

B. Quinn

VICTORIAN DRUG TRENDS 2008
Findings from the
Illicit Drug Reporting System (IDRS)

Australian Drug Trends Series No. 22

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2008**



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Illicit Drug Reporting System
(IDRS)**

Brendan Quinn

**The Macfarlane Burnet Institute for Medical Research and Public
Health**

Australian Drug Trends Series No. 22

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ABBREVIATIONS

ACC	Australian Crime Commission
ADIS	Alcohol and Drug Information Service
AGDH&A	Australian Government Department of Health and Ageing
A&TSI	Aboriginal and/or Torres Strait Islander
BBVI	Blood-borne viral infection(s)
BZD	Benzodiazepine(s)
EDRS	Ecstasy and related Drugs Reporting System
GHB	Gamma-hydroxy-butyrate
HBV	Hepatitis B virus
HCV	Hepatitis C virus
IDRS	Illicit Drug Reporting System
IDU	Injecting drug user(s)
KE	Key expert(s)
LSD	<i>d</i> -lysergic acid
MAS	Metropolitan Ambulance Service
MDMA	3,4-methylenedioxymethamphetamine
NDARC	National Drug and Alcohol Research Centre
NHMD	National Hospital Morbidity Database
NSP	Needle and Syringe Program(s)
PBS	Pharmaceutical Benefits Scheme
PCR	Patient Care Record
PDI	Party Drug Initiative
REU	Regular ecstasy user(s)
VIFM	Victorian Institute of Forensic Medicine
YDRS	Youth Drug Reporting System

GLOSSARY OF TERMS

Cap	Small amount, typically enough for one injection
Illicit pharmaceuticals	Pharmaceuticals (e.g. antidepressants, antipsychotics, benzodiazepines, morphine, oxycodone, pharmacotherapies, morphine) obtained from a prescription in someone else's name, e.g. through buying them from a dealer or obtaining them from a friend, partner, etc. The definition does not distinguish between the inappropriate use of licitly obtained pharmaceuticals, such as the injection of buprenorphine or morphine, and appropriate use
Licit pharmaceuticals	Pharmaceuticals obtained by a prescription in the user's name. This definition does not take account of 'doctor shopping' practices; however, it differentiates between prescriptions for self as opposed to pharmaceuticals purchased through a dealer or prescribed to a partner, friend, etc
Lifetime injection	Injection (typically intravenous) on at least one occasion in the participant's lifetime
Lifetime use	Use on at least one occasion in the participant's lifetime via one or more of the following routes of administration: injection, smoking, snorting and/or swallowing
Point	0.1 gram, although may also be used as a term referring to an amount for one injection (similar to a 'cap'; see above)
Recent injection	Injection (typically intravenous) in the last six months
Recent use	Use in the last six months via one or more of the following routes of administration: injecting, smoking, snorting and/or swallowing
Session	A single continuous period of drug use
Use	Use via one or more of the following routes of administration: injecting, smoking, snorting and/or swallowing

EXECUTIVE SUMMARY

Background

In 1998 the Australian Government Department of Health and Ageing (AGDH&A) commissioned the National Drug and Alcohol Research Centre (NDARC) to implement a national Illicit Drug Reporting System (IDRS), following a successful pilot study in Sydney during 1996 and a multi-state trial in 1997 (Hando et al., 1997; Hando & Darke, 1998; Hando et al., 1998). The 1998 IDRS study was conducted in New South Wales, Victoria and South Australia (McKetin et al., 1999), with each state undertaking an injecting drug user (IDU) survey, key expert (KE) survey, and analysis of available secondary indicator data.

In 1999, the IDRS study was replicated in New South Wales, Victoria and South Australia, with all other remaining states and territories participating through the collection of secondary indicator data and completion of KE interviews. In 2000, the IDRS became a truly national drug trend monitoring system when all states and territories conducted the complete study.

The aim of the IDRS study is to monitor emerging trends related to the use of heroin, methamphetamine, cocaine and cannabis. The IDRS study provides nationally comparable data with respect to patterns of illicit drug use and related harms, and provides a basis for better informing future policy and research initiatives.

The value of Victorian IDRS findings

Available Victorian health and law enforcement indicator data sources provide important information in relation to illicit drug use prevalence and related morbidity and mortality within this jurisdiction. However, the majority of these data sources are by nature *lag indicators* (where the most recent data available may be up to 12 months old in some cases), and are therefore insufficient on their own for strategic early warning purposes.

Since 1997 in Victoria, the IDRS has been a strategic early warning mechanism concerning illicit drug trends because it has strived to supplement available secondary indicator data sources with *lead indicators* (such as that provided by direct surveys with sentinel IDU groups and KE) of drug prices, purity, availability and current patterns of use. Findings from successive IDRS studies conducted in metropolitan Melbourne have informed health, law enforcement and community sector responses to illicit drugs in Victoria since 1997.¹ Some recent examples of where the IDRS methodology or Victorian data have been used include:

- in the development of research into cocaine markets in Victoria and New South Wales (Shearer et al., 2005);
- in research into the course and consequences of the heroin shortage in Victoria (Dietze et al., 2003);
- in drug trend monitoring research on patterns and characteristics of psychostimulant use in Melbourne (Johnston et al., 2004);

¹ For specific examples of how previous Victorian IDRS findings have been utilised please refer to: Fry & Miller, 2001; Fry & Miller, 2002; Jenkinson et al., 2003; Jenkinson et al., 2004; Jenkinson & O’Keeffe, 2005; Jenkinson & O’Keeffe, 2006; and Jenkinson & Quinn, 2007.

- in the review of the Victorian Drug Treatment Service System (Ritter et al., 2003);
- in Stage One of Australia's Drug Policy Modelling Project (DPMP) (Moore, Caulkins & Dietze, 2005);
- in policy development and review activities and inquiries conducted by the Victorian Government (Victorian Department of Human Services, 2006; Victorian Department of Human Services, 2007a; Drugs and Crime Prevention Committee, 2004; Drugs and Crime Prevention Committee 2006; and Di Natale & Ritter, 2003);
- in the annual *Victorian Drug Statistics Handbook* (Victorian Department of Human Services, 2009b);
- in a national survey examining attitudes, understanding and experiences of drug-driving (Mallick et al., 2007); and
- in research into the use of amphetamine-type stimulants (ATS), in addition to prevention and early intervention of methamphetamine-related harms (Jenkinson & Quinn, 2008).

Victorian IDRS data has also been disseminated widely via conferences, community forums, posters, magazine articles, and peer-reviewed publications.

A key advantage of the IDRS study is that it has replicated core methods across each state and territory over a number of years (this is the twelfth year the study has been conducted in Melbourne). At a national level, this has permitted the identification of emerging jurisdictional differences with respect to illicit drug markets, and in turn has enhanced the capacity of health and law enforcement sectors to develop proactive responses to illicit drug issues.

Summary of 2008 Victorian drug trends

The Centre for Epidemiology and Population Health Research of the Macfarlane Burnet Institute for Medical Research and Public Health conducted the Melbourne arm of the 2008 IDRS study between June and October 2008. The project consisted of:

1. A structured survey of 150 current IDU recruited from a number of sites across the Melbourne metropolitan area;
2. Semi-structured interviews with 38 KE from a variety of professional settings, selected according to their knowledge about illicit drug use, and level of contact with illicit drug users during the six months preceding the survey; and
3. Analysis of secondary illicit drug use indicators.

Data collected via these three methods were analysed in order to identify illicit drug-related trends in Melbourne for the 2007/2008 year. Where appropriate, these data were also compared to findings from the 1997 to 2007 applications of the IDRS in Melbourne.

The 2008 IDRS study detected a number of trends of relevance during the preceding six to 12 months. Table A provides a summary of identified trends in price, availability, purity and prevalence of use for the four main illicit drug types explored in this study – heroin, methamphetamine, cocaine and cannabis. These are discussed in turn, along with summary details on other drug trends and associated harms/drug-related issues.

Heroin

Nearly three-quarters (73%, n=109) of the IDU survey respondents reported that heroin was their main drug of choice, and 86% (n=129) reported having used and injected heroin during the preceding six months. Prevalence of recent heroin use by Melbourne IDU respondents remained relatively stable in 2008 (86% compared to 85% in 2007, 76% in 2006, 89% in 2005, 86% in 2004 and 90% in 2003).

Respondents reported using heroin on a median of 81 days during the past six months, with over one-fifth (21%, n=32) reporting use of heroin on a daily basis during that time. Frequency of reported heroin use increased in 2008 (81 days compared to a median of 72 days in 2007).

In 2008, respondents reported paying (median price): \$47.50 for a cap, \$100 for a quarter-gram, \$180 for a half-gram, and \$300 for one gram (on the last occasion of purchase). The reported prices of a cap and quarter-gram of heroin remained relatively stable in 2008, although the reported prices of a half-gram and gram of heroin decreased slightly. As in previous years, the most popular purchase amount of heroin was a half-gram (n=61), followed by a cap (n=52).

Current heroin purity was reported as low (45%, n=54) to medium (43%, n=51) by the majority of IDU respondents who commented (n=119). Of the 12 KE who commented on current heroin purity, the majority (n=9) reported that it was low at the time of interview. As in previous years, a higher proportion of recent heroin users (n=128) reported most commonly using heroin rock (78%, n=100), in comparison to powder (22%, n=28) during the last six months. More specifically, the most common form of heroin used by recent heroin users was white/off-white rock (70%, n=89), as opposed to white/off white powder (16%, n=20), brown rock (9%, n=11), or brown powder (6%, n=8).

The majority of IDU respondents who commented on the availability of heroin (n=121) reported it as either very easy (51%, n=62) or easy (38%, n=46) to obtain at the time of interview, and that availability had been stable over the past six months (76%, n=92). Most participants who commented on where they usually sourced their heroin (n=116) reported that they usually purchased from known dealers (70%, n=85). Common venues (locations) where participants normally scored heroin were reported to be an agreed public location (60%, n=73), home delivery (28%, n=34), dealer's home (27%, n=33), or street market (24%, n=29). KE comments supported IDU reports that heroin was very easy or easy to obtain, and that mobile dealing was more common than street dealing in many areas.

Participant reports of lifetime heroin overdose (59%, n=74), and recent heroin overdose (13%, n=19), increased in comparison to the previous year (49% and 7% respectively in 2007), with 8% of participants (n=12) reporting that they had received naloxone during the last six months, an increase since 2007 (4%). While KE generally indicated that overall rates of non-fatal and fatal heroin overdoses had remained stable in the last six to 12 months, seven KE reported an increase in overdose rates, while three KE reported a reduction in overdose rates during that time.

Corresponding with an increase in the number of IDU survey respondents who reported that heroin was their drug of choice in 2008, the reported frequency of heroin use also increased this year, as did reports of lifetime and recent heroin overdose, and recent receipt of naloxone. Reported prevalence of heroin use, however, remained stable in comparison to the previous year. Heroin purity levels (based on the purity of drug seizures made by Victoria Police – Forensic Services Department) remained relatively

stable in comparison to 2007 levels, as did heroin prices. These trends in heroin use will continue to be monitored.

Table A: Price, availability, purity and prevalence of use for heroin, methamphetamine, cocaine and cannabis in Melbourne, Victoria, 2008

	Heroin	Methamphetamine	Cocaine	Cannabis
Price				
<i>Cap/point</i>	\$47.50	\$40-\$50	\$100	Gram \$20 (hydro)
<i>Gram</i>	\$300	\$200-\$370	\$345 (\$290-\$400)	Ounce \$250 (hydro)
	Generally stable prices	Generally stable prices	Stable prices	Stable
Availability	<ul style="list-style-type: none"> • Availability very easy to easy and stable • Mostly accessed through known dealers at agreed public locations 	<ul style="list-style-type: none"> • Availability (speed and crystal meth/ice) generally very easy or easy and stable • Sourced from known dealers and friends 	<ul style="list-style-type: none"> • Availability easy (67%) and stable (83%) • Sourced from known dealers 	<ul style="list-style-type: none"> • Cannabis readily available • Stable • Accessed through friends and known dealers
Purity	<ul style="list-style-type: none"> • Average purity 22% (range=3%-63%)^a • Purity low to medium^b 	<ul style="list-style-type: none"> • Average purity 21% (range=10%-57%)^a • Speed medium (38%) to low (36%), crystal meth/ice high (46%) to medium (38%)^b, reports of change variable 	<ul style="list-style-type: none"> • Average purity 39% (range=7%-76%)^a • Purity medium (55%) to low (27%), stable^b 	<ul style="list-style-type: none"> • Hydro purity high to medium^b • Bush purity medium to high^b • Stable potency^b
Use	<ul style="list-style-type: none"> • White/off-white rock (70%), white/off-white powder (16%) • Increasing frequency of use, stable prevalence of use • Most widely used illicit drug (86%) 	<ul style="list-style-type: none"> • Slight decrease in prevalence of use of speed, base and crystal meth/ice • Frequency of use around once per fortnight (median 12 days) 	<ul style="list-style-type: none"> • Reported prevalence of cocaine use stable • Very low frequency of use (median 4.5 days) 	<ul style="list-style-type: none"> • Most frequently used illicit drug • Commonly used concurrently with other drugs

^a Based on the purity of drug seizures made by Victoria Police (Forensic Services Department)

^b Based on IDU estimates of purity/THC potency

Methamphetamine

Different forms of methamphetamine are currently available in Australia. For the past six years, the IDRS study has collected information on the use, price, purity and availability of three main forms of methamphetamine: speed, base and crystal meth/ice, along with information on the use of amphetamine liquid and pharmaceutical stimulants (e.g. dexamphetamine, Ritalin[®]).

As in previous years, almost the entire sample (97%, n=145) of IDU survey respondents reported having used at least one of the three main forms of methamphetamine (speed, base or crystal meth/ice) during their lifetime, and 69% (n=103) reported use during the previous six months (speed 64%, crystal meth/ice 39%, and base 5%). Eleven percent of the sample (n=16) also reported recent use of pharmaceutical stimulants (prescribed or not prescribed), and 3% (n=4) reported using amphetamine liquid. As in 2007, the reported prevalence of use of speed, crystal meth/ice and base among IDU survey respondents decreased slightly in 2008 compared to the previous year. The prevalence of liquid amphetamine use remained stable.

As in 2007, KE noted that methamphetamine use is still prevalent among IDU in Melbourne. In contrast to IDU survey reports, eight KE reported increased use of methamphetamine during the last six months. However, six KE reported a decrease in use of methamphetamine during the last six months.

Injecting was again reported to be the most commonly used route of methamphetamine administration by IDU during the past six months (66%, n=99). Smaller numbers of respondents reported smoking (23%, n=34), snorting (5%, n=8), and swallowing (5%, n=7) methamphetamine during that time. KE noted that injecting was the preferred route of speed administration, while ice was reportedly injected and smoked.

As in 2007, those who had used methamphetamine during the past six months (n=103) reported a median of 12 days of use (speed 12 days, crystal meth/ice six days, base two days, and liquid two days). Eleven respondents (7%) reported using methamphetamine between every second day and daily during that time (compared to 13 respondents in 2007).

In 2008, the reported median prices for a point of the main forms of methamphetamine were: speed \$40, and crystal meth/ice \$50 (no respondents were able to report on the price for a point of base). Half-gram prices were: speed \$100, crystal meth/ice \$200, and base \$150. Most participants reported that prices had remained stable over the past six months.

As in 2007, the majority of IDU survey participants reported that methamphetamine (particularly speed and crystal meth/ice) was currently easy or very easy to access, and that availability had remained stable over the past six months. In terms of sourcing methamphetamine, most participants reported scoring from known dealers or friends at agreed public locations.

Reports regarding current speed purity were less disparate than in 2007, with the majority of those who commented (n=64) reporting that it was presently medium (38%, n=24) or low (36%, n=23), and over the six months purity was stable (39%, n=24) to decreasing (34%, n=21). Of those who commented on the purity of crystal meth/ice (n=26), most reported that it was high (46%, n=12) to medium (38%, n=10), with over half (54%, n=13) reporting that crystal meth/ice purity had remained stable over the last six months. Once again there were too few reports regarding the purity of base to identify any trends.

KE reported that methamphetamine was often a component of polysubstance use for many IDU, commonly used in combination with alcohol, cannabis, benzodiazepines and heroin, often to combat the 'comedown' effects resulting from psychostimulant use. A number of KE (n=5) also reported that violent, aggressive and/or volatile behaviour was often symptomatic of methamphetamine use, which was reportedly problematic for workers attempting to engage them with treatment. KE also noted that methamphetamine users were often likely to engage in unsafe sex ("they feel

bulletproof”), resulting in consequences such as STIs, unplanned pregnancies and sexual assaults.

Despite a slight decrease in prevalence of speed, crystal meth/ice and base use among IDU survey respondents, findings from the 2008 IDRS study suggest that the prevalence of methamphetamine use (in particular speed) among IDU in Melbourne remains quite high. Whilst frequency of methamphetamine use remains lower than for other drug types, patterns of use will continue to be monitored given the prevalence of methamphetamine use among IDU and potential harms associated with use of this drug (e.g. mental health issues).

Cocaine

Although over two-thirds of the respondents to the 2008 IDU survey (69%, n=103) reported lifetime use of cocaine, only 3% (n=4) identified it as their main drug of choice.

Twenty-four percent (n=36) of the IDU sample reported having used cocaine during the previous six months (compared to 22% in 2007, 19% in 2006, 15% in 2005 and 10% in 2004), with injecting being the principal reported route of cocaine administration during that time (19%, n=29). Among those who reported using cocaine during the past six months (n=36), frequency of use was very low (median=4.5 days), suggesting irregular, opportunistic use patterns.

In 2008, five participants commented on the current price of a cap of cocaine, with all five reporting a current price of \$100 per cap, with another five participants reporting that the current price for one point of cocaine was also \$100. Only two participants commented on the current price per gram of cocaine, reporting a median price of \$345 (range=\$290-\$400). All 11 participants who commented on changes to the price of cocaine during the last six months reported that it had remained stable.

Of those respondents who reported any recent cocaine use (n=36), the majority (92%, n=33) reported mostly using cocaine in powder form (as opposed to cocaine rock or ‘crack’, a smokeable form of cocaine). Eleven respondents commented on current cocaine purity, with more than half (55%, n=6) reporting that it was currently medium, and 27% (n=3) reporting it to be low. Twelve participants reported on changes to the purity of cocaine during the last six months, with most (75%, n=9) reporting that it had remained stable during that time.

Approximately two-thirds (67%, n=8) of the participants who commented on current cocaine availability (n=12) reported that it was currently easy to access, with the majority (83%, n=10) reporting that cocaine availability had remained stable during the six months prior to interview. Respondents most commonly reported buying cocaine from known dealers (100%, n=12), or friends (27%, n=3).

With a relatively stable prevalence of use in 2008, a low proportion of participants reporting cocaine to be their drug of choice and continual low frequency of use, and 14 KE reporting occasional use of cocaine by only a minority clients, cocaine use among the IDU sample in Melbourne still remains low and infrequent and appears to be fairly opportunistic.

The expansion of drug trend monitoring research to other sentinel groups (e.g. psychostimulant users) will provide a clearer picture of cocaine trends in Melbourne.

Cannabis

Reported cannabis use among Melbourne's IDU participants decreased in 2008. Almost all respondents (95%, n=143) reported having used cannabis in their lifetime, while 74% (n=111) reported cannabis use in the preceding six months (compared to 83% in 2007, 83% in 2006, 86% in 2005, 80% in 2004, and 88% in both 2003 and 2002). In contrast to previous years, in 2008, cannabis was not the most widely used illicit drug by IDU respondents during the previous six months (heroin was used by 86% of respondents during that time), though it continued to be the most frequently used in terms of number of days (median=175 days).

As in previous years, the overwhelming majority of IDU who commented on cannabis thought it was easy to very easy to obtain, and that availability had remained stable in the preceding six months. Cannabis was commonly accessed through social networks and known dealers, and, as in previous years, the type most commonly used by those respondents who had used cannabis in the last six months was hydroponic (88%, n=98).

In 2008, median prices reported for hydroponic cannabis (on the most recent occasion of purchase) were: one gram \$20, three grams \$50, one quarter-ounce \$80, one half-ounce \$150, and one ounce \$250. Prices reported for these quantities remained relatively stable in 2008.

The potency of hydroponic cannabis was described by the majority of 77 respondents as high (56%, n=43) to medium (38%, n=29) and stable (62%, n=48), while reports from 22 respondents regarding the potency of bush/naturally-grown cannabis suggested that it was medium (64%, n=14) to high (18%, n=4) and stable (76%, n=16).

Seven KE reported that cannabis was the primary drug of choice among the drug users with whom they had the most contact. In addition, in 2008, many of the remaining KE reported that most (n=24) or all (n=4) clients currently engaged in cannabis use, noting that it was commonly used in combination with heroin, methamphetamine, alcohol, tobacco, benzodiazepines and ecstasy.

Other drugs

The 2008 Melbourne IDRS study has again provided evidence of widespread prescription drug use by participating IDU (e.g. benzodiazepines, morphine, methadone, buprenorphine, buprenorphine/naloxone and antidepressants). The majority of IDU (69%, n=104) reported use of benzodiazepines during the six months prior to interview, with most of those respondents (65%, n=68) reporting that they mainly obtained their benzodiazepines licitly during that time. In 2008, reported rates of recent benzodiazepine injection remained relatively stable (7%, n=11, compared to 11%, n=17 in 2007), while frequency of benzodiazepine injection remained low, with a reported median of 11 days (compared to 10 days in 2007).

As in the previous year, in 2008 participants were asked about their use of both illicit buprenorphine (Subutex[®]) and illicit buprenorphine/naloxone (Suboxone[®]). Less than one-fifth (19%, n=29) of IDU respondents reported illicit buprenorphine use during the past six months, and 17% (n=25) reported injecting the drug during that time (compared to 24% in 2007), on a median of 24 days. For those respondents who reported injecting their prescribed buprenorphine during the last six months (11%, n=17), a median of 150 days was reported.

Over one-third (35%, n=53) of IDU respondents reported using any buprenorphine/naloxone in the last six months, with 18% (n=27) reporting recent use of non-prescribed buprenorphine/naloxone, and 16% (n=24) reporting injection of any

buprenorphine/naloxone during that time. Of those respondents who reported using any buprenorphine/naloxone in the past six months (n=53), the majority (64%, n=34) reported mostly obtaining it licitly. Frequency of Suboxone[®] use increased in 2008, with a median of 40 days' use reported (17 days in 2007). Frequency of Suboxone[®] injection also increased slightly in 2008, with a median of 12 days reported (about twice per month), as opposed to five days in 2007.

Reported prevalence of methadone use (prescribed or non-prescribed methadone syrup or Physeptone[®] tablets) remained relatively stable in Melbourne in 2008 (52%, n=78), although reported rates of recent methadone injection increased very slightly (15%, n=23, compared to 11% in 2007). Of those who reported methadone use during the last six months (n=78), the majority reported mostly using prescribed methadone (71%, n=55). Frequency of non-prescribed methadone use remained low with a reported median of six days (approximately once per month).

Over two-fifths (41%, n=61) of IDU respondents reported using morphine in the past six months, with the vast majority of these participants (92%, n=56) reporting injection of morphine during that time. Prevalence of morphine use remained stable in comparison to the previous year (41% in both 2007 and 2008), while frequency of recent morphine use has remained low and stable since 2003. As in previous years, the types of morphine most commonly used by IDU respondents who reported recent use (n=61) were MS Contin[®] and Kapanol[®]. Over one-quarter of participants (27%, n=40) also reported recent use of oxycodone, with 24% (n=36) reporting recent oxycodone injection, although frequency of oxycodone use remained low (median of five days).

Over half (58%, n=87) of the IDU surveyed reported lifetime use of oxycodone, and 27% (n=40) reported using it during the past six months (compared to 29% in 2007). Frequency of oxycodone use during the past six months was low, with a median of five days (out of 180) reported. The main brand of oxycodone reportedly used by IDU respondents was OxyContin[®].

Nineteen percent of the IDU interviewed (n=28) reported using other opiates during the previous six months (21% in 2007, 8% in 2006, 12% in 2005, 27% in 2004), and the majority of these respondents (71%, n=20) reported obtaining these licitly. The main type of other opiate used by these respondents was Panadeine Forte[®] (54%, n=15) and, as reported in previous years, the overall frequency of use during the last six months was low, with a median of 11 days reported (nine in 2007).

Close to one-quarter (23%, n=34) of respondents also reported ecstasy use within the past six months, although frequency of use remained low (median of three days). As in previous years, the primary route of recent ecstasy administration for this group (n=34) was oral (91%, n=30), with over one-third (35%, n=12) reporting recent ecstasy injection. Recent prescription stimulant (11%, n=16), hallucinogen (7%, n=10), and inhalant use (3%, n=5) was relatively uncommon among this group.

In contrast, nearly two-thirds (61%, n=91) of participants reported recent use of alcohol on a median of 24 days (about once per week). Only 1% of participants (n=2) reported injecting alcohol in the last six months. Lastly, as in previous years, nearly all the 2008 IDU sample (95%, n=142) reported recent tobacco use on a median of 180 days.

Associated harms/drug-related issues

Nine percent (n=14) of the 2008 IDU sample reported borrowing another person's used needle/syringe during the past month (compared to 7% in 2007), usually from a regular sex partner or close friend, while 16% (n=24) reported loaning a used needle/syringe to

someone else during that time (10% in 2007). In addition, over half the IDU sample (59%, n=89) reported using any other injecting equipment after someone else during the past month, most commonly spoons (31%, n=47), and filters (19%, n=29). With regard to location of injection, most participants reported last injecting in a private home (63%, n=94), with the majority also reporting most commonly injecting in a private home during the last month (71%, n=107).

Overall, IDU reports suggested that rates of borrowing and loaning injecting equipment were generally stable to increasing in 2008, although there were reductions in the reported rates of using spoons/other mixing containers and water after someone else during the last month.

As in 2007, self-reported recent experience of heroin overdose and receipt of naloxone increased in 2008. Other significant harms associated with injecting drug use (including injection-related health problems and blood-borne viral infections (BBVI) such as hepatitis C virus (HCV)), also continue to be of concern.

In 2008, of those IDU respondents who reported driving a car at least once in the last six months (47%, n=71), 18% (n=13) reported driving while over the legal blood alcohol limit, while the majority (85%, n=60) reported driving soon after taking any illicit drug(s), most commonly after using heroin (68%, n=41), cannabis (65%, n=39), or speed (28%, n=17).

Overall, it was seen that the level of self-reported criminal activity among IDU increased in 2008. In contrast, the majority of KE reported that crime levels had generally remained stable. As in 2007, IDU reported that police activity had generally been stable to increasing during the past six months, while again, the majority of KE generally reported that such activity had remained stable.

Conclusions

The 2008 Victorian IDRS study has again provided evidence of both changes and stability within the illicit drug markets of metropolitan Melbourne.

The demographic characteristics of the 2008 Melbourne IDU sample were similar to those reported in previous years (which is not unexpected, given that the recruitment strategies remained the same). Also consistent with previous surveys, the majority of the sample reported that heroin was the last drug they injected (59%, n=89), the drug they injected most often in the last month (65%, n=98), and their drug of choice (73%, n=109). The latter two proportions were both higher than those reported in 2007. In comparison to previous years, heroin was also the most widely used illicit drug in 2008, with 86% of the sample (n=129) reporting heroin use during the last six months, followed by cannabis (74%, n=111).

Findings from the 2008 study suggest that there have been some changes to heroin use in Melbourne recently. While heroin reportedly remained very easy or easy to access in 2008, and the reported prevalence of heroin use by IDU remained stable, frequency of reported heroin use increased this year, as did reports of lifetime and recent overdose, and recent receipt of naloxone. KE generally reported that the prevalence and frequency of heroin use had remained stable during the previous year. Heroin purity levels were reportedly low to medium and stable, while the price also remained relatively stable in comparison to the previous year. These trends in heroin use and any associated outcomes will continue to be monitored.

Findings from the 2008 study suggest that methamphetamine use continues to be widespread among the IDU interviewed in Melbourne; however, prevalence of

methamphetamine use decreased slightly this year, and frequency of use remains lower than for other drug types. As in 2007, these drugs (in particular speed and crystal meth/ice) were reportedly easy to obtain and were again predominantly sourced through known dealers and friends (social networks). As in previous years, a number of KE noted that violent, aggressive and/or volatile behaviour was often symptomatic of methamphetamine use, which was reportedly problematic for workers attempting to engage users with treatment. KE also noted that methamphetamine use was commonly associated with elevated mental health issues, including irrational thinking, hysteria, and paranoia. Given some of the potential harms associated with the use of methamphetamine, these trends will continue to be monitored.

Among the IDU surveyed in Melbourne, prevalence and frequency of cocaine use remains low. This may be due to the lack of availability, the cost, and possibly the widespread availability and use of other drug types in this city. In contrast, heroin was the most widely used illicit drug by participating Melbourne IDU, with cannabis the most frequently used in terms of number of days. While there was a reduction in reported prevalence of cannabis use by the IDRS sample in 2008 in comparison to previous years, the Melbourne cannabis market continues to be relatively stable.

The 2008 study has again provided evidence of significant prescription drug use by IDU (e.g. benzodiazepines, morphine, methadone, buprenorphine, buprenorphine-naloxone and antidepressants). There is also evidence of misuse of these drug types by some of the IDU surveyed. In 2008, IDU also reported experiencing injection-related harms specific to these drug types.

In 2008, continuing trends in the level of injection-related health problems experienced by IDU (such as vein damage, poor general health and HCV) have again been reported. Further research is needed to investigate strategies that could potentially reduce some of these risks and harms.

The experience in Melbourne has shown that the IDRS is an effective drug trend monitoring system and is valuable for informing policy and research.

Implications of 2008 findings

While the aim of the IDRS study is to monitor emerging trends in illicit drug use and related outcomes, it is not intended as a comprehensive and detailed investigation of illicit drug markets. The role of the Melbourne arm of the IDRS study is to identify yearly illicit drug use trends, and provide recommendations regarding key issues that warrant further monitoring and/or in-depth investigation.

The findings of the 2008 Melbourne IDRS study suggest the following priority areas:

1. Continued monitoring of illicit drug markets for trends in price, purity, availability, patterns of drug use, and related outcomes.
2. Expansion of Victoria's routine drug trend monitoring, through new methods and new sentinel groups, to improve the understanding of intersecting drug markets and related outcomes.
3. Further research to monitor the characteristics and impact of psychostimulant use in Melbourne, along with consideration of the impact of these drug types upon both the health and law enforcement sectors.
4. Further research into drug-driving, particularly in regard to people's understanding of impairment and the circumstances in which they drive soon after taking illicit drugs.

5. Further research to explore the nature and extent of prescription drug use among IDU in Melbourne, and the health harms associated with prescription drug misuse.
6. Further research to gain a better understanding of the determinants of both unsafe injecting and sex practices, particularly for those practices that increase the risk of BBVI.

Since 1997, the Melbourne arm of the national IDRS study has proven to be a reliable, cost-effective and informative mechanism for the monitoring of illicit drug trends in this city. It yields data that are comparable from year-to-year and across jurisdictions, and it is a study that has much to offer health and law enforcement sectors in their efforts to respond more effectively to illicit drug trends.

1.0 INTRODUCTION

In 1998 the Australian Government Department of Health and Ageing (AGDH&A) commissioned the National Drug and Alcohol Research Centre (NDARC) to implement a national Illicit Drug Reporting System (IDRS), following a successful pilot study in Sydney during 1996 and a multi-state trial in 1997 (Hando et al., 1997; Hando & Darke, 1998; Hando et al., 1998). The 1998 IDRS study was conducted in New South Wales, Victoria and South Australia (McKetin et al., 1999), with each state undertaking an injecting drug user (IDU) survey, key expert (KE) survey, and analysis of available secondary indicator data.

In 1999, the IDRS study was replicated in New South Wales, Victoria and South Australia, with all other remaining states and territories participating through the collection of secondary indicator data and completion of KE interviews. In 2000, the IDRS became a truly national drug trend monitoring system when all states and territories conducted the complete study. This is the twelfth year that the IDRS study has been conducted in Melbourne.

The aim of the IDRS study is to monitor emerging trends related to the use of heroin, methamphetamine, cocaine and cannabis. The IDRS study provides nationally comparable data with respect to patterns of illicit drug use and related harms, and provides a basis for better informing future policy and research initiatives.

The *Victorian Drug Trends 2008* report summarises data collected during the months of June through October 2008 as part of the Melbourne arm of the 2008 IDRS study. The findings of this report pertain primarily to the 2007/2008 financial year, unless otherwise indicated. The report provides an outline of the methods utilised in collecting data for this period, and then presents a socio-demographic and drug use history overview of the IDU sample. The main study findings are then presented for recent trends in the use of heroin, methamphetamine, cocaine, cannabis, and other drugs. Following this, drug-related harms, general health, and other issues of significance are examined. The report concludes with a summary and discussion of the main findings and implications.

For details regarding illicit drug trends for the whole of Victoria, readers should refer to the annual *Victorian Drug Statistics Handbook* (Victorian Department of Human Services, 2009b). Readers are also referred to the forthcoming *Australian Drug Trends 2008* monograph for national IDRS data and jurisdictional comparisons (available from NDARC, University of New South Wales, Sydney).

1.1 Study aims

The primary aims of the 2008 Victorian IDRS were:

1. To document the market characteristics (i.e. price, purity, availability) and patterns of use primarily of heroin, methamphetamine, cocaine and cannabis among IDU in Victoria.
2. To identify and document any drug-related harms and relevant trends among this population.
3. To detect and document emerging drug trends of national significance that require further and more detailed investigation.

2.0 METHOD

This study replicates the IDRS methodology used annually since 1997, incorporating: a survey of IDU; interviews with KE recruited from a variety of professional settings; and analysis of secondary indicators of illicit drug trends in Victoria. The information provided by these three methods has been used to identify trends and outcomes associated with illicit drug use in Victoria. These trends primarily relate to those observed within metropolitan Melbourne for the 2007/2008 financial year.

2.1 Survey of IDU

Structured face-to-face interviews were conducted with 150 current IDU recruited from metropolitan Melbourne between June and July 2008. To be eligible to participate, respondents must have injected at least monthly in the six months prior to interview, and have resided in Melbourne for at least the previous 12 months. Convenience sampling was facilitated by posted advertisements and recruitment notices distributed throughout Needle and Syringe Programs (NSP), as well as snowballing methods (recruitment of friends and associates via word of mouth).

Five agencies assisted the research team as recruitment and interview sites for the IDU survey component of the study:

- Southern Hepatitis/HIV/AIDS Resource and Prevention Service (SHARPS), Frankston;
- Health Information Exchange/Access Health, St Kilda;
- Next Door Primary Health Service and Melbourne Inner-City Needle Exchange (MINE), Collingwood;
- Open Family, Footscray; and
- South East Alcohol and Drug Services (SEADS), Dandenong.

The structured interview schedule employed in this study comprised core questions used in previous IDRS studies conducted in Melbourne. The interview schedule contained questions relating to demographics; drug use; the price, purity and availability of drugs; crime; risk-taking behaviour; health; and general trends. The average duration of each interview was approximately 38 minutes and participants were reimbursed \$40 for their time and out-of-pocket expenses. Ethics approval for this study was obtained from the Victorian Department of Human Services, Human Research Ethics Committee, and the Peninsula Health Human Research and Ethics Committee. Data analysis was conducted using SPSS for Windows Version 14.0.

2.2 Survey of KE

A total of 38 KE (18 female, 20 male) participated in face-to-face and phone interviews between the months of July and October 2008. Twenty-four KE (63%) were recruited from the pool of KE who had taken part in previous IDRS and/or EDRS studies (Quinn, 2008; Jenkinson & Quinn, 2007; Jenkinson & O'Keefe, 2005; Jenkinson & O'Keefe, 2006; Jenkinson et al., 2004; Jenkinson et al., 2003; Fry & Miller, 2001; Fry & Miller, 2002; Dwyer & Rumbold, 2000; Rumbold & Fry, 1999). Other KE participants were recruited as replacements for, or alternatives to, previous participants drawn from the same agencies/services, on the basis of referrals received from professionals in the field, or as individuals representing agencies/services not previously surveyed.

KE involved in the 2008 IDRS consisted of: drug treatment workers (e.g. drug and alcohol counsellors) (n=15), NSP workers (n=5), outreach workers (n=4), law enforcement personnel (n=4), medical practitioners (e.g. general practitioners (GPs)) (n=2), researchers (n=1), pharmacists (n=1), government representatives (n=1), nurses (n=1), youth workers (n=1), paramedics (n=1), first aid officers (n=1), and lawyers (n=1). Excluding law enforcement personnel, participants were selected on the basis of having had average weekly contact with illicit drug users over the preceding six months, and/or contact with 10 or more different illicit drug users during that period, and/or expert knowledge in one or more areas relating to the use, possession, manufacture and/or trafficking of illicit substances.

Whilst some KE participants were screened after they had received sample copies of the KE interview schedule, project information sheet and consent form – providing them with the opportunity to consider whether they would be able to address questions from the interview schedule – other KE were deemed eligible after telephone screening and did not wish or request to receive an advance copy of materials. The KE interview schedule included sections on patterns of drug use, drug market characteristics, criminal behaviour among users, and health and lifestyle issues.

As in previous years, heroin was again nominated by most (n=22) of the surveyed Melbourne KE as the main illicit drug used by the people with whom they had contact. Seven KE identified cannabis as the main illicit drug used by their clients, six KE reported that methamphetamine was mostly used by clients, while only one KE reported that clients mainly used morphine. In contrast, two KE were unable to identify one main illicit drug of use among clients, due to lack of client contact (e.g. government representative). KE also reported that, in addition to these drugs, the clients with whom they had contact were using alcohol, tobacco, cocaine, ecstasy, prescription drugs such as pharmacotherapies (i.e. methadone, buprenorphine, Suboxone[®]) and benzodiazepines, opioids such as morphine, and other prescription drugs such as Unisom[®].

KE interviews took an average of 34 minutes to complete (range=20-45 mins). Detailed notes were made by the interviewer during each interview, and raw data was transcribed and coded soon after the conclusion of the interview using Microsoft Excel.

2.3. Other indicators

Primary information collected from the IDU survey and KE interviews was supplemented by data obtained from a number of secondary indicator sources of illicit drug use and related morbidity and mortality. Where possible, data relating to trends for the 2007/2008 financial year are reported, unless otherwise indicated. For secondary indicators where current data is not available, the most recently available data has been included.

Indicator data sources accessed for this study are described in the following sections:

Surveys reporting on illicit drug use prevalence in Victoria

- Data on the prevalence of drug use in the community is typically derived from large-scale population surveys. The most recent household surveys from which estimates of illicit drug use within the community are available include the Australian Institute of Health and Welfare (AIHW) 2007 National Drug Strategy Household Survey (NDSHS) (AIHW, 2008), and the 2004 Victorian Youth Alcohol and Drug Survey (Premier's Drug Prevention Council, 2005).

Drug seizure purity levels

- The Drug Analysis Branch of the Victoria Police Forensic Services Department conducts purity analyses for all drug seizures made by the Victoria Police. Since 2001, the Victoria Police Forensic Services Department has provided drug purity data for inclusion in the IDRS report. This report presents data for the 2007/2008 financial year.

Drug-related arrest data

- Information pertaining to drug-related arrests in Victoria has been obtained from the Australian Crime Commission (ACC). The Victoria Police and the Australian Federal Police (AFP) provide arrest data to the ACC for the *Illicit Drug Data Report*. This report presents drug-related arrest data for the 2006/2007 financial year (2007/2008 data was not available at the time of publication).

Specialist drug treatment presentations

- The Victorian Department of Human Services funds community-based agencies to provide specialist alcohol and drug treatment services across the state. The collection of client information is a mandatory requirement and occurs via a formalised client data collection system called the Alcohol and Drug Information System (ADIS). The ADIS data presented in this report represents courses of treatment (not client numbers) for the 2006/2007 financial year.
- The Drugs and Poisons Regulation Group of the Victorian Department of Human Services maintains a database that records all methadone, buprenorphine and buprenorphine-naloxone (Suboxone[®]) permits in Victoria. This is the major source of information regarding the characteristics of consumers of the Victorian pharmacotherapy programs and is an important source of information regarding treatment for opiate dependence. Data from the quarterly phone census of client numbers for the period January 2000 to October 2008 is presented in the current report.
- DirectLine is a 24-hour specialist telephone service in Victoria (operated by Turning Point Alcohol & Drug Centre) that provides counselling, referral and advice about drug use and related issues. All calls to DirectLine are logged to an electronic database that can provide information about caller drugs of concern, calls from drug users, and calls about drug users. This report presents data for the period 1999-2007.

Ambulance attendances at non-fatal drug overdoses and other episodes

- Turning Point Alcohol & Drug Centre manages an electronic drug-related ambulance attendance database, comprising information obtained from the Melbourne Metropolitan Ambulance Service (MAS) Patient Care Records (Dietze et al., 2000). Reliable data is available from June 1998 (with missing data for the periods May 2001 to July 2001, October 2002 February 2003, and June 2004 to July 2004). Although the database includes overdose-related calls for all types of drugs, the dataset is best suited to the monitoring of non-fatal heroin-related overdose due to the availability of a biological marker of heroin involvement (i.e. the administration of naloxone and subsequent patient response). Data for the period January 2006 to December 2007 are presented in this report.

National Hospital Morbidity Database

- The National Hospital Morbidity Database (NHMD) is compiled by the AIHW. It is a collection of electronic records for admitted patients in public and private hospitals in Australia. *Principal diagnosis* (the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital) has been reported. This report presents drug-related (opioid, amphetamine, cocaine and cannabis) hospital admissions for Victoria and Australia, 1999/2000-2006/2007 (Roxburgh & Burns, in press).
- Note: the Australian Bureau of Statistics (ABS) has changed the way they collate deaths data, making comparisons to earlier overdose bulletins published by NDARC (Degenhardt & Roxburgh, 2007a; Degenhardt & Roxburgh, 2007b) difficult. Since 2003, the ABS has progressively ceased visiting jurisdictional coronial offices to manually update causes of death that had not been loaded onto the computerised National Coronial Information System (NCIS). It was in 2006, that the ABS began to rely solely on data contained on the NCIS at the time of closing the deaths data file. In addition, a number of jurisdictions, notably New South Wales and Queensland, reported backlogs in cases that *had* been finalised by the coroner (i.e. cases where the coroner had determined the cause of death), but not yet been loaded onto the NCIS. This is likely to have an impact on the number of opioid-related deaths recorded at a national level in 2006, given that New South Wales and Queensland recorded the highest number of opioid-related deaths in Australia during the period 2000-2005. Accordingly, only drug-related deaths for 2006 are reported here. These data should be interpreted in conjunction with the ABS Technical Note 2: Coroner Certified Deaths, 3303.0 2006.²

Heroin-related fatalities

- Mortality information from heroin-related deaths was obtained from data collated by the Victorian Institute of Forensic Medicine (VIFM) (Woods et al., in press). This report presents VIFM data from 1991-2007.

Blood-borne viral infections surveillance data

- Blood-borne viral infections (BBVI), such as the human immunodeficiency virus (HIV/AIDS) and the hepatitis B virus (HBV) and hepatitis C (HCV) are a major health risk for individuals who inject drugs. The Communicable Diseases Section, Public Health Branch of the Department of Human Services, records notifications of infectious diseases in Victoria. This report presents findings from the Department of Human Services HIV and HCV surveillance data.
- The Australian Needle and Syringe Program Survey has been conducted yearly by the National Centre in HIV Epidemiology and Clinical Research since 1995. It is designed to supplement sentinel BBVI surveillance efforts via a short questionnaire on demographic and behavioural characteristics of NSP clients and serological testing of finger-prick blood samples. In 2007, the survey obtained data from 243 participants across seven NSP in Melbourne (National Centre in HIV Epidemiology and Clinical Research, 2008).

² Excerpt taken from: Roxburgh, A., & Burns, L. (in press). Drug-induced deaths in Australia, 2006 Edition. Sydney: National Drug and Alcohol Research Centre.

2.4. Data analysis

The IDU survey results are used as the primary basis on which to estimate drug trends. IDU surveys provide the most comparable information on drug price, availability and use patterns in all jurisdictions and over time. However, purity of drug seizures data provided by Victoria Police is an objective indicator of drug purity, and is also presented in this report.

For continuous, normally distributed variables, *t*-tests were employed and means reported. Categorical variables were analysed using χ^2 . All analyses on IDU survey data were conducted using SPSS for Windows, Version 14.0.2 (SPSS inc, 2006).

Content analysis was used for the open-ended responses in KE interviews (Kellehear, 1993). Categorical data for KE estimates of drug price, purity and availability were analysed using Microsoft Excel.

3.0 RESULTS

3.1 Overview of the IDU sample

A total of 150 current IDU were interviewed in 2008. The sample was drawn from 59 suburbs primarily across the inner, western, northern and outer south-eastern suburbs of Melbourne (see Figure 1). Most of the participants lived in close proximity to the five recruitment sites. The number of people recruited from each site was: St Kilda n=30; Dandenong n=30; Collingwood n=31; Frankston n=29; and Footscray n=30.

The demographic characteristics of the 2008 sample are summarised in Table 1. The majority of participants were male (79%, n=119) and ranged in age from 21 to 56 years, with a mean age of 35.1 years (SD=7.12). Over two-thirds of respondents were securely accommodated, either living in their own residence (50%, n=75) or a parent's home (17%, n=26), while 15% (n=22) were residing at a boarding house or hostel and another 15% (n=22) were homeless/with no fixed address at the time of interview. As in 2007, most participants (86%, n=129) were not currently employed; however, a significant proportion had acquired trade/technical qualifications (43%, n=64), and a smaller number university qualifications (6%, compared to 21% in 2007) post secondary school. The majority of participants (83%, n=124) again reported that English was the main language spoken at home, with the remaining 17% (n=26) indicating that they most commonly spoke other languages, including Vietnamese, Croatian, Lebanese, Turkish, Italian and Maltese. Three percent (n=5) of participants identified as being of Aboriginal and/or Torres Strait Islander (A&TSI) origin.

Table 1: Demographic characteristics of the IDU survey sample

Characteristic	2007 N=150	2008 N=150
Age (yrs)	32 (range=18-51)	35 (range=21-56)
Sex (% male)	63	79
Heterosexual (%)	89	91
Accommodation (%):		
Own house/flat (includes renting)	47	50
Parents' house	15	17
Boarding house/hostel	15	15
Shelter/refuge	1	3
Drug treatment residence	-	1
No fixed address/homeless	17	15
Employment (%):		
Not employed	86	86
Full-time	5	3
Part-time/casual	4	8
Home duties	1	1
Student	1	1
Currently engaged in sex work (%)	5	5
A&TSI (%)	5	3
School education (yrs)	10	10
Tertiary education (%):		
None	43	51
Trade/technical	34	43
University/college	21	6
Currently in drug treatment (%)	40	61
Prison history (%)	53	52

Source: IDRS IDU interviews

A total of 105 participants (70%) had engaged in some form of drug treatment during the six months prior to interview. Of these people, 70% (n=73) had engaged in one type of treatment and 30% (n=32) in two or more different treatment types during that period. Sixty-one percent of the 2008 respondents (n=92) were currently receiving drug treatment. The most common types of drug treatment for this group were methadone maintenance (54%, n=50), Suboxone[®] maintenance (24%, n=22), and buprenorphine maintenance (14%, n=13). For this group (n=92), the mean length of time that they had been engaged in their current treatment type was 24.8 months, although this varied considerably (SD=40.3). Thirty-four people (37%) had been in treatment for six months or less, 37 people (40%) between six and 24 months, and 19 (21%) for more than two years. Two respondents were unable to provide estimates for how many months they had been in treatment.

3.2. Drug use history and current drug use

3.2.1. Duration of injecting career

The mean reported age for first injection of a drug was in the late teens (18.4 years, SD=5.1), ranging from 7 to 48 years. The mean number of years since first injection to the present was 16.7 years (SD=7.7). There was considerable variation in the length of experience of injecting drug use among those surveyed (range=2-37 years). Approximately seven percent of participants (n=10) reported first injecting drugs within the last five years, with 13% (n=19) reporting first injecting 6-10 years ago. The drugs most frequently used on the first occasion of injection were heroin (48% compared to 47% in 2007, 51% in 2006, 53% in 2005, 43% in 2004, 45% in 2003, 44% in 2002, and 54% in 2001) and amphetamines (47% compared to 49% in 2007, 46% in 2006, 43% in 2005, 53% in 2004, 50% in 2003, 51% in 2002, and 41% in 2001).

3.2.2. Drug use history (last four weeks)

Nearly two-thirds (65%, n=98) of the sample reported that heroin was the drug they had injected most often during the past month, with a slightly smaller proportion reporting that it was also the last drug they had injected (59%, n=89). Nearly three-quarters (73%, n=109) of participants reported that heroin was their drug of choice.

Fewer respondents (15%, n=23) indicated that they had most often injected methamphetamine during the past month, with a larger proportion reporting that it was the last drug injected (19%, n=28). In 2008, the proportions of participants reporting heroin as the drug injected most often and last drug injected were relatively stable in comparison to the previous year (61% and 60%, respectively). Proportions reporting methamphetamine as the drug injected most often and the last drug injected were also relatively stable (see Table 2). Eleven percent of the sample (n=16) reported that methamphetamine (speed or crystal meth/ice) was their drug of choice, while 5% (n=8) nominated other types of drugs as their preferred drug of choice, such as LSD, alcohol and ecstasy. Slightly more respondents (7%, n=10) reported that cannabis was their drug of choice.

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

Variable	2007 N=150	2008 N=150
Age first injection (years)	19 (range=7-36)	18 (range=7-48)
First drug injected (%)		
Heroin	47	48
Amphetamine	49	47
Cocaine	1	1
Other opioids	1	2
Drug of choice (%)		
Heroin	69	73
Methamphetamine	16	11
Cannabis	5	7
Morphine	3	2
Cocaine	-	3
Other drugs	7	5
Drug injected most often in last month (%)		
Heroin	61	65
Methamphetamine	17	15
Morphine	5	3
Buprenorphine	11	7
Other drugs	6	9
Last drug injected (%)		
Heroin	60	59
Methamphetamine	17	19
Morphine	7	5
Cocaine	-	2
Buprenorphine	11	5
Frequency of injecting in last month (%)		
Weekly or less	14	17
More than weekly	25	34
Once a day	23	19
Two to three times per day	30	25
More than three times per day	7	3

Source: IDRS IDU interviews

Close to one-third (31%, n=47) of the 2008 respondents reported having engaged in drug injection at least once a day during the month prior to interview (refer to Table 2), compared to 40% observed in 2007, 53% in 2006, 40% in 2005, 51% in 2004 and 49% in 2003 (Quinn, 2008; Jenkinson & Quinn, 2007; Jenkinson & O'Keeffe, 2005; Jenkinson & O'Keeffe, 2006; Jenkinson et al., 2004).

3.2.3. Drug use history (last six months and lifetime)

Table 3 shows the self-reported drug use history of the IDU survey sample over the six months prior to interview, and lifetime, as well as routes of administration and recent frequency of use. The majority of respondents reported lifetime use of heroin (99%, n=149), tobacco (97%, n=146), methamphetamine (97%, n=145), cannabis (95%, n=143), alcohol (95%, n=142), and benzodiazepines (88%, n=132).

Tobacco (95%, n=142), heroin (85%, n=129) and cannabis (74%, n=111) were the drugs most commonly used during the previous six months. Significant numbers also reported

using benzodiazepines (69%, n=104), methamphetamine (69%, n= 103), and alcohol (61%, n=91) during that time. The drugs most commonly reported to be injected during the past six months were heroin (86%, n=129), methamphetamine (66%, n=99), and morphine (37%, n=56).

As noted in previous Melbourne IDRS studies, polydrug use was the norm for IDU survey respondents. Those who reported heroin as their drug of choice (73%, n=109) most commonly reported using tobacco (95%, n=104), heroin (93%, n=102), cannabis (72%, n=78), benzodiazepines (71%, n=77), methamphetamine (63%, n=69), and alcohol (59%, n=64) during the past six months. Those who reported methamphetamine as their drug of choice (11%, n=16) most commonly reported using methamphetamine (100%, n=16), tobacco (88%, n=14), cannabis (75%, n=12), benzodiazepines (75%, n=12), and alcohol (56%, n=9) during that time.

Table 3: Drug use history of the 2008 Victorian IDRS IDU sample (N=150)

Drug Class	Ever used %	Ever injected %	Injected last 6 mths %	Days injected in last 6 mths*	Ever smoked %	Smoked last 6 mths %	Ever snorted %	Snorted last 6 mths %	Ever swallowed+	Swallowed last 6 mths+ %	Used^ last 6 mths %	Days in treatment* last 6 mths	Days used^ in last 6 mths*
Heroin	99	99	85	72	54	4	25	1	28	2	85		81
Homebake heroin	23	23	4	15	2	0	1	0	2	0	4		15
<i>Any heroin (inc. homebake)</i>	99	99	86	90	54	4	25	1	29	2	86		90
Methadone (prescribed)	71	19	8	34					69	36	37	180	180
Methadone (not prescribed)	51	18	8	7					40	13	19		6
Physeptone® (prescribed)	3	3	1	1	0	0	0	0	3	1	1	180	180
Physeptone® (not prescribed)	19	15	3	1	0	0	1	0	9	3	4		2
<i>Any methadone (inc. Physeptone®)</i>	81	37	15	5					78	47	52		138
Buprenorphine (prescribed)	56	39	11	150	3	1	1	1	52	12	15	150	90
Buprenorphine (not prescribed)	48	40	17	24	3	1	1	1	27	4	19		11
<i>Any buprenorphine (exc. buprenorphine-naloxone)</i>	77	58	24	72	5	1	1	1	65	16	30		72
Buprenorphine-naloxone (prescribed)	35	15	9	8	1	0	0	0	33	22	23	120	81
Buprenorphine-naloxone (not prescribed)	23	13	11	6	0	0	0	0	14	9	18		5
<i>Any buprenorphine-naloxone</i>	45	22	16	12	1	0	0	0	39	28	35		40
Morphine (prescribed)	22	16	2	25	1	0	1	0	18	2	3	18	26
Morphine (not prescribed)	74	71	37	4	1	0	0	0	33	8	40		5
<i>Any morphine</i>	75	72	37	5	1	0	1	0	39	9	41		5
Oxycodone (prescribed)	13	9	3	35	1	1	1	0	11	2	4	60	48
Oxycodone (not prescribed)	55	51	23	5	1	1	1	0	24	5	25		5
<i>Any oxycodone</i>	58	53	24	5	1	1	1	0	29	7	27		5
Other opioids (not elsewhere classified)	31	5	1	2	0	0	0	0	27	17	19		11

Source: IDRS IDU interviews

^ Refers to any route of administration, i.e. includes use via injection, smoking, swallowing, and snorting

* Among those who had used/injected

+ Refers to/includes sublingual administration of buprenorphine

Category includes speed powder, base, crystal/ice and amphetamine liquid (does not include pharmaceutical stimulants)

Table 3: Drug use history of the IDU sample, 2008 (continued)

Drug Class	Ever used %	Ever injected %	Injected last 6 mths %	Days injected in last 6 mths*	Ever smoked %	Smoked last 6 mths %	Ever snorted %	Snorted last 6 mths %	Ever swallowed ⁺ %	Swallowed last 6 mths ⁺ %	Used [^] last 6 mths %	Days in treatment* last 6 mths	Days used [^] in last 6 mths*
Speed powder	95	95	62	12	34	10	52	5	43	5	64		12
Base/point/wax	37	35	5	2	7	1	1	0	5	0	5		2
Ice/shabu/crystal	80	73	36	6	43	17	4	1	6	1	39		6
Amphetamine liquid	17	16	3	2					4	0	3		2
<i>Any form methamphetamine[#]</i>	97	96	66	12	56	23	53	5	45	5	69		12
Pharmaceutical stimulants (prescribed)	7	1	0	0	0	0	0	0	7	1	1		170
Pharmaceutical stimulants (not prescribed)	35	18	5	3	1	1	0	0	20	5	10		2
<i>Any form pharmaceutical stimulants</i>	37	7	5	3	1	1	0	0	24	5	11		2
Cocaine	69	55	19	6	11	1	35	7	13	3	24		4
Hallucinogens	70	9	0	0	1	0	1	0	69	7	7		4
Ecstasy	73	26	8	2	3	1	9	1	67	20	23		3
Benzodiazepines (prescribed)	75	15	3	5	3	1	1	0	73	45	45		128
Benzodiazepines (not prescribed)	73	14	6	12	1	0	1	0	71	49	51		11
<i>Any form benzodiazepines</i>	88	23	7	11	3	1	2	0	87	68	69		48
Alcohol	95	10	1	1					95	61	61		24
Cannabis	95										74		175
Inhalants	22										3		1
Tobacco	97										95		180

Source: IDRS IDU interviews

[^] Refers to any route of administration, i.e. includes use via injection, smoking, swallowing, and snorting

* Among those who had used/injected

⁺ Refers to/includes sublingual administration of buprenorphine

[#] Category includes speed powder, base, crystal/ice and amphetamine liquid (does not include pharmaceutical stimulants)

4.0 HEROIN

In 2008, heroin was the most widely used illicit drug by IDU survey respondents during the last six months (86%, n=129), while all but one respondent (99%, n=149) reported lifetime use of the drug. Prevalence of recent heroin use remained relatively stable in 2008 in comparison to the previous year (86% compared to 85% in 2007, 76% in 2006, 89% in 2005, 86% in 2004 and 90% in 2003).

Price, purity and availability of heroin were identified from information obtained from 81% of the IDU sample (n=121) who felt confident to comment on heroin trends.

4.1. Use

4.1.1. Prevalence of heroin use

The most recent survey of heroin use in the general community of Victoria was undertaken within the 2007 NDSHS. The findings of this survey suggest low levels of heroin use within the Victorian community, with 0.3% of the Victorian population aged 14 years and over reporting use of this drug within the past 12 months (AIHW, 2008). A small proportion (0.1%) also reported using other opiates/opioids (excluding pharmacotherapies) for non-medical purposes during that time. Findings reported in the 2007 survey also estimate that 0.5% of the Victorian population aged 14 years and over had injected drugs during the past 12 months (AIHW, 2008).³

Additional indicators of injecting drug use are available from the Australian NSP Survey conducted annually through the National Centre in HIV Epidemiology and Clinical Research (National Centre in HIV Epidemiology and Clinical Research, 2004; National Centre in HIV Epidemiology and Clinical Research, 2008). In addition to finger-prick blood samples and self-reported risk behaviour information, the 2007 national survey of NSP clients collected self-reported information regarding the last drug injected by participants. Over one-half (54%, n=131) of the 243 NSP clients recruited from five NSP sites in Victoria reported that they had last injected heroin (36% in 2006, 54% in 2005, 59% in 2004, 58% in 2003, 57% in 2002, 58% in 2001, and 87% in 2000), while a slightly smaller proportion in this year's IDRS IDU sample reported that heroin was the last drug they injected (59%, n=89).

4.1.2. Current patterns of heroin use

Nearly three-quarters (73%, n=109) of the IDU survey respondents reported that heroin was their main drug of choice, and 86% (n=129) reported having used and injected heroin (including homebake) during the preceding six months. Prevalence of recent heroin use by Melbourne IDU respondents remained relatively stable in 2008 in comparison to the previous year (86% compared to 85% in 2007, 76% in 2006, 89% in 2005, 86% in 2004 and 90% in 2003).

Of those IDU who reported using heroin in the last six months (n=129), the most common route of heroin administration was injection (100%, n=129), with 5% (n=6) reporting smoking the drug (i.e. heating heroin and inhaling the resulting vapours), 3% (n=4) reporting swallowing it, and 1% (n=1) of respondents reporting snorting heroin during that time.

³ The sample was based on households, therefore homeless and institutionalised persons were not included in the survey.

4.1.3. Heroin colour flashcard analysis

For the first time in 2008, IDU participants who had used heroin in the last six months (n=129) were shown a 'flashcard' displaying 12 pictures of a variety of heroin colours that ranged from nearly black (colour no. 1) to white (colour no. 12) in colour.⁴ These participants were asked to identify which heroin colour(s) they had recently used, and were also asked which colour they had used most in the last six months. Please refer to the national IDRS report for a colour copy of the flashcard (Stafford et al., 2009), while a black and white copy is included in this report as Appendix A.

Participants who had recently used heroin (n=129) most commonly reported using colour no. 11 (81%, n=105) and/or colour no. 12 (62%, n=80), the two white/off-white heroin pictures, while approximately one-quarter of recent heroin-using participants (25%, n=32) each reported using heroin colour nos. 7, 8 and/or 9, which were more brown or beige in appearance. Over half (53%, n=68) of those participants who had recently used heroin (n=129) reported most commonly using heroin colour no. 11 in the last six months, followed by colour no. 12 (28%, n=36), and colour no. 8 (6%, n=10).

4.1.4. Heroin preparation method

The use of different coloured heroin may require an additional step, such as the use of citric acid or heating, in the preparation for injection. Consequently, in addition to questions regarding the heroin colour flashcard, participants who had recently used heroin (n=129) were asked how – or if – they knew when citric/acetic acid was required to prepare (i.e. dissolve) their heroin. These participants most frequently reported that they did not know when the preparation of heroin required citric acid (40%, n=52), while smaller proportions of participants reported that citric acid was required when the heroin did not dissolve in water (14%, n=18), when their dealer informed them that it was needed (14%, n=18), when the heroin was a certain colour (12%, n=15), or that they had never needed to use citric acid in the preparation of heroin (7%, n=9).

Participants who had used either white/off white and/or brown/beige heroin in the last six months (according to the heroin colour flashcard) were asked how often they had needed to heat the drug when preparing it. Among those who had used white/off white heroin and commented (n=121), approximately three-quarters (75%, n=91) reported that they had never heated it. Only 4% (n=5) reported that they had needed to heat white/off white heroin all of the time. Of those who had used brown/beige heroin and commented (n=69), over half (58%, n=40) reported that they had never heated it in the last six months, while 19% (n=13) reported that they had heated brown/beige heroin every time in the last six months (Table 4).

⁴ Please note that the appearance of heroin does not necessarily indicate the geographic source of the drug.

Table 4: Heroin preparation method among those who commented and recently used either white/off white or brown/beige heroin, 2008

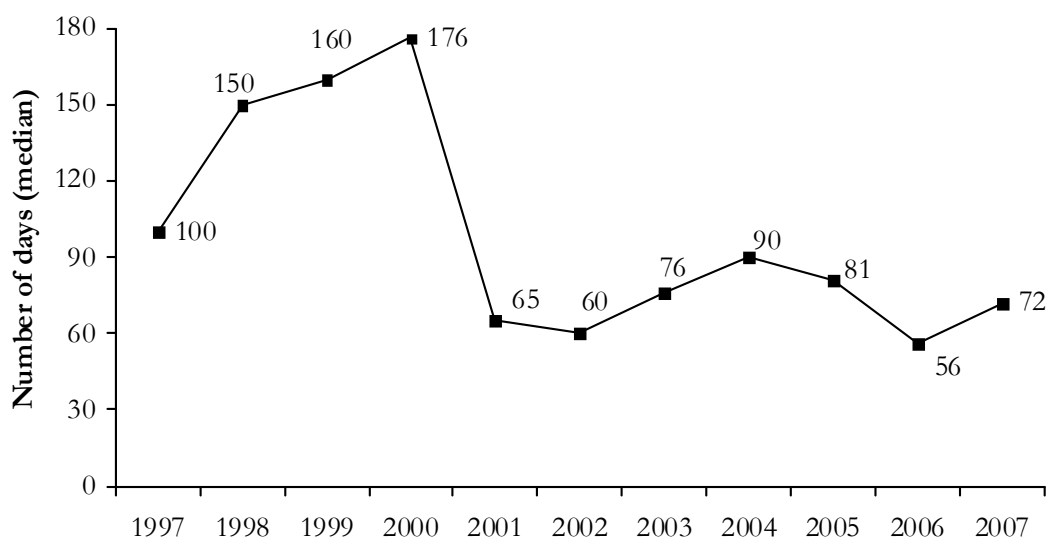
	How often did you heat it?		How often did you use acid to cook it up?	
	White/off white (n=121)	Brown/beige (n=69)	White/off white (n=30)	Brown/beige (n=29)
Never	75	58	90	93
A little of the time	12	16	10	7
Some of the time	5	4	0	0
Quite a bit of the time	3	3	0	0
All of the time	4	19	0	0

Source: IDRS IDU interviews

Those participants who reported heating their heroin in the last six months were also asked how often they had required acid to cook it up. Of those who reported using white/off-white heroin and heating it (n=30), the majority (90%, n=27) reported that they had not required acid to prepare their heroin, while three participants (10%) reported that they had used acid a little of the time. Similarly, of those participants who reported using brown/beige heroin and heating it (n=29), the majority (93%, n=27) reported never using acid to prepare it during the last six months, while two (7%) participants reported using acid a little of the time (Table 4).

Respondents reported using heroin on a median of 81 days during the past six months, with over one-fifth (21%, n=32) reporting using heroin on a daily basis during that time. Frequency of recent heroin use increased to a median of 81 days in 2008, continuing the upward trend following a low of 51 days in 2006 (see Figure 1).

Figure 1: Number of days of heroin use in preceding six months, 1997-2008



Source: IDRS IDU interviews

Of the KE able to comment on frequency of heroin use among clients (n=21), the majority (n=14) reported that use was predominantly at least once daily. In contrast, four KE reported that frequency of heroin use was mixed, ranging from occasional to multiple times per day, while three KE reported that heroin use was less frequent (e.g. one-three times per week). KE noted that frequency of heroin use, and the amount of heroin used by clients, differed greatly between individuals and was affected by a number of variables, including a user's financial situation, heroin price, purity and availability, type of use (e.g. dependent, recreational), and involvement in treatment (i.e. heroin users currently involved in drug treatment, such as pharmacotherapies, reportedly used less frequently than those not involved in treatment).

As noted in previous IDRS reports, of those KE able to comment on the predominant route of heroin administration (n=30), the overwhelming majority (n=29) reported that most to all heroin-using clients injected the drug. Seven of these KE commented that generally only a minority of clients smoked heroin, noting that such users were often younger clients with shorter drug-using careers (individuals who had not yet 'upgraded' to injecting drugs), or Vietnamese heroin users who were wary of gaining track marks through injecting. One KE (a youth worker) reported that smoking was the main route of heroin administration by the users they had contact with/knowledge of, which was attributed to the young age of clients.

The demographic profile of heroin users reported by KE was similar to that reported in the 2007 IDRS with regard to age, ranging from 14-70 years with the majority being in their late twenties or early thirties; gender (again predominantly male); the majority being early school leavers (i.e. left during or on completion of Year 9, 10 or 11, with low rates of tertiary education); and employment (majority were unemployed and/or on sickness benefits), with a minority identifying as sex workers. KE noted that those heroin users operating as sex workers were largely female.

While the ethnicity of heroin users was largely described as Caucasian by KE, five reported that the majority of heroin users they had contact with/knowledge of were Vietnamese. KE also reported that only a minority of heroin users were of A&TSI or African origin. Two KE reported an increase in the use of heroin by African communities in Melbourne.

KE generally reported that the majority of heroin users they had contact with/knowledge of had previously been incarcerated and/or experienced some form of contact with the criminal justice system. One KE (who worked primarily with young users), however, noted that, due to the young age of clients, only a minority had previously been incarcerated.

As in previous years, KE indicated that heroin users generally engaged in polysubstance use, reporting a variety of licit and illicit substances that users regularly consumed in addition to heroin, including: tobacco, alcohol, methamphetamine (primarily speed and/or crystal meth/ice), cannabis, tobacco, licit and illicit pharmaceuticals (e.g. benzodiazepines, morphine, Unisom[®]), pharmacotherapies, and cocaine. As in the previous year, KE noted that heroin users often sought substitutes to heroin (e.g. benzodiazepines, morphine) when they were unable to obtain heroin of an acceptable quality, or when they were unable to access heroin at all (e.g. due to poor availability or lack of money).

While heroin use was generally reported to be stable in the last six months, eight KE reported a number of changes during that time. Two of these KE reported increased use of heroin, which one attributed to increased heroin availability. In contrast, two KE

reported a reduction in heroin use, which one KE attributed to increased police activity. Due to a reduction in heroin quality and availability, one KE reported an increase in polysubstance use involving heroin, such as heroin mixed with cocaine and/or benzodiazepine (BZD). With regard to routes of heroin administration, one KE reported that an increase in heroin price had resulted in more people injecting heroin instead of smoking it (“better value for money”), while another KE reported an increase in the number of people using cotton wool as a means of filtering, as opposed to use of cigarette filters. Lastly, as previously noted, two KE reported an increase in the use of heroin by African communities in Melbourne.

4.2. Price

In 2008, respondents reported that the current median price of a ‘cap’ of heroin was \$50 (n=88), and a gram was \$325 (n=73).

Prices paid for heroin by Melbourne IDU on the last occasion of purchase are presented in Table 5. The median and modal (most frequently reported) price, price range, and the number of respondents who reported purchasing each amount during the past six months are reported.

In 2008, respondents reported paying (median price): \$47.50 for a cap, \$100 for a quarter-gram, \$180 for a half-gram, and \$300 for a gram (on the last occasion of purchase). The reported prices of a cap and quarter-gram of heroin was relatively stable in 2008, though the reported prices of a half-gram and gram of heroin decreased slightly (see Table 5). As in 2007, the most popular purchase amount of heroin was a half-gram (n=61), followed by a cap (n=52).

Table 5: Price of most recent heroin purchases by IDU, 2008

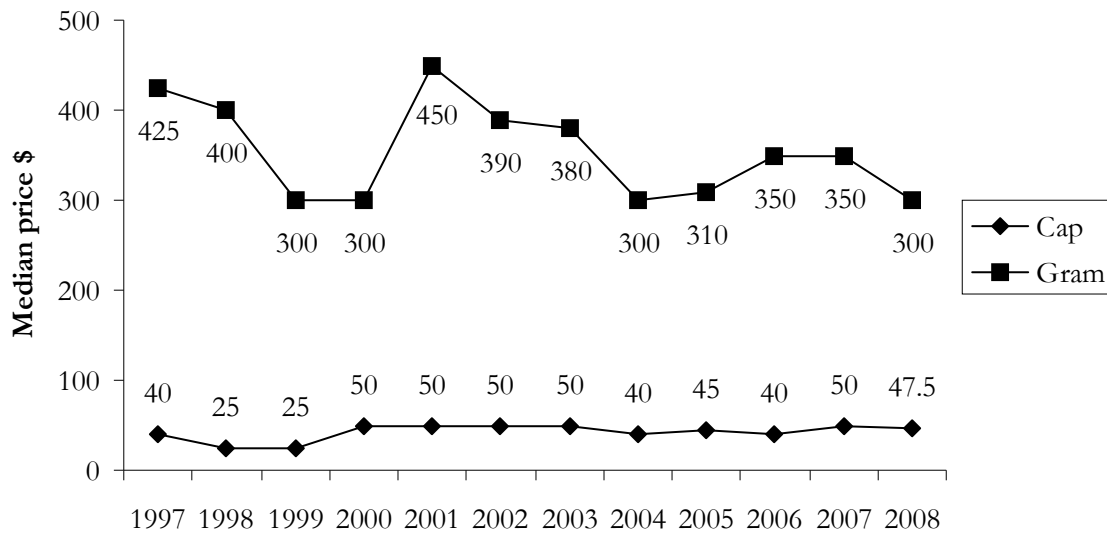
Amount	Median price* \$	Modal price* \$	Price range* \$	Number of purchasers*
Cap	47.50 (50)	50 (50)	20-100 (20-100)	52 (38)
Quarter-gram	100 (100)	100 (100)	70-120 (100-170)	37 (24)
Half-gram	180 (200)	150 (200)	100-380 (90-300)	61 (58)
Gram	300 (350)	250 (350)	120-420 (90-500)	35 (26)

Source: IDRS IDU interviews

* 2007 data is presented in brackets

Data presented in Figure 2 shows the most recent purchase price (median) of heroin in Melbourne from 1997-2008. The reported price of a cap of heroin (≈ 0.1 gram) has remained relatively stable since 2000, at \$40-\$50. The reported price per gram of heroin has fluctuated more during this time, peaking at \$450 in 2001 (during the reported reduction in heroin supply in Melbourne). Between 2002 and 2004, gram prices again decreased; however, prices increased in both 2004 and 2005. The reported median price of a gram of heroin remained stable at \$350 in 2006 and 2007, although it decreased to \$300 in 2008.

Figure 2: Median price of a gram and cap of heroin estimated from IDU purchases, 1997-2008



Source: IDRS IDU interviews

The majority of those who commented on the price of heroin (70%, n=121) reported that it had been stable over the previous six months (compared to 73% who reported it as stable in 2007, 41% in 2006, 61% in 2005, 59% in 2004, 66% in 2003, and 49% in 2002). Thirteen percent reported that it had increased during that time (compared to 4% in 2007, 30% in 2006, 17% in 2005, 9% in 2004, and 14% in 2003), with a further 10% reporting that the price had recently decreased (compared to 8% in 2007, 12% in 2006, 11% in 2005, 21% in 2004, and 13% in 2003). A smaller proportion of participants (6% in the 2008 sample) reported that the price of heroin had fluctuated during the past six months.

Twelve KE were able to comment on the current price of heroin. With regard to the current price of a cap of heroin, eight KE reported a median price of \$42.50 (range=\$25-\$100). Three KE reported that one quarter-gram of heroin was usually purchased for \$100, while two KE reported that one half-gram of heroin cost \$200. Lastly, as in 2007, only two KE were able to comment on the price per gram of heroin, reporting a median price of \$375 (range=\$350-\$400).

In accordance with the majority of IDU participants who commented on changes to the price of heroin, of those KE able to comment (n=12), the majority (n=9) reported that it had remained stable during the last six months. The remaining KE reported that the price of heroin had increased (n=2) or decreased (n=1) during that time.

4.3. Availability

The majority of IDU respondents who commented on the availability of heroin (n=121) reported it as either very easy (51%, n=62) or easy (38%, n=46) to obtain at the time of interview (June 2008 to July 2008), with smaller numbers indicating that it was currently difficult (9%, n=7) or very difficult (1%, n=1) to access. Just over three-quarters of these respondents (76%, n=92) reported that heroin availability had been stable over the last six months, with smaller numbers claiming that it had become more difficult (11%,

n=13), or easier to obtain (9%, n=11). Three percent (n=3) thought heroin availability had fluctuated during that time.

Most of the participants who commented on who they sourced their heroin from (n=116), reported that they usually scored/purchased from known dealers (70%, n=85). Thirty-three percent (n=40) also reported purchasing from friends, over one-quarter reported street dealers (26%, n=31), and 12% (n=15) reported purchasing heroin from acquaintances. These participants also commented on the venues (locations) where they normally scored heroin, with most reporting an agreed public location (60%, n=73), and smaller proportions reporting home delivery (28%, n=34), a dealer's home (27%, n=33), or a street market (24%, n=29).

Half the number of KE (n=19) were able to comment on the current availability of heroin, with the vast majority (n=18) reporting that it was currently very easy (n=16) or easy (n=2) to source. Only one KE reported that heroin was currently difficult to obtain.

Of the KE who commented on changes to the availability of heroin during the last six months (n=23), the majority (n=16) supported the reports of most IDU survey respondents, noting that the availability of heroin had remained stable during that time. Smaller numbers of KE reported that heroin had become easier (n=5), or more difficult to source (n=2), during the last six months.

4.4. Purity

In 2008, of those participants who reported recent heroin use (86%, n=129), 88% (n=114) reported using heroin rock during the past six months, and 53% (n=69) reported using heroin powder during that time. As in previous years, of those respondents able to comment (n=128), a higher proportion of the IDU sample reported that they had most commonly used heroin rock (78%, n=100), compared to powder (22%, n=28) during the previous six months (Quinn, 2008; Jenkinson & Quinn, 2007; Jenkinson & O'Keeffe, 2005; Jenkinson & O'Keeffe, 2006; Jenkinson et al., 2004). More specifically, white/off-white rock (70%, n=89) was used more commonly than brown rock (9%, n=11), and white/off-white powder (16%, n=20) was used more commonly than brown powder (6%, n=8).

The majority of participants who commented on the current heroin purity (n=119) reported that it was low (45%, n=54) to medium (43%, n=51). Smaller proportions of these respondents reported that heroin purity was currently high (6%, n=7) or fluctuating (6%, n=7).

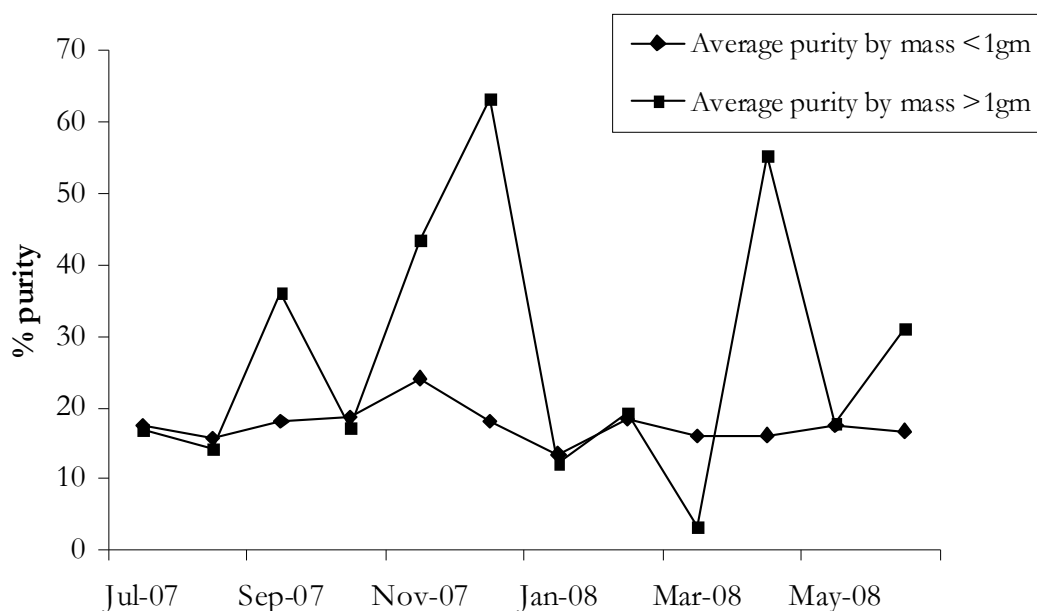
With regard to changes to heroin purity over the past six months, participant responses (n=115) were more varied. Over two-fifths (41%, n=47) of these participants reported that heroin purity had generally remained stable in the last six months, while 30% (n=34) reported that heroin purity had increased during that time. Smaller proportions of participants reported that heroin purity had fluctuated (16%, n=18) or decreased (14%, n=16) in the last six months.

The average purity level of heroin seizures (for <1gm and >1gm amounts) made by law enforcement agencies in Victoria during the 2007/2008 financial year is shown in Figure 3.

The overall average purity level of heroin seizures analysed between July 2007 and June 2008 was 22% (range=3%-63%). The purity of smaller heroin seizures (<1gm) was relatively stable (between 13%-24%) over this period, while the purity of larger seizures (>1gm) fluctuated in comparison, rising sharply from October 2007 (17%) to December 2007 (63%), and then again in April 2008 (55%). The average purity of heroin seizures

made during 2007/2008 remained relatively stable in comparison to that observed in 2006/2007 (23%), although it remains much lower than the average purities reported during the height of the heroin supply in Melbourne: 68% in 1998, 60% in 1999, 47% in 2000 (Quinn, 2008).

Figure 3: Average purity of heroin seizures by Victorian law enforcement, July 2007 to June 2008



Source: Victoria Police Forensic Services Department

KE reports (n=17) regarding the main form of heroin used by clients were mixed, with nine KE reporting that heroin rock was most commonly used, and six KE reporting that heroin powder was most commonly used. Two KE reported that clients used comparable proportions of rock and powder. KE noted that the heroin most commonly used by clients (regardless of form) was generally white/off-white in colour.

Of the 12 KE who commented on current heroin purity, the majority (n=9) reported that it was low at the time of interview. KE reports (n=17) regarding changes to heroin purity during the last six months were less consistent, however, with six reporting that the quality of heroin had increased during that time, five reporting that it had decreased, another five reporting that it had remained stable, and one KE reporting that heroin purity had fluctuated during the last six months.

4.5. Summary of heroin trends

Table 6 contains a summary of trends in the price, purity, availability and use of heroin as ascertained by the 2008 Victorian IDRS study.

Heroin is reported as very easy to easy to obtain at present, and availability has generally been stable over the past six months. The reported prices of cap of heroin remained relatively stable in 2008, while the price of a gram of heroin decreased. The current purity of heroin was reported as low to medium with varying reports regarding changes to heroin purity during the last six months. Prevalence of recent heroin use by participating Melbourne IDU remained stable in 2008, while frequency increased slightly.

Table 6: Summary of heroin price, availability, purity and use trends in Melbourne, 2008

Price (median) Cap Gram	<ul style="list-style-type: none"> • \$47.50 (stable) • \$300 (decreased)
Availability	<ul style="list-style-type: none"> • Very easy (51%) to easy (38%) and stable (76%) • Mostly accessed through known dealers (70%) or friends (33%)
Purity	<ul style="list-style-type: none"> • Average purity 22% (range=3%-63%)^a • Low (45%) to medium (43%)^b • Stable (41%), increasing (30%), fluctuating (16%), decreasing (14%)^b
Use	<ul style="list-style-type: none"> • White/off-white rock (70%), white/off-white powder (16%) • Stable prevalence of use • Increasing frequency of use

^a Based on purity of drug seizures made by Victoria Police (Victoria Police Forensic Services Department)

^b Based on IDU reports

5.0 METHAMPHETAMINE

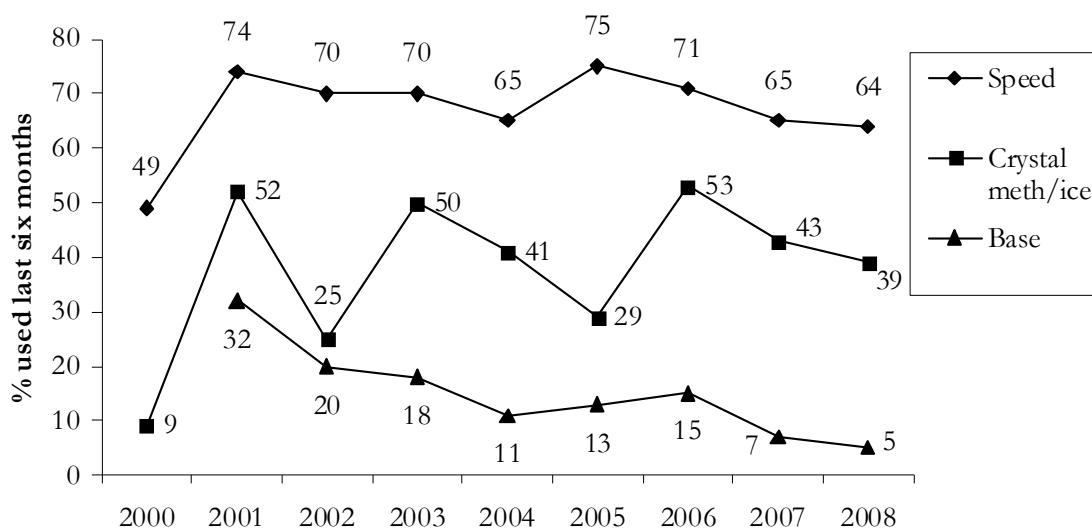
Different forms of methamphetamine are currently available in Australia. For the past six years the IDRS study has collected information on the use, price, purity and availability of three main forms of methamphetamine: speed, base and crystal meth/ice, along with information on the use of amphetamine liquid and pharmaceutical stimulants (e.g. dexamphetamine, Ritalin[®]).

As in previous years, almost the entire sample (97%, n=145) of IDU survey respondents reported having used at least one of the three main forms of methamphetamine (speed, base or crystal meth/ice) in their lifetime, and over two-thirds 69% (n=103) reported use during the previous six months (speed 64%, crystal meth/ice 39%, and base 5%). Eleven percent (n=16) of the sample also reported recent use of pharmaceutical stimulants (prescribed or not prescribed), and 3% (n=4) reported amphetamine liquid use.

Lifetime injection of speed was reported by 95% of the sample, crystal meth/ice (73%), base (35%), liquid (16%) and pharmaceutical stimulants (7%). Recent injection of speed (last six months) was reported by 62% of the sample, crystal meth/ice (36%), base (5%), liquid (3%) and pharmaceutical stimulants (5%).

Speed powder remains the most commonly used and injected form of methamphetamine by Melbourne IDU respondents. As in the previous year, prevalence of use of speed, crystal meth/ice and base all decreased slightly in 2008 (see Figure 4).

Figure 4: Proportion of IDU reporting methamphetamine use in the past six months, 2000-2008



Source: IDRS IDU interviews

In 2008, six KE reported that methamphetamine was the primary drug of choice among most of the drug users they had contact with. In contrast to previous years, of the remaining KE able to comment on levels of methamphetamine use among clients (n=30), most (n=20) reported that only a minority of clients (i.e. “a few”) currently used methamphetamine. Smaller numbers of KE reported that half (n=7), most (n=1), or all clients (n=1) currently engaged in methamphetamine use, while one KE reported that no clients presently used methamphetamine.

Only a minority of KE (n=10) were able to comment on the market characteristics of speed or crystal meth/ice, or methamphetamine generally. Similarly, with regard to use, KE commented primarily on the use of crystal meth/ice and speed powder, and the use of methamphetamine in general. It is important to note that when KE reports refer to ‘methamphetamine’, it includes all possible derivatives, such as speed powder, base and crystal meth/ice, unless otherwise stated.

In 2008, 43% (n=64) of the IDU sample were able to confidently comment on the market characteristics (i.e. price, purity and availability) of speed powder, while 18% (n=27) could comment on crystal meth/ice. As only 2% (n=2) of participants could comment on the current market characteristics of base, there is no discussion regarding the price, purity or availability of this particular form of methamphetamine.

5.1. Use

5.1.1. Prevalence of methamphetamine use

The most recent survey of methamphetamine use in the general community of Victoria was undertaken within the 2007 NDSHS. According to the findings of this survey, 2.3% of the Victorian population aged 14 years and over had used methamphetamine for non-medical purposes within the past 12 months (AIHW, 2008).⁵

Additional indicators of injecting drug use are available from the Australian NSP Survey conducted annually through the National Centre in HIV Epidemiology and Clinical Research (National Centre in HIV Epidemiology and Clinical Research, 2004; National Centre in HIV Epidemiology and Clinical Research, 2008). In addition to finger-prick blood samples and self-reported risk behaviour information, the 2007 national survey of NSP clients collected self-reported information regarding the last drug injected by participants. Over one-fifth (21%, n=51) of the 243 NSP clients recruited from five NSP sites in Victoria reported that they had last injected amphetamine (35% in 2006, 23% in 2005, 16% in 2004, 24% in 2003, 23% in 2002, 24% in 2001, and 6% in 2000), with a similar proportion of the 2008 IDU sample reporting that amphetamine was the last drug they injected (19%, n=28).

Data from the 2004 Victorian Youth Alcohol and Drug Survey (Premier’s Drug Prevention Council, 2005) found that of the 16-24 year olds surveyed (N=6,005), 15% reported having used methamphetamine in their lifetime and 10% reported use in the 12 months prior to the survey. The main forms of methamphetamine used were powder (87%) and crystal (19%) and most respondents reported snorting (72%) or swallowing (59%) these drug types (Premier’s Drug Prevention Council, 2005).

5.1.2. Current patterns of methamphetamine use

Almost all 2008 IDU survey respondents reported lifetime use of at least one form of methamphetamine (speed 95%, crystal meth/ice 80%, base 37%, and amphetamine

⁵ The sample was based on households, therefore homeless and institutionalised persons were not included in the survey.

liquid 17%), while 11% nominated methamphetamine as their drug of choice (compared to 16% in 2007).

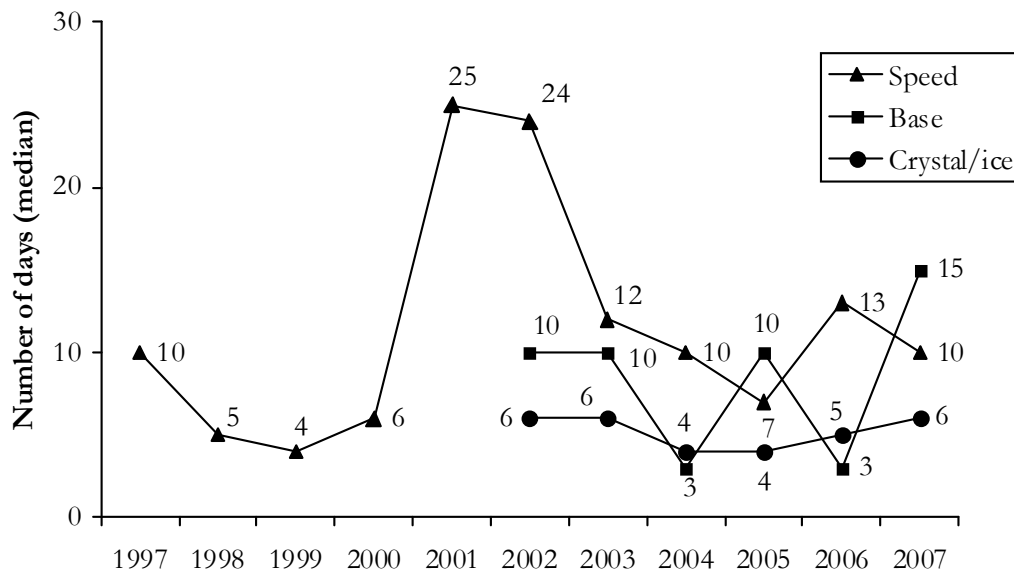
Over two-thirds (69%, n=103) of IDU survey respondents reported using methamphetamine during the past six months (speed 64%, crystal meth/ice 39%, base 5%, and liquid 3%). Apart from the reported prevalence of liquid methamphetamine use (which remained stable), there were slight decreases in the reported prevalence of speed, base and crystal meth/ice use this year in comparison to 2007 (speed 65%, crystal meth/ice 43%, base 7%). The number of respondents reporting use of at least one form of methamphetamine also decreased in comparison to the last two years (69% compared to 74% in 2007, 81% in 2006, 79% in 2005, 71% in 2004, and 79% in 2003).

Injecting was reported to be the most commonly used route of methamphetamine administration during the previous six months (66%, n=99). Smaller numbers reported smoking (23%, n=34), snorting (5%, n=8) and swallowing (5%, n=7) methamphetamine during that time.

As in 2007, those who had used methamphetamine during the past six months (n=103) reported a median of 12 days use (speed 12 days; crystal meth/ice six days; base two days; and liquid two days). Eleven respondents to the 2008 IDU survey reported using methamphetamine between every second day and daily during the previous six months (compared to 13 respondents in 2007).

Whilst frequency of speed use increased slightly and frequency of crystal meth/ice use remained stable in 2008, reported frequency of base use reached its lowest level since collection of data regarding base use commenced in 2002 (see Figure 5), following a peak of a median of 15 days use in 2007.

Figure 5: Number of days used past six months (median) by IDU participants – speed, base and crystal/ice, 1997-2008*



Source: IDRS IDU interviews

* Data not available for base and crystal/ice prior to 2002

Fourteen KE reported changes to the prevalence of methamphetamine use in the last six months. In contrast to the IDU survey reports mentioned above (which indicate a decrease in speed, crystal meth/ice and base use), eight KE reported increased use of methamphetamine during that time, with four of these KE specifying increased reports of crystal meth/ice use, and one KE reporting an increase in use of speed. In contrast, six KE reported a decrease in use of methamphetamine during the last six months.

As in the previous year, in 2008, only four KE commented on frequency of methamphetamine use among clients. Two of these KE reported that methamphetamine was mainly used on a daily basis, while the remaining two KE reported that use was less frequent, such as weekly or monthly. One of these latter KE noted that those using on methamphetamine on weekends usually did so constantly from Thursday to Monday.

Twenty-two KE were able to comment on the predominant route of methamphetamine administration (for speed and/or crystal meth/ice). Of those KE able to comment on the use of speed powder (n=18), the majority (n=12) reported that speed was mainly injected. Smaller numbers of KE reported that the predominant route of speed administration was snorting (n=3), smoking (n=2), or oral ingestion (n=1).

Responses regarding the predominant route of crystal meth/ice administration were more varied. Seventeen KE were able to comment, with eight reporting that crystal meth/ice was usually injected, and six KE reported that it was usually smoked. Smaller numbers of KE reported that crystal meth/ice was predominantly administered orally (n=2) or snorted (n=1).

Methamphetamine was again reported to be a common aspect of polysubstance use. KE noted that other drugs commonly used in addition to methamphetamine were depressant substances such as alcohol, cannabis, benzodiazepines and heroin, often to combat the 'comedown' effects resulting from psychostimulant use. One KE reported that sex workers used methamphetamine on top of heroin to stay awake and work, while another KE reported that use of methamphetamine was particularly low amongst pharmacotherapy users.

Five KE noted that violent, aggressive and/or volatile behaviour was often symptomatic of methamphetamine use, which was reportedly problematic for workers attempting to engage them with treatment. KE also noted that methamphetamine users were often more chaotic or erratic in comparison to users of other drugs (e.g. heroin, cannabis), with use commonly associated with elevated mental health issues, including irrational thinking, hysteria, and paranoia. KE reported that such behaviour and mental health issues sometimes resulted in consequences involving the criminal justice system (examples included involvement in aggravated burglaries, or assaults against police). KE also noted that methamphetamine users were often more likely to engage in unsafe sex ("they feel bulletproof"), resulting in consequences such as sexually transmitted infections (STIs), unplanned pregnancies and sexual assaults.

5.2. Price

Prices paid for speed, base and crystal meth/ice by Melbourne IDU on the last occasion of purchase are presented in Table 7. The median and modal (most frequently reported) price, price range, and the number of respondents who reported purchasing each quantity in the past six months, are reported.

Speed

Forty-three percent (n=64) of IDU survey respondents were able to comment on the current price of speed, with median and modal prices listed in Table 7. Prices reported

for all three quantities of speed have remained relatively stable since 2003, although in 2007 the median price of a point of speed decreased to \$40, down from \$50 in the previous year.

Unlike 2007, half-grams were the most commonly purchased quantity of speed by respondents (n=36) in the last six months, with participants reporting both a median and modal price of \$100 for the last half-gram of speed purchased, followed by grams (n=33), and points (n=28). Of those who commented on changes to the price of speed during the last six months (n=59), the majority (83%, n=49) reported that prices had remained stable during that time, while smaller numbers reported that the price of speed had fluctuated (8%, n=5), increased (7%, n=4), or decreased (2%, n=5) in the six months prior to interview.

Crystal meth/ice

Eighteen percent (n=27) of participants were able to comment on the current price of crystal meth/ice, with median and modal prices listed below in Table 7. As in 2007, points were the most commonly purchased quantity of crystal meth by respondents (n=13) in the last six months, with participants reporting a median and modal price of \$50 for last point of crystal meth purchased. Participants also reported purchasing half-grams (n=11) and grams (n=11) of crystal meth in the six months prior to interview. While prices reported for a point of crystal meth remained relatively stable this year, both the median and modal price of a gram of the drug increased in 2008.

Over two-thirds (70%, n=16) of the 23 participants who commented on changes to the price of crystal meth/ice reported that it had remained stable over the past six months, while 26% (n=6) reported an increase in price, with one remaining participant (4%) reporting that the price of crystal meth had fluctuated during that time.

Table 7: Price of most recent methamphetamine purchases by IDU, 2008

Amount	Median price* \$	Modal price* \$	Price range* \$	Number of purchasers*
<i>Speed</i>				
Gram	200 (200)	200 (200)	80-500 (90-250)	33 (17)
Half-gram	100 (100)	100 (100)	50-200 (50-170)	36 (19)
Point (0.1 gram)	40 (50)	50 (50)	20-100 (20-50)	28 (20)
<i>Base</i>				
Gram	200 (150)	200 (150)	200 (150)	1 (1)
Half-gram	150 (-)	150 (-)	150 (-)	1 (0)
<i>Ice</i>				
Gram	370 (350)	400 (300 ^a)	200-400 (300-400)	7 (2)
Half-gram ^b	200 (-)	200 (-)	100-220 (-)	11 (-)
Point (0.1 gram)	50 (50)	50 (50)	20-100 (40-50)	13 (15)

Source: IDRS IDU interviews

* 2007 data is presented in brackets

^a Multiple modes exist. The smallest value is shown

^b 2007 data not available

In 2008, very few KE (n=3) were able to comment on the current price, or changes to the price, of methamphetamine, therefore any trends should be treated with caution. One KE reported that one half-gram of methamphetamine could be purchased for \$100, while a point ranged from \$20-\$50. Another KE reported that the price of one cap of crystal meth ranged from \$50-\$80.

With regard to changes to the price of methamphetamine over the last six to 12 months, one KE reported that it had increased, another reported that it had fluctuated, and one last KE reported that the price of methamphetamine had remained stable during that time.

5.3. Availability

Similar to last year, of those who commented on methamphetamine availability, the majority of IDU reported that speed and crystal meth/ice were currently easy to very easy to access, and that availability had remained stable over the past six months. In terms of the main sources of methamphetamine, most people reported scoring from known dealers or friends.

At the time of interview, six KE reported that methamphetamine (speed and/or crystal meth) was generally very easy (n=5) or easy (n=1) to obtain. Eight KE commented on changes to methamphetamine availability over the last six months, with the majority (n=5) reporting that it had remained stable during that time. In contrast, smaller numbers

of KE reported that methamphetamine had become easier (n=2) or more difficult to source (n=1) in the last six to 12 months.

Speed

The majority of IDU respondents who commented on the availability of speed (n=64) reported that it was either very easy (47%, n=30), or easy (33%, n=21) to obtain at present, with one-fifth (20%, n=13) reporting difficulty in obtaining the drug. Most of those able to comment on changes to the availability of speed in the last six months (n=62) indicated that it had remained stable (58%, n=36), with 18% (n=11) reporting that it had become more difficult, and 19% (n=12) reporting that it had become easier during that time. The remaining 5% (n=3) of these participants reported that the availability of speed had fluctuated during the last six months.

Participants who commented on where they sourced their speed during the past six months (n=62), mainly reported scoring/purchasing from known dealers (50%, n=31), friends (50%, n=31), and street dealers (23%, n=14). Participants also commented on types of venues (locations) at which they normally scored speed during the last six months (n=62), with most reporting an agreed public location (56%, n=35), a dealer's home (32%, n=20), or a friend's home (29%, n=18).

Crystal meth/ice

The majority of those who commented on the current availability of crystal meth (n=25) reported that it was easy (52%, n=13) or very easy (20%, n=5) to obtain at present. In comparison, the remaining participants (28%, n=7) reported experiencing difficulty when sourcing crystal meth. Of those who commented on changes to crystal meth/ice availability over the last six months (n=23), the majority (70%, n=16) reported that it had remained stable during that time, while 27% (n=4) reported that it had become more difficult to obtain, and 13% (n=3) of these participants reported that crystal meth/ice availability had become easier to obtain during the last six months.

Most participants who commented on who they sourced their crystal meth from during the past six months (n=22) mainly reported scoring/purchasing from known dealers (64%, n=14), friends (50%, n=11), or acquaintances (36%, n=8). With regard to the types of venues (locations) where participants normally scored crystal meth (n=22), close to three-quarters (73%, n=16) reported scoring from an agreed public location, with smaller numbers of participants reporting that they usually scored at a dealer's home (41%, n=9), or a friend's home (32%, n=7).

5.4. Purity

Participants reported using a variety of methamphetamine forms during the past six months, including speed powder 64% (65% in 2007, 71% in 2006, 75% in 2005, 65% in 2004, 70% in 2003, and 70% in 2002), crystal meth/ice 39% (43% in 2007, 53% in 2006, 29% in 2005, 41% in 2004, 50% in 2003, and 26% in 2002), methamphetamine base 5% (8% in 2007, 15% in 2006, 13% in 2005, 11% in 2004, 18% in 2003, and 19% in 2002), amphetamine liquid 3% (3% in 2007 and 2006, 5% in 2005, 2% in 2004, 5% in 2003, and 7% in 2002) and pharmaceutical stimulants 11% (6% in 2007, 9% in 2006, 9% in 2005, 9% in 2004, and 6% in 2003). The two sections below describe participant responses to questions regarding the purity of speed powder and crystal meth/ice during the last six months.

Speed

Reports regarding the current purity of speed powder were less disparate in 2008 than in previous years. Of those who commented (n=64), similar proportions reported that it was either medium (38%, n=24) or low (36%, n=23), with smaller numbers reporting that the purity of speed was currently high (14%, n=9) or fluctuating (13%, n=8). In 2008, nearly two-fifths (39%, n=24) of those who commented on changes to speed purity (n=61) reported that it had remained stable during the previous six months. In contrast, just over one-third of these participants (34%, n=21) reported that it had decreased, while smaller proportions reported that it had fluctuated (20%, n=12) or increased (7%, n=4) in the last six months.

Crystal meth/ice

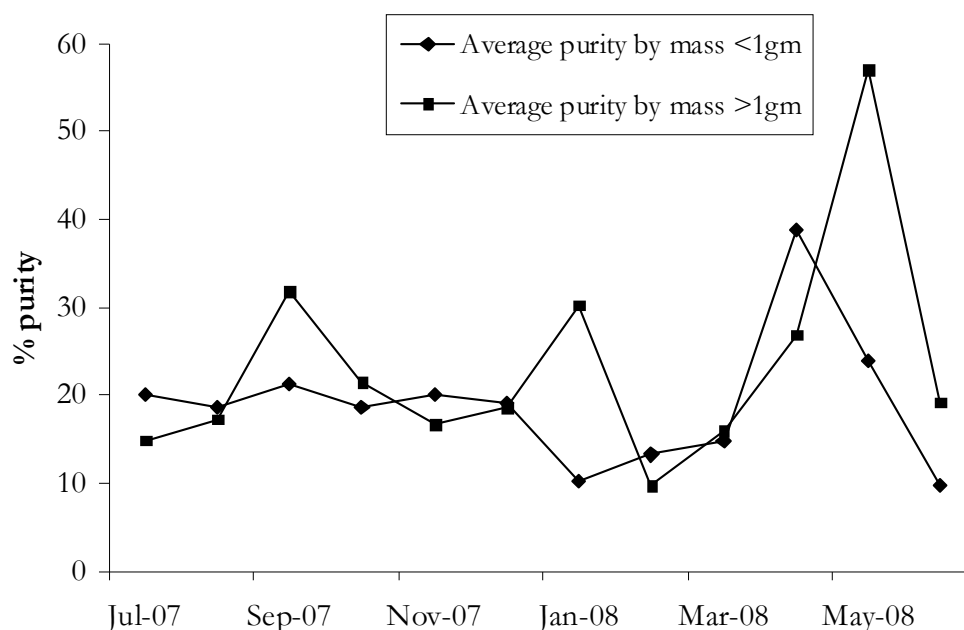
Most of the participants who commented on current crystal meth purity (n=26) reported that it was high (46%, n=12) to medium (38%, n=10) at present. Smaller numbers of respondents reported that crystal meth/ice purity was currently low (12%, n=3), or fluctuating (4%, n=1). Of those who commented on changes to crystal meth purity in the last six months (n=24), just over half reported that it had remained stable (54%, n=13) during that time. In contrast, one-third of these participants (33%, n=8) reported that it had increased, while smaller numbers reported that it had decreased (17%, n=2), or fluctuated (4%, n=1) during the last six months.

The average purities of <1gm and >1gm methamphetamine seizures by law enforcement agencies in Victoria during the 2007/2008 financial year are shown in Figure 6. The average purities of both smaller (<1gm) and larger (>1gm) seizures were variable over the 12-month period, with the average purity of smaller seizures peaking in April 2008 (39%), and larger seizures peaking one month later in May (57%).

The mean purity of all seizures of methamphetamine analysed in Victoria during the 2007/2008 financial year was 21% (range=10% to 57%), compared to 18% reported in 2006/2007, 19% reported in 2005/2006, 21% reported in 2004/2005, 31% reported in 2003/2004, 33% reported in 2002/2003, 20% reported in 2001/2002 and 21% reported in 2000/2001 (Quinn, 2008).

As in previous years, there were very few amphetamine seizures (as opposed to methamphetamine seizures) made by law enforcement agencies in Victoria during the 2007/2008 financial year. The purity of the small amount of amphetamine seized was generally low (<20%), with an average of 11% for 2007/2008. (Unpublished data: Victoria Police Forensic Services Department).

Figure 6: Average purity of methamphetamine seizures by Victorian law enforcement, July 2007 to June 2008



Source: Victoria Police Forensic Services Department

Only five KE commented on the current purity of methamphetamine, with varied responses. Two KE reported that methamphetamine purity currently fluctuated, while the remaining KE reported that it was high (n=1), medium (n=1), or low (n=1). With regard to changes to methamphetamine purity over the last six to 12 months, responses were once again varied: two KE reported that methamphetamine purity had fluctuated during that time, with the remaining KE reporting that it had remained stable (n=1), increased (n=1), or decreased (n=1) in the last six to 12 months.

Most KE (n=34) were able to comment on the predominant form of methamphetamine (i.e. speed powder, crystal meth/ice, methamphetamine base, methamphetamine liquid) used by the people they had contact with in the last six to 12 months. The majority of these KE (n=20) reported that speed and crystal meth/ice were both used as commonly as each other by users, while smaller numbers of KE reported that speed (n=9) or crystal meth/ice (n=4) were the predominant forms of methamphetamine used by clients. As in 2006 and 2007, one law enforcement KE (from the Victoria Police Forensic Service Department), noted that the majority of methamphetamine seized by Victoria Police in 2008 was crystalline in form, though was predominantly cut with dimethyl sulphone and was therefore lower in purity (average 15%-20%) than the higher-grade crystal meth/ice seen prior to 2006/2007, which was 70%-80% pure on average.

5.5. Summary of methamphetamine trends

Trends in methamphetamine price, availability, purity and use are summarised in Table 8. Findings from this year's IDRS study suggest that the prevalence of methamphetamine use among IDU in Melbourne continues to be high (despite slight decreases in reported prevalence of use by the 2008 sample), though frequency of use is generally low in comparison to other drugs such as heroin and cannabis. After a peak in 2007, frequency of base use decreased noticeably in 2008, though due to such a small number of base users in Victorian IDRS samples, it is hard to identify any clear trends. As in previous

years, these drugs were reported to be predominantly sourced through known dealers and friends (social networks).

Table 8: Summary of methamphetamine price, availability, purity and use trends in Melbourne, 2008

	Speed	Base	Crystal/ice
Last price paid			
<u>Point</u>			
Median	\$40	-	\$50
Mode	\$50	-	\$50
<u>Half-gram</u>			
Median	\$100	\$150 [^]	\$200
Mode	\$100	\$150 [^]	\$200
<u>Gram</u>			
Median	\$200	\$200 [^]	\$370
Mode	\$200	\$200 [^]	\$400
	<ul style="list-style-type: none"> • Speed prices generally stable • Reported crystal meth gram prices increased in 2008, though point prices remained stable 		
Availability	<p>n=64</p> <ul style="list-style-type: none"> • Very easy (47%) to easy (33%) • Stable (58%) to difficult (18%) • Sourced from known dealers (50%), friends (50%), street dealers (23%) 	<p>n=2</p> <ul style="list-style-type: none"> • Easy (100%)[^], • Stable (50%)[^], more difficult (50%)[^] 	<p>n=25</p> <ul style="list-style-type: none"> • Easy (52%) to very easy (20%) • Stable (70%) • Sourced from known dealers (64%), friends (50%), acquaintances (36%)
	<ul style="list-style-type: none"> • Availability generally easy to very easy and stable • Generally sourced from known dealers or friends 		
Purity	<p>n=64</p> <ul style="list-style-type: none"> • Current purity medium (38%) to low (36%) • Purity stable (39%), decreased (34%), fluctuated (20%) 	<p>n=1</p> <ul style="list-style-type: none"> • Purity high (100%)[^], fluctuated (100%)[^] 	<p>n=26</p> <ul style="list-style-type: none"> • Purity high (46%) to medium (38%) • Purity stable (54%) to increasing (33%)[^]
Use	<ul style="list-style-type: none"> • Prevalence of use of speed, base and crystal meth/ice use decreased very slightly in comparison to 2007 • As in 2007, overall frequency of methamphetamine use was around twice per month (median of 12 days) 		

^a Multiple modes exist. The smallest value is shown

[^] Small numbers reported (n<10)

6.0 COCAINE

Twenty-four percent of the Melbourne IDRS survey respondents (n=36) reported using cocaine during the past six months; however, only 12 respondents were able to comment on the price, purity and/or availability of this drug. Data collected from these 12 participants have been included in this report; however, it is difficult to draw many conclusions, or to identify clear trends from such a small sample. Cocaine use by the IDU surveyed in Melbourne still appears to be fairly opportunistic.

As in the previous year, in 2008 no KE were able to report *exclusively* on cocaine, though some KE were able to comment on the availability, purity and/or patterns of cocaine use in the last six to 12 months.

6.1. Use

6.1.1. Prevalence of cocaine use

The most recent survey of cocaine use within the general community of Victoria was undertaken within the 2007 NDSHS. According to the findings of this survey, 1.6% of the Victorian population aged 14 years and over had used methamphetamine for non-medical purposes within the past 12 months (AIHW, 2008).⁶

Consistent with low numbers in previous years, in 2007 none of the 243 NSP clients recruited from seven NSP sites in Victoria for the annual Australian NSP Survey reported that cocaine was the last drug they injected (2% in 2006, 3% in 2005, <1% in 2004, 0% in 2003), while only 2% (n=3) of the 2008 IDRS sample reported last injecting cocaine (National Centre in HIV Epidemiology and Clinical Research, 2008).

Data from the Victorian Youth Alcohol and Drug Survey (Premier's Drug Prevention Council, 2005) indicates that, of the 16-24 year olds sampled (N=6,005), reported use of cocaine was infrequent, with 6% reporting ever having used cocaine, and 3% reporting use in the 12 months prior to survey.

6.1.2. Current patterns of cocaine use

Although over two-thirds of the respondents to the IDU survey (69%, n=103) reported lifetime use of cocaine, only 3% (n=4) identified cocaine as their main drug of choice. Twenty-four percent (n=36) of the IDU surveyed reported having used cocaine in the previous six months (compared to 22% in 2007, 19% in 2006, 15% in 2005 and 10% in 2004), and 19% (n=29) reported injecting the drug during that time. Seven percent (n=10) of participants reported snorting cocaine in the last six months.

Among those who reported using cocaine during the past six months (n=36), frequency of use was very low (median=4.5 days), suggesting irregular, opportunistic use patterns.

Only 14 KE reported any use of cocaine by the IDU they had contact with/knowledge of, with all reporting that only a few (n=9) or very few (n=5) clients engaged in cocaine use. While these KE generally reported no changes to the use of cocaine by IDU in the last six months, four KE reported increased use, with one KE noting an increasing trend of IDU – particularly Vietnamese IDU – mixing heroin and cocaine due to poor heroin quality. In contrast, two KE reported that cocaine use had decreased among IDU in the last six months.

⁶ The sample was based on households, therefore homeless and institutionalised persons were not included in the survey.

Only seven KE commented on the predominant route of cocaine administration among clients, with the majority (n=5) reporting that cocaine was usually injected by users. The remaining two KE reported that cocaine was usually snorted (n=1) or smoked (n=1).

6.2. Price

In 2008, five participants were able to comment on the current price of a cap of cocaine, with all five reporting a current price of \$100 per cap (compared to \$50 in 2007), with another five participants all reporting that the current price for a point of cocaine was also \$100. Only two participants commented on the current price for one gram of cocaine, reporting a median price of \$345 (range=\$290-\$400).

Of those participants who reported purchasing any quantity of cocaine during the previous six months (n=11), over half (55%, n=6) reported purchasing a cap at least once during that time. Another four respondents all reported purchasing a point of cocaine in the last six months, with all four reporting that they last paid \$100 for this quantity, while one respondent reported recently purchasing two points of cocaine, also last paying \$100. No respondents reported purchasing a gram of cocaine in the last six months.

In 2008, all 11 respondents (100%) who were able to comment on changes to the price of cocaine during the last six months reported that it had remained stable. In contrast, one KE reported that the price of cocaine had decreased during that time.

Table 9 summarises the last purchase price of cocaine in Melbourne reported by the IDU who participated in the 1997-2008 IDRS studies. Although data collected in Melbourne over the past 12 years suggests that the price of a cap of cocaine ranges from \$50-100, and a gram of cocaine ranges from \$200-\$400, it is not possible to identify clear trends due to the consistently small number of price reports obtained each year from IDU samples. In 2008, no participants who reported recent cocaine use reported purchasing a gram in the last six months.

Table 9: Prices of last purchase of cocaine in Melbourne reported by IDU survey respondents 1997-2008

Cocaine	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Cap (\$)												
median	60	80	60	80	100	65	-----	-----	50	-----	-----	100
mode	50 ^a	50 ^a	60	80	100	30 ^a	-----	-----	50	-----	-----	100
range	50- 200	50- 100	-----	-----	50- 200	30- 110	-----	-----	-----	-----	-----	-----
purchasers (n)	3	3	1	1	5	4	-----	-----	1	-----	-----	6
Gram (\$)												
median	325	220	230	238	225	200	250	200	350	400	375	-----
mode	400	200	220 ^a	250	200	150 ^a	250	200	270 ^a	400	200 ^a	-----
range	200- 500	175- 400	220- 240	150- 250	200- 500	150- 450	-----	200	270- 400	-----	200- 550	-----
purchasers (n)	12	21	2	6	15	7	1	2	3	1	2	-----

Source: IDRS IDU interviews

^a Multiple modes exist. The smallest value is shown

6.3. Availability

Of the 12 participants who were able to report on the current availability of cocaine, approximately two-thirds (67%, n=8) reported that it was currently easy to access. In

comparison, the remaining four participants reported that cocaine was currently very difficult (25%, n=3) or difficult (8%, n=1) to source. The majority of these respondents (83%, n=10) reported that cocaine availability had been stable during the previous six months, while the remaining two participants reported that cocaine had become easier (8%, n=1) or more difficult (8%, n=1) to obtain during that time. Two KE reported that availability of cocaine had increased in the last six months.

Of the respondents who reported purchasing cocaine during the last six months (n=11), all reported most commonly buying cocaine from known dealers (100%, n=11). Other sources of cocaine during that time included friends (27%, n=3), street dealers (9%, n=1), and mobile dealers (9%, n=1). In terms of the scoring (buying) location, participants reported that they usually purchased cocaine from a dealer's home (82%, n=9) or agreed public location (36%, n=4).

6.4. Purity

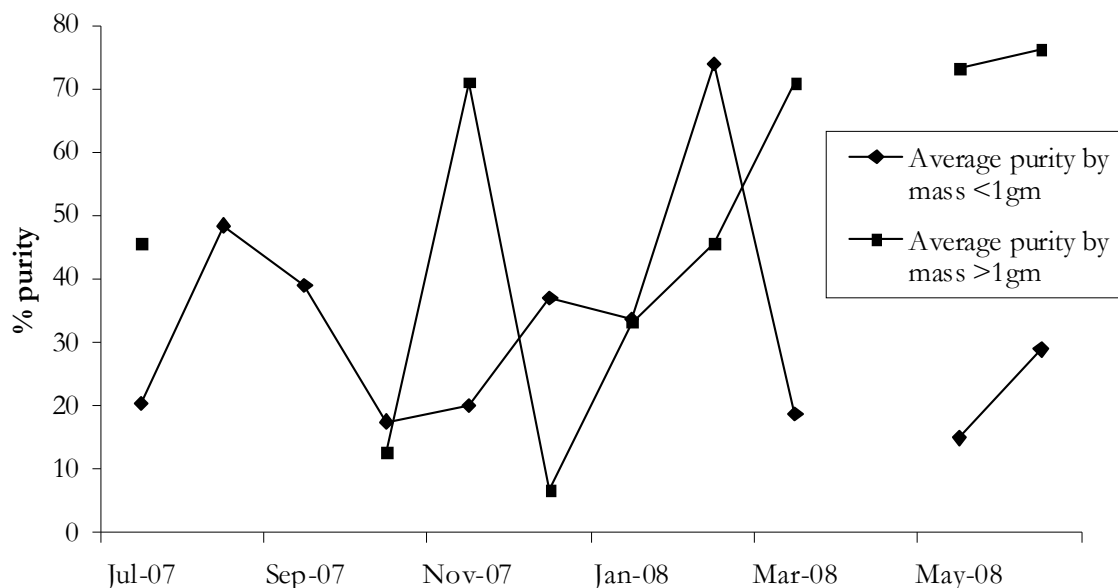
Twenty-two percent (n=33) of those who participated in the 2008 IDU survey reported having used cocaine in powder form during the past six months (compared to 21% in 2007, 18% in 2006, 14% in 2005, 7% in 2004, 13% in 2003, and 16% in 2002). In comparison, four respondents (3%) reported using cocaine in rock form, with one respondent (1%) reported use of 'crack' (a smokeable form of cocaine). Of those respondents who reported any recent cocaine use (n=36), the majority (92%, n=33) reported mostly using cocaine in powder form.

Of the 11 respondents who commented on current cocaine purity, over half (55%, n=6) reported that it was currently medium. Smaller numbers of participants reported that cocaine was currently of low (27%, n=3), high (8%, n=1) or fluctuating (8%, n=1) purity. Twelve participants reported on changes to the purity of cocaine during the last six months, with most (75%, n=9) reporting that it had remained stable during that time. The remaining three participants reported that cocaine purity had decreased (17%, n=2) or increased (8%, n=1) in the last six months.

One law enforcement KE commented on the purity of cocaine, reporting that it currently ranged from 25%-30% at the time of interview, down from 30%-40% the previous year. This KE also noted that cocaine seized by police was generally in "loose powder form".

The average purity levels of cocaine seizures analysed by law enforcement agencies in Victoria during the 2007/2008 financial year are shown in Figure 7. There were no seizures of smaller amounts of cocaine (<1gm) in April 2008, and no seizures of larger amounts of cocaine (>1gm) in August and September 2007, and April 2008.

Figure 7: Average purity of cocaine seizures by Victorian law enforcement, July 2007 to June 2008



Source: Victoria Police Forensic Services Department

The mean purity of all seizures analysed during this period was 39% (range=7% to 76%), compared to 41% in 2006/2007, 37% in 2005/2006, 42% in 2004/2005, 40% in 2003/2004, 27% in 2002/2003, 38% in 2001/2002 and 40% in 2000/2001. Hence, whilst there was variability in the purity of cocaine seized by Victoria Police during 2007/2008 (see Figure 7), the average purity of cocaine seizures in this jurisdiction has generally ranged from approximately 30%-40% since 2000/2001 (Quinn, 2008).

6.5. Summary of cocaine trends

Trends in cocaine price, availability, purity, and use are summarised in Table 10. In general, it appears that cocaine use remains infrequent among IDU in Melbourne. Only 12 participants (8% of the IDU sample) could comment on the market characteristics of cocaine. This may be due to the prohibitive cost, and possibly the widespread availability and use of other drug types in Melbourne in comparison to cocaine.

Table 10: Summary of cocaine price, availability, purity and use trends in Melbourne, 2008

Price Cap Point	<ul style="list-style-type: none"> • \$100 • \$100 • Stable (100%, n=11)
Availability	<ul style="list-style-type: none"> • Easy (67%, n=8), difficult (25%, n=3) • Stable (83%, n=10)
Purity	<ul style="list-style-type: none"> • Average purity 39% (range=7%-76%)^a • Medium (55%, n=6) to low (27%, n=3), stable (75%, n=9)^b
Use	<ul style="list-style-type: none"> • Recent reported use relatively stable in comparison to previous year (24% compared to 22%) • Very low frequency of use (median 4.5 days out of 180), suggesting opportunistic use patterns • Sourced from known dealers • Trends are not clear and require further research

^a Based on purity of drug seizures made by Victoria Police (Victoria Police Forensic Services Department)

^b Based on IDU reports

7.0 CANNABIS

In 2008, nearly three-quarters of IDRS participants (74%, n=111) reported using cannabis in the last six months (down from 83% in 2006 and 2007), with the majority (95%, n=143) reporting having used cannabis in their lifetime. Over half (57%, n=86) of the respondents to the 2008 survey were able to report on the market characteristics of cannabis.

As in previous years, questions related to cannabis were asked separately for hydroponic cannabis (hydro) and bush/naturally-grown cannabis (bush) (Jenkinson & Quinn, 2007; Jenkinson & O’Keeffe, 2005; Jenkinson & O’Keeffe, 2006; Jenkinson et al., 2004). Of the respondents who had used cannabis in the last six months (n=111), most reported using hydro during that time (96%, n=107), while 47% (n=52) reported having used bush during that time (compared to 96% who had used hydro and 57% who had used bush during the same time period in 2007). In 2008, participants who had recently used cannabis (n=111) were also asked how often they mixed cannabis with tobacco, with the vast majority (91%, n=101) that they combined cannabis and tobacco all the time. Smaller numbers of these participants reported mixing cannabis and tobacco quite a bit of the time (2%, n=2), some of the time (1%, n=1), or a little bit of the time (1%, n=1), while 5% (n=6) reported that they never combined cannabis and tobacco.

Seven KE reported that cannabis was the primary drug of choice among most of the drug users with whom they had the most contact. As in previous years, the remaining KE generally agreed that cannabis was a “constant” substance used by many of Melbourne’s IDU. Cannabis was commonly reported to be used as a secondary drug in combination with heroin, methamphetamine, benzodiazepines, morphine, alcohol, and tobacco. KE noted that cannabis was often used by IDU to combat the comedown effects of stimulants such as methamphetamine and ecstasy, an observation also noted in reference to regular ecstasy users (REU) in the 2008 EDRS (Kong, 2009).

7.1. Use

7.1.1. Prevalence of cannabis use

The most recent survey of cannabis use within the general community of Victoria was undertaken within the 2007 NDSHS. The findings of this survey suggest that cannabis is the most commonly used illicit drug within the Victorian community, with 8.8% of the Victorian population aged 14 years and over reporting use of the drug within the past 12 months (AIHW, 2008).⁷

Data from the 2004 Victorian Youth Alcohol and Drug Survey (Premier’s Drug Prevention Council, 2005) show that cannabis was the most frequently and widely used illicit drug by the 6,005 young people surveyed. Approximately half (48%) of the 16-24 year olds sampled reported lifetime use of cannabis, and over one-quarter of the sample (27%) reported use in the 12 months prior to the survey. Alcohol and tobacco were reported to be the drugs most commonly used at the same time as cannabis.

7.1.2. Current patterns of cannabis use

IDU survey respondents who reported cannabis use in the past six months (74%, n=111) reported using this drug on a median of 175 days during that period, with a mode of 180

⁷ The sample was based on households, therefore homeless and institutionalised persons were not included in the survey.

days (i.e. daily use). Of all the illicit drugs discussed in the IDRS, cannabis remains the most frequently used drug.

Only seven KE reported that cannabis was the primary substance used by clients in the last six to 12 months. With regard to frequency of use, five of these KE reported that most primary cannabis users used at least once daily. In contrast, one KE reported that cannabis use was “more of a weekend thing”, while the remaining KE reported that frequency of cannabis use among clients ranged from social (e.g. sporadic, opportunistic) to daily.

As reported in the 2007 IDRS, of the remaining KE who reported on prevalence of cannabis use among clients (n=28), the majority (n=20) indicated that most (n=24) or all (n=4) clients currently used cannabis. The remaining KE reported that only half (n=5) or a few (n=3) clients engaged in cannabis use.

Cannabis use among clients was generally reported to be stable by KE (“it’s always around”), though a minority of KE (n=4) did report changes to the use of cannabis use in the last six months to 12 months. One of these KE reported an increase in the number of clients combining cannabis with crystal meth/ice, particularly as a means of combating the comedown effects of psychostimulants, while another KE reported an increase in the number of people using cannabis while withdrawing or reducing use of other substances (i.e. as a substitute). Another KE reported increased use of hydro among clients, while the remaining KE reported a general reduction in cannabis use in the last six to 12 months.

KE reported that smoking was the main route of cannabis administration, usually via bongs or joints, with KE noting that oral administration of cannabis (e.g. when baked in biscuits, cakes, etc.) was generally minimal among clients.

Types of drug treatment reportedly utilised by cannabis users included counselling, outreach services, residential rehabilitation, residential withdrawal, home-based withdrawal and detox. One KE noted that residential rehabilitation in particular had extensive waiting lists (“it’s difficult (for users) waiting around for a bed”).

While KE generally reported that treatment seeking behaviour among cannabis users had been stable in the last six to 12 months, one KE noted that there had recently been an increased number of referrals for cannabis treatment, particularly increased numbers of clients accessing residential withdrawal.

As in previous years, KE reported that for many clients cannabis was commonly a component of polysubstance use. Drugs reportedly used in combination with cannabis included alcohol, tobacco (“all (users) mix tobacco with cannabis”), heroin, methamphetamine and ecstasy (as previously stated, particularly to combat the comedown effects of such drugs), and benzodiazepines.

7.2. Price

Prices paid for hydro and bush cannabis on the last occasion of purchase by Melbourne IDU are presented in Table 11. The median and modal (most frequently reported) price, and the number of respondents who reported purchasing each quantity during the past six months are reported.

Table 11: Price of most recent cannabis purchases by IDU, 2008*

Amount	Hydro median price (\$)	Hydro modal price (\$)	Hydro no. of purchasers	Bush median price (\$)	Bush modal price (\$)	Bush no. of purchasers
Ounce	250 (240)	200 (200 ^a)	31 (20)	200 (240)	200 (200 ^a)	7 (8)
Half-ounce	150 (145)	150 (150)	16 (7)	110 (120)	100 ^a (90 ^a)	2 (2)
Quarter-ounce	80 (70)	80 (70)	41 (38)	80 (80)	80 (80)	5 (8)
Three grams	50 (50)	50 (50)	27 (13)	50 (50)	50 (50)	3 (3)
Gram	20 (20)	20 (20)	53 (39)	20 (20)	20 (20)	10 (14)

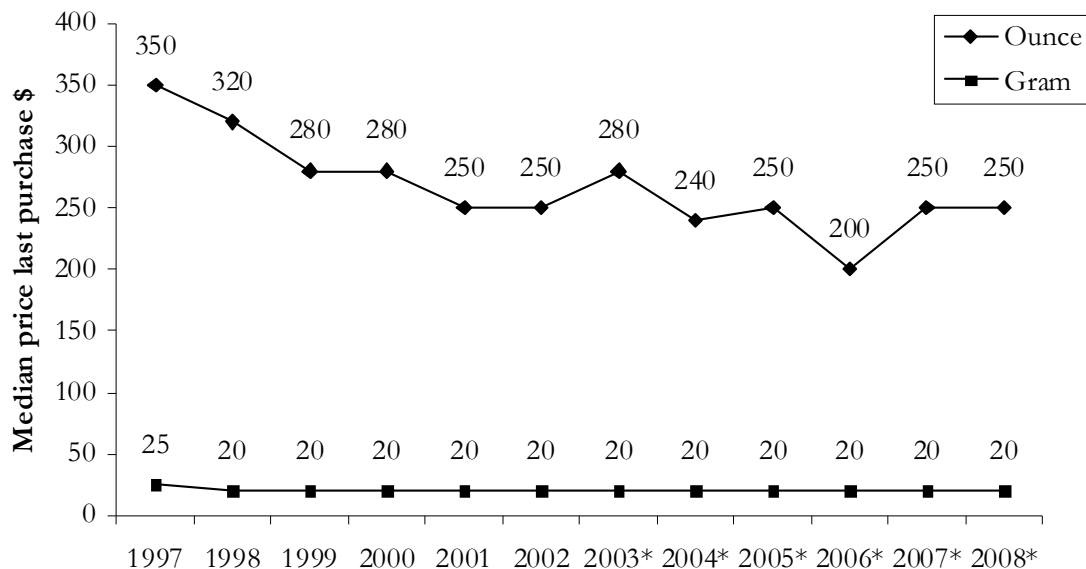
Source: IDRS IDU interviews

* 2007 data in brackets

^a Multiple modes exist. The smallest value is shown

Prices of cannabis in Melbourne reported by IDU survey participants in the 1997-2008 IDRS studies are shown in Figure 8. This shows that the reported price of a gram of cannabis has been generally stable, while the price per ounce has been less consistent. The price per ounce of cannabis remained stable in 2008 at \$250 in comparison to the previous year, following a low of \$200 in 2006.

Figure 8: Price of cannabis* in Melbourne reported by IDU survey respondents 1997-2008



Source: IDRS IDU interviews

* 2003-2008 prices reflect those for hydro cannabis only (the form most often used). Any increase may be due to this distinction

Hydro

Median prices reported for hydro on the most recent occasion of purchase were: gram \$20, three grams \$50, quarter-ounce \$80, half-ounce \$150, and ounce \$250. Prices reported for these quantities of hydro remained relatively stable in 2008, although the median prices of both a quarter-ounce and ounce increased by \$10 each (to \$80 and \$250 respectively). During the previous six months, the most commonly purchased quantities of hydro were grams (n=53), quarter-ounces (n=41), and ounces (n=31).

Of those IDU who commented on changes to the price of hydro during the last six months (n=77), the majority (83%, n=64) reported that it had remained stable, while smaller numbers indicated that prices had increased (6%, n=5), fluctuated (6%, n=5), or decreased (4%, n=3) during that time.

Bush

In terms of bush, median prices reported on the most recent occasion of purchase were: gram \$20, three grams \$50, quarter-ounce \$80, half-ounce \$110, and ounce \$200. Of those respondents able to comment on changes to the price of bush in the last six months (n=21), the majority (76%, n=16) reported that it had remained stable during that time. The most common purchase quantities of bush in the past six months were grams (n=10) and ounces (n=7).

7.3. Availability

Hydro

As in previous years, the overwhelming majority of the IDU sample who commented on the availability of hydro (n=79), reported that it was either very easy (67%, n=53) or easy (28%, n=22) to source, and that the availability of this form of cannabis had remained stable during the preceding six months (76%, n=60). A smaller proportion of respondents reported that hydro had become easier (13%, n=10) to obtain during that time. This group (n=77) reported commonly purchasing cannabis from friends (64%, n=49), known dealers (44%, n=34), acquaintances (14%, n=11) and street dealers (13%, n=10). The reported locations (or venues) where people (n=77) normally purchased hydro included an agreed public location (40%, n=31), friend's home (39%, n=30), dealer's home (26%, n=20), and home delivery (25%, n=19).

Bush

Of those who were able to comment on the availability of bush (n=22), the majority reported that it was currently very easy (50%, n=11) or easy (32%, n=7) to source, with smaller proportions reporting that it was currently difficult (15%, n=3) or very difficult (5%, n=1) to obtain. Nearly three-quarters (71%, n=15) of those participants able to comment on changes to the availability of bush (n=21) reported that it had remained stable during the past six months, with 19% (n=4) reporting that it had become easier to source during that time. Of those who purchased bush in the last six months (n=19), common sources were reported to be friends (74%, n=14) and known dealers (26%, n=5). The locations (or venues) that people reported normally purchasing bush from included a friend's home (47%, n=9), an agreed public location (32%, n=6), or home delivery (32%, n=6).

7.4. Potency

Participants (n=111) had used a variety of cannabis forms during the six months prior to interview, including: hydro (96%, n=107), bush (47%, n=52), hash (5%, n=6) and hash

oil (2%, n=2). As in previous years, of those IDU respondents who had used cannabis in the last six months (74%, n=111), the type reported to be most commonly used was hydroponic (88%, n=98).

Hydro

Of the 77 respondents who reported on the current potency of hydro, the majority generally rated it as high (56%, n=43) to medium (38%, n=29). The majority of these respondents (62%, n=48) reported that the potency had remained stable during the last six months, with smaller proportions reporting that it had increased (21%, n=16), fluctuated (9%, n=7), or decreased (8%, n=6) during that time.

Bush

Of those who commented on the current potency of bush (n=22), the majority (64%, n=14) reported that it was medium. In comparison, 18% (n=4) of these participants reported that the potency of bush was currently high. Twenty-one IDRS participants commented on changes to the potency of bush cannabis during the last six months, with over three-quarters (76%, n=16) reporting that it had remained stable during that time. A smaller proportion (14%, n=3) reported that the potency of bush had increased in the last six months.

7.5. Summary of cannabis trends

A summary of cannabis trends is shown in Table 12. The Melbourne cannabis market and patterns of use continue to be relatively stable. Reported cannabis availability and perceived potency remained relatively unchanged between 1997 and 2008. Cannabis was the most frequently used drugs in terms of number of days by the 2008 IDRS sample.

Table 12: Summary of cannabis price, availability, purity and use trends in Melbourne, 2008

Price (median) Gram Ounce	<ul style="list-style-type: none"> • \$20 (hydro); \$20 (bush) • \$250 (hydro), \$200 (bush) • Prices stable
Availability	<ul style="list-style-type: none"> • Hydro: availability in last 6 months very easy (67%) to easy (51%) and stable (76%) • Bush: very easy (50%) to easy (32%) and stable (71%)
Potency	<ul style="list-style-type: none"> • Hydro: high (56%) to medium (38%) and stable (62%)^a • Bush: medium (64%) and stable (76%)^a
Use	<ul style="list-style-type: none"> • Most frequently used illicit drug in terms of number of days (daily use) • Cannabis commonly used concurrently with other drugs • Accessed primarily through social networks and known dealers

^a Based on IDU estimates of THC potency

8.0 OTHER OPIOIDS

8.1 Use of illicit methadone

For the purposes of the IDRS study, the category ‘methadone’ includes methadone syrup and methadone in tablet form (known as Physeptone[®]). Eighty-one percent (n=122) of the 2008 IDU sample reported lifetime use of methadone, which is similar to proportions reported over the past six years (79% in 2007).

Over one-third of respondents (37%, n=) reported lifetime injection of methadone, while only 15% (n=23) reported injection of methadone during the six months prior to interview. This is, however, the highest proportion of IDRS participants who have reported recent methadone injection since the study commenced in Melbourne in 1997 (11%, in 2007, 7% in 2006, 3% in 2005, 5% in 2004, 2% in 2003, 3% in 2002, 6% in 2001). KE generally reported that injection of methadone was either minimal or non-existent amongst clients. One KE (a government representative) noted that rates of methadone injection were “by far the lowest in Victoria”, because in Victoria it is diluted before providing it to clients, and methadone is not diluted in any other Australian state or territory.

Prescribed methadone syrup was reported to have been used by 37% of respondents (n=55) during the previous six months (38% in 2007), and non-prescribed methadone syrup by 19% of respondents (n=28) during that time (19% in 2007). Only one participant (1%) reported using prescribed Physeptone[®] tablets during the last six months, with a slightly larger proportion (4%, n=6) reporting use of non-prescribed Physeptone[®] during that time. Of those who reported using any form of methadone during the past six months (n=78), the majority (71%, n=55) reported mostly using prescribed (licit) methadone syrup, with less than one-quarter (24%, n=19) of these participants reporting that they had mostly used illicit methadone syrup during that time. In accordance with IDU responses, KE generally reported that licit methadone was the predominant form of methadone used by clients in the last six months.

The median number of days use for those who reported using any form of methadone during the past six months (n=78) was 138 days (compared to 146 days in 2007). Frequency of non-prescribed methadone use (n=32) during the past six months was low, with a median of six days reported (approximately once per month), a slight increase from a median of three days reported in 2007. For those who were enrolled in a methadone maintenance program during the last six months (n=56), a median of 176 days use was reported (176 days in 2007).

Only seven respondents (5%) were able to comment on the current price of methadone syrup solution (in millilitres). Three respondents reported a median price of \$28 for 100ml of methadone solution (range=\$20-\$40), one participant reported that 1ml of methadone usually costs \$1, another reported that the price of 50ml of methadone ranges from \$10-\$25, another participant reported that 20ml of methadone normally costs \$80, while the remaining participant reported a price of \$100 for 150ml of methadone. No participants reported purchasing Physeptone[®] during the past six months.

Eight participants commented on changes to the price of illicit methadone during the last six months, with the majority (88%, n=7) reporting that it had remained stable during that time. The remaining participant (13%, n=1) reported that the price of illicit methadone had increased in the last six months.

With regard to methadone availability, of the participants who commented (n=8), the majority reported that it was currently very easy (50%, n=4) or easy (13%, n=1) to source, while the remaining three participants (37%, n=3) reported difficulty accessing methadone. The majority of these participants (88%, n=7) reported that methadone availability had remained stable during the last six months, while the remaining participant (13%) reported that it had become more difficult to source during that time. Participants (n=8) reported most commonly purchasing methadone from social networks, such as friends (63%, n=5) or acquaintances (38%, n=3).

Eleven KE reported any changes to the use of methadone in the last six months, with seven KE reporting increased use during that time. Two KE specified that rates of methadone injection had increased, while one KE reported that use of methadone had generally increased after people had tried Suboxone[®] and decided that they preferred methadone as a form of drug treatment. Another KE noted that a program through a local magistrate's court had been linking people to methadone treatment. In contrast, four KE reported a reduction in rates of methadone use in the last six months, which three KE attributed to an increased uptake of Suboxone[®], and one attributed to an increase in heroin availability (and thus, heroin use).

8.2. Use of illicit buprenorphine

In 2008, most (77%, n=115) of the IDRS respondents reported lifetime use of buprenorphine (Subutex[®]; licit or illicit), and 30% (n=45) reported using this drug recently (in the last six months). As in previous years, respondents were asked about both prescribed and non-prescribed use of buprenorphine. In terms of use during the past six months, 15% (n=23) of the sample reported having used prescribed buprenorphine (compared to 20% in 2007), and 19% (n=29) reported having used non-prescribed buprenorphine during that time (26% in 2007). The main reported reasons for using non-prescribed buprenorphine by those who commented (n=21), were to alleviate withdrawal symptoms (38%, n=8), because they were seeking an opiate effect (19%, n=4), to self-treat dependence (14%, n=3), and because illicit buprenorphine is cheaper than heroin/other opiates (10%, n=2). Frequency of reported buprenorphine use (prescribed or non-prescribed) increased in 2008 (72 days compared to a median of 60 days in 2007).

Of the KE who commented on the predominant form of buprenorphine used by clients in the last six months (n=23), the majority (n=18) reported that use was largely licit. Smaller numbers of KE reported the buprenorphine use was mostly illicit (n=3), or that there were similar levels of licit and illicit use (n=2).

Nearly two-thirds of the 150 IDU respondents (65%, n=98) reported ever swallowing buprenorphine, and 16% (n=24) had done so recently. In comparison, over half (58%, n=87) of the respondents reported ever injecting buprenorphine (51% in 2007, 61% in 2006, 63% in 2005, 56% in 2004, 51% in 2003, and 37% in 2002), and 24% (n=36) reported doing so during the last six months (32% in 2007, 38% in 2006, 39% in 2005, 43% in 2004, 39% in 2003, and 33% in 2002).

For those who reported recent injection of their prescribed buprenorphine (11%, n=17), a median of 150 days (out of 180 days) was reported, a notable increase in comparison to a reported frequency of 30 days in 2007. For those who reported recently injecting non-prescribed buprenorphine (16%, n=24), a median of 24 days use was reported (approximately once per week), again an increase in comparison to the previous year (17 days).

Twelve KE commented on routes of buprenorphine administration, with varied responses. Five KE reported that buprenorphine users predominantly injected the pharmacotherapy, while another five reported that it was usually administered orally. Two KE reported that buprenorphine was similarly injected and orally administered.

With regard to the market characteristics of illicit buprenorphine, eight IDU survey respondents reported a median price of \$10 for 5mg of buprenorphine (range=\$7.50-\$15), six participants reported a median price of \$20 for 8mg (range=\$10-\$20), while only four participants reported a median price of \$7.50 for 2mg of illicit buprenorphine (range=\$5-\$20).

Nineteen participants (13%) commented on the current availability of illicit buprenorphine, with the majority reporting that it was presently easy (42%, n=8) or very easy (32%, n=6) to source. The remaining five participants (26%) reported experiencing difficulty accessing illicit buprenorphine. Nineteen participants also commented on changes to the availability of buprenorphine during the past six months, with the majority (63%, n=12) reporting that it had remained stable during that time. In contrast, close to one-third of these participants (32%, n=6) reported that illicit buprenorphine had become more difficult to source in the last six months, while the remaining participant (5%) reported that it had become easier to obtain during that time. Twenty respondents reported sourcing illicit buprenorphine most commonly from friends (60%, n=12), or acquaintances (25%, n=5).

Five KE reported a reduction in buprenorphine use in the last six months, which three KE attributed to the reduction in buprenorphine prescriptions/dispensers, and corresponding increase in use of Suboxone[®]. Another KE reported that decreased rates of buprenorphine use were a result of increased heroin availability (and a resultant increase in heroin use). One KE noted that buprenorphine was becoming increasingly unpopular because of the damage associated with inappropriate use of buprenorphine (i.e. injection), such as abscesses and endocarditis.

8.3. Use of buprenorphine-naloxone

Until recently (i.e. early-mid 2006), the only buprenorphine preparation available in Australia for the treatment of opioid dependence was Subutex[®], a sublingual tablet containing only buprenorphine (the mono product). A second sublingual preparation, Suboxone[®], containing buprenorphine and naloxone (the combination product) was approved by the Therapeutic Goods Administration (TGA) on 27 July 2005 (Lintzeris et al., 2006), and became available on the Pharmaceutical Benefits Scheme (PBS) on 1 April 2006 (AGDH&A, 2006). This combination product was developed to limit the abuse potential of buprenorphine by reducing the potential for injection, especially by opioid-dependent users who are not in treatment (Lintzeris et al., 2006). The advantage of Suboxone[®] for some consumers is the potential for unsupervised dosing.

Less than half (45%, n=67) of the 2008 IDRS sample reported lifetime use of buprenorphine/naloxone (prescribed or non-prescribed), with over one-third (35%, n=53) reporting use during the past six months. As in 2007, these proportions increased again in 2008 (33% reported lifetime use 25% recent use of Suboxone[®] in 2007); however, such changes could be attributed to an increasing number of IDU continuing to access Suboxone[®] following its implementation as a treatment option in April 2006 (refer to Figure 17). Of the IDU respondents who reported using any Suboxone[®] in the past six months (n=53), the majority (64%, n=34) reported that they mostly obtained it licitly (i.e. with a prescription in their own name).

Twenty-three percent (n=34) of IDRS respondents reported using prescribed Suboxone[®] (13%, n=19) during the past six months, with a slightly smaller proportion (18%, n=27) reporting use of non-prescribed Suboxone[®] during that time. Over one-fifth of participants (22%, n=33) reported lifetime injection of Suboxone[®], with 16% (n=24) doing so in the last six months. Of those participants who used non-prescribed Suboxone[®] during that time (n=27), the main reported reasons for doing so were to alleviate withdrawal symptoms (22%, n=6), and because they were seeking an opiate effect (22%, n=6).

Frequency of Suboxone[®] use increased in 2008, with a median number of 40 days use reported during the last six months (compared to 17 days in 2007). Frequency of Suboxone[®] injection also increased slightly in 2008, with a median of 12 days reported (about twice per month), in comparison to five days in 2007.

Thirty-four KE commented on proportions of Suboxone[®]-using clients, with most (n=31) reporting that only a minority of clients used the pharmacotherapy. In addition, three KE reported that approximately half the number of clients used Suboxone[®]. KE also reported that the predominant form of Suboxone[®] used by clients was licit, with oral ingestion the most common route of Suboxone[®] administration (and minimal to no injection). Eleven KE reported increased use of Suboxone[®] during the last six months, while two reported a reduction in use, which one attributed to increased uptake of methadone, and another KE attributed to increased availability of heroin (and a resultant increase in heroin use).

Only thirteen IDU survey participants (9%) were able to comment on the price of Suboxone[®] in the last six months, therefore any trends should be treated with caution. Three respondents all reported that a 2mg tablet of Suboxone[®] could be purchased for \$5, four respondents reported a median price of \$5 for 4mg of Suboxone[®] (range=\$5-\$10), while five respondents reported a median price of \$10 for an 8mg Suboxone[®] tablet (range=\$5-\$20).

Likewise, only a small number of participants (9%, n=14) were able to comment on the current availability of illicit Suboxone[®], with the majority of these participants (86%, n=12) reporting that it was currently either very easy (50%, n=7) or easy (36%, n=5 to access), with the remaining respondents reporting that Suboxone[®] was currently very difficult (7%, n=1) or difficult (7%, n=1) to source. Thirteen (9%) participants commented on changes to Suboxone[®] availability over the last six months, with over half (54%, n=7) reporting that it had remained stable during that time. In contrast, four of these participants (31%) reported that Suboxone[®] had become easier to access in the last six months, while two of these participants (15%) reported that it had become more difficult to source during that time.

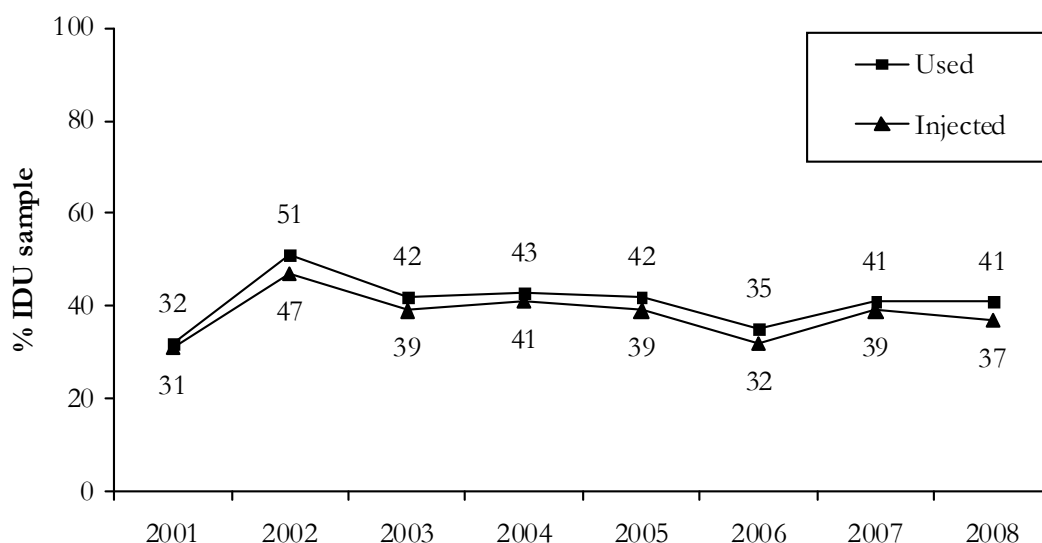
Sixteen participants (11%) commented on who they obtained illicit Suboxone[®] from in the last six months, reporting that it was mostly sourced through friends (50%, n=8), known dealers (19%, n=3) and acquaintances (19%, n=3). Half of these participants (n=8) reported that they mainly purchased illicit Suboxone[®] during the last six months, while the remaining half (n=8) reported that it was usually given to them for free (i.e. a gift) during that time. Most of these participants (75%, n=12) reported that the Suboxone[®] was originally someone else's takeaway dose (44%, n=7), or someone else's daily dose (42%, n=5).

8.4. Morphine

Approximately three-quarters (75%, n=113) of the IDU surveyed reported lifetime use of morphine, and 41% (n=61) reported using it during the past six months. The prevalent route of administration of morphine among the 2008 IDRS sample was injecting, with 72% (n=108) reporting lifetime injection and 37% (n=56) reporting injecting morphine during the past six months. Thirty-nine percent of the sample (n=58) reported ever swallowing morphine, and 9% (n=13) reported doing so in the past six months.

Reported prevalence of use and injection of morphine during the past six months remained stable from 2003-2005. After a slight decrease in 2006, prevalence of use increased back to the approximate 2003-2005 levels and remained stable at approximately 41% in both 2007 and 2008 (see Figure 9). Frequency of morphine use in the last six months has remained low and stable since 2003, with a median of five days just less than once a month reported (five days in 2007, seven days in 2006, five days in 2005, six days in 2004, seven days in 2003). The median frequency of morphine injection in 2008 was also five days (four days in 2007, six days in 2006, five days in 2005 and 2004, six days in 2003).

Figure 9: Proportion of IDU reporting morphine use and injection (past six months), 2001-2008



Source: IDRS IDU interviews

Forty percent (n=60) of the 2008 IDRS sample reported using non-prescribed morphine during the past six months, while only 3% (n=4) reported using prescribed morphine during that time. Of the group who had used any morphine during the past six months (n=61), the majority (93%, n=57) reported mostly using non-prescribed morphine. Twenty-seven of these users commented on reasons for the use of illicit morphine, most commonly reporting that they used the drug to alleviate withdrawal symptoms (41%, n=11), because they were seeking an opiate effect (22%, n=6), because it is cheaper than heroin/other opiates (19%, n=5), or to alleviate pain (15%, n=4). As in previous years,

the types of morphine most commonly used by IDU respondents who reported recent use were MS Contin[®] (66%, n=40), and Kapanol[®] (23%, n=14).

As in 2007, 19% of the IDU sample (n=29) felt confident enough to comment on the price and availability of non-prescribed (illicit) morphine. Given this small number of respondents, any trends should be once again be interpreted with caution.

Prices paid for two brands of morphine – MS Contin[®] and Kapanol[®] – on the last occasion of purchase by Melbourne IDU are presented in Table 13. The median and modal (most frequently reported) price, and the number of respondents who reported purchasing each quantity during the past six months are reported. The most common amount of morphine bought by 2008 IDU participants (n=18) was 100mg of MS Contin[®], with a median price of \$45.

Table 13: Price of most recent morphine purchases by IDU, 2008

Amount	MS Contin [®] median price (\$)	MS Contin [®] modal price (\$)	MS Contin [®] no. of purchasers	Kapanol [®] median price (\$)	Kapanol [®] modal price (\$)	Kapanol [®] no. of purchasers
30mg tablet*	20	10 ^a	3	-	-	-
50mg capsule*	-	-	-	20	20 ^a	5
60mg tablet*	20	20	11	-	-	-
100mg tablet/capsule*	45	50	18	40	40	9

Source: IDRS IDU interviews

* MS Contin[®] comes in the form of 5mg, 10mg, 30mg, 60mg and 100mg tablets, while Kapanol[®] is produced in 20mg, 50mg and 100mg capsules. No IDU reported purchasing the amounts that are not shown here

^a Multiple modes exist. The smallest value is shown

Over half (56%, n=15) of those who could comment on price changes to non-prescribed (illicit) morphine (n=27) reported that it had remained stable during the past six months. In contrast, one-third (33%, n=9) of these respondents reported that the price of illicit morphine had increased in the last six months, while a smaller proportion (11%, n=3) reported that it had decreased during that time. Of those respondents who reported buying morphine in the last six months (n=25), most reported buying from friends (76%, n=19), or acquaintances (40%, n=10).

Of those who commented on current availability of non-prescribed morphine (n=25), the majority reported that it was easy (40%, n=10) or very easy (24%, n=6) to obtain at the time of interview, while over one-third of these respondents (36%, n=9) reported difficulty accessing illicit morphine at present. Nearly two-thirds of these respondents (64%, n=16) reported that availability had remained stable over the past six months, while smaller proportions reported that it had become more difficult (24%, n=6) or easier to source non-prescribed morphine during that time.

Of the 33 KE who commented on current morphine use amongst clients, the majority (n=29) reported that only a minority (n=21), or no clients (n=8), presently engaged in

use of morphine. The remaining KE reported that approximately half (n=2), or most clients (n=2), currently used morphine. In accordance with IDU responses, KE reported that MS Contin[®] was the most popular brand of morphine used by clients, followed by Kapanol[®]. Of those KE who commented on the licit or illicit nature of the morphine clients were using (n=18), the majority (n=10) reported that client use of morphine was mostly illicit. In contrast, four KE reported that clients mostly used licit morphine, while another four KE reported that clients were using comparable proportions of licit and illicit morphine.

Of those KE who were able to comment on the predominant route of morphine administration by clients (n=12), the majority (n=9) reported that morphine was mostly injected. Two KE reported that morphine was equally injected and orally administered, while one KE reported that the predominant route of morphine administration amongst clients was oral ingestion.

Only six KE reported any changes to the use of morphine in the last six months, with three reporting a reduction in use during that time (which one KE attributed to a reduction in morphine availability). In contrast, two KE reported an increase in use of morphine in the last six months, while another KE reported that use had fluctuated during that time in accordance with fluctuating availability.

8.5. Oxycodone

Over half (58%, n=87) of the IDU surveyed reported lifetime use of oxycodone, with just over one-quarter (27%, n=40) reporting oxycodone use during the past six months (compared to 29% in 2007, 27% in 2006 and 17% in 2005). Twenty-four percent (n=36) of the 2008 sample reported injecting oxycodone during the past six months (compared to 28% in 2007, 25% in 2006 and 15% in 2005) and 7% (n=10) reported swallowing the drug during that time. Frequency of oxycodone use (prescribed or non-prescribed) during the past six months was low, with a median of five days (range=1-180) reported, remaining relatively stable in comparison to the previous year (four days). The median frequency of oxycodone injection in 2008 was five days (range=1-134), following on from a median of five days in 2007, and four days in both 2005 and 2006.

As in previous years, the form of oxycodone most commonly used by this group during the past six months was non-prescribed (illicit) oxycodone (90%, n=36), with the remaining 10% (n=4) reporting that they most often obtained oxycodone via a prescription in their own name (Quinn, 2008; Jenkinson & Quinn, 2007). Those who commented on reasons for recent use of non-prescribed oxycodone (n=10) mainly reported using it to alleviate withdrawal symptoms (40%, n=4), or because they were seeking an opiate effect (40%, n=4). The main brand of oxycodone reportedly used during the last six months was OxyContin[®] (88%, n=35).

Only 9% of the 2008 IDU sample (n=14) felt confident enough to comment on the market characteristics of non-prescribed (illicit) oxycodone. Once again, given this small number of respondents, any trends should be interpreted with caution.

Ten of these participants reported last purchasing an 80mg OxyContin[®] tablet in the six months preceding interview for a median price of \$30 (range=\$20-\$40), while four participants all reported last purchasing a 40mg OxyContin[®] tablet for \$20. Of the 13 respondents able to comment on changes to the price of oxycodone during the last six months, the majority (77%, n=10) reported that it had remained stable during that time. The remaining three respondents (23%) reported that the price of oxycodone had increased in the last six months.

With regard to oxycodone availability, of the 14 participants who commented, the majority reported that it was either very easy (43%, n=6) or easy (29%, n=4) to access at the time of interview, while the remaining participants (29%, n=4) reported that it was currently difficult to source. Most of these participants (71%, n=10) believed that oxycodone had remained stable over the last six months, with smaller proportions reporting that it had become easier (21%, n=3), or more difficult (7%, n=1) to source during that time. Those who purchased oxycodone in the last six months (n=13) reported usually buying from friends (62%, n=8), known dealers (54%, n=7), or acquaintances (38%, n=5).

8.6. Other opioids

Thirty-one percent (n=46) of the IDU sample reported ever using other opiates (not elsewhere classified, e.g. codeine), with a smaller proportion (5%, n=7) reporting lifetime injection of such substances.

Nineteen percent (n=28) of the IDU interviewed reported using other opiates during the previous six months (21% in 2007, 8% in 2006, 12% in 2005, 27% in 2004), and the majority of these respondents (71%, n=20) reported mostly obtaining other opiates licitly during that time. The primary route of administration of other opiates by this group (n=28) was swallowing (93%, n=26), with two respondents (7%) reporting that they had injected them during the last six months. No participants reported ever smoking or snorting other opiates.

As in 2007, the main type of other opioid used by these respondents was Panadeine Forte[®] (54%, n=15). The overall frequency of use during the last six months was low, with a median of 11 days reported (nine days in 2007).

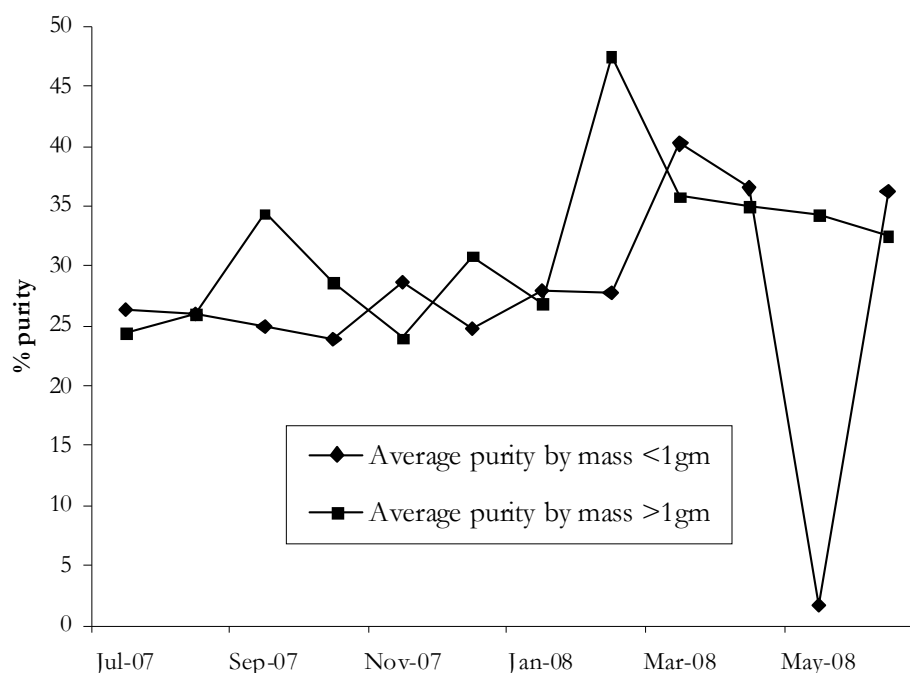
9.0 OTHER DRUGS

9.1 Ecstasy

Nearly three-quarters (73%, n=109) of survey participants reported having used ecstasy (3,4-methylenedioxymethamphetamine or MDMA) at least once in their lifetime, with less than one-quarter (23%, n=34) reporting use within the last six months (compared to 26% in 2007, 24% in 2006, 30% in 2005, 23% in 2004, 25% in 2003, 31% in 2002, and 39% in 2001). Twenty-six percent (n=39) of IDU interviewed reported that they had injected ecstasy before (33% in 2007, 37% in 2006 and 2005, 33% in 2004, 44% in 2003, 36% in 2002, 31% in 2001, and 15% in 2000), with 8% (n=12) having done so within the six months prior to interview (12% in 2007, 10% in 2006, 12% in 2005, 8% in 2004, 12% in 2003, 14% in 2002, 21% in 2001, and 8% in 2000). Frequency of ecstasy injection was low, with those participants reporting such recent use (n=12), doing so on a median of two days. The primary route of administration of ecstasy for this group (n=34) during the last six months was oral (91%, n=30), and the median number of days of ecstasy use during that time was three days (compared to 1 in 2007).

The average purity level of MDMA seizures analysed by law enforcement agencies in Victoria during the 2007/2008 financial year was 29% (range=2% to 48%) (see Figure 10). The average purity of smaller ecstasy seizures remained relatively stable (23%-29%) from July 2007 to February 2008, before a spike in March 2008 (40%), followed by a sharp decrease to 2% in May. The purity of larger ecstasy seizures fluctuated during the year, with a peak of 48% in February 2008. Overall, average purity of ecstasy was similar to that recorded in the previous nine financial years: 28% in 2006/2007, 33% in 2005/2006, 30% in 2004/2005, 32% in 2003/2004, 30% in 2002/2003, 31% in 2001/2002, 31% in 2000/2001, 34% in 1999/2000, and 28% in 1998/1999.

Figure 10: Purity of ecstasy (MDMA) seizures by Victorian law enforcement, July 2007 to June 2008



Source: Victoria Police Forensic Services Department

Thirty-four KE commented on levels of ecstasy use among the clients they had contact with/knowledge of, with the majority reporting that only a minority (n=21), or no clients (n=10) currently engaged in use of ecstasy. In contrast, smaller numbers of KE reported that approximately half (n=1), most (n=1), or all clients (n=1) used ecstasy. KE generally reported ecstasy use to be sporadic, opportunistic and social, often in nightclub environments. As in the previous year, KE noted that ecstasy use was more prevalent amongst younger clients. One ambulance paramedic KE noted that ecstasy was the most commonly reported psychostimulant in drug-related attendances, though use of ecstasy was uncommon among IDU in particular.

As in 2007, KE generally reported no changes to ecstasy use in the last six to 12 months; however, three KE reported increased levels of use (one law enforcement KE noted that users in Melbourne’s eastern suburbs were moving away from methamphetamine to ecstasy), while one KE reported a reduction in ecstasy use during that time.

All nine KE who commented on the predominant route of ecstasy administration reported that users primarily consumed the drug orally. KE also noted that ecstasy was usually obtained and consumed by users in pill form (as opposed to MDMA powder, for example). Accordingly, one law enforcement KE reported that the ecstasy seized by police during 2007/2008 was predominantly in pill form, with a minimal amount of “colourless capsules” seized that contained MDMA powder. This KE noted that the purity of ecstasy seizures (i.e. MDMA content) had generally increased in comparison to the previous year.

While the IDU surveyed in the 2008 IDRS study were able to provide some information on ecstasy trends in Melbourne, a clearer picture of ecstasy use can be gained through contact with other sentinel groups, such as psychostimulant or REU. For the past six

years the EDRS, which employs a similar methodology to the IDRS study, has been conducted in every Australian jurisdiction. One component of this study involves the collection of information from REU, on patterns of use, price and availability of ecstasy, as well as on the use of methamphetamine, cocaine, gamma-hydroxy-butyrate (GHB), *d*-lysergic acid (LSD), and ketamine. Results from the 2008 EDRS study will be available in early 2009 (Kong, 2009).

9.2. Hallucinogens

Over two-thirds of the 2008 IDU sample (70%, n=105) reported lifetime use of hallucinogens, and 9% (n=13) had ever injected any type of hallucinogen. Only small numbers of respondents reported having used hallucinogenic mushrooms (5%, n=7) or LSD/‘trips’ (5%, n=7) during the previous six months.

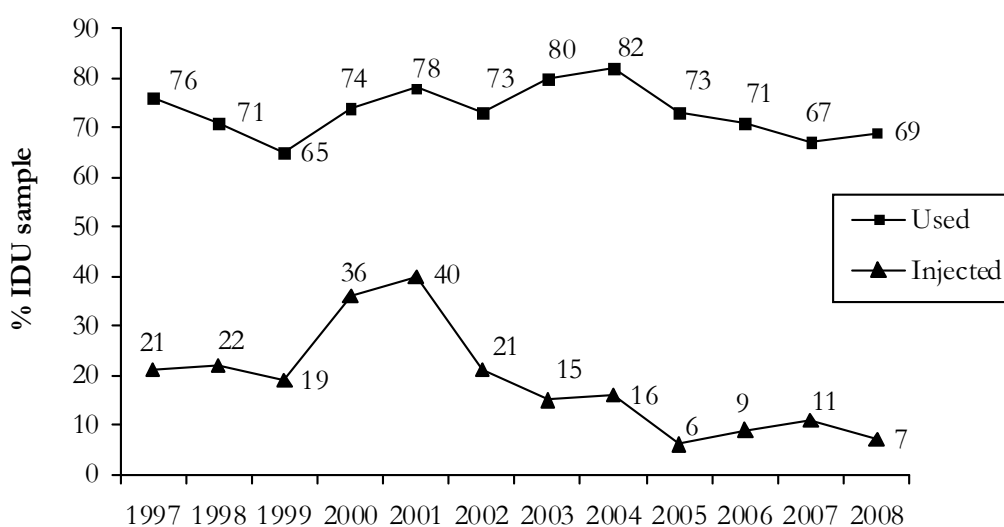
Of those participants who reported recent hallucinogen use (n=10), all reported that swallowing was the main route of hallucinogen administration in the last six months. No participants reported injecting hallucinogens during that time. Reported frequency of hallucinogen use was low, with a median of four days reported during the last six months (compared to two days in 2007).

AGAIN reflecting the low levels of use reported by IDU survey respondents, only a small number of KE (n=10) reported any contact with/knowledge of hallucinogen users in the last six months. All these KE reported that only a minority of clients had engaged in use of either mushrooms or LSD. No KE reported any changes to the use of hallucinogens in the last six months.

9.3. Benzodiazepines

Over two-thirds of the 2008 IDU participants (69%, n=104) reported using benzodiazepines (BZD) during the past six months, with 7% (n=11) reporting intravenous use (see Figure 11), and 68% (n=102) reporting oral administration of benzodiazepines during this period. Prevalence of BZD use remained relatively stable in 2008 (69%, compared to 67% in 2007, 71% in 2006, 73% in 2005, and 82% in 2004); however, reported frequency of use decreased markedly (a median of 48 days in 2008, compared to 90 days in 2007, 50 days in 2006, 24 days in 2005, and 30 days in 2004).

Figure 11: Proportion of IDU reporting benzodiazepine use and injection (past six months), 1997-2008



Source: IDRS IDU interviews

The proportion of IDU who reported BZD injection steadily rose from 1999 to 2001; however, since that time there has been a considerable reduction in the number of respondents reporting BZD injection. The reduction of this mode of administration in 2002 was probably reflective of changes made on 1 May 2002 to the prescribing authority for temazepam on the PBS (Breen et al., 2003), and also the impact of the Victorian Department of Human Services, Temazepam Injection Prevention Initiative, which was implemented in November 2001 (Dobbin, 2002). More recently (in March 2004) all gel-cap temazepam formulations were withdrawn from the market (Wilce, 2004).

In 2008, reported rates of recent BZD injection remained relatively stable (7%, $n=11$, compared to 11% in 2007), as did frequency of BZD injection in comparison to the previous year (a median of 11 days reported, compared to 10 days in 2007).

Less than half (45%, $n=68$) of the 2008 IDU sample reported using prescribed BZD during the past six months, while just over half 51% ($n=76$) reported using non-prescribed (illicitly obtained) BZD during that time. Of those participants who reported using BZD during the past six months ($n=104$), 65% ($n=68$) reported mostly obtaining them via a prescription in their own name.

Of those able to comment on the types of BZD used in the last six months ($n=96$), the most common types used were diazepam, e.g. Valium[®] (65%, $n=62$), alprazolam, e.g. Xanax[®] (23%, $n=22$), and temazepam, e.g. Temaze[®] (7%, $n=7$).

Most KE ($n=34$) were able to comment on proportions of clients using BZD in the last six to 12 months. Of these, the majority reported that most ($n=20$) to all ($n=2$) clients currently engaged in BZD use. Smaller numbers of KE reported that only a minority ($n=6$), or approximately half the number of clients ($n=6$), currently engaged in BZD use.

With regard to the predominant nature of BZD used by clients (i.e. licit or illicit), of those KE who commented ($n=32$), the majority ($n=19$) reported that users consumed comparable proportions of licit and illicit BZD. Smaller numbers of KE reported that

BZD use was predominantly licit (n=7), or illicit (n=6). KE noted that clients continue to 'doctor-shop' for BZD.

As in previous years and similar to the responses of IDU survey participants, the most common forms of BZD reportedly used by clients were Xanax[®]/alprazolam (n=23) and Valium[®]/diazepam (n=18), followed by temazepam (n=5), Serepax[®]/oxazepam (n=2), and Rivotril[®]/clonazepam (n=2). One KE (a government representative) noted that "almost all" deaths resulting from a mixture of morphine and/or heroin with BZD involved diazepam.

KE generally reported that BZD were mainly consumed orally by users, with a minimal amount of BZD injection, although two KE did report that the predominant route of BZD administration among clients was injecting. One KE reported an increase in the number of clients injecting BZD in the last six to 12 months.

Only eight KE reported changes to BZD use in the last six months. Of these, six KE reported increased use. Two of these KE specified an increase in Xanax[®] use in particular, while a third KE reported that BZD use had generally increased due to a reduction in heroin purity. In contrast, one KE reported that BZD use had recently decreased.

As in previous years, the KE reported that BZD were commonly used as secondary substances to other drugs, including heroin (e.g. to 'top up' heroin use), methamphetamine and other psychostimulants (often as a means of combating the resultant comedown effects), cannabis, morphine and alcohol.

9.4. Inhalants

Twenty-three percent (n=34) of IDU respondents reported having ever used inhalants; however, only a very small number (3%, n=5) had used inhalants during the six months prior to interview (5% in 2007, 4% in 2006, 2% in 2005, 3% in both 2004 and 2003, 8% in both 2002 and 2001). Nitrous oxide and 'spray paint' were the types of inhalants most commonly used by this group during the previous six months.

Reflecting the low rates of inhalant use reported by survey respondents, only 17 KE reported any contact with inhalant users in the last six to 12 months, with all seventeen reporting that inhalants were only used by a minority of clients. As in 2007, inhalant use was perceived to be uncommon among IDU, and more common among younger individuals. One KE (a GP) noted that harms often resulting from inhalant use included brain damage and visual damage (e.g. from staring at the sun while intoxicated). Only four KE reported any changes to inhalant use in the last six months, with three reporting a reduction in use of inhalants during that time. In contrast, one KE reported an increase in inhalant use in the last six months. KE generally reported that spray paint was the most common form of inhalant used by the clients with whom they had contact.

9.5. Alcohol and tobacco

While the majority of the 2008 IDU survey respondents reported ever using alcohol (95%, n=142), less than two-thirds (61%, n=91) of respondents reported alcohol use during the previous six months (compared to 65% in 2007). The median number of days of alcohol use for this group was 24 days (or approximately once a week), although 14% (n=13) of these respondents reported drinking alcohol on a daily basis. Only a minority of respondents (10%, n=15) reported ever injecting alcohol, with two respondents (1%) reporting that they had injected alcohol in the last six months.

Of those KE who commented on prevalence of alcohol use (n=35), the majority (n=21) reported that most (n=17) to all (n=4) clients currently engaged in any use of alcohol. In contrast, 11 KE reported that only a minority of clients used alcohol, while three KE reported that approximately half the number of clients engaged in alcohol use. One KE noted that many cannabis users commenced or increased use of alcohol when trying to give-up cannabis; similarly, another KE reported that some clients substituted heroin with alcohol when attempting to cease or reduce heroin use. A KE working in a hospital emergency department reported that 80% of drug-related presentations were a result of alcohol, with intoxicated users presenting as disorderly, very abusive, drowsy and/or confused. This KE noted that these multiple symptoms made it difficult to determine if alcohol users had ingested any additional substances. In addition, an ambulance paramedic KE reported that alcohol was the most common drug of concern in drug-related presentations.

Only seven KE reported any changes to alcohol use in the last six months, with all but one reporting increased use during that time. One of these KE reported an increase in both quantity and frequency of alcohol use, particularly by young women.

As in previous years, KE again noted that alcohol was a common component of polydrug use, often used in addition to such substances as methamphetamine, cannabis, cocaine, ecstasy, pharmacotherapies (one KE reported that clients used alcohol to 'top up' the effects of methadone), and heroin.

Almost the entire IDU sample reported ever using tobacco (97%, n=146), with the majority also reporting use during the previous six months (95%, n=142). Of these respondents, 96% (n=136) reported daily use (180 days) during that time.

Of the 33 KE who commented on the prevalence of tobacco use among clients, the majority reported that all (n=16) or most (n=14) of the clients they had contact with smoked tobacco. The remaining three KE reported that only half (n=2) or a few (n=1) clients engaged in tobacco use. No KE reported and changes to tobacco use in the last six months.

9.6. Unisom®

In 2008, five IDU participants reported that they had used Unisom Sleepgels® – an antihistamine gel-cap used particularly for short-term treatment of insomnia (<http://mims.hcn.net.au>, accessed 10 February 2009) – on the day prior to interview (one noted that they used it in combination with heroin). In addition, this year a number of KE (n=8) reported that the Unisom® was increasingly being used by Melbourne IDU. These KE noted that while only a minority of IDU presently engaged in use of Unisom®, it was increasingly used particularly as a component of polysubstance use involving heroin (e.g. to 'top up' the effects of heroin). KE noted that Unisom® was usually injected by users, and that it was particularly common amongst Vietnamese IDU. These KE reported that the use of Unisom® (particularly when injected) often resulted in a number of harms, including septic joints, endocarditis, cellulitis, deep vein thrombosis, abscesses and infection.

As a consequence of increasing Unisom® use, its associated health harms, and an emerging Unisom® 'black market', KE reported that many pharmacists in a number of Melbourne suburbs had ceased stocking that pharmaceutical. Recent media also highlighted the issue of inappropriate Unisom® use by IDU in Victoria and South Australia, and the resultant impact on local pharmacists (Charrison, 2009).

The use of Unisom[®] by Melbourne IDU will continue to be monitored by the Victorian IDRS.

9.7. Summary of other drug trends

Reports from the Victorian IDU and KE in 2008 suggest:

- High levels of lifetime ecstasy use; however, low levels of recent ecstasy use among IDU. Ecstasy is mainly administered orally, with lower rates of injecting;
- Low levels of recent hallucinogen use among IDU;
- Moderate to high levels of lifetime and recent use of BZD, with participants mostly obtaining BZD via a prescription in their own name;
- Low levels of recent BZD injection;
- Low levels of inhalant use among the 2008 IDU sample;
- High levels of lifetime alcohol use, though moderate levels of recent use, with a minority of participants reporting daily alcohol use in the last six months; and
- Very high lifetime and recent use of tobacco.

10.0 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

10.1. Overdose and drug-related fatalities

10.1.1. Heroin

Self-reported overdose

Self-reported heroin overdose data for the years 1997-2008 are summarised in Table 14. Over half (59%, n=88) of the 2008 respondents reported that they had ever experienced one or more heroin overdoses, and 81% (n=122) had witnessed another person's overdose. The respondents who had previously experienced an overdose reported a median of 36 months (or three years) since they last overdosed, and a median of three overdoses in total. Of the respondents to the 2008 survey, 13% (n=19) reported having experienced at least one overdose within the previous six months, and 8% (n=12) had received naloxone (a fast-acting opioid antagonist given to reverse the effects of heroin in the case of an overdose) during that time. Four percent of respondents (n=6) reported overdosing on heroin at least once in the last month.

Table 14: Reported experience of heroin overdose for IDU survey respondents, 1997-2008

Heroin overdose ^a	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Lifetime overdose	138 (56%)	148 (52%)	83 (54%)	83 (55%)	88 (58%)	96 (62%)	90 (59%)	89 (59%)	89 (59%)	96 (64%)	74 (49%)	88 (59%)
Lifetime receipt of naloxone ^b	51 (37%)	99 (35%)	52 (34%)	64 (42%)	68 (45%)	80 (51%)	75 (49%)	75 (50%)	62 (41%)	75 (50%)	- -	- -
Overdose last 6 mths	42 (17%)	54 (19%)	37 (24%)	40 (27%)	20 (13%)	17 (11%)	12 (8%)	15 (10%)	16 (11%)	3 (2%)	11 (7%)	19 (13%)
Received naloxone last 6 mths	25 (10%)	37 (13%)	25 (16%)	29 (20%)	19 (13%)	14 (9%)	8 (5%)	10 (7%)	10 (7%)	2 (1%)	6 (4%)	12 (8%)
Witnessed overdose	194 (76%)	229 (78%)	111 (72%)	128 (85%)	116 (77%)	131 (85%)	126 (83%)	116 (77%)	128 (85%)	113 (75%)	107 (71%)	122 (81%)

Source: IDRS IDU interviews

^a Proportion of all respondents in 1997 (N=254), 1998 (N=293), 1999 (N=154), 2000 (N=152), 2001 (N=151), 2002 (N=156), 2003 (N=152), 2004 (N=150), 2005 (N=150), 2006 (N=150), 2007 (N=150), 2008 (N=150)

^b Question not asked in 2007 or 2008

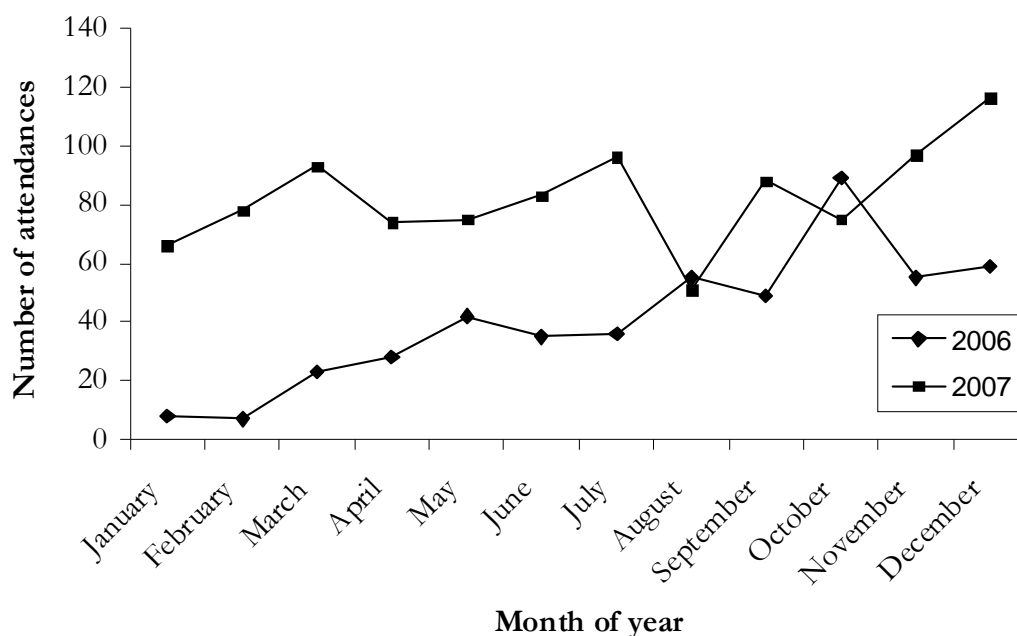
Table 14 shows that, in 2008, reported lifetime experience of heroin overdose by IDU respondents increased in comparison to the previous year, when it reached its lowest level (49%) since the IDRS commenced in Melbourne in 1997. Reported recent experience of overdose (within last six months) also increased in 2008, as did receipt of naloxone. Reports of having ever witnessed another person's overdose also increased in 2008 to 81% (in comparison to 71% in 2007).

Non-fatal heroin overdose attended by ambulance

A database of Melbourne Metropolitan Ambulance Service (MAS) attendances at drug-related overdose episodes is maintained by Turning Point Alcohol & Drug Centre and contains reliable data from June 1998 onwards. Figure 12 shows the monthly totals of non-fatal heroin overdose for the periods of January 2006 to December 2007.

During 2007, there were 992 non-fatal heroin overdoses attended by the MAS, more than double the previous year's total (486). The number of non-fatal heroin overdoses attended each month tended to fluctuate somewhat during 2007, though there was a general increase throughout the year, from 66 recorded in January to 116 recorded in December. The average estimated age of cases in both years was similar, with an average of 32.3 years in 2006, and 32.5 years in 2007 (analysis by S. Cvetkovski, Turning Point Alcohol & Drug Centre).

Figure 12: Monthly totals of non-fatal heroin overdose in Melbourne, January 2006 to December 2007



Source: MAS and Turning Point Alcohol & Drug Centre

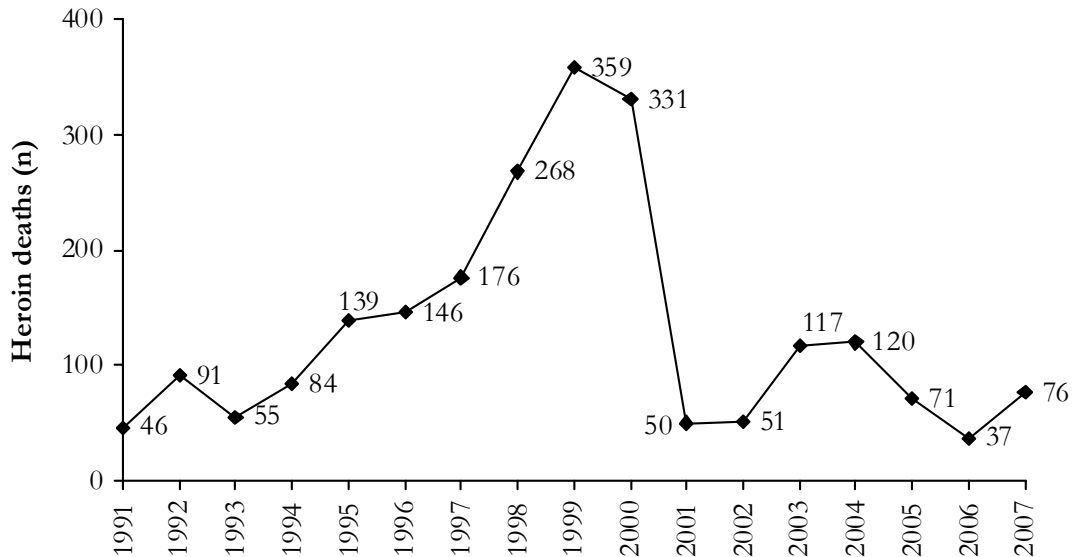
Monthly numbers of non-fatal heroin overdoses attended by ambulances in Melbourne continue to remain significantly lower than the peak of 461 recorded in December 1999 (Jenkinson et al., 2004).

Heroin-related deaths

The data for trends in heroin-related mortality in Victoria are summarised in Figure 13. This figure, based on Victorian Institute of Forensic Medicine data (Woods et al., in press), shows an increasing trend in the number of heroin-related deaths in Victoria throughout the 1990s, before a dramatic decline in numbers between 2000 (n=331) and 2001 (n=50). The sharp decline in fatalities from 2000 to 2001 is consistent with the timing of what is known as a severe period of reduction in Melbourne's heroin supply (Miller et al., 2001). During 2001-2004 the number of heroin-related deaths in Victoria again increased (to figures similar to those seen in the early-mid 1990s). In 2005,

however, the number of deaths decreased (to n=71), with the declining rate continuing in 2006 (to n=37), remaining much lower than the peak of 359 reported in 1999. In 2007, however, the rate once again increased to 76.

Figure 13: Heroin-related deaths in Victoria, 1991-2007



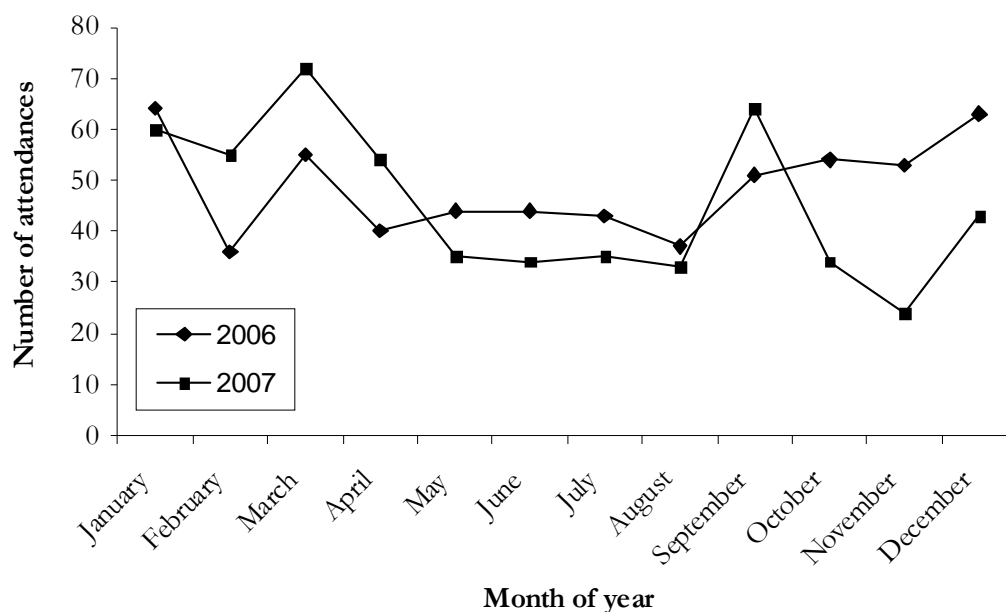
Source: Victorian Institute of Forensic Medicine (Woods et al., in press)

10.1.2. Methamphetamine

Amphetamine-related events attended by ambulance

The database maintained by Turning Point also records other drugs (in addition to heroin) that are mentioned in a patient care record (PCR). However, in contrast to heroin overdose, where there are definitive clinical symptoms of overdose (such as pinpoint pupils and a positive response to naloxone), these cases only report when the drug names are recorded by the ambulance officers on the PCR. Therefore, the figures reported here and in the following sections (cocaine and ecstasy) should only be interpreted as indicators and would significantly under-report the actual number of people seen by ambulance officers who had used these drugs.

Figure 14: Monthly totals of ambulance attendance where amphetamines were mentioned in Melbourne, January 2006 to December 2007



Source: MAS and Turning Point Alcohol & Drug Centre

Figure 14 reports the monthly totals of ambulance attendances where amphetamine use was mentioned in Melbourne, January 2006 to December 2007. During 2007, ambulance attendances where amphetamine use was recorded tended to fluctuate, ranging between 24 and 72 per month during this time. The total number of ambulance attendances where amphetamine use was mentioned decreased slightly in 2007 to 543, down from 584 in 2006. The approximate average estimated age of cases for both 2006 and 2007 was 28 (analysis by S. Cvetkovski, Turning Point Alcohol & Drug Centre).

10.1.3. Cocaine

Cocaine-related events attended by ambulance

In 2007 there was a total of 60 ambulance attendances in Melbourne where cocaine use was mentioned, remaining relatively stable in comparison to the previous year (there were 61 in total in 2006, 48 in 2005, 26 in 2004 and 23 in 2003). The estimated average age of cases in 2006 was 30 years (which was similar to the 29 years reported in 2006, 28 years in 2005, 30 years in 2004 and 29 years in 2003) (analysis by S. Cvetkovski, Turning Point Alcohol & Drug Centre). As noted in previous years (Quinn, 2008; Jenkinson & Quinn, 2007; Jenkinson & O’Keeffe, 2005; Jenkinson & O’Keeffe, 2006; Jenkinson et al., 2004), these numbers are still too small to provide clear trends, but generally indicate that people who use cocaine in Melbourne are not coming into contact with ambulance services often.

10.1.4. Other drugs

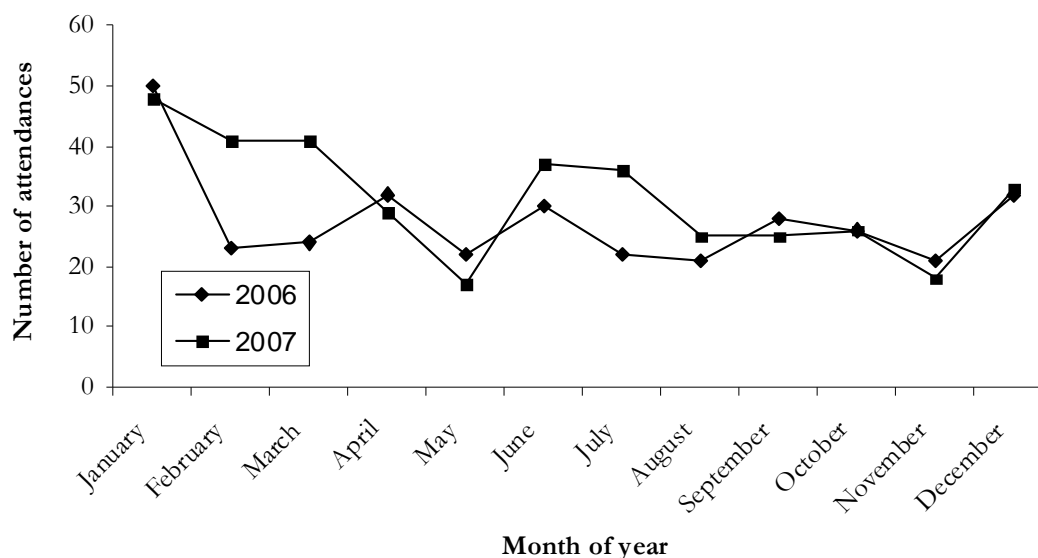
Ecstasy-related events attended by ambulance

Figure 15 reports the monthly totals of ambulance attendances where ecstasy use was mentioned in Melbourne, January 2006 to December 2007. Ambulance attendances

where ecstasy use was recorded ranged between 17-50 per month during 2006-2007, peaking in January each year.

In 2007, there were a total of 376 attendances where ecstasy use was mentioned, an increase in comparison to the previous year (N=331). The average estimated age of cases in 2007 was 23 years, which is comparable to previous years (24 years in 2006, 23 years in 2005, 24 years in 2004, and 25 years in 2003) (analysis by S. Cvetkovski, Turning Point Alcohol & Drug Centre).

Figure 15: Monthly totals of ambulance attendance where ecstasy was mentioned in Melbourne, January 2006 to December 2007



Source: MAS and Turning Point Alcohol & Drug Centre

10.2. Drug treatment

10.2.1. Heroin

Alcohol and Drug Information System (ADIS)

Data on people seeking treatment from specialist alcohol and drug agencies⁸ in Victoria is collected via ADIS. During 2006/2007, 50,826 courses of treatment were delivered to 27,202 clients⁹ in Victorian specialist alcohol and drug services. Of these, approximately 14% of the courses of treatment delivered to 13% of clients were for heroin-related problems, making heroin the most frequently occurring drug of concern after alcohol (43% of courses of treatment delivered to 41% of clients) and cannabis (23% of courses of treatment delivered to 23% of clients). Approximately 8% of the total courses of treatment were delivered to 10% of clients for amphetamine and other stimulant-related¹⁰ problems (Source: ADIS Database, Victorian Department of Human Services, unpublished data).

⁸ Federal and state government funded.

⁹ Clients in specialist alcohol and drug services include both drug users and non-users. Non-users may include partner, family or friends.

¹⁰ Other stimulants include substances such as ecstasy and cocaine.

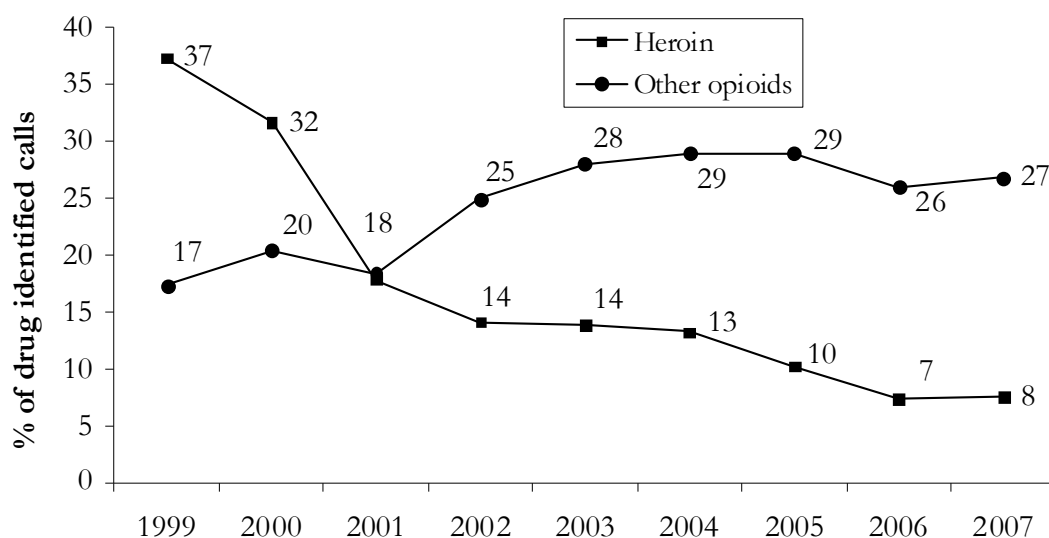
DirectLine calls

DirectLine is a 24-hour specialist telephone service in Victoria (operated by Turning Point Alcohol & Drug Centre) that provides counselling, referral and advice about drug use and related issues. All calls to DirectLine are logged to an electronic database that can provide information about callers' drugs of concern, calls from drug users, and calls about drug users. Call numbers provide an indication of the level of concern about particular drug types.

During 2007, DirectLine responded to 2,240 calls where heroin was identified as a drug of concern. This represents approximately 8% of all drug-identified calls to DirectLine in that year (Turning Point Alcohol & Drug Centre Inc, unpublished data). The proportion of drug-related calls where heroin was identified steadily decreased from 1999-2002, and has remained decreasing to stable since (see Figure 16).

An additional 7,938 calls were made in 2007 where other opioids were identified as a drug of concern. This represents approximately 27% of all drug-identified calls in that year (Turning Point Alcohol & Drug Centre Inc, unpublished data). The proportion of drug-identified calls regarding other opioids¹¹ remained relatively stable in comparison to previous years (26% in 2006, 29% in 2004 and 2005, and 28% in 2003), as demonstrated in Figure 16.

Figure 16: DirectLine calls where drug of concern identified as heroin or other opioids*, 1999-2007



Source: DirectLine, Turning Point Alcohol & Drug Centre Inc (unpublished data).

* Other opioids include methadone, buprenorphine, buprenorphine-naloxone, morphine and codeine. Analgesics (not further defined), and paracetamol were also included in this category. It is important to note that methadone- and buprenorphine-related calls may be regarding licit use and not necessarily illicit use

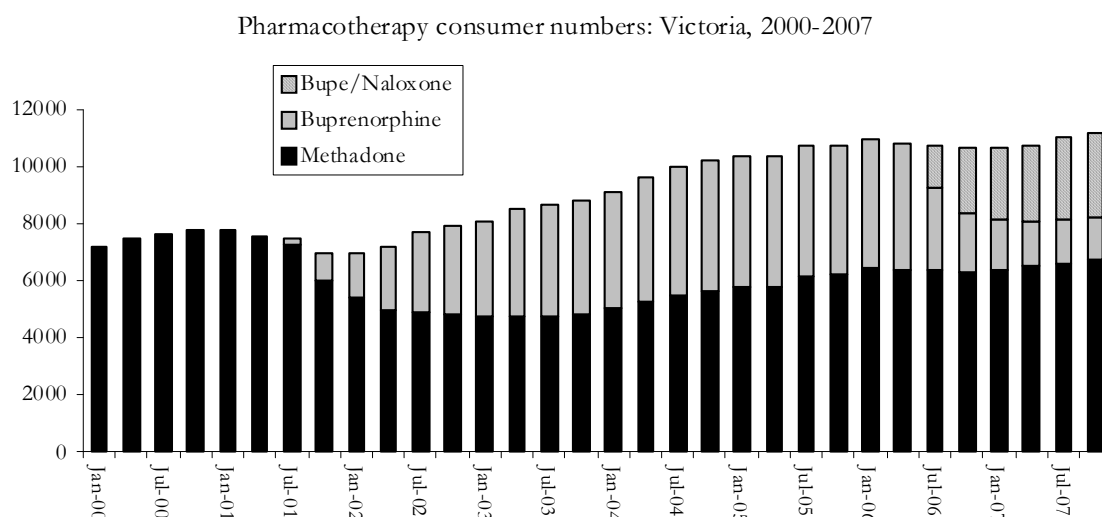
¹¹ Other opioids include: licit and illicit methadone, buprenorphine, buprenorphine-naloxone, morphine and codeine. Analgesics (not further defined) were also included in this category, as was paracetamol. Therefore, this grouping is not strictly 'other opioids'.

Pharmacotherapy consumers

Data from the Victorian Department of Human Services Drugs and Poisons Regulation Group records of methadone, buprenorphine and buprenorphine/naloxone consumers (in Victoria) are shown in Figure 17. The Drugs and Poisons Regulation Group conducts a routine phone census of all pharmacies to monitor consumer numbers.

This demonstrates a relatively steady decrease in the number of consumers registered on the methadone maintenance program from April 2001 (n= 7,571) to January 2003 (n=4,745), and a concomitant increase in the number of consumers registered on buprenorphine (Subutex®) during that time. In 2003, the number of consumers registered on methadone maintenance stabilised at approximately 4,800 before increasing again during 2004-2006 and remaining relatively stable since then. Approximately 4,500 consumers were registered on buprenorphine (Subutex®) between April 2004 and April 2006; however, since that time there has been a dramatic reduction in the number of consumers registered on this drug. This decrease in the number of buprenorphine consumers coincides with the introduction of a second buprenorphine preparation in Australia, the buprenorphine/naloxone combination drug (Suboxone®). Suboxone® was approved by the TGA on 27 July 2005 (Lintzeris et al., 2006), and became available on the PBS on 1 April 2006 (AGDH&A, 2006). Since that time, a large proportion of buprenorphine consumers have been transferred to buprenorphine/naloxone, and an increase in the number of prescribed Suboxone® users continued throughout 2007 and 2008 (with a concurrent decrease in the number of buprenorphine prescriptions in Victoria). In October 2008, there were 7,232 consumers registered on methadone, 1,125 consumers registered on the combination buprenorphine/naloxone product (Suboxone®), and 3,442 consumers registered on buprenorphine (Subutex®) in Victoria.

Figure 17: Census estimate of the number of Victorian pharmacotherapy consumers, January 2000 to October 2008



Source: Drugs and Poisons Regulation Group, Victorian Department of Human Services

Of the 92 IDU participants who were currently in treatment, over half (54%, n=50) reported that the main type of drug treatment they were in was methadone maintenance.

The other main treatment types were buprenorphine/naloxone (Suboxone[®]) maintenance (24%, n=22), and buprenorphine (Subutex[®]) maintenance (14%, n=13).

KE reported that heroin-using clients were currently involved in a range of drug treatments. As in previous years, primary treatments were reported to be pharmacotherapies (primarily methadone and Suboxone[®]), counselling, and detox (home and residential), followed by rehabilitation programs, naltrexone treatment, the ‘four C’s’ (counselling, consulting, continuing care), Narcotics Anonymous support, and treatment with other pharmaceuticals/prescription drugs (e.g. benzodiazepines, antidepressants). In accordance with IDU participant reports and the numbers recorded in Figure 17, KE generally reported that most individuals involved in pharmacotherapy treatment were on methadone, followed by Suboxone[®], then buprenorphine. As in previous years, KE noted that many individuals were often deterred by long waiting lists for drug treatment services such as detox, withdrawal and rehabilitation, and therefore either failed to seek out treatment, or gave-up soon after initially being denied treatment.

Reflecting a continuing trend first identified in 2006 (recorded in Figure 17), KE generally reported that more users were taking up Suboxone[®], with a concurrent decrease in the number of buprenorphine prescribers and dispensers. Other recent changes to treatment-seeking behaviours that were identified by KE included: reports that some users had tried Suboxone[®], not liked this form of drug treatment and reverted back to methadone (it “reacted badly with their bodies”, methadone takeaways are “more available”); an increased number of ambulance attendances resulting from an increase in non-fatal heroin overdoses; more people seeking treatment for opiate dependence due to increased police activity in the area (“it is too dangerous to deal, therefore users often go on pharmacotherapies”); and conversely, a reduction in street-based client contact due to increased police activity in the area.

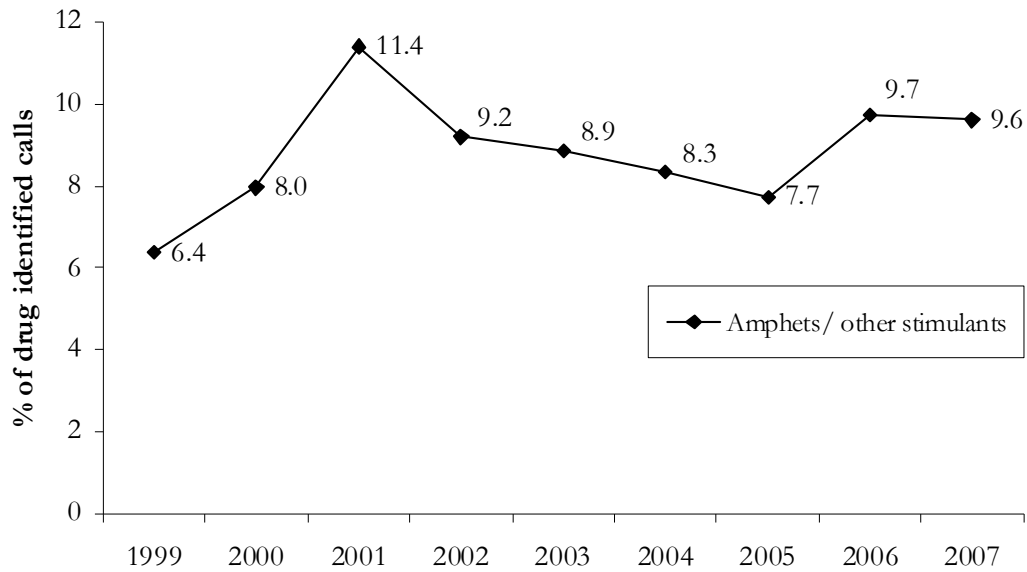
10.2.2. Methamphetamine

DirectLine calls

During 2007, DirectLine responded to 2,846 calls where amphetamines and/or other stimulants¹² were identified as a drug of concern. This represents approximately 10% of all drug-identified calls to DirectLine in that year (Turning Point Alcohol & Drug Centre Inc, unpublished data). This proportion remained relatively stable in comparison to the previous year, following a gradual decline in the proportion of drug-related calls where amphetamines and/or other stimulants were identified since a peak of 11.4% in 2001, and then an increase in 2006 (see Figure 18).

12 Amphetamines and/or other stimulants include: amphetamines, ecstasy, cocaine, other stimulants, and instances where callers simply reported use of ‘party drugs’.

Figure 18: DirectLine calls where drug of concern identified as amphetamines and/or other stimulants, 1999-2007



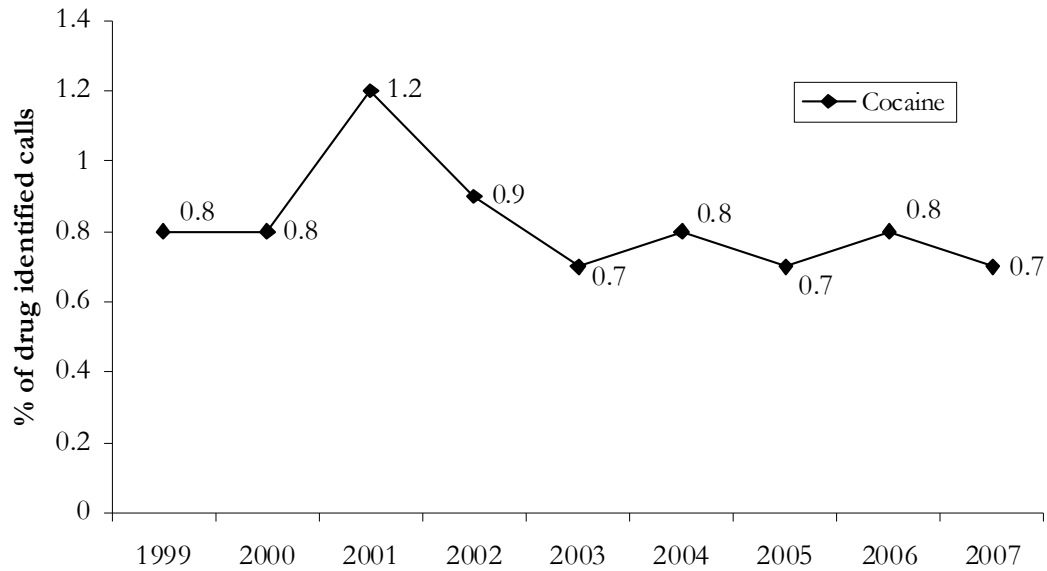
Source: DirectLine, Turning Point Alcohol & Drug Centre Inc (unpublished data)

10.2.3. Cocaine

DirectLine calls

During 2007, DirectLine responded to 236 calls where cocaine was identified as a drug of concern. As in previous years, this represents less than 1% of all calls made to DirectLine during that time where a drug of concern was cited (Turning Point Alcohol & Drug Centre Inc, unpublished data). The proportion of drug-related calls where cocaine was identified has remained very low (around 1%) during the past nine years (see Figure 19).

Figure 19: DirectLine calls where drug of concern identified as cocaine, 1999-2007



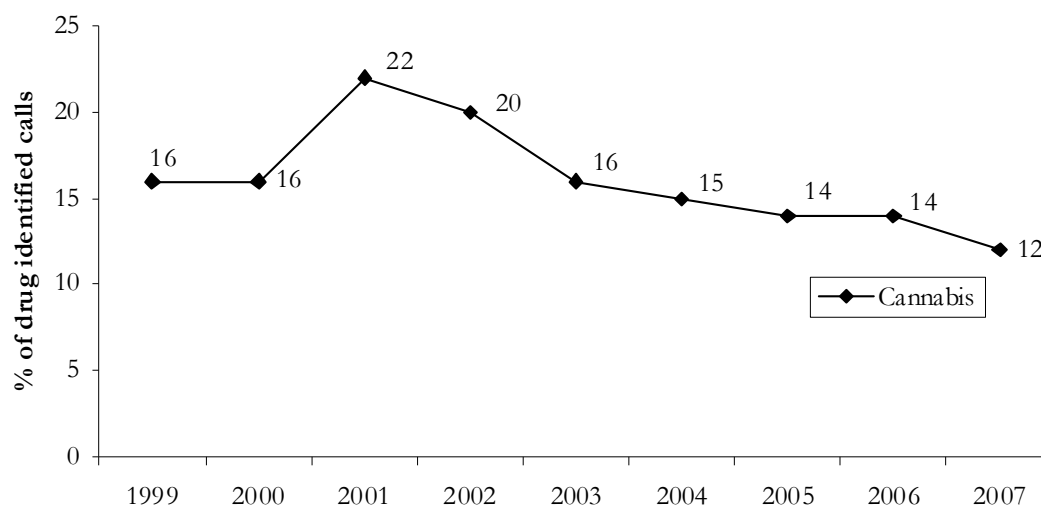
Source: DirectLine, Turning Point Alcohol & Drug Centre Inc (unpublished data)

10.2.4. Cannabis

DirectLine calls

During 2007, DirectLine responded to 3,430 calls where cannabis was identified as a drug of concern. This represents approximately 12% of all drug-identified calls to DirectLine during that year (Turning Point Alcohol & Drug Centre Inc, unpublished data). The proportion of drug-related calls where cannabis was identified has remained decreasing to stable since 2001, when cannabis-related calls peaked at 22%. In 2007, the percentage of drug-identified calls where cannabis was identified reached its lowest level (12%) since 1999 (see Figure 20).

Figure 20: DirectLine calls where drug of concern identified as cannabis, 1999-2007



Source: DirectLine, Turning Point Alcohol & Drug Centre Inc (unpublished data)

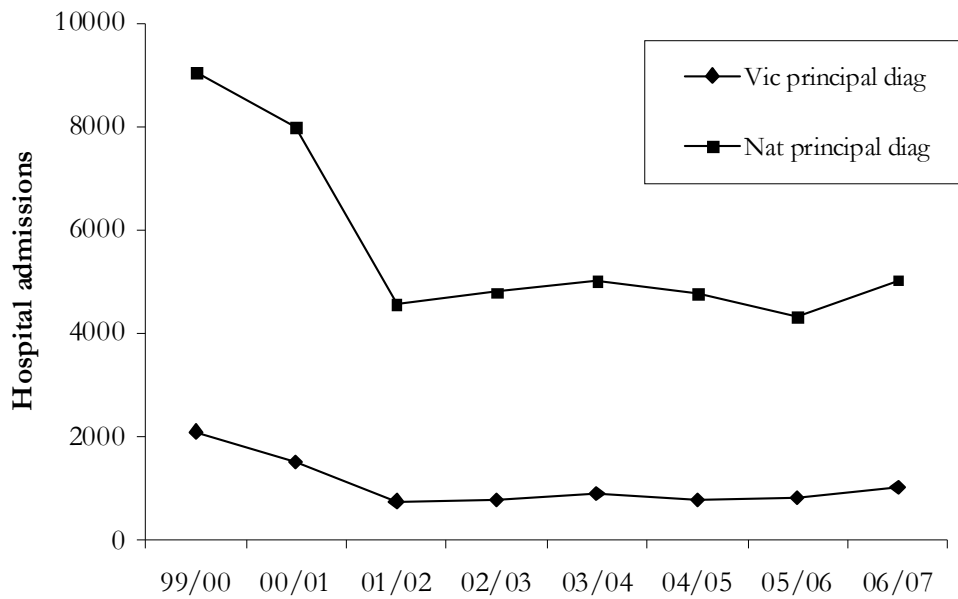
10.3. Hospital admissions

The NHMD is compiled by the AIHW. It is a collection of electronic records for admitted patients in public and private hospitals. Drug-related (opioid, amphetamine, cocaine and cannabis) hospital admissions are reported below for Victoria and Australia, 1999/2000-2006/2007. *Principal diagnosis* refers to the diagnosis established (after study) to be chiefly responsible for occasioning the patient's episode of care in hospital.

10.3.1. Heroin

Opioid-related hospital admissions for Victoria and Australia (among persons aged 15-54 years) are presented in Figure 21. It is evident from this data that the number of opioid-related hospital admissions, both in Victoria and nationally, decreased between 1999/2000-2001/2002. This is consistent with both IDU and KE reports of a reduction in Melbourne's heroin supply during that period (Jenkinson et al., 2004). Since that time, the number of opioid-related hospital admissions has remained relatively stable, both in Victoria and Australia. Opioid-related hospital admissions account for the highest proportion of drug-related admissions (compared to amphetamine, cocaine and cannabis).

Figure 21: Opioid-related hospital admissions, Victoria and national, 1999/2000-2006/2007

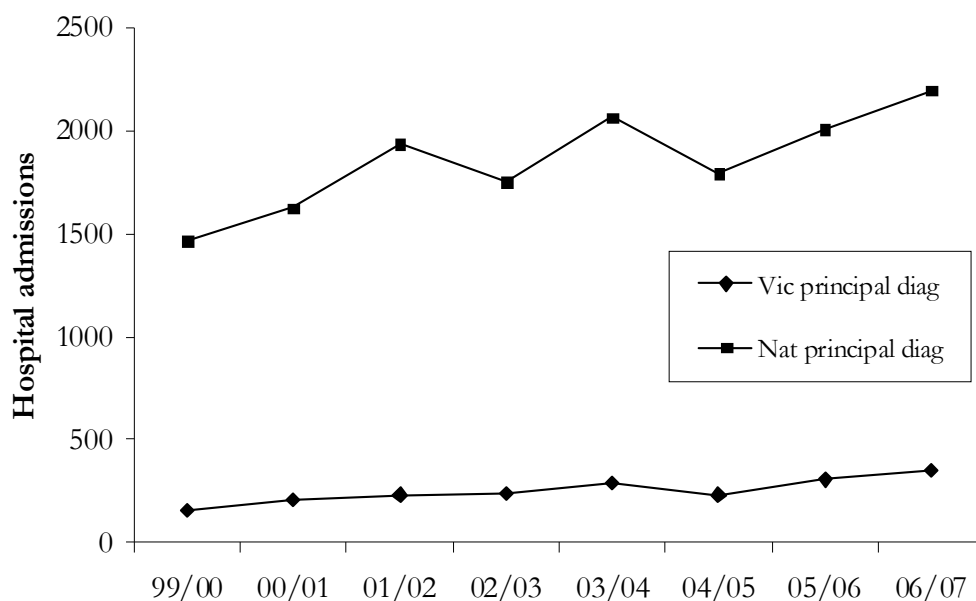


Source: Roxburgh & Burns (in press); AIHW

10.3.2. Methamphetamine

Amphetamine-related hospital admissions for Victoria and Australia (among persons aged 15-54 years) are presented in Figure 22. It is evident from this data that the number of amphetamine-related hospital admissions has generally been stable to increasing over the period of analysis, with the highest number of amphetamine-related hospital admissions (both in Victoria and nationally) recorded during 2006/2007.

Figure 22: Amphetamine-related hospital admissions, Victoria and national, 1999/2000-2006/2007

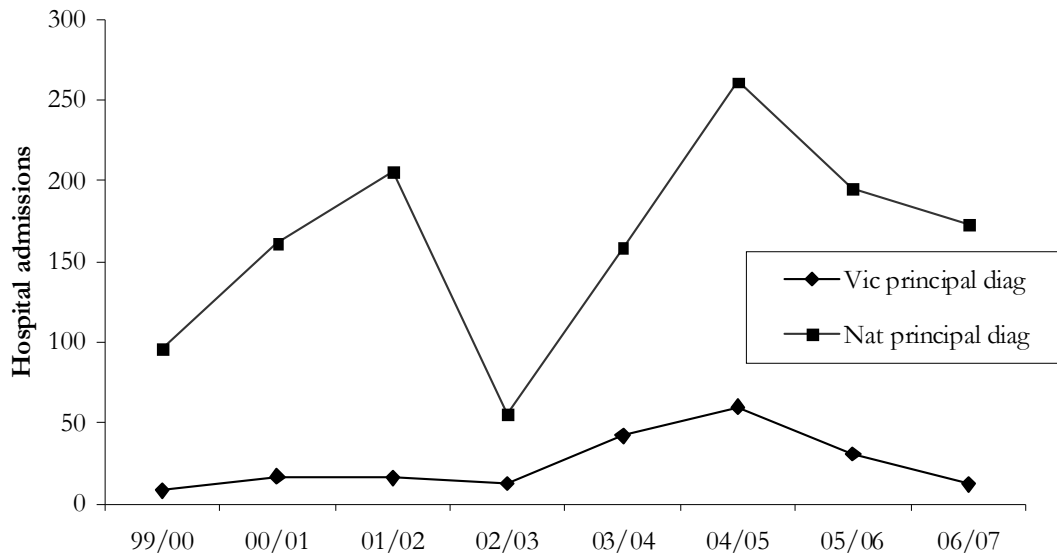


Source: Roxburgh & Burns (in press); AIHW

10.3.3. Cocaine

Cocaine-related hospital admissions for Victoria and Australia (among persons aged 15-54 years) are presented in Figure 23. It is evident from this data that the number of cocaine-related hospital admissions in Victoria was relatively stable between 1999/2000-2002/2003, while rates increased during 2003/2004 and 2004/2005. Nationally, the number of cocaine-related hospital admissions increased between 1999/2000 and 2001/2002, and then significantly decreased in 2003, before increasing in both 2003/2004 and 2004/2005. During the following two years (2005/2006 and 2006/2007) the number of cocaine-related hospital admissions decreased both in Victoria and nationwide. The number of cocaine-related hospital admissions continues to be much lower than for opioids or amphetamines.

Figure 23: Cocaine-related hospital admissions, Victoria and national, 1999/2000-2006/2007

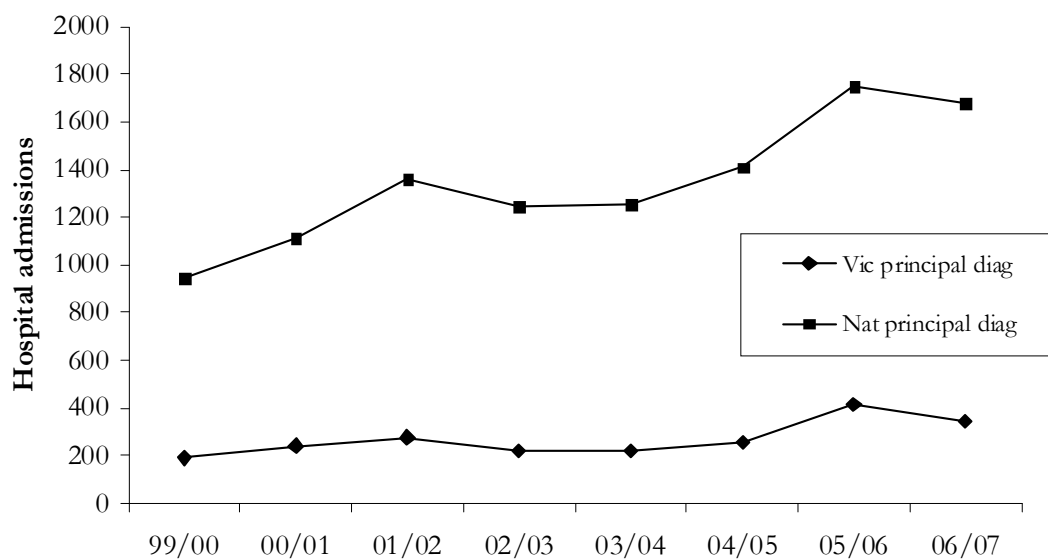


Source: Roxburgh & Burns (in press); AIHW

10.3.4. Cannabis

Cannabis-related hospital admissions for Victoria and Australia (among persons aged 15-54 years) are presented in Figure 24. It is evident from this data that the number of cannabis-related hospital admissions nationally has gradually increased over the period of analysis, peaking in 2005/2006 with 1,748 admissions, while in Victoria the rates have been more stable during this time.

Figure 24: Cannabis-related hospital admissions, Victoria and national, 1999/2000-2006/2007



Source: Roxburgh & Burns (in press); AIHW

10.4. Injecting risk behaviours

10.4.1. Sharing of injecting equipment

The sharing of needles/syringes and other equipment associated with the preparation and injection of drugs carries significant risk of exposure to BBVI such as HIV, and HBV or HCV) (Crofts et al., 1999).

Sixteen percent of respondents (n=24) reported loaning a used needle to someone else during the past month, and 9% (n=14) reported borrowing someone else's used needle during that time. Nine of these participants reported using a needle after only one person in the last month, while the remaining five reported borrowing a needle from two people during that time (usually a regular sex partner or close friend). The majority of these participants (93%, n=13) reported cleaning the used needle the last time they borrowed one, mainly via flushing the used fit with water only (31%, n=4), with hot/boiling water (15%, n=2), or with an alcoholic swab and flushing the needle with water (15%, n=2).

One-third (33%, n=8) of those participants who reported loaning their own used needles to other people during the last month (n=24) reported having done so once, 45% (n=11) twice, and 21% (n=5) had done so three or more times.

In 2008, reports of both borrowing and loaning used needles increased slightly in comparison to the previous year (see Table 15). Despite this increase, only 5% of participants (n=7) reported experiencing any difficulty when attempting to source clean needles in the last six months. The main reasons for experiencing such difficulty as reported by these participants (n=7), were: limited operating hours of an NSP/needle dispensing service (86%, n=6), and the geographical location of an NSP/needle dispensing service (29%, n=2).

Table 15: IDU self-reported injecting risk practices (past month), 1999-2008

Risk practice (past month)	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Borrowed a used N/S (%)	9	19	15	17	10	11	15	12	7	9
Lent a used N/S (%)	22	35	24	22	24	21	23	17	10	16
Used spoon/mixing container after someone else (%)	38	46	38	43	41	41	46	31	41	31
Used filter after someone else (%)	17	18	12	15	24	13	27	9	19	19
Used tourniquet after someone else (%)	7	11	12	13	7	13	11	6	7	11
Used water after someone else (%)	--	33	17	23	24	32	33	19	29	17
Used any injecting equipment after someone else (%)	43	53	47	49	43	46	50	35	45	59

Source: IDRS IDU interviews

Fifty-nine percent (n=89) of the sample reported using any other injecting equipment after someone else during the past month, an increase in comparison to previous years. The injecting equipment participants reported most commonly using after someone else included spoons (31%, n=47), and filters (19%, n=29).

Over half of the sample (54%, n=81) reported reusing their own needles in the last month a median of two times (range=1-10+ times).

10.4.2. Blood-borne viral infections

BBCI (HIV, HBV and HCV) represent a major health risk for individuals who inject drugs. An integrated surveillance system has been established in Australia for the purposes of monitoring the spread of these infections. The sharing of equipment for injecting illicit drugs has infrequently resulted in HIV transmission in Australia, but transmission of the HCV continues to occur at very high rates among people who inject drugs.

The Communicable Diseases Section, Public Health Branch, Department of Human Services, records notifications of infectious diseases in Victoria. Table 16 shows the trend in Victorian notifications of HIV diagnoses, where injecting drug use was identified as the exposure category, by year of diagnosis, 1995-2007. This table shows that throughout this period there has been a consistently low proportion of HIV diagnoses where injecting drug use was identified as the exposure category. At the end of 2007, injecting drug use had been identified as an exposure factor in only 2% of all Victorian HIV infections (Victorian Department of Human Services, 2008).

Table 16: Annual number of notifications of HIV diagnoses in Victoria where injecting drug use has been identified as the likely exposure factor, 1995-2007

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Number	15	14	15	13	6	10	11	5	10	8	10	8	5
% of HIV diagnoses	8	7	8	9	5	7	5	2	4	4	4	3	2

Source: Quinn, 2008; Victorian Department of Human Services, 2008.

The evidence of low rates of HIV infection among IDU is reinforced by the results of a study of attendees at seven fixed-site metropolitan NSP in Victoria in 2007, in which none of the 240 respondents provided blood tests that were found to be HIV positive (see Table 17) (National Centre in HIV Epidemiology and Clinical Research, 2008).

In contrast, the situation with regard to HCV among IDU in Victoria is of major concern, as there is evidence of a continuing high level of prevalence of HCV infection among this group. This is demonstrated in the findings of the sentinel surveillance data for attendees at seven fixed-site metropolitan NSP in Victoria in 2007, in which 73% of the sample (67% in 2006, 71% in 2005, 69% in 2004, 66% in 2003, 58% in 2002, and 70% in 2001) were found to have HCV antibodies (see Table 17) (National Centre in HIV Epidemiology and Clinical Research, 2004; National Centre in HIV Epidemiology and Clinical Research, 2008).

Table 17: Prevalence of HCV & HIV infection among NSP clients, Victoria, 2004-2007

	2004			2005			2006			2007		
	Male n=122	Female n=65	Total n=189*	Male n=101	Female n=76	Total n=189*	Male n=121	Female n=67	Total n=177*	Male n=139	Female n=65	Total n=205*
HCV %	67	74	69	69	75	71	63	72	67	72	74	73
HIV %	0.8	0.0	0.5	1.0	0.0	0.5	0.8	0.0	0.6	0.0	0.0	0.0

Source: National Centre in HIV Epidemiology and Clinical Research, 2008

* Total includes people whose sex was not reported or reported as transgender

The Communicable Diseases Section, Public Health Branch, Department of Human Services, also collects data on notifications received for HCV infection (newly acquired and not further specified). In 2008, the Communicable Diseases Section received 2,469 notifications of HCV infection in 2008 compared to 2,797 notifications in 2007, 2,768 notifications in 2006, and 3,012 notifications in 2004 (Victorian Department of Human Services, 2009a).¹³ The number of HCV infection notifications has remained relatively stable over the past four years, with carriage rates remaining unacceptably high and indicative of persisting levels of unsafe injecting practices among some IDU.

10.4.3. Location of injections

Table 18 shows that 63% (n=94) of the IDU sample reported that they had last injected in a private home, while others reported last injecting in public locations, such as the street/park or beach (13%, n=19), or public toilets (12%, n=18). Nine percent (n=13) of participants reported last injecting in a car.

Likewise, the usual or most frequent location of injection during the past month was in a private home (71%, n=107) with smaller proportions of participants reporting most often injecting in public toilets (11%, n=16), the street/park or beach (7%, n=11), or in cars (7%, n=10).

Table 18: Location in which 2008 IDU respondents had last injected (N=149)⁺

Last injecting location	%
Private home	63
Public toilet	12
Street/park or beach	13
Car	9
Other (e.g. stairwell of building)	3

Source: IDRS IDU interviews

⁺ Missing data for one respondent

The reported locations of last injection were similar to those reported in previous IDRS studies (Quinn, 2008; Jenkinson & Quinn, 2007; Jenkinson & O’Keeffe, 2005; Jenkinson & O’Keeffe, 2006; Jenkinson et al., 2004).

10.4.4. Self-reported injection-related health problems

Reports by the participants in the IDU survey of injection-related health problems in the previous month are summarised in Table 19. Under two-thirds (63%, n=95) of respondents reported experiencing at least one type of these problems, with scarring/bruising (47%, n=70), and difficulty injecting (39%, n=58) being the problems most commonly reported. As in 2007, the median number of injection-related health problems during the past month was two.

¹³ Numbers do not necessarily reflect the true incidence of the disease and relate to notifications received by the Department of Human Services.

Table 19: Injection-related health problems (past month) reported by participants in the 2006, 2007 and 2008 IDU surveys

Type of problem (%)	2006 (N=150)	2007 (N=150)	2008 (N=150)
Prominent scarring/bruising	49	63	47
Difficulty injecting	43	35	39
Dirty hit (made me feel sick)	23	17	15
Thrombosis	8	9	10
Abscesses/infections from injecting	3	10	7
Overdose	3	3	3

Source: IDRS IDU interviews

In comparison to the previous year, in 2008, a smaller proportion of respondents reported that they had experienced prominent scarring/bruising in the last month (47%, compared to 63% in 2007), though the proportions of respondents reporting other injection-related problems remained relatively stable in comparison to 2007 (Quinn, 2008; Jenkinson & Quinn, 2007).

In 2008, participants were also asked if they had injected benzodiazepines, methadone, buprenorphine, Suboxone[®], or morphine during the last month and, if so, whether they had experienced any injection-related problems specific to those drug types during that time. The number of participants who reported recently injecting those drug types, and the proportion who reported experiencing problems, are shown in Table 20.

Table 20: Proportions reporting injection-related health problems specific to each drug type (last month), 2008

Injection problems (%)	Benzodiazepines (n=8)	Methadone (n=12)	Buprenorphine (n=26)	Suboxone® (n=15)	Morphine (n=27)
No problems	25 (n=2)	8 (n=1)	23 (n=6)	20 (n=3)	33 (n=9)
Overdose	-	-	-	-	-
Abscess/infection	25 (n=2)	-	12 (n=3)	20 (n=3)	7 (n=2)
Dirty hit	-	25 (n=3)	15 (n=4)	13 (n=2)	7 (n=2)
Scarring/bruising	38 (n=3)	83 (n=10)	62 (n=16)	40 (n=6)	44 (n=12)
Thrombosis	13 (n=1)	-	23 (n=6)	13 (n=2)	7 (n=2)
Swelling of arm	38 (n=3)	25 (n=3)	39 (n=10)	40 (n=6)	19 (n=5)
Swelling of leg	13 (n=1)	-	15 (n=4)	7 (n=1)	7 (n=2)
Swelling of hand	13 (n=1)	17 (n=2)	31 (n=8)	13 (n=2)	7 (n=2)
Swelling of feet	13 (n=1)	-	15 (n=4)	7 (n=1)	7 (n=2)
Hospitalisation	-	-	4 (n=1)	-	-
Dependence	25 (n=2)	42 (n=5)	50 (n=13)	40 (n=6)	19 (n=5)
Gangrene	-	-	-	-	-
Numbness	-	-	8 (n=2)	7 (n=1)	-
Skin ulcers	13 (n=1)	-	4 (n=1)	-	-
Difficulty finding veins to inject into	63 (n=5)	67 (n=8)	77 (n=20)	67 (n=10)	52 (n=14)
Contact with ambulance	-	-	4 (n=1)	-	-
Contact with police	-	8 (n=1)	8 (n=2)	-	-

Source: IDRS IDU interviews

While KE generally reported that sharing of needles and other injecting equipment were minimal amongst the IDU they had contact with/knowledge of, KE again commented on other unsafe injecting practices that continued to be demonstrated by clients, including polysubstance use (e.g. “alcohol use with heroin increases (a user’s) chances of overdose”); reusing injecting equipment, ineffective/improper cleaning of injecting equipment; using alone; injecting into unsafe/risky areas of the body (e.g. the neck, armpits, groin or eyes); bingeing; filtering through cigarette filters; failure to use wheel/pill filters; using in unsafe/inappropriate/unhygienic environments (e.g. public toilets); and using too much heroin at a time (“pushing the boundaries”).

KE also listed a number of ongoing injection-related harms that were experienced by clients in the last six to 12 months, including damaged/loss of veins, muscle damage, abscesses, scarring/bruising, infection, loss of limbs, cellulitis, ulcers, and endocarditis.

As in previous years, in 2008 KE reported that BBVI, particularly HCV, continued to be problematic for many clients. While the majority of KE noted that BBVI rates had generally remained stable in the last six months, three KE reported a reduction in rates of HCV during that time, while two KE reported that rates of HCV had increased in the last six months (one KE noted that this occurred particularly amongst Indigenous IDU). KE noted that generally only a minority of clients were HIV positive.

10.5. Crystal smoking (pipes) risk behaviours

Twenty-six IDU participants (17%) reported smoking crystal meth/ice in the last six months. These participants (n=26) reported mainly sourcing their crystal smoking pipes from friends (65%, n=17) or shops (23%, n=6) during that time. When asked what they would do if they were unable to source new pipes, these participants (n=26) reported that they would usually inject crystal meth/ice instead of smoking (62%, n=16), or would make their own pipe/ or use something else as a means of smoking (38%, n=10). Only one participant reported that they would not use crystal meth/ice if they could not source a pipe.

Nineteen participants (13%) commented on the current availability of crystal pipes, with just over half (53%, n=10) reporting that they were currently very easy to source. In contrast, the remaining participants (n=9) reported that crystal pipes were either difficult (37%, n=7) or very difficult (11%, n=2) to source at the time of interview. Eighteen participants commented on changes to the availability of crystal pipes over the last six months, with equal proportions reporting that availability had remained stable (44%, n=8), or that pipes had become more difficult to source (44%, n=8), during that time. In contrast, two participants (11%) reported that crystal pipes had become easier to source in the last six months.

Of those participants who reported smoking crystal meth/ice in the last six months (n=26), the majority (81%, n=21) reported having shared a pipe during that time, with participants using a pipe a median of four times after someone else had already used it.

10.6. Mental and physical health problems and psychological distress

Over two-fifths (41%, n=62) of the 2008 IDU survey respondents reported that they had experienced any mental health problem(s) during the past six months (compared to 45% in 2007). Similar to the results of previous years, of those who reported experiencing at least one mental health problem in the last six months (n=62), respondents reported most commonly experiencing depression (69%, n=43), anxiety (37%, n=23), manic-depression/Bipolar disorder (16%, n=10), schizophrenia (11%, n=7), and paranoia (6%, n=4) (Quinn, 2008; Jenkinson & Quinn, 2007; Jenkinson & O’Keeffe, 2006). Sixty-three percent (n=39) of those IDU who reported having experienced any mental health problem(s) during that time (n=62) reported having attended a health professional for this. As a result of attending a mental health professional in the last six months, 77% (n=30) of these respondents were prescribed at least one type of mental health medication; 39% (n=15) were prescribed antidepressants, another 39% (n=15) were prescribed benzodiazepines, and 33% (n=13) were prescribed antipsychotic medication.

Reflecting the responses of IDU survey participants, KE again identified depression (n=22) and anxiety (n=16) as the most prevalent forms of mental illness among the clients they had contact with/knowledge of, followed by schizophrenia (n=12), personality disorder (n=8), psychosis (n=8), bipolar disorder (n=7), borderline

personality disorder (n=5), acquired brain injury (n=4), paranoia (n=3), and post-traumatic stress disorder (n=3).

10.6.1. Kessler Psychological Distress Scale (K10)

In 2008, the 10-item K10, a questionnaire designed to measure the level of distress and severity associated with psychological symptoms in population surveys (Kessler et al., 2002),¹⁴ was also administered to IDU participants. Scores to the K10 range from 10 (indicating no distress) to 50 (indicating very high psychological distress). According to the four K10 categories described in the 2004/2005 National Health Survey (ABS, 2006), scores from 10-15 were considered to be 'low', 16-21 as 'moderate', 22 -29 as 'high' and 30-50 as 'very high'.

One hundred and forty-six participants in the 2008 IDU sample (97%) completed the scale in reference to the past four weeks, achieving a mean score of approximately 23 (range=7-47). In accordance with the aforementioned categories, 31% (n=45) of these respondents reported being very highly distressed, and another 20% (n=29) reported being highly distressed, compared to 4% and 9% of respondents to the 2004/2005 National Health Survey (ABS, 2006). In contrast, 21% (n=30) of those who completed the K10 scale (n=146) reported being moderately distressed, with the remaining 29% (n=42) reporting low or no distress, compared to 63% and 24% of respondents to the 2004/2005 National Health Survey (ABS, 2006).

10.6.2. Mental and physical health problems (SF-8)

The Short Form-8 Health Survey (SF-8) is an eight-item questionnaire which aims to provide information on the general health and wellbeing of participants in population surveys. It was included in the IDRS for the first time in 2008, and measures eight health concepts, including physical functioning, physical health problems, bodily pain, general health, energy/fatigue, social functioning, and role limitations due to emotional problems and psychological distress and wellbeing. The scores generated by these eight variables are combined to produce two composite scores – the mental component score (MCS) and the physical component score (PCS) (Lefante et al., 2005).

The scoring system of the SF-8 was designed to obtain a mean of 50 and a standard deviation of 10 (Lefante et al., 2005). In 2008, the Victorian IDU sample scored a mean of 41.2 (SD=13.5) for the MCS, and 46.9 (SD=9.04) for the PCS, compared to a national MCS score of 49.8 and PCS score of 50.1 (ABS, 2006), indicating that the 2008 Victorian sample have poorer physical and mental health than the Australian population average.¹⁵ In comparison, the national IDRS sample (N=909) achieved an MCS mean of 40.7 (SD=12.9), and a PCS mean of 45.5 (SD=10.4), though the differences between the national and Victorian MCS and PCS scores were not significant. For further discussion, refer to the 2008 national IDRS report (Stafford et al., 2009).

10.7. Driving risk behaviour

For the past four years, IDU survey respondents have been asked about driving risk behaviour. Forty-seven percent (n=71) of the 2008 IDU sample reported that they had driven a car at least once in the past six months (compared to 41% in 2007). Of those, 18% (n=13) reported that they had driven while over the limit of alcohol during that time, on a median of five occasions. Over one-quarter of recent drivers (28%, n=20) reported being given a random breath test (RBT) during the past six months, with one

¹⁴ See <http://www.crufad.unsw.edu.au/K10/k10info.htm> for further information (sourced 17 March 2008).

¹⁵ The SF-8 scores were transformed into SF-36 scores using weighted syntax to make them comparable with the general Australian population scores.

respondent reporting that they were found over the legal limit on any occasion during that time (compared no respondents over the legal limit in 2007).

Of those who reported that they had driven a car in the past six months (n=71), 85% (n=60) reported that they had driven soon after taking an illicit drug (i.e. a non-prescribed drug) during that time, on a median of 30 occasions. Most reported that driving soon after taking heroin (68%, n=41), cannabis (65%, n=39), or speed (28%, n=17) during the past six months (see Table 21).

Table 21: Driven soon after taking illicit drugs (past six months), 2005-2008

After which illicit drugs* (%)	2005 (n=71)	2006 (n=62)	2007 (n=51)	2008 (n=60)
Heroin	80	58	77	68
Cannabis	49	44	53	65
Speed	29	42	29	28
Crystal meth/ice	4	15	4	7
Buprenorphine	13	16	8	7
Benzodiazepines	10	11	16	12
Ecstasy	6	3	2	2

Source: IDRS IDU interviews

* Among those who had driven soon after taking an illicit drug

Those participants who had driven after taking any illicit drug in the last six months (n=60) were asked to describe how impaired they perceived their driving to be on the last occasion they had done so, with over half (58%, n=35) reporting that their recent drug use had no impact on their driving abilities. In contrast, one-quarter of these participants (25%, n=15) reported that their driving was 'slightly impaired' following drug use, while 5% (n=3) reported that it was 'quite impaired'. Seven percent (n=4) of these respondents reported that recent drug use had 'slightly improved' their driving abilities, with the remaining 5% (n=3) reporting that their driving abilities had been 'quite improved' following drug use.

These participants were also asked how long after taking an illicit drug they commenced driving (on the last occasion), resulting in a reported median of half an hour (range=0-20 hours). Of those participants who had driven after taking any illicit drugs in the last six months (n=60), 13% (n=8) reported being given a random drug test (RDT) by police during that time. None of these participants were found to be under the influence of any illicit drugs when tested.

10.8. General health care

While KE noted that the type and amount of health-related issues among clients had generally remained constant in the last six to 12 months, a minority of KE (n=14) reported a number of different changes to client health during that time. Seven KE reported an increase in overdose rates (both fatal and non-fatal) among clients in the last six to 12 months, while, conversely, three KE reported a reduction in overdose rates during that time. Three KE also reported a decrease in BBVI transmissions and/or presentations among clients (primarily HCV), while two KE reported increased rates of

BBVI among clients (one KE specified an increase among Indigenous clients in particular).

A number of KE (n=22) reported that dental problems were “absolutely huge” among the users KE had contact with/knowledge of. One KE stated that “there is a large unmet need for alleviation of dental problems among IDU”, noting that it was often beneficial to pursue “creative options” with local dentists; this KE reported that an arrangement with a local dentist had resulted in the dentist meeting with/treating four IDU patients per week for minimal cost. In addition, KE noted that dental problems among IDU were often drug-related, with methamphetamine or ecstasy users often grinding their teeth or experiencing dry mouths, while one KE reported that long-term methadone users in particular presented with dental issues. One KE noted that a lack of bulk-billing dentists in Melbourne prevented many IDU from seeking help or treatment for dental problems.

Eighteen KE commented on sexual activity among clients. These KE generally reported that unsafe sexual activity (e.g. unprotected sex, prostitution) was a consistent problem among IDU, with consequences such as unplanned pregnancies, transmission of sexually transmitted infections (STI), and sexual abuse. However, KE did note that users of heroin and cannabis in particular often had low libidos/sex drives as a result of using these drugs, and therefore engaged in sexual activity less often than users of other substances, such as methamphetamine, and consequently experienced less sex-related problems. Two KE reported that knowledge of safe sex practices was low among clients, while KE generally reported that the majority of clients who engaged in sex work were females.

As in previous years, KE reported that clients experienced a range of other ongoing health problems in the last six to 12 months, including poor diet/malnutrition (n=14), poor general/personal hygiene (n=7), weight loss/underweight (n=3), liver problems (n=3; particularly associated with hepatitis and/or alcohol use), diabetes (n=2), scabies (n=2), and respiratory problems (n=2), which KE associated primarily with cannabis use.

10.9. Services requested

Consistent with results of previous IDRS reports, in 2008, the majority of KE (n=29) reported that lack of stable or appropriate accommodation (e.g. safe, affordable, long term) continued to be a major concern for many clients. KE noted that homelessness remained a “chronic” issue for a number of IDU, with many other individuals living in temporary or crisis accommodation, such as hostels and boarding or “rooming” houses. As in previous years, KE reported that client contamination (i.e. living with people who reinforce an individual’s drug use and/or compound their mental health issues) was also a significant problem for many IDU. In addition, homelessness and unsafe or inappropriate accommodation were also reportedly associated with a greater number of health problems among clients.

Ten KE reported that a number of clients experienced legal issues, such as involvement with child protection services, or breaching suspended sentences, and required affordable legal assistance as a result. In addition, seven KE reported that many clients experienced financial hardship, often as a result of spending too much money on drugs or a lack of foresight in regards to bills (e.g. excessive mobile phone expenditure). One KE reported that some IDU have resorted to crime (e.g. robberies) as a result of financial issues.

11.0 LAW ENFORCEMENT TRENDS RELATED TO DRUG USE

11.1. Reports of criminal activity among IDU participants

Forty-seven percent of IDU participants (n=71) reported involvement in some type of criminal activity during the preceding month, and 43% (n=65) reported that they had been arrested during the previous 12 months (compared to 45% in 2007, 53% in 2006 and 2005, 55% in 2004). Forty-two percent of arrests (n=27) were in relation to property crime, 26% (n=17) to use/possession of drugs, 6% (n=4) to violent crime, and 5% (n=3) to fraud. Twelve percent (n=8) of respondents who had been arrested during the past 12 months (n=65) reported multiple (two or more) types of charges.

As shown in Table 22, dealing (35%, n=52) and property crime (21%, n=31) were again the most common crimes reported in the last month, with fewer respondents reporting involvement in fraud (5%, n=7) or violent crime (3%, n=4). The amount of self-reported involvement in any criminal activity increased in comparison to the previous year, to similar levels reported in both 2005 and 2006.

Table 22: Criminal activity reported by IDU during the last month, 2002-2008

Type of crime	2002 (N=155) ¹	2003 (N=150) ²	2004 (N=147) ³	2005 (N=147) ³	2006 (N=147) ³	2007 (N=149) ¹	2008 (N=150)
Property crime (%)	39	35	28	26	20	22	21
Dealing (%)	41	40	30	25	35	24	35
Fraud (%)	14	7	8	4	5	5	5
Violent crime (%)	9	10	8	7	2	7	3
Any crime (%)	63	59	53	48	48	38	47

Source: IDRS IDU interviews

¹ Missing data for one respondent

² Missing data for two respondents

³ Missing data for three respondents

Of the KE who commented (n=33), the majority (n=22) reported that crime levels (excluding dealing and trafficking – see following section) among IDU had remained stable over the last six to 12 months, with no significant changes regarding levels of illegal sex work or fraud in particular. In contrast, 11 KE reported increased crime rates among IDU during that time, with the majority of these KE (n=10) reporting increased rates of violent crime in particular during the last six to 12 months, such as assault and “violent thefts” of items such as mobile phones.

Smaller numbers of KE also reported increased rates of property crime (n=2), driving offences (n=1), and fraud (n=1) among clients in the last six to 12 months. Three law enforcement KE reported an increase in the number of seizures during that time, particularly of heroin, methamphetamine, cannabis and ecstasy.

11.1.1. Drug involvement in criminal activity

In 2008, IDU participants were asked for the first time if they were under the influence of any licit or illicit drug(s) when they last committed a criminal offence. Of those participants who reported committing a property crime in the last month (n=31), the

majority (68%, n=21) reported being under the influence of any drug(s) when last doing so, most commonly heroin (52%, n=11), BZD (43%, n=9), methadone (19%, n=4), and/or cannabis (19%, n=4).

Of those participants who reported committing selling drugs to someone in the last month (n=52), the majority (87%, n=45) reported being under the influence of any drug(s) when last doing so, most commonly heroin (60%, n=27), cannabis (31%, n=14), BZD (13%, n=6), and/or Subutex[®]/buprenorphine (13%, n=6).

Two participants reported being under the influence of any drug(s) the last time they committed fraud, with both reporting only being under the influence of heroin when doing so. Of those IDU participants who reported committing a violent crime in the last month (3%, n=4), three respondents reported being under the influence of any drug(s), including heroin (67%, n=2), alcohol (33%, n=1), cannabis (33%, n=1), and/or BZD (33%, n=1).

11.1.2. Motivations for involvement in criminal activity

For the first time in 2008, participants were also asked about the main reasons for their involvement in criminal activity during the last month. With regard to their last offence, participants (n=31) reported most commonly committing a property crime because they needed money to buy drugs (35%, n=11), or they needed money to support themselves/their families (32%, n=10). Those who reported dealing drugs in the last month (n=52), also reported most commonly doing so the last time because they needed money to buy drugs (60%, n=31), or to support themselves/their families (31%, n=16). Those who recently committed fraud also most commonly reported last doing so because they needed money to buy drugs (57%, n=4), while half (n=2) of those who recently committed a violent crime (n=4) did so because they lost their temper.

11.1.3. Dealing and trafficking

As in the previous year, in 2008, KE reported that trafficking and dealing activity had generally remained stable among IDU in the last six to 12 months. Three KE, however, reported increased dealing/trafficking activity during that time. One of these KE specified that there had been more dealing in Melbourne's CBD due to a reduction in police activity in the area, while another noted that increased user demand of cannabis had resulted in a greater number of people dealing the drug. In contrast, another three KE reported a reduction in dealing/trafficking activity among IDU in the last six to 12 months, which two KE attributed to increased police activity (e.g. "blitzes" and "crack downs").

As in previous years, KE noted that dealers and traffickers commonly used mobile phones to sell drugs during the last six to 12 months. KE noted that continued use of mobile phones resulted in less 'static' street-dealing, providing dealers and users with the convenience of arranging a location to meet over the phone, though police presence was also reportedly a factor contributing to the increasing popularity of 'mobile dealing' among dealers/traffickers. KE reported that continued use of mobile phones for drug deals often resulted in less visible public dealing/trafficking activity.

In 2008, KE reported that common locations of dealing/trafficking activity were private homes, public housing estates, and public locations such as car parks, shopping centres and hotels.

11.2. Reports of police activity towards IDU participants

IDU survey respondents were asked questions regarding their perceptions of changes in police activity during the past six months, and the impact of any changes. Just under half the number of respondents (47%, n=71) believed that police activity had remained stable during that period, while a nearly one-third (32%, n=48) reported that police activity had increased recently. Remaining relatively stable in 2008, only 5% of respondents (n=7) reported that there had been less police activity during the past six months (see Table 23).

Table 23: Police activity as reported by IDU, 2003-2008

	2003 N=152	2004 N=150	2005 N=150	2006 N=150	2007 N=150	2008 N=150
<i>Police activity in last 6 months (%)</i>						
More activity	59	60	52	39	41	32
Stable	32	26	35	49	43	47
Less activity	3	3	3	3	3	5
Don't know	6	11	10	9	13	16

Source: IDRS IDU interviews

Similar to the results of previous IDRS studies, in 2008, of those KE able to comment (n=33), the majority (n=20) reported that police activity towards IDU had remained stable in the last six to 12 months. A minority of KE (n=12), however, reported increased police activity in their respective areas during that time, including increased beat police/increased visible activity in the area (n=7); increased use of undercover police (n=6), e.g. “around commission flats”); increased number of busts/blitzes/crackdowns in the area (n=5); increased police activity around drug user agencies (n=4), e.g. “police are hanging around our office more”; increased use of ‘sniffer’ dogs (n=2); and increased contact with IDU (n=2). Two KE noted that increased police activity was not always directly associated with IDU, e.g. in two areas an increase in visible police presence was reportedly a result of police operations targeting public drinking in particular.

As in previous years, a number of KE reported that the relationship between some police and clients remained problematic. One KE reported that, due to increased police presence in the area and increased police harassment of clients, IDU were avoiding services such as NSP, “to the point that users haven’t been picking up (clean) needles”. Similarly, increased visible police presence in another area had reportedly resulted in a reduction in client contact with street-based health workers (e.g. Foot Patrol).

In contrast to these negative reports, one KE noted that no clients had complained about police in the last six months, while another KE reported that the local police were “incredibly supportive” of NSP staff.

11.3. Arrests

The following section details drug-related (opioids, methamphetamine, cocaine and cannabis) consumer and provider arrests for Victoria and Australia, 2006-2007, from data provided by the ACC. Proportions (%) should be interpreted with caution due to the lack of uniformity across states and territories in the recording and storing of data on illicit drug arrests.

11.3.1. Heroin

Table 24 details consumer (e.g. possession/use) and provider (e.g. trafficking/manufacture) arrests for heroin and other opioids during 2006-2007 (Victoria and

Australia). During that financial year, just over half (49%) of the arrests made in Australia for heroin and other opioid offences occurred in Victoria. In both Victoria and nationally, the total numbers of consumer and provider arrests for heroin and other opioids decreased slightly in comparison to 2005-2006 (N=1,159 and 2,249 respectively in 2005-2006).

Table 24: Heroin and other opioids: consumer and provider arrests, Victoria and national, 2006-2007⁺

	Victoria (N)	Australia (N)	% of national arrests
Consumer	691	1,096	63.0
Provider	377	744	50.7
TOTAL*	1,068	2,161	49.4

Source: ACC

* Includes those offenders for whom consumer/provider status was not stated

+ 2007-2008 data not available at the time of publication

11.3.2. Methamphetamine

Table 25 details consumer (e.g. possession/use) and provider (e.g. trafficking/manufacture) arrests for amphetamine-type stimulants, during 2006-2007 (in Victoria and Australia). During that financial year just over one-fifth (22%) of the arrests made in Australia for amphetamine-type stimulant offences occurred in Victoria. In Victoria and nationally the total number of consumer and provider arrests for amphetamine-type stimulants remained increased since 2005-2006 (N=2,838 and 11,848, respectively in 2005-2006).

Table 25: Amphetamine-type stimulants: consumer and provider arrests, Victoria and national, 2006-2007⁺

	Victoria (N)	Australia (N)	% of national arrests
Consumer	2,323	10,896	21.3
Provider	1,083	4,291	25.2
TOTAL*	3,406	15,216	22.4

Source: ACC

* Includes those offenders for whom consumer/provider status was not stated

+ 2007-2008 data not available at the time of publication

11.3.3. Cocaine

Table 26 details consumer (e.g. possession/use) and provider (e.g. trafficking/manufacture) arrests for cocaine during 2006-2007 (in Victoria and Australia). During that financial year less than one-fifth (19%) of the arrests made in Australia for cocaine offences occurred in Victoria. In Victoria and nationally the total number of consumer and provider arrests for cocaine increased since 2005-2006 (n=98 and 396 respectively in 2005-2006).

Table 26: Cocaine: consumer and provider arrests, Victoria and national, 2006-2007+

	Victoria (N)	Australia (N)	% of national arrests
Consumer	71	380	18.7
Provider	56	315	17.8
TOTAL*	127	695	18.3

Source: ACC

* Includes those offenders for whom consumer/provider status was not stated

+ 2007-2008 data not available at the time of publication

11.3.4. Cannabis

Table 27 details consumer (e.g. possession/use) and provider (e.g. trafficking/manufacture) arrests for cannabis during 2006-2007 (in Victoria and Australia). As in the previous financial year, during 2006-2007 approximately 12% of the arrests made in Australia for cannabis offences occurred in Victoria. In Victoria, the total number of consumer and provider arrests for cannabis remained relatively stable since 2005-2006 (N=6,901 in 2005-2006).

Table 27: Cannabis: consumer and provider arrests, Victoria and national, 2006-2007+

	Victoria (N)	Australia (N)	% of national arrests
Consumer	5,018	48,381	10.4
Provider	1,817	8,392	21.7
TOTAL*	6,835	56,859	12.0

Source: ACC

* Includes those offenders for whom consumer/provider status was not stated

+ 2007-2008 data not available at the time of publication

11.4. Recent use and expenditure on illicit drugs

IDU survey respondents were asked about their drug use on the preceding day. Their responses (along with those reported in 2004-2007) are summarised in Table 28. Ninety-seven percent of respondents (n=145) reported using at least one drug type on the day preceding interview (median two drug types, range=one to five) with the most commonly used drugs being cannabis (53%, n=79), heroin (45%, n=67) and benzodiazepines (30%, n=45). Seventy-four percent (n=107) of the survey respondents who had used drugs on the day prior to interview (n=145) had used two or more different drugs.

Table 28: Drugs used on day prior to interview (IDU survey, 2004-2008)

Type of drug ⁺ %	2004 (N=150)	2005 (N=150)	2006 (N=150)	2007 (N=149)	2008 (N=150)
Cannabis	51	48	44	42	53
Heroin	49	45	37	40	45
Alcohol	26	25	23	21	24
Benzodiazepines	39	27	18	31	30
Buprenorphine	25	25	17	12	10
Methadone	13	12	11	17	25
Suboxone [®]	-	-	3	3	8
Morphine	7	7	6	9	7
Other opiates	4	0	1	4	3
Antidepressants	12	14	1	7	4
Speed	10	9	15	10	13
Base	0	0	0	0	0
Crystal meth/ice	1	0	1	2	2
Cocaine	1	1	1	1	3

Source: IDRS IDU interviews

⁺ Respondents were permitted to report more than one drug type

Nearly two-thirds (65%, n=97) of the sample reported purchasing illicit drugs on the day prior to interview. In terms of their illicit drug expenditure, approximately 27% (n=40) of the 2008 sample had spent between \$1 and \$99, and 38% (n=57) had spent more than \$100 (see Table 29). The median amount spent on illicit drugs on the day prior to interview (by those who had purchased any drugs) was \$100 (in comparison to a median of \$25 in 2007).

Table 29: Amount spent on illicit drugs on day prior to interview (IDU survey, 2004-2008)

Amount (\$)	2004 (N=150) %	2005 (N=150) %	2006 (N=146) ¹ %	2007 (N=149) ² %	2008 (N=150) %
Nothing	32	40	42	34	35
Less than \$20	5	7	4	8	5
\$20-49	17	12	13	12	11
\$50-99	13	15	10	16	11
\$100-199	23	13	13	17	21
\$200-399	5	8	10	11	13
\$400 or more	5	4	8	2	4

Source: IDRS IDU interviews

¹ Missing data for four respondents

² Missing data for one respondent

12.0 SUMMARY OF ASSOCIATED HARMS/DRUG-RELATED ISSUES

The main drug-related issues to emerge from the Melbourne arm of the 2087 IDRS study include:

- Changes in patterns of drug use were observed, most notably an increase in frequency of recent heroin use among the IDU sample (although prevalence of heroin use remained stable); there were corresponding increases in the number of both fatal and non-fatal heroin overdoses reported during 2008, in addition to the number of IDU respondents reporting lifetime and recent heroin overdose experiences.
- Reported prevalence of methamphetamine use (speed, crystal meth/ice, base) among the IDU sample decreased slightly in 2008; however, methamphetamine use is still very common among IDU in Melbourne.
- Cannabis remained the most frequently used drug among the IDU sample, and was again the drug most frequently used on the day prior to the IDRS interview.
- As in previous years, the majority of IDU were polydrug users. Seventy-four percent of survey respondents who had used drugs on the day prior to interview had used two or more different drugs.
- High rates of HCV infection were reported among IDU, while rates of needle/syringe and other equipment sharing increased in 2008.
- There were continuing reports of injection-related health problems (e.g. prominent scarring/bruising and difficulty injecting), with increased reports of people experiencing heroin overdose.
- Mental health issues (in particular depression and anxiety) were commonly reported.
- IDU commonly reported having driven soon after taking an illicit drug in the last six months.
- Self-reported criminal activity generally increased in 2008.
- KE again noted that the most frequently requested services by clients included access to stable/appropriate/long-term accommodation, dental services, legal aid and financial assistance.

13.0 STUDY LIMITATIONS

The aim of the IDRS study is to monitor emerging trends in illicit drug use and related issues within the community. The study is not designed to provide a definitive or detailed explication of these trends. Rather, the primary purpose of the IDRS findings is to (where appropriate) inform future policy and research responses to the public health and law enforcement challenges presented by illicit drug use in each state and territory within Australia.

The IDRS approach relies on the perceptions of expert individuals involved in and exposed to the illicit drug scene (both individuals who inject drugs and professionals working with these groups). Where possible, these reports are compared against secondary indicators. However, given the hidden nature of illicit drug use, the availability of reliable indicator data is often limited.

Further, the IDRS study principally gathers evidence on emerging trends among people in contact with drug treatment, health and other services (e.g. the IDU interviews are primarily conducted at Melbourne NSP). Since this population is not necessarily representative of all illicit drug users (e.g. those who do not routinely access such services, and recreational/non-dependent illicit drug users), the generalisability of the present results is limited. Another key limitation of the IDRS methodology is that it only describes drug use issues within metropolitan Melbourne and fails to provide a comprehensive picture of drug use issues across the whole state of Victoria. To provide such a comprehensive picture, the IDRS methodology would need to be expanded to regional areas of Victoria.

14.0 IMPLICATIONS

While the aim of the IDRS study is to monitor emerging trends in illicit drug use and related outcomes, it is not intended as a comprehensive and detailed investigation of illicit drug markets. The role of the Melbourne arm of the IDRS study is to identify yearly illicit drug use trends, and provide recommendations regarding key issues that warrant further monitoring and/or in-depth investigation.

The findings of the 2008 Melbourne IDRS study suggest the following priority areas:

1. Continued monitoring of illicit drug markets for trends in price, purity availability, patterns of drug use, and related outcomes.

The IDRS study has again demonstrated its value as an informative and reliable drug trend monitoring study. It provides comparable data relating to illicit drug use and related outcomes, in a timely and cost-effective manner. Data from recent years have highlighted the dynamic nature of the illicit drug markets in Melbourne and the need to monitor fluctuations and the way these may impact on patterns of drug use. For example, if the frequency of heroin use continues to increase, (a trend observed in 2008), patterns of drug use, and in turn health-related issues and treatment-seeking behaviours may change. The continued monitoring of illicit drug markets is therefore vital, and will add to our understanding of patterns of drug use and our ability to inform strategic policies and limit any associated harms.

2. Expansion of Victoria's routine drug trend monitoring, through new methods and new sentinel groups, to improve the understanding of intersecting drug markets and related outcomes.

The experience in Victoria and nationally has shown that the IDRS methodology can be extended to other sentinel groups of drug users for the purpose of monitoring trends in different market segments. For example, the IDRS drug trend monitoring methods have been successfully adapted for the purpose of exploring benzodiazepine use among IDU (Breen et al., 2003), and to explore patterns of drug use among party drug/psychostimulant users (Stoovè et al., 2005; Johnston et al., 2004). In 2006 the IDRS methodology was also adapted for a research study with at-risk young people living in Melbourne: the Youth Drug Reporting System (YDRS) Study. Expansion of core methods from existing monitoring systems to other important groups of drug users (e.g. new initiates to intravenous drug use) or drug market settings not currently included in such monitoring (e.g. rural/regional markets) should also be investigated. Further, the feasibility of incorporating new data collection methods such as web-based surveys (successfully implemented in the Victorian Psychostimulant Monitoring Project and the Cocaine Markets Study)¹⁶ might also be considered as a means of enhancing sampling and market coverage of existing core monitoring systems.

3. Further research to monitor the characteristics and impact of psychostimulant use in Melbourne, along with consideration of the impact of these drug types upon both health and law enforcement sectors.

Whilst the IDRS study is able to monitor trends in psychostimulant use among regular IDU, it cannot provide information on psychostimulant use and related outcomes among all sentinel groups of interest. The annual, national EDRS and the Cocaine Markets Study (completed in 2005) provide important additional information about these drug markets in other sentinel groups of drug users (i.e. REU, regular cocaine users). However, given

¹⁶ Johnston et al., 2004; Shearer et al., 2005.

the evidence among the IDRS sample of widespread use of methamphetamine (particularly speed and crystal meth/ice), and the anecdotal reports, particularly from KE, that the use of these drug types could be associated with negative effects (such as methamphetamine-related mental health issues and substance-related aggression), further research is required to gain a greater understanding of these drug types. In turn, health and law enforcement professionals working with drug-using populations may be required to develop informed strategies to manage people who may experience negative effects due to the use of these drugs.

4. Further research into drug-driving, particularly in regard to people's understanding of impairment and the circumstances in which they drive soon after taking illicit drugs.

In 2008, approximately 85% of those IDU participants who had driven a car during the past six months reported having driven soon after taking an illicit drug during that time. These IDU respondents reported most commonly driving after using heroin, cannabis or speed. Findings from this study suggest that there is not one particular group at risk of drug-driving, and across-the-board education about how different drugs affect driving ability should be provided to IDU. The insightful drug-driving research of Mallick et al. (2007) highlighted a need for further research examining user/public understanding of impairment and the circumstances in which they drive soon after taking illicit drugs, in addition to research examining the prevalence of drug-driving behaviour among specific drug-using groups, to help inform the development of effective education resources.

5. Research to explore the nature and extent of pharmaceutical drug use among IDU in Melbourne, and the health harms associated with pharmaceutical drug misuse.

There continues to be reports of diversion and injection of prescription and non-prescription pharmaceuticals by some IDU respondents. In particular, KE in 2008 highlighted the reportedly increasing trend of Unisom[®] use among Melbourne's IDU, with consequences including septic joints, endocarditis, cellulitis, deep vein thrombosis, abscesses and infection, noting that a number of local pharmacists were ceasing to stock the drug as a result. This issue was also covered by local media (Charrison, 2009). Given the continuing reports of diversion, misuse and injection of pharmaceuticals by some IDU respondents, and the associated harms specific to misuse of some pharmaceuticals, further research into patterns of use, and factors that would reduce the harms associated with the injection of these drug types, is needed.

6. Further research to gain a better understanding of the determinants of unsafe injecting and sex practices, particularly for those that increase the risk of BBVI (e.g. HIV, HCV and HBV).

In 2008, rates of needle/syringe and other equipment sharing reportedly increased, and injection-related health problems continue to be reported by both IDU and KE, with HCV carriage rates remaining unacceptably high. Ongoing emphasis on strategies to reduce the rates of needle/syringe and other injection equipment sharing is needed (particularly among some groups), and the development and dissemination of harm reduction resources should continue to be a priority.

Since 1997, the Melbourne arm of the national IDRS study has proven to be a reliable, cost-effective and informative mechanism for the monitoring of illicit drug trends in Victoria. It yields data that are comparable from year-to-year and across jurisdictions, and it is a study that has much to offer health and law enforcement sectors in their efforts to respond more effectively to illicit drug trends.

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