Australian

Capital Territory

Kerryn Butler and Lucy Burns

ACT DRUG TRENDS 2013

Findings from the

Illicit Drug Reporting System (IDRS)

Australian Drug Trends Series No. 111

AUSTRALIAN CAPITAL TERRITORY

DRUG TRENDS

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Please note that as with all statistical reports there is the potential for minor revisions to data in this report over its life.

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ABBREVIATIONS

ABCI	Australian Bureau of Criminal Intelligence
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ACTGAL	Australian Capital Territory Government Analytical Laboratory
ACC	Australian Crime Commission
ADDInc	Assisting Drug Dependents Incorporated
AGDH&A	Australian Government Department of Health and Ageing
ADP	Alcohol and Drug Program, ACT Health
AFP	Australian Federal Police
AIHW	Australian Institute of Health and Welfare
ATS	amphetamine-type stimulants
AUDIT	Alcohol Use Disorders Identification Test
BBVI	blood-borne viral infections
BPI	Brief Pain Inventory
CI	confidence intervals
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders IV
FTND	Fägerstrom Test for Nicotine Dependence
GP	general practitioner
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IDRS	Illicit Drug Reporting System
IRID	injection-related injuries and diseases
KE	key expert(s)
K10	Kessler Psychological Distress Scale
LOC	loss of consciousness

MCS	mental component score
MSIC	Medically Supervised Injecting Centre
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NNDSS	National Notifiable Diseases Surveillance System
NSP	Needle and Syringe Program
OST	opioid substitution treatment
OTC	over the counter
PO	pharmaceutical opioids
PWID	people who inject drugs
SCON	Simple Cannabis Offence Notices
SDS	Severity of Dependence Scale
SF-12	Short Form 12-Item Health Survey
SPSS	Statistical Package for the Social Sciences

GLOSSARY OF TERMS

Cap	Small amount, typically enough for one injection.
Daily use	Use occurring on each day in the past six months, based on a maximum of 180 days.
Diverted/diversion	Selling, trading, giving or sharing of one's medication to another person, including through voluntary, involuntary and accidental means.
Eight-ball	3.5 grams
Half-weight	0.5 grams
Illicit	Illicit obtainment refers to pharmaceuticals obtained from a prescription in someone else's name, e.g. through buying them from a dealer or obtaining them from a friend or partner. The definition does not distinguish between the inappropriate use of prescribed pharmaceuticals, such as the injection of methadone syrup or benzodiazepines, and appropriate use.
Licit	Licit obtainment of pharmaceuticals refers to pharmaceuticals (e.g. methadone, buprenorphine, morphine, oxycodone, benzodiazepines, antidepressants) 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 bought on the street or those prescribed to a friend or partner.
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: injecting, smoking, snorting and/or swallowing.
Point	0.1 grams
Recent injection	Injection (typically intravenous) on at least one occasion 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.

EXECUTIVE SUMMARY

Common terms throughout the report:

- **People who inject drugs (PWID):** people who have injected a drug on six or more separate occasions in the previous six months
- **Recent use:** used at least once in the previous six months
- **Sentinel group:** a surveillance group that points toward trends and harms
- **Median:** the middle value of an ordered set of values
- **Mean:** the average
- **Frequency:** the number of occurrences within a given time period.

KEY FINDINGS FROM THE 2013 IDRS

The Illicit Drug Reporting System (IDRS) is intended to serve as a monitoring system, identifying emerging trends of local and national concern in illicit drug markets. The IDRS consists of three components: interviews with a sentinel group of people who regularly inject drugs (PWID[1]) conducted in the capital cities of Australia; interviews with key experts (KE), professionals who have regular contact with illicit drug users through their work; and analysis and examination of indicator data sources related to illicit drugs. *Australian Drug Trends 2012* draws largely on the PWID participant survey and indicator data components of the IDRS, while KE are relied upon to provide contextual information within jurisdictions. As such, this information is reported more fully in the individual state/territory reports, to which the reader is also referred.

DEMOGRAPHICS OF THE PARTICIPANT SAMPLE

One hundred participants were recruited to the 2013 IDRS ACT participant survey component. The mean age of the ACT sample was 40 years (range 20–62 years) and 71% were male. Almost the entire sample spoke English as their main language at home (99%), and almost a quarter (23%) identified as being of Aboriginal and/or Torres Strait Islander descent. More than four-fifths (82%) of the sample were currently unemployed, almost two-thirds (63%) reported a previous prison history and over half (58%) were in current treatment, mainly methadone.

CONSUMPTION PATTERN RESULTS

Current drug use

- The mean age of first injection was 18 years. The drug most often reported as the first drug injected was heroin (49%) followed by methamphetamine (46%).
- Heroin was nominated by over half (58%) of the sample as their drug of choice, followed by methamphetamine and cannabis.
- The drug injected most often in the last month broadly followed the same pattern. Fifty-five percent of the sample reported injecting heroin most often in the last month, followed by methamphetamine (39%).

[1] The term 'participants' is used throughout the report to refer to the IDRS participant sample. Participants completing the key expert survey are referred to as KE, or key experts (see Glossary).

- Thirty-seven percent of participants reported daily injecting.

Heroin

- In 2012, heroin remained the drug of choice for the majority of participants.
- Seventy-five percent had used heroin in the previous six months, stable from 2011 (79%).
- Median days of heroin use in the preceding six months was 50 days (approximately 2 days per week.

Methamphetamine

- The IDRS distinguishes between methamphetamine powder ('speed'), methamphetamine base, and crystal methamphetamine ('ice' or 'crystal').
- The vast majority (87%) of participants reported using some form of methamphetamine at least once in their lifetime and two-thirds (66%) reported recent use, in the past 6 months.
- Crystal methamphetamine remains the most common form used with 61% of the sample reporting recent use. Almost a quarter of participants nominated crystal as their drug of choice, significantly more than 2012.

Cocaine

- A significantly smaller proportion of participants reported lifetime use of cocaine compared with 2012: 54% in 2013 vs 71% in 2012.
- The recent use of cocaine remained low in the ACT with 16% reporting use in the preceding six months. The median days of use also remains low at three and a half days, ranging from one to ten days.

Cannabis

- Seventy-five percent of PWID reported recent cannabis use in 2013 (81% in 2012).
- Cannabis was the most common illicit drug used the day prior to interview (61%).
- Median days of cannabis use in the six months preceding interview was 180.
- A significant decrease in the proportion of participants reporting recent use of bush was observed.

Other opioids

- Around half (55%) of the sample reported recent use of methadone (any form) and around one-quarter (28%) reported recently injecting. Recent use of illicit methadone remains stable at 25%.
- Nineteen percent of the sample reported recent use of buprenorphine (any form).
- A fifth (21%) of the sample reported recent use of buprenorphine-naloxone (any form).
- Almost a quarter (23%) reported recently using illicit morphine on a median of six days in the past 6 months.
- Seventeen percent of the sample reported recently using illicit oxycodone. The most common brand used is Oxycontin®.

Other drugs

- A significantly smaller proportion of participants reported the lifetime use of ecstasy compared with 2012 (42% in 2013 vs 70% in 2012).
- A similar pattern is observed with the report of lifetime use of hallucinogens. (40% in 2013 vs 77% in 2012).
- Benzodiazepine and alprazolam use remains stable with 46% recently using any form of benzodiazepine (any form) and 21% reporting recently using alprazolam (any form).
- Use of pharmaceutical stimulants remains low with 7% using any form recently on a median of 5 days in the past 6 months.
- The lifetime use of Seroquel® was reported by 34% of the sample; 18% reported recently using Seroquel®.
- Lifetime use of inhalants was reported by 18% of the sample; however, no participants reported using inhalants in the last six months.
- Sixty-one percent of the sample reported recent alcohol use with 34% of those being daily drinkers.
- As in previous years, tobacco was widely used among the 2013 sample, with 89% having used it in the preceding six months.

DRUG MARKET: PRICE, PURITY, AVAILABILITY AND PURCHASING PATTERNS

Heroin

- Price for heroin remained stable at $50 per cap and $300 per gram. A significantly higher proportion of respondents indicated that heroin had been difficult to obtain although the majority (75%) reported it was very easy or easy to obtain. A significantly smaller proportion reported the availability to have remained stable with 28% reporting it had become more difficult to obtain over the past 6 months. Sixty-three percent of those who commented reported that the current purity of heroin was low, significantly more than in 2012. Accordingly a significant increase in the proportion of respondents reporting the purity was decreasing was observed.

Methamphetamine

- The price for speed has remained stable with reports of one point costing $50 with very small numbers able to comment on the price of base. The price of crystal has also remained stable at $100 for one point. There have been no significant differences in either the availability or reported purity of speed or base over the past 6 months; however, a significant increase in the proportion of respondents reporting purity of crystal to be medium was seen.

Cocaine

- Small numbers were able to comment on the price, purity, availability and purchasing of cocaine. The price of a gram and a cap of cocaine were $350 and $50 respectively. The majority of those who commented reported the availability of cocaine to be difficult.

Cannabis

- The median cost of a gram of hydroponic cannabis was $20, while the median cost of an ounce of hydroponic cannabis was $300. Price for both forms of cannabis (bush and hydroponic) was reported as 'stable' over the last six months. Participants reported the potency of hydro as 'high' and bush 'medium'. This remained stable over the last six months. The availability of both forms of cannabis was considered 'very easy' or 'easy' to obtain.

Methadone

- The majority of those who commented reported the price of 'illicit' methadone syrup to be a median of $1 per millilitre. The majority of respondents reported the availability to be easy (44%) and very easy (22%), with most reporting the availability to have remained stable over the past 6 months.

Buprenorphine

- Only very small numbers commented on the price, purity and availability of buprenorphine in the ACT. Availability was reported to be very easy (33%) and easy (50%) and that this had remained stable over the past six months.

Buprenorphine-naloxone

- Only two participants were able to comment on the price and availability of illicit buprenorphine-naloxone (Suboxone®). As such, median price and availability will not be reported for the ACT for 2013. Please see the National IDRS report for further information.

Morphine

- Small numbers commented on the price, purity and availability of morphine in the ACT with prices and availability remaining stable from 2012.

Oxycodone

- Only small numbers were able to comment on the prices of illicit oxycodone with all reporting the price had remained stable over the previous 6 months.

HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

Overdose and drug-related fatalities

- Twenty-three percent of participants reported having overdosed on heroin in the 12 months prior to interview.

- More than two-thirds of participants (70%) had heard of the take-home naloxone program in ACT with a third reporting they had completed the training in naloxone administration and obtained a prescription.

- Non-heroin overdoses accounted for significantly more call-outs compared to the previous reporting period. Heroin overdoses continue to represent only a small number of the total number of ambulance call-outs to overdoses.

Drug Treatment

- Fifty-eight percent of participants reported being currently in treatment with 44% of the sample engaged with methadone treatment.

Hospital separations

- The number of opioid-related hospital separations continues a downward trend for a third year in a row with 102.7 admissions per million being reported for the 2010–11 period. Separations relating to methamphetamines continue to remain stable at 48.9 per million admissions.

Injecting risk behaviours

- Needle and Syringe Programs were by far the most common source of needles and syringes in the preceding six months (88%), followed by chemists (23%). Receptive sharing ('borrowing') of needles/syringes was reported by 6% of participants in the month preceding interview, usually with a close friend.
- The majority of IDRS participants reported last injecting in a private location (83%), with smaller proportions last injecting in a public location such as in a public toilet, on the street or in a car. Half (53%) of the IDRS sample experienced an injection-related problem in the preceding month, most commonly significant scarring or bruising and difficulty injecting (e.g. in finding a vein).

Blood-borne viral infections

- In Australia, hepatitis C virus (HCV) continued to be more commonly notified than hepatitis B virus (HBV). The prevalence of human immunodeficiency virus (HIV) among those people who inject drugs in Australia has also remained stable at relatively low rates over the past decade, with HCV more commonly reported.

Alcohol Use Disorders Identification test - consumption

- Sixty-one percent of males and 43% females scored 5 or more on the AUDIT-C, indicating the need for further assessment.

- The mean score on the AUDIT-C was 5.6 among those who drank alcohol recently.

Mental health problems and psychological distress

- Thirty-six percent of the IDRS sample self-reported a mental health problem in the preceding six months, most commonly depression (56% of respondents) and/or anxiety (25%).
- A significantly larger proportion of those who had experienced a problem reported attending a mental health professional compared to 2012 (49% in 2012 vs 81% in 2013).

- Seventy-five percent of participants who reported experiencing a mental health problem had been prescribed medication for this problem during the past six months. A significant decrease in the proportion of participants reporting using benzodiazepines was seen (80% in 2012 down to 37% in 2103).
- Higher levels of psychological distress, as measured by the Kessler Psychological Distress Scale (K10), were reported by the IDRS sample compared to the Australian general population, with 32% reporting 'high' distress (7% in the general population) and 17% reporting 'very high' distress (2% in the general population). Those reporting a 'very high' level of distress have been identified as possibly requiring clinical assistance.
- IDRS had significantly lower mental and physical component scores compared to the Australian population on the Short Form 12-item Health Survey (SF-12).

Driving risk behaviour

- Driving with an alcohol content above the prescribed legal limit for driving was reported by 9% of participants who had driven in the preceding six months. Eighty-three percent of recent drivers reported driving soon after taking an illicit drug during that time (mainly heroin). The median time between taking drugs and driving was 30 minutes (range=1–360 mins).

LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

Reports of criminal activity

- Participant reports of criminal activity remained stable compared to previous years, with 32% of the sample reporting engagement in criminal behaviour in the preceding month. The most common types of crime committed were drug dealing and property crime.

Arrests

- Twenty-three percent of the sample reported having been arrested in the preceding 12 months.
- Cannabis arrests continued to account for the majority of all drug-related arrests in Australia.

Expenditure on illicit drugs

- Among the sample who commented, 59% reported spending money on illicit drugs the day before interview. The median amount spent by those who had purchased drugs was $80.

SPECIAL TOPICS OF INTEREST

Pharmaceutical opioids

- Forty-nine percent of the sample recently used pharmaceutical opioids such as methadone and oxycodone.
- Of those who recently used pharmaceutical opioids, 39% reported using them for pain relief.

Brief Pain Inventory

- Nine percent of the sample reported experiencing pain (other than everyday pain) in the last seven days. The majority of pain was reported to be chronic non-cancer pain (73% of those who commented) followed by chronic cancer pain (18% of those who commented).

Stimulant and opioid dependence

- Of those who recently used a stimulant drug (mainly methamphetamine) and commented, the median SDS was 2.0, with 45% scoring four or above indicating dependence.
- Of those who recently used an opioid drug (mainly heroin) and commented, the median SDS score was 7.0, with 78% scoring five or above indicating presence of dependence.

Opioid substitution treatment medication injection.

- Twenty-seven percent of participants reported recently injecting methadone, 12% reported recently injecting buprenorphine, and 4% injected buprenorphine-naloxone film and 4% buprenorphine-naloxone tablets.

Hepatitis C testing and treatment

- Ninety-seven percent of the sample reported having been tested for HCV with 63% reporting a positive result for antibodies. Of those who tested positive to antibodies 59% reported having further testing or follow up. Further tests include PCR tests to see if the virus is active (65%) and PCR viral genotype test to determine which strain of infection was present (73%).

Discrimination

- Forty-three percent of the sample reported having experienced discrimination in the last 12 months. The main locations where discrimination had taken place were reported to be at a pharmacy (by 39%), by police (34%) and at a hospital (27%).

1 INTRODUCTION

The Illicit Drug Reporting System (IDRS) monitors trends in the illicit drug market in Australia. The IDRS was implemented nationally in Australia, following a successful pilot study in Sydney in 1996 (Hando, O'Brien, Darke et al., 1997) and trials in New South Wales, Victoria and South Australia in 1997 (Hando and Darke, 1998). In the year 2000, the IDRS study was carried out in all Australian states and territories, with each jurisdiction conducting a survey with people who inject drugs (PWID), interviewing key experts (KE) and incorporating routinely collected indicator data from secondary sources. The IDRS is conducted annually in each Australian state and territory.

The IDRS triangulates three forms of data: (a) a survey of approximately 100 PWID; (b) interviews with KE, with expert knowledge of drug markets; and (c) indicator data sources relating to illicit drug trends in the Australian Capital Territory (ACT). In 2012, the IDRS was funded by the Australian Government Department of Health and Ageing (AGDH&A). The authors would like to acknowledge this organisation for continuing to fund this critical project.

This *ACT Drug Trends 2013* report presents findings from the 2013 ACT IDRS study. The report commences with a summary of the methodology used in data collection for the IDRS, and then provides an overview of the demographics of the PWID respondents. This is followed by an outline of the current drug use and consumption patterns of the PWID sample. The report also presents findings on recent drug use trends pertaining to the price, purity, availability and purchasing patterns of heroin, methamphetamine, cocaine, cannabis and other drugs. The report then discusses harms associated with injecting drug use, as well as mental health issues, drug driving and criminal activity among the 2013 PWID sample.

1.1 Study aims

The IDRS is designed to act as a strategic early warning system to monitor trends and issues emerging from illicit drug markets in Australia. The first aim of the IDRS is to collect data to monitor the price, purity, availability and use of four major illicit drug classes – heroin, methamphetamine, cocaine and cannabis. The IDRS supplements existing sources of data on illicit drug trends, and thus supports a multifaceted approach to the task of monitoring the Australian illicit drug market. The second aim of the IDRS is to highlight issues of concern in relation to drug trends that may require further investigation.

2 METHOD

In order to document emerging trends in the illicit drug market, the IDRS triangulates three data sources: (a) a survey of PWID; (b) a semi-structured interview with KE working as professionals in the drug field; and (c) the collection of routine indicator data that provide information on illicit drug trends and other drug-related issues. These data sources are triangulated against each other to determine if the information obtained is valid, and are then compared to the results of previous years to detect the emergence of trends.

2.1. Survey of people who inject drugs

In July of 2013, a structured interview was administered face to face to 100 current PWID in the ACT. The interview collected information on the demographic characteristics and drug use history of the sample, as well as the price, purity and availability of heroin, methamphetamine, cocaine and cannabis. Survey items included demographics, drug use history, market characteristics (including price, perceived purity and perceived availability) of the main drugs investigated by the IDRS, health-related trends associated with drug use (including injection-related harms, risk behaviours, overdose and mental health) and law enforcement-related harms associated with drug use (including recent criminal activity and perceptions of police activity). In 2013, amendments were made to the questionnaire in an attempt to collect more detailed information on: the knowledge and perceptions PWID have concerning hepatitis C infection, exposure to discrimination, and the oral health of PWID.

The IDRS interviews were conducted by NDARC research staff and took approximately one hour to administer. Participants were recruited through Directions ACT (an organisation that provides a Needle and Syringe Program (NSP) in the ACT) and the Canberra Alliance for Harm Minimisation and Advocacy. Posters were placed at Directions ACT asking potential participants to come to Directions ACT to be screened (according to the selection criteria which required participants to have injected at least monthly in the past six months, to have lived in the ACT for the previous 12 months, and be at least 17 years of age) and, if they were eligible, make an appointment for the next week. Participants were reimbursed $40 for their time. Ethics approval for the ACT arm of the IDRS was obtained from the University of New South Wales ethics committee.

2.2. Survey of key experts

Between August and November 2013, professionals were interviewed as KE for the IDRS. As criteria for study entry, KE had had contact with a minimum of 10 different PWID in the six months prior to interview. All interviews were conducted over the phone and took approximately 20–40 minutes to administer. The interview included sections on: the demographic characteristics of illicit drug users; patterns of use; price, purity and availability of the different drugs; criminal and police activity; and health and treatment issues. Where KE comments are not reported in a chapter, this is due to low numbers reporting on a specific drug.

2.3. Other indicators

Data collected from PWID surveys and KE interviews were supplemented by routinely collected Australian indicator data sources relating to illicit drug use and other drug-related issues. The entry criteria for indicator data are listed below.

- The data should be available at least annually.
- The data should include 50 or more cases.
- The data should provide details of illicit drug use.
- The data should be collected in the main study site (i.e. the ACT).
- The data should include details on at least one of the four main illicit drugs under investigation.

The indicator data sources meeting the above criteria included in the 2013 IDRS study are described below.

- **Purity of drug seizures**. In 2013, the Australian Crime Commission (ACC) provided data on the median purity of illicit drug seizures made by local police in the ACT. This report presents the purity of drug seizures from the 2001–02 financial year to 2011–2012.

- **Number and weight of drug seizures**. Data on the number and weight of drug seizures made by ACT local police were provided by the ACC. Data includes number of seizures and amount seized in grams from 2001–02 to 2011–2012, by each drug type.

- **Drug-specific arrests**. The ACC provided data on the number of consumer (user-type offences) and provider (supply-type offences) arrests made by the Australian Federal Police (AFP) and ACT local police. This report provides the number of arrests for each drug type from 2001–02 to 2011–2012.

- **Simple Cannabis Offence Notices (SCON)**. Data for this report on the number of SCON issued in the ACT from 2001–02 to 2011–2012 were provided by the ACC.

- **Drug withdrawal services**. The number of clients participating in detoxification programs with the Arcadia House Withdrawal Centre is presented by quarter, for each drug type from 2001–02 to 2011–12. Assisting Drug Dependents Incorporated (ADDInc) provides these data.

- **Overdoses**. The number of overdoses in the ACT attended by the ACT Ambulance Service is presented. The data are provided by ACT Ambulance Service and include the number of heroin overdoses per financial year and quarter 2001–02 to 2012–2013.

- **Hospital admissions**. The 2012 IDRS study includes data on the number of hospital admissions due to opioids, methamphetamines and cannabis among those aged 15 to 54 years from 2001–02 to 2011–2012. These data are provided by the Australian Institute of Health and Welfare (AIHW) and ACT Health.

- **Blood-borne viral infections surveillance data**. Data pertaining to the prevalence of blood-borne viral infections (BBVI) in the ACT are derived from the National Notifiable Diseases Surveillance System (NNDSS) (National Notifiable Diseases Surveillance System, 2012), and the *Australian NSP Survey National Data Report 1995–2010* provided by the Kirby Institute (previously known as the National Centre in HIV Epidemiology and Clinical Research) (The Kirby Institute, May 2011) .

2.4. Data analysis

Analyses were conducted using the Statistical Package for the Social Sciences (SPSS) for Windows, Version 21.0. The data collected in 2013 was compared with data collected from comparable samples of PWID from 2000 onward, recruited as part of the IDRS. As each of these samples was recruited using the same methods, meaningful comparisons can be made. Further analysis was conducted on the main drugs of focus in the IDRS to test for significant differences between 2012 and 2013 for recent use, purity and availability. Confidence intervals (CI) were calculated using an Excel spreadsheet available at http://www.cebm.net/index.aspx?o=1023 (Tandberg). This calculation tool was an implementation of the optimal methods identified by Newcombe (Newcombe, 1998). Significance testing using the Mann-Whitney U calculation was used to compare 2011 and 2012 median days of use for the major drug types discussed.

3 DEMOGRAPHICS

3.1. Overview of the IDRS participant sample

A total of 100 regular PWID were interviewed in the ACT in 2013. The demographic characteristics of the sample are summarised in Table 1 below. In 2013, the mean age of the sample was 40 years (range=20–62 years, SD=8.93), and 71% were male. There was no significant difference between the mean age of male and female respondents. Almost all (99%) of the respondents reported English as the main language spoken at home and 23% identified as Aboriginal and/or Torres Strait Islander. The majority of participants reported that they were single (55%), were married/in a de facto relationship (23%), or had a partner (13%). In 2013, only 5% of participants were 25 years old or below.

The mean number of formal school years completed was 10 (range=6–12 years, SD=1.68). Forty-two percent of participants reported that they had trade or technical qualifications, and 9% reported that they had university or other tertiary qualifications. Eighty-two percent of participants interviewed in 2013 were unemployed (77% in 2012), 8% were currently employed full time (13% in 2012) and 9% were employed on a casual or part-time basis (6% in 2012). The vast majority of respondents (77%) reported living in a privately owned or rented house or flat, with 10% of respondents reporting to have no fixed address. Almost two-thirds (63%) of participants reported that they had a prison history (43% in 2012).

Fifty-eight percent of participants indicated that they were currently involved in some form of drug treatment. The most common form of drug treatment was methadone maintenance treatment, with a further 13% of participants engaged in both buprenorphine and/or buprenorphine-naloxone maintenance treatment. The median length of time participants had been participating in their current treatment was 36 months (range=1 month to 26 years). Of those respondents currently in treatment, only 42% had been engaged in treatment for six months or more, with the majority (58%) participating in their current treatment for six months or less.

Table 1: Demographic characteristics of the PWID sample, 2012–2013

	2012 N=99	**2013 N=100**
Age (mean years)	40	**40**
School education (mean years)	10	**10**
Sex (% male)	65	**71**
Heterosexual (%)	92	**93**
Relationship status (%)		
Single	60	**55**
Partner	17	**13**
Married/de facto	17	**23**
Separated	1	**5**
Divorced	4	**3**
Widowed	1	**1**
Accommodation (%)		
Own house/flat (includes renting)	89	**77**
Parent's/family house	2	**9**
Boarding house/hostel	6	**2**
Shelter/refuge	1	**2**
No fixed address/homeless	2	**10**
Employment (%)		
Not employed	77	**82**
Full-time	13	**8**
Part-time/casual	6	**9**
Home duties	1	**0**
Full time student	2	**1**
Income per week (mean)	$452	**$452**
English main language spoken at home (%)	97	**99**
Aboriginal and/or Torres Strait Islander (%)	15	**23**
Tertiary education (%)		
None	37	**49**
Trade/technical	45	**42**
University/college	16	**9**
Currently in drug treatment (%)	54	**58**
Methadone maintenance (%)	40	**44**
Buprenorphine maintenance (%)	6	**2**
Buprenorphine-naloxone (%)	6	**11**
Prison history (%)	43	**63**

Source: ACT IDRS PWID interviews, 2012–2013

4 CONSUMPTION PATTERNS

4.1. Current drug use

The injection histories of participants in the 2012 and 2013 samples are summarised in Table 2. The mean age of first injection was 18 years (range=12–45 years, SD=6.36). The first drug respondents report ever injecting was heroin (49%), followed by methamphetamine (46%).

Heroin was nominated as the drug of choice for the majority of participants (58%) in 2013; the same proportion as reported in 2012. In 2013, the percentage of respondents nominating ice as their drug of choice increased to 22% (10% in 2012). This is a significant increase (22% vs 10% in 2012, $p<0.05$) Five percent of respondents nominated speed as their drug of choice, a decrease from 14% in 2012. Overall, 27% of participants nominated methamphetamine (in any form) as their drug of choice in 2013, remaining stable from 2012 (24%). Cannabis was nominated as drug of choice by 9% of participants.

Heroin was the drug injected most often in the month prior to the interview (55%) and was the last drug injected by 48% of respondents. A small increase in the proportion of participants nominating ice as the drug most often injected in the last month was observed with 26% in 2013 compared to 16% in 2012 and a small decrease was also seen in those reporting speed being the drug most often injected in the past month from 16% in 2012 to 8% in 2013. Both the increase in ice and the decrease in speed are not statistically significant.

In 2013, 26% of the sample reported a discrepancy between their drug of choice and the drug they injected most often in the previous month. Of those that reported a discrepancy (n=26), most respondents reported that this was due to availability (19%), price (19%), being in drug treatment (8%), or their drug of choice being a non-injectable (15%). Other reasons included dependence-related reasons.

Table 2: Injection history, drug preferences and polydrug use of PWID, 2012–2013

	2012 N=99	**2013** **N=100**
Age first injection (mean years)	19	**18**
First drug injected (%)		
Heroin	37	**49**
Methamphetamine	52	**46**
Cocaine	3	**2**
Methadone	0	**0**
Other opioids	0	**1**
Other	4	**2**
Drug of Choice (%)		
Heroin	58	**58**
Methamphetamine - powder (speed)	14	**5**
Methamphetamine - base	0	**0**
Methamphetamine - crystal	10	**22**↑
Cocaine	0	**1**
Methadone	4	**1**
Cannabis	7	**9**

Other	7	**2**
Drug injected most often last month (%)		
Heroin	49	**55**
Methamphetamine -powder (speed)	19	**8**
Methamphetamine - base	0	**0**
Methamphetamine - crystal	16	**26**
Methadone	7	**4**
Subutex/buprenorphine	7	**2**
Other / have not injected in last month	2	**5**
Most recent drug injected (%)		
Heroin	49	**48**
Cocaine	0	**0**
Methamphetamine -powder (speed)	16	**8**
Methamphetamine - base	0	**0**
Methamphetamine - crystal	20	**31**
Methadone	5	**5**
Subutex/buprenorphine	6	**3**
Morphine	1	**1**
Other	3	**4**

Source: ACT IDRS PWID interviews, 2012–2013
↓↑ Statistical significance $p<0.05$

The frequency of injection reported by participants from 2009 to 2013 is presented in Table 3. In 2013, more than a third (37%) of the sample reported an injection frequency of once per day (27%), two or three injections per day (9%), or more than three injections per day (1%). This pattern is different from recent years in that the proportion of PWID reporting '2–3 times daily or more' has decreased and those that report 'daily' injections have seen a corresponding increase.

Table 3: Frequency of injection among PWID in the ACT, 2009–2013

	2009	2010	2011	2012	2013
Frequency (%)	N=100	N=101	N=98	N=99	**N=100**
Weekly or less	20	20	24	18	**25**
Daily–weekly	35	36	35	40	**38**
Daily	21	20	19	15	**27**
2–3 times daily	21	18	19	22	**9**
More than 3 times a day	3	6	4	4	**1**

Source: ACT IDRS PWID interviews, 2000–2013

POLYDRUG USE

As in previous years, the IDRS participants sampled were polydrug users. Table 4 and Table 5 show the prevalence of drug use by the ACT sample in the past six months for the most commonly used drugs investigated by the IDRS. Use of tobacco, cannabis, methamphetamine (any form) and heroin are all common. Substantial proportions of the sample reported recent use of three of the four main drugs monitored by the IDRS: heroin (75%); cannabis (75%); and methamphetamine (any form; 66%).

Key findings are discussed by relevant drug type (heroin, methamphetamine, cocaine, cannabis, other opioids, other drugs) in the sections that follow.

FORMS OF DRUGS AND ROUTE OF ADMINISTRATION USED IN PRECEDING SIX MONTHS

Participants were asked what forms of the main drug types they had used in the six months preceding interview and which form they had used most during that time. Route of administration for each drug is also recorded. Table 4 and Table 5 depict the proportion of participants who reported having used different forms of drugs in the preceding six months and the route of administration used.

Key expert comments

Demographics reported by KE of PWID that they had contact with were consistent with PWID reports.

KE reported that polydrug use was common and often problematic. Polydrug use was commonly associated with cannabis and alcohol.

KE mainly reported the use of heroin, crystal, cannabis and alcohol use. The use of prescription drugs was also frequently reported.

Table 4: Drug use in the six months preceding interview, ACT, 2013

Drug class	Ever used %	Ever injected %	Injected last 6 months %	Median days injected last 6 months	Ever smoked %	Smoked last 6 months %	Ever snorted %	Snorted last 6 months %	Ever swallow %	Swallow last 6 months %	Used^ last 6 months %	Median days used^ last 6 months %
Heroin	92	92	73	50	33	4	9	2	11	1	75	50
Homebake heroin	50	48	15	6	2	1	3	0	3	1	15	6
Any heroin (inc. homebake)	*92*	*92*	*73*	*50*	*34*	*4*	*11*	*2*	*12*	*2*	*75*	*72*
Methadone (prescribed)	63	27	12	36					57	40	44	180
Methadone (illicit)	49	35	18	4.5					23	10	25	5
Physeptone (prescribed)	15	6	1	1					13	6	6	12.5
Physeptone (illicit)	24	18	4	4					10	2	6	4
Any methadone (incl. physeptone)	*24*	*48*	*28*	*11*					*64*	*44*	*55*	*180*
Buprenorphine (prescribed)	25	12	0	-					20	4	4	180
Buprenorphine (illicit)	34	27	12	18					12	4	16	11
Buprenorphine-naloxone tablet (prescribed)	14	5	0	-					11	2	2	126
Buprenorphine-naloxone tablet (illicit)	21	17	8	27					9	3	9	6
Buprenorphine-naloxone film (prescribed)	17	1	1	180					17	11	11	90
Buprenorphine-naloxone film (illicit)	10	3	1	6					6	3	6	4.5
Morphine (prescribed)	18	12	4	7.5					9	4	6	52
Morphine (illicit)	53	46	20	6	2	1	1	0	17	10	23	6
Oxycodone (prescribed)	9	5	2	75	2	0	1	0	7	4	4	135
Oxycodone (illicit)	42	36	17	6					12	2	17	6
OTC codeine	17	1	1	6					16	9	10	9.5
Other opiates (not elsewhere classified)	28	4	1	10					27	11	11	12
Speed powder	63	59	28	5.5	13	3	20	1	18	2	29	6
Amphetamine liquid	16	16	3	24	0	0	0	0	3	0	3	24
Base/point/wax	26	25	5	2	2	0	2	0	5	1	6	4
Ice/shabu/crystal	76	73	59	30	28	16	5	1	6	3	61	32
Any form of (meth)amphetamine	*87*	*83*	*64*	*32*	*30*	*16*	*21*	*1*	*25*	*5*	*66*	*44*

Table 5: Drug use in the six months preceding interview, ACT, 2013

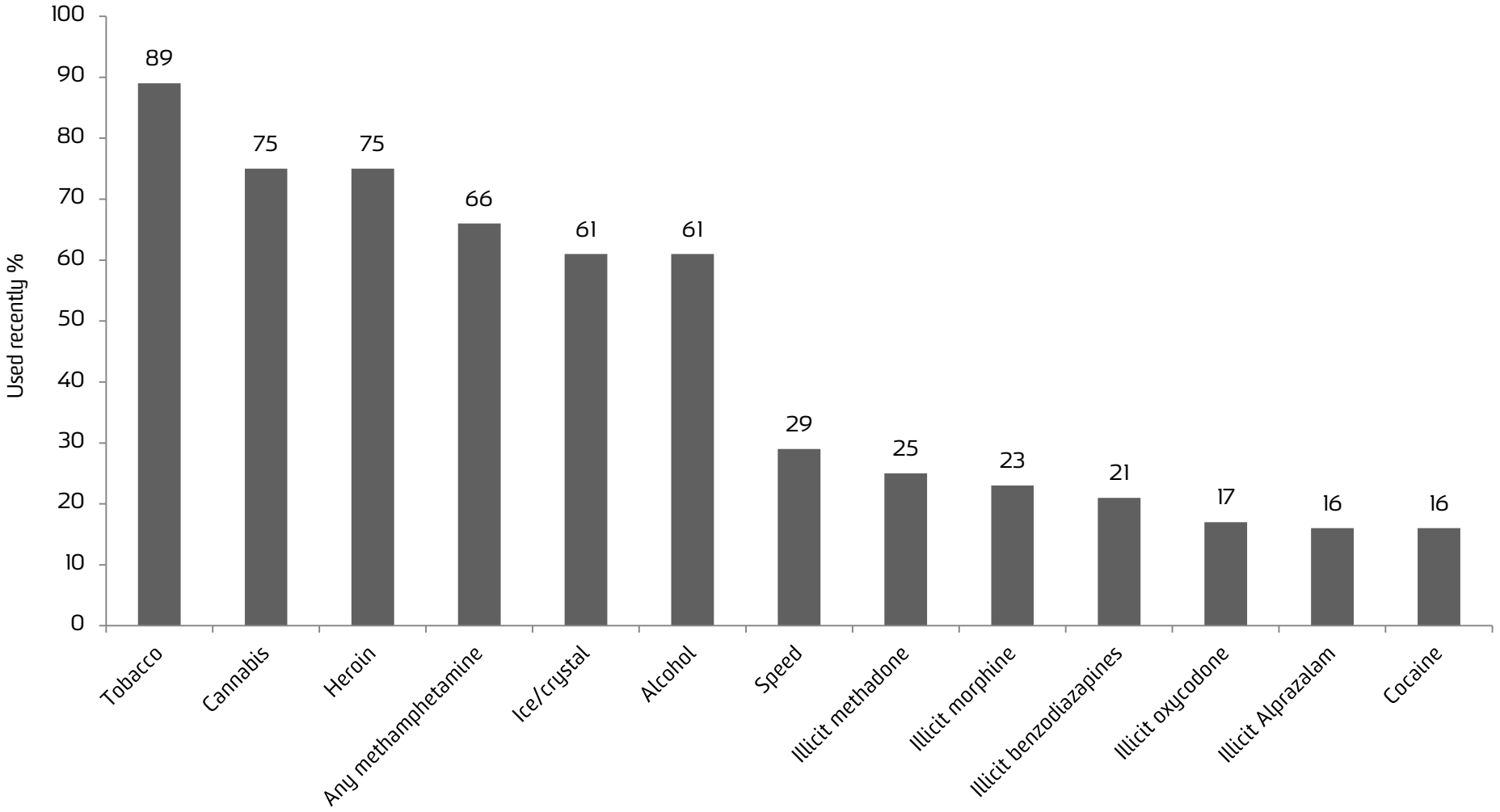
Drug class	Ever used %	Ever injected %	Injected last 6 months %	Median days injected last 6 months	Ever smoked %	Smoked last 6 months %	Ever snorted %	Snorted last 6 months %	Ever swallow %	Swallow last 6 months %	Used^ last 6 months %	Median days used^ last 6 months %
Pharmaceutical stimulants (prescribed)	12	5	1	90					10	2	2	145
Pharmaceutical stimulants (illicit)	25	19	4	3.5					17	5	7	5
Any form of pharmaceutical stimulants	*31*	*22*	*4*	*3.5*	-	-	-	-	*23*	*6*	*8*	*6*
Cocaine	53	42	12	2.5	7	2	28	6	4	0	16	3.5
Hallucinogens	40	4	0	0	2	0	1	0	39	5	5	3
Ecstasy	43	21	3	1	2	0	3	0	37	3	6	1.5
Alprazolam (prescribed)	13	3	0	-					12	6	6	180
Alprazolam (illicit)	25	3	1	10					24	16	16	6
Any alprazolam	*32*	*4*	*1*						*32*	*21*	*21*	
Seroquel (prescribed)	19	1	0	-					19	9	9	60
Seroquel (illicit)	24	1	0	-					23	12	12	9.5
Any Seroquel	*34*	*2*	*0*	-					*34*	*18*	*18*	*27*
Benzodiazepines, other (prescribed)	42	1	0	-					42	30	30	180
Benzodiazepines, other (illicit)	33	4	1	6					30	20	21	7
Any form of benzodiazepines, other	*64*	*8*	*1*						*66*	*46*	*46*	
Alcohol	83	2	0	-	-	0	-	-	83	61	61	24
Cannabis	91	-	-	-	88	74	0	0	25	5	75	180
Tobacco	93	-	-	-			-	-		-	89	180
Steroids	5	5	2	24					1	0	2	102
Fentanyl	18	13	8	8					5	3	11	5
Synthetic cannabinoids	6				6	5	0	0	0	-	5	1

Source: ACT IDRS interviews, 2013

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

* Among those who had used/injected, # Category includes speed powder, base, ice/crystal and amphetamine liquid (oxblood). Does not include pharmaceutical stimulant

Figure 1: Drug use in the six months preceding interview, ACT, 2013



Source: ACT IDRS PWID interviews, 2013.

4.2. Heroin

Key points

- In 2012, heroin remained the drug of choice for the majority of participants.
- 75% had used heroin in the previous six months, stable from 2011 (79%).
- Median days of heroin use in the preceding six months was 50 days (approximately 2 days per week.

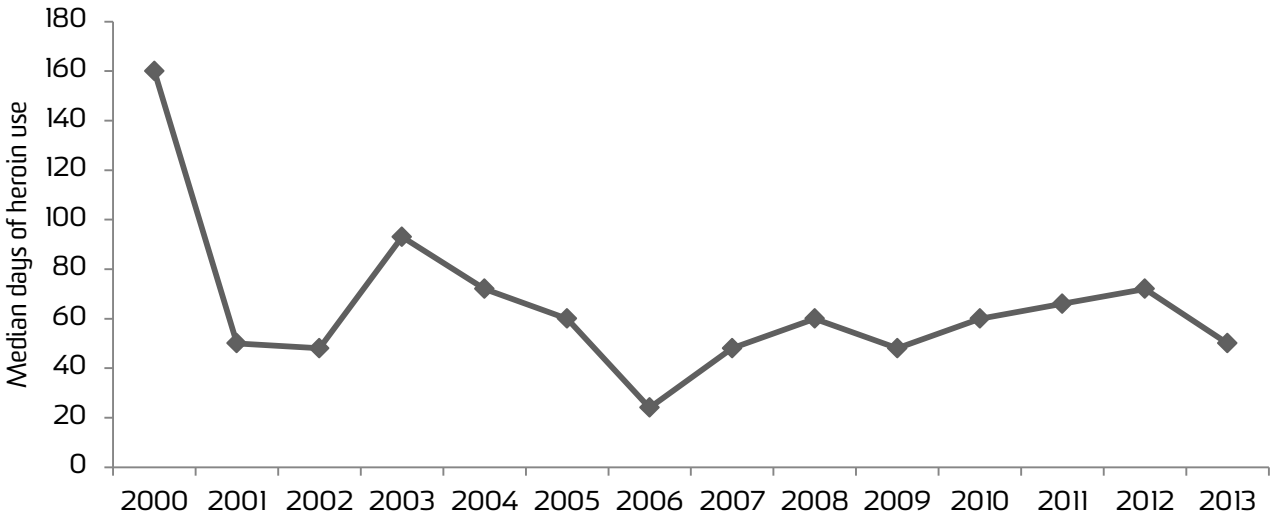
In 2013, 92% of respondents reported that they had used heroin at least once in their lifetime and three-quarters (75%) reported the use of heroin in the six months preceding interview, which was similar to 2012 (74%).

Heroin was nominated as the drug of choice by over half of the participants in 2013 (58%), which was the same proportion reported in 2012. More than half of the respondents reported heroin as the drug most often injected in the last month (55%) and 48% reported that it was the last drug they injected.

Almost all participants who had used heroin in the preceding six months (n=75) reported injecting it. A third of the respondents (33%) reported that they had smoked heroin at least once in their lifetime but just 4% had done so in the six months preceding the interview; 11% reported they had swallowed heroin at least once in their lifetime and only 1% had done so in the last six months; and 9% reported they had snorted heroin at least once in their lifetime.

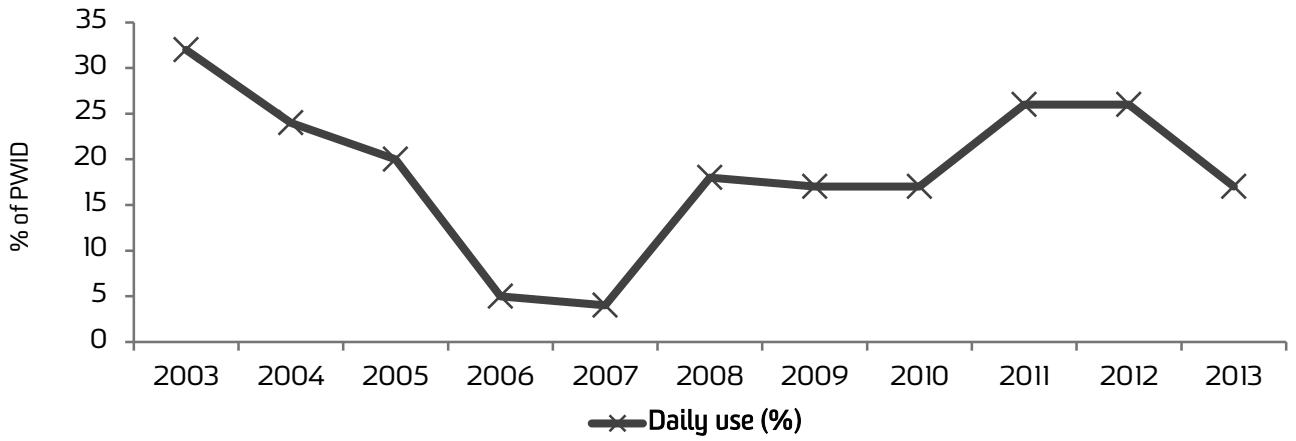
Of those participants who had used heroin in the six months prior to the interview, the median number of days of use during this period trended downwards to 50 days (72 days in 2012) as seen in Figure 2. The number of days that heroin was used in the preceding six months ranged from one day to every day.

Figure 2: Median days of recent heroin use in the ACT, 2003–2013



Source: ACT IDRS PWID interviews, 2003–2013

Figure 3: Proportion of participants reporting recent daily heroin use, in the ACT, 2003–2013



Source: ACT IDRS PWID interviews, 2003–2013

As shown in Figure 3, the proportion of participants reporting daily heroin use in the six months preceding interview decreased to 17% from 26% in 2012. In 2013, heroin was nominated by 32% of the sample as having been used on the day prior to the interview. While this is a significant increase from 6% nominating using heroin the day before interview in 2012 (p<0.05), it has returned to similar proportions as seen in 2011.

Homebake is a form of heroin made from pharmaceutical products and involves the extraction of diamorphine from pharmaceutical opioids such as codeine and morphine. In 2013, half (50%) of participants reported that they had used homebake heroin at least once in their lifetime. Fifteen percent reported the use of homebake heroin in the six months preceding interview. All of those who reported recent use of homebake heroin had injected it. In 2013, the median days of homebake heroin use was six days (range=1–72).

PREPARATION AND COLOUR

Brown heroin was first identified in NSW by the Medically Supervised Injecting Centre (MSIC) in 2006. Participants in the IDRS first commented on the presence of brown heroin in the same year. In 2007, the issue was first investigated by asking participants to describe the colour forms of heroin they had used over the last six months, in addition to the 'form most used'. In 2008, this investigation was expanded by asking participants what colour forms of heroin they used and the preparation techniques employed when using these colour forms.

Traditionally, heroin originating from the Golden Triangle (from where Australia's heroin has predominantly originated in the past) has been white or off-white in colour. This form of heroin had an acidic (acetone/hydrochloride) base and was relatively easy to prepare for injection as it was more refined and easy to dissolve in water. In contrast, heroin produced in the Golden Crescent, a region producing heroin that has traditionally been seen very rarely in Australia, was traditionally brown in colour and less refined. It

required the use of heat, and often an acid, to prepare for injection, and was also more amenable to smoking as a route of administration.

More recently, however, the picture has become less clear, with at least one documented instance of white acidic heroin production occurring in Afghanistan (Zerell, Ahrens and Gerz, 2005). Furthermore, information from border seizures indicates that it is not possible to determine the geographic origin of the drug based on colour alone (Australian Federal Police (AFP), personal communication with the authors). Therefore, while the following information provides an indication of the appearance of heroin used by participants of the IDRS at the street level, it is not possible to draw conclusions about its geographic origin, purity or preparation method required for injection based on these data alone.

COLOUR AND FORM

Among those PWID who had used heroin in the six months previously, 66% reported that they had used heroin powder which was white/off-white in colour (see Table 6). The next most common form used was white/off-white rock (25%). A fifth of PWID reported that they had used brown heroin powder (20%) and 10% reported using brown heroin rock in the six months preceding interview. Fifty-nine percent reported that white/off-white heroin powder was the form of heroin they most used, followed by white/off-white rock (7%) and brown powder (7%).

Table 6: Forms of heroin used and most common form used recently, ACT, 2012–2013

Heroin form used in the last six months	2012 (n=73)	**2013 (n=75)**
Heroin powder		
White/off-white	39	**66**
Brown	38	**20**
Other colour	6	**2**
Heroin rock		
White/off-white	13	**25**
Brown	4	**10**
Other colour	1	**3**
Homebake	7	**7**
Heroin form used MOST OFTEN in last six months		
Heroin powder		
White/off-white	74	**59**
Brown	9	**7**
Other colour	1	**0**
Heroin rock		
White/off-white	12	**7**
Brown	3	**1**
Other colour	1	**1**
Homebake	0	**0**

Source: ACT IDRS PWID interviews, 2012–2013

PREPARATION

In 2013, participants reported on methods of preparation employed when using heroin (preparing with either heat or acid). Participants were asked if they had used heat or acid the last time they injected and the colour of the heroin used. Of those who had injected heroin in the past six months (n=75), 27% reported that they had used heat the last time they injected and three participants reported using acid. Eighty-two percent (n=22) of those who had used heat or acid the last time they injected reported that the colour of heroin was white or off-white while 15% (n=4) reported that the colour was brown or beige.

Key expert comments - heroin

The majority of KE reported that heroin was the main illicit drug used by the regular users that they had contact with.

4.3. Methamphetamine

Key points

- The vast majority (87%) of participants reported using some form of methamphetamine at least once in their lifetime and two-thirds (66%) reported recent use, in the past 6 months.
- Crystal methamphetamine remains the most common form used with 61% of the sample reporting recent use. Almost a quarter of participants nominated crystal as their drug of choice, significantly more than 2012.

The 2013 IDRS questionnaire collected data on three different forms of methamphetamine: methamphetamine powder (speed), base methamphetamine (base), and crystal methamphetamine (crystal).

LIFETIME USE

Any methamphetamine

In 2013, the vast majority (87%) of participants reported using some form of methamphetamine (i.e. speed, base, crystal, amphetamine liquid) at least once in their lifetime. Eighty-three percent of participants also reported having injected some form of methamphetamine at least once in their lifetime.

Speed

Sixty-three percent of participants reported using speed in their lifetime with 59% of those reporting ever injecting speed. Thirteen percent reported ever smoking speed, 20% reported ever snorting speed and 18% reported ever swallowing speed.

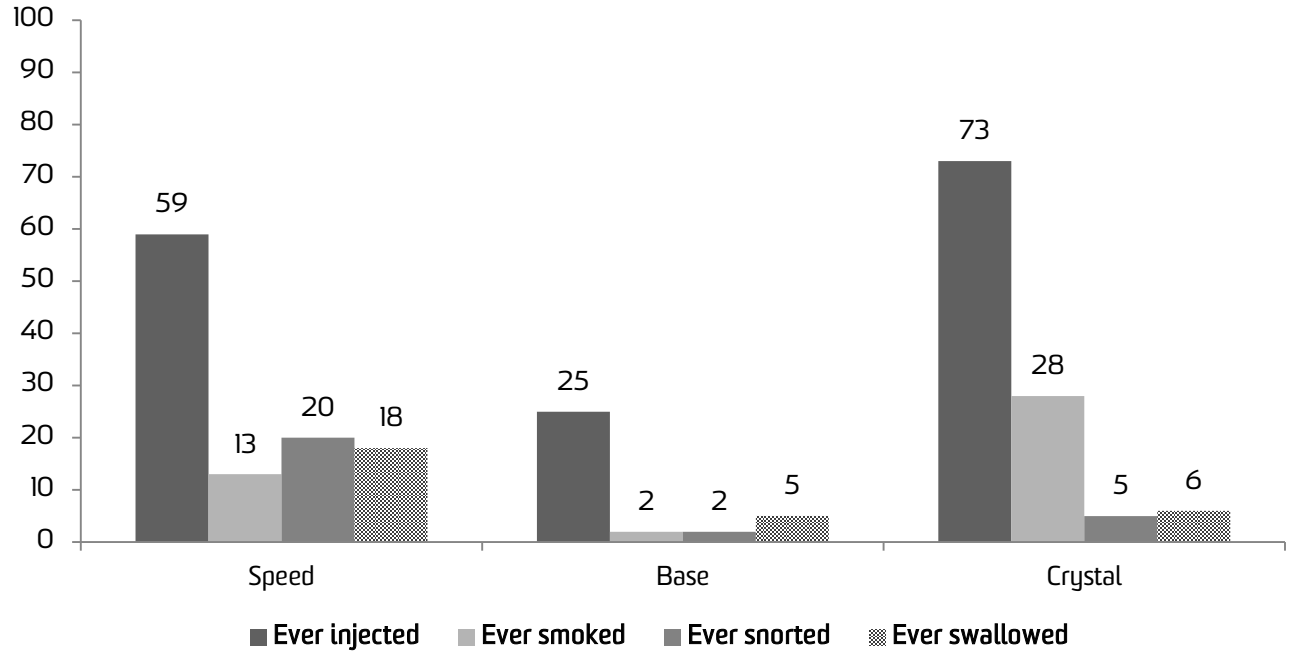
Base

Approximately a quarter of participants (26%) reported ever having used base with 25% of those reporting ever injecting base. Only five percent reported ever swallowing base and two percent reported ever smoking base.

Crystal

Three-quarters (76%) of participants reported having ever used crystal, with 73% reporting ever injecting crystal. Twenty-eight percent reported ever smoking crystal. The other routes of administration were less frequent with only 6% reporting ever swallowing crystal and only 5% reporting ever snorting crystal.

Figure 4: Lifetime use and route of administration for methamphetamine



Source: ACT IDRS PWID interviews, 2003–2013

CURRENT PATTERNS OF METHAMPHETAMINE USE

Any methamphetamine

In 2013, 66% of ACT participants reported using any methamphetamine in the six months preceding interview. Median days of use for any methamphetamine increased to 44 days in 2013 (from 32 in 2012). Methamphetamine (in any form) was commonly reported as the drug type used on first injection (39%; 54% in 2012). Thirty-four percent of participants reported methamphetamine to be the drug type most often injected in the last month (35% in 2012).

Speed

Twenty-nine percent of participants reported the use of speed in the six months preceding interview (42% in 2012). See Figure 5.

The most common route of administration was injection, which was reported by almost all participants who had recently used speed (97%). Of those who had recently used speed, smaller proportions reported smoking (10%), swallowing (7%) and snorting (3%) speed in the six months preceding interview.

Median days of use was six days (range=1–180) and the median days of injection was 5.5 (range=1–180), (14 and 14.5 days in 2012, respectively). This equates to approximately monthly use. Two participants reported daily use of speed.

A third (33%) of participants reported that speed was the first drug ever injected (42% in 2012), 8% reported speed as the most common drug they injected in the last month (19% in 2012), and 8% reported speed as the most recent drug injected (16% in 2012). In 2013, 5% reported that speed was their drug of choice, down from 14% in 2012.

Base

Six percent reported the recent use of base (15% in 2012). See Figure 5. Injection was the most common route of administration (83%) reported by participants who had recently used base. In 2012, one participant reported recently swallowing it.

Median days of use were four (less than monthly). The median number of days that base was injected in the preceding six months was two. In 2012, no participants reported that they had used base every day.

No participants reported that base was their first drug injected. No participants reported that it was the most common drug injected in the last month, or that it was the last drug injected.

Crystal

Almost two-thirds of the participants (61%) reported the recent use of crystal (66% in 2012). See Figure 5. Almost all (97%) participants who had recently used crystal had done so by injection (100% in 2012). Approximately one-quarter (26%) of recent crystal users had smoked crystal in the six months prior to interview. Smaller proportions of the sample reported swallowing (5%) in the six months preceding interview. One participant reported recently snorting.

Amongst those who had used crystal in the previous six months, the median days of use was 32 (13 in 2012). Amongst recent injectors the median days of injection was 13; approximately fortnightly use (12 in 2011). Just over one in every 10 recent ice users reported using ice daily, similar to 2012 results.

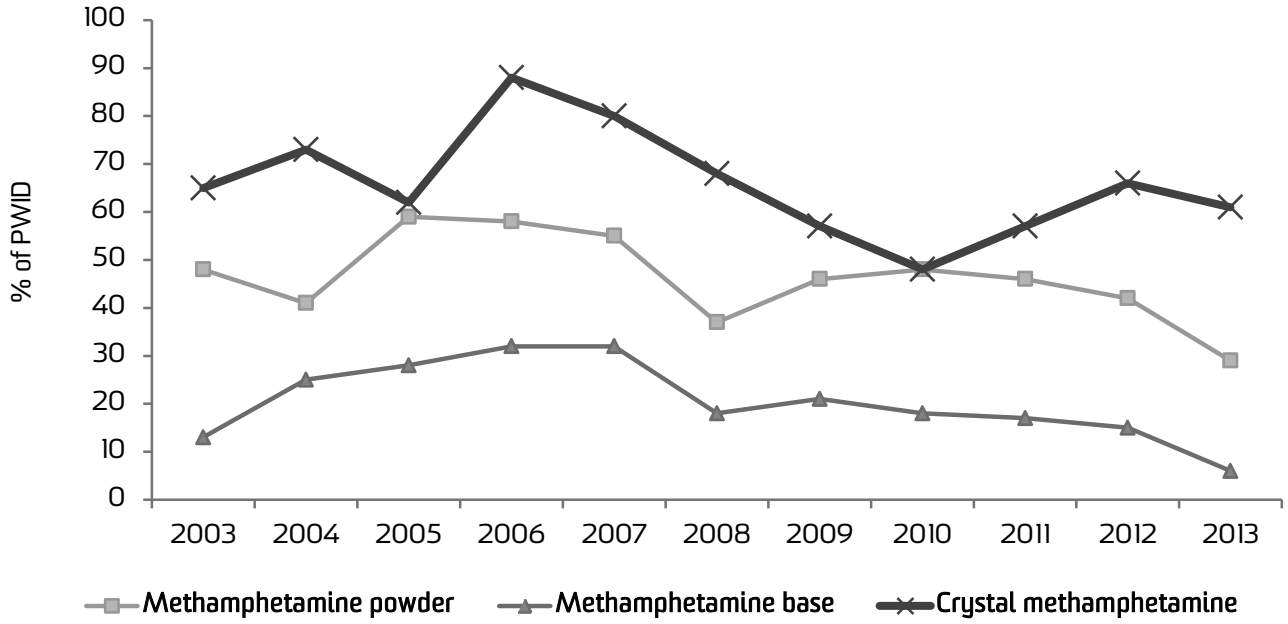
Crystal was the first drug injected by 13% of participants (9% in 2012), the drug injected most often in the last month by 26% (16% in 2012), and the last drug injected by 31% (20% in 2012). Almost a quarter (22%) of participants nominated crystal as their drug of choice, significantly more than last year (10% in 2012) (p<0.05).

Liquid amphetamine

In 2013, whilst 16% of participants reported that they had used liquid amphetamine at least once in their lifetime, only 3% reported the recent use of liquid amphetamine. This is a significantly lower proportion reporting lifetime use than in 2012 (34%; p<0.05). All participants who reported using liquid amphetamine recently had swallowed it.

The median number of days of use was eight days (range=1–90).

Figure 5: Methamphetamine use in the past six months in the ACT, 2003–2013



Source: ACT IDRS PWID interviews, 2003–2013

4.4. Cocaine

Key points

- A significantly smaller proportion of participants reported lifetime use of cocaine compared with 2012: 54% in 2013 vs 71% in 2012.
- The recent use of cocaine remained low in the ACT with 16% reporting use in the preceding six months. The median days of use also remains low at three and a half days, ranging from one to ten days.

LIFETIME USE

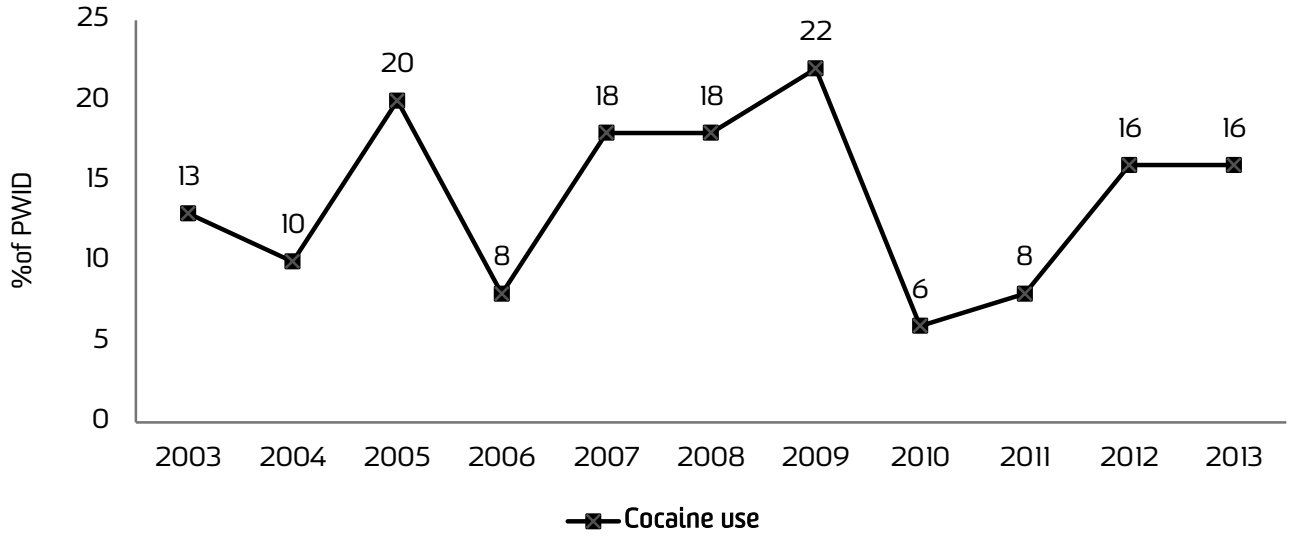
In 2013, 54% of participants reported that they had used cocaine at least once in their lifetime, a significant (p<0.05) decrease from 71% in 2012. More than three-quarters (79%) of those PWID who had ever used cocaine reported having injected cocaine. Of those who had ever used cocaine, 53% reported having snorted cocaine, 13% had smoked cocaine, and 8% had swallowed the drug.

CURRENT PATTERNS OF COCAINE USE

In 2013, the proportion of participants reporting recent use of cocaine remained constant at 16%. Among recent cocaine users, the most common route of administration in 2013 was injection (75% of recent users). In the preceding six months, 38% of participants had snorted cocaine, 13% had smoked it, and no recent users had reported swallowing it. The median days of cocaine use remained low at three and a half days, ranging from one day to 10 days.

Just two percent of participants reported that cocaine was the first drug they had ever injected (3% in 2012). One participant nominated cocaine as their drug of choice. No participants nominated cocaine as the drug they injected most often last month or as the last drug injected.

Figure 6: Proportion of PWID reporting cocaine use in the past six months in the ACT, 2003–2013



Source: ACT IDRS PWID interviews, 2003–2013

4.5. Cannabis

Key points

- 75% of PWID reported recent cannabis use in 2013 (81% in 2012).
- Cannabis was the most common illicit drug used the day prior to interview (61%).
- Median days of cannabis use in the six months preceding interview was 180.
- A significant decrease in the proportion of participants reporting recent use of bush was observed.

LIFETIME USE

In 2013, the vast majority of participants (92%, 99% in 2012) reported using cannabis at least once in their lifetime.

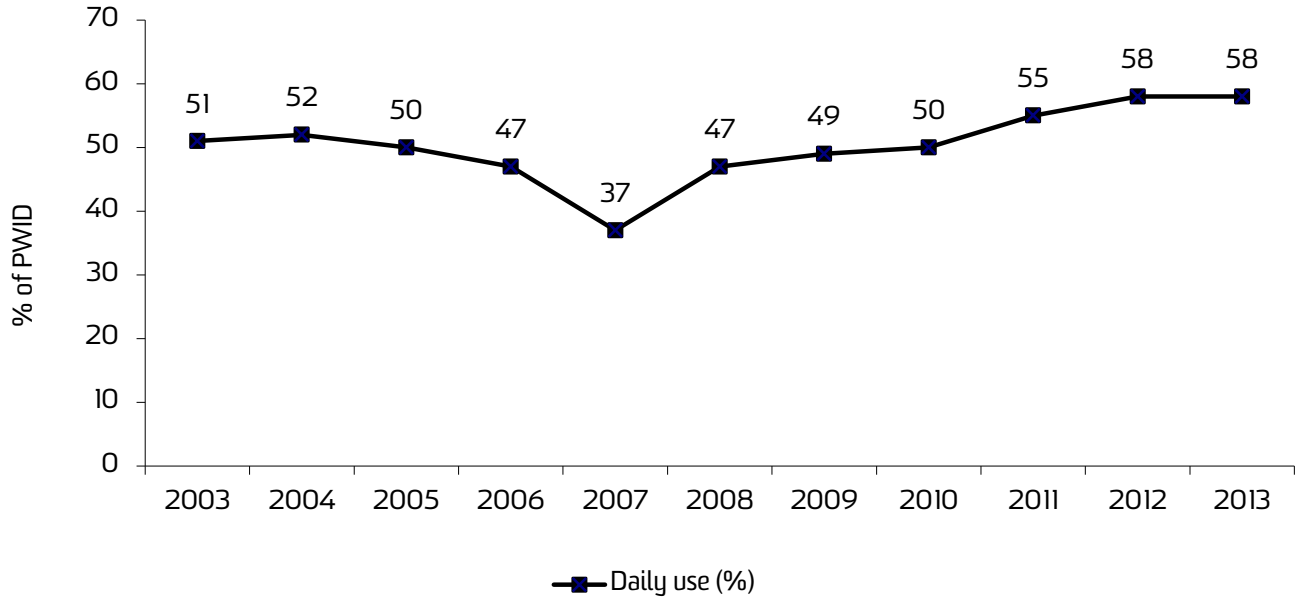
CURRENT PATTERNS OF CANNABIS USE

Three-quarters (75%) of participants reported having used cannabis in the six months preceding interview (81% in 2012). The median number of days of use in the previous six months was 180 which equates to daily use (equal to 2012). As can be seen from Figure 7, the proportion of participants reporting daily cannabis use has remained relatively stable over the previous years. In 2013, the proportion of participants reporting daily use remained stable (59%; 58% in 2012). Nine percent of participants nominated cannabis as their drug of choice in 2013 (similar to 7% in 2012).

Recent cannabis users were asked how much cannabis they had smoked on the last day of use, as measured by the number of cones or joints used on that occasion, either by themselves, or shared with others. Among those who responded, cannabis had typically been smoked in cones (84%) rather than joints (7%). Among those who had smoked cones, the median number used on the last day was six (range=0.5–50 cones), while the number of joints smoked was one (range=1–3 joints). Daily users of cannabis had smoked a median of seven cones (range=1–50) on the last day of use.

Of those respondents who had used cannabis in the past six months, 96% had used hydroponic cannabis (hydro) (91% in 2012), 47% had used bush (70% in 2012), 13% had used hashish (13% in 2012), and 12% reported using hashish oil (9% in 2012). Hydro was the form of cannabis used most often (91%; 90% in 2012). The decrease seen in the proportion of participants who reported recent use of bush was of statistical significance (p>0.05): 47% in 2013 vs 70% in 2012.

Figure 7: recent daily cannabis use and cannabis use on the day preceding the interview, 2003–2013



Source: ACT IDRS PWID interviews, 2003–2013

Key expert comments - cannabis

Most KE reported that cannabis use was common, with many PWID using frequently.

4.6. Other opioids

Key points

- Around half (55%) of the sample reported recent use of methadone (any form) and around one-quarter (28%) reported recently injecting. Recent use of illicit methadone remains stable at 25%.
- Nineteen percent of the sample reported recent use of buprenorphine (any form).
- A fifth (21%) of the sample reported recent use of buprenorphine-naloxone (any form).
- Almost a quarter (23%) reported recently using illicit morphine on a median of six days in the past 6 months. (30% in 2012 on a median of four days)
- Seventeen percent of the sample reported recently using illicit oxycodone. The most common brand used is Oxycontin®.

The IDRS investigates the use patterns, harms and market characteristics of a number of pharmaceutical opioids, including methadone, buprenorphine, buprenorphine-naloxone, morphine and oxycodone. In this section, licit use is defined as use of pharmaceuticals obtained with one's own prescription and used as prescribed. Illicit use is defined as use of pharmaceuticals obtained from a prescription in someone else's name.

METHADONE

Methadone is prescribed for the treatment of opioid dependence, usually as a syrup preparation and is often dosed under supervised conditions. Take-away doses are available for some patients. Physeptone tablets (pill form of methadone) are less common in Australia and are usually prescribed for people in methadone treatment who are travelling, or, in a minority of cases, where the methadone syrup is not tolerated. As mentioned previously, illicit use of methadone and physeptone was defined as the use of medication not obtained with a prescription in the participant's name. The participant may have bought the medication on the street or obtained it from a friend or acquaintance.

Licit methadone and physeptone

The proportion of participants indicating that they had ever used licit methadone remained stable (63% in 2013 and 69% in 2012). Forty-four percent of participants in 2013 reported recent use of licit methadone (42% in 2012). In 2013, 91% of participants who had recently used licit methadone reported having swallowed it. In addition, 27% of participants reported having used licit methadone by injection in the six months prior to interview, which remained stable (11% in 2012). Seventy-eight percent (73% in 2012) reported that licit methadone syrup was the most common form used recently (last six months). Among those who reported using licit methadone in the preceding six months, 77% reported daily use. The median number of days of use for licit methadone was 180.

Fifteen percent of participants reported ever using licit physeptone (21% in 2012) and 6% reported use of licit physeptone in the preceding six months (6% in 2012). Seventeen percent of participants reported

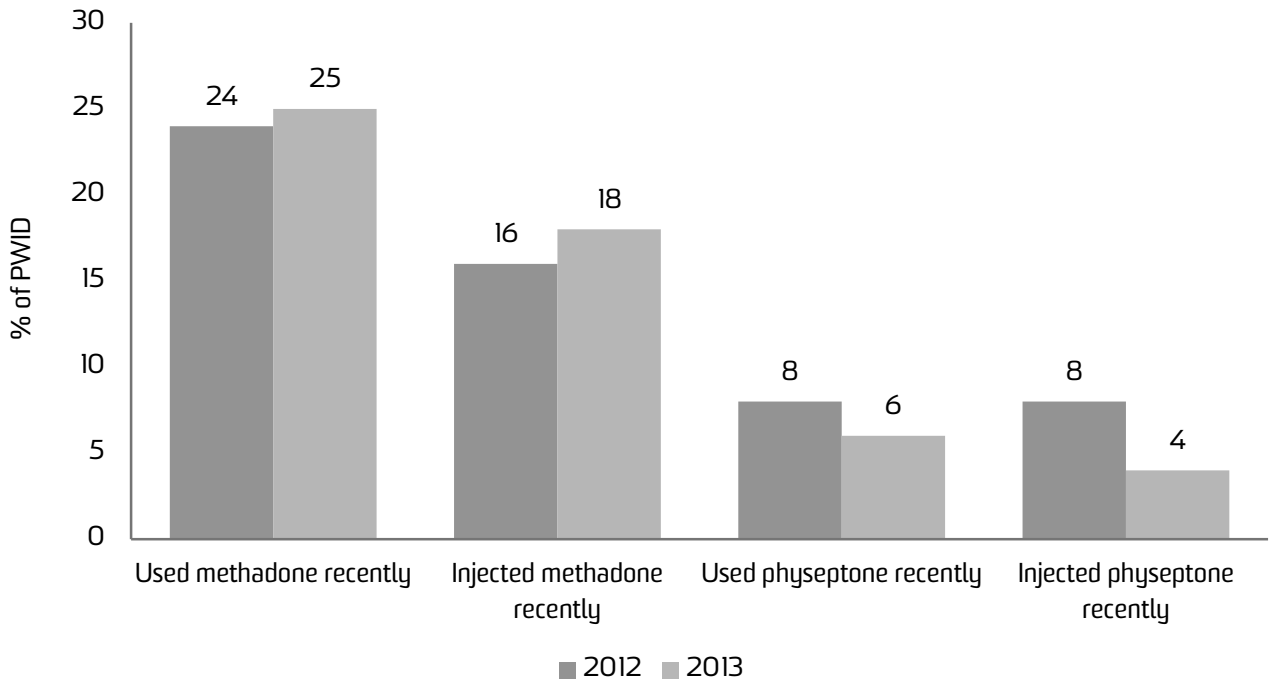
injecting licit physeptone recently. The median number of days reported using licit physeptone remained low at 12.5 days (range=1–48).

Illicit methadone and physeptone

In 2013, the self-reported lifetime use of illicit methadone amongst participants decreased significantly to 49% of participants from 69% in 2012, ($p<0.01$). This decrease sees reports return to levels seen prior to 2012. As can be seen in Figure 8, the proportion of participants reporting recent use of illicit methadone has remained stable in 2013 at 25% (24% in 2012). Of those participants who had used illicit methadone in the previous six months, 72% reported injecting it (67% in 2012) and 40% reported swallowing. Of those participants who had recently used illicit methadone, 32% had used it on 10 or more days in the six months preceding interview, compared to 29% in 2012. The median number of days of use for illicit methadone remained stable at five days (three days in 2012).

In 2013, 24% reported ever using illicit physeptone (31% in 2012); however, only 6% of participants reported recent use of illicit physeptone (8% in 2012). Sixty-seven percent of participants who recently used illicit physeptone reported the recent injection of illicit physeptone (100% in 2012). The median number of days for using illicit physeptone was four (1.5 days in 2012).

Figure 8: Recent use and injection of illicit methadone and illicit physeptone among PWID, 2012–2013



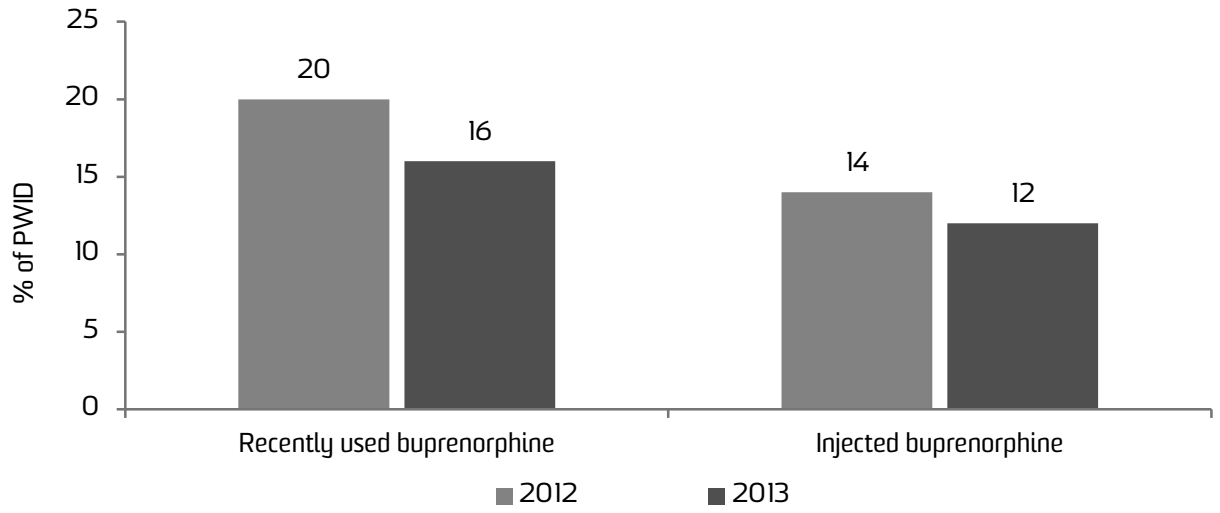
Source: ACT IDRS PWID interviews, 2009–2013

BUPRENORPHINE

In 2013, 25% of participants reported that they had ever used licit buprenorphine, i.e. buprenorphine prescribed to them (28% in 2012). Use of prescribed buprenorphine in the six months preceding interview remains low at 4% (10% in 2012). All participants who reported recent use of prescribed buprenorphine reported having swallowed the drug. Amongst those who had used licit buprenorphine in the preceding six months, the median number of days of use increased again to 180 days in 2013 from 135 days in 2012.

Thirty-four percent of participants reported the lifetime use of illicit buprenorphine, stable compared to 2012 (42%). The proportion of participants who had used illicit buprenorphine in the six months prior to interview also remained stable in 2012 (16%, 20% in 2012) (see Figure 9). In terms of route of administration, 75% of PWID who recently used illicit buprenorphine reported injecting it in the six months preceding interview; a quarter of participants reported swallowing the drug. In 2013, the median number of days of use for illicit buprenorphine remained stable at 11 days (10 days in 2012).

Figure 9: Recent use and injection of illicit buprenorphine among PWID, 2009–2013



Source: ACT IDRS PWID interviews, 2009–2013

BUPRENORPHINE-NALOXONE (SUBOXONE®)

For the second year in a row, participants were asked about the use of buprenorphine-naloxone film which became available on the Pharmaceutical Benefits Scheme (PBS) to treat opiate dependence in late 2011. The film dissolves faster under the tongue compared to the tablet, reducing the opportunity for clients to remove the dose from the mouth and misuse it (Therapeutic Goods Administration, March 2011 http://www.tga.gov.au/pdf/auspar/auspar-suboxone.pdf).

In the ACT, one in ten PWID reported recently using any form of buprenorphine-naloxone tablet (licit use 2% and illicit use 9%) on a median of 28.5 days (approximately weekly). In 2013, 16% of PWID reported recently using any form of buprenorphine-naloxone film (licit use 11% and illicit use 6%) on a median of 90 days (every second day) in the last six months.

Tablet

Licit use – the number of participants who reported that they had ever used licit buprenorphine-naloxone (tablet form) decreased to 14% in 2013 from 20% in 2012. This downward trend has continued from a reported 34% in 2011. Only 2% of participants reported the use of prescribed buprenorphine-naloxone in the six months preceding interview (4% in 2012). All participants who had recently used prescribed buprenorphine-naloxone tablet (n=4) reported having swallowed it. No participants reported injecting their own buprenorphine-naloxone in the six months prior to interview.

Illicit use – 21% of participants reported that they had ever used illicit buprenorphine-naloxone (tablet form), while less than one in ten (9%) reported using buprenorphine-naloxone (tablet) in the six months prior to interview. The majority of participants who reported recent use (89%) reported injecting the illicit form while a third (33%) reported swallowing it. The median days of use was six days suggesting that use is low and sporadic.

Film

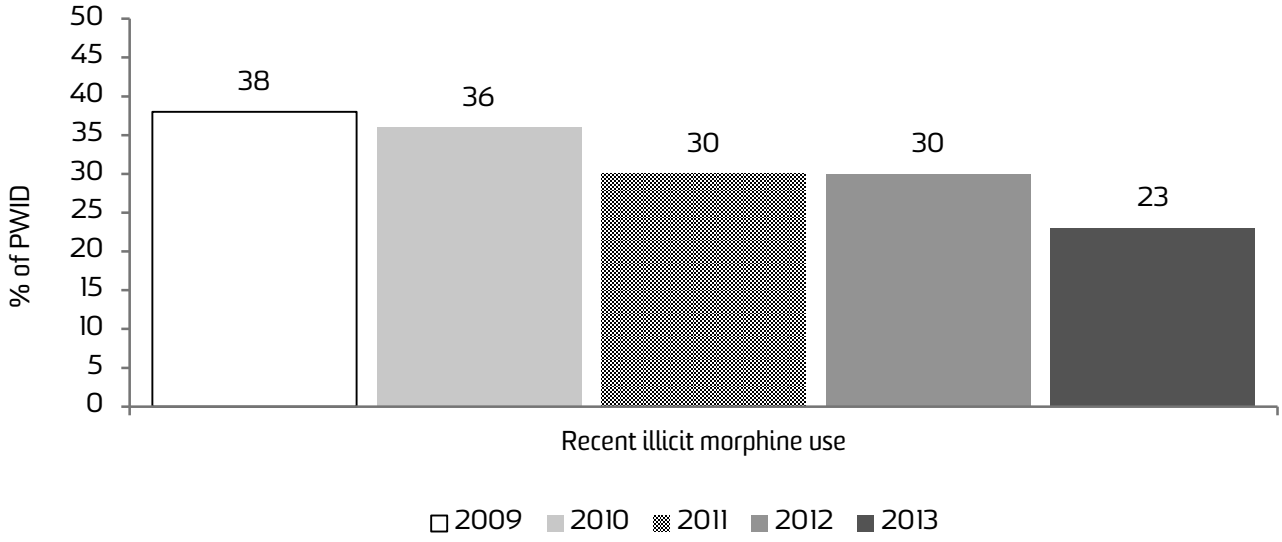
Licit use – Seventeen percent of participants reported that they had ever used licit buprenorphine-naloxone film and 11% reported the recent use of prescribed buprenorphine-naloxone film. All recent users reported swallowing the film with one participant also reporting injecting it. Median days use in the previous six months is 90 days, approximately every second day.

Illicit use – one in ten PWID reported that they had ever used illicit buprenorphine-naloxone film with six percent reporting the recent use of illicit buprenorphine-naloxone film. Half of the recent users reported swallowing the film while one participant reported injecting the film. A third of recent users did not report route of administration. Median days of use remain low at four and a half days in the previous six months.

MORPHINE

Fifty-four percent of participants reported using illicit morphine at least once in their lifetime, and almost one-quarter (23%) of participants reported recent use (see Figure 10). Twenty percent reported recent injection of illicit morphine (27% in 2012). Of those participants who had recently used illicit morphine, the most common route of administration was injecting (87%, 90% in 2012). In 2013, the median number of days of use for illicit morphine was six days, suggesting low and sporadic use. MS Contin® was the preferred brand of morphine for almost two-thirds (61%, 76% in 2012) of recent morphine users.

Figure 10: Recent use of illicit morphine among PWID in the last six months, 2009–2013

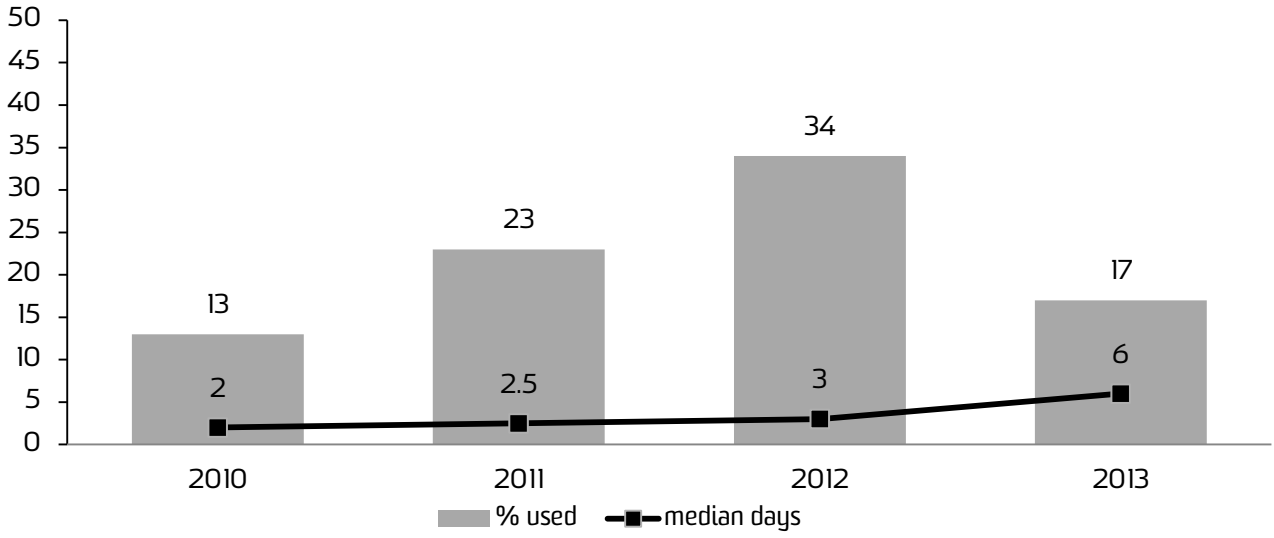


Source: ACT IDRS PWID interviews, 2009–2013

OXYCODONE

Forty-two percent of participants reported that they had used illicit oxycodone at least once in their lifetime (60% in 2012). The upward trend of recent use of illicit oxycodone does not continue in 2013 with only 17% of participants reporting using illicit oxycodone in the previous six months. The median number of days of illicit oxycodone increased to six days (see Figure 11). All recent users reported injecting illicit oxycodone in the previous six months (92% in 2012). The most common brand used remained Oxycontin® (68%).

Figure 11: Recent illicit oxycodone use and median days of use, 2010–2013



Source: ACT IDRS PWID interviews, 2010–2013

OVER THE COUNTER CODEINE

Seventeen percent of participants reported that they had ever used OTC codeine. One in ten participants reported that they had used OTC codeine in the six months prior to interview on a median of 9.5 days. The vast majority (90%) of recent OTC codeine users had swallowed it and one participant reported that they had recently injected OTC codeine. Brands commonly reported were Nurofen Plus®, Panadeine®, as well as doxylamine succinate with brand name, Dolased®. The median number of pills taken by participants on the last occasion that OTC codeine was used was four.

FENTANYL

In 2013, the IDRS survey included questions on the use of Fentanyl. Eighteen percent of participants reported that they had ever used fentanyl. One in ten (11%) reported using fentanyl in the last six months. The median number of days of use in the past six months was five days, indicating that use is low and sporadic. The majority of recent fentanyl users had injected it (73%).

4.7. Other drugs

Key points

- A significantly small proportion of participants reported the lifetime use of ecstasy compared with 2012 (42% in 2013 vs 70% in 2012).
- A similar pattern is observed with the report of lifetime use of hallucinogens (40% in 2013 vs 77% in 2012).
- Benzodiazepine and alprazolam use remains stable with 46% recently using benzodiazepine (any form) and 21% reporting recently using alprazolam (any form).
- Use of pharmaceutical stimulants remains low with 7% using any form recently on a median of 5 days in the past 6 months.
- The lifetime use of Seroquel® was reported by 34% of the sample and 18% reported recently using Seroquel®.
- Lifetime use of inhalants was reported by 18% of the sample; however, no participants reported using inhalants in the last six months.
- Sixty-one percent of the sample reported recent alcohol use with 34% of those being daily drinkers.
- As in previous years, tobacco was widely used among the 2013 sample, with 89% having used it in the preceding six months.

ECSTASY

In 2013, significantly fewer participants (42%) reported lifetime use of ecstasy (70% in 2012 $p<0.005$). and 6% reported recent use (12% in 2012) (see Table 7). Half of recent ecstasy users (50%) reported injecting ecstasy and half (50%) reported swallowing it in the previous six months. Use of ecstasy by participants in the ACT was infrequent, with the median number of days used in the six months prior to interview remaining very low at one day.

Table 7: Patterns of ecstasy use among participants in the last six months in the ACT, 2009–2013

	2009 N=100	2010 N=101	2011 N=98	2012 N=99	**2013 N=100**
Recent use (%)	20	9	14	12	**6**
Recent injecting (%)	2	1	3	3	**3**
Median days used*	2	1	2	3.5	**1**

Source: ACT IDRS PWID interviews, 2009–2013
*****Among those that reported recent use.

HALLUCINOGENS

Significantly ($p<0.005$) less participants reported having used hallucinogens at some stage in their lifetime (40%, 77% in 2012) and recent use (i.e. in the preceding six months) is also low, with 5% reporting use in the six months preceding interview on a median of three days.

BENZODIAZEPINES (OTHER)

Two-thirds (64%) of participants had reported the use of any form (licit and illicit) of other benzodiazepines at some stage in their lifetime. Forty-six percent reported the recent use of any form of other benzodiazepines on a median of 60 days in the last six months.

From 2011 onwards participants were asked separately about the use of alprazolam and other benzodiazepines use (see below).

ALPRAZOLAM

Sixty-eight percent of participants reported using some form of alprazolam in their lifetime (13% licit and 25% illicit). One in five (21%) reported recently using any form of alprazolam (6% licit and 16% illicit) on a median of 10 days in the last six months.

PHARMACEUTICAL STIMULANTS

This includes drugs such as dexamphetamine and methylphenidate, which are medications most commonly prescribed for attention deficit hyperactivity disorder.

Licit – 12% of participants reported ever using licit pharmaceutical stimulants (those prescribed to them), which was similar to 2012 (10%). Two percent reported using licit pharmaceutical stimulants in the preceding six months (2% also in 2012). Median number of days of use for licit pharmaceutical stimulants increased to 145 days from 91 days in 2012.

Illicit – one-quarter (25%) of participants reported using illicit pharmaceutical stimulants at least once in their lifetime (37% in 2012). Seven percent reported using illicit pharmaceutical stimulants over the preceding six months (12% in 2012). The median days of use of illicit pharmaceutical stimulants remained stable in 2013 at five days in the six months preceding interview (six in 2012).

Recent use of any pharmaceutical stimulants (licit and illicit) decreased in 2013 with 8% of participants reporting use in the past six months compared with 13% reporting recent use in 2012. Recent injection of pharmaceutical stimulants (both licit and illicit) was reported by 4% of the sample, a decrease from 11% in 2012 (Table 8). The median number of days of any use (licit and illicit) was 6 days (range=1–180).

Table 8: Recent pharmaceutical stimulant use (licit/illicit) among participants in the ACT, 2009–2013

	2009 N=100	2010 N=101	2011 N=97	**2012** **N=99**	**2013** **N=100**
Recent use (%)	24	35	29	**13**	**7**
Recent injecting (%)	18	26	26	**11**	**4**
Median days used*	6	5	6	**5**	**5**

Source: ACT IDRS PWID interviews, 2009–2013

*****Among those that reported recent use. Maximum=180 days

SEROQUEL® (QUETIAPINE)

A third (34%) of participants reported lifetime use of Seroquel® (quetiapine) (19% licit, 24% illicit). Less than one–fifth (18%) had used Seroquel® in the last six months (9% licit, 12% illicit).

Licit use of Seroquel® had been used on a median of 60 days (range=3–180) compared to 9.5 days (range=1–48) for illicit use.

INHALANTS

Less than one-fifth (18%) of participants reported ever having inhaled volatile substances such as amyl nitrate, petrol, glue and/or lighter fluid. No participants reported use in the six months preceding interview.

ALCOHOL AND TOBACCO

The majority (83%) of participants in 2013 reported having used alcohol at least once during their lifetime. In 2013, 61% of participants reported the recent use of alcohol (Table 9). The median days of alcohol use in the six months prior to interview was 24 days in 2013 (just over twice weekly), with 34% of those who had used alcohol in the past six months reporting being daily drinkers.

Use of tobacco was also very high among participants in the ACT in 2013. Almost all participants (93%) reported ever having used tobacco and 89% reported recent tobacco use, as shown in Table 9. The median days of tobacco use has remained stable over the last eight years at 180 days (i.e. daily smokers). There were no significant differences in use from 2011 to 2012.

Table 9: Patterns of recent alcohol and tobacco use among PWID in the ACT, 2009–2013

	2009 N=100	2010 N=101	2011 N=98	2012 N=99	**2013 N=100**
Recent use (%)					
Alcohol	68	66	70	65	**61**
Tobacco	96	94	96	94	**89**
Median days used*					
Alcohol	48	30	16	54	**24**
Tobacco	180	180	180	180	**180**

Source: ACT IDRS PWID interviews, 2009–2013

*****Among those that reported recent use. Maximum=180 days

5 DRUG MARKET: PRICE, PURITY, AVAILABILITY AND PURCHASING PATTERNS

5.1. Heroin

Key points

- Price for heroin remained stable at $50 per cap and $300 per gram.
- Increase in the proportion of participants reporting that heroin had been difficult to obtain.
- Sixty-three percent of those who commented reported that the current purity of heroin was low.

In this section, the patterns of use, price, purity and availability of heroin are discussed. The figures about the heroin market refer to the 75 participants who commented on heroin trends in the ACT in 2013.

PRICE

Participants were asked to comment on the last time they purchased heroin in the six months prior to interview. The median reported prices for purchased values of heroin in 2013 were similar to the prices reported by participants in 2012. In both 2013 and 2012, the median price of a cap of heroin was reported to be $50. The median price of a gram in 2012 was $300, the same price as reported in 2012. The median price for a quarter–gram of heroin also remained stable at $80 as did the median price for a half-gram ($150).

Table 10 presents participant reports of changes in the price of heroin in the six months preceding the interview. Consistent with purchase prices, the majority (73%) of those who commented on heroin trends in 2013 reported that the price had remained stable in the previous six months.

Table 10: Participants' reports of heroin price changes in the last six months, 2012–2013

Price change	2012 n=70	2013 n=75
Increasing (%)	**7**	**15**
Stable (%)	**84**	**73**
Decreasing (%)	**4**	**7**
Fluctuating (%)	**4**	**6**

Source: ACT IDRS PWID interviews, 2012–2013

AVAILABILITY

Table 11 presents participant reports of the current availability of heroin in the ACT. The majority of participants who commented on the availability of heroin in the ACT reported that it was very easy (43%) to easy (32%) to obtain. In 2013, the proportion of participants reporting that heroin was difficult to obtain increased from 6% in 2012 to 20%. This increase is of statistical significance $p<0.05$.

Table 11: Participants' reports of heroin availability in the past six months, 2012–2013

Current availability	2012 n=72	**2013 n=74**
Of those who responded:		
Very easy (%)	57	**43**
Easy (%)	38	**32**
Difficult (%)	6	**20**↑
Very difficult (%)	0	**4**
Availability change over the last six months		
Of those who responded:		
More difficult (%)	7	**28**
Stable (%)	83	**58**↑
Easier (%)	7	**5**
Fluctuates (%)	3	**8**

Source: ACT IDRS PWID interviews, 2012–2013
↑↓ Statistical significance $p<0.05$

Participants were asked to comment on changes in the availability of heroin in the ACT in the six months prior to interview (see Table 11). In 2013, the majority of participants believed heroin availability had remained stable (58%) although this was a significant decrease from the proportion who reported availability was stable in 2012 ($p<0.05$).

In 2013, the majority (42%) of participants who reported purchasing heroin in the six months prior to interview last bought it from friends. Over a third (37%) reported last purchasing heroin from a known dealer and 11% reported purchasing heroin from a street dealer. Smaller proportions reported last obtaining heroin from an acquaintance (4%) or an unknown dealer (4%). The most commonly reported places for the last purchase of heroin were agreed public locations (43%), a dealer's home (24%), a friend's home (15%) and home delivery (11%).

PURITY

Participants were asked to comment on the perceived purity of heroin in the ACT (Table 12). In 2013, the proportion of participants nominating current purity as low increased from 32% in 2012 to 63% in 2013. This decrease is of statistical significance $p<0.05$. A decrease in perceived purity as medium (26%) and high (7%) is also observed. Significantly more participants reported heroin purity to be decreasing over the previous six months (35% in 2013 compared with 12% in 2012, $p<0.05$), whilst 42% reported purity to be stable.

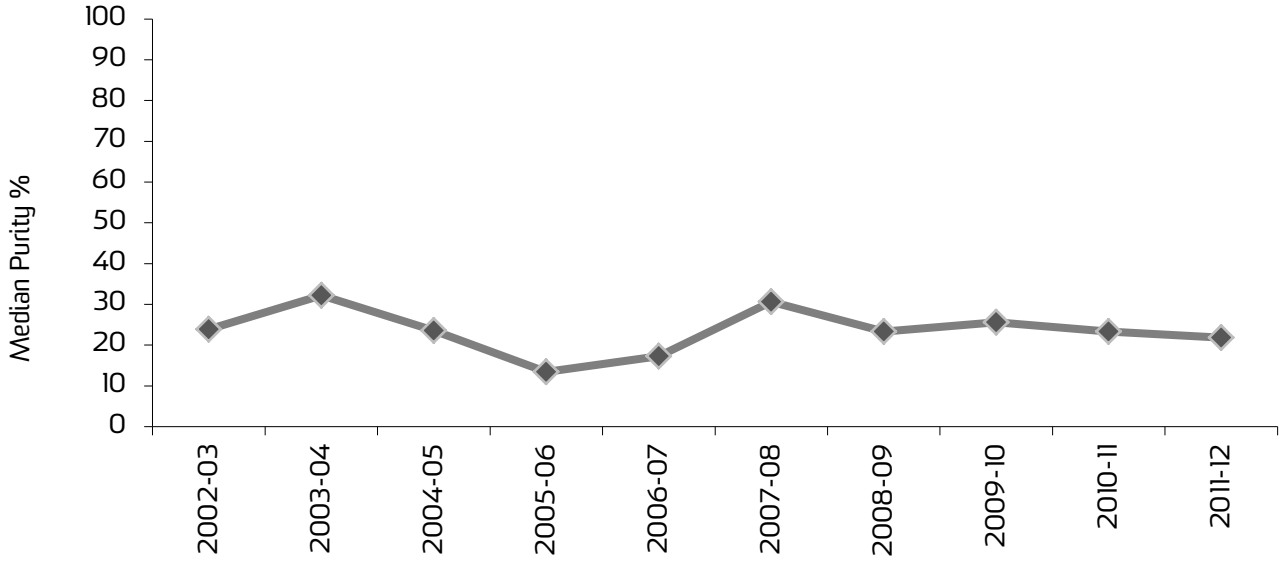
Table 12: Participants' perceptions of heroin purity in the past six months, 2012–2013

Current purity	2012 n=72	**2013 n=73**
Of those who responded:		
High (%)	16	**7**
Medium (%)	38	**26**
Low (%)	32	**63**↑
Fluctuates (%)	15	**4**
Purity change over the last six months		
Of those who responded:		
Increasing (%)	17	**9**
Stable (%)	49	**42**
Decreasing (%)	12	**35**↑
Fluctuating (%)	22	**14**

Source: ACT IDRS PWID interviews, 2012–2013
↑↓ Statistical significance $p<0.05$

Figure 12 presents data from the Australian Crime Commission (ACC) on the purity of heroin seizures made by ACT local police, by financial year, from July 2002 to June 2012. Data were not available at the time of printing for more recent seizure purity estimates.

Figure 12: Median purity of heroin seizures by ACT local police, July 2002 to June 2012



Source: *Illicit Drug Data Report* Australian Crime Commission, ACC, 2003–2012

5.2. Methamphetamine

Key points

- The price for speed has remained stable with reports of one point costing $50.
- Only very small numbers able to comment on the price of base.
- The price of crystal has also remained stable at $100 for one point.
- No significant differences in either the availability or reported purity of speed or base.
- Significant increase in the proportion of respondents reporting purity of crystal to be medium was seen.

In 2013, a significantly smaller proportion of the entire sample was able to comment on trends in the price, purity, availability and use of speed (25% compared with 60% in 2012) (p<0.05). A smaller proportion of participants were able to comment on base (4%, 11% in 2012). Fifty-three percent of the sample was able to comment on crystal trends (58% in 2012).

PRICE

Speed

In 2013, the median price for a point (0.1 grams) of speed remained stable at $50 (see Table 13). The price of a gram of speed decreased from $250 in 2012 to $200 in 2013. No participants commented on the price of an eight-ball (3.5 grams) in 2013. Low numbers commented on the price of a half-weight (0.5 gram).

The most common amount of speed purchased was a point, with 48% of participants who commented on speed reporting that they had bought a point of speed in the six months preceding interview.

Of those participants that commented on speed in 2013, 71% believed the price to be stable, similar to 2012 proportions. A quarter (24%) of participants believed the price of speed was increasing (18% in 2012) while no participants reported that they thought the price was decreasing.

Table 13 - Price and changes in price for methamphetamine powder, ACT, 2012–2013

Median price - speed	2012	2013
Point (0.1 gram)	**$50**	**$50**
(range)	(20–100)	(15–100)
Half-weight (0.5 gram)	**$150**	**$110^**
(range)	(80–200)	(50–350)
Gram	**$250**	**$200^**
(range)	(50–500)	(40–300)
Eight-ball (3.5 grams)	**700^**	-
(range)	(600–1200)	-

Change in price	n=38	n=21
% Increasing	18	**24**
% Stable	80	**71**
% Decreasing	0	**0**
% Fluctuating	3	**5**

Source: ACT IDRS PWID interviews, 2012–2013
^ Small numbers reporting (n<10), interpret with caution

Base

The median price of a point of base purchased by participants in 2013 was reported to be $65; however, this is based on only a small number of participants that responded so data should be interpreted with caution. Very small numbers reported on the price per half-weight and gram of base in 2013 so, again, the figures in Table 14 should be interpreted with caution. The median price per half-weight and per gram of base was reported at $230 and $475 respectively. No participants reported on the price of an eight-ball of base. Findings indicate that base was not commonly purchased by participants in the ACT in 2013. Of those that commented on base in 2013, the majority (67%) reported the price to have remained stable in the six months preceding interview. A third believed that the price of base was fluctuating (33%).

Table 14: Price and changes in price for methamphetamine Base, ACT, 2012–2013

Median price - base	2012	2013
Point (0.1 gram)	**$20^**	**$65^**
(range)	(20–50)	(30–100)
Half-weight (0.5 gram)	**$150^**	**$230^**
(range)	(100–200)	**(110–350)**
Gram	**$200^**	**$475^**
(range)	(200–400)	**(250–700)**
Eight-ball (3.5 grams)	**$650^**	-
(range)	(550–750)	-
Of those that responded	n=10	**n=3**
% Increasing	10	**0**
% Stable	80	**67^**
% Decreasing	0	**0**
% Fluctuating	10	**33^**

Source: ACT IDRS PWID interviews, 2012–2013
^ Small numbers reporting (n<10), interpret with caution

Crystal

In 2013, the median price of a point of crystal purchased by participants remained stable at $100. The median price of a half-weight increased from $275 in 2012 to $350 in 2013. The price of a gram increased from $575 in 2012 to $700 in 2012.

The most common amount of crystal purchased was a point, with 88% of participants who commented on crystal reporting that they had bought this amount in the past six months.

Of those who commented, the majority (72%) reported the price to have remained stable in the six months preceding the interview. Fourteen percent of respondents reported price to be increasing in the six months prior to interview.

Table 15: Price and changes in price for crystal methamphetamine, ACT, 2012–2013

Median price - crystal	2012	**2013**
Point (0.1 gram)	**$100**	**$100**
(range)	(50–100)	(25–100)
Half-weight (0.5 gram)	**$275^**	**$350**
(range)	(200–350)	(250–500)
Gram	**$575**	**$700**
(range)	(100–800)	(300–900)
Eight-ball (3.5 gram)	**$1600^**	-
(range)	(1200–2000)	-
Of those that responded	n=57	**n=50**
% Increasing	31	**14**
% Stable	64	**72**
% Decreasing	2	**4**
% Fluctuating	4	**10**

Source: ACT IDRS PWID interviews, 2012–2013

^ Small numbers reporting (n<10), interpret with caution

Participants were asked to comment on the current availability, as well as any changes in availability, of the different methamphetamine forms in the ACT in 2012. Findings are presented separately for powder, base and crystal in Table 16, Table 17 and Table 18.

AVAILABILITY

Speed

Of those who commented on the current availability of speed (n=25), more than half (52%) reported speed to be easy and very easy (28%) to obtain.

Three-quarters (76%) of the participants that commented on speed thought that the availability had remained stable in the six months prior to interview.

Participants who bought speed (n=24) reported that they obtained it through: friends (42%), known dealers (29%), and acquaintances (13%). The most commonly reported places of speed purchases were at a dealer's home (33%) home delivered (25%), a friend's home (21%), or an agreed public location (17%).

Table 16: Availability of methamphetamine powder, ACT, 2012–2013

Availability - Speed	2012	**2013**
Responded	n=38	**n=25**
Very easy	58	**28**
Easy	40	**52**
Difficult	3	**20**
Very difficult	0	**0**
Change in availability		
% More difficult	8	**16**
% Stable	84	**76**
% Easier	5	**4**
% Fluctuates	3	**4**

Source: ACT IDRS PWID interviews, 2012–2013

Base

Very small numbers reported on the availability of base (n=4) so caution is advised when interpreting the results presented here. Three participants reported that base was easy to obtain and one participant reported that base was very easy to obtain. All participants who commented reported that the availability of base had remained stable in the past six months.

Among those who had purchased base (n=4) in 2013, one reported that they last purchased base through friends, two had purchased through a known dealer and one had purchased from an unknown dealer. Two participants who purchased base reported they last did so at a dealer's home, one reported they had purchased it at a friend's home, and one reported they purchased from an agreed public location.

Table 17: Availability of methamphetamine base, ACT, 2012–2013

Availability - base	2012	2013
Responded	n=10	**n=4**
Very easy	50	**25^**
Easy	20	**75^**
Difficult	20	**0**
Very difficult	10	**0**
Change of availability		
% More difficult	0	**0**
% Stable	88	**100^**
% Easier	0	**0**
% Fluctuates	12	**0**

Source: ACT IDRS PWID interviews, 2012–2013

Crystal

Of those who commented on the current availability of crystal (n=52), the majority reported it to be very easy (39%) to easy (50%) to obtain in the ACT in 2013.

In 2013, more than three-quarters (77%) of participants reported that crystal availability had remained stable. Fourteen percent reported that crystal was easier to obtain and 6% reported that it was more difficult to obtain.

Thirty-nine percent of the participants who reported that they had bought crystal (n=52) said they obtained it from a known dealer. Thirty-seven percent reported that they had obtained crystal through a friend, and 12% reported that they had obtained it through a street dealer. The most common venues where participants had last purchased crystal from included: a friend's home (29%), a dealer's home (27%), an agreed public location (23%), or had it home delivered (19%).

Table 18: Availability of crystal methamphetamine, ACT, 2011–2012

Availability - crystal	2012	2013
Responded	n=56	**n=52**
Very easy	57	**39**
Easy	34	**50**
Difficult	5	**12**

Availability - crystal	2012	2013
Very difficult	4	**0**
Change of availability		
% More difficult	14	**6**
% Stable	68	**77**
% Easier	9	**14**
% Fluctuates	9	**4**

Source: ACT IDRS PWID interviews, 2012–2013

PURITY

Speed

In 2013, 39% of participants who commented on the purity of speed (n=23) reported that it was of medium purity. Thirty percent reported that purity was low and 17% reported purity was high.

Of those who commented (n=24), half (50%) of participants reported that the purity of speed had decreased. Almost a third (29%) of participants reported that the purity of speed had remained stable and 8% reported that purity had increased.

Base

In 2013, among those who commented on the purity of base (n=4), one reported the purity to be high, one reported purity to be medium, whilst the remaining two reported it to fluctuate.

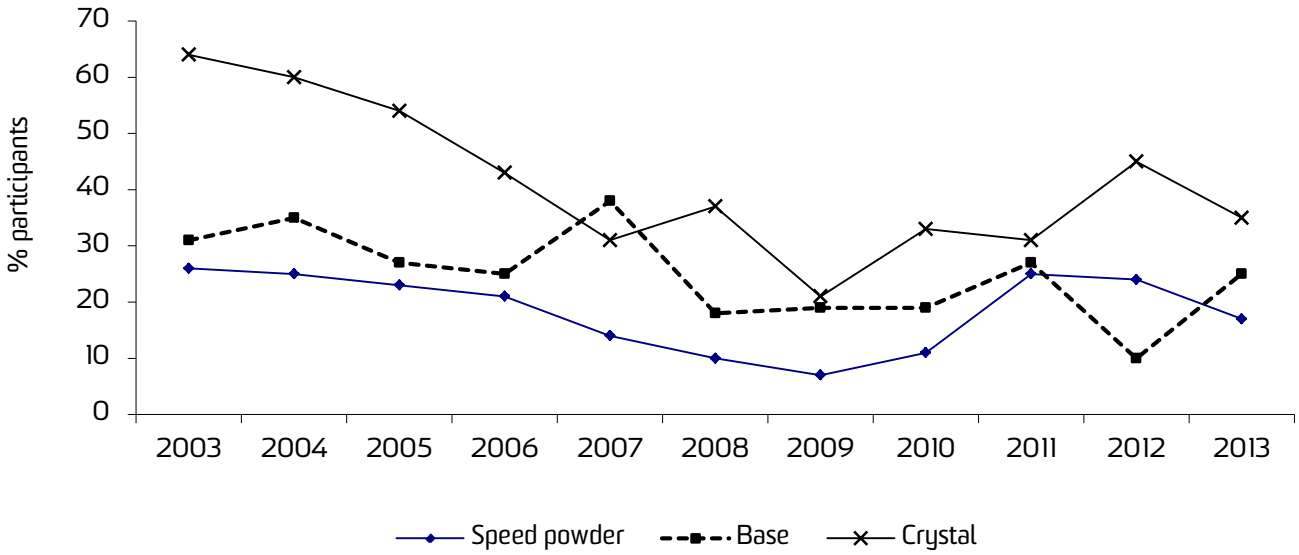
Of participants who commented on base purity (n=3), one reported the purity to be decreasing, while two reported in to be fluctuating. Caution is advised when interpreting these results due to the low number of participants who responded.

Crystal

In 2013, among those who commented on the purity of crystal (n=52), results were mixed. Thirty-five percent reported purity to be high and the same proportion reported purity to be medium. Seventeen percent reported purity to be low. There was a statistically significant increase in the proportion of participants who reported purity to be medium from 15% in 2012 to 35% in 2013. (p<0.05).

Similar to 2012, in 2013, there were mixed reports from participants concerning the change in purity of crystal over the preceding six months. Thirty-nine percent of participants who commented (n=52) reported that the purity of crystal was stable while 20% reported that purity had decreased over the six months preceding interview. Sixteen percent reported that the purity had increased and 25% reported that the purity of ice had fluctuated over the six months preceding interview.

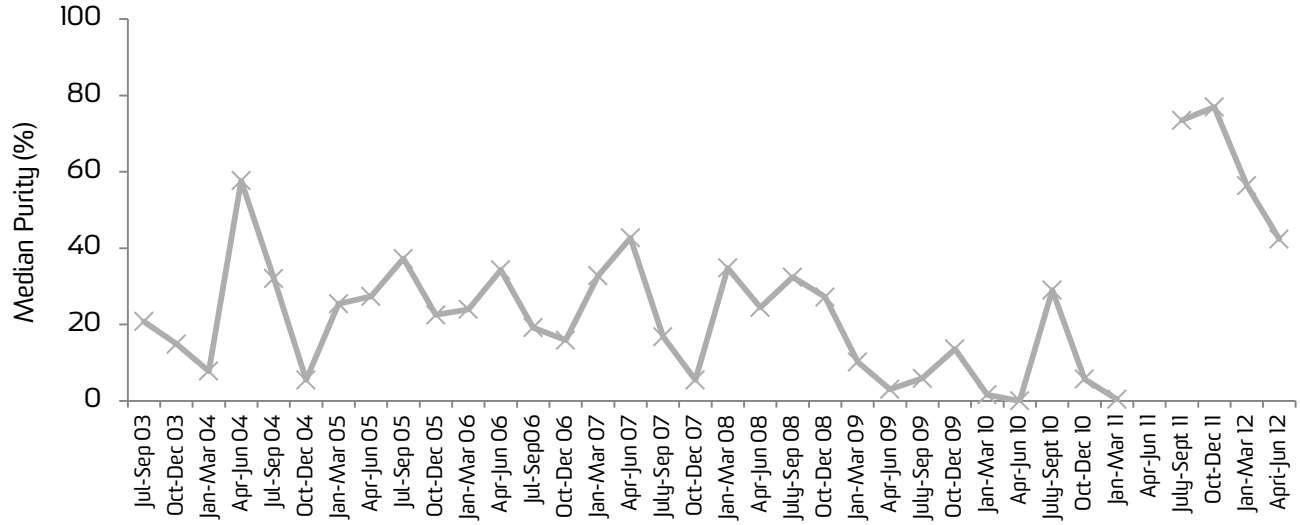
Figure 13: Proportion of participants reporting methamphetamine purity as high, 2003–2013



Source: ACT IDRS PWID interviews, 2003–2013

As shown in Figure 14, analysis of ACT police amphetamine seizures indicates that the median amphetamine purity in the ACT in the 2011–12 financial year has increased. The median purity is 71.4% in the 2011–12 financial year compared with 23.8% in the 2010–11 financial year. More recent data were not available at the time of printing.

Figure 14: Median purity of amphetamine seizures by ACT local police, 2003–04 to 2011–12



Source: Australian Crime Commission; ACC, 2003–2012
NB: Data not available for the 2012–2013 financial year

5.3. Cocaine

In 2013, 9% of participants (n=9) were able to comment on the price, purity and availability of cocaine. Due to small numbers reporting, caution is advised when interpreting these results and comparison to 2012 figures is limited.

PRICE

In 2013, the median reported price for purchased values of a point of cocaine was $50 and a quarter-gram of cocaine was $90. The median price paid for half a gram of cocaine was $200 and the median price for a gram was $350. The majority of participants (88%) who commented (n=8) believed that the price of cocaine had remained stable in the six months preceding interview.

PURITY

Of those who were able to comment (n=8), reports on purity were mixed. Over a third (38%) believed that cocaine purity was currently high while a quarter reported that purity was either low or fluctuated (25%). The remaining 13% reported purity of cocaine to currently be medium. Reports on the change in purity were also mixed with 43% reporting purity was stable and 43% reporting purity was decreasing. The remaining 14% reported purity was fluctuating.

AVAILABILITY

Participants who were able to comment (n=9) reported cocaine to be difficult (56%), easy (33%) and very easy (11%) to obtain. Seventy-one percent of those who commented believed that availability had remained stable in the six months preceding interview. Cocaine was most commonly obtained from friends (50%) and known dealers (38%).

5.4. Cannabis

Key points

- The median cost of a gram of hydroponic cannabis was $20.
- The median cost of an ounce of hydroponic cannabis was $300.
- Price for both forms of cannabis (bush and hydroponic) was reported as 'stable' over the last six months.
- Participants reported the potency of hydro as 'high' and bush 'medium'.
- The availability of both forms of cannabis was considered 'very easy' or 'easy' to obtain.

Participants were asked to comment on the price, purity and availability of two different forms of cannabis: outdoor-cultivated cannabis (bush) and indoor-cultivated cannabis (hydro). Nearly two-thirds of the participants (60%) commented on hydroponic trends in the ACT, while 25% reported on bush cannabis.

PRICE

The median prices for hydroponic cannabis and the reported changes are presented in Table 19. The median prices for bush cannabis and the reported changes in price are shown in Table 20.

Hydro

The median price of a gram of hydro purchased by participants in 2013 remained stable at $20 and a quarter-ounce also remained stable at $90. A half-ounce increased slightly to $160 and the median price of an ounce also increased slightly to $300.

The most common amount of hydro purchased was a gram, with 38 participants reporting that they had bought a gram in the six months preceding the interview. A quarter-ounce was the next most common amount purchased. Of those who commented on hydro in 2013, 83% reported that the price had remained stable.

Bush

The median price of a gram of bush cannabis purchased by participants remained stable at $20 in 2013. The median price of a quarter-ounce remained similar to 2012, increasing from $80 to $85 in 2013. The median price of a half-ounce also increased slightly from $150 to $160. The price of an ounce of bush cannabis was reported to be $300 in 2013.

The most common amount of bush cannabis purchased was a gram, with 15 participants reporting that they had bought a gram in the six months preceding interview. As can be seen in Table 20, of those that commented on bush cannabis in 2013, the majority (88%) reported that the price of bush had remained stable in the six months preceding interview.

Table 19: Price and changes in price for hydroponic cannabis, ACT, 2012–2013

Median Price – Cannabis (Hydro)	2012	**2013**
Gram	$20	**$20**
(range)	(10–25)	(10–25)
Quarter-ounce	$90	**$90**
(range)	(50–120)	(70–110)
Half-ounce	$150	**$160**
(range)	(140–180)	(130–200)
Ounce	$290	**$300**
(range)	(200–400)	(250–400)
Change in price	n=62	**n=60**
% Increasing	5	**8**
% Stable	82	**83**
% Decreasing	3	**2**
% Fluctuating	5	**7**

Source: ACT IDRS PWID interviews, 2012–2013
^ Interpret with caution, n=<10

Table 20: Price and changes in price for bush cannabis, ACT, 2012–2013

Median Price – Cannabis (Bush)	2012	**2013**
Gram	$20	**$20**
(range)	(10–20)	(10–20)
Quarter-ounce	$80	**$85**
(range)	(70–100)	(50–100)
Half-ounce	$140	**$150**
(range)	(130–150)	(100–180)
Ounce	$220	**$265**
(range)	(200–250)	(200–400)
Change in price	n=25	**n=25**
% Increasing	8	**0**
% Stable	84	**88**
% Decreasing	0	**4**
% Fluctuating	0	**8**

Source: ACT IDRS PWID interviews, 2012–2013
^ Interpret with caution, n=<10

AVAILABILITY

Participants were asked to comment on the current availability, as well as any changes in availability, of both hydro and bush in the ACT in 2013. Findings are presented separately for each type of cannabis.

Hydro

Of those that commented on the current availability of hydro (n=61), the majority reported it to be very easy (53%) and easy (39%) to obtain. There were no significant differences between 2012 and 2013 (p>0.05).

The majority (84%) of participants commenting on hydro thought that the availability had remained stable in the six months prior to interview, similar to 2012 (89%). Recent hydro users who bought hydro predominantly reported last purchasing it from a friend (48%), a known dealer (21%) or a street dealer (12%). The most common places for purchasing hydro were from a friend's home (39%), a dealer's home (21%), and an agreed public location (18%).

Table 21: Availability of hydro cannabis, ACT, 2012–2013

Availability – Hydroponic Cannabis	2012	**2013**
Responded	n=62	n=61
% Very easy	58	53
% Easy	39	39
% Difficult	3	7
% Very difficult	0	2
Changes in availability	n=62	**n=61**
% More difficult	5	7
% Stable	89	84
% Easier	2	5
% Fluctuates	5	5

Source: ACT IDRS PWID interviews, 2012–2013

Bush

The majority of those that commented on the current availability of bush cannabis (n=26) reported that bush was easy (54%) to obtain. A further 23% reported that bush cannabis was very easy to obtain. Nineteen percent reported that it was difficult to obtain. Of those that commented, 69% reported that bush availability had remained stable in the six months preceding interview, as shown in Table 22.

The majority of bush purchases were through a friend (58%), followed by a known dealer (23%) and acquaintances (8%). Purchases most often occurred at a friend's home (58%), an agreed public location (12%), or from a dealer's home (12%).

Table 22: Availability of bush cannabis, ACT, 2012–2013

Availability – Bush Cannabis	2012	2013
Responded	n=26	n=26
% Very easy	54	23
% Easy	31	54
% Difficult	12	19
% Very difficult	0	4
Change in availability	n=26	n=26
% More difficult	8	19
% Stable	73	69
% Easier	12	8
% Fluctuates	0	4

Source: ACT IDRS PWID interviews, 2012–2013

POTENCY

Respondents were asked (based on their experience) to estimate the current strength or potency of hydro and bush cannabis, as well as to report perceived change in potency of both hydro and bush. Results are presented below separately for each form (Figure 16 and Figure 17).

Hydro

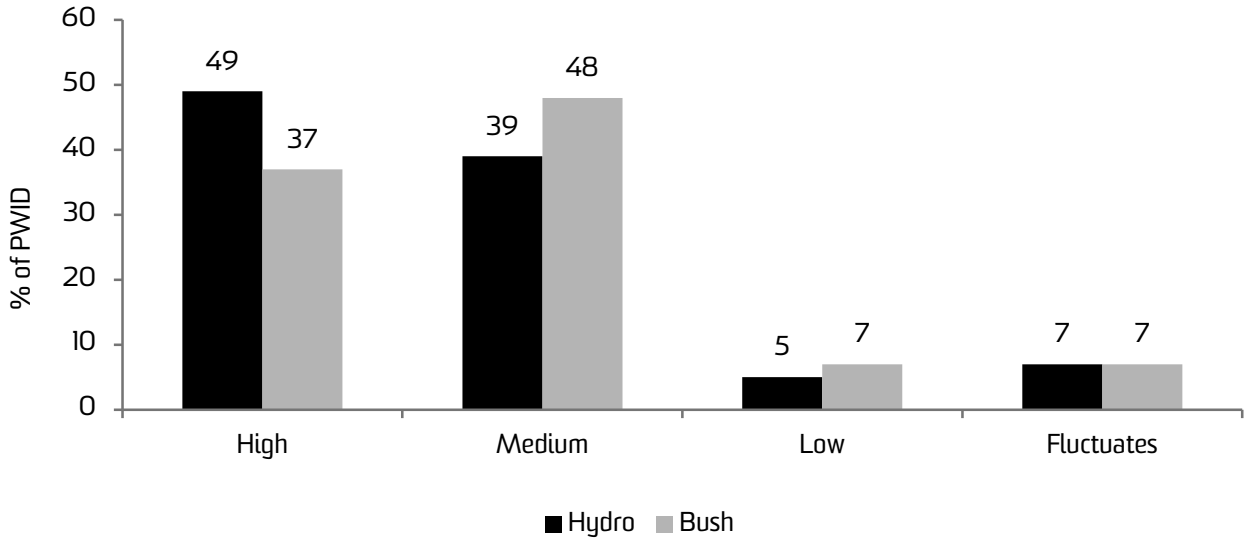
The majority of participants who commented on hydro reported that its potency was high (49%) in the six months preceding interview (see Figure 16). Over a third (39%) of the participants reported that the potency was medium. The majority (64%) of participants reported that hydro potency was stable in 2013. There were no significant differences in the reported potency or potency change of hydro from 2012 to 2013 ($p>0.05$).

Bush

The potency of bush cannabis was generally reported to be medium (48%); however, 37% reported it to be high while 7% reported it to be low. No significant differences were found between 2012 and 2013.

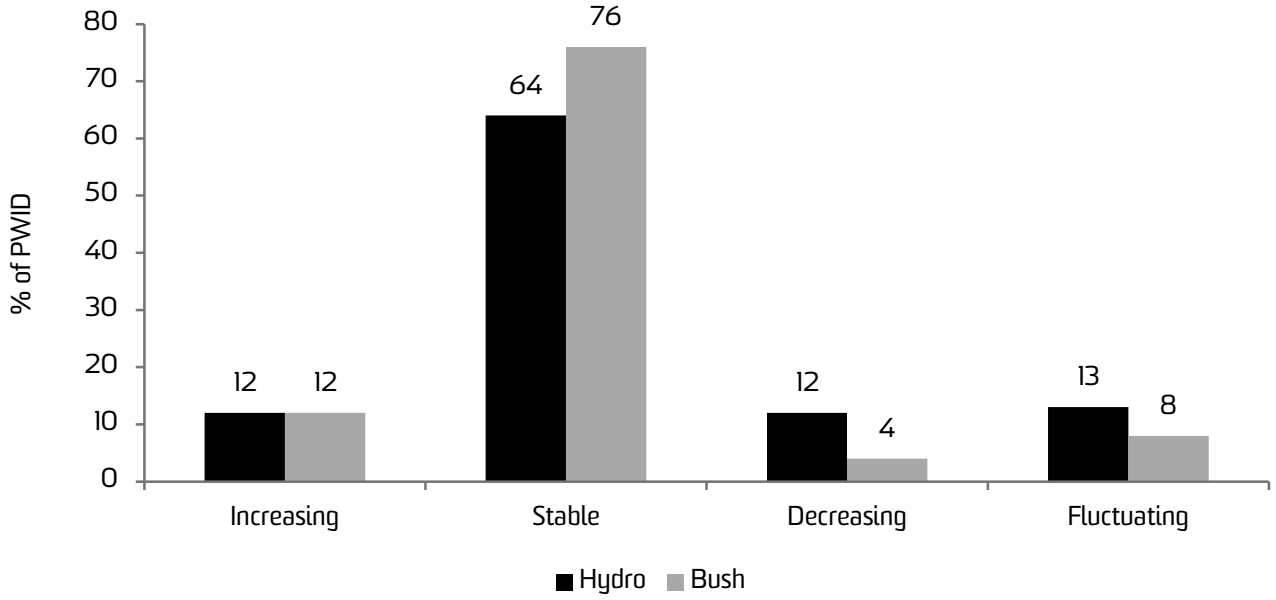
As can be seen in Figure 16, the majority (76%) of respondents who commented on bush cannabis reported that the potency had remained stable in the six months prior to the interview. There were no significant differences in reports of potency change of bush cannabis between 2012 and 2013 ($p>0.05$).

Figure 15: Perceived potency of cannabis among those who responded, 2013



Source: ACT IDRS PWID interviews, 2013

Figure 16: Change in perceived cannabis potency, ACT 2013



Source: ACT IDRS PWID interviews, 2013

5.5. Methadone

PRICE

In 2013, 20 participants commented on the current price of street (illicit) methadone in the ACT. The median price reported for a millilitre of methadone was $1.00 in 2013. The large majority of participants (88%) who commented reported that the price of methadone remained stable over the six months preceding interview.

AVAILABILITY

Participants were asked to comment on the current availability of illicit methadone and if there had been any change in availability in the six months preceding interview. As can be seen in Table 23, reports on the current availability of street methadone varied. Similar proportions reported street methadone to currently be easy (44%) and difficult (33%). Twenty-two percent of respondents who commented on the current availability of street methadone reported it to be very easy to obtain, while no one commented that methadone was very difficult to obtain. The majority (71%) of participants reported that the availability of methadone had remained stable in the past six months. There were no significant differences between 2012 and 2013 in regards to the reported availability or change in availability of methadone (p>0.05).

Table 23: Reported availability of illicit methadone, ACT, 2011–2012

Availability – Illicit Methadone	2012	**2013**
Responded	n=19	n=18
% Very easy	21	22
% Easy	42	44
% Difficult	37	33
% Very difficult	0	0
Change in availability		
% More difficult	16	12
% Stable	74	71
% Easier	5	0
% Fluctuates	5	18

Source: ACT IDRS PWID interviews, 2012–2013

In 2013, of participants who reported that they had bought methadone (n=17), 94% reported that they had obtained it through a friend, and 6% had obtained it from a known dealer. Most commonly, participants had last obtained methadone from a friend's home (47%), at an agreed public location (24%) or by home delivery (18%). Just over half (53%) of participants had bought methadone while 41% had been given methadone for free.

5.6. Buprenorphine

PRICE

In 2013, only two participants were able to comment on the price for a 2 mg tablet of buprenorphine, reporting the median price to be $17.50. The median price for an 8 mg tablet increased to $50 (from $40 in 2012). These results should be interpreted with caution, however, due to very low numbers responding. The majority of participants (67%) who commented (n=6) believed that the price of buprenorphine had remained stable in the six months preceding interview, while 33% reported that the price had increased.

AVAILABILITY

Although reports on the availability of buprenorphine were mixed, generally participants who were able to comment (n=6) reported buprenorphine to be very easy (33%) to easy (50%) to obtain. Another 17% reported that it was difficult to obtain. Half (50%) of those who commented believed that availability had remained stable in the six months preceding interview, whilst 33% of participants reported that buprenorphine had become more difficult to obtain and 17% reported that it had become easier to obtain. Buprenorphine was most commonly obtained from friends (50%), a known dealer (33%) or street dealer (17%). The most common venue was from an agreed public location (33%), or a friend's home (33%).

5.7. Buprenorphine-naloxone

PRICE AND AVAILABILITY

Only two participants were able to comment on the price and availability of illicit buprenorphine-naloxone (Suboxone®). As such, median price and availability will not be reported in 2012.

5.8. Morphine

In 2013, 10 participants commented on trends in price and availability of illicitly obtained morphine in the ACT. Findings are presented below.

PRICE

Participants were asked to comment on the current price of different brands of morphine tablets. As can be seen in Table 24, the median price for 100 mg of MS Contin® tablets was reported to be $50 and the median price for 100 mg of Kapanol® capsules was also reported to be $50. Due to small numbers commenting on the price of illicitly obtained morphine, caution is advised when interpreting findings. Participants were asked to comment on any change in the price of morphine in the six months preceding interview. Among those that responded (n=9), the vast majority (89%) reported that the price of morphine had remained stable over the past six months.

Table 24: Price and change in price of illicit morphine, ACT, 2012–2013

Median Price – Illicit morphine	2012	**2013**
MS Contin® - 60 mg	$20^ (20–30)	$30^ (30–80)

Median Price – Illicit morphine	2012	**2013**
MS Contin® - 100 mg	$50^ (35–50)	$50^ (5–60)
Kapanol® - 100 mg	$55^ (50–60)	$50^ (no range)
Change in price	n=15	**n=9**
% Increasing	13	11^
% Stable	73	89^
% Decreasing	7	0
% Fluctuating	7	0

Source: ACT IDRS PWID interviews, 2012–2013
^ indicates small number (<10)

AVAILABILITY

In 2013, of those who commented on morphine availability (n=9), 56% reported it to be difficult to obtain, whilst 34% reported it to be easy and 11% very easy.

Of those who commented (n=10), most (70%) reported that morphine availability had remained stable in the six months preceding interview. Twenty percent reported that it was more difficult to obtain and 10% reported that availability had fluctuated.

Most commonly, participants obtained morphine from a friend (70%). Participants had most commonly last obtained methadone at a friend's home (40%) or via home delivery (30%).

5.9. Oxycodone

In 2013, seven participants were able to comment on the price, purity and availability of illicit oxycodone. The median price reported for an 80 mg tablet of Oxycontin® was $40 (n=4). These results should be interpreted with caution, however, due to very low numbers responding. All participants who commented (n=5) believed that the price of oxycodone had remained stable in the six months preceding interview.

AVAILABILITY

Reports on the availability of illicit oxycodone were varied. A third of respondents reported that the availability of oxycodone was easy (33%) or difficult (33%) with the remaining third split between very easy (17%) and very difficult (17%). The majority (67%) of those who commented believed that availability had remained stable in the six months preceding interview, whilst 17% of participants reported that oxycodone had become more difficult to obtain and 17% reported that it had fluctuated. Oxycodone was most commonly obtained from friends (57%).

6 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

6.1. Overdose and drug-related fatalities

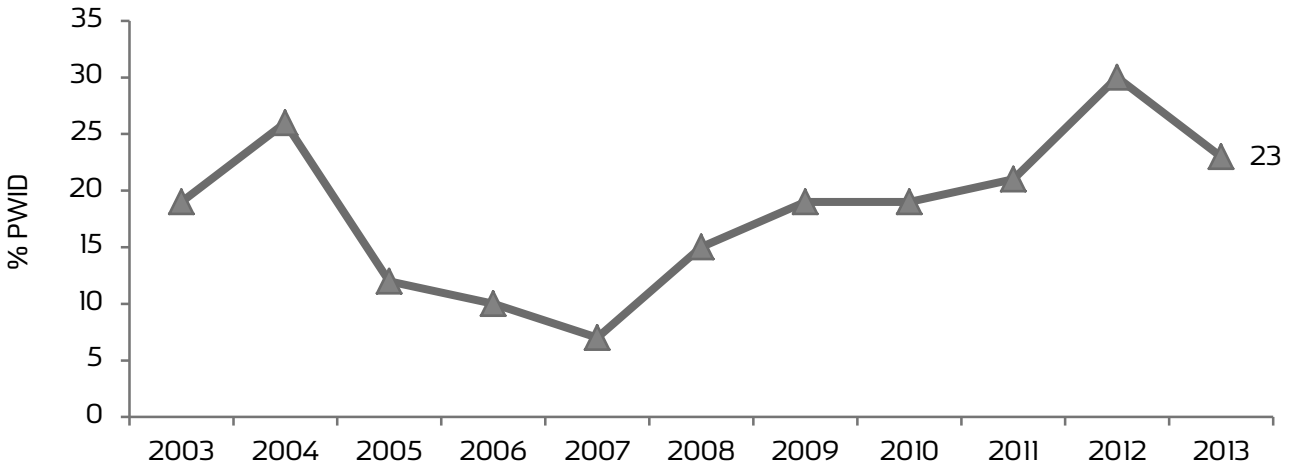
HEROIN AND OTHER OPIOIDS

Non-fatal overdose

In 2013, 48% of participants reported having overdosed on heroin at least once at some point in their lives, similar to 51% in 2012. Of participants who reported ever having overdosed on heroin the median number of times overdosed was two (range=1–200).

As can be seen from Figure 18, in 2013, 23% of participants reported having overdosed on heroin in the year prior to the interview; compared to 30% in 2012. Two participants reported overdosing on heroin in the past month.

Figure 17: Proportion of PWID reporting heroin overdose in the year preceding interview, 2003–2013



Source: ACT IDRS PWID interviews, 2003–2013

In 2013, participants who reported overdosing on heroin in the previous year (n=11) were asked what treatment they received immediately after the overdose. Most participants (64%) reported receiving treatment or information in relation to their overdose. Five participants reported receiving Narcan®, one participant reported receiving CPR from a friend/peer, and there were four reports of ambulance attendance.

NALOXONE PROGRAM

In 2011, a peer based Naloxone distribution program was established which aimed to expand the availability of naloxone as a prescription medication for potential overdose victims. The availability of naloxone is accompanied by appropriate programs which train potential overdose witnesses in comprehensive overdose

prevention and management strategies including naloxone administration. Participants were asked about their knowledge and/or experience with this program.

Participants were then asked if they had heard about take-home naloxone programs. Of those who commented (n=98), 70% reported that they had heard of the take-home naloxone program. When asked if they would support the expansion of the naloxone program, the majority reported that they would 'strongly support' an expansion (71%), 22% reported that they would 'support' an expansion, while 1% reported that they would 'oppose' or 'strongly oppose' an expansion (Table 25). In the ACT, 22% reported that they had been resuscitated with naloxone by somebody who had been trained through the naloxone program.

A third (32%) of participants reported that they had completed training in naloxone administration along with a prescription for naloxone. Of those who had completed the course (n=31), 29% (n=9) had used the naloxone to resuscitate someone who had overdosed on an average of two people (range 1–4 people).

Participants who had not completed training in naloxone administration were asked what they would do if they witnessed someone overdose or found someone they had suspected had overdosed. The majority of respondents reported that they would call 000 (91%), while 31% reported that they would perform mouth-to-mouth cardiopulmonary resuscitation (CPR; Table 25).

Participants who had not completed training in naloxone administration and commented were also asked if naloxone was available would they; (a) carry naloxone if trained in its use? (b) administer naloxone after witnessing someone overdose?, (c) want peers to give them naloxone if they overdosed?, and (d) stay with someone after giving them naloxone? Ninety-six percent reported that they would stay with someone after giving them naloxone, 94% reported that they would administer naloxone after witnessing someone overdose, 88% would want their peers to give them naloxone if they overdosed and 68% reported that they would carry naloxone on them.

Table 25: Take-home naloxone program and distribution, 2013

	ACT n=98
Heard of naloxone (%)	92
Naloxone description (%)	n=90
Reverses heroin	74
Help start breathing	9
Re-establish consciousness	27
Other	4
Heard of the take-home naloxone program (%)	n=98
Yes	70
No	30
Expand naloxone program (%)	n=98

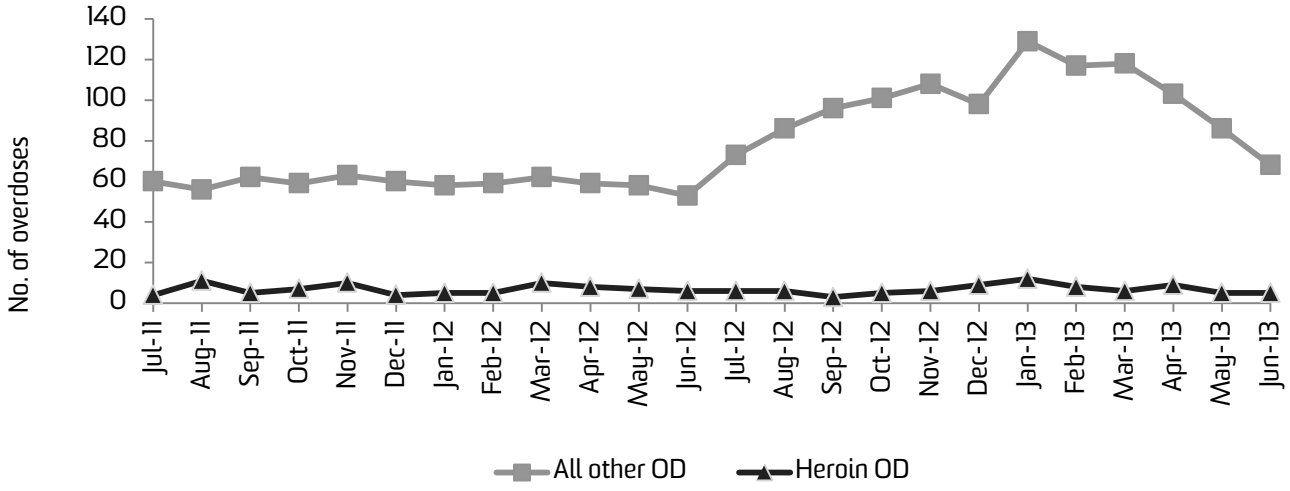
Strongly support	71
Support	22
Neutral	4
Oppose	1
Strongly oppose	0
Don't know enough to say	1
Witness overdose (%)	n=98
Turn victim on side	33
Mouth-to-mouth CPR	31
Call 000	91
Stay with victim	24
Other remedies	12
If naloxone was available would you: (%)	n=66
Carry naloxone if trained	68
Administer naloxone after overdose	94
Want peers to give you naloxone	88
Stay after giving naloxone	96

Source: ACT IDRS PWID interviews, 2013

AMBULANCE ATTENDANCES FOR OVERDOSE IN ACT

The following graphs (Figure 190, Figure 20 and Figure 21) present data pertaining to ambulance calls in the ACT to reported heroin overdoses. In the 2012–13 financial year, there were significantly more (p<0.05) ambulance calls to overdoses in the ACT (n=1,183) compared to the 2011–12 financial year, where there were a total of 791 ambulance calls to overdoses in the ACT. Much of this increase has been driven by the number of non-heroin overdoses which increased from 90% of attendances (n=709 in 2011–12) to 93% of attendances (n= 1,103 in 2012–13). This is a significant increase (p<0.05). As can be seen from Figure 20, ambulance calls relating to heroin overdoses represent only a small proportion of the total number of ambulance calls for overdoses in the ACT. Other drug overdoses may be due to alcohol, prescription medication and benzodiazepines.

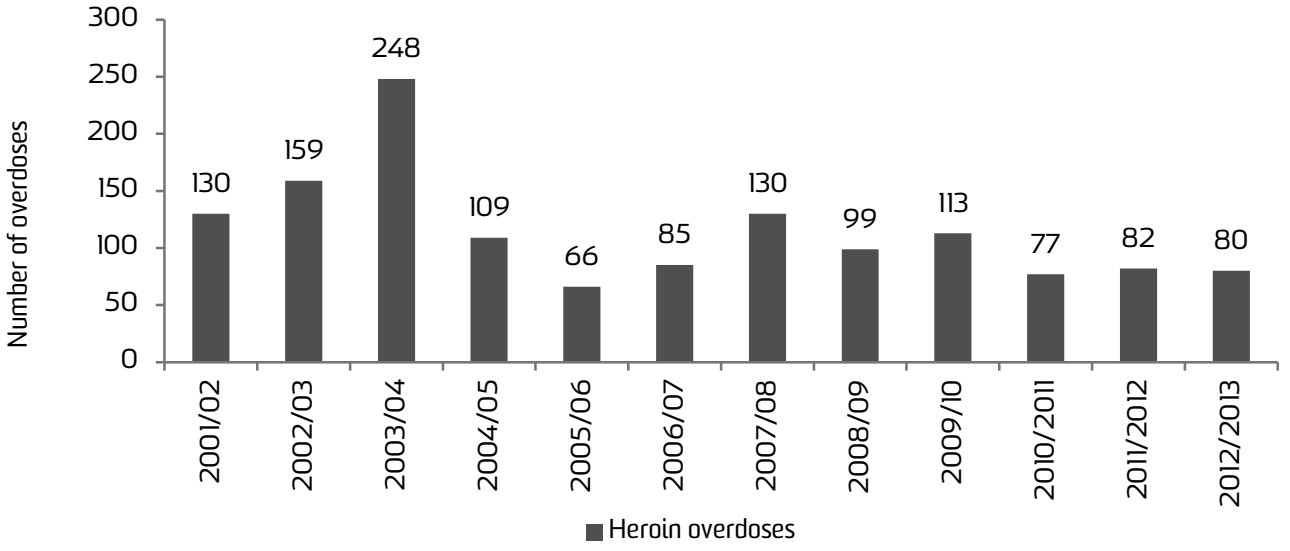
Figure 18: Overdoses attended by ACT Ambulance Service, by month, 2011–2013



Source: ACT Ambulance Service, 2011–2013

As can be seen from Figure 19, in the 2012–13 financial year, there was a total of 80 heroin overdoses attended by the ACT Ambulance Service. This was a decrease from 82 heroin overdoses attended in 2011–12.

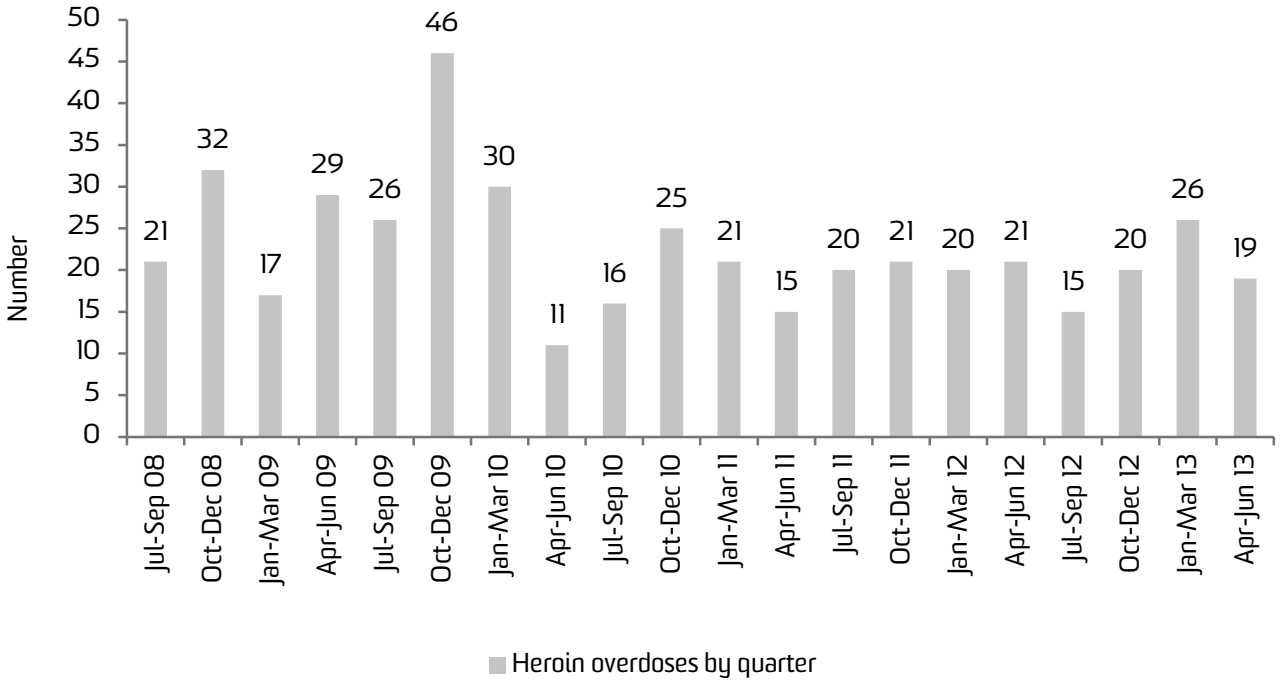
Figure 19: Heroin overdoses attended by ACT Ambulance Service, 2001–02 to 2012–13



Source: ACT Ambulance Service, 2001–2013

Figure 20 depicts the number of heroin overdoses attended by the ACT Ambulance Service by quarter. When analysed by quarter, the number of heroin overdoses in the Ambulance Service in the ACT has varied over the past five years.

Figure 20: Heroin overdoses attended by ACT Ambulance Service, by quarter, July 08 to June 13



Source: ACT Ambulance Service, 2010–2013

OTHER DRUGS

Non-fatal overdose

In addition to heroin overdose, participants were asked whether they considered themselves to have ever accidentally overdosed on any other drug(s).

Just over one-fifth (21%) of participants reported overdosing on a drug other than heroin at some point in their life on a median of one time. Only one participant reported overdosing on any other drug in the previous year.

6.2. Drug treatment

IDRS PARTICIPANT SURVEY

Participants interviewed for the IDRS who were currently in treatment (58%) were asked a number of questions about their reported treatment. Participants reported a median of 36 months (ranging from one month to 26 years) in any current treatment. Those in current methadone treatment (44% of the sample) reported a median of 36 months (ranging from one month to 25 years). One-third (33%) of participants in current treatment reported that they had been in treatment for 12 months or less.

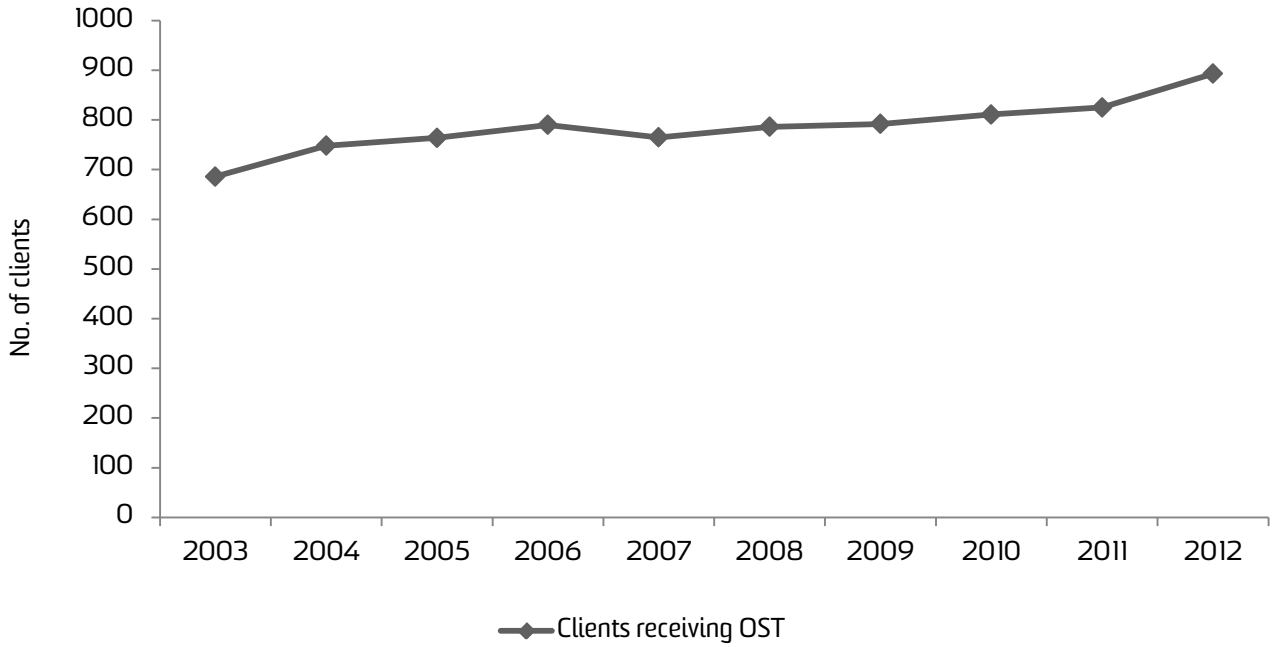
Eleven percent of the national sample reported current buprenorphine-naloxone treatment, 2% buprenorphine, and 1% reported being in drug counselling treatment.

PHARMACOTHERAPY

Opioid substitution treatment

Methadone maintenance treatment is an established form of opioid substitution treatment (OST) in all jurisdictions in Australia. In 2000, Subutex® (buprenorphine hydrochloride) was registered in Australia and listed on the Pharmaceutical Benefits Scheme (PBS) in March 2001. Suboxone® (buprenorphine-naloxone) was registered in Australia in 2005 and listed on the PBS in April 2006. The total number of clients registered in OST has steadily increased over the years. Clients receiving OST in the ACT reached its highest number in 2012 with 893 clients registered for OST on a snap-shot day in 2012. (See Figure 21)

Figure 21: Clients receiving OST in the ACT 2003–2012



Source: (Australian Institute of Health and Welfare, 2012b)

The majority (82%) of OST clients in ACT were registered for methadone treatment, while 14% were registered for buprenorphine- naloxone and four percent were registered for buprenorphine treatment on a snap-shot day in 2012.

Over two-thirds (71%) of OST clients in ACT were dosed at a pharmacy, followed by 18% who were dosed at a public clinic. Eleven percent of OST clients in ACT were dosed at a correctional facility.

OTHER TREATMENT TYPES

Treatment statistics collected by the Alcohol and Other Drug Treatment Services – National Minimum Data Set (AODTS-NMDS) provide measure of service utilisation for clients of alcohol and other drug treatment

services. This collection provides ongoing information on the demographics of clients who use these services, the treatment they receive, and the drug of concern for which they are seeking treatment. In 2011–12, 4,010 episodes of treatment were reported of clients seeking treatment for their own drug use in the ACT. The principal drug of concern refers to the main substance that the client stated led them to seek treatment from the alcohol and other drug treatment agency. Only clients seeking treatment for their own substance use are included in the analysis involving principal drug of concern.

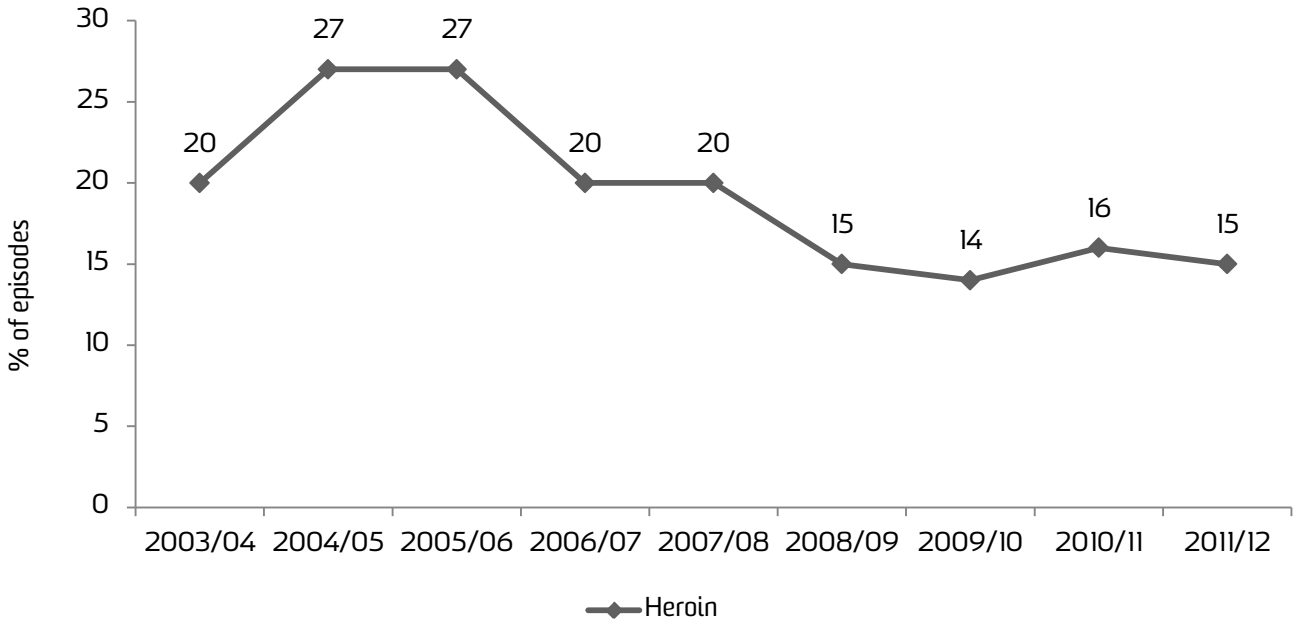
Alcohol

In 2011–12, alcohol accounted for almost half (48%, n=1,935) of all closed treatment episodes. This is a significant decrease from 2010–11 where 54% (n=1,671) of all episodes indicated alcohol as the principle drug of concern (p<0.05).

Heroin

Figure 22 shows that the proportion of closed treatment episodes, for clients where heroin was identified as the principal drug of concern, has remained stable over recent years. In 2011–12, heroin accounted for 15% (n=608) of episodes.

Figure 22: Closed treatment episode, heroin, (excl. pharmacotherapy), 2003–04 to 2011–12

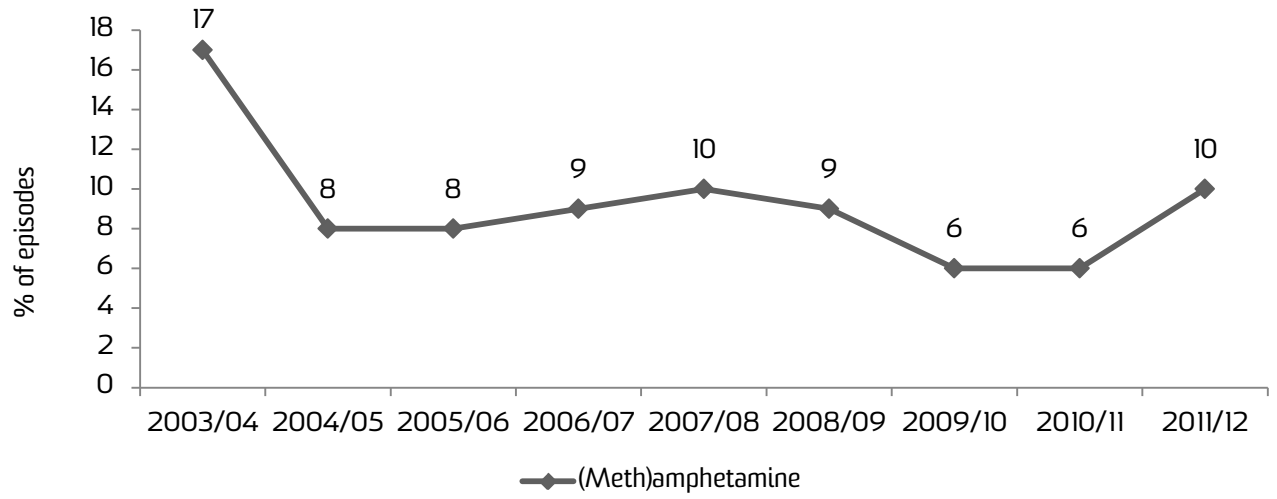


Source: (Australian Institute of Health and Welfare, 2012b)

Methamphetamine

As can be seen in Figure 23, there has been a significant increase in the proportion of episodes where (meth)amphetamine was identified as the principal drug of concern (p<0.01). In 2011–12, (meth)amphetamine accounted for 15% (n=409) of closed treatment episodes.

Figure 23: Closed treatment episodes, (meth)amphetamine, 2003–04 to 2011–12

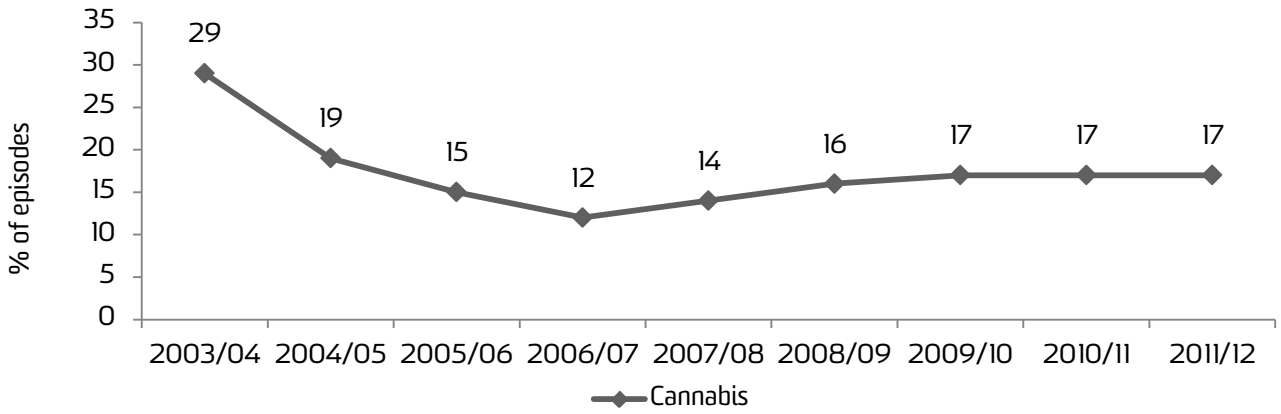


Source: Australian Institute of Health and Welfare, 2012b

Cannabis

As can be seen from Figure 24 the proportion of closed treatment episodes where cannabis was identified as the principal drug of concern has remained stable for the previous three years. In 2011–12, cannabis accounted for 17% (n=696) of all closed treatment episodes.

Figure 24: Closed treatment episodes, cannabis, 2003–04 to 2011–12

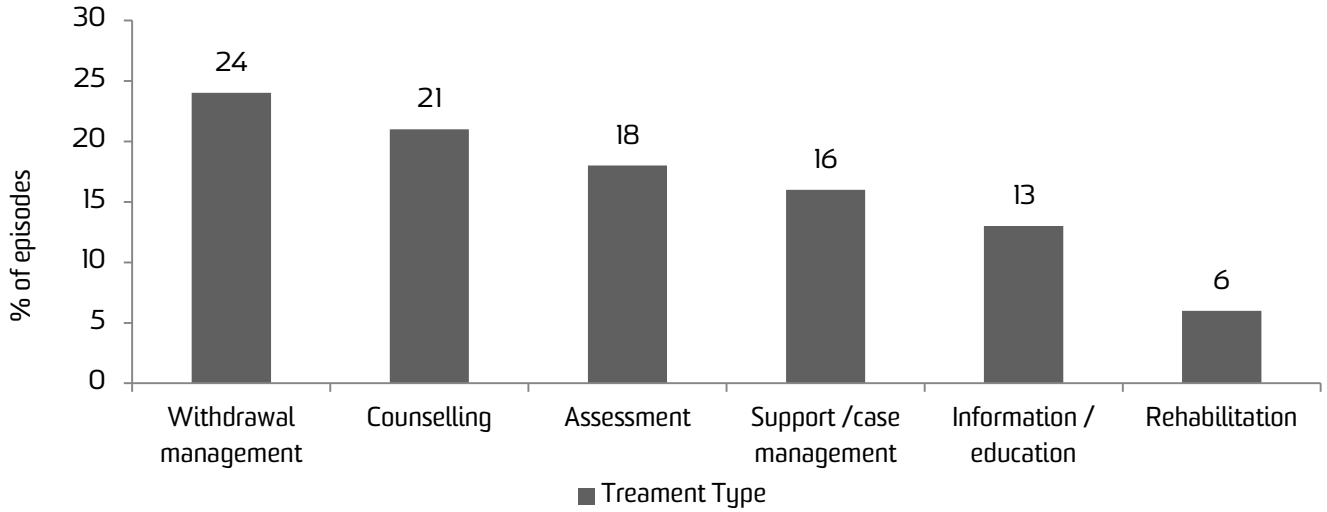


Source: Australian Institute of Health and Welfare, 2012b

TREATMENT TYPES

In 2011–12, the main type of treatment reported was withdrawal management (24%) followed by counselling (21%), assessment only (18%), support and case management (16%), and information and education (13%). Six percent of closed treatment episodes were for rehabilitation (Figure 25).

Figure 25: Type of treatment provided, ACT, 2011–12



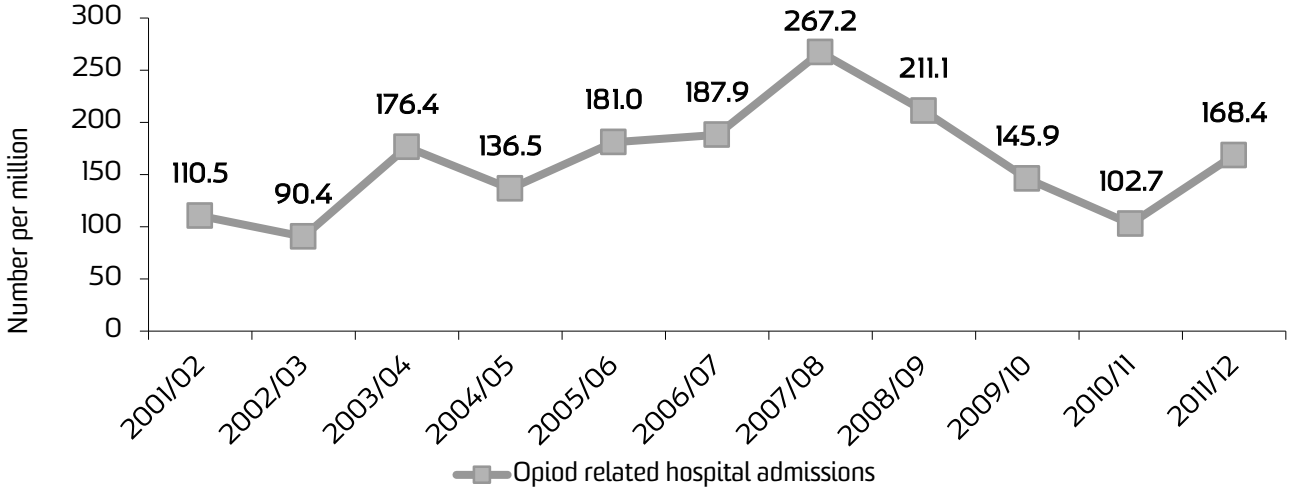
Source: Australian Institute of Health and Welfare, 2012b

6.3. Hospital admissions

HEROIN INCLUDING OTHER OPIOIDS

The number per million persons of inpatient hospital admissions among persons aged 15–54 years, with a principal diagnosis relating to opioids, is shown in Figure 26. The AIHW defines primary diagnosis as the diagnosis established to be chiefly responsible for occasioning the patient's episode of care in hospital. As can be seen from Figure 26, the number of opioid-related hospital admissions has not continued its downward trend and has risen to 168.4 per million persons in 2011–12.

Figure 26: Hospital admissions, opioids, ACT, 2001–02 to 2011–12.

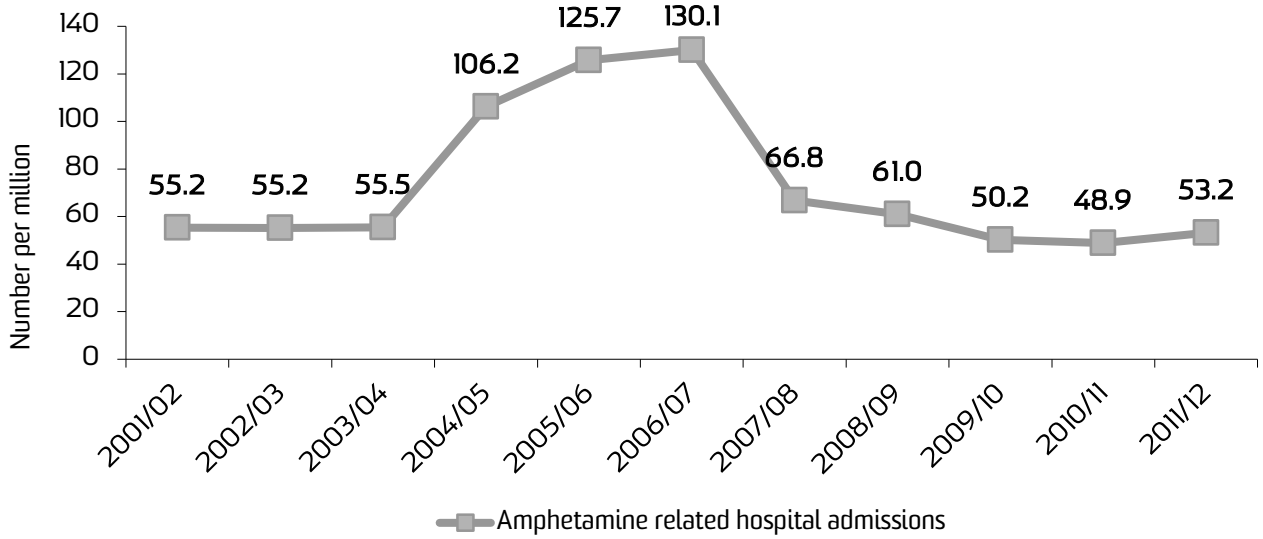


Source: AIHW; ACT Department of Health; Roxburgh and Burns, in press

METHAMPHETAMINE

Figure 27 shows the number of hospital admissions in the ACT, of persons aged 15–54 years, where amphetamine was implicated in the primary diagnosis. The number of amphetamine-related hospital admissions in the ACT has remained lower than 150 per million persons in the last 10 years (see Figure 27). In 2011–12, admissions have remained relatively stable at 53.18 per million persons.

Figure 27: Hospital admissions, amphetamine, ACT, 2001–02 to 2011–12.



Source: AIHW; ACT Department of Health; Roxburgh and Burns, 2013; Roxburgh and Burns, in press

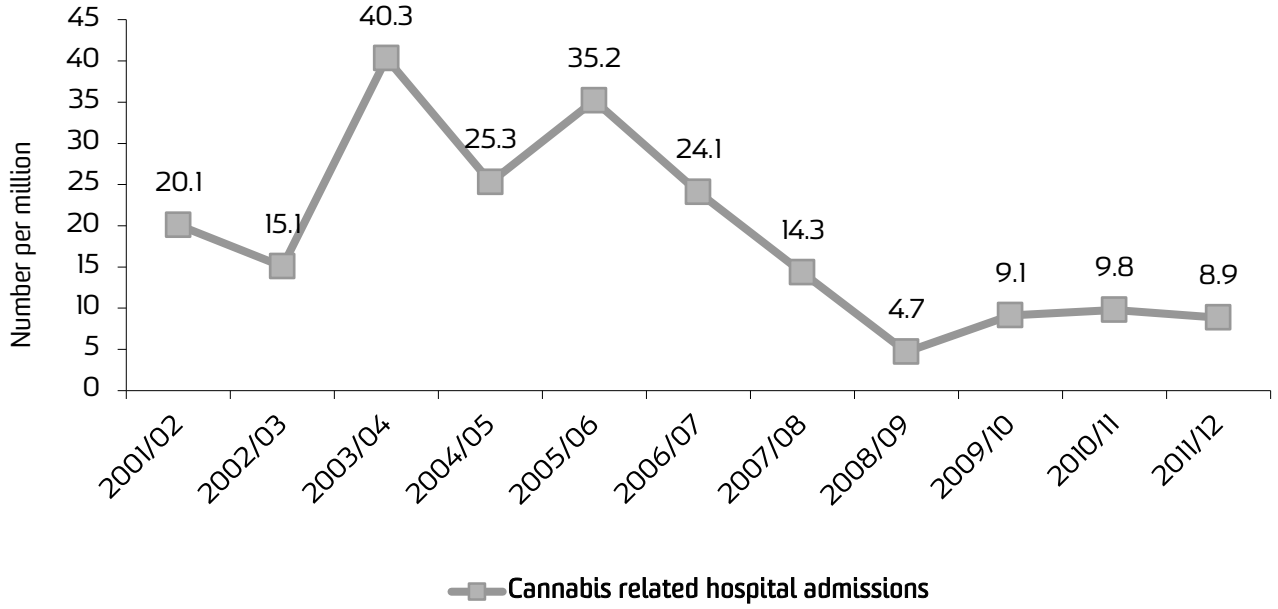
COCAINE

Numbers of hospital admissions in the ACT where cocaine was implicated in the primary diagnosis have remained lower than 10 per million persons aged 15–54 years in the last 10 years. In 2011–12, there were 4.43 cocaine-related hospital admissions per million recorded in the ACT.

CANNABIS

As can be seen from Figure 28, the number of cannabis-related hospital admissions per million persons has fluctuated over the last 10 years. In 2011–12, there were 8.86 cannabis-related hospital admissions per million persons recorded in the ACT, similar proportions to 2010–11.

Figure 28: Hospital admissions, cannabis, ACT, 2001–02 to 2011–12



Source: AIHW; ACT Department of Health; Roxburgh and Burns, in press

6.4. Injecting risk behaviour

ACCESS TO NEEDLES AND SYRINGES

Needle and Syringe Programs (NSP) were by far the most common source of needles and syringes in the preceding six months (88%), followed by chemists (23%). NSP vending machines were used by 7% of participants. Proportions reporting obtaining needles and syringes from a friend (6%), partner (1%) and/or dealer (3%) were observed at very low proportions. Hospitals and outreach/peer workers were also accessed.

In comparison, data from the 2010 National Drug Strategy Household survey (NDSHS) reported that around 65% of recent injectors (used in the previous 12 months) obtained needles and syringes from a chemist, followed by 37% at NSP (Australian Institute of Health and Welfare, 2011).

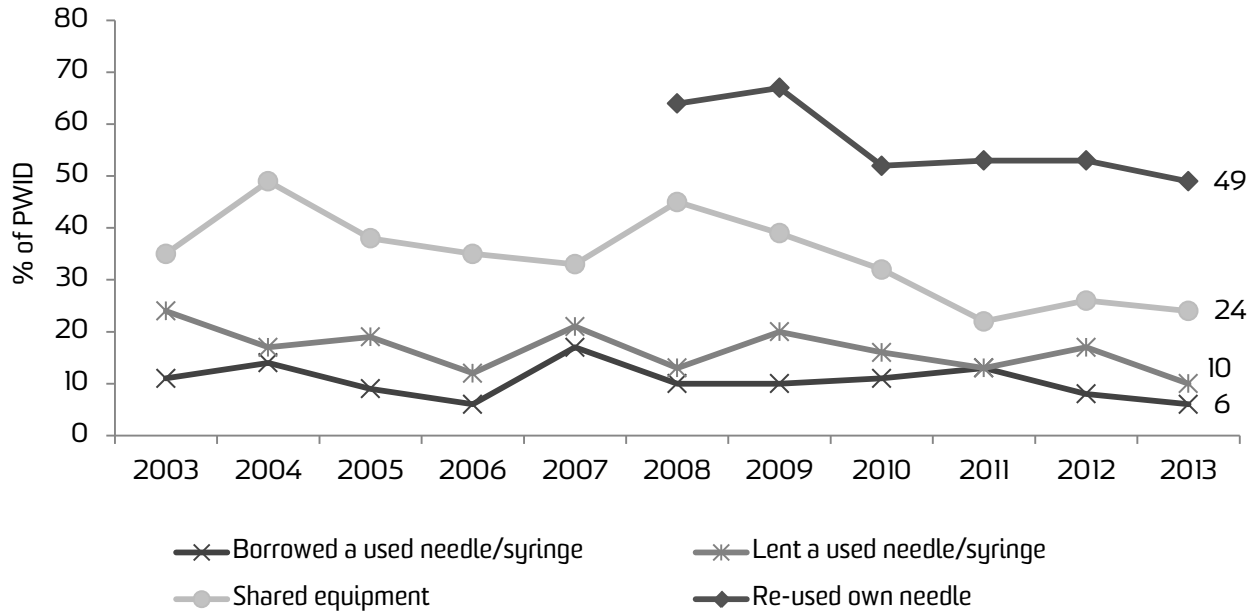
SHARING OF INJECTING EQUIPMENT AMONG PWID

Figure 29 presents the proportion of participants in the 2013 sample who reported recently sharing injecting equipment. In the month preceding interview, 6% (n=6) of participants had injected with syringes that had already been used by someone else. Most (67%) participants who had borrowed a needle reported that one person had used the needle before them. Most respondents (83%) reported that the people who had used syringes prior to themselves were close friends (n=5).

The proportion of participants who reported lending used needles declined to 10% in 2013 (17% in 2012). Of the 10 participants reporting lending needles in the month prior to interview, four participants reported that someone else used their needle one time after they had used it and three respondents reported that

their needle was used between three and five times after they had used it and three participants reported that their needle was used more than five times after they had used it.

Figure 29: Proportion of PWID reporting sharing injecting equipment, 2003–2013



Source: ACT IDRS PWID interviews, 2003–2013

As well as sharing needles and syringes, participants may also share other injecting equipment such as spoons and other mixing containers, swabs, tourniquets and water. In 2013, 24% of the sample reported having used other injecting equipment after it had been used by someone else. The proportion of participants reporting using a spoon/mixing container after someone else was 15% in 2013. As can be seen in Table 26, 4% of participants reported using a filter after someone else. The proportion reporting using a tourniquet after someone else is 7%, while no participants reported sharing swabs in 2013.

Table 26: Proportion of PWID reporting sharing other injecting equipment by type, 2009–2012

Injecting equipment used after someone else:	2009 N=100	2010 N=101	2011 N=98	2012 N=99	2013 N=100
Spoon / mixing container (%)	34	29	17	15	15
Filter (%)	12	14	5	5	4
Tourniquet (%)	11	7	7	2	5
Water (%)	22	17	11	3	7
Swabs	7	6	2	0	0

Source: ACT IDRS PWID interviews, 2009–2013

Participants in the 2013 IDRS were also asked questions about the site on their body where they had last injected. Four-fifths (82%) of participants reported that they last injected in their arm. Nine percent of participants reported last injecting in their hand or wrist, 4% in their leg, 3% in their foot and 2% in their neck.

LOCATION OF INJECTIONS

Table 27 presents a summary of the last location of drug injection among the ACT IDRS samples from 2009 to 2013. In 2013, the majority (83%) of participants reported that their last location of injection was a private home. Nine percent reported a public toilet as their last location of injection, and 2% reported a public place (such as a street or a park). Three percent of participants reported a car as the last location for injection.

Table 27: Location of last injection in the month preceding interview, ACT, 2009–2013

	2009	2010	2011	2012	**2013**
Location of last injection (%)	N=100	N=101	N=98	N=99	**N=100**
Private home	83	86	79	90	**83**
Public toilet	8	1	6	5	**9**
Street/park/beach	3	3	3	3	**2**
Car	6	6	7	2	**3**

Source: ACT IDRS PWID interviews, 2009–2013

SELF-REPORTED INJECTION-RELATED HEALTH PROBLEMS

In 2013, 53% of participants reported having experienced at least one injection-related health problem in the month preceding interview. Thirteen percent of participants reported experiencing a 'dirty hit' (i.e. a hit that made them feel sick) in the month preceding interview. The most common drugs implicated in a dirty hit amongst the sample were heroin (n=2), methamphetamine (n=2), oxycodone (n=2), and methadone (n=1). As can be seen from Table 28, the most commonly experienced injection-related problem in 2012 was scarring/bruising of injection sites (74%) followed by difficulty injecting (57%).

Table 28: Injection-related health problems, ACT, 2009–2013

	2009	2010	2011	2012	**2013**
Injection-related health problems in past month (%)	68	57	66	61	**53**
Problem: (%)					
Scarring/bruising*	43	38	30	65	**74**
Difficulty injecting*	39	21	21	53	**57**

	2009	2010	2011	2012	**2013**
'Dirty hit'*	19	17	22	24	**13**
Infections/abscesses*	0	10	7	9	**8**
Overdose*	4	5	10	2	**2**

Source: ACT IDRS PWID interviews, 2009–2013
*Among those who reported an injection problem

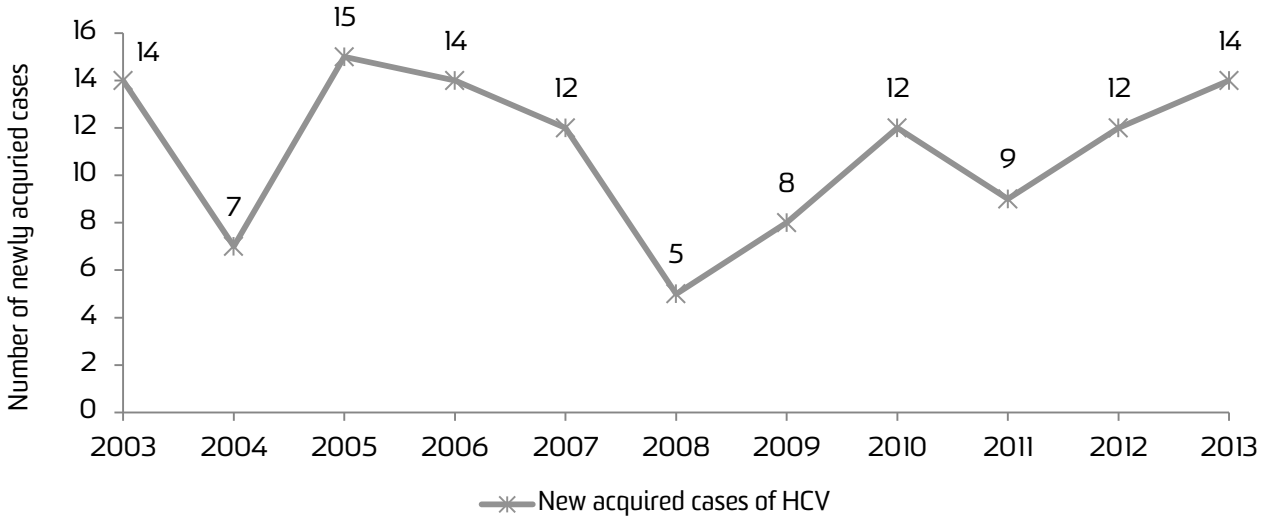
6.5. Blood-borne viral infections

Data presented in this section are derived from the NNDSS (National Notifiable Diseases Surveillance System, 2013).

The human immunodeficiency virus (HIV) prevalence among participants in the ACT remains low, which reflects the picture for Australian PWID as a whole (The Kirby Institute, July 2013). From 2000 to 2011, there have been no HIV positive cases in the ACT sample surveyed for the annual NSP survey (The Kirby Institute, July 2013)

In 2013, there were 378 new cases of the hepatitis C virus (HCV) reported nationally, of which 14 were reported in the ACT. This is a slight increase from the 12 cases of newly acquired HCV reported in 2012 (National Notifiable Diseases Surveillance System, 2013). Figure 30 presents the number of newly diagnosed cases of HCV in the ACT from 2003 to 2013.

Figure 30: Number of newly diagnosed HCV cases in the ACT, 2003–2013[2]

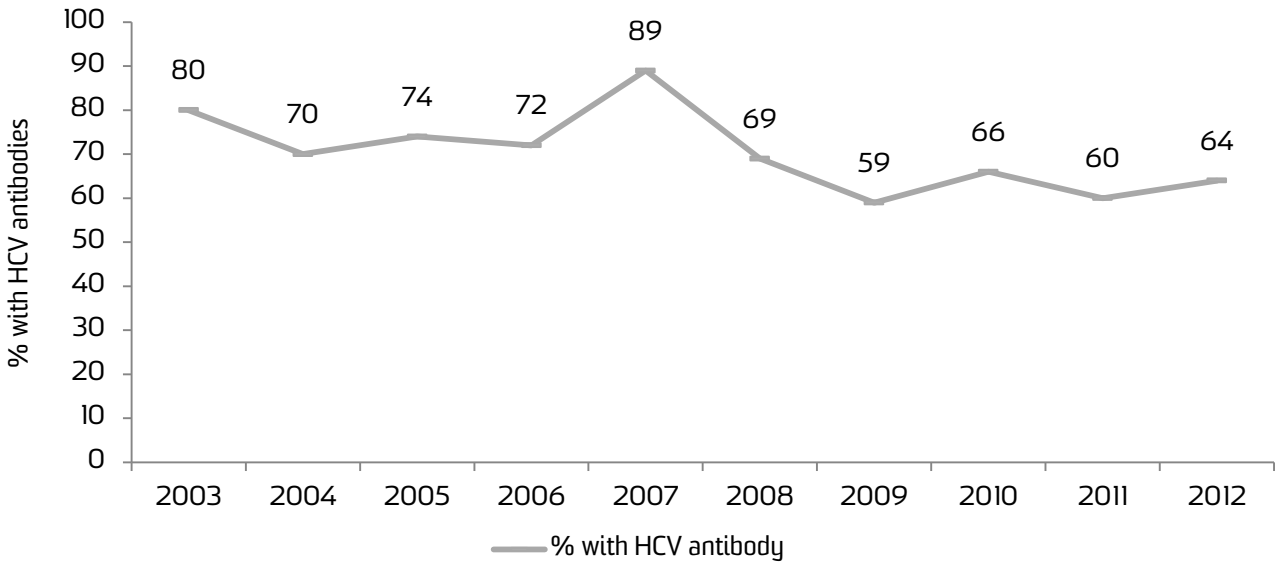


Source: Data accessed on 6 February 2014: National Notifiable Diseases Surveillance System, 2013

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

The HCV antibody prevalence among the PWID sampled for the NSP annual survey (The Kirby Institute, July 2013) is shown in Figure 31. As can be seen from this figure, from 2003 to 2007, HCV antibody prevalence remained relatively stable. In 2008 we saw a peak of 89% of PWID who were tested returning positive results for antibodies. Since this time there has been a small decrease in the proportion testing positive. In 2012, 78 PWID were tested in the ACT for the HCV antibody prevalence. Of these participants 64% (n=50) tested positive for HCV antibodies.

Figure 31: HCV antibody prevalence among PWID, ACT, 2003–2012



Source: Kirby Institute, July 2013

In 2013, there were four new notifiable cases of the hepatitis B virus (HBV) in the ACT (National Notifiable Diseases Surveillance System, 2013). The number of unspecified cases of HBV was 111 in 2013 (National Notifiable Diseases Surveillance System, 2013).

6.6. Alcohol Use Disorders Identification Test

Recently a lot of media attention has focused on young people and alcohol. However, there has been less focus on alcohol use amongst people who regularly inject drugs. People who regularly inject drugs are particularly at risk for alcohol-related harms due to a high prevalence of HCV. Half of the participants interviewed in the Australian NSP Survey 2012 (n=2,391) self-reported having previously tested positive for HCV antibodies (Kirby Institute, May 2013). Given that the consumption of alcohol has been found to exacerbate HCV infection and to increase the risk of both non-fatal and fatal opioid overdose and depressant overdose (Darke, Rossand Hall, 1996; Schiffand Ozden, 2004; Coffin, Tracy, Bucciarelli et al., 2007; Darke, Duflouand Kaye, 2007) it is important to monitor risky drinking among PWID.

The information on alcohol consumption currently available in the IDRS includes the prevalence of lifetime and recent use, and number of days of use over the preceding six months. Participants in the IDRS were asked the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) as a valid measure of identifying

heavy drinking (Bush, Kivlahan, McDonell et al., 1998). The AUDIT-C is a three item measure, derived from the first three consumption questions in the AUDIT. Dawson et al 2005 reported on the validity of the AUDIT-C, finding that it was a good indicator of alcohol dependence, alcohol use disorder and risky drinking.

Among ACT IDRS participants who drank alcohol in the past year, the overall mean score on the AUDIT-C was 5.6 (median=5, range 1–12). No significant differences were found for gender. Males and females scoring similar on the AUDIT-C (6.0 versus 4.9; $p>0.05$). According to Dawson et al 2005 and Haber et al 2009 in '*Guidelines for the Treatment of Alcohol Problem's,* a cut-off score of 5 or more indicated that further assessment was required.

More than half (55%) of the participants who drank in the past year scored 5 or over on the AUDIT-C. Sixty-one percent of males and 43% females scored 5 or more indicating the need for further assessment (Table 29).

Table 29: AUDIT-C among people who inject drugs and drank alcohol in the past year, 2012–2013

	National 2012 n=640	National 2013	ACT 2012 n=75	ACT 2013 n=64
Score of 5 or more				
All participants (%)	56	54	63	55
Males (%)	60	58	64	61
Females (%)	50	47	60	43

Source: IDRS ACT PWID interviews, 2012–2013

6.7. Mental health problems and psychological distress

SELF-REPORTED MENTAL HEALTH PROBLEMS

In 2013, 36% of participants interviewed reported having had a mental health problem other than drug dependence in the six months preceding interview. Of those reporting a mental health problem, the most common were depression (56%), anxiety (25%) and schizophrenia (17%) (see Table 30).

Most (89%) of those who reported mental health problems reported that they had attended a mental health professional in the previous six months; this is a significant increase on the proportion who reported the same in 2012 (49% in 2012 vs 81% in 2013 $p<0.05$). In 2012, participants were asked whether they were prescribed any medication from the mental health professional for their mental health problems. Of those who reported attending a mental health professional in the previous six months (n=27), a quarter (26%) reported being prescribed an anti-depressant, and 27% reported they had been prescribed an anti-psychotic. There was a significant decrease in the proportion of PWID who were prescribed a benzodiazepine (80% in 2012 vs 37% in 2013 $p<0.05$). A quarter (25%) of those who had attended a health professional in the preceding six months were not prescribed any medication (see Table 30).

Table 30: Summary of mental health problems experienced by PWID in the ACT, 2012, 2013

	2012	**2013**
Self-reported mental health problem last six months (%)	35	**36**
Self-reported mental health problems (%)*	(n=35)	**(n=36)**
Depression (%)	80	**56**
Anxiety (%)	51	**25**
Bipolar disorder (%)	14	**8**
Panic (%)	6	**11**
Phobias (%)	3	**3**
Paranoia (%)	0	**6**
Schizophrenia (%)	14	**17**
Drug-induced psychosis	3	**14**
Attended mental health professional (%)*	49	**81↑**
No medication (%)**	41	**25**
Prescribed anti-depressant (%)**	50	**26**
Prescribed anti-psychotic (%)**	44	**27**
Prescribed benzodiazepines (%)**	80	**37↓**

Source: ACT IDRS PWID interviews, 2012, 2013

* Of those who reported a mental health problem in the preceding six months

** Of those who attended a mental health professional

↓↑ Statistical significance at $p<0.05$

KESSLER PSYCHOLOGICAL DISTRESS SCALE

The Kessler 10 (K10) was administered in 2013 to obtain a measure of psychological distress. It is a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured by the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) / the Structured Clinical Interview for DSM disorders (SCID; Andrews and Slade, 2001; Kessler, Andrews, Colpe et al., 2002).

The minimum score of the scale is 10 (indicating no distress) and the maximum is 50 (indicating very high psychological distress). The mean score of the sample was 21.2 (range=8–43, median 21, SD=8.5). The 2010 NDSHS provided the most recent Australian population norms available for the K10, and used four categories to describe degree of distress: scores from 10–15 were considered to be low, 16–21 as moderate, 22–29 as high and 30–50 as very high. According to this classification, 23% of the 2013 PWID scored in the low range, 28% in the moderate distress range, 32% were in the high distress range, and 17% in the very high distress range. As can be seen in Table 31, whilst the majority in the NDSHS scored between 10–15 (70%), the IDRS sample scored more frequently in the moderate (28%) to high (32%).

Table 31: K10 scores in the 2010 NDSHS and the ACT IDRS interviews, 2012–2013

K10 Score	Level of psych. distress	National Drug Strategy Household Survey	2012 ACT IDRS (N=99)	2013 ACT IDRS (N=100)
10–15	No/low distress	70	**29**	**23**
16–21	Moderate distress	21	**18**	**28**
22–29	High distress	7	**26**	**32**
30–50	Very high distress	2	**27**	**17**

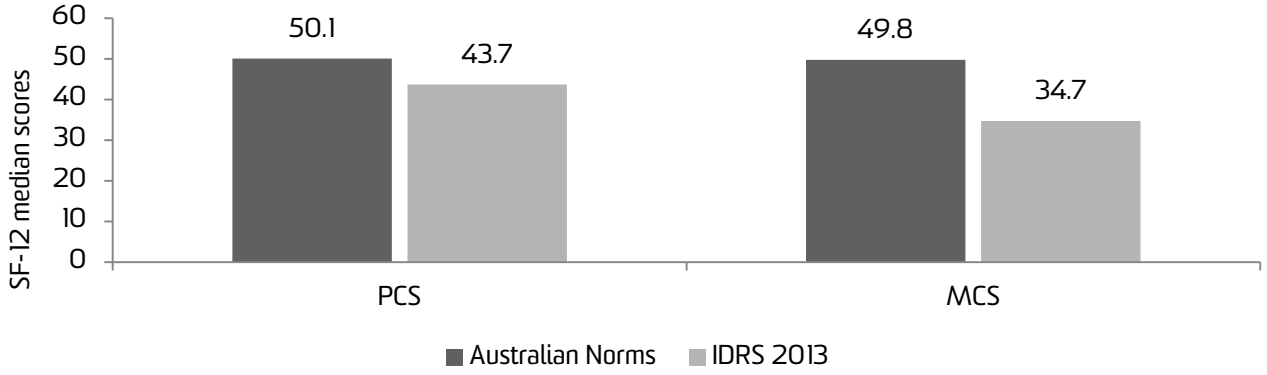
Source: AIHW, 2011; ACT IDRS PWID interviews, 2012–2013

MENTAL AND PHYSICAL HEALTH PROBLEMS

The Short Form 12-Item Health Survey (SF-12) is a questionnaire designed to provide information on general health and wellbeing and includes 12 questions from the SF–36 (Ware, Snow, Kosinski et al., 1993). It measures health status across eight dimensions concerning physical functioning, role limitations due to physical health problems, bodily pain, general health, energy/fatigue, social functioning, role limitations due to emotional problems and psychological distress and wellbeing. The scores generated by these eight components are combined to generate two composite scores: the physical component score (PCS) and the mental component score (MCS) (Ware, Kosinski and Keller, 1995, 1996). A higher score indicates better health.

The SF-12 scoring system was developed to yield a mean of 50 and a standard deviation of 10. Participants in the 2013 ACT IDRS scored a mean of 43.7 (SD=10.7) for the PCS and 34.7 (SD=11.1) for the MCS (Table 32)

Figure 32: SF-12 scores for ACT IDRS compared with the general Australian population (ABS), 2013



Source: IDRS participant interviews 2013 , Australian Bureau of Statistics, 1995

Figure 32 presents the MCS and PCS for participants interviewed in the ACT IDRS compared with those of the general Australian population[3] from the National Health Survey (ABS, 1995). It appears that IDRS participants in 2013 had a significantly lower MCS compared with the Australian population average (34.8% versus 49.8%; t_{59}= -10.51; p<0.05). It was also found that ACT IDRS participants reported a significantly lower PCS score than the Australian population (43.7% versus 50.1%; t_{59}= –4.62; p<0.05) (Table 32). The MCS and PCS were found to be statistically significantly lower than the Australian population mean score. This would indicate that IDRS participants had poorer mental and physical health than the population average.

Table 32: SF-12 Mental and Physical Health Mean Component Scores by jurisdiction, 2013

SF-12 Component scores	SF–36 Australian Population Norms (ABS)	SF-12 Australian Population Norms (ABS)	National N=606	ACT n=60
MCS	49.8	53.70	35.3	34.8
PCS	50.1	52.22	41.9	43.7

Source: IDRS participant interviews, Australian Bureau of Statistics, 1995, Australian Bureau of Statistics, 1997

[3] The SF-12 scores were transformed into SF-36 scores using weighted syntax to make them comparable with the general Australian population scores.

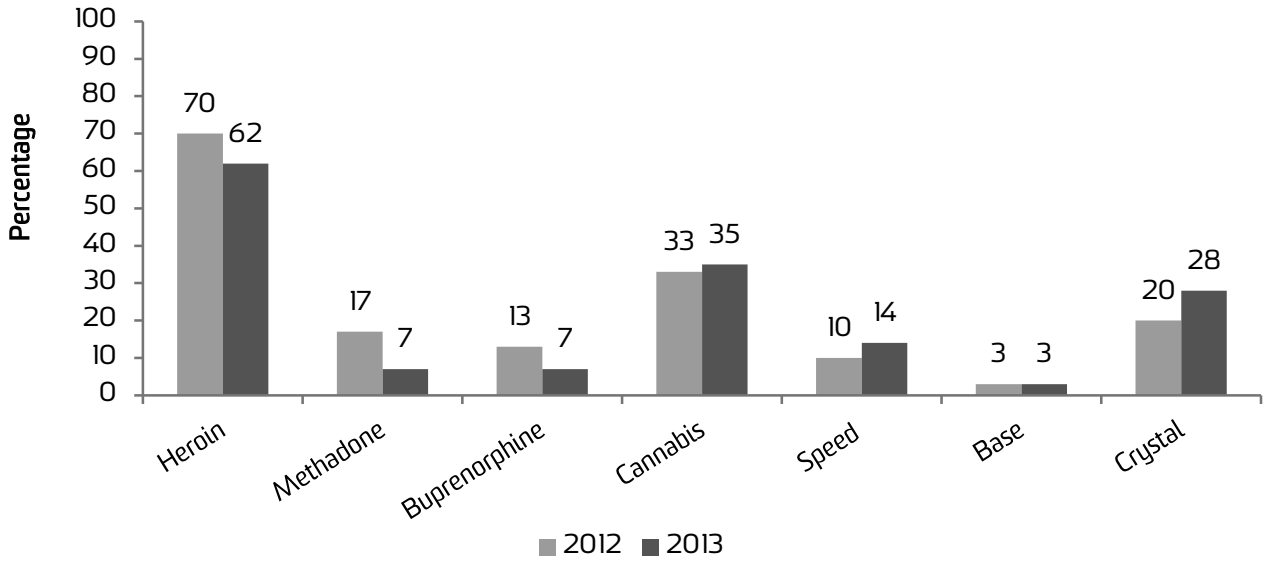
6.8. Driving risk behaviour

Participants were asked about driving behaviour following the use of alcohol or drugs. More than a third of the IDRS sample (39%, n=35) reported having driven a vehicle in the six months preceding interview. Of those, 49% had a full unrestricted license and 40% had no current license. Three participants reported having driven whilst over the limit of prescribed concentration of alcohol on a medium of two times in the past six months.

Twenty-nine participants (83% of those who had driven in the past six months) reported that they had driven soon after taking drugs during that time. Participants reported that they had driven soon after taking drugs on a median of 12 times (range=1–180) during the preceding six months. The median time between taking drugs and driving was 30 minutes (range=1–360).

Drugs taken before the participants had driven during the past six months for 2012–2013 are presented in Figure 33. The most common drugs used before driving reported by participants in 2013 were heroin (62%), cannabis (35%), crystal (28%), methadone (7%) and buprenorphine/buprenorphine-naloxone (7%).

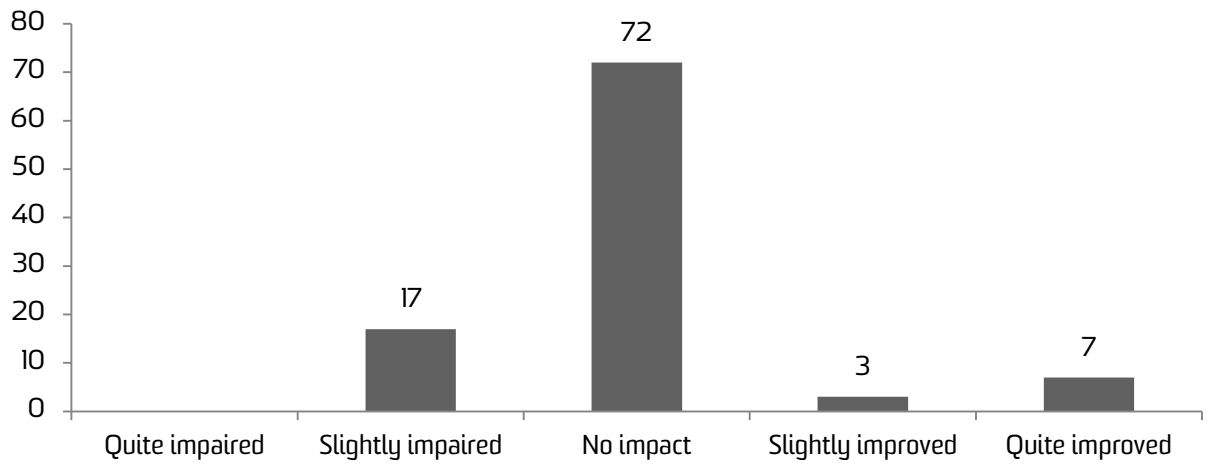
Figure 33: Participants reporting driving soon after taking drugs, by drug type, 2012–2013



Source: ACT IDRS PWID interviews, 2012–2013
NB: Of those who have driven in the past six months

In 2013, participants were asked about their perceptions of driving impairment as a result of driving under the influence of drugs in the six months preceding interview (Figure 34). The majority of participants reported that drugs had no impact on their driving ability (72%) and no participants felt that their driving ability had been quite impaired.

Figure 34: Participants' reports of perceived driving impairment, ACT, 2013



Source: ACT IDRS PWID interviews, 2013
NB: Of those who have driven whilst under the influence of drugs in the past six months

Random roadside saliva drug-driving testing remains a controversial issue in the ACT. At the time participant interviews were conducted, testing has been implemented for the past 18 months. Five participants reported ever having been saliva drug tested with one participant reporting a positive result for amphetamine use.

Participants were asked if the introduction of random roadside saliva drug driving testing had changed their drug driving behaviour. Forty-one percent (n=12) reported that it had in the following ways: more than half (58%) said they would wait a few hours before driving, and a third (33%) said they would *not* drive after using drugs.

IDRS participants who had driven in the past six months were asked questions to gauge the deterrent value of this practice. When asked, *Out of the next 100 people who drive after taking drugs, how many do you think will be caught? p*articipants reported a median of five people with more than one in ten respondents indicating they thought none would be caught. The majority (61%) indicated that they would drive after taking drugs in the next six months a median of four times.

7 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

7.1. Reports of criminal activity

As can be seen in Table 33, in 2013, 23% of participants reported that they had been arrested in the last 12 months (22% in 2012).

The proportion of participants in 2013 that reported engaging in at least one act of criminal activity in the month prior to interview was 32%. Eighteen percent of participants reported being involved in drug dealing and 18% of participants reported committing property crime in the previous month.

Table 33: Criminal activity among participants, ACT, 2012–2013

	2012 N=99	**2013 n=100**
Arrested last 12 months (%)	22	**23**
Crime arrested for (%)		
Property crime	7	**36**
Dealing	5	**5**
Fraud	0	**9**
Violent crime	10	**32**
Driving offence	11	**5**
Committed at least one crime in the last month (%)	35	**32**
Crime committed (%)		
Property crime	19	**18**
Dealing	25	**18**
Fraud	3	**3**
Violent crime	3	**5**

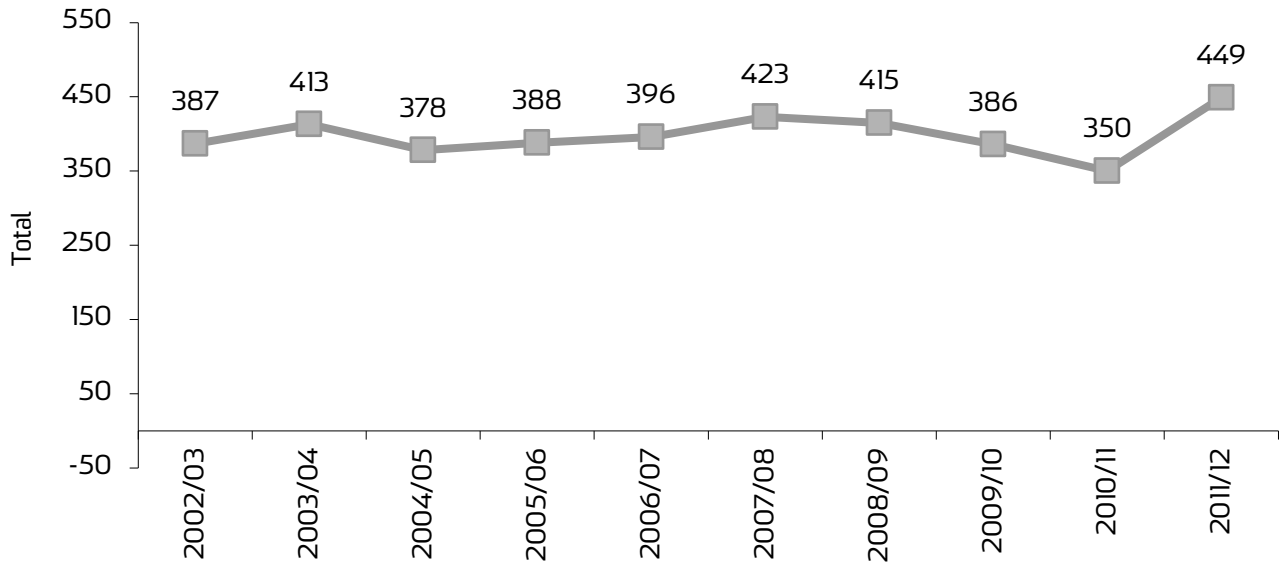
Source: ACT IDRS PWID interviews, 2012–2013

ARRESTS

ALL DRUGS

As can be seen in Figure 35, the number of drug-specific arrests made by ACT police has remained fairly steady since 2002–03. In 2011–12, a slight upward trend is observed in the number of drug-specific arrests made (449) when compared to 2010–2011 (350). In 2011–12, 85% of all drug-related arrests in the ACT were males.

Figure 35: Number of drug-specific arrests for all drugs, ACT, 2002–03 to 2011–12



Source: ABCI, 2000–2002; ACC, 2003–2013
NB: Data not available for the 2012–2013 financial year

The ACC classifies offenders who are charged with user-type offences (e.g. possession of illicit drugs and illicit drug use) as consumers. Offenders who are charged with supply-type offences (such as trafficking, selling, manufacture or cultivation) are categorised as providers.

The total number of consumer arrests in the ACT in 2011–12 was 360. As can be seen in Table 34, the number of females arrested for user-related offences remained stable at 57 arrests in 201–12 from 53 arrests in 2010–11. The number of males charged with user-type offences rose slightly (303, compared to 256 in 2010–11). The total number of provider arrests in 2011–12 was 89; this is a significant increase on the number of provider arrests in 2010–11 (p<0.05, 89 in 2011–12 vs 51 in 2010–11).

Table 34: Number of consumer and provider arrests for all drugs, ACT, 2001–2002 to 2011–12

Year	Consumer		Provider		Total arrests
	Male	Female	Male	Female	
2001–2002	182	39	41	11	273
2002–2003	253	61	58	11	387
2003–2004	262	61	77	12	413
2004–2005	236	36	87	19	378
2005–2006	254	51	79	4	388
2006–2007	274	59	57	6	396
2007–2008	283	74	57	9	423

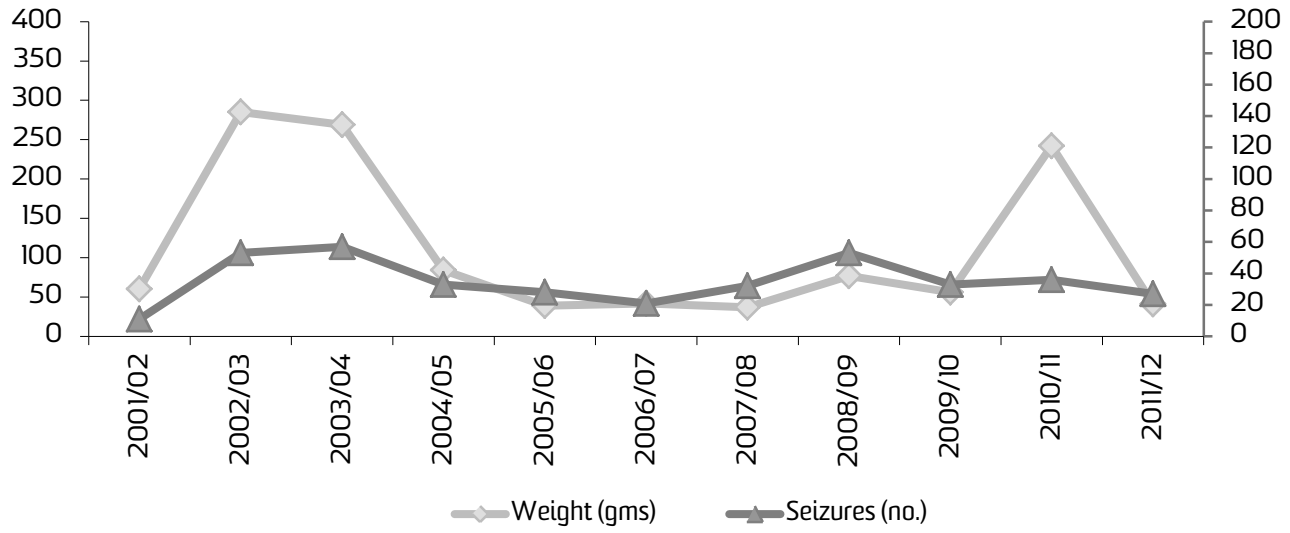
Year	Consumer		Provider		Total arrests
	Male	Female	Male	Female	
2008–2009	282	79	44	10	415
2009–2010	278	54	49	5	386
2010–2011	256	53	31	10	350
2011–2012	**303**	**57**	**78**	**11**	**449**

Source: ABCI, 2000–2002; ACC, 2003–2013
NB: data not available for the 2012–2013 financial year

HEROIN

The number of heroin seizures and total weight seized for each financial year period from 2001–02 is presented in Figure 36. The number of seizures made in 2011–12 decreased from 36 in the 2010–11 financial year to 27. The weight of seizures also decreased from 242 grams in 2010–11 to 41 grams in 2011–12.

Figure 36: Number and weight of heroin seizures in the ACT, 2001–02 to 2011–12



Source: ABCI, 2000–2002; ACC, 2003–2013
NB: Data not available for 2012–2013 financial year

Table 35 summarises the number of heroin and other opioids consumer and provider arrests in the ACT from 2001–02 to 2011–12 (more recent data were not available at the time of printing). The total number of heroin-related arrests in 2011–12 (28 arrests) remained relatively stable from 33 arrests in 2000–11.

Table 35: Number of heroin consumer and provider arrests, ACT, 2001–2002 to 2011–12

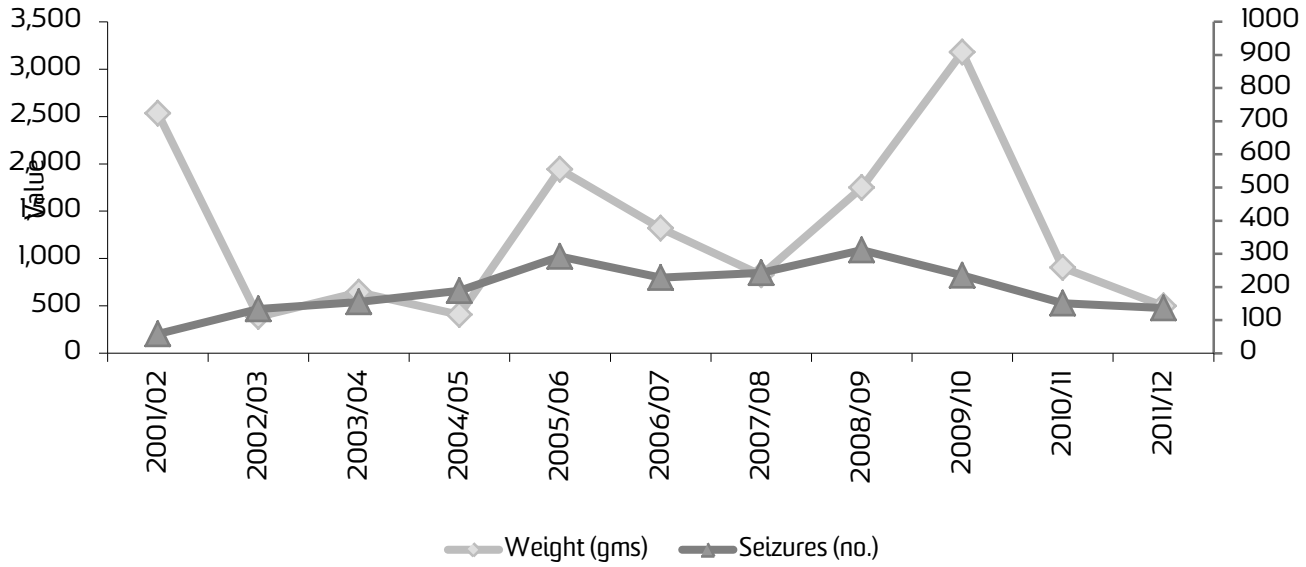
Year	Consumer		Provider		Total arrests
	Male	Female	Male	Female	
2001–2002	13	4	3	0	20
2002–2003	24	7	6	2	40
2003–2004	18	5	15	0	39
2004–2005	18	4	13	0	35
2005–2006	18	2	8	0	28
2006–2007	14	2	5	1	22
2007–2008	28	8	7	2	45
2008–2009	26	9	10	3	48
2009–2010	16	5	9	0	30
2010–2011	15	7	9	2	33
2011–2012	**9**	**11**	**6**	**2**	**28**

Source: ABCI, 2000–2002; ACC, 2003–2012
NB: Data not available for the 2012–13 financial year

METHAMPHETAMINE

Figure 37 shows the number and weight of methamphetamine seizures in the ACT from 2001–02 to 2011–12. In 2011–12, the number of seizures continue a downward trend to 136 from 151 in 2010–11. The weight of seizures also decreased from 905 grams of amphetamine-type stimulants to 499 grams seized in 2011–12.

Figure 37: Number and weight of amphetamine-type stimulant seizures, ACT, 2001–02 to 2011–12



Source: ABCI, 2000–2002; ACC, 2003–2013; NB: Data not available for the 2012–13 financial year

Table 36 presents the number of consumer and provider arrests for amphetamine-type stimulants (ATS) made in the ACT between 2001 and 2012. ATS include amphetamine, methamphetamine and phenethylamines. The ACC classifies consumers as offenders who are charged with user-type offences (e.g. possession and use of illicit drugs), whereas providers are offenders who are charged with supply-type offences (e.g. trafficking, selling, manufacture or cultivation). The number of consumer and provider arrests doubled compared to the previous reporting year, with a total of 124 arrests recorded in 2011–12, compared to 60 arrests in 2010–11

Table 36: Amphetamine-type stimulants consumer and provider arrests, ACT, 2001–02 to 2011–12

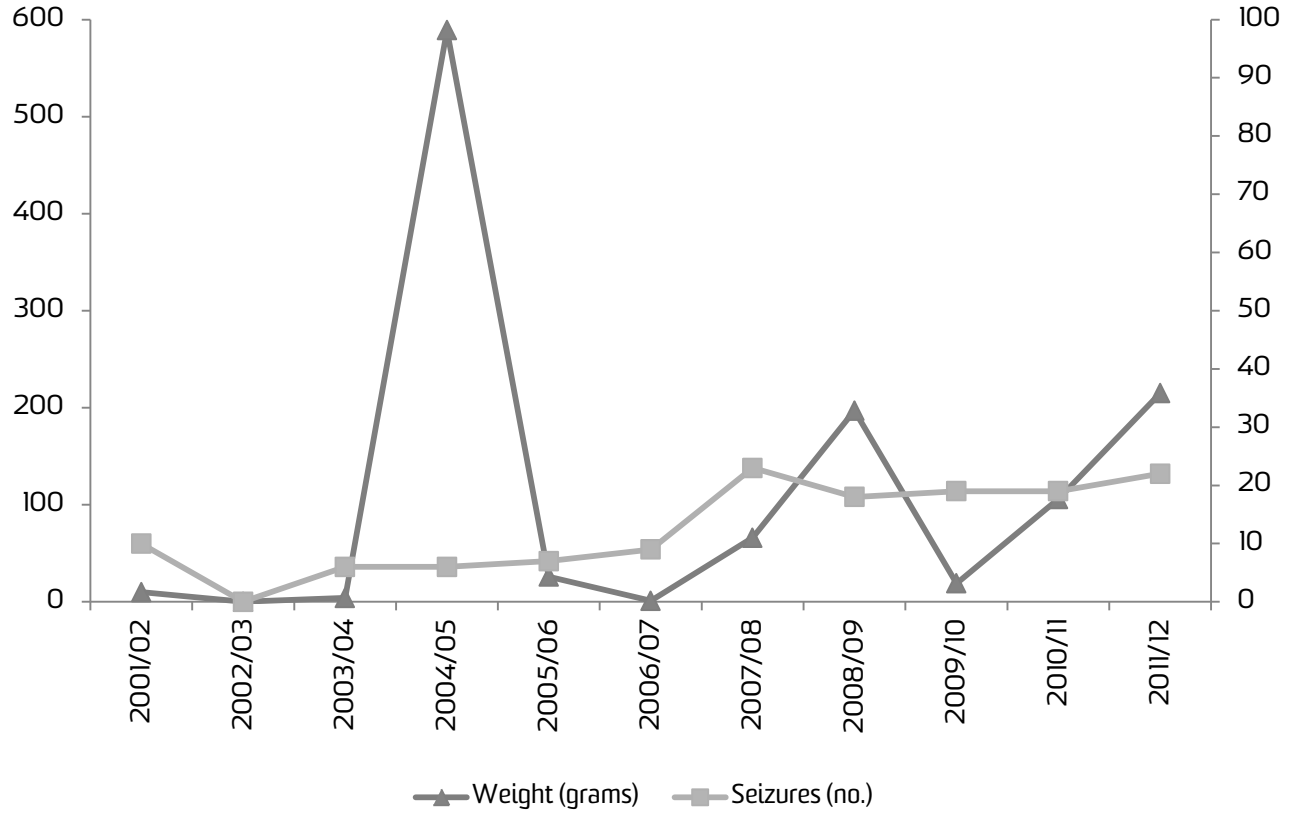
Year	Consumer		Provider		Total arrests
	Male	Female	Male	Female	
2001–2002	44	4	9	3	60
2002–2003	41	11	8	4	64
2003–2004	60	16	19	4	99
2004–2005	51	7	27	9	94
2005–2006	50	9	46	1	106
2006–2007	77	22	30	3	132
2007–2008	77	23	28	5	133
2008–2009	68	19	20	3	110
2009–2010	64	12	21	3	100
2010–2011	42	9	7	2	60
2011–2012	**88**	**14**	**16**	**6**	**124**

Source: ABCI, 2000–2002; ACC, 2003–2013
NB: Data not available for the 2012–13 financial year

COCAINE

Figure 38 shows the number and weight of cocaine seizures in the ACT from July 2001 to June 2012. In 2011–12, the number of seizures remained low at 22 while the weight of seizures increased to 215 grams.

Figure 38: Number and weight of cocaine seizures in the ACT, 2001–02 to 2011–12



Source: ABCI, 2000–2002; ACC, 2003–2013
NB: Data not available for the 2012–13 financial year

In 2011–12 there were nine consumer arrests for cocaine and one provider arrest recorded (see Table 37).

Table 37: Number of cocaine consumer and provider arrests, ACT, 2001–02 to 2011–12

Year	Consumer		Provider		Total arrests
	Male	Female	Male	Female	
2001–2002	2	0	1	0	3
2002–2003	2	0	0	0	2
2003–2004	1	0	1	0	2
2004–2005	2	1	4	0	7
2005–2006	2	0	3	0	5
2006–2007	7	0	0	0	7

Year	Consumer		Provider		Total arrests
	Male	Female	Male	Female	
2007–2008	3	0	1	0	4
2008–2009	10	1	3	0	14
2009–2010	8	0	0	0	8
2010–2011	5	1	7	5	18
2011–2012	**9**	**0**	**1**	**0**	**10**

Source: ABCI, 2000–2002; ACC, 2003–2013
NB: Data not available for the 2012–13 financial year

CANNABIS

Table 38 shows the number and weight of cannabis seizures in the ACT from 2001 to 2012. In 2011–12 there was a decrease in the number of cannabis seizures to 469 (632 in 2010–11). The weight of cannabis seizures for 2011–12 was 405,169 grams by ACT local police.

Table 38: Number and weight of cannabis seizures by ACT local police, 2001–02 to 2011–12.

Year	Seizures (no.)	Weight (grams)
2001–2002	387	406,521
2002–2003	624	470,691
2003–2004	591	627,934
2004–2005	553	566,770
2005–2006	458	302,205
2006–2007	497	204,555
2007–2008	675	300, 914
2008–2009	593	169,902
2009–2010	746	740,418
2010–2011	632	420,795
2011–2012	**469**	**405,169**

Source: ABCI, 2000–2002; ACC, 2003–2012
Note: Data not available for the 2012–13 financial year

Table 39 summarises the number of cannabis consumer and provider arrests in the ACT from 2001 to 2012. In the ACT, the greatest numbers of drug-specific arrests are due to user-type and supply-type cannabis offences. The number of males charged with consumer-type offences remains stable at 193 in 2011–12. The number of females charged with supply-type offences has remained relatively low and stable since 2005–06.

Table 39: Number of cannabis consumer and provider arrests, ACT, 2001–02 to 2011–12

Year	Consumer/user		Provider/supplier		Total arrests
	Male	Female	Male	Female	
2001–2002	115	29	26	8	178
2002–2003	151	36	4	5	196
2003–2004	177	40	42	8	267
2004–2005	156	22	40	10	228
2005–2006	177	40	20	3	240
2006–2007	168	35	19	2	224
2007–2008	166	41	18	2	227
2008–2009	165	50	10	3	228
2009–2010	187	36	19	2	244
2010–2011	192	36	8	1	237
2011–2012	**193**	**32**	**37**	**3**	**265**

Source: ABCI, 2000–2002; ACC, 2003–2013, NB: Data not available for the 2012–13 financial year

In the ACT, a Simple Cannabis Offence Notice (SCON) and a small fine are used to deal with minor cannabis offences, whereby the offence is expiated on payment of the fine. Table 40 presents the total number of SCONs given out in the ACT from 2001 to 2012. The number of SCONs remained stable at 94.

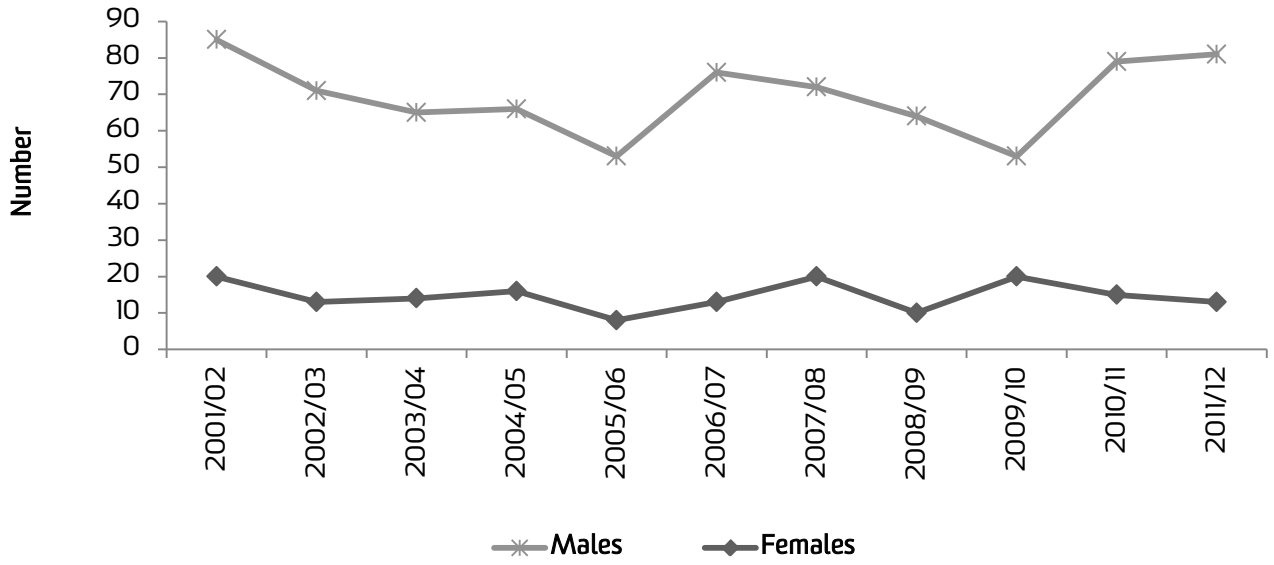
Table 40: Number of Simple Cannabis Offence Notices, ACT, 2001–02 to 2011–12

Year	Number of SCONs
2001–2002	105
2002–2003	84
2003–2004	79
2004–2005	82
2005–2006	61
2006–2007	89
2007–2008	92
2008–2009	74
2009–2010	73
2010–2011	94
2011–2012	**94**

Source: ABCI, 2000–2002; ACC, 2003–2013
NB: Data not available for the 2012–13 financial year

As can be seen in Figure 39, the proportion of SCONs received by females has remained consistently low (13 SCONs given to females in 2011–12). The number of SCONs given to females in the ACT has remained relatively stable since 2000. In 2011–12, 81 SCONs were given to males in the ACT. This is consistent with recent years.

Figure 39: Number of Simple Cannabis Offence Notices, by gender, ACT, 2001–02 to 2011–2012



Source: ABCI, 2000–2002; ACC, 2003–2013
NB: Data not available for the 2012–13 financial year

7.2. Expenditure on illicit drugs

In 2013, 59% of participants reported having spent money on illicit drugs on the day prior to interview. Among these, the median expenditure on drugs was $80. (See Table 41). In 2013, 48% of participants spent $50 or more on illicit drugs on the day prior to the interview.

Table 41: Expenditure on illicit drugs on the day prior to interview, ACT, 2009–2013

	2009 N=100	2010 N=101	2011 N=98	2012 N=99	**2013** **N=100**
Nothing	42	40	32	31	41
Less than $20	8	3	6	5	0
$20-$49	10	16	13	8	11
$50-$99	19	21	19	24	20
$100-$199	20	11	22	20	17
$200-$399	1	8	7	12	7
$400 or more	0	0	1	0	4
Median expenditure ($)	80	70	90	80	80

Source: ACT IDRS PWID interviews, 2009–2013

8 SPECIAL TOPICS OF INTEREST

8.1. Pharmaceutical opioids

Since the heroin shortage of 2001, the IDRS has noted an increase in the use and injection of morphine and oxycodone. Over the same period the age of PWID has also increased. The Australian Needle and Syringe Program survey (Kirby Institute, July 2012) noted similar findings over the same period. We know from a number of Australian and international studies that PWID experience excess morbidity and mortality when compared to those in the general population (English, Holman, Milne et al., 1995; Hulse, English, Milne et al., 1999; Randall, Degenhardtand et al., 2001; Vlahov, Wang, Galai et al., 2004) and that prescribers are often reluctant to prescribe opioid analgesics to people with a history of injecting drug use (Merrill and Rhodes, 2002; Baldacchino, Gilchrist, Fleming et al., 2010). This section aimed to examine the complex interplay among PWID, pain management and the extra-medical use of pharmaceutical opioids (PO).

In 2013, participants in the IDRS were asked questions about the use of PO and pain. Pharmaceutical opioids included methadone, buprenorphine, buprenorphine-naloxone, morphine, oxycodone, and other PO such as fentanyl, pethidine and tramadol. Of the 2013 ACT IDRS sample who commented (N=100), around half (49%) reported the use of PO in the last 12 months (Table 42). Among those who had recently used PO and commented (N=49), 35% reported using PO for pain relief, while 39% reported using PO as a substitute for heroin.

Among those who recently used PO for pain relief (n=19), the majority (79%) obtained the PO from their own script while 5% reported purchasing them from somebody else. Small numbers reported trading or receiving them as a gift.

Of those who used their own prescription of PO (n=15), 73% reported the prescription origin as a Pharmaceutical Benefits Scheme (PBS) prescription from regular doctor, 13% from a private prescription from regular doctor, and 13% from a PBS prescription from another doctor.

Those participants who had recently used PO for pain relief were asked if they had been refused PO in the past six months (n=19). The majority commented ‘no’, while 11% believed they were refused due to an injecting history (Table 42).

Table 42: Pharmaceutical opioid use amongst PWID, 2013

	National N=846	**ACT N=100**
Used pharmaceutical opioids in the last 12 months (%)	67	**49**
Reason for using pharmaceutical opioids in the last 12 months* (%)	N=563	**n=49**
Pain relief	29	**39**
As a substitute for heroin	31	**35**
To prevent withdrawal	19	**12**
To experience an opioid effect	10	**6**
To top up heroin	1	**2**
Other reason	10	**6**
Method of obtaining pharmaceutical opioids for pain relief in the last 12 months## (%)	n=163	**n=19**
On own prescription	66	**79**
Purchased	23	**5**
Trading with others	6	**5**
Gift from others	4	**11**
Other	1	**0**
Refused pharmaceutical opioids medications for pain relief last 6 months## (%)	n=161	**n=19**
No	77	**79**
Yes, not clinically appropriate	3	**5**
Yes, injecting history	12	**11**
Other	8	**5**

Source: ACT IDRS participant interviews 2013
* Among those who recently used pharmaceutical opioids
Among those who used pharmaceutical opioids for pain relief

8.2. Brief Pain Inventory

In 2013, the Brief Pain Inventory (BPI) was asked to examine the association between injecting drug use and the legitimate therapeutic goals of pharmaceutical opioids (e.g. pain management). Comparisons been PWID and the general population, both in Australia and internationally, have consistently shown excess mortality and morbidity (English, Holman, Milne et al., 1995; Hulse, English, Milne et al., 1999; Vlahov, Wang, Galai et al., 2004) yet there is no current evidence in Australia on the characteristics or the extent to which PWID obtain pharmaceutical opioids (licitly or illicitly) for the management of chronic non-malignant pain. Furthermore, there is growing evidence that prescribers are often reluctant to prescribe pharmaceutical opioids to people with a history of injecting drug use (Baldacchino, Gilchrist, Fleming et al., 2010). This section sought to examine the complex interplay among PWID, pain management and the extra-medical use of pharmaceutical opioids.

The BPI is a tool used for the assessment of pain in both clinical and research settings. The BPI uses rating scales from 0 to 10. For questions 3 to 6, 0 is 'no pain' and 10 is 'pain as bad as you can imagine'. The mean of questions 3 to 6 is then calculated to make the 'pain severity score'. For questions 9A to 9G, 0 is 'does not interfere' and 10 is 'completely interferes'. The mean of questions 9A to 9G is then calculated to make the 'pain interference score'. The 'pain interference score' looks at how much pain interferes with daily activities: general activity; mood; walking; normal work; relations; sleep and enjoyment of life.

In Table 43, 9% (n=11) of the 2013 ACT IDRS sample experienced pain (other than everyday pain) in the last seven days. Of those who experienced pain, the majority (73%) reported the pain as chronic non-cancer pain (continuous pain which lasts for more than three months), while 9% reported acute pain and 18% chronic cancer/malignant pain. The mean 'pain severity score' was 4.4 (SD 1.9; range 0–7), with almost a third (30%) scoring 5 or more. A score of 10 refers to pain 'as bad as you can imagine'.

Of those who experienced pain (other than everyday pain) the last seven days (n=11), 64% reported the pain due to an accident/injury or assault, 36% due to an illness/disease. Twenty-seven percent reported that they were in pain at the time of the interview. The majority (91%) reported pain for more than three months.

Table 43: Brief Pain Inventory (BPI) among PWID who commented, by jurisdiction, 2013

	National	ACT
Experienced pain (other than everyday pain) last 7 days** (%)	n=96	**n=11**
Acute/short term pain	14	**9**
Chronic non-cancer pain	77	**73**
Chronic cancer	6	**18**
Other	3	**0**
Mean 'Pain Severity' score	5.2	**4.4**

Source: IDRS Injecting drug user interviews

**Among those who reported pain other than everyday pain in the last 7 days

8.3. Stimulant and opioid dependence

Understanding whether participants are dependent is an important predictor of harm, and typically demonstrates stronger relationships than simple frequency of use measures.

In 2013, the participants in the IDRS were asked questions from the Severity of Dependence Scale (SDS) for the use of stimulants and opioids.

The SDS is a five-item questionnaire designed to measure the degree of dependence on a variety of drugs. The SDS focuses on the psychological aspects of dependence, including impaired control of drug use, preoccupation with, and anxiety about use. The SDS appears to be a reliable measure of the dependence construct. It has demonstrated good psychometric properties with heroin, cocaine, amphetamine, and methadone maintenance patients across five samples in Sydney and London (Dawe, Loxton, Hides et al., 2002) .

Previous research has suggested that a cut-off of 4 is indicative of dependence for methamphetamine users (Topp and Mattick, 1997) and a cut-off value of 3 for cocaine (Kayeand Darke, 2002). No validated cut-off for opioid dependence exists; however, researchers typically use a cut-off value of 5 for the presence of dependence.

Of those who had recently used a stimulant and commented (n=60), the median SDS score was 2 (Mean 3.7; range 0–14), with 45% scoring 4 or above. Females reported a significantly higher mean stimulant SDS score than males (6.4 versus 2.7; $p<0.05$). Females were also significantly more likely to score 4 or above compared to males (71% vs 35%, $p<0.05$). Of those who scored 4 or above (n=27), 82% reported specifically attributing responses to methamphetamines, 4% cocaine, and 4% other.

Of those who had recently used an opioid and commented (n=85), the median SDS score was 7 (Mean 6.9, range 0–15), with 78% scoring 5 or above. There were no significant differences regarding gender and mean opioid SDS score. Of those who scored 5 or above (n=66), 76% reported specifically attributing responses to heroin, 21% methadone, 5% buprenorphine, 3% oxycodone and 2% morphine.

8.4. Opioid substitution treatment medication injection

Due to the introduction of buprenorphine-naloxone film in 2011, questions were included in the 2013 IDRS survey asking about the recent injection (last six months) of opioid substitution treatment (OST) medications (methadone, buprenorphine and buprenorphine-naloxone).

Of the 2013 ACT IDRS sample, 27% of participants reported recently injecting methadone, 12% reported recently injecting buprenorphine, 4% buprenorphine-naloxone film and 4% buprenorphine-naloxone tablet.

Please refer to Larance and colleagues for further information on OST medication injection (Larance, Degenhardt, Lintzeris et al., 2011a; Larance, Sims, White et al., in preparation).

8.5. Hepatitis C testing and treatment

Despite efforts to improve access to antiviral therapy for hepatitis C virus (HCV) infection, and improved treatment outcomes, treatment uptake for chronic HCV infection remains low among people who inject drugs (Doab, Treloar and Dore, 2005).

The aim of this module was to assist in a) determining the extent of knowledge PWID have regarding a hepatitis C (HCV) diagnosis, b) their knowledge and perceptions about diagnosis and available treatment, and c) what are the perceived barriers to treatment uptake.

The vast majority of the 2013 ACT IDRS sample (97%) had been tested for HCV in their lifetime with 63% reporting a positive result for HCV antibodies. Of those with a positive result for HCV antibodies, 33% reported this result more than 12 months ago and 30% within the last 12 months. Of those with a positive result for HCV antibodies, 59% reported undergoing further testing for HCV, i.e. to determine whether an active virus is present and which genotype. The main reasons for no further testing among those who commented (n=26) were 'wasn't a priority' (46%) and 'provider didn't mention the need for further tests' (27%; Table 44).

Among those who received further tests (n=37), 65% reported a polymerase chain reaction (PCR) test (to see if the virus is active) and 73% a PCR viral genotype test. Almost two-thirds (63%) of those who received a PCR test (n=24) reported that the test showed an active virus. Genotype one was the most common genotype reported among those who received a PCR viral genotype test. The community GP (35%) was the most common location of the last HCV test.

Of those who received a PCR test and commented (n=15), 13% reported that they had received HCV medical/antiviral treatment. Of those who had received treatment (n=2), one reported that the treatment was successful, while the other participant reported they are currently in treatment. Treatment is considered successful if the patient clears the virus as proved by a negative PCR result six months or more after treatment finishes. This is referred to a 'sustained virological result' and is effectively a 'cure'.

Sixty percent of those who reported an active HCV result and commented (n=13) were aware of the new HCV treatment. Of those aware of the treatment (n=9), 78% reported that they would consider the new HCV treatment. Of those who commented (n=7), the main setting they would consider convenient for treatment was a HCV clinic (71%), followed by the GP (57%).

Table 44: Hepatitis C testing and treatment, 2013

	National N=887	ACT N=100
Ever tested for HCV (%)	91	97
Positive HCV test (%)	N=547	n=63
Within last 12 months	43	48
More than 12 months	57	52
Further testing for HCV antibody	59	59

	National N=887	ACT N=100
Reasons for no further testing (%)	n=219	n=26
Provider didn't mention the need for further tests	22	27
Wasn't a priority	33	46
Blood tests are difficult for me	3	8
Don't feel sick	6	8
Concerned about confidentiality	1	4
Other reason	37	12
Further tests for HCV (%)	n=319	n=37
PCR test (see if virus is active)	67	65
PCR viral genotype test	41	73
Other	4	0
Location last tested for HCV (%)	n=304	n=37
Community GP	38	32
OST clinic	12	19
Specialist clinic	12	16
Prison	10	14
Other	28	19

Source: IDRS Injecting drug user interviews

8.6. Discrimination

Very often PWID manage complex situations in relation to poor treatment and discriminatory practices. The discrimination module aimed to complement the work that the Australian Injecting and Illicit Drug Users League (AIVL) have initiated with the AIVL National Anti-Discrimination Project (Parr and Bullen, February 2010).

Sixty-one percent of the 2013 ACT IDRS sample commented on the discrimination section. Of those who responded (n=96), 43% reported discrimination within the last 12 months, 18% over 12 months ago and 40% reported no discrimination. Those who had experienced a discrimination in the last 12 months (n=41), reported the main location of the discrimination taking place was at a pharmacy (39%), followed by police (34%) and a hospital (27%). The majority (81%) reported the main reason (perceived) for the discrimination was 'because I'm an injecting drug user (or people think I am)'. A quarter (24%) reported that they were refused service while 12% were 'outed' as a person who uses drugs as a result of the discrimination. The majority (93%) did not try to resolve the discrimination (Table 45).

Table 45: Discrimination among people who inject drugs, by jurisdiction, 2013

	National	ACT
Ever discriminated against (%)	n=793	n=96
Yes, within the last 12 months	47	43
Yes, but no in the last 12 months	16	18
No	37	40
Location of discrimination (%)	n=372	n=41
Doctor/prescriber	22	24
Pharmacy	26	39
Dentist	3	12
Health services	9	15
Government service, i.e. housing or Centrelink	14	20
Police	24	34
Hospital	21	27
Needle and Syringe Program	2	5
Drug and alcohol service	5	10
Prison	4	7
Other	50	39
Reason for the discrimination (%)	n=372	n=41
Person who injects drugs	79	81
On OST medication	19	22
HCV positive	10	12
HIV positive	1	2
Other	14	15

	National	ACT
Result of discrimination (%)	n=372	n=41
Refused service	18	24
Taken off/ reduced OST medication	2	2
'Outed' as a person who uses drugs	11	12
Experienced violence/abuse	18	5
Lost job	4	2
Other	49	59
Tried to resolve discrimination (%)	n=372	n=41
No didn't try to resolve	89	93
Australian Human Rights Commission	<1	0
Health Care Complaint Commission	<1	2
Directly to service provider/organisation	6	0
Other	4	5

Source: IDRS Injecting drug user interviews

8.7. Oral Health Impact Profile

The oral health of people who inject drugs (PWID) has traditionally been neglected in research, service provision and health promotion. In order to address this issue we included the Oral Health Impact Profile (OHIP-14, Slade, 1997), an internationally-recognised measure of Oral Health Related Quality of Life (OHRQoL), in the 2013 IDRS. OHRQoL is defined as an individual's assessment of how oral functional factors, psychological factors, social factors and experience of oro-facial pain or discomfort affect his or her well-being.

The OHIP-14 is a self-filled questionnaire that focuses on seven dimensions of impact (functional limitation, pain, psychological discomfort, physical disability, psychological disability, social disability and handicap) with participants being asked to respond according to frequency of impact on a 5-point Likert scale coded never (score 0), hardly ever (score 1), occasionally (score 2), fairly often (score 3) and very often (score 4) using a 12-month recall period. However, the IDRS asked participants to respond based on the last three months (instead of 12 mths).

For this report the OHIP-14 was divided into the seven dimensions of impact, and percentages calculated for those who responded 'occasionally', 'fairly often' and 'very often'. Physical pain had the higher impact with 51% of those who commented (n=93) reporting either: 'occasionally', 'fairly often' and 'very often'. This was followed by psychological disability (52%) and psychological discomfort (47%; Table 46).

A mean scale score of the 14 items was computed, with higher scores indicating poorer oral health-related quality of life. Participants can have an overall OHIP-14 total score ranging from zero to 56. Using the 'additive' method, the mean OHIP-14 total score for the national sample was 14.2 (range 0–46). Twenty-eight percent of those who commented scored 'zero' (Table 46).

Table 46: Oral Health Impact Profile 14 short form (OHIP-14) score, 2013

	National	ACT
Dimensions of impact	N=810	n=93
Functional limitation	37	34
Physical pain	51	51
Psychological discomfort	43	47
Physical disability	39	36
Psychological disability	48	52
Social disability	34	40
Handicap	35	39
Mean total scores	13.0	14.2
(range)	(0–46)	(0–46)
Score of 'zero' (%)	27	28

Source: IDRS Injecting drug user interviews

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