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D. McKell and L. Burns

NSW DRUG TRENDS 2014
Findings from the
Illicit Drug Reporting System (IDRS)

Australian Drug Trends Series No. 128

NEW SOUTH WALES DRUG TRENDS 2014

Findings from the Illicit Drug Reporting System (IDRS)

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ABBREVIATIONS

ABCI	Australian Bureau of Criminal Intelligence
ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ADIS	Alcohol and Drug Information Service
ADM	Automatic dispensing machine(s)
AFP	Australian Federal Police
AGDH&A	Australian Government Department of Health and Ageing
AIHW	Australian Institute of Health and Welfare
ANSPS	Australian Needle and Syringe Program Survey
AODTS	Alcohol & Other Drug Treatment Services
AUDIT-C	Alcohol Use Disorders Identification Test - Consumption
BBVI	Blood-borne viral infections
BNX	Buprenorphine-naloxone (Suboxone)
BOCSAR	NSW Bureau of Crime Statistics and Research
BPI	Brief Pain Inventory
BPN	Buprenorphine (Subutex)
CI	Confidence interval
CNMP	Chronic non-malignant pain
CPR	Cardiopulmonary resuscitation
DATS	Drug and Alcohol Treatment Services
DMT	Dimethyltryptamine
ED	Emergency department
EDRS	Ecstasy and related Drugs Reporting System
FDS	Family Drug Support
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
IDC	Internal dispensing chute(s)
IDRS	Illicit Drug Reporting System
IDU	Injecting Drug Use
IRID	Injection-related injuries or diseases
K10	10-item Kessler Psychological Distress Scale
KE	Key expert(s)
MCS	Mental Component Score
MDMA	3,4-methylenedioxymethamphetamine
MH	Mental health
MMT	Methadone maintenance treatment
MSIC	Medically Supervised Injecting Centre
NA	Narcotics Anonymous
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NCIS	National Coronial Information System

NDARC	National Drug and Alcohol Research Centre
NNDSS	National Notifiable Diseases Surveillance System
NSP	Needle and Syringe Program
NSW	New South Wales
NSW MDS	New South Wales Minimum Data Set
NSW MDS DATS	NSW Minimum Data Set for Drug and Alcohol Treatment Services
OP	Outpatient
OST	Opioid substitution treatment
OTC	Over the counter
PBS	Pharmaceutical Benefits Scheme
PCS	Physical Component Score
PDI	Party Drugs Initiative
PIED	Performance and image enhancing drug(s)
PMA	Para-methoxyamphetamine
PO	Pharmaceutical opioids
PWI	Personal Wellbeing Index
PWID	People who inject drugs
RDT	Roadside drug testing
REPIDU	Research and Education Program for Injecting Drug Users
SD	Standard deviation
SDS	Severity of Dependence Scale
SF-12	Short Form 12-Item Health Survey
SNOMED	Systematized Nomenclature of Medicine
SNRI	Serotonin-norepinephrine reuptake inhibitor
SPSS	Statisitical Package for the Social Sciences
STI	Sexually transmitted infection
THC	delta-9 tetrahydro-cannabinol

GLOSSARY OF TERMS

Cap	A small amount, typically enough for one injection
Cook up	The use of heat to dissolve in the preparation for injection
Central Sydney	In the PWID survey data refers to participants recruited in Kings Cross and Redfern; in the KE survey, data refers to participants referring to these and/or surrounding suburbs in the inner city, e.g. Surry Hills, Darlinghurst
Days of use/injection	180 days: daily use/injection over preceding 6 months
	90 days: use/injection every 2nd day over preceding 6 months
	24 days: weekly use/injection over preceding 6 months
	12 days: fortnightly use/injection over preceding 6 months
Diverted/ diversion	The selling, trading, giving or sharing of one's medication to another person, including through voluntary, involuntary and accidental means.
Eightball	3.5 grams
Extra-medical use	Use of a prescribed medication without prescription, or not 'as directed' by a doctor but not excluding the possibility that use may be driven by medical reasons
Fit	Slang derived from 'outfit' referring to a needle and syringes
Fitpack	A small package of needle and syringes and related injecting equipment dispensed by Needle and Syringe Programs, vending machines, pharmacy or via Outreach
Halfweight	0.5 grams
Illicit	Illicit obtainment refers to pharmaceuticals obtained from a prescription in someone else's name, e.g. through buying them from a dealer or obtaining them from a friend or partner. The definition does not distinguish between the inappropriate use of licitly obtained pharmaceuticals, such as the injection of methadone syrup or benzodiazepines, and appropriate use
Licit	Licit obtainment of pharmaceuticals refers to pharmaceuticals (e.g. methadone, buprenorphine, morphine, oxycodone, benzodiazepines, antidepressants) obtained by a prescription in the user's name. This definition does not take account of 'doctor shopping' practices; however, it differentiates between prescriptions for self as opposed to pharmaceuticals bought on the street or those prescribed to a friend or partner
Lifetime injection	Injection (typically intravenous) on at least one occasion in the participant's lifetime
Lifetime use	Use on at least one occasion in the participant's lifetime via one or more of the following routes of administration: injecting; smoking; snorting; and/or swallowing
Point	0.1 grams, although may also be used as a general term referring to an amount for one injection (similar to a 'cap'; see above)

Recent injection	Injection (intravenous) on at least one occasion in the last six months
Recent use	Use in the last six months via one or more of the following routes of administration: injecting; smoking; snorting; and/or swallowing
South-West Sydney	In the PWID survey data refers to participants recruited in Liverpool and Canterbury; in the KE survey data refers to participants referring to these and/or surrounding suburbs, e.g. Fairfield, Cabramatta
Use	Use via one or more of the following routes of administration: injecting; smoking; snorting; and/or swallowing
Score	To purchase or obtain drugs
Sentinel surveillance	In the context of the IDRS, systematic, ongoing collection and analysis of data from sub-populations (PWID) considered to have the potential to provide an early indication of emerging trends in illicit drug use and associated harms

EXECUTIVE SUMMARY

Common terms used throughout the report	
People who inject drugs (PWID) regularly	A person or 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 towards trends and harms
Median	The middle value of an ordered set of values
Mean	The average
Frequency	Number of occurrences within a given time period

Demographic characteristics of people who inject drugs (PWID)

In 2014, 150 people participated in the IDRS survey. Seventy-five percent were male, 93% reported they were not currently working or were currently receiving income support (such as disability or sickness benefits or the Newstart jobseeker's allowance) at the time of interview. The average age of respondents was 40 years (range 19−64 years). Thirty-seven percent of the sample identified as Aboriginal and/or Torres Strait Islanders[1]. Ninety-four percent of the sample identified English as the main language spoken at home. Thirty-one percent of the sample had completed year 10, and 16% had completed year 12 at high school. Forty-nine percent had obtained a trade or technical qualification, and 7% had completed a university or college qualification such as a degree. Forty-three percent had not completed any further education after leaving school. The majority (79%) of participants reported previous prison history and the average age of first injection was 19 years (range 9−39).

Patterns of drug use among the PWID sample

Heroin

Following the trends of previous years, heroin was still the preferred drug of choice (66%) in 2014 and this remained stable with reports from last year (62% in 2013). Heroin was the drug most often injected in the month prior to interview (60%) which is a non-statistically significant increase when compared with 2013 (50%). Heroin remains the drug people had injected most recently (60%; 50% in 2013) and 85% of participants reported use on one or more occasions in the six months preceding interview (85% in 2013). The median days of recent heroin use also increased to 120 days (90 days in 2013). The proportion of participants reporting daily use was 41%, remaining stable with the 42% who reported daily use in 2013.

[1] Please note that the Aboriginal and/or Torres Strait Islander proportion of the sample is not indicative of numbers of Indigenous persons who regularly inject drugs.

The median price for a gram of heroin increased to $400 ($350 in 2013), while the price for a cap remained 'stable' with 2013 ($50). Heroin remained accessible in 2014, with 87% (86% in 2013) of those who commented reporting that it was either 'easy' or 'very easy' to obtain. The majority of participants that commented (72%; 67% in 2013) on ease of availability reported it had remained 'stable'.

Participant reports (among those who commented) on heroin purity continued to be mixed in 2014. Thirty-seven percent of the participants that commented reported current purity as 'low' (38% in 2013), which remained 'stable', and over one-third (36%; 38% in 2013) reported it as 'medium'. Thirty-seven percent (37% in 2013) of those commenting considered purity levels to have remained 'stable' over the preceding six months, while just under one-quarter (23%; 28% in 2013) commented that it had 'decreased'.

Methamphetamine

The proportion reporting any recent methamphetamine use (speed powder, base, ice or liquid[2,3]) remained 'stable' in 2013 (75%; 75% in 2013). Considered separately, the use of each of these forms of methamphetamine also remained 'stable'; speed (17%; 14% in 2013), base (12% 12% in 2013), ice (74%; 74% in 2013) and liquid (2%; 1% in 2013). Among those reporting any recent use (speed, base, ice, liquid) the median number of days increased to 39 days, a significant finding when compared with the 18 days reported in 2013. The majority had used each form of methamphetamine weekly or less over the six months preceding interview. The proportion of participants (16%) reporting daily use of any type of methamphetamine had increased (7% in 2013).

A 'point' (0.1 of a gram) remained the most popular purchase amount for all three main forms of methamphetamine, and the median price remained 'stable' at $50 for speed powder, base and ice/crystal. Those purchasing ice/crystal and speed powder by the gram and half-gram increased in 2014, but there were insufficient numbers of purchases of other forms of methamphetamine to comment on price changes.

Consistent with 2013, speed and ice/crystal forms of methamphetamine were typically reported by the majority of users as 'very easy' or 'easy' to obtain, whereas the availability of base varied. Availability for all forms was typically reported to have remained 'stable' over the six months preceding interview.

[2] Methamphetamine powder (referred to as 'speed' or 'speed powder') is typically a fine-grained powder, generally white or off-white in colour, but may range from white through to beige or pink due to differences in the chemicals used to produce it. Base (which can also be known as 'pure', 'wax' or 'point') is the paste methamphetamine that is 'moist', 'oily' or 'waxy' and is often brownish in colour. Ice comes in crystalline form, in either translucent or white crystals (sometimes with a pink, green or blue hue) that vary in size. A fourth form, liquid amphetamine or 'oxblood', has also been identified, and is typically red/brown in colour.

[3] In previous years, 'any form' of methamphetamine included pharmaceutical stimulants. In 2006 and 2007, they were considered separately from methamphetamine. Prevalence and frequency of pharmaceutical stimulant use have remained low and stable in NSW.

Cocaine

Cocaine use among PWID decreased significantly ($p<0.05$) in 2014 with 32% of the sample reporting recent use compared with 47% in 2013. The median days of cocaine use decreased in 2014 from 6 days to a median of 3 days (bi-monthly use). Daily cocaine use also remained 'stable with 6% of users reporting daily use (5% in 2013). Reports of crack cocaine were once again almost non-existent among the PWID sample, a finding reflected in KE reports. The majority (85%; 70% in 2013) reported cocaine availability to be 'easy' or 'very easy'. The median price per 'cap' of cocaine remained ''stable' in 2014 at $50 and was the most common purchase amount (n=25). The median price of a gram increased in 2014 from $300 in 2013, to $400. Fewer participants reported purchases in all purchase amounts for cocaine, therefore, results should be interpreted with caution. Participants reporting cocaine purity as 'medium' decreased in 2014 (30% versus 40% in 2013).

Cannabis

The cannabis market continued to remain relatively unchanged since the commencement of the NSW IDRS in 1996. The majority of participants (77%; 82% in 2013) in the 2014 participant sample reported having used cannabis in the six months prior to interview. There was a slight decrease in the median frequency of use among PWID from 100 days in 2013 to 96 days in 2014.

In line with previous years, a large proportion of participants reported use of both the hydroponic ('hydro') and outdoor-grown ('bush') forms of cannabis, with hydro appearing to dominate the market. The number of participants reporting purchase of resin (hashish) and oil (hash oil) continued to remain very rare and infrequent. The price of hydroponic cannabis remained 'stable' at $20 per gram (the most popular purchase amount), and PWID reported that it was readily available, i.e. 'easy' or 'very easy' to obtain (90% versus 97% in 2013). The price per gram of bush cannabis was also $20, but, as in previous years, larger purchase quantities of bush were slightly cheaper than for the equivalent quantity of hydro. Bush continued to be reported as less easily available than hydro, with fewer participants able to complete survey items on bush market characteristics (price, potency and availability). Potency of hydroponic cannabis continued to be reported as 'high', and bush continued to be reported as 'medium'.

Use of pharmaceuticals

The IDRS monitors the extra-medical use patterns and market characteristics of opioid pharmaceutical medications including both those prescribed for opioid substitution treatment (OST) (i.e. methadone, buprenorphine, buprenorphine-naloxone), and those prescribed for pain relief (i.e. morphine and oxycodone).

Non-prescribed methadone

Just one-quarter (27%) of participants reported use of illicitly obtained methadone syrup in the six months preceding interview, which is stable compared with 2013 (25%). Use remained stable and relatively infrequent (approximately monthly). Twenty-two percent of all participants reported injecting illicit methadone syrup in the preceding six months (15% in 2013), and the frequency (median days) of injection also remained stable at approximately monthly. Those participants that could comment on the availability of non-prescribed methadone reported that it was 'very easy' or 'easy' to obtain (67% versus 64% in 2013). The median price of 50 cents per millilitre remained 'stable'.

Recent use and injection of Physeptone obtained without prescription continued to remain uncommon.

Non-prescribed buprenorphine and buprenorphine-naloxone

The recent use and injection of non-prescribed buprenorphine in the preceding six months increased in 2014. The frequency of injection of non-prescribed buprenorphine over this period continued to remain low and stable.

Buprenorphine-naloxone (Suboxone) tablets have been investigated by the IDRS since it was listed on the Pharmaceutical Benefits Scheme (PBS) in April 2006. In September 2011, buprenorphine-naloxone film was also added to the PBS, and so was also investigated in the 2014 IDRS. Five percent of the sample reported recent use of illicit buprenorphine-naloxone tablets (6% in 2013), with 15% reporting recent use of buprenorphine-naloxone film (5% in 2013). The median number of days of use for illicit buprenorphine-naloxone tablets or film increased in 2014 (16 and 7 days respectively). In addition, recent injection of either tablets or film (4% and 7%, respectively) increased in 2014, but remained low.

Morphine

An increase in prevalence of any recent morphine use among the NSW IDRS PWID sample had been observed since 2001; and this continued in 2014 (29% versus 20% in 2013). Recent use of non-prescribed morphine also remained 'stable' (25%; 19% in 2013), as did recent injection (25%; 19% in 2013). The median number of days non-prescribed morphine was injected was 24 compared with 6 days in 2013.

MS Contin remained the most common brand of morphine used. The median price for 100mg MS Contin tablets ('grey nurses') was $50 per tablet, a $10 increase on 2013 prices. Participants typically reported that it was 'very easy' or 'easy' to obtain. Availability was generally considered to have remained 'stable'.

Oxycodone

Since 2005, a distinction has been made between prescribed and non-prescribed other opioids in an effort to monitor the non-prescribed use of, and problems associated with, the diversion of oxycodone. Until 2005, oxycodone was included under 'other opioids'.

Forty-four percent of all participants reported use of any (prescribed or non-prescribed) oxycodone in the six months preceding interview, a finding consistent with 2013 (43%). Participants reported using oxycodone a median of 20 days (i.e. almost weekly) which is stable with 2013 (20 days). The proportion of PWID reporting recent injection of oxycodone was also stable (39% versus 37% in 2013), however, the median number of days injected decreased from 30 in 2013 to 20 days in 2014.

Thirty-seven percent (39% in 2013) of the sample felt confident to comment on the price and/or availability of illicit oxycodone in 2014. As per previous years the most common purchase amounts were 80mg OxyContin tablets, bought for a median price of $50 (range: $10−$150) each. Over half (53%) of those participants who could comment reported that availability was considered 'more difficult' when compared with 24% of participants in 2013. Despite recent use and median days of use of oxycodone remaining 'stable', availability reports were mixed and have shifted when compared with 2013.

Over the counter codeine

Since 2009, survey specific questions were asked about over the counter (OTC) codeine use and it was subsequently removed from the 'other opioids' classification. In 2014, 22% of the sample reported recent use of OTC codeine, on a median of 12 days (42%; 24 days in 2013) with one percent of participants reporting recent injection. Recent injection reports of any other opioids were low.

Benzodiazepines

Prevalence of benzodiazepine use remained relatively stable with 59% (66% in 2013) reporting use in the six months preceding interview and the frequency of use remained stable at 29 days (30 days in 2013). The injection of benzodiazepines remained low with 3% (5% in 2013) reporting any injection in the past six months on a median of 2 days in 2014.

Six percent had recently used 'licit' alprazolam on a median of 30 days while 37% had recently used 'illicit' alprazolam on a median of 12 days. Twenty-eight percent of the NSW sample reported having used 'licitly' obtained other benzodiazepines on a median of 53 days in the last six months, while 38% reported using 'illicitly' obtained other benzodiazepines on a median of 7 days in the six months preceding interview.

Excluding alprazolam, the most commonly used brand of benzodiazepine was diazepam (79%; including Valium, Valpam and Antenex), followed by clonazepam (12%; Rivotril) and oxazepam (7%; Serepax).

Seroquel®

Twenty-one percent of the sample had used Seroquel® in the last six months (10% licit, 13% illicit), consistent with the 21% of participants in 2013. 'Licit' Seroquel® has been used on a median of 180 days compared to three days for 'illicit' Seroquel®.

Other drugs

Hallucinogens, ecstasy and inhalant use were relatively low within this sample. Two percent of all participants reported recent hallucinogen use in 2014. Although more than half (52%) of the sample had tried ecstasy, recent use was reported by only 9% of the sample on a median of 3 days. Prevalence of recent inhalant use (e.g. nitrous oxide, amyl nitrate) remained low at 3%.

Alcohol and tobacco

Fifty percent of participants had consumed alcohol in the preceding six months on a median of 12 days, i.e. approximately once per fortnight. This was a decrease from 2013 in which 66% of participants who had consumed alcohol in the preceding six months did so on a median of 24 days (i.e. approximately once per week use). Five percent of participants reported daily use of alcohol.

Tobacco remained the most commonly used substance investigated by the IDRS, with virtually all participants (93%) reporting smoking tobacco in the six months preceding interview on a median of 180 days (i.e. daily); a finding that has remained consistent since 1996 when the project commenced. Unlike smoking prevalence in the general population (Australian Institute of Health and Welfare, 2014), smoking among IDRS participants has not declined over time.

Health-related trends associated with drug use

Twenty-eight percent of all participants who had ever experienced a non-fatal heroin overdose had done so in the year prior to interview (19% in 2013). Eight participants reported heroin overdose in the month preceding the interview (n=3 in 2013).

Overall, participant reports of borrowing and lending of needles and syringes, as well as sharing of other injecting equipment, remained stable in 2014.

The most commonly reported location for last injection remained a private home and this remained stable with 2013.

Again in 2014, participants were asked the site on their body for their last injection. The majority (74%) reported their arm, 13% reported hand/wrist and smaller proportions reported their leg (5%), groin (3%) or neck (1%).

Fifty-five percent of PWID participants who had injected in the last month reported at least one injection-related problem during this time (68% in 2013). As per 2013, the most commonly reported problems were prominent scarring/bruising of injection sites (40%; 48% in 2013) and difficulty injecting (35%; 46% in 2013).

Twenty-nine percent of the sample reported experiencing a mental health problem, other than drug dependence, in the preceding six months (45% in 2013), with 75% reporting seeking advice from a mental health professional (63% in 2013). Depression continued to be the most commonly reported problem (64%; 67% in 2013), amongst those who reported a mental health illness.

Again in 2014, the 10-item Kessler Psychological Distress Scale (K10) was administered. The K10 assesses recent levels of psychological distress (anxiety and depressive symptomatology). Approximately equal proportions of participants fell into the 'high' or 'very high distress' level of psychological distress category, at a proportion higher than the Australian normative value.

Law enforcement-related trends associated with drug use

The proportion of PWID participants that reported being arrested in the previous 12 months increased to 46% of the entire sample (42% in 2013). Self-reported crime trends continued to follow those reported in previous years with the two most commonly reported crimes in the month prior to interview being drug dealing (25%; 30% in 2013) property crime (24%; 19% in 2013). The daily expenditure on drugs and alcohol (excluding tobacco and prescribed medication) increased in 2014 to a median of $100 per participant ($85, in 2013). The range of daily expenditure was $8−$1,000.

1 INTRODUCTION

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

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

The IDRS has operated in NSW since 1996. The data described in this report represent a summary of drug trends detected by the NSW IDRS in 2014. Results are summarised by drug type to provide the reader with an abbreviated picture of illicit drug markets and recent trends. NSW drug trends from previous years can be found in the annual *NSW Drug Trends* reports. All IDRS reports from previous years (in NSW and for all other jurisdictions) may be downloaded in full from the NDARC website http://ndarc.med.unsw.edu.au (under 'Drug Trends'). Quarterly bulletins are also produced on IDRS and related data (also available on the NDARC website), and IDRS results are also disseminated in a range of forums including national and international conferences and at the annual Drug Trends Conference. Details of all of these may also be found on the NDARC website.

A separate study monitoring trends in ecstasy and related drug use (the Ecstasy and related Drugs Reporting System, or EDRS, formerly known as the Party Drugs Initiative, or PDI) commenced in NSW in 2000 and has been conducted nationally since 2003. Findings are reported elsewhere (Dunn, Degenhardt, & Stafford, 2006; Stafford et al., 2006). Copies of these reports may also be downloaded from the NDARC website: http://ndarc.med.unsw.edu.au (under 'Drug Trends').

1.1 Study aims

As in previous years, the specific aims of the 2014 NSW IDRS were:

Aims of NSW IDRS

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

2 Method

The IDRS considers three main sources of information when documenting drug trends:

Main sources informing the NSW IDRS

- A quantitative survey of people who inject drugs (PWID) participants;
- A semi-structured interview with key experts (KE), who are professionals working in the illicit drug field, and have regular contact with, and/or specialised knowledge of, people who inject drugs, dealers or manufacturers; and
- A collation of existing indicator data on drug-related issues.

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

Data from these three sources are triangulated against each other to determine the convergent validity of trends detected. The data sources complement each other in the nature of the information they provide. Data from the 2014 IDRS were also compared with IDRS findings from previous years to determine changes in drug trends and related issues over time.

2.1 Survey of people who inject drugs (PWID) regularly

In the 2014 NSW IDRS, the PWID survey consisted of face-to-face interviews with 150 PWID, conducted in Sydney during June 2014. Sixty percent of the sample was recruited from the inner city (Kings Cross and Redfern), and the remainder from Sydney's South-West (Liverpool, Canterbury). In previous years, interviews were conducted at Cabramatta rather than Liverpool; closure of the service at Cabramatta in mid-2003 resulted in the requirement to find a new interview site from 2004 onwards. As with the other locations where recruitment is conducted, Liverpool was selected as it is a key illicit drug market area, and it is in these markets that trends in illicit drug use are likely to first emerge. It should be noted that a shift in the site to South-Western Sydney (in close proximity to a pharmacotherapy treatment service) since 2004 is likely to have contributed to a slight over-representation of methadone and buprenorphine clients within the sample and this should be taken into consideration when interpreting our findings.

Participants were recruited from various sites offering Needle and Syringe Program facilities. Potential participants were screened for eligibility— i.e. criteria for entry to the study were: (i) at least monthly injection of any drug in the six months preceding the interview; and (ii) resident in Sydney for the preceding 12 months, with no significant periods of incarceration, residential rehabilitation, therapeutic community or other time away during that period. This ensures current knowledge of the drug market. The interview schedule included sections on demographics; drug use history; the price, purity and availability of illicit drugs; the colour of heroin, criminal activity; injection related behaviour; driving risk behaviour; health (mental and drug-related); and general drug trends. Participants were interviewed within the agencies that

assisted with recruitment and were interviewed, where possible, at coffee shops and fast-food outlets close by. Interviews took about 60 minutes to conduct, were interviewer-administered and participants were reimbursed $40 for their time and travel expenses. Descriptive analyses of the quantitative data derived from the PWID survey were conducted using SPSS Statistics for Windows, Release 22.0.

2.2 Survey of key experts (KE)

Twenty-four KE who had regular contact with, and/or specialist knowledge of, people using illicit drugs[4], drug dealers or drug manufacturers, were interviewed during September and October 2014. To be eligible, participants must have had at least weekly contact with people using or supplying illicit drugs, and/or contact with a minimum of ten different people using or supplying illicit drugs in the six months preceding the interview. As broad a range of KE as possible were interviewed in 2014 including drug treatment workers, therapeutic community and residential detoxification workers, law enforcement officers, registered nurses, clinical nurse consultants and user group representatives. KE are recruited from a range of geographical areas across Sydney, both within and outside the drug market areas in which PWID participants are recruited. KE selection is based upon a desire to interview persons who have contact with a broader group of people who use drugs, including people who inject drugs and who have knowledge of drug markets that is broader than the information that we obtain from our participants, and can give some indication of trends across Sydney and NSW.

The KE interview schedule was a semi-structured instrument, based on previous years of the IDRS, and covered similar topic areas to the PWID interview. The interview included sections on drug use patterns; drug price, purity and availability; criminal activity; and health and treatment issues. Interviews took approximately 30 minutes to conduct, and were conducted face-to-face, over the phone or through completion of an online questionnaire. Notes were taken during the interview and content analysis conducted to identify recurring themes and patterns in the data.

2.3 Other indicators

To complement and validate data collected from the participant user and KE surveys, a range of secondary data sources were examined. These included health, survey and law enforcement data. The pilot study for the IDRS recommended that such data should be available at least annually, include 50 or more cases, be brief, be collected in the main study site (i.e. Sydney, New South Wales, for the present study), and cover the four main illicit drugs, i.e. heroin, methamphetamine, cocaine and cannabis.

[4] The people who use illicit drugs to whom KE refer are typically, but not exclusively, injecting drug users.

Data sources that have been included in this report are:

Other indicators informing the NSW IDRS

- Alcohol and Drug Information Service – calls received regarding problematic drug use;
- Family Drug Support – telephone support service for family members affected by problematic drug use, and for people who use drugs themselves;
- Australian Bureau of Statistics – overdose data;
- Australian Crime Commission – purity data from police seizures;
- Australian Government Department of Health, National Notifiable Diseases Surveillance System – notifications of hepatitis C and hepatitis B;
- Sydney Medically Supervised Injecting Centre – data on drugs injected at the centre;
- Kirketon Road Centre Needle and Syringe Program data on last drug injected;
- National Centre in HIV Epidemiology and Clinical Research (NCHECR) – human immunodeficiency virus (HIV) and hepatitis C virus (HCV) seroprevalence data from the annual Needle and Syringe Program (NSP) Survey;
- NSW Bureau of Crime Statistics and Research – incidents recorded for possession/use;
- NSW Department of Health – drug-related visits to emergency departments, NSW ambulance callouts to overdoses, numbers registering for opioid pharmacotherapy treatment, number of units dispensed from public NSP and pharmacies, number of treatment episodes by drug type, drug-related inpatient hospital admissions and toxicology data from suspected drug users in which drugs were detected; and
- NSW Police – number of clandestine methamphetamine and 3,4-methylene-dioxymethamphetamine (MDMA) laboratory detections.

3 DEMOGRAPHICS

3.1 Overview of people who inject drugs (PWID) regularly

The demographic characteristics of the 150 PWID participants who took part in the interview in 2014 are presented below (Table 1).

The mean age of the sample was 40 years (range 19−64), 75% were male and 37% identified themselves as Aboriginal and/or Torres Strait Islander.[5] The vast majority identified as heterosexual (91%) and reported that English was the main language they spoke at home (94%). The educational status of the sample varied, from the completion of grade 3 (<1%) through to completion of year 12 (16%). Fifty-six percent had completed year 10 or higher. Forty-nine percent had obtained a trade or technical qualification and 7% had completed a university or college qualification such as a degree. Less than half (43%) had not completed any further education after leaving school.

The majority of the sample (93%) reported that they were currently not employed or receiving a government pension. Eighty-five percent of the sample reported that their main source of income over the preceding month had been a pension or government benefit, while 3% reported a wage or salary, 9% nominated criminal activity and 1% reported sex work. Fifty-five percent of participants reported being single, while just over one-fifth (22%) reported being married or de facto. Sixteen percent had a current partner and smaller proportions reported being separated/divorced (6%), or widowed/widower (1%).

[5] Please note that Aboriginal and/or Torres Strait Islander proportion of sample is not indicative of numbers of Indigenous persons who regularly inject drugs.

Table 1: Demographic characteristics of PWID participants, 2010−2014

Characteristic	2010 N=154	2011 N=150	2012 N=151	2013 N=151	**2014 N=150**
Mean age (years) (range)	39.3 (19−58)	40.0 (21−58)	39.6 (19−59)	40.1 (23−63)	**40.0 (19-64)**
Sex (% male)	61	65	60	60	**75**
Aboriginal and/or Torres Strait Islander* (%)	22	17	29	27	**37**
School education (mean no. years, range)	9.7 (3−12)	9.8 (4−12)	9.8 (0−12)	10 (4−12)	**9 (3-12)**
Employment (%)					
Not employed/on a pension	88	84	93	95	**93**
Full time	1	4	1	1	**3**
Part-time/casual	9	6	3	4	**1**
Home duties	1	2	1	0	**1**
Student	1	2	1	1	**1**
Sexual identity (%)					
Heterosexual	84	84	87	85	**91**
Bisexual	7	11	10	11	**7**
Gay or lesbian	6	5	2	3	**2**
Other	3	1	1	1	**0**
Tertiary education (%)					
No qualification	55	52	49	44	**43**
Trade/tech	36	42	46	49	**49**
University/college	9	5	5	7	**7**
Current relationship status (%)					
Married/de facto	26	28	18	22	**22**
Regular partner	16	20	18	20	**16**
Single	53	43	60	45	**55**
Separated/divorced	3	5	3	10	**6**
Widowed/widower	2	3	1	3	**1**
Currently in drug treatment^ (%)	67	72	60	61	**51**
Prison history (%)	69	71	66	70	**79**

Source: IDRS PWID interviews

^ Refers to any form of drug treatment, including pharmacotherapies, counselling, detoxification, etc.

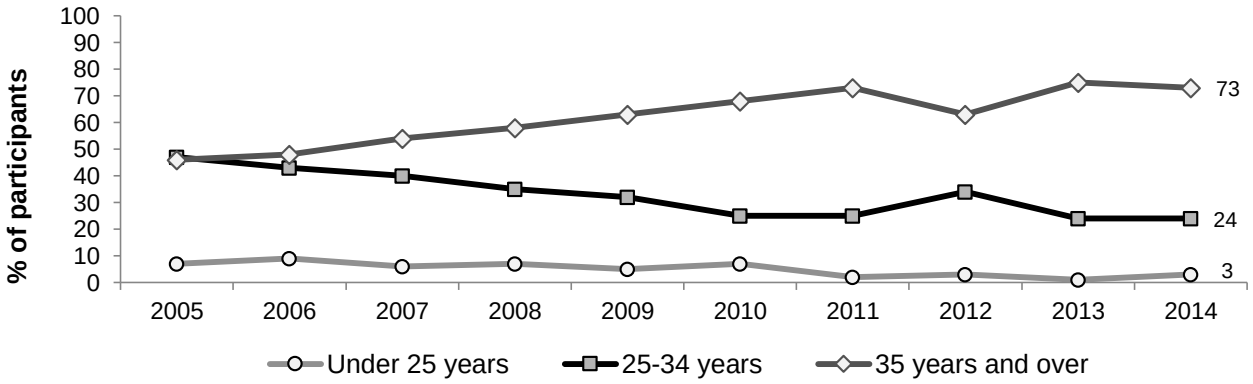
*Aboriginal and/or Torres Strait Islander proportion of sample is not indicative of numbers of Indigenous persons who regularly inject drugs

3.1.1 Age of the PWID sample over time

The mean age (40 years) of the sample is in keeping with the gradual increase in age over time. The 35 years and over age group, representing the majority (73%) of the sample, has remained consistent with the 75% of all participants in 2013. Correspondingly, since 1996 the proportion of younger users interviewed generally decreased over time (see Figure 1). There are several reasons that could contribute to this. First, it may be that fewer younger users are accessing NSP (where recruitment is conducted) in recent years, or are less willing to take part in research conducted at NSP. Second, in recent years, younger PWID are more likely to be using methamphetamine than their older counterparts (Degenhardt et al., 2008), and some research

has shown that methamphetamine users may be less likely to access health services such as NSP (Kelly, McKetin, & McLaren, 2005). Finally, there may simply be fewer young people beginning regular drug injection; some evidence has suggested that there have been lower numbers of hepatitis C infections among younger age groups in recent years, which would be consistent with this possibility (Day, Degenhardt, Gilmour, & Hall, 2005). Further research is required to investigate these possibilities in greater detail.

Figure 1: Age distribution of PWID in the NSW (Sydney) IDRS samples, 2005−2014



Source: IDRS PWID interviews

3.1.2 Recruitment

Participants were asked if they had taken part in the IDRS or the EDRS in previous years, as shown in Table 2. Only a small minority (2%) reported having been interviewed for the Ecstasy and related Drugs Reporting System (EDRS) previously. Just under one-third (31%) of participants in 2014 reported having taken part in the IDRS survey previously (between 1996 and 2013). The majority of participants had been recruited by way of advertisements placed in NSP, followed by word of mouth (Table 2).

Table 2: Previous participation in the IDRS and EDRS and source of participant recruitment, 2010−2014

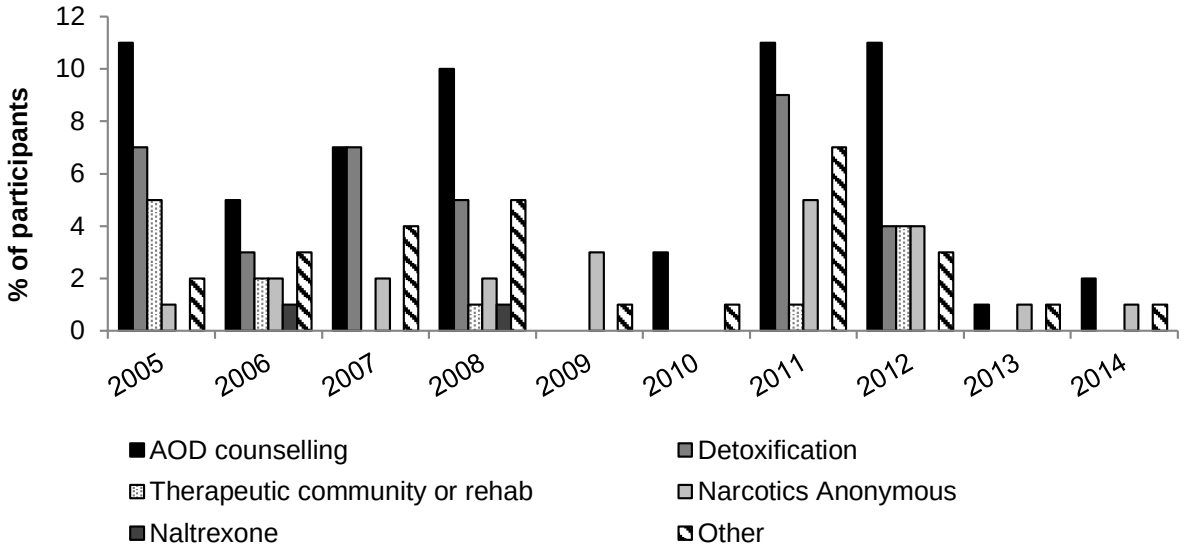
	2010 N=154	2011 N=150	2012 N=151	2013 N=151	**2014 N=150**
Participated in IDRS in previous years (%)	30	32	35	35	**31**
Where found out about IDRS survey recruitment (%)					
Needle and Syringe Program (NSP)	53	57	49	39	**48**
Treatment provider	4	4	7	13	**5**
Advert in street press	0	0	1	2	**0**
Word of mouth	43	36	40	33	**39**
Participated in EDRS in previous years (%)	3	4	4	3	**2**

Source: IDRS PWID interviews

3.1.3 Current and previous drug treatment

Fifty-one percent of participants reported that they were currently in drug treatment. Of those participants currently engaged in treatment, 38% (50% in 2013) reported methadone/biodone as their main form of treatment, 11 participants (7% of those in treatment) reported they were on buprenorphine-naloxone (Suboxone), and three participants (2% of those in treatment) reported buprenorphine (Subutex). Three participants nominated that drug counselling was their main form of treatment (2% of entire sample) while one participant reported attending Narcotics Anonymous. There were no reports of naltrexone treatment, therapeutic community or detoxification. However, as participants were asked about the 'main' type of treatment they were currently receiving, it is important to note that participants who cited pharmacotherapy as their main form of drug treatment may also have been engaged in a number of treatments (e.g. counselling, detoxification, case management, etc.). Participants were also asked if they had been in treatment at any stage over the past six months (Figure 2); just over one-half (56%) reported 'not' having been in any form of drug treatment over this time.

Figure 2: Proportion of participants reporting treatments other than opioid replacement pharmacotherapy in the past six months, 2005−2014



Source: IDRS PWID interviews

NB: Multiple responses could be selected. Survey item was first included in 2001

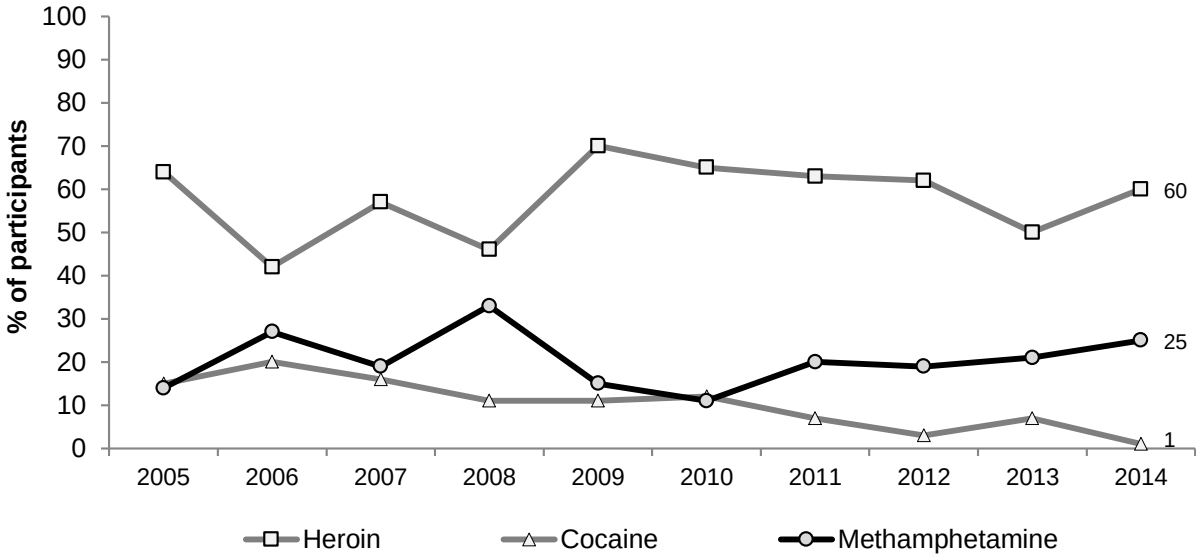
4 CONSUMPTION PATTERNS

4.1 Drug use history and current drug use

The mean age of first injection was 19.36 years (SD 5.9, range 9−39) (Table 3). Similar to previous years, heroin was the first drug injected by the majority of participants (55%), followed by methamphetamine (32%) and cocaine (7%). Heroin remained the most commonly reported drug of choice (66%), remaining stable from 2013 and 2012 (62% and 67% respectively).

As in previous years, heroin remained the drug most often injected in the month preceding the interview (60%); however, this is not a statistically significant increase on the 50% of participants who reported it in 2013 (Figure 3). Again in 2014, heroin remained the most common recently injected drug (59%) (Table 3). Thirty-seven percent of all participants reported injecting '2 to 3 times per day' in the month preceding the interview, while 29% reported injecting 'more than weekly, not daily.'

Figure 3: Drug injected most last month, 2005−2014



Source: IDRS PWID interviews
NB: Survey item was first included in 1999

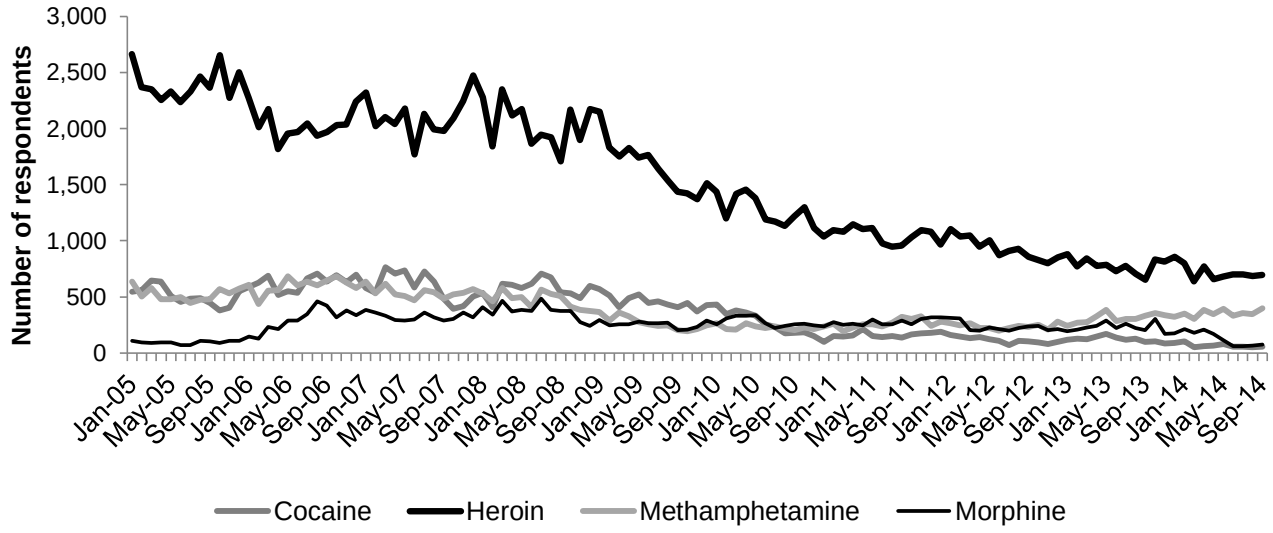
Table 3: Injection history, drug preferences and polydrug use of PWID participants, 2010−2014

Variable	2010 N=154	2011 N=150	2012 N=151	2013 N=151	**2014 N=150**
Age first injection (mean years)	18.7	19.44	19.11	19.59	**19.36**
First drug injected (%)					
Heroin	61	63	58	57	**55**
Methamphetamines	33	33	33	36	**32**
Cocaine	3	3	5	3	**7**
Morphine	1	0	1	0	**1**
Drug of choice (%)					
Heroin	71	70	67	62	**66**
Cocaine	11	7	5	9	**4**
Methamphetamine (any form)	10	16	15	17	**17**
Speed	*3*	*1*	*3*	*1*	***3***
Base	*0*	*1*	*0*	*1*	***0***
Crystal methamphetamine (ice)	*7*	*14*	*12*	*15*	***13***
Benzodiazepines	0	1	1	0	**1**
Cannabis	3	3	2	4	**4**
Drug injected most often in last month (%)					
Heroin	65	63	62	50	**60**
Cocaine	12	7	3	7	**1**
Methamphetamine (any form)	11	20	19	23	**28**
Speed	*3*	*1*	*2*	*1*	***3***
Base	*1*	*1*	*0*	*1*	***0***
Crystal methamphetamine (ice)	*7*	*18*	*17*	*21*	***25***
Benzodiazepines	1	0	0	0	**1**
Morphine	5	1	4	2	**5**
Oxycodone	N/A	3	5	11	**2**
Most recent drug injected (%)					
Heroin	62	61	59	50	**59**
Cocaine	11	5	5	7	**2**
Methamphetamine (any form)	11	17	23	24	**25**
Speed	*3*	*1*	*3*	*2*	***1***
Base	*3*	*1*	*1*	*1*	***0***
Crystal methamphetamine (ice)	*5*	*15*	*19*	*21*	***24***
Benzodiazepines	2	0	0	0	**0**
Morphine	5	4	3	3	**4**
Oxycodone	N/A	3	8	11	**4**
Frequency of injecting in last month (%)					
Not injected in last month	1	1	1	1	**0**
Weekly or less	15	13	14	13	**11**
More than weekly, but less than daily	30	43	34	35	**29**
Once per day	18	14	14	16	**11**
2−3 times a day	26	23	23	28	**37**
>3 times a day	10	7	15	7	**11**

Source: IDRS PWID interviews
N/A= not available
NB: Percentages do not equate to 100 as more than one response may have been selected

Figure 4 (below) illustrates the most recent drug injected as reported by respondents attending three inner city NSP. While heroin continued to be reported as the last drug injected by the majority of respondents, there had been an overall decline in the numbers reporting heroin throughout the reporting period. This trend, however, was stable in the twelve months to August 2014 with the lowest level recorded in February with 637 visits. The numbers reporting methamphetamine (all forms) over the past 12 months is generally stable with only the occasional minor fluctuation. The number of people nominating cocaine in the 12 months to September 2014 also declined to be the lowest since 2003 (only 49 respondents in February 2014). The number of respondents nominating morphine (and other pharmaceutical opioids) steadily increased since August 2004 (26 visits) peaking again at an all-time high of 483 visits in July 2008 after a period of stabilisation in 2007. Attendances in the 12 months to September 2014 remained low and stable. The lowest recorded numbers for morphine during this period was 58 visits in July 2014.

Figure 4: Number of respondents attending three inner city NSP reporting heroin, methamphetamine, cocaine and morphine as last drug injected, Jan 2005- September 2014



Source: Three inner city NSP

The polydrug use histories of PWID participants, including routes of administration, are presented in Table 4. Recent use of the four main drugs monitored by the IDRS remained common: heroin (85%), cannabis (77%), methamphetamine (any form 75%) and cocaine (32%) (Figure 5). Further discussion of the use of these drugs may be found under the relevant section headings elsewhere in the report.

Table 4: Polydrug use history of the PWID sample, 2014

Drug Class	Ever used %	Ever injected %	Injected last 6 mths %	Median days injected in last 6 months*	Ever smoked %	Smoked last 6 mths %	Ever snorted %	Snorted last 6 mths %	Ever swallowed %	Swallowed last 6 mths+ %	Used^ last 6 mths %	Median days in treatment* last 6 mths	Median days used^ in last 6 mths*
Heroin	99	98	83	120	55	11	17	2	16	3	85		120
Homebake heroin	38	36	8	5	1	0	0	0	1	0	9		5
Any heroin (inc. homebake)	99	97	84	120	55	11	17	2	16	3	87		120
Methadone (prescribed)	71	38	9	22					67	39	41	180	180
Methadone (not prescribed)	55	45	22	7					32	11	27		7
Physeptone (prescribed)	7	3	0	0	0	0	0	0	6	0	0	0	0
Physeptone (not prescribed)	18	10	3	9	1	0	1	0	7	1	3		7
Any methadone (inc. Physeptone)	85	59	27	16					73	45	57		177
Buprenorphine 'Subutex' (prescribed)	36	13	1	180	7	0	1	0	33	2	3	135	135
Buprenorphine 'Subutex' (not prescribed)	46	35	16	6	15	5	2	0	13	5	22		6
Any buprenorphine (excl. buprenorphine-naloxone)	66	41	17	6	19	5	2	0	40	6	24		7
Buprenorphine-naloxone 'Suboxone' tablets (prescribed)	19	3	0	0	1	0	0	0	17	1	2	30	30
Buprenorphine-naloxone 'Suboxone' tablets (not prescribed)	21	15	4	14	7	1	0	0	7	1	5		16
Any buprenorphine-naloxone 'Suboxone' tablets	35	18	8	14	8	1	0	0	21	2	7		25
Buprenorphine-naloxone 'Suboxone' film (prescribed)	17	2	1	108	1	0	0	0	16	8	9	150	120
Buprenorphine-naloxone 'Suboxone' film (not prescribed)	28	16	7	14	5	3	0	0	12	6	15		7
Any buprenorphine-naloxone 'Suboxone' Film	41	17	7	15	5	3	0	0	26	13	22		20
Any buprenorphine-naloxone (any form)	51	26	8		11	4	0	0	35	14	23		
Morphine (prescribed)	17	13	4	3	1	1	1	1	5	1	6	5	5
Morphine (not prescribed)	59	56	25	24	1	0	1	0	9	3	25		22
Any morphine	63	61	27	14	1	1	1	0	11	4	29		19
Oxycodone (prescribed)	18	11	6	20	1	0	1	1	15	8	9	25	21
Oxycodone (not prescribed)	69	64	37	20	1	0	1	0	15	7	40		20

Source: IDRS PWID interviews

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

* Among those who had used/injected

+ Refers to/includes sublingual administration of buprenorphine (trade name Subutex) and buprenorphine-naloxone (trade name Suboxone)

NB: Buprenorphine-naloxone was first listed on the Pharmaceutical Benefits Scheme (PBS) in April 2006

Table 4: Polydrug use history of the PWID sample, 2014 (continued)

Drug Class	Ever used %	Ever injected %	Injected last 6 mths %	Median days injected in last 6 months*	Ever smoked %	Smoked last 6 mths %	Ever snorted %	Snorted last 6 mths %	Ever swallowed %	Swallowed last 6 mths+ %	Used^ last 6 mths %	Median days in treatment* last 6 mths	Median days used^ in last 6 mths*
Any oxycodone	75	35	39	20	1	0	1	1	25	13	44		20
Fentanyl	25	23	15	2	21	0	1	0	1	0	15		2
Other opioids (not elsewhere classified)	55	2	1	12	1	0	0	0	52	22	24		5
OTC codeine	40	4	1	4	0	0	0	0	38	20	22		12
Speed powder	77	71	17	6	10	1	29	1	23	1	17		6
Base/point/wax	51	47	11	3	3	1	3	1	7	1	12		4
Ice/shabu/crystal	86	83	73	24	43	25	2	1	7	2	74		28
Amphetamine liquid	30	27	1	102					6	1	2		90
Any form methamphetamine#	*96*	*92*	*73*	*38*	*45*	*26*	*29*	*1*	*27*	*4*	*75*		*39*
Pharmaceutical stimulants (prescribed)	7	2	1	180	1	1	1	1	6	1	1		180
Pharmaceutical stimulants (not prescribed)	11	7	2	12	1	1	1	1	7	1	2		12
Any form pharmaceutical stimulants	*16*	*8*	*2*	*12*	*1*	*1*	*1*	*0*	*11*	*1*	*3*		*96*
Cocaine	85	81	32	3	13	3	33	3	5	1	32		3
Hallucinogens	48	8	1	6	1	1	1	1	45	2	2		2
Ecstasy	52	17	3	3	1	1	5	1	47	6	9		3
Alprazolam (prescribed)	16	3	1	1	0	0	0	0	16	6	6		30
Alprazolam (not prescribed	63	7	2	2	0	0	0	0	61	37	37		12
Any form alprazolam	65	7	2		0	0	0	0	63	39	39		
Other benzodiazepines (prescribed)	52	3	//1	24	0	0	0	0	51	27	28		53
Other benzodiazepines (not prescribed)	56	5	1	2	0	0	0	0	53	37	38		7
Any benzodiazepine (excl. alprazolam)	75	6	1		0	0	0	0	71	49	51		
Any form benzodiazepine	83	11	3	2	0	0	0	0	80	57	59		28
Steroids	9	8	1	25	0	0	0	0	3	0	1		25
Seroquel (prescribed)	21	1	1	1					21	9	10		180
Seroquel (not prescribed)	37	1	1	2					37	11	13		3
Any form Seroquel	55	2	1	42					54	19	21		19
Alcohol	96	3	0	0					94	48	50		12
Cannabis	97				95	74			16	2	77		96
Inhalants	14										3		5
Tobacco	97										93		180

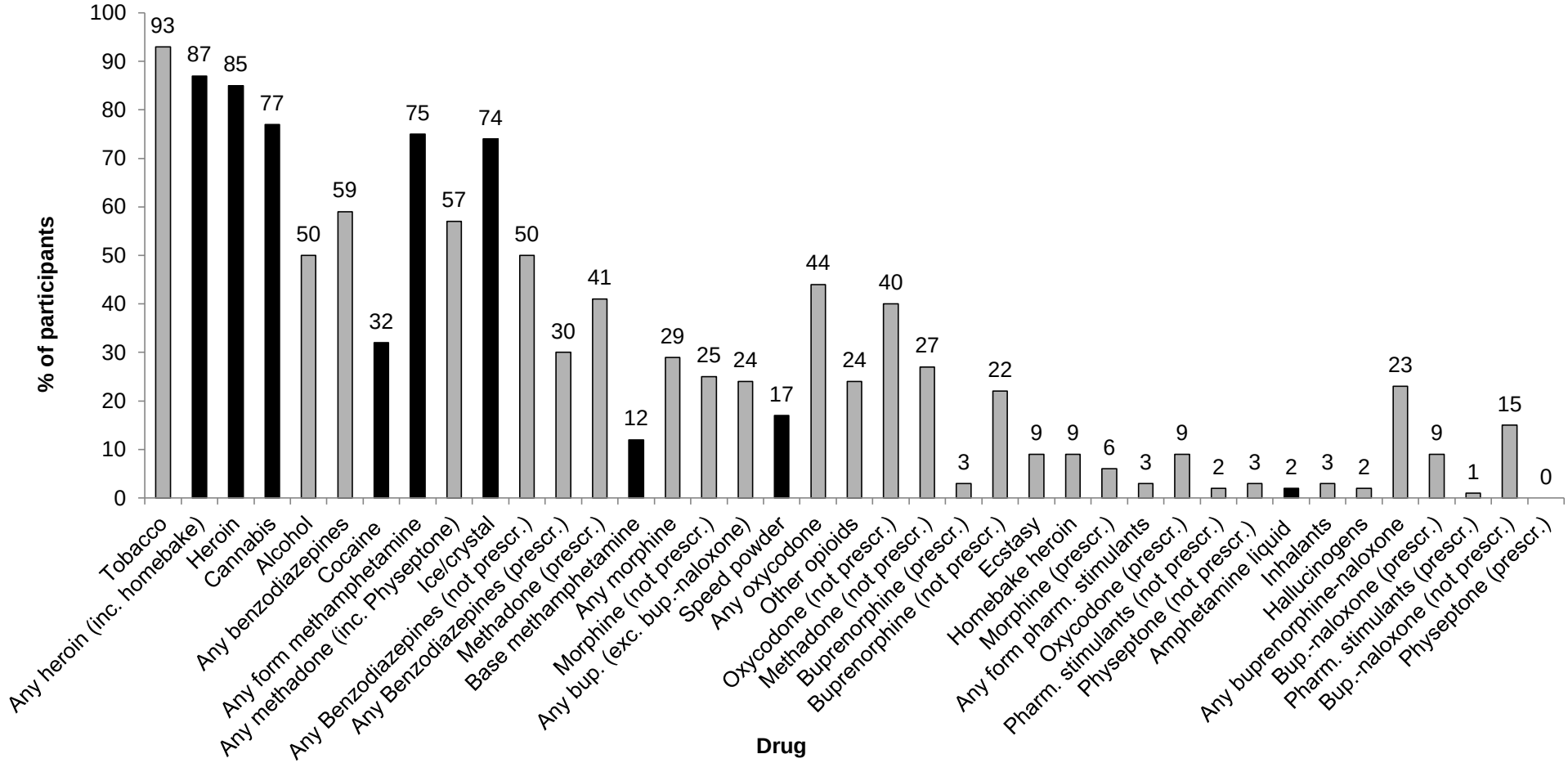
Source: IDRS PWID interviews

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

* Among those who had used/injected

Category includes speed powder, base, ice/crystal and amphetamine liquid (oxblood)

Figure 5: Prevalence of drug use in the six months preceding interview, NSW 2014*



Source: IDRS PWID interviews

* Key drugs investigated in the IDRS (i.e. heroin, methamphetamine, cocaine and cannabis) shown in black
NB: 'Any heroin' includes heroin and homebake heroin. 'Any form methamphetamine' includes speed powder, base, ice/crystal and liquid amphetamine. 'Any methadone' includes licit (prescr.) and illicit (not prescr.) methadone syrup and Physeptone. 'Any morphine', 'any buprenorphine', 'any oxycodone', 'any form pharmaceutical stimulants' and 'any form bup.-naloxone' include licit and illicit forms of the drug in any formulation unless otherwise specified. 'Other opioids' refers to opioids not elsewhere classified. 'Use' refers to any form of administration and does not necessarily imply injection for further information on routes of administration, please refer to Table 4.

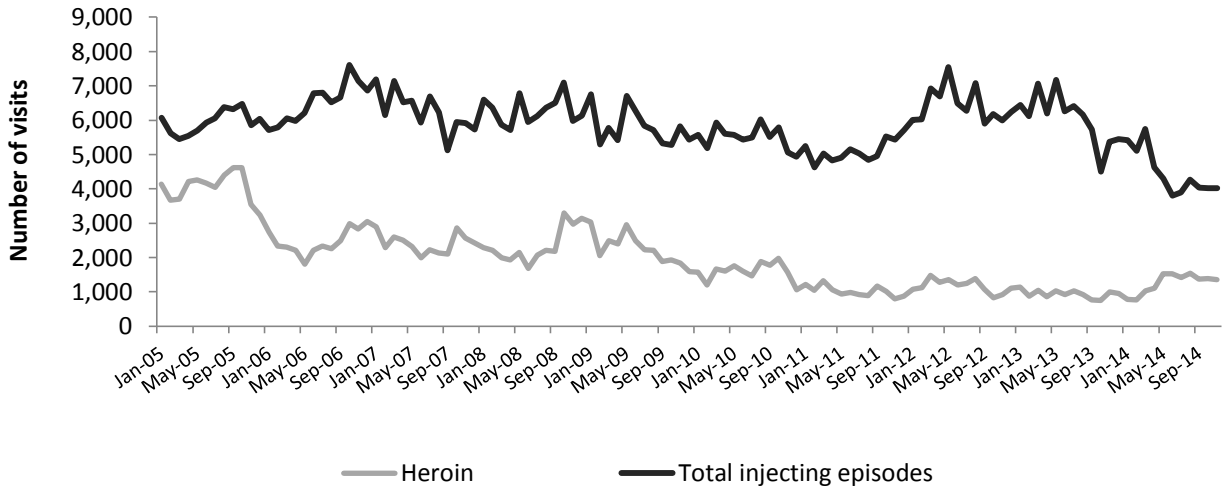
4.2 Heroin

4.2.1 Heroin use among PWID participants

The majority of participants (85%) had used heroin in the six months preceding interview; this remained stable with the 83% reported in 2013. Heroin remained the drug of choice for 66% of the sample (Table 3), stable also with the 62% reporting it in 2013. Heroin was most commonly nominated for 'drug injected last' (59%), representing a slight increase on the 50% reporting it in 2013. Heroin was nominated as the 'drug injected most often in the last month' (60%), which is a non-statistically significant increase on the 50% of participants that reported it in 2013.

Figure 6 shows the number of attendances to the Sydney MSIC in Kings Cross where heroin was the drug injected (based on client reports) between January 2005 and November 2014. The following caveats need to be considered when interpreting these data. First, the hours of operation changed over the first two years of operation (increasing from four hours to 12 hours per day) and, second, the number of individuals attending increased continuously over this period, as people who inject drugs (PWID) became aware of this new service. Heroin had been the drug most commonly injected since the centre opened, with the exception of July 2001−January 2002 where cocaine was equally or more commonly injected, and until more recently when 'other opioids' (predominantly oxycodone and morphine) were equally or more commonly injected (see Figure 19). There has been a steady downward trend in attendances for heroin injection since 2009, and in the 12 months to November 2014 heroin has accounted for approximately 14−40% of all attendances to Sydney MSIC.

Figure 6: Number of attendances to Sydney MSIC where heroin was injected and total number of visits, Jan 2005−November 2014



Source: Sydney MSIC, Kings Cross

NB: Total visits refers to the total number of valid visits at which a response was given

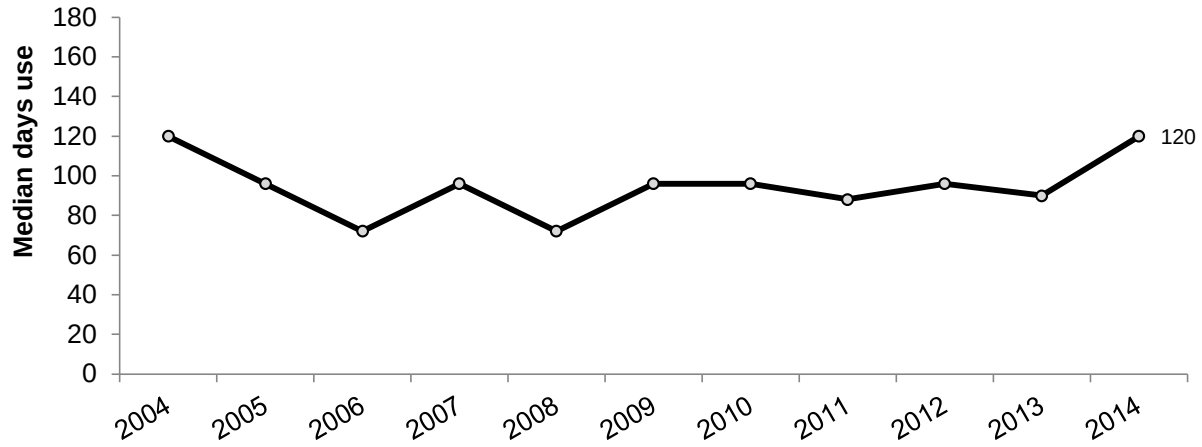
4.2.1.1 Homebake

Homebake use remained infrequent and uncommon among the PWID sample of the NSW IDRS. Nine percent of the sample reported use in the last six months (Table 4), which is stable with the 10% who reported in 2013 and comparable with the 7% reported two years prior in 2012. Eight percent of participants reported homebake injection in the last 6 months which is stable with the 9% who reported it in 2013.

4.2.2 Current patterns of heroin use

The median number of days of heroin use in the six months preceding interview increased from 90 days in 2013, to 120 days in 2014 representing a statistically significant increase. This represents a peak in use not observed since 2004 (120 days) (Figure 7). Over the last decade, the median days of heroin use has consistently been 96 days, or approximately every second day. The recent use of heroin reported by participants in 2014 has remained stable at 85% (83% in 2013).

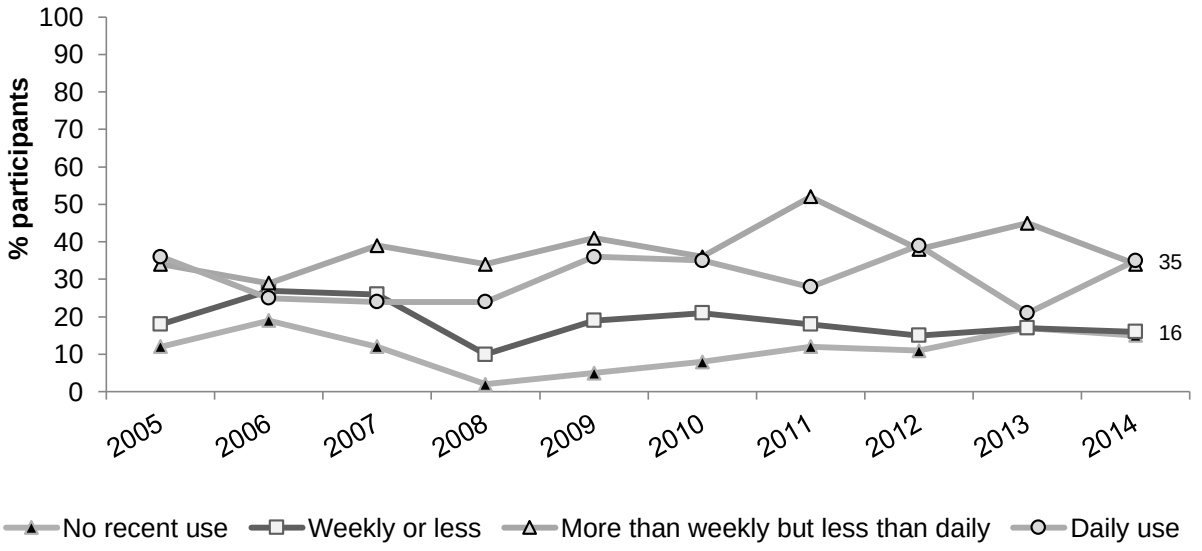
Figure 7: Median days of heroin use in the past six months, 2004−2014



Source: IDRS PWID interviews

In 2014, just over one-third (35%) of those who had used heroin reported daily use. This is a statistically significant increase ($p < 0.05$) from 21% of participants who reported daily heroin use in 2013 (Figure 8). A similar portion of participants (34%) reported more than weekly, but less than daily use, which was a decrease from 2013 (45%) (Figure 8). Sixteen percent reported using weekly or less and just over one-half (51%) of those that had used heroin reported use on the day prior (36% in 2013).

Figure 8: Patterns of heroin use, 2005−2014



Source: IDRS PWID interviews

4.2.3 Forms of heroin used

As in previous years, participants were asked about the forms of heroin they had used over the preceding six months. Seventy-nine percent of participants who had reported recent use of heroin described it as white/off-white 'powder' or 'rock' (84% in 2013) and 69% reported recent use of heroin described as brown/beige 'powder' or 'rock' (63% in 2013). The form most used (over the preceding six months) among those who could comment was white/off-white 'powder' (36%; 39% in 2013), followed by white/off-white 'rock' (27%; 26% in 2013). The use of brown 'rock' remained stable (19%; 19% in 2013) while there was a slight increase in the use of brown 'powder' (16%; 14% in 2013).

4.2.4 Heroin forms and preparation

Traditionally, Australia's heroin has originated from the Golden Triangle (Myanmar, Laos PDR and Thailand) (Ciccarone, 2009; UNODC, 2009) and 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 quite refined and water soluble. In contrast, heroin produced in the Golden Crescent region (Afghanistan and Pakistan) is rarely seen in Australia (Ciccarone, 2009), and is usually brown in colour and less refined. Typically brown heroin is alkaline and, therefore, requires heating and often citric or ascorbic acid to make it water soluble for injection. It is also considered more amenable to smoking as a route of administration.

More recently it has been demonstrated that heroin colour is not a reliable determinant of geographic origin (Zerell, Ahrens, & Gerz, 2005). Therefore, while the following information provides an indication of the appearance of heroin used by participants of the IDRS, it is not possible to draw conclusions about its geographic origin, purity or the preparation method required for its injection based on these data alone. Further research into this area is required before firmer conclusions can be drawn.

Brown heroin was first identified in NSW in 2006. Participants in the IDRS first commented on the presence of brown heroin in the same year. In 2007, the issue was investigated by asking participants to describe the colour forms of heroin they had used over the last six months, in addition to the 'form most used'.

Again in 2014, participants were asked if they had used heat and/or citric/ascorbic/acetic acid to prepare heroin for injection on the last occasion of injection. Twenty-five percent reported using heat on the last occasion, a significant decrease ($p<0.05$) from 49% in 2013, while 7% reported using any form of citric/ascorbic/acetic acid.

Participants were also asked to identify the colour of the heroin on the last occasion of injection where heat and/or citric/ascorbic/acetic acid had been used in preparation. Of those who reported using heat or acid on the last occasion, the majority (63%) of respondents described the colour of heroin as brown/beige (72%; in 2013) and 22% described it as white/off-white in colour.

4.2.4.1 Homebake

The median number of days of homebake use in the preceding six months was 5 (i.e. approximately monthly use, range 1-90 days) and remained stable from the 5 days reported in 2013. The median number of days on which it had been injected by users in this time was 5 and was consistent with the 5 days (range 1-90 days) reported in 2013.

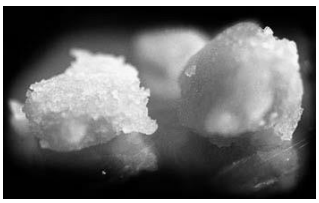
4.3 Methamphetamine

In response to the increasing diversification of the methamphetamine markets in Australia identified by the 2001 IDRS (Topp, Degenhardt, Kaye, & Darke, 2002), data were collected for three different forms of methamphetamine: methamphetamine powder (referred to here as 'speed' or 'speed powder'); methamphetamine base ('base'); and crystal methamphetamine ('ice' or 'crystal'). 'Speed' is also a generic term for methamphetamine; however, here it refers only to the powder form. It is typically a fine-grained powder, generally white or off-white in colour, but may range from white through to beige or pink due to differences in the chemicals used to produce it. Base (which can also be known as 'pure', 'wax' or 'point') is the paste methamphetamine that is 'moist', 'oily' or 'waxy' and is often brownish in colour. It can be difficult to dissolve for injection due to its oily consistency. Ice/crystal comes in crystalline form, in either translucent or white crystals (sometimes with a pink, green or blue hue) that vary in size. A fourth form, liquid amphetamine or 'oxblood', has also been identified, and is typically red/brown in colour. However, as it is used infrequently, PWID are not surveyed regarding its price, purity or availability. Previous research indicated that participants were able to differentiate between these forms when surveyed (Breen et al., 2004; Roxburgh, Breen, & Degenhardt, 2004), and clarification was made with participants that they and the interviewer were referring to the same forms of methamphetamine.

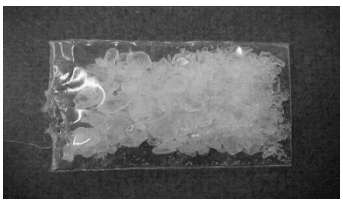
Photographs most commonly identified by PWID participants as being of speed powder, base and ice, NSW

Speed powder

Base



Ice



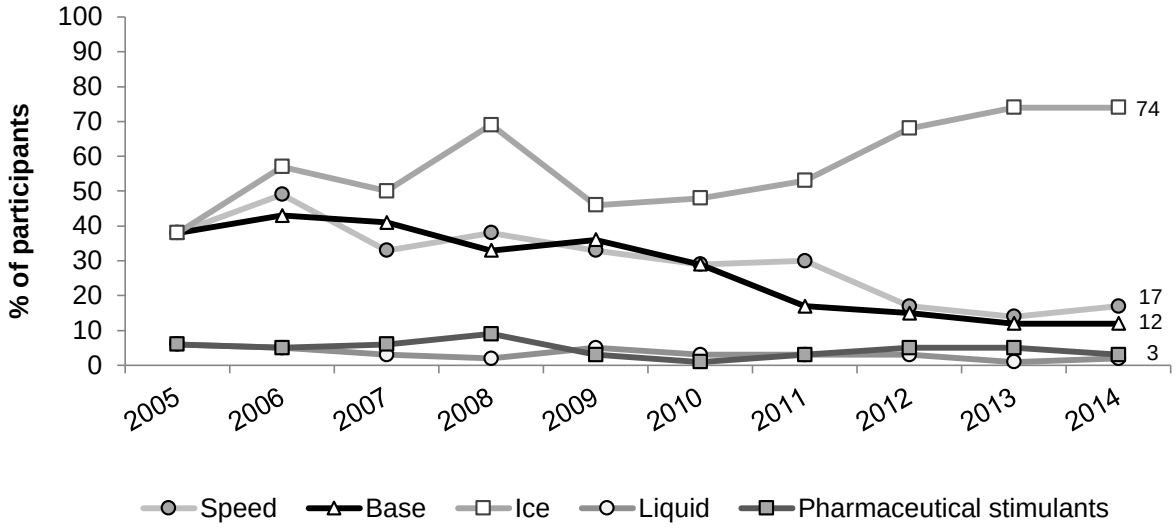
NB: For further information specific to the Sydney methamphetamine market, including supply, use patterns and harms, see McKetin, McLaren, & Kelly (2005)

4.3.1 Methamphetamine use among PWID participants

The proportion (75%) reporting the use of any form of methamphetamine (speed, base, ice/crystal or liquid) in the six months preceding interview remained stable in 2014 (75% in 2013). Considered separately, the most commonly used form was ice/crystal (74%; 74% in 2013), followed by speed (17%; 14% in 2013) and then base (12%; 12% in 2013). Liquid amphetamine (also known as 'oxblood') remained considerably less common, with 2% (1% in 2013) of participants reporting use in the last six months (Figure 9). These figures are consistent with usage patterns across all forms of methamphetamine reported in 2013, with the exception of the slight decreases in the use of speed and liquid amphetamine.

Again in 2014, a distinction was made between the licit versus illicit use of pharmaceutical stimulants (including prescription amphetamines). Only two participants reported use of prescribed pharmaceutical stimulants in the six months preceding interview; while the use of non-prescribed pharmaceutical stimulants continued to remain low in 2014, with only 2% (4% in 2013) of participants reporting recent use. The recent use of any pharmaceutical stimulants by this group has remained at less than 10% since 2005 (Figure 9).

Figure 9: Proportion of PWID reporting methamphetamine and pharmaceutical stimulant use in the past six months, 2005−2014



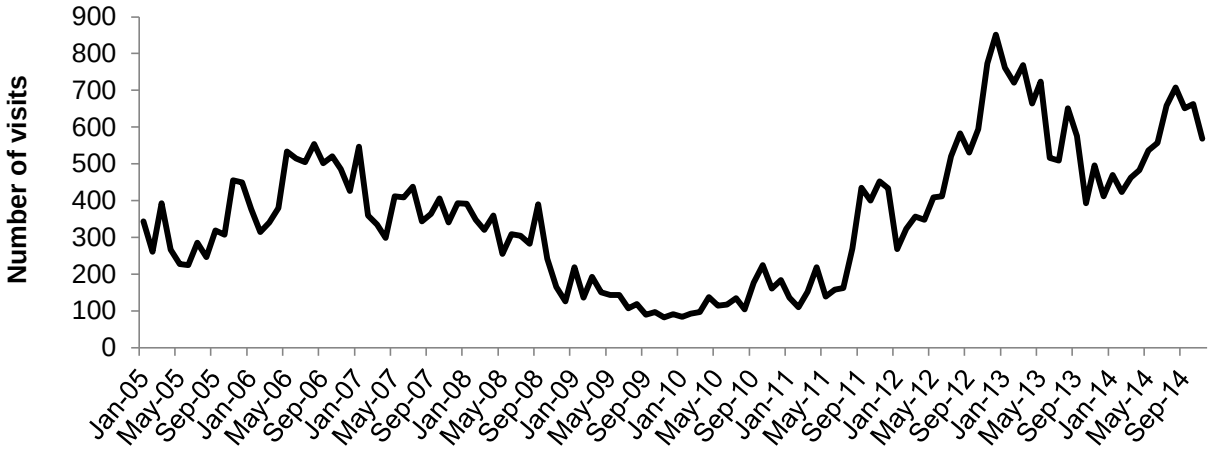
Source: IDRS PWID interviews

NB: Pharmaceutical stimulants also include prescribed use

Figure 10 shows the number of attendances to the Sydney Medically Supervised Injecting Centre (MSIC) where methamphetamine was the drug injected.[6] Numbers reporting methamphetamine have steadily increased over the past few years from 176 in September 2010 to 852 in December 2012. This continued in 2014 following a period of decline in 2013 (lowest 393 in October). Attendances peaked in August at 708, representing approximately 17% of all injecting episodes.

[6] The following caveats need to be considered when interpreting these data: 1) hours of operation changed over the first two years of operation (from four to up to 12 per day); and 2) the numbers of individuals attending increased continuously over the first two years of operation as PWID became aware of this new service.

Figure 10: Number of attendances to Sydney MSIC where methamphetamine was injected, January 2005−November 2014



Source: Sydney MSIC, Kings Cross

4.3.2 Current patterns of methamphetamine use

The proportion (75%; 75% in 2013) of participants reporting any recent methamphetamine use (speed, base, ice/crystal) remained stable in 2014. Among those reporting any recent use (speed, base, ice, liquid) the median number of days of use was 39 days, representing a statistically significant increase from the 18 days reported by participants in 2013. The majority of those who had used methamphetamine had used each form weekly or less over the six months preceding interview, followed by more than weekly, but less than daily (Table 5 and Figure 11).

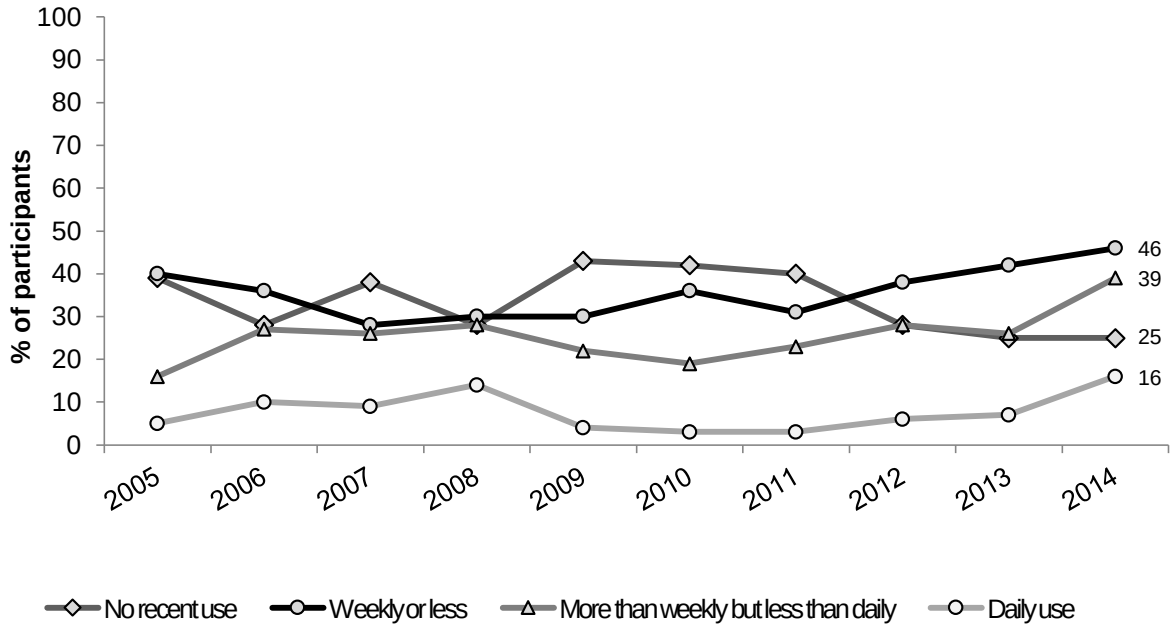
The use of any pharmaceutical stimulants (prescribed and non-prescribed) continues to remain very low (3%; 5% in 2013) among this sample of PWID, and changes in patterns of use should be interpreted with caution. The median number of days of any recent pharmaceutical stimulant use increased from 6 days to 96 (approximately every second day). It should be noted that two of the four participants who were able to respond were daily users. Illicitly obtained pharmaceutical stimulants were used on a median of 12 days in the past 6 months (6 days in 2013). Only 1% of participants (1% in 2013) had recently used pharmaceutical stimulants that were prescribed to them.

Table 5: Patterns of methamphetamine use in the last six months, by type, 2014

Form used	Among the entire sample		Among those who had used		
	% who had *not* used in the last 6 months	% who had used	% used weekly or less^	% used more than weekly, but less than daily	% used daily
Speed powder	83 [86]	17 [14]	76 [71]	16 [14]	8 [2]
Base	88 [88]	12 [12]	78 [89]	11 [11]	11 [0]
Ice/crystal	26 [27]	74 [73]	49 [58]	35 [34]	16 [8]
Any form of methamphetamine*	25 [25]	75 [75]	46 [42]	39 [26]	16 [7]

Source: IDRS PWID interviews
* Also includes liquid methamphetamine
^ Excludes those who had not used
[ ] Indicates % used in previous year

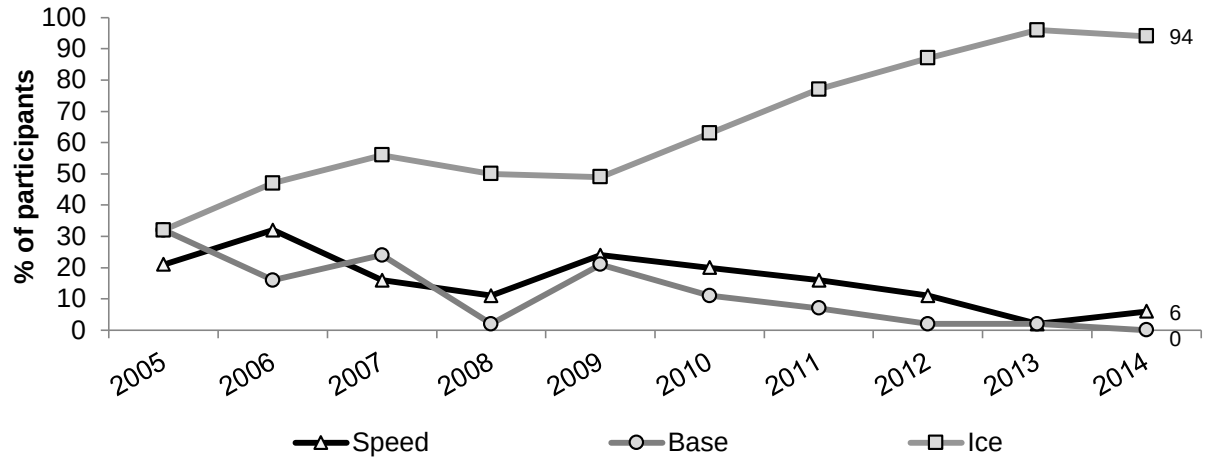
Figure 11: Patterns of methamphetamine use (any form) among those who had used, 2005−2014



Source: IDRS PWID interviews

As in previous years, participants who had used methamphetamine were also asked which form they had used most often in the six months preceding interview. Ninety-four percent of recent users (70% of entire sample) nominated ice/crystal (96% in 2013), 6% nominated speed powder (2% in 2013) and no participants nominated base (2% in 2013) (Figure 12).

Figure 12: Methamphetamine form most used in the preceding six months, among recent methamphetamine users, 2005−2014



Source: IDRS PWID interviews

NB: Data collection on the form most used commenced in 2001. Pharmaceutical stimulants included in figures in 2005; excluded in data from 2006−2012

4.4 Cocaine

As stated previously, and comparable to previous years, it was difficult to find cocaine KE this year. This suggested that cocaine use was not typically widespread among PWID outside the main drug market areas in which the IDRS survey was conducted. It also suggested there may be hidden groups of users who were not coming to the attention of health services and/or law enforcement agencies in relation to their cocaine use. For more information on cocaine markets in Sydney, see Shearer et al., 2007 and Shearer et al., 2005).

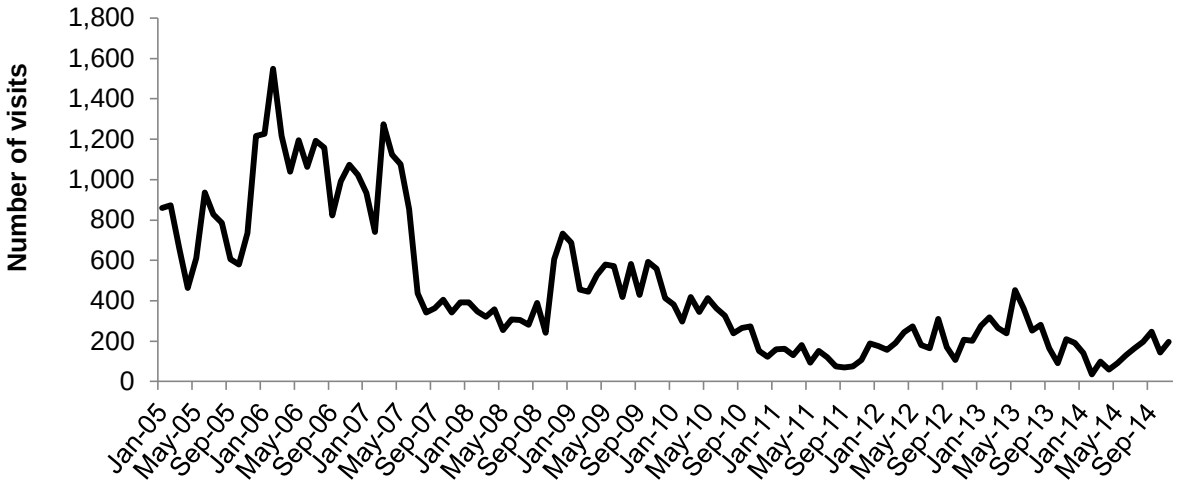
4.4.1 Cocaine use among PWID participants

In 2014, thirty-two percent of PWID participants reported cocaine use in the preceding six months, representing a statistically significant decrease ($p > 0.05$) on numbers reported in 2013 (41%). Only 5 percent (5% in 2013) of the sample reported use of cocaine on the day prior to interview. Two percent reported cocaine as the drug last injected (7% in 2013).

Figure 13 shows the number of attendances to the Sydney MSIC where cocaine was the drug injected.[7] There have been several marked peaks in these attendances during the past 12 years: December 2001 (2,010 attendances), February 2006 (1,549) and March 2007 (1,273). Since late 2011, despite some fluctuations, cocaine injecting at the MSIC has remained relatively low to April 2014, after which, there has been a slight increase. For the majority of this period, these attendances have accounted for less than 5% of the total of injecting episodes.

[7] The following caveats need to be considered when interpreting these data: 1) hours of operation changed over the first two years of operation (from four to up to 12 per day); and 2) the numbers of individuals attending increased continuously over the first two years of operation as PWID became aware of this new service.

Figure 13: Number of attendances to Sydney MSIC where cocaine was injected, January 2005−November 2014

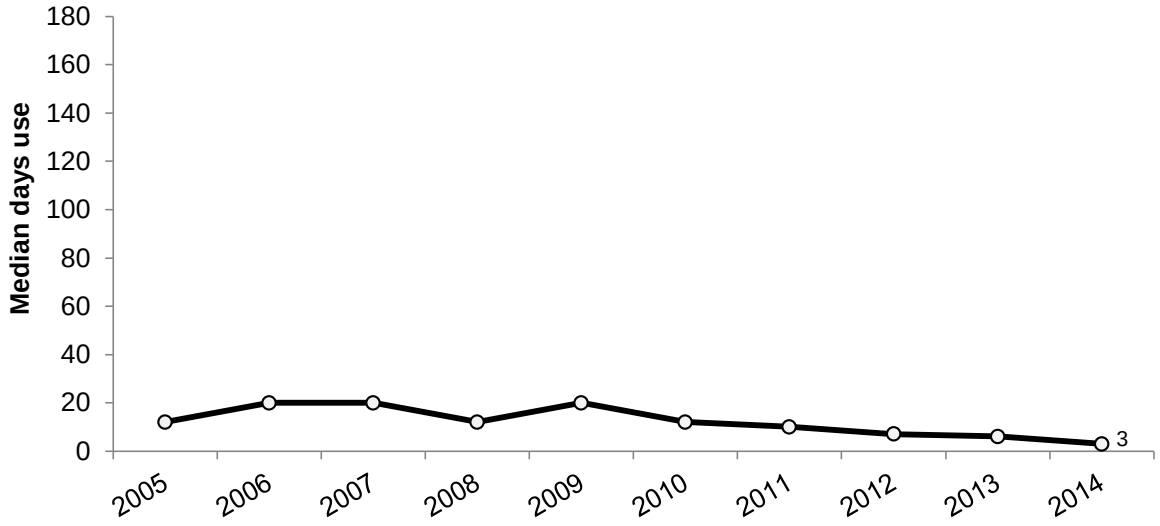


Source: Sydney MSIC, Kings Cross

4.4.2 Current patterns of cocaine use

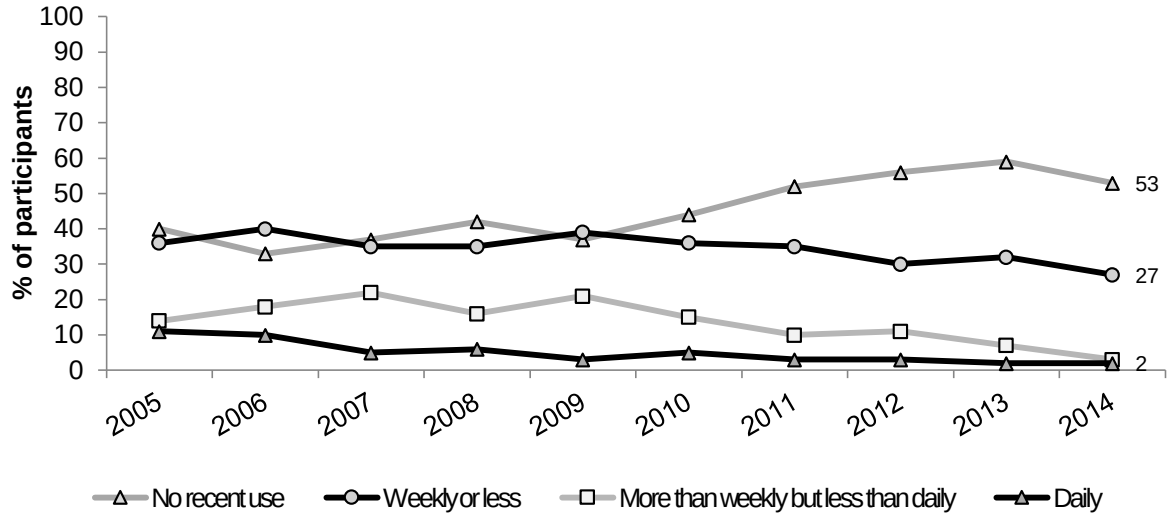
Frequency of cocaine use among PWID participants in the last six months decreased slightly in 2014. Cocaine was used on a median of 3 days (bi-monthly) in 2014 (6 days in 2013) (Figure 14). Daily cocaine use remained stable with 6% (5% in 2013) of recent users (2% of all participants) reporting daily use (Figure 15).

Figure 14: Median days of cocaine use in the past six months, 2005−2014



Source: IDRS PWID interviews

Figure 15: Patterns of cocaine use, 2005−2014



Source: IDRS PWID interviews

Participants were also asked which form of cocaine they had used most often over the last six months. Seventy-five percent of participants who had recently used cocaine reported that powder was the form they had used most often in the last six months, which is stable from 2013 (74%). Fifty percent of recent users reported rock cocaine as the form most used (23% in 2013), and there were only two participants reporting using crack cocaine (4%) as the form most used. No participants reported having used any crack cocaine in the six months preceding interview (7% in 2013) and, furthermore, no KE reported hearing about the use of crack cocaine, indicating that, similar to previous years, its use remained rare.

4.5 Cannabis

The IDRS has differentiated between hydro and bush prices since 2003, and since 2004 it has also differentiated between potency and availability of the two main forms used in Australia. Information on hashish (hash) and hash oil prices are collected but, as its use remained sporadic, information about potency and availability are not sought from PWID participants. Since 2007, participants have been asked whether they were able to distinguish between hydro and bush cannabis forms.

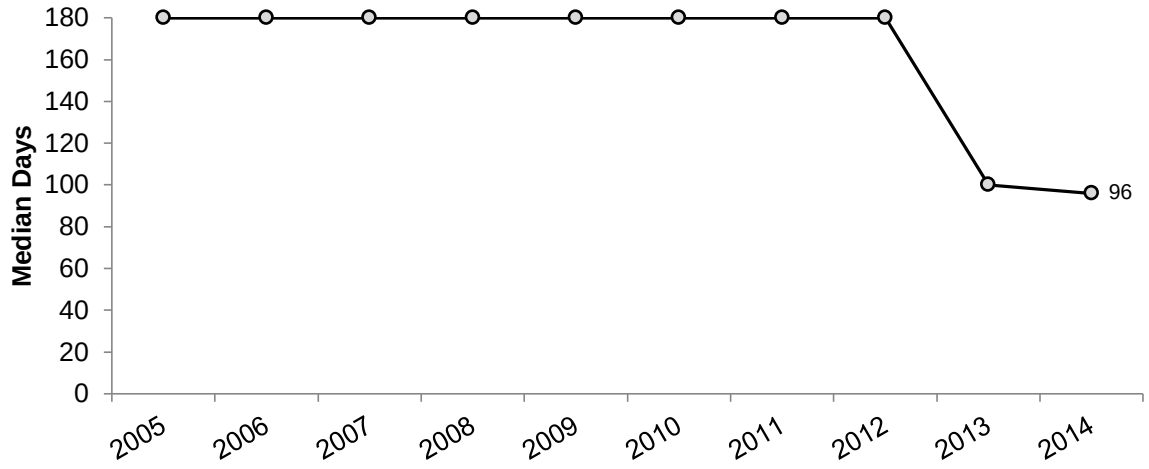
4.5.1 Cannabis use among PWID participants

Recent use of cannabis continued to remain high among participants in 2014. Seventy-seven percent of participants reported recent use of cannabis (80% in 2013 and 72% in 2012) and the proportion reporting cannabis use on the day prior to interview remained stable in 2014, at 47% (42% in 2013).

4.5.2 Current patterns of cannabis use

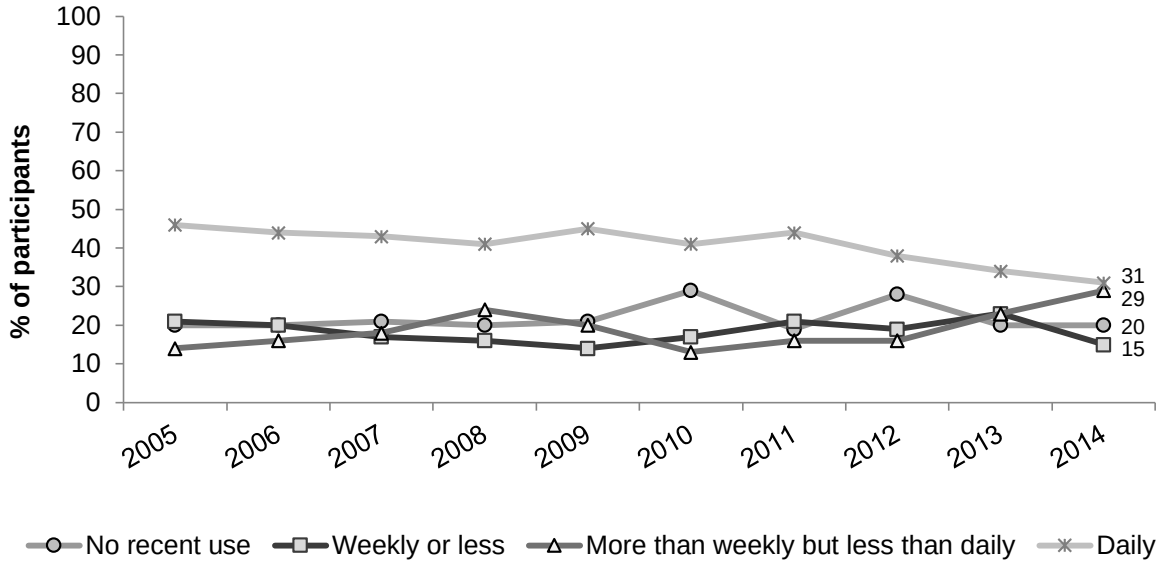
Among those who had used, the median number of days of cannabis use was 96 days in the preceding six months (100 days in 2013). Prior to 2013, the median days of cannabis use was 180 days; a figure which had previously been stable for the past 10 years (Figure 16). The proportion of recent consumers of cannabis reporting daily use of cannabis remained stable in 2014 (41%; 42% in 2013). Participants who had smoked cannabis in the last six months were also asked about the quantity used and methods of cannabis use on the last occasion.

Figure 16: Median number of days of cannabis use among those who had used cannabis in the past six months, 2005−2014



Source: IDRS PWID interviews

Figure 17: Patterns of cannabis use, 2005−2014



Source: IDRS PWID interviews

Ninety-seven percent of respondents who had used cannabis reported using hydro in the preceding six months (92% in 2013), and 43% of cannabis users reported using bush during this time (39% in 2013). Eleven percent of recent cannabis users reported use of hashish (7% in 2013) and 4% of participants (3% in 2013) had used hash oil. When asked which form of cannabis they had 'used most often' in the last six months, the vast majority (95%) of recent users reported hydro, 5% reported bush and one participants reported hash oil. These rates remain stable with 2013.

4.6 Pharmaceutical opioids

The IDRS monitors the extra-medical use (non-prescribed and/or not 'as directed' by a doctor) patterns and market characteristics of opioid pharmaceutical medications including both those prescribed for opioid substitution treatment (OST) (i.e. methadone, buprenorphine, buprenorphine-naloxone), and those prescribed for pain relief (i.e. morphine and oxycodone), as these have been associated with a range of public health concerns, including toxicity, mortality, and, where injected, injection-related problems such as vein damage and infections (O'Brien, et al., 2006). With regard to OST, it is imperative to consider that screening of participants ensured that those sampled had all been active in the illicit drug markets of the area, and thus were able to provide meaningful data on market indicators.

While just under half (47%) of those sampled in 2014 were engaged in OST at the time of interview, responses presented are not representative of all clients engaged in drug treatment services.

Below in Table 6 are the definitions used when discussing opioids use.

Table 6: Definitions used when discussing opioid use

Pharmaceutical opioids (including OST)
Use of these substances is broadly split into the following categories (Black et al., 2008). 1. Use of licitly obtained opioids, i.e. use of opioids obtained by a prescription in the user's name, through any route of administration. 2. Use of illicitly obtained opioids, i.e. those obtained from a prescription in someone else's name, through any route of administration ('illicit use'). 3. Use of any opioids, i.e. does not distinguish between licit and illicit methods of obtainment. **Injection** 1. Injection of licitly obtained opioids. 2. Injection of illicitly obtained opioids. 3. Injection of any opioids.

NB: See Glossary for further details of terms. For information on data covering the use of licitly obtained methadone, buprenorphine and buprenorphine-naloxone and data on OST, please see section 6.3 'Drug treatment'.

4.6.1 Methadone

Methadone is prescribed for the treatment of opioid dependence. It is usually prescribed as a syrup preparation, and is often dosed under supervised conditions. Take-away doses are available for some patients depending on various state/territory regulations. Physeptone tablets are less common in Australia and are usually prescribed for people in methadone treatment who are travelling, or in a minority of cases, where the methadone syrup is not tolerated. As mentioned previously, illicit use of methadone and Physeptone was defined as the use of medication not obtained with a prescription in the participant's name. The participant may have bought the medication on the street or obtained it from a friend or acquaintance. See also section 6.3 'Drug treatment' for information on the use of prescribed methadone.

As in previous years, detailed data were collected in 2014 regarding the purchase, frequency of use and injection of illicit methadone syrup and Physeptone tablets. This was to provide further clarification regarding the use of methadone prescribed for treatment and the diversion of prescribed methadone. Information on prescribed (licit) methadone may be found in section 6.3.

Just over one-quarter (27%) of all participants reported using non-prescribed methadone in the six months preceding interview (28% in 2013). The frequency of use among recent users was a median of 7 days (5 days in 2013). In 2014, participants were asked, 'What were the main reasons you used illicit methadone in the last 6 months?' Of those that could comment, 36% reported that it was used 'as a substitute for heroin', 16% reported that it was due to 'intoxication', and 14% reported 'self-treatment.'

Twenty-two percent of participants reported injecting illicitly obtained methadone in the preceding six months on a median of 7 days which was comparable to 2013 (22%; median 5 days). Twenty-seven percent of all participants reported injection of any form of methadone (i.e. syrup or Physeptone tablets; prescribed or non-prescribed) on a median of 16 days (6 days in 2013).

Non-prescribed methadone liquid was the form of methadone used most by 27% of those who reported methadone use. Use of non-prescribed Physeptone remained uncommon, with only 3% of participants reporting use in the preceding six months (2% in 2013) and only 3% reported injecting Physeptone in the 6 months prior to interview.

4.6.2 Buprenorphine

Twenty-two percent of all participants (22% in 2013) reported the use of non-prescribed buprenorphine in the preceding six months. In 2014, frequency of use, increased slightly occurring on a median of six days (two in 2013). Those reporting non-prescribed buprenorphine injection increased slightly (16%; 9% in 2013) on a median of 6 days, a decrease on the ten days reported in 2013.

Seventeen percent of participants reported injecting any form of buprenorphine (excluding buprenorphine-naloxone) in the preceding six months (9% in 2013) on a median of 6 days (15 days in 2013). No participants reported any injection-related problem ('dirty hit') or overdose associated with buprenorphine. The prevalence of buprenorphine injection increased when compared with 2013 but the median days of use decreased.

4.6.3 Buprenorphine-naloxone (Suboxone)

Questions on buprenorphine-naloxone (Suboxone) have been included in the PWID survey since 2006 when it was first listed on the Pharmaceutical Benefits Scheme in tablet form. In 2011, the buprenorphine-naloxone 'film' became available (Therapeutic Goods Administration, March 2011).

Of the NSW sample, 7% reported recently using any form of buprenorphine-naloxone 'tablet' (licit use 2% and illicit use 5%) on a median of 25 days (4 days in 2013), while 22% of the sample reported recently using any form of buprenorphine-naloxone 'film' (licit use 9% and illicit use 15%) on a median of 20 days (33 days in 2013) in the last six months. Injecting either the buprenorphine-naloxone 'tablet' or 'film' was low (4% tablet and 7% film).

4.6.4 Morphine

It should be noted that, in some cases, 'morphine' appears to be a generic term used by people who use or inject drugs to refer to opioid pills, a finding reported by KE and also reflected in PWID participant interviews, with some interviewers reporting initial participant confusion between drugs such as MS Contin (morphine) and OxyContin (oxycodone). However, in the majority of cases it was confirmed that participants were correctly referring to morphine rather than oxycodone.

In January 2006, changes were made to the legislation governing the prescription of morphine and a number of other opioids such as oxycodone (Pharmaceutical Services Branch, NSW Health, personal communication, January 2007). Previously, doctors could prescribe such drugs for up to two months, after which time they were required to obtain an authority to continue. Following the amendment, the two month requirement was removed with the exception of people determined to be drug dependent[8] where the requirement still remained.

4.6.4.1 Use patterns

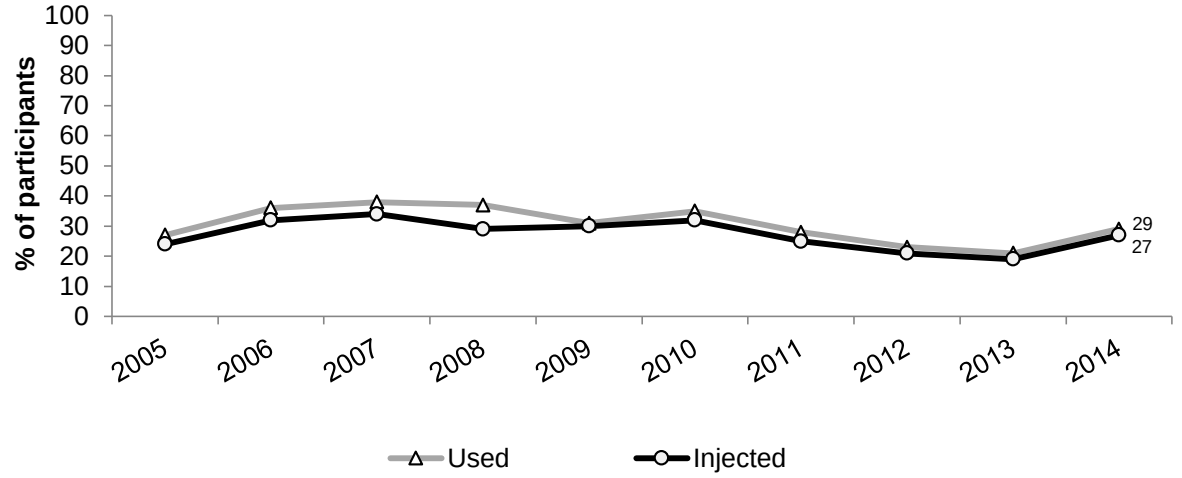
Since 2006, a distinction has been drawn between the use of morphine obtained via prescription and the use of non-prescribed morphine (Table 4). Twenty-five percent (19% in 2013) reported use of non-prescribed morphine on a median of 22 days (6 days in 2013). One-quarter (25%) of participants reported the recent injection of non-prescribed morphine on a median of 24 days (18% on a median of 6 days in 2013). In 2014, participants were asked 'What were your main motivations for non-prescribed morphine use?' Sixty-four percent of recent users reported 'a substitution for heroin', 22% reported 'self-treatment', and 17% reported 'intoxication'.

The use of prescribed morphine was noticeably less prevalent (6% had recently used it; 4% had injected it in the same period) which remained comparable with 2013 (3% recently used; 3% recently injected). Frequency of use was stable at a median of 5 days in the last six months (6 days in 2013). Frequency of injection was also reported on a median of 3 days in the six months preceding interview (6 days in 2013).

To enable comparison with previous years, the following information refers to 'any' form of morphine, i.e. no distinction has been made between prescribed and non-prescribed morphine. In 2014, approximately 29%; 21% in 2013) of participants reported using any morphine in the preceding six months on a median of 19 days (6 days in 2013). In terms of injection 27% (19% in 2013) reported injection of any morphine on a median of 14 days (6 days in 2013) in this time (Figure 18).

[8] 'Drug dependent' is defined as 'a person who has acquired, as a result of repeated administration: (a) a drug of addiction, or (b) a prohibited drug within the meaning of the *Drug Misuse and Trafficking Act 1985,* an overpowering desire for the continued administration of such a drug'. See the *Poisons and Therapeutic Goods Act 1966 No 31* for details.

Figure 18: Proportion of PWID reporting morphine use and injection in the past six months 2005−2014



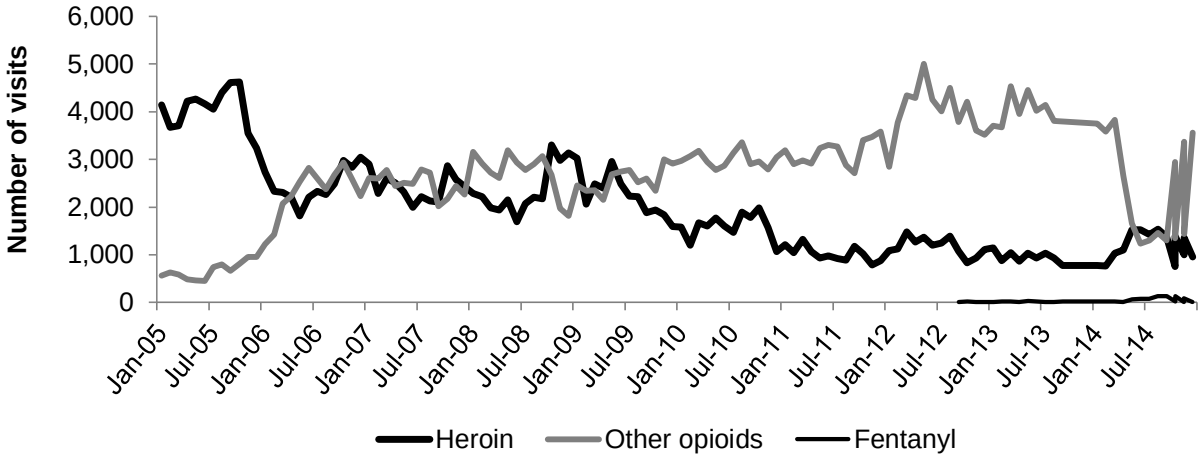
Source: IDRS PWID interviews

NB: Prior to 2001, morphine was included under 'other opioids'

Two percent of recent users reported daily morphine use, with the majority (56%; 16% of entire sample) reporting using weekly or less often. No participants reported experiencing problems that they attributed to morphine injection in the past month, either in the form of a 'dirty hit' or an overdose.

The number of visits to Sydney MSIC where other opioids, including morphine and oxycodone, were injected is presented in Figure 19. The number of attendances where other opioids were injected has been increasing since 2004 and peaked in May 2012 (5006 injections). After a sharp decline to 'other opioids' in February 2014, heroin injection briefly exceed this trend for the first time since May 2009. Other opioids injections have again surpassed heroin with a sharp, erratic increase and account for the greatest proportion of total injections at the MSIC.

Figure 19: Number of attendances to Sydney MSIC where other opioids (including morphine)* and heroin were injected, January 2005−November 2014

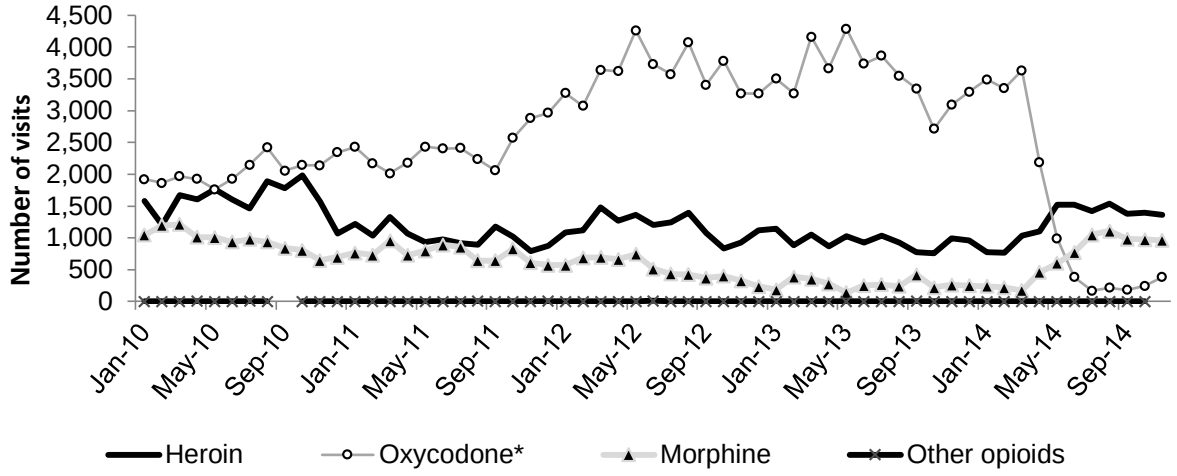


Source: Sydney MSIC, Kings Cross

* Excludes heroin, methadone, buprenorphrine, buperenorphine-naloxone and includes morphine and oxycodone

In March 2014, oxycodone injection decreased sharply and heroin became the most prevalent opioid injected at the Sydney MSIC for the first time since November 2009. Morphine injection also exceeded oxycodone injection in June of the same year. Both heroin and morphine injection increased at the same point before plateauing out in June (Figure 20). Please note: the reformulation to Oxycontin occurred on April 1, 2014, which may explain the sharp decrease in the number of oxycodone injecting episodes and increase in heroin and morphine.

Figure 20: Number of attendances to Sydney MSIC where morphine, oxycodone and other opioids were injected, January 2010−November 2014



Source: Sydney MSIC, Kings Cross
*Oxycontin Purdue (OP) are included in oxycodone totals

4.6.6 Oxycodone

For information on the reformulation of Oxycontin® (oxycodone) that became effective from April 1, 2014, please see section 5.8 ‘Oxycodone’.

4.6.6.1 Use patterns

This was the seventh year in which a distinction was made between prescribed and non-prescribed oxycodone (e.g. OxyContin, Endone) and other opioids, due to concerns that the use of non-prescribed, and problems associated with diversion of oxycodone, may be increasing. In previous years, oxycodone was included under ‘other opioids’.

Seventy-five percent of all participants reported having used oxycodone (whether obtained via prescription or other methods) at some stage in their lifetime, and 35% reported having ever injected it (Table 4). Forty-four percent of all participants reported using any (prescribed or non-prescribed) oxycodone in the six months preceding interview on a median of twenty days (around weekly use). The recent injection of any oxycodone remained stable in 2014 (39% compared with 37% in 2013).

With regard to non-prescribed oxycodone use, 40% (40% in 2013) of participants reported use in the preceding six months, on a median of 20 days (23 days in 2013). Two percent (1% of entire sample) of participants reporting recent illicit use were daily users (180 days). Sixty percent (24% of entire sample) of people reporting use in the last 6 months were using weekly or less often. Injection of non-prescribed oxycodone in the last six months was reported by 37% of the sample on a median of 20 days (36% on a median of 30 days in 2013). Overall, these figures suggest that the frequency of non-prescribed oxycodone use has remained stable in 2014. This finding is consistent with many key expert testimonials who explain that oxycodone use, and especially injection, remains common in Sydney.

In response to the question 'What were your main motivations for non-prescribed oxycodone use?', 49% reported substitution for heroin and/or other opioids, 20% of recent users reported intoxication and 16% reported self-treatment as the main motivation.

With regard to prescribed oxycodone, 9% of participants reported use in the preceding six months, on a median of 21 days (9%; 31 days in 2013). Injection of prescribed oxycodone in the last six months was reported by 6% of the sample on a median of 20 days (7%; 31 days in 2013). These reports suggested that use of prescribed oxycodone had remained stable, while the frequency of injection had decreased.

Of those reporting any recent oxycodone use, the vast majority (86%; 86% in 2013) mostly used non-prescribed oxycodone rather than prescribed oxycodone. The most common brand used among those who recently used oxycodone was OxyContin (93%, 40% of entire sample). There were only two participants reporting use of Endone and one participant reporting OxyNorm as the brand most commonly used.

4.6.7 Fentanyl

In 2014, 25% of the NSW sample reported using fentanyl in their lifetime (15%in 2013). Fifteen percent reported using fentanyl on a median of 2 days in the last six months (9%; median 6 days in 2013). Fentanyl was injected by 15% of the sample on a median of 2 days in the last six months. Among those who recently used fentanyl the form most used was illicit (91%; 9% licit).

4.7 Over the counter codeine

Again in 2014, the IDRS survey included questions on the use of over the counter (OTC) codeine. Forty percent of all participants reported that they had ever used OTC codeine. Twenty-two percent of all participants reported that they had used OTC codeine in the six months prior to interview on a median of 12 days (13%; median 24 days in 2013). Only two participants reported a recent OTC codeine injection. The brands most commonly reported as being used were Nurofen Plus (35%), Panadeine (24%) and chemists own brand (10%).

4.8 Other opioids

Over one-half (55%) of all participants reported that they had ever used opioids other than those listed above at least once in their lifetime, and 2% had ever injected them. In the six months prior to interview, 24% of participants reported the use of other opioids on a median of 5 days. Comparisons with data prior to 2009 should be interpreted with caution as OTC codeine was not included in its own section until 2009; rather, it was under the category of other opioids. It should be also noted that 'other opioids' does not include homebake.

4.9 Other drugs

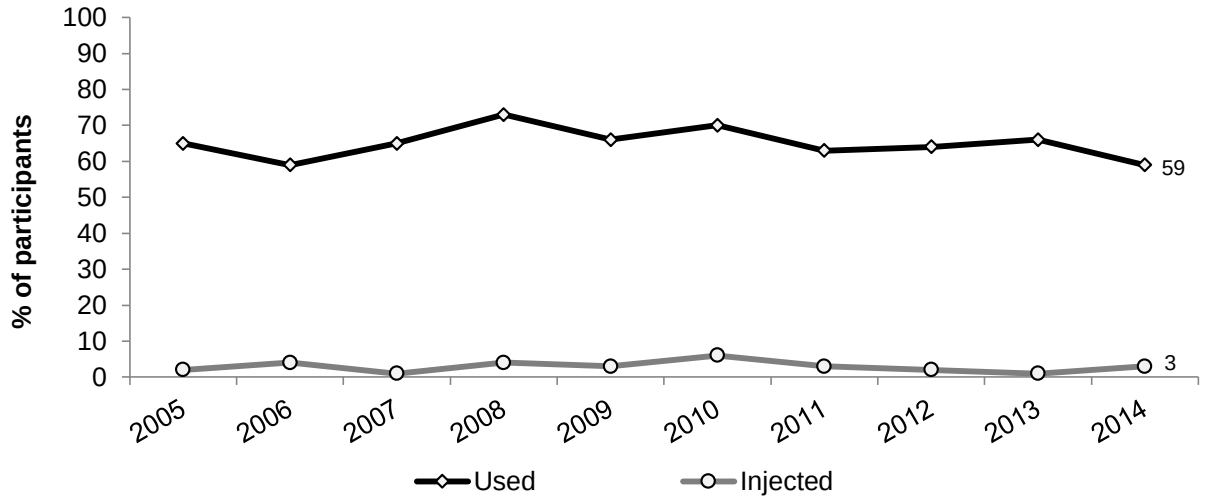
4.9.1 Benzodiazepines

Eighty-three percent of the NSW sample had reported the use of any benzodiazepines at some stage in their lifetime. Fifty-nine percent (66% in 2013) reported the recent use of any benzodiazepines on a median of 28 days in the last six months (30 days in 2013) (Table 4). Among those who recently used any benzodiazepines, 11% reported using them daily in the last six months.

Only small numbers reported recently injecting any benzodiazepines (3%) on a median of 2 days in the last six months (Figure 21 and Figure 22).

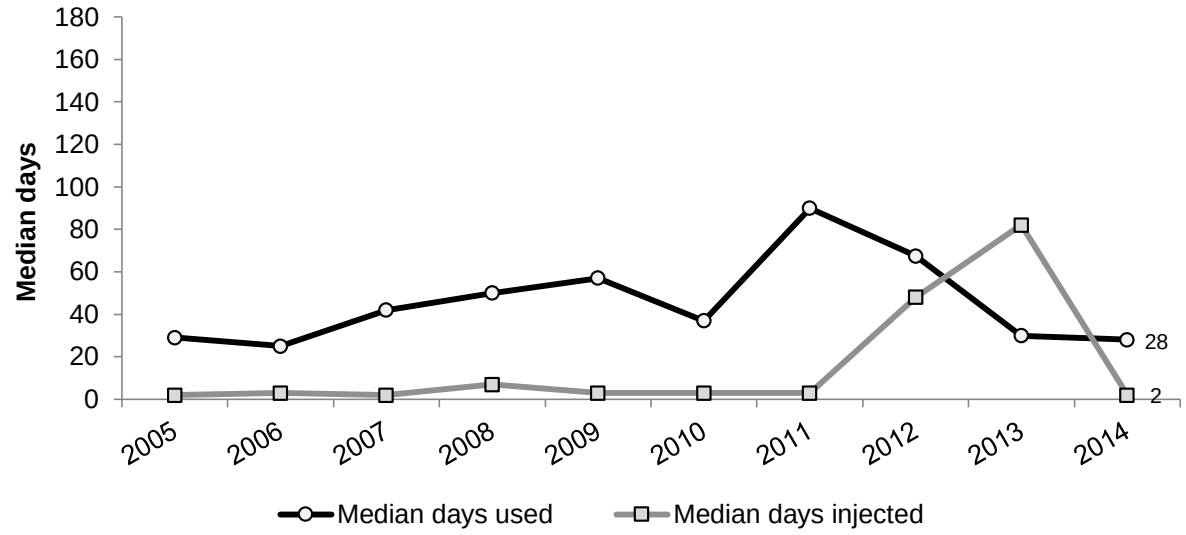
Since 2012 participants have been asked separately about the use of alprazolam and other benzodiazepines use (see section 4.9.1.1).

Figure 21: Proportion of PWID participants reporting (prescribed and non-prescribed) benzodiazepine use and injection in the preceding six months, 2005−2014



Source: IDRS PWID interviews

Figure 22: Median days use and injection of (prescribed and non-prescribed) benzodiazepines in the past six months, 2005−2014



Source: IDRS PWID interviews
NB: Collection of data on the number of days injected commenced in 2003. The median days used in 2011 should be interpreted with caution as a number of changes were made to the questionnaire which might explain the increase

4.9.1.1 Alprazolam

Sixty-five percent of the NSW sample reported using some form of alprazolam in their lifetime (16% licit and 63% illicit). Thirty-nine percent reported using any form of alprazolam in the past 6 months. Six percent had recently used 'licit' alprazolam on a median of 30 days (60 days in 2013) while 37% had recently used 'illicit' alprazolam on a median of 12 days (Table 7).

Smaller proportions of participants reported injecting alprazolam at some stage in their life (3% licit, 7% illicit), with 2% injecting any form of alprazolam in the last six months (Table 4).

Table 7: Alprazolam use patterns, 2014

	NSW (N=150)
Recent use (%)	
Licit	6
Illicit	37
Any form (licit and/or illicit)	39
Median days used *	
Licit	30
Illicit	12

Source: IDRS PWID interviews

* Among those who reported recent use or injection. Maximum number of days, i.e. daily use = 180

4.9.1.2 Other benzodiazepines

Seventy-five percent of the NSW sample had used any form of other benzodiazepines not including alprazolam in their lifetime (Table 4) (52% licit and 56% illicit). Half of the participants (51%) recently used any form of other benzodiazepines (Table 8). Twenty-eight percent of the NSW sample reported having used 'licitly' obtained other benzodiazepines on a median of 53 days in the last six months, whereas 38% percent reported using 'illicitly' obtained other benzodiazepines on a median of 7 days in the six months preceding interview (Table 8). One percent of those who could comment reported recently injecting other benzodiazepines (any form – excludes alprazolam) in the last six months.

Table 8: Other benzodiazepine (excludes alprazolam) use patterns, 2014

	NSW (N=150)
Recent use (%)	
Licit	28
Illicit	38
Any form (licit and/or illicit)	51
Median days used *	
Licit	53
Illicit	7

Source: IDRS participant interviews

* Among those who reported recent use or injection. Maximum number of days, i.e. daily use = 180

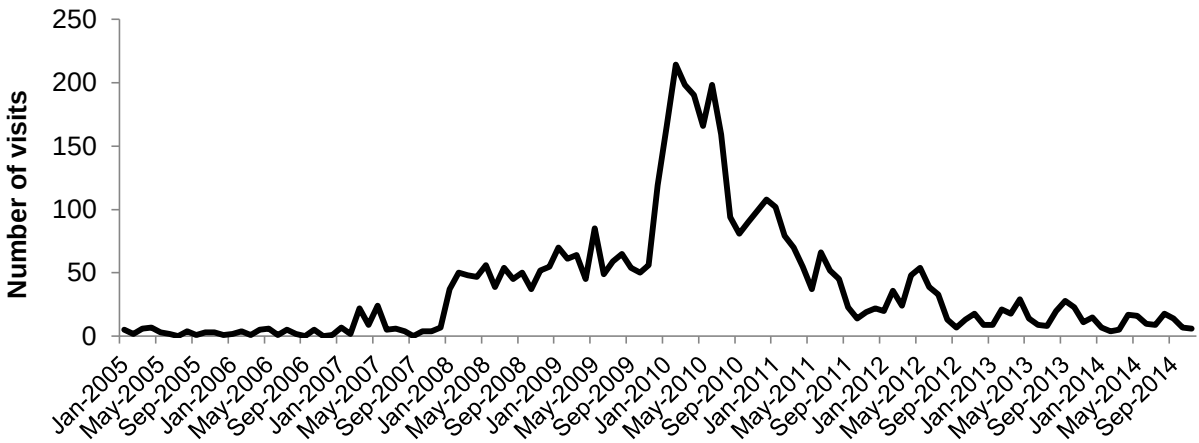
Excluding alprazolam, the most commonly used brand of benzodiazepine was diazepam (74%; including Valium, Valpam and Antenex), followed by clonazepam (14%;Rivotril), and oxazepam (10%; Serepax). Sixteen percent of all participants reported benzodiazepine use on the day prior to interview (23% in 2013).

In 2013, the prevalence of benzodiazepine injection was comparable with recent years (3% in 2014; 1% in 2013; 1% in 2012; 3% in 2011; 6% in 2010; 3% in 2009). Overall, the prevalence of benzodiazepine injection and the frequency of injection has remained stable over the past few years.

4.9.1.3 MSIC data

In January 2010, benzodiazepine injections increased sharply for several months. Over the past 12 months to November 2014, attendances for benzodiazepine injection at the MSIC have remained very low and stable.

Figure 23: Number of attendances to Sydney MSIC where benzodiazepines were injected, January 2005−November 2014



Source: Sydney MSIC, Kings Cross

4.9.2 Seroquel® (quetiapine)

Since 2011, participants have been asked about the use of Seroquel® (quetiapine). Of the NSW sample, 55% reported a lifetime use of Seroquel® (21% licit, 37% illicit). Twenty-one percent of the sample had used Seroquel® in the last six months (10% licit, 11% illicit). 'Licit' Seroquel® had been used on a median of 180 days compared to three days for 'illicit' Seroquel®. One percent of all participants reported injecting any form of Seroquel® in the last six months (Table 4).

4.9.3 Hallucinogens

Approximately half (48%, 53% in 2013) of PWID participants reported having used hallucinogens at some stage in their lifetime with 2% reporting recent use (Table 4). Eight percent of the sample had injected hallucinogens at some stage in the past (6% in 2013) and one participant reported having injected them in the last six months. Overall, these figures of the use of hallucinogens were stable when compared with 2013.

4.9.4 Ecstasy

Ecstasy use within this sample of participants in NSW continued to remain at relatively low levels. More than half (52%) of participants reported use of ecstasy in their lifetime, and 9%

reported having used it within the six months prior to interview (7% in 2013). Seventeen percent of participants had reported ever injecting ecstasy, and 3% reported having injected ecstasy in the six months preceding interview on a median of 3 days (Table 4).

A separate monitoring system investigating trends in ecstasy and related drug use and related issues had been conducted in New South Wales since 2000 and across all Australian jurisdictions since 2003. This is called the Ecstasy and related Drugs Reporting System (EDRS; formerly known as the Party Drugs Initiative, or PDI). Information, reports and bulletins from this study are available from the NDARC website http://ndarc.med.unsw.edu.au (under 'Drug Trends').

4.9.5 Steroids

Nine percent of the NSW sample reported ever using steroids. Two participants reported use in the six months preceding interview on a median of 25 days (Table 4). Two participants reported recently injecting steroids (note: small numbers reporting, interpret with caution).

4.9.6 New psychoactive substances

Five percent of participants reported ever using new psycoactive substances (NPS) such as synthetic cathinones (e.g.mephedrone), tryptamines (e.g. dimethyltryptamine [DMT]) and phenethylamines (e.g. 2C-x class). Two participants reported use in the six months preceding interview on a median of 2 days. Two participants reported recently injecting NPS.

4.9.7 Synthetic cannabinoids

Seventeen percent of all participants (31% in 2013) reported ever using synthetic cannabinoids (e.g. K2, Spice). Twenty-four percent of all participants reported use in the six months preceding interview on a median of six days. No participants reported injecting a synthetic cannanbinoid.

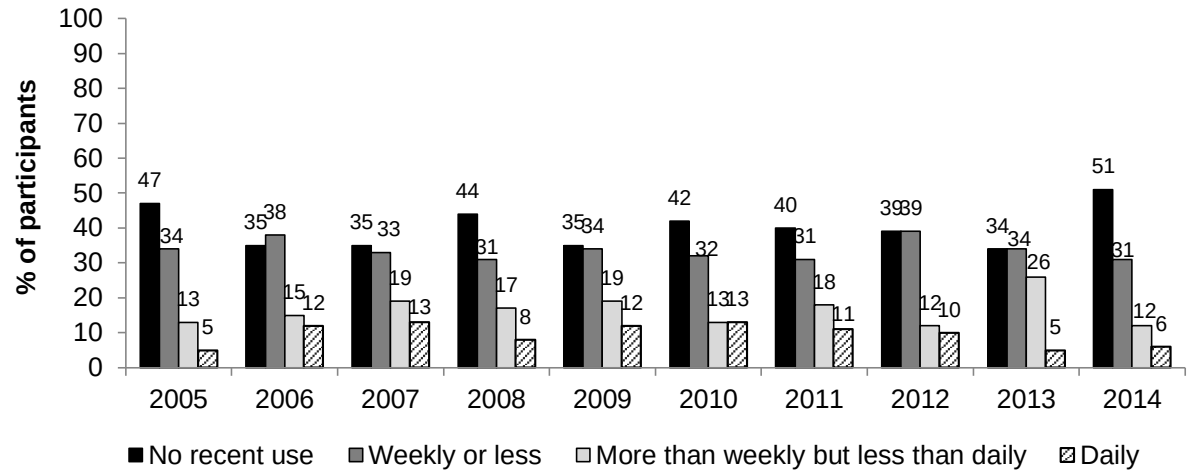
4.9.8 Inhalants

Fourteen percent of participants (20% in 2013) reported ever having inhaled volatile substances such amyl nitrate, petrol, glue and/or lighter fluid (butane) (Table 4). Recent use (3%) remained low and stable as did the frequency of use (5 days). The main form of inhalant reported being recently used by participants was amyl nitrate. There were no KE reports regarding use of inhalants.

4.9.9 Alcohol

Half (50%) of all participants in the sample had consumed alcohol in the six months prior to interview on a median of 12 days (i.e. once per fortnight; range 1−180). The recent use of alcohol decreased as did the frequency of use (66% and 24 days in 2013). Six percent of all participants reported daily use of alcohol. Thirty-one percent of all participants (35% in 2013) drank weekly or less often and 12% consumed alcohol more than weekly, less than daily (Figure 24). Overall, these figures were generally consistent with levels reported over the last 3 years. Rates of daily use in the entire sample (6%) were comparable with the general population aged 14 and over (6.5%), while rates of drinking weekly were lower than the general population (37% general population versus 31% of the NSW IDRS sample) (Australian Institute of Health and Welfare, 2014).

Figure 24: Patterns of alcohol use, 2005−2014

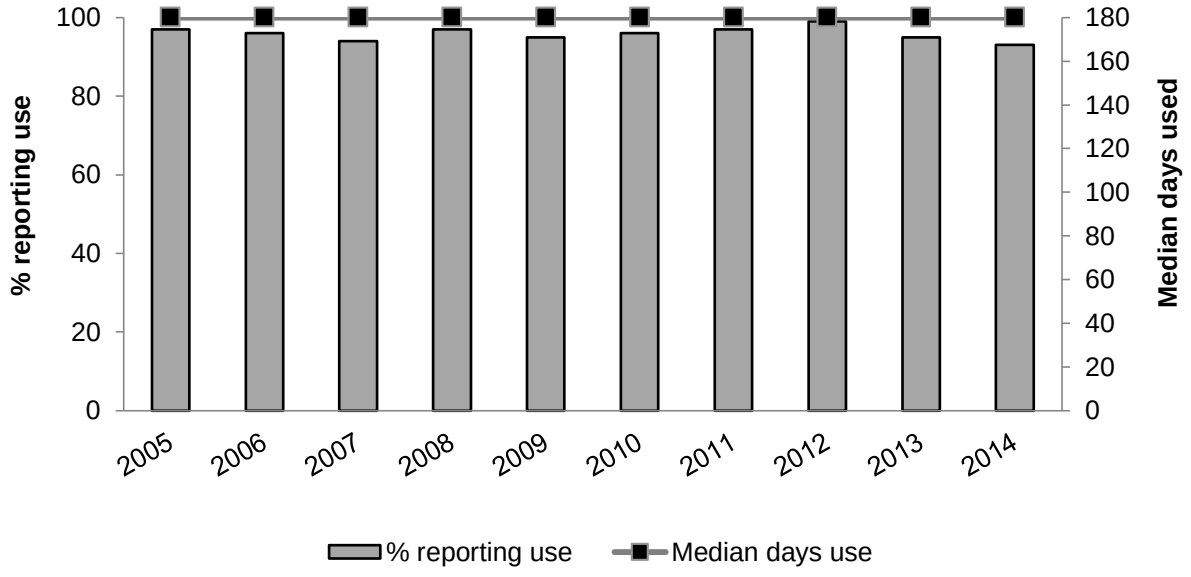


Source: IDRS PWID interviews

4.9.10 Tobacco

Tobacco continued to remain the most commonly used substance investigated by the IDRS. The vast majority of participants (93%) reported smoking tobacco in the last six months on a median of 180 days (Table 4), i.e. daily use (range 1−180). Ninety percent of those who had smoked tobacco in the preceding six months were daily smokers. High prevalence and frequency of tobacco use has been reported since 2005. This figure for PWID continues to be substantially higher than among the general Australian population (14% of whom are daily smokers), and, contrary to trends noted in the general population, the prevalence of smoking among IDRS is not declining over time (Australian Institute of Health and Welfare, 2014). The use of tobacco is the single most preventable cause of morbidity and mortality in Australia (Begg et al., 2007). Given the prevalence of smoking among the IDRS sample (Figure 1), this is of particular concern.

Figure 25: Participant reports of tobacco use in the last six months, 2005−2014



Source: IDRS PWID interviews

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

5.1 Heroin

When asked to comment on the price, purity and/or availability of heroin, 86% of the PWID sample felt confident to answer at least some of these survey items. The remaining 14% did not feel confident to answer any questions on the heroin market, and this is likely to reflect a proportion of people who inject drugs but do not use heroin, or come into contact with users or dealers of heroin, regularly enough to be able to comment. Use of homebake heroin (a form of heroin made from pharmaceutical products, involving the extraction of diamorphine from pharmaceutical opioids such as codeine or morphine) is also discussed within this section; however, as its use remained uncommon, detailed market characteristics have not been obtained.

5.1.1 Heroin price

The prices participants paid for heroin on the last occasion of purchase are shown in Table 9. Again in 2014, the median price reported for a cap of heroin remained unchanged at $50 and has remained unchanged since 2002. The median price for a gram of heroin increased from $350 in 2013 to $400 (Table 9). These prices continue to remain substantially higher than prices reported in 2000 ($220 per gram; $25 per cap), prior to the reported heroin shortage in 2001.

Seventy-two percent of the entire sample reported buying heroin in points, an amount more commonly used in previous years to refer to purchase amounts of methamphetamine and cocaine. A ‘point’ traditionally referred to 0.1 gram, although anecdotal evidence suggests that, similar to a ‘cap’ or a ‘deal’, the term may be used to refer to a quantity used for one injection rather than as a description of the weight.

As shown in Table 9, price ranges were extremely wide. This may reflect purity/availability within that particular person’s network and the numbers reporting.

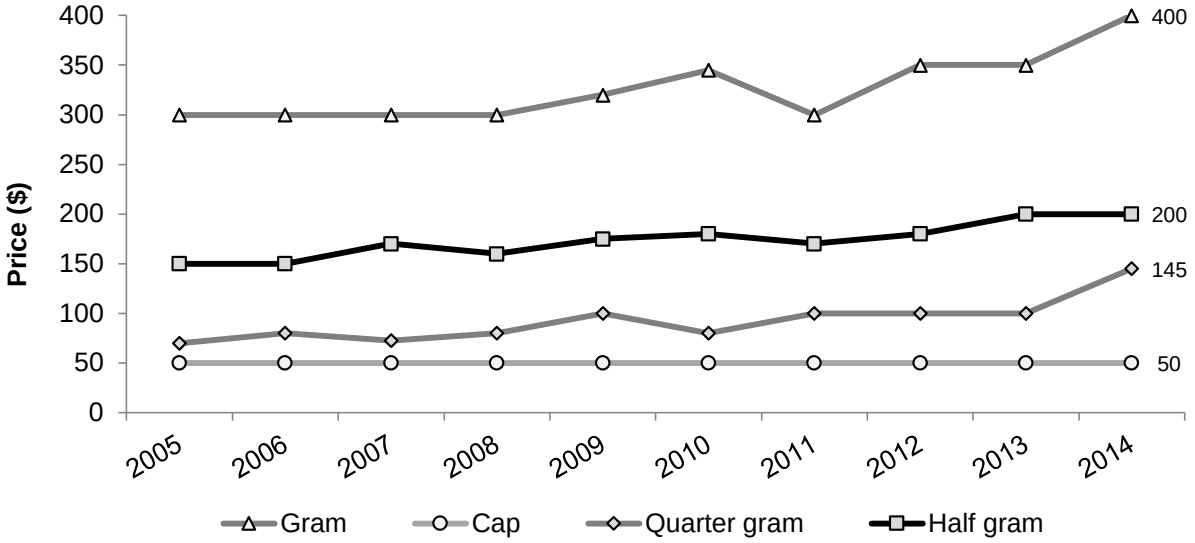
Table 9: Price of most recent heroin purchases by PWID participants, 2013−2014

Amount	Median price* $	Range $	Number of purchasers*
Cap	50 (50)	35-100	108 (102)
Quarter gram	145 (100)	50-250	24 (24)
Half gram (‘halfweight’)	200 (200)	50-400	55 (50)
Gram	400 (350)	50-800	44 (40)

Source: IDRS PWID interviews
* 2013 data are presented in brackets

Heroin prices have remained relatively stable since 2005 (Figure 26); however, it should be noted that participants and KE sometimes reported that the amount of a drug bought within a purchase amount (e.g. as a ‘cap’ or a ‘fifty-dollar deal’) had fluctuated or decreased over the past few years.

Figure 26: Median prices of heroin estimated from PWID purchases, 2005−2014



Source: IDRS PWID interviews
NB: Survey items relating to quarter and half grams were first included in 1998

In addition to survey items on last purchase price, participants were also asked whether they thought the price of heroin had changed over the last six months ('don't know', 'increasing', 'stable', 'decreasing' and 'fluctuating').

Seventy-nine percent of participants reported price stability over the preceding six months. Seventeen percent of those who commented thought that price had increased over the preceding six months (comparable with 23% in 2013). Three percent reported heroin prices had fluctuated, and a smaller proportion (3%, 3% in 2013) reported that prices had decreased in the previous six months.

5.1.2 Availability

Participants were asked about current heroin availability (whether it was 'very easy', 'easy', 'difficult' or 'very difficult') and whether this had changed in the last six months ('easier', 'stable', 'more difficult' or 'fluctuates'). Again in 2014, the majority of participants reported that heroin was 'very easy' (50%) or 'easy' (37%) to obtain (Table 10; Figure 27). Twelve percent (reported that heroin was 'difficult' to obtain (13% in 2013) and only 2% of participants claimed that heroin was 'very difficult' to obtain.

The vast majority (85%) of the sample were able to comment on heroin availability in the last 6 months: 72% reported that heroin availability over this time had remained 'stable'; smaller proportions of participants claimed that ease of access to heroin had become 'easier' (13%) or 'more difficult' (11%) to obtain (Table 10).

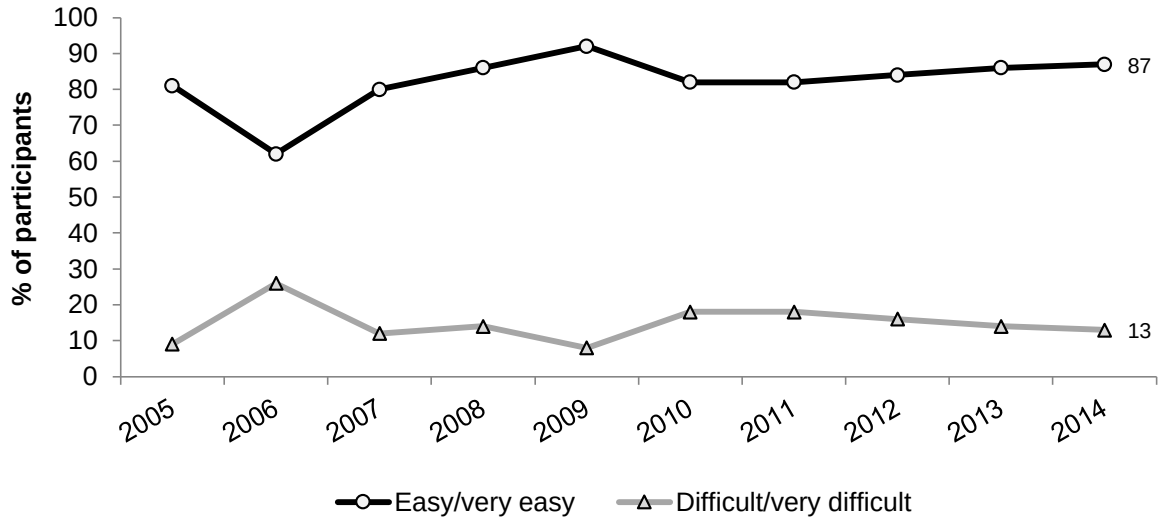
Table 10: Participants' reports of heroin availability in the past six months, 2010−2014

	2010 N=154	2011 N=150	2012 N=151	2013 N=151	**2014 N=150**
Current availability					
Did not respond* (%)	8	13	13	15	**15**
Did respond (%)	92	87	87	85	**85**
Of those who responded:					
Very easy (%)	57	50	38	52	**50**
Easy (%)	26	32	46	34	**37**
Difficult (%)	14	16	14	13	**12**
Very difficult (%)	4	2	2	1	**2**
Availability change					
Did not respond* (%)	8	14	13	16	**16**
Did respond (%)	92	86	87	84	**84**
Of those who responded:					
More difficult (%)	20	19	14	18	**11**
Stable (%)	70	64	77	67	**72**
Easier (%)	9	11	5	10	**13**
Fluctuates (%)	1	6	4	5	**4**

Source: IDRS PWID interviews

* 'Did not respond' refers to participants who did not feel confident enough in their knowledge of the heroin market to respond to survey items

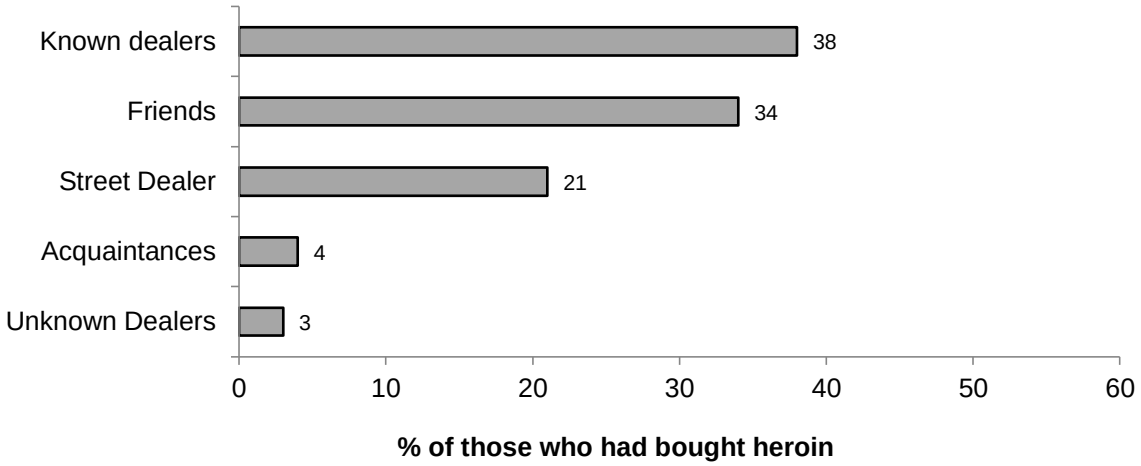
Figure 27: Participant reports of current heroin availability, 2005−2014



Source: IDRS PWID interviews

Of those participants that had purchased heroin in the last six months (81%), the most common sources of heroin on the last occasion of purchase were ‘known dealers’ (38%), ‘friends’ (34%) and ‘street dealers’ (21%) (Figure 28). Participants reported scoring from a range of locations, both public (e.g. street market, agreed public location) and private (e.g. dealer’s home, home delivery) with the most common remaining an ‘agreed public location’ (29%) (Figure 29).

Figure 28: People from whom heroin was purchased on the last occasion, 2014



Source: IDRS PWID interviews
NB: More than one response could be selected

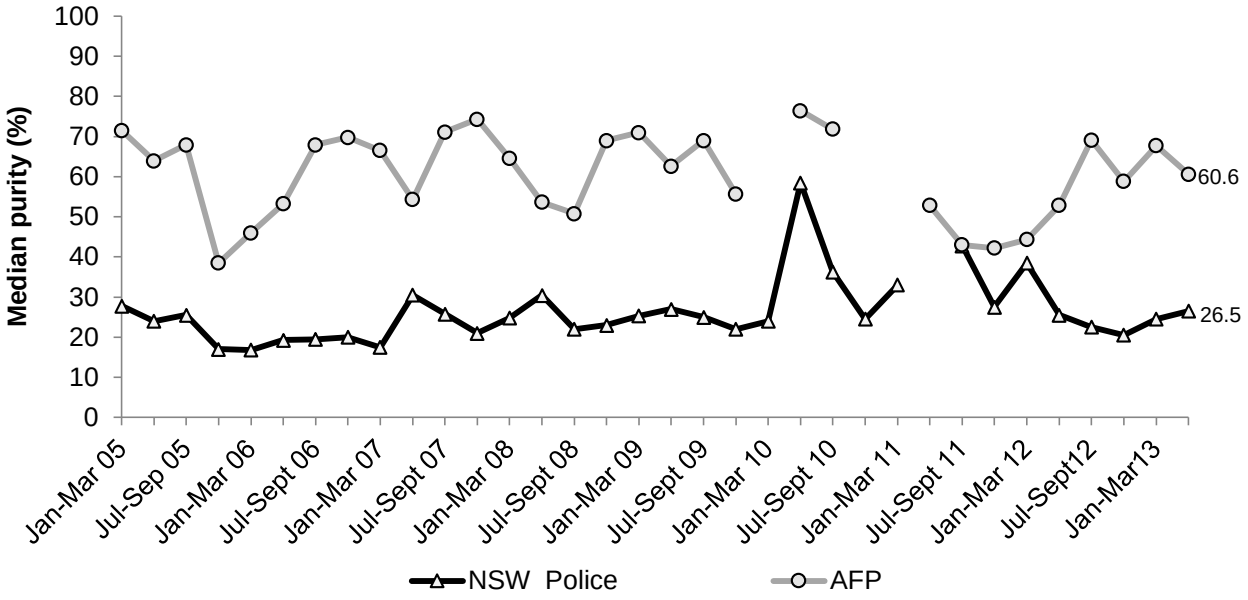
Figure 29: Locations where heroin was purchased on the last occasion, 2014

Source: IDRS PWID interviews
NB: More than one response could be selected

5.1.3 Purity

Figure 30 shows the analysed median purity of NSW Police heroin seizures from January 2005 to June 2013. In 2012/13, the overall median purity of heroin (23%; range: 8−70%) reported by NSW Police decreased when compared with the 2010/11 reporting period (30%; range 2-84.5%). Overall, the purity of Australian Federal Police (AFP) heroin seizures that were analysed during 2012/13 increased, with a median of 68.2% in the 12 months to June 2013 (43.4% in 2011/12; 56% in 2010/11).

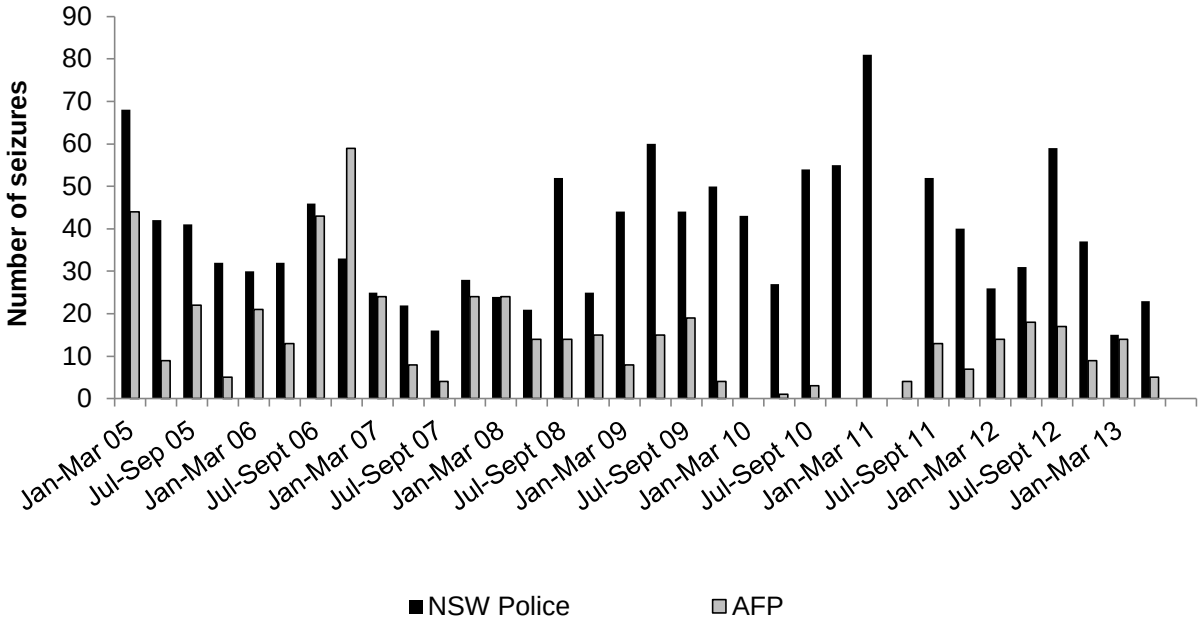
Figure 30: Purity of heroin seizures analysed in NSW, by quarter, January 2005−June 2013



Source: Australian Crime Commission (2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014)
NB: No AFP seizure data for NSW January-March 2010, October-December 2010 and January-March 2011; no NSW Police data for April-June 2011

Figure 31 shows the number of heroin seizures upon which the above purity figures were based. It should be noted that not every seizure is analysed. In addition, the period between the date of seizure by police and the date of receipt at the laboratory can vary greatly, and no adjustment has been made to account for double-counting that may occur in joint operations between the AFP and NSW Police. The total number of heroin seizures analysed by NSW Police in 2012/13 was 134 (149 cases in 2011/12). The total number of heroin seizures analysed by the AFP decreased slightly from 52 in 2011/12 to 45 for the same period in 2012/13 (Figure 31).

Figure 31: Number of heroin seizures analysed in NSW, by quarter, January 2005− June 2013



Source: Australian Crime Commission (2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014)

Participants were also asked to comment on their perception of the current purity of heroin. Thirty-seven percent of those who commented reported it to be ‘low’ purity, 36% also reported it to be ‘medium’, 15% reported it ‘fluctuates’ and 13% believed it to be ‘high' (Table 11). These purity figures are consistent with those reported in 2013. Since the commencement of the IDRS in 1996, only small proportions of participants have reported purity to be ‘high’, instead selecting ‘medium’ or ‘low’ most frequently (Figure 32). This was also the case in 2014, with 13% (n=16) of participants rating current heroin purity as ‘high’. While this may reflect a change in purity, it may also reflect individual levels of tolerance to heroin.

Participant perceptions of purity change over the last six months varied: approximately half of those that could comment reported that it had remained stable (37% in 2013) and 23% reported that it had decreased (28% in 2013). These results are comparable with 2013 (Table 11).

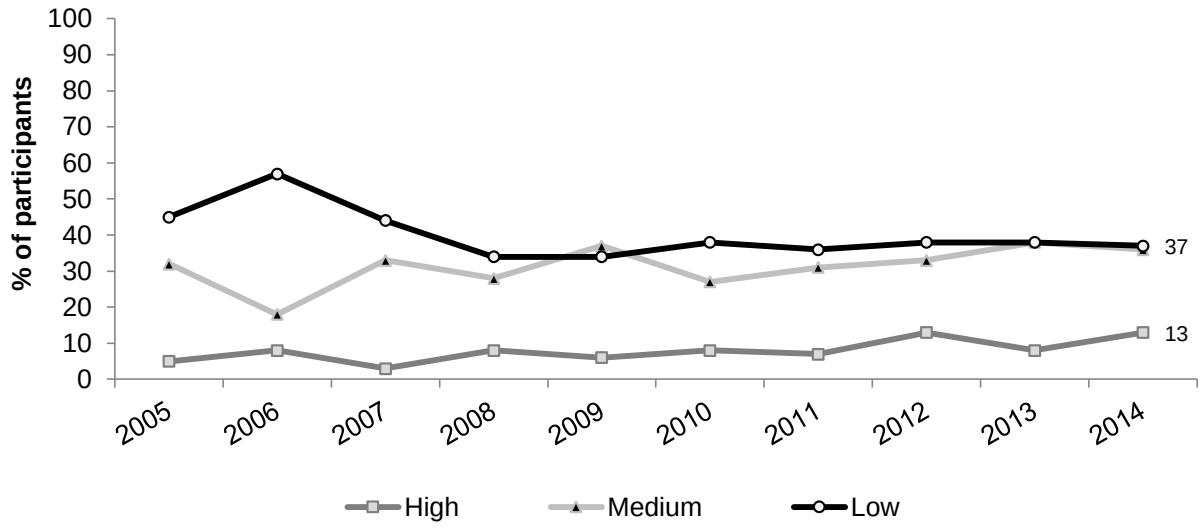
Table 11: Participants' perceptions of heroin purity in the past six months, 2010−2014

	2010 N=154	2011 N=150	2012 N=151	2013 N=151	**2014 N=150**
Current purity					
Did not respond* (%)	11	15	16	17	**17**
Did respond (%)	89	85	84	83	**83**
Of those who responded:					
High (%)	9	8	13	8	**13**
Medium (%)	31	37	33	38	**36**
Low (%)	43	42	38	38	**37**
Fluctuates (%)	18	13	17	16	**15**
Purity change					
Did not respond* (%)	13	17	16	19	**19**
Did respond (%)	87	83	84	81	**81**
Of those who responded:					
Increasing (%)	7	11	13	16	**11**
Stable (%)	41	32	35	37	**48**
Decreasing (%)	36	37	31	28	**23**
Fluctuating (%)	17	20	21	19	**18**

Source: IDRS PWID interview

* 'Did not respond' refers to participants who did not feel confident enough in their knowledge of the heroin market to respond to survey items

Figure 32: Proportion of PWID participants reporting current heroin purity as high, medium or low, 2005−2014



Source: IDRS PWID interviews

5.1.4 Trends in heroin use

As in previous years, the PWID survey contained a number of open-ended questions which asked participants about any general trends in drug use that they had noticed; for example, in the number of users and the types of drugs used. As in previous years, comments on general trends in heroin use included several comments that the quality of heroin had decreased (this may be influenced, at least in part, by tolerance). Furthermore, the lack of heroin purity is resulting in an increase in PWID using oxycodone where there was greater confidence in ingredient quality. There were many comments, however, stating that heroin usage was on the increase and this was found to be reasonably stable in the IDRS data in 2014.

5.1.5 Key expert comments

- KE comments reflected findings in the PWID survey that heroin remained the drug of choice amongst this group, despite the continuing use of non-prescribed pharmaceutical opioids.
- Heroin is reportedly easy to obtain and this has remained stable.
- The price of a point/cap of heroin was consistent with previous years at $50.
- The majority of KE reports indicate that heroin purity has increased.
- Health KE are concerned about the risk of overdose for those PWID who are returning to heroin following the reformulation of Oxycontin.

5.2 Methamphetamine

Participants were asked if they were able to comment on the price, purity and/or availability of speed powder, base and/or ice. In 2014, 15% of the PWID sample felt confident to answer at least some of the survey items regarding speed powder; 11% commented on the price, purity and/or availability of base; and 71% commented on ice/crystal. These proportions are consistent with 2013. The remainder did not feel confident to answer any questions on one or more of these drug forms, and this was likely to reflect a proportion of users who did not use, or come into contact with methamphetamine users or dealers regularly enough to be able to comment.

5.2.1 Price

5.2.1.1 Speed powder

As per previous years, and other drug types, points of speed were the most popular and prices have continued to remain stable. There was an decrease in those participants purchasing speed by 'halfweights' and grams and the median price per 'eightball' more than halved when compared with 2013. The number of people reporting a price per 'eightball' remained low. Due to this, comparisons with 2013 should be interpreted with caution due to the low number (n ≤ 10) reporting. As shown in Table 12, price ranges were extremely wide. In most cases, this is likely to be a reflection of purity/availability within that particular person's network and various other circumstances which may influence the cost of a particular purchase.

Table 12: Price of most recent methamphetamine purchases by PWID participants, 2013−2014

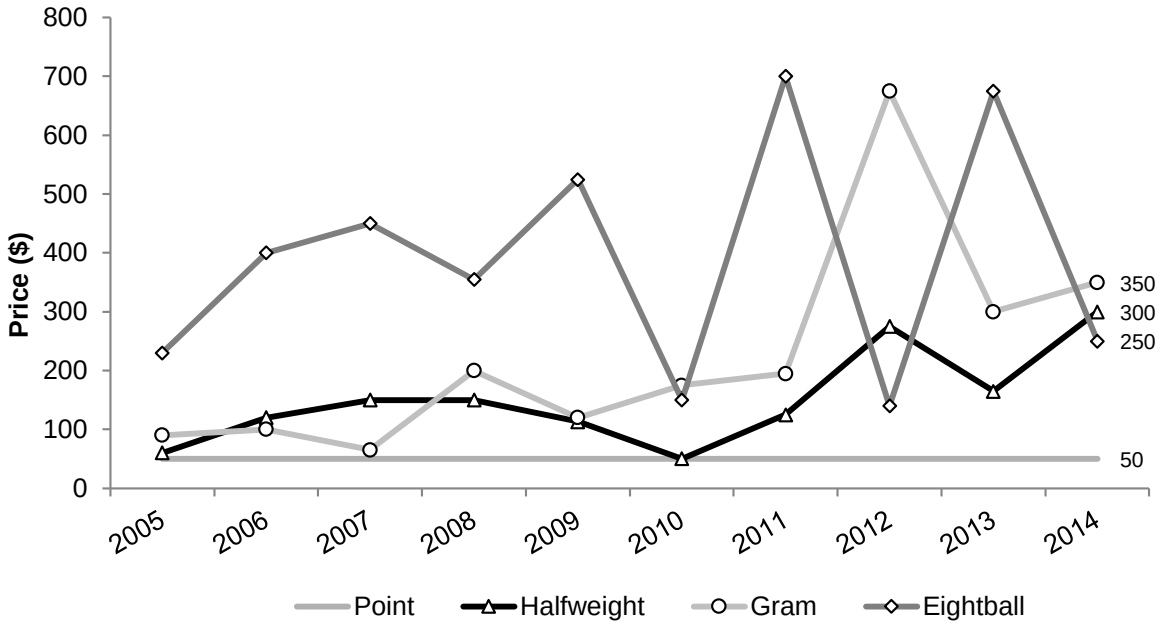
Amount	Median price* $	Range $	Number of purchasers*
Speed powder			
Point (0.1 gram)	50 (50)	13-100	15 (17)
'Halfweight' (0.5 grams)	300 (300)	30-300	5 (10^)
Gram	350 (300)	50-600	5 (11)
'Eightball' (3.5 grams)	250 (675)	150-1800	5 (4^)
Base			
Point (0.1 gram)	50 (50)	13-50	11(11)
'Halfweight' (0.5 grams)	125 (150)	100-150	2 (5^)
Gram	150 (100)	100-350	3 (3^)
'Eightball' (3.5 grams)	- (220)	-	- (2^)
Ice/crystal meth			
Point (0.1 gram)	50 (50)	30-100	96 (83)
'Halfweight' (0.5 grams)	250 (200)	100-350	33 (28)
Gram	475 (388)	50-600	30 (20)
'Eightball' (3.5 grams)	1150 (1200)	450-1500	18 (10^)

Source: IDRS PWID interviews
* 2013 data are presented in brackets
^ n ≤ 10 results should be interpreted with caution

The median price per point of speed has remained the same since data were first collected on this purchase amount since 2005 ($50). It is important to note, however, that comparisons with the 2013 data should be interpreted with caution due to the low number of reported purchasers for weights other than points this year.

Participants were also asked if the price of speed powder had changed in the last six months, and 76% of those who commented (11% of all participants) reported price as 'stable' over the last six months. This remained consistent with comments from 2013. Similarly, the proportion of participants reporting an increase in price (19%; 3% of all participants) remained stable compared with 2013. Fewer participants (5%; 1% of all participants) reported a decrease in prices in 2014, with no reports of the price of speed powder 'fluctuating'. Overall, this suggests prices had remained relatively 'stable' over the last six months.

Figure 33: Median prices of speed powder estimated from PWID purchases, 2005−2014



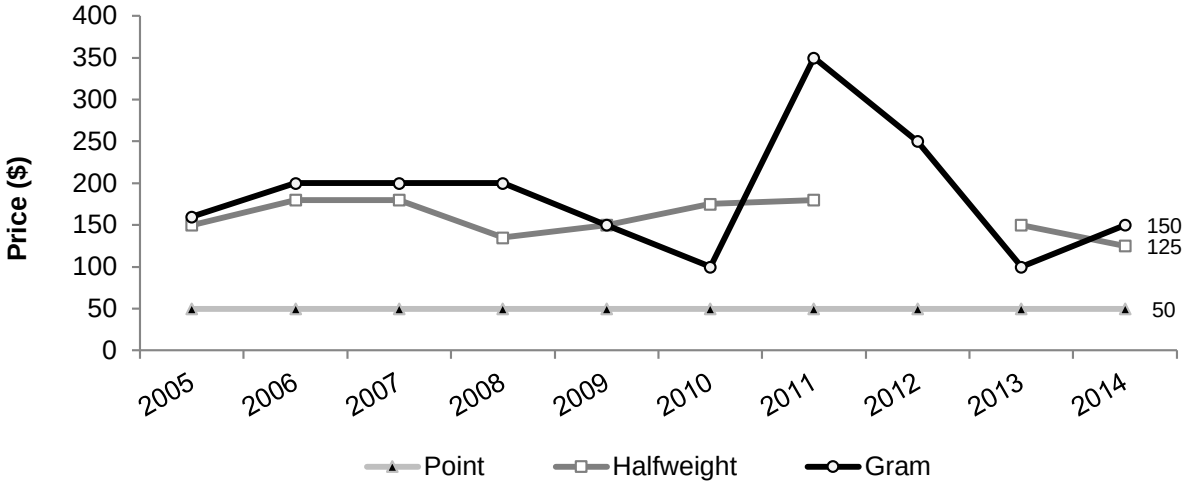
Source: IDRS PWID interviews

5.2.1.2 Base

The most popular purchase amount for base, as with all other forms of methamphetamine, continued to be a point, the smallest reported amount (Table 12). This has been a consistent finding over the preceding years of the IDRS in NSW. Seven percent of all participants reported buying base in points in the preceding six months, making it the most popular purchase amount. Fewer participants (n ≤ 10 for each amount) reported buying larger, more expensive amounts such as grams.

The median price per point of base remained stable, while the median prices for other amounts were based on small numbers (10 responses or less) of participant responses, and should be interpreted with caution, particularly as the price ranges were fairly wide. Prices have remained fairly 'stable' since 2005 (Figure 34).

Figure 34: Median prices of base estimated from PWID purchases, 2005−2014



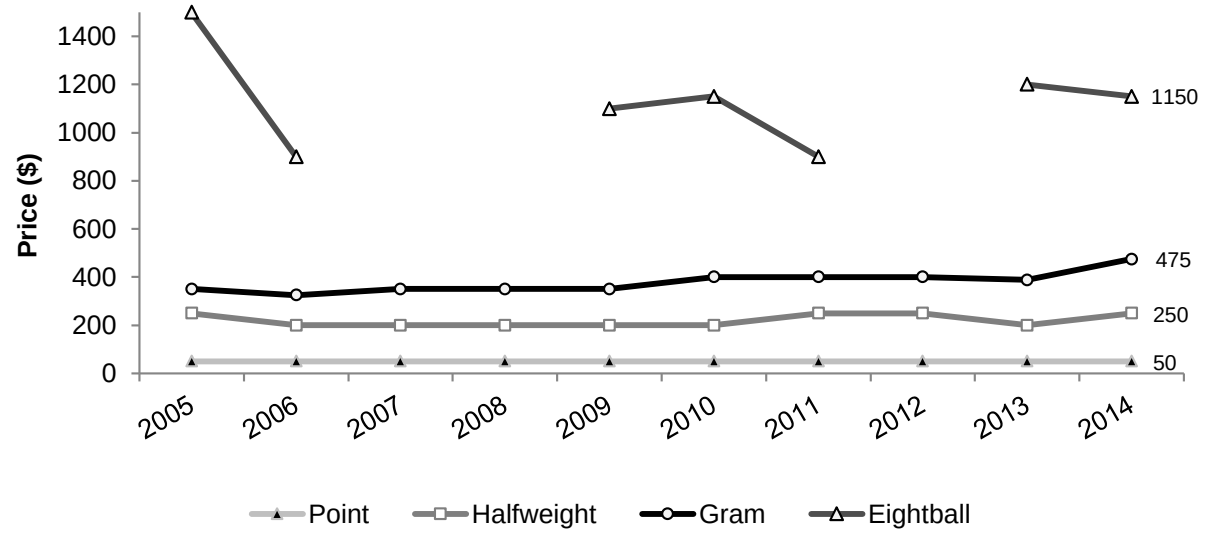
Source: IDRS PWID interviews
NB: Median price per eightball not shown due to small numbers reporting purchase

The majority of participants that commented on base generally thought that the price had remained 'stable' over the preceding six months (69%; 6% of all participants). Fifteen percent reported that it had 'decreased' (1% of entire sample) one participant reported it had 'fluctuated', while another participant reported the price of base had 'decreased'. Overall, prices appear to have remained comparable to 2013. Few participants reported recent purchases larger than a point, therefore, these results should be treated with caution.

5.2.1.3 Ice/crystal

Again, as with speed and base, the most commonly purchased amounts of ice/crystal were points (64% of participants reporting at least one purchase in the last 6 months). There was a slight increase in the number of those reporting purchases of 'halfweights', grams and an 'eightball'. (33, 30 and 18 participants each, respectively) (Table 12). In 2014, prices for points of ice/crystal have remained stable (Figure 35).

Figure 35: Median prices of ice/crystal estimated from PWID purchases, 2005−2014



Source: IDRS PWID interviews

NB: Median price per eightball not shown due to small numbers reporting purchase

The majority of participants who commented on ice/crystal generally thought that the price had remained 'stable' over the preceding six months (78%; representing 52% of the entire sample verses 61% in 2013). Thirteen percent stated that it had 'increased' (representing 9% of the entire sample versus 27% in 2013), 5% (5% of the entire sample) reported it had 'fluctuated', and 4% reported a 'decrease' in price. Overall, there was an increase in participants reporting the price of ice/crystal as 'stable,' while fewer participants reported the price 'increasing'.

5.2.2 Availability

5.2.2.1 Speed powder

Participants were asked 'How easy is it to get speed [powder] at the moment?'. The response options available were 'very easy', 'easy', 'difficult', and 'very difficult'. Among those who could comment, availability was reported as 'easy' (52%), 'very easy' (29%), or 'difficult' (14%) to obtain, with a small number of participants reporting that it was 'very difficult' to obtain (5%) (

Table 13). The majority of the sample that commented reported availability in the preceding six months was stable (74%), which is consistent with the 72% of participants who reported it in 2013.

Fifteen percent of all participants reported purchasing speed powder in the six months preceding the interview. The most common source of the purchase were 'friends' (30%; 46% in 2013), and 'known dealers' (30%; 27% in 2013). Other participants reported purchasing from 'street dealers' (25%; 23% in 2013), with only a small proportion obtaining it from other sources. (Figure 36). Nearly half of those participants who could comment reported scoring on the 'street market' (45%; 23% in 2013), 'home delivery' (20%; 23% in 2013), or at an 'agreed public location' (15%; 18% in 2013). The remaining participants obtained speed powder at a 'friend's home', (10%), or a 'dealer's home', (5%), (Figure 37).

5.2.2.2 Base

The current availability of base was reported to be 'very easy' (40%), 'easy' (26%), 'very difficult' (20%), and 'difficult' (13%) to obtain among those that could comment. Sixty-seven percent (7% of all participants) reported that availability over the past six months was 'stable', while 27% (3% of all participants) reported it to be 'more difficult' (Table 13). Eleven percent of the entire sample (13% in 2013) reported purchasing base in the six months preceding interview, of those that reported a purchase, it was most commonly from 'friends' (31%), 'street dealers' (23%), and 'known dealers' (23%) (Figure 36). Locations at which base had most commonly been purchased included a 'friend's home' (36%; 22% in 2013), the 'street market' (29%; 11% in 2013), an 'agreed public location' (14%; 17% in 2013), 'home delivery' (7%; 17% in 2013), and the 'dealer's home' (7%; 11% in 2013) (Figure 37).

5.2.2.3 Ice/crystal

Fifty-two percent of participants noted ice was either 'very easy' or 'easy' (41%) to obtain. These figures are comparable with 2013 (Table 13). The majority of those who commented (77%, or 54% of entire sample) reported that availability over the last six months had remained 'stable', with 11% reporting that it had become 'easier', 9% percent reporting that it had become 'more difficult', and only 3% reported that availability had fluctuated over the last six months (Table 13). Seventy-one percent of all participants had purchased ice in the six months preceding interview (68% in 2013). Among these, the most commonly reported sources were 'friends' (37%), 'known dealers' (32%), and 'street dealers' (18%) (Figure 36). The most commonly reported locations of purchase were a 'street market' (30%), 'friend's home' (19%), 'home delivery' (18%) and 'dealer's home' (17%), and 'agreed public location' (14%) (Figure 37).

Table 13: Participants' reports of methamphetamine availability in the past six months, 2013−2014

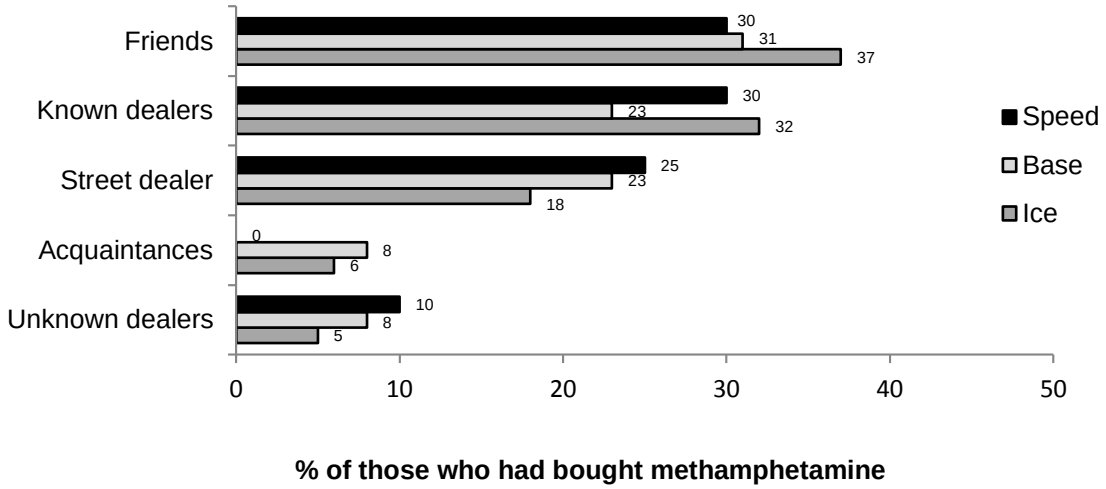
	Powder		Base		Ice/Crystal	
	2013 (N=151)	**2014 (N=150)**	2013 (N=151)	**2014 (N=150)**	2013 (N=151)	**2014 (N=150)**
Current availability						
Did not respond* (%)	83	**86**	87	**90**	32	**30**
Did respond (%)	17	**14**	13	**10**	68	**70**
Of those who responded:						
Very easy (%)	24	**29**	26	**40**	46	**52**
Easy (%)	56	**52**	32	**27**	46	**41**
Difficult (%)	20	**14**	26	**13**	8	**5**
Very difficult (%)	0	**5**	16	**20**	0	**2**
Don't know^ (%)	0	**0**	0	**0**	0	**0**
Availability change						
Did not respond* (%)	83	**87**	87	**90**	33	**30**
Did respond (%)	17	**13**	13	**10**	67	**70**
Of those who responded:						
More difficult (%)	20	**16**	37	**27**	13	**9**
Stable (%)	72	**74**	58	**67**	73	**77**
Easier (%)	8	**11**	5	**0**	11	**11**
Fluctuates (%)	0	**0**	0	**7**	3	**3**
Don't know^ (%)	0	**0**	0	**0**	0	**0**

Source: IDRS PWID interviews

* 'Did not respond' refers to participants who did not feel confident enough in their knowledge of the market to respond to survey items

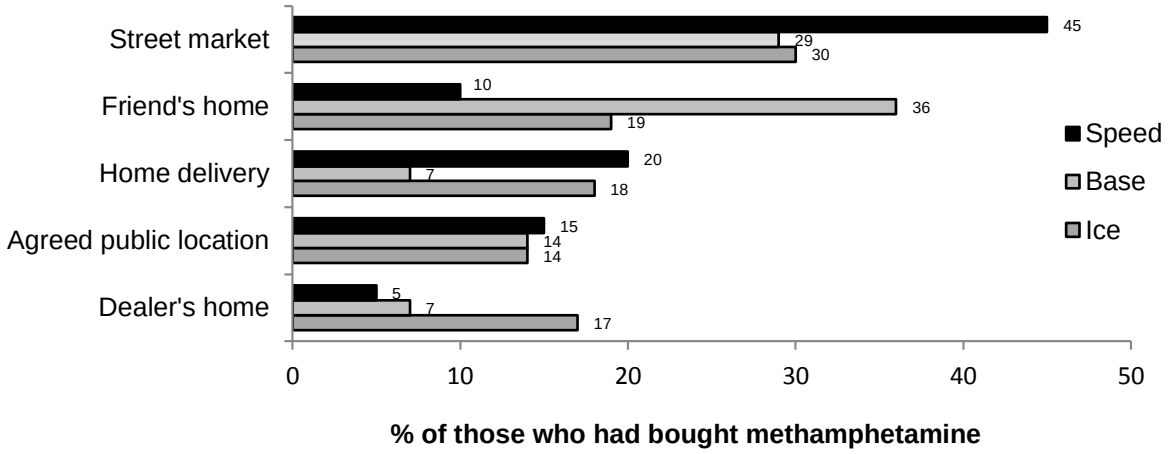
^ 'Don't know' refers to participants who were able to respond to survey items on price and/or purity, but had not had enough contact with users/dealers to respond to items concerning availability

Figure 36: People from whom methamphetamine was purchased in the preceding six months, 2014



Source: IDRS PWID interviews
NB: More than one response could be selected

Figure 37: Locations where methamphetamine was scored in the preceding six months, 2014



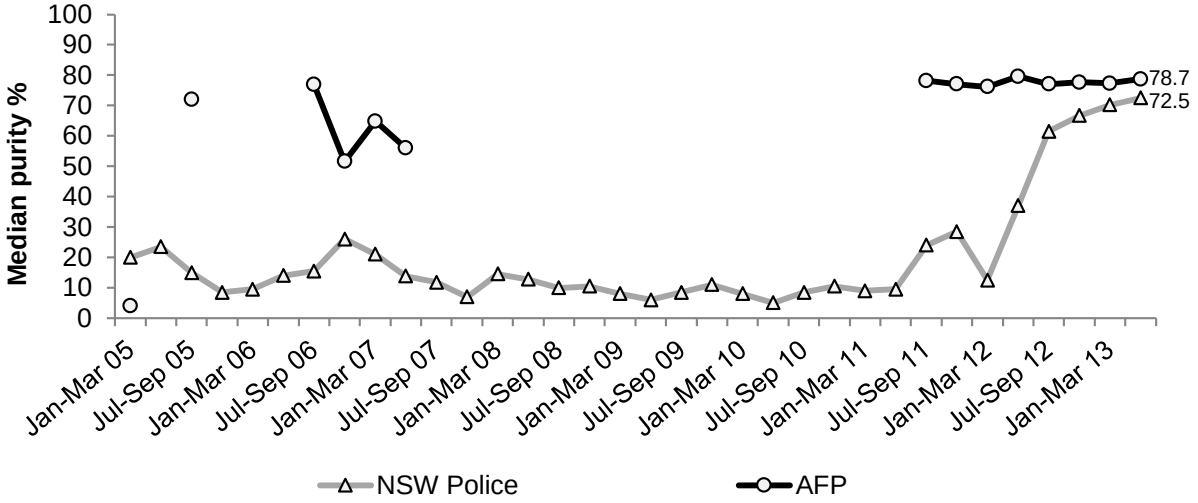
Source: IDRS PWID interviews

NB: More than one response could be selected

5.2.3 Purity

Figure 38 shows the median purity of methylamphetamine seizures analysed in NSW for the period January 2005 to June 2013. As analysis by both NSW Police and the AFP has been sporadic since 2004, meaningful interpretation of methylamphetamine purity levels is difficult. In 2012/13, the median purity of all seizures analysed by NSW Police rose sharply to 68% (range 1%-89%) from 19.5% (range 1%−90%) reported in 2011/12. The purity of AFP seizures has remained high and consistent since July 2011. It should be noted that figures do not represent the purity levels of all methylamphetamine seizures – only those that have been analysed at a forensic laboratory. In addition, the period between the date of seizure by police and the date of receipt at the laboratory can vary greatly, and no adjustment has been made to account for double-counting from joint operations between the AFP and NSW Police.

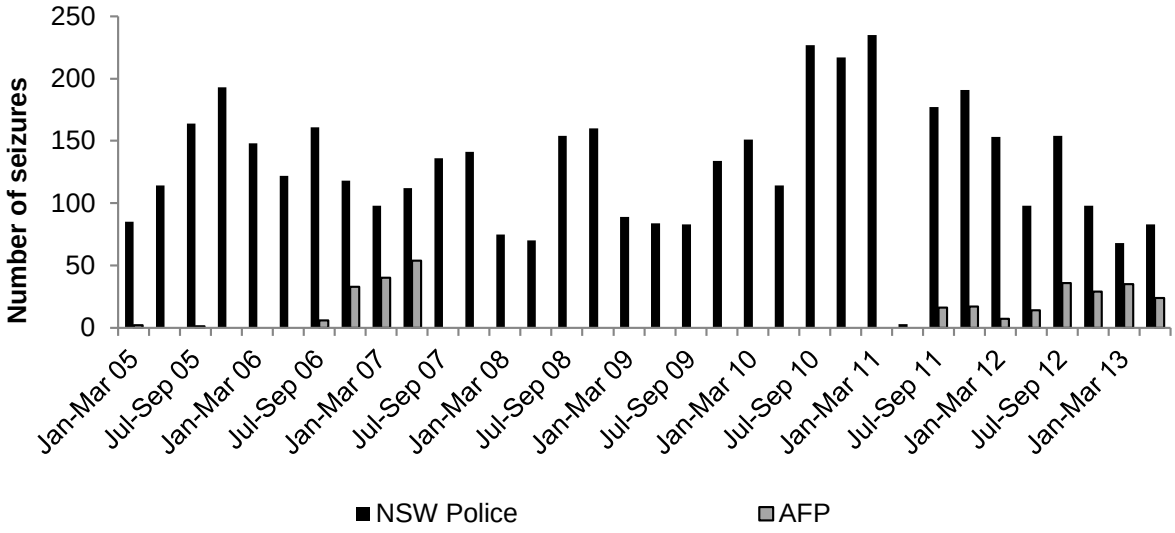
Figure 38: Purity of methylamphetamine seizures analysed in NSW, by quarter, January 2005−June 2013



Source: Australian Crime Commission (2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014).

Figure 39 shows the number of methylamphetamine seizures upon which the above purity figures are based. As analysis of AFP seizures has been sporadic since 2004 and non-existent in the 3 years to June 2011, meaningful interpretation is difficult. The number of seizures analysed by NSW Police has decreased in the 12 months to June 2013 (403 in 2012/13 versus 619 in 2011/12).

Figure 39: Number of methylamphetamine seizures analysed in NSW, by quarter, January 2005- June 2013



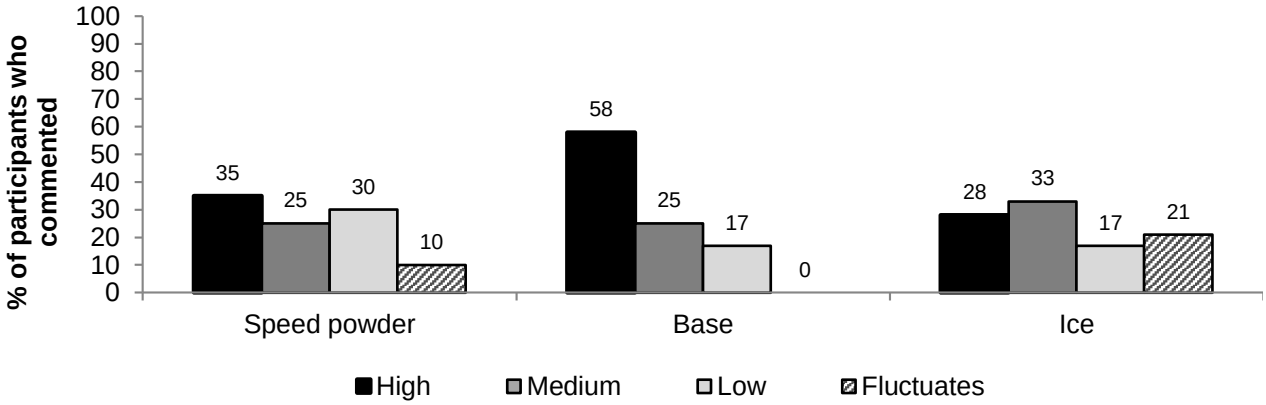
Source: Australian Crime Commission (2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014)

5.2.3.1 Speed powder

Thirteen percent of the sample commented on the perceived current purity of speed powder (16% in 2013). In 2014, comments on perceived purity were mixed. Thirty-five percent of those who could comment described speed powder as 'high' and similar numbers reported purity as either 'low' (30%) or 'medium' (25%). Ten percent (2% of all participants) thought that speed powder purity 'fluctuated' (Figure 40). Purity reports of speed powder are comparable with 2013.

Reports on changes in speed purity were also mixed. Forty-seven percent of participants who commented reported that purity was 'stable', while 32% of participants thought that speed purity had 'decreased' over the preceding six months. Sixteen percent also commented it had 'fluctuated' and 5% reported that it had 'increased' (2% and 1% of the entire sample, respectively). Overall, this remains comparable with 2013.

Figure 40: Participant perceptions of methamphetamine purity (speed powder, base and ice), among those who commented, 2014



Source: IDRS PWID interviews

5.2.3.2 Base

Fifty-eight percent of recent users (5% of entire sample) commented that base purity was currently 'high' and 25% said it was 'medium' purity. A smaller proportion of participants also commented that base purity was currently 'low' (17%; 1% of all participants). There were no reports of base purity fluctuating.

In reporting on changes in purity it was generally reported to have remained stable (78%; 5% of entire sample), with lesser amounts reporting it had 'increased' (22%; 1% of entire sample) over the six months preceding interview. No participants reported a change in base purity as 'decreasing' or 'fluctuating'.

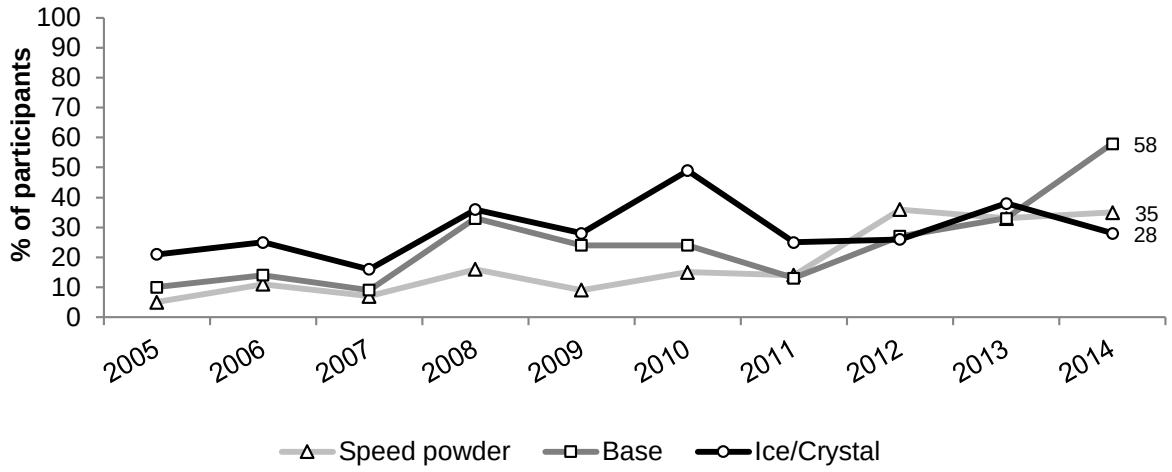
5.2.3.3 Ice/crystal

Thirty-three percent (21% of entire sample) of recent users reported the purity of ice/crystal as 'medium'. Twenty-eight percent reported it as 'high', while 21% reported ice/crystal purity as 'fluctuating' (18% and 13% of entire sample, respectively). The remaining 17% (11% of entire sample) of people reporting recent ice/crystal use commented it was 'low' (Figure 40). These figures are comparable with values reported in 2013.

When asked about whether purity had changed over the last six months, 38% (24% of all participants) believed that it remained 'stable'. An equal proportion of participants reported the purity change as 'decreasing' or 'fluctuating' (both 25%; 16% of the entire sample) and a further 12% of participants reported the purity change as 'increasing'.

Figure 41 shows the proportion of PWID participants reporting the purity of each form of methamphetamine as 'high'. The perceived purity of speed powder remained comparable with 2013, and those reporting base purity as high increased. Similarly, those reporting a decrease in ice purity as high was observed, however, these figures should be interpreted with caution due to the low numbers commenting (Figure 41).

Figure 41: Proportion of participants* reporting speed powder, base and ice/crystal purity as 'high', 2005−2014



Source: IDRS PWID interviews
* Numbers for ice/crystal and base are ≤10, therefore interpret with caution
NB: Data on all three forms commenced in 2002.

5.2.4 Trends in methamphetamine use

All participants were asked at the end of the survey if they had observed any recent changes in drug use. A reoccurring theme was that use of ice/crystal had increased in the 6 months prior to interview particularly amongst younger and first time illicit drug users. However in 2014 IDRS data, this was found to be reasonably stable.

5.2.5 Key expert comments

- Health and law KE report ice/crystal is widespread and readily available.
- Both health and law KE generally believed that the use of ice/crystal has increased among PWID in 2014.
- Unpredictable behavior of ice/crystal users makes it difficult for health KE to administer treatment and provide safe injecting advice.
- Some health KE report regular opioid users are using ice/crystal occasionally.
- Health KE are concerned the age of initiation for ice/crystal users is getting younger.

5.3 Cocaine

Twenty-two percent of participants reported that they were able to comment on the price, purity and/or availability of cocaine in 2014, which is a slight decrease on the 29% that could comment in 2013. The remainder did not feel confident to answer any questions on the cocaine market, and this is likely to reflect a proportion of users who do not use, or come into contact with users, or dealers of, cocaine regularly enough to be able to comment.

5.3.1 Price

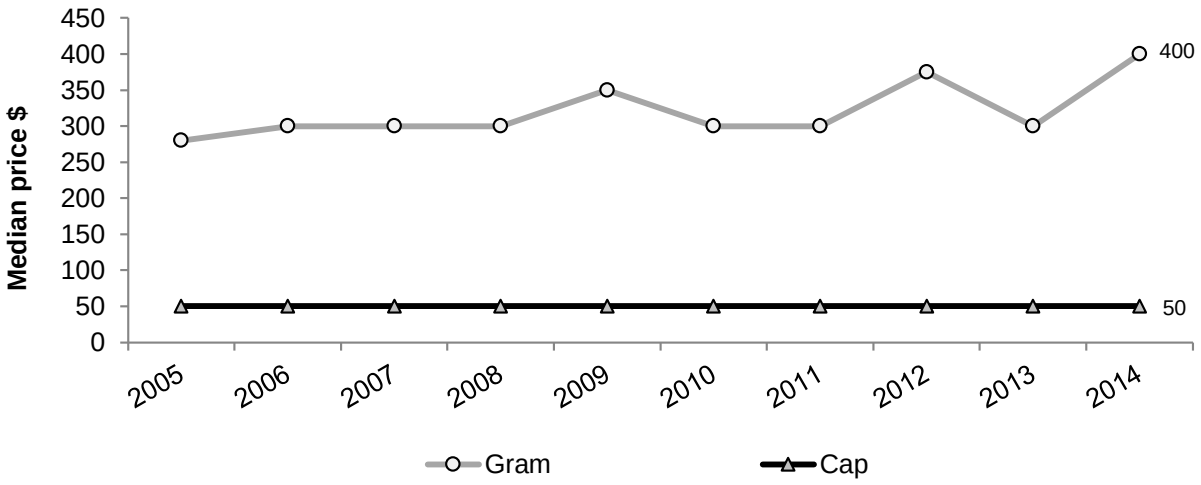
Prices paid for cocaine by PWID participants on the last occasion of purchase are presented in Table 14 and Figure 42. The median price for caps, the most popular purchase amount, remained stable. Reported purchases of quarter grams remained uncommon with an insufficient number of participants (n ≤ 10) able to comment on price (Table 14).

Table 14: Price of most recent cocaine purchases by PWID participants, 2013−2014

Amount	Median price* $	Range $	Number of purchasers*
Cap	50 (50)	50-100	25 (32)
Quarter gram	85 (150)	70-100	2^ (3^)
'Half weight' (0.5 grams)	262 (200)	150-350	6^ (16)
Gram	400 (300)	100-1000	12 (14)

Source: IDRS PWID interviews
*2013 data are presented in brackets
^n ≤ 10 results should be interpreted with caution

Figure 42: Median price of a gram and cap of cocaine estimated from PWID participant purchases, 2005−2014



Source: IDRS PWID interviews

The majority of participants (73%; 16% of entire sample) that could comment on cocaine reported that the price had remained 'stable' in the preceding six months. Nine percent (2% of entire sample) of those commenting reported that the price of cocaine had 'increased', 6% (1% of entire sample) reported it had 'decreased' and one participant reported the price 'fluctuated' over the past 6 months.

5.3.2 Availability

Forty-seven percent (10% of entire sample) of participants commenting on cocaine market characteristics (price, purity and/or availability) thought that it was 'easy' and 38% (8% of entire sample) thought it was 'very easy' to obtain cocaine (Table 15). Sixteen percent (3% of entire sample) of those that could comment, thought it was 'difficult' to obtain and there were no participants reports of cocaine being 'very difficult' to obtain (Table 15).

Sixty-nine percent of participants (15% of entire sample) commenting on cocaine reported that availability had remained 'stable' (Table 15). Twenty-two percent (5% of the entire sample) reported that it had become 'more difficult' to obtain over the last six months, and 9% (2% of the entire sample) thought it had become 'easier' (Table 15). There were no reports on the availability of cocaine fluctuating.

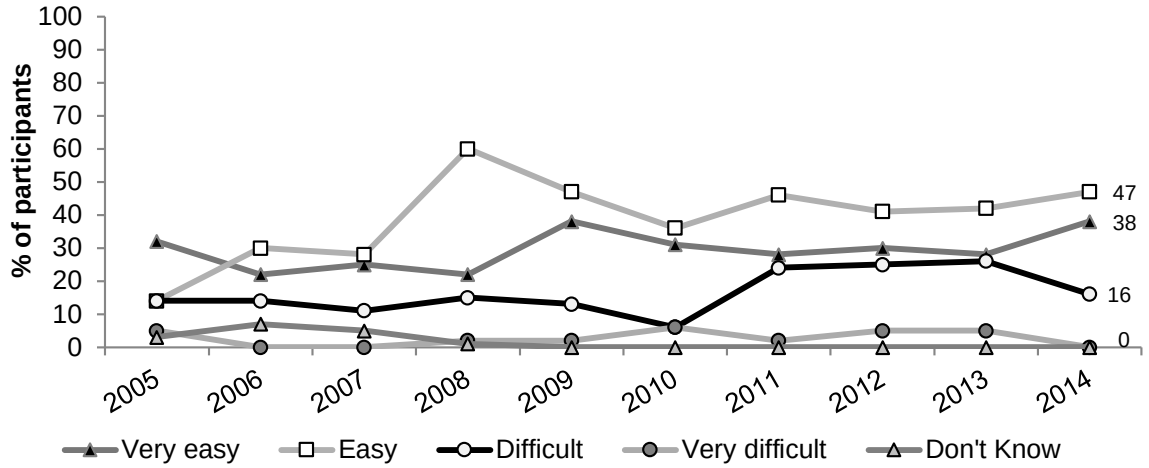
Figure 43 shows the availability of cocaine over time since 2005.

Table 15: Participants' reports of cocaine availability in the past six months, 2010−2014

	2010 (N=154)	2011 (N=150)	2012 (N=151)	2013 (N=151)	**2014 (N=150)**
Current availability					
Did not respond* (%)	47	63	71	72	**79**
Did respond (%)	53	37	29	28	**21**
Of those who responded:					
Very easy (%)	31	27	30	28	**38**
Easy (%)	36	45	41	42	**47**
Difficult (%)	27	23	25	26	**16**
Very difficult^ (%)	6	2	5	5	**0**
Don't know^ (%)	0	4	0	0	**0**
Availability change					
Did not respond* (%)	49	63	72	72	**79**
Did respond (%)	51	37	28	28	**21**
Of those who responded:					
More difficult (%)	23	27	19	31	**22**
Stable (%)	67	55	65	60	**69**
Easier (%)	6	11	12	10	**9**
Fluctuates^ (%)	4	2	5	0	**0**
Don't know^ (%)	0	5	0	0	**0**

Source: IDRS PWID interviews
* 'Did not respond' refers to participants who did not feel confident enough in their knowledge of the cocaine market to respond to survey items
^ 'Don't know' refers to participants who were able to respond to survey items on price and/or purity of cocaine, but had not had enough contact with users/dealers to respond to items concerning availability

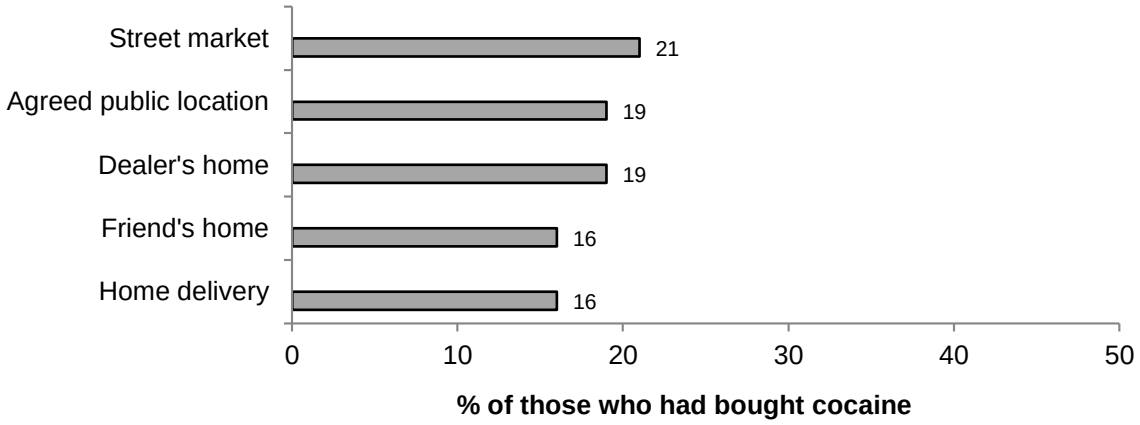
Figure 43: Participant reports of current cocaine availability, 2005−2014



Source: IDRS PWID interviews

The most common sources of purchasing cocaine over the preceding six months were friends (40%), followed closely by known dealers (30%) and street dealers (19%). Figure 44 shows the locations where these purchases were most commonly made, with the most common venues being a street market (21%), an agreed public location (19%), or dealer's home (19%). Equal proportions of participants nominated 'home delivery', (16%) or a 'friend's home' (16%).

Figure 44: Locations where cocaine was scored in the preceding six months, 2014



Source: IDRS PWID interviews
NB: More than one response could be selected

5.3.3 Purity

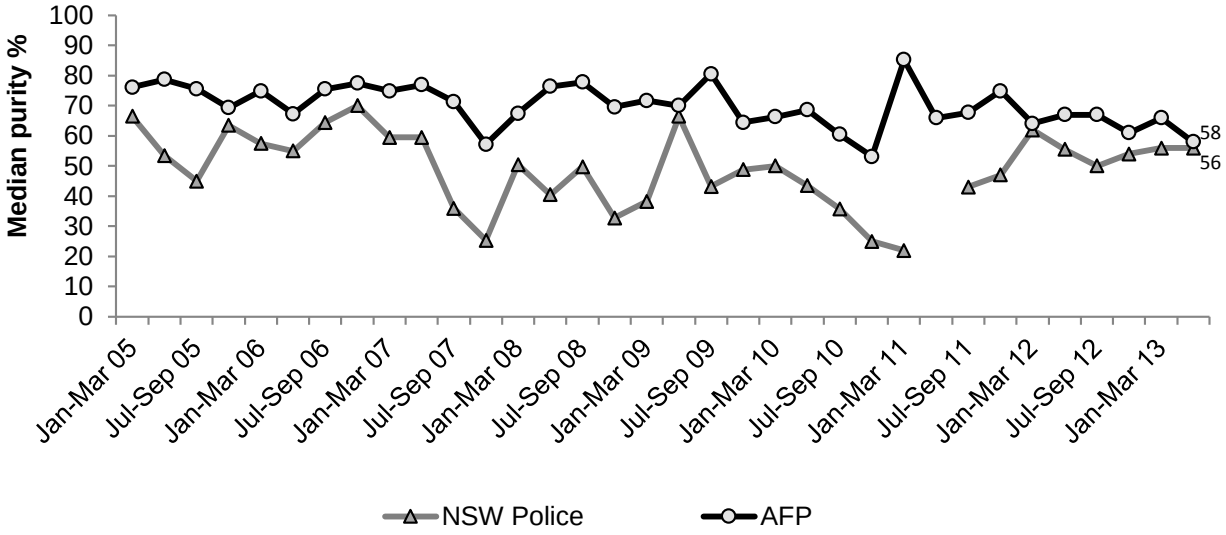
Since recording commenced, the total median purity of cocaine seizures analysed by the NSW Police has fluctuated but has remained stable since March 2012.

The overall total seizures analysed by the AFP remained relatively stable over the same period (Figure 45). The total median purity of cocaine analysed by the AFP, however, was comparable with 2011/12 values (66.7%) at 65% (Figure 45).

Purity figures, however, should be interpreted with caution, particularly where they are based on small numbers of seizures (refer to Figure 46).

It should also be noted that figures do not represent the purity levels of all cocaine seizures – only those that have been analysed at a forensic laboratory. The period between the date of seizure by police and the date of receipt at the laboratory can vary greatly. No adjustment has been made to account for double-counting from joint operations between the AFP and state/territory Police.

Figure 45: Purity of cocaine seizures analysed in NSW, by quarter, January 2005−July 2013



Source: Australian Crime Commission (2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014)

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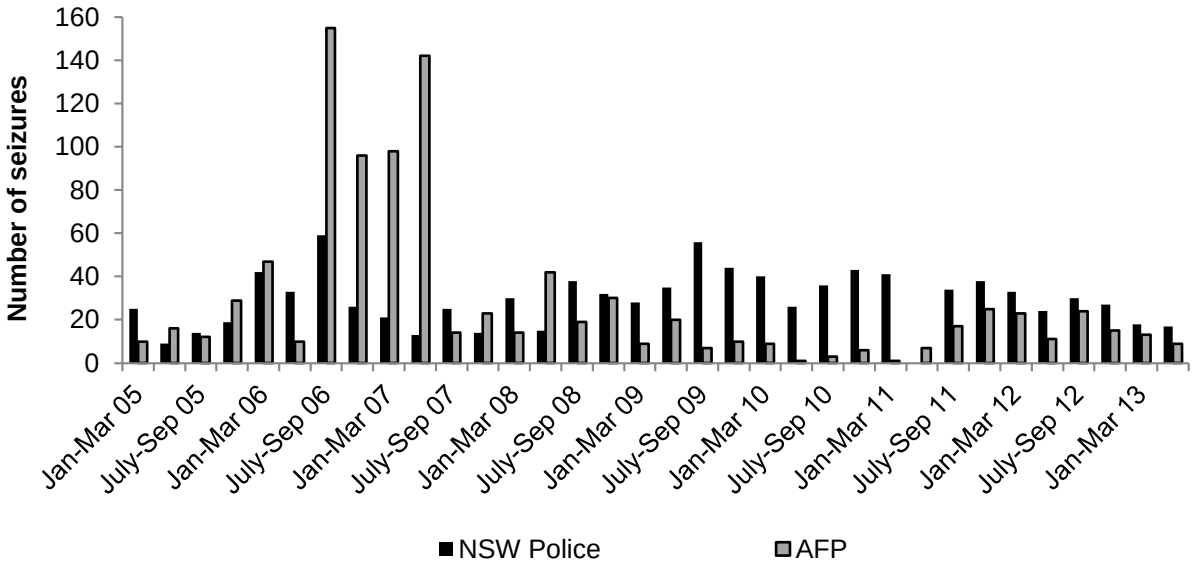
Figure 46 shows the number of seizures analysed in NSW between January 2005 and June 2013. The total number of seizures analysed by NSW Police decreased in the 12 month period until June 2012 (92 cases in 2012/13 versus 129 cases in 2011/12).

The number of cases analysed by the AFP decreased slightly from 76 cases in 2011/12 to 61 cases in 2012/13 (Figure 46).

Figure 46: Number of cocaine seizures analysed in NSW, by quarter, January 2005−July 2013



Source: Australian Crime Commission (2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014)

Twenty-two percent of all participants could comment on current purity of cocaine. Of these, 30% (6% of the entire sample) reported cocaine to be 'medium' purity. Twenty-seven percent (5% of entire sample) reported cocaine to currently be 'low' purity. Twenty-three percent of those who could comment (5% of entire sample) reported purity to be currently 'high' and 20% (4% of entire sample) reported that the purity of cocaine 'fluctuated' (Table 16). Comments on purity changes in the 6 months prior to interview were mixed. Forty-one percent of those who could comment (34% or 8% of entire sample) believed it was 'stable' while similar proportions reported recent purity was 'decreasing' (28%; 5% of entire sample) or 'fluctuating' (21%; 4% of entire sample. Ten percent of those who could comment reported recent cocaine purity as 'increasing'.

Table 16: Participants' perceptions of cocaine purity in the past six months, 2010−2014

	2010 (N=154)	2011 (N=150)	2012 (N=151)	2013 (N=151)	**2014 (N=150)**
Current purity					
Did not respond* (%)	50	64	72	72	**80**
Did respond (%)	50	36	28	28	**20**
Of those who responded					
High (%)	25	11	14	21	**23**
Medium (%)	36	30	48	40	**30**
Low (%)	26	38	26	33	**27**
Fluctuates (%)	13	18	12	7	**20**
Don't know^ (%)	0	4	0	0	**0**
Purity change					
Did not respond* (%)	47	64	74	73	**81**
Did respond (%)	53	36	26	27	**19**
Of those who responded					
Increasing (%)	12	13	8	7	**10**
Stable (%)	44	29	40	34	**41**
Decreasing (%)	23	32	30	44	**28**
Fluctuating (%)	21	20	23	15	**21**
Don't know^ (%)	0	7	0	0	**0**

Source: IDRS PWID interviews

*'Did not respond' refers to participants who did not feel confident enough in their knowledge of the cocaine market to respond to survey items

^'Don't know' refers to participants who responded to survey items on price and/or availability of cocaine, but had not had enough contact with users and/or dealers, or had not used often enough to feel able to respond to items concerning purity

5.3.4 Trends in cocaine use

In response to general, open-ended questions on changes in drug use, there were very few participants able to comment on cocaine. Due to the cost of cocaine, this could be a reflection of affordability, an individual's supply networks, or both.

5.3.5 Key expert comments

- Continuing a theme from last year, KE reported cocaine was viewed as expensive by PWID and use was quite low and infrequent.
- Of the few KE who could comment on cocaine in detail, it was generally reported that cocaine was not a preferred option for PWID due to the cost, and the effects are not as long lasting when compared with some other drugs.
- Cocaine was not observed as much during the week by health KE, but appeared to be more prevalent amongst employed, social users on weekends.
- Some regular heroin users are using cocaine occasionally.

5.4 Cannabis

Participants were asked if they were able to comment on the price, potency and/or availability of hydroponic ('hydro') and/or outdoor-grown ('bush') cannabis, and in 2014, 69% of the sample felt confident to answer at least some of the survey items on hydro. By contrast, 20% of participants were able to report on bush price, purity and/or availability, supporting previous years' findings that indicated hydro tends to dominate the Sydney market.

5.4.1 Price

Prices paid for hydro and bush by PWID participants on the last occasion of purchase are presented in (Figure 17). As in previous years, hydro appeared to be the more popular form of cannabis with fewer participants reporting the purchase of bush. Purchase of the resin (hashish) and oil (hash oil) forms remained uncommon.

5.4.1.1 Hydroponic cannabis

Participants were surveyed concerning the price paid the last time they had bought hydro. The median price paid for a gram of hydro was $20, the same as in previous years (Figure 17). In 2014, the median price of a quarter ounce of hydroponic cannabis increased by $10 to $100, while the price of an ounce remained stable at $300. The median price for half an ounce decreased from $180 in 2013 to $160 (Table 17). As in previous years, and comparable with other drugs surveyed (e.g. heroin, cocaine, methamphetamine), the most popular purchase amount of hydro was the smallest generally available, i.e. grams (n=83), followed by quarter ounces (n=43).

Participants were also asked whether they thought that prices had changed over the six months preceding interview. The majority of PWID participants who commented (80%) reported that the price was 'stable', with smaller proportions stating that it had 'increased' (8%), or 'fluctuated' (7%). Two participants reported a decrease in prices.

5.4.1.2 Bush cannabis

In 2014, the median price for a gram of bush cannabis ($20) remained stable (Table 17). The number of reported purchases for all other amounts was low (<10) so results should be interpreted with caution (Table 17).

The most popular purchase amount for bush remained at a gram (n=19), consistent with previous years, excluding 2006 when an ounce was reported as the most purchased amount. There was a tendency for larger quantities of bush to be slightly cheaper than for hydro, continuing a consistent pattern since 2003.

The majority of participants who commented (86%; 17% of the entire sample) thought prices of bush cannabis had remained 'stable.' Seven percent reported an 'increase', while there were no reports of a 'decrease' or 'fluctuation' in the recent price of bush cannabis

Again in 2014, price ranges for larger quantities of hydroponic and bush cannabis were wide. This is likely to be a reflection of potency/availability within that particular person's network and various other circumstances which may influence the cost of a particular purchase.

Table 17: Price of most recent cannabis purchases by PWID participants, 2013−2014

Amount	Median price* $	Range $	Number of purchases*
Hydro			
Gram	20 (20)	10-110	83 (75)
Quarter ounce	100 (90)	65-130	43 (39)
Half ounce	160 (180)	110-300	31 (29)
Ounce	300 (300)	220-500	34 (34)
Bush			
Gram	20 (20)	10-20	19 (18)
Quarter ounce	80 (70)	50-120	7^ (13)
Half ounce	140 (140)	120-175	5^ (8)
Ounce	220 (240)	100-320	9^ (13)

Source: IDRS PWID interviews
*2013, median prices are in brackets
^n ≤ 10 results should be interpreted with caution

5.4.1.3 Hash and hash oil

Four participants reported buying hash or hash oil in the six months preceding interview. This indicated that the use of these forms of cannabis remained low and infrequent.

5.4.2 Availability

5.4.2.1 Hydroponic cannabis

Just over half of all participants commenting on hydro availability thought it was 'very easy' (55%; 38% of all participants) or 'easy' (35%; 24% of all participants) to obtain. Nine percent of participants commenting reported current availability as 'difficult' (Table 18). The majority (79%; 51% of all participants) reported availability as 'stable' over the preceding six months. Note that prior to 2004 no distinction was drawn between hydro and bush availability, with participants instead being surveyed about cannabis availability generally. From 2000 until 2004, approximately half of all respondents reported that cannabis was 'very easy' to obtain.

5.4.2.2 Bush cannabis

The majority of participants reported current bush cannabis availability to be 'easy' (63%; 13% of the sample) to obtain, while a further 20% who responded suggested that availability was 'very easy' (4% of the sample). Only four participants (13% of those who responded; 3% of the entire sample) reported that bush cannabis was 'difficult' to obtain. One participant reported obtaining bush cannabis as 'very difficult' (Table 18). There was a statistically significant increase ($p<0.05$) in those participants reporting the recent availability of bush cannabis as 'stable' (86% versus 52% in 2013. The remaining participants who commented reported recent availability as either 'difficult' (7%) or 'fluctuating' (7%).

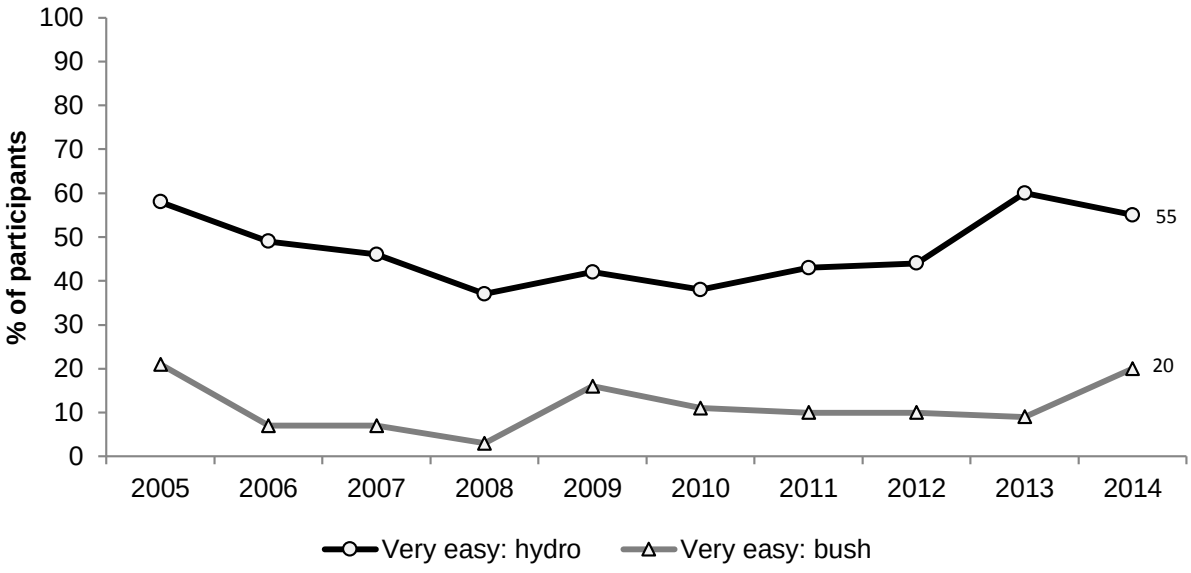
(Figure 47) represents those participants reporting the availability of hydro and bush cannabis as 'very easy' from 2005 onwards.

Table 18: Participants' reports of cannabis availability in the past six months, 2013−2014

	Hydro		Bush	
	2013 (N=151)	**2014 (N=150)**	2013 (N=151)	**2014 (N=150)**
Current availability				
Did not respond* (%)	36	**31**	79	**80**
Did respond (%)	64	**69**	21	**20**
Of those who responded:				
Very easy (%)	60	**55**	9	**20**
Easy (%)	37	**35**	63	**63**
Difficult (%)	3	**9**	28	**13**
Very difficult (%)	0	**1**	0	**3**
Availability change				
Did not respond* (%)	36	**35**	79	**81**
Did respond (%)	64	**65**	21	**19**
Of those who responded:				
More difficult (%)	4	**10**	26	**7**
Stable (%)	90	**79**	52	**86**
Easier (%)	4	**9**	16	**0**
Fluctuates (%)	2	**2**	7	**7**

Source: IDRS PWID interviews
*'Did not respond' refers to participants who did not feel confident enough in their knowledge of the market to respond to survey items.
NB: Changes were made to the administration of the cannabis section of the survey in 2006, resulting in differences between response rates

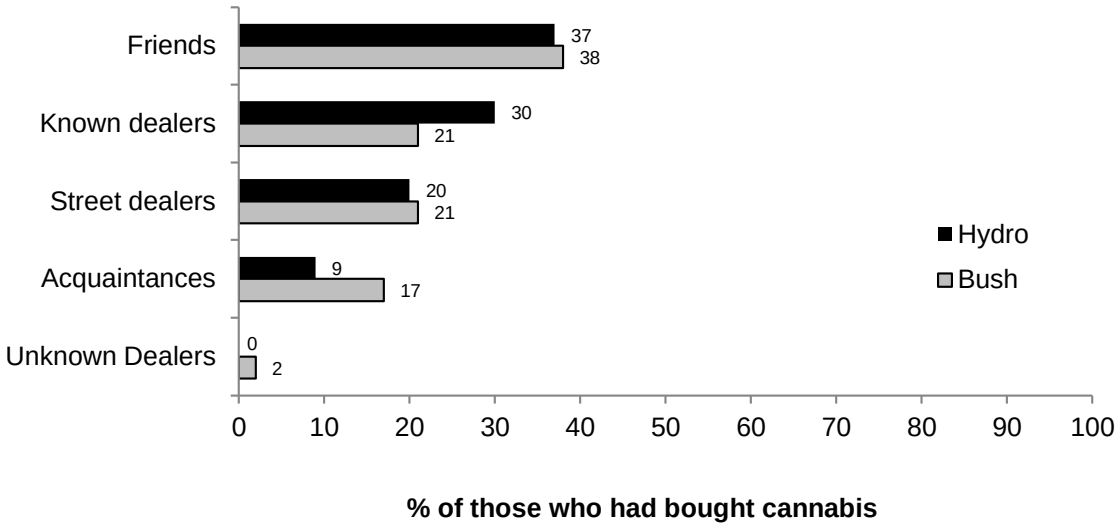
Figure 47: Participant reports of current cannabis availability, 2005−2014



Source: IDRS PWID interviews
NB: A distinction between hydroponic and bush cannabis was introduced in 2004. Prior to this time, survey items referred to any form of cannabis

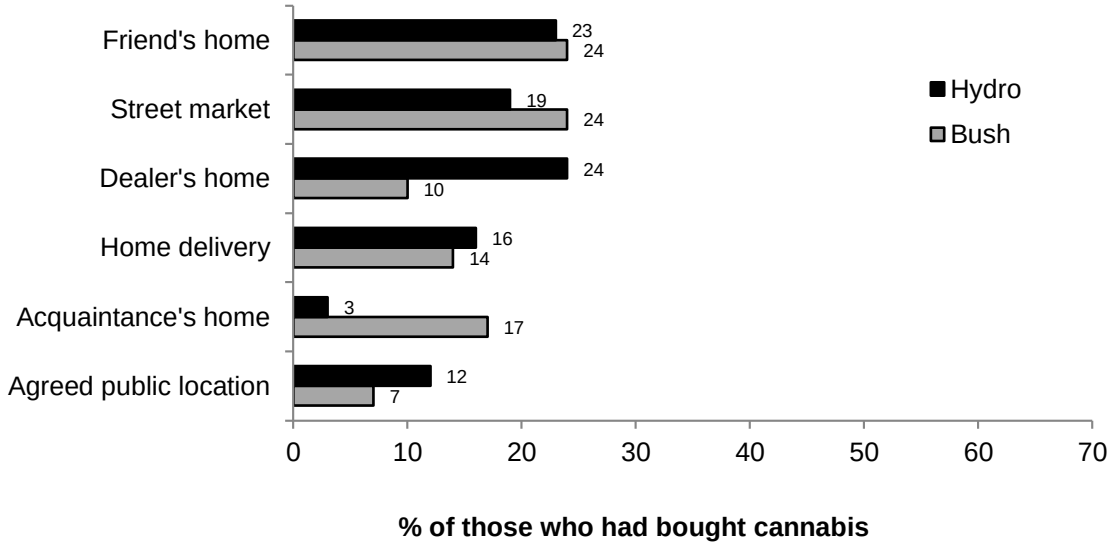
Sixty-nine percent of all participants had purchased hydro in the preceding six months and 20% of participants had purchased bush. Patterns of purchase of hydro and bush were fairly similar, with those who had purchased in the last six months predominantly obtaining it through friends, from known dealers and/or from street dealers (Figure 48). Locations where cannabis was scored were varied, including public and private locations (Figure 49).

Figure 48: People from whom cannabis was purchased in the preceding six months, 2014



Source: IDRS PWID interviews
NB: More than one response could be selected

Figure 49: Locations where cannabis was purchased in the preceding six months, 2014



Source: IDRS PWID interviews
NB: More than one response could be selected

5.4.3 Potency

Participants were questioned about their perceptions of current potency of hydro and bush (whether it was 'low', 'medium', 'high', 'fluctuates' or that they 'did not know'), and whether they thought that the potency had changed over the last six months (response options were 'stable', 'increasing', 'decreasing' and 'fluctuating').

5.4.3.1 Hydroponic cannabis

The majority of participants commenting on hydro reported it as currently being of 'high' potency (59%; 40% of the entire sample), followed by 27% (19% of the entire sample) who rated it as being of 'medium' potency. Only 1% of participants thought that it was of 'low' potency, and 13% (9% of the entire sample) believed that it had 'fluctuated'. The majority (57% of those commenting; 38% of the entire sample) believed that potency had remained 'stable' in the preceding six months, with smaller proportions reporting that it had 'fluctuated' (22%; 15% of the entire sample), 'increased' (15%; 10% of the entire sample) or 'decreased' (6%; 4% of the entire sample). Despite some fluctuations, these figures followed a similar pattern to 2013.

5.4.3.2 Bush cannabis

Among those who commented, 46% (9% of entire sample) thought bush was of 'medium' potency, 21% reported bush potency as either 'high' or 'fluctuating' (4% of the sample) and the remaining participants who could comment thought it was of 'low' potency (11%; 2% of the sample). When asked about whether potency had changed over the last six months, 57% of the respondents that commented (11% of all participants) reported that potency had remained 'stable'. Twenty-eight percent (5% of the sample) reported recent potency of bush cannabis had 'fluctuated' and smaller proportions reported it was 'decreasing' (11%; 2% of the sample) or 'increasing' (4%; 1% of the sample).

Overall, these findings indicated that, according to PWID perceptions, hydroponic cannabis appeared to dominate the market, and was generally seen as being higher in potency than outdoor-grown 'bush' cannabis. Potency of both forms was generally perceived to have remained stable in 2014.

No routine data is currently collected on cannabis potency in Australia. Therefore, KE were only able to comment based on perceptions and anecdotal reports.

5.4.4 Cannabis trends

As in previous years, there were minimal participant comments on open-ended survey items on general drug trends with reference to cannabis. This may in part be due to lack of noticeable changes occurring among this group.

5.4.5 Key expert comments

- There was consensus among health KE that the prevalence of use remained high for this group, although it was not primarily the drug of concern.
- Health KE report many of their clients are using cannabis daily.
- Availability was high and the price remained stable with previous years.
- Most clients are focused on the purchase price, not the measurement in weight.

5.5 Methadone

As with other drug types, all participants were asked about the price, purity and availability of non-prescribed methadone. Thirty-three percent of the sample, (34% in 2013) were able to comment on the price, purity and/or availability of illicit methadone. Among participants who had used any form of methadone in the preceding six months, the median price for methadone liquid was reported to be 50 cents per ml, which is stable with the data from previous years.

Only two participants were able to comment on the price of Physeptone tablets, with a median price of $10 for 5mg tablet and $13 for a 10mg tablet. Interpret figures with caution due to small numbers reporting.

In response to the question 'Has the price of illicit methadone changed in the past six months?', the majority of those commenting (63%; 19% of the entire sample) reported that the price had remained 'stable' during this time. This was a non-statistically significant increase from the 47% that reported it 'stable' in 2013. Twenty-eight percent (9% of the entire sample) reported prices had 'increased'. Smaller proportions of people stated that the price had 'fluctuated' (7%; representing 2% of the entire sample) and only one participant reported it had 'decreased'.

There were mixed responses in regards to the current availability of non-prescribed methadone. Forty-four percent of those who could comment reported it 'very easy' (39% in 2013) to obtain while a further 29% of participants reported obtaining illicit methadone 'difficult' (39%in 2013). Twenty-three percent found it 'very easy' to obtain and only two participants reported it 'very difficult' to obtain.

When asked whether availability had changed over the preceding six months, the majority of those commenting (77%; 22% of the entire sample) reported that it had remained *'*stable*'.* Nineteen percent (5% of all participants) reported that it had become 'more difficult' in the preceding six months and two participants reported it to be 'easier' to obtain. No participants reported any fluctuation in recent methadone availability.

Overall, the findings suggest that the illicit methadone market has remained relatively stable in terms of price and availability over the past few years. Of those that had obtained methadone, it was most commonly acquired from 'friends' (68%), 'known dealers' (11%), with equal proportions obtaining from 'acquaintances' and 'street dealers' (8%). The most commonly reported locations of purchase were 'street market' (36%), 'friend's home' (25%), or an 'agreed public location' (19%). The remaining participants who obtained methadone, did so through 'home delivery' (6%), a 'dealer's home' (3%) or a 'chemist' (3%).

5.6 Buprenorphine

Thirteen percent of participants (8% in 2013) commented on the price and/or availability of non-prescribed buprenorphine, suggesting that while they may not have personally used it during this time, they were aware of some market characteristics. Buprenorphine (Subutex) is available in 0.4mg, 2mg and 8mg tablets (MIMS, 2007).

Just under two-thirds (63%; 7% of entire sample) of those who commented reported current availability was 'stable' while the remaining participants reported availability was 'increasing' (38%). Nearly half of the participants who commented (47%; 5% of entire sample) reported that availability of buprenorphine was 'easy' over the preceding 6 months, while 24% believed it was 'very easy'. A further 18% of participants reported the change in availability as 'difficult', while the remaining 12% suggested it was 'very difficult'. Small numbers of participants commented on the availability and recent availability of buprenorphine, therefore, results should be interpreted with caution. Overall, these findings suggested that while there was a market for non-prescribed buprenorphine, it was less available than non-prescribed methadone in NSW.

A question was added in 2007 that asked participants about the last occasion on which they used buprenorphine that wasn't prescribed to them, and what their main reasons for doing so were. In 2014, the main responses were as a substitute for heroin (67%) and for self-treatment (17%).

5.7 Morphine

Twenty-four percent of participants felt confident enough to respond to survey items concerning price and/or availability of illicit morphine, (21% in 2013). MS Contin continued to remain the most common brand of morphine used.

The median price for 100mg MS Contin tablets ('grey nurses') increased in 2014 to $50 per tablet ($40 in 2013; range $10−$150). Fourteen participants commented on 60mg MS Contin (median price $28) with less than 10 participants commenting on 30mg, 10mg (median price $15, $10 and $5 respectively). Nine participants were able to comment on the price of 100mg Kapanol (median price $40); therefore, results should be interpreted with caution. No participants commented on the price of Anamorph.

Fifty-three percent (12% of entire sample) of those commenting on the market for non-prescribed morphine reported that the price had remained 'stable' over the preceding six months (63% in 2013). Forty-four percent (10% of entire sample) of these participants believed that it had 'increased' (37% in 2013), and one participant reported that the price had 'decreased'. Overall, these figures are comparable to 2013.

The majority (77% or 18% of the sample; 61% in 2013) commented that non-prescribed morphine was 'very easy' or 'easy' (31% and 46% respectively) to obtain. Twenty percent (5% of the sample) believed it to be 'difficult' (39% in 2013), with one participant reporting morphine 'very difficult' to obtain. Sixty-nine percent (67% in 2013) of those commenting stated that availability had remained 'stable' over the preceding six months, while 16% reported the change in availability of morphine as 'more difficult'. A further 16% of participants reported the change to recent availability of morphine as 'easier'.

In 2014, morphine was most commonly purchased from 'street dealers' (46% of those commenting), 'friends' (27%), and 'known dealers' (21%). The source of purchase did alternate between 'street dealers' and 'friends' in 2014, but otherwise figures have remained comparable with participant reports from 2013. The most commonly reported locations of purchase were from a 'street market' (55%), an 'agreed public location' (16%) or 'home delivery' (13%).

5.8 Oxycodone

In 2014, Oxycontin® (oxycodone) tablets were reformulated with physicochemical properties in order to make them harder to crush for unsanctioned routes of administration, such as snorting and injecting. These changes took effect from 1 April 2014, and IDRS participants were subsequently asked to distinguish between existing non-formulated Oxycontin® (i.e. 'original stock') and reformulated Oxycontin®.

Thirty-seven percent of all participants were confident enough to complete survey items concerning the market for non-prescribed oxycodone, which remained stable with the 39% of participants from 2013. As per previous years, the most commonly purchased amounts were 80mg original 'OC' tablets (OxyContin, n=41), bought for a median of $50 each (range $10−$150). The second most commonly purchased amount, 40mg original 'OC' OxyContin, had a median price of $25 (range $20−$50). Eighteen percent of participants (6% of the sample) purchased 20mg original 'OC' Oxycontin at a median of $15 (range $10−$30). Fewer participants (n<10) purchased 15mg, 10mg and 5mg 'OP' OxyContin at a median price of $13, $5 and $5 respectively. There were few reports of any participants using Endone, or Oxynorm

tablets and no participants reporting the use of Targin or Prolodone. See also section 8.2 'Oxycodone use' for further information.

The overall price for oxycodone was reported as 'increasing' over the past six months (63% of those commenting), representing a shift from the 55% of participants in 2013 who reported it as 'stable'. Thirty percent stated price had remained 'stable', and 4% reporting that it had 'fluctuated'. Smaller numbers reported the price 'decreasing' (2%). Availability was reported by the majority of those commenting to have been 'difficult' (37%; 16% in 2013) to obtain over the preceding six months, while 28% (2% in 2013) reported it had become 'very difficult'. Twenty-two percent reported it had become 'easy' (44% in 2013), and 14% of participants believed it to be 'very easy' to obtain (38% in 2013). Overall, there appears to have been a shift in the availability of oxycodone when compared with 2013. This may be a response by PWID to the reformulation of Oxycontin which occurred April 1, 2014. Just over one-half (53% of those who could comment) thought that current availability of oxycodone was 'more difficult' and 41% thought it 'stable', smaller amounts thought it was 'easier' (4%) and only one participant commented that recent oxycodone availability had 'fluctuated'.

Oxycodone remained most commonly purchased from 'friends' (37%) 'street dealers' (35%), and 'known dealers' (22%) with smaller proportions reporting 'acquaintances', and 'known dealers' and (2% each). The most commonly cited locations for purchase were the 'street market' (45%), an 'agreed public location' (24%), or a 'friend's home' (13%). The remaining participants obtained oxycodone through 'home delivery' (11%) or 'other' means (9%).

5.8.1 Key expert comments

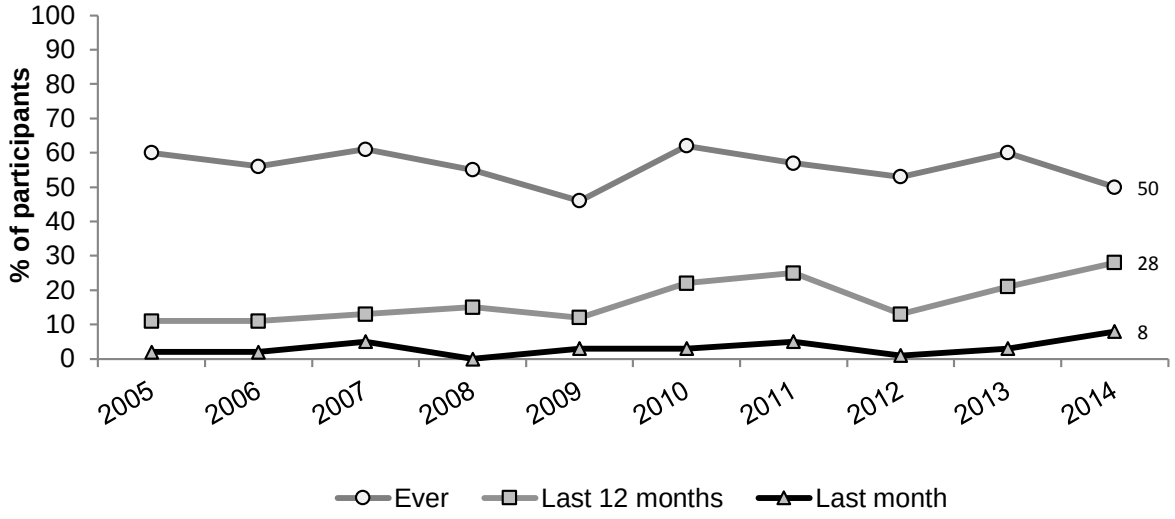
- Some KEs noted that the reformulation of Oxycontin seemed to have changed the prevalence of use, however, there didn't seem to be an increase in the use of other drugs, or admissions into treatment.
- Since the reformulation, other health KE report a slight increase in the use of Fentanyl, MS Contin and heroin
- Health KE noted a high level of misinformation among clients about the safest way to prepare pharmaceutical opioid tablets for injection.
- A recurring theme among health KE was the prohibitive costs to their service of purchasing pill filters.

6 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

6.1 Overdose and drug-related fatalities

Fifty percent of participants reported having overdosed on heroin in their lifetime and 28% had done so the 12 months preceding the interview (21% in 2013). There were six reports of heroin overdose (8% of those who could comment) in the month prior to interview (three in 2013) (Figure 50).

Figure 50: Proportion of PWID participants who had ever overdosed, overdosed in the past 12 months, and the past month, on heroin 2005−2014

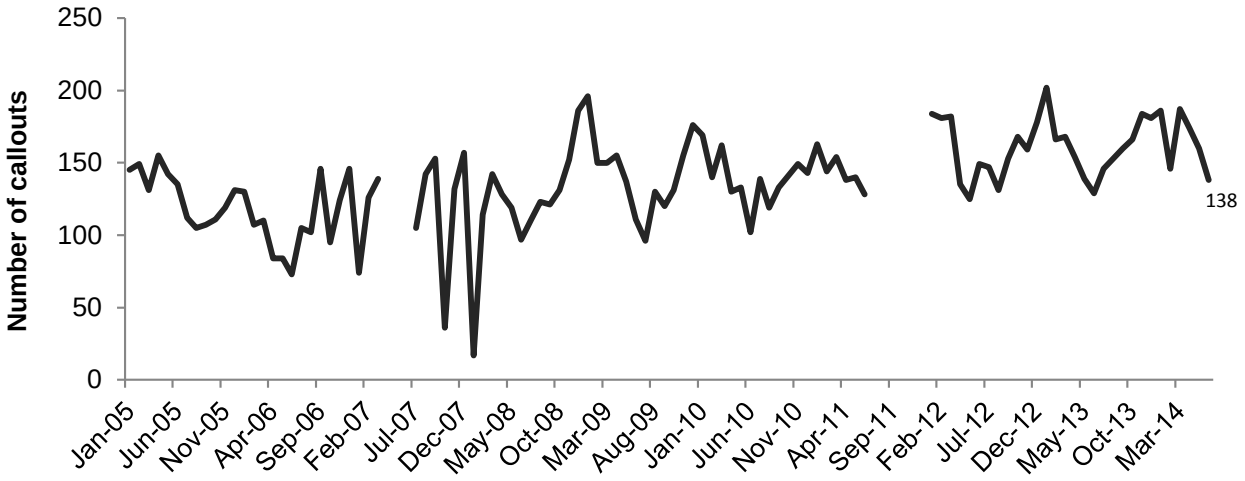


Source: IDRS PWID interviews

Twenty-one percent of all participants (23% in 2013) reported that they had accidentally overdosed on other drugs excluding heroin and morphine on a median of one time only. Thirty-nine percent (29% in 2013) reported they had accidentally overdosed on other drugs excluding heroin and morphine in the 12 months prior to interview and five participants reported accidental overdose on other drugs in the past month.

The number of callouts to overdoses in NSW decreased dramatically in late 2000, and has not returned to levels recorded prior to 2000. Overall, NSW ambulance callouts have remained stable over the last decade, and this has continued in the 12 months to June 2014 (Figure 51). For further information on ambulance callouts to overdoses in Inner Sydney, see National Centre in HIV Epidemiology and Clinical Research (2007).

Figure 51: Number of ambulance callouts to overdoses January 2005−June 2014

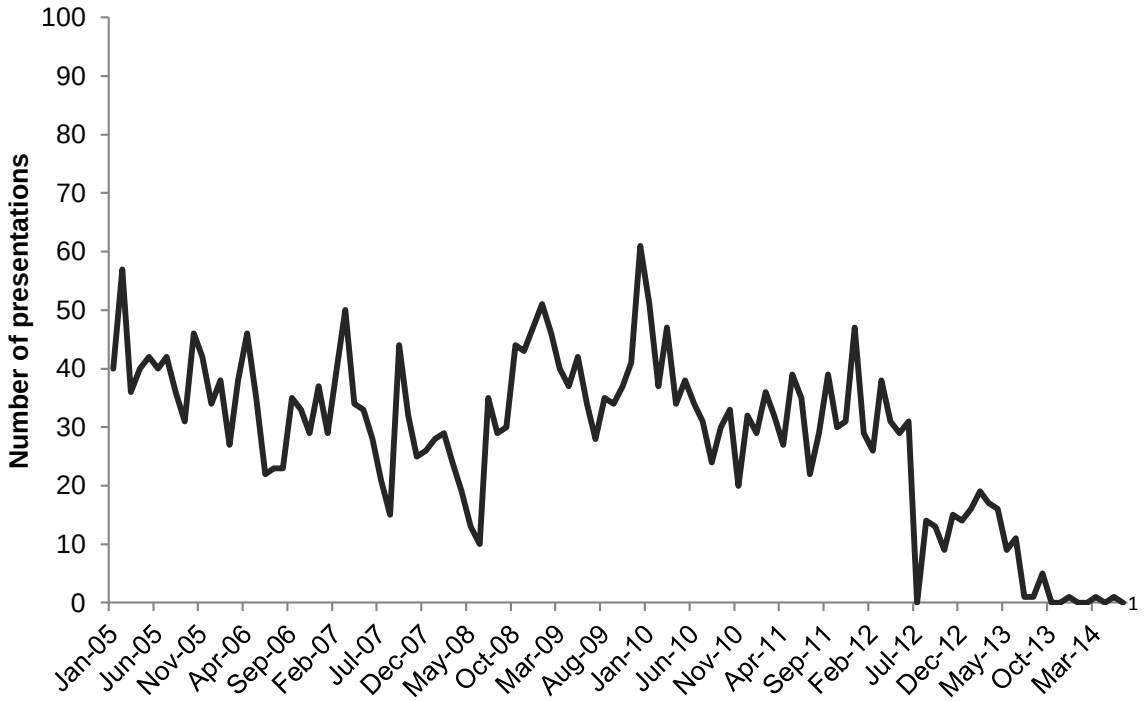


Source: Ambulance Service of NSW case sheet database

6.1.1 Heroin

Heroin overdose presentations to NSW emergency departments were relatively stable at less than 50 presentations from February 2010-June 2012. Figures have dropped off to less than 20 presentations per month during the period July 2012−June 2014; however, it's unclear whether this may be related to a change in the use of Systematized Nomenclature of Medicine (SNOMED) codes (Figure 52).

Figure 52: Heroin overdose presentations to NSW emergency departments, January 2005−June 2014

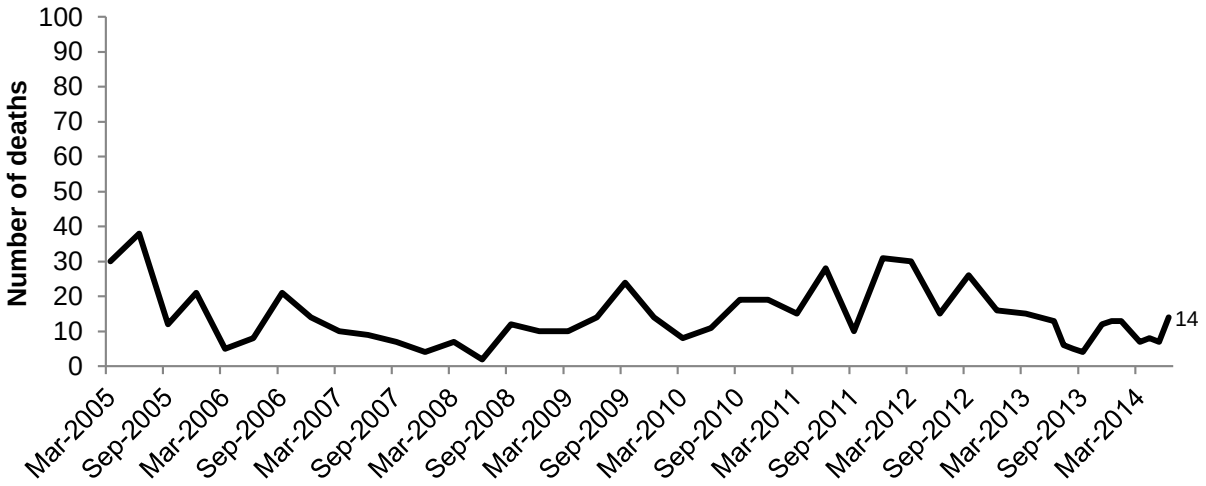


Source: Emergency Department Information System, NSW Health, 2014
NB: Figures refer to overdose only and do not include presentations for use disorders

6.1.1.1 Fatal overdose

In the 12 months to June 2014, there were relatively few deaths of people suspected of drug use (as determined by police or pathologists) in which morphine was detected (Figure 53). There was, however, a spike in fatalities in the three month periods leading up to December 2011 and March 2012 with 31 and 30 deaths reported, respectively, the highest numbers since mid-2005, in which 38 deaths were reported. Figures reached a peak in the late 1990s and have gradually decreased since 2000/01. As noted by other data sources, morphine-related deaths decreased dramatically in early 2001.

Figure 53: Number of suspected drug-related deaths in which morphine was detected post-mortem, by quarter, March 2005−June 2014



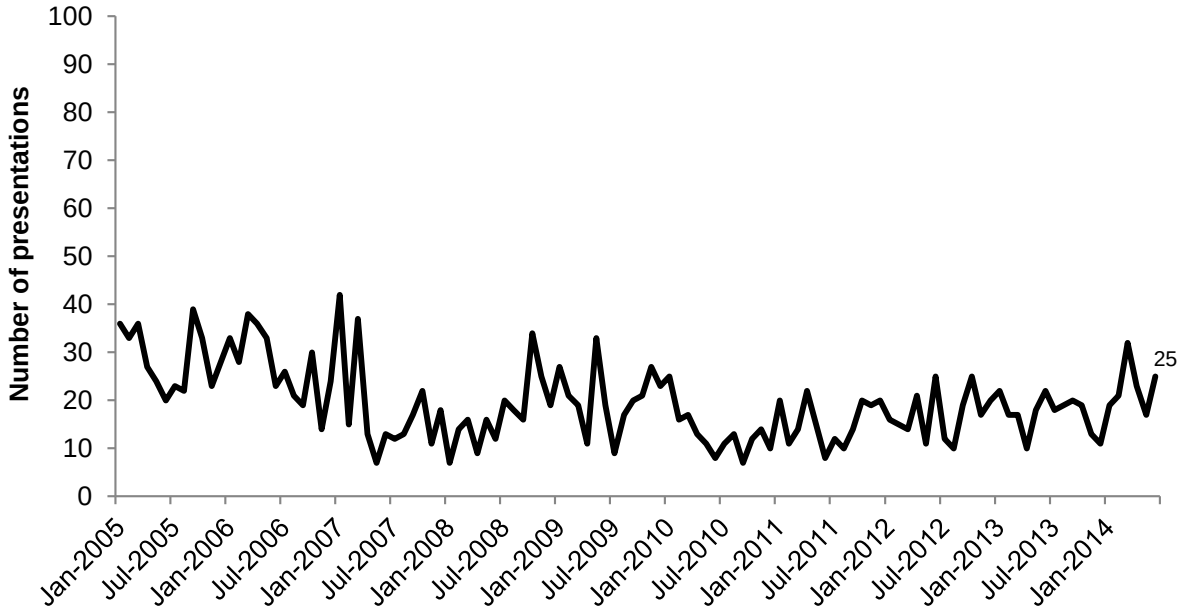
Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories, NSW Health, 2014
NB: These numbers relate to deaths in which morphine (a metabolite of heroin) was detected; however, there may have also been other drugs present

6.1.2 Methamphetamine

6.1.2.1 Non-fatal overdose

The number of amphetamine overdose presentations to NSW emergency departments fluctuated over the last decade and continued in 2013/14, ranging between 11 and 32 presentations per month (Figure 54).

Figure 54: Amphetamine overdose presentations to NSW emergency departments, January 2005−June 2014



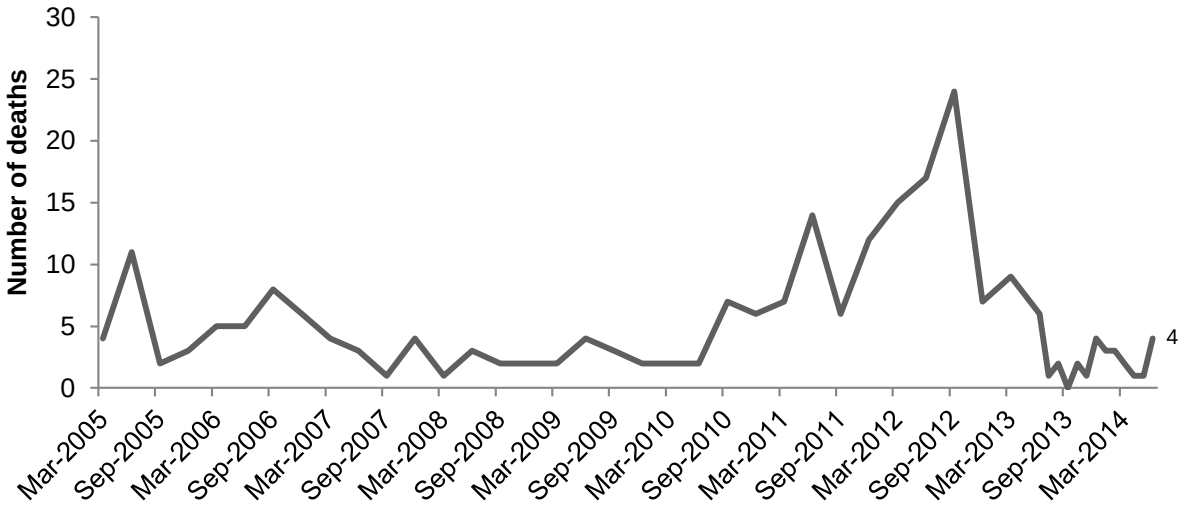
Source: Emergency Department Information System, NSW Health, 2014
NB: Figures refer to overdose only and do not include presentations for use disorders

6.1.2.2 Fatal overdose

The number of deaths of individuals suspected of drug use where amphetamines were detected post mortem in NSW has increased in 2012/13, peaking in the September 2012 quarter at 24 deaths, the highest number recorded in one quarter over the 18 year period. In the last two years, these figures have remained stable and appear to be returning to the peaks seen between 2005 and 2010 (Figure 55).

It is important to note that these figures do not include methylenedioxymethamphetamine, methylenedioxyamphetamine, or p-methoxy-amphetamine. Pseudoephedrine and ephedrine are also excluded as only deaths related to illicit amphetamines are presented.

Figure 55: Number of deaths of individuals suspected of drug use, in which illicit amphetamines were detected post-mortem, NSW, by quarter, March 2005−June 2014



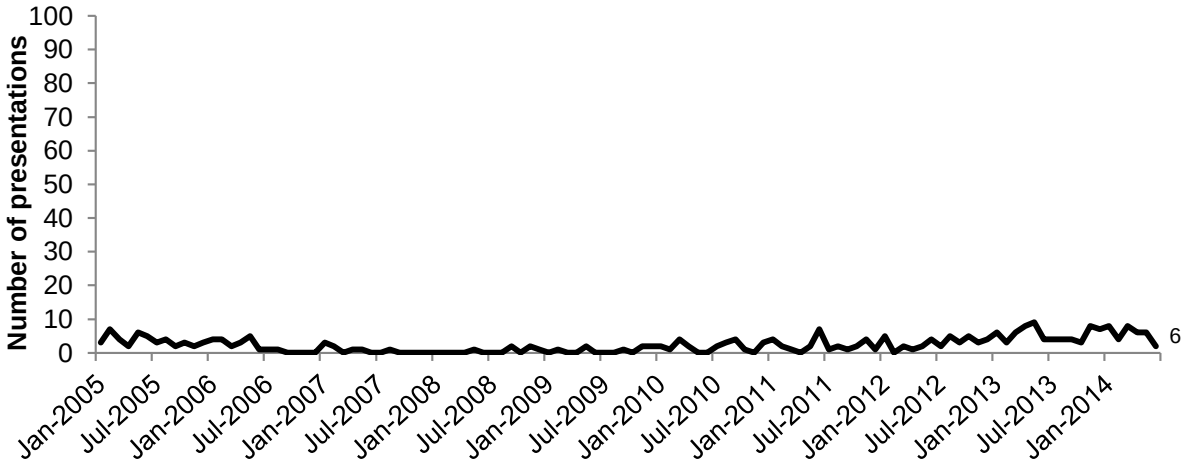
Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories, NSW Health, 2014
NB: These numbers relate to deaths in which amphetamines, including methamphetamine, were detected; however, there may have also been other drugs present

6.1.3 Cocaine

6.1.3.1 Non-fatal overdose

The number of cocaine overdose presentations to NSW emergency departments has remained lower than ten per month since February 2002; however, they have increased compared to previous years (Figure 56). From July 2005-June 2012 there were a total of 123 cocaine overdose presentations compared with 122 in the two years to June 2014.

Figure 56: Cocaine overdose presentations to NSW emergency departments, January 2005−June 2014

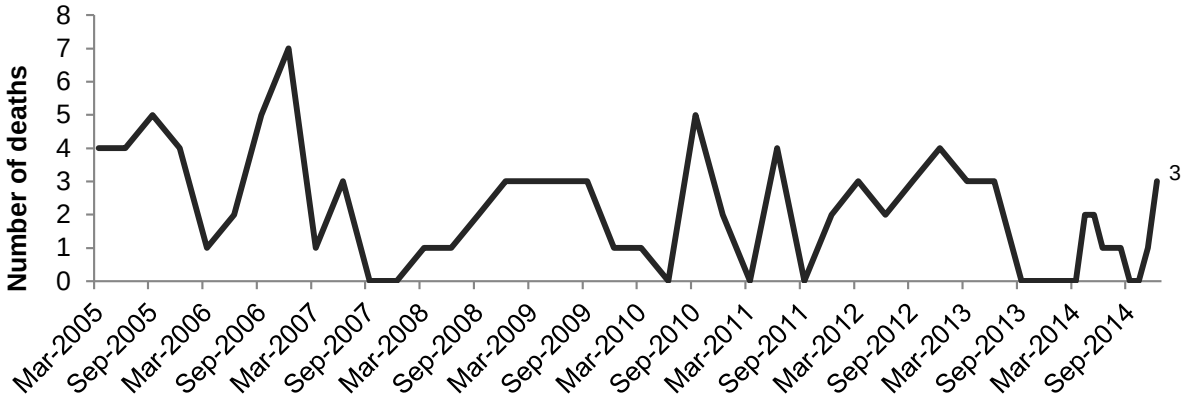


Source: Emergency Department Information System, NSW Health, 2014
NB: Figures refer to overdose only and do not include presentations for use disorders

6.1.3.2 Fatal overdose

The number of drug-related deaths in which cocaine was detected post-mortem has remained low over the last 12 months to December 2014 (Figure 57), following a peak in the late 1990s. These deaths have not exceeded 20 in any given quarter over the past 12 years and have remained at five or less per quarter since 2007.

Figure 57: Number of deaths of individuals suspected of drug use, in which cocaine was detected post-mortem, NSW, by quarter, March 2005−December 2014

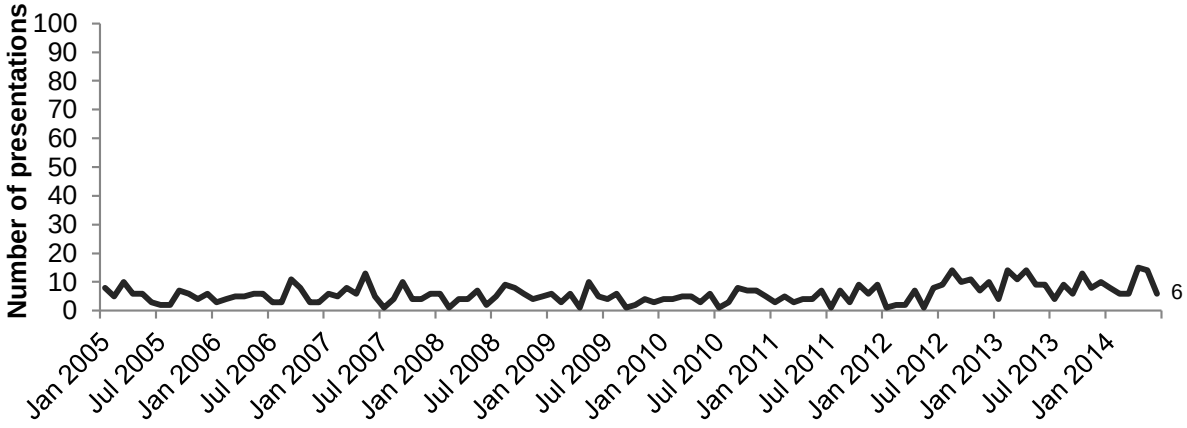


Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories, NSW Health, 2014
NB: These numbers relate to deaths in which cocaine was detected; however, there may have also been other drugs present

6.1.4 Cannabis

The number of cannabis toxicity presentations to emergency departments has remained at less than 20 per month since 1997. The past 12 months to June 2014 has seen this trend continue remaining low and stable (Figure 58).

Figure 58: Cannabis toxicity presentations to NSW emergency departments, January 2005−June 2014



Source: Emergency Department Information System, NSW Health, 2014
NB: Figures refer to overdose only and do not include presentations for use disorders

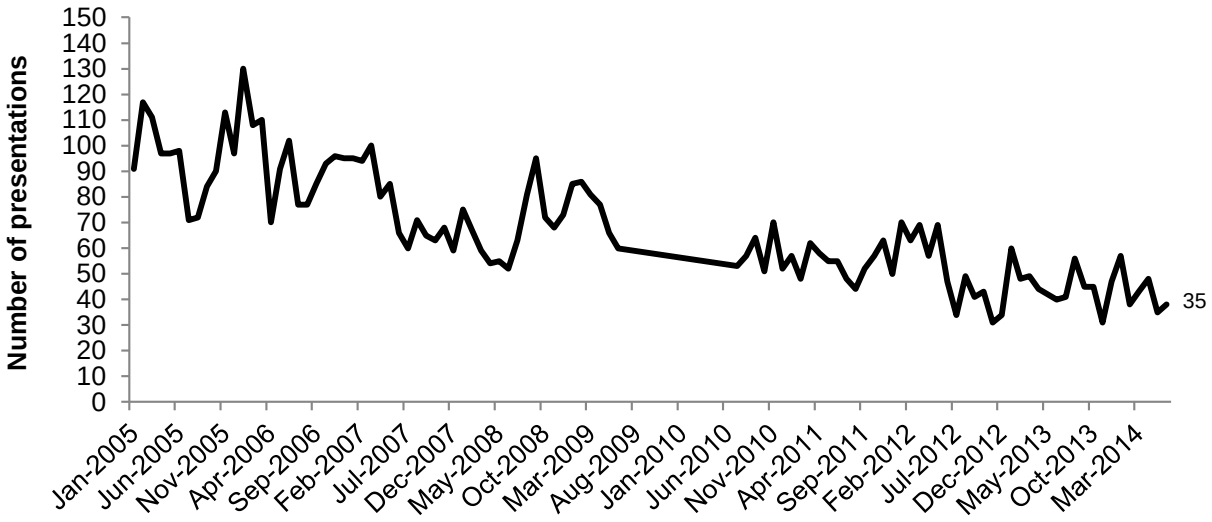
6.1.5 Benzodiazepines

6.1.5.1 Non-fatal overdose

The number of benzodiazepine overdose presentations to NSW emergency departments has fluctuated over the past 12 months to June 2014 (between 31 and 57 presentations per month; Figure 59) and continues to decline over time. There appears to be a continuing decline in these presentations; however, this may also reflect that coding practices have changed.

With the introduction of the SNOMED coding system, an increasing number of codes related to benzodiazepine overdose have been introduced, which may in turn impact on the accuracy of data coding of these presentations.

Figure 59: Benzodiazepine overdose presentations to NSW emergency departments, January 2005−June 2014



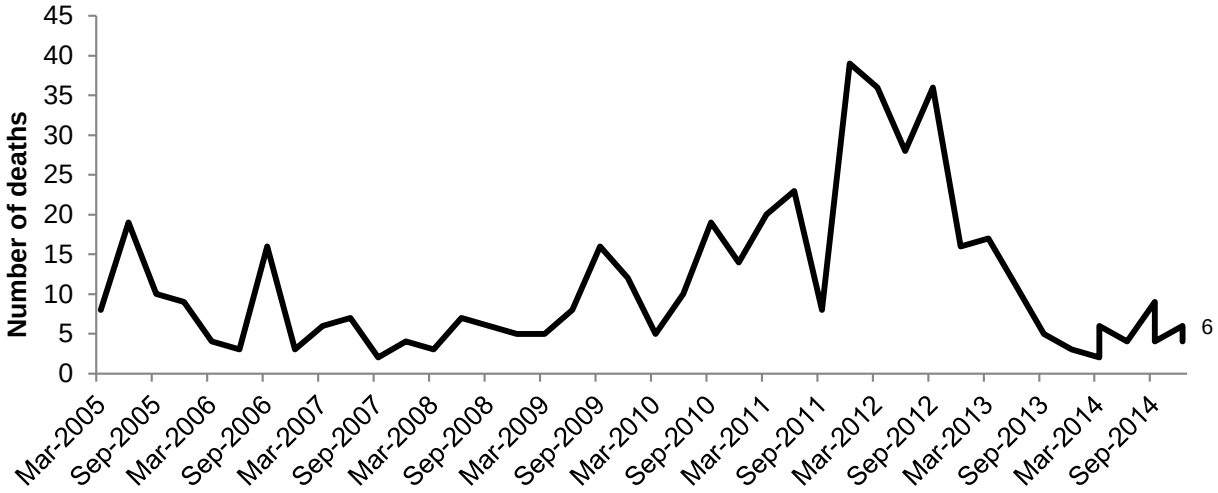
Source: Emergency Department Information System, NSW Health 2014
NB: Figures refer to overdose only and do not include presentations for use disorders

6.1.5.2 Fatal overdose

The suspected number of deaths of people who use drugs in which benzodiazepines were detected post-mortem has fluctuated over the last 15 years (Figure 60) although there has been a decline in numbers since early 2000.

Over the last decade, deaths attributed to benzodiazepines have remained at 23 or less with the exception of December 2011- September 2012 period in which they peaked at 39 deaths.

Figure 60: Number of deaths of individuals suspected of drug use, in which benzodiazepines were detected post-mortem, NSW, by quarter, March 2005−December 2014



Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories NSW Health, 2014
NB: These numbers relate to deaths in which benzodiazepines were detected; however, there may have also been other drugs present

6.2 Calls to telephone helplines

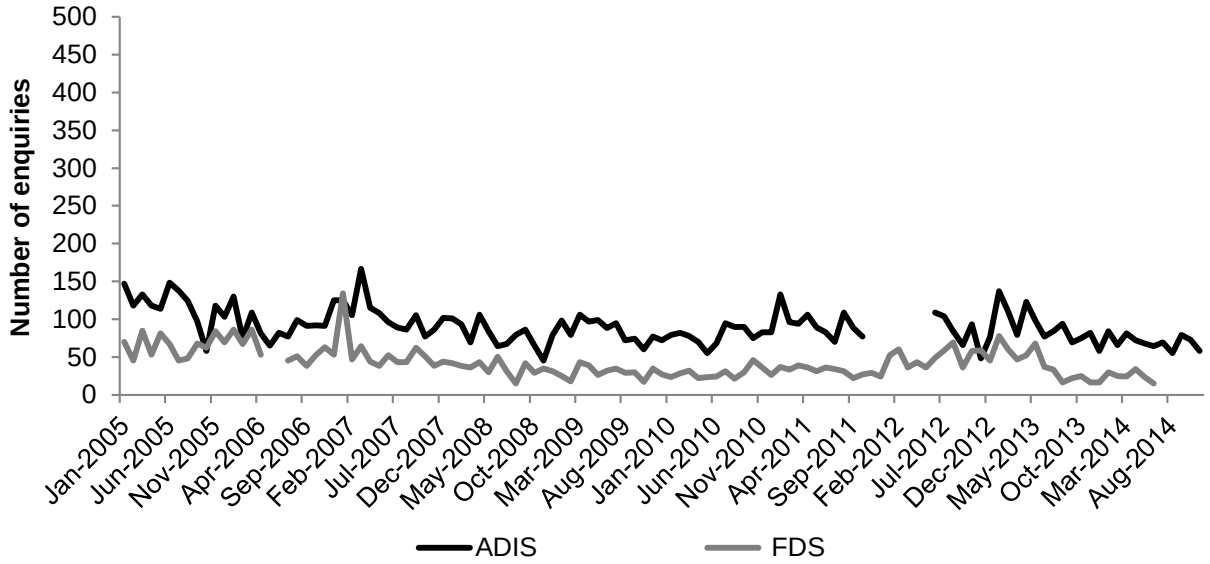
6.2.1 Heroin

Figure 61 shows the number of calls to the Alcohol and Drug Information Service (ADIS) where heroin was mentioned as any drug of concern, and to the Family Drug Support (FDS) line regarding heroin as the primary drug of concern.

The number of enquiries to FDS regarding heroin were lower than numbers received at ADIS, reflecting the different sizes and target groups of these services.

The number of calls to both services regarding heroin has remained stable, ranging between 55−84 calls a month for ADIS and 15−34 calls a month to FDS.

Figure 61: Number of enquiries to ADIS and FDS regarding heroin, January 2005−November 2014

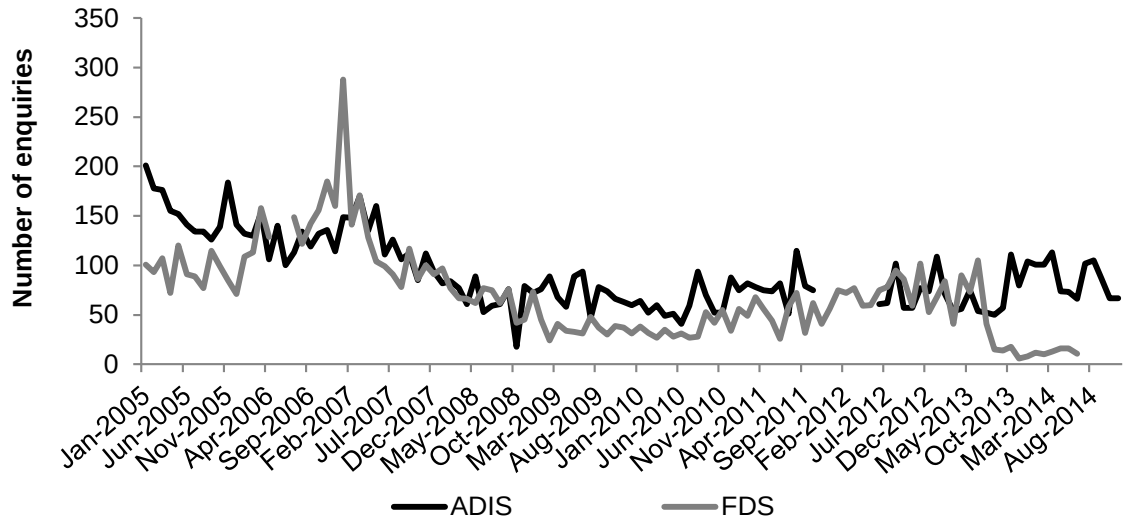


Source: NSW ADIS and FDS
NB: FDS data were only available on a monthly basis and refer to calls where any mention of heroin was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where heroin was mentioned as any drug of concern. ADIS data were unavailable for the period November-June 2012. FDS data were unavailable for the period May-June 2006

6.2.2 Methamphetamine

Figure 62 shows the number of calls to the ADIS and FDS lines regarding methamphetamines. The numbers of enquiries to ADIS have been sporadic in the 12 months to November 2014, and calls FDS in the 12 months to June have been low. (ADIS range: 50−104; FDS range: 6−41).

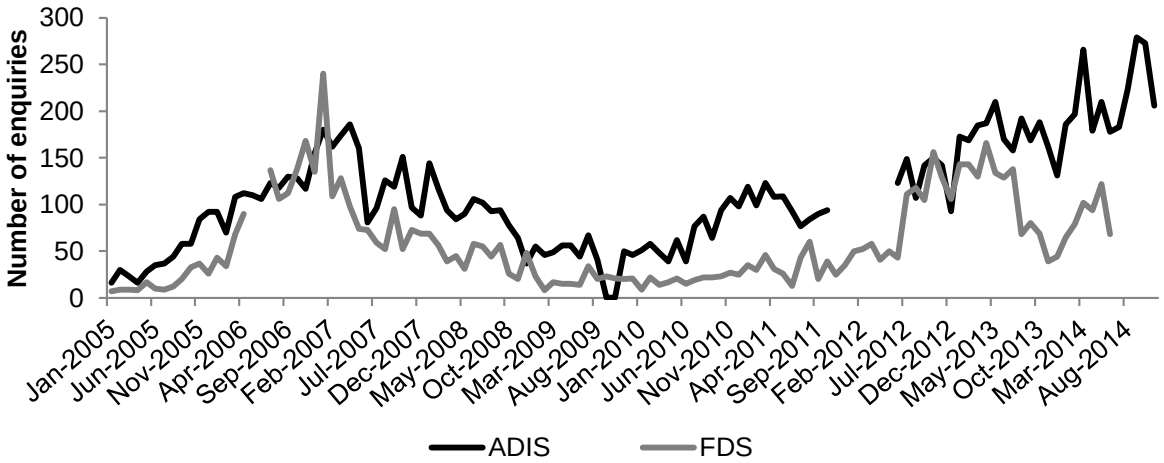
Figure 62: Number of enquiries to ADIS and FDS regarding methamphetamines 2005−November 2014



Source: NSW ADIS and FDS
NB: FDS data refer to calls where any mention of amphetamines was made. ADIS data refer to the number of calls where amphetamines were mentioned as any drug of concern. ADIS data were unavailable for the period July−November 2004 and November−June 2012. FDS data were unavailable for the period May−July 2006. FDS data includes national figures in 2012/13

Figure 63 shows the number of calls to the ADIS and FDS lines regarding ice/crystal methamphetamine. In the last 12 months, calls to both services have been sporadic but gradually increasing.

Figure 63: Number of enquiries to ADIS and FDS regarding ice/crystal methamphetamine, January 2005−November 2014

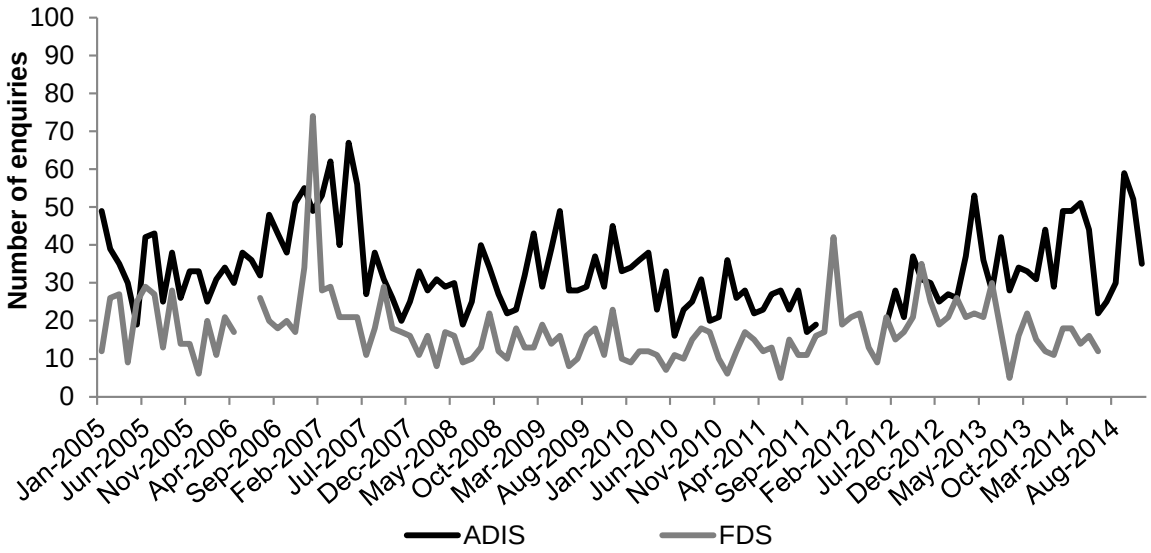


Source: NSW ADIS and FDS
NB: FDS data were only available on a monthly basis and refer to calls where any mention of ice/crystal methamphetamine was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where ice was mentioned as any drug of concern. ADIS data were unavailable for the period November−June 2012. FDS data were unavailable for the period May−July 2006

6.2.3 Cocaine

Figure 64 shows the number of calls to the ADIS and FDS lines regarding cocaine. Despite fluctuations, the number of calls per month to both ADIS and FDS have remained relatively stable (ADIS range: 22−59; FDS range: 5−22) over the 12 months to November 2014.

Figure 64: Number of enquiries to ADIS and FDS regarding cocaine, January 2005−November 2014



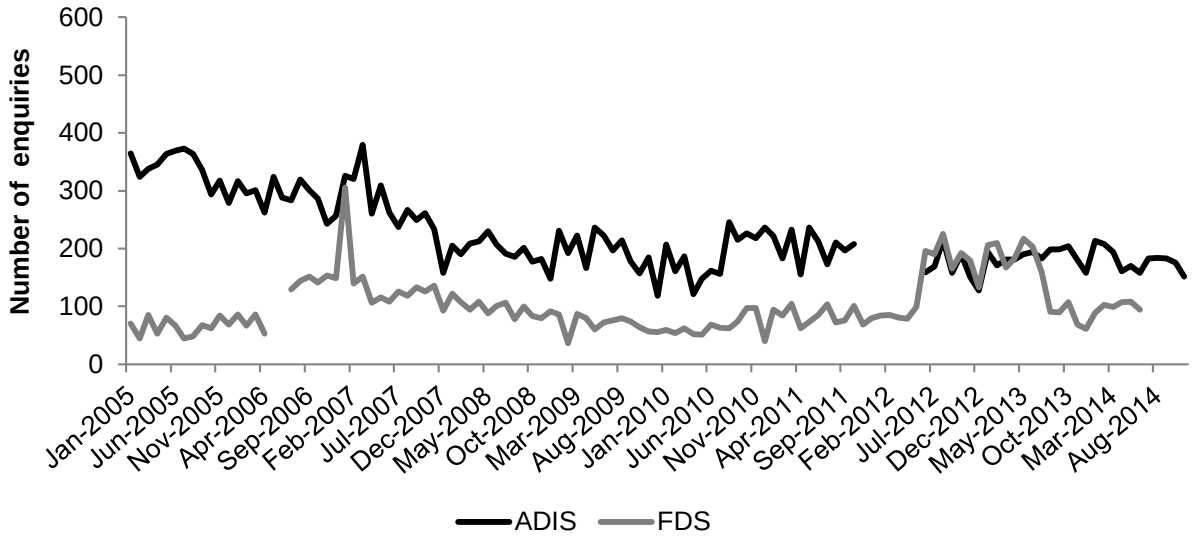
Source: NSW ADIS and FDS

NB: FDS data were only available on a monthly basis and refer to calls where any mention of cocaine was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where cocaine was mentioned as any drug of concern. ADIS data were unavailable November−June 2012. FDS data were unavailable for the period May−July 2006

6.2.4 Cannabis

The number of calls to ADIS and FDS regarding cannabis has remained relatively stable in the 12 months to December 2014 (Figure 65).

Figure 65: Number of enquiries to ADIS and FDS regarding cannabis, January 2005−November 2014



Source: ADIS and FDS

NB: FDS data were only available on a monthly basis and refer to calls where any mention of cannabis was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where cannabis was mentioned as any drug of concern. In 2014, ADIS data includes synthetic cannabis. ADIS data were unavailable November−June 2012. FDS data were unavailable for the period May−June 2006

6.3 Drug treatment

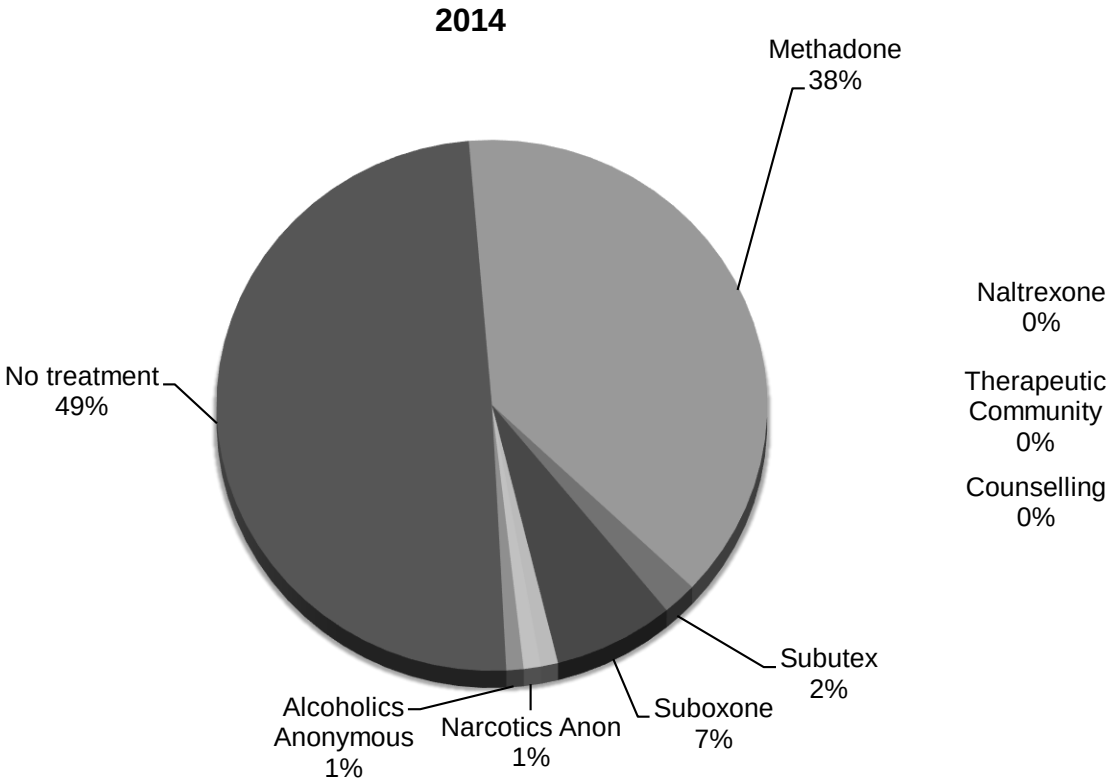
6.3.1 Forms of treatment

Half of all surveyed (51%) PWID participants were in some form of treatment at the time of interview, which is a decrease on the 61% who were in some form of treatment in 2013.

Of those currently in drug treatment, 92% reported being currently in a form of OST, with the majority (74%) of those currently on OST receiving methadone and smaller amounts receiving buprenorphine-naloxone (Suboxone) (14%) or buprenorphine (4%). Those currently in treatment had been in that treatment for a median of 36 months (i.e. three years).

Fifty-six percent of all participants had been in some form of treatment in the past six months. Of these, 74% (38% of the entire sample) had been on methadone maintenance treatment (MMT), 14% (7% of the entire sample) had been on buprenorphine-naloxone (Suboxone) treatment, and 4% (2% of the entire sample) reported subutex. Smaller numbers of participants reported accessing other treatments over the past six months, for example, detoxification (1%) and Alcoholics Anonymous (1%). There were no reports of naltrexone treatment or of any participants accessing therapeutic communities or counselling services in the six months prior to interview (Figure 66).

Figure 66: Proportion of participants reporting any form of drug treatment in last 6 months, 2014



Source: IDRS PWID interviews
NB: More than one form of treatment could be nominated

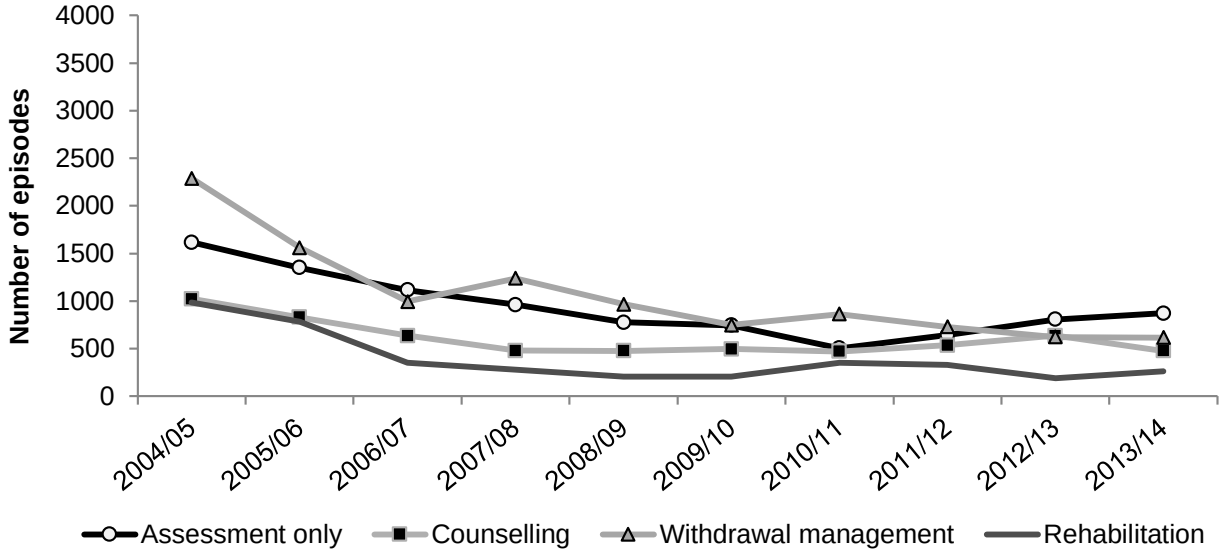
6.3.2 Heroin treatment

Figure 67 shows the number of closed treatment episodes based on the date of commencement by treatment type where the principal drug of concern was heroin.

All forms of heroin treatment have declined between 2004/05 and 2010/11. Since then, numbers entering for assessment only have been gradually increasing, while those entering rehabilitation over the same period, have remained stable. Numbers receiving counselling treatment have also remained stable since 2010/11, and the numbers entering withdrawal management has gradually declined.

It is important to interpret these data with caution as they are based on closed episodes and episodes may be excluded if not completed in the period.

Figure 67: Number of heroin treatment episodes by treatment type, NSW 2004/05−2013/14



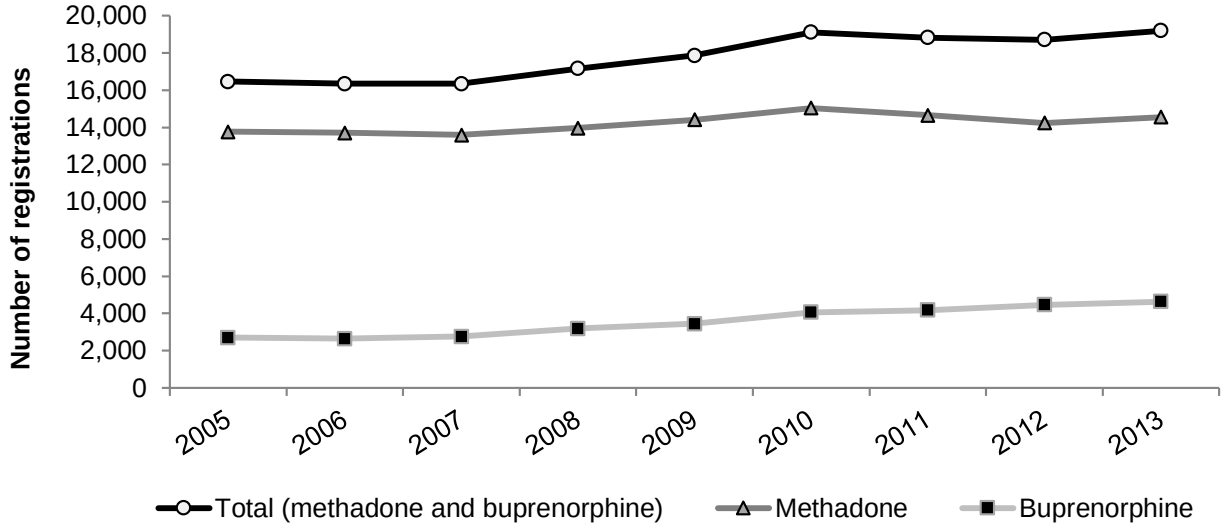
Source: NSW Minimum Data Set (NSW MDS) for Alcohol and other Drug Treatment Services (AODTS), NSW Health, 2014
NB: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement

Figure 68 shows that the number of people receiving all forms of opioid substitution treatment in NSW increased from 16,469 on the 30th June 2005 to 19,179 on the 30th June 2013. Overall, in 12 months to the end of June 2013 there was a slight increase in the numbers seen in 2012 (18,715 versus 19,197).

The vast majority of opioid pharmacotherapy clients received methadone. The number of people receiving buprenorphine has generally increased since its introduction in 2000. As of June 2013, 34% of Australia's 2,355 pharmacotherapy sites were located in NSW and were dosing 19,197 clients. The vast majority of sites (680) were pharmacies, with smaller amounts of hospitals (75), public clinics (36), private clinics (12) or correctional settings (1). The same data for 2014 was not available at the time of publication.

Fifty-seven percent of opioid pharmacotherapy clients obtained their treatment through a private provider, 33% received it through a public prescriber, 9% were in correctional facilities and 1% obtained their treatment through a public/private prescriber i.e. prescribing that cannot be separated into public or private prescribers (Australian Institute of Health and Welfare, 2014).

Figure 68: Number of registrations for opioid substitution treatment on the 30th June each year, NSW, 2005−2013



Source: (Australian Institute of Health and Welfare, 2014)

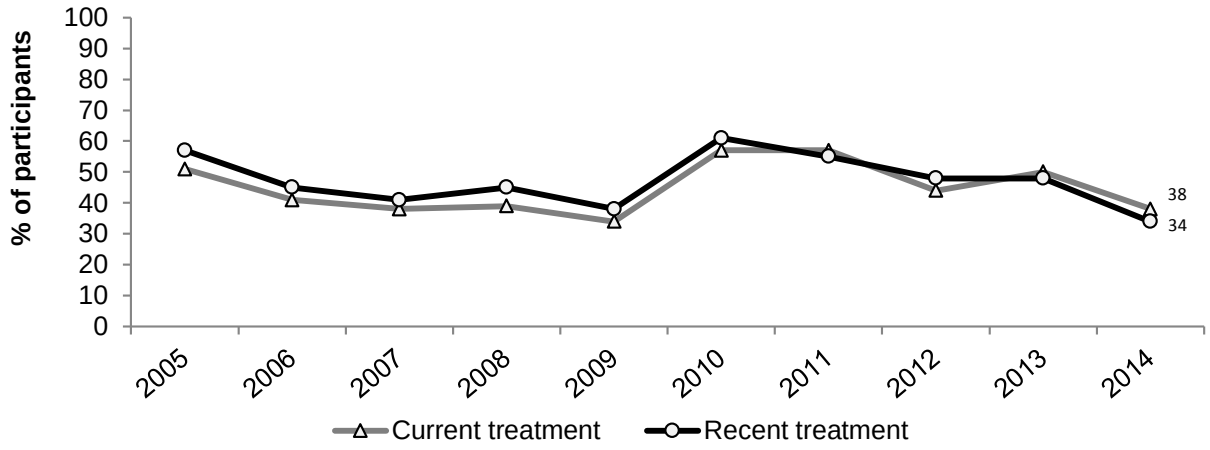
NB: Buprenorphine pharmacotherapy was introduced in NSW in 2000. Data for 2013 were unavailable at the time of publication. In NSW, unlike all other jurisdictions, clients prescribed buprenorphine/naloxone (Suboxone) are counted under buprenorphine

6.3.3 Methadone treatment

A distinction was made between the use of prescribed (where the prescription was in the participant's name) and non-prescribed (where the prescription was in someone else's name) methadone and Physeptone (a tablet form of methadone). This section discusses the use of prescribed methadone and Physeptone only.

Thirty-eight percent of participants had used methadone that had been prescribed to them in the preceding six months (Figure 69) (56% in 2013) and 9% reported injecting prescribed methadone during this time. No participants reported recent use of prescribed Physeptone tablets. Overall, there has been a gradual decline in the proportion of PWID participants reporting current engagement in a methadone maintenance treatment (MMT) (Figure 69). Thirty-four percent of PWID reported receiving methadone treatment at some point in the preceding six months (recent treatment) (48% in 2013). As in previous years, methadone syrup was the predominant form of OST used.

Figure 69: Proportion of participants reporting methadone treatment, 2005−2014



Source: IDRS PWID interviews

Amongst those who had been on a methadone program in the six months preceding interview, the median number of days of use in the preceding six months was 180 days, i.e. daily use (the same as 2012/13). Sixty-three percent of methadone users reported daily use (78% in 2013).

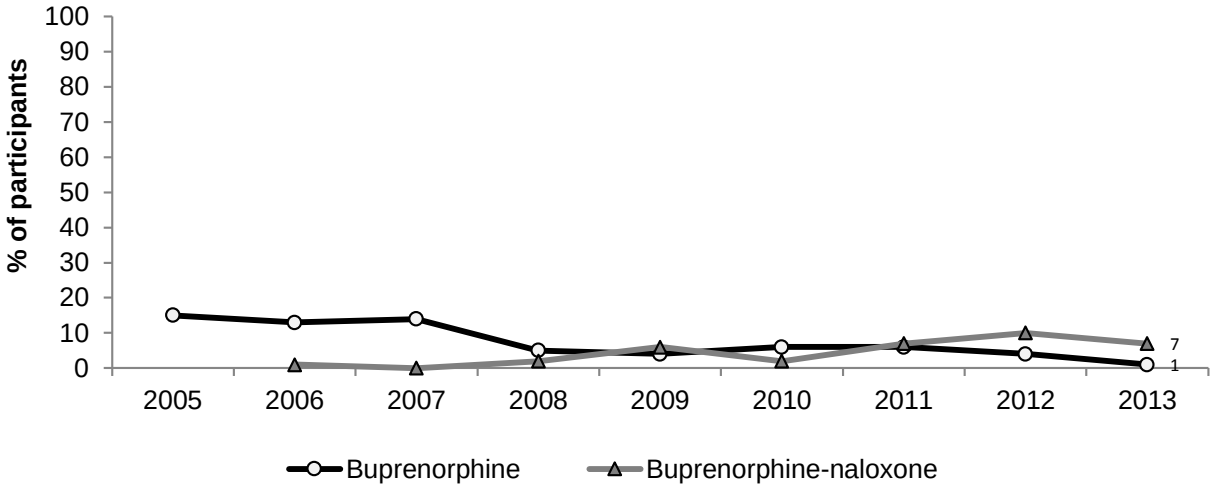
It should be noted that the IDRS deliberately recruits a 'sentinel' population of people who inject drugs and are current and active participants in illicit drug markets. As a consequence, those in the PWID samples who report being in treatment may not be representative of treatment populations more generally, particularly those who withdraw from injecting drug use and/or illicit drug market activity once engaged in treatment. Similarly, as regular injecting drug use is a requirement for participation in the IDRS survey, participants who are also engaged in methadone treatment – of whom there is a substantial proportion in the 2014 IDRS – may not be representative of methadone clients generally.

6.3.4 Buprenorphine treatment (including buprenorphine-naloxone)

As with methadone, a distinction was made between the use of prescribed and non-prescribed buprenorphine. Following the listing of buprenorphine-naloxone (Suboxone) on the Pharmaceutical Benefits Scheme in April 2006, questions were also included on this drug. In addition, a distinction was made between buprenorphine-naloxone (Suboxone) in both its tablet and sublingual film form.

Just over one-third (36%) of the sample reported ever having been prescribed buprenorphine (Subutex). Three percent of participants reported using it in the preceding six months which is stable with the 5% reported in 2013. One percent stated they were currently participating in buprenorphine treatment (4% in 2012) (Figure 70). Among those who used prescribed buprenorphine, the median number of days of use in the last six months was 135 days, (median 90 days in 2013). When used as a maintenance treatment, buprenorphine can be dosed daily or every two days. The median days in treatment increased to 135 days (range 7−180 days; 90 in 2013). Please note that buprenorphine may also be prescribed during opioid detoxification.

Figure 70: Proportion of participants reporting current buprenorphine treatment, 2005−2014



Source: IDRS PWID interviews
NB: Buprenorphine-naloxone (Suboxone) item first included in 2006

In the last six months, 2% of participants had used prescribed buprenorphine-naloxone tablets and 9% prescribed buprenorphine-naloxone sublingual film. The median number of days of use in the last six months for any buprenorphine-naloxone tablets was 25 days (30 days licit; 16 days illicit) and the median days of use any for buprenorphine-naloxone film was 20 days (120 days licit; 7 days illicit). The median number of days enrolled in treatment for buprenorphine-naloxone tablets and film was 30 and 150 days, respectively. Note: small numbers commenting so interpret with caution. No participants reported recent injection of prescribed buprenorphine-naloxone in its tablet form and one participant reported recent injection of buprenorphine-naloxone in its film form.

6.3.5 Methamphetamine treatment

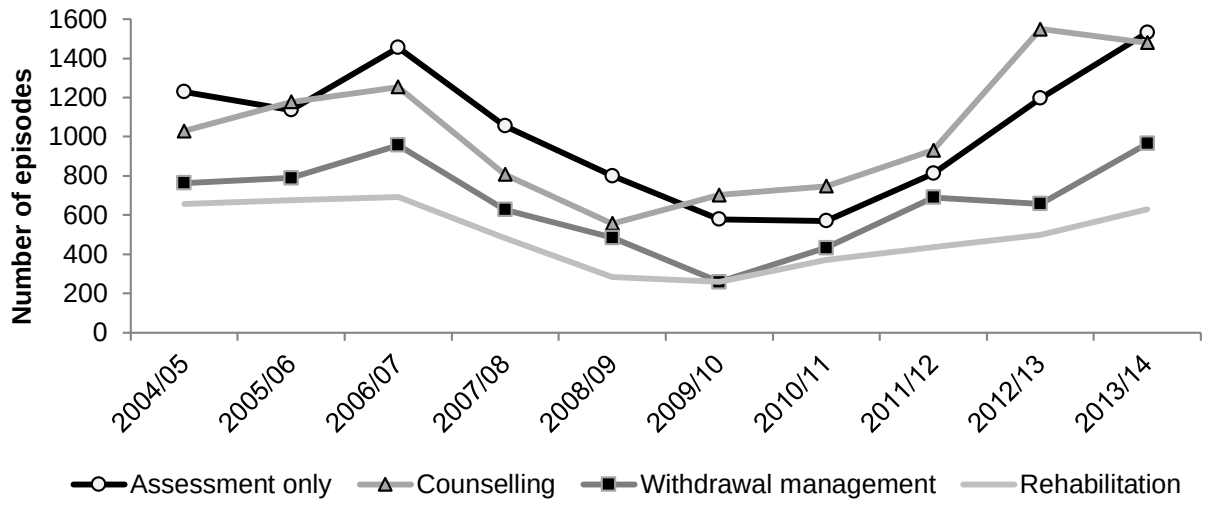
Over the past 12 months, the number of closed treatment episodes, based on the date of commencement where the principal drug of concern was amphetamines, have all increased with the exception of counselling, which has declined gradually from 2012/13 when it peaked (Figure 71).

It does appear, however, that all treatment episodes are on the rise, and have exceeded the numbers recorded in 2006/07 when all treatment episodes were the highest over the last decade.

It is important to interpret these data with caution as they are based on closed episodes and episodes may be excluded if not completed in the period. Prior to 2006/07, there was a steady increase in numbers receiving 'assessment only' and 'withdrawal management', while 'rehabilitation' has remained relatively stable since recording commenced in 2000/01.

As noted above, these increases should be interpreted with caution.

Figure 71: Number of amphetamine treatment episodes by treatment type, NSW, 2004/05−2013/14



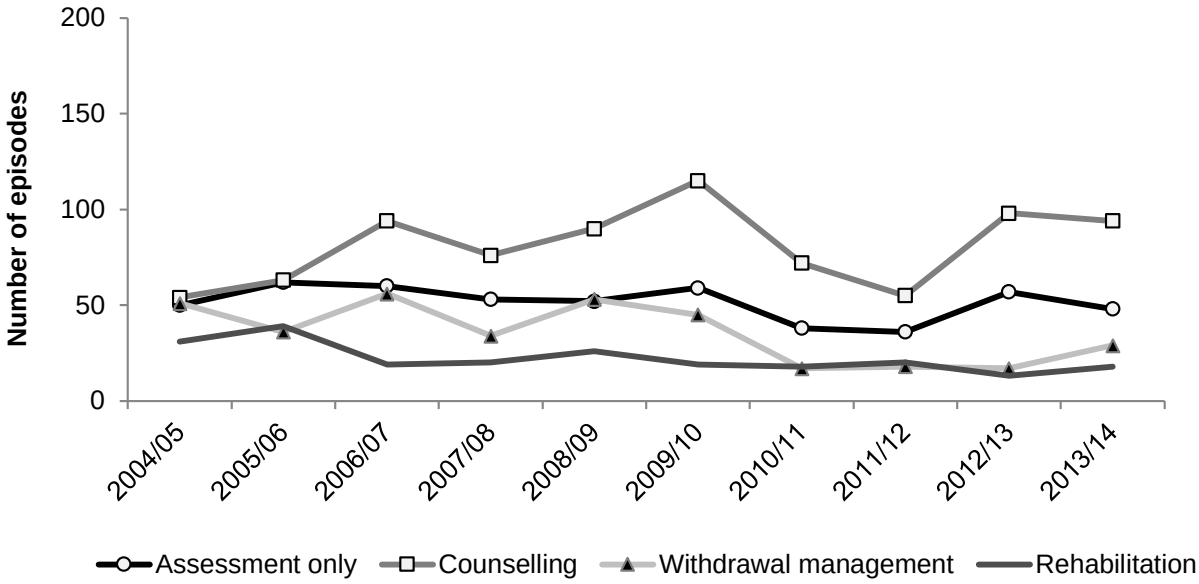
Source: NSW MDS AODTS, NSW Health, 2014
NB: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement

6.3.6 Cocaine treatment

Apart from a spike in ‘counselling’ in 2009/10 where the principal drug of concern was cocaine, the number of closed treatment episodes based on the date of commencement has remained at less than 100 per treatment type since 2004/05.

In 2013/14, all forms of cocaine treatment types have remained stable (Figure 72). It is important to interpret these data with caution as they are based on closed episodes, and episodes maybe excluded if not completed in the period.

Figure 72: Number of cocaine treatment episodes by treatment type, NSW, 2004/05−2013/14



Source: NSW MDS AODTS, NSW Health, 2014
NB: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement

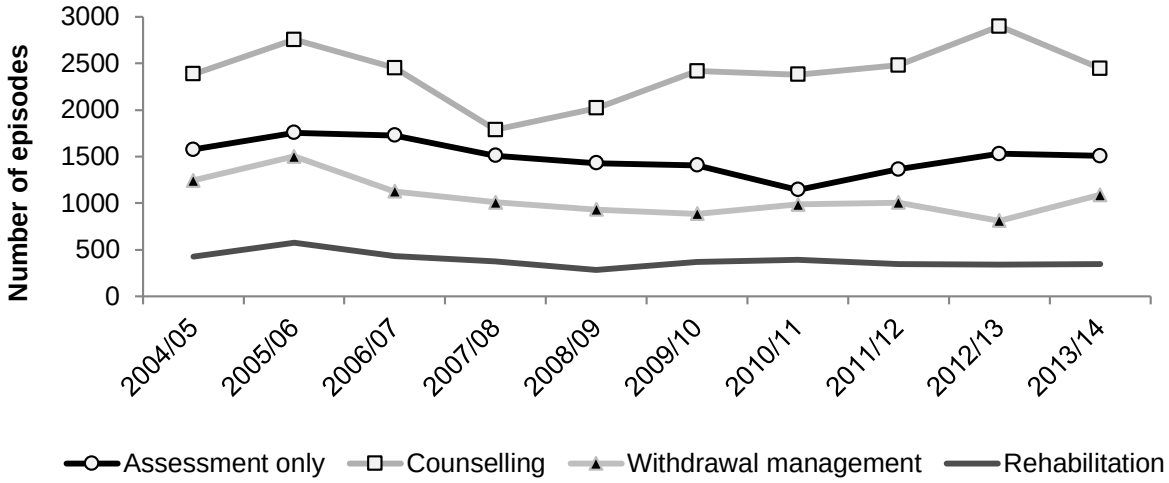
6.3.7 Cannabis treatment

Figure 73 shows the number of closed treatment episodes by treatment type, based on the date of commencement where the principal drug of concern was cannabis.

After peaking in 2012/13, numbers entering for ‘counselling’ have decreased slightly in the last 12 months. Those entering ‘withdrawal management’, ‘assessment only’, and ‘rehabilitation’, remained stable, continuing a trend observed over the last decade.

As noted above, it is important to interpret these data with caution as they are based on closed episodes and episodes may be excluded if not completed in the period.

Figure 73: Number of cannabis treatment episodes by treatment type, NSW, 2004/05−2013/14



Source: NSW MDS AODTS, NSW Health, 2014
NB: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement

6.4 Hospital admissions

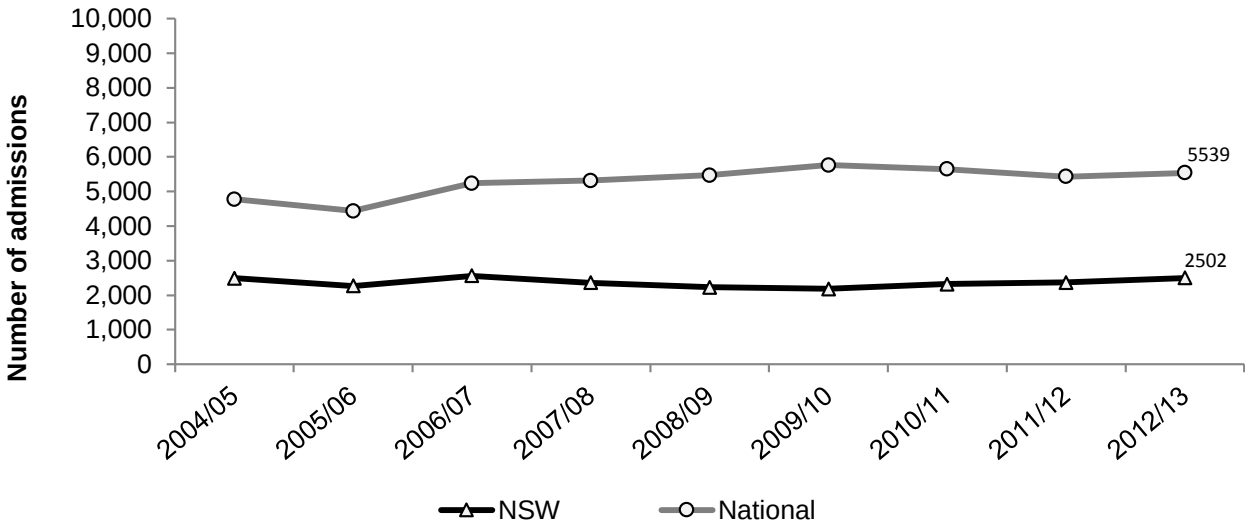
6.4.1 Heroin

The number of hospital separations among persons aged 15−54 years in which the principal diagnosis was opioid-related is shown in Figure 74.

A principal diagnosis that is opioid-related is recorded where opioids are established (after discharge) to be chiefly responsible for occasioning the patient's episode of care.

Figures decreased around 2001/02, coinciding with a reduction in the availability of heroin, and since this time have remained relatively stable in NSW and nationally.

Figure 74: Number of principal opioid-related hospital admissions among people aged 15−54, NSW and Australia, 2004/05−2012/13



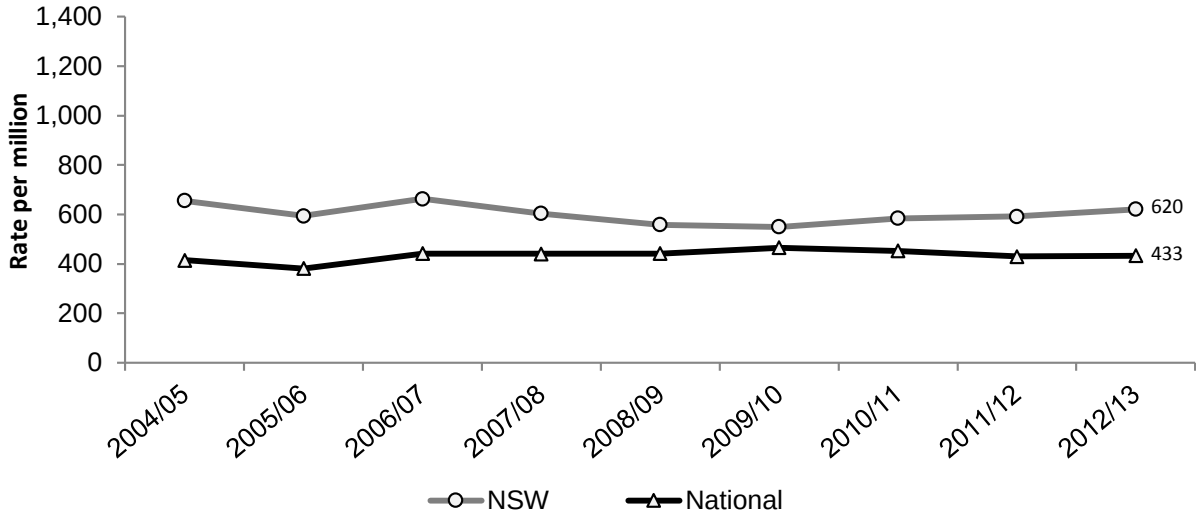
Source: Roxburgh and Burns (in press)

Figure 75 shows the number per million persons aged 15−54 years of opioid-related hospital admissions**.**

Numbers have remained relatively stable over the past 12 months. NSW figures have consistently remained higher than the national figures.

The number of admissions per million persons in both NSW and nationally remain substantially lower than in previous years and NSW continues to account for two-fifths (40%) of all opioid-related hospital admissions in Australia.

Figure 75: Number per million persons of principal opioid-related hospital admissions among people aged 15−54 years, NSW and nationally, 2004/05−2012/13

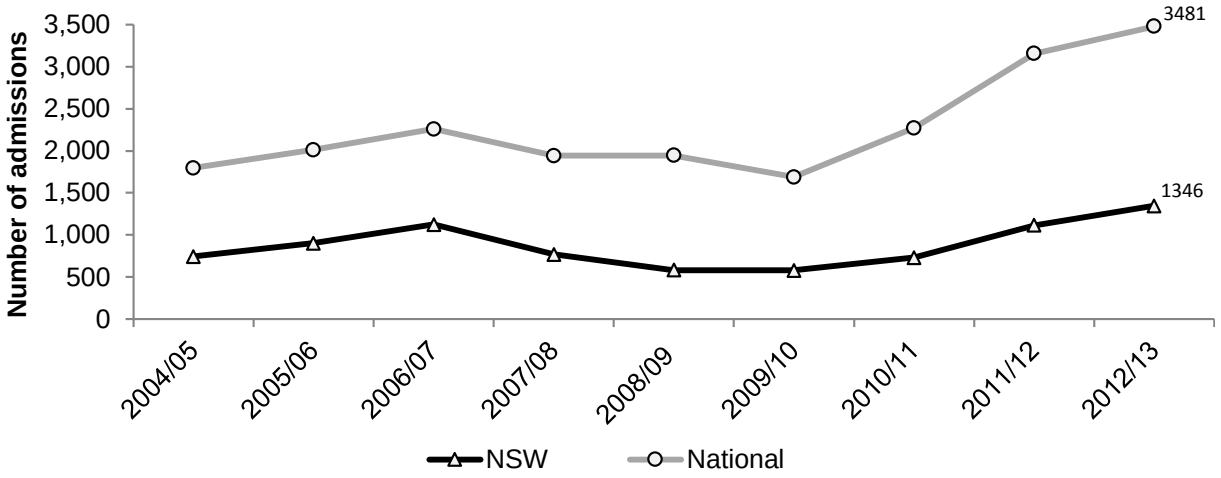


Source: Roxburgh and Burns (in press)

6.4.2 Methamphetamine

The number of inpatient hospital admissions among persons aged 15−54 years in which the principal diagnosis was amphetamine-related is shown in Figure 76. In 2012/13, admissions in NSW were the highest since the 2006/07 period (1,346). Overall, this trend has remained stable and consistently lower than the national figures.

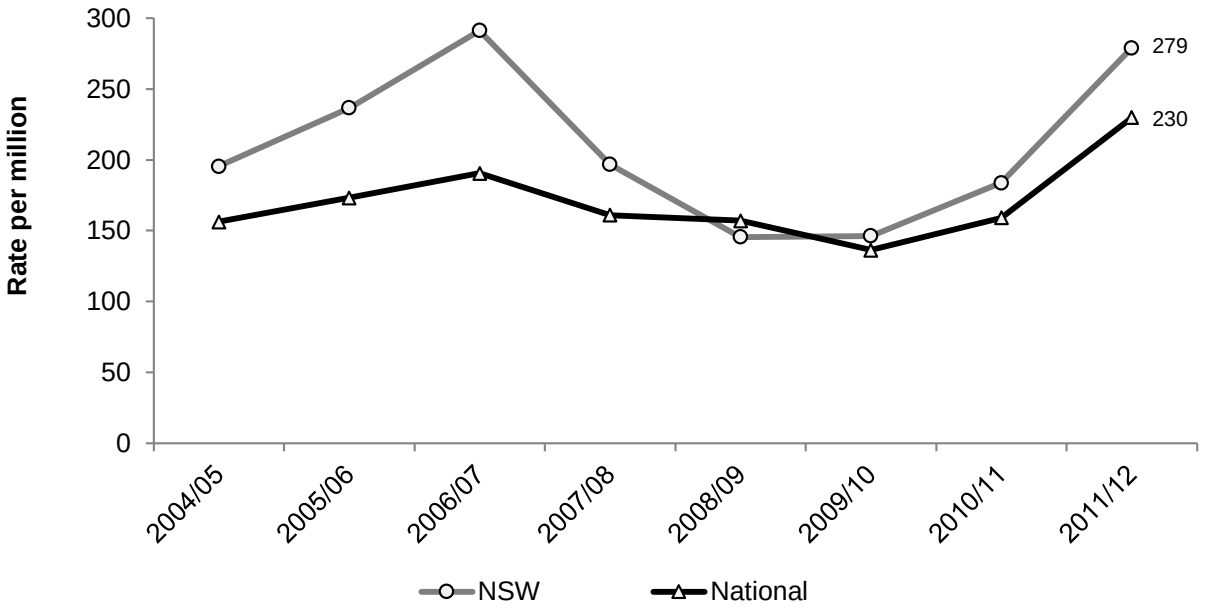
Figure 76: Number of principal amphetamine-related hospital admissions among persons aged 15−54, NSW and nationally, 2004/05−2012/13



Source: Roxburgh and Burns (in press)

Figure 77 shows the number per million persons of hospital admissions in which the principal diagnosis was amphetamine-related. Numbers in both NSW and nationally have continued to increase over the past few years.

Figure 77: Number per million persons of principal amphetamine-related hospital admissions among people aged 15−54 years, NSW and nationally, 2004/05−2012/13

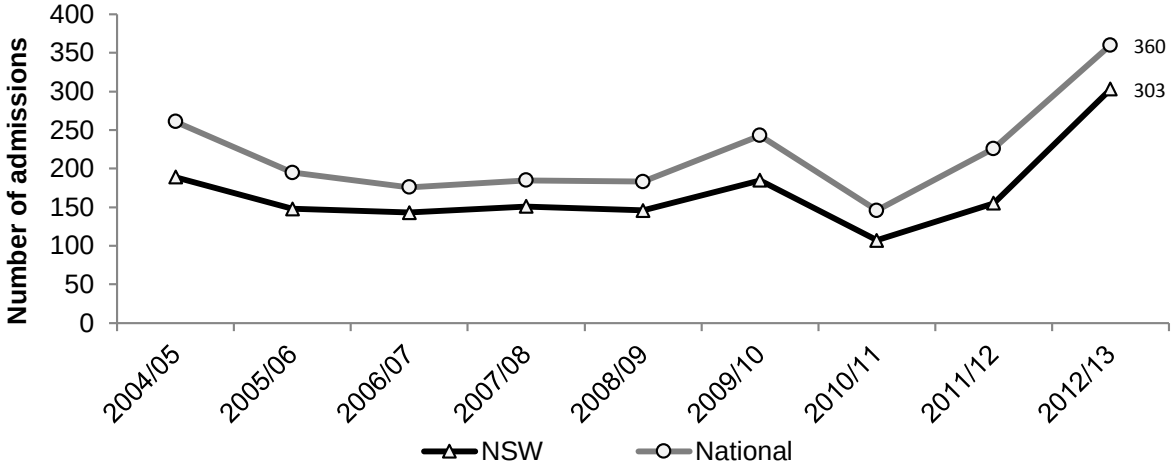


Source: Roxburgh and Burns (in press)

6.4.3 Cocaine

The numbers of inpatient hospital separations in which the principal diagnosis was cocaine-related are shown in Figure 78. Overall, figures were stable between 2004/05 and 2009/10, however, in the years following, there has been a steady increase resulting in the highest recorded both nationally (360 separations) and in NSW (303 separations) over the last decade.

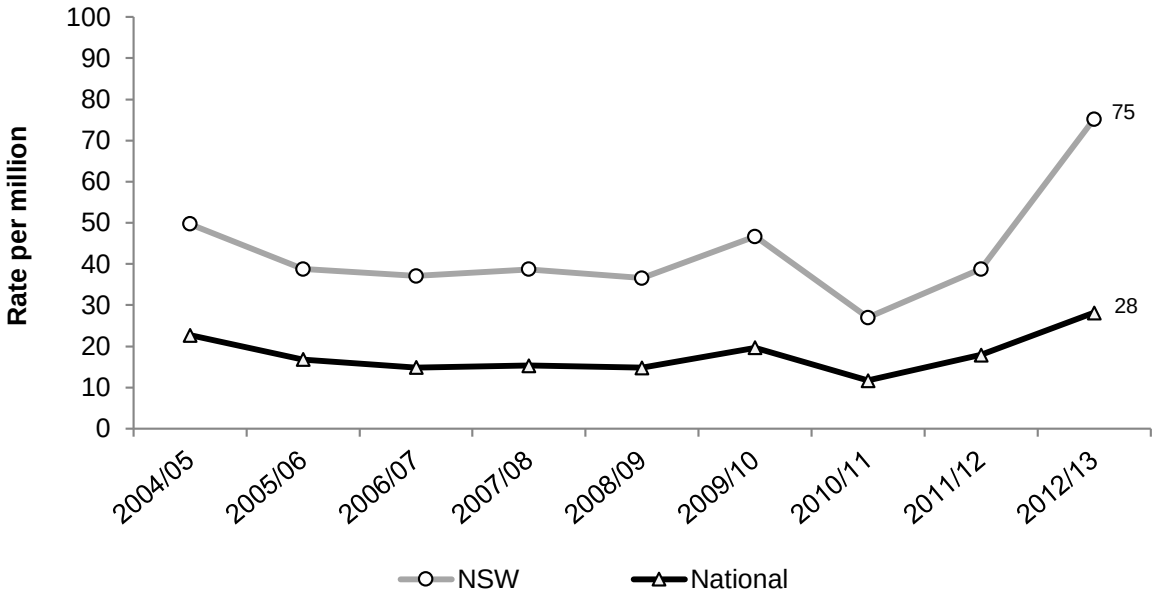
Figure 78: Number of principal cocaine-related hospital admissions among persons aged 15−54, NSW and nationally, 2004/05−2012/13



Source: Roxburgh and Burns (in press)

The number per million persons of cocaine-related hospital admissions is shown in Figure 79. Numbers in NSW and nationally have remained stable across time; a small peak was recorded in both figures in 2009/10 before decreases occurred the following year. The last two years, cocaine-related admissions have increased to the highest levels recorded in NSW (75) and nationally (28) over the last decade.

Figure 79: Number per million persons of principal cocaine-related hospital admissions among people aged 15−54 years, NSW and nationally, 2004/05−2012/13

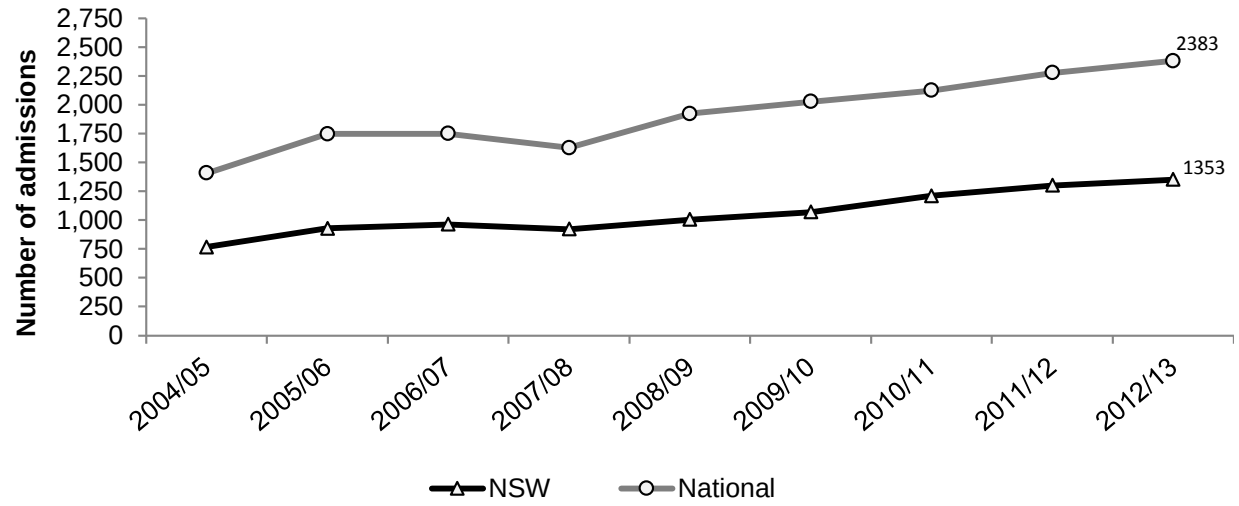


Source: Roxburgh and Burns (in press)

6.4.4 Cannabis

The number of hospital admissions in which the principal diagnosis was cannabis-related is shown in Figure 80. Across time and continuing to 2012/13, figures have gradually increased both in NSW and nationally.

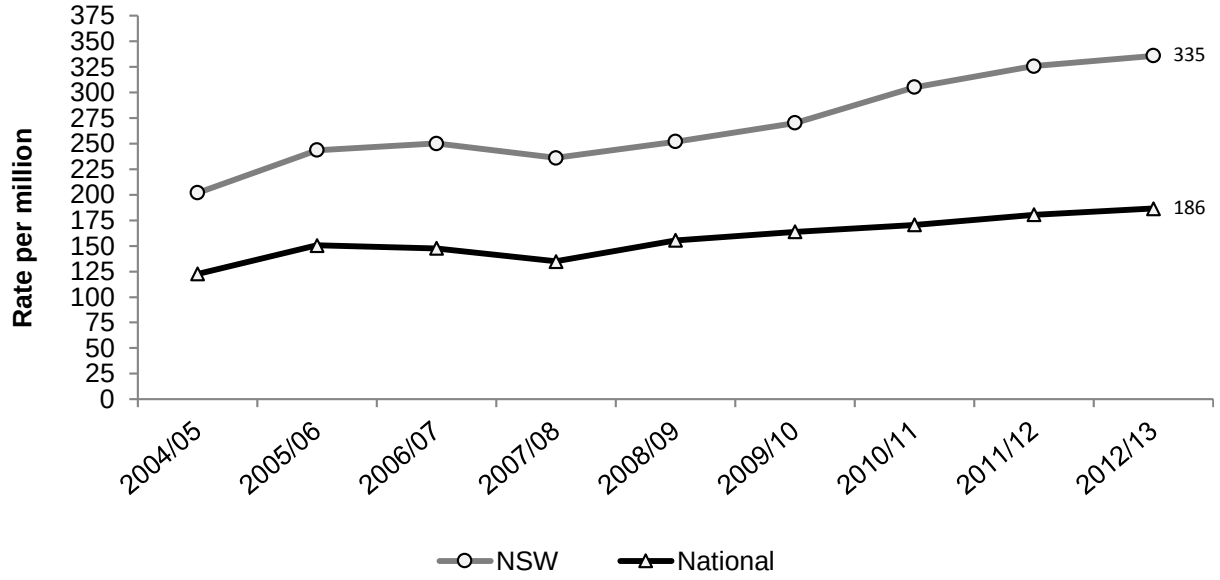
Figure 80: Number of principal cannabis-related hospital admissions among persons aged 15−54, NSW and nationally, 2004/05−2012/13



Source: Roxburgh and Burns (in press)

Figure 81 shows the number per million persons of cannabis-related hospital admissions among people aged 15−54 years. Both nationally and in NSW, numbers have continued to increase gradually over time.

Figure 81: Number per million persons of principal cannabis-related hospital admissions among people aged 15−54 years, 2004/05−2014/15



Source: Roxburgh and Burns (in press)

6.5 Injecting risk behaviours

6.5.1 Sharing of injecting equipment by PWID participants

6.5.1.1 Needle and Syringe Programs

There are currently 31 primary, 387 secondary Needle and Syringe Program (NSP) outlets and 221 automatic dispensing machines (ADM) and internal dispensing chutes (IDC) operating throughout New South Wales. Primary outlets provide sterile injecting equipment, safe sex materials, education on safer injecting practices, and referral to drug treatment programs, hepatitis clinics, sexual health, mental health services and other health and welfare agencies. Primary outlets undertake a range of other core service provision such as community safe sharps management, health promotion and community education activities. Some primary outlets also provide primary health care, such as hepatitis B vaccinations and HIV and hepatitis C testing.

Secondary outlets (e.g. in hospital emergency departments, community health centres and non-government organisations) also provide sterile injecting equipment, safe sex materials and educational information. Automatic dispensing machines and internal dispensing chutes offer greater availability through 24/7 access.

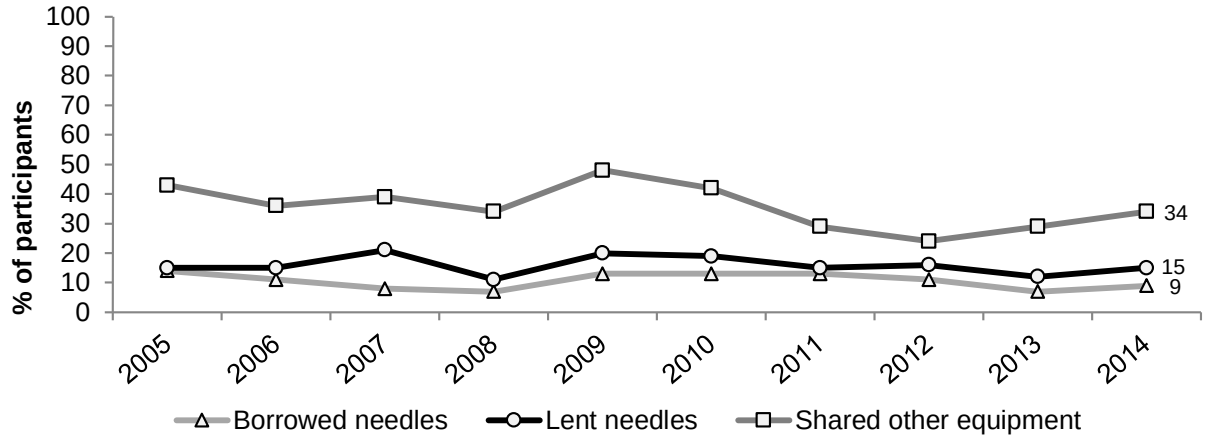
Equipment obtained through primary and secondary outlets and ADM and IDC is typically in the form of a Fitpack® containing sterile needles and syringes, alcohol swabs, and sterile water. The Fitpack® also functions as a safe disposal container for used sharps. There are currently 514 pharmacies participating in the Pharmacy NSP Fitpack® scheme, further enhancing access through a broad range of locations. The number of needles and syringes dispensed by pharmacies has remained relatively stable and most of the equipment is dispensed from public NSP (NSW Health, 2014).

In 2014, participants in the IDRS were asked from what sources they obtained their needle and/or syringes over the last 6 months. Results showed the vast majority of participants (91%) obtained needles and/or syringes from the NSP (public sector). It is important to note that this number may also be high due to the method of IDRS recruitment via advertisements at NSP sites. Just under one half of all participants reported they obtained needles and/or syringes from an NSP vending machine (43%). The third most popular source was chemist/pharmacy (32%), followed by friends (19%). Other sources reported included hospital (12%), partner (7%), dealer (5%), or outreach/peer worker (4%).

In line with previous data, 99% of participants reported that they had injected on at least one occasion in the month preceding interview.

Nine percent of these participants reported using a needle that had already been used by someone else (‘borrowed needle’). This remained stable with 7% of participants who reported this in 2013 and 11% in 2012 (Figure 82). Fifteen percent of those who had injected in the last month reported passing needles on to other PWID (‘lent needle’) in 2013, which remained stable with the 12% reported in 2013.

Figure 82: Proportion of PWID reporting sharing injecting equipment in the month preceding interview, 2005−2014



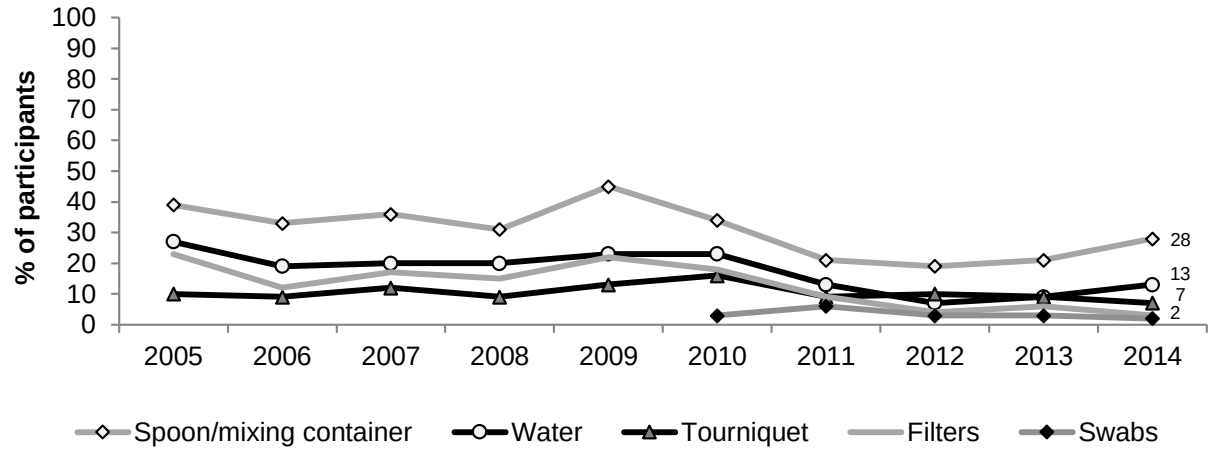
Source: IDRS PWID interviews

NB: Survey items on other injecting equipment (including spoons, water, filters and tourniquets) were first included in 1999. Figure excludes participants who had not injected in the last month (2005 n=4; 2006 n=1; 2007 n=2; 2008 n=2; 2012 n=1; 2013 n=2). In 2009 (n=152), 2010 (n=154) 2011 (n=150) and 2014 (n=150) all participants reported injection in month prior to interview

As in previous years, sharing of injecting equipment was more common than sharing of needles and syringes. Thirty-four percent reported sharing a filter, spoon, water, tourniquet and/or other item of injecting paraphernalia in the month preceding interview which is stable with the 29% reporting sharing equipment in 2013.

Figure 83 shows a breakdown of the types of injecting equipment PWID participants reported sharing. Among those reporting any sharing in the past month, 'spoon/mixing container' remained the most commonly shared item (83%; 28% of entire sample), followed by 'water' (37%; 13% of entire sample), tourniquets (22%; 7% of entire sample), filters (16%; 5% of entire sample), and swabs (6%; 2% of entire sample). Overall these figures are consistent with 2013.

Figure 83: Proportion of PWID participants reporting sharing other injecting equipment by type, 2005−2014



/

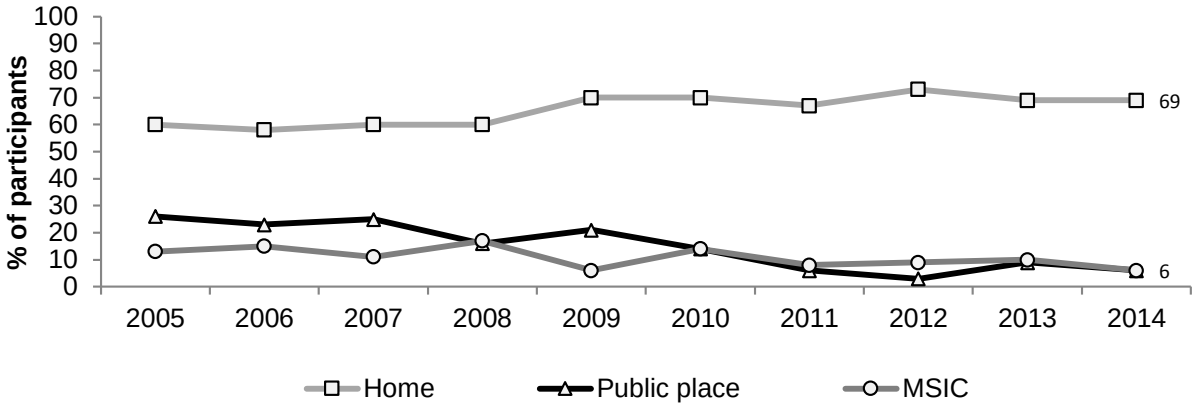
Source: IDRS PWID interviews

NB: Survey items on other injecting equipment (including spoons, water, filters and tourniquets) were first included in 1999 and swabs in 2010. Figure excludes participants who had not injected in the last month (2005 n=4; 2006 n=1; 2007 n=2; 2008 n=2; 2012 n=1; 2013 n=1; 2014 n=1). In 2009 (n=152), 2010 (n=154) and 2011 (n=150) all participants reported injection in month prior to interview

6.5.3 Location of injections

The most commonly reported location for last injection remained at a private home (69%; 69% in 2013). Eight percent reported a 'shooting room', 6% reported Sydney MSIC (10% in 2013) and a further 6% reported street/park as the locations of their most recent injection (Figure 84).

Figure 84: Last location for injection, 2005−2014



Source: IDRS PWID interviews

NB: Excludes those who had not injected in the last month (2005 n=4; 2006 n=1; 2007 n=2; 2008 n=2; 2012 n=1; 2013 n=1; 2014 n=149). In 2009 (n=152), 2010 (n=154) and 2011 (n=150) all participants reported injection in month prior to interview

6.5.4 Injection sites

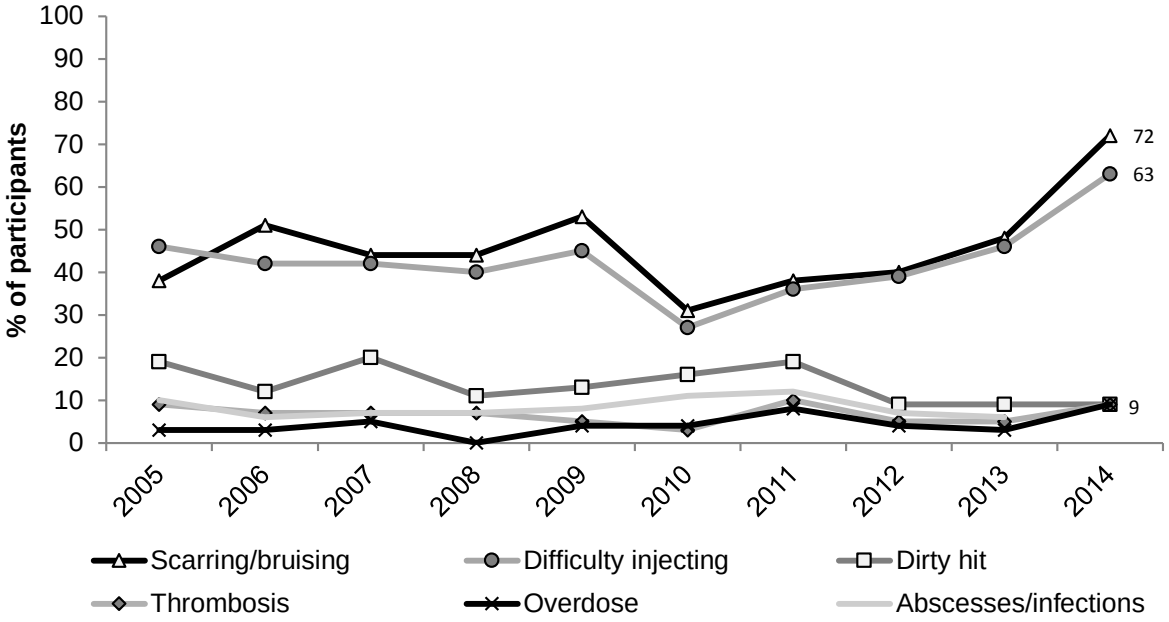
Again in 2014, participants were also asked questions about the site on their body where they had last injected. Seventy-six percent of participants reported that they last injected in their 'arm'. Thirteen percent of participants reported last injecting in their 'hand or wrist', 5% reported last injecting in their 'leg', 3% reported their 'groin' and 1% reported their 'neck' or 'foot'. This remained stable with 2013.

6.5.5 Injection-related health problems

Participants were asked whether they had experienced any of the following injection-related problems in the month before interview: overdose; a dirty hit; prominent scarring and/or bruising; thrombosis/blood clots; difficulty injecting; and/or abscesses or infections. Fifty-five percent of all PWID participants who had injected in the last month reported at least one injection-related problem during this time (69% in 2013). As in previous years, the most commonly reported problems were prominent scarring/bruising of injection sites (72%) and difficulty injecting (63%). Significantly more participants ($p>0.05$) reported experiencing overdose when compared with the previous year (15% in 2014 versus 4% in 2013). Equal proportions of all participants reported experiencing a 'dirty hit' that made them feel sick, problems of abscesses or infections associated with injecting, thrombosis (all 9%).

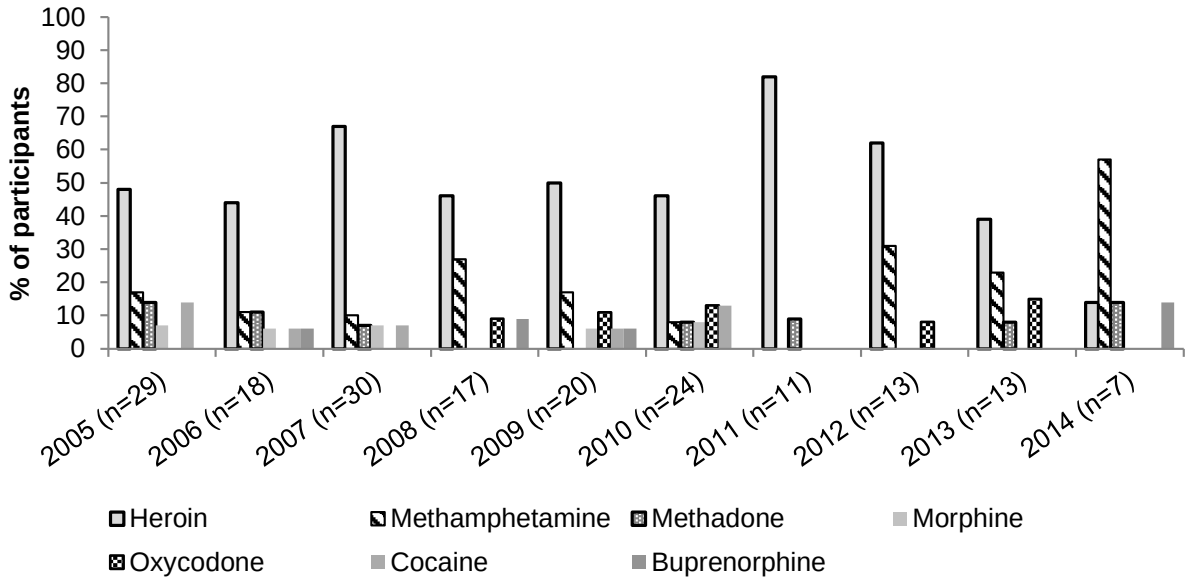
Figure 85 shows that while the proportion reporting prominent 'scarring or bruising' has remained the most commonly reported injection-related problem since 1997 (with the exception of 2005), since 2007 the issue of having 'difficulty injecting' has risen to almost equal levels in proportion of prevalence reported. Reports of thrombosis and abscesses/infections have continued to remain low and relatively stable. For the past 11 years overdose has remained the least commonly reported injection-related problem and this continued in 2014. For further information on overdose, see also section 6.1 'Overdose and drug-related fatalities'.

Figure 85: Proportion of PWID reporting injection-related problems in past month, by problem type, 2005−2014



Source: IDRS PWID interviews
NB: Includes all participants

Figure 86: Main drug causing dirty hit in last month, 2005−2014



Source: IDRS PWID interviews

As with overdose, participants who had experienced a 'dirty hit' in the last month were asked what they considered to have been the main drug they would attribute it to, and whether they had been using any other drugs at the time (polydrug use). The majority of participants who had experienced a dirty hit (n=7) continued to attribute it to methamphetamine (57%; representing 3% of the entire sample) (Figure 86). Please note: small numbers reporting, interpret with caution.

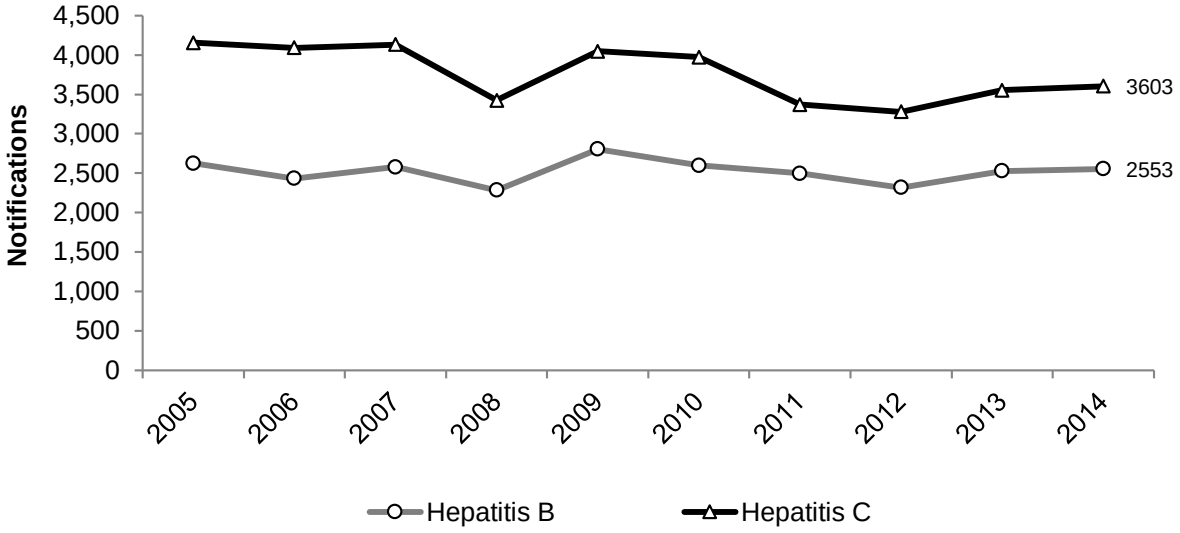
6.6 Blood-borne viral infections

People who inject drugs are at greater risk of acquiring blood-borne viral infections (BBVI) such as hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV) than the general population through the sharing of needles, syringes and other equipment. For more detailed information on BBVI, please see the Australian NSP Survey (Kirby Institute, May 2011).

Figure 87 shows the total number of notifications for HBV and HCV in NSW.

Incident (newly acquired) infections and unspecified infections (i.e. notifications where the timing of the disease acquisition is unknown) are presented. HCV continued to be more commonly notified than HBV, with the number of notifications increasing slightly in the 12 months to 2014 (3,603 notifications versus 3,553 notifications in 2013). HBV notifications have remained relatively stable since 2005 (2,626 notifications versus 2,553 in 2014). Notifications for both HCV and HBV still remained lower than levels reported in 2009.

Figure 87: Total notifications for (unspecified and incident) HBV and HCV infections, NSW, 2005−2014



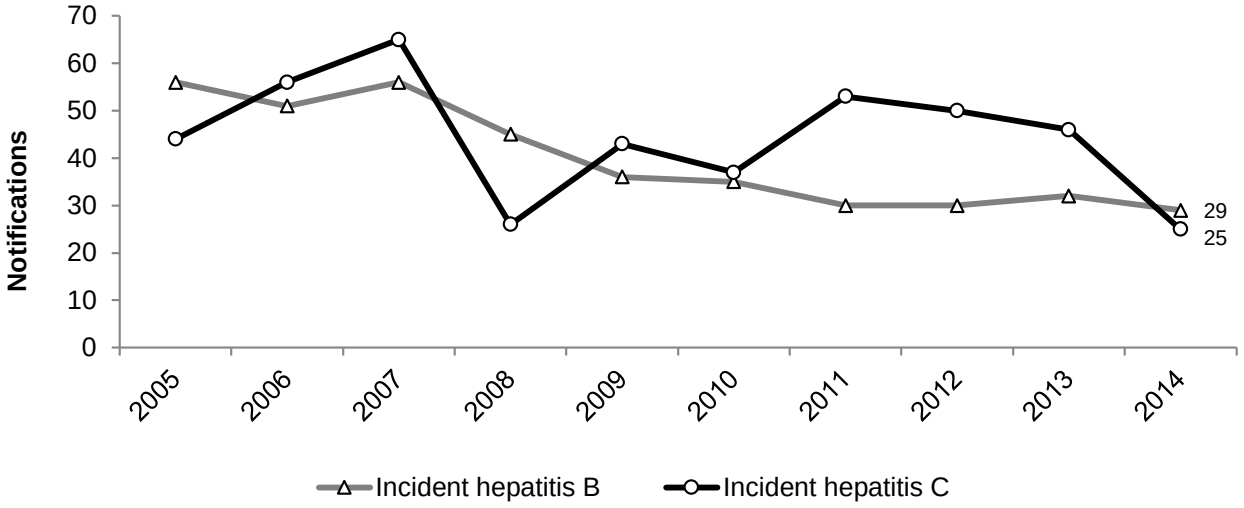
Source: Communicable Diseases Network – Australia – National Notifiable Diseases Surveillance System (NNDSS)[9]

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

Trends in the number of incident notifications for HBV and HCV in NSW are shown in (Figure 88).

HBV incident reporting had remained stable and low in 2014 (29 notifications; 32 in 2013 and 30 in 2012). A steady decline had been observed in the number of HCV incident, from 65 in 2007 to 25 in 2014; however, it increased to 53 incident notifications in 2011 before commencing a decline in notifications.

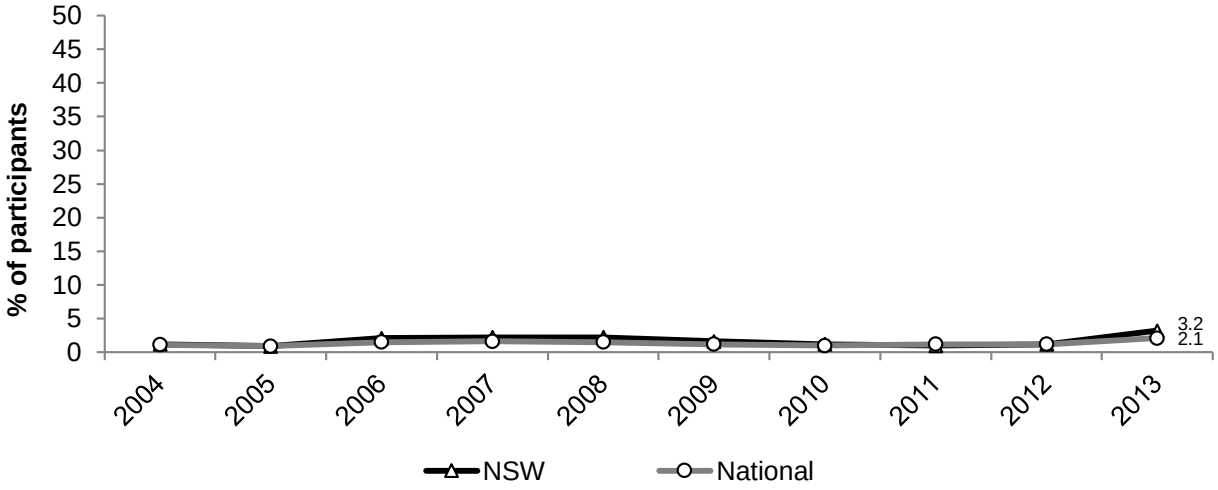
Figure 88: Total notifications for incident HBV and HCV infection, 2005−2014



Source: Communicable Diseases Network – Australia – NNDSS[11]

HIV antibody prevalence among NSP participants remained low and stable both in NSW (3.2%) and at a national level (2.1%). The NSW figure recorded a small increase in the last 12 months (1.2% in 2012), as did the national figure (1.2% in 2012). Overall, figures for the prevalence of HIV antibody in NSW and nationally remain low and stable (Figure 89).

Figure 89: Prevalence of HIV antibody among NSP survey participants, 2004−2013

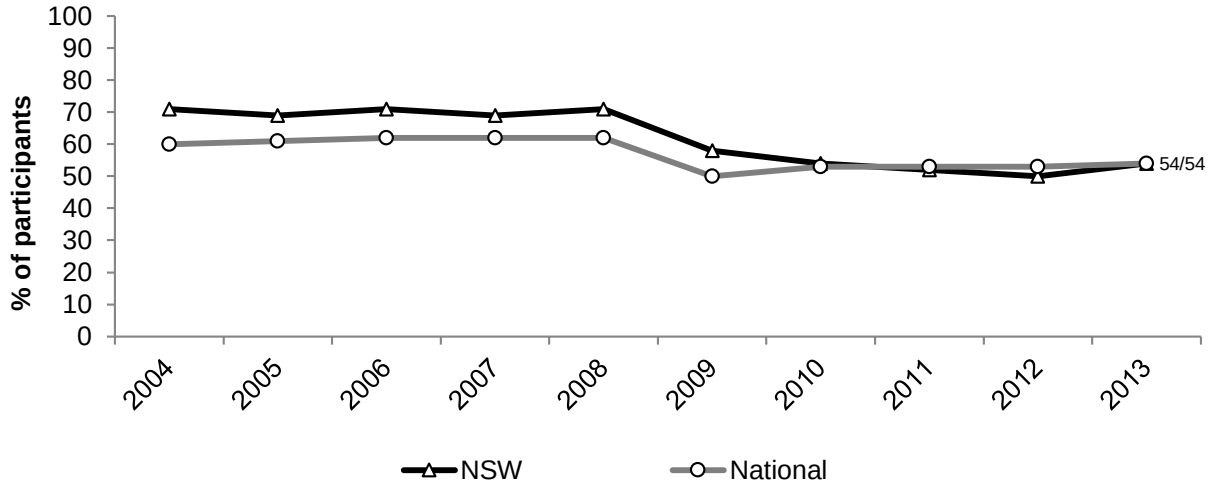


Source: The Kirby Institute

NB: Data for 2014 were unavailable at the time of publication

Detection of hepatitis C (HCV) antibody in capillary blood tests (finger-prick samples) conducted on NSW participants were reported as high in 2013. In 2013, the NSW prevalence (50%) is comparable with the national figure (53%), and both of these figures are consistent with 2010 values (54% and 53%, respectively; (Figure 90).

Figure 90: Prevalence of HCV antibody among NSP survey participants, 2004−2013



Source: The Kirby Institute

NB: Data for 2014 were unavailable at the time of publication

6.7 Alcohol Use Disorders Identification Test-Consumption

Recently a lot of media attention has focused on young people and alcohol. However, there has been less focus on alcohol use amongst people who regularly inject drugs. People who regularly inject drugs are particularly at risk for alcohol related harms due to a high prevalence of the hepatitis C virus (HCV). Half of the participants interviewed in the Australian NSP Survey 2011 (n=2,395) were found to have HCV antibodies (Kirby Institute, May 2011). 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 (Coffin et al., 2007; Darke, Duflou, & Kaye, 2007; Darke, Ross, & Hall, 1996; Schiff & Ozden, 2004) 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, et al., 1998). The AUDIT-C is a three item measure, derived from the first three consumption questions in the AUDIT. Dawson et al (Dawson, et al., 2005) reported on the validity of the AUDIT-C finding that it was a good indicator of alcohol dependence, alcohol use disorder and risk drinking.

Among IDRS participants who drank alcohol in the past year, the overall mean score on the AUDIT-C was 5.2 (median=5, range 1-12). No significant differences were found for gender. Males and females scoring similar on the AUDIT-C (5.4 versus 4.7; $p > 0.05$) according to Dawson and colleagues (Dawson et al., 2005) and Haber and colleagues (Haber, Lintzeris, Proude, & Lopatko, 2009) *Guidelines for the Treatment of Alcohol Problems* a cut-off score of five or more indicated that further assessment was required.

Just over half (51%) of the participants who drank in the past year scored 5 or over on the AUDIT-C. Fifty-one percent of males and 54% females scored 5 or more indicating the need for further assessment (Table 19).

Table 19: AUDIT-C among people who injected drugs and drank alcohol in the past six months, 2014

	2014
Mean AUDIT-C score SD (range)	5.2 3.4 (1-12)
Score of 5 or more*	n=92
All participants (%)	51
Males (%, n=65)	51
Females (%, n=26)	54

Source: IDRS participant interviews
*Among those who drank alcohol in the past year

6.8 Opioid and stimulant dependence

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

In 2014, the participants in the IDRS were asked questions from the Severity of Dependence Scale (SDS) for the use of stimulants and opioids.

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

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

Of those who had recently used a stimulant and commented (n=117), the median SDS score was 5 (mean 4.0; range 0−14), with 54% of those who could comment scoring 4 or above. There were no significant differences regarding gender and mean stimulant SDS score (4.9 females versus 4.7 males). No significant difference was found between gender and those scoring 4 or above. Of those who scored 5 or above (n=51), 66% reported specifically attributing responses to methamphetamines and 11% cocaine, with smaller proportions of participants (2%) reporting pharmaceutical stimulants.

Of those who had recently used an opioid and commented (n=139), the median SDS score was 8 (mean 7.7, range 0−15), with 75% scoring 5 or above. There were no significant differences regarding gender and mean opioid SDS score nor were there any significant differences between gender and those scoring 5 or more (84% female versus 73% male). Of those who scored 5 or above (n=119), 67% reported specifically attributing responses to heroin, 9% methadone, 3% oxycodone, 2% buprenorphine-naloxone, and 1% buprenorphine. No participants who scored over 5 attributed their opioid dependence to morphine.

6.9 Mental and physical health problems and psychological distress

Just under one-third (30%) of all participants reported experiencing a mental health problem other than drug dependence in the preceding six months, a statistically significant decrease when compared with 2013 (46%). As in previous years, the most commonly reported problem was depression (64%; 19% of all participants). Of those reporting a mental health problem, 27% (8% of all participants) reported anxiety, 25% (7% of all participants) reported schizophrenia, 16% (5% of all participants) reported manic-depression/bipolar, and 14% (4% of all participants) reported drug induced psychosis. Fewer participants (n<10) reported paranoia, panic, personality disorders, phobias and obsessive compulsive disorder, however, due to the small numbers, these results should be interpreted with caution.

Seventy-five percent of the sample had attended a health professional for a mental health problem during this time. Of those that reported a mental health problem in the six months prior to interview, 50% (11% of all participants) reported receiving prescribed antidepressant medication for treatment of that condition.

Among the most commonly prescribed antidepressant medications for treatment were Avanza (mirtazapine), followed by Endep (amitriptyline) and Efexor (venlafaxine). Smaller numbers reported being prescribed Lexapro (escitalopram), fluoxetine (generic), and Deptran (doxepin). Twenty-one percent (21% of all participants) reported receiving prescribed antipsychotic medications for treatment of their mental health issue (44% or 12% of all participants in 2013). The most commonly reported antipsychotic medications for treatment were Seroquel (quetiapine) and Zyprexa (olanzapine). Twenty-two percent (5% of entire sample) reported being prescribed benzodiazepines for mental health issues in the six months prior to interview. For more information on use of benzodiazepines, see section 4.9.

6.9.1 Psychological distress measure

The 10-item Kessler Psychological Distress Scale (K10) (Kessler et al., 2002) was first included in the IDRS in 2007. The K10 is a questionnaire designed to yield a global measure of 'psychological distress' based on questions about the level of anxiety and depressive symptoms experienced in the most recent 4-week period. The normative values for the Australian population, in conjunction with the scoring categories for distress, were available from the 2010 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2011). K10 scores were classified in accordance with the following: 10 to 15 as 'low' levels of psychological distress, 16 to 21 as 'moderate' levels of psychological distress, 22 to 29 as 'high' levels of psychological distress, and 30 to 50 as 'very high' levels of psychological distress.

Of those that answered this section (n=142), the mean score was 22.31 (median 21; SD 9.38; range 10−46). As is evident below, IDRS participant scores vastly differed from those reported among the Australian general population, with a larger proportion reporting 'high' and 'very high' distress (Table 20). However, it should be noted that these categories were developed from studies of the general population and the extent to which they would apply to the IDRS sample has not been established.

Table 20: Kessler 10 scores in the 2010 National Drug Strategy Household Survey and NSW PWID participant sample 2010−2014

K10 category	**National Drug Strategy Household Survey 2010**	IDRS 2010 N=154	IDRS 2011 N=148	IDRS 2012 N=149	IDRS 2013 N= 146	**IDRS 2014 N= 142**
% reporting no or low distress	**70**	15	16	13	16	**30**
% reporting moderate distress	**21**	24	19	21	24	**21**
% reporting high distress	**7**	29	28	28	34	**26**
% reporting very high distress	**2**	32	37	38	23	**23**

Source: PWID participant interviews; Australian Institute of Health and Welfare (2008, 2011)

6.10 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. It is the frontline medication for the reversal of heroin and other opioid overdose in particular. 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 the reversal of opioid effects. 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. Shortly after, a similar program started in NSW and some other states have followed suit (for more information refer to http://www.cahma.org.au/naloxone.html and/or http://www.naloxoneinfo.org).

In 2014, the IDRS included a series of questions about take-home naloxone and naloxone more broadly. Ninety-two percent of all participants had previously heard of naloxone. Just under half (44%) of those who had heard of naloxone (n=135), reported that naloxone was used to 're-verse heroin', while 26% reported the use of naloxone was to 're-establish consciousness'. Six per cent said naloxone was used to 'help start breathing' and 30% gave 'other' reasons (Table 21).

Participants were then asked if they had heard about take-home naloxone programs. Of those who commented (n=147), 40% reported that they had heard of the take-home naloxone program, while 59% had not. Of those who commented (n=145), 3% reported that they had completed training in naloxone administration along with a prescription for naloxone. Of those who had completed the course (n=5), one participant had used the naloxone to resuscitate someone who had overdosed.

Participants who had not completed training in naloxone administration were asked what they would do if they witnessed someone having an overdose or found someone they had suspected had overdosed. The majority (96%) of those who commented (n=139) reported that they would 'call 000', 34% would perform mouth-to-mouth cardiopulmonary resuscitation (CPR), 26% reported that they would 'stay with the victim', and 22% would 'turn the victim on their side' (Table 21).

Participants who had not completed training in naloxone administration and commented (n=139) were also asked if naloxone was available would they a) carry naloxone if trained in its use, b) administer naloxone after witnessing someone overdose, c) want peers to give them naloxone if they overdosed, and d) stay with someone after giving them naloxone. Seventy-one percent reported that they would stay with someone after giving them naloxone, 70% reported that they would administer naloxone after witnessing someone overdose, 65% would want their peers to give them naloxone if they overdosed and 55% reported that they would carry naloxone on them (Table 21).

Table 21: Take-home naloxone program and distribution, 2014

	NSW N=150
Heard of naloxone (%)	92
Naloxone description (%)	n=125
Reverses heroin	44
Help start breathing	6
Re-establish consciousness	26
Other	30
Heard of the take-home naloxone program (%)	n=147
Yes	40
No	59
Witness overdose (%)	n=139
Turn victim on side	22
Mouth-to-mouth CPR	34
Call 000	96
Stay with victim	26
Other remedies	14
If naloxone was available would you: (%)	n=139
Carry naloxone if trained	55
Administer naloxone after overdose	70
Want peers give you naloxone	65
Stay after giving naloxone	71

Source: IDRS injecting drug user interviews

6.11 Key expert comments

The most reoccurring themes in relation to health-related trends among KE were:

- Mental health issues continue to be a major problem for PWID and there were ongoing issues with engaging and referring clients into mental health (MH) services.
- Dental health, stable housing and personal hygiene remained ongoing areas of health concern for this population.
- Poor vein care, in part due to increased injection of pharmaceutical opioids designed for oral consumption, is leading to increased difficulty in finding veins, as well as increased rates of infection.
- Although the use of pill filters is increasing, it is still quite low, and this leads to many associated problems such as emphysema and abscesses.
- Polydrug use, particularly the use of benzodiazepines with opioids and/or alcohol was a recurring comment in the management of overdoses.
- Performance and image enhancing drug (PIED) users were utilizing NSP resources but not the services available making them a difficult demographic to engage with.
- Non-fatal overdoses remained low and stable.

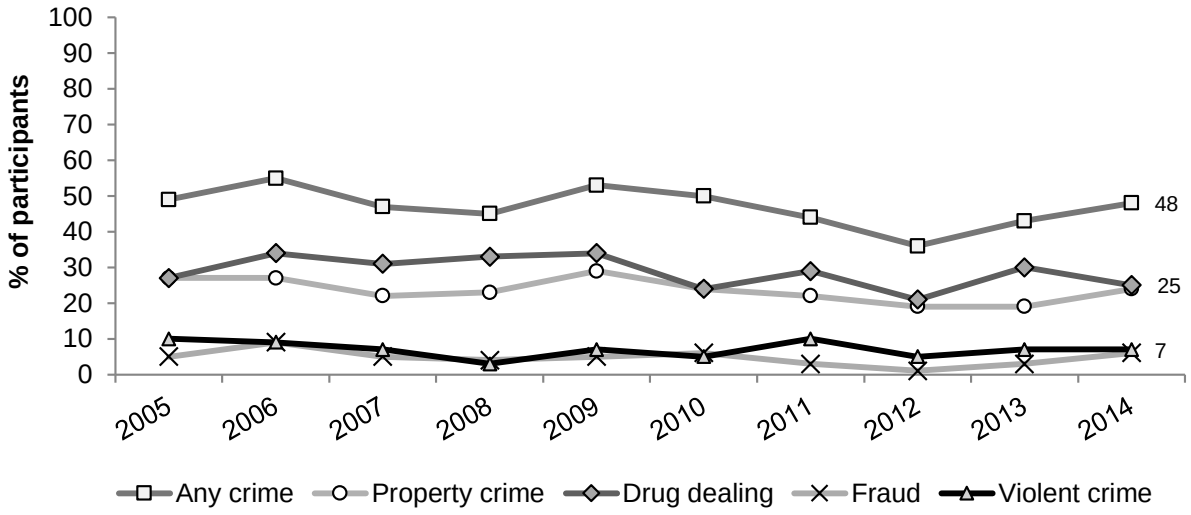
7 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

7.1 Reports of criminal activity among PWID

Forty-three percent of participants reported engaging in any form of crime in the month prior to interview (43% in 2013). With the exception of 2012 (36%), the proportion of the sample reporting any crime in the month prior to interview appears to have remained stable at approximately 45−55% of participants each year for the past decade (Figure 91).

The two most commonly reported crimes were, as in previous years, drug dealing and property crime (25% and 24% of the entire sample respectively). Seven percent of PWID participants reported engaging in violent crime (7% in 2013) and 6% reported fraud (3% in 2013).

Figure 91: Proportion of participants reporting engagement in criminal activity in the last month by offence type, 2005−2014



Source: IDRS PWID interviews

The percentage of participants that reported being arrested in the previous 12 months increased slightly to 48% of the entire sample (42% in 2013) (Table 22). The most commonly cited reasons for arrest in the last 12 months were property crime (15%; 14% in 2013) and possession/use of a prohibited drug (13%; 13% in 2013).

Reported arrests for reasons pertaining to violent crime (includes assault, violence in a robbery, armed robbery, sexual assault) remain stable (6%; 9% in 2013). Small proportions reported having been arrested for driving offences (5%), drug dealing/trafficking (4%), or use/possession of weapons (1%).

Table 22: Criminal activity in the month prior to interview, as reported by PWID participants, 2010−2014

	2010 N=154	2011 N=150	2012 N=151	2013 N=151	**2014 N=150**
Criminal activity in last month					
Dealing (%)	24	29	21	30	**25**
Property crime (%)	24	22	19	19	**24**
Fraud (%)	6	3	1	3	**6**
Violent crime (%)	5	10	5	7	**7**
Any crime (%)	50	50	36	43	**43**
Arrested in last 12 months (%)	44	37	36	42	**48**

Source: IDRS PWID interviews

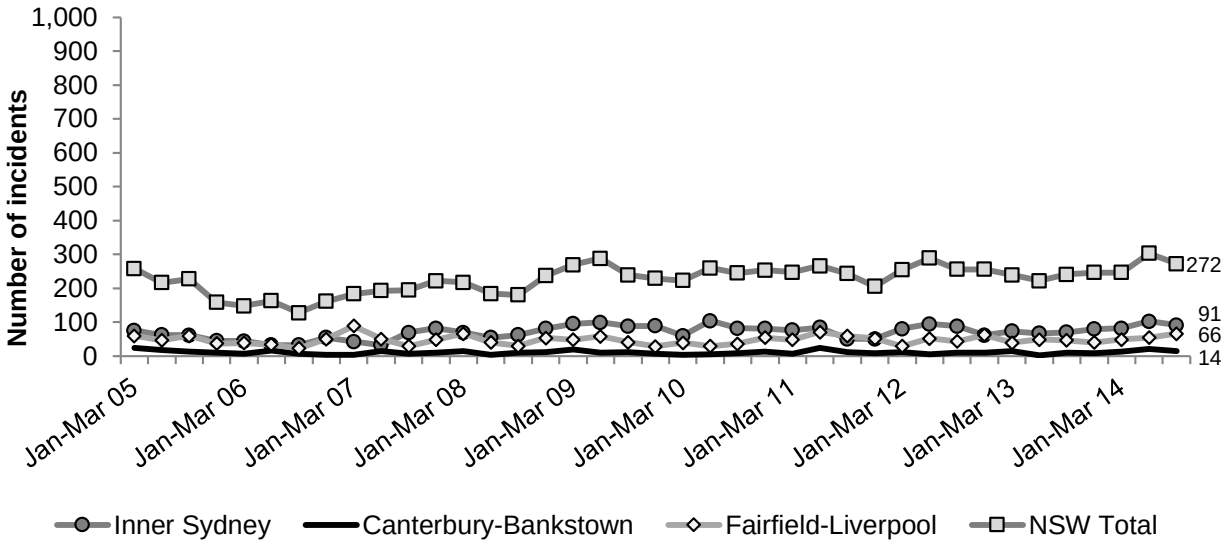
7.2 Arrests

7.2.1 Heroin

Figure 92 illustrates the number of police recorded criminal incidents for narcotics (heroin, methadone and opium) possession/use by quarter in the Inner Sydney area, the Fairfield-Liverpool area, the Canterbury-Bankstown area, and NSW as a whole from Jan 2005 to September 2014.[10]

As can be seen below, possession/use of narcotics in NSW peaked in April-June 2014, with 303 recorded incidents. However, the number of incidents across all areas has remained stable over the past decade (Figure 92).

Figure 92: Recorded incidents of narcotic possession/use by geographic area per quarter, January 2005−September 2014



Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 14th January 2015)
NB: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both

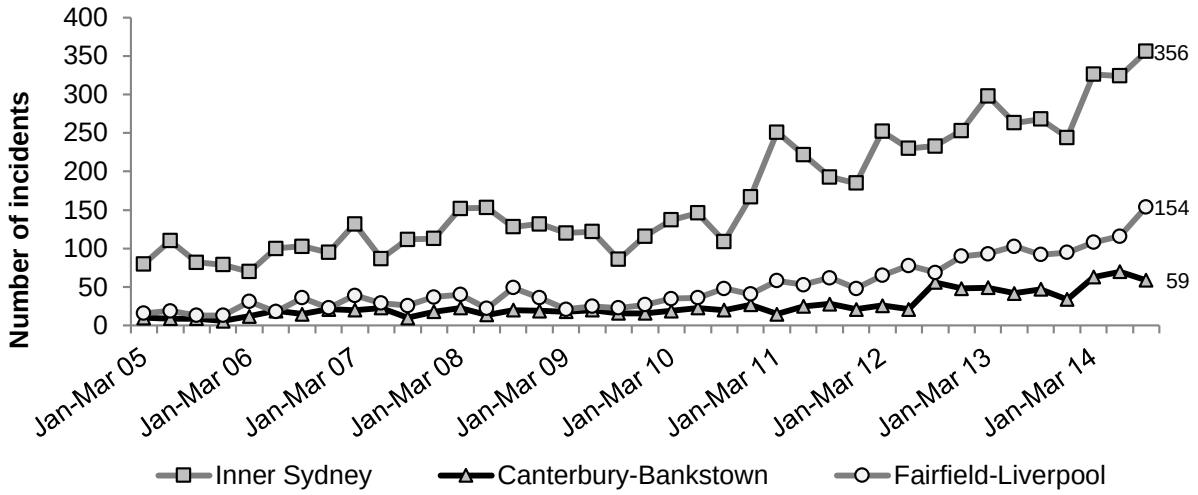
[10] The regions Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown refer to ABS Statistical Subdivisions.

7.2.2 Methamphetamine

Figure 93 shows the number of criminal incidents per quarter for amphetamine possession/use across Sydney.

Recorded incidents in Canterbury-Bankstown have continued to remain stable since September 2012, while possession/use of amphetamine in Fairfield-Liverpool and Inner Sydney has been trending upwards over the same period.

Figure 93: Recorded incidents of amphetamine possession/use by geographic area per quarter, January 2005−September 2014

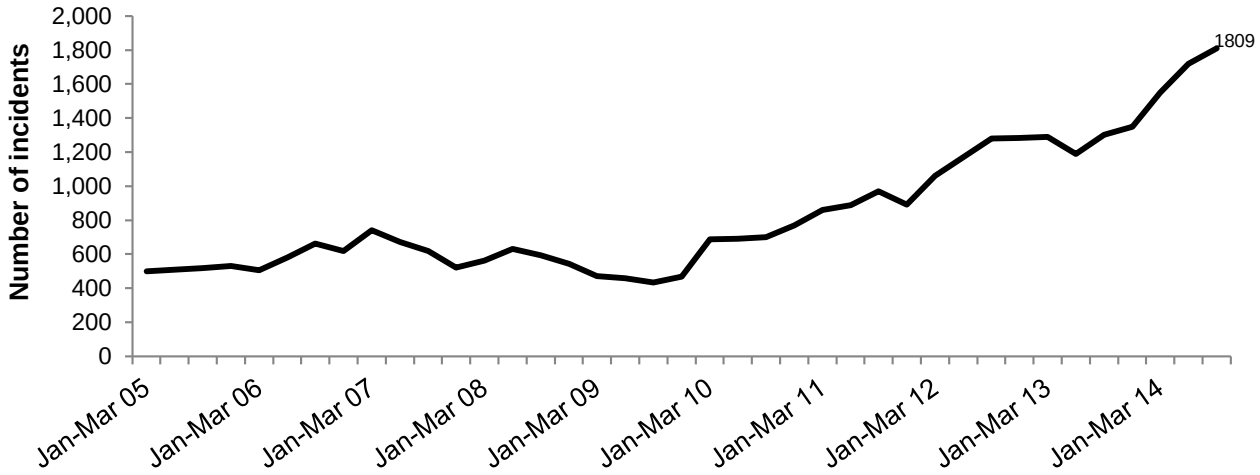


Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 12th January 2015).
NB: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both

State-wide there has been an overall upward trend in police recorded incidents of amphetamine possession/use since 1996.

This trend has continued in the 12 months to September 2014 when NSW as a whole recorded the highest number of incidents (1,809 incidents in July-September 2014) (Figure 94) since recording began in 1996 (Figure 94).

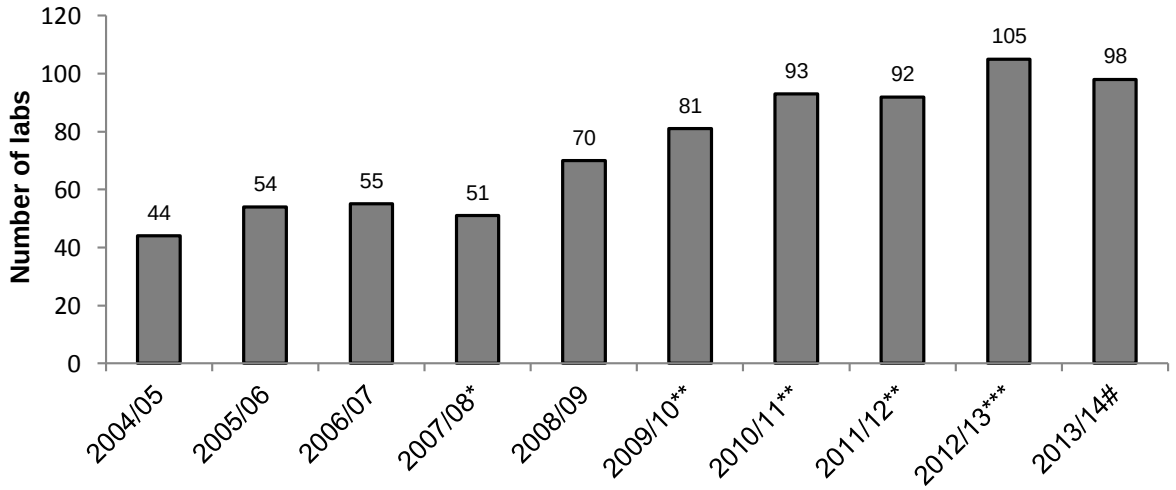
Figure 94: Recorded incidents of amphetamine possession/use (whole of NSW) per quarter, January 2005−September 2014



Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 14th January 2015).
NB: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both

In 2013/14, there were 98 detections of clandestine laboratories detected in NSW (Figure 95).

Figure 95: Number of clandestine methamphetamine and MDMA laboratories detected by NSW Police, 2004/05−2013/14



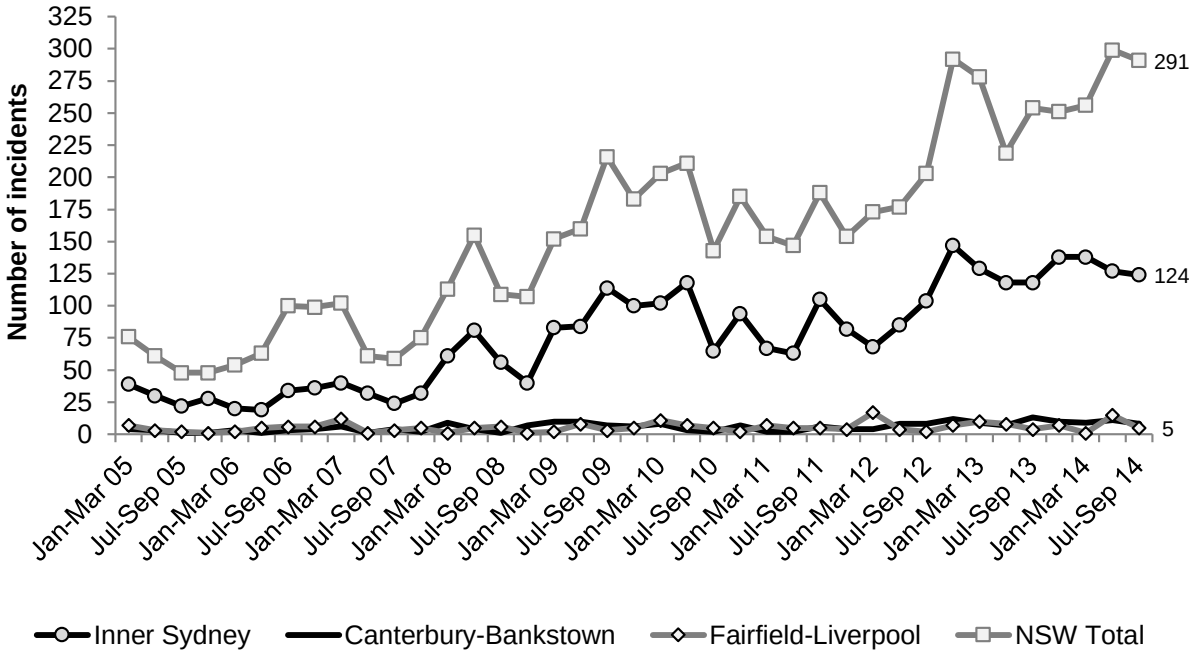
Source: NSW Police
* Includes 2 para-methoxyamphetamine (PMA) laboratories
**Includes 1 PMA laboratory
***Includes two 2-CB labs
Includes two synthetic cannabinoid labs
NB: Data may include active, non-active and historical laboratories as well as storage sites

7.2.3 Cocaine

Figure 96 shows the number of police recorded criminal incidents for cocaine possession/use in Inner Sydney, Fairfield-Liverpool, Canterbury-Bankstown and NSW as a whole.

Levels have remained higher in Inner Sydney than in the South-West areas of Fairfield-Liverpool and Canterbury-Bankstown since data collection commenced in 1996/97. The October-December quarter of 2012 had the highest number of incidents recorded in Inner Sydney and trends have remained relatively stable over the 12 months to September 2014 (Figure 96).

Figure 96: Recorded incidents of cocaine possession/use by geographic area per quarter, January 2005−September 2014



Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 14th January 2015).
NB: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both

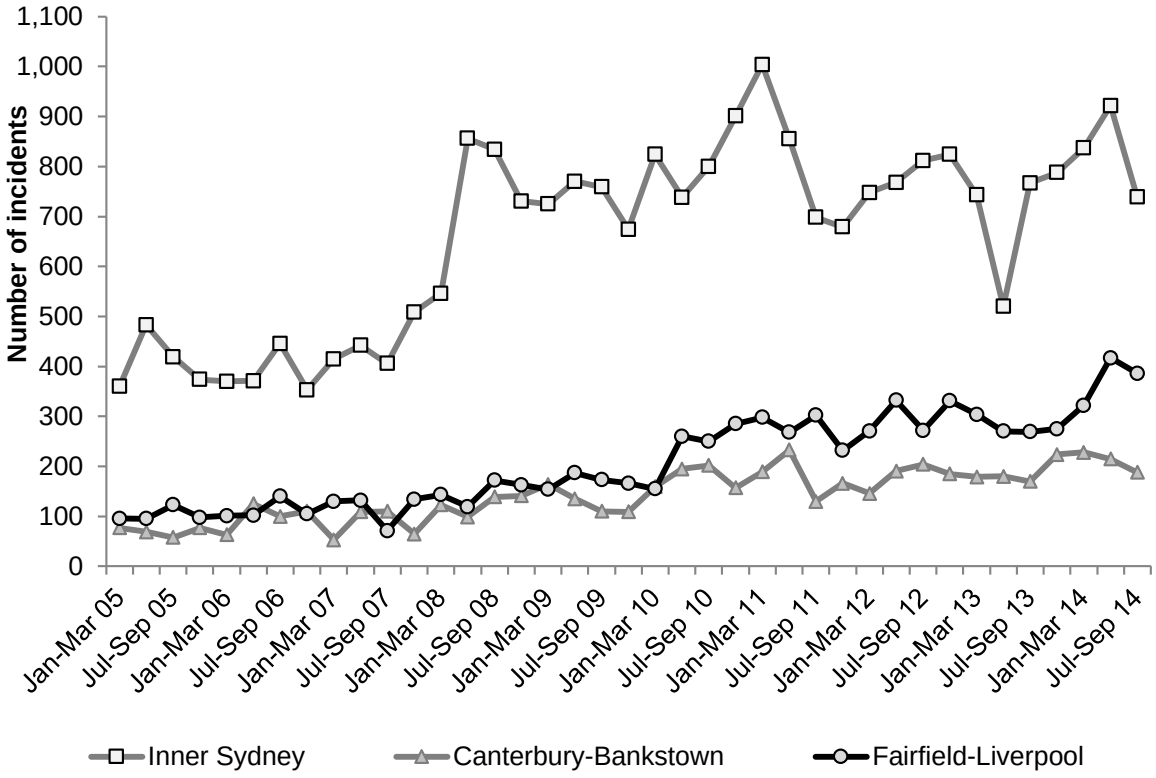
7.2.4 Cannabis

Figure 97 shows the number of police recorded criminal incidents of cannabis possession/use per quarter in the Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown areas.

With the exception of April-June 2013 in Inner Sydney, trends have remained stable across all precincts: Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown overall.

The number of incidents recorded in the Fairfield-Liverpool and Canterbury-Bankstown areas has remained stable for the past two years and proportionally lower than inner city figures. The number of incidents recorded in Fairfield-Liverpool in April-June 2014 (417) was the highest seen for this area since data were first collected in July-September 1996.

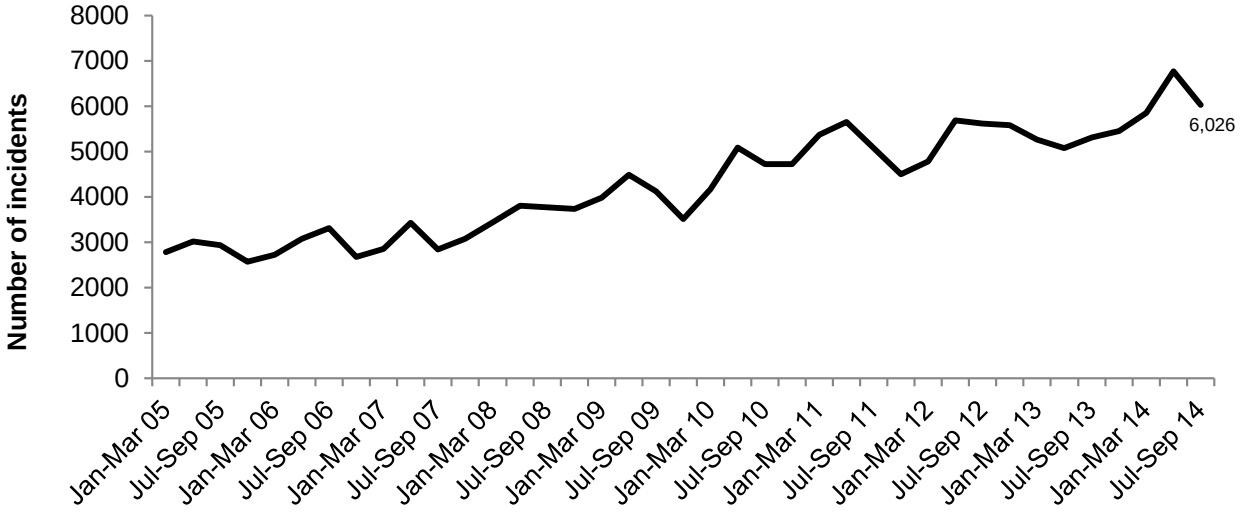
Figure 97: Recorded incidents of cannabis possession/use by geographic area per quarter, January 2005−September 2014



Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 14th January 2015).
NB: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both

In the 12 months to June 2014, there had been a gradual increase in the number of recorded incidents of cannabis possession/use per quarter across NSW, however, this trend decreased in the July-September quarter to 6,026 incidents (Figure 98). Cannabis possessions per quarter have gradually increased over the past 10 year period and for the 12 months to June 2014, include the highest recorded number of incidents (6,765 April-June 2014).

Figure 98: Recorded incidents of cannabis possession/use (whole of NSW) per quarter, January 2005−September 2014



Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 14th January 2015).
NB: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both

7.3 Expenditure on illicit drugs

Sixty-seven percent of participants reported purchasing drugs on the day prior to interview (68% in 2013), spending a median of $100 (range $8−$1,000). Among participants who had bought drugs on the day before interview, 25% had spent between $100−$199, 16% had spent between $50 and $99, 12% between $200−$399, 6% between $20−$49, and 4% spent less than $20. The same number of participants (4%) reported spending $400 or more on drug purchases on the day prior to interview. One-third (33%) of those that reported obtaining drugs on the day prior to interview reported spending nothing ($0).

7.4 Key expert comments

The most reoccurring themes in relation to law enforcement-related trends among KE were:

- The reported availability of speed and base appears to be decreasing, whereas, the availability of ice/crystal was reportedly increasing.
- Purity reports from law KE were mixed.
- The number of police detainees using ice had increased in the year preceding the interview.

8 SPECIAL TOPICS OF INTEREST

8.1 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 et al., 2008) . Whilst research examining substance use among homeless populations has been undertaken, 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.

The lifetime prevalence of homelessness among the 2014 PWID sample was 85% (Table 23). Of those PWID with a homelessness history, 29% 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 just over four years (range: <1-31 years). Two-fifths (40%) of these participants were identified to be chronic, long-term rough sleepers, as they reported that they had slept rough or stayed in emergency accommodation every day for at least six months because they had nowhere else to live.

Participants reported the main factor that contributed to their first episode of homelessness were drug use/dependence (49%), relationship breakdown with family (33%), domestic violence (14%), financial difficulties (12%), mental health problems (9%), physical or sexual abuse (9%) and unemployment (also 9%). Among the participants who had been homeless, approximately one-half (51%) reported being homeless for more than three years of their lives. Participants also reported heightened exposure to various forms of violence during the last six months of their most recent episode of homelessness, with over one-quarter reporting being robbed (28%), physically attacked (27%), stood over (21%) and with one-fifth reporting being mugged (20%) during this time.

Table 23: Homelessness history among people who inject drugs, 2014

	NSW n=150
% lifetime homelessness history	85
% factors contributing to first episode of homelessness*#	(n=124)
Relationship breakdown (family)	33
Drug use/dependence	49
Financial difficulties	12
Unemployment	9
Domestic violence	14
Mental health problems	9
Relationship breakdown (friends)	6
Alcohol use/dependence	8
Physical or sexual abuse	9
Released from prison	6
Gambling	2
Physical health problems	6
Disability	2
% length of time since last homeless episode*	**(n=124)**
Currently homeless	29
In the past six months	13
7-12 months	10
1-2 years	13
2-5 years	12
More than 5 years	23
% total duration of homelessness over lifetime*	**(n=122)**
Less than six months	16
6-11 months	7
1-2 years	26
3-5 years	17
6-10 years	14
More than 10 years	20
% exposed to violence during last 6mths of homelessness	**(n=94)**
Physically attacked	27
Stood over	21
Robbed	28
Mugged	20

Source: IDRS participant interviews
* Among those with a homelessness history
# Multiple responses allowed

Table 24 shows within the subsample of PWID with a homeless history, the proportion who have experienced various states of homelessness in their lifetimes and in the past six months, and the age at which they first experienced each state. The most commonly experienced forms of homelessness during both lifetime and the past six months were sleeping rough (89%; 40%), couch surfing (73%; 28%), boarding rooms/hostels (63%; 16%) and crisis accommodation (61%; 16%). In terms of the first age participants experienced each state of homelessness, on average participants experienced rough sleeping, couch surfing, living in caravan parks, at younger ages (22 years; 22 years; 23 years) compared to the ages which they first used homelessness

services in the forms of crisis accommodation, medium/long-term accommodation and boarding houses/hostels (26 years; 27 years; 27 years).

Table 24: Proportion who experienced different forms of homelessness*, 2014

	NSW n=128
Slept rough	
Lifetime (%)	89
Last 6 mths (%)	40
Mean age of first episode	22
(range)	(5-53)
Crisis or emergency accommodation	
Lifetime (%)	61
Last 6 mths (%)	16
Mean age of first episode	26
(range)	(8-53)
Medium or long term accommodation	
Lifetime (%)	29
Last 6 mths (%)	8
Mean age of first episode	27
(range)	(2-42)
Lived with relatives, friends or acquaintances (couch surfing)	
Lifetime (%)	73
Last 6 mths (%)	28
Mean age of first episode	22
(range)	(2-47)
Boarding or rooming houses or hostels (other than on holiday)	
Lifetime (%)	63
Last 6 mths (%)	16
Mean age of first episode	27
(range)	(5-50)
Caravan park (other than on holiday)	
Lifetime (%)	41
Last 6 mths (%)	3
Mean age of first episode	23
(range)	(9-52)

Source: IDRS participant interviews
* Among those with a homelessness history

8.2 Oxycodone use

Over the past decade there has been a considerable rise in the prescribing of pharmaceutical opioids in Australia: between 1992 and 2012, the number of pharmaceutical opioid dispensing episodes in Australia increased 15-fold (Blanch, Perarson & Haber, 2014) . The rise in opioid prescriptions – including oxycodone—has seen a concurrent increase in extra-medical use of these medications among samples of people who inject drugs. This includes tampering with opioid medications (e.g. crushing, chewing, snorting, smoking, injecting or dissolving/drinking opioid medications intended for oral administration; (Katz, et al., 2011)) to allow a larger quantity of the active ingredient to become available and resulting in increased euphoric effects.

In response, pharmaceutical companies have begun developing formulations that are less prone to tampering. Oxycodone is a semi-synthetic opioid agonist prescribed for the treatment of moderate to severe chronic pain. It is available in eight different products in Australia, with OxyContin® being the most frequently prescribed controlled release formulation. A new tamper resistant formulation of controlled release oxycodone hydrochloride tablets (Reformulated OxyContin®) was released onto the Australian market in April 2014. The tablets are designed to be bioequivalent to the original formulation, but employ a controlled release technology (that makes them difficult to crush) with a hydro-gelling matrix (so the tablet develops into a viscous gel when dissolved in water) (Sellers et al., 2013). Early U.S. surveillance of the reformulation suggests that there have been reductions in misuse (Butler, et al., 2013; Havens, et al., 2014) , street price (Sellers, et al., 2013) and OxyContin® poisonings (Severtson, et al., 2013) .

Post-marketing surveillance of the new formulation is currently underway in Australia (Degenhardt, et al., 2015) , and early findings have indicated that there has been a decline in national pharmacy sales of 80mg OxyContin® (the dose most commonly used and injected among people who inject drugs), as well as a reduction in prevalence of overall use and injection, street price and attractiveness for misuse via tampering among a prospective cohort of people who tamper with pharmaceutical opioids (Degenhardt et al., Submitted; Larance et al., Submitted) .

The oxycodone module was developed to examine patterns of use and misuse of oxycodone products, given changes in the types of oxycodone products available in 2014 (with the introduction of Reformulated OxyContin®). Participants were asked about their use of Original OxyContin® and Reformulated OxyContin®. Of those who commented (N=149), 68% reported ever using any form of oxycodone. Of those who reported lifetime use of oxycodone (N=101), the majority (54%) reported recent use of Original OxyContin®, followed by Reformulated OxyContin® (12%) (Table 23).

Table 25: Lifetime and recent use of oxycodone (any form), 2014

	NSW n=149
% Ever used oxycodone (any form)	68
Recent use of oxycodone (any form)*	n=101
% Endone®	5
% Original OxyContin®	54
% Reformulation OxyContin®	12
% OxyNorm® tabs	5
% OxyNorm® liquid	0
% OxyNorm® Solution	0
% Targin®	0
% Proladone®	0

Source: IDRS participant interviews

*Among those who reported ever using oxycodone

Please refer to Degenhardt, Larance and colleagues for further information on changes in use and misuse of oxycodone products following the introduction of Reformulated OxyContin®, as monitored by the National Opioid Medications Abuse Deterrence (NOMAD) study (Degenhardt, et al., 2015; Degenhardt, et al., Submitted; Larance, et al., Submitted) .

8.3 Ageing

People who inject drugs are an ageing cohort, so to develop a better understanding of the health issues they face, questions were included in the 2014 IDRS on the lifetime diagnosis of chronic conditions and how often they are using the various health services.

Table 26 presents data on lifetime and recent diagnosis of a chronic condition and if treatment was received in the last 12 months. Of those who commented (N=150), approximately two-fifths (38%) reported a lifetime diagnosis of asthma with 57% of those commenting they either still had the condition or received treatment for the condition in the last 12 months (Table 26). Fifteen percent reported a lifetime diagnosis of cancer or stroke (Table 26).

Table 26: Lifetime and recent diagnosis of chronic conditions and treatment received in the last 12 months among PWID, 2014

NSW (n=150)	
Asthma	
Lifetime diagnosis	38
Had condition or received treatment last 12 months*	(n=56) 57
Cancer	
Lifetime diagnosis	15
Had condition or received treatment last 12 months*	(n=12) 33
Stroke	
Lifetime diagnosis	15
Had condition or received treatment last 12 months*	(n=11) 27
Heart/circulatory condition	
Lifetime diagnosis	13
Had condition or received treatment last 12 months*	(n=19) 53
Gout, rheumatism, arthritis	
Lifetime diagnosis	8
Had condition or received treatment last 12 months*	(n=22) 73
Diabetes/high blood sugar levels	
Lifetime diagnosis	8
Had condition or received treatment last 12 months*	(n=10) 60
Respiratory disease	
Lifetime diagnosis	7
Had condition or received treatment last 12 months*	(n=22) 23
Skin problems	
Lifetime diagnosis	7
Had condition or received treatment last 12 months*	(n=12) 67

Source: IDRS PWID interviews
*Among those with a lifetime diagnosis of the chronic condition

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