New South Wales

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NSW DRUG TRENDS 2016
Findings from the Illicit Drug Reporting System (IDRS)

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NEW SOUTH WALES DRUG TRENDS 2016

Findings from the Illicit Drug Reporting System (IDRS)

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ACIC	Australian Criminal Intelligence Commission
ADIS	Alcohol and Drug Information Service
AFP	Australian Federal Police
AIHW	Australian Institute of Health and Welfare
ANSPS	Australian Needle and Syringe Program Survey
AUDIT-C	Alcohol Use Disorders Identification Test - Consumption
BBVI	Blood-borne viral infections
CPR	Cardiopulmonary resuscitation
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
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
NCIS	National Coronial Information System
OST	Opioid substitution treatment
OTC	Over the counter
PBS	Pharmaceutical Benefits Scheme
PDI	Party Drugs Initiative
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
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

Guide to days of use/injection

180 days	Daily use/injection* over preceding six months
90 days	Use/injection* every second day
24 days	Weekly use/injection*
12 days	Fortnightly use/injection*
6 days	Monthly use/injection*

*As appropriate

EXECUTIVE SUMMARY

Demographic characteristics of people who inject drugs (PWID) sample

In 2016, 150 people participated in the IDRS survey. Seventy-three percent were male and the average age of respondents was 44 years (range: 19−72 years). Twenty-four percent of the sample identified as Aboriginal and/or Torres Strait Islanders[1]. Ninety-seven percent of the sample identified English as the main language spoken at home. The majority (89%) reported that they were not currently working at the time of interview. Twenty-nine percent of the sample had completed year 10 and 20% had completed year 12 at high school. Forty-four percent had not completed any further education after leaving school. Two-thirds (67%) reported a previous prison history and 54% were in treatment at the time of interview, primarily opioid substitution treatment.

Patterns of drug use among the NSW sample

The mean age of first injection among the NSW IDRS sample was 20 years. The majority of participants reported that heroin was the first drug injected (56%), followed by methamphetamine (35%). Heroin remained the preferred drug of choice (60%), as well as the drug injected most often in the month preceding interview and the most common drug last injected (55%, respectively).

Polydrug use was common in 2016, a consistent finding across all years of the IDRS. Participants reported use of a median of 14 different drug types across their lifetime and a median of 10 drug types during the six months prior to interview. There were significant changes in the lifetime use and recent use of certain drugs. Specifically, there was a significant increase in the use of 'any' methamphetamine ($p<0.05$). With regards to recent use, there were significant increases in the use of crystal methamphetamine, 'any methamphetamine', illicit physeptone ($p<0.05$) and illicit buprenorphine ($p<0.01$). There was a significant decrease in the recent use of homebake ($p<0.05$).

Heroin

The majority of participants (86%) had used heroin in the six months preceding interview (91% in 2015) on a median of 90 days (range: 1–180 days). The vast majority of recent heroin users (96%) reported injecting heroin within the preceding six months on a median of 96 days (range: 1–180 days). The proportion of participants reporting daily use was 35% (43% in 2015).

Of the 129 participants who had recently used heroin, 90% reported use of a white/off white powder or rock form of heroin (89% in 2015), and 76% reported using a brown powder or rock form of heroin (62% in 2015). The form most used over the preceding six months was white/off white powder (45%; 41% in 2015), followed by white/off white rock (22%; 31% in 2015).

Homebake use remained uncommon and infrequent among the NSW sample, with nine participants reporting recent use (6%; 15% in 2015).

[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.

On an average day, the median amount of heroin used was two points (range: 0.25–8 points) or 0.5 grams (range: 0.25–2 grams).

In the 12 months to September 2016, heroin has accounted for approximately 44% of all attendances to the Sydney Medically Supervised Injecting Centre (MSIC).

Methamphetamine

Seventy-seven percent of participants had recently used 'any' form of methamphetamine (speed powder, base, crystal methamphetamine or liquid[2,3]), a significant increase from 66% in 2015 ($p<0.05$). Considered separately, the most commonly used form of methamphetamine was crystal methamphetamine (77%; 65% in 2015), which had also significantly increased ($p<0.05$). This was followed by speed (17%; 13% in 2015), and then base (11%; 6% in 2015). Liquid amphetamine remained considerably less common, with only one participant reporting use in the last six months (n=4 in 2015).

Participants reported using speed powder on a median of 7 days (range: 1–180 days); base was used on a median of 4.5 days (range: 1–180 days); and crystal methamphetamine was used on a median of 48 days (range: 1–180 days). Twenty-one participants (18%) reported daily use of methamphetamine in the six months preceding interview (n=13 in 2015).

All participants using 'any' form of methamphetamine reported having done so by injecting in the six months prior to interview.

On an average day, the median amount of speed powder used was two points (range: 1–5 points) or 0.5 grams (range: 0.5–2 grams). The median amount of base used on an average day was two points (range: 0.5–5 points) or 0.5 grams (range: 0.5–1 gram). The median amount of crystal methamphetamine used throughout the course of a typical day was one point (range: 0.20–10 points) or 0.5 grams (range: 0.25–1 gram).

Numbers reporting methamphetamine injection at the Sydney MSIC have steadily increased over the past three years from 762 injections in January 2013 to 1274 in September 2016, representing approximately 30% of all injecting episodes.

Cocaine

Twenty-five percent of all participants reported cocaine use in the preceding six months (34% in 2015) on a median of six days (range: 1–180 days). Of these, 92% reported injecting cocaine in the preceding six months. Eight percent of all participants reported daily cocaine use (n=3).

Eighty-one percent of recent cocaine users reported using powder (94% in 2015), and 19% had used crack (4% in 2015). A significant increase was observed in the number of participants reporting recent use of rock (47%; 32% in 2015) ($p<0.01$).

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[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.

On an average day, the median amount of cocaine used was one point (range: 0.50–6 points) or 0.25 grams (range: 0.24–4 grams).

Cocaine injections have accounted for approximately 2% of the total number of injecting episodes at the Sydney MSIC.

Cannabis

The cannabis market continued to remain relatively unchanged since the commencement of the NSW IDRS in 1996, and recent use of cannabis remained high among participants in 2016 (76%; 79% in 2015). Cannabis was used on a median of 155 days (range: 1–180 days). Of those who had recently used cannabis, 47% reported daily use (43% in 2015).

Ninety-four percent of respondents who had used cannabis reported using hydro in the preceding six months (93% in 2015), and 43% of cannabis users reported using bush during this time (38% in 2015). Ninety-four percent of recent users reported they had used hydro most often in the six months preceding interview.

On an average day, the median amount of cannabis used was 5.5 cones (range: 1–120 cones) or two joints (range: 1–8 joints). Among daily users, the median number of cones smoked in the last six months was 10 (range: 2–120 cones) and the median number of joints used among daily users in the last six months was three (range: 2–6 joints).

Opioids

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

In 2016, 47% of people who inject drugs (PWID) reported recent use of some type of illicit opioid (excluding heroin) (57% in 2015).

Illicit Methadone

Thirty percent of all participants reported having used illicit methadone syrup (25% in 2015) on a median of nine days (range: 1–150 days) in the six months preceding interview, and the average amount used per day in the last six months was a median of 50ml (range: 10–200ml). Seven participants reported having used illicit Physeptone® tablets (n=4 in 2015) on a median of two days in the last six months (range: 1–30 days), and the average amount recently used per day was a median of 10mg (range: 3–50mg).

Illicit Buprenorphine

Eleven percent of all participants (9% in 2015) reported having used illicit buprenorphine on a median of four days (range: 1−180 days) in the six months prior to interview. The average amount used per day in the last six months was a median of 8mg (range: 3–24mg).

Illicit Buprenorphine-naloxone

Sixteen percent of all participants reported having used illicit buprenorphine-naloxone on a median of four days (range: 1–30 days) in the six months prior to interview. The average amount used per day in the last six months was a median of 8mg (range: 4–32mg). Of the twenty-four participants that were able to comment, 42% of all Suboxone® users (n=10) reported that the type they had used most during the last six months was illicit Suboxone® film.

Illicit Morphine

Sixteen percent of participants reported they had used illicit morphine in the six months prior to interview (19% in 2015) on a median of 12 days (range: 1−180 days). The average amount of illicit morphine used per day in the last six months was a median of 100mg (range: 2−200mg). The main brand of morphine used was MS Contin® (75%, n=15).

Illicit Oxycodone

In 2016, oxycodone was divided into three different forms, consisting of 'generic oxycodone', 'OP oxycodone' and 'other oxycodone'.[4]

Nineteen percent (n=29) reported recent use of illicit generic oxycodone on a median of ten days (range: 1–180 days). The average amount of illicit generic oxycodone used per day in the last six months was a median of 80mg (range: 2–400mg).

Twelve percent (n=18) reported recent use of illicit OP oxycodone on a median of five days (range: 2–100 days). The average amount of illicit OP oxycodone used per day in the last six months was a median of 80mg (range: 5–150mg).

Four participants reported recent use of illicit 'other' oxycodone.

Fentanyl

Seventeen percent (n=26) reported using fentanyl (15% in 2015) on a median of six days (range: 1−180 days) in the six months preceding interview, and the average amount used per day was a median of 50mg (range: 6–100mg) or 87.5ug/hr (range: 25–1000ug/hr).

Over the counter (OTC) codeine

Fifteen percent reported use within the preceding six months (9% in 2015) on a median of four days (range: 1–157 days). The main brand of OTC codeine used by participants was Nurofen Plus (46%; n=10).

Other opioids

Nineteen percent of participants (16% in 2015) reported that they had used 'other opioids' (excluding those mentioned above) in the six months preceding interview on a median of 5.5 days (range: 1−48 days). Among those who recently used 'other opioids', the form most used was licit (54%; 46% illicit), and the majority of participants reported that Panadeine Forte® (n=22, 82%) was the main brand used.

Other drugs

Illicit benzodiazepines

Thirty-five percent of participants reported recent illicit use of alprazolam on a median of six days (range: 1−180 days); and 31% reported recent illicit use of benzodiazepines excluding alprazolam on a median of six days (range: 1−180 days) within the preceding six months.

[4] In April 2014 'Reformulated OxyContin®' (branded with an 'OP' on each tablet) was introduced designed to be tamper resistant. The 'original oxycodone' OxyContin®' (branded with an 'OC') was withdrawn. In September 2014 generic 'non-tamper-resistant oxycodone' was made available in Australia.

Among participants who had recently used benzodiazepines, 25% reported using them on a daily basis.

Illicit pharmaceutical stimulants

Three participants reported illicit use of pharmaceutical stimulants within the preceding six months.

Illicit Seroquel® (quetiapine)

Eleven percent reported using illicit Seroquel® on a median of three days (range: 1−30 days) in the six months preceding interview (10% in 2015).

Ecstasy and Hallucinogens

Eleven participants had used ecstasy on a median of 2 days (range: 1-6 days) and eight participants had used some type of hallucinogen on a median of 2 days (range: 1–4 days) in the six months prior to interview (n=11 and n=2 in 2015, respectively).

The main forms of ecstasy used by participants were pills (n=8), followed by capsules (n=3). The main forms of hallucinogens used by participants were LSD (n=4), followed by mushrooms (n=3) and 'other' (n=1).

Steroids

There were no reports of steroid use in the six months preceding interview.

New psychoactive substances (NPS)

Three participants reported recent use of NPS (n=1 in 2015).

Synthetic cannabinoids

Eleven percent of participants reported recent use of synthetic cannabinoids (8% in 2015) on a median of one day (range: 1–30 days).

Inhalants

Seven participants reported using inhalants (n=3 in 2015).

Alcohol

Fifty-seven percent of the sample (51% in 2015) had used alcohol in the six months preceding interview on a median of 11 days (range: 1−180 days). Among recent users of alcohol, ten participants reported daily use of alcohol.

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 preceding six months, consistent with 2015 reports, on a median of 180 days, i.e. daily use (range: 15−180 days). Ninety-four percent of those who had smoked tobacco in the preceding six months were daily smokers.

E-cigarettes

Thirteen percent reported using e-cigarettes (16% in 2015) on a median of three days (range: 1−30 days) in the six months preceding interview.

Drug Market: price, purity, availability and purchasing patterns

Heroin

The median price of heroin was reported to be $50 for a cap and $200 for a half weight, with the price primarily reported as 'stable' (75%) over the preceding six months.

The majority of participants reported that heroin was either 'easy' or 'very easy' to obtain (92%), and that availability had largely remained 'stable' (79%) over the preceding six months.

There was variation in participant reports of heroin purity. Twenty-three percent of those who commented reported that purity was 'high', a significant increase from 8% in 2015 ($p<0.01$). Thirty-six percent reported purity to be 'low' and 29% reported purity to be 'medium'. Thirty-eight percent reported that the purity of heroin had remained 'stable' over the preceding six months and 21% reported purity had 'increased', which was a significant increase from 10% in 2015 ($p<0.05$).

The largest proportion of participants obtained heroin was 'known dealers' (38%), most commonly at a 'street market' (30%).

An upward trend has been observed in the number of heroin seizures over the last decade (Australian Criminal Intelligence Commission 2016), and the total weight increased from 5.17kg in 2013/14 to 106.38kg 2014/15.

Methamphetamine

The median price for all three forms of methamphetamine was $50 for a point. The price was largely reported to have remained 'stable' in the six months preceding interview for all three forms of methamphetamine (powder 81%; base 70%; crystal 74%).

The majority of those commenting considered methamphetamine powder and methamphetamine crystal to be of 'medium' purity (39% and 29%, respectively), yet the largest proportion of those able to comment regarded methamphetamine base to be of 'high' purity (56%). For all three forms of methamphetamine, the purity was mostly reported to have remained 'stable' (powder 54%; base 100%; crystal 40%).

An upward trend has been observed in the number of methamphetamine seizures over the last decade (Australian Criminal Intelligence Commission 2016), and the total weight had noticeably increased from 478.29kg in 2013/14 to 5974.67kg in 2014/15.

Methamphetamine powder and base were mostly reported as being 'difficult' to obtain (31% and 30%, respectively), whereas crystal methamphetamine was largely reported as 'easy' or 'very easy' to obtain (97%). The availability was largely reported to have remained 'stable' over the preceding six months for all forms of methamphetamine (powder 67%; base 80%; crystal 71%).

The largest proportion of participants obtained methamphetamine from 'friends' (powder 77%; base 7%; crystal 44%, respectively), mostly from a 'friends home' (powder 39%; base 57%; crystal 23%).

Cocaine

The price for a cap of cocaine remained stable at $50. The majority of participants able to comment (75%) reported that the price had remained 'stable' in the preceding six months.

Thirty-eight percent of participants reported that the purity of cocaine had 'decreased', with equal proportions stating that purity had remained 'stable' and purity had 'fluctuated' (29%, respectively).

The majority of participants reported that cocaine was 'difficult' to obtain (38%).

Participants obtained cocaine primarily from ‘friends’ (41%), most often from an ‘agreed public location’ (36%).

The number and total weight of cocaine seizures (Australian Criminal Intelligence Commission 2016) have steadily increased over time.

Cannabis

The price for both hydro and bush cannabis was generally reported as ‘stable’ in 2016 (92% and 86%, respectively) at $20 for a gram.

The potency of hydro was reported as ‘high’ by most of the participants (56%). The majority of participants reported bush cannabis to also be of ‘high’ potency (46%). This was largely reported as ‘stable’ (64% and 67%, respectively) in the six months preceding interview.

Availability had remained ‘stable’ over the preceding six months (hydro 75%; bush 79%) and the majority of participants reported both types of cannabis as ‘easy’ or ‘very easy’ to obtain (hydro 93%; bush 79%).

Participants obtained cannabis primarily from ‘friends’ (hydro 46%; bush 48%), most often from a ‘friend’s home’ (26%, respectively) or a ‘dealer’s home’ (hydro 22%; bush 26%).

Methadone

The median last purchase price for methadone liquid was 92 cents per ml, which was generally reported as remaining ‘stable’ (85%) in the six months preceding interview.

Illicit methadone was most reported as ‘easy’ to obtain (48%), and the majority of those able to answer reported that this had remained ‘stable’ (79%).

Participants most commonly obtained illicit methadone through ‘friends’ (71%) at a ‘friends home’ (48%).

Morphine

The price for 100mg of MS Contin® and 100mg of Kapanol® had generally remained ‘stable’ (n=13) in the six months preceding interview, at $50 and $40, respectively.

Illicit morphine was mostly reported as ‘easy’ or ‘very easy’ to obtain (n=13). The majority of those able to answer reported that availability had remained ‘stable’ (n=10) in the preceding six months.

Participants most commonly obtained illicit morphine through ‘friends’ (n=5) at an ‘agreed public location’ (n=5).

Oxycodone

Equal proportions of participants reported the price of illicit ‘generic and other’ oxycodone to be ‘stable’ or ‘increasing’ (n=9, respectively) in the six months preceding interview.

The majority of participants reported the availability of illicit ‘generic or other’ oxycodone as being ‘easy’ or ‘very easy’ to obtain (76%), and oxycodone ‘OP’ was generally reported as ‘easy’ to obtain (n=4). The availability of ‘generic or other’ oxycodone and oxycodone ‘OP’ had remained stable (n=16; n=12, respectively).

Participants most commonly obtained ‘generic or other’ or ‘OP’ oxycodone through a ‘friend’ (n=9, n=5), most often at an ‘agreed public location’ (n=6; n=4) or a ‘friend’s home’ (n=3; n=4).

Benzodiazepines

The median price for an illicit diazepam pill was ‘$1.50 and for an illicit alprazolam pill, the median price was $10. The majority of those who could comment (54%) reported the price of illicit benzodiazepines had remained ‘stable’.

Over half of those who could comment (51%) reported the availability of illicit benzodiazepines to be ‘difficult’ to obtain, which was significantly higher than 2015 reports (19%; $p<0.05$). Fifty-seven percent reported availability had remained ‘stable’.

Participants most commonly obtained illicit benzodiazepines through ‘friends’ (42%), most often at a ‘street market’ (50%).

Other Drugs

The number of participants who answered questions relating to ecstasy, hallucinogens, illicit buprenorphine (Subutex®), illicit buprenorphine-naloxone (Suboxone®), illicit antidepressants, illicit antipsychotics, illicit pharmaceutical stimulants, steroids and fentanyl markets were extremely low (n ≤10).

Health-related issues

Overdose and Drug-Related Fatalities

Among participants who had ever overdosed on heroin, 27% had overdosed in the past 12 months and four participants had overdosed in the month preceding interview.

Not including heroin, morphine, methadone or oxycodone, seven participants had overdosed on any other drug in the past 12 months and one participant had overdosed in the last month.

In 2012, there were 564 accidental deaths nationally due to opioids, and most of these deaths occurred in NSW (n=157), which accounted for 28% of the total number of deaths.

Drug related deaths and emergency department data

The number of suspected drug related deaths where amphetamines were detected post-mortem in NSW appears to have increased from mid-2014 onward. On the other hand, the number of suspected drug related deaths where cocaine was detected post-mortem has remained consistently low.

Heroin overdose presentations to NSW emergency departments have stabilised at a lower level in the past two years after declining in 2012. The total number of amphetamine overdose and cocaine overdose presentations to NSW emergency departments has fluctuated over time.

Health Service Use

Telephone calls to ADIS and the Family Drug Support (FDS) regarding heroin remained relatively stable over the past 12 months apart from a spike in May 2016 with 101 calls to ADIS, and falling back down to 63 calls in June 2016.

Telephone calls to ADIS and FDS regarding methamphetamine reveal an upward trend, which has continued in the past 12 months to June 2016. Crystal methamphetamine has also been increasing substantially since 2012.

NSW drug-related hospital admissions

The number of opioid-related hospital admissions has remained stable in NSW over the past 10 years. Conversely, the number of amphetamine-related hospital admissions, cocaine-related hospital admissions and cannabis-related hospital admissions has all steadily increased in NSW and nationally.

Drug Treatment

Fifty-four percent of the NSW sample reported being in drug treatment at the time of interview, and they had been in treatment for a median of 30 months. Specifically, 74% reported being on a methadone program and 20% reported being on a buprenorphine or buprenorphine-naloxone program.

Eight percent of the sample reported a hospital admission for methamphetamine psychosis on a median of two occasions in the past year, and 3% of the sample reported admission to hospital for other methamphetamine related issues on a median of one occasion in the past year.

Seventeen percent of participants had tried to access treatment over the preceding six months but were unable to.

Based on results from the NSW Minimum Data Set (MDS), all forms of heroin treatment, except residential rehabilitation, have declined between 2007/08 and 2014/15. On the other hand, the number of amphetamine related episodes have risen steeply since 2008/09, with the highest numbers being observed between 2013/14 and 2014/15.

Opioid and Stimulant Dependence

Of those who recently used an opioid drug and commented (n=137) the median severity of dependence (SDS) score was seven, with 83% scoring five or above, indicative of opioid dependence.

Of those who had recently used a stimulant drug and commented (n=119), the median SDS score was five, with 59% scoring four or above, indicative of stimulant dependence.

Mental Health

Thirty-five percent of all participants reported experiencing a mental health problem in the preceding six months. Depression and anxiety continue to be the most commonly reported disorders.

Among those who had recently experienced a mental health problem, 67% reported that they had attended a professional for such problems.

Sixty-six percent of the IDRS sample reported ‘high’ to ‘very high’ levels of psychological distress, much higher than general population data.

Alcohol Use Disorders Identification Test

Forty-five percent of males and 30% of females scored five or more on the AUDIT-C, indicating a need for further assessment.

Naloxone Program and Distribution

One hundred and forty-seven participants had heard of naloxone, and 48% of those who commented reported that they had not heard of the take-home naloxone program.

Twenty-seven participants had completed training in naloxone administration, and 44% of these participants had used naloxone to resuscitate someone who had overdosed.

Twenty-one participants reported that they had heard about the rescheduling of naloxone (i.e. available OTC) and 37% of the sample believed that OTC naloxone should be free.

All of those who commented reported that they would administer naloxone after witnessing someone overdose, 99% reported that they would stay with someone after giving them naloxone and 80% reported that they would carry naloxone on their person.

Injecting Risk Behaviours

Injecting Risk Behaviour

Borrowing and sharing of needles remained stable in 2016, at 10% and 18%, respectively (7% and 14% respectively in 2015). Sharing of injecting equipment, including mixing containers, tourniquets and filters was more common (26%; 29% in 2015).

Fifty-four percent of the sample reported re-using their own needles in the last month, a significant increase from 2015 (40%; $p<0.05$).

Sterile needles and syringes were most commonly obtained from a NSP, though a range of other sources were also used. Eighty-eight percent of participants reported that they had last injected in a private home.

Injection-related problems were experienced by 70% of the sample (66% in 2015). The most common problems experienced were prominent scarring/bruising around the injection site and difficulty finding a vein to inject.

Twenty-eight percent of the sample reported injecting either a partner or friend after injecting themselves with either a new or used needle in the last month, and 18% reported that somebody else injected them after injecting themselves either a new or used needle in the past month.

Blood-borne Viral Infections

In Australia, Hepatitis C (HCV) continued to be more commonly notified than Hepatitis B (HBV), though a decline in newly acquired HBV and newly acquired HCV infections was observed in 2016.

The prevalence of human immunodeficiency virus (HIV) among PWID in NSW remained low yet increased slightly from 2.5 to 3.1

Driving

Forty-two participants had reported that they had driven a vehicle in the six months prior to interview, and of those, two participants reported driving while over the legal alcohol limit.

Sixty-nine percent of recent drivers reported driving within three hours of taking illicit or non-prescribed drug(s) in the six months preceding interview.

Law Enforcement-Related Trends Associated with Drug Use

Criminal Activity among Participants

Forty-one percent reported committing ‘any crime’ in 2016 (46% in 2015), with drug dealing being the most commonly reported crime.

The proportion of the sample who had been arrested in the preceding 12 months remained stable at 33% (38% in 2015).

Lifetime prison history decreased significantly, with 67% of the sample reporting that they had been incarcerated at some point throughout their life (80% in 2015; $p<0.05$).

Arrests

The number of total arrests for heroin and other opioids, amphetamine-type stimulants, cocaine and cannabis increased in 2014/15.

In 2014/15, there were 98 clandestine laboratories detected in NSW (98 in 2013/14). These figures have more than doubled in the past decade.

Expenditure on Illicit Drugs

The median expenditure on illicit drugs the day before interview was $70.

Special Topics of Interest

Blood Donations

Of those who commented, 10% reported that they have given blood in their lifetime.

Five participants who had given blood reported that they had commenced injecting drug use before donating blood.

Homelessness

Ninety percent of the sample reported lifetime prevalence of homelessness; 37% were homeless at the time of interview.

The mean duration of their current episode of homelessness was two years.

The most commonly experienced forms of homelessness during both lifetime and the six months prior to interview were sleeping rough (82%; 38% respectively) and couch surfing (66%; 32% respectively).

Unfair Treatment

Of those who commented, 32% reported that they had ‘never’ been unfairly treated.

Seventy-five participants reported being unfairly treated in the last 12 months, mostly by the police (36%), and/or a family member (28%), most often at a public location (43%).

Sixteen percent admitted to being unfairly treatment ‘daily or more’.

1 INTRODUCTION

The Illicit Drug Reporting System (IDRS) is Australia's national illicit 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, cannabis and other drugs. The IDRS is a sensitive and timely indicator of drug trends both nationally and by jurisdiction. 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 trends in illicit drug markets. As well as drug trends, the findings highlight areas where further research is required, or where changes may need to be made in terms of education, health promotion, treatment services and policy.

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 2016. 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 2016 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 (Hando, Darke et al. 1998). 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 2016 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)

In the 2016 NSW IDRS, the survey consisted of face-to-face interviews with 150 PWID, conducted in Sydney during May and June 2016. Sixty-five 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 NSP facilities. Potential participants were screened for eligibility— i.e. criteria for entry to the study were: (i) at least 17 years of age (ii) at least monthly injection of any drug in the six months preceding interview; and (iii) 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 24.0.

2.2 Survey of key experts (KE)

Thirteen KE who had regular contact with, and/or specialist knowledge of people using illicit drugs[5], drug dealers or drug manufacturers, were interviewed between October and December 2016. 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 2016 including drug treatment workers, therapeutic community and residential detoxification workers, law enforcement officers, medical officers 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 PWID 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 Criminal Intelligence Commission (formally 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;
- 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

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

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

Key Findings

- The mean age of the 2016 sample was 43 years (43 years in 2015).

- Seventy-three percent of the sample were male (66% in 2015) and the majority were unemployed (89%, 94% in 2015).

- Two-thirds had a history of previous imprisonment and significantly more males than females reported a history of imprisonment.

- The median number of years spent at school was 10, with 25% completing years 11 and/or 12.

- Forty-four percent of the sample had no tertiary qualifications, 47% had a trade/technical qualification and 9% had a university education.

- Over half of the sample reported being in current drug treatment (54%), primarily opioid substitution treatment (64% in 2015).

- The majority of the sample (88%) received a government allowance/pension.

- Forty-six percent of the sample lived in rental accommodation and 27% reported having no fixed address or were homeless.

3.1 Overview of people who inject drugs (PWID) regularly

The demographic characteristics of the 150 participants interviewed in 2016 are summarised in Table 1.

The mean age of the sample remained stable in 2016 at 43 years (range: 19−72 years). Seventy-three percent of the sample were male and 24% identified as Aboriginal and/or Torres Strait Islander (39% in 2015). The majority (89%) were unemployed and two-thirds had a history of previous imprisonment (67%). Of those reporting a prison history, significantly more males (n=82) than females (n=18) reported a history of imprisonment ($p<0.01$). The median number of years spent at school was 10 (range: 3−12 years), with one-quarter of the sample (25%) reporting completion of years 11 and/or 12. Forty-four percent of the sample reported having no tertiary qualifications. Of those who did report having a tertiary qualification, most had completed a technical or trade qualification (47%) and 9% had completed a university qualification.

In regards to income, 88% of participants reported receiving some form of government pension, allowance or benefit in the previous month. The mean income per week was reported as $382. In 2016, participants were not asked to specify their main source of income.

Forty-six percent of the participant sample resided in rental accommodation. Twenty-seven percent reported having no fixed address or were homeless, and 17% reported residing in a boarding house or hostel. Seven participants resided in their own house/flat, four participants lived at their family/parent's home, two participants in a shelter/refuge, and a further three participants did not specify their place of residence.

Two-thirds of the sample (66%) were single at the time of interview and 17% were married or in a de facto relationship. Fourteen participants had a regular partner, six participants were separated and a further six participants were divorced.

In 2016, 54% of the sample was in drug treatment at the time of the interview. Of those in treatment, the vast majority of participants (94%) reported being in maintenance pharmacotherapy treatment. More specifically, 74% reported being on a methadone program and 20% reported being on a buprenorphine program, including those receiving Suboxone® treatment. Four participants were receiving drug counselling at the time of interview, and one participant was attending Narcotics Anonymous. There were no reports of participants receiving naltrexone treatment or participation in detoxification programs. The median amount of time spent in current treatment was 30 months (range: 1−288 months).

In summary, compared to 2015, the 2016 sample characteristics remained relatively stable.

Table 1: Demographic characteristics of IDRS sample, 2012−2016

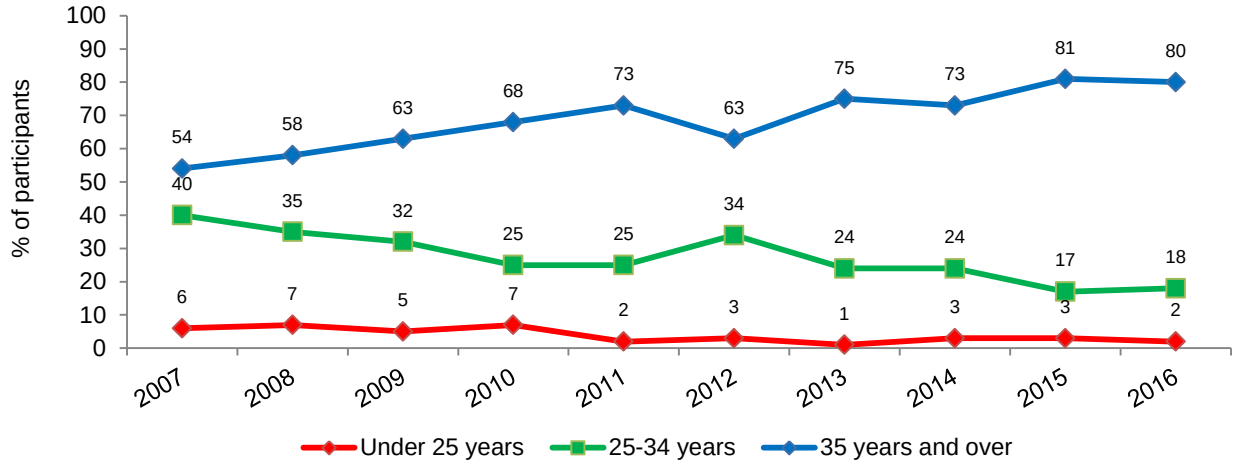
	2012 N=151	2013 N=151	2014 N=150	2015 N=150	2016 N=150
Mean age (years) (range)	39.6 (19−59)	40.1 (23−63)	40.0 (19−64)	43 (19−71)	**43 (19−72)**
Sex (% male)	60	60	75	66	**73**
Aboriginal and/or Torres Strait Islander* (%)	29	27	37	39	**24**
School education (mean no. years, range)	9.8 (0−12)	10 (4−12)	9 (3−12)	9 (0−12)	**10 (3−12)**
Employment (%)					
Not employed/on a pension	93	95	93	94	**89**
Full time	1	1	3	2	**1**
Part-time/casual	3	4	1	3	**5**
Home duties	1	0	1	1	**0**
Student	1	1	1	0	**0**
Sexual identity (%)					
Heterosexual	87	85	91	86	**87**
Bisexual	10	11	7	11	**9**
Gay or lesbian	2	3	2	3	**4**
Other	1	1	0	1	**0**
Tertiary education (%)					
No qualification	49	44	43	45	**44**
Trade/tech	46	49	49	47	**47**
University/college	5	7	7	7	**9**
Current relationship status (%)					
Married/de facto	18	22	22	17	**17**
Regular partner	18	20	16	16	**9**
Single	60	45	55	61	**66**
Separated/divorced	3	10	6	4	**8**
Widowed/widower	1	3	1	1	**0**
Currently in drug treatment^ (%)	60	61	51	64	**54**
Prison history (%)	66	70	79	80	**67**

Source: IDRS participant 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 (80%) of the sample (81% in 2015). 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, 2007−2016



Source: IDRS participant interviews.

3.1.2 Recruitment

The majority of participants had been recruited by word of mouth and by advertisements in NSPs (43%, respectively) (Table 2).

Table 2: Source of participant recruitment, 2012−2016

	2012 N=151	2013 N=151	2014 N=150	2015 N=150	2016 N=150
IDRS survey recruitment (%)					
Needle and Syringe Program (NSP)	49	39	48	31	**43**
Treatment provider	7	13	5	10	**4**
Advert in street press	1	2	0	0	**2**
Word of mouth	40	33	39	48	**43**
Participated in EDRS in previous years (%)	4	3	2	2	**1**

Source: IDRS participant interviews.

4 CONSUMPTION PATTERNS

Key Findings

- The mean age of first injection was 20 years.

- The majority of participants reported that heroin was the first drug injected.

- Heroin remained the preferred drug of choice for 60% of participants, though this was a significant decrease from 72% in 2015.

- Heroin was the drug injected most often in the last month and the most recent drug injected.

- Polydrug use over the last six months remained widespread among the sample.

- With regards to lifetime use, there was a significant increase in the use of 'any' methamphetamine.

- In regards to recent use, there were significant increases in the use, 'any' methamphetamine (driven by a significant increase in crystal methamphetamine use specifically), illicit physeptone, and illicit buprenorphine. There was a significant decrease in the recent use of homebake.

4.1 Lifetime and current drug use

The median age of first injection was 18 years (range: 11−44 years) (Table 3). Similar to previous years, heroin was the first drug injected by the majority of participants (56%), followed by methamphetamine (35%) and cocaine (3%). Heroin remained the most commonly reported drug of choice (60%).

As in previous years, heroin remained the drug injected most often in the month preceding interview (Table 3) and the most common drug last injected (55% respectively) (Table 3). The second most common drug last injected was crystal methamphetamine, and this was significantly higher than 2015 (23%; $p<0.01$). Over half of the participants (53%) injected at least once a day in the preceding month. Eleven percent of participants reported injecting 'more than three times a day', 21% reported injecting '2 to 3 times per day', 21% reported 'once daily injection', 33% reported 'more than weekly, but less than daily' and 12% reported injecting 'weekly or less'.

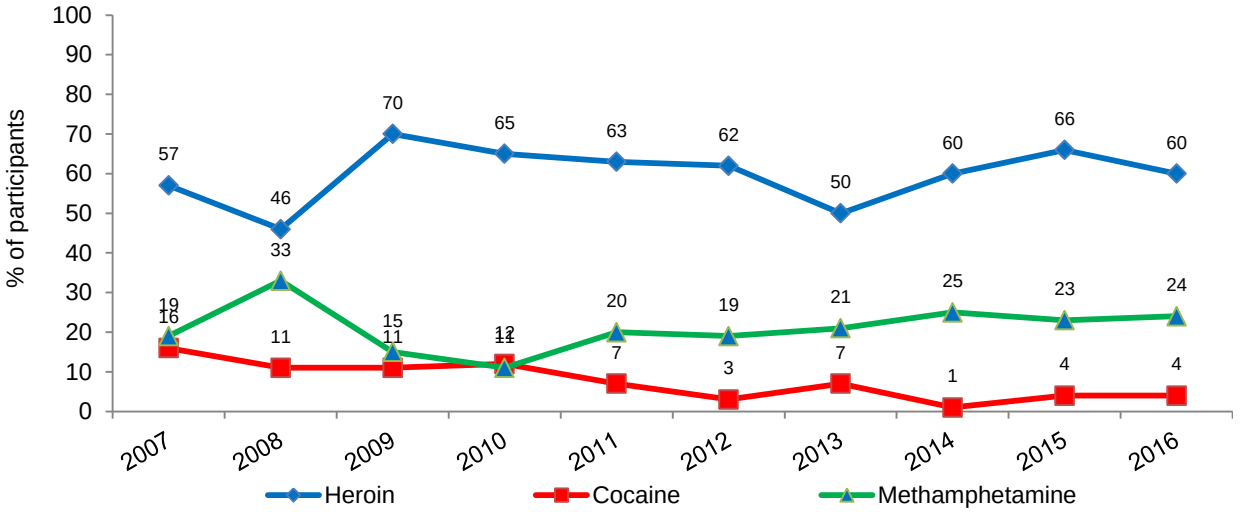
Table 3: Injection history, drug preferences and polydrug use of PWID participants, 2012−2016

	2012 N=151	2013 N=151	2014 N=150	2015 N=150	2016 N=150
Age first injection (mean years)	19	20	19	19	**20**
First drug injected (%)					
Heroin	58	57	55	58	**56**
Methamphetamines	33	36	32	31	**35**
Cocaine	5	3	7	6	**3**
Morphine	1	0	1	1	**1**
Drug of choice (%)					
Heroin	67	62	66	72	**60**
Cocaine	5	9	4	3	**4**
Methamphetamine (any form)	15	17	17	17	**24**
Speed	3	1	3	4	**1**
Base	0	1	0	0	**0**
Crystal methamphetamine	12	15	13	13	**23↑**
Benzodiazepines	1	0	1	0	**0**
Cannabis	2	4	4	4	**3**
Drug injected most often in last month (%)					
Heroin	62	50	60	66	**55**
Cocaine	3	7	1	4	**2**
Methamphetamine (any form)	19	23	28	23	**37**
Speed	2	1	3	1	**0**
Base	0	1	0	0	**0**
Crystal methamphetamine	17	21	25	22	**37↑**
Benzodiazepines	0	0	1	0	**0**
Morphine	4	2	5	1	**0**
Oxycodone	5	11	2	3	**1**
Most recent drug injected (%)					
Heroin	59	50	59	60	**55**
Cocaine	5	7	2	5	**2**
Methamphetamine (any form)	23	24	25	24	**36**
Speed	3	2	1	1	**0**
Base	1	1	0	0	**0**
Crystal methamphetamine	19	21	24	23	**36↑**
Benzodiazepines	0	0	0	0	**0**
Morphine	3	3	4	1	**1**
Oxycodone	8	11	4	2	**1**
Frequency of injecting in last month (%)					
Not injected in last month	1	1	0	1	**1**
Weekly or less	14	13	11	21	**12**
More than weekly, but less than daily	34	35	29	19	**33**
Once per day	14	16	11	15	**21**
2−3 times a day	23	28	37	29	**21**
>3 times a day	15	7	11	15	**11**

Source: IDRS participant interviews.

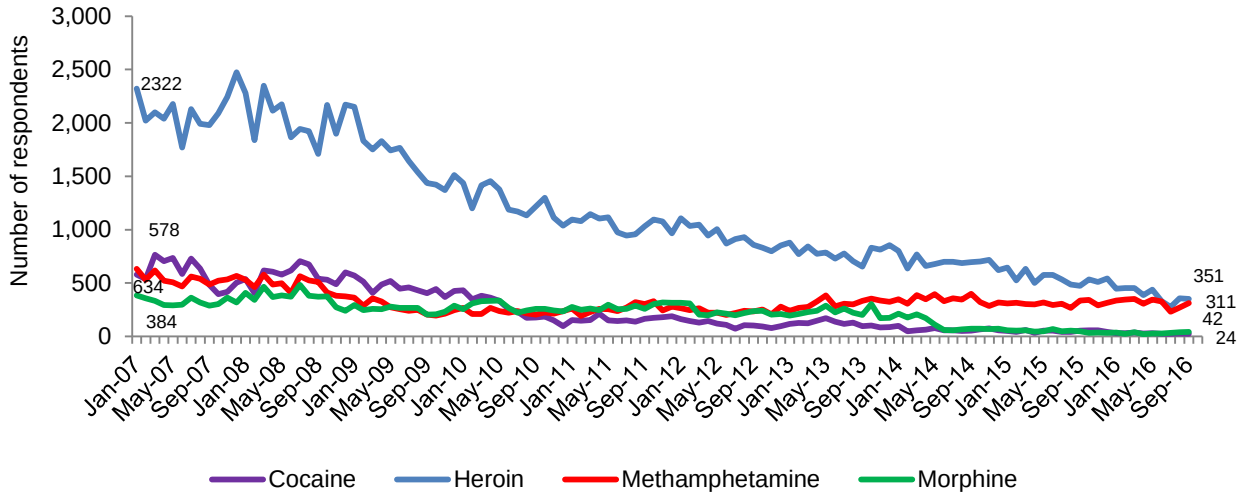
↑ Significant increase between 2015 and 2016 ($p<0.05$).

Figure 2: Drug injected most last month, 2007−2016



Source: IDRS participant interviews.
Note: Survey item was first included in 1999.
Figure 3 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 respondents, though there has been a continuing decline in the number or respondents reporting heroin from 2005 (n=2665 in January 2005 compared to n=351 in September 2016). 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 at a low level.

Figure 3: Number of respondents attending three inner city NSP reporting heroin, methamphetamine, cocaine and morphine as last drug injected, Jan 2007−September 2016



Source: Three inner city NSPs.

Table 4: Polydrug use among PWID, 2015−2016

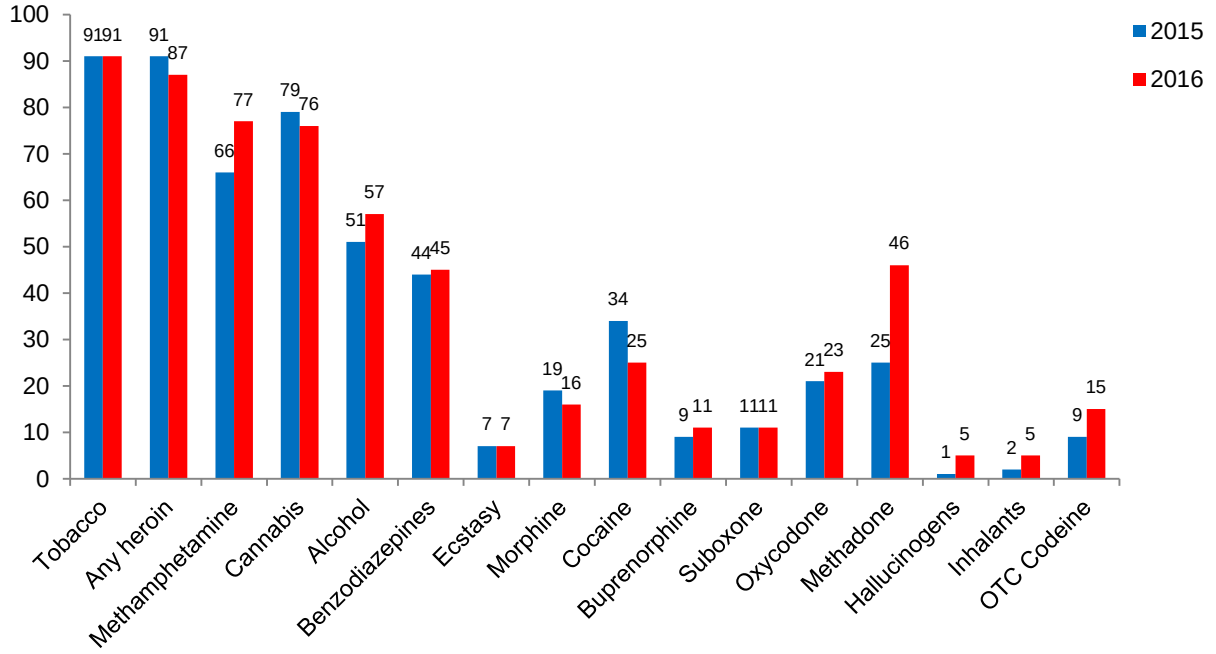
Polydrug use (median)	2015 (n=146)	**2016 (n=143)**
Number of drug classes ever used	14 (1−23)	**14 (5−23)**
Number of drug classes used in last 6 months	7 (1−20)	**10 (4−17)**

Source: IDRS participant interviews.

Polydrug use was common among IDRS participants and this has remained consistent across the years. Participants were asked about their history of use of 25 separate substances. These substances consisted of; heroin, any methadone, any oxycodone, any morphine, any buprenorphine, any buprenorphine-naloxone, any benzodiazepine, any pharmaceutical stimulant, methamphetamine powder, methamphetamine base, liquid methamphetamine, crystal methamphetamine, cocaine, cannabis, inhalants, hallucinogens, ecstasy, fentanyl, steroids, any new psychoactive stimulant, OTC codeine, other opioids, Seroquel®, alcohol and tobacco. Only illicit use of a drug was analysed. In 2016, participants reported use of a median of 14 (range: 5–23) drug types across their lifetime and a median of 10 (range: 4−17) during the six months prior to interview; this appeared to be a slight increase from 2015 (see Table 4).

The drugs most commonly used among the participants in the last six months were tobacco, 'any' heroin, 'any' methamphetamine, cannabis and alcohol (see Figure 4). This remained stable from 2015. More detailed information on the use of these drugs can be found under the relevant section headings in the report.

Figure 4: Prevalence of drug use among PWID in the six months preceding interview, NSW 2016*



Source: IDRS participant 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. 'Methadone' includes illicit (not prescr.) methadone liquid and Physeptone®. 'Morphine' 'buprenorphine', 'oxycodone', 'suboxone' and 'benzodiazepines' includes only illicit tablet and film forms of the drug in any formulation unless otherwise specified. 'Use' refers to any form of administration and does not necessarily imply injection; for further information on routes of administration, please refer to Table 5.

In 2016, there were a number of significant changes in the lifetime and recent use of certain drugs. In regards to lifetime use, there was a significant increase in the use of 'any' methamphetamine from 89% in 2015 to 97% in 2016 (p<0.05).

In regards to recent use, there were significant increases in the recent use of 'any methamphetamine', specifically crystal methamphetamine (77%; 65% in 2015), and illicit physeptone (5%; 3% in 2015) (p<0.05, respectively). There was also an increase in the recent use of illicit buprenorphine (11%; 9% in 2015) (p<0.01). There was a significant decrease in the use of homebake (6%; 15% in 2015) (p<0.05). A more detailed history of participants' drug use can be found in Table 5.

Table 5: Drug use history and routes of administration of the sample, 2016

Drug Class	Ever used %	Ever inject %	Use last 6 months %	Inject last 6 months %	Smoke last 6 months %	Snort last 6 months %	Swallow last 6 months %	Days used last 6 months^*	Days inject last 6 months*
Heroin	99	99	86	83	13	2	1	90	96
Homebake	35	33	6	4	2	0	0	2	8
Any Heroin	**99**	**99**	**87**	**83**	**14**	**2**	**1**	**96**	**96**
Methadone - licit	60	32	39	10			36	180	24
Methadone – illicit	47	35	18	16			7	9	8
Physeptone – licit	15	7	1	0	0	0	1	91	0
Physeptone – illicit	21	13	5	2	0	0	3	2	2
Any Methadone	**79**	**52**	**49**	**21**	**0**	**0**	**42**	**180**	**21**
Buprenorphine – licit	32	20	5	2	1	0	5	90	10
Buprenorphine – illicit	31	25	11	9	1	0	3	4	4
Any Buprenorphine	**49**	**35**	**15**	**11**	**2**	**0**	**7**	**7**	**4**
Buprenorphine Naloxone – licit	32	12	9	3	0	0	8	80	3
Buprenorphine Naloxone – illicit	31	21	11	8	1	0	3	4	4
Any Buprenorphine Naloxone	**42**	**26**	**16**	**9**	**1**	**0**	**10**	**36**	**4**
Generic Oxycodone – licit	10	7	2	1	0	0	1	30	14
Generic Oxycodone – illicit	46	41	19	15	1	0	5	10	19
OP Oxycodone – licit	6	4	2	1	0	0	1	180	4
OP Oxycodone – illicit	23	16	12	9	0	0	5	5	3
Other Oxycodone – licit	9	5	3	1	0	0	3	5	1
Other Oxycodone – illicit	16	15	3	3	0	0	1	6	5.5
Any Oxycodone	**66**	**55**	**25**	**17**	**1**	**0**	**11**	**19**	**14**
Morphine – licit	18	10	4	3	1	0	1	150	64
Morphine – illicit	49	45	16	14	0	0	2	12	14
Any Morphine	**59**	**49**	**18**	**16**	**0**	**0**	**3**	**15**	**15**
Other Opioids	41	3	19	1	0	0	18	6	5
OTC Codeine	35	5	15	0	0	0	15	4	0
Methamphetamine Powder	83	75	17	15	5	4	2	7	7
Methamphetamine Base	60	55	11	10	1	0	1	5	5
Methamphetamine Crystal	89	88	77	71	31	5	5	48	48
Any form Methamphetamine	**97**	**95**	**77**	**71**	**31**	**8**	**7**	**54**	**60**
Pharmaceutical Stimulants – licit	8	3	2	1	0	0	2	180	180
Pharmaceutical Stimulants – illicit	15	8	2	1	0	0	1	2	2

Source: IDRS participant 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®).
Note: Buprenorphine-naloxone was first listed on the Pharmaceutical Benefits Scheme (PBS) in April 200

Table 5: Drug use history and routes of administration of the sample, 2016 (Continued)

Drug Class	Ever used %	Ever inject %	Use last 6 months %	Inject last 6 months %	Smoke last 6 months %	Snort last 6 months %	Swallow last 6 months %	Days used last 6 months^*	Days inject last 6 months*
Cocaine	84	76	25	23	2	5	1	6	6
Hallucinogens	56	13	5	0	1	0	4	2	0
Ecstasy	57	27	7	3	0	0	6	2	1
Alprazolam – licit	17	3	7	0	0	0	7	180	0
Alprazolam – illicit	57	5	33	1	0	0	32	10	4
Other Benzodiazepines – licit	38	3	19	0	0	0	19	90	0
Other Benzodiazepines – illicit	51	5	35	1	0	1	34	10	6
Any Benzodiazepines (including Alprazolam)	**78**	**12**	**53**	**1**	**0**	**1**	**52**	**24**	**7**
Seroquel – licit	26	1	11	0	0	0	10	180	0
Seroquel – illicit	31	1	11	0	0	0	11	3	0
Any Seroquel	**51**	**2**	**21**	**0**	**0**	**0**	**21**	**10**	**0**
Alcohol	93	7	57	0			55	11	0
Cannabis	95		76		73		4	155	
Tobacco	96		91					180	
E-Cigarettes	96		13					3	
Inhalants	17		5					5	
Steroids	5	5	0	0	0	0	0	0	0
Fentanyl	28	24	17	17	0	0	1	6	6
NPS	4	1	2	0	1	1	1	1	0
Synthetic Cannabis	27	1	11	0	11	0	0	1	0

Source: IDRS participant interviews.
^ Refers to any route of administration, i.e. includes use via injection, smoking, swallowing, and snorting.
* Among those who had used/injected.

4.2 Heroin

Key Findings

- In 2016, 86% reported recent use of heroin (91% in 2015).
- Heroin was used on a median of 90 days within the six months preceding interview (120 days in 2015). Daily use decreased to 25% from 43% in 2015.
- Ninety-six percent of recent heroin users reported injecting heroin on a median of 96 days.
- White/off white powder or rock was the most commonly used form of heroin used by participants in 2016.
- On an average day, the median amount used was two points or 0.5 grams.

4.2.1 Heroin use among PWID

The majority of participants (86%) had used heroin in the six months preceding interview (91% in 2015). Heroin remained the drug of choice for 60% of the sample, which was a significant decrease from 72% in 2015 ($p<0.05$) (Table 5). Heroin was most commonly nominated as the most recent drug injected (55%), a slight decrease from 60% reporting it in 2015. Additionally, heroin was nominated by 55% of the sample as the 'drug injected most often in the last month' (66% in 2015).

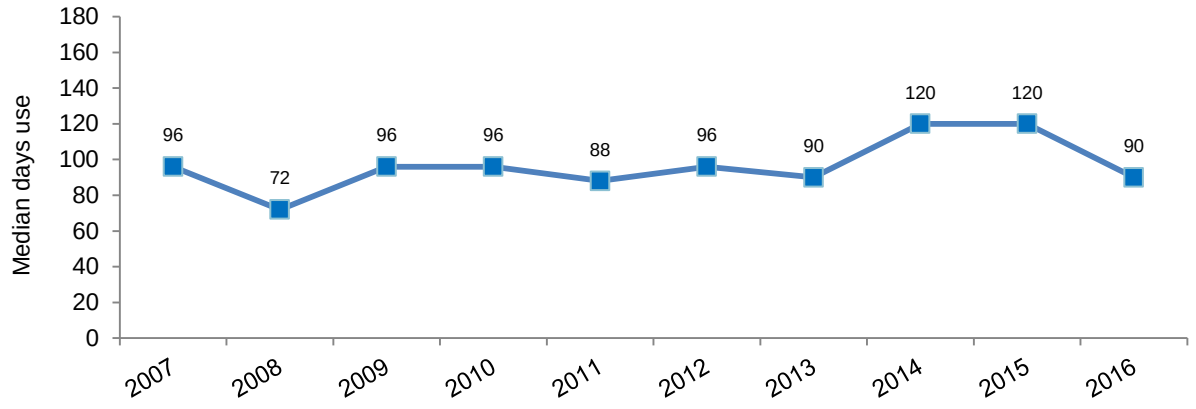
Heroin was used on a median of 90 days (range: 1–180 days) in the preceding six months, a slight decrease from 2015 (120 days), which was last observed in 2013. Nevertheless, over the last decade, the median days of use has remained fairly consistent (Figure 5). The vast majority of recent heroin users (96%) reported injecting heroin within the preceding six months on a median of 96 days (range: 1–180 days). Among recent users of heroin, about one-third (35%) reported daily use in 2016 (43% in 2015).

Table 6: Recent heroin use of IDRS participants, 2015−2016

	2015	**2016**
Recent use (%)	91	**86**
Median days of use*	120	**90**
Daily use * (%)	43	**35**

Source: IDRS participant interviews.
*Among those who had used. Maximum number of days, i.e. daily use, is 180. See page ix for guide to days of use/injection.

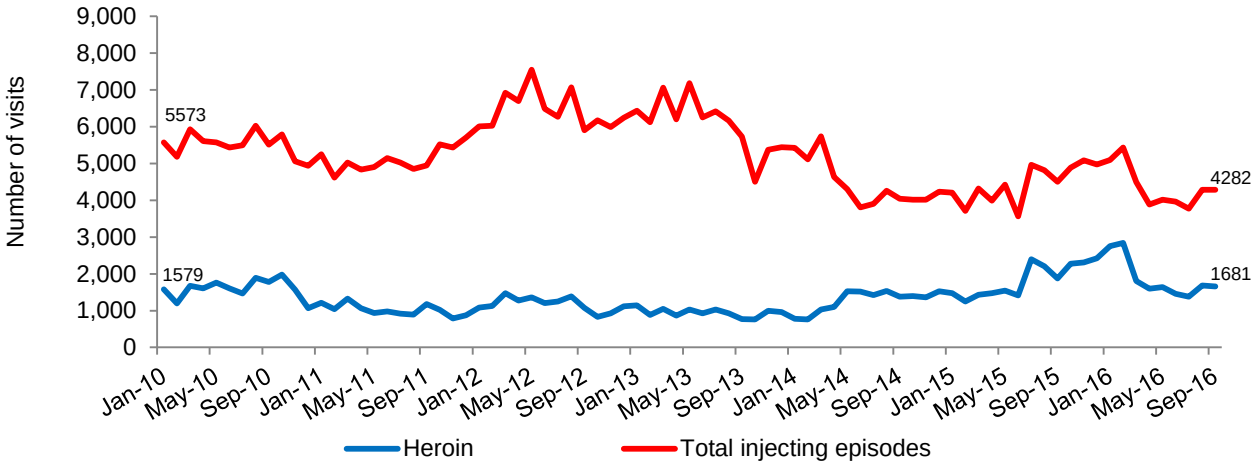
Figure 5: Median days of heroin use* in the past six months, 2007–2016



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

Figure 6 shows the number of attendances to the Sydney Medically Supervised Injecting Centre (MSIC) in Kings Cross where clients report heroin as the drug injected between January 2010 and September 2016.[6] A steady downward trend in attendances for heroin injection was observed in October 2012. Nevertheless, heroin injection has once more increased since March 2014. In the 12 months to September 2016, heroin has accounted for approximately 44% of all attendances to Sydney MSIC.

Figure 6: Number of attendances to Sydney MSIC where heroin was injected and total number of visits, January 2010–September 2016



Source: Sydney MSIC, Kings Cross.
Note: Total visits refer to the total number of valid visits at which a response was given.

4.2.2 Forms of heroin used

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 ROA.

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 and IDRS participants 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'.

As in previous years, participants were asked about the forms of heroin they had used over the preceding six months. Of the 129 participants who had recently used heroin, 90% (n=116)

[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.

reported use of a white/off white powder or rock form of heroin (89% in 2015), and 76% (n=98) reported using a brown powder or rock form of heroin (62% in 2015). The form most used over the preceding six months among those who could comment was white/off-white powder (45%; 41% in 2015), followed by white/off-white rock (22%; 31% in 2015). The use of 'rock' differed somewhat from 2015, with 21% using brown rock in 2016 compared with 17% in 2015, and brown powder was used by 12% of participants, compared with 6% in 2015. There were however no significant differences between 2015 and 2016 reports.

Homebake is a form of heroin made from pharmaceutical products and involves the extraction of diamorphine from pharmaceutical opioids such as codeine and morphine. Homebake use remained uncommon and infrequent among the NSW sample, with nine participants (6%) reporting recent use (15% in 2015) on a median of two days (range: 1–175 days). Six participants reported injecting homebake in the preceding six months (n=23 in 2015), on a median of 7.5 days (range: 2–175 days).

Table 7: Reports of heroin forms used in the last six months among those who had recently used heroin, 2015–2016

	2015	**2016**
Used last 6 months (%)	(n=136)	**(n=129)**
White/off-white powder or rock	89	**90**
Brown powder or rock	62	**76**
Form most used last 6 months	(n=133)	**(n=125)**
White powder or rock	71	**66**
Brown powder or rock	23	**33**
Homebake	2	**1**
Other colour	4	**0**

Source: IDRS participant interviews.

4.2.3 Quantity of heroin use

Participants were asked about the quantity of heroin used on an average day in the six months prior to interview. Sixty-six percent (n=85) reported using points, 23% (n=30) reported using grams and 11% (n=14) reported using 'other'. On an average day, the median amount used was two points (range: 0.25–8 points) or 0.5 grams (range: 0.25–2 grams).

Key expert comments

- KE comments reflected findings in the PWID survey that heroin remained the drug of choice among this group, and that heroin is used by 60–70% of NSP clients.
- 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.
- One KE mentioned that in the few months preceding interview, urine drug screening was "full of heroin again". Prior to this, there was a period when urine drug screens more so contained a mixture of prescription opioids, benzodiazepines and methamphetamine.
- 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.
- One KE stated "more of my clients die of this drug than any other".

4.3 Methamphetamine

Key Findings

- Seventy-seven percent of participants had recently used 'any' form of methamphetamine, which was a significant increase from 2015 (66%).

- Recent use of crystal methamphetamine was reported by 77% of the sample (65% in 2015), which significantly increased and was the most commonly used form of methamphetamine.

- Speed was used by 17% of participants in the last six months (13% in 2015), followed by base (11%; 6% in 2015).

- The median days of crystal methamphetamine use doubled from 24 days in 2015 to 48 days in 2016.

- Of the 116 participants who reported recently using some form of methamphetamine, 18% reported daily use during that period.

- All participants using any form of methamphetamine reported having done so by injection in the six months prior to interview.

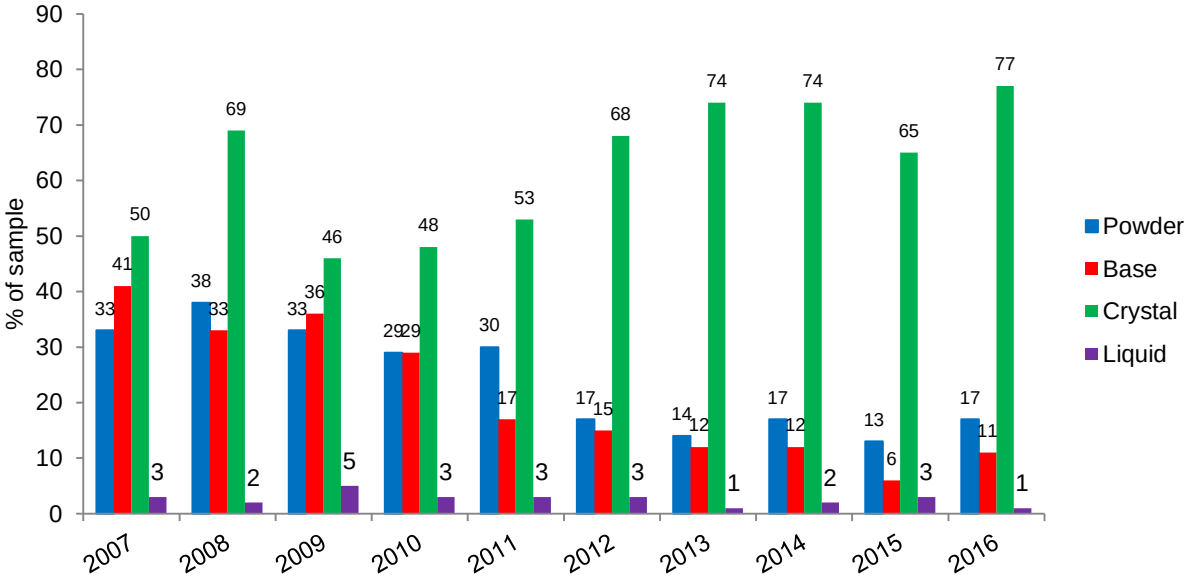
- The median amount used on an average day in the last six months was two points or 0.5 grams for speed and base methamphetamine. The median amount of crystal used on an average day in the last six months was one point or 0.5 grams.

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. Crystal methamphetamine 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.

4.3.1 Use of methamphetamine

In 2016, 77% of participants had used any form of methamphetamine in the six months preceding interview (66% in 2015), which represents a significant increase from 2015 ($p<0.05$). Considered separately, the most commonly used form of methamphetamine was crystal methamphetamine (77%; 65% in 2015), which had also significantly increased ($p<0.05$). This was followed by speed (17%; 13% in 2015), and then base (11%; 6% in 2015). Liquid amphetamine remained considerably less common, with only one participant reporting use in the last six months (four participants in 2015) (Figure 7).

Figure 7: Methamphetamine, percentage of participants that used in the last six months, 2007–2016

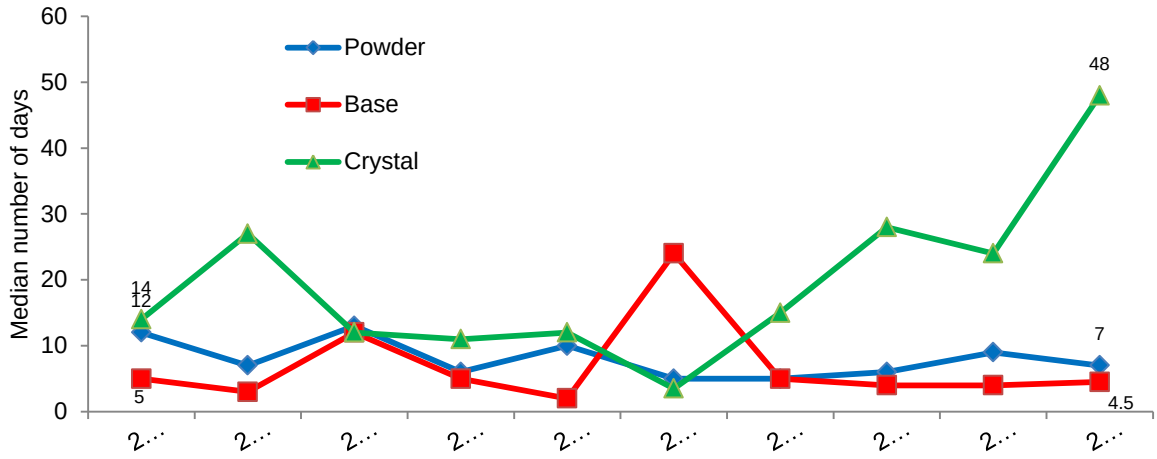


Source: IDRS participant interviews.
Note: Liquid methamphetamine n ≤ 10 results should be interpreted with caution.

4.3.2 Methamphetamine frequency of use

As can be seen from Figure 8, there have been changes in the median days of different forms of methamphetamine over time. The median days of base has fluctuated over the years, with a sharp rise in 2012 and a subsequent decline in 2013, which plateaued and remained stable. Participants reported using base on a median of 4.5 days (range: 1–180 days) (4 days in 2015). The median days of crystal methamphetamine doubled to 48 days (24 days in 2015) (range: 1–180 days), though this was not a significant increase. The frequency of use for powder methamphetamine (as measured by the median number of days used in the six months prior to interview) remained stable in 2016. Participants reported using powder on a median of 7 days (range: 1–180 days) (9 days in 2015).

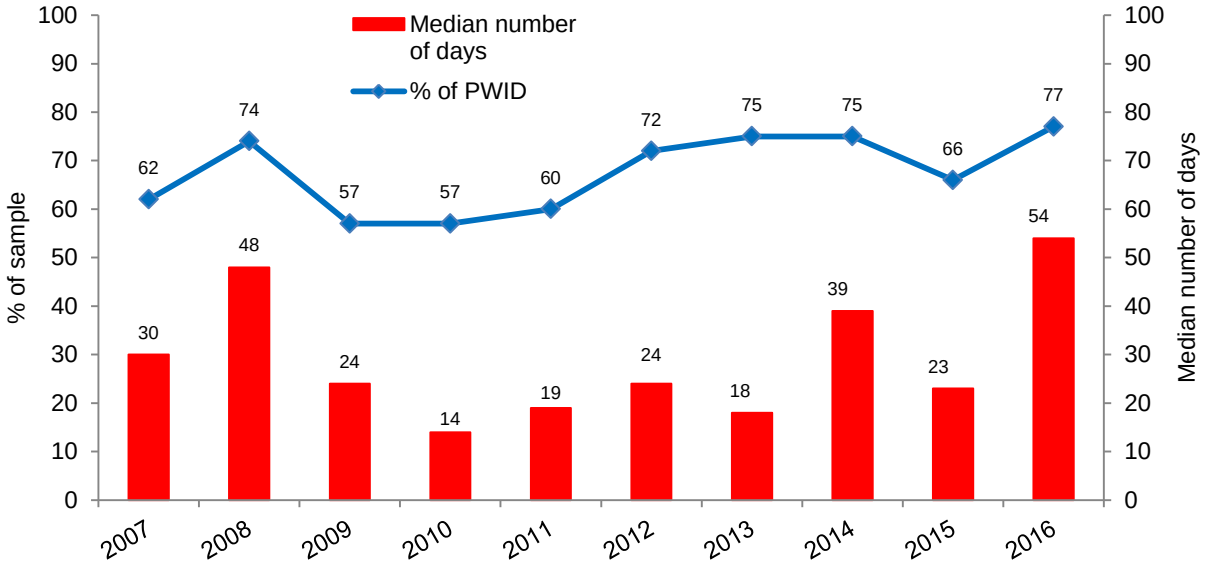
Figure 8: Methamphetamine, median number of days used in the last six months, 2007-2016



Source: IDRS participant interviews.
Note: Median number of days for liquid methamphetamine was not reported due to small numbers (n<10).

The long-term trend in the use of any form of methamphetamine is depicted in Figure 9. Overall in 2016, 77% of participants had used some form of methamphetamine (powder, base, crystal and/or liquid) in the six months preceding interview; this was a significant increase from 2015 ($p<0.05$). Recent users of methamphetamine reported that they had used on a median of 54 days (range: 1–180 days) in a six month period (23 days in 2015).

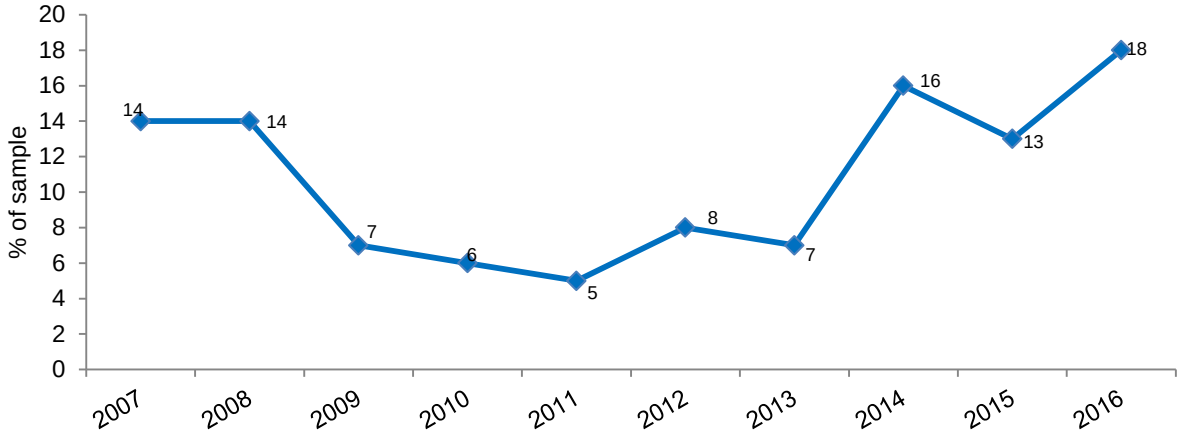
Figure 9: Recent use and median number of days used of any form of methamphetamine, 2007–2016



Source: IDRS participant interviews.
Note: Results of those reporting recent use in the previous six months.

Of the 116 participants who reported using some form of methamphetamine in the last six months, 82% reported 'weekly or more' use of methamphetamine (82% in 2015) and 18% reported daily use during that period (13% in 2015). Furthermore, 82% reported weekly or more use of methamphetamine. The long-term trend for the percentage of participants using any form of methamphetamine on a daily basis is depicted in Figure 10. As shown, the prevalence of daily methamphetamine use has fluctuated over the past decade. Daily use increased in 2016, though this proved insignificant.

Figure 10: Methamphetamine, percentage that used daily in the last six months*, 2007–2016

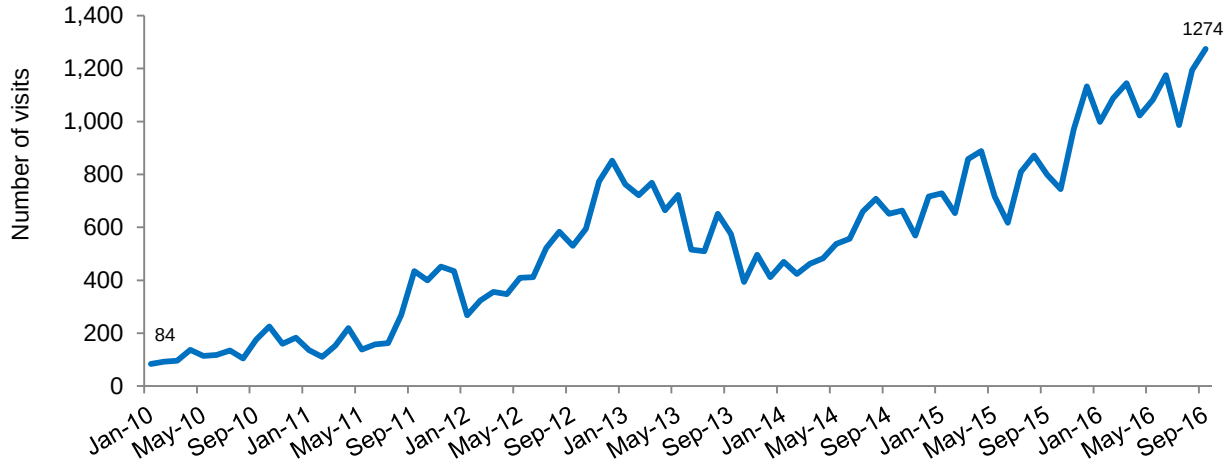


Source: IDRS participant interviews.

All participants using any form of methamphetamine reported having done so by injecting in the six months prior to interview. With regards to speed powder, seven participants reported smoking, six participants reported snorting and three participants reported swallowing in the preceding six months. One participant reported smoking base methamphetamine and one participant had swallowed it in the preceding six months. Thirty-one percent reported smoking crystal methamphetamine in the past six months, while the proportion of participants who reported snorting and swallowing crystal remained low (n=7 and n=8, respectively). All results remained stable from 2015.

Figure 11 shows the number of attendances to the MSIC where methamphetamine was the drug injected.[7] Numbers reporting methamphetamine have steadily increased over the past three years from 762 in January 2013 to 1274 in September 2016, representing approximately 30% of all injecting episodes.

Figure 11: Number of attendances to Sydney MSIC where methamphetamine was injected, January 2010–September 2016



Source: Sydney MSIC, Kings Cross.

4.3.3 Quantity of methamphetamine use

Participants were asked about the quantity of the different forms of methamphetamine used in the last six months in an average day. The median quantities reported for speed, base and crystal are reported below.

4.3.3.1 Speed

Of those who used speed powder, 65% (n=17) reported using points, 27% (n=7) reported using grams and 8% (n=2) reported using 'other'. The median amount used on an average day in the last six months was two points (range: 1–5 points) or 0.5 grams (range: 0.5–2 grams).

4.3.3.2 Base

Of those who used base, 56% (n=9) reported using points and 44% (n=7) reported using grams. On an average day in the last six months, the median amount used was two points (range: 0.5–5 points) or 0.5 grams (range: 0.5–1 gram).

[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.

4.3.3.3. Crystal

Of those who used crystal methamphetamine, 82% (n=95) reported using points, 15% (n=17) reported using grams, and 3% (n=4) reported using 'other'. The median amount of crystal used on an average day in the last six months was one point (range: 0.20–10 points) or 0.5 grams (range: 0.25–1 gram).

Throughout the course of a typical day, the median amount of points used in the last six months was one (range: 0.20–10 points). The median amount of grams used in the previous six months was 0.5 (range: 0.25–1 gram).

Key expert comments

- The majority of KE considered methamphetamine, especially crystal 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 (16 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, dental issues and skin issues (due to scratching and picking) were noted.
- KE stressed the need for more treatment services to reduce use and harms associated with methamphetamine use.
- KE highlighted the need to prohibit 'scaremongering ice campaigns' on the television, as the majority of crystal methamphetamine users cannot relate to these images as it does not reflect them. The campaigns 'merely appeal to the masses'.
- Law enforcement KE stated that there was continued organized crime involvement, especially in terms of importation of the finished product and domestic manufacture of methamphetamine.
- KE reported that small-scale clandestine laboratories were decreasing, yet large scale laboratories were increasing. The large clandestine laboratories cook 5–10kg of methamphetamine, which is a big indicator of organised crime.

4.4 Cocaine

Key Findings

- Twenty-five percent of participants reported cocaine use in the preceding six months (34% in 2015).

- Ninety-two percent of recent cocaine users reported recently injecting cocaine (96% in 2015).

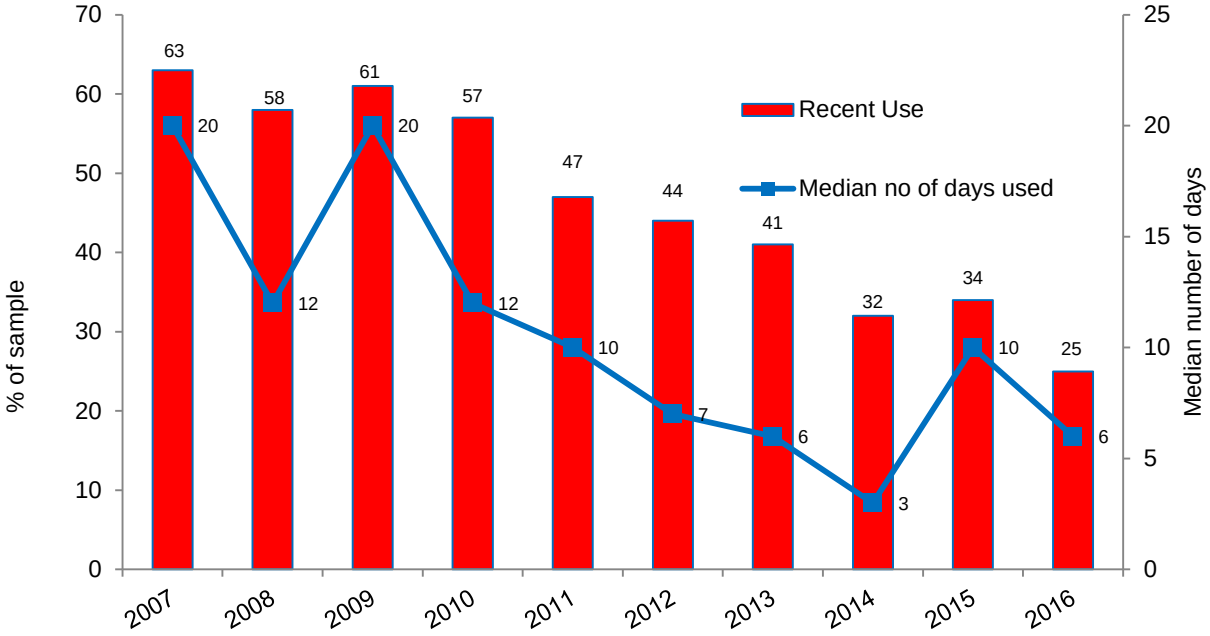
- Of those that reported recent use, 81% had used powder (94% in 2015), 47% had used rock (32% in 2015) and 19% had used crack (4% in 2015).

- On an average day, the median amount of cocaine used was one point or 0.25 grams.

4.4.1 Use of cocaine

In 2016, twenty-five percent of all participants reported cocaine use in the preceding six months (34% in 2015). Of these, 92% (n=34) reported injecting cocaine in the preceding six months. Three participants reported cocaine as the drug last injected (n=8 in 2015). As one can see from Figure 12, numbers reporting recent cocaine use have steadily decreased over the past decade, from 63% in 2007 down to 25% in 2016.

Figure 12: Cocaine, recent use and median number of days used, 2007–2016



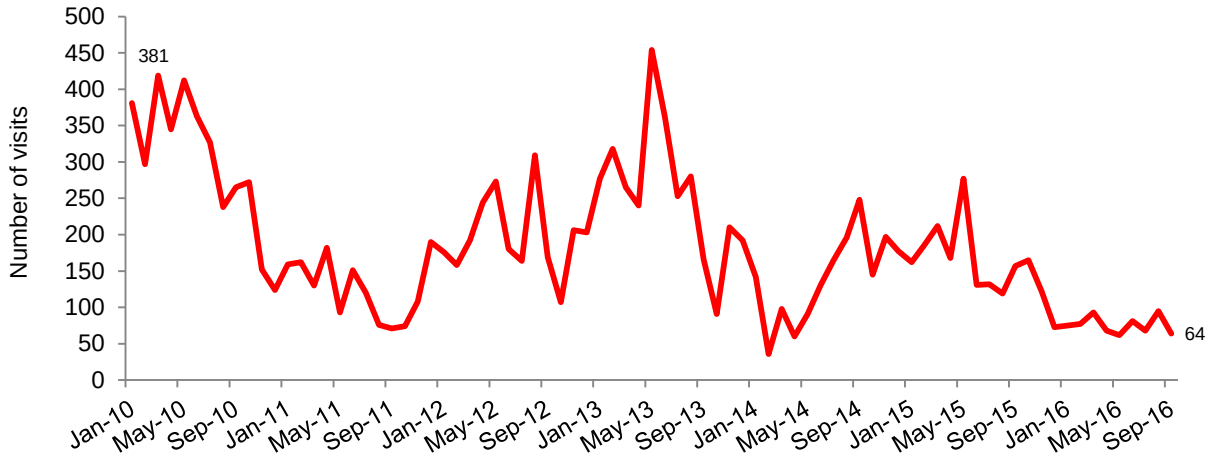
Source: IDRS participant interviews.
Note: Results from those reporting recent use in the previous six months.

4.4.2 Current patterns of cocaine use

Participants that had recently used cocaine reported use on a median of six days (range: 1–180 days) (10 days in 2015) (Table 5). Daily cocaine use remained stable with eight percent of all participants reporting daily use (n=3).

Figure 13 shows the number of attendances to the Sydney MSIC where cocaine was the drug injected.[8] Cocaine injecting at the MSIC has remained low and stable over the past 12 months to September 2016. For the majority of this period, cocaine injections have accounted for approximately 2% of the total number of injecting episodes.

Figure 13: Number of attendances to Sydney MSIC where cocaine was injected, January 2010–September 2016



Source: Sydney MSIC, Kings Cross.

4.4.3 Forms of cocaine used

Participants were also asked which forms of cocaine they had used over the last six months. Of those that reported recent use, 81% had used powder (94% in 2015) and 19% had used crack (4% in 2015). Half (47%) of those that recently used cocaine had used rock (32% in 2015), indicating a significant increase ($p<0.01$).

4.4.4 Quantity of cocaine use

Participants were asked about the quantity of cocaine used on an average day in the six months prior to interview. Forty-one percent (n=15) reported using points, 46% (n=17) reported using grams and 14% (n=5) reported using 'other'. On an average day, the median amount of cocaine used was one point (range: 0.50–6 points) or 0.25 grams (range: 0.25–4 grams).

Key expert comments

- Cocaine was reported to be the third most detected drug behind cannabis and crystal methamphetamine.
- Law enforcement KE reported that cocaine was mainly detected in affluent areas.

[8] 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.

4.5 Cannabis

Key Findings

- Lifetime and recent use of cannabis remained high in 2016 at 95% and 76%, respectively (95% and 79% in 2015, respectively).

- Cannabis was used on a median of 155 days in the past six month period (120 days in 2015), with half (47%) reporting daily use (43% in 2015).

- Of the participants who had used cannabis recently, 94% reported the use of hydro and 43% reported the use of bush within that period.

- Eight participants reported use of 'hash' and five participants reported use of 'hash oil'.

- On an average day, the median amount of cannabis used was 5.5 cones or two joints.

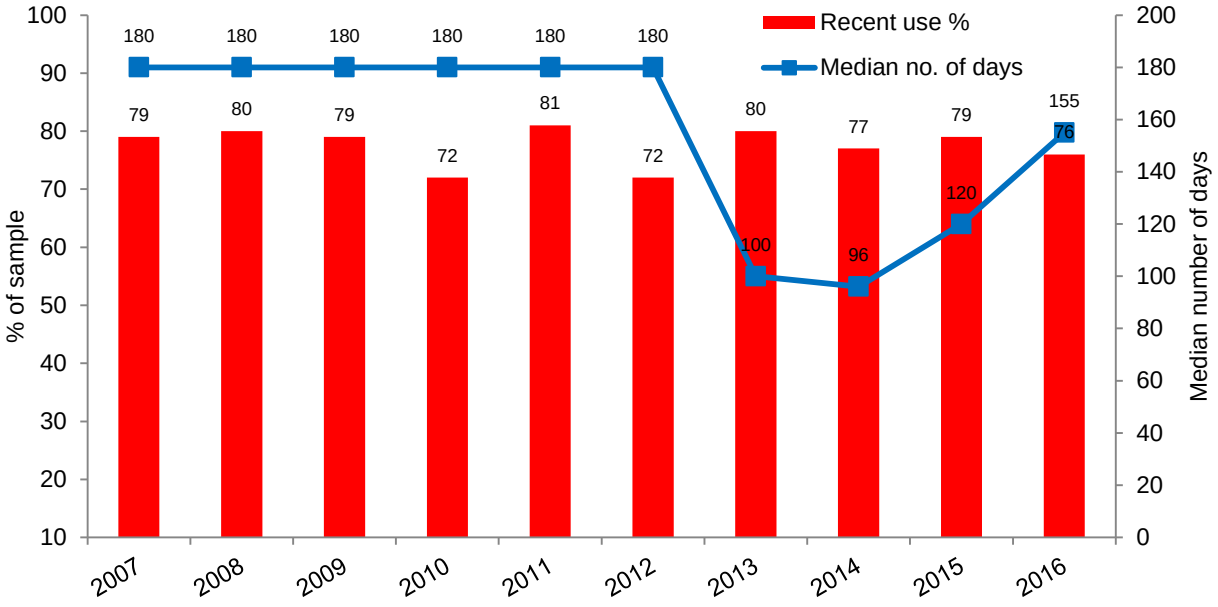
The IDRS has differentiated between hydro and bush prices since 2003, and since 2004 it has also collected information on the potency and availability of the two main forms used in Australia. Information on hashish (hash) and hash oil prices are collected but, as its use is sporadic, information about potency and availability are not sought from PWID participants.

4.5.1 Current patterns of cannabis use

It is worth noting that participants were recruited on the basis of their injecting drug use (rather than use of illicit drugs overall), therefore the following data may not be representative of cannabis users in general. That is, the IDRS reports on cannabis use by a sample of PWID only.

In 2016, the proportion of participants who reported lifetime use of cannabis remained stable at 95% and recent use continued to remain high among participants. Of those who had ever used cannabis, 76% reported having used cannabis in the preceding six months (79% in 2015). This has generally remained stable for the last decade (see Figure 14). Cannabis was used on a median of 155 days (range: 1–180). Of those who had recently used cannabis, 47% reported daily use (43% in 2015).

Figure 14: Cannabis, recent use and median number of days used, 2007-2016



Source: IDRS participant interviews.

4.5.2 Forms of cannabis

Ninety-four percent of respondents who had used cannabis reported using hydro in the preceding six months (93% in 2015), and 43% of cannabis users reported using bush during this time (38% in 2015). Seven percent (n=8) of recent cannabis users reported use of hashish (4% in 2015) and five participants (n=2 in 2015) had used hash oil. When asked which form of cannabis they had 'used most often' in the last six months, the vast majority (94%) of recent users reported hydro and 5% (n=6) reported bush.

4.5.3 Quantity of cannabis use

Participants were asked about the quantity of cones and joints used on an average day in the six months prior to interview. Readers should note that the term 'cone' refers to the indentation in a pipe/bong or a pipe/bong attachment in which cannabis is inserted to be ignited. The term 'cones', in the context of the question, refers to the average number of times the 'cone' was filled and the contents smoked per day. A 'bong' is a water-pipe apparatus, which enables the filtering of cannabis smoke through a chamber. Fifty-seven percent (n=64) reported using 'cones', 12% (n=13) reported using 'joints' and 31% (n=35) reported using 'other' methods. On an average day, the median amount used was 5.5 cones (range: 1–120 cones) or two joints (range: 1–8 joints). Among daily users, the median number of cones smoked in the last six months was 10 (range: 2–120 cones) and the median number of joints used among daily users was three (range: 2–6 joints).

Key expert comments

- One KE believed that cannabis was the most problematic drug at the current time.
- KE reported that cannabis use was associated with poor mental health, mostly in terms of high co-morbid anxiety and depression.
- Increased levels of violence towards parents were also reported by KE.
- One KE reported that cannabis use is becoming problematic with our ageing population, with an increase in smoking related chronic obstructive pulmonary disease.

4.6 Opioids

Key Findings

- In 2016, heroin was the most commonly used opioid in the six months prior to interview (87%), followed by licit or illicit methadone (49%).

- When all the opioid substance categories are collapsed, 47% of participants had used some type of illicit opioid in the six months prior to interview (excluding heroin).

- Thirty percent of participants reported having used illicit methadone syrup (25% in 2015) on a median of nine days in the last six months and the average amount used per day in the last six months was a median of 50ml.

- Seven participants reported having used illicit Physeptone® tablets (n=4 in 2015) on a median of two days in the last six months and the average amount recently used per day was a median of 10mg.

- Eleven percent of participants (9% in 2015) reported having used illicit buprenorphine on a median of four days in the six months prior to interview and the average amount used per day was a median of 8mg.

- Sixteen percent of participants reported having used illicit buprenorphine-naloxone on a median of four days in the six months prior to interview. The average amount used per day in the last six months was a median of 8mg.

- Sixteen percent of participants reported they had used illicit morphine in the six months prior to interview (19% in 2015) on a median of 12 days. The average amount of illicit morphine used per day in the last six months was a median of 100mg.

- Nineteen percent reported recent use of illicit generic oxycodone on a median of ten days and the average amount of illicit generic oxycodone used per day was a median of 80mg.

- Twelve percent reported recent use of illicit OP oxycodone on a median of five days. The average amount of illicit OP oxycodone used per day in the last six months was a median of 80mg.

- Four participants reported recent use of illicit other oxycodone on a median of 5.5 days. The average amount of illicit other oxycodone used per day in the last six months was a median of 90mg.

- Seventeen percent reported using fentanyl (15% in 2015) on a median of six days in the six months preceding interview, and the average amount used per day was a median of 50mg or 87.5 ug/hr.

- Fifteen percent reported using OTC (9% in 2015) on a median of four days in the six months preceding interview. The main brand of OTC codeine used by participants was Nurofen Plus.

- Nineteen percent of participants (16% in 2015) reported that they had used other opiates in the six months preceding interview on a median of 5.5 days. The majority of participants reported that Panadeine Forte® was the main brand used.

The IDRS investigates the use patterns, harms and market characteristics of a number of pharmaceutical opioids including methadone, buprenorphine, buprenorphine-naloxone, morphine, oxycodone, fentanyl, over the counter codeine, and other opioids (not specified elsewhere). Use of these substances is broadly split into the following categories:

Use

1. Use of licitly obtained opioids, i.e. use of opioids obtained by a prescription in the user's name, through any ROA (includes the use of these medications as prescribed).

2. Use of illicitly obtained opioids, i.e. those obtained from a prescription in someone else's name, through any ROA ('illicit use').
3. Use of 'any' opioids, i.e. includes both licit and illicit obtained opioids.

Injection

1. Injection of licitly obtained opioids.
2. Injection of illicitly obtained opioids.
3. Injection of 'any' opioids.

Note on interpretation: The IDRS documents the use of opioid medications, licitly obtained or otherwise, among a sentinel sample of PWID. These include opioids prescribed for opioid substitution treatment (OST) – i.e. methadone, buprenorphine and buprenorphine-naloxone maintenance treatments – in addition to opioids prescribed for pain relief (including morphine and oxycodone). It is important to note that while a proportion of the 2016 sample were in treatment at the time of interview, responses are not representative of all clients engaged in drug treatment services.

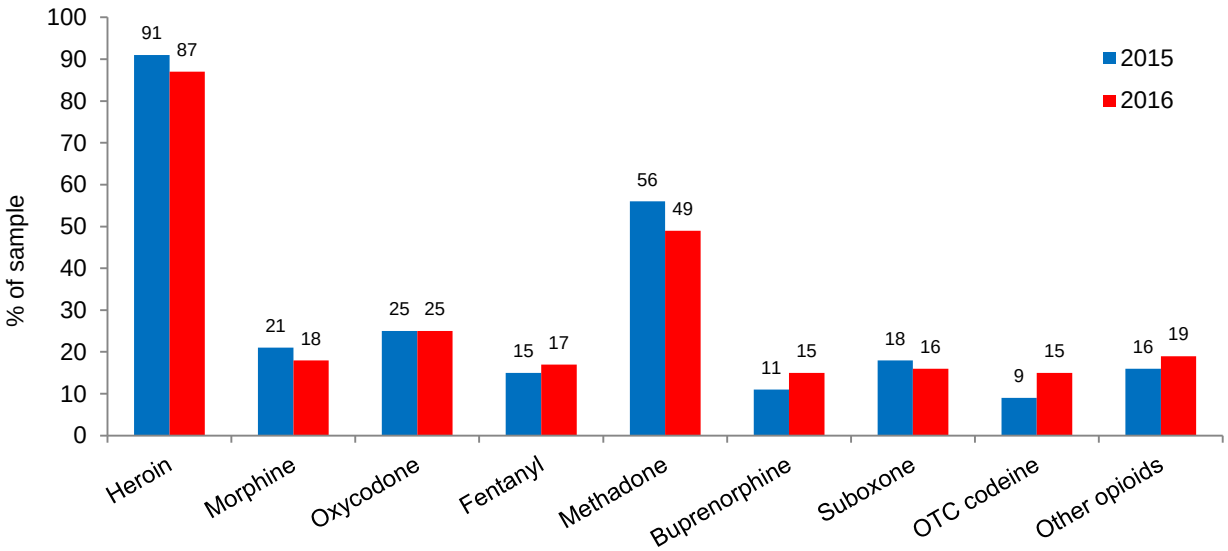
4.6.1 Overview of opioid use among participants

Table 5 provides data on the recent use and ROA of opioids for the 2016 participant sample.

Heroin use among participants is described in detail in section 4.2, with the focus on the use of other opioids described in this section. Data is presented for illicit use only, except for fentanyl and other opioids, which do not distinguish between licit and illicit use. It should be noted that some of the sample sizes for these sections were relatively small and should be interpreted with caution.

As can be seen in Figure 15, heroin was the most commonly used opioid in the six months prior to interview (87%), followed by licit or illicit methadone (49%).

Figure 15: Recent use of opioids amongst NSW participants, 2015–2016



Source: IDRS participant interviews.
Note: these figures include licit and illicit use, except for heroin and OTC codeine, which include illicit/non-medicinal use only.
Note: Other opioids include opioids not specified elsewhere (e.g. Panadeine Forte®).

When all the opioid substance categories are collapsed (i.e. morphine, oxycodone, fentanyl, methadone, buprenorphine, buprenorphine-naloxone, OTC codeine and other opioids), 47% of participants had used some type of illicit opioid substance in the six months prior to interview (57% in 2015).

4.6.2 Use of illicit 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 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.

Thirty percent of all participants (25% in 2015) reported having used illicit methadone syrup on a median of nine days (range: 1−150 days) in the last six months and the average amount used per day in the last six months was a median of 50ml (range: 10−200ml). Of those, 89% of participants reported injecting illicit methadone syrup on a median of eight days (range: 1−150 days).

Seven participants reported having used illicit Physeptone® tablets (n=4 in 2015) on a median of two days in the last six months (range: 1−30 days), and the average amount recently used per day was a median of 10mg (range: 3−50mg). Of those, 43% of participants reported injecting illicit Physeptone® tablets and had done so on a median of two days (range: 1−6 days).

Of those who reported lifetime methadone use, the form most used was licit liquid methadone (60%).

4.6.3 Use of illicit Buprenorphine[9]

Eleven percent of all participants (9% in 2015) reported having used illicit buprenorphine on a median of four days (range: 1−180 days) in the six months prior to interview. Of these, 82% of participants reported injecting illicit buprenorphine and had done so on a median of four days (range: 1−180 days). The average amount used per day in the last six months was a median of 8mg (range: 3−24mg).

Of those who reported recent buprenorphine use, the form most used was illicit buprenorphine (70%).

4.6.4 Use of illicit Buprenorphine-naloxone

In 2016, participants were asked about the use of any form of buprenorphine-naloxone, which included either ‘tablet’ or ‘film’ forms. In previous years, participants were asked about buprenorphine-naloxone tablets and film separately.

Sixteen percent of all participants reported having used illicit buprenorphine-naloxone on a median of four days (range: 1−30 days) in the six months prior to interview. Of these, 75% of participants reported injecting illicit buprenorphine-naloxone and had done so on a median of four days (range: 1−30 days). The average amount used per day in the last six months was a median of 8mg (range: 4−32mg). Of the twenty-four participants that were able to comment, half of all Suboxone® users (50%; n=12) reported that the type they had used most during the last six months was licit Suboxone® film. Ten participants reported using illicit Suboxone® film, and two participants reported using illicit Suboxone® tablets.

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

4.6.5 Use of illicit Morphine

Sixteen percent of participants reported they had used illicit morphine in the six months prior to interview (19% in 2015) on a median of 12 days (range: 1−180 days). Of these, 88% of participants reported injecting illicit morphine and had done so on a median of 14 days (range: 1−180 days). The average amount of illicit morphine used per day in the last six months was a median of 100mg (range: 2−200mg).

The majority of all morphine users (85%, n=22) reported that the type they had used most during the last six months was illicit morphine. The main brand of morphine used was MS Contin® (75%, n=15).

4.6.6 Use of illicit Oxycodone[10]

In 2016, oxycodone was divided into three different forms, consisting of 'generic oxycodone', 'OP oxycodone' and 'other oxycodone'.

Two-thirds of the sample reported lifetime use of any form of oxycodone (63% in 2015) and one-quarter reported recent use (25% in 2015). Thirty-eight participants reported using any form of oxycodone on a median of 19 days (range: 1−180 days) in the six months preceding interview (14 days in 2015). Twenty-six participants reported recent injection of any form of oxycodone on a median of 14 days (range: 1−180 days).

4.6.6.1 Generic Oxycodone

Nineteen percent (n=29) reported recent use of illicit generic oxycodone on a median of ten days (range: 1−180 days). Of those, 76% reported injecting illicit generic oxycodone on a median of 19 days (range: 1−180 days) in the preceding six months. The average amount of illicit generic oxycodone used per day in the last six months was a median of 80mg (range: 2−400mg).

4.6.6.2 OP Oxycodone

Twelve percent (n=18) reported recent use of illicit OP oxycodone on a median of five days (range: 2−100 days). Of those, 72% of participants reported injecting illicit OP oxycodone on a median of three days (range: 2−30 days) in the six months prior. The average amount of illicit OP oxycodone used per day in the last six months was a median of 80mg (range: 5−150mg).

4.6.6.3 Other Oxycodone

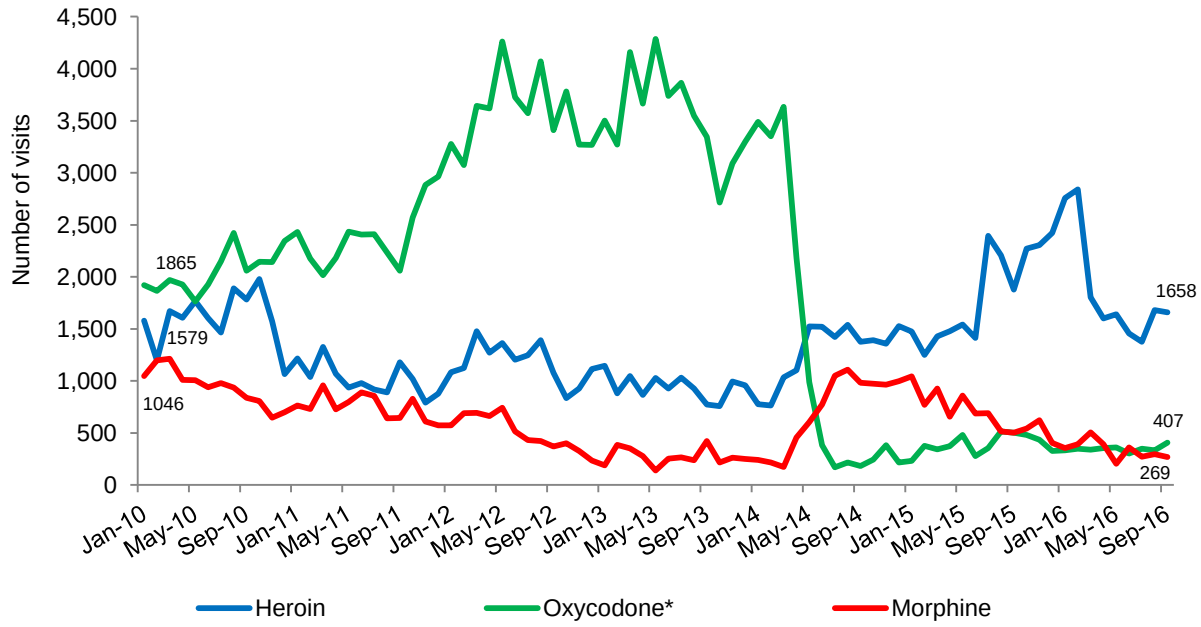
Four participants reported recent use of illicit other oxycodone on a median of 5.5 days (range: 1−10 days). Of those, all four participants reported injecting illicit other oxycodone in the six months preceding interview. The average amount of illicit other oxycodone used per day in the last six months was a median of 90mg (range: 20−300mg).

The form most used for all oxycodone users was illicit (n=28; 90%, for Generic Oxycodone; n=18; 86%, for OP Oxycodone; and n=7; 78%, for Other Oxycodone).

The number of visits to Sydney MSIC where heroin, morphine and oxycodone were injected is presented in Figure 17. In April 2014, corresponding with the introduction of 'OP' oxycodone, figures declined dramatically and as a result, heroin injecting episodes now outnumber both oxycodone and morphine visits at the MSIC.

[10] In April 2014 'Reformulated OxyContin®' (branded with an 'OP' on each tablet) was introduced designed to be tamper resistant. The 'original oxycodone' OxyContin® (branded with an 'OC') was withdrawn. In September 2014 generic 'non-tamper-resistant oxycodone' was made available in Australia.

Figure 16: Number of attendances to Sydney MSIC where heroin, morphine and oxycodone were injected, January 2010−September 2016



Source: Sydney MSIC, Kings Cross.
*OxyContin Purdue (OP) is included in oxycodone totals.

4.6.7 Use of Fentanyl (licit and illicit)

Seventeen percent (n=26) reported using fentanyl (15% in 2015) on a median of six days (range: 1−180 days) in the six months preceding interview, and the average amount used per day was a median of 50mg (range: 6−100mg) or 87.5 ug/hr (range: 25−1000ug/hr). Of those who had recently used fentanyl, 96% had done so by injection on a median of six days (range: 1−80 days). Eighty-nine percent of participants (n=23) had used illicit Fentanyl in the six months preceding interview.

4.6.8 Use of over the counter (OTC) codeine

Codeine is a mild opioid. In Australia, OTC codeine is readily available in pharmacies. It is mainly used for the relief of mild to moderate pain. OTC codeine medications vary in codeine quantity and are only available in combination (usually with analgesics or decongestants). There are associated health concerns with the prolonged use of OTC codeine, most notably the risk of liver damage. There are also health risks associated with the overdose of combination drugs such as paracetamol. For more information on the harms associated with OTC codeine use, see Dutch (2008) and Dyer, Martin et al. (2004).

Since 2009, participants have been asked about their use of OTC codeine and from 2012 onwards participants were asked about non-medicinal use only. These questions were included to investigate the extra-medical use of OTC codeine, frequency of use, main brands used and the amount of tablets/capsules used per dose.

In 2016, 36% of participants reported ever using OTC codeine for non-medicinal purposes. Fifteen percent reported use within the preceding six months (9% in 2015) on a median of four days (range: 1–157 days). No participants reported that they had injected OTC codeine in the six months preceding interview. The main brand of OTC codeine used by participants was Nurofen Plus (46%; n=10).

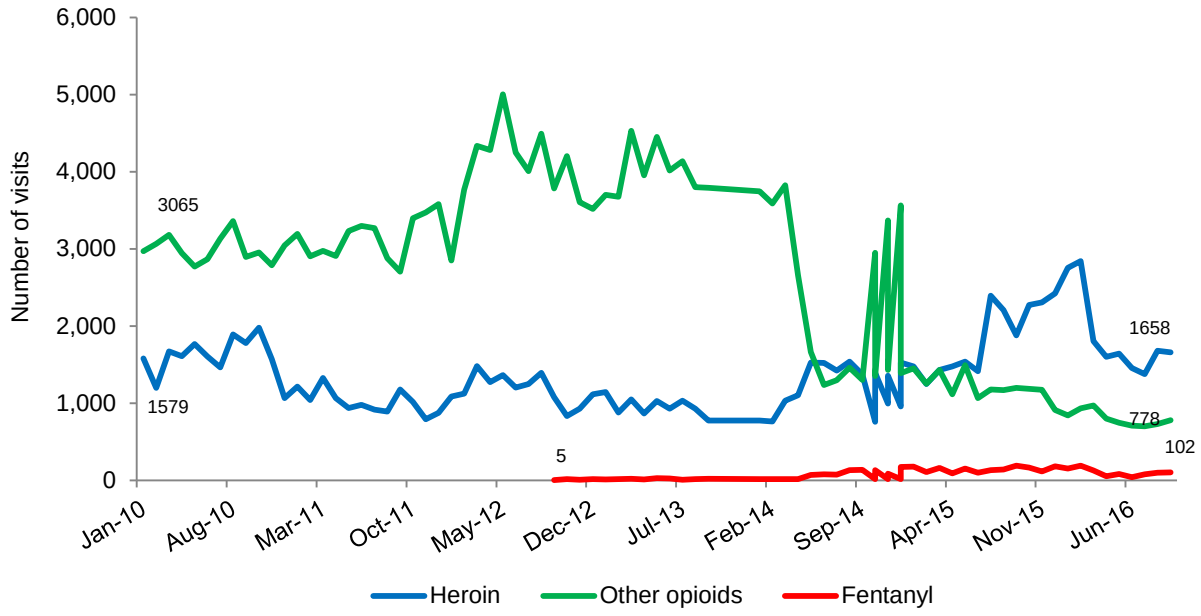
4.6.9 Use of other opioids (not elsewhere specified) (licit and illicit)

Nineteen percent of participants (16% in 2015) reported that they had used other opiates in the six months preceding interview on a median of 5.5 days (range: 1−48 days). One participant reported recent injection of other opiates on a median of five days.

Among those who recently used other opiates, the form most used was licit (54%; 46% illicit), and the majority of participants reported that Panadeine Forte® (n=22, 82%) was the main brand used.

The number of visits to Sydney MSIC where other opioids, including morphine and oxycodone, were injected is presented in Figure 17. The number of attendances where other opioids were injected increased to a peak of 5006 injections in May 2012, though a dramatic decline in oxycodone injecting followed due to the introduction of 'OP' oxycodone in April 2014 (as mentioned earlier). 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 very low in comparison to heroin and other opioids.

Figure 17: Number of attendances to Sydney MSIC where other opioids (including morphine)*, fentanyl and heroin were injected, January 2010-September 2016



Source: Sydney MSIC, Kings Cross.
* Other opioids include morphine and oxycodone and excludes heroin, methadone, buprenorphine and buprenorphine-naloxone.

Key expert comments

- Law enforcement KE reported that pharmaceuticals were the fourth most detected drug in 2015 (n=2244 detections), an increase from 2014 (n=1927 detections). On the contrary, a health KE reported that there is less prevalence of prescription opioid presentations.
- One KE stated that there were increasing reports of generic oxycodone use.
- The age of pharmaceutical opioid users has decreased according to law enforcement KE, decreasing from 36.8 years in 2015 to 34.1 years in 2016.

4.7 Other drugs

Key Findings

- Thirty-five percent of participants reported recent illicit use of alprazolam (35% in 2015) on a median of six days and 31% reported recent illicit use of other benzodiazepines (31% in 2015) on a median of six days within the preceding six months.

- Among participants who had recently used benzodiazepines, 25% reported using them on a daily basis.

- Three participants reported recent illicit use of pharmaceutical stimulants (n=1 in 2015) within the preceding six months and they reported using on a median of two days. The most common brand used was Dexamphetamine®.

- Eleven percent reported recently using illicit Seroquel® (10% in 2015) on a median of three days in the six months preceding interview.

- Eleven participants had used ecstasy (n=11 in 2015) on a median of 2 days and eight participants had used some type of hallucinogen (n=2 in 2015) on a median of 2 days in the six months prior to interview.

- There were no reports of participants using steroids in the past six months (n=2 in 2015).

- Three participants reported recent use of NPS (n=1 in 2015) on a median of one day.

- Eleven percent of participants (8% in 2015) reported recent use of synthetic cannabinoids on a median of one day.

- Seven participants reported using inhalants (n=3 in 2015) on a median of five days in the preceding six months.

- Alcohol had reportedly been recently consumed by 57% of the sample (51% in 2015) on a median of 11 days in the preceding six months. Among recent users of alcohol, ten participants reported daily use of alcohol.

- The vast majority of participants (91%) reported smoking tobacco in the preceding six months (91% in 2015) on a median of 180 days, i.e. daily use. Ninety-four percent of those who had smoked tobacco in the preceding six months were daily smokers.

- Thirteen percent reported using e-cigarettes (16% in 2015) on a median of three days in the six months preceding interview.

4.7.1 Illicit Benzodiazepines[11]

In 2016, participants were again asked to distinguish between their use of alprazolam (Xanax®) and other benzodiazepines. Fifty-three percent of participants reported lifetime-use of illicit alprazolam and 51% reported lifetime use of illicit other benzodiazepines. Thirty-five percent of participants reported recent illicit use of alprazolam on a median of six days (range: 1−180 days); and 31% reported recent illicit use of other benzodiazepines on a median of six days (range: 1−180 days) within the preceding six months. These results were consistent with 2015 results.

[11] 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

All participants who had used other illicit benzodiazepines reported use by swallowing and five participants reported recently injecting illicit alprazolam on a median of 5.5 days (range: 1−6 days) in the preceding six months.

Among those who recently used alprazolam and other benzodiazepines, the form most used was illicit (91%; n=49 and 57%; n=43, respectively).

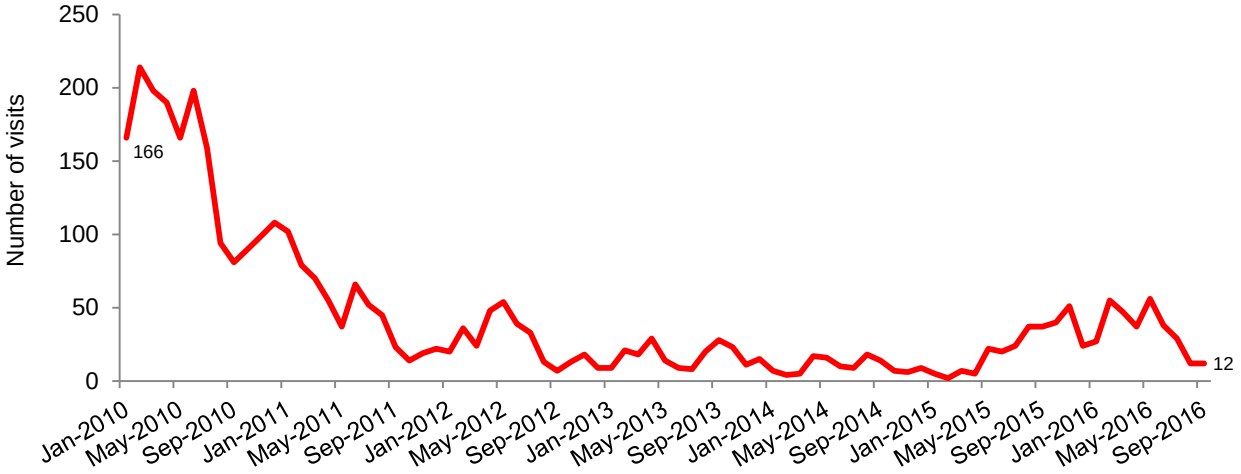
Among those who had used 'other benzodiazepines' in the preceding six months, the main brand used was diazepam (Valium®) (46%; n=23). This remained stable from 2015 (43%; n=24).

Among participants who had recently used benzodiazepines, 25% reported using them on a daily basis.

4.7.1.2 MSIC data

Numbers injecting benzodiazepines at the MSIC have increased slightly in 2016, but have not returned to levels observed in 2010 (Figure 18). Numbers of benzodiazepine injections account for less than 1% of the total monthly number of injections reported at the MSIC.

Figure 18: Number of attendances to Sydney MSIC where benzodiazepines were injected, January 2010−September 2016



Source: Sydney MSIC, Kings Cross.

4.7.2 Illicit pharmaceutical stimulants

Since 2004, participants have been asked about their use of pharmaceutical stimulants. This includes drugs such as Dexamphetamine® and methylphenidate, which are medications most commonly prescribed for attention deficit hyperactivity disorder (BBVI). From 2006, the IDRS has asked about licit and illicit forms of pharmaceutical stimulants.

In 2016, 15% of the sample reported using illicit pharmaceutical stimulants at least once in their lifetime (21% in 2015). However, only three participants reported illicit use within the preceding six months (n=1 in 2015), and they reported using on a median of two days (range: 1−40 days). Recent injection of illicit pharmaceutical stimulants was reported by two participants on a median of 1.5 days (range: 1−2 days).

Among those who had used illicit pharmaceutical stimulants, most participants reported that the most common brand used was Dexamphetamine® (n=3).

4.7.3 Illicit Seroquel® (quetiapine)

In 2016, participants were asked about their use of Seroquel®; an antipsychotic which is used to treat major psychotic and depression disorders. Thirty-one percent of the sample reported lifetime use of illicit Seroquel®, whilst 11% reported using illicit Seroquel® on a median of three days (range: 1−30 days) in the six months preceding interview (10% in 2015). Swallowing was

the only ROA for illicit Seroquel®, with no participants reporting injection within the preceding six months.

4.7.4 Ecstasy and Hallucinogens

Details regarding the use of ecstasy (3,4-methylenedioxymethamphetamine − MDMA), hallucinogens, lysergic acid diethylamide (LSD) or 'trips', and naturally occurring compounds such as magic mushrooms, are provided in Table 5.

The majority of participants reported that they had used ecstasy (57%; n=86) and hallucinogens (56%; n=84) within their lifetime. Smaller numbers reported recent use. Eleven participants had used ecstasy on a median of 2 days (range: 1−6 days) and eight participants had used some type of hallucinogen on a median of 2 days (range: 1−4 days) in the six months prior to interview (n=11 and n=2 in 2015, respectively). Five ecstasy users also reported that they had injected ecstasy on a median of one day (range: 1−4 days). No participants reported injecting hallucinogens during the past six months. The main forms of ecstasy used by participants were pills (n=8), followed by capsules (n=3). The main forms of hallucinogens used by participants were LSD (n=4), followed by mushrooms (n=3) and 'other' (n=1).

Since 2000, the use of ecstasy and related drugs among a separate sample of primarily non-injecting drug users has been examined on an annual basis. This was initially done as a module of the IDRS, but from 2000 has been conducted as a separate study known as the Ecstasy and Related Drugs Reporting System (EDRS) – formerly the Party Drugs Initiative (PDI). State and national reports are produced annually: see http://ndarc.med.unsw.edu.au/group/drug-trends.

4.7.5 Steroids

Eight participants reported lifetime use of steroids. There were no reports of participants using steroids in the past six months.

4.7.6 New psychoactive substances

Six participants reported lifetime use of new psychoactive substances (NPS) such as synthetic cathinones (e.g. mephedrone), tryptamines (e.g. dimethyltryptamine [DMT]) and phenethylamines (e.g. 2C-x class). Three participants reported recent use of NPS (n=1 in 2015) on a median of one day (range: 1−2 days). There were no reports of participants injecting NPS in the six months preceding interview.

4.7.7 Synthetic cannabinoids

Twenty-seven percent of participants reported lifetime use of synthetic cannabinoids (e.g. K2, Spice). Eleven percent of participants reported recent use of synthetic cannabinoids (8% in 2015) on a median of one day (range: 1−30 days). There were no reports of participants injecting synthetic cannabinoids in the six months preceding interview.

4.7.8 Inhalants

Seventeen percent of the sample reported lifetime use of inhaling dangerous substances, such as amyl nitrate, petrol, glue and/or lighter fluid. Seven participants reported using inhalants (n=3 in 2015) on a median of five days (range: 1−10 days) in the preceding six months.

4.7.9 Alcohol

The majority of participants reported that they had consumed alcohol within their lifetime (93%). Fifty-seven percent of the sample (51% in 2015) had used alcohol in the six months preceding interview and they had done so on a median of 11 days (range: 1−180 days). Among recent users of alcohol, ten participants reported daily use of alcohol.

4.7.10 Tobacco

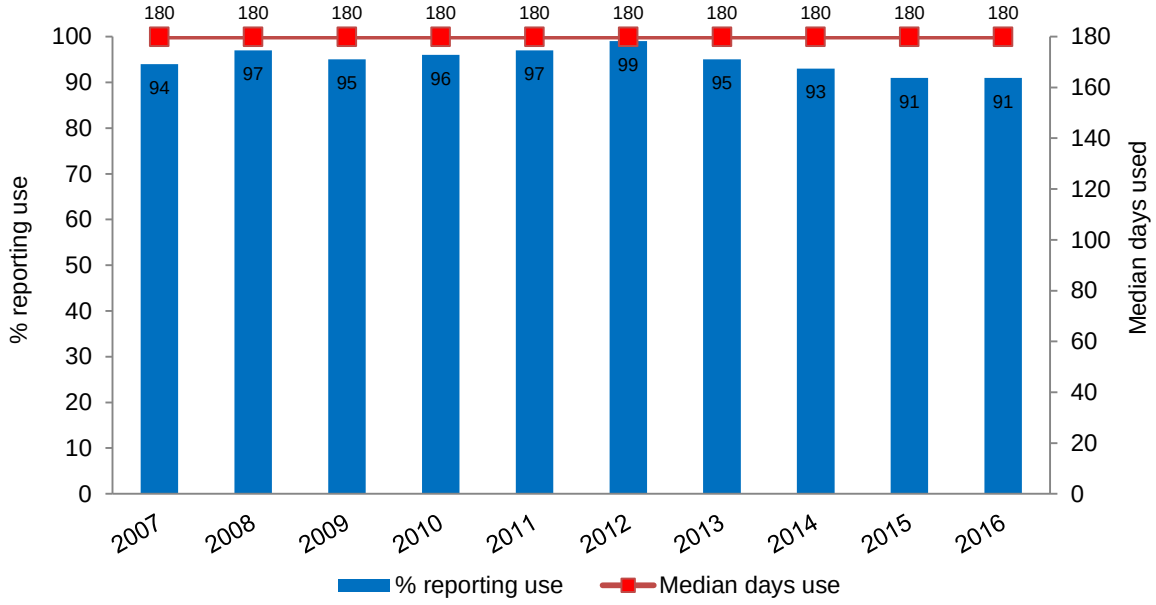
Tobacco continued to remain the most commonly used substance investigated by the IDRS. Ninety-seven percent reported lifetime use of tobacco. The vast majority of participants (91%)

reported smoking tobacco in the preceding six months, consistent with 2015 reports, on a median of 180 days, i.e. daily use (range: 15−180 days). Ninety-four 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 among PWID (see Figure 19). 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.

4.7.11 E-cigarettes

Twenty-two percent of the sample reported lifetime use of e-cigarettes, and 13% reported using e-cigarettes (16% in 2015) on a median of three days (range: 1−30 days) in the six months preceding interview.

Figure 19: Participant reports of tobacco use in the last six months, 2007–2016



Source: IDRS participant interviews.

Key expert comments

- Almost all KEs mentioned alcohol as a drug of concern, especially for illicit drug users. One KE mentioned that users drinking at risky levels results in 'unpredictable violent behavior and suicidal ideation.'
- Two KE noted that there was an increasing market for Lyrica® and both raised concerns about its abuse potential, noting it is a drug that needs to be closely monitored.
- KE commented that benzodiazepine use increases problematic behavior of clients.
- One KE noted that since becoming a Schedule 8 (controlled) drug, alprazolam is now less available, though 'there is still a lot of diazepam and temazepam.' The same KE stated that 'benzodiazepine dependence is a massive problem for people discharging from psychiatric treatment – it seems it is too easily given out to settle people and prevent aggression in the ward, with inadequate emphasis on safe reduction of them.'
- Three KE reported that they saw more crystalline forms of MDMA rather than ecstasy pills or capsules. There is a perception that crystal form is 'better' and 'safer' as crystal is more 'pure'.
- There was a general belief among KEs that steroid use had increased recently.
- A few KEs commented on the lack of understanding amongst steroid users and the lack of services, therefore leading to an ill-informed group of users, putting their safety at risk.
- One KE described steroid users as 'young people from an established background to look good and macho.'
- Most KE noted that the use of NPS was not common among their clientele. However, one law enforcement KE reported that ethylone was one of the most common substances detected in the preceding year, increasing from 15 detections in 2014/15 to 59 in 2015/16.

5 PRICE, PURITY AND AVAILABILITY

5.1 Heroin

Key Findings

- The median price of heroin was reported to be $50 for a cap and $200 for a half weight, with the price primarily reported as 'stable' over the preceding six months.

- The majority of participants reported that heroin was either 'easy' or 'very easy' to obtain, and that availability had largely remained 'stable' over the preceding six months.

- There was variation in participant reports of heroin purity. Twenty-three percent reported that the purity was 'high', a significant increase from 8% in 2015. Thirty-six percent of those who commented reported purity to be 'low'. Almost two-fifths of participants reported that purity had remained 'stable' over the preceding six months.

- An upward trend was observed in the number of heroin seizures over the last decade, and the total weight had increased in 2014/15.

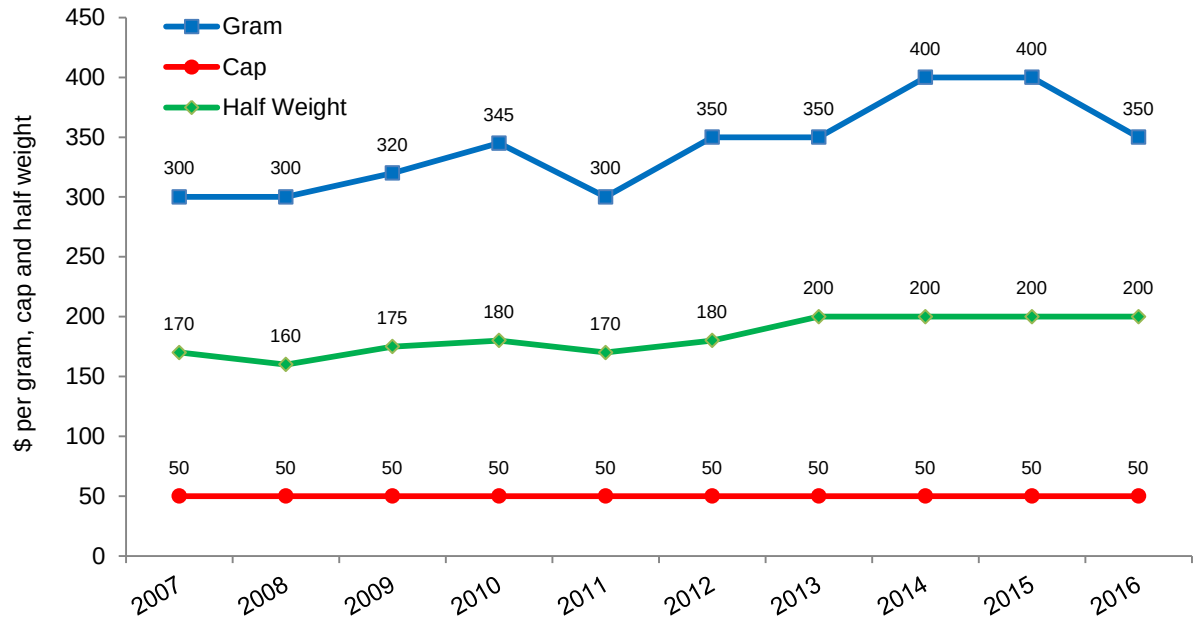
- Among those able to comment, the largest proportion obtained heroin from 'known dealers' (38%), most commonly at a 'street market' (30%).

In 2016, 86% of the sample was confident enough to complete survey items relating to the heroin market characteristics including price, purity and availability.

5.1.1 Price of Heroin

Among those who could comment on the price of heroin (86%; n=129), the majority of participants reported price per cap/point, per half weight or per gram. The median price at last purchase for a cap of heroin was $50 (range: $0−$100; n=97) and the last purchase price for a half weight of heroin was $200 (range: $70−$400; n=53). The median price for a gram of heroin was $350 (range: $160−$650; n=26). The price of a cap and half weight has generally remained stable since 2007, though the price of a gram has fluctuated over the years **(**Figure 20).

Figure 20: Median prices of heroin estimated from PWID purchases, 2007−2016



Source: IDRS participant interviews.

Of those participants who were confident to report on the current price of heroin (n=123), three-quarters reported the price as being 'stable' over the last six months. Fifteen percent of those who commented reported that the price had 'increased' over the preceding six months, six percent reported heroin prices had 'fluctuated' and a smaller proportion (4%) reported that prices had 'decreased' in the previous six months. No significant changes were observed regarding price changes between 2015 and 2016 (see Table 8).

Table 8: Change in price of heroin over last six months, 2015−2016

Reported price status	2015 (n=129)	**2016 (n=123)**
	% able to answer	
Increasing	19	**15**
Stable	73	**75**
Decreasing	5	**4**
Fluctuating	4	**6**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

5.1.2 Availability of heroin

Table 9 and Table 10 summarise the current availability of heroin and changes in heroin availability over the last six months, as perceived by participants. Of those who were able to answer questions regarding the availability of heroin (n=126), the majority reported it was either 'easy' or 'very easy' to obtain heroin (92%), with only 8% reporting that it was 'difficult' to obtain. The majority (79%) of those able to answer (n=123) perceived that heroin availability had remained 'stable' in the six months preceding interview. There were no significant differences between 2015 and 2016 reports regarding availability of heroin.

Table 9: Availability of heroin currently, 2015−2016

How easy is it to get heroin at the moment?	2015 (n=132)	**2016 (n=126)**
	% able to answer	
Very easy	52	**52**
Easy	37	**40**
Difficult	8	**8**
Very difficult	3	**0**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

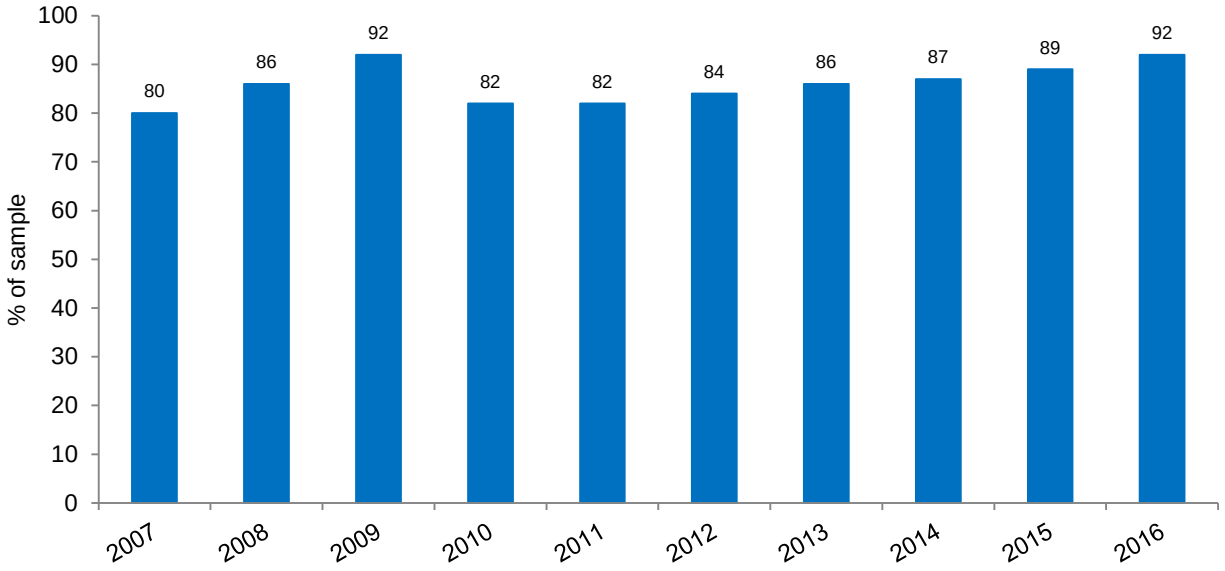
Table 10: Change in availability of heroin over the last six months, 2015−2016

Has availability changed in the last six months?	2015 (n=131)	**2016 (n=123)**
	% able to answer	
More difficult	13	**9**
Stable	73	**79**
Easier	11	**9**
Fluctuates	3	**3**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Long-term trend data for the availability of heroin are presented in Figure 21. As can be seen, the proportion of participants who reported that heroin was 'very easy' or 'easy' to obtain in the six months prior to interview has remained relatively high yet stable over the past decade. In 2016, 92% of participants able to answer reported that heroin was 'easy' or 'very easy' to obtain (89% in 2015).

Figure 21: Availability of heroin as easy or very easy in the last six months, 2007−2016



Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

5.1.3 Purity of heroin – participant reports

Table 11 and Table 12 summarise the current purity of heroin and the changes in heroin purity over the last six months, as reported by participants. Among those able to comment (n=124), 36% reported that the current purity of heroin was 'low' and 29% reported that the purity was 'medium'. Twenty-three percent reported that the purity was 'high', which was a significant increase from 8% in 2015 ($p<0.01$). Of those able to answer (n=123), 38% reported that the purity of heroin had remained 'stable' over the preceding six months, with one-quarter reporting that it had 'decreased' and 15% reporting that it had 'fluctuated' in the last six months. These results are comparable with 2015. About one-fifth of participants reported that purity had 'increased' in the six months prior to interview, which was a significant increase from 10% in 2015 ($p<0.05$).

Table 11: Current purity/strength of heroin, 2015−2016

How pure would you say heroin is at the moment?	2015 (n=129)	**2016 (n=124)**
	% able to answer	
High	8	**23**
Medium	38	**29**
Low	39	**36**
Fluctuates	16	**13**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

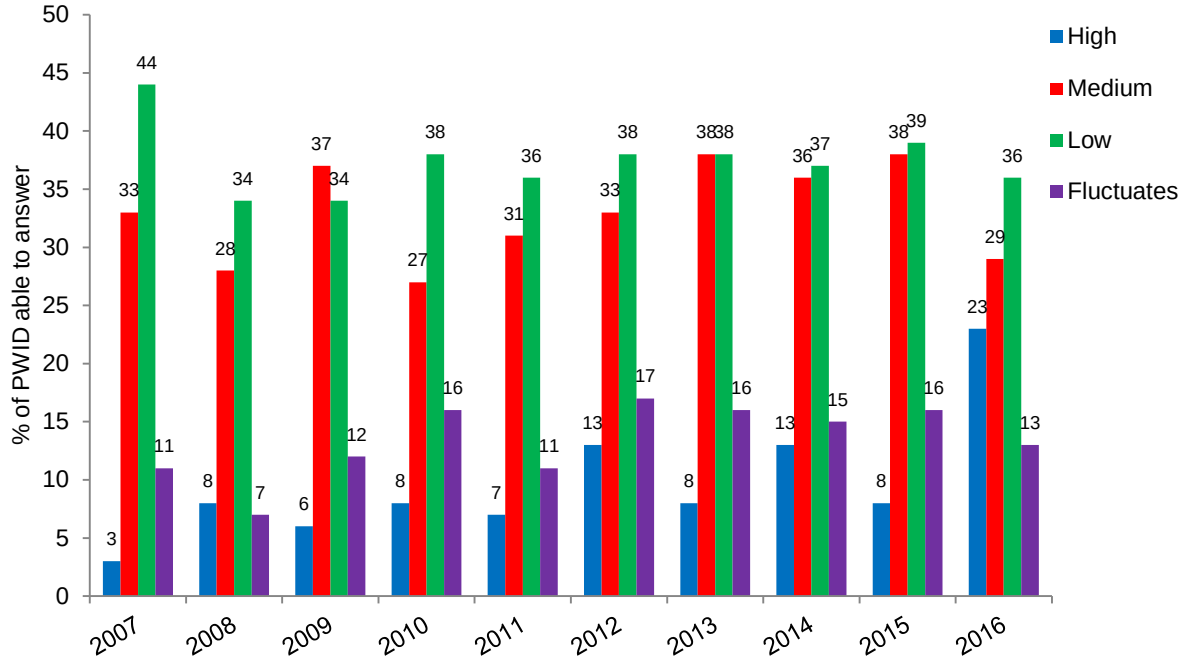
Table 12: Change in purity/strength of heroin in the last six months, 2015−2016

Has the purity of heroin changed in the last six months?	2015 (n=126)	**2016 (n=123)**
	% able to answer	
Increasing	10	**21**
Stable	38	**38**
Decreasing	30	**25**
Fluctuating	21	**15**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Figure 22 shows the trend in purity of heroin, as perceived by participants from 2007 onwards. Despite various fluctuations over the years, it can be seen that purity has generally been reported as being low to medium. Significantly more participants had reported that heroin was of high purity in 2016 (23%) compared to 2015 (8%) ($p<0.01$).

Figure 22: Perception of current purity of heroin, 2007−2016



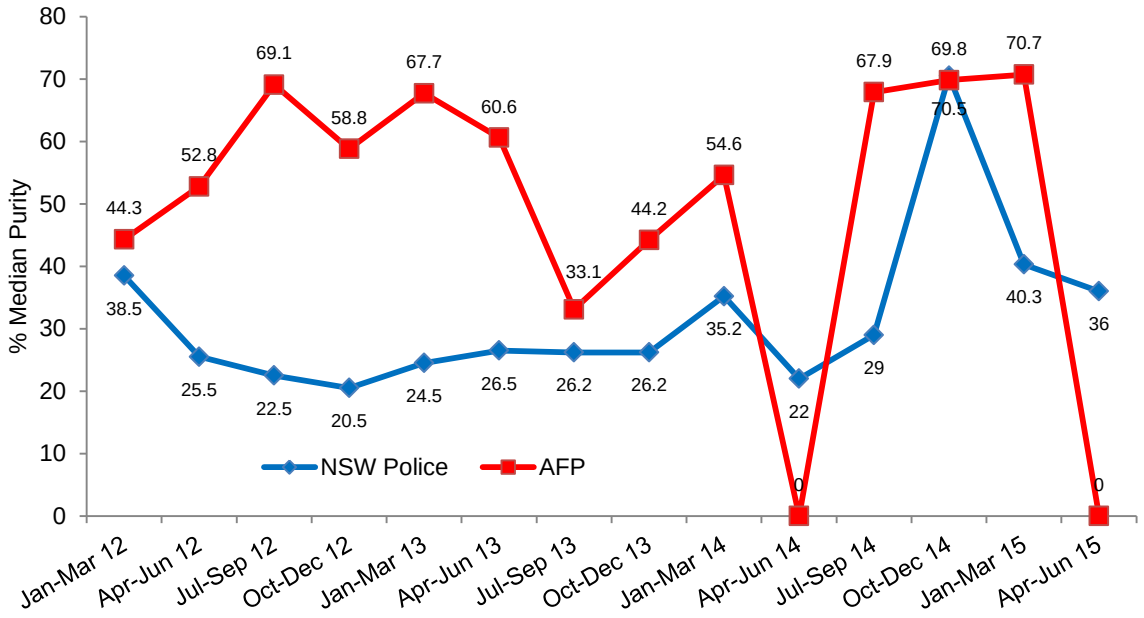
Source: IDRS participant interviews.
Note: 'Don't know' was excluded from 2009 onwards.

5.1.4 Purity of heroin – drug seizure data

Participant reports of purity are subjective and depend on a number of factors including the health and tolerance of the individual. A more objective measure of purity is derived from the analysis of drug seizures. The purity figures reported below are provided by the Australian Criminal Intelligence Commission (ACIC) (formally the Australian Crime Commission, ACC) and there are some important issues to consider when examining purity measures. These data do not reflect the total weight of a particular drug seized in each year, but only those samples and seizures submitted for analysis. They relate to an unrepresentative sample of the illicit drugs available in Australia, and this should be considered when drawing conclusions from the purity data presented. In addition, there is typically a lag of several months between the seizure and receipt of profiling results (Australian Criminal Intelligence Commission 2016).

ACIC data were unavailable for 2015/16 at the time of publication and the data provided by the ACIC only relates to the purity data on heroin seized in NSW during the last financial year: 2014/15 (Australian Criminal Intelligence Commission 2016). Figure 23 shows the analysed median purity of NSW Police heroin seizures from January 2012−June 2015. In 2014/15, the overall median purity of heroin was 45.5% (range: 10−78%) reported by NSW Police compared with the 27% in the 2013/14 reporting period (range: 5−76%). Overall, the purity of Australian Federal Police (AFP) heroin seizures that were analysed during 2014/15 increased, with a median of 70.1% (range: 29.5−75.3%), compared with a median of 51.5% in the 12 months to June 2014. Purity figures for 2014/15 are based on 115 heroin seizures analysed by NSW Police (representing 14% of all heroin seizures detected by NSW Police) and 16 heroin seizures analysed by the AFP (representing 8% of all heroin seizures detected by the AFP). Purity data was not available for 2015/16.

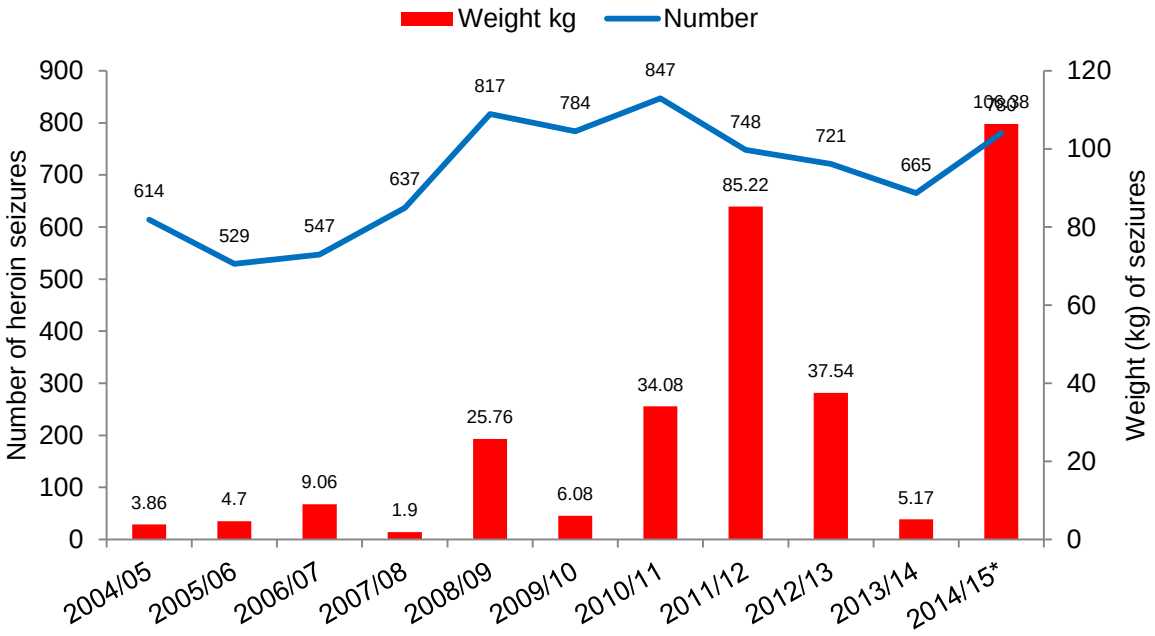
Figure 23: Purity of heroin seizures analysed in NSW, by quarter, January 2012-June 2015



Source: Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015, Australian Criminal Intelligence Commission 2016.

An upward trend has been observed in the number of heroin seizures over the last decade, and the total weight had noticeably increased in 2014/15 (Figure 24).

Figure 24: Number and weight of heroin seizures detected by NSW Police, July 2004−June 2015



Source: Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015, Australian Criminal Intelligence Commission 2016.

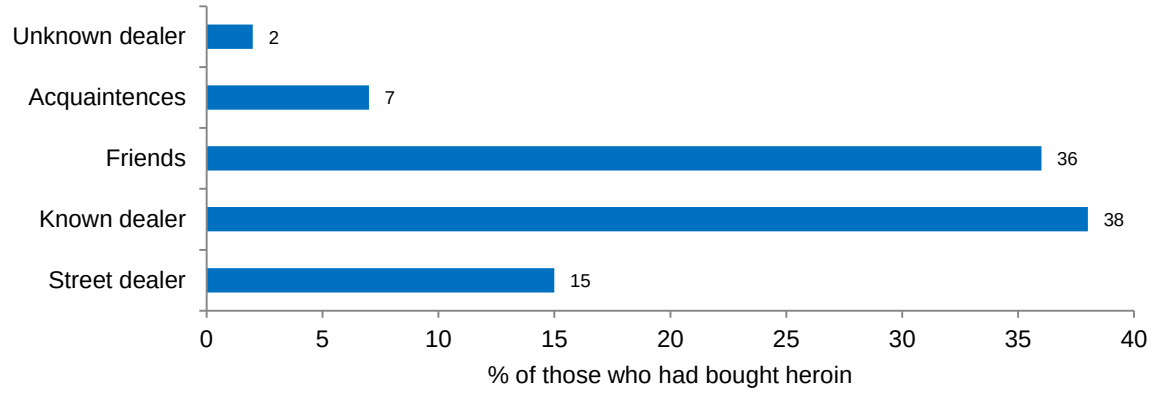
Note: 2014/15 data was provided by NSW Police, while earlier data is extracted from the Illicit Drug Data Reports produced by the ACC.

5.1.5 Purchasing patterns of heroin

Participants were also asked about the person from whom, and the location from where, they had last obtained heroin (see Figure 25 and Figure 26). Among those able to comment (n=125), 38% of participants reported they usually obtained heroin from 'known dealers' and 36% of the sample obtained heroin from a 'friend' in 2016. These results remained stable from 2015.

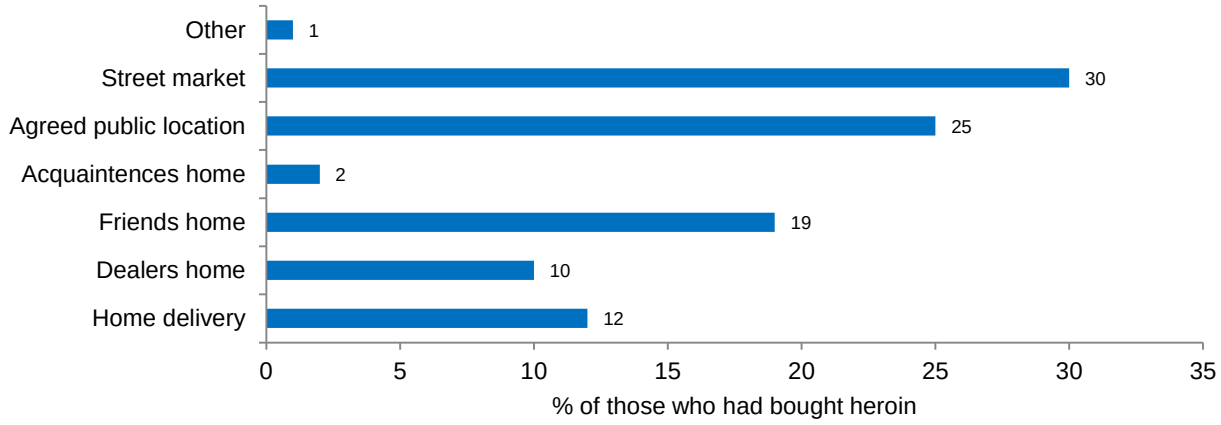
A 'street market' was the most commonly reported last purchase venue (30%), followed by an 'agreed public location', reported by one-quarter of participants. These results were comparable with 2015 data.

Figure 25: People from whom heroin was purchased on the last occasion, 2016



Source: IDRS participant interviews.
Note: More than one response could be selected.

Figure 26: Locations where heroin was purchased on the last occasion, 2016



Source: IDRS participant interviews.
Note: More than one response could be selected.

Key expert comments

- Overall, heroin availability has increased.
- The price of a point/cap of heroin was consistent with previous years at $50, and reportedly had remained stable.
- The majority of KE reports indicate that heroin purity is 'high', an increase in the last 6−12 months. However, there were some reports of 'medium' purity, which had fluctuated in the past 6−12 months.

5.2 Methamphetamine

Key Findings

- The median price for all three forms of methamphetamine was $50 for a point. The price was largely reported to have remained 'stable' in the six months preceding interview.

- The majority of those commenting considered methamphetamine powder and methamphetamine crystal to be of 'medium' purity, and the largest proportion of those able to comment regarded methamphetamine base to be of 'high' purity.

- The purity was largely reported to have remained 'stable' in the six months preceding interview, for all three forms of methamphetamine.

- Methamphetamine powder and base were mostly reported as being 'difficult' to obtain, whereas crystal methamphetamine was largely reported as 'easy' or 'very easy' to obtain.

- The majority of those able to comment reported that the availability of all three forms of methamphetamine had remained 'stable' over the preceding six months.

- The majority of methamphetamine users who were able to answer reported obtaining all forms of methamphetamine from 'friends', mostly from a 'friend's home'.

In 2016, 11% of the sample was confident enough to complete survey items relating to market characteristics for methamphetamine powder; 7% methamphetamine base; and 69% crystal methamphetamine.

5.2.1 Price of methamphetamine

5.2.1.1 Methamphetamine – powder

A small number of participants (n<10) were able to comment on the price for methamphetamine powder and therefore median price data is not presented.

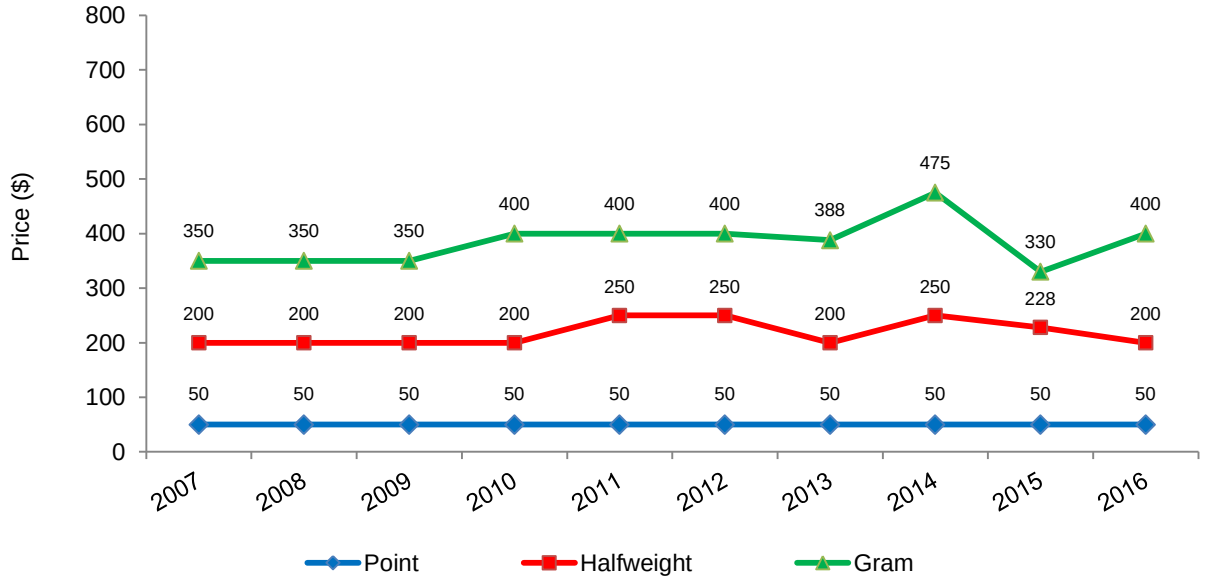
5.2.1.2 Methamphetamine – base

A small number of participants (n<10) were able to comment on the price for methamphetamine base and therefore median price data is not presented.

5.2.1.3 Methamphetamine – crystal

Crystal methamphetamine was the only form of methamphetamine where numerous PWID were able to comment on price. The last reported price paid for a point of crystal was a median of $50 (range: $40–$100; n=87). The median price for a half weight of crystal was $200 (range: $100−$400; n=33), and $400 for a gram (range: $50−$600; n=31) (see Figure 27).

Figure 27: Median prices of crystal methamphetamine estimated from participant purchases, 2007–2016



Source: IDRS participant interviews.
* Numbers for powder and base are ≤10, therefore interpret with caution.

It is important to note that changes in the last purchase price for the different forms of methamphetamine are difficult to gauge due to the fact that few participants have been able to comment, except for crystal methamphetamine.

Table 13 summarises participant reports of recent changes in the price of the three forms of methamphetamine. The majority of participants answering this section reported the price of powder, base and crystal methamphetamine to have remained 'stable'. Smaller numbers reported any of the three forms to be 'increasing'. Furthermore, only three participants reported that crystal methamphetamine had 'fluctuated' in price and no participants had reported that powder or base methamphetamine had 'fluctuated'. No significant changes were observed regarding price changes between 2015 and 2016.

Table 13: Change in price of methamphetamine over last six months, 2015−2016

Reported price status	Powder		Base		Crystal	
	2015 (n=21)	**2016 (n=16)**	2015 (n=10)	**2016 (n=10)**	2015 (n=93)	**2016 (n=102)**
	% able to answer					
Increasing	10	**6**	40	**10**	13	**11**
Stable	71	**81**	40	**70**	69	**74**
Decreasing	19	**13**	10	**20**	13	**13**
Fluctuating	0	**0**	10	**0**	5	**3**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

5.2.2 Purity of methamphetamine – participant reports

Table 14 and Table 15 summarise the current purity of the three forms of methamphetamine and the changes in methamphetamine purity over the last six months. In regards to methamphetamine powder, the largest proportion of participants perceived current purity as 'medium', unlike 2015 reports. In regards to crystal methamphetamine, unlike 2015 reports, the highest proportion of participants perceived current purity as 'medium' and just over one-quarter reported the purity to be of 'high' quality. These figures did not present any significant differences.

Table 14: Purity/strength of methamphetamine currently, 2015−2016

How pure would you say powder/base/crystal is at the moment?	Powder		Base		Crystal	
	2015 (n=21)	**2016 (n=13)**	2015 (n=10)	**2016 (n=9)**	2015 (n=88)	**2016 (n=103)**
	% able to answer					
High	29	**15**	30	**56**	31	**26**
Medium	29	**39**	20	**44**	30	**29**
Low	33	**15**	30	**0**	18	**22**
Fluctuates	10	**31**	20	**0**	22	**22**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Across all three forms of methamphetamine, the largest proportion of participants reported that purity had remained 'stable' in the six months preceding interview, as can be seen from Table 15. Though numbers were small, 100% of participants reported base purity as remaining 'stable' in 2016, which was a significant increase from 2015 ($p<0.05$).

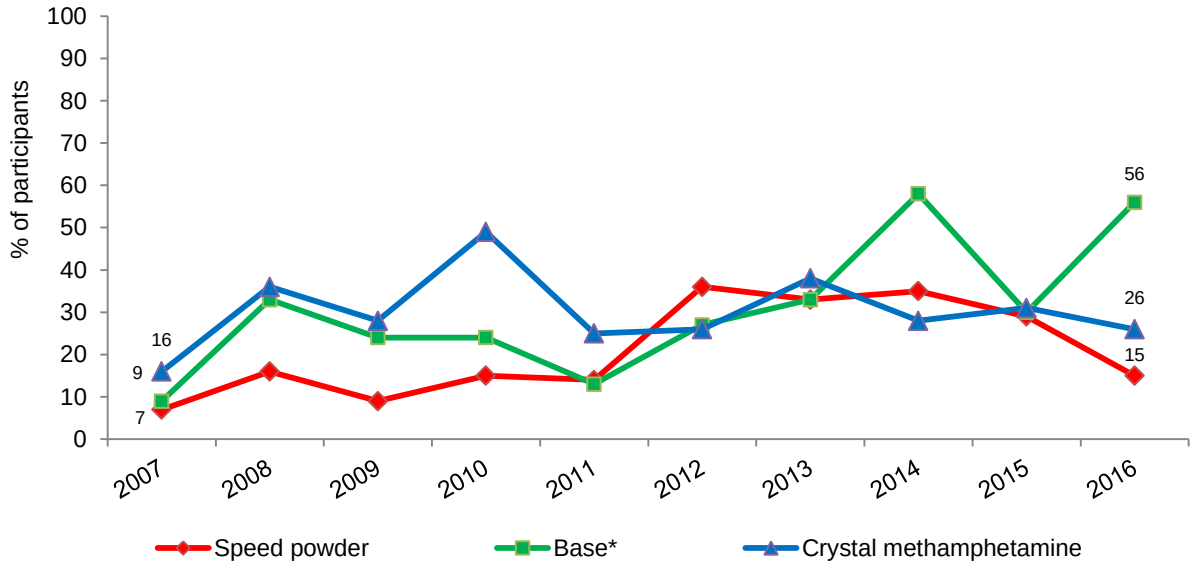
Table 15: Change in purity/strength of methamphetamine in last six months, 2015–2016

Has the purity of powder/base/crystal changed in the last 6 months?	Powder		Base		Crystal	
	2015 (n=22)	**2016 (n=13)**	2015 (n=10)	**2016 (n=9)**	2015 (n=89)	**2016 (n=101)**
	% able to answer					
Increasing	14	**15**	30	**0**	21	**9**
Stable	46	**54**	40	**100**	32	**40**
Decreasing	36	**15**	20	**0**	29	**23**
Fluctuating	5	**15**	10	**0**	18	**29**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Figure 28 illustrates the proportion of participants reporting the purity of each form of methamphetamine as 'high'. The perceived purity of crystal methamphetamine remained comparable with 2015; however, there was a slight decrease in those reporting speed powder as 'high' and an increase in those reporting base purity as 'high'. These figures, however, did not present any significant differences.

Figure 28: Proportion of participants* reporting speed powder, base and crystal methamphetamine purity as 'high', 2007–2016



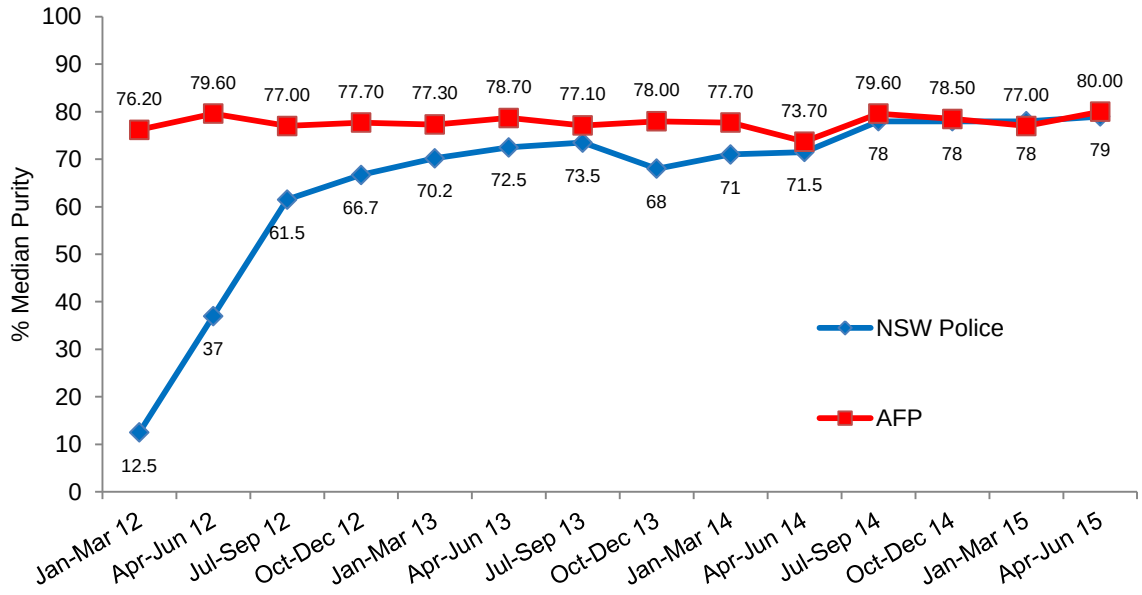
Source: IDRS participant interviews.
* Numbers for base are ≤10, therefore interpret with caution.
Note: Data on all three forms commenced in 2002.

5.2.3 Purity of methamphetamine – drug seizure data

The ACIC provides purity data for state/territory police and AFP seizures that have been analysed for methylamphetamine. There are important caveats (in addition to those already discussed within the heroin section) to consider when interpreting these data. The purity of methylamphetamine fluctuates widely in Australia as a result of a number of factors, including the type and quality of chemicals used in the production process and the expertise of the 'cooks' involved, as well as whether the seizure was locally manufactured or imported. During 1999/00 and 2014/15, forensic analysis of seizures of methylamphetamine in Australia revealed purity levels ranging from less than 1% to 83.6%, with higher purity often relating to one single seizure rather than being representative of a large number of seizures. This wide range in both purity and numbers of seizures analysed should be considered when looking at the median purity figures presented.

The ACIC data were unavailable for 2015/16 at the time of publication. As such, data provided by the ACIC relates to methamphetamine seizures in NSW during the last financial year: 2014/15 (Australian Criminal Intelligence Commission 2016). Figure 29 shows the median purity of methamphetamine seizures analysed in NSW for the period January 2012–June 2015. In 2014/15, the median purity of seizures analysed by NSW Police remained relatively high at above 70%. The purity of AFP seizures analysed has also remained high and consistent since January 2012. Purity figures for 2014/15 are based on 1,030 methamphetamine seizures analysed by NSW Police (representing 10% of all methamphetamine seizures detected by NSW Police) and 72 seizures analysed by the AFP (3% of all methamphetamine seizures detected by the AFP).

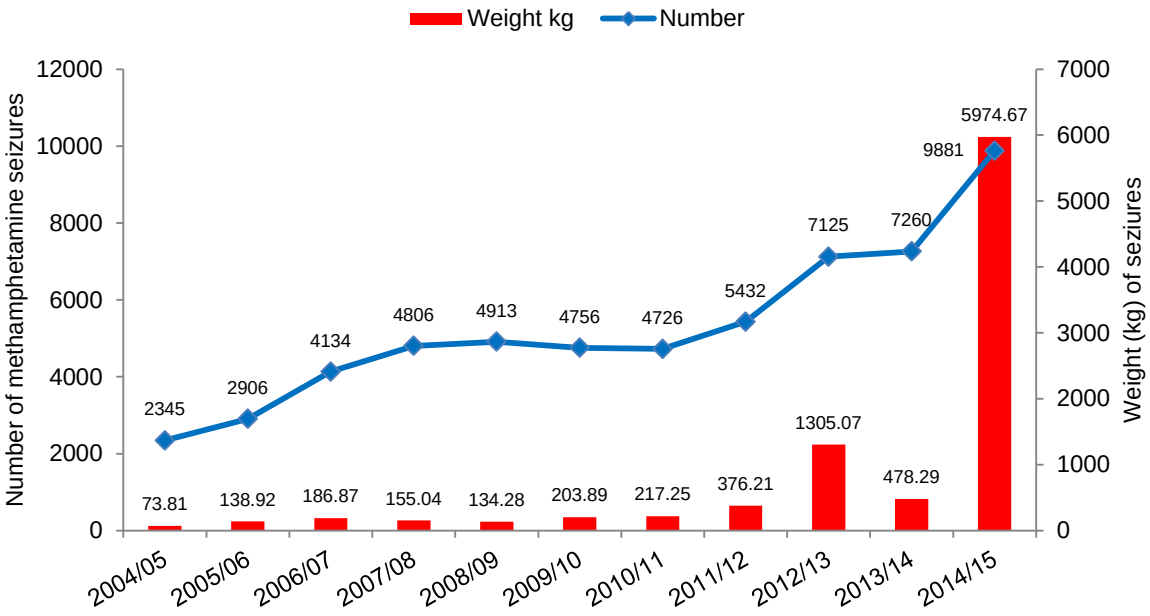
Figure 29: Purity of methamphetamine seizures analysed in NSW, by quarter, January 2012−June 2015



Source: Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015; Australian Criminal Intelligence Commission 2016.

An upward trend has been observed in the number of methamphetamine seizures over the last decade, and the total weight had significantly increased in 2014/15 (Figure 30).

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



Source: Australian Crime Commission 2005, Australian Crime Commission 2006, Australian Crime Commission 2007, Australian Crime Commission 2008, Australian Crime Commission 2009, Australian Crime Commission 2010, Australian Crime Commission 2011, Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015, Australian Criminal Intelligence Commission 2016.
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 Availability of methamphetamine

Table 16 and Table 17 summarise the current availability of the three main forms of methamphetamine and the changes in availability over the last six months, as reported by participants. In 2016, the largest numbers were able to comment on crystal methamphetamine. Methamphetamine powder and base were mostly reported as being 'difficult' to obtain, and crystal methamphetamine was largely reported as 'easy' or 'very easy' to obtain. The majority of those able to comment reported that the availability of all three forms of methamphetamine had remained 'stable' over the preceding six months. There were no significant differences between 2015 and 2016 reports regarding availability of methamphetamine.

Table 16: Availability of methamphetamine currently, 2015−2016

How easy is it to get powder/base/crystal at the moment?	Powder		Base		Crystal	
	2015 (n=23)	**2016 (n=16)**	2015 (n=10)	**2016 (n=10)**	2015 (n=95)	**2016 (n=104)**
	% able to answer					
Very easy	61	**25**	50	**30**	58	**61**
Easy	13	**25**	10	**20**	33	**36**
Difficult	17	**31**	20	**30**	7	**4**
Very difficult	9	**19**	20	**20**	2	**0**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

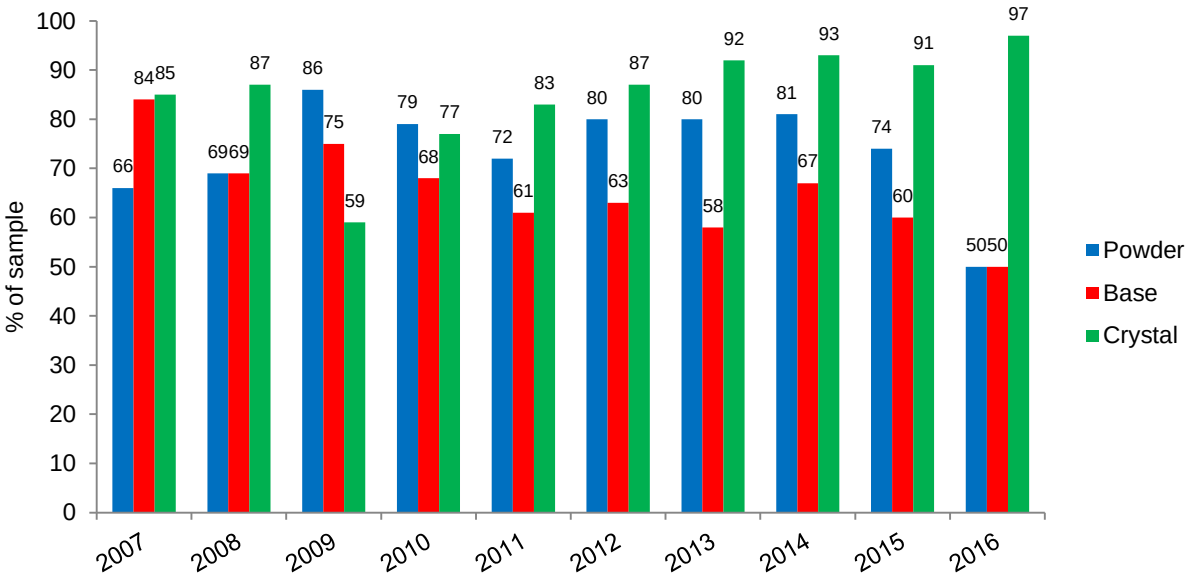
Table 17: Change in availability of methamphetamine over the last six months, 2015−2016

Has availability changed in the last 6 months?	Powder		Base		Crystal	
	2015 (n=23)	**2016 (n=15)**	2015 (n=10)	**2016 (n=10)**	2015 (n=95)	**2016 (n=104)**
	% able to answer					
More difficult	13	**13**	40	**20**	11	**5**
Stable	74	**67**	30	**80**	75	**71**
Easier	9	**13**	30	**0**	15	**19**
Fluctuates	4	**7**	0	**0**	0	**5**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Long-term trend data depicting the availability of methamphetamine from 2007 onwards, as reported by participants, are presented in Figure 31. As shown, methamphetamine has generally been considered 'easy' or 'very easy' to obtain across all years and for all forms.

Figure 31: Availability of methamphetamine in the last six months, easy or very easy, 2007–2016

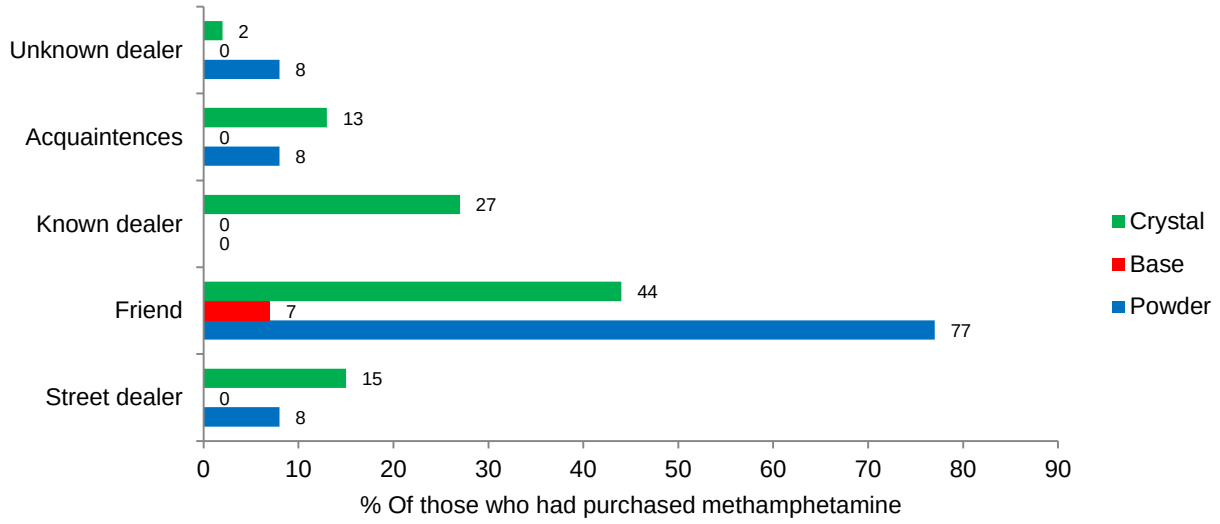


Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

5.2.5 Purchasing patterns of methamphetamine

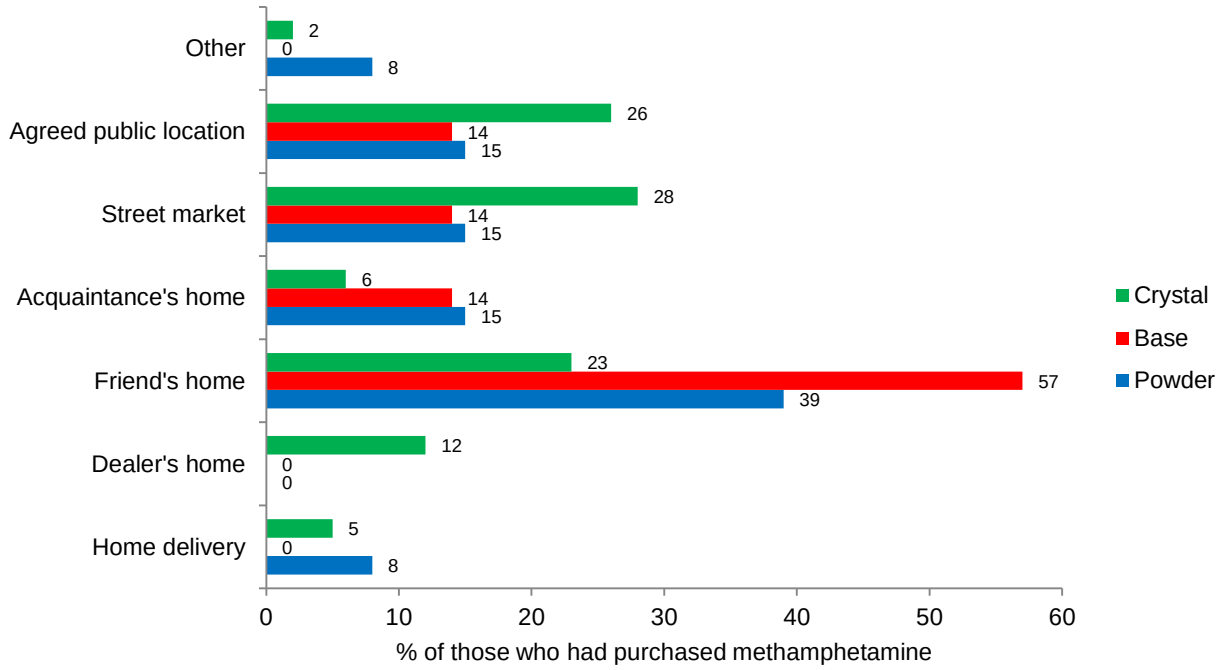
Participants were asked about both the source and location from which they had last obtained the various forms of methamphetamine. Figure 32 demonstrates that the majority of methamphetamine users who were able to answer reported obtaining all forms of methamphetamine from 'friends'. Figure 33 reveals that the location/venue from which participants most commonly obtained all forms of methamphetamine was from a 'friend's home'.

Figure 32: People from whom methamphetamine forms were purchased in the preceding six months, 2016



Source: IDRS participant interviews.
only one response allowed.

Figure 33: Locations where methamphetamine was obtained in the preceding six months, 2016



Source: IDRS participant interviews.
only one response allowed.

Key expert comments

- The majority of health and law KE report crystal methamphetamine is in high demand and readily available.
- Price reports were stable with KE generally reporting crystal methamphetamine to be $50 per point.
- Purity reports were mixed but were mostly reported to be high, with law enforcement KE reporting it to be 71% pure.

5.3 Cocaine

Key Findings

- The price for a cap of cocaine remained stable in 2016 at $50.

- The largest proportion of those able to answer reported that the current purity of cocaine was 'medium' (42%).

- Of those able to answer, 38% of participants reported that the purity of cocaine had 'decreased', with equal proportions stating that purity had remained 'stable' and purity had 'fluctuated' (29%, respectively).

- The majority of participants reported that cocaine was 'difficult' to obtain (38%). Two-thirds of those able to answer perceived that cocaine availability had remained 'stable' in the six months preceding interview.

- Participants obtained cocaine primarily from 'friends', most commonly from an 'agreed public location'.

Sixteen percent of participants reported that they were able to comment on the price, purity and/or availability of cocaine in 2016.

5.3.1 Price of cocaine

The largest number of participants (n=14) were able to comment on the price of caps, which remained stable from 2007 at $50 per cap in 2016 (range: $50–$100). Reported purchases of quarter grams and ounces remained uncommon with an insufficient number of participants (n ≤ 10) able to comment on price in 2016.

The majority of participants (75%; n=18) who could comment on cocaine reported that the price had remained 'stable' in the preceding six months. Of those commenting, four participants reported that the price of cocaine had 'increased' and two participants reported the price had 'fluctuated'. No participants commented that the price of cocaine had 'decreased'. No significant changes were observed regarding price changes between 2015 and 2016.

5.3.2 Purity of cocaine – participant reports

Table 18 and Table 19 summarise the current purity of cocaine and the changes in cocaine purity over the last six months, as reported by participants. In 2016, the largest proportion of those able to answer (n=24) reported that the current purity of cocaine was 'medium' (42%), with 29% reporting that the purity was 'low', 17% reporting that it had 'fluctuated', and 13% reporting that purity was 'high'. Of those able to answer (n=24), 38% of participants reported that the purity of cocaine had 'decreased', with equal proportions stating that purity had remained 'stable' and purity had 'fluctuated', (29%, respectively). No significant changes were observed regarding current purity and purity changes between 2015 and 2016.

Table 18: Current purity/strength of cocaine, 2015−2016

How pure would you say cocaine is at the moment?	2015 (n=37)	**2016 (n=24)**
	% able to answer	
High	19	**13**
Medium	38	**42**
Low	32	**29**
Fluctuates	11	**17**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Table 19: Change in purity/strength of cocaine in last six months, 2015−2016

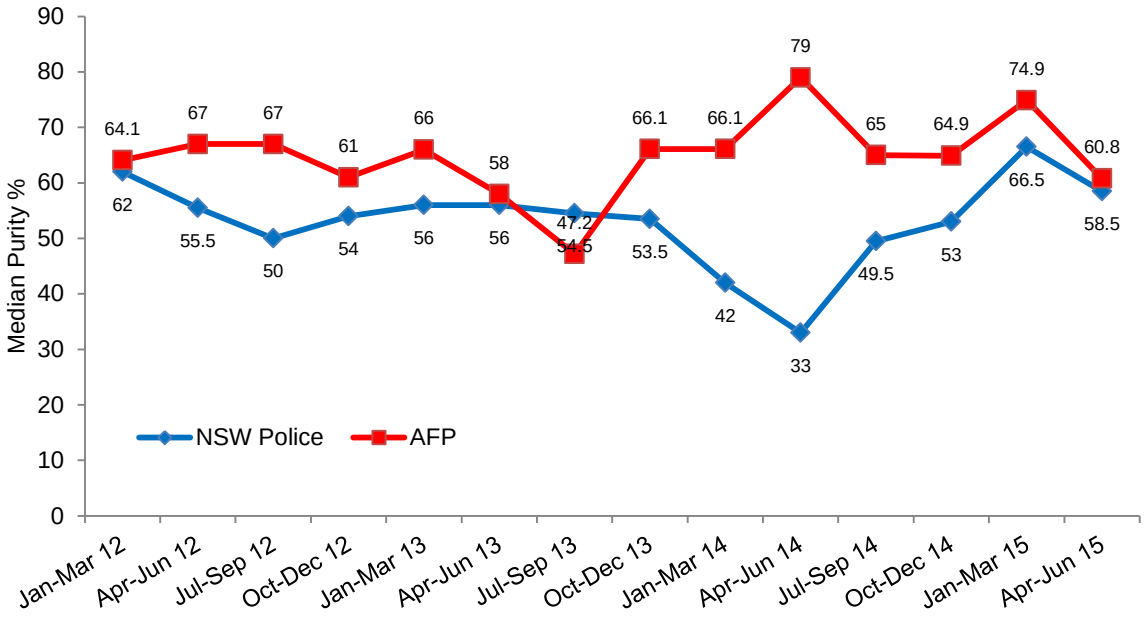
Has the purity of cocaine changed in the last 6 months?	2015 (n=36)	**2016 (n=24)**
	% able to answer	
Increasing	8	**4**
Stable	33	**29**
Decreasing	36	**38**
Fluctuating	22	**29**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

5.3.3 Purity of cocaine – drug seizure data

The total median purity of cocaine seizures analysed by NSW Police has fluctuated considerably (Figure 34). Purity figures for 2014/15 are based on 262 seizures analysed by NSW Police (representing 17% of all cocaine seizures detected by NSW Police) and 37 seizures analysed by the AFP (representing 7% of all seizures detected by the AFP). Purity data was not available for 2015/16.

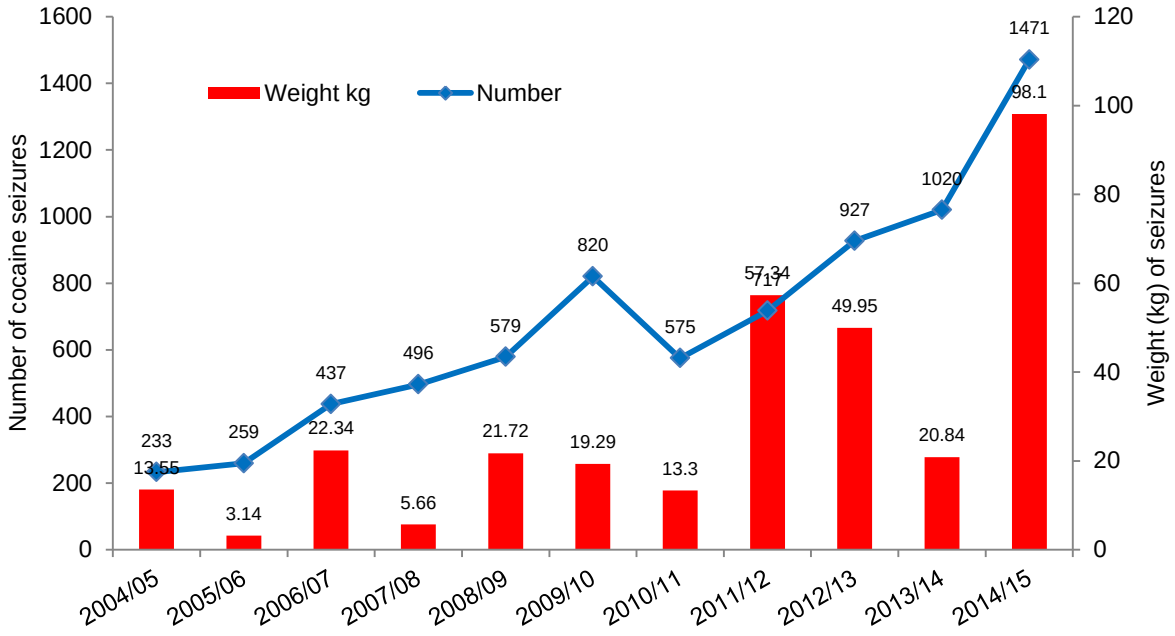
Figure 34: Purity of cocaine seizures analysed in NSW, by quarter, January 2012−June 2015



Source: Australian Crime Commission 2012, Australian Crime Commission 2013, Australian Crime Commission 2014, Australian Crime Commission 2015, Australian Criminal Intelligence Commission 2016.
Note: Purity levels are only representative of seizures, which were analysed.

Figure 35 shows the number of cocaine seizures detected by the NSW Police. Numbers and the total weight of seizures have steadily increased, especially over the past four years.

Figure 35: Number of cocaine seizures detected by NSW Police, July 2004−July 2015



Source: Australian Crime Commission 2005, Australian Crime Commission 2006, Australian Crime Commission 2007, Australian Crime Commission 2008, Australian Crime Commission 2009, Australian Crime Commission 2010, Australian Crime Commission 2011, Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015, Australian Criminal Intelligence Commission 2016.
Note: 2014/15 data was provided by NSW Police, while earlier data is extracted from the Illicit Drug Data Reports produced by the ACC.

5.3.4 Availability of cocaine

Table 20 and Table 21 summarise the current availability of cocaine and changes in cocaine availability over the last six months, as perceived by participants. Of those participants in the IDRS sample who were able to comment (n=24), over one-third (38%) reported that it was 'difficult' to obtain (19% in 2015). One-quarter of participants commented that that it was 'very easy' to obtain, and one-third believed it to be 'easy' to obtain. Two-thirds of those able to answer perceived that cocaine availability had remained 'stable' in the six months preceding interview, though one-quarter stated it to be 'more difficult' to obtain. There were no significant differences between 2015 and 2016 reports regarding availability of cocaine.

Table 20: Availability of cocaine currently, 2015−2016

How easy is it to get cocaine at the moment?	2015 (n=37)	**2016 (n=24)**
	% able to answer	
Very easy	49	**25**
Easy	30	**33**
Difficult	19	**38**
Very difficult	3	**4**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

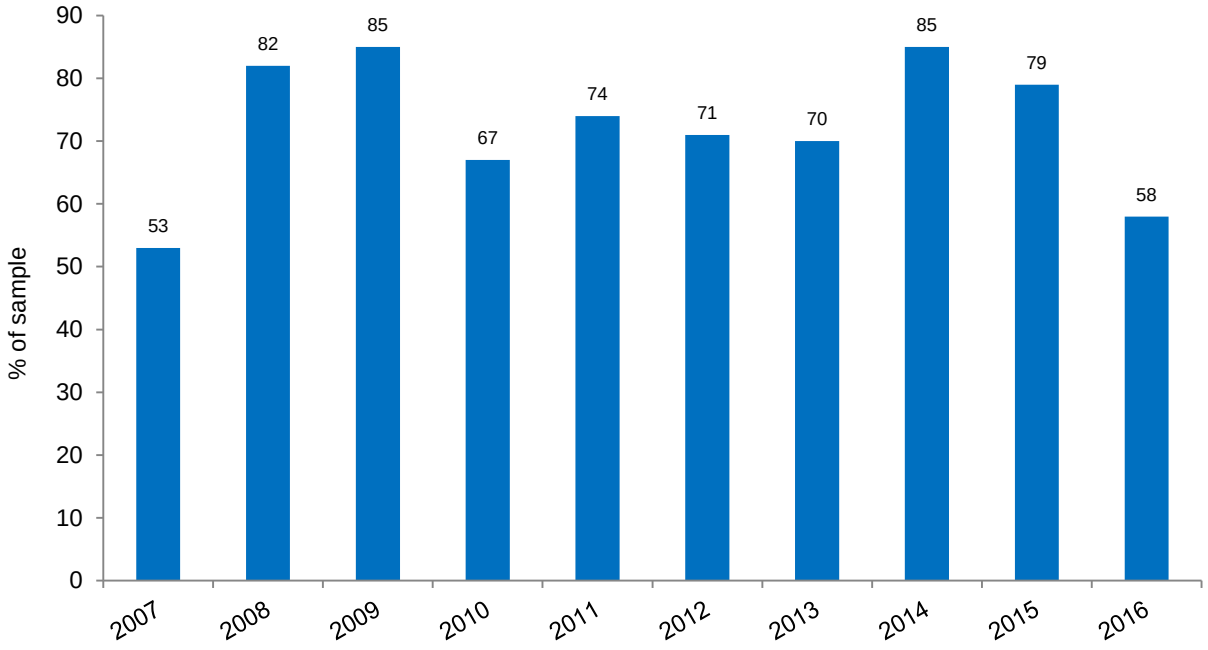
Table 21: Change in availability of cocaine over the last six months, 2015−2016

Has availability changed in the last 6 months?	2015 (n=37)	**2016 (n=24)**
	% able to answer	
More difficult	16	**25**
Stable	76	**67**
Easier	5	**0**
Fluctuates	3	**8**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Figure 36 shows the long-term trend data in the proportion of participants reporting availability of cocaine as 'easy' or 'very easy', from 2007 onwards. As can be seen, the reported ease of availability has fluctuated over the years.

Figure 36: Availability of cocaine as easy or very easy in the last six months, 2007−2016

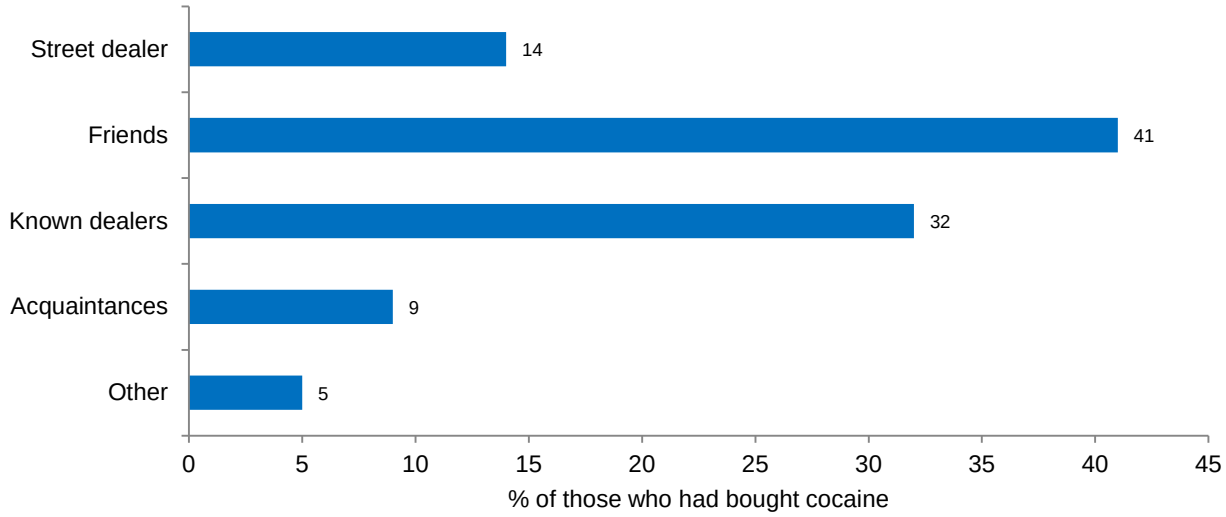


Source: IDRS participant interviews.

5.3.5 Purchasing patterns of cocaine

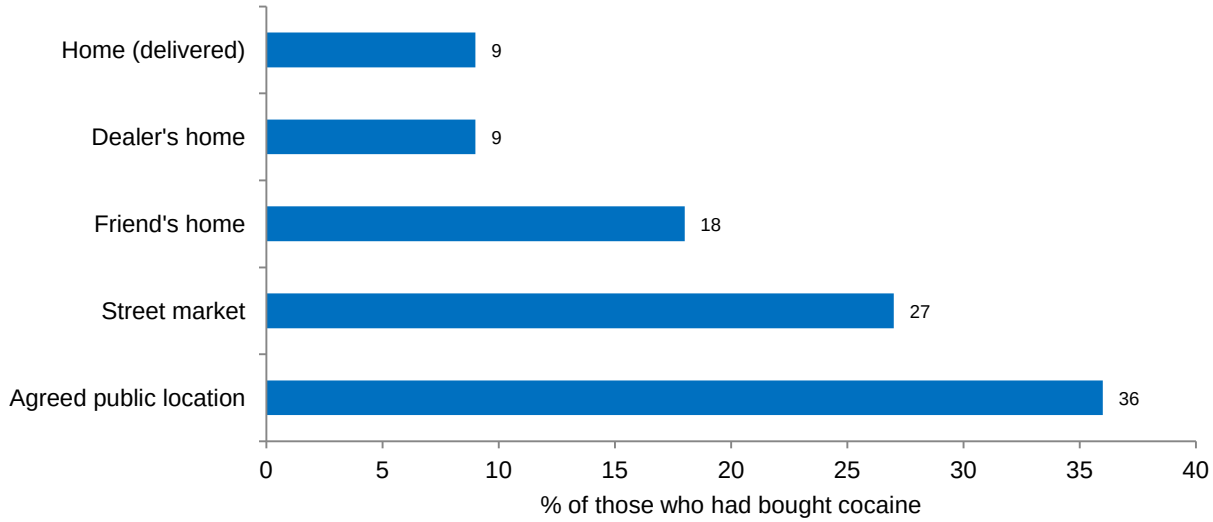
Participants were asked about both the source and location from which they had last obtained cocaine. Figure 37 shows that the majority of cocaine users who were able to answer reported obtaining cocaine from 'friends' (41%; n=9), followed by 'known dealers' (32%; n=7). The location from which participants most commonly obtained cocaine was an 'agreed public location' (36%; n=8), followed by a 'street market' (27%; n=6) (Figure 38).

Figure 37: People from whom cocaine was purchased in the preceding six months, 2016



Source: IDRS participant interviews.
Note: More than one response could be selected.

Figure 38: Locations where cocaine was scored in the preceding six months, 2016



Source: IDRS participant interviews.
Note: More than one response could be selected.

Key expert comments

- The majority of KE reported the price of cocaine to be stable.
- Law enforcement KE reported cocaine to be of medium purity, sitting at roughly 50%.
- It was generally acknowledged by KE that cocaine was available with the number of detections increasing, though small quantities were generally found.

5.4 Cannabis

Key Findings

- The price for both hydro and bush cannabis was generally reported as 'stable' in 2016 at $20 for a gram.

- The potency of hydro was reported as 'high' by the majority of participants. The majority of participants reported bush cannabis to also be of 'high' potency.

- The majority of participants reported the strength of cannabis had remained 'stable' in the six months preceding interview.

- The majority of participants reported both types of cannabis as 'easy' or 'very easy' to obtain. Availability had remained 'stable' over the preceding six months.

- Participants obtained cannabis primarily from 'friends', most often from a 'friend's home' or a 'dealer's home'.

From 2003, to ensure more detailed information was collected on the different forms of cannabis, the cannabis section was separated into hydro (hydroponically grown) and bush (grown outdoors).

In 2016, 59% of the sample was confident enough to complete survey items relating to hydro, and 17% of the sample was confident enough to complete survey items relating to bush.

5.4.1 Price of Hydroponic cannabis

As in previous years, hydro appeared to be the more popular form of cannabis with fewer participants reporting the purchase of bush (Table 22). 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 (range: $20–$50), similar to previous years. In 2016, the median price for a quarter ounce and ounce of hydroponic cannabis remained stable at $90 (range: $10–$100) and $300 (range: $250–$420) respectively. The median price for half an ounce was $165 in ($170 in 2015). The most popular purchase amount of hydro was grams (n=63), followed by quarter ounces (n=33) (Table 22).

5.4.2 Price of Bush cannabis

Participants were surveyed concerning the price paid the last time they had bought bush. In 2016, the median price for a gram of bush cannabis remained stable at $20. The most popular purchase amount for bush remained to be a gram (n=10), consistent with previous years, excluding 2006 when an ounce was reported as the most purchased amount. The number of reported purchases for all other amounts was low (<10), thus results are not presented.

Table 22: Price of last cannabis purchased, 2015−2016

	2015	**2016**
Price ($) HYDRO		
Per gram	20	**20**
Per quarter ounce	100	**90**
Per ounce	300	**300**
Per bag	50^	**50**
Price ($) BUSH		
Per gram	20	**20**

Source: IDRS participant interviews.
^Small numbers (n<10).

Table 24 summarises participant reports of recent changes in the price of cannabis. The price of both hydro and bush cannabis was generally reported as remaining 'stable' over the last six months, which was especially so for hydro cannabis, as a significant increase was observed from 2015 ($p<0.05$).

Table 23: Change in price of cannabis over the last six months, 2015−2016

Reported price status	Hydro		Bush	
	2015 (n=90)	**2016 (n=88)**	2015 (n=34)	**2016 (n=22)**
	% able to answer			
Increasing	14	**6**	0	**5**
Stable	79	**92**	91	**86**
Decreasing	3	**1**	9	**5**
Fluctuating	3	**1**	0	**5**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

5.4.3 Potency of cannabis

Table 24 and Table 25 summarise the current potency of cannabis and the changes in cannabis potency over the last six months, according to participant reports. In 2016, the strength of hydro was reported as 'high' by the majority of participants, unchanged from 2015. About half of participants reported bush cannabis to also be of 'high' potency, unlike 2015 reports where about half reported it to be of 'medium' potency. The majority of participants reported that the potency of both hydro and bush cannabis had remained 'stable' over the last six months, consistent with 2015 reports. No significant changes were observed regarding potency of cannabis between 2015 and 2016.

Table 24: Current potency/strength of cannabis, 2015−2016

How strong would you say cannabis is at the moment?	Hydro		Bush	
	2015 (n=92)	**2016 (n=88)**	2015 (n=34)	**2016 (n=24)**
	% able to answer			
High	55	**56**	35	**46**
Medium	27	**28**	47	**38**
Low	5	**8**	15	**8**
Fluctuates	12	**8**	3	**8**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Table 25: Change in potency/strength of cannabis in last six months, 2015−2016

How the strength of cannabis changed in the last 6 months?	Hydro		Bush	
	2015 (n=90)	**2016 (n=88)**	2015 (n=34)	**2016 (n=24)**
	% able to answer			
Increasing	9	**17**	12	**8**
Stable	63	**64**	68	**67**
Decreasing	13	**6**	9	**4**
Fluctuating	14	**14**	12	**21**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

5.4.4 Availability of cannabis

Table 26 and Table 27 summarise the current availability of cannabis and the changes in cannabis availability over the last six months, according to participant reports. In 2016, the majority of participants reported both types of cannabis as 'easy' or 'very easy' to obtain; 93% for hydro and 79% for bush. The majority of participants also reported that the availability of hydro and bush cannabis had remained 'stable' in the six months preceding interview, even though a significant decrease was observed in those who reported the availability of hydro remaining 'stable' from 2015 to 2016 ($p<0.05$).

Table 26: Availability of cannabis currently, 2015-2016

How easy is it to get cannabis at the moment?	Hydro		Bush	
	2015 (n=93)	**2016 (n=88)**	2015 (n=36)	**2016 (n=24)**
	% able to answer			
Very easy	65	**57**	33	**33**
Easy	29	**36**	31	**46**
Difficult	5	**7**	31	**21**
Very difficult	1	**0**	6	**0**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

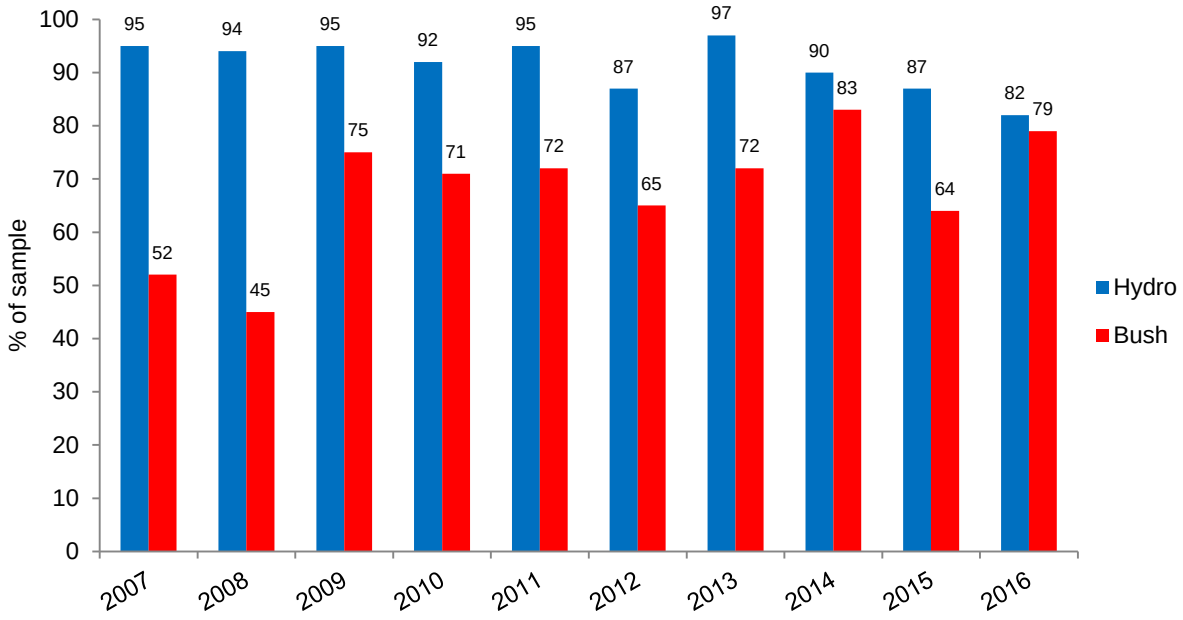
Table 27: Change in availability of cannabis over the last six months, 2015−2016

Has availability changed in the last 6 months?	Hydro		Bush	
	2015 (n=93)	**2016 (n=88)**	2015 (n=36)	**2016 (n=24)**
	% able to answer			
More difficult	3	**10**	14	**17**
Stable	90	**75**	75	**79**
Easier	5	**11**	8	**0**
Fluctuates	1	**3**	3	**4**

Source: IDRS participant interviews.
Note: 'Don't know' was excluded.

Figure 39 shows the long-term trend in the proportion of participants reporting availability of cannabis as 'easy' or 'very easy', from 2007. The reported ease of availability has fluctuated little over the years, and generally remained readily available. In 2016, the majority of the sample reported that both hydro and bush cannabis were 'easy' or 'very easy' to obtain.

Figure 39: Availability of cannabis in the last six months, easy or very easy, 2007–2016

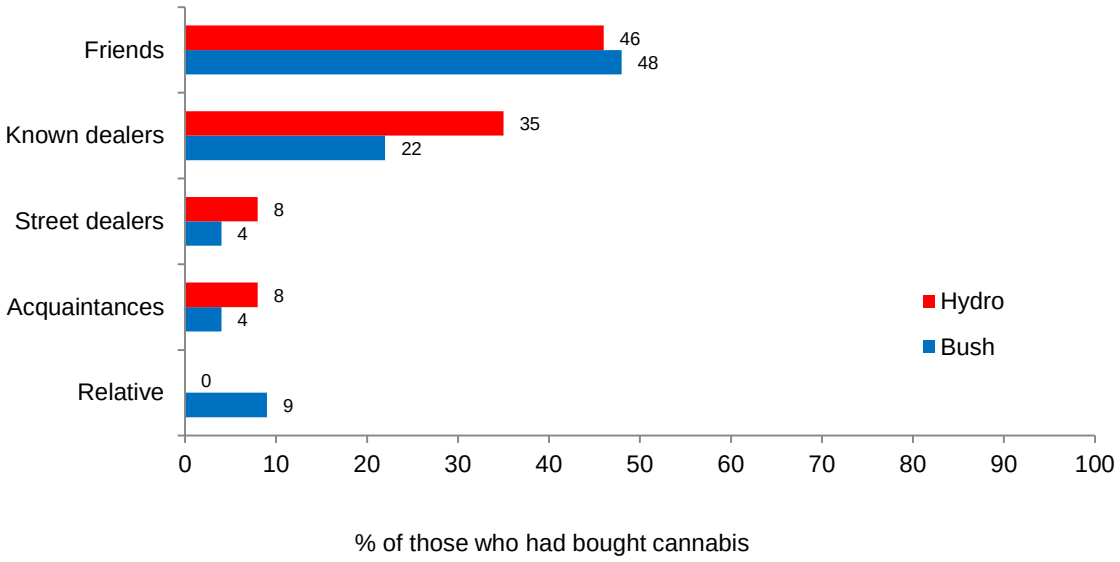


Source: IDRS participant interviews.
Note: 'Don't know' was excluded from 2009 onwards.

5.4.5 Purchasing patterns of cannabis

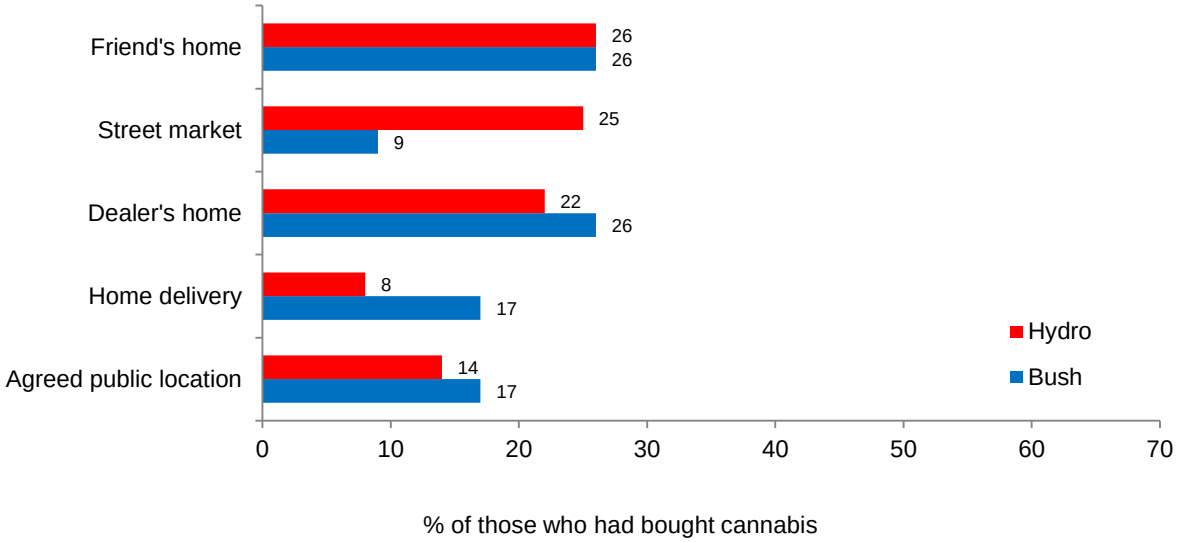
Figure 40 and Figure 41 presents information collected from participants on the source (both person and venue) from which participants had last obtained cannabis in 2016. Purchase patterns of hydro and bush were fairly similar, with those who had purchased in the last six months predominantly obtaining it through 'friends' and from 'known dealers'. Locations where cannabis was scored were also fairly similar; predominant locations for collection included a 'friend's home' or a 'dealer's home', followed closely by a 'street market', 'agreed public location' or 'home delivery'.

Figure 40: People from whom cannabis was purchased in the preceding six months, 2016



Source: IDRS participant interviews.
Note: More than one response could be selected.

Figure 41: Locations where cannabis was purchased in the preceding six months, 2016



Source: IDRS participant interviews.
Note: More than one response could be selected.

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.
- Law enforcement KE reported that availability had increased and the prices for hydro and bush cannabis are now comparable, whereas hydro has historically been more expensive.
- Hydro is still mainly cultivated in residential dwellings in the Sydney metropolitan area, and bush is grown in the north/north western region of NSW.
- One KE reported that Asian cultivators generally have bigger operations (between 500–600 plants), whilst non-Asian cultivators generally have just a few plants (for personal use).

5.5 Methadone

Key Findings

- The median last purchase price for methadone liquid was 92 cents per ml (range: 25 cents–$5.00). This had generally remained stable in the six months preceding interview.

- Illicit methadone was mostly reported as 'easy' to obtain (48%). The majority of those able to answer reported that availability had remained 'stable'.

- Participants most commonly obtained illicit methadone through 'friends' at a 'friend's home'.

As with other drug types, all participants were asked about the price, purity and availability of illicit methadone. Twenty-two percent of the sample (n=33) felt confident to report on the price, purity and/or availability of illicit methadone.

5.5.1 Price 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 92 cents per ml (n=18; range: 25 cents–$5.00) (55 cents per ml in 2015). Figures should be interpreted with caution, however, due to small numbers reporting.

Of the thirty-two participants who were able to comment on whether the price of illicit methadone had changed in the six months preceding interview, the majority reported that the price had remained stable (85%). Three participants reported that the price had increased, and two participants stated that the price had fluctuated. No participants reported a decrease in price. No significant changes were observed regarding price changes between 2015 and 2016.

5.5.2 Availability of illicit methadone

Forty-eight percent of those that could comment reported that the availability of illicit methadone was 'easy' to obtain (n=15). Eight participants found it 'very easy' to obtain, and a further eight participants found it 'difficult' to obtain. When asked whether availability had changed over the preceding six months, the majority of those commenting (79%; n=23) reported that it had remained 'stable'. Four participants reported that it had become 'more difficult' in the preceding six months, and the remaining participants reported that the availability change was either 'easier' (n=1) or 'fluctuating' (n=1). There were no significant differences between 2015 and 2016 reports regarding availability of illicit methadone.

5.5.3 Purchasing patterns of illicit methadone

Of those that had obtained illicit methadone, it was most commonly acquired from 'friends' (71%; n=17), with smaller numbers obtaining it from 'acquaintances' (n=4), 'street dealers' (n=2) and 'unknown dealers' (n=1). The most commonly reported location of purchase was from a 'friend's home' (n=11), followed by an 'agreed public location' (n=6), 'street market' (n=3), an 'acquaintance's house' (n=2) and 'home delivery' (n=1).

5.6 Morphine

Key Findings

- The median last purchase price for 100mg of MS Contin® was $50 and 100mg of Kapanol® was $40; this had generally remained stable in the six months preceding interview.

- Illicit morphine was mostly reported as 'easy' or 'very easy' to obtain. The majority of those able to answer reported that availability had remained 'stable' in the preceding six months.

- Participants most commonly obtained illicit morphine through 'friends' at an 'agreed public location'.

Ten percent of participants (n=15) felt confident enough to respond to survey items concerning price and/or availability of illicit morphine. MS Contin® continued to remain the most common brand of morphine used.

5.6.1 Price of illicit morphine

The median price for 100mg MS Contin® tablets ('grey nurses') remained stable at $50 per tablet (range $40−$50). Few participants (n<10) commented on 60mg MS Contin® and no participant purchases of 5mg or 10mg tablets. Two participants were able to comment on the price of 100mg Kapanol®.

Eighty-seven percent (n=13) of those commenting for illicit morphine reported that the price had remained 'stable' over the preceding six months. The remaining two participants believed that the price had 'increased'. No significant changes were observed regarding price changes between 2015 and 2016.

5.6.2 Availability of illicit morphine

Of those able to comment, the majority of participants reported that illicit morphine was 'easy' (n=8) or 'very easy' (n=5) to obtain. Two participants believed it to be 'very difficult' to obtain. Seventy-one percent (n=10) 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 'easier'. One participant commented that the change in recent availability of morphine was 'more difficult' and a further one participant reported that availability had 'fluctuated'. There were no significant differences between 2015 and 2016 reports regarding availability of illicit morphine.

5.6.3 Purchasing patterns of illicit morphine

In 2016, morphine was most commonly purchased from 'friends' (n=5), 'street dealers' (n=3), 'known dealers' (n=2), 'acquaintances' and 'unknown dealers' (n=1, respectively). The most commonly reported locations of purchase from those who could comment were from an 'agreed public location' (n=5), a 'street market' and a 'friend's home' (n=3, respectively). One participant reported obtaining morphine from an 'other' location.

5.7 Oxycodone

Key Findings

- Equal proportions of participants reported the price of illicit 'generic and other' oxycodone to be 'stable' or 'increasing' in the six months preceding the interview.

- The majority of participants reported the availability of illicit 'generic or other' oxycodone as being 'easy' or 'very easy' and oxycodone 'OP' was generally reported as 'easy' to obtain.

- Most participants reported that availability of 'generic or other' oxycodone and oxycodone 'OP' had remained 'stable'.

- Participants most commonly obtained 'generic or other' or 'OP' oxycodone through a 'friend', most often at an 'agreed public location' or a 'friend's home'.

In 2016, oxycodone was divided into two separate groups for price, purity and availability. These groups included 'Generic or other' oxycodone and 'OP' oxycodone[12]. Sixteen percent of participants (n=24) felt confident enough to respond to survey items concerning price and/or availability of illicit 'generic or other' oxycodone, and 10% of participants (n=15) were able to comment on 'OP' oxycodone.

5.7.1 Price of illicit oxycodone

A small number of participants (n<10) were able to comment on prices for specific formulations of 'generic or other' oxycodone and 'OP' oxycodone and therefore median price data is not presented.

Twenty participants were able to comment on the price changes in the preceding six months for 'generic or other' oxycodone and 'OP' oxycodone. Nine participants reported the price of illicit 'generic and other' oxycodone as stable over the last six months, and a further nine participants commented that it had increased. Two participants reported that illicit 'generic and other' oxycodone had decreased in the preceding six months. The majority of participants commented that illicit 'OP' oxycodone had remained stable (n=10), with three participants reporting it had decreased, and one commenting that it had increased over the preceding six months. No significant changes were observed regarding price changes between 2015 and 2016.

There were insufficient purchases of Endone®, OxyNorm®, Targin® or Proladone® to report on prices.

5.7.2 Availability of illicit oxycodone

Of those participants in the IDRS sample who were able to comment (n=21), 76% reported the availability of illicit 'generic or other' oxycodone as being 'easy' or 'very easy' (38%, respectively; n=16) and 19% (n=4) reported availability as 'difficult' and 5% (n=1) as 'very difficult' to obtain. Forty-seven percent (n=7) reported the availability of oxycodone 'OP' as 'easy', 13% (n=2) as 'very easy' and a further 40% (n=6) as 'difficult' to obtain. The majority reported the availability of 'generic or other' oxycodone and oxycodone 'OP' as stable over the last six months (73% and 86% respectively).

[12] In April 2014 'Reformulated OxyContin®' (branded with an 'OP' on each tablet) was introduced designed to be tamper resistant. The 'original oxycodone' OxyContin® (branded with an 'OC') was withdrawn. In September 2014 generic 'non-tamper-resistant oxycodone' was made available in Australia.

Due to the change in reporting in 2016, no significance testing was carried out on the current availability of ‘illicit’ ‘generic or other’ or ‘OP’ oxycodone for ‘very easy’, ‘easy’, ‘difficult’ and ‘more difficult’ between 2015 and 2016.

5.7.3 Purchasing patterns of illicit oxycodone

Of those who had bought illicit ‘generic or other’ or ‘OP’ oxycodone (n=18), the most common source was through a ‘friend’ (50% and 46%, respectively). The most common place of purchase for illicit ‘generic or other’ oxycodone was ‘an agreed public location’ (33%; n=6), a ‘street market’ (28%; n=5) and a ‘friend’s home’ (n=17%; n=3). With regards to ‘OP’ oxycodone, the most common place of purchase was an ‘agreed public location’ and a ‘friend’s home’ (36%; n=4, respectively).

5.8 Benzodiazepines

Key Findings

- The median price for an illicit diazepam pill was $1.50 and for an illicit alprazolam pill, the median price was $10. The majority of those who could comment reported the price of illicit benzodiazepines had remained 'stable'.

- Over half of those who could comment reported the availability of illicit benzodiazepines to be 'difficult' to obtain, significantly higher than 2015 reports. Fifty-seven percent of those who could comment reported availability to be 'stable.'

- Participants most commonly obtained illicit benzodiazepines through 'friends' at a 'street market'.

In 2016, participants were asked about the price, availability and purchasing patterns of benzodiazepines in the last six months. Twenty-seven percent of participants were able to comment (n=40). Among those who commented, the most common brand of benzodiazepines reported were alprazolam (Xanax) (n=20), followed by diazepam (Valium) (n=12).

5.8.1 Price of illicit benzodiazepines

The median price for an illicit diazepam pill was $1.50 (n=10; range: $1–$25) and for an illicit alprazolam pill, the median price was $10 (range: $5–$100). Of those participants in the IDRS sample who were able to comment (n=39), the majority (54%) reported the price of illicit benzodiazepines had remained 'stable' over the last six months. No significant changes were observed regarding price changes between 2015 and 2016.

5.8.2 Availability of illicit benzodiazepines

Of those participants in the IDRS sample who were able to comment (n=39), 51% reported the availability of illicit benzodiazepines as 'difficult', significantly higher than 19% who reported availability as 'difficult' in 2015 ($p<0.05$). Twenty-six percent reported availability as 'easy' and 21% as 'very easy' to obtain. Over half (57%) of those who commented reported availability as 'stable' and 41% as 'more difficult' to obtain in the last six months.

5.8.3 Purchasing patterns of illicit benzodiazepines

Of those who had bought illicit benzodiazepines, the most common source was through a 'friend' (42%) or a 'street dealer' (24%). The most common places of purchase was a 'street market' (50%), a 'friend's home' or at an 'agreed public location' (21%, respectively).

5.9 Other drugs

The number of participants who answered questions relating to ecstasy, hallucinogens, illicit buprenorphine (Subutex®), illicit buprenorphine-naloxone (Suboxone®), illicit antidepressants, illicit antipsychotics, illicit pharmaceutical stimulants, steroids and fentanyl markets were extremely low (n<10). Data from these sections will not be presented.

6 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

Key Findings

Overdose and Drug-Related Fatalities

- Among participants who had ever overdosed on heroin (n=82), 27% had overdosed in the past 12 months and four participants had overdosed in the past month.

- Seven participants had overdosed on any other drug (not including heroin, morphine, methadone or oxycodone) in the past 12 months, and one participant had overdosed in the last month.

- In 2012, there were 564 accidental deaths nationally due to opioids, and most of these deaths occurred in New South Wales (n=157). These accounted for 28% of the total number of deaths.

- The number of suspected drug-related deaths where amphetamines were detected post-mortem in NSW appears to have increased from mid-2014 onward. On the other hand, the number of suspected drug-related deaths were cocaine was detected post-mortem has remained consistently low.

- Heroin overdose presentations to NSW emergency departments have stabilised at a lower level in the past two years after declining in 2012. The total number of amphetamine overdose and cocaine overdose presentations to NSW emergency departments has fluctuated over time.

Health Service Use

- Telephone calls to ADIS and FDS regarding heroin remained relatively stable over the past 12 months apart from a spike in May 2016 with 101 calls to ADIS, and falling back down to 63 calls in June 2016.

- Telephone calls to ADIS and FDS regarding methamphetamine reveal an upward trend, which has continued in the past 12 months to June 2016. Crystal methamphetamine has also been increasing substantially since 2012.

Drug Treatment

- Fifty-four percent of the NSW IDRS sample reported being in drug treatment at the time of interview, and they had been in treatment for a median of 30 months. The predominant form of treatment being received was maintenance pharmacotherapy treatment. Specifically, among those in treatment, 74% reported being on a methadone program, and 20% reported being on a buprenorphine or buprenorphine-naloxone program.

- Eight percent of the sample reported a hospital admission for methamphetamine psychosis on a median of two occasions in the past year, while 3% of the sample reported admission to hospital for other methamphetamine related issues on a median of one occasion in the past year.

- Seventeen percent of participants had tried to access treatment over the preceding six months but were unable to. Sixty-five percent had tried to access treatment for heroin use and 19% had tried to access treatment for methamphetamine use.

- Based on results from the NSW MDS, all forms of heroin treatment, except residential rehabilitation, have declined between 2007/08 and 2014/15.

- Also based on the results from the NSW MDS, the number of amphetamine related episodes have risen steeply since 2008/09, with the highest numbers being observed between 2013/14 and 2014/15 over the last decade.

- The number of opioid-related hospital admissions has remained stable in NSW over the past 10 years. On the other hand, the number of amphetamine-related hospital admissions, cocaine-related hospital admissions and cannabis-related hospital admissions has all steadily increased in NSW and nationally.

Opioid and Stimulant Dependence

- Of those who recently used an opioid drug and commented (n=137) the median SDS score was seven, with 83% scoring five or above, indicative of opioid dependence. Scores were significantly higher for males than females.

- Of those who recently used a stimulant drug and commented (n=119), the median SDS score was five, with 59% scoring four or above, indicative of stimulant dependence.

Mental Health

- Thirty-five percent of all participants reported experiencing a mental health problem in the preceding six months. Among those who had suffered from a mental health problem, depression and anxiety continued to be the most commonly reported disorders.

- Among those who had recently experienced a mental health problem, 67% reported that they had attended a professional for such problems.

- Just under two-thirds of the IDRS sample (66%) was assessed as having 'high' to 'very high' levels of psychological distress. This was much higher than what has been reported among the general population.

Alcohol Use Disorders Identification Test

- Forty-five percent of males and 30% of females scored 5 or more on the AUDIT-C, indicating a serious need for further assessment.

Naloxone Program and Distribution

- Eighty-eight percent of those who commented (n=147) had heard of naloxone. Half of those who had heard of naloxone and commented (n=125) reported that naloxone was used to 'reverse heroin', while 30% reported the use of naloxone to 're-establish consciousness'.

- Forty-eight percent of those who commented (n=147) reported that they had not heard of the take-home naloxone program.

- Eighteen percent of those who commented (n=147) reported that they had completed training in naloxone administration. Of the twenty-seven participants who had completed the course, 44% had used naloxone to resuscitate someone who had overdosed.

- Twenty-one participants reported that they had heard about the rescheduling of naloxone.

- Thirty-seven percent of the sample believed that naloxone OTC should be free.

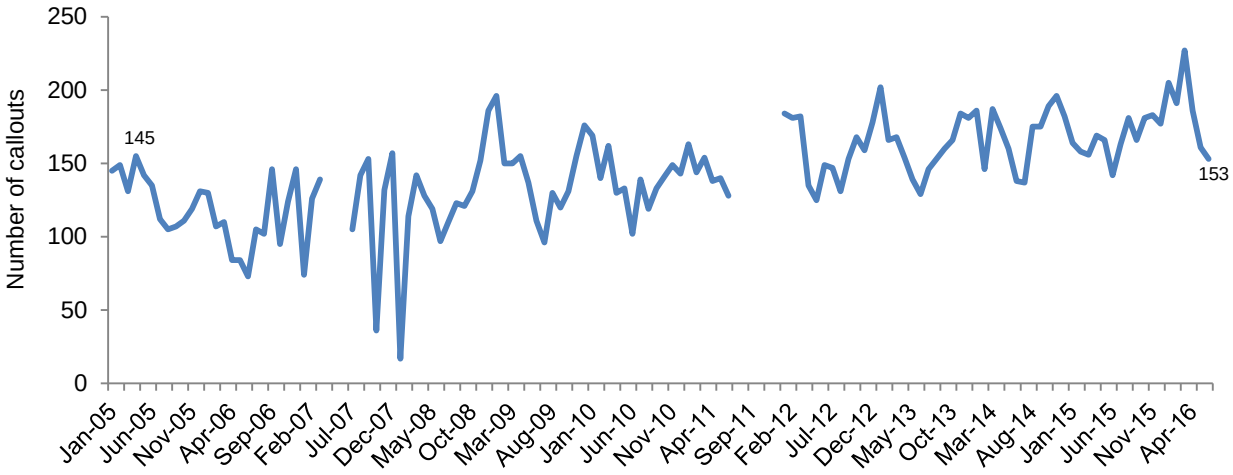
- No participants reported that they had been resuscitated with naloxone, which was obtained OTC at a pharmacy.

- One hundred percent of those who commented (n=79) reported that they would administer naloxone after witnessing someone overdose, 99% reported that they would stay with someone after giving them naloxone and 80% reported that they would carry naloxone on their person.

6.1 Overdose and drug-related fatalities

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 137 to 227 calls per month (Figure 42).

Figure 42: Number of ambulance callouts to overdoses January 2005−June 2016



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

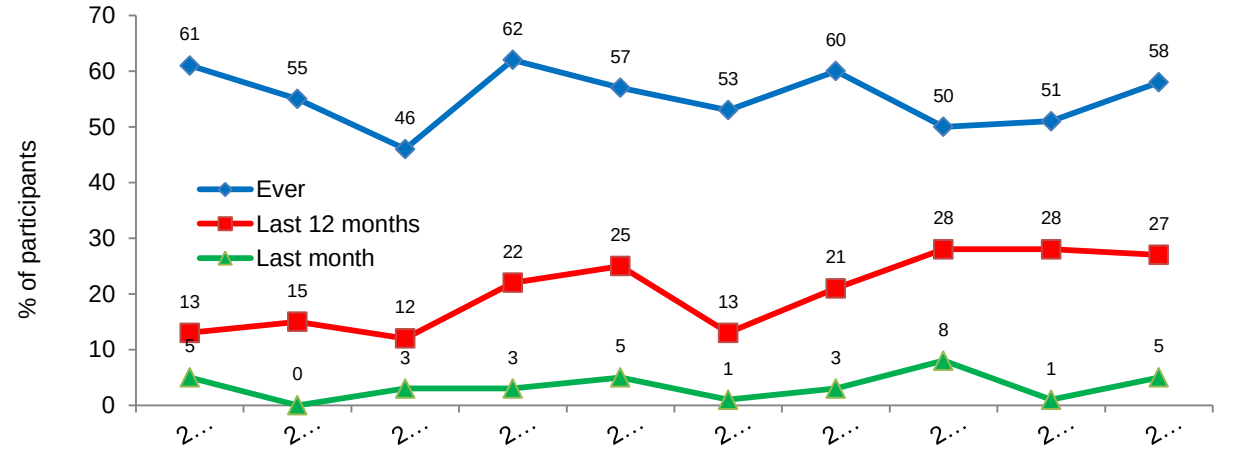
6.1.1 Heroin

6.1.1.1 Non-fatal opioid overdose

Of the 148 participants who reported lifetime use of heroin, eighty-two (58%) participants reported that they had overdosed on heroin on a median of two occasions (range: 1−40 occasions). Of these, 81% (n=42) had overdosed six times or less, with the majority reporting that they had overdosed once in their lifetime (n=26; 32%).

Among participants who had ever overdosed on heroin, 27% (n=22) had done so in the past 12 months and four participants (5%) had overdosed in the past month (see Figure 43).

Figure 43: Proportion of participants who had ever overdosed, overdosed in the past 12 months, and the past month, on heroin 2007-2016



Source: IDRS participant interviews.

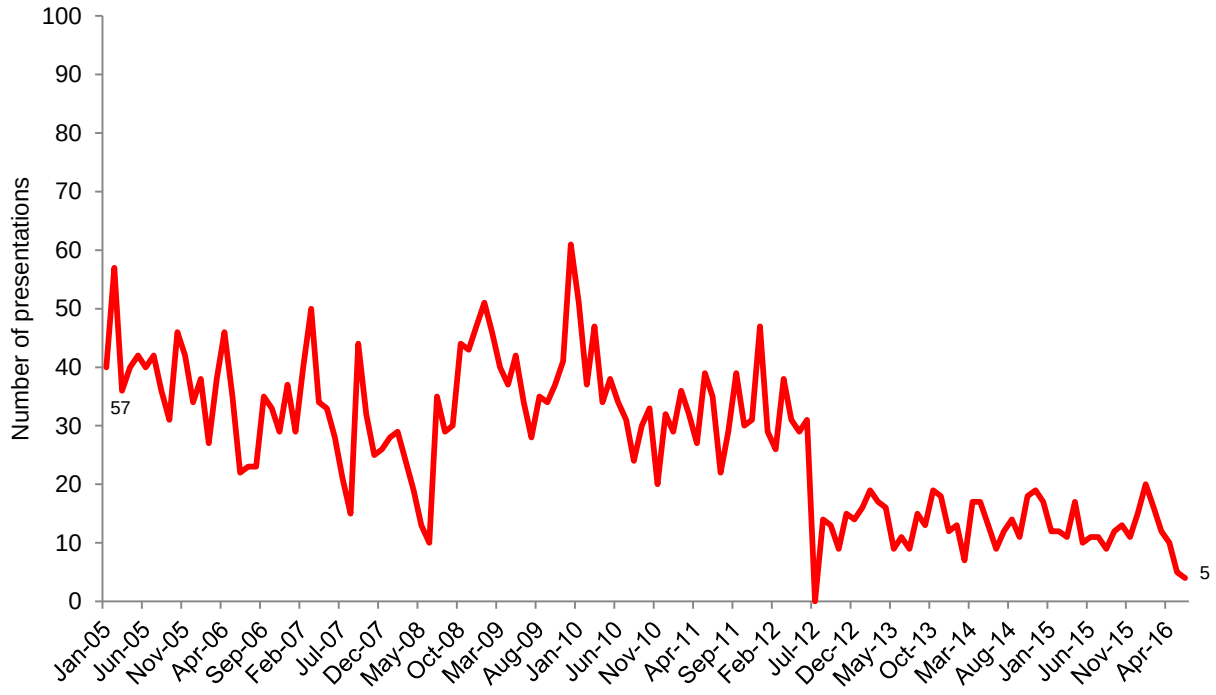
Long-term trends in the experience of lifetime, past 12 month and past month overdose among those who had ever used heroin, is depicted in Figure 43. As can be seen, lifetime overdose has remained high. In 2016, the proportion of heroin users who reported lifetime experience of overdose was 58%. Past year heroin overdoses declined in 2012, but increased and has remained stable from 2014 with over one-quarter (28%) reporting an overdose in the past year in 2016.

Participants were also asked about the treatment they received following a heroin overdose in the past year. Of the twenty-two participants who commented, 55% had an ambulance attend, 50% received Narcan® and 41% (n=9) received oxygen. Five participants did not receive treatment, four participants attended the hospital emergency department and three participants received CPR from a health professional, and CPR from a friend/partner, respectively.

Participants were also asked about the treatment or information they received following their most recent heroin overdose. Of those who commented (n=22), 96% did not receive any information or treatment after the recent overdose, though one participant received information from a drug health service.

Heroin overdose presentations to NSW emergency departments have stabilised at a lower level in the past two years after declining in 2012 (Figure 44).

Figure 44: Heroin overdose presentations to NSW emergency departments, January 2005−June 2016



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

6.1.1.2 Fatal opioid overdose

The Australian Bureau of Statistics (ABS) collates and manages the national causes of death database, utilising information from the National Coronial Information System (NCIS). Prior to 2003, ABS staff visited coronial offices to manually update information about the cause of death for records that had not yet been loaded onto the NCIS. Since 2003, the ABS has progressively ceased visiting jurisdictional coronial offices, therefore ceasing manual updates of deaths that were not already included on the NCIS.

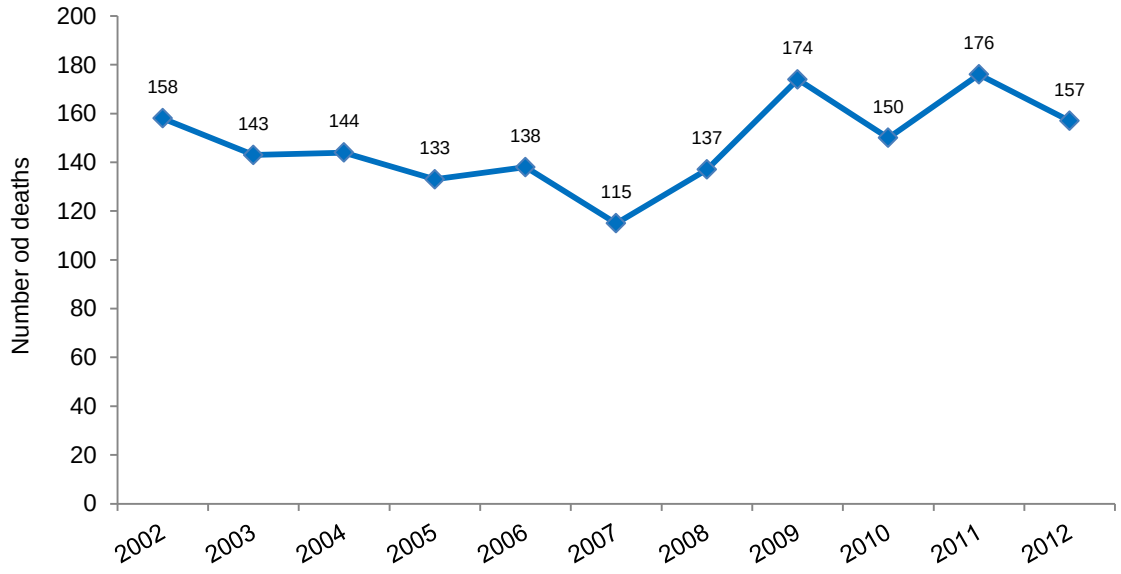
In 2006, the ABS relied solely on the data contained on the NCIS at the time the ABS ceased processing the deaths data. Since 2007, the causes of death data have been subject to a revisions process. The preliminary data is released and then two successive revisions are released 12 months apart from the date of the release of preliminary data. The 2006 data were not subject to this revision process, and are therefore likely to be incomplete. This is likely to result in an underestimate of the number of opioid induced deaths recorded in 2006. We have tried to offset this underestimate by analysing the changes between preliminary and final findings for both 2007 and 2008. We have averaged the changes across both years, and applied it to the 2006 figures. This data should be interpreted with caution.

Data for 2007−2010 represent the second and final revision of each dataset, and are therefore methodologically comparable. Again these data should be interpreted with caution as figures may change. The result of the revisions process is a longer time from the reporting of a death to finalisation by the coroner. These revisions will most likely result in an increase in the number of deaths. This is particularly true for deaths that are drug related, as coronial investigations can be complex and lengthy in nature.

The ABS has implemented a number of additional strategies, including examination of death certificates and coroners reports, to ensure that as many of the deaths as possible have a cause of death coded at the time the data file is closed.

In 2012, there were 564 accidental deaths due to opioids at a national level (617 in 2011). Most of these deaths occurred in New South Wales (n=157), which accounted for 28% of the total number of deaths. This reflected a decrease from 2011, in which NSW recorded 176 deaths due to accidental opioid overdose (Figure 45). It should be noted that the deaths reported are opioid-related and not necessarily heroin overdose deaths. Note that 2012 has the most recent available data.

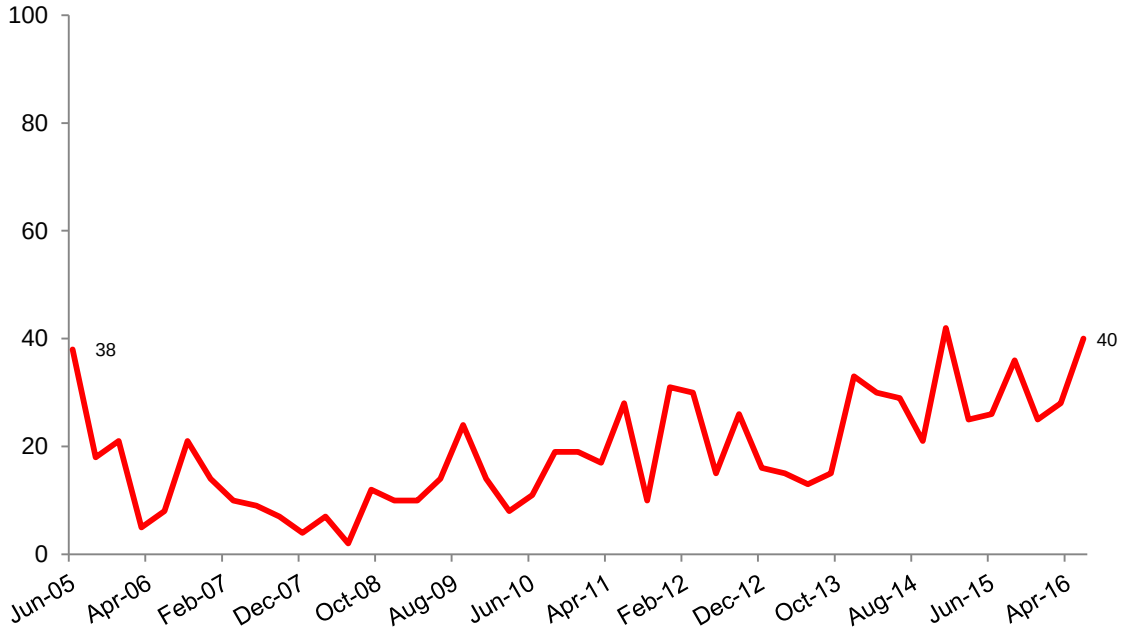
Figure 45: Number of accidental deaths due to opioids among those aged 15–54 years in NSW, 2002–2012



Source: ABS causes of death data (Roxburgh and Breen 2016).
Note: The 2006 data will be underestimated and not necessarily reflective of a downward trend (given that enhanced methodology was not introduced until 2007); the 2007–2010 data are the final figures after two revisions.

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 46).

Figure 46: Number of suspected drug-related deaths in which morphine was detected post-mortem, by quarter, March 2005–June 2016



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

6.1.2.1 Non-fatal overdose

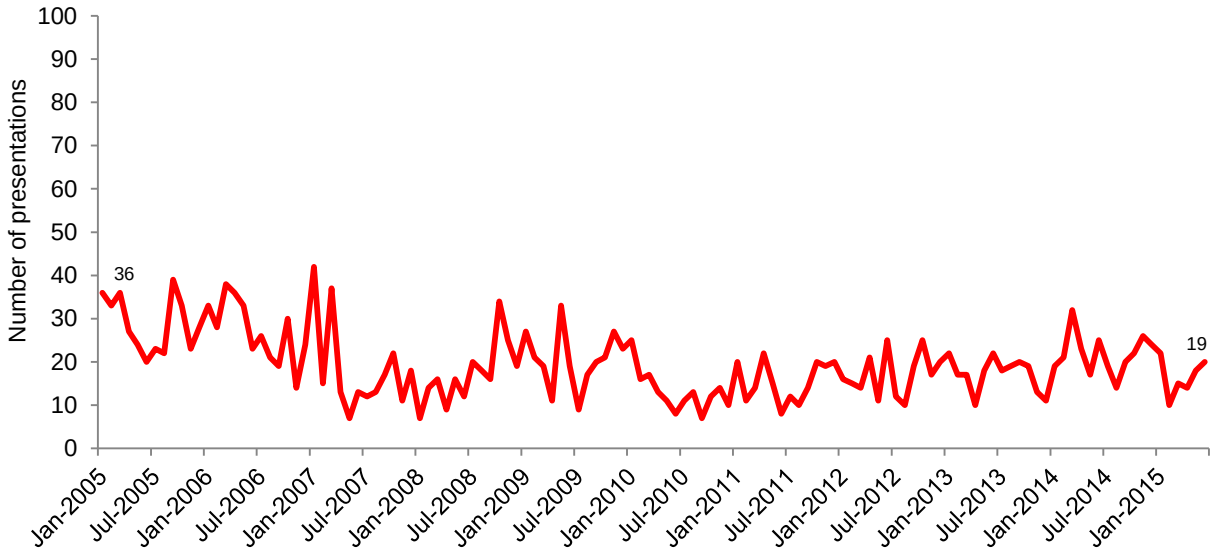
Participants were asked to specify how many times they had accidentally overdosed on any other drug (not including heroin, morphine, methadone or oxycodone), how long since that had happened, and which drugs were involved. Eleven percent (n=15) reported that they had accidentally overdosed on another drug within their lifetime, and they had done so on a median of thirteen occasions (range: 1–336 occasions). Of these, seven participants had overdosed in the past 12 months, and one participant had overdosed in the last month.

6.1.3 Methamphetamine

6.1.3.1 Non-fatal overdose

The total number of amphetamine overdose presentations to NSW emergency departments has fluctuated over time (Figure 47).

Figure 47: Amphetamine overdose presentations to NSW emergency departments, January 2005−June 2016



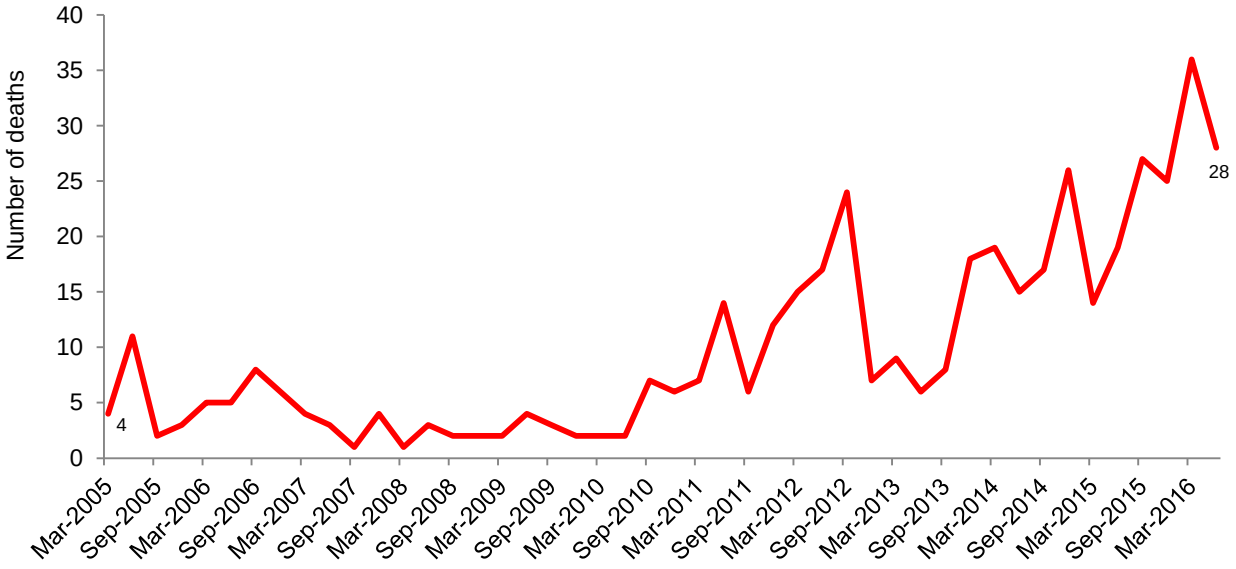
Source: Emergency Department Information System, NSW Ministry of Health.
Note: Figures refer to overdose only and do not include presentations for use disorders.

6.1.3.2 Fatal overdose

The number of suspected drug related deaths where amphetamines were detected post-mortem in NSW appears to have increased from mid-2014 onward. The numbers have steadily risen in the past year, with the number of drug-related deaths rising to 36% in March 2016 (Figure 48).

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 48: Number of deaths of individuals suspected of drug use, in which illicit amphetamines were detected post-mortem, NSW, by quarter, March 2005–June 2016



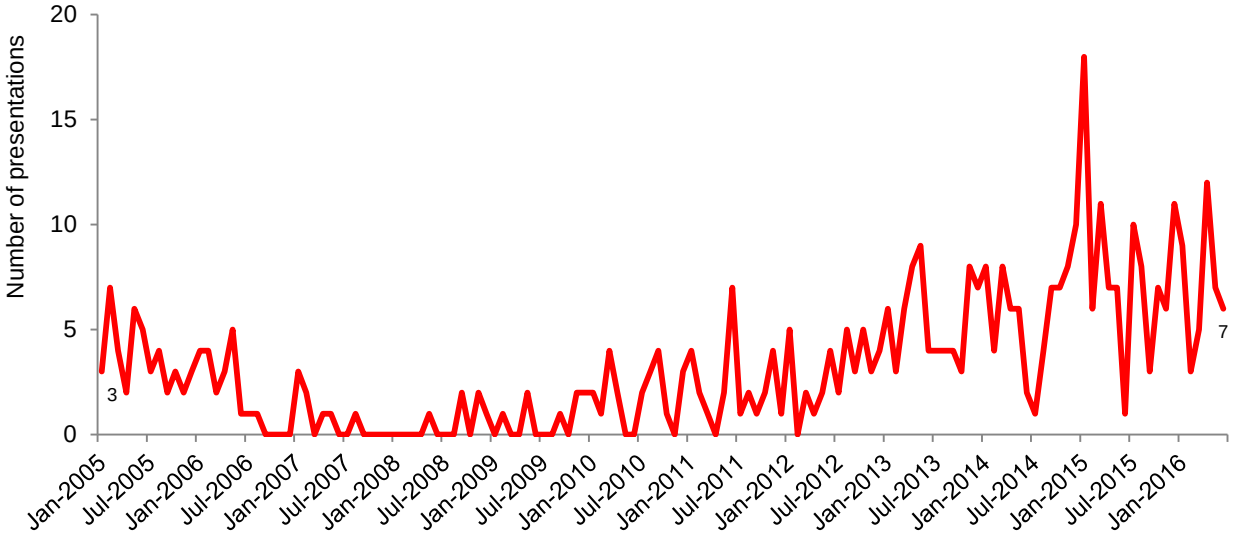
Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories, NSW Ministry of Health.
Note: These numbers relate to deaths in which amphetamines, including methamphetamine, were detected; however, there may have also been other drugs present.

6.1.4 Cocaine

6.1.4.1 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 166 overdose presentations to NSW emergency departments (Figure 49).

Figure 49: Cocaine overdose presentations to NSW emergency departments, January 2005–June 2016

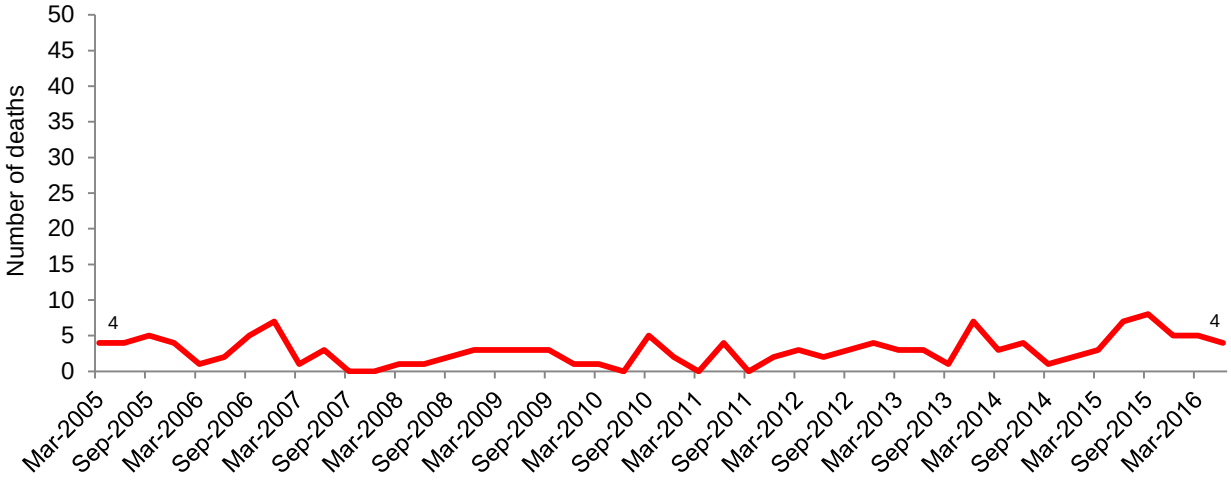


Source: Emergency Department Information System, NSW Ministry of Health.
Note: Figures refer to overdose only and do not include presentations for use disorders.

6.1.4.2 Fatal overdose

The number of suspected drug related deaths where cocaine was detected post-mortem has remained low over time (Figure 50).

Figure 50: Number of deaths of individuals suspected of drug use, in which cocaine was detected post-mortem, NSW, by quarter, March 2005–June 2016

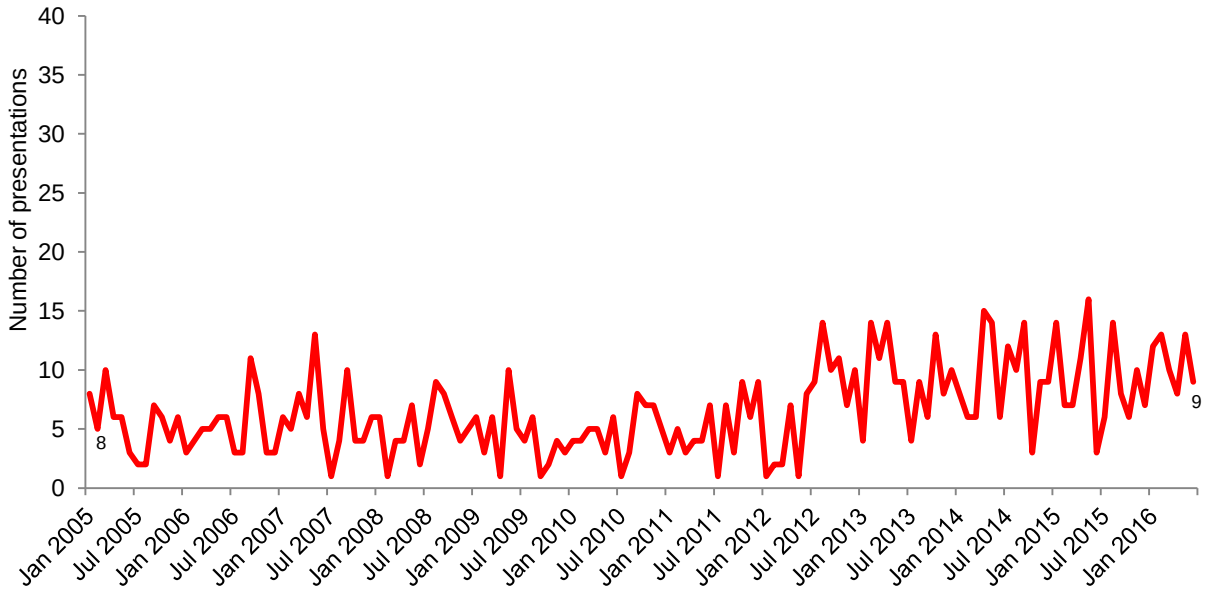


Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories, NSW Ministry of Health.
Note: These numbers relate to deaths in which cocaine was detected; however, there may have also been other drugs present.

6.1.5 Cannabis

The number of cannabis toxicity presentations to emergency departments has remained relatively low; however, since mid-2012, presentations fluctuated at higher levels (Figure 51).

Figure 51: Cannabis toxicity presentations to NSW emergency departments, January 2005–June 2016



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

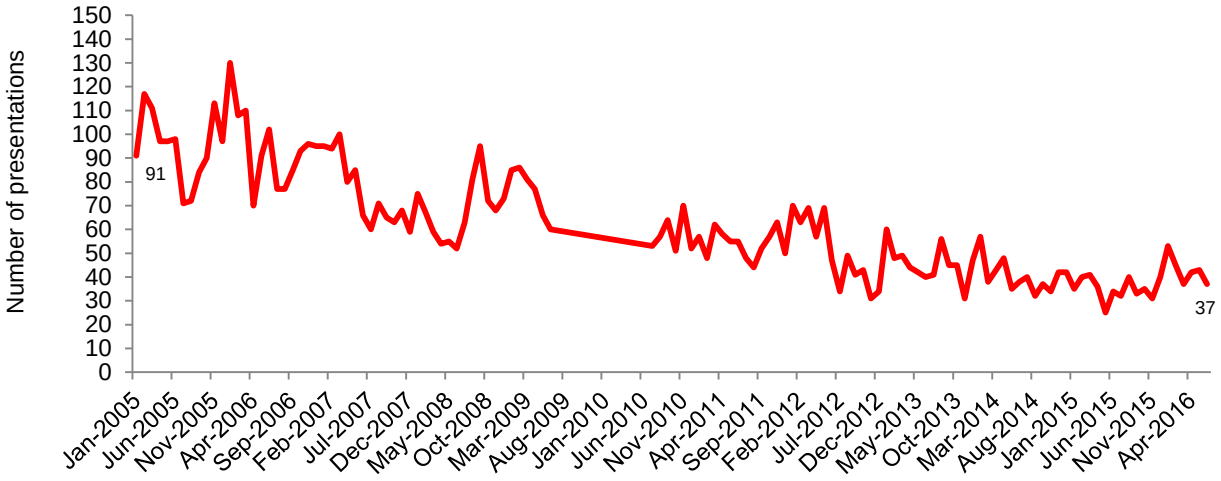
6.1.6 Benzodiazepines

6.1.6.1 Non-fatal overdose

The number of benzodiazepine overdose presentations to NSW emergency departments continues to decline over time (Figure 52).

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 52: Benzodiazepine overdose presentations to NSW emergency departments, January 2005–June 2016

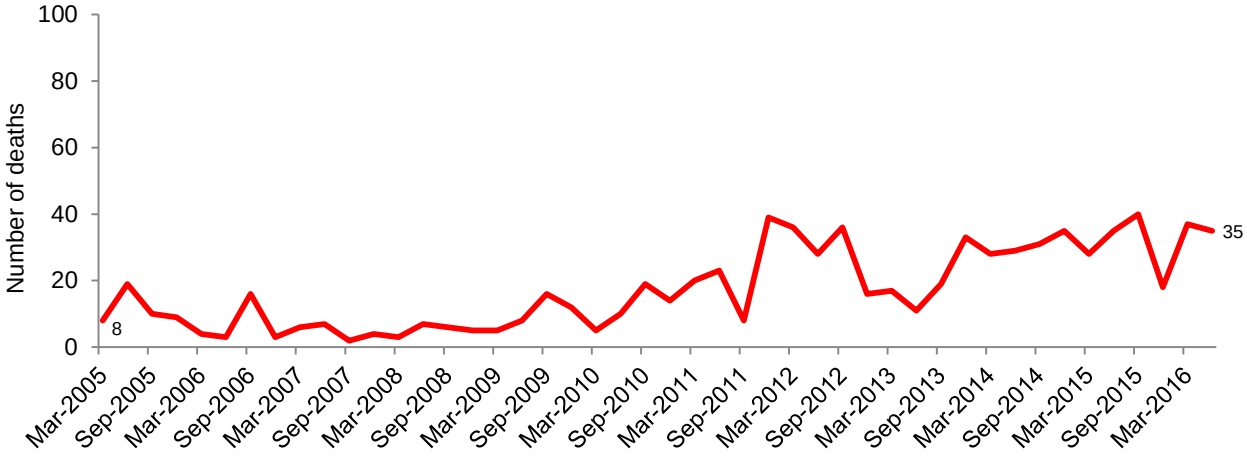


Source: Emergency Department Information System, NSW Ministry of Health.
Note: Figures refer to overdose only and do not include presentations for use disorders.

6.1.6.2 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 53).

Figure 53: Number of deaths of individuals suspected of drug use, in which benzodiazepines were detected post-mortem, NSW, by quarter, March 2005–June 2016



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

6.2 Health service use

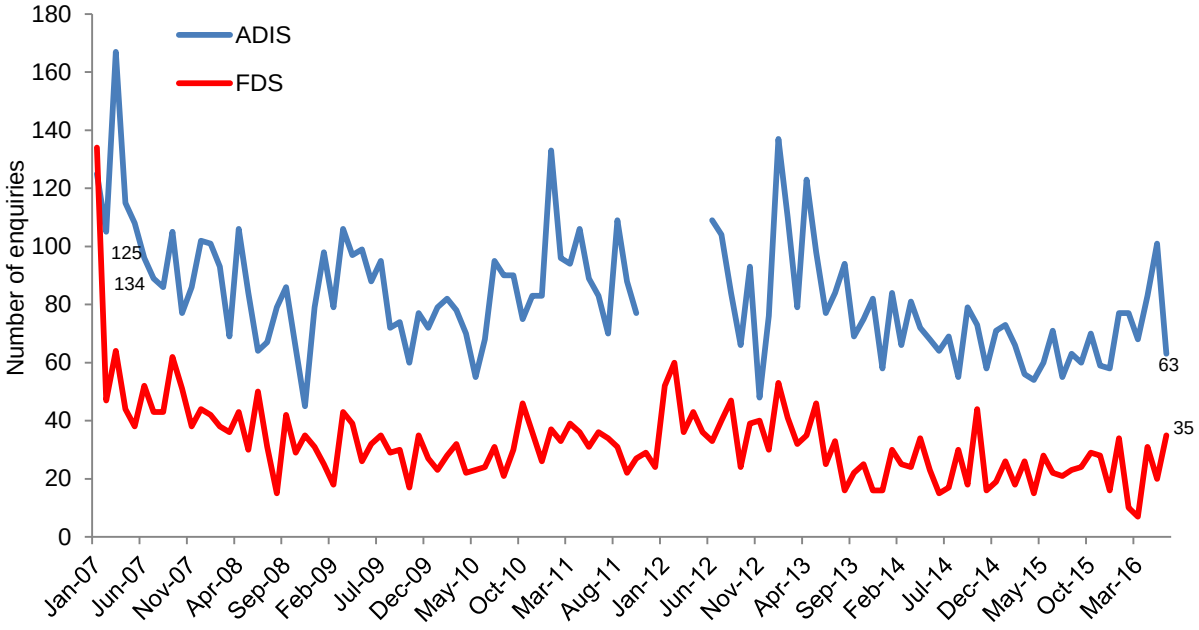
6.2.1 Heroin

Figure 54 shows the number of calls to ADIS where heroin was mentioned as any drug of concern, and to the FDS helpline regarding heroin as the primary drug of concern.

The number of enquiries to the 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 apart from a spike in May 2016 with 101 calls to ADIS, and reducing to 63 calls in June 2016. Calls ranged between 55−101 calls per month for ADIS and 7−35 calls per month to the FDS.

Figure 54: Number of enquiries to ADIS and FDS regarding heroin, January 2005−June 2016

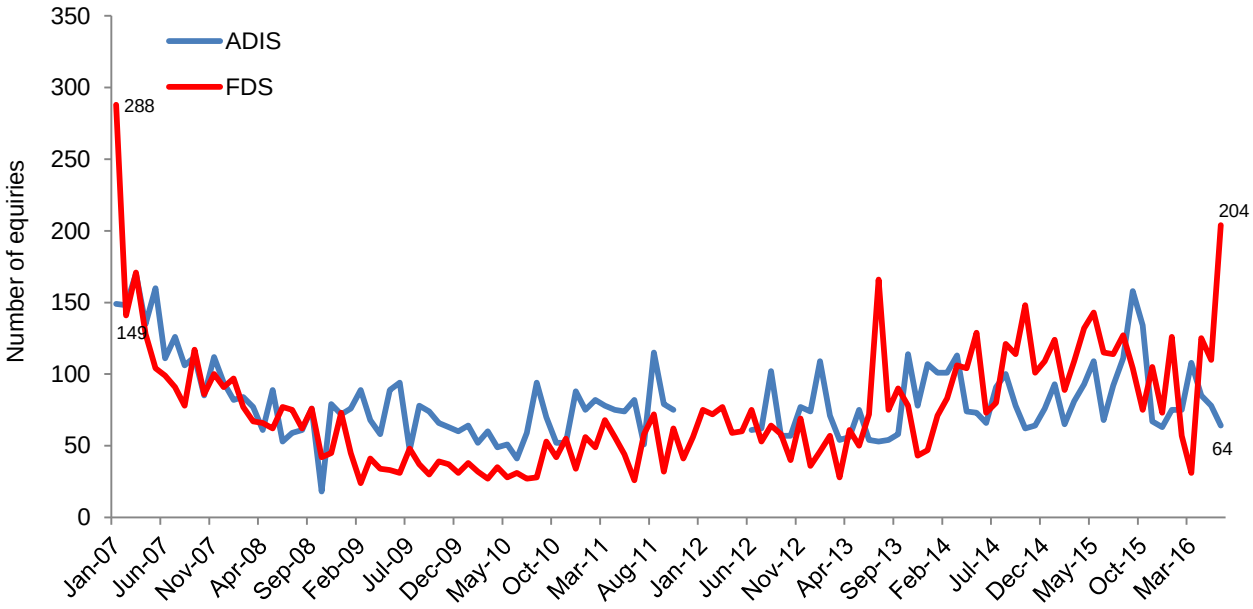


Source: NSW ADIS and FDS.
Note: FDS data were only available on a monthly basis and refer to calls where any mention of heroin was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where heroin was mentioned as any drug of concern. Breaks 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 55 shows the number of calls to ADIS and the FDS lines regarding methamphetamine. An upward trend in these calls has continued in the past 12 months to June 2016 (ADIS range per month: 63−158; FDS range: 31−204).

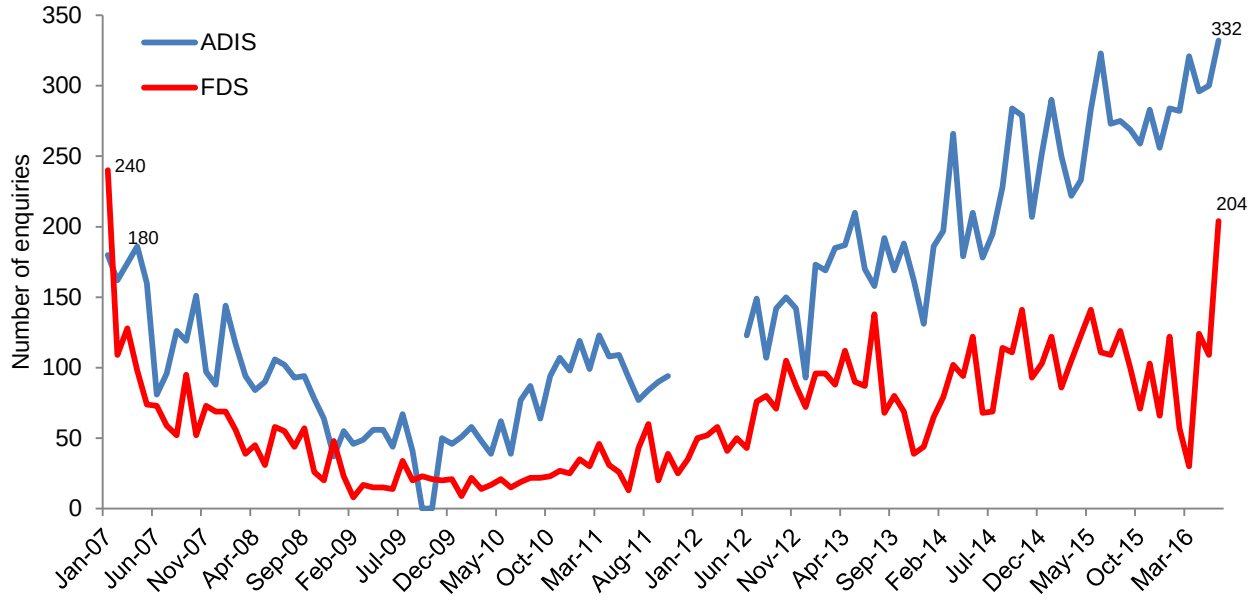
Figure 55: Number of enquiries to ADIS and FDS regarding methamphetamine January 2007−June 2016



Source: NSW ADIS and FDS.
Note: 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 56 shows the number of calls to ADIS and the FDS lines regarding crystal methamphetamine. Calls to both services for crystal methamphetamine have been increasing since 2012.

Figure 56: Number of enquiries to ADIS and FDS regarding crystal methamphetamine, January 2007−June 2016

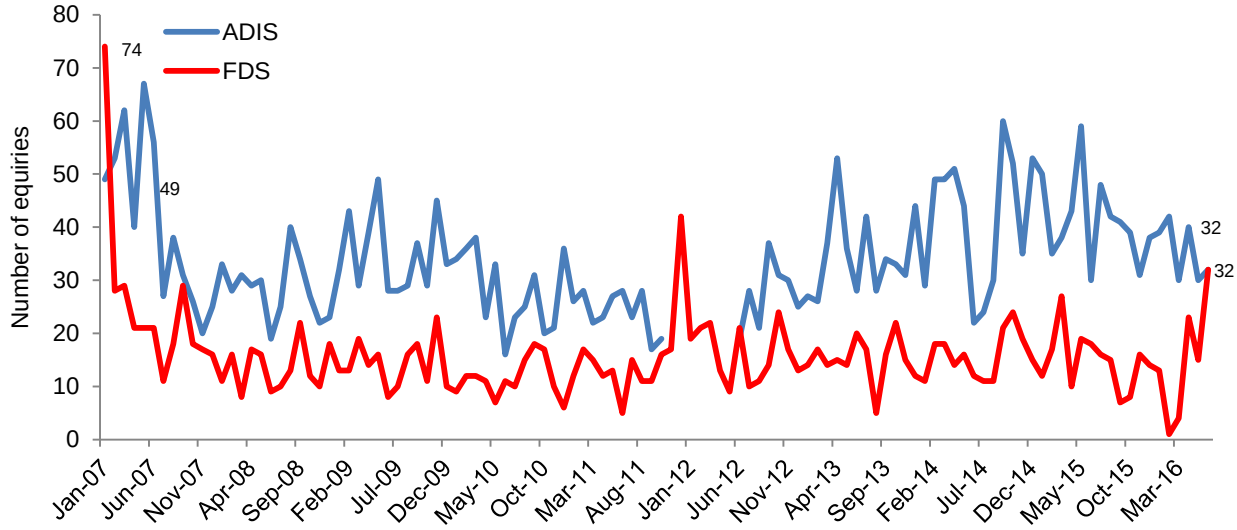


Source: NSW ADIS and FDS.
Note: FDS data were only available on a monthly basis and refer to calls where any mention of ice/crystal methamphetamine was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where ice was mentioned as any drug 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.

6.2.3 Cocaine

Figure 57 shows the number of calls to ADIS and the FDS lines regarding cocaine. Calls to the FDS appear to have remained relatively stable from mid-2012 and there has been a gradual

Figure 57: Number of enquiries to ADIS and FDS regarding cocaine, January 2007−June 2016

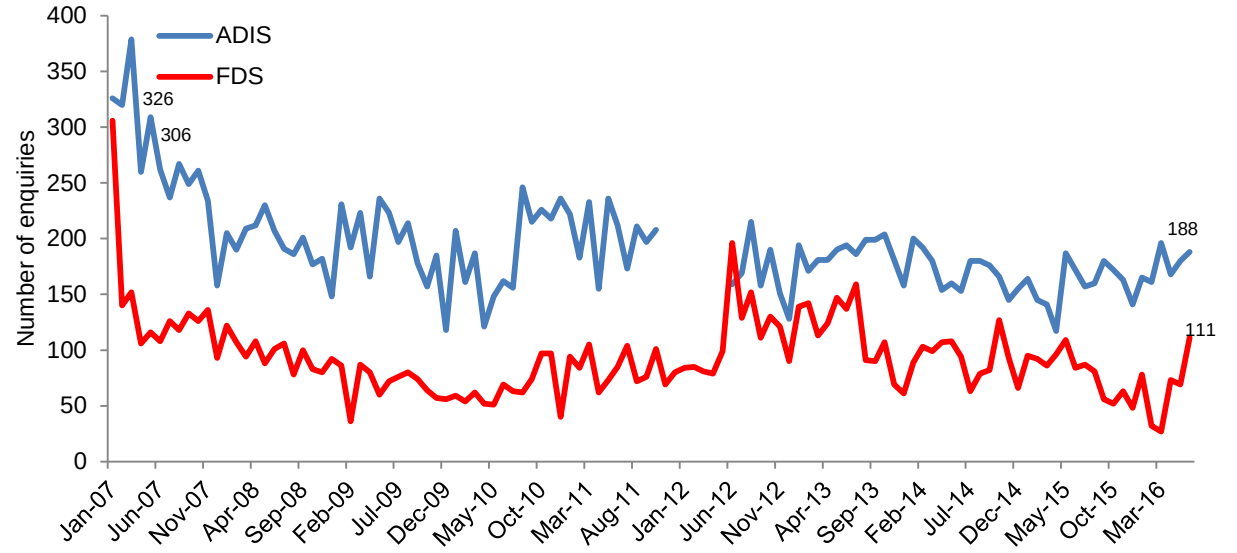


Source: NSW ADIS and FDS.
Note: FDS data were only available on a monthly basis and refer to calls where any mention of cocaine was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where cocaine was mentioned as any drug of concern. Breaks 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 the FDS regarding cannabis has remained relatively stable in the 12 months to June 2016 (Figure 58).

Figure 58: Number of enquiries to ADIS and FDS regarding cannabis, January 2007−June 2016



Source: NSW ADIS and FDS.
Note: 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 IDRS participant survey

Over half (54%) of the NSW IDRS sample was in drug treatment at the time of the interview, with the majority of participants in maintenance pharmacotherapy treatment. Participants who were currently in treatment (54%) were asked a number of questions about their treatment. Participants reported a median of 30 months (range: one month–24 years) in any current treatment. Among those in treatment, 74% of participants were in current methadone treatment and reported being in treatment for a median of 48 months (range: one month–24 years). Sixteen percent of the sample reported current buprenorphine-naloxone treatment, 4% reported buprenorphine treatment, 5% reported drug counselling and 1% reported Narcotics Anonymous.

Participants were asked 'What forms of treatment have you been in over the last six months?' Of those participants who commented (n=65); forty-one participants reported previous methadone treatment; ten participants reported buprenorphine-naloxone treatment; eight participants reported detoxification; seven participants reported drug counselling; four participants reported subutex/buprenorphine treatment, and one participant reported therapeutic community and 'other', respectively.

In 2016, participants were specifically asked about opioid and methamphetamine treatment in the past year. Over half of the IDRS sample had been on opioid substitution treatment for their opioid use in the past year (55%). The median number of times this group had started opioid treatment in the past year was one (range: 1–50 times).

Among those who commented (n=17), the median number of times methamphetamine treatment was started at a drug treatment centre in the past year was one (range: 1–4 times). Eight percent of the sample (n=12) reported a hospital admission for methamphetamine psychosis on a median of two occasions (range: 1–6 times) in the past year, and 3% of the sample (n=4) reported admission to hospital for other methamphetamine related issues on a median of one occasion in the past year.

In 2016, 17% of participants had tried to access treatment over the preceding six months but were unable to. Sixty-five percent (n=17) had tried to access treatment for heroin use and 19% (n=5) had tried to access treatment for methamphetamine use. Participants attempted to access a range of services including: rehab/therapeutic community and an opioid substitution program (n=7, respectively), detox (n=3), a general practitioner (GP) and a psychiatrist (n=2, respectively), and a counsellor and a psychologist (n=1, respectively).

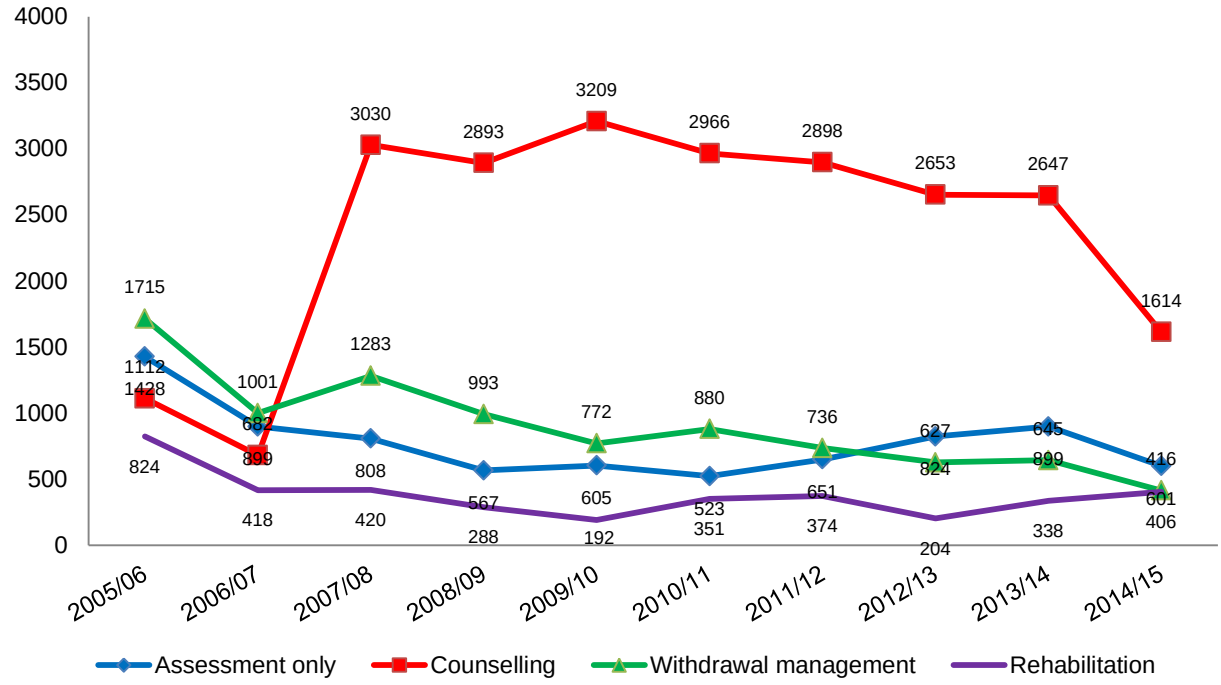
There were mixed reports regarding the availability of treatment. Forty percent of those who commented reported that it was 'easy' to get into treatment at the moment. Almost equal portions reported it to be 'very easy' (20%) or 'difficult' (18%) to get into treatment. Nine percent reported it to be 'very difficult' and 13% did not know.

6.3.2 Treatment for heroin use

Figure 59 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. These data are based on closed treatment episodes and episodes may be excluded if not completed in the time period.

All forms of heroin treatment, except residential rehabilitation have declined between 2007/08 and 2014/15.

Figure 59: Number of heroin treatment episodes by treatment type, NSW 2005/06−2014/15



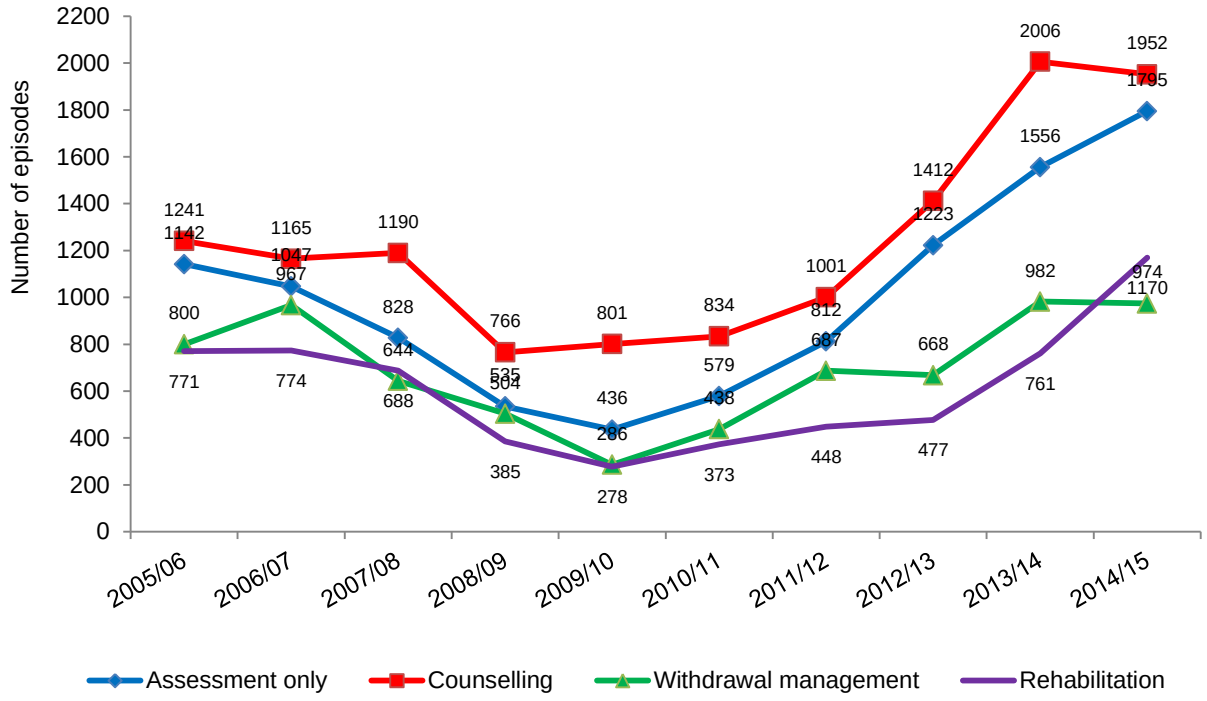
Source: NSW Minimum Data Set (NSW MDS) for Alcohol and other Drug Treatment Services (AODTS), NSW Ministry of Health.
Note: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement.

6.3.3 Treatment for methamphetamine use

There has been increasing numbers of closed treatment episodes where amphetamines were the principal drug of concern in the past 12 months (Figure 60).

The number of amphetamine related episodes have risen steeply since 2008/09, with the highest numbers being observed between 2013/14 and 2014/15 over the last decade.

Figure 60: Number of amphetamine treatment episodes by treatment type, NSW, 2005/06−2014/15

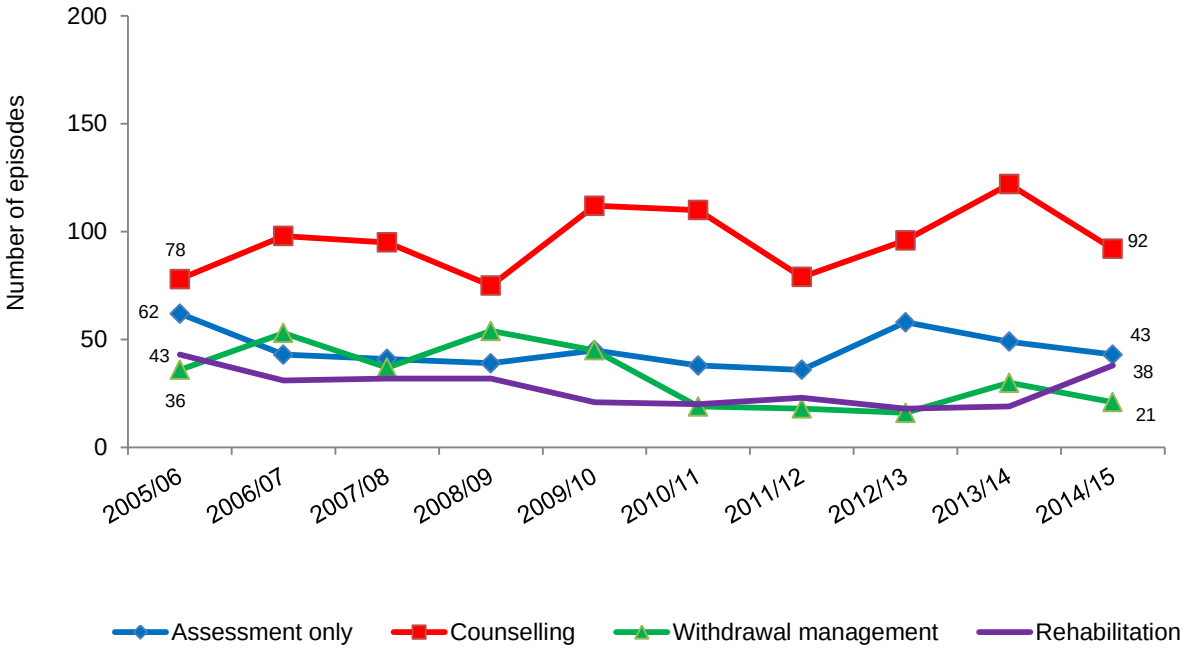


Source: NSW MDS AODTS, NSW Ministry of Health.
Note: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement.

6.3.4 Treatment for cocaine use

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. A higher number of episodes for counselling have been observed across all years (Figure 61).

Figure 61: Number of cocaine treatment episodes by treatment type, NSW, 2005/06–2014/15

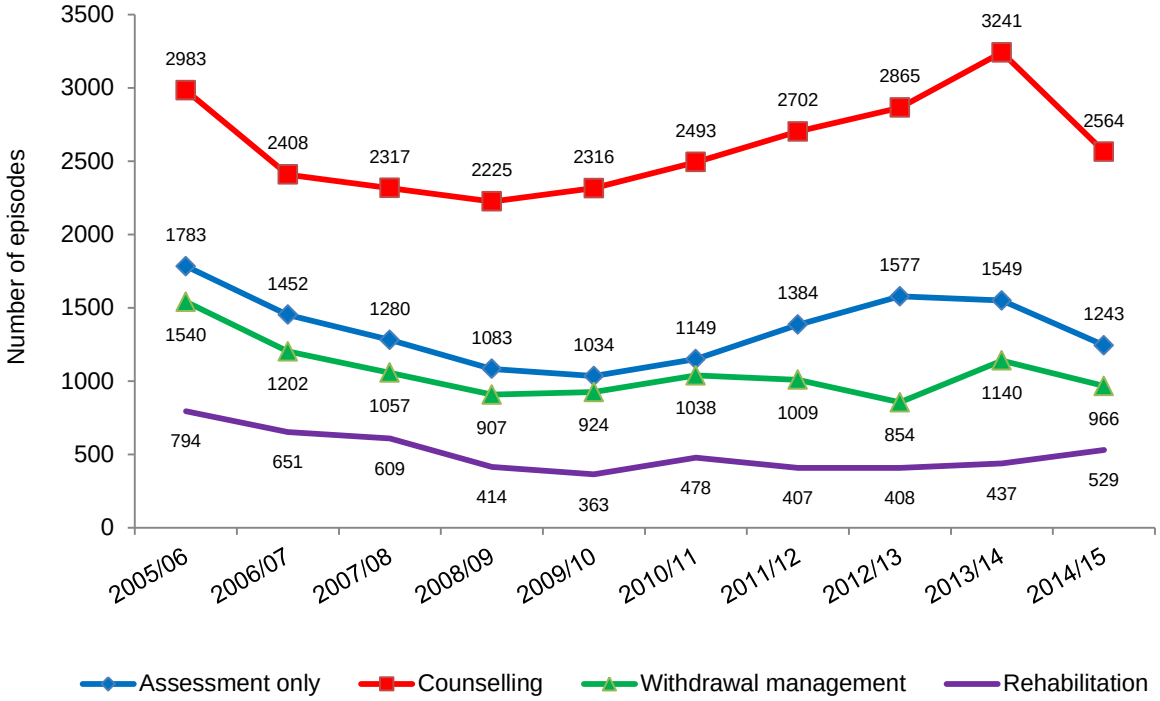


Source: NSW MDS AODTS, NSW Ministry of Health.
Note: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement.

6.3.5 Treatment for cannabis use

Figure 62 shows the number of closed treatment episodes by treatment type where the principal drug of concern was cannabis. After peaking in 2013/14, numbers entering for counselling have declined.

Figure 62: Number of cannabis treatment episodes by treatment type, NSW, 2005/06−2014/15



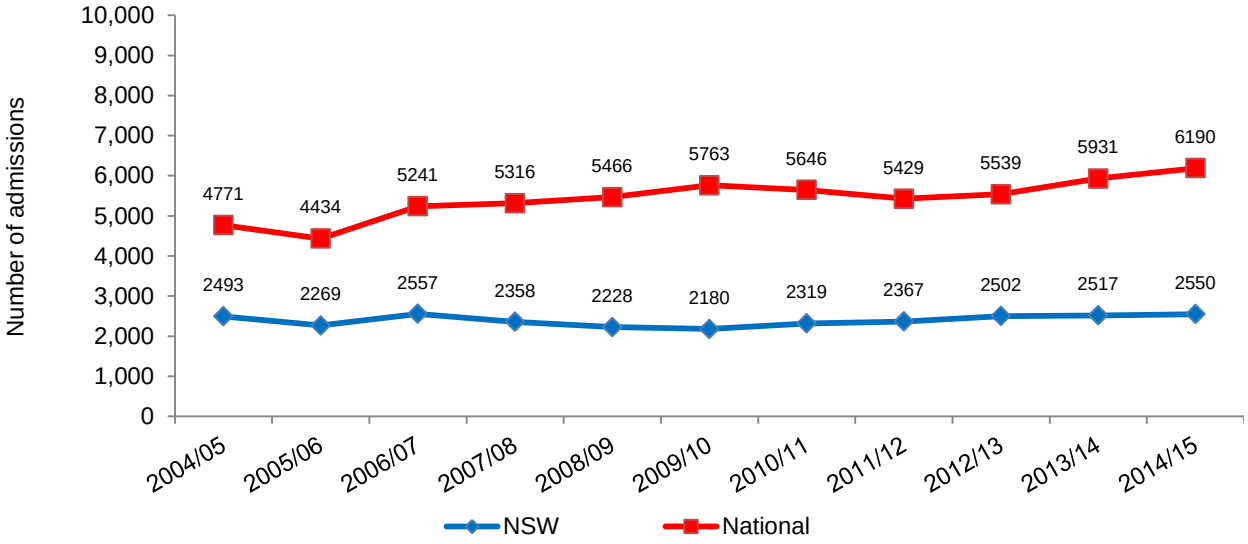
Source: NSW MDS AODTS, NSW Ministry of Health.
Note: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement.

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 63). National figures have trended upwards slightly, from 5,931 in 2013/14 to 6,190 admissions in 2014/15, as there have been increases in other jurisdictions. Admissions include heroin and other opioids such as morphine, oxycodone and fentanyl.

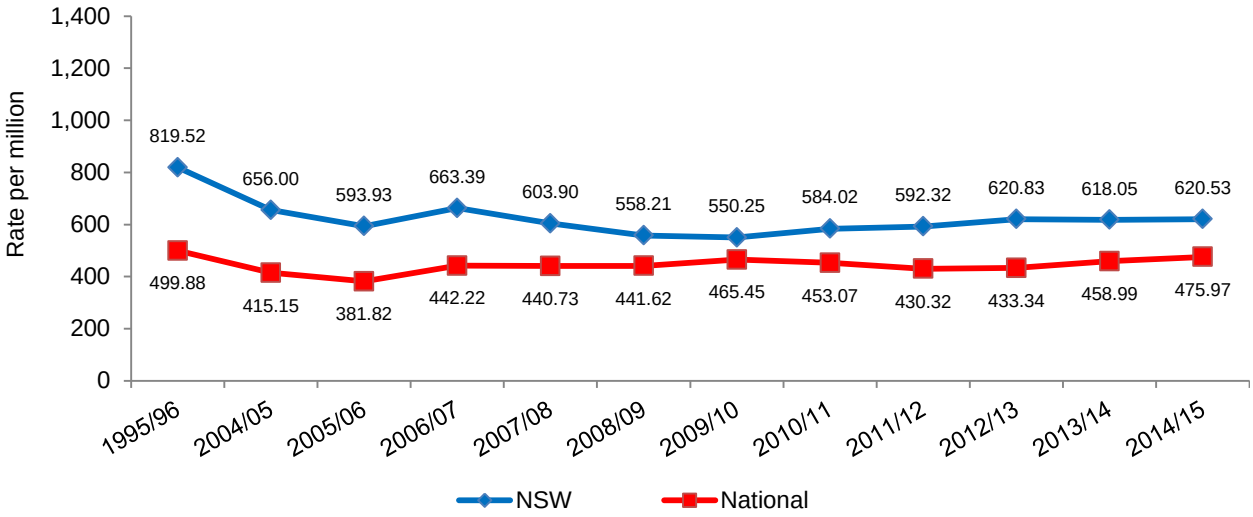
Figure 63: Number of principal opioid-related hospital admissions among people aged 15–54, NSW and Australia, 2004/05–2014/15



Source: AIHW, NSW Ministry of Health, A. Roxburgh and C. Breen (2017).

Figure 64 shows the rates per million persons aged 15–54 years of opioid-related hospital admissions.

Figure 64: Rates per million persons of principal opioid-related hospital admissions among people aged 15–54 years, NSW and nationally, 2004/05–2014/15

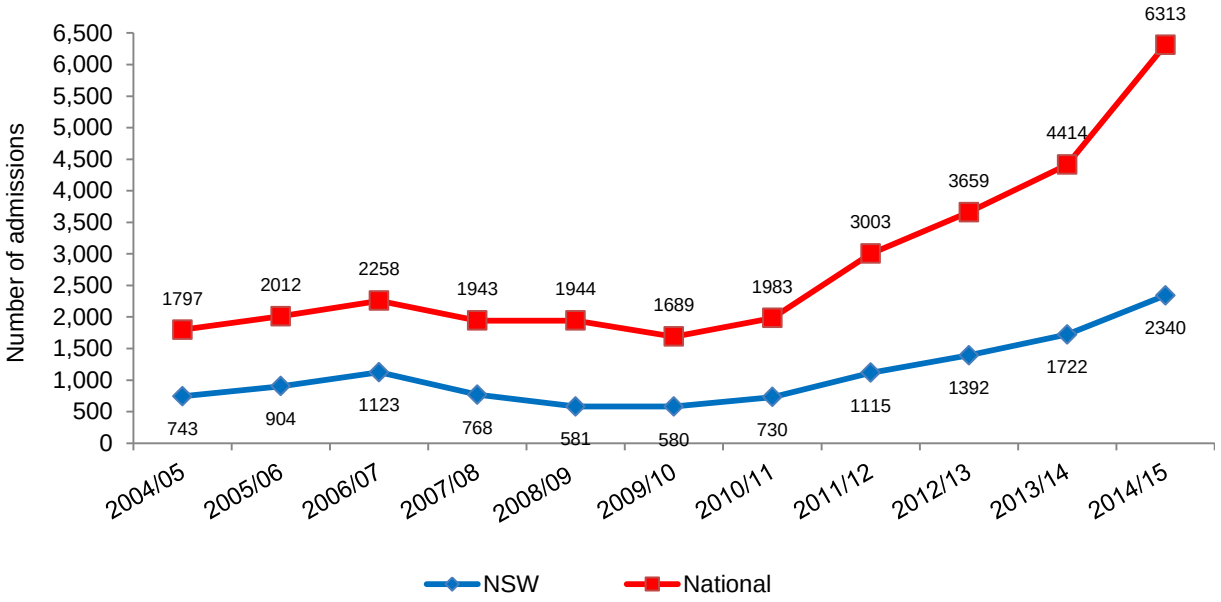


Source: AIHW, NSW Ministry of Health, A. Roxburgh and C. Breen (2017).

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 five years (Figure 65).

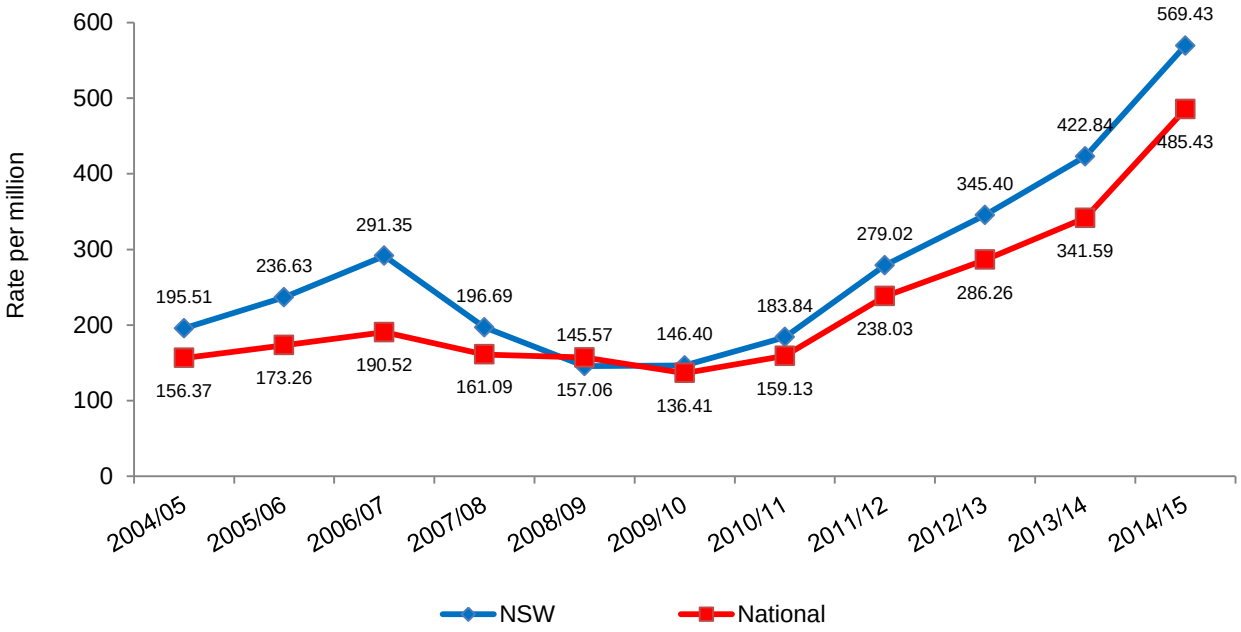
Figure 65: Number of principal amphetamine-related hospital admissions among persons aged 15−54, NSW and nationally, 2004/05−2014/15



Source: AIHW, NSW Ministry of Health, A. Roxburgh and C. Breen (2017).

Figure 66 shows the rates per million persons of amphetamine-related hospital admissions.

Figure 66: Rates per million persons of principal amphetamine-related hospital admissions among people aged 15−54 years, NSW and nationally, 2004/05−2014/15

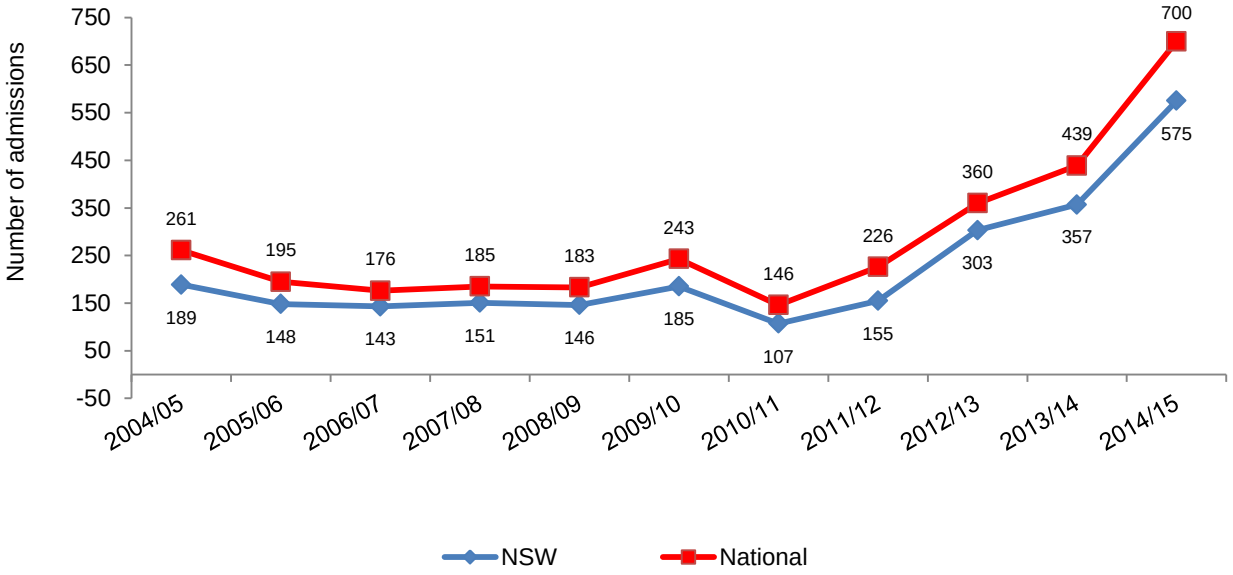


Source: AIHW, NSW Ministry of Health, A. Roxburgh and C. Breen (2017).

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 four years and comprise the majority (82%) of cocaine-related admissions at a national level (Figure 67).

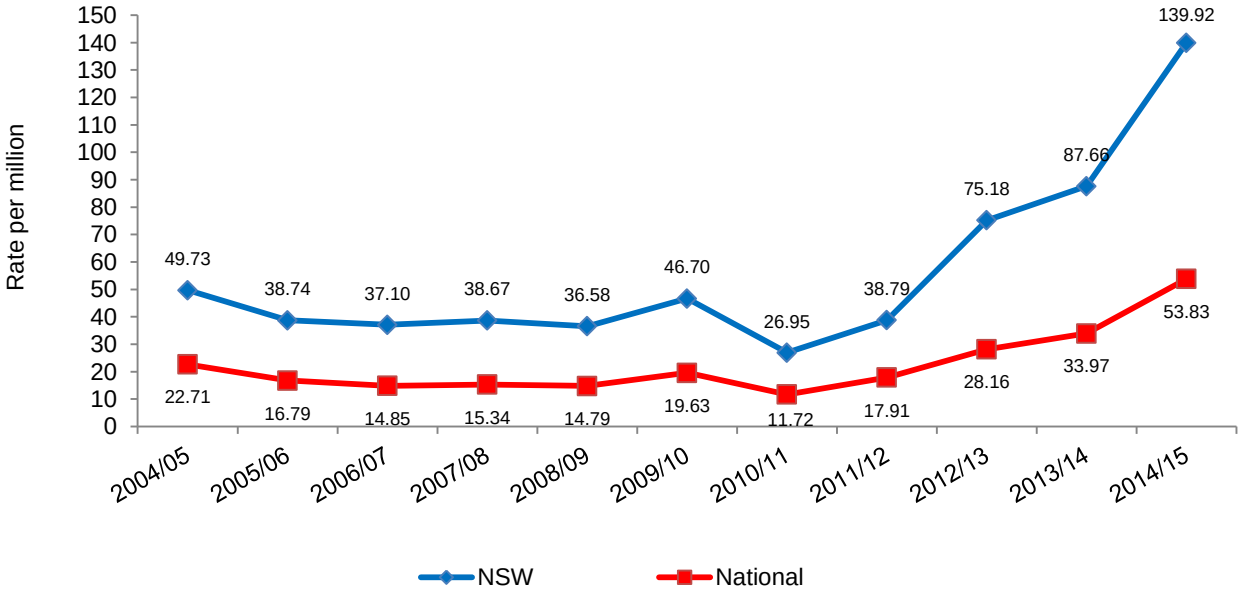
Figure 67: Number of principal cocaine-related hospital admissions among persons aged 15−54, NSW and nationally, 2004/05−2014/15



Source: AIHW, NSW Ministry of Health, A. Roxburgh and C. Breen (2017).

Figure 68 shows the rates per million persons of cocaine-related hospital admissions.

Figure 68: **Rates per million persons of principal cocaine-related hospital admissions among people aged 15−54 years, NSW and nationally, 2004/05−2014/15**

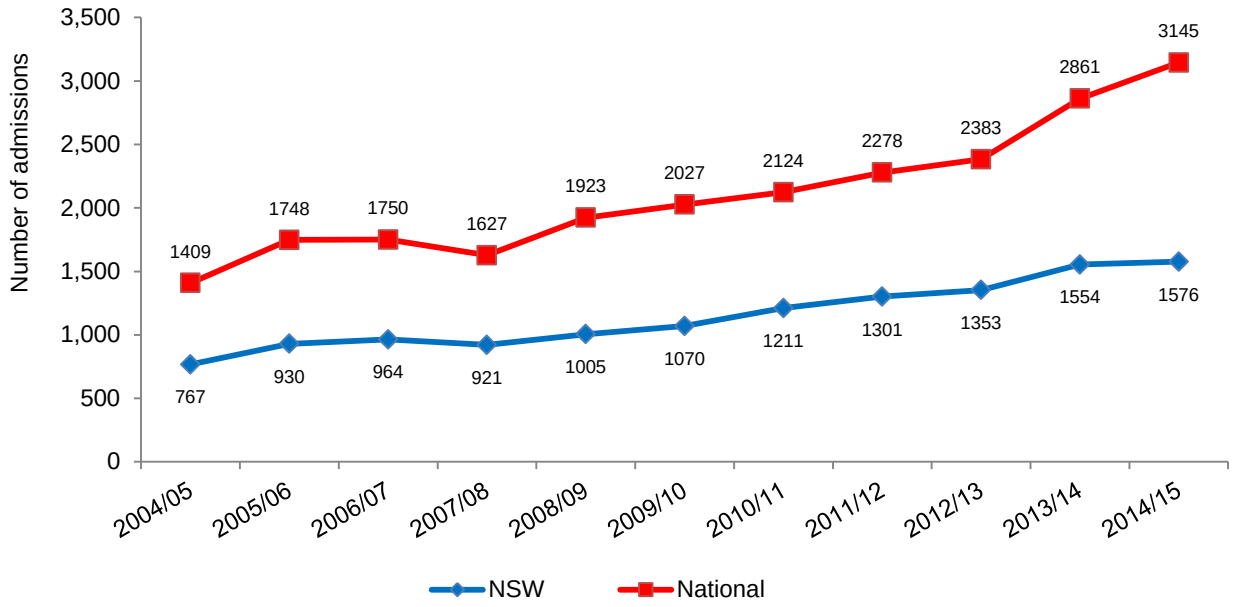


Source: AIHW, NSW Ministry of Health, A. Roxburgh and C. Breen (2017).

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 69).

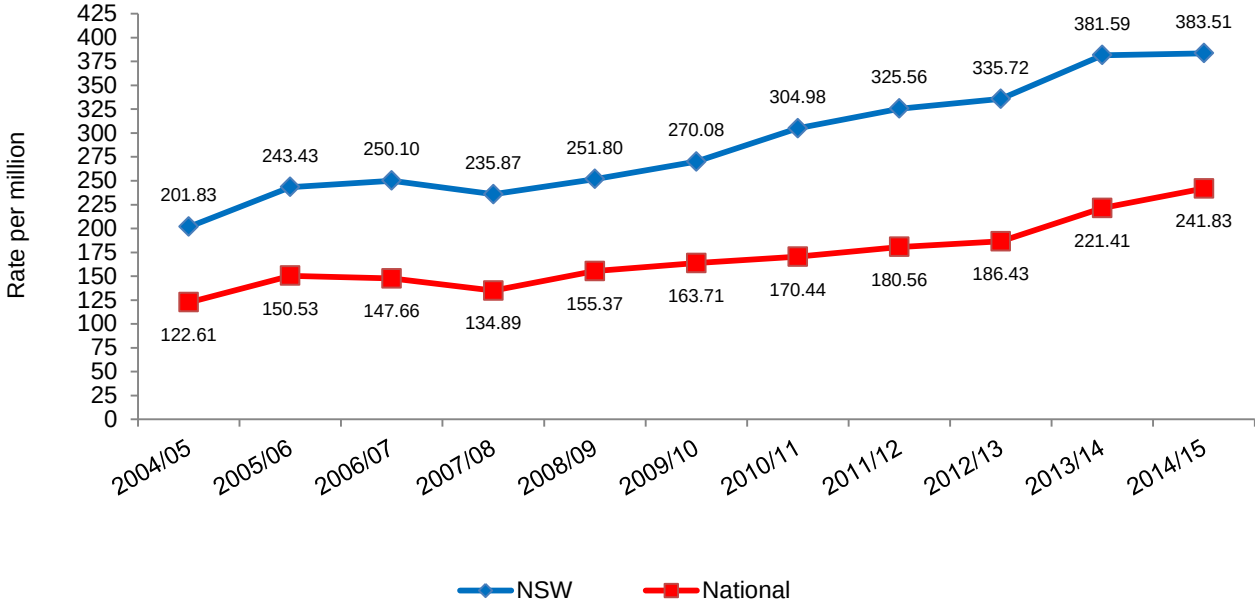
Figure 69: Number of principal cannabis-related hospital admissions among persons aged 15−54, NSW and nationally, 2004/05−2014/15



Source: AIHW, NSW Ministry of Health, A. Roxburgh and C. Breen (2017).

Figure 70 shows the rates per million persons of cannabis-related hospital admissions.

Figure 70: Rates per million persons of principal cannabis-related hospital admissions among people aged 15−54 years, 2004/05−2014/15



Source: AIHW, NSW Ministry of Health, A. Roxburgh and C. Breen (2017).

6.5 Opioid and stimulant dependence

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

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

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

Of those who had recently used an opioid and commented (n=137), the median SDS score was seven (mean 7.5; range: 0−15), with 83% scoring five or above. Scores were significantly higher for males (*M*=7.1, *SD*=3.5) than for females (*M*=8.9, *SD* 4.3, t(135)=2.48, p<0.05). Of those who scored five or above (n=113), 71% reported specifically attributing responses to heroin, 21% methadone, 4% buprenorphine and 2% morphine and oxycodone, respectively.

Of those who had recently used a stimulant and commented (n=119), the median SDS score was five (mean 5.3; range: 0−15), with 59% scoring four or above which is indicative of stimulant dependence. There were no significant differences regarding gender and those scoring four or above. Of those who scored four or above (n=70), 90% reported specifically attributing responses to methamphetamine, 9% cocaine, and one participant reported attributing their response to pharmaceutical stimulants.

6.6 Mental and physical health problems and psychological distress

Thirty-five percent of all participants reported experiencing a mental health problem other than drug dependence in the preceding six months (39% in 2015). As in previous years, among those with a mental health problem, the most commonly reported problems were depression (60%; 52% in 2015) and anxiety (48%; 33% in 2015). Seventeen percent reported schizophrenia and post-traumatic stress disorder, respectively. Fewer participants (n<10) reported manic-depression/bipolar, phobia, panic, OCD, paranoia, personality disorder and psychosis. No participants reported experiencing mania.

Among those who had experienced a mental health problem in the preceding six months, 67% (n=35) reported that they had attended a professional for such problems. Of those who reported attending a mental health professional, 60% reported visiting a psychiatrist, 49% visited a GP, 26% visited a psychologist and 23% visited a counsellor.

Thirty-eight participants reported that they had been prescribed medication for their mental health disorder in the preceding six months; predominantly antidepressants (n=20), followed by antipsychotics (n=19) and benzodiazepines (n=8).

6.6.1 Psychological distress measure

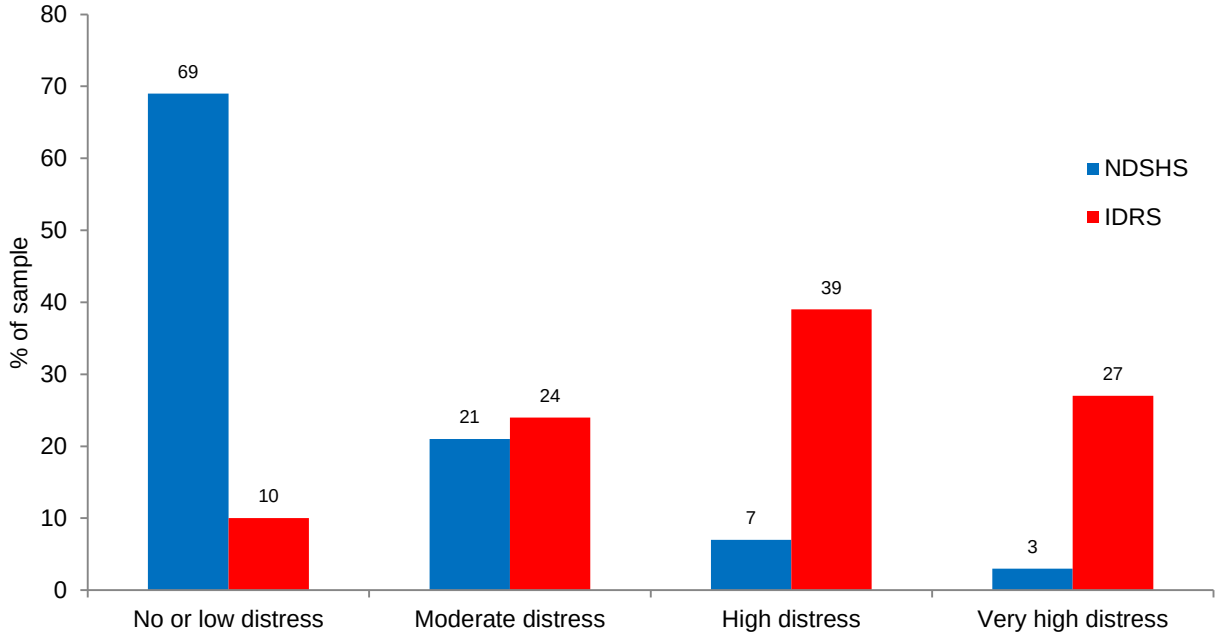
The Kessler Psychological Distress Scale (K10) was also administered to participants in order to obtain a measure of psychological distress. The K10 is a 10-item standardised measure with good psychometric properties that identifies clinical levels of psychological distress as measured by the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) and the Structured Clinical Interview for DSM disorders (SCID) (Andrews and Slade 2001; Kessler, Andrews et al. 2002). The K10 asks about the level of anxiety and depressive symptoms that a person may

have experienced in the preceding four week period (Australian Institute of Health and Welfare 2014). It should be noted that the K10 does not require that individuals give reasons for the psychological distress reported in the previous month, nor whether this was an unusual or normal month for the individual.

The minimum score that can be obtained is 10 (indicating no distress) and the maximum is 50 (indicating very high psychological distress) (Andrews and Slade 2001). The 2013 National Drug Strategy Household Survey (NDSHS) (Australian Institute of Health and Welfare 2014) provided the most recent Australian population norms available for the K10, and used four categories to describe degrees of distress: scores from 10−15 were considered to be low, 16−21 as moderate, 22−29 as high and 30−50 as very high. Using these categories, IDRS participants reported greater levels of high and very high distress compared to the general population (see Figure 71).

Of those that answered this section (n=143), the mean score was 24.3 (median 24; SD 7.95; range: 10−44). Ten percent of the IDRS sample had scores between 10 and 15 on the K10 (low risk), 24% scored between 16 and 21 (moderate distress), 39% scored from 22 to 29 (high distress), and 27% scored from 30−50 (very high distress).

Figure 71: K10 scores in the NDSHS (2013) and the NSW IDRS Interviews (2016)



Source: IDRS participant interviews; Australian Institute of Health and Welfare 2014.
Note: The extent to which cut-offs derived from population samples can be applied to the IDRS population is yet to be established and, therefore, these findings should be taken as a guide only. NDSHS findings refer to participants aged 18 and older.

When asked to rate their health, 4% of the sample reported that their health was ‘excellent’, 12% reported that it was ‘very good’, 42% reported it as ‘good’, 29% said it was ‘fair’ and 13% reported that it was ‘poor’.

6.7 Alcohol Use Disorders Identification Test-Consumption

PWID are at particular risk of alcohol-related harms due to a high prevalence of the hepatitis C virus (HCV). HCV antibody prevalence was stable at between 53% and 57% over the period 2011 to 2015, according to the Australian Needle and Syringe Program Survey (ANSPS), annually undertaken by the Kirby Institute (Iversen and 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 (Darke, Ross et al. 1996; Schiff and Ozden 2004; Coffin, Tracy et al. 2007), it is important to monitor risky drinking among PWID.

The information on alcohol consumption available from the IDRS includes the prevalence of lifetime and recent use, and number of days of use over the preceding six months. Ninety-three percent of PWID had used alcohol in their lifetime, and 57% had used alcohol in the six months preceding interview, on a median of 11 days (range: 1−180 days). Participants of the IDRS were asked the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) as a valid measure of identifying heavy drinking (Bush, Kivlahan et al. 2005). The AUDIT-C is a three-item measure, derived from the first three consumption questions in the AUDIT. Dawson, Grant et al. (2005) reported on the validity of the AUDIT-C, finding that it was a good indicator of alcohol dependence, alcohol use disorder and risky drinking.

In 2016, the overall mean score on the AUDIT-C was 4.7 (SD=3.5, range: 1−12) (Table 28). There was no significant difference between male and female scores. A cut-off score of five or more indicates the need for further assessment (Dawson, Grant et al. 2005; Haber, Lintzeris et al. 2009).

Forty-one percent of the sample scored five or more on the AUDIT-C (49% in 2015). The proportion of males who scored five or more decreased to 45% (50% in 2015) and 30% of females scored five or more (49% in 2015).

Table 28: AUDIT-C among PWID, 2015−2016

	2015 (n=88)	**2016 (n=100)**
Mean AUDIT-C score*	5.1	**4.7**
(SD; range)	(3.4; 1–12)	**(3.5; 1–12)**
Score of 5 or more* (%)	49	**41**
Males	50	**45**
Females	49	**30**

Source: IDRS participant interviews.
*Amongst participants who had consumed alcohol in the past 12 months.

6.8 Naloxone program and distribution

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

Since 2013, the IDRS has included a series of questions about take-home naloxone and naloxone more broadly. Of the participants who commented in 2016 (n=147), 88% had heard of naloxone. Half (50%) of those who had heard of naloxone and commented (n=125) reported that naloxone was used to 'reverse heroin', while 30% reported the use of naloxone to 're-establish consciousness'. Fourteen percent said naloxone was used to 'help someone start breathing' and 23% gave 'other' reasons.

Participants were then asked if they had heard about take-home naloxone programs. Among those who commented (n=147), 52% reported that they had heard of take-home naloxone programs, while 48% had not. Four participants reported that they had been resuscitated with naloxone by somebody who had been trained through the take-home naloxone program.

Of those who commented (n=147), 18% reported that they had completed training in naloxone administration and had received a prescription for naloxone. Of those who had completed the course (n=27), 44% had used the naloxone to resuscitate someone who had overdosed. The mean number of people who had been resuscitated was four.

In 2016, participants were asked if they had heard about the rescheduling of naloxone (which is now available OTC without a prescription). Of those who commented (n=147), 14% reported that they had heard about the rescheduling of naloxone. Participants were then asked how much they would be willing to pay OTC at a pharmacy for naloxone in a prefilled syringe with accompanying needle and instruction materials. Thirty-seven percent stated that naloxone OTC should be free and cost $0. Thirteen percent were willing to pay $5 and 17% were willing to pay $30.

Participants were then asked if they had been resuscitated with naloxone by someone who obtained naloxone OTC from a pharmacy. No participants reported that they had been resuscitated with naloxone, which was obtained OTC at a pharmacy. Two participants reported that they had themselves obtained naloxone OTC without a prescription from a pharmacy.

Of those who had obtained naloxone OTC from a pharmacy (n=2), one participant reported that they had resuscitated someone who had overdosed. The median number of people attempted to resuscitate by injecting them with naloxone purchased from OTC was four.

Participants who had <u>not</u> obtained naloxone OTC without a prescription from a pharmacy were asked: 'now that naloxone is available OTC would you purchase it from a pharmacy?' Of those who commented (n=143), 64% reported that they would purchase naloxone OTC. Participants were asked if they would (a) carry naloxone on your person? (b) administer naloxone after witnessing someone overdose? and (c) stay with someone after giving them naloxone? Eighty per cent of those who commented (n=79) reported that they would carry the naloxone on their person, 100% reported that they would administer naloxone after witnessing someone overdose and 99% reported that they would stay with someone after giving them naloxone.

7 INJECTING RISK BEHAVIOURS

Key Findings

Injecting Risk Behaviour

- Receptive sharing (borrowing) and lending of needles/syringes remained stable in 2016, at 10% and 18% respectively, consistent with 2015 reports. Sharing of injecting equipment such as mixing containers (e.g. spoons), tourniquets and filters was more common (26%).

- Fifty-four percent of the sample reported re-using their own needles in the last month; a significant increase from 2015.

- Sterile needles and syringes were most commonly obtained from a NSP; although a range of other sources were also used. The majority of participants (88%) reported that they had last injected in a private home.

- Seventy percent of the sample reported experiencing an injection-related problem in the preceding month. The most common problems experienced were prominent scarring/bruising around the injection site and difficulty injecting (e.g. in finding a vein), consistent with 2015 reports.

- Twenty-eight percent of the sample reported injecting either a partner or friend after injecting themselves with either a new or used needle in the last month. Eighteen percent reported that somebody else injected them after injecting themselves with either a new or used needle in the past month.

Blood-borne Viral Infections

- In Australia, Hepatitis C (HCV) continued to be more commonly notified than Hepatitis B (HBV), though in 2016, a decline in newly acquired HBV and newly acquired HCV infections was observed. The prevalence of human immunodeficiency virus (HIV) among PWID in NSW remained low yet increased slightly from 2.5 to 3.1.

Driving

- Forty-two participants had reported that they had driven a vehicle in the six months prior to interview.

- Of those who had recently driven, two participants reported driving while over the legal alcohol limit.

- Twenty-nine recent drivers (69%) reported driving within three hours of taking illicit or non-prescribed drug(s) in the six months preceding interview.

7.1 Injecting risk behaviour

7.1.1 Access to needles and syringes

Participants reported that they had obtained needles and syringes on a median of four occasions in the month preceding interview (range: 0–72 occasions; n=145). In addition, the median number of new needles and syringes obtained within the preceding month was 60 (range: 0–600; n=144), with participants reporting that they had given away or sold a median of two needles or syringes (range: 0–500; n=141). The median number of needles and syringes collected for oneself the last time they were obtained was 25 (range: 0–300; n=145) and the median number of needles and syringes that participants had stored away was 10 (range: 0–650; n=147). Twelve percent reported that they had experienced difficulty in obtaining needles/syringes in the preceding month. Participants had injected on a median of 30 days in the preceding month (range: 2–540 days; n=146). The median number of needles required to successfully inject each hit was one (range: 1–90; n=147), though the majority of participants (84%) needed only one needle to successfully inject a hit.

In 2016, participants were also asked if they were able to access filters from the same place from which they obtained their needles and syringes. The vast majority (94%) of those who answered reported that they were able to obtain filters if they wanted them. The main filters comprised of cotton filters (76%), followed by wheel filters (25%) and cigarette filters (20%). Nine participants did not know what filters they were able to access.

NSPs were by far the most common source of needles and syringes in the preceding six months (88%), followed by NSP vending machines (39%) and a chemist (13%). There was a range of other sources also used, as can be seen in Table 29.

Table 29: Main sources of needles and syringes in the preceding six months, 2016

Accessing from (%)	2016 (n=147)
NSP	**88**
NSP vending machine	**39**
Chemist	**13**
Partner	**1**
Friend	**11**
Dealer	**2**
Hospital	**7**
Outreach/peer worker	**2**

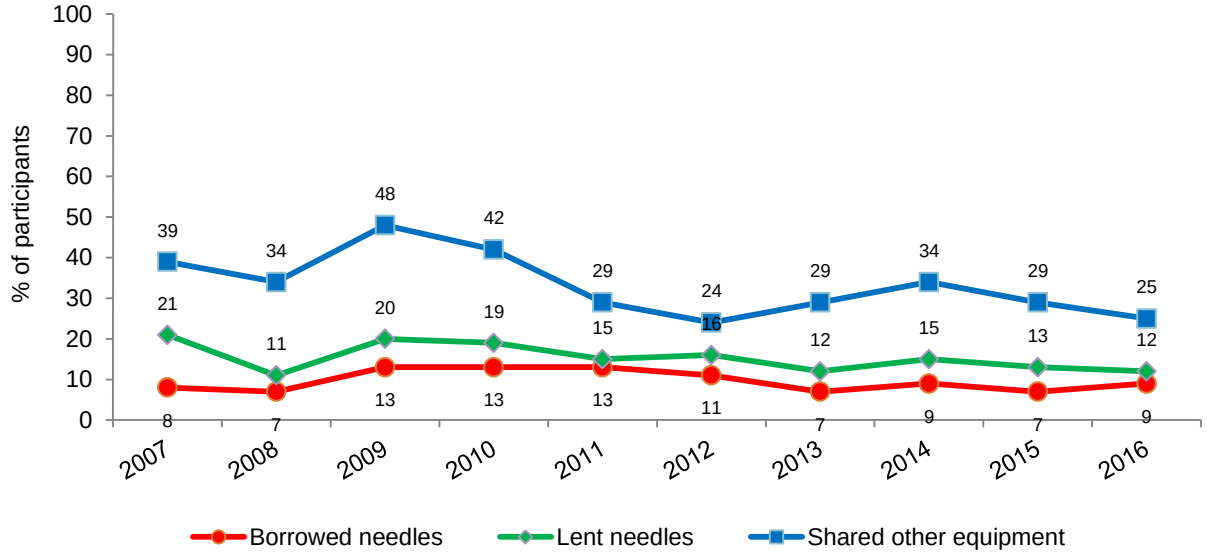
Source: IDRS participant interviews.
Note: Multiple responses allowed.

7.1.2 Sharing of injecting equipment

The sharing of injecting equipment remains an issue of concern due to the risk of transmission of blood-borne viral infections (BBVI) such as HIV and HCV. In 2016, 10% of participants reported that they had used a needle *after* someone else ('borrowed'). This was stable from 2015 (7%). In comparison, 18% of participants reported that they had used a needle *before* someone else in the month prior to interview ('lent'). This was stable from 2015 (14%) (see Figure 72). Participants who had used a needle after someone else in the last month (n=14) had typically used after a regular partner (n=6), a close friend (n=6) or an acquaintance (n=1).

Twenty-eight percent of the sample reported injecting either a partner or friend after injecting themselves with either a new or used needle in the last month. Eighteen percent reported that somebody else injected them after injecting themselves with either a new or used needle in the last month.

Figure 72: Sharing of needles and injecting equipment by participants in the month preceding interview, 2007–2016



Source: IDRS participant interviews.

Over one-quarter of the sample (26%) reported that they had shared injecting equipment other than needles and syringes in the preceding month (29% in 2015) (Table 30). The sharing of used needles remained low, yet relatively stable in 2016, as did the sharing of other equipment during the last year (Figure 72).

Table 30: Sharing of injecting equipment (other than needles) among participants who shared equipment in the month preceding interview, 2015–2016

Injecting equipment (%)	2015 (n=43)	**2016 (n=38)**
Spoons/mixing container	67	**58**
Filters	35	**13**
Tourniquet	33	**21**
Water	40	**16**
Swabs	7	**5**
Wheel filter	7	**0**

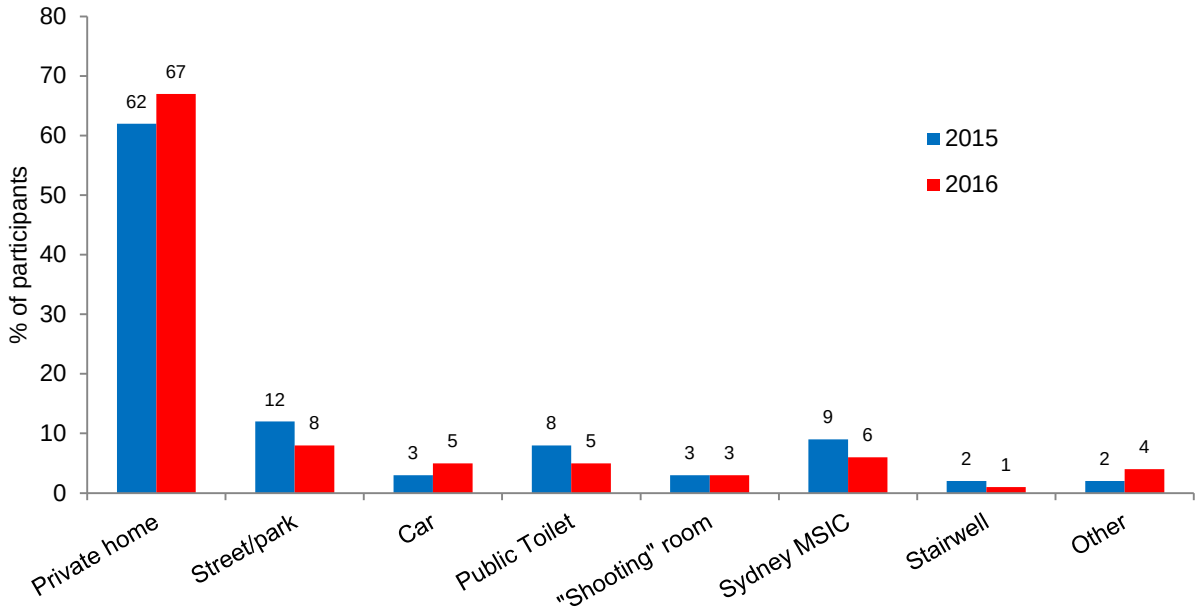
Source: IDRS participant interviews.
Note: Multiple responses allowed.

Fifty-four percent of the sample had re-used their own needle in 2016, a significant increase from 2015 (40% in 2015) ($p<0.05$). Of those who commented (n=147) the median number of times one reused their own needles in the last month was one (range: 0–5 times). Twelve percent had re-used their needle once, 22% had re-used their own needle twice, 14% had re-used 3–5 times and two participants re-used their own needles 6–10 times. The most common syringe size which was used in the last month was 1ml (80%; n=115), which was also the most common syringe size re-used in the last month (41%; n=58).

7.1.3 Location of injection

In 2016, the majority of participants reported that the last location in which they had injected drugs was a private home (67%), with very small proportions reporting use in public locations (see Figure 73). The last location of injecting was unchanged compared to 2015.

Figure 73: Location when last injected in the last month preceding interview, 2015–2016



Source: IDRS participant interviews.

7.1.4 Injection site

Participants were asked questions about the site on their body where they had last injected. The majority of participants reported that their last injection 'site' was their arm (69%) (72% in 2015), followed by their hand/wrist (11%), their neck (8%), their leg (7%) and their groin (3%).

7.1.5 Self-reported injecting-related health problems

Participants were asked if they had experienced any of six different injecting-related health problems in the last month (as listed in Table 31). In 2016, 70% of the sample reported experiencing at least one type of injection-related health problem in the month prior to interview (66% in 2015). By far the most commonly experienced problems were prominent scarring or bruising around the injection site (71%) and difficulty injecting (56%); both of which were stable with 2015 reports. The majority of participants (84%) reported that they required only one needle to successfully inject themselves, 10% required two needles, three participants required three needles, and two participants reported needing five needles for their last successful injection. Five participants reported needing six needles or more to successfully inject themselves.

Table 31: Injection-related health problems experienced in the month preceding interview, 2015–2016

Reported injection related health problems (%)	2015 (n=97)	**2016 (n=104)**
Overdose	5	**6**
Dirty hit	25	**14**
Abscesses/infections	13	**15**
Prominent scarring/bruising	76	**71**
Difficulty injecting	65	**56**
Thrombosis	11	**6**
Any problems (%)	66	**70**

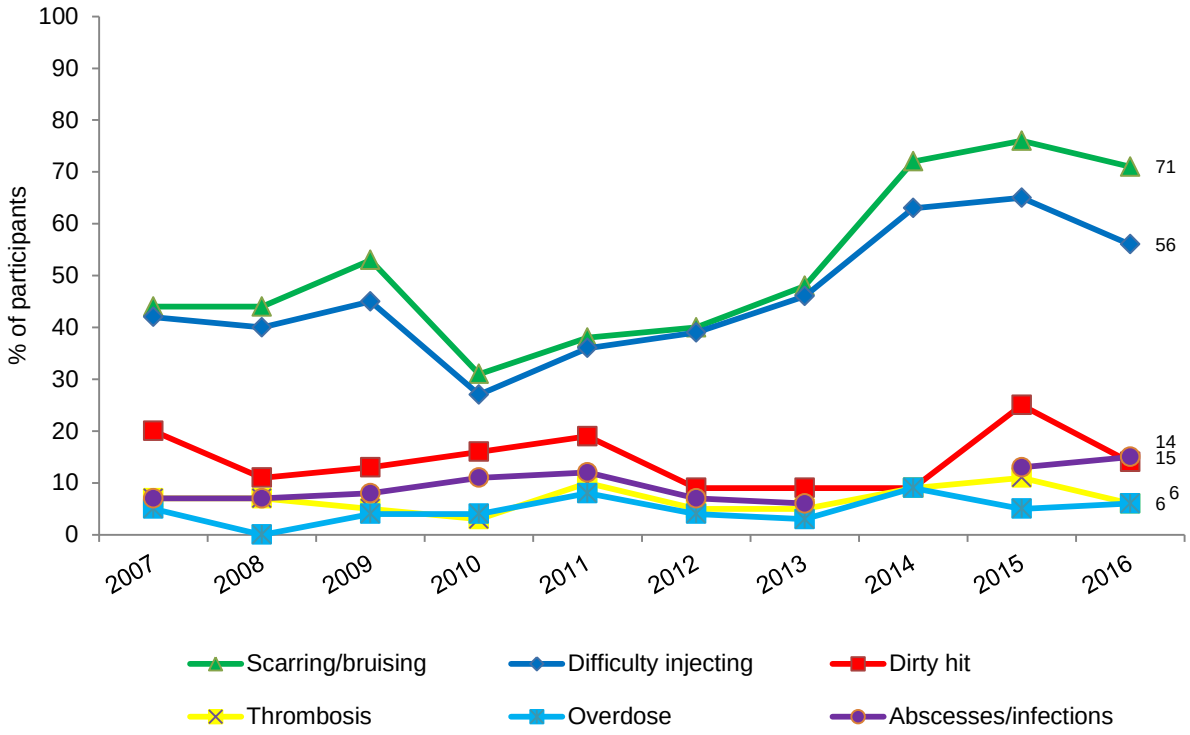
Source: IDRS participant interviews.

Among those who had experienced an overdose in the last month (n=6), four participants had overdosed on heroin and two participants had overdosed on methamphetamine.

Among those who had experienced a 'dirty' hit in the last month (n=14), six participants attributed it to methamphetamine, five participants attributed it to heroin and three participants credited it to methadone.

Figure 74 depicts the long-term trends for experience of injection-related problems from 2007 onwards. 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 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, along with thrombosis. For further information on overdose, see also section 6.1 'Overdose and drug-related fatalities'.

Figure 74: Proportion of PWID reporting injection-related problems in past month, by problem type, 2007−2016



Source: IDRS participant interviews.

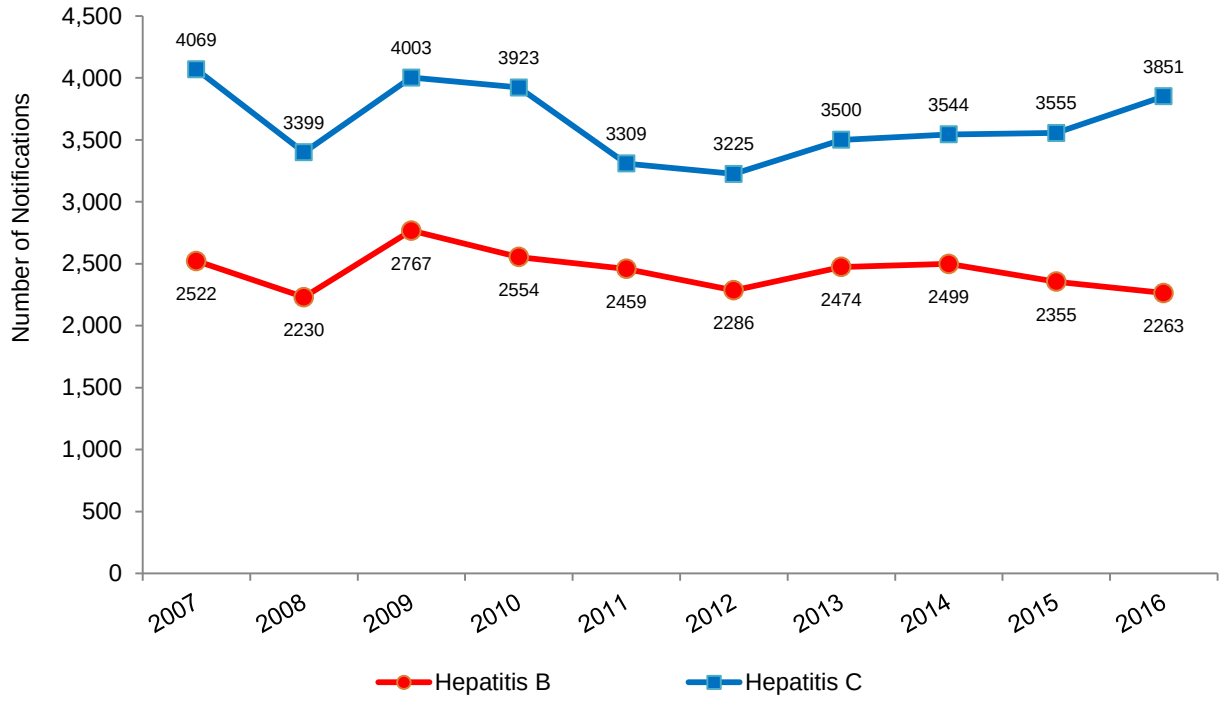
7.2 Blood-borne viral infections

PWID are at significantly greater risk of acquiring HBV, HCV[13] and HIV because blood-borne viral infections (BBVI) can be transmitted via the sharing of needles, syringes and equipment. For more detailed information on BBVI see the Australian NSP Survey (Iversen & Maher, 2016).

Figure 75 and Figure 76 present the total number of notifications for HBV and HCV in NSW from the Communicable Diseases Network – National Notifiable Diseases Surveillance System (NNDSS). Incident or newly acquired infections, and unspecified infections (i.e. where the timing of the disease acquisition is unknown) are presented. In 2016, HCV continued to be more commonly notified than HBV, though there were decreases in both HBV and HCV infections.

HCV continued to be more commonly notified than HBV, with the number of notifications increasing slightly in 2016 (3,851 notifications versus 3,555 in 2015). HBV notifications have remained relatively stable (2,263 notifications versus 2,355 in 2015). Notifications for both HCV and HBV still remained lower than levels reported in 2007 and 2009.

Figure 75: Total notifications for unspecified HBV and HCV infections, NSW, 2007−2016



Source: Communicable Diseases Network – Australia – National Notifiable Diseases Surveillance System (NNDSS).[14]
Note: Data accessed on 9 December 2016. Figures are updating on an ongoing basis.

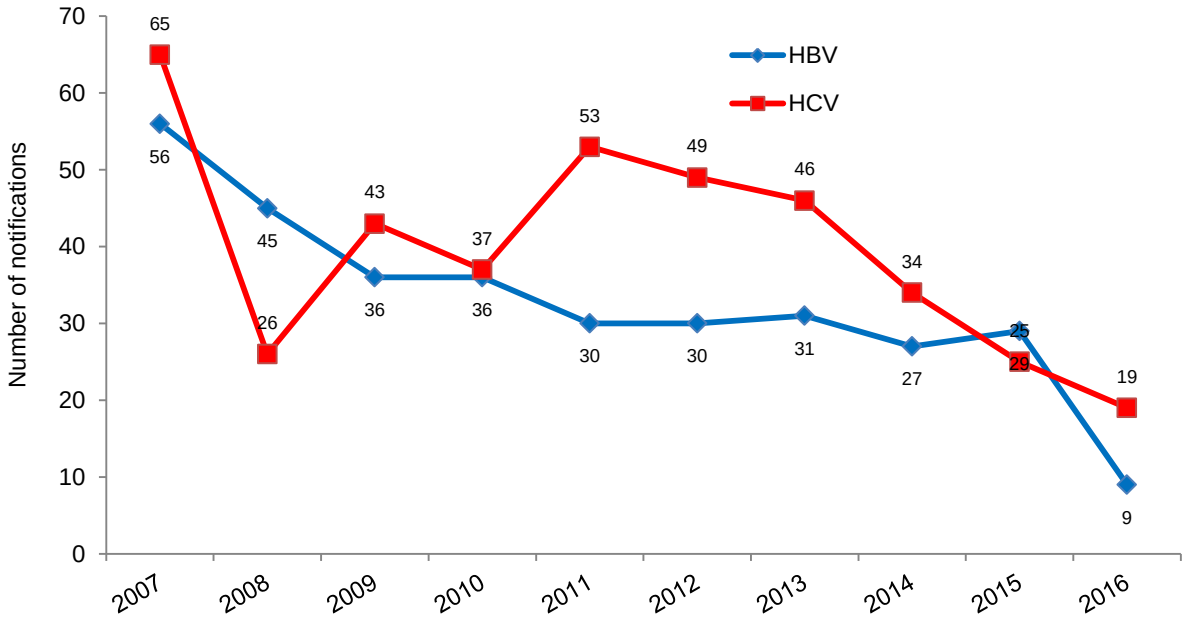
[13] HCV antibody testing has only been available since 1990.

[14] 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 76.

A steady decline has occurred over time in the number of HCV incident notifications, from 65 in 2007 to 19 in 2016. A decline has also been observed in the number of HBV notifications, from 56 in 2007 to 9 in 2016.

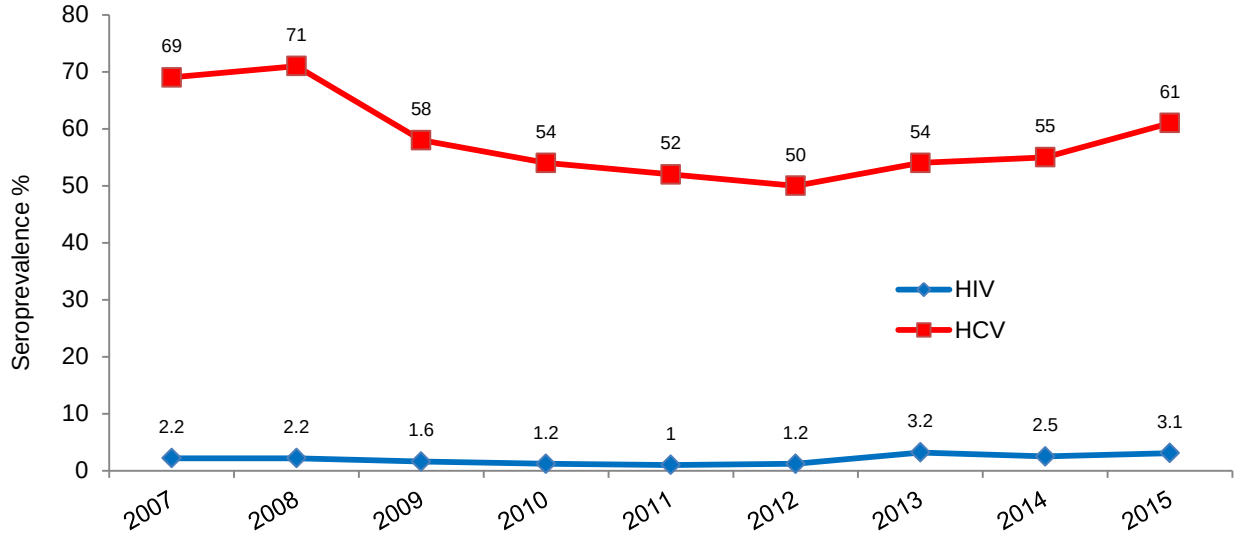
Figure 76: Total notifications for newly acquired HBV and HCV infections, 2007−2016



Source: Communicable Diseases Network – Australia – NNDSS.[11]
Note: Data accessed on 9 December 2016. Figures are updating on an ongoing basis.

In 2015, the prevalence of HIV among PWID in NSW remained low yet increased slightly from 2.5 to 3.1. HCV prevalence among this group was much higher at 61%, which was a slight increase from 55% in 2014 (see Figure 77).

Figure 77: HIV and HCV antibody prevalence among NSP survey participants, NSW, 2007-2015



Source: Australian NSP Survey (Iversen & Maher, 2016).

7.3 Driving

7.3.1 Self-reported driving under the influence of alcohol and illicit drugs

Random breath testing assesses blood alcohol content, whilst roadside saliva drug testing looks for the presence of cannabis, methamphetamine and MDMA. Drivers undergo confirmatory laboratory testing if found to be positive. Random breath testing (RBT) for alcohol has been widely implemented in Australia for some time and saliva drug testing is becoming more common.

Forty-two participants reported that they had driven a vehicle in the six months prior to interview ('recent drivers'). Among these participants, two participants (5%) had driven while over the legal alcohol limit and twenty-nine participants (69%) had driven within three hours of taking illicit or non-prescribed drug(s) in the previous six months.

8 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

Key Findings

Criminal Activity among Participants

- Forty-one percent reported committing 'any crime' in 2016 (46% in 2015), with drug dealing being the most commonly reported crime.

- The proportion of the sample who had been arrested in the preceding 12 months remained stable at 33% (38% in 2015).

- Lifetime prison history decreased significantly, with 67% of the sample reporting that they had been incarcerated at some point throughout their life (80% in 2015).

Arrests

- The number of total arrests for heroin and other opioids, amphetamine-type stimulants, cocaine and cannabis increased in 2014/15.

- In 2014/15, there were 98 clandestine laboratories detected in NSW (98 in 2013/14). These figures have more than doubled in the past decade.

Expenditure on illicit drugs

- The median expenditure on illicit drugs the day before interview was $70.

8.1 Reports of criminal activity among participants

In 2016, 41% reported involvement in any type of crime during the last month, a non-significant decrease from 2015 (46% in 2015). The most commonly reported types of crime remained stable from 2015, with participants primarily reporting involvement in drug dealing (30%), followed by property crime (22%), and smaller numbers reporting fraud and violent crime (6%, respectively). In 2016, the number of participants who reported having ever been in prison decreased significantly ($p<0.05$). Fifteen participants reported recently being a victim of violent crime and of these, 93% believed that the perpetrator was under the influence of drugs or alcohol when they last experienced violence.

The proportion of participants who reported being arrested in the 12 months prior to interview remained stable at 33% (see Table 32). Among the participants who had been arrested in the preceding 12 months (n=49), fourteen participants were arrested for use/possession of drugs, twelve participants were arrested for property crime and ten participants were arrested for violent crime. Smaller numbers reported being arrested for dealing//trafficking (n=3), fraud (n=2), a driving offence (n=1) and breaching an apprehended violence order (AVO) (n=1). Twelve participants reported being arrested for 'other reasons'.

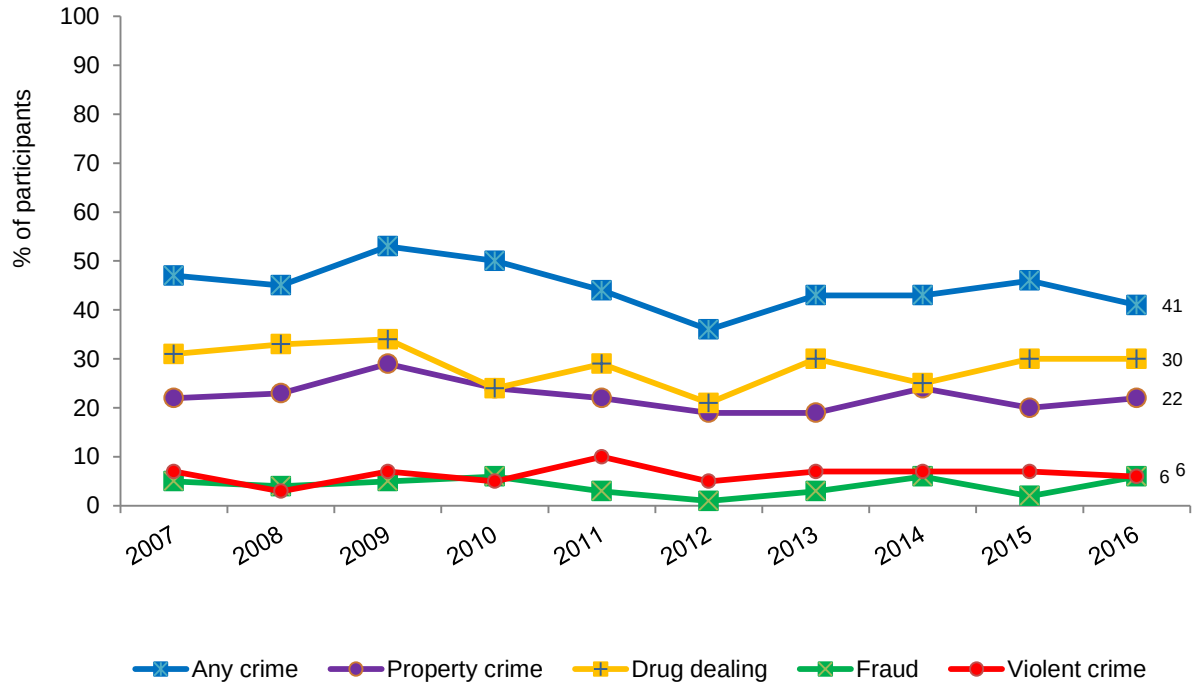
Table 32: Criminal activity in the month prior to interview, as reported by participants, 2015−2016

Criminal behaviour (%)	2015 (n=145)	**2016 (n=149)**
Criminal activity in last month		
Property crime	20	**22**
Drug dealing	30	**30**
Fraud	2	**6**
Violent crime	7	**6**
Any crime	*46*	***41***
Arrested in last 12 months	38	**33**
Ever in prison	80	**67**

Source: IDRS participant interviews.

Figure 78 shows the long-term trends in criminal activity, by offence type, from 2007 onwards. Fraud and violent crime remained consistently low, and property crime and drug dealing have remained consistent across the years, without much variation.

Figure 78: Self-reported involvement in crime, by offence type, in the month prior to interview, 2007−2016



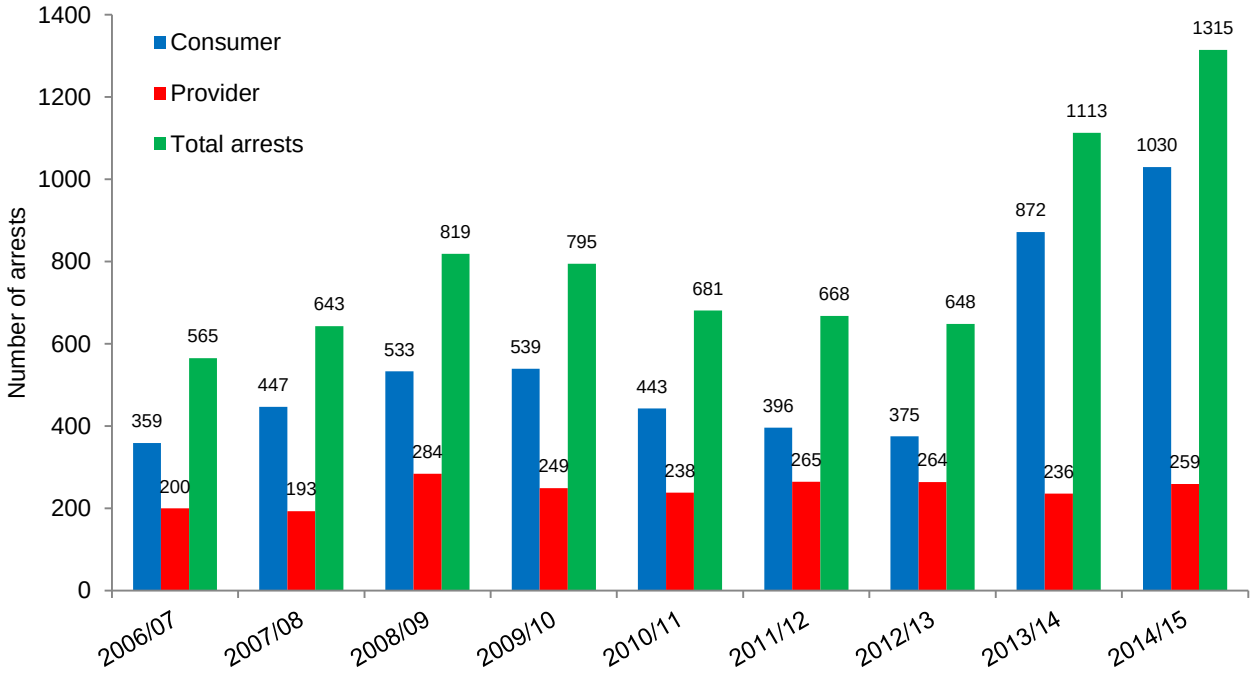
Source: IDRS participant interviews.

8.2 Arrests

8.2.1 Heroin and other opioids

Figure 79 presents the number of consumer and provider arrests for heroin and other opioids made in NSW between 2006/07 and 2014/15. 'Heroin and other opioids' include opioid analgesics such as heroin, methadone and pethidine and opiate analgesics including codeine, morphine and opium. The Australian Criminal Intelligence Commission (ACIC) classifies consumers as offenders who are charged with user-type offences (e.g. possession and use of illicit drugs), whereas providers are offenders who are charged with supply-type offences (e.g. importation, trafficking, selling, manufacture or cultivation). In 2014/15, the number of consumer arrests increased to 1030 arrests from 872 arrests in 2013/14, as did the number of provider arrests but only slightly, from 236 in 2013/14 to 259 in 2014/15.

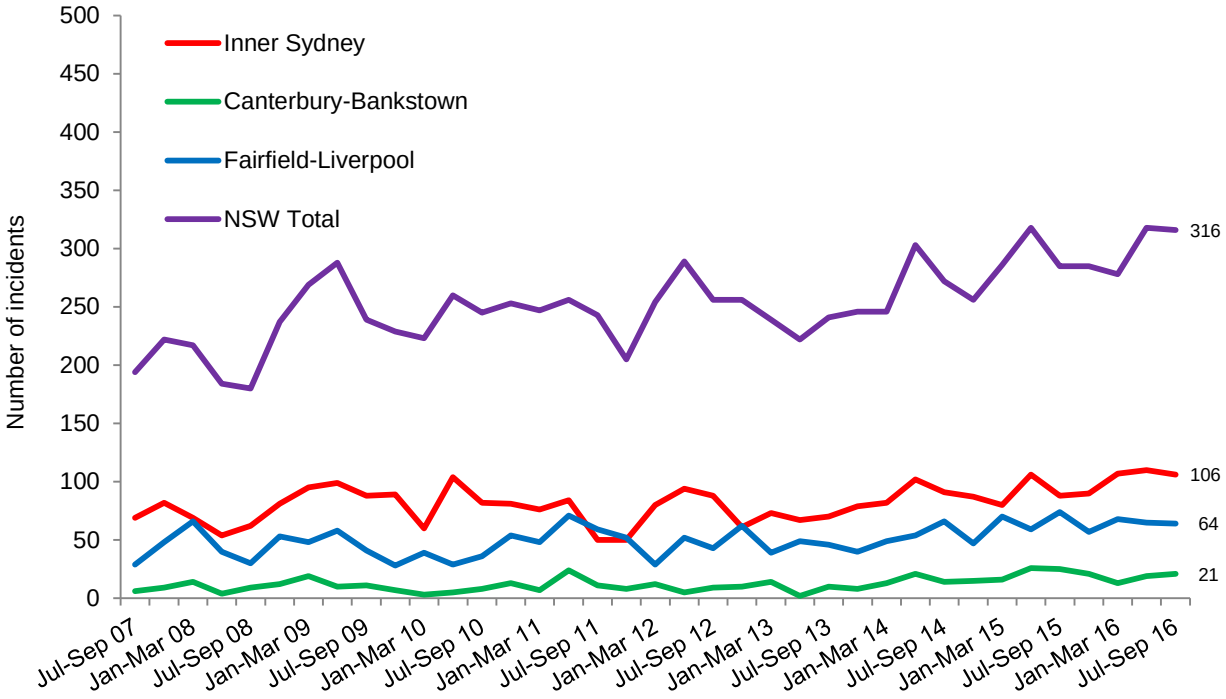
Figure 79: Number of heroin and other opioid consumer and provider arrests, 2006/07–2014/15



Source: Australian Crime Commission 2007; Australian Crime Commission 2008; Australian Crime Commission 2009; Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015; Australian Criminal Intelligence Commission 2016.
Note: Data not available for the 2015/16 financial year.

Figure 80 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 July 2007 to September 2016.[15] The number of incidents across all areas has remained stable over the past decade.

Figure 80: Recorded incidents of narcotic possession/use by geographic area per quarter, July 2007−September 2016



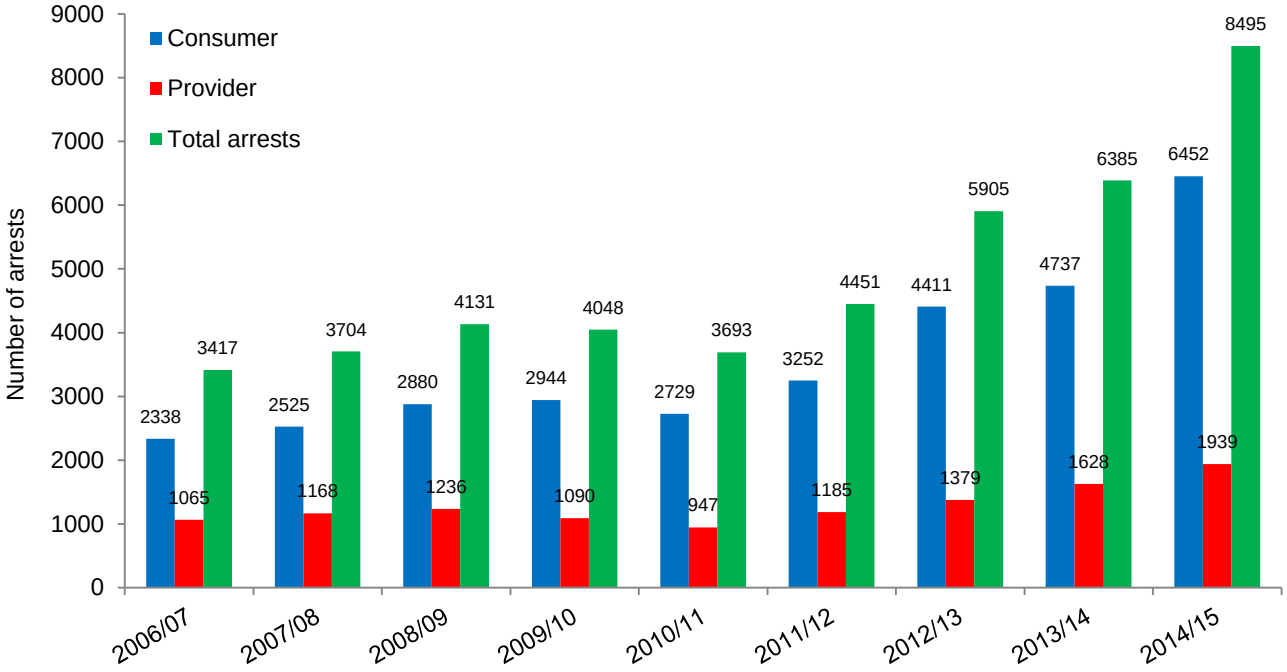
Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 12th December 2016).
Note: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both.

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

8.2.2 Amphetamine-type stimulants

Figure 81 presents the number of consumer and provider arrests for amphetamine-type stimulants made in NSW between 2006/07 and 2014/15. Amphetamine-type stimulants include amphetamine, methamphetamine and phenethylamines. The number of total arrests increased in 2014/15 from 6,385 in 2013/14 to 8,495 arrests, continuing an overall upward trend that has been observed since 2011/12.

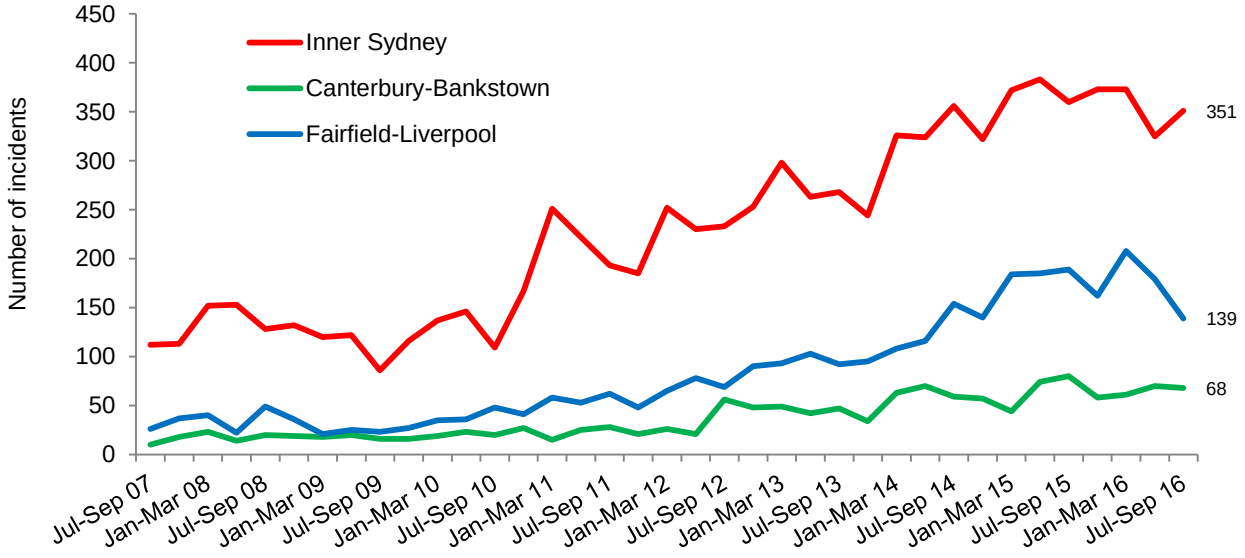
Figure 81: Number of amphetamine-type stimulants consumer and provider arrests, 2006/07–2014/15



Source: Australian Crime Commission 2007; Australian Crime Commission 2008; Australian Crime Commission 2009; Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015; Australian Criminal Intelligence Commission 2016.
Note: Data not available for the 2015/2016 financial year.

Figure 82 shows the number of criminal incidents per quarter for amphetamine possession/use across Sydney. An upward trend was observed for all three areas apart from a slight decrease in July–September 2016 in the Fairfield/Liverpool area.

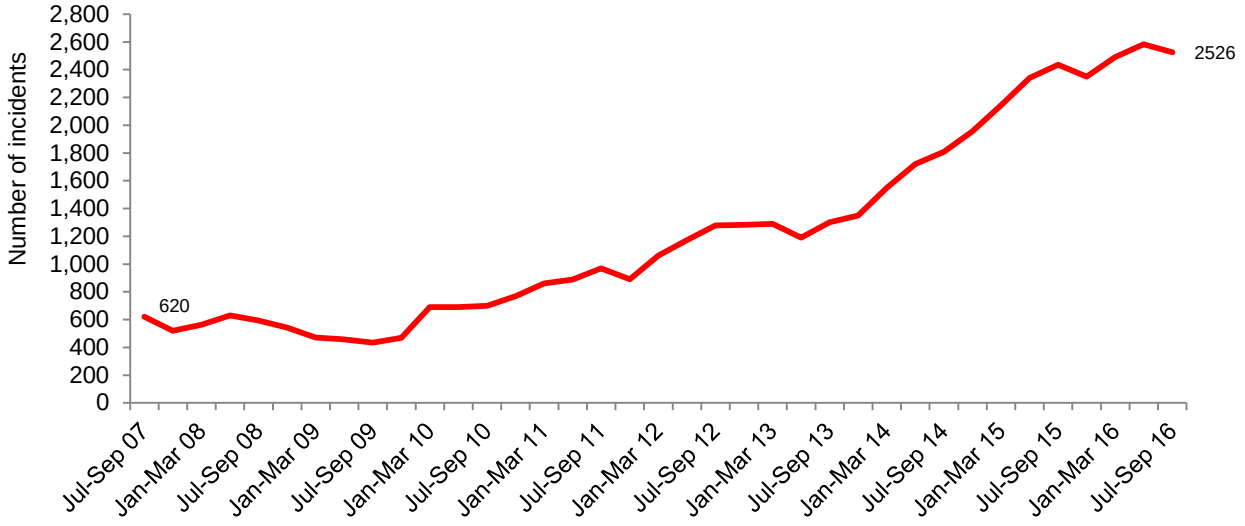
Figure 82: Recorded incidents of amphetamine possession/use by geographic area per quarter, July 2007−September 2016



Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 12th December 2015).
Note: 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 steadily increased since 2010 (Figure 83).

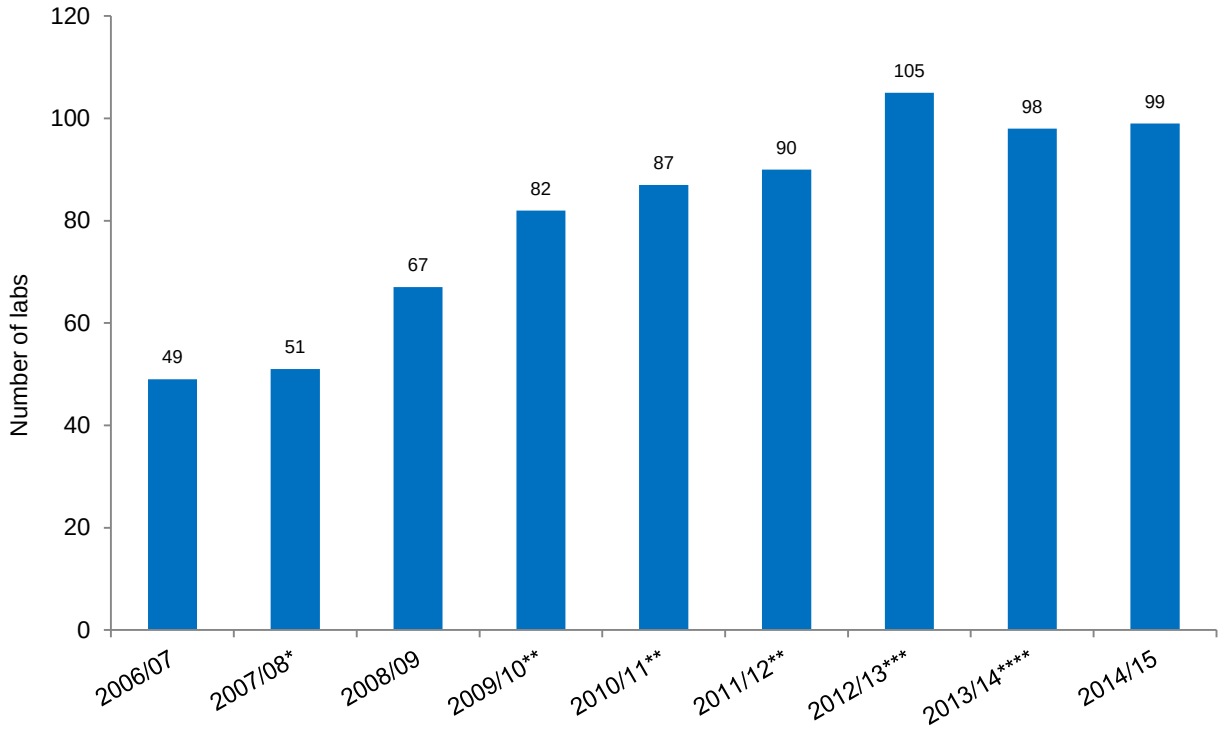
Figure 83: Recorded incidents of amphetamine possession/use in NSW per quarter, July 2007−September 2016



Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 12th December 2015).
Note: 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 2014/15, there were 98 clandestine laboratories detected in NSW (Figure 84). These figures have more than doubled in the past decade.

Figure 84: Number of clandestine methamphetamine and MDMA laboratories detected by NSW Police, 2006/07−2014/15

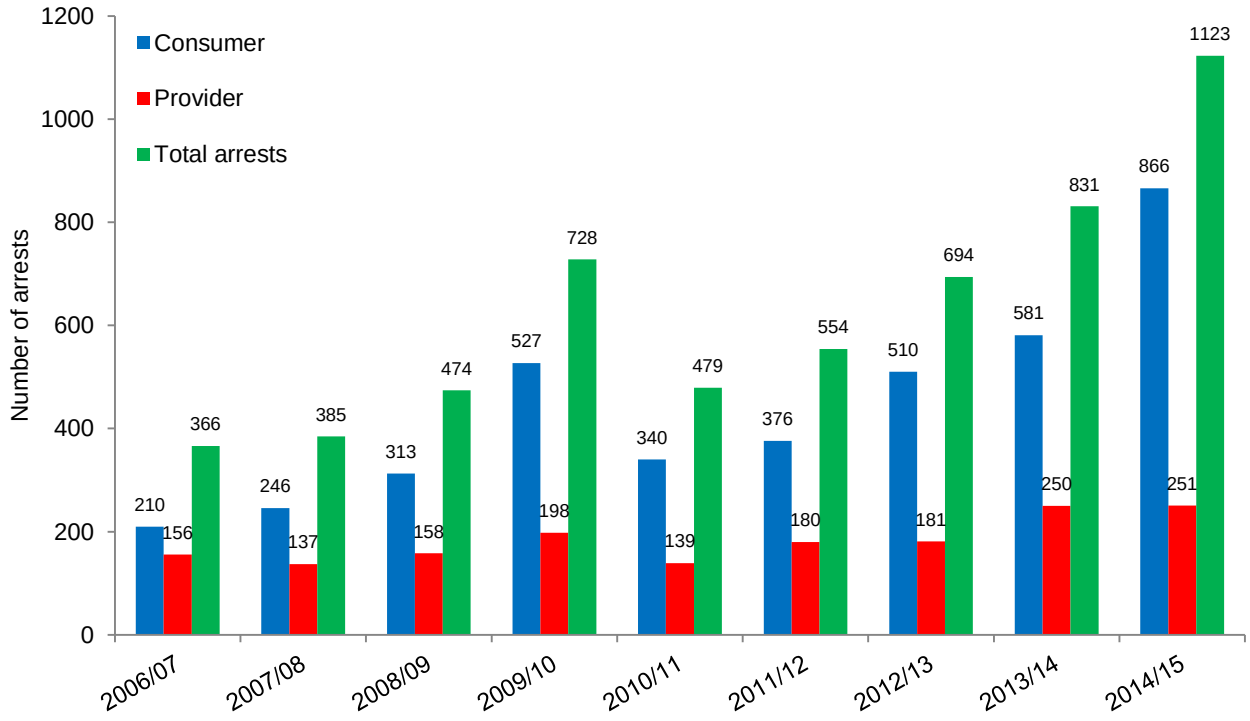


Source: Australian Crime Commission 2007; Australian Crime Commission 2008; Australian Crime Commission 2009; Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015; Australian Criminal Intelligence Commission 2016.
* Includes two para-methoxyamphetamine (PMA) laboratories.
**Includes one PMA laboratory.
***Includes two 2-CB laboratories
****Includes two synthetic cannabinoid laboratories.
Note: Data may include active, non-active and historical laboratories as well as storage sites.

8.2.3 Cocaine

In 2014/15, consumer arrests increased from 581 in 2013/14 to 866. Provider arrests remained stable from 250 in 2013/14 to 251 in 2014/15. The total number of cocaine-related arrests increased from 831 in 2013/14 to 1,123 in 2014/15 (Figure 85).

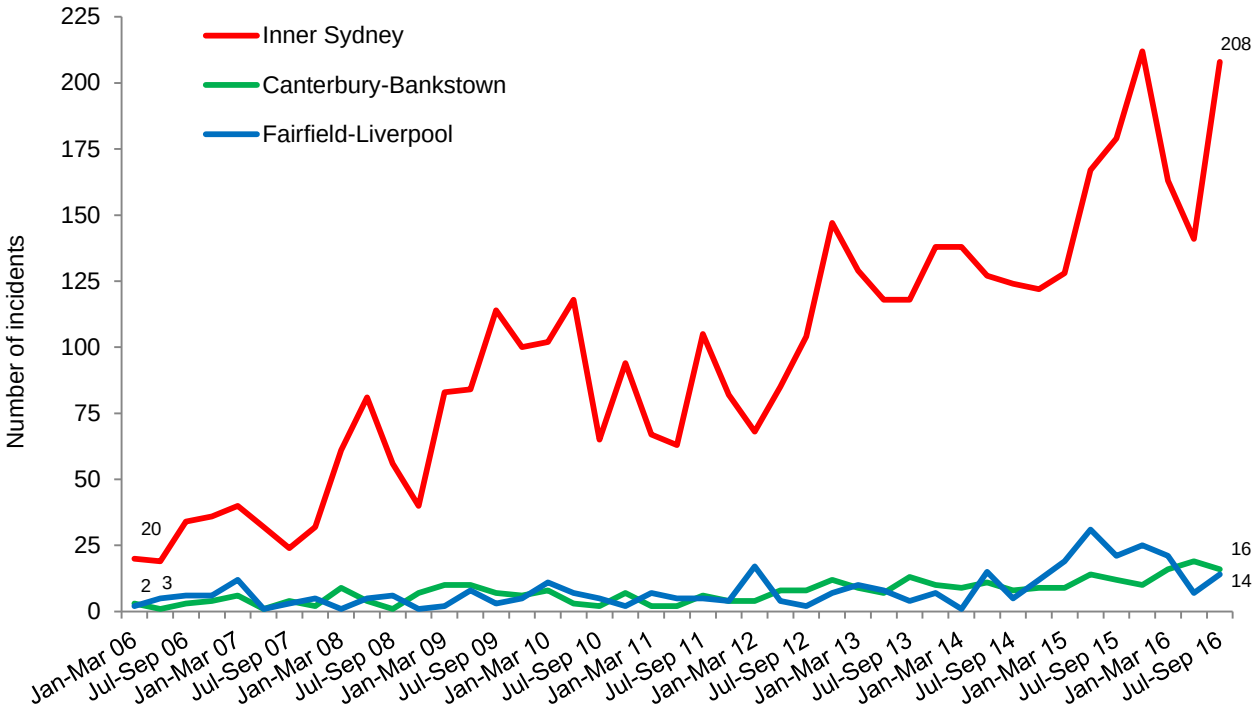
Figure 85: Number of cocaine consumer and provider arrests, 2006/07–2014/15



Source: Australian Crime Commission 2007; Australian Crime Commission 2008; Australian Crime Commission 2009; Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015, Australian Criminal Intelligence Commission 2016.
Note: Data not available for the 2015/16 financial year.

Figure 86 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 2016.

Figure 86: Recorded incidents of cocaine possession/use by geographic area per quarter, July 2007−September 2016

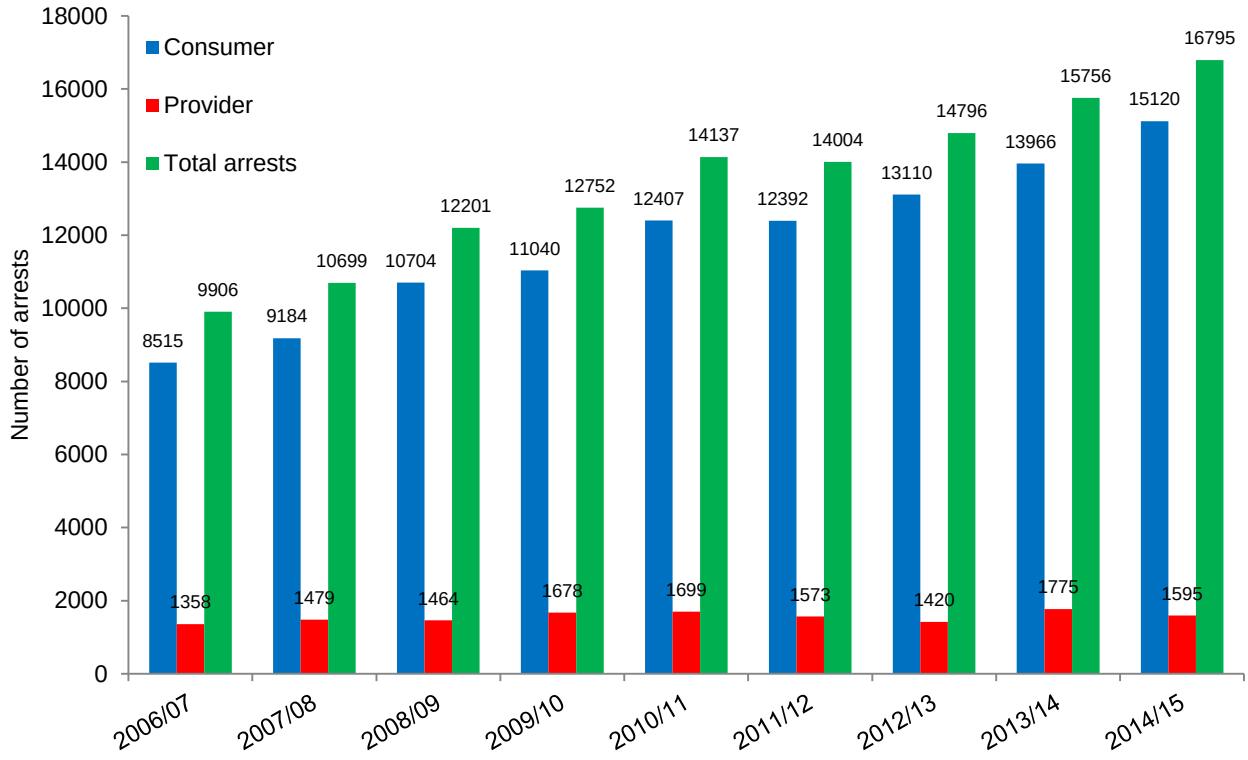


Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 12th December 2016).
Note: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both.

8.2.4 Cannabis

Figure 87 presents the number of cannabis consumer and provider arrests in NSW from 2006/07 to 2014/15. Total cannabis arrests increased only slightly in 2014/15 from 15,756 arrests in 2013/14 to 16,795 arrests, as did consumer arrests. Contrary to this, provider arrests decreased slightly from 1,775 arrests in 2013/14 to 1,595 arrests in 2014/15.

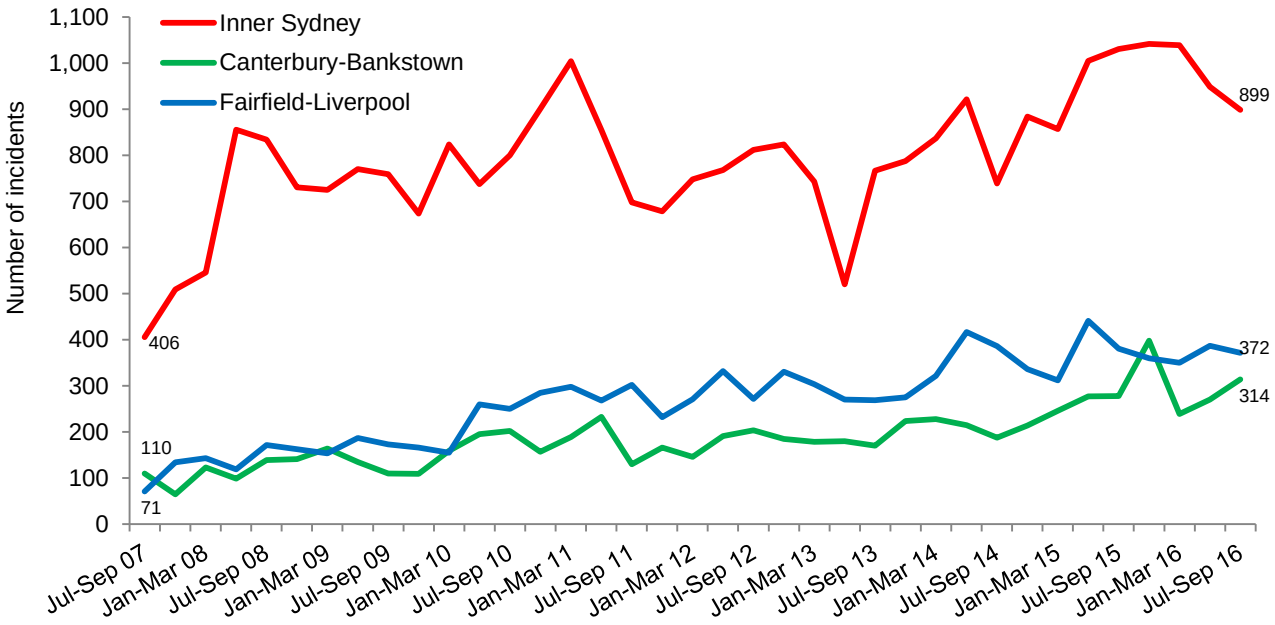
Figure 87: Number of cannabis consumer and provider arrests, 2006/07–2014/15



Source: Australian Crime Commission 2007; Australian Crime Commission 2008; Australian Crime Commission 2009; Australian Crime Commission 2010; Australian Crime Commission 2011; Australian Crime Commission 2012; Australian Crime Commission 2013; Australian Crime Commission 2014; Australian Crime Commission 2015, Australian Criminal Intelligence Commission 2016.
Note: Data not available for the 2015/16 financial year.

Figure 88 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 2007, especially in Inner Sydney.

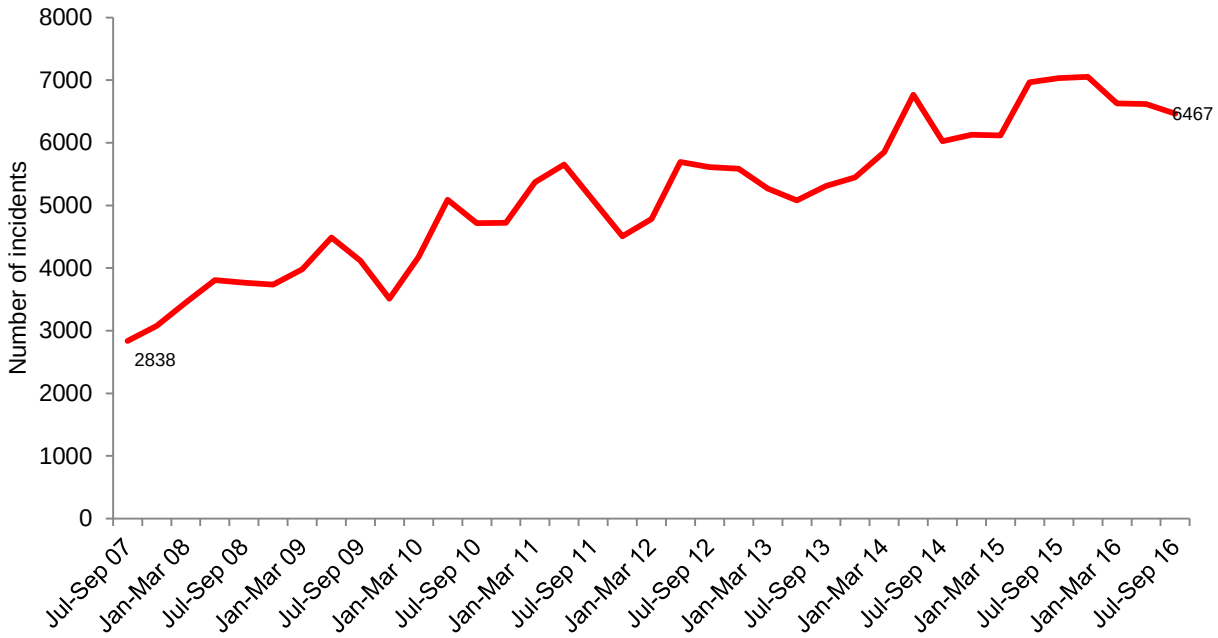
Figure 88: Recorded incidents of cannabis possession/use by geographic area per quarter, July 2007−September 2016



Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 12th December 2016).
Note: 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.

Figure 89 demonstrates an upward trend in the number of recorded incidents of cannabis possession/use per quarter across NSW.

Figure 89: Recorded incidents of cannabis possession/use (whole of NSW) per quarter, July 2007−September 2016



Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init accessed 12th December 2016).
Note: 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.

8.3 Expenditure on illicit drugs

All participants had purchased illicit drugs on the day prior to interview. Among all participants, the median amount spent on illicit drugs was $70 (range; $5–$1500). Table 33 presents the breakdown of the amounts spent on illicit drugs (i.e. excluding alcohol, tobacco and licit supplies of prescription medications) by the whole sample on the day before interview.

Table 33: Expenditure on illicit drugs on the day preceding interview, 2015-2016

Expenditure (%)	2015 (n=149)	**2016 (N=150)**
Nothing	32	**29**
Less than $20	3	**6**
$20–$49	11	**9**
$50–$99	13	**25**
$100–$199	20	**17**
$200–$399	11	**9**
$400 or more	8	**5**
Median expenditure* ($)	100	**70**

Source: IDRS participant interviews.
*Among those who had spent money on drugs.

9 SPECIAL TOPICS OF INTEREST

9.1 Blood donations

Key Findings

- Of those who commented, 10% reported that they had given blood in their lifetime.

- Five participants who had given blood reported that they had commenced injecting drug use before donating blood.

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 (n=146), 10% reported that they had given blood in their lifetime. One-third (33%) of those that had given blood (n=15) reported that they had commenced injecting drug use before donating blood. Participants were asked about their most recent episode between injection and blood donation. Of those participants who commented (n=4), one participant reported that they had injected less than one month before they donated blood, and three participants reported injecting between one month and one year before donating blood.

9.2 Homelessness

Key Findings

- In 2016, 90% of the sample reported lifetime prevalence of homelessness; 37% were homeless at the time of interview.

- The mean duration of their current episode of homelessness was two years.

- The most commonly experienced forms of homelessness during both lifetime and the six months prior to interview were sleeping rough and couch surfing.

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

In 2014, the IDRS included a module on homelessness, which revealed the high lifetime (85%) and recent (29%) prevalence of homelessness among the NSW IDRS participants. To better understand the risk factors associated with different degrees of homelessness severity, four questions from the 2014 module were repeated in 2016.

Among those who commented (n=150), the lifetime prevalence of homelessness among the 2016 NSW sample was 90% (Table 34). Of those participants with a homelessness history, 37% were currently homeless at the time of interview. It is clear that the rate of homelessness among PWID is notably higher than the general Australian population estimate of 0.5% (Australian Bureau of Statistics, 2012). For those participants who were currently homeless, the mean duration of their current episode of homelessness was reported to be two years (range: <1–288 months).

Table 34: Homelessness history among people who inject drugs, 2016

	National N=877	**NSW N=150**
% Lifetime homelessness history	80	**90**
% Length of time since last homeless episode*	(N=688)	**(n=131)**
Currently homeless	25	**37**
In the past six months	14	**15**
7–12 months	4	**5**
1–2 years	9	**4**
2–5 years	13	**13**
More than 5 years	34	**27**
% Total duration of homelessness over lifetime*	(N=677)	**(n=131)**
Less than six months	23	**13**
6–11 months	11	**12**
1–2 years	25	**24**
3–5 years	18	**26**
6–10 years	12	**14**
More than 10 years	12	**12**

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

Table 35 shows within the subsample of participants with a homeless history, the proportion that have experienced various states of homelessness in their lifetime and in the past six months. The most commonly experienced forms of homelessness during both lifetime and the past six months were sleeping rough (82%; 38% respectively), couch surfing (66%; 32% respectively), boarding rooms/hostels (54%; 16% respectively) and crisis accommodation (52%; 11% respectively).

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

	National N=812	**NSW N=148**
% Lifetime		
Slept rough	72	**82**
Crisis or emergency accommodation	46	**52**
Medium or long term accommodation	27	**29**
Lived with relatives, friends or acquaintances (couch surfing)	66	**66**
Boarding or rooming houses or hostels (other than on holiday)	47	**54**
Caravan park (other than on holiday)	35	**30**
% Last six months		
Slept rough	26	**38**
Crisis or emergency accommodation	10	**11**
Medium or long term accommodation	7	**7**
Lived with relatives, friends or acquaintances (couch surfing)	25	**32**
Boarding or rooming houses or hostels (other than on holiday)	11	**16**
Caravan park (other than on holiday)	3	**2**

Source: IDRS participant interviews.

9.3 Unfair Treatment

Key Findings

- Of those who commented, 32% reported that they had 'never' been unfairly treated.

- Seventy-five participants reported being unfairly treated in the last 12 months, mostly by the police (36%) and/or a family member (28%), mostly at a public location (43%).

- Sixteen percent admitted to being unfairly treated 'daily or more'.

Being discriminated against is a common event for people who use illicit drugs, particularly those who inject drugs. The IDRS provided an opportunity to obtain important insights into the multiple origins and impacts of unfair treatment against PWID.

The questions included in the IDRS aimed to clarify the relationships between unfair treatment, mental and physical health issues and quality of life as well as help to inform policy and improve the quality of services. The questions also aimed to identify the location in which PWID are most likely to experience unfair treatment to help reduce future occurrences of this.

The 'Unfair Treatment' questions are based on previous 2013 IDRS questions, developed in conjunction with the Australian Injecting and Illicit Drug Users League (AIVL) (Stafford and Burns, 2014), and two validated and well-accepted scales. The personal well-being index (PWI-A) (International Wellbeing Group, 2013) has been previously used in the IDRS and was well-accepted by participants, while the Discrimination and Stigma Scale (DISC-12) has been used to evaluate discrimination against people with mental health disorders (Thornicroft et al., 2009).

In 2016, 32% of those who commented (n=142) reported that they had 'never' been unfairly treated, and 16% reported that they had not experienced unfair treatment in the last 12 months. However, 21% reported unfair treatment 'monthly', 16% 'weekly but not daily' and 16% experienced unfair treatment 'daily or more'.

Seventy-five participants admitted to being treated unfairly in the last 12 months, and reported they had been treatment unfairly by the police (36%), in keeping or making friends (33%), by family (28%), by people in the neighbourhood (25%), when getting help for physical health problems (25%), and when obtaining welfare benefits (21%). A public location was reported as the venue at which most of the unfair treatment occurred (43%); mainly by the police (30%), general public (23%), or a family member (10%).

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