

New South Wales

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**NSW DRUG TRENDS 2015
Findings from the
Illicit Drug Reporting System (IDRS)**

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NEW SOUTH WALES DRUG TRENDS 2015



Findings from the Illicit Drug Reporting System (IDRS)

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ADIS	Alcohol and Drug Information Service
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
CI	Confidence interval
CPR	Cardiopulmonary resuscitation
DATS	Drug and Alcohol Treatment Services
DMT	Dimethyltryptamine
EDRS	Ecstasy and related Drugs Reporting System
FDS	Family Drug Support
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
IDRS	Illicit Drug Reporting System
IDU	Injecting Drug Use
K10	10-item Kessler Psychological Distress Scale
KE	Key expert(s)
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
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
PCR	Polymerase chain reaction
PDI	Party Drugs Initiative

PIED	Performance and image enhancing drug(s)
PMA	Para-methoxyamphetamine
PO	Pharmaceutical opioids
PWID	People who inject drugs
SD	Standard deviation
SDS	Severity of Dependence Scale
SNOMED	Systematized Nomenclature of Medicine
SPSS	Statistical Package for the Social Sciences

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 2 nd 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
Session	Period of continuous use

EXECUTIVE SUMMARY

Common terms used throughout the report

People who inject drugs (PWID)	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) sample

In 2015, 150 people participated in the IDRS survey. Sixty-six percent were male and the average age of respondents was 43 years (range 19–71 years). Thirty-nine percent of the sample identified as Aboriginal and/or Torres Strait Islanders¹. Ninety-nine percent of the sample identified English as the main language spoken at home. The majority (93%) reported that they were not currently working at the time of interview. Thirty-five percent of the sample had completed year 10 and 15% had completed year 12 at high school. Forty-five percent had not completed any further education after leaving school. The majority (80%) of participants reported a previous prison history and the average age of first injection was 19 years (range 10–43).

Patterns of drug use among the PWID sample

Heroin

Following trends of previous years, heroin was still the preferred drug of choice (72%) in 2015 and this remained stable from 2014 (66%). Heroin was the drug most often injected in the month prior to interview (66%) and the drug people had injected most recently (60%). The majority (91%) of participants reported heroin use on one or more occasions in the six months preceding interview (85% in 2014). The median days of recent heroin use remained stable at 120 days (120 days in 2014). The proportion of participants reporting daily use was 43% (35% in 2014).

The median price for a gram of heroin remained stable at \$400 (\$400 in 2014), as did the price for a cap (\$50). Heroin remained accessible in 2015, with 89% (87% in 2014) of those who commented reporting that it was either 'very easy' or 'easy' to obtain. The majority of participants that commented (73%; 72% in 2014) on ease of availability reported that it had remained 'stable'.

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.

Participant reports on heroin purity continued to be mixed in 2015. Thirty-nine percent of the participants that commented reported current purity as 'low' (37% in 2014) and over one-third (38%; 38% in 2014) reported it as 'medium'. Thirty-eight percent (37% in 2014) of those commenting considered purity levels to have remained 'stable' over the preceding six months and 30% (23%; in 2014) commented that it had 'decreased'.

Methamphetamine

Two thirds of the sample (66%) reported recent use of 'any' recent methamphetamine (speed powder, base, crystal methamphetamine or liquid^{2,3}) (75% in 2014). Considered separately, the use of each of these forms of methamphetamine remained 'stable'; speed (13%; 17% in 2014), base (6%; 12% in 2014), crystal methamphetamine (65%; 74% in 2014) and liquid (3%; 2% in 2014). The median number of days of 'any' (speed, base, crystal methamphetamine, liquid) methamphetamine use was 23 (39 days in 2014). The majority had used each form of methamphetamine weekly or less over the six months preceding interview. The proportion of participants (13%) reporting daily use of any type of methamphetamine remained stable (16% in 2014).

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 a point for all forms. There were insufficient numbers of purchases of other forms of methamphetamine to comment on price changes.

Consistent with 2014, speed and crystal methamphetamine forms of methamphetamine were typically reported by the majority of users as 'very easy' or 'easy' to obtain. The reported availability of base varied. Overall, availability for all forms of methamphetamine was typically reported to have remained 'stable' over the six months preceding interview.

Cocaine

Cocaine use among PWID remained stable in 2015 with 34% of the sample reporting recent use (32% in 2014). Cocaine was used on a median of 10 days (3 in 2014). Daily cocaine use remained 'stable' with 8% of users reporting daily use (6% in 2014). The majority (79%; 85% in 2014) reported cocaine availability to be 'easy' or 'very easy'. The median price per 'cap' of cocaine remained 'stable' in 2015 at \$50 and was the most common purchase amount (n=25). The median price of a gram of cocaine remained stable in 2015, at \$400. Fewer participants reported purchases in all other purchase amounts for cocaine; therefore, results should be interpreted with caution. The number of participants reporting cocaine purity as 'medium' increased in 2015 (38% versus 30% in 2014).

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.

Cannabis

The cannabis market continued to remain relatively unchanged since the commencement of the NSW IDRS in 1996. The majority of participants (79%; 77% in 2014) in the 2015 participant sample reported having used cannabis in the six months prior to interview. Cannabis was used on a median of 120 days (96 days in 2014) and 43% reported daily cannabis use.

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 median 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 (94% versus 90% in 2014). The median 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). Of those who could comment, the current potency of hydroponic cannabis continued to be reported as 'high', and the current potency of bush was mostly reported to be 'medium'.

Use of pharmaceuticals

The IDRS monitors the 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). In this report 'licit' refers to pharmaceuticals obtained by a prescription in the user's name and 'illicit' refers to pharmaceuticals obtained from a prescription in someone else's name.

Non-prescribed (illicit) methadone

One-quarter (25%) of participants reported use of illicitly obtained methadone syrup in the six months preceding interview (27% in 2014). Use remained stable and relatively infrequent. Nineteen-percent of all participants reported injecting illicit methadone syrup in the preceding six months (22% in 2014), and the median days of injection also remained stable at 4 days. Those participants that could comment on the availability of illicit methadone reported that it was 'very easy' or 'easy' to obtain (75% versus 67% in 2014). The median price of 55 cents per millilitre remained 'stable'.

Recent use and injection of Physeptone obtained without prescription remained uncommon.

Non-prescribed (illicit) buprenorphine and buprenorphine-naloxone

Nine percent of all participants (22% in 2014) reported the use of non-prescribed buprenorphine in the preceding six months and 7% reported injection (16% in 2014). Non prescribed buprenorphine was used on a median of four days (6 in 2014) and injected on a median of 5 days (6 days in 2014).

Buprenorphine-naloxone 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 2015 IDRS. Three percent of the sample reported recent use of illicit buprenorphine-naloxone tablets (5% in 2014), with 10% reporting recent use of illicit buprenorphine-naloxone film (15% in 2014). The median number of days of use for illicit buprenorphine-

naloxone tablets was 3 days and 2 days for film. Injection of the buprenorphine-naloxone 'tablet' or 'film' was low (3% tablet and 7% film) and consistent with 2014 data.

Morphine

Recent use of any form (prescribed or non-prescribed) of morphine was reported by 21% of the NSW IDRS sample (29% in 2014). Recent use of non-prescribed (illicit) morphine was reported by 19% (25% in 2014) and recent injection by 18% (25% in 2014). The median number of days non-prescribed morphine was injected was 6 days, compared with 24 days in 2014.

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

Oxycodone

In 2014, OxyContin® (oxycodone) tablets were reformulated 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-reformulated OxyContin® (i.e. 'original stock') and reformulated OxyContin®.

Twenty-five percent of all participants (44% in 2014) reported use of any (prescribed or non-prescribed) oxycodone in the six months preceding interview. Participants reported using oxycodone on a median of 14 days (approximately fortnightly) (20 days in 2014). The recent injection of any oxycodone decreased significantly from 39% in 2014 to 20% in 2015.

The proportion of PWID reporting the recent use of non-prescribed oxycodone in the preceding six months decreased significantly from 40% in 2014 to 21% in 2015 on a median of 11 days (20 days in 2014). Injection of non-prescribed oxycodone in the last six months was reported by 18% of those who commented on a median of 13 days (37% on a median of 20 days in 2014).

Nineteen percent (37% in 2014) of the sample felt confident to comment on the price and/or availability of illicit oxycodone in 2015. The most common purchase amounts were 80mg Reformulated OxyContin® tablets, bought for a median price of \$40 each (range: \$10–\$100). Of those participants who could comment, current availability of oxycodone was considered 'very easy' (42%) or 'easy' (31%) to obtain.

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 2015, 9% of the sample reported recent use of OTC codeine, on a median of 8 days (22%; 12 days in 2014) and two participants reported recent injection.

Benzodiazepines

About half (53%) of the sample reported recent use of licit or illicit benzodiazepines (59% in 2014). The frequency of use remained stable at 23 days (28 days in 2014). The injection of licit or illicit benzodiazepines remained low with 4% (3% in 2014) reporting injecting in the past six months on a median of 6 days.

Over a third (35%) had recently used 'illicit' alprazolam on a median of 6 days and 3% had recently used 'licit' alprazolam on a median of 48 days. Excluding alprazolam, the most

commonly used brand of other benzodiazepine was diazepam (74%; including Valium, Valpam and Antenex), followed by oxazepam (10%; Serepax) and clonazepam (7%; Rivotril).

Seroquel®

Twenty-three percent of the sample had used any form of Seroquel® in the preceding six months (21% in 2014). Fourteen percent had used 'licit' Seroquel® on a median of 180 days and 10% used 'illicit' Seroquel® on a median of four days.

Other drugs

Hallucinogens, ecstasy and inhalant use were relatively low within this sample. Although about a half (51%) of the sample had tried ecstasy, recent use was reported by only 7% of the sample on a median of 3 days. One percent of all participants reported recent hallucinogen use in 2015. Prevalence of recent inhalant use (e.g. nitrous oxide, amyl nitrate) remained low at 2%.

Alcohol and tobacco

Fifty-one percent of participants had consumed alcohol in the preceding six months on a median of 10 days, i.e. approximately once per fortnight. This remained stable from 2014 (50%; median of 12 days). Five percent of all participants reported daily use of alcohol.

Tobacco remained the most commonly used substance investigated by the IDRS, with the vast majority of all participants (91%) 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

Fifty-one percent of participants reported having overdosed on heroin in their lifetime and 28% had done so in the 12 months preceding interview. One participant reported heroin overdose in the month preceding interview (n=6 in 2014).

Participant reports of borrowing and lending of needles and syringes, as well as sharing of other injecting equipment, remained stable in 2015.

The most commonly reported location for last injection remained at a private home and this remained stable from 2014. Participants were asked the site on their body for their last injection. The majority (72%) reported their arm, 9% reported hand/wrist and smaller proportions reported their leg (7%), neck (5%) or groin (3%). Sixty-six percent of PWID participants who had injected in the preceding month reported at least one injection-related problem during this time (55% in 2014). As per 2014, the most commonly reported problems were prominent scarring/bruising of injection sites (76%) and difficulty injecting (65%).

Thirty-nine percent of the sample reported experiencing a mental health problem, other than drug dependence, in the preceding six months (29% in 2014) and 76% reported seeking advice from a mental health professional (75% in 2014). Depression continued to be the most commonly reported problem (52%; 64% in 2014), among those who reported a mental health problem.

The 10-item Kessler Psychological Distress Scale (K10) was administered. The K10 assesses recent levels of psychological distress (anxiety and depressive symptomatology). Of those who commented, over half of the participants (55%) 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

Over a third (38%) of PWID participants reported being arrested in the previous 12 months decreased (48% in 2014). 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 (29%; 25% in 2014) and property crime (19%; 24% in 2014). The daily expenditure on drugs and alcohol (excluding tobacco and prescribed medication) remained stable in 2015 at a median of \$100 per participant.

1 INTRODUCTION

The Illicit Drug Reporting System (IDRS) is Australia's 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 heroin, cocaine, methamphetamine and cannabis. The IDRS identifies 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 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 2015. 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 <http://ndarc.med.unsw.edu.au> or Drug Trends websites <http://www.drugtrends.org.au/>. Quarterly bulletins are also produced on IDRS and related data 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 above websites.

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. Copies of EDRS reports and bulletins may also be downloaded from the NDARC <http://ndarc.med.unsw.edu.au> or Drug Trends <http://www.drugtrends.org.au/> websites.

1.1 Study aims

As in previous years, the specific aims of the 2015 NSW IDRS were:

- 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 may require further investigation.

2 METHOD

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

- A quantitative survey of people who inject drugs (PWID);
- 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 located within known drug market areas are an appropriate sentinel group for detecting illicit drug trends and related issues, due to their high exposure to a variety of illicit drugs. PWID 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 to complement the PWID survey data. The collation of indicator data provides a precise and reliable measure of drug trends, often at a population level.

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 2015 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 2015 NSW IDRS, the survey consisted of face-to-face interviews with 150 PWID, conducted in Sydney during May and June 2015. 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). Prior to 2004 PWID were recruited from Cabramatta rather than Liverpool. Due to the closure of a service in Cabramatta in mid-2003, Liverpool was selected as a new interview site 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 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 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; 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 or at coffee shops and fast-food outlets close by. Interviews were administered by trained interviewers, took about 60 minutes to complete, 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-two KE who had regular contact with, and/or specialist knowledge of people using illicit drugs⁴, drug dealers or drug manufacturers, were interviewed during September and October 2015. 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 2015 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 larger 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 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. Data sources that have been included in this report are:

- 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) seroprevalance data from the annual Needle and Syringe Program (NSP) Survey;

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

- 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 2,4 methylene dioxymethamphetamine (MDMA) laboratory detections.

3 DEMOGRAPHICS

3.1 Overview of people who inject drugs (PWID) regularly

The demographic characteristics of the 150 PWID who took part in the interview in 2015 are presented below (Table 1).

The mean age of the sample was 43 years (range 19–71), 66% were male and 39% identified as Aboriginal and/or Torres Strait Islander.⁵ The vast majority identified as heterosexual (86%) and reported that English was the main language they spoke at home (99%). The educational status of the sample varied, from no schooling (1%) through to completion of year 12 (15%). Thirty-five percent had completed year 10. Forty-seven percent had obtained a trade or technical qualification and 7% had completed a university or college qualification such as a degree. About half (45%) had not completed any further education after leaving school.

The majority of the sample (93%) reported that they were currently not employed. Ninety-four percent of the sample reported that their main source of income over the preceding month had been a pension or government benefit. Sixty-one percent of participants reported being single, 17% reported being married or a de facto and 16% had a regular partner. Smaller proportions reported being separated/divorced (4%), 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, 2011–2015

Characteristic	2011 N=150	2012 N=151	2013 N=151	2014 N=150	2015 N=150
Mean age (years) (range)	40.0 (21–58)	39.6 (19–59)	40.1 (23–63)	40.0 (19–64)	43 (19–71)
Sex (% male)	65	60	60	75	66
Aboriginal and/or Torres Strait Islander* (%)	17	29	27	37	39
School education (mean no. years, range)	9.8 (4–12)	9.8 (0–12)	10 (4–12)	9 (3–12)	9 (0–12)
Employment (%)					
Not employed/on a pension	84	93	95	93	94
Full time	4	1	1	3	2
Part-time/casual	6	3	4	1	3
Home duties	2	1	0	1	1
Student	2	1	1	1	0
Sexual identity (%)					
Heterosexual	84	87	85	91	86
Bisexual	11	10	11	7	11
Gay or lesbian	5	2	3	2	3
Other	1	1	1	0	1
Tertiary education (%)					
No qualification	52	49	44	43	45
Trade/tech	42	46	49	49	47
University/college	5	5	7	7	7
Current relationship status (%)					
Married/de facto	28	18	22	22	17
Regular partner	20	18	20	16	16
Single	43	60	45	55	61
Separated/divorced	5	3	10	6	4
Widowed/widower	3	1	3	1	1
Currently in drug treatment^ (%)	72	60	61	51	64
Prison history (%)	71	66	70	79	80

Source: IDRS PWID interviews

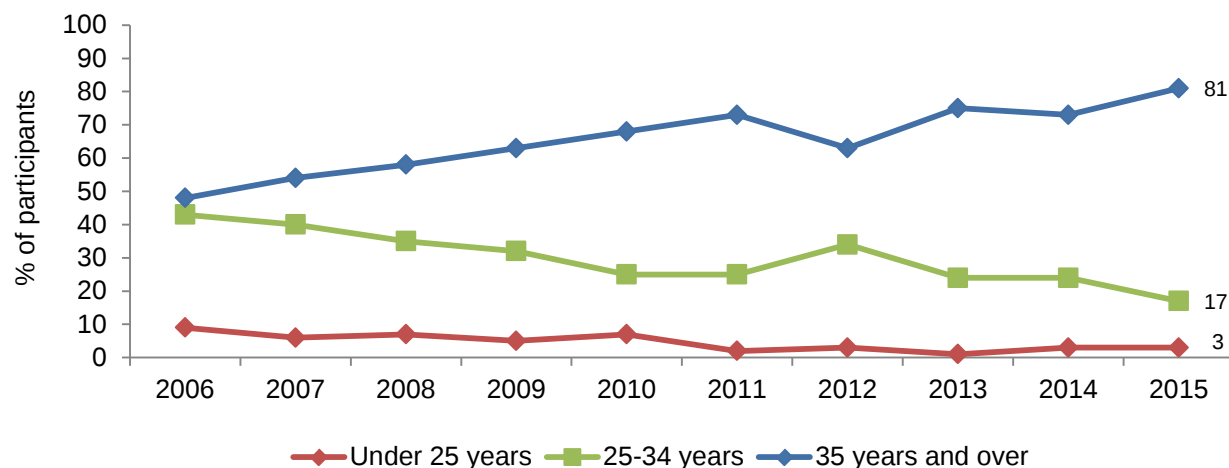
^ Refers to any form of drug treatment, including pharmacotherapies, counselling, detoxification, etc.

*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 (43 years) of the sample is in keeping with the gradual increase in age over time. The 35 years and over age group represents the majority (81%) of the sample (73% in 2014). The proportion of younger users interviewed generally has remained low and stable (Figure 1).

Figure 1: Age distribution of PWID in the NSW (Sydney) IDRS samples, 2006–2015



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 2015 reported having taken part in the IDRS survey previously (between 1996 and 2014). The majority of participants had been recruited by word of mouth and by advertisements in NSPs (Table 2).

Table 2: Previous participation in the IDRS and EDRS and source of participant recruitment, 2011–2015

	2011 N=150	2012 N=151	2013 N=151	2014 N=150	2015 N=150
Participated in IDRS in previous years (%)	32	35	35	31	31
IDRS survey recruitment (%)					
Needle and Syringe Program (NSP)	57	49	39	48	31
Treatment provider	4	7	13	5	10
Advert in street press	0	1	2	0	0
Word of mouth	36	40	33	39	48
Participated in EDRS in previous years (%)	4	4	3	2	2

Source: IDRS PWID interviews

3.1.3 Current and previous drug treatment

Sixty-four percent of participants reported that they were currently in drug treatment. Of those participants currently engaged in treatment, 53% (38% in 2014) reported methadone as their main form of treatment, 11 participants (7% of those in treatment) reported they were on buprenorphine-naloxone (Suboxone), and two participants (1% of those in treatment) reported buprenorphine (Subutex). There were no reports of participants in naltrexone treatment, Narcotics Anonymous, drug counselling or detoxification programs.

Participants were also asked if they had been in treatment at any stage over the past six months. About half (53%) reported they had been in any form of drug treatment over this time. The majority of those that had been in treatment were in opioid substitution treatment and small numbers reported other treatment including; drug counselling (n=10), detoxification (n=5) or treatment in a therapeutic community (n=2).

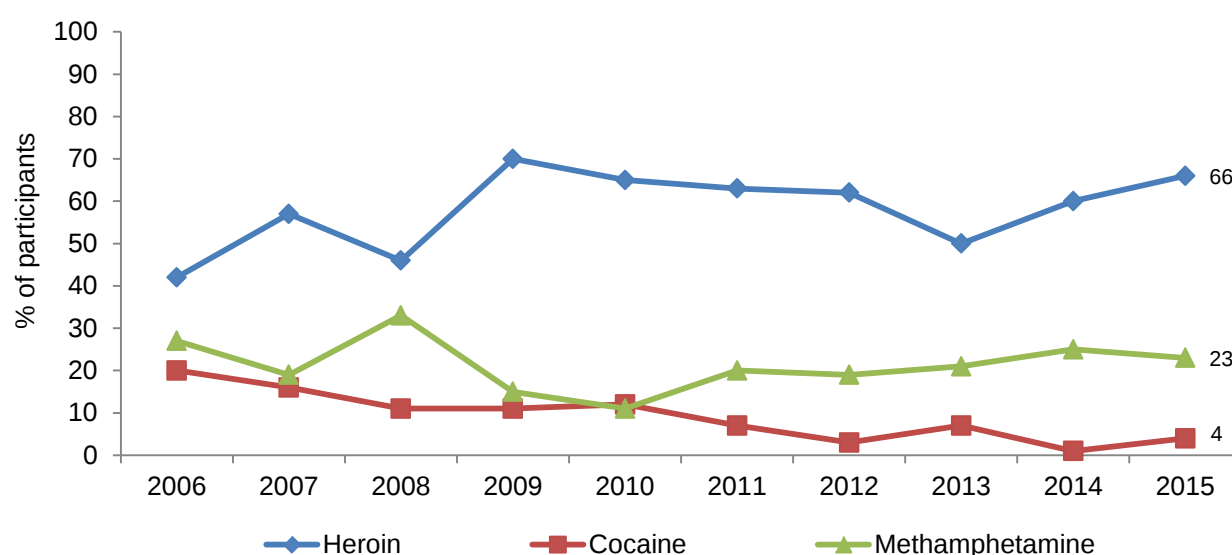
4 CONSUMPTION PATTERNS

4.1 Drug use history and current drug use

The mean age of first injection was 19 years (SD 6.2, range 10–43) (Table 3). Similar to previous years, heroin was the first drug injected by the majority of participants (58%), followed by methamphetamine (31%) and cocaine (6%). Heroin remained the most commonly reported drug of choice (72%), remaining stable from the previous two years (66% in 2014 and 62% in 2013).

As in previous years, heroin remained the drug injected most often in the month preceding the interview (66%) (Figure 2) and the most common drug last injected (60%) (Table 3). Over half of the participants (59%) injected at least once a day in the preceding month. Fifteen percent of participants reported injecting 'more than three times a day', 29% reported injecting '2 to 3 times per day' in the month preceding the interview, 15% reported once daily injection, 19% reported 'more than weekly, but less than daily' and 21% reported injecting 'weekly or less'.

Figure 2: Drug injected most last month, 2006–2015



Source: IDRS PWID interviews

NB: Survey item was first included in 1999

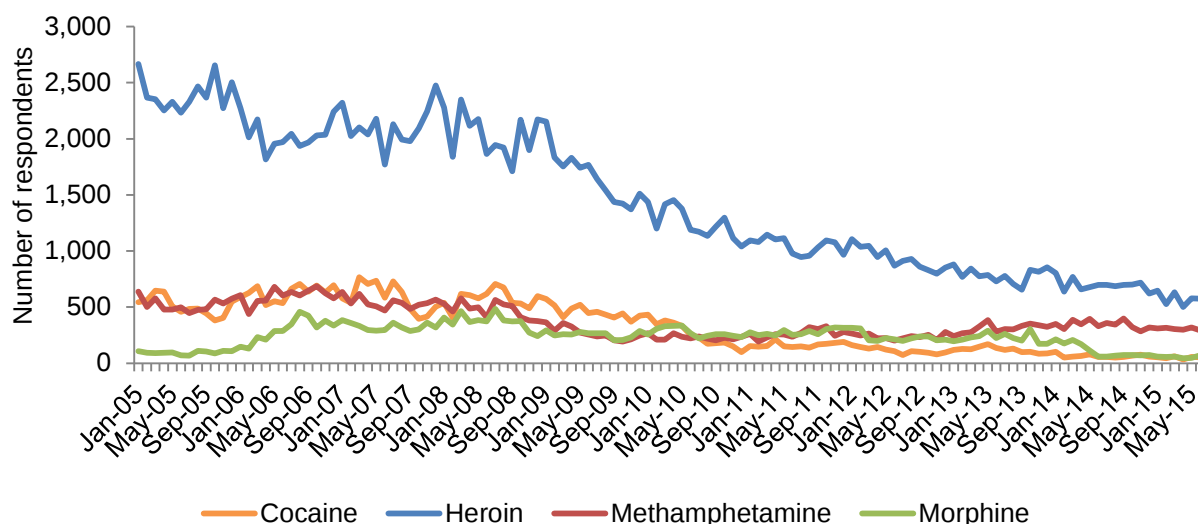
Table 3: Injection history, drug preferences and polydrug use of PWID participants, 2011–2015

Variable	2011 N=150	2012 N=151	2013 N=151	2014 N=150	2015 N=150
Age first injection (mean years)	19	19	20	19	19
First drug injected (%)					
Heroin	63	58	57	55	58
Methamphetamines	33	33	36	32	31
Cocaine	3	5	3	7	6
Morphine	0	1	0	1	1
Drug of choice (%)					
Heroin	70	67	62	66	72
Cocaine	7	5	9	4	3
Methamphetamine (any form)	16	15	17	17	17
Speed	1	3	1	3	4
Base	1	0	1	0	0
Crystal methamphetamine (ice)	14	12	15	13	13
Benzodiazepines	1	1	0	1	0
Cannabis	3	2	4	4	4
Drug injected most often in last month (%)					
Heroin	63	62	50	60	66
Cocaine	7	3	7	1	4
Methamphetamine (any form)	20	19	23	28	23
Speed	1	2	1	3	1
Base	1	0	1	0	0
Crystal methamphetamine (ice)	18	17	21	25	22
Benzodiazepines	0	0	0	1	0
Morphine	1	4	2	5	1
Oxycodone	3	5	11	2	3
Most recent drug injected (%)					
Heroin	61	59	50	59	60
Cocaine	5	5	7	2	5
Methamphetamine (any form)	17	23	24	25	24
Speed	1	3	2	1	1
Base	1	1	1	0	0
Crystal methamphetamine (ice)	15	19	21	24	23
Benzodiazepines	0	0	0	0	0
Morphine	4	3	3	4	1
Oxycodone	3	8	11	4	2
Frequency of injecting in last month (%)					
Not injected in last month	1	1	1	0	1
Weekly or less	13	14	13	11	21
More than weekly, but less than daily	43	34	35	29	19
Once per day	14	14	16	11	15
2–3 times a day	23	23	28	37	29
>3 times a day	7	15	7	11	15

Source: IDRS PWID interviews

Figure 3 (below) presents the drug last injected by respondents attending three inner city NSPs. Heroin continued to be reported as the last drug injected by the most of respondents but there has been a continuing decline in the number of respondents reporting heroin from 2005. The numbers reporting methamphetamine (all forms) as the last drug injected over the past 12 months remained relatively stable. The number of people reporting cocaine and morphine in the last 12 months remained relatively stable at a lower level.

Figure 3: Number of respondents attending three inner city NSP reporting heroin, methamphetamine, cocaine and morphine as last drug injected, Jan 2005- June 2015



Source: Three inner city NSPs

The polydrug use histories of PWID participants, including routes of administration, are presented in Table 4. The PWID reported using a median of 7 different drugs (range 1-20) in the past six months.

Substantial proportions reported recent use of the four main drugs monitored by the IDRS: heroin (91%), cannabis (79%), methamphetamine (any form) (66%) and cocaine (34%) (Figure 4). More detailed information on the use of these drugs are found under the relevant section headings in the report.

Table 4: Drug use history and routes of administration of the sample, 2015

Drug Class	Ever used %	Ever injected %	Injected last 6 mths %	Median days injected in last 6 months*	Smoked last 6 mths %	Snorted last 6 mths %	Swallowed last 6 mths %	Used^ last 6 mths %	Median days used^ in last 6 mths*
Heroin	98	95	86	120	6	2	1	91	120
Homebake heroin	37	35	15	7	0	0	0	15	7
Any heroin (inc. homebake)	98	96	86	140	6	2	1	91	130
Methadone (prescribed)	68	33	11	48			39	47	180
Methadone (not prescribed)	46	36	19	4			9	25	4
Physeptone (prescribed)	10	5	0	0	0	0	0	0	0
Physeptone (not prescribed)	23	15	2	2	0	0	1	3	2
Any methadone (inc. Physeptone)	81	55	21	7			43	56	180
Buprenorphine 'Subutex' (prescribed)	30	18	1	10	0	0	1	2	10
Buprenorphine 'Subutex' (not prescribed)	33	24	7	5	1	0	3	9	4
Any buprenorphine (excl. buprenorphine-naloxone)	50	35	8	6	1	0	5	11	5
Buprenorphine-naloxone 'Suboxone' tablets (prescribed)	19	7	1	24	0	0	1	1	57
Buprenorphine-naloxone 'Suboxone' tablets (not prescribed)	17	13	3	3	0	0	1	3	3
Any buprenorphine-naloxone 'Suboxone' tablets	31	17	3	4	0	0	2	4	4
Buprenorphine-naloxone 'Suboxone' film (prescribed)	20	6	1	30	0	0	7	8	165
Buprenorphine-naloxone 'Suboxone' film (not prescribed)	23	12	6	2	1	0	6	10	2
Any buprenorphine-naloxone 'Suboxone' Film	37	16	7	2	1	0	13	17	8
Any buprenorphine-naloxone (any form)	44	23	11		1	0	13	18	
Morphine (prescribed)	12	9	3	180	0	0	3	4	180
Morphine (not prescribed)	48	44	18	6	1	0	3	19	6
Any morphine	53	47	19	6	1	0	5	21	6
Oxycodone (prescribed)	18	11	6	10	0	0	5	10	24
Oxycodone (not prescribed)	57	47	18	13	1	1	5	21	11

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: Drug use history and routes of administration of the sample, 2015 (continued)

å	Ever used %	Ever injected %	Injected last 6 mths %	Median days injected in last 6 months*	Smoked last 6 mths %	Snorted last 6 mths %	Swallowed last 6 mths ⁺ %	Used [^] last 6 mths %	Median days used [^] in last 6 mths*
Any oxycodone	63	49	20	10	1	1	9	25	14
Fentanyl	24	20	15	7	0	0	1	15	7
Other opioids (not elsewhere classified)	41	4	1	5	0	0	0	16	7
OTC codeine	34	5	1	7	0	0	9	9	8
Speed powder	77	73	11	6	0	2	1	13	9
Base/point/wax	51	47	5	6	1	1	1	6	4
Crystal methamphetamine/shabu	81	79	61	24	1	0	2	65	24
Amphetamine liquid	31	27	3	22			1	3	22
Any form methamphetamine [#]	89	87	62	22	23	2	3	66	23
Pharmaceutical stimulants (prescribed)	7	2	0	0	0	0	0	0	0
Pharmaceutical stimulants (not prescribed)	21	10	1	2	0	0	1	1	2
Any form pharmaceutical stimulants	25	10	1	2	0	0	1	1	2
Cocaine	83	79	33	11	0	5	1	34	10
Hallucinogens	45	11	1	3	1	1	0	1	4
Ecstasy	51	19	3	2	0	0	4	7	3
Alprazolam (prescribed)	18	3	0	0	0	0	3	3	48
Alprazolam (not prescribed)	53	7	3	6	0	0	33	35	6
Any form alprazolam	60	8	3		0	0	35	37	
Other benzodiazepines (prescribed)	39	3	1	3	0	0	23	24	72
Other benzodiazepines (not prescribed)	50	5	0	0	0	0	30	31	6
Any benzodiazepine (excl. alprazolam)	66	7	1		0	0	43	45	
Any form benzodiazepine	74	14	4	6	0	0	51	53	23
Steroids	9	7	0	0	0	0	1	1	105
Seroquel (prescribed)	27	1	0	0			13	14	180
Seroquel (not prescribed)	27	1	0	0			10	10	4
Any form Seroquel	51	1	0	0			22	23	180
Alcohol	88	3	0	0			49	51	10
Cannabis	95				73		2	79	120
Inhalants	20							2	2
Tobacco	97							91	180

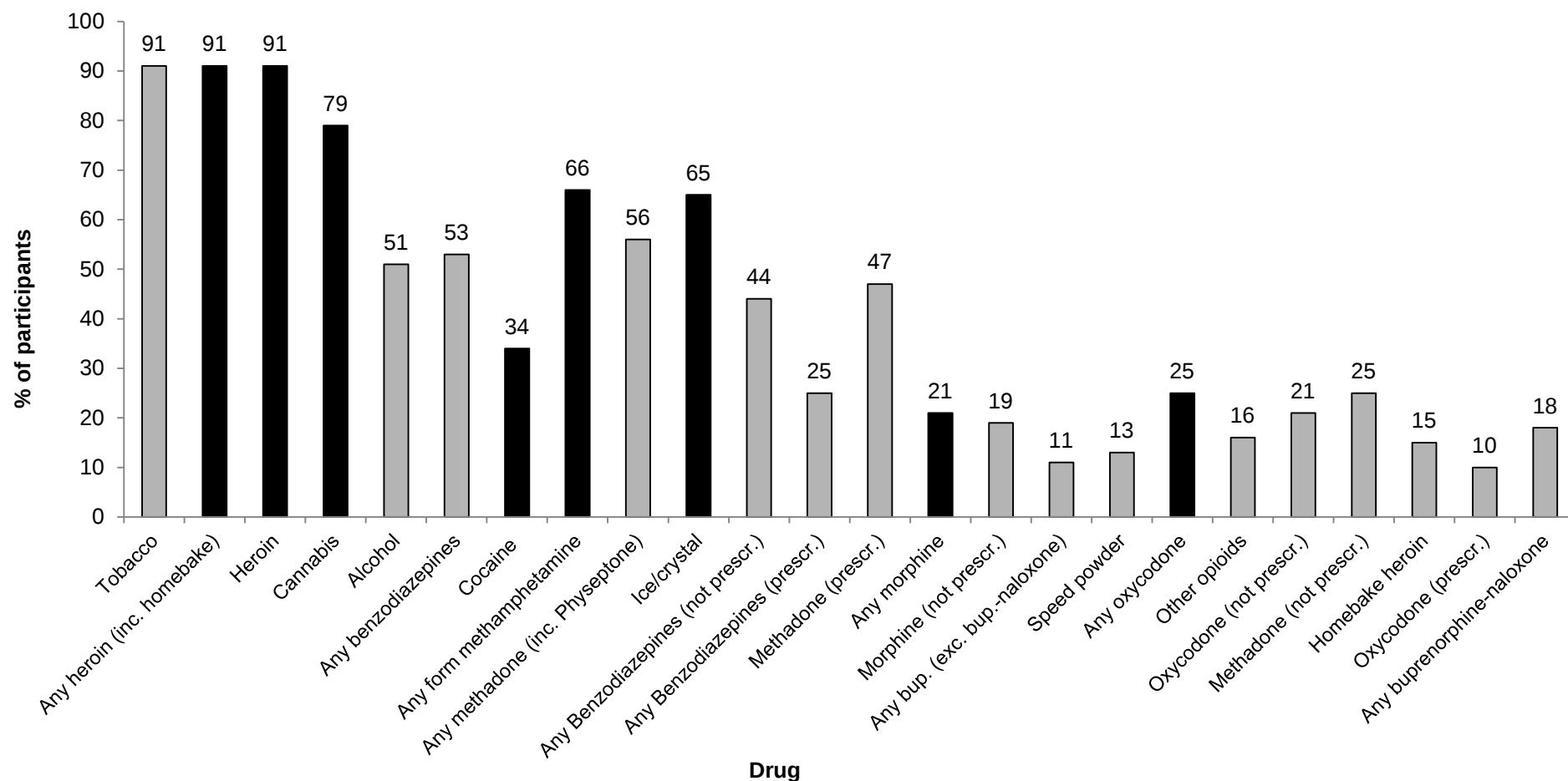
Source: IDRS PWID interviews

[^] 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, crystal methamphetamine and amphetamine liquid (oxblood)

Figure 4: Prevalence of drug use among PWID in the six months preceding interview, NSW 2015*



Source: IDRS PWID interviews

* Key drugs investigated in the IDRS (i.e. heroin, methamphetamine, cocaine and cannabis) shown in black; 'Any heroin' includes heroin and homebake heroin. 'Any methamphetamine' includes speed, base, crystal and liquid amphetamine. 'Any methadone' includes licit (prescr.) and illicit (not prescr.) methadone liquid and Physeptone®. 'Any morphine', 'any buprenorphine', 'any oxycodone', 'any Seroquel', 'any buprenorphine' and 'any form bup.-naloxone' includes licit and illicit tablet and film 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. Only those drugs reporting 10% or more are shown. '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.

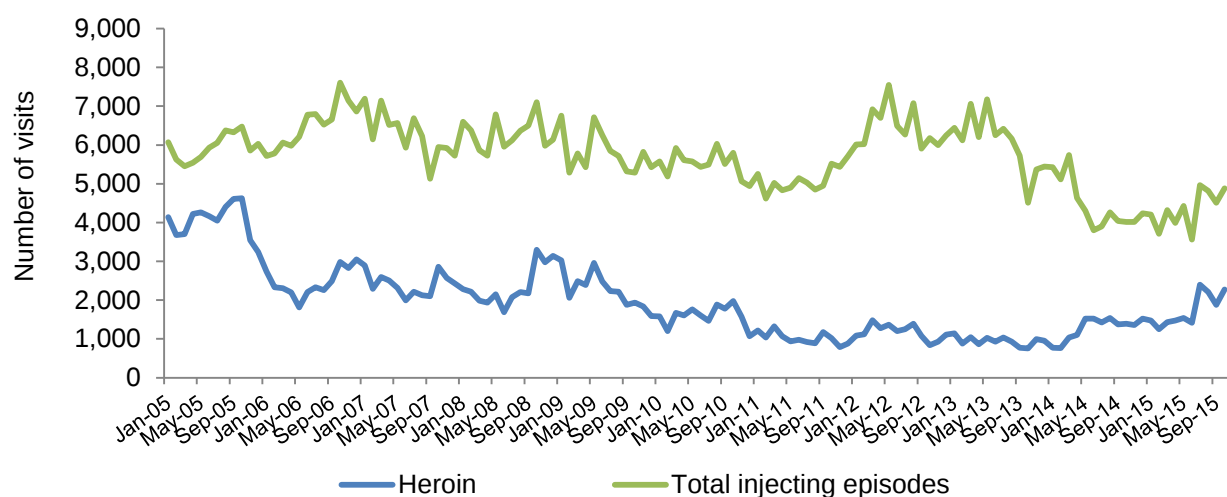
4.2 Heroin

4.2.1 Heroin use among PWID participants

The majority of participants (91%) had used heroin in the six months preceding interview (85% on 2014). Heroin remained the drug of choice for 72% of the sample (66% in 2014) (Table 3). Heroin was most commonly nominated for 'drug injected last' (60%), consistent with the 59% reporting it in 2014. Heroin was nominated by two thirds of the sample (66%) as the 'drug injected most often in the last month' (60% in 2014).

Figure 5 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 October 2015. The MSIC was opened in 2001 and the hours of operation changed over the first two years, increasing from four hours to 12 hours per day. The number of individuals attending increased as 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. There has been a steady downward trend in attendances for heroin injection since May 2012. In the 12 months to October 2015, heroin has accounted for approximately 33–47% of all attendances to Sydney MSIC.

Figure 5: Number of attendances to Sydney MSIC where heroin was injected and total number of visits, Jan 2005–October 2015



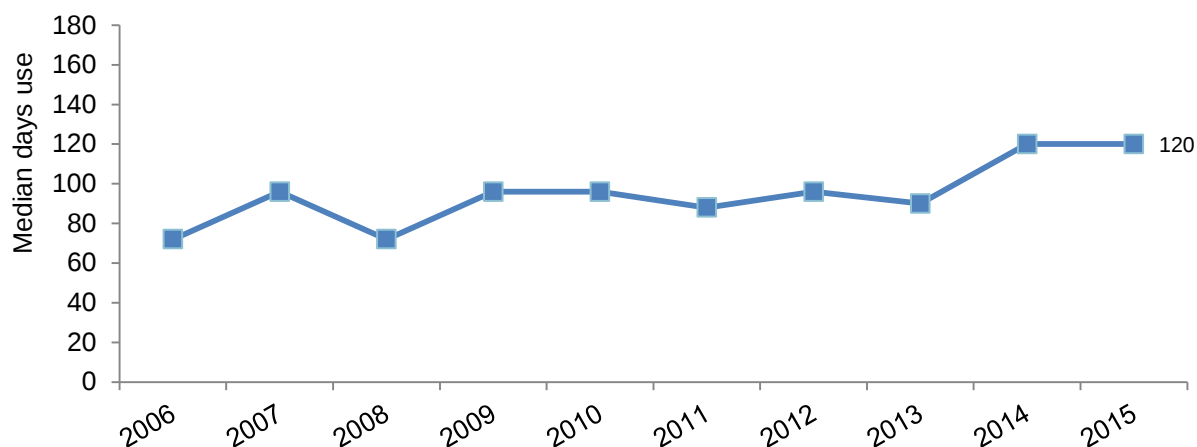
Source: Sydney MSIC, Kings Cross

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

4.2.2 Current patterns of heroin use

The vast majority of participants in 2015 (91%) reported recent use of heroin (85% in 2014). The median number of days of heroin use in the six months preceding interview was 120 days, which is consistent with 2014. This represents the highest frequency of use since 2004 (120 days) (Figure 6). Over the last decade, the median days of heroin use has consistently been 96 days, or approximately every second day. Half (50%) of those that had used heroin reported use on the day prior to interview (51% in 2014).

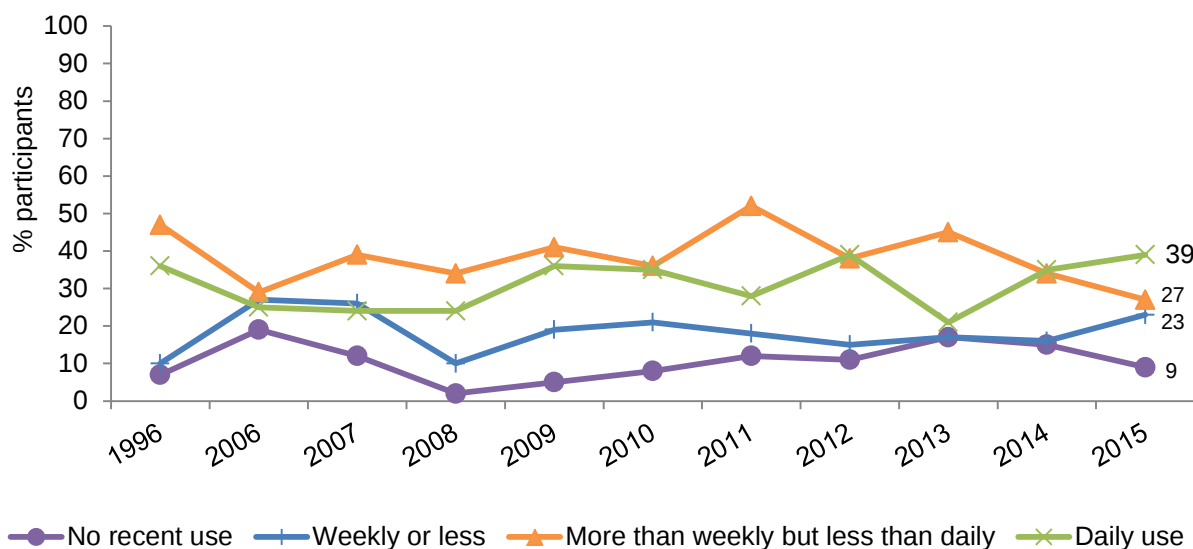
Figure 6: Median days of heroin use* in the past six months, 2006–2015



Source: IDRS PWID interviews
*Among those that reported recent heroin use

In 2015, nine percent of PWID had not used heroin in the past six months. Over one-third (39%) of reported daily heroin use, 27% reported 'more than weekly but less than daily' use and 23% reported using 'weekly or less' (Figure 7).

Figure 7: Patterns of heroin use among NSW PWID, 2006–2015



Source: IDRS PWID interviews

Among those that reported recent heroin use 43% reported daily use, 38% reported 'more than weekly but less than daily' use and 18% reported using 'weekly or less'.

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 has an acidic (acetone/hydrochloride) base and is relatively easy to prepare for injection as it is 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, 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.

In the past decade 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 firm 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. Since 2007, the issue was investigated by asking participants to describe the colour of the forms of heroin they had used over the last six months, in addition to the 'form most used'.

In 2015 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. Thirty-four percent reported using heat on the last occasion (25% in 2014) and 9% reported using any form of citric/ascorbic/acetic acid (7% in 2014).

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 (55%) of respondents described the colour of heroin as brown/beige (63%; in 2014) and 36% described it as white/off-white in colour (22% in 2014).

4.2.4.1 Forms of heroin used

As in previous years, participants were asked about the forms of heroin they had used over the preceding six months. Eighty-nine percent of participants who had reported recent use of heroin described it as white/off-white 'powder' or 'rock' (79% in 2014) and 62% reporting recent use of heroin described it as brown/beige 'powder' or 'rock' (69% in 2014). The form most used over the preceding six months among those who could comment was white/off-white 'powder' (41%; 36% in 2014) and white/off-white 'rock' (31%; 27% in 2014). The use of brown 'rock' remained stable (17%; 19% in 2014) and 6% reported the use of brown 'powder' (16% in 2014).

4.2.4.2 Homebake

Homebake is a form of heroin made from pharmaceutical opioids. Homebake use remained uncommon and infrequent among the PWID sample of the NSW IDRS. Fifteen percent of the sample reported use in the last six months (9% in 2014) and all 15% reported injecting homebake (8% in 2014).

The median number of days of homebake during this time was 7 (i.e. approximately monthly use, range 1-90 days) and remained stable from the 5 days reported in 2014. The median number of days on which it had been injected by users in this time was 7 days and was consistent with the 5 days (range 1-90 days) reported in 2014.

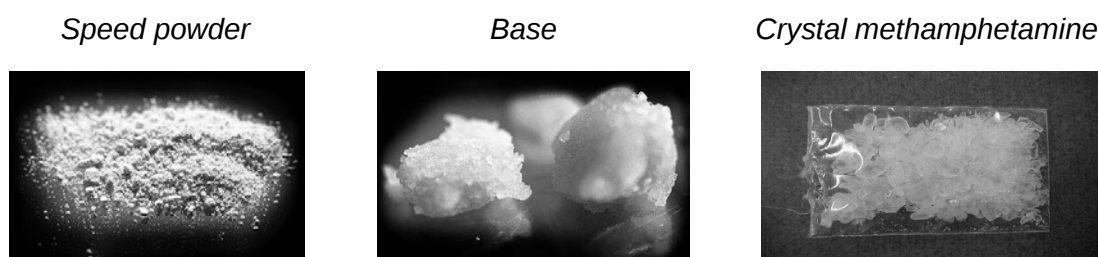
Key expert comments

- KE comments reflected findings in the PWID survey that heroin remained the drug of choice among this group.
- Five KE believed that heroin was one of the most problematic drugs at the present time. The reasons for this were varied and included; the addictive nature of the drug, physical issues (e.g. hygiene, injecting (vein care) and circulation), mental (e.g., PTSD and depression) and social impacts (e.g. financial problems, relationship problems, stigma and criminal activity) that the drug can have on the individual.
- KE commented that heroin users tend to be older in age (40+) than other PWID and slightly more males than females.
- Some KE expressed concern regarding an increase in heroin overdoses and the high risk of overdosing due to reduced availability of narcan/naloxone in recent times.
- A few KE commented that heroin use has increased post the introduction of Reformulated OxyContin®.

4.3 Methamphetamine

From 2002, in response to the increasing diversification of the methamphetamine markets in Australia identified by the 2001 IDRS (Topp, Degenhardt, Kaye, & Darke, 2002), data has been collected on 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. In the IDRS it refers only to the powder form of methamphetamine. 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; A Roxburgh, Breen, & Degenhardt, 2004), and clarification was made to ensure participants and the interviewers were referring to the same forms of methamphetamine.

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

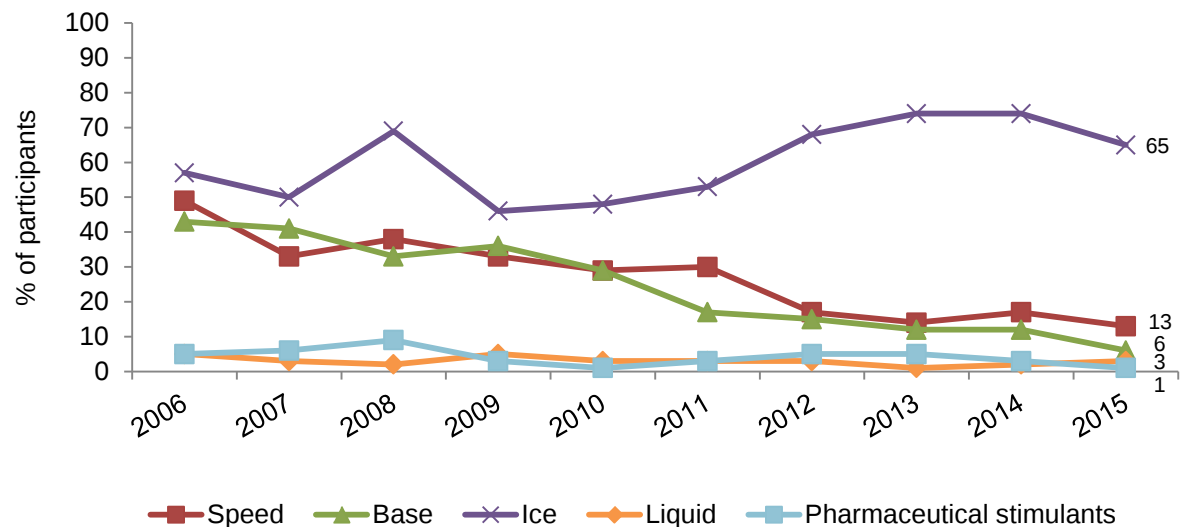


4.3.1 Methamphetamine use among PWID participants

Two thirds (66%) of the sample reported the use of any form of methamphetamine (speed, base, crystal methamphetamine or liquid) in the six months preceding interview decreased (75% in 2014). Considered separately, the most commonly used form was crystal methamphetamine (65%; 74% in 2014), followed by speed (13%; 17% in 2014) and then base (6%; 12% in 2014). Liquid amphetamine (also known as 'oxblood') remained considerably less common, with 3% (2% in 2014) of participants reporting use in the last six months (Figure 9). These figures represent a non-significant decline in usage patterns across all forms of methamphetamine reported in 2015.

Again in 2015, a distinction was made between the licit versus illicit use of pharmaceutical stimulants. No participants reported use of prescribed pharmaceutical stimulants in the six months preceding interview. The use of non-prescribed pharmaceutical stimulants continued to remain low in 2015, with 1% (2% in 2014) of participants reporting recent use. The recent use of any pharmaceutical stimulants by this group has remained at less than 10% since 2005 (Figure 8).

Figure 8: Proportion of PWID reporting methamphetamine and pharmaceutical stimulant use in the past six months, 2006–2015

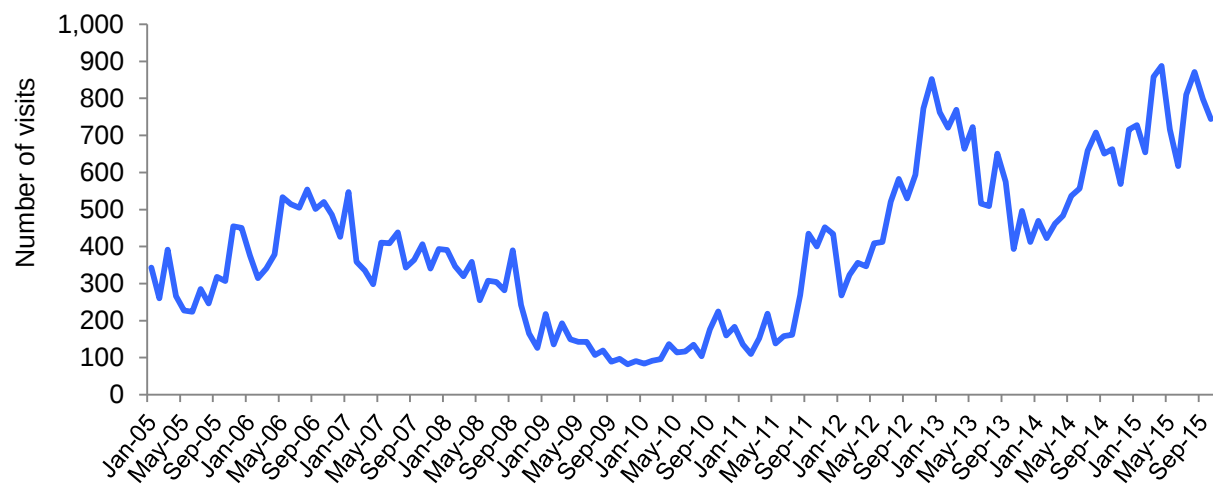


Source: IDRS PWID interviews

NB: Pharmaceutical stimulants also include prescribed use

Figure 9 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 three years from 268 in January 2012 to 744 in October 2015, representing approximately 15% of all injecting episodes.

Figure 9: Number of attendances to Sydney MSIC where methamphetamine was injected, January 2005–October 2015



Source: Sydney MSIC, Kings Cross

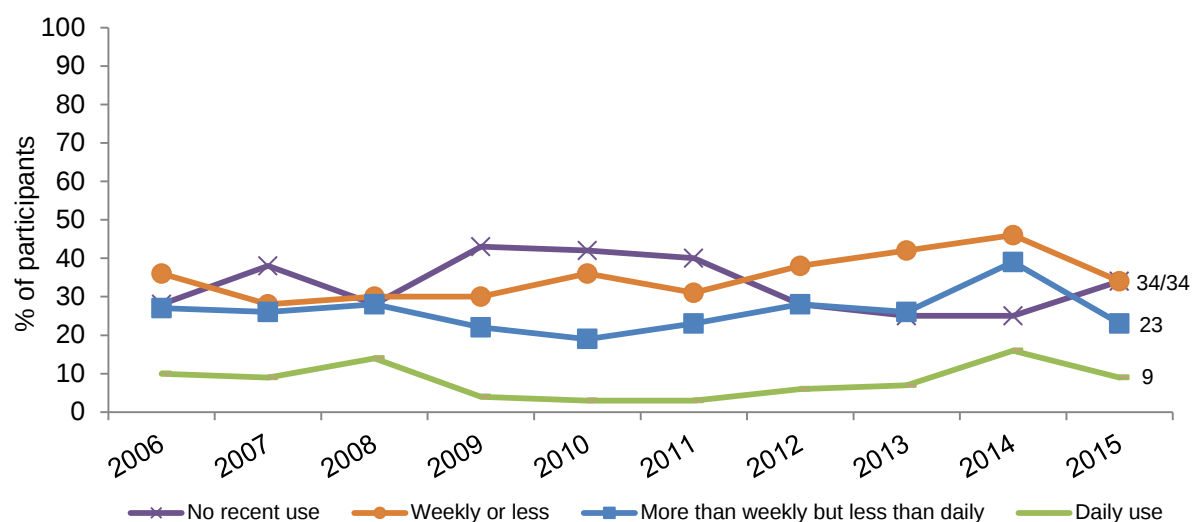
⁶ The MSIC opened in 2001. The hours of operation changed over the first two years of operation (from four to up to 12 per day); and the numbers of individuals attending increased as PWID became aware of the service.

4.3.2 Current patterns of methamphetamine use

The proportion (66%; 75% in 2014) of participants reporting any recent methamphetamine use (speed, base, crystal methamphetamine) declined slightly in 2015. Among those reporting any recent use (speed, base, crystal methamphetamine, liquid) the median number of days of use was 23 days (39 days in 2014). Half (52%) of those who had used methamphetamine had used any form weekly or less over the six months preceding interview, followed by more than weekly but less than daily (37%), with 13% using daily (Figure 10 and Table 5)

The use of any pharmaceutical stimulants (prescribed and non-prescribed) continues to remain very low (1%; 3% in 2014) 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 decreased from 6 days to 2 days. Illicitly obtained pharmaceutical stimulants were used by one participant only on 1 day in the past 6 months (12 days in 2014). No participants (1% in 2014) had recently used pharmaceutical stimulants that were prescribed to them.

Figure 10: Patterns of methamphetamine use (any form) among NSW PWID, 2006–2015



Source: IDRS PWID interviews

Most (70%) of those that reported recent use of speed powder reported using 'weekly or less'. A quarter used powder 'more than weekly but less than daily' and 5% reported daily use. The majority that used base (89%) reported 'weekly or less' use and 11% used 'more than weekly but less than daily'. Half of those (52%) that reported recent crystal methamphetamine used 'weekly or less', 36% reported more than weekly but less than daily use and 12% used daily.

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-five percent of recent users (63% of entire sample) nominated crystal methamphetamine (94% in 2014), 4% nominated speed powder (6% in 2014) and one participant nominated liquid methamphetamine. No participants nominated base in 2015 (Figure 11).

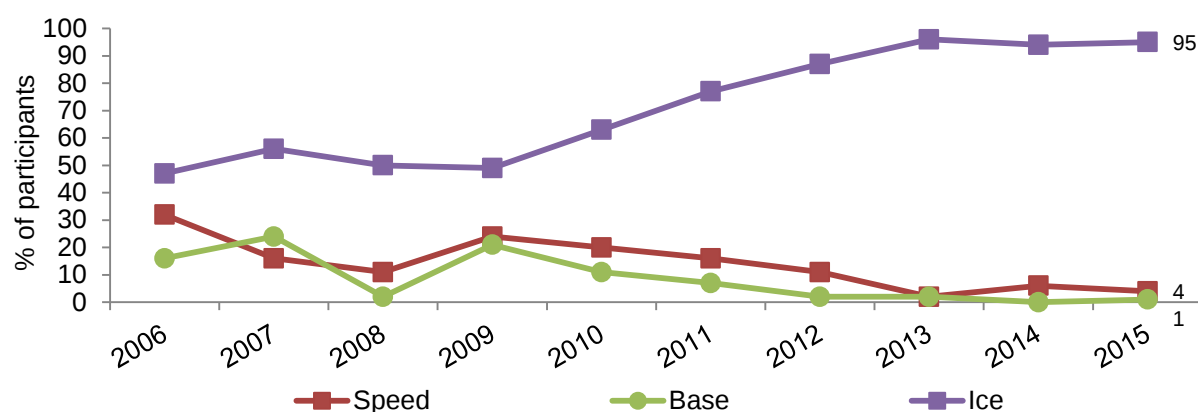
Table 5: Patterns of methamphetamine use in the last six months, by type, 2015

	Among whole sample		Among those that reported recent use					
	% who had used		% used weekly or less		% used more than weekly, but less than daily		% used daily	
Form used	2014	2015	2014	2015	2014	2015	2014	2015
Speed powder	17	13	76	70	16	25	8	5
Base	12	6	78	89	11	11	11	0
Crystal/methamphetamine	74	65	49	52	35	36	16	12
Any form of methamphetamine*	75	66	46	52	39	37	16	13

Source: IDRS PWID interviews

* Also includes liquid methamphetamine

Figure 11: Methamphetamine form most used in the preceding six months, among recent methamphetamine users, 2006–2015



Source: IDRS PWID interviews

Key expert comments

- The majority of KE considered methamphetamine to be the most problematic drug at the present time.
- There was variation in what KE believe the average age of methamphetamine users to be with a wide age range reported (17 to 70 years).
- Most KE reported that the majority of methamphetamine users were male, mostly unemployed with high rates of contact with the justice system.
- Widespread concern regarding the prevalence of mental health issues among this group; depression, psychosis and paranoia, chaotic behavior and aggression. Physical deterioration resulting from methamphetamine use, sleep deprivation, malnutrition, weight loss, hygiene issues and skin issues (due to scratching and picking) were noted.
- Limited engagement with methamphetamine users makes it difficult for health KE to administer treatment and provide safe injecting advice.
- Law enforcement KE highlighted the ease of methamphetamine production, indicated that small labs are hard to detect and the precursors are easy to purchase.
- KE mentioned the public health risk associated with the manufacturing process which involves highly volatile and poisonous gases and poses a high risk to manufacturers and surrounding community.

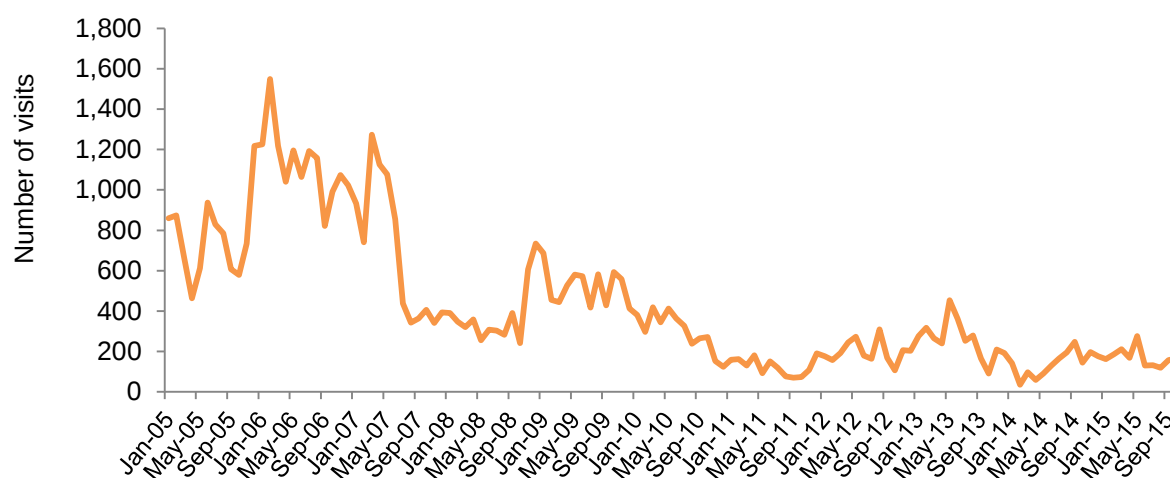
4.4 Cocaine

4.4.1 Cocaine use among PWID participants

In 2015, thirty-four percent of all PWID participants reported cocaine use in the preceding six months (32% in 2014). Eleven percent of the sample reported use of cocaine on the day prior to interview (11% in 2014). Five percent reported cocaine as the drug last injected (2% in 2014).

Figure 12 shows the number of attendances to the Sydney MSIC where cocaine was the drug injected.⁷ Cocaine injecting at the MSIC has remained low and stable over the past 12 months to October 2015. For the majority of this period, cocaine injections have accounted for less than 5% of the total of injecting episodes.

Figure 12: Number of attendances to Sydney MSIC where cocaine was injected, January 2005–October 2015



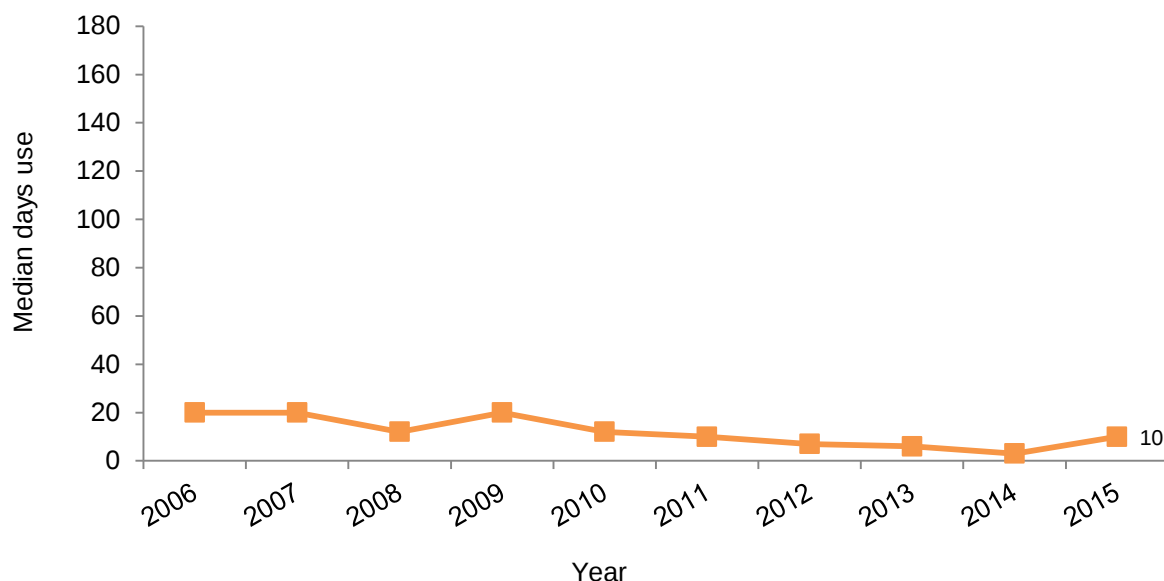
Source: Sydney MSIC, Kings Cross

4.4.2 Current patterns of cocaine use

PWID that had recently used cocaine reported use on a median of 10 days (range 1-180 days) (3 days in 2014) (Figure 13). Among those that reported recent cocaine use 71% reported 'weekly or less' use and 22% used cocaine 'more than weekly but less than daily'. Eight percent (n=4) reported daily use.

⁷ The MSIC opened in 2001. The hours of operation changed over the first two years of operation (from four to up to 12 per day); and the numbers of individuals attending increased as PWID became aware of the service.

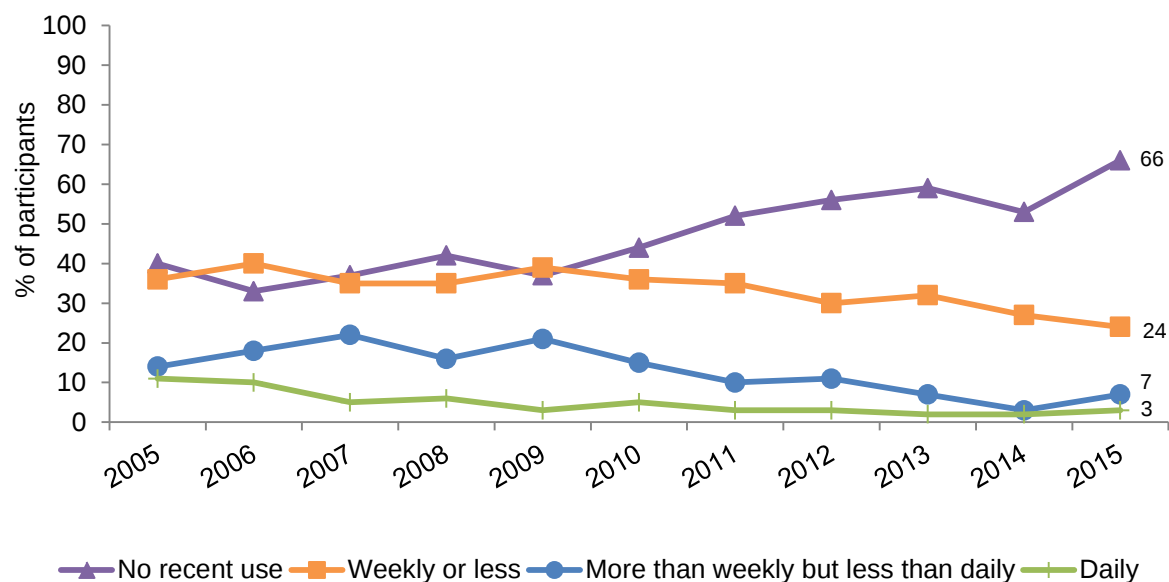
Figure 13: Median days of cocaine use in the past six months, 2006–2015



Source: IDRS PWID interviews

Two thirds of PWID had not used cocaine in the past six months. A quarter (24%) of the NSW sample reported 'weekly or less' cocaine use and 7% used cocaine 'more than weekly but less than daily'. Daily cocaine use remained stable with 3% of all participants reporting daily use (Figure 14).

Figure 14: Patterns of cocaine use in NSW PWID, 2006–2015



Source: IDRS PWID interviews

4.4.3 Forms of cocaine

Participants were also asked which forms of cocaine they had used over the last six months. Of those that reported recent use, 94% had used powder, 32% had used rock and a small proportion had used crack (4%, n=2). The form used most recently was powder (82%; 75% in 2014) and rock (18%). Crack cocaine was not reported as a form most used and no KE reported hearing about the use of crack cocaine, indicating its use remained rare.

Key expert comments

It was difficult to find KE with a wide knowledge of the cocaine market. 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.

- Only one KE believed cocaine to be the most problematic drug due to its prevalence.
- It was generally acknowledged by KE that cocaine was available with the number of detections increasing.
- KE reported that cocaine was not a preferred option for PWID due to the cost and the length of drug effect compared with other drugs.

4.5 Cannabis

The IDRS has differentiated between hydro and bush prices since 2003, and since 2004 it has also collected information on the 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 is sporadic, information about potency and availability are not sought from PWID participants.

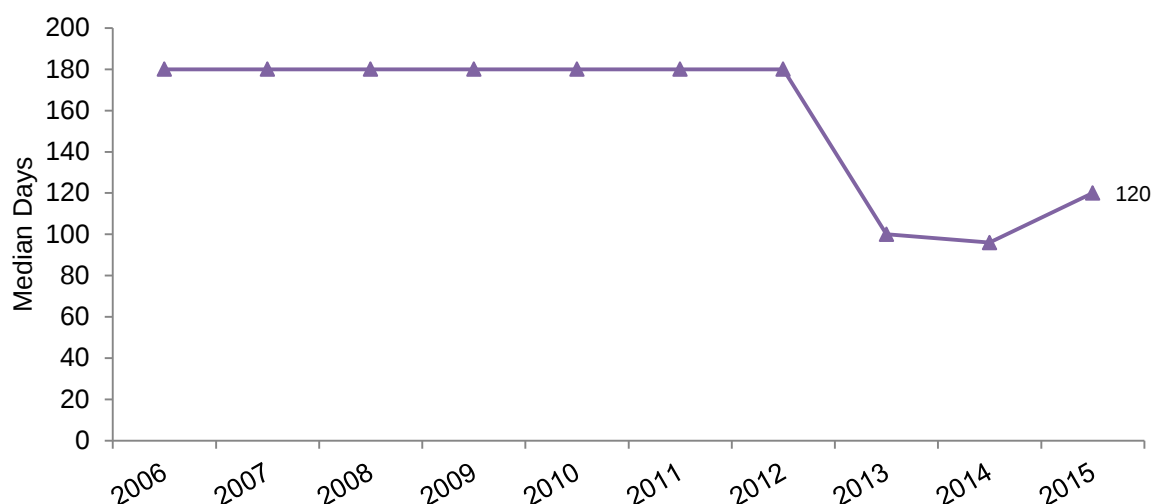
4.5.1 Cannabis use among PWID participants

Recent use of cannabis continued to remain high among participants in 2015. Seventy-nine percent of participants reported recent use of cannabis (77% in 2014) and the half (51%) reported cannabis use on the day prior to interview in 2015 (47% in 2014).

4.5.2 Current patterns of cannabis use

Among those who had used, the median number of days of cannabis use was 120 days in the preceding six months (96 days in 2014). Prior to 2013, the median days of cannabis use was 180 days, indicating daily use and this had been stable for the past 10 years (Figure 15).

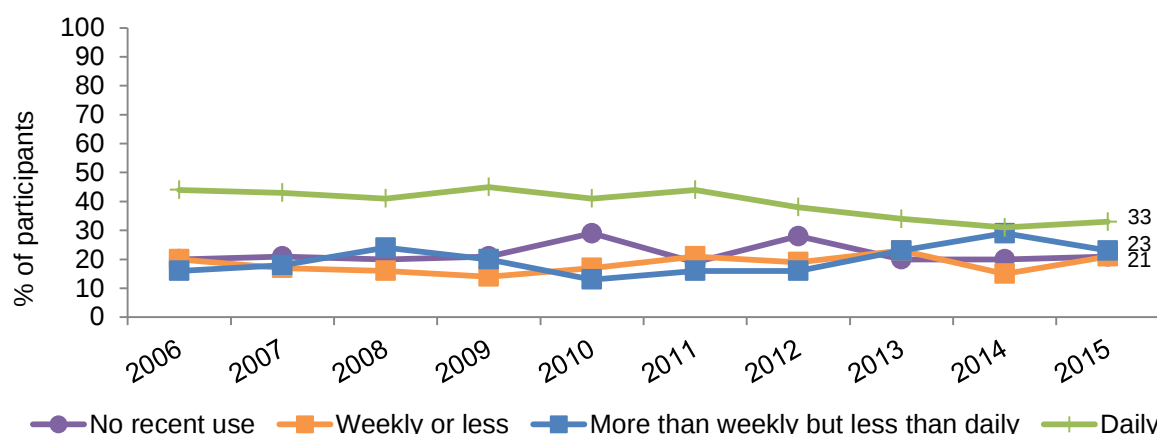
Figure 15: Median number of days of cannabis use among those who had used cannabis in the past six months, 2006–2015



Source: IDRS PWID interviews

Daily use was reported by 43% of the participants in 2015 (41% in 2014). An additional 19% of recent users reported using cannabis at least every second day, 16% at least weekly and 22% reported using cannabis fortnightly or less.

Figure 16: Patterns of cannabis use among the NSW IDRS sample, 2006–2015



Source: IDRS PWID interviews

Recent cannabis users were asked how much cannabis they had smoked on the last day of use, as measured by the number of cones or joints used on that occasion. 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. Of those that commented 68% reported smoking cones, and 8% joints. PWID reported smoking a median of 4 cones (range 0.5-25) or 1.5 joints (range 1-3) the last occasion of use. Daily users of cannabis had smoked a median of five cones (range=2–20 cones).

4.5.3 Forms of cannabis

Ninety-three percent of respondents who had used cannabis reported using hydro in the preceding six months (97% in 2014), and 38% of cannabis users reported using bush during this time (43% in 2014). Four percent of recent cannabis users reported use of hashish (11% in 2014) and 2% of participants (4% in 2014) had used hash oil. When asked which form of cannabis they had 'used most often' in the last six months, the vast majority (93%) of recent users reported hydro and 7% reported bush.

Key expert comments

- Two KE believed that cannabis was the most problematic drug at the current time.
- One KE reported the average age of use to be 30 years, and for those who were caught with a cannabis plant, the average age varied between 30-50 years. A different KE commented that age of initiation appears to have dropped from those starting at 15-16, to now starting using cannabis at 13-14 years old.
- KE reported that many of their clients are using cannabis in addition to other substances.
- KE expressed concern regarding the level of use among younger users and the resulting effect on their health, education, employment and relationships.

4.6 Pharmaceutical opioids

The IDRS investigates the use patterns, harms and market characteristics of a number of pharmaceutical opioids including those prescribed for opioid substitution treatment (OST) (i.e. methadone, buprenorphine, buprenorphine-naloxone), and those prescribed for pain relief (i.e. morphine and oxycodone).

Table 6: Definitions for opioid use

Pharmaceutical opioids (including OST)
Use of these substances is broadly split into the following categories
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. 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'.

About half (54%) of PWID sampled in 2015 were engaged in OST at the time of interview. Data presented are not representative of all clients engaged in drug treatment services.

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 in NSW. 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.

As in previous years, detailed data were collected in 2015 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. Detailed information on prescribed (licit) methadone may be found in section 6.3 'Drug treatment'.

Of those who reported methadone use, the form most used was licit liquid methadone (86%).

One-quarter (25%) of all participants reported using non-prescribed methadone in the six months preceding interview (27% in 2014). The frequency of use among recent users was a median of 4 days (7 days in 2014). In 2015, participants were asked, 'What were the main reasons you used illicit methadone in the last 6 months?' Of those that could comment, 31% reported that it was used 'as a substitute for heroin', 28% reported it was for 'self-treatment', and 11% reported that it was due to 'intoxication.'

Nineteen percent of participants reported injecting illicitly obtained methadone in the preceding six months on a median of 4 days (22%; median 7 days in 2014). Twenty-one 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 7 days (16 days in 2014).

Use of non-prescribed Physeptone remained uncommon, with only 3% of participants reporting use in the preceding six months (3% in 2014) with 2% reporting Physeptone injection in the 6 months prior to interview.

4.6.2 Buprenorphine⁸ (Subutex)

Nine percent of all participants (22% in 2014) reported the use of non-prescribed buprenorphine in the preceding six months. In 2015, frequency of use was reported on a median of four days (6 in 2014). Those reporting non-prescribed buprenorphine injection (7%; 16% in 2014) on a median of 5 days, which is consistent with the 6 days reported in 2014.

The prevalence of any form of buprenorphine injection decreased compared with 2014 but the frequency of use remained stable. Eight percent of participants reported injecting any form of buprenorphine (excluding buprenorphine-naloxone) in the preceding six months, which was a significant decrease from 17% in 2014 ($p < 0.05$). This occurred on a median of 6 days (6 days in 2014). No participants reported any injection-related problem ('dirty hit') or overdose associated with buprenorphine.

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, 4% reported recently using any form (i.e. licit or illicit) buprenorphine-naloxone 'tablet' (licit use 1% and illicit use 3%) on a median of 4 days, (25 days in 2014). Seventeen percent of the sample reported recently using any form of buprenorphine-naloxone 'film' (licit use 8% and illicit use 10%) on a median of 8 days (20 days in 2014) in the last six months. Injection of the buprenorphine-naloxone 'tablet' or 'film' was low (3% tablet and 7% film) and consistent with 2014 data.

Participants were asked about the last occasion on which they used buprenorphine that was not prescribed to them, and what their main reasons for doing so were. In 2015, among the seven participants that commented, four reported they used it as substitute for heroin, two participants for self-treatment and one participant for intoxication.

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 by some

⁸Buprenorphine has been available for opioid substitution therapy (OST) in Australia since 2001. Initially mono-buprenorphine sublingual tablets (marketed as Subutex®) were introduced, followed by buprenorphine-naloxone sublingual tablets (marketed as Suboxone®) from 2006, and buprenorphine-naloxone (Suboxone®) sublingual film from October 2011. There is jurisdictional variation in the policy regarding prescribing and uptake of the different forms (Larance, Dietze, et al., 2015).

interviewers reporting initial participant confusion between drugs such as MS Contin (morphine) and OxyContin® (oxycodone). 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 dependent⁹ where the requirement still remained.

4.6.4.1 Use patterns

Since 2006, a distinction has been made between the use of morphine obtained via prescription and the use of non-prescribed morphine (i.e. licit or illicit) in the IDRS survey (Table 4).

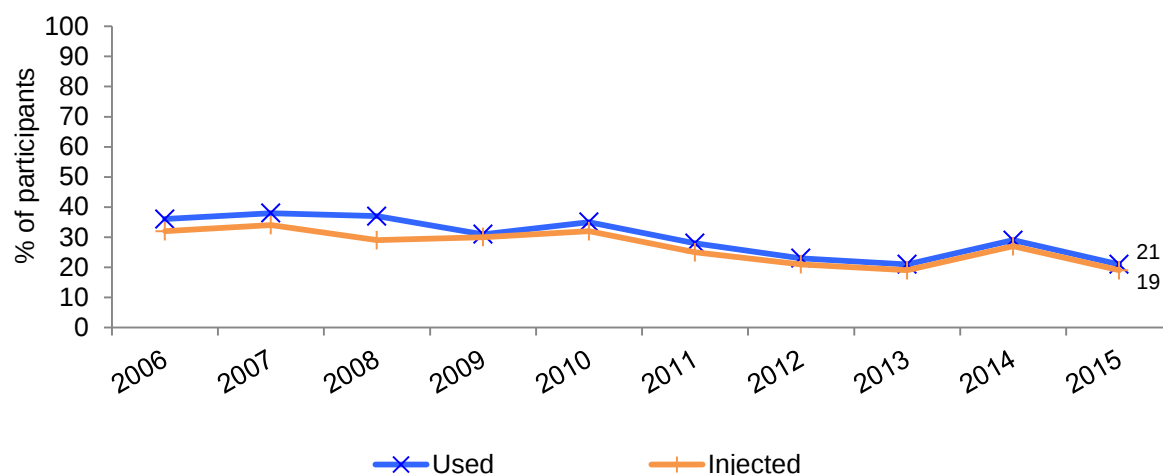
Nineteen percent (25% in 2014) reported use of non-prescribed morphine on a median of 6 days, a non-significant decline from 22 days in 2014. Less than one-quarter (18%) of participants reported the recent injection of non-prescribed morphine on a median of 6 days (25%; median of 24 days in 2014). In 2015, participants were asked 'What were your main motivations for non-prescribed morphine use?' Twenty-eight percent of recent users reported 'a substitution for heroin', 22% reported 'self-treatment', and 17% reported 'intoxication'.

The recent use of prescribed morphine was low and figures should be interpreted with caution due to the small number of participants reporting. Four percent reported recent use and 3% had injected it in the past six months (6% had recently used it; 4% had recently injected in 2014). Frequency of use increased significantly to a median of 180 days in the last six months, compared with 5 days in 2014 ($p < 0.05$). Frequency of injection also increased to a median of 180 days in the six months preceding interview (3 days in 2014).

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 2015, 21% (29% in 2014) of participants reported using any morphine in the preceding six months on a median of 6 days, a non-significant decrease from 19 days in 2014. In terms of injection, 19% (19% in 2014) reported injection of any morphine on a median of 6 days (14 days in 2014) during this time (Figure 17).

⁹ '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 17: Proportion of PWID reporting morphine use and injection (prescribed and not prescribed) in the past six months 2006–2015

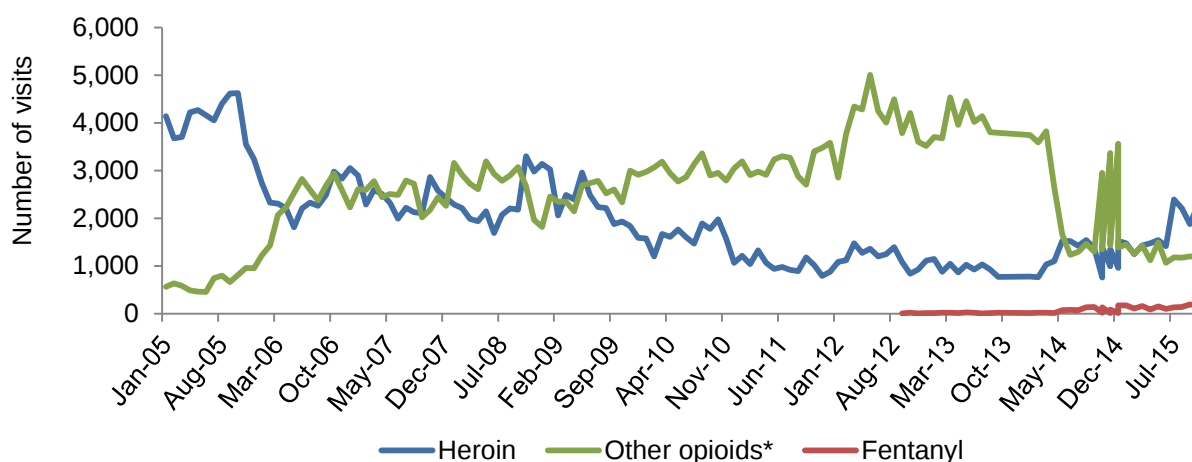


Source: IDRS PWID interviews

Three percent of recent users reported daily morphine use, with the majority (74%; 15% 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 18. The number of attendances where other opioids were injected increased to a peak of 5006 injections in May 2012. In April 2014, these figures declined dramatically, primarily due to a dramatic decline in oxycodone injecting episodes. Heroin injecting episodes now outnumber other opioid injecting episodes at the MSIC. Fentanyl injecting episodes, as a subset of other opioid injecting episodes, have increased since early 2014, but these figures are low in comparison to heroin and other opioids.

Figure 18: Number of attendances to Sydney MSIC where other opioids (including morphine)*, fentanyl and heroin were injected, January 2005–October 2015



Source: Sydney MSIC, Kings Cross

* other opioids includes morphine and oxycodone and excludes heroin, methadone, buprenorphine, buprenorphine-naloxone

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 eighth 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 and problems associated with non-prescribed oxycodone, may be increasing. In previous years, oxycodone was included under 'other opioids'.

Sixty-three percent of all participants reported having used oxycodone (whether obtained via prescription or other methods) at some stage in their lifetime, and 49% reported having ever injected it (Table 4). Twenty-five percent of all participants (44% in 2014) reported using any (prescribed or non-prescribed) oxycodone in the six months preceding interview on a median of fourteen days (approximately fortnightly use) (20 days in 2014). The recent injection of any oxycodone decreased significantly from 39% in 2014 to 20% in 2015 ($p<0.000$).

With regards to non-prescribed oxycodone use, 21% of participants reported use in the preceding six months, a significant decrease from 40% in 2014 ($p<0.000$), on a median of 11 days (20 days in 2014). Thirteen percent of recent illicit oxycodone users (3% of entire sample) were daily users (180 days). Fifty-seven percent (11% of entire sample) of people reporting use in the last 6 months were using weekly or less often. The remaining 30% of recent users (6% of entire sample) were using illicit oxycodone more than weekly but less than daily. Injection of non-prescribed oxycodone in the last six months was reported by 18% of those who commented on a median of 13 days (37% on a median of 20 days in 2014). Overall, these figures suggest that the frequency of non-prescribed oxycodone use has decreased in 2015. This finding is consistent with key expert reports that oxycodone use has decreased in NSW.

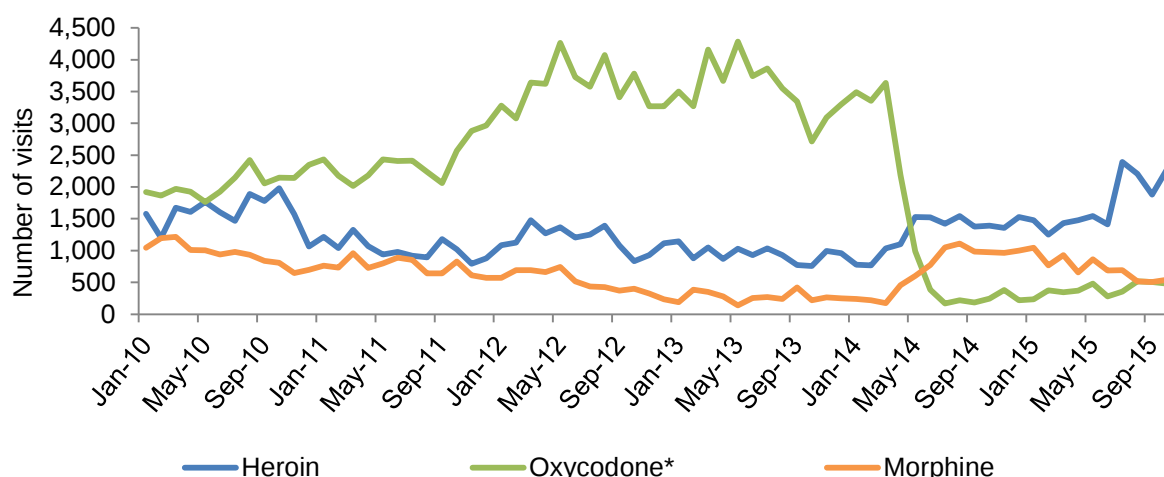
In response to the question 'What were your main motivations for non-prescribed oxycodone use?' 52% reported substitution for heroin and/or other opioids, 19% of recent users reported intoxication and 19% reported self-treatment as the main motivation.

With regard to prescribed oxycodone, 10% of participants reported use in the preceding six months, on a median of 24 days (9%; 21 days in 2014). Injection of prescribed oxycodone in the last six months was reported by 6% of the sample on a median of 10 days (6%; 20 days in 2014).

Of those reporting any recent oxycodone use, the vast majority (79%; 86% in 2014) mostly used non-prescribed oxycodone rather than prescribed oxycodone. The most common brand used among those who recently used oxycodone was OxyContin® (56%; 12% of the sample). There were seven participants reporting use of the generic controlled-release oxycodone, four participants reporting use of Endone and one participant reporting OxyNorm as the brand most commonly used.

In April 2014, when oxycodone injection decreased sharply, heroin became the most prevalent opioid injected at the Sydney MSIC. At the same time, there was also an increase recorded in morphine injections, although this has since declined (Figure 19). The reformulation of OxyContin® occurred on April 1, 2014, which likely explains the sharp decrease in the number of oxycodone injecting episodes at the MSIC.

Figure 19: Number of attendances to Sydney MSIC where heroin, morphine, and oxycodone were injected, January 2010–October 2015



Source: Sydney MSIC, Kings Cross

*OxyContin Purdue (OP) are included in oxycodone totals

4.6.7 Fentanyl

In 2015, 24% of the NSW sample reported using fentanyl in their lifetime (25% in 2014). Fifteen percent reported using fentanyl on a median of 7 days in the preceding six months (15%; median 2 days in 2014). Fentanyl was injected by 15% of the sample on a median of 7 days in the last six months. Among those who recently used fentanyl the form most used was illicit (83%; 17% licit).

4.7 Over the counter codeine

Again in 2015, 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. Nine percent of all participants reported that they had used OTC codeine in the six months prior to interview on a median of 8 days (22%; median 12 days in 2014). Two participants reported recent OTC codeine injection. The brands most commonly reported as being used were Nurofen Plus (43%), Panadeine (15%) and Mersyndol (15%).

4.8 Other opioids

Two-fifths (41%) of all participants reported that they had ever used opioids other than those listed above at least once in their lifetime, and 4% had ever injected them. In the six months prior to interview, 16% of participants reported the use of other opioids on a median of 7 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 also be noted that 'other opioids' does not include homebake.

Key expert comments

- Two KE believed that Fentanyl was the main problematic drug at the current time. One reported that the risk of overdose is greater when using Fentanyl, and commented on the difficulty in preparing the drug for injection, which makes it 'unpredictable' for clients. The other KE also expressed concern regarding overdose 'because of its potency'.
- KE reported the majority of Fentanyl users are male and are generally unemployed, with an average age of 35-40.
- One KE commented, 'There have been more enquiries about Fentanyl, not necessarily an increase in use, but an increase in interest.'
- Health KE noted a high level of misinformation among clients about the safest way to prepare pharmaceutical opioid tablets for injection.

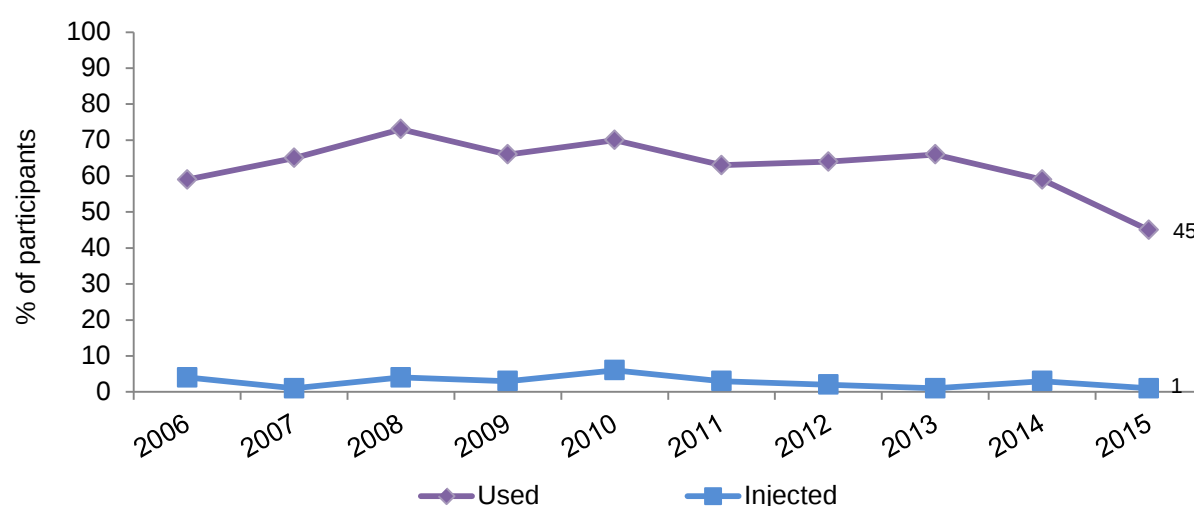
4.9 Other drugs

4.9.1 Benzodiazepines

Seventy-four percent of the NSW sample had reported the use of any benzodiazepines at some stage in their lifetime. Fifty-three percent (59% in 2014) reported the recent use of any benzodiazepines on a median of 23 days in the last six months (28 days in 2014) (Table 4). Among those who recently used any benzodiazepines, 12% reported using them daily in the last six months.

Only small numbers reported recently injecting any benzodiazepines (4%) on a median of 6 days in the last six months (Figure 20).

Figure 20: Proportion of PWID participants reporting (prescribed and non-prescribed) benzodiazepine use and injection in the preceding six months, 2006–2015



Source: IDRS PWID interviews

4.9.1.1 Alprazolam¹⁰

Since 2012, participants have been asked separately about the use of alprazolam. Sixty percent of the NSW sample reported using alprazolam in their lifetime (18% licit and 53% illicit). Thirty-seven percent reported using alprazolam in the past 6 months. Three percent had recently used 'licit' alprazolam on a median of 48 days (30 days in 2014) and 35% had recently used 'illicit' alprazolam on a median of 6 days (Table 7).

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

Table 7: Alprazolam use patterns, 2015

	NSW (N=150)
Recent use (%)	
Licit	3
Illicit	35
Any form (licit and/or illicit)	37
Median days used *	
Licit	48
Illicit	6

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 Benzodiazepines excluding alprazolam

Sixty-six percent of the NSW sample had used benzodiazepines excluding alprazolam in their lifetime (Table 4) (39% licit and 50% illicit). Just under half of all participants (45%) recently used any form of benzodiazepines (excluding alprazolam) (Table 8). Twelve percent of all participants reported benzodiazepine use on the day prior to interview (16% in 2014).

Twenty-four percent of the NSW sample reported having used 'licitly' obtained other benzodiazepines on a median of 72 days in the last six months, whereas 31% percent reported using 'illicitly' obtained benzodiazepines on a median of 6 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.

Excluding alprazolam, the most commonly used benzodiazepine was diazepam (74%; including Valium, Valpam and Antenex). Smaller proportions used oxazepam (10%; Serepax) and clonazepam (7%; Rivotril).

¹⁰ It was recognised that alprazolam was a benzodiazepine that was potent and may be prone to abuse. The IDRS research team decided to collect data separately for alprazolam from 2011. The abuse liability was recognised nationally with the rescheduling of alprazolam from Schedule 4 to Schedule 8 from February 1 2014 <http://www.tga.gov.au/book/part-scheduling-proposals-referred-march-2013-meeting-acms>

Table 8: Other benzodiazepine (excludes alprazolam) use patterns, 2015

	NSW (N=150)
Recent use (%)	
Licit	24
Illicit	31
Any form (licit and/or illicit)	45
Median days used *	
Licit	72
Illicit	6

Source: IDRS participant interviews

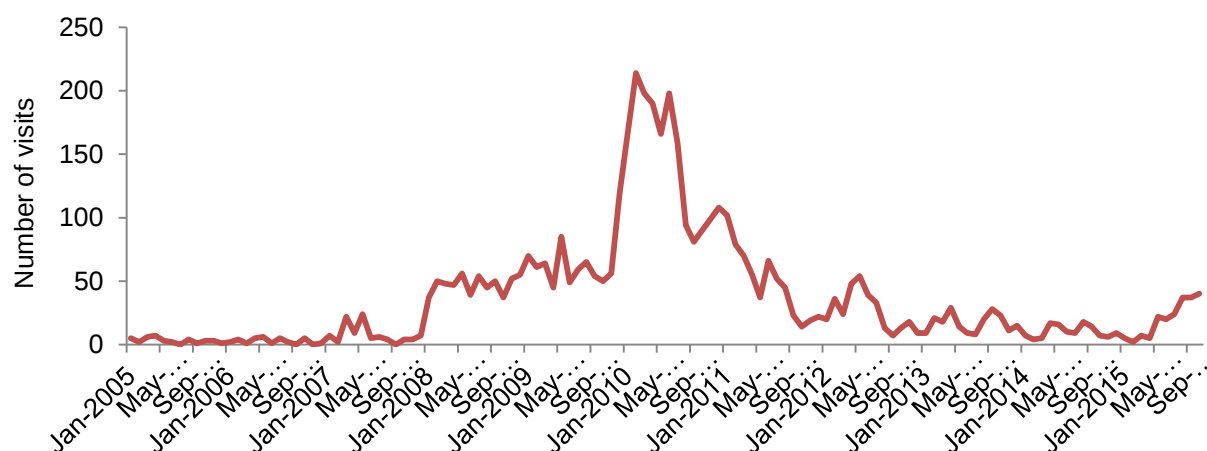
* Among those who reported recent use or injection. Maximum number of days, i.e. daily use = 180

The prevalence of benzodiazepine injection and the frequency of injection has remained stable over the past few years. In 2015, the prevalence of benzodiazepine injection was 4%, a finding comparable with recent years (3% in 2014; 1% in 2013; 1% in 2012; 3% in 2011).

4.9.1.3 MSIC data

Numbers injecting benzodiazepines at the MSIC have increased from April to October 2015, but have not returned to levels seen in 2010 (Figure 23).

Figure 21: Number of attendances to Sydney MSIC where benzodiazepines were injected, January 2005–October 2015



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, 51% reported a lifetime use of Seroquel® (27% licit, 27% illicit). Twenty-three percent of the sample had used Seroquel® in the last six months (14% licit, 10% illicit). 'Licit' Seroquel® had been used on a median of 180 days compared to four days for 'illicit' Seroquel®. There were no reports of participants injecting Seroquel® in the last six months (Table 4).

4.9.3 Hallucinogens

Forty-five percent (48% in 2014) of participants reported having used hallucinogens at some stage in their lifetime with 1% reporting recent use (Table 4). Eleven percent of the sample had

injected hallucinogens at some stage in their life (8% in 2014) and one participant reported having injected them in the last six months.

4.9.4 Ecstasy

Ecstasy use continued to remain at relatively low levels. More than half (51%) of participants reported use of ecstasy in their lifetime and 7% reported having used it within the six months prior to interview (9% in 2014). Nineteen 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 study 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). Information, reports and bulletins from this study are available from the NDARC website and Drug Trends websites (<http://ndarc.med.unsw.edu.au> and <http://www.drugtrends.org.au>).

4.9.5 Steroids

Steroid use among the IDRS sample remains low and figures should be interpreted with caution due to the small number of participants reporting. Nine percent of all participants reported having ever used steroids. One percent reported use in the six months preceding interview on a median of 105 days (Table 4). No participants reported recently injecting steroids.

4.9.6 New psychoactive substances

New psychoactive substances (NPS) use remains low and figures should be interpreted with caution due to the small number of participants reporting. Four percent of participants reported ever using NPS such as synthetic cathinones (e.g. mephedrone), tryptamines (e.g. dimethyltryptamine [DMT]) and phenethylamines (e.g. 2C-x class). One percent of all participants reported use in the six months preceding interview on a median of 6 days. One percent of all participants reported recently injecting NPS.

4.9.7 Synthetic cannabinoids

Twenty-five percent of all participants (17% in 2014) reported ever using synthetic cannabinoids (e.g. K2, Spice). Eight percent of all participants reported use in the six months preceding interview (24% in 2014), on a median of one day. No participants reported injecting a synthetic cannabinoid.

4.9.8 Inhalants

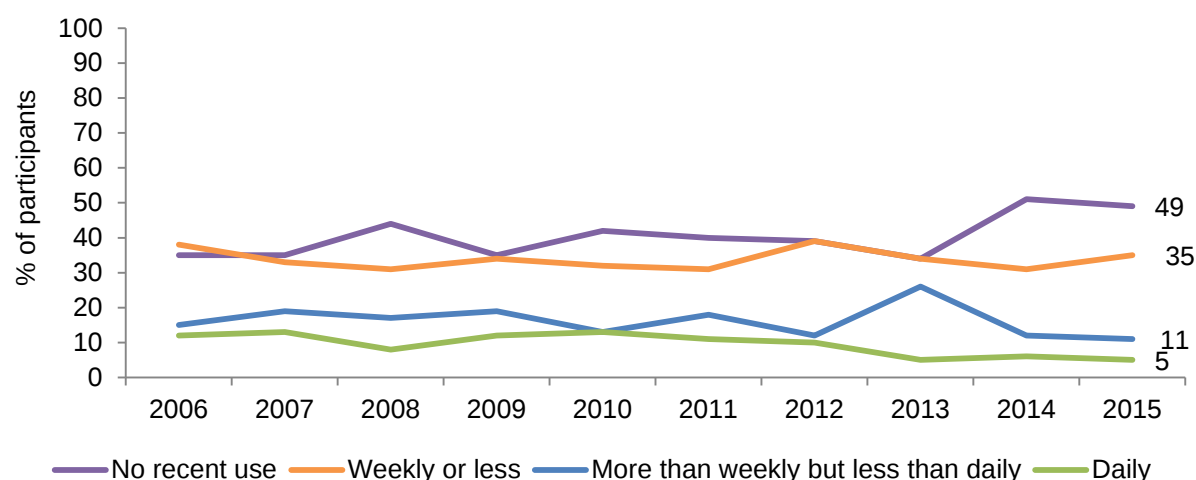
Twenty percent of participants (14% in 2014) reported ever having inhaled volatile substances such as amyl nitrate, petrol, glue and/or lighter fluid (butane) (Table 4). Recent use (2%) remained low and stable as did the frequency of use (median of 2 days). The main form of inhalant reported being recently used by participants was amyl nitrate. There were no KE reports regarding use of inhalants.

4.9.9 Alcohol

Half (51%) of all participants in the sample had consumed alcohol in the six months prior to interview on a median of 10 days (i.e. approximately once per fortnight; range 1–180). The recent use of alcohol remained stable as did the frequency of use (50% and 12 days in 2014). Five percent of all participants reported daily use of alcohol. Thirty-five percent of all participants (31% in 2014) drank weekly or less often and 11% consumed alcohol more than weekly but less than daily (Figure 22). Overall, these figures were generally consistent with levels reported over the last 3 years. Rates of daily use in the entire sample (5%) and rates of drinking weekly (35%)

were comparable with the general population aged 14 and over (6.5% and 37% respectively) (Australian Institute of Health and Welfare, 2014).

Figure 22: Patterns of alcohol use among PWID, 2006–2015

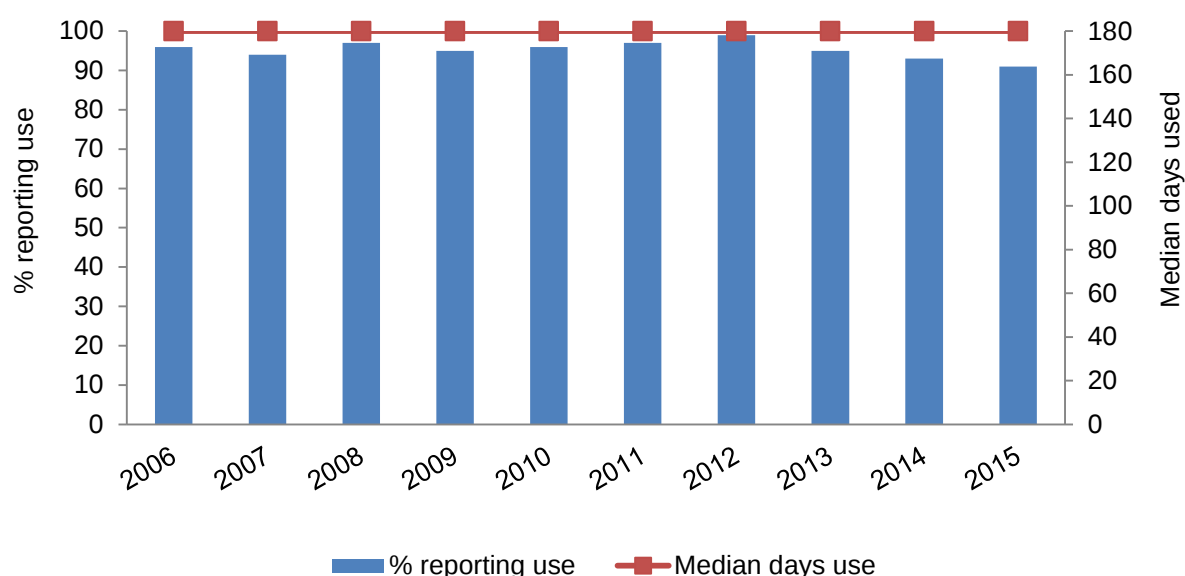


Source: IDRS PWID interviews

4.9.10 Tobacco

Tobacco continued to remain the most commonly used substance investigated by the IDRS. The vast majority of participants (91%) reported smoking tobacco in the last six months on a median of 180 days (Table 4), i.e. daily use (range 1–180). Eighty-eight 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). 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, 2011). The use of tobacco is the single most preventable cause of morbidity and mortality in Australia (Begg et al., 2007) and given the high prevalence of smoking among PWID targeted interventions to reduce smoking rates in this population are required.

Figure 23: Participant reports of tobacco use in the last six months, 2006–2015



Source: IDRS PWID interviews

Key expert comments

- KE believed that more research was needed in regards to benzodiazepines.
- Two KE commented that benzodiazepine use increases problematic behavior of clients as well as the probability of being incarcerated.
- Two KEs reported that they saw more ecstasy capsule use in the last 6 months and another two KEs noted an increase in the use of crystal MDMA.
- There was a general belief among KEs that steroid use had increased recently. The average age was generally thought to be 20-40 years, mostly male and mostly employed.
- A few KEs commented on the lack of understanding amongst users and the lack of services, therefore leading to an ill-informed group of users, putting their safety at risk.
- Three KE believed that steroids were the most problematic drug at the current time.
- Three KEs noted that there were spikes in NPS and synthetic cannabis use before the change in legislation in October 2013 concerning these substances. Nevertheless, since the Poisons and legislation amendment, the use of both NPS and synthetic cannabis has 'died out'.
- Almost all KEs mentioned alcohol as a drug of concern, especially for illicit drug users.
- Alcohol affects both the victims and perpetrators of crime. The people who often present with high alcohol intoxication come from wide-ranging backgrounds, from 18-30 years of age.

5 PRICE, PURITY, AVAILABILITY AND PURCHASING PATTERNS

5.1 Heroin

The majority of PWID (89%) were able to comment on questions relating to the price, purity and/or availability of heroin. The remaining 11% did not feel confident to answer any questions on the heroin market. These PWID include 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.

5.1.1 Heroin price

The prices participants paid for heroin on the last occasion of purchase are shown in Table 9. In 2015, the median price reported for a 'cap' of heroin remained unchanged at \$50 reflecting the same price since 2002. The median price for a gram of heroin remained stable at \$400. These prices continue to remain higher than prices reported in the year 2000 (\$220 per gram; \$25 per cap), prior to the reported heroin shortage in 2001.

Seventy-eight percent of the entire sample reported buying heroin in 'caps' or 'points'. 'Points' are 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 an accurate description of the weight.

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

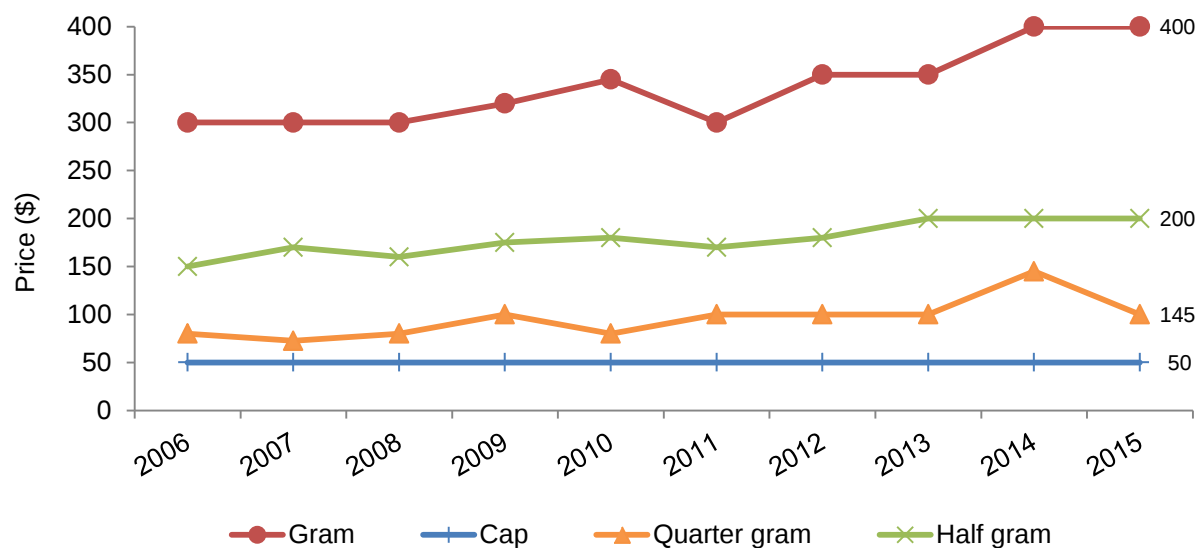
Table 9: Price of most recent heroin purchases by PWID participants, 2014–2015

Amount	Median price \$		Range \$	Number of purchasers	
	2014	2015		2014	2015
Cap	50	50	30-100	108	104
Quarter gram	145	100	20-200	24	39
Half gram ('halfweight')	200	200	50-350	55	47
Gram	400	400	50-800	44	29

Source: IDRS PWID interviews

Heroin prices have remained relatively stable since 2005 (Figure 24). 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 24: Median prices of heroin estimated from PWID purchases, 2006–2015



Source: IDRS PWID interviews

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.

Seventy-three percent of participants reported price stability over the preceding six months. Nineteen percent of those who commented thought that price had increased over the preceding six months (comparable with 17% in 2014). Five percent reported heroin prices had decreased, and a smaller proportion (4%, 3% in 2014) reported that prices had fluctuated 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' to obtain) and whether this had changed in the last six months ('easier', 'stable', 'more difficult' or 'fluctuates'). Again in 2015, the majority of participants reported that heroin was 'very easy' (52%) or 'easy' (37%) to obtain (Table 10; Figure 25). Eight percent reported that heroin was 'difficult' to obtain (12% in 2014) and 3% of participants claimed that heroin was 'very difficult' to obtain.

The vast majority (88%) of the sample were able to comment on changes in heroin availability in the last 6 months. About three quarters (73%) reported that heroin availability had remained 'stable' and smaller proportions of participants reported that ease of access to heroin had become 'more difficult' (13%) or 'easier' (11%) to obtain (Table 10).

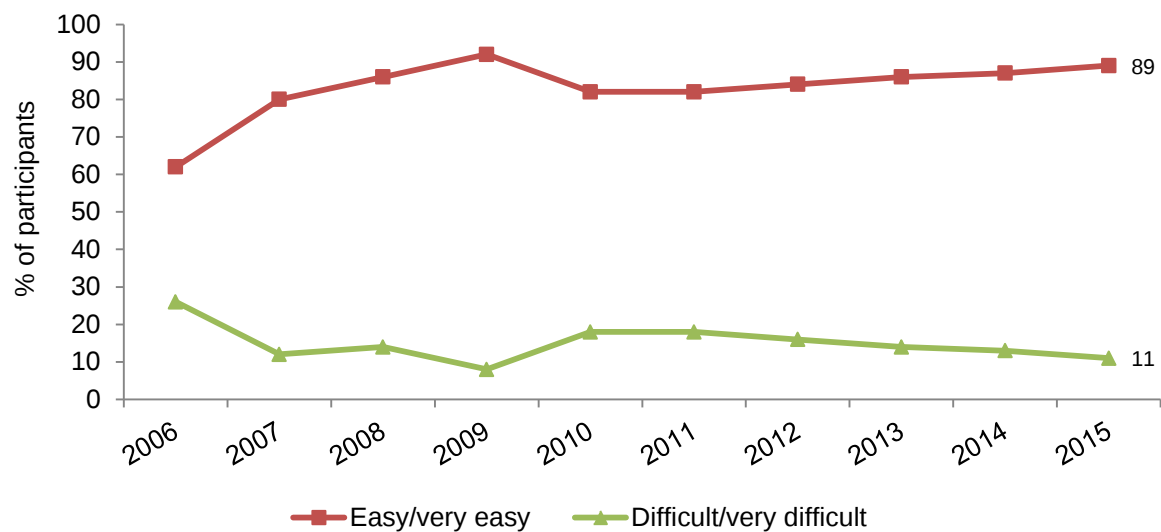
Table 10: Participant reports of heroin availability in the past six months, 2011–2015

	2011 N=150	2012 N=151	2013 N=151	2014 N=150	2015 N=150
Current availability					
Responded* (%)	87	87	85	85	88
Of those who responded:					
Very easy (%)	50	38	52	50	52
Easy (%)	32	46	34	37	37
Difficult (%)	16	14	13	12	8
Very difficult (%)	2	2	1	2	3
Availability change					
Responded (%)	86	87	84	84	87
Of those who responded:					
More difficult (%)	19	14	18	11	13
Stable (%)	64	77	67	72	73
Easier (%)	11	5	10	13	11
Fluctuates (%)	6	4	5	4	3

Source: IDRS PWID interviews

*Participants who did not feel confident enough in their knowledge of the heroin market did not respond to these survey items

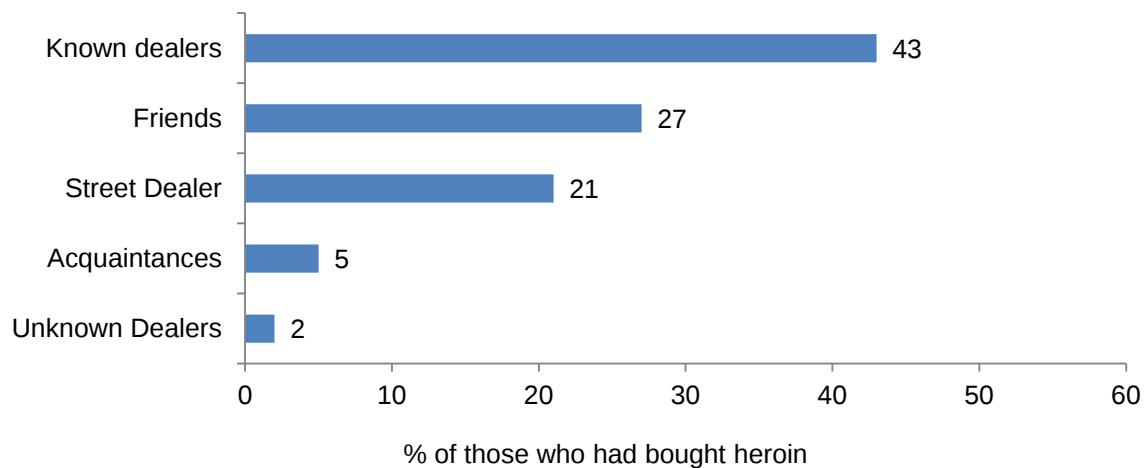
Figure 25: Participant reports of current heroin availability, 2006–2015



Source: IDRS PWID interviews

Of those participants that had purchased heroin in the last six months (n=130) the most common sources of heroin on the last occasion of purchase were 'known dealers' (43%), 'friends' (27%) and 'street dealers' (21%) (Figure 26). 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' (31%) (Figure 27).

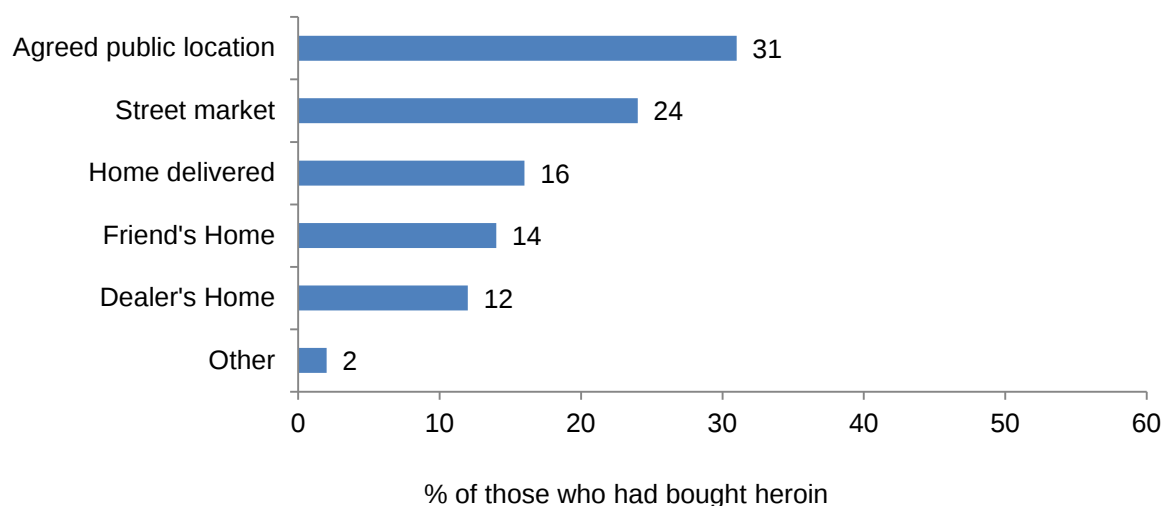
Figure 26: People from whom heroin was purchased on the last occasion, 2015



Source: IDRS PWID interviews

NB: More than one response could be selected

Figure 27: Locations where heroin was purchased on the last occasion, 2015



Source: IDRS PWID interviews

NB: More than one response could be selected

5.1.3 Purity – PWID reports

Participants were asked to comment on their perception of the current purity of heroin. Thirty-nine percent of those who commented reported it to be 'low' purity, with an additional 38% of all participants reporting it to be 'medium'. A further 16% of all participants reported it 'fluctuates' and 8% believed it to be 'high' (Table 11). These purity figures are consistent with those reported in 2014. 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 28). This was also the case in 2015, with 8% (n=10) of participants rating current heroin purity as 'high'. This may reflect a change in purity or it may individual levels of tolerance to heroin.

Participant perceptions of purity change over the last six months varied: 38% of those that could comment reported that it had remained stable (48% in 2014) and 30% reported that it had decreased (23% in 2014). Twenty-one percent reported the purity had fluctuated and the remaining 10% of participants reported it had increased. Overall, these results are comparable with 2014 (Table 11).

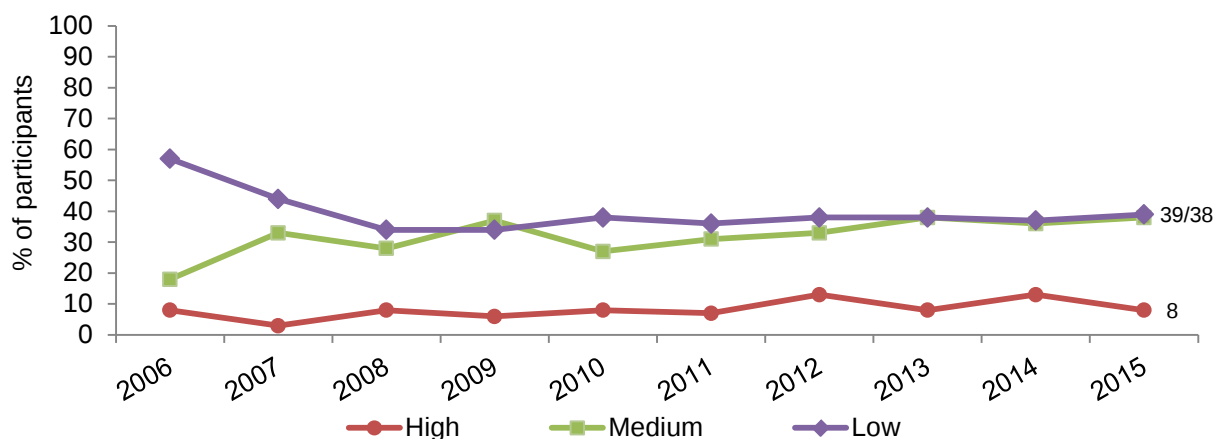
Table 11: Participants' perceptions of heroin purity in the past six months, 2011–2015

	2011 N=150	2012 N=151	2013 N=151	2014 N=150	2015 N=150
Current purity					
Responded* (%)	85	84	83	83	86
Of those who responded:					
High (%)	8	13	8	13	8
Medium (%)	37	33	38	36	38
Low (%)	42	38	38	37	39
Fluctuates (%)	13	17	16	15	16
Purity change					
Responded* (%)	83	84	81	81	84
Of those who responded:					
Increasing (%)	11	13	16	11	10
Stable (%)	32	35	37	48	38
Decreasing (%)	37	31	28	23	30
Fluctuating (%)	20	21	19	18	21

Source: IDRS PWID interviews

*Participants who did not feel confident enough in their knowledge of the heroin market did not respond to these survey items

Figure 28: Proportion of PWID participants reporting current heroin purity as high, medium or low, 2006–2015

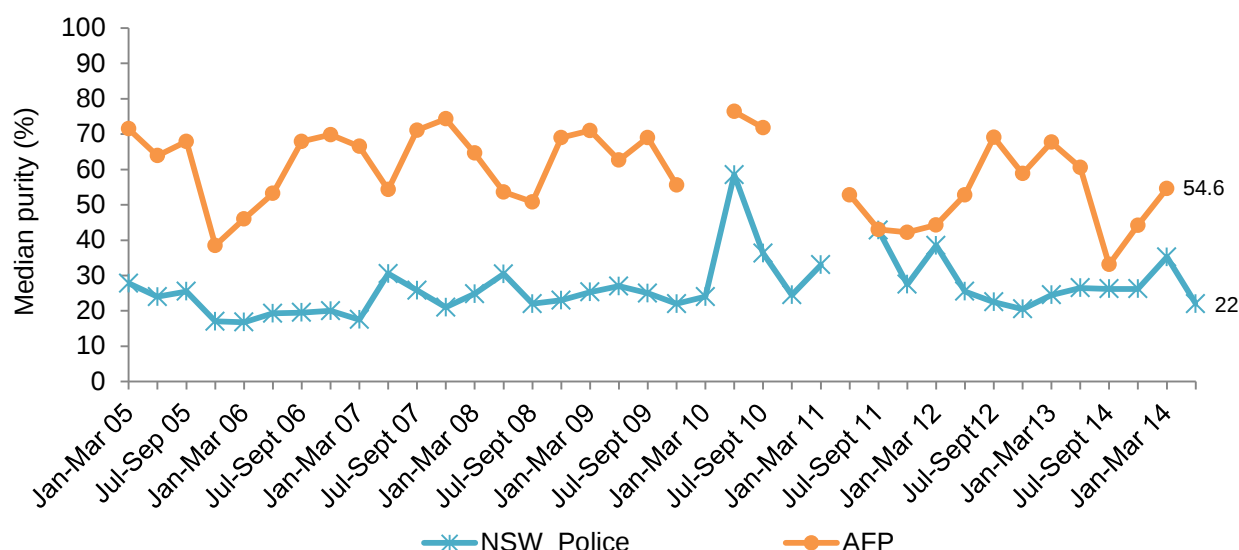


Source: IDRS PWID interviews

5.1.4 Purity – seizure data

Figure 29 shows the analysed median purity of NSW Police heroin seizures from January 2005 to June 2014. In 2013/14, the overall median purity of heroin was 27% (range: 5–76%) reported by NSW Police compared with the 23% in the 2010/11 reporting period (range: 8–70%). Overall, the purity of Australian Federal Police (AFP) heroin seizures that were analysed during 2013/14 decreased, with a median of 51.5% in the 12 months to June 2014 (68.2% in 2012/13; 43.4% in 2011/12; 56% in 2010/11). Purity figures for 2013/14 are based on 112 heroin seizures analysed by NSW Police (representing 17% of all heroin seizures detected by NSW Police) and 14 heroin seizures analysed by the AFP (representing less than 1% of all heroin seizures detected by the AFP) (Figure 31). Purity data was not available for 2014/15.

Figure 29: Purity of heroin seizures analysed in NSW, by quarter, January 2005–June 2014

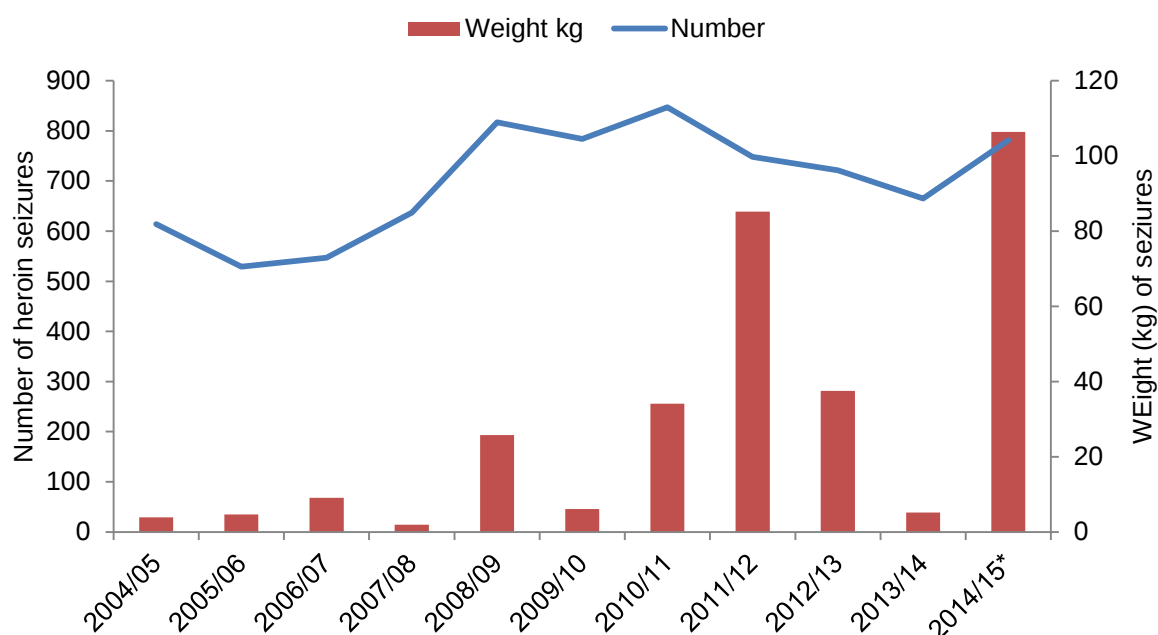


Source: Australian Bureau of Criminal Intelligence (2001, 2002); Australian Crime Commission (2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012)

NB: Gaps in the series represent data that wasn't available. Purity levels are only representative of seizures which are analysed.

There has been an upward trend in the number of heroin seizures, and the total weight was relatively high in 2014/15 (Figure 30).

Figure 30: Number and weight of heroin seizures detected by NSW Police, July 2004–June 2015



Source: Australian Bureau of Criminal Intelligence (2001, 2002); Australian Crime Commission (2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012) and NSW Police Force
 Note: 2014/15 data was provided by NSW Police, while earlier data is extracted from the Illicit Drug Data Reports produced by the ACC.

5.1.5 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. As in previous years, comments on general trends in heroin use included several comments that the quality of heroin had decreased. There were many comments stating that heroin use was on the increase.

Key expert comments

- Heroin availability is stable but this can vary depending on an individual's networks.
- The price of a point/cap of heroin was consistent with previous years at \$50.
- The majority of KE reports indicate that heroin purity is either unreliable or low.
- Health KE are concerned the variability of heroin purity increases the risk of overdose.

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 2015, 16% of the sample felt confident to answer at least some of the survey items regarding speed powder, 10 participants commented on the price, purity and/or availability of base and 63% of the sample commented on crystal methamphetamine. These proportions are consistent with 2014. The remainder did not feel confident to answer any questions on one or more of these drug forms, and this reflects PWID who did not use methamphetamine, 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. The number of people reporting other amounts remained low. Due to this, comparisons with 2014 should be interpreted with caution due to the low number ($n \leq 10$) 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, 2014–2015

Amount	Median price*		Range \$	Number of purchasers	
	2014	2015		2014	2015
Speed powder					
Point (0.1 gram)	50	50	40-100	15	13
'Halfweight' (0.5 grams)	300^	200^	50-250	5^	6^
Gram	350^	350^	350-350	5^	1^
'Eightball' (3.5 grams)	250^	338^	300-375	5^	2^
Base	2014	2015		2014	2015
Point (0.1 gram)	50	50^	50-100	11	7^
'Halfweight' (0.5 grams)	125^	-	-	2^	0
Gram	150^	100^	100	3^	1^
'Eightball' (3.5 grams)	-	280^	280	-	1^
Crystal methamphetamine	2014	2015		2014	2015
Point (0.1 gram)	50	50	25-100	96	78
'Halfweight' (0.5 grams)	250	228	50-300	33	20
Gram	475	330	50-590	30	15
'Eightball' (3.5 grams)	1150	1250^	800-1700	18	4^

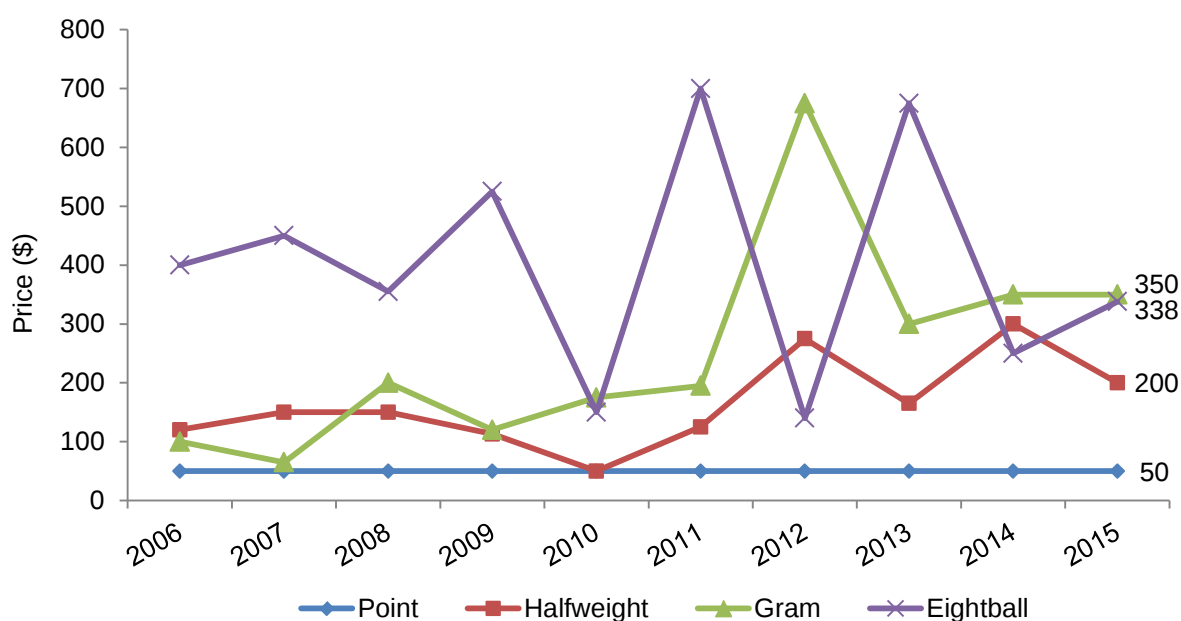
Source: IDRS PWID interviews

^ $n \leq 10$ 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 that comparisons with the 2014 data on amounts other than points should be interpreted with caution due to the low number of reported purchasers.

Participants were also asked if the price of speed powder had changed in the last six months. Seventy-one percent of those who commented (n=15) reported the price as 'stable' over the last six months. This remained consistent with comments from 2014. Of those who could comment, four participants reported the price of speed powder had 'decreased' and two participants reported that the price had 'increased'. There were no reports of the price of speed powder 'fluctuating'.

Figure 31: Median prices of speed powder estimated from PWID purchases, 2006–2015



Source: IDRS PWID interviews

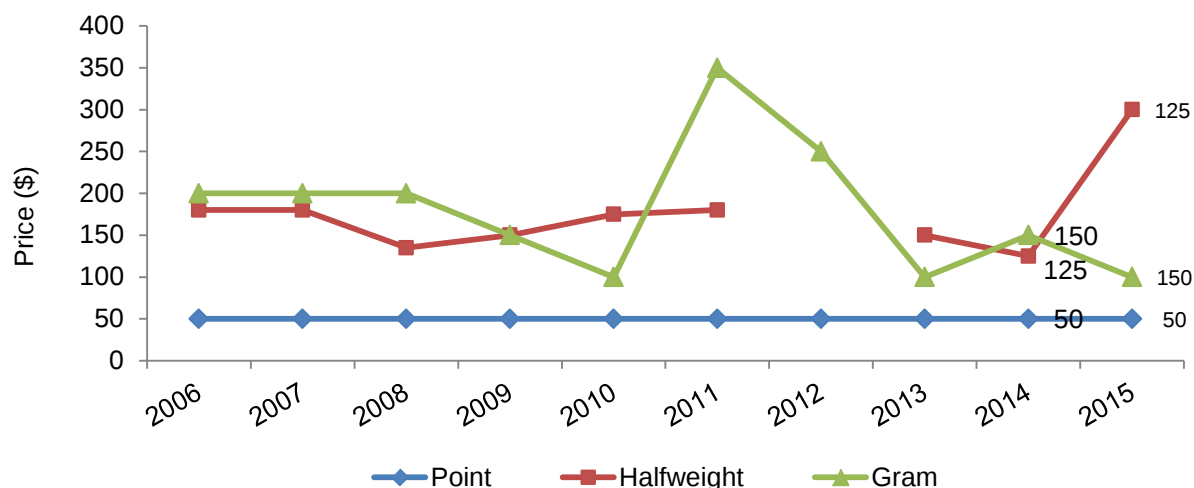
NB: Small numbers (<10) reporting halfweight, gram and eightball, interpret with caution

5.2.1.2 Base

Few participants ($n \leq 10$ for each amount) reported buying 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).

The median prices were based on small numbers (< 10) and should be interpreted with caution, particularly as the price ranges were fairly wide. Prices have remained fairly 'stable' since 2005 (Figure 32).

Figure 32: Median prices of base estimated from PWID purchases, 2006–2015



Source: IDRS PWID interviews

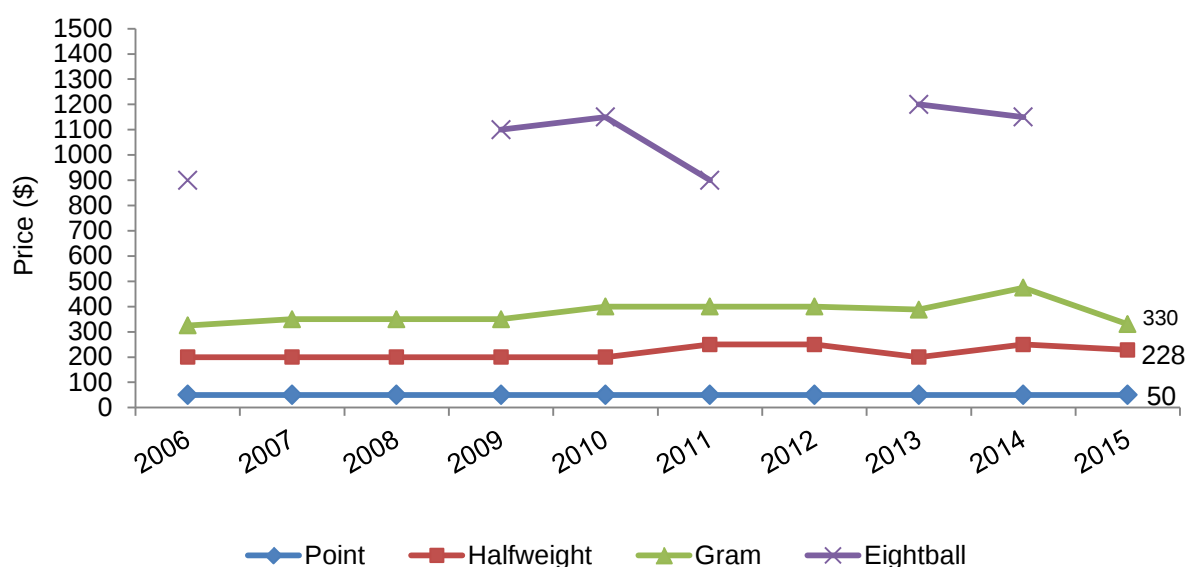
NB: small numbers (n<10) reporting, interpret with caution.

Equal proportions of participants, who could comment on base, generally thought that the price had either remained 'stable' (n= 4) or 'increased' (n=4) over the preceding six months. One participant reported that it had 'decreased' and one reported that it had 'fluctuated'. Few participants reported recent purchases and these results should be interpreted with caution.

5.2.1.3 Crystal methamphetamine

As with speed and base, the most commonly purchased amounts of crystal methamphetamine were points with half (52%) of participants reported at least one purchase in the last 6 months (Table 12). In 2015, prices for points of crystal methamphetamine have remained stable (Figure 33).

Figure 33: Median prices of crystal methamphetamine estimated from PWID purchases, 2006–2015



Source: IDRS PWID interviews

NB: Median price per eightball not shown some years due to small numbers (n<10) reporting purchase

The majority of participants who commented on crystal methamphetamine (69%) thought that the price had remained 'stable' over the preceding six months. Thirteen percent stated that it had 'increased' and a further 13% reported that it had 'decreased'. Five participants reported that it had 'fluctuated'. Overall, participants reporting any recent price change of crystal methamphetamine remained stable, despite the slight increase in those reporting the price change had 'decreased'.

5.2.2 Availability

5.2.2.1 Speed powder

Participants were asked 'How easy is it to get speed powder at the moment?'. Responses were mixed among those who could comment with 61% (n=14), reporting speed powder as 'very easy', four participants reporting it as 'difficult', and three participants it as 'easy' to obtain. The remaining two participants reported speed powder was 'very difficult' to obtain (Table 14).

The majority of the sample that commented (74%) reported availability had been stable in the preceding six months (74% in 2014).

Fourteen percent of all participants reported purchasing speed powder in the six months preceding the interview. The most common source of the purchase was 'friends' (n=9), and 'street dealers' (n=6). Other participants reported purchasing from 'known dealers' (n=3), and 'mobile dealers' (n=3) (Figure 34). Of those who could comment, eight participants reported scoring speed powder at an 'agreed public location' and six participants obtaining speed powder from a 'friend's home'. Five participants obtained speed powder via the 'street market' and two participants reported obtaining it from the 'dealer's home' (Figure 35).

5.2.2.2 Base

The current availability of base was mixed. Of those that could comment, five participants reported it to be 'very easy' to obtain, two participants reported it 'very difficult', and a further two participants reported it 'difficult'. One participant reported it as being 'easy' to obtain.

Four participants reported that availability over the past six months was 'more difficult', three participants reported it to be 'stable' and another three participants reported base availability to have been 'easier' in the past six months (Table 13).

Seven percent of the entire sample (11% in 2014) reported purchasing base in the six months preceding interview. Of those that reported purchasing base, it was most commonly from 'friends' (n=5) and 'known dealers' (n=2). Smaller proportions of participants reported purchasing base from 'acquaintances' (n=1) and 'relatives' (n=1) (Figure 34). Locations at which base had most commonly been purchased included a 'friend's home' (n=5), an 'agreed public location' (n=3), the 'street market' (n=1) and an 'acquaintances house' (n=1) (Figure 35). Numbers reporting on base availability are low, and should be interpreted with caution.

5.2.2.3 Crystal methamphetamine

Fifty-eight percent of participants that responded noted crystal methamphetamine was 'very easy' to obtain and 33% reported crystal was 'easy' to obtain. These figures are comparable with 2014 (Table 13). The majority of those who commented (75%) reported that availability over the last six months had remained 'stable' and 15% reporting that it had become 'easier'. Ten participants reported that crystal methamphetamine had become 'more difficult' to obtain (Table 13).

Table 13: Participants' reports of methamphetamine availability in the past six months, 2014–2015

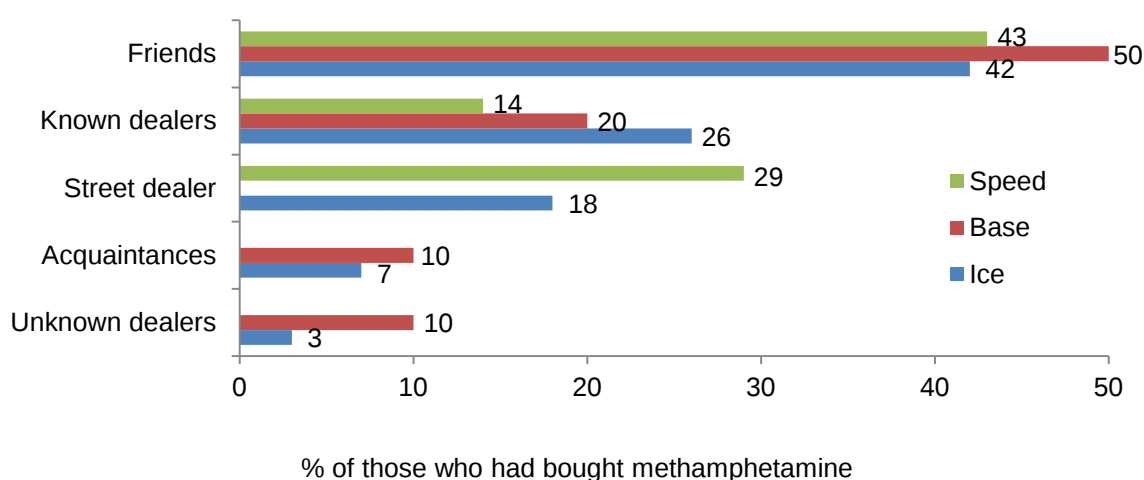
	Powder		Base		Crystal methamphetamine	
	2014 (N=150)	2015 (N=150)	2014 (N=150)	2015 (N=150)	2014 (N=150)	2015 (N=150)
Current availability						
Responded (%)	14	15	10	7	70	63
Of those who responded:						
Very easy (%)	29	61	40	50	52	58
Easy (%)	52	13	27	10	41	33
Difficult (%)	14	17	13	20	5	7
Very difficult (%)	5	9	20	20	2	2
Don't know^ (%)	0	0	0	0	0	0
Availability change						
Responded (%)	13	15	10	7	70	63
Of those who responded:						
More difficult (%)	16	13	27	40	9	11
Stable (%)	74	74	67	30	77	75
Easier (%)	11	9	0	30	11	15
Fluctuates (%)	0	4	7	0	3	0
Don't know^ (%)	0	0	0	0	0	0

Source: IDRS PWID interviews

^ '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

Sixty-two percent of all participants had purchased crystal methamphetamine in the six months preceding interview (71% in 2014). Among these, the most commonly reported sources were 'friends' (42%), 'known dealers' (26%), and 'street dealers' (18%) (Figure 34). The most commonly reported locations of purchase were an 'agreed public location', (28%), the 'street market' (27%), 'dealer's home' (17%), and a 'friend's home' (16%) (Figure 35).

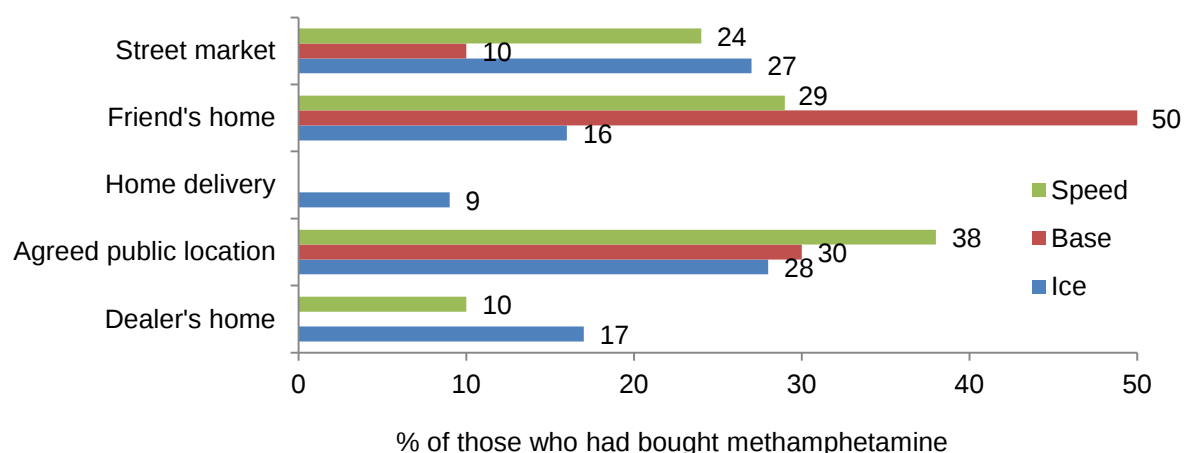
Figure 34: People from whom methamphetamine was purchased in the preceding six months, 2015



Source: IDRS PWID interviews

NB: More than one response could be selected

Figure 35: Locations where methamphetamine was scored in the preceding six months, 2015



Source: IDRS PWID interviews

NB: More than one response could be selected

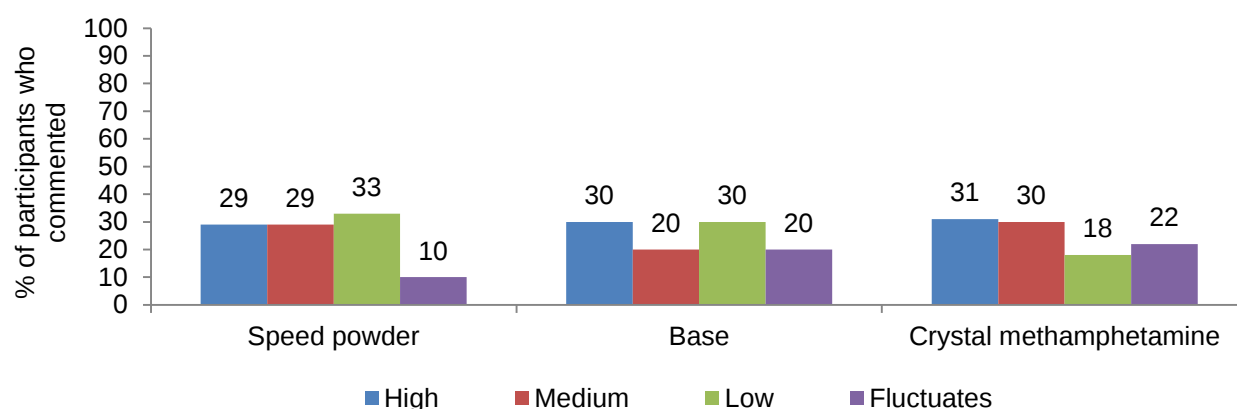
5.2.3 Purity

5.2.3.1 Speed powder – PWID reports

Fourteen percent of the sample (n=21) commented on the perceived current purity of speed powder (13% in 2014). In 2015, comments on perceived purity were mixed. Of those who could comment, seven participants described speed powder as 'low' and similar numbers reported purity as either 'high' (n=6) or 'medium' (n=6). Two participants thought that speed powder purity had 'fluctuated' (Figure 36). Purity reports of speed powder are comparable with 2014.

Reports on changes in speed purity were also mixed. Of those who commented, ten participants reported that purity was 'stable', while eight participants thought that speed purity had 'decreased' over the preceding six months. Three participants commented it had 'increased' and one participant reported that it had 'fluctuated'. Overall, this remains comparable with 2014.

Figure 36: Participant perceptions of methamphetamine purity (speed powder, base and crystal methamphetamine), among those who commented, 2015



Source: IDRS PWID interviews

5.2.3.2 Base – PWID reports

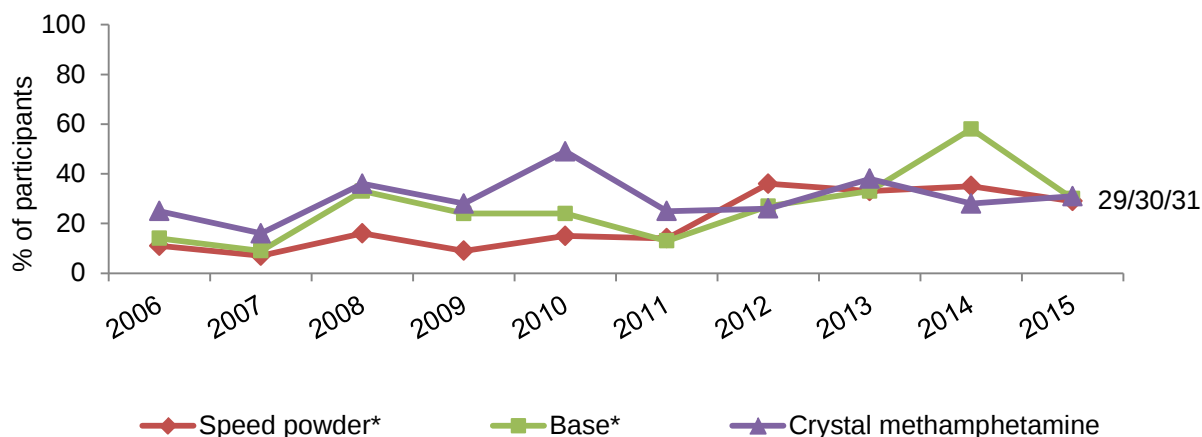
Of those who could comment, three participants reported that recent purity was currently 'high' and a further three participants reported that it was 'low' in purity. Two participants reported that base purity was currently 'medium' (n=2) and two participants fluctuating (n=2). With regards to reporting on changes in purity, it was generally reported to have remained stable (n=4), with lesser amounts reporting it had 'increased' (n=3) or 'decreased' (n=2) over the six months preceding interview. One participant reported a change in base purity as 'fluctuating'. Participant reports for base are low, therefore, should be interpreted with caution.

5.2.3.3 Crystal methamphetamine – PWID reports

Thirty-one percent of recent users reported the purity of crystal methamphetamine as 'high'. Thirty percent reported it as 'medium' and 22% reported crystal methamphetamine purity as 'fluctuating'. The remaining 18% of people reporting recent crystal methamphetamine use believed purity was 'low' (Figure 36). These figures are comparable with values reported in 2014. When asked about whether purity had changed over the last six months, 32% believed that it had remained 'stable'. A similar proportion of participants reported the purity had 'decreased' (29%) with fewer participants reporting the purity had 'increased' (21%). The remaining participants (18%) reported the purity had 'fluctuated'.

Figure 37 shows the proportion of participants reporting the purity of each form of methamphetamine as 'high'. The perceived purity of speed powder and crystal methamphetamine remained comparable with 2014; however, there was a decrease in those reporting base purity as 'high'. These figures should be interpreted with caution due to the low numbers commenting (Figure 37).

Figure 37: Proportion of participants* reporting speed powder, base and ice/crystal purity as 'high', 2006–2015



Source: IDRS PWID interviews

* Numbers for speed powder and base are ≤ 10 , therefore interpret with caution

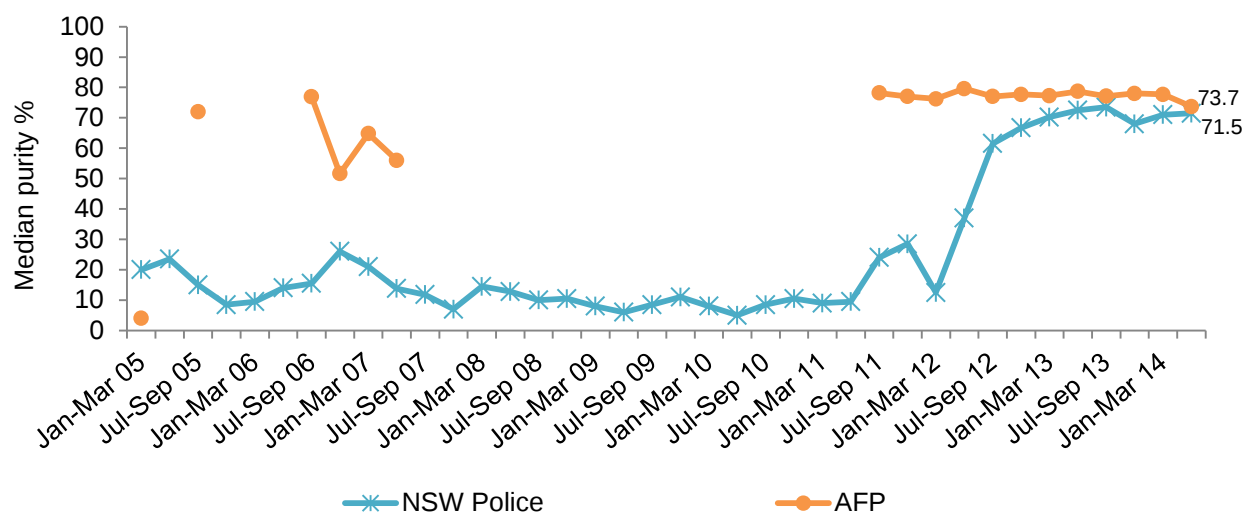
NB: Data on all three forms commenced in 2002.

5.2.4 Purity – drug seizure data

Figure 38 shows the median purity of methamphetamine seizures analysed in NSW for the period January 2005 to June 2014. As analysis by the AFP has been sporadic since 2004, interpretation of methamphetamine purity levels during this time is difficult. In 2013/14, the median purity of seizures analysed by NSW Police remained relatively high at above 70%. The purity of AFP seizures analysed has remained high and consistent since July 2011. Purity figures for 2013/14 are based on 655 methamphetamine seizures analysed by NSW Police (representing 9% of all methamphetamine seizures detected by NSW Police – Figure 39) and 88

seizures analysed by the AFP (2% of all methamphetamine seizures detected by the AFP). Purity data was not available for 2014/15.

Figure 38: Purity of methamphetamine seizures analysed in NSW, by quarter, January 2005–June 2014

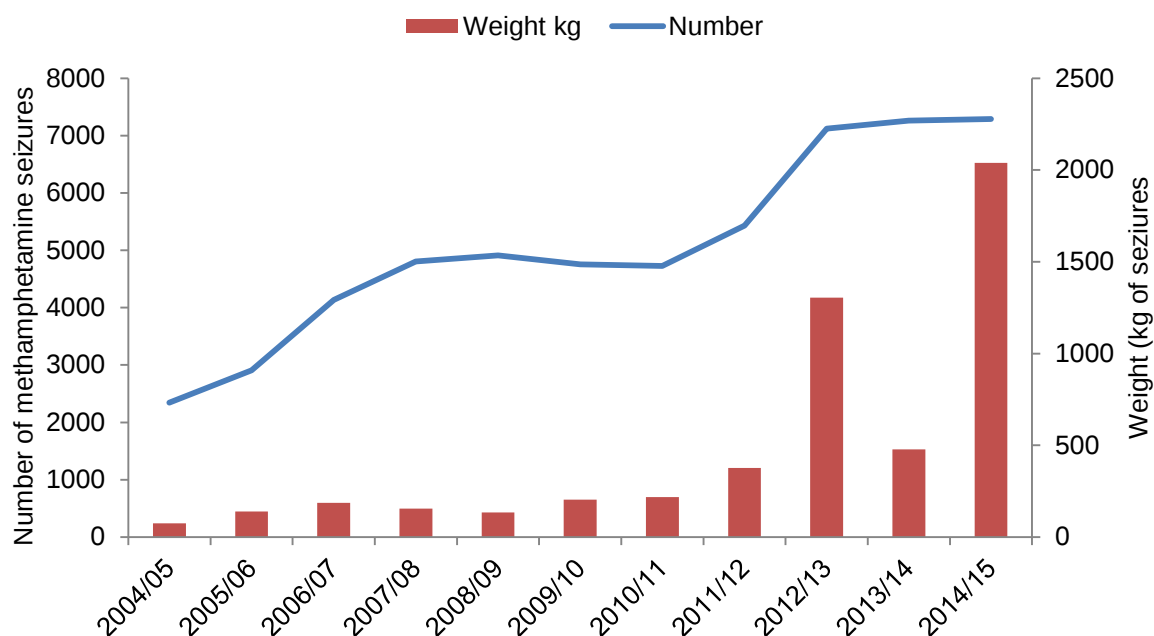


Source: Australian Bureau of Criminal Intelligence (2001, 2002); Australian Crime Commission (2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012).

NB: Gaps in the series represent data that was not available. Purity levels are only representative of seizures which are analysed.

Both the number and weight of methamphetamine seizures has been relatively high in the past 3 years (Figure 39).

Figure 39: Number and weight of methamphetamine seizures detected by NSW Police, July 2004 – June 2015



Source: Australian Bureau of Criminal Intelligence (2001, 2002); Australian Crime Commission (2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012).

Note: 2014/15 data was provided by NSW Police, while earlier data is extracted from the Illicit Drug Data Reports produced by the ACC.

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 the use of crystal methamphetamine had increased in the 6 months prior to interview particularly among younger and first time illicit drug users.

Key expert comments

- The majority of health and law KE report crystal methamphetamine is readily available.
- Purity reports were mixed.
- Price reports are stable with one KE reporting purchases of methamphetamine over the internet.
- Law KE reported an increase in methamphetamine detections and that the scale of production appears to be increasing.

5.3 Cocaine

Twenty-five percent of participants reported that they were able to comment on the price, purity and/or availability of cocaine in 2015, which is consistent with the 22% that could comment in 2014. The remainder of participants 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 participants on the last occasion of purchase are presented in Table 14 and Figure 40. The median price for caps, the most popular purchase amount, remained stable. Reported purchases of quarter grams and half weights remained uncommon with an insufficient number of participants ($n \leq 10$) able to comment on price (Table 14).

Table 14: Price of most recent cocaine purchases by PWID participants, 2014–2015

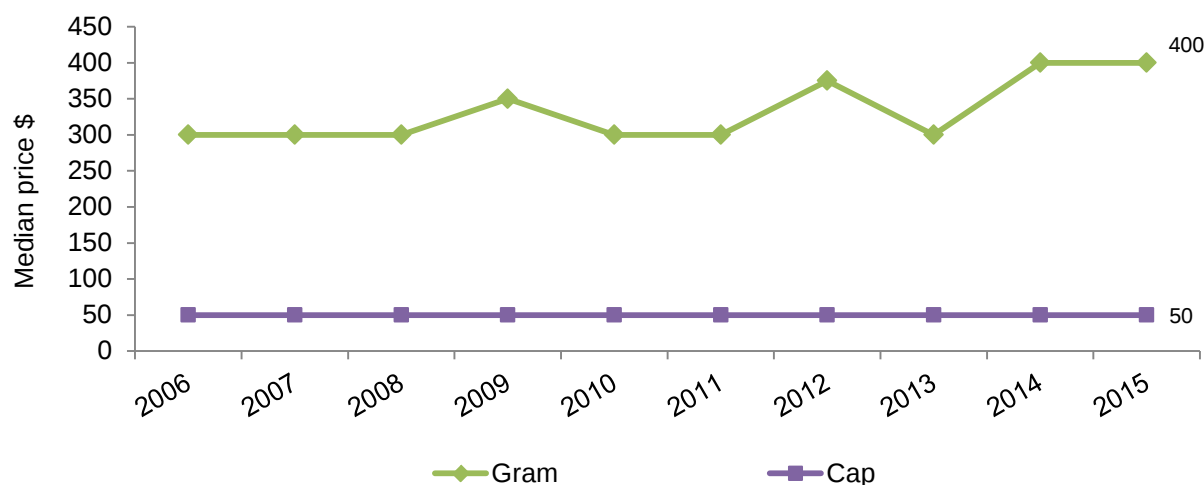
Amount	Median price* \$	Range \$	Number of purchasers*
Cap	50 (50)	50-100	25 (25)
Quarter gram	150 (85)	100-200	2^ (2^)
'Half weight' (0.5 grams)	200 (262)	120-250	(6^)
Gram	400 (400)	100-750	(12)

Source: IDRS PWID interviews

*2014 data are presented in brackets

^ $n \leq 10$ results should be interpreted with caution

Figure 40: Median price of a gram and cap of cocaine estimated from participant purchases, 2006–2015



Source: IDRS PWID interviews

The majority of participants (71%; $n=24$) that could comment on cocaine reported that the price had remained 'stable' in the preceding six months. Of those commenting, eight participants reported that the price of cocaine had 'increased' and two participants reported the price had 'fluctuated'. There were no reports the price of cocaine had 'decreased'.

5.3.2 Availability

Forty-nine percent of participants (n=18) commenting on cocaine market characteristics (price, purity and/or availability) thought that it was 'very easy' to obtain with a further 30% of participants (n=11) reporting cocaine as 'easy' to obtain (Table 15). Of those that could comment, seven participants thought that it was 'difficult' to obtain and one participant reported cocaine as being 'very difficult' to obtain (Table 15).

Seventy-six percent of participants (n=28) commenting on cocaine reported that availability had remained 'stable' (Table 15). Six participants reported that it had become 'more difficult' to obtain over the last six months, and two participants thought that it had become 'easier' (Table 15). One participant reported that the availability of cocaine had 'fluctuated'. Figure 43 shows the availability of cocaine over time since 2006.

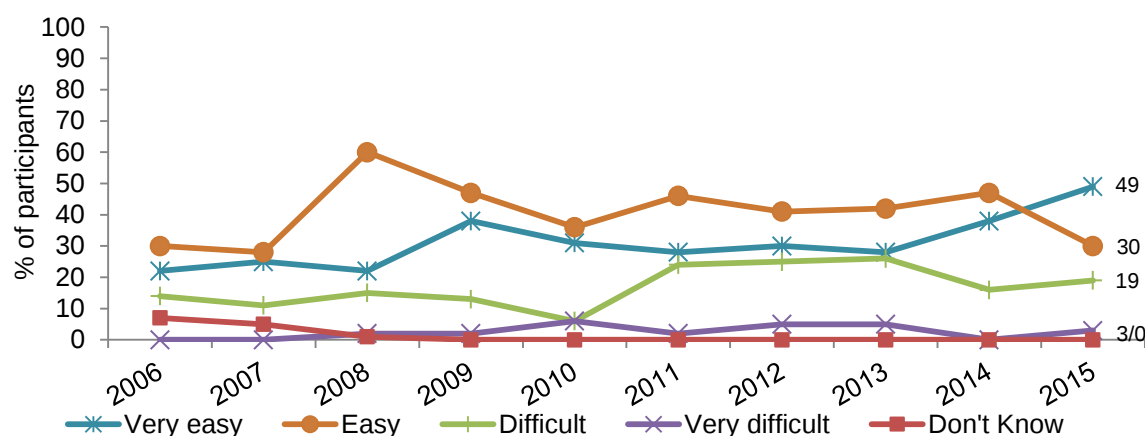
Table 15: Participants' reports of cocaine availability in the past six months, 2011–2015

	2011 (N=150)	2012 (N=151)	2013 (N=151)	2014 (N=150)	2015 (N=150)
Current availability					
Responded (%)	37	29	28	21	25
Of those who responded:					
Very easy (%)	27	30	28	38	49
Easy (%)	45	41	42	47	30
Difficult (%)	23	25	26	16	19
Very difficult^ (%)	2	5	5	0	3
Don't know^ (%)	4	0	0	0	0
Availability change					
Responded (%)	37	28	28	21	25
Of those who responded:					
More difficult (%)	27	19	31	22	16
Stable (%)	55	65	60	69	76
Easier (%)	11	12	10	9	5
Fluctuates^ (%)	2	5	0	0	3
Don't know^ (%)	5	0	0	0	0

Source: IDRS PWID interviews

^ '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

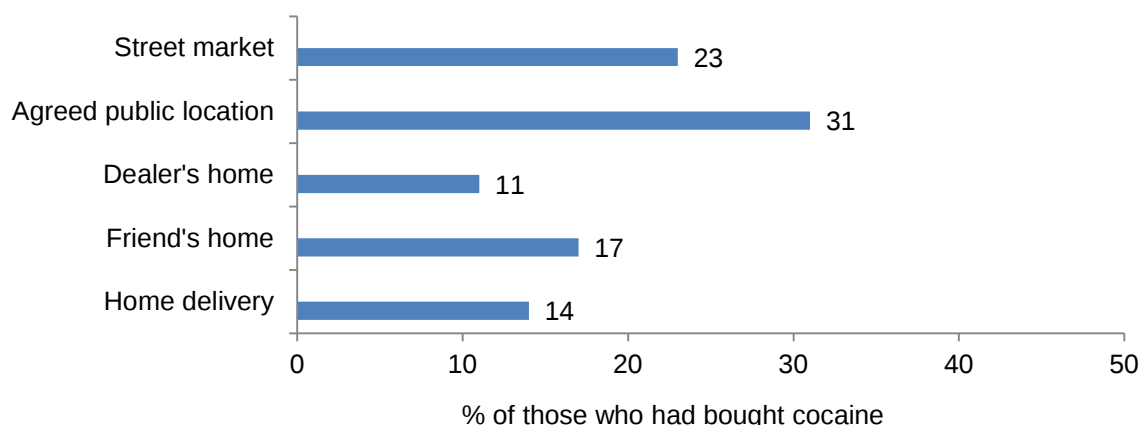
Figure 41: Participant reports of current cocaine availability, 2006–2015



Source: IDRS PWID interviews

The most common sources of cocaine purchase over the preceding six months were from friends or from known dealers (34%; n=12, respectively). Figure 42 shows the locations where these purchases were most commonly made, with the most common venues being an 'agreed public location' (31%; n=11) or a street market (23%, n=8). Fewer participants nominated a friend's home (n=6), 'home delivery' (n=5) or the 'dealer's home' (n=4).

Figure 42: Locations where cocaine was scored in the preceding six months, 2015



Source: IDRS PWID interviews

NB: More than one response could be selected

5.3.3 Purity – PWID reports

Twenty-five percent of all participants could comment on the current purity of cocaine. Of these, 38% (n=14) reported cocaine to be of 'medium' purity. Thirty-two percent (n=12) reported cocaine to currently be of 'low' purity. Of those who could comment, seven participants reported purity to currently be 'high' and four participants reported that the purity of cocaine had 'fluctuated' (Table 16).

Comments on purity changes in the 6 months prior to interview were mixed. Thirty-six percent of those who could comment (n=13) reported that it had 'decreased' while similar proportions reported recent purity was 'stable' (33%; n=12). Smaller proportions of participants that could comment on cocaine reported that recent purity had 'fluctuated' (n=8), and three participants reported recent purity had 'increased'.

Table 16: Participants' perceptions of cocaine purity in the past six months, 2011–2015

	2011 (N=150)	2012 (N=151)	2013 (N=151)	2014 (N=150)	2015 (N=150)
Current purity					
Responded (%)	36	28	28	22	25
Of those who responded					
High (%)	11	14	21	23	19
Medium (%)	30	48	40	30	38
Low (%)	38	26	33	27	32
Fluctuates (%)	18	12	7	20	11
Don't know^ (%)	4	0	0	0	0
Purity change					
Responded (%)	36	26	27	19	24
Of those who responded					
Increasing (%)	13	8	7	10	8
Stable (%)	29	40	34	41	33
Decreasing (%)	32	30	44	28	36
Fluctuating (%)	20	23	15	21	22
Don't know^ (%)	7	0	0	0	0

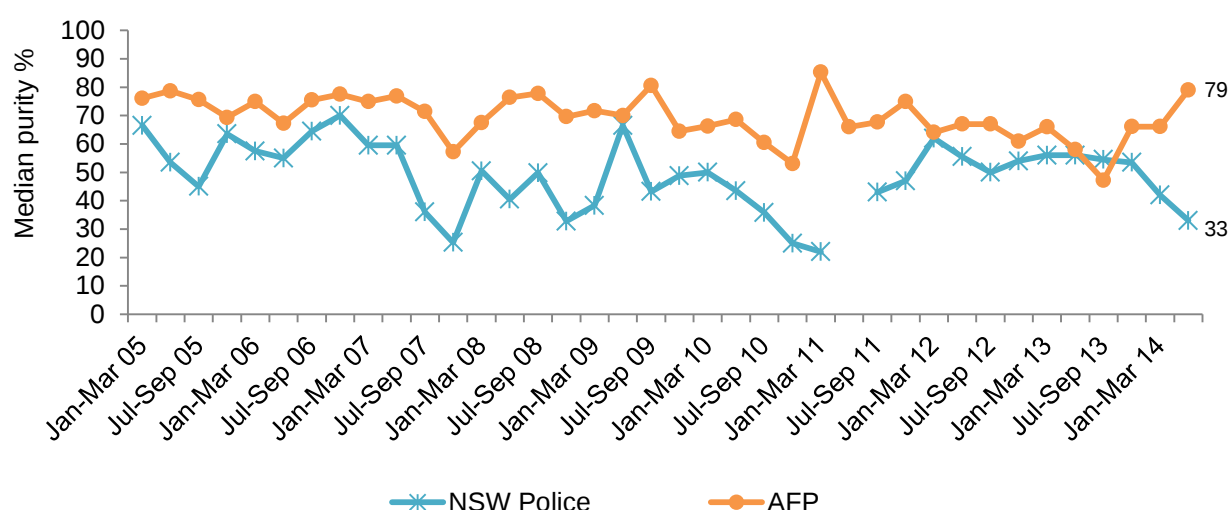
Source: IDRS PWID interviews

^'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 Purity – drug seizure data

The total median purity of cocaine seizures analysed by the NSW Police has fluctuated. Seizures analysed by the AFP have recorded increasing purity levels over time and those analysed by the NSW Police show declining cocaine purity levels (Figure 44). Purity figures for 2013/14 are based on 169 seizures analysed by the NSW Police (representing 16% of all cocaine seizures detected by NSW Police) and 45 seizures analysed by the AFP (representing 4% of all seizures detected by the AFP). Purity data was not available for 2014/15.

Figure 43: Purity of cocaine seizures analysed in NSW, by quarter, January 2005–June 2014

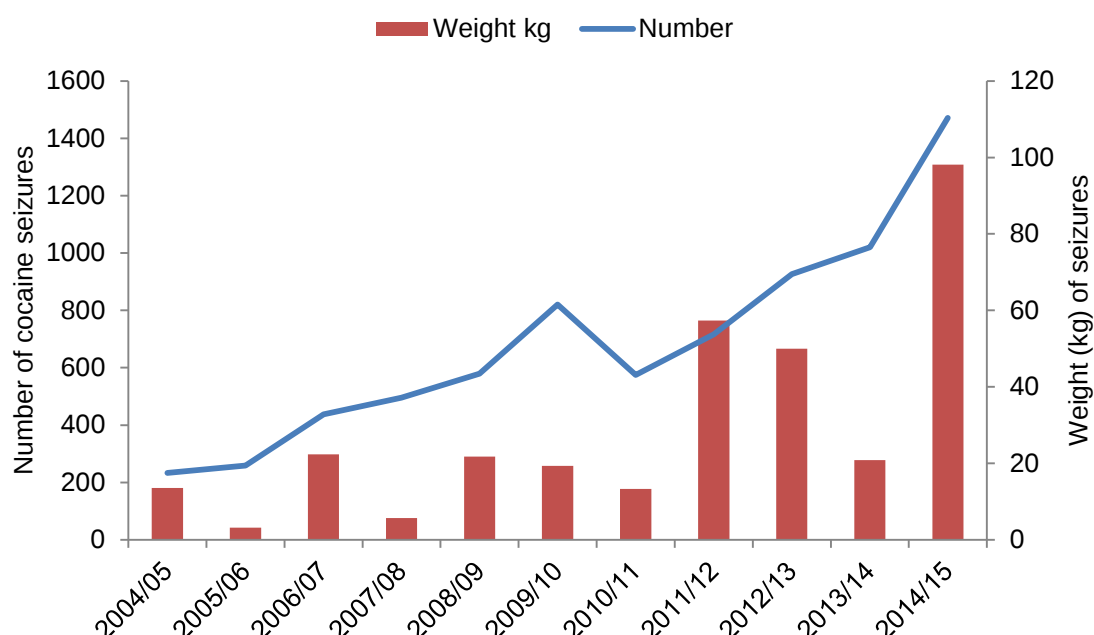


Source: Australian Bureau of Criminal Intelligence (2001, 2002); Australian Crime Commission (2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012).

NB: Purity levels are only representative of seizures which are analysed.

Figure 44 shows the number of cocaine seizures detected by the NSW Police. Numbers and the total weight of seizures have steadily increased over the past four years.

Figure 44: Number of cocaine seizures detected by NSW Police, July 2004 – July 2015



Source: Australian Bureau of Criminal Intelligence (2001, 2002); Australian Crime Commission (2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012)

Note: 2014/15 data was provided by NSW Police, while earlier data is extracted from the Illicit Drug Data Reports produced by the ACC.

5.3.5 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.

Key expert comments

- KE reported cocaine was viewed as expensive by PWID and use was quite low and infrequent.
- The majority of KE reported the price of cocaine to be stable.
- Cocaine availability was generally considered hard to obtain for infrequent users, but easier for regular users with regular contacts.
- There were few KE purity reports. One health KE reported as availability was low, individuals are being sold other substances.

5.4 Cannabis

Participants were asked if they were able to comment on the price, purity and/or availability of hydroponic ('hydro') and/or outdoor-grown ('bush') cannabis, and in 2015, 63% of the sample felt confident to answer at least some of the survey items on hydro. By contrast, 25% 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 participants on the last occasion of purchase are presented in Figure 16. As in previous years, hydro appeared to be the more popular form of cannabis with fewer participants reporting the purchase of bush.

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 16). In 2015, the median price of a quarter ounce and ounce of hydroponic cannabis remained stable at \$100 and \$300 respectively. The median price for half an ounce increased slightly in 2015 from \$160 in 2014 to \$165 (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=70), followed by quarter ounces (n=27).

Participants were also asked whether they thought that prices had changed over the six months preceding interview. The majority of participants who commented (79%) reported that the price of hydroponic cannabis was 'stable', with smaller proportions stating that it had 'increased' (14%). Equal proportions of participants reported the current price of hydro cannabis had either 'fluctuated' (3%) or 'decreased' in price (3%).

5.4.1.2 Bush cannabis

In 2015, 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), thus results should be interpreted with caution (Table 17).

The most popular purchase amount for bush remained to be a gram (n=24), 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 (91%; 21% of the entire sample) thought that prices of bush cannabis had remained 'stable.' Nine percent reported a 'decrease', while there were no reports of an 'increase' or 'fluctuation' in the recent price of bush cannabis.

Again in 2015, price ranges for larger quantities of hydroponic and bush cannabis were widespread. 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 participants, 2014–2015

Amount	Median price* \$	Range \$	Number of purchases*
Hydro			
Gram	20 (20)	10-100	70 (83)
Quarter ounce	100 (100)	50-350	27 (43)
Half ounce	165 (160)	150-180	12 (31)
Ounce	300 (300)	190-700	20 (34)
Bush			
Gram	20 (20)	10-50	24 (19)
Quarter ounce	80 (80)	70-150	6^ (7^)
Half ounce	150 (140)	90-180	5^ (5^)
Ounce	250^ (220)	150-300	4^ (9^)

Source: IDRS PWID interviews

*2014, median prices are in brackets

^n ≤ 10 results should be interpreted with caution

5.4.2 Availability

5.4.2.1 Hydroponic cannabis

The majority of all participants commenting on hydro availability thought that it was ‘very easy’ (65%) or ‘easy’ (29%) to obtain. Smaller proportions of participants commenting reported current availability to be ‘difficult’ (5%*n*=5) or ‘very difficult’ (*n*=1) (Table 18). The majority (90%) 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

Bush cannabis availability reports were mixed, with one-third of participants who could comment reporting availability to be ‘very easy’ (33%; *n*=12). Equal proportions who responded suggested that availability was either ‘easy’ (31%; *n*=11) or ‘difficult’ (31%; *n*=11) to obtain. Two participants reported that it was ‘very difficult’ to obtain (Table 18). The majority of participants (75%; *n*=27) reported any recent change in access to bush cannabis as ‘stable’. Five participants reported it to be ‘more difficult’, three participants reported it to be ‘easier’ and one participant reported the change to be ‘fluctuating’.

Figure 45 represents those participants reporting the availability of hydro and bush cannabis to be ‘very easy’ from 2006 onwards.

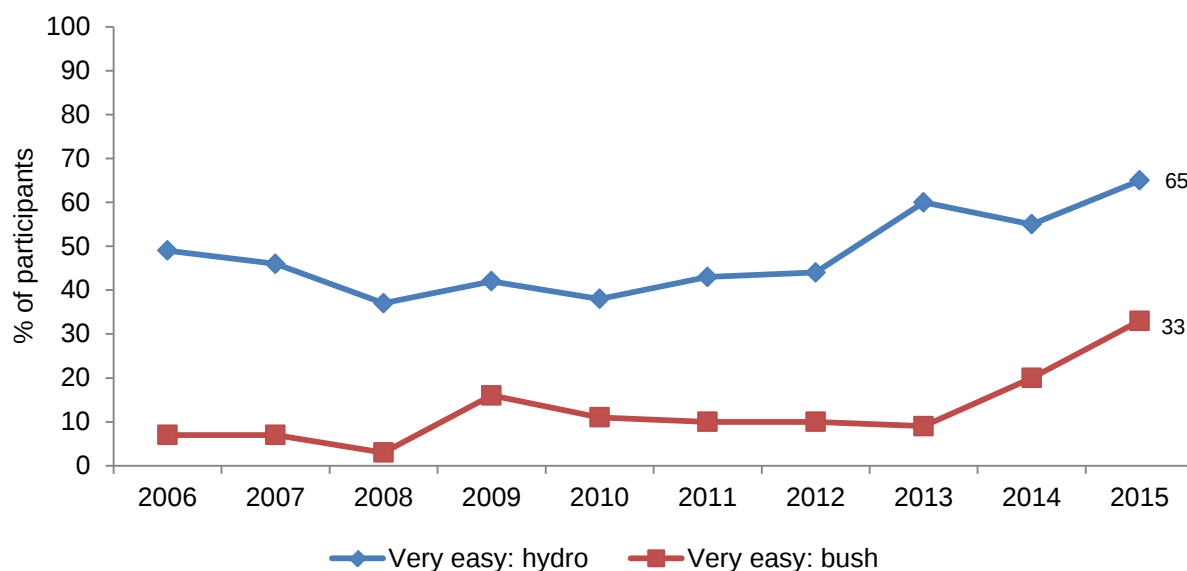
Table 18: Participants' reports of cannabis availability in the past six months, 2014–2015

	Hydro		Bush	
	2014 (N=150)	2015 (N=150)	2014 (N=150)	2015 (N=150)
Current availability				
Responded (%)	69	62	20	24
Of those who responded:				
Very easy (%)	55	65	20	33
Easy (%)	35	29	63	31
Difficult (%)	9	5	13	31
Very difficult (%)	1	1	3	6
Availability change				
Responded (%)	65	62	19	24
Of those who responded:				
More difficult (%)	10	3	7	14
Stable (%)	79	90	86	75
Easier (%)	9	5	0	8
Fluctuates (%)	2	1	7	3

Source: IDRS PWID interviews

NB: Changes were made to the administration of the cannabis section of the survey in 2006, resulting in differences between response rates

Figure 45: Participant reports of current cannabis availability, 2006–2015

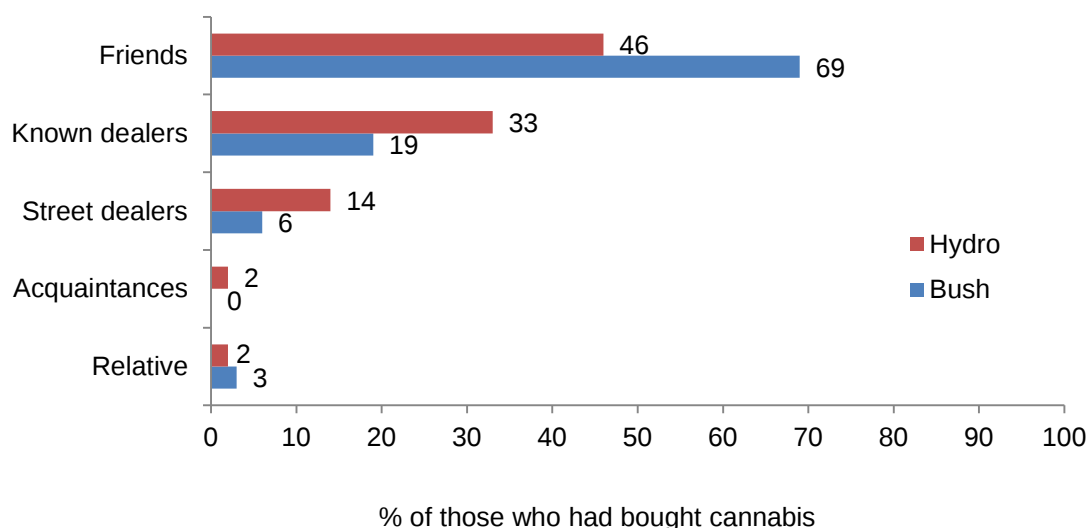


Source: IDRS PWID interviews

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-one percent of all participants had purchased hydro in the preceding six months and 24% of participants had purchased bush. Purchase patterns 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 46). Locations where cannabis was scored were varied, including 'public' and 'private locations' (Figure 47).

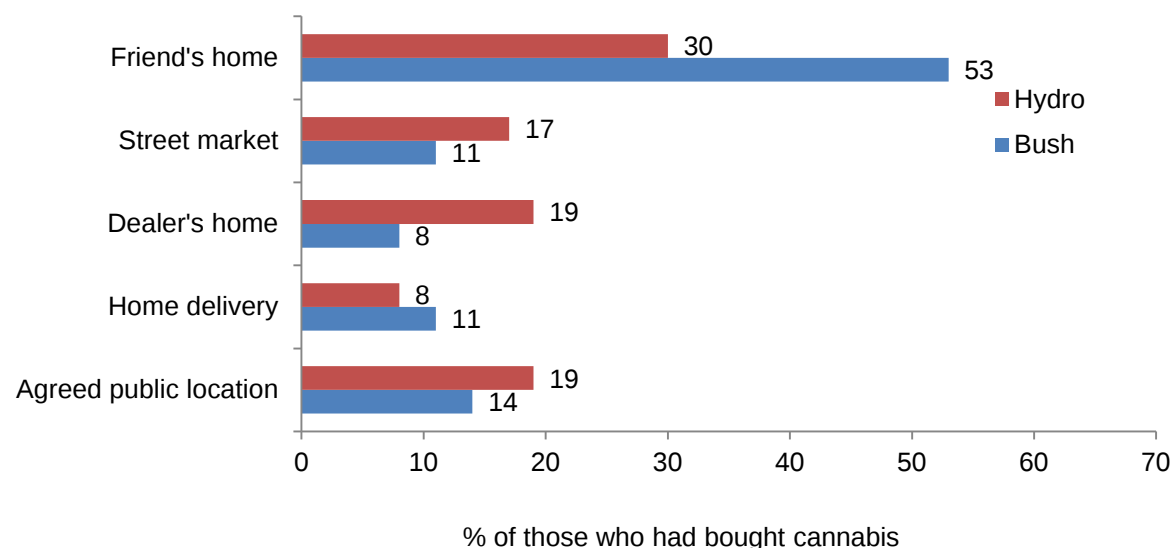
Figure 46: People from whom cannabis was purchased in the preceding six months, 2015



Source: IDRS PWID interviews

NB: More than one response could be selected

Figure 47: Locations where cannabis was purchased in the preceding six months, 2015



Source: IDRS PWID interviews

NB: More than one response could be selected

5.4.3 Purity – PWID reports

Participants were questioned about their perceptions of the current purity of hydro and bush (whether it was 'low', 'medium', 'high', 'fluctuates' or that they 'did not know'), and whether they thought that the purity 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 (55%; n=51) and 27% (n=25) who rated it as being of 'medium' potency. Twelve percent of participants (n=11) thought that the potency 'fluctuates', and five participants believed that it was 'low'. The majority (63% of those commenting; n=57) believed that potency had remained 'stable' in the preceding six months, with smaller proportions reporting that it had 'fluctuated' (14%; n=13), 'decreased' (13%; n=12) or 'increased' (n=8). Despite some fluctuations, these figures followed a similar pattern to 2014.

5.4.3.2 Bush cannabis

Among those who commented, 47% (n=16) thought that bush was of 'medium' purity, 35% (n=12) reported the purity to be 'high', five participants reported the purity to be 'low' and one participant thought that the purity had 'fluctuated'. When asked about whether the purity had changed over the last six months, 68% of the respondents who commented (n=23) reported that purity had remained 'stable'. Equal numbers of participants reported recent purity of bush cannabis had either 'fluctuated' (n=4) or 'increased' (n=4). Three participants commented that the recent change in purity was 'decreasing'.

Overall, these findings indicated that, according to participant 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 2015.

No routine data is currently collected on cannabis potency in Australia. 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.

Key expert comments

- Consistent with previous years, the prevalence of cannabis use remained high for this group, although it was not primarily the drug of concern.
- Availability was high and the price remained stable with previous years.

5.5 Methadone

As with other drug types, all participants were asked about the price, purity and availability of non-prescribed methadone. Twenty-five percent of the sample, (33% in 2014) 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 55 cents per ml, which is stable with the data from previous years.

Only one participant was able to comment on the price of Physeptone tablets, with a median price of \$15 for a 10mg tablet. Figures should be interpreted with caution, however, due to small numbers reporting.

In response to the question 'Has the price of illicit methadone changed in the past six months?' half (53%) of those commenting (53%; n=18) reported that the price had remained 'stable' during this time. Thirty-five percent (n=12) reported the price had 'increased' and smaller proportions of people stated that the price was 'decreasing' (n=3). One participant reported that the price of illicit methadone had 'fluctuated'.

The majority of participants that could comment reported the availability of non-prescribed methadone was either 'very easy' (46%; n=16) or 'easy' (29%; n=10) to obtain. Seven participants found it 'difficult' to obtain and two participants reported it to be 'very difficult' to obtain. When asked whether availability had changed over the preceding six months, the majority of those commenting (77%; n=27) reported that it had remained 'stable'. Six participants reported that it had become 'more difficult' in the preceding six months, and the remaining participants reported the availability change was either 'easier' (n=1) or 'fluctuating' (n=1).

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' (57%; n=17) and 'street dealers' (n=7), with smaller proportions obtaining it from 'acquaintances' (n=3) and 'known dealers' (n=2). The most commonly reported locations of purchase were from a 'street market' (n=8), a 'friend's home' (n=7), or at an 'agreed public location' (n=7). The remaining participants who obtained methadone did so through 'home delivery' (n=4), a 'dealer's home' (n=3) or a 'chemist' (n=1).

5.6 Buprenorphine

Nine participants were able to comment on the price and/or availability of non-prescribed buprenorphine, with a median price of \$25 for a 2mg tablet of Subutex® and \$20 for an 8mg tablet of Subutex®. One hundred percent of those able to comment reported that the price had remained 'stable' during this time.

Of those who commented, six participants reported current availability of non-prescribed buprenorphine was 'easy' to obtain with a further two participants reporting that it was 'very easy' to obtain. There was one report of non-prescribed buprenorphine being 'difficult' to obtain. In regards to a change in availability of non-prescribed buprenorphine, five participants reported that the recent market was 'stable'. Equal proportions of participants commented that change in recent availability was 'easier' or 'fluctuating' (n=2, respectively). 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.

In 2015, of those who commented, buprenorphine was most commonly purchased from 'friends' (n=7), followed by 'street dealers' and 'acquaintances' (n=1, respectively). The most commonly reported locations of purchase from those who would comment were from a 'friend's home'

(n=5), an 'agreed public location' (n=2), a 'street market' and a 'dealer's home' (n=1, respectively).

5.7 Morphine

Twelve percent of participants felt confident enough to respond to survey items concerning price and/or availability of illicit morphine, (24% in 2014). MS Contin continued to remain the most common brand of morphine used.

The median price for 100mg MS Contin tablets ('grey nurses') remained stable at \$50 per tablet (range \$40–\$80). Few participants (n<10) commented on 60mg MS Contin (median price \$33) with no participant purchases of 5mg, 10mg, or 30mg tablets. Four participants were able to comment on the price of 100mg Kapanol (median price \$40); therefore, results should be interpreted with caution. Only one participant commented on the price of a 30mg Anamorph tablet (median \$30).

Seventy-seven percent (n=13) of those commenting for non-prescribed morphine reported that the price had remained 'stable' over the preceding six months. Of those able to comment, three participants believed that the price had 'increased', and one participant reported that the price had 'fluctuated'.

Of those able to comment, the majority of participants reported that non-prescribed morphine was 'easy' (n=7) or 'very easy' (n=6) to obtain. Three participants believed it to be 'very difficult' to obtain, and two participants reporting morphine 'difficult' to obtain. Eighty-two percent (n=14) of those commenting stated that availability had remained 'stable' over the preceding six months, and two participants reported the change in availability of morphine as being 'more difficult'. One participant commented that the change in recent availability of morphine was 'easier'.

In 2015, morphine was most commonly purchased from 'friends' (n=8), 'street dealers' (n=4), and 'known dealers' (n=3). The most commonly reported locations of purchase from those who could comment were from a 'street market' (n=6), an 'agreed public location' (n=6), and two participants obtaining morphine from a 'friend's home' or a 'dealer's home'.

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-reformulated OxyContin® (i.e. 'original stock') and reformulated OxyContin®.

In 2015, nineteen percent of all participants were confident enough to complete survey items concerning the market for non-prescribed oxycodone, which is a significant decrease on the 37% of participants in 2014. The most commonly purchased amounts were 80mg tablets of the Reformulated OxyContin® (n=15), bought for a median of \$40 each (range \$10–\$100). The second most commonly purchased amount, 40mg Reformulated OxyContin®, had a median price of \$23 (range \$5–\$80; n=8). Six participants had purchased 80mg tablets of the Generic controlled-release oxycodone at a median price of \$40 (range \$25–\$50). There were insufficient purchases of Endone®, OxyNorm®, or Proladone® to report on prices and no participants reported the use of Targin®. See also section 8.2 'Oxycodone use' for further information.

The overall price for oxycodone was reported as 'increasing' over the past six months (50% of those commenting; n=14), consistent with 2014 reports. Ten participants stated that the price of oxycodone had remained 'stable', and four participants reported that it had 'decreased'.

Oxycodone was reported to be 'very easy' (42%; n=11) or 'easy' to obtain (31%; n=8) by the majority able to comment. Five participants reported it as difficult to obtain and two participants and very difficult.

Sixty-three percent of those who could comment (n=17) thought that the current availability of oxycodone was 'stable' and nine participants thought that it was 'more difficult'. One participant thought that it was 'fluctuating'.

Oxycodone remained most commonly purchased from 'friends' (58%; n=14) and 'known dealers' (n=4). One participant reported obtaining oxycodone from 'acquaintances', their 'partner' or a 'relative' (n=1, respectively). The most commonly cited locations for purchase were the 'street market' (n=7), a 'friend's home' (n=7), or at an 'agreed public location' (n=6). The remaining participants obtained oxycodone through 'home delivery' (n=2) or at a 'dealer's' home' (n=2).

Key Expert comments

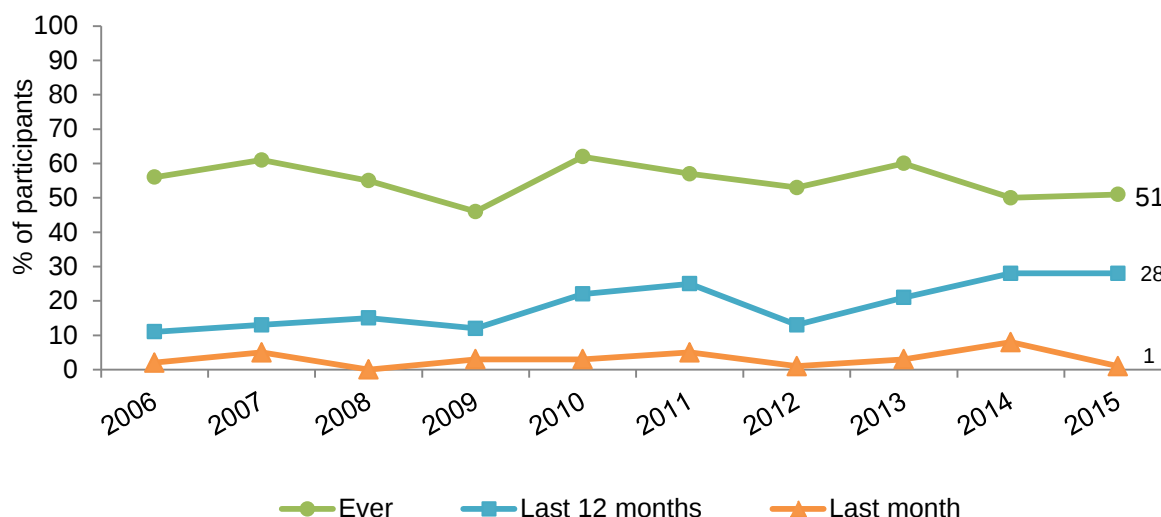
- There were no comments on the price, purity or availability of pharmaceutical opioids by KE.
- Since the introduction of Reformulated OxyContin[®], many KE reported a decrease in oxycodone use altogether.

6 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

6.1 Overdose and drug-related fatalities

Fifty-one percent of participants reported having overdosed on heroin in their lifetime and 28% had done so in the 12 months preceding the interview (28% in 2014). There was one report of heroin overdose in the month prior to interview (six in 2014) (Figure 48).

Figure 48: Proportion of PWID participants who had ever overdosed, overdosed in the past 12 months, and the past month, on heroin 2006–2015

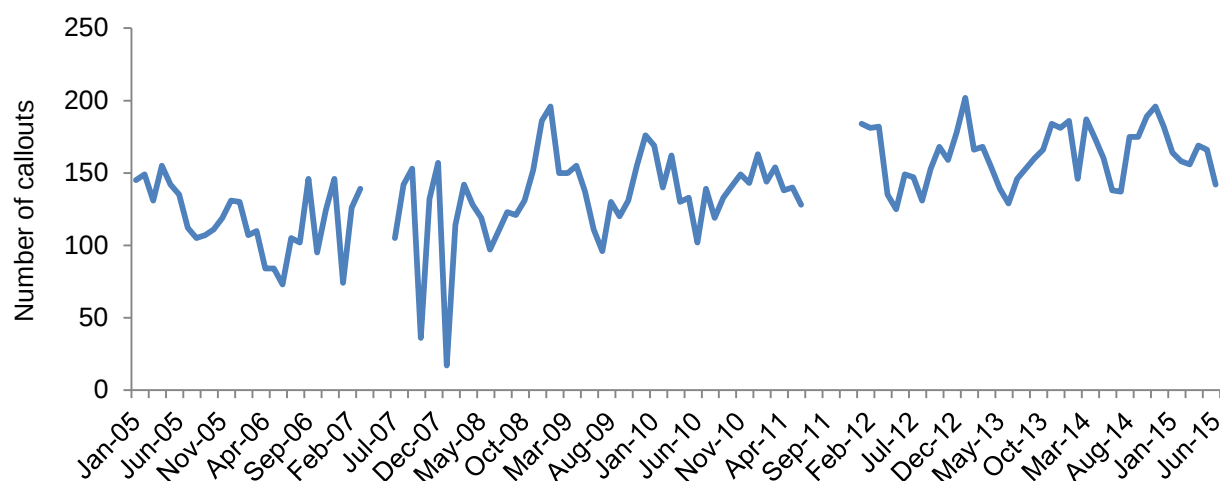


Source: IDRS PWID interviews

Seventeen percent of all participants (21% in 2014) reported that they had accidentally overdosed on other drugs excluding heroin and morphine on a median of two times. Thirty-one percent (39% in 2014) reported that they had accidentally overdosed on other drugs excluding heroin and morphine in the 12 months prior to interview, however there were no participants who 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. NSW ambulance callouts have fluctuated over the past two years, remaining within the range of 150 to 200 calls per month (Figure 49).

Figure 49: Number of ambulance callouts to overdoses January 2005–June 2015



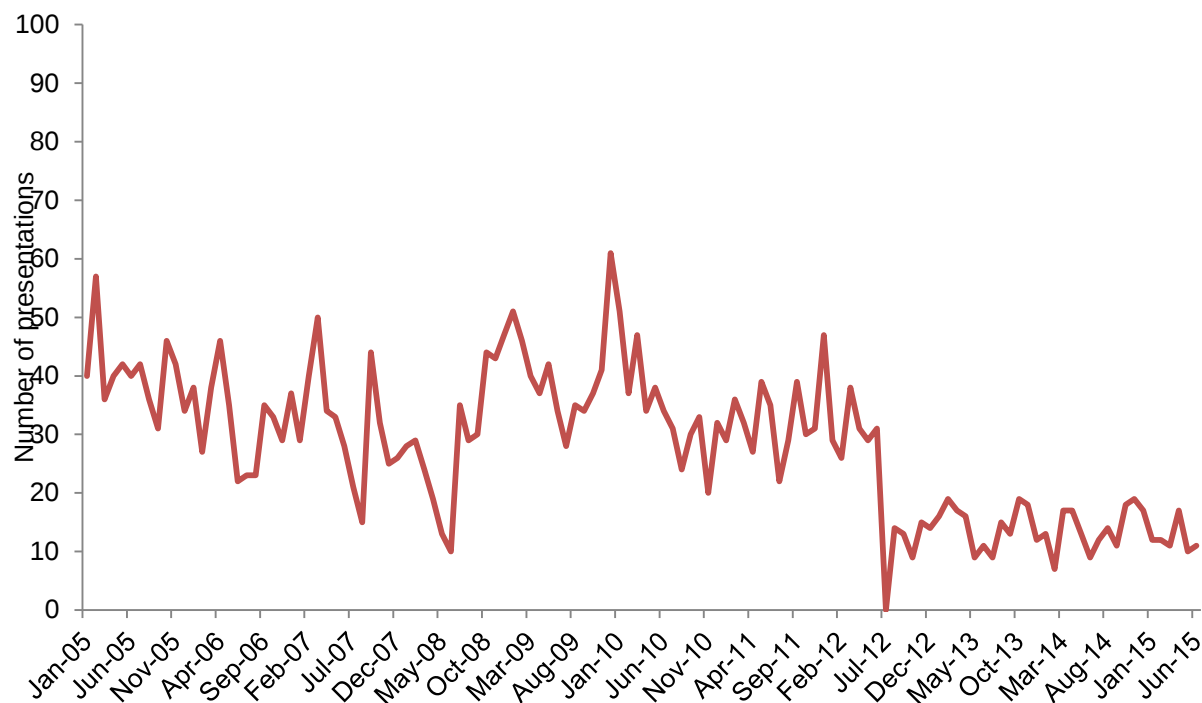
Source: Ambulance Service of NSW case sheet database. Breaks in data series represent periods where data were unavailable.

6.1.1 Heroin

Heroin overdose presentations to NSW emergency departments have stabilised at a lower level in the past two years after declining in 2012 (Figure 51).

6.1.1.1 Non-fatal overdose

Figure 50: Heroin overdose presentations to NSW emergency departments, January 2005–June 2015

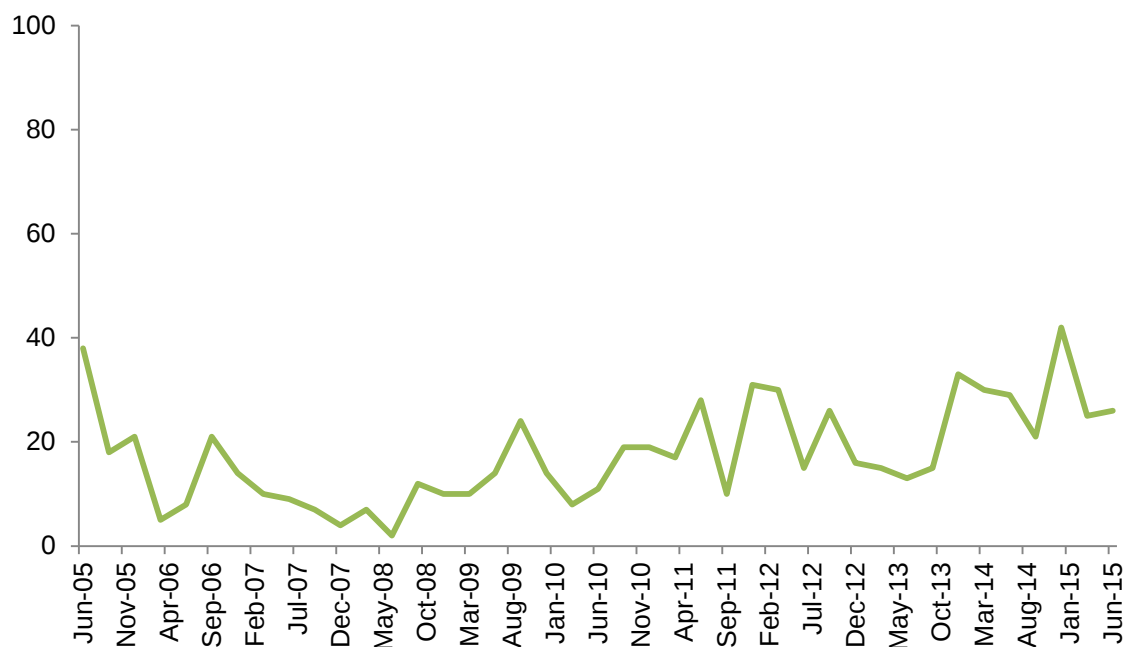


Source: Emergency Department Information System, NSW Ministry of Health
NB: Figures refer to overdose only and do not include presentations for use disorders

6.1.1.2 Fatal overdose

In the past decade, there has been an upward trend in deaths of people suspected of drug use (as determined by police or pathologists) in which morphine was detected post mortem (Figure 51).

Figure 51: Number of suspected drug-related deaths in which morphine was detected post-mortem, by quarter, March 2005–June 2015



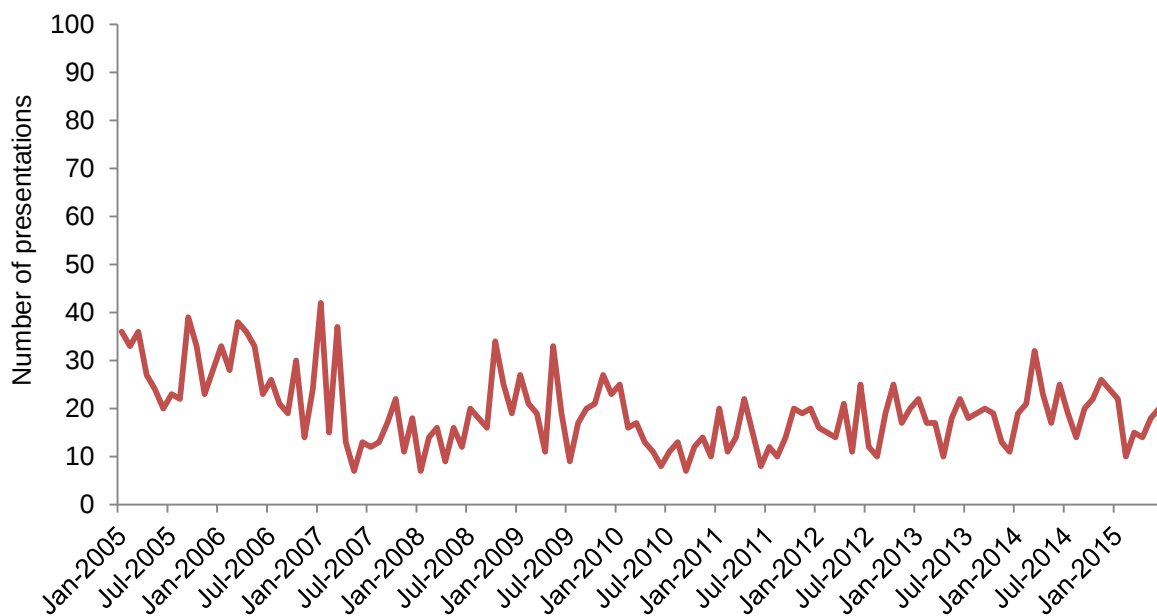
Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories, NSW Ministry of Health,
NB: These numbers relate to deaths in which morphine (a metabolite of heroin) was detected; however, there may have also been other drugs present

6.1.2 Methamphetamine

6.1.2.1 Non-fatal overdose

The total number of amphetamine overdose presentations to NSW emergency departments has fluctuated over time (Figure 52).

Figure 52: Amphetamine overdose presentations to NSW emergency departments, January 2005–June 2015



Source: Emergency Department Information System, NSW Ministry of Health

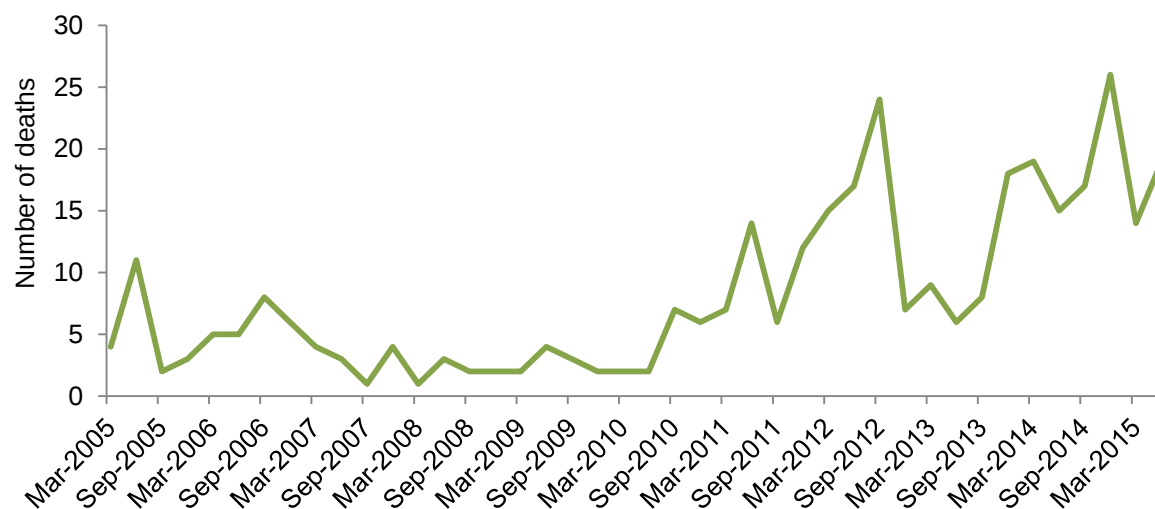
NB: Figures refer to overdose only and do not include presentations for use disorders

6.1.2.2 Fatal overdose

The number of suspected drug related deaths where amphetamines were detected post-mortem in NSW appears to have increased from mid-2014 onward. The numbers remain under 20 per quarter with the exception of mid-to-late 2012 and late-2014 (Figure 53).

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

Figure 53: Number of deaths of individuals suspected of drug use, in which illicit amphetamines were detected post-mortem, NSW, by quarter, March 2005–June 2015



Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories, NSW Ministry of Health

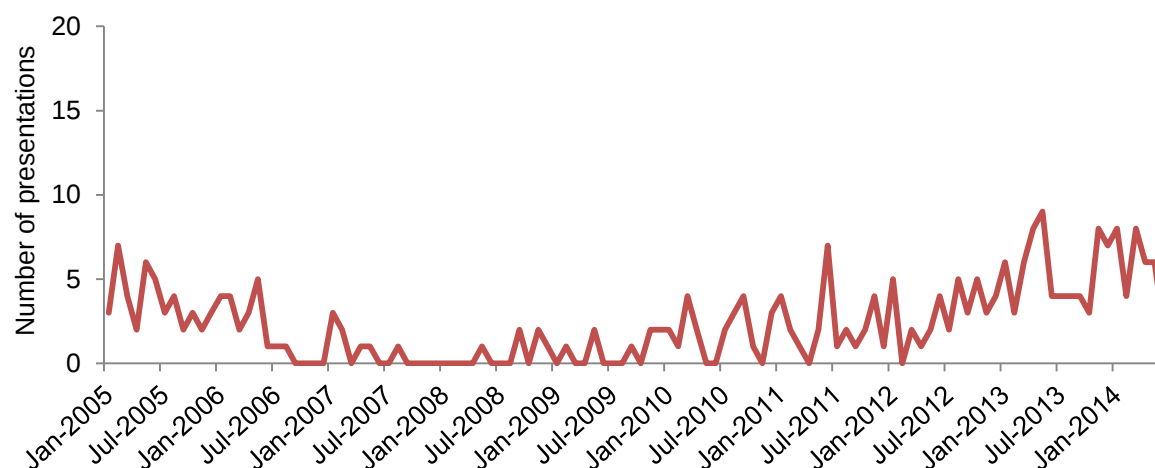
NB: These numbers relate to deaths in which amphetamines, including methamphetamine, were detected; however, there may have also been other drugs present

6.1.3 Cocaine

6.1.3.1 Non-fatal overdose

The number of cocaine overdose presentations to NSW emergency departments has become more variable since early-2013. During 2014/15, there were a total of 87 overdose presentations to NSW emergency departments

Figure 54: Cocaine overdose presentations to NSW emergency departments, January 2005–June 2015



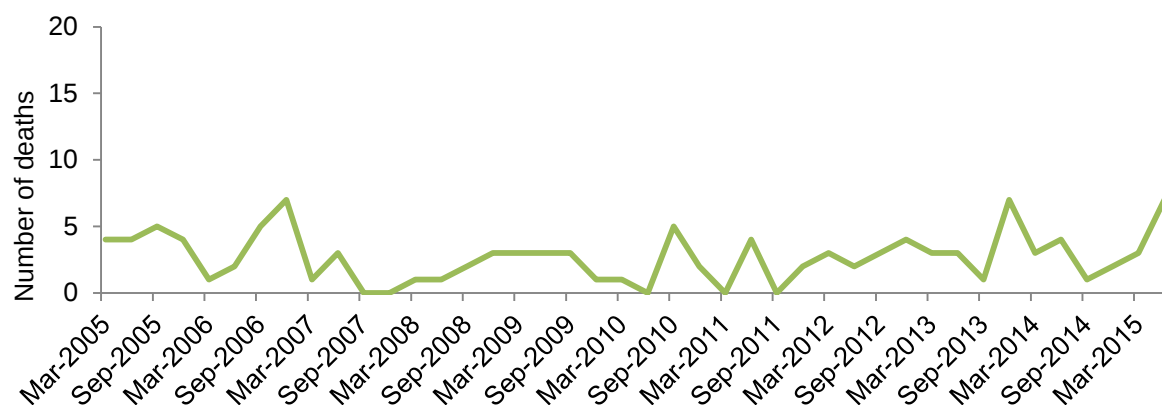
Source: Emergency Department Information System, NSW Ministry of Health

NB: Figures refer to overdose only and do not include presentations for use disorders

6.1.3.2 Fatal overdose

The number of suspected drug related deaths where cocaine was detected post-mortem has remained low over time (Figure 55).

Figure 55: Number of deaths of individuals suspected of drug use, in which cocaine was detected post-mortem, NSW, by quarter, March 2005–June 2015



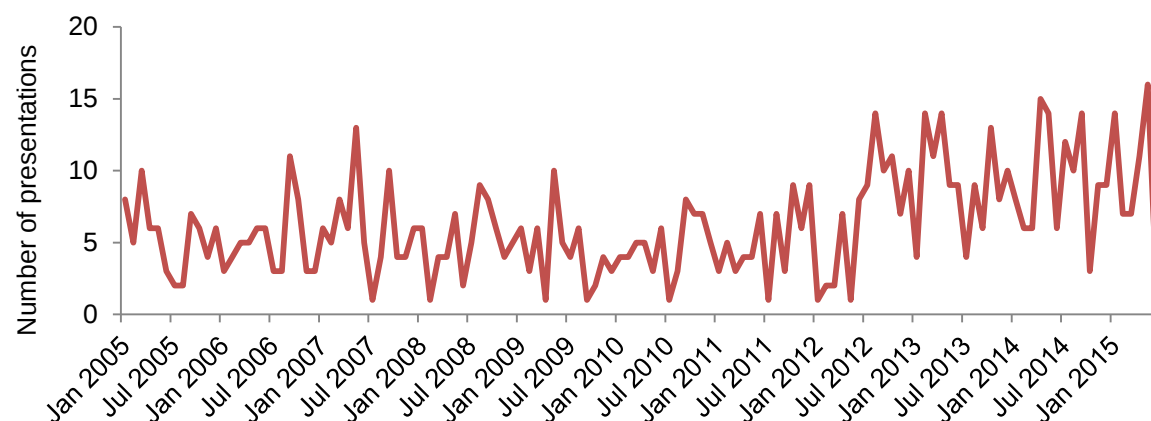
Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories, NSW Ministry of Health

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 relatively low; however, since mid-2012, presentations fluctuated at higher levels (Figure 56).

Figure 56: Cannabis toxicity presentations to NSW emergency departments, January 2005–June 2015



Source: Emergency Department Information System, NSW Ministry of Health

NB: Figures refer to overdose only and do not include presentations for use disorders

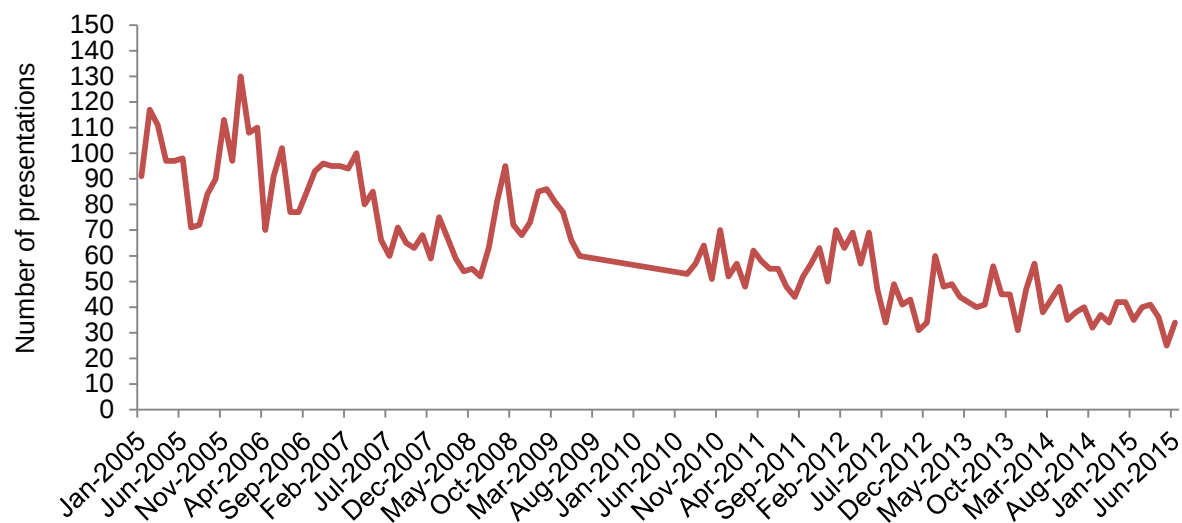
6.1.5 Benzodiazepines

6.1.5.1 Non-fatal overdose

The number of benzodiazepine overdose presentations to NSW emergency departments continues to decline over time (Figure 57).

Additional codes related to benzodiazepine overdose have been introduced with the introduction of the Systematized Nomenclature of Medicine (SNOMED) coding system. This may impact on the accuracy of data coding of these presentations.

Figure 57: Benzodiazepine overdose presentations to NSW emergency departments, January 2005–June 2015



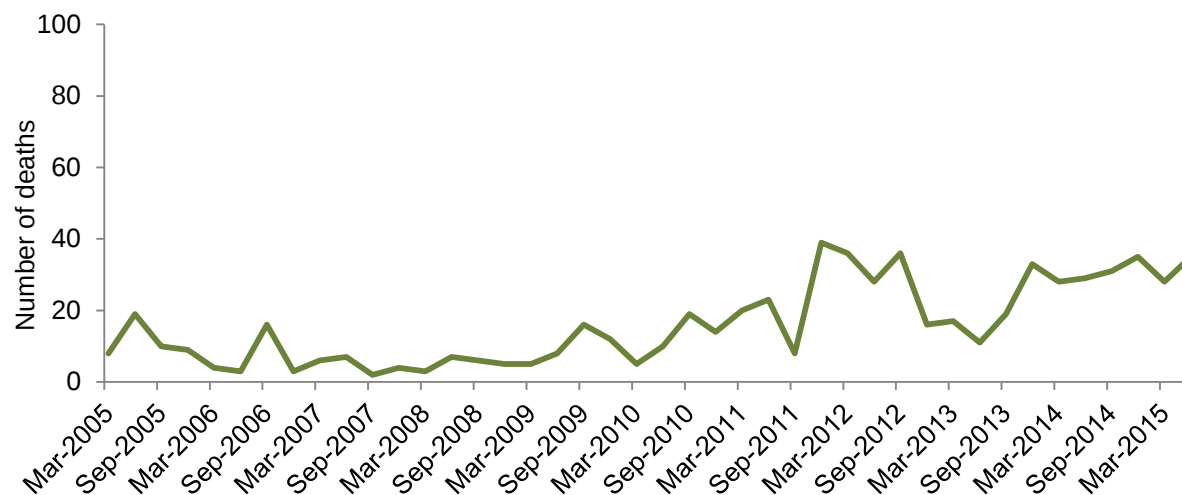
Source: Emergency Department Information System, NSW Ministry of Health

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, with an upward trend evident from 2012 onwards (Figure 58).

Figure 58: Number of deaths of individuals suspected of drug use, in which benzodiazepines were detected post-mortem, NSW, by quarter, March 2005–June 2015



Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories NSW Ministry of Health

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

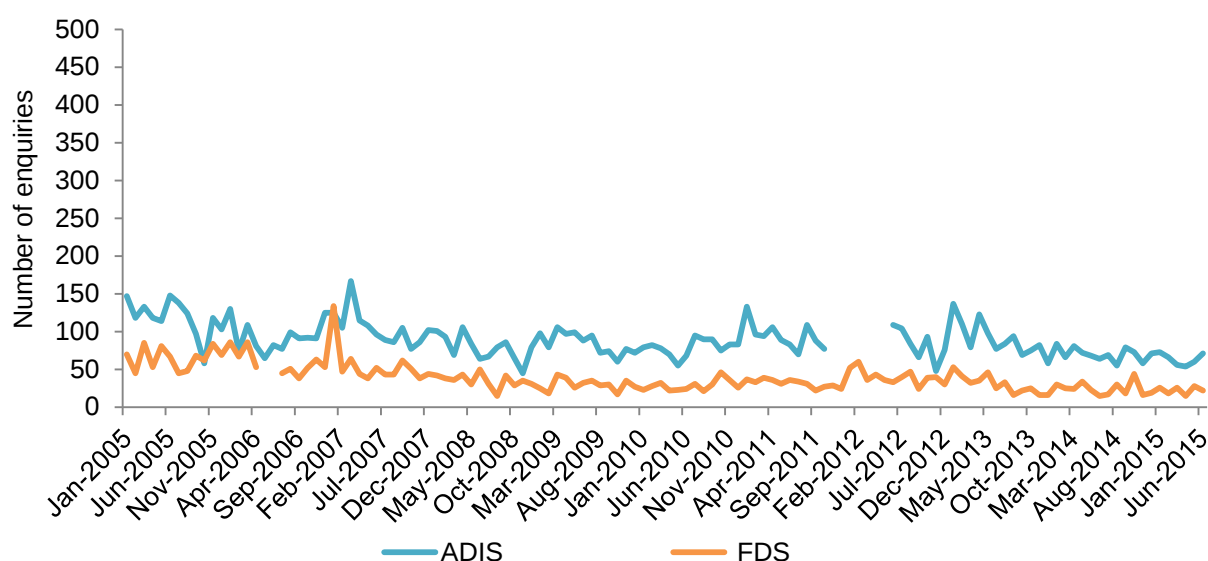
6.2.1 Heroin

Figure 59 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 over the past 12 months to June 2015, ranging between 54–79 calls a month for ADIS and 15–44 calls a month to FDS.

Figure 59: Number of enquiries to ADIS and FDS regarding heroin, January 2005–Jun 2015



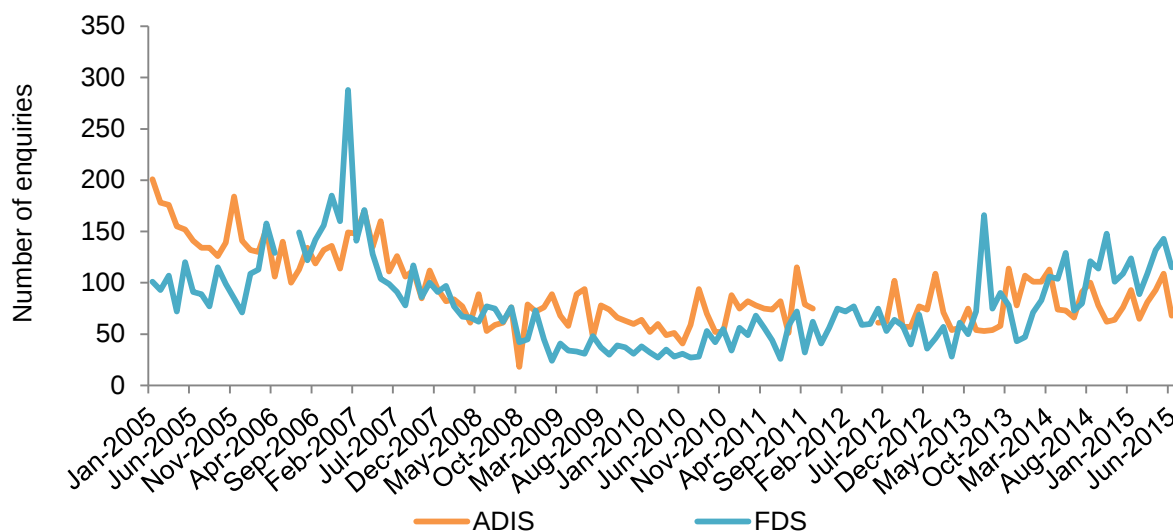
Source: NSW ADIS and FDS

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. Breaks in the data series represent time periods where data were unavailable. FDS data in 2012/13 has been estimated as only national totals were available.

6.2.2 Methamphetamine

Figure 60 shows the number of calls to the ADIS and FDS lines regarding methamphetamines. There has been an upward trend in these call in the past 12 months to June 2015 (ADIS range per month: 62–109; FDS range: 80–143).

Figure 60: Number of enquiries to ADIS and FDS regarding methamphetamines 2005–Jun 2015

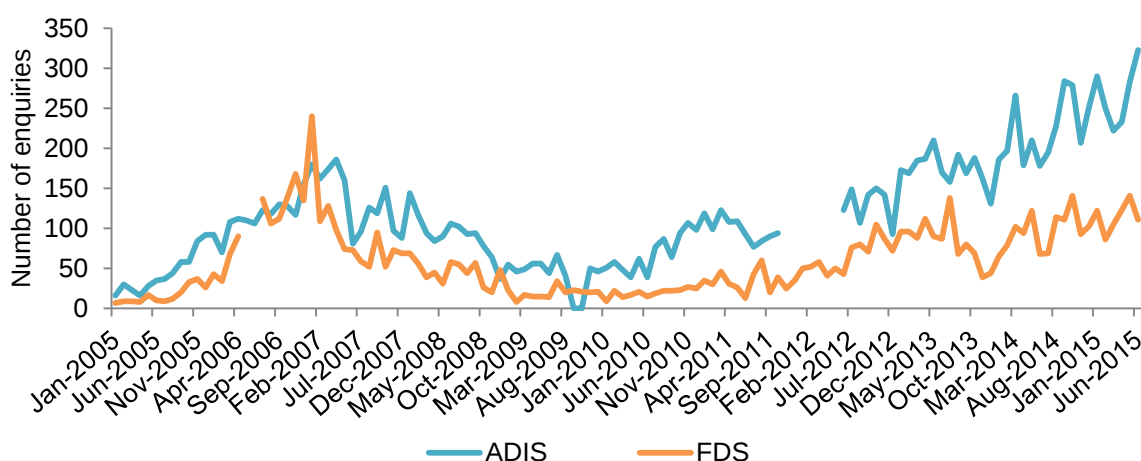


Source: NSW ADIS and FDS

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. Breaks in the data series represent time periods where data was unavailable. FDS data in 2012/13 has been estimated as only national totals were available.

Figure 61 shows the number of calls to the ADIS and FDS lines regarding crystal methamphetamine. Calls to both services for crystal methamphetamine have been increasing since 2012.

Figure 61: Number of enquiries to ADIS and FDS regarding crystal methamphetamine, January 2005–June 2015



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. Breaks in the data series represent time periods where data were unavailable. FDS data in 2012/13 has been estimated as only national totals were available.

Figure 62 shows the number of calls to the ADIS and FDS lines regarding cocaine. Calls to FDS appear to have remained relatively stable from mid-2012 and there has been a gradual upward trend in the number of ADIS calls from mid-2012.

The graph displays the monthly number of enquiries for two services, ADIS and FDS, over a ten-year period. The Y-axis, labeled 'Number of enquiries', ranges from 0 to 100 in increments of 10. The X-axis represents time, with labels every three months from Jan-2005 to Jun-2015. The ADIS line (blue) starts at approximately 50 enquiries in Jan-2005, fluctuates, and reaches a peak of about 75 in early 2007. It then generally declines but remains higher than FDS, with another notable peak of around 60 in early 2015. The FDS line (orange) starts lower, around 25 enquiries, and shows more frequent and sharper fluctuations. It peaks at approximately 42 in early 2012 and ends at about 20 enquiries in Jun-2015. Both services show a similar seasonal pattern, with peaks occurring roughly every 12-18 months.

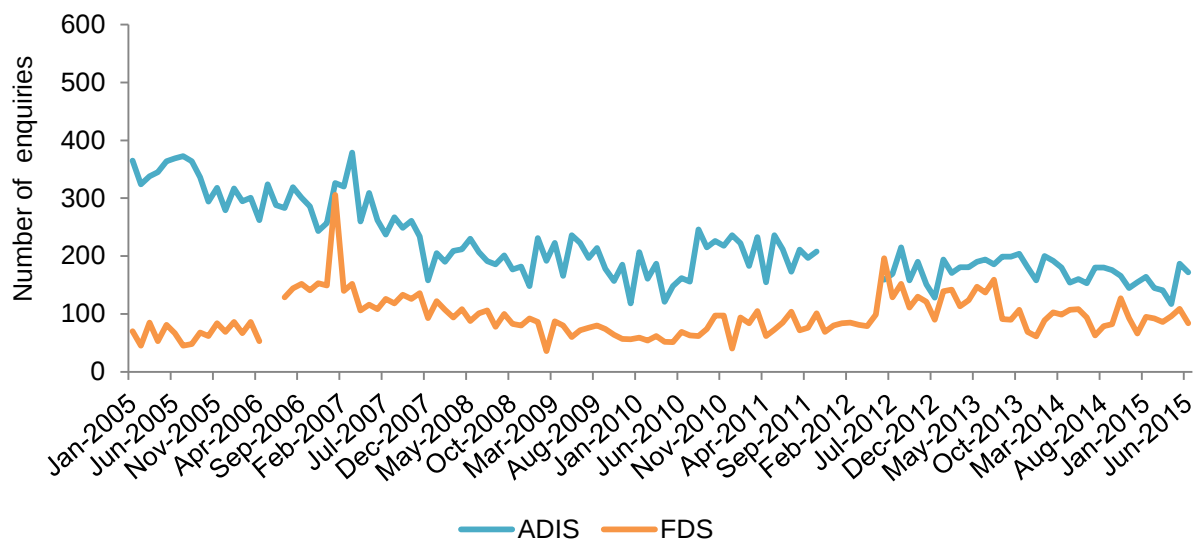
Date	ADIS	FDS
Jan-2005	50	25
Jul-2005	30	28
Jan-2006	42	28
Jul-2006	25	18
Jan-2007	48	25
Jul-2007	75	28
Jan-2008	35	15
Jul-2008	20	10
Jan-2009	40	15
Jul-2009	25	10
Jan-2010	45	15
Jul-2010	20	10
Jan-2011	35	15
Jul-2011	20	10
Jan-2012	42	42
Jul-2012	25	15
Jan-2013	52	15
Jul-2013	30	10
Jan-2014	50	15
Jul-2014	25	10
Jan-2015	60	20
Jun-2015	30	20

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. Breaks in the data series represent time periods where data were unavailable. FDS data in 2012/13 has been estimated as only national totals were available.

6.2.4 Cannabis

The number of calls to ADIS and FDS regarding cannabis has remained relatively stable in the 12 months to June 2015 (Figure 63).

Figure 63: Number of enquiries to ADIS and FDS regarding cannabis, January 2005–June 2015



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. Breaks in data represent time periods where data were unavailable. FDS data in 2012/13 has been estimated as only national totals were available.

6.3 Drug treatment

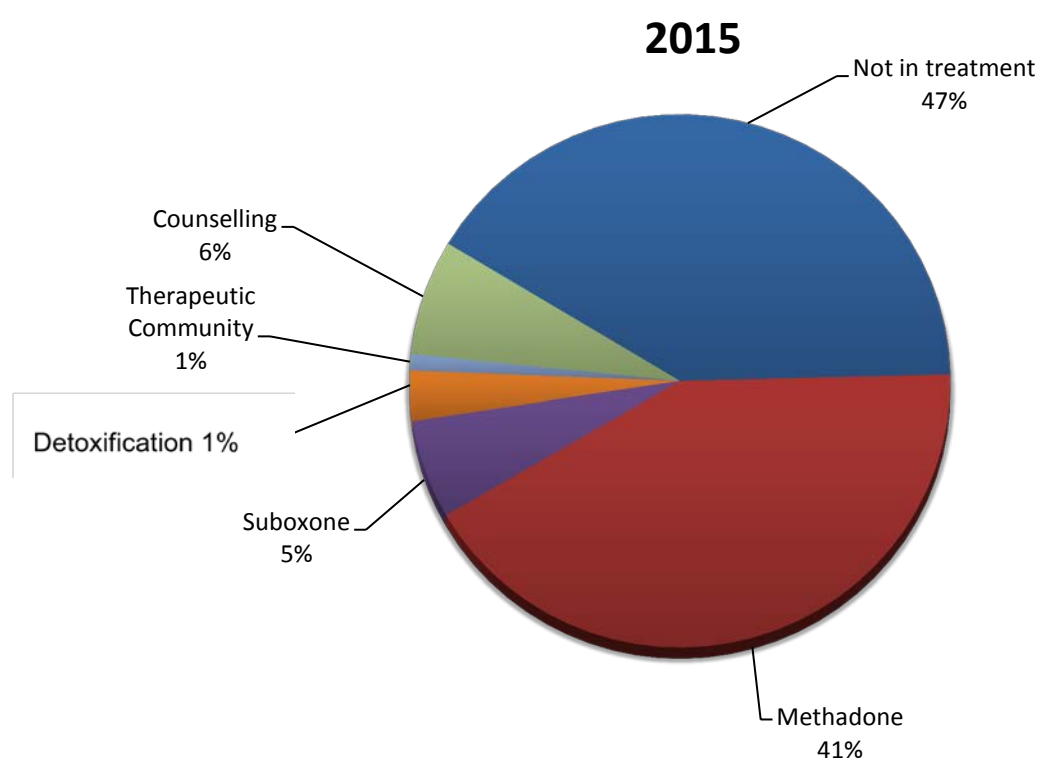
6.3.1 Forms of treatment

Sixty-four percent of participants were in some form of treatment at the time of interview (51% of in 2014).

Of those currently in drug treatment, the vast majority (98%) reported being currently in a form of OST. Almost two thirds (63%) of those currently on OST received methadone, 11% buprenorphine-naloxone (Suboxone) and 1% buprenorphine (Subutex). Those currently in treatment had been in that treatment for a median of 24 months (i.e. two years).

Fifty three percent of all participants had been in some form of treatment in the past six months. Of those in treatment, 86% had been on methadone maintenance treatment (MMT), and 11% had been on buprenorphine-naloxone (Suboxone) treatment. Smaller numbers of participants reported accessing other treatments over the past six months including; drug counselling (13%), detoxification (6%) and therapeutic communities (3%). There were no reports of naltrexone treatment or of any participants accessing Narcotics or Alcoholics Anonymous in the six months prior to interview (**Figure 64**).

Figure 64: Proportion of participants reporting any form of drug treatment in last 6 months, 2015



Source: IDRS PWID interviews

NB: More than one form of treatment could be nominated

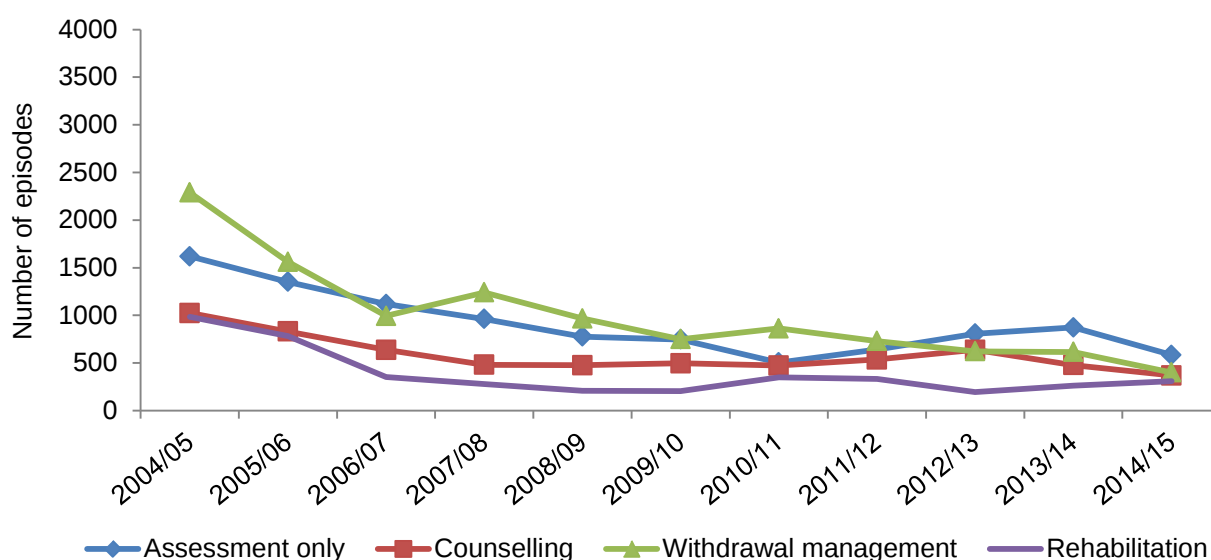
6.3.2 Treatment for heroin use

Figure 65 shows the number of closed treatment episodes based on the date of commencement by treatment type where heroin was the principal drug of concern. Opioid substitution treatment is not included.

All forms of heroin treatment, except residential rehabilitation have declined between 2004/05 and 2014/15.

These data are based on closed treatment episodes and episodes may be excluded if not completed in the time period.

Figure 65: Number of heroin treatment episodes by treatment type, NSW 2004/05–2014/15



Source: NSW Minimum Data Set (NSW MDS) for Alcohol and other Drug Treatment Services (AODTS), NSW Ministry of Health.

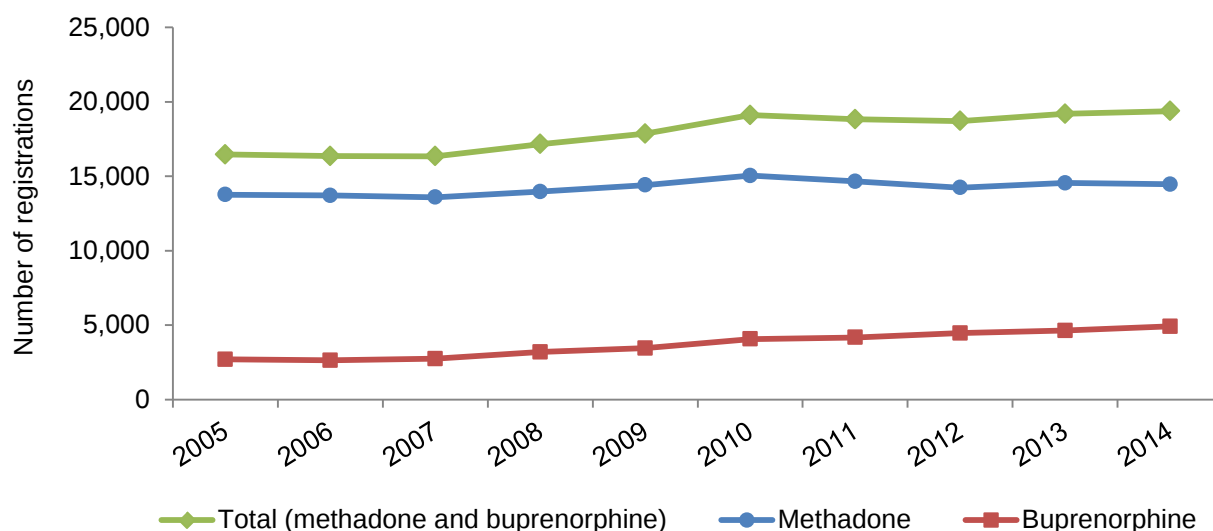
NB: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement.

Figure 66 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 19,381 on the 30th June 2014. Over the past 12 months to June 2014 there was a slight increase in the numbers enrolled (from 19,197 in 2013).

The majority (69%) of opioid pharmacotherapy clients received methadone. The number of people receiving buprenorphine has increased since its introduction in 2000. As of June 2014, 34% (825) of Australia's 2,432 pharmacotherapy sites were located in NSW and were dosing 20,850. The vast majority (85%) of these sites (700) were pharmacies, with smaller numbers of other site types recorded. The number of public clinics (36) remained unchanged in NSW to June 2014.

Just over half (52%) of opioid pharmacotherapy clients obtained their treatment through a private provider, 24% received it through a public prescriber, and 7% within correctional facilities (Australian Institute of Health and Welfare, 2015).

Figure 66: Number of registrations for opioid substitution treatment on the 30th June each year, NSW, 2005–2014



Source: (Australian Institute of Health and Welfare, 2015)

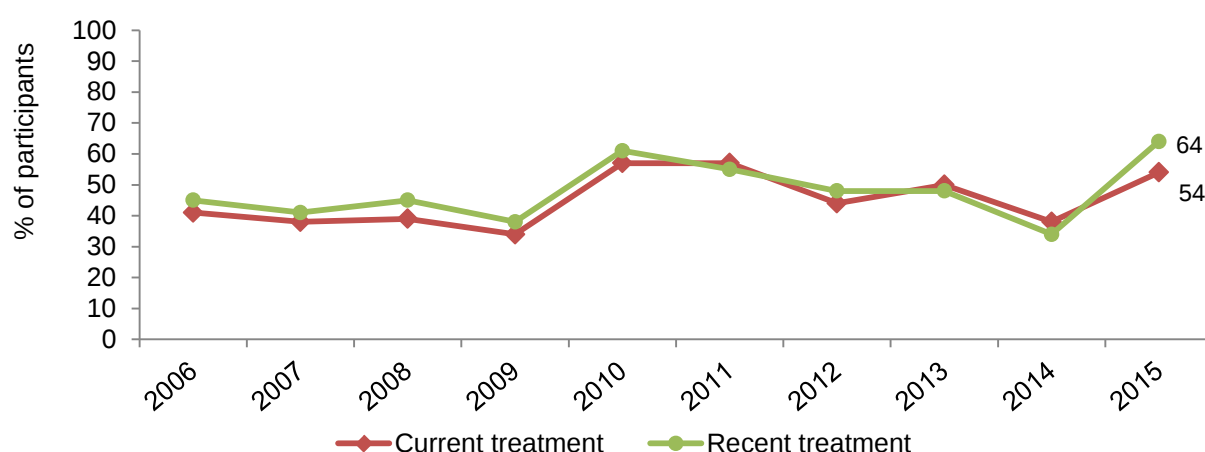
NB: Buprenorphine pharmacotherapy was introduced in NSW in 2000. In NSW, unlike all other jurisdictions, clients prescribed buprenorphine/naloxone (Suboxone) are counted under buprenorphine.

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.

Over half (54%) of participants reported currently being in methadone treatment and using methadone that had been prescribed to them in the preceding six months (Figure 68) (38% in 2014). Smaller proportions (11% reported injecting prescribed methadone during this time. The median amount of time on methadone treatment among those currently in treatment was 27 months (range 1 month to 33 years). No participants reported recent use of prescribed Physeptone tablets. Sixty-four percent of PWID reported receiving methadone treatment at some point in the preceding six months (recent treatment) (34% in 2014). As in previous years, methadone syrup was the predominant form of OST used.

Figure 67: Proportion of participants reporting methadone treatment, 2006–2015



Source: IDRS PWID interviews

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. Regular injecting drug use is a requirement for participation in the IDRS survey. As a consequence, PWID who report being in treatment may not be representative of treatment populations more generally, particularly people who cease injecting drug use and/or illicit drug market activity once engaged in treatment.

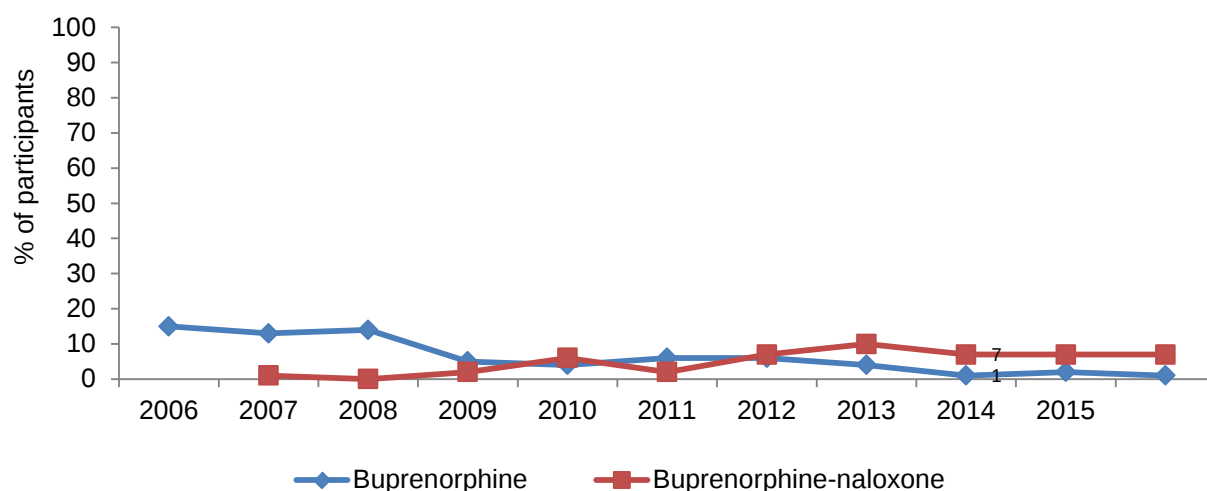
6.3.4 Buprenorphine treatment (including buprenorphine-naloxone)

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 under one-third (30%) of the sample reported ever having been prescribed buprenorphine (Subutex). Two participants (1%) reported using it in the preceding six months (3 participants in 2014). The two participants had been in treatment for 3 months and 2.3 years respectively.

In the last six months, one percent of participants had used prescribed buprenorphine-naloxone tablets and 8% prescribed buprenorphine-naloxone sublingual film. Seven percent stated they were currently participating in buprenorphine-naloxone treatment. The median number of days in buprenorphine-naloxone treatment among those currently in treatment was 24 months (range 2 months to 8 years). One participant reported recent injection of prescribed buprenorphine-naloxone in its tablet form and two participants reported recent injection of buprenorphine-naloxone in its film form. Small numbers commented and data should be interpreted with caution.

Figure 68: Proportion of participants reporting current buprenorphine treatment, 2006–2015



Source: IDRS PWID interviews

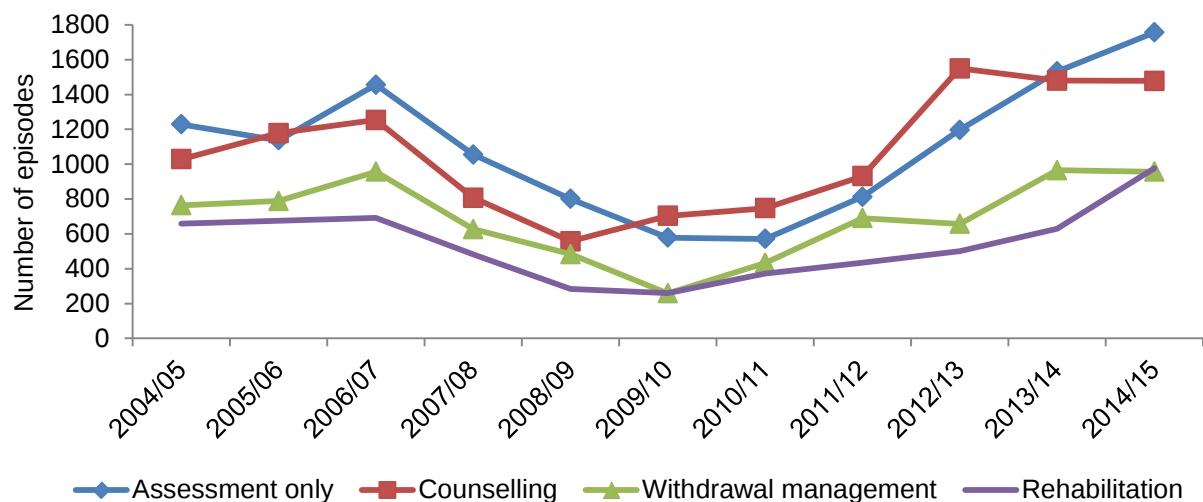
NB: Buprenorphine-naloxone (Suboxone) item first included in 2006

6.3.5 Methamphetamine treatment

There has been increasing numbers of closed treatment episodes where the principal drug of concern was amphetamines in the past 12 months (Figure 69).

Numbers are higher than the last increase seen in 2006/07, when amphetamine related episodes were the highest over the last decade.

Figure 69: Number of amphetamine treatment episodes by treatment type, NSW, 2004/05–2014/15



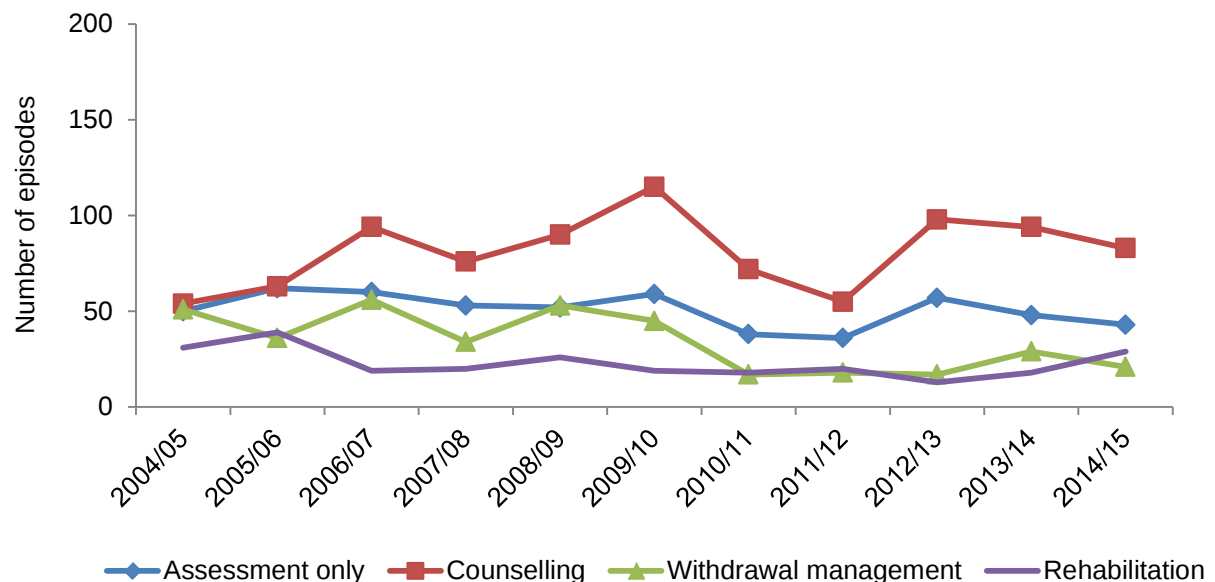
Source: NSW MDS AODTS, NSW Ministry of Health

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

The number of closed treatment episodes where cocaine was the principal drug of concern has remained relatively low and stable in the 12 months to June 2015 for all forms of treatment except counselling. There has been a higher number of episodes for counselling since 2011/12 (Figure 71).

Figure 70: Number of cocaine treatment episodes by treatment type, NSW, 2004/05–2014/15



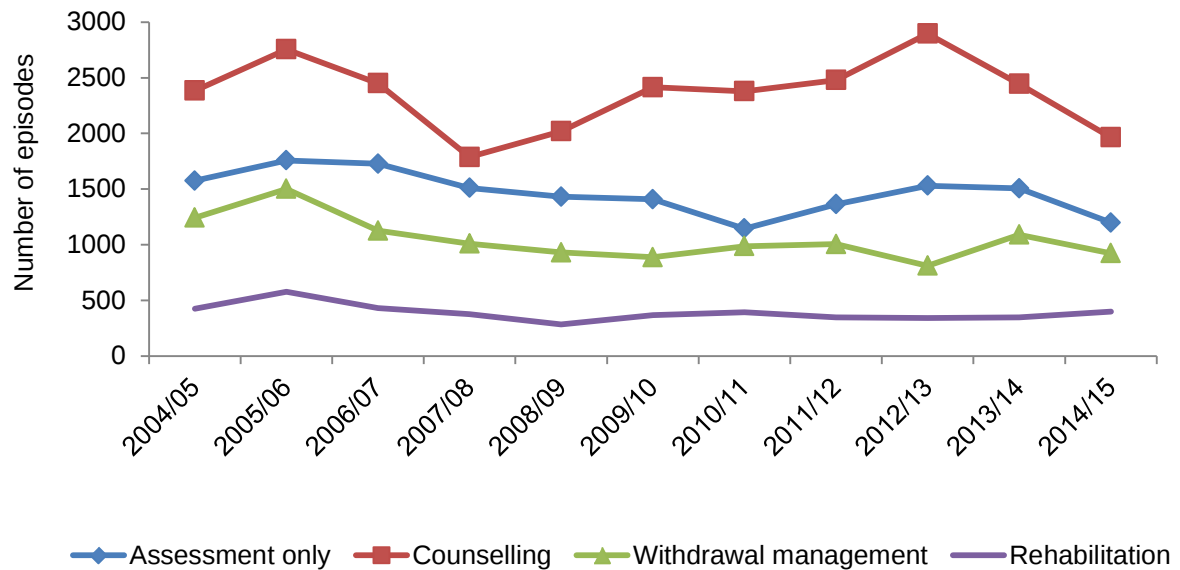
Source: NSW MDS AODTS, NSW Ministry of Health

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 71 shows the number of closed treatment episodes by treatment type where the principal drug of concern was cannabis. After peaking in 2012/13, numbers entering for counselling have declined.

Figure 71: Number of cannabis treatment episodes by treatment type, NSW, 2004/05–2014/15



Source: NSW MDS AODTS, NSW Ministry of Health

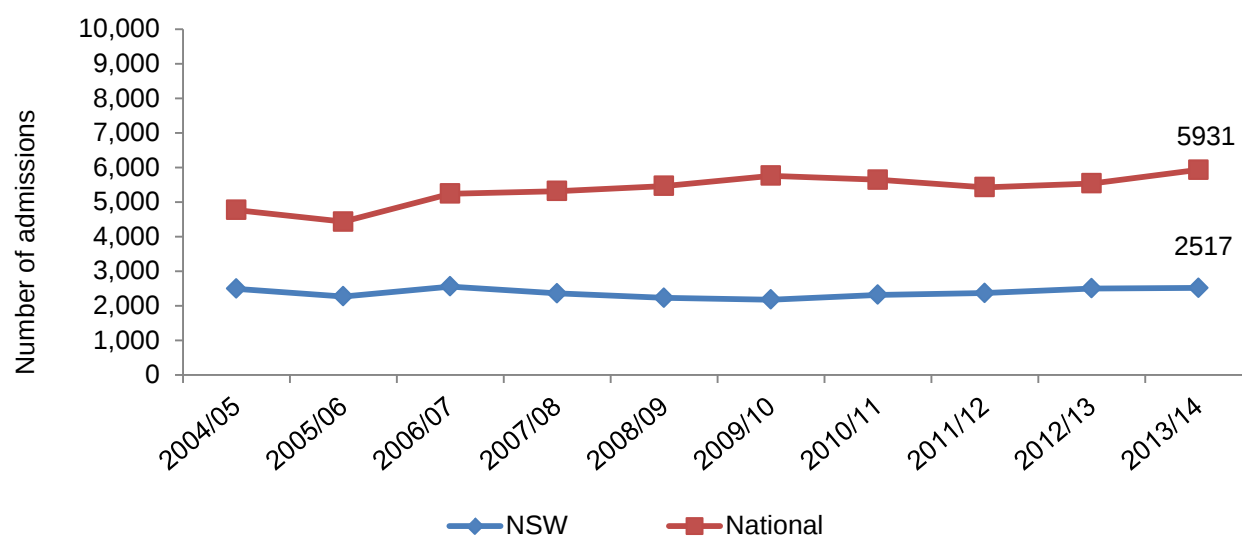
NB: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement

6.4 Hospital admissions

6.4.1 Opioids

The number of opioid-related hospital admissions (where opioid-related problems were recorded as the principal diagnosis) has remained stable in NSW over the past 10 years (Figure 72). National figures have trended upwards slightly in 2013/14, as there have been increases in other jurisdictions. Admissions include heroin and other opioids such as morphine, oxycodone and fentanyl.

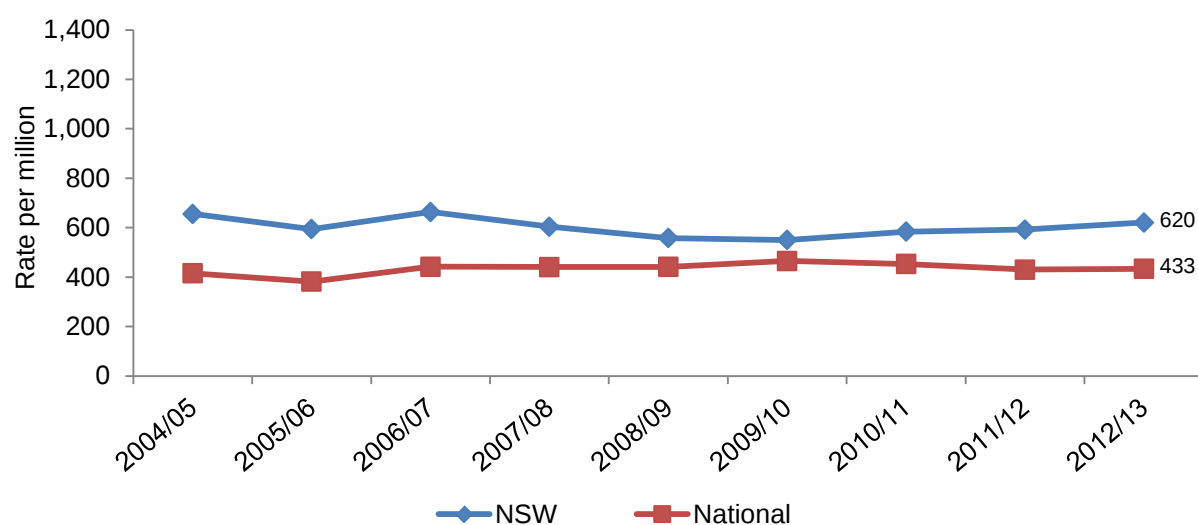
Figure 72: Number of principal opioid-related hospital admissions among people aged 15–54, NSW and Australia, 2004/05–2013/14



Source: AIHW, NSW Ministry of Health, A. Roxburgh and Burns (in press)

Figure 73 shows the rates per million persons aged 15–54 years of opioid-related hospital admissions.

Figure 73: Rates per million persons of principal opioid-related hospital admissions among people aged 15–54 years, NSW and nationally, 2004/05–2013/14

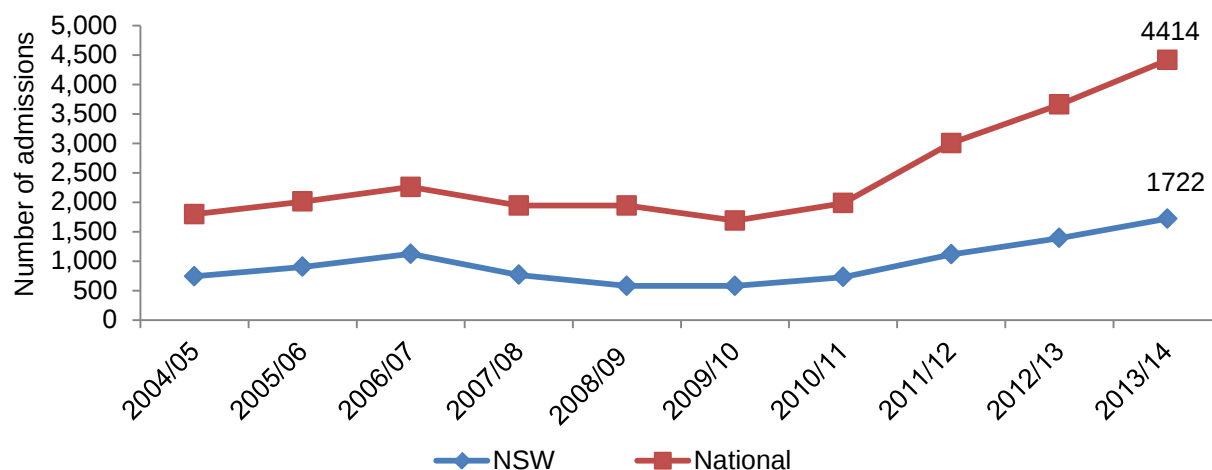


Source: AIHW, NSW Ministry of Health, A. Roxburgh and Burns (in press)

6.4.2 Methamphetamine

The number of amphetamine-related hospital admissions (where amphetamine-related problems were recorded as the principal diagnosis) has steadily increased in NSW (and nationally) over the past 4 years (Figure 75).

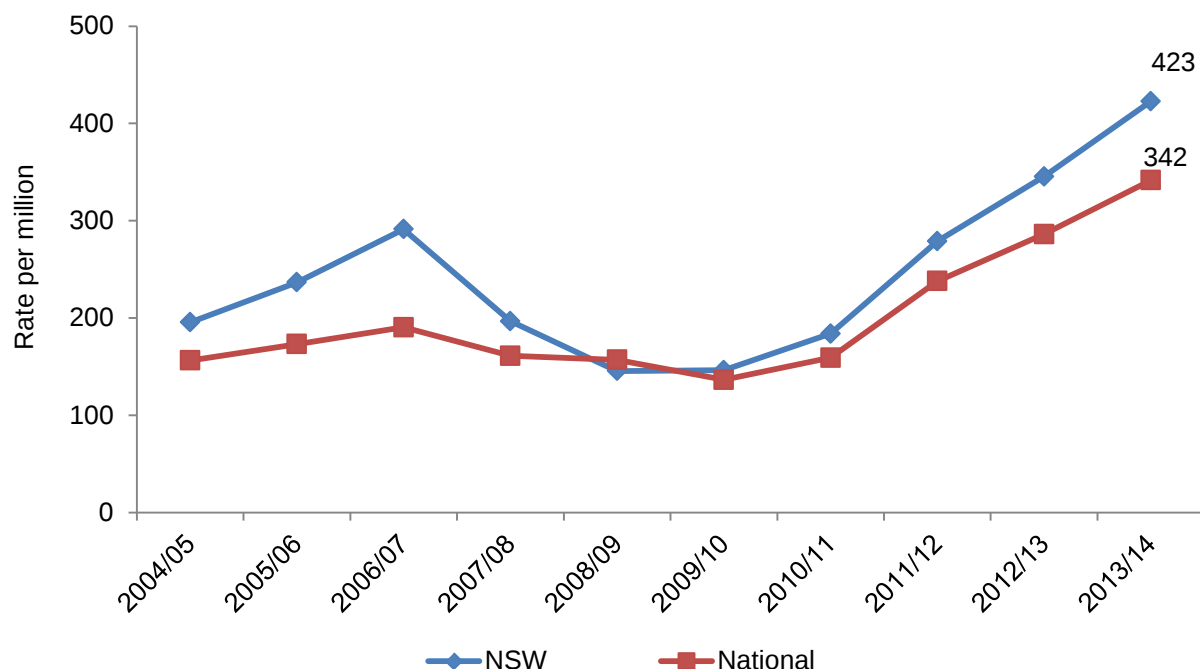
Figure 74: Number of principal amphetamine-related hospital admissions among persons aged 15–54, NSW and nationally, 2004/05–2013/14



Source: AIHW, NSW Ministry of Health, A. Roxburgh and Burns (in press)

Figure 75 shows the rates per million persons of amphetamine-related hospital admissions.

Figure 75: Rates per million persons of principal amphetamine-related hospital admissions among people aged 15–54 years, NSW and nationally, 2004/05–2013/14

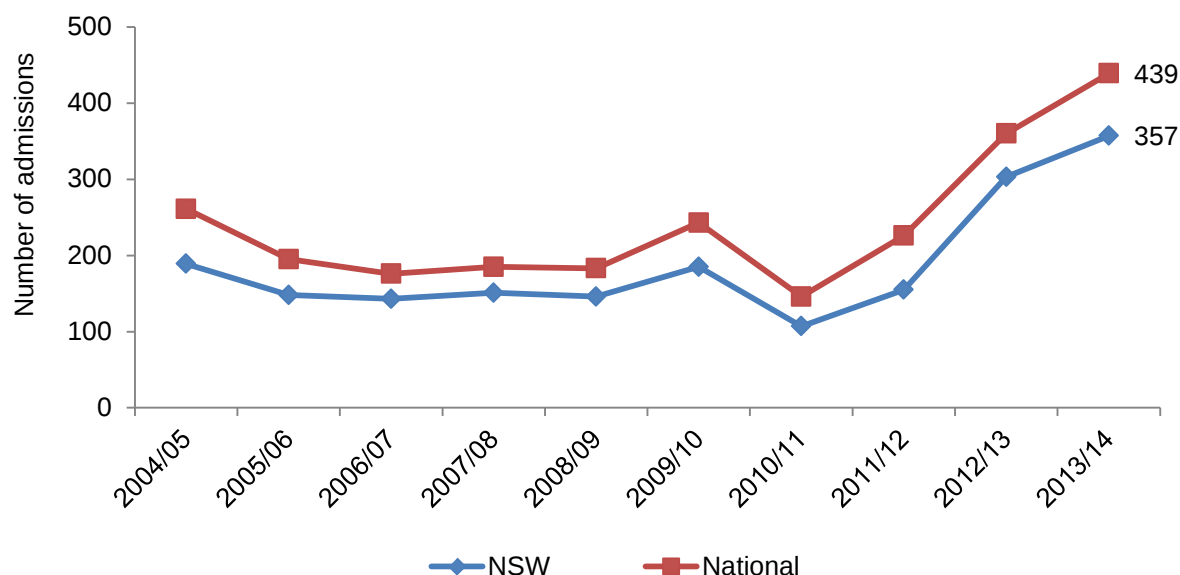


Source: AIHW, NSW Ministry of Health, A. Roxburgh and Burns (in press)

6.4.3 Cocaine

The numbers of cocaine-related hospital admissions (where cocaine-related problems were recorded as the principal diagnosis) have steadily increased in NSW over the past 3 years and comprise the majority (81%) of cocaine-related admissions at a national level (Figure 76).

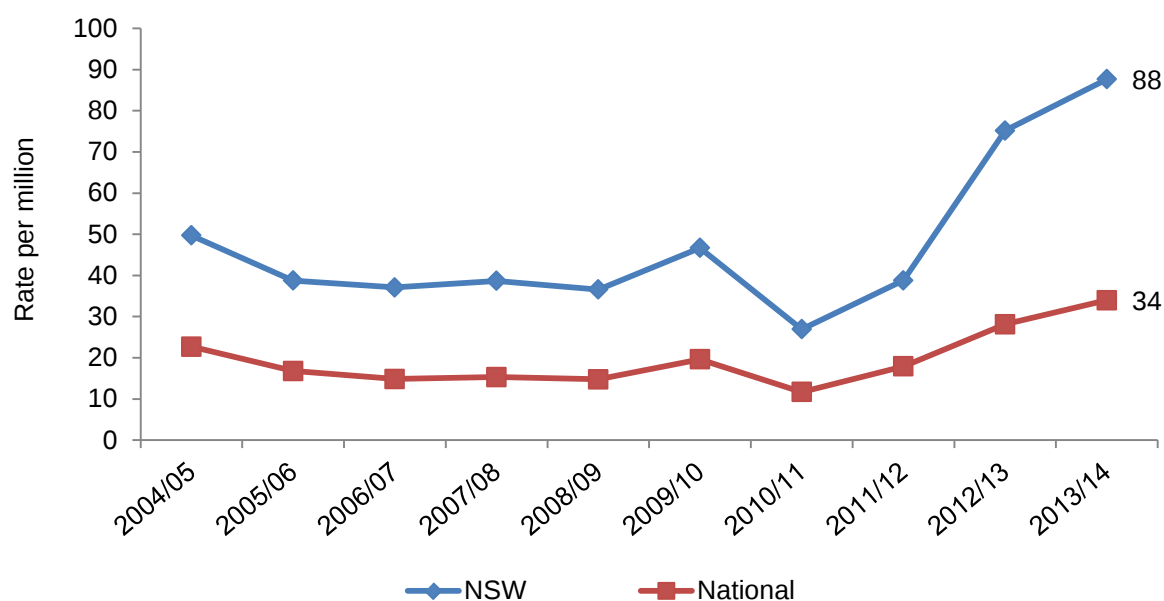
Figure 76: Number of principal cocaine-related hospital admissions among persons aged 15–54, NSW and nationally, 2004/05–2013/14



Source: AIHW, NSW Ministry of Health, A. Roxburgh and Burns (in press)

Figure 78 shows the rates per million persons of cocaine-related hospital admissions.

Figure 77: Rates per million persons of principal cocaine-related hospital admissions among people aged 15–54 years, NSW and nationally, 2004/05–2013/14

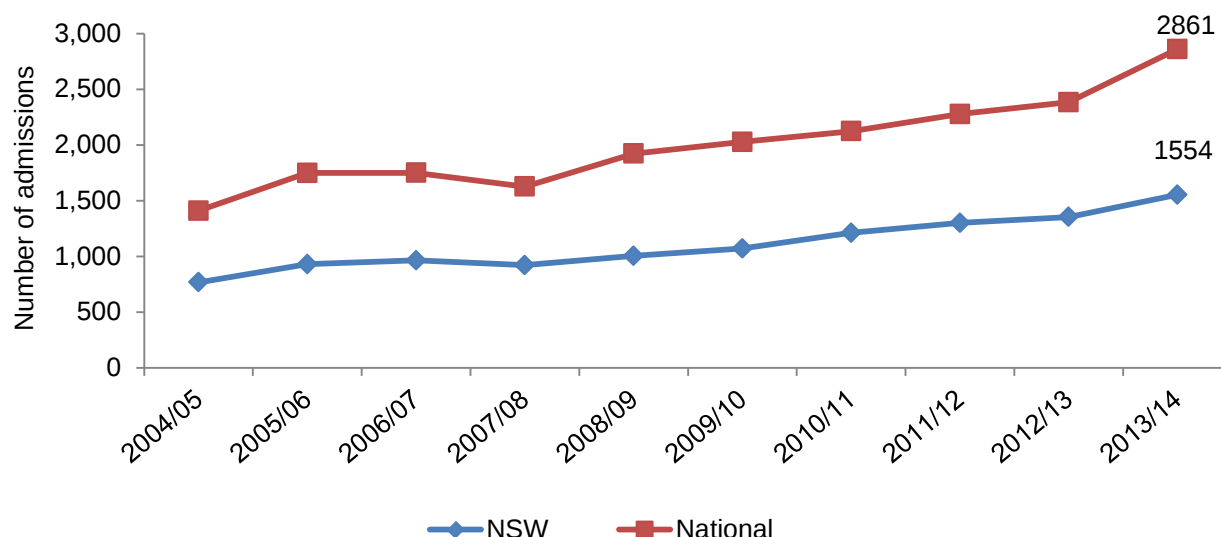


Source: AIHW, NSW Ministry of Health, A. Roxburgh and Burns (in press)

6.4.4 Cannabis

The number of cannabis-related hospital admissions (where cannabis-related problems were recorded as the principal diagnosis) has steadily increased in NSW and nationally over the past 10 years (Figure 78).

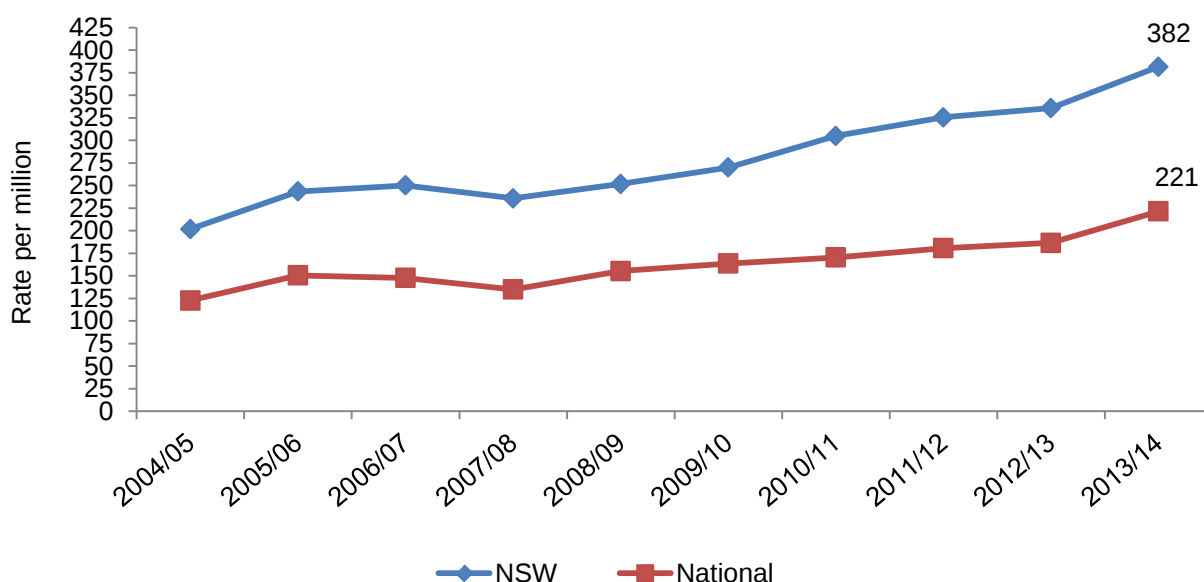
Figure 78: Number of principal cannabis-related hospital admissions among persons aged 15–54, NSW and nationally, 2004/05–2013/14



Source: AIHW, NSW Ministry of Health, A. Roxburgh and Burns (in press)

Figure 79 shows the rates per million persons of cannabis-related hospital admissions.

Figure 79: Rates per million persons of principal cannabis-related hospital admissions among people aged 15–54 years, 2004/05–2013/14



Source: AIHW, NSW Ministry of Health, A. Roxburgh and Burns (in press)

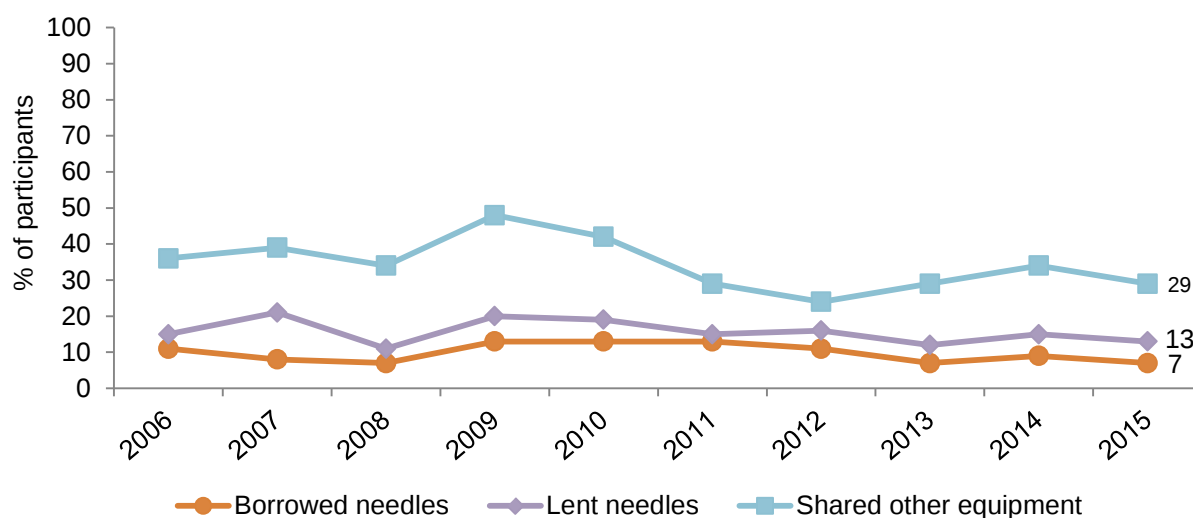
6.5 Injecting risk behaviours

6.5.1 Sharing of injecting equipment by PWID participants

In 2015, 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 Needle and Syringe Program (NSP) outlets. It is important to note that this number may also be high due to the method of IDRS recruitment via advertisements at NSP sites. Two-fifths (42%) of all participants reported they obtained needles and/or syringes from an NSP vending machine. The third most popular source was from a chemist/pharmacy (22%), followed by friends (16%) and hospitals (16%). Other sources reported included outreach/peer worker (10%), their dealer (6%), or partner (4%).

In line with previous data, 99% of participants reported that they had injected on at least one occasion in the month preceding interview. Seven percent of these participants reported using a needle that had already been used by someone else ('borrowed needle'). This remained stable with 9% of participants who reported this in 2014 and 7% in 2013 (Figure 80). Fourteen percent of those who had injected in the last month reported passing needles on to other PWID ('lent needle') in 2015 (15% in 2014). Twenty-nine percent of all participants reported sharing injecting equipment (other than needles) with someone else.

Figure 80: Proportion of PWID reporting sharing injecting equipment in the month preceding interview, 2006–2015



Source: IDRS PWID interviews

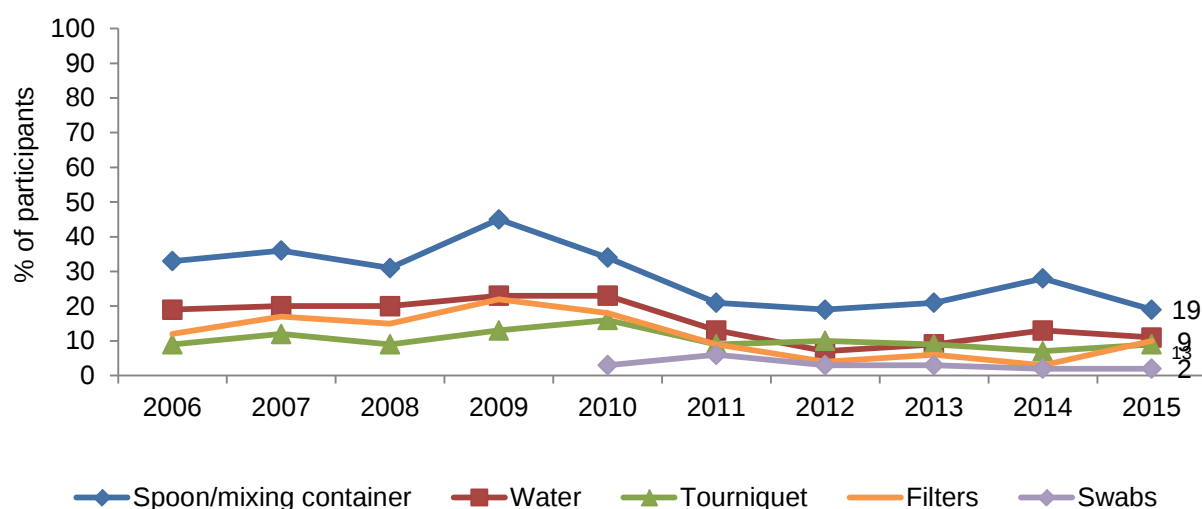
NB: Survey items on other injecting equipment (including spoons, water, filters and tourniquets) were first included in 1999. Figure excludes participants who had not injected in the last month (2005 n=4; 2006 n=1; 2007 n=2; 2008 n=2; 2012 n=1; 2013 n=2). In 2009 (n=152), 2010 (n=154), 2011 (n=150), 2014 (n=150) and 2015 (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. Twenty-nine percent reported sharing a filter, spoon, water, tourniquet and/or other item of injecting paraphernalia in the month preceding interview (34% in 2014).

Figure 81 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 (67%; 19% of entire sample), followed by 'water' (40%), filters (35%), tourniquets (33%) and swabs and wheel filters (7%).

Overall these figures are consistent with 2014.

Figure 81: Proportion of PWID participants reporting sharing other injecting equipment by type, 2006–2015



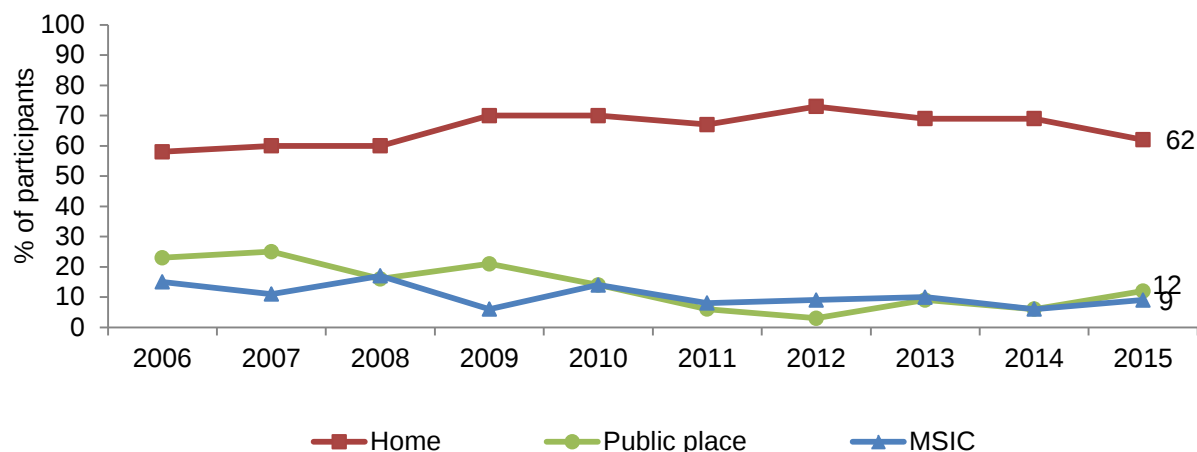
Source: IDRS PWID interviews

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; 2015 n=2). 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 injection

The most commonly reported location for last injection remained at a private home (62%; 69% in 2014). Twelve percent reported a 'street/park', 9% reported Sydney MSIC (6% in 2014) and a further 8% reported a public toilet as the location of their most recent injection (Figure 82).

Figure 82: Last location for injection, 2006–2015



Source: IDRS PWID interviews

NB: Excludes those who had not injected in the last month (2006 n=1; 2007 n=2; 2008 n=2; 2012 n=1; 2013 n=1; 2014 n=149; 2015 n=3). 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

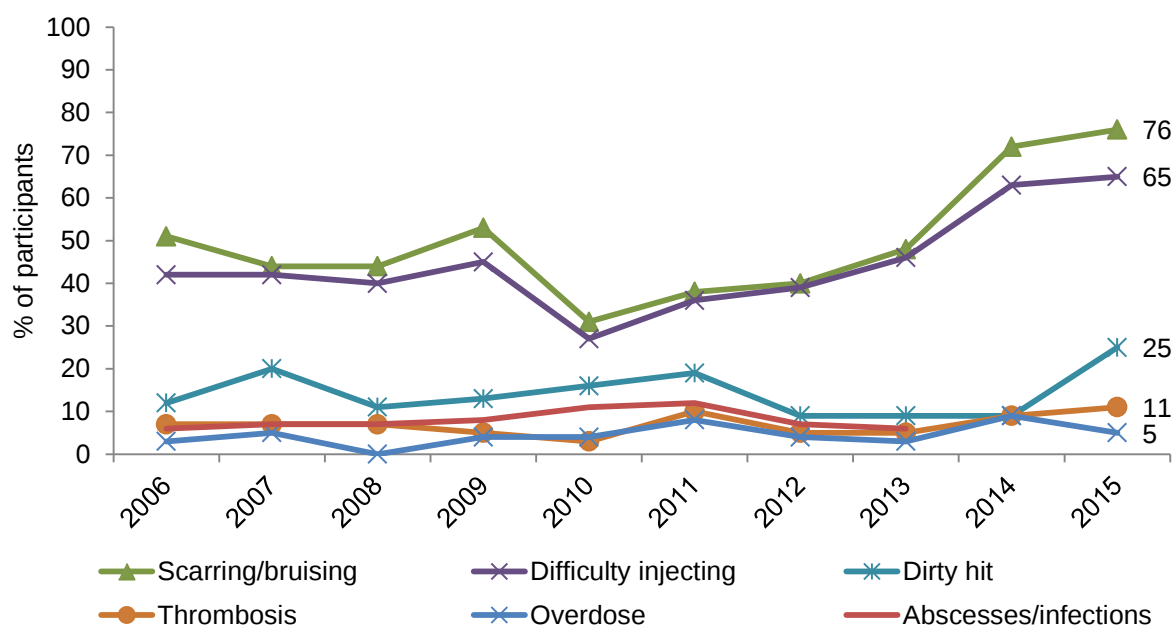
Participants were asked questions about the site on their body where they had last injected. Seventy-two percent of participants reported that they last injected in their 'arm'. Nine percent of participants reported last injecting in their 'hand or wrist', 7% reported last injecting in their 'leg', 5% reported their 'neck', 3% reported their 'groin' and 2% reported their 'foot'. This remained stable from 2014.

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. Sixty-six percent of all PWID participants who had injected in the last month reported at least one injection-related problem during this time (55% in 2014). As in previous years, the most commonly reported problems were prominent scarring/bruising of injection sites (76%) and difficulty injecting (65%). Significantly more participants ($p<0.01$) reported experiencing a 'dirty hit' when compared with the previous year (25% in 2015 compared with 15% in 2014). Thirteen percent reported they had abscesses/infections from injecting, 11% reported thrombosis and 5% reported overdosing in the month preceding interview.

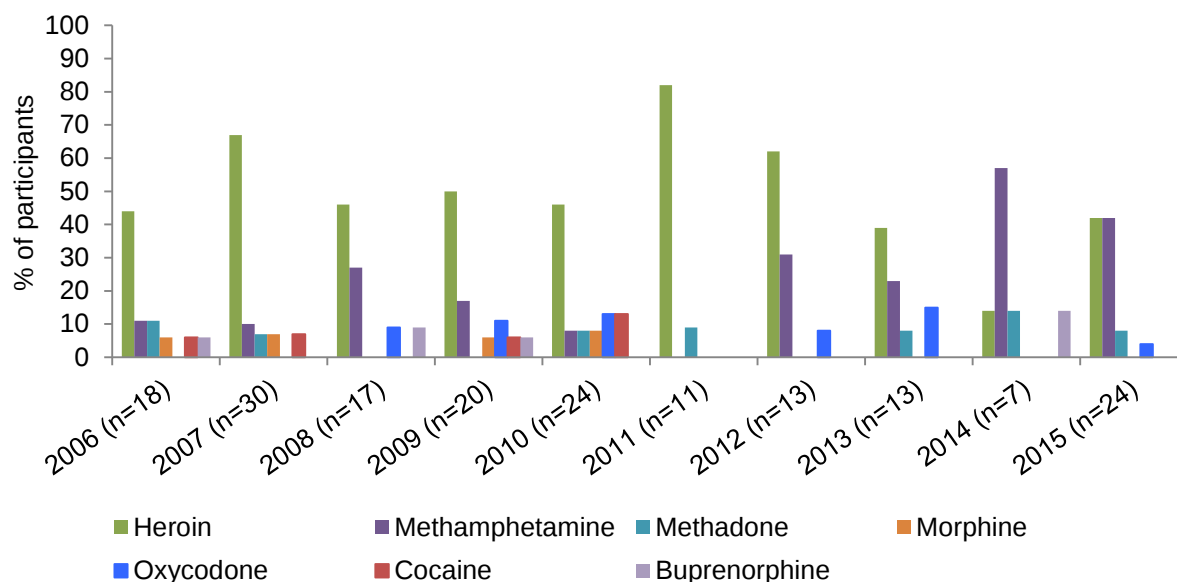
Figure 83 shows that while the proportion reporting prominent 'scarring or bruising' has remained the most commonly reported injection-related problem since 1997 (with the exception of 2005), since 2007 the issue of having 'difficulty injecting' has risen to almost equal levels in proportion of prevalence reported. Reports of thrombosis and abscesses/infections have continued to remain low and relatively stable. For the past 12 years overdose has remained the least commonly reported injection-related problem and this continued in 2015. For further information on overdose, see also section 6.1 'Overdose and drug-related fatalities'.

Figure 83: Proportion of PWID reporting injection-related problems in past month, by problem type, 2006–2015



Source: IDRS PWID interviews
NB: Includes all participants

Figure 84: Main drug causing dirty hit in last month, 2006–2015



Source: IDRS PWID interviews

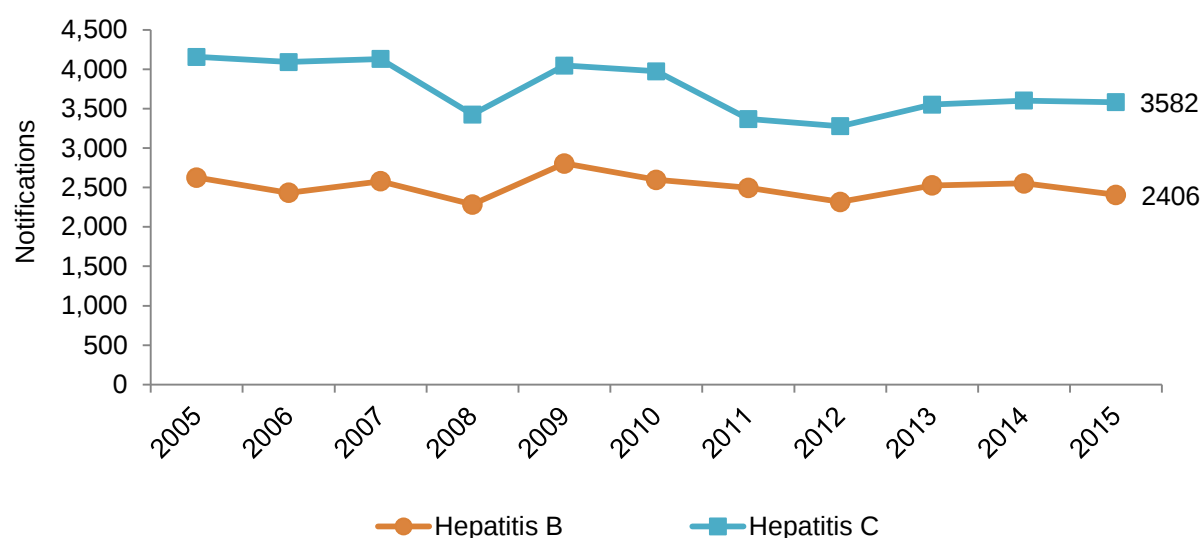
As with overdose, participants who had experienced a ‘dirty hit’ in the last month were asked what they considered to have been the main drug they would attribute it to, and whether they had been using any other drugs at the time (polydrug use). Equal numbers of participants who had experienced a dirty hit (n=24) attributed it to methamphetamine and heroin (Figure 84). In some years small number (n<10) responded and data should be interpreted 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 see the Australian NSP Survey (Iversen & Maher, 2015).

(Figure 85) 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, remaining stable in 2015 (3,582 notifications versus 3,603 in 2014). HBV notifications have also remained relatively stable (2,406 notifications versus 2,553 in 2014). Notifications for both HCV and HBV still remained lower than levels reported in 2009.

Figure 85: Total notifications for (unspecified and incident) HBV and HCV infections, NSW, 2005–2015



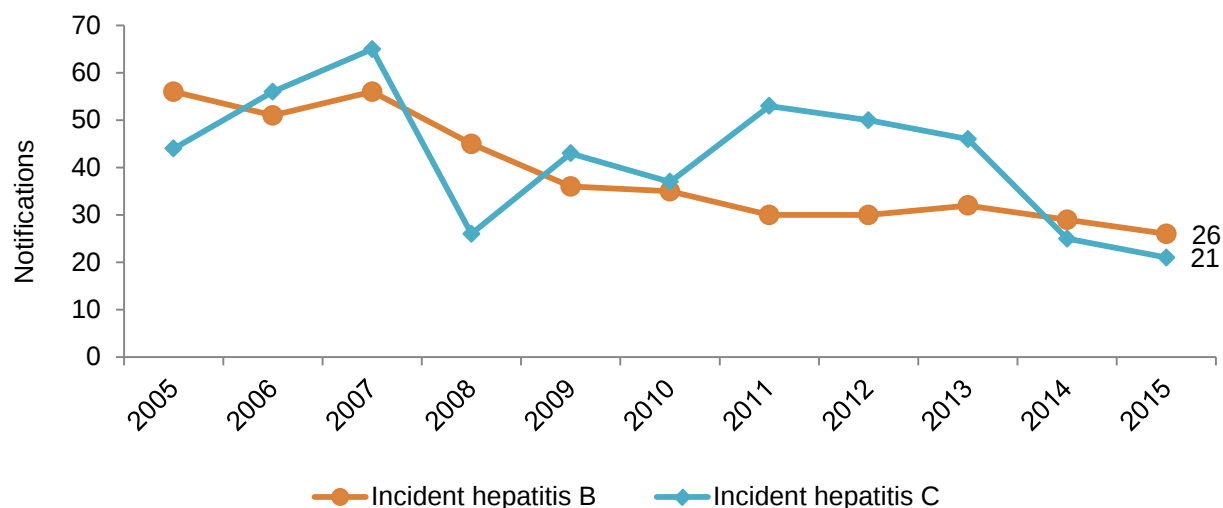
Source: Communicable Diseases Network – Australia – National Notifiable Diseases Surveillance System (NNDSS)¹¹

¹¹ 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 86).

HBV incident notifications remained stable and low in 2015 with 26 notifications (29 in 2014). A steady decline has occurred over time in the number of HCV incident notifications, from 65 in 2007 to 21 in 2015.

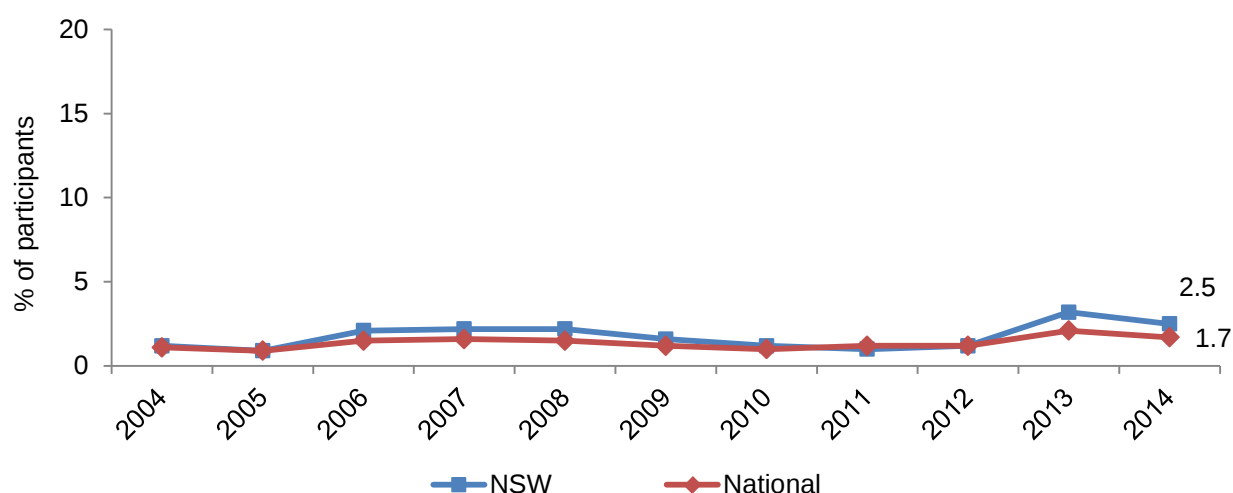
Figure 86: Total notifications for incident HBV and HCV infection, 2005–2015



Source: Communicable Diseases Network – Australia – NNDSS¹¹

HIV antibody prevalence among NSP participants remained low and stable both in NSW (2.5%) and at a national level (1.7%). Both the national and NSW figures stabilised in 2014 after a slight increase in 2013. These figures overall remain low and stable (Figure 87) (Iversen & Maher, 2015).

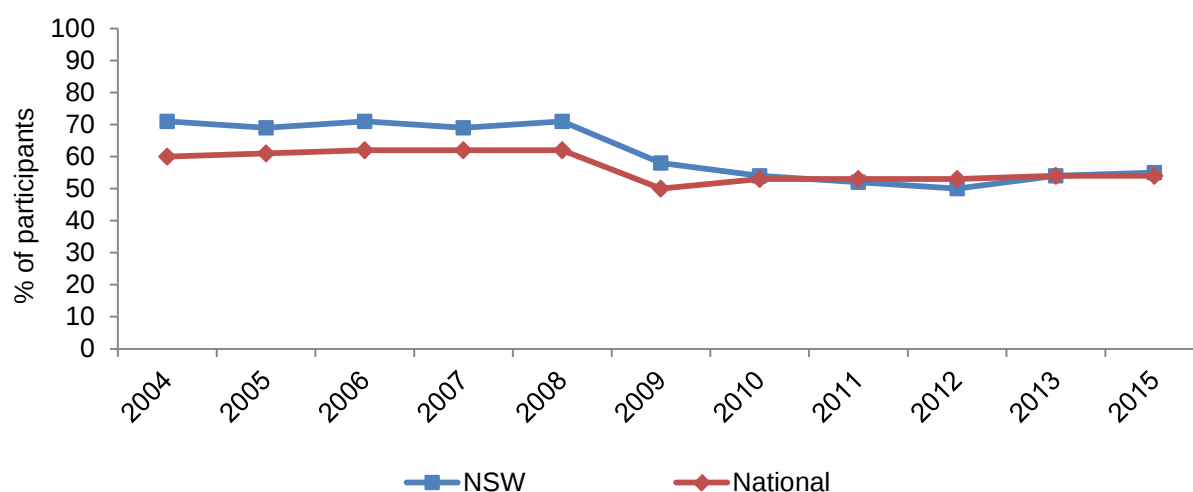
Figure 87: Prevalence of HIV antibody among NSP survey participants, 2004–2014



Source: The Kirby Institute, Australian NSP Survey 1995-2014 (Iversen & Maher, 2015) .

Detection of hepatitis C (HCV) antibody in capillary blood tests (finger-prick samples) conducted on NSW participants were reported as high in 2014 at 55% of the sample. This figure was 54% for the national sample (Figure 88) (Iversen & Maher, 2015).

Figure 88: Prevalence of HCV antibody among NSP survey participants, 2004–2014



Source: The Kirby Institute, Australian NSP Survey 1995-2014 (Iversen & Maher, 2015).

6.7 Alcohol Use Disorders Identification Test-Consumption

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 (54%) of the participants interviewed in the Australian NSP Survey 2014 (n=1,188) were found to have HCV antibodies (Iversen & Maher, 2015). 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, Dufrou, & Kaye, 2007; Darke, Ross, & Hall, 1996; Schiff & Ozden, 2004) it is important to monitor risky drinking among PWID.

In addition to information on lifetime, recent use, and number of days of alcohol use in the preceding six months, PWID were also administered the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C). The AUDIT-C is a three item measure, derived from the first three consumption questions in the AUDIT. Dawson and colleagues (Dawson, Grant, Stinson, & Zhou, 2005) reported on the validity of the AUDIT-C finding that it was a good indicator of alcohol dependence, alcohol use disorder and risky drinking.

A cut-off score of five or more indicates the need for further assessment (Dawson et al. 2005) (Haber et al., 2009). Forty-nine percent of the sample scored five or more on the AUDIT-C (51% in 2014). The overall mean score on the AUDIT-C was 5.1 (SD=3.4, range: 1-12). No significant differences were found for gender.

The proportion of males who scored five or more remained stable at 50% (51% in 2014) and 49% of females scored five or more (54% in 2014) (Table 19).

Table 19: AUDIT-C among people who injected drugs and drank alcohol in the past six months, 2015

	2015 (n=88)
Mean AUDIT-C score (SD; range)	5.1 (3.4; 1-12)
Score of 5 or more*	49
Males (%; n=27)	50
Females (%; n=16)	49

Source: IDRS participant interviews

*Among those who drank alcohol in the past year

6.8 Opioid and stimulant dependence

Dependence on a substance is an important predictor of harm. In 2015, 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 is 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=107), the median SDS score was 5 (mean 5.2; range 0–15), with 55% scoring 4 or above which is indicative of stimulant dependence. There were no significant differences regarding gender and those scoring 4 or above. Of those who scored 4 or above (n=59), 78% reported specifically attributing responses to methamphetamine and 19% cocaine, with smaller proportions of participants (3%) reporting no particular stimulant.

Of those who had recently used an opioid and commented (n=141), the median SDS score was 9 (mean 8.8, range 0–15), with 86% scoring 5 or above. There was not a significant difference between gender and those scoring 5 or more. Of those who scored 5 or above (n=120), 78% reported specifically attributing responses to heroin, 13% methadone, 3% oxycodone, and 1% buprenorphine and morphine, respectively.

6.9 Mental and physical health problems and psychological distress

Under two-thirds (39%) of all participants reported experiencing a mental health problem other than drug dependence in the preceding six months (29% in 2014). As in previous years, among those with a mental health problem, the most commonly reported problems were depression (52%) and anxiety 33%. About a quarter (26%) reported schizophrenia and bipolar disorder (24%). Fewer participants (n<10) reported mania, drug-induced psychosis, paranoia, personality disorders, post-traumatic stress disorder and obsessive compulsive disorder and no participants reported experiencing phobia, panic or other psychosis.

Seventy-six 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, 60% (n=24) reported receiving prescribed antidepressant medication for treatment

of that condition. The most commonly prescribed antidepressant medication for treatment was Avanza (mirtazapine). Smaller numbers reported being prescribed Endep (amitriptyline), Efexor (venlafaxine), Lexapro (escitalopram), fluoxetine (generic), Cipramil (citalopram), Cymbalta (duloxetine), Pristiq (desvenlafaxine), Zoloft (sertraline) and Deptran (doxepin).

Fifty-eight percent (n=23) reported receiving prescribed antipsychotic medication for treatment of their mental health issue. The most commonly reported antipsychotic medications for treatment were Seroquel (quetiapine) and Zyprexa (olanzapine).

Twenty-three percent (n=9) 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 2013 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2014). 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=143), the mean score was 24.8 (median 23; SD 9.44; range 10–48). A third (34%) of the IDRS sample scored 30 or above indicating very high distress. A lower proportion of IDRS participants scored in the no or low distress category and a larger proportion of participants reported 'high' and 'very high' distress compared to the general population sample (Table 20).

Table 20: Kessler 10 scores in the 2013 National Drug Strategy Household Survey and NSW PWID participant sample 2011–2015

K10 category	National Drug Strategy Household Survey 2013	IDRS 2011 n=148	IDRS 2012 n=149	IDRS 2013 n= 146	IDRS 2014 n= 142	IDRS 2015 n= 143
% reporting no or low distress	69.3	16	13	16	30	18
% reporting moderate distress	20.6	19	21	24	21	27
% reporting high distress	7.2	28	28	34	26	21
% reporting very high distress	2.8	37	38	23	23	34

Source: PWID participant interviews;(Australian Institute of Health and Welfare, 2014)

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 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 (refer to <http://www.cahma.org.au/naloxone.html> and/or <http://www.naloxoneinfo.org>).

Since 2013, the IDRS included a series of questions about take-home naloxone and naloxone more broadly. Of those who commented, 92% of participants had previously heard of naloxone. Two-fifths (43%) of those who had heard of naloxone (n=124), reported that naloxone was used to 'reverse heroin' and 37% reported the use of naloxone was to 're-establish consciousness'. Seven percent said naloxone was used to 'help start breathing' and 28% gave 'other' reasons (Table 21).

Participants were then asked if they had heard about take-home naloxone programs. Of those who commented (n=146), 56% reported that they had heard of the take-home naloxone program and 44% had not. Fifteen percent reported that they had completed training in naloxone administration along with a prescription for naloxone. Of those who had completed the course (n=22), six participants (27%) had used 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 (95%) of those who commented (n=121) reported that they would 'call 000', 35% would perform mouth-to-mouth cardiopulmonary resuscitation (CPR), 12% reported that they would 'stay with the victim', and 30% would 'turn the victim on their side' (Table 21).

Participants who had not completed training in naloxone administration and commented (n=81) 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. All participants reported that they would administer naloxone after witnessing someone overdose, 99% percent reported that they would stay with someone after giving them naloxone, 98% would want their peers to give them naloxone if they overdosed and 90% reported that they would carry naloxone on them (Table 21).

Table 21: Take-home naloxone program and distribution, 2015

	NSW N=150
Heard of naloxone (%)	92
Naloxone description (%)	(n=124)
Reverses heroin	43
Help start breathing	7
Re-establish consciousness	37
Other	28
Heard of the take-home naloxone program (%)	(n=146)
Yes	56
No	44
Witness overdose (%)	(n=121)
Turn victim on side	30
Mouth-to-mouth CPR	35
Call 000	95
Stay with victim	12
Other remedies	17
If naloxone was available would you: (%)	(n=81)
Carry naloxone if trained	90
Administer naloxone after overdose	100
Want peers give you naloxone	98
Stay after giving naloxone	99

Source: IDRS injecting drug user interviews

Key expert comments

The common 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.
- Stable housing and personal hygiene remained ongoing areas of health concern for this population.
- Poor vein care, in part due to injection of pharmaceutical opioids designed for oral consumption, contributes to increased difficulty in finding veins and increased rates of infection.
- Polydrug use, particularly the use of benzodiazepines with opioids and/or alcohol was acknowledged as contributing to overdoses.
- Non-fatal overdoses remained low and stable.
- Performance and image enhancing drug (PIED) users were utilizing NSP resources but not the services available making them a difficult demographic to engage with.

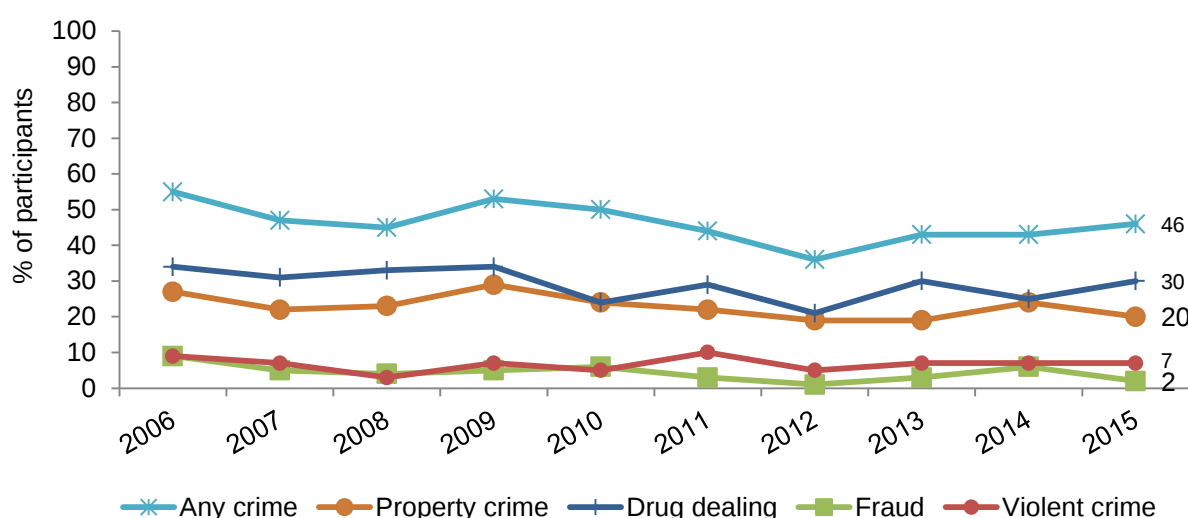
7 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

7.1 Reports of criminal activity among PWID

Forty-six percent of participants reported engaging in any form of crime in the month prior to interview (43% in 2014). Participation in crime has been reported by between 36% and 55% of the sample for the past decade (Figure 89).

The two most commonly reported crimes were, as in previous years, drug dealing and property crime (30% and 20% of the entire sample respectively). Seven percent of PWID participants reported engaging in violent crime (7% in 2014) and 2% reported fraud (6% in 2014).

Figure 89: Proportion of participants reporting engagement in criminal activity in the last month by offence type, 2006–2015



Source: IDRS PWID interviews

Table 22: Criminal activity in the month prior to interview, as reported by PWID participants, 2011–2015

	2011 N=150	2012 N=151	2013 N=151	2014 N=150	2015 n=145
Criminal activity in last month					
Dealing (%)	29	21	30	25	30
Property crime (%)	22	19	19	24	20
Fraud (%)	3	1	3	6	2
Violent crime (%)	10	5	7	7	7
Any crime (%)	50	36	43	43	46
Arrested in last 12 months (%)	37	36	42	48	38

Source: IDRS PWID interviews

7.2 Arrests

Thirty eight percent of participants reported being arrested in the past year (48% in 2014) (

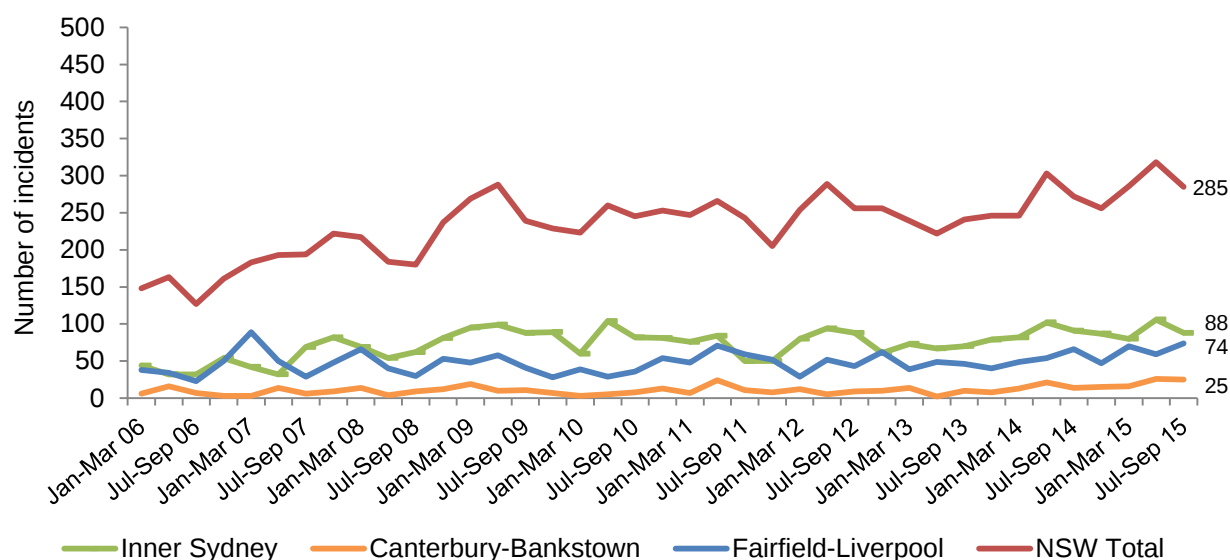
Table 22). The most commonly cited reasons for arrest in the last 12 months were property crime (27%; 15% in 2014) and possession/use of a prohibited drug (27%; 13% in 2014).

Seventeen percent reported arrests for reasons pertaining to violent crime including; assault, violence in a robbery, armed robbery, sexual assault (6% in 2014). Smaller proportions of participants reported having been arrested for driving offences (10%), and use/possession of weapons (4%).

7.2.1 Heroin arrests

Figure 90 shows 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 2015.¹² The number of incidents across all areas has remained stable over the past decade (Figure 90).

Figure 90: Recorded incidents of narcotic possession/use by geographic area per quarter, January 2006–September 2015



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 10th December 2015)

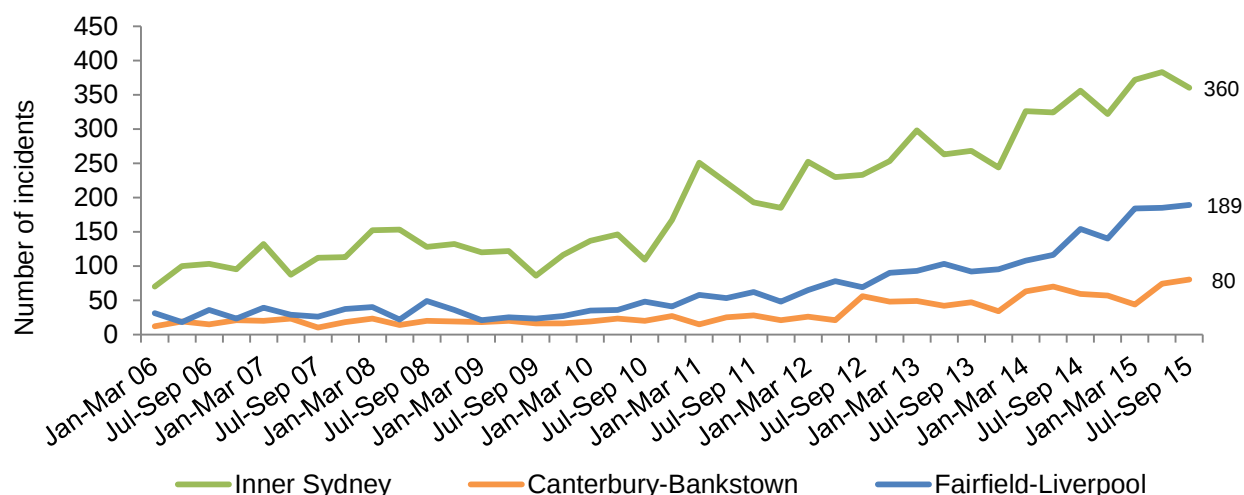
NB: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both

¹² The regions Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown refer to ABS Statistical Subdivisions.

7.2.2 Methamphetamine

Figure 91 shows the number of criminal incidents per quarter for amphetamine possession/use across Sydney. Recorded incidents in Fairfield-Liverpool and Inner-Sydney have been trending upwards, increasing by 46% and 14% respectively over the past two years. Recorded incidents in Canterbury-Bankstown have remained stable over this two year period.

Figure 91: Recorded incidents of amphetamine possession/use by geographic area per quarter, January 2006–September 2015

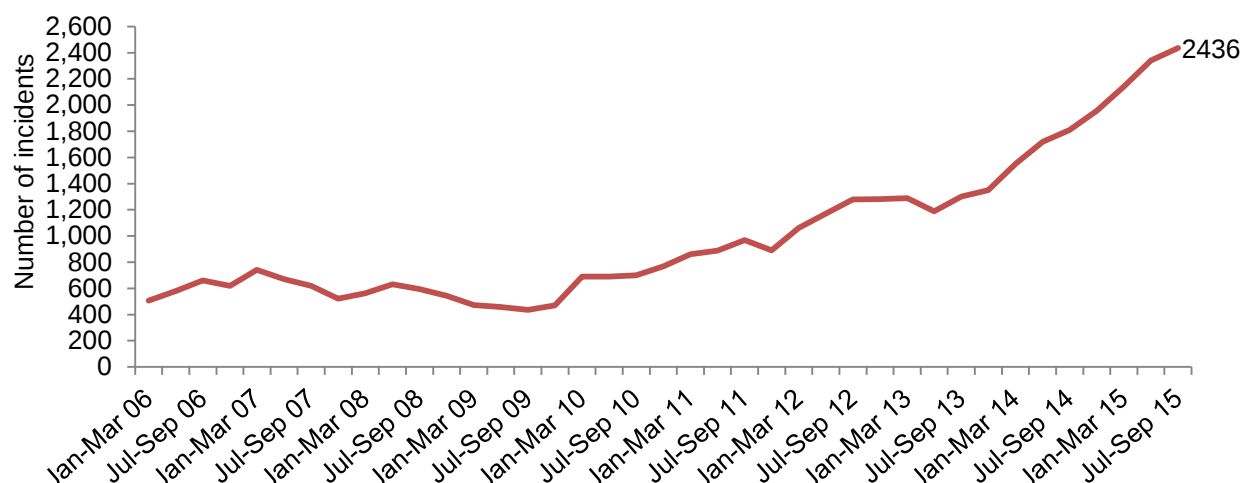


Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at <http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init> accessed 10th December 2015).

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

Trends in amphetamine possession-use incidents in NSW overall have increased 36% in the past two years (Figure 93).

Figure 92: Recorded incidents of amphetamine possession/use in NSW per quarter, January 2006–September 2015

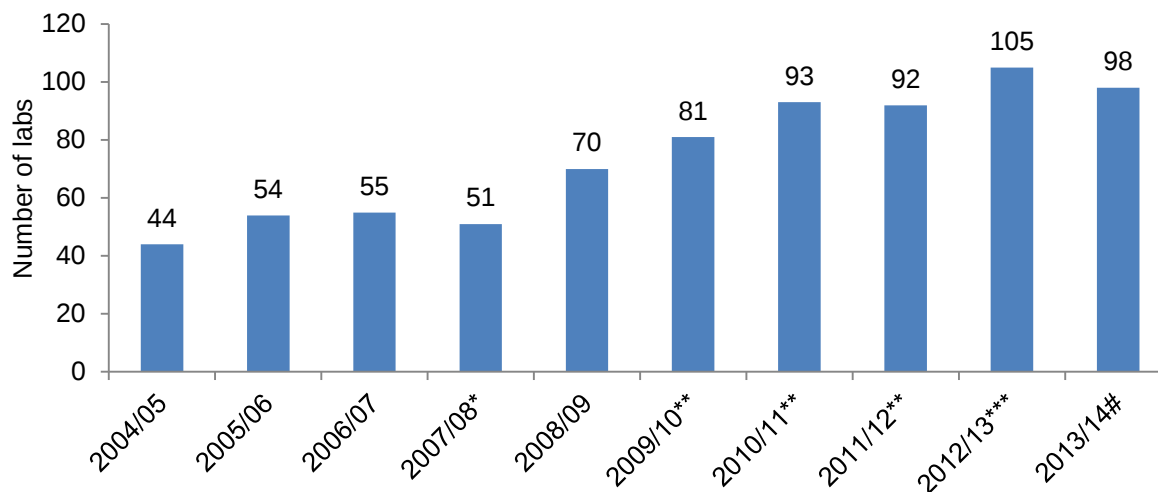


Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at <http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init> accessed 10th December 2015).

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 clandestine laboratories detected in NSW (Figure 93). These figures have more than doubled in the past decade.

Figure 93: Number of clandestine methamphetamine and MDMA laboratories detected by NSW Police, 2004/05–2013/14



Source: NSW Police

* Includes two para-methoxyamphetamine (PMA) laboratories

**Includes one PMA laboratory

***Includes two 2-CB labs

Includes two synthetic cannabinoid labs

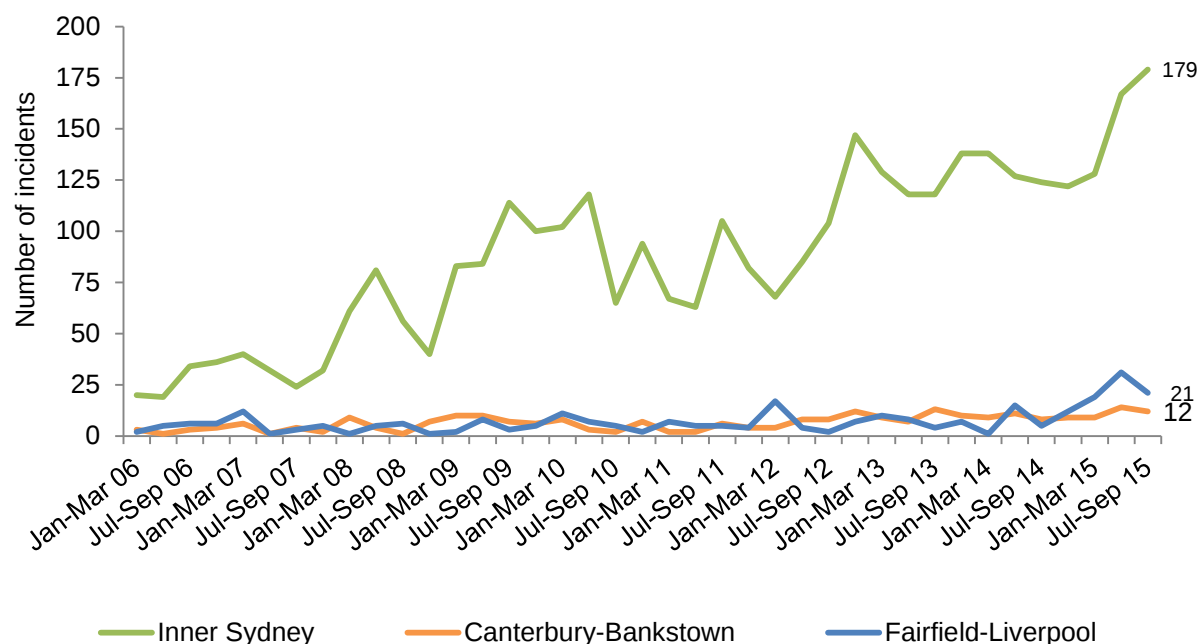
NB: Data may include active, non-active and historical laboratories as well as storage sites

7.2.3 Cocaine

Figure 94 shows the number of police recorded criminal incidents for cocaine possession/use in Inner Sydney, Fairfield-Liverpool, and Canterbury-Bankstown.

Figures 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. There has been an upward trend in cocaine related incidents in the Inner Sydney area in 2015 (Figure 96).

Figure 94: Recorded incidents of cocaine possession/use by geographic area per quarter, January 2006–September 2015



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 10th December 2015).

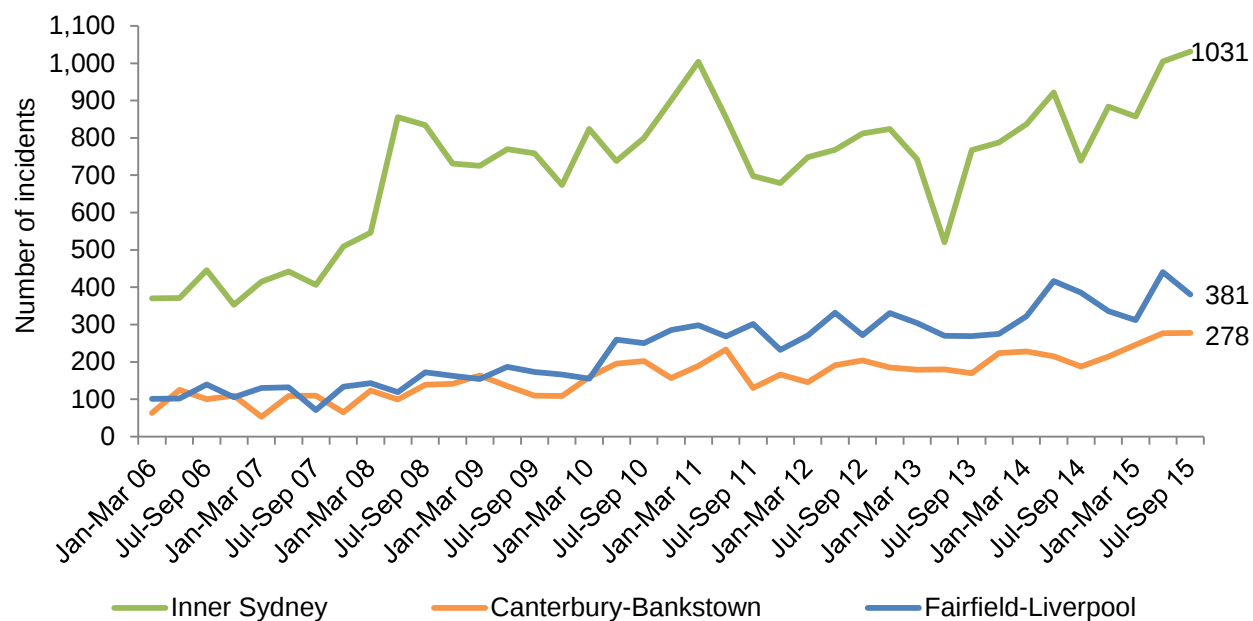
NB: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both

7.2.4 Cannabis

Figure 95 shows the number of police recorded criminal incidents of cannabis possession/use per quarter in the Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown areas.

Trends in these areas for cannabis possession use incidents have fluctuated since 2006. In the past year Inner Sydney and Canterbury-Bankstown have recorded increases (14% and 18% respectively). Incidents in Fairfield-Liverpool have remained stable over the past two years (Figure 96).

Figure 95: Recorded incidents of cannabis possession/use by geographic area per quarter, January 2006–September 2015

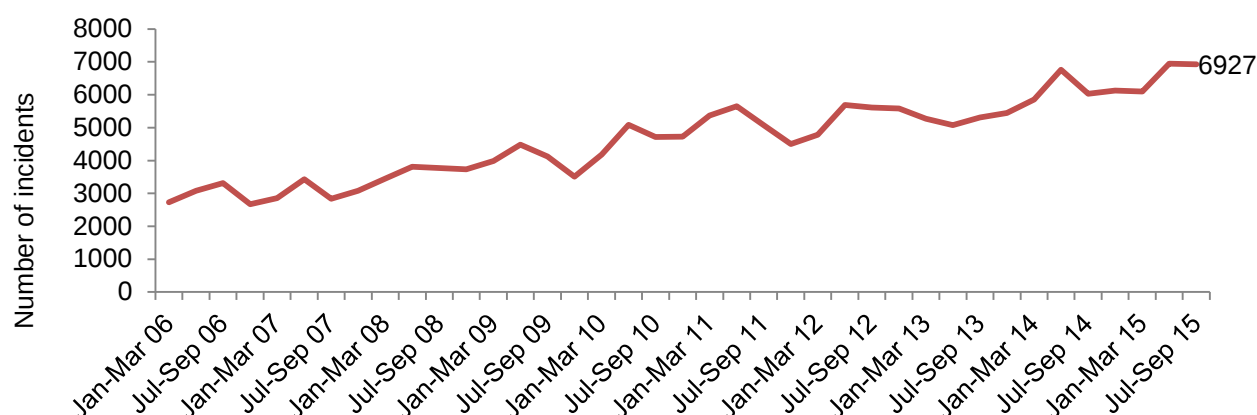


Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at <http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init> accessed 10th December 2015).

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 past 2 years there has been a modest (7%) increase in the number of recorded incidents of cannabis possession/use per quarter across NSW (Figure 97).

Figure 96: Recorded incidents of cannabis possession/use (whole of NSW) per quarter, January 2006–September 2015



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 10th December 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 (67% in 2014), spending a median of \$100 (range \$10–\$1,900). Among participants who had bought drugs on the day before interview, 20% had spent between \$100–\$199, 13% had spent between \$50 and \$99, 11% between \$200–\$399, 11% between \$20–\$49, and 3% spent less than \$20. The same number of participants (8%) reported spending \$400 or more on drug purchases on the day prior to interview. One-third (32%) of those that reported obtaining drugs on the day prior to interview reported spending nothing (\$0).

Key expert comments

The common themes for KE regarding law enforcement-related trends were:

- The scale of methamphetamine production, specifically crystal methamphetamine is increasing, and its use appears to have spread more broadly across the community which appears evident due to random drug testing.
- Distribution of methamphetamine is the result of large organised networks, not exclusively outlaw motorcycle gangs. There appears to be a large Asian contingent, mostly from China and Hong Kong, where equipment is made.
- Precursors to produce methamphetamine are easy to obtain and smaller labs are hard to detect which makes it difficult to police.
- Clandestine labs create a public health concern as there is a high risk to the manufacturers and surrounding neighbours' health, due to its highly poisonous gases.
- Detections of MDMA labs are increasing.
- The majority of MDMA descends from the Netherlands, where purity is between 70%-80%.
- Detections of cannabis have risen by 6%, and are continuing to rise every year.
- Prior to 2015, performance and image enhancing drugs (PIEDS) were a low priority. However, since the one-punch law amendments were established, penalties for possession of steroids increased.

8 SPECIAL TOPICS OF INTEREST

8.1 Hepatitis C testing

Hepatitis C (HCV) is a major public health problem in Australia. Recent estimates report 230,000 people living in Australia have chronic HCV, with up to 95% of newly diagnosed HCV infections occurring due to injecting risk behaviour (The Kirby Institute, 2015)

Treatment options for HCV are currently experiencing rapid developments. Despite efforts to improve access to anti-viral therapy for HCV infection and hence treatment outcomes, uptake for chronic HCV infection treatment remains low among people who inject drugs with HCV (Iversen & Maher, 2015).

Testing for HCV antibodies (anti-HCV) reveals whether the patient has ever been exposed to the virus. Once a person tests positive for antibodies they will always have the antibodies present in their blood. However, this test cannot distinguish between an active infection or a previous infection. A HCV RNA (ribonucleic acid the genetic material of the virus) test is required to confirm an active virus. These tests are commonly called PCR tests or a polymerase chain reaction test.

Previous IDRS national survey data (Stafford & Burns, 2014) regarding Hepatitis C testing reveals a large minority (41%) of people who test positive for HCV antibodies (anti-HCV) have either not had their status confirmed by PCR testing or are unsure. This low level of testing suggests that a large proportion of the IDRS national sample are not receiving adequate testing (K. Butler et al., 2015).

The aim of this module was to a) determine rates of, and referrals to polymerase chain reaction (PCR) testing, and b) determine the extent of knowledge PWID possess regarding HCV transmission.

The majority (94%) of the NSW sample had been tested for HCV antibodies (anti-HCV) in their lifetime with 68% reporting a positive result. The median number of anti-HCV tests was reported to be three in NSW (range 1-200 times). The majority of PWID reported that the test had been ordered by their regular GP (26%), followed by an OST clinic (14%), liver specialist (10%) and OST prescribing doctor (8%) (Table 23).

Fifty-five percent of the NSW sample who commented (n=92) reported a PCR test to determine if the virus was active with the median number of PCR tests being two. The majority of PWID reported that the PCR test had been ordered by their regular GP (26%), followed by a liver specialist (16%), OST clinic (12%) and OST prescribing doctor (10%) (Table 23).

All participants who had screened positive to an antibody test or a PCR test were asked what they remember discussing with the health professional at the time of diagnosis. A third (35%) remembered discussing the impact of dietary choices on HCV, 21% the benefit of limiting alcohol intake, 10% the long term effects of HCV, 8% the available treatments for HCV, 5% the different strains of HCV (genotypes) and 4% the types of tests needed. Three percent could not remember what they were told (Table 23).

Table 23: Hepatitis C testing among PWID in NSW, 2015

	NSW n=143
% Ever tested for HCV	94
% Antibody positive result	(n=135)
Yes	68
No	30
Unsure	2
% Ordered the anti-body test	(n=92)
Regular GP	26
OST clinic	14
OST doctor	8
Liver specialist	10
Other	30
Unsure	12
Median number of times tested for antibodies ever (range) [#]	3 (1-200)
% Screened or tested for RNA (PCR test)	(n=92)
Yes	55
No	32
Unsure	13
% Ordered the PCR test	(n=51)
Regular GP	26
OST clinic	12
OST doctor	10
Liver specialist	16
Other	22
Unsure	16
Median number of times tested for RNA ever (range) [*]	2 (1-12)
% Discussed by a health professional when told HCV antibody or RNA positive	(n=80)
Long term effects of HCV	10
Genotypes	5
Different tests	4
Available treatments	8
Alcohol intake	21
Dietary choices	35
Other	3
Don't know/ can't remember	3

Source: IDRS participant interviews

[#] Among those who were ever HCV tested and commented^{*} Among those who were ever PCR tested and commented

Participants were also asked to endorse a list of statements related to their perceptions of HCV as either true or false. Questions included: Don't feel sick I must have cleared HCV; I don't have symptoms I can't pass on HCV; Treatment for HCV only works for a few people; If I already have HCV, I can't get it again; If I wait, HCV will clear up on its own; I can wait until I feel really sick before seeking treatment and I can't get HCV treatment if I am still injecting drugs. The majority of participants believed the statements to be false indicating most participants had a moderately good understanding of the virus (Table 24). There are areas for improvements in knowledge, for example 40% believed that HCV treatment only works for a few people and about 20% were incorrect with the other statements.

Table 24: Perceptions of HCV in NSW, 2015

	NSW
% Don't feel sick I must have cleared HCV	(n=144)
True	19
False	81
Unsure	0
% Don't have symptoms I can't pass on HCV	(n=144)
True	19
False	80
Unsure	1
% Treatment for HCV works only for a few people	(n=144)
True	40
False	51
Unsure	8
% I have HCV, I can't get it again	(n=144)
True	18
False	79
Unsure	3
% If I wait, HCV will clear up on its own	(n=144)
True	22
False	76
Unsure	2
% I can wait until I feel real sick before seeking treatment	(n=144)
True	15
False	84
Unsure	1
% I can't get HCV treatment if still injecting drugs	(n=144)
True	19
False	76
Unsure	4

Source: IDRS participant interviews

8.2 Oxycodone use

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

In response, pharmaceutical companies have developed formulations that are less prone to tampering. Oxycodone is a semi-synthetic opioid agonist prescribed for the treatment of moderate to severe chronic pain. A tamper resistant formulation of controlled release oxycodone hydrochloride tablets (Reformulated OxyContinC) was released onto the Australian market 1st April 2014 (rapidly replacing the original version, OxyContinV). The tablets are designed to be bioequivalent to the original formulation, and employ a controlled release technology (that makes them difficult to crush) with a hydro-gelling matrix. This makes the tablet develop into a viscous gel when dissolved in water (Sellers, Perrino, Colucci et al., 2013). Early U.S. surveillance of the reformulation suggests that there have been reductions in misuse (S. F. Butler et al., 2013; Havens, Leukefeld, Deveaugh-Geiss, Coplan, & Chilcoat, 2014), street price (Sellers, Perrino, Colucci, & Harris, 2013) and OxyContin® poisonings (Severtson et al., 2013).

Following the introduction of Reformulated OxyContin®, a newer generic formulation of oxycodone (Oxycodone Sandoz®) was released in Australia 1st September, 2014 and listed with public subsidy (on the Pharmaceutical Benefits Scheme) 1st December, 2014. This generic formulation does not have tamper resistant and is available in tablet sizes similar to the original OxyContin® product.

Post-marketing surveillance of the Reformulated OxyContin® and generic oxycodone formulations is underway in Australia (Degenhardt, Larance, et al., 2015) Early findings indicate 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, Bruno, et al., 2015; Larance, Lintzeris, et al., 2015; Peacock, Degenhardt, Hordern, et al., 2015; Peacock, Degenhardt, Larance, et al., 2015).

Given the concerns regarding the extra-medical use of oxycodone and the changes in the types of oxycodone available, the aim of the oxycodone module was to examine the use and misuse of oxycodone products. Participants were asked about their use of the original OxyContin®, in addition to Reformulated OxyContin®.

In 2015, of the NSW sample who commented (n=146), around half (51%) reported ever using oxycodone (either licit or illicit). Of those who reported ever using oxycodone (n=74), a quarter (25%) reported recently using the Reformulated Oxycodone tablets (either licit or illicit), 24% percent reported recently using the Original Oxycodone tablets and 21% reported recent use of the generic formulation. Eighteen percent reported recently using Endone (Table 25).

Two thirds (66%) (75% in 2014) of those who reported the recent use of original (non-tamper resistant) OxyContin® brand reported recently using the 80mg tablets and 17% (n=3) used the 40mg tablets (16% in 2014). The original (non-tamper resistant) OxyContin® brand was reported to be used on a median of eight days in the last six months and injected on median of one day (10 days used in 2014). In 2015 the Reformulated OxyContin® was reported to be used on a median of seven days in the last six months (twelve days in 2014).

Table 25: Lifetime and recent use of oxycodone (any form) in NSW, 2015

	NSW	
	n=149 2014	n=146 2015
% Ever used oxycodone	68	51
Recent use of oxycodone (licit or illicit)*	(n=101)	(n=74)
% Endone	5	18
% Original Oxycodone 'OC'	54	24
% Reformulation Oxycodone 'OP'	12	25
% Generic controlled released Oxycodone	n.a.	21
% OxyNorm tabs	5	10
% OxyNorm liquid	0	3
% OxyNorm Solution	0	1
% Targin	0	0
% Proladone	0	1

Source: IDRS participant interviews

*Among those who reported ever using oxycodone.

8.3 Blood donations

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

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

Of those who commented in NSW (n=135), 7% reported that they had given blood in their lifetime. Over one-quarter (30%) of those that had given blood reported that they had commenced injecting drug use before donating blood (Table 26).

Table 26: Blood donations in NSW, 2015

	NSW n=135
% Ever donated blood	7
% Commenced injecting drug use before blood donation*	30

Source: IDRS participant interviews

* Among those who had ever donated blood

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