J. Weekley, S. Pointer & R. Ali

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

NDARC Technical Report No. 213

SA
DRUG TRENDS
2004

Findings from the Illicit Drug Reporting System (IDRS)

Josephine Weekley, Sophie Pointer and Robert Ali

Drug and Alcohol Services Council of South Australia[1]

NDARC Technical Report No. 213

ISBN 0 7334 2210 1

---

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

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGEMENTS

This research was funded by the Australian Government Department of Health and Ageing and the National Drug Law Enforcement Research Fund through the National Drug and Alcohol Research Centre. The authors would like to thank Ms Jennifer Stafford, Ms Courtney Breen, Dr Louisa Degenhardt, Dr Richard Mattick, Ms Amanda Roxburgh and Ms Emma Black of NDARC for their support and assistance throughout this study.

The authors also wish to acknowledge and thank:

- The four research interviewers who conducted the interviews with injecting drug users: Nitsan Atkinson, Aylza Donald, Justin Hay and Elizabeth Hunt.

- The 29 key experts who willingly provided their time, efforts and experience to contribute to the IDRS.

- Staff at the Clean Needle Program Sites around Adelaide who assisted in the recruitment of the injecting drug users, and who gave generously of their time and resources in facilitating this process.

- The organisations that generously provided us with indicator data or advice where indicator data was not available at the time of publication, including the Australian Bureau of Statistics, the Australian Crime Commission, the Australian Institute of Health and Welfare, the South Australian Police, the South Australian Ambulance Service, the Royal Adelaide Hospital, the South Australian Alcohol and Drug Information Service, the National Drug and Alcohol Research Centre, and the Drug and Alcohol Services Council.

Finally, the authors wish to thank the 101 injecting drug users who participated in the IDU survey in 2004, and shared their experiences with us.

ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ADIS	Alcohol and Drug Information Service
AFP	Australian Federal Police
ATSI	Aboriginal and Torres Strait Islander
CNP	Clean Needle Program
DASC	Drug and Alcohol Services Council[2]
IDRS	Illicit Drug Reporting System
IDU	Injecting Drug Users
KES	Key Experts
MDMA	3, 4-methylenedioxymethamphetamine ('ecstasy')
NDARC	National Drug and Alcohol Research Centre
NSP	Needle and Syringe Program
RAH	Royal Adelaide Hospital
SA	South Australia
SAPOL	South Australian Police

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

EXECUTIVE SUMMARY

Demographic characteristics of injecting drug users (IDU)

One hundred and one IDU participated in the 2004 IDRS. The median age of the sample was 32 years and 61% of participants were male. Almost two-thirds (63%) of the sample was unemployed and over half (59%) had a history of previous imprisonment. The median number of years spent at school was 10. Over half the sample (54%) reported having some kind of post secondary school qualifications and almost half (48%) were currently undertaking some form of treatment for drug use. Compared to 2003, in 2004 there were slightly more males in the sample, more who reported having a tertiary qualification from a university or college, and more who were in some form of treatment for drug use at the time of interview.

Patterns of drug use among IDU

The drug most commonly first injected by the sample was amphetamine (53%), followed by heroin (39%). Compared to 2003, in 2004 there was no change in the proportions nominating heroin and methamphetamine as their preferred drug among the IDU sample. Specifically, 48% reported heroin as their drug of choice and 34% reported some form of methamphetamine as their drug of choice. However, similar proportions reported heroin or methamphetamine as the drug most injected in the last month. Since 2002 there has been an increase in the proportion of IDU that reported injecting heroin most often in the last month (22% to 33% to 37%) and a concurrent decrease in the proportion reporting methamphetamine as the drug most injected (57% to 43% to 39%). Therefore, in 2004 there is still a discrepancy between what people want to use and what they are actually using, which may depend on a variety of factors including price, availability and quality of what is available.

Polydrug use was common among the IDU in 2004 and has remained consistently so across the years, with no real differences being reported from 2003 to 2004. Similar to 2003, in 2004 there was substantial crossover between heroin users and methamphetamine users in the IDU sample. Thirty-six IDU (36%) had used both heroin and some form of methamphetamine, in the last six months.

Frequency of injecting in the last month was greater than weekly for two-thirds of the sample, with 38% reporting injecting at least once a day. Overall, there was a decrease in the reported frequency of injecting in the last month, from 2003 to 2004.

Heroin

Overall, there was a decrease in the price of heroin from 2003 to 2004, continuing the downward trend since the peak in 2002, with the price now the same as the pre-shortage level of 2000 ($320 per gram). Heroin was still considered 'easy' or 'very easy' to obtain by most IDU and availability was reported as stable to easier in the preceding six months. There was an increase in the proportion of IDU obtaining heroin from a dealer's home or from a street dealer, and a concomitant decrease in the proportion being supplied by mobile dealers. According to the majority of IDU, heroin purity remained at low to medium levels in 2004, with increased proportions also reporting fluctuating or decreasing purity. IDU perceptions were supported by indicator data, which shows the median purity of SAPOL heroin seizures has remained relatively stable across the last

few years, with median purity of 25% in 2003/04. Purity of SAPOL heroin seizures remains well below pre-shortage levels.

A small increase in the proportion of IDU that had recently used heroin was noted, continuing the increase since 2002. There was however, a decrease in the median number of days used following the dramatic rise in frequency seen in 2003. This may indicate a stabilisation of heroin use following the post-shortage 'bounce-back' of 2003.

Analysis of IDU that nominated heroin as their drug of choice indicated users continue to supplement or substitute their heroin use with other opioid substances such as morphine and methadone. There was an increase in the proportion of IDU reporting use of rock heroin and a decrease in the proportion of IDU reporting use of powder heroin, and a slight majority (59%) reported rock as the form *used most* in the last six months. It was suggested by several KES though that rock heroin is actually compressed powder heroin.

SAPOL data revealed that total heroin-related possession and provision offences remained relatively stable from 2002/2003 to 2003/2004. KES provided little or no comment on street level offending, unless to say that no change in type or level of crime had occurred recently.

Similarly, experience of recent heroin overdose among IDU remained low. This was reflected in the latest ABS data on opioid overdose deaths, which showed a decline in the number of accidental opioid overdose deaths in SA from 2002 to 2003.

The proportion of opioid-related calls to ADIS remained stable. An analysis of the presentations to all DASC treatment services for heroin or other opioids also revealed little change since 2003. However, a small increase was apparent in the proportion of clients admitted to DASC inpatient (detox) services nominating any type of opioid substance (including heroin) as their primary drug of concern (18.7%), representing a slightly higher proportion than those nominating amphetamines as their primary drug of concern (17.4%). Both state (SA) and national hospital data showed the number of opioid-related admissions were stable (as at 2002/03) and still below pre-heroin shortage levels. SA emergency data attendances for heroin and other opioids also appeared stable in 2003/04 compared to the previous year, and below pre-shortage levels.

Methamphetamine

Overall there have been decreases in the price of all three forms of methamphetamine from 2003 to 2004. In contrast to 2003, there was little difference in the median price paid for a 'point' of all three forms of methamphetamine in 2004. The median price of a gram of powder remains considerably cheaper than either base or crystal. Again it was noticeable in 2004 that there were wide ranges in reported prices paid, particularly of a gram, across all types of methamphetamine. IDU reported the price of all forms of methamphetamine as stable. KES reports are in agreement with IDU information on price.

In 2004, all forms of methamphetamine were reported as 'easy' or 'very easy' to obtain by the majority of IDU able to comment, and base methamphetamine was considered easiest to obtain, followed by powder and crystal. The majority also reported that availability of all forms had recently been stable or getting easier. Availability was largely unchanged compared to 2003, except for a perceived increase in availability of base

methamphetamine. The majority of KES also reported availability as 'easy ' or 'very easy' and stable. There was a decline in the proportion of IDU reporting that they usually obtained powder and base methamphetamine from mobile dealers, and rise in the proportion scoring from dealer's homes.

Since 2003, there has been an overall slight increase in the perceived purity of all forms of methamphetamine. Purity of all forms was considered largely stable, but perceptions were somewhat equivocal with substantial proportions of IDU reporting change or fluctuation in purity recently. However, the base and crystal forms were still perceived as high or medium purity by the majority of those IDU able to comment. Overall, SAPOL seizure data indicates that the median purity of methamphetamine has remained stable, with median purity of 19.8% in 2003/04. However, there was a decline in median purity over the last three quarters of 2003/04, which may indicate the start of a downward trend.

The proportion of IDU reporting recent use of any methamphetamine remained stable, but large decreases were seen in the frequency of use of base and crystal methamphetamine. However, there was only limited support of decreased use of methamphetamine among IDU from KES reports.

SAPOL data revealed an increase in methamphetamine related provision offences, but the number of possession/use offences remained stable compared to 2003. There was also evidence from SAPOL data on clandestine laboratory detections that local manufacture of methamphetamine was still a major contributor to the SA methamphetamine market.

Nationally, the number of accidental deaths with methamphetamine as the underlying cause increased in 2003 compared to 2002, according to ABS data. Calls to ADIS in SA regarding methamphetamine remained stable, but there was a decrease in both total admissions to DASC treatment services and to DASC's inpatient (detox) services with methamphetamine as the primary drug of concern. State (SA) hospital admissions data showed the number of amphetamine-related admissions was continuing to increase (as at 2002/03), though national data showed a slight decline in numbers from 2001/02 to 2002/03. SA (RAH) emergency data attendances for amphetamines may suggest a decline in the number of amphetamine-induced psychosis.

Cocaine

Similar to 2003, only a very small number of IDU were able to supply information regarding the price, purity or availability of cocaine, which was reflective of the very low numbers of IDU that had used cocaine in the last six months (a total of 6, compared to 15 in 2003). In addition, although several KES were able to provide some information on cocaine, this was limited and none could nominate cocaine as their main area of expertise. Consequently, the data for price, purity and availability of cocaine in 2004 is of limited value.

The small number of KES and IDU either using cocaine or able to provide information in itself indicates the lack of a sizeable and visible cocaine market in Adelaide, particularly amongst the IDU sampled by the IDRS. Indicator data, such as the number of cocaine possession and provision offences, calls to ADIS, DASC treatment services data for cocaine, and SA hospital admissions data also support this presumption. However, this

does not exclude the possibility that a cocaine market exists beyond the scope of this survey.

Cannabis

Overall, there had been little, if any, change in cannabis market indicators since 2003.

The median price paid for either a 'bag' or an ounce of cannabis has been stable for a number of years, with little difference in price between the hydro and bush/outdoor types ($200 or $180 per ounce, respectively). The majority of IDU reported that the price of cannabis had remained stable in the past six months. Approximately 80% of IDU able to comment perceived either hydro or bush cannabis was 'very easy' or 'easy' to obtain and around two-thirds reported that availability had been stable in the previous six months. The majority reported scoring the cannabis they had used last from a friend and that the source had been a small-time 'backyard' user/grower. Eighty-five percent or more also perceived the potency of either hydro or bush as high or medium, and over two-thirds reported that the potency had been stable recently.

The proportion of IDU reporting recent use, and the frequency of use, of cannabis remained high, with the majority reporting mainly using hydro cannabis in the six months prior to interview. KES reported no changes in any parameter of the cannabis market, or use of cannabis among IDU, in 2004 compared to 2003.

A continuing decline in the number of provision offences related to cannabis was recorded by SAPOL in 2004, but possession/use offences remained the same as for 2003. The number of calls to ADIS concerning cannabis remained stable, as did the total number of presentations to DASC treatment services. Cannabis-related hospital admissions were stable as at 2002/03.

Other opioids

As in recent years, in 2004 the use of other opioid substances by IDU was common, with 79% reporting recent use of some type of opioid substance, excluding heroin. There were some changes however, in the use of other opioids by IDU in the 2004 sample. Specifically, although the proportion of IDU reporting recent use of morphine or other opioids (oxycodone or codeine) remained stable, there was a decrease in the frequency of use, particularly of morphine, following a rise over the last couple of years. The price and availability of morphine was unchanged since 2003, so this decrease was most likely influenced by the increased availability, and decreased price, of heroin over the same period. As in 2003, the majority of morphine users reported use by injecting, and mainly used illicit supplies of Kapanol® and MS Contin®.

In addition, in 2004 there was a decrease in the proportion of IDU that reported recent use of illicit methadone, while the proportion reporting use of illicit buprenorphine remained stable. Although there was no change in the proportions reporting use of *illicit* buprenorphine by injecting, there was a doubling of the proportion reporting recent injection of *licit* buprenorphine, concomitant with an increase in the percent of IDU on a buprenorphine treatment program in 2004. It is worth noting however, that of those IDU that reported use of any methadone or buprenorphine, 75% or more reported *mainly* licit use in the last six months.

KES reports of other opioid use were primarily within the context of heroin-using IDU and supported a perception that users were continuing to use other opioids to substitute or supplement their heroin use, despite the 'return' of heroin.

Other drugs

There was no change in the proportion of IDU reporting recent use of ecstasy, but a decline in the proportion reporting recent use of hallucinogens in 2004. Frequency of use of both substance types was low and unchanged. There was also no change in the proportion of IDU reporting recent use or injecting of benzodiazepines, but a continuing increase in the frequency of use since 2002 was noted. Most IDU reported use of a licit supply, mainly of diazepam. Anti-depressant use was also stable, with almost exclusively licit use reported.

Associated harms

Despite a decrease in frequency of injecting seen among methamphetamine users in the 2004 survey, there was a marked increase in the proportion of the sample reporting sharing of injecting equipment (excluding needles) in the month before interview. Along with KES reports of complacency and ignorance of 'safe' injecting practices among some IDU, particularly the younger and more naïve methamphetamine users, this suggests that reinforcement and/or wider dissemination of harm-reduction messages is required. The high rate of sharing among IDU may impact on what has been a positive downward trend in HCV prevalence over recent years.

The 2004 survey identified that injecting of morphine was common, as was injecting of methadone and buprenorphine, with the use of buprenorphine by injecting more than doubling compared to 2003. Despite a decrease in the prevalence of morphine injecting, there were large proportions of injectors of morphine, methadone and buprenorphine that reported injecting-related problems such as substance dependence, scarring and bruising, difficulty finding veins, and abscesses or infections. Several KES commented that these problems were exacerbated by lack of IDU access and/or proper (single) use of filters and other injecting equipment (primarily due to financial constraints).

Both IDU and KES reported mental health issues as generally stable in 2004. There was no change in IDU reported attendance to a health professional for a mental health problem, with attendance to a GP for depression and/or anxiety predominating. KES concurred with the predominance of depression and anxiety, particularly among opioid users, and that this had been stable recently. There were mixed reports however, regarding whether there had been any change in the prevalence of mental health problems associated with methamphetamine use.

An analysis of expenditure on drugs demonstrated that of those who reported having spent money on illicit drugs on the day preceding interview, heroin users had spent twice as much as methamphetamine users.

There was no change in the prevalence or type of criminal involvement reported by IDU, with drug dealing and property crime remaining the most common. Most IDU perceived that police activity was either stable or increasing and the majority reported that police activity had not made it more difficult to obtain drugs recently.

Implications

In the 2004 SA IDRS survey more evidence is emerging of a stabilisation of patterns of heroin use since the 2001 shortage. In contrast, while heroin use appears to be stabilising, a downturn in some parameters of methamphetamine use have appeared. The following issues were identified from the results of the 2004 survey, which will require ongoing attention from policy makers, researchers and health professionals;

- The increase in availability of heroin in South Australia over the last two years has seen patterns of use among IDU stabilise and approximate pre-shortage patterns. In contrast, there has not been an upturn in secondary indicators such as drug related crimes and overdose experience. Careful monitoring of secondary indicators must be carried out to identify any early indicators of an increase in crime and/or overdose so that early interventions can be instigated. In the case of overdose, vigilance is particularly warranted as the indicator data reported stems from the previous year.

- A substantial downturn in the intensity of methamphetamine use among South Australian IDU has been one of the more surprising findings of the 2004 SA IDRS survey. The sharp decrease in the median number of days used, particularly for base and crystal, stands in contrast to the majority of key expert reports of very little change in the patterns of use. A minority of KES did comment on changes in use and suggested users had "backed off" in their intensity of use and a few also noted a recent decline in attendances to services for methamphetamine related problems. The reasons for this apparent discrepancy between user accounts and KES accounts requires further investigation.

- Although the proportion of IDU reporting use of buprenorphine remains small it is increasing at a steady rate reflecting the uptake of buprenorphine as a form of opioid substitution therapy. The proportion of the sample injecting any buprenorphine, licit or illicit, has doubled since last year and most of this was accounted for by users injecting their licitly obtained supply. With the proportion of IDU taking up buprenorphine as an opioid substitution therapy set to rise a close eye should be kept on the rate of injecting and associated injecting problems.

- Investigations need to be undertaken to see why a sudden rise in sharing of equipment has occurred particularly as a sustained decrease was recorded in 2002 and 2003. Moreover, the discrepancies between KES need to be fully investigated to understand how such disparate views are being held and what potential impact they may have on the provision of resources for educating users about the dangers of sharing injecting equipment. It may be that KES have access to different populations of users and that this will require further elucidation in future reports.

1. INTRODUCTION

The Illicit Drug Reporting System (IDRS) was trialled in 1997 under the auspices of the National Drug and Alcohol Research Centre (NDARC) to examine drug trends in three Australian jurisdictions. This work was commissioned and supported by the Commonwealth Department of Health and Ageing. The trial consisted of conducting the complete IDRS in New South Wales, Victoria and South Australia (see Hando *et al.,* 1998 for a national comparison, and Cormack *et al.,* 1998 for the South Australian findings). The 'core' IDRS incorporated a triangulated approach to data collection on drug trends, and consisted of a survey of injecting drug users, a semi-structured survey of key experts who had regular contact with drug users, and secondary data sources or indicators relevant to drug use.

The IDRS process was repeated in 1998 in the same three jurisdictions, and in 1999 they were joined by Western Australia, Northern Territory, Australian Capital Territory, Queensland and Tasmania. For a review of the history and progression of the IDRS Nationally up to 2000 see Darke, Hall and Topp (2000). The year 2004 is the eighth year that the IDRS has been conducted in South Australia, and the sixth year that it has included all states and territories (see Breen *et al.,* 2004 for a national comparison of 2003 findings, and Weekley *et al.,* 2004 for the South Australian perspective).

The IDRS provides a coordinated and ongoing monitoring system predominantly focusing on heroin, methamphetamine, cocaine and cannabis, and acts as a strategic early warning system for emerging illicit drug problems. The IDRS is a sensitive and timely indicator of drug trends both nationally and by jurisdiction, is simple to execute and cost-effective. As well as drug trends, the findings highlight areas where further research is required, or where changes need to be made in terms of education, health promotion, treatment services and policy.

The 2004 South Australian Drug Trends Report summarises information collected by the South Australian component of the national IDRS from three sources: a survey of injecting drug users, key informant interviews with professionals working in the drug and alcohol or related fields, and existing and up-to-date data indicators relating to drugs and drug use. The three sources complement each other, each having their own strengths and weaknesses. The results are summarised by drug type in tables designed to provide the reader with a 'snapshot' overview of drug trends in South Australia.

Study Aims

The aim of the South Australian component of the 2004 IDRS was to provide information on drug trends in South Australia, particularly focusing on the 12 months between mid-2003 and mid-2004.

2. METHOD

A triangulated approach was utilised for this study, with information on drug trends coming from three primary sources. This approach is based on a procedure outlined by Hando & Darke (1998). The three sources were as follows:

- A survey of injecting drug users (IDU);
- A semi-structured survey of key experts (KES) who work in the drug and alcohol area, or some related field, and who have regular contact with drug users;
- An examination of existing and current indicators (Other indicators) relating to drugs, drug use and drug-related issues.

2.1 Survey of injecting drug users (IDU)

A sample of 101 injecting drug users (IDU) was interviewed in June and July 2004. Criteria for entry into the study were: having injected drugs at least once a month in the previous six months, being over 16 years of age, and living in the Adelaide metropolitan area for at least the last 12 months.

Participants were recruited through Clean Needle Program sites across Adelaide. Clients of the service were invited to participate by the CNP peer educator and/or the IDRS interviewer directly or given a study flyer providing information and details on how to arrange participation. Awareness of the study then spread via 'word of mouth' and further recruitment occurred by 'snowballing'.

Since 2001, to be consistent with the IDRS data collection procedures in other jurisdictions, trained research interviewers have conducted the interviews with the IDU. In 2004, four research interviewers with a sound working knowledge of issues related to illicit and injecting drug use were trained on administration of the survey instrument. The purpose and content of the survey was fully explained and informed consent was obtained from participants prior to the interviews being conducted. Interviews were conducted at a time convenient to the participant and generally in a room provided by the agency associated with the CNP or an agreed location nearby. The average time to complete an IDU interview was 40 minutes (range: 15 to 80 minutes) and subjects were compensated $30 for their time.

The structured interview (survey instrument) was based on previous research conducted at NDARC (see Darke *et al.,* 1992, 1994). Sections on demographics, drug use, price, purity and availability of drugs (heroin, methamphetamine, cocaine, cannabis, morphine and methadone), crime, risk-taking, health and general trends were included. In general, participants were asked to consider changes on the above parameters over the previous six to 12 months (mid-2003 to mid-2004). The largely quantitative data were analysed statistically using SPSS for Windows, Version 12.01 (SPSS, 2004).

2.2 Survey of key experts (KES)

Entry criteria for the KES were: at least weekly contact with illicit drug users in the previous six months, or contact with 10 or more illicit drug users in the previous six months, or specialist knowledge of drug markets in SA. All KES were paid or volunteer

workers in drug treatment agencies, other health and community services, drug user groups, SA police, Clean Needle Programs or research organisations. Key experts were recruited based on their participation in previous IDRS surveys, and on recommendations made by existing KES and colleagues. Potential KES were contacted via telephone and assessed for suitability according to the criteria. A mutually convenient time was then made for either an interview in person or over the telephone.

In 2004, 29 KES were interviewed (11 males and 18 females) from August to late October 2004. Key experts comprised a range of persons from various professions: sixteen health workers (youth workers, community drug and alcohol workers, psychologists, medical officers, nurses, and drug & alcohol counsellors), nine user representatives (peer educators, outreach and clean needle program workers) and four law enforcement officers and police intelligence analysts.

Key experts were asked to identify the main illicit drug used by the drug users they had the most contact with in the previous six months, or (if they had limited or no contact with users) the main illicit drug they were most knowledgeable about. Methamphetamine was the most identified drug used by the users KES had most contact with in 2004. However, compared to 2003, more KES identified heroin and other opiates as the drugs most used by users they had contact with. In 2004, cocaine and cannabis were not identified by any KES as the main illicit drugs used by users they had most contact with. It should therefore be noted that several KES were asked to focus on cannabis and cocaine when their knowledge encompassed these drug types as well as methamphetamine or heroin, in an effort to gather more information with regard to these drug types. Several KES did 'double' interviews where they were interviewed in relation to both methamphetamine users and heroin & other opiate users, separately. Three KES had broad knowledge and covered 'all drugs' in their interviews. In all, 17 interviews were completed with methamphetamine as the main focus, and 11 were completed with heroin (and other opiates) as the main focus. In addition, 4 interviews included a focus on cannabis and one included a focus on cocaine. Most KES also provided useful information on at least one other illicit drug or illicit drug using group additional to the main focus of their interview.

The KES interview was semi-structured and took approximately 60 minutes to administer. The majority of interviews were conducted face-to-face (n=25) and the remainder were conducted by telephone. The instrument used was based on previous research conducted at NDARC for the World Health Organisation (Hando & Flaherty, 1993) and included sections on demographics, drug use patterns, drug price, purity and availability, criminal behaviour, police activity and health issues. In general, KES were asked for information on the above parameters relevant to the previous six to 12 months, in particular any changes to those parameters over that period. The responses to the semi-structured interview were transcribed and analysed for content and trends. Information gained from these interviews was largely qualitative in nature.

2.3 Other indicators

To complement and validate data collected from the injecting drug user and key informant surveys, a range of secondary data sources were utilised including population surveys and other health and law enforcement data. The pilot study for the IDRS (Hando *et al.,* 1997) recommended that secondary indicator data should:

- Be available at least annually;
- Include 50 or more cases;
- Provide brief details of illicit drug use;
- Be located in the main study site (Adelaide or South Australia for the present study);
- Include details of the four main illicit drugs under investigation.

Data sources that fulfilled the above criteria and were included in the report were:

- Telephone advisory data provided by the Alcohol and Drug Information Service (ADIS) of South Australia;
- Australian Needle and Syringe Program (NSP) Survey data;
- Admissions data from the Drug and Alcohol Services Council (DASC);
- Purity of drug seizures made by South Australian Police (SAPOL) and the Australian Federal Police (AFP), provided by the Australian Crime Commission (ACC);
- State-wide rates of drug-related arrests provided by SAPOL;
- Number of clandestine laboratory detections in South Australia provided by SAPOL;
- State-wide and national rates of opioid-related fatalities provided by the Australian Bureau of Statistics (ABS), in Degenhardt *et al.,* (2004a);
- National rates of methamphetamine-related, and cocaine-related, fatalities provided by the Australian Bureau of Statistics (ABS), in Degenhardt *et al.,* (2004b);
- Drug-related hospital admissions data (state and national) provided by the Australian Institute of Health and Welfare (AIHW).

National Notifiable Diseases Surveillance System (NNDSS) data, from the Australian Government Department of Health and Ageing, was also included as an indicator of BBV infection rates. BBV transmission is correlated to injecting drug use and despite this data not having drug specific breakdowns it is a useful indicator of injecting-related trends.

2.4 Notes

2.4.1 Methamphetamine

Prior to 2001, IDRS reports used the overarching term 'amphetamines' to refer to both amphetamine and methamphetamine. 'Amphetamine' is used to denote the sulphate of amphetamine, which throughout the 1980's was the form of illicit amphetamine most available in Australia (Chesher, 1993). Chemically, amphetamine and methamphetamine differ in molecular structure but are closely related. In Australia today, the powder traditionally known as 'speed' is almost exclusively methamphetamine rather than amphetamine. The more potent forms of this family of drugs, known by terms such as ice, shabu, crystal meth, base and paste, have been identified as becoming more widely available and used in all jurisdictions (Topp & Darke, 2002), are also methamphetamine. Therefore the term methamphetamine was used from 2001 onward to refer to the drugs available that were previously termed 'amphetamines'. The terms are used interchangeably within this report unless specifically noted within the text. For a further discussion of this issue see White, Breen & Degenhardt (2003).

2.4.2 Price, purity and availability

It should be noted that the price, purity and availability sections of the IDU survey were not restricted to users of the particular drug, but to those *who feel confident of their knowledge* of these parameters of the market. In addition, participants may answer any or all price,

purity and availability sections, thereby the sample sizes (n) per section may fluctuate for any given drug. In addition, people who answered *"don't know"* to the initial question for each price, purity and availability section were eliminated from the sample for that section, to increase the validity of remaining categories. The sample sizes are therefore reported in each table (n=*x*). Care should be taken in interpreting category percentages that may be associated with small sample sizes.

3. RESULTS

3.1 Overview of the IDU sample

The demographic characteristics of the 101 IDU interviewed in 2004 are summarised in Table 3.1, with the 2003 sample characteristics provided for comparison.

There was some overlap of the 2004 IDRS IDU sample with previous year's samples. Twenty-seven percent of the 2004 sample stated that they had participated in the IDRS before; 20% in the year 2003, 10% in the year 2002, 4% in each of the years 2001 and 2000, and fewer in earlier years.

Table 3.1: Demographic characteristics of IDU sample

Characteristic	2004 n=101	2003 n=120
Age (median in years)	32	34
Gender (% male)	61	53
Identify as ATSI (%)	14	11
Employment (%)		
Not employed	63	68
Full time	3	3
Part time/casual	13	15
Student	6	3
Home duties	15	13
School Education (median in years)	10	10
Tertiary Education (%)		
None	46	53
Trade/technical	29	32
University/college	26	16
Currently in treatment (%)	48	33
Prison history (%)	41*	33
Area of Adelaide (%)		
Central/Eastern	21	18
Western	27	30
Southern	29	30
Northern	22	21
No fixed address/missing	2	2

Source: IDRS IDU interviews
* data missing for one participant

The median age of the sample was similar to past years, at 32 (range 16 to 55 years) and 61% of participants were male (compared to 53% in 2003, and 66% in 2002). Almost two-thirds (63%) of the sample was unemployed and 41% had a history of previous imprisonment. The median number of years spent at school was 10 (range 5 to 12 years).

Almost half the sample (46%) reported having no tertiary qualifications, 29% had completed a trade or technical course and 26% had completed a university/college course (an increase from 16% in 2003). The proportion of the sample currently in some form of treatment for drug use at the time of interview was nearly half (48%) (compared to a third in 2003), the majority of whom were in a maintenance pharmacotherapy treatment. Specifically, in 2004, 30% were on a methadone program and 17% were on a buprenorphine program, compared to 23% and 7% in 2003, respectively.

In 2004, the majority of IDU reported some form of government pension, allowance or benefit as their main source of income in the month prior to interview (84%). The remaining IDU reported their main source of income was a wage (13%), from criminal activity (1%) or from sex work (2%).

Compared to 2003, in 2004 there were more males in the sample, more who reported having a tertiary qualification from a university or college, and more who were in some form of treatment for drug use at the time of interview.

The majority of KES reports of demographics of drug user populations they have contact with replicate those of the sample: majority male (~60-70%), unemployed with approximately 10 years of school education, and significant proportions with a history of imprisonment or currently in treatment for drug use (most likely a maintenance pharmacotherapy). Of note were the reported differences between methamphetamine users and heroin users in terms of average age (~25 years compared to ~30 years, respectively), current treatment status (heroin users were reportedly more likely to be in some form of treatment for their drug use) and employment status (methamphetamine using clients of CNPs were reportedly more likely to be employed than their heroin using counterparts). On examination of the IDU survey data, recent heroin users were more likely to be currently in treatment for drug use (56% v 39%) than recent methamphetamine users. There was no difference in the average age of recent heroin and methamphetamine users, or in their employment status. However, recent methamphetamine users were more likely to be male than recent heroin users (75% v 56%).

3.2 Drug use history and current drug use

The injecting history, drug preferences and polydrug use of IDU are summarised in Table 3.2, and drug use history and recent drug use of IDU are summarised in Table 3.3 and Figure 3.4, respectively.

The median age of first injection by the IDU sample was 18 years (range 11 to 46). The drug most commonly first injected by the sample was amphetamine (53%), followed by heroin (39%). A comparison of 2004 with 2003 shows little difference except that in 2004 slightly more reported first injecting heroin, and slightly fewer reported first injecting methamphetamine.

Compared to 2003, in 2004 there was no change in the proportions nominating heroin and methamphetamine as their preferred drug among the IDU sample. Specifically, 48% reported heroin as their drug of choice and 34% reported some form of methamphetamine as their drug of choice. As can be seen in Figure 3.1 the pattern of preference seems to more closely resemble that seen prior to the shift that reached its 'peak' in 2002.

Similarly, since 2002 there has been an increase in the proportion of IDU that reported injecting heroin most often in the last month (22% to 33% to 37%) and a concurrent decrease in the proportion reporting methamphetamine as the drug most injected (57% to 43% to 39%) (see Figure 3.2). In addition, the increased proportion reporting heroin as last drug injected seen in 2003 compared to 2002 was maintained in 2004 (at 36%) and the decrease in the proportion reporting methamphetamine as the last drug injected continued (60% to 44% to 40%) across the same period. These parameters all point to a continuing return or stabilisation of heroin among this group of IDU, though still not a full return to pre-shortage status. In particular, despite heroin being the most preferred drug among IDU in 2004, by 48%, there was still a lower proportion reporting that heroin was the drug they injected most in the last month (37%). This suggests there is still a discrepancy between what people want to use and what they are actually using, which may depend on a variety of factors including price, availability and quality of what is available.

Frequency of injecting in the last month was greater than weekly for 68% of the sample, a decrease compared to 2003 (87%), with 38% reporting injecting at least once a day (also a decrease from 47% in 2003). Therefore, reported frequency of injecting in the last month decreased overall from 2003 to 2004.

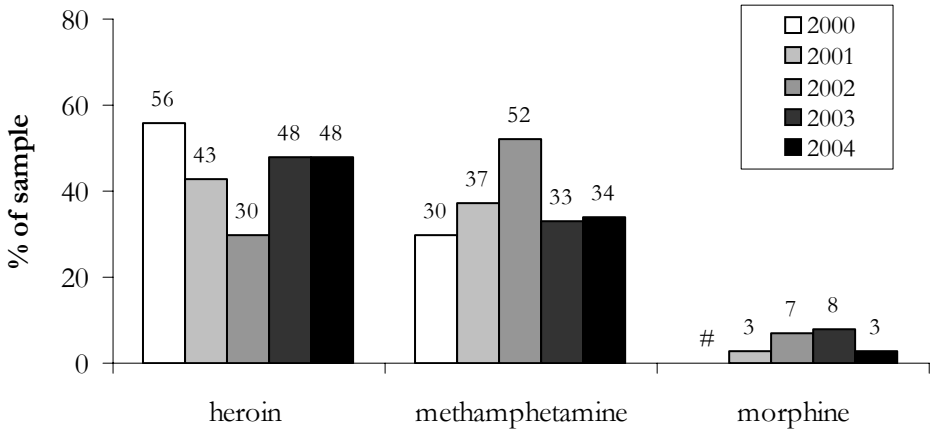
Table 3.2: Injecting history, drug preferences and polydrug use of IDU

Variable	2004 n=101	2003 n=120
Age first injected (median in years)	18	18
First drug injected (%)		
Heroin	39	30
Amphetamine	53	61
Cocaine	1	-
Morphine	2	4
Other	6	5
Drug of choice (%)		
Heroin	48	48
Methamphetamine	34*	33
Cocaine	2	3
Cannabis	7	5
Morphine	3	8
Other	7	4
Drug injected most often in last month (%)		
Heroin	37	33
Methamphetamine	39	43
Cocaine	1	-
Morphine	13	14
Methadone	6	6
Other	5	2
No drug in last month	-	2
Most recent drug injected (%)		
Heroin	36	35
Methamphetamine	40	44
Morphine	13	14
Methadone	5	4
Other	7	2
Frequency of injecting in last month (%)		
Weekly or less	32	13
More than weekly but less than daily	31	41
Once a day	14	15
2 – 3 times a day	19	23
>3 times a day	5	8
Polydrug use (median)		
Number of drug classes ever used	12 (4-16)	12 (4-16)
Number of drug classes used in last 6 months	6 (3-12)	7 (2-14)
Number of drug classes ever injected	5 (1-10)	5 (1-12)
Number of drug classes injected in last 6 months	2 (1-7)	2 (1-9)

Source: IDRS IDU interviews

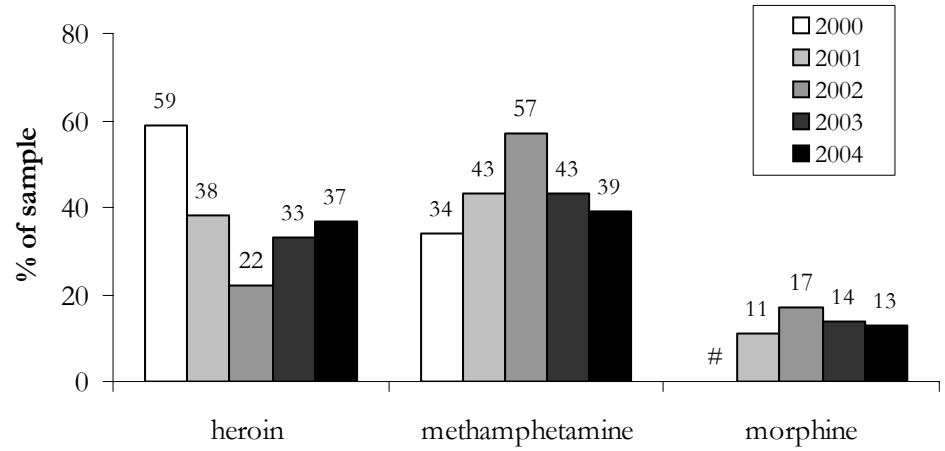
* collapsed categories: powder, base, crystal and 'ox blood' (a liquid form)

Figure 3.1: Trend for drug of choice, 2000 to 2004



Source: IDRS IDU interviews
morphine was not separated from 'other opiates' in 2000

Figure 3.2: Trend for drug injected most in last month, 2000 to 2004

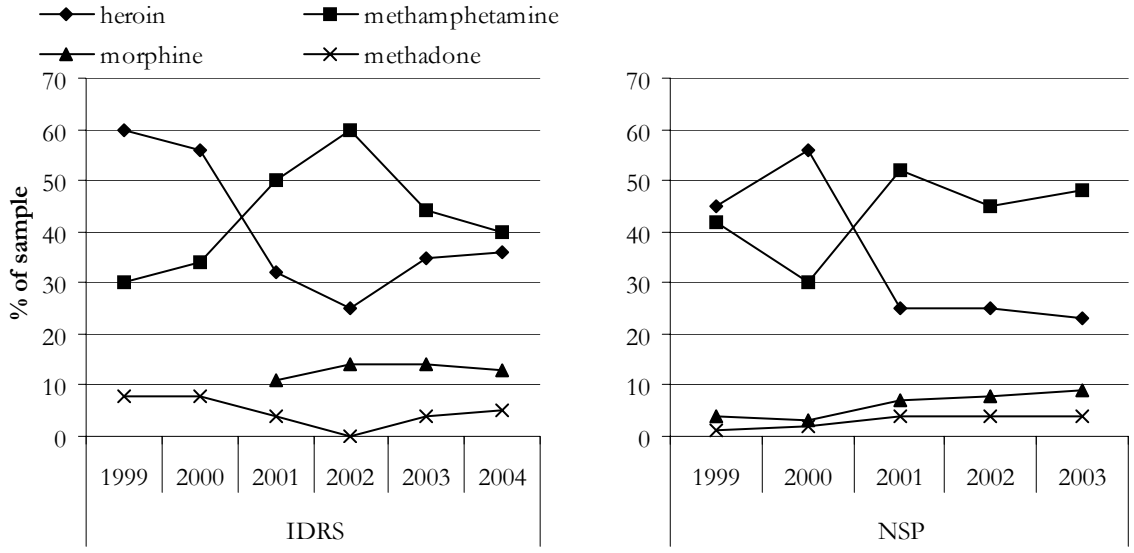


Source: IDRS IDU interviews
morphine was not separated from 'other opiates' in 2000

Considering that the IDRS and the Annual Needle and Syringe Program survey in South Australia sample from essentially the same injecting drug user population (i.e. IDU accessing CNPs in Adelaide) it could be expected that the samples from each survey had a similar drug using profile for a given year. On comparison however, distinct differences were seen for several parameters that were common to both surveys. For example, as Figure 3.3 shows, there was a discrepancy between the results of the surveys in several years regarding 'most recent drug injected'. In particular, although both samples exhibited the dramatic shift from heroin use to methamphetamine use between 2000 and 2001 (as a result of the heroin shortage), the NSP survey sample has not shown the return to heroin use in 2003 and 2004 that the IDRS sample has. The ratio of heroin to methamphetamine as the last drug injected by IDU was also quite different for each survey in 1999. In addition, the IDRS has consistently recorded a slightly higher proportion of IDU nominating morphine as the last drug injected. On investigation, these differences could not be explained by age or gender of IDU as both survey samples were very similar in this regard. One major difference may have arisen from the sampling

framework – IDRS was only able to recruit from the CNPs that were open during business hours and so excluded the largest CNP in the central Adelaide area that was primarily open after usual business hours. It is likely that this service, which was included in NSP sampling, is accessed by IDU with a wider profile of use and demographics (i.e. more 'recreational' users and more employed users).

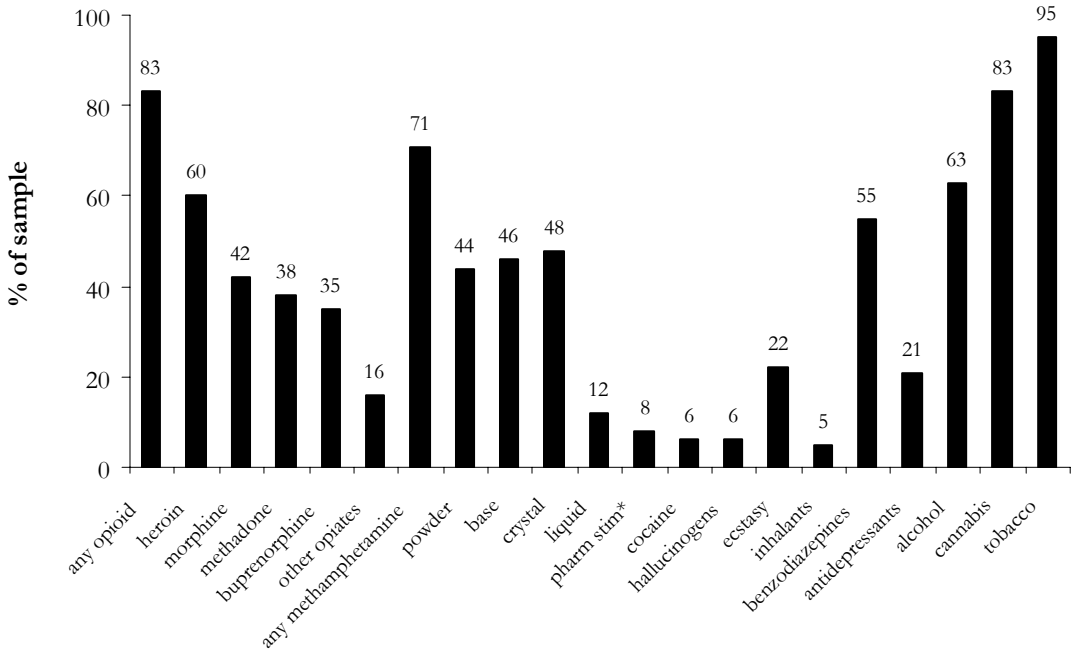
Figure 3.3: Comparison of most recent drug injected, for IDRS and NSP survey samples, 1999 to 2004*



Source: IDRS IDU surveys and **NSP surveys** (NCHECR, 2004), respectively
* NSP Survey results for 2004 were not available at the time of writing
Note: morphine was not separated from 'other opiates' in 1999 or 2000 IDRS

Polydrug use was common among the IDU in 2004 and has remained consistently so across the years, with no real differences being reported from 2003 to 2004 (see Table 3.2). In 2004, IDU reported use of a median 12 (range 4 – 16) drug classes across their lifetime and a median of 6 (range 3 – 12) during the 6 months prior to interview. The drug classes most commonly used among the IDU across their lifetime were: cannabis, alcohol, tobacco, any methamphetamine, any opioid, and hallucinogens (see Table 3.3). The drug classes most commonly used among the IDU in the last 6 months were: tobacco, cannabis, any opioid, any methamphetamine, alcohol, heroin, and benzodiazepines (Figure 3.4). This order of commonality has not changed from 2003, though the proportions reporting use of some drug types was different. In particular, the proportion of IDU reporting use of any methadone was lower (38% compared to 48% in 2003) and for buprenorphine was higher (35% compared to 23% in 2003). It is likely that this change reflects a shift in prescribing from methadone to buprenorphine, or the increasing uptake of buprenorphine among this group.

Figure 3.4: Recent Drug Use: percentage of the IDU to have used each substance type in the last 6 months



Source: IDRS IDU interviews
* pharm stim = pharmaceutical stimulants (eg. dexamphetamine)

Similar to 2003, in 2004 there was substantial crossover between heroin users and methamphetamine users in the IDU sample. Thirty-six IDU (36%) had used both heroin and some form of methamphetamine, in the last six months. However, twenty-five IDU (41% of heroin users) reported use of heroin but not use of any form of methamphetamine, and thirty-six IDU (50% of methamphetamine users) reported use of some form of methamphetamine but not use of heroin, in that time.

Of the forty-eight IDU that nominated heroin as their drug of choice, 42 (88%) had used heroin in the previous six months, 22 (46%) had used morphine, 25 (52%) had used any methadone (licit or illicit) and 22 (46%) had used any buprenorphine (licit or illicit). In addition, 24 (50%) had used some form of methamphetamine. Similarly, there was overlap of drug classes used by those IDU who nominated methamphetamine as their preferred drug. Of the 34 IDU reporting methamphetamine as their drug of choice, all but one had used some form of methamphetamine in the last 6 months, 8 (24%) had used heroin during that period and 11 (32%) had used morphine.

A comparison with the 2003 survey revealed a number of interesting differences. A marked decrease in the frequency of use (median days used) of the three main forms of methamphetamine was apparent, as well as a decrease in the proportion of IDU using methamphetamine daily. However, there was no change in the prevalence of recent use of any methamphetamine. Also, while there was a decrease in the median number of days IDU reported using heroin, a slight increase in the proportion reporting recent use was seen, and heroin use parameters seem to have stabilised overall. Prevalence of use of cocaine among IDU continued to decline, but patterns cannabis use remained stable.

Table 3.3: Drug use history and routes of administration of the IDU sample (% of total sample; n=101)

Drug Class	Ever used	Ever Injected	Injected last 6 mths	Ever smoked	Smoked last 6 mths	Ever snorted	Snorted last 6 mths	Ever Swallow	Swallow last 6 mths	Used last 6 mths	No. days used last 6 mths* (range)	No. days injected last 6 mths** (range)
Heroin	81	79	58	48	6	16	0	16	1	60	48 (1-180)	48 (1-180)
Methadone - licit	55	29	13					55	28	28	180 (72-180)	24 (72-140)
Methadone - illicit	48	34	11					35	7	13	3 (1-28)	3 (1-24)
Physeptone# - licit	10	2	0	0	0	0	0	9	4	4	180 (14-180)	-
Physeptone# - illicit	32	20	6	0	0	0	0	23	7	10	6 (1-20)	4.5 (1-6)
Any methadone	**71**	**49**	**21**							**38**	**180 (1-180)**	
Buprenorphine - licit	35	21	14	1	1	0	0	35	27	27	100 (3-180)	14 (1-100)
Buprenorphine - illicit	19	16	11	0	0	0	0	4	2	12	2 (1-10)	2 (1-10)
Any buprenorphine	**46**	**30**	**21**							**35**	**90 (1-180)**	
Morphine	70	67	40	2	0	0	0	42	22	42	19 (1-180)	12 (1-180)
Homebake	27	27	3	3	0	0	0	1	0	3	24 (1-180)	24 (1-180)
Other opioids	36	23	11	5	0	0	0	19	9	16	8 (1-180)	10 (1-180)
Any opioid §	**91**	**88**	**78**							**83**	-	

Source: IDRS IDU interviews * Median number of days used by those IDU who had used the drug class in the last 6 months; ** Median number of days used by those IDU who had injected the drug class in the last 6 months; # Physeptone is a tablet form of methadone; § *Any opioid* includes all opioid substances (heroin, methadone/physeptone, buprenorphine, morphine, homebake and other opioids)

Table 3.3 (continued): Drug use history and routes of administration of the IDU sample (% of total sample; n=101)

Drug Class	Ever used	Ever Injected	Injected last 6 mths	Ever smoked	Smoked last 6 mths	Ever snorted	Snorted last 6 mths	Ever Swallow	Swallow last 6 mths	Used last 6 mths	No. days used last 6 mths* (range)	No. days inj. last 6 mths** (range)
Methamphetamine: Powder form	88	85	37	18	0	63	8	52	4	44	5 (1-90)	10 (1-90)
Methamphetamine: Base/paste form	61	58	45	1	0	2	1	22	10	46	6 (1-155)	6 (1-155)
Methamphetamine: Crystal/ice form	71	66	43	9	2	10	3	18	6	48	6 (1-180)	6 (1-180)
Methamphetamine liquid	35	33	12					7	1	12	2 (1-48)	2 (1-48)
Pharmaceutical stimulants	44	22	2	2	0	3	0	32	7	8	4.5 (1-8)	2 (1-3)
Methamphetamine: any form[##]	**93**	**93**	**69**							**71**	**24 (1-180)**	
Cocaine	60	41	4	13	1	42	4	8	0	6	1.5 (1-25)	3 (1-20)
Hallucinogens	85	26	2	4	1	1	0	85	5	6	1.5 (1-30)	7 (2-12)
Ecstasy	65	37	12	4	0	13	4	54	15	22	2 (1-20)	1.5 (1-5)
Benzodiazepines	81	31	9	5	0	0	0	78	55	55	48 (1-180)	6 (1-180)
Anti-depressants	48	3	1					48	21	21	180 (1-180)	2 *(n=1)*
Alcohol	99	13	0					99	63	63	24 (1-180)	-
Cannabis	100									83	180 (1-180)	
Tobacco	97									95	180 (24-180)	
Inhalants	46									5[§§]	1 (1-4)	

Source: IDRS IDU interviews * Median number of days used by those IDU who had used the drug class in the last 6 months; ** Median number of days used by those IDU who had injected the drug class in the last 6 months; [##] *Methamphetamine: any form* includes powder, base/paste, crystal/ice, liquid and pharmaceutical stimulants; [§§] data missing for one participant

An analysis of recent use of heroin, methamphetamine and morphine, by area of Adelaide that the IDU resided in, was undertaken to determine whether there were any differences in patterns of use across the different metropolitan areas. Table 3.4 details the proportions of IDU from each area that had used each drug (or form of methamphetamine) in the six months prior to interview and shows some interesting variations, though none were statistically significant. In particular, a smaller proportion of IDU residing in the north of Adelaide had recently used either heroin or morphine (45% and 23%, respectively), compared to the other areas of Adelaide. At the same time, IDU from the north, along with those in the west, were more likely to have recently used some form of methamphetamine (particularly base), than IDU from the southern or central/eastern areas of Adelaide. Other points of note are that IDU in the central/eastern area were more likely to have recently used the crystal form of methamphetamine than any other form, as well as being more likely to have recently used morphine than IDU from other areas of Adelaide. IDU from the southern area of Adelaide were the least likely to have recently used the crystal form of methamphetamine.

Table 3.4: Recent* use of heroin and methamphetamine by area of Adelaide

	% of IDU per area of Adelaide				% of whole IDU sample (n=101)
	Central/East (n=21)	West (n=27)	South (n=29)	North (n=22)	
Heroin	67	70	59	45	**60**
Any methamphetamine**	67	78	62	82	**71**
Powder	43	48	34	50	**44**
Base	29	56	38	64	**46**
Crystal	67	41	34	59	**48**
Morphine	62	44	41	23	**42**

Source: IDRS IDU interviews

* in the previous six months ## *Methamphetamine: any form* includes powder, base/paste, crystal/ice, liquid and pharmaceutical stimulants

4. HEROIN

Sixty-two percent of IDU were able to provide answers on one or more aspects of the heroin market (price, purity and/or availability) in 2004, similar to the 57% able to do so in 2003.

4.1 Price

The *current* price of heroin was estimated by the IDU to be a median $375/gram (range $200-500, n=32) or $50/cap (range $45-150, n=38). The estimations for the larger amount of a gram (though not for a 'cap') was higher than the median price paid *at last purchase* by IDU, as listed in Table 4.1. The median price *at last purchase* for a gram of heroin was $320, a substantial decrease from 2003 when the median last purchase price was $425/gram. The median price *at last purchase* for a half-weight was reported as $180; also a decrease from the 2003 median price of $200. The median price *at last purchase* of a 'cap' of heroin was unchanged from 2003 at $50.

Table 4.1: Price of most recent heroin purchases by IDU, 2003* & 2004

Amount bought	Median price paid, $ (range)	Number of IDU purchasers
'cap'	50 (30 – 150) *50 (50 - 100)*	27 *40*
gram	320 (150 – 400) *425 (350- 550)*	10 *10*
'half-weight' (1/2 gram)	180 (50 – 250) *200 (150 - 300)*	25 *23*
¼ gram	100 (50 – 150) *100 (100 - 180)*	15 *16*
1/8 gram	50 (50) *50 (40 - 100)*	3 *9*

Source: IDRS IDU interviews
* 2003 data in italics
Note: all purchases were within six months of interview

Of those IDU who were confident to report on the current price of heroin (n=62), approximately two-thirds (68%) reported the price as stable over the last six months (see Table 4.2). As can be seen, this, and other categories of recent change in price of heroin, was similar to 2003 reports.

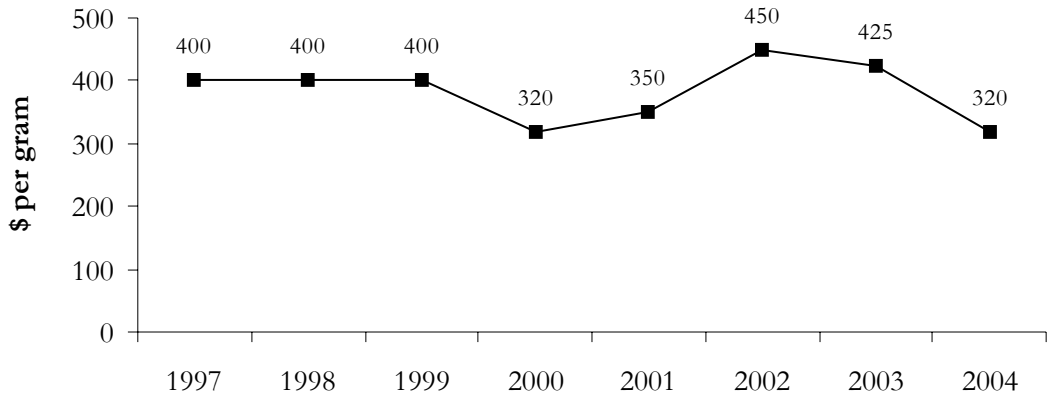
Table 4.2: Change in price of heroin over last 6 months, 2003 & 2004

Reported price status	% of IDU able to answer	
	2003 (n=68)	2004 (n=62)
don't know	6	8
increasing	15	13
stable	71	68
decreasing	3	7
fluctuating	6	5

Source: IDRS IDU interviews

Overall, there was a continuing downward trend in the median price for a gram of heroin from 2002 to 2004, back to the pre-shortage price of $320 per gram reported in 2000 (see Figure 4.1). It should be noted however, that the median price of a gram of heroin has been based on small sample sizes (n<15) since 2001.

Figure 4.1: Median price of a gram of heroin, last purchase, 1997 - 2004



Source: IDRS IDU interviews

Five health and peer educator KES reported the price of a 'cap' of heroin to be $50, the same as the median price reported by IDU. KES reports of the price of a gram varied from $300 to $450 (average $350, n=6), and the price of half a gram ranged from $100 to $250 (average $167, n=3). Three KES believed that the price of heroin was currently stable, while two others reported a decrease in price over the last six months. Two peer educator KES also commented that amounts were "on weight" recently, where previously they were likely to be under-weight.

4.2 Availability

Tables 4.3 and 4.4 summarise the current availability of heroin and changes in heroin availability over the last six months, according to IDU report. The majority of IDU answering the section regarding availability of heroin in 2004 reported it was either 'easy' or 'very easy' to obtain heroin and that this availability was stable or had become easier in the last six months. Though the total proportion reporting these two categories was stable compared to the 2003 sample, in 2004 the proportion reporting availability as 'very easy' was larger (55% v 34%).

Table 4.3: Availability of heroin currently, 2003 & 2004

How easy is it to get heroin at the moment?	% of IDU able to answer	
	2003 (n=67)	2004 (n=62)
very easy	34	55
easy	54	34
difficult	12	11
very difficult	0	0

Source: IDRS IDU interviews

Table 4.4: Change in availability of heroin over the last 6 months, 2003 & 2004

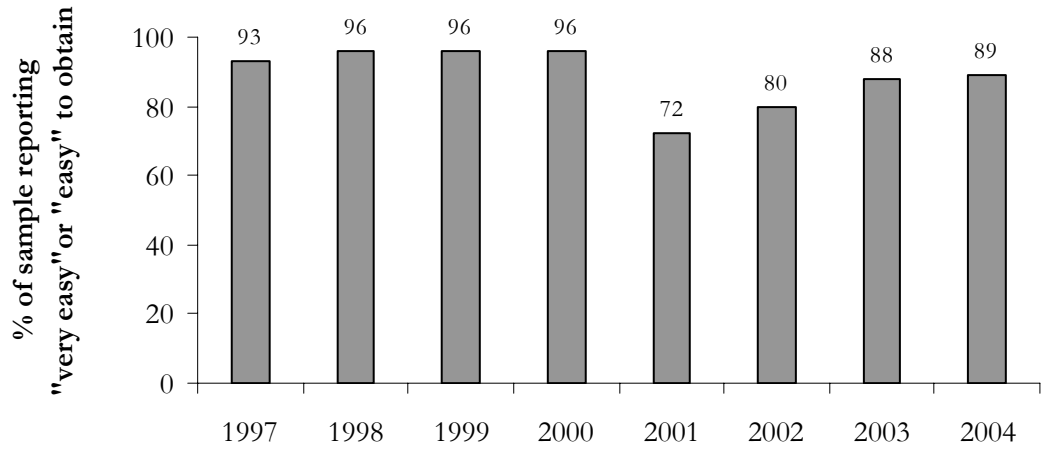
Has [availability] changed in the last 6 months?	% of IDU able to answer	
	2003 (n=67)	2004 (n=62)
don't know	3	3
more difficult	8	13
stable	66	57
easier	19	24
fluctuates	5	3

Source: IDRS IDU interviews

Similar to the IDU reports, the majority of KES (n=9) believed that heroin was easy or very easy to obtain and that this availability had remained stable or had become easier in the past six to twelve months. Two KES did mention however, that there were small numbers of IDU reporting difficulty obtaining heroin and that some may be able to access other opiates more easily. One health KES reported a belief that it was difficult to obtain heroin in the southern area of Adelaide.

Taken together, these parameters indicate that availability of heroin had increased and was either stable or becoming easier in the year since the 2003 survey. Furthermore, long-term trend data for the availability of heroin, as reported by IDU in all previous surveys, is presented in Figure 4.2 and shows a gradual increase in the proportions indicating that heroin was 'very easy' or 'easy' to obtain in the six months prior to interview, since 2001. However, ease of obtainability has remained below (albeit slightly) the levels seen prior to that time, which coincides with the heroin shortage.

Figure 4.2: Availability of heroin in the last 6 months, 1997 - 2004



Source: IDRS IDU interviews

Table 4.5 shows the usual source or method of obtaining heroin, and the time taken to obtain it, for the last two years of the survey. The majority of IDU that had recently used heroin, and who provided information on the source of their heroin in the six months prior to interview (n=58), reported they usually obtained heroin from a dealer's home (43%) – an increase from 25% in 2003. Compared to 2003, there was also an increase in the proportion of IDU reporting usually obtaining heroin from a street dealer (from 5% to 12%), and a concomitant decrease in the proportion reporting obtaining heroin from a mobile dealer (from 41% to 14%). There was also a small decrease in the median reported time it took to obtain heroin from 23 minutes to 15 minutes, from 2003 to 2004.

Table 4.5: Usual method, and time taken, to obtain heroin in the last 6 months, 2003 & 2004

	% of heroin users able to answer	
Usual source *or* method of obtainment	**2003 (n=61)**	**2004 (n=58)**
Street dealer	5	12
Dealer's home	25	43
Mobile dealer	41	14
Friend*	8	14
Home delivered	21	17
Usual time taken to obtain heroin, *median minutes (range)*	23 (1 - 160)	15 (1 - 1440)

Source: IDRS IDU interviews

* includes obtained as a gift from friend

4.3 Purity

Tables 4.6 and 4.7 summarise the current purity of heroin and the changes in heroin purity over the last six months, according to IDU. In 2004, the purity of heroin was reported by the majority of those able to answer as low or medium, but the change in

purity over the last six months was equivocal, with equal proportions reporting in each category. Compared to 2003, when the purity of heroin was also generally reported as low to medium, there seems to be a trend toward a decrease in purity of heroin in 2004 given the decrease in the proportions stating current purity was high (from 19% to 9%) and the increase in the proportion stating purity was fluctuating (from 5% to 18%).

Table 4.6: Current purity/strength of heroin, 2003 & 2004

How pure would you say heroin is at the moment?	% of IDU able to answer	
	2003 (n=64)	2004 (n=56)
high	19	9
medium	33	32
low	44	41
fluctuates	5	18

Source: IDRS IDU interviews

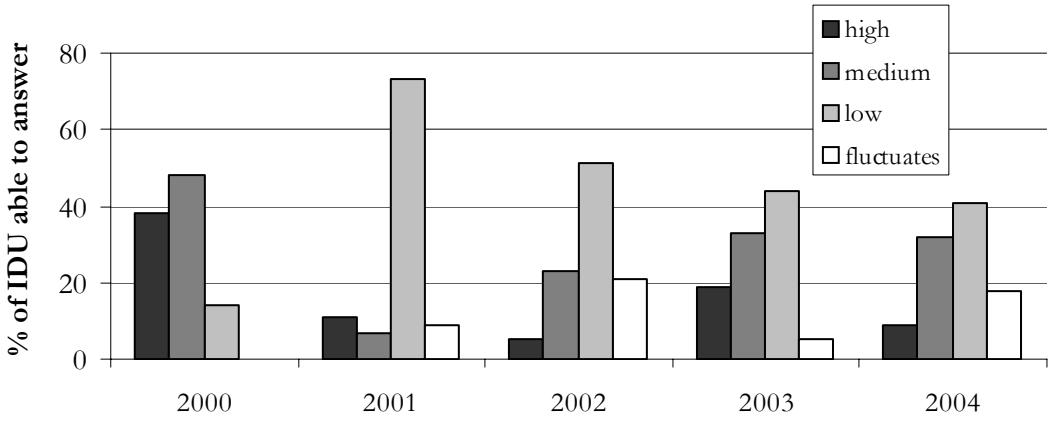
Table 4.7: Change in purity/strength of heroin in last 6 months, 2003 & 2004

Has the purity of heroin changed in the last 6 months?	% of IDU able to answer	
	2003 (n=64)	2004 (n=56)
increasing	36	23
stable	42	23
decreasing	11	25
fluctuating	11	27

Source: IDRS IDU interviews

Figure 4.3 shows the trend in purity of heroin, as perceived by IDU, from 2000 onward. It can be seen that despite an increase in perceived purity since the heroin shortage (post 2001), the perception remains that purity has not returned to pre-shortage quality.

Figure 4.3: Perception of current purity of heroin, among IDU, 2000 - 2004

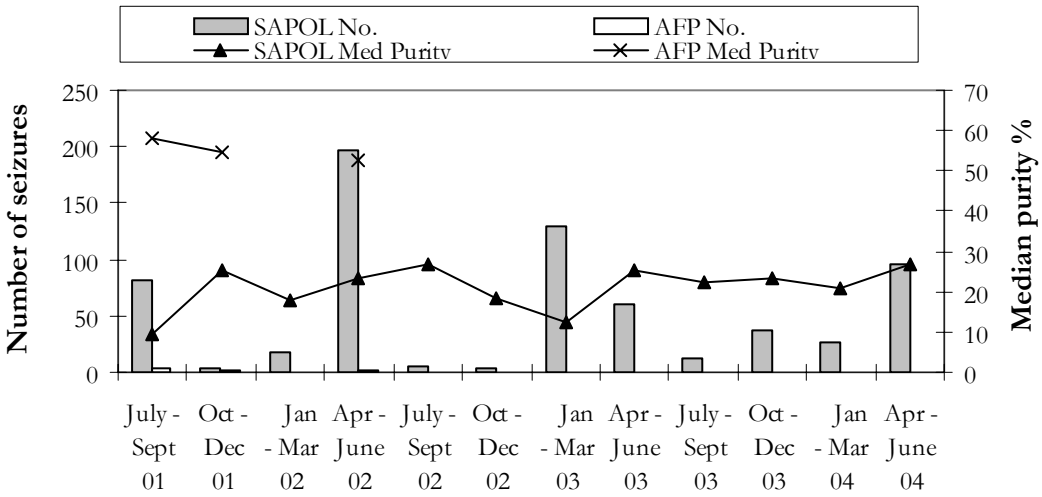


Source: IDRS IDU interviews
Note: the category 'fluctuates' was not included in 2000.

The Australian Crime Commission (ACC) provided purity data on heroin seized in SA during the last financial year 2003/2004 (ACC, *in press*). Figure 4.4 shows the number of seizures received and analysed by the state forensic laboratory per quarter, and the

median purity per quarter of those seizures, from 2001/02 to 2003/04. No heroin seizures by the Australian Federal Police were analysed in 2003/2004. The total number of SAPOL heroin seizures analysed in 2003/04 was 172 and the median purity was 25.0%. The vast majority of seizures analysed were less than or equal to 2 grams. Despite quarterly variation, and variation in the number of seizures, the median purity of SAPOL heroin seizures has remained relatively stable across the three financial years depicted, with median purity of 22.4% in 2001/02 (n=298), 18.9% in 2002/03 (n=247), and 25% in 2003/04 (n=172). The median purity for these years was considerably lower than that reported for SAPOL seizures in pre-shortage 1999/00 (48.3%, n=246).

Figure 4.4: Number of heroin seizures analysed and median heroin purity in SA 2001/2002 – 2003/2004



Source: Australian Crime Commission

There was a range of KES comment on the current purity of heroin, with one health KES reporting a reliable had stated to them that it was "not good", another peer educator KES reporting purity as 'medium', and four other KES reporting purity to be fluctuating from low to high dependent on user's contacts. These comments were in concordance with IDU reports, but reports from four KES (mostly peer educators) that purity of heroin had been increasing in the last six to twelve months were not as supportive of IDU reports. This may be due to the range of purity that seems to exist dependent on the user's level of contact with (and within) the market.

4.4 Use

4.4.1 Heroin use among IDU

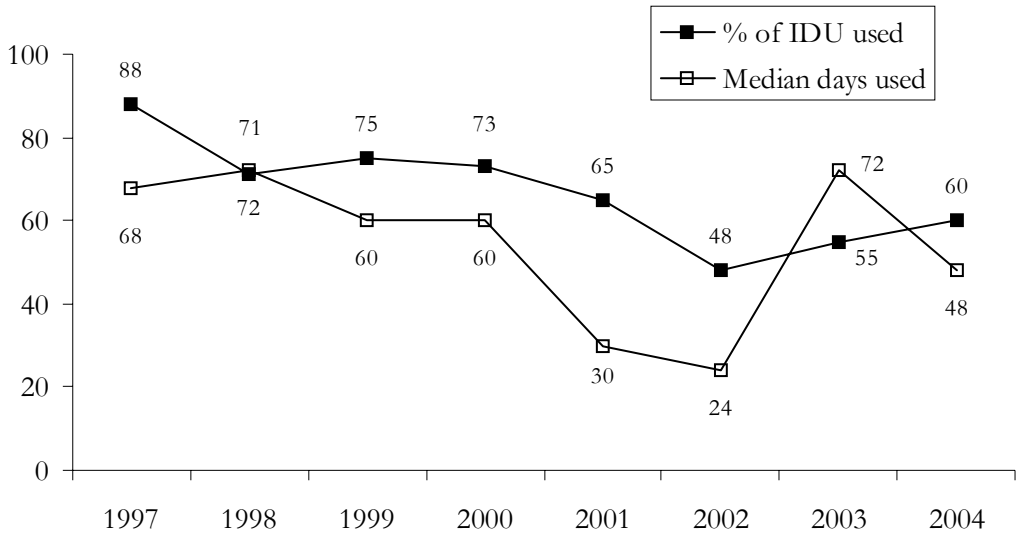
Thirty-nine percent of IDU reported heroin as the first drug ever injected, 48% nominated heroin as their drug of choice, 37% reported heroin as the drug most often injected in the last month, and 36% reported heroin was the last drug they injected.

4.4.2 Current patterns of heroin use

Sixty-one (60%) of the participating IDU interviewed in 2004 had used heroin on a median of 48 days in the last six months (range 1 - 180), all but two of whom had injected heroin in that time. Compared to 2003, there was a small increase in the

proportion of the IDU that had used heroin in the last six months (55% to 60%) and a decrease in the median number of days heroin was used during that time (72 days to 48 days)(see Figure 4.5). An analysis of the mean number of days used revealed that the difference between the years was not statistically significant.

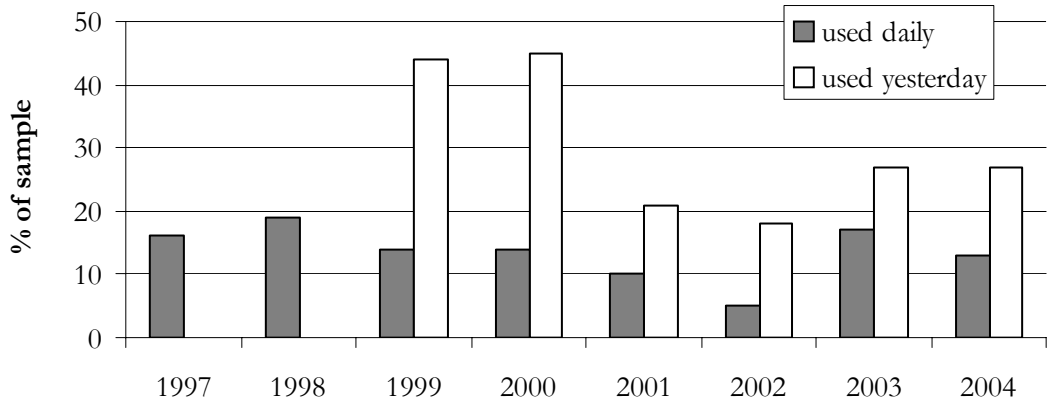
Figure 4.5: Heroin – Recent* use & Median number of days used#, 1997 - 2004



Source: IDRS IDU interviews
* in the previous six months; # by those reporting use in the previous six months

Contributing to the decrease in median number of days used was a small decrease in the proportion of IDU that reported use of heroin on a daily basis, from 17% in 2003 to 13% in 2004, as depicted in Figure 4.6. This follows a substantial increase in the proportion reporting daily use from 2002 (5%). Overall, if the spike in median days used for 2003 was anomalous, the trend in both % IDU using heroin and the frequency of use of heroin continues toward the pre-shortage levels of 2000.

Figure 4.6: Heroin - % of IDU that used daily* & %used yesterday, 1997 - 2004



Source: IDRS IDU interviews
* in the previous six months

As shown in Table 4.8, in 2004 just under 50% (n=30) of the heroin-using IDU had injected (any drug) once a day or more in the month prior to interview, the same as in 2003. In addition, twenty-one percent of heroin-using IDU (n=13) reported using and injecting heroin on a daily basis in the sixth months prior to interview. Six percent of the sample had used heroin by smoking and one IDU reported use by swallowing in the six months prior to interview (see Table 3.3).

Table 4.8: Frequency of injecting (any drug) heroin users, 2004

Frequency of injecting in the last month	% of heroin users (n=61)
Weekly or less	18
More than weekly, less than daily	33
Once a day	18
2 to 3 times a day	28
More than 3 times a day	3

Source: IDRS IDU interviews

Of the 61 IDU that had used heroin in the last six months, 59% (n=36) reported heroin as the last drug that they injected. The remaining heroin using IDU reported the last drug injected as morphine (13%, n=8), another opioid (methadone 3%, n=2; buprenorphine 3%, n=2; other opiate 3%, n=2), some form of methamphetamine (powder 7%, n=4; base 2%, n=1; crystal 7%, n=4) or benzodiazepines (3%, n=2).

Of the forty-eight IDU that nominated heroin as their drug of choice in 2004, 42 (88%) had used heroin in the previous six months, 22 (46%) had used morphine and 25 (52%) had used any methadone (licit or illicit). In addition, 24 (50%) had used some form of methamphetamine. Compared to 2003, there was a drop in the proportion reporting use of any methadone (from 66%), but recent use of the other drugs listed was unchanged for this group.

Nineteen IDU nominated heroin as their drug of choice but reported that the drug they had injected most in the last month was something other than heroin. Of these IDU, thirteen had mostly injected some other opioid substance (morphine, methadone, buprenorphine or 'homebake') in that period, seven of whom gave reasons of drug price, purity or availability for not injecting mostly heroin. The remaining six IDU had injected methamphetamine most, the reasons for which were again given as due to the price or availability of the drug, by the majority (n=5). Only 7% (n=4) of the IDU that reported use of heroin in the last six months had not used another opiate or opioid drug as well, during that period. These data are similar to that for 2003 and indicate that IDU continue to supplement or replace their use of heroin with other opioid and non-opioid drugs.

Of 60 IDU that had used heroin in the six months prior to interview *(data missing for one person)*, 49 (82%) reported use of a powder form of heroin, 56 (93%) reported using heroin rock and 4 (7%) reported using 'homebake', a crude opioid substance derived from pharmaceutical preparations containing codeine (Reynolds *et al.*, 1997). A higher proportion of heroin users reported heroin rock, compared to heroin powder, as the

form they had *used most* in the last six months (59% v 40%, n=58: data missing for three people). Compared to 2003, there was a decrease in the proportion of IDU reporting use of powder heroin (from 92% to 82%) and an increase in the proportion reporting use of rock heroin (from 77% to 93%). There was little change in the proportion reporting heroin rock as the form they had *used most* (53% in 2003 v 59% in 2004).

Of the few KES able to comment on the form of heroin available in Adelaide, more reported it was mainly rock, but several also suggested that this was actually compressed powder, with one peer educator KES commenting "you never see much real rock in SA". All KES agreed that injecting was still the most common practice and two KES commented that use by injecting had replaced smoking as the primary route of administration for Vietnamese heroin users. There was no clear pattern of change in frequency or quantity of heroin use, though a small number reported increased frequency of use that they attributed to an increased availability and decreased price of heroin over the last year – "back to pre-drought picture".

There was a general consensus among KES that IDU were polydrug users with heroin users commonly using a range of other drugs, particularly cannabis, tobacco and other opiates and to a lesser extent alcohol, methamphetamine and benzodiazepines. The extent and regularity of use of these other drugs was reported as varying widely, but generally KES commented that other opiates such as morphine would be commonly used among this group, though this may have dropped in 2004 due to the re-emergence of heroin. Two KES noted an increase in the prevalence of injecting of the opioid substitution medication, buprenorphine, and one noted the emergence of the illicit use of Tramadol® (a synthetic analgesic with opioid-like effects) as a substitute for Kapanol® (morphine).

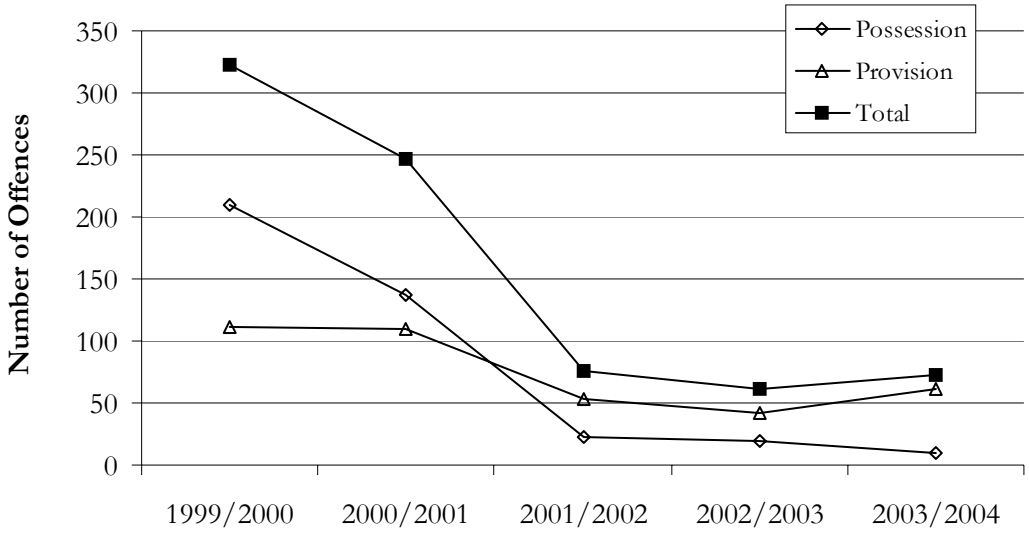
4.5 Heroin related harms

4.5.1 Law enforcement

The total number of drug-related possession and provision offences for 2003/2004 was 2985, which continues a decline seen over the last couple of years (3131 in 2002/2003, 3673 in 2001/2002 and 3864 in 2000/2001) (SAPOL Annual Reports, 2000-2004). This decline in total numbers was primarily due to a decline in 'possession/use' offences, which would have been impacted by the introduction of the Police Drug Diversion Initiative in 2001.

The number of heroin possession/use and provision (incorporating import/export drugs, sell/trade drugs, produce/manufacture drugs categories) offences reported or becoming known to police from 1999/2000 to 2003/2004 (as reported by SAPOL) is presented in Figure 4.7. As can be seen, total heroin-related possession and provision offences remained relatively stable from 2002/2003 to 2003/2004. There was only a small decrease in the number of possession offences, and a small increase in provision offences, for heroin from 2002/2003 to 2003/2004. Heroin possession and provision offences made up only 2.4% of the total number of drug possession and provision offences in 2003/2004, similar to 2% in 2002/2003.

Figure 4.7: Number of heroin related offences reported by SAPOL in South Australia, 1999/2001 – 2003/2004



Source: South Australian Police Annual Reports (2000-2001 to 2003-2004)

4.5.2 Health

Heroin overdose

Of the 82 IDU that reported having used heroin in their lifetime, 42 (51%, *data missing for 2 participants*) also reported lifetime experience of heroin overdose between one and 12 times (median=2 times). Eighty-eight percent (n=37) had overdosed six times or less, and the majority (57%) had overdosed once (n=15, 36%) or twice (n=9, 21%). The number of overdoses experienced across lifetime was similar to that reported in the IDRS for the past 4 years (see Table 4.9).

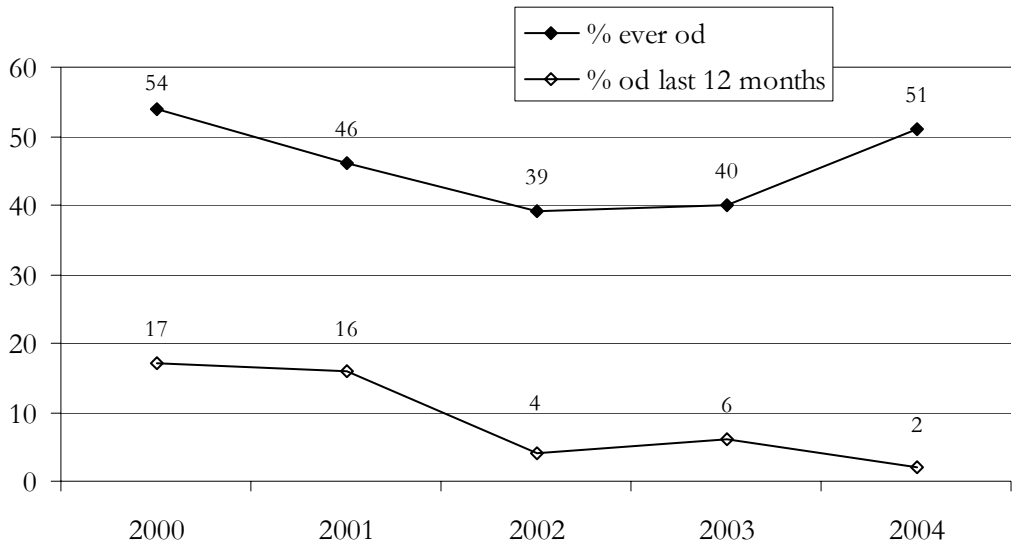
Table 4.9: Lifetime experience of heroin overdose among those IDU reporting *ever* used heroin, 2000 – 2004

Heroin overdose variable	2000 (n=47)	2001 (n=40)	2002 (n=33)	2003 (n=42)	2004 (n=42)
% overdosed once	32	40	42	38	36
% overdosed twice	26	20	21	14	21
% overdosed 3 times or more	42	40	36	48	43

Source: IDRS IDU interviews

The long-term trend in experience of overdose across lifetime and experience of overdose in the last twelve months is depicted in Figure 4.8. As seen in the graph, prevalence of recent heroin overdose has remained stable and low since 2002 following a decrease from previous years. The prevalence of lifetime experience of heroin overdose among the IDU sample in 2004 was higher than in the last 2 years. The median amount of time between interview and last overdose was 60 months (range 6 to 240, n=42), which was slightly longer than that reported in 2002 (48 months, range 1 to 360; n=42). Forty-one percent of the 2003 SA NSP survey participants reported lifetime experience of overdose (with any drug) and 9% had experienced overdose in the last 12 months (NCHECR, 2004).

Figure 4.8: Experience of heroin overdose ever and in the last 12 months, as a proportion of the whole IDU sample, 2000 – 2004



Source: IDRS IDU interviews

Twenty-three IDU (55% of those who had experienced heroin overdose) reported having ever had the opioid antagonist naloxone (Narcan®) administered for heroin overdose. No IDU had received Narcan® in the last twelve months. The median amount of time between interview and last Narcan® administration was 60 months (range 24 to 240). Therefore, despite the increase in the proportion reporting lifetime experience of heroin overdose in 2004, the proportion of IDU reporting having received Narcan® as a result of heroin overdose was lower than in 2003 (64%) and the amount of time since last Narcan administration was longer (median 36 months in 2003).

Sixty-eight participants (67% of IDU) reported having ever been present when someone else had overdosed, a median 3.5 times (range 1 to 50), and a median 29 months prior to interview (range 1 month to 16 years). Twenty-one IDU (31%) reported witnessing someone else's overdose within 12 months of interview. In comparison, 60% of IDU reported being present at another user's overdose a median 5 times, and a median 36 months prior to interview, in 2003.

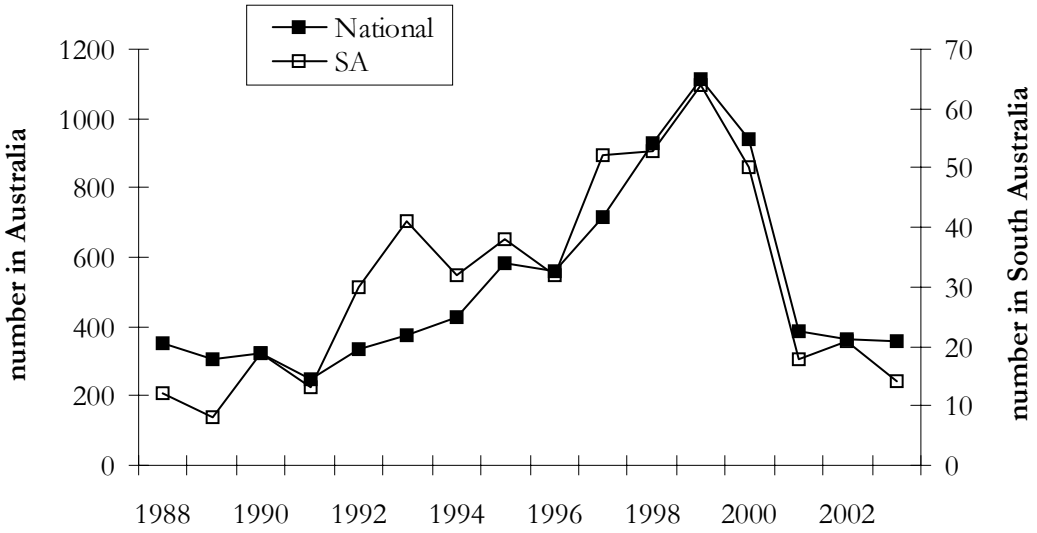
Three KES commented that no increase in heroin overdose had been noted over the past six months, with one suggesting a lessening of overdose incidence in that time was more likely. However, one KES based in the west of Adelaide suggested that an increase in opiate overdose had resulted from the increased availability of heroin and had been the subject of education campaigns in the area. Another KES who worked as an ambulance officer noted a decrease in heroin overdose call-outs but a marked increase in 'pharmaceutical narcotic agents' (such as morphine and recently, Tramadol®) overdoses. Some of these medications are sustained release formulations, causing particular problems with regard to antagonist treatment.

Opioid overdose

Australian Bureau of Statistics (ABS) data (Figure 4.9) show a plateau in opioid overdose deaths in both SA and nationally from 2001 to 2003 (Degenhardt *et al.*, 2004a). In SA, there were 14 deaths due to opioid overdose in 2003, a decrease from 21 in 2002.

Opioid overdose deaths in SA accounted for 3.9% of the national total, a decrease from 6% in 2002, and the lowest since 1989.

Figure 4.9: Number of accidental opioid deaths, among those aged 15-54 years, in SA compared to national figures, 1988-2003

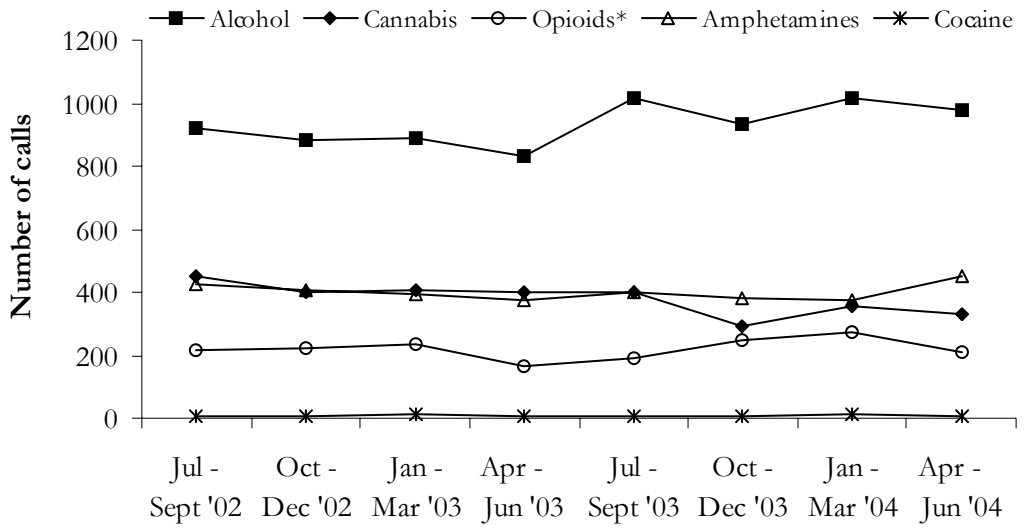


Source: Australian Bureau of Statistics morbidity database (Degenhardt et al, 2004a)

Treatment Services - ADIS

Telephone calls to the SA Alcohol and Drug Information Service (ADIS) regarding any opioid substances accounted for 6.9% of the total coded telephone contacts (drug-related) in the 2003/2004 financial year (n=13,336), a similar proportion as for 2002/2003 (6.3% of a total 13,825) and 2001/2002 (6.6% of a total 12,538). In 2004, the breakdown of number of calls per opioid substance category (eg. heroin, methadone) was unavailable. Figure 4.10 depicts the number of opioid related calls per quarter for the last two financial years compared to calls related to other drug types.

Figure 4.10: Number of drug related calls to ADIS per quarter, by selected drug type, Jul 2002 – June 2004



Source: SA ADIS

* 'opioids' includes all calls coded under the categories heroin, methadone, buprenorphine, naltrexone, opioid pharmacotherapies and other opioids

Treatment Services - DASC

Readers are reminded that a new data system, the Client Management Engine-DASC Information System (CME-DIS) was introduced in July 2002, which may have impacted on the data trends, therefore, readers are advised to treat any interpretation cautiously.

Presentations to all treatment services of the SA Drug and Alcohol Services Council (DASC) are presented in Table 4.10 and show that the proportion of clients nominating heroin as their primary drug of concern remained stable in 2003/2004 compared to 2002/2003 (18.8% v 18.6%), following the increase seen from 2001/2002 (10.3%). In 2003/2004, heroin remained the second most commonly nominated primary drug of concern by clients of DASC, after alcohol, followed by amphetamines.

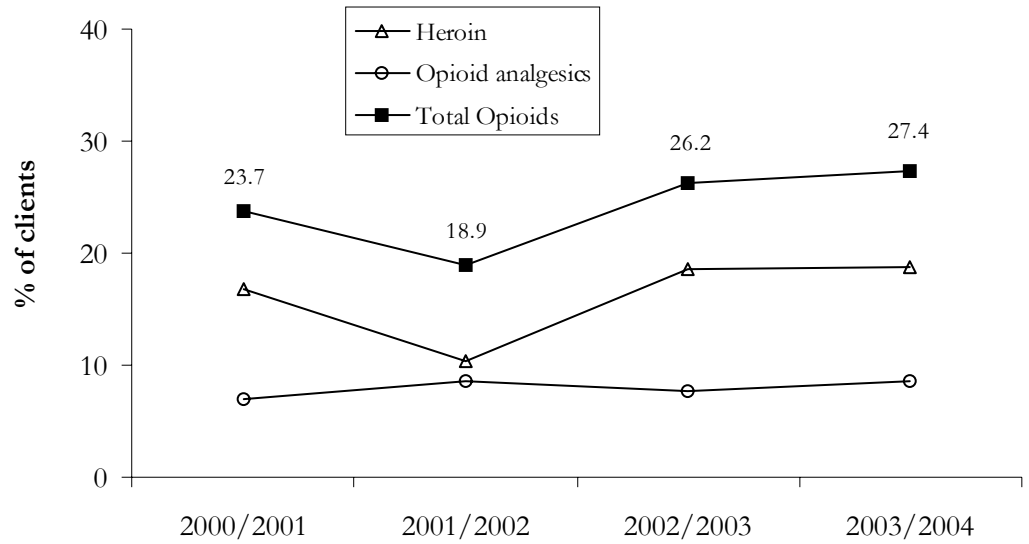
Table 4.10: Primary drug of concern nominated by clients of the Drug and Alcohol Services Council, as a percentage of total number of presentations, 2000/01 - 2003/04

Drug type	2000/2001	2001/2002	2002/2003*	2003/2004
Alcohol	40.2	41.6	41.4	41.3
Amphetamines	10.7	14.5	18.1	15.9
Heroin	16.7	10.3	18.6	18.8
Opioid analgesics	7.0	8.5	7.6	8.6
Cannabis	8.4	10.7	9.8	11.1
Benzodiazepines	2.0	1.9	2.4	2.1
Cocaine	0.2	0.3	0.2	0.2
Tobacco	0.1	0.2	-	0.2
Other	8.5	2.3	1.4	1.3
Unknown	6.2	9.7	0.5	0.5

Source: Drug and Alcohol Services Council
* During this period a new data collection system (CME-DIS) was employed to meet the requirements of the National Minimum Data Set for Alcohol and Other Drug Treatment Services (NMDS-AODTS).

A stable pattern of presentations to DASC regarding 'any opioid' was also observed. In 2003/2004 the proportion of clients nominating any type of opioid substance (including heroin) as their primary drug of concern was 27.4, compared to 26.2% in 2002/2003 (see Figure 4.11).

Figure 4.11: Percentage of DASC presentations with opioids as the primary drug of concern, 2000/01 – 2003/04*



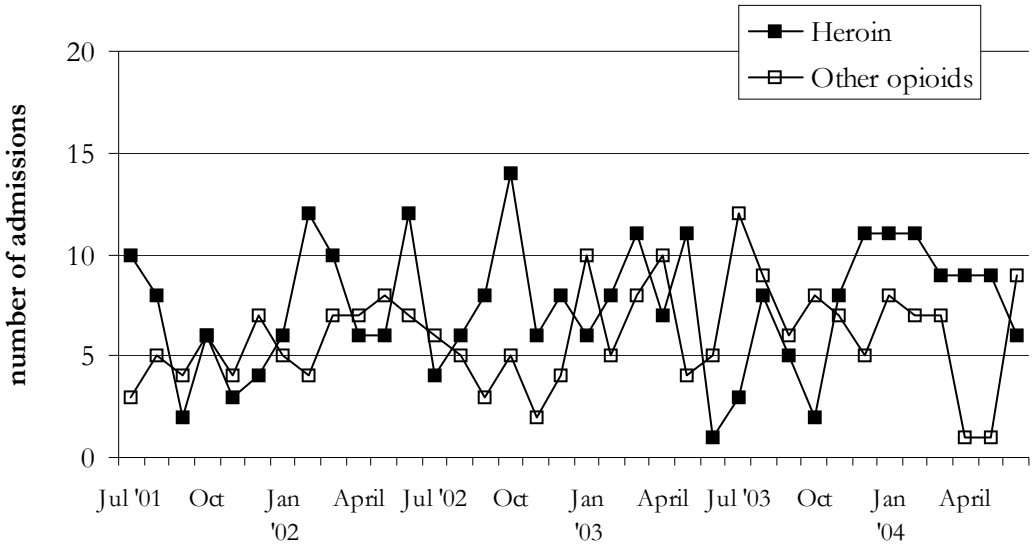
Source: Drug and Alcohol Services Council
* During 2002/2003 a new data collection system was employed to meet the requirements of the National Minimum Data Set for Alcohol and Other Drug Treatment Services (NMDS-AODTS).

Figure 4.12 presents the number of admissions to DASC inpatient detoxification treatment services for heroin or other opioids during the period July 2001 to June 2004. The number of admissions where heroin was the primary drug of concern has remained stable over the past three years. In 2003/2004 there was a total of 92 inpatient detox admissions to DASC for heroin, compared to 90 and 85 in the previous years. The

number of admissions for other opioids however, increased slightly from 67 in 2002/2003 to 80 in 2003/2004. Though the gap between the number of inpatient admissions for heroin and amphetamines had narrowed compared to 2002/2003, there were still considerably fewer inpatient detox admissions for heroin (92) compared to amphetamines (159) during the 2003/2004 year.

When the data was analysed in terms of whether the primary drug of concern for inpatient detox admissions was amphetamines or an opioid substance (heroin or other opioid analgesics), it was noted that there has been a slight shift in the balance of figures. After alcohol, which invariably constitutes close to 50% of detox admissions, in 2002/2003 amphetamines dominated as the primary illicit drug of concern for 19.5% of clients to inpatient services. In the same year a total of 16.7% nominated an opioid as their primary drug of concern (9.6% heroin and 7.1% other opioid analgesics). In 2003/2004 the proportion nominating amphetamines as their primary drug of concern had decreased to 17.4% while the proportion nominating an opioid increased to 18.7% (10% heroin and 8.7% other opioid analgesics).

Figure 4.12: Number of admissions to DASC inpatient treatment services per month, with heroin or other opioids as the primary drug of concern, Jul 2001 – Jun 2004*



Source: Drug and Alcohol Services Council

* During 2002/2003 a new data collection system (CME-DIS) was employed to meet the requirements of the National Minimum Data Set for Alcohol and Other Drug Treatment Services (NMDS-AODTS).

Data regarding number of people on a maintenance pharmacotherapy program (methadone or buprenorphine) in the year 2003/2004 were unavailable at the time of writing and are therefore not included in this report.

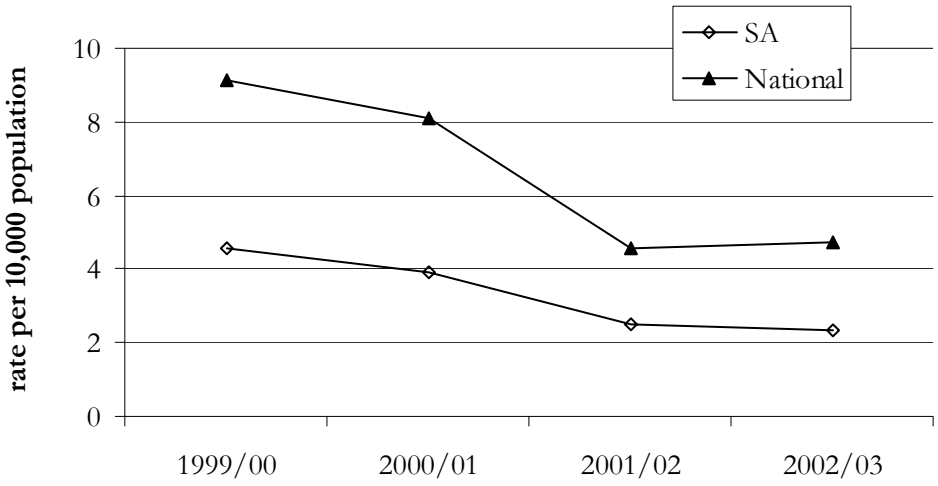
Opioid-related Hospital Admissions

Data up to the end of the 2002/2003 financial year was provided by the Australian Institute of Health and Welfare from the National Hospital Morbidity Dataset. This data reports on both state specific and national drug-related hospital admissions[3], according to

[3] The National Hospital Morbidity Dataset includes admissions data from public and private hospitals across metropolitan, regional and remote locations.

ICD-10 classification. The substance by far most commonly involved in a primary diagnosis for South Australian hospital admissions was alcohol, followed by amphetamines, opioids, cannabis and cocaine (see Appendix – Figure A). The pattern for national data differed in that admissions for opioids outnumbered those for amphetamines across all years (see Appendix – Figure B). Figure 4.13 shows that both the SA and national rates of admission to hospital for opioids (primary diagnosis) declined from 1999/00 to 2001/02, but were stable from 2001/02 to 2002/03. The total number of admissions to SA hospitals where opioid-related disorders were recorded as the primary diagnosis had decreased from 389 in 1999/00 to 198 in 2002/03.

Figure 4.13: Rate of opioid-related admissions* (primary diagnosis) to hospital in South Australia, compared to nationally, by financial year totals, July 1999 to June 2003



Source: Australian Institute of Health and Welfare
* for persons aged between 15 and 54 years
Note: A 'primary diagnosis' was given when opioids were considered chiefly responsible for the patient's episode of care in hospital

Emergency Department admissions

Information on drug-related attendances to the Emergency Department was provided by from the Royal Adelaide Hospital (RAH), the largest central public hospital in Adelaide, and is presented in Table 4.11. Again, it is noteworthy that alcohol accounted for by far the most attendances across all years. It can be seen that for heroin there was a rapid decline in the number of attendances from 1999/2000 to 2001/2002 (at the height of the heroin shortage), with numbers remaining low in the years following. For other opioids there was a similar decline in the number of attendances from 1999/2000 to 2001/2002, but an increase in 2002/2003 that was maintained in 2003/2004. Interestingly, in the year prior to the heroin shortage (1999/2000) attendances for heroin were more than double those for other opioids, whereas in the years since, attendances for other opioids have outnumbered those for heroin.

Table 4.11: Number of attendances* to the emergency department at the Royal Adelaide Hospital, SA, from 1999/2000 to 2003/2004 (per drug or diagnosis)

	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004
Amphetamines	103	88	76	65	81
Cocaine	1	2	2	0	1
LSD	1	1	2	1	2
GHB	0	0	48	28	28
Alcohol	1,068	1,066	1,118	994	1,106
Cannabis	18	12	16	9	11
Heroin	221	121	30	38	25
Other opioids**	97	79	45	64	57
Benzodiazepines	143	201	170	138	138
Antidepressants	88	117	104	79	80
Drug addiction#	25	32	27	38	20
Drug-induced psychosis#	17	34	67	52	44
Drug withdrawal#	32	35	35	26	24
Other##	577	640	533	434	442
TOTAL	*2,391*	*2,428*	*2,273*	*1,966*	*2,059*

Source: Royal Adelaide Hospital Emergency Department

* coded as drug or poisoning-related

** includes opium, methadone, other narcotics (morphine, codeine, pethidine etc), and opioid withdrawal

not otherwise specified, excluding alcohol

includes all other poisonings related to food, drug (medical & non-medical), chemical and other toxins

SA Ambulance data

The South Australian Ambulance Service (SAAS) provided information regarding the number of drug-related call-outs to the service over the past several years. However, this data was not included here as changes to coding of call-outs and lack of drug specific detail made it difficult to isolate drug-related trends in the IDRS context. However, a SAAS KES reported that while a decrease in the number of call-outs to heroin overdose had declined, there had been a marked increase in the number of call-outs to pharmaceutical narcotic overdoses (eg. MS Contin®, Kapanol® and recently, Tramadol®).

4.6 Trends in heroin use

As in 2003, in 2004 the IDU comments regarding general trends in heroin use were fewer than those regarding amphetamine use and more variable. Several IDU reported a general increase in the use of heroin in terms of numbers of people using, as well as frequency of use, primarily due to a decrease in price and increased availability. However, an equal number reported that many who had shifted to using amphetamines due to the heroin shortage had not shifted back to using heroin despite it's increased availability. There seemed to be consensus that more people, and younger people, were using illicit drugs (including heroin and speed) generally.

KES reports tended to confirm the IDU reports of an increase in use of heroin due to increased availability, except for one KES who felt availability and use had not increased in the south of Adelaide.

4.7 Summary of heroin trends

Table 4.12 contains a summary of trends in the price, purity, availability and use of heroin in the previous 12 months. Overall, there was a decrease in the price of heroin from 2003 to 2004, continuing the downward trend since the peak in 2002, with the price now the same as the pre-shortage level of 2000 ($320 per gram). Heroin was still considered 'easy' or 'very easy' to obtain by most IDU and availability was reported as stable to easier in the preceding six months. There was an increase in the proportion of IDU obtaining heroin from a dealer's home or from a street dealer, and a concomitant decrease in the proportion being supplied by mobile dealers. According to the majority of IDU, heroin purity remained at low to medium levels in 2004, with increased proportions also reporting fluctuating or decreasing purity. There was no clarity as to recent change in purity.

The median purity of SAPOL heroin seizures appears to have remained relatively stable across the last three financial years (2001/02 to 2003/04), with median purity of 25% in 2003/04. Purity of SAPOL heroin seizures remains well below pre-shortage levels.

A small increase in the proportion of IDU that had recently used heroin was noted, continuing the increase since 2002. There was however, a decrease in the median number of days used following the dramatic rise in frequency seen in 2003. This may indicate a stabilisation of heroin use following the post-shortage 'bounce-back' of 2003.

Analysis of IDU that nominated heroin as their drug of choice indicated users continue to supplement or substitute their heroin use with other opioid substances such as morphine and methadone. There was an increase in the proportion of IDU reporting use of rock heroin and a decrease in the proportion of IDU reporting use of powder heroin, and a slight majority (59%) reported rock as the form *used most* in the last six months. It was suggested by several KES though that rock heroin is actually compressed powder heroin.

SAPOL data revealed that total heroin-related possession and provision offences remained relatively stable from 2002/2003 to 2003/2004. KES provided little or no comment on street level offending, unless to say that no change in type or level of crime had occurred recently.

Similarly, experience of recent heroin overdose among IDU remained low. This was reflected in the latest ABS data on opioid overdose deaths, which showed a decline in the number of accidental opioid overdose deaths in SA from 2002 to 2003.

The proportion of opioid-related calls to ADIS remained stable. An analysis of the presentations to all DASC treatment services for heroin or other opioids also revealed little change since 2003. However, a small increase was apparent in the proportion of clients admitted to DASC inpatient (detox) services nominating any type of opioid substance (including heroin) as their primary drug of concern (18.7%), representing a slightly higher proportion than those nominating amphetamines as their primary drug of concern (17.4%). Both state (SA) and national hospital data showed the number of opioid-related admissions were stable (as at 2002/03) and still below pre-heroin shortage levels. SA emergency data attendances for heroin and other opioids also appeared stable in 2003/04 compared to the previous year, and below pre-shortage levels.

Table 4.12: Trends in the price, availability, purity and use of heroin

Price	
Gram	$320 ($150-$400); decreased since 2003, currently stable
Cap	$50; stable
Availability	Very easy to easy; stable to easier
Purity	25.0% (ACC); relatively stable Low to medium (IDU); recent change equivocal. Remains below ACC reported pre-shortage level.
Use	Small increase in % used recently, but decrease in frequency of use since 2003.
Other indicators	Number of heroin possession and provision offences were relatively unchanged (SAPOL). Small decrease in SA opioid overdose deaths (ABS). No change in opioid-related calls to ADIS (ADIS). Small increase in inpatient (detox) treatment admissions for opioids, but proportion of total clients for heroin and other opioids was stable (DASC). Hospital admissions stable and below pre-shortage levels in 2002/03 (AIHW).

5. METHAMPHETAMINE

For further information regarding the methamphetamine market in Australia, see also Topp and Churchill (2002).

In 2002, the IDRS collected data on three different forms of methamphetamine in order to collect more comprehensive data on the use, purity and availability of each. Flashcards with colour photographs were introduced to clarify more precisely the characteristics of the different forms of methamphetamines that are marketed under a variety of names, but can be categorised into three main forms: 'speed/powder', 'base/paste', and 'crystal/ice' (see Breen *et al.*, 2003). For ease of understanding (and comparability with previous IDRS reports these three main forms will be referred to as powder, base and crystal, respectively, in the following sections. Also, due to this categorisation, price, purity and availability data prior to 2002 is not directly comparable to data collected in the years following the 2002 IDRS report and care should be taken when interpreting the changes in these parameters, as reported in the following sections.

5.1 Price

Overall there have been decreases in the price of all three forms of methamphetamine from 2003 to 2004. In contrast to 2003, there was little difference in the median price paid for a 'point' of all three forms of methamphetamine, with a substantial decrease in the price paid for a 'point' of crystal in 2004 bringing it closer in price to powder and base. The median price of a gram of powder remains considerably cheaper than either base or crystal, having halved compared to 2003. Again it is noticeable in 2004 that there were wide ranges in reported prices paid, particularly of a gram, across all types of methamphetamine. This could be attributable to several factors such as variability in quality and quantity for a given 'amount', or (as indicated by both IDU and KES) the relationship between user and supplier. A more frequent user may obtain methamphetamine more cheaply when they have an established relationship with a dealer. A detailed discussion of price information for each of the three forms of methamphetamine follows.

Please note that in 2004 considerably fewer IDU were able to comment on the price of methamphetamine, compared to the previous two years.

Methamphetamine – powder form

The *current* price of powder methamphetamine was estimated to be a median $75/gram ($40-250, n=22) or $27.50/'point' (range $10-50, n=14) by IDU. The estimated price of a point of powder was the same as the median price *paid* by IDU, *at last purchase*, but the estimated price of a gram of powder was higher than the median price paid *at last purchase*, as listed in Table 5.1. The median price paid for a gram of powder was $50, a decrease from 2003 when the median last purchase price was $100.

Methamphetamine – base form

The *current* price of base methamphetamine was estimated to be a median $200/gram ($10-300, n=13) or $25/'point' ($20-50, n=23) by IDU. The estimated price of a point of base was the same as the median price *paid* by IDU *at last purchase*, but the estimated price of a gram of base was slightly lower than the median price paid *at last purchase*, as listed in Table 5.1. Decreases were seen in the median price *paid* by IDU *at last purchase*

for some amounts bought: the median price paid for a gram of base in 2004 was $180, compared to $200 in 2003, and the median price paid for a 'point' of base was $25 compared to $30 in 2003. However, the price of a 'half-weight' (half a gram) remained the same at $100, as did the less commonly purchased 'eightball' (3.5grams) at $500.

Methamphetamine – crystal form

The *current* price of crystal methamphetamine was estimated to be a median $200/gram ($10-400, n=13) or $25/'point' ($20-50, n=21) by IDU. These estimations were slightly different to the median price *paid* by IDU, *at last purchase*, for the different amounts of crystal, as listed in Table 5.1. The median price of $190 paid for a gram of crystal in 2004 was slightly lower than the $200 reported for 2003, while the decrease in the median price paid for a 'point' of crystal from $50 in 2003 to $30 in 2004 was more substantial.

Table 5.1: Price of most recent methamphetamine purchases by IDU, 2003* & 2004

Amount bought	Median price paid, $ (range)			Number of IDU purchasers		
	powder	base	crystal	powder	base	crystal
'point'	27.50 (20 – 50) *25 (20 - 100)*	25 (18 – 50) *30 (20 - 75)*	30 (20 – 50) *50 (20 - 50)*	10 *25*	21 *30*	13 *30*
gram	50 (40 – 200) *100 (25 - 450)*	180 (10 – 220) *200 (50 - 300)*	190 (10 – 400) *200 (50 - 400)*	11 *19*	9 *16*	10 *21*
'half-weight' (½ gram)	100 (100) *100 (25 - 200)*	100 (100) *100 (40 - 150)*	100 (80 – 125) *100 (100 - 150)*	7 *12*	11 *22*	8 *19*
'eightball' (3.5grams)	- *465 (100 - 500)*	500 (140 – 750) *500 (500 - 550)*	# *540 (100 - 740)*	- *10*	6 *8*	# *8*

Source: IDRS IDU interviews

* 2003 data in italics, # n<5: not reported

Note: all purchases were within six months of interview

Table 5.2 summarises the IDU reports of change in the price of the three main forms of methamphetamine over the last six months, for 2003 and 2004. In both years, the price of each type of methamphetamine was reported as stable by the majority of IDU answering this section. There was little difference in the reported stability of the price of all forms of methamphetamine across the two years. For powder and crystal there was a small increase in the proportion of IDU that didn't know if the price had changed in the last six months, possibly indicating newcomers to the market for these forms.

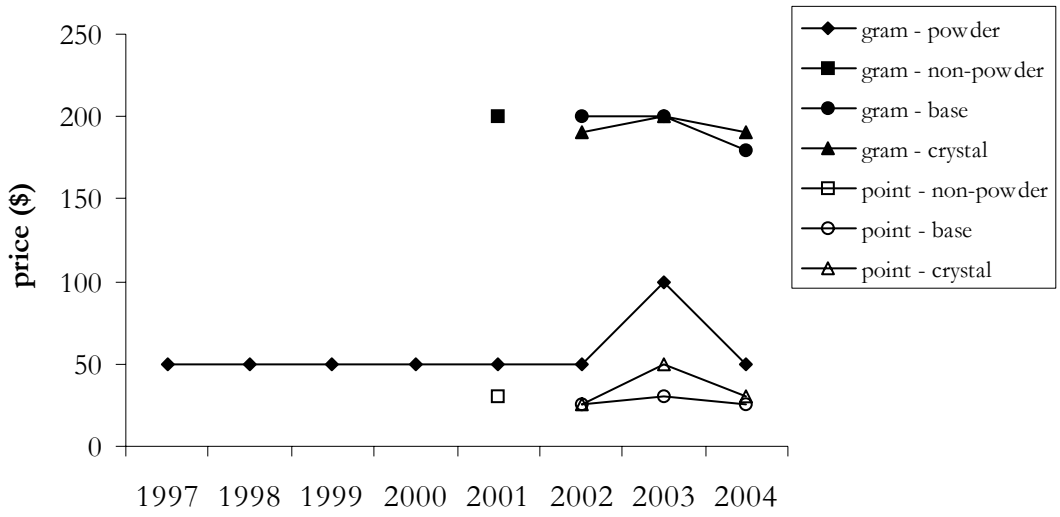
Table 5.2: Change in price of methamphetamine over last 6 months, 2003 & 2004

Reported price status	Powder		Base		Crystal	
	% of IDU able to answer					
	2003 (n=50)	2004 (n=38)	*2003 (n=58)*	2004 (n=40)	*2003 (n=50)*	2004 (n=41)
don't know	*16*	21	*14*	8	*22*	27
increasing	*8*	0	*9*	5	*4*	5
stable	*60*	63	*69*	75	*64*	61
decreasing	*12*	11	*3*	8	*6*	7
fluctuating	*4*	5	*5*	5	*4*	0

Source: IDRS IDU interviews

Longer-term changes in the 'last purchase' price of a 'point' or gram for the different forms of methamphetamine are depicted graphically in Figure 5.1.

Figure 5.1: Median price of methamphetamine, at last purchase, 1997 - 2004



Source: IDRS IDU interviews

Health and service provision KES were generally unable to provide information regarding price of methamphetamine, except two KES who commented that price was dependent on the closeness of the user to the manufacturing or supply source, whether the user was also dealing themselves, and that price decreased with increase in the amount bought (i.e. it was "cheaper to buy in bulk"). Other KES reported that price ranged from $20 to $50 per point, or around $200 per gram, and two KES reported an 'eightball' could range from $300 or $400 to $1000 or $1100. Several also commented that price varied according to quality and closeness to the source with "neat/pure" (i.e. uncut) or crystal demanding a higher price. All KES able to comment agreed that the price of methamphetamine had been stable recently. These KES reports are in agreement with IDU information.

5.2 Availability

Tables 5.3 and 5.4 summarise the current availability of the three main forms of methamphetamine, and the changes in availability over the last six months, according to IDU report. In 2004, availability of all three types of methamphetamine was reported as

'easy' or 'very easy' to obtain by the majority of IDU able to answer these sections (80% or more). Base was considered easiest to obtain (63% reported 'very easy'), followed by powder (54% reported 'very easy') and crystal (36% reported 'very easy'). The majority also reported that availability of all forms had been stable or getting easier over the last 6 months (over 65%). Compared to 2003, the reported availability was largely unchanged in 2004, except for what seems to be an increase in availability of base methamphetamine. Readers are again reminded however, that fewer IDU were able to comment on availability in 2004 (see *n* values in Table 5.3), which may limit the validity of findings.

Table 5.3: Availability of methamphetamine currently, 2003 & 2004

How easy is it to get [powder/base/crystal] at the moment?	Powder		Base		Crystal	
	% of IDU able to answer					
	2003 (n=43)	2004 (n=35)	*2003 (n=55)*	2004 (n=40)	*2003 (n=46)*	2004 (n=36)
very easy	*58*	54	*33*	63	*33*	36
easy	*33*	31	*53*	33	*52*	44
difficult	*7*	14	*9*	5	*11*	14
very difficult	*2*	0	*5*	0	*4*	6

Source: IDRS IDU interviews

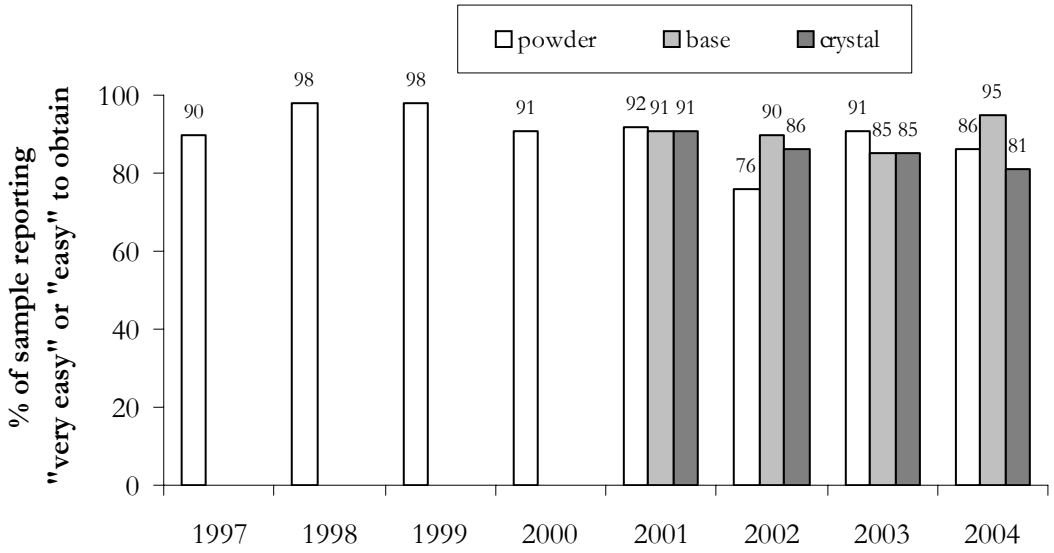
Table 5.4: Change in availability of methamphetamine over the last 6 months, 2003 & 2004

Has [availability] changed in the last 6 months?	Powder		Base		Crystal	
	% of IDU able to answer					
	2003 (n=43)	2004 (n=35)	*2003 (n=55)*	2004 (n=40)	*2003 (n=46)*	2004 (n=36)
don't know	*2*	9	*4*	3	*4*	11
more difficult	*9*	14	*9*	8	*9*	17
stable	*74*	63	*71*	58	*65*	47
easier	*9*	6	*13*	28	*20*	22
fluctuates	*5*	9	*4*	5	*2*	3

Source: IDRS IDU interviews

Figure 5.2 shows the trend in availability of methamphetamine, as reported by IDU, since 1997. As can be seen, methamphetamine has generally been considered 'easy' or 'very easy' to obtain across all these years. It is also notable that ease of availability of base methamphetamine seems to have dominated in Adelaide (at least since the distinction between different forms was made to the survey in 2001).

Figure 5.2: Availability of methamphetamine in the last 6 months, 1997- 2004



Source: IDRS IDU interviews

As can be seen in Table 5.5, there were some differences in how methamphetamine users sourced the different forms of the drug, particularly base or powder, in 2004 compared to 2003, though the largest percentage reported that they obtained all forms from a friend. In particular, there was a shift in the proportion reporting obtaining base from a mobile dealer to obtaining it from a dealer's home or having it delivered to their own home. Similarly, there was a shift in the proportion of IDU reporting obtaining powder from a mobile dealer to obtaining from a dealer's home or a street dealer. The median time *usually* taken to score was 15 minutes for powder, 20 minutes for base, and 30 minutes for crystal.

Table 5.5: Usual method, and time taken, obtaining methamphetamine in the last 6 months, 2003 & 2004

Usual source *or* method of obtainment	% of methamphetamine users able to answer					
	Powder		Base		Crystal	
	2003 (n=45)	2004 (n=32)	*2003 (n=51)*	2004 (n=39)	*2003 (n=50)*	2004 (n=38)
Street dealer	*9*	13	*8*	8	*4*	3
Dealer's home	*16*	22	*16*	31	*22*	21
Mobile dealer	*29*	16	*31*	13	*22*	16
Friend*	*36*	40	*39*	38	*40*	40
Home delivered	*9*	6	*2*	10	*10*	16
Other	*2*	3	*4*	-	*2*	5
Usual time taken to obtain heroin, *median minutes (range)*	*30 (1-120)*	15 (1 - 120)	*30 (1-1440)*	20 (1 - 300)	*30 (1-10080)*	30 (1- 2880)

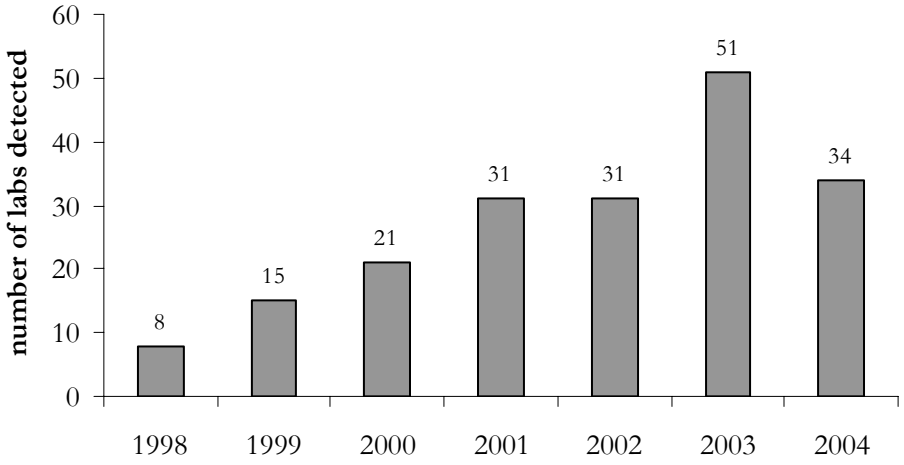
Source: IDRS IDU interviews

* includes obtained as a gift from friend

Similar to IDU reports, the overwhelming majority of KES able to comment reported that methamphetamine was 'easy' or 'very easy' to obtain, and that this had been generally stable recently. One peer educator KES commented that crystal ('ice') was definitely not as easy to obtain as other forms, but was becoming easier. Law enforcement KES commented on the continuing predominance of the base form of methamphetamine in the Adelaide IDU market.

Data supplied by the South Australian Police shows the dramatic increase in the detection of clandestine laboratories in South Australia since 1998 (see Figure 5.3). Following a peak of 51 detections in 2003, the number of laboratories detected decreased to 34 in 2004. The majority of these clandestine laboratories have been relatively small-scale operations for the production of primarily methamphetamine, using pseudoephedrine as the chemical precursor. It is thought that this type of manufacture has escalated in recent years and constitutes a significant proportion of local methamphetamine supply, particularly to the IDU market. The quality and form of methamphetamine produced by this method varies widely, but is commonly a paste-like or gluggy, semi-liquid substance (known as 'paste', 'base' or simply 'meth').

Figure 5.3: Police detection of clandestine laboratories in SA, 1998 to 2004



Source: South Australian Police

In 2004, however, there has been evidence from clandestine laboratory detection to show that production of the purer crystalline form of methamphetamine ('ice'), as well as MDMA (3, 4-methylenedioxymethylamphetamine *or* 'ecstasy'), is being undertaken locally.

The increase in number of clandestine laboratory detections since 1998 can not be wholly explained by an increased focus of policing on such activity, as many detections occur peripheral to other investigations. However, the decrease in the total number of clandestine laboratories detected, from 51 in 2003 to 34 in 2004, was affected by a legislative change that occurred in early 2004, requiring police to have more evidence in cases of 'manufacture' of a drug (SADC, 2004). Consequently, there were a number of laboratories detected in 2004 that were not prosecuted or recorded as such due to lack of evidence, contributing to the drop in numbers seen.

5.3 Purity

Tables 5.6 and 5.7 summarise the current purity of the three forms of methamphetamine and the changes in methamphetamine purity over the last six months, according to IDU. As shown in Table 5.6, there were some differences reported regarding the purity of the three different forms of methamphetamine in 2004, with the trend being an increase in purity from powder to base to crystal, as would be expected. Perceived purity of powder was mixed, but higher proportions reported medium or low purity, with a substantial proportion also reporting purity as fluctuating. For base, purity was reported as medium or high by the highest proportion of those able to answer (51% and 23%). Crystal was reported largely as high or medium purity (by 49% and 34%, respectively). The largest proportion of those able to answer for each type of methamphetamine reported that this purity had been stable in the last six months. However, substantial proportions also reported the purity of powder as fluctuating (20%), base as either fluctuating (28%) or increasing (23%), and crystal as equally either decreasing or increasing (20%), in that time.

Since 2003, there has been an overall slight increase in the perceived purity of all forms of methamphetamine. The proportion of IDU reporting purity of powder as high increased from 7% to 17%, with concomitant small decreases in the proportion reporting the purity of powder as low or fluctuating. For the base form, there was an increase in the proportion reporting purity as medium, with a concomitant decrease in the proportions reporting purity as low. In addition, the proportion of IDU reporting crystal as high increased from 40% to 49%. This overall increase in perceived purity of all forms of methamphetamine in 2004 to some extent reverses the decline in perceived purity that was reported in 2003 compared to 2002.

Table 5.6: Purity/strength of methamphetamine currently, 2003 & 2004

How pure would you say [powder/base/crystal] is at the moment?	Powder		Base		Crystal	
	% of IDU able to answer					
	2003 (n=42)	2004 (n=35)	*2003 (n=52)*	2004 (n=39)	*2003 (n=42)*	2004 (n=35)
high	*7*	17	*25*	23	*40*	49
medium	*33*	34	*44*	51	*33*	34
low	*33*	26	*21*	13	*12*	9
fluctuates	*27*	23	*10*	13	*14*	9

Source: IDRS IDU interviews

Table 5.7: Change in purity/strength of methamphetamine in last 6 months, 2003 & 2004

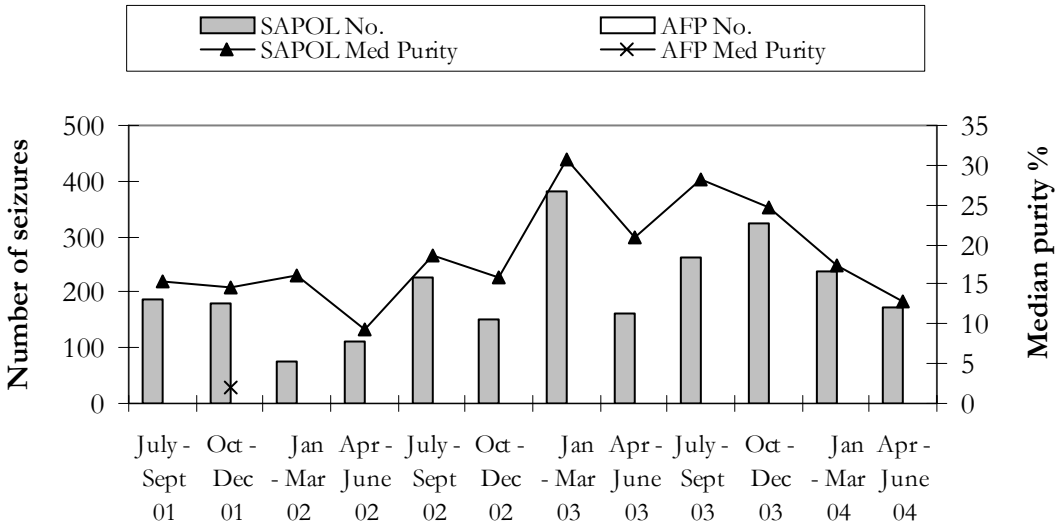
Has the purity of [powder/base/crystal] changed in the last 6 months?	Powder		Base		Crystal	
	% of IDU able to answer					
	2003 (n=42)	2004 (n=35)	*2003 (n=52)*	2004 (n=39)	*2003 (n=42)*	2004 (n=35)
don't know	*0*	14	*0*	3	*2*	9
increasing	*10*	6	*8*	23	*14*	20
stable	*26*	46	*52*	36	*52*	40
decreasing	*31*	14	*25*	10	*17*	20
fluctuating	*33*	20	*15*	28	*14*	11

Source: IDRS IDU interviews

There was little distinction of the different forms of methamphetamine when KES were asked to comment on purity. Four KES believed that the purity of methamphetamine fluctuated, two that it was low or "cut a lot", with three reporting that 'crystal meth' or 'pure' was high or higher purity, currently. Three KES reported purity had been fluctuating recently, two that it was stable and one that it had increased. This variability in KES comment reflects the variability seen in the reports from IDU regarding recent changes in methamphetamine purity.

The Australian Crime Commission (ACC) provided quarterly data on methamphetamine seized in SA during the last financial year 2003/2004 (ACC, *in press*). Figure 5.4 shows the number of seizures received and analysed by the state forensic laboratory (within the quarter depicted) and the median purity per quarter of those seizures, from 2001/02 to 2003/04. The total number of SAPOL methamphetamine seizures analysed for July03 to June04 was 992 and the median purity was 19.8%. The majority of seizures analysed were less than or equal to 2 grams. Overall, the number of seizures and the median purity of methamphetamine seized by SAPOL in SA for the past two financial years has remained stable, with median purity of 21.5% in 2002/03 (n=921) and 19.8% in 2003/04 (n=992), an increase from 15% in 2001/02 (n=551). However, there was a decline in median purity over the last three quarters of 2003/04, which may indicate the start of a downward trend. Only one methamphetamine seizure by the Australian Federal Police was analysed across this timeframe, in 2001/2002.

Figure 5.4: Number of methamphetamine seizures analysed and median methamphetamine purity in SA 2001/2002 – 2003/2004



Source: Australian Crime Commission

5.4 Use

5.4.1 Methamphetamine use among IDU

Fifty-three percent of IDU reported amphetamine as the first drug ever injected, 34% nominated methamphetamine as their drug of choice, 39% reported methamphetamine as the drug most often injected in the last month, and 40% reported methamphetamine

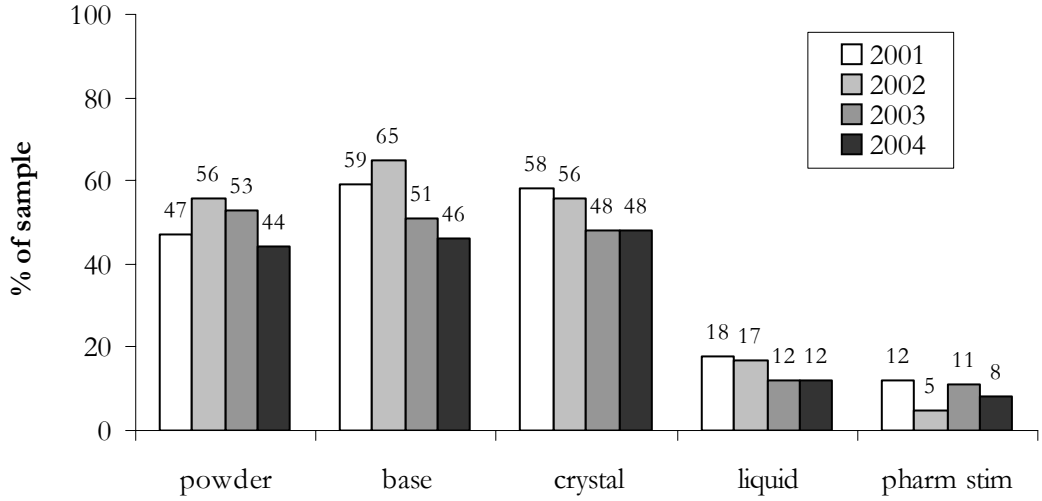
was the last drug they injected (see Table 3.2). Recent methamphetamine users were more likely to be male than recent heroin users (75% v 56%).

5.4.2 Current patterns of methamphetamine use

In 2004, between 44% and 48% of the participating IDU reported use of the three main forms of methamphetamine in the six months prior to interview, most of whom reported having done so primarily by injecting (see Table 3.3). Specifically, in the last six months, 44% of IDU reported use of powder methamphetamine a median of 5 days (range 1 - 90), 46% reported use of base methamphetamine a median of 6 days (range 1 - 155), and 48% of IDU reported use of crystal methamphetamine a median of 6 days (range 1 – 180). In addition, 12% of IDU (12%) reported use of liquid methamphetamine a median of 2 days (range 1 – 48) and 8% reported use of pharmaceutical stimulants (such as dexamphetamine) a median of 4.5 days (range 1 – 8), in the last six months.

Compared to 2003, the proportions of the IDU sample reporting use of both the powder and base forms, but not the crystal form, of methamphetamine had decreased, from 53% to 44% and from 51% to 46%, respectively (see Figure 5.5). Although these decreases were small, 2004 was the third year in a row that these proportions had declined.

Figure 5.5: Methamphetamine – % of IDU that used in the last 6 months, 2001 - 2004



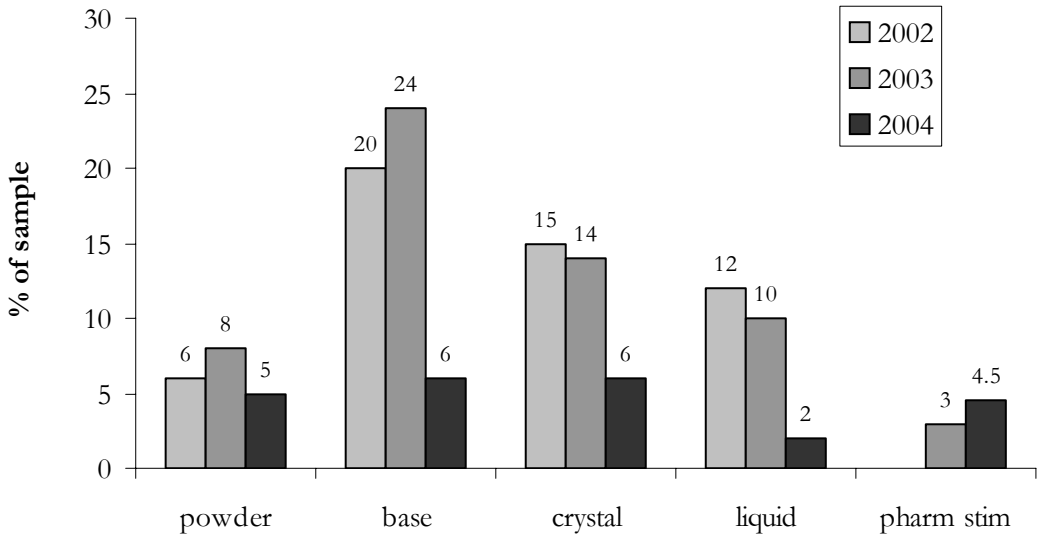
Source: IDRS IDU interviews

Note: 2001 was the first year to collect data on % IDU to have used each of the separate powder, base, crystal and liquid forms, and pharmaceutical stimulants.

More substantial and significant was the decrease in the reported frequency of use (as measured by median number of days used) of either powder, base or crystal forms of methamphetamine in 2004 compared to 2003 (see Figure 5.6). The largest decrease was seen in the median number of days use of base methamphetamine, from 24 to 6, among those reporting recent use of base. A large decline was also seen for the median number of days crystal methamphetamine was used (from 14 to 6), among those reporting recent use of crystal. The decline in the median number of days use of the powder form was smaller (from 8 to 5), but recent use of this form is generally lower than for base or

crystal among IDU anyway. There was also a decrease in the frequency of use of liquid methamphetamine, and a small increase in frequency of use of any pharmaceutical stimulants (eg. dexamphetamine), but the percentages of IDU reporting recent use of these forms was small.

Figure 5.6: Methamphetamine – median number of days used in the last 6 months*, 2002 - 2004



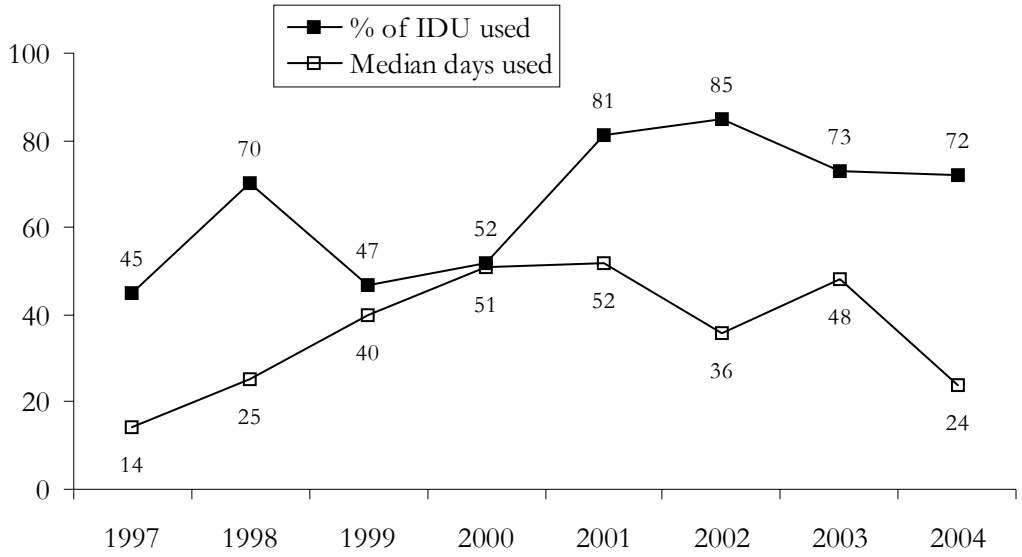
Source: IDRS IDU interviews

* used by those IDU that reported use of each form in the last 6 months

Note: 2002 was the first year to collect data on number of days used for the separate powder, base, crystal and liquid forms, and 2003 was the first year to collect data on number of days used pharmaceutical stimulants.

Overall, in 2004, 71% of the IDU sample had used some form of methamphetamine (powder, base, crystal, liquid or pharmaceutical stimulants) for a median of 24 days (range 1 – 180) in the six months prior to interview. This compares with 73% of IDU reporting use of some form of methamphetamine a median of 48 days (range 1 – 180), in 2003. The long-term trend in these parameters of use are depicted in Figure 5.7 and show a plateau in the prevalence and frequency of recent use of methamphetamine over the last few years, with a marked decline in frequency of use in the last year.

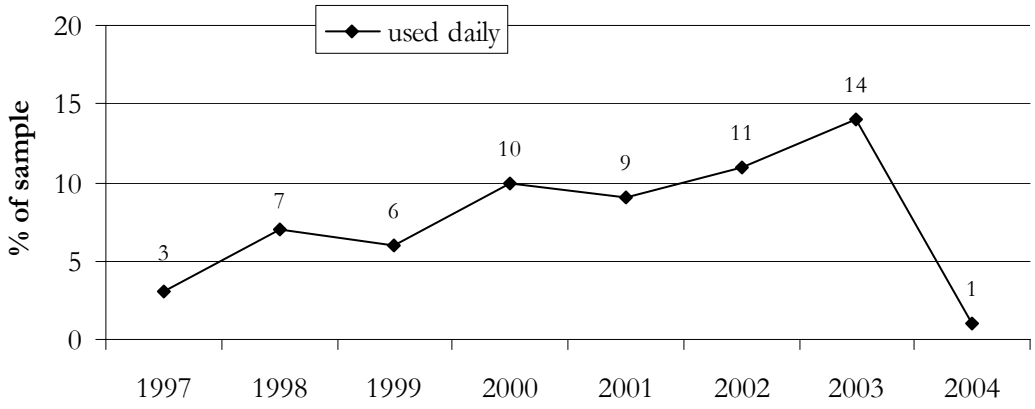
Figure 5.7: Methamphetamine – Recent* use & Median number of days used[#], 1997 – 2004**



Source: IDRS IDU interviews
* in the previous 6 months; # by those reporting use in the previous six months
** from 1997 to 2001 refers to reported use of any amphetamine/methamphetamine; from 2002 refers to collapsed reported use of powder, base, crystal and liquid forms, and pharmaceutical stimulants (2003 & 2004 only).

Of the 72 IDU that reported using some form of methamphetamine in the last six months, only one reported daily use (of the crystal form) during that period. Compared to 2003, there was a substantial decrease in the proportion of methamphetamine users reporting daily use of any methamphetamine (from 14%). In 2003, seven methamphetamine users reported use of base, and six use of crystal, on a daily basis. The long-term trend for percent of IDU using some form of methamphetamine daily is depicted in Figure 5.8, and shows a small but steady increase in this parameter over past years, until the drop in 2004.

Figure 5.8: Methamphetamine - % of IDU that used daily in the last 6 months, 1997 - 2003



Source: IDRS IDU interviews

As would be expected of a primarily injecting drug user sample, over 80% of the IDU using each form of methamphetamine reported having done so by injecting in the last six months (more so for base and crystal forms). From 1% to 14% of methamphetamine users had used each form of the drug by swallowing in the last six months, with fewer reporting use by snorting or smoking in that time (see Table 3.3). The exception to this was pharmaceutical stimulants, which were mainly used orally.

Of the 34 IDU reporting methamphetamine as their drug of choice, all but one had used some form of methamphetamine in the last 6 months, 11 (32%) had used morphine and 8 (24%) had used heroin during that period. Seventy-one percent (n=51) of IDU reporting use of *any* methamphetamine in the last six months also reported use of *any* opioid substance during that period.

Approximately equal proportions of methamphetamine users reported base (36%) or crystal (34%) as the form they had *used most* in the last six months, closely followed by powder (29%). One percent of IDU nominated pharmaceutical stimulants as the form they had *used most* in that period. Compared to 2003 there was a larger proportion of IDU reporting powder methamphetamine as the form they had *used most* in the preceding six months (29% v 17%).

As shown in Table 5.8, around 30% of methamphetamine users (compared to over 40% in 2003) injected any drug once a day or more in the last one month. No differences were seen in the frequency of injecting among users of the three different forms of methamphetamine. Compared to 2003, injecting frequency (of any drug) in the month preceding interview has shifted considerably toward a decrease in frequency among users of all forms of methamphetamine. The main difference between the two years was an increase in the proportion of the samples reporting injecting of any drug on a weekly or less basis, and concomitant decreases in the proportions reporting injecting more than once a day.

Table 5.8: Frequency of injecting among methamphetamine users, 2004

Frequency of injecting in the last month	% of methamphetamine users		
	Powder (n=44)	Base (n=46)	Crystal (n=48)
Weekly or less	30	37	27
More than weekly, less than daily	39	37	44
Once a day	9	9	10
2 to 3 times a day	18	13	13
More than 3 times a day	5	4	6

Source: IDRS IDU interviews

KES provided a lot of information on the forms of methamphetamine available in SA. There was consensus among KES that there was no real clarity in the various names of methamphetamine and the different forms of methamphetamine. That is, the terms "speed", "whiz", "meth" and "crystal meth" would be used interchangeably by users and could refer to any and all forms of methamphetamine. The term that was an exception to this was "ice" which was generally only used to refer to the pure crystalline form and generally applied to what was perceived as an imported (from overseas) product. The majority of KES also reported that there was substantial variability in what the various forms looked like – from powders to liquid to watery/gluggy/waxy/crystalline pastes to small rock-like opaque crystals to clear ice-like crystals – and it was noted by several that

the users had given up trying to distinguish the physical forms, instead seeking a particular desired effect or simply obtaining whatever was available to them from their usual source. There was consensus among KES that the majority of what was available was the base or paste form and that it was often the product of an unsophisticated manufacturing process. Two KES reported that there was "a lot" of "pure" or "neat" (i.e. uncut) product getting around that was relatively high purity, and that crystal was being produced locally. Several KES reported that there was some "ice" around but it generally wasn't common and that availability was variable. One commented that they thought users did not like 'ice' - they believed there was other comparably strong forms of methamphetamine available in Adelaide at a cheaper price.

KES also confirmed IDU reports that prevalence of smoking as a route of administration of methamphetamine was low in this group. Several KES mentioned that users would swallow if they were having problems with injecting (eg. collapsed veins).

Contrary to IDU survey data, the majority of KES reported no changes in the frequency of use of methamphetamine by the IDU they had come in contact with over the last year. A couple commented that some users they knew had "backed-off" their use temporarily when they realised it was causing them problems, or when they had noticed others in their peer group having problems. Others, though, reported the users they had contact with would use "as often as they can" and may only be restricted by lack of finances. Several KES reported that cycles of binge use were common, with users using methamphetamine daily for up to weeks at a time, and then having a break from use before repeating the cycle. Only two treatment service KES reported that they had very recently noticed a decline in the number of clients attending their services with amphetamine-related problems, suggesting a decrease in use in the IDU community.

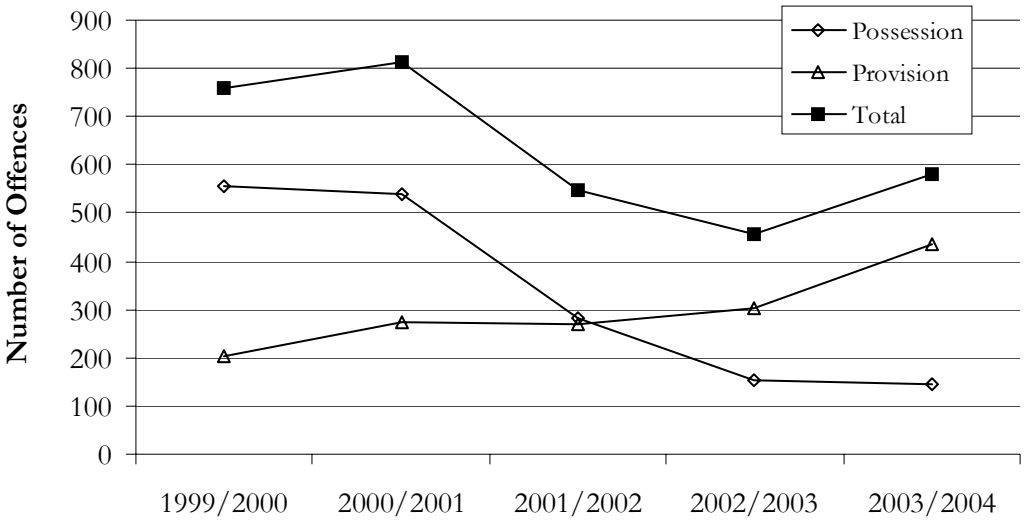
5.5 Methamphetamine related harms

5.5.1 Law enforcement

Figure 5.9 presents the number of amphetamine possession/use and provision (incorporating import/export drugs, sell/trade drugs, produce/manufacture drugs categories) offences reported or becoming known to police from 1999/2000 to 2003/2004 (SAPOL Annual Reports, 2000-2004). The total number of possession and provision offences for 2003/2004 period was 2985, which continues a decline seen over the last couple of years (3131 in 2002/2003, 3673 in 2001/2002 and 3864 in 2000/2001). This decline in total numbers was primarily due to a decline in 'possession/use' offences, which would have been impacted by the introduction of the Police Drug Diversion Initiative in 2001.

As can be seen in Figure 5.9, the number of amphetamine possession offences remained stable, but there was an increase in provision offences for amphetamines, from 2002/2003 to 2003/2004. Amphetamine possession and provision offences made up 19.5% of the total number of drug possession and provision offences in 2003/2004, an increase from 14.6% in 2002/2003.

Figure 5.9: Number of amphetamine related offences reported by SAPOL in South Australia, 1999/2001 – 2003/2004



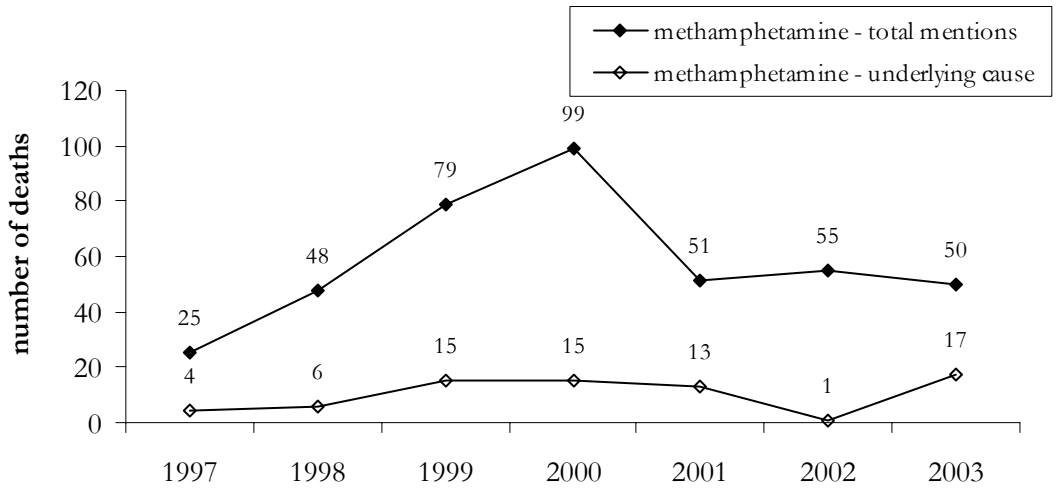
Source: South Australian Police Annual Reports (2000-2001 to 2003-2004)

5.5.2 Health

Methamphetamine-related deaths

Degenhardt, Roxburgh and Black (2004b) investigated Australian Bureau of Statistics data in relation to the number of accidental drug-induced deaths in which methamphetamine and cocaine were mentioned. This includes deaths where methamphetamine was determined to be either the underlying cause - the *primary* factor responsible for the person's death - as well as where methamphetamine was noted but another drug was thought to be primarily responsible for the death *(mentions)*. The *underlying cause* data are a subset of the *total mentions* data. National data regarding methamphetamine related deaths, 1997 to 2003, are presented in Figure 5.10.

Figure 5.10: Number of accidental drug-induced deaths mentioning methamphetamine among those aged 15-54 years in Australia, 1997-2003



Source: Australian Bureau of Statistics morbidity database (Degenhardt et al, 2004b)

The total number of deaths Australia-wide in which methamphetamine was mentioned has remained relatively stable from 2001 to 2003. Of the fifty drug-induced deaths that mentioned methamphetamine in 2003, over half occurred in New South Wales (n=27), nine in Western Australia and eight in Victoria. Unfortunately, South Australian specific data were unavailable. Seventeen deaths were recorded as having methamphetamine as the underlying cause of death in 2003, an increase compared to 2002 (one death).

Treatment Services - ADIS

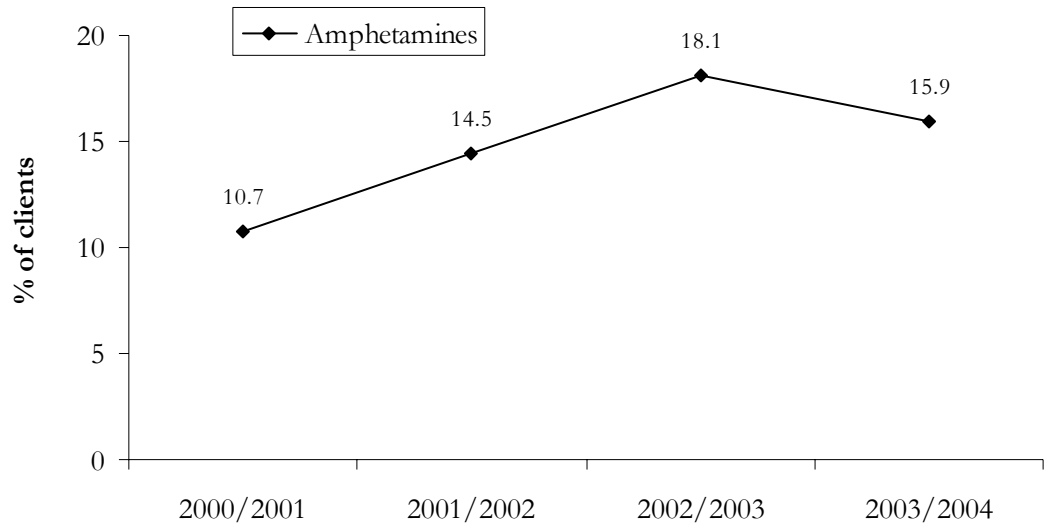
Telephone calls to the SA Alcohol and Drug Information Service (ADIS) regarding amphetamines accounted for 12% of the total coded telephone contacts (drug-related) in the 2003/2004 financial year (n=13,336), a similar proportion as for 2002/2003 (11.6% of a total 13,825) and 2001/2002 (11.7% of a total 12,538). Figure 4.10 (page 29) depicts the number of amphetamine related calls per quarter for the last two financial years compared to calls related to other drug types.

Treatment Services - DASC

Readers are reminded that a new data system, the Client Management Engine-DASC Information System (CME-DIS) was introduced in July 2002, which may have impacted on the data trends, therefore, readers are advised to treat any interpretation cautiously.

Presentations to all treatment services of DASC are presented in Table 4.10 (page 30) and show that the proportion of clients nominating amphetamine as their primary drug of concern has decreased in 2003/2003, compared to 2002/2003 (from 18.1% to 15.9%)(Figure 5.11). This follows two consecutive years of increase in the proportion of clients nominating amphetamine as their primary drug of concern. In 2003/2004 amphetamines remained the third most commonly nominated primary drug of concern by clients of DASC, after alcohol and heroin.

Figure 5.11: Percentage of DASC presentations with amphetamines as the primary drug of concern, 2000/01 – 2003/04*

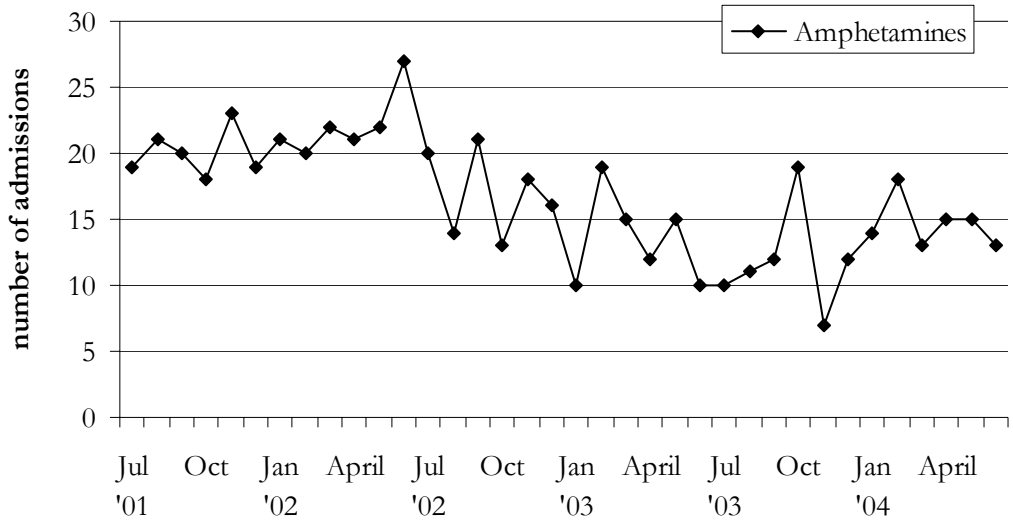


Source: Drug and Alcohol Services Council

* During 2002/2003 a new data collection system was employed to meet the requirements of the National Minimum Data Set for Alcohol and Other Drug Treatment Services (NMDS-AODTS).

Figure 5.12 presents the number of admissions to DASC inpatient detoxification treatment services for amphetamines during the period July 2001 to June 2004. The number of inpatient admissions where amphetamines were the primary drug of concern declined for the third year in a row in 2003/2004, albeit not as steeply as previous years. There were 159 admissions to inpatient detox services in 2003/2004 compared to 182 in 2002/2003 and 253 in 2001/2002. While inpatient admissions with amphetamines as the primary illicit drug of concern outnumbered heroin (alone) admissions in 2003/2004, they were outnumbered by admissions for heroin and other opioid substances combined (see also page 30).

Figure 5.12: Number of admissions to DASC inpatient treatment services, with amphetamines as the primary drug of concern, Jul 2001 – Jun 2004*

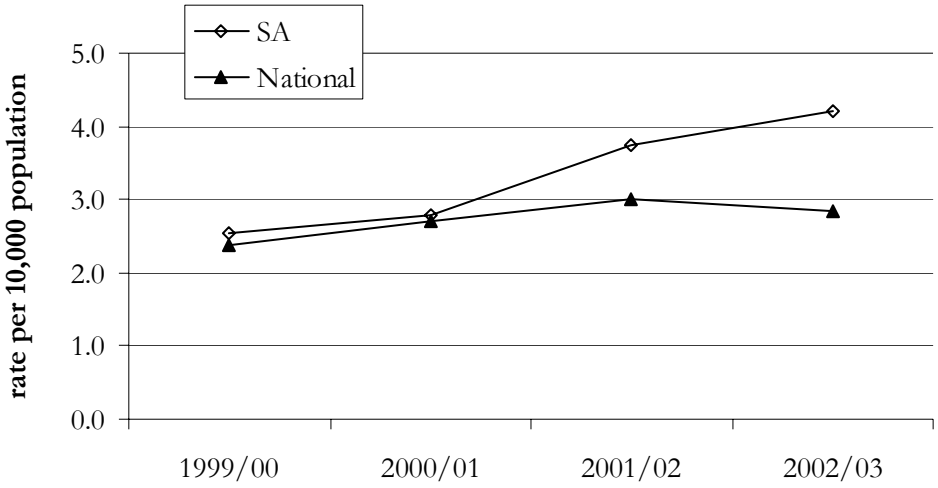


Source: Drug and Alcohol Services Council
* During 2002/2003 a new data collection system was employed to meet the requirements of the National Minimum Data Set for Alcohol and Other Drug Treatment Services (NMDS-AODTS).

Amphetamine-related Hospital Admissions

Data up to the end of the 2002/2003 financial year was provided by the Australian Institute of Health and Welfare from the National Hospital Morbidity Dataset. This data reports on both state specific and national drug-related hospital admissions, according to ICD-10 classification. See Appendix – Figure A for a comparison of substance-related admissions (primary diagnosis) to SA hospitals from 1999/00 to 2002/03. Figure 5.13 shows both the SA and national rate of admissions to hospital for amphetamines (primary diagnosis) per year for the same period. The SA rate shows a continual steady increase from 1999/00 to 2002/03, but the national rate shows a slight decline from 2001/02 to 2002/03. The total number of admissions to SA hospitals with a primary diagnosis involving amphetamines was 356 in 2002/03 compared to 215 in 1999/00.

Figure 5.13: Rate of amphetamine-related admissions* (primary diagnosis) to hospital in South Australia, compared to nationally, by financial year totals, July 1999 to June 2003



Source: Australian Institute of Health and Welfare
* for persons aged between 15 and 54 years
Note: A 'primary diagnosis' was given when amphetamines were considered chiefly responsible for the patient's episode of care in hospital

Emergency Department admissions

Information on drug-related attendances to the Emergency Department was also obtained from the Royal Adelaide Hospital (RAH), the largest central public hospital in Adelaide, and is presented in Table 4.11 (page 33). It can be seen that attendances regarding amphetamines have fluctuated somewhat across the years depicted and no real trend is apparent. However, if the diagnosis 'drug-induced psychosis' (which includes amphetamine-induced psychosis) is examined, it can be seen that a gradual decline in numbers has been recorded since the peak that occurred in 2001/2002.

5.6 Trends in methamphetamine use

When asked about recent general trends in drug use, the overwhelming majority of IDU commenting held the view that more, and younger, people were using 'speed', and that they were doing so more frequently and in larger quantities. Most did not differentiate between the different forms of methamphetamine, but several commented that this increased used referred to all forms, while several others specifically stated that there was increased use of base or crystal/'ice'. Several IDU commented that they had noticed either less 'speed' or 'crystal meth' use among their peers (n=2), less amphetamine use generally (n=1), or less drug use generally among friends (n=2) or the wider community (n=2), but these IDU were in the minority.

One KES commented that methamphetamine using clients of a large southern area CNP outnumbered heroin/opiate using clients three to one and no change in the number of methamphetamine using clients had occurred recently – indicating no change in prevalence or frequency of use in this community.

KES reports and IDU comments on general trends, in the main, did not support the IDU survey results showing a decline in frequency of use of methamphetamines among this group of users.

5.7 Summary of methamphetamine trends

Table 5.9 contains a summary of trends in the price, purity, availability and use of methamphetamine in the previous 12 months. Overall there have been decreases in the price of all three forms of methamphetamine from 2003 to 2004. In contrast to 2003, there was little difference in the median price paid for a 'point' of all three forms of methamphetamine in 2004. The median price of a gram of powder remains considerably cheaper than either base or crystal. Again it was noticeable in 2004 that there were wide ranges in reported prices paid, particularly of a gram, across all types of methamphetamine. IDU reported the price of all forms of methamphetamine as stable. KES reports are in agreement with IDU information on price.

In 2004, all forms of methamphetamine were reported as 'easy' or 'very easy' to obtain by the majority of IDU able to comment, and base methamphetamine was considered easiest to obtain, followed by powder and crystal. The majority also reported that availability of all forms had recently been stable or getting easier. Availability was largely unchanged compared to 2003, except for a perceived increase in availability of base methamphetamine. The majority of KES also reported availability as 'easy ' or 'very easy' and stable. There was a decline in the proportion of IDU reporting that they usually obtained powder and base methamphetamine from mobile dealers, and a rise in the proportion scoring from dealer's homes.

Since 2003, there has been an overall slight increase in the perceived purity of all forms of methamphetamine. Purity of all forms was considered largely stable, but perceptions were somewhat equivocal with substantial proportions reporting change or fluctuation in purity recently. However, the base and crystal forms were still perceived as high or medium purity by the majority of those IDU able to comment. Overall, SAPOL seizure data indicates that the median purity of methamphetamine has remained stable, with median purity of 19.8% in 2003/04. However, there was a decline in median purity over the last three quarters of 2003/04, which may indicate the start of a downward trend.

The proportion of IDU reporting recent use of any methamphetamine remained stable, but large decreases were seen in the frequency of use of base and crystal methamphetamine. There was only limited support of decreased use of methamphetamine among IDU from KES reports.

SAPOL data revealed an increase in methamphetamine related provision offences, but the number of possession/use offences remained stable compared to 2003. There was also evidence from SAPOL data on clandestine laboratory detections that local manufacture of methamphetamine was still a major contributor to the SA methamphetamine market.

Nationally, the number of accidental deaths with methamphetamine as the underlying cause increased in 2003 compared to 2002, according to ABS data. Calls to ADIS in SA regarding methamphetamine remained stable, but there was a decrease in both total admissions to DASC treatment services and to DASC's inpatient (detox) services with methamphetamine as the primary drug of concern. State (SA) hospital admissions data showed the number of amphetamine-related admissions was continuing to increase (as at 2002/03), though national data showed a slight decline in numbers from 2001/02 to 2002/03. SA (RAH) emergency data attendances for amphetamines may suggest a decline in the number of amphetamine-induced psychosis

Table 5.9: Trends in the price, availability, purity and use of methamphetamine

Price	
Powder (point)	$27.50 ($20-$50); unchanged since 2003
(gram)	$50 ($40-$200); decreased since 2003 currently stable
Base (point)	$25 ($18-$50); decreased since 2003
(gram)	$180 ($10-$220); decreased since 2003 currently stable
Crystal (point)	$30 ($20-$50); decreased since 2003
(gram)	$190 ($10-$400); decreased since 2003 currently stable
Availability	Very easy to easy for all forms; stable to easier for all forms. Decline in the proportion scoring from mobile dealers, and rise in the proportion scoring from dealer's homes (powder & base) (IDU).
Purity	19.8% (ACC); stable to decreasing? Small increase in perceived purity of all forms (IDU). Powder: medium to low; stable or fluctuating. Base: medium to high; mainly stable but recent change somewhat equivocal. Crystal: high to medium; mainly stable but recent change somewhat equivocal.
Use	% reporting recent use of any methamphetamine remained stable. Decrease in % using daily. Decrease in median days used all forms.(IDU) Limited support of decreased use from KES.
Other indicators	Amphetamine possession/use offences stable; provision offences increased (SAPOL). Accidental deaths where methamphetamine was the *underlying cause* increased nationally in 2003 compared to 2002, but *total mentions* remained stable (ABS). No change in amphetamine -related calls to ADIS (ADIS). Decrease in both total admissions to DASC treatment services and inpatient (detox) services (DASC). 2002/03 data showed amphetamine-related hospital admissions in SA continued to rise, though national numbers declined (AIHW).

6. COCAINE

Historically, relatively small numbers of IDU IDRS participants have been able to provide information with regard to the cocaine market in Adelaide. Similar to 2003, only a very small number of IDU (n=5) were able to supply information regarding the price, purity or availability of cocaine, which was reflective of the very low numbers of IDU that had used cocaine in the last six months (a total of 6, compared to 15 in 2003). In addition, eight KES were able to provide some information on cocaine, all as peripheral to their main interview. Despite efforts, no KES who could nominate cocaine as the main drug used by the users they had contact with, or who could nominate cocaine as their main area of expertise, were identified in Adelaide. Consequently, the data for price, purity and availability of cocaine in 2004 is of limited value and the following information should be viewed with caution.

6.1 Price

In 2004, the *current* price of cocaine was estimated by the IDU to be a median of $225 per gram (range $180 – 350, n = 4). Only three IDU were able to provide information on the price of cocaine *at last purchase*. One reported having paid $200 for a gram and $650 for 4 grams *at last purchase* of each amount. A second reported having paid $180 for a gram, and a third, $50 per 'cap'. Although these parameters of price are somewhat lower than those reported in 2003, the sample sizes in both years were too small to allow any conclusions to be drawn. In 2004, four IDU reported that the price of cocaine had remained stable over the last six months. Two KES provided information on price; one stating cocaine cost approximately $300 per gram, the other that it had recently only been available as 2 gram amounts at $500.

6.2 Availability

Four IDU were able to provide information on current ease of access to cocaine in 2004: three reported cocaine was 'easy' or 'very easy' to obtain and one reported it was difficult to obtain, in the last six months. All four IDU stated availability had been stable during that period.

Of the five IDU able to comment on cocaine price, purity and availability parameters, four reported they usually sourced cocaine from a friend, and that it took a median 70 minutes to obtain (range "immediately" to one day). The remaining one IDU reported they were not a recent user of cocaine and therefore had not sourced it in the last six months. Three KES commented that there was "not much around", and that cocaine fluctuated in availability even for those who had access to it, while another reported that there had briefly been a small amount available in Adelaide in 2004. One user representative KES said that they have contact with a group that had "no problem getting it". Law enforcement KES reported few seizures of cocaine had been made in 2004.

Given the small sample sizes for this section in this and the previous year, no clear inference regarding trends in availability can be made. It may be that the small (and decreasing) number of IDU able to provide information is an indication of the decreasing availability of cocaine to the IDU population in particular, and to the Adelaide

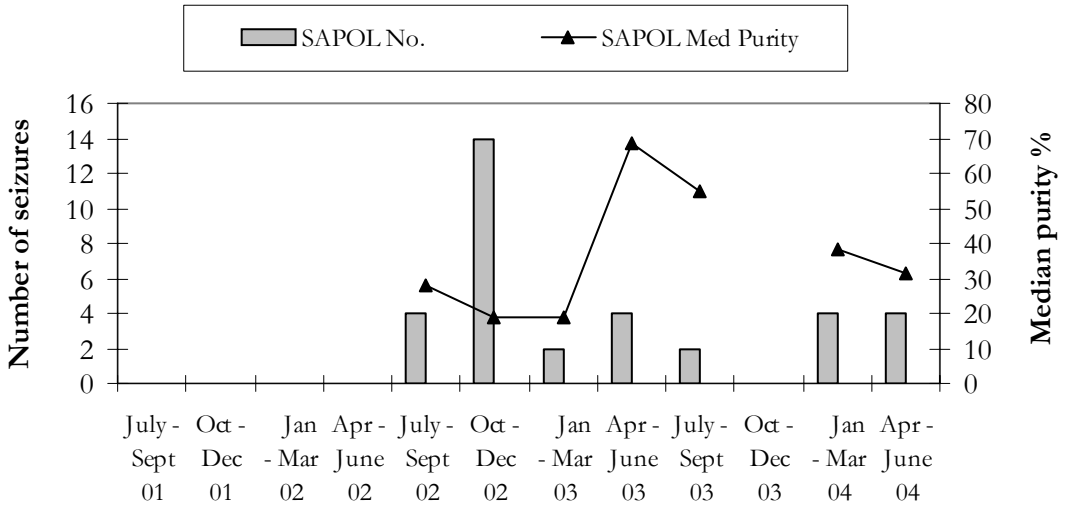
market in general, but this does not exclude the possibility that a cocaine market exists beyond the scope of this survey.

6.3 Purity

Of the five IDU able to provide information on the current purity of cocaine in 2004, three perceived the purity as high and two perceived it as low. Two IDU reported that the purity of cocaine was increasing, one that it had remained stable, and one that it was fluctuating, during the past six months. The remaining one IDU was unable to comment on recent changes in purity.

The Australian Crime Commission (ACC) provided quarterly data on methamphetamine seized in SA during the last financial year 2003/2004 (ACC, *in press*). Figure 6.1 shows the number of seizures received and analysed by the state forensic laboratory (within the quarter depicted) and the median purity per quarter of those seizures, from 2001/02 to 2003/04. There were very few seizures by SAPOL and none recorded by the AFP for the time period depicted. The total number of SAPOL methamphetamine seizures analysed for July03 to June04 was 10 and the median purity was 38.5%. The small number of seizures and the lack of comparable data from previous years makes meaningful analysis impossible.

Figure 6.1: Number of cocaine seizures analysed and median cocaine purity in SA 2001/2002 – 2003/2004



Source: Australian Crime Commission

6.4 Use

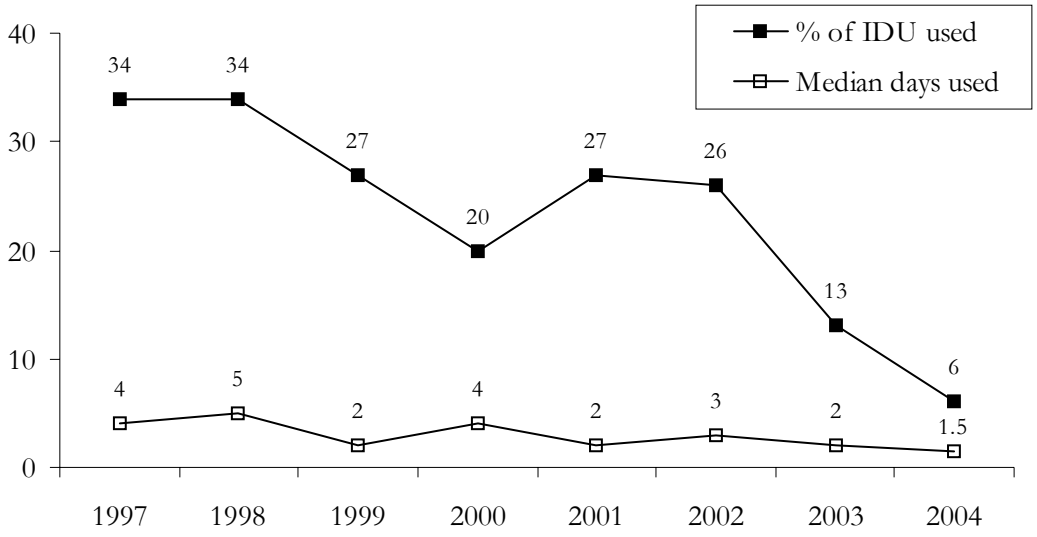
6.4.1 Cocaine use among IDU

In 2004, only two of the participating IDU nominated cocaine as their drug of choice and one reported cocaine as the first drug ever injected or as the drug most often injected in the last month. None reported cocaine as the last drug they injected. However, 60% of IDU reported they had used cocaine in their lifetime, and 41% reported they had injected cocaine in their lifetime.

6.4.2 Current patterns of cocaine use

Only six (6%) of the IDU sample reported using cocaine a median of 1.5 days (range 1 - 25) in the last six months, four of whom had injected cocaine in that time. Compared to previous years, there was a marked decrease in the proportion of the IDU sample that had used cocaine in the last six months (from 13% in 2003 and 26% in 2002), and the median number of days cocaine was used was consistently low. Indeed, the proportion of the sample that had used cocaine continued a steep downward trend (most notably since 2002) and was lower in 2004 than any previous IDRS survey, while the long-term trend for median number of days used has been relatively stable but also at the lowest point in 2004 (see Figure 6.2).

Figure 6.2: Cocaine – Recent* use & Median number of days used#, 1997 - 2004



Source: IDRS IDU interviews
* in the previous 6 months; # by those reporting use in the previous six months

Of the six IDU that reported use of cocaine in the last six months, five reported cocaine powder was the form they had used most during that time *(data missing for one participant)*. One IDU reported having used crack cocaine in the last six months. The limited information provided by KES in 2004 suggests that there are two distinct (but perhaps not exclusive) groups that have access to and use cocaine in Adelaide. One user group was reported as being high-income earners, "go-getters" who "have access to things of better quality, including drugs", and who have had no contact with the criminal justice system. It was also reported that some, but not all, in this group would use by injecting. The other user group was reported to be "upper level bikies and prostitutes", with one KES commenting that cocaine use was common within this group. The consensus seemed to be that the cocaine market was very exclusive and not widespread in Adelaide.

6.5 Cocaine related harms

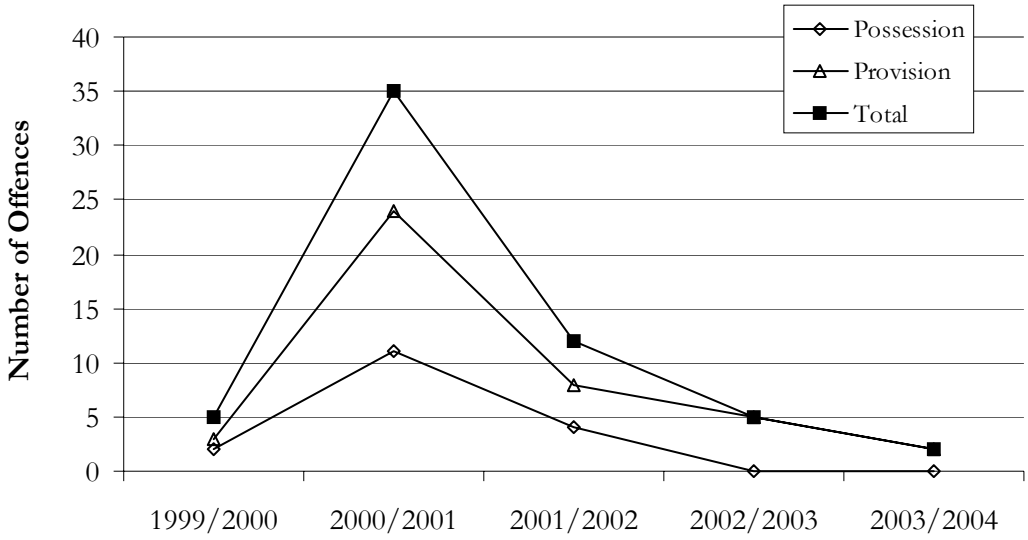
6.5.1 Law enforcement

Figure 6.3 presents the number of cocaine possession/use and provision (incorporating import/export drugs, sell/trade drugs, produce/manufacture drugs categories) offences

reported or becoming known to police from 1999/2000 to 2003/2004 (SAPOL Annual Reports, 2000-2004). The total number of possession and provision offences for 2003/2004 period was 2985, which continues a decline seen over the last couple of years (3131 in 2002/2003, 3673 in 2001/2002 and 3864 in 2000/2001). This decline in total numbers was primarily due to a decline in 'possession/use' offences, which would have been impacted by the introduction of the Police Drug Diversion Initiative in 2001.

As can be seen in Figure 6.3, the number of cocaine possession offences remained at zero, and the number of provision offences for cocaine remained low, from 2002/2003 to 2003/2004. Cocaine possession and provision offences made up less than 0.1 % of the total number of drug possession and provision offences in 2003/2004, continuing a decline from the 'spike' of 0.9% (n=35) in 2000/2001.

Figure 6.3: Number of cocaine related offences reported by SAPOL in South Australia, 1999/2001 – 2003/2004

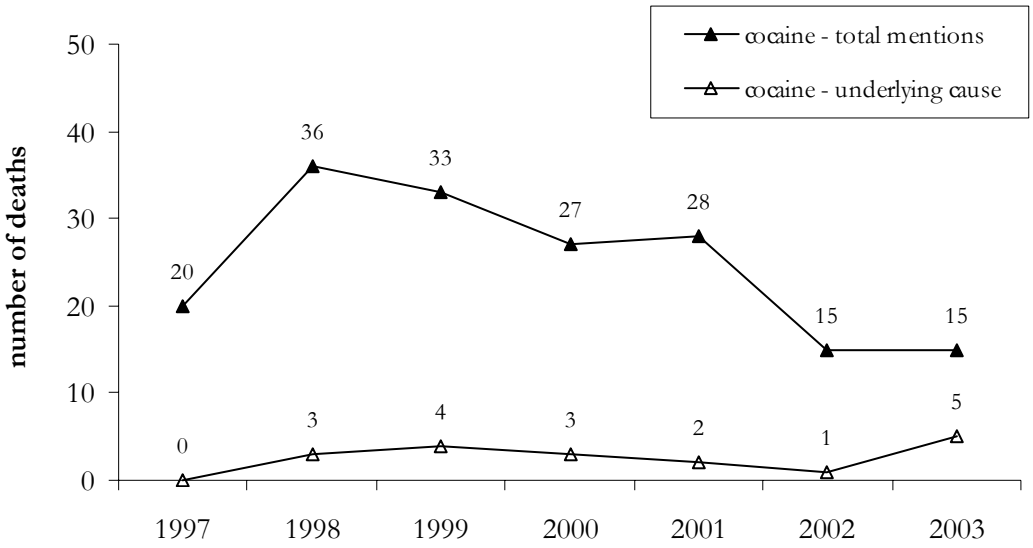


Source: South Australian Police Annual Reports (2000-2001 to 2003-2004)

6.5.2 Health

Degenhardt, Roxburgh and Black (2004b) investigated Australian Bureau of Statistics data in relation to the number of accidental drug-induced deaths in which methamphetamine and cocaine were mentioned. This includes deaths where cocaine was determined to be either the underlying cause - the *primary* factor responsible for the person's death - as well as where cocaine was noted but another drug was thought to be primarily responsible for the death *(mentions)*. The *underlying cause* data are a subset of the *total mentions* data. The cocaine data for the years 1997 to 2003 are presented in Figure 6.4.

Figure 6.4: Number of accidental drug-induced deaths mentioning cocaine among those aged 15-54 years in Australia, 1997-2003



Source: Australian Bureau of Statistics morbidity database

The total number of deaths Australia-wide in which cocaine was mentioned has remained stable from 2002 to 2003. All of the fifteen drug-induced deaths that mentioned cocaine in 2003 occurred in New South Wales. Five deaths were recorded as having cocaine as the underlying cause of death in 2003, the most recorded since 1997.

Treatment Services – ADIS

Telephone calls to the SA Alcohol and Drug Information Service (ADIS) regarding cocaine accounted for only 0.20% (n=27) of the total coded telephone contacts (drug related) in the 2003/2004 financial year, approximately the same proportion as in 2002/2003 (0.25%, n=35), but lower than the 0.4% seen in 2001/2002 (n=50). Figure 4.10 (page 29) depicts the number of cocaine related calls per quarter for the last financial year compared to calls related to other drug types.

Treatment Services – DASC

Readers are reminded that a new data system, the Client Management Engine-DASC Information System (CME-DIS) was introduced in July 2002, which may have impacted on the data trends, therefore, readers are advised to treat any interpretation cautiously.

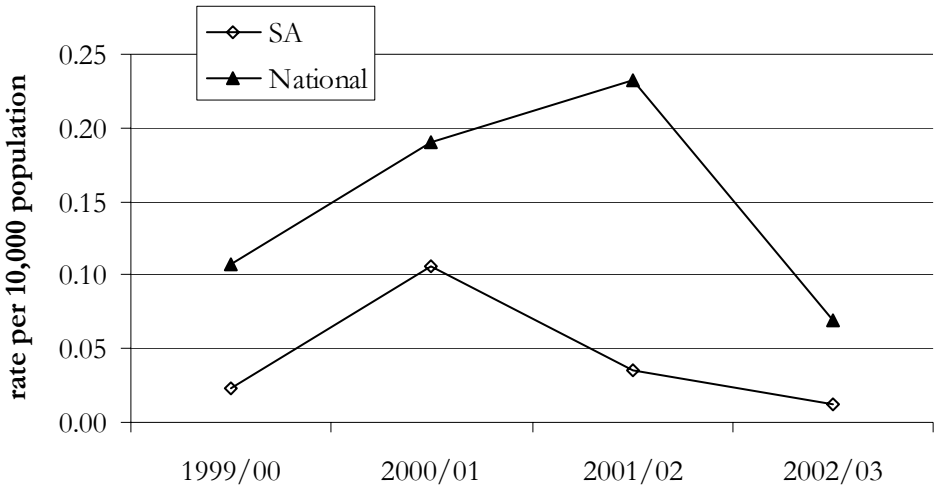
Presentations to all treatment services of the SA Drug and Alcohol Services Council (DASC) are presented in Table 4.10 (page 30) and show that the proportion of clients nominating cocaine as their primary drug of concern has remained stable and low across all years reported. In 2003/2004 only 0.2% of presentations to all DASC treatment services nominated cocaine as their primary drug of concern. There were only two admissions to DASC inpatient detoxification treatment services in 2003/2004, the same number as for 2002/2003.

Cocaine-related Hospital Admissions

Data up to the end of the 2002/2003 financial year was provided by the Australian Institute of Health and Welfare from the National Hospital Morbidity Dataset. This data reports on both state specific and national drug-related hospital admissions, according to ICD-10 classification. See Appendix – Figures A for a comparison of substance-related

admissions (primary diagnosis) to SA hospitals from 1999/00 to 2002/03. The pattern of the rate of admissions per population was somewhat different in SA compared to nationally. The rates of cocaine-related admissions (primary diagnosis) to hospitals in SA has declined following a peak in 2000/01, whereas nationally a sharper decline was seen following a sharper peak a year later, in 2001/02 (see Figure 6.5). In SA only very small numbers of admissions to hospital with a cocaine-related primary diagnosis were recorded over the time period depicted, with only one such admission in 2002/03.

Figure 6.5: Rate of cocaine-related admissions* (primary diagnosis) to hospital in South Australia, compared to nationally, by financial year totals, July 1999 to June 2003



Source: Australian Institute of Health and Welfare
* for persons aged between 15 and 54 years
Note: A 'primary diagnosis' was given when cocaine was considered chiefly responsible for the patient's episode of care in hospital

6.6 Trends in cocaine use

Several IDU reported the cost of cocaine as prohibitive and that 'crystal meth' offered a cheaper and longer-lasting alternative, with similar drug effects (increased energy and confidence etc).

6.7 Summary of cocaine trends

Similar to 2003, only a very small number of IDU were able to supply information regarding the price, purity or availability of cocaine, which was reflective of the very low numbers of IDU that had used cocaine in the last six months (a total of 6, compared to 15 in 2003). In addition, although several KES were able to provide some information on cocaine, this was limited and none could nominate cocaine as their main area of expertise. Consequently, the data for price, purity and availability of cocaine in 2004 is of limited value.

The small number of KES and IDU either using cocaine or able to provide information in itself indicates the lack of a sizeable and visible cocaine market in Adelaide, particularly amongst the IDU sampled by the IDRS. Indicator data, such as the number of cocaine possession and provision offences, calls to ADIS, DASC treatment services data for

cocaine, and SA hospital admissions data also support this presumption. However, this does not exclude the possibility that a cocaine market exists beyond the scope of this survey.

Due to the limited information available, a summary table of cocaine trends will not be presented and readers are again advised to view the results presented in this section with caution.

7. CANNABIS

Readers should note that in March 2003 the law in South Australia changed, introducing a prohibition on the growing (for personal use) of *any* hydroponically grown cannabis plants and restricting the number of 'outdoor' grown plants, allowable for 'personal use'.

To ensure more detailed information was collected on the different forms of cannabis, the cannabis section was separated, from 2003 onward, into 'hydro' (hydroponically grown) and 'bush' (grown outdoors). IDU were therefore asked to consider these two types of cannabis separately for all questions except 'perceived source' (Section 7.2).

The following sections refer to a 'bag' as a standard measure (particular to the South Australian cannabis market). A detailed investigation of the weight/content of a bag of cannabis was undertaken in 2002 (Longo *et al.*, 2003). Briefly, in the 2002 survey 33 IDU gave a single value of the average weight of cannabis bags sold in South Australia, with a median of 2 grams and a mean of 2.5 grams. A further 19 gave both a lower and upper weight range for cannabis bags. The median lower range was 2 grams (mean 2.1) and the median upper range was 3 grams (mean 2.9). It can be understood therefore, that the amount of cannabis in a 'bag' may fluctuate, but that a 'bag' in SA generally conveys a weight of cannabis between 2 and 3 grams.

7.1 Price

Almost 80% of the participating IDU were able to provide information regarding the price of cannabis in 2004. The *current* price of cannabis was estimated to be a median $200/ounce of hydro (range $170-350, n=58) or $200/ounce of bush (range $100-350, n=46) by IDU. These estimations were the same (for hydro) or similar (for bush) to the median prices *paid* by IDU for the different amounts of cannabis, *at last purchase*, as listed in Table 7.1.

There was very little difference in the reported prices of hydro compared to bush cannabis. The most common amount purchased in the last six months was a 'bag' and the reported median price *paid* by IDU *at last purchase* was $25, for either hydro or bush. The next most commonly reported purchase was of an ounce and there was a small difference in the median price *paid, at last purchase* for hydro ($200, n=28) compared to bush ($180, n=18). This difference in price between hydro and bush was not seen in the price *paid* for a half ounce of cannabis. Only one IDU reported buying a gram of 'hash' (cannabis resin) and two reported buying a cap of 'hash' oil, in the last six months, therefore no reliable data on the price of cannabis resin or oil is available. The prices reported for a half-ounce, ounce and 'bag' of cannabis are the same as reported by the IDRS IDU since 2002.

As occurred in 2003, in 2004 IDU provided more information on last purchase of hydro than of bush, indicating that IDU had purchased more hydro than bush in the last six months.

Table 7.1: Price of most recent cannabis purchases by IDU, 2003* and 2004

Amount bought	Median price paid, $ (range)		Number of IDU purchasers	
	hydro	bush	hydro	bush
'bag'	25 (20 - 25) *25* *(20 - 30)*	25 (20 - 25) *25* *(10 - 50)*	45 *64*	25 *46*
¼ ounce	60 (50 – 60) *50* *(50 - 110)*	# # *#*	7 *18*	# *#*
½ ounce	100 (100 – 120) *100* *(70 - 200)*	100 (50 – 120) *100* *(70 - 100)*	16 *27*	10 *12*
ounce	200 (100 - 280) *200* *(150 - 250)*	180 (100 - 250) *180* *(50 - 250)*	28 *33*	18 *19*

Source: IDRS IDU interviews

* 2003 data in italics, # n<5: not reported

The price of cannabis was reported as stable over the last six months by over 50% of IDU in 2004 (see Table 7.2). Compared to 2003, there was a decrease in the proportion reporting that cannabis price was fluctuating in the last six months (with an increase in the proportion that were unable to report on recent changes in price).

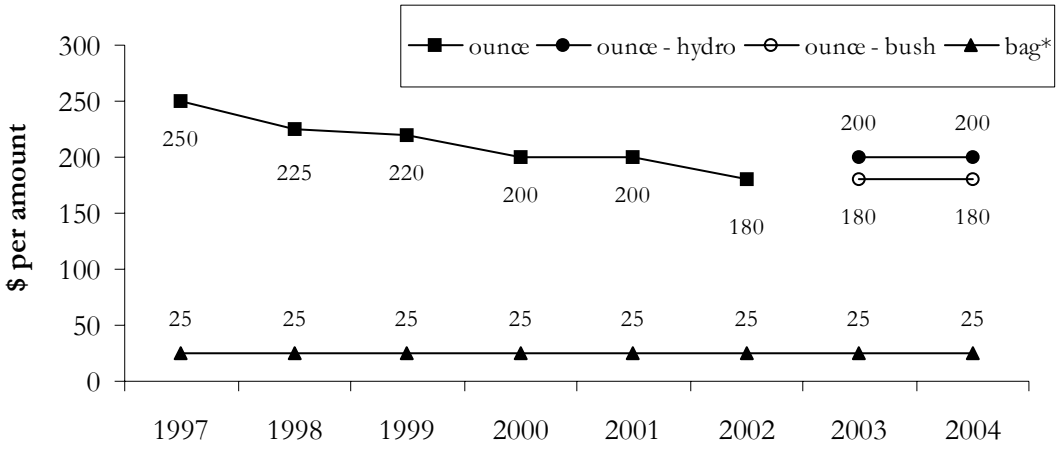
Table 7.2: Change in price of cannabis over the last 6 months, 2003 & 2004

Reported price status	% of IDU able to answer		
		2004	
	2003 (n=93)	hydro (n=79)	bush (n=69)
don't know	7	13	23
increasing	14	15	15
stable	59	62	58
decreasing	5	5	1
fluctuating	15	5	3

Source: IDRS IDU interviews

The long-term trend in the price of a 'bag' or an ounce of cannabis is depicted graphically in Figure 7.1. It can be seen that the price of these amounts of cannabis has remained very stable over the years, particularly since 2000.

Figure 7.1: Median price of a 'bag' or an ounce of cannabis, 1997 - 2004



Source: IDRS IDU interviews
* denotes either hydro or bush in 2003 or 2004

Similar to IDU, KES who commented reported no change in the price of cannabis over the last twelve months. Three KES (including law enforcement) commented that the changes in legislation (of 2003) had not seemed to have impacted on the market in SA as yet.

7.2 Availability

Tables 7.3 and 7.4 summarise the current availability of cannabis and the changes in cannabis availability over the last six months, according to IDU report. In 2004 the majority of IDU reported both types of cannabis as 'easy' or 'very easy' to obtain (83% for hydro and 78% for bush), with approximately two-thirds of those able to answer reporting availability of both types as stable in the last six months.

Table 7.3: Availability of cannabis currently, 2003 & 2004

How easy is it to get cannabis at the moment?	% of IDU able to answer		
	2003 (n=91)	2004	
		hydro (n=73)	bush (n=60)
very easy	35	47	37
easy	47	37	42
difficult	16	14	17
very difficult	1	3	5

Source: IDRS IDU interviews

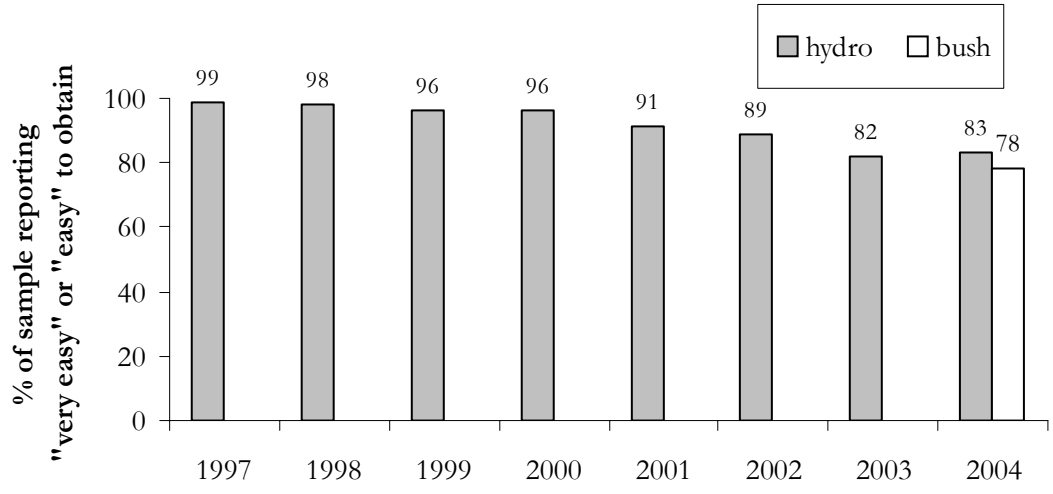
Table 7.4: Change in availability of cannabis over the last 6 months, 2003 & 2004

Has [availability] changed in the last 6 months?	% of IDU able to answer		
	2003 (n=91)	2004	
		hydro (n=73)	bush (n=60)
don't know	0	1	3
more difficult	27	15	18
stable	49	66	65
easier	13	10	5
fluctuates	10	8	8

Source: IDRS IDU interviews

Figure 7.2 shows the long-term trend in the proportion of IDU reporting availability of cannabis as 'easy' or 'very easy', since 1997. Despite a small but steady decline from 2000 to 2003, reported ease of obtainability remained steady in 2004 compared to the previous year. Overall, cannabis remains relatively easy to obtain in Adelaide with around 80% of IDU reporting no difficulty in obtaining the drug. Three KES (including law enforcement) commented that the changes in legislation (of 2003) had not seemed to have impacted on the availability of cannabis in SA. One KES however, commented that bush cannabis was very difficult to obtain in Adelaide and expensive, but this market was seasonal and it was generally available in May. Law enforcement KES also commented that bush was available seasonally, at the end of summer.

Figure 7.2: Availability of cannabis in the last six months, 1997 - 2004



Source: IDRS IDU interviews
Note: in 2004, availability of hydro and bush was asked separately

Table 7.5 presents information collected from IDU on the usual source and time taken to obtain the cannabis they had used recently. Similar to 2003, in 2004 the majority of IDU able to comment reported that they had *usually* obtained cannabis from a friend (55% for hydro, 59% for bush) in the six months prior to interview. A further 19% or 15% (hydro and bush, respectively) reported they had *usually* scored cannabis at a dealer's home and 11% reported they grew their own supply during that period (both hydro and bush). Very few reported having obtained either type of cannabis from any other source. The median time *usually* taken to score cannabis was 20 minutes (range: 1 minute to 1 day) for hydro and a slightly quicker 13 minutes (range: 1 minute to 6 hours) for bush.

Table 7.5: Usual method, and time taken, obtaining cannabis in the last 6 months, 2003 & 2004

Usual source *or* method of obtainment	% of cannabis users able to answer		
	2003 (n=90)	2004	
		hydro (n=75)	bush (n=61)
Street dealer	4	4	7
Dealer's home	21	19	15
Mobile dealer	8	7	3
Friend*	57	55	59
Home delivered	2	4	3
Grow your own	2	11	11
other	6	1	2
Usual time taken to obtain heroin, *median minutes (range)*	30 (1 – 1440)	20 (1 – 1440)	13 (1 – 360)

Source: IDRS IDU interviews
* includes obtained as a gift from friend

Perceived source of cannabis used by IDU

IDU that had used cannabis in the past six months (and were confident to answer questions on availability of cannabis) were asked if they knew the original source of the cannabis they had used the last time they had used it (whether hydro or bush). As presented in Table 7.6, of 69 IDU, most (48%) reported the source as a small-time, 'backyard' user/grower, 16% reported having used what they had grown themselves, while 10% reported the source as a large scale cultivator/supplier. The remaining 26% didn't know the source of the cannabis they had last used. The majority of those reporting the source of the cannabis they had last used stated they were very sure of this source (86%). Compared to 2003, there was an increase in the percentage of IDU reporting that they had last used cannabis that they had grown themselves.

Table 7.6: Perceived production source of cannabis*, 2003 & 2004

Perceived source	% of cannabis users able to answer	
	2003 (n=82)	2004 (n=69)
Don't know	39	26
Grew my own	2	16
Small-time 'backyard' user/ grower	51	48
Large scale cultivator/supplier	7	10
"Very sure" of source**	88	86

Source: IDRS IDU interviews
* IDU were asked: "Last time you used cannabis, as far as you know, what was the original source of that cannabis?"
** of those who were able to state the source

Law enforcement KES described little change in the pattern of supply in the previous 12 months. The predominant supply network still consists of smaller 'backyard' growers feeding into to larger syndicates.

7.3 Potency

Tables 7.7 and 7.8 summarise the current potency of cannabis and the changes in cannabis potency over the last six months, according to IDU report. In 2004, the strength of both hydro and bush cannabis was reported as high or medium (by 85% or more of IDU able to answer) and largely stable, in the last 6 months. There has been no change in the perceived potency of cannabis compared to 2003. In addition, no change in potency over the previous six to twelve months was noted by the few KES that commented.

Table 7.7: Current potency/strength of cannabis, 2003 & 2004

How strong would you say cannabis is at the moment?	% of IDU able to answer		
	2003 (n=90)	2004	
		hydro (n=72)	bush (n=62)
high	52	56	48
medium	32	29	39
low	6	7	7
fluctuates	10	8	7

Source: IDRS IDU interviews

Table 7.8: Change in potency/strength of cannabis in last 6 months, 2003 & 2004

Has the strength of cannabis changed in the last 6 months?	% of IDU able to answer		
	2003 (n=90)	2004	
		hydro (n=72)	bush (n=62)
don't know	2	0	2
increasing	9	14	8
stable	66	69	73
decreasing	10	7	7
fluctuating	13	10	11

Source: IDRS IDU interviews

7.4 Use

7.4.1 Cannabis use among IDU

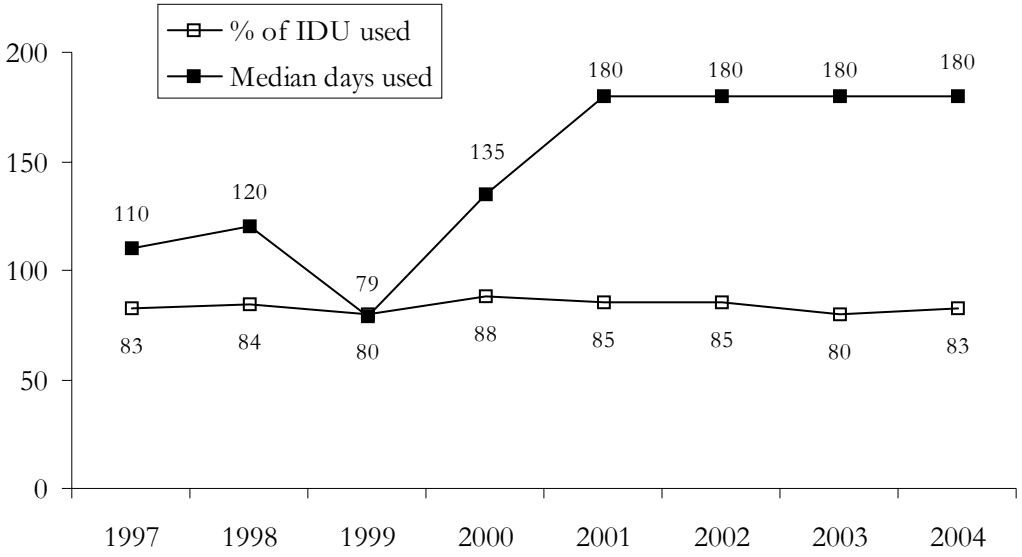
It is worth noting that because participants were recruited on the basis of their injecting drug use (rather than use of illicit drugs in general) the following data regarding patterns of cannabis use may not be typical of cannabis users in general, but specific to an IDU population. The IDRS reports on cannabis use among an IDU sample only.

7.4.2 Current patterns of cannabis use

Eighty-three percent of the IDU sample reported having used cannabis a median of 180 days (range 1 - 180), during the last six months. Cannabis, though generally not the drug of choice among the IDU sample (see Table 3.2), was used commonly and the

prevalence of use in the last six months among this group was second only to smoking. This pattern of use remains largely unchanged from that reported in 2003. Indeed, the proportions of the IDU who had recently used cannabis has remained stable across all the years the IDRS has been conducted, and the median number of days cannabis was used by the IDU in the previous six months has been stable since 2001 (see Figure 7.3).

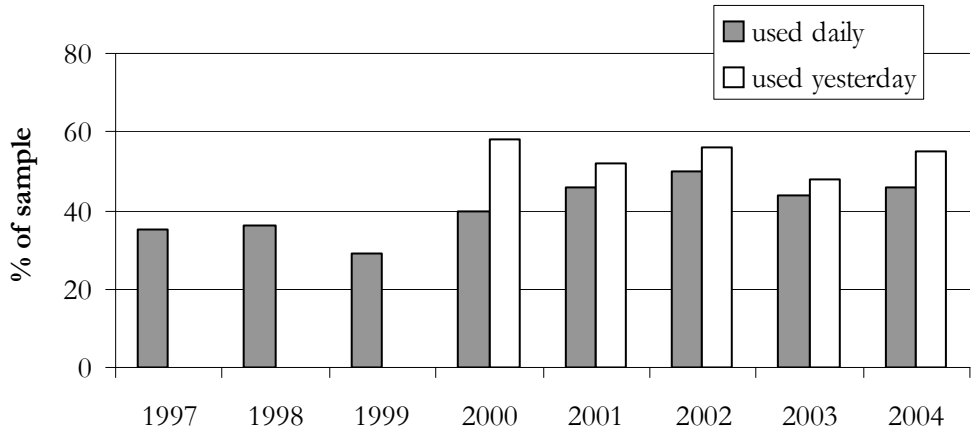
Figure 7.3: Cannabis – Recent* use & Median number of days used#, 1997 - 2004



Source: IDRS IDU interviews
* in the previous 6 months; # by those reporting use in the previous six months

Forty-six percent of IDU (n=46) stated they had used on a daily basis in the last six months, and 55% (n=56) reported they had used the drug on the day preceding the interview. These proportions were similar to those reported in 2003, when 44% of cannabis users reported daily use and 48% reported use of cannabis on the day preceding the interview. The trend for these parameters of cannabis use continues to be generally stable over the long term (see Figure 7.4).

Figure 7.4: Cannabis - % of IDU that used daily & used yesterday, 1997 – 2004*



Source: IDRS IDU interviews
* data for '% used yesterday' was not collected in 1997 to 1999, inclusive.

Of the 84 IDU that had used cannabis recently, 77 (92%) reported use of hydro, and 73 (87%) reported use of bush, within that period. In addition, 22 (26%) reported use of 'hash' (cannabis resin) and 13 (15%) reported use of 'hash oil'. An overwhelming majority of the cannabis using IDU reported hydro as the form they had *used most* in the last six months (80%, n=66). Eighteen percent (n=15) reported bush was the form they had *used most*, and one IDU reported 'hash oil' was the form *used most* in the last six months *(data for this parameter for two cannabis users was missing)*. Apart from a decrease in the proportions reporting they had recently used 'hash' or 'hash oil' (47% and 29% in 2003, respectively), these patterns of cannabis use were similar to those reported in 2003.

KES reported no change in the patterns of use among IDU over the previous six to twelve months.

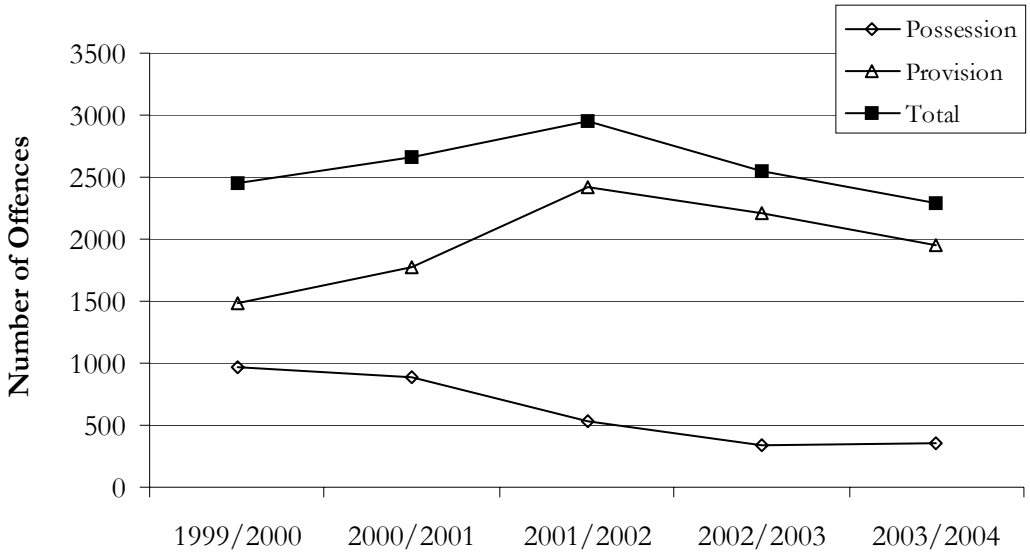
7.5 Cannabis related harms

7.5.1 Law enforcement

Figure 7.5 presents the number of cannabis possession/use and provision (incorporating import/export drugs, sell/trade drugs, produce/manufacture drugs categories) offences reported or becoming known to police from 1999/2000 to 2003/2004 (SAPOL Annual Reports, 2000-2004). The total number of possession and provision offences for 2003/2004 period was 2985, which continues a decline seen over the last couple of years (3131 in 2002/2003, 3673 in 2001/2002 and 3864 in 2000/2001). This decline in total numbers was primarily due to a decline in 'possession/use' offences, which would have been impacted by the introduction of the Police Drug Diversion Initiative in 2001.

As can be seen in Figure 7.5, the number of cannabis possession offences remained stable, and the number of provision offences for cannabis decreased, from 2002/2003 to 2003/2004. Historically, cannabis related offences have made up the majority of drug possession and provision offences, and continued to do so in 2003/2004 when 76.8% of the total number of such offences was cannabis related. This proportion is similar to the 81.3% seen in 2002/2003 and 80% seen in 2001/2002.

Figure 7.5: Number of cannabis related offences reported by SAPOL in South Australia, 1999/2001 – 2003/2004



Source: South Australian Police Annual Reports (2000-2001 to 2003-2004)

7.5.2 Health

Treatment Services - ADIS

Telephone calls to the SA Alcohol and Drug Information Service (ADIS) regarding cannabis accounted for 10.3% of the total coded telephone contacts (drug related) in the 2003/2004 financial year, which was slightly lower than the 12% recorded in 2002/2003, and the 14% recorded in 2001/2002. Enquiries regarding cannabis were the third most common drug-related enquiry type, following enquiries regarding alcohol (29.6% of total) and amphetamines (12% of total). Figure 4.10 (page 29) depicts the number of cannabis related calls per quarter for the last two financial years compared to calls related to other drug types.

Treatment Services - DASC

Readers are reminded that a new data system, the Client Management Engine-DASC Information System (CME-DIS) was introduced in July 2002, which may have impacted on the data trends, therefore, readers are advised to treat any interpretation cautiously.

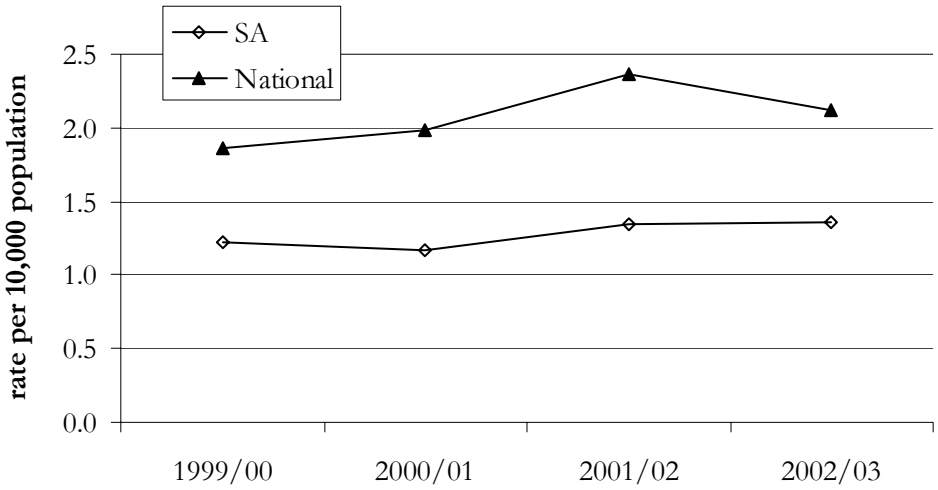
Presentations to all treatment services of the SA Drug and Alcohol Services Council (DASC) are presented in Table 4.10 (page 30) and show that the proportion of clients nominating cannabis as their primary drug of concern remained stable in 2003/2004 compared to all previous years reported. In 2003/2004 cannabis accounted for 11.1% of total presentations to DASC treatment services and remained the fourth most commonly nominated primary drug of concern, after alcohol, amphetamines and heroin.

Cannabis-related Hospital Admissions

Data up to the end of the 2002/2003 financial year was provided by the Australian Institute of Health and Welfare from the National Hospital Morbidity Dataset. This data reports on both state specific and national drug-related hospital admissions, according to ICD-10 classification. See Appendix – Figure A for a comparison of substance-related admissions (primary diagnosis) to SA hospitals from 1999/00 to 2002/03. The rates of cannabis-related admissions (primary diagnosis) to hospitals in SA, and nationally, were

generally stable from 1999/00 to 2002/03 (see Figure 7.6). There were a total of 115 admissions to SA hospitals with a cannabis-related primary diagnosis in 2002/03, similar to the 104 recorded for 1999/00.

Figure 7.6: Rate of cannabis-related admissions* (primary diagnosis) to hospital in South Australia, compared to nationally, by financial year totals, July 1999 to June 2003



Source: Australian Institute of Health and Welfare
* for persons aged between 15 and 54 years
Note: A 'primary diagnosis' was given when cannabis was considered chiefly responsible for the patient's episode of care in hospital.

7.6 Trends in cannabis use

No IDU made any mention of cannabis when asked to comment on their perception of general drug trends, which in itself suggests that there was no aspect of cannabis use considered an issue among IDU currently. Several KES reported that cannabis use was a "stable" among IDU and its use was considered by many to be on par with tobacco smoking.

7.7 Summary of cannabis trends

Table 7.9 contains a summary of trends in the price, purity, availability and use of cannabis in the previous 12 months. Overall, there had been little if any change in these parameters since 2003.

The median price paid for either a 'bag' or an ounce of cannabis has been stable for a number of years, with little difference in price between the hydro and bush types ($200 or $180 per ounce, respectively). The majority of IDU reported that the price of cannabis had remained stable in the past six months. Approximately 80% of IDU able to comment perceived either hydro or bush cannabis was 'very easy' or 'easy' to obtain and around two-thirds reported that availability had been stable in the previous six months. The majority reported scoring the cannabis they had used last from a friend and that the source had been a small-time 'backyard' user/grower. Eighty-five percent or more also perceived the potency of either hydro or bush as high or medium, and over two-thirds reported that the potency had been stable recently.

KES reported no changes in any parameter of the cannabis market, or use of cannabis among IDU, in 2004 compared to 2003.

A continuing decline in the number of provision offences related to cannabis was recorded by SAPOL in 2004, but possession/use offences remained the same as for 2003.

The number of calls to ADIS concerning cannabis remained stable, as did the total number of presentations to DASC treatment services. Cannabis-related hospital admissions were stable as at 2002/03.

Table 7.9: Trends in the price, availability, purity and use of cannabis

Price	
Hydro (ounce)	$200 ($100 - 280); no change since 2003
(bag)	$25 ($20 - $25); no change since 2003
	currently stable
Bush (ounce)	$180 ($100 - 250); no change since 2003
(bag)	$25 ($20 - $25); no change since 2003
	currently stable
Availability	Very easy to easy; stable (both hydro and bush). Majority reported scoring from friends. (IDU).
Potency	High to medium (both hydro and bush); stable. (IDU).
Use	% reporting recent use remained high. No change in frequency of use. Hydro remained the most used by large majority.
Other indicators	Continued decline in number of provision offences, possession offences were stable (SAPOL) Calls to ADIS stable (ADIS). Total presentations to DASC treatment services stable (DASC). Hospital admissions stable as at 2002/03 (AIHW).

8. OPIOIDS

It should be noted that in the following sections, the terms *licit* and *illicit* refer to the source of supply of the drug, not the way in which it was used. That is, obtainment or use of a drug was considered *licit* when the supply was from a person's own prescription only and *illicit* if the supply was from any other source (eg. a friend's prescription supply or a black-market supply).

8.1 Overview of opioid use among IDU

Table 3.3 provides data on the history of use and route of administration of opioid substances for the 2004 IDU sample. Opioid substances include heroin, morphine, 'homebake' (a crude opioid substance derived from codeine; Reynolds *et al.*, 1997) and other opioids (such as codeine, pethidine, oxycodone), as well as methadone/physeptone and buprenorphine.

Heroin was the opioid used by the largest proportion of the IDU sample (60%), followed by morphine (42%) and either licit or illicit methadone (38%) and buprenorphine (35%). Heroin use among IDU is described in detail in Section 4.4, with use of other opioids described in Sections 8.2 (morphine), 8.3 (methadone), 8.4 (buprenorphine) and 8.5 (other opioids), following.

When all the opioid substance categories (heroin, morphine, homebake and other opioids, plus any methadone or buprenorphine) were collapsed, it was evident that 83% (n=84) of IDU had used some type of opioid substance (including licit and illicit use) in the six months prior to interview. When licit use (of methadone or buprenorphine) was excluded, 78% (n=79) had used any of these substances in that time. Excluding heroin, 79% (n=80) of IDU had used some other opioid substance in the six months prior to interview.

KES reports of other opioid use were primarily within the context of heroin-using IDU and reflected a perception that users were continuing to use other opioids to substitute or supplement their heroin use. Most KES commented that use of other opioids was common among this group, a few commented that this use had decreased with the increased availability of heroin, while one KES reported an increase in use of morphine in particular in southern Adelaide (where they believed heroin was still difficult to access). Several KES commented on the emergence of Tramadol® (a synthetic analgesic with opioid-like effects)(n=2), the increased use of Oxycontin® (oxycodone) (n=2), and the increased illicit use and injecting of buprenorphine (n=2).

8.2 Morphine

2004 is the second year that IDRS survey participants were asked to provide information on the price and availability of illicit morphine.

8.2.1 Price

Fewer IDU could comment on the price of morphine in 2004 compared to 2003. In 2004, 23 IDU estimated that the *current* price of morphine was a median $30 per 100mg (range $10-50 per 100mg). This was the same as had been reported in 2003, and was the

same as the median price *paid* by IDU *at last purchase* of 100mg of either MS Contin® or Kapanol® for both years (see Table 8.1). In addition, 100mg (in tablet form) was the most commonly purchased amount and Kapanol® was the most commonly purchased brand of morphine, for both years. In 2004, the majority of those IDU able to answer also reported the price of morphine as stable to increasing during that time (see Table 8.2).

Table 8.1: Price of most recent morphine purchases by IDU, 2003* & 2004

Amount bought	Median price paid, $ (range)	Number of IDU purchasers
MS Contin® – 60mg	# *15 (10-45)*	# *5*
MS Contin® – 100mg	30 (20-40) *30 (15-58)*	13 *14*
Kapanol® – 50mg	# *15 (10-25)*	# *9*
Kapanol® – 100mg	30 (10-50) *30 (10-78)*	18 *27*

Source: IDRS IDU interviews
* 2003 data in italics, # n<5: not reported

Table 8.2: Change in price of morphine over the last 6 months, 2003 & 2004

Reported price status	% of IDU able to answer	
	2003 (n=46)	2004 (n=26)
don't know	11	12
increasing	20	19
stable	57	62
decreasing	4	8
fluctuating	9	0

Source: IDRS IDU interviews

8.2.2 Availability

Tables 8.3 and 8.4 summarise the current availability of morphine and the changes in morphine availability over the last six months, according to IDU report. In 2004, the majority of IDU able to answer (72%, n=18) reported morphine as 'easy' or 'very easy' to obtain, with over three quarters of those able to answer reporting this availability as stable (76%, n=19), in the six months prior to interview. Compared to 2003, a greater proportion perceived that it was 'very easy' to obtain morphine (36% v 24%), but an equal proportion regarded it was difficult (24%), in 2004.

Table 8.3: Availability of morphine currently, 2003 & 2004

How easy is it to get morphine at the moment?	% of IDU able to answer	
	2003 (n=42)	2004 (n=25)
very easy	24	36
easy	50	36
difficult	24	24
very difficult	2	4

Source: IDRS IDU interviews

Table 8.4: Change in availability of morphine over the last 6 months, 2003 & 2004

Has [availability] changed in the last 6 months?	% of IDU able to answer	
	2003 (n=42)	2004 (n=25)
don't know	0	4
more difficult	19	12
stable	57	76
easier	21	4
fluctuates	2	4

Source: IDRS IDU interviews

Table 8.5 presents information collected from IDU on the usual source and time taken to obtain the morphine they had used recently. Most of the IDU that reported use of morphine in the last 6 months and were able to answer (n=23) stated that they *usually* obtained morphine from a friend (57%), which was similar to that reported by IDU in 2003 (48%). However, in 2004 there was a substantial drop in the percentage of IDU reporting that they *usually* obtained morphine from a dealer's home (32% to 4%), and a concomitant rise in the percentage reporting they usually scored from a street dealer (3% to 26%). In 2004, the *usual* length of time taken to score was a median 30 minutes, slightly higher than the median 18 minutes reported in 2003.

Table 8.5: Usual method, and time taken, obtaining morphine in the last 6 months, 2003 & 2004

Usual source *or* method of obtainment	% of morphine users able to answer	
	2003 (n=31)	2004 (n=23)
Street dealer	3	26
Dealer's home	32	4
Mobile dealer	13	4
Friend*	48	57
Home delivered	0	4
other	3	4
Usual time taken to obtain heroin, *median minutes (range)*	18 *(1 - 120)*	30 *(5 - 180)*

Source: IDRS IDU interviews

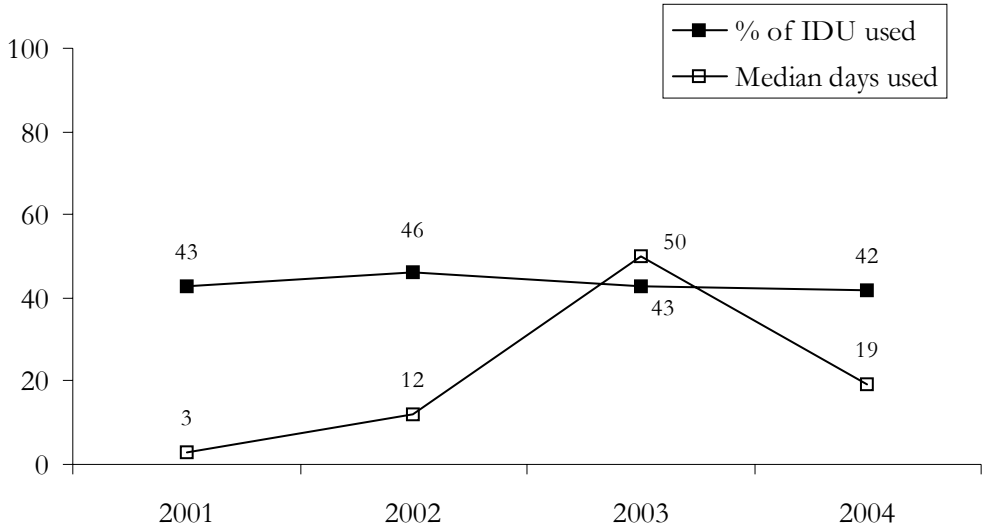
* includes obtained as a gift from friend

8.2.3 Use of morphine among IDU

Two IDU reported morphine as the first drug ever injected, three nominated morphine as their drug of choice and 13% reported morphine as the drug most often injected in the last month or as the last drug they injected (see Table 3.2).

Forty-two percent of IDU (n=42) reported they had used morphine in the last six months a median 19 days (range 1 to 180). Although the proportion of the sample reporting recent use of morphine remained stable compared to previous years, there was a marked decrease in the median number of use days from 2003 to 2004 (from 50 to 19 days) following a sharp increase from 2002 to 2003 (12 to 50 days) (see Figure 8.1).

Figure 8.1: Morphine – Recent* use & Median days used#, 2001 - 2004



Source: IDRS IDU interviews
* in the previous 6 months; # by those reporting use in the previous six months

All but two of the IDU that had used morphine (95%) reported having done so by injecting, a median of 12 days (range 1 to 180) during the last six months. Again, this constitutes a decrease in frequency of use of morphine (by injecting) compared to 2003, when the median days use by injecting was 22 (range 1 to 180). Fifty-two percent of morphine users (n=22) also reported recent oral use of the drug in 2004 and 19% (n=8) reported daily use of morphine, 14% (n=6) by injecting. Compared to 2003, in 2004 similar proportions of morphine users reported recent injecting use, oral use, or daily use of morphine (98%, 47% and 20% in 2003, respectively), though a slightly smaller proportions reported daily use by injecting (18% in 2003).

More than half of those IDU reporting morphine use in the last 6 months (22 of 42=52%) had nominated heroin as their drug of choice.

Twenty-nine percent of recent morphine users (n=12) reported use of *licit* morphine and 81% (n=34) reported use of *illicit* morphine. These proportions were similar to those reported by morphine using IDU in previous years (27% and 78% in 2003; 28% and 85% in 2002, respectively). In 2004, the majority (64%, n=27) also reported that the type they had *used most* during the last six months was *illicit*. The main brand of morphine

used by IDU in that time was Kapanol® (by 48%, n=20), followed by MS Contin® (by 19%, n=8). The proportion reporting Kapanol® as the main brand used was smaller than for 2003 (65%), but data regarding this question was missing for 10 morphine users in 2004 so the validity of results was compromised.

Morphine overdose
Similar to 2003 few people reported experience of morphine overdose. In 2004 only three IDU reported having ever overdosed on morphine, all only once in their life, and only one had done so within the last 12 months.

8.3 Methadone

Please note, the category of methadone includes methadone syrup and methadone in a tablet form, known as physeptone. It should also be noted that sample sizes for these sections were relatively small and therefore should be interpreted with caution.

8.3.1 Price of illicit methadone

2004 is the second year that IDRS survey participants were asked to provide information regarding the price and availability of illicit methadone. Methadone syrup in SA is generally prescribed as a 5mg/ml solution but it cannot be assumed that this is the dosage of black-market supplies, as the syrup may have been further diluted. Therefore, users may know the amount of methadone syrup bought in terms of the *ml* amount or the *mg* dosage a total volume contains, hence the breakdown of prices given below. Only a small number of IDU were able to provide information on the price of illicit methadone in 2004, similar to 2003.

The *current* price of methadone was estimated by IDU to be a median 50cents/ml of syrup (range $0.33-2.50, n=14) or a median 50cents/mg tablet (range $0.5-$5.00, n=9). The median prices *paid* by IDU at *last purchase* was 50cents/ml of syrup (range $0.42-$2.50, n=3), or $1.25/mg dose of syrup (range $0.38-$2.50, n=4), or $6/10mg physeptone tablet (range $4-$10, n=7). The majority of IDU able to answer reported that the price of illicit methadone had been stable in the six months prior to interview (61%, n=17).

8.3.2 Availability of illicit methadone

Tables 8.6 and 8.7 summarise the current availability of illicit methadone and the changes in methadone availability over the last six months, according to IDU report. In 2004 the majority of IDU able to answer (72%, n=18) reported methadone as 'easy' or 'very easy' to obtain, with almost all of those able to answer reporting availability as stable (88%, n=22).

Table 8.6: Availability of illicit methadone currently, 2003 & 2004

How easy is it to get methadone at the moment?	% of IDU able to answer	
	2003 (n=21)	2004 (n=25)
very easy	10	20
easy	52	52
difficult	33	28
very difficult	5	0

Source: IDRS IDU interviews

Table 8.7: Change in availability of illicit methadone over the last 6 months, 2003 & 2004

Has [availability] changed in the last 6 months?	% of IDU able to answer	
	2003 (n=21)	2004 (n=25)
don't know	14	0
more difficult	10	4
stable	67	88
easier	5	4
fluctuates	5	4

Source: IDRS IDU interviews

Only 12 IDU that had used methadone illicitly in the last 6 months were able to provide information on where they obtained the drug. Eight (67%) reported that they *usually* obtained the drug from a friend, three (25%) from a street dealer. The *usual* time taken to score methadone was a median 30 minutes. Of the 12 IDU able to comment, 9 stated the source of their *last* illicit methadone purchase as a 'take-away' (i.e. somebody else's prescribed 'take-away' dose) and three didn't know the source.

All parameters of availability were similar to those reported in 2003.

8.3.3 Use of illicit methadone

2004 was the second year that IDRS survey participants were asked to provide separate information on the use of licit and illicit methadone syrup and physeptone tablets as per the categories in Table 3.3.

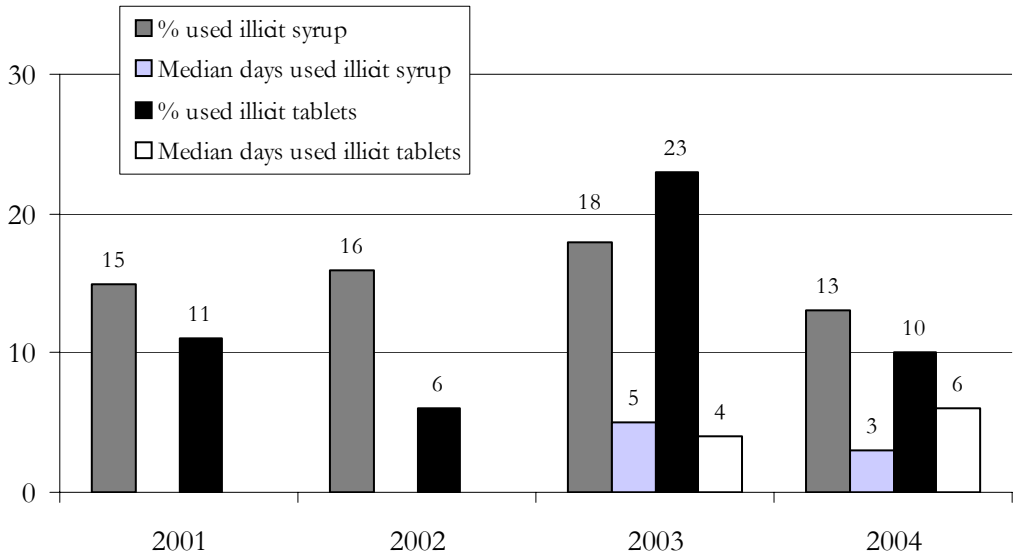
Thirteen of the participating IDU reported having used illicit methadone syrup a median of 3 days (range 1 to 28) in the last six months. Of those, 11 (85%) reported use of illicit methadone syrup by injecting a median of 3 days (range 1 to 24), and 7 (54%) reported use by swallowing, during that period. This constituted a decrease compared to 2003 when 18% of IDU reported use of illicit methadone syrup a median of 5 days (range 1 to 120), 41% by injecting a median of 12 days (range 1 to 120), 73% by swallowing. No IDU reported use of illicit methadone syrup on a daily basis in either year.

Ten of the participating IDU reported having used illicit physeptone tablets a median of 6 days (range 1 to 20) in the last six months. Of those, 6 (60%) reported use of illicit physeptone tablets by injecting a median 4.5 days (range 1 to 6), and 7 (70%) reported use by swallowing, during that period. This also constituted a decrease compared to 2003 when 23% of IDU reported use of illicit physeptone tablets a median 4 days (range 1 to

150), 70% by injecting a median of 3 days (range 1 to 150), 59% by swallowing. No IDU reported daily use of illicit physeptone tablets on a daily basis in either year.

Figure 8.2 depicts the trend in recent use of illicit methadone since 2001. The most notable feature is the fluctuation in the percentage of IDU that had recently used physeptone over this time period, which peaked in 2003 at 23% but had dropped back to 10% in 2004.

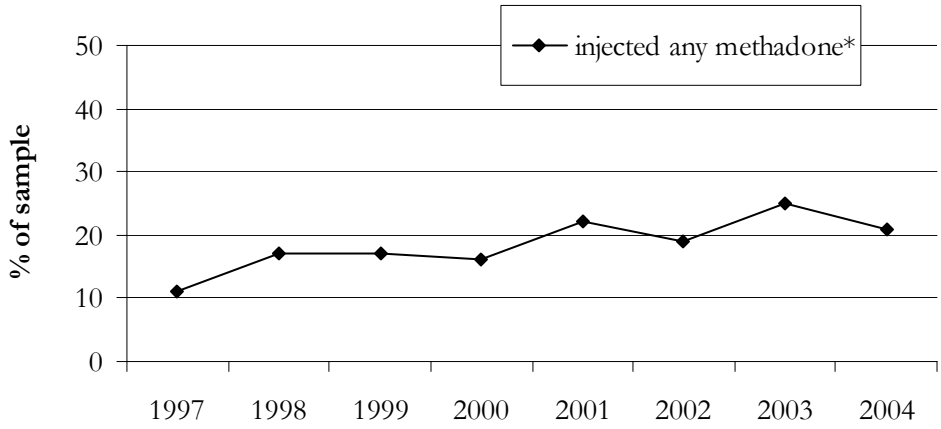
Figure 8.2: Illicit Methadone – Recent* use & Median number of days used#, 2001 - 2004



Source: IDRS IDU interviews
* in the previous 6 months; # by those reporting use in the previous six months

Figure 8.3 shows that the proportion reporting injecting of any methadone (either from a licit or illicit source) has been relatively stable since 2001.

Figure 8.3: Injecting of methadone by IDU in the last 6 months, 1997 - 2004



Source: IDRS IDU interviews
* includes licitly or illicitly sourced methadone syrup and physeptone

The total proportion of IDU that reported use of *any* methadone (syrup or tablets, licit or illicit) had decreased from 48% in 2003 to 38% in 2004. Of the 38 IDU that reported use of *any* methadone in 2004, 71% (n=27) reported licit methadone syrup as the form *used most* and 8% (n=3) reported licit physeptone tablets as the form *used most*, in the six months prior to interview. Therefore, approximately three quarters of the methadone using IDU reported predominantly using methadone from a licit source. This compares to roughly equal proportions reporting using mainly licit (53%) or illicit (47%) methadone in 2003.

The decrease in reported recent use of *any* methadone would at least in part have been due to a decrease in the number of IDU currently or previously (within the six months prior to interview) enrolled in a methadone treatment program. Specifically, in 2004, 30% were currently on a methadone program, compared to 23% in 2003. In 2004, of the 30 IDU that were currently on a methadone program, 27 had been on the program for at least the last six months and nine of these (9/27=33%) also reported use of either illicit methadone syrup (n=3), illicit physeptone tablets (n=5), or both (n=1), during the six months prior to interview.

8.4 Buprenorphine

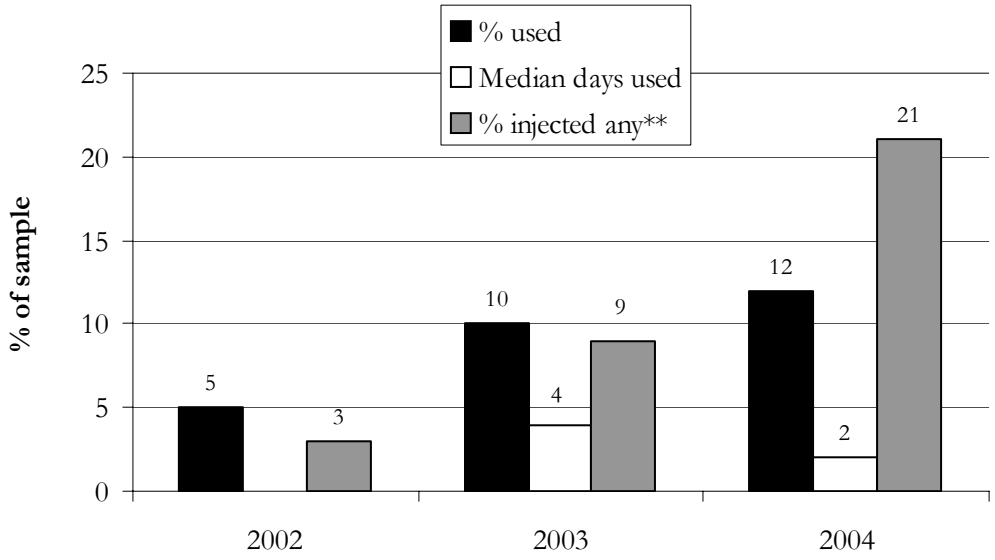
8.4.1 Use of illicit buprenorphine

2004 was the second year that IDRS survey participants were asked to provide separate information on the use of licit and illicit buprenorphine as per the categories in Table 3.3.

Twelve participating IDU reported having used illicit buprenorphine a median of 2 days (range 1 to 10) in the last six months. Of those, eleven (92%) reported use of illicit buprenorphine by injecting a median of 2 days (range 1 to 10) and 2 (17%) reported use by swallowing, during that period. No IDU reported use of illicit buprenorphine on a daily basis.

Figure 8.4 shows that the proportion reporting the use of illicit buprenorphine among IDU has remained stable since last year in terms of the percentage reporting recent use. Frequency of use in terms of median days used decreased slightly (from 4 to 2 days) in that time. However, the proportion of the sample that reported recent injecting of *any* buprenorphine – that is, their *licit* (prescribed) dose or an *illicit* supply - had more than doubled compared to 2003 (from 9% to 21%). This increase was mostly affected by an increase in the percent of IDU that reported having recently injected their *licit* supply (from 3% to 14%), as well as by the increase in number of IDU currently on a buprenorphine treatment program.

Figure 8.4: Illicit Buprenorphine – Recent* use and injecting & Median number of days used#, 2002 - 2004



Source: IDRS IDU interviews
* in the previous 6 months; # by those reporting use in the previous six months
** includes licitly or illicitly sourced buprenorphine

The total proportion of IDU that reported recent use of *any* buprenorphine (licit or illicit) had increased from 23% in 2003 to 35% in 2004. Of the 35 IDU reporting use of any buprenorphine (licit or illicit), 26 (74%) reported licit buprenorphine as the form they *used most*, with the remainder (26%, n=9) reporting that illicit buprenorphine was the form they *used most*, in the six months prior to interview. Compared to 2003, although a larger number of IDU reported use of *any* buprenorphine in 2004, similar proportions reported the form *used most* recently as licit buprenorphine (74% v 67%).

The increase in reported recent use of *any* buprenorphine would at least in part have been due to an increase in the number of IDU currently or previously (within the six months prior to interview) enrolled in a buprenorphine treatment program. Specifically, in 2004, 17% of IDU were currently on a buprenorphine program, compared to 7% in 2003, and a further 9% had been on a buprenorphine program at some point within the six months prior to interview, compared to 4% in 2003.

8.5 Other opioids

The category 'other opioids' includes any other opiates (such as opium) or opioid analgesic substances such as codeine, pethidine, oxycodone and the like.

Sixteen (16%) of the participating IDU reported use of other opioids a median of 8 days (range 1 – 180), with 2 IDU reporting daily use, in the last six months. The majority of other opioid users (69%, n=11) had used these substances by injecting, with 9 IDU (56%) reporting use by swallowing. Four IDU (25%) reported *licit* use and 13 (81%) reported *illicit* use during the six months prior to interview. Furthermore, the majority of other opioid users (69%, n=11) reported *mainly* illicit use in that time. The main types used were some brand of oxycodone (by 50%, n=8) - primarily OxyContin® (n=5) - or codeine (by 19%, n=3).

Compared to 2003, in 2004 there was a similar proportion of IDU reporting use of other opioids (15% in 2003), but they reported doing so less frequently on average (median days used was 20 in 2003) with fewer reporting daily use (5 IDU in 2003). However, those that were using were sourcing their other opioids *mainly* illicitly and primarily oxycodone, in contrast to 2003 when other opioid users reported *mainly* licit use (61%) of primarily codeine (50%).

Two KES commented that oxycodone was increasingly popular, though more difficult to obtain than morphine, and considered better because its effect more closely resembled that of heroin.

8.6 Summary of opioids

A summary of trends for opioids other than heroin is presented in Table 8.8.

Table 8.8: Trends in the price, availability and/or use of opioids

Morphine	
Price	\$30/100mg (\$10-50) Kapanol®; no change since 2003, currently stable (IDU).
Availability	Easy to very easy; stable (IDU).
Use	% used recently stable, but decrease in frequency of use since 2003. Majority report recent use by injecting; unchanged since 2003. Recent oral use also common. Mainly use illicit supply; primarily Kapanol® and MS Contin®
Illicit Methadone	
Price	Limited information due to small sample.
Availability	Easy to very easy; stable (IDU).
Use	Decrease in % used recently (methadone or physeptone), frequency of use stable. Use by injecting common, also oral use; no change in % injecting. Decrease in % reporting mainly illicit use (21% in 2004).
Illicit Buprenorphine	% used recently and frequency of use stable, despite increase in % of sample on a buprenorphine treatment program, but increase in recent injecting of *licit* supply since 2003. No change in % reporting mainly illicit use (25% in 2004).
Other opioids	% used recently stable, but decrease in frequency of use since 2003. Use by injecting common, also oral use. Mainly use illicit supply, primarily oxycodone; change from 2003 when use was mainly licit, primarily codeine or oxycodone.

9. OTHER DRUGS

9.1 Ecstasy and hallucinogens

Use of ecstasy (MDMA) and hallucinogens (including LSD or 'trips', and naturally occurring compounds such as 'magic mushrooms') among the IDU sample in the last six months is summarised in Table 3.3.

Although a sizeable proportion of the IDU sample had used ecstasy (22%), only 6% had used some type of hallucinogen in the last six months, and neither had been consumed frequently in that time, with the median days of use being 2 (range 1 to 20) and 1.5 (range 1 to 30), respectively. Both ecstasy and hallucinogens had been used mainly orally, although 12% of IDU also reported having used ecstasy by injecting during the last six months. In 2004, the proportion of IDU reporting recent use of hallucinogens had decreased (from 18%), but other parameters of use for these two drug classes were very similar to those reported in 2003.

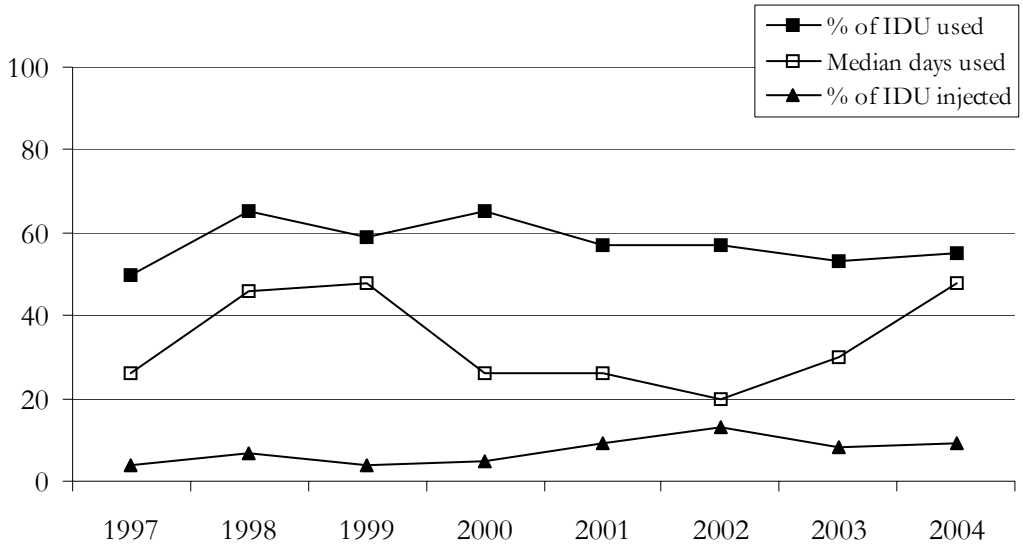
Ecstasy and related drugs use has been examined annually in SA among a separate sample of primarily non-injecting drug users since 2000, previously as a module of the IDRS, but now known as the Party Drugs Initiative. State-specific and national reports are produced annually (e.g., Weekley *et al.*, 2004, and Breen *et al.*, 2004).

9.2 Benzodiazepines

Fifty-five percent of IDU reported use of benzodiazepines a median of 48 days (range 1-180) in the last six months, 27% (n=15) of whom reported using benzodiazepines on a daily basis. All reported use by swallowing, and 16% (n=9) reported use by injecting a median of 6 days (range 1-180), in that time. Compared to 2003, in 2004 a similar proportion of IDU reported recent use and injecting of benzodiazepines, but reported doing so more frequently on average (median days used was 30 in 2003).

As shown in Figure 9.1, the median number of days benzodiazepines were used, by those reporting recent use, increased for the second year in a row, despite a decrease in the proportion using daily from 34% in 2003 to 27% in 2004. However, the long-term trends indicate that both the prevalence of use, and use by injecting, among the sample seem to be relatively stable.

Figure 9.1: Benzodiazepines - Recent* use and injection, & Median number of days used#, 1997 - 2004



Source: IDRS IDU interviews
* in the previous 6 months; # by those reporting use in the previous six months

Of the 55 IDU that reported use of benzodiazepines, 73% (n=40) reported use of licit benzodiazepines and 60% (n=33) reported use of illicit benzodiazepines, in the six months prior to interview. The majority of benzodiazepine users (71%, n=39) also reported that they had used *mainly* licit benzodiazepines in that time. It should be remembered however, that a so-called *licit* supply may be achieved by the practice of "doctor shopping". These parameters of use were very similar to those reported in 2003, though a slightly higher proportion of users reported *mainly* licit use of benzodiazepines in 2004 (71% cf. 61% in 2003).

As was the case in previous years, in 2004 the majority of users reported the *main* type of benzodiazepine used in the six months prior to interview was diazepam (by 65%, n=36). Others reported the main types used as oxazepam (13%, n=7), temazepam (7%, n=4) and alprazolam (7%, n=4).

KES report that benzodiazepines are commonly used by heroin IDU, but that frequency of use varies from irregular and opportunistic to regular and dependent use. A couple of KES believed that use of benzodiazepines prior to or with heroin as a means to prolong the effects was still being practiced by a minority of heroin users. Others commented that benzodiazepines (particularly Valium® or Xanax®) were commonly used as a "stop gap type thing". KES reports of benzodiazepines use among primarily amphetamine users was mixed, several commenting that use was common to help with sleep and comedown from amphetamine use, others that use was not common or tended to be opportunistic or binge-like.

9.3 Anti-depressants

Twenty-one (21%) IDU reported use of anti-depressants a median of 180 days (range 1-180), 57% (n=12) of those on a daily basis, in the last six months. All reported use by swallowing and only one participant reported use by injecting on two occasions. These parameters of use remain largely unchanged since 2002.

Similarly to 2003, anti-depressant use among the IDU sample in 2004 was primarily licit, with 91% (n=19) of recent users reporting *mainly* licit use and only two IDU reporting any illicit use of anti-depressants, within the past six months. The main type of antidepressant used (by 13 IDU) was a selective serotonin re-uptake inhibitor (SSRIs), in particular: citalopram (n=6), paroxetine (n=3), sertraline (n=3) and fluvoxamine (n=1). A further four IDU reported mainly using a tricyclic antidepressant; mirtazapine (n=3) and amitriptyline (n=1) *(data missing for the remaining four antidepressant users)*. Similar proportions reported use of SSRIs and tricyclics in 2003.

Primarily licit use of anti-depressants by IDU (as prescribed) was confirmed by KES reports that no illicit use had been noted, and that it was not uncommon for heroin users in particular to be prescribed such medication, particularly following stabilisation on a pharmacotherapy.

9.4 Summary of other drugs

A summary of trends in the use of other drugs is found in Table 9.1.

Table 9.1: Summary of trends in the use of other drugs

Ecstasy and hallucinogens	No change in % recently used ecstasy (22%); decrease in % recently used hallucinogens (to 6%). Frequency of use low and unchanged since 2003.
Benzodiazepines	No change in % recently used or % recently injected, but continuing increase in frequency of use noted. 71% report mainly using a licit supply, primarily diazepam; slight increase compared to 2003.
Anti-depressants	No change in % recently used or frequency of use. Almost exclusively licit use reported; most common type used was an SSRI, no change since 2003.

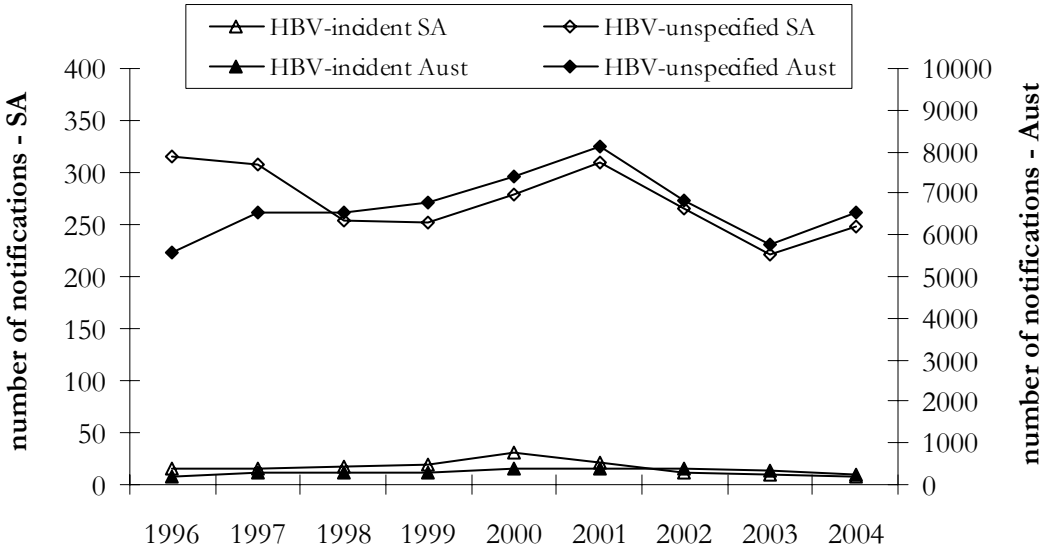
10. ASSOCIATED HARMS

10.1 Blood borne viruses

The risks of acquiring hepatitis B (HBV) and C (HCV) are greatly increased in IDU populations. Blood borne viruses can be transmitted by the sharing of needles, syringes and other injecting equipment. State and Territory health departments report viral hepatitis notifications to the Communicable Diseases Australia - National Notifiable Diseases Surveillance System (CDA-NNDSS). The CDA-NNDSS differentiates between incident infections (i.e., newly acquired) and unspecified infections (i.e., those where the timing of disease acquisition is unknown). Readers should note that the data reported cannot be directly attributed to IDU specific cases. Readers should also note that the CDA-NNDSS made adjustments to their data for previous years, so numbers reported here may differ to earlier reports (CDA-NNDSS web-site, accessed January 2005).

The number of incident and unspecified notifications for HBV in SA, compared to nationally, are presented in Figure 10.1. The number of incident notifications of HBV in SA was recorded as 8 in 2004. Incidence notifications have been stable in SA for the last three years following a decline from a 'peak' of 30 in 2000. The number of incident notifications of HBV nationally has also shown a decline in the last three years. In 2004, the number of unspecified HBV notifications in SA reported to CDA-NNDSS was 248, constituting a slight upturn following the gradual decrease in unspecified notifications in previous years. The pattern was similar to the national unspecified HBV notifications where a decrease in number occurred from 2001 to 2003, followed by an upturn in 2004.

Figure 10.1: Number of HBV incident and unspecified notifications in SA and nationally, 1996 to 2004

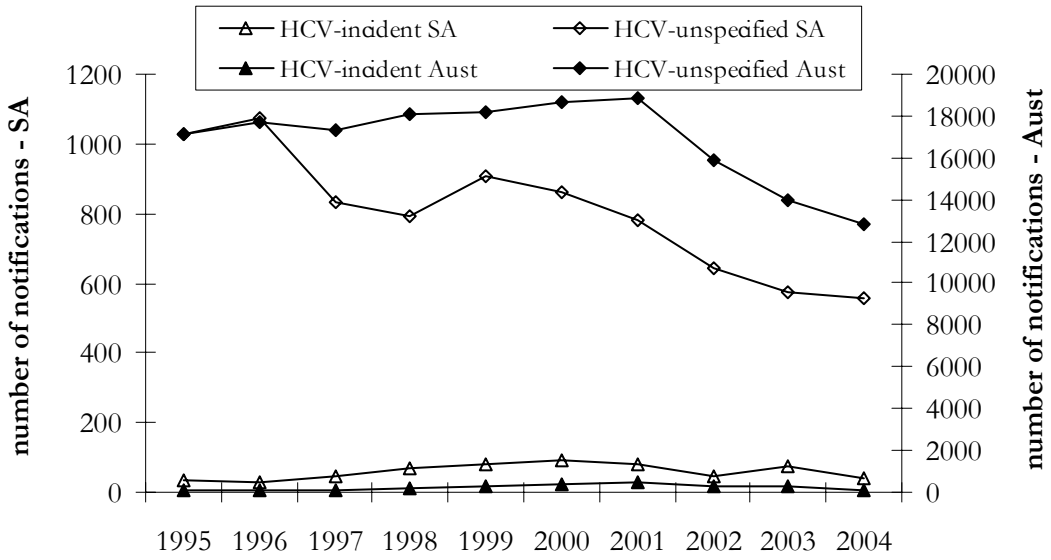


Source: Australian Government Department of Health and Ageing; CDA-NNDSS

The number of incident and unspecified notifications for HCV in SA, compared to nationally, are presented in Figure 10.2. The numbers of incident notifications of HCV show fluctuation over the past few years. In 2004, the number of South Australian incidents was 42, a decrease from 74 in 2003, with 44 in 2002 and 81 in 2001. The

numbers of HCV notifications nationally show less fluctuation and have largely decreased since 2001 to a level substantially below the last six years.

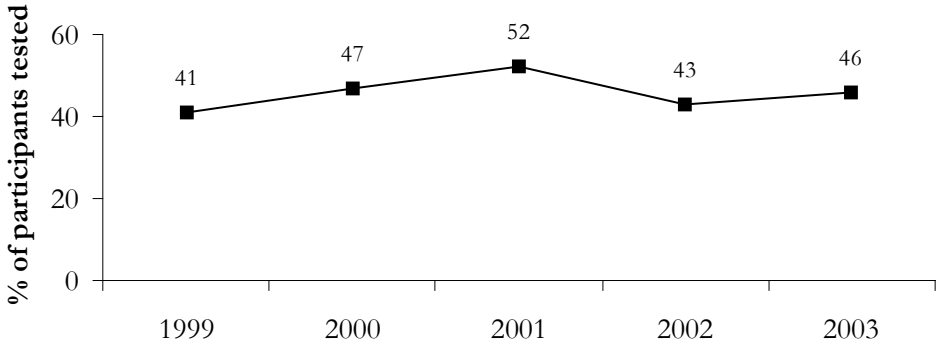
Figure 10.2: Number of HCV incident and unspecified notifications in SA and nationally, 1995 to 2004



Source: Australian Government Department of Health and Ageing; CDA-NNDSS

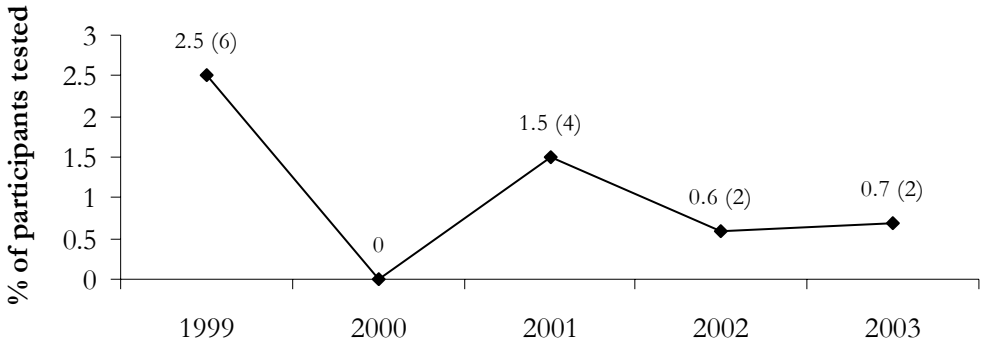
The Annual Needle and Syringe Program (NSP) survey conducted in South Australia in 2003 revealed HCV prevalence of 46% among injecting drug users participating in the survey, similar to that seen in previous years (see Figure 10.3)(NCHECR, 2004). There was slightly higher HCV prevalence among males (43%) compared to females (39%). NSP survey results also showed a low prevalence of HIV among those participants tested (0.7%, or two people), the same as in 2002 (see Figure 10.4)(NCHECR, 2004).

Figure 10.3: HCV antibody prevalence among NSP survey participants in South Australia, 1997 - 2003



Source: Australian NSP Survey National Data Report 1999 - 2003 (NCHECR, 2004)

Figure 10.4: HIV antibody prevalence among NSP survey participants in South Australia, 1997 - 2003



Source: Australian NSP Survey National Data Report 1999 - 2003 (NCHECR, 2004)

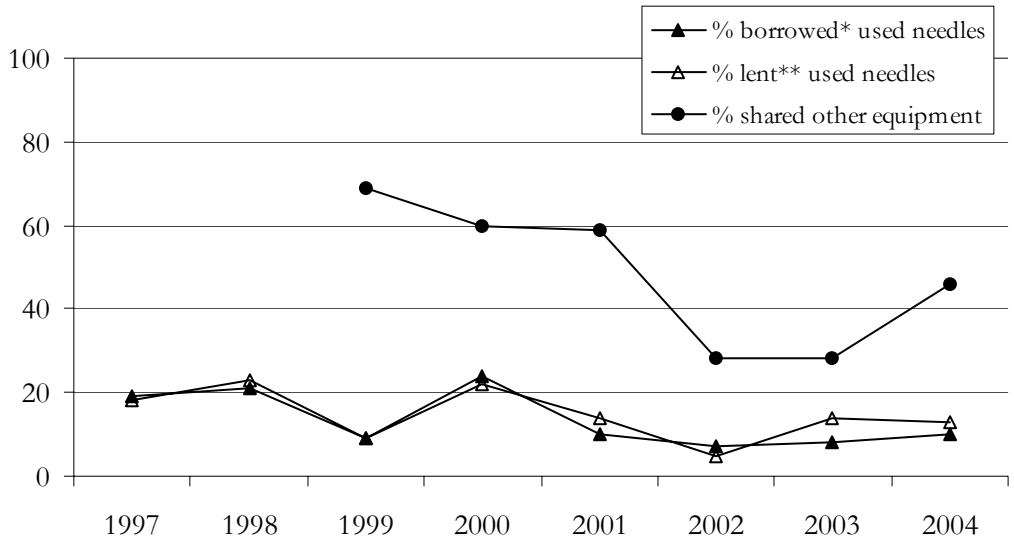
10.2 Sharing of injecting equipment among IDU

The majority of IDU reported that they had not used a needle after someone else (90%, n=91) or before someone else (87%, n=88) in the month prior to interview. These parameters of injecting related risk, as measured by the IDRS, have remained stable for the past four years and indicate a small but persistent proportion (around 10%) of IDU that are at high risk of blood borne virus (BBV) infection and re-infection through needle sharing. Similarly, 14% of 2003 NSP survey participants reported having re-used another's needle and syringe in the last month (NCHECR, 2004).

In the 2004 IDRS, of those that had used a needle *after* someone else, all but one had done so after one other person only, the majority after their regular sex partner (n=8). One person had used a needle after two separate people. With regard to the frequency, four people had used a needle *after* someone else only once, two had done so twice, three had done so 3 to 5 times and one had done so 6 to 10 times, in the last month. Of those that had used a needle *before* someone else, 7 had done so once, 4 had done so twice, and 2 had done so three to five times, in the past month.

Sharing of injecting equipment other than needles was reported by a higher percentage of IDU, and was also markedly higher than that reported for the previous two years (see Figure 10.5). Specifically, 46% of IDU reported that they had shared one or more pieces of injecting equipment, other than needles, in the past six months, compared to 28% in 2002 and 2003.

Figure 10.5: Sharing of needles and injecting equipment by IDU in the month preceding interview, 1997 – 2004



Source: IDRS IDU interviews

* borrowed means to have used a needle *after* someone else had already used it

** lent means to have used a needle *before* someone else used it

As listed in Table 10.1, there were increases in the proportions reporting sharing, for all the categories of injecting equipment, from 2003 to 2004. The largest increase was in the proportion reporting sharing of filters (from 7% to 29%). Sizeable increases were also seen in the proportions reporting sharing water (14% to 34%) and sharing of spoons or containers used to mix drugs prior to injecting (from 18% to 34%). This is of concern given the increased risk of BBV transmission among IDU associated with sharing of injecting equipment.

Table 10.1: Sharing of injecting equipment (other than needles) among IDU in the month preceding interview, 2003 & 2004

Injecting equipment	2003 (n=120) % of IDU	2004 (n=101) % of IDU
Spoons/mixing container	18	34
Filters	7	29
Tourniquet	11	12
Water	14	34

Source: IDRS IDU interviews

There were mixed reports from KES regarding the awareness and injecting risk behaviour of IDU in 2004, across both primarily heroin or methamphetamine users. Five KES commented that they felt users they came into contact with had a good awareness of risk and 'safe' practices and generally reported not sharing, or were 'getting wiser' to the risk of BBV transmission through sharing of equipment. Four other KES however, reported that they felt many users they came into contact with had become blasé about BBV risk or that there was less awareness of the risks of BBV transmission through sharing of needles or other injecting equipment, particularly among younger amphetamine users.

10.3 Location of injecting

In 2003, the majority of IDU reported their *usual* location when injecting drugs in the last month was a private home (89% of IDU, n=90), with small proportions reporting use in public locations (see Table 10.2). The same proportions per location were reported for location when *last* injected. The *usual* location of injecting was relatively unchanged compared to 2003.

Table 10.2: Usual location when injecting in the month preceding interview, 2003 & 2004

Location when injecting	2003 (n=120) % of IDU	2004 (n=101) % of IDU
Private home	85	89
Street/car park/beach	2	4
Car	10	5
Public toilet	1	2
Not injected in last month	1	-
Missing data	2	-

Source: IDRS IDU interviews

10.4 Injecting related health problems

IDU were asked if they had experienced six different injecting related health problems in the last one month (as listed in Table 10.3). In 2004, 61% of the IDU sample reported experiencing at least one type of injecting related health problem in the month prior to interview. Of these IDU, 53% had experienced more than one problem related to their injecting in that period. By far the most commonly experienced problems were prominent scarring or bruising around the injection site (45%), followed by difficulty injecting (36%). Compared to 2003, there were slight decreases in experience of both these problems. However, there was a small increase in the proportion reporting abscesses or infections related to injecting in the last month, from 4% in 2003 to 10% in 2004. Experience of other injecting related health problems remained stable across this time period.

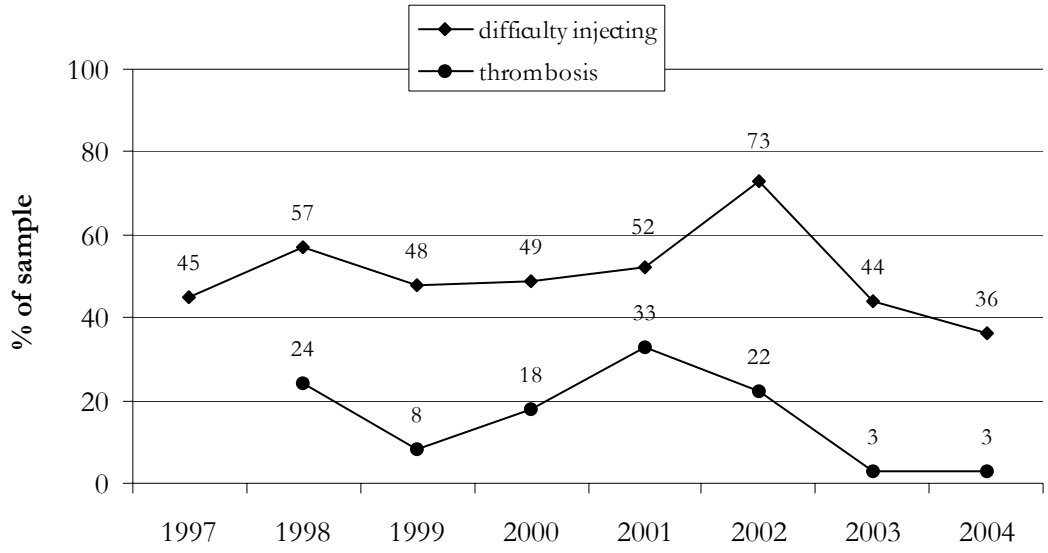
Table 10.3: Injecting related health problems experienced in the month preceding interview, 2002 - 2004

	2003 (n=120) % of IDU	2004 (n=101) % of IDU
Overdose	3	1
Dirty hit	14	16
Abscesses/infections	4	10
Prominent scarring/bruising	51	45
Difficulty injecting	44	36
Thrombosis	3	3

Source: IDRS IDU interviews

Figure 10.6 depicts the long-term trends for experience of difficulty injecting and thrombosis since 1997. Experience of thrombosis continues to decline from a peak in 2001, and experience of difficulty injecting has maintained a return to previous levels following a spike in 2002.

Figure 10.6: Experience of difficulty injecting and thrombosis among IDU in the month preceding interview, 1997 – 2004



Source: IDRS IDU interviews

IDU were also asked about their experience of injecting related health problems specific to injecting of benzodiazepines, methadone, buprenorphine and morphine, if they had injected these drugs in the month prior to interview.

An analysis of the number of IDU experiencing problems due to injecting these substances *in the last one month* revealed the following:

- Benzodiazepines - 3 of 5 injectors (60%) experienced one or more of the following problems; self-reported benzodiazepine dependence (n=2), swelling of their arm (n=2), scarring/bruising (n=1), difficulty finding veins (n=1).
- Methadone - 12 of 15 injectors (80%) experienced one or more of the following problems; self-reported methadone dependence (53%, n=8), difficulty finding veins (47%, n=7), scarring/bruising (33%, n=5), swelling of arm (33%, n=5), swelling of hand (20%, n=3), dirty hit (13%, n=2) or abscesses/infections (7%, n=1).
- Buprenorphine - 7 of 13 injectors (54%) experienced one or more of the following problems; self-reported buprenorphine dependence (n=5), scarring/bruising (n=3), difficulty finding veins (n=3), dirty hit (n=2), abscesses/infections (n=1), swelling of hand (n=1), vomiting/sweating (n=1) or "circulation problems due to bad veins" (n=1).
- Morphine - 14 of 28 injectors (50%) experienced one or more of the following problems; scarring/bruising (32%, n=9), difficulty finding veins (32%, n=9), self-reported morphine dependence (29%, n=8), abscesses/infections (11%, n=3), dirty hit (7%, n=2), swelling of arm (4%, n=1), swelling of hand (4%, n=1), vomiting/sweating (4%, n=1) or 'pins & needles' in hands (4%, n=1).

Compared to 2003, in 2004 similar numbers reported injecting and experience of problems related to injecting of benzodiazepines and methadone. In 2004 however, there was almost double the number of IDU reporting injecting of buprenorphine in the last month (13 v 7), though a similar proportion reported experience of related problems (54% v 57%), compared to 2003. There was also a decrease in the number of IDU reporting injecting of morphine (28 v 40), and in the proportion that reported experience of problems related to it (50% v 70%), in 2004 compared to 2003. The most commonly reported problems among injectors of these four drug types in the last month were similar for both years.

Several KES commented on injecting related health problems, primarily in reference to vein care and related problems such as infections and abscesses. Although two KES noted a decrease in occurrence of problems over the last year, all remarked that injecting-related problems for users continued to be an issue particularly with regard to methamphetamine use and injecting of morphine, methadone or buprenorphine. Problems reported as associated with methamphetamine injecting included vein damage due to the quality of the product (often considered 'dirty' or corrosive) and frequency of injecting, as well as infections arising from unhygienic practices (such as re-using a mix or 'wash' for a later injection). Problems associated with injecting of morphine were primarily thought to be the result of users not filtering out the non-soluble 'chalk' contained in tablet preparations or re-use (against recommendation) of filters (therefore non-sterile as well as inefficient), and include infections, abscesses, ulcers and difficulty with injecting and collapsed veins. Similar problems were associated with the injecting of methadone and buprenorphine, both of which are preparations designed for oral administration and are likely to cause vein health problems when injected. Comment was made by several KES that re-use, and sometimes sharing, of equipment meant for single use (eg. filters, water, winged-infusions etc) was a primary factor in injecting-related problems, but that costs of obtaining and use of such equipment as recommended were prohibitive to users.

10.5 Expenditure on illicit drugs

Overall, the median amount spent on illicit drugs yesterday reported by the IDU sample was $12.50 (range $0 - $500; n=101). This compares to a median amount of $25 (range $0 - $650; n=118) reported in 2003.

Table 10.4 presents the breakdown of the amounts spent on illicit drugs (i.e., excluding alcohol, tobacco and licit supplies of prescription medications), on the day before interview, by the whole sample, by those IDU that reported heroin as the drug they injected most in the last month, and by those that reported methamphetamine as the drug they injected most in the last month. The median amount spent on the day prior to interview is also given, for those that reported having bought illicit drugs that day. It can be seen that a larger percentage of primarily heroin-using IDU had spent money on illicit drugs on the day before interview, and had spent double the amount (on average), than their primarily methamphetamine-using counterparts.

Table 10.4: Expenditure on illicit drugs on the day preceding the interview, 2004

Amount	% of whole sample (n=101)	% of IDU who injected heroin most in last month (n=37)	% of IDU who injected methamphetamine* most in last month (n=39)
Nothing	48	38	54
Less than $20	4	3	0
$20 - $49	10	3	10
$50 - $99	16	11	26
$100 - $199	14	27	8
$200 - $399	7	16	0
$400 or more	2	3	3
Median $ expenditure**	50 *(n=53)*	100 *(n=23)*	50 *(n=18)*

Source: IDRS IDU interviews

* powder, base or crystal methamphetamine

** of those that reported spending money on illicit drugs on the day preceding interview

10.6 Mental health problems

In 2004, 47% of IDU reported experiencing a mental health problem (other than drug dependence) in the six months preceding interview.

Table 10.5 shows that the proportions of the sample that reported actually attending a professional was lower than the proportion reporting having experienced a problem (32% in 2004), but that the percentages per different category of professional were very similar across the three years depicted. In 2004, 4 people also reported receiving psychological or counselling support from correctional services psychologists (n=2) or parole officers (n=2).

Table 10.5: IDU attendance of a health professional, for a mental health problem, in the last 6 months, 2002 - 2004

Type of health professional	2002 (n=100) % of IDU	2003 (n=120) % of IDU	2004 (n=101) % of IDU
General Practitioner	14	17	23
Psychiatrist	14	13	15
Psychologist	8	8	6
Counsellor	9	10	9
Social worker	0	6	9
Mental health nurse	4	4	3
Community health nurse	2	2	2
Hospital emergency department	2	6	3
Psychiatric ward	0	2	3
Any	**30**	**32**	**32**

Source: IDRS IDU interviews

Note: percentages in each column do not total 100% as IDU could report attendance of more than one mental health professional

Table 10.6 reports the proportions of IDU, per mental health problem, that sought professional help for a mental health problem, in the six months prior to interview. As can be seen, there was very little difference between the years shown, with depression and anxiety being the most commonly reported problems.

Table 10.6: Mental health problem for which IDU sought help when attending a health professional in the last 6 months, 2002 - 2004

Mental health problem	2002 (n=100) % of IDU	2003 (n=120) % of IDU	2004 (n=101) % of IDU
Depression	17	21	22
Mania	0	2	0
Manic depression	0	3	2
Anxiety	8	15	13
Phobias	2	4	0
Panic	1	8	1
Paranoia	5	4	0
Drug-induced psychosis	3	1	3
Schizophrenia	1	1	3

Source: IDRS IDU interviews

Note: percentages in each column do not total 100% as IDU could report more than one mental health problem

These IDU reports were confirmed by KES comment that the most common problems seen among IDU generally were depression, anxiety and personality disorders (particularly borderline personality disorder and antisocial personality disorder). Several KES also reported that smaller percentages suffered bipolar disorder or psychosis, and a smaller percentage again would have a diagnosis of schizophrenia. It was also generally noted, and well understood by drug and alcohol treatment service providers universally, that drug and alcohol problems are seen "hand-in-hand" with mental health problems and a whole range of other related problems (eg. history of abuse, social isolation, unemployment, housing problems). As one KES put it, when people are at the point of seeking help "the wheels have fallen off". Clients of these services, and therefore those with whom health KES have most contact with, will generally represent the extreme end of the user spectrum and may not be representative of the wider IDU 'community'. However, reports from peer educator KES, who on the whole had contact with a larger population and wider variety of IDU, agreed with health KES in what they perceived the most common mental health problems to be among IDU generally.

There was consensus among all KES able to comment that mental health problems had not changed in nature or frequency, with regard to primarily heroin or other opiate users, in the last year. Depression and/or anxiety remained the most common mental health problems for this group. However, with regard to mental health problems associated primarily with methamphetamine, or polydrug, users, KES comments were mixed. Eight KES reported an increase in mental health problems associated with methamphetamine use, ranging from increased aggression, anxiety and heightened paranoia to methamphetamine-induced psychosis. Conversely, four KES reported a decline in these methamphetamine-related mental health problems, as well as a perceived decrease in "chaotic use" among those still using, and a decrease in disruptive and aggressive behaviour at services. Four other KES reported methamphetamine-related mental health problems as stable compared to last year.

10.7 Substance related aggression

For the first time in 2004, IDU were asked whether they had themselves, or whether they had seen others, become verbally or physically aggressive following drug use, and if so, after use of which drugs had this occurred in the preceding six months. The results showed that 23% of IDU reported they had become verbally aggressive following use of a drug in the preceding six months, and 7% reported that they had become physically aggressive following use of a drug in that time. Perhaps unsurprisingly, much larger percentages of IDU reported verbal (62%) or physical (45%) aggression in others following drug use. However, no clear association could be drawn between these reports of verbal and physical aggression following drug use and a particular drug or drugs.

10.8 Criminal and police activity

In 2004, a similar proportion of the IDU reported involvement in any type of crime during the last month (41%) or had been arrested in the twelve months prior to interview (26%), compared to 2003 (see Table 10.7). The most commonly reported types of crime were also the same as for 2003, with IDU primarily reporting involvement in drug dealing (31%) followed by property crime (14%). There were no significant differences in the proportions of males and females reporting either involvement in each type of criminal activity, in the frequency of criminal involvement in the last month, or in the proportions that had been arrested in the last 12 months.

Table 10.7: Criminal and police activity as reported by IDU, 2003 & 2004

	2003 (n=120) % of IDU	2004 (n=101) % of IDU
Criminal activity in last month		
Property crime	11	14
Drug dealing	28	31
Fraud	7	3
Violent crime	3	1
Any crime	*38*	*41*
Arrested in last 12 months	21	26
Perception of police activity in last 6 months		
More activity	32	35
Stable	38	49
Less activity	4	2
Don't know	27	15
More difficult to obtain drugs recently		
Yes	21	28
No	78	71

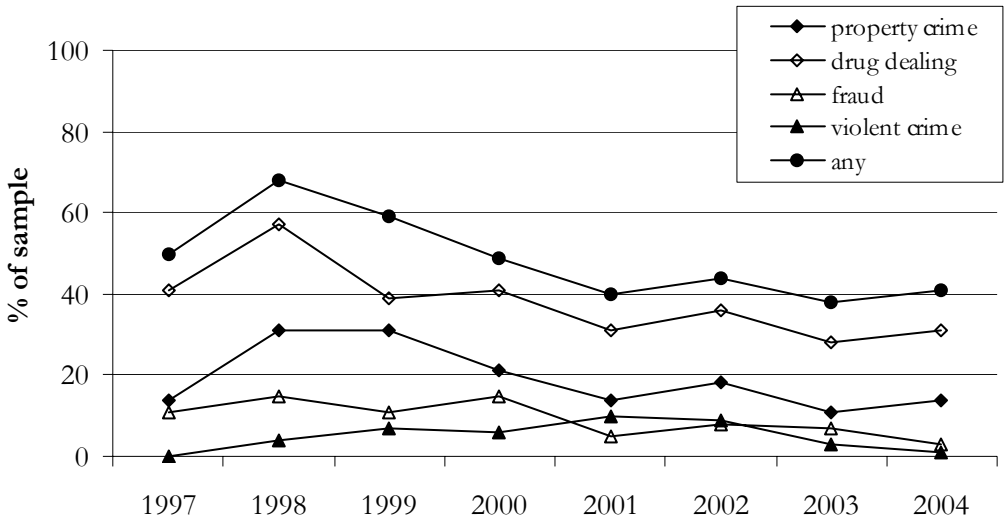
Source: IDRS IDU interviews

Of the 26 IDU that had been arrested in the preceding twelve months, the most common reasons for arrest were a driving offence (42%, n=9; includes 3 driving under the influence of alcohol and 2 involving driving under the influence of drugs) or property crime (27%, n=7). There were also three arrests each for drug dealing and violent crime. Only two IDU (8%) were arrested for use/possession of a prohibited substance.

For those able to comment, most IDU perceived that police activity in the last six months was either stable (49%) or increasing (35%). In comparison to 2003 there was an increase in the perception that police activity was stable. As in 2003, the majority of IDU in 2004 (71%) believed that police activity had not made it more difficult to obtain drugs recently.

Figure 10.7 shows the long-term trends regarding involvement in any criminal activity, and per each type of criminal activity measured, among IDRS IDU samples since 1997. It can be seen that there was a steady decline in *any* criminal activity from 1998 to 2001, from which time the prevalence of criminal involvement has been fairly stable. The two most prominent types of criminal activity, across all years, were drug dealing followed by property crime. Prevalence of all types of criminal activity among the IDRS IDU samples has been generally stable over the past four years of reporting.

Figure 10.7: IDU reported involvement in crime, by offence type, in the month prior to interview, 1997 – 2004



Source: IDRS IDU interviews

KES were asked to comment on the criminal activity of users as well as their perceptions of changes in police activity in the previous six to 12 months. Very few changes were reported in the pattern of criminal activity associated with heroin users with property crime still thought to dominate, along with prostitution. Several KES also reported no change in crime specifically related to methamphetamine users. However, a few KES commented that crime perpetrated by methamphetamine users seemed to be increasingly violent (i.e. more aggravated assault, sexual offences, and hold-ups with weapons). One KES commented that there seemed to be an increase in petty crime (theft etc) associated with methamphetamine use and that this, along with disruptive behaviour was part of the 'mind-set' of particularly young users (aided by the increased confidence and decreased perception of risk bestowed by amphetamine use). As in 2003, several KES reported increases in domestic violence and assaults against women, primarily associated with methamphetamines.

10.9 Summary of associated harms

A summary of trends in harms associated with illicit drug use among IDU is found in Table 10.8.

Table 10.8: Summary of trends in associated harms

Blood borne viruses	The numbers of incident notifications for HBV were stable, but unspecified notifications increased, both in SA and nationally (NNDSS). The number of both incident and unspecified notifications for HCV decreased in SA and nationally (NNDSS). HCV & HIV prevalence among IDU in SA was stable (NCHECR).
Injecting related issues	Increased % reporting sharing equipment since 2003 (IDU). No change in reported usual location of injecting (IDU). Increased prevalence of injecting of buprenorphine and associated problems, but decreased prevalence of morphine injecting and associated problems, in last month (IDU).
Expenditure on illicit drugs	Overall expenditure decreased since 2003, but primarily heroin users' expenditure greater than methamphetamine users' (unchanged).
Mental health issues	Generally stable (IDU). KES reports equivocal regarding problems associated with methamphetamine use, but no change otherwise.
Criminal & police issues	No change in prevalence of any criminal involvement, or arrest in previous 12 months (IDU). Drug dealing or property crime remain most common (IDU). IDU perceptions of police activity stable.

11. DISCUSSION

While the focus of the IDRS is the four main illicit drugs (heroin, methamphetamine, cocaine and cannabis), in 2004 the IDRS continued to capture information about the use of a number of pharmaceutical substances (morphine, methadone and buprenorphine) that had previously been flagged as potential areas of concern. The results provide the most up-to-date picture of substance use, and the harms associated with use, among IDU in South Australia. This information is vital in order to assist policy makers and health professionals to better service clients of treatment agencies and to help in the formulation and implementation of harm minimisation strategies.

The overall results of the 2004 survey suggest that the heroin market in SA has continued to stabilise and parameters of use return toward pre-shortage levels, whilst frequency of use of methamphetamine has decreased despite continued indication of a strong methamphetamine market presence. Use and injecting of pharmaceutical compounds, and the associated harms, was again highlighted, as was increased prevalence of sharing of injecting equipment and the concomitant risk of BBV transmission.

11.1 Heroin

The 2003 IDRS reported that there had been an apparent shift toward pre-shortage patterns of use, price and availability, though not of perceived purity, of heroin among IDU in SA. In 2004, it seems that the heroin market may have stabilised further, with price returning to pre-shortage levels and availability stable to increasing, though purity was still considered to be below pre-shortage quality and opinion on the recent trend in purity was mixed. Though some fluctuation in frequency of use was seen compared to 2003, overall patterns of use also showed signs of stabilisation toward pre-shortage levels. In addition, analysis of IDU that nominated heroin as their drug of choice indicated users continue to supplement or substitute their heroin use with other opioid substances such as morphine and methadone. The trends in these parameters were largely supported by KES.

Secondary indicator data also suggest that there has been little change in other signs of heroin use or heroin-related harms. In particular, the number of heroin-related possession or provision offences recorded by SAPOL, and the number of calls to ADIS or the number of presentations to DASC treatment services, remained relatively stable for the 2003/2004 financial year. ABS data showed a decline in accidental opioid overdose deaths in SA, and AIHW data showed opioid-related hospital admissions were stable, in 2003. It should be noted though that the ABS and AIHW data lag a year behind IDU information and consequently their usefulness, as indicators of 'emerging' trends, is somewhat restricted in the IDRS context. However, recent experience of heroin overdose among IDU was low and stable compared to 2003 and opioid-related attendances at a local hospital emergency department were stable.

Overall, it seems that although there has been a continuing return of heroin in SA, given stabilisations in use and availability, as well as decreases in price, over the past two years, the heroin market in SA has not fully 'regained' it's pre-shortage status, at least for many IDU. This conclusion is drawn from indications that purity remains low, IDU continue to supplement or substitute use with other opioids, and secondary indicators suggest the prevalence of heroin-related harms are stable.

11.2 Methamphetamine

The greatest impact of the heroin shortage was the concomitant rise in methamphetamine use and the growth in availability of different, more potent forms of the drug. In 2004, however, despite the market parameters of price, availability and perceived purity indicating that methamphetamine continues to have a strong presence in SA, IDU reported a marked decrease in the use of all forms of methamphetamine compared to previous years. In particular, the price of all forms of methamphetamine showed decreases (though was generally considered stable), and availability remained easy. In addition, there was an overall slight increase in perceived purity, and purity of the base and crystal forms was perceived as high or medium by IDU. Indicator data also showed an increase in the number of methamphetamine provision offences recorded by SAPOL in 2003/2004, as well as evidence that local methamphetamine manufacture continued to be a major contributor to the SA market. It seems unlikely then that these market parameters explain the marked decrease in use of methamphetamine that was reported by IDU.

There was only limited support of a decrease in frequency of use of methamphetamine among IDU from KES reports, with the majority reporting no change in use parameters. A small number did indicate that fewer instances of methamphetamine-related disruptive behaviours or mental-health problems had been observed at treatment services, and that a decrease in the number of methamphetamine-related presentations to treatment had been noted recently. In support of this, a small decrease in presentations (both total presentations and inpatient detox admissions) to DASC treatment services for amphetamines was recorded in 2003/2004. No clear trend was seen in local hospital emergency attendances for amphetamines, though a decrease in attendances for amphetamine-related psychosis was suggested in that year.

Overall, indicators suggest that the methamphetamine market remains strong in SA, but that IDU may be 'backing-off' and decreasing their use for reasons that are not as yet clear. It is too early to say whether this decrease in frequency of methamphetamine use will become a sustained downward trend or was anomalous to the 2004 IDRS.

11.3 Cocaine

Similar to previous years, only a very small number of IDU were able to supply information regarding the price, purity or availability of cocaine, which was reflective of the very low numbers of IDU that had used cocaine in the last six months. In addition, although several KES were able to provide some information on cocaine, this was limited and none could nominate cocaine as their main area of expertise. Consequently, the data for price, purity and availability of cocaine in 2004 is of limited value.

The small number of KES and IDU either using cocaine or able to provide information in itself indicates the lack of a sizeable and visible cocaine market in Adelaide, particularly amongst the IDU sampled by the IDRS. Indicator data, such as the number of cocaine possession and provision offences, calls to ADIS, DASC treatment services data for cocaine, and SA hospital admissions data also support this presumption. However, this does not exclude the possibility that a cocaine market exists beyond the scope of this survey.

11.4 Cannabis

The greater level of detail that was collected regarding cannabis price and use by IDU in the 2003 survey, with the differentiation between two different forms of cannabis (bush and hydro) was expanded further in 2004 to incorporate the parameters of availability and potency. Overall, there has been little, if any, change in any of these parameters since 2003.

In particular, the price, availability and perceived potency were unchanged from 2004, suggesting that changes to legislation (of early 2003) have not as yet had a substantial impact on the SA cannabis market. Almost half of those able to comment reported that the source of the cannabis they had last used had been a small-time 'backyard' user/grower. Cannabis use was prevalent among IDU and frequency of use high, with parameters of use being generally stable over the long-term.

KES reported no changes in any parameter of the cannabis market, or use of cannabis among IDU, since 2003. Moreover, secondary indicator data also supported the view of a stable cannabis market, and stability in indicators of cannabis-related harms in SA.

11.5 Other opioids

As in recent years, in 2004 the use of other opioid substances by IDU was common, with 79% reporting recent use of some type of opioid substance, excluding heroin. There were some changes however, in the use of other opioids by IDU in the 2004 sample. Specifically, although the proportion of IDU reporting recent use of morphine or other opioids (oxycodone or codeine) remained stable, there was a decrease in the frequency of use, particularly of morphine, following a rise over the last couple of years. The price and availability of morphine was unchanged since 2003, so this decrease was most likely influenced by the increased availability, and decreased price, of heroin over the same period. As in 2003, the majority of morphine users reported use by injecting, and mainly used illicit supplies of Kapanol® and MS Contin®.

In addition, in 2004 there was a decrease in the proportion of IDU that reported recent use of illicit methadone, while the proportion reporting use of illicit buprenorphine remained stable. Although there was no change in the proportions reporting use of *illicit* buprenorphine by injecting, there was a doubling of the proportion reporting recent injection of *licit* buprenorphine, concomitant with an increase in the percent of IDU on a buprenorphine treatment program in 2004. It is worth noting however, that of those IDU that reported use of any methadone or buprenorphine, 75% or more reported *mainly* licit use in the last six months.

KES reports of other opioid use were primarily within the context of heroin-using IDU and supported a perception that users were continuing to use other opioids to substitute or supplement their heroin use, despite the 'return' of heroin.

11.6 Other drugs

There was no change in the proportion of IDU reporting recent use of ecstasy, but a decline in the proportion reporting recent use of hallucinogens in 2004. Frequency of use of both substance types was low and unchanged. There was also no change in the proportion of IDU reporting recent use or injecting of benzodiazepines, but a continuing

increase in the frequency of use since 2002 was noted. Most IDU reported use of a licit supply of benzodiazepines, mainly of diazepam. Anti-depressant use was also stable, with almost exclusively licit use reported.

11.7 Associated harms

Despite a decrease in frequency of injecting seen among methamphetamine users in the 2004 survey, there was a marked increase in the proportion of the sample reporting sharing of injecting equipment (excluding needles) in the month before interview. Along with KES reports of complacency and ignorance of 'safe' injecting practices among some IDU, particularly the younger and more naïve methamphetamine users, this suggests that reinforcement and/or wider dissemination of harm-reduction messages is required. The high rate of sharing among IDU may impact on what has been a positive downward trend in HCV prevalence over recent years.

In 2003 a number of additional questions were added in order to obtain more detail on the harms associated with injecting non-injectable substances. A higher proportion of IDU reported injecting non-injectable substances after the heroin shortage (Longo *et al.*, 2001) and this trend has continued. The 2004 survey identified that injecting of morphine was common, as was injecting of methadone and buprenorphine, with the use of buprenorphine by injecting more than doubling compared to 2003. Despite a decrease in the prevalence of morphine injecting, there were large proportions of injectors of morphine, methadone and buprenorphine that reported injecting-related problems such as substance dependence, scarring and bruising, difficulty finding veins, and abscesses or infections. Several KES commented that these problems were exacerbated by lack of IDU access and/or proper (single) use of filters and other injecting equipment (primarily due to financial constraints).

As in previous years, both IDU and KES reported on mental health issues, which were generally reported as stable in 2004. There was no change in IDU reported attendance to a health professional for a mental health problem, with attendance to a GP for depression and/or anxiety predominating. KES concurred with the predominance of depression and anxiety, particularly among opioid users, and that this had been stable recently. There were mixed reports however, regarding whether there had been any change in the prevalence of mental health problems associated with methamphetamine use.

An analysis of expenditure on drugs demonstrated that of those who reported having spent money on illicit drugs on the day preceding interview, heroin users had spent twice as much as methamphetamine users.

There was no change in the prevalence or type of criminal involvement reported by IDU, with drug dealing and property crime remaining the most common. Most IDU perceived that police activity was either stable or increasing and the majority reported that police activity had not made it more difficult to obtain drugs recently.

12. IMPLICATIONS

In the 2004 SA IDRS survey more evidence is emerging of a stabilisation of patterns of heroin use since the 2001 shortage. In contrast, while heroin use appears to be stabilising, a downturn in some parameters of methamphetamine use have appeared. The following issues were identified from the results of the 2004 survey, which will require ongoing attention from policy makers, researchers and health professionals;

- The increase in availability of heroin in South Australia over the last two years has seen patterns of use among IDU stabilise and approximate pre-shortage patterns. In contrast, there has not been an upturn in secondary indicators such as drug related crimes and overdose experience. Careful monitoring of secondary indicators must be carried out to identify any early indicators of an increase in crime and/or overdose so that early interventions can be instigated. In the case of overdose, vigilance is particularly warranted as the indicator data reported stems from the previous year.

  Investigations also need to be carried out to ascertain why a concomitant rise in heroin overdose has not been seen in the indicator data or reported by IDU. One potential reason may be that IDU have identified and developed protective strategies over the last couple of years to prevent overdose.

- A substantial downturn in the intensity of methamphetamine use among South Australian IDU has been one of the more surprising findings of the 2004 SA IDRS survey. The sharp decrease in the median number of days used, particularly for base and crystal, stands in contrast to the majority of key expert reports of very little change in the patterns of use. A minority of KES did comment on changes in use and suggested users had "backed off" in their intensity of use and a few also noted a recent decline in attendances to services for methamphetamine related problems. The reasons for this apparent discrepancy between user accounts and KES accounts requires further investigation.

  When direct information from users is not available very often information from 'experts in the field' is sought and decisions can be made that directly effect service provision. Explanations for discrepancies such as the one identified with respect to methamphetamine use need to be sought in order to better understand the validity of information collected from user and key expert sources. The discrepancies that occur between IDU, KES and indicator data are a timely reminder of the need to interpret results from the IDRS with caution and utilise the triangulation methods made available from all three sources before drawing conclusions.

- Although the proportion of IDU reporting use of buprenorphine remains small it is increasing at a steady rate reflecting the uptake of buprenorphine as a form of opioid substitution therapy. The proportion of the sample injecting any buprenorphine, licit or illicit, has doubled since last year and most of this was accounted for by users injecting their licitly obtained supply. With the proportion of IDU taking up buprenorphine as an opioid substitution therapy set to rise a close eye should be kept on the rate of injecting and associated injecting problems.

- The proportion of IDU reporting use of clean needles has been above 80% for the past 4 years. In contrast, the proportion of IDU reporting sharing of injecting equipment other than needles has remained at much higher levels. In 2004, substantial rises in the sharing of equipment was seen. For example, four times as many IDU reported sharing of filters in 2004 than in 2003. As with the discrepancies in KES reports regarding methamphetamine use among IDU, a similar situation was revealed concerning the sharing of injecting equipment. Approximately half of the KES sampled believed that IDU had a good knowledge of the dangers of sharing equipment and were engaging in safe practices. In contrast, other KES reported that IDU were becoming more blasé about the risks of sharing injecting equipment and that younger methamphetamine users were less aware of the dangers of BBV transmission.

  Investigations need to be undertaken to see why a sudden rise in sharing of equipment has occurred particularly as a sustained decrease was recorded in 2002 and 2003. Moreover, the discrepancies between KES need to be fully investigated to understand how such disparate views are being held and what potential impact they may have on the provision of resources for educating users about the dangers of sharing injecting equipment. It may be that KES have access to different populations of users and that this will require further elucidation in future reports.

REFERENCES

Australian Crime Commission (2003). *Australian Illicit Drug Report 2001-2002*. Canberra: Australian Crime Commission.

Australian Crime Commission (2004). *Australian Illicit Drug Report 2002-2003*. Canberra: Australian Crime Commission.

Australian Crime Commission (in press). *Australian Illicit Drug Report 2003-2004*. Canberra: Australian Crime Commission.

Breen, C., Degenhardt, L., Roxburgh, A., Bruno, R., Duquemin, A., Fetherston, J., Fischer, J., Jenkinson, R., Kinner, S., Longo, M., Rushforth, C. (2003). *Australian Drug Trends 2002: Findings from the Illicit Drug Reporting System (IDRS)*. NDARC Monograph No. 50. Sydney: National Drug and Alcohol Research Centre.

Breen, C., Degenhardt, L., Roxburgh, A., Bruno, R., Fetherston, J., Jenkinson, R., Kinner, S., Moon, C., Proudfoot, P., Ward, J. and Weekley, J. (2004). *Australian Drug Trends 2003: Findings from the Illicit Drug Reporting System (IDRS)*. NDARC Monograph No. 51. Sydney: National Drug and Alcohol Research Centre.

Breen, C., Degenhardt, L., White, B., Bruno, R., Chanteloup, F., Fisher, J., Johnston, J., Kinner, S., Moon, C., Proudfoot, P., and Weekley, J. (2004). *Australian Party Drug Trends 2003: Findings from the Party drugs Initiative (PDI)*. NDARC Monograph No. 52. Sydney: National Drug and Alcohol Research Centre.

CDA-NNDSS (January 2005). Communicable Diseases Australia - National Notifiable Diseases Surveillance System. Australian Government Department of Health and Ageing. Accessible at: http://www1.health.gov.au/cda/Source/CDA-index.cfm

Chesher, G.B. (1993) Pharmacology of the sympathomimetic psychostimulants. In: D. Burrows, B. Flaherty & M. MacAvoy (Eds.), *Illicit Psychostimulant Use in Australia* (pp. 9-30). Canberra: Australian Government Publishing Service.

Cormack, S., Faulkner, C., Foster Jones, P., & Greaves, H. (1998) *South Australian Drug Trends 1997. Findings from the Illicit Drug Reporting System (IDRS).* NDARC Technical Report No. 57. Sydney: National Drug and Alcohol Research Centre.

Darke, S., Cohen, J., Ross, J., Hando, J., & Hall, W. (1994) Transitions between routes of administration of regular amphetamine users. *Addiction* 89:1077-1083.

Darke, S., Hall, W., & Topp, L. (2000) *The Illicit Drug Reporting System (IDRS) 1996-2000*. NDARC Technical Report No. 101. Sydney: National Drug and Alcohol Research Centre.

Darke, S., Hall, W., Ross, M.W., & Wodak, A. (1992) Benzodiazepine use and HIV risk taking behaviour among injecting drug users. *Drug and Alcohol Dependence* 31:31-36.

Degenhardt, L., Roxburgh, A. and Black, E. (2004a). *2003 Australian Bureau of Statistics data on accidental opioid induced deaths*. Sydney: National Drug and Alcohol Research Centre.

Degenhardt, L., Roxburgh, A. and Black, E. (2004b). *Cocaine and amphetamine mentions in accidental drug-induced deaths in Australia 1997-2003*. Sydney: National Drug and Alcohol Research Centre.

Hando J & Darke S (1998) *NSW Drug Trends 1997. Findings from the Illicit Drug Reporting System (IDRS).* NDARC Monograph No. 56. Sydney: National Drug and Alcohol Research Centre.

Hando J & Flaherty B (1993) *Procedure manual for the key informant study*. World Health Organisation Initiative on cocaine. Geneva, World Health Organisation Programme on Substance Abuse.

Hando J, Darke S, Degenhardt L, Cormack S & Rumbold G (1998) *Drug Trends 1997. A comparison of drug use and trends in three Australian states: Results from a national trial of the Illicit Reporting Drug System (IDRS).* NDARC Monograph, No. 36. Sydney: National Drug and Alcohol Research Centre.

Hando J, O'Brien S, Darke S, Maher L & Hall W (1997). *The Illicit Drug Reporting System Trial: Final Report.* NDARC Monograph No. 31. Sydney: National Drug and Alcohol Research Centre.

Longo, M., Christie, P., Ali, R. & Humeniuk, R. (2003). *South Australian Drug Trends 2002: Findings from the Illicit Drug Reporting System.* NDARC Technical Report Number 146. Sydney: National Drug and Alcohol Research Centre.

National Centre in HIV Epidemiology and Clinical Research (2004). *Australian NSP Survey National Data Report 1995-2003*. National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, NSW.

Reynolds, J., Lenton, S., Charlton, M. and Caphorn, J. (1997). Shopping, baking and using: the manufacture, use and problems associated with heroin made in the home from codeine based pharmaceuticals. *In* Erikson, P.A., Riley, D.A., Cheung, Y.T. and O'Hare, P.A. *Harm Reduction: A new direction for drug policies and programs.* University of Toronto Press, Toronto. pp. 324-339.

South Australian District Court (2004). *R v Avory: SADC 55*

South Australia Police Annual Report 2000-2001, 2001-2002, 2002-2003 and 2003-2004.

SPSS Version 12.0.1. for Windows (2004). SPSS Inc.

Topp, L. & Churchill, A. (2002). Australia's dynamic methamphetamine market. *Drug Trends Bulletin, June 2002;* available at: http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.bulletins

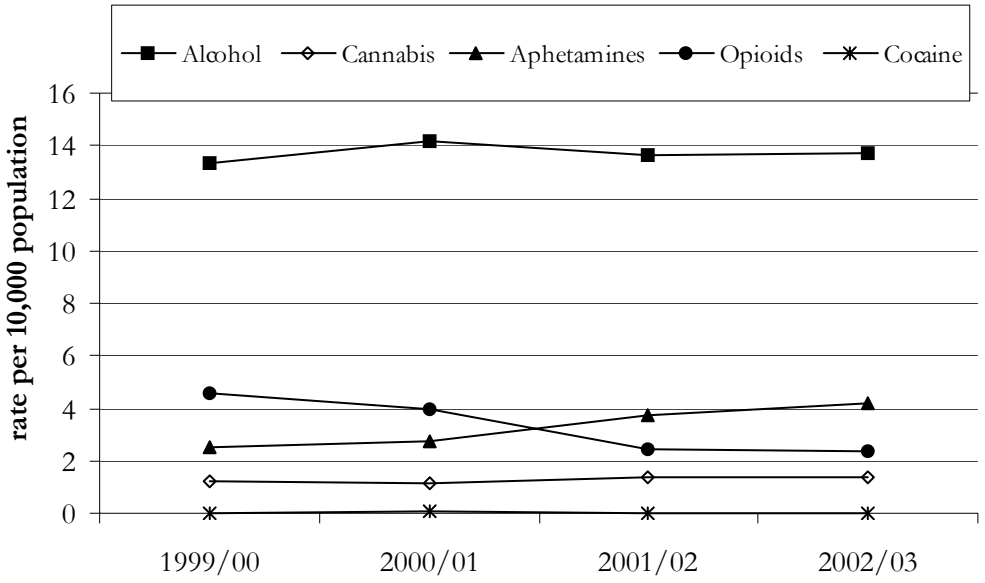
Weekley, J., Pointer, S. and Ali, R. (2004). *South Australian Drug Trends 2003: Findings from the Illicit Drug Reporting System (IDRS).* NDARC Technical Report No. 176. Sydney: National Drug and Alcohol Research Centre.

Weekley, J., Pointer, S. and Ali, R. (2004). *South Australian Party Drug Trends 2003: Findings from the Party drugs Initiative (PDI).* NDARC Technical Report No. 184. Sydney: National Drug and Alcohol Research Centre.

White, B., Breen, C. & Degenhardt, L. (2003). *NSW Party Drug Trends 2002: Findings from the Illicit Drug Reporting System (IDRS)* Party Drugs Module. NDARC Technical Report N0. 162. Sydney: National Drug and Alcohol Research Centre.

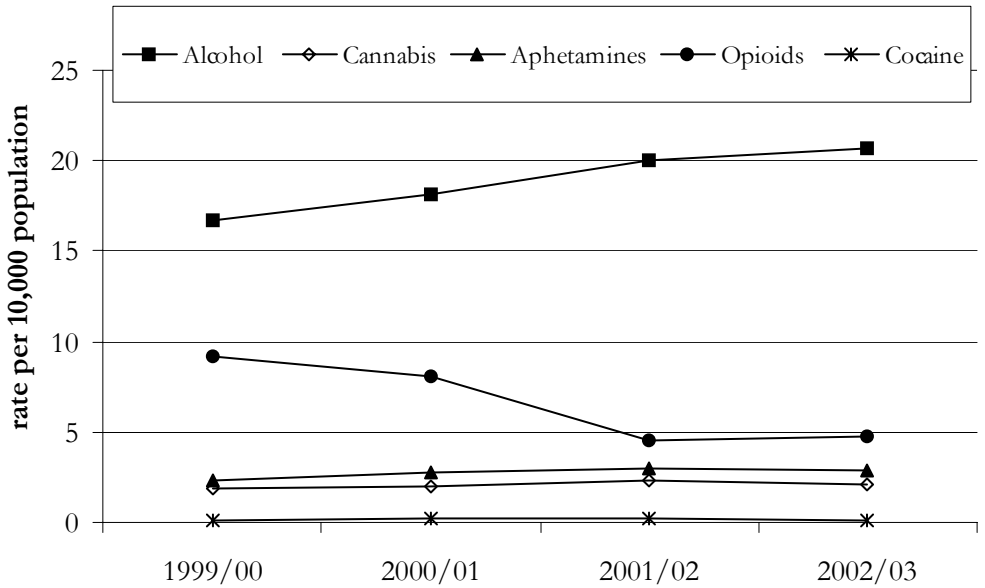
APPENDIX

Figure A: Rate of substance-related admissions* (primary diagnosis) to hospital in South Australia, July 1999 to June 2003



Source: Australian Institute of Health and Welfare
* for persons aged between 15 and 54 years
Note: 'primary diagnosis' was given to those admissions where the substance was considered the primary reason for the patient's episode of care.

Figure B: Rate of substance-related admissions* (primary diagnosis) to hospital in Australia, July 1999 to June 2003



Source: Australian Institute of Health and Welfare
* for persons aged between 15 and 54 years
Note: 'primary diagnosis' was given to those admissions where the substance was considered the primary reason for the patient's episode of care.