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K. Butler and C. Breen

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Findings from the

Illicit Drug Reporting System (IDRS)

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Illicit Drug Reporting System

(IDRS)

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ABBREVIATIONS

ACIC	Australian Criminal Intelligence Commission
ACT	Australian Capital Territory
AFP	Australian Federal Police
AHOD	Australian HIV Observational Database
AIHW	Australian Institute of Health and Welfare
AIVL	Australian Injecting and Illicit Drug Users League
AODTS-NMDS	Alcohol and Other Drug Treatment Services-National Minimum Dataset
ATS	Amphetamine-type stimulants
AUDIT-C	Alcohol Use Disorders Identification Test-Consumption
BBVI	Blood-borne viral infections
Bush	Outdoor-cultivated cannabis
CI	Confidence Intervals
CPR	Cardiopulmonary resuscitation
DSM-5	Diagnostic and Statistical Manual of Mental Disorders-5
EDRS	Ecstasy and Related Drugs Reporting System
GP	General Medical Practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
Hydro	Hydroponically grown cannabis
IDRS	Illicit Drug Reporting System
K10	Kessler Psychological Distress Scale
KE	Key expert(s); see Method section for further details
MSIC	Medically Supervised Injecting Centre
N (or n)	Number of participants
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey

NNDSS	National Notifiable Diseases Surveillance System
NPS	New psychoactive substances
NSP	Needle and syringe program(s)
OST	Opioid substitution treatment
OTC	Over the counter
PBS	Pharmaceutical Benefits Scheme
PCR	Polymerase chain reaction
PWID	Person/people who inject(s) drugs
SCID	Structural Clinical Interview for DSM
SCON	Simple Cannabis Offence Notices
SDS	Severity of Dependence scale
SPSS	Statistical Package for the Social Sciences

GLOSSARY OF TERMS

Cap	Small amount, typically enough for one injection
Half weight	0.5 gram
Illicit	Illicit 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
Indicator data	Sources of secondary data used in the IDRS
Person(s) who inject(s) drugs	Also referred to as PWID. In the context of the IDRS, refers to persons participating in the PWID Survey component of the IDRS (see Method section for further details)
Key expert(s)	Also referred to as KE; persons participating in the Key Expert Survey component of the IDRS (see Method section for further details)
Licit	Licit 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
Participant	In the context of this report refers to persons who participated in the PWID survey (does not refer to key expert participants unless stated otherwise)
Point	0.1 gram although may also be used as a term referring to an amount for one injection (similar to a 'cap'; see above)
Recent injection	Injection (typically intravenous) in the six months preceding interview
Recent use	Use in the six months preceding interview via one or more of the following routes of administration: injecting, smoking, snorting and/or swallowing
Session	A period of continuous use

Use	Use via one or more of the following routes of administration: injecting, smoking, snorting and/or swallowing

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

Guide to days of use/injection:

180 days	daily use/injection over preceding six months
90 days	use/injection every second day
24 days	weekly use/injection
12 days	fortnightly use/injection
6 days	monthly use/injection

EXECUTIVE SUMMARY

KEY FINDINGS FROM THE 2016 IDRS

The Illicit Drug Reporting System (IDRS) is 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. *ACT Drug Trends* draws largely on the PWID participant survey and indicator data components of the IDRS, and KE are relied upon to provide contextual information.

DEMOGRAPHICS OF THE PARTICIPANT SAMPLE

One hundred participants were recruited to the 2016 IDRS Australian Capital Territory (ACT) participant survey component. The mean age of the ACT sample was 44 years (range=23–63 years) and 73% were male. Almost the entire sample spoke English as their main language at home (98%), and 24% identified as being of Aboriginal and/or Torres Strait Islander descent. More than four-fifths (85%) of the sample were currently unemployed, just over half (56%) reported a previous prison history. Forty-six percent reported they were in current treatment, mainly methadone.

CONSUMPTION PATTERN RESULTS

Current drug use

- The mean age of first injection was 20 years. The drug most often reported as 'the first drug injected' was methamphetamine powder (44%), followed by heroin (36%).
- Heroin was nominated by over half (53%) of the sample as their drug of choice, followed by methamphetamine (any form; 37%) and cannabis (5%).
- The drug injected most often in the last month followed the same pattern. Fifty-one per cent of the sample reported injecting heroin most often in the last month, followed by methamphetamine (40%).
- Forty-two per cent of participants reported at least daily injecting.

Heroin

- In 2016, heroin remained the drug of choice for half of the sample.
- Seventy per cent had used heroin in the previous six months.
- Heroin was used on a median or 72 days in the preceding six months (approximately two days per week).

Methamphetamine

- The vast majority (97%) of participants reported using some form of methamphetamine at least once in their lifetime and 82% reported recent use in the past six months.

[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).

- Crystal methamphetamine remains the most common form used with 83% of the sample reporting recent use on a median of 35 days in the past six months.
- In contrast to crystal methamphetamine, speed (powder) and base use have declined in recent years.

Cocaine

- Almost two-thirds of participants reported lifetime use of cocaine.
- The recent use of cocaine remained low in the ACT, with 8% reporting use in the preceding six months. The median days of use also remained low at four days.

Cannabis

- Sixty-nine per cent of PWID reported recent cannabis use in 2016 (81% in 2015).
- Daily use was reported by 52% of the sample.
- Median number of cones smoked last time used was six cones.
- Hydroponic cannabis remained the most common form of cannabis used (84% used recently).

Other opioids

- Recent use of illicit methadone was reported by one in ten PWID with the majority of them reporting injecting it.
- Similar proportions reported the recent use of illicit buprenorphine (11%).
- One in fifteen reported recent use of illicit buprenorphine-naloxone (7%)
- Recent use of illicit oxycodone remains stable at 12% of the sample using on a median of one day in the previous six months.

Other drugs

- Small proportions report the recent use of:
  - ecstasy (1%);
  - illicit pharmaceutical stimulants (4%);
  - inhalants (1%); and
  - hallucinogens (5%).
- Benzodiazepine and alprazolam use remains stable, with 51% recently using benzodiazepine (licit and illicit) and 15% reporting recently using alprazolam (licit and illicit).
- The recent use of illicit Seroquel® was reported by 13% of the sample.
- Recent alcohol use was reported by over half (55%).
- Tobacco remained common, recently used by 90% of the sample.

DRUG MARKET: PRICE, PURITY, AVAILABILITY AND PURCHASING PATTERNS

Heroin

Price for heroin remained stable at $50 per cap and $300 per gram. One in three of those who commented reported current purity to be high.

Methamphetamine

The price of speed has remained stable with reports of one point costing $50. The price of crystal has remained stable at $500 for one gram. There were no significant differences in either the availability or reported purity of crystal, speed or base.

Cocaine

Cocaine use in the ACT remains low and insufficient numbers were able to comment on price, perceived purity and availability. Refer to *Australian Drug Trends* for national figures (Stafford and Breen 2017).

Cannabis

The median cost of a gram of hydroponic cannabis was $20. The median cost of an ounce of hydroponic cannabis was $250. The 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.

Methadone

Due to small numbers commenting on the price, purity and availability of methadone, accurate information is not available. Refer to Australian Drug Trends for national figures (Stafford and Breen 2017).

Buprenorphine, buprenorphine-naloxone, morphine, and oxycodone

Due to small numbers commenting on the price, purity and availability of buprenorphine, buprenorphine-naloxone, morphine and oxycodone, accurate information is not available. Refer to Australian Drug Trends for national figures (Stafford and Breen 2017).

HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

Overdose and drug-related fatalities

Three per cent of participants reported having overdosed on heroin in the 12 months prior to interview.

Four-fifths of participants (80%) had heard of the take-home naloxone program in ACT with nearly half (48%) reporting they had completed the training in naloxone administration and obtained a prescription.

Heroin overdoses continue to represent only a small number of the total number of ambulance call-outs to overdoses.

Drug treatment

Forty-six per cent of participants reported being currently in treatment with 43% of the sample engaged in methadone treatment.

Hospital separations

The number of cocaine-related hospital separations has increased to higher than ten per million (34.97) for the first time in twenty years. Cannabis rates continue to fluctuate with 56.83 admissions per million being reported for the 2014-2015 period. Separations relating to methamphetamines are reported to be 109.29 per million admissions (122.84 in previous year).

Injecting risk behaviours

Needle and Syringe Programs were the most common sources for obtaining needles and syringes in the preceding six months (89%), followed by chemists (16%), and vending machines (12%).

The majority of IDRS participants reported last injecting in a private location (80%), with small proportions (12%) last injecting in a public location such as in a public toilet, or on the street. Two-thirds (65%) of the IDRS sample experienced an injection-related problem in the preceding month, most commonly significant scarring or bruising and difficulty injecting (e.g. finding a vein).

Blood-borne viral infections

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

Alcohol Use Disorders Identification Test – Consumption

Sixty-one per cent of participants who drank in the past year scored five or more on the AUDIT-C indicating the need for further assessment.

Opioid dependence

Seventy-two per cent of those who had recently used an opioid and commented, scored five or above on the SDS, indicating dependence.

Mental health problems and psychological distress

Forty per cent of the ACT IDRS sample self-reported a mental health problem in the preceding six months, most commonly depression (65% of respondents) and/or anxiety (43%). Many (73%) of those who had experienced a problem reported attending a mental health professional.

Higher levels of psychological distress, as measured by the Kessler Psychological Distress Scale (K10), were reported by the ACT IDRS sample compared to the Australian general population, with 26% reporting very high distress (3% in the general population) and 28% reporting high distress (7% in the general population). Those reporting a very high level of distress possibly require clinical assistance.

LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

Reports of criminal activity

Participant reports of criminal activity remained stable compared to previous years, with 33% of the sample reporting engagement in criminal behaviour in the preceding month. Drug dealing and property crime were recorded as the most common types of crime committed.

Arrests

Twenty-six per cent 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, 57% 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

Homelessness

Seventy-three per cent of the ACT sample reported being homeless at some point in their lives. One in five of those reported being currently homeless with their current episode of homelessness reported to be of mean duration of 2.5 years.

Oxycodone use

One-third (35%) of the sample who commented reported having slept rough in the past six months.

Blood donations

Of those who commented, 12% reported that they had given blood in their lifetime. Due to low numbers reporting in the ACT, further information is provided in the National Report (Stafford and Breen 2017).

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 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. In 2016, the IDRS was funded by the Australian Government Department of Health.

This *ACT Drug Trends 2016* report presents findings from the 2016 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 2016 PWID sample.

Study aims

The IDRS is a national illicit drug monitoring system designed to identify emerging trends of local and national concern in 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 collates data from 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.

Survey of people who inject drugs

In June of 2016, a structured face-to-face interview was administered to 100 current PWID in the ACT. Survey items included demographics, drug use history, market characteristics (including price, perceived purity and perceived availability) of the main drugs (heroin, methamphetamine, cocaine and cannabis) 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). In 2016, amendments were made to the questionnaire in an attempt to collect more detailed information on homelessness and blood donations among PWID.

The IDRS interviews were conducted by trained interviewers 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 (CAHMA). Eligible participants had to have resided in the ACT for the previous twelve months, be regular injectors, and be aged 17 years of age or older. Participants were reimbursed $40 for their time. Ethics approval was obtained from the University of New South Wales ethics committee.

Survey of key experts

Between August and December 2016, 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 via an online survey instrument, or 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. KE comments are not reported in a chapter when low numbers reported on a specific drug.

Other indicators

Data collected from PWID surveys and KE interviews were supplemented by routinely collected 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 2016 IDRS study are described below.

- **Purity of drug seizures**. In 2016, the Australian Criminal Intelligence Commission (ACIC) 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 2004–05 to 2014–15 financial years.
- **Number and weight of drug seizures**. Data on the number and weight of drug seizures made by ACT local police were provided by the ACIC. Data includes number of seizures and amount seized in grams 2004–05 to 2014–15, by each drug type.
- **Drug-specific arrests**. The ACIC 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 2004–05 to 2014–15.
- **Simple Cannabis Offence Notices (SCON)**. Data for this report on the number of SCON issued in the ACT 2004–05 to 2014–15 were provided by the ACIC.
- **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 and total overdoses from 2014-16.
- **Hospital admissions**. The 2016 IDRS study includes data on the number of hospital admissions due to opioids, methamphetamines and cannabis among those aged 15 to 54 years from 2005-06 to 2014–15. 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 2016), and the *Australian NSP Survey National Data Report 2015* provided by the Kirby Institute (previously known as the National Centre in HIV Epidemiology and Clinical Research) (The Kirby Institute May 2011).

Data analysis

Analyses were conducted using the Statistical Package for the Social Sciences (SPSS) for Windows, Version 22.0 (IBM 2013). The data collected in 2016 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 2015 and 2016 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 2015 and 2016 median days of use for the major drug types discussed.

3 DEMOGRAPHICS

Overview of the IDRS participant sample

A total of 100 regular PWID were interviewed in the ACT in 2016. The demographic characteristics of the sample are summarised in Table 1 below and are similar to the 2015 sample with no significant changes noted. In 2016, the mean age of the sample was 44 years (range=23–63 years, SD=8.57), and 73% were male. Almost all (98%) of the respondents reported English as the main language spoken at home, and 24% identified as Aboriginal and/or Torres Strait Islander. The participants reported that they were single (65%), had a partner (17%), or were married/in a de facto relationship (8%).

The mean number of formal school years completed was 10 (range=4–12 years, SD=1.74). Fifty-two per cent of participants reported that they had trade or technical qualifications, and 11% reported that they had university or other tertiary qualifications. Eighty-five per cent of participants interviewed in 2016 were unemployed (81% in 2015), 3% were currently employed full time (5% in 2015, 9% in 2014), and 9% were employed on a casual or part-time basis. The vast majority of respondents (79%) reported living in a privately owned, or rented house or flat and 8% of respondents reported having no fixed address. Over half (56%) of participants reported that they had a prison history (51% in 2015, 47% in 2014).

Forty-six per cent 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 (36%), with a further 7% of participants engaged in buprenorphine or buprenorphine-naloxone maintenance treatment. The median length of time participants had been participating in their current treatment was 22 months (range=1 month to 25 years). Of those respondents currently in treatment, 89% had been engaged in treatment for six months or more, with 11% participating in their current treatment for less than six months.

Table 1: Demographic characteristics of the PWID sample, 2015–2016

	2015 N=100	2016 N=100
Age (mean years)	42	**44**
School education (mean years)	10	**10**
Sex (% male)	72	**73**
Heterosexual (%)	93	**92**
Relationship status (%)		
Single	62	**65**
Partner	20	**17**
Married/de facto	9	**8**
Separated	3	**6**
Divorced	3	**3**
Accommodation (%)		
Own house/flat (includes renting)	80	**79**
Parent's/family house	1	**-**
Boarding house/hostel	1	**5**
Shelter/refuge	7	**3**
No fixed address/homeless	9	**8**
Employment (%)		
Not employed	81	**85**
Full-time	5	**3**
Part-time/casual	9	**9**
Home duties	1	**-**
Full time student	2	**1**
Income per week (mean)	480	**379**
English main language spoken at home (%)	97	**98**
Aboriginal and/or Torres Strait Islander (%)	21	**24**
Tertiary education (%)		
None	38	**37**
Trade/technical	49	**52**
University/college	13	**11**
Currently in drug treatment (%)	53	**46**
Methadone maintenance (%)	38	**36**
Buprenorphine maintenance (%)	4	**1**
Buprenorphine-naloxone (%)	6	**6**
Prison history (%)	51	**56**

Source: ACT IDRS PWID interviews, 2015–16.

4 CONSUMPTION PATTERNS

Current drug use

The injection histories of participants are summarised in Table 2. The mean age of first injection was 20 years (range=10–57 years, SD=7.64). The first drug respondents reported ever injecting was methamphetamine powder (44%) or heroin (36%).

Heroin was nominated as the drug of choice for the majority of participants (53%) in 2016; similar proportions as reported in 2015. In 2016, the percentage of respondents nominating crystal methamphetamine as their drug of choice remained relatively stable at 31% (28% in 2015). Five per cent of respondents nominated speed as their drug of choice (6% in 2015). Overall, 37% of participants nominated methamphetamine (in any form) as their drug of choice in 2016, remaining stable from 2015 (34%). Cannabis was nominated as drug of choice by 5% of participants.

Heroin was the drug injected most often in the month prior to the interview (51%) and was the last drug injected by 46% of respondents. The proportion of participants nominating crystal methamphetamine as the drug most often injected in the last month remained stable with 40% in 2016 compared to 37% in 2015.

In 2016, 21% 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=21), most respondents reported that this was due to availability (29%), health effects (5%), price (10%), or purity (19%).

Table 2: Injection history, drug preferences and polydrug use of PWID, 2015–2016

	2015 N=100	2016 N=100
Age first injection (mean years)	19	**20**
First drug injected (%)		
Heroin	42	**36**
Methamphetamine powder	43	**44**
Crystal methamphetamine	9	**15**
Cocaine	2	**2**
Other opioids	1	**1**
Other	2	**1**
Drug of Choice (%)		
Heroin	58	**53**
Methamphetamine – powder (speed)	6	**5**
Methamphetamine – crystal	28	**31**
Cocaine	-	**1**
Methadone	1	**2**
Cannabis	4	**5**
Other	3	**3**
Drug injected most often last month (%)		
Heroin	55	**51**
Methamphetamine – powder (speed)	3	**4**
Methamphetamine – crystal	37	**40**
Methadone	1	**4**
Buprenorphine/buprenorphine-naloxone	1	**-**
Other/have not injected in last month	2	**1**
Most recent drug injected (%)		
Heroin	57	**46**
Cocaine	-	**-**
Methamphetamine – powder (speed)	2	**3**
Methamphetamine – crystal	32	**46**
Methadone	2	**5**
Buprenorphine/buprenorphine-naloxone	2	**-**
Morphine	1	**-**
Other	3	**-**

Source: ACT IDRS PWID interviews, 2015–16.
↓↑ Statistical significance $p<0.05$.

The frequency of injection reported by participants from 2012 to 2016 is presented in Table 3. In 2016, the most commonly reported frequency of injecting was 'more than weekly, less than daily' by 38% of the sample. There have been no significant differences in these patterns from 2015.

Table 3: Frequency of injection among PWID in the ACT, 2012–2016

	2012	2013	2014	2015	2016
Frequency (%)	N=99	N=100	N=100	N=100	**N=100**
Weekly or less	18	25	18	17	**19**
Daily–weekly	40	38	41	34	**38**
Daily	15	27	23	14	**24**
2–3 times daily	22	9	12	25	**14**
More than 3 times a day	4	1	3	8	**4**

Source: ACT IDRS PWID interviews, 2012–16.

POLYDRUG USE

As in previous years, the IDRS participants sampled reported polydrug use and Table 4 shows 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.

Table 4: Drug use history of the sample, 2016

	Ever used %	Ever injected %	Injected last six months %	Median days injected in last six months*	Used last six months^ %	Median days used in last six months	Smoked last six months %	Snorted last six months %	Swallowed last six months+ %
Heroin	92	91	67	60	70	72	3	-	1
Homebake heroin	54	48	13	3	14	3	1	-	-
Any heroin (inc. homebake)	**92**	**91**	**69**	**54**	**70**	**72**	**4**	**-**	**1**
Methadone (prescribed)	62	32	12	16	39	180			33
Methadone (illicit)	45	32	8	36	11	10			3
Physeptone (prescribed)	16	7	-	-	3	4	-	-	3
Physeptone (illicit)	16	9	1	7	3	5	-	-	2
Any methadone (inc. Physeptone)	**78**	**50**	**18**	**16**	**44**	**180**	**-**	**-**	**34**
Buprenorphine (prescribed)	25	10	-	-	1	70	-	-	1
Buprenorphine (illicit)	24	23	6	2	8	3	-	-	2
Any buprenorphine	**40**	**26**	**6**	**2**	**25**	**3**	**-**	**-**	**3**
Buprenorphine-naloxone (prescribed)	20	8	3	24	9	90	-	-	8
Buprenorphine-naloxone (illicit)	21	18	6	46	7	4	-	-	1
Any buprenorphine-naloxone	**32**	**21**	**9**	**90**	**16**	**90**	**-**	**-**	**9**
Morphine (prescribed)	22	16	2	64	4	24	-	-	-
Morphine (illicit)	47	43	8	2	12	5	-	-	2
Any morphine	**64**	**55**	**10**	**6**	**16**	**6**	**-**	**-**	**2**
Oxycodone (prescribed)	15	8	1		3		-	-	2
Oxycodone (illicit)	40	32	9		12		-	-	3
Any oxycodone	**50**	**35**	**9**	**1**	**14**	**1**	**-**	**-**	**5**
Fentanyl	23	17	3	5	5	5	-	-	-
Over the counter codeine	51	10	1	14	19	6	-	-	19
Other opioids (not elsewhere classified)	42	1	1	2	16	8	-	-	16

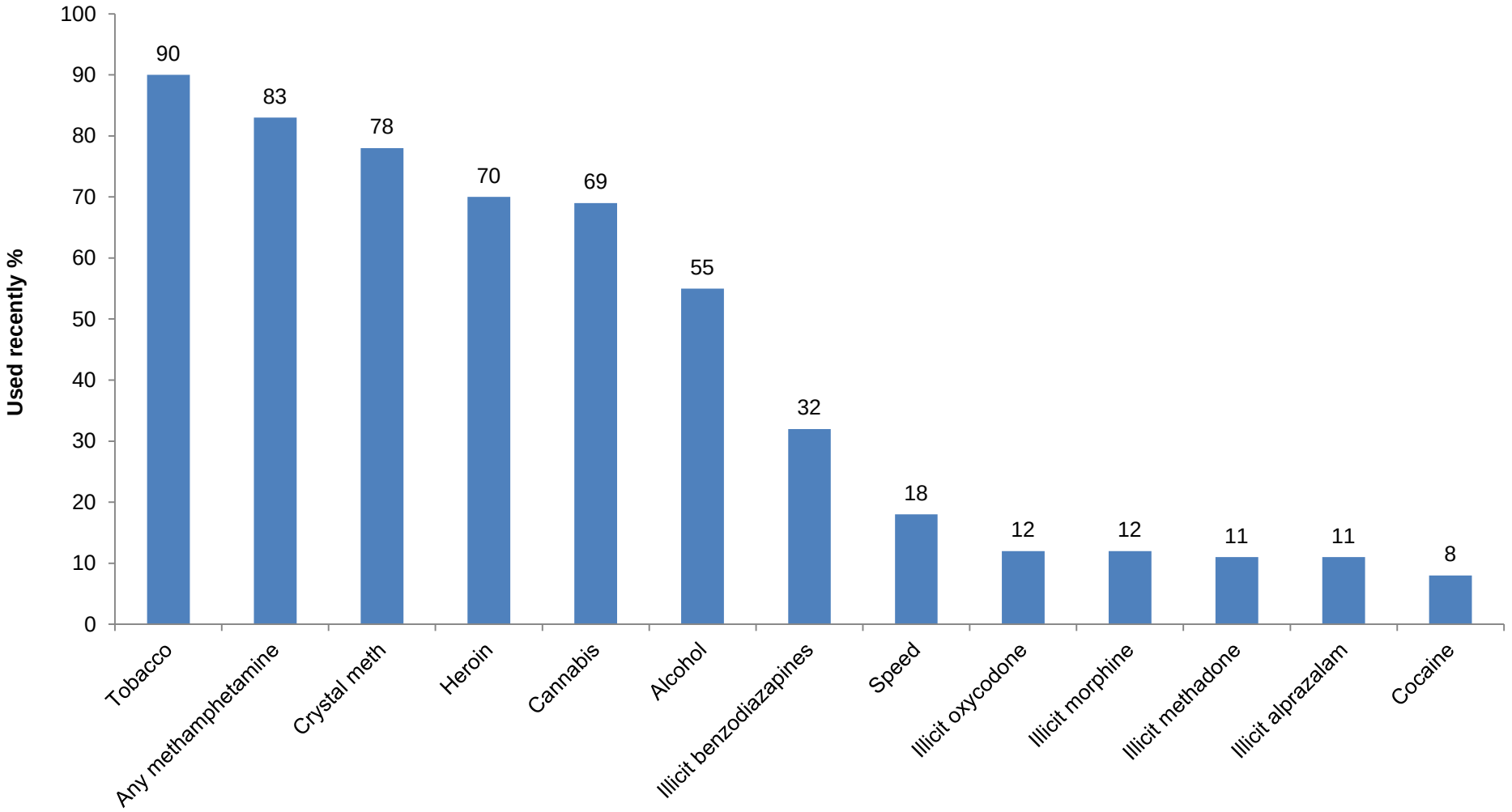
Source: ACT IDRS PWID interviews, 2016
+ Refers to/includes sublingual administration of buprenorphine
* Among those who had used/injected
- Represents no response

Table 4: Drug use history of the ACT sample, 2016 (continued)

	Ever used %	Ever injected %	Injected last six months %	Median days injected in last six months *	Used last six months^ %	Median days used last six months	Smoked last six months %	Snorted last six months %	Swallowed last six months+ %
Speed	82	71	13	12	18	8	1	3	3
Base/point/wax	39	38	5	5	5	5	-	-	-
Crystal methamphetamine	93	86	74	47	78	38	24	2	4
Amphetamine liquid	42	40	2	4	2	4			-
Any methamphetamine #	**97**	**93**	**78**	**47**	**83**	**35**	**24**	**5**	**7**
Pharmaceutical stimulants (prescribed)	12	7	1	1	2	81	-	-	1
Pharmaceutical stimulants (illicit)	29	19	2	4	4	4	-	-	1
Any pharmaceutical stimulants	**36**	**24**	**3**	**2**	**5**	**2**	**-**	**-**	**2**
Cocaine	65	56	7	5	8	4	-	3	-
Hallucinogens	58	14	-	-	5	1	-	1	4
Ecstasy	52	30	-	-	1	1	-	1	-
Alprazolam (prescribed)	15	3	1	4	5	92	-	1	4
Alprazolam (illicit)	28	4	1	4	11	3	-	-	10
Other benzodiazepines (prescribed)	39	9	2	63	30	180	-	-	30
Other benzodiazepines (illicit)	40	13	1	120	32	18	-	-	22
Any benzodiazepines	**69**	**20**	**2**	**63**	**51**	**72**	**-**	**1**	**50**
Seroquel (prescribed)	25	1	-	-	13	120	1	-	13
Seroquel (illicit)	27	-	-	-	10	3	-	-	10
Any Seroquel	**43**	**1**	**-**	**-**	**20**	**18**	**1**	**-**	**20**
Alcohol	84	9	1	1	55	50			54
Cannabis	89				69	180	67		2
Inhalants	21				1	1			
Steroids	7	4	-	-	-	-	-	-	-
New Psychoactive Substances	9	5	3	1	5	1	-	-	2
Synthetic cannabinoids	27	1	-	-	10	1	9	-	-
Tobacco	95				90	180			

Source: ACT IDRS PWID interviews, 2016
+ Refers to/includes sublingual administration of buprenorphine
* Among those who had used/injected
- Represents no response

Figure 1: Drug use in the six months preceding interview, ACT, 2016



Source: ACT IDRS PWID interviews, 2016.

Heroin

Key points

- In 2016, heroin remained the drug of choice for half of the sample.
- Seventy per cent had used heroin in the previous six months.
- Heroin was used on a median or 72 days in the preceding six months (approximately two days per week).

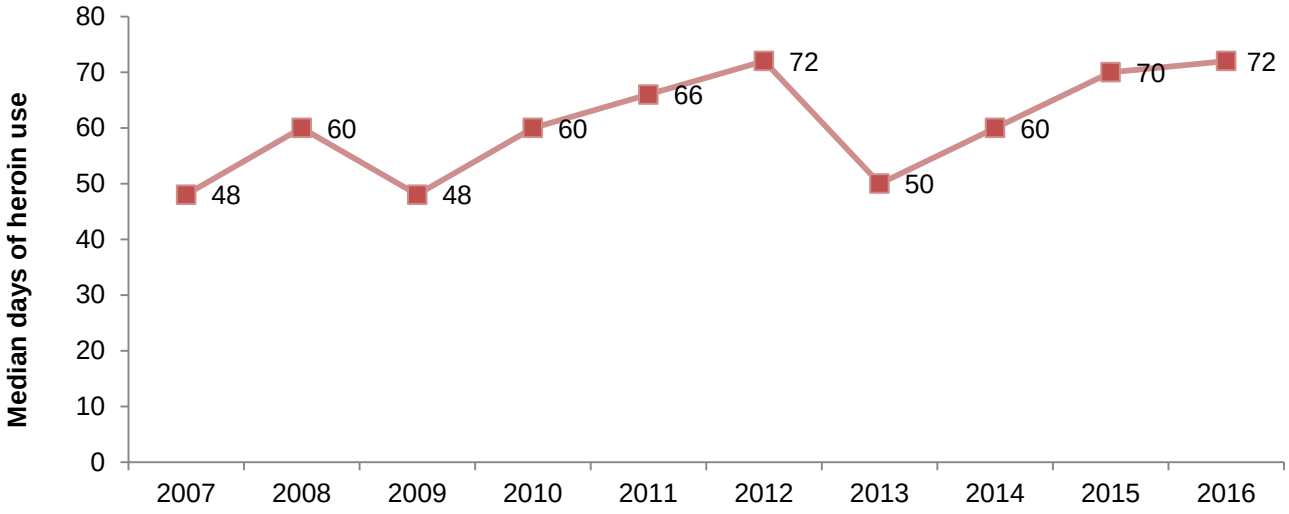
In 2016, 92% of respondents reported that they had used heroin at least once in their lifetime and 70% reported the use of heroin in the six months preceding interview.

Heroin was nominated as the drug of choice by over half of the participants in 2016 (53%). Half (51%) of the respondents reported heroin as the drug most often injected in the last month, and 46% reported that it was the last drug they injected.

The majority (96%) of participants who had used heroin in the preceding six months (n=70) reported injecting it. Few participants (4%) reported smoking heroin in the six months preceding the interview and one participant reported they had swallowed heroin in the last six months.

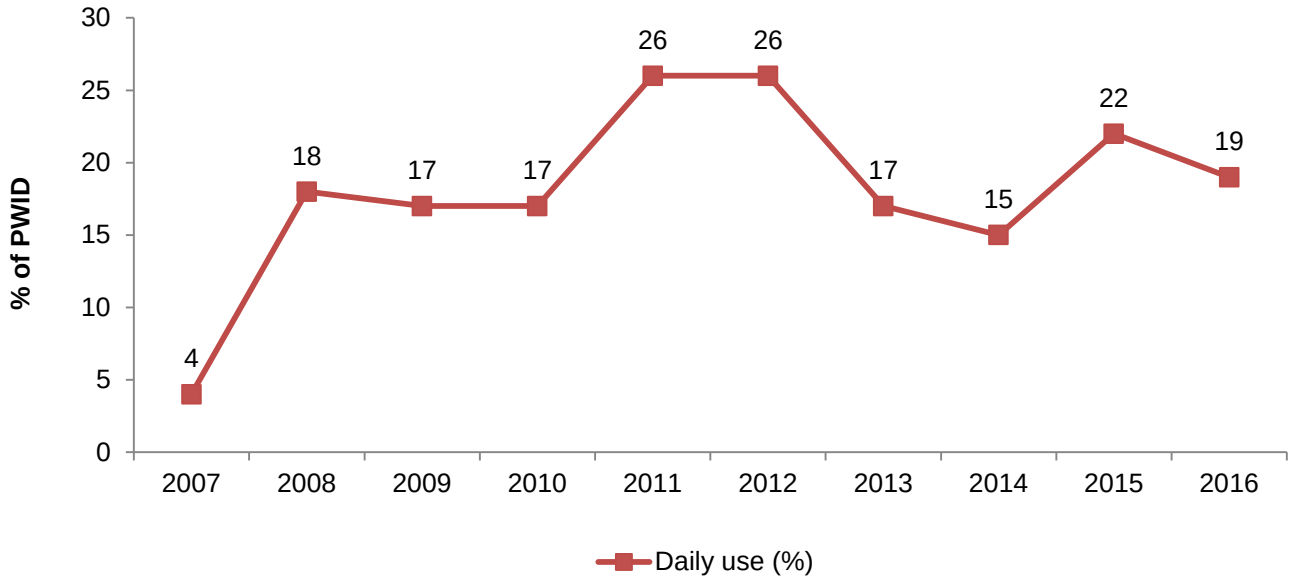
Of those participants who had used heroin in the six months prior to the interview, the median number of days of use during this period continues to trend upwards from 2013 to 72 days as seen in Figure 2. The number of days that heroin was used in the preceding six months ranged from one day to every day.

Figure 2: Median days of recent heroin use in the ACT, 2007–2016



Source: ACT IDRS PWID interviews, 2007–16.

Figure 3: Proportion of participants reporting recent daily heroin use in the ACT, 2007–2016



Source: ACT IDRS PWID interviews, 2007–16.

As shown in Figure 3, the proportion of participants reporting daily heroin use in the six months preceding interview was 19% in 2016.

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 2016, more than half (54%) of participants reported that they had used homebake heroin at least once in their lifetime. Fourteen per cent reported the use of homebake heroin in the six months preceding interview. Almost all of those who reported recent use of homebake heroin had injected it, while one participant reported smoking it. In 2016, the median days of homebake heroin use was three days (range=1–30).

PREPARATION AND COLOUR

Brown heroin was first identified in New South Wales (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 of heroin they had used over the last six months, in addition to the form most used.

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.

Information from border seizures indicates that it is not possible to determine the geographic origin of the drug based on colour alone (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 preceding interview, 74% reported that they had used heroin powder which was white/off-white in colour (Table 5). The next most common form used was white/off-white rock (42%). One in five PWID reported that they had used brown heroin powder (20%) and 19% reported using brown heroin rock in the six months preceding interview. Nearly two-thirds (62%) reported that white/off-white heroin powder was the form of heroin they most used, followed by white/off-white rock (24%).

Table 5: Forms of heroin used and most common form used recently, ACT, 2015–2016

Heroin form used in the last six months	2015 (n=79)	2016 (n=70)
Heroin powder		
White/off-white	83	**74**
Brown	25	**20**
Other colour	5	**0**
Heroin rock		
White/off-white	33	**42**
Brown	14	**19**
Other colour	3	**1**
Homebake	11	**14**
Heroin form used MOST OFTEN in last six months		
Heroin powder		
White/off-white	72	**62**
Brown	8	**6**
Other colour	1	**0**
Heroin rock		
White/off-white	14	**24**
Brown	5	**9**
Other colour	0	**0**
Homebake	1	**0**

Source: ACT IDRS PWID interviews, 2015–16.

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 in the six months preceding interview.

Methamphetamine

Key points

- The vast majority (97%) of participants reported using some form of methamphetamine at least once in their lifetime and 82% reported use in the past six months.
- Crystal methamphetamine remains the most common form used with 83% of the sample reporting recent use on a median of 35 days in the past six months.
- In contrast to crystal methamphetamine, speed (powder) and base use have declined in recent years.

The 2016 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 2016, the vast majority (97%) of participants reported using some form of methamphetamine (i.e. speed, base, crystal, amphetamine liquid) at least once in their lifetime.

Speed

Eighty-two per cent of participants reported using speed in their lifetime, 87% (n=71) of those participants reporting having injected speed.

Base

Thirty-nine per cent of participants reported ever having used base, with almost all of those (97%) reporting having injected base.

Crystal

Ninety-three per cent of participants reported having ever used crystal, with the majority (93%) reporting having injected crystal.

CURRENT PATTERNS OF METHAMPHETAMINE USE

Any methamphetamine

In 2016, 83 of ACT participants reported using any methamphetamine in the six months preceding interview. Median days of use for any methamphetamine remained stable at 35 days in 2016 (32 in 2015, 48 in 2014). Methamphetamine (in any form) was reported as the drug type used on first injection by 60% of the sample. Forty-four per cent of participants reported methamphetamine to be the drug type most often injected in the last month (39% in 2015).

Speed

Eighteen per cent of participants reported the use of speed in the six months preceding interview compared to 15% in 2015 (Figure 4).

The most common route of administration was injection, which was reported by more than two-thirds of participants who had recently used speed (72%). Of those who had recently used speed, smaller proportions reported snorting (17%), and smoking (6%) speed in the six months preceding interview.

Median days of use was eight days (range=1–30) among the previous six months. This equates to approximately monthly use.

Forty-four per cent of participants reported that speed was the first drug ever injected, 4% reported speed as the drug they injected most in the last month, and 3% reported speed as the most recent drug injected. In 2016, 5% reported that speed was their drug of choice.

Base

Five per cent reported the recent use of base (Figure 4). Injection was the most common route of administration reported by all participants who had recently used base. In 2016, no participants reported recently smoking it.

Base was injected on a median of five days (approximately monthly) in the preceding six months.

One participant reported that base was the first drug injected. No participants reported base as the drug injected most in the last month, or the last drug injected.

Crystal

More than three-quarters of the participants (78%) reported the recent use of crystal (79% in 2015; Figure 4). Almost all (95%) participants who had recently used crystal had done so by injection. Almost a third (31%) 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. Two participants reported recently snorting crystal.

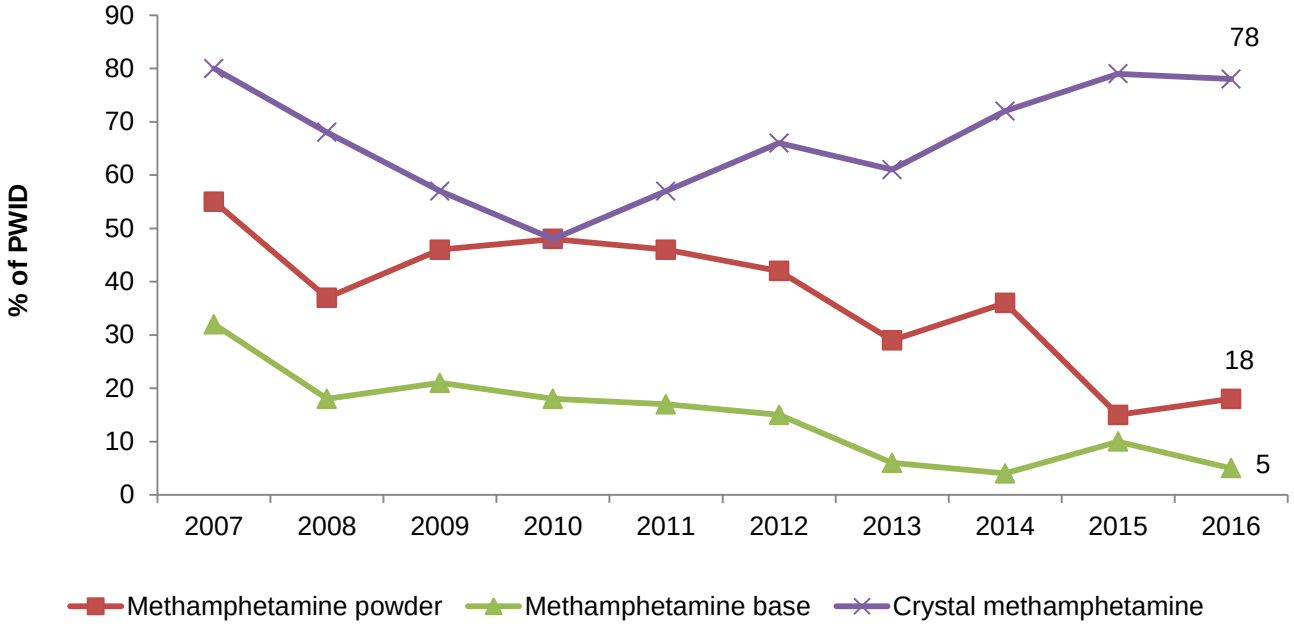
Among those who had used crystal in the previous six months, the median days of use was 38 (40 in 2015). Among recent injectors the median days of injection was 47; almost twice weekly use. Almost one in every six recent crystal users (17%) reported using crystal daily.

Crystal was the first drug injected by 15% of participants, the drug injected most often in the last month by 41%, and the last drug injected by 46%. Nearly one-third (31%) of participants nominated crystal as their drug of choice.

Liquid amphetamine

In 2016, 42% of participants reported that they had used liquid amphetamine at least once in their lifetime. Two participants reported the recent use of liquid amphetamine.

Figure 4: Methamphetamine use in the past six months in the ACT, 2007–2016



Source: ACT IDRS PWID interviews, 2007–16.

Cocaine

Key points

- Almost two-thirds of participants reported lifetime use of cocaine.
- The recent use of cocaine remained low in the ACT, with 8% reporting use in the preceding six months. The median days of use also remained low at four days.

LIFETIME USE

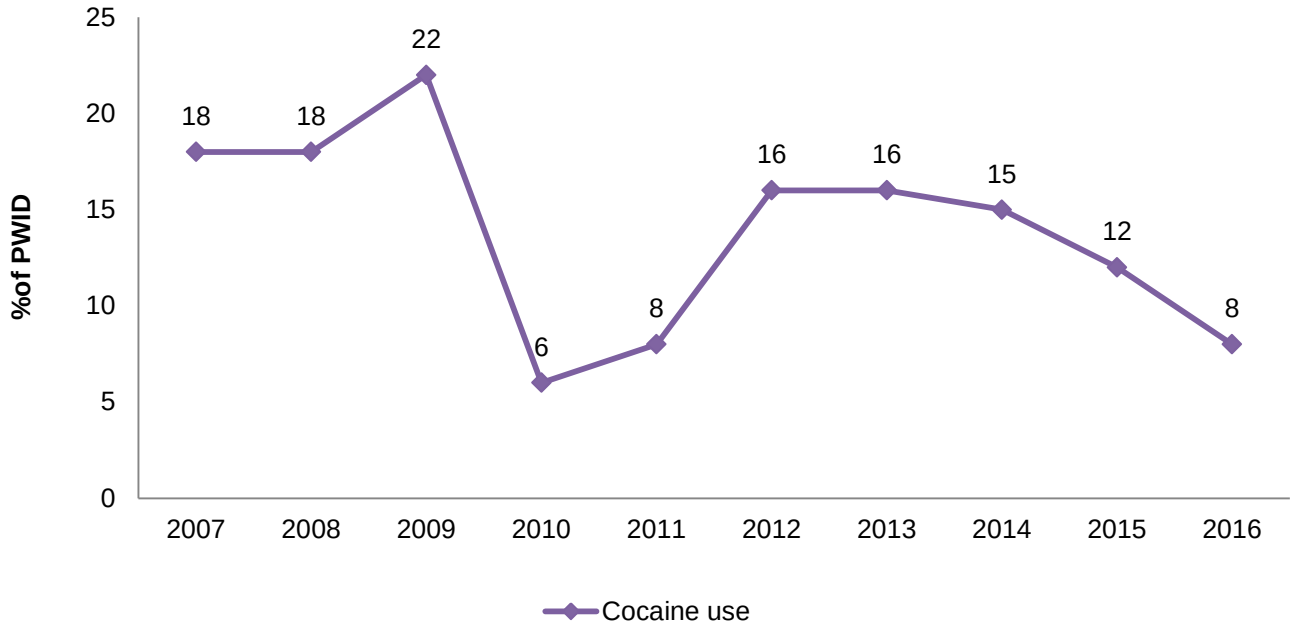
In 2016, 65% of participants reported that they had used cocaine at least once in their lifetime. Eighty-six per cent of those PWID who had ever used cocaine reported having injected cocaine.

CURRENT PATTERNS OF COCAINE USE

In 2016, the proportion of participants reporting recent use of cocaine was 8% continuing a downward trend from 2012 (Figure 5). Among recent cocaine users, the most common route of administration in 2016 was injection (88%). In the preceding six months, 38% of participants had snorted cocaine and no participants had smoked it. The median days of cocaine use remained low at four days, ranging from one day to 30 days.

Just 2% of participants reported that cocaine was the first drug they had ever injected. One participant nominated cocaine as their drug of choice none reported it as the drug they injected most often last month, or as the last drug injected.

Figure 5: Proportion of PWID reporting cocaine use in the past six months in the ACT, 2007–2016



Source: ACT IDRS PWID interviews, 2007–16.

Cannabis

Key points

- Sixty-nine per cent of PWID reported recent cannabis use in 2016 (81% in 2015).
- Daily use was reported by 52% of the sample.
- Median number of cones smoked last time was six cones.
- Hydroponic cannabis remained the most common form of cannabis used (84% used recently).

LIFETIME USE

In 2016, the vast majority of participants (89%) reported using cannabis at least once in their lifetime.

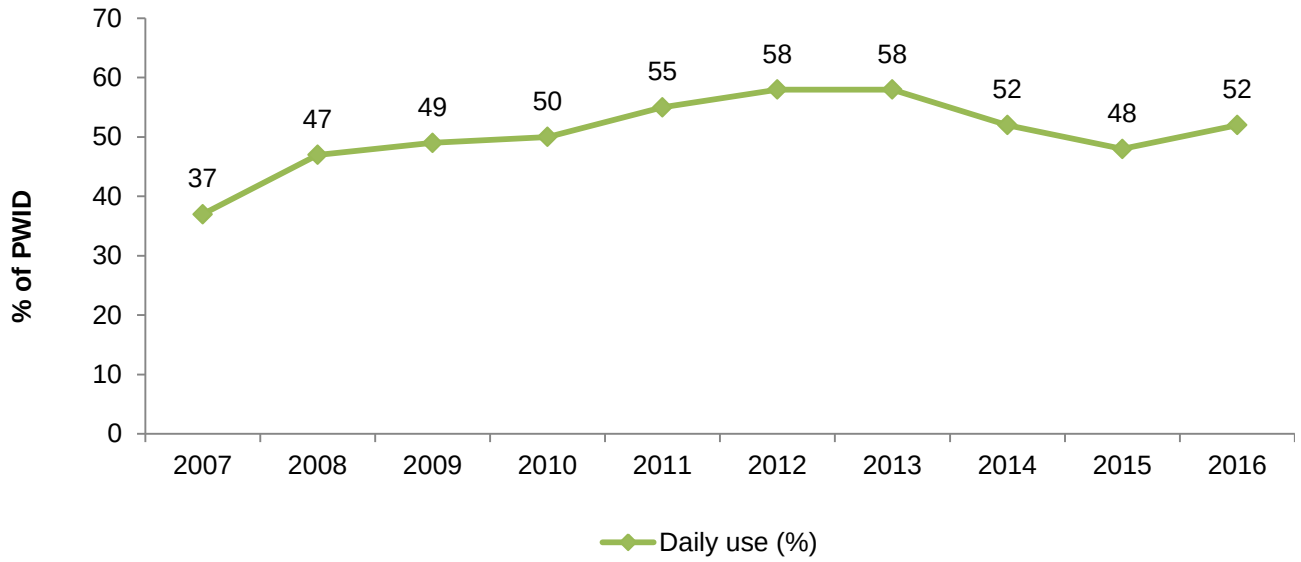
CURRENT PATTERNS OF CANNABIS USE

Two-thirds (69%) of participants reported having used cannabis in the six months preceding interview (81% in 2015). The median number of days of use in the previous six months was 180, which equates to daily use. Among recent cannabis users the proportion of participants reporting daily cannabis use has remained relatively stable (52%) (Figure 6). Five per cent of participants nominated cannabis as their drug of choice in 2016 (same as 2014 and 2015).

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 (46%) rather than joints (9%). Among those who had smoked cones, the median number used on the last day was six (range=1–40 cones) and the number of joints smoked was two and a half (range=1–10 joints). Daily users of cannabis had smoked a median of 10 cones (range=4–40) on the last day of use.

Of those respondents who had used cannabis in the past six months, 84% had used hydroponic cannabis (hydro), 56% had used bush, 16% had used hashish, and 7% reported using hashish oil. Hydro was the form of cannabis used most often (81% of respondents in 2016).

Figure 6: Recent daily cannabis use, 2007–2016



Source: ACT IDRS PWID interviews, 2007–16.

Key expert comments – Cannabis

Most KE reported that cannabis use was common and used frequently by many PWID.

Other opioids

Key points

- Recent use of illicit methadone was reported by one in ten PWID with the majority of them reporting injecting it.
- Similar proportions report the recent use of illicit buprenorphine (11%).
- One in fifteen report recent use of illicit buprenorphine-suboxone (7%)
- Recent use of illicit oxycodone remains stable at 12% of the sample using on a median of one day in the previous six months

The IDRS investigates the use patterns, harms and market characteristics of a number of pharmaceutical opioids, including methadone, buprenorphine, buprenorphine-naloxone, morphine and oxycodone, over-the-counter opioids, and fentanyl. 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 (a pill form of methadone) are less common 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 was 64% (72% in 2015). Thirty-nine per cent of participants in 2016 reported recent use of licit methadone (42% in 2015). In 2016, 85% of participants who had recently used licit methadone reported having swallowed it. In addition, 31% of participants reported having used licit methadone by injection in the six months prior to interview. Among those who reported using licit methadone in the preceding six months, 69% reported daily use. The median number of days of use for licit methadone was 180, indicating daily use.

Sixteen per cent of participants reported ever using licit physeptone (23% in 2015) and three per cent reported use of licit physeptone in the preceding six months. All of the recent licit physeptone users reported swallowing it.

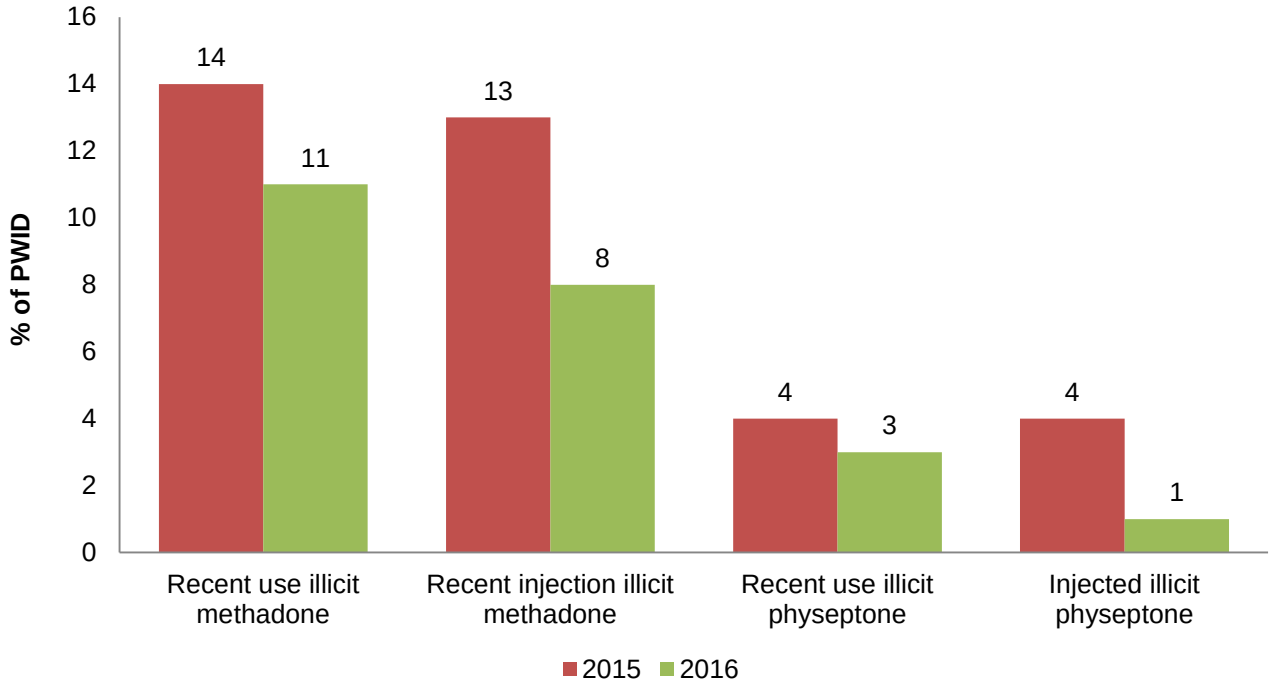
Illicit methadone and physeptone

In 2016, the self-reported lifetime use of illicit methadone among participants remained stable at 45% of participants (45% in 2015). As can be seen in Figure 7, the proportion of participants reporting recent use of illicit methadone is 11%. Eight per cent of participants reported recently

injecting illicit methadone. The median number of days of use for illicit methadone was ten days (range=1-90).

In 2016, 16% reported ever using illicit physeptone (31% in 2015) and 3% of participants reported recent use of illicit physeptone. One participant who recently used illicit physeptone reported injecting it.

Figure 7: Recent use and injection of illicit methadone and illicit physeptone among PWID, 2015-2016



Source: ACT IDRS PWID interviews, 2015-16.
NB: interpret with caution, n=<10.

BUPRENORPHINE[2]

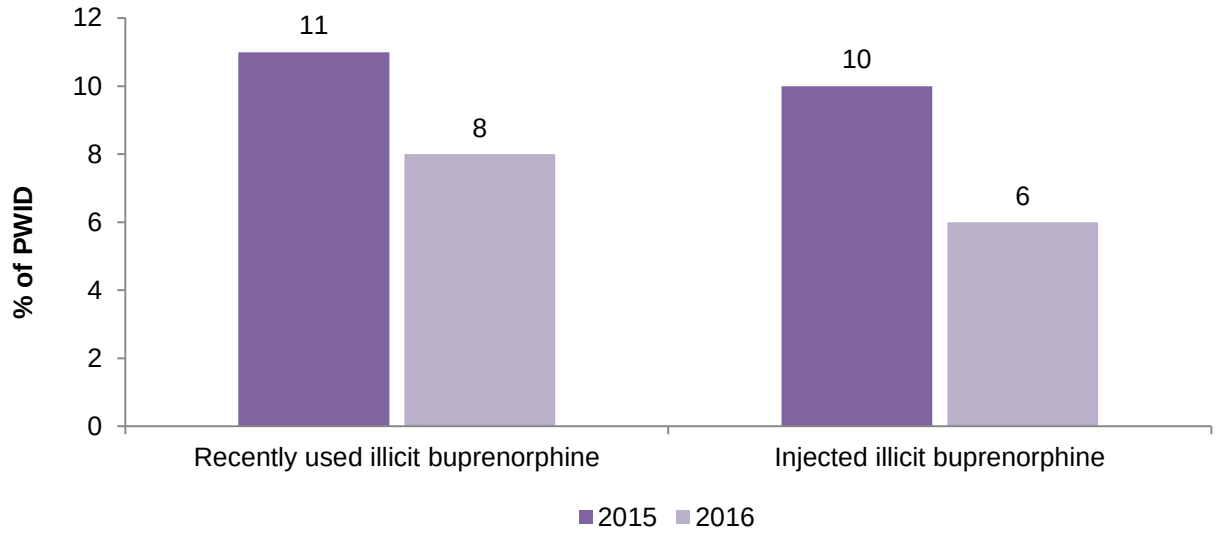
In 2016, 25% of participants reported that they had ever used licit buprenorphine, i.e. buprenorphine prescribed to them (32% in 2015). Use of prescribed buprenorphine in the six months preceding interview remains low with just one participant reporting recent use.

Twenty-four per cent of participants reported the lifetime use of illicit buprenorphine (40% in 2015). The proportion of participants who had used illicit buprenorphine in the six months prior to interview was eight per cent (Figure 8). In terms of route of administration, most PWID who recently used illicit

[2] Buprenorphine has been available for opioid substitution therapy (OST) in Australia since 2001. Initially mono-buprenorphine sublingual tablets (marketed as Subutex®) were introduced, followed by buprenorphine-naloxone sublingual tablets (marketed as Suboxone®) from 2006, and buprenorphine-naloxone (Suboxone®) sublingual film from October 2011. There is jurisdictional variation in the policy regarding prescribing and uptake of the different forms (Larance et al 2015). 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 2000 http://www.tga.gov.au/pdf/auspar/auspar-suboxone.pdf).

buprenorphine reported injecting it in the six months preceding interview (75% of recent users, n=6). In 2016, the median number of days of use for illicit buprenorphine was two and a half days.

Figure 8: Recent use and injection of illicit buprenorphine among PWID, 2015–2016



Source: ACT IDRS PWID interviews, 2015-2016

BUPRENORPHINE-NALOXONE (SUBOXONE®)

Participants were asked about the use of buprenorphine-naloxone tablet (available since 2006) and buprenorphine-naloxone film, which became available on the Pharmaceutical Benefits Scheme (PBS) to treat opiate dependence in late 2011. In 2016, participants were asked about the use of any form of buprenorphine-naloxone which included either 'tablet' or 'film' forms. In previous years, participants were asked about buprenorphine-naloxone tablets and films separately.

In the ACT, sixteen per cent of PWID reported recently using any form of buprenorphine-naloxone (licit/illicit) on a median of ninety days in the past six months.

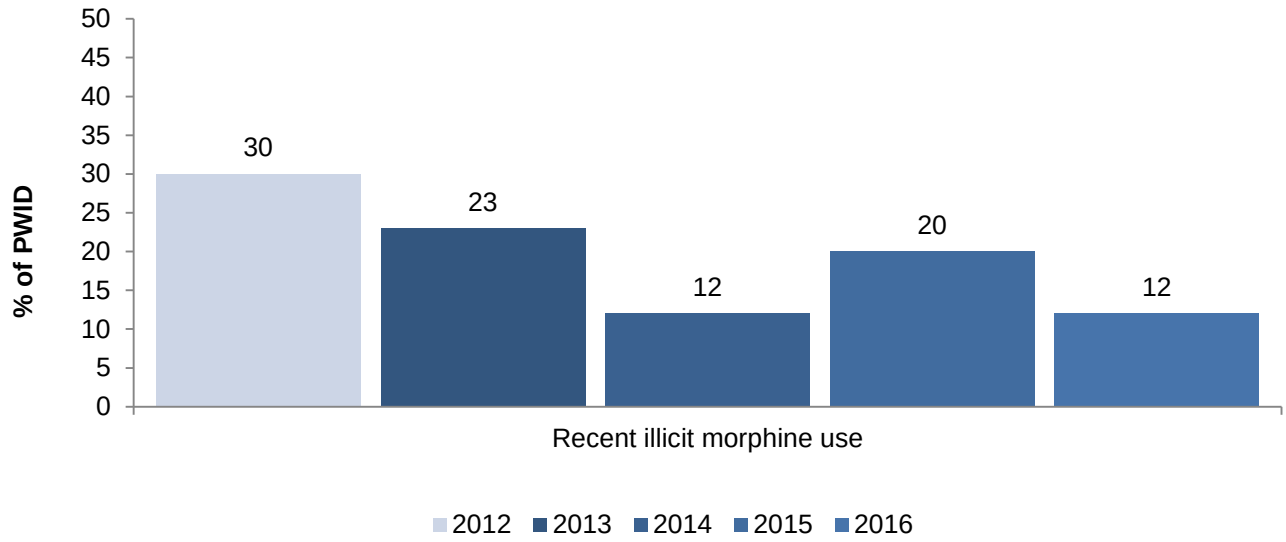
Licit use – the number of participants who reported that they had ever used licit buprenorphine-naloxone remained stable at 20% (21% in 2015). Nine per cent reported the use of prescribed buprenorphine-naloxone in the six months preceding interview.

Illicit use – Twenty-one per cent of participants reported that they had ever used illicit buprenorphine-naloxone (tablet form) and seven per cent reported using buprenorphine-naloxone in the six months prior to interview.

MORPHINE

Forty-seven per cent of participants reported using illicit morphine at least once in their lifetime and twelve per cent of participants reported recent use (Figure 9). Of those participants who had recently used illicit morphine, the most common route of administration was injecting (67%; 95% in 2015). In 2016, the median number of days of use for illicit morphine was five days, suggesting low and sporadic use. MS Contin® was the preferred brand of morphine for half (62%) of recent morphine users.

Figure 9: Recent use of illicit morphine among PWID in the last six months, 2012–2016

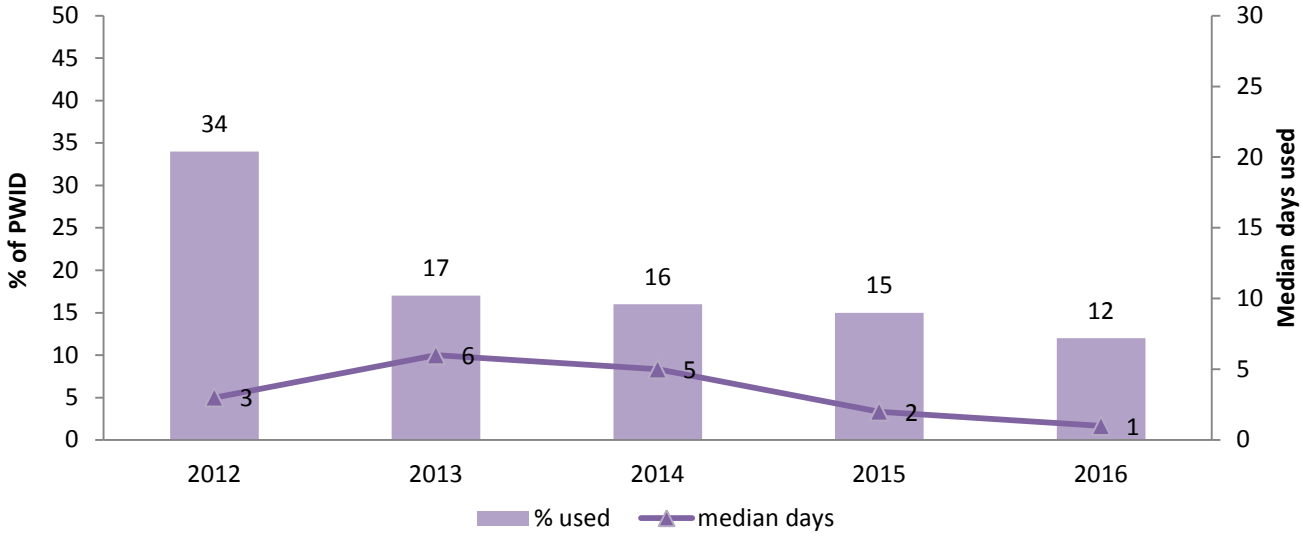


Source: ACT IDRS PWID interviews, 2012–16.

OXYCODONE

Forty per cent of participants reported that they had used illicit oxycodone at least once in their lifetime (56% in 2015). The median number of days of recent illicit oxycodone use has decreased to one day (Figure 10).

Figure 10: Recent illicit oxycodone use and median days of use, 2012–2016



Source: ACT IDRS PWID interviews, 2012–16.

OVER THE COUNTER CODEINE

Forty-two per cent of participants reported that they had ever used over the counter (OTC) codeine and 16% of participants reported that they had used OTC codeine in the six months prior to interview on a median of 8 days. All recent OTC codeine users had swallowed it and one participant reported injection of OTC codeine. Brands reported were Nurofen Plus®, Panadeine Forte®, as well as doxylamine succinate with brand name, Dolased® or Mersyndol® and Chemists Own pain tablet/capsule.

FENTANYL

In 2016, the IDRS survey included questions on the use of fentanyl. Nearly one-quarter (23%) of participants reported that they had ever used fentanyl. Use of fentanyl in the ACT is low with just one in twenty (5%) PWID reported using the drug in the last six months.

Other drugs

Key points

- Small proportions report the recent use of:
  - ecstasy (1%);
  - pharmaceutical stimulants (illicit) (4%);
  - inhalants (1%); and
  - hallucinogens (5%).
- Benzodiazepine and alprazolam use remains stable, with 51% recently using benzodiazepine (licit and illicit) and 15% reporting recently using alprazolam (licit and illicit).
- The recent use of illicit Seroquel® was reported by 13% of the sample.
- Recent alcohol use was reported by over half (55%).
- Tobacco remained common, recently used by 90% of the sample.

ECSTASY

In 2016, fifty-two per cent of PWID reported lifetime use of ecstasy (61% in 2015), and one participant reported recent use. Information on ecstasy use and markets is routinely collected by the EDRS project (Butler and Breen 2017, Stafford and Breen 2017).

HALLUCINOGENS

Fifty-eight per cent of participants reported having used hallucinogens at some stage in their lifetime (57% in 2015) and recent use was low, with 5% reporting use in the six months preceding interview.

BENZODIAZEPINES (EXCLUDING ALPRAZOLAM)[3]

Nearly two-thirds (63%) of participants reported ever having used benzodiazepines (39% licit and 40% illicit). Fifty-one per cent of participants had reported the recent use of any form (32% licit and 27% illicit) of benzodiazepines (excluding alprazolam). Illicit benzodiazepines were used on a median of 17.5 days in the last six months.

ALPRAZOLAM

Smaller proportions of participants reported the lifetime use of some form of alprazolam with 35% reporting use of either licit or illicit alprazolam (15% licit and 28% illicit). Fifteen per cent reported recently using any form of alprazolam (5% licit and 11% illicit). Illicit alprazolam was used on a median of three days in the last six months.

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[3] It was recognised that alprazolam was a benzodiazepine that was potent and may be prone to abuse. The IDRS research team decided to collect data separately for alprazolam from 2011. The abuse liability was recognised nationally with the rescheduling of alprazolam from Schedule 4 to Schedule 8 from February 1 2014: http://www.tga.gov.au/book/part-scheduling-proposals-referred-march-2013-meeting-acms. From 2011 onwards participants were asked separately about the use of alprazolam and other benzodiazepines use.

PHARMACEUTICAL STIMULANTS

Pharmaceutical stimulants include drugs such as dexamphetamine and methylphenidate, medications most commonly prescribed for attention deficit hyperactivity disorder.

Licit – Twelve per cent of participants reported ever using licit pharmaceutical stimulants (those prescribed to them). Only two participants reported using licit pharmaceutical stimulants in the preceding six months.

Illicit – Twenty-nine per cent of participants reported using illicit pharmaceutical stimulants at least once in their lifetime (35% in 2015). Four per cent reported using illicit pharmaceutical stimulants over the preceding six months. The median days of use of illicit pharmaceutical stimulants was low at four days in the preceding six month (range=1–10).

Recent use of any pharmaceutical stimulants (licit and illicit) was reported by 5% of the total sample in 2016.

Table 6: Recent pharmaceutical stimulant use (licit/illicit) among participants in the ACT, 2012–2016

	2012 N=99	2013 N=100	2014 N=100	2015 N=100	2016 N=100
Recent use (%)	13	8	12	13	5
Recent injecting (%)	11	4	10	12	3
Median days used*	5	5	7.5	2	2

Source: ACT IDRS PWID interviews, 2012–16.
***Among those that reported recent use. Maximum=180 days.

SEROQUEL® (QUETIAPINE)

Forty-three per cent of participants reported lifetime use of Seroquel® (quetiapine) (25% licit, 27% illicit). One-fifth (20%) had used Seroquel® in the last six months (13% licit, 10% illicit).

Licit use of Seroquel® had been used on a median of 120 days (range=1–180) compared to three days (range=1–90) for illicit use.

INHALANTS

Twenty-one per cent of participants reported ever having inhaled volatile substances such as amyl nitrate, petrol, glue and/or lighter fluid. One participant reported use in the six months preceding interview.

ALCOHOL AND TOBACCO

The majority (84%) of participants in 2016 reported having used alcohol at least once during their lifetime. In 2016, 55% of participants reported the recent use of alcohol (Table 7). The median days of alcohol use in the six months prior to interview was 50 days in 2016 (just over twice weekly) and 24% of those who had used alcohol in the past six months reporting being daily drinkers.

Use of tobacco was almost universal among participants in the ACT in 2016. The vast majority of participants (95%) reported ever having used tobacco and 90% reported recent tobacco use, as shown in Table 7. The median days of tobacco use has remained stable over the last ten years at

180 days (i.e. 89% reported being daily smokers). There were no significant differences in use from 2015 to 2016.

Table 7: Patterns of recent alcohol and tobacco use among PWID in the ACT, 2012–2016

	2012 N=99	2013 N=100	2014 N=100	2015 N=100	2016 N=100
Recent use (%)					
Alcohol	65	61	54	60	**55**
Tobacco	94	89	88	96	**90**
Median days used *					
Alcohol	54	24	44	30	**50**
Tobacco	180	180	180	180	**180**

Source: ACT IDRS PWID interviews, 2012–16.
***Among those that reported recent use. Maximum=180 days.

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

Heroin

Key points

- Price for heroin remained stable at $80 for a quarter-gram and $300 per gram.
- One in three of those who commented reported current purity to be high.

In this section, the patterns of use, price, purity and availability of heroin are discussed. The data on heroin markets presented below reflect information provided by 66 participants who commented on heroin trends in the ACT in 2016.

PRICE

Participants were asked to comment on the price for the last time they purchased heroin in the six months prior to interview. The median reported prices of heroin in 2016 were similar to the prices reported by participants in 2015. In both 2015 and 2016, the median price of a gram was $300. The median price for a quarter-gram of heroin also remained stable at $80, as did the median price for a half-gram ($150). The price reported for a cap of heroin increased from $50 to $80. This may be due to an inconsistent interpretation of how much a 'cap' weighs.

Table 8 presents participant reports of changes in the price of heroin in the six months preceding the interview. Consistent with purchase prices, the majority (82%) of those who commented on heroin trends in 2016 reported that the price had remained stable in the previous six months.

Table 8: Participants' reports of heroin price changes in the last six months, 2015–2016

Price change	2015 n=76	2016 N=66
Increasing (%)	1	**12**
Stable (%)	87	**82**
Decreasing (%)	5	**3**
Fluctuating (%)	7	**3**

Source: ACT IDRS PWID interviews, 2015–16.

AVAILABILITY

Table 9 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 (41%) or easy (39%) to obtain. Participants were also asked to comment on changes in the availability of heroin in the ACT in the six months prior to interview. In 2016, the majority of participants believed heroin availability had remained stable (74%).

Table 9: Participants' reports of heroin availability in the past six months, 2015–2016

Current availability	2015 n=75	2016 (n=66)
Of those who responded (%)		
Very easy	52	**41**
Easy	40	**39**
Difficult	8	**18**
Very difficult	-	**2**
Availability change over the last six months		
Of those who responded (%)		
More difficult	10	**17**
Stable	76	**74**
Easier	7	**5**
Fluctuates	8	**5**

Source: ACT IDRS PWID interviews, 2015–16.
↑↓ Statistical significance $p<0.05$.

In 2016, the most common source participants reported purchasing heroin from in the six months prior to interview was from a known dealer (46%), a friend (37%) or a street dealer (5%). The most commonly reported places for the last purchase of heroin were an agreed public location (32%), a friend's home (30%), and a dealer's home (24%).

PERCEIVED PURITY

Participants were asked to comment on the perceived purity of heroin in the ACT (Table 10). In 2016, significantly more participants reported the purity of heroin to be high (30% in 2016; 8% in 2015). Half (47%) reported that purity remained stable in the past six months.

Table 10: Participants' perceptions of heroin purity in the past six months, 2015–2016

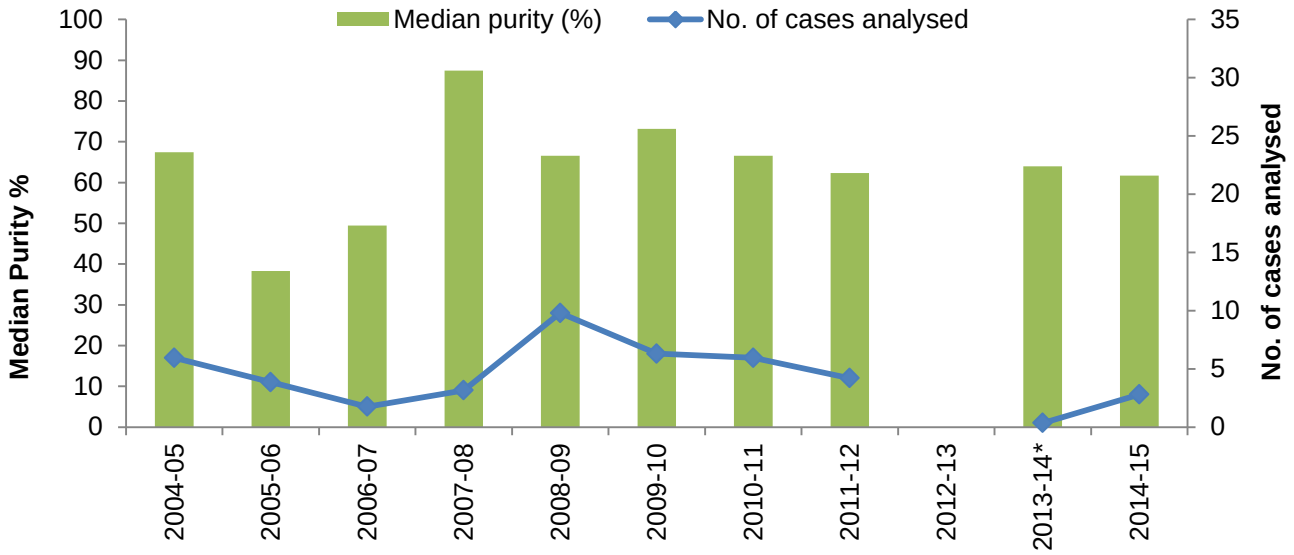
Current purity	2015 n=73	2016 (n=66)
Of those who responded (%)		
High	8	**30** ↑
Medium	34	**33**
Low	51	**27**↓
Fluctuates	7	**9**
Purity change over the last six months		
Of those who responded (%)		
Increasing	12	**23**
Stable	53	**48**
Decreasing	18	**17**
Fluctuating	16	**11**

Source: ACT IDRS PWID interviews, 2015–16.
↑↓ Statistical significance $p<0.05$.

SEIZURE PURITY DATA

Figure 11 presents data from the ACC on the purity of heroin seizures[4] made by ACT local police, by financial year, from July 2004 to June 2015. Eight seizures made by the state police in Canberra were analysed during the last reported period. Caution is advised when interpreting data due to low number of cases analysed. Data were not available at the time of printing for more recent seizure purity estimates.

Figure 11: Median purity of heroin seizures by ACT local police, July 2004–June 2015



Source: Illicit Drug Data Report, ACC, 2004–15.
* 2013–14 data depicts AFP case.

[4] Figures do not represent the purity levels of all heroin seizures – only those that have been analysed at a forensic laboratory.

Methamphetamine

Key points

- The price of speed has remained stable with reports of one point costing $50.
- The most common form of methamphetamine, which received comment, was crystal methamphetamine with 52% of the sample reporting price, purity and availability.
- The price of a point of crystal is reported to be $85.
- There were no significant differences in either the availability or reported purity of crystal, speed or base.

PRICE

Speed (Methamphetamine powder)

In 2016, the median price for a point (0.1 grams) of speed remained stable from 2015 at $50 (Table 11). Low numbers (n<10) commented on the price of a gram and therefore data is not presented. The most common amount of speed purchased was a point, with 52% of participants who commented on speed reporting that they had bought a point of speed in the six months preceding interview. Of those participants who commented on speed in 2016, most (59%) believed the price to have been stable in the six months preceding interview.

Table 11: Price and changes in price for methamphetamine powder, ACT, 2015–2016

Median price – speed	2015	2016
Point (0.1 gram)	$50	**$50**
(range)	(30–100)	**(20–100)**
Gram	-	**-**
(range)	-	**-**
Change in price (%)	**n=17**	**N=22**
Increasing	0	**14**
Stable	88	**59**
Decreasing	12	**18**
Fluctuating	-	**9**

Source: ACT IDRS PWID interviews, 2015–16.
^ Small numbers reporting (n<10); interpret with caution.

Base

Due to the very small number reported on the availability of base (n=2), the ACT findings will not be presented. Refer to *Australian Drug Trends* for national figures (Stafford and Breen 2017).

Crystal

In 2016, the median price of a point of crystal purchased by participants was reported to be $85. The median price of a half-weight was $250 and the price of a gram remains stable at $500.

The most common amount of crystal purchased was a point, with 80% of participants who commented on crystal reporting that they had bought this amount in the past six months.

Of those who commented, the majority (67%) reported the price to have remained stable in the six months preceding the interview.

Table 12: Price and changes in price for crystal methamphetamine, ACT, 2015–2016

Median price – crystal	2015	2016
Point (0.1 gram)	$100	**$85**
(range)	(15—100)	**(21–100)**
Half-weight (0.5 gram)	$250	**$250**
(range)	(50–500)	**(40–400)**
Gram	$500	**$500**
(range)	(100–700)	**(50–700)**
Of those that responded (%)	**n=68**	**n=63**
Increasing	10	**6**
Stable	78	**67**
Decreasing	4	**21**
Fluctuating	7	**6**

Source: ACT IDRS PWID interviews, 2015–16.
^ Small numbers reporting (n<10); interpret with caution.

AVAILABILITY

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 2016. Findings are presented separately for powder and crystal in Table 13 and Table 14. Low numbers (n<10) were able to comment on base and data is not presented.

Speed

Of those who commented on the current availability of speed (n=25), most (84%) reported speed to be easy (40%), or very easy (44%) to obtain.

Nearly two-thirds (60%) of the participants that commented on speed thought that the availability had remained stable in the six months prior to interview.

Table 13: Availability of methamphetamine powder, ACT, 2015–2016

Availability – speed	2015	2016
Responded	n=18	**n=25**
Very easy	61	**44**
Easy	28	**40**
Difficult	6	**4**
Very difficult	0	**12**
Change in availability (%)		
More difficult	11	**20**
Stable	67	**60**
Easier	11	**16**
Fluctuates	6	**4**

Source: ACT IDRS PWID interviews, 2015–16.

Participants who bought speed (n=21) reported that they obtained it through: friends (38%), known dealers (19%), and street dealers (19%). The most commonly reported places of speed purchases were at an agreed public location (48%), a friend's home (24%), and a dealer's home (10%).

Crystal

Of those who commented on the current availability of crystal (n=65), the majority reported it to be very easy (54%), or easy (45%) to obtain.

In 2016, almost three-quarters (70%) of participants reported that crystal availability had remained stable. Eighteen per cent reported that crystal was easier to obtain and 5% reported that it was more difficult in the past six months.

Table 14: Availability of crystal methamphetamine, ACT, 2015–2016

Availability – crystal	2015	2016
Responded	n=70	**n=65**
Very easy	50	**34**
Easy	46	**45**
Difficult	1	**2**
Very difficult	0	**0**
Change of availability (%)	**2015**	**2016**
More difficult	9	**5**
Stable	70	**70**
Easier	14	**18**
Fluctuates	4	**8**

Source: ACT IDRS PWID interviews, 2015–16.

Fifty-two per cent of the participants who reported that they had bought crystal said they obtained it from friends, 27% reported that they had obtained it from a known dealer, and 11% reported that they had obtained it through an acquaintance. The most common venues where participants had last purchased crystal from included: a friend's home (37%), an agreed public location (24%), or a dealer's home (16%).

PERCEIVED PURITY

Speed

In 2016, reports of perceived purity were mixed. Thirty-eight per cent reported purity to be medium followed by 25% reporting purity to be high, followed by 21% reporting purity to be low. Likewise, reports of the change in purity also varied with 50% reporting purity were stable, 23% reported purity had decreased, and 14% reporting purity had increased or was fluctuating (14%).

Base

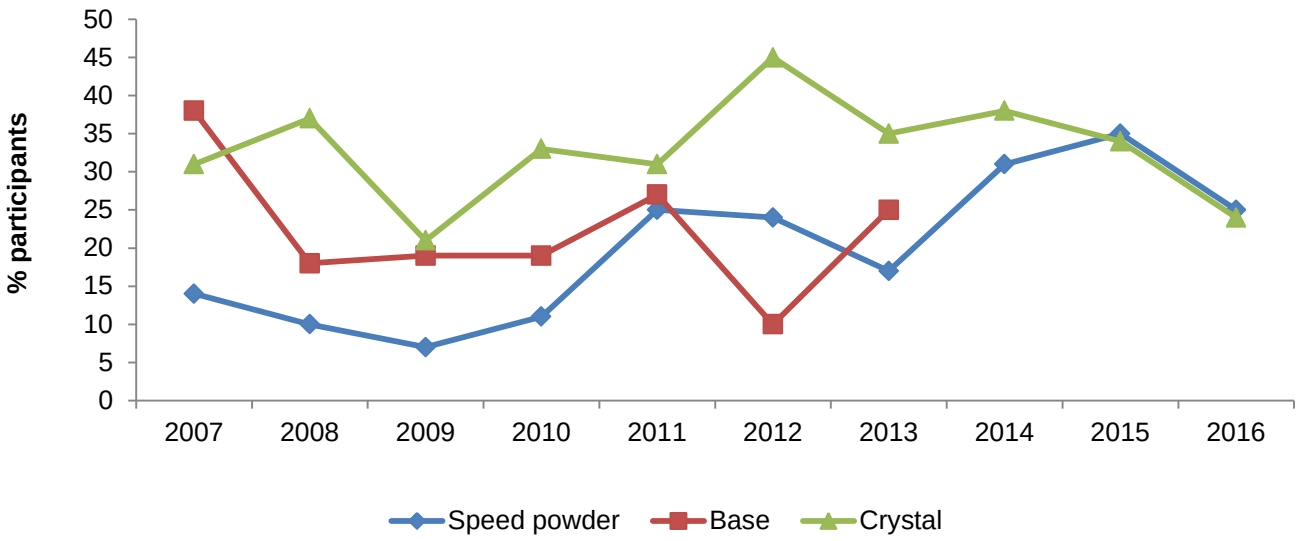
In 2016, only one participant reported on the purity of base. Due to the extremely low number of participants who responded, ACT findings will not be presented. Refer to *Australian Drug Trends* for national figures (Stafford and Breen 2017).

Crystal

In 2016, among those who commented on the perceived purity of crystal (n=63), results were mixed. Forty-three per cent reported purity of crystal to be medium, followed by 24% reporting purity to be high, 16% reporting purity to be low and 18% reporting purity was fluctuating.

Similarly, there were mixed reports from participants concerning the change in purity of crystal over the preceding six months. Forty-one per cent of participants who commented reported that the purity of crystal was stable, 30% reported that purity was fluctuating, 22% reported it had decreased and 8% reported it increased.

Figure 12: Proportion of participants reporting methamphetamine purity as high, 2007–2016



Source: ACT IDRS PWID interviews, 2007–16.
No data for base for 2014–16 as numbers too low.

Cocaine

Key points

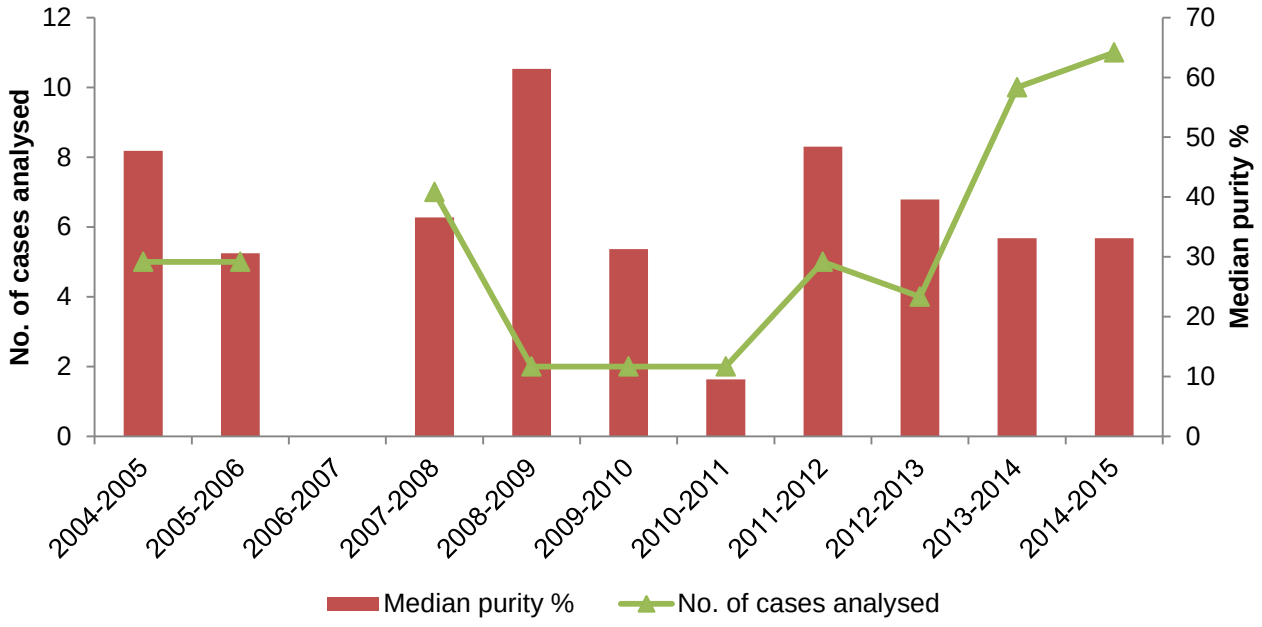
- Cocaine use in the ACT remains low and insufficient numbers were able to comment on price, perceived purity and availability.

In 2016, two participants were able to comment on the price, purity and availability of cocaine. Due to small numbers reporting (n<10) the ACT data is not presented. For more national figures please refer to *Australian Drug Trends* (Stafford and Breen 2017).

SEIZURE PURITY DATA

Figure 13 presents data from the ACC on the purity of cocaine seizures[5] made by ACT local police, by financial year, from July 2004 to June 2015. Caution is advised when interpreting data due to low number of cases analysed in some years. Data were not available at the time of printing for more recent seizure purity estimates.

Figure 13: Median purity of cocaine seizures by ACT local police, July 2004–June 2015



Source: Illicit Drug Data Report, ACC, 2004–16.

[5] Figures do not represent the purity levels of all cocaine seizures – only those that have been analysed at a forensic laboratory.

Cannabis

Key points

- The median cost of a gram of hydroponic cannabis was $20.
- The median cost of an ounce of hydroponic cannabis was $250.
- The 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). Over half of the participants (55%) commented on trends in hydro in the ACT and 29% reported on bush cannabis.

PRICE

The median prices for hydroponic cannabis and the reported changes are presented in Table 15. The median prices for bush cannabis and the reported changes in price are shown in Table 16.

Hydro

The median price of a gram of hydro purchased by participants in 2016 remained stable at $20. The most common amount of hydro purchased was a gram, with 39 participants reporting that they had bought a gram in the six months preceding the interview. The vast majority (91%) of those who commented reported the price of hydro to have been stable in the six months preceding interview.

Table 15: Price and changes in price for hydroponic cannabis, ACT, 2015–2016

Median price – cannabis (hydro)	2015	2016
Gram	$20	**$20**
(range)	(10–25)	(10–25)
Quarter-ounce	$85	**$80**
(range)	(55–800)	(60–100)
Half-ounce	$150	**$150**
(range)	(70–300)	(140–180)
Ounce	$300	**$250**
(range)	(250–350)	(230–320)
Change in price (%)	**n=50**	**n=55**
Increasing	8	**7**
Stable	78	**91**
Decreasing	2	**0**
Fluctuating	12	**2**

Source: ACT IDRS PWID interviews, 2015–16.
^ Interpret with caution, n=<10.

Bush

The median price of a gram of bush cannabis purchased by participants was $20 in 2016. Bush cannabis was reported by fewer participants, with just 26 participants commenting. As can be seen in Table 16, of those that commented on bush cannabis in 2016, the majority (92%) reported that the price of bush had remained stable in the six months preceding interview.

Table 16: Price and changes in price for bush cannabis, ACT, 2015–2016

Median price – cannabis (bush)	2015	2016
Gram	**$20**	**$20**
(range)	(10–20)	(10–25)
Quarter-ounce	**$80**	**$80^**
(range)	(50–100)	(70–90)
Half-ounce	**$150**	**$150^**
(range)	(130–180)	(140–160)
Ounce	**$250**	**$255^**
(range)	(100–320)	(150–325)
Change in price (**%**)	n=17	n=26
Increasing	12	0
Stable	77	92
Decreasing	12	4
Fluctuating	0	4

Source: ACT IDRS PWID interviews, 2015–16.
^ Interpret with caution, n=<10.

AVAILABILITY

Participants were asked to comment on the current availability and any changes in availability, of both hydro and bush in the ACT in 2016. Findings are presented separately for each type of cannabis.

Hydro

Of those that commented on the current availability of hydro (n=55), the majority reported it to be very easy (42%) and easy (51%) to obtain as shown in Table 17. There were no significant differences between 2015 and 2016.

The majority (78%) of participants commenting on hydro thought that the availability had remained stable in the six months prior to interview. Recent hydro users who bought hydro predominantly reported last purchasing it from a friend (60%) or a known dealer (21%). The most common places for purchasing hydro were from a friend's home (42%), an agreed public location (23%), or a dealer's home (21%).

Table 17: Availability of hydro cannabis, ACT, 2015–2016

Availability – hydroponic cannabis (%)	2015	2016
Responded	n=52	**n=55**
Very easy	64	**42**
Easy	27	**51**
Difficult	10	**7**
Very difficult	0	**0**
Changes in availability (%)	**n=52**	**n=55**
More difficult	8	**11**
Stable	73	**78**
Easier	10	**11**
Fluctuates	10	**0**

Source: ACT IDRS PWID interviews, 2015–16.

Bush

The majority of those that commented on the current availability of bush cannabis (n=26) reported that bush was very easy (27%) or easy (42%) to obtain. Most (77%) reported that bush availability had remained stable in the six months preceding interview, as shown in Table 18.

The majority of bush purchases were through a friend (68%), or a known dealer (16%). Purchases most often occurred at a friend's home (48%), or an agreed public location (20%).

Table 18: Availability of bush cannabis, ACT, 2015–2016

Availability – bush cannabis (%)	2015	2016
Responded	n=17	**n=26**
Very easy	35	**27**
Easy	41	**42**
Difficult	18	**23**
Very difficult	6	**8**
Change in availability (%)	n=17	**n=26**
More difficult	18	**23**
Stable	53	**77**
Easier	12	**0**
Fluctuates	18	**0**

Source: ACT IDRS PWID interviews, 2015–16.

PERCEIVED POTENCY

Respondents were asked to estimate the current strength or potency of hydro and bush cannabis (based on their experience), as well as to report perceived change in potency of both hydro and bush. Results are presented below separately for each form (Figure 14 and Figure 15).

Hydro

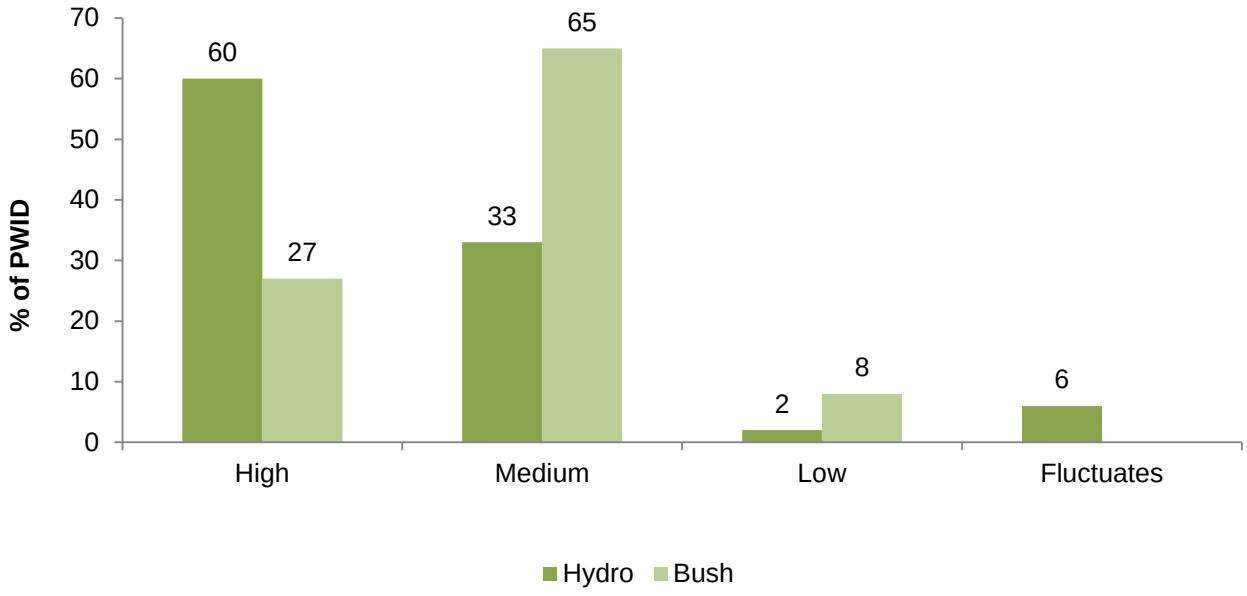
The majority of those who commented (55%) indicated that the perceived potency of hydro was high in the six months preceding interview (see Figure 14). One-third (33%) reported that hydro potency was medium. More than two-thirds (73%) reported that the potency of hydro had remained stable in the last six months (Figure 15).

Bush

The potency of bush cannabis was generally reported to be medium (65%) and 27% reported it to be high. No significant differences were found between 2015 and 2016.

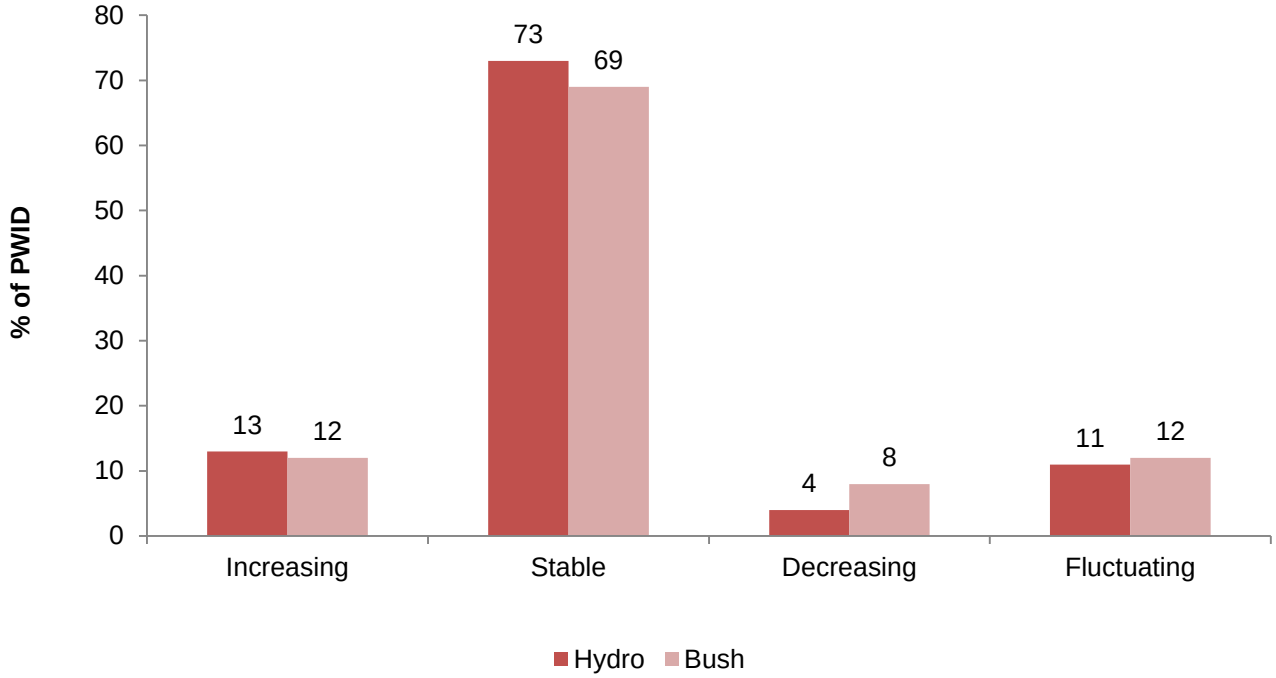
As can be seen in Figure 15, the majority (69%) of respondents who commented on bush cannabis reported that the potency had remained stable in the six months prior to the interview.

Figure 14: Perceived potency of cannabis among those who responded, 2016



Source: ACT IDRS PWID interviews, 2016

Figure 15: Change in perceived cannabis potency, ACT 2016



Source: ACT IDRS PWID interviews, 2016

Methadone

PRICE

In 2016, twelve participants commented on the current price of street (illicit) methadone in the ACT. Due to the small numbers reporting on some of the variables of interest, caution is advised when interpreting these results. For more accurate information please refer to *Australian Drug Trends* for national figures (Stafford and Breen 2017).

The median price reported for a millilitre of methadone was $1.00 in 2016. All participants 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 19, reports on the current availability of illicit methadone varied. There were no significant differences between 2015 and 2016 in regards to the reported availability or change in availability of methadone (p>0.05).

Table 19: Reported availability of illicit methadone, ACT, 2015–2016

Availability – illicit methadone (%)	2015	2016
Responded	n=6	**n=11**
Very easy	17	**18**
Easy	67	**55**
Difficult	0	**18**
Very difficult	17	**9**
Change in availability (%)		
More difficult	17	**9**
Stable	83	**91**
Easier	0	**0**
Fluctuates	0	**0**

Source: ACT IDRS PWID interviews, 2015–16.

In 2016, of participants who reported that they had bought methadone (n=9), participants reported that they had obtained it through a friend, from a street dealer, a known dealer, and an acquaintance in even proportions.

Buprenorphine

In 2016, participants were asked to comment on the price and availability of buprenorphine. Due to small numbers (n=1) ACT findings will not be presented. See *Australian Drug Trends* for national figures (Stafford and Breen 2017).

Buprenorphine-naloxone

In 2016, participants were asked to comment on the price and availability of illicit buprenorphine-naloxone (Suboxone®). Due to small numbers (n=3) ACT findings will not be presented. See *Australian Drug Trends* for national figures (Stafford and Breen 2017).

Morphine

In 2016, participants were asked to comment on price and availability of illicit morphine in the ACT. Due to small numbers (n=3) ACT findings will not be presented. See *Australian Drug Trends* for national figures (Stafford and Breen 2017).

Oxycodone

In 2016, participants were asked to comment on the price and availability of illicit oxycodone. Due to small numbers (n=1) ACT findings will not be presented. See *Australian Drug Trends* for national figures (Stafford and Breen 2017).

6 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

Overdose and drug-related fatalities

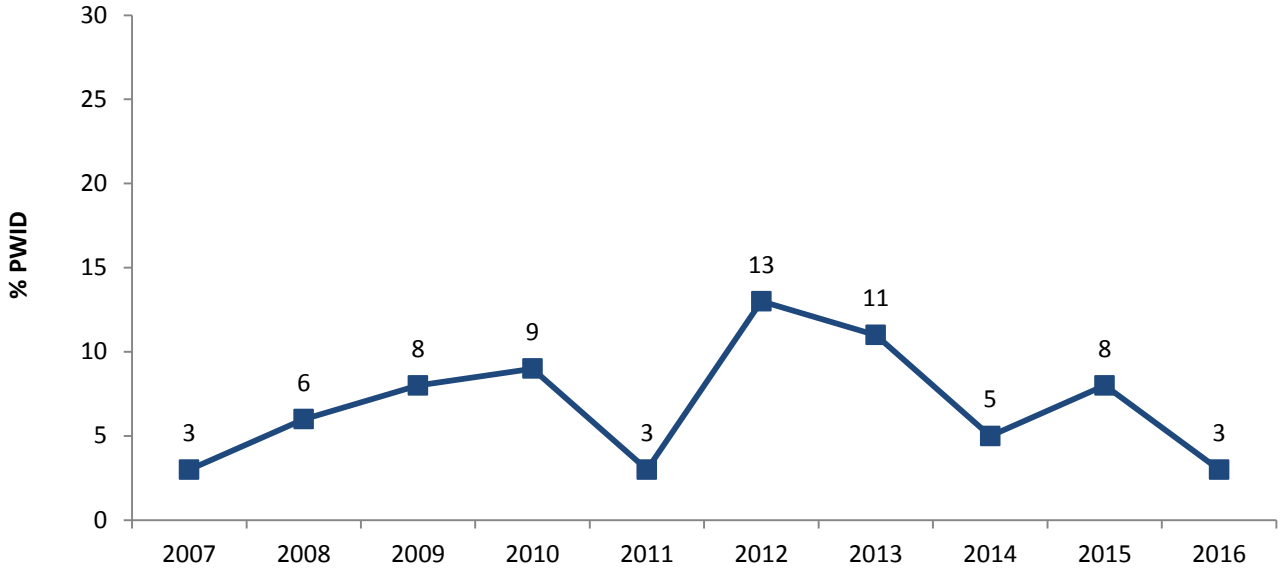
HEROIN AND OTHER OPIOIDS

Non-fatal overdose

In 2016, 26% of participants reported having overdosed on heroin at least once at some point in their lives. Of participants who reported ever having overdosed on heroin the median number of times overdosed was three (range=1–40).

In 2016, 3% of participants reported having overdosed on heroin in the year prior to the interview compared to 8% in 2015; this has decreased over time from 13% in 2012 (Figure 16). One participant reported overdosing on heroin in the past month.

Figure 16: Proportion of PWID reporting heroin overdose in the year preceding interview, 2007–2016



Source: ACT IDRS PWID interviews, 2007–16.

In 2016, participants who reported overdosing on heroin in the previous year (n=3) reported receiving treatments including cardiopulmonary resuscitation (CPR), Narcan®, oxygen, or hospital emergency attendance.

NALOXONE PROGRAM AND DISTRIBUTION

Naloxone is a short-acting opioid antagonist that has been used for over 40 years to reverse the effects of opioids, particularly in the case of overdose. In Australia, naloxone has largely only been available for use by medical doctors (or those auspiced by medical doctors such as nurses and paramedics) for overdose response. In 2012, a take-home naloxone program commenced in the ACT through which naloxone was made available to peers and family members of people who inject drugs for the reversal of opioid overdose as part of a comprehensive overdose response package. This program was shortly followed by similar programs in NSW, VIC and WA. In early 2016, the Australian Therapeutic Goods Administration (TGA) effectively placed 'naloxone when used for the treatment of opioid overdose' on a dual listing of Schedule 3 and Schedule 4, meaning naloxone can be purchased over-the-counter (OTC) at pharmacies without a prescription (Lenton, Dietze et al. 2016) but dual listing means it is still available at reduced cost via prescription.

Since 2013, the IDRS has included a series of questions about take-home naloxone and naloxone more broadly. Of the participants in the ACT who commented in 2016 (N=92), 87% had heard of naloxone. More than two-thirds (69%) of those who had heard of naloxone reported that naloxone was used to 'reverse heroin', while 23% reported the use of naloxone to 're-establish consciousness'. Fifteen per cent said naloxone was used to 'help start breathing' and 15% gave 'other' reasons (Table 20).

Participants were then asked if they had heard about take-home naloxone programs. Among the ACT sample, who commented (N=91), 80% reported that they had heard of take-home naloxone programs (Table 20). In the ACT, twelve per cent reported that they had been resuscitated with naloxone by somebody who had been trained through the take-home naloxone program.

Of the ACT sample, who commented (N=91), 48% reported that they had completed training in naloxone administration and had received a prescription for naloxone. Of those who had completed the course (N=44), 52% had used the naloxone to resuscitate someone who had overdosed. Participants reported resuscitating a median of two people (range=1–24).

In 2016, participants were asked if they had heard about the rescheduling of naloxone (which is now available OTC without a prescription). Of the ACT sample, who commented (N=91), 14% reported that they had heard about the rescheduling (Table 20). Participants were then asked how much they would be willing to pay OTC at a pharmacy for naloxone in a prefilled syringe with accompanying needle and instruction materials. Forty-six per cent stated that naloxone OTC should be free and 28% were willing to pay either $5–$30.

Participants were then asked if they had been resuscitated with naloxone by someone who obtained naloxone OTC from a pharmacy. Of the ACT sample, who commented (N=90), 2% reported that they had been resuscitated with naloxone which was obtained OTC at a pharmacy. Three participants reported that they had themselves obtained naloxone OTC without a prescription from a pharmacy.

Of those who had obtained naloxone OTC from a pharmacy (N=3), one reported that they had resuscitated someone who had overdosed.

Participants who had <u>not</u> obtained naloxone OTC were asked: 'Now that naloxone is available OTC would you purchase it from a pharmacy?' Of those who commented (N=88), 76% reported that they

would purchase naloxone OTC. Participants were asked if they would (a) carry naloxone on your person? (b) administer naloxone after witnessing someone overdose? and (c) stay with someone after giving them naloxone? Sixty-two per cent of those who commented (N=34) reported that they would carry the naloxone on their person, 97% reported that they would administer naloxone after witnessing someone overdose, and 87% reported that they would stay after giving the naloxone.

Table 20: Take-home naloxone program and distribution (among those who commented), 2016

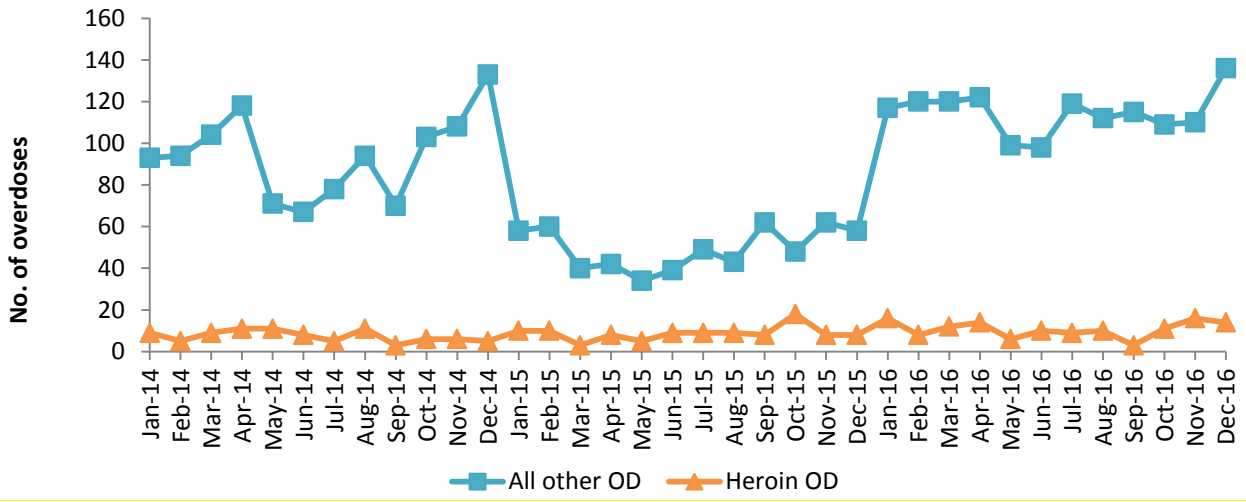
	2016 (n=)
Heard of naloxone (%)	87
Naloxone description (%)	**n=87**
Reverses heroin	69
Help start breathing	15
Re-establish consciousness	23
Heard of the take-home naloxone program (%)	
Yes	80
No	20
Heard of naloxone rescheduling (%)	**n=91**
Yes	86
No	14

Source: ACT IDRS PWID interviews, 2016.
* naloxone over the counter from a pharmacy without a prescription.

AMBULANCE ATTENDANCES FOR OVERDOSE IN ACT

Figure 17 presents data pertaining to ambulance calls in the ACT to reported overdoses. In 2016, 1,506 ambulance calls to attend overdoses in the ACT were recorded. Ambulance calls relating to heroin overdoses represent only a small proportion of the total number of ambulance calls for overdoses in the ACT.

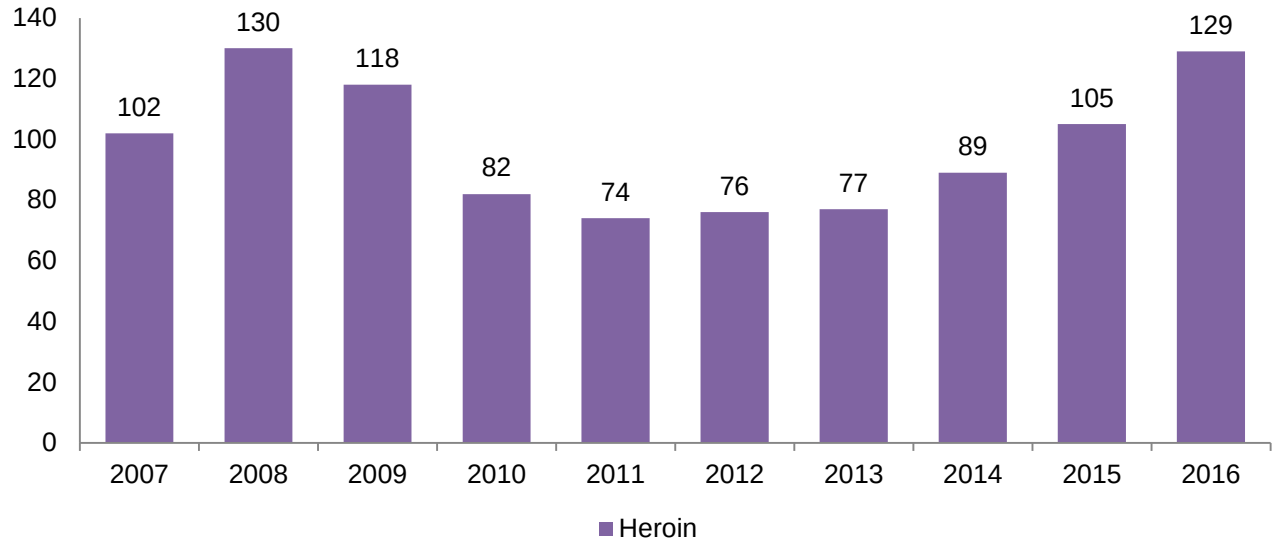
Figure 17: Overdoses attended by ACT Ambulance Service, by month, 2014–2016



Source: ACT Ambulance Service, 2014–2016

As can be seen from Figure 18, in 2016, there was a total of 129 heroin overdoses attended by the ACT Ambulance Service.

Figure 18: Heroin overdoses attended by ACT Ambulance Service, 2007–2016



Source: ACT Ambulance Service, 2007–2016

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).

Seven per cent of participants reported overdosing on a drug other than heroin at some point in their life on a median of four times. Substances most commonly reported were crystal methamphetamine, morphine, methadone, and oxycodone.

Drug treatment

Participants interviewed for the IDRS who were currently in treatment (46%) were asked a number of questions about their reported treatment. Participants reported a median of 22 months (ranging from less than one month to 25 years) in any current treatment. Those in current opioid substitution treatment (OST) (43% of the total sample) reported a median of 22 months (ranging from less than 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.

Eighty-four per cent of those in opioid substitution treatment were receiving methadone maintenance, 2% reported buprenorphine treatment and 14% buprenorphine-naloxone treatment.

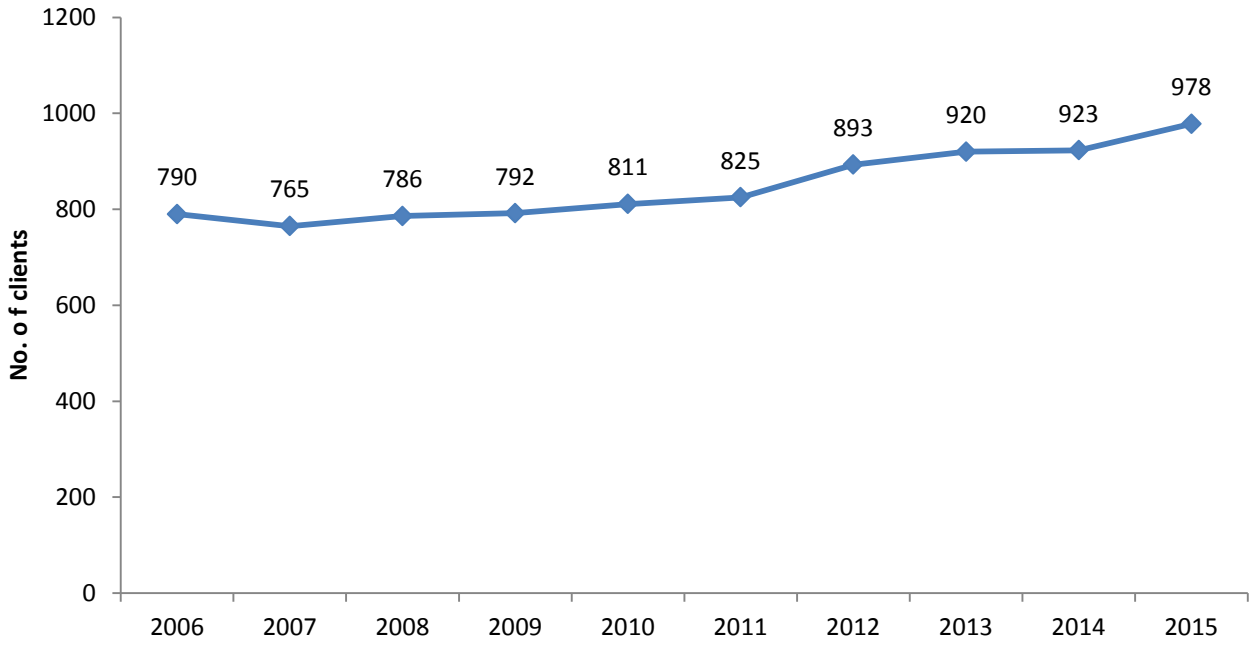
PHARMACOTHERAPY

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 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 2015 with 978 clients registered for OST on a snap-shot day in 2015 (Figure 19). Figures for 2016 have not yet been released.

Figure 19: Clients receiving OST in the ACT 2006–2015



Source: AIHW, 2016.

The majority (79%) of OST clients in ACT were registered for methadone treatment; 20% were registered for buprenorphine-naloxone and one per cent was registered for buprenorphine treatment on a snap-shot day in 2015.

Over two-thirds (72%) of OST clients in the ACT were dosed at a pharmacy and 17% were dosed at a public clinic. Eleven per cent of OST clients in the 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 a 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 2014–15, 5,100 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. Data for 2015/16 is not yet available.

Alcohol

In 2014–15, alcohol accounted for almost half (47%, n=2,372) of all closed treatment episodes.

Heroin

Figure 20 shows that heroin has remained the third most common drug, after alcohol and cannabis, for clients seeking treatment in the ACT, accounting for 9% (n=451) of episodes.

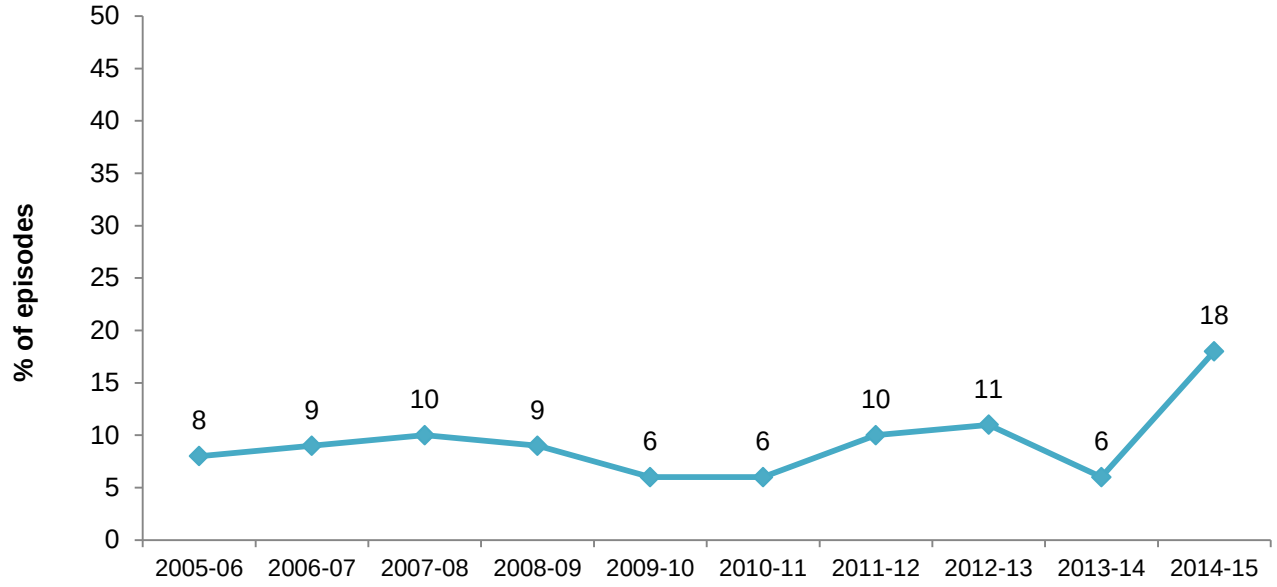
Figure 20: Closed treatment episode, principal drug – heroin, 2005–06 to 2014–15

Source: AIHW, 2016.

Methamphetamine

As can be seen in Figure 21, methamphetamine was identified as the principal drug of concern in 18% (n=907) of closed treatment episodes. This returns to levels not seen since 2003-04 (17%).

Figure 21: Closed treatment episodes, principal drug – methamphetamine, 2005–06 to 2014-15



Source: AIHW, 2016
Note: these figures include amphetamine and methamphetamine.

Cannabis

As can be seen from Figure 22 the proportion of closed treatment episodes where cannabis was identified as the principal drug of concern has remained stable for the previous six years. In 2014–15, cannabis accounted for 17% (n=844) of all closed treatment episodes.

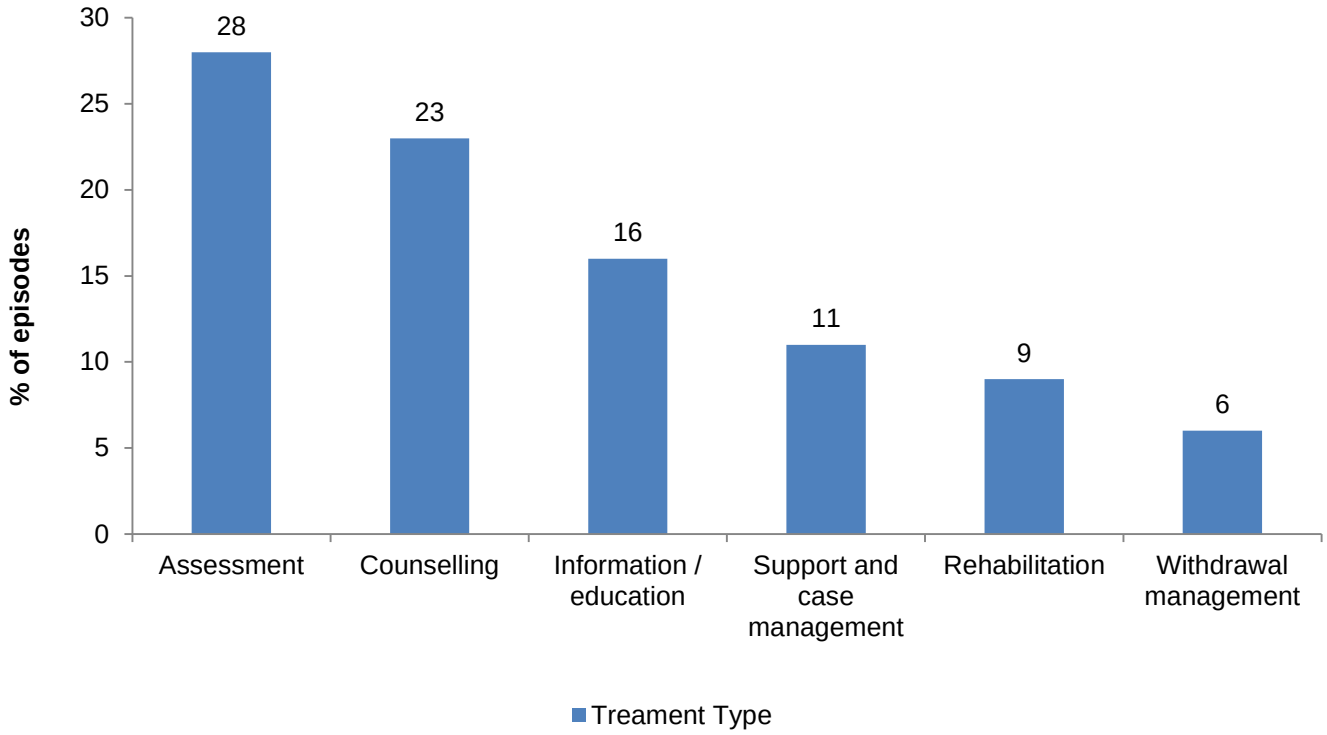
Figure 22: Closed treatment episodes, principal drug – cannabis, 2005–06 to 2014-15

Source: AIHW, 2016.

TREATMENT TYPES

In 2014–15, the main type of treatment reported was: assessment only (28%); counselling (23%); information and education only (16%); support and case management (11%); rehabilitation (9%); and withdrawal management (6%) (Figure 23).

Figure 23: Type of treatment provided, ACT, 2014–15



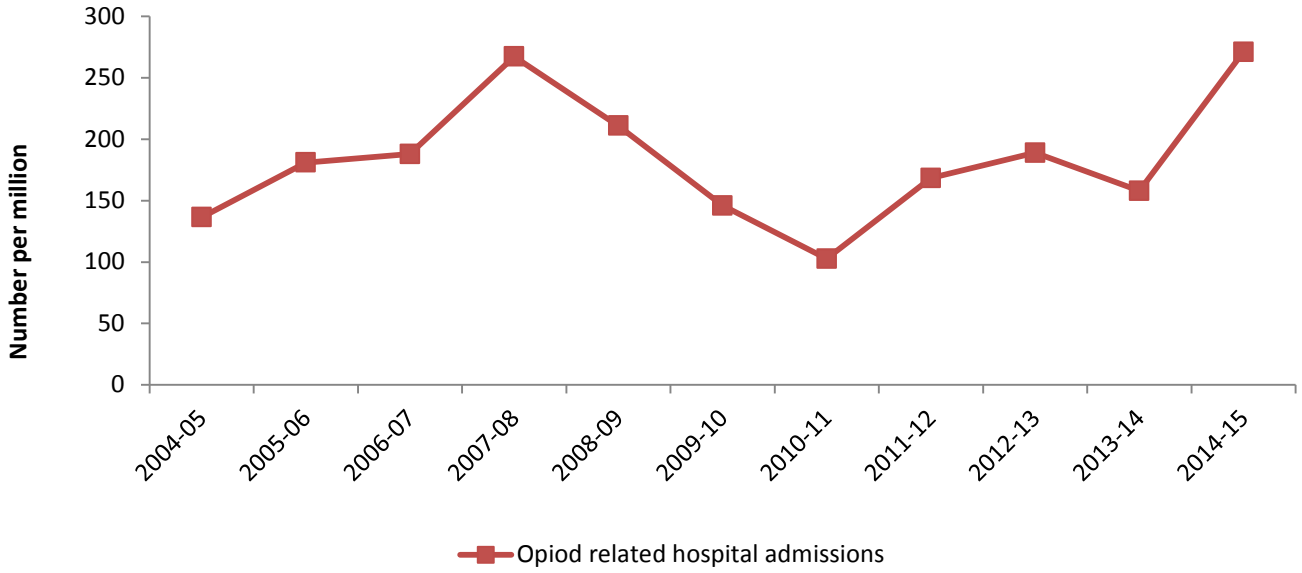
Source: AIHW, 2016.

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 24 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 24 the number of opioid-related hospital admissions in 2014–15 is 271.05 per million persons. At the time of print the 2015–16 data for hospital admissions were not available.

Figure 24: Hospital admissions, opioids, ACT, 2004–05 to 2014–15

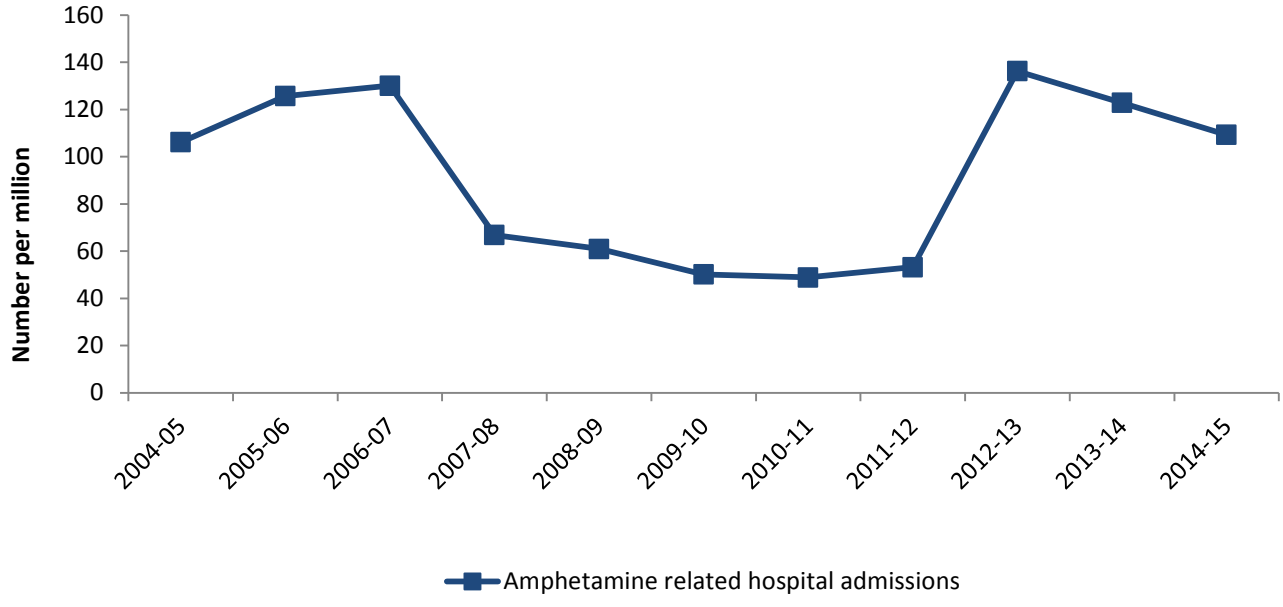


Source: AIHW; ACT Department of Health; Roxburgh and Breen, (2016).

METHAMPHETAMINE

Figure 25 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 in 2014-15 is 109.29 per million persons. At the time of print the 2015–16 data for hospital admissions were not available.

Figure 25: Hospital admissions, amphetamine, ACT, 2004–05 to 2014–15.



Source: AIHW; ACT Department of Health; (Roxburgh and Burns 2012, Roxburgh and Burns in press).

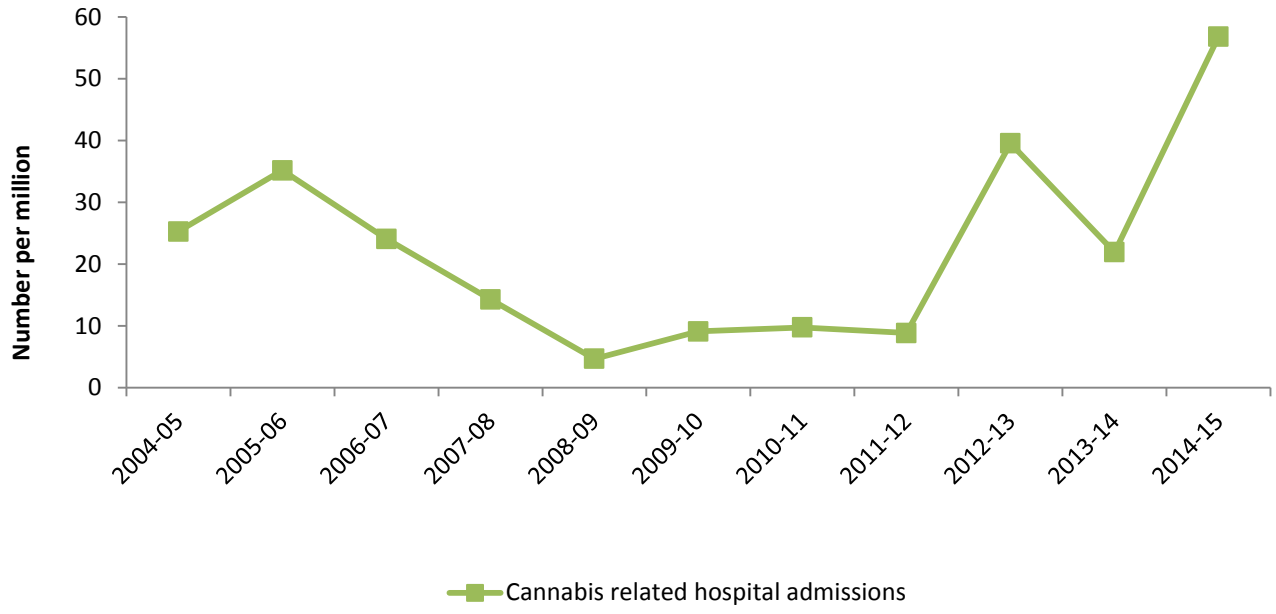
COCAINE

In 2014–15, there were 34.97 cocaine-related hospital admissions per million persons recorded in the ACT. This is an increase from lower than 10 per million persons aged 15–54 years in the last 20 years where cocaine was implicated in the primary diagnosis. At the time of print the 2015–16 data for hospital admissions were not available.

CANNABIS

As can be seen from Figure 26, the number of cannabis-related hospital admissions per million persons has fluctuated over the last 10 years. In 2014-15, there were 56.83 cannabis-related hospital admissions per million persons recorded in the ACT. At the time of print the 2015–16 data for hospital admissions were not available.

Figure 26: Hospital admissions, cannabis, ACT, 2004–05 to 2014–15



Source: AIHW; ACT Department of Health; Roxburgh and Breen (2016)

Injecting risk behaviour

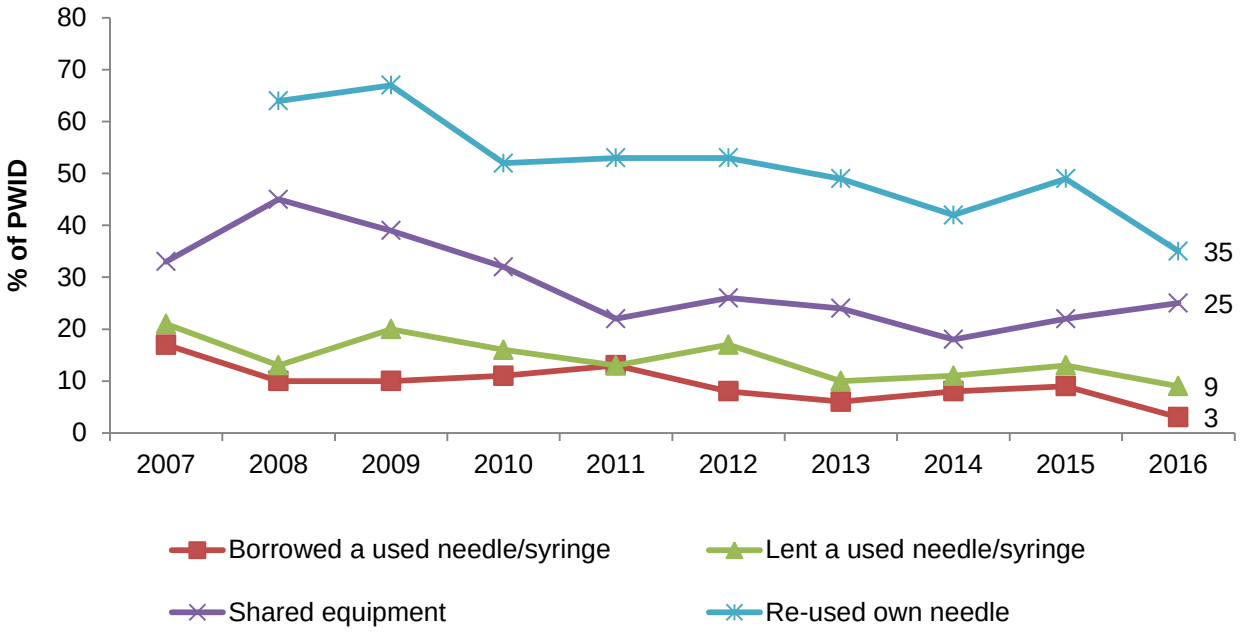
ACCESS TO NEEDLES AND SYRINGES

Needle and syringe programs (NSP) were by far the most common source of needles and syringes in the preceding six months (89%), followed by chemists (16%). NSP vending machines were used by 12% of participants. Obtaining needles and syringes from a friend (10%), and/or a partner (2%) was reported by lower proportions. Six per cent of participants reported having trouble accessing needles and syringes in the previous month.

SHARING OF INJECTING EQUIPMENT AMONG PWID

Figure 27 presents the proportion of participants over time who reported recently sharing injecting equipment. In 2016, 3% of participants had injected with syringes that had already been used by someone else in the month preceding interview. The proportion of participants who reported lending used needles remained stable at 9% in 2016. One-third (35%) reported reusing their own needle.

Figure 27: Proportion of PWID reporting sharing injecting equipment, 2007–2016



Source: ACT IDRS PWID interviews, 2007–16.

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 2016, 25% 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 22% in 2016. As can be seen in Table 21, 7% of participants reported using water after someone else and 8% reported using tourniquet after someone else.

Table 21: Proportion of PWID reporting sharing other injecting equipment by type, 2012–2016

Injecting equipment used after someone else:	2012	2013	2014	2015	2016
	N=99	N=100	N=100	N=100	**N=100**
Spoon/mixing container (%)	15	15	18	17	**22**
Filter (%)	5	4	6	2	**4**
Tourniquet (%)	2	5	17	3	**8**
Water (%)	3	7	17	5	**7**
Swabs	0	0	11	0	**3**

Source: ACT IDRS PWID interviews, 2012–16.

Participants in the 2016 IDRS were also asked questions about the site on their body where they had last injected. The vast majority (78%) of participants reported that they last injected in their arm.

Ten per cent of participants reported last injecting in their hand or wrist, 5% in their leg, and 3% in their foot.

LOCATION OF INJECTIONS

Table 22 presents a summary of the last location of drug injection among the ACT IDRS samples from 2012 to 2016. In 2016, the majority (80%) of participants reported that their last location of injection was a private home, 6% reported a public toilet, and 6% reported a public place (such as a street or a park or public stairwell). Two participants reported a car as the last location for injection in 2016.

Table 22: Location of last injection in the month preceding interview, ACT, 2012–2016

	2012	2013	2014	2015	2016
Location of last injection (%)	N=99	N=100	N=94	N=98	**N=100**
Private home	90	83	85	85	**80**
Public toilet	5	9	9	3	**6**
Street/park/beach	3	2	2	3	**6**
Car	2	3	1	0	**2**

Source: ACT IDRS PWID interviews, 2012–16.

SELF-REPORTED INJECTION-RELATED HEALTH PROBLEMS

In 2016, 62% of participants reported having experienced at least one injection-related health problem in the month preceding interview. As can be seen from Table 23, the most commonly experienced injection-related problem in 2016 was difficulty injecting (74%) followed by scarring/bruising of injection sites (65%).

Table 23: Injection-related health problems, ACT, 2012–2016

Injection-related health problems in past month (%)	2012	2013	2014	2015	2016
	n=61	n=53	n=56	n=66	**n=62**
Problem: (%)					
Scarring/bruising*	65	74	70	71	**65**
Difficulty injecting*	53	57	68	65	**74**
'Dirty hit'*	24	13	14	6	**7**
Infections/abscesses*	9	8	9	9	**15**
Overdose*	2	2	5	4	**8**

Source: ACT IDRS PWID interviews, 2012–16.
*Among those who reported an injection problem.

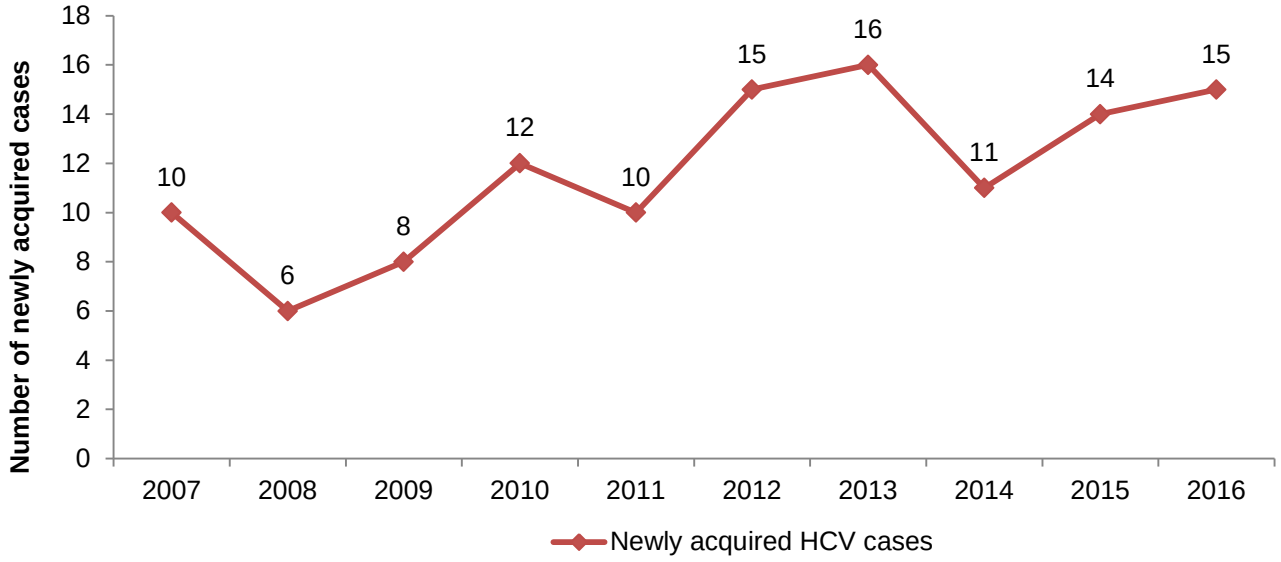
Blood-borne viral infections

Data presented in this section are derived from the National Notifiable Diseases Surveillance System (NNDSS) and the Australian HIV Observational Database (AHOD).

The human immunodeficiency virus (HIV) prevalence among participants in the ACT remains low reflecting the prevalence among Australian PWID as a whole (The Kirby Institute May 2011). From 2009 to 2015, there have been no new HIV positive cases in the ACT sample surveyed for the annual NSP survey (Memedovic, Iversen et al. 2016). In 2016, there were 434 new cases of the

hepatitis C virus (HCV) reported nationally, of which 15 were reported in the (National Notifiable Diseases Surveillance System 2016). Figure 28 presents the number of newly diagnosed cases of HCV in the ACT from 2007 to 2016.

Figure 28: Number of newly diagnosed HCV cases in the ACT, 2007–2016



Source: Data accessed on 4 January 2017: NNDSS, 2016.

In 2016, there was one new notifiable cases of the hepatitis B virus (HBV) in the ACT (NNDSS, 2016).

Alcohol Use Disorders Identification Test

People who regularly inject drugs are particularly at risk for alcohol-related harms due to a high prevalence of the HCV. 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 2000, Schiff and Ozden 2004, Coffin, Tracy et al. 2007, Darke, Duflou et al. 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, 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 et al. 1998). The AUDIT-C is a three-item measure, derived from the first three consumption questions in the AUDIT. Dawson and colleagues (Dawson, Grant 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 IDRS participants in the ACT who drank alcohol in the past year, the overall mean score on the AUDIT-C was 6.2 (median=6, range=1–12). There were no gender differences in AUDIT-C scores. According to Dawson and colleagues (Dawson, Grant et al. 2005) and Haber and colleagues' (Haber, Lintzeris et al. 2009) *Guidelines for the Treatment of Alcohol Problems*, a cut-off score of five or more indicated that further assessment is required.

More than half (61%) of the participants who drank in the past year scored five or more on the AUDIT-C. Sixty-six per cent of males and 52% females scored five or more indicating the need for further assessment (Table 24).

Table 24: AUDIT-C among people who inject drugs and drank alcohol in the past year, 2015–2016

	2015 n=78	2016 n=69
Score of 5 or more (%)		
All participants	51	**61**
Males	52	**66**
Females	47	**52**

Source: IDRS ACT PWID interviews, 2015–16.

Opioid and stimulant dependence

In 2016, the participants in the IDRS were asked questions from the Severity of Dependence Scale (SDS) for the use of stimulants and opioids. Understanding whether participants are dependent is an important predictor of harm, and provides information to complement quantity and frequency of use measures.

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 et al. 2002). Previous research has suggested that a cut-off of four is indicative of dependence for methamphetamine users (Topp and Mattick 1997) and a cut-off value of three for cocaine (Kaye and 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 an opioid and commented (n=72), the median SDS score was seven (mean=7.3, range=0–15), with 72% scoring five or above indicative of opioid dependence. Three-quarters (74%) reported specifically attributing responses to heroin, 22% methadone, 3% buprenorphine, and 2% morphine.

Of those who had recently used a stimulant and commented (n=77), the median SDS score was 4 (mean=4.4, range=0–14), with 54% scoring four or above indicative of stimulant dependence. Almost all (97%) reported specifically attributing responses to methamphetamine with few (3%) attributing responses to cocaine.

Mental health problems and psychological distress

SELF-REPORTED MENTAL HEALTH PROBLEMS

In 2016, 40% of participants interviewed self-reported having had a mental health problem other than drug dependence in the six months preceding interview. Of those who self-reported a mental health problem and commented (n=40), the most common problems were depression (65%), anxiety (43%), and Post-traumatic Stress Disorder (PTSD) (18%) (Table 25).

Most (73%) of those who self-reported mental health problems reported that they had attended a mental health professional in the previous six months. In 2016, participants were asked whether they were prescribed any medication from the mental health professional for their self-reported mental health problems. Of those who reported attending a mental health professional in the previous six months (n=29), nearly two-thirds (61%) reported they had been prescribed an anti-depressant, 26% reported being prescribed an anti-psychotic, and 39% report being prescribed a benzodiazepine. A little less than half (43%) of those who had attended a health professional in the preceding six months were not prescribed any medication (Table 25).

Table 25: Summary of mental health problems experienced by PWID in the ACT, 2015–2016

	2015	2016
Self-reported mental health problem last six months (%)	32	**40**
Self-reported mental health problems (%)*	(n=32)	**(n=40)**
Depression	69	**65**
Anxiety	44	**43**
Bipolar disorder	19	**18**
(Any) Personality disorder	16	**8**
Schizophrenia	13	**10**
Drug-induced psychosis	9	**3**
Post-traumatic Stress Disorder – PTSD	25	**18**
Attended mental health professional (%)*	91	**73**
No medication**	28	**43**
Prescribed anti-depressant**	55	**61**
Prescribed anti-psychotic**	31	**26**
Prescribed benzodiazepines**	34	**39**

Source: ACT IDRS PWID interviews, 2015–16.
* Of those who reported a mental health problem in the preceding six months.
** Of those who attended a mental health professional (n=29).
↓↑ Statistical significance at $p<0.05$.

KESSLER PSYCHOLOGICAL DISTRESS SCALE

The Kessler 10 (K10) was administered in 2016 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 5 (DSM-5), and the Structured Clinical Interview for DSM disorders (SCID) (Kessler and Mroczek 1994, Kessler 2002, American Psychiatric Association 2013). The K10 relates to the level of anxiety and depressive symptoms a person may have felt in the preceding four-week period.

The minimum score was 10 (indicating no/low distress) and the maximum was 50 (indicating very high psychological distress) (Andrews and Slade 2001). Among participants who completed the full scale (n=93), the mean score was 24.1 (median=23; SD=9.8; range=10–50). The 2013 National Drug Strategy Household Survey 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. Using these categories, IDRS participants reported greater levels of high and very high distress compared to the general population (Table 26).

Table 26: K10 scores in the 2010 NDSHS and the ACT IDRS interviews, 2015–2016

K10 Score	Level of psych. distress	National Drug Strategy Household Survey	2015 ACT IDRS	2016 ACT IDRS
10–15	No/low distress	69	28	**18**
16–21	Moderate distress	21	22	**28**
22–29	High distress	7	25	**28**
30–50	Very high distress	3	25	**26**

Source: AIHW, 2014b; ACT IDRS PWID interviews, 2015–16.

Participants were also asked, in general, if they would rate their health as excellent, very good, good, fair or poor. Of those who commented (n=97): 4% reported their health as excellent, 9% very good, 41% good, 32% fair, and 13% poor. This compares to 17.2% of the general population reporting their health as excellent, 38.2% reporting it as very good, 32.1% as good, 10.6% as fair and 2% as poor (AIHW, 2014b).

Driving risk behaviour

Participants were asked about driving behaviour following the use of alcohol or drugs. One-third of the IDRS sample (33%; n=33) reported having driven a vehicle in the six months preceding interview. Of those who had driven in the previous six months, 18% reported having driven while over the limit of prescribed concentration of alcohol on a medium.

Seventeen participants (52% of those who had driven in the past six months) reported that they had driven within three hours of taking drugs.

7 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

Reports of criminal activity

As can be seen in Table 27, in 2016, 26% of participants reported that they had been arrested in the last 12 months.

The proportion of participants in 2016 that reported engaging in at least one act of criminal activity in the month prior to interview was 33%. Twenty-six per cent of participants reported being involved in drug dealing and 14% of participants reported committing property crime in the previous month.

Table 27: Criminal activity among participants, ACT, 2015–2016

	2015	2016
	(N=100)	**(N=100)**
Arrested last 12 months (%)	22	**26**
Crime arrested for (%)	n=22	**n=25**
Property crime	20	**16**
Dealing	0	**0**
Fraud	0	**0**
Violent crime	30	**10**
Committed at least one crime in the last month (%)	33	**33**
Crime committed (%)		
Property crime	13	**14**
Dealing	27	**26**
Fraud	0	**0**
Violent crime	5	**1**

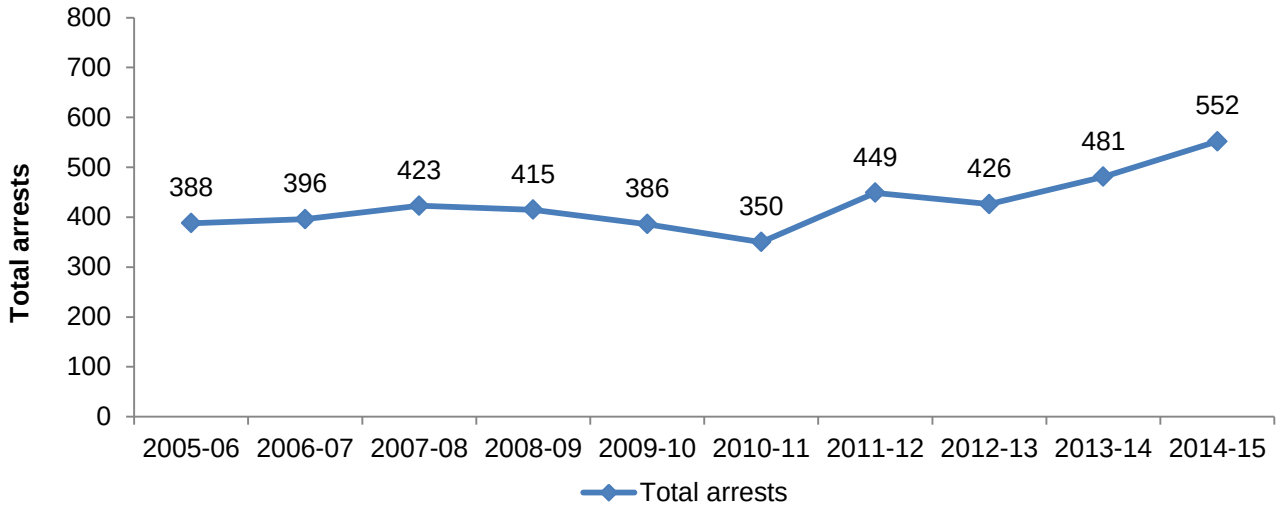
Source: ACT IDRS PWID interviews, 2015–16.

ARRESTS – POLICE DATA

ALL DRUGS

As can be seen in Figure 29, presents the number of drug-specific arrests made by ACT police. In 2014-15, 85% of all the people arrested for drug-related offences in the ACT were males.

Figure 29: Number of drug-specific arrests for all drugs, ACT, 2005–06 to 2014–15



Source: ACC, 2004–16.
NB: Data not available for the 2015–16 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 (e.g. trafficking, selling, manufacture or cultivation) are categorised as providers.

As can be seen in Table 28, the numbers of consumer and provider arrests are higher for males than females. The total number of consumer arrests in the ACT in 2014–15 was 385 (325 male and 60 female). The total number of provider arrests in 2014–15 was 167.

Table 28: Number of consumer and provider arrests for all drugs, ACT, 2005–06 to 2014–15

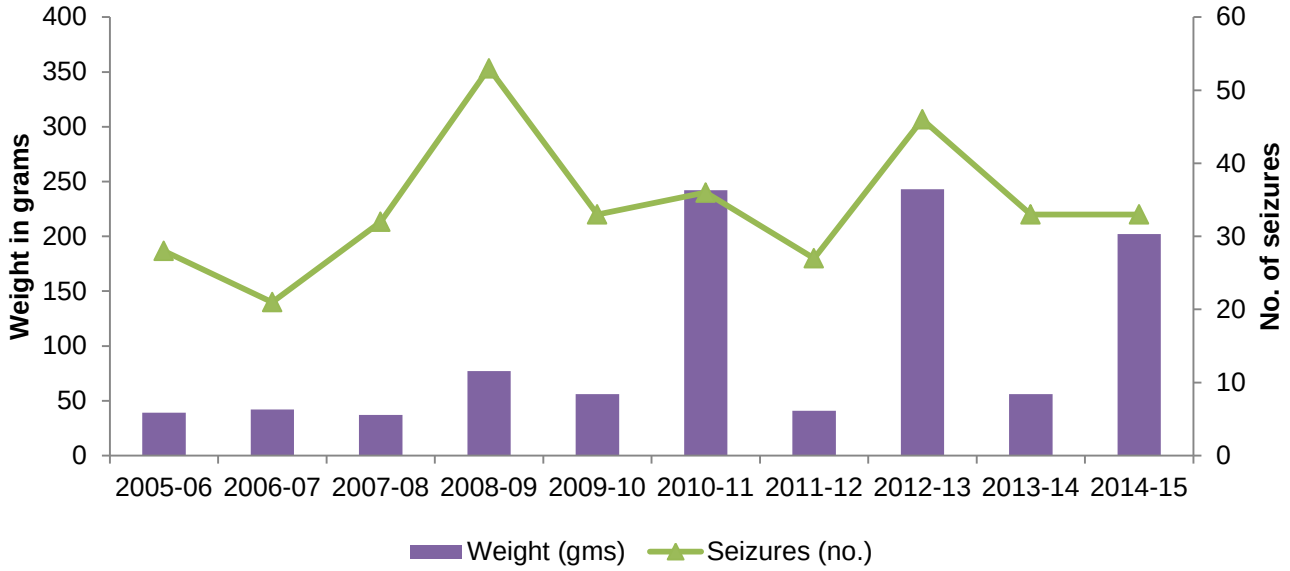
Year	Consumer		Provider		Total arrests
	Male	Female	Male	Female	
2005–06	254	51	79	4	388
2006–07	274	59	57	6	396
2007–08	283	74	57	9	423
2008–09	282	79	44	10	415
2009–10	278	54	49	5	386
2010–11	256	53	31	10	350
2011–12	303	57	78	11	449
2012–13	289	60	67	10	426
2013-14	298	65	100	18	481
2014-15	**325**	**60**	**146**	**21**	**552**

Source: ACC, 2005–15.
NB: Data not available for the 2015–16 financial year.

HEROIN

The number of heroin seizures[6] and total weight seized for each financial year period from 2005–06 is presented in Figure 30. In the 2014–15 reporting period, 33 seizures totalling 202 grams were recorded.

Figure 30: Number and weight of heroin seizures in the ACT, 2005–06 to 2014–15



Source: ACIC, 2005–16.
NB: Data not available for the 2015–16 financial year.

Table 29 summarises the number of heroin and other opioids consumer and provider arrests in the ACT from 2005–06 to 2014–15. More recent data were not available at the time of printing. 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).

[6] Includes only those seizures for which a drug weight was recorded. No adjustment has been made to account for double counting data from joint operations between the AFP and state/territory police.

Table 29: Number of heroin consumer and provider arrests, ACT, 2005–06 to 2014–15

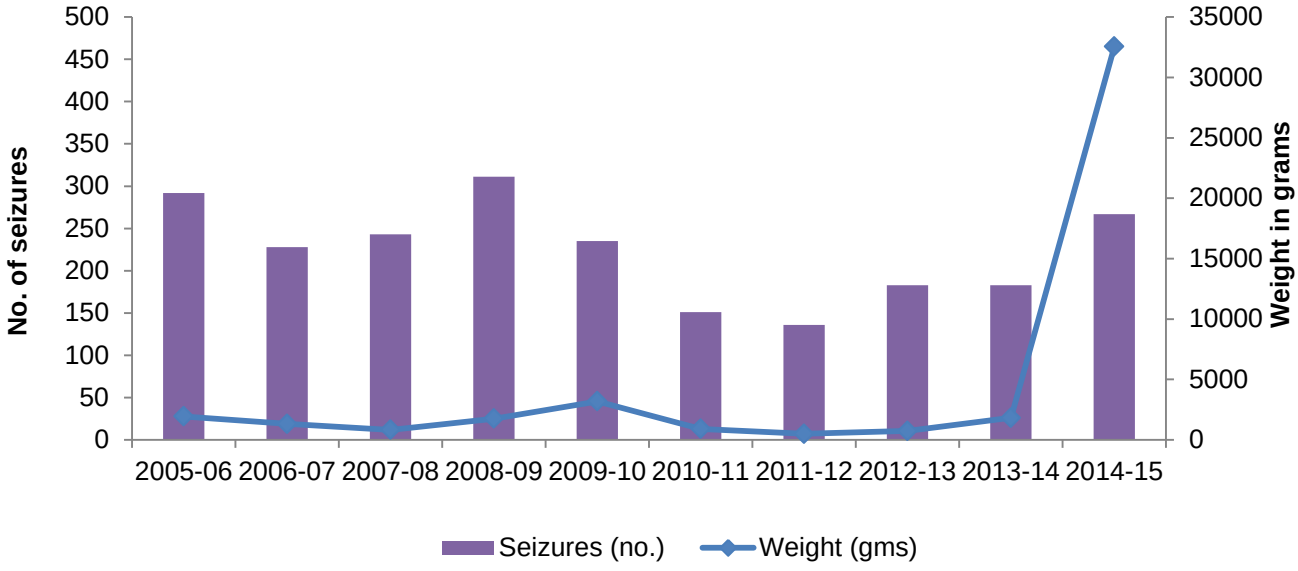
Year	Consumer		Provider		Total arrests
	Male	Female	Male	Female	
2005–06	18	2	8	0	28
2006–07	14	2	5	1	22
2007–08	28	8	7	2	45
2008–09	26	9	10	3	48
2009–10	16	5	9	0	30
2010–11	15	7	9	2	33
2011–12	9	11	6	2	28
2012–13	10	4	4	2	20
2013–14	6	3	5	3	17
2014–15	**13**	**2**	**12**	**0**	**27**

Source: ACIC, 2005–16.
NB: Data not available for the 2015–16 financial year.

AMPHETAMINE-TYPE STIMULANTS

Figure 31 shows the number and weight of amphetamine-type stimulant seizures in the ACT from 2005–06 to 2014–15[7]. Amphetamine-type stimulants include amphetamines, methamphetamines and phenethylamines. In 2014–15, the number of seizures rose to 267. The weight of seizures increased to 32,559 grams of amphetamine-type stimulants.

Figure 31: Number and weight of amphetamine-type stimulant seizures, ACT, 2005–06 to 2014–15



Source: ACIC, 2005–16.
NB: Data not available for the 2015–16 financial year.

[7] Includes only those seizures for which a drug weight was recorded. No adjustment has been made to account for double counting data from joint operations between the AFP and state/territory police.

Table 30 presents the number of consumer and provider arrests for amphetamine-type stimulants (ATS) made in the ACT between 2005–06 and 2014–15. 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).

Table 30: Amphetamine-type stimulants consumer and provider arrests, ACT, 2005–06 to 2014–15

Year	Consumer		Provider		Total arrests
	Male	Female	Male	Female	
2005–06	50	9	46	1	106
2006–07	77	22	30	3	132
2007–08	77	23	28	5	133
2008–09	68	19	20	3	110
2009–10	64	12	21	3	100
2010–11	42	9	7	2	60
2011–12	88	14	16	6	124
2012–13	72	9	23	1	105
2013–14	82	16	53	6	157
2014–15	**82**	**15**	**32**	**5**	**134**

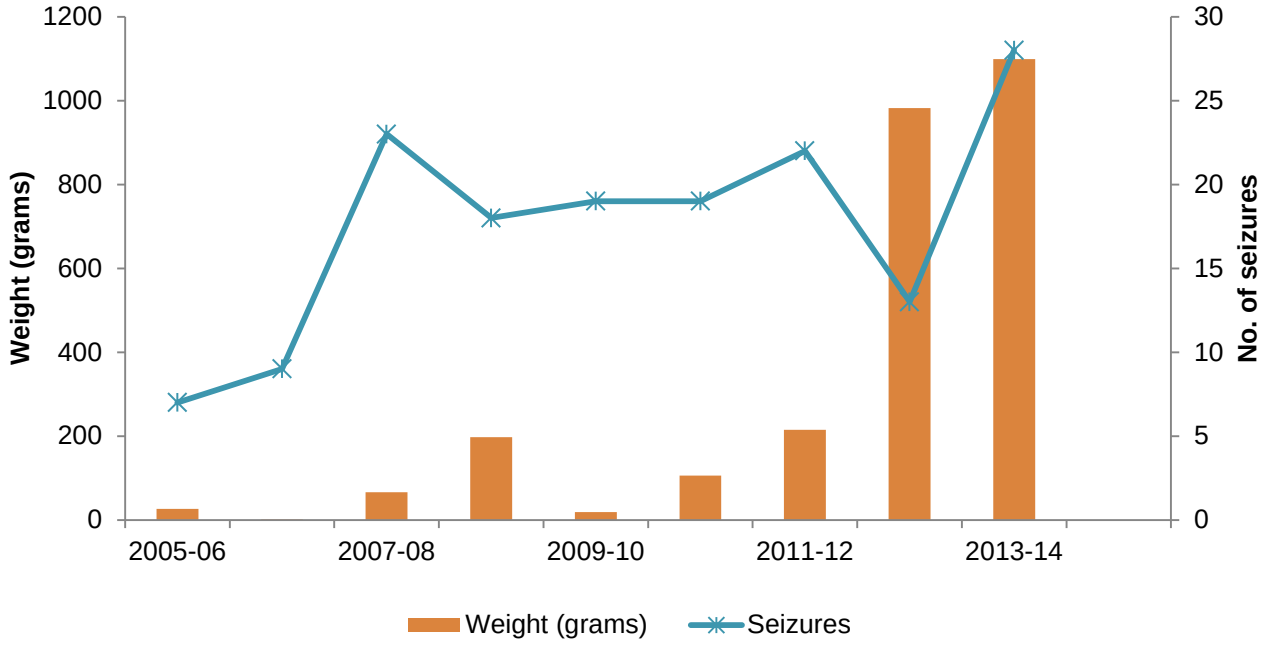
Source: ACIC, 2005–16.
NB: Data not available for the 2015–16 financial year.

COCAINE

Figure 32 shows the number and weight of cocaine seizures in the ACT from July 2005 to June 2015[8]. In 2014–15, there were no seizures recorded by state police. The Australian Federal police recorded 11 seizures weighing 113 grams.

[8] Includes only those seizures for which a drug weight was recorded. No adjustment has been made to account for double counting data from joint operations between the AFP and state/territory police.

Figure 32: Number and weight of cocaine seizures in the ACT, 2005–06 to 2014–15



Source: ACIC, 2005–2016
2014–15* represents seizures made by AFP not state police.
NB: Data not available for the 2015-2016 financial year

In 2014–15 there were 19 arrests for cocaine recorded (Table 31).

Table 31: Number of cocaine consumer and provider arrests, ACT, 2005–06 to 2014–15

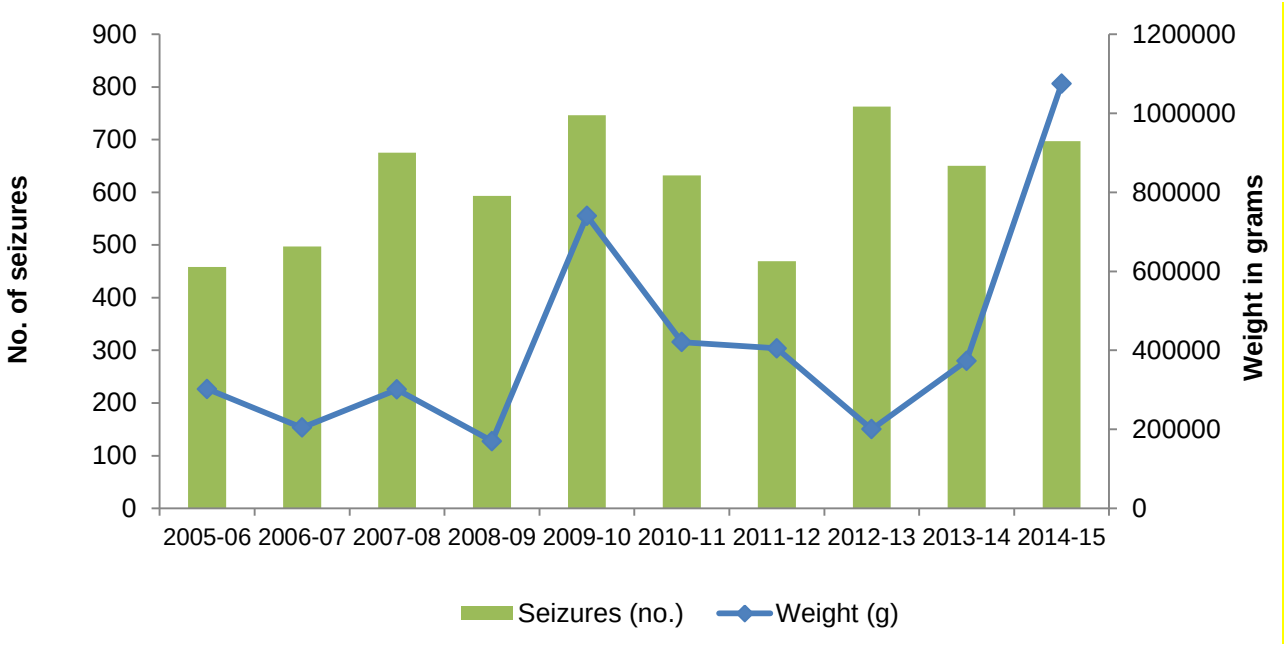
Year	Consumer		Provider		Total arrests
	Male	Female	Male	Female	
2005–06	2	0	3	0	5
2006–07	7	0	0	0	7
2007–08	3	0	1	0	4
2008–09	10	1	3	0	14
2009–10	8	0	0	0	8
2010–11	5	1	7	5	18
2011–12	9	0	1	0	10
2012–13	6	0	7	4	17
2013–14	15	1	7	1	24
2014–15	**11**	**2**	**6**	**1**	**19**

Source: ACIC, 2005–16.
NB: Data not available for the 2015–16 financial year.

CANNABIS

Figure 33 shows the number and weight of cannabis seizures in the ACT from 2005 to 2015[9]. In 2014-15, there were 664 cannabis seizures. The weight of cannabis seizures was 1,074,636 grams.

Figure 33: Number and weight of cannabis seizures by ACT local police, 2005–06 to 2014–15



Source: ACIC, 2005–2016
NB: Data not available for the 2015–2016 financial year

Table 32 summarises the number of cannabis consumer and provider arrests in the ACT from 2005 to 2015. In the ACT, the greatest numbers of drug-specific arrests are due to cannabis offences.

Table 32: Number of cannabis consumer and provider arrests, ACT, 2005–06 to 2014–15

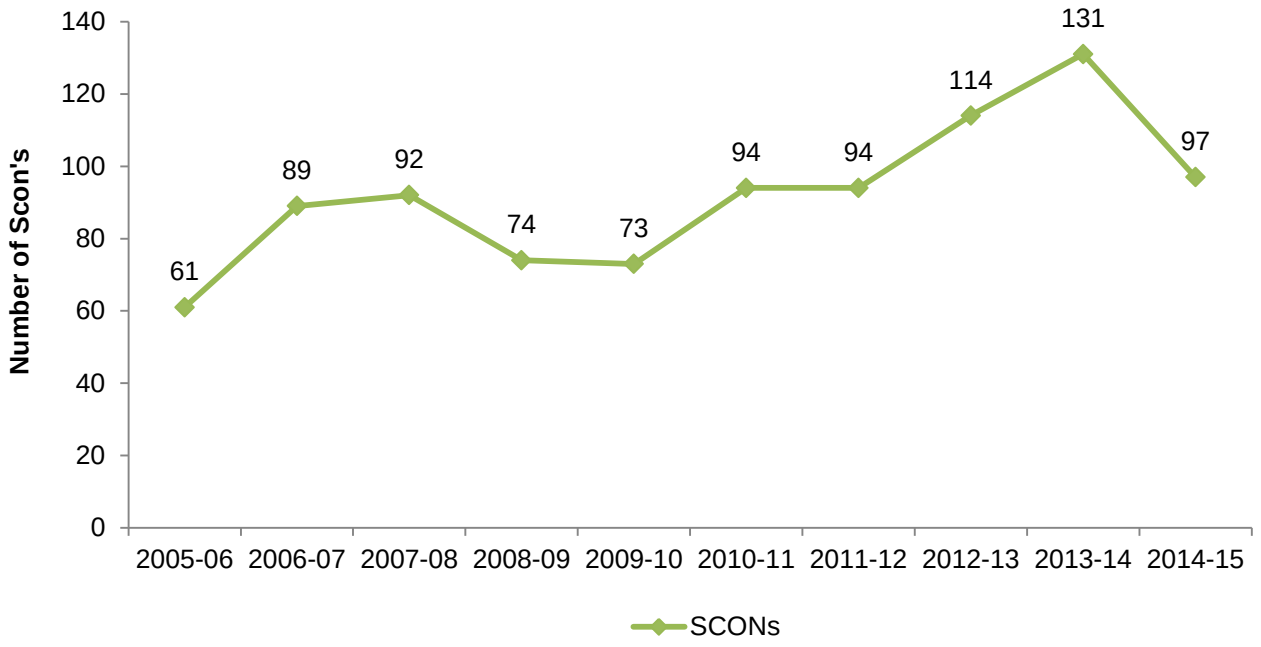
Year	Consumer/user		Provider/supplier		Total arrests
	Male	Female	Male	Female	
2005–06	177	40	20	3	240
2006–07	168	35	19	2	224
2007–08	166	41	18	2	227
2008–09	165	50	10	3	228
2009–10	187	36	19	2	244
2010–11	192	36	8	1	237
2011–12	193	32	37	3	265
2012–13	200	47	27	3	277
2013–14	191	45	22	8	266
2014–15	**210**	**42**	**67**	**15**	**334**

Source: ACIC, 2005–16.
NB: Data not available for the 2015–16 financial year.

[9] Includes only those seizures for which a drug weight was recorded. No adjustment has been made to account for double counting data from joint operations between the AFP and state/territory police.

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. If the fine is paid within 60 days, no criminal record will be recorded. Figure 34 presents the total number of SCONs given out in the ACT from 2005 to 2015.

Figure 34: Number of Simple Cannabis Offence Notices, ACT, 2005–06 to 2014–15



Source: ACIC, 2005–16.
NB: Data not available for the 2015–16 financial year.

Expenditure on illicit drugs

In 2016, 57% of participants reported having spent a median of $80 on illicit drugs on the day prior to interview (Table 33).

Table 33: Expenditure on illicit drugs on the day prior to interview, ACT, 2012–2016

	2012	2013	2014	2015	2016
	N=99	N=100	N=100	N=99	**N=100**
Nothing	31	41	45	43	**43**
Less than $20	5	0	7	7	**4**
$20–$49	8	11	11	8	**6**
$50–$99	24	20	16	12	**20**
$100–$199	20	17	13	15	**15**
$200–$399	12	7	6	11	**12**
$400 or more	0	4	2	4	**0**
Median expenditure ($)	80	80	80	100	**80**

Source: ACT IDRS PWID interviews, 2012–16.

8 SPECIAL TOPICS OF INTEREST

Homelessness

A notable proportion of people who are homeless experience higher rates of mental health disorders compared to the general population. Specifically, substance use disorders have been repeatedly recorded as the most common mental health diagnosis amongst homeless populations throughout Western countries (Fazel, Khosla et al. 2008). Research examining substance use among homeless populations has been undertaken but very few studies have looked at the relationship of homelessness amongst heavy substance users, including PWID. The aim of this module was to obtain information on the lifetime and recent homelessness experiences amongst PWID.

In 2014, the IDRS included a module on homelessness, which revealed the high lifetime (76%) and recent (23%) prevalence of homelessness among the IDRS participants. To better understand the risk factors associated with different degrees of homelessness severity, four questions were repeated in 2016.

Among those who commented (N=78), the lifetime prevalence of homelessness among the 2016 PWID sample in the ACT was 73% (Table 34). Of those PWID with a homelessness history, 19% were currently homeless at the time of interview. It is clear that the rate of homelessness among PWID is notably higher than the general Australian population estimate of 0.5% (Australian Bureau of Statistics 2012). For those PWID who were currently homeless, the mean duration of their current episode of homelessness was reported to be two and half years (range=<1–28 years).

Table 34: Homelessness history among PWID, by jurisdiction, 2016

	ACT n=78
% Lifetime homelessness history	73
% Length of time since last homeless episode*	**(n=72)**
Currently homeless	19
In the past six months	24
7–12 months	3
1–2 years	14
2–5 years	11
More than 5 years	29
% Total duration of homelessness over lifetime*	**(n=71)**
Less than six months	27
6–11 months	7
1–2 years	16
3–5 years	23
6–10 years	11
More than 10 years	17

Source: IDRS participant interviews 2016.
* Among those with a homelessness history and commented.

Table 35 shows within the sub-sample of PWID with a homeless history, the proportion that have experienced various states of homelessness in their lifetimes and in the past six months in each state. The most commonly experienced forms of homelessness during both lifetime and the past six months were sleeping rough (85%; 35% respectively), couch surfing (68%; 31% respectively), boarding rooms/hostels (46%; 9% respectively) and crisis accommodation (53%; 10% respectively).

Table 35: Different forms of homelessness (lifetime & last six months), by jurisdiction, 2016

	ACT n=78
% Lifetime	
Slept rough	85
Crisis or emergency accommodation	53
Medium- or long-term accommodation	36
Lived with relatives, friends or acquaintances (couch surfing)	68
Boarding or rooming houses or hostels (other than on holiday)	46
Caravan park (other than on holiday)	37
% Last six months	
Slept rough	35
Crisis or emergency accommodation	10
Medium- or long-term accommodation	12
Lived with relatives, friends or acquaintances (couch surfing)	31
Boarding or rooming houses or hostels (other than on holiday)	9
Caravan park (other than on holiday)	5

Source: IDRS participant interviews 2016.

Blood donations

In Australia and most other territories around the world (excluding Japan), people with a history of injecting drug use comprise a 'risk group' who are permanently excluded from donating blood and blood products due to the high risk of infection from BBVI and sexually transmitted infections such as HCV and HIV (regardless of past injecting drug use 'remoteness' and current BBVI status).

In 2014 the Australian Red Cross Blood Service commissioned the Burnet Institute to conduct a review of international literature and guidelines to evaluate the appropriateness of their current eligibility criteria around blood donation and injecting drug use. One of the review's main outcomes was the paucity of data on prevalence of lifetime blood donation among PWID, which precludes calculations of estimates of the risk associated with changing the exclusion/deferral period from permanent to a reduced timeframe (e.g. 5 years).

Of those who commented in the ACT (n=57), 12% reported that they had given blood in their lifetime. One participant of those that had given blood (n=7) reported that they had commenced injecting drug use before donating blood. Due to the low number reporting, further information is provided in the *Australian Drug Trends Report* (Stafford and Breen 2017).

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