

Raimondo Bruno & Stuart McLean

TASMANIAN DRUG TRENDS 2003
Findings from the
Illicit Drug Reporting System (IDRS)

NDARC Technical Report No. 178

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DRUG TRENDS
2003**



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Illicit Drug Reporting System
(IDRS)**

Raimondo Bruno*[#] & Stuart McLean*

*School of Pharmacy and #School of Psychology,
University of Tasmania

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ABBREVIATIONS

ABCI	Australian Bureau of Criminal Intelligence
ACC	Australian Crime Commission
ADIS	Alcohol and Drug Information Service
AFP	Australian Federal Police
AIHW	Australian Institute of Health and Welfare
ASSAD	Australian School Students' Alcohol and Drugs survey
COTSA	Clients of Treatment Service Agencies
DACAS	Drug and Alcohol Clinical Advisory Service
DHHS	Department of Health and Human Services
IDRS	Illicit Drug Reporting System
IDU	Injecting drug user
KI	Key Informant
KIS	Key Informant Study
MMT	Methadone Maintenance Therapy
NDARC	National Drug and Alcohol Research Centre, University of New South Wales
NDLERF	National Drug Law Enforcement Research Fund
NDSHS	National Drug Strategy Household Survey
NSP	Needle and Syringe Program
NAP	Needle Availability Program
OTHER	Refers to other (secondary) indicators
SIS	State Intelligence Services, Tasmania Police
SD	Standard Deviation
SPSS	Statistical Package for the Social Sciences
SSRI	Specific Serotonin Reuptake Inhibitor
TASPOL	Tasmania Police
TCA	Tricyclic Antidepressant

EXECUTIVE SUMMARY

In 1998, the National Drug and Alcohol Research Centre was commissioned by the Commonwealth Department of Health and Family Services (now the Australian Government Department of Health and Ageing) to begin a national trial of the Illicit Drug Reporting System (IDRS), following previous employment of the methodology in New South Wales, South Australia and Victoria. The intention of the IDRS was to provide a coordinated approach to the monitoring of data associated with the use of heroin, cocaine, methamphetamine and cannabis, in order that this information could act as an early warning indicator of the availability and use of drugs in these categories.

The 1999, the Tasmanian component of the national IDRS gathered information on drug trends using two methods: key informant interviews with professionals working in drug-related fields, and an examination of existing indicators. For the 2000 IDRS, funding was provided by the National Drug Law Enforcement Research Fund to expand this methodology and include a survey of people who regularly inject illicit drugs in addition to the methods employed previously. This funding and methodology was continued in 2001 and into 2003.

Injecting drug user (IDU) survey

One hundred people that regularly injected illicit drugs (IDU) were interviewed using a standardised interview schedule which contained sections on demographics, drug use, price, purity and availability of drugs, crime, risk-taking, health and general drug trends.

Key informant (KI) survey

Thirty-one professionals working with substance-using populations provided information about a range of illicit drug use patterns in clients they had direct contact with. These 'key informants' (KI) included needle availability program staff, drug treatment workers, health workers, youth and outreach workers, and staff from police and community corrections. Of these informants, 7 reported on groups that predominantly used opioids (diverted pharmaceuticals), 11 on cannabis and 13 on groups primarily using methamphetamine.

Other indicators

In order to complement and validate the key informant interview data, a range of drug use indicator data was sought from both health and law enforcement sectors. Guidelines for the acceptability of these sources aimed to ensure national comparability, and required that the sources were available annually, included 50 or more cases, were collected in the main study site and included details on the main illicit drug types under study.

Included in this analysis were telephone advisory data, drug offence data, Hepatitis C incidence data, data from the 1998 and 2001 National Drug Household Studies, and data from clients of the State's Needle Availability and Pharmacotherapy programs, as well as drug and alcohol treatment services.

Demographic characteristics of injecting drug users (IDU)

Demographic characteristics of the regular injecting drug user (IDU) participants interviewed were generally very similar to those interviewed in previous Hobart IDRS studies. Participants were predominantly male (70%), and had an average age in the late twenties (29 years). On average, participants had completed 10 years of education, and two-thirds (69%) were currently unemployed. One-quarter of participants had a previous prison history, which was a reduction from the one-third seen in the previous two IDU samples. A high proportion of the current IDU participants were currently involved in some sort of drug treatment, with 58% currently enrolled in a methadone maintenance program.

The majority of participants (68%) were injecting a few times per week, but not every day, with 17% injecting at least once per day. As per previous IDRS IDU samples, two-thirds (64%), reported an opiate as their drug of choice, with the remainder predominantly nominating a stimulant drug. While heroin was the most commonly nominated drug of choice (41%), it was rarely the drug most commonly used by IDU participants (just 3%), with 48% most commonly using methadone, 29% methamphetamine, and 19% most commonly injecting morphine in the six months prior to interview.

Patterns of drug use among IDU

The 2003 IDRS detected a number of trends during the preceding six to twelve months. Table A below provides a summary of the trends in price, availability and prevalence of use of the major drug types examined in the current study:

Table A: Price, availability, purity and prevalence of use of heroin, methamphetamine, cannabis, methadone and morphine

	Heroin	Methamphetamine		Cannabis	Morphine	Methadone
		'Paste'	Crystal	Bush/Hydro		
Price						
1 mg	-	-	-	-	\$0.7-0.8, stable/↓	\$1, stable
0.1 gram	\$50, stable/↓	\$50, stable	\$50, stable	-	\$70, stable/↓	\$80, stable
Gram	\$350, stable	\$300, stable	\$350, stable	\$10/25, stable	-	-
Ounce	-	-	-	\$150/300, stable	-	-
Availability	Mixed reports Stable	Very easy Stable	Very easy Increased	Very easy Stable	Easy-Very easy Stable/↓	Easy-Very easy Stable/↓
Purity*	Mixed reports Stable	Medium-high Fluctuating	High Stable	Medium/High Stable	Pharmaceutical	Pharmaceutical
Prevalence of use	Slight increase but very low	Possible decrease	Increase	Stable	Stable amount, ↓ frequency	Increase in use of Physeptone

**Note: based on IDU and key informant estimates of purity/potency*

Heroin

While the availability of heroin in the state appeared to have been slowly increasing during 1999 and 2000, data from the 2001 and 2002 IDRS studies suggested that the drug was becoming increasingly difficult to access locally. Indicators from the current study suggest that the decline has halted and availability of the drug has stabilised at a low level. Recent use of heroin was seen in just 26% of the IDRS IDU sample, despite the fact that 41% regarded it as their drug of choice. Use of heroin among clients of the state's Needle Availability Program remained below 2% of all client transactions in 2002/03.

The small number of participants that could report prices for heroin indicated that the drug was purchased for \$50 per 'packet' (approximately 0.1g) and \$350 per gram; similar prices to those reported in previous IDRS studies. As further evidence of a low availability of the drug locally, the majority of individuals that had recently used the drug reported it as 'difficult' or 'very difficult' to access and Tasmania police have not made any seizures of heroin in the past two financial years.

Methamphetamine

Over the past three years of the IDRS in Hobart, higher-purity forms of methamphetamine have steadily increased in availability in the state. This easy availability of high-potency forms of the drug may have made use of methamphetamine particularly attractive among IDU, with almost all of those surveyed in the current study using some 'form' of the drug in the six months prior to interview (89%), despite the participants predominantly preferring opioids (64%). Moreover, the proportion of clients of the state's Needle Availability Program reporting predominant use of methamphetamine has steadily increased from 31% of recorded transactions (almost 3,000 cases) in 2000 to 50% in 2003 (almost 15,000 transactions).

In terms of the 'forms' of methamphetamine used among the IDU cohort, the traditional low-purity powder form, which reports from Tasmania police suggest remains the most common form of the drug available in the Tasmanian market, was used by approximately half of the IDU participants in the current study. However, a major change was seen this year in the level of availability of the higher-potency forms of the drug. Among the 2002 IDRS IDU participants, the 'form' of methamphetamine most commonly used was the waxy, sticky, gel-like 'base/paste' presentation of the drug, used by 74% of the cohort. In 2003, this was used by less than half of the respondents (46%). Instead, it appears that the availability of the particularly high purity form, crystalline methamphetamine ('crystal meth' or 'ice') has substantially increased in 2003, and has become the form most commonly used among the IDU cohort in the current study. In the 2002 study, just 20% of the IDU cohort had recently used this form of the drug, however, in the 2003 study, 69% had recently used crystal methamphetamine.

IDU reported all forms of methamphetamine to be easily available in the preceding six months. Indeed, both IDU and key informants regarded the ready availability of relatively high potency methamphetamine (crystal methamphetamine in particular) as responsible for anecdotal descriptions of an increasing number of people using methamphetamine, particularly among younger individuals (mid teens to twenty years), in recent months. There were also continued anecdotal suggestions of methamphetamine attracting opiate users away from that market.

However, with the greater availability and use of higher purity methamphetamine came anecdotal suggestions of increases in the negative effects of methamphetamine use, such as paranoia and agitation, among IDU. Moreover, both key informants and IDU reported concerns around recent anecdotal reports of deaths due to heart failure associated with excessive crystalline methamphetamine use. While such information is yet to be verified, it is clear that, with these indications of expanding levels of availability and use, careful monitoring of both the methamphetamine market and the impacts on the physical and mental health of users is warranted in the coming years.

Cocaine

It appears that the availability and use of cocaine in Hobart continues to be very low, at least within the populations surveyed in the current study or accessing government services. This low availability of the drug locally is supported by similar low levels of use in a recent sample of 100 regular ecstasy users in Hobart (Bruno & McLean, 2004a). Only a very small proportion of the IDRS IDU sample reported recent use of the drug (9%), which locally is almost exclusively a powder. By the few IDUs who could comment on trends in availability, cocaine was considered difficult to access, a situation that was considered stable in the preceding six-month period. The cocaine that is used by Tasmanian IDU appears generally to be imported in small quantities by users directly from dealers in mainland states. Tasmania Police made no seizures of cocaine in 2002/03, following just single seizures in the preceding two financial years. These patterns of low levels of availability seem to have remained reasonably stable over the past few years, however, it is noteworthy that increasing proportions of the Tasmanian IDU sample over the past three years have reported lifetime use (39%, 47% and 52% in the 2001, 2002, and 2003 surveys respectively) of cocaine.

Cannabis

Most aspects of the cannabis market and patterns of use appear to be relatively stable. Among the IDU surveyed, cannabis use continued to be almost ubiquitous, with 88% using the drug in the preceding six months, and the majority of these individuals using the drug daily. IDU regarded purchase prices of cannabis as remaining stable in the preceding six months. Hydroponically-cultivated cannabis head remains the form most commonly smoked by IDU, although substantial proportions also reported using both hydroponically-grown (95%) and outdoor cannabis (89%) in the preceding six months. In concert with this, intelligence reports from Tasmania police in recent years have indicated an increasing trend toward hydroponic cultivation of the drug, with increasing proportions of cannabis seizures being indoor or hydroponic in origin, and reports from all three state Drug Investigation Services branches suggesting that outdoor plantations of cannabis seem to be on the decrease.

Pharmaceutical Opioids

Overall, patterns of use and availability of pharmaceutical opioids such as morphine and methadone seem to have generally remained stable since the 2000 IDRS, with 72% of the current IDU sample using morphine and 85% methadone in the six months prior to interview. However, emerging trends noted in previous years within this class of drugs have continued into 2003. The median frequency of use of morphine in the preceding six months within the 2003 IDU sample continued to decline from previous studies, falling from 52 days in the 2000 study to just 21 days among the current cohort. Perhaps balancing this decline in frequency of use of morphine, the proportion of the IDRS IDU samples using Physeptone (methadone) tablets has steadily increased across the past four annual surveys (used by 30% of the IDU sample in 2000 and 64% in 2003). There does not appear to be any substantial increase in the diversion of methadone syrup, with illicit access to methadone was more commonly via Physeptone tablets than through diverted syrup.

MS Contin remains the most commonly used formulation of morphine, although reported use of Ordine, a liquid preparation of the drug, appears to have been increasing over the past four years. Virtually all of those using morphine or methadone tablets had accessed these substances from illicit sources in the six months prior to interview,

indicating that access to these products is primarily not coming via doctor shopping from the users themselves.

While some key informants noted a decrease in both benzodiazepine use and injection amongst opiate-using groups, of concern were IDU reports of increasing use of methadone syrup and alprazolam simultaneously (in the same syringe) and a return of a similar mode of use of methadone syrup and temazepam gel capsules. This pattern of use is of considerable concern, not solely due to the deleterious effects of injection of benzodiazepines but also due to the increased risk of overdose on use of multiple central nervous system depressant drugs. Given anecdotal reports of two recent deaths associated with coincident methadone and alprazolam use, this pattern of use merits careful attention in the coming months, particularly from front-line health intervention workers.

Alkaloid Poppies

Continuing the trend seen in the past two years of the IDRS, both use of preparations of alkaloid poppies and the number of poppy crop thefts remained low in 2003. Rates of both were around one-third that of the rates seen in the 2000 study: in 2003, only 12% of the IDU surveyed reported using some preparation of alkaloid poppies, with 20,223 poppy capsules stolen, in comparison to the 34% reporting use and 62,500 capsules stolen in 2000.

Buprenorphine

Buprenorphine, recently adopted as a maintenance treatment option for opioid addiction in the state, appears to have made little impact on the illicit opioid market, with only three individuals participating in the 2003 survey reporting illicit use of the drug. However, given that substantial levels of diversion has occurred in jurisdictions where buprenorphine maintenance treatment is more common, careful monitoring of this issue is clearly warranted as Tasmania's buprenorphine program expands, particularly given the existing culture of use of pharmaceutical products among local IDU.

Benzodiazepines

There are clear indications that there has been a further reduction of the injection of benzodiazepines among IDU between 2001/02 and 2002/03. The proportion of the IDU sample reporting injection of benzodiazepines in the preceding six months fell from 38% in the 2002 study to 31% in the 2003 sample. While it appears that harm reduction efforts, by front-line workers, medical practitioners and policy changes may have had a considerable impact on patterns of benzodiazepine use, there remains a relatively high level of benzodiazepine injection within Hobart when compared to other jurisdictions, despite a reduction in the availability of temazepam gel capsules that are particularly favoured for injection. There are early indications that alprazolam may be replacing the market for temazepam gel capsules among those IDU particularly interested in benzodiazepine injection, with alprazolam injection increasing in recent months. Moreover, this form appears to be used in similar ways to temazepam capsules, such as in simultaneous combination with methadone syrup. This is a particular concern given the serious psychological and physical harms associated with benzodiazepine injection. Additionally, the level of use and availability of benzodiazepines generally remains high within local IDU (used by 88% of the 2003 IDU sample, and 83% of the 2002 cohort), particularly among primary users of opiates, which is again of concern given the increased risk of overdose when the two substances are combined. As such, patterns of benzodiazepine use and injection in the state continue to warrant very close attention.

Associated harms

Self-reported rates to sharing of needles or syringes among clients of non-pharmacy Needle Availability Program outlets have steadily declined over time from 2.6% of all transactions in 1995/96 to 0.63% in 2002/03. However, 6% of the current IDRS IDU cohort reported using another person's used needle in the month prior to interview. Similar to the improving trends for sharing of needles and syringes, self-reported rates of sharing of other injection equipment (such as water, tourniquets and mixing containers) has steadily decreased among clients of non-pharmacy Needle Availability Program outlets (5.5% in 1996/97 to 0.4% in 2002/03) and 87% of the current IDRS IDU cohort had not shared any such injection equipment in the month prior to interview. Tourniquets remain the most commonly shared item among IDRS IDU cohorts.

Blood borne viruses, such as HIV/AIDS and hepatitis B and C are a major health risk for individuals who inject drugs. Surveillance data on the number of hepatitis C cases reported to the Public Health department indicate that, following a marked dip in incident cases of hepatitis C between 2000 and 2001, reported incident cases of infection have increased only slightly between 2001 and 2003, with 24 incident cases recorded in 2003.

Comparing reported rates of injection-related harms among the 2002 and 2003 Tasmanian IDRS participants, there were little changes in the level of experience of the commonest problems of scarring and difficulties finding veins to inject into, both indicative of vascular damage, with approximately half of the IDU participants experiencing these issues in the month prior to interview. Experience of 'dirty hits' (feeling physically unwell soon after injection, often associated with the injection of contaminants or impurities) appears to have increased substantially between the 2002 and 2003 cohorts (from 18% to 31%), and was primarily associated with the injection of methadone syrup. Overall, a substantial level of injection-related health problems are experienced by local injecting-drug users, at a relative rate considerably higher than IDU in other jurisdictions. This is reflective of the increased harms associated with the injection of pharmaceutical preparations of drugs, which is substantially more common in Tasmania than other jurisdictions. However, local IDU experienced a much lower rate of (non-fatal) overdose than users in other jurisdictions, due to the greater control over the dose of the drug afforded by use of standardised pharmaceutical preparations. While this rate of experience of overdose remains low among Tasmanian IDU, rates of fatal opiate overdoses have been increasing over the past 14 years, rising from less than 10 deaths per million population (aged between 15-44 years) to over 30 deaths per million in recent years.

Implications

The findings of the Tasmanian 2003 IDRS suggest the following areas for further investigation and possible consideration in policy:

- As Tasmanian illicit drug use culture has been consistently shown to substantially differ from other jurisdictions (with regard to, for example, patterns of use of pharmaceutical products rather than substances such as heroin, due the low local availability of this drug), drug education programs and harm minimisation information campaigns need to be tailored to the particular needs and types of substances used within the state.

- Extension of a regular drug trend monitoring framework into other regions within the state (such as Launceston and the North-West coast) as there has been little specific research examining patterns of drug use within these areas, and due to their access to air and sea ports and establishment of organised motor cycle group headquarters, availability and use of illicit substances may differ substantially in these regions from patterns seen in Hobart.
- Continued emphasis on, and support for, targeted strategies to further reduce the rates of sharing of needles/syringes and other injection equipment (such as tourniquets, filters and mixing containers) among IDU, as well as to minimise the harms associated with poor injecting practice through improving awareness and adoption of safe injection techniques and vein care among IDU.
- Investigation into the factors associated with the experience of ‘dirty hits’ among local IDU and development of strategies to reduce this occurrence.
- Continuing monitoring of the expanding methamphetamine market and patterns of methamphetamine use.
- As use and availability of the high-potency crystalline methamphetamine appears to be substantially increasing, clear and practical harm-reduction information for use of this form of the drug should be accessed and distributed to consumers and health intervention workers. Additionally, since increased levels of use of such high-potency methamphetamine may increase the level of experience of the negative effects of excessive methamphetamine use, development and implementation of practical strategies and training for dealing with such affected individuals should be considered for front line health intervention workers and emergency services workers.
- Continued monitoring of the availability and potency of heroin available locally, particularly given that mainland heroin markets appear to have returned to a relatively easy availability of the drug in 2002.
- With the firm establishment of a culture of injection of methadone syrup locally (although this remains predominantly within individuals enrolled in the state methadone maintenance program injecting their own methadone), continued consideration of pragmatic harm reduction approaches to such use is warranted: either at the level of the consumer, with use of butterflies and biological filters; and/or at the policy level, requiring use of sterile water for dilution of methadone doses or switching to Biodone syrup, as this preparation does not contain the agent sorbitol, which can cause irritation and harm to the venous system. Given the increased level of recent experience of ‘dirty hits’, primarily associated with methadone syrup injection, among the current IDU cohort, these issues merit renewed attention.
- Use of liquid preparations of morphine (Ordine) has continued to rise over the past three years of the IDRS. This is of some concern as the drug is typically sold ‘preloaded’ in syringe barrels, and it is often unclear to the user if the injection equipment or the solution is free from infection or contamination. Approaches to reducing the potential harms of this situation, such as increasing the awareness of the

risk of this situation among users, or varying prescription practices to reduce the availability of larger containers of the drug, merit consideration as use expands.

- Given that injection of buprenorphine carries with it a substantial degree of risk for the development of abscesses, careful monitoring of diversion of the drug is warranted as Tasmania's buprenorphine program expands. If, as has been seen in other jurisdictions with larger buprenorphine maintenance programs, injection of the drug becomes an issue locally, IDU should be made aware of harm-reducing injection techniques for the drug through front-line harm reduction workers.
- Research into factors that would reduce the harms associated with the intravenous use of the pharmaceutical preparations of morphine, methadone and benzodiazepines commonly used within the local IDU population, and dissemination of this information to users through continued training of Needle Availability Program staff and peer groups.
- Continued monitoring of the intravenous use of benzodiazepines, particularly in terms of the combined injection of alprazolam and methadone syrup, as this is a practice that substantially increases the risk of overdose.
- Characterisation and potency testing of cannabis cultivars to investigate continuing reports of high or increasing potency of cannabis.
- Research examining the extent of use, and demographic profiles of (mis)users of drugs such as anabolic steroids, inhalants, and pharmaceutical stimulants in the state, as these populations are not well accessed within the methodology of the IDRS.

1. INTRODUCTION

In 1998, the National Drug and Alcohol Research Centre was commissioned by the Commonwealth Department of Health and Family Services (now the Australian Government Department of Health and Ageing) to begin a national trial of the Illicit Drug Reporting System (IDRS), following a successful pilot study of the methods in New South Wales in 1996 (Hando, O'Brian, Darke, Maher & Hall, 1997) and a multi-state trial of the methodology in New South Wales (Hando & Darke, 1998), South Australia (Cormack, Faulkner, Foster-Jones & Greaves, 1998) and Victoria (Rumbold & Fry, 1998) the following year.

The intention of the IDRS is to provide a co-ordinated approach to the monitoring of trends associated with the use of methamphetamine, opioids, cannabis and cocaine, in order that this information could act as an early indicator of emerging trends in illicit drug use. Additionally, the IDRS aims to be timely and sensitive enough to signal the existence of emerging problems of national importance rather than to describe phenomena in detail, instead providing direction for issues that may require more detailed data collection or are important from a policy perspective.

The full IDRS methodology involves a triangulated approach to data collection on drug trends, involving standardised surveys of people who regularly inject illicit drugs, a qualitative survey of individuals who have regular first-hand contact with groups of people who use illicit drugs ('key informants'), and an examination of existing available data sources or indicators relevant to drug use in each state. Following a replication of the IDRS process in 1998 in New South Wales, Victoria and South Australia, the IDRS was expanded nationally, with these states continuing to follow the full methodology, while Western Australia, Northern Territory, the Australian Capital Territory, Queensland and Tasmania examined drug use trends using an abbreviated design, utilising key informant interviews and examination of secondary data sources only. The National Drug Law Enforcement Research Fund has provided these states with additional funding to expand data collection to the full IDRS methodology for 2000 through to the current year.

The 2003 Tasmanian Drug Trends Report summarizes the information gathered in the Tasmanian component of the national IDRS using the three methods outlined above: a survey of people who regularly inject illicit drugs, key informant interviews with professionals working with individuals who use illicit drugs, and an examination of existing indicators relating to drugs and drug use in the state. The methods are intended to complement and supplement each other, with each having its various strengths and limitations. Results are summarized by drug type to provide the reader with an abbreviated picture of illicit drug usage in Hobart and recent trends. Reports detailing Tasmanian drug trends from 1999 (Bruno & McLean, 2000), 2000 (Bruno & McLean 2001), 2001 (Bruno & McLean, 2002), 2002 (Bruno & McLean, 2003) and state comparisons (McKetin et al., 2000; Topp et al, 2001, Topp et al, 2002, Breen et al., 2003), are available as technical reports from the National Drug and Alcohol Research Centre, University of New South Wales.

1.1 Study Aim

The specific aim of the Tasmanian component of the IDRS was to provide information on trends in illicit drug use in Tasmania that require further investigation.

2. METHOD

The IDRS is essentially a convergent validity study, where information from three main sources, each with its own inherent advantages and limitations, is compiled and compared to determine drug trends. The three components of the IDRS are: a survey of people who regularly inject illicit drugs (IDU), a key informant study of professionals working in the illicit drug (or related) field that have regular direct contact with individuals who use illicit drugs, and an examination of existing indicator data on drug-related issues. Details of each dataset are provided below. Previous work with the IDRS methodology has found that injecting drug users are a good sentinel group for detecting illicit drug trends due to their high exposure to many types of illicit drugs. This group also possess' first-hand knowledge of the price, purity and availability of illicit drugs. Key informant interviews provide contextual information about drug use patterns and health-related issues, such as treatment presentations. The collection and analysis of existing drug use indicator data provides quantitative contextual support for the drug trends detected by the IDU and key informant surveys (McKetin, Darke & Kaye, 1999).

Data sources complemented each other in the nature of the information they provided, with information from the three sources used to determine whether there was convergent validity for detected trends, and the most reliable or 'best' indicator of a particular trend used when summarising trends. Findings from the 2003 Tasmanian IDRS are also compared with findings from the previous Tasmanian studies (Bruno & McLean, 2000; Bruno & McLean, 2001; Bruno & McLean, 2002; Bruno & McLean 2003) to determine any changes in drug trends over time.

2.1 Survey of injecting drug users (IDU)

The IDU survey was completed during June and July 2003, and consisted of face-to-face interviews with 100 people who regularly inject illicit drugs. Inclusion criteria for participation in the study were that the individual must have injected at least once monthly in the six months prior to interview, and have resided in Hobart for the past twelve months or more. Participants were recruited using a variety of methods, including advertisements distributed through needle availability program outlets (NAPs), pharmacies (through flyers included with injection equipment) or health services, and snowball methods (recruitment of friends and associates through word of mouth). Participants were interviewed at places convenient to them, such as health services, NAPs or, where invited by the participant, private homes. Three agencies: NUFIT; The Link Youth Health Service; and the Tasmanian Council on AIDS, Hepatitis and Related Diseases (TASCAHRD) assisted the researchers by participating as recruitment and interview sites for IDRS participants. The major location for recruitment and subsequent interview was Hobart city, although approximately one third of the sample was recruited and interviewed in Glenorchy city (in the northern suburbs of Hobart).

A standardised interview schedule used in previous IDRS research (Hando & Darke, 1998; McKetin et al., 1999; Topp, Hando & Darke, 2001) was administered to participants. The interview schedule contained sections on demographics, drug use, price, purity and availability of drugs, crime, risk-taking, health and general drug trends. Participants were screened for appropriateness both by referring staff members of the recruitment sites and the interviewers, the latter through a series of questions designed to

elicit participant's knowledge of injecting drug use practice. Both the University of New South Wales and University of Tasmania institutional Ethics Committees granted ethical approval for the survey. Participants were given an information sheet describing the interview content prior to commencement (subsequent to screening), allowing them to make a more informed decision about their involvement. Information provided was entirely confidential, and participants were informed they were free to withdraw from participation without prejudice or to decline to answer any questions if they so wished. Interviews generally lasted between 25 and 40 minutes (ranging from 20 to 75 minutes), and participants were reimbursed \$30 for their time and out-of-pocket expenses.

Data analysis was conducted using SPSS for windows, release 11.0.1 (SPSS Inc, 2002).

2.2 Survey of key informants (KIS)

Thirty-one key informants who were working with illicit drug users in the greater Hobart area participated in face-to-face interviews between July and September 2003. Fourteen (45%) participants were recruited from the pool of key informants that had taken part in the 2002 IDRS (Bruno & McLean, 2003), while 12 (39%) had also participated in the 2001 IDRS (Bruno & McLean, 2002), with 8 (26%) participating in the 2000 IDRS, and 3 (10%) in the 1999 study. All other participants in the current study were identified and recruited either as replacements for the 2002 IDRS participants drawn from the same agencies or on the basis of referrals from the Tasmanian IDRS steering committee or professionals in the field.

Key informants included youth workers (n=4), members of the department of justice (police; probation and parole: n=6), and pharmacists (n=1), with the remainder working specifically in the drug and alcohol field, comprising psychologists/counsellors (n=6), outreach/street workers (n=2), general practitioners prescribing methadone or specialising in alcohol and other drug treatment (n=2), and other health professionals working in a variety of more general roles in the drug and alcohol field, including assessment, nursing, needle and syringe availability, and advocacy (n=10).

Entry criteria for inclusion in the study were, at least, weekly contact with illicit drug users in the past 6 months and/or contact with 10 or more illicit drug users in the last 6 months. All key informants satisfied these criteria: the median number of days contact with illicit drug users in the past 6 months was 4 days per week (mode 5 days per week, range 1 - 6), and all key informants reported contact with more than 10 users in the week prior to interview (with 35% seeing more than 50 in the past week, and 84% had contact with more than 20 individuals in this time).

Thirty-five percent were males. Key informants predominantly rated that they were moderately certain of the information they provided in the interviews (61%), with all but one of the remainder reporting being very certain of their information (32%). Although the key informants predominantly came from generic services (55%, n=17), many worked with special populations, including youth (32%, n=10), prisoners (6%, n=2), persons identifying as Aboriginal (6%, n=2) and injecting drug users (23%, n=7).

Key informants were asked to specify the main illicit drug used by the drug users they had most contact with in the past 6 months. The majority of key informants reported on the use of methamphetamine (n=13), with the remainder reporting on groups of primary

morphine (n=4), methadone (n=3) or cannabis (n=11) users. This breakdown is a slight shift to that in the 2000 and 1999 Tasmanian IDRS surveys, where there was a more even proportion of key informants reporting on the use of methamphetamines and of opioids, and the 2001 and 2002 surveys where the majority of key informants reported on primary users of opioids. However, this is unlikely to necessarily indicate a substantial change in the illicit-drug using patterns of the individuals tapped in the key informant survey, as most informants were referring to predominantly poly-substance using populations.

The interview schedule was a structured instrument that included sections on drug use patterns, drug availability, criminal behaviour and health issues. Interviews took between 30 and 120 minutes to administer. Notes were taken during the interview and subsequently transcribed in full. Open-ended responses were analysed using a word processor, sorting for recurring themes across respondents. Single reports from key informants have been presented where they were deemed reliable by the interviewer, and where the information provided contributed to the explanation of particular trends. Closed-ended questions were analysed using SPSS for Windows, release 11.0.1 (SPSS Inc, 2001).

2.3 Other indicators

To complement and validate data collected from the key informant study and IDU survey, a range of secondary data sources was examined, including survey, health, and law enforcement data. The pilot study for the IDRS (Hando et al., 1997) recommended that such data should be available at least annually; include 50 or more cases; provide brief details of illicit drug use; be collected in the main study site (Hobart or Tasmania for the current study); and include details on the four main illicit drugs under investigation. However, due to the relatively small size of the illicit drug using population in Tasmania (in comparison to other jurisdictions involved in the IDRS), and a paucity of available data (several key services are in the process of adopting computerised or more systematic information storage and retrieval systems), the above recommendations have been used as a guide only. Indicators not meeting the above criteria should be interpreted with due caution, and attention is drawn to relevant data limitations in the text.

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

- *Needle Availability Program Data*

The Needle Availability Program (NAP) has been operating in Tasmania since the introduction of the HIV/AIDS Preventive Measures Act in 1993. Staff record the number of needle/syringes ordered from all 90 outlets participating in the program, and for participating non-pharmacy outlets, data is collected regarding age, sex, equipment shared since last visit, last drug used, and disposal methods for each client transaction. The data provided represents responses from 34,124 occasions of service in the 2002/03 financial year. It should be noted that data is not necessarily collected systematically for all data fields – for example, while there are 34,124 recordings for gender of client, there

are only 29,846 recorded for the substance used (87.5%¹). Additionally, there is some inconsistencies between outlets in the wording of questions asked of clients, most notably in the question regarding substance used (the majority of services ask “what is the drug you most often inject” while some find that asking “what is the drug you are about to inject” more useful for health intervention purposes), which may impede clear comparisons of trends across years for this dataset.

- *Prevalence of last drug injected by IDU in Tasmania, provided by the Australian Needle and Syringe Program (NSP), on behalf of the collaboration of Australian Needle and Syringe Programs*

The Australian NSP survey has been carried out over one week each year since 1995. During a designated survey week, NSP staffs ask all clients who attend to complete a brief, self-administered questionnaire and provide a finger-prick blood sample (for testing the presence of blood-borne viruses such as Hepatitis B and C). The data provided here represent the last drug reported to be injected by survey respondents in Tasmania each year from 1995 to 2001 (1995 n=6; 1996 n=18; 1997 n=23; 1998 n=51; 1999 n=25; 2000 n=27; 2001 n=28; 2002 n=151: Buddle, Zhou, & MacDonald 2003).

- *The 1998 and 2001 National Drug Strategy Household Surveys*

This survey represents a prevalence study of drug use amongst the general community, surveying 1,031 individuals in Tasmania in the 1998 study, and 1,349 individuals in 2001, who were over 14 years of age, could speak English, and who lived in private dwellings (Australian Institute of Health and Welfare, 1999; 2002). The survey covered the following illicit drugs: cannabis, methamphetamine, hallucinogens, cocaine, ecstasy/designer drugs and heroin. Respondents were asked whether they had ever used these drugs and whether they had used them within the past twelve months.

- *1996 and 1999 Australian School Students' Alcohol and Drugs (ASSAD) Surveys*

This is a triennial survey on secondary school students' use of tobacco and alcohol, conducted by the Tasmanian Cancer Council, and extended by the Department of Health and Human Services to include questions on the use of other licit and illicit substances. The 1996 survey includes data from 2,553 Tasmanian students from years 7 to 12. In 1999, 2,671 Tasmanian students from years 7 to 12 were surveyed.

- *Police and Justice Department Data*

Tasmania Police State Intelligence Services, the Australian Crime Commission (ACC, previously the Australian Bureau of Criminal Intelligence, ABCI), and the state Justice Department have provided information on drug seizures, charges, and costs. State Intelligence Services have been producing detailed monthly summaries of such information since July 1999, while information from the other sources is presented in annual figures. Data on the purity of drugs seized is also provided through the ACC, however, drugs are only analysed by Tasmania Police Forensic Services in seizures where the person involved denies that the powder in question contains illicit substances. Hence,

¹ However, this is a marked improvement in the data recording rate – in 2000/01, only 44% of the 32,507 occasions of service included information regarding principle drug used, while in 2001/02, the relevant rate was 78%.

for the 2002/03 financial year, a very small number of samples of methamphetamine were analysed for purity.

- *Urine screens of prisoners*

The Tasmanian Justice Department has conducted random urine screens of prisoners since 1993, aiming to test approximately 10% of the state's prison population monthly. Since 1995 these screens have been increasingly based on suspicion of drug use, rather than on a purely random basis, and sample sizes have increased reasonably steadily over time (1995/96 n=111; 1996/97 n=283; 1997/98 n=253; 1998/99 n=267; 1999/00 n=359; 2000/01 n=541; 2001/02 n=561; 2002/03 n=467).

- *Blood borne virus surveillance data*

Blood borne viruses, and, in particular HIV/AIDS and hepatitis B and C are a major health risk for individuals who inject drugs. An integrated surveillance system has been established in Australia for the purposes of monitoring the spread of these diseases. The Department of Health and Human Services, Public Health Division, records notifications of diagnoses of HIV and hepatitis B and C in Tasmania, and, where possible, records the relevant risk factors for infection that the person may have been exposed to. There are limitations to the interpretation of this dataset in terms of monitoring trends in the spread of these viruses. For example, many injecting drug users who have been exposed to hepatitis C may not undergo testing. Further, it is difficult to confidently determine whether notifications represent new cases or those that have been established for some time.

- *Tasmanian Pharmacotherapy Program Data*

Pharmaceutical Services in the Department of Health and Human Services maintains a database that records all methadone and buprenorphine program registrations in Tasmania. The number of annual new admissions to the program, and information regarding the number of active daily clients are presented.

- *Coronial Findings On Illicit Drug-Related Fatalities*

Mortality data regarding illicit drug related deaths prior to 2000 was obtained from the state coroners office. Data provided contains a summary of the toxicology analysis for each case. More recent figures in this report were provided by Australian Bureau of Statistics annual reports on fatal opioid overdoses among 15 to 44 year olds (Degenhardt, 2001; 2002; 2003).

- *Doctor Shopping Data*

Data regarding patterns of doctor shopping in the State was examined due to the high level of use of pharmaceutical products among Tasmanian IDU noted in previous IDRS reports. The Health Insurance Commission identifies people as "doctor shoppers" if, in one year, a person: 1) sees 15 or more general practitioners; 2) has 30 or more Medicare consultations, and 3) obtains more Pharmaceutical Benefits Scheme (PBS) prescriptions that appears to be clinically necessary. Data is broken down by the type of drugs accessed by each identified "doctor shopper" during each financial year period.

- *Tasmanian Alkaloid Poppy Crop Data*

Tasmania has had a commercial opiate alkaloid industry for many years, where farmers are licensed to grow the poppy (*Papaver somniferum*) for production of codeine and related products by pharmaceutical companies. The Tasmanian Government has international obligations under the United Nations Convention on Narcotic Drugs to ensure licensing of crops and that there is limited diversion, as some of the poppy strains grown can be converted into opium. Data on diversion rates of Tasmanian poppy crops has been provided by the Poppy Board of the Tasmanian Justice Department, as this is a useful indicator of potential illicit use of opium or poppy tar.

- *Telephone Advisory Services Data*

Tasmania has two 24-hour alcohol and drug-related telephone information services. In mid-May 2000, Turning Point Alcohol and Drug Centre in Victoria took over responsibility for administration of the Tasmanian Alcohol and Drug Information Service (ADIS), a confidential drug and alcohol counselling, information and referral service. Additionally, at that same time a new information service, the Drug and Alcohol Clinical Advisory Service (DACAS) was established to provide health professionals assistance with the clinical management of drug and alcohol problems. Turning point systematically record data for each call received, which comprised 2208 and 63 calls to ADIS and DACAS respectively during the 2000/01 financial year; 2129 and 94 calls to the respective services in 2001/02; with 1984 and 48 calls to the respective services in 2002/03.

3. RESULTS

3.1 Overview of the IDU sample

A total of 100 individuals were interviewed. The demographic characteristics of the IDU sample are presented in Table 1 below. The mean age of participants was 28.6 years (SD = 7.8, range 17-57), with 70% being male. There was no significant difference in the mean age of males and females participating in the survey (males 28.8 years, females 28.0 years, Mann-Whitney $U = 915, p=0.31$).

Table 1: Demographic characteristics of IDU sample

Characteristic	n=100
Mean age (years)	28.6 (range 17-57)
Sex (% male)	70
Ethnicity (%):	
English speaking background	100
Non-English speaking background	0
Aboriginal or Torres Strait Islander	14
Employment (%):	
Not employed	69
Full time	3
Part time / casual	7
Student	7
Home Duties	14
Accommodation (%):	
Own house/flat	60
Parent's/family house	19
Boarding house/hostel	4
Friends/house-sitting	6
No fixed address/homeless	11
School education (mean years)	10.3 (range 7-12)
Tertiary education (%):	
None	74
Trade / technical	21
University	4
Prison History (%)	25
Treatment History (%):	
Not currently in treatment	35
Methadone maintenance therapy	58
Buprenorphine maintenance therapy	3
Drug & alcohol counselling	3

Among those sampled, there was a mean of 10.3 years (SD = 1.3, range 7-12) of school education, with twenty-one percent of participants having trade or technical qualifications and four percent having university qualifications. The majority of the sample (69%) were not currently employed, with a further 14% involved in home duties, and 7% enrolled students, while 7% were working on a casual basis, and 3% working

full-time. When asked about their main source of income, the majority (87%) reported this as a government pension, allowance or benefit, with 7% reporting this as a wage, 1% as from family members, one from sex work, and 4% as being via criminal activity. The sample was drawn from 27 suburbs within the northern, eastern, southern, and inner city areas of Hobart, with the bulk of participants either living in close proximity to Hobart city (30%) or Glenorchy city (21%)².

One quarter of the sample (25%) of participants had been imprisoned at some stage in their lives, with males not being significantly more likely than females to have been so, as 30% of males and 13% of females had a previous prison history: $\chi^2(1, n=100) = 2.3, p = 0.13$.

Almost two-thirds (65%) of the sample were in some form of drug treatment at the time of interview, with the majority (58% of the sample) reporting methadone maintenance therapy as their primary treatment. Mean duration of time on methadone maintenance was 66 months (median= 30 months, SD = 184 months, range 1-1400 months). Three individuals each were currently receiving primary treatment via buprenorphine maintenance therapy (mean duration = 14.3 months, range 1-24 months) or drug counselling³. Fifteen of the individuals currently receiving methadone maintenance therapy were also involved in drug counselling, and 4 had been through detoxification in the six months prior to interview. One of the people receiving buprenorphine was also receiving counselling. One participant had switched from methadone maintenance to buprenorphine maintenance in the six months prior to interview. No participant reported using naltrexone in the six months prior to interview.

² A more detailed breakdown, on the basis of local council areas, is as follows: Hobart City n=35; Glenorchy City n=26; Clarence n=13; Brighton n=8; Kingborough n=5; no fixed address n=11.

³ None of the three individuals concerned could recall the duration of their involvement in drug counselling.

3.2 Drug use history and current drug use

The mean reported age at first injection of a drug was in the late teens (18.3 years, SD = 5.1 years), ranging from 11 to 50 years. There was no significant difference between age of first injection for males and females in the sample (17.9 and 19.1 years respectively).

As previous IDRS reports in Tasmania and other states (McKetin, Darke & Kaye, 2000) and local key informants have indicated that there may have been a fall in the age of initial injection among new recruits to injecting, the sample was dichotomised (using a median split) into those currently aged 25 years or younger, and those aged more than 25 years. The younger group were, on average, four years younger at initial injection than the older IDU (16.2 vs. 20.0 years respectively: Mann-Whitney U = 635.5, $p < 0.001$). However, when the sample was divided according to the length of individual injection careers (into those that started injecting within the past eight years, and those who started injecting more than eight years ago, based on a median split) there was no difference in the age of initial injection (18.5 vs. 18.0 years respectively⁴). Taken together, these results may be interpreted as indicating that while young people may indeed be taking up injection of drugs at a younger age, new recruits to injecting are not simply restricted to younger individuals.

There was considerable variation in the length of participant's injecting drug use careers, with the mean length of time since first injection being 10.3 years, ranging from 1 to 32 years (median = 8.5 years). There were no sex differences with regard to length of injection career, with mean injection career for males (10.9 years) not significantly longer than for the females sampled (8.9 years).

Methamphetamine was the first drug injected by 46% of respondents, with 29% reporting morphine, 18% reporting heroin, 3% methadone, and 4% other substances (including cocaine, codeine and ketamine: Table 2). There was a significant length of injection career-related difference in first drug injected. Those participants who had first injected within the past eight years had a larger proportion of people reporting pharmaceutical opioids as first drug injected (36% methamphetamine, 52% morphine, 6% methadone, 4% heroin, 2% ketamine), in comparison to the longer-term injecting group, where methamphetamine, and, to a lesser extent, heroin, were more predominant (56% methamphetamine, 6% morphine, 32% heroin, 2% cocaine and 4% other opiates): $\chi^2(7, n=100)=38.3, p < 0.001$. Of the 46 respondents that reported methamphetamine as their first drug injected, 29 (63%) had most often injected opioids in the month prior to interview (7 participants reporting morphine, 21 methadone, 1 heroin).

Heroin was the reported drug of choice for the majority of participants (41%), followed by methamphetamine (25%), as indicated in Table 2 below. Despite this high preference for heroin, only five participants reported it as their last drug injected, and only 3% as the drug most often injected in the month prior to interview. The drugs most commonly used were methadone (48%), morphine (19%), and methamphetamine (29%).

⁴ For consistency with the 2000 and 2001 IDRS reports, where the median split was at an injecting career of 7 and 5 years respectively, the same results hold under both these circumstances.

Table 2: Drug of initiation into injecting, drug of choice and current injection patterns for IDU in the current study

n=100	First drug injected %	Drug of choice* %	Last drug injected* %	Drug most often injected in last month* %
Heroin	18	41	5	3
Methadone	3	13	49	48
Morphine	29	10	18	19
Methamphetamine	46	25	26	29
Cocaine	1	2	1	1
Ecstasy	0	0	0	0
Benzodiazepines	0	3	2	0
Other	3	7	0	0

**One participant reported their drug of choice, their drug most often injected, and their last drug injected as a 'speedball' of cocaine and heroin. This has been recorded in both the relevant cells, hence proportions in these columns sum to 101%.*

Frequency of injection by IDU during the month prior to interview (Table 3) was varied, with most injecting more than once per week (85%), and 17% injecting at least once per day. There was no difference in the frequency of injection between younger (25 years and younger) and older (over 25 year-old) IDU.

Table 3: Frequency of injection during the last month

Frequency of injection during the last month	%
Weekly or less	15
More than weekly	68
Once a day	8
Two to three times per day	6
More than three times per day	3

Respondents were asked how much they had spent on illicit drugs on the day before the interview. The responses to this question are summarised in Table 4. This indicates that just under half of the sample (45%) had spent money on illicit drugs on the day before the interview, and that this was most commonly between \$20 and \$99. The average amount of money spent amongst the sample was \$31 (SD \$81, range \$0-700, median = \$0). Amongst only those 45 participants who had spent money on illicit drugs on the day prior to interview, the average amount of money spent was \$70 (SD \$110, range \$7-700, median = \$45)

Table 4: Amount spent on illicit drugs on day prior to interview

Amount spent on day prior to interview	%
Nothing	55
Less than \$20	7
\$20-49	16
\$50-99	12
\$100-199	7
\$200-399	2
\$400 or more	1

Respondents reported the drugs they used on the day prior to their interview (Table 5). Only 5% had not used any drugs, with almost three-quarters (72%) using cannabis on the day before their interview. Methadone (50%, although only used by four people who were not currently enrolled in methadone maintenance therapy), benzodiazepines (43%), methamphetamine (16%) and morphine (11%) use were also commonly used in this time.

Polydrug use was widespread, with 81% of those reporting using drugs taking more than one drug on the day prior to interview, and the median number of drugs used was two (36%). Multiple studies have clearly established that the risk of overdose increases when central nervous system depressants are used in addition to opioids (see Warner-Smith, Lynskley, Darke & Hall, 2000), with concomitant use of alcohol or benzodiazepines with opioids proving especially prominent in opioid overdose fatalities. Of concern then was the finding that 47% of the IDU sample reported using an opioid in conjunction with either benzodiazepines (38%) or alcohol (9%) or both (4%) on the previous day.

Table 5: Drugs taken on the day prior to interview among the IDU sample

Drug (n=100)	%
Cannabis	72
Methadone	50
Benzodiazepines	43
Morphine	11
Methamphetamine: powder	6
Methamphetamine: base/paste	4
Methamphetamine: crystal	6
Amphetamine: pharmaceutical	4
Heroin	1
Cocaine	1
Alcohol	17
Antidepressants	6
Buprenorphine	3
Other opiates	3
Did not take any drugs	5

**Note: could list more than one drug*

Participants were also asked about their usual place of injection and where they had last injected. These responses are summarised in Table 6 below, indicating that the majority of the sample tend to inject in private homes (85% usually, 72% last time they injected), while much smaller proportions tend to inject in public places (14% usually, 28% last time).

Table 6: Location in which respondents usually injected in the month prior to interview, and location of last injection

Location	Usual %	Last %
Private Home	85	72
Public Toilet	3	9
Car	9	12
Street/park or beach	2	7

Drug use histories of the IDU respondents are summarised in Table 7 below. There was a substantial level of polydrug use among this group, as almost all individuals had used methadone syrup, physeptone, morphine, methamphetamine, hallucinogens, benzodiazepines, alcohol, cannabis and tobacco at some stage in their lives. Of the 17 possible drug classes (treating all forms of methamphetamine and methadone as single classes of drugs), subjects had used a median of 12 (mean = 12.4, sd = 2.1, range 6-16) drug classes in their lives, and 8 (mean = 8, sd = 2.2, range 3-14) in the preceding six months. A median of 6 drug classes had been injected over their lifetimes (mean = 6.5, sd = 2.3, range 2-12), and 4 (mean = 3.8, sd = 1.6, range 1-8) in the preceding six months⁵.

The demographic characteristics of the Tasmanian 2003 IDU sample are generally very similar to the previous Tasmanian IDU samples (Bruno & McLean, 2003; 2002; 2001). This may partially reflect a moderate degree of overlap in the IDRS samples over time: of the 100 participants in the 2003 study, 37% participated in the 2002 study, 30% in the 2001 study, and 14% in 2000. This is consistent with previous IDRS samples: in 2002, 39% participated in the 2001 study, and 16% in the 2000 IDRS (11 participated in both); of the 100 participants in the 2001 study, 15% also participated in 2000. Notable discrepancies between the 2003 IDU and previous IDU samples are discussed in subsequent sections of this report.

⁵ These figures appear greater than previous Tasmanian IDRS reports, due to the inclusions of buprenorphine and homebake new drug classes in the 2002 study.

Table 7: Drug use history of the IDU sample (N=100)

Drug Class	Ever used %	Ever Injected %	Injected last 6 months %	Median number of days injected in last 6 months#	Ever Smoked %	Smoked last 6 months %	Ever snorted %	Snorted last 6 months %	Ever Swallowed %	Swallowed last 6 months %	Used last 6 months %	Median number of days used in last 6 months#
Heroin	73	71	26	4	24	3	14	0	14	0	26	5
Methadone svrup (licit)	69	65	53	48					69	59	59	180
Methadone svrup (illicit)	66	63	46	24					29	15	48	24†
Phvsentone (licit)	9	6	2	11	0	0	0	0	5	1	2	12
Phvsentone (illicit)	88	78	56	12	1	0	0	0	37	22	64	12†
Morphine	96	93	69	21	4	2	3	1	55	25	72	21
Homebake	13	11	2	7	2	0	0	0	2	1	3	4
Other opiates	68	24	5	1	30	6	0	0	65	28	30	3
Methamphet. powder	94	94	51	6	7	1	46	5	37	7	51	8*
Methamphet. liquid	9	7	1	1					2	0	1	1*
Methamphet. base	83	81	46	10	1	0	2	0	13	4	46	10*
Crystal methamphet.	73	70	66	8	17	11	2	0	10	8	69	8*
Pharmaceutical stimulants	85	75	45	4	7	1	8	2	47	21	50	5*
Cocaine	52	34	7	4	5	0	27	6	7	0	9	4
Hallucinogens	84	28	1	1	3	1	1	1	84	21	21	2
Ecstasy	66	40	13	1	0	0	9	4	61	26	33	2
Benzodiazepines	95	66	31	5	11	1	3	1	95	87	88	48
Alcohol	100	9	1	1					100	75	75	18
Cannabis	99										88	180
Anti-Depressants	49	4	1	1					49	22	22	180
Inhalants	56										8	2
Tobacco	97										93	180
Buprenorphine (licit)	9	2	1	6	1	1	1	1	9	4	4	101
Buprenorphine (illicit)	4	4	3	24	0	0	0	0	0	0	3	24
Polydrug use (eann drug classes used out of 17)	12	6	4								8	

#Among those using the drug

*Median days used any form of methamphetamine/pharmaceutical stimulant = 20;

†Median days used any methadone among those not receiving maintenance treatment = 24.5

4. HEROIN

Less than one-fifth of respondents on the IDU survey were able to comment confidently on the price, purity or availability of heroin (n=17). Of the key informants reporting on groups that predominantly used opioids (n=7), none reported that the group they had most contact with had primarily used heroin in the past six months.

Among the IDU sample, 73% reported they had tried heroin at some stage in their lives, and almost all of these had injected heroin (71% of sample). Twenty-six percent had used heroin in the past six months, all injecting the drug.

The demographics of the group that had used heroin in the past six months was similar to that of other IDU (see Section 3.0) in terms of sex, age, cultural and educational background, drug treatment and employment status, prison history, frequency of injection, duration of injection career, and age at first injection.

Of those IDU surveyed who had used heroin in the past six months (n=26), 69% regarded heroin as their drug of choice, 15% methamphetamine, and 4% each of methadone, opium, psychedelic mushrooms and 'speedballs' (heroin and cocaine used together). Only 3% of the entire IDU sample indicated that heroin was the drug they had most often used in the month prior to interview, despite 40% reporting it as their drug of choice. When asked to clarify the reasons for this discrepancy, 18 respondents (48%) reported that they had not recently used heroin due to low availability, 2 (5%) due to the high price of the drug, 1 (3%) due to low purity of the heroin available to them, and 2 (5%) reported staying away from heroin as it was less effective while they were also receiving opioid replacement therapies.

4.1 Price

IDU who could comment on the price of heroin generally referred to purchasing it in units of 'points' (referring to 0.1 g), 'packets' or 'tastes', the latter two appearing to be a generic descriptor for a varying amount of the drug. Perhaps reflecting this, IDU reports on the estimated weight of the heroin they had recently purchased were highly variable. IDU reports of price of heroin are summarised in Table 8 below.

The price of heroin was reported to be stable by the majority of IDU that could confidently comment (92%, n=11), with the remaining respondents reporting fluctuating prices (8%, n=1). While the reported purchase prices in Table 8 may appear to suggest stable or slightly decreased model prices in comparison to the 2002 survey, the number of individuals reporting prices are so small, and the amount involved (particularly in reference to the most popular purchase amount, 'cap'/'taste'/'point') so variable, that it is difficult to clearly make such an inference.

Table 8: Price of heroin purchased by IDU, 2000-2003 IDRS

Descriptor	2000 IDRS		2001 IDRS		2002 IDRS		2003 IDRS		
	n	Modal Price*	n	Modal Price*	n	Modal Price*	n	Modal Price*	Price Range
Last 'Cap', 'taste', 'point' (~0.05-0.15g)	1	\$50	15	\$50	12	\$100	7	\$50	\$50-100
Last 2 'points'/'tastes' (~0.2g)	2	\$100	8	\$100	2	\$92.50*	1	\$100	\$100
Last 1/4 gram (0.25g)	1	\$50	1	\$100	4	\$135*	1	\$100	\$100
Last half-weight (0.5g)	0	-	1	\$170	1	\$250	0	-	-
Last gram (1.0g)	2	\$375*	2	\$300	1	\$350	2	\$350	\$300-400

*where multiple modes existed, median price was substituted.

The Australian Crime Commission (ACC, previously the Australian Bureau of Criminal Intelligence) provides quarterly figures on the price of covert drug purchases and informant reports of prices in each Australian jurisdiction. According to these figures, a 'taste' (0.1-0.3 g) of heroin cost \$50, and a true gram \$400-\$500, in Hobart during the 2001/02 financial year (Table 9). These estimates were reasonably consistent with IDU reports of price in the 2002 IDRS survey, and provide support for the assertion that local heroin prices remained relatively stable throughout the 2001/02 financial year, particularly as ACC reported prices of heroin in Tasmania had not changed between January 2000 and June 2002. Price information for the 2002/03 financial year was not available in time for inclusion in this report.

Table 9: Heroin prices in Tasmania reported by the Australian Crime Commission, 1997-2003

Amount	Jul-Jun 1997/98	Jul-Jun 1998/99	Jul-Jun 1999/00	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002
1 Taste/Cap (0.1-0.3 gm)	\$60-80	\$50	\$50	\$50	\$50	\$50	\$50
1/2 Weight (0.4 - 0.6 gm)	\$150	\$100-200	\$100-200	\$100-200	\$100-200	\$100-200	\$100-200
1 Street weight (0.6 - 0.8 gm)	\$400	\$400	\$200-400	\$200-300	\$200-300	\$200-300	\$200-300
Full Gram	\$600	\$500-700	\$400-600	\$400-500	\$400-500	\$400-500	\$400-500

Source: Australian Crime Commission & Tasmania Police State Intelligence Services

4.2 Availability

Of the IDU sample that were able to comment on trends in the availability of heroin, there was a split in responses, with 57% (n=8) reporting it as difficult (36%) or very difficult for them to obtain (21%), while 43% (n=6) reported it as easy (36%) or very easy (7%) for them to obtain. The majority (77%, n=10) reported that the availability of heroin had remained stable over the past six months, with 15% (n=2) reporting that heroin availability had fluctuated in this time. No key informants could comment on the availability of heroin. All key informants talking about patterns of heroin use amongst the groups of IDU they knew (n=13) referred to its use as sporadic, and limited to a small proportion of their groups.

In another indication of relatively stable limited availability of heroin locally, only 26% of the IDU sample in 2003 reported recent use of the drug, with a median frequency of use of only five times in the preceding six months. These figures are very similar to those obtained in the 2002 and 2001 IDRS samples. This low level of use in a regularly injecting sample of individuals, where 40% regard heroin as their drug of choice, is a good indication that the drug is in poor supply. Furthermore, when those IDU that reported heroin as their drug of choice were asked the reasons for this not being the drug they had most often used in the past month, 18 (48%) reported that they had not recently used heroin due to low availability of the drug.

Most IDU reported usually purchasing heroin in the past six months from a friend (33%, n=5), with smaller proportions reporting usually accessing from a dealer's home (20%, n=3), or a street or mobile dealer (13%, n=2 respectively). Twenty percent (n=3) reported usually purchasing the drug through a contact in a mainland jurisdiction and having it sent down directly to them. A similar pattern emerged when people were asked who they purchased the drug from last time they bought heroin, with 46% (n=6) reporting friends, 14% (n=2) a dealer's home, 14% (n=2) a mobile dealer, 7% (n=1) a street dealer and as a 21% (n=3) getting it sent down from the mainland. Median time estimated as taken to score heroin was 240 minutes (range 0 – 5760 minutes, n=15) usually in the past 6 months, but just 60 minutes (range 0 – 5760 minutes, n=15) for the last time scored heroin.

There were no seizures of heroin made by Tasmania police in the 2001/02 or 2002/03 financial years, in comparison to one seizure (totalling 3 grams) in 2000/01, and five seizures (totalling approximately 18 grams) in 1999/00. No seizures of heroin were reported to the Australian Bureau of Criminal Intelligence (now the ACC) in 1996/97 or 1997/98.

Taken together, it appears that the historical pattern of limited availability of heroin locally has continued over the last six to twelve months (availability over time is detailed in Figure 1). While some better-connected IDU appear to have reasonably stable access to the drug, the availability of heroin in the state is still relatively low, as indicated by the low level of recent use of the drug by the IDU sample.

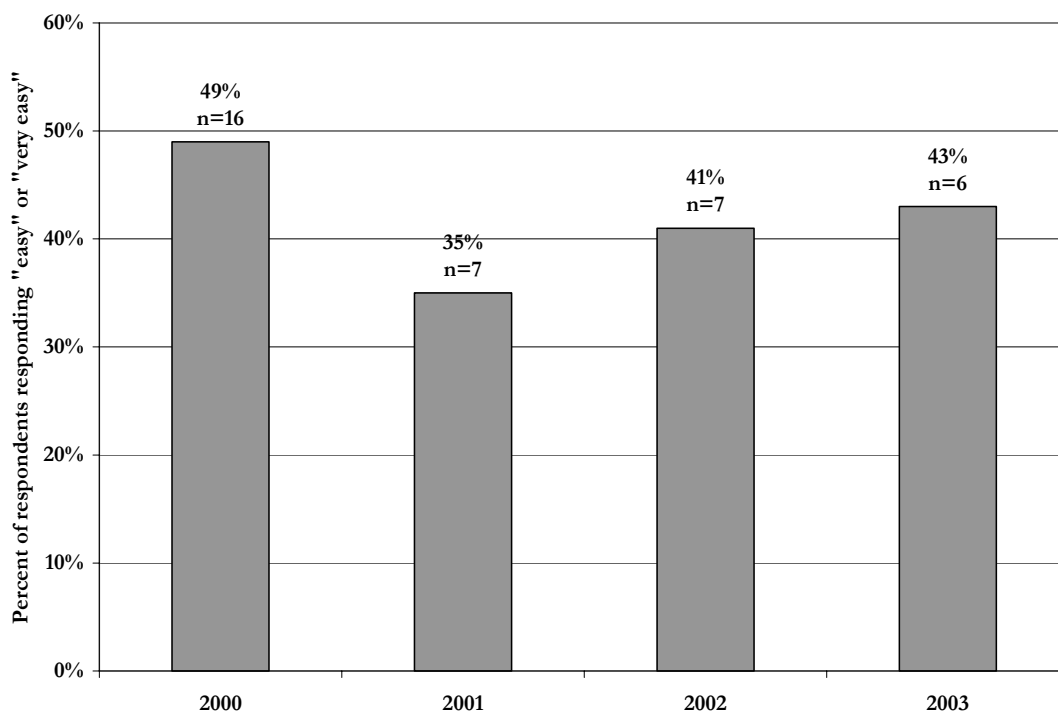


Figure 1: IDU reports of availability of heroin: 2000-2003 IDRS

4.3 Purity

Following trends seen in previous years, most IDU that could comment on purity of heroin they had used reported it as low (25%, n=3) or medium (33%, n=4) purity, although 25% (n=3) regarded purity as high, and 17% (n=2) reported purity as fluctuating. No key informants could comment on the purity of heroin used by the groups that they were familiar with. In previous surveys, IDU have commented that this low quality of heroin (at a relatively high cost) had led them to be generally wary of buying heroin for fear of being 'ripped off', and because of this, they preferred to purchase pharmaceutical morphine, as the exact quantity of drug purchased is clear.

Of the IDU sample, 13% reported use of heroin powder in the last 6 months, with 14% using rock form heroin. There was almost an even split between those IDU that reported heroin rock (13%) and heroin powder (12%) as the form they had most commonly used in the past six months. In previous IDRS surveys, key informants and IDU have noted that, in general, heroin sold as 'rock' was actually powder, compressed to look like true 'rock' form heroin. Similar reports were made by key informants in Victorian IDRS studies (e.g. Dwyer & Rumbold, 2000). As noted in previous IDRS reports, these two forms may reflect two very different qualities of heroin available, which goes some way to reconciling the reports of purity discussed above. Anecdotal reports from several IDU and KI suggest that the powder form heroin available in the state is heavily 'cut' and very low in purity, with the purity of rock form heroin being slightly higher. In previous years, those that had most often used powder form heroin most commonly reported the purity of heroin as low, with those most often using rock form heroin commonly reporting purity as medium. However, this pattern did not hold in the current data set, although

the small sample size of participants that had used heroin recently renders it difficult to easily identify any particular trends in the data.

There was some division among IDU in regard to trends in the purity of heroin over the preceding six months, with 44% (n=4) indicating a stable purity over this time, 44% (n=4) reporting that purity had fluctuated, and 11% (n=1) that purity had been increasing. No key informant could confidently comment on trends in purity of heroin. As there have been no seizures of heroin made by Tasmania Police or the Australian Federal Police in 2002/03, no objective purity data is available for comparison.

There are two pieces of objective purity data available for heroin seized within Tasmania. The first relates to a single seizure of less than two grams, made by the Australian Federal Police and analysed during the first quarter of 2000, which returned a measurement of 74.6% purity. The second relates to eight seizures of less than two grams, made by Tasmania Police and analysed during the third quarter of 2002, which returned a median measurement of 70.4% purity (range 69.6-71.0%). It should be noted that there may be a delay of days to several months between the date of the seizure and the date of receipt of the samples in the laboratory, and as such it is not clear which financial year these analyses refer to.

4.4 Use

4.4.1 Prevalence of heroin use

The 1998 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 1999) reported that 1.8% (n=15) of Tasmanians sampled had ever used heroin, while 0.5% (n=5) had used it in the year prior to interview. While the small numbers involved mean that meaningful inferences are difficult to draw, the figures from the 2001 survey (Australian Institute of Health and Welfare, 2002) are very similar, with 0.3% (n=4) of Tasmanians sampled reporting using heroin in the year prior to interview.

Reported use of heroin as the main drug injected by non-pharmacy Needle Availability Program (NAP) outlet clients had shown a steady decrease between 1999/00 and 2001/02, decreasing from 4.3% to just 0.7% of clients in this time. However, while still remaining relatively low, particularly given the attractiveness of heroin among IDU, the figures for 2002/03 represent a clear increase over the preceding financial year, with 446 clients (1.5%) reporting heroin as the drug that they most often inject. While there are acute limitations of the data collected from Needle Availability Program outlets (see Section 2.3), this slight increase in use does correlate with changes in availability of heroin seen at a national level (see Breen et al 2003). It is important to note that this data may underestimate the extent of heroin use, as different NAP outlets ask slightly differing questions in regard to drug use – with some asking ‘what is the drug you most often inject’, while others prefer ‘what is the drug you are about to inject’. As indicated previously, although 26% of the IDU sample had used heroin in the past six months, only 3% reported it as the drug they most often injected. Additionally, there was a very high level of polydrug use amongst those who reported recent use of heroin (detailed below).

Table 10: Percentage of heroin reported as ‘drug most often injected’ by Tasmanian non-pharmacy Needle Availability Program outlets, 1997-2003

Year	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Number of clients reporting heroin	390	257	457	405	143	446
Percent of total clients reporting heroin	5.7%	2.9%	4.3%	2.8%	0.7%	1.5%

Source: Sexual Health, Department of Health and Human Services

The Australian Needle and Syringe Program Survey (National Centre in HIV Epidemiology and Clinical Research on behalf of the Collaboration of Australian Needle and Syringe Programs) has reported heroin as the last drug injected of 10% or less of their Tasmanian participants for their 1996, 1997, 1998 and 1999 surveys, increasing to 22% in 2000, and declining from 2001 into 2002 (Table 11). This trend is generally consistent with that seen from the NAP client data. However, given that these studies only sampled a very small number of clients each year, these figures should be interpreted with caution.

Table 11: Australian Needle and Syringe Program (NSP) Survey: Prevalence of heroin within “last drug injected”, 1996-2002

	1996		1997		1998		1999		2000		2001		2002	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Heroin	1	6	0	0	5	10	2*	8	6 [#]	22	3 [†]	11	5	3
Total Sample Size	18		23		51		25		27		28		151	

Source: National Centre in HIV Epidemiology and Clinical Research on behalf of the Collaboration of Australian Needle and Syringe Programs.

*Note: these two cases reporting heroin injection actually reported their last drug injected as heroin and morphine combined; [#]Of these 6 individuals, 3 reported their last drug injected as heroin only, 2 as a mixture of heroin, cocaine and methamphetamine, and 1 as a mixture of heroin and cocaine. [†]Of these 3 individuals, 1 reported their last drug injected as a mixture of heroin and cocaine, 1 as a mixture of heroin, morphine and methadone, and 1 as a mixture of heroin and methadone

Tasmania Police State Intelligence Services reported no arrests involving offences relating to heroin in the 2002/03, 2001/02 or 2000/01 financial years⁶. Due to the small numbers (n=5 in 1999/00) and lack of specificity of reporting of opioid-related arrests in previous years⁷, the identification of trends from such data is difficult.

⁶ A single seizure of heroin, totalling 3g was made in the Southern region in 2000/01. This was a find of three capsules containing heroin on a nightclub dance-floor. Hence, no charges could be laid.

⁷ Data specifically regarding heroin-related offences prior to 1999/00 is unavailable as the Australian Crime Commission reports offences related to all opioids (including, for example, morphine and methadone) within a single category.

4.4.2 Heroin use among IDU

Twenty-six percent of the IDU sample reported using heroin in the six months prior to interview. The median number of days that heroin was used in the past six months by this group was 5 (range 1-180). All those that reported using heroin in this time had injected the drug, although three had both injected and smoked heroin in the preceding six months. There was a very high level of polydrug use amongst those who had used heroin in the past six months (Table 12), predominantly of other opioids and benzodiazepines, a finding in keeping with reports from key informants that, because of fluctuating availability, primary users of opioids have to be flexible in their patterns of use, turning to other opioids or benzodiazepines if their opioid of choice is unavailable. Additionally, there was a high level of use of methamphetamine amongst this group, although it was generally used less frequently than other opioids.

Table 12: Patterns of drug use reported by those IDU who had used heroin in the past 6 months (n=26)

	% of those who had used heroin in last 6 months reporting use	Median days use for those using the drug
Methadone syrup (illicit)	58	24 (range 2-96)
Physeptone (illicit)	69	24 (range 4-72)
Morphine	77	12 (range 2-180)
Other opioids	46	4 (range 1-48)
Benzodiazepines	92	24 (range 1-180)
Cannabis	92	180 (range 2-180)
Methamphetamine		
<i>powder</i>	46	11 (range 2-24)
<i>base/point</i>	35	20 (range 3-72)
<i>ice/crystal</i>	77	6 (range 1-96)
Alcohol	65	20 (range 1-180)

These patterns of use reported by the IDU sample are supported by key informant reports of some low levels of heroin use amongst primary users of methamphetamine (n=6 of 13 key informants), and of other opioids (n=5 of 7 key informants). Additionally, all key informants regarded the use of heroin by the users they had contact with as rare or sporadic at best.

4.5 Trends in heroin use

The majority of indicators, and findings such as the low median rate of use of heroin (5 days in last 6 months amongst those who had used the drug) and, that of the 40% of the IDU sample that reported heroin as their drug of choice, less than half (45%) of these had recently used heroin, indicate that relatively stable and low availability of heroin in the state has continued in 2003. However, with the high use of other opioids and very stable strong preference for heroin amongst the IDU sampled by the IDRS, future trends in use of heroin in the state continue to merit close attention, particularly as heroin markets nationally and globally regain equilibrium.

4.6 Summary of heroin trends

Table 13: Summary of Heroin Trends

<p>Price (mode) <i>'packet'/'taste' point (0.05-0.15g)</i> <i>gram</i></p>	<ul style="list-style-type: none"> • \$50, stable (possibly decreasing) • \$350, stable
<p>Availability</p>	<ul style="list-style-type: none"> • variable among IDU: difficult to very difficult (57%); easy to very easy (43%) • availability stable (77%) • IDU and other data indicate a reasonably stable, low, level of availability of heroin over the past 6-12 months
<p>Purity and form</p>	<ul style="list-style-type: none"> • Both 'rock' and powder heroin used, but few have used both forms • Very mixed opinions regarding purity, with many IDU wary of purity of the drug purchased locally • Estimates of purity levels suggest generally stable (44%) or fluctuating (44%) purity
<p>Use</p>	<ul style="list-style-type: none"> • Used by 26% of the IDU sample in past six months, but low rate of use (median = 5 days) despite high preference as drug of choice • Use most common amongst regular users of other opioids

5. METHAMPHETAMINE

In previous years, IDRS reports have used the overarching term 'amphetamines' to refer to both amphetamine and methamphetamine. Throughout the 1980s, the form of illicit amphetamine most available in Australia was amphetamine sulphate (Chesher, 1993). Following the legislative controls introduced in the early 1990s on the distribution of the main precursor chemicals for the production of amphetamine sulphate (Wardlaw, 1993), illicit manufacturers were forced to rely on different procedures for the preparation of amphetamine. Throughout the 1990s, the proportion of amphetamine-type substance seizures that were methamphetamine⁸ (rather than amphetamine) steadily increased until methamphetamine clearly dominated the market (ABCI, 1999, 2000, 2001). Across Australia today, the powder traditionally known as 'speed' is almost exclusively methamphetamine rather than amphetamine. The more potent forms of this family of drugs, known by terms such as ice, shabu, base, paste and crystal meth, are also methamphetamine. Therefore, the term methamphetamine will now be used in the IDRS to refer to the drugs available in this class.

As methamphetamine markets across the country have expanded over the past few years, it has become apparent that there is a diversity of forms of methamphetamine sold in the Australian illicit drug market. While there is some disagreement among both users and researchers as to the nature of these forms, it is clear that these are marketed differently to IDU and sold on differing price scales. As such, trends in regard to each of these forms will be discussed separately where appropriate.

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

Powder form methamphetamine⁹ is the form of the drug which has traditionally been available in Australia. This is commonly a powder that can range from fine to more crystalline or coarse, and may take different colours (commonly white, yellow, brown, orange or pink), depending on the chemical process used in its production and the quality of that process. It is produced within Australia, most commonly in small, portable 'laboratories', and is usually based on pharmaceutical pseudoephedrine (extracted from, for example, *Sudafed* tablets). Because of its powder form, it is fairly easy to 'cut' (dilute) and is commonly sold at fairly low purity/potency. In the 2003 IDRS survey, IDU that reported using each 'form' of methamphetamine were asked to indicate what each 'form' they had purchased in the past six months most closely resembled from a series of exemplars¹⁰, and common responses for methamphetamine powder are included in Table 14 below, although it was commonly reported as a beige/yellowy/off-white powder.

⁸ Methamphetamine is an abbreviation of the name methylamphetamine, and as such, both terms are interchangeable.













⁹ Powder form methamphetamine is also referred to in National and other jurisdiction IDRS reports as 'speed'.

¹⁰ The exemplars provided, along with a discussion of the proposed groupings of the pictures, is available at: <http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.bulletins>, and an article discussing evolving changes in Australian methamphetamine markets by Topp and Churchill (2002) is also accessible at the same address.

The two other 'forms' of methamphetamine are traditionally higher in potency (due to being more difficult to 'cut') and have been increasing in availability across all Australian Jurisdictions in the past few years (Topp et al, 2002). The first, referred to in some jurisdictions as 'base' or 'paste' is commonly a gluggy, oily, 'wet' powder. Although it does not seem to have a particular moniker in Tasmania, it is usually sold in units of 'points' (0.1 grams) in comparison to powder methamphetamine, which is traditionally sold in gram units at similar prices. This form of the drug appears oily because the conversion process from pseudoephedrine to methamphetamine produces the alkaline (base) form of methamphetamine, which is 'oily'. To convert this to a more easily injectable form (methamphetamine hydrochloride crystals, which may take the appearance of powder, or, when no impurities are present, and carefully crystallised, may take the form of the 'ice' crystals discussed below) requires a high level of skill, and when not completed correctly, the result of this process is an oily powder that often has a yellow or brownish tinge due to the presence of iodine and other impurities (Topp & Churchill, 2002). IDU survey respondents that had recently purchased this form of the drug locally reported it as appearing as a 'oily', 'gunky', 'gluggy' gel, brown or 'bloody' in colour (not unlike tree sap, burnt sugar or dried honey) and indicative exemplars of this form of the drug are included in Table 14.

The final form of methamphetamine, often referred to as 'ice' or 'crystal meth(amphetamine)' is the product of a careful production process, and is believed to chiefly be imported into Australia from Asian countries (Topp & Churchill, 2002). It commonly appears as clear, ice-like, crystals, and as such, is difficult to 'cut' (dilute), resulting in a relatively high-purity/potency product. While it appears that the availability of this 'form' of methamphetamine is relatively limited in Tasmania, those IDU survey respondents that had recently purchased this form locally provided exemplars as detailed in Table 14, although it was commonly reported as white / clear crystals or rocks, looking like crushed glass or rock salt (with crystals commonly larger than sugar crystals).

Table 14. Indicative methamphetamine forms reported by those using the drug in the IDU survey*

Methamphetamine powder forms			
			
<i>2003: Used n=20/40, used most n=13/17 2002: Used n=16/35, used most n=5/13</i>	<i>2003: Used n=5/40, used most n=2/17 2002: Used n=15/35, used most n=3/13</i>	<i>2003: Used n=11/40, used most n=1/17 2002: Used n=23/35, used most n=6/13</i>	<i>2003: Used n=3/40, used most n=1/17 2002: Used n=4/35, used most n=1/13</i>
Methamphetamine 'base' or 'paste' forms			
			
<i>2003: Used n=9/37, used most n=5/21 2002: Used n=12/74, used most n=4/58</i>	<i>2003: Used n=7/37, used most n=5/21 2002: Used n=28/74, used most n=16/58</i>	<i>2003: Used n=10/37, used most n=2/21 2002: Used n=25/74, used most n=16/58</i>	<i>2003: Used n=3/37, used most n=3/21 2002: Used n=10/74, used most n=5/58</i>
Methamphetamine 'crystal' or 'ice' forms			
			
<i>2003: Used n=40/54, used most 32/43 2002: Used n=11/20, used most n=0/3</i>	<i>2003: Used n=10/54, used most 7/43 2002: Used n=4/20, used most n=0/3</i>	<i>2003: Used n=2/54, used most 2/43 2002: Used n=5/20, used most n=2/3</i>	<i>2003: Used n=1/54, used most 1/43 2002: Used n=4/20, used most n=0/3</i>

*Note: All participants reporting use of any form of methamphetamine were asked to nominate the exemplars that most closely resembled the methamphetamine they had used within each 'form'. More than one exemplar could be nominated within each 'form' of the drug. The proportion of participants thus nominating each of the most common exemplars is detailed above as 'used n'. For the 'form' of methamphetamine that had been most commonly used by each respondent, each was asked to nominate the exemplar that most closely resembled the methamphetamine they had used most often ('used most'), and could again nominate more than one exemplar if required

Eighty-seven percent of the respondents on the IDU survey were able to confidently comment on aspects of the price, purity and availability of some form of methamphetamine. For the 2003 IDRS, IDU were asked to differentiate between methamphetamine powder, 'base/paste' and crystalline methamphetamine. This distinction had a good level of face validity to those IDU surveyed, despite there often being a substantial amount of overlap in the physical form of these 'groups'. IDU reported making these distinctions on the basis of physical form, purchase cost and potency of subjective simulant effect. Fifteen IDU were able to report distinct trends for all three 'forms' of methamphetamine, 72 reported trends on two 'forms', while the majority reported on the most commonly used 'form', crystal methamphetamine. Fifty IDU reported trends on methamphetamine powder, 44 reported on 'base/paste', and 65 on crystalline methamphetamine.

Eighty-eight percent of the IDU sample had used methamphetamine at some time in the six months prior to interview. Both participants that had used methamphetamine in the past six months ($n=81$), and those that reported methamphetamine as the drug they most often injected in the preceding month ($n=29$) were similar to other IDU (see section 3.0) in terms of sex, cultural background, accommodation type, frequency of injection, duration of injection career, educational and employment levels and prison history. However, those that reported methamphetamine as the drug they had most often injected were significantly less likely to be receiving methadone maintenance therapy (42%) than those that did not (64%: $\chi^2(1, n=100) = 4.1, p = 0.04$) and were significantly more likely to be receiving buprenorphine maintenance therapy (11%) than those that had most often used a drug other than methamphetamine in the preceding six months (0%: $\chi^2(1, n=100) = 7.6, p = 0.06$). Additionally, those that had most commonly injected methamphetamine in the month prior to interview were more likely to report this as their drug of choice (62%) than those that had most commonly injected other substances (10%: $\chi^2(11, n=100) = 33.16, p < 0.001$). Finally, the mean age of those that had used methamphetamine in the six months prior to interview was significantly younger than those that had not (27.3 years vs. 37.6 years respectively: Mann-Whitney $U = 204.5, p=0.001$).

Thirteen key informants reported on groups that primarily used methamphetamine. Key informants included justice workers / police ($n=2$), outreach / support workers ($n=2$), needle availability program workers ($n=2$), alcohol and other drug-specific workers ($n=6$) and a general health worker. Key informants were familiar with methamphetamine users from virtually the whole range of Hobart suburbs (with 6 not being able to specify any areas in particular), including the northern suburbs ($n=5$), eastern shore ($n=3$), and inner Hobart suburbs ($n=3$). Locations mentioned tended to be in lower socio-economic regions, although this is likely to simply reflect the nature of the services the key informants worked for, as the majority were in the public sector. All key informants described primary users of methamphetamine from an English-speaking background, covering an age range between 15 and 60. Reported modal ages matched this wide spectrum, with key informants referring to groups ranging between 19 and 31, although the most common modal age reported was 25 ($n=5$). In contrast to previous IDRS samples, where the methamphetamine users described by key informants were predominantly males (in 2002, the modal proportion of males was 70%), there was a much closer gender balance among the users described, with estimates ranging from 33-95% male, but a mode of 60% males. Education history of methamphetamine users described covered the whole range from low levels to university graduates. Key

informants described methamphetamine users with high levels of unemployment, with the remainder in a range of part-time and full-time occupations.

5.1 Price

As discussed above, and indicated in previous Tasmanian IDRS reports, it is clear that there are three main 'forms' of non-pharmaceutical methamphetamine available in Hobart, each with separate pricing schedules, which will be discussed separately.

IDU reported the price of 'base/paste' methamphetamine as costing \$50 per 'point' (0.1 g: modal price estimate \$50, range \$50-80, n=30), and \$350 per gram (modal price estimate \$350, range \$220-400, n=5). This represents a slight drop in comparison to the modal estimated costs for the 2002 survey (\$50-80 per 'point', \$400 per gram). These price estimates are reasonably consistent with the modal prices reported as actually paid for their last purchased 'point' of 'base/paste' (mode=\$50, range \$20-80, n=24) and last gram (mode=\$300, range \$200-400, n=6: Table 15).

Modal market price reported by IDU for the higher-purity crystalline methamphetamine / 'ice' was again, \$50 per 'point' (0.1 g: modal price estimate \$50, range \$50-100, n=46), and \$350 per gram (range \$300-500, n=3). These corresponded closely with the price IDU reported as actually paying for their last 'point' of crystalline methamphetamine (mode = \$50, range \$20-70, n=49) and last gram (median = \$350, range \$150-500, n=8: Table 15).

The median (there was no single mode reported) market price reported by IDU for the traditional powder methamphetamine was \$120 for a gram (range \$70-350, n=8), which was substantially lower than the price IDU reported as paying for their last gram (median \$215, range \$80-400, n=10: Table 15). Modal market prices for a 'point' of methamphetamine powder (mode \$50, range \$30-80, n=33), however, more closely matched the prices most recently paid by IDU (mode \$50, range \$40-80, n=27). The discrepancy in price of the larger purchase amounts of the drug most likely reflects the fact that powder methamphetamine is sold in widely varying degrees of purity due to its easy 'cutting' with other substances.

Reported modal market prices for pharmaceutical stimulants were \$5 per 10mg methylphenidate tablet (Ritalin, Attenta: range \$1.50-10, n=6) and \$5 per 5mg dexamphetamine tablet (range \$1.5-10, n=8). These exactly matched the modal prices for the last purchase of these pharmaceuticals \$5 per 10mg methylphenidate tablet (range \$1.50-10, n=23) and \$5 per 5mg dexamphetamine tablet (range \$1-10, n=40).

Five key informants could confidently comment on costs of methamphetamine to the groups that they were familiar with, reporting prices reasonably consistent to those detailed by the IDU: \$50-200 per gram of methamphetamine (n=3); and \$50 (range \$20-50) per 'point' of methamphetamine (n=4).

The majority of both key informants and IDU who commented on price of any form of methamphetamine reported that prices had remained stable over the preceding six months (80% of KI, n=4/5; 82% of IDU referring to powder, n=37; 92% of IDU referring to base, n=35; 100% of IDU referring to crystal methamphetamine, n=10; and 57% of IDU referring to pharmaceutical stimulants, n=21). A minority of IDU felt that

there had been price changes in regard to methamphetamine powder (4% reporting increasing prices, n=2; 4% fluctuating prices, n=2; and 9% decreasing prices, n=4). Similarly, a minority reported changes in 'base/paste' methamphetamine (3% reporting fluctuating prices, n=1; 5% decreasing prices, n=2). However, there was greater variation in responses to prices of pharmaceutical stimulants, with 22% (n=8) reporting increasing process, 19% (n=7) reporting decreased prices, and 3% (n=1) fluctuating prices.

While the small number of participants reporting prices for some purchase categories, and the high variability of reported prices (Table 15) renders making clear comparisons difficult, it appears that, concordant with IDU reports, market prices for methamphetamine remain reasonably similar to those reported in the 2002 IDRS. There are some indications, however, for slight decreases to prices of crystal methamphetamine and 'base/paste', particularly in relation to larger purchase amounts of the drug.

Table 15: Most common amounts and prices of methamphetamine purchased by IDU

Descriptor*	2000 Survey		2001 Survey		2002 Survey		2003 Survey	
	Modal Price (range in parentheses)	n	Modal Price (range in parentheses)	n	Modal Price (range in parentheses)	n	Modal Price (range in parentheses)	n
Crystal Methamphetamine								
<i>'point' or packet (0.1 g; 0.05-0.1 g)</i>	#	#	#	#	\$50 (\$20-120)	12	\$50 (\$20-70)	49
<i>2 points (0.2 g; 0.15-0.2 g)</i>	#	#	#	#	\$150	1	\$65 (\$50-80)	4
<i>quarter-gram (0.25 g; 0.2-0.3 g)</i>	#	#	#	#	\$180	1	-	-
<i>half-gram (0.5 g; 0.4-0.6 g)</i>	#	#	#	#	\$275 (\$200-275)	3	\$195 [†] (\$190-300)	4
<i>gram (1.0 g)</i>	#	#	#	#	\$400	1	\$350 [†] (\$150-500)	8
Methamphetamine base/paste[#]								
<i>'point' or packet (0.1 g; 0.05-0.1 g)</i>	\$50 (\$40-100)	52	\$50 (\$50-80)	34	\$50 (\$25-80)	66	\$50 (\$50-80)	24
<i>2 points (0.2 g; 0.15-0.2 g)</i>	\$80 (\$70-100)	19	\$80 (\$50-100)	13	\$80 [†] (\$50-150)	7	\$70 (\$50-80)	4
<i>quarter-gram (0.25 g; 0.2-0.3 g)</i>	-	-	-	-	\$100 (\$100-150)	4	-	-
<i>half-gram (0.5 g; 0.4-0.6 g)</i>	\$250 (\$150-250)	3	\$150 (\$50-400)	18	\$200 (\$80-400)	32	\$200 (\$150-400)	8
<i>gram (1.0 g)</i>	\$350 (\$280-400)	8	\$400 (\$80-450)	17	\$400	29	\$300 [†] (\$200-400)	6
Methamphetamine powder								
<i>'point' or packet (0.1 g; 0.05-0.1 g)</i>	-	-	\$50 (\$40-80)	15	\$50 (\$50-60)	12	\$50 (\$40-80)	27
<i>half-gram (0.5 g)</i>	\$50	3	\$50 (\$50-60)	4	\$50 (\$50-800)	10	\$70 [†] (\$50-200)	4
<i>gram (0.8 g; 0.8-1.0 g)</i>	\$80 (\$50-100)	6	\$50 (\$50-100)	5	\$80 (\$50-450)	18	\$215 [†] (\$80-400)	8
Pharmaceutical stimulants								
<i>dexamphetamine tablet (5 mg)</i>	-	-	\$5 (\$1-10)	29	\$2 (\$2-5)	5	\$5 (\$1-10)	40
<i>methylphenidate tablet (10 mg)</i>	-	-	\$5 (\$2-10)	14	-	-	\$5 (\$1-10)	23

*Note: Common quantities and weight range for each purchase unit in parentheses, [†]Median price was substituted where no single mode was reported.

[#]Note: prior to 2002, higher purity methamphetamine was not separated into 'crystal' and 'base/paste' forms; as base/paste methamphetamine was the predominant form of higher purity methamphetamine available on the market during these years, prices have been allocated to this form, however, due caution should be made when inferring price changed based on this data.

Tasmania Police area drug bureaux gather regular information regarding current prices of illicit drugs, both through informant reports and covert drug purchases. Since July 1999, Tasmania Police State Intelligence Services has produced monthly reports of local drug seizures and these estimated costings. Prior to this, quarterly price figures were provided through the Australian Bureau of Criminal Intelligence (ABCI, now the Australian Crime Commission). While data from the 2002/03 financial year was not available for inclusion in the current report, in April-June 2002, low-purity powder methamphetamine cost \$40-\$50 for a 'street gram' (0.6-0.8g), and \$70-\$80 for a true gram. These prices were consistent with IDU and key informant reports of prices for the lower quality methamphetamine in the 2002 IDRS survey. Tasmania Police also report the price of 'points' (0.1g) of 'uncut' crystalline methamphetamine to have cost \$40-\$50 since January 2000, only changing to a price range of \$40-70 in January 2002. This price range is consistent with prices reported by IDU in the 2003 IDRS study, supporting IDU suggestions that the price of methamphetamine had remained stable in the preceding six months.

Table 16: Methamphetamine prices in Tasmania reported by the Tasmania Police Drug Bureaux, 1996-2003

	Point (~0.1g)	Street Gram (0.6-0.8g)	Full Gram (1.0g)	Ounce (28 gms)
July-Sept 1996	<i>price not reported</i>	\$50-80	\$100-120	\$1400
Oct-Dec 1996	<i>price not reported</i>	\$50-80	\$100-120	\$1400
Jan-Mar 1997	<i>price not reported</i>	\$50-80	\$100-120	\$1400
April-June 1997	<i>price not reported</i>	\$70-80	\$100-120	\$1400
July-Sept 1997	<i>price not reported</i>	\$50	\$100-120	\$1200-1400
Oct-Dec 1997	<i>price not reported</i>	\$50	\$100-120	\$1400-1600
Jan-Mar 1998	<i>price not reported</i>	\$50	\$70-100	\$1400-1600
April-June 1998	<i>price not reported</i>	\$50	\$70	\$1400-1600
July-Sept 1998	<i>price not reported</i>	<i>price not reported</i>	<i>price not reported</i>	<i>price not reported</i>
Oct-Dec 1998	<i>price not reported</i>	\$50	\$70-80	\$1200-1400
Jan-Mar 1999	<i>price not reported</i>	\$50	\$70-80	\$1200-1400
April-June 1999	<i>price not reported</i>	\$50	\$70-80	\$1200-1400
July-Sept 1999	\$50	<i>price not reported</i>	<i>price not reported</i>	<i>price not reported</i>
Oct-Dec 1999	\$50	\$50	\$70-80	\$1200-1400
Jan-Mar 2000	\$40-50	\$40-50	\$70-80	\$1200-1400
April-June 2000	\$40-50	\$40-50	\$70-80	\$1200-1400
July-Sept 2000	\$40-50	\$40-50	\$70-80	\$1200-1400
Oct-Dec 2000	<i>price not reported</i>	\$40-50	\$70-80	\$1200-1400
Jan-Mar 2001	\$40-50	\$40-50	\$70-80	\$1200-1400
April-June 2001	\$40-50	\$40-50	\$70-80	\$1200-1400
July-Sept 2001	\$40-50	\$40-50	\$70-80	\$1200-1400
Oct-Dec 2001	\$40-50	\$40-50	\$70-80	\$1200-1400
Jan-Mar 2002	\$40-70	\$40-50	\$70-80	\$1200-1400
April-June 2002	\$40-70	\$40-50	\$70-80	\$1200-1400

Source: Australian Crime Commission, Tasmania Police State Intelligence Services

5.2 Availability

Across all 'forms' of methamphetamine, most KI and IDU reporting on availability suggested that the drug was easy or very easy to obtain (IDU: very easy 49%, easy 35%; KI: very easy 75%, easy 25%), and that availability of the drug had remained stable (IDU: 48%; KI: 44%) or had increased (IDU: 44%; KI 44%) in the preceding six months. Trends for each 'form' of the drug are discussed separately below.

Almost all IDU sampled who could comment on the availability of powder form methamphetamine thought it was easy or very easy to obtain (80%, n=39), with the majority (41%, n=20) reporting that it was very easy to access. The clear majority also reported that the availability of powder methamphetamine had remained stable in the preceding six months (62%, n=29), with smaller proportions reporting an increase (17%, n=8), or decrease (21%, n=10), in availability.

In regards to 'base/paste' forms of methamphetamine, remarkably similar trends were reported, with 52% (n=23) of IDU reporting it as very easy to obtain, and 30% (n=13) regarding this form as easily accessed. Just 19% (n=8) suggested that it had been difficult for them to access 'base/paste' methamphetamine in the preceding six months. Again, most regarded this level of availability as remaining stable during this time (55%, n=23), although 24% (n=10) reported increased availability, and 21% (n=9) decreased availability.

Trends were slightly different for crystalline methamphetamine. This form of the drug was substantially less commonly used by IDU in previous IDRS studies, with almost equal proportions finding it difficult/very difficult and easy/very easy to access in the 2002 study. However, in 2003, there are clear indications that the availability of this form of the drug has increased substantially, with 52% (n=33) regarding it as very easy to access, and 37% regarding it as easily accessed. In keeping with this trend, 80% (n=39) reported that this form had become easier to access in the preceding six months, with only a small minority reporting that availability had remained stable (18%, n=9) or decreased (2%, n=1) in this time. Reports from key informants in regard to the availability of crystal methamphetamine also followed this trend, with 100% regarding the drug as very easy (50%, n=2) or easy to access (50%, n=2), and 60% reporting that this availability marked an increase in the preceding six months (n=3; the remainder reporting a stable level of availability).

In contrast to these reports of easy availability of most illicit forms of stimulants, IDU indicated that prescription stimulants such as dexamphetamine or methylphenidate were more challenging to access, with almost even proportions indicating that these were difficult or very difficult (54%, n=25) and easy or very easy (46%, n=21) to access. The majority of IDU also reported that the availability of these stimulants had decreased (48%, n=21) in the six months prior to interview, although a substantial proportion (39%, n=17) felt that this level of availability had remained stable.

As can be seen from Figure 2 below, IDU reports of availability of powder and base/paste methamphetamine have remained relatively stable when compared to the results of the 2002 IDRS. However, fitting with IDU reports of increased availability of crystal methamphetamine in 2003, the proportion of IDU regarding this form of the

drug as easily or very easily available has almost doubled from the 2002 study (45%) to 2003 (86%).

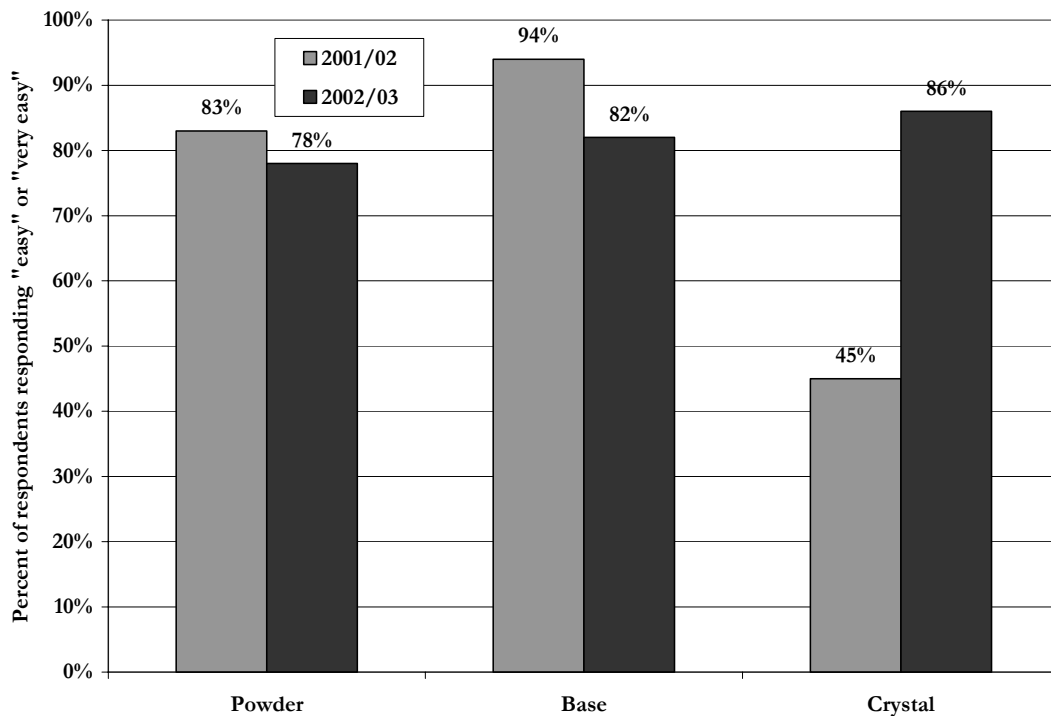


Figure 2: IDU reports of ease of availability of different methamphetamine forms: 2002-2003 IDRS

Tasmania Police seizures (Table 17) of methamphetamine have slightly reduced in 2002/03, down to 2022 g, following a reasonably stable level of seizures in the preceding two financial years – 3130 g in 2000/01, and 3211 g seized in 2001/02.

There does not appear to be a substantial street-based methamphetamine scene, with the majority of IDU usually purchasing the drug (over all forms) from dealer’s homes (37%), through friends (29%) or mobile dealers (18%), and most commonly taking 30 minutes to ‘score’ the drug (Table 18). IDU reported that methamphetamine powder was most commonly purchased at a dealer’s home (38%), via a mobile dealer (22%), or through a friend (26%), with only 12% reporting most commonly purchasing this form of methamphetamine from a street dealer. Similar patterns were reported for ‘base/paste’ methamphetamine, with 18% most commonly purchasing via a mobile dealer, 21% via a friend, and 48% from a dealer’s home, with just 7% most commonly purchasing ‘base/paste’ from a street dealer. Crystalline methamphetamine was reported as most commonly being purchased through a friend (37%) or from a dealer’s home (29%), with only a small number of IDU reporting usually purchasing this form from a street dealer (9%) or importing it from a mainland jurisdiction (2%).

Table 17. Tasmania Police data for methamphetamine July 1999-June 2003

	Jul- Sept 1999	Oct- Dec 1999	Jan- Mar 2000	Apr- Jun 2000	Jul- Sept 2000	Oct- Dec 2000	Jan- Mar 2001	Apr- Jun 2001	Jul- Sept 2001	Oct- Dec 2001	Jan- Mar 2002	Apr- Jun 2002	Jul- Sept 2002	Oct- Dec 2002	Jan- Mar 2003	Apr- Jun 2003
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Methamphetamine Powder Seized (g)*

<i>South</i>	289	1011	310	287	987	126	50	280	193	276	900	177	781.3	100.5	441.8	15.2
<i>North</i>	4	49	8	70	13	4	16	70	24	46	1	0	31	165.2	0	27.1
<i>West</i>	57	48	68	40	30	1043	15	396	39	783	184	588	2	141.5	80	236.4
total	350g	1108g	386g	397g	1030g	1173g	81g	746g	256g	1105g	1085g	765g	814.3g	407.2g	521.8g	278.7g
% within southern region	83%	91%	80%	72%	96%	11%	62%	38%	75%	25%	83%	23%	96%	25%	85%	5%

Methamphetamine Tablets Seized

<i>South</i>	24	5	13	80	2	0	0	0	1	0	1	0	23	1	21	0
<i>North</i>	0	0	12	0	2	2	17	0	0	0	0	0	11	2	0	11
<i>West</i>	8	0	0	0	0	0	0	0	0	0	42	0	0	1	0	0
total	32	5	25	80	4	2	17	0	1	0	43	0	34	4	21	11
% within southern region	75%	100%	52%	100%	50%	0%	0%	0%	100%	0%	2%	0%	68%	25%	100%	0%

Price in Southern District

<i>Taste</i>	\$50	\$50	\$50	\$40-50	\$40-50	\$40-50	\$40-50	\$40-50	\$40-50	\$40-50	\$40-70	\$40-70	n/r	n/r	n/r	n/r
<i>Gram</i>	\$80	\$70-80	\$70-80	\$70-80	\$70-80	\$70-80	\$70-80	\$70-80	\$70-80	\$70-80	\$70-80	\$70-80	n/r	n/r	n/r	n/r

*This row includes powder seized and verified as containing methamphetamine, and unknown powder seized, believed to be methamphetamine.
n/r: information was not available for inclusion in the current report.

Table 18: Pathways to access of methamphetamine by IDU

	Methamphetamine form			
	Powder (n=50) %	'Base/paste' (n=44) %	'Ice'/Crystal (n=65) %	All Forms (n=159) %
<u>Usual Access</u>				
<i>Street Dealer</i>	12 (n=6)	7 (n=3)	9 (n=6)	9 (n=15)
<i>Dealer's Home</i>	38 (n=19)	48 (n=21)	29 (n=19)	37 (n=59)
<i>Friend</i>	26 (n=13)	21 (n=9)	37 (n=24)	29 (n=46)
<i>Mobile Dealer</i>	22 (n=11)	18 (n=8)	14 (n=9)	18 (n=28)
<i>Home Delivery</i>	-	5 (n=2)	8 (n=5)	4 (n=7)
<i>Gift</i>	-	2 (n=1)	2 (n=1)	1 (n=2)
<i>Sent down from mainland</i>	-	-	2 (n=1)	1 (n=1)
<i>Median Time To Access</i>	30 min (range 0-360 min)	20 min (range 0-300 min)	30 min (range 0-4320 min)	30 min (range 0-4320 min)
<u>Last Time Purchased</u>				
<i>Street Dealer</i>	12 (n=6)	7 (n=3)	9 (n=6)	9 (n=15)
<i>Dealer's Home</i>	38 (n=19)	46 (n=20)	32 (n=21)	38 (n=60)
<i>Friend</i>	26 (n=13)	23 (n=10)	39 (n=25)	30 (n=48)
<i>Mobile Dealer</i>	22 (n=11)	18 (n=8)	14 (n=9)	18 (n=28)
<i>Home Delivery</i>	-	5 (n=2)	6 (n=4)	4 (n=6)
<i>Gift</i>	-	2 (n=1)	-	1 (n=1)
<i>Median Time To Access</i>	30 min (range 0-360 min)	20 min (range 0-300 min)	30 min (range 0-480 min)	30 min (range 0-480)

5.3 Form and Purity

Eighty-eight percent of the IDU sample reported using some form of methamphetamine in the six months prior to interview, with the drug predominantly being injected by this sample. Median frequency of use of any form of methamphetamine was 20 days in the preceding six-month period (which is approximately three times per month), ranging between 1 and 180 days in this time. These rates are highly similar to those reported in the previous IDRS surveys, as, in 2002, 89% of the sample reported using methamphetamine, at a median frequency of 25 days in the preceding six months, in 2001 85% had used the drug, at a median frequency of 24 days, and in 2000, 83% used methamphetamine, at a median frequency of 25 days.

IDU reports of the forms of methamphetamine they had used in the previous six months clearly show that a wide range of forms and potencies of the drug are available to the IDU community. Fifty-eight percent of those recently using methamphetamine reported using powder form methamphetamine (n=51). Similar to the 2002 study, no IDU reported use of true liquid form methamphetamine (often known as 'ox blood') in the previous six months. Recent use of pharmaceutical stimulants according to a medical practitioner's prescription (i.e. licitly) was relatively uncommon in the sample (n=4: dexamphetamine n=3; methylphenidate n=2, both n=1), but use of illicit/diverted tablets was more common (n=43: dexamphetamine n=42, methylphenidate n=14, both =13).

The physical presentation of the other 'forms' of methamphetamine purchased by IDU are described in Section 5.0 above, with exemplars displayed in Table 14. The 'oily', 'gunky', 'gluggy' gel, brown or 'bloody' in colour base/paste methamphetamine was by far the most commonly used form of the drug in the 2002 IDRS sample, used in the past six months by 83% (n=74) of IDU that had used the drug. However, among the 2003 respondents, its use was far less common, used by just 52% of those using methamphetamine in the preceding six months (n=46). The white/clear crystal methamphetamine, which was used by just 22% of methamphetamine-using IDU in the 2002 study (n=20), was used by the majority of such participants in the current study (77%, n=68) in the six months prior to interview. This major shift in use can be seen in Figure 3 below.

When asked to describe the form of methamphetamine that they had used most often in the preceding six months, 65% (n=58) reported crystalline methamphetamine, with most frequent use of base/paste methamphetamine (23%, n=20), methamphetamine powder (17%, n=15), and illicit pharmaceutical stimulants (15%, n=13) substantially less common.

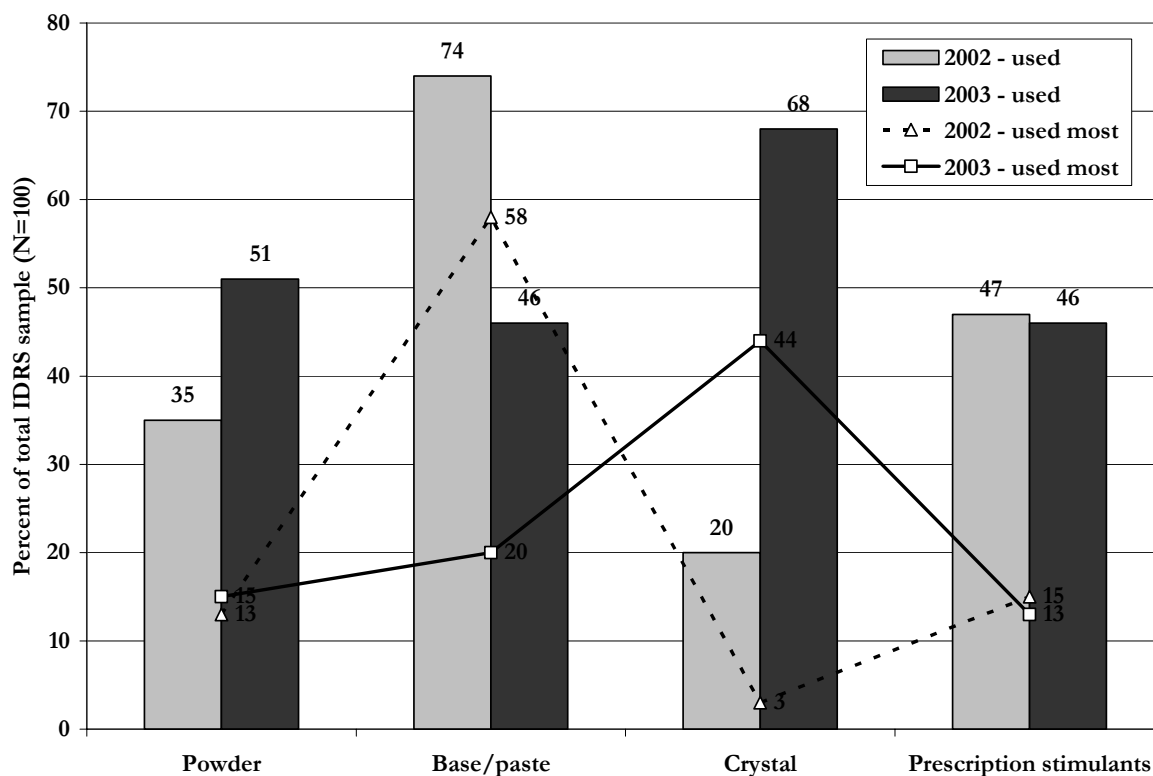


Figure 3: Use of various forms of methamphetamine and prescription stimulants among IDRS IDU participants, 2002-2003.

When asked to describe the purity of powder form methamphetamine, IDU responses were quite mixed, with 30% (n=15) describing it as low purity, 28% (n=14) describing it as medium in purity, and 32% (n=16) reporting purity as having fluctuated in the preceding six months. There was also some dissension in regard to the stability of this level or purity, with 46% (n=21) reporting that purity had fluctuated in the past six months, 30% believing that purity had remained stable (n=14), and 17% reported that purity had decreased in this time (n=14).

The purity of 'base/paste' methamphetamine also appears to be quite variable, with 32% (n=14) reporting purity to have fluctuated in the preceding six months, 41% (n=18) reporting that this form was medium in purity, and 25% (n=11) that 'base/paste' was quite high in purity. When asked about the stability of the purity of 'base/paste' methamphetamine, again 46% (n=18) reported that this fluctuated, although 38% (n=15) reported purity as having remained stable, with 10% (n=4) reporting that purity had increased, and 5% (n=2) that purity had decreased, in this time.

Crystalline methamphetamine was generally regarded as high (77%, n=49) or medium (19%, n=12) in purity by IDU. Most reported this level of purity to have remained stable in the preceding six months (75%, n=6), with single IDU reports of increasing (13%, n=1), and decreasing (13%, n=1) purity levels in this time. Many IDU could not provide information about changes in purity as they had only started using this form of the drug in the preceding six months.

Ten key informants felt confident in reporting on the purity of methamphetamine available to the groups they were familiar with, and these reports were similar to those from IDU: the majority reporting a high (50%, n=5, with two key informants specifically referring to crystal methamphetamine) or fluctuating level of purity (40%, n=4), with only a single report of medium level purity (10%). As would be expected given the increase in availability of the high-purity crystal methamphetamine, when asked about the stability of methamphetamine purity in the preceding six months, the majority of key informants reported that purity had increased 60% (n=6, with two KI specifically referring to crystal methamphetamine) with a smaller proportion (30%, n=3) reporting that purity had fluctuated in this time.

Data for purity of methamphetamine received at police analytical laboratories has been provided for the 1997/98 to 2002/03 financial years (Table 19, Table 20). Drugs seized by Tasmania Police are only tested for composition and purity if the alleged offender pleads not guilty to the associated charge. Hence, purity data for drug seizures in the state are minimal. This very restricted sample size renders it difficult to make inferences about trends in purity of methamphetamine. However, the data does seem to suggest that the level of purity of consumer-type amounts of methamphetamine seized in Tasmania has remained relatively stable over the period 1997/98 to 2000/01. The apparent sharp ‘jump’ in purity of analysed methamphetamine samples between 2000/01 and 2001/02 may simply reflect the analysis of a more representative sampling of methamphetamine seizures (afforded by the greater sample size). These purity figures are in line with IDU and KI reports of ‘medium’ purity levels of the drug. While examination of Table 20 shows that the ‘jump’ in purity in 2001/02 relates to samples analysed in the October-December 2001 and January-March 2002 period, with subsequent samples returning to lower purity levels, the range in purity levels (0.1-71% in 2001/02 and 2-79% in 2002/03) has remained similar over the past two financial years.

Table 19. Purity of seizures of methamphetamine made by Tasmania Police received for laboratory testing, 1997/98 – 2002/03

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
<=2 g						
<i>n</i>	4	31	9	10	20	30
<i>avg % purity</i>	5 %	5 %	7.4 %	10.4%	26.6%	12.7%
> 2g						
<i>n</i>	2	8	11	14	28	13
<i>avg % purity</i>	7 %	21 %	6.6 %	3.6 %	19.2%	11.2%
Total						
<i>n</i>	6	39	20	24	48	43
<i>avg % purity</i>	6 %	8 %	7 %	6.4 %	22.2%	12.2%
<i>Range in % purity</i>	3-8%	2-59%	2-26%	0.5-50%	0.1-70.6%	1.9-78.5%

Source: Australian Bureau of Criminal Intelligence; Australian Crime Commission; Tasmania Police State Intelligence Services

Note: No seizures made by the Australian Federal Police in the state were analysed during this period. All analysed seizures of amphetamines in this period revealed methylamphetamine rather than amphetamine.

Table 20. Purity of Tasmanian seizures of methamphetamine made by Tasmania Police received for laboratory testing, by quarter, July 1999-June 2003

	Jul-Sep 1999	Oct-Dec 1999	Jan-Mar 2000	Apr-Dec 2000	Jan-Mar 2001	Apr-Jun 2001	Jul-Sep 2001	Oct-Dec 2001	Jan-Mar 2002	Apr-Jun 2002	Jul-Sep 2002	Oct-Dec 2002	Jan-Mar 2003	Apr-Jun 2003
<=2 g														
<i>n</i>	2	1	6	-	9	1	1	6	12	1	3	4	4	19
<i>median % purity</i>	15.3%	3.0%	6.0%	-	3.2%	5.2%	9.0%	31.1%	26.0%	6.7%	6.4%	5.9%	13.1%	13.1%
> 2g														
<i>n</i>	1	2	8	-	12	2	6	7	13	2	1	4	7	1
<i>median % purity</i>	6.0 %	2.5%	6.0%	-	3.8%	3.1%	5.5%	30.1%	20.0%	18.5%	6.3%	10.4%	12.8%	7.6%
Total														
<i>n</i>	3	3	14	-	21	3	7	13	25	3	4	8	11	20
<i>avg % purity</i>	6.0%	2.5%	6.0%	-	3.4%	4.3%	6.8%	30.1%	24.9%	6.7%	6.4%	10.4%	12.8%	13.0%

Source: Australian Bureau of Criminal Intelligence; Australian Crime Commission; Tasmania Police State Intelligence Services

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

Tasmania Police report that the majority of methamphetamine in the Tasmanian illicit drug market is imported into the state, most commonly by members of organised motorcycle groups or particular criminal groups, via post or domestic sea or air terminals. Several key informants supported this view. However, two justice-related key informants noted that there had been reports of increasing local production of methamphetamine within the state. In 2001/02, three illegal methamphetamine production laboratories (or 'box labs') were detected by Tasmania Police, an increase from the one located in 2000/01. As detailed in the 2002 IDRS report, police intelligence at the time suggested that the methamphetamine produced in local methamphetamine 'laboratories' is based on pharmaceutical pseudoephedrine, and local methamphetamine laboratories are more often using pharmacy-grade reagents (iodine in particular) in the production of the drug, often purchased via the internet. In the current study, one justice-related key informant reported that there was no evidence for local production of crystal methamphetamine, but that this form of the drug was commonly imported from mainland jurisdictions.

These multiple pathways of access and production sources may underlie the fluctuating nature of the forms and potency of methamphetamine in the local illicit drug market. In support of this, in the 2002 IDRS study, several IDU reported that the presentation (colour and consistency as well as potency) of the 'form' of methamphetamine available from their regular 'dealer' would fluctuate regularly, with some dealers having two or more different presentations of the drug available for sale at one time.

5.4 Use

5.4.1 Prevalence of methamphetamine use

The most recent survey of methamphetamine use within the general community of Tasmania was undertaken within the 2001 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2002), which sampled 1349 Tasmanian residents. Results indicated that 2.1% (n=28) had used the drug in the 12 months prior to interview. This is a slight increase from the 1.6% of those sampled in the 1998 Household Survey (Australian Institute of Health and Welfare, 1999; sample size = 1,031) reporting use of the drug in the preceding 12 months. Lifetime prevalence of methamphetamine use is not available from the 2001 Survey, but the 1998 survey indicated that 6.3% of those sampled reported ever using methamphetamine. The 2001 survey estimates 3,700 injecting drug users aged 14 years and over in the state, with methamphetamine being the predominant drug injected amongst these individuals (86% of recent injecting drug users injecting methamphetamine, 41% injecting other opiates – morphine or methadone). In comparison, all of the respondents in the 1998 Survey that reported injecting illicit drugs (n=6) in the 12 months prior to interview had injected methamphetamine.

The Australian School Students Alcohol and Drugs (ASSAD) Survey (Cancer Council of Tasmania, 1997) sampled 2,553 students in years 7 to 12 from schools across Tasmania during the 1996 school year, and 2,671 students in 1999 (Cancer Council of Tasmania, 2001). Results were divided between 12-15 year olds, and 16-17 year olds. Within the younger age group, in the 1996 study, 6% of those sampled reported ever using methamphetamine, with 4% reporting lifetime use of the drug in the 1999 study. In regard to recent use, 2% of those interviewed in 1996 and 3% of those interviewed in the

1999 study reported use in the month prior to interview. Reported lifetime use among 16-17 year olds surveyed was slightly higher, with 5% of those surveyed in 1996 and 7% of those surveyed in 1999 ever using methamphetamine, but 3% of those sampled in both studies reported using the drug in the month prior to interview. These rates are generally consistent with those found in the 2001 and 1998 National Drug Strategy Household Surveys, and there were no significant changes in patterns of methamphetamine use between the 1996 and 1999 ASSAD surveys.

The Australian Needle and Syringe Program Survey (National Centre in HIV Epidemiology and Clinical Research on behalf of the Collaboration of Australian Needle and Syringe Programs) has reported methamphetamine as the last drug injected of around 30% of their Tasmanian participants for their 1997 and 1998 surveys, and a slightly lower proportion reporting methamphetamine (20%) in their 1999 survey, rising to 41% in 2000, falling again to 25% in 2001, and returning to 30% in the 2002 survey. However, these studies only sampled small numbers of clients (23, 51, 25, 27, 28 and 151 clients respectively), with such small sample sizes rendering it difficult to make any reliable inferences regarding trends in use.

Since 1997, clients of non-pharmacy Needle Availability Program (NAP) outlets have been asked which drug they mostly inject. While methamphetamine has been the most commonly reported single drug used for the past 5 years, the proportion of NAP clients reporting methamphetamine as the drug they most commonly use was in steady decline from 56% in 1996/97 to 30% in 2000/01 (Figure 4). However, this trend has been reversed in the past two financial years, with the proportion increasing to 37% in 2001/02 and further to 50% in 2002/03. However, this data should be interpreted with some caution, as these patterns of use were reported by only around 40% of total needle and syringe outlet clients prior to 2001/02, rising to almost 80% in 2001/02 and 88% in 2002/03, because data was previously collected inconsistently across services due to staff time limitations. As such, the apparent recent increase in proportions of NAP clients reporting methamphetamine use in the past two financial years, in contrast to trends over preceding years, may simply reflect this more consistent level of reporting across NAP outlets.

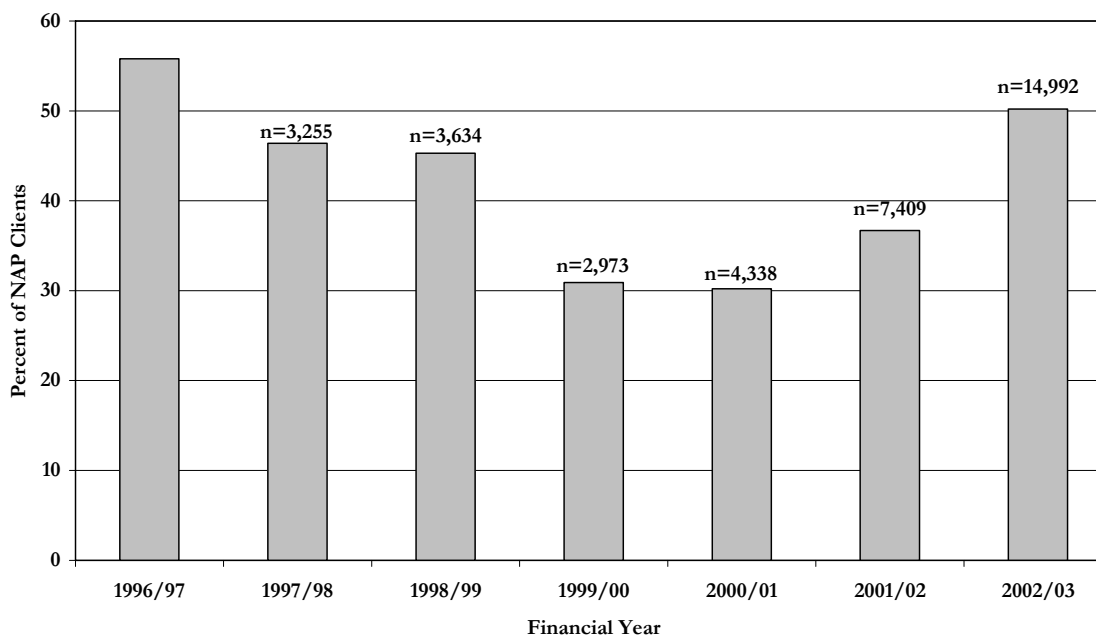


Figure 4: Percentage of methamphetamine reported as ‘drug most often injected’ by Tasmanian non-pharmacy Needle Availability Program clients, 1996/97-2002/03

Source: Sexual Health, Department of Health and Human Services

Data from urine screens of Tasmanian prisoners revealed a very low rate of sympathomimetic amines among positive tests, accounting for 3% or less of all positive tests between 1995/96 and 2002/03. These figures may underestimate the level of use amongst this group however, due to the relatively rapid elimination of this drug from the body.

5.4.2 Current patterns of methamphetamine use

Of the IDU surveyed, 100% had used some form of methamphetamine at some time in their lives, with 88% using some form in the past 6 months, however, only 25% of the sample indicated that methamphetamine was their drug of choice. These patterns are highly similar to those surveyed in the 2000-2002 Tasmanian IDRS studies. Of the 25 IDU that reported methamphetamine as their drug of choice, the majority (72%, n=18) reported methamphetamine as the drug they had most often injected in the month prior to interview. Of these seven IDU that had not used their drug of choice most often in the preceding month, 4 instead most commonly injected morphine, and 3 methadone. Three of this group explained this discrepancy in as due to the financial costs associated with methamphetamine use (all three were receiving methadone maintenance treatment), one due to addiction to opiates and one reported choosing to stay away from methamphetamine.

For those IDU that had primarily used any form of methamphetamine in the past 6 months (n=29), the drug was used for a median of 53 days in that period (range 7-152). In the 62 IDU that had most frequently used another illicit (all but one were primary

users of some form of opioid) and had used methamphetamine recently, it had been used a median 15 days (range 1-180) in the past 6 months. Taken together, it is clear that a moderate level of methamphetamine use is common amongst primary users of other drugs, which was supported by comments from key informants reporting on primary users of either cannabis or opioids that some form of methamphetamine was occasionally used by the people with whom they were in contact with (n=7/7 of primary opiate-using groups; n=11/11 of primary cannabis-using groups). Most recreational users of methamphetamine in these groups were noted by key informants to use intravenously. The majority of these key informants were not able to differentiate between forms of methamphetamine used by these groups (n=10/18), although those that could make such a distinction indicated that their groups most commonly used methamphetamine powder (n=7, predominantly referring to primary cannabis using groups) or crystal methamphetamine (n=7, predominantly referring to primary opioid using groups).

Key informant reports suggested that the most common other drug used by primary methamphetamine users was cannabis, with moderate to high levels of use of benzodiazepines, both often being used functionally to help users 'come down' from their methamphetamine use. Key informants also reported opioid use in a small percentage of primary methamphetamine users, and that substantial proportions of primary methamphetamine users were also using ecstasy recreationally.

5.5 Methamphetamine related harms

5.5.1 Law enforcement

Arrest data for methamphetamine-related offences indicate a marked increase in the number of arrests between 1998/99 and 2000/01, continuing into 2001/02 (Table 21). While the number of arrests decreased slightly between 2001/02 and 2002/03, these rates remain substantially greater than those seen prior to 2000/01. The main increase over time has come from those charged with 'consumer'-type offences (such as use and possession), consistent with reports of increased availability and use of methamphetamines (discussed below).

Table 21: Consumer and provider arrests for methamphetamine and related substances, 1996/97-2002/03

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
	n	n	n	n	n	n	n
<i>Consumers</i>							
Female	3	5	0	4	9	18	9
Male	15	9	4	14	51	53	33
Unknown	0	1	2	2	0	0	5
Total	18	15	6	20	60	71	47
<i>Providers</i>							
Female	0	0	0	0	1	6	2
Male	2	0	1	7	9	12	16
Unknown	0	0	0	1	0	0	0
Total	2	0	1	8	10	18	18
Total Arrests	20	15	7	28	70	89	65

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

Note: "Consumer" refers to persons charged with use-type offences (e.g. possession, administration), while "provider" refers to persons charged with supply-type offences (e.g. supply, cultivation or manufacture). Where a person has been charged with multiple offences within a category, that person is only counted once in these statistics. Data from 2001/02 is based on SIS data and is preliminary only.

5.5.2 Health

Eleven key informants and two IDU reported that there had been an (anecdotal) increase in overdoses related to crystalline methamphetamine in recent months. There were anecdotal reports of 2-4 recent deaths in the south of the state due to heart problems following use of crystal methamphetamine. Single key informants also noted increases in strokes and seizures (the latter also supported by one IDU) due to crystal methamphetamine use.

As noted in the previous sections, crystalline methamphetamine has recently become much more easily available in Hobart, and anecdotal reports from users suggest that this form is substantially more pure than the methamphetamine generally sold in the state. With greater potency also comes exacerbation of the unwanted side effects of the drug, and several key informants noted a marked increase in agitation (n=4), violence (n=3) and related problems amongst their clients in the preceding six months, associated with methamphetamine use. Three key informants also noted clear increases in paranoia and amphetamine-related psychosis amongst their clients in this period. One key informant noted that some users of crystal methamphetamine had been somewhat turned off the drug due to the side effects and problems associated with the drug.

5.6 Trends in methamphetamine use

It is very clear that the major shift in the local methamphetamine market in 2003 has been a greatly increased availability of the highly potent crystal methamphetamine, or 'ice'. IDU generally reported that this increase in availability of this form of the drug began sometime between January and April, 2003 (n=11: January n=17; March n=4; April n=19), although some reported this ready availability as beginning 8-12 months prior to interview (n=7), and some reporting this as only beginning 1-2 months prior to interview (n=10).

The high potency and easy availability of crystalline methamphetamine has caused multiple changes to the local illicit drug market. As noted by one IDU, "crystal methamphetamine has replaced base", an opinion also shared by three key informants. As displayed in Figure 3 above, while base/paste methamphetamine was by far the most commonly used form of the drug among the 2002 IDRS participants, in 2003, use of crystal methamphetamine had more than doubled (20% of the sample in 2002, 68% in 2003) and use of base had almost halved (74% of the sample in 2002, 46% in 2003). Thirty-four IDU also noted that use of crystal methamphetamine was more common in the preceding six months.

Additionally, one IDU noted that crystal methamphetamine was a "very attractive drug, luring more people into taking more drugs". Seven key informants and fourteen IDU reported that more people seemed to be using methamphetamine, and crystal methamphetamine in particular, in the preceding six months. Increases in the number of younger users, particularly those in their late teens (14-20 years, noted by 11 IDU and 2 key informants) and especially among young females (noted by 6 IDU and 5 KI) were reported by many of the individuals interviewed in the current study.

Continuing a trend noted in the 2002 IDRS study, nine IDU noted that they had seen primary users of opioids change to being primary users of methamphetamine in the preceding six months, both due to the increased quality and increased availability of the drug. In conjunction with this, and increase in both the amount and frequency of methamphetamine use among existing users was noted by 26 and 7 IDU respectively. Additionally, seven key informants that worked closely with regular injecting drug users noted that polydrug use was increasingly common amongst their client groups in the preceding six months, to the extent of clients using methamphetamine and opioids on the same day or using opioids or benzodiazepines to come down from crystal methamphetamine use.

5.7 Summary of methamphetamine trends

Table 22: Summary of trends in methamphetamine use

	Methamphetamine 'Powder'	'Base/Paste' Methamphetamine	Crystalline Methamphetamine
Price (mode) <i>'point' / packet (~0.1g)</i> <i>gram</i>	<ul style="list-style-type: none"> • \$50, stable • \$215, stable 	<ul style="list-style-type: none"> • \$50, stable • \$300, stable 	<ul style="list-style-type: none"> • \$50, stable • \$350, stable
Availability	<ul style="list-style-type: none"> • Easy to very easy to obtain • Availability stable 	<ul style="list-style-type: none"> • Very easy to obtain • Availability stable 	<ul style="list-style-type: none"> • Very easy to access • Availability markedly increased
Purity and form	<ul style="list-style-type: none"> • IDU reports of low-medium, fluctuating purity • ~6% from the small number of methamphetamine seizures analysed, stable between 1997/98 –2000/01 • Form: beige/yellowy/of-white powder 	<ul style="list-style-type: none"> • IDU reports of medium to high purity, quality stable or fluctuating • Form: oily/'gunky'/gluggy brown gel 	<ul style="list-style-type: none"> • IDU reports of high purity, quality stable • Form: white/clear, hard crystals or 'rocks' similar to crushed glass or rock salt
Use	<ul style="list-style-type: none"> • Used by half (51%) of the IDU sample, but uncommon as the form of methamphetamine predominantly used 	<ul style="list-style-type: none"> • Used by almost half of the IDU sample recently (44%), a large decline from comparative levels in 2002 (74%) 	<ul style="list-style-type: none"> • Used by two-thirds of the IDU sample, despite being the drug of choice for only a small proportion of the group • High purity and easy availability has attracted more use
Other trends	<ul style="list-style-type: none"> ▪ IDU and key informant reports of an increasing number of users, an increase in younger users (14-20 years), particularly among young females, and use in increasing frequency and amount by existing users. IDU reports of a continuation of a trend noted in 2001, with increasing numbers of IDU shifting from being predominant users of opioids to becoming predominant users of methamphetamine. These trends are associated with the crystalline form of methamphetamine ▪ Concerns around anecdotal reports of recent deaths due to heart failure following use of crystalline methamphetamine, and increases in the prevalence of negative effects of methamphetamine use (paranoia, agitation, psychosis) amongst current users 		

6. COCAINE

Similar to the patterns in the previous Tasmanian IDRS surveys, only a very small number of IDU (n=2) could comment on price, purity or availability of cocaine. However, 52% of the sample indicated that they had tried cocaine at some stage in their lives, with 9 respondents reporting that they had used cocaine in the six months prior to interview (7 had injected and 6 had snorted the drug), although the median frequency of use was only four times in this period (range 1-74 times overall; median frequency of injection 4 times, range 1-72). The cocaine that these participants had used was almost exclusively powder, with one IDU reporting use of cocaine in a crystalline powder form (not smokeable crystals). Due to the extremely small number of respondents who were able to provide information on cocaine, the information provided in this section should be interpreted with caution. With this noted, however, the reported extent of recent use of the drug is slightly lower than in the 2002 study (n=12).

Only two IDU reported cocaine as being their drug of choice, and just one reported this as the drug they had most often injected in the preceding month (the other most commonly injecting methadone). When asked the reasons for this discrepancy, that individual put this down to low availability of the drug.

6.1 Price

Only two IDU could provide information on the price of cocaine, with IDU reporting purchase prices of \$80 for approximately 0.1g of cocaine (n=1) and \$250 for approximately 1g of the drug (n=1). These prices, particularly gram prices, are reasonably equivalent to those reported in southern mainland jurisdictions in 2003 (Breen et al 2004). Tasmania Police have been unable to report prices of cocaine from either informant reports or covert bust operations between 1995/96 and 1999/00, however, in 2001 Southern Drug Investigation Services estimated the price of cocaine as \$250 per gram, on the basis of an informant report, and the price reported by Tasmania Police remained stable during the remainder of the 2001/02 financial year. Price information for 2002/03 was not available for inclusion in the current report.

6.2 Availability

For the two IDU that could comment on the availability of cocaine, one reported it as being difficult for them to access the drug, and the other indicating that it was very difficult to access the drug in the preceding six months. No key informants could comment on the availability of cocaine to the individuals they had contact with. In regard to stability of the availability of the drug, both IDU the difficulty in accessing the drug was a situation that had remained stable in the preceding six months.

Of the two IDU reporting cocaine trends, both reported usually purchasing the drug through a friend. Both indicated that this requires some pre-arrangement, as the third party organises for the drug to be sent down from a contact in a mainland jurisdiction, rather than having the drug easily available for sale. Once the drug arrived in the state, the two IDU reported that it usually took a median of 90 minutes (range 60-120) for them to 'score'. Both IDU reported using this same approach last time they purchased the drug, although the median time to access the drug was slightly less (60 minutes, range 0-120 minutes).

While there had been no seizures of cocaine made by Tasmania Police made between 1995/96 and 1999/00, two seizures, totalling 29g were made in 2000/01, both by Western Drug Intelligence Services in November, 2000. One seizure of cocaine was made from a person intercepted upon arrival into the state, who was also in possession of a number of tablets of ecstasy. The other seizure resulted from a search of the home of a member of an organised motor-cycle gang. There were no seizures of cocaine made by Tasmania Police in 2001/02 or 2002/03.

Just six of the thirty-one key informants reported rarely hearing about use of cocaine among their groups, and where some use was reported, it was generally in very small proportions of their clients (1-2%, n=3) or while clients were in other jurisdictions. Taken together, these reports, and the small number of respondents who had used cocaine in the past six months (n=9) and that were able to report on trends (n=2), it would seem that there is a very low availability of cocaine in Tasmania, at least among the demographic sampled in this survey.

6.3 Purity

The two IDU that had used cocaine recently reported that it was high in purity, and that this level of purity had remained stable over the preceding six months. The last analysed sample of cocaine seized within the state by Tasmania Police was from the first quarter of 2001. This was an amount of less than two grams, and was analysed during the first quarter of 2002 at 44.0% purity.

6.4 Use

According to the findings of the 1998 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 1999) 2.3% of surveyed Tasmanian residents (n=29) reported ever trying cocaine, while only 0.1% (n=3) had used it in the 12 months prior to interview. Findings of the 2001 survey (Australian Institute of Health and Welfare, 2002) were very similar, with 0.2% of those sampled reporting using the drug in the preceding year.

Of the 2,553 year 7 to 12 students sampled from Tasmanian schools in 1996 by the Australian School Students Alcohol and Drugs (ASSAD) Survey (Cancer Council of Tasmania, 1997), 3% indicated they had ever tried cocaine. Among the 2,671 students surveyed in 1999 (Cancer Council of Tasmania, 2001), 5% reported ever trying the drug. There were no significant changes in patterns of reported cocaine use between the 1996 and 1999 studies.

6.4.1 Cocaine use among IDU

Only 0.1% of clients of non-pharmacy Needle Availability Program clients in 2002/03 indicated that cocaine was the drug they most often injected. This figure has been reasonably stable over the past three financial years (Table 23), relating to around 10-30 clients each year. However, it is important to note that, despite there being some discrepancy between NAP outlets in the question asked (some asking 'what is the drug you most often inject', while others prefer 'what is the drug you are about to inject'), it is likely that the question 'what is the drug you most often inject' will tend to underestimate the extent of use of cocaine, as just one of the IDU sampled in the IDRS survey reported

it as the drug they most often used in the preceding month, despite nine recently using the drug and two indicating that it was their drug of choice.

None of the participants in any of the 1995, 1996, 1997, 1998 or 1999 Australian Needle and Syringe Program Survey (National Centre in HIV Epidemiology and Clinical Research on behalf of the Collaboration of Australian Needle and Syringe Programs, 2002) has reported cocaine as the last drug they injected, although in 2000, one participant reported last using a combination of heroin and cocaine, with the same report occurring again in 2001 and 2002. However, since these studies only relate to very small samples of participants (6, 18, 23, 51, 25, 27, 28 and 151 clients respectively), they were of very limited power for the detection of low frequency occurrences such as the injection of cocaine.

Table 23: Percentage of cocaine reported as ‘drug most often injected’ by Tasmanian non-pharmacy Needle Availability Program clients, 1997/98-2002/03

Year	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Number of clients reporting cocaine	12	28	19	13	20	36
Percent of total clients reporting cocaine	0.2%	0.3%	0.2%	0.1%	0.1%	0.1%

Source: Sexual Health, Department of Health and Human Services

6.4.2 Current patterns of cocaine use

Of the nine IDU that reported using cocaine in the past six months, the median amount of use was four days in the last six months (range 1-74 days).

Just six of the thirty-one key informants made mention of cocaine use among the users they had the most contact with, although this was often contextualised by key informants reporting use as generally in very small proportions of their clients (1-2%, n=3) or while clients were in other jurisdictions. The majority of key informants (n=25) indicated that there was no current use of cocaine amongst the groups they came into contact with.

6.5 Summary of cocaine trends

In summary, it appears that the availability and use of cocaine in Hobart is very low, at least within the populations surveyed in the current study or accessing government services. The cocaine that is used by Tasmanian IDU appears generally to be directly imported by consumers from dealers in mainland states. These patterns seem to have remained reasonably stable over the past few years, however, it is noteworthy that increasing proportions of the Tasmanian IDU sample over the past three years have reported lifetime use (39%, 47% and 52% in the 2001, 2002 and 2003 surveys respectively) of cocaine.

7. CANNABIS

Among the IDU respondents, cannabis was the most commonly used illicit drug, with 99% of the sample using it at some time in their lives, and 88% using in the six months prior to interview. For the first time in the IDRS study, participants were asked to comment separately on trends around ‘bush’ (outdoor-grown) cannabis and indoor/hydroponically grown cannabis. Seventy-three IDU could comment confidently on aspects of price, potency, and availability of indoor/hydroponically grown cannabis, 65 reported trends on bush/outdoor cannabis, with 64 reporting trends on both types. Almost all key informants reported, or suspected (some did not directly discuss cannabis use due to the nature of their professional roles) some level of cannabis use within the populations they had contact with.

Ten key informants reported on groups that were primary users of cannabis. Key informants included five individuals associated with justice/police, four drug and alcohol specific workers (including counsellors) and one outreach worker. Key informants were familiar with cannabis users from all suburbs of Hobart. The groups of cannabis users described by key informants were predominantly from an English-speaking background, with various levels of education backgrounds and current employment. Cannabis users that key informants were familiar with ranged in age from teenagers to 60 years, although the majority were in their twenties.

7.1 Price

The modal market price reported by the IDU for indoor/hydroponically grown cannabis was \$25 per gram (n=24, range \$10-25), and \$300 per ounce (n=34, range \$150-390). These were slightly higher than the modal market prices reported for bush/outdoor cannabis, at \$10-25 per gram (bimodal, n=6 for each of \$10/gram and \$25/gram, range \$10-25) and \$200 per ounce (n=31, range =\$50-325). These prices were reasonably consistent with prices reported by the key informants: modal price \$25 per gram (n=5, range \$20-25). While there was good agreement that these were the ‘market prices’ for cannabis, most IDU did not report paying these prices for the last amounts of cannabis they purchased.

For their last purchase of bush/outdoor grown cannabis, a \$25 ‘deal’ was reported to contain 1-7g (mode 2.0g) of cannabis, with 3.5-14g (mode 7.0g) in a \$50 ‘deal’¹¹. With the exception of \$25 ‘deals’, the most common amount of outdoor cannabis purchased by IDU was, as per previous IDRS surveys, was quarter ounce (7g) amounts (n=29). The median last purchase price for a quarter ounce of outdoor cannabis was \$60 (no mode, range \$25-90, n=29). Ounces of outdoor cannabis were a median of \$150 (no mode, range \$100-200, n=20).

In general, purchase costs for indoor/hydroponically cultivated cannabis were slightly higher than the reported costs for bush/outdoor cannabis. ‘Deals’ costing \$25 contained a mode of 1g (range 1-2g, n=46), with \$50 ‘deals’ containing a mode of 3.5g (range 2-7g, n=16) of cannabis. The more commonly-purchased quarter-ounce amounts of

¹¹ This amount is likely to be skewed by a substantial number of IDU purchasing quarter-ounce amounts for \$50.

hydroponically cultivated cannabis were reported to be a modal last purchase price of \$80 (range 50-250, n=47), \$20 more than the comparable figure for outdoor cannabis. Modal last purchase prices for an ounce of hydroponically cultivated cannabis were double that of outdoor cannabis, at \$300 (range \$200-350, n=27). The modal prices of cannabis reported by IDU are summarised in Table 24 below.

The majority of IDU (70% overall, 73% in relation to outdoor cannabis and 66% in relation to hydroponic cannabis) and key informants (100%, n=7) reported that the price of cannabis had not changed in the last six months. A noteworthy minority reported decreasing prices for outdoor cannabis (21%, n=13), and equal minorities reported increasing and decreasing prices for hydroponic cannabis (14%, n=10 respectively). As previous studies have not made such clear distinctions in pricing of indoor and outdoor cultivated cannabis it is somewhat difficult to make clear comparisons to price data from previous years, however, the reported prices in the current study appear reasonably consistent with previous years, particularly when the preference for hydroponically cultivated cannabis among the previous samples is taken into consideration.

Tasmania Police provide quarterly figures on the price of covert drug purchases and reports by informants. According to prices reported to the ABCI (now the ACC), in June 2002, one gram of cannabis cost \$20-\$25 and one ounce cost \$200-\$350, similar to prices nominated by IDU and key informants in the current study (Table 25). While price data for the 2002/03 financial year was not available for inclusion in the current report, prices reported by Tasmania Police have remained stable between April 2001 and June 2002, and the similarity between these prices and those reported by IDU in 2003 add further support to IDU and key informant reports of price stability in 2003.

Tasmania Police also report the price of one gram of cannabis hash/resin as \$30-50 in the 2001/02 financial year. Only a single IDU reported a price for cannabis hash in the current study, at \$75 per gram.

Table 24: Modal prices of cannabis in Hobart purchased by IDU (range in parentheses)

	2000 IDRS			2001 IDRS			2002 IDRS			2003 IDRS					
Unit	Modal amount (grams)	Modal Price	n	Modal amount (grams)	Modal Price	n	Modal amount (grams)	Modal Price	n	Modal amount (grams)	Modal Price	n	Modal amount (grams)	Modal Price	n
	<i>All cannabis types</i>			<i>All cannabis types</i>			<i>All cannabis types</i>			<i>Bush / outdoor</i>			<i>Indoor / hydroponic</i>		
\$10 deal	-	-	-	-	-	-	1.0 g (0.5-7.0 g)	\$10	5	1.0 g (1.0-3.0 g)	\$10	4	0.6 g* (0.5-1.0 g)	\$10	3
\$25 deal	1.0 g (1.0-2.5 g)	\$25	37	1.5 g (1.0-2.5 g)	\$25	39	1.0 g (0.8-7.0 g)	\$25	18	2.0 g (1.0-7.0 g)	\$25	27	1.0 g (1.0-2.0 g)	\$25	46
\$50 deal	2.0 g (2.0-7.0 g)	\$50	13	3.0g* (2.0-7 g)	\$50	22	7.0 g† (2.0-28.0 g)	\$50	23	7.0 g (3.5-14.0 g)	\$50	15	3.5 g (2.0-7.0 g)	\$50	16
Quarter ounce	7 g	\$90 (\$50-120)	55	7 g	\$80 (\$40-150)	71	7 g	\$80 (\$10-120)	70	7 g	\$60* (\$25-90)	29	7 g	\$80 (\$50-250)	47
Half ounce	14 g	\$150 (\$100-250)	17	14 g	\$150 (\$70-180)	30	14 g	\$150 (\$40-225)	56	14 g	\$80* (\$50-130)	7	14 g	\$150 (\$140-250)	16
Ounce	28 g	\$280* (\$100-350)	16	28 g	\$250 (\$100-400)	50	28 g	\$250 (\$50-390)	62	28 g	\$150* (100-200)	20	28 g	\$300 (\$200-350)	27

* Median substituted, as no single mode exists; †This amount is likely to be skewed by a substantial number of IDU purchasing quarter-ounce amounts for \$50. The most common amount of cannabis purchased other than the reported mode was 3.5 g, which is more consistent with IDU reports of the amount commonly received if asking specifically for a \$50 'deal'.

Table 25: Cannabis prices in Tasmania, 1996-2002

	Deal (1 gm approx)			1/4 Bag (7 gms)		1/2 Bag (14 gms)		1 Ounce (28 gms)	
	Leaf	Head	Hydro*	Head	Hydro*	Head	Hydro*	Head	Hydro*
Jan-Mar 1996	\$15	\$30-40	-	-	-	-	-	\$300-450	-
April-June 1996	\$15	\$25-50	-	-	-	-	-	\$250-500	-
July-Sept 1996	\$15	\$25-50	-	-	-	-	-	\$350-450	-
Oct-Dec 1996	\$10	\$25-50	-	-	-	-	-	\$350-450	-
Jan-Mar 1997	\$10	\$25-50	-	-	-	-	-	\$350-450	-
April-June 1997	\$10	\$25	\$50	\$80	\$100	\$175	\$200	\$350-450	\$450
July-Dec 1997	\$10	\$25	\$50	\$80	\$100-120	\$150-175	\$200-250	\$350-450	\$450
Jan-Mar 1998	\$10	\$25	\$50	\$80	\$100-120	\$160	\$200-250	\$400	\$450
April-June 1998	\$10	\$25	\$50	\$80	\$100-120	\$160	\$200-250	\$250-350	\$350-450
Oct-Dec 1998	\$10	\$20-25	\$25	\$80-90	\$90-110	\$160-180	\$180-230	\$300-350	\$350-450
Jan-June 1999	\$10	\$20-25	\$25	\$80-90	\$90-110	\$160-180	\$180-230	\$300-350	\$350-450
Oct-Dec 1999	\$5-10	\$20-25	\$25	\$80-90	\$90-110	\$160-180	\$180-230	\$300	\$350-400
Jan-June 2000	\$5	\$25	\$25	\$80-90	\$90-110	\$150-160	\$170-220	\$300	\$300-400
July-Sept 2000	\$5	\$25	\$25	\$80-90	\$90-110	\$150-160	\$170-220	\$300	\$300-400
Oct-Dec 2000	\$5	\$25	\$25	\$80-90	\$90-110	\$150-160	\$170-220	\$300	\$300-350
Jan-Mar 2001	\$5	\$25	\$25	\$80-90	\$90-110	\$150-160	\$170-220	\$300	\$300-350
April-June 2001	\$5	\$20-25	\$25	\$80-90	\$90-110	\$150-160	\$170-220	\$200-300	\$300-350
July-Sept 2001	\$5	\$20-25	\$25	\$80-90	\$90-110	\$150-160	\$170-220	\$200-300	\$300-350
Oct-Dec 2001	\$5	\$20-25	\$25	\$80-90	\$90-110	\$150-160	\$170-220	\$200-300	\$300-350
Jan-Mar 2002	\$5	\$20-25	\$25	\$80-90	\$90-110	\$150-160	\$170-220	\$200-300	\$300-350
April-June 2002	\$5	\$20-25	\$25	\$80-90	\$90-110	\$150-160	\$170-220	\$200-300	\$300-350

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

**Note: Reporting criteria were expanded in April 1997 to provide separate data for (outdoor) cannabis head and hydroponically grown cannabis or "skunk". Thus, definitions of what constitutes cannabis "leaf" and "head" may have changed during this time period*

7.2 Availability

Across both indoor and outdoor cultivated cannabis, the majority of the IDU sample reported that cannabis was very easy (76%, n=104) or at least easy (23%, n=21) to obtain, and that the availability of cannabis had remained stable (85%, n=116) in the preceding six months. Key informants echoed these reports, with 83% (n=10) reporting that cannabis was very easily accessed (with the remainder indicating that it was easy for consumers to access), and that this level of availability had remained stable (90%, n=1) in the six months prior to interview. Trends in availability and routes of access will be discussed separately for each type of cannabis below.

In regard to outdoor or 'bush' cannabis, the majority of the IDU commenting believed this to be very easily (67%, n=43) or at least easily (31%, n=20) accessed in the preceding six months, and that this situation had remained stable in this time (87%, n=55). However, equal minorities believed outdoor cultivated cannabis had become easier (6%, n=4) or more difficult (6%, n=4) to access in this time. Most IDU reported usually purchasing this type of cannabis from friends (57%, n=37) or at a dealer's home (25%, n=16), with small minorities growing the drug themselves (6%, n=4) or purchasing from a 'street dealer' (8%, n=5). A similar pattern was reported when IDU were asked how they last purchased their cannabis, with 55% reporting purchase through friends (n=36), 26% at a dealer's home (17%), 8% through a 'street dealer' (n=5) and 6% had grown their own (n=4). Median time estimated to score outdoor/bush cannabis usually was 20 minutes (range 0-4320 minutes, n=62), and also 20 minutes (range 0-2880 minutes, n=62) for the last cannabis purchase.

Almost all IDU reporting on hydroponic / indoor cultivated cannabis (85%, n=61) regarded it as very easily accessed in the preceding six months, with those few dissenting (15%, n=11) reporting that it was easy for them to access in this time. Again, almost all believed that this availability of the drug had remained stable in the preceding six months (87%, n=61), with only small numbers reporting decreased (6%, n=4), increased (4%, n=3) or fluctuating (3%, n=2) availability in this time. As per trends reported for outdoor cultivated cannabis, hydroponically cultivated cannabis was reported as usually being purchased from friends (53%, n=39) or at a dealer's home (33%, n=24), with only a small proportion (6%, n=4) of IDU reporting growing it themselves. Again, these modes of access were virtually the same when IDU were asked where they last purchased their hydroponically cultivated cannabis, with 54% (n=39) reporting buying from a friend, 35% (n=24) from a dealer's house, and just 4% (n=3) grew their own cannabis. Median reported time to 'score' hydroponic cannabis was somewhat shorter than trends reported for outdoor cultivated cannabis – 15 minutes (0-2880 minutes, n=71) usually, and 15 minutes (range 0-360 minutes) last time respondents purchased the drug.

IDU were also asked about the source of the cannabis that they had used last time they had used the drug. Among those that reported 'very sure' or 'moderately sure' of the original source of the drug, the majority (52%, n=25) believed it to have been grown by small-time, 'backyard' user/growers, with 31% (n=15) reporting it to have been grown by a larger-scale cultivator/supplier (such as a crime syndicate, or organised motor-cycle group), and 17% (n=8) grew their own cannabis. These figures are remarkably similar to those reported in the 2002 study (66% small-time user/grower; 26% large scale cultivator/supplier; 8% grew own cannabis).

7.3 Potency

The cannabis used in the past six months by those participating in the IDU survey was marijuana head (the flowering top sections of the female plant), with most cannabis-using IDU reporting some use of both hydroponically-grown (94%) and outdoor crops (or 'bush buds', 89%). Most reported a preference for hydroponically grown head, which was borne out by the finding that 81% reported this as the form of cannabis that they had most often used in the last six months, in comparison to 19% reporting predominant use of outdoor crops. Reports made by key informants were in line with these patterns, and use of cannabis leaf was almost non-existent among the groups the key informants were familiar with. Thirteen percent of the IDU sample had used hash, and 10% had used hash oil in the preceding six months.

In concert with the reporting of predominant use of hydroponically grown cannabis, in 2001 Tasmania Police reported an increasing trend toward hydroponic, or indoor,¹² production of the drug. In 1999/00, approximately 12,700 Indian hemp plants were seized by Tasmania Police, of which 16% were grown hydroponically. In comparison, during 2000/01, 10,500 plants were seized, of which 38% were hydroponically cultivated. This trend was continued in 2001/02, with 41% of the 12,000 plants seized in this period being hydroponically cultivated. Cannabis seizures in 2002/03 were not divided according to cultivation type due to inconsistencies in recording on exhibit sheets, however, in 2002/03, 9,556 plants were seized state-wide by Tasmania police.

All key informants reporting use of cannabis among their groups stated that the predominant method of cannabis use was smoking through 'buckets' or 'bongs' (water pipes) rather than 'joints' (cannabis cigarettes) or cannabis cookies, although one indicated that use of 'buckets' was more common amongst younger users, and that 'joints' were more common amongst older users.

The potency of cannabis across both modes of cultivation was generally rated as 'high' (39%) or 'medium' (36%) by the IDU sample, with most respondents indicating that this potency had remained stable (72%) in the preceding six month period. Key informant reports were generally in concert with those of the IDU, indicating that the potency of cannabis was 'high' (67%, n=2) or fluctuating (33%, n=1) in the preceding six months, and that this had remained stable (60% , n=3) or fluctuated (40%, n=2) in this time.

Potency of outdoor or 'bush' cultivated cannabis was regarded by IDU as generally being 'medium' (52%, n=35), with smaller proportions reporting 'low' (21%, n=14) or fluctuating (19%, n=13) purity in the preceding six months. This level of potency was regarded as having remained stable (80%, n=52), although a small number of IDU felt that purity had fluctuated (14%, n=9) in this period.

Hydroponically cultivated cannabis, however, was generally reported by IDU as being 'high' (68%, n=49) or 'medium' (21%, n=15) in purity. This was predominantly regarded as remaining stable in the preceding six months (65%, n=47), although there were some reports of increasing (19%, n=14) or fluctuating (14%, n=10) purity in this time.

¹² For the purpose of reporting, Tasmania Police record all cannabis plants seized that had been grown indoors as hydroponically cultivated, rather than just those plants that are grown without the use of soil.

Seizures of cannabis by Tasmania Police are not analysed for potency, and as such no empirical data is available to examine trends in potency.

7.4 Use

7.4.1 Prevalence of cannabis use

The 1998 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 1999), which sampled 1031 Tasmanian residents, indicated that 37.5% had ever used cannabis, while 15.8% had used the drug in the 12 months prior to interview. These patterns were stable for both urban and rural survey participants. Of those urban respondents who had ever used cannabis, 6% reported using daily, 8% weekly, 11% monthly or every few months, and 13% used cannabis less often, with 56% not using during the 12 months prior to interview. Of those currently using cannabis, 55% obtained it from friends or acquaintances. Ten percent of participants further indicated that cannabis was their favourite drug (from a selection which also included tobacco and alcohol). Following a similar trend to the rest of the country, around 22% of Tasmanian participants indicated that they had been offered cannabis in this period.

Findings of the 2001 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2002) indicated a decline in the proportion of participants reporting recent use of cannabis, with 11.9% of the 1349 participants sampled reporting use of the drug in the year prior to interview, down from 15.8% in the 1998 survey. Prevalence of cannabis use in the 12 month period prior to survey was estimated to be 22.1% in people aged between 14-24 (24.3% in males, 19.8% in females), 22.9% in 25-39 year olds (29.8% in males, 16.7% in females), and 3.4% in those aged 40 and above (4.3% males, 2.6% females).

The 1996 Australian School Students Alcohol and Drugs (ASSAD) Survey (Cancer Council of Tasmania, 1997) sampled 2,553 students in years 7 to 12 from schools across Tasmania during the 1996 school year. Results indicated that 34% of 12-15 year olds (37% males, 31% females), and 54% of 16-17 year olds (57% males, 50% females) reported using cannabis at some stage in their lives. Eighteen percent of the 12-15 year olds, and 25% of the 16-17 year olds surveyed reported smoking cannabis in the month prior to interview. Within the 1999 sample of 2,671 students (Cancer Council of Tasmania, 2001), 30% of 12-15 year-olds (31% males, 28% females), and 48% of the 16-17 year olds surveyed (52% males, 42% females) surveyed reported using cannabis at some stage in their lives. In terms of recent use, 17% of the 12-15 year olds surveyed and 19% of the 16-17 year olds surveyed reported using cannabis in the month prior to interview. The main difference between the findings of the 1996 and 1999 studies was a statistically significant reduction in reported rates of both lifetime and recent use of cannabis between these samples. The rates of use reported in these surveys are somewhat elevated in comparison to the prevalence estimates reported in the 2001 National Drug Strategy Household Survey, but this may be expected given the more experimental nature of these younger age groups in comparison to the wider age range sampled in the Household survey.

Cannabis has made up the vast majority of positive urine screen tests amongst Tasmanian prison inmates since the inception of such screens in 1993. The proportion of

all positive urine screens indicating cannabis use has remained at around 70-80% between 1997/98 and 2002/03, despite the number of positive tests more than doubling (from 97 in 1997/98, to 215 in 2000/01, although dropping to 136 in 2001/02 and 120 in 2002/03) during this period. It should be noted that cannabis remains detectable for a longer period of time than most other drugs, and as such is the most likely drug to be identified in such screening procedures.

7.4.1 Cannabis use among IDU

While cannabis was reported as the drug of choice for only 2% of the IDU sample, 88% of the entire sample reported some use of cannabis in the preceding six months. Of those who had used cannabis, the median frequency of use in the past six months was 180 days (range 2-180), which equates to daily use of the drug. The majority of cannabis users described by key informants also smoked cannabis daily.

Many of the cannabis users who were known to the key informants were polydrug users. Other drugs that were used included ecstasy, benzodiazepines, amphetamines, morphine and methadone, although use was generally sporadic and limited to a small percentage of these groups. Almost all key informants reported or suspected some level of cannabis use within the populations they had contact with.

7.5 Cannabis related harms

7.5.1 Law enforcement

When asked about changes in the level of criminal activity among the cannabis users that key informants had contact with, the majority indicated that there had been no change in the past six months. While most indicated that there had been no change in the level of property crimes (n=7), three key informants noted an increase in opportunistic property crimes among this demographic, including bag snatching and shop-lifting. Two key informants noted seeing more younger 'dealers' of cannabis in recent months, although these were noted as being user-dealers selling to friends to offset the costs associated with their own level of use (6 key informants noted no change in the extent of dealing by cannabis users). While most key informants also noted no change in violent crimes among the cannabis users they had contact with (n=4), two noted an increase in violent behaviours, such as bag snatching and assault, and one noted that there had been an increase in violent undertones among dealers chasing up cannabis-related debts in recent months.

An increase in the number of cannabis-using individuals being diverted to treatment or brief intervention was noted by almost all key informants discussing cannabis-related trends (n=7).

7.5.2 Health

Most key informants reported that there had been little change in health-related trends within cannabis users over the past six months. However, one key informant involved in drug treatment noted an increase in the number of people seeking counselling or support for their use. Two key informants also noted that some clients, particularly amongst the older end of their client groups, reported using cannabis for its medicinal properties.

Whole most (n=7) key informants noted no change in mental health issues among their cannabis-using clients, where some level of depression and anxiety was often seen, two noted an increase in mental health problems amongst their clients in recent months, most notably among younger females. Two also noted an increase in aggression and problematic behaviours amongst clients with high levels of cannabis use.

7.6 Trends in cannabis use

One key informant and two IDU noted a decrease in the age that people were beginning to use cannabis in recent months, with 'children as young as 12' using the drug. One key informant and one IDU also perceived an increase in the level of cannabis use amongst males in their late teens / early twenties, although there is no objective data to support such an assertion.

Following trends discussed elsewhere in this report, four key informants noted an increase in the use of methamphetamine (in particular crystalline methamphetamine) amongst primary cannabis-using groups, with a further three key informants reporting an increase in the use of ecstasy, particularly amongst younger individuals.

7.7 Summary of cannabis trends

Table 26: Summary of cannabis trends

	Outdoor / ‘bush’	Indoor / hydroponic
Price <i>Gram</i> <i>Quarter-Ounce</i> <i>Ounce</i>	<ul style="list-style-type: none"> • \$10 • \$60 • \$150 • prices stable 	<ul style="list-style-type: none"> • \$25 • \$80 • \$300 • prices stable
Availability	<ul style="list-style-type: none"> • Easy-very easy to obtain • Availability stable 	<ul style="list-style-type: none"> • Very easy to obtain • Availability stable
Potency	<ul style="list-style-type: none"> • Medium-low (based on IDU and key informant estimates) • Potency level stable 	<ul style="list-style-type: none"> • High-medium (based on IDU and key informant estimates) • Potency level stable
Use	<ul style="list-style-type: none"> • Most widely used illicit drug • Indications of decreasing prevalence of use of cannabis in recent years in the State from two large studies (NSDS and ASSAD) • High level of daily use among IDU sample and groups discussed by key informants • Hydroponically-grown head increasingly preferred by users • Predominantly smoked using ‘buckets’ and ‘bongs’ (water pipes) 	
Other Trends	<ul style="list-style-type: none"> • Increase in methamphetamine (particularly crystalline methamphetamine) and ecstasy among some users • Continued anecdotal reports of decreasing age of cannabis users 	

8. OPIOIDS

Seven key informants reported on groups of people who were primarily users of opioids; that is, populations that were using both diverted pharmaceutical morphine and methadone; either at equal frequency, or using one preferentially, but also regularly using the other depending on availability. When pressed to describe an illicit drug that was predominantly used among members of their group, four key informants indicated morphine, and three nominated methadone. Similar trends were noted among the IDU sample, with there being a large overlap between people reporting recent use of these drugs – of those who reported use of morphine in the six months prior to interview, 94% also reported use of some form of methadone (Table 27). Additionally, of those who had used morphine in the six months prior to interview, 50% reported methadone as the drug they most often injected in the past month (26% reporting this as being morphine: Table 28). Because of this substantial level of overlap, trends for these drugs are discussed together here.

Table 27: Use of other drugs by those reporting use of morphine in the past six months (n=72)

Drug	% of morphine users reporting use	Median days used by those who had used the drug (range in parentheses)
Heroin	28	4.5 (1-180)
Other Opioids	32	4 (1-180)
Benzodiazepines	96	60 (1-180)
Cannabis	90	180 (2-180)
Methadone Syrup (licit)	61	180 (2-180)
Methadone Syrup (illicit)	54	24 (2-180)
Physeptone (illicit)	75	10 (1-180)
Methamphetamine (<i>any</i>)	85	15 (1-180)
<i>Powder</i>	47	6 (1-120)
<i>Base/paste</i>	40	3 (1-48)
<i>Crystal</i>	67	10 (1-98)
Homebake	1	4 (4)

Table 28: Drug of choice and drug most often injected among those reporting use of morphine in the past six months (n=72)

	Drug of choice %	Drug most often injected %
Heroin	42	3
Methadone	14	50
Morphine	14	26
Methamphetamine	17	19
Benzodiazepine	4	0

Key informants reporting on the use of opioids included needle and syringe outlet staff (n=3), drug treatment workers (n=2), a pharmacist and an outreach worker.

Key informants were familiar with users of opioids from all Hobart suburbs, but they were often from inner-city suburbs, or lower socio-economic areas from the eastern shore or northern suburbs. The majority of key informants described opioid users from a predominantly English-speaking background, ranging in age between 16 and 68 years, although most were in their mid-twenties. A preponderance of males was noted among these groups, with key informants noting their primary-opioid populations were between 50-90% male (median = 75%). Most opioid users described by key informants had completed 9 to 10 years of schooling (although a wide range of education history was noted) and were currently unemployed.

Of the IDU sample, 96% reported they had tried morphine at some stage in their lives, and all but three of these had injected morphine. Seventy-two percent had used morphine in the past six months, with all but three injecting the drug in this time, and recent oral use only reported by 25% of the sample. Similar patterns of use were found for illicit physeptone tablets of methadone, with 88% of the sample ever using the drug, and all but 10 having injected. Of the 64 participants using illicit physeptone tables in the past six months, 56 had injected the drug and 22 had used the drug orally. Use of illicit methadone syrup was slightly less common, with 66% of the sample ever using illicit syrup, and 63% injecting it at some stage in their lives. Almost half the sample (48%) had used illicit methadone syrup in the preceding six months, with all but two reporting recent injection (46% of the sample) and a smaller proportion swallowing syrup (15%) in this time. As would be expected given the high proportion of the current IDU sample that were receiving methadone maintenance treatment at the time of interview (58%), more than two-thirds (69%) of the sample had used methadone syrup accessed licitly at some stage of their lives, although it is noteworthy that again almost all had injected licitly-accessed syrup (65%) at some time, which is not consistent with a supervised methadone maintenance program. Fifty-nine percent of the sample had used methadone syrup as part of a maintenance program in the preceding six months, although, again, almost all had recently injected the medication (53% of the sample). Participants receiving licit prescriptions of physeptone tablets of methadone were much less common, with just 9% of the sample being in receipt of these at some stage of their lives (6% had injected licitly-accessed physeptone at some stage), with just 2% of the sample receiving these via legitimate means in the preceding six months, both of whom had injected the drug in this time.

The demographics of the group that had used opioids (n=89) in the past six months was similar to that of other IDU (see Section 3.0) in terms of sex, age, cultural and educational background, treatment and employment status, prison history, frequency of injection and age of first injection. Participants who had used either drug in the past six months were more likely to report an opioid as their drug of choice, drug most often injected and last drug injected than those who had not used an opioid, and those that were currently in methadone maintenance therapy were more likely to nominate methadone as the drug they most often injected in the past month.

Seventy-three participants in the IDU sample could comment on aspects of price, purity and availability of morphine, with 56 respondents providing information on illicit methadone syrup and 67 commenting on illicit physeptone tablet trends.

8.1 Price

8.1.1 Morphine

Both key informants and IDU reported the market price of morphine as around \$1 per milligram, the same price reported in previous IDRS reports. However, as indicated in Table 29 below, the modal price that users paid for their most recent purchase of the drug was generally lower than this figure. The majority of both IDU (70%, n=47) and key informants (75%, n=3) commenting on morphine prices believed that these prices had remained stable over the preceding six months, although noteworthy proportions also reported a decrease in price during this period (12% of IDU, n=8). Comparison of the modal prices for most recent purchases of the drug amongst the 2001 and 2002 IDRS survey respondents provide some support for reports of stable prices, although there may have been some decreases in the price of 100mg MS Contin tablets (a drop of \$10 from the 2002 study), and in all sizes of Kapanol capsules (\$5 drops for both 20mg and 50mg capsules in comparison to 2002).

Table 29: Market prices of morphine reported by IDU and modal price for most recent purchase of particular forms of the drug (reported price range in parentheses).

Preparation	2000 IDRS		2001 IDRS		2002 IDRS		2003 IDRS	
	Price	n	Price	n	Price	n	Price	n
Morphine \$ per mg	\$1	20	\$1	8	\$1	15	\$1	14
Morphine \$ per 100 mg	\$80	2	\$80	5	\$75*	3	\$75	8
MS Contin								
10 mg tablet	\$8 (\$3-15)	9	\$5 (\$5-10)	3	\$7.50 (\$5-10)	2	\$5(\$5-15)	3
30 mg tablet	\$25 (\$8-40)	41	\$25 (\$10-35)	42	\$20 (\$10-30)	45	\$20 (\$20-30)	18
60 mg tablet	\$50 (\$13-60)	62	\$40/\$50 (\$18-60)	74	\$50 (\$18-60)	86	\$50 (\$15-60)	51
100 mg tablet	\$80 (\$15-100)	54	\$80 (\$50-100)	68	\$80 (\$20-100)	73	\$70 (\$12-100)	44
Kapanol								
20 mg capsule	\$15 (\$10-20)	16	\$10 (\$5-25)	14	\$20 (\$10-20)	14	\$15 (\$10-30)	9
50 mg capsule	\$40 (\$15-50)	36	\$40 (\$25-50)	40	\$40 (\$15-50)	43	\$35 (\$12-50)	35
100 mg capsule	\$80 (\$60-100)	12	\$80 (\$50-90)	31	\$80 (\$50-100)	36	\$70 (\$17-100)	22
Anamorph								
30 mg tablet	\$25 (\$15-30)	29	\$25 (\$15-30)	26	\$25 (\$10-30)	44	\$20* (\$10-30)	9
Oxycontin								
40 mg tablet	-	-	-	-	\$15	1	\$20 (\$20)	4

*Median substituted for mode, as no single mode existed.

8.1.2 Methadone

Both key informants and IDU reported the market price of methadone as around \$1 per milligram, the same price reported in previous IDRS reports. However, prices that IDU respondents reported paying for the were highly variable, and, as indicated in Table 30 below, the modal price that users paid for their most recent purchase of larger amounts of the drug was generally lower than the \$1 per milligram figure. Since the nature of access to the drug does not easily allow for standard purchase amounts to be made, IDU were asked to report the amounts and costs of their most recent purchase of methadone, and these were divided into purchases of less than 80mg or 80mg and above, on the basis of a clear split in the data. Among those purchases of less than 80mg, the modal price paid by IDU was \$1 per milligram, while modal prices for amounts 80mg and above were approximately 80 cents per milligram (Table 30). Two key informants (100%) and the

clear majority of IDU reported that these prices had remained stable in the past six months both for methadone syrup (73%, n=51) and for physeptone tablets (79%, n=45). While noteworthy minorities reported increasing prices for both types of methadone (16%, n=11 for syrup, 11%, n=6 for physeptone), when the modal purchase prices for methadone in 2002 and 2003 are compared (Table 30), there appears to have been no notable price changes in this period.

Table 30: Market prices of methadone reported by IDU and modal price for most recent purchase of particular forms of the drug (reported price range in parentheses).

Preparation	2000 IDRS		2001 IDRS		2002 IDRS		2003 IDRS	
	Price	n	Price	n	Price	n	Price	n
Methadone \$ per mg	\$1	40	\$1 (\$0.4-1)	49	\$1 (\$0.5-1)	49	\$1 (\$0.5-1)	29
Methadone syrup (price per mg)								
<i>Amounts less than 80 mg</i>	\$1.0 (\$0.5-1.0)	30	\$1.0 (\$0.5-1)	11	\$1.0 (\$0.4-1)	19	\$1.0 (\$0.3-1)	21
<i>Amounts greater than 80 mg</i>	\$0.8 (\$0.5-1.2)	23	\$0.55 (\$0.3-1)	15	\$0.8 (\$0.4-0.9)	24	\$0.8 (\$0.5-1)	22
<i>All purchase amounts</i>	\$1.0 (\$0.5-1.2)	53	\$1.0 (\$0.3-1.0)	26	\$1.0 (\$0.4-1.0)	43	\$1.0 (\$0.3-1.0)	43
Physeptone								
<i>5 mg tablet</i>	-	0	\$7*(\$5-10)	3	\$5	1	-	-
<i>10 mg tablet</i>	\$10 (\$4-12)	17	\$10 (\$2-15)	53	\$10 (\$5-15)	53	\$10 (\$3-20)	62

8.2 Form

8.2.1 Morphine

IDU respondents were asked to nominate the preparations of morphine that they had used in the preceding six months. Of the 72 participants reporting use of morphine in the preceding six months, use of illicit MS Contin (86%, n=62) and illicit Kapanol (58%, n=42) was most common, with smaller proportions reporting use of illicit Ordine¹³ (liquid morphine: 31%, n=22), illicit Anamorph (21%, n=15) or illicit MS Mono (1%, n=1). Use of licitly-accessed morphine in the preceding six months was relatively scarce within the IDU sample, with single individuals reporting use of licit MS Contin and Kapanol in this period. When asked to nominate which form they had used most often in the preceding six months, 70% (n=49) reported illicit MS Contin, 17% illicit Kapanol (n=12), 7% illicit Ordine (n=5), 3% illicit Anamorph (n=2), and 1% licit MS Contin and Kapanol respectively. This pattern was supported by four key informants, and the predominance of MS Contin is in concert with patterns noted in previous Tasmanian IDRS reports. Use of Ordine has been steadily decreasing in the past three IDRS samples, with the proportions nominating it as the form of morphine they had most often used increasing from 2% in 2002 to 7% in the current study, following anecdotal reports of use beginning in 2001. Finally, it is clear from these figures that only a very small minority of those using morphine (3%) had accessed this from licit¹⁴ sources in the preceding six months.

¹³ Ordine is morphine.hydrochloride in aqueous (water) solution, and contains sugar as a preservative.

¹⁴ During interviewing, 'licit means' was defined as having the drug prescribed directly to the individual, whether appropriate or otherwise. By this definition, doctor shopping would be considered as 'licit means'.

8.2.2 Methadone

Seventy-seven percent of the IDU sample had reported use of methadone syrup in the past six months, the majority of whom had been on a methadone maintenance program within this time (75%, n=58). Of those that had used methadone syrup, 62% (n=48) had purchased diverted methadone syrup at some stage in the preceding six months (including 50% of those individuals that were receiving methadone maintenance therapy).

Use of the tablet preparation of methadone, Physeptone, was reported in a greater percentage of the sample (65% of the sample, and 76% of those reporting recent use of methadone) in the preceding six months. Of the 65 individuals who reported use of Physeptone tablets, this was primarily accessed illicitly (by 64 individuals), with only 2 IDU accessing the drug via licit means. This level of recent use of Physeptone, by 65% of the sample represents a continuation of an increasing trend first noted in 2001, where just 30% of the Tasmanian IDRS sample had recently used Physeptone in 2000, increasing to 42% in 2001, and 56% in 2002.

When asked to describe the form of methadone they had predominantly used in the preceding six months, 67% (n=57) indicated licit methadone syrup, 19% (n=16) illicit methadone syrup, and 14% (n=12) illicit physeptone tablets.

8.2.3 Other Pharmaceutical Opioids and Related Substances

Due to recent developments of new opiate-based or strong analgesic pharmaceuticals and the known interest among the Tasmanian illicit drug market for pharmaceutical preferences for drugs, IDU were also asked about use of other pharmaceutical opiates and related substances in the preceding six months. Sixteen percent of the sample reported using illicitly accessed OxyContin (oxycodone), 5% reported use of illicit Endone (oxycodone), and 2% had used illicitly accessed pethidine in the preceding six months.

8.3 Availability

8.3.1 Morphine

The majority of the IDU sample who commented on trends reported that morphine was easy or very easy to for them to obtain (75%: 34% easy, 41% very easy), and that the availability of morphine had remained stable (65%) in the past six months (although a noteworthy minority reported decreasing availability in this time: 27%). In line with IDU reports, all key informants thought that morphine was easy or very easy to obtain (67% very easy, n=2/3), and that availability had remained stable (75%, n=3) or become easier to access (25%, n=1) during the past six months. One key informant noted an increase in the availability of Ordine in the preceding six months, with another reporting an increase in oxycontin in this time.

Among this sample, IDU reported usually purchasing morphine in the past six months from a friend (43%, n=31), with slightly smaller proportions reporting usually accessing from a dealer's home (27%, n=20), a mobile dealer (11%, n=8), or a street dealer (18%, n=13). A similar pattern emerged when people were asked who they purchased the drug from last time they bought morphine, with 43% (n=31) reporting via friends, 28% (n=20) from a dealer's home, 19% (n=14) from a street dealer, and 10% (n=7) through a

mobile dealer. Median time estimated as taken to score morphine was 30 minutes (mode = 60 minutes, range 0 – 2,880 minutes, n=72) usually in the past 6 months, and 30 minutes (mode = 30 minutes, range 0 – 2,880 minutes, n=72) for the last time scored morphine.

Seizures of morphine and other narcotic pills by Tasmania Police have remained reasonably stable between 1999/00 and 2002/03: 215 tablets (100 of these being morphine) in 1999/00; 322 tablets in 2000/01 (21 morphine tablets); 254 tablets (63 morphine) in 2001/02, and 211 morphine tablets in 2002/03 a finding adding some support to IDU reports of stable availability of these drugs over these years.

8.3.2 Methadone

The current IDRS study is the first to clearly distinguish between illicit methadone syrup and illicit methadone (Physeptone) tablet trends.

There was a split among IDU when asked to comment on the level of availability of illicit Physeptone tablets, with just over half reporting them as easily or very easily accessed (52%, 36% easy, n=22; 16% very easy, n=10) and just under half (48%) reporting them as difficult or very difficult to access (36% difficult, n=22; 11% very difficult, n=7). While almost half those reporting indicated that the availability of Physeptone had remained stable in the preceding six months (49%, n=30), almost as many (39%, n=24) reported that availability had decreased in this time. Most IDU reported usually purchasing physeptone through a friend (64%, n=39) or at a dealer's home (26%, n=16) with 7% (n=4) usually purchasing from a street dealer and 3% (n=2) purchasing through a mobile dealer. When asked where they last purchased the drug from, 71% (n=44) reported purchasing from a friend (n=44), 21% from a dealer's home (n=13), 5% from a street dealer (n=3) and 3% from a mobile dealer (n=2). While IDU reported that it usually took them 30 minutes to 'score' physeptone (mode = 0 minutes, range 0-1440 minutes, n=61) in the past six months, the median time last taken to 'score' the drug was just 20 minutes (median = 0 minutes, range 0-1440 minutes, n=61).

In regard to illicit methadone syrup, the majority of respondents felt that it was easy or very easy for them to access the drug (82%: very easy 47%, n=20, easy 35%, n=15), although, as noted by one IDU, 'it is very easy to access if you have a pre-existing arrangement, but very difficult if you try to find it on a whim'. Similar to trends for Physeptone tablets, the majority felt that availability had remained stable (67%, n=29) in the preceding six months, although a substantial proportion felt that it had become more difficult to access recently (26%, n=11). IDU that had used illicit methadone syrup reported that they almost exclusively usually purchased the drug from friends (79%, n=35) in the preceding six months, although a small number usually purchased from a dealer's home (11%, n=5) or a street dealer (9%, n=4). When asked about the source of their last purchase of illicit methadone syrup, 82% (n=36) reported this as coming from a friend, 9% (n=4) from a dealer's home, and 7% (n=3) from a street dealer. Due to concerns among some key informants in previous years about use of 'spat out' doses of methadone syrup, IDU were asked about the source of their last illicit purchase of methadone syrup, with 100% reporting that the drug had some from a 'take-away'¹⁵ dose.

¹⁵ Within the Tasmanian Methadone Maintenance Program, individuals predominantly receive their daily doses in a supervised manner. However, where appropriate, prescribers may authorise a limited number of 'takeaway' doses, where daily doses can be picked up in advance and consumed as is convenient for the individual.

When asked how long it took IDU to ‘score’ illicit methadone syrup, respondents indicated it taking a median of 0 minutes to score the drug both usually and the last time they had ‘scored’ in the preceding six months (mode = 0 minutes, range 0-1440 minutes, n=44). This can be interpreted in terms of the ‘pre-arrangements’ noted by the IDU above – in the 2001 IDRS, one key informant, a user group representative, and two IDU, reported a trading system amongst a group of IDU on the methadone program, where, when people picked up two or three ‘takeaway’ doses of methadone, some people would give the doses not required for that day to friends, with the expectation of reciprocation later in the week. This system protects users from ‘bingeing’ and using all their takeaway doses in one day, thus having to find a replacement opioid to hold them until their next methadone dose. Similar ‘in-kind’ and pre-organised systems were described in the 2002 and 2003 studies. This may be reflected in the pathways of access to illicit methadone syrup (discussed above and in Table 31), with almost all reporting accessing their last illicit methadone through a friend, while purchases through ‘street dealers’ – most commonly methadone program clients approached outside a pharmacy for their takeaway dose – were substantially less common.

When IDU reports of the availability of illicit methadone and morphine are compared over time (Figure 5), it appears that there may be some indications of a declining availability of these drugs in recent years, particularly so for methadone.

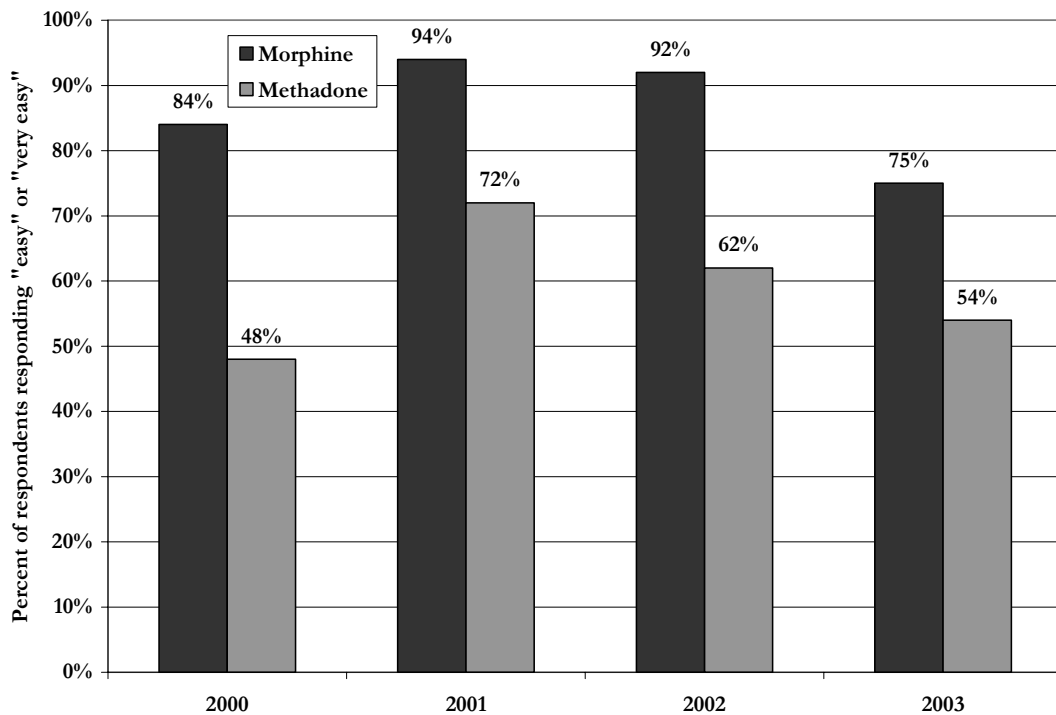


Figure 5: IDU reports of ‘easy’ or ‘very easy’ availability of illicit pharmaceutical opiates 2000-2003.

Table 31: Pathways to illicit methadone access

	Illicit Methadone Syrup (n=48)	Illicit Physeptone Tablets (n=64)
Source of last illicit syrup[#]		
<i>Take-away dose</i>	100% (n=44)	n/a
<i>Didn't know source</i>	0	n/a
Usual source of illicit purchase[#]		
<i>Friend</i>	79% (n=35)	64% (n=39)
<i>Street dealer</i>	9% (n=4)	7% (n=4)
<i>Dealer's home</i>	11% (n=5)	26% (n=16)
<i>Mobile dealer</i>	-	3% (n=2)
<i>Median time to 'score'</i>	0 min (range 0-1,440 min)	30 min (range 0-1,440 min)
Last source of illicit purchase[#]		
<i>Friend</i>	82% (n=36)	71% (n=44)
<i>Street dealer</i>	7% (n=3)	5% (n=3)
<i>Dealer's home</i>	9% (n=4)	21% (n=13)
<i>Mobile dealer</i>	-	3% (n=2)
<i>Median time to 'score'</i>	0 min (range 0-1,440 min)	20 min (range 0-1,440 min)
Use		
Form of illicit methadone used most in last six months	n =35	n=36
Median days used	24 (2-180)	12 (1-180)

*at any time in the preceding six months; [#]for those reporting source

8.4 Patterns of Opioid Use

8.4.1 Prevalence of opioid use

Of the 1031 Tasmanian residents participating in the 1988 National Drug Household Survey (Australian Institute of Health and Welfare, 1999), 0.7% (n=4) reported ever using methadone, with only 0.6% (n=3) of respondents reporting use of this drug in the 12 months prior to interview. Similarly, in the 2001 National Drug Household Survey (n=1,349: Australian Institute of Health and Welfare, 2002), 0.1% (n=1) of respondents reported using methadone for non-maintenance purposes, and 0.7% (n=9) reported using other opiates for non-medical purposes in the year prior to interview. These low rates of users make it difficult to meaningfully detect trends in use.

Data from clients of non-pharmacy Needle Availability Program outlets reporting an opioid as the drug they most often inject have been highly variable over the past seven years (Figure 6), due primarily to clients nominating the catch-all 'opiates-narcotics'

category rather than specifying a specific single drug. When this data is collapsed, a trend becomes clearer, with the percentage of clients reporting opioids (excluding heroin) as the drug they most often injected steadily increasing from 32.1% in 1996/97 to 56.6% in 2000/01, then decreasing again to 53.0% in 2001/02 and further still to 45.3% in 2002/03. Also noteworthy is the indication that, although injection of morphine had consistently been reported as more popular than injection of methadone to 1998/99, the popularity of both drugs was equivalent in 1999/00, and in 2000/01, methadone was more commonly reported substance, a trend continuing into 2002/03. These, however, may not be new trends, as responses in the opiates/narcotics category may have masked the true level of injection of methadone in previous years.

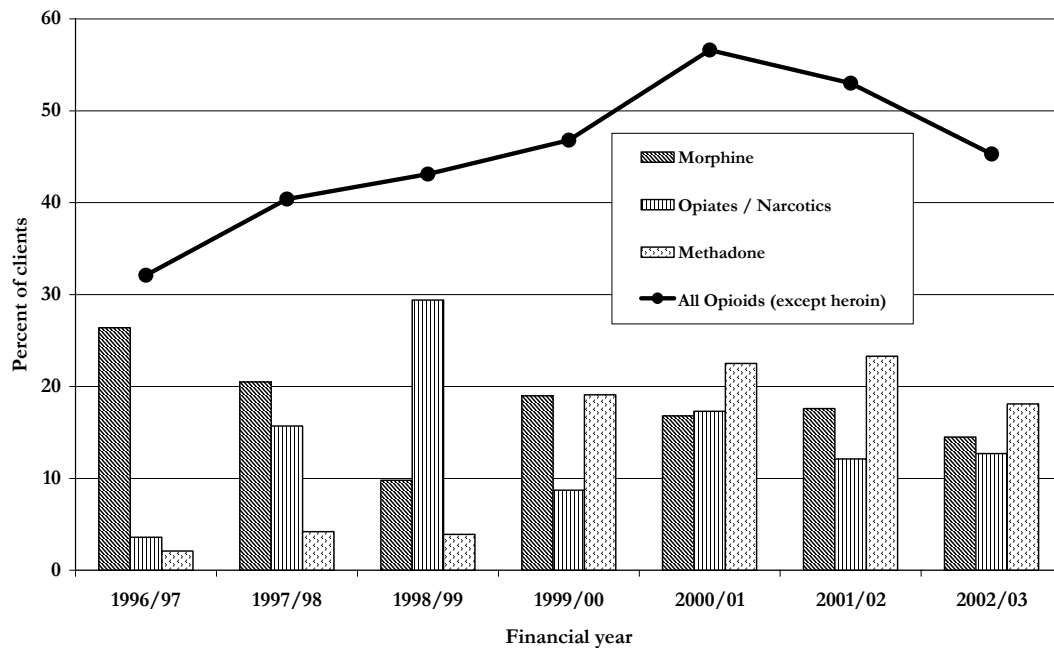


Figure 6: Percentages of opioids reported as ‘drug most often injected’ by Tasmanian Needle Availability Program clients, 1996/97-2002/03

Source: Sexual Health, Department of Health and Human Services

The Australian Needle and Syringe Program Survey (National Centre in HIV Epidemiology and Clinical Research on behalf of the Collaboration of Australian Needle and Syringe Programs) has reported opioids as the last drug injected of 50% or more of their Tasmanian participants for their 1996-2002 surveys (Table 32). However, given that these studies only utilised relatively small sample sizes (18, 23, 51, 25, 27, 28 and 151 clients respectively), these figures should be interpreted with caution.

Table 32: Australian Needle and Syringe Program (NSP) Survey: Prevalence of opioids within “last drug injected”, 1996-2002

	1996		1997		1998		1999		2000		2001		2002	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Heroin	1	6	0	0	5	10	2*	8	6 [#]	22	3 [†]	11	5	3
Methadone	5	28	10	43	17	33	11	46	9	33	11	39	49	32
Morphine	6	33	4	17	10	20	5	26	8	30	11	39	25	16
Total Sample Size	18		23		51		25		27		28		151	

Source: National Centre in HIV Epidemiology and Clinical Research on behalf of the Collaboration of Australian Needle and Syringe Programs.

*Note: during the 1999 and 2000 surveys 16% (n=4), 11% (n=3) and 18% (n=5) participants respectively reported using some combination of opioids, and percentages have been adjusted accordingly to reflect this

There has been a steady growth in the number of clients on Tasmania’s methadone maintenance program since 1995. Currently there are around 480 daily recipients of methadone, more than treble the number on the program in 1995. However, this increase in numbers is likely to primarily reflect the long-term nature of methadone maintenance therapy, as the number of new applications for the program had remained consistent between 1997-2001 (approximately 200 new applications per annum), and has been decreasing in the past two financial years. In 2001/02, there was a drop in this number of new admissions to methadone maintenance to 148 (Figure 7) and in 2002/03, this had dropped to 104, the difference partially accounted for by the number of new admissions to buprenorphine maintenance (n=23 in 2001/02, n=32 in 2002/03), which was made available as a treatment option for the first time in 2000/01. Figure 8 indicates an apparent increase in new admissions to maintenance pharmacotherapies in 2000/01, but this primarily reflects an influx of individuals that were previously receiving treatment with methadone switching to buprenorphine.

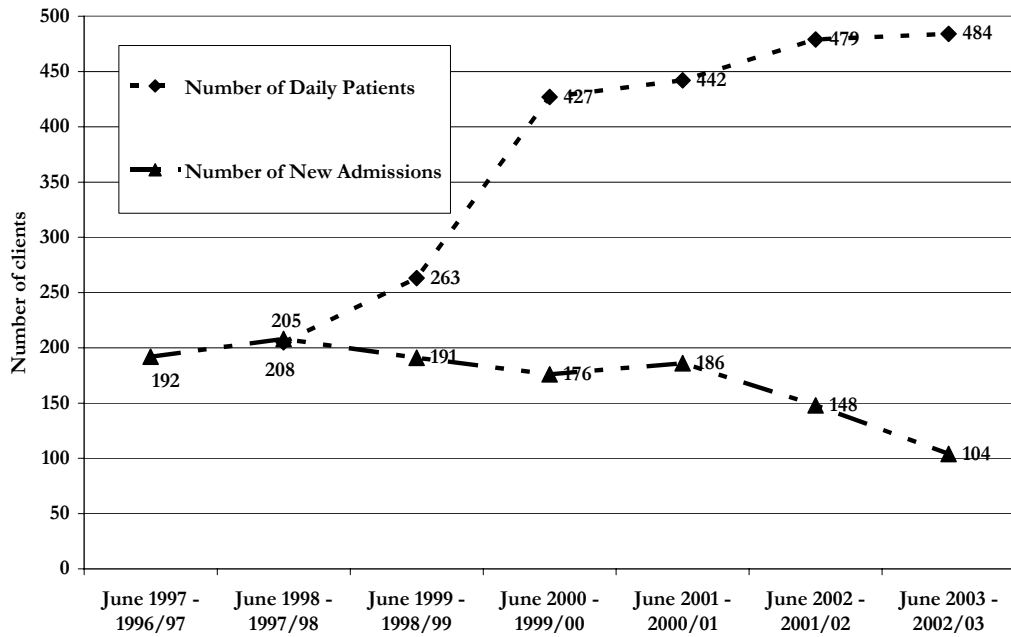


Figure 7: Growth of the Tasmanian methadone maintenance program, 1995-2003

Source: Pharmaceutical Services, Department of Health and Human Services, Tasmania

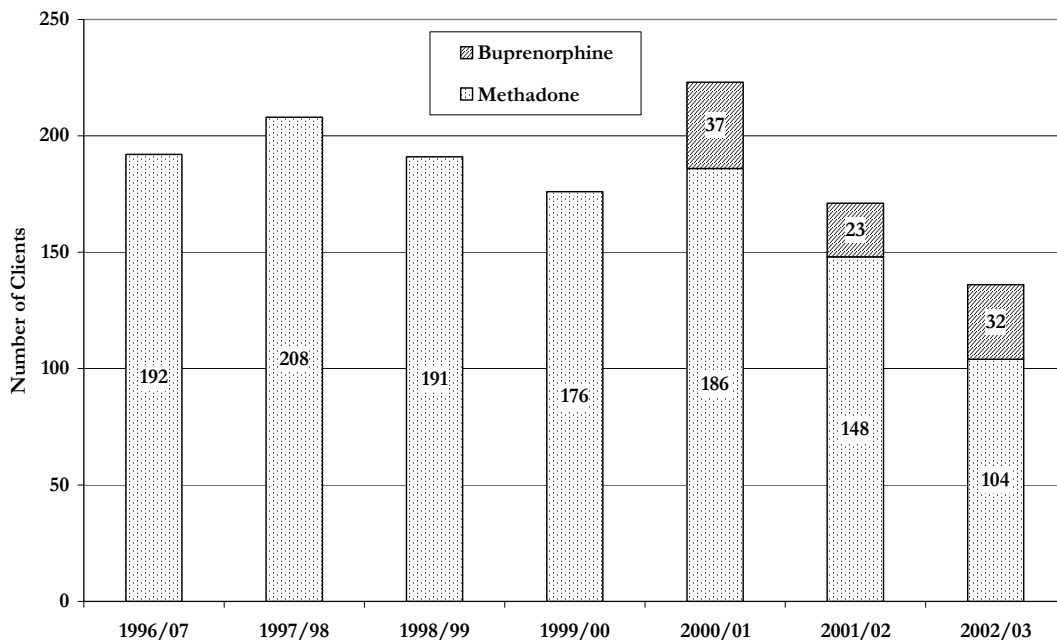


Figure 8: New admissions to maintenance pharmacotherapy treatments in Tasmania, 1995-2003

Source: Pharmaceutical Services, Department of Health and Human Services, Tasmania

Tasmanian prescription rates for Schedule 8 pharmaceuticals¹⁶ since 1991 were also provided by Pharmaceutical Services (DHHS). During this time, Tasmanian consumption of morphine has been consistently 120% or more of the national average, and increasing over recent years to 133% in 2002, while national use has stabilised (Figure 9). Following this trend of increasing prescription of morphine within the state, the number of applications received by Tasmanian Pharmaceutical Services for approval to prescribe narcotics¹⁷ has steadily increased from 351 in 1989/90 to over 1700 applications in 2002/03¹⁸ (Figure 10).

In contrast, despite the use of methadone syrup amongst a large proportion of the IDU sample in all three Tasmanian IDRS studies, local rates of consumption of methadone syrup has been continuously below that of the national average in the past ten years (Figure 11). These proportions are distorted, however, by the high numbers of methadone maintenance patients in New South Wales. Noteworthy also is the sharp decline in consumption of methadone syrup nationally in 2001, possibly associated with the wide introduction of buprenorphine maintenance treatment. In contrast to the trend for use of methadone syrup, Tasmanian consumption of methadone 10 mg tablets has been consistently above 200% that of the national average since 1992 (Figure 12) with a rapid increase over the past few years. It is worth noting that increasing numbers of IDU surveyed in the Tasmanian IDRS studies have reported recent use of 10mg Physeptone (methadone) tablets (30% in 2000, 42% in 2001, 56% in 2002, 65% in 2003), following this general trend. When these two trends are combined, overall rate of consumption of methadone in the state equals that of the Australian average after years of local rates being below the average nationally (Figure 13).

While a proportion of these differences in consumption rates can be accounted for by prescription practices and the aging nature of the Tasmanian population, it does, however, indicate a certain willingness to prescribe tablet opioids among Tasmanian doctors. This said, these practices do not seem to apply to the injecting drug user population, as a near-negligible proportion of IDU reported accessing opioids via licit means¹⁹ in the six months prior to interview: with the exception of methadone as part of a maintenance program, only 4 IDU reported accessing morphine or methadone tablets via licit means in this time.

¹⁶ Pharmaceuticals classed under Schedule 8 are variously classed as narcotic substances or drugs of addiction / dependence in differing jurisdictions.

¹⁷ The Alcohol and Drug Dependency Act 1968 requires medical practitioners to seek the approval of the Secretary of Pharmaceutical Services when narcotics are prescribed for a patient for more than two months, or for a person who is drug dependent

¹⁸ It is worth noting that the level of compliance in regard to submission of applications is significantly dependent on reminders being sent to doctors, and as such these figures are unlikely to reflect the absolute number of cases requiring such a submission.

¹⁹ During interviewing, 'licit means' was defined as having the drug prescribed directly to the individual. By this definition, doctor shopping would be considered as 'licit means', which suggests that there is a stable illicit source of these drugs to IDU.

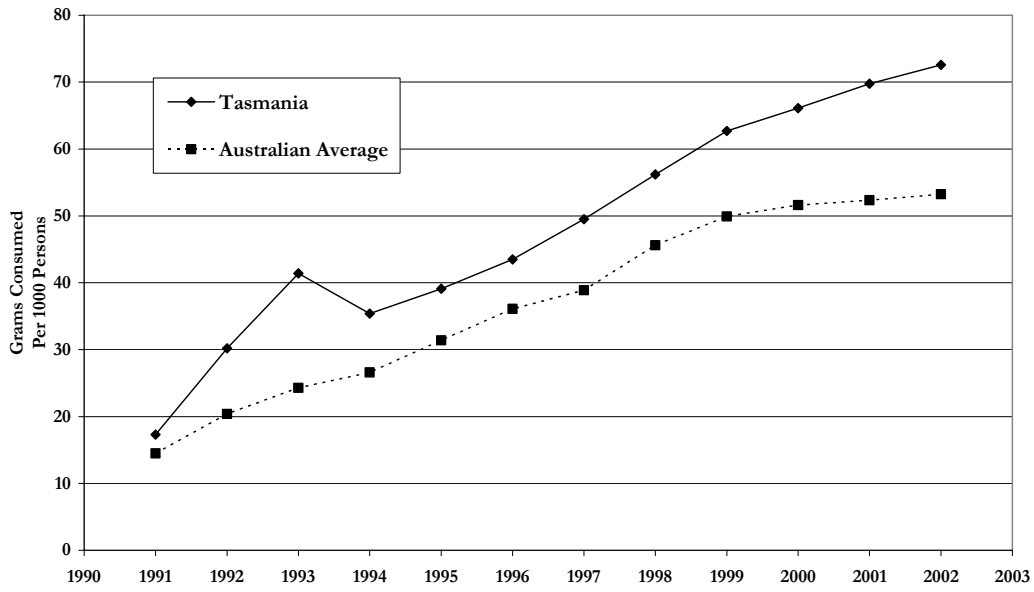


Figure 9: Consumption of morphine per 1000 persons, 1991-2002

Source: Pharmaceutical Services, Department of Health and Human Services

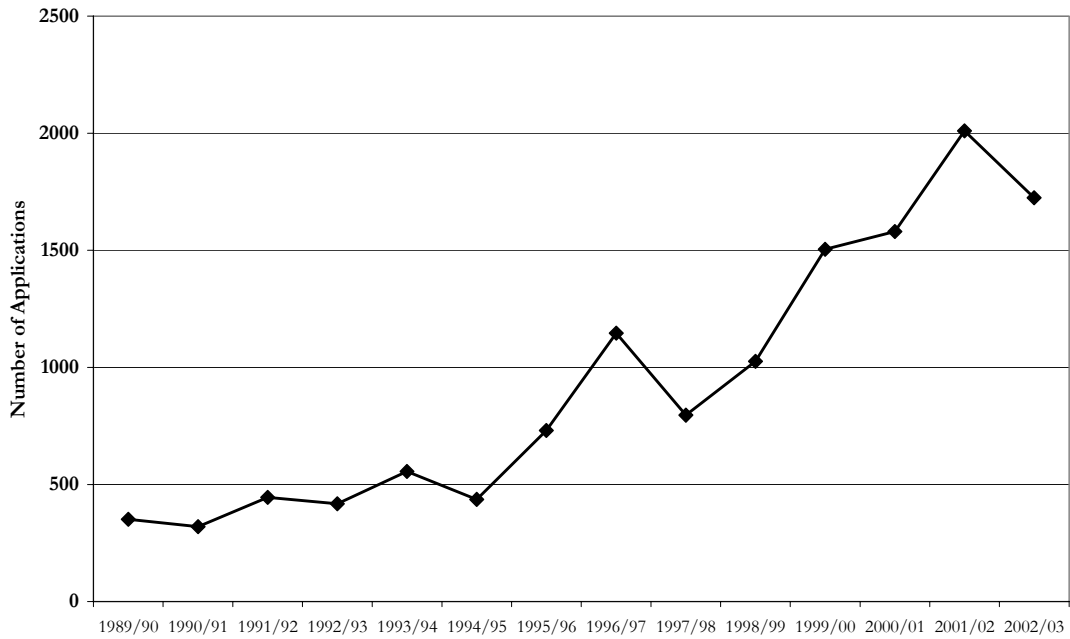


Figure 10: S22 applications received by Pharmaceutical Services, Tasmania: 1989/90-2002/03

Applications are for approval to prescribe narcotics to a patient for more than two months or for a person who is drug dependent. Source: Pharmaceutical Services, Department of Health and Human Services

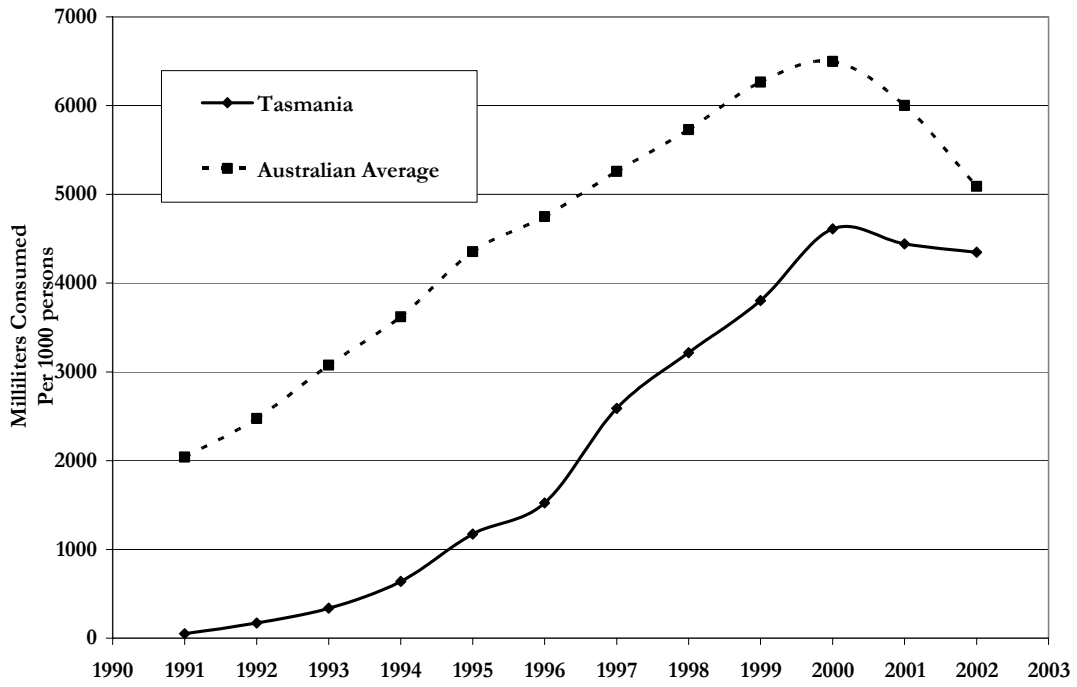


Figure 11: Consumption of methadone syrup per 1000 persons, 1991-2002

Source: Pharmaceutical Services, Department of Health and Human Services

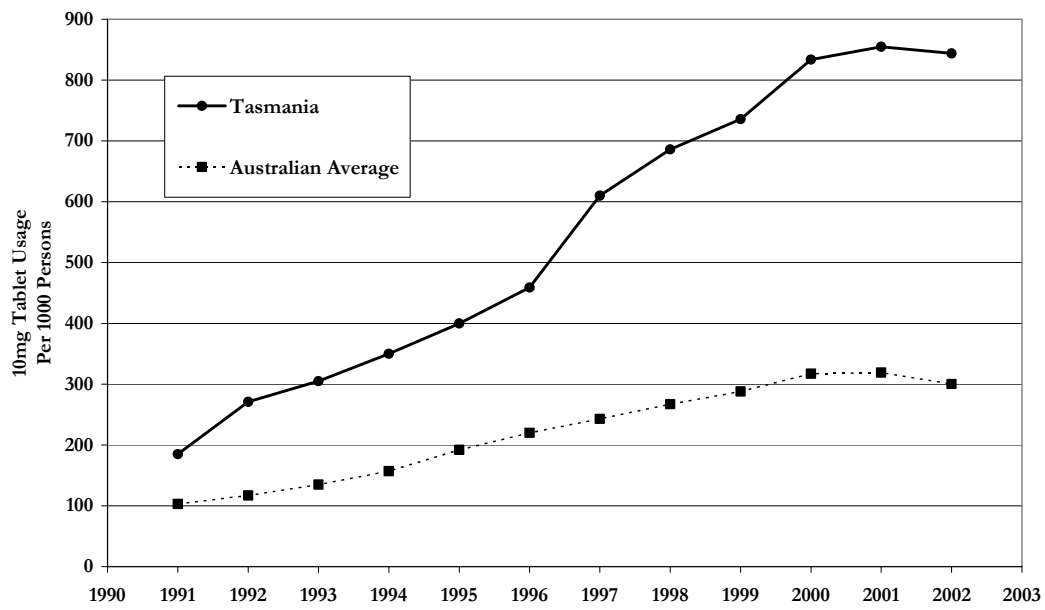


Figure 12: Consumption of methadone 10mg tablets per 1000 persons, 1991-2002

Source: Pharmaceutical Services, Department of Health and Human Services

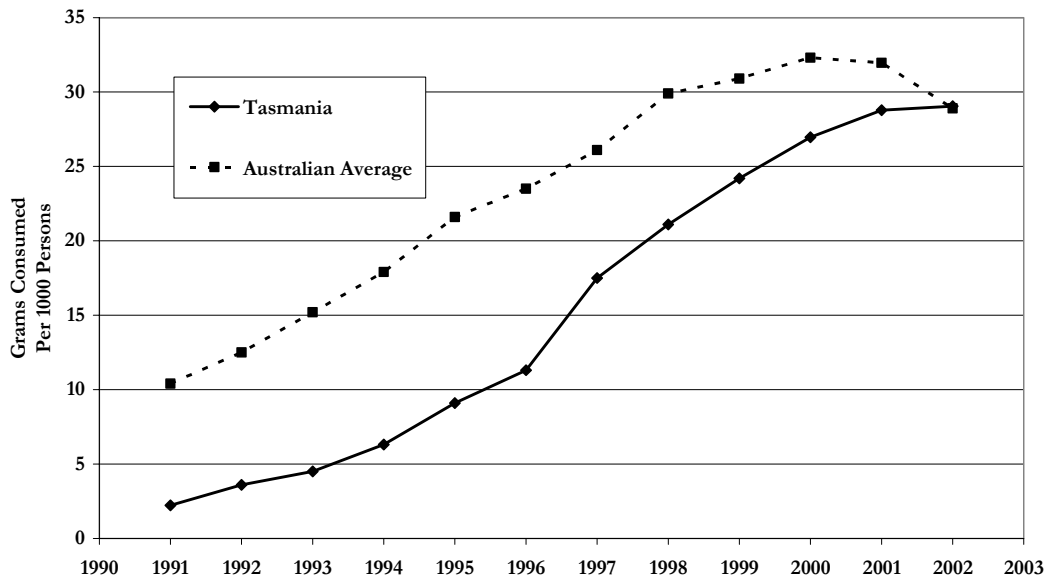


Figure 13: Consumption of methadone per 1000 persons, 1991-2001

Source: Pharmaceutical Services, Department of Health and Human Services

8.4.2 Current patterns of opioid use

Morphine

Morphine was reported as the drug of choice of 10% of the IDU sample, with 72% of the entire sample reporting some use of morphine in the preceding six months. Of those who had used morphine, the median frequency of use in the past six months was 21 days (range 1-180), which equates to use of the drug approximately three in every four weeks. Morphine was reported as the last drug injected prior to interview for 18% of the IDU sample, and as the drug most injected for 19% in the past month. These figures are all decreases from those seen in the previous IDRS samples, most notably in terms of frequency of injection (median 24 days in 2002, 21 days in 2003), proportions reporting morphine as the drug they had most often injected (30% in 2002, 19% in 2003) and as the drug last injected (25% in 2002, 19% in 2003). These changes are particularly noteworthy given that, as per previous years, the 2003 sample is a predominantly opioid-preferring population.

Methadone

Methadone was reported as the drug of choice of 13% of the IDU sample, with 85% of the entire sample reporting some use of methadone in the preceding six months. In regards to use of methadone syrup, the median frequency of use of licit syrup in the past six months was 180 days (range 2-180), with use of illicit methadone syrup a median frequency of 24 days (range 2-180). These patterns are almost identical to those reported in the 2002 survey. Licit physeptone tablets were only used by 2% of the IDU sample in the preceding six months, at a median frequency of 12 times in this time. While use of illicitly-accessed physeptone tablets was much more common in the sample (64%), the median frequency of use was the same (12 days). As levels of use of methadone were not broken down in to syrup and tablet preparations in previous years, it is difficult to infer any changes in frequencies of use across these samples. Methadone was injected in the preceding six months by almost all of those reporting use of the drug in this time (95%: n=81/85).

Primary users of opioids were reported by key informants to have a high level of polydrug use, with regular use of cannabis, methamphetamine, and benzodiazepines. While oral use of benzodiazepines was predominant among these groups, key informants also reported some intravenous use of benzodiazepines, although this was noted as a decreasing issue by one key informant. These reports are supported by the substance use trends seen in the IDU sample (see Table 27 and 28).

8.5 Opioid related harms

8.5.1 Law enforcement

In the 2001/02 financial year, 34 arrests (23 consumers, 11 providers) were made by Tasmania Police involving offences relating to opioids (including heroin and other narcotics²⁰), a pattern which appears reasonably stable in comparison to 17 arrests (13 consumers, 4 providers) in 2000/01²¹, 19 arrests (14 consumers, 5 providers), in 1999/00, 25 arrests (24 consumers, 1 provider) in 1998/99, 16 arrests (15 consumers, 1 provider) in 1997/98 and 28 arrests (24 consumers, 5 providers) in 1996/97. In the 2002/03 financial year, counting rules had changed, so clear comparative data is not available.

Key informants reporting on groups that primarily used opioids generally reported no noteworthy changes in the levels of crimes committed by this group in the preceding six months. While no changes were noted in levels of dealing or fraud (n=2 respectively), two key informants noted increased in shoplifting in recent months and one an increase in car break-ins among the groups they were familiar with (two key informants noted no changes in the level of property crimes). Two key informants reported no changes in the extent of violent crimes committed by the opioid-using groups they were familiar with, however two noted an increase in the level of assaults or intimidatory behaviour toward clients on the methadone program to obtain diverted takeaway doses.

²⁰ For recording purposes, Tasmania Police class any Schedule 8 drug as 'Narcotic'. Schedule 8 drugs are "Drugs of Addiction".

²¹ Arrest data quoted here may differ slightly from figures reported in the ABCI annual 'Australian Illicit Drug Reports', as some opioid-related data may be classified there under 'other drugs'. Data here reflects that provided by Tasmania Police State Intelligence Services.

When asked about recent changes in police activity, three key informants noted no recent changes in relation to opioid users, while there were single key informant reports of an increase in use of police cautions/diversion, increase in vigilance toward illicit methadone syrup selling, while another perceived a change in focus from opioids towards methamphetamines. Four IDU also noted an increase in busts/surveillance on morphine dealers in the preceding six months.

8.5.2 Health

In regard to recent changes in the health of opioid using groups that key informants had contact with, most again noted no major changes. However, three key informants noted an increase in overdoses in recent months (through combinations of multiple central nervous system depressants, not simply due to a single opioid), and an increase in blood-bourne-virus infection among opioid using groups was noted by two key informants. While one key informant noted an increase in injection-related problems among these groups in the preceding six months, another noted improvement in these behaviours, as well as a decline in the ‘shake and bang’ injection process (IDU simply shaking pills in a syringe filled with warm water, and rapidly injecting the resulting product).

IDU participants that had injected opioids in the month prior to interview were asked if they had experienced any health problems associated with this injection (Table 33a). Just over half (51%) had injected morphine in this time, and two-thirds (68%) had injected some form of methadone. Of those that had recently injected morphine, half (49%) reported experiencing no harms associated with this injection. The most common problems associated with morphine injection were prominent scarring or bruising (29%) and difficulty finding veins to inject into (24%), suggesting venous damage. However, in stark contrast to the trends for morphine injection, 96% of those recently injecting methadone reported experiencing some methadone injection-related harms. The commonest problem reported was dependence (77%). Similar to trends for morphine, indicators of venous damage, such as difficulty finding veins (44%) or prominent scarring or bruising (32%) were also common. However, almost one-third reported recently experiencing a ‘dirty hit’ (an injection that made the individual feel physically sick) associated with methadone injection, an experience which is commonly related to injection of impurities or contaminants. Anecdotal reports from IDU suggest that this may be due to non-sterile water being used to dilute take-away doses of methadone syrup.

Key informants were asked about recent changes in the mental health of the opioid-using groups that they had been in contact with over the preceding six months. While the majority did not note any changes in mental health in this time, two key informants noted an increase in paranoia or psychosis (primarily in conjunction with crystalline methamphetamine use), one reported seeing more anxiety issues among clients, and a further two noted seeing more depression among the groups they had contact with in the preceding six months.

Table 33a Injection-related problems experienced by recent morphine and methadone injectors

	Morphine		Methadone	
	%	n	%	n
Percent of sample injecting in the past month	51	51	68	68
Injection-related problem experienced				
<i>No problems</i>	49	25	4	3
<i>Overdose</i>	-	0	-	0
<i>Abscesses/infections</i>	4	2	3	2
<i>'Dirty bit'</i>	4	2	29	20
<i>Prominent scarring/bruising</i>	29	15	32	22
<i>Thrombosis / blood clotting</i>	-	0	6	4
<i>Swelling of arm</i>	6	3	12	8
<i>Swelling of leg</i>	-	0	4	3
<i>Swelling of hand</i>	4	2	12	8
<i>Swelling of feet</i>	-	0	4	3
<i>Hospitalisation</i>	-	0	2	1
<i>Contact with ambulance</i>	-	0	-	0
<i>Contact with police</i>	-	0	4	3
<i>Dependence</i>	18	9	77	52
<i>Difficulty finding veins to inject into</i>	24	12	44	30
<i>Skin ulcers</i>	-	0	-	0
<i>Gangrene</i>	-	0	-	0
<i>Rash</i>	6	3	-	0

8.6 Trends in patterns of opioid use

Multiple trends in opioid use were noted by both key informants and IDU respondents. Following trends noted in previous IDRS surveys, seven IDU noted more of their associates shifting from primary opioid use to primary methamphetamine use, due to the quality and easy availability of methamphetamine. Perhaps in conjunction with this, six key informants noted an increase in polydrug use amongst primary opioid users, with four key informants and two IDU noting that this change may be associated with use of crystalline methamphetamine. Both key informants and IDU reported cases of people using crystal methamphetamine and morphine on the same day, often within an hour of each other.

Changes in the number and demographics of opioid users were also noted by participants. Eight IDU reported noting more people using morphine in the preceding six months, particularly younger individuals (14-17 year olds). Eight IDU also noted seeing more people using methadone, both illicit syrup and physeptone tablets, in the preceding six months, also noting seeing more of their associates using methadone on a daily basis. Key informants also noted seeing a larger number of younger people using opioids in recent months, particularly younger females (under 24 years: n=4), and that younger individuals (20-24 years) were more likely to be polydrug users.

While two key informants noted a decrease in both benzodiazepine use and injection amongst the groups that they had contact with in the preceding six months, of concern were IDU reports of increasing use of methadone syrup and alprazolam simultaneously (in the same syringe; n=2) and a return of a similar pattern of use of methadone syrup and temazepam gel capsules (n=1 IDU; n=2 KI). This combination of use is of considerable concern, not solely due to the deleterious effects of injection of benzodiazepines (see Fry & Bruno, 2002) but also due to the increased risk of overdose on use of multiple central nervous system depressant drugs. Given anecdotal reports of two recent deaths associated with coincident methadone and alprazolam use, this pattern of use merits careful attention in the coming months, particularly from front-line health intervention workers.

8.7 Summary

Table 33: Summary of trends in opioid use

	Morphine	Methadone
Price	<ul style="list-style-type: none"> • \$0.7-0.8/mg, stable or decreasing • \$70/100 mg, stable or decreasing 	<ul style="list-style-type: none"> • \$1/mg, stable • \$80/100 mg, stable
Availability	<ul style="list-style-type: none"> • Easy to very easy • Stable to decreasing 	<ul style="list-style-type: none"> • Easy to very easy • Stable to decreasing
Form	<ul style="list-style-type: none"> • MS Contin predominant • Ordine use may be increasing 	<ul style="list-style-type: none"> • Both Physeptone tablets and methadone syrup accessed illicitly • Increasing use of Physeptone tablets
Use	<ul style="list-style-type: none"> • Steady increase in use of illicit Physeptone tablets of morphine over the past four years (30% in 2000, 64% in 2003), although there are early indications of a declining availability of these tablets • Morphine appears to be losing users to crystalline methamphetamine and Physeptone • Anecdotal reports of an increase in younger people (teen-age) using opioids 	
Other trends	<ul style="list-style-type: none"> • Anecdotal reports of an increasing use of methadone syrup and alprazolam simultaneously, a practice which carries an increased risk of overdose • Continuing anecdotal reports suggesting many users changing from being primary users of opioids to being primary users of methamphetamine • These opioids are not coming from direct doctor shopping by IDU 	

9. BENZODIAZEPINES

Almost all (95%) of the IDU sample had used benzodiazepines at some stage in their lives. Similarly, 95% had ever swallowed benzodiazepines, with 87% swallowing a benzodiazepine in the preceding six months. While this indicates a particularly high level of use of these drugs amongst IDU, of particular note is the fact that 66% of the sample had ever injected benzodiazepines, with 31% injecting in the six months prior to interview. Similar rates of injection were seen in the previous Tasmanian IDRS survey participants (38%, 37%, 37% in the six months prior to interview respectively in 2002, 2001 and 2000), and are very high in comparison to benzodiazepine injection rates reported in other jurisdictions (in the 2002 IDRS, recent injection of benzodiazepines over all those surveyed nationally was 21%: Breen et al, 2003).

Demographic patterns of those that had used benzodiazepines in the past 6 months were generally similar to those of other IDU (see Section 3.1), in terms of age, sex, cultural background, education, treatment and prison history, employment status, drug of choice, age of first injection and frequency of injection. However, those that had used benzodiazepines were significantly more likely to be receiving some form of drug treatment than those that did not use benzodiazepines (70% vs. 33%: $\chi^2(6)=23.27$, $p=0.001$). There were no demographic differences between those that had injected benzodiazepines in the preceding six months and those that had not.

Frequency of use of benzodiazepines was a median of 48 days in the past six months among those using the drug (range 1-180), slightly increased when compared to the median frequency of use amongst the 2002 IDRS sample (30 days, range 1-180). Among the 31 individuals that had recently injected benzodiazepines, the median frequency of injection was 5 days in the preceding six months.

High levels of oral benzodiazepine use in the last six months were seen among those IDU who had most often injected methadone (94%), morphine (89%) and methamphetamine (76%). Injection of benzodiazepines was more evenly balanced, seen across approximately one third of those that had most commonly injected morphine, methadone and methamphetamine (Table 34).

Key informants reported similar patterns of use among the groups they had most contact with, reporting use among primary users of cannabis (n=3 of 11 key informants), where use of the drug was limited and predominantly oral; and use among primary users of methamphetamine (n=8 of 13 key informants), reporting some intravenous use, but it was still predominantly swallowed, particularly for 'coming down' from methamphetamine use. Key informants also noted use of benzodiazepines among primary users of opioids (n=6 of 7 key informants), with swallowing most common although some intravenous use was also noted. One key informant, in contact with a particularly large number of (predominantly opioid-preferring) IDU noted a decrease in both injection and overall use of benzodiazepines amongst the individuals that they had recent contact with.

Table 34: Patterns of use of benzodiazepines amongst primary users of other drugs in the IDU sample

(n=100, number of respondents in parentheses)

Drug most injected in the past month	Swallowed benzodiazepines in past 6 months	Injected benzodiazepines in the past 6 months
Methadone (n=48)	94% (n=48)	33% (n=16)
Morphine (n=19)	89% (n=17)	32% (n=6)
Methamphetamine (n=29)	76% (n=22)	31% (n=9)

When asked to nominate the main type of benzodiazepine used in the past six months, diazepam (54%: Valium, 50%), and alprazolam (12%: Xanax 10%; Kalma 2%) were most common, with lower levels of primary use of oxazepam (8%: Serepax 6%; Murelax 2%), nitrazepam (5% mogadon); temazepam (5%: Normison 3%; Euhypnos 1%; Temaze 1%), clonazepam (Paxam 1%) and flunitrazepam (Hypnodorm 1%).

Examination of Table 35 clearly indicates that, as per trends in 2001 and 2002, Valium (diazepam) is the most commonly used benzodiazepine among those swallowing the drug (used by 81% of those swallowing a benzodiazepine in the preceding six months). However, temazepam gel capsule formulations (52%; median frequency 4.5 days, range 1-72 days) and alprazolam preparations (35%; median frequency 20 days, range 1-144 days) were more commonly used among those injecting benzodiazepines than diazepam (19%; median frequency 4.5 days, range 1-10: Table 36). Comparing benzodiazepine forms injected in the 2001 and 2002 surveys, it is clear that use of Normison capsules of temazepam has decreased, in keeping with the restrictions on their prescription, and that injection of alprazolam, particularly Xanax, has increased. This pattern is consistent with reports from both IDU and key informants that simultaneous injection of alprazolam with methadone syrup had increased in recent months, a practice which substantially increases the risk of overdose due to the additive effects of multiple central nervous system depressants.

Table 35: Recent oral benzodiazepine use

Benzodiazepine	Proportion using this benzodiazepine/brand orally in the preceding six# months			Median number of days used orally
	2001 IDRS (n=74)	2002 IDRS (n=80)	2003 IDRS (n=87)	
	%	%	%	
Kalma (<i>alprazolam</i>)	-	8 (n=6)	1 (n=1)	180
Xanax (<i>alprazolam</i>)	16 (n=12)	14 (n=11)	34 (n=29)	15
Lexotan (<i>bromazepam</i>)	-	3 (n=2)	4 (n=3)	2
Paxam (<i>clonazepam</i>)	-	3 (n=2)	4 (n=3)	3
Rivotril (<i>clonazepam</i>)	8 (n=6)	8 (n=6)	1 (n=1)	1
Antenex (<i>diazepam</i>)	12 (n=9)	19 (n=15)	4 (n=3)	180
Diazemuls (<i>diazepam</i>)	3 (n=2)	-	-	-
Ducene (<i>diazepam</i>)	8 (n=6)	5 (n=4)	5 (n=4)	60
Valium (<i>diazepam</i>)	84 (n=62)	73 (n=58)	81 (n=69)	24
Valium liquid (<i>diazepam</i>)	-	-	1 (n=1)	1
Valpam (<i>diazepam</i>)	-	-	1 (n=1)	6
Hypnodorm (<i>flunitrazepam</i>)	5 (n=4)	10 (n=8)	13 (n=11)	24
Rohypnol (<i>flunitrazepam</i>)	24 (n=18)	-	-	-
Alodorm (<i>nitrazepam</i>)	1 (n=1)	5 (n=4)	1 (n=1)	6
Mogadon (<i>nitrazepam</i>)	34 (n=25)	20 (n=16)	22 (n=19)	12
Alepam (<i>oxazepam</i>)	1 (n=1)	5 (n=4)	-	-
Murelax (<i>oxazepam</i>)	5 (n=4)	1 (n=1)	2 (n=2)	180
Serepax (<i>oxazepam</i>)	36 (n=27)	31 (n=25)	32 (n=27)	5
Euhypnos* (<i>temazepam</i>)	4 (n=3)	5 (n=4)	5 (n=4)	7
Normison* (<i>temazepam</i>)	45 (n=33)	21 (n=17)	1 (n=1)	2
Temaze* (<i>temazepam</i>)	18 (n=13)	30 (n=24)	8 (n=7)	6
Temaze (tablets)			14 (n=12)	17
Temtabs (<i>temazepam</i>)	-	9 (n=7)	1 (n=1)	-

*signifies those benzodiazepines available in gel capsule formulation; #2002 data is for the five-month period Jan-April, and June, 2002

Table 36: Recent intravenous benzodiazepine use

Benzodiazepine	Proportion using this benzodiazepine/brand intravenously in the preceding six# months			
	2001 IDRS (n=38)	2002 IDRS (n=38)	2003 IDRS (n=31) [†]	
	%	%	%	Median number of days injected
Alprax (<i>alprazolam</i>)	-	-	4 (n=1)	48
Kalma (<i>alprazolam</i>)	-	3 (n=1)	13 (n=3)	10
Xanax (<i>alprazolam</i>)	11 (n=4)	8 (n=3)	38 (n=9)	20
Paxam (<i>clonazepam</i>)	-	-	13 (n=3)	10
Rivotril (<i>clonazepam</i>)	-	-	4 (n=1)	2
Antenex (<i>diazepam</i>)	-	5 (n=2)	-	-
Valium (<i>diazepam</i>)	8 (n=3)	16 (n=6)	13 (n=3)	6
Valium liquid (<i>diazepam</i>)	-	-	13 (n=3)	2
Hypnodorm (<i>flunitrazepam</i>)	3 (n=1)	5 (n=2)	13 (n=3)	3
Rohypnol (<i>flunitrazepam</i>)	5 (n=2)	-	-	-
Alepam (<i>oxazepam</i>)	-	3 (n=1)	-	-
Serepax (<i>oxazepam</i>)	3 (n=1)	5 (n=2)	-	-
Euhypnos* (<i>temazepam</i>)	8 (n=3)	24 (n=9)	46 (n=11)	5
Normison* (<i>temazepam</i>)	82 (n=31)	53 (n=20)	8 (n=2)	6
Temaze* (<i>temazepam</i>)	24 (n=9)	47 (n=18)	29 (n=7)	2
Temtabs (<i>temazepam</i>)	-	5 (n=2)	4 -	-

*signifies those benzodiazepines available in gel capsule formulation; #2002 data is for the five-month period Jan-April, and June, 2002; †data only collected on 24 of the 31 individuals reporting injecting use of benzodiazepines in the preceding six months; proportions are calculated relative to these 24 participants.

9.1 Availability and Access

Key informants generally found it difficult to separate licit and illicit use of benzodiazepines amongst their groups, as often there was a substantial amount of overlap in use, with, for example, some people receiving diverted medications as a gift from a friend, or others bingeing on a benzodiazepine prescription then having to purchase diverted benzodiazepines to maintain their usual base level of use. When IDU were asked what their usual source of benzodiazepines was in the preceding six months, 48% of those that had used the drug reported predominantly accessing benzodiazepines via licit means (for genuine symptoms), 27% usually had benzodiazepines given to them by friends or relatives, and just 24% reported usually purchasing benzodiazepines. Only a single IDU reported usually accessing benzodiazepines through doctor shopping (Table 37). These modes of access are quite similar to those reported in preceding IDRS studies, with approximately half accessing via licit means, approximately two-fifths either being given or purchasing the drug from friends, and only a minority purchasing benzodiazepines from a ‘dealer’.

Table 37: Methods of obtaining benzodiazepines in the six[#] months prior to interview: 2001-2003 IDRS

Mode of access	2001 IDRS		2002 IDRS		2003 IDRS
	All methods used (n=69) %	Primary method used (n=69) %	All methods used (n=75) %	Primary method used (n=75) %	Primary method used (n=88)* %
Doctors (genuine symptoms)	57 (n=39)	45 (n=31)	53 (n=40)	47 (n=35)	48 (n=38)
Doctors (fake symptoms)	9 (n=6)	9 (n=6)	8 (n=6)	1 (n=1)	1 (n=1)
Forged prescriptions	0 (n=0)	0 (n=0)	0 (n=0)	0 (n=0)	0 (n=0)
Altered existing prescriptions	0 (n=0)	0 (n=0)	0 (n=0)	0 (n=0)	0 (n=0)
Friends (gift or purchase) †	67 (n=46)	42 (n=29)	59 (n=44)	35 (n=26)	27 (n=21) ‡
Friends (purchase) †	†	†	†	†	20 (n=16) ‡
Family	3 (n=2)	1 (n=1)	8 (n=6)	3 (n=2)	n/a
Dealer / street (purchased)	23 (n=16)	3 (n=2)	28 (n=21)	13 (n=10)	4 (n=3)
Dealer / street (swap drugs)	4 (n=3)	0 (n=0)	12 (n=9)	1 (n=1)	n/a

[#]Note: 2002 data refers to a four-month period of accessing benzodiazepines (January-April 2002), due to the nature of the survey questions. *Data was only collected on 79 participants: proportions are calculated with reference to this number. †In 2003, data were divided according to purchase from friend or gift from friend to clarify trends from previous years.

In May 2002, changes were made to the Pharmaceutical Benefits Scheme (PBS) that meant that it was substantially more difficult to receive subsidised prescriptions of gel capsule formulations of benzodiazepines. When asked about ease of access of gel capsule formulations from doctors in the six months prior to interview, the majority of IDU commenting believed it difficult or very difficult to access these formulations (72%), and that it had become harder to access these forms from a doctor in the past six months (86%). However, most regarded it as easy or very easy (71%) to access tablet formulations of benzodiazepines from a doctor, and that this had remained stable in the preceding six months (72%). These trends did not necessarily follow in regard to illicit access of benzodiazepines: a slightly smaller proportion of IDU reporting trends believed that it was difficult or very difficult (63%) to access gel capsule formulations illicitly in the six months prior to interview, as did the proportion regarding it to have become more difficult to access these formulations in this time (67%). Tablet formulations were again reported as being easy or very easy to access (80%) and that there had been no changes in availability via illicit means (61%) in the preceding month.

Table 38: Ease of access of benzodiazepines in the six months prior to interview

		%	n	%	n
		From a Medical Practitioner		From 'the street'	
Gel Capsules					
Ease of access					
	<i>Very easy</i>	14	1	19	5
	<i>Easy</i>	14	1	19	5
	<i>Difficult</i>	29	2	37	10
	<i>Very difficult</i>	43	3	26	7
Access change					
	<i>More difficult</i>	86	6	67	20
	<i>Stable</i>	14	1	27	8
	<i>Easier</i>	-	0	7	2
	<i>Fluctuates</i>	-	0	-	0
Tablets					
Ease of access					
	<i>Very easy</i>	38	17	39	28
	<i>Easy</i>	33	15	41	29
	<i>Difficult</i>	20	9	18	13
	<i>Very difficult</i>	9	4	1	1
Access change					
	<i>More difficult</i>	26	11	23	17
	<i>Stable</i>	72	31	61	46
	<i>Easier</i>	2	1	15	11
	<i>Fluctuates</i>	-	-	1	1

9.2 Price

Perhaps reflecting the multiple paths to access of benzodiazepines by IDU (for example, licit prescription, gifts, trade for other items or drugs, as well as illicit purchase), IDU provided highly varying accounts of the cost of their last purchase of diverted benzodiazepines. Most common prices reported were \$5 per 2 mg alprazolam (Xanax or Kalma) tablet, \$1 per 5 mg diazepam (Valium) tablet, \$2.50-\$5 per 1-2 mg flunitrazepam (Rohypnol) tablet, \$0.50-\$3 per 5 mg nitrazepam (Mogadon) tablet, \$0.80-\$2.50 per 30 mg oxazepam (Serepax) tablet, \$1-\$5 per 10 mg temazepam (Euhypnos, Normison or Temaze) gelcap, and \$4-\$6 per 20 mg temazepam gelcap (Table 38a). Most of these prices are similar to those reported in previous IDRS studies, with the possible exception of gel capsules of temazepam, where there are some indications of slightly increasing prices from the 2002 survey.

Table 38a: Modal price per tablet of last purchase of diverted benzodiazepines

Benzodiazepine	2001 IDRS			2002 IDRS			2003 IDRS		
	N	Modal Price (per tablet)	Price Range (per tablet)	N	Modal Price (per tablet)	Price Range (per tablet)	N	Modal Price (per tablet)	Price Range (per tablet)
Alprax (<i>alprazolam</i>)									
2 mg	-	-	-	-	-	-	1	\$5	-
Kalma (<i>alprazolam</i>)									
2 mg	-	-	-	1	\$2.50	-	1	\$5	-
Xanax (<i>alprazolam</i>)									
1 mg	-	-	-	-	-	-	1	\$5	-
2 mg	7	\$5	\$2-5	2	\$4.25 [#]	\$3.50-5	7	\$5	\$1.50-8
Rivotril (<i>clonazepam</i>)									
2 mg	5	\$2.50	\$1-5	-	-	-	2	\$1.50 [#]	\$0.50-2.50
Paxam (<i>clonazepam</i>)									
2 mg	-	-	-	-	-	-	1	\$1	-
Antenex (<i>diazepam</i>)									
5 mg	-	-	-	1	\$1	-	-	-	-
Diazemuls (<i>diazepam</i>)									
5 mg	1	\$1.25	-	-	-	-	-	-	-
Valium (<i>diazepam</i>)									
5 mg	30	\$1	\$0.5-5	14	\$1	\$0.75-3	17	\$1	\$0.40-3
Hypnodorm (<i>flunitrazepam</i>)									
1 mg	-	-	-	1	\$2.50	-	10	\$2.50 [#]	\$1.20-3
2 mg	2	\$5	-	2	\$4.50 [#]	\$4-5	2	\$5.00	-
Rohypnol (<i>flunitrazepam</i>)									
1 mg	-	-	-	5	\$5	\$1-5	-	-	-
2 mg	22	\$5	\$1.25-5	1	\$2.50	-	-	-	-
Alodorm (<i>nitrazepam</i>)									
5 mg	1	\$1.25	-	-	-	-	-	-	-
Mogadon (<i>nitrazepam</i>)									
5 mg	9	\$2	\$1-5	4	\$2	\$1-5	7	\$1.25 [#]	\$0.50-3
Murelax (<i>oxazepam</i>)									
15 mg	1	\$1	-	-	-	-	-	-	-
Serepax (<i>oxazepam</i>)									
15 mg	3	\$2.50 [#]	\$1-5	-	-	-	-	-	-
30 mg	11	\$2.25 [#]	\$1-5	4	\$1	\$1-2	4	\$1.85 [#]	\$0.80-2.50
Euhypnos (<i>temazepam</i>)									
*10 mg	-	-	-	1	\$1.50	-	1	\$2.50	-
*20 mg	3	\$4 [#]	\$1.25-10	4	\$4.50 [#]	\$3-10	7	\$4.80 [#]	\$1.50-7
Normison (<i>temazepam</i>)									
10 mg tablet	-	-	-	4	\$3.50 [#]	\$1-5	-	1	-
*10 mg capsule	30	\$2	\$0.8-5	1	\$2.50	-	1	\$5	-
*20 mg capsule	12	\$4 [#]	\$2-10	12	\$3.50 [#]	\$1-10	1	\$4	-
Temaze (<i>temazepam</i>)									
10 mg tablet	-	-	-	2	\$2.50 [#]	\$1-4	3	\$2.50 [#]	\$1-3
*10 mg capsule	5	\$2	\$1-5	2	\$2.25 [#]	\$1-3.50	2	\$1.15 [#]	\$1-1.25
*20 mg capsule	-	-	-	1	\$3	-	2	\$5.50 [#]	\$5-6
Temtabs (<i>temazepam</i>)									
10 mg	-	-	-	1	\$1	-	-	-	-

* signifies gel capsule formulation, [#] signifies cases where multiple modes existed – in these cases, median prices are reported

9.3 Prevalence of Benzodiazepine Use

Of the Tasmanians surveyed in the 1998 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 1999), 7.9% (n=75) indicated that they had ever tried benzodiazepines for non-medical purposes, and 2.9% (n=28) reported use in the year prior to the survey. However, in the 2001 National Drug Household Survey (n=1,349: Australian Institute of Health and Welfare, 2002), only 1.0% (n=13) of respondents reported using benzodiazepines for non-medical purposes in the year prior to interview. While these are low base rates of reported benzodiazepine users, this does seem to indicate a slight reduction in the prevalence of benzodiazepine (mis)use in this three-year period.

Benzodiazepines have consistently comprised approximately 10-16% of all positive urine screens among Tasmanian prisoners between 1996/97 and 2000/01, despite markedly increasing numbers of positive urine screens during this period. However, in 2001/02, the proportion of positive urine screens indicating use of benzodiazepines had dropped to 7% (n=9), the lowest proportion since 1995/96 (6%). During 2002/03, however, the proportion of positive urine screens testing positive for benzodiazepines returned to 14%, a similar level to that been in the 1996/97-2000/01 period.

Reported use of benzodiazepines as the main drug injected by non-pharmacy Needle Availability Program outlet clients has undergone massive changes in the past four years: with an increase from 0.3% to 13.5% of clients between 1998/99 and 1999/00, returning to more modest levels (3.5%) in 2000/01. This proportion remained reasonably stable at 3.8% in 2001/02, dropping again in 2002/03, to less than 1% of all client transactions (Table 39). While there are limitations with this dataset (see Section 2.3), it would appear that the apparent rapid increase in benzodiazepine use between 1998/99 and 1999/00 stabilised at a lower level during 2000/01 and 2001/02, and the level of primary benzodiazepine use may have returned to more traditional low levels during 2002/03. While data from the Needle Availability Program is likely to underestimate the true level of injection of benzodiazepines (as the question usually asked is ‘what is the drug you usually inject’), there is some support for these trends, as the proportion of IDRS IDU samples reporting recent injection of benzodiazepines remained stable between 2000 and 2002 (37% in 2000 and 2001, 38% in 2002), dropping slightly in 2003 to 31%. This turnaround is likely to reflect the combined impacts of the decreased availability (both from the efforts of prescribers and the changes to PBS subsidies) and the education efforts of many of the local needle availability outlet staff.

Table 39: Percentage of benzodiazepines reported as ‘drug most often injected’ by Tasmanian non-pharmacy Needle Availability Program clients, 1996-2003

Year	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Number of clients reporting benzodiazepines	18	24	1294	505	761	52
Percent of total clients reporting benzodiazepines	0.3%	0.3%	13.5%	3.5%	3.8%	0.2%

Source: Sexual Health, Department of Health and Human Services

9.4 Benzodiazepine-related Harms

9.4.1 Law enforcement

Trends from Tasmania Police in regard to benzodiazepines appear to have remained relatively stable between 2000/01 and 2001/02, with seizures of 2,511 pills and 78 arrests (72 consumers, 6 providers) associated with Schedule 4 drugs in 2001/02, in comparison to 2,374 pills and 93 arrests (84 consumers, 9 providers) in 2000/01. Counting rules for this data had changed in 2002/03 so directly comparable data is not available for this period.

9.4.2 Health

No key informants noted any particular changes in health problems associated with benzodiazepine use or injection amongst the substance-using populations they had recent contact with. IDU that had injected any benzodiazepine in the month prior to interview were asked if they had experienced any problems that they associated with this use (Table 39a). While just 12% of the sample had injected the drug in this time, only one-third of these reported experiencing no problems associated with recent benzodiazepine injection. The problems most commonly reported were difficulty finding veins to inject into (42%, n=5) and prominent scarring or bruising (33%, n=4), both indicating venous damage. Abscesses or infections associated with benzodiazepine injection were experienced by one-quarter of those recently injecting the drug (25%, n=4). Single individuals also reported experiencing thrombosis or swelling (8%, n=1 respectively), possibly indicating clotting or particulate matter forming in the individual's venous system.

Table 39a Injection-related problems experienced by recent benzodiazepine injectors

	Morphine	
	%	n
Percent of sample injecting in the past month	12	12
Injection-related problem experienced		
<i>No problems</i>	33	4
<i>Overdose</i>	-	0
<i>Abscesses/infections</i>	25	3
<i>'Dirty bit'</i>	-	0
<i>Prominent scarring/bruising</i>	33	4
<i>Thrombosis / blood clotting</i>	8	1
<i>Swelling of arm</i>	-	0
<i>Swelling of leg</i>	-	0
<i>Swelling of hand</i>	-	0
<i>Swelling of feet</i>	8	1
<i>Hospitalisation</i>	-	0
<i>Contact with ambulance</i>	-	0
<i>Contact with police</i>	8	1
<i>Dependence</i>	17	2
<i>Difficulty finding veins to inject into</i>	42	5
<i>Skin ulcers</i>	8	1
<i>Gangrene</i>	-	0

9.5 Summary

There are clear indications that there has been a further reduction of the injection of benzodiazepines among IDU between 2001/02 and 2002/03, following a reduction between 1999/00 and 2000/01. While it appears that harm reduction efforts, by front-line workers, medical practitioners and policy changes may have had a considerable impact on patterns of benzodiazepine use, there remains a relatively high level of benzodiazepine injection within Hobart when compared to other jurisdictions, despite a reduction in the availability of temazepam gel capsules that are particularly favoured for injection. There are early indications that alprazolam may be replacing the market for temazepam gel capsules among those IDU particularly interested in benzodiazepine injection, with alprazolam injection increasing in recent months, and this form being used in similar ways to temazepam capsules, such as in simultaneous combination with methadone syrup. This is a particular concern given the serious psychological and physical harms associated with benzodiazepine injection. Additionally, the level of use and availability of benzodiazepines generally remains high within local IDU, particularly among primary users of opiates, which is again of concern given the increased risk of overdose when the two substances are combined. As such, patterns of benzodiazepine use and injection in the state continue to warrant very close attention.

10. OTHER DRUGS

10.1 Ecstasy

Key informants reported low levels of mainly recreational use of ‘ecstasy’²² among users of other illicit drugs, most common amongst primary users of methamphetamine (noted by 9 of the 13 key informants reporting on primary methamphetamine groups), with some use among primary cannabis users and primary users of opioids (noted by 7/11 and 1/7 of the cannabis and opioid key informants respectively).

From the 1998 National Drug Strategy Household Survey for Tasmania (Australian Institute of Health and Welfare, 1999), 2.4% of those surveyed reported ever using ecstasy (n=28), while 0.7% (n=8) had used it in the year prior to the survey. A very similar rate (0.8%, n=10) reported use of ecstasy in the year prior to interview in the 2001 National Drug Household Survey (n=1,349: Australian Institute of Health and Welfare, 2002). Such low base rates of use render trends difficult to identify, but the similarity of the figures would suggest a stable prevalence of ecstasy use between these two surveys.

In the IDU sample, 66% had used ecstasy at some stage in their lives. Swallowing of the drug was most common, reported by 61% of the sample at some stage of their lives, and 26% in the preceding six months. Injection of ecstasy was reported by 40% of the sample at some stage in their lives, while 13% had injected the drug in the past six months, at a median frequency of once in this period. In total, 33% of the sample reported using ecstasy in the past six months, with a median frequency of use of two days (range 1-24 days) in this period. These indications of use generally represent slight increases over the proportions reported in the 2002 IDRS sample, where recent swallowing was reported by 20%, and recent injection by 13%, with 26% using the drug in total, at a median frequency of use of two days (range 1-24 days) in the six months preceding interview. This is particularly noteworthy as all indicators of use in the 2002 survey represented increased over the figures in the 2001 study.

Demographics of those who had used ecstasy in the past six months did not differ from those of the larger IDU sample (see Section 3.1), in terms of age, sex, cultural background, education, treatment history, employment status, age of first injection or frequency of injection. However, those that had recently used ecstasy were significantly less likely to have a prison history than those that had not used the drug (12% vs. 31% had a prison history respectively: χ^2 (1, n=100) = 3.4, $p < 0.037$). Such overall similarities are consistent with reports from key informants that recreational use of ecstasy was common amongst primary users of both stimulant and depressant drugs.

Trends in regard to price, purity and availability of ecstasy are not examined in detail within the IDRS study. However, a study conducted during a similar time-frame and methodology to the current study, using regular ecstasy users as the drug user cohort, has been conducted (Bruno & McLean, 2004a) and examines trends in ecstasy and other

²² Intelligence reports from Police suggest that much of the tablets sold as ‘ecstasy’ may not necessarily contain MDMA as the primary active ingredient. As such, in this section, the term ‘ecstasy’ will be used to refer to tablets or powder sold under that name.

'party drug' use in greater depth. This study suggests that ecstasy is 'easy' or 'very easy' to obtain by consumers in Hobart, and that this situation has remained stable during the early months of 2003. Subjective reports from consumers of the drug suggest that the purity of ecstasy available in Hobart during the early months of 2003 was generally variable, and that it cost \$40-50 per tablet.

During 2002/03, Tasmania Police seized 94 'ecstasy' tablets, a slight decrease from the 305 tablets seized in 2001/02 and 268 in 2000/01. No seizures of ecstasy tablets were reported by Tasmania Police to the ABCI (now the ACC) between 1995/96 and 1998/99, and just 3 were seized in 1999/00. There were three samples of phanethylamines (the class of drugs that ecstasy, or MDMA, and drugs such as MDA, MDEA and mescaline belong to) seized by Tasmania Police analysed for purity in 2003, returning a median purity of 28.5% (range 28.5-28.6%: ACC, 2004)

Findings of the dedicated study into ecstasy use in Hobart (Bruno & McLean, 2004a) clearly indicate that ecstasy is relatively easily available locally, and used by a broadening demographic group of individuals. This, and the information from Tasmania Police seizures, suggests that the availability of ecstasy has slowly increased in Hobart during recent years, just as it has across the country. With this greater availability of the drug in Tasmania, local IDU samples have shown an increasing exposure to the drug over time. However, the very low median frequency of use, and the relatively small proportion of this regular injecting drug user cohort reporting recent use of ecstasy, suggests that ecstasy use is generally a limited, recreational event among such groups, with regular injecting drug users tending to preferentially use methamphetamines or opioids at substantially greater frequency.

10.2 Prescription Stimulants (dexamphetamine, methylphenidate)

While no key informants specifically noted use of prescription stimulants such as methylphenidate (Ritalin, Attenta) or dexamphetamine amongst the substance using groups they had recent contact with, half (50%) of the IDU sample had recently used these drugs. Dexamphetamine was the more commonly used drug, used by 45% of the sample, with 16% using methylphenidate in the preceding six months.

In the IDU sample, 85% had used prescription stimulants at some stage in their lives. Injection of these drugs was most common, reported by 75% of the sample at some stage of their lives, and 45% in the preceding six months, at a median frequency of four times in this period (range 1-48). Swallowing of prescription stimulants was reported by 47% of the sample at some stage in their lives, while 21% had swallowed these drugs in the past six months. In total, 50% of the sample reported using prescription stimulants in the past six months, with a median frequency of use of five days (range 1-60 days) in this period. While use of these drugs appears common among the IDU cohort, it appears that they are predominantly used as a second-line drug, as just 14% (n=13) of those using stimulant drugs (methamphetamine or prescription stimulants) reported methylphenidate or dexamphetamine as the stimulant they had most commonly used in the preceding six months.

This level of prescription stimulant use among the IDU sample, while at a low median frequency, represents an increase from the rate of use among the 2002 IDRS IDU cohort

(44%), and is double the proportion reporting use of these drugs in the 2001 study (22%).

When asked the sources of their prescription stimulants, IDU reported that these drugs were almost invariably accessed via illicit means: just 5 IDU reported accessing prescription stimulants from a medical practitioner in the preceding six months.

Demographics of those who had used prescription stimulants in the past six months did not differ from those of the larger IDU sample (see Section 3.1), in terms of sex, cultural background, treatment and prison history, employment status, age of first injection or frequency of injection. Key informants in previous IDRS studies have suggested that such prescription stimulants are more commonly used by younger (predominantly school-age) people. This was partially supported by the finding that those that had used prescription stimulants in the preceding six months were significantly younger than those that had not (27.2 vs. 30.0 years respectively: Mann-Whitney $U = 875.0$, $p=0.01$). In keeping with this, those that had recently used pharmaceutical stimulants had completed a slightly but significantly lower number of years of education (10.0 years vs. 10.5 years respectively: Mann-Whitney $U = 962.0$, $p=0.04$).

Reported modal market prices for pharmaceutical stimulants were \$5 per 10mg methylphenidate tablet (Ritalin, Attenta: range \$1.50-10, $n=6$) and \$5 per 5mg dexamphetamine tablet (range \$1.5-10, $n=8$). These exactly matched the modal prices for the last purchase of these pharmaceuticals \$5 per 10mg methylphenidate tablet (range \$1.50-10, $n=23$) and \$5 per 5mg dexamphetamine tablet (range \$1-10, $n=40$). The majority of IDU who commented on price of prescription stimulants indicated that these prices had remained stable (57%, $n=21$) in the preceding six months. However, there was some variation in these reports, with 22% ($n=8$) reporting increasing prices, 19% ($n=7$) reporting decreased prices, and 3% ($n=1$) fluctuating prices.

There was some division among IDU reports of ease of access to prescription stimulants such as dexamphetamine or methylphenidate, with almost even proportions indicating that these were difficult or very difficult (54%, $n=25$) and easy or very easy (46%, $n=21$) to access. The majority of IDU also reported that the availability of these stimulants had decreased (48%, $n=21$) in the six months prior to interview, although a substantial proportion (39%, $n=17$) felt that this level of availability had remained stable.

Tasmanian prescription rates of methylphenidate and dexamphetamine (Figures 14 and 15) provide some context for these reports. Over the past decade, prescriptions of these stimulants have steadily grown nationally, most markedly for dexamphetamine. Tasmanian consumption rates of methylphenidate had been consistently below that of the Australian average until 1998, and rose to 128% that of the national average in 1999. Tasmanian consumption rates of dexamphetamine have also overtaken a steadily increasing national rate of prescription. Tasmanian prescription rates of methylphenidate and dexamphetamine were 141.7% and 119.5% that of the Australian average in 2002.

While these generally increasing trends indicate an escalating utilisation of methylphenidate and dexamphetamine by Australian doctors, these increasing prescription rates do not necessarily indicate an increase in abuse of these medications. However, these rates do reflect an increasing amount of these drugs used within the local community, which brings with it an increasing potential for abuse of these drugs.

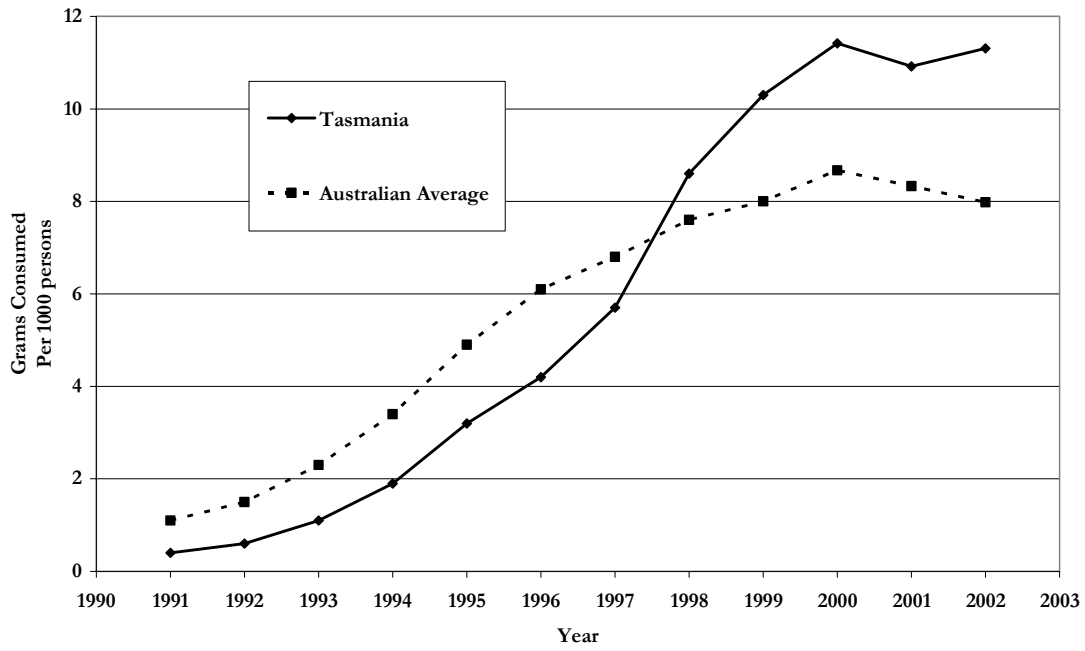


Figure 14: Consumption of methylphenidate (Ritalin) per 1000 persons, 1991-2002

Source: Pharmaceutical Services, Department of Health and Human Services

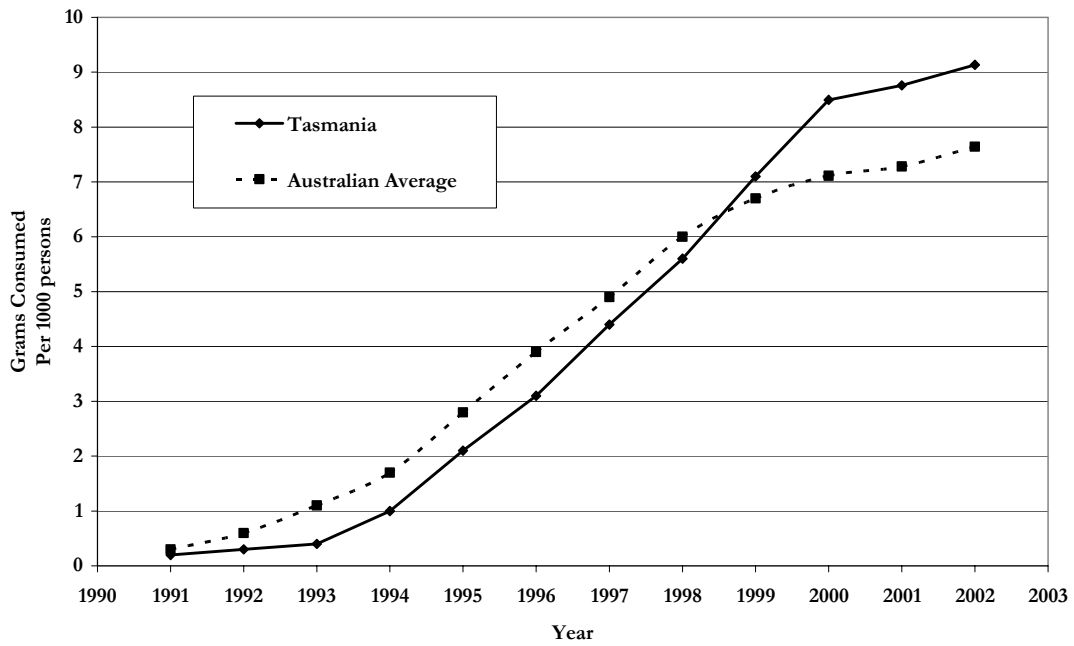


Figure 15: Consumption of dexamphetamine per 1000 persons, 1991-2002

Source: Pharmaceutical Services, Department of Health and Human Services

10.3 Inhalants

While 56% of the IDU respondents reported ever using inhalants, only 8% had used them in the six months prior to interview. Three of those reporting use of inhalants had used nitrous oxide (two using the drug just once in the preceding six months, the other using it three times in this period), while one had used amyl nitrate (twice in the past six months). Most key informants were not aware of any recent use of inhalants amongst the drug users they had contact with, regarding current use as rare (n=3) or non-existent (n=27). The three key informants that reported some use of inhalants suggested that this was primarily among younger (school age) individuals. In previous IDRS studies, key informants reported that the substance users they were associated with were extremely negative toward use of inhalants, regarding it as a 'primary school thing'.

10.4 Hallucinogens

Twenty-one percent of the IDU respondents reported use of hallucinogens in the six months prior to interview, although almost all (84%) had used something from this class of drugs at some stage in their lives. The current frequency of use was rare, with only a median of two days use in the past six months among those whom reported use of the drug (range 1-60 times). The majority of participants had only used the drug once (n=10) or twice (n=4) in this time. These indications of use are all similar to those reported in previous Hobart IDRS samples, with the exception of a substantially reduced proportion of the sample reporting recent hallucinogen use between 2001 and 2002 (26% in 2001, 16% in 2002).

Key informant reports followed a similar theme, with 2 key informants noting irregular, recreational use of hallucinogens amongst a small proportion of the users they had contact with. Twenty-eight key informants noted no current use of hallucinogens amongst the IDU they worked with.

Among the IDU sample, 5 individuals reported use of LSD in the preceding six months, and 14 people noted using mushrooms in this time (one individual had used both). Two key informants each noted use of LSD among the users that they were working with. In the 2001 IDRS, two key informants noted that hallucinogen use and availability was primarily seasonal, maximising during the summer months for LSD and winter for mushrooms.

The Party Drugs Initiative conducted in Hobart in mid-2003 (Bruno & McLean, 2004a) found higher relative levels of use (albeit also at a low frequency) among regular ecstasy users (38% of the 100 ecstasy users using psychedelic mushrooms in the six months prior to interview, and 24% using LSD).

Tasmania Police reported prices of LSD tabs as \$20-\$25 during the 2001/02 and 2000/01 financial years, a potential decrease on the \$15-\$30 reported during 1999/00. Price information for 2002/03 was not available for inclusion in the current report.

Tasmania Police seized 5 tabs of LSD during 2001/02 (all during December, 2001), and 8 tabs during 2000/01 (all during August 2000), compared to 109 tabs during the 1999/00 financial year, all during the summer October-December 1999 quarter. During

2002/03, Tasmania Police (Western District) seized 488 tabs believed to be LSD (and sold as such by the 'dealer') but forensic tests of the seized tabs indicated negative results for any drug.

10.5 Alkaloid Poppies

In the IDU sample, 68% reported using some opioid other than morphine, methadone or heroin at some stage in their lives. Use of such opioids in the six months prior to interview was only reported by 30% of the sample. Of these, 12 reported predominant use of some preparation of alkaloid poppies (described by the IDU as opium, opium tar or poppy 'tea'), with the remainder reporting use of pethidine (n=3), oxycodone (n=5), and tramadol (n=2), all of which are pharmaceutical analgesics.

This level of recent use of alkaloid poppies (12%) is highly similar to that reported within the 2001 and 2002 IDRS samples (13% and 14% respectively), and represents a continued, substantial drop from the proportions reporting use of alkaloid poppy presentations in the 2000 survey (34%). Within the 2003 sample, median frequency of use of an alkaloid poppy preparation was five days in the preceding six months (range 1-48 days).

Demographics of those who had used some preparation of alkaloid poppies in the past six months did not differ from those of the larger IDU sample (see Section 3.1), in terms of age, cultural background, education, treatment or prison history, employment status, age of first injection or frequency of injection. The only exception was that those that had recently used poppy preparations were significantly more likely to be female than those that did not (67% vs. 25% respectively: $\chi^2(1, n=100) = 8.7, p < 0.03$). However, given that such a gender bias has not appeared in any of the preceding IDRS studies, it is possible that this relationship is simply an idiosyncrasy of this dataset.

Only a single key informant specifically noted any recent use of alkaloid poppy preparations amongst the groups they had contact with.

Tasmania Police State Intelligence Services have reported stable prices of \$10 and \$20 per 'ball' of poppy tar between January 2000 and June 2001, but have not reported price information for alkaloid poppy preparations since this time. During 2002/03, Tasmania Police reported seizing 7 capsules, 1473.3g of capsules, 84 poppy plants and 2g of poppy tar. Tasmania Police seized 382 individual capsules plus 9.319 kg of capsules in 2001/02. In 2000/01, Tasmania Police reported seizing 3,522 capsules of alkaloid poppies, a similar amount to the 3,933 capsules and 50g of poppy tar seized in the 1999/00 financial year. (Table 40). However, this mixture of reporting renders it difficult to identify trends in seizure data.

The diversion rate of Tasmanian alkaloid poppy crops, shown in Table 40 below, had been in steady decline between 1995 and 1998. Contrary to this trend, however, 1998/99 and 1999/00 saw a substantial amount of poppies stolen from crops. It should be noted that a small number of particularly large hauls were largely responsible for these rates of diversion (in one case, a single haul of approximately 50,000 capsules were stolen). In concert with trends suggesting a decline in alkaloid poppy use amongst IDU during 2001, there has been a major decrease in the numbers of poppies stolen during 2000/01 when compared to the previous two financial years (7,765 capsules in comparison to over

60,000 in previous years). The 2001/02 financial year saw a doubling of the number of stolen poppy capsules (15,946) in comparison to the previous year, and, while this has risen again in 2002/03 (20,223), this level of diversion remains substantially lower than the annual number of capsules stolen between 1996/97 and 1999/00. Tasmania Police report that this decline in diversion is likely to be attributed both to a more pro-active approach by Tasmania Police poppy task forces and the decision by producers not to specifically identify thebaine poppy crops. This is a substantial deterrent to illicit use, as thebaine poppies are physically identical to morphine-producing crops, with the exception that thebaine acts as a central nervous system stimulant (morphine behaves in the opposite way, and is a central nervous system depressant), causing adverse strychnine-like convulsions after high doses. In support of this, in 2001, one key informant, a user group representative, noted negative experiences with thebaine-based diverted poppies amongst the IDU they were familiar with, with the individuals concerned not returning to use of poppy preparations.

Table 40: Tasmanian alkaloid poppy crop diversion rates, 1996-2003.

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Number of capsules stolen	42,426	30,424	66,013	62,700	7,765	15,946	20,223
Cost per hectare of securing poppy crops	\$45	\$39	\$33	\$27	\$28	\$28	\$30
Number of capsules stolen per hectare sown	3.95	2.44	4.41	2.99	0.39	0.81	1.11
Number of theft incidents reported	46	38	34	39	20	27	27
% of IDU sample reporting use	-	-	-	34	13	14	12
Median days used among IDU using	-	-	-	6 (1-151)	6 (1-81)	4 (1-45)	5 (1-48)
TASPOL seizures	-	-	-	3,933 capsules*; 50g tar	3,522 capsules*	382 capsules*; plus 9319g of capsules	7 capsules plus 1473.3g capsules; 84 plants; 2g tar

*Source: Poppy Board, Justice Department of Tasmania; *May be an overestimate of seizures as Tasmania Police data is an amalgamation of plants, capsules and weight of seizures. Data reported here is the best estimate of seizure quantity*

10.6 Other Substances

10.6.1 Homebake

Following identification of homebake as a re-emergent issue in the 2001 West Australian IDRS (Hargreaves & Lenton, 2002), 2003 is the second year of the national study that has included specific questions on use of homebake. 'Homebake' is a term used to describe the end product of an illicit drug manufacturing process, typically conducted within domestic kitchens, using codeine-based pharmaceuticals to make morphine and/or heroin. The manufacturing process involves the initial extraction of codeine from these pharmaceuticals, which is converted to morphine. Subsequent reactions convert morphine to heroin in the form of a dark paste, which requires dilution to be injected. Depending on the skill of the 'cook', the end result is usually a combination of heroin, morphine and codeine, although varying amounts of unwanted chemicals used in the manufacturing process (pyridine hydrochloride, chloroform) may also be present (Hargreaves & Lenton, 2002).

While no key informants noted any use of homebake amongst the groups they had contact with, 13% of the 2003 IDU sample reported they had used homebake at some stage in their lives. Injection of the drug was most common, reported by 11% at some stage in their lives, and 2% in the preceding six months, at a median frequency of seven times in this time. Lifetime use of homebake by smoking (2%) and swallowing (2%) was much less common, with only 1% reporting swallowing the drug in the six months prior to interview. In total, 3% of the IDU sample reported some use of homebake in the past six months, with a median frequency of use of only 4 days (range 1-10 days) in this period.

10.6.2 Antidepressants

Almost half (49%) of the IDU sample had used antidepressants at some stage in their lives. Injection of antidepressants was rare, reported by only 4% of the sample at some stage in their lives and 1% in the preceding six months, with this individual injecting just once in this time. All 49 of those who had ever used antidepressants had swallowed the drug at some stage, with 22% of the sample reporting swallowing of antidepressants in the past six months. Of those that had recently used the drug, the majority were receiving antidepressants for legitimate reasons (75%), while only five had accessed the drug illicitly in this period. The individual that reported injecting antidepressants in the preceding six months had accessed the drug illicitly. IDU that reported recent use of antidepressants were no more likely to be currently involved in treatment for their substance use than those that had not used the drug. Median frequency of use of antidepressants was 180 days in the preceding six months (range 120-180) among those receiving antidepressants for legitimate reasons, and only 72 days in this period (range 1-180 days) among those accessing the drug illicitly. Specific serotonin reuptake-inhibiting (SSRI) drugs were most commonly used (77% SSRI : citalopram, n=3; fluvoxamine, n=4; sertraline, n=3; fluoxetine n=4), although both tricyclic antidepressants (TCA: 9%: doxepin, n=2) and monoamine oxidase inhibiting drugs (MAOI: 5%: mirtrazepine, n=1). The remainder (n=5) could not recall the antidepressant they had used.

These patterns of use were very similar to those reported in the 2002 IDRS survey participants, where 48 had ever used antidepressants, 28% using in the preceding six months (4% illicitly), with a median frequency of use of 180 days (range 1-180) among those receiving the drug for legitimate reasons and 2 days (range 1-10) amongst those predominantly using illicitly-accessed antidepressants. Highly similar patterns of use were also seen in the 2001 survey participants.

10.6.3 Buprenorphine

With the advent of buprenorphine as a maintenance treatment option for opioid addiction, trends in buprenorphine use were examined for the first time in the 2002 IDRS survey. In the current cohort of IDU, only 13 reported ever using buprenorphine, with only 4 using the drug licitly in the preceding six months, and 3 using the drug illicitly in this time. Among those that had accessed the drug licitly, all had swallowed buprenorphine, and just one had injected the drug in the preceding six months (six times in this period). Median frequency of licit use in the preceding six months was 101 days (range 5-180 days). All three individuals who reported illicitly accessing buprenorphine in the preceding six months had injected the drug, at a median frequency of 24 days in this time (range 1-24).

While no key informants reported hearing of injection of illicit buprenorphine amongst the substance using individuals they had contact with, given the high use of diverted pharmaceutical opioids among the regular IDU population, trends in use of buprenorphine merit close attention as the drug is more widely adopted as a treatment option in the coming years.

10.7 Summary of trends for other drugs

The IDRS methodology is not particularly well-suited to gathering data regarding trends in use of other illicit drugs such as ecstasy, hallucinogens and inhalants, as these populations often do not come into contact with the services key informants are involved with, or they do not meet the criteria for inclusion in the IDU survey. As such, trends identified here should be interpreted with due caution and may merit further investigation using more appropriate methodologies.

The main trends identified for these categories of drugs were:

- While rates of use of pharmaceutical stimulants have been steadily increasing over the past three Hobart IDRS IDU cohorts, and was used by half the participants in the current study, these are generally used infrequently, and are rarely the stimulant drug most commonly used by such individuals
- Multiple sources of information suggest that the availability of ecstasy has slowly increased in Hobart during recent years, just as it has across the country. With this greater availability of the drug locally, local IDU samples have shown an increasing exposure to the drug over time. However, ecstasy use is generally a limited, recreational event among such groups.
- Continuing low rates of diversion and use of alkaloid poppies
- Limited use of diverted buprenorphine among the 2003 IDRS IDU cohort

11 DRUG-RELATED ISSUES

11.1 Treatment

11.1.1 Census of Clients of Treatment Service Agencies (COTSA)

In May 2001, all services identified nationally as providing face-to-face specialist treatment for alcohol and other drug problems were surveyed and asked to report the characteristics of the clients they treated during a 24-hour period. In Tasmania, 15 agencies were identified, and all contributed data to the census. Of the 147 clients reported on, 134 were substance users themselves (the remainder were individuals affected by other's substance use), with an average age of 32 years (SD 11.6 years). Thirty percent of substance-using clients were female, and 4.8% of clients identified as Aboriginal or Torres Strait Islanders. In terms of employment, 18% were currently employed, 31% unemployed, 21% pensioners, 7% students and 10% prisoners. Client's main drug problems (as reported by the agency) are summarised in Table 41, with alcohol use (35%), opioid use (30%) and cannabis use (16%) most common. When compared to the patterns of problem drugs from the 1995 COTSA census, there appears to have been a seismic shift in the types of problems treatment agencies are required to address, with the proportion of clients receiving treatment for alcohol-related problems dropping from 63% in 1995 to 35% in 2001, and an increasing prevalence of opioid- and amphetamine- related clients (increases of 10% to 30% and 4% to 9% respectively).

Table 41: Census of Clients of Treatment Service Agencies (Tasmanian and National Data) 1995 and 2001

	Tasmania		National	
	1995 %	2001 %	1995 %	2001 %
Alcohol	63.3	35.1	49.3	35.1
Opioids*	10.1	29.9	33.6	39.1
Amphetamines	3.8	9.0	6.5	8.3
Cannabis	13.9	15.7	6.7	9.3
Benzodiazepines		1.4		2.3
Cocaine		0		0.7
Polydrug including opioids	2.5	2.2	7.4	7.1
Polydrug excluding opioids	0	11.2	3.5	5.1
<i>Injecting drug use</i>		30.6		45.7
Clients		147		5304

*Note: *includes polydrug including opioids. Source: Shand and Mattick (2001)*

11.1.2 Tasmanian Alcohol and Other Drug Treatment Minimum Dataset

The National Minimum Data Set for Alcohol and other Drug Treatment Services was developed as a nationally consistent response to data collection for alcohol and other drug treatment services. Data collection began on July 1, 2000, and data from Tasmanian government and non-government agencies across the state is presented in Table 42 below. Data from clients receiving only methadone maintenance treatment, and admitted patients in psychiatric hospitals or general hospital wards are not included in these figures.

The findings from the 2001/02 data are generally consistent with the findings of the 2001 COTSA census, with 66% of those receiving services being male, an average age of 33.6 years (SD 12.3 years), and a small proportion (7%) identifying as being Aboriginal or Torres Strait Islanders. Some history of injecting drug use was noted in 29.7% of clients in the 2001/02 dataset, with 18.4% reporting injecting drug use in the three months prior to data collection. Figures for the reported principal drug of concern again reflect the predominance of treatment for alcohol (36.7%), with treatment for cannabis (24.7%), nicotine (16.6%) and amphetamine (9.5%) also common. However, in stark contrast to the findings of the 2001 COTSA census, only 9.6% of clients in the 2001/02 treatment data had an opiate as their principal drug of concern (both datasets excluded clients receiving methadone maintenance treatment only from their figures).

There appears to have been little substantial change in either the reported demographics or the presenting drugs of concern between the 2000/01 and the 2001/02 datasets. However, it is difficult to make clear inferences as there is currently some inconsistency in the recording of data, and in those cases where some changes are suggested (such as increases in the number of individuals treated overall and increase in treatment where nicotine was the principal drug of concern) it is unclear whether these reflect real changes or simply an increase in participating agencies or consistent data recording processes.

Table 42: Tasmanian Alcohol and Other Drug Treatment Services Minimum Data Set, 2000/01-2001/02

	2000/01	2001/02
Total Data Set		
<i>n</i>	1404	1735
<i>% receiving service for own use</i>	91% (n=1279)	97% (n=1691)
For those receiving service for own use		
Sex (% male)	65% (n=826)	66% (n=1116)
Mean Age (years)	31.8 (SD=11.6)	33.6 (SD=13.3)
Aboriginal or Torres Strait Islander	8% (n=103)	7% (n=123)
Injecting Drug Use History		
<i>Current (0-3 months prior)</i>	23.8% (n=304)	18.4% (n=311)
<i>Recent (3-12 months prior)</i>	5.2% (n=66)	5.4% (n=92)
<i>Historical (>12 months prior)</i>	5.2% (n=66)	5.9% (n=100)
<i>None</i>	28.4% (n=363)	38.7% (n=654)
<i>Not Stated</i>	37.5% (n=480)	31.5% (n=534)
Principal drug of concern		
<i>Alcohol</i>	38.8% (n=496)	36.7% (n=620)
<i>Nicotine</i>	2.4% (n=31)	16.6% (n=280)
<i>Cannabis</i>	22.7% (n=290)	24.7% (n=418)
<i>Amphetamine</i>	12.1% (n=155)	9.5% (n=161)
<i>Cocaine</i>	0.2% (n=3)	0.0% (n=0)
<i>Other Stimulants</i>	0.9% (n=11)	0.6% (n=10)
<i>'Ecstasy' and related</i>	0.1% (n=1)	0.3% (n=5)
<i>Heroin</i>	2.3% (n=30)	1.1% (n=18)
<i>Morphine</i>	6.6% (n=84)	7.2% (n=121)
<i>Metbadone</i>	6.0% (n=77)	0.2% (n=3)
<i>Other Opiates/ Analgesics</i>	4.1% (n=53)	1.1% (n=19)
<i>Benzodiazepines</i>	2.9% (n=37)	1.7% (n=29)
<i>Other</i>	0.8% (n=10)	0.4% (n=7)
Method of use of principal drug of concern		
<i>Ingest</i>	48.1% (n=615)	40.9% (n=691)
<i>Smoke</i>	24.7% (n=316)	40.4% (n=684)
<i>Inject</i>	21.3% (n=273)	16.6% (n=281)
<i>Sniff</i>	0.2% (n=3)	0.2% (n=3)
<i>Inhale</i>	0.2 (n=2)	0.1% (n=1)
<i>Other/Not reported</i>	5.5% (n=70)	1.8% (n=31)
Other drugs of concern		
<i>Alcohol</i>	9.8% (n=125)	6.8% (n=115)
<i>Nicotine</i>	4.1% (n=52)	6.9% (n=115)
<i>Cannabis</i>	18.3% (n=234)	13.9% (n=235)
<i>Amphetamine</i>	9.3% (n=119)	6.6% (n=111)
<i>Cocaine</i>	1.2% (n=15)	0.3% (n=5)
<i>Other Stimulants</i>	0.4% (n=5)	0.6% (n=10)
<i>'Ecstasy' and related</i>	1.6% (n=21)	0.8% (n=14)
<i>Heroin</i>	2.7% (n=35)	0.9% (n=15)
<i>Morphine</i>	4.9% (n=63)	3.4% (n=57)
<i>Metbadone</i>	2.9% (n=37)	1.2% (n=21)
<i>Other Opiates/ Analgesics</i>	0.7% (n=9)	0.4% (n=7)
<i>Benzodiazepines</i>	9.3% (n=119)	3.5% (n=60)
<i>Other</i>	1.6% (n=21)	1.4% (n=24)

Note: multiple presentations of the same individual excluded.

11.1.3 Alcohol and Drug Information Service Data

The Tasmanian Alcohol and Drug Information Service (ADIS), previously administered by Department of Health and Human Services staff at Hobart's detoxification service, was transferred to Turning Point Alcohol and Drug Centre in Victoria in mid-May 2000. Turning Point systematically record data for each call received, which was not possible in previous years due to high demands on Department of Health and Human Services staff time. However, during 1998/99, staff were able to record data for 840 calls to ADIS (not all calls to the service were recorded). The primary drug mentioned in the call was noted in the majority of cases (Figure 15). During this period, the majority of calls pertaining to illicit drugs were regarding cannabis (18%), followed by opioids (13%) and methamphetamine (7%). A trend toward a slight increase in opioid-related inquiries was noted during this period. Data from previous years was unavailable, rendering it difficult to make comparisons.

Data from calls made to the Turning Point-administered ADIS from May 15, 2000 to June 30, 2002 were provided, with 2422 calls being made between May 15, 2000 and June 30, 2001, 2208 over the 2000/01 financial year and 1827 over the 2001/02 financial year. In 2002/03, the reporting period changed to the 12 month period from April 2002-March 2003, during which 1984 calls were made to ADIS. For comparative purposes, this period will be treated as a financial year period, as the ADIS reports only provide information on a 12-month period (rather than a monthly period).

For calls regarding specific persons using drugs (either from the person themselves or about them from parents, partners, etc), information regarding the drug or drugs used is detailed in Figure 16. While this follows similar patterns to 1998/99 ADIS data, due to its more systematic recording and its referral to a specific sub-group of calls, the two data sets are not directly comparable, and as such have been displayed in separate figures.

Due to the fact that quarterly data is not available, it is difficult to make clear inferences regarding trends, however, in all sets of ADIS data the bulk of calls pertaining to illicit drugs were regarding cannabis use, followed by opioids and methamphetamine. The makeup of the calls in regards to people using specific drugs during the past three years have all been very similar, with the only notable changes being a decrease in calls regarding heroin, and a decrease in calls relating to amphetamines between 2001/02 and 2002/03.

Demographic characteristics of drug users identified in calls to ADIS during the 2000/01 financial year indicate that the majority of drug users identified were aged between 22 and 40 years of age (59%), although a sizeable proportion of calls related to people in the 16 to 18 year age group (15.5%). There appeared to be a slight upward shift in the age of drug users identified in ADIS calls during 2001/02, as, while the majority were again aged between 22 and 40 years (56.4%), calls related to people in the 16 to 18 year age group had decreased by 5% (to 10.2%), while calls relating to people more than 40 years of age increased 6% (to 19% of calls). Demographic characteristics of drug users in the 2002/03 data were highly similar to the 2001/02 figures, with 57% aged between 22 and 40 years, 10.7% 16 to 18 years, and 19.2% more than 40 years of age.

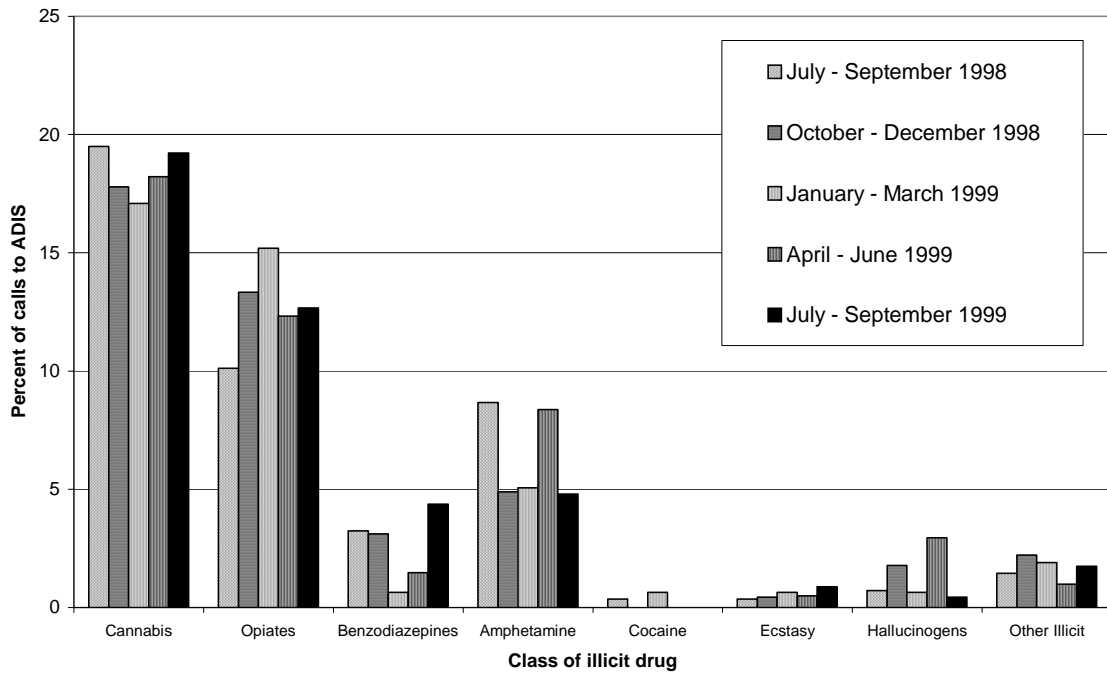


Figure 15: Percentage of calls to ADIS by drug type (1998/99)

Source: Alcohol and Drug Services, Department of Health and Human Services

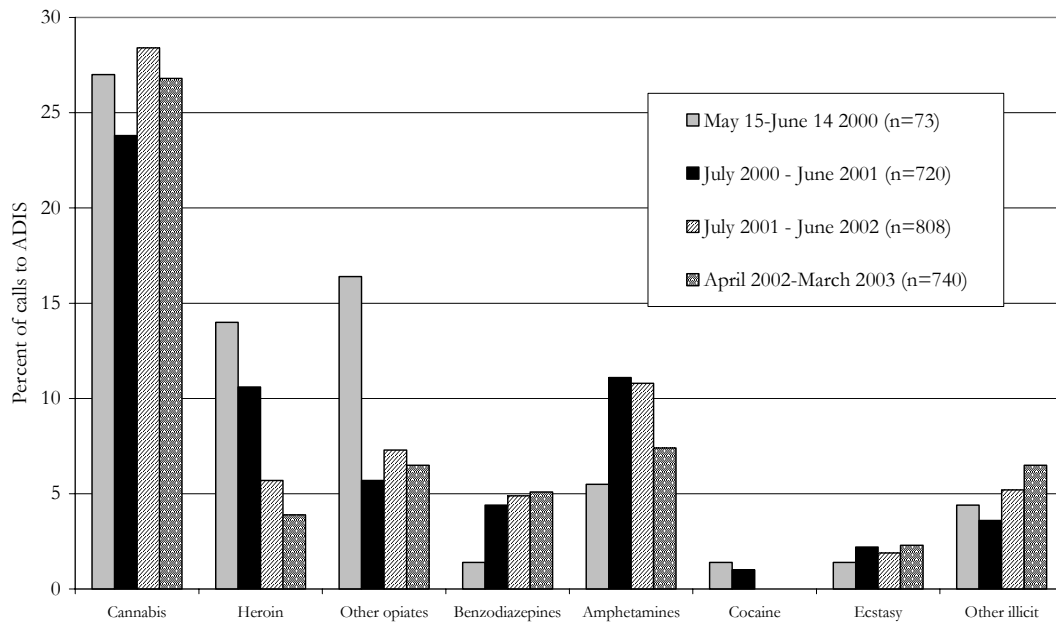


Figure 16: Percentage of calls to ADIS referring to persons using specific drugs, May 14, 2000 – March 2003

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

Among the calls relating to people using drugs in the 2000/01 year, there was an approximately equal gender distribution (50.1% male), which was particularly noteworthy given that statistics from similar services in Victoria have consistently demonstrated a preponderance of male drug users in calls to their services, usually in the order of 60% male. In 2001/02, the drug users identified in calls to ADIS fell more closely to this 'traditional' bias, with 58% of calls relating to males, a trend that continued further into 2002/03, where 62% of calls related to males.

Turning Point also provide a specialist alcohol and drug telephone service targeted specifically to health professionals to assist with clinical management of drug and alcohol problems: the Drug and Alcohol Clinical Advisory Service (DACAS). Of the 63 calls to the service in the 2000/01 financial year, the majority were from medical practitioners (69.4%) although there was also a sizeable level of utilisation of the service by nurses (12.2%), general drug and alcohol staff (10.2%) and youth/welfare workers (6.1%). In line with the patterns of problem drug use identified within the COTSA study (Table 41), the majority of calls were regarding opioids (50%: prescription opioids 25%, methadone 15.4%, heroin 9.6%), with a substantial proportion of consultations regarding psychostimulants (such as methamphetamine: 15.4%), benzodiazepines (9.6%) and cannabis (9.6%).

Very similar patterns were seen among the 59 calls made to DACAS in the 2001/02 financial year. Again, the majority of calls were made by medical practitioners (68.8%), with some utilisation by pharmacists (8.3%), nurses (6.3%), social workers (2.1%), and general drug and alcohol staff (2.1%). The majority of calls again related to opioids (40.7%: methadone 22.0%, prescription opioids 6.8%, heroin 6.8%, buprenorphine 2.1%), with a lower proportion of calls relating to psychostimulants (11.8%), benzodiazepines (11.9%), and cannabis (6.8%).

In the April 2002-March 2003 period, the annual number of calls to DACAS had again fallen from previous years, with 48 calls in total made to the service (although approximately 10 were of an administrative rather than information-related nature). In keeping with previous trends, the majority of calls were made by medical practitioners (47.8%), with some utilisation by nurses (13.0%), general alcohol and drug workers (13.0%), youth workers (4.3%), psychologists (4.3%) and other medical practitioners (4.3%). The majority of calls related to methadone (22.2%), alcohol (18.5%) and cannabis (18.5%), with smaller numbers relating to benzodiazepines (11.1%), and inhalants (7.4%). This represents an increase in the proportion of calls in relation to alcohol and cannabis in relation to the other drugs.

11.2 Overdose

While all but two participants included in the IDU sample reported that they had ever used some form of opioid, only one third (34%) had ever experienced an opioid overdose (28 of these 34 individuals experiencing an overdose associated with heroin use, and 6 experiencing an overdose due to morphine), with only 5% having overdosed in the previous year (Table 43). Of those who had ever overdosed on either drug, the median number of times they had overdosed was twice (range 1-20 for heroin overdose, range 1-2 for morphine). Among those that had ever experienced an overdose, the median time since their last overdose was four and a half years prior to interview among those that had overdosed on heroin, and two years among those that had overdosed on

morphine. These overdose rates are substantially lower than those reported in other jurisdictions, with the proportion of IDU ever experiencing an opiate overdose in the 2002 IDRS over the national study sample (n=929) being 47% (47% on heroin, 3% on morphine), with 12% experiencing at least one overdose in the year prior to interview (11% on heroin, 2% on morphine). This discrepancy most likely reflects the different patterns of drug use in Hobart in comparison to these other states – while heroin use, (predominant in other jurisdictions) in the past six months was reported by around a quarter of the current IDU sample, use of pharmaceutical preparations of opioids was much more common (recently used by 89% of the sample), and this preference for pharmaceutical opioids where the dose of the drug is known reduces the likelihood of accidental overdose. These rates of personal experience of opioid overdose are all very similar to those identified in the 2002 IDRS survey.

Table 43: Reported experience of opioid overdose among the IDU sample (N=100)

	% of IDU in past month			
	2000 IDRS	2001 IDRS	2002 IDRS	2003 IDRS
Overdosed (ever)	31%	25%*	33%	34%: <i>28% heroin; 6% morphine</i>
Median times ever overdosed	twice	once	once	twice (heroin or morphine)
Overdosed (in last 12 months)	10%	8%	7%	4%
Administered naloxone (ever)	14%	13%	21%	19% (15% heroin)
Administered naloxone (<i>last 12 months</i>)	7%	3%	3%	3%
Witnessed an overdose (ever)	50%	54%	61%	65%
Median times ever witnessed overdose	twice	twice	twice	twice
Witnessed an overdose (<i>last 12 months</i>)	24%	51%	26%	34%

*Note: *All but one of these cases reported overdosing on heroin, rather than any other opioid. The varying case was a reported morphine overdose.*

Of note is that only half of those who indicated they had ever had an opioid overdose had ever been administered Narcan (47%). Narcan (naloxone) is a fast-acting opioid antagonist given to reverse the effects of opioids in the event of an overdose. However, three of the four IDU who reported an opioid overdose in the past 12 months had been administered Narcan in this period. Overall, those who had been administered Narcan reported a median period of 54 months since they were last administered the drug (range 0-480 months), similar to the figures for reports of experience of opioid overdose generally.

Sixty-five percent of the IDU respondents reported ever witnessing one or more overdoses (median = twice). Those respondents that had ever witnessed an overdose reported a median period of 12 months since they last experienced such an event (range 0-240 months). One-third (34%) of the participants reported witnessing an overdose in the 12 months prior to interview. These indicators represent substantially greater proportions of recent experience (26% witnessing an overdose in the 2002 cohort, 34% in 2003), and a reduction in the median time since an overdose was last witnessed (two years among the 2002 cohort, one year among the 2003 cohort) between the 2002 and 2003 cohorts.

The number of opioid related fatalities among those aged 15-44 years noted by the State Coroners office has remained quite small during the period 1988-2002 (Figure 17), these minimal figures rendering clear analysis of trends difficult. However, when the rate of deaths per million population are considered, it becomes clearer that there has been an increase in rates of overdose over time in Tasmania, from less than 10 deaths per million population prior to 1990 to over 30 deaths per million population in recent years.

To 1999, there was approximately an even sex distribution among these victims of opioid-related fatalities, although in 2000 the five fatalities related to four males and a single female, and in 2001 the figures reflect the death of two males and three females. The seven accidental deaths due to opioids in 2002 related to seven males and two females. With the exception of a single fatal overdose clearly associated with heroin use, the cases to 1999 largely relate to methadone or morphine. Benzodiazepines were also present in many of these cases²³.

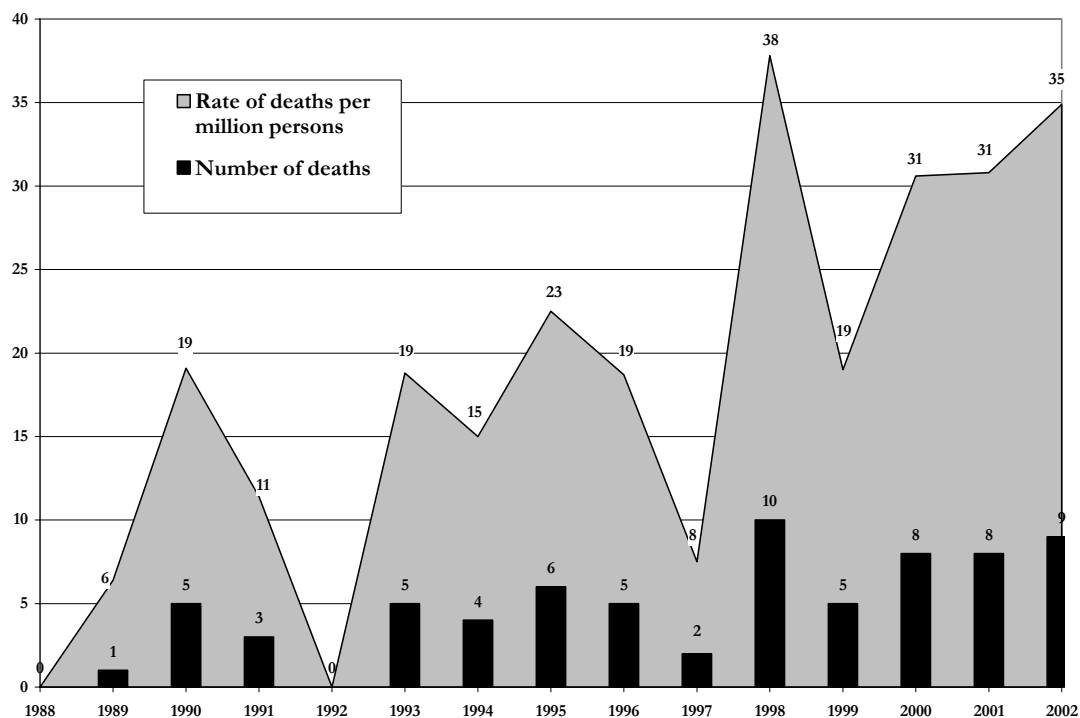


Figure 17: Number of opioid overdose deaths among those aged 15-44 years, 1988-2002

Source: Degenhardt (2001; 2002; 2003) and State Justice Department Coroners Office

²³ Toxicological and demographic detail for cases in 2000 and 2001 was not provided to the authors.

11.3 Blood borne viruses

Blood borne viruses, and in particular HIV/AIDS and hepatitis B and C are a major health risk for individuals who inject drugs. An integrated surveillance system has been established in Australia for the purposes of monitoring the spread of these diseases. The Department of Health and Human Services, Public Health Division, records notifications of diagnoses of HIV and hepatitis B and C in Tasmania, and, where possible, records the relevant risk factors for infection the person may have been exposed to. Table 44 indicates the number of cases of blood-borne virus infection recorded in the state between 1991 and 2003. In regards to the markedly increased incident (new) cases of hepatitis C infection between 1997 and 1998, this is likely to simply reflect improvement in the surveillance system. Following a marked dip in incident cases of hepatitis C between 2000 and 2001, reported incident cases of infection have only slightly increased, with 24 cases recorded in 2003. Reported unspecified (not new infections) infections in 2003, however, almost doubled from the 381 recorded in 2002 to 700 cases. This change is likely to reflect the impact of improved monitoring and enhanced awareness of hepatitis C following recent awareness projects in the state.

All incident cases of hepatitis C between 1996 and 2000 had injecting drug use as a recent risk factor for infection²⁴. However, no cases of HIV infection in the past seven years have had relatively recent injecting drug use as a risk factor for acquiring the infection.

Table 44: Rates of notifiable blood-borne viruses in Tasmania 1991-2003

Year	Blood-Borne Virus			
	Hepatitis C (incident)	Hepatitis C (Unspecified)	Hepatitis B (Incident) [#]	HIV (Incident)
1991	n/a	n/a	0	6
1992	n/a	n/a	0	10
1993	n/a	n/a	0	1
1994	n/a	n/a	0	5
1995	1	274	7	2
1996	5	291	8	7
1997	2	234	1	2
1998	18	275	5 (5)	2
1999	18	310	6 (5)	0
2000	31	335	18 (5)	1
2001	7	381	21	0
2002	15	381	19	n/a
2003	24	700	22	n/a

[#]Number of incident cases of hepatitis B infection where illicit drug use was present as a risk factor for acquiring the infection are presented in parentheses. 'n/a' refers to cases where either no data is available or where recorded data was not specifically broken into incident and unspecified cases. *Source: Communicable Diseases Network - Australia New Zealand - National Notifiable Diseases Surveillance System, and Public Health, Department of Health and Human Services; National Centre in HIV Epidemiology and Clinical Research (2002).*

²⁴ Such detailed information was not available to the authors for cases identified since 2001.

11.4 Sharing of injecting equipment among IDU

The sharing of needles, syringes and other equipment associated with the preparation or injection of drugs is important with respect to the risk of exposure to blood borne viruses such as HIV and hepatitis B and C. Clients of non-pharmacy Needle Availability Program outlets are routinely asked whether they have shared needles and syringes or other injection equipment since their last visit to the service.

Reported sharing of needles/syringes by clients of non-pharmacy Needle Availability Program outlets overall in Tasmania have shown a reasonably steady decline since 1995/96 (Figure 18). While data on recent sharing has not necessarily been uniformly recorded for every client transaction in these services, among those where information was collected, the reported proportion of clients recently sharing needles/syringes has declined from 2.63% of recorded transactions state-wide in 1995/96 to just 0.63% in 2002/03. Following a similar overall trend to that of sharing of needles and syringes, reported rates of sharing of other injection equipment (such as spoons, mixing containers or tourniquets) has steadily declined from 5.48% of all recorded client transactions state-wide in 1996/97 to 0.42% in 2002/03 (Figure 19).

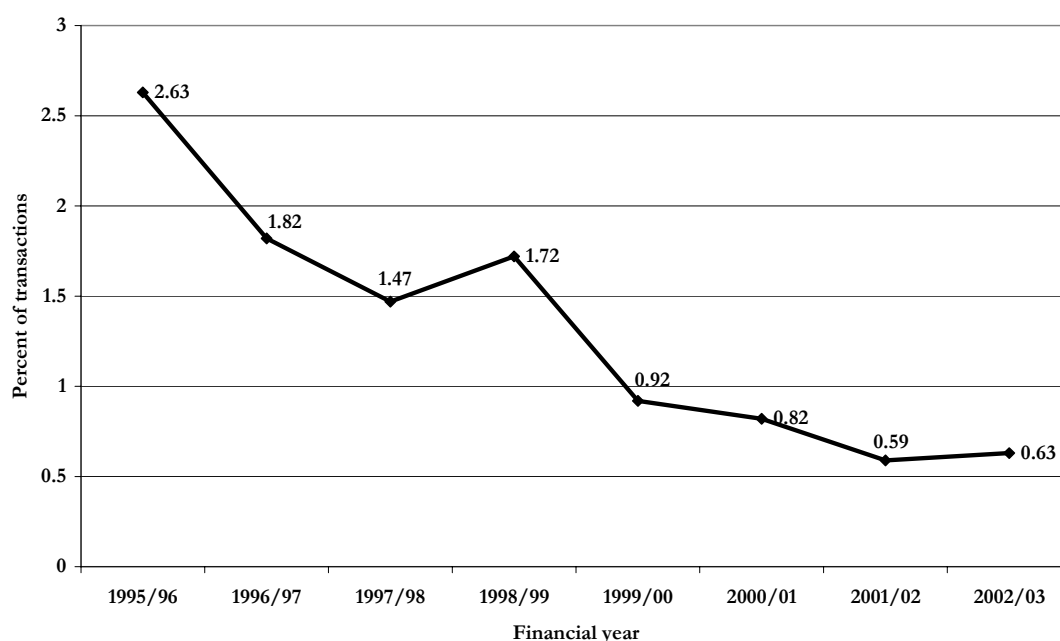


Figure 18: Reported sharing of needles and syringes by non-pharmacy Needle Availability Program clients 1995/96-2002/03

Source: Sexual Health, Department of Health and Human Services

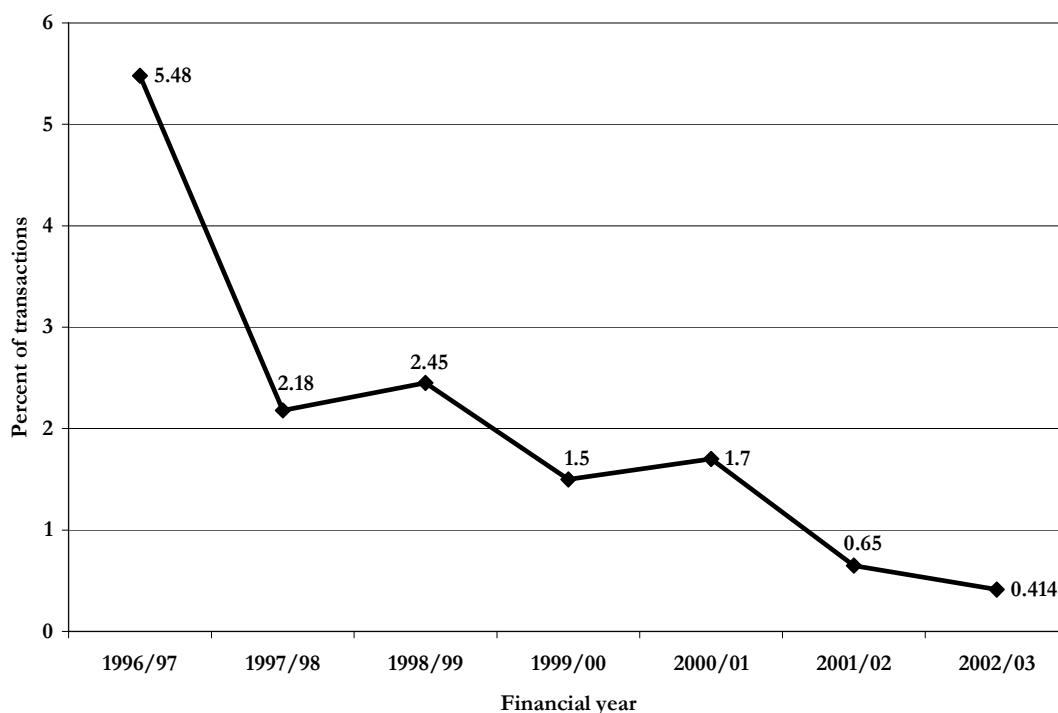


Figure 19: Reported sharing of other injection equipment by non-pharmacy Needle Availability Program clients 1995/96-2002/03

Source: Sexual Health, Department of Health and Human Services

Among the 2003 IDU sample, only three respondents reported lending a used needle/syringe to others in the month prior to interview, a clear decline from the 12% of the 2000 sample (Table 45). Among these samples of regular injecting drug users in Hobart, the proportion of respondents reporting using a needle/syringe after it had been used by someone else had remained stable at 10% of the 2000-2002 samples, dropping to 6% of the 2003 cohort (Table 45). While declining, this level of recent sharing of needles among a regular injecting cohort is substantially greater than that seen in the NAP client data. All of those in the 2003 cohort who had injected with a used needle/syringe reported that only one other person had used the syringe prior to them. People who had used the syringe previously were reported to be a regular sexual partner (n=2), close friends (n=2), and acquaintances (n=2).

Similar to the reported sharing of needles/syringes, respondents reported quite a low rate of sharing of other types of injecting equipment, with 87% not sharing any form of injection equipment in the month prior to interview. By far, tourniquets were the most commonly shared item (11%), with single IDU reporting sharing spoons/mixing containers and filters, and just two sharing waters. While sharing of any equipment during the injection process puts IDU at risk of exposure to blood-borne viruses, these low reported rates of sharing of both needles and other equipment indicate a good awareness of safe injection practices amongst IDU.

When the reported rates of sharing of injection equipment for the 2000 and 2001 Tasmanian IDU samples are compared, there appears to have been a substantial drop in sharing between these groups. While a portion of this change may be due to a change in

definition of ‘sharing’ between the two surveys²⁵, the continuation of this decline into the 2002 and 2003 studies adds weight to the veracity of the indications of a reduction in risky injection practices among IDU.

Table 45: Proportion of the IDU sample (n=100) reporting sharing of injection equipment in the month prior to interview

Injection equipment sharing	% of IDU in past month			
	2000	2001	2002	2003
	IDRS %	IDRS %	IDRS %	IDRS %
Borrowed used needles	10	10	10	6
Lent used needle to others	12	6	1	3
Shared spoons/mixing container	53	5	1	1
Shared water	35	7	1	2
Shared filters	32	3	1	1
Shared tourniquets	29	10	14	11

11.5 Injection related health problems

There was a substantial rate of injection-related problems reported by the IDU surveyed, with 76% reporting at least one such problem in the preceding month (Table 46). This rate of experience of injection-related health problems is commensurate with those identified across the national sample of IDU in the 2002 IDRS (68%, n=929), despite the lower frequency of injection of the Tasmanian IDU sample in comparison to these states (only 17% of the Tasmanian IDU sample reported injecting once a day or more frequently, in comparison to 47% of IDU in the 2002 national sample). This is likely to reflect the increased harms associated with the injection of pharmaceutical products by Tasmanian IDU, relative to drugs such as heroin, which are more freely available in these other states. Pharmaceutical products such as morphine tablets are often covered with a waxy film that cannot be completely removed in the preparation of the drug for injection, such waxy build-ups potentially damaging injection sites, and other pharmaceuticals such as Normison (temazepam) have been specifically designed to not be amenable for injection. Accordingly, the most commonly reported problems among the Tasmanian IDU were scarring/bruising of injection sites and difficulty injecting, indicating vascular damage. Noteworthy in this data is that reported rates of thrombosis (coagulation of blood in a blood vessel) which have been reported as greater amongst Tasmanian IDU samples than the national sample in 2000 and 2001, dropped to a level beneath the national average in 2002 (5% in Tasmanian IDU, 9% in the 2002 national sample), before returning to 10% in 2003. However, perhaps a relative benefit of the Tasmanian culture of injection of pharmaceutical products is the low rate of experience of overdose in comparison with other jurisdictions (0% in the 2000-2003 Tasmanian samples, in comparison to 10% of the 2000 national sample, and 3% of the 2002 national sample) due to the fact that users can be more confident about the purity and quantities

²⁵ In the 2000 IDRS survey, interviewers recorded practices such as individuals using the same mixing container but drawing from it using individual sterile syringes as ‘sharing’ as such behaviour is not recommended as part of safest injection practice. In 2001, interviewers only recorded sharing if there was clear risk of exposure to blood-borne viruses – for example, the aforementioned scenario would not be classified as sharing, but double-dipping in a shared injection mix or using another person’s uncleaned tourniquet or spoon would be classified as sharing.

of opioids they are using, and hence can tailor their use according to their level of tolerance.

Table 46: Injection-related health problems reported by participants in the IDU survey in the month prior to interview (n=100)

Injection-related health problems	% experiencing the problem in the last month			
	Tasmanian IDRS 2000 (n=100) %	Tasmanian IDRS 2001 (n=100) %	Tasmanian IDRS 2002 (n=100) %	Tasmanian IDRS 2003 (n=100) %
Scarring/bruising	59	42	53	49
Difficulty injecting	50	48	48	51
Thrombosis	18	21	5	10
“Dirty Hit”	15	31	18	31 [#]
Infections/abscesses	9	9	8	8
Overdose	0	0	0	0
At least one injection-related problem	78 (range 1-5, median 2*)	72 (range 1-5, median 2*)	72 (range 1-5, median 2*)	76 (range 1-5, median 2*)
Median injection frequency	More than once per week	More than once per week	More than once per week	More than once per week
% injecting daily	31	29	29	17

*for those noting injection-related problems; [#]83% of these were due to methadone injection; 10% to morphine and 7% attributed to methamphetamine.

Comparing rates of recent injection-related problems for the 2002 and 2003 Tasmanian IDU samples, most levels appear to have remained relatively stable, with a few notable exceptions. Reported rates of scarring/bruising, and difficulty finding veins, both indicative of vascular damage, had remained stable between 2002 and 2003. Rates of experience of ‘dirty hits’ and thrombosis, in contrast to the changes seen between 2001 and 2002, had increased between the 2002 and 2003 cohorts. Experience of a ‘dirty hit’ - feeling physically unwell soon after injection - is commonly due to the injection of contaminants or impurities. In the 2002 cohort, this experience was not closely associated with the injection of any particular substance (such as reflecting the use of a particular cutting agent): of the 18 IDU reporting recent experience of ‘dirty hits’, 8 reported this to have been associated with the injection of methadone, 6 with morphine, and 4 with methamphetamine. However, in the current cohort, this was clearly associated with the injection of methadone, with 83% of these cases attributed by IDU as relating to methadone injection, 10% to injection of morphine and 7% to methamphetamine. Commonly, IDU suggested that this was due to non-sterile water being used for the dilution of methadone syrup. In keeping with this suggestion, in the 2002 study, one key informant, a methadone prescriber with a large client base, noted an increasing number of people feeling ‘sick’ from injection of methadone syrup, which they suggested as possibly due to the increased dilution of these doses in 2001.

The majority of key informants noted no substantial changes in the experience of injection-related problems amongst the substance-using groups they had contact with in

the preceding six months. However, two key informants, both medical specialists in Alcohol and Drug work seeing a large number of individuals, noted recent increases in injection-related complications in the preceding six months. In particular, an increase in lung problems among 'older' males (40 years and above), and strokes, both reflecting damage from particulate matter or clots travelling through the venous system.

11.6 Mental health problems

As there exists a substantial body of work identifying increased rates of mental health issues among those who use illicit drugs, IDU participants were asked if they had attended a health professional for a mental health problem (other than drug dependence) in the six months prior to interview (Table 46a).

While attendance to a health professional for such issues is likely to underestimate the real prevalence of mental health problems in this group (as it is common for many people not to seek help for these issues), a relatively high proportion of IDU reported recently presenting to services for mental health concerns. Approximately one-quarter of IDU participants (28%) had recently attended some professional for a mental health issue. The majority of these individuals had presented to a general practitioner for assistance (20%; Table 46a) rather than a dedicated mental health professional (14%). Both these proportions are similar to those seen in the 2002 study.

The most common, self-reported, reason for seeking support among IDU was depression (18% of respondents), followed by anxiety and anxiety-related issues (e.g. panic attacks: 14%). In keeping with trends reported by key informants in relation to the recent increase of high-potency crystalline methamphetamine use among IDU cohorts, self-reported presentations for paranoia and anxiety (both symptoms commonly seen on over-use of methamphetamine) had clearly increased between the 2002 and 2003 cohorts. Reported presentations for anxiety had increased from 4% in the 2002 cohort to 12% in the current study, and presentations for paranoia had similarly increased from 1% in 2002 to 4% in 2003. Reported rates of presentations for most other issues had remained stable across the 2002 and 2003 cohorts. While the proportion presenting for psychosis and related problems (psychotic episodes, schizophrenia, drug induced psychosis) was substantially lower than that for mood disorders, this proportion (4% of each of the 2002 and 2003 samples) is clearly greater than that experienced among the general population (1%).

Table 46a Proportion of IDU participants attending a health professional for a mental health problem other than addiction in the six months prior to interview.

	2002 IDRS	2003 IDRS
	%	%
<i>% attending a health professional for a mental health problem in past six months</i>	25	28
<i>% attending GP</i>	16	20
<i>% attending mental health professional</i>	12	14
<i>Specific mental health problems experienced</i>		
<i>Depression</i>	15	18
<i>Bipolar</i>	2	4
<i>Anxiety</i>	4	12
<i>Panic</i>	3	2
<i>Paranoia</i>	1	4
<i>Schizophrenia / psychosis</i>	4	4
<i>Obsessive-compulsive disorder</i>	1	-
<i>Attention deficit hyperactivity disorder</i>	2	2
<i>Anger management</i>	2	1
<i>Personality disorder</i>	3	-

11.7 Criminal and police activity

Half (52%) of the IDU respondents reported involvement in some type of criminal activity in the preceding month (Table 47), a level that is commensurate to that reported by IDU in previous IDRS studies (55% of IDU in the 2002 national sample, $n=929$, Breen et al, 2003). The most commonly reported crimes were dealing of drugs (32%) and property crime (22%), with relatively few respondents reporting involvement in violent crime (5%) or fraud (3%). Most IDU reporting involvement in criminal activity in the month prior to interview indicated that they had engaged in such activities less than once per week. However, substantial proportions reported more frequent recent involvement in dealing (7% daily, 10% more than once per week, 10% weekly, 5% less than weekly) and property crimes such as stealing or shoplifting (2% daily, 7% more than once per week, 10% once per week, 13% less than once per week). Forty-six percent of IDU respondents had been arrested in the previous twelve months. The most common grounds for arrest were property crime (21%) or violent crimes (5%), and miscellaneous charges such as outstanding warrants (5%), failure to appear (4%), or drunk and disorderly (5%). Only a very small proportion of respondents had been arrested in the past year for possession (2%), fraud (3%), or drugs and driving (3%). Despite the high level of reported recent involvement in dealing, none of those interviewed reported being arrested for dealing in the year prior to interview.

On examination of rates of reported criminal activity in the 2002 and 2003 Tasmanian IDRS samples (Table 47), there appears to have been little change in crime rates between these surveys, with the exception of slightly increased rates of involvement in, and arrests for, fraud (both increasing by around 3% between the 2002 and 2003 samples), and slightly decreased rates of reported involvement in, and arrests for, property crimes and violent crimes.

Among the key informants interviewed, most considered rates of property crime to have remained stable among the substance-using groups that they were associated with in the preceding six months ($n=17$). However, nine key informants perceived increases in the level of property crime in this time, most commonly in terms of opportunistic, unplanned crimes, such as shoplifting ($n=5$) or bag-snatching ($n=2$). A similar pattern was found for rates of dealing among individuals that key informants were familiar with, with 14 key informants perceiving the level of dealing to have remained stable in the preceding six months, and six perceiving an increase in this time. These key informants noted that dealing had increased, particularly among younger individuals, to support their personal substance use ($n=3$), although there were single key informant reports of seeing more dealing of ecstasy in nightclubs, more dealing from cars, and more 'middle class' dealers. Only a single key informant perceived any increase in the level of fraud amongst their client groups (with six perceiving no change in the preceding six months). Finally, there was an even balance between key informants perceiving no recent changes to the level of violent crimes among their client group in the preceding six months ($n=8$), and those perceiving an increase in this time ($n=8$). Where increases were perceived, this was noted as relating to dealers following up drug debts ($n=2$), intimidation to access take-away doses of methadone ($n=2$), out-of-character incidents (such as domestic violence) related to methamphetamine use ($n=2$), and being more common among younger individuals ($n=2$).

Table 47. Reported criminal activity among IDU (n=100)

Activity	2000 IDRS %	2001 IDRS %	2002 IDRS %	2003 IDRS %
<i>Crime (% in last month)</i>				
Dealing	49	41	34	32
Property crime	18	23	28	22
Violent crime	10	4	6	5
Fraud	5	4	2	6
<i>Any crime</i>	<i>64</i>	<i>56</i>	<i>50</i>	<i>52</i>
<i>Arrested last 12 months (%)</i>				
Arrested for property crime	16	13	25	21
Arrested for use/possession	9	1	9	2
Arrested for violent crime	6	9	14	5
Arrested for fraud	2	0	0	3
Arrested for dealing/trafficking	1	2	1	0
Arrested for driving offence	*	4	5	2
Arrested for alcohol and driving	*	2	2	1
Arrested for drugs and driving	*	0	3	3
Arrested for other reason	10	17	8	16

**Note: Comparable data for these cells was not gathered in the 2000 IDRS study*

11.8 Perceptions of police activity

Respondents were asked a number of questions regarding their perceptions of changes in police activity in the past six months and the impact of these changes (Table 48). Among those IDU that felt confident in providing a response, 31% believed that police activity had remained stable, and 25% reported an increase in police activity in this time. However, most had not experienced any reduction in their ability to purchase drugs by any recent changes in local police activity (76%). Recent ‘busts’ of dealers, specifically dealers of morphine (n=4), cannabis (n=4) and methamphetamine (n=4) were noted by IDU. Increases in proactive policing approaches in recent months were also noted by several IDU, such as increased surveillance of dealer’s homes (n=3), more patrolling of common injection sites (such as particular parks or city locations: n=2), and more searching of users (n=4).

Table 48: Perceptions of police activity among IDU

Question	%
<i>Have there been changes in police activity in the last six months?</i>	
More activity	25
Stable	31
Less activity	1
Don’t know	43
<i>Has police activity made it more difficult to buy drugs recently?</i>	
Yes	19
No	76
Don’t know	5

Key informants reported similar perceptions of police activity, with a substantial proportion of those that could confidently comment (55%, n=16) reporting no recent changes in police activity toward the users they came into contact with. Several key informants noted changes in police activity in the preceding six months, in regard to increased vigilance around methadone maintenance collection points (n=1), and a perception of an increased focus on methamphetamine and ecstasy over morphine in response to the trends of increased use of these drugs (n=2).

Similar to trends noted in previous years, five key informants noted an increase in a more ‘community policing’-based approach to substance users, with police preferring to educate or counsel users through the diversion program (discussed below) than involve them further in the criminal justice system. Additionally, three key informants involved in the alcohol and other drug sector noted an increased collaboration with police in the preceding six to twelve months.

Such an approach by police is likely to reflect their investment in early intervention to help deflect first time offenders away from the criminal justice system. In July 1998, Tasmania Police introduced a Cannabis Cautioning Program, which gave police officers the discretion to caution first-time minor cannabis offenders. Following a successful trial of the program, the eligibility criteria for cautioning were expanded to include consideration of non-first time offenders (ABCI, 2001). In March 2000, under a series of

initiatives funded by the Council of Australian Governments, the program was further adapted within the Tasmanian Early Intervention and Diversion Framework. This current diversion model now extends to cover individuals who have been apprehended for no more than three offences in the past ten years, and follows a three-tiered approach to diversion.

Individuals with a first minor cannabis offence are cautioned and provided with health and legal information, as well as contact details of referral and treatment services, and do not receive any criminal record. Second-time offenders are cautioned and diverted into a brief face-to-face intervention with a health professional. Again, there is no criminal conviction, however if they fail to attend the brief intervention the individual is prosecuted for the drug offence. Third-time offenders are cautioned and diverted directly to assessment and treatment through the Department of Health and Human Services Alcohol and Drugs Service. Charges are not pursued providing attendance and compliance with the requirements of treatment as assessed. In the case of a first offence with an illicit drug other than cannabis, individuals are immediately diverted to the third tier of diversion (as per third time cannabis offenders). This initiative appears to be increasingly well supported by Tasmania Police, as there has been a steady rise in the number of cautions or diversions issued since the inception of the new diversion system (Table 49).

Table 49: Drug diversions or cautions issued by Tasmania Police 1999-2002

	Jul- Sept 2000	Oct- Dec 2000	Jan- Mar 2001	Apr- Jun 2001	Jul- Sept 2001	Oct- Dec 2001	Jan- Mar 2002	Apr- Jun 2002	Jul- Sept 2002	Oct- Dec 2002	Jan- Mar 2003	Apr- Jun 2003
Number of cautions / diversions statewide	161	147	213	243	242	238	274	224	235	280	189	286
% diversions in Southern district	52	39	54	44	42	36	39	43	41	37	32	44
Number diverted to health intervention statewide#	20	30	46	55	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	64 (34)	51 (24)	61 (27)	87 (46)
% health intervention diversions in South†	20	50	39	56	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	35	25	48	59

Source: Tasmania Police State Intelligence Services Statewide Illicit Drug Reports; Alcohol and Drug Service
*Note: These figures may differ from data submitted to the Australian Crime Commission if the decision to charge persons was altered to a caution after the figures were forwarded to State Intelligence Services. *This data refers to the period March-June 2000. 'n/a' refers to cases where the relevant data was not provided to the authors; #Data in parentheses represent the number of individuals diverted to health interventions that complied with the request.; †Proportions relate to the percent of those that complied with the diversion request in the southern region.*

Data pertaining to drug-related arrests in Tasmania in between 1995/96 and 2002/03 are shown below in Table 50. This data illustrates a marked increase in arrests for methamphetamine-related offences for 2000/01 and 2001/02 (declining slightly in 2002/03) in comparison to previous years, a trend consistent with reports of increasing

availability and use of methamphetamine in the state. The steady increase in cannabis-related arrests may simply reflect the increase in utilisation of ‘official’ cautions and diversions by Tasmania police (which are included in these statistics) over ‘unofficial’ warnings, which would not be recorded in these statistics.

Table 50: Number of arrests (including cautions and diversions) for cannabis, methamphetamine, opioid and cocaine related offences in Tasmania, 1995/96-2002/03

Type of offence	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Cannabis	2518	1079	1196	736	799	1050	1540	1863
Methamphetamine	42	20	15	7	28	70	89	65
Opioids	41	28	16	25	9	9	34	7
Cocaine	0	0	0	0	0	4	1	0

Source: Australian Illicit Drug Reports 1995/96-2000/01, Australian Bureau of Criminal Intelligence (now the Australian Crime Commission), and Tasmania Police State Intelligence Services Statewide Illicit Drug Reports.

Note: 2001/02 data is provisional and is based on data provided to State Intelligence Services, which may differ from official statistics and counting rules used by the Australian Crime Commission (formerly ABCI)

Table 51 below indicates the proportion of arrests for offences relating to the possession or use of illicit drugs (consumer offences) as opposed to supply-type (provider) offences. Between 2001/02 and 2002/03, there appears to have been an increase in the proportion of consumer offences for both cannabis and opioids. This is mirrored in terms of the increased number of persons for consumer type offences both before the Hobart Magistrates Court and among those imprisoned on drug-related offences in this period (Table 52). While such changes are likely to relate to multiple issues, given that approximately just half of the individuals diverted to health interventions in 2002/03 complied with this offence (Table 50), this level of non-compliance to the diversion initiative may be contributing to this trend.

The proportion of consumer offences for methamphetamine, however, appear to have declined in 2002/03, continuing the trend seen in 2000/01 and 2001/02, which is more reflective of Tasmania Police’s focus towards suppliers (Table 51). Between 2001/02 and 2002/03, there have been increases in the number of individuals before the Hobart Magistrates Court, the Supreme Court of Tasmania and placed in prison for supply-type offences (Table 52).

Table 51: Consumer arrests (including cautions and diversions) for cannabis, methamphetamine and opioid-related offences as a proportion of all drug-related arrests in Tasmania 1996/97-2002/03

Drug Type	% consumers						
	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
Cannabis	49	76	93	88	96	72	96
Methamphetamine	90	100	86	71	86	79	72
Opioids	86	94	96	78	89	68	86

Source: Australian Illicit Drug Reports 1995/96-2000/01, Australian Bureau of Criminal Intelligence (now the Australian Crime Commission), and Tasmania Police State Intelligence Services Statewide Illicit Drug Reports.

Note: 2001/02 data is provisional and is based on data provided to State Intelligence Services, which may differ from official statistics and counting rules used by the Australian Crime Commission (formerly ABCI)

Table 52: Number of individuals before Tasmanian courts or imprisoned on drug charges, 1996-2003

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

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

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

11.9 Doctor Shopping

Since a significant proportion of illicit drug use in Tasmania involves abuse of pharmaceutical products, patterns of doctor shopping in the state were reviewed. The Health Insurance Commission identifies people as “doctor shoppers” if, in one year, a person: 1) sees 15 or more different general practitioners; 2) has 30 or more Medicare consultations, and 3) obtains more Pharmaceutical Benefits Scheme (PBS) prescriptions than appears to be clinically necessary.

Following national trends, the number of identified doctor shoppers in the state has declined over the past five financial years, from 184 in 1995/96 to 134 in 2000/01 (Table 54). Amongst the group of identified doctor shoppers in 2000/01, benzodiazepines were the most commonly accessed medication, followed by codeine-based compounds and narcotic analgesics. It is notable that the number of identified doctor shoppers accessing each of these drug types increased between 2000/01 in comparison to the numbers accessing in 1999/00. It is unclear at this stage whether this represents a trend toward increases in doctor shopping or if this simply relates to changes in identification or reporting processes, and as such is an issue that merits attention in coming years.

The largest number of scripts obtained by identified doctor shoppers was also for benzodiazepines. However, it should be noted that, while the median number of scripts for both benzodiazepines and codeine compounds obtained by Tasmanian doctor shoppers has remained fairly stable over the past four financial years (or have possibly declined, in the case of benzodiazepines), the median number of prescriptions for narcotic analgesics per doctor shopper has been steadily increasing. Since 1995/96, median prescriptions for narcotic analgesics has more than doubled from 9 scripts per doctor shopper, to 22 in 2000/01, with a concomitant increase in the range of the number of scripts accessed (Table 54).

Data from the IDU survey suggests that, despite the high level of misuse of pharmaceutical products among the regular IDU cohort in the current study, doctor shopping is not a common mode of access to these drugs. In regard to benzodiazepines, only a single IDU reported accessing these drugs through faking symptoms, and none of the IDU participants had forged prescriptions or altered existing prescriptions to access benzodiazepines in the preceding six months. Similarly, there were only single IDU reports of accessing MS Contin, Kapanol or Endone, and two individuals accessing Physeprone from a medical practitioner in the preceding six months, with the majority of these cases being legitimate access due to pain-related conditions. This situation has remained consistent across all four Hobart IDRS studies. It appears that the level of availability of pharmaceutical opioids and related substances from illicit sources currently is at such a level that IDU do not feel compelled to resort or rely on doctor shopping to access these drugs. Given the Hobart illicit drug market’s level of reliance on pharmaceutical opioids, it is possible that a substantial decline in this level of illicit availability may induce an increase in doctor shopping in order for IDU to access these drugs. As such, patterns of doctor shopping in the state, while currently appearing to not a major issue among IDU, merit continued close monitoring.

Table 53: Doctor shopping patterns in Tasmania 1995/96-2000/01

	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01
Number of doctor shoppers enrolled nationally	9,931	10,296	9,738	9,348	8,780	8,179
Number of doctor shoppers enrolled in Tasmania	184	183	162	146	104	134
<u>Benzodiazepines</u>						
<i>Number of Tasmanian doctor shoppers accessing</i>	173	169	155	140	98	127
<i>Median scripts per doctor shopper</i>	13	14	30	37	27	29
<i>25-75 percentile of accessed scripts</i>	5-30	7-31	14-56	20-62	12-54	11-48
<u>Narcotic Analgesics</u>						
<i>Number of Tasmanian doctor shoppers accessing</i>	96	95	101	81	61	79
<i>Median scripts per doctor shopper</i>	9	8	15	16	26	22
<i>25-75 percentile of accessed scripts</i>	4-29	3-17	3-52	4-50	11-63	4-52
<u>Codeine Compounds</u>						
<i>Number of Tasmanian doctor shoppers accessing</i>	155	148	133	113	81	105
<i>Median scripts per doctor shopper</i>	9	9	14	14	9	12
<i>25-75 percentile of accessed scripts</i>	3-20	4-21	5-37	4-37	4-31	4-37

*Source: Professional Review Division, Health Insurance Commission
2001/02 and 2002/03 data was not available at the time of printing.*

11.10 Summary of Drug-Related Issues

Overdoses

- The number of opioid related fatalities among those aged 15-44 years noted by the State Coroners office has remained reasonably low during the period 1988-2002, however, in this time the number of deaths has increased from less than 10 deaths per million population to over 30 deaths per million population in recent years
- Despite high levels of opioid use among regular injecting drug using cohorts in Hobart, recent experience of non-fatal overdose is very low among these groups

Blood Borne Viruses

- With the exception of a marked dip in incident cases of hepatitis C between 2000 and 2001, both reported incident and unspecified (not new infections) cases of hepatitis C appear to have slowly increased between 2001 and 2003.

Sharing of Injection Equipment

- Self-reported rates of sharing of needles or syringes among non-pharmacy Needle Availability Program clients state-wide have declined from 2.6% of all transactions in 1995/96 to 0.63% in 2002/03
- However, all IDRS studies in Hobart have suggested that 5-10% of these cohorts share used needles or syringes at least once in a month
- Self-reported rates of sharing of other injection equipment among non-pharmacy Needle Availability Program clients state-wide have declined from 5.5% of all transactions in 1996/97 to 0.4% in 2002/03. Among IDRS cohorts, tourniquets remain the most commonly shared item as per trends in preceding years.

Injection Related Problems

- A substantial proportion of IDU surveyed experience injection-related health problems, at a relative rate greater than those seen amongst IDU in other jurisdictions, possibly due to the increased harms associated with the injection of pharmaceuticals
- Scarring, difficulties finding veins to inject into (indicative of vascular damage) and experience of 'dirty hits' (feeling physically unwell soon after injection, often associated with the injection of contaminants or impurities) were the commonest injection related problems experienced by the current IDRS IDU cohort

Mental Health Comorbidity

- Approximately one-quarter of the IDRS IDU participants reported presenting to a health professional for a mental health issue in the preceding six months. This rate of presentations is substantially greater than that seen in the general population.

Crime

- Approximately 50% of the IDRS IDU self-reported involvement in some form of criminal activity in the month prior to interview, a level similar to that seen in IDRS IDU samples in other jurisdictions. Crimes most commonly reported were drug dealing, and, to a lesser extent, property crime (such as shoplifting or burglaries). Self-reported involvement in property crime and violent crimes among the current IDU cohort has decreased slightly from the 2002 sample

12 SUMMARY

As a whole, the patterns of drug use identified in the 2003 IDRS generally reflected continuations or stabilisations of those identified in the 2002 report (Bruno & McLean, 2003). Summaries of major trends for each drug class are reported below by drug type.

12.1 Heroin

While the availability of heroin in the state appeared to have been slowly increasing during 1999 and 2000, data from the 2001 and 2002 IDRS studies suggested that the drug was becoming increasingly difficult to access locally. Indicators from the current study suggest that the decline has halted and availability of the drug has stabilised at a low level. Recent use of heroin was seen in just 26% of the IDRS IDU sample, despite the fact that 41% regarded it as their drug of choice. Use of heroin among clients of the state's Needle Availability Program remained below 2% of all client transactions in 2002/03.

The small number of participants that could report prices for heroin indicated that the drug was purchased for \$50 per 'packet' (approximately 0.1g) and \$350 per gram; similar prices to those reported in previous IDRS studies. As further evidence of a low availability of the drug locally, the majority of individuals that had recently used the drug reported it as 'difficult' or 'very difficult' to access and Tasmania police have not made any seizures of heroin in the past two financial years.

12.2 Methamphetamine

Over the past three years of the IDRS in Hobart, higher-purity forms of methamphetamine have steadily increased in availability in the state. This easy availability of high-potency forms of the drug may have made use of methamphetamine particularly attractive among IDU, with almost all of those surveyed in the current study using some 'form' of the drug in the six months prior to interview (89%), despite the participants predominantly preferring opioids (64%). Moreover, the proportion of clients of the state's Needle Availability Program reporting predominant use of methamphetamine has steadily increased from 31% of recorded transactions (almost 3,000 cases) in 2000 to 50% in 2003 (almost 15,000 transactions).

In terms of the 'forms' of methamphetamine used among the IDU cohort, the traditional low-purity powder form, which reports from Tasmania police suggest remains the most common form of the drug available in the Tasmanian market, was used by approximately half of the IDU participants in the current study. However, a major change was seen this year in the level of availability of the higher-potency forms of the drug. Among the 2002 IDRS IDU participants, the 'form' of methamphetamine most commonly used was the waxy, sticky, gel-like 'base/paste' presentation of the drug, used by 74% of the cohort. In 2003, this was used by less than half of the respondents (46%). Instead, it appears that the availability of the particularly high purity form, crystalline methamphetamine ('crystal meth' or 'ice') has substantially increased in 2003, and has become the form most commonly used among the IDU cohort in the current study. In the 2002 study, just 20% of the IDU cohort had recently used this form of the drug, however, in the 2003 study, 69% had recently used crystal methamphetamine.

IDU reported all forms of methamphetamine to be easily available in the preceding six months. Indeed, both IDU and key informants regarded the ready availability of relatively high potency methamphetamine (crystal methamphetamine in particular) as responsible for anecdotal descriptions of an increasing number of people using methamphetamine, particularly among younger individuals (mid teens to twenty years), in recent months. There were also continued anecdotal suggestions of methamphetamine attracting opiate users away from that market.

However, with the greater availability and use of higher purity methamphetamine came anecdotal suggestions of increases in the negative effects of methamphetamine use, such as paranoia and agitation, among IDU. Moreover, both key informants and IDU reported concerns around recent anecdotal reports of deaths due to heart failure associated with excessive crystalline methamphetamine use. While such information is yet to be verified, it is clear that, with these indications of expanding levels of availability and use, careful monitoring of both the methamphetamine market and the impacts on the physical and mental health of users is warranted in the coming years.

12.3 Cocaine

It appears that the availability and use of cocaine in Hobart continues to be very low, at least within the populations surveyed in the current study or accessing government services. This low availability of the drug locally is supported by similar low levels of use reported in a recent sample of 100 regular ecstasy users in Hobart (Bruno & McLean, 2004). Only a very small proportion of the IDRS IDU sample reported recent use of the drug (9%), which was almost exclusively a powder. By the few IDUs who could comment on trends in availability, cocaine was considered difficult to access, a situation that was considered stable in the preceding six-month period. The cocaine that is used by Tasmanian IDU appears generally to be imported in small quantities by users directly from dealers in mainland states. Tasmania Police made no seizures of cocaine in 2002/03, following single seizures in the preceding two financial years. These patterns of low levels of availability seem to have remained reasonably stable over the past few years, however, it is noteworthy that increasing proportions of the Tasmanian IDU sample over the past three years have reported lifetime use (39%, 47% and 52% in the 2001, 2002, and 2003 surveys respectively) of cocaine.

12.4 Cannabis

Most aspects of the cannabis market and patterns of use appear to be relatively stable. Among the IDU surveyed, cannabis use continued to be almost ubiquitous, with 88% using the drug in the preceding six months, and the majority of these individuals using the drug daily. IDU regarded purchase prices of cannabis as remaining stable in the preceding six months. Most common purchase amounts were \$10 per gram, \$60 per quarter-ounce (7g) and \$150 per ounce (28g) for outdoor-cultivated cannabis, and slightly higher for indoor or hydroponically cultivated cannabis, at \$25 per gram, \$80 per quarter-ounce (7g) and \$300 per ounce (28g).

Hydroponically-cultivated cannabis head remains the form most commonly smoked by IDU, (80% of those who used cannabis), although substantial proportions also reported using both hydroponically-grown (95%) and outdoor cannabis (89%) in the preceding six months. In concert with this, intelligence reports from Tasmania police in recent years have indicated an increasing trend toward hydroponic cultivation of the drug, with

increasing proportions of cannabis seizures being indoor or hydroponic in origin, and reports from all three state Drug Investigation Services branches suggesting that outdoor plantations of cannabis seem to be on the decrease.

IDU generally regarded cannabis as 'easy' or 'very easy' to access, and most commonly purchased cannabis through friends in the preceding six months. In alignment with this, when asked about the cultivator of their purchases, the majority (52%) believed it to have been grown by small-time 'backyard' user/growers, rather than cultivated by larger scale suppliers (for example, a 'crime syndicate': 31%).

12.5 Opioids

Overall, patterns of use and availability of other opioids such as morphine and methadone seem to have generally remained stable since the 2000 IDRS, with 72% of the current IDU sample using morphine and 85% methadone in the six months prior to interview. However, emerging trends noted in previous years within this class of drugs have continued into 2003. The median frequency of use of morphine in the preceding six months within the 2003 IDU sample continued to decline from previous studies, falling from 52 days in the 2000 study, 31 days in 2001, 24 days in 2002 to just 21 days among the current cohort. Perhaps balancing this decline in frequency of use of morphine, the proportion of the IDRS IDU samples using Physeptone (methadone) tablets has steadily increased across the past four annual surveys (used by 30% of the IDU sample in 2000, 42% in 2001, 56% in 2002 and 64% in 2003). There does not appear to be any substantial increase in the diversion of methadone syrup. In support of this, illicit access to methadone was more commonly via Physeptone tablets than through diverted methadone syrup.

MS Contin remains the most commonly used formulation of morphine, although reported use of Ordine, a liquid preparation of the drug, appears to have been increasing over the past four years. Virtually all of those using morphine or methadone tablets had accessed these substances from illicit sources in the six months prior to interview, indicating that access to these products is primarily not coming via doctor shopping from the users themselves.

While some key informants noted a decrease both in benzodiazepine use and injection amongst opiate-using groups, of concern were IDU reports of increasing use of methadone syrup and alprazolam simultaneously (in the same syringe) and a return of a similar pattern of use of methadone syrup and temazepam gel capsules combined. This method of use is of considerable concern, not solely due to the deleterious effects of injection of benzodiazepines but also due to the increased risk of overdose on use of multiple central nervous system depressant drugs. Given anecdotal reports of two recent deaths associated with coincident methadone and alprazolam use, this pattern of use merits careful attention in the coming months, particularly from front-line health intervention workers.

Continuing the trend seen in the past two years of the IDRS, both use of preparations of alkaloid poppies and the number of poppy crop thefts remained low in 2003. Rates of both were around one-third that of the rates seen in the 2000 study: in 2003, only 12% of the IDU surveyed reported using some preparation of alkaloid poppies, with 20,223 poppy capsules stolen, in comparison to the 34% reporting use and 62,500 capsules stolen in 2000.

Buprenorphine, recently adopted as a maintenance treatment option for opioid addiction in the state, appears to have made little impact on the illicit opioid market, with only three individuals participating in the 2003 survey reporting illicit use of the drug (all injecting the drug). However, given that substantial levels of diversion have occurred in jurisdictions where buprenorphine maintenance treatment is more common, careful monitoring of this issue is clearly warranted as Tasmania's buprenorphine program expands, particularly given the existing culture of use of pharmaceutical products among local IDU.

12.6 Benzodiazepines

There are clear indications that there has been a further reduction of the injection of benzodiazepines among IDU between 2001/02 and 2002/03, following a reduction between 1999/00 and 2000/01. The proportion of the IDU sample reporting injection of benzodiazepines in the preceding six months fell from 38% in the 2002 study to 31% in the 2003 sample, at a median frequency of just six days in this time. While it appears that harm reduction efforts, by front-line workers, medical practitioners and policy changes may have had a considerable impact on patterns of benzodiazepine use, there remains a relatively high level of benzodiazepine injection within Hobart when compared to other jurisdictions, despite a reduction in the availability and use of temazepam gel capsules that are particularly favoured for injection. There are early indications that alprazolam may be replacing the market for temazepam gel capsules among those IDU particularly interested in benzodiazepine injection, with alprazolam injection increasing in recent months: used by 3% of the 2002 cohort, at a median frequency of 7 days in the preceding six months, and 11% of the 2003 sample, at a median frequency of 20 days. Moreover, this form appears to be used in similar ways to temazepam capsules, such as in simultaneous combination with methadone syrup. This is a particular concern given the serious psychological and physical harms associated with benzodiazepine injection. Additionally, the level of use and availability of benzodiazepines generally remains high within local IDU (used by 88% of the 2003 IDU sample, and 83% of the 2002 cohort), particularly among primary users of opiates, which is again of concern given the increased risk of overdose when the two substances are combined. As such, patterns of benzodiazepine use and injection in the state continue to warrant very close attention.

12.7 Injection-Related Issues

Self-reported rates of sharing of needles or syringes among clients of non-pharmacy Needle Availability Program outlets have steadily declined over time from 2.6% of all transactions in 1995/96 to 0.63% in 2002/03. However, 6% of the current IDRS IDU cohort reported using another person's used needle in the month prior to interview (a decline from 10% of participants in the 2000-2002 studies). Similar to the improving trends for sharing of needles and syringes, self-reported rates of sharing of other injection equipment (such as water, tourniquets and mixing containers) has steadily decreased among clients of non-pharmacy Needle Availability Program outlets (5.5% in 1996/97 to 0.4% in 2002/03) and 87% of the current IDRS IDU cohort had not shared any such injection equipment in the month prior to interview. Tourniquets remain the most commonly shared item among IDRS IDU cohorts, as per trends in previous years.

Blood borne viruses, such as HIV/AIDS and hepatitis B and C are a major health risk for individuals who inject drugs. Surveillance data on the number of hepatitis C cases

reported to the Public Health department indicate that, following a marked dip in incident cases of hepatitis C between 2000 and 2001, reported incident cases of infection have increased only slightly between 2001 and 2003, with 24 incident cases recorded in 2003.

Comparing reported rates of injection-related harms among the 2002 and 2003 Tasmanian IDRS participants, there were little changes in the level of experience of the commonest problems of scarring and difficulties finding veins to inject into, both indicative of vascular damage, with approximately half of the IDU participants experiencing these issues in the month prior to interview. Experience of 'dirty hits' (feeling physically unwell soon after injection, often associated with the injection of contaminants or impurities) appears to have increased substantially between the 2002 and 2003 cohorts (from 18% to 31%), and was primarily associated with the injection of methadone syrup. Overall, substantial levels of injection-related health problems were experienced by local injecting-drug users, at a relative rate considerably higher than IDU in other jurisdictions. This is reflective of the increased harms associated with the injection of pharmaceutical preparations of drugs, which is substantially more common in Tasmania than other jurisdictions. However, local IDU experienced a much lower rate of (non-fatal) overdose than users in other jurisdictions, due to the greater control over the dose of the drug afforded by use of standardised pharmaceutical preparations. While this rate of experience of overdose remains low among Tasmanian IDU, rates of fatal opiate overdoses have been increasing over the past 14 years, rising from less than 10 deaths per million population (aged between 15-44 years) to over 30 deaths per million population in recent years.

12.8 Methodological Considerations

The aim of the IDRS is to gather evidence of emerging drug trends in illicit drug use and related problems within the community. The IDRS methodology is heavily dependant on the perceptions of individuals involved in, and exposed to, the illicit drug use 'scene' (both individuals who inject drugs and professionals working with these groups). While these subjective impressions are combined with other, more objective, indicator data where possible to support and substantiate these reports, given the inherently covert nature of illicit drug use, available indicator data is limited and often insensitive to the trends of interest in this study.

The focus of the IDRS on surveying professionals in drug and alcohol-related fields, and often those people accessing their services, has meant that the study over-represents low educational and socio-economic groups, given that the charter of the majority of these agencies is to provide services to these populations. As such, the methodology leaves the major group of illicit drug users – those who use substances occasionally and non-problematically – largely untapped. Due to this gap, it would be inappropriate to regard the IDRS as providing a representative overview of illicit drug use or the demographics of those who use illicit drugs. Importantly, this methodology in its current form does not adequately tap accurate information about drugs that are more commonly used recreationally (for example, ecstasy) and more focal research within different demographic groups is required to provide better information in these areas.

It is important to note that the purpose of the IDRS is simply to detect trends that warrant further investigation, not to explore and verify such trends. As such, the

concurrent use of the three data sets included in this study, each with their own inherent strengths and limitations, affords an efficient and appropriate approach to achieving the aims of the study. In subsequent years, the validity of the IDRS will be further enhanced by the development of more systematic data sets (e.g. for drug and alcohol counselling services, ambulance and coroner data), and the incorporation of the results of several projects currently underway in the state (e.g. those funded by the National Illicit Drug Strategy).

13 IMPLICATIONS

The findings of the Tasmanian 2003 IDRS suggest the following areas for further investigation and possible consideration in policy:

- As Tasmanian illicit drug use culture has been consistently shown to substantially differ from other jurisdictions (with regard to, for example, patterns of use of pharmaceutical products rather than substances such as heroin, due the low local availability of this drug), drug education programs and harm minimisation information campaigns need to be tailored to the particular needs and types of substances used within the state.
- Extension of a regular drug trend monitoring framework into other regions within the state (such as Launceston and the North-West coast) as there has been little specific research examining patterns of drug use within these areas, and due to their access to air and sea ports, and establishment of organised motor cycle group headquarters, availability and use of illicit substances may differ substantially in these regions from patterns seen in Hobart.
- Continued emphasis on, and support for, targeted strategies to further reduce the rates of sharing of needles/syringes and other injection equipment (such as tourniquets, filters and mixing containers) among IDU, as well as to minimise the harms associated with poor injecting practice through improving awareness and adoption of safe injection techniques and vein care among IDU.
- Investigation into the factors associated with the experience of ‘dirty hits’ among local IDU and development of strategies to reduce this occurrence.
- Continuing monitoring of the expanding methamphetamine market and patterns of methamphetamine use.
- As use and availability of the high-potency crystalline methamphetamine appears to be substantially increasing, clear and practical harm-reduction information for use of this form of the drug should be accessed and distributed to consumers and health intervention workers. Additionally, since increased levels of use of such high-potency methamphetamine may increase the level of experience of the negative effects of excessive methamphetamine use, development and implementation of practical strategies and training for dealing with such affected individuals should be considered for front line health intervention workers and emergency services workers.
- Continued monitoring of the availability and potency of heroin available locally, particularly given that mainland heroin markets appear to have returned to a relatively easy availability of the drug in 2002.
- With the firm establishment of a culture of injection of methadone syrup locally (although this remains predominantly within individuals enrolled in the state methadone maintenance program injecting their own methadone), continued consideration of pragmatic harm reduction approaches to such use is warranted: either at the level of the consumer, with use of butterflies and biological filters;

and/or at the policy level, requiring use of sterile water for dilution of methadone doses or switching to Biodone syrup, as this preparation does not contain the agent sorbitol, which can cause irritation and harm to the venous system. Given the increased level of recent experience of ‘dirty hits’, primarily associated with methadone syrup injection, among the current IDU cohort, these issues merit renewed attention.

- Use of liquid preparations of morphine (Ordine) has continued to rise over the past three years of the IDRS. This is of some concern as the drug is typically sold ‘preloaded’ in syringe barrels, and it is often unclear to the user if the injection equipment or the solution is free from infection or contamination. Approaches to reducing the potential harms of this situation, such as increasing the awareness of the risk of this situation among users, or varying prescription practices to reduce the availability of larger containers of the drug, merit consideration as use expands.
- Given that injection of buprenorphine carries with it a substantial degree of risk for the development of abscesses, careful monitoring of diversion of the drug is warranted as Tasmania’s buprenorphine program expands. If, as has been seen in other jurisdictions with larger buprenorphine maintenance programs, injection of the drug becomes an issue locally, IDU should be made aware of harm-reducing injection techniques for the drug through front-line harm reduction workers.
- Research into factors that would reduce the harms associated with the intravenous use of the pharmaceutical preparations of morphine, methadone and benzodiazepines commonly used within the local IDU population, and dissemination of this information to users through continued training of Needle Availability Program staff and peer groups.
- Continued monitoring of the intravenous use of benzodiazepines, particularly in terms of the combined injection of alprazolam and methadone syrup, as this is a practice that substantially increases the risk of suicide.
- Characterisation and potency testing of cannabis cultivars to investigate continuing reports of high or increasing potency of cannabis.
- Research examining the extent of use, and demographic profiles of (mis)users of drugs such as anabolic steroids, inhalants, and pharmaceutical stimulants in the state, as these populations are not well accessed within the methodology of the IDRS.

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