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NSW DRUG TRENDS 2004
Findings from the Illicit Drug Reporting System (IDRS)

NDARC Technical Report No. 211

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ABBREVIATIONS

ABCI	Australian Bureau of Criminal Intelligence
ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ADIS	Alcohol and Drug Information Service
AFP	Australian Federal Police
ATSI	Aboriginal/Torres Strait Islander
BBVI	Blood borne viral infection
FDS	Family Drug Support
HBV	Hepatitis B virus
HCV	Hepatitis C virus
IDRS	Illicit Drug Reporting System
IDU	Injecting Drug Users
KE	Key Experts
NCHECR	National Centre for HIV Epidemiology and Clinical Research
NDARC	National Drug and Alcohol Research Centre
NDLERF	National Drug Law Enforcement Research Fund
NSP	Needle and Syringe Programme
NSW	New South Wales

EXECUTIVE SUMMARY

Demographic characteristics of injecting drug users (IDU)

One hundred and fifty seven IDU participated in the 2004 IDRS. Sixty-eight percent were male, 83% were unemployed and the average age of respondents was 34 years. Fifty-eight percent had not completed any further education after school, 40% had obtained a trade or technical qualification and 3% had completed a university degree. Sixty seven percent had a previous prison history. The average age of first injection was 20.1 years.

Patterns of drug use among IDU

Heroin

Consistent with previous years, the vast majority of the IDU sample nominated heroin as their drug of choice (78%), the drug they had injected most often in the month preceding interview (80%) and the most recent drug they had injected (80%). However, the median number of days' use in the preceding six months has decreased quite markedly from 170 days in 2003 to 120 days in 2004. In accordance with this, the proportion of IDU reporting daily heroin use[1] in the preceding six months decreased further from 47% in 2003 to 38% in 2004, which is consistent with increasing numbers reporting current engagement in drug treatment (47% in 2003 to 60% in 2004). There were fewer IDU reporting daily use than prior to the heroin shortage in 2001.

The median price for a gram of heroin ($300) and a cap of heroin ($50) remained stable in 2004. Prices remained higher than those reported in 2000.

Heroin availability remained similar to 2003 levels, with the overwhelming majority (93%) of IDU reporting that heroin was 'easy' to 'very easy' to obtain (compared to 91% in 2003). Sixty-six percent thought that availability had remained stable (70% in 2003). Seven percent reported that heroin was 'difficult' to obtain (no change from 2003) and 18% (20% in 2003) thought it had become more difficult.

Seventy-four percent of IDU thought that heroin was of 'low' to 'medium' purity. NSW police seizure data indicated that the median purity of low-level heroin seizures remains low (approximately 30%) and has not returned to levels reported prior to 2001.

Key Expert comments on the price and availability of heroin were consistent with IDU reports.

The indicator data analysed showed relatively stable rates in 2003/2004 (compared to the previous year) of recorded police incidents for heroin possession/use; ambulance callouts to heroin overdoses; detections of heroin in suspected drug-related deaths; and overdose presentations to emergency departments. Numbers across these data collections remained substantially lower than figures recorded prior to 2001, suggesting that the NSW heroin market has not returned to pre-shortage levels.

[1] "Use" refers to any route of administration, i.e. includes use via injection, smoking, swallowing, and snorting.

Methamphetamine

Fifty six percent of IDU had used some form of methamphetamine (speed, base or ice) in the preceding six months, a proportion comparable to 2003 (53%). Similar proportions reported use of speed (35%; 31% in 2003) and base (31%; 32% in 2003), while there was a slight increase in proportions using ice (45%; 38% in 2003).

A 'point', i.e. 0.1 of a gram, was a popular purchase amount for all three forms of methamphetamine, and the median price remained stable at $50 for speed, base and ice.

Speed remained readily available with 79% of IDU commenting reporting that it was 'very easy' or 'easy' to obtain, and that availability had remained stable (68%). Base was also 'easy' or 'very easy' to obtain (77%), with availability remaining stable (63%). Availability of ice increased substantially in 2003, with 79% reporting that it was 'easy' to 'very easy' to obtain. These figures remain similar to those reported in 2003, and consistent with this, 58% of IDU commenting thought that ice availability had remained stable.

Key Experts reported on a range of methamphetamine forms, with ice the most commonly mentioned, and comments were consistent with those of IDU. Indicator data presented a rather mixed picture, with some indicators remaining higher in the last twelve months than previously (e.g. recorded incidents of possession/use, calls to telephone helplines), while others have remained relatively stable (amphetamine related deaths) or decreased (overdose).

Cocaine

The prevalence and frequency of cocaine use remained relatively low following a substantial decrease in 2003. Forty-seven percent of IDU reported cocaine use in the preceding six months (compared to 53% in 2003 and 79% in 2002) and the median number of days' use remained at approximately once per month (6 days), as compared with five days in 2003 and 24 days in 2002. Prevalence rates were the lowest reported since 1997.

Availability also remained similar to 2003, with 29% reporting it 'difficult' or 'very difficult' to obtain, compared with 33% in 2003. Sixty-six percent thought it was 'easy' or 'very easy' (compared with 66% in 2003, and a decrease from 74% in 2002). Just over half the sample (55%; comparable to 54% in 2003) thought availability had remained stable, while 20% thought it had become more difficult (28% thought so in 2003).

The median price for a gram of cocaine has increased for the first time since the commencement of the IDRS in 1996, with prices for other amounts remaining stable.

Key Expert comments and indicator data were generally consistent with those of IDU.

Cannabis

The cannabis market has remained relatively unchanged since the commencement of the IDRS, and the majority of IDU (79%) continued to report cannabis use. Frequency of use among these IDU remained at 180 days (daily use) in 2004.

The price of hydroponic cannabis was $20 per gram and the overwhelming majority (95%) of IDU reported that it was readily available. The price per gram of bush cannabis was the same as for hydro ($20), but larger amounts were slightly cheaper than for hydro. Bush was less readily available, with 54% reporting it to be 'easy' to 'very easy' to obtain. Potency of hydroponic cannabis was reported to be 'high' and bush was reported to be 'medium'.

Key Expert reports on cannabis were consistent with those of IDU. Indicator data also reflected the stability of the market, with very little change occurring over the past year.

Use of illicit pharmaceuticals

Illicit Methadone

Almost one third of IDU reported use of illicit methadone syrup in the preceding six months (an increase from 18% in 2003), although the number of days on which they had done so remained relatively sporadic (approximately once per month). Approximately half of this group had been engaged in methadone treatment during this period, indicating that methadone was being diverted to IDU engaged in treatment, as well as to those who were not.

Just over one fifth (22%) of IDU reported injecting illicit methadone syrup in the preceding six months, and just over half (60%) of this group were engaged in methadone treatment during this period.

Fifteen percent of IDU reported illicit methadone syrup as the form they had used most in the preceding six months, 13% (n=3) of whom were engaged in treatment in the preceding six months.

Illicit methadone was considered to be readily available with 72% reporting that it was 'easy' to 'very easy' to obtain. A quarter reported it was 'difficult'. Twenty-five percent of IDU reported buying illicit methadone in the past six months, primarily from street dealers and friends.

Smaller proportions of IDU reported using illicit physeptone tablets (1%; n=2) in the preceding six months, one of whom was engaged in methadone treatment.

Illicit Buprenorphine

Small percentages (8%) reported the use of illicit buprenorphine in the preceding six months, with only a minority (8%, n=1) reporting engagement in buprenorphine treatment during this period. Five percent of IDU reported injecting illicit buprenorphine in the preceding six months on a median of two days, none of whom were in treatment. Eight percent of IDU reported illicit buprenorphine as the

form they had used most in the preceding six months, one of whom was engaged in treatment. These figures are comparable to 2003 data.

Morphine

Prevalence of morphine use (29%) and injection (25%) in the preceding six months has increased slightly since 2001. Frequency of morphine use has remained relatively stable at a median of four days. Morphine was predominantly obtained from illicit sources. MS Contin was the most common brand of morphine used, with 100mg tablets costing a reported median price of $20. Twenty-one percent reported buying morphine (15% in 2003), predominantly from street dealers.

Morphine was not considered to be readily available, although larger proportions than previous years reported it to be 'easy' (30%) to 'very easy' (23%) to obtain.

Other opioids

The proportion of IDU reporting recent use and injection of other opioids such as pethidine and codeine remained stable at 22% (use; 23% in 2003) and 4% (injection; 2% in 2003). Frequency of use remained stable (median of six days, compared to five days in 2003). Panadeine Forte, a pharmaceutical drug containing 30mg codeine, continued to be the main form used and approximately half (53%) of those reporting other opioid use had obtained them illicitly.

Benzodiazepines

Despite a restriction in the availability of benzodiazepine gel capsule preparations (Euhypnos, Nocturne, Normison & Temaze) being introduced on 1 May 2002, and the subsequent removal from these drugs from the pharmaceutical market in March 2004, IDU continued to use and inject benzodiazepines. Prevalence of benzodiazepine use and injection remained relatively stable at 67% and 13%, respectively (62% and 19% in 2003). However, the median number of days on which benzodiazepines were used increased sharply (60 days in 2004 as compared with 18 days in 2003) and the median number of days on which they were injected decreased (9 days in 2003 as compared with 20 days in 2003). Among those reporting daily use, 30% (n=9) reported intravenous use in the preceding six months. Half the sample reported benzodiazepines reported sourcing them illicitly, and Valium/diazepam, Serepax/oxazepam and Normison/temazepam were the most commonly reported forms used.

Associated harms

The proportion of IDU sharing needles increased, with 13% reporting that they had used a needle after someone else in the preceding month (7% in 2003) and 21% reporting that someone else used a needle after them (12% in 2003). The proportion reporting shared use of other injecting equipment such as filters and water also increased slightly (52%, compared to 43% in 2003).

Since 2001, there has been a steady increase in the proportions of IDU reporting a private home as both their usual injection location (from 55% in 2001 to 69% in 2004) and the location of their last injection (from 47% in 2001 to 64% in 2004). Less than a fifth of IDU reported that their usual location was a public place (17%; as compared to 42% in 2001) and less than a quarter reported it as their most recent location for injection (24% in 2004, as compared to 49% in 2001). Twelve percent

reported that they usually injected at the Medically Supervised Injecting Centre in Kings Cross, and 11% reported it had been the location in which they had last injected (these figures were 8% and 7% in 2003, respectively).

Sixty-four percent of IDU reported injection related health problems in the past month (compared to 60% in 2003), with 38% reporting multiple problems (from 30% in 2003). Consistent with previous years, prominent scarring/bruising of injection sites (46%) and difficulty injecting (40%) were the most frequent problems reported. Over half of the sample (61%) reported ever having overdosed. Two percent reported an overdose in the month preceding interview, while figures for overdose within the past twelve months were slightly higher at 16%.

There was little change in the proportion (83%) of IDU who reported spending money on drugs on the day prior to interview, although the median amount of money spent decreased slightly from $100 in 2003 to $80 in 2004. Decreases were also observed in the proportions who had spend $100 or more (from 46% in 2003 to 36% in 2004) and $200 or more (from 23% in 20003 to 13% in 2004).

Half the sample (53%) of the sample reported experiencing a mental health problem other than drug use in the preceding six months, and 60% of this group reported seeking advice from a mental health professional during this time (usually a GP). Depression continued to be the most commonly reported mental health problem (24%, compared to 16% in 2003), followed by anxiety (10%; 5% in 2003).

Proportions reporting involvement in criminal activity in the month preceding interview (51%) remained relatively stable, and the most commonly reported offences were property crime (33%; 31% in 2003) and drug dealing (28%; 36% in 2003). Forty-three percent of IDU had been arrested in the previous twelve months, representing little change from 49% in 2003. As in previous years, approximately two thirds of IDU perceived that police activity had increased in the preceding six months. Half the sample reported that this activity had had an impact on their ability to obtain drugs, representing an increase from 33% who said so in 2003.

Implications

The findings of the 2004 NSW IDRS indicate that further attention is required in the following areas:

- Further research into drug trends and associated harms of methamphetamine use studying a group of primary methamphetamine users (McKetin et al., in preparation).
- Development of effective treatment programmes for methamphetamine users, and development of strategies to engage and retain users in these programmes.
- More detailed research into the nature of the cocaine market (that supplies IDU) in Sydney.
- Careful monitoring by medical practitioners relating to the diversion of methadone and other opioids. Increasing trends towards this have been noted in other jurisdictions.
- Ongoing surveillance of patterns and prevalence of benzodiazepine use, and careful monitoring by medical practitioners of the clinical need for their prescription.
- Increasing focus on the development of educational material regarding overdose and the dangers of sharing injecting equipment other than needles.
- Increase awareness of the need for treatment of the concomitant mental health problems that many IDU may be experiencing in addition to their drug dependence. Despite the fact that many IDU were aware that they had such problems, relatively few were receiving help for them. The patterns of comorbidity among this group need to be assessed and effective methods of intervention considered in future work. In particular, the likelihood that comorbid mental health problems may affect treatment outcome needs to be acknowledged and addressed by both mental health and drug treatment services.

1. INTRODUCTION

The Illicit Drug Reporting System (IDRS) is Australia's federally funded national drug monitoring system. The purpose of the IDRS is to provide a standardised, comparable approach to the monitoring of data relating to the use of opiates, cocaine, methamphetamine and cannabis. The IDRS is intended to act as a strategic early warning system, identifying emerging drug problems of national concern. It is not intended to describe phenomena in detail, but rather, is designed to indicate the need for more detailed data collection by providing sensitive and timely data on emerging trends in illicit drug markets.

One component of the IDRS involves interviews with regular IDU to obtain information on use patterns and drug markets. IDU are recruited as a sentinel group of users that are active in illicit drug markets. The information from the IDU survey is therefore not representative of illicit drug use in the general population, nor is it indicative of all illicit or injecting drug users, but identifies emerging trends that require further monitoring.

The IDRS has operated in NSW since 1996. The data described in this report represent a summary of drug trends detected by the NSW IDRS in 2004. Results are summarised by drug type to provide the reader with an abbreviated picture of illicit drug markets and recent trends. NSW drug trends from previous years can be found in the annual *NSW Drug Trends* reports (Roxburgh et al., 2003, Breen et al., 2004, Roxburgh et al., 2004, Darke et al., 2002b, Darke et al., 2001, McKetin et al., 2000, McKetin et al., 1999, Hando et al., 1998a, Hando and Darke, 1998, O'Brien et al., 1996). All IDRS reports from previous years (in NSW and for all other jurisdictions) may be downloaded from the NDARC website: national (http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.national), and jurisdictional

(http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.state).

Papers on specific issues using NSW data from the IDRS have also been published in the peer reviewed literature (Breen et al., 2002, Darke et al., 2002a, Darke et al., 2002c, Darke et al., 2002d, Day et al., 2003, Degenhardt et al., 2003, Fry and Bruno, 2002, Griffiths et al., 2000, Hando et al., 1998b, McKetin, 2000, Shand et al., 2003, Topp et al., 2004, Topp et al., 2003a, Topp et al., 2003b, Topp et al., 2002).

Since 2000, trends in the use of ecstasy and other related drugs have formed a separate, specialised component of the IDRS, and are reported elsewhere (White et al., 2004, White et al., 2003, Breen et al., 2002). Previous copies of these reports may also be downloaded from the NDARC website: http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.state).

Study Aims

As in previous years, the specific aims of the 2004 NSW IDRS were:

1. to monitor the price, purity, availability and patterns of use of heroin, methamphetamine, cocaine and cannabis; and
2. to identify emerging trends in NSW illicit drug markets that require further investigation.

2. METHOD

The IDRS analyses three main sources of information to document drug trends:

1. a quantitative survey of injecting drug users (IDU);

2. a semi-structured interview with Key Experts (KE; formerly known as Key Informants), who are professionals working in the illicit drug field, and have regular contact with and/or specialised knowledge of illicit drug users, dealers or manufacture; and

3. a collation of existing indicator data on drug-related issues.

Previous IDRS research has demonstrated that IDU are an appropriate sentinel group for detecting illicit drug trends, due to their high exposure to many types of illicit drugs. IDU also have first hand knowledge of the price, purity and availability of the main illicit drug classes. KE interviews are used to provide contextual information about drug use patterns and health-related issues, such as treatment presentations. The collation of indicator data provides a precise and reliable measure of drug trends, often at a community level, which may have been detected by the IDU and KE surveys.

Data from these three sources are triangulated against each other to determine the convergent validity of trends detected. The data sources complement each other in the nature of the information they provide. Data from the 2004 IDRS were compared with IDRS findings from previous years to determine changes in drug trends over time.

2.1. Survey of injecting drug users (IDU)

In the 2004 NSW IDRS the IDU survey consisted of face-to-face interviews with 157 IDU, conducted in June and early July 2004. Half (50%) of the sample was recruited from the inner city of Sydney (Kings Cross and Redfern), and the remainder from Sydney's South-West (Liverpool, Canterbury). In previous years, the NSW IDRS was conducted at Cabramatta rather than Liverpool; closure of the service at Cabramatta in mid-2003 resulted in the requirement to find a new interview site for 2004. As with the other locations where recruitment is conducted, Liverpool was selected as it is a key illicit drug market area and it is in these markets that trends in illicit drug use are likely to first emerge.

IDU were recruited from treatment and support agencies as well as Needle and Syringe Programmes (NSP). Potential participants were screened for eligibility; criteria for entry to the study were: (i) at least monthly injection of any drug in the six months preceding the interview; and (ii) residence in Sydney for the preceding twelve months, with no significant periods of incarceration during that time.

The interview schedule included sections on demographics, drug use history, the price, purity and availability of illicit drugs, criminal activity, injection risk-taking behaviour, health and general drug trends. Participants were interviewed within the agencies that assisted with recruitment where possible, or at coffee shops and fast-food outlets. Interviews took about 30-40 minutes to conduct, and participants were reimbursed $30 for

their time and expenses. Descriptive analyses of the quantitative data derived from the IDU survey were conducted using SPSS for Windows, Release 12.0.1 (2003).

2.2 Survey of Key Experts (KE)

Sixty KE who had regular contact with, and/or specialist knowledge of, illicit drug users[2], dealers or drug manufacture, were interviewed in July and August 2004. To be eligible, participants must have had at least weekly contact with illicit drug users or suppliers, and/or contact with a minimum of ten different illicit drug users or suppliers in the six months preceding the interview. A broad range of KE were interviewed in 2004 including: drug treatment workers (including counsellors; n=21), health education officers (including needle and syringe programme workers; n=12), law enforcement officers (n=15), nurses (n=5), doctors (n=1), researchers (n=3), an intake officer, a user group representative and a residential rehab manager.

KE are recruited from a range of geographical areas across Sydney, including the drug market areas in which IDU are recruited. KE selection is based upon a desire to interview persons who have contact with a broader group of drug users including IDU, and who have knowledge of drug markets that is broader than the information that we obtain from IDU, and can give some indication of trends across Sydney and NSW.

Twenty-seven KE reported on the use and/or supply of heroin, 17 on the use, manufacture and/or supply of methamphetamine, 11 on cannabis use and/or supply, and five on the use and supply of cocaine. As in the 2003 NSW IDRS, cocaine Key Experts were extremely difficult to find, with many professionals reporting that there was very little cocaine available among the users they came into contact with and therefore that use in these groups remained uncommon. A number of service providers and previous cocaine KE were approached to act as cocaine KE in 2004 but without success as they had only had contact with one or two users and thus did not feel able to comment. Two health professionals and three law enforcement personnel acted as cocaine Key Experts in 2004.

The KE interview schedule was a semi-structured instrument, based on previous IDRS research, which followed a similar structure to the IDU interview. The interview included sections on drug use patterns, drug price, purity and availability, criminal activity, and health and treatment issues. Interviews took between 30 and 60 minutes to conduct, and were conducted over the telephone with the exception of one that was conducted face-to-face. Notes were taken during the interview and content analysis conducted to identify recurring themes and patterns in the data.

2.3 Other indicators

To complement and validate data collected from the IDU and KE surveys, a range of secondary data sources were examined. These included health, survey, 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; be brief; be collected in the main study site (i.e., Sydney for the present study); and cover the four main illicit drugs, i.e. heroin, methamphetamine, cocaine and cannabis.

[2] The illicit drug users to whom KE refer are typically, but not exclusively, injecting drug users.

Data sources that have been included in this report are:

- Alcohol and Drug Information Service – calls received regarding problematic drug use;
- Family Drug Support – telephone support service for family members affected by problematic drug use and for users themselves;
- Australian Bureau of Statistics – overdose data;
- Australian Crime Commission - purity data from Police seizures
- Australian Government Department of Health and Ageing, National Notifiable Diseases Surveillance System – notifications of Hepatitis C and Hepatitis B
- Medically Supervised Injecting Centre – data on drug injected at the Centre
- Needle and Syringe Programmes data on last drug injected
- NSW Bureau of Crime Statistics and Research – incidents recorded for possession/use
- NSW Department of Health – drug-related visits to emergency departments, NSW ambulance callouts to overdoses, numbers registering for opioid pharmacotherapy treatment, number of treatment episodes by drug type and gender, drug-related inpatient hospital admissions and toxicology data from suspected drug users in which drugs were detected.

3. RESULTS

3.1. Overview of the IDU sample

The demographic characteristics of the 157 IDU interviewed in 2004 are presented in Table 1. The mean age of the sample was 34 (SD 8.2, range 19-55), and 68% of the respondents were male. The majority (83%) were unemployed, and 67% had a previous prison history, similar to the 2003 sample. The mean number of school years completed was 9.4 (SD 1.8, range 2-12). Just under half of the sample (43%) had completed a tertiary qualification, representing an increase from 53% in 2003. Of those who had a tertiary qualification, 40% had completed a trade or technical qualification and 3% had completed a university or college qualification.

Table 1: Demographic characteristics of the IDU sample, 2003-2004

Characteristic	2003 N=154	2004 N=157[3]
Age (yrs)	33.1	34.0
Sex (% male)	68	68
Employment (%):		
Not employed	86	83
Full time	3	3
Part time/casual	8	8
Home Duties	2	5
Student	1	<1
Sex Work	17	11[4]
ATSI (%)	33	-
School education (yrs)	9.6	9.4
Tertiary education (%):		
None	47	58
Trade/technical	47	40
University/college	6	3
Currently in drug treatment (%)	47	60[5]
Prison history (%)	68	67

Source: IDRS IDU Interviews

[3] Data from one participant was not reported for the following variables: employment status, tertiary education, current drug treatment and prison history. For these variables, N=156.

[4] Questions concerning sex work differed slightly from 2003 to 2004 and differences should be interpreted with caution.

[5] A substantial increase in drug treatment was seen in the 2004 sample as compared with 2003 (47% in 2003 vs. 60% in 2004). The proportion of IDU reporting current engagement in drug treatment has been steadily increasing over the last three years, and this finding may partially be a reflection of this. However this finding must also be at least partially attributed to the change of one of the interview sites between 2003 and 2004. Participants at the new site were more likely to report being engaged in treatment than at the former site, where treatment was comparatively uncommon. Consequently, while there has been an increasing trend among IDU to report current engagement in treatment across all NSW sites, comparisons with previous years should still be interpreted with caution.

The majority (60%) of the sample was currently in drug treatment; 49% reported that methadone maintenance was their main form of treatment, 10% reported buprenorphine treatment and less than 1% reported counselling as their main form of treatment. Proportions in current treatment represent an increase from 47% in 2003. No IDU reported being in naltrexone treatment either currently or in the preceding six months.

Data regarding the proportion of IDU who identified as being of Aboriginal and/or Torres Strait Islander (ATSI) descent were not collected in 2004. Eighty-eight percent of IDU reported that English was the language they most commonly spoke at home. The most commonly spoken languages other than English were Vietnamese (3%), Arabic (3%) and Greek (3%).

KE reports of demographic characteristics reflected those of the sample; the majority were male, the age range was broad (although users were predominantly in their mid 20s to mid 30s), many users had a prison history (although, again, this varied substantially), a small minority had completed high school and the majority were unemployed. IDU who were in treatment were predominantly on methadone maintenance while smaller proportions were on buprenorphine. As a large proportion of KE were Alcohol and Other Drug (AOD) counsellors, a fairly large proportion of the data refers to IDU engaged in drug counselling. While many KE reported that the majority of IDU they had contact with were from English speaking backgrounds, some reported seeing clients from Asian, Middle-Eastern, Pacific Island, Indigenous and European backgrounds.

3.2. Drug use history and current drug use

The mean age of first injection was 20.1 years (SD 6.0, range 11-42) (Table 2, page 21). Similar to the 2003 sample, heroin was the first drug injected by the majority (62%) of participants, followed by amphetamines (32%), cocaine (3%) and morphine (1%).

Heroin was the drug of choice for 78% of respondents, methamphetamine for 10%, cocaine for 8% and cannabis for 2%. Benzodiazepines were the drug of choice for less than 1% of IDU. These proportions are relatively similar to those reported in 2003. The proportion nominating cocaine as their drug of choice (8%) remained lower than at the peak of the heroin shortage (29% in 2001). The corresponding increase in respondents nominating heroin as their drug of choice that occurred between 2001 and 2003 (from 61% in 2001 to 72% in 2002 and 84% in 2003) has levelled off, remaining similar to 2003 at 78% in 2004.

The proportion of IDU reporting injecting heroin most often in the month preceding interview remained stable (83% in 2003 to 80% in 2004). Similarly, the proportions of IDU reporting injecting cocaine (2% in 2003 to 4% in 2004) and methamphetamine (8% in 2003 to 11% in 2004) most often in the last month remained fairly constant. A decrease was observed in the proportion of IDU reporting benzodiazepines as the drug injected most often (from 5% in 2003 to none in 2004) (Table 2). There was little change in proportions reporting methamphetamine as the drug they injected most often in the last month, although a slight but steady increase has been observed since 2001 (4% in 2001, 6% in 2002, 8% in 2003, 11% in 2004).

Table 2: Injection history, drug preferences and polydrug use of IDU

Variable	**2003 N=154**	**2004 N=157**
Age first injection (years)	20.0	20.1
First drug injected (%)		
Heroin	62	62
Amphetamine	34	32
Cocaine	3	3
Morphine	1	1
Drug of choice (%)		
Heroin	84	78
Cocaine	4	8
Methamphetamine (any form)	6	10
- Speed	-*	*4*
- Base	-*	*2*
- Crystal Methamphetamine (ice)	-*	*5*
Benzodiazepines	3	<1
Cannabis	3	2
Drug injected most often in last month (%)		
Heroin	83	80
Cocaine	2	4
Methamphetamine (any form)	8	11
- Speed	-*	*4*
- Base	-*	*1*
- Crystal Methamphetamine (ice)	-*	*6*
Benzodiazepines	5	-
Morphine	-	<1
Other/Have not injected in last month	<1	5
Most recent drug injected (%)		
Heroin	77	80
Cocaine	4	5
Methamphetamine (any form)	13	13
- Speed	-*	*5*
- Base	-*	*2*
- Crystal (ice)	-*	*6*
Benzodiazepines	3	-
Morphine	<1	1
Frequency of injecting in last month (%)		
Less than daily	33	43
Once a day	11	10
2-3 times a day	34	33
>3 times a day	22	14
Polydrug use		
Mean number of drug classes ever tried	10.2	11.0
Mean number of drug classes used in last 6 months	6.7	7.0
Mean number of drug classes ever injected	4.6	4.9
Mean number of drug classes injected in last 6 months	2.6	2.8

Source: IDRS IDU interviews

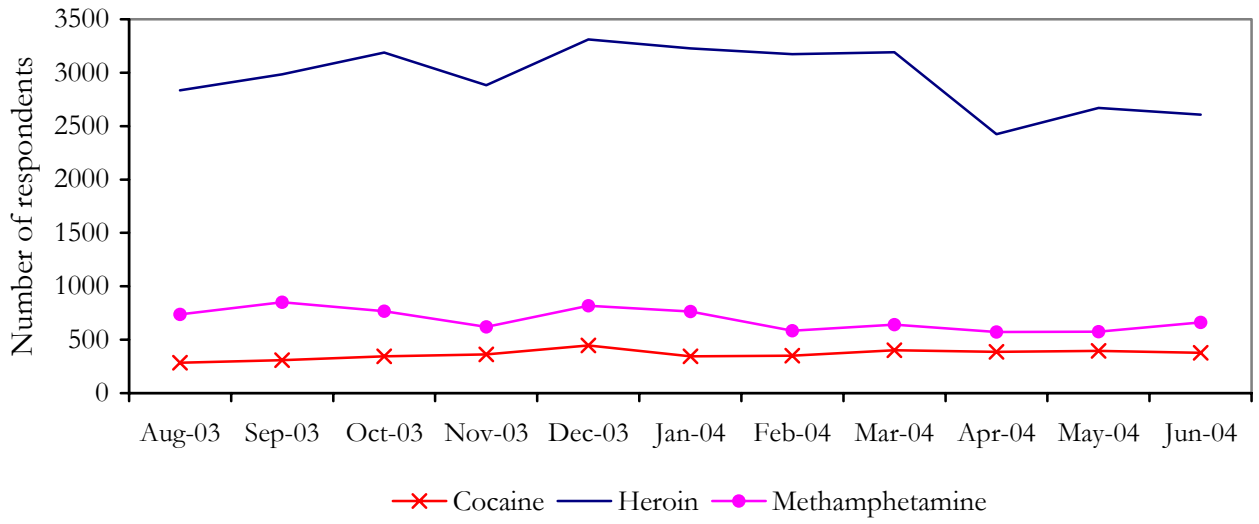
* Data were not collected in 2003

There was little change in the proportions of IDU reporting heroin (77% in 2003 and 80% in 2004), cocaine (4% in 2003 and 5% in 2004) and methamphetamine (13% in 2003 and 12% in 2004) as the drug most recently injected. However, there was a slight decrease in proportion reporting benzodiazepines as the most recent drug injected (3% in 2003 and 0% in 2004), decreases that were also observed in the proportions reporting them as their drug of choice (3% in 2003 and <1% in 2004) and the drug most frequently injected during the last month (5% in 2003 and 0% in 2004).

In 2004, questions were included on 17 drug classes. Consistent with previous years the IDU sample engaged in extensive polydrug use, with respondents reporting that they had used an average of 11.0 (SD 2.9, range 3-17) drug classes in their lives and 7.0 (SD 2.5, range 1-14) in the six months preceding interview. Respondents had injected an average of 4.9 drug classes (SD 2.3, range 1-12) at some time in their lives, and an average of 2.8 (SD 1.7, range 1-8) drug classes in the preceding six months (Table 2).

Figure 1 shows the most recent drug injected as reported by respondents attending three inner city needle syringe programmes, and the pattern is consistent with IDRS reports. The majority of attendees reported heroin as the last drug injected, followed by methamphetamine. Numbers have remained relatively stable over the preceding year, with the exception of heroin, where numbers have decreased since March 2004.

Figure 1: Number of respondents attending three inner city needle syringe programmes reporting heroin, methamphetamine and cocaine as last drug injected, August 2003 – June 2004



Source: Three inner city needle syringe programmes

The polydrug use histories of IDU, and routes of administration are presented in Table 3 (page 24). Recent use of the four main drugs monitored by the IDRS remained common: heroin (95%), cannabis (79%), cocaine (47%) and methamphetamine (56%).

Differences between 2003 and 2004 regarding heroin use include a substantial decrease in the median number of days' heroin use from 170 to 120, a decrease in the percentage reporting daily heroin use (47% in 2003 to 38%). There has also been an increase in the number of days of methadone use by those prescribed methadone, from 162 days in 2003 to 180 days in 2004.

Patterns of cocaine use remained similar, with a slight decrease in the proportion of IDU reporting recent cocaine use (53% in 2003 to 47% in 2004), and virtually no change in either the proportion reporting daily use (3% in 2003 and 3% in 2004) or the median number of days of cocaine use (5 days in 2003 to 6 days in 2004). All these figures contrast noticeably with figures reported in 2001, when the highest proportions of respondents reporting recent use (84%), the highest proportion of daily users (29%), and the highest median number of days used (90 days) were recorded.

The median number of days of cannabis use remained at the maximum level possible (180 days- daily use- in 2003 and 2004), and slight increases were observed in the proportion of IDU reporting recent injection of ice (35% in 2003 to 41% in 2004) and recent ice use overall (38% in 2003 to 45% in 2004).

Noticeable differences in use patterns of other drug types include: an overall increase in median number of days of methadone use[6] (140 days in 2003 to 180 days in 2004, probably reflecting a larger proportion of IDU who were in methadone treatment), an overall decrease in median days of buprenorphine use[7] (60 days in 2003 to 45 days in 2004) and a slight increase in the proportion of IDU reporting recent oral use of other opioids (12% in 2003 to 20% in 2004). Changes were also seen in patterns of benzodiazepine use, with an increase in the proportion reporting recent oral use (58% in 2003 to 64% in 2004) and the median number of days used (18 days in 2003 to 60 days in 2004). However, a decrease was observed in the median number of days upon which benzodiazepines were injected (20 in 2003 to 9 in 2004). Overall, these changes suggest that, with the exception of buprenorphine, IDU may be substituting a range of related drugs and sedatives for heroin.

[6] Refers to any form of methadone or physeptone, whether obtained licitly or illicitly.
[7] Refers to any form of buprenorphine, i.e. licit or illicit.

Table 3: Polydrug use history of the IDU sample

Drug Class	Ever used %	Ever Injected %	Injected last 6 mths %	Days injected in last 6 mths*	Ever Smoked %	Smoked last 6 mths %	Ever snorted %	Snorted last 6 mths %	Ever Swallowed %	Swallowed last 6 mths %	Used^ last 6 mths %	Days used^ in last 6 mths*
Heroin	100	99	94	120	57	10	26	4	19	6	95	120
Methadone (prescribed)	73	33	10	10					73	56	56	180
Methadone (not prescribed)	51	43	22	5					35	15	29	5
Physeptone (prescribed)	10	5	1	25	<1	-	-	-	9	<1	2	4
Physeptone (not prescribed)	20	13	<1	2	<1	-	-	-	13	1	1	2
Buprenorphine (prescribed)	36	7	2	48	1	1	-	-	36	17	17	90
Buprenorphine (not prescribed)	12	8	5	2	<1	-	-	-	5	5	8	2
Morphine	57	52	24	4	1	<1	<1	-	27	13	29	5
Homebake	14	14	<1	45	1	-	1	-	1	<1	1	24
Other opiates	35	14	4	2	3	1	<1	<1	27	20	22	6
Speed powder	80	75	33	6	9	3	48	6	36	5	35	7
Base/point/wax	49	48	30	8	4	3	7	3	12	3	31	6
Ice/shabu/crystal	64	57	41	7	24	13	3	3	7	4	45	5
Amphetamine liquid	28	26	5	1					9	<1	5	1
Pharmaceutical stimulants	24	8	2	2	<1	<1	<1	<1	21	5	6	5
Cocaine	90	87	44	6	22	4	38	8	8	<1	47	6
Hallucinogens	63	8	-	-	1	<1	<1	-	62	5	5	1
Ecstasy	61	22	10	1	1	-	6	2	55	15	21	2
Benzodiazepines	85	29	13	9	1	-	<1	-	82	64	67	60
Alcohol	94	3	-	-					94	60	60	12
Cannabis	96										79	180
Anti-Depressants	41	-	-	-					41	22	22	175
Inhalants	29										6	2
Tobacco	98										96	180

^ Refers to any route of administration, i.e. includes use via injection, smoking, swallowing, and snorting * Among those who had used/injected.

4. HEROIN

Ninety-four percent of IDU commented on the price, purity and availability of heroin, and the following percentages refer to this proportion of IDU. Twenty-three KE commented on the availability and use of heroin, with 19 commenting on price and fewer on purity.

4.1 Price

Prices paid for heroin by IDU on the last occasion of purchase are shown in Table 4 below. The median price reported for a gram of heroin remains unchanged from 2002 and 2003 at $300 per gram. This price remains substantially higher than prices reported in 2000 ($220), prior to the heroin shortage in 2001 (Figure 2, page 26). In 2004, prices varied by geographical location; the median price per gram was $335 in inner Sydney as compared with $300 in the South West. Similarly, the median price per quarter gram was $100 in the inner city and $75 in the South West. Prices for other amounts bought remained the same irrespective of general geographic area.

Caps of heroin remained the most popular purchase amount, while numbers purchasing half grams (halfweights) of heroin increased from 57 in 2003 to 80 in 2004. Numbers purchasing grams (weights) of heroin also increased, from 21 in 2003 to 34 in 2004. A number of IDU reported buying heroin in amounts specified by price, with seven instead referring to "fifties" and four referring to "hundreds". Seven IDU reported buying heroin in points.

Table 4: Price of most recent heroin purchases by IDU, 2003-2004

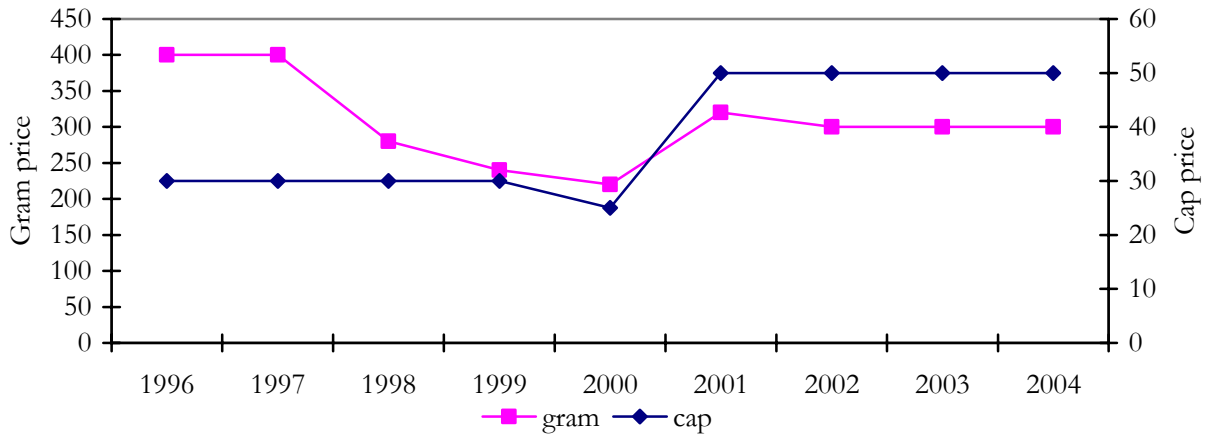
Amount	Median price* $	Number of purchasers*
Gram	300 (300)	34 (21)
Cap	50 (50)	98 (102)
Half gram	150 (150)	80 (57)
Quarter gram	70 (70)	51 (57)

Source: IDRS IDU interviews

* 2003 data is presented in brackets

Consistent with purchase prices, 78% of IDU commenting on heroin reported that the price had remained stable in the preceding six months, representing an increase from 52% and 71% who thought so in 2002 and 2003, respectively. Fourteen percent thought the price had increased (22% in 2003), 3% thought it fluctuated (4% in 2003), and 4% thought the price had decreased (3% said so in 2003).

Figure 2: Median price of a gram (and cap) of heroin estimated from IDU purchases, 1996 – 2004



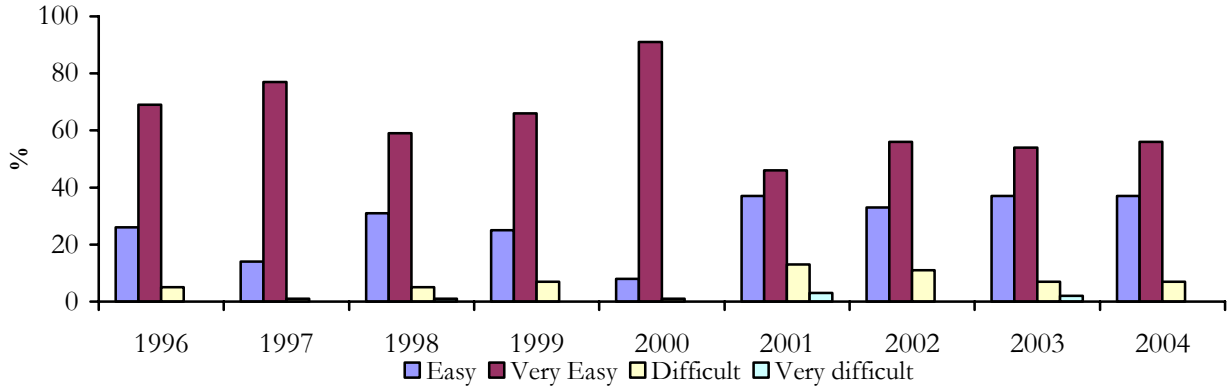
Source: IDRS IDU interviews

KE comments on the price of heroin ranged from $250 to $400 a gram, and the majority of those who commented reported that caps cost $50. Consistent with IDU reports, most KE thought the price had remained stable.

4.2 Availability

Ninety-three percent of IDU commenting on heroin reported that it was 'easy' (37%) to 'very easy' (56%) to obtain; comparable to 91% in 2003 (37% 'easy' and 54% 'very easy'). Seven percent thought it 'difficult' (the same as in 2003) and none reported it to be 'very difficult' to obtain (2% in 2003; Figure 3).

Figure 3: IDU reports of ease of availability of heroin in the past six months, 1996 – 2004

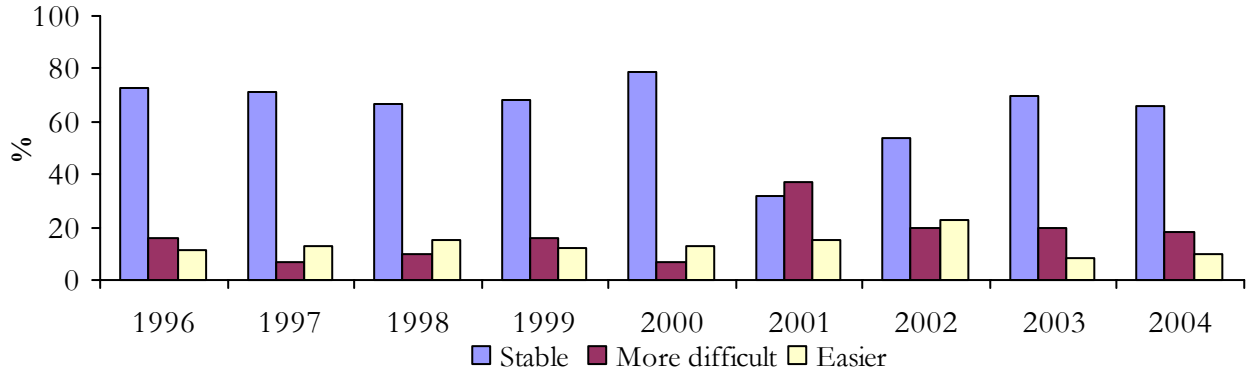


Source: IDRS IDU interviews

Reports of heroin availability were very similar to those reported in 2003. The majority of IDU (66%) that commented thought that heroin availability had remained stable (70% in 2003) in the preceding six months, while 18% thought it had become 'more difficult' (20% in 2003). Ten percent reported that heroin had become 'easier' to obtain (8% in 2003) and 6% thought availability 'fluctuated' (Figure 4).

Consistent with IDU comments, the majority of KE reported that heroin was 'easy' to 'very easy' to obtain. KE opinions on availability were more mixed, although the majority reported that availability had remained stable over the preceding six months.

Figure 4: IDU reports of change in availability of heroin in the past six months, 1996-2004



Source: IDRS IDU interviews

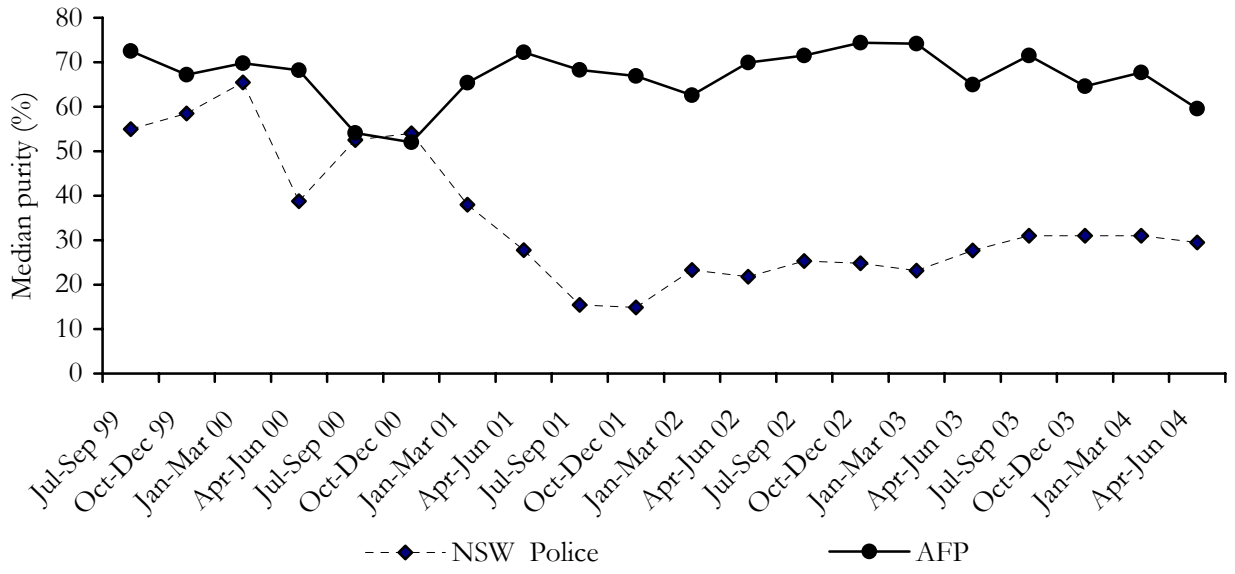
Methods of purchase were similar to those reported in 2003. IDU who reported purchasing heroin bought it predominantly by contacting dealers on mobile phones (45% in 2003 and 46% in 2004), from street dealers (31% in 2003 and 27% in 2004), home delivery (12% in 2003 and 5% in 2004) and the dealer's home (9% in 2003 and 12% in 2004). Nine percent bought or received heroin as a gift from a friend (3% in 2003). The usual time it took IDU to score heroin was generally between one and sixty minutes (median 15 minutes).

KE reports on whether methods of purchase had changed were mixed, with a sizeable proportion stating that methods of purchase had remained stable over the preceding six months.

4.3 Purity

Figure 5 shows that the median purity of NSW Police heroin seizures analysed remained stable over the past twelve months, and remains substantially lower (at approximately 30%) than levels reported in early 2001. With the exception of the last half of 2000 (when purity dropped to below 60%), the purity of Australian Federal Police (AFP) heroin seizures that were analysed remained relatively stable between 1999 and 2004 at between approximately 60% to 70%. This is consistent with AFP seizures being larger seizures that are detected at the border, at a higher level of distribution than state police seizures, prior to the heroin being 'cut' for lower, street level distribution. Purity of AFP seizures for the past two years however, should be interpreted with caution as it is based on small numbers of seizures (refer Figure 6, page 29).

Figure 5: Purity of heroin seizures analysed in NSW, by quarter, 1999 – 2004

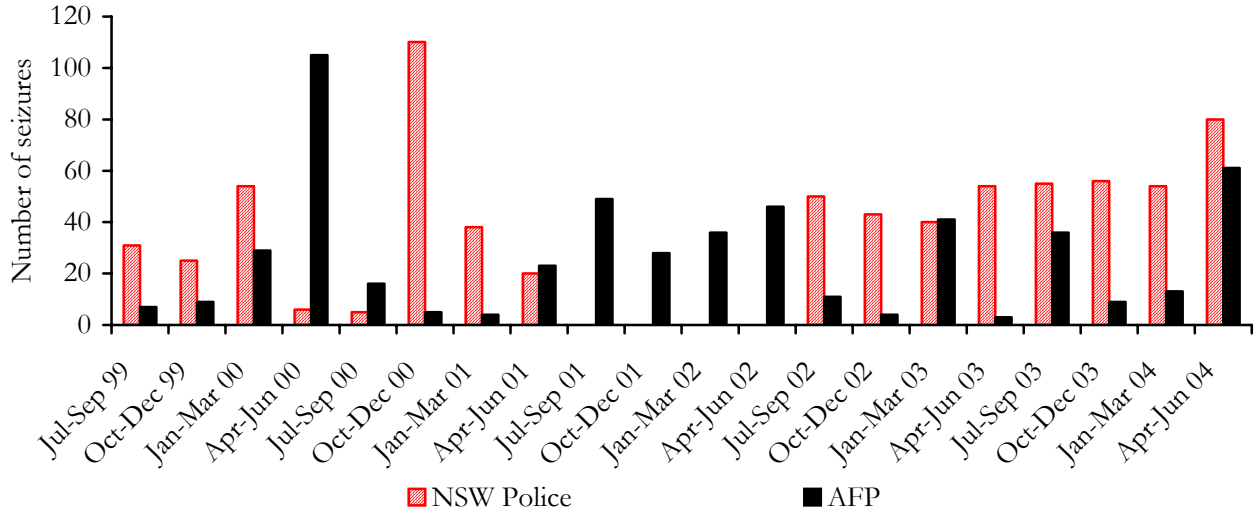


Source: ABCI 2001, 2002; ACC, 2003 & 2004

Figure 6 shows the number of heroin seizures upon which the above purity figures are based. It should be noted that not every seizure is analysed. In addition, the period between the date of seizure by police and the date of receipt at the laboratory can vary greatly, and no adjustment has been made to account for double counting joint operations between the AFP and NSW Police.

In the past two years, NSW Police have analysed approximately 60 seizures per quarter. The number of seizures analysed by the AFP per quarter have fluctuated over this period, with the lowest number analysed in the third quarter of 2003 (3 seizures) and the highest in the second quarter of 2004 (61 seizures).

Figure 6: Number of heroin seizures analysed in NSW, by quarter, 1999 – 2004



Source: ABCI 2001, 2002; ACC, 2003 & 2004

* NSW Police data for numbers of seizures for 2001/2002 were unavailable.

The majority (74%) of IDU commenting thought that heroin purity was 'low' (39%) to 'medium' (35%), 12% reported purity was 'high,' and 12% thought it fluctuated (comparable figures in 2003 were 37% 'low', 44% 'medium', 7% 'high' and 9% 'fluctuated'). Thirty-four percent of IDU commenting reported that purity had decreased (28% thought so in 2003), 28% thought that it had fluctuated (22% thought so in 2003), 26% thought it had remained stable (34% in 2003) and only 10% thought purity had increased in the preceding six months (15% thought so in 2003). IDU comments were generally consistent with NSW Police seizure data, and it is likely that these seizures rather than AFP seizures are reaching this group of street level users.

Consistent with IDU reports, many KE who commented thought heroin was of low to medium purity. No KE reported heroin purity as high and four KE thought purity was variable (fluctuating).

Half of the KE commenting thought purity had fluctuated in the preceding six months while three thought that it had remained stable and two thought it had decreased. One KE thought it had increased. These comments were generally consistent with IDU comments about heroin purity.

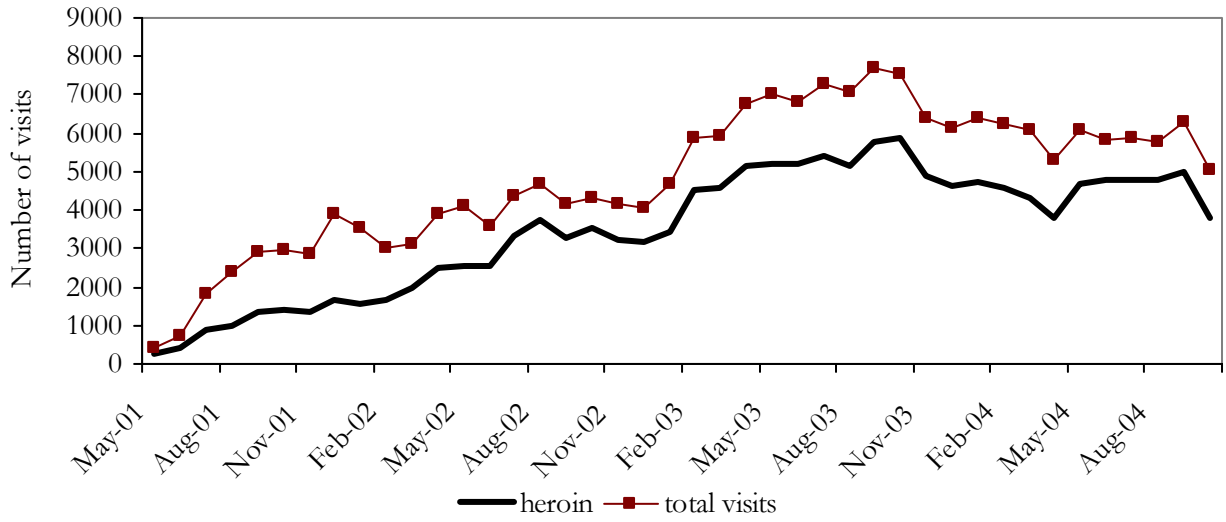
4.4 Use

4.4.1 Heroin use among IDU

Ninety-five percent of the sample had used heroin in the preceding six months. In 2004, similar proportions reported heroin as their drug of choice (78% compared to 84% in 2003), the drug injected most often in the month preceding interview (80% compared to 83% in 2003); and the last drug injected (80% compared to 77% in 2003).

Figure 7 shows the number of attendances to the Sydney Medically Supervised Injecting Centre (MSIC), in Kings Cross where heroin was the drug injected (based on client reports). The following caveats need to be considered when interpreting this data: 1) Hours of operation changed over the first 2 years of operation (from four to up to twelve per day) and 2) The numbers of individuals attending increased continuously over the first 2 years of operation, as IDU became aware of this new service. However, heroin has remained the drug most commonly injected since the centre opened, with the exception of July 2001-January 2002 where cocaine was equally or more commonly injected. Clients who injected heroin have accounted for over 70% of all visits since June 2002.

Figure 7: Number of attendances to MSIC where heroin was injected, and total number of visits, 2001-2004



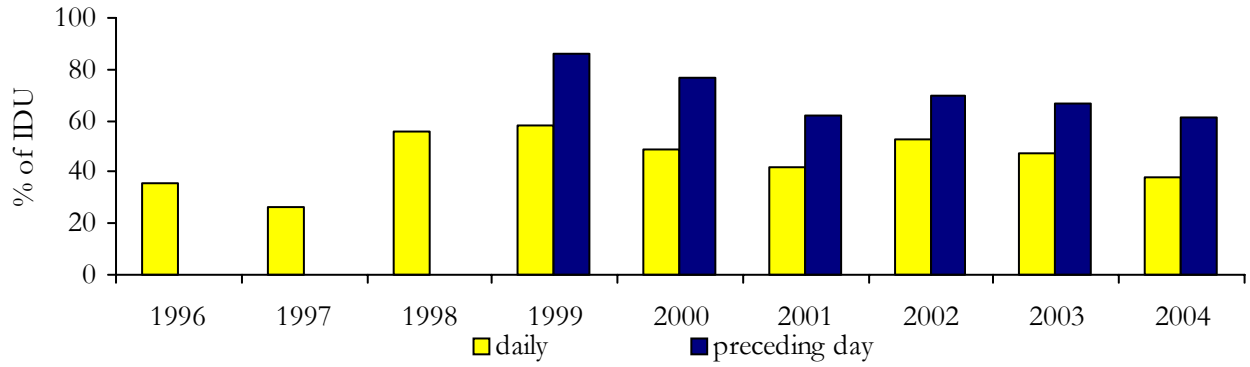
Source: Medically Supervised Injecting Centre, Kings Cross
NB: Total visits refers to the total number of valid visits at which a response was given

The overwhelming majority of KE reported that both prevalence and frequency of heroin use had remained stable in the preceding six months. The majority of KE believed that IDU were using heroin between one and three times per day, with some reports of between once per fortnight/weekly to four times per day. There were no reports of a change in the quantity of heroin being used.

4.4.2 Current patterns of heroin use

The median number of days of heroin use in the six months preceding interview decreased dramatically from 170 days (i.e. almost daily use) in 2003 to 120 days in 2004. The proportion of IDU reporting daily heroin use during this period also decreased from 47% in 2003 to 38% in 2004. Consistent with this, a slightly lower proportion (61%) of IDU reported heroin use on the day prior to interview compared with 2003 (71%, Figure 8).

Figure 8: Proportion of IDU reporting daily heroin use in preceding six months, and heroin use on the day preceding interview, 1996-2004



Source: IDRS IDU interviews
NB: Data collection on drugs used on the preceding day commenced in 1999.

Ninety-three percent of IDU who reported recent heroin use had used heroin powder and 93% reported using heroin rock in the six months preceding interview. Over half of the sample (52%) stated that heroin rock was the form they had used most often during this period. Several IDU reported that "rock" and "powder" forms often came together in the same deal.

Of the KE who commented, the majority reported that both rock and powder forms were used, and similar proportions reported mainly powder or mainly rock. However, it should be noted that nearly half of the KE sampled were uncertain of the heroin form used, and some reported that both forms sometimes came within the same deal. In addition there may be discrepancies in what users and KE classify as rock and powder.

KE reports were in agreement with IDU regarding route of administration of heroin. The vast majority reported that the main route of administration for heroin was injection while several made reference to a minority of users smoking heroin (this is consistent with 10% of IDU reporting that they smoked heroin in the preceding six months, Table 3 page 24). One KE noted that the relative proportions of those who inject and those who smoke heroin differs by cultural group, e.g. in Asian cultures in which "chasing the dragon" is a more traditional route of administration.

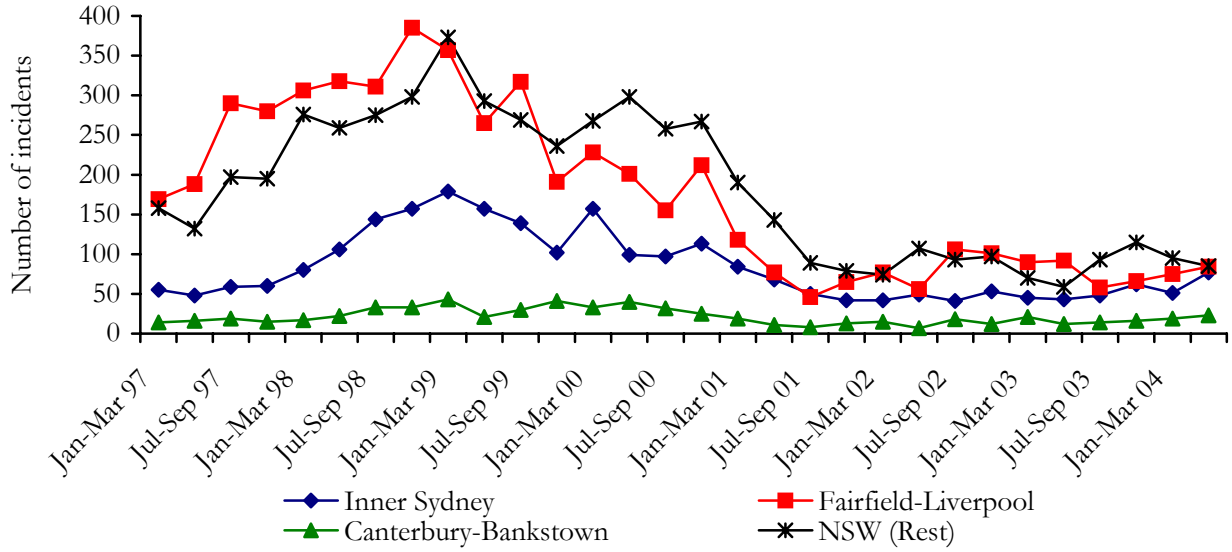
4.5 Heroin related harms

4.5.1 Law enforcement

Figure 9 shows the number of police recorded criminal incidents for heroin possession/use in the Inner Sydney area, the Fairfield-Liverpool area, the Canterbury-Bankstown area and the remainder of NSW from January 1997[8]. It is evident that the numbers of incidents detected declined throughout 2001 and have subsequently remained lower than levels prior to the heroin shortage. Throughout much of this period, incidents recorded in the Fairfield-Liverpool area are higher than in the Canterbury-Bankstown and Inner Sydney areas, and are often equivalent to figures from the rest of the state.

[8] The regions Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown refer to ABS Statistical Subdivisions.

Figure 9: Recorded incidents of heroin possession/use by geographic area 1997-2004



Source: NSW Bureau of Crime Statistics and Research

NB- Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both.

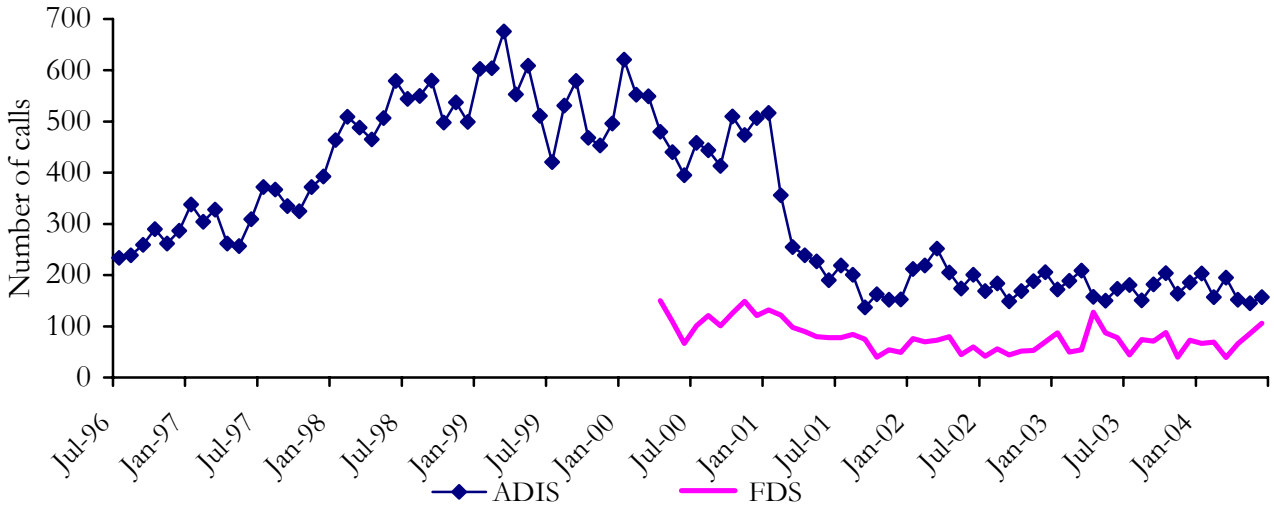
4.5.2 Health

Calls to telephone helplines

Figure 10 shows the number of calls to the Alcohol and Drug Information Service (ADIS) and to the Family Drug Support (FDS) line regarding heroin as the primary drug of concern. The number of enquiries to FDS regarding heroin were much lower than numbers received at ADIS, reflecting the different sizes of these services. FDS is a family support line and callers are often younger than callers utilising the ADIS service.

The number of calls to ADIS regarding heroin remained relatively stable over the last twelve months and they remained lower than numbers received prior to 2001. During 2001, calls almost halved from 517 in January 2001 to 255 in March 2001, and a decrease in the number of calls to FDS at this time was also observed. Calls to FDS regarding heroin remained relatively stable in the last three years with the exceptions of a sharp increase in the month of April 2003 (128 calls), and have increased again in the second quarter of 2004, although they remain lower than numbers recorded in 2000.

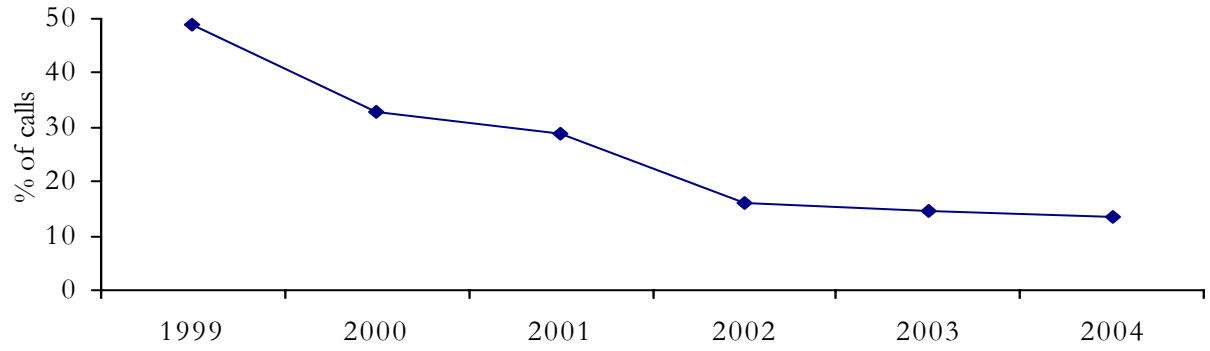
Figure 10: Number of enquiries to ADIS and FDS regarding heroin, 1996-2004



Source: Alcohol and Drug Information Service and Family Drug Support
N.B. Family Drug Support data were only available on a monthly basis from April 2000 and refers to calls where any mention of heroin was made. ADIS data refers to the number of calls where heroin was the primary drug of concern.

Yearly data (April-March) from Family Drug Support is shown in Figure 11 below, and shows that the proportion of calls relating to heroin has remained fairly stable over the past two years. This proportion remains substantially lower than those reported in the period 1999-2001.

Figure 11: Proportion of calls regarding heroin, 1999-2004

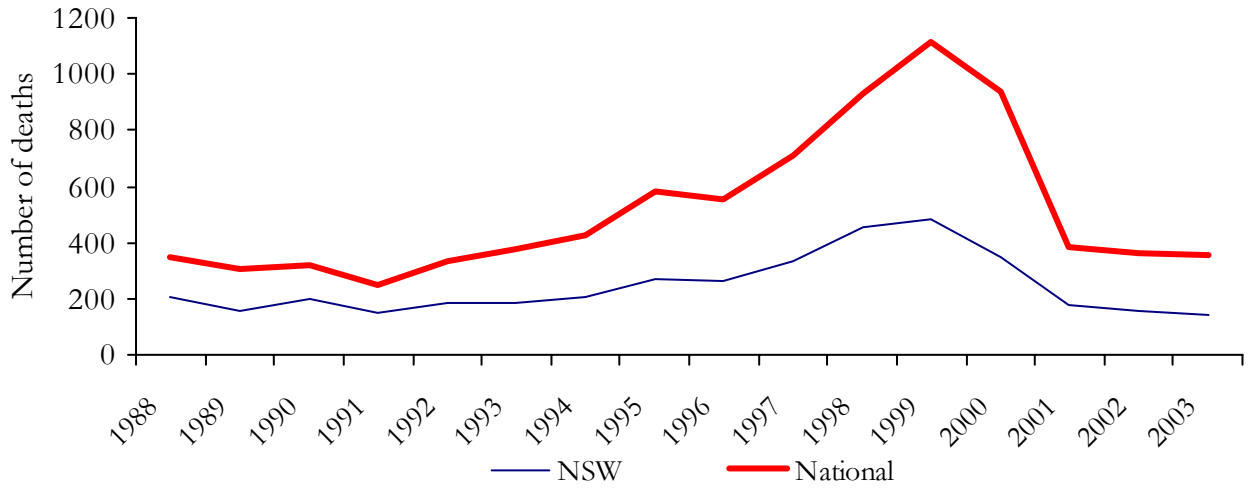


Source: Family Drug Support

Overdose

Figure 12 (overleaf) shows Australian Bureau of Statistics (ABS) data on accidental opioid deaths among those aged 15-54 in Australia and NSW for the period 1988-2003 (Degenhardt et al., 2004b). Deaths in NSW have remained relatively stable since 2001, and have accounted for just under half (between 40 – 46%) of the national total since this time. As in previous years, males accounted for the majority (71%) of the 2003 deaths in NSW (this figure was 82% in 2002). The number of deaths remained lower than those recorded in the period 1996-2001, in which they peaked in 1999 at 481.

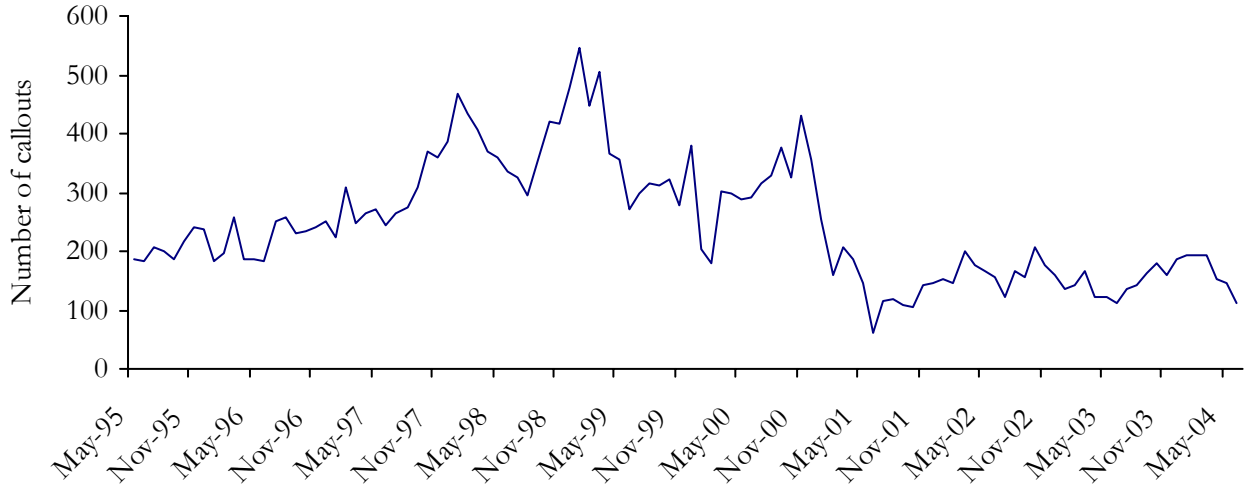
Figure 12: Number of accidental deaths due to opioids among those aged 15-54 years in NSW and Australia, 1988-2003



Source: Australian Bureau of Statistics mortality database

NSW ambulance callouts to overdoses has also remained relatively stable at approximately 100 to 200 calls per month since July 2001 (Figure 13). The number of calls decreased dramatically in late 2000, and has not returned to levels recorded during the period 1998 to 2000, during which they peaked at 545 in January 1999.

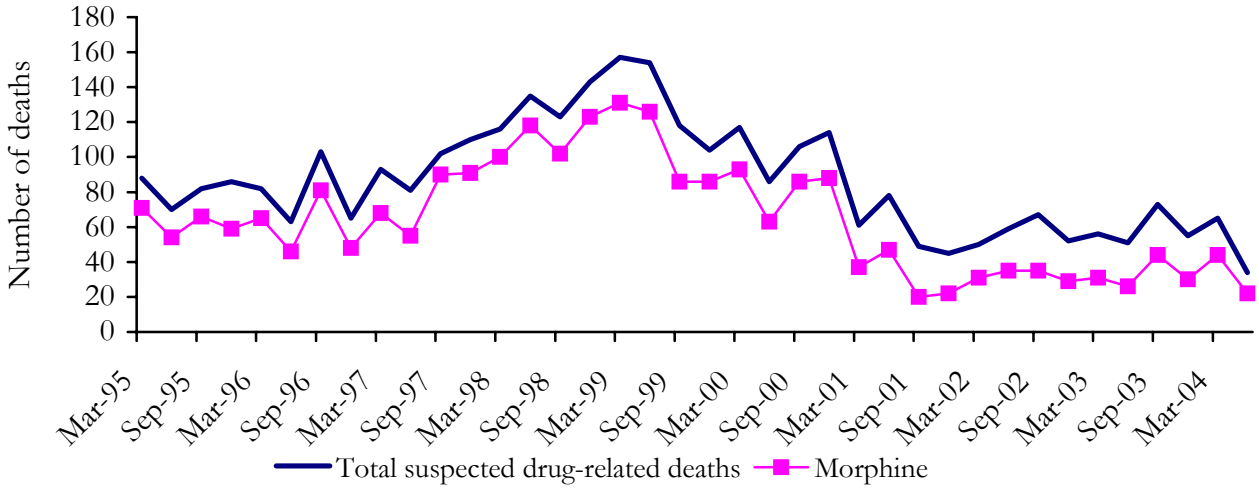
Figure 13: Number of ambulance callouts to overdoses 1995 – 2004



Source: Ambulance Service of NSW case sheet database

A similar pattern was observed in the number of deaths of suspected drug users (as determined by police or pathologists) in which morphine was detected, with figures remaining relatively stable in the past three years (Figure 14). Morphine related deaths made up approximately half of the total number of deaths in which drugs were detected during this period. As noted by other data sources, morphine related deaths decreased dramatically in early 2001. Since this time, figures have remained much lower than numbers recorded in earlier years.

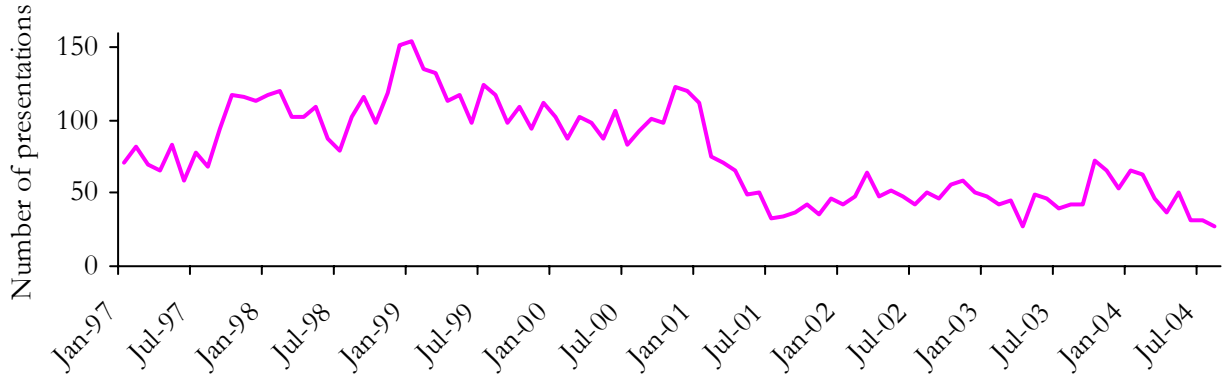
Figure 14: Number of suspected drug related deaths in which morphine was detected post mortem and total number of drug related deaths, 1995-2004



Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories
N.B. These numbers relate to deaths in which morphine (a metabolite of heroin) was detected, however there may have also been other drugs present.

A slight peak in the number of heroin overdose presentations to NSW emergency departments was observed in late 2003-early 2004, with 72 presentations in October 2003 (Figure 15). This increase represents the highest number of presentations since early 2001, when a downward trend in numbers was observed. However, following the peak in late 2003, levels decreased to among the lowest recorded since 1997.

Figure 15: Heroin overdose presentations to NSW emergency departments, 1997-2004



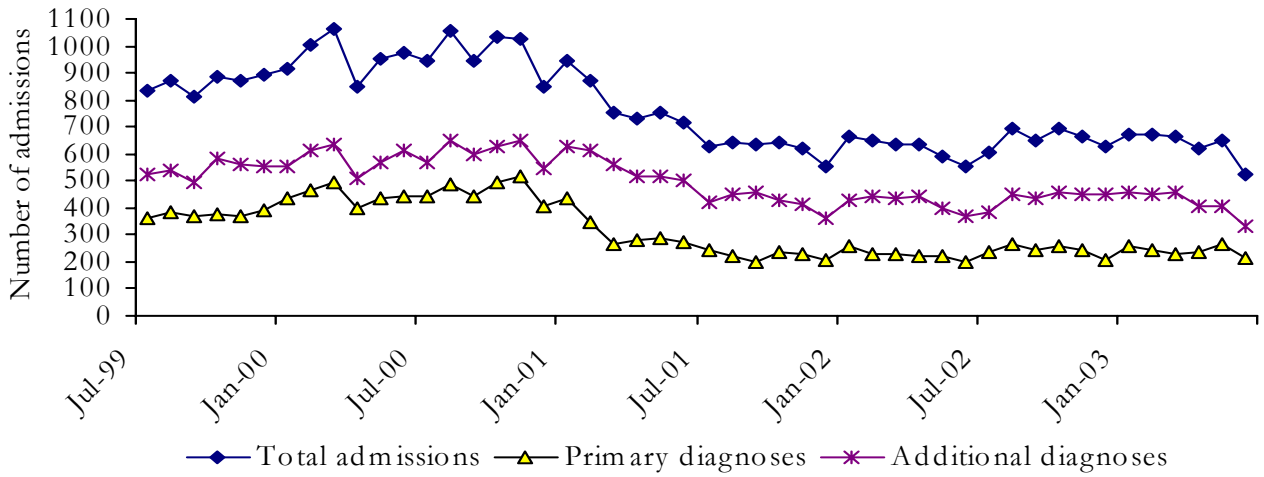
Source: Emergency Department Information System, NSW Department of Health

Hospital Admissions

The number of hospital separations among persons aged 15-54 years in which opioids were coded as the principal and/or an additional diagnosis are shown in Figure 16 below. Diagnoses are based on ICD-10 (Second Edition) codes, and it is possible for one admission to have opioids as both a principal

and as an additional diagnosis[9]. Similar to IDU data and other indicators, figures have remained lower over the past two years, following a decrease in 2001.

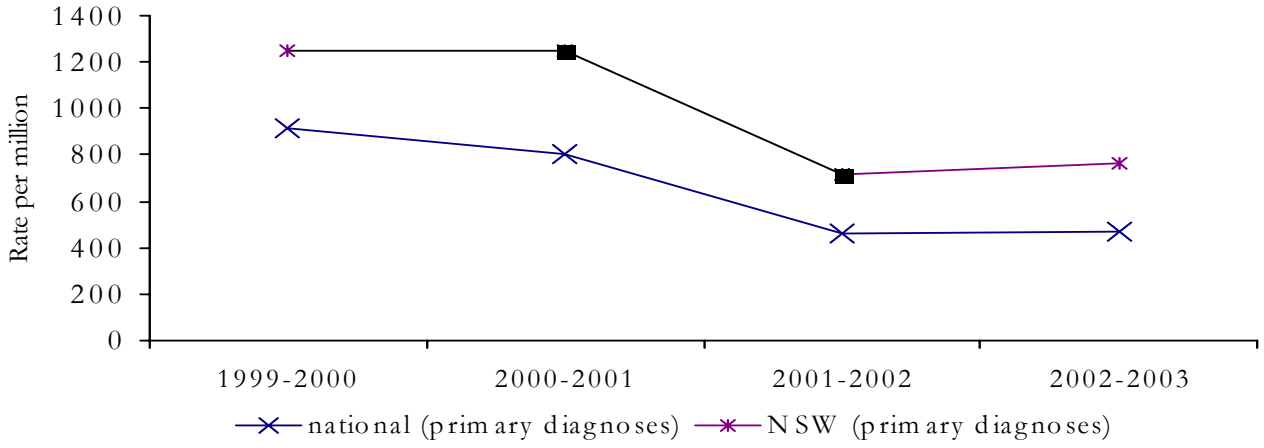
Figure 16: Number of inpatient hospital admissions in persons aged 15-54 where opioids were implicated, NSW 1999-2004



Source: Australian Institute of Health and Welfare

Figure 17 shows the rates of inpatient hospital admissions where opioids were the primary diagnosis per million people aged 15-54 years. Although there has been a slight increase between 2001/2002 and 2002/2003, rates have remained substantially lower than in previous years. Since 1999/2000, NSW has consistently accounted for approximately 50% of inpatient admissions in across Australia where opioids were the primary diagnosis.

Figure 17: Rate of inpatient hospital admissions where opioids were the primary diagnosis per million people aged 15-54 years, NSW and nationally, 1999/2000 to 2000-2003



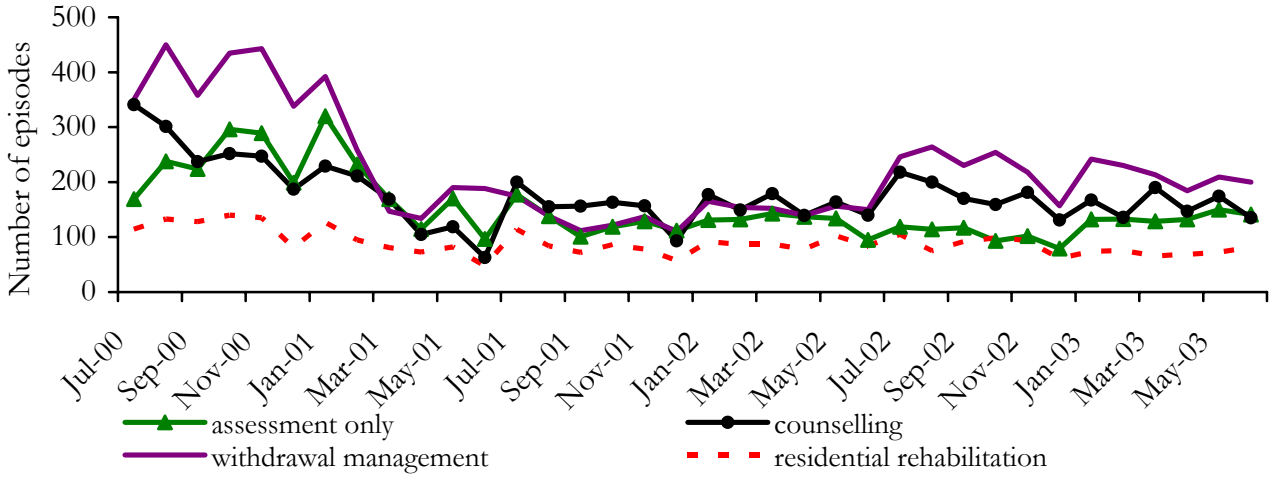
Source: Australian Institute of Health and Welfare

[9] Principal diagnosis: The diagnosis established (after study) to be chiefly responsible for occasioning the patient's episode of care in hospital. Additional diagnosis: A condition or complaint either co-existing with the principal diagnosis or arising during the episode of care.

Treatment

Figure 18 shows the number of closed treatment episodes based on the date of commencement where the principal drug of concern was opioids, by treatment type. Data for 2003/2004 were unavailable at the time of publication. Numbers entering for assessment only between July 2002 and June 2003 remained relatively stable, although somewhat lower than numbers throughout 2000. Numbers entering residential rehabilitation also remained relatively stable in the previous twelve months, ranging between 61 and 105 per month. Numbers entering withdrawal management were slightly higher in 2002/2003 than during 2001 however, they remained lower (between 150 and 264 per month) than numbers throughout 2000 (between 338 to 450 per month). Numbers entering counselling between July 2002 and June 2003 fluctuated between 131 and 218 per month.

Figure 18: Number of heroin treatment episodes by treatment type, NSW July 2000-June 2003

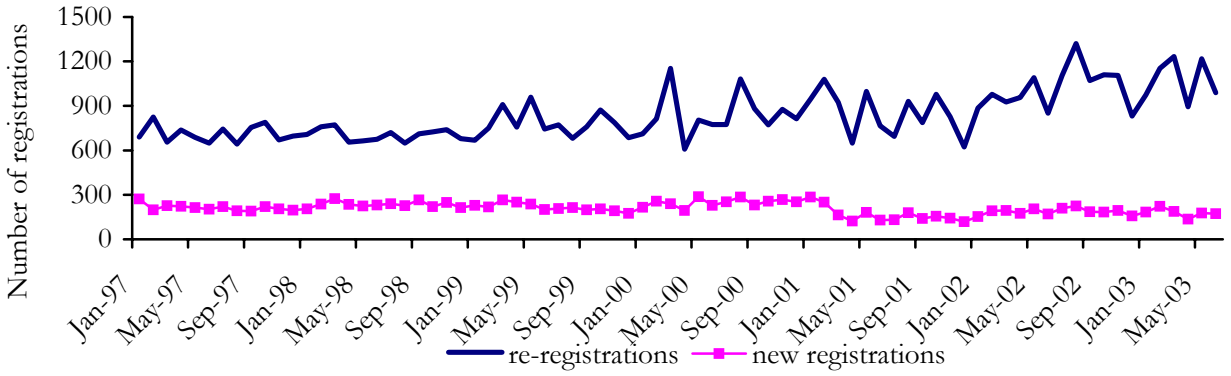


Source: National Minimum Data Set (NMDS) for Alcohol and Other Drug Treatment Services, NSW Department of Health.

N.B.The NMDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period.

Figure 19 shows that although there were fluctuations in the number of re-registrations for opioid pharmacotherapy during the period 1997 to 2003, numbers had been increasing over the last two years. Numbers for new registrations remained relatively stable since mid-2001. Data for 2003/2004 were unavailable at the time of publication.

Figure 19: Number of registrations for opioid pharmacotherapy, NSW 1997-2003



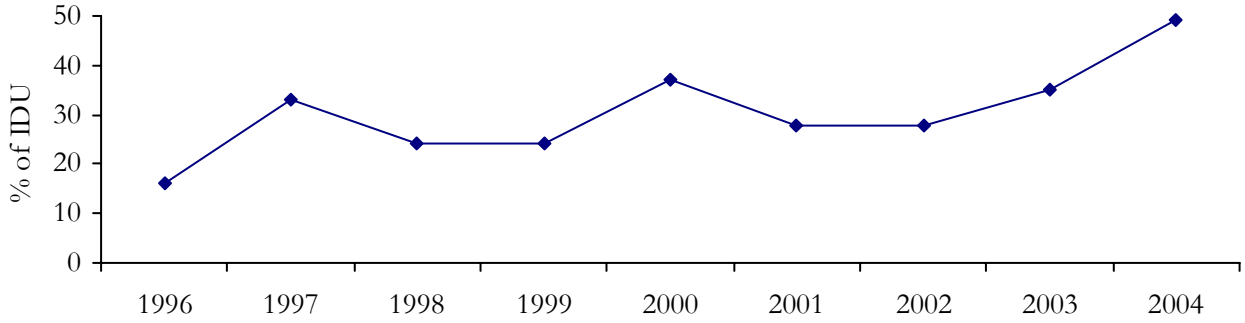
Source: Pharmaceutical Services Branch, NSW Department of Health

Methadone treatment

As in the 2003 IDRS, in 2004 a distinction was made between the use of prescribed (licit; where the prescription was in the participant's name) and non-prescribed (illicit, i.e. the prescription was in someone else's name) methadone and physeptone. This section will discuss the use of prescribed methadone and physeptone only. The use of illicit (or non-prescribed) methadone and physeptone will be discussed under 'Opioids'.

Fifty-six percent of IDU had used methadone that had been prescribed for them in the preceding six months (44% reported any use of licit methadone during this period in 2003), a third of whom also reported illicit methadone use. Ten percent of IDU reported injecting prescribed methadone in the six months preceding interview. Two percent of IDU reported using prescribed physeptone tablets, and only two IDU reported injecting prescribed physeptone in the preceding six months. There has been a steady increase in the proportion of IDU reporting current engagement in a methadone maintenance programme, from 16% in 1996 to 49% in 2004 (Figure 20). Over half of IDU (55%) reported receiving methadone treatment in the preceding six months (compared to 34% in 2001). Methadone syrup was the predominant form used.

Figure 20: Proportion of IDU reporting current methadone treatment, 1996-2004



Source: IDRS IDU interviews

Among those who used prescribed methadone, the median number of days of use in the preceding six months was 180 days compared with 162 days in 2003. The median number of days' use of prescribed physeptone use was four days, representing a decrease from 35 days in 2003; however these figures are based on small numbers. Seventy-one percent of methadone users reported daily use, representing a substantial increase from 45% in 2003. Similarly, the proportion of IDU reporting methadone use on the day prior to interview doubled, from 23% in 2003 to 47% in 2004.

Overall, IDU reports indicated a substantial increase in both the prevalence and the frequency of methadone use, consistent with increased numbers reporting engagement in a methadone treatment programme. However, it should be noted that the IDRS deliberately recruits a 'sentinel' population of IDU who are current and active participants in illicit drug markets. As a consequence, those in the IDU samples who report being in treatment may not be representative of treatment populations more generally.

Buprenorphine treatment

The 2004 IDRS also distinguished between the use of prescribed and non-prescribed buprenorphine. Use of illicit (or non-prescribed) buprenorphine will be discussed under 'Opioids.' Thirty-six percent of IDU reported ever having been prescribed buprenorphine (compared with 30% in 2003), and 17% reported using it in the preceding six months (this figure was 23% in 2003). Ten percent stated they were currently participating in buprenorphine treatment (this figure was 9% in 2003) and 16% (compared with 21% in 2003) reported receiving buprenorphine treatment in the preceding six months. Among those who used buprenorphine, the median number of days of use was 90 (compared to 60 in 2003). Only six IDU reported daily use (compared with three in 2003). IDU data indicated that the prevalence of participation in buprenorphine treatment has remained fairly stable, while frequency of buprenorphine use has increased.

A number of KE reported that they had noticed an increase in client enquiries regarding buprenorphine treatment, although reports were mixed.

4.6 Trends in heroin use

As in previous years of the IDRS, when IDU commented on general trends in heroin use, the main trend reported was that younger people were using heroin. Consistent with the 2003 IDRS, a number of IDU also commented that there appeared to be more female users, and that they were often involved in prostitution, in addition to a broader range of people using heroin.

As compared with the 2003 IDRS, similar numbers of IDU reported that the general prevalence of heroin use (as opposed to their own use) had declined, representing a decrease from previous years. Again, as in 2003, IDU reported that the frequency of heroin use among those other than themselves still using heroin had increased. This was often attributed to low purity. A number of IDU stated that while the number of injections had increased, the amount used on each occasion of use had decreased.

In contrast to IDU data, the majority of KE reported that patterns of heroin use- including number of users and frequency of use- had remained stable. Nevertheless, there were a few KE reports of slightly decreasing trends. A broader range of ethnic groups using heroin was noted by some KE.

4.7 Summary of heroin trends

- The price of a gram of heroin remained stable in 2004, however, it has remained substantially higher than prices reported prior to the heroin 'shortage' in 2001.
- IDU reports of heroin availability suggest that it has remained relatively stable and has not returned to levels recorded prior to 2001.
- The purity of AFP heroin seizures remained relatively stable over the past twelve months at approximately 60% to 70%. The purity of NSW Police seizures also remained stable, although at a lower level (approximately 30%).
- The majority of IDU thought heroin was of low to medium purity. A third thought that purity had decreased and a quarter thought that purity had remained stable.
- Frequency of heroin use has decreased since 2004.
- Indicator data were relatively stable for the past twelve months, with some slight decreases in early 2004. Figures for all data collections have remained substantially lower than figures recorded prior to 2001.

5 METHAMPHETAMINE

In response to the increasing diversification of the methamphetamine markets in Australia identified by the 2001 IDRS (Topp et al., 2002), data is collected for three different forms of methamphetamine; methamphetamine powder ('speed'); methamphetamine base ('base'), and crystal methamphetamine ('ice'). Speed is typically fine-grained powder, generally white or off-white in colour, but may range from white through to beige or pink due to differences in the chemicals used to produce it. Base is the paste methamphetamine that is 'moist', 'oily' or 'waxy' and is often brownish in colour. It can be difficult to dissolve for injection due to its oily consistency. Ice comes in crystalline form, in either translucent or white (sometimes with a pink, green or blue hue) crystals that vary in size. A fourth form, liquid amphetamine or 'oxblood', has also been identified, however as it is used infrequently, IDU are not surveyed regarding its price, purity or availability.

Thirty six percent of IDU commented on the price, purity and availability of speed, 25% commented on base, and 37% commented on ice. The following percentages refer to these proportions of IDU commenting on methamphetamine.

Ten KE commented on use patterns of one or more forms of methamphetamine. Among these, six mentioned speed powder (as opposed to 'speed' being used as a generic term for methamphetamine), six base and nine mentioned ice use patterns among the users with whom they had contact. Many provided information about methamphetamine in general, without making a distinction between different forms. Smaller numbers of KE reported on price, purity and availability.

5.1 Price

Prices paid for speed, base and ice by IDU on the last occasion of purchase are presented in Table 5 below:

Table 5: Price of most recent methamphetamine purchases by IDU, 2004

Amount	Median price* $	Number of purchasers*
Speed		
Gram	100 (50)	3 (8)
"Halfweight" (0.5 grams)	50 (50)	10 (13)
Point (0.1 gram)	50 (50)	13 (11)
Base		
Gram	200 (200)	5 (5)
"Halfweight" (0.5 grams)	150 (150)	11 (2)
"Eightball" (3.5 grams)	425 (250)	4 (3)
Point	50 (50)	22 (23)
Ice		
Gram	280 (250)	9 (7)
"Halfweight" (0.5 grams)	150 (150)	13 (6)
Point (0.1 gram)	50 (50)	28 (32)

Source: IDRS IDU interviews
* 2003 data is presented in brackets

Speed

As with previous years, the amounts of speed most commonly purchased were points and halfweights (median price $50 for both, the same as 2003). Fewer IDU purchased grams, and no eightball purchases were reported in 2004 (compared with seven eightball purchases in 2003, median price $200).

The median price of a gram of speed was $100, representing an increase from $50 reported in 2003 and a return to the median price reported in 2002. However, the number of IDU purchasing a gram of

speed were small and have been steadily decreasing over the past few years, from 15 in 2002 to eight in 2003 and three in 2004.

Prices have generally remained stable in 2004, and 75% of IDU commenting reported such stability in the preceding six months (71% reported stable prices in 2003). Twelve percent who commented thought that prices had increased (as compared with only 4% in 2003), 7% didn't know (15% in 2003) and a smaller proportion (4%) thought that prices had decreased (a decrease from 9% in 2003). Two percent reported the price to have fluctuated (the same as 2003).

Three KE commented on speed price, with the price for a gram reported to range from $80 to $100- reports consistent with IDU data. An eightball was reported to range from $150 to $250. Prices were generally agreed to have remained stable.

Base

Twenty-two IDU reported buying base in points in the preceding six months, making it the most popular purchase amount (23 IDU reported buying points in 2003). Fewer IDU reported buying grams, eightballs and halfweights of base (Table 5).

The median price for points, halfweights and grams of base remained the same as prices reported in 2003 ($50, $150 and $200, respectively). The median price for an eightball was reportedly $425, which represents a substantial increase from $220 in 2003. However, this price is based on only two IDU reports and therefore should be interpreted with caution.

Seventy-three percent of those who commented (as compared with 65% in 2003) reported that the price of base had remained stable over the preceding six months. Fifteen percent stated that it had increased (4% said so in 2003), 5% that it had decreased (4% in 2003), 5% didn't know (23% in 2003) and 2% thought that it had fluctuated (4% in 2003).

Four KE commented on the price of base, with the price for a point ranging from $30 to $50. Price was generally reported to have remained stable over the preceding six months.

Ice

As with speed and base, the most commonly purchased amounts of ice were points (28 purchases) and halfweights (13 purchases). Prices for these amounts remained the same as those reported in 2003 at $50 and $150, respectively. Nine respondents reported purchasing a gram of ice, at a median price of $280, an increase from $250 in 2003. Only two respondents reported buying an eightball in the six months preceding interview (Table 5).

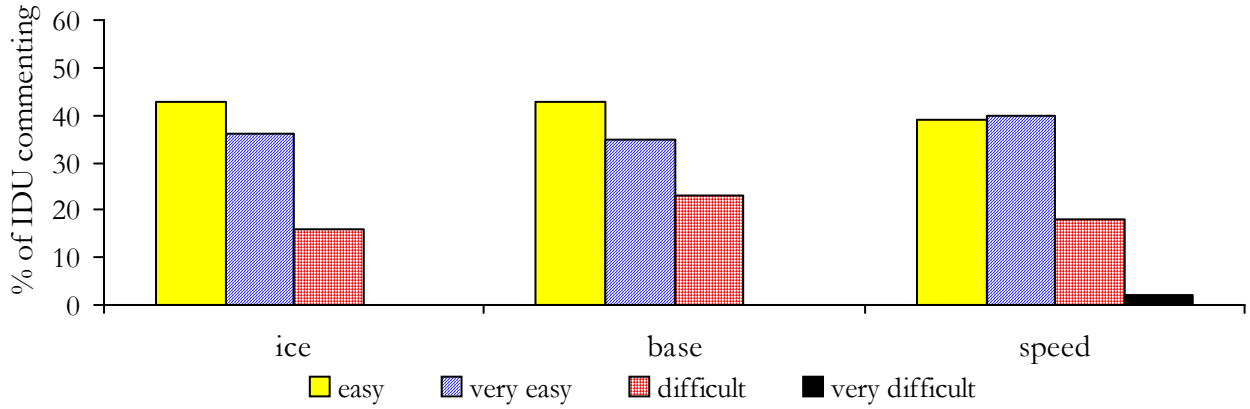
Fifty-six percent of IDU commenting thought the price of ice had remained stable (53% thought so in 2003) in the preceding six months, 15% thought it had increased (10% in 2003) 12% thought it had decreased (7% in 2003) and 10% didn't know (29% in 2003). Seven percent thought that it had fluctuated (none thought so in 2003).

Five KE commented on the price of ice, with the price for a point ranging from $35 to $75. As with speed and base, the price for ice was generally believed to have remained stable over the preceding six months.

5.2 Availability

Among the IDU who reported on the availability of speed, 79% thought it 'very easy' (40%) to 'easy' (39%) to obtain (35% thought it 'very easy' and 40% 'easy' in 2003). Eighteen percent commenting believed that it was 'difficult' and 2% 'very difficult' (Figure 21). Sixty-eight percent of the IDU commenting on speed thought that availability had remained stable in the preceding six months (53% thought so in 2003) while 14% thought that it had become 'easier' to obtain. Seven percent reported that it had become 'more difficult' and two percent thought that availability 'fluctuated'.

Figure 21: IDU reports of ease of availability of speed, base and ice in the past six months, 2004



Source: IDRS IDU interviews

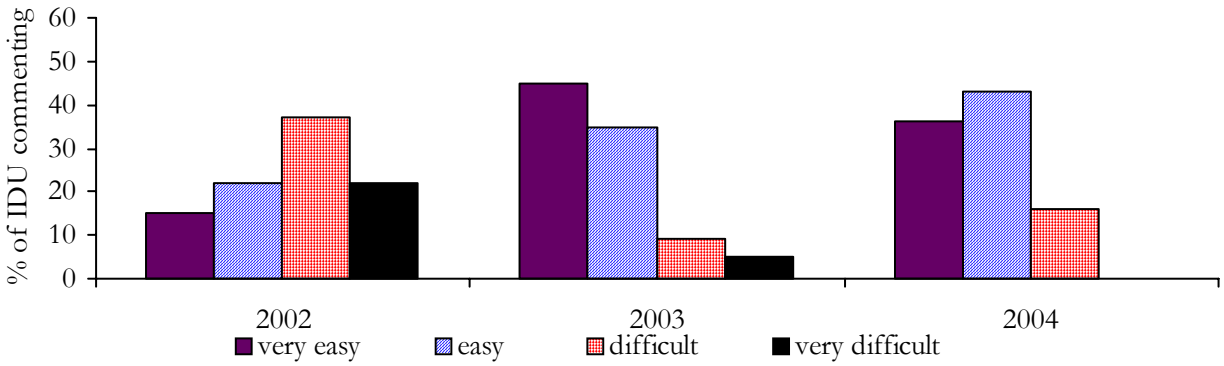
Similar to the 2003 IDRS, 77% of IDU commenting on base reported that it was 'easy' (43%, compared to 42% in 2003) to 'very easy' (35%, compared to 33% in 2003) to obtain. Twenty-three percent thought it 'difficult' (19% in 2003) to obtain. Sixty-three percent of IDU commenting believed that base availability had remained 'stable' in the six months preceding interview, while 15% thought it had become 'easier' (the same as 2003) and 7% (15% in 2003) thought it 'more difficult' to obtain.

KE comments were concordant with IDU data, suggesting that base was 'easy' to 'very easy' to obtain. Availability was generally reported to have increased, although it should be noted, that numbers of KE commenting on base availability were small (n=4).

The majority (79%) of IDU commenting on ice reported that it was 'easy' (43%- as compared with 35% in 2003) to 'very easy' (36%; 45% in 2003) to obtain (Figure 22). Sixteen percent though it 'difficult' and none thought it 'very difficult' to obtain. These figures suggest that ice availability has remained relatively stable since 2003. Consistent with these reports, the majority (58%) of those commenting stated that ice availability had remained 'stable' to obtain in the preceding six months (an increase from 38% in 2003). Fifteen percent thought that it had become 'more difficult' to obtain, 10% thought it had become 'easier' and 9% believed it had 'fluctuated'.

In agreement with IDU data, most KE who commented reported that ice was 'easy' to 'very easy' to obtain. Availability was generally reported to have remained stable over the preceding six months.

Figure 22: IDU reports of ease of availability of ice in the past six months, 2002– 2004



Source: IDRS IDU interviews

IDU predominantly bought speed from street dealers (21%), friends (14%) and by visiting a dealer's home (13%). Purchasing patterns were similar to those reported in 2003, with the exception of a reduction in proportions arranging purchase via mobile phones. Nearly one third (27%) of IDU reported buying speed by contacting dealers on mobile phones in the 2003 IDRS. In 2004 this figure decreased to 9%. The median time that IDU reported it usually took them to score speed was 20 minutes (the same as in 2003).

IDU usually obtained base by contacting dealers via mobile phone (30%), from street dealers (28%) and from dealers' homes (13%). These figures represent a slight increase in the proportions using mobile phones as their main method of scoring (21% in 2003), and a decrease in proportions reporting usually receiving it as a gift from friends (15% in 2003 to none in 2004). The median time to score was half an hour (the same as 2003).

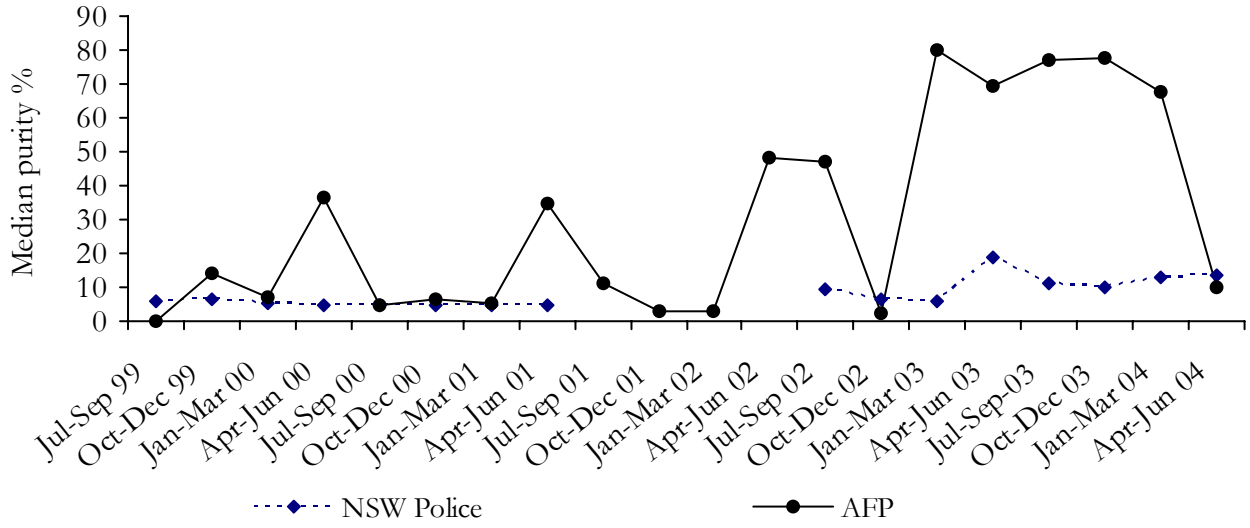
IDU predominantly bought ice from a street dealer (28%) and by arrangement via mobile phone (24%). Proportions reporting usually visiting a dealer's home, purchasing from a friend and receiving it as a gift from friend were evenly divided (10% each). These figures are similar to those reported in 2003, with the exception of purchase from a street dealer (40% in 2003). The median time IDU reported it usually took them to score was half an hour- twice that reported in 2003 (15 minutes).

5.3 Purity

Figure 23 shows the median purity of methamphetamine seizures analysed in NSW for the period 1999 to 2004. The median purity of AFP seizures was relatively high (ranging between 50 and 80%) in the past twelve months with the exception of the second quarter of 2004 when it was 9.8% (range 2%-78%). These figures should be interpreted with caution as they are based on small numbers of seizures analysed (Figure 24, page 47). In contrast, NSW Police seizures that were analysed were lower in purity (at approximately 10% to 15%), and remain higher than the median purity levels recorded previously (approximately 6%).

It should be noted that figures do not represent the purity levels of all methamphetamine seizures – only those that have been analysed at a forensic laboratory. In addition, the period between the date of seizure by police and the date of receipt at the laboratory can vary greatly, and no adjustment has been made to account for double counting joint operations between the AFP and NSW Police.

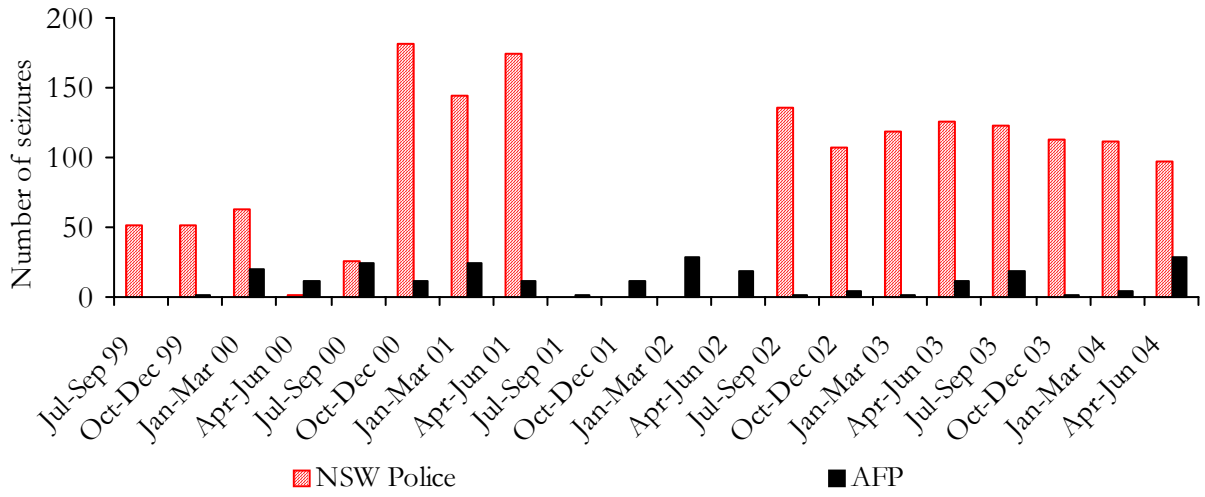
Figure 23: Purity of methamphetamine seizures analysed in NSW, by quarter, 1999 – 2004



Source: ABCI 2001, 2002; ACC, 2003 & 2004
NB: NSW Police data for 2001/2002 were unavailable.

Figure 24 shows the number of methamphetamine seizures upon which the above purity figures are based. Numbers of AFP seizures analysed have remained below 30 per quarter since 1999. The number of NSW Police seizures analysed has remained higher, at approximately 100 seizures per quarter, for the past twelve months.

Figure 24: Number of methamphetamine seizures analysed in NSW, by quarter, 1999 – 2004



Source: ABCI 2001, 2002; ACC, 2003 & 2004
NB: NSW Police data for 2001/2002 were unavailable.

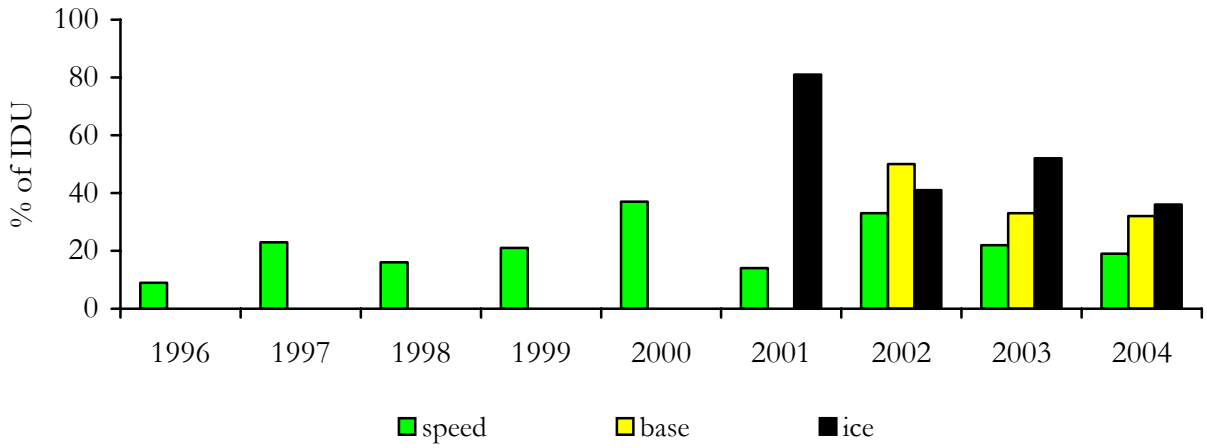
The majority (58%) of IDU commenting on speed thought that purity was 'medium' (32%) or 'low' (26%). Nineteen percent thought that purity was 'high', while 7% thought it 'fluctuated'. These figures are similar to the 2003 IDRS. Thirty-nine percent reported that purity had remained stable in the preceding six months (36% in 2003), while 21% thought it had decreased (12% in 2003) and 18% thought it had fluctuated (16% in 2003). Only four percent thought that it had increased (15% in 2003).

The majority (71%) of IDU commenting on base thought that it was of 'medium' (39%) to 'high' (32%) purity, while 17% thought it was 'low' and 10% thought that it 'fluctuated'. These figures are similar to the 2003 IDRS, where 68% reported purity to be 'medium' (35%) to 'high' (33%). Fifty-one percent reported that purity had remained stable in the preceding six months (40% in 2003), while 20% believed it had decreased (17% in 2003) and 10% that it had increased (13% in 2003). Fifteen percent thought that purity had fluctuated (8% in 2003).

The majority (78%) of IDU perceived ice to be of 'medium' (41%; 26% in 2003) to 'high' (36%; 52% in 2003) quality, while only 3% thought it was 'low' and 9% thought it 'fluctuated'. Forty-four percent thought that purity had remained stable in the previous six months, while 24% thought it had decreased (15% in 2003) and 10% that it had increased (12% in 2003). Nine percent thought that purity had fluctuated (10% in 2003).

Figure 25 shows the proportion of IDU reporting the purity of each form of methamphetamine as 'high'. Greater proportions of IDU reported ice and base as being 'high' in purity than speed.

Figure 25: Proportion of IDU reporting speed, base and ice purity as 'high', 1996-2004



Source: IDRS IDU interviews
N.B. Data on base purity was not collected until 2002, while ice purity commenced in 2001.

KE reports were mixed, with all forms fluctuating in purity. Speed was generally agreed to be less pure than ice and base; however, few were able to comment on whether purity had changed in the preceding six months.

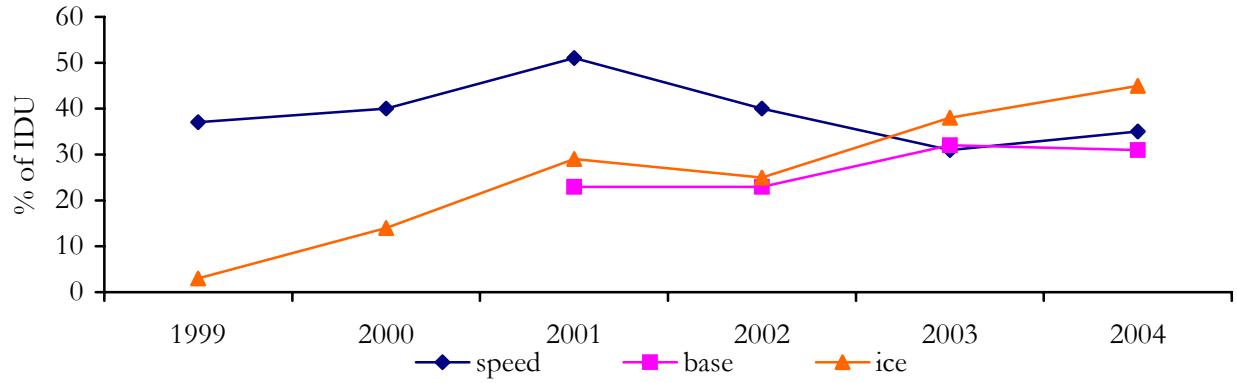
5.4 Use

5.4.1 Methamphetamine use among IDU

Fifty-six percent of IDU had used some form of methamphetamine (speed, base or ice) in the six months preceding interview, similar to the 2003 sample (53%). With regards to the different forms, 35% reported using speed (31% reported speed use in 2003), 31% reported using base (32% in 2003) and 45% reported using ice (38% in 2003) during this period. These figures, aside from a slight increase in prevalence of ice use, represent little change from 2003 (Figure 26).

Figure 26 shows that the prevalence of speed use has decreased since 2001, while use of the more potent forms of methamphetamine, particularly ice, has increased since this time. It should be noted that data collection on the use of base did not commence until 2001.

Figure 26: Proportion of IDU reporting methamphetamine use in the past six months, 1999-2004

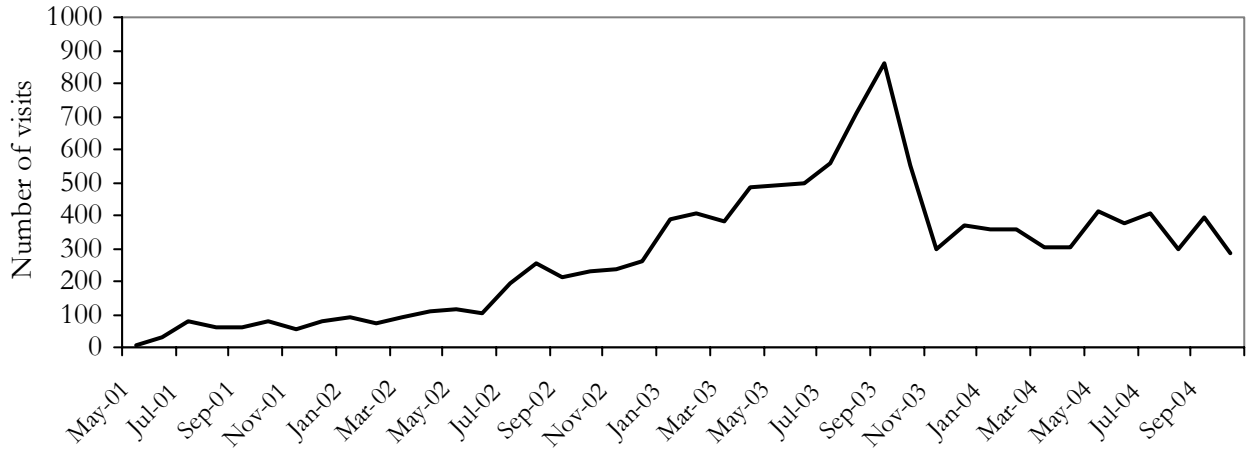


Source: IDRS IDU interviews

Smaller percentages (5%) reported using amphetamine liquid in the preceding six months, the median number of days used was five and the median days injected was one. Recent use of pharmaceutical stimulants remains relatively low, with only 6% of IDU reporting use in the preceding six months (a slight increase from 1% in 2003). The median number of days on which IDU had used pharmaceutical stimulants was five. Two percent of the sample had injected pharmaceutical stimulants on a median of two days.

Figure 27 shows the number of attendances to the Medically Supervised Injecting Centre (MSIC) where methamphetamine was the drug injected[10]. Numbers reporting methamphetamine have increased gradually since 2001, reaching a peak in September 2003 (861 visits, accounting for 11% of all visits), followed by a steep decline. Figures have remained relatively stable since December 2003, accounting for between 5-7% of visits.

Figure 27: Number of attendances to MSIC where methamphetamine was injected, 2001-2004



Source: Medically Supervised Injecting Centre, Kings Cross

[10] The following caveats need to be considered when interpreting this data: 1) Hours of operation changed over the first 2 years of operation (from four to up to twelve per day) and 2) The numbers of individuals attending increased continuously over the first 2 years of operation as IDU became aware of this new service.

One KE had also noted a similar peak in methamphetamine use in late 2003 followed by a decrease in 2004 (this KE referred specifically to ice). Other KE reports were mixed, with some noting no change, and others an increase in use over the preceding six months (i.e. approximately January-June 2004).

5.4.2 Current patterns of methamphetamine use

The median number of days of speed use (i.e. via any route of administration) in the preceding six months was seven (3 in 2003), for base it was six (2 in 2003) and for ice it was five days (the same as 2003). Only one respondent reported daily speed use in the preceding six months, with 26% of those who had used speed having done so once per week or more (an increase from 15% in 2003). However, the majority (60%) of those who had used speed had done so on 10 days or less (79% in 2003). These figures represent a marginal increase in the number of days' use among the 35% of IDU who reported recent use of speed.

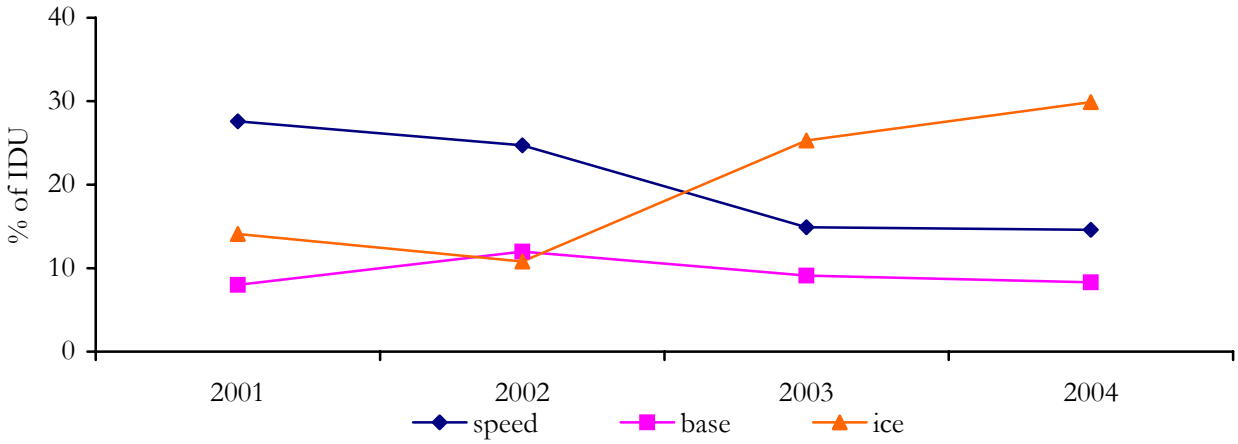
There were no reports of daily base or ice use, with one third (33%) of those reporting base use having used once per week or more in the preceding six months (14% in 2003). The majority (54%) had used on ten days or less (80% in 2003). Thirty-one percent of IDU who had used ice had done so once per week or more (29% in 2003), again with the majority (56%; 58% in 2003) having used on ten days or less. These figures represent a slight increase in days of base use by IDU who had used in the preceding six months. Days of ice use among those who used ice remain similar to 2003 figures.

Considered together, among those who had used any form of amphetamine/methamphetamine in the last six months (including speed, base, ice, liquid amphetamine and pharmaceutical stimulants), the median number of days' use was 26. This represents a substantial increase from 8 days in 2003.

KE reports regarding any change in the frequency of speed, base and ice use were mixed. This may be a reflection of the sporadic patterns of use reported by IDU.

Proportions of IDU reporting ice as the methamphetamine form most used in the preceding six months remained similar to the 2003 IDRS (30% compared to 25% in 2003). Proportions reporting speed (15%; same as in 2003) or base (8%; 9% in 2003) as the form used most often also remained stable. This represents a change from previous years, when speed was the predominant form of methamphetamine used by IDU (Figure 28, page 51).

Figure 28: Methamphetamine form most used in the preceding six months, 2001-2004



Source: IDRS IDU interviews
NB- Data collection on the form most used commenced in 2001.

KE comments also reflected those of IDU with the majority reporting ice as the form most used among IDU, although an increased number of KE than in 2003 noted either that base was the form most used or that the group of users to whom they referred commonly used a number of forms rather than predominantly using ice.

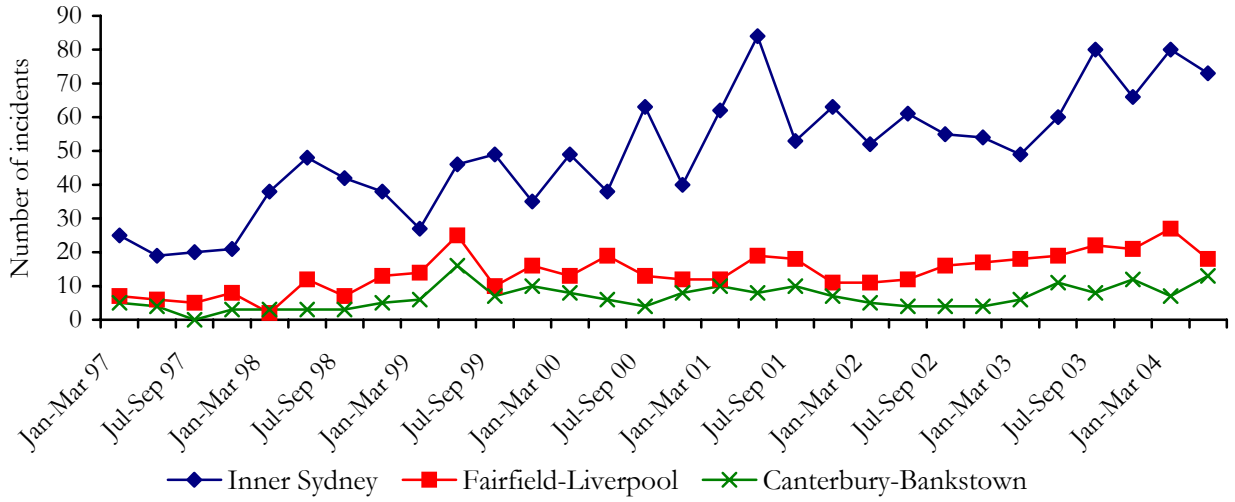
5.5 Methamphetamine related harms

5.5.1 Law enforcement

Figure 29 shows that the number of police recorded criminal incidents per month for amphetamine possession/use is higher in the Inner Sydney area than it is in Fairfield-Liverpool and Canterbury-Bankstown[11]. Recorded incidents in the Inner Sydney area fluctuated between 18 and 29 incidents per month in the last twelve months. Overall, there was a slight increase in recorded incidents compared with the previous year, although this has remained lower than the sharp increases noted in the early half of 2001. The number of incidents recorded for the Liverpool-Fairfield and Canterbury-Bankstown areas have remained relatively stable in the past three years, with a slight peak of 16 incidents in Fairfield-Liverpool during February 2004.

[11] The regions Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown refer to ABS Statistical Subdivisions.

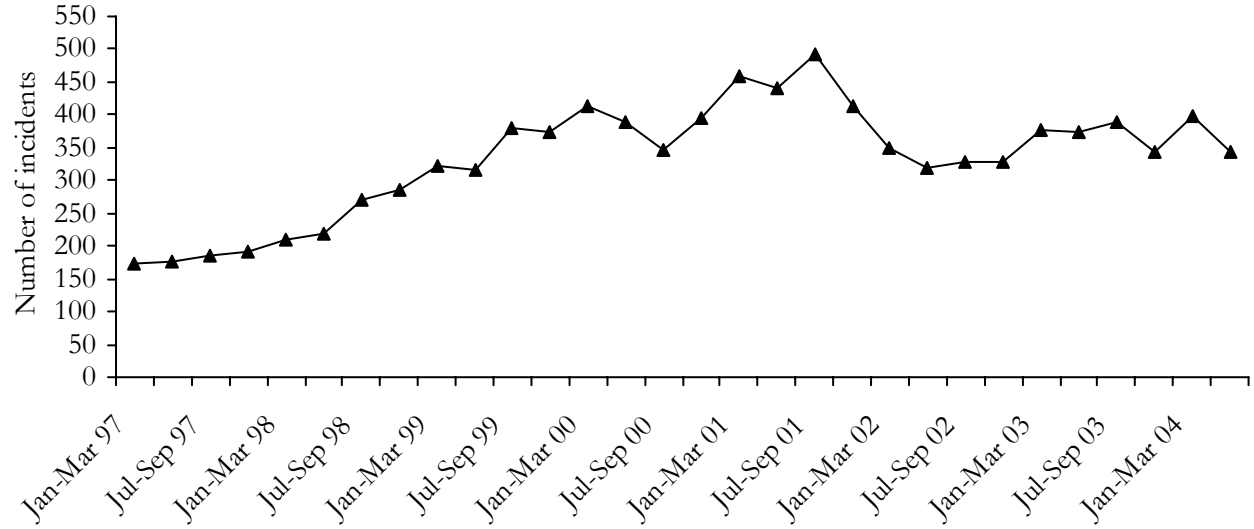
Figure 29: Recorded incidents of amphetamine possession/use by geographic area, 1997 –2004



Source: NSW Bureau of Crime Statistics and Research
NB- Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both.

The increases in early 2001 noted in Inner Sydney (which occurred during the "peak" of the heroin shortage) also occurred across the rest of NSW (Figure 30). Although the number of recorded incidents in early 2001 appears to have been the highest since 1997, the overall pattern of incidents of amphetamine use recorded by police appears to be a continuing upward trend.

Figure 30: Recorded incidents of amphetamine possession/use by geographic area (remainder of NSW), 1997 –2004

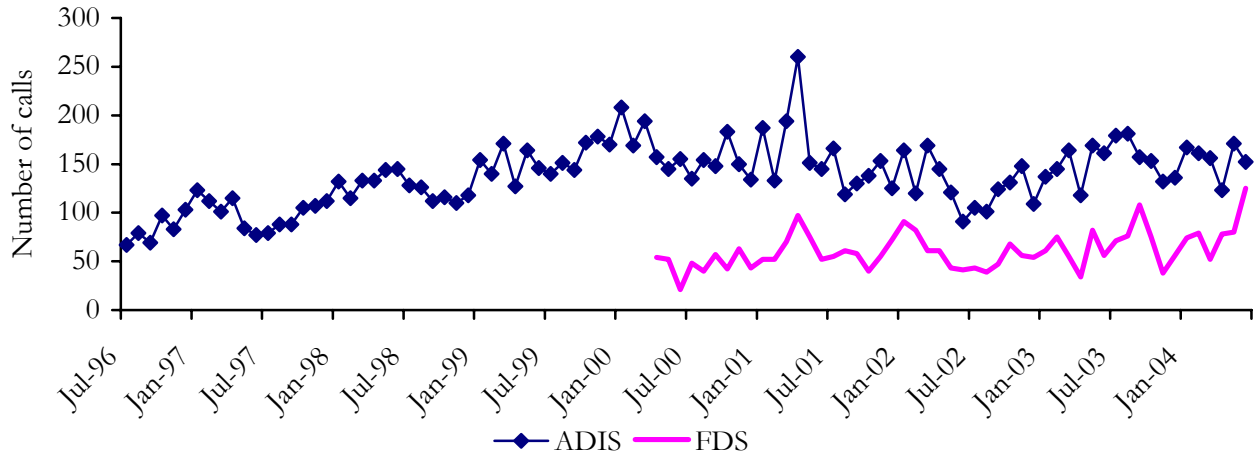


Source: NSW Bureau of Crime Statistics and Research
NB- Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both.

5.5.2 Health

Figure 31 shows the number of calls to the ADIS and FDS lines regarding amphetamines. Similar to heroin, the number of enquiries to FDS regarding amphetamines was much lower than numbers received at ADIS during the period 2000 to 2003. Figures for both ADIS and FDS have fluctuated in the past twelve months however, a steady increase was evident in the number of calls received by FDS regarding amphetamines during this period, with the greatest number of calls ever recorded being received in June 2004. Calls to both services regarding amphetamines increased in early 2001, simultaneous to the decrease in number of calls received regarding heroin.

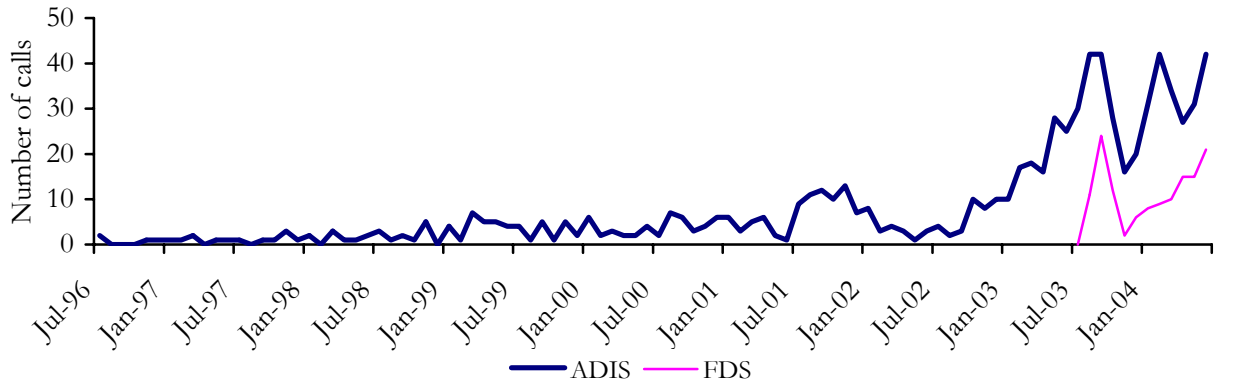
Figure 31: Number of enquiries to ADIS and FDS regarding amphetamines, including 'ice', 1996-2004



Source: Alcohol and Drug Information Service and Family Drug Support
N.B. Family Drug Support data were only available from April 2000 and refers to calls where any mention of amphetamines was made. ADIS data refers to the number of calls where amphetamines were the primary drug of concern.

Figure 32 shows the number of calls for ice, one of the more potent forms of methamphetamine. Whilst these figures have fluctuated, with an increase in 2001 consistent with Figure 31 above, a sudden decrease in late 2003 can also be observed. Although the number of calls remains relatively low, a clear increase can be seen in the number of calls relating to this more potent form of methamphetamine since the late 1990s.

Figure 32: Number of enquiries to ADIS and FDS regarding 'ice', 1996-2004



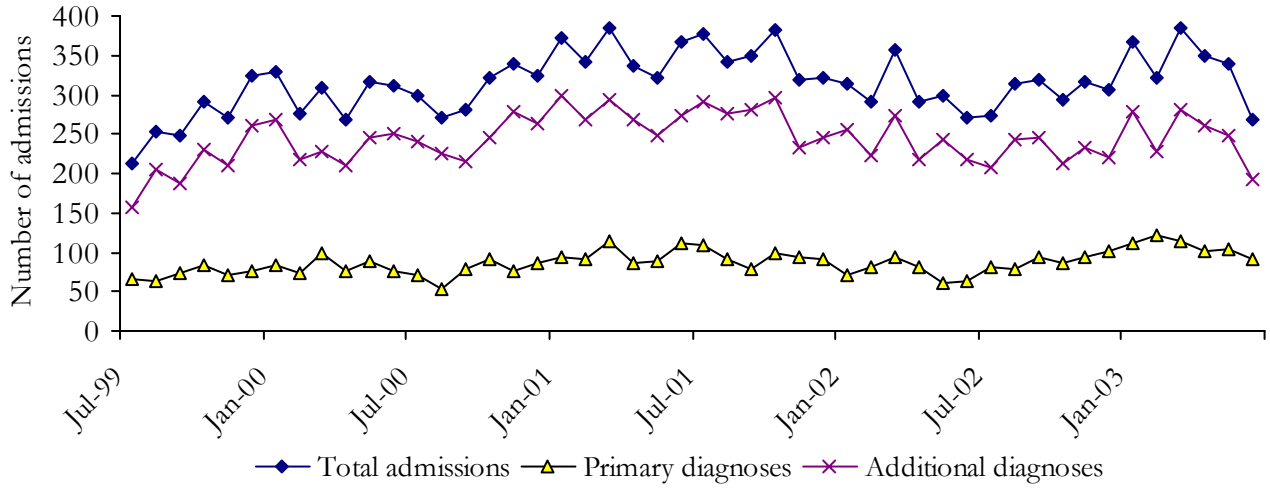
S

ource: Alcohol and Drug Information Service and Family Drug Support
N.B. Family Drug Support commenced distinguishing between forms of amphetamine/methamphetamine in July 2003. Family Drug Support data refers to calls where any mention of ice was made. ADIS data refers to the number of calls where ice was the primary drug of concern.

Similar to 2003, a number of KE reported concern surrounding an increase in mental health problems related to use (notably psychotic symptoms). However, in 2004 a number of other KE reported a decrease in psychotic symptoms, which was attributed by one KE to users becoming more careful in their use of the more potent forms.

The number of inpatient hospital admissions among persons aged 15-54 years in which amphetamines were implicated as a principal and/or an additional diagnosis among are shown in Figure 33 below. As outlined previously, diagnoses are based on ICD-10 (Second Edition) codes, and it is possible for one admission to have amphetamines as both a principal and as an additional diagnosis[12]. These figures refer to persons aged between 15-54 years of age. Figures have fluctuated over the time period 1999/2000 – 2002/2003.

Figure 33: Total number of inpatient hospital admissions in persons aged 15-54 where amphetamines were implicated, NSW 1999-2003

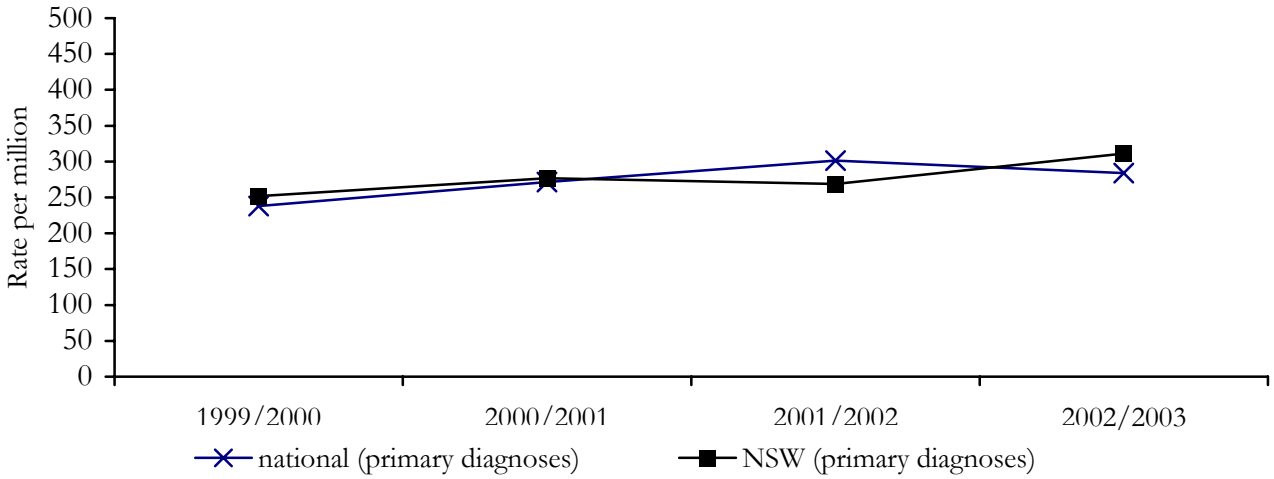


Source: Australian Institute of Health and Welfare

Figure 34 shows the rates of hospital admissions where amphetamines were the primary diagnosis per million people aged 15-54 years. Rates have remained similar across all four years and are comparable to the national rate over this period. Between 1999/2000 and 2002/2003, NSW has accounted for approximately one third of all inpatient admissions where amphetamines were the primary diagnosis.

[12] Principal diagnosis: The diagnosis established (after study) to be chiefly responsible for occasioning the patient's episode of care in hospital. Additional diagnosis: A condition or complaint either co-existing with the principal diagnosis or arising during the episode of care.

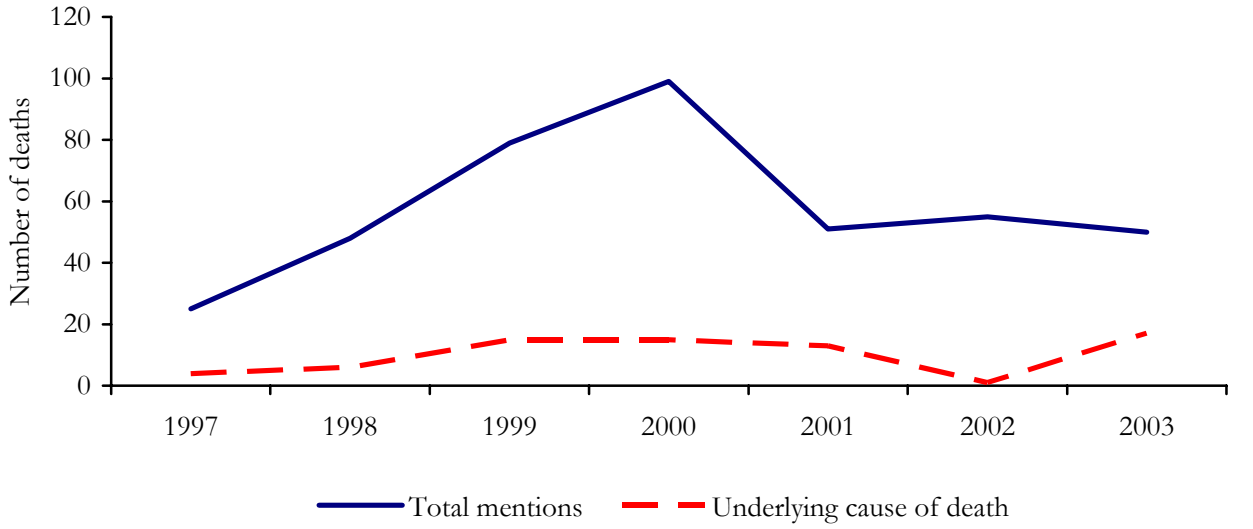
Figure 34: Rate of inpatient hospital admissions where amphetamines were the primary diagnosis per million people aged 15-54 years, NSW and nationally, 1999/2000 to 2002/2003



Source: Australian Institute of Health and Welfare

Figure 35 shows Australian Bureau of Statistics (ABS) data on accidental drug-induced deaths in which methamphetamine was mentioned among those aged 15-54 in Australia for the period 1997-2003 (Degenhardt et al., 2004c). This includes deaths where it was determined to be the underlying cause of death, as well as those where methamphetamine was detected but where another drug was believed to be primarily responsible. Deaths have remained relatively stable since 2001, following a sharp increase in total mentions in 2001. The number of deaths in which methamphetamine was determined to be the underlying cause has remained relatively stable over time at less than 20 per year, with 17 recorded in 2003.

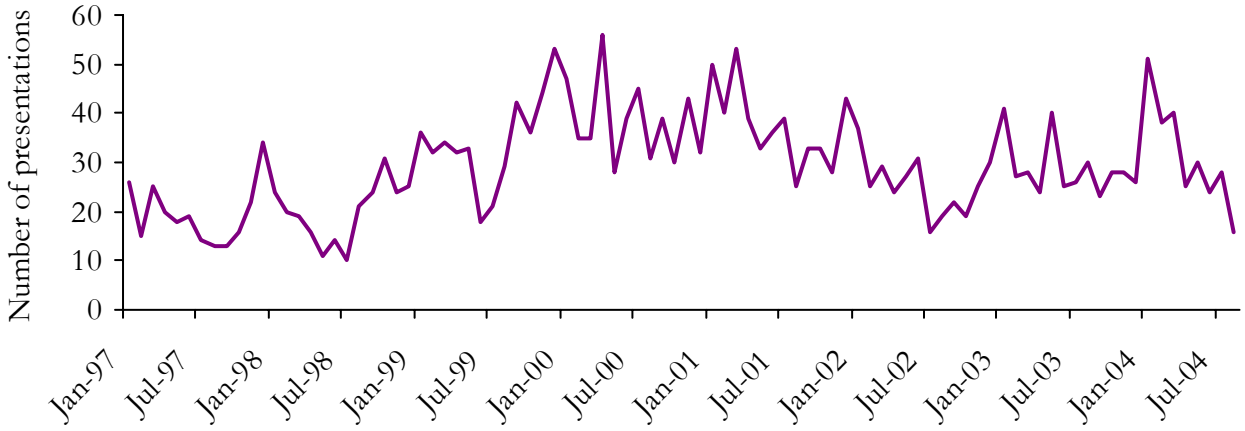
Figure 35: Number of accidental drug-induced deaths mentioning methamphetamine (total and underlying) among those aged 15-54 years in Australia, 1997-2004



Source: Australian Bureau of Statistics Causes of Death database

The total number of amphetamine overdose presentations to NSW emergency departments fluctuated in the past twelve months, peaking at 51 in January 2004 and decreasing to 16 in August 2004 (Figure 36).

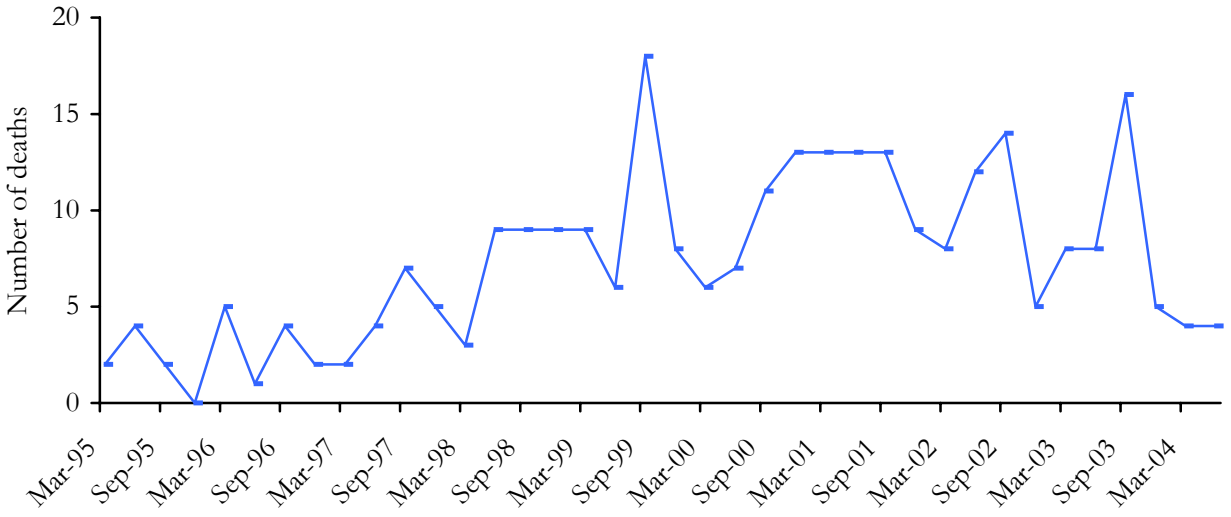
Figure 36: Amphetamine overdose presentations to NSW emergency departments, 1997-2004



Source: Emergency Department Information System, NSW Department of Health

The number of suspected drug related deaths in which methamphetamine was detected (Figure 37) has fluctuated over the past two years and, in the first half of 2004, decreased to the lowest level reported since 1998.

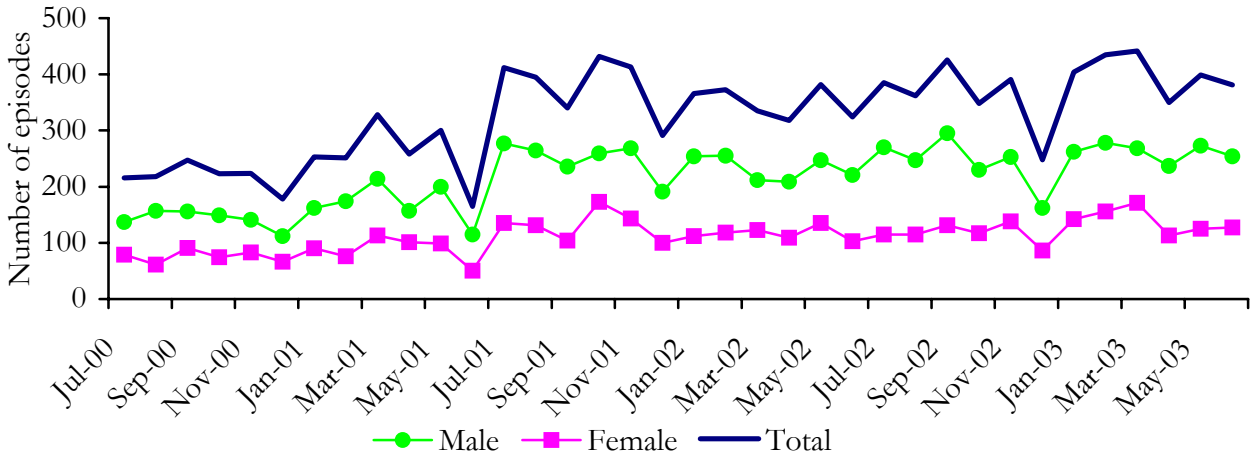
Figure 37: Number of suspected drug related deaths in which amphetamines were detected post mortem, 1995-2004



Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories
N.B. These numbers relate to deaths in which amphetamines, including methamphetamine, were detected, however there may have also been other drugs present.

The number of closed treatment episodes based on the date of commencement where the principal drug of concern was amphetamines remained relatively stable over the period July 2002 to June 2003 (Figure 38, page 57). Prior to this, there was a steady increase from 178 in December 2000 to 300 in May 2001, coinciding with the peak of the heroin shortage, and figures remained relatively stable at a higher rate between 2001 and 2002. Data for 2003/2004 were unavailable at the time of publication.

Figure 38: Number of ATS treatment episodes by gender, NSW July 2000 – June 2003



Source: NMDS-AODTS, NSW Department of Health.

N.B.The NMDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period.

5.6 Trends in methamphetamine use

All participants were asked at the end of the survey if there were any recent changes in the types of drugs their friends had been using. Approximately two thirds of IDU commenting on recent changes in the types of drugs being used reported increased use of one or more forms of methamphetamine. Ice was the form most commonly reported (47%), while 13% of those commenting reported a move to base and 5% to speed.

KE comments were mixed, with some noting an increase in methamphetamine use (typically ice, and often among users who predominantly used heroin), and others noting no change. This may reflect different patterns of use across different groups of users.

5.7 Summary of methamphetamine trends

- Prices have remained relatively stable over time for all three forms of methamphetamine.
- All three forms of methamphetamine remained readily available compared to 2003, particularly ice and speed. Availability had generally remained stable over the preceding six months.
- Prevalence of speed and base use remained similar to 2003, while use of ice increased slightly. This represents a shift away from speed use and toward use of the more potent forms of methamphetamine since 2001.
- Patterns of methamphetamine use continued to be sporadic across all three forms, with very small numbers reporting daily ice use in the preceding six months. However, while the proportions of IDU reporting recent methamphetamine use remained relatively stable, those who had used any form of amphetamine had done so on a greater number of days during the past six months (from approximately once per month in 2003 to approximately once per week).
- Ice remained the most commonly used form of methamphetamine in the preceding six months.
- Indicator data showed a somewhat mixed picture with regard to amphetamine use although all data showed increases during 2001. Some indicators (e.g. recorded incidents of amphetamine possession/use in some areas of Sydney, calls to telephone helplines) have remained higher over the past 12 months than previously, while others have continued to fluctuate (amphetamine related deaths, overdose, inpatient hospital admissions).

6 COCAINE

Forty-eight percent of IDU commented on the price, purity and availability of cocaine, and the following percentages refer to this proportion of IDU. As stated previously, cocaine KE were difficult to find this year, as many had not had contact with cocaine users. As a consequence, only two KE reported on the use, three on purity and price and four on the availability of cocaine.

6.1 Price

Prices paid for cocaine by IDU on the last occasion of purchase are presented in Table 6. The median price for a gram of cocaine was $290, an increase from $200 reported in all previous years (Figure 39, page 60). However, only six IDU had recently purchased a gram, with each reporting paying a different amount (range $180-$400). Despite this, an increase in the median price per gram by all those commenting (i.e. who had not necessarily purchased it themselves; n=25) was also observed (from $200 in 2003 to $250 in 2004), so this may be indicative of a genuine market increase.

The median prices for halfweights and quarter grams also increased, although due to small numbers commenting on the latter, results should be interpreted with caution. The median price for a cap of cocaine was $50, the same price reported in 2003 (Figure 39).

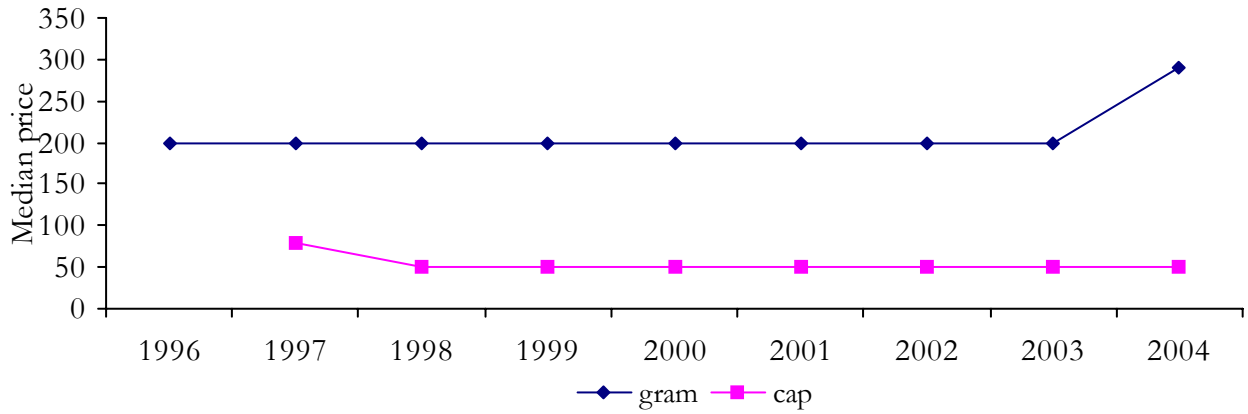
Caps continued to be the most popular purchase amount. Numbers purchasing caps remained lower than in 2002, when 84 respondents reported purchase. Likewise, numbers reporting purchase of grams, half grams and quarters also remained comparable to 2003, but much lower than in 2002.

Table 6: Price of most recent cocaine purchases by IDU, 2004

Amount	Median price* $	Number of purchasers*
Gram	290 (200)	6 (11)
Cap	50 (50)	34 (37)
"Halfweight" (0.5 grams)	140 (100)	12 (11)
Quarter gram	72.50 (70)	4 (4)

Source: IDRS IDU interviews
*2003 data is presented in brackets

Figure 39: Median price of a gram and cap of cocaine estimated from IDU purchases, 1996-2004



Source: IDRS IDU interviews

Seventy percent of IDU commenting on cocaine reported that the price had remained stable in the preceding six months (67% said so in 2003). Sixteen percent thought that the price had increased (22% in 2003), 1% thought it had decreased (2% in 2003) and 13% didn't know (7% in 2003).

One KE who reported on price stated that a gram of cocaine ranged from $180-$350 a gram depending on supply networks, while the other two reported that a gram generally cost from $200-$300. All three reported that the price had remained stable in the preceding six months.

6.2 Availability

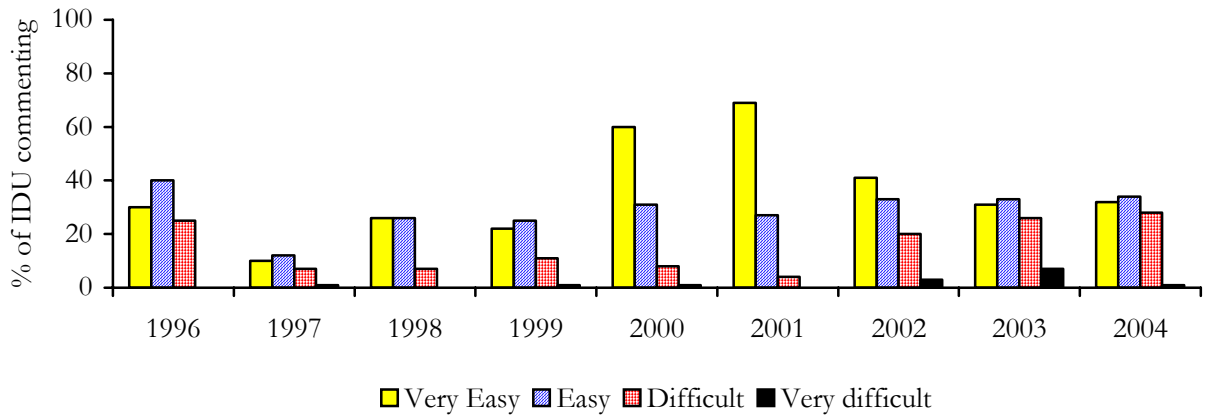
Sixty-six percent of IDU commenting on cocaine reported that it was 'easy' (34%; compared to 33% in 2003) to 'very easy' (32%, compared to 31% in 2003) to obtain (Figure 40, page 61). Approximately one third (29%) thought that cocaine was 'difficult' (28%, compared with 26% in 2003) to 'very difficult' (1%; 7% in 2003) to obtain.

Approximately half (55%) of those commenting believed that availability had remained stable (54% thought so in 2003), while 20% thought it had become more difficult (compared to 28% in 2003). Eleven percent thought that cocaine had become easier to obtain (12% in 2003) and 1% thought it had fluctuated in the preceding six months.

IDU usually bought cocaine from street dealers (30%) and through contacting dealers on a mobile phone (24%; 33% in 2003). Smaller percentages reported purchasing cocaine from friends (9%; 6% in 2003), a dealer's home (5%; 4% in 2003), obtaining it as a gift from a friend (4%; 8% in 2003) or by organising for the dealer to bring it to their home (3%; the same as in 2003). With the exception of a reduction in the proportion purchasing cocaine via use of a mobile phone (33% in 2003), purchasing patterns remained similar to the 2003 IDRS. The median time IDU reported it usually took them to score cocaine was 15 minutes (the same as in 2003).

KE reports were mixed, with one reporting that for street-level users, availability of cocaine was sporadic and generally difficult to obtain unless good contacts had been established. Another reported that poor quality cocaine was relatively easy to obtain. Two KE reported that it was relatively easy to obtain cocaine; however, these KE referred to groups of non-IDU users including nightclub-goers. No notable changes in any of these patterns of availability had been observed over the preceding six months.

Figure 40: IDU reports of ease of availability of cocaine in the past six months, 1996 – 2004

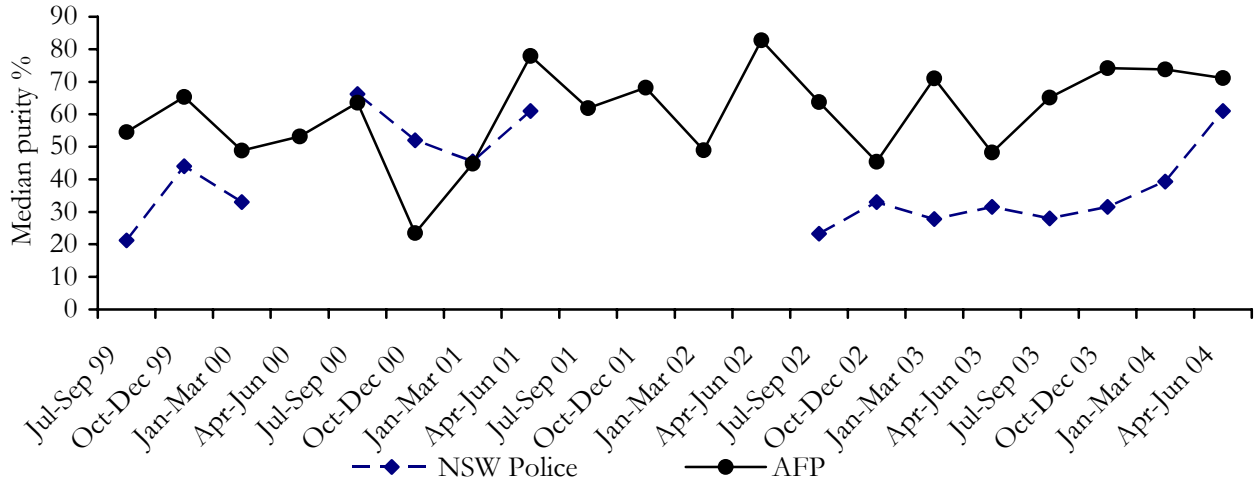


Source: IDRS IDU interviews

6.3 Purity

The purity of cocaine seizures analysed by the NSW Police Service has increased over the past twelve months from 32% to 61% (Figure 41, page 62), representing an increase to levels recorded in 2000/01 (Data for the period 2001/2002 for the NSW Police Service were unavailable). The purity of cocaine seizures analysed by the AFP has also increased slightly over the past twelve months from 48% to 71%. Consistent with data on heroin purity, the purity of AFP cocaine seizures was higher than the purity of NSW Police cocaine seizures for reasons previously discussed. Some of the purity figures however, need to be interpreted with caution as they are based on small numbers of seizures (refer Figure 42, page 62). It should also be noted that figures do not represent the purity levels of all cocaine seizures – only those that have been analysed at a forensic laboratory. The period between the date of seizure by police and the date of receipt at the laboratory can vary greatly. No adjustment has been made to account for double counting joint operations between the AFP and State/Territory Police.

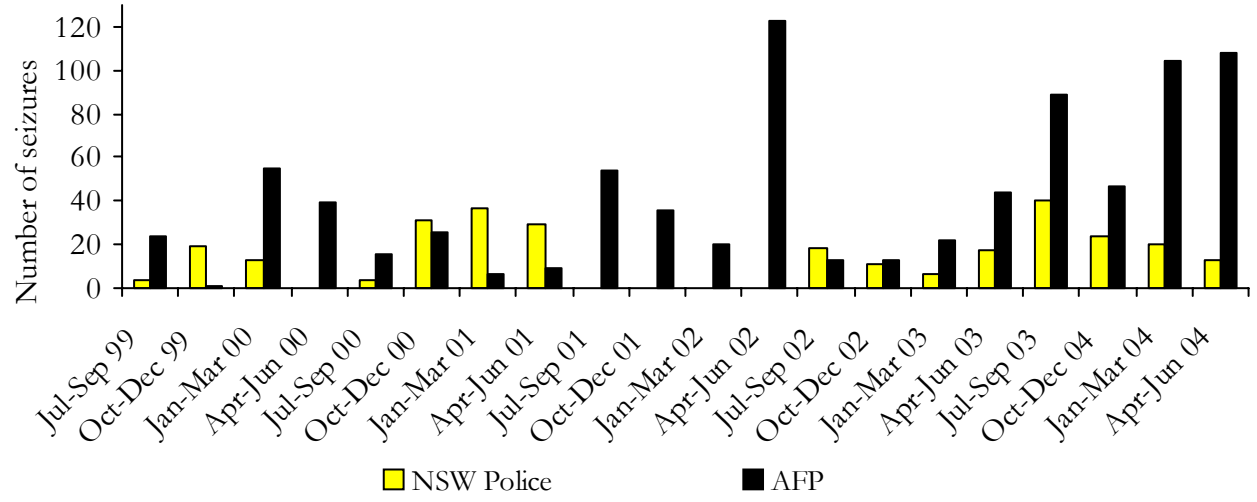
Figure 41: Purity of cocaine seizures analysed in NSW, by quarter, 1999 – 2004



Source: ABCI 2001, 2002; ACC, 2003 & 2004
NB NSW Police data for 2001/2002 were unavailable.

Figure 42 shows the number of seizures analysed in NSW between 1999 and 2004. The number of seizures analysed by the NSW Police has remained relatively stable over the past eighteen months at approximately 20 per quarter, with the exception of the third quarter of 2003 when 40 seizures were analysed. The number of seizures analysed by the AFP increased from 13 in the September 2002 quarter to 108 in the April 2004 quarter.

Figure 42: Number of cocaine seizures analysed in NSW, by quarter, 1999 – 2004



Source: ABCI 2001, 2002; ACC, 2003 & 2004
NB NSW Police data for 2001/2002 were unavailable.

The majority (60%) of IDU commenting on cocaine reported purity as being 'medium' (34%) to 'low' (26%). Twenty-one percent reported that cocaine was of 'high' purity. These figures are in contrast to 2003, where 44% reported it to be of low purity and only 8% believed it to be of high purity. Twenty-six percent thought that cocaine purity had decreased in the preceding six months (as compared with

37% in 2003), while 22% thought it had remained stable. Fifteen percent thought that purity had increased (an increase from 9% in 2003), and 16% thought it had fluctuated (7% thought so in 2003).

KE reports of cocaine purity varied and this is a reflection of information obtained from seizures from higher levels of supply in addition to information obtained from the street level. However there was some agreement that, at the street level, cocaine tended to be of fluctuating but low purity, and that this had not changed over the preceding six months.

6.4 Use

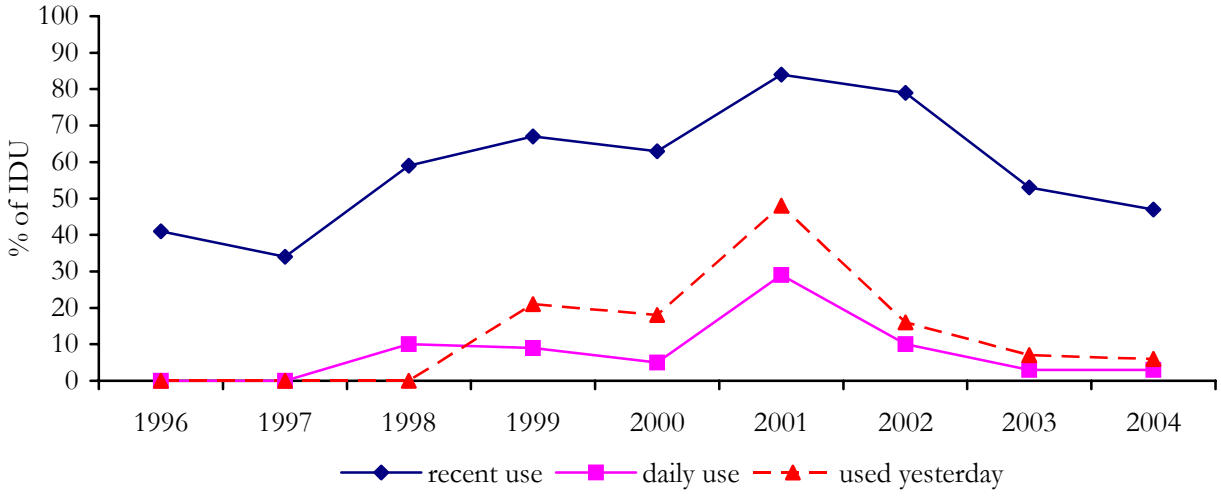
6.4.1 Cocaine use among IDU

Approximately half (47%) of IDU reported cocaine use in the preceding six months, similar to 2003 (53%). This represents the lowest proportions reported since 1998 (Figure 43).

6.4.2 Current patterns of cocaine use

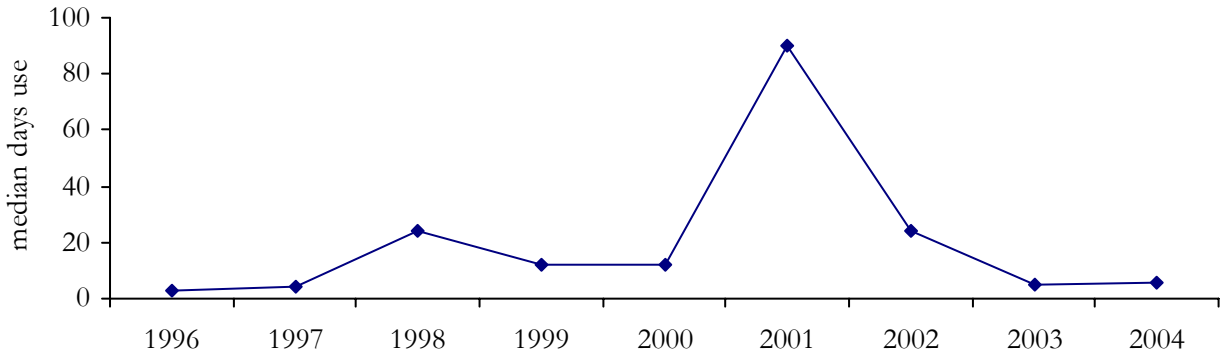
Frequency of cocaine use among IDU remained similar to 2003; IDU reported use on a median of six days in the preceding six months (this figure was 5 days in 2003) (Figure 44, page 64). Proportions reporting daily use in the preceding six months also remained relatively low at 3% (6% among cocaine users). Six percent of IDU reported cocaine use on the day prior to interview (comparable to 7% in 2003). These figures represent little or no change from 2003 and remain lower than levels reported in previous years (Figure 43).

Figure 43: Proportion of IDU reporting cocaine use in the past six months, daily use, and use on the day preceding interview, 1996-2004



Source: IDRS IDU interviews

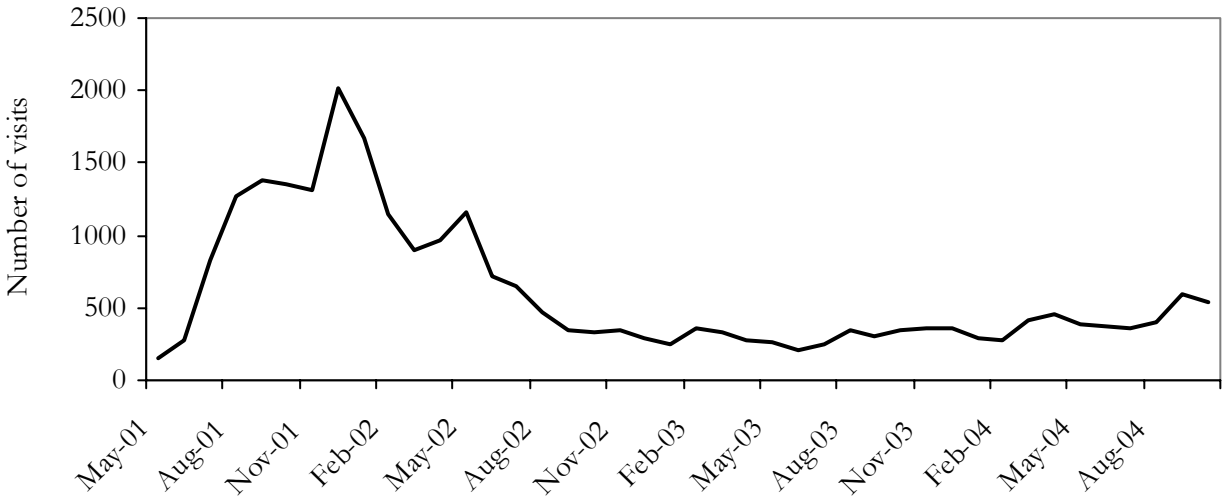
Figure 44: Median days cocaine use in the past six months, 1996-2004



Source: IDRS IDU interviews

Figure 45 below shows the number of attendances to the Medically Supervised Injecting Centre (MSIC) in the period May 2001 – October 2004. Figures have remained relatively stable since August 2002, increasing slightly towards the end of 2004. The following caveats need to be considered when interpreting this data: 1) Hours of operation changed over the first 2 years of operation (from four to up to twelve per day) and 2) The numbers of individuals attending increased continuously over the first 2 years of operation, as IDU became aware of this new service. However, levels have remained substantially lower than those reported during late 2001 – early 2002, when indicators of cocaine use (according to self-report by IDU and according to a range of other data from routine surveillance systems) suggested that cocaine use was at its peak among this group.

Figure 45: Number of attendances to MSIC where cocaine was injected, 2001-2004



Source: Medically Supervised Injecting Centre, Kings Cross

Of the three KE who commented on cocaine use patterns, one referred to injecting drug users, one to youth and the other referred to a group who were not typically IDU. Among injecting drug users, use tended to be a in a binge rather than daily use pattern. It was not possible for this KE to give a clearer indication of use patterns as these varied substantially from person to person. The second KE commented that, among youth, cocaine had decreased as a drug of concern among entrants to rehab

from 16% in 2001 to 7% in 2004, none of whom nominated it as their primary drug of concern (3% nominated it as such in 2001). The third KE reported that use ranged from anything between daily to very occasionally, and that the route of administration was via inhalation. As in previous years, the difficulty experienced in locating KE who had had recent contact with cocaine users suggests that cocaine use among IDU has remained sporadic since 2003.

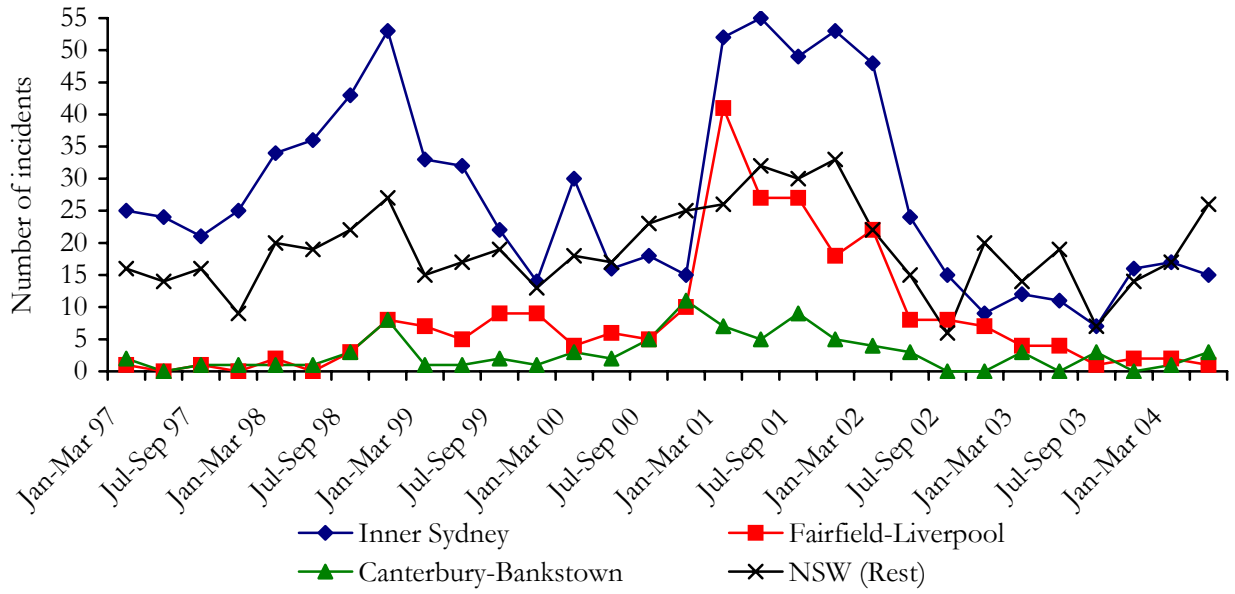
All of the IDU reporting cocaine use stated that cocaine powder was the form most used in the preceding six months. Two respondents reported use of 'crack' cocaine. Since 2003, interviewers have been asked to prompt for route of administration where participants report crack use. If participants state that they had injected 'crack', it is not coded as 'crack', as this form of cocaine is only bioavailable when smoked (Platt, 1997).

6.5 Cocaine related harms

6.5.1 Law enforcement

Figure 46 shows that the number of police recorded criminal incidents for cocaine possession/use were higher in the Inner Sydney area than in Fairfield-Liverpool and Canterbury-Bankstown, and, for the most part, higher than numbers recorded in the rest of NSW during the period 1997 to 2002[13]. Since early 2003, figures for Inner Sydney, while remaining higher than those in Fairfield-Liverpool and Canterbury-Bankstown, have remained similar to or lower than the rest of NSW. Incidents of cocaine possession/use recorded in the Inner Sydney area reflect IDU reports of cocaine use, with peaks occurring in both 1998 and 2001. Smaller increases were also recorded in Canterbury-Bankstown and Fairfield-Liverpool during these periods, with a noticeable peak in recorded incidents in the latter area during 2001.

Figure 46: Recorded incidents of cocaine possession/use by geographic area, 1997-2004



Source: NSW Bureau of Crime Statistics and Research
NB- Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both.

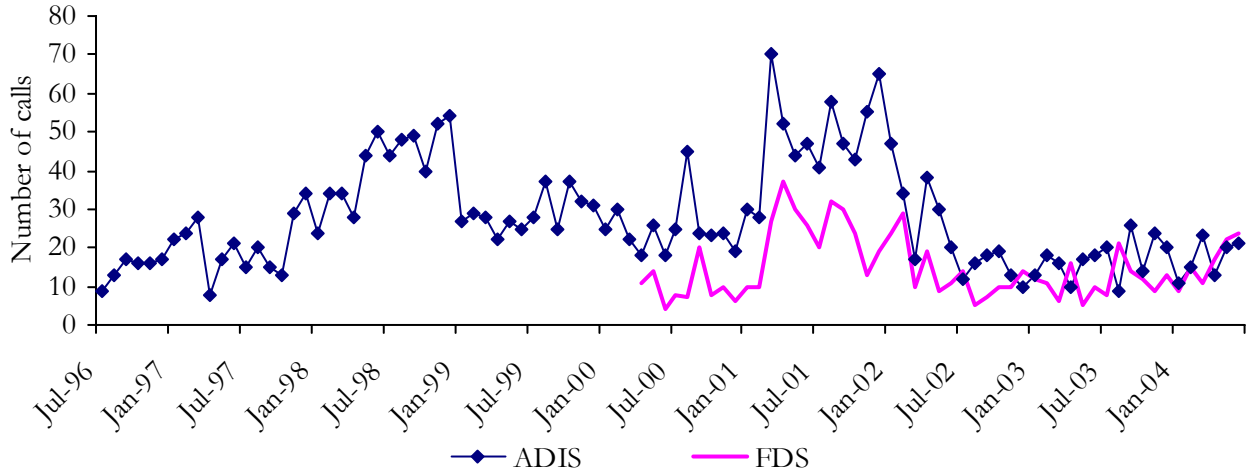
[13] The regions Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown refer to ABS Statistical Subdivisions.

6.5.2 Health

Calls to telephone helplines

Figure 47 shows the number of calls to the ADIS and FDS lines regarding cocaine. Similar to both amphetamines and heroin, the number of enquiries to FDS regarding cocaine has generally been lower than numbers received at ADIS, although numbers have been comparable in the last eighteen months. Figures for both ADIS and FDS have remained relatively stable in the last eighteen months, with calls to ADIS returning to levels recorded pre-1998. Calls to ADIS were also consistent with patterns of cocaine use (Figure 43, page 63 & Figure 44, page 64), and the number of police incidents recorded for cocaine possession/use (Figure 46), with peaks occurring in 1998 and 2001. Calls to FDS regarding cocaine also increased throughout 2001, but have decreased since that time.

Figure 47: Number of enquiries to ADIS and FDS regarding cocaine, 1996-2004

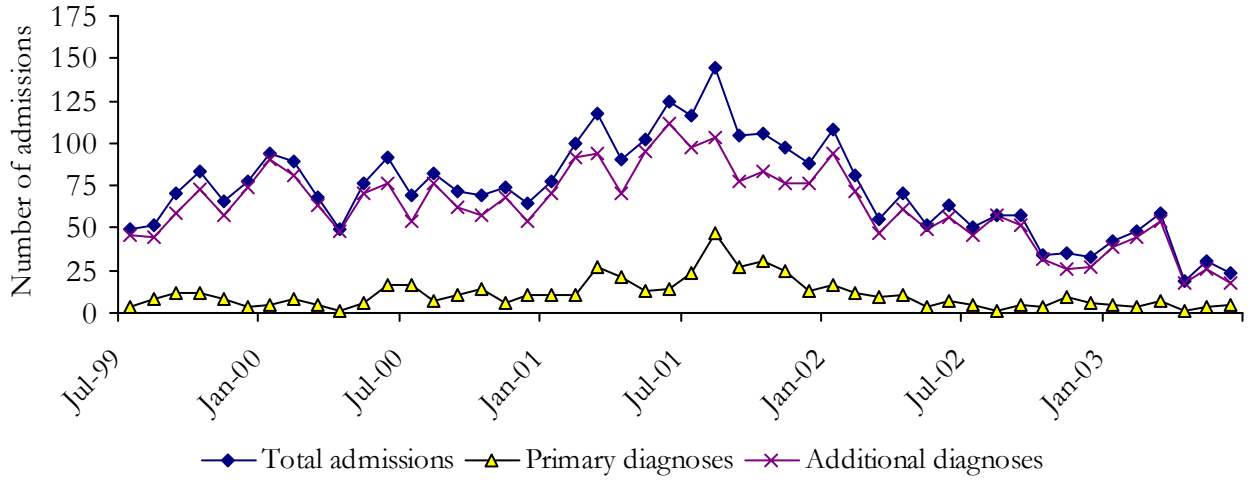


Source: Alcohol and Drug Information Service and Family Drug Support
N.B. Family Drug Support data were only available from April 2000 and refers to calls where any mention of cocaine was made. ADIS data refers to the number of calls where cocaine was the primary drug of concern.

The number of inpatient hospital separations in which cocaine was implicated as a principal and/or an additional diagnosis are shown in Figure 48. As outlined previously, diagnoses are based on ICD-10 (Second Edition) codes, and it is possible for one admission to have cocaine as both a principal and as an additional diagnosis[14]. Similar to IDU data and other indicators, figures have remained lower over the past two years, following a peak in admissions during 2001.

[14] Principal diagnosis: The diagnosis established (after study) to be chiefly responsible for occasioning the patient's episode of care in hospital. Additional diagnosis: A condition or complaint either co-existing with the principal diagnosis or arising during the episode of care.

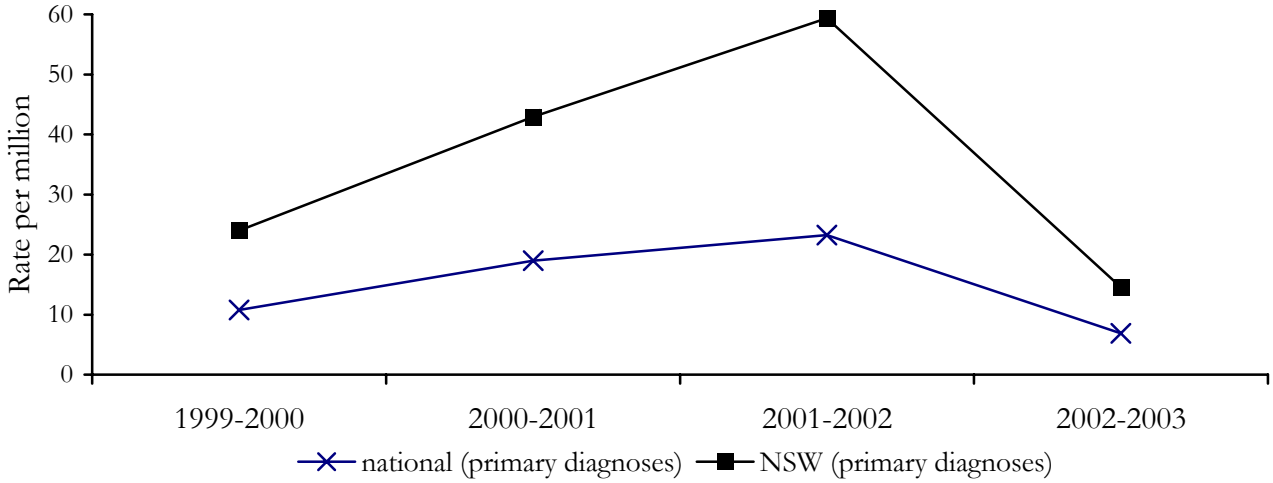
Figure 48: Total number of inpatient hospital admissions in persons aged 15-54 where cocaine was implicated, NSW 1999-2004



Source: Australian Institute of Health and Welfare

The rates of inpatient hospital admissions where cocaine was the primary diagnosis per million people aged 15-54 years are shown in Figure 49 below. In accordance with IDU and other indicators, rates in NSW peaked in 2001, and decreased quite markedly between 2001/2002 and 2002/2003. Nationally, NSW has accounted for between 70 – 85% of inpatient admissions where cocaine was the primary diagnosis since 1999/2000.

Figure 49: Rate of inpatient hospital admissions where cocaine was the primary diagnosis per million people aged 15-54 years, NSW and nationally, 1999/2000 to 2000-2003

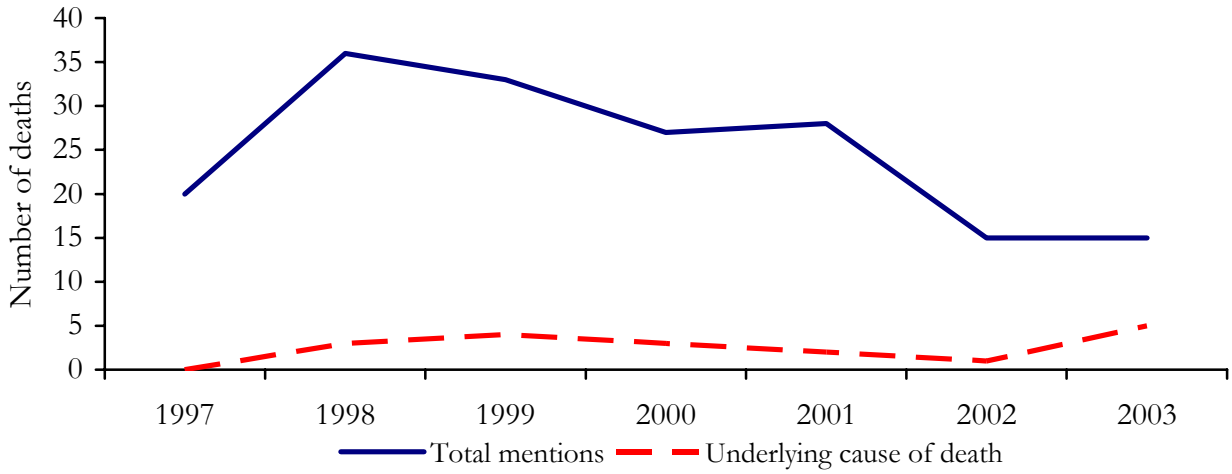


Source: Australian Institute of Health and Welfare

Figure 50 shows ABS data on accidental drug-induced deaths in which cocaine was mentioned among those aged 15-54 in Australia for the period 1997-2003 (Degenhardt et al., 2004c). This includes deaths where cocaine was determined to be the underlying cause of death, as well as those where it was mentioned but where another drug was believed to be primarily responsible (usually opioids). Deaths have remained relatively stable since 2002, following a decline in total mentions between 2001- 2002.

The number of deaths in which cocaine was determined to be the underlying cause has remained in single figures since 1997, with the greatest number (5) recorded in 2003.

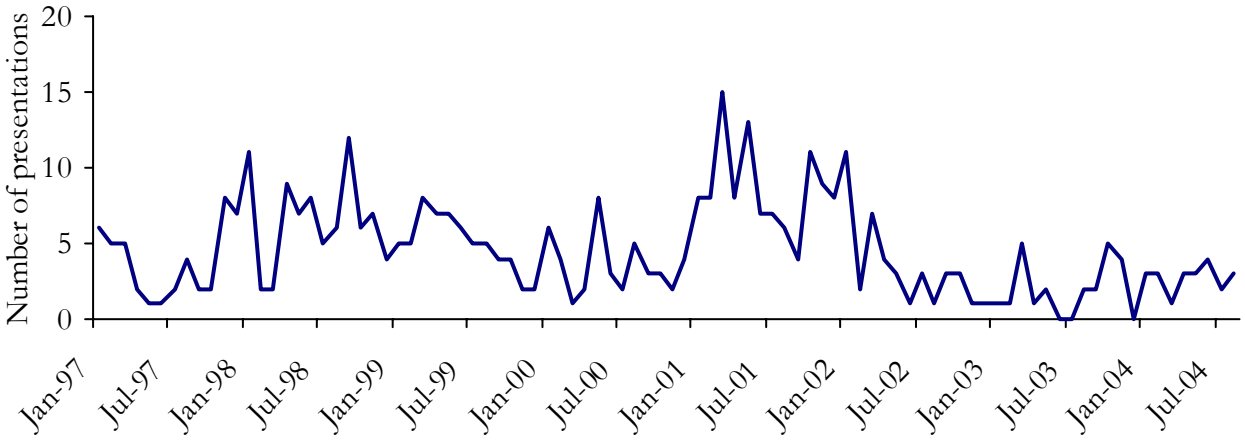
Figure 50: Number of accidental drug-induced deaths mentioning cocaine (total and underlying) among those aged 15-54 years in Australia, 1997-2003



Source: Australian Bureau of Statistics mortality database

The number of cocaine overdose presentations to NSW emergency departments has remained extremely low in the past two years (Figure 51). This is consistent with cocaine use patterns (Figure 43, page 63 & Figure 44, page 64) and IDU reports of cocaine availability (Figure 40, page 61), with a substantial peak in numbers during 2001, and declining in early 2002.

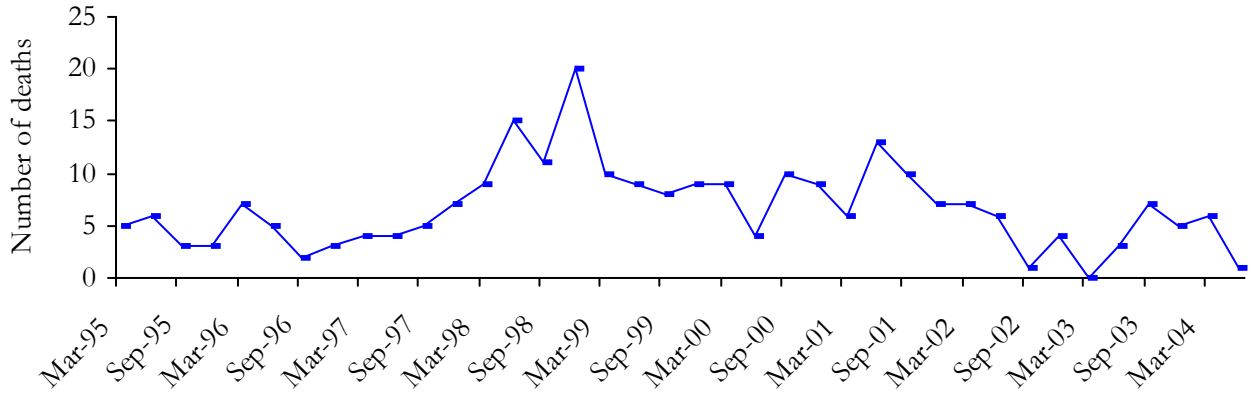
Figure 51: Cocaine overdose presentations to NSW emergency departments, 1997-2004



Source: Emergency Department Information System, NSW Department of Health

The number of drug related deaths in which cocaine was detected post mortem have remained relatively low for the past two years (Figure 52, page 69), following substantial increases in December 1998, and again throughout 2001.

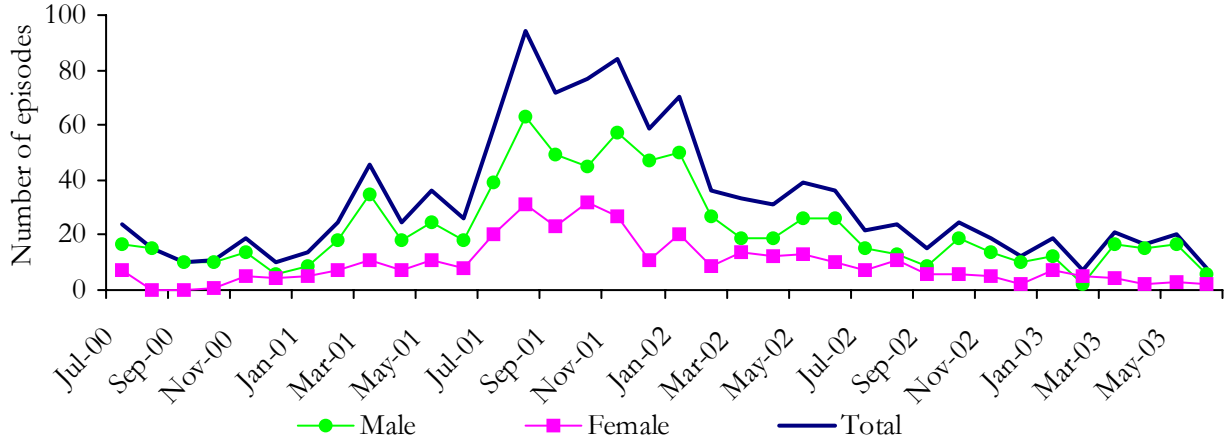
Figure 52: Number of suspected drug related deaths where cocaine was detected post mortem, 1995-2004



Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories
N.B. These numbers relate to deaths in which cocaine was detected, however there may have also been other drugs present.

The number of closed treatment episodes based on the date of commencement where the principal drug of concern was cocaine remained stable and relatively low for the period July 2002 to June 2003 (Figure 53). Consistent with all other indicator data, numbers showed a steady increase from 25 in April 2001 to 94 in August 2001, representing the highest during the period 2000 to 2003. Figures remained higher throughout 2001, with decreases commencing in January 2002. More males than females entered treatment programmes for cocaine during this period. Data for 2003/2004 were unavailable at the time of publication.

Figure 53: Number of cocaine treatment episodes by gender, NSW July 2000 – June 2003



Source: NMDS-AODTS, NSW Department of Health.
N.B.The NMDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period.

6.6 Trends in cocaine use

When asked about general trends in drug use, only two participants made specific mention of cocaine, with one reporting that a greater number of younger people appeared to be using cocaine, and the other reported observing increased cocaine-related aggression. That 99% of the sample did not

mention cocaine use in response to this open-ended question ('Has there been any recent change in the number or type of people using drugs?') supports other data to suggest that prevalence remains low. Relatively low proportions of IDU commented on price (51%), purity and availability (48% each), suggesting that the downward trend in use noted in the 2003 IDRS has been maintained. Similarly, in 2004 only small numbers of KE were located who felt they had had enough contact with and/or knowledge about cocaine users to comment.

6.7 Summary of cocaine trends

- The median price for a gram of cocaine has increased for the first time since the commencement of the IDRS in 1996. The price for a cap has remained stable since 1998.
- Cocaine availability remained similar to 2003, with 29% reporting that it was 'difficult' or 'very difficult' to obtain.
- Purity of cocaine appears to have increased slightly since 2003, although remains variable.
- Frequency of cocaine use remained relatively low and proportions that reported recent cocaine use were the lowest since 1998.
- Consistent with patterns of cocaine use and reported availability, indicator data generally showed that trends relating to cocaine had remained low and relatively stable, with a decrease in the number of deaths relating to cocaine (accidental deaths in which cocaine was detected, and accidental drug-induced deaths in which cocaine was mentioned).

7 CANNABIS

Eighty-four percent of IDU commented on price, potency and availability of hydroponic cannabis, and 57% of IDU commented on price, potency and availability of outdoor grown 'bush' cannabis. The following percentages refer to these proportions of IDU.

This year represents the first in which potency and availability information was separated for hydroponically grown ('hydro') and outdoor grown cannabis ('bush').

7.1 Price

Prices paid for hydro and bush by IDU on the last occasion of purchase are presented in Table 7. Hydro appeared to be the more popular form of cannabis with fewer IDU reporting the purchase of bush.

Hydro

The median prices paid for a gram of hydro was $20, the same as in 2002. Median prices for a quarter ounce of hydro ($90), a half ounce ($160) and an ounce ($300) all represented a slight decrease from hydroponic cannabis prices reported in 2003 and a return to 2002 prices[15].

Grams were the most popular hydro purchase amount (n=76), followed by quarter ounces (n=54), ounces (n=21) and half ounces (n=17). Nine participants reported buying 'bags' of hydro. Ten IDU reported buying hydro in 'sticks' (median price $20).

Consistent with reported prices for hydro, the majority (80%) of IDU who commented thought prices had remained stable. Seven percent thought that the price of hydro had decreased, 5% thought it had increased, 2% thought that the price had fluctuated and 5% said they didn't know.

Bush

Prices for bush remained similar to those reported in 2003, except the price for an ounce which decreased from $225 to $175. However, only small numbers reported purchasing this amount, and paid a wide range of prices ($100-$400).

Similar to hydro, the most popular purchase amount for bush was a gram (n=22), and the median reported price ($20) was the same as a gram of hydro. Smaller numbers reported buying a quarter ounce (n=13), a half ounce (n=3) and/or an ounce (n=6), and price changes from 2003 may be a reflection of that (Table 7). In addition, the prices paid for bush tended to range more widely than those paid for hydro.

[15] The distinction between hydro and bush prices commenced in 2003 and so comparisons against previous years should be made with a degree of caution.

Again, consistent with reported prices for bush, the majority (67%) of IDU who commented thought prices had remained stable, 5% thought it had increased and 3% thought it had fluctuated. None thought that the price had increased. Compared to hydro, a greater proportion of IDU (25%) didn't know whether prices had changed over the preceding six months; reports again consistent with the predominance of hydro as the form most frequently used.

Table 7: Price of most recent cannabis purchases by IDU, 2004

Amount	Hydro Median price* ($)	Range	Hydro Number of purchasers	Bush Median price* ($)	Range	Bush Number of purchasers
Ounce	300 (310)	$200-$450	21	175 (225)	$100-$400	6
Half ounce	160 (180)	$140-$200	17	150 (-)	$120-$250	3
Quarter ounce	90 (100)	$70-$140	54	90 (80)	$20-$140	13
Gram	20 (20)	$10-$30	76	20 (20)	$10-$50	22

Source: IDRS IDU interviews
**2003 median prices are in brackets*

Hash and Hash Oil

Only two IDU reported buying hash in the preceding six months, and one IDU reported buying a cap of hash oil.

Many KE were unable to comment on the price of cannabis- however, among the few that did, the price for a gram was reported to be $20, a quarter was $100-$130 and a pound was reported to cost $3,000- $4,000. A specific distinction between bush and hydro was not drawn. Despite being unsure of specific cannabis prices, over half of the KE stated that the price had remained stable over the preceding six months.

7.2 Availability

A distinction between hydroponic and outdoor 'bush' cannabis was made in the 2004 IDRS. The vast majority (95%) of IDU commenting on hydro thought it was 'very easy' (67%) or 'easy' (28%) to obtain, with 91% reporting availability as 'stable' over the preceding six months. In contrast, approximately half (54%) of those commenting reported that bush was 'very easy' (30%) or 'easy' (24%) to obtain, with 26% reporting it to be 'difficult' (25%) or 'very difficult' (1%), and 20% didn't know. The majority (63%) of IDU reported that bush availability had remained stable over the preceding six months, with 14% reporting that it had become more difficult, and 23% reporting that they didn't know.

Patterns of purchase of hydro and bush forms of cannabis were similar, with IDU who commented predominantly buying from street dealers (hydro- 30%; bush- 26%) friends (hydro- 20%; bush- 16%)

and via mobile phone (hydro- 17%; bush- 13%). Hydro was also commonly purchased from a dealer's home (15%), whereas only 4% of IDU had obtained bush in this way. Three percent of those commenting had obtained bush by growing their own. The median time in which IDU reported it usually took them to score hydro was ten minutes; the same as for bush. These patterns, while not directly comparable to 2003 data (due to the distinction between hydro and bush), indicate that there has been little or no change.

Of the KE who felt able to comment on availability (n=10), all reported that cannabis was easy or very easy to obtain and that availability had remained stable in the preceding six months.

7.3 Potency

The majority (88%) of IDU commenting on hydro reported it as being of 'high' (62%) to 'medium' (26%) potency. Only three percent thought that it was of 'low' potency, and 5% believed that it fluctuated. The majority (68%) believed that potency had remained stable in the preceding six months, with similar proportions reporting that it had increased (10%), decreased (8%) or fluctuated (8%). Five percent stated that they did not know.

Bush cannabis was perceived to be of slightly lower potency, with 63% reporting it to be 'medium' (43%) or 'high' (20%). Seventeen percent thought that it was of 'low' potency, and only 2% thought it fluctuated. Just over half (54%) of those who commented reported that potency had remained stable over the preceding six months, with similar proportions stating that it had increased (8%), decreased (8%) or fluctuated (6%). One quarter (25%) stated that they did not know.

As noted previously, 2004 was the first year in which IDU were asked about the potency of hydro and bush forms of cannabis and so comparisons with previous years should be made with a degree of caution (previously, IDU were asked to comment on 'cannabis' generally, the most predominant form of which was reported to be hydroponic). However, 2004 data for hydro is similar to 2003 IDRS data for 'cannabis', where 57% reported it to be of 'high' potency and 30% reported it to be of 'medium' potency, and 70% believed that this had remained stable over the preceding six months.

Only three KE commented on cannabis potency, with one reporting it to be of 'medium' strength and the others believing it to be variable. Two reported that potency had remained stable, and two reported that it had fluctuated over the preceding six months.

7.4 Use

7.4.1 Cannabis use among IDU

As in previous years, there was little change in the prevalence of cannabis use among IDU. Seventy-nine percent had used cannabis in the preceding six months (the same as 2003). Prevalence of cannabis use among sentinel groups of IDU in NSW has remained relatively stable since the commencement of the IDRS in 1996.

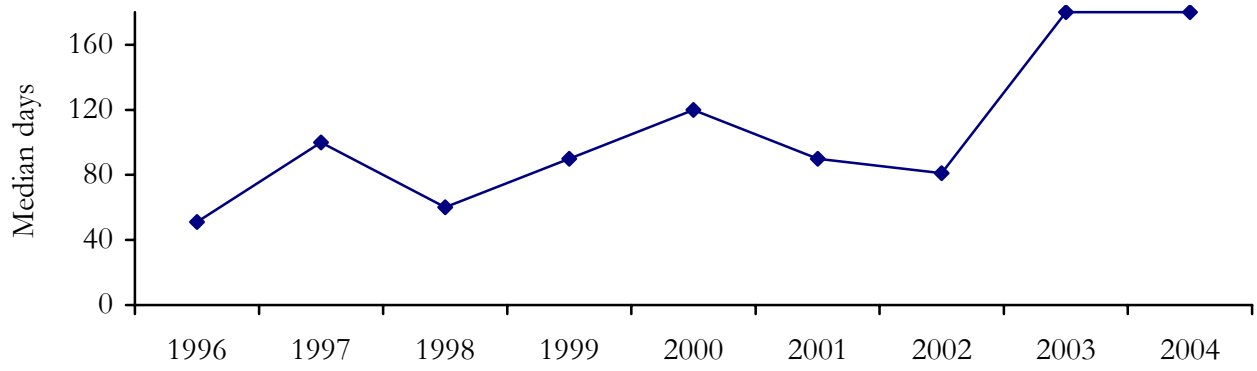
7.4.2 Current patterns of cannabis use

The median number of days cannabis use by those who used was 180 in the preceding six months (i.e. daily). This represents no change from 2003, with levels remaining substantially higher than in previous years (Figure 54).

Forty-six percent of IDU (59% of the cannabis users) reported daily use in the preceding six months compared to 40% in 2003.

In agreement with IDU data, the majority of the cannabis KE reported that there had been no change in the frequency or quantity of use. The majority reported that daily use was the usual pattern, with some using a couple of times per week. The quantity used on an occasion of use ranged from two cones up to 40 cones per day.

Figure 54: Median number of days of cannabis use in the past six months, 1996-2004



Source: IDRS IDU interviews

Consistent with larger proportions of IDU reporting they had bought hydro, 98% of respondents who had used cannabis reported using hydro in the preceding six months, and 74% of cannabis users reported using bush (as compared with 95% and 67% in 2003, respectively). Eight percent of cannabis users reported using hashish, and 6% hash oil, a slight increase from 2003 where 5% reported hash and 3% hash oil use. Ninety-two percent of those who had used cannabis reported hydro as the predominant form used (85% in 2003) and 8% reported bush (9% in 2003).

All KE who commented reported hydroponic cannabis as the form predominantly used, with the exception of one who reported outdoor-grown to be more common.

7.5 Cannabis related harms

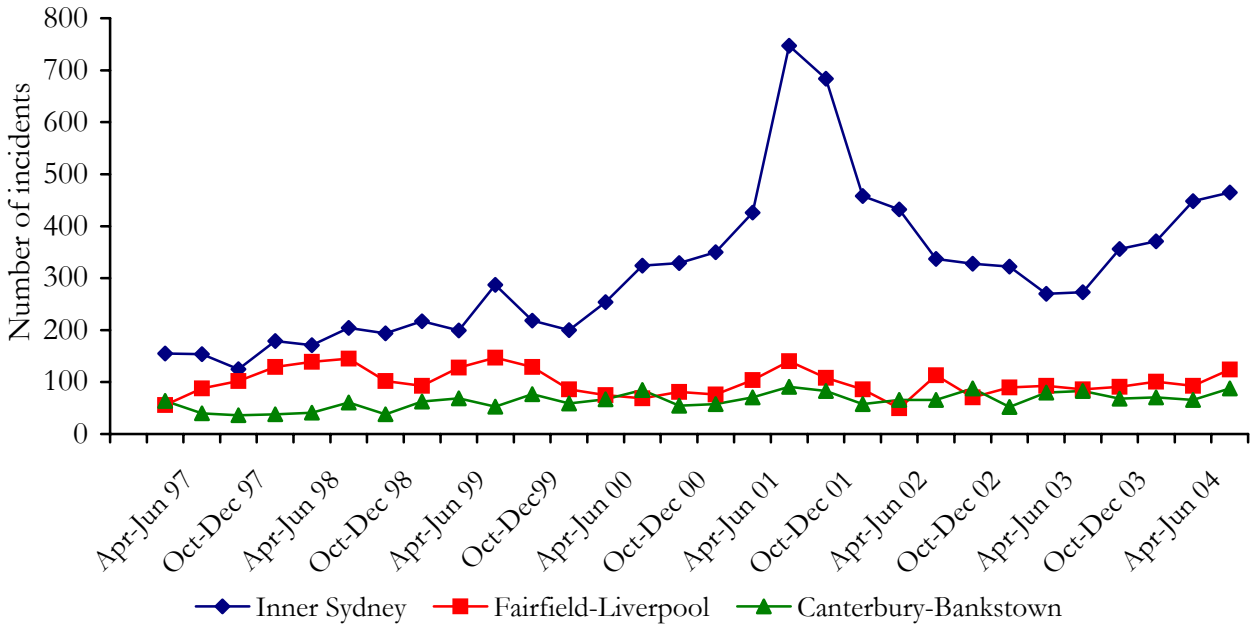
7.5.1 Law enforcement

Figure 55 shows the number of police recorded criminal incidents of cannabis possession/use in the Inner Sydney area, Fairfield-Liverpool and Canterbury-Bankstown[16]. The number of recorded incidents

[16] The regions Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown refer to ABS Statistical Subdivisions.

in the Inner Sydney area has increased gradually since the second quarter of 2003, although they remain lower than those recorded during early-mid 2001. The numbers of incidents recorded in the Fairfield-Liverpool and Canterbury-Bankstown areas are much lower than inner city figures, and have remained stable over time.

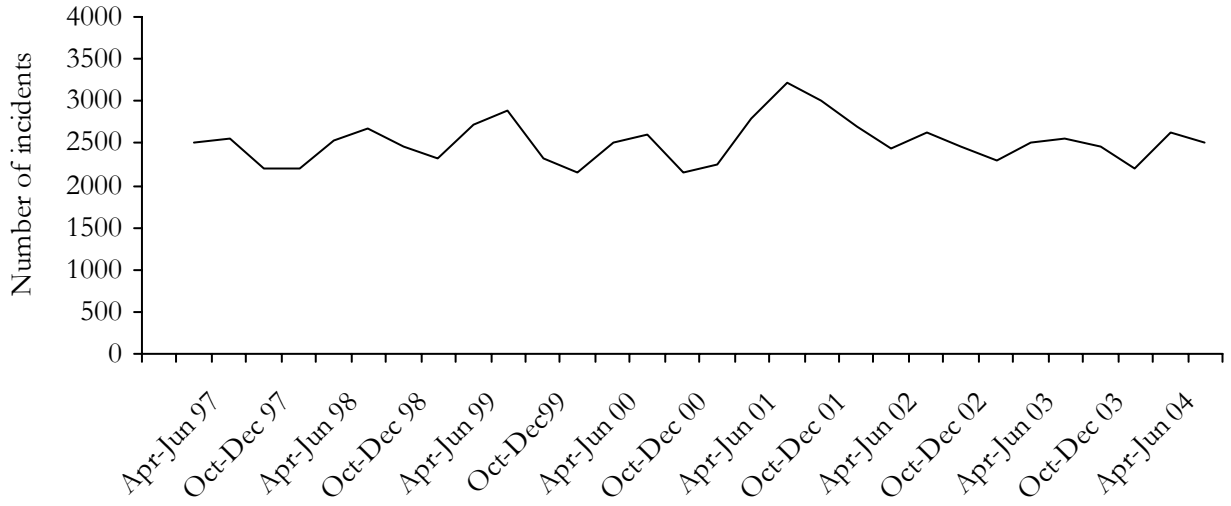
Figure 55: Recorded incidents of cannabis possession/use by geographic area, 1997-2004



Source: NSW Bureau of Crime Statistics and Research
NB- Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both.

Across the remainder of NSW, recorded incidents of cannabis possession/use have remained relatively stable over time (Figure 56, page 76). Similar to increases noted in Inner Sydney, a substantial peak occurred in early-mid 2001 (3223 incidents).

Figure 56: Recorded incidents of cannabis possession/use by geographic area (remainder of NSW), 1997-2004



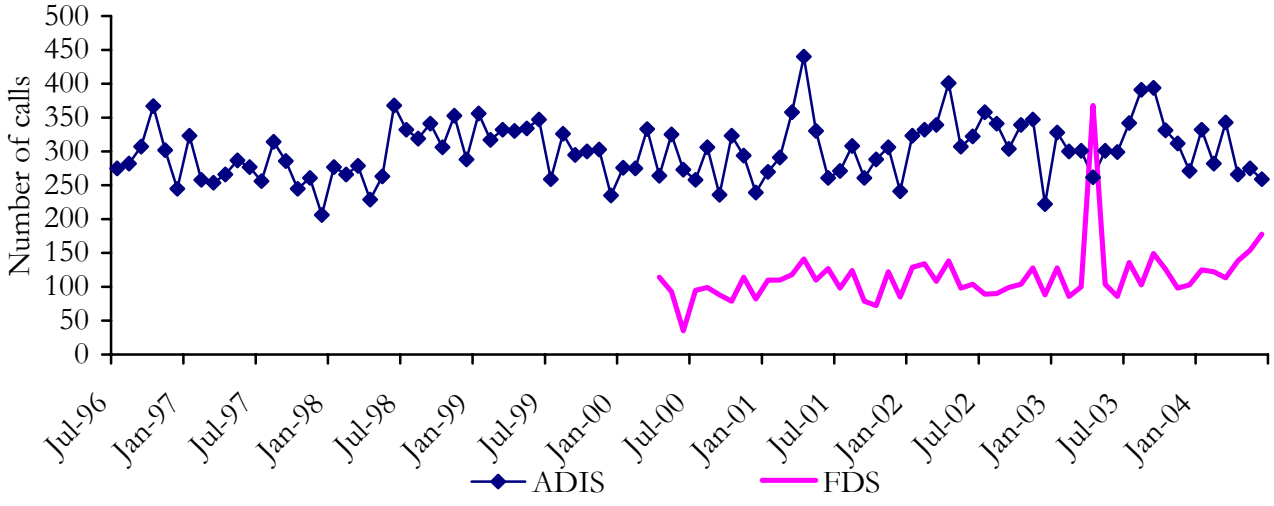
Source: NSW Bureau of Crime Statistics and Research
NB- Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both.

7.5.2 Health

Calls to telephone helplines

The number of calls to ADIS regarding cannabis has remained relatively stable since 2001 (Figure 57). The number of calls to FDS has also remained relatively stable over this period, increasing slightly during early 2004 and reaching the highest number of calls recorded (178) in June, with the exception of April 2003. However, the peak in 2003 may be due to an irregularity in the data recorded rather than reflecting a real increase.

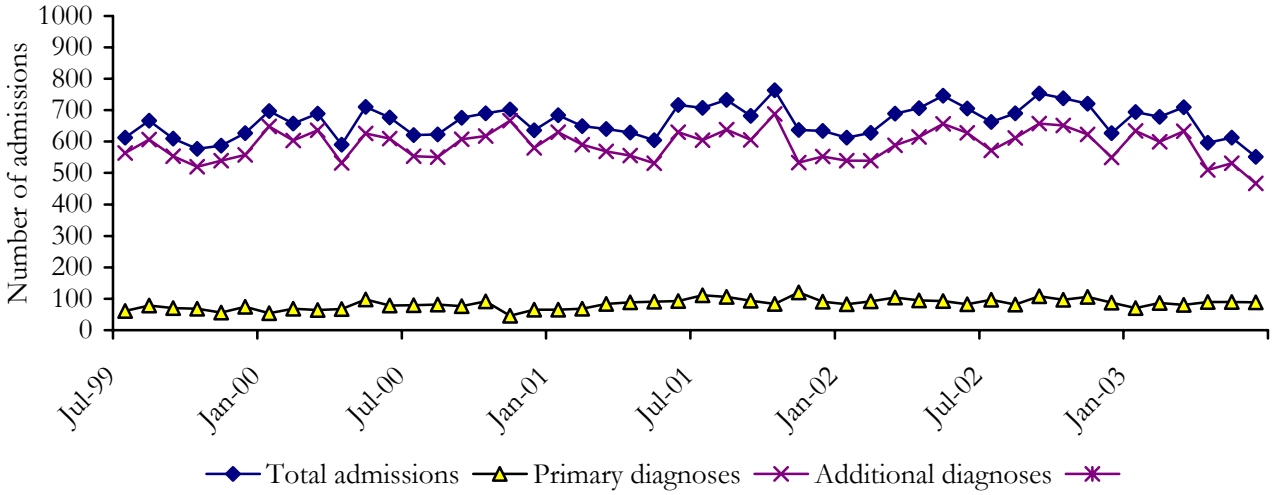
Figure 57: Number of enquiries to ADIS and FDS regarding cannabis, 1996-2004



Source: Alcohol and Drug Information Service and Family Drug Support
N.B. Family Drug Support data were only available from April 2000 and refers to calls where any mention of cannabis was made. ADIS data refers to the number of calls where cannabis was the primary drug of concern.

The number of hospital admissions in which cannabis was implicated as a principal and/or an additional diagnosis among are shown in Figure 58 below. As specified in previous chapters, diagnoses are based on ICD-10 (Second Edition) codes, and it is possible for one admission to have cannabis as both a principal and as an additional diagnosis[17]. These figures refer to persons aged between 15-54 years of age. Similar to IDU data and other indicators, figures have remained stable since 1999.

Figure 58: Number of inpatient hospital admissions in persons aged 15-54 where cannabis was implicated, NSW 1999-2004

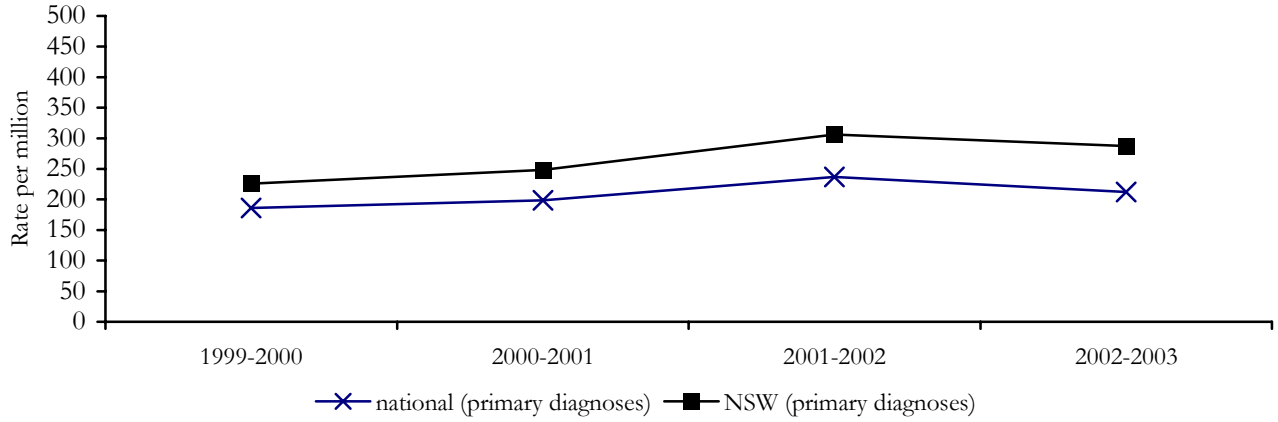


Source: Australian Institute of Health and Welfare

Figure 59 shows the rates of hospital admissions where cannabis was the primary diagnosis per million people aged 15-54 years. Rates in NSW remain higher than nationally, and have increased slightly from 225 per million persons in 1999/2000 to 287 per million persons in 2002/2003. Since 1999/2000, NSW has accounted for between 40-45% of Australian inpatient admissions where cannabis was the primary diagnosis.

Figure 59: Rate of inpatient hospital admissions where cannabis was the primary diagnosis per million people aged 15-54 years, 1999/2000 to 2002/2003

[17] Principal diagnosis: The diagnosis established (after study) to be chiefly responsible for occasioning the patient's episode of care in hospital. Additional diagnosis: A condition or complaint either co-existing with the principal diagnosis or arising during the episode of care.



Source: Australian Institute of Health and Welfare

7.6 Trends in cannabis use

Prevalence of cannabis use remained unchanged among IDU, with patterns of price, purity, availability and use similar to those noted in 2003.

7.7 Summary of cannabis trends

- Prices for grams of cannabis have remained stable, and lower than prices reported between 1996 and 1999. Bush cannabis was slightly cheaper than hydroponic cannabis for larger amounts, and the same price for smaller amounts.
- Hydroponic and outdoor grown cannabis remained readily available, particularly the hydroponic form.
- The potency of hydroponic cannabis was perceived to be 'high' and to have remained stable over the preceding six months. Bush cannabis was perceived to be of slightly lower potency and that this had remained stable.
- Hydroponic cannabis remained the most commonly used form of cannabis, although a substantial proportion of IDU had also recently used bush cannabis. Use of hash and hash oil remains uncommon.
- Prevalence of cannabis use remained stable.
- Frequency of cannabis use remained fairly stable in 2004.
- Indicator data suggested that the prevalence of cannabis use within the broader community, and harms related to such use, has remained relatively stable. An increase in the number of police detections has occurred in inner Sydney since 2003.

8 OPIOIDS

8.1 Use of illicit methadone

As in 2003, detailed data regarding the purchase, frequency of use and injection of illicit methadone syrup was collected in 2004 to provide further clarification regarding the use of methadone prescribed for treatment and the diversion of prescribed methadone.

Twenty-nine percent of IDU (18% in 2003) reported using illicit methadone syrup in the six months preceding interview, and had done so on a median of five days (6 days in 2003). Just over half of this group (58%, compared to 54% in 2003) had been engaged in methadone treatment during this period.

Twenty-two percent of IDU (11% in 2003) reported injecting illicitly obtained methadone syrup in the preceding six months on a median of five days (the same as in 2003). Over half (60%) of those injecting illicit methadone syrup were engaged in methadone treatment during this period.

Fifteen percent of IDU (8% in 2003) reported illicit methadone syrup as the form most often used in the preceding six months, 13% of whom (n=3) were in methadone treatment during this period.

Among IDU who had used any form of methadone in the preceding six months, the median price for methadone liquid was reported to be 50c per ml. The majority of IDU commenting (72%) reported that the price had remained stable over the six months preceding interview.

Among those commenting on current availability of illicit methadone (n=60), 72% thought it was 'easy' (50%) or 'very easy' (22%) to obtain, while 25% thought it 'difficult' (22%) or 'very difficult' (3%) to obtain. These figures were similar to the 2003 IDRS. Twenty-five percent of IDU reported buying illicit methadone in the past six months (16% in 2003), primarily from street dealers and friends.

One percent of IDU (n=2) reported using illicit physeptone tablets in the preceding six months (5% in 2003) on a median number of two days (three days in 2003). One of these respondents was engaged in methadone treatment during this period.

Among IDU who reported injecting any form of methadone or physeptone in the previous six months, 54% (42% in 2003) reported doing so in the month prior to interview. One third of those who had injected it during this period reported injection related problems due to methadone (50% in 2003), the most common being difficulty finding veins (46%) followed by swelling of the arm (38%; 9% in 2003). No participants reported experiencing skin ulcers due to methadone, as compared with 18% in 2003.

8.2 Use of illicit buprenorphine

Eight percent of IDU (5% in 2003) reported the use of illicit buprenorphine in the preceding six months on a median of two days (five in 2003). Of this group, 8% (n=1) had been engaged in

buprenorphine treatment during this period. This represents a substantial decrease from 43% in 2003; however conclusions should not be drawn as only small numbers reported use.

Five percent of IDU reported injecting illicit buprenorphine on a median of two days. None of these IDU were engaged in buprenorphine treatment during this period.

Eight percent of IDU (34% of those who had used buprenorphine) reported illicit buprenorphine as the form most often used in the past six months, one of whom was in buprenorphine treatment during this period. Three IDU reported they had injected buprenorphine in the past month, and did not report any resulting injection related problems.

8.3 Morphine

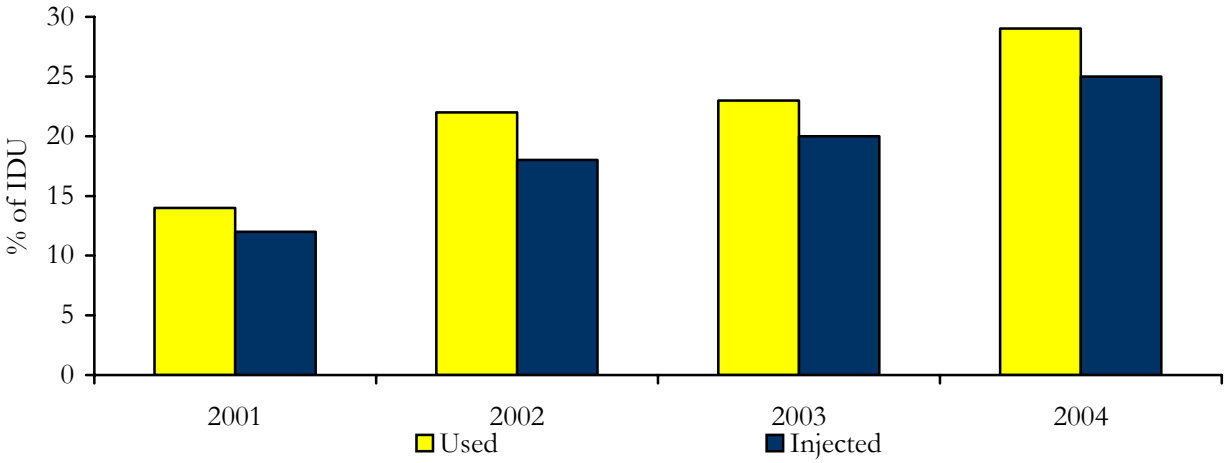
Almost one third (29%) of IDU reported using morphine in the preceding six months on a median of five days (compared to 23% on a median of three days in 2003). Eighty-six percent of the morphine users reported illicit morphine use during this period.

One quarter of IDU reported injecting morphine (20% reported doing so in 2003) on a median of four days. Eighty-seven percent of those who reported recent morphine injection had used illicit morphine in the preceding six months. Twenty-one percent of the sample reported purchasing morphine in the preceding six months (15% in 2003), predominantly from street dealers. Fifty-three percent of the sample reported that illicit morphine was 'easy' (30%; 22% in 2003) or 'very easy' (23%; 19% in 2003) to obtain, and 58% reported that availability had remained stable over the preceding six months. Thirty-seven percent thought that it was 'difficult' (35%) or 'very difficult' (15%) to obtain, while 5% thought it fluctuated.

Fifty-eight percent of IDU who reported injecting morphine in the preceding six months had also done so in the previous month (43% said so in 2003), with 60% of this group reporting injection related problems due to morphine (43% in 2003). The most common problems among those injecting in the previous month were difficulty finding veins (38%), morphine dependence (28%), abscesses/infections (20%) and scarring/bruising (20%).

Figure 60 shows that the prevalence of morphine use and injection has gradually increased since 2001. Frequency of morphine use has remained stable.

Figure 60: Proportion of IDU reporting morphine use and injection in the past six months 2001-2004



Source: IDRS IDU interviews

Morphine was predominantly from illicit sources with 78% of morphine users reporting illicit morphine as the form most used (this figure was 82% in 2003). MS Contin was the most common brand of morphine used, and 14% of IDU (9% in 2003) reported buying 100mg MS Contin tablets at a median price of $20 (the same price as 2003).

Among those commenting on illicit morphine (n= 40), 53% reported that it was 'easy' (30%) or 'very easy' (23%) to obtain while 38% reported that it was 'difficult' (35%) or 'very difficult' (3%). This presents a similarly varied picture to the 2003 IDRS in which 41% of those who commented thought it 'easy' (22%) to 'very easy' (19%) to obtain while 50% of this group thought it 'difficult'.

Twenty-two percent of IDU (16% in 2003) reported buying illicit morphine in the preceding six months, predominantly from street dealers (48%) and friends (18%). The median length of time to score morphine was 20 minutes. Sixty percent of those commenting reported that the price for illicit morphine had remained stable over the preceding six months.

8.4 Other opioids

Twenty-two percent of IDU reported using other opioids such as codeine and pethidine in the preceding six months (compared to 13% in 2003 and 23% in 2002). The median number of days on which other opioids had been used in the preceding six months was six (5 in 2003 and 2002). Among this group, just over half (58%) reported using illicit opioids during this period, an increase from 35% in 2003. Injecting patterns remained similar to those reported in 2003, with 4% of IDU (2% in 2003) reported injecting these drugs on a median of two days (2.5 days in 2003). Panadeine Forte (which contains 30mg codeine) continued to be the predominant type of opioid used.

9 OTHER DRUGS

9.1 Benzodiazepines

As in 2003, IDU continued to use and inject benzodiazepines despite a restriction in the availability of benzodiazepine gel capsule preparations (Euhypnos, Nocturne, Normison & Temaze) introduced on 1 May 2002. Gel caps were subsequently removed completely from the pharmaceutical market at the end of March 2004 and a concomitant reduction in injection has been noted.

In 2004, 67% of IDU reported benzodiazepine use in the preceding six months on a median of 60 days (62% reported benzodiazepine use on a median of 18 days in 2003). Thirteen percent of IDU reported injecting benzodiazepines, as compared to 19% in 2003. The median number of days benzodiazepines were injected was 9 (20 days in 2003). Seventeen percent of IDU reported daily benzodiazepine use, representing an increase from 10% in 2003.

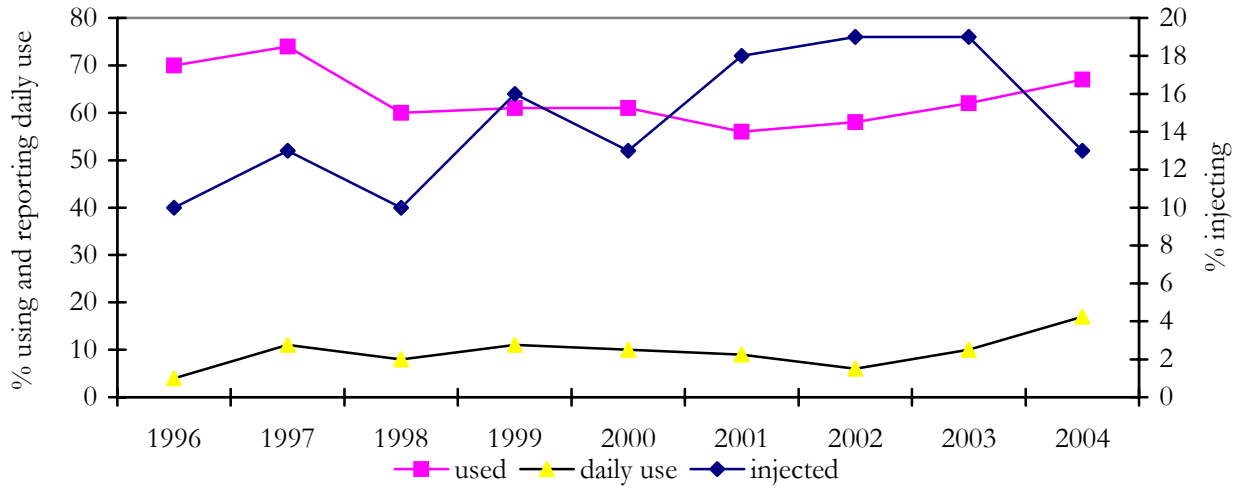
Among those reporting daily benzodiazepine use, just under a third (30%; n=9) reported intravenous use in the preceding six months. This represents a decrease from 47% in 2003. Among IDU who had injected benzodiazepines in the preceding six months, the most commonly used brand was Normison (43%; a form of temazepam available in either tablet or gel cap form). One participant reported that the main brand used was Euhypnos (a brand of temazepam which is only available in gel cap form). Overall this suggests a decrease in the use of gel caps, consistent with the ongoing restriction in availability of these preparations. No respondents reported daily injection of benzodiazepines.

Fifty-two percent of IDU reported obtaining their benzodiazepines from illicit sources (40% in 2003), and 38% reported illicit benzodiazepines as the main form used (24% in 2003). Among respondents who had used benzodiazepines, the most commonly used form remained diazepam (48%; the same as 2003), followed by oxazepam (23%; 12% in 2003) and temazepam (15%; 29% in 2003). This represents an increase in the use of oxazepam (mainly Serepax) and a decrease in the use of temazepam (predominantly Normison) from the levels seen in 2002/2003, consistent with reports of decreased access to this form of benzodiazepine among IDU. Nevertheless, the proportion of IDU reporting benzodiazepine use on the day prior to interview increased to 27% (17% in 2003).

A number of IDU commenting on drug trends reported that IDU were moving to benzodiazepine use, and this is perhaps unsurprising given the sustained reduction in heroin supply.

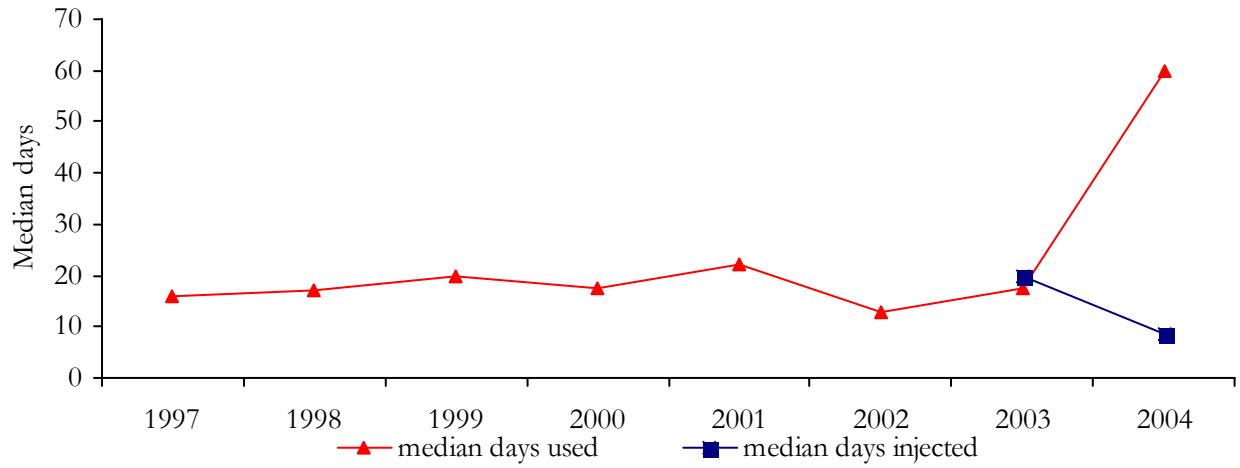
Overall, the prevalence of benzodiazepine use among IDU has remained relatively stable, and the trend towards injection of benzodiazepines in previous years has decreased since 2003, representing a return to 2000 figures (Figure 61, page 83). Frequency of use has increased substantially, while frequency of injection has decreased (Figure 62, page 83).

Figure 61: Proportion of IDU reporting benzodiazepine use, daily use and injection in the preceding six months 1996-2004



Source: IDRS IDU interviews

Figure 62: Median days use and injection of benzodiazepines in the past six months, 1997-2004



Source: IDRS IDU interviews
NB Collection of data on the number of days injected commenced in 2003.

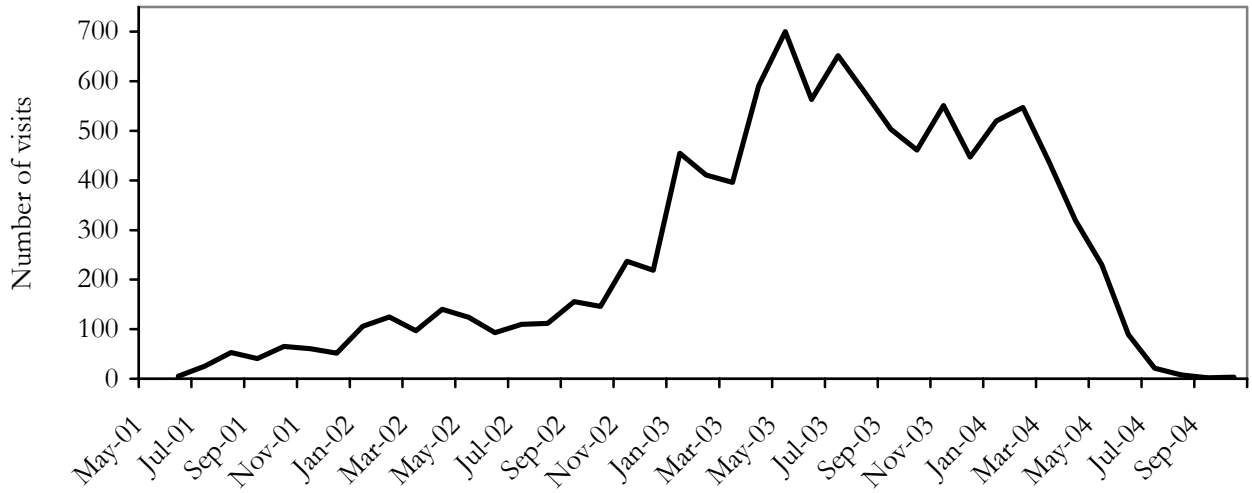
Forty-eight percent of IDU who reported injecting benzodiazepines in the preceding six months had also done so in the preceding month (n=10; 70% in 2003), with 80% reporting injection related problems due to the injection of benzodiazepines. The most common problems reported among those injecting in the previous month were difficulty finding veins to inject into (70%), scarring and bruising (60%) and swelling of the arm (40%).

Whilst there was a low prevalence of benzodiazepine injection in the preceding month, experience of problems among those who inject them remained high. Sixty percent (n=8) of this group reported more than one injection related problem due to recent benzodiazepine injection.

Data from the Medically Supervised Injecting Centre (MSIC) in Kings Cross show that the number of clients who inject benzodiazepines has decreased dramatically during 2004, from 520 in January to

three in October (Figure 63). The most commonly injected benzodiazepines at MSIC were temazepam gel caps, and the withdrawal of these from the Australian pharmaceutical market at the end of March 2004 resulted in the dramatic decline observed. This data is also consistent with IDRS IDU reports.[18]

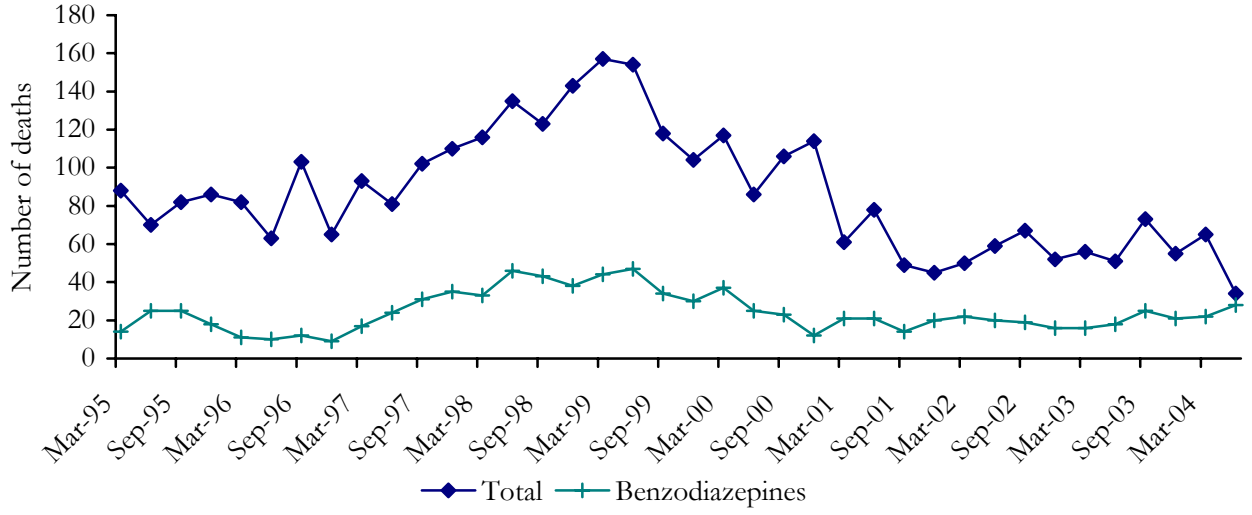
Figure 63: Number of attendances to MSIC where benzodiazepines were injected, 2001-2004



Source: Medically Supervised Injecting Centre, Kings Cross

The number of deaths of suspected drug users in which benzodiazepines were detected (Figure 64) has remained relatively stable in the past three years, and in June 2004 they were detected in almost all (28 of 34) drug-related deaths.

Figure 64: Number of suspected drug related deaths in which benzodiazepines were detected post mortem and total number of drug related deaths, 1995-2004

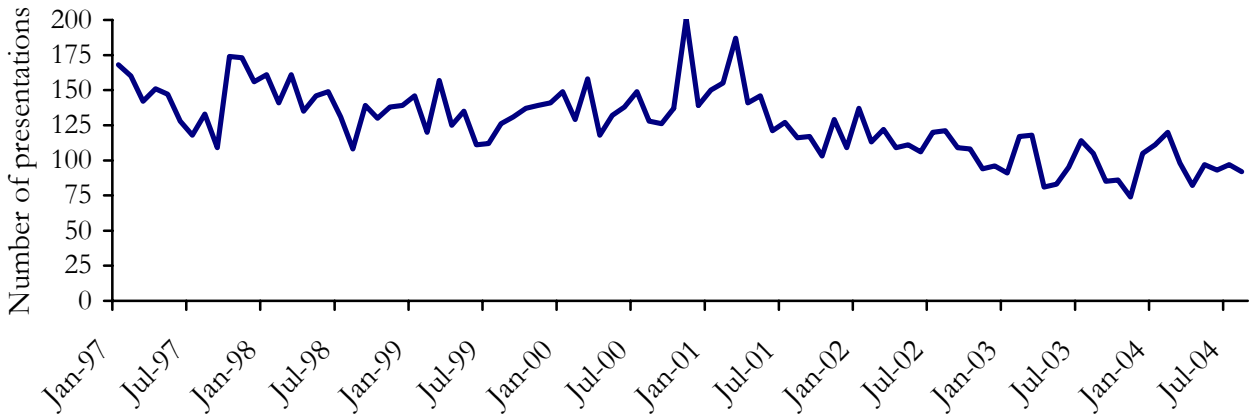


Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories
N.B. These numbers relate to deaths in which benzodiazepines were detected, however there may have also been other drugs present.

[18] The following caveats need to be considered when interpreting this data: 1) Hours of operation changed over the first 2 years of operation (from four to up to twelve per day) and 2) The numbers of individuals attending increased continuously over the first 2 years of operation as IDU became aware of this new service.

The number of benzodiazepine overdose presentations to NSW emergency departments has decreased gradually since 2001 (Figure 65). It is important to note, however, that the majority of overdose presentations occur among older women and people who may have intentionally overdosed; it is likely that IDU form only a minority of suspected overdoses at EDs.

Figure 65: Benzodiazepine overdose presentations to NSW emergency departments, 1997-2004



Source: Emergency Department Information System, NSW Department of Health

9.2 Antidepressants

Forty-one percent of the IDU sample reported lifetime use of antidepressants, and none reported having ever injected them. Twenty-two percent had used them in the last six months on a median of 175 days (17% had done so on a median of 135 days in 2003). Female participants were significantly more likely to report having ever used anti-depressants than their male counterparts (54% females vs. 36% males, 95% CI: 0.24-0.97). However, there were no significant differences in recent use: 25% of females had used antidepressants on a median of 175 days and 22% of males had done so on 162 days in the preceding six months. Two participants reported recent illicit antidepressant use. The most common types of antidepressant used (whether licit or illicit) were venlafaxine (Effexor), citalopram (Cipramil), doxepin (Deptran) and mirtazapine (Avanza).

As in the 2003 IDRS, questions concerning recent mental health issues such as depression were included. The most commonly reported mental health problem was depression (38%). Of those who reported experiencing depression in the preceding six months, just under two thirds (62%) reported consulting a health professional about depression. For further details please refer to Section 8: Associated Harms- Mental health problems (page 90).

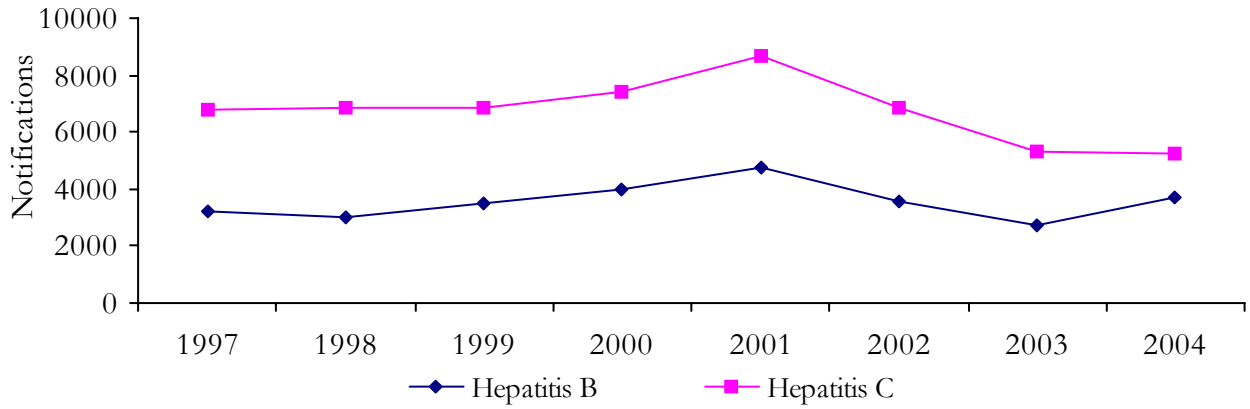
10 ASSOCIATED HARMS

10.1 Blood borne viral infections

People with a history of injecting drug use are at significantly greater risk of acquiring hepatitis B (HBV), hepatitis C (HCV) and Human Immunodeficiency Virus (HIV) than the general population (NCHECR, 2002). This is because blood-borne viral infections (BBVI) can be transmitted through the sharing of needles, syringes and other equipment.

Figure 66 shows the total number of notifications for HBV and HCV in NSW. Incident (newly acquired) infections and unspecified infections (i.e. notifications where the timing of the disease acquisition is unknown) are presented. HCV continued to be more commonly notified than HBV, and there remains a downward trend in notifications of HCV since 2001. HBV notifications have increased from 2,702 in 2003 to 3,678 in 2004 but remain lower than levels reported in 2001.

Figure 66: Total notifications for (unspecified and incident) HBV and HCV infections, NSW 1997 – 2004

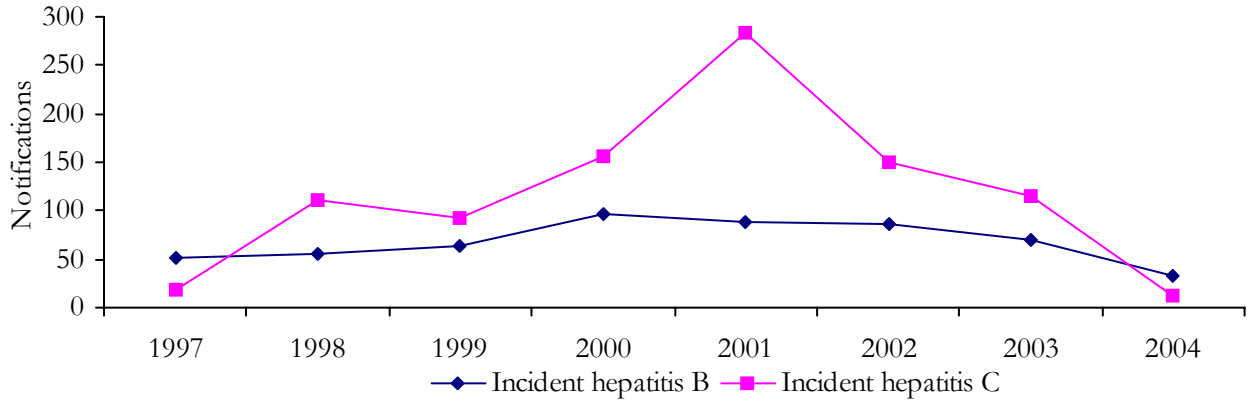


Source: Communicable Diseases Network – Australia – National Notifiable Diseases Surveillance System[19]
NB: The 2004 data refers to January-November inclusive and is provisional data only.

Trends in the number of incident notifications for HBV and HCV in NSW are shown in Figure 67. HBV incident reporting has decreased in the past twelve months from 70 in 2003 to 33 in 2004. A dramatic decline occurred in the number of HCV incident notifications, from 115 in 2003 to 13 in 2004.

[19] ***Notes on interpretation***
There are several caveats to the NNDSS data that need to be considered. As no personal identifiers are collected, duplication in reporting may occur if patients move from one jurisdiction to another and are notified in both. In addition, notified cases are likely to only represent a proportion of the total number of cases that occur, and this proportion may vary between diseases, between jurisdictions, and over time.

Figure 67: Total notifications for incident HBV and HCV infections, 1997-2004



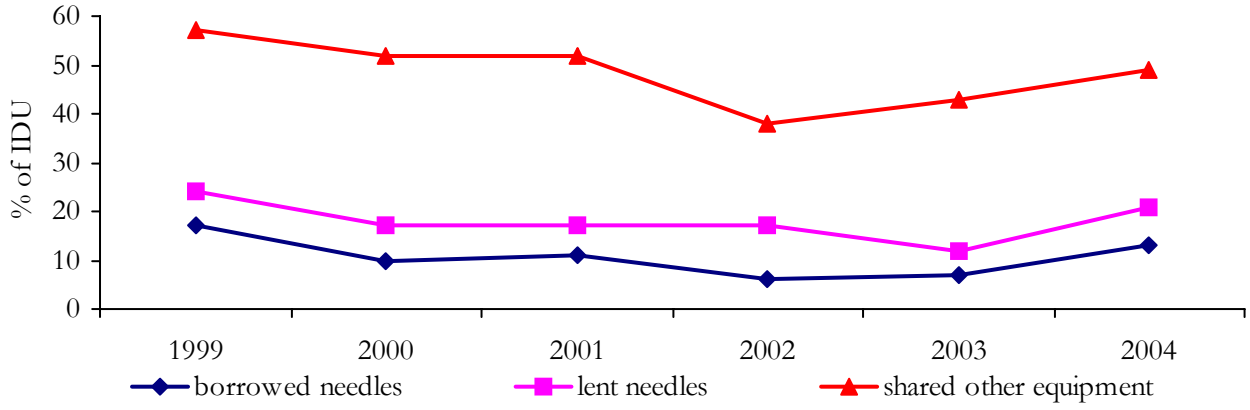
Source: Communicable Diseases Network – Australia – National Notifiable Diseases Surveillance System[20]
NB: The 2004 data refers to January-November inclusive and is provisional data only.

10.2 Sharing of injecting equipment among IDU

In the month preceding interview, 13% (n=20) of participants reported using a needle that had already been used by someone else ("borrowed needle"), an increase from 7% in 2003 (Figure 68). All of these respondents reported that only one other person had used the needle before them, with the exception of one participant who reported that it had already been used by between three and five others. People who had used the syringe first were typically a regular sex partner (n=8), a close friend (n=8), or an acquaintance (n=3).

Twenty-one percent of participants (n=32) reported passing needles on to other IDU ("lent needle") in 2004, an increase from 12% in 2003.

Figure 68: Proportion of IDU reporting sharing injecting equipment in the month preceding interview, 1999-2004



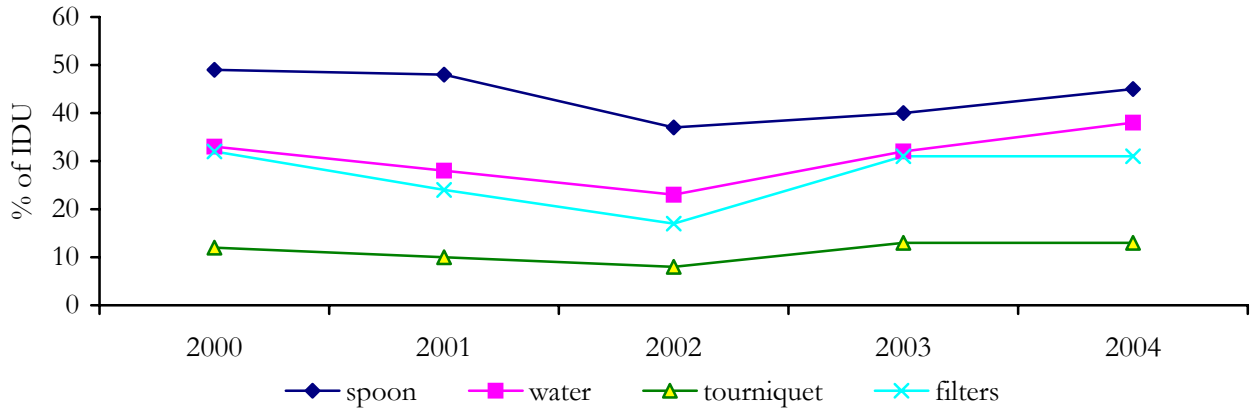
Source: IDRS IDU interviews
Note: Other injecting equipment include spoons, water, filters and tourniquets

[20] ***Notes on interpretation***
There are several caveats to the NNDSS data that need to be considered. As no personal identifiers are collected, duplication in reporting may occur if patients move from one jurisdiction to another and are notified in both. In addition, notified cases are likely to only represent a proportion of the total number of cases that occur, and this proportion may vary between diseases, between jurisdictions, and over time.

As in previous years, sharing of injecting equipment was more common, with 52% reporting doing so (compared with 43% in 2003). Overall, Figure 68 shows a concerning upward trend in IDU reports of borrowing and lending of needles and syringes and particularly sharing of other injecting equipment.

Figure 69 shows a breakdown of the types of injecting equipment IDU reported sharing. Spoons/mixing containers were the most commonly shared item (45%), followed by water (38%), filters (31%) and tourniquets (13%). Overall this data indicates that the rates of sharing equipment have remained relatively stable over the past year, following an increase between 2002/2003.

Figure 69: Proportion of IDU reporting sharing other injecting equipment by type, 2000-2004



Source: IDRS IDU interviews

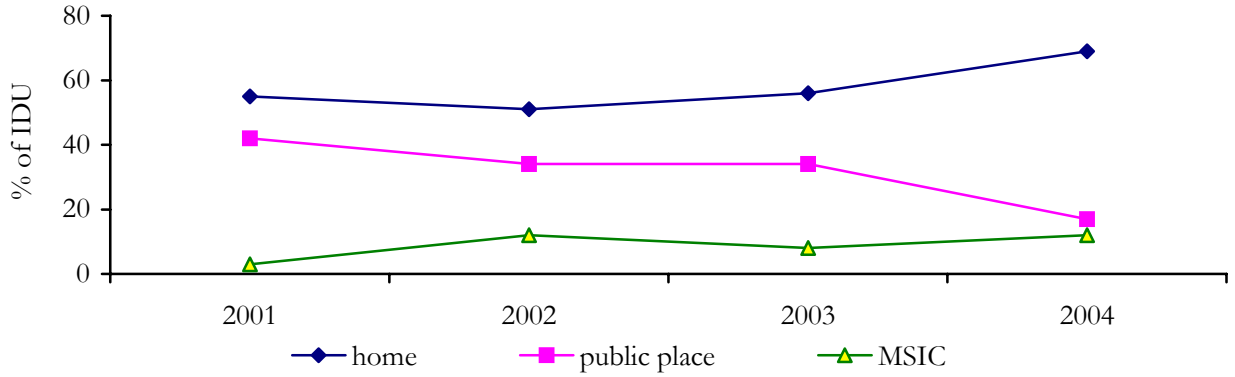
10.2.1 Summary

Rates of reporting of newly acquired (incident) HBV and HCV to health authorities have decreased over the past three years. IDRS survey data suggest that the proportions of IDU borrowing and/or lending needles has increased slightly compared to 2003. The proportion of IDU who reported sharing of other injecting equipment has remained relatively stable, although slight increases were reported in the sharing of water and spoons. This continues to be of concern with regard to the transmission of blood borne viral infections such as HBV and HCV.

10.3 Location of injections

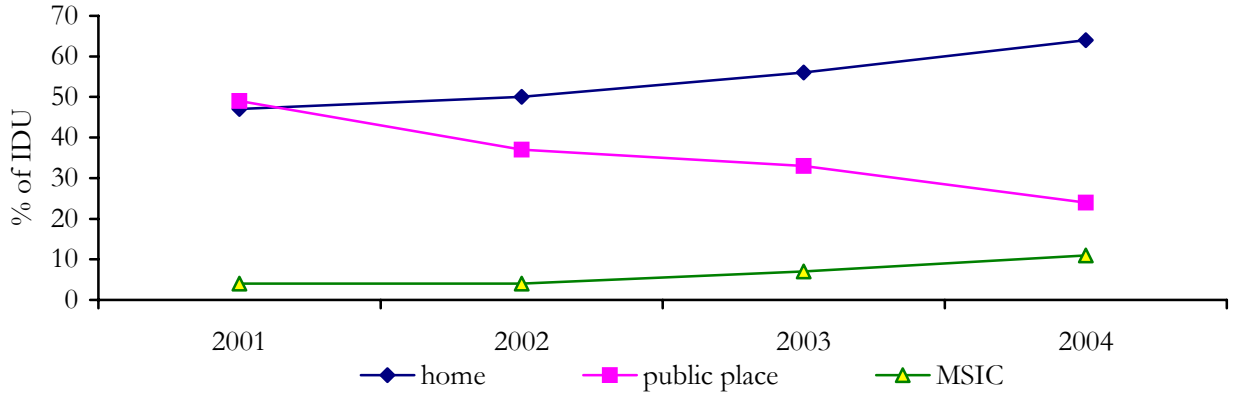
The most commonly reported usual location for injection in the month preceding interview was at a private home (69%), with 64% reporting a private home as the location for their most recent injection. Seventeen percent of participants reported that their usual location for injection was a public place (e.g. street, car or public toilet), and 24% reported that a public place was the location of their most recent injection. An increase was also observed in the proportion of participants reporting MSIC as their usual and last location for injection (from 8% in 2003 to 12% in 2004, and 7% in 2003 to 11% in 2004, respectively) (Figures 70 & 71, page 89).

Figure 70: Proportion of IDU reporting usual location for injection in the month preceding interview 2001-2004



Source: IDRS IDU interviews

Figure 71: Proportion of IDU reporting the last location for injection, 2001-2004



Source: IDRS IDU interviews

These figures demonstrate a consistent downward trend in the proportion of IDU reporting public places as the usual and most recent locations for injecting. This is a positive trend, since public injecting has previously been associated with significant risk behaviours among IDU, such as rushing injection for fear of apprehension, injecting the total "deal", and sharing of injecting equipment among those injecting together (Maher et al., 1998).

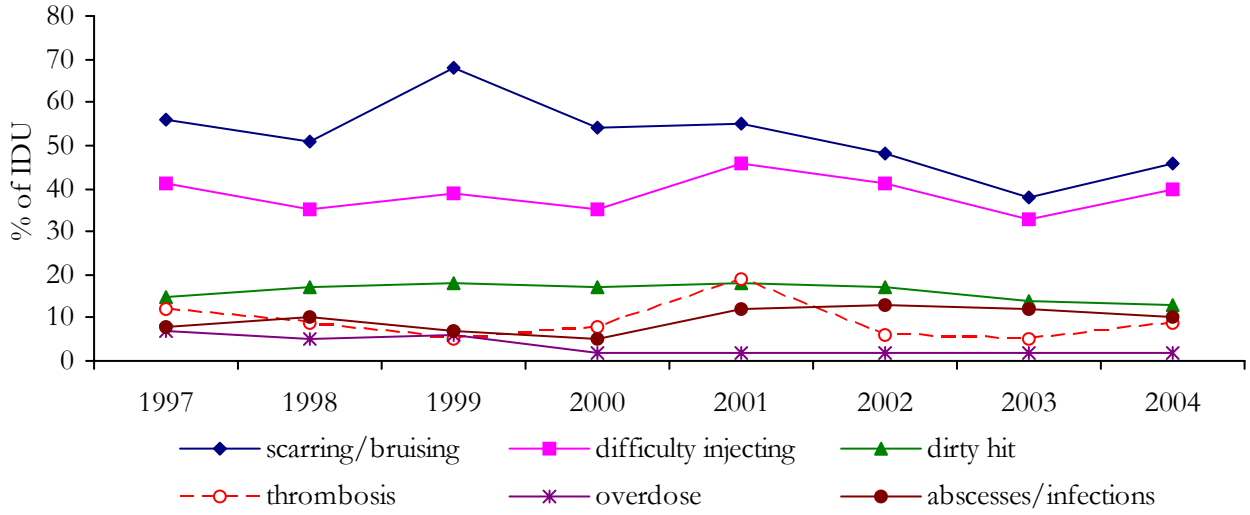
10.4 Injection-related health problems

Almost two thirds (64%) of IDU reported at least one injection-related problem in the month preceding interview (this figure was 60% in 2003). Thirty-eight percent reported two or more problems during this period (a slight increase from 30% in 2003). As in previous years, the most commonly reported problems were prominent scarring/bruising of injection sites (46%) and difficulty injecting (40%). Smaller proportions reported experiencing a 'dirty hit' (13%), abscesses or infections from injecting (10%), thrombosis (9%) and overdose (2%). Of those reporting a 'dirty hit' (n=20), the majority (n=16) attributed it to heroin while two IDU attributed it methamphetamine, and two did not respond. Of those who had overdosed on heroin in the past month (n=3), one had overdosed on

heroin alone, and one reported using benzodiazepines in conjunction with heroin at the time of overdose (the third did not respond).

Figure 72 shows that the proportions reporting prominent scarring or bruising and difficulty injecting in the past month have increased slightly in the past year, following a previous downward trend. Reports of thrombosis have also increased, although they have not reached levels reported in 2001. Proportions reporting a dirty hit, overdose, and abscesses or infections have remained relatively stable.

Figure 72: Proportion of IDU reporting injection-related problems by problem type, 1997-2004



Source: IDRS IDU interviews

10.5 Expenditure on illicit drugs

Despite 98% of IDU reporting drug use on the day prior to interview, only 83% reported spending money on drugs the previous day (similar to 2003). The median amount spent was $80 (range $5 to $400), a decrease from $100 (range $5 to $1500) in 2003. Thirty-six percent of the sample had spend $100 or more on that day (46% said so in 2003) and 13% had spent $200 or more (23% said so in 2003). As in previous years there was a significant correlation between the amount spent on drugs on the day prior to interview and frequency of injecting, with those injecting more frequently reporting having spent larger amounts on the day prior to interview (Spearman's $r=.48$, $p< .001$).

10.6 Mental health problems

Fifty percent of IDU reported experiencing a mental health problem other than drug use in the preceding six months. The most commonly reported problem was depression (38%), followed by anxiety (19%), paranoia (7%), panic (6%), bipolar disorder (5%), drug induced psychosis (3%), a personality disorder (2%), schizophrenia (2%), other psychosis (not drug-induced; 2%), phobias (1%) and obsessive-compulsive disorder (1%).

Thirty percent of the sample had attended a health professional for a mental health problem during this time (26% said so in 2003). This represents 60% of those reporting experience of a mental health problem other than drug use in the preceding six months. The most commonly reported health professionals consulted by IDU were GPs (17%; the same as 2003), psychiatrists (8%; 17% in 2003), psychologists (8%; 4% in 2003), counsellors (8%; 7% in 2003), community health nurses (<1%; 4% in 2003) and mental health nurses (3%; 4% in 2003).

The most commonly reported problems sought help for were depression (24%; 16% in 2003), anxiety (10%; 5% in 2003), bipolar disorder (2%; 1% in 2003), panic (2%; 1% in 2003) and schizophrenia (2%; 3% in 2003). Two participants reported consulting a health professional regarding drug-induced psychosis (1%, as compared with 4% in 2003). Despite 7% of the sample reporting that they had experienced paranoia in the preceding six months, no participants reported seeking professional advice for it (this figure was 2% in 2003).

10.7 Substance related aggression

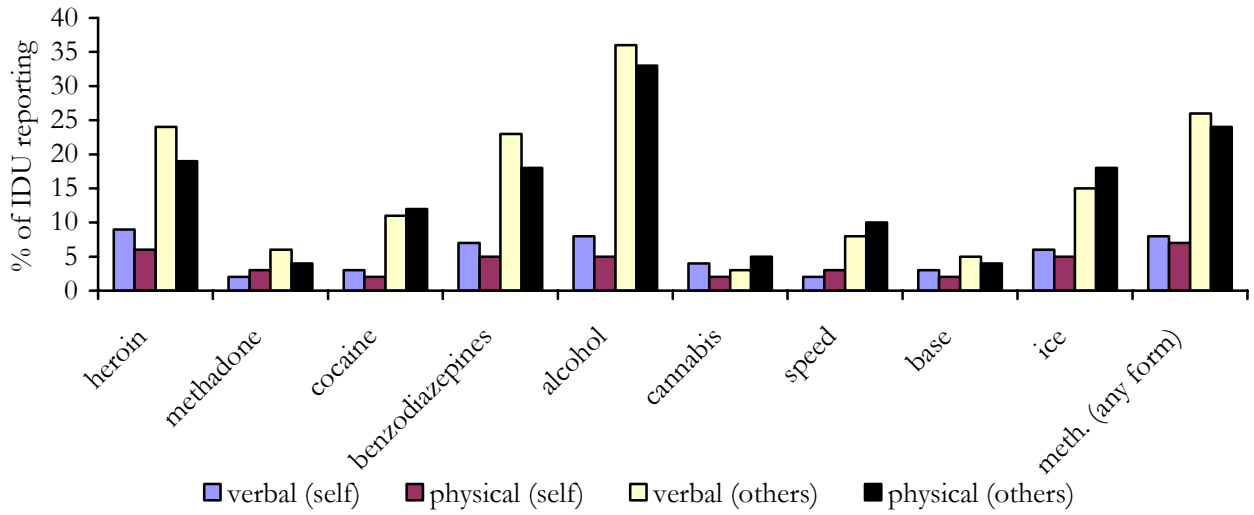
The 2004 IDU survey included questions regarding substance-related aggression. Twenty-six percent of IDU reported that they had become verbally aggressive following use[21] of a drug in the last six months, and 18% reported that they had become physically aggressive following use of a drug in the preceding six months. Larger proportions reported seeing that they had seen someone else that they knew become verbally (73%) or physically (65%) aggressive following use of a drug in the six months preceding interview.

The most commonly reported drugs after which IDU reported becoming aggressive recently were heroin (9% verbal, 6% physical), alcohol (8% verbal, 5% physical), benzodiazepines (7% verbal, 5% physical) and ice (6% verbal, 5% physical; Figure 73, page 92). Any form of methamphetamine (speed, base and ice) was reported to have been used prior to experiencing verbal aggression in 8% and physical aggression in 7% of IDU.

Over a third of IDU had observed other people they knew becoming verbally (36%) or physically (33%) aggressive in the preceding six months following use of alcohol. Heroin (24% verbal, 19% physical), benzodiazepines (23% verbal, 18% physical) and ice (15% verbal, 18% physical) were also the most commonly reported drugs that others had used prior to becoming aggressive. However, considered together, approximately one quarter of respondents reported observing someone that they knew become verbally or physically aggressive following use of any form of methamphetamine (26% and 24%, respectively).

[21] The question was worded as such that responses could refer to being under the influence, and/or during withdrawal from, a drug.

Figure 73: Proportions of IDU reporting their own and others' aggression (verbal and physical) following use of a drug



Source: IDRS IDU interviews

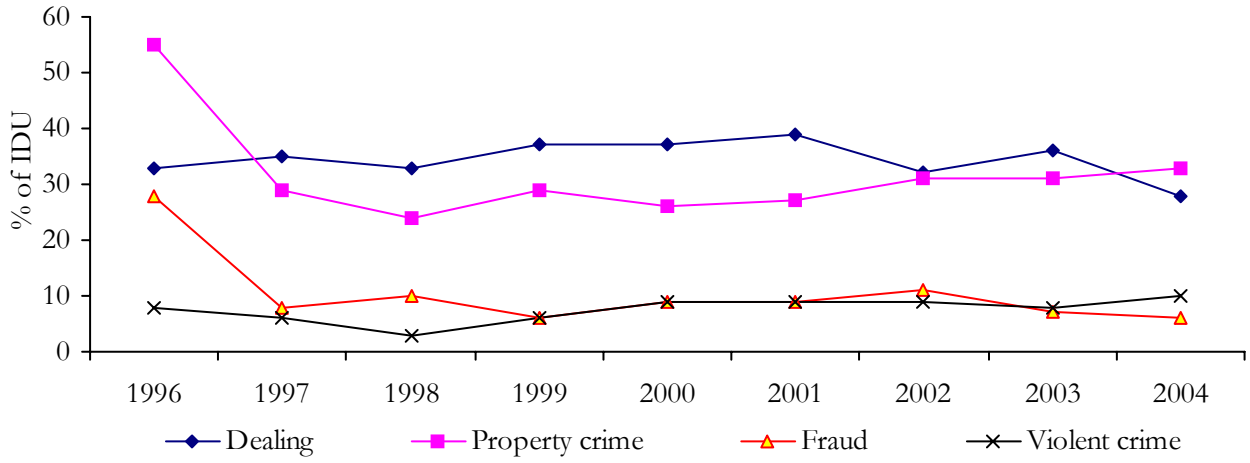
10.8 Criminal and police activity

Fifty percent of IDU reported engaging in any form of crime in the month preceding interview, virtually identical to the 2003 proportion (55%). The most commonly reported crimes were property crime (33%; 31% in 2003) and drug dealing (28%; a decrease from 36% in 2003). Ten percent of IDU reported engaging in violent crime (8% in 2003) and 6% reported fraud (7% in 2003).

Forty-three percent of IDU had been arrested in the previous twelve months, representing a decrease from 49% in 2003. As in the 2003 IDRS, the most commonly cited reasons for arrest were property crime (19%; 20% in 2003), violent crime (7%; 10% in 2003), possession/use of a prohibited drug (7%; 8% in 2003) and drug dealing/trafficking (4%; 6% in 2003). Males were slightly more likely to report engaging in crime in the month preceding interview, with 56% of males reporting such activity as compared with 38% of females (OR 2.059, 95% CI: 1.03-4.1). There was no significant difference between the proportions of males and females reporting arrest in the previous twelve months (47% versus 34%).

Figure 74 shows that over time there has been a relatively stable proportion of IDU engaging in these four types of offences.

Figure 74: Proportion of IDU reporting engagement in criminal activity by offence type, 1996-2004



Source: IDRS IDU interviews

KE also generally reported that numbers engaging in these offences had remained stable. However, a number of KE reported a decrease in the number of break and enters in areas including Kings Cross and overall across NSW. An exception to this was Liverpool where break and enters were reported to have increased in some localities. A number of KE reported that there had been an increase in violent crime among methamphetamine users in some areas of Sydney.

Seventy percent of IDU reported a perceived increase in police activity in the preceding six months, comparable to 67% in 2003 (Table 8, page 94). Just over one quarter (26%) thought that it had remained stable, while only two participants thought that there has been less police activity. Overall these figures are comparable to those reported in 2003.

Among those who had perceived a recent increase in police activity, 19% reported an increased presence of drug detection dogs in public areas (compared with 1.5% of IDU who noted an increase in police dogs in 2003). Ten percent of IDU commenting mentioned an increase in stop and search procedures.

Equal numbers of KE reported that police activity towards illicit drug users had either increased or remained stable in the preceding six months.

Just over half of the sample (53%) reported that police activity had not made it more difficult for them to score drugs. This represents a decrease from 2003, where 66% of the sample reported that their ability to score had been unaffected (Table 8).

Table 8: Criminal and police activity as reported by IDU, 2003 – 2004

	2003 N= 154 %	2004 N=157 %
Criminal activity in last month:		
Dealing	36	28
Property crime	31	33
Fraud	7	6
Violent crime	8	10
Any crime	55	51
Arrested in last 12 months	49	43
Police activity in last 6 months		
More activity	67	70
Stable	23	26
Less activity	3	1
Don't know	7	3
More difficult to obtain drugs recently		
Yes	33	46
No	66	53

Source: IDRS IDU interviews

10.8.1 Summary

While IDU reports of recent involvement in criminal activity have remained relatively stable, a slight decrease was noted in the proportions reporting drug dealing. However, drug dealing remained the second most commonly reported offence after property crime. Compared to 2003, smaller proportions of IDU reported having been arrested in the preceding twelve months.

Perceived levels of police activity remained similar to previous years, with the exception of an increase in the use of drug detection dogs. A greater proportion of IDU than previous years reported that police activity had made it more difficult for them to obtain drugs recently.

11 DISCUSSION

This year's IDU sample was comparable to the 2003 sample in terms of demographic characteristics such as age, gender, employment status and prison history. However, much larger proportions were engaged in drug treatment. The proportions of respondents engaged in drug treatment have been steadily increasing over the past three years, and results may be partly a reflection of this, particularly as other indicators suggest that heroin price, purity and availability have not returned to pre-shortage levels. However it is also important to note that a change of site to one located in close proximity to a methadone unit is likely to have influenced these results- consequently, comparisons with previous years should be made with caution.

11.1 Heroin

The frequency of heroin use (as measured by the median number of days' use and the proportion of daily users) in the preceding six months decreased from 2003. Price remained stable, and while it was reported to be readily available, reports of heroin purity indicated that it remained of fairly low quality. This suggests that the heroin market has yet to recover from the shortage reported in 2001, and a move away from near-daily heroin use and toward other drugs, most notably methadone (both licit and illicit) and benzodiazepines among those actively engaged in the illicit drug market.

There may be several explanations for this. Research undertaken in Australia by one of the authors (Louisa Degenhardt) and others suggests there has been a sustained change in the nature of the heroin market in Australia (Degenhardt et al., 2005, Degenhardt and Day, 2004). A less consistent supply of heroin available post 2000 could well lead to less frequent use, particularly if the purity is also low. In addition it may be that IDU find it difficult to sustain their heroin use at higher levels due to increased price, and have reduced their use accordingly. While heroin prices have remained stable since 2002, they remain higher than prices reported prior to 2001. Finally, less frequent use of heroin may be consistent with higher proportions of IDU in methadone treatment, a phenomenon that has been well documented in the literature (Hall et al., 1998).

Both law enforcement and health indicator data showed sustained, lower, levels of heroin related harm following the heroin shortage, with fewer incidents recorded for possession and use of heroin, fewer calls to telephone helplines regarding problematic use, fewer inpatient hospital admissions relating to opioids, fewer ambulance callouts to overdoses, fewer heroin overdose presentations, and fewer deaths in which morphine was detected. Conversely, increasing numbers of re-registrations for opioid pharmacotherapy in NSW were observed throughout 2002/2003 (data were unavailable for the period 2003/2004). All of these findings suggest there has been a decrease in heroin use among the general community.

Overall, trends in heroin price, purity and availability continue to indicate that the heroin shortage in 2001 has had a sustained impact on illicit drug markets in Sydney. Indicator data also suggested a broader impact on heroin use among the general community. Nonetheless, IDU who have remained active in Sydney's illicit drug markets have maintained regular access to, and continue to use heroin, albeit less frequently.

11.2 Methamphetamine

Overall the price, perceived purity and availability of all three forms of methamphetamine indicated that there has been little change in the market since 2003, when a substantial increase in ice availability was observed. The ready availability of all three forms was reflected in use patterns, with approximately one third of the sample reporting recent speed and base use, and just under half reporting recent ice use. Despite use remaining relatively sporadic, overall use of methamphetamine (all forms) has increased from just over once per month (8 days in the last 6 months) in 2003 to just over once per week (26 days) in 2004.

Law enforcement and health indicator data showed a mixed pattern, with the number of recorded incidents of amphetamine possession/use in some areas of Sydney and number of calls to information services regarding problematic amphetamine use remaining higher over the past twelve months than immediately prior, while others have continued to fluctuate (amphetamine related deaths, inpatient hospital admissions, overdose). This suggests that, while use has increased slightly among IDU, fortunately the more worrying health-related harms experienced among the wider community have not followed suit as yet.

Interestingly, the number of closed treatment episodes for amphetamine use remained relatively stable over time, indicative that methamphetamine users continue to be a difficult group to engage in treatment. This remains a concern given that the 2001 National Drug Strategy Household Survey findings show that methamphetamine is the second most commonly used illicit drug after cannabis among the broader community in Australia, and is used on a regular basis (from weekly to daily) by 11% of those reporting methamphetamine use in the past twelve months (Australian Institute of Health and Welfare, 2002) Questions included in the IDU survey this year indicated that, after alcohol, methamphetamine (particularly ice) was the main drug after which aggression was most commonly observed or experienced by IDU, reflecting some health KE concerns regarding methamphetamine-related harms, particularly drug induced agitation and aggression. The data suggests the need for the development of effective treatment programmes for methamphetamine users as well as the implementation of strategies to engage and retain these users in treatment.

Overall, data indicated the previously noted increase in both the availability and recent use of ice has been sustained. However, among primary opioid injectors (as IDU in the IDRS sample seem to be) in the context of a sustained reduction in heroin supply, methamphetamine use appears to be somewhat opportunistic. In the event that heroin availability returns to Sydney drug markets at levels reported prior to the shortage, this may lead to a reduction in methamphetamine use among this group. Other research being conducted at NDARC suggests that there are dedicated methamphetamine injectors for whom the use of this drug is a very frequent and problematic form of drug use (McKetin et al., in preparation).

11.3 Cocaine

Cocaine use patterns remained comparable to those reported in 2003. While a sizeable proportion (47%) of the sample had used cocaine in the preceding six months, use remaining sporadic (averaging approximately once per month). This represents a marked contrast from 2001, when a marked increase in cocaine use was observed following a substantial reduction in heroin supply.

Similar to 2003 reports, cocaine remained harder to obtain than in previous years, with just under one third reporting it to be 'difficult' or 'very difficult' to obtain. This also appears to be reflected in the price- while the price for a cap of cocaine remained the same, slightly larger amounts (grams, half grams and quarter grams) all increased. A larger proportion of IDU perceived purity to be of 'high' purity than in 2003, suggesting that there has been a slight increase in purity, however, the majority still believed it to be 'medium' to 'low'. Whether this increase is maintained, however, remains to be seen.

Indicator data reflected IDU data, with trends related to cocaine use remaining low and relatively stable, with a decrease in the number of deaths relating to cocaine.

Overall, data suggested that the marked reduction in cocaine use has been sustained since 2003. Prices have increased slightly, which may be indicative of the continued (relative) difficulty in obtaining it, and/or the slight increase in perceived purity among IDU. As in 2003, if the availability of cocaine were to increase in Sydney, there may be a concurrent increase in cocaine use among IDU.

11.4 Cannabis

Consistent with previous years of the IDRS, there was very little change documented in cannabis trends among IDU with the majority of the sample reporting recent use, and 47% reporting daily use in the preceding six months. Given that this increase is occurring in the context of consistently high prices for heroin, lower heroin purity, and reduced frequency of heroin use, it may be that IDU are continuing to substitute or supplement their heroin use with cannabis.

While hydroponic cannabis continued to be the predominant form of cannabis used, three quarters of those using cannabis also reported using bush. Smaller proportions reported using hash (8%) and hash oil (6%).

Generally, indicator data suggested that cannabis use in the broader community has not changed recently, with the number and rate of inpatient hospital admissions and calls to telephone helplines related to cannabis remaining relatively stable. The number of incidents recorded for cannabis possession and use have remained stable across NSW, with the exception of inner Sydney where the number has increased- possibly due to an increased use of drug detection dogs in the area over this period.

Overall, the only change detected in cannabis use among IDU is the increased number of detections in the inner Sydney area. All other aspects of cannabis use recorded remained consistently stable.

11.5 Other opioids

An increase was observed in the proportions of IDU reporting use of illicit methadone in the last six months, from approximately one fifth to one third of respondents in 2003 and 2004, respectively. Approximately half of this group reported being engaged in methadone maintenance treatment during this period. Use of illicit methadone remained sporadic, with respondents reporting use approximately once per month. Given the very sporadic nature of this illicit methadone use, and the high rate of methadone treatment among this sample, it may be that some IDU obtain methadone to substitute for missed doses and maintain them until their next clinic visit.

A smaller proportion (22%) reported injecting methadone from illicit sources and, of these, just over half had been engaged in methadone treatment. This also represents an increase from 2003, and while concerning, it should also be noted that the median number of days on which it was injected remained relatively infrequent (averaging just under once per month) and this had not changed from 2003. Three IDU who reported predominantly using illicit methadone (15%) in the preceding six months had been engaged in methadone treatment during this period. Smaller proportions reported use (n=2) of illicit physeptone tablets, one of whom was engaged in treatment.

Similar to 2003, small proportions (8%) reported use of illicit buprenorphine in the preceding six months, one of whom (8%) was in buprenorphine treatment during this period. One of the thirteen IDU who reported predominantly using illicit buprenorphine had been engaged in buprenorphine treatment during this period.

These data indicated that diversion of methadone (and to a lesser extent buprenorphine) to IDU both in and out of treatment continues to occur. As would be expected, the vast majority of those who reported primarily using methadone or buprenorphine from illicit sources were not engaged in treatment. Injection of methadone and buprenorphine did not appear to be a significant issue among IDU in Sydney, although, similar to the slightly increased rates of illicit use detailed above, it appears to be becoming more of an issue than previously.

11.6 Benzodiazepines

The prevalence of benzodiazepine use has remained relatively stable, while frequency of use among the IDU sample increased dramatically. Almost one fifth (17%) of IDU reported daily benzodiazepine use (compared to 10% in 2003), and approximately one third of this group reported injecting benzodiazepines (representing a decrease from 2003). Just over half of the sample reported obtaining benzodiazepines illicitly, while an increase was noted in the proportion reporting predominantly using illicit benzodiazepines in the preceding six months (from 24% in 2003 to 38% in 2004). Diazepam (Valium) was the most popular brand of benzodiazepine used, followed by oxazepam (Serepax) and temazepam (Normison). There were anecdotes from a number of IDU about a perceived shift towards use of benzodiazepines.

A slight decrease in the proportion of IDU reporting injection of benzodiazepines was recorded between 2003 and 2004, from 19% in 2003 to 13% in 2004. Just under half of the group injecting benzodiazepines reported gel capsules as the predominant form used in the preceding six months. The majority of IDU who had injected benzodiazepines in the past month reported injection-related problems, most notably difficulty finding veins to inject into, prominent scarring and bruising, and

swelling of the arm. As interviews were conducted only three months after the withdrawal of gel caps from the pharmaceutical market, it is possible that further decreases in benzodiazepine injection will be observed in 2005.

Indicator data were consistent with IDU data, with a decrease in injection following withdrawal of temazepam gel capsules as evidenced in the number of MSIC clients reporting injection. While the number of deaths of suspected drug users in which benzodiazepines were detected has remained relatively stable since 2002. Given that the overall number of drug-related deaths has decreased, they are implicated in the majority of deaths that do occur, which is consistent with a profile of greater polydrug use particularly among heroin dependent persons since the reduction in the availability and quality of heroin in NSW.

Overall, the data indicated that the restrictions introduced in May 2002 and March 2004 to limit and then withdraw the supply of benzodiazepine gel capsules have impacted on injecting behaviours. However, IDU in Sydney continued to access (both licitly and illicitly) benzodiazepines, and used them much more frequently. Continued vigilance to minimise the diversion of benzodiazepines for injection seems warranted.

11.7 Associated harms

The proportion of IDU reporting borrowing used needles remained relatively stable while those lending used needles increased slightly. Worryingly, there was also a slight increase in the proportions reporting sharing other injecting equipment including spoons, water and filters, from 43% in 2003 to 52% in 2004.

Indicator data showed a downward trend in the number of newly acquired (incident) Hepatitis C infections. There may be a number of reasons for this. Some IDU may be engaging in safer injecting practices to a greater extent than in previous years (although this is not reflected in the IDU surveys conducted this year). A second, plausible reason for this reduction derives from evidence to suggest that the number of heroin-dependent injecting drug users in NSW appears to have declined since 2001 (Degenhardt et al., 2004a), with those who remained active IDU tending to have been more entrenched drug users and to have already contracted the hepatitis C virus through their injecting drug use. It has been argued to be most likely that those who stopped injecting were recent initiates to injecting who had not yet contracted hepatitis C (Degenhardt and Day, 2004).

Nevertheless, given that IDU are at particular risk of contracting blood borne viral infections, the sharing of injecting equipment continues to be an issue of concern. Data indicated that among those who continue to inject drugs, equipment continues to be shared among IDU, suggesting that an increased and sustained focus on the harms associated with sharing is required. Educational strategies need to address the issue that sharing of any injection-related equipment is potentially dangerous, and increased availability of needles, syringes and other injecting equipment should also be considered.

Proportions reporting injection-related problems have remained relatively stable, while proportions reporting specific problems have either remained stable or increased slightly. Benzodiazepine injectors were more likely to report injection-related problems than those who didn't inject benzodiazepines. It is

hoped that injection of benzodiazepines will continue to decline with the withdrawal of benzodiazepine gel caps.

Locations for injection have changed, with an increased proportion reporting injection at home and a corresponding decline in those reporting injecting in a public place. This has a number of positive implications, including an increase in the likelihood that IDU will inject in a safer manner since fear of apprehension may be less of an issue in the home. However, if IDU are injecting alone, they may be at increased risk of overdosing and failing to receive medical attention if they require it. Efforts to increase IDU awareness regarding overdose prevention and safety would be worth considering.

Half the sample reported experiencing a mental health problem other than drug dependence in the preceding six months. Depression and anxiety were the most commonly reported problems. However, only 30% had attended a health professional (usually their GP) regarding such issues during this time. This raises some concern regarding accessibility of services to this group.

Substance related aggression was observed by a significant minority of IDU within the preceding six months. The majority of respondents had observed instances of others (not necessarily other IDU, but anyone known to them) becoming aggressive following use of a substance in the preceding six months. The most commonly reported drug after which this occurred was alcohol, followed by heroin, benzodiazepines and methamphetamine. Clearly, the IDU interviewed for the IDRS are witness to significant levels of violence, which might reasonably be considered in future work.

There was little change in proportions reporting engagement in criminal activity or offence types, although there was a slight decrease observed in numbers reporting drug dealing. This group remained relatively engaged in criminal activity with just under half of the sample being arrested in the previous twelve months. Other than an observed increase in use of drug detection dogs, there was no change in perceptions of police activity in 2004 as compared with 2003.

12 IMPLICATIONS

The findings of the 2004 NSW IDRS indicated several areas of illicit drug use that require further attention including:

- Further research into drug trends and associated harms of methamphetamine use studying a group of primary methamphetamine users (McKetin et al., in preparation).
- Development of effective treatment programmes for methamphetamine users, and development of strategies to engage and retain users in these programmes.
- More detailed research into the nature of the cocaine market (that supplies IDU) in Sydney.
- Careful monitoring by medical practitioners and other health professionals as appropriate relating to the diversion of methadone and other opioids. Increasing trends towards this have been noted in other jurisdictions.
- Ongoing surveillance of patterns and prevalence of benzodiazepine use, and careful monitoring by medical practitioners and other health professionals, as appropriate of the clinical need for their prescription.
- Increasing focus on the development of educational material regarding overdose and the dangers of sharing injecting equipment other than needles.
- Increase awareness of the need for treatment of the concomitant mental health problems that many IDU may be experiencing in addition to their drug dependence. Despite the fact that many IDU were aware that they had such problems, relatively few were receiving help for them. The patterns of comorbidity among this group need to be assessed and effective methods of intervention considered in future work. In particular, the likelihood that comorbid mental health problems may affect treatment outcome needs to be acknowledged and addressed by both mental health and drug treatment services.

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