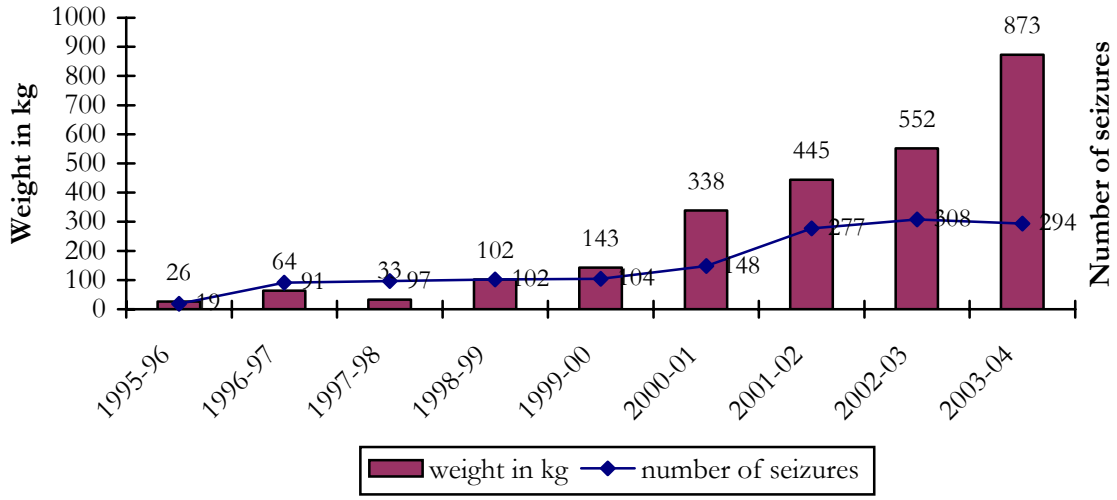
Appendix 12: Patterns of polydrug use among REUs in SA, WA, NT and QLD, 2000 to 2004

	SA					WA		NT		QLD				
Variable	**2000 (n=50)**	**2001 (n=70)**	**2002 (n=68)**	**2003 (n=101)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=104)**	**2004 (n=71)**	**2000 (n=50)**	**2001 (n=117)**	**2002**	**2003 (n=136)**	**2004 (n=161)**
Number drug types ever used (mean)*	12	10	11	10	10	9	9	10	9	11	11	n/a	8	9
Number drug types used last 6 months (mean)*	9	8	9	7	7	6	7	7	6	8	8	n/a	6	6
Cocaine														
% ever used	54	51	59	57	59	44	36	50	39	70	69	n/a	37	45
% used last 6 months	32	34	49	37	26	17	16	5	16	56	41		18	21
Methamphetamine powder														
% ever used	98	94	94	82	86	93	88	89	85	94	85	n/a	67	65
% used last 6 months	90	74	72	65	62	83	78	81	73	66	65		57	42
Methamphetamine base														
% ever used	#	#	85	75	84	54	46	47	59	n/a	n/a	n/a	43	55
% used last 6 months			82	70	72	32	31	32	45				34	36
Crystalline methamphetamine														
% ever used	#	#	91	60	60	91	89	55	58	16	67	n/a	49	60
% used last 6 months			88	48	47	77	79	40	35	8	55		38	42
LSD														
% ever used	94	79	91	73	77	62	50	80	63	86	79	n/a	41	52
% used last 6 months	50	50	66	30	36	22	11	25	31	48	40		18	18
MDA														
% ever used	42	23	24	31	30	12	19	21	28	40	40	n/a	24	29
% used last 6 months	28	21	22	21	14	1	6	6	10	28	24		18	16
Amyl nitrate														
% ever used	74	44	46	40	43	43	36	47	41	52	50	n/a	27	44
% used last 6 months	32	17	25	13	16	16	15	8	25	26	25		9	21
Nitrous oxide														
% ever used	96	69	77	82	74	65	62	31	44	82	70	n/a	38	45
% used last 6 months	74	53	53	55	47	43	43	4	16	38	40		18	22
Ketamine														
% ever used	26	19	34	47	51	25	21	18	32	30	27	n/a	27	32
% used last 6 months	16	16	28	36	39	12	10	7	18	14	10		14	16
Anti-depressants														
% ever used	38	21	35	24	31	30	25	43	24	36	36	n/a	23	34
% used last 6 months	14	13	29	12	14	17	13	24	11	20	23		12	14
GHB														
% ever used	34	23	49	34	35	20	11	17	20	18	27	n/a	13	20
% used last 6 months	18	19	38	12	12	8	5	4	6	12	15		6	6

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004 n/a - data not collected

SA data not presented as data was coded differently; as methamphetamine 'non powder' and 'powder' * out of a possible 19 drug types in 2002, 2003 and 2004.

Appendix 13: Number and weight in kilograms of detections of MDMA at the Australian Border, financial years 1995/96 to 2003/04



Source: Australian Customs Service 2004

Appendix 14: Price and availability of ecstasy in NSW, ACT, VIC and TAS, 2000 to 2004

	NSW					ACT		VIC		TAS	
Variable	**2000 (n=94)**	**2001 (n=163)**	**2002 (n=88)**	**2003 (n=102)**	**2004 (n=104)**	**2003 (n=66)**	**2004 (n=116)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**
Median price per tablet (range)	$40 (30 - 50)	$35 (10 - 70)	$35 (18-50)	$35 (22-55)	$35 (13-50)	$35 (25-40)	$35 (20-40)	$30 (20-50)	$30 (13-45)	$50 (30-50)	$40 (30-50)
% reported price stable	53	55	64	59	58	61	61	59	58	72	64
% reported price decreased	38	29	26	25	30	27	18	22	16	15	15
% score from friends	83	90	86	80	76	92	88	94	89	90	92
% score from work colleagues	12	12	11	15	11	18	15	11	17	12	12
% score from dealers	63	50	76	60	55	82	58	54	52	66	62
% score from acquaintances	30	28	38	27	15	42	51	25	37	34	34
% score from unknown people	27	22	14	15	10	23	22	12	23	7	19
% score at friend's home	59	69	74	64	51	68	68	72	62	56	77
% score at own home	45	30	32	29	20	38	37	42	40	30	44
% score at dealer's home	35	33	51	34	40	53	43	37	41	47	35
% score on the street*	20	20	13	11	1	26	5	6	10	7	3
% reported 'very easy' to obtain	70	72	71	63	67	67	55	59	70	43	68
% reported 'easy' to obtain[#]	27	23	15	23	28	18	43	32	26	29	25
% availability stable	69	68	72	73	72	64	67	75	76	53	43
% availability increased/easier	21	28	18	11	14	21	24	14	12	20	34
% purity medium	27	30	31	30	32	39	31	31	24	23	20
% purity fluctuates	n/a	31	15	27	25	27	24	29	35	46	34
% purity change – stable	15	32	39	35	34	33	34	26	31	29	16

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

* includes other venue/ public place from 2000-2002

[#] in 2002 and 2003 an extra category 'moderately easy' was included for availability. n/a – data not collected

Appendix 15: Price and availability of ecstasy in SA, WA, NT and QLD, 2000 to 2004

	SA					WA		NT		QLD				
Variable	**2000 (n=50)**	**2001 (n=70)**	**2002 (n=68)**	**2003 (n=101)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=104)**	**2004 (n=71)**	**2000 (n=50)**	**2001 (n=117)**	**2002**	**2003 (n=136)**	**2004 (n=161)**
Median price per tablet (range)	$45 (30-55)	$40 (15-50)	$35 (25-50)	$35 (20-50)	$35 (7-40)	$40 (25-50)	$50 (25-60)	$50 (20-80)	$50 (15-80)	$40 (30 -50)	$40 (15 -60)	n/a	$35 (17-50)	$35 (17-65)
% reported price stable	48	51	60	67	66	68	62	58	66	53	62	n/a	63	53
% reported price decreased	20	26	37	19	16	12	19	3	6	38	29	n/a	12	22
% score from friends	98	96	32	93	84	91	89	78	73	83	90	n/a	74	67
% score from work colleagues	22	20	16	16	8	19	13	8	16	12	8	n/a	13	15
% score from dealers	58	63	9	55	46	63	53	46	52	63	34	n/a	71	68
% score from acquaintances	50	64	52	34	29	36	47	26	39	30	12	n/a	29	23
% score from unknown people	24	13	15	11	14	9	33	14	26	27	6	n/a	6	11
% score at friend's home	94	61	77	66	62	75	71	62	49	80	83	n/a	59	53
% score at own home	74	49	61	40	40	33	33	28	38	45	35	n/a	31	30
% score at dealer's home	54	30	52	45	32	43	42	36	30	35	23	n/a	56	57
% score on the street*	4	27	15	10	4	14	5	16	9	20	12	n/a	9	8
% reported 'very easy' to obtain	32	74	82	61	56	61	54	29	58	70	67	n/a	57	69
% reported 'easy' to obtain#	62	19	10	23	41	26	38	28	27	27	31	n/a	27	26
% availability stable	64	56	81	61	60	63	64	53	68	69	67	n/a	66	64
% availability increased/easier	20	33	9	21	18	16	15	10	20	21	25	n/a	23	13
% purity medium	36	30	29	31	35	31	15	40	28	24	24	n/a	49	33
% purity fluctuates	n/a	44	32	44	28	33	25	22	21	n/a	43	n/a	29	24
% purity change - stable	22	39	19	26	29	21	13	37	18	32	28	n/a	39	28

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

* includes other venue/ public place from 2000-2002 # in 2002 and 2003 an extra category 'moderately easy' was included for availability n/a – data not collected

Appendix 16: Price of other drugs in NSW, ACT, VIC and TAS, 2000 to 2004

Drug	NSW					ACT		VIC		TAS	
	2000 (n=94)	2001 (n=163)	2002 (n=88)	2003 (n=102)	2004 (n=104)	2003 (n=66)	2004 (n=116)	2003 (n=100)	2004 (n=100)	2003 (n=100)	2004 (n=100)
LSD	**n=16**	**n=46**	**n=39**	**n=14**	**n=14**	**n=20**	**n=23**	**n=18**	**n=33**	**n=39**	**n=40**
Median price (per tab)	$10	$10	$15	$15	$20	$20	$20	$15	$20	$20	$20
Range	(3-25)	(5-45)	(8-25)	(4-30)	(10-35)	(10-30)	(15-30)	(6.50-25)	(4-40)	(5-50)	(10-50)
Methamphetamine powder (speed)			**n=18**	**n=20**	**n=24**	**n=6**	**n=23**	**n=33**	**n=34**	**n=11**	**n=18**
Median price (per gram)	n/a	n/a	$60	$55	$60	$175	$80	$180	$180	$200	$300
range			(40-100)	(40-190)	(30-40)	(70-250)	(40-300)	(30-300)	(50-250)	(30-300)	(50-400)
Methamphetamine base	**n=9**	**n=13**	**n=11**	**n=13**	**n=12**	**n=15**	**n=21**	**n=10**	**n=6**	**n=16**	**n=14**
Median price (per 'point')	$50	$50	$40	$40	$37.50	$40	$40	$32.50	$28.75	$50	$50
Range	(50-80)	(10-80)	(20-50)	(20-50)	(20-70)	(30-50)	(30-80)	(20-230)	(25-50)	(35-300)	(40-200)
Crystalline methamphetamine	**n=5**	**n=13**	**n=6**	**n=15**	**n=28**	**n=22**	**n=18**	**n=29**	**n=20**	**n=29**	**n=11**
Median price (per point)	$50	$50	$50	$50	$40	$45	$47.50	$40	$40	$50	$50
Range	(50-80)	(10-80)	(40-70)	(30-70)	(40-100)	(30-300)	(10-100)	(20-50)	(25-50)	(7-100)	(40-75)
MDA	**n=8**	**n=24**	**n=26**	**n=18**	**n=10**	**n=12**	**n=7**	**n=2**	**n=7**	**n=15**	**n=9**
Median price (per capsule)	$50	$50	$50	$45	$47.50	$40	$40	$35	$35	$50	$40
Range	(40-60)	(20-80)	(25-60)	(30-60)	(35-60)	(25-50)	(27-50)	(30-40)	(8-45)	(35-60)	(35-60)
Ketamine	**n=3**	**n=3**	**n=32**	**n=11**	**n=11**	**n=0**	**n=1**	**n=10**	**n=10**	**n=2**	**n=1**
Median price (per gram)	$200	$150	$160	$150	$200		$200	$200	$195	$100	$50
Range	n/a	(50-200)	(20-200)	(80-200)	(100-200)		-	(100-200)	(150-250)	(50-150)	-
Cocaine				**n=22**	**n=16**	**n=7**	**n=27**	**n=14**	**n=16**	**n=9**	**n=8**
Median price (per gram)	n/a	n/a	n/a	$200	$200	$250	$250	$250	$277.50	$250	$325
range				(150-400)	(200-450)	(180-300)	(180-600)	(100-400)	(100-400)	(200-400)	(200-400)

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

n/a – data not collected

Note: Data for GHB not presented as very few were able to comment on price

Appendix 17: Price of other drugs in SA, WA, NT and QLD, 2000 to 2004

Drug	SA					WA		NT		QLD				
	2000 (n=50)	2001 (n=70)	2002 (n=68)	2003 (n=101)	2004 (n=100)	2003 (n=100)	2004 (n=100)	2003 (n=104)	2004 (n=71)	2000 (n=50)	2001 (n=117)	2002	2003 (n=136)	2004 (n=161)
LSD	**n=38**	**n=43**	**n=44**	**n=33**	**n=40**	**n=28**	**n=20**	**n=10**	**n=22**	**n=29**	**n=70**		**n=24**	**n=19**
Median price (per tab)	$10	$10	$10	$10	$10	$20	$25	$25	$25	$15	$15	n/a	$20	$20
Range	(6-15)	(5-25)	(4-20)	(6-20)	(5-20)	(15-40)	(15-40)	(10-30)	(12-30)	(6-30)	(6-50)		(15-35)	(12-30)
Methamphetamine powder			**n=34**	**n=27**	**n=35**	**n=25**	**n=22**	**n=24**	**n=25**				**n=38**	**n=25**
Median price (per gram)	n/a	n/a	$42.50	$40	$50	$200	$300	$60	$100	n/a	n/a	n/a	$200	$180
Range			(25-50)	(20-250)	(30-250)	(50-400)	(200-500)	(50-300)	(50-700)				(20-300)	(20-240)
Methamphetamine base	**n=34**	**n=28**	**n=44**	**n=41**	**n=46**	**n=10**	**n=6**	**n=22**	**n=14**	**n=31**	**n=74**		**n=27**	**n=32**
Median price (per 'point')	$40	$30	$25	$25	$25	$50	$50	$50	$50	$30	$30	n/a	$25	$27.50
Range	(20-50)	(10-50)	(15-50)	(15-50)	(20-180)	(50-50)	(25-50)	(20-100)	(15-80)	(15-80)	(13-120)		(15-200)	(15-50)
Crystalline methamphetamine	**n=34#**	**n=33**	**n=47**	**n=20**	**n=25**	**n=42**	**n=43**	**n=26**	**n=14**	**n=6**	**n=37**		**n=37**	**n=38**
Median price (per point)	$40	$35	$25	$25	$25	$50	$50	$65	$50	$35	$40	n/a	$40	$40
Range	(20-50)	(7-75)	(15-50)	(20-50)	(20-300)	(25-70)	(30-180)	(40-100)	(35-100)	(20-40)	(10-60)		(20-300)	(20-60)
MDA	**n=8**	**n=13**	**n=12**	**n=6**	**n=0**	**n=2**	**n=2**	**n=5**	**n=2**	**n=10**	**n=21**		**n=8**	**n=7**
Median price (per capsule)	$50	$50	$42.50	$42.50	-	$55	$47.50	$60	$55	$40	$40	n/a	$37.50	$35
Range	(40-50)	(10-50)	(30-60)	(30-50)	-	(50-60)	(45-50)	(30-100)	(50-60)	(35-60)	(30-60)		(30-60)	(30-50)
Ketamine	**n=3**	**n=3**	**n=1**	**n=18**	**n=11**	**n=0**	**n=0**	**n=0**	**n=3**	**n=1**	**n=2**		**n=3**	**n=0**
Median price (per gram)	$40	$40	$200	$200	$200				$200	$50	$142.50	n/a	$25	
Range	(40-50)	(30-150)	-	(100-360)	(100-300)				(60-500)	-	(35-250)		(15-200)	
Cocaine				**n=23**	**n=20**	**n=6**	**n=6**	**n=5**	**n=3**				**n=17**	**n=14**
Median price (per gram)	n/a	n/a	n/a	$210	$250	$325	$400	$280	$250	n/a	n/a	n/a	$250	$237.50
Range				(150-300)	(200-450)	(250-400)	(300-500)	(60-500)	(200-400)				(200-300)	(50-450)

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

n/a – data not collected

in SA in 2000 there was no distinction made between methamphetamine base and ice, therefore the price reported is the same and includes both.

Note: Data for GHB not presented as very few were able to comment on price

Appendix 18: Injecting risk behaviour among REUs by jurisdiction, 2004

	National	NSW	ACT	VIC	TAS	SA	WA	NT	QLD
Ever injected	22	23	12	15	15	25	22	37	32
Median number of drugs ever injected* (range)	3 (1-13)	1.5 (1-11)	2.5 (1-6)	4 (1-13)	2 (1-9)	3 (1-12)	3 (1-8)	4.5 (1-12)	3 (1-10)
Injected last 6 months*	69	46	43	67	60	48	91	71	90
Median number of drugs injected last 6 months* (range)	2 (1-9)	2 (1-4	2.5 (1-6)	2 (1-9)	1 (1-4)	2.5 (1-6)	1 (1-5)	3 (1-6)	2 (1-8)

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004 *Among those that had injected

Appendix 19: Injecting drug use history among those REUs that had ever injected, 2004

	Ever injected (%) n=193	Mean age first injected (SD) n=193	First drug injected (%) n=193
Speed	75	20.2 (5.3)	46 (n=89)
Base	62	23.1 (6.8)	15 (n=29)
Ecstasy	58	23.2 (6.6)	2 (n=4)
Crystal	58	23.8 (6.9)	9 (n=18)
Heroin	50	21.2 (5.3)	16 (n=31)
Cocaine	31	22.8 (5.9)	1 (n=1)
Other opiates[1]	28	21.9 (5.1)	3 (n=5)
Benzodiazepines	22	22.6 (5.8)	-
Ketamine	19	25.0 (6.2)	1 (n=1)
MDA	12	24.0 (6.3)	-
Any drug	4	25.0 (6.4)	-

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

1. Note: Includes codeine, physeptone tablets, morphine, and pethidine.

Appendix 20: Recent injecting drug use patterns (recent injectors) among REUs, 2004

	% injected past 6 mths n=131	Median days injected last 6 mths[1] (range)	Last drug injected[1] n=131
Speed	60	10 (1-180)	22
Base	60	10 (1-180)	25
Crystal	48	12 (1-180)	19
Ecstasy	35	5 (1-180)	4
Heroin	31	10 (1-180)	18
Cocaine	12	1 (1-25)	-

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004
1. Of those who had injected in the preceding six months

Appendix 21: Context and patterns of recent injection, 2004

	National N=131	NSW n=11	ACT n=6	VIC n=10	TAS n=9	SA n=12	WA n=20	NT n=17	QLD n=46
Frequency of self injection									
Every time (%)	75	73	33	90	56	75	85	94	70
Sometimes (%)	8	18	33	0	0	8	10	0	7
Rarely (%)	2	9	0	0	0	0	5	0	2
People usually inject with*									
Close friends (%)	66	56	67	50	56	58	80	77	65
Regular partner (%)	29	27	33	50	11	25	45	35	20
No one (%)	21	27	17	20	11	17	5	12	35
Locations injected*									
Own home (%)	79	82	83	70	89	83	80	82	74
Friend's home (%)	66	82	67	40	78	75	75	47	67
Car (%)	35	46	33	30	33	33	50	18	35
Dealer's home (%)	28	36	17	30	11	17	35	29	28
Street (%)	19	36	33	40	0	0	35	12	13
Public toilet (%)	18	18	17	30	0	8	30	12	20
Venue toilet (%)	15	36	17	10	11	0	20	6	15
Median times injected any drug last 6 months (range)	30 (1-1800)	32.5 (2-264)	12.5 (1-160)	30 (1-360)	20 (1-72)	91 (8-1800)	30 (1-720)	30 (2-520)	45 (1-320)
Injected under the influence or coming down (%)	76	82	50	90	67	100	70	82	70

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004. *could nominate more than one response

Appendix 22: Prevalence of sexual activity and number of sexual partners in the preceding six months by jurisdiction, 2004

	National N=852	NSW n=104	*ACT* n=116	VIC n=100	TAS n=100	SA n=100	WA n=100	NT n=71	QLD n=161
Penetrative sex (%)	93	92	96	94	92	94	93	96	88
No. sexual partners (%)*	(n=790)	(n=96)	(n=111)	(n=94)	(n=92)	(n=94)	(n=93)	(n=68)	(n=142)
1 person	45	48	40	47	44	48	55	39	39
2 people	19	21	23	19	16	18	12	20	23
3-5 people	27	24	32	27	34	25	24	28	24
Sex with regular partner (%)*	84	85	86	80	86	92	81	79	84
Always use protection (%)	26	32	21	19	21	20	29	32	33
Sex with casual partner (%)*	59	52	68	59	61	51	54	62	61
Always use protection (%)	56	68	53	58	36	48	62	64	62
Anal sex (%)*	20	33	11	19	8	16	19	23	27
No. of times had anal sex	(n=157)	(n=32)	(n=12)	(n=18)	(n=8)	(n=15)	(n=18)	(n=16)	(n=38)
≤ Mthly	71	78	50	78	88	80	61	81	63
≤ Fortnightly	13	16	42	6	0	7	11	0	16
≥ Weekly	16	6	8	17	13	13	28	19	21

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004
* of those who had penetrative sex in the last 6 months

Appendix 23: Drug use during sex in the preceding six months by jurisdiction, 2004

	National N=852	NSW n=104	*ACT* n=116	VIC n=100	TAS n=100	SA n=100	WA n=100	NT n=71	QLD n=161
Penetrative sex while on drugs* (%)	79	90	78	80	80	76	67	88	74
No. times had sex while on drugs	(n=620)	(n=86)	(n=87)	(n=75)	(n=74)	(n=71)	(n=62)	(n=60)	(n=105)
Once	14	11	17	13	19	14	21	10	8
Twice	17	13	21	15	22	27	15	10	12
3 -5 times	29	28	28	27	24	28	23	33	34
6 - 10 times	16	21	12	11	19	10	18	13	22
Ten +	25	28	22	34	16	21	24	34	24
Drugs used (%)									
Ecstasy	84	77	87	85	93	86	69	84	89
Cannabis	36	34	36	32	42	32	34	33	43
Alcohol	46	59	53	41	64	31	31	39	38
Speed	24	19	20	35	26	25	18	36	21
Base	11	8	9	1	5	30	3	10	19
Ice	14	20	3	15	1	13	45	8	11
Cocaine	6	12	16	1	4	4	3	-	4
Ketamine	3	11	-	1	-	6	-	-	4
GHB	3	6	-	15	-	1	-	-	2

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

* of those who had penetrative sex

Appendix 24: Driving after taking drugs in the last six months among REUs by jurisdiction, 2004

	National N=852	NSW n=104	*ACT* n=116	VIC n=100	TAS n=100	SA n=100	WA n=100	NT n=71	QLD n=161
Driven soon after* taking a drug (%)	60	48	72	63	68	61	59	59	51
Drugs used (%)**	N=505	n=50	n=83	n=63	n=68	n=61	n=56	n=42	n=82
Ecstasy	69	56	65	73	66	71	64	69	83
Cannabis	57	46	59	48	74	51	54	62	59
Alcohol	52	42	70	41	75	39	46	52	43
Speed	41	40	27	59	44	34	50	52	31
Base	23	14	15	8	9	57	13	26	43
Ice	24	16	13	22	-	28	61	19	37
Cocaine	8	20	13	8	2	5	-	2	9
Ketamine	4	6	-	11	2	5	-	2	5
LSD	5	4	-	8	6	11	2	7	5
Heroin	3	-	1	6	-	2	4	-	10

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004 *within one hour of taking

Appendix 25: Proportion of REUs who accessed health help by main drug type used and main reason, 2004

	Ecstasy (%)	Speed (%)	Base (%)	Crystal (%)	Cannabis (%)	Alcohol (%)	Main reason
GP	39	7	9	14	5	3	Depression
Counsellor	27	11	0	16	11	3	Dependence
D&A worker	12	8	8	24	8	4	Dependence
Emergency	18	12	6	18	0	6	Overdose
Psychologist	40	20	7	20	7	7	Psychosis/anxiety
First aid	60	7	7	7	0	14	Physical problem
Ambulance	21	14	7	14	0	7	Overdose
Psychiatrist	42	8	8	0	8	8	Depression
Hospital	33	0	8	8	0	17	Psychosis
Social worker	27	18	0	0	27	0	Dependence

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

Appendix 26: Self-reported drug-related problems, by jurisdiction, 2004

	2000 (n=194)	2001 (n=350)	2002 (n=156)	2003 (n=809)	2004 (n=852)
Occupational/study problems (%)	51	53	47	38	44
Relationship/social problems (%)	43	38	39	34	37
Financial problems (%)	34	33	39	40	38
Legal/police problems (%)	4	6	6	8	7

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

Appendix 27: Self-reported criminal activity among REUs in the last month, 2000 to 2004

	2000 (n=194)	2001 (n=350)	2002 (n=156)	2003 (n=809)	2004 (n=852)
Crime committed in last month					
Property crime	7	9	8	7	6
Drug dealing	39	40	42	33	19
Fraud	2	4	3	2	1
Violent crime	2	4	3	2	2
Any crime	57	55	47	37	24
Arrested in last 12 months	9	9	6	11	10

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

Appendix 28: Self-reported criminal activity among REUs recruited in NSW, ACT, VIC and TAS, 2000 to 2004

	NSW					ACT		VIC		TAS	
Criminal activity	**2000 (n=94)**	**2001 (n=163)**	**2002 (n=88)**	**2003 (n=102)**	**2004 (n=104)**	**2003 (n=66)**	**2004 (n=116)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**
% Any crime in last month	49	44	43	31	18	45	11	49	33	30	19
% Drug dealing in last month	40	38	40	28	12	42	9	41	29	25	16
% Property crime in last month	11	12	5	4	5	3	3	10	9	4	6
% Fraud in last month	3	4	1	1	4	3	1	3	2	1	0
% Violent crime in last month	2	4	2	5	4	0	0	2	2	0	0
% Paid for ecstasy through dealing drugs	35	36	22	19	19	23	10	19	18	19	8
% Paid for ecstasy through property crime	4	3	0	3	2	0	0	2	0	1	0
% Arrested last 12 months	14	13	6	5	11	5	6	12	17	6	3

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

Appendix 29: Self-reported criminal activity among REUs recruited in SA, WA, NT and QLD, 2000-2004

	SA					WA		NT		QLD				
Criminal activity	**2000 (n=50)**	**2001 (n=70)**	**2002 (n=68)**	**2003 (n=101)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=104)**	**2004 (n=71)**	**2000 (n=50)**	**2001 (n=117)**	**2002**	**2003 (n=136)**	**2004 (n=161)**
% Any crime in last month	24	53	53	37	25	38	30	36	35	50	41	n/a	11	23
% Drug dealing in last month	24	44	45	35	21	36	25	28	28	50	61	n/a	31	20
% Property crime in last month	2	13	12	3	6	5	10	14	4	2	3	n/a	9	6
% Fraud in last month	0	9	6	1	1	2	4	3	0	2	1	n/a	4	1
% Violent crime in last month	2	4	3	3	0	0	4	3	6	0	3	n/a	3	2
% Paid for ecstasy through dealing drugs	20	46	56	32	12	25	17	29	13	42	31	n/a	18	14
% Paid for ecstasy through property crime	2	0	3	1	0	1	2	12	4	0	3	n/a	6	2
% Arrested last 12 months	0	3	7	10	5	9	13	24	16	8	8	n/a	13	12

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

Appendix 30: Perceptions of police activity among REUs, 2000-2004

Perception	2000 (n=194)	2001 (n=350)	2002 (n=156)	2003 (n=809)	2004 (n=852)
Recently been more police activity	23	41	63	31	34
Recently been less police activity	4	4	5	4	3
Police activity remained stable	38	44	30	38	35
Unable to comment on police activity	35	11	3	28	28
Police activity not made more difficult to score	88	90	89	80	86

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

Appendix 31: Perceptions of police activity among REUs in NSW, ACT, VIC and TAS, 2000 to 2004

	NSW					ACT		VIC		TAS	
Perception	**2000 (n=94)**	**2001 (n=163)**	**2002 (n=88)**	**2003 (n=102)**	**2004 (n=104)**	**2003 (n=66)**	**2004 (n=116)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**
Recently been more police activity	32	49	78	37	45	19	16	19	58	55	31
Recently been less police activity	5	5	2	7	1	14	4	3	1	1	4
Police activity remained stable	52	34	16	36	41	48	59	56	31	24	35
Unable to comment on police activity	11	12	3	20	13	20	21	22	10	20	30
Police activity not made more difficult to score	87	94	88	80	85	85	88	86	90	72	83

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004

Appendix 32: Perceptions of police activity among REUs in 2000 and 2001 by jurisdiction

	SA					WA		NT		QLD				
Perception	**2000 (n=50)**	**2001 (n=70)**	**2002 (n=68)**	**2003 (n=101)**	**2004 (n=100)**	**2003 (n=100)**	**2004 (n=100)**	**2003 (n=104)**	**2004 (n=71)**	**2000 (n=50)**	**2001 (n=117)**	**2002**	**2003 (n=136)**	**2004 (n=161)**
Recently been more police activity	8	30	43	22	27	29	29	38	48	22	22	n/a	25	29
Recently been less police activity	-	7	9	1	3	6	4	1	3	6	6	n/a	2	3
Police activity remained stable	14	61	47	37	27	34	38	30	23	34	34	n/a	41	24
Unable to comment on police activity	78	1	2	41	43	31	29	32	27	38	16	n/a	32	45
Police activity not made more difficult to score	86	89	91	87	86	82	89	64	73	92	86	n/a	88	89

Source: PDI interviews 2000, 2001, 2002, 2003 and 2004