

**D. McKell and L. Burns**

**NSW DRUG TRENDS 2013  
Findings from the  
Illicit Drug Reporting System (IDRS)**

**Australian Drug Trends Series No. 110**



# **NEW SOUTH WALES DRUG TRENDS 2013**



## **Findings from the Illicit Drug Reporting System (IDRS)**

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## ABBREVIATIONS

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

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

## GLOSSARY OF TERMS

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

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

## EXECUTIVE SUMMARY

### Common terms used throughout the report

<b>People who inject drugs (PWID) regularly</b>	A person or people who have injected a drug on six or more separate occasions in the previous six months
<b>Recent use</b>	Used at least once in the previous six months
<b>Sentinel group</b>	A surveillance group that points towards trends and harms
<b>Median</b>	The middle value of an ordered set of values
<b>Mean</b>	The average
<b>Frequency</b>	Number of occurrences within a given time period

### Demographic characteristics of people who inject drugs (PWID)

In 2013, 151 people participated in the IDRS survey. Sixty percent were male, 95% reported they were not currently working or were currently receiving income support (such as disability or sickness benefits or the Newstart jobseeker's allowance) at the time of interview. The average age of respondents was 40 years (range 23–63 years). Twenty-seven percent of the sample identified as Aboriginal and/or Torres Strait Islanders<sup>1</sup>. Ninety-five percent of the sample identified English as the main language spoken at home. Fifty-six percent of the sample had completed year 10, and 19% had completed year 12 at high school. Forty-nine percent had obtained a trade or technical qualification, and 7% had completed a university or college qualification such as a degree. Forty-four percent had not completed any further education after leaving school. The majority (70%) of participants reported previous prison history and the average age of first injection was 20 years (range 10–40).

### Patterns of drug use among the PWID sample

#### *Heroin*

Following the trends of previous years, heroin was still the preferred drug of choice (62%) in 2013 and this remained stable with reports from last year (69% in 2012). Heroin was the drug most often injected in the month prior to interview (50%) however, this was a statistically significant decrease ( $p < 0.05$ ) when compared with 2012 (62%). Heroin remains the drug people had injected most recently (50%; 59% in 2012) and 85% of participants reported use on one or more occasions in the six months preceding interview (89% in 2012). The median days of recent heroin use also remained stable at 90 days (96 days in 2012). The proportion of participants reporting daily use was 26% (39% in 2012). This was also a statistically significant decrease ( $p < 0.05$ ).

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



The median price for a gram (\$350) of heroin remained stable (\$350 in 2012) as did the price for a cap (\$50). Prices continued to remain higher than those reported prior to the heroin shortage in 2001. Heroin remained accessible in 2013, with 86% (84% in 2012) of those who commented reporting that it was either 'easy' or 'very easy' to obtain. The majority of participants that commented (67%; 77% in 2012) on ease of availability reported it had remained stable.

Participant reports (among those who commented) on heroin purity continued to be mixed in 2013. Thirty-eight percent of the participants that commented reported current purity as low, which remained stable, and over one-third (38%; 35% in 2012) reported it as medium. Thirty-seven percent (33% in 2012) of those commenting considered purity levels to have remained stable over the preceding six months, while just over one-quarter (28%; 26% in 2012) commented that it had decreased.

### *Methamphetamine*

The proportion reporting any recent methamphetamine use (speed powder, base, ice or liquid<sup>2,3</sup>) increased in 2013 (from 72% in 2012 to 75% in 2013), though this change was not statistically significant. Among those reporting any recent use (speed, base, ice, liquid) the median number of days decreased to 18 days, down from 24 days in 2012. The majority had used each form of methamphetamine weekly or less over the six months preceding interview. The proportion (7% in 2013) of participants reporting daily use of any type of methamphetamine was lower.

A 'point' (0.1 of a gram) remained the most popular purchase amount for all three main forms of methamphetamine, and the median price remained stable at \$50 for speed powder, base and ice/crystal. Those purchasing ice/crystal and speed powder by the gram and half-gram increased in 2013, but there were insufficient numbers of purchases of any form of methamphetamine to comment on price changes.

Consistent with 2012, speed and ice/crystal forms of methamphetamine were typically reported by the majority of users as 'very easy' or 'easy' to obtain, whereas the availability of base varied. Availability for all forms was typically reported to have remained stable over the six months preceding interview.

### *Cocaine*

Cocaine use among PWID remained consistent in 2013 with 47% of the sample reporting recent use (also 47% in 2012). The median days of use among users also remained

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<sup>2</sup> 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.

<sup>3</sup> 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.

stable in 2013 at a median of 6 days (approximately monthly use). Daily cocaine use also remained stable with 5% of users reporting daily use (5% in 2012). Reports of crack cocaine were once again almost non-existent among the PWID sample, a finding reflected in KE reports. The majority (70%; 71% in 2012) reported cocaine availability to be 'easy' or 'very easy'. The median price per 'cap' of cocaine remained stable in 2013 at \$50 and was the most common purchase amount (n=32). The median price of a gram decreased in 2013 from \$375 in 2012 to \$300 however, there was an increase in those purchases by this amount (n=14). More participants reported purchases in half-grams (n=16), though there were low numbers reporting purchases in any other measurement; therefore, results should be interpreted with caution. Participants reporting cocaine purity as 'medium' in 2013 remained 'stable' (40% versus 48% in 2012).

### *Cannabis*

The cannabis market continued to remain relatively unchanged since the commencement of the NSW IDRS in 1996. The majority of participants (82%; 72% in 2012) in the 2013 participant sample reported having used cannabis in the six months prior to interview. There was a non-statistically significant decrease in the median frequency of use among PWID from 180 days in 2012 to 100 days in 2013.

In line with previous years, a large proportion of participants reported use of both the hydroponic ('hydro') and outdoor-grown ('bush') forms of cannabis, with hydro appearing to dominate the market. The number of participants reporting purchase of resin (hashish) and oil (hash oil) continued to remain very rare and infrequent. The price of hydroponic cannabis remained stable at \$20 per gram (the most popular purchase amount), and significantly more PWID reported that it was readily available, i.e. 'easy' or 'very easy' to obtain (97% versus 87% in 2012,  $p < 0.05$ ). The price per gram of bush cannabis was also \$20, but, as in previous years, larger purchase quantities of bush were slightly cheaper than for the equivalent quantity of hydro. Bush continued to be reported as less easily available than hydro, with fewer participants able to complete survey items on bush market characteristics (price, potency and availability). Potency of hydroponic cannabis continued to be reported as 'high', and bush continued to be reported as 'medium'.

## **Use of pharmaceuticals**

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

### *Non-prescribed methadone*

One-quarter (25%) of participants reported use of illicitly obtained methadone syrup in the six months preceding interview, which is stable compared with 2011 (23%). Use remained stable and relatively infrequent (approximately monthly). Fifteen percent of participants reported injecting illicit methadone syrup in the preceding six months (18% in 2011), and the frequency (median days) of injection also remained stable at approximately monthly. However, significantly fewer of those that could comment on the availability of non-prescribed methadone reported that it was 'very easy' or 'easy' to obtain (64% versus 80% in 2011). The median price of 50 cents per millilitre remained stable.

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

### *Non-prescribed buprenorphine and buprenorphine-naloxone*

The recent use and injection of non-prescribed buprenorphine in the preceding six months remained stable in 2012. The frequency of injection of non-prescribed buprenorphine over this period continued to remain low and stable.

Buprenorphine-naloxone (Suboxone) tablets have been investigated by the IDRS since it was listed on the Pharmaceutical Benefits Scheme (PBS) in April 2006. In September 2011, buprenorphine-naloxone film was also added to the PBS, and so was also investigated in the 2012 IDRS. Six percent of the sample reported recent use of illicit buprenorphine-naloxone tablets (7% in 2011), with 5% reporting recent use of buprenorphine-naloxone film. The median number of days of use for illicit buprenorphine-naloxone tablets or film was low, with less than monthly use reported. In addition, very low numbers reported recent injection of either tablets or film (2% and 1%, respectively).

### *Morphine*

An increase in prevalence of any recent morphine use among the NSW IDRS PWID sample had been observed since 2001; however, in 2013 it remained comparable with 2012 (20% versus 23% in 2012). Recent use of non-prescribed morphine also remained stable (19%; 19% in 2012), as did recent injection (19%; 19% in 2012). The median number of days non-prescribed morphine was injected was 6.

MS Contin remained the most common brand of morphine used. The median price for 100mg MS Contin tablets ('grey nurses') was \$40 per tablet, consistent with 2012 prices. Participants typically reported that it was 'very easy' or 'easy' to obtain. Availability was generally considered to have remained stable.

### *Oxycodone*

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

Seventy-four participants reported use of any (prescribed or non-prescribed) oxycodone in the six months preceding interview, a significant increase on 2012 (n=43). Participants reported using oxycodone a median of 20 days (i.e. almost weekly) which is stable with 2012 (20 days). Although the proportion of PWID reporting recent injection of oxycodone was stable (37% versus 42% in 2012), the median number of days injected increased from 24 in 2012 (i.e. almost weekly use) to 30 days in 2013.

Thirty-nine percent of the sample felt confident to comment on the price and/or availability of illicit oxycodone in 2013, a slight decrease from 42% in 2012. As per previous years the most common purchase amounts were 80mg OxyContin tablets, bought for a median price of \$40 (range: \$20-\$100) each. The majority (83%; 71% in 2012) of participants commenting reported that availability was considered 'easy' or 'very easy', with availability generally considered to have remained stable.

### *Over the counter codeine*

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

### *Benzodiazepines*

Prevalence of benzodiazepine use remained relatively stable with 66% (64% in 2012) reporting use in the six months preceding interview and the frequency of use increased from a median of 67.5 days in 2012 to 81.5 days in 2013. The injection of benzodiazepines remained low with 5% (2% in 2012) reporting any injection in the past six months.

Twelve percent had recently used 'licit' alprazolam on a median of 60 days while 47% had recently used 'illicit' alprazolam on a median of 12 days. Twenty-nine percent of the NSW sample reported having used 'licitly' obtained other benzodiazepines on a median of 49 days in the last six months while 33% reported using 'illicitly' obtained other benzodiazepines on a median of 10 days in the six months preceding interview.

Excluding alprazolam, the most commonly used brand of benzodiazepine was diazepam (70%; including Valium, Valpam and Antenex), followed by oxazepam (12%; Serepax), and clonazepam (9%; Rivotril).

### *Seroquel*

Twenty-one percent of the sample had used Seroquel® in the last six months (12% licit, 10% illicit), a significant decrease from 38% in 2012. 'Licit' Seroquel® has been used on a median of 120 days compared to three days for 'illicit' Seroquel®.

### *Other drugs*

Hallucinogens, ecstasy and inhalant use were relatively low within this sample. Four participants reported recent hallucinogen use in 2013. Although more than half (55%) of the sample had tried ecstasy, recent use was reported by only 7% of the sample on a median of 4 days. Prevalence of recent inhalant use (e.g. nitrous oxide, amyl nitrite) remained low at 3%.

### *Alcohol and tobacco*

Sixty-six percent of participants had consumed alcohol in the preceding six months (61% in 2012) on a median of 24 days, i.e. approximately once per week. This was an increase from 2012 in which participants who had consumed alcohol in the preceding six months did so on a median of 12 days (i.e. fortnightly use). Eight percent of participants reported daily use of alcohol.

Tobacco remained the most commonly used substance investigated by the IDRS, with virtually all participants (94%) reporting smoking tobacco in the six months preceding interview on a median of 180 days (i.e. daily); a finding that has remained consistent since 1996 when the project commenced. Unlike smoking prevalence in the general population (Australian Institute of Health and Welfare, 2011a), smoking among IDRS participants has not declined over time.

## **Health-related trends associated with drug use**

Nineteen percent of all participants who had ever experienced a non-fatal heroin overdose had done so in the year prior to interview (13% in 2012). There were three reports of overdose in the month preceding the interview (n=1 in 2012).

Overall, participant reports of borrowing and lending of needles and syringes, as well as sharing of other injecting equipment, remained stable in 2013.

The most commonly reported location for last injection remained a private home and this remained stable with 2012.

Again in 2013, participants were asked the site on their body for their last injection. The majority (70%) reported their arm or hand/wrist (16%) and only small proportions reported their neck, groin, leg or foot.

Sixty-eight percent of PWID participants who had injected in the last month reported at least one injection-related problem during this time (61% in 2012). As per 2013, the most commonly reported problems were prominent scarring/bruising of injection sites (48%; 39% in 2012) and difficulty injecting (46%; 34% in 2012).

Forty-five percent of the sample reported experiencing a mental health problem, other than drug dependence, in the preceding six months (45% in 2012), with 63% reporting seeking advice from a mental health professional (72% in 2012). Depression continued to be the most commonly reported mental health problem (30%; 31% in 2012).

Again in 2013, the 10-item Kessler Psychological Distress Scale (K10) was administered. The K10 assesses recent levels of psychological distress (anxiety and depressive symptomatology). The majority of participants fell into the 'high' or 'very high distress' level of psychological distress category, at a proportion higher than the Australian normative value.

Three percent of the entire sample had driven under the influence of any alcohol in 2013. Nineteen percent of the entire sample had driven 'soon' after taking (an) illicit drug(s), with heroin being the most common drug last taken before driving.

## **Law enforcement-related trends associated with drug use**

The proportion of PWID participants that reported being arrested in the previous 12 months increased to 42% of the entire sample (36% in 2012). Self-reported crime trends continued to follow those reported in previous years with the two most commonly reported crimes in the month prior to interview being drug dealing (30%; 21% in 2012) and property crime (19%; 19% in 2012). The daily expenditure on drugs and alcohol (excluding tobacco and prescribed medication) increased in 2013 to a median of \$85 per participant (\$50, in 2012). The range of daily expenditure was \$7–\$1000.

# 1 INTRODUCTION

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

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

The IDRS has operated in NSW since 1996. The data described in this report represent a summary of drug trends detected by the NSW IDRS in 2013. Results are summarised by drug type to provide the reader with an abbreviated picture of illicit drug markets and recent trends. NSW drug trends from previous years can be found in the annual *NSW Drug Trends* reports. All IDRS reports from previous years (in NSW and for all other jurisdictions) may be downloaded in full from the NDARC website <http://ndarc.med.unsw.edu.au> (under 'Drug Trends'). Quarterly bulletins are also produced on IDRS and related data (also available on the NDARC website), and IDRS results are also disseminated in a range of forums including national and international conferences and at the annual Drug Trends Conference. Details of all of these may also be found on the NDARC website.

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

## 1.1 Study aims

As in previous years, the specific aims of the 2012 NSW IDRS were:

### Aims of NSW IDRS

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

## 2 METHOD

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

### Main sources informing the NSW IDRS

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

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

Data from these three sources are triangulated against each other to determine the convergent validity of trends detected. The data sources complement each other in the nature of the information they provide. Data from the 2013 IDRS were also compared with IDRS findings from previous years to determine changes in drug trends and related issues over time.

### 2.1 Survey of people who inject drugs (PWID) regularly

In the 2013 NSW IDRS, the PWID survey consisted of face-to-face interviews with 151 PWID, conducted in Sydney during June 2013. Fifty-seven percent of the sample was recruited from the inner city (Kings Cross and Redfern), and the remainder from Sydney's South-West (Liverpool, Canterbury). In previous years, interviews were conducted at Cabramatta rather than Liverpool; closure of the service at Cabramatta in mid-2003 resulted in the requirement to find a new interview site from 2004 onwards. As with the other locations where recruitment is conducted, Liverpool was selected as it is a key illicit drug market area, and it is in these markets that trends in illicit drug use are likely to first emerge. It should be noted that a shift in the site to South-Western Sydney (in close proximity to a pharmacotherapy treatment service) since 2004 is likely to have contributed to a slight over-representation of methadone and buprenorphine clients within the sample and this should be taken into consideration when interpreting our findings.

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

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

## **2.2 Survey of key experts (KE)**

Seventeen KE who had regular contact with, and/or specialist knowledge of, people using illicit drugs<sup>4</sup>, drug dealers or drug manufacturers, were interviewed during September and October 2013. 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 2013 including drug treatment workers, therapeutic community and residential detoxification workers, law enforcement officers, registered nurses, clinical nurse consultants and user group representatives. KE are recruited from a range of geographical areas across Sydney, both within and outside the drug market areas in which PWID participants are recruited. KE selection is based upon a desire to interview persons who have contact with a broader group of people who use drugs, including people who inject drugs and who have knowledge of drug markets that is broader than the information that we obtain from our participants, and can give some indication of trends across Sydney and NSW.

The KE interview schedule was a semi-structured instrument, based on previous years of the IDRS, and covered similar topic areas to the PWID interview. The interview included sections on drug use patterns; drug price, purity and availability; criminal activity; and health and treatment issues. Interviews took approximately 30 minutes to conduct, and were conducted face-to-face or over the phone. 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:

#### **Other indicators informing the NSW IDRS**

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

## 3 DEMOGRAPHICS

### 3.1 Overview of people who inject drugs (PWID) regularly

The demographic characteristics of the 151 PWID participants who took part in the interview in 2013 are presented below (Table 1).

The mean age of the sample was 40 years (range 23–63), 60% were male and 27% identified themselves as Aboriginal and/or Torres Strait Islander.<sup>4</sup> The vast majority identified as heterosexual (85%) and reported that English was the main language they spoke at home (95%). The educational status of the sample varied, from the completion of grade 4 (<1%) through to completion of year 12 (19%). Fifty-six percent had completed year 10 or higher. Forty-nine percent had obtained a trade or technical qualification and 7% had completed a university or college qualification such as a degree. Less than half (44%) had not completed any further education after leaving school.

The majority of the sample (95%) reported that they were currently not employed or receiving a government pension. Ninety-five percent of the sample reported that their main source of income over the preceding month had been a pension or government benefit, while 1% reported a wage or salary, 3% nominated criminal activity and 1% reported sex work. Forty-five percent of participants reported being single, while just over one-fifth (22%) reported being married or de facto, and a similar proportion (20%) had a current partner. Smaller proportions reported being separated (5%), divorced (5%), or widowed/widower (3%).

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<sup>4</sup> Please note that Aboriginal and/or Torres Strait Islander proportion of sample is not indicative of numbers of Indigenous persons who regularly inject drugs.

**Table 1: Demographic characteristics of PWID participants, 2009–2013**

<b>Characteristic</b>	<b>2009 N=152</b>	<b>2010 N=154</b>	<b>2011 N=150</b>	<b>2012 N=151</b>	<b>2013 N=151</b>
Mean age (years) (range)	38.2 (19–52)	39.3 (19–58)	40.0 (21–58)	39.6 (19–59)	<b>40.0 (23–63)</b>
Sex (% male)	65	61	65	60	<b>60</b>
Aboriginal and/or Torres Strait Islander* (%)	20	22	17	29	<b>27</b>
School education (mean no. years, range)	10 (5–12)	9.7 (3–12)	9.8 (4–12)	9.8 (0–12)	<b>10 (4–12)</b>
<b>Employment (%)</b>	<b>86</b>	<b>88</b>	<b>84</b>	<b>93</b>	<b>95</b>
Not employed/on a pension	2	1	4	1	<b>1</b>
Full time	9	9	6	3	<b>4</b>
Part-time/casual home duties	3	1	2	1	<b>0</b>
Student	0	1	2	1	<b>1</b>
<b>Sexual identity (%)</b>					
Heterosexual	88	84	84	87	85
Bisexual	8	7	11	10	11
Gay or lesbian	3	6	5	2	3
Other	1	3	1	1	1
<b>Tertiary education (%)</b>					
No qualification	57	55	52	49	<b>44</b>
Trade/tech	36	36	42	46	<b>49</b>
University/college	7	9	5	5	<b>7</b>
<b>Current relationship status (%)</b>					
Married/de facto	21	26	28	18	<b>22</b>
Regular partner	16	16	20	18	<b>20</b>
Single	52	53	43	60	<b>45</b>
Separated/divorced	9	3	5	3	<b>10</b>
Widowed/widower	1	2	3	1	<b>3</b>
Currently in drug treatment^ (%)	47	67	72	60	<b>61</b>
Prison history (%)	65	69	71	66	<b>77</b>

Source: IDRS PWID interviews

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

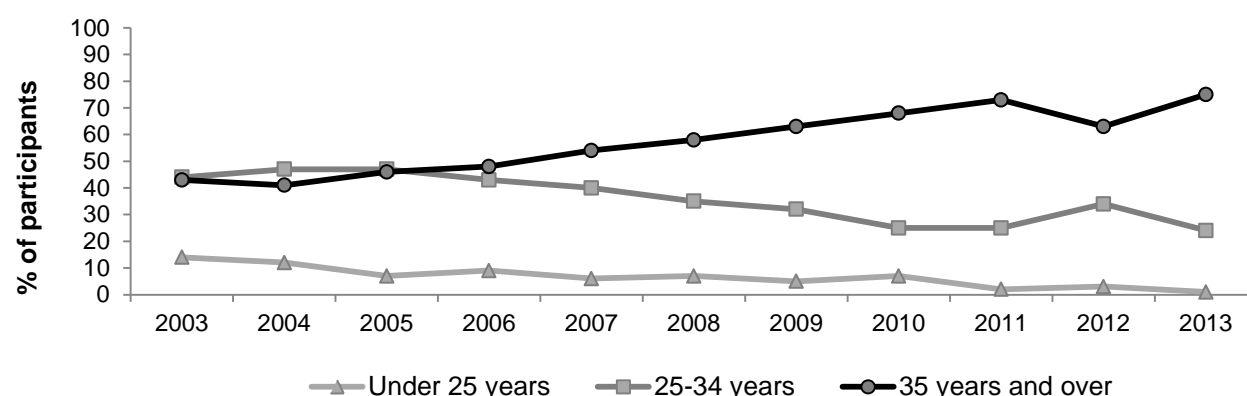
Aboriginal and/or Torres Strait Islander proportion of sample is not indicative of numbers of Indigenous persons who regularly inject drugs.

### 3.1.1 Age of the PWID sample over time

The mean age (40.1 years) of the sample is in keeping with the gradual increase in age over time. The 35 years and over age group, representing the majority (75%) of the sample, has continued to increase over time. Correspondingly, since 1996 the proportion of younger users interviewed generally decreased over time (see Figure 1). There are several reasons that could contribute to this. First, it may be that fewer younger users are accessing NSP (where recruitment is conducted) in recent years, or are less willing to take part in research conducted at NSP. Second, in recent years, younger PWID are more likely to be using methamphetamine than their older counterparts (Deganhart et al., 2008), and some research has shown that

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

**Figure 1: Age distribution of PWID in the NSW (Sydney) IDRS samples, 2003–2013**



Source: IDRS PWID interviews

### 3.1.2 Recruitment

Participants were asked if they had taken part in the IDRS or the EDRS in previous years, as shown in Table 2. Only a small minority (3%) reported having been interviewed for the Ecstasy and related Drugs Reporting System (EDRS) previously. Just over one-third (35%) of participants in 2013 reported having taken part in the IDRS survey previously (between 1996 and 2012). The majority of participants had been recruited by way of advertisements placed in NSP, followed by word of mouth (Table 2).

**Table 2: Previous participation in the IDRS and EDRS and source of participant recruitment, 2009–2013**

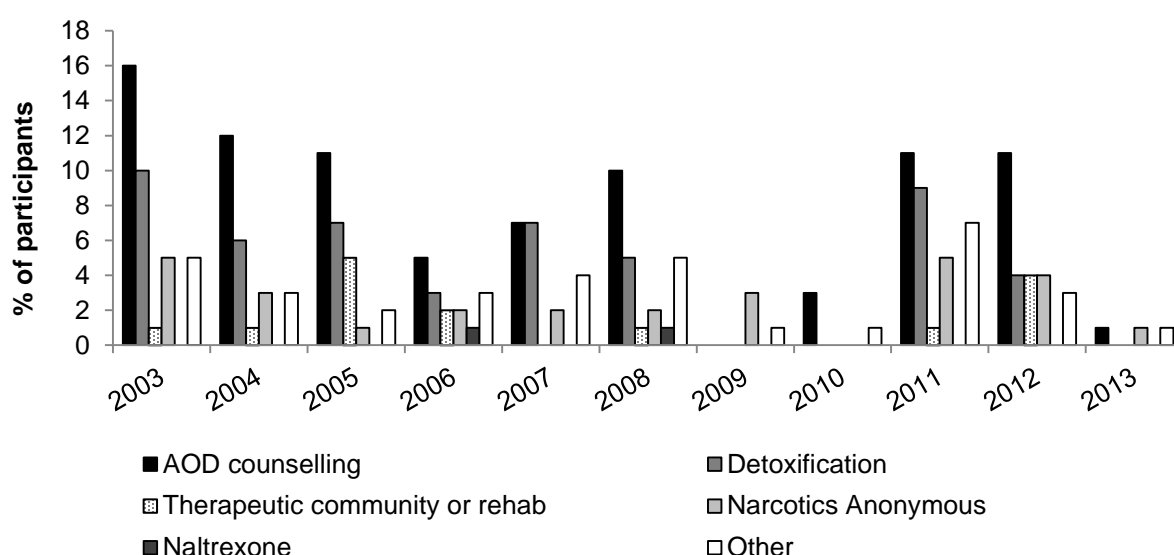
	2009 N=152	2010 N=154	2011 N=150	2012 N=151	2013 N=151
Participated in IDRS in previous years (%)	22	30	32	35	<b>35</b>
<b>Where found out about IDRS survey recruitment (%)</b>					
Needle and Syringe Program (NSP)	60	53	57	49	<b>39</b>
Treatment provider	7	4	4	7	<b>13</b>
Advert in street press	1	0	0	1	<b>2</b>
Word of mouth	33	43	36	40	<b>33</b>
Participated in EDRS in previous years (%)	1	3	4	4	<b>3</b>

Source: IDRS PWID interviews

### 3.1.3 Current and previous drug treatment

Sixty-one percent of participants reported that they were currently in drug treatment. Of those participants currently engaged in treatment, 50% (74% in 2012) reported methadone/buprenorphine as their main form of treatment, and two participants (1% of the sample) reported buprenorphine and 10 participants (7% of entire sample) reported they were on buprenorphine-naloxone (Suboxone). Two participants nominated that drug counselling was their main form of treatment (1% of entire sample) while one participant reported attending Narcotics Anonymous. There were no reports of naltrexone treatment, therapeutic community or detoxification. However, as participants were asked about the 'main' type of treatment they were currently receiving, it is important to note that participants who cited pharmacotherapy as their main form of drug treatment may also have been engaged in a number of treatments (e.g. counselling, detoxification, case management, etc.). Participants were also asked if they had been in treatment at any stage over the past six months (Figure 2); just under one-third (31%) reported 'not' having been in any form of drug treatment over this time.

**Figure 2: Proportion of participants reporting treatments other than opioid replacement pharmacotherapy in the past six months, 2003–2013**



Source: IDRS PWID interviews

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

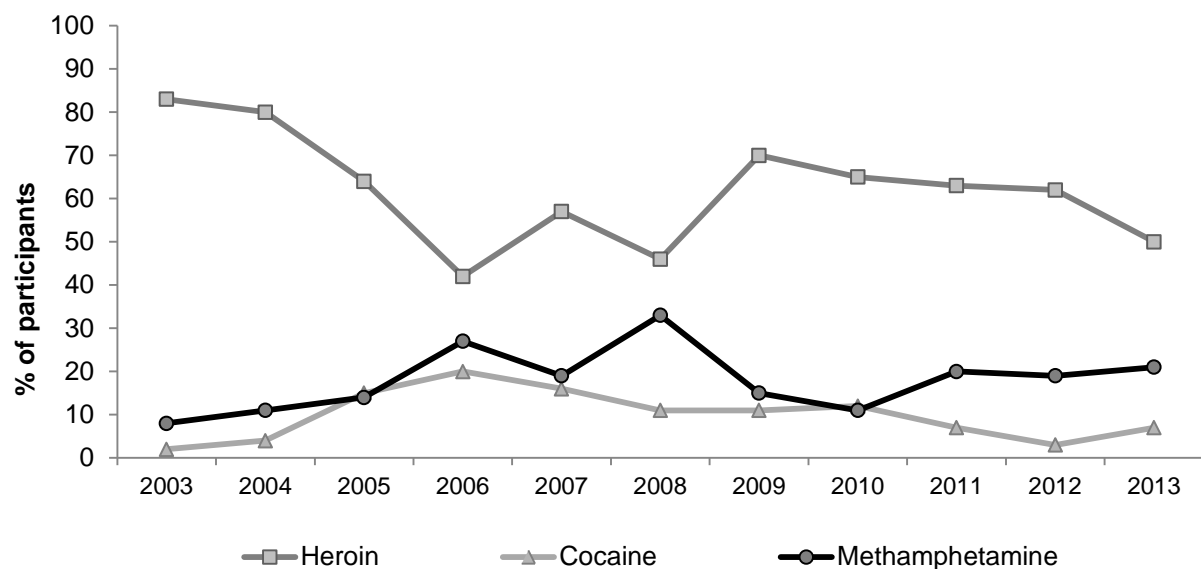
## 4 CONSUMPTION PATTERNS

### 4.1 Drug use history and current drug use

The mean age of first injection was 19.59 years (SD 6.1, range 10–40) (Table 3). Similar to previous years, heroin was the first drug injected by the majority of participants (57%), followed by methamphetamine (36%) and cocaine (3%). Heroin remained the most commonly reported drug of choice (62%), remaining stable from 2012 and 2011 (67% and 70% respectively).

As in previous years, heroin remained the drug most often injected in the month preceding the interview (50%); however, this was significantly less ( $p < 0.05$ ) than 2012 (62%) (Figure 3). Again in 2013, heroin remained the most common recently injected drug (50%) (Table 3). Significantly less ( $p < 0.05$ ) participants reported injecting 'more than 3 times a day' in the month preceding the interview, reversing a trend from 2012 (7% versus 15%;  $p < 0.05$ ).

**Figure 3: Drug injected most last month, 2003–2013**



Source: IDRS PWID interviews

NB: Survey item was first included in 1999

**Table 3: Injection history, drug preferences and polydrug use of PWID participants, 2009–2013**

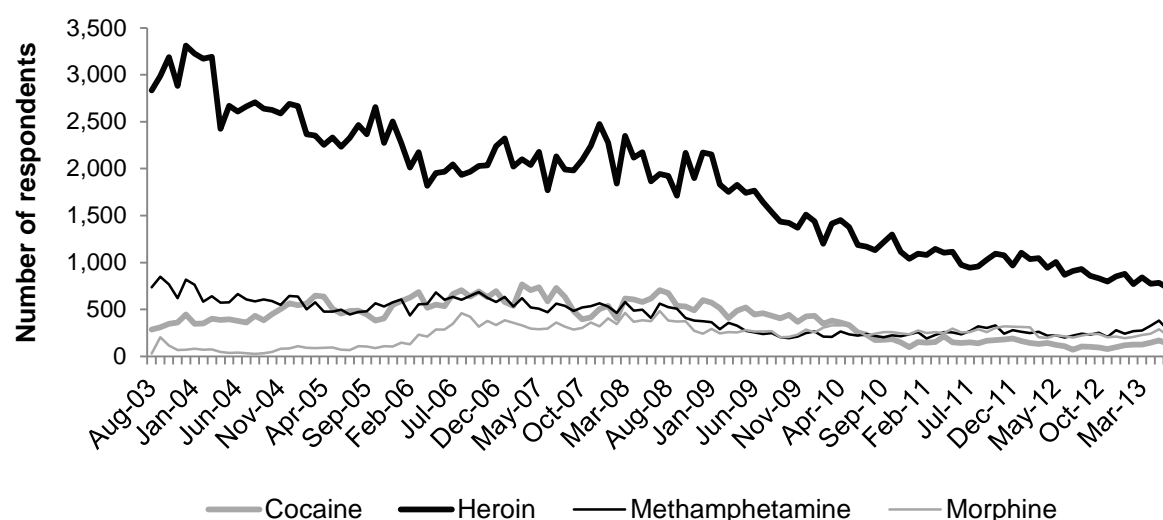
Variable	2009 N=152	2010 N=154	2011 N=150	2012 N=151	2013 N=151
Age first injection (mean years)	18.8	18.7	19.44	19.11	19.59
<b>First drug injected (%)</b>					
Heroin	58	61	63	58	57
Methamphetamines	34	33	33	33	36
Cocaine	5	3	3	5	3
Morphine	0	1	0	1	0
<b>Drug of choice (%)</b>					
Heroin	72	71	70	67	62
Cocaine	10	11	7	5	9
Methamphetamine (any form)	13	10	16	15	17
<i>Speed</i>	5	3	1	3	1
<i>Base</i>	1	0	1	0	1
<i>Crystal methamphetamine (ice)</i>	7	7	14	12	15
Benzodiazepines	1	0	1	1	0
Cannabis	3	3	3	2	4
<b>Drug injected most often in last month (%)</b>					
Heroin	70	65	63	62	50
Cocaine	11	12	7	3	7
Methamphetamine (any form)	15	11	20	19	23
<i>Speed</i>	5	3	1	2	1
<i>Base</i>	1	1	1	0	1
<i>Crystal methamphetamine (ice)</i>	9	7	18	17	21
Benzodiazepines	0	1	0	0	0
Morphine	3	5	1	4	2
Oxycodone	N/A	N/A	3	5	11
<b>Most recent drug injected (%)</b>					
Heroin	64	62	61	59	50
Cocaine	13	11	5	5	7
Methamphetamine (any form)	14	11	17	23	24
<i>Speed</i>	5	3	1	3	2
<i>Base</i>	3	3	1	1	1
<i>Crystal methamphetamine (ice)</i>	6	5	15	19	21
Benzodiazepines	1	2	0	0	0
Morphine	4	5	4	3	3
Oxycodone	N/A	N/A	3	8	11
<b>Frequency of injecting in last month (%)</b>					
Not injected in last month	0	1	1	1	1
Weekly or less	15	15	13	14	13
More than weekly, but less than daily	33	30	43	34	35
Once per day	17	18	14	14	16
2–3 times a day	24	26	23	23	28
>3 times a day	11	10	7	15	7

Source: IDRS PWID interviews

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

Figure 4 (below) illustrates the most recent drug injected as reported by respondents attending three inner city NSPs. While heroin continued to be reported as the last drug injected by the majority of respondents, there has been an overall decline in the numbers reporting heroin throughout the reporting period. This decline continued in 2013, with two of the lowest levels recorded since 2003 reported in the past 12 months (April 2013: 775 and June 2013: 729 respondents nominating heroin as the last drug injected). The numbers reporting methamphetamine (all forms) over the past 12 months is generally stable with only the occasional fluctuation. The number of people nominating cocaine in the 12 months to June 2013 also declined to be the lowest since 2003 (only 72 respondents in July 2012). The number of respondents nominating morphine (and other pharmaceutical opioids) steadily increased since August 2004 (26 visits) peaking again at an all-time high of 483 visits in July 2008 after a period of stabilisation in 2007. This remained stable in the 12 months prior to June 2013. The lowest recorded numbers during this period was 195 visits in January 2013.

**Figure 4: Number of respondents attending three inner city NSPs reporting heroin, methamphetamine, cocaine and morphine as last drug injected, August 2003–June 2013**



Source: Three inner city NSPs

The polydrug use histories of PWID participants, including routes of administration, are presented in Table 4. Recent use of the four main drugs monitored by the IDRS remained common: heroin (83%), cannabis (80%), methamphetamine (any form 75%) and cocaine (41%) (Figure 5). Further discussion of the use of these drugs may be found under the relevant section headings elsewhere in the report.



**Table 4: Polydrug use history of the PWID sample, 2013**

Drug Class	Ever used %	Ever injected %	Injected last 6 mths %	Median days injected in last 6 months*	Ever smoked %	Smoked last 6 mths %	Ever snorted %	Snorted last 6 mths %	Ever swallowed %	Swallowed last 6 mths+ %	Used^ last 6 mths %	Median days in treatment* last 6 mths	Median days used^ in last 6 mths*
Heroin	98	97	82	76	48	7	19	1	11	2	83		90
Homebake heroin	34	31	9	5	2	1	1	0	0	0	10		5
Any heroin (inc. homebake)	98	97	83	95	48	7	19	0	11	2	84		85
Methadone (prescribed)	78	36	13	28					76	55	56	180	180
Methadone (not prescribed)	55	40	23	5					27	9	28		5
Physeptone (prescribed)	15	6	1	180	1	0	1	0	11	1	2	180	180
Physeptone (not prescribed)	19	11	1	25	1	0	1	0	9	1	2		3
Any methadone (inc. Physeptone)	88	58	31	28					80	58	66		180
Buprenorphine 'Subutex' (prescribed)	42	17	2	7	5	1	1	0	37	5	5	90	90
Buprenorphine 'Subutex' (not prescribed)	29	19	9	10	5	1	0	0	12	4	11		2
Any buprenorphine (excl. buprenorphine-naloxone)	56	28	9	15	8	1	1	0	44	8	15		21
Buprenorphine-naloxone 'Suboxone' tablets (prescribed)	18	3	0	0	0	0	0	0	18	3	3	150	7
Buprenorphine-naloxone 'Suboxone' tablets (not prescribed)	15	7	1	3	0	0	0	0	9	4	5		3
Any buprenorphine-naloxone 'Suboxone' tablets	27	11	1	3	0	0	0	0	24	16	7		4
Buprenorphine-naloxone 'Suboxone' film (prescribed)	18	1	1	30	0	0	0	0	17	12	11	-	72
Buprenorphine-naloxone 'Suboxone' film (not prescribed)	12	7	3	3	0	0	0	0	7	3	6		3
Any buprenorphine-naloxone 'Suboxone' Film	26	7	3	3	0	0	0	0	22	13	15		33
Any buprenorphine-naloxone (any form)	35	9	3		0	1	0	0	33	6	18		-
Morphine (prescribed)	24	18	3	6	0	0	0	0	9	0	3	-	6
Morphine (not prescribed)	49	45	18	6	0	0	0	0	10	3	19		6
Any morphine	61	53	19	6	0	0	0	0	15	3	20		6
Oxycodone (prescribed)	23	15	7	31	0	0	0	0	13	3	9	14	31
Oxycodone (not prescribed)	58	51	36	30	0	0	0	0	13	5	40		23

Source: IDRS PWID interviews

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

\* Among those who had used/injected

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

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

**Table 4: Polydrug use history of the PWID sample, 2013 (continued)**

Drug Class	Ever used %	Ever injected %	Injected last 6 mths %	Median days injected in last 6 months*	Ever smoked %	Smoked last 6 mths %	Ever snorted %	Snorted last 6 mths %	Ever swallowed %	Swallowed last 6 mths+ %	Used^ last 6 mths %	Median days in treatment* last 6 mths	Median days used^ in last 6 mths*	
Any oxycodone	66	52	37	30	0	0	0	0	23	8	43		20	
Other opioids (not elsewhere classified)	30	2	0	0	0	0	0	0	29	14	14		6	
OTC codeine	30	4	1	1	1	1	0	0	28	12	13		24	
Speed powder	82	68	12	4	9	1	33	2	24	2	14		5	
Base/point/wax	56	50	11	5	4	1	5	1	14	3	12		5	
Ice/shabu/crystal	89	82	68	14	40	23	5	2	6	3	74		15	
Amphetamine liquid	27	25	1	1					6	0	1		1	
Any form methamphetamine#	96	91	70	14	44	23	36	5	32	5	75		18	
Pharmaceutical stimulants (prescribed)	6	1	0	0	0	0	1	01	6	1	1		51	
Pharmaceutical stimulants (not prescribed)	18	5	2	5	1	1	2	1	15	3	4		6	
Any form pharmaceutical stimulants	20	5	2	5	1	1	3	4	17	3	5		6	
Cocaine	87	76	38	6	17	2	32	0	9	1	41		6	
Hallucinogens	53	6	1	1	3	1	1	0	52	1	3		8	
Ecstasy	55	13	1	2	0	0	2	0	51	6	7		4	
Alprazolam (prescribed)	23	1	0	0	0	0	0	0	22	11	12		60	
Alprazolam (not prescribed)	63	2	1	82	0	0	0	0	61	46	47		12	
Any form alprazolam	68	3	1		0	0	0	0	66	50	51			
Other benzodiazepines (prescribed)	50	3	0	0	0	0	0	0	48	29	29		49	
Other benzodiazepines (not prescribed)	55	3	0	0	0	0	0	0	54	31	33		10	
Any benzodiazepine (excl. alprazolam)	72	3	11		0	0	0	0	70	49	50			
Any form benzodiazepine	82	5	1	82	0	0	0	0	80	64	66		30	
Steroids	7	6	2	10	0	0	0	0	3	1	3		7	
Seroquel (prescribed)	27	1	1	6					26	11	12		120	
Seroquel (not prescribed)	36	3	1	2					33	9	10		3	
Any form Seroquel	56	3	2	2					52	19	21		10	
Alcohol	98	3	1	1					94	63	66		24	
Cannabis	97				93	78			19	5	80		100	
Inhalants	20									3	2			
Tobacco	98									95	180			

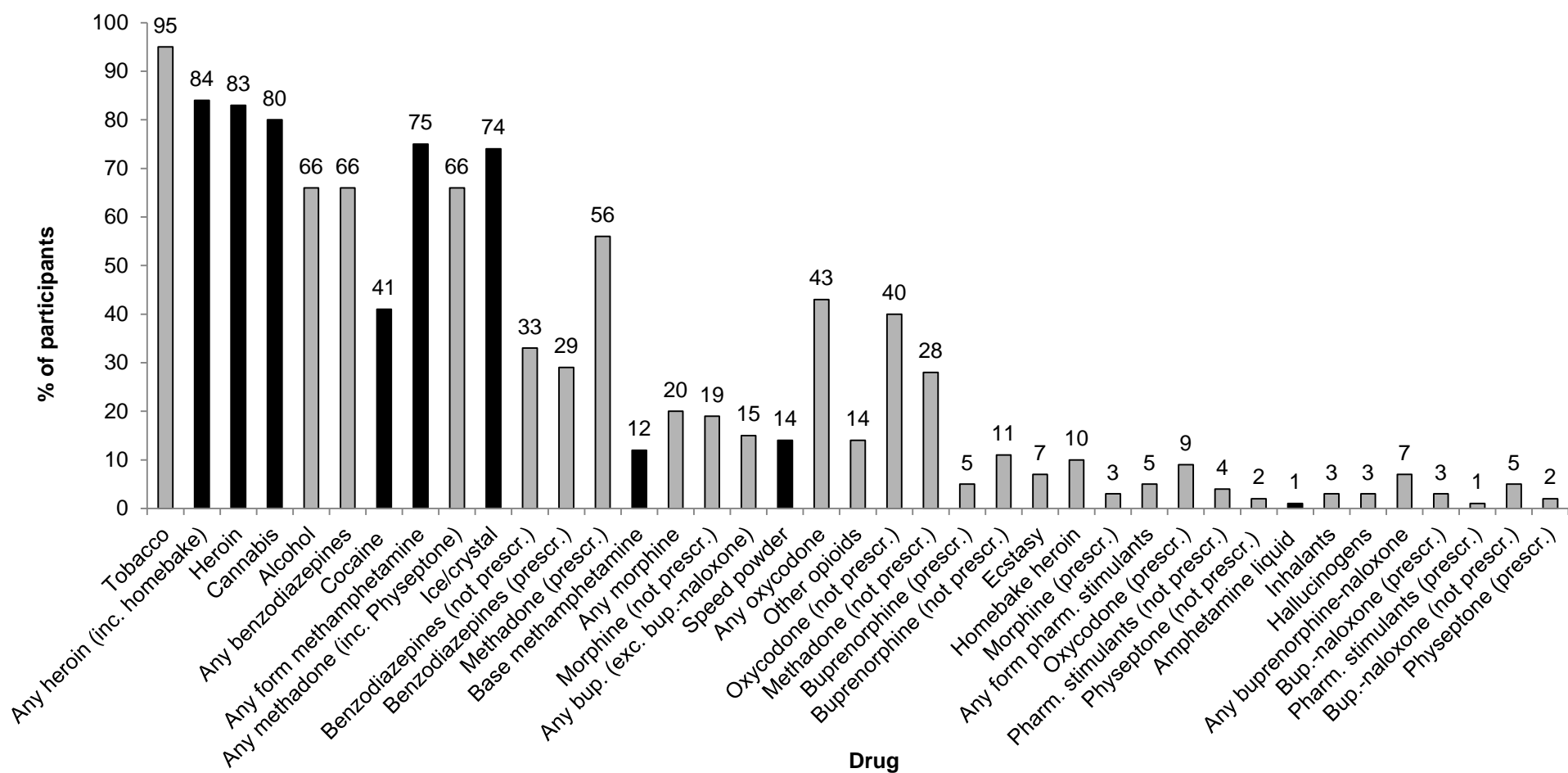
Source: IDRS PWID interviews

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

\* Among those who had used/injected

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

Figure 5: Prevalence of drug use in the six months preceding interview, NSW 2013\*



Source: IDRS PWID interviews

\* Key drugs investigated in the IDRS (i.e. heroin, methamphetamine, cocaine and cannabis) shown in black.

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

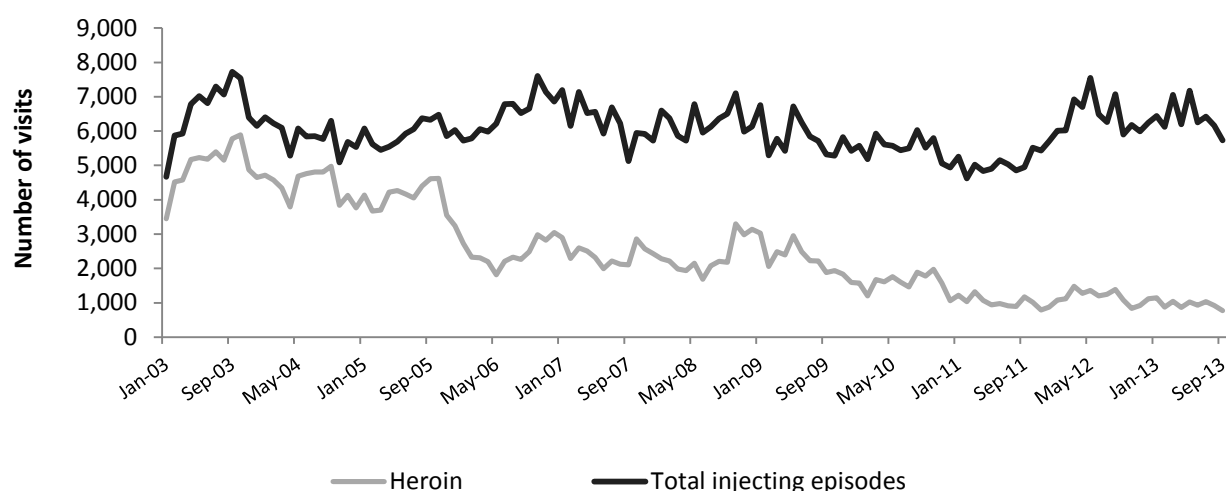
## 4.2 Heroin

### 4.2.1 Heroin use among PWID participants

The majority of participants (83%) had used heroin in the six months preceding interview; this remained stable with the 89% reported in 2012. Heroin remained the drug of choice for 62% of the sample (Table 3), stable also with the 67% reporting it in 2012. Heroin was most commonly nominated for 'drug injected last' (50%), stable with the 59% reporting it in 2012. Despite heroin continuing to be the 'drug injected most often in the last month' (50%), this was a significant decrease on the 62% of participants that reported it in 2012.

Figure 6 shows the number of attendances to the Sydney MSIC in Kings Cross where heroin was the drug injected (based on client reports) between 2001 and 2013. The following caveats need to be considered when interpreting these data. First, the hours of operation changed over the first two years of operation (increasing from four hours to 12 hours per day) and, second, the number of individuals attending increased continuously over this period, as people who inject drugs (PWID) became aware of this new service. Heroin had been the drug most commonly injected since the centre opened, with the exception of July 2001–January 2002 where cocaine was equally or more commonly injected, and until more recently when 'other opioids' (predominantly oxycodone and morphine) were equally or more commonly injected (see Figure 19). There has been a steady downward trend in attendances for heroin injection since 2009, and in the 12 months to June 2013 heroin has accounted for approximately 14–20% of all attendances to Sydney MSIC.

**Figure 6: Number of attendances to Sydney MSIC where heroin was injected and total number of visits, May 2001– September 2013**



Source: Sydney MSIC, Kings Cross

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

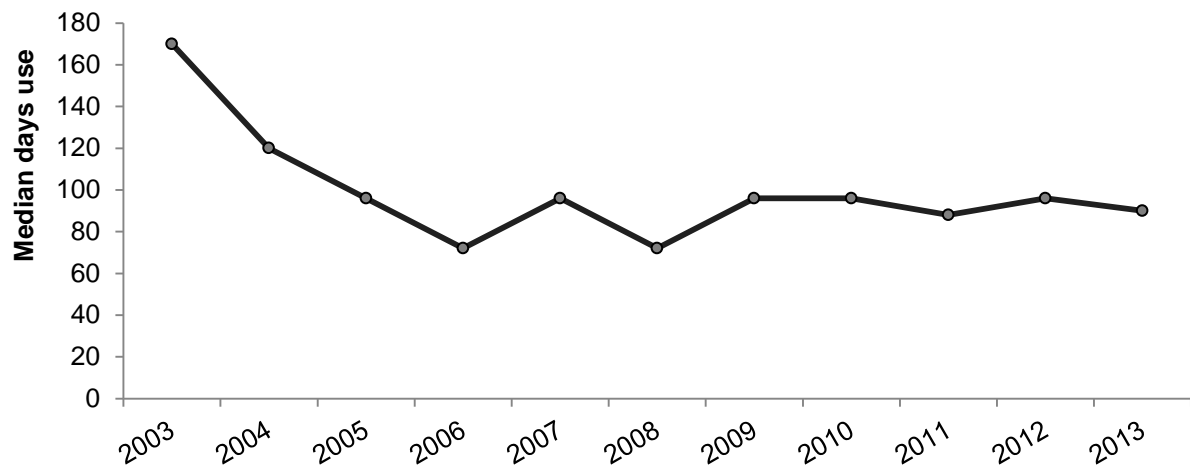
#### 4.2.1.1 Homebake

Homebake use remained uncommon among the PWID sample of the NSW IDRS. Ten percent of the sample reported use in the last six months (Table 4), which is a non-statistically significant increase from the 7% reported in 2012 and is comparable with the 11% reported two years prior in 2011. Nine percent reported injection in the last 6 months, a non-statistically significant decrease from the 7% reported in 2012.

#### 4.2.2 Current patterns of heroin use

The median number of days of heroin use in the six months preceding interview remained stable in 2013 at 90, approximately every second day. In comparison, 11 years earlier (2002) the median days use was daily (180 days; Figure 7). Similarly, the prevalence of recent heroin use reported in 2013 has also remained stable (83% versus 89% in 2012).

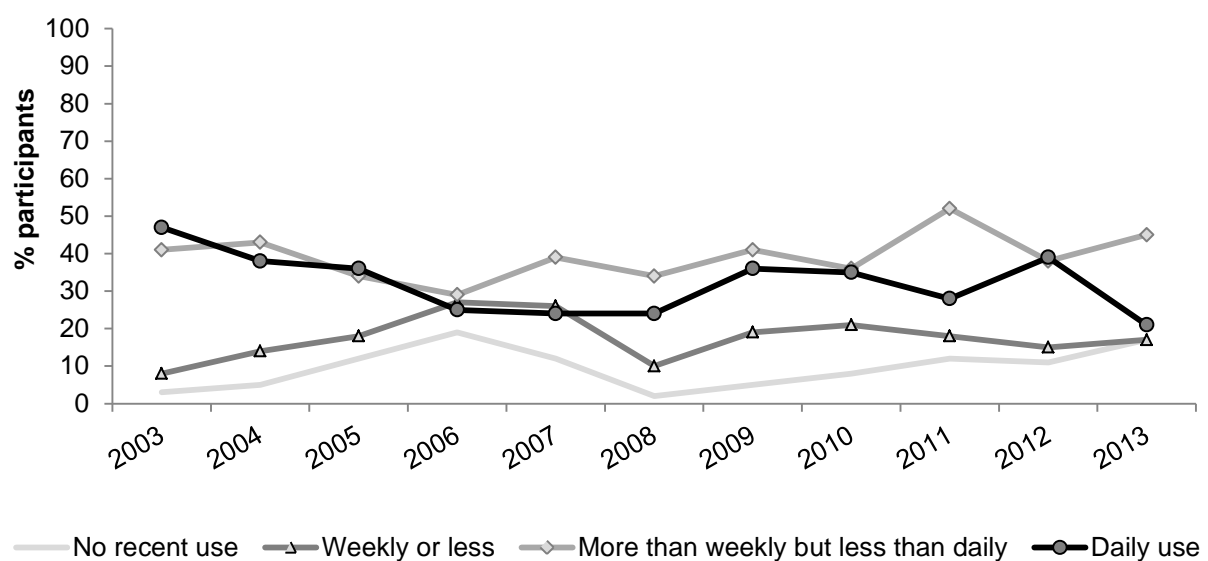
**Figure 7: Median days of heroin use in the past six months, 2003–2013**



Source: IDRS PWID interviews

In 2013, just over one-fifth (21%) of those who had used heroin reported daily use. This is a significant decrease from 39% in 2012 ( $p < 0.05$ ) (Figure 8). Almost half (45%) of the sample reported more than weekly, but less than daily use, which was a slight increase from 2012 (38%) (Figure 8). Just over one-third (36%) of all participants reported use on the day prior (48% in 2012).

**Figure 8: Patterns of heroin use, 2003–2013**



Source: IDRS PWID interviews

### 4.2.3 Forms of heroin used

As in previous years, participants were asked about the forms of heroin they had used over the preceding six months. Eighty-four percent of participants who had reported recent use of heroin described it as white/off-white 'powder' or 'rock' (96% in 2012) and 63% reported recent use of heroin described as brown/beige 'powder' or 'rock', an increase on the 51% of participants who reported it in 2012. The form most used (over the preceding six months) among those who could comment was white/off-white 'powder' (39%; 48% in 2012), followed by white/off-white 'rock' (26%; 36% in 2012). Fourteen percent of those who could comment nominated beige/brown 'powder' (11% in 2012) and 19% had used beige/brown 'rock' most often; a statistically significant increase ( $p<0.05$ ) on the 5% who reported it in 2012.

### 4.2.4 Heroin forms and preparation

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

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

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

Again in 2013, participants were asked if they had used heat and/or citric/ascorbic/acetic acid to prepare heroin for injection on the last occasion of injection. Forty-nine percent reported using heat on the last occasion, a significant increase ( $p<0.05$ ) from 35% in 2012, while 12% reported using any form of citric/ascorbic/acetic acid.

Participants were also asked to identify the colour of the heroin on the last occasion of injection where heat and/or citric/ascorbic/acetic acid had been used in preparation. Of those who reported using heat or acid on the last occasion, the majority (72%) of respondents described the colour of heroin as brown/beige and 13% described it as white/off-white in colour. This was a highly significant decrease ( $p<0.01$ ) on the 39% of participants who reported it in 2012.

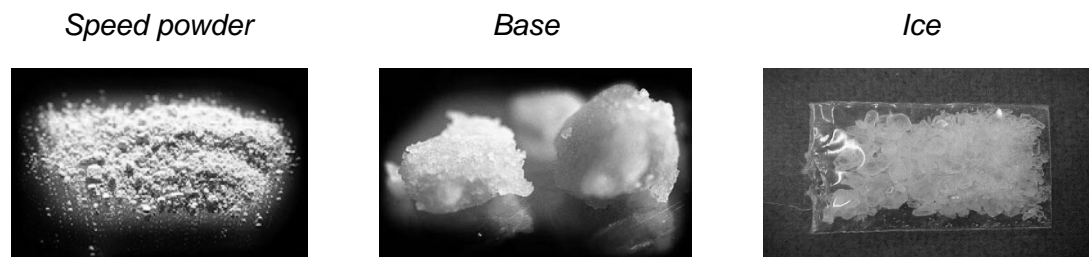
#### 4.2.4.1 Homebake

The median number of days of homebake use in the preceding six months was 5 (i.e. approximately monthly use, range 2–48 days) and remained stable from the 6 days reported in 2012. The median number of days on which it had been injected by users in this time remained stable, i.e. 6 days in 2012 versus 5 days (range 2–48 days) in 2013.

### 4.3 Methamphetamine

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

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



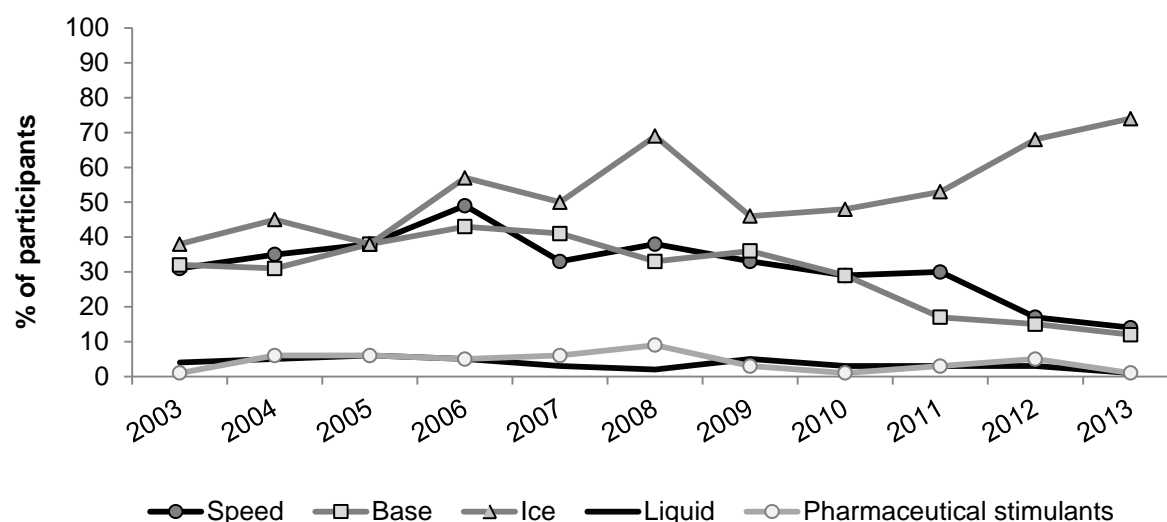
NB: For further information specific to the Sydney methamphetamine market, including supply, use patterns and harms, see McKetin, McLaren et al. (2005)

#### **4.3.1 Methamphetamine use among PWID participants**

The proportion (75%) reporting the use of any form of methamphetamine (speed, base, ice/crystal or liquid) in the six months preceding interview increased slightly in 2013 from 72% in 2012. Considered separately, the most commonly used form was ice/crystal (74%; 71% in 2012), followed by speed (14%; 17% in 2012) and then base (12%; 15% in 2012). Liquid amphetamine (also known as 'oxblood') remained considerably less common, with only 1% (also 3% in 2012) of participants reporting use in the last six months (Figure 9). These figures represent a slight increase in the proportion indicating recent crystal methamphetamine use in 2013, with a slight decrease in the proportion reporting recent speed, base and liquid amphetamine use.

Again in 2013, a distinction was made between the licit versus illicit use of pharmaceutical stimulants (including prescription amphetamines). Only two participants reported use of prescribed pharmaceutical stimulants in the six months preceding interview; while the use of non-prescribed pharmaceutical stimulants continued to remain low in 2013, with only 4% (4% in 2012) of participants reporting recent use. The recent use of any pharmaceutical stimulants by this group has remained at less than 10% since 1999 (Figure 9).

**Figure 9: Proportion of PWID reporting methamphetamine and pharmaceutical stimulant use in the past six months, 2003–2013**



Source: IDRS PWID interviews

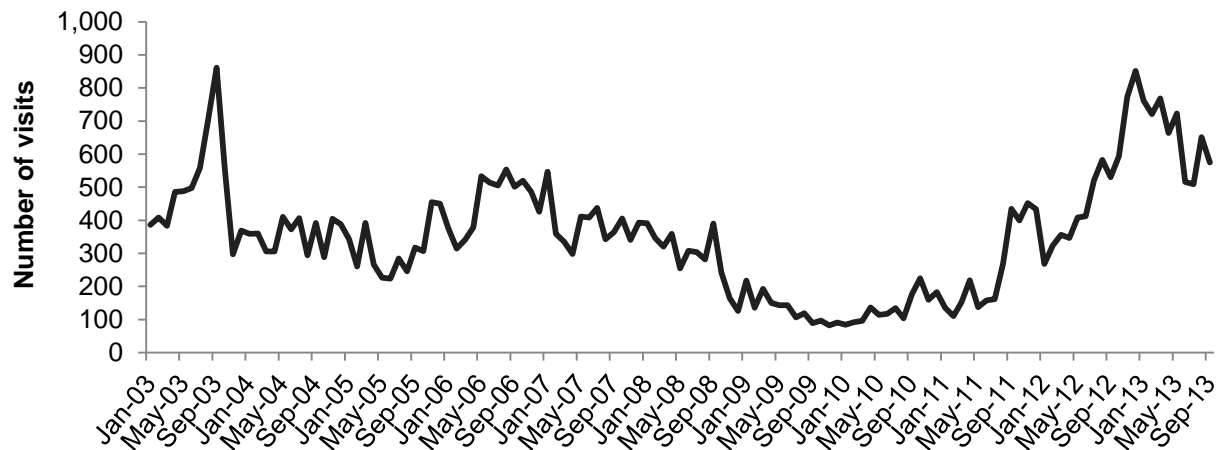
NB: Pharmaceutical stimulants also include prescribed use

Figure 10 shows the number of attendances to the Sydney Medically Supervised Injecting Centre (MSIC) where methamphetamine was the drug injected.<sup>5</sup> Numbers reporting methamphetamine have steadily increased over the past few years from 176 in September 2010 to 575 in September 2013. These attendances peaked in December 2012 at 852, representing approximately 14% of all injecting episodes.

<sup>5</sup> The following caveats need to be considered when interpreting these data: 1) hours of operation changed over the first two years of operation (from four to up to 12 per day); and 2) the numbers of individuals attending increased continuously over the first two years of operation as PWID became aware of this new service.



**Figure 10: Number of attendances to Sydney MSIC where methamphetamine was injected, January 2003–September 2013**



Source: Sydney MSIC, Kings Cross

#### 4.3.2 Current patterns of methamphetamine use

The proportion (75%; 72% in 2012) of participants reporting any recent methamphetamine use (speed, base, ice/crystal) remained stable in 2013. Among those reporting any recent use (speed, base, ice, liquid) the median number of days of use was 18 days, a decrease from 24 days (approximately weekly use) in 2012. The majority of users had used each form weekly or less over the six months preceding interview, followed by more than weekly, but less than daily (Table 5 and Figure 11).

The use of any pharmaceutical stimulants (prescribed and non-prescribed) continues to remain very low (5%; 5% in 2012) among this sample of PWID, and changes in patterns of use should be interpreted with caution. The median number of days of any recent pharmaceutical stimulant use decreased to 6 days (monthly use; 12 days in 2012). Illicitly obtained pharmaceutical stimulants were used on a median of 6 days in the past 6 months (18 days in 2012). Only 1% of participants (1% in 2012) had recently used pharmaceutical stimulants that were prescribed to them.

**Table 5: Patterns of methamphetamine use in the last six months, by type, 2013**

Form used	Among the entire sample		Among those who had used		
	% who had <u>not</u> used in the last 6 months	% who had used	% used weekly or less <sup>^</sup>	% used more than weekly, but less than daily	% used daily
Speed powder	86 [83]	14 [17]	71 [81]	14 [19]	2 [0]
Base	88 [85]	12 [15]	89 [86]	11 [14]	0 [0]
Ice/crystal	27 [32]	73 [68]	58 [57]	34 [38]	8 [9]
Any form of methamphetamine*	25 [28]	75 [72]	42 [53]	26 [39]	7 [8]

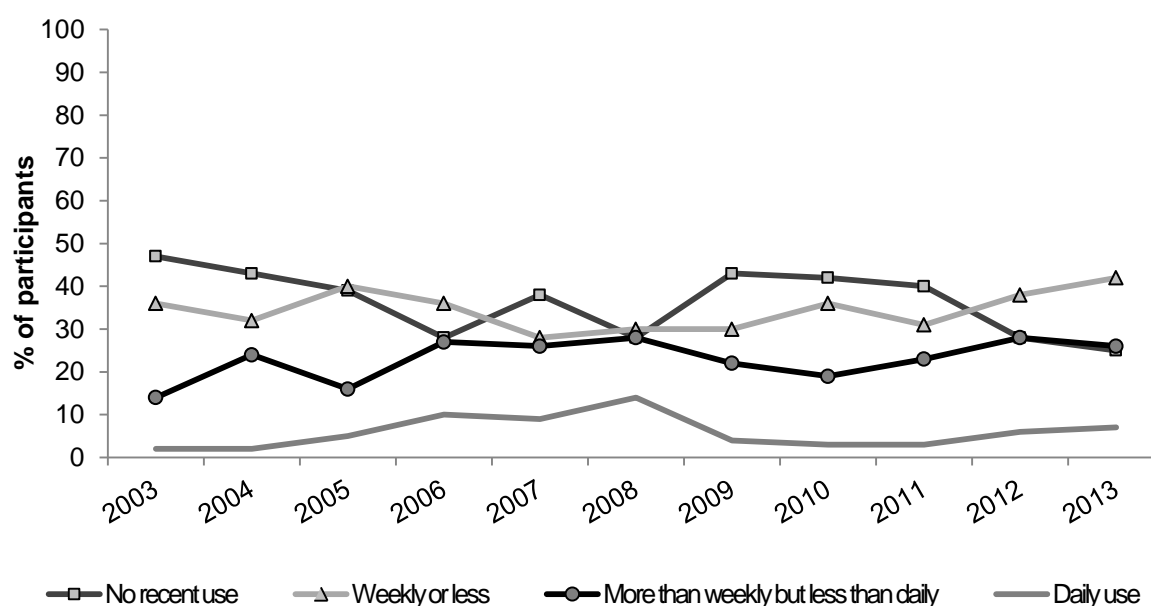
Source: IDRS PWID interviews

\* Also includes liquid methamphetamine

<sup>^</sup> Excludes those who had not used

[ ] Indicates % used in previous year

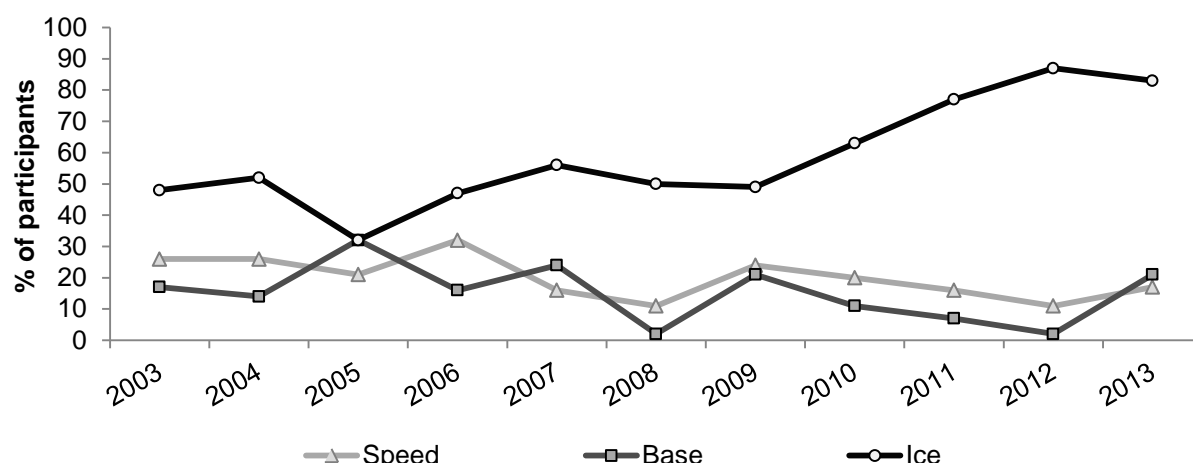
**Figure 11: Patterns of methamphetamine use (any form) by PWID participants, 2003–2013**



Source: IDRS PWID interviews

As in previous years, participants who had used methamphetamine were also asked which form they had used most often in the six months preceding interview. Ninety-six percent of recent users (72% of entire sample) nominated ice/crystal (87% in 2012), 2% nominated speed powder (11% in 2012) and 2% nominated base (2% in 2012) (Figure 12; Table 5).

**Figure 12: Methamphetamine form most used in the preceding six months, among recent methamphetamine users, 2003–2013**



Source: IDRS PWID interviews

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

## 4.4 Cocaine

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

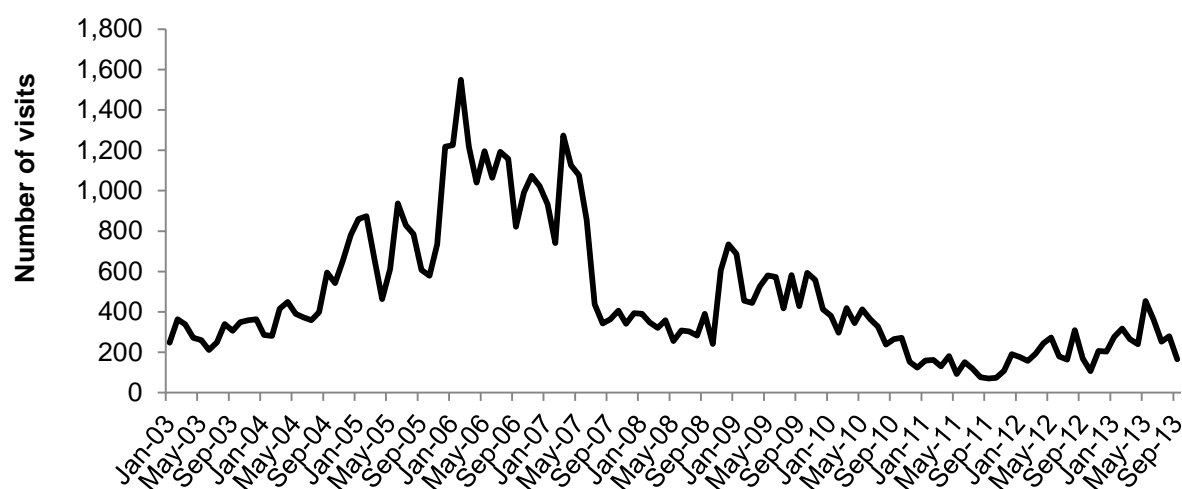
### 4.4.1 Cocaine use among PWID participants

Forty-one percent of PWID participants in 2013 reported cocaine use in the preceding six months, consistent with 2012 numbers (44%). Only 5 percent (10% in 2012) of the sample reported use of cocaine on the day prior to interview. Seven percent reported cocaine as the drug last injected (5% in 2012).

Figure 13 shows the number of attendances to the Sydney MSIC where cocaine was the drug injected.<sup>6</sup> There have been several marked peaks in these attendances during the past 12 years: December 2001 (2,010 attendances), February 2006 (1,549) and March 2007 (1,273). Since late 2011, despite some fluctuations, cocaine injecting at the MSIC has remained relatively low to September 2013, and for the majority of this period, these attendances have accounted for less than 5% of the total of injecting episodes.

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

**Figure 13: Number of attendances to Sydney MSIC where cocaine was injected, January 2003–September 2013**

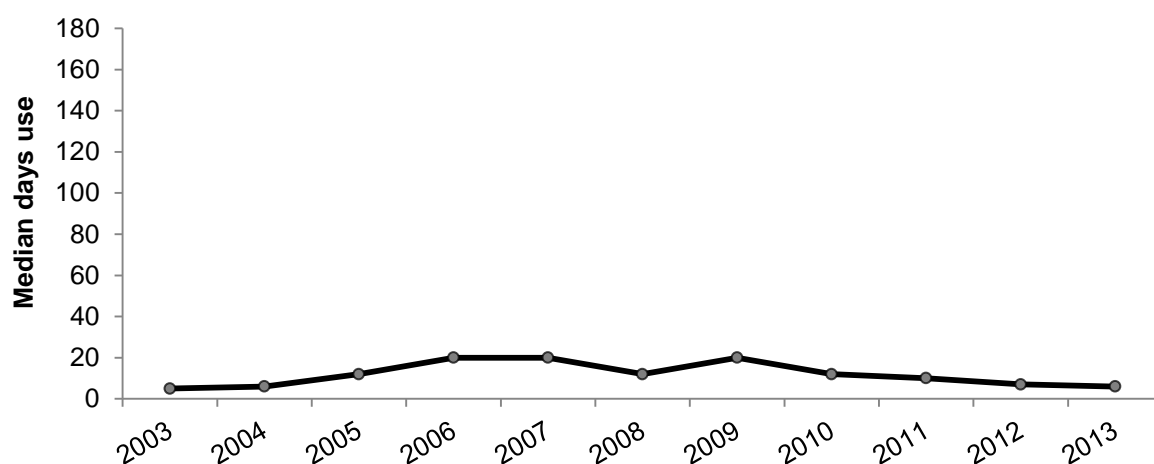


Source: Sydney MSIC, Kings Cross

#### 4.4.2 Current patterns of cocaine use

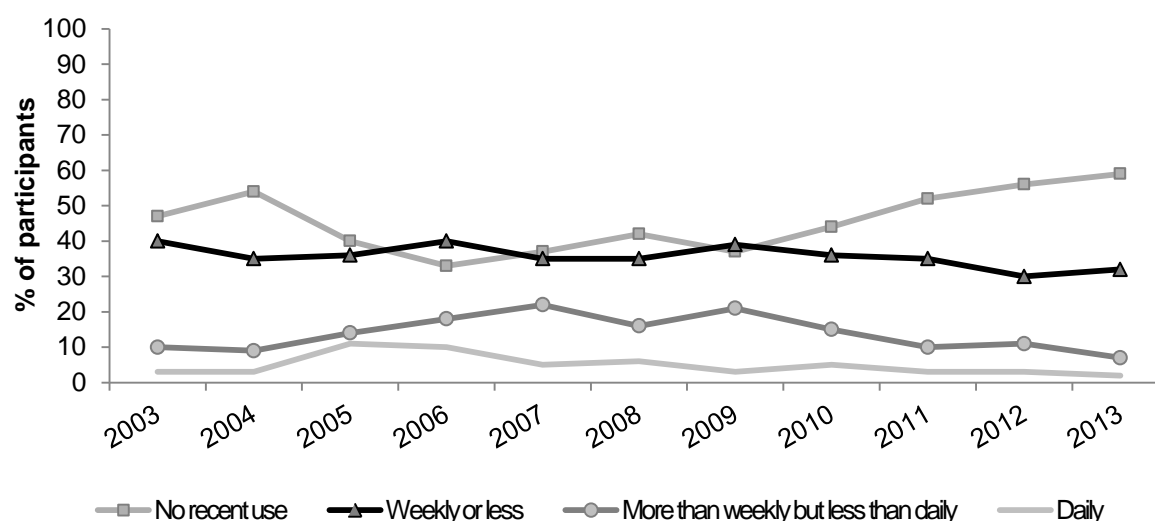
Frequency of cocaine use among PWID participants in the last six months remained stable in 2012. Cocaine was used on a median of 6 days (monthly) in 2013 (7 days in 2012) (Figure 14). Daily cocaine use remained stable with 5% (5% in 2012) of recent users (2% of all participants) reporting daily use (Figure 15).

**Figure 14: Median days of cocaine use in the past six months, 2003–2013**



Source: IDRS PWID interviews

**Figure 15: Patterns of cocaine use, 2003–2013**



Source: IDRS PWID interviews

Participants were also asked which form of cocaine they had used most often over the last six months. Seventy-four percent of participants who had recently used cocaine reported that powder was the form they had used most often in the last six months, which is stable from 2012 (79%). Twenty-three percent of recent users reported rock cocaine as the form most used (21% in 2012), and there were only two participants reporting using crack cocaine (3%) as the form most used. Seven percent of recent users (8% in 2012) reported having used any crack cocaine in the six months preceding interview. No KE reported hearing about the use of crack cocaine, indicating that, similar to previous years, its use remained rare.

## 4.5 Cannabis

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

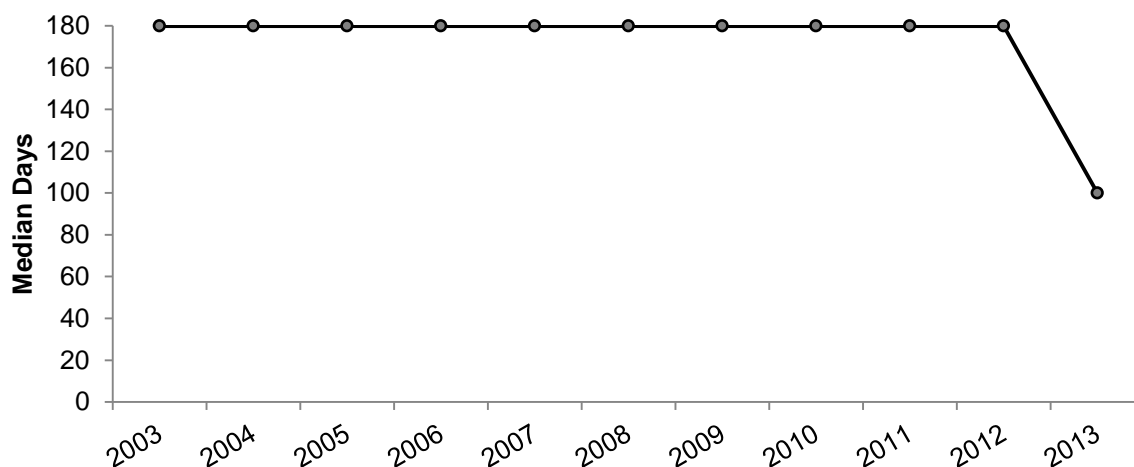
### 4.5.1 Cannabis use among PWID participants

Recent use of cannabis continued to remain high among participants in 2013. Eighty percent of participants reported recent use of cannabis (72% in 2012 and 81% in 2011) and the proportion reporting cannabis use on the day prior to interview remained stable in 2013, at 42% (42% in 2012).

### 4.5.2 Current patterns of cannabis use

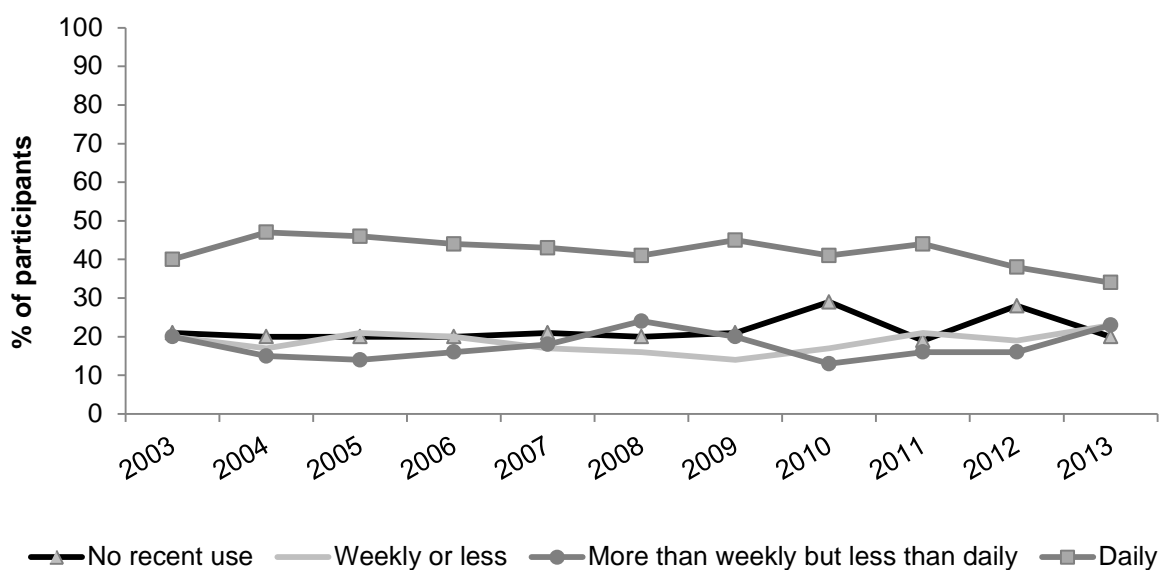
The median number of days of cannabis use, among those who used, was 100 days in the preceding six months. This is a decrease on those participants that had been using cannabis on a median of 180 days; a figure which had previously been stable for the past 10 years (Figure 16). The proportion of recent consumers of cannabis reporting daily use of cannabis remained stable in 2013 (42%; 34% of entire sample). Participants who had smoked cannabis in the last six months were asked about the quantity used and methods of cannabis use on the last occasion.

**Figure 16: Median number of days of cannabis use among those who had used cannabis in the past six months, 2003–2013**



Source: IDRS PWID interviews

**Figure 17: Patterns of cannabis use, 2003–2013**



Source: IDRS PWID interviews

Ninety-two percent of respondents who had used cannabis reported using hydro in the preceding six months (95% in 2012), and 39% of cannabis users reported using bush during this time (42% in 2012). Seven percent of recent cannabis users reported use of hashish (5% in 2012) and only 3% of participants (3% in 2012) had used hash oil. When asked which form of cannabis they had ‘used most often’ in the last six months, the vast majority (92%) of recent users reported hydro, 8% reported bush and no participants reported hash oil. These rates remain stable with 2012.

## 4.6 Pharmaceutical opioids

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

While the majority (58%) of those sampled in 2013 were engaged in OST at the time of interview, responses presented are not representative of all clients engaged in drug treatment services.

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

**Table 6: Definitions used when discussing opioid use**

<b>Pharmaceutical opioids (including OST)</b>
Use of these substances is broadly split into the following categories (Black et al., 2008). <ol style="list-style-type: none"><li>1. Use of licitly obtained opioids, i.e. use of opioids obtained by a prescription in the user's name, through any route of administration.</li><li>2. Use of illicitly obtained opioids, i.e. those obtained from a prescription in someone else's name, through any route of administration ('illicit use').</li><li>3. Use of any opioids, i.e. does not distinguish between licit and illicit methods of obtainment.</li></ol> <b>Injection</b> <ol style="list-style-type: none"><li>1. Injection of licitly obtained opioids.</li><li>2. Injection of illicitly obtained opioids.</li><li>3. Injection of any opioids.</li></ol>

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

### 4.6.1 Methadone

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

As in previous years, detailed data were collected in 2013 regarding the purchase, frequency of use and injection of illicit methadone syrup and Physeptone tablets. This was to provide further clarification regarding the use of methadone prescribed for treatment and the diversion of prescribed methadone. Information on prescribed (licit) methadone may be found in section 6.3.

Just over one-quarter (28%) of all participants reported using non-prescribed methadone in the six months preceding interview (25% in 2012). The frequency of use among recent users was a median of 5 days (4 days in 2012). In 2013 participants were asked, 'What were the main reasons you used illicit methadone in the last 6 months?' Of those that could comment, 33% reported that it was used 'as a substitute for heroin', 17% reported that it was for 'self-treatment', and 11% reported missing their regular dose.

Twenty-three percent of participants reported injecting illicitly obtained methadone in the preceding six months on a median of 5 days (i.e. approximately once a month), which was comparable to 2012 (15% of participants on a median of 4 days). Thirty-one percent of all participants reported injection of any form of methadone (i.e. syrup or Physeptone tablets; prescribed or non-prescribed) on a median of 6 days

Non-prescribed methadone liquid was the form of methadone used most by 20% of those who reported methadone use. Use of non-prescribed Physeptone remained uncommon, with only 2% of participants reporting use in the preceding six months (3% in 2012) and only 1% reported injecting Physeptone in the 6 months prior to interview.

#### **4.6.2 Buprenorphine**

Eleven percent of all participants (13% in 2012) reported the use of non-prescribed buprenorphine in the preceding six months. The frequency of use in 2013 remained stable with use occurring on a median of two days (four in 2012). Those reporting non-prescribed buprenorphine injection remained stable (9%; 11% in 2012) on a median of 10 days, an increase on the three days reported in 2012.

Nine percent of participants reported injecting any form of buprenorphine (excluding buprenorphine-naloxone) in the preceding six months (13% in 2012) on a median of 15 days (4 days in 2012); however, this was not a statistically significant increase. No participants reported any injection-related problem ('dirty hit') or overdose associated with buprenorphine. The prevalence and frequency of buprenorphine injection remained comparable with 2012.

#### **4.6.3 Buprenorphine-naloxone (Suboxone)**

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

Of the NSW sample, 7% reported recently using any form of buprenorphine-naloxone 'tablet' (licit use 3% and illicit use 5%) on a median of 4 days (approx. once a week), while 15% of the sample reported recently using any form of buprenorphine-naloxone 'film' (licit use 11% and illicit use 6%) on a median of 33 days in the last six months. Injecting either the buprenorphine-naloxone 'tablet' or 'film' was low (1% tablet and 3% film).



#### 4.6.4 Morphine

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

In January 2006, changes were made to the legislation governing the prescription of morphine and a number of other opioids such as oxycodone (Pharmaceutical Services Branch, NSW Health, personal communication, January 2007). Previously, doctors could prescribe such drugs for up to two months, after which time they were required to obtain an authority to continue. Following the amendment, the two month requirement was removed with the exception of people determined to be drug dependent<sup>7</sup> where the requirement still remained.

##### 4.6.4.1 Use patterns

Since 2006, a distinction has been drawn between the use of morphine obtained via prescription and the use of non-prescribed morphine (Table 4). Nineteen percent (21% in 2012) reported use of non-prescribed morphine on a median of 6 days (10 days in 2012). Almost one-fifth (18%) of participants reported the recent injection of non-prescribed morphine on a median of 6 days (19% on a median of 10 days in 2012). In 2013 participants were asked 'What were your main motivations for non-prescribed morphine use?' Twenty-eight percent of recent users reported 'a substitution for heroin', 25% reported 'self-treatment', and 22% reported 'intoxication'.

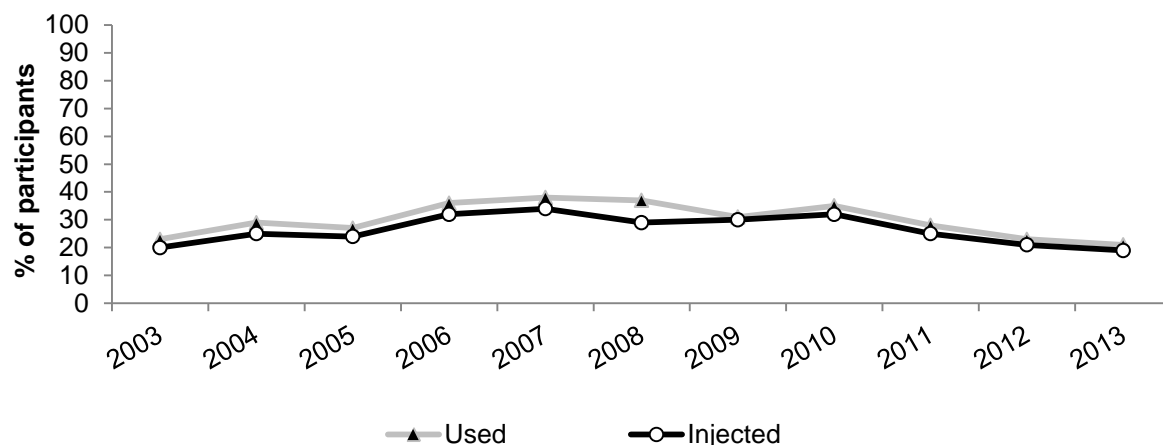
The use of prescribed morphine was noticeably less prevalent (3% had recently used it; 3% had injected it in the same period) which remained comparable with 2012 (6% recently used; 5% recently injected). Frequency of use was stable at a median of 6 days in the last six months (6 days in 2012). Frequency of injection was also reported on a median of 6 days in the six months preceding interview (4 days in 2012).

To enable comparison with previous years, the following information refers to 'any' form of morphine, i.e. no distinction has been made between prescribed and non-prescribed morphine. In 2013, approximately one-quarter (21%; 23% in 2012) of participants reported using any morphine in the preceding six months on a median of 6 days (10 days in 2012). In terms of injection 19% (21% in 2012) reported injection of any morphine on a median of 6 days (10 days in 2012) in this time (Figure 18).

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<sup>7</sup> 'Drug dependent' is defined as 'a person who has acquired, as a result of repeated administration: (a) a drug of addiction, or (b) a prohibited drug within the meaning of the *Drug Misuse and Trafficking Act 1985*, an overpowering desire for the continued administration of such a drug'. See the *Poisons and Therapeutic Goods Act 1966 No 31* for details.

**Figure 18: Proportion of PWID reporting morphine use and injection in the past six months 2003–2013**



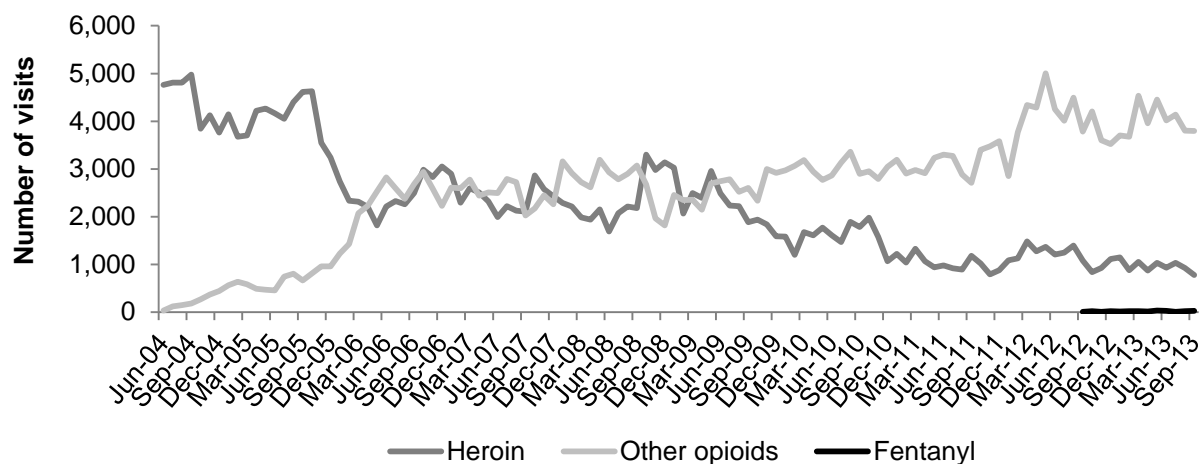
Source: IDRS PWID interviews

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

Three percent of recent users reported daily morphine use, with the majority (80%; 16% of entire sample) reporting using weekly or less often. No participants reported experiencing problems that they attributed to morphine injection in the past month, either in the form of a 'dirty hit' or an overdose.

The number of visits to Sydney MSIC where other opioids, including morphine and oxycodone, were injected is presented in Figure 19. The number of attendances where other opioids were injected has increased since 2004, and, for the first time in May and June of 2006, other opioids accounted for a greater proportion of injections than heroin. Since May 2009 other opioids have again surpassed heroin, and account for the greatest proportion of total injections at the MSIC.

**Figure 19: Number of attendances to Sydney MSIC where other opioids (including morphine)\* and heroin were injected, June 2004–September 2013**

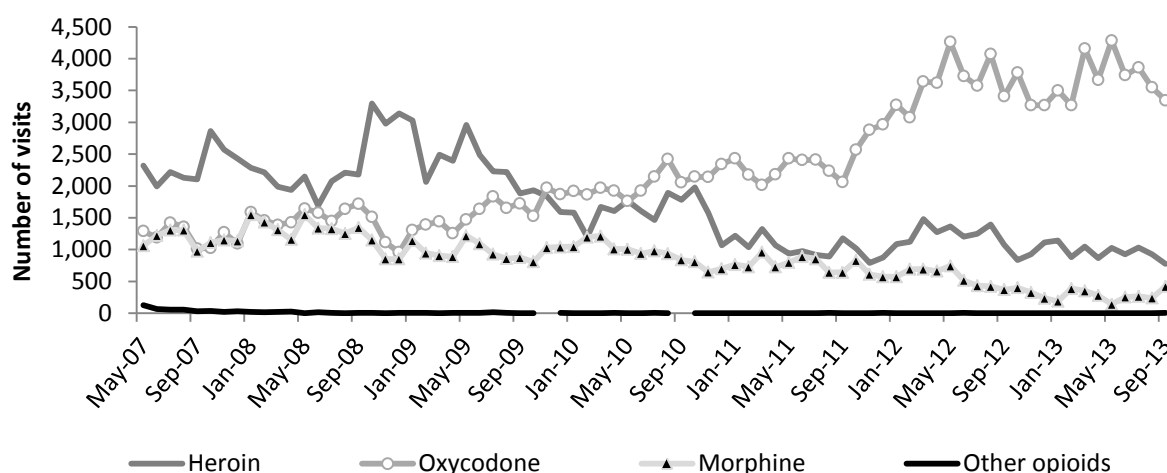


Source: Sydney MSIC, Kings Cross

\* Excludes heroin, methadone, buprenorphine, buprenorphine-naloxone and includes morphine and oxycodone.

Since January 2008 oxycodone has been the most prevalent pharmaceutical opioid injected in attendances to the Sydney MSIC. In the 12 months to September 2013, attendances for oxycodone injection at the Sydney MSIC continued to increase and oxycodone continued to be the most common opioid injected. Attendances for heroin injection at MSIC were characterised by a downward trend over the same period (Figure 20).

**Figure 20: Number of attendances to Sydney MSIC where morphine, oxycodone and other opioids were injected, May 2007–September 2013**



Source: Sydney MSIC, Kings Cross

## 4.6.6 Oxycodone

For information on changes to oxycodone prescribing legislation that became effective from January 2006, please see section 5.7 'Morphine'.

### 4.6.6.1 Use patterns

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

Sixty-six percent of all participants reported having used oxycodone (whether obtained via prescription or other methods) at some stage in their lifetime, and 52% reported having ever injected it (Table 4). Forty-three percent of all participants reported using any (prescribed or non-prescribed) oxycodone in the six months preceding interview on a median of twenty-three days (around weekly use). The recent injection of any oxycodone decreased slightly in 2013 (37% versus 42% in 2012); however, this decrease was not statistically significant.

With regard to non-prescribed oxycodone use, 40% (46% in 2012) of participants reported use in the preceding six months, on a median of 23 days (10 days in 2012). Twenty-one percent (9% of entire sample) of participants reporting recent illicit use were daily users (180 days). Just over half (53%; 22% of entire sample) of people reporting use in the last 6 months were using weekly or less often. Injection of non-prescribed oxycodone in the last six months was reported by 36% of the sample on a median of 30 days (40% on a median of 20 days in 2012). Overall, these figures suggest that the frequency of non-prescribed oxycodone use has increased in 2013. This finding is consistent with many key expert testimonials who explain that oxycodone use, and especially injection, is on the rise in Sydney.

In response to the question 'What were your main motivations for non-prescribed oxycodone use?', 48% reported substitution for heroin and/or other opioids, 27% of recent users reported self-treatment and 12% reported intoxication as the main motivation.

With regard to prescribed oxycodone, 9% of participants reported use in the preceding six months, on a median of 31 days (11%; 7 days in 2012). Injection of prescribed oxycodone in the last six months was reported by 7% of the sample on a median of 31 days (9%; 25 days in 2012). These reports suggested that use of prescribed oxycodone had remained stable, while the frequency of injection had decreased.

Of those reporting any recent oxycodone use, the vast majority (86%; 81% in 2012) mostly used non-prescribed oxycodone rather than prescribed oxycodone. The most common brand used among those who recently used oxycodone was OxyContin (89%, 38% of entire sample). There were only three participants reporting Endone and two participants generic oxycodone as the brand most commonly used.

#### **4.6.7 Fentanyl**

In 2013, 15% of the NSW sample reported using fentanyl in their lifetime. Nine percent reported using fentanyl on a median of 6 days in the last six months. Fentanyl was injected by 9% of the sample on a median of 6 days in the last six months. Among those who recently used fentanyl the form most used was illicit (93%; 7% licit).

#### **4.7 Over the counter codeine**

Again in 2013, the IDRS survey included questions on the use of over the counter (OTC) codeine. Just under a third (30%) of participants reported that they had ever used OTC codeine. Thirteen percent of all participants reported that they had used OTC codeine in the six months prior to interview on a median of 24 days. Only one participant reported a recent OTC codeine injection. The brands most commonly reported as being used were Nurofen Plus (33%), Mersyndol (17%) and Fiorinal (11%).

#### **4.8 Other opioids**

Around one-third (30%) of participants reported that they had ever used opioids other than those listed above at least once in their lifetime, and 2% had ever injected them. In the six months prior to interview, 14% of participants reported the use of other opioids on a median of 6 days. Comparisons with data prior to 2009 should be interpreted with caution as OTC codeine was not included in its own section until 2009; rather, it was under the category of other opioids. It should be also noted that 'other opioids' does not include homebake.

#### **4.9 Other drugs**

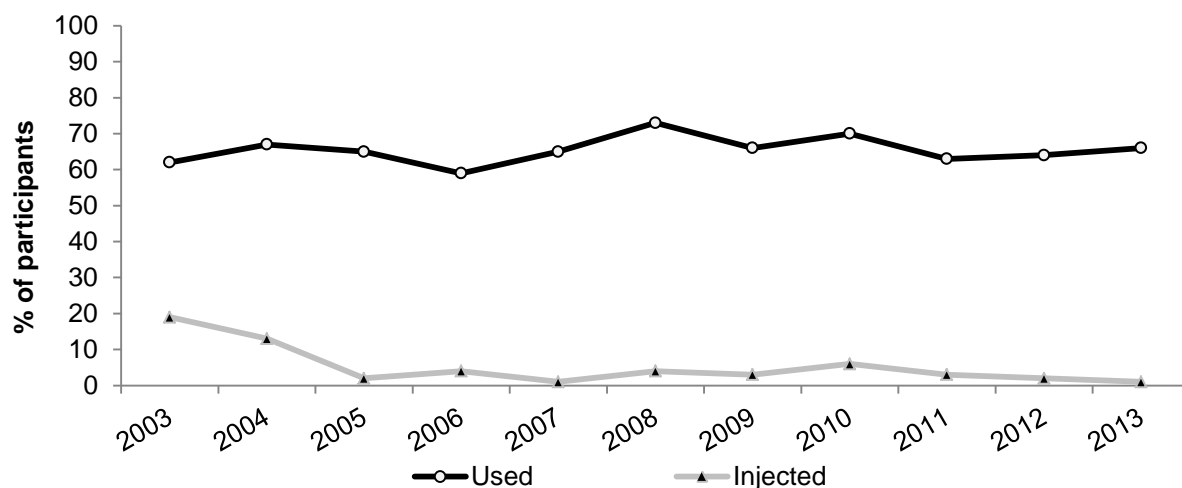
##### **4.9.1 Benzodiazepines**

Eighty-two percent of the NSW sample had reported the use of any benzodiazepines at some stage in their lifetime. Sixty-six percent (64% in 2012) reported the recent use of any benzodiazepines on a median of 30 days in the last six months (67.5 days in 2012) (Figure 21 and Figure 22). Among those who recently used any benzodiazepines, 12% reported using them daily in the last six months.

Only small numbers reported recently injecting any benzodiazepines (1%) on a median of 30 days in the last six months (Figure 21 and Figure 22).

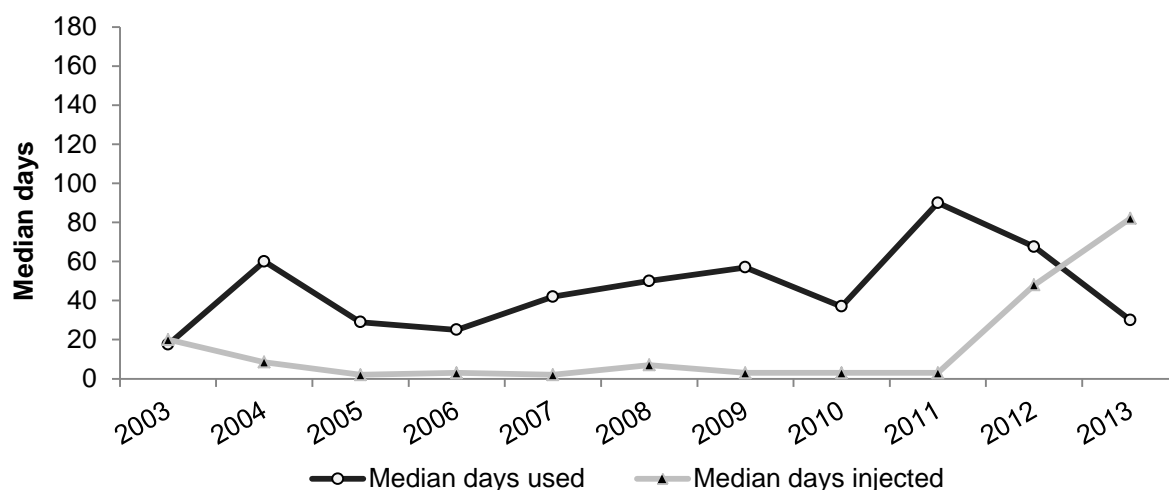
Since 2012 participants have been asked separately about the use of alprazolam and other benzodiazepines use (please see below).

**Figure 21: Proportion of PWID participants reporting (prescribed and non-prescribed) benzodiazepine use and injection in the preceding six months, 2003–2013**



Source: IDRS PWID interviews

**Figure 22: Median days use and injection of (prescribed and non-prescribed) benzodiazepines in the past six months, 2003–2013**



Source: IDRS PWID interviews

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

#### 4.9.1.1 Alprazolam

Sixty-eight percent of the NSW sample reported using some form of alprazolam in their lifetime (23% licit and 63% illicit). Half (51%) reported recently using any form of alprazolam on a median of 20 days in the last six months. Twelve percent had recently used 'licit' alprazolam on a median of 60 days (170 days in 2012) while 47% had recently used 'illicit' alprazolam on a median of 12 days (Table 7).

Smaller proportions of participants reported injecting alprazolam at some stage in their life (1% licit, 2% illicit), with 1% injecting any form of alprazolam (also all illicit) in the last six months.

**Table 7: Alprazolam use patterns, 2013**

	NSW (N=151)
<b>Recent use (%)</b>	
Licit	12
Illicit	47
Any form (licit and/or illicit)	51
<b>Median days used *</b>	
Licit	60
Illicit	12

Source: IDRS PWID interviews

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

#### 4.9.1.2 Other benzodiazepines

Seventy-two percent of the NSW sample had used any form of other benzodiazepines not including alprazolam in their lifetime (50% licit and 55% illicit). Half of the participants (50%) recently used any form of other benzodiazepines (Table 8). Twenty-nine percent of the NSW sample reported having used 'licitly' obtained other benzodiazepines on a median of 49 days in the last six months, whereas 33% percent reported using 'illicitly' obtained other benzodiazepines on a median of 10 days in the six months preceding interview (Table 8). No respondents reported recently injecting other benzodiazepines (any form – excludes alprazolam) in the last six months.

**Table 8: Other benzodiazepine (excludes alprazolam) use patterns, 2013**

	<b>NSW (N=151)</b>
<b>Recent use (%)</b>	
Licit	29
Illicit	33
Any form (licit and/or illicit)	50
<b>Median days used *</b>	
Licit	49
Illicit	10

Source: IDRS participant interviews

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

Excluding alprazolam, the most commonly used brand of benzodiazepine was diazepam (70%; including Valium, Valpam and Antenex), followed by oxazepam (12%; Serepax), and clonazepam (9%; Rivotril). Twenty-three percent of all participants reported benzodiazepine use on the day prior to interview (30% in 2012).

In previous years, there had been concern relating to the injection of, and injection-related problems associated with, benzodiazepines, particularly temazepam gelatine capsules (Euhypnos, Nocturne, Normison and Temaze). These gel cap formulations were restricted on 1 May 2002, and subsequently removed completely from the pharmaceutical market at the end of March 2004. In 2013, the prevalence of benzodiazepine injection was comparable with recent years (1% in 2013; 1% in 2012; 3% in 2011; 6% in 2010; 3% in 2009). Overall, the prevalence of benzodiazepine injection and the frequency of injection has remained stable over the past few years.

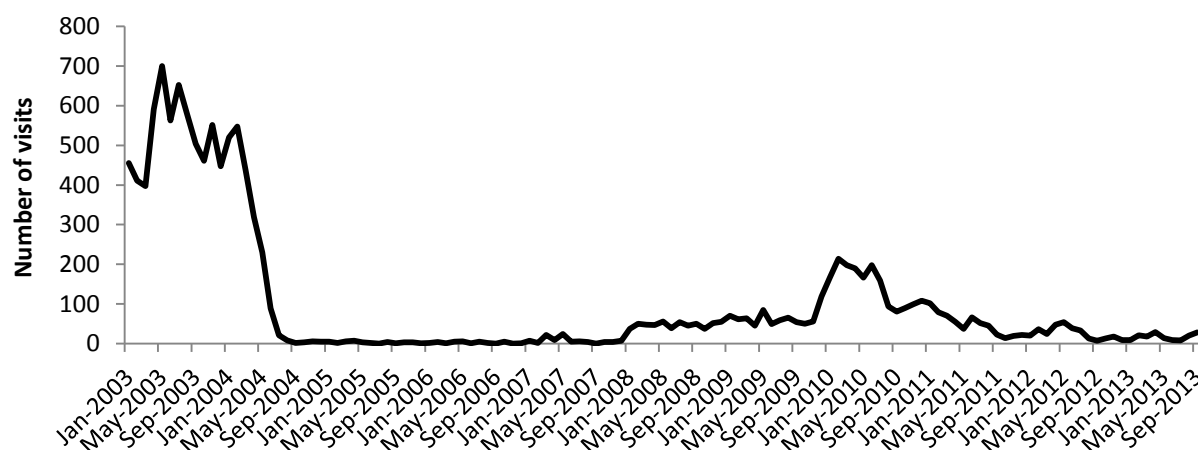
#### 4.9.1.3 MSIC data

Data from the Sydney MSIC show that the number of clients who injected benzodiazepines fell dramatically with the withdrawal of temazepam capsules from the Australian pharmaceutical market at the end of March 2004.<sup>8</sup> In January 2010, benzodiazepine injections increased sharply for several months. Over the past 12 months to September 2013, attendances for benzodiazepine injection have remained very low.

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<sup>8</sup> The following caveats need to be considered when interpreting these data: 1) hours of operation changed over the first two years of operation (from four to up to 12 per day); and 2) the numbers of individuals attending increased continuously over the first two years of operation as PWID became aware of this new service

**Figure 23: Number of attendances to Sydney MSIC where benzodiazepines were injected, January 2003–September 2013**



Source: Sydney MSIC, Kings Cross

For further discussion of benzodiazepine injection and related problems in Australia, including those associated with temazepam capsules, see Breen et al. (2003) and Wilce (2004).

#### 4.9.2 Seroquel® (quetiapine)

Since 2011, participants have been asked about the use of Seroquel® (quetiapine). Of the NSW sample, 56% reported a lifetime use of Seroquel® (27% licit, 36% illicit). Twenty-one percent of the sample had used Seroquel® in the last six months (12% licit, 10% illicit). 'Licit' Seroquel® had been used on a median of 120 days compared to three days for 'illicit' Seroquel®. Two percent of all participants reported injecting any form of Seroquel® in the last six months.

#### 4.9.3 Hallucinogens

Approximately half (53%, 50% in 2012) of PWID participants reported having used hallucinogens at some stage in their lifetime with four participants reporting recent use (Table 4). Six percent of the sample had injected hallucinogens at some stage in the past (5% in 2012) and one participant reported having injected them in the last six months. These figures, overall, represented stability in the use of hallucinogens when compared with 2012.

#### 4.9.4 Ecstasy

Ecstasy use within this sample of participants in NSW continued to remain at relatively low levels. More than half (55%) of participants reported use of ecstasy in their lifetime, and 7% reported having used it within the six months prior to interview (7% in 2012). Thirteen percent of participants had reported ever injecting ecstasy, though only 1 participant (1 in 2012) reported having injected ecstasy in the six months preceding interview on a median of 2 days.

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



#### **4.9.5 Steroids**

Seven percent of the NSW sample reported ever using steroids. Four participants reported use in the six months preceding interview on a median of 7 days. Three participants reported recently injecting steroids (note: small numbers commenting, interpret with caution).

#### **4.9.6 New psychoactive substances**

Three percent of participants reported ever using new psychoactive substances (NPS) such as synthetic cathinones (e.g. mephedrone), tryptamines (e.g. dimethyltryptamine [DMT]) and phenethylamines (e.g. 2C-x class). Two participants reported use in the six months preceding interview on a median of 4 days. Two participants reported recently injecting NPS.

#### **4.9.7 Synthetic cannabinoids**

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

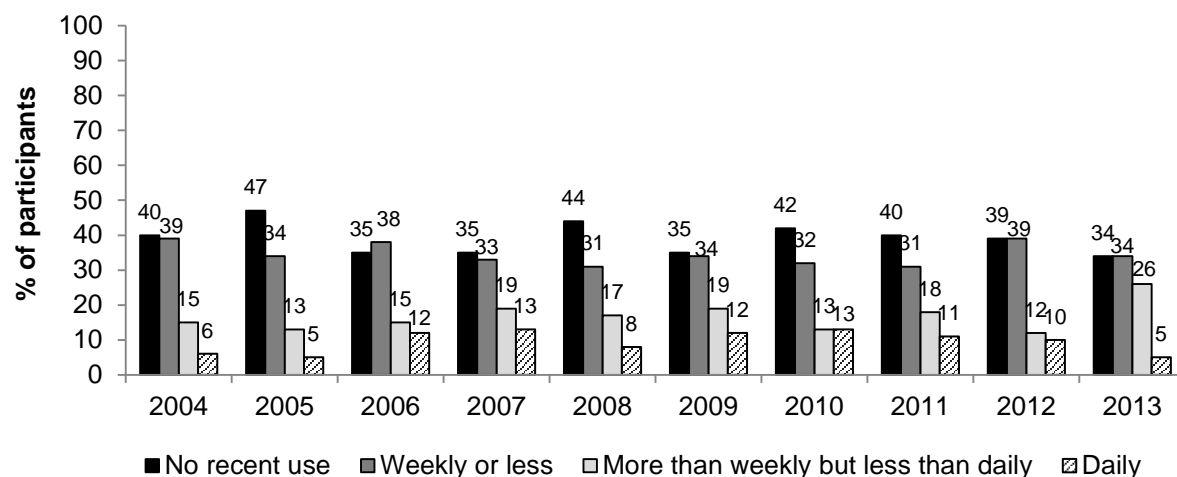
#### **4.9.8 Inhalants**

Twenty percent of participants (21% in 2012) reported ever having inhaled volatile substances such as amyl nitrite, petrol, glue and/or lighter fluid (butane) (Table 4). Recent use (3%) remained low and stable as did the frequency of use (2 days). The main form of inhalant reported being recently used by participants was amyl nitrite. There were no KE reports regarding use of inhalants.

#### **4.9.9 Alcohol**

Two-thirds (66%) of the participants in the sample had consumed alcohol in the six months prior to interview on a median of 24 days (i.e. once per week; range 1–180). The recent use of alcohol remained stable and the frequency of use increased (61% and 12 days in 2012). Five percent of all participants reported daily use of alcohol. Thirty-five percent of all participants (39% in 2012) drank weekly or less often (Figure 24). Overall, these figures were generally consistent with levels reported over the last 3 years. Rates of daily use in the entire sample (5%) were comparable with the general population aged 14 and over (7%), while rates of drinking weekly were lower than the general population (39% general population versus 34% of the NSW IDRS sample) (Australian Institute of Health and Welfare, 2011).

**Figure 24: Patterns of alcohol use, 2004–2013**

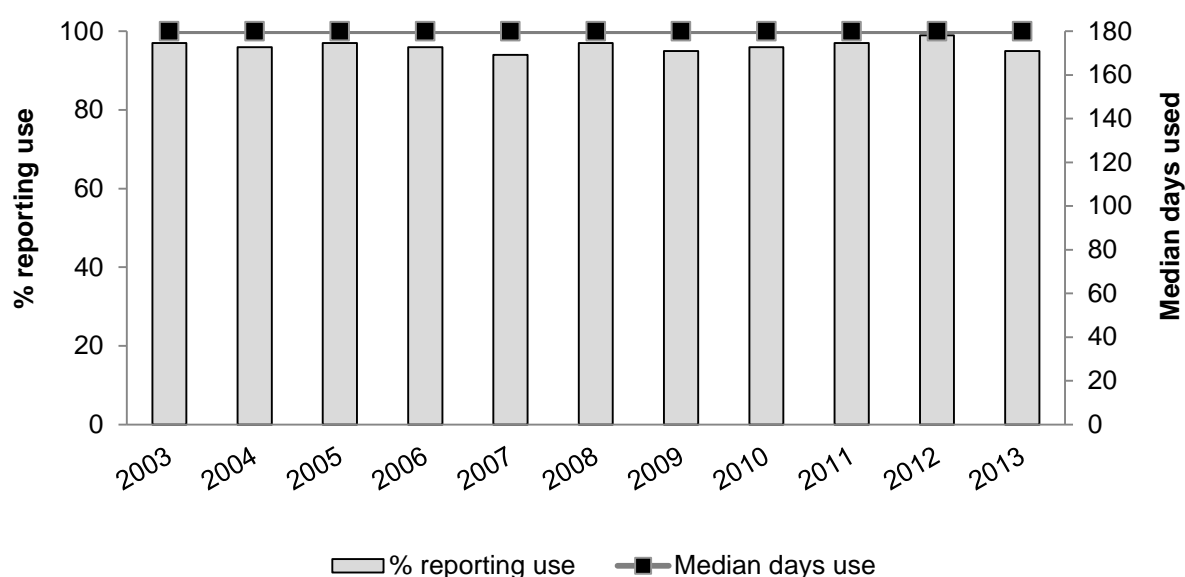


Source: IDRS PWID interviews

#### 4.9.10 Tobacco

Tobacco continued to remain the most commonly used substance investigated by the IDRS. The vast majority of participants (95%) reported smoking tobacco in the last six months on a median of 180 days (Table 4), i.e. daily use (range 1–180). Ninety percent of those who had smoked tobacco in the preceding six months were daily smokers. High prevalence and frequency of tobacco use has been reported since 1996 (Figure 25). This figure continues to be substantially higher than among the general Australian population (15% of whom are daily smokers), and, contrary to trends noted in the general population, the prevalence of smoking among IDRS is not declining over time (Australian Institute of Health and Welfare, 2011). The use of tobacco is the single most preventable cause of morbidity and mortality in Australia (Begg et al., 2007). Given the prevalence of smoking among the IDRS sample and that they are continuing to age over time (Figure 1), this is of particular concern.

**Figure 25: Participant reports of tobacco use in the last six months, 2003–2013**



Source: IDRS PWID interviews

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

### 5.1 Heroin

When asked to comment on the price, purity and/or availability of heroin, 85% of the PWID sample felt confident to answer at least some of these survey items. The remaining 15% did not feel confident to answer any questions on the heroin market, and this is likely to reflect a proportion of people who inject drugs but do not use heroin, or come into contact with users or dealers of heroin, regularly enough to be able to comment. Use of homebake heroin (a form of heroin made from pharmaceutical products, involving the extraction of diamorphine from pharmaceutical opioids such as codeine or morphine) is also discussed within this section; however, as its use remained uncommon, detailed market characteristics have not been obtained.

#### 5.1.1 Heroin price

The prices participants paid for heroin on the last occasion of purchase are shown in Table 9. Again in 2013, the median price reported for a cap of heroin remained unchanged at \$50 and has remained unchanged since 2002. A gram of heroin remained stable at \$350 (Table 9). These prices continue to remain substantially higher than prices reported in 2000 (\$220 per gram; \$25 per cap), prior to the reported heroin shortage in 2001 (Figure 26).

Thirty participants (20% of entire sample) reported buying heroin in points, an amount more commonly used in previous years to refer to purchase amounts of methamphetamine and cocaine. A 'point' traditionally referred to 0.1 gram, although anecdotal evidence suggests that, similar to a 'cap' or a 'deal', the term may be used to refer to a quantity used for one injection rather than as a description of the weight.

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

**Table 9: Price of most recent heroin purchases by PWID participants, 2012–2013**

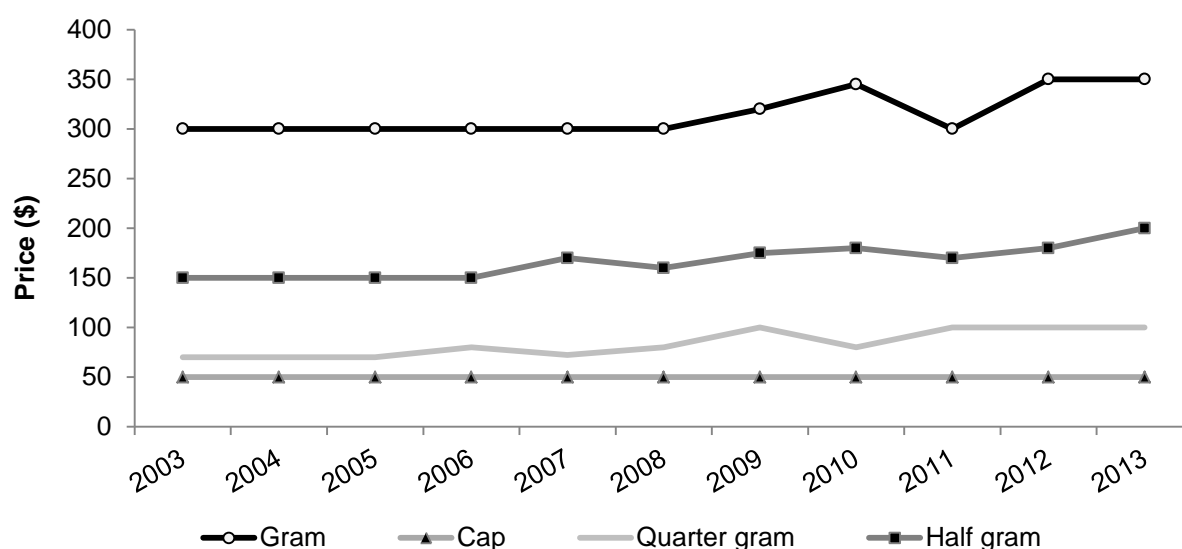
Amount	Median price* \$	Range \$	Number of purchasers*
Cap	50 (50)	40–100	102 (77)
Quarter gram	100 (100)	50–150	24 (21)
Half gram ('halfweight')	200 (180)	20–450	50 (37)
Gram	350 (350)	50–800	40 (21)

Source: IDRS PWID interviews

\* 2012 data are presented in brackets

Heroin prices have remained relatively stable since 2003 (Figure 26); however, it should be noted that participants and KE sometimes reported that the amount of a drug bought within a purchase amount (e.g. as a 'cap' or a 'fifty-dollar deal') had fluctuated or decreased over the past few years.

**Figure 26: Median prices of heroin estimated from PWID purchases, 2003–2013**



Source: IDRS PWID interviews

NB: Survey items relating to quarter and half grams were first included in 1998

In addition to survey items on last purchase price, participants were also asked whether they thought the price of heroin had changed over the last six months ('don't know', 'increasing', 'stable', 'decreasing' and 'fluctuating'). Sixty-nine percent of participants reported price stability over the preceding six months. Twenty-three percent of those who commented thought that price had increased over the preceding six months (comparable with 22% in 2012). Five percent reported heroin prices had decreased, and a smaller proportion (3%, 3% in 2012) reported that prices had fluctuated in the previous six months.

### 5.1.2 Availability

Participants were asked about current heroin availability (whether it was 'very easy', 'easy', 'difficult' or 'very difficult') and whether this had changed in the last six months ('easier', 'stable', 'more difficult' or 'fluctuates'). Again in 2013, the majority of participants reported that heroin was 'easy' (34%) or 'very easy' (52%) to obtain (Table 10; Figure 27). Thirteen percent (reported that heroin was difficult to obtain (14% in 2012) and only 1% of participants claimed that heroin was 'very difficult' to obtain.

The vast majority (85%) of the sample were able to comment on heroin availability in the last 6 months: 67% reported that heroin availability over this time had remained stable; smaller proportions of participants claimed that ease of access to heroin had become 'more difficult' (18%) or 'easier' (10%) to obtain (Table 10).

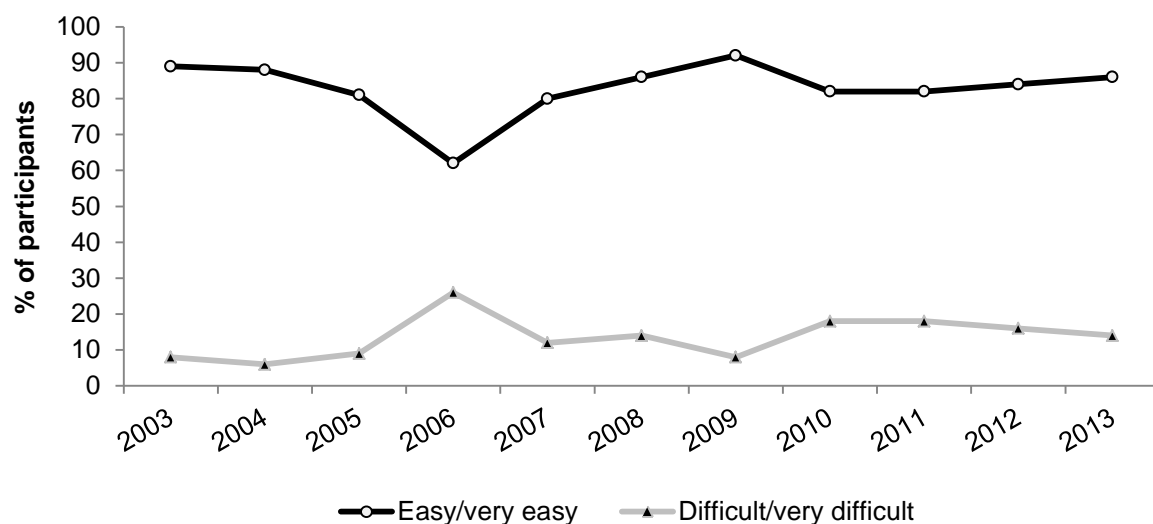
**Table 10: Participants' reports of heroin availability in the past six months, 2008–2013**

	2008 N=151	2009 N=152	2010 N=154	2011 N=150	2012 N=151	2013 N=151
<b>Current availability</b>						
Did not respond* (%)	17	6	8	13	13	<b>15</b>
Did respond (%)	83	94	92	87	87	<b>85</b>
<b>Of those who responded:</b>						
Very easy (%)	39	59	57	50	38	<b>52</b>
Easy (%)	46	33	26	32	46	<b>34</b>
Difficult (%)	13	8	14	16	14	<b>13</b>
Very difficult (%)	1	0	4	2	2	<b>1</b>
<b>Availability change</b>						
Did not respond* (%)	17	6	8	14	13	<b>16</b>
Did respond (%)	83	94	92	86	87	<b>84</b>
<b>Of those who responded:</b>						
More difficult (%)	17	14	20	19	14	<b>18</b>
Stable (%)	67	72	70	64	77	<b>67</b>
Easier (%)	10	11	9	11	5	<b>10</b>
Fluctuates (%)	2	3	1	6	4	<b>5</b>

Source: IDRS PWID interviews

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

**Figure 27: Participant reports of current heroin availability, 2003–2013**



Source: IDRS PWID interviews

Of those participants that had purchased heroin in the last six months (85%), the most common sources of heroin on the last occasion of purchase were known dealers (41%), street dealers (28%) and friends (26%) (Figure 28). Participants reported scoring from a range of locations, both public (e.g. street market, agreed public location) and private (e.g. dealer's home, home delivery) with the most common remaining an 'agreed public location' (30%) (Figure 29).

**Figure 28: People from whom heroin was purchased on the last occasion, 2013**



Source: IDRS PWID interviews

NB: More than one response could be selected

**Figure 29: Locations where heroin was purchased on the last occasion, 2013**



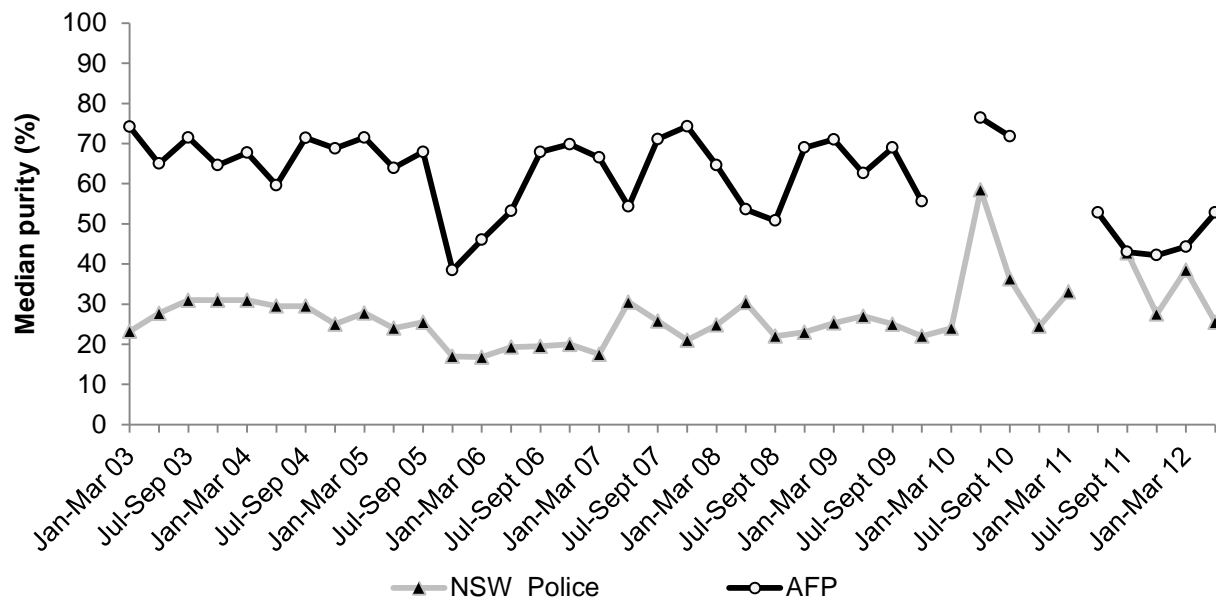
Source: IDRS PWID interviews

NB: More than one response could be selected

### 5.1.3 Purity

Figure 30 shows the analysed median purity of NSW Police heroin seizures from 2003 to 2012. The overall median purity in 2010/11 (30%; range: 2–84.5%) reported by NSW Police remained comparable with the 2000/11 reporting period (24.5% in 2009/10). Overall, the purity of Australian Federal Police (AFP) heroin seizures that were analysed during 2011/12 decreased, with a median of 43.4% in the 12 months to June 2012 (56% in 2011/12; 67.8% in 2009/10).

**Figure 30: Purity of heroin seizures analysed in NSW, by quarter, 2003–2012**

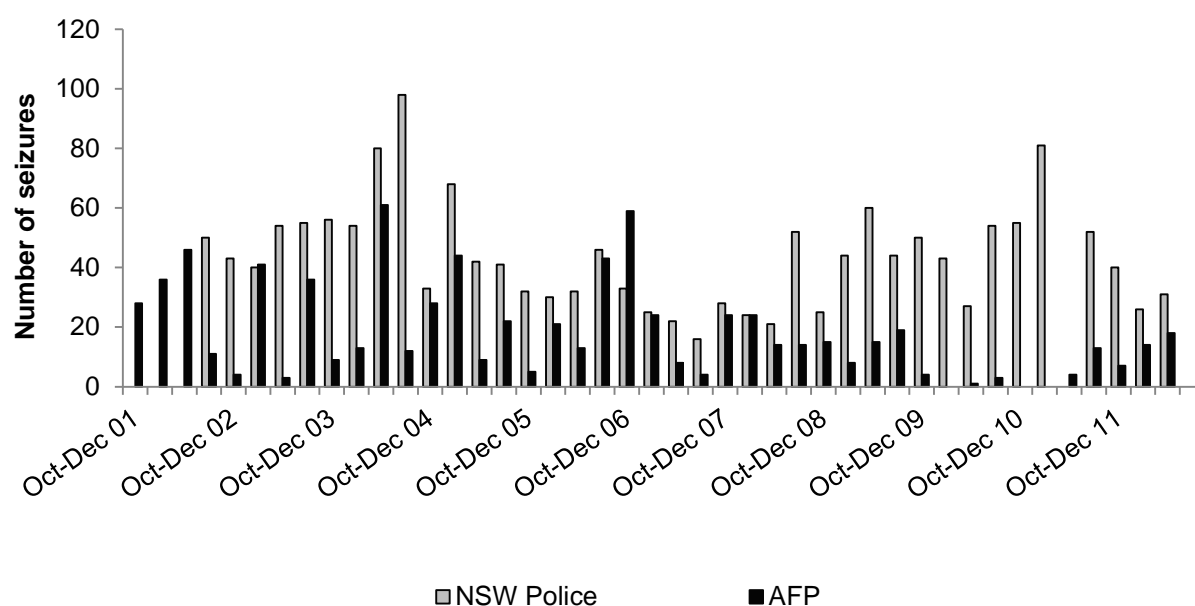


Source: Australian Bureau of Criminal Intelligence (2001, 2002); Australian Crime Commission (2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012)

NB: Data were unavailable for 2012/13 at time of publication; no AFP seizure data for NSW January-March 2010, October-December 2010 and January-March 2011; no NSW Police data for April-June 2011.

Figure 31 shows the number of heroin seizures upon which the above purity figures were based. It should be noted that not every seizure is analysed. In addition, the period between the date of seizure by police and the date of receipt at the laboratory can vary greatly, and no adjustment has been made to account for double-counting that may occur in joint operations between the AFP and NSW Police. The total number of heroin seizures analysed by NSW Police in 2011/12 was 149 (190 cases in 2010/11). The total number of heroin seizures analysed by the AFP increased from 7 in 2010/11 to 52 for the same period (Figure 31).

**Figure 31: Number of heroin seizures analysed in NSW, by quarter, 2001/02–2011/12**



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

NB: NSW Police data for numbers of seizures for 2001/02 were unavailable. Data were unavailable for 2012/13 at time of publication

Participants were also asked to comment on their perception of the current purity of heroin. Thirty-eight percent of those who commented reported it to be low purity, 38% also reported it to be 'medium', 16% reported it 'fluctuates' and 8% believed it to be 'high' (Table 11). Since the commencement of the IDRS in 1996, only small proportions of participants have reported purity to be high, instead selecting 'medium' or 'low' most frequently (Figure 32). This was also the case in 2013, with only 8% of participants rating current heroin purity as 'high'. While this may reflect a change in purity, it may also reflect individual levels of tolerance to heroin.

Participant perceptions of purity change over the last six months varied: approximately one-third (37%) reported that it has remained stable (35% in 2012) and 28% reported that it had decreased (31% in 2012). These results are comparable with 2012 (Table 11).



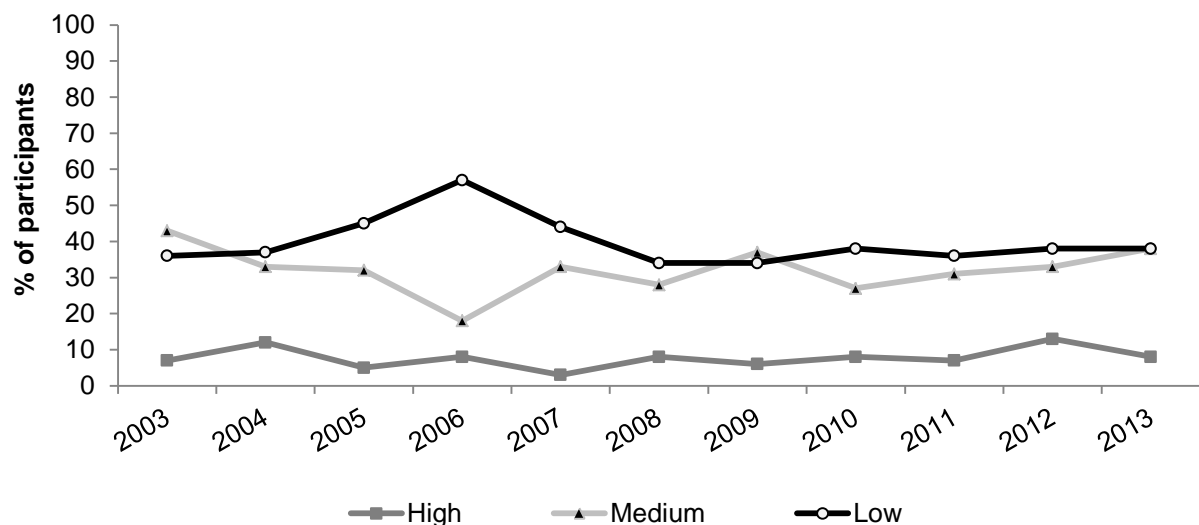
**Table 11: Participants' perceptions of heroin purity in the past six months, 2007–2013**

	2007 N=153	2008 N=151	2009 N=152	2010 N=154	2011 N=150	2012 N=151	2013 N=151
<b>Current purity</b>							
Did not respond* (%)	6	17	6	11	15	16	17
Did respond (%)	94	83	94	89	85	84	83
<b>Of those who responded:</b>							
High (%)	4	10	6	9	8	13	8
Medium (%)	35	34	39	31	37	33	38
Low (%)	47	42	40	43	42	38	38
Fluctuates (%)	11	8	13	18	13	17	16
<b>Purity change</b>							
Did not respond* (%)	5	17	6	13	17	16	19
Did respond (%)	96	83	94	87	83	84	81
<b>Of those who responded:</b>							
Increasing (%)	13	18	16	7	11	13	16
Stable (%)	38	27	33	41	32	35	37
Decreasing (%)	22	37	30	36	37	31	28
Fluctuating (%)	19	10	18	17	20	21	19

Source: IDRS PWID interviews

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

**Figure 32: Proportion of PWID participants reporting current heroin purity as high, medium or low, 2003–2013**



Source: IDRS PWID interviews

#### 5.1.4 Trends in heroin use

As in previous years, the PWID survey contained a number of open-ended questions which asked participants about any general trends in drug use that they had noticed; for example, in the number of users and the types of drugs used. As in previous years, comments on general trends in heroin use included several comments that the quality of heroin had decreased (this may be influenced, at least in part, by tolerance). Furthermore, the lack of heroin purity is resulting in an increase in PWID using oxycodone where there was greater confidence in ingredient quality. There were many comments, however, stating that ice usage was on the increase, and this was found to be increasing in the IDRS data in 2013.

#### 5.1.5 Key expert comments

- Comments on heroin purity from KE were mixed; several commented that the current purity of heroin had fluctuated so much that it was hard to know what someone would get.
- Some health KE reported a lack of trust in heroin purity was leading to an increase in the prevalence of Oxycontin use.
- Availability of heroin was mixed with reports it was either stable or had increased, but this was dependent on the availability of Oxycontin.
- KE comments reflected findings in the PWID survey that heroin remained the drug of choice amongst this group, despite the continuing use of non-prescribed pharmaceutical opioids.
- The price of a point/cap of heroin was reported to be stable at \$50.
- In contrast to reports from previous years, law KE commented that alkaline 'brown' heroin was slightly more common than white heroin, indicating possible Afghani origin.

## 5.2 Methamphetamine

Participants were asked if they were able to comment on the price, purity and/or availability of speed powder, base and/or ice. In 2013, 17% of the PWID sample felt confident to answer at least some of the survey items regarding speed powder; 13% commented on the price, purity and/or availability of base; and 68% commented on ice/crystal. These proportions are consistent with 2012. The remainder did not feel confident to answer any questions on one or more of these drug forms, and this was likely to reflect a proportion of users who did not use, or come into contact with methamphetamine users or dealers regularly enough to be able to comment.

### 5.2.1 Price

#### 5.2.1.1 Speed powder

As per previous years, and other drug types, points of speed were the most popular and prices have continued to remain stable. There was an increase in those participants purchasing speed by 'halfweights' and grams and the median price per gram more than halved when compared with 2012. The number of people reporting a price per 'eightball' remained low. Due to this, comparisons with 2012 should be interpreted with caution due to the low number ( $n \leq 10$ ) reporting. As shown in Table 12, price ranges were extremely wide. In most cases, this is likely to be a reflection of purity/availability within that particular person's network and various other circumstances which may influence the cost of a particular purchase.

**Table 12: Price of most recent methamphetamine purchases by PWID participants, 2012–2013**

Amount	Median price* \$	Range \$	Number of purchasers*
<b>Speed powder</b>			
Point (0.1 gram)	50 (50)	no range	17 (13)
'Halfweight' (0.5 grams)	165 (275)	50–250	10 <sup>^</sup> (2 <sup>^</sup> )
Gram	300 (675)	50–480	11 (2 <sup>^</sup> )
'Eightball' (3.5 grams)	675 (140)	600–1000	4 <sup>^</sup> (1 <sup>^</sup> )
<b>Base</b>			
Point (0.1 gram)	50 (50)	40–50	11 (15)
'Halfweight' (0.5 grams)	150 (–)	50–250	5 <sup>^</sup> (0 <sup>^</sup> )
Gram	100 (250)	80–250	3 <sup>^</sup> (1 <sup>^</sup> )
'Eightball' (3.5 grams)	220 (140)	90–350	2 <sup>^</sup> (1 <sup>^</sup> )
<b>Ice/crystal meth</b>			
Point (0.1 gram)	50 (50)	20–100	83 (75)
'Halfweight' (0.5 grams)	200 (250)	150–350	28 (11)
Gram	388 (400)	250–600	20 (10 <sup>^</sup> )
'Eightball' (3.5 grams)	1200 (900)	600–1500	10 <sup>^</sup> (2 <sup>^</sup> )

Source: IDRS PWID interviews

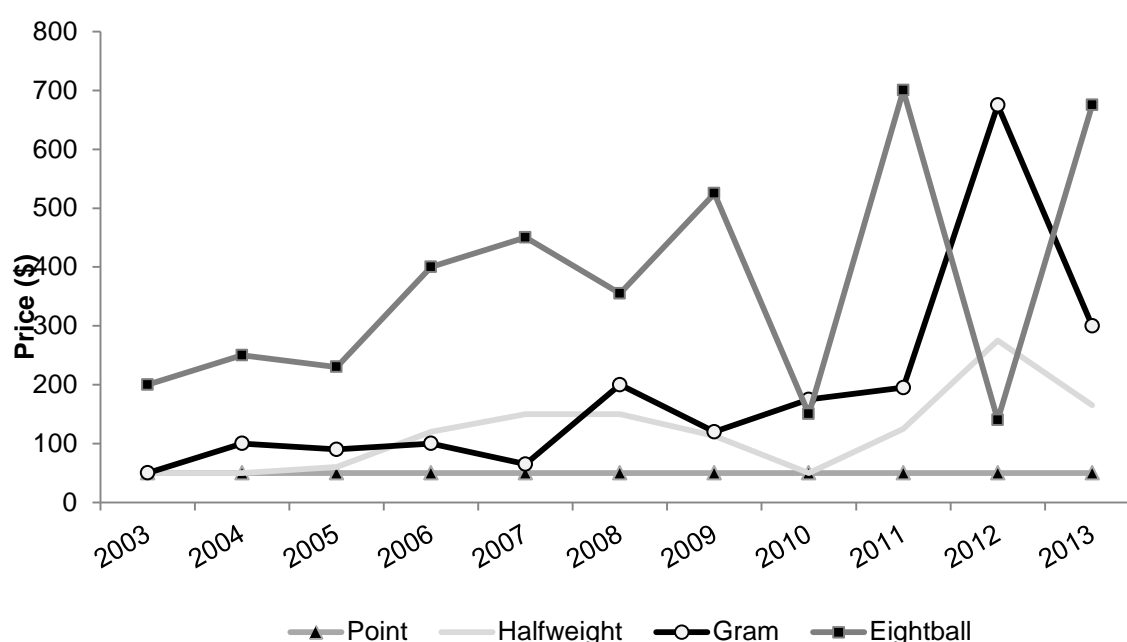
\* 2012 data are presented in brackets

<sup>^</sup>  $n \leq 10$  results should be interpreted with caution

The median price per point of speed has remained the same since data were first collected on this purchase amount in 2002 (\$50) (Figure 33). It is important to note, however, that comparisons with the 2012 data should be interpreted with caution due to the low number of reported purchasers for weights other than points this year.

Participants were also asked if the price of speed powder had changed in the last six months, and 72% of those who commented (9% of all participants) reported price as 'stable' over the last six months. This remained consistent with comments from 2012. Similarly, the proportion of participants reporting an increase (17%; 2% of all participants) remained stable from 2012 (15%; 3% of all participants). Fewer participants (6%; 1% of all participants) reported a decrease in prices in 2013, with an equal amount of participants (6%; 1% of all participants) reporting the price 'fluctuating'. Overall, this suggests prices had remained relatively stable over the last six months.

**Figure 33: Median prices of speed powder estimated from PWID purchases, 2003–2013**



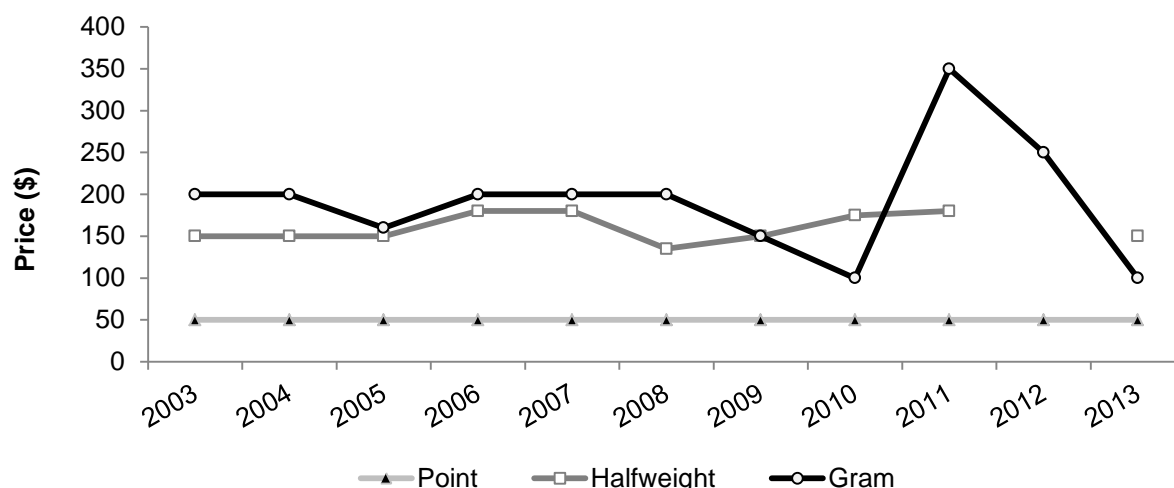
Source: IDRS PWID interviews

### 5.2.1.2 Base

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

The median price per point of base remained stable, while the median prices for other amounts were based on small numbers (10 responses or less) of participant responses, and should be interpreted with caution, particularly as the price ranges were fairly wide. Prices have remained fairly stable since 2002, with the exception of a gram of base (Figure 34).

**Figure 34: Median prices of base estimated from PWID purchases, 2003–2013**



Source: IDRS PWID interviews

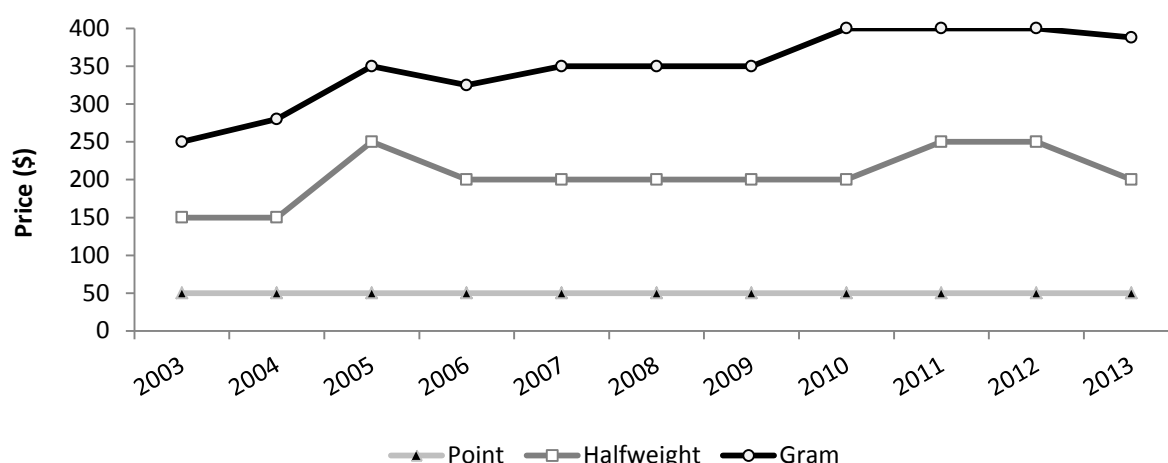
NB: Median price per eightball not shown due to small numbers reporting purchase

The majority of participants that commented on base generally thought that the price had remained 'stable' over the preceding six months (72%; 9% of all participants). Seventeen percent reported that it had 'increased' (2% of entire sample), one participant reported it had 'fluctuated', while another participant reported the price of base had 'decreased'. With the exception of the price of base per gram, overall, prices appear to have remained comparable to 2012. Few participants reported recent purchases larger than a point, therefore these results should be treated with caution.

### 5.2.1.3 Ice/crystal

Again, as with speed and base, the most commonly purchased amounts of ice/crystal were points (72% of participants reporting at least one purchase in the last 6 months). Fifty-five percent of all participants reported at least one purchase of ice/crystal in the last 6 months, with an increase in those reporting purchases of 'halfweights', grams and an 'eightball'. (28, 20 and 10 participants each, respectively) (Table 12). In 2013, prices for points of ice/crystal have remained stable (Figure 35). Price comparisons for amounts other than points should be interpreted with caution due to the low numbers reported in 2012 (Table 12).

**Figure 35: Median prices of ice/crystal estimated from PWID purchases, 2003–2013**



Source: IDRS PWID interviews

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

The majority of participants who commented on ice/crystal generally thought that the price had remained ‘stable’ over the preceding six months (61%; representing 40% of the entire sample). Twenty-seven percent stated that it had ‘increased’ (representing 17% of the entire sample), 8% (5% of the entire sample) reported it had ‘fluctuated’, and 4% reported a ‘decrease’ in price. Overall, comments on price changes in 2013 are comparable with 2012.

## 5.2.2 Availability

### 5.2.2.1 Speed powder

Participants were asked ‘How easy is it to get speed [powder] at the moment?’. The response options available were ‘very easy’, ‘easy’, ‘difficult’, and ‘very difficult’. Among those who could comment, availability was reported as ‘very easy’ (24%), ‘easy’ (56%), or ‘difficult’ (20%) to obtain, with no participants reporting that it was ‘very difficult’ to obtain (

Table 13). The majority of the sample that commented reported availability in the preceding six months was stable (72%), an increase on the 63% of participants who reported it in 2012.

Twelve percent of all participants reported purchasing speed powder in the six months preceding the interview. The most common source of the purchase was ‘friends’ (46%; 35% in 2012), ‘known dealers’ (27%; 15% in 2012), ‘street dealers’ (23%; 35% in 2012), with only a small proportion obtaining it from other sources. There was shift in some of the locations speed powder was obtained (Figure 36). Equal proportions of participants reported scoring on the ‘street market’ (23%; 50% in 2012), or a ‘friend’s home’ (23%; 10% in 2012), ‘dealers home’ (18%; 5% in 2012), ‘home delivery’, (18%; 5% in 2012), or an ‘agreed public location’ (14%; 30 in 2012), (Figure 37).

### 5.2.2.2 Base

The current availability of base was reported to be ‘easy’ (32%), ‘difficult’ (26%) and ‘very easy’ (26%) to obtain among those that could comment. Fifty-eight percent (7% of all participants) reported that availability over the past six months was ‘stable’, while 37% (5% of all participants) reported it to be ‘more difficult (Table 13). Thirteen percent of the entire sample (13% in 2012) reported purchasing base in the six months preceding interview, of those that reported a purchase, it was most commonly from friends (39%), street dealers (28%), and known dealers (22%) (Figure 36). Locations at which base had most commonly been purchased included an

'agreed public location' (28%; 15% in 2012), a 'friend's home' (22%; 15% in 2012), a 'dealer's home' (17%; 15% in 2012), 'home delivery' (17%; 8% in 2012), 'street market' (11%; 38% in 2012), and an acquaintance's home (6%; 8% in 2012) (Figure 37).

### 5.2.2.3 Ice/crystal

Forty-six percent of participants (representing 31% of all participants) commenting on ice/crystal stated that it was either 'very easy' or 'easy' (46%) to obtain. These figures are comparable with 2012 (Table 13). The majority of those who commented (73%, or 49% of entire sample) reported that availability over the last six months had remained stable, with 13% reporting that it had become 'more difficult', 11% percent reporting that it had become 'easier', and only 3% reported that availability had fluctuated over the last six months (Table 13). Sixty eight percent of all participants had purchased ice in the six months preceding interview (54% in 2012). Among these, the most commonly reported sources were 'friends' (40%), 'known dealers' (31%), and 'street dealers' (23%) (Figure 36). The most commonly reported locations of purchase were a street market (25%), agreed public location (24%), friend's home (18%), dealer's home (16%), and home (delivered; 12%) (Figure 37).

**Table 13: Participants' reports of methamphetamine availability in the past six months, 2012–2013**

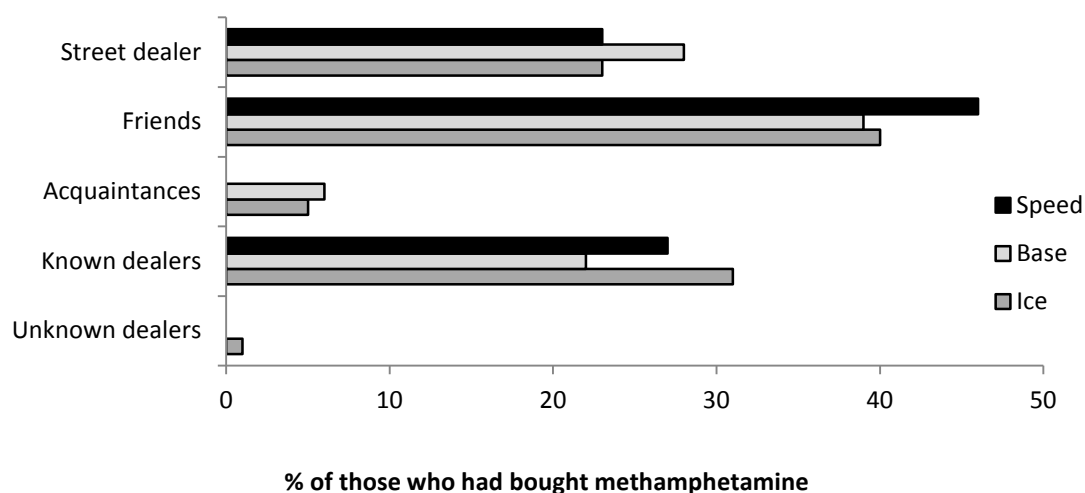
	Powder		Base		Ice/Crystal	
	2012 (N=151)	2013 (N=151)	2012 (N=151)	2013 (N=151)	2012 (N=151)	2013 (N=151)
<b>Current availability</b>						
Did not respond* (%)	83	<b>83</b>	89	<b>87</b>	38	<b>32</b>
Did respond (%)	17	<b>17</b>	11	<b>13</b>	62	<b>68</b>
<b>Of those who responded:</b>						
Very easy (%)	32	<b>24</b>	38	<b>26</b>	42	<b>46</b>
Easy (%)	48	<b>56</b>	25	<b>32</b>	45	<b>46</b>
Difficult (%)	20	<b>20</b>	38	<b>26</b>	13	<b>8</b>
Very difficult (%)	0	<b>0</b>	0	<b>16</b>	1	<b>0</b>
Don't know^ (%)	0	<b>0</b>	0	<b>0</b>	0	<b>0</b>
<b>Availability change</b>						
Did not respond* (%)	84	<b>83</b>	89	<b>87</b>	38	<b>33</b>
Did respond (%)	16	<b>17</b>	11	<b>13</b>	62	<b>67</b>
<b>Of those who responded:</b>						
More difficult (%)	21	<b>20</b>	25	<b>37</b>	10	<b>13</b>
Stable (%)	63	<b>72</b>	75	<b>58</b>	73	<b>73</b>
Easier (%)	13	<b>8</b>	0	<b>5</b>	15	<b>11</b>
Fluctuates (%)	4	<b>0</b>	0	<b>0</b>	2	<b>3</b>
Don't know^ (%)	0	<b>0</b>	0	<b>0</b>	0	<b>0</b>

Source: IDRS PWID interviews

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

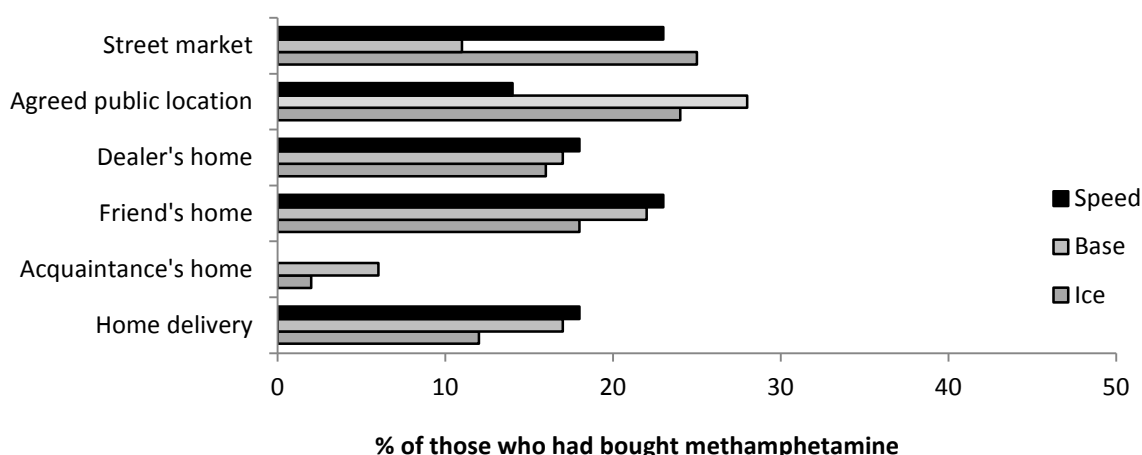
^ 'Don't know' refers to participants who were able to respond to survey items on price and/or purity, but had not had enough contact with users/dealers to respond to items concerning availability

**Figure 36: People from whom methamphetamine was purchased in the preceding six months, 2013**



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

**Figure 37: Locations where methamphetamine was scored in the preceding six months, 2013**



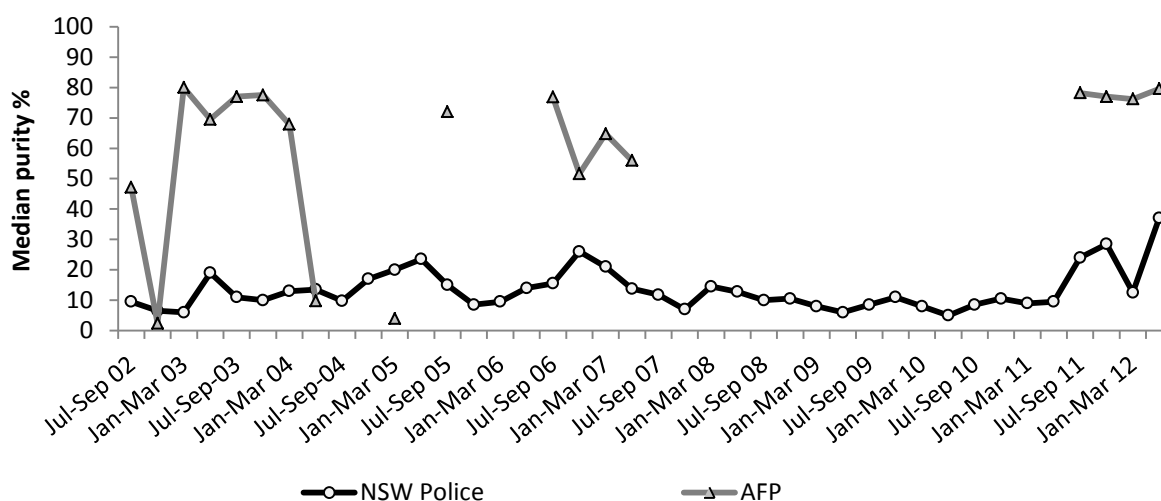
Source: IDRS PWID interviews  
NB: More than one response could be selected

### 5.2.3 Purity

Figure 38 shows the median purity of methylamphetamine seizures analysed in NSW for the period July 2002 to June 2012. As analysis by both NSW Police and the AFP has been sporadic since 2004, meaningful interpretation of methylamphetamine purity levels is difficult. The median purity of all seizures analysed by NSW Police increased in 2011/12 to 19.5% (range 1%–90%) with 9% reported in 2010/11. It should be noted that figures do not represent the purity levels of all methylamphetamine seizures – only those that have been analysed at a forensic laboratory. In addition, the period between the date of seizure by police and the date of receipt at the laboratory can vary greatly, and no adjustment has been made to account for double-counting from joint operations between the AFP and NSW Police.



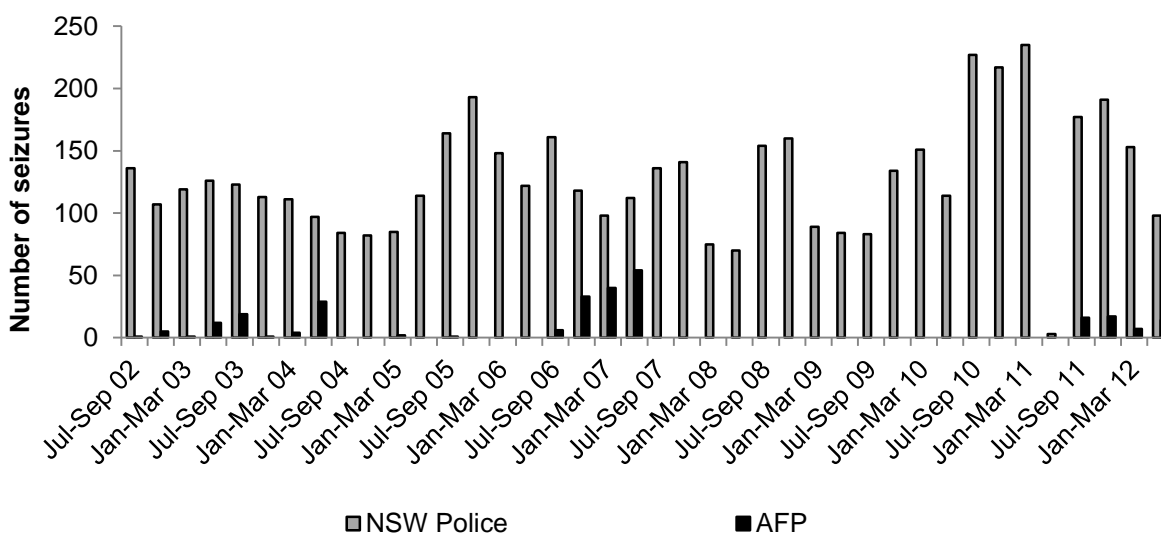
**Figure 38: Purity of methylamphetamine seizures analysed in NSW, by quarter, 2002/03–2011/12**



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

Figure 39 shows the number of methylamphetamine seizures upon which the above purity figures are based. As analysis of AFP seizures has been sporadic since 2004 and non-existent in the 3 years to June 2011, meaningful interpretation is difficult. The number of seizures analysed by NSW Police has remained stable in the 12 months to June 2012 (619 in 2011/2012 verses 682 in 2010/2011).

**Figure 39: Number of methylamphetamine seizures analysed in NSW, by quarter, 2002/03–2011/12**



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

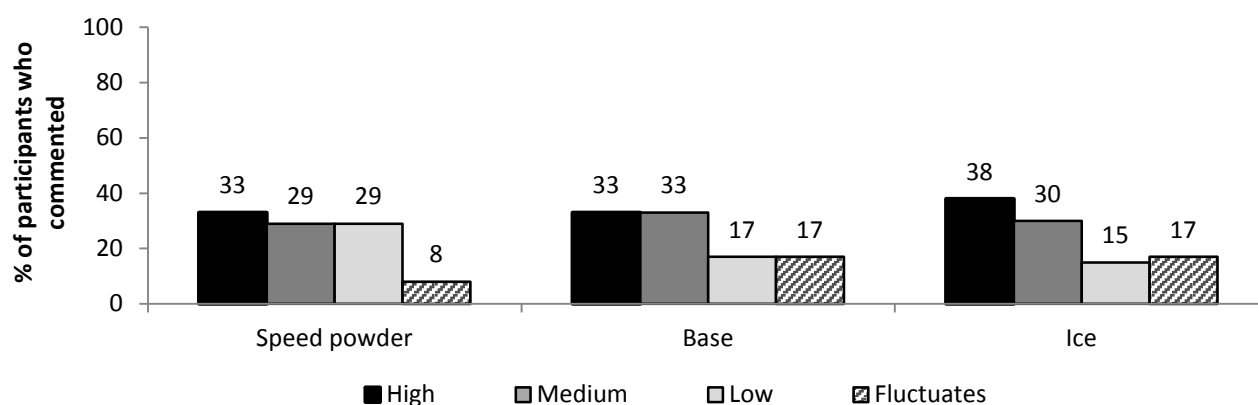
NB: NSW Police data for the financial year 2001/02 were unavailable.

### 5.2.3.1 Speed powder

Sixteen percent of the sample commented on the perceived current purity of speed powder (15% in 2012). In 2013, comments on perceived purity were mixed. Thirty-three percent of those who could comment described speed powder as 'high' and equal numbers reported purity as either 'medium' or 'low' (both 29%). Eight percent (1% of all participants) thought that speed powder purity 'fluctuates' (Figure 40). This is comparable with 2012.

Reports on changes in speed purity were also mixed. Fifty-two percent of participants who commented reported that purity was 'stable', while 22% of participants thought that speed purity had decreased over the preceding six months. Twenty-two percent also commented it had 'fluctuated' and 4% reported that it had 'increased' (8% and 1% of the entire sample, respectively). Overall, this remains comparable with 2012.

**Figure 40: Participant perceptions of methamphetamine purity (speed powder, base and ice), among those who commented, 2013**



Source: IDRS PWID interviews

### 5.2.3.2 Base

Thirty-three percent of recent users (4% of entire sample) commented that base was currently either 'medium' or 'high' purity. An equal proportion of participants also commented that base purity was currently either 'low' or 'fluctuates' (17%; 2% of all participants).

In reporting on changes in purity it was generally reported to have remained stable (65%; 7% of entire sample), with lesser amounts reporting it had 'fluctuated' (18%; 2% of entire sample) or had 'increased' (12%; 1% of the entire sample) over the six months preceding interview. Only one participant believed purity had 'decreased'.

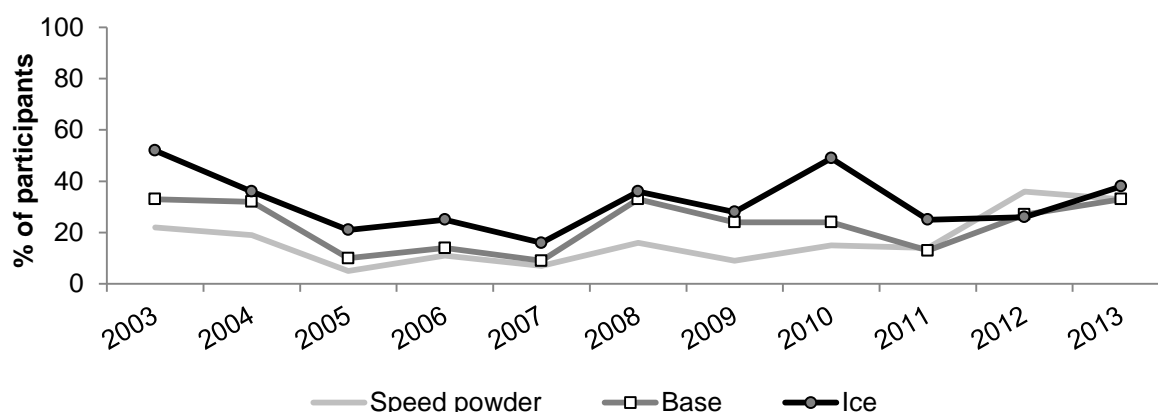
### 5.2.3.3 Ice/crystal

Thirty-eight percent (25% of entire sample) of recent users reported the purity of ice/crystal as 'high'. Thirty percent reported it as 'medium', while 17% reported ice/crystal purity 'fluctuates' (19% and 11% of entire sample, respectively). The remaining 15% (7% of entire sample) of people reporting recent ice/crystal use commented it was 'low' (Figure 40). These figures are comparable with values reported in 2012.

When asked about whether purity had changed over the last six months, 44% (29% of all participants) believed that it remained 'stable' and 25% (17% of the entire sample) thought it had 'decreased'. Almost one-fifth (19%; 13% of the entire sample) of recent ice/crystal users believed it had 'fluctuated', and 11% reported that it had 'increased' (7% of the entire sample).

Figure 41 shows the proportion of PWID participants reporting the purity of each form of methamphetamine as 'high'. The perceived purity of each form remained comparable with 2012, and differences in perceived speed and base purity in 2013 should be interpreted with caution due to the low numbers commenting on 'high' purity (Figure 41).

**Figure 41: Proportion of participants reporting speed powder, base and ice/crystal purity as 'high', 2003–2013**



Source: IDRS PWID interviews

NB: Data on all three forms commenced in 2002

## 5.2.4 Trends in methamphetamine use

All participants were asked at the end of the survey if they had observed any recent changes in drug use. A reoccurring theme was that use of ice/crystal had increased in the 6 months prior to interview.

## 5.2.5 Key expert comments

- KE generally believed that the use of ice/crystal had increased among PWID in 2013.
- The majority of reports regarding the availability of speed were that it was stable from 2012, with some reports of an increase in availability.
- There were few reports regarding base. Those KE that could comment suggested very small numbers of PWID were using base while others suggested its use was non-existent in 2013.
- The prices across all amounts for both crystal/ice and speed remained stable according to KE.

## 5.3 Cocaine

Twenty-nine percent of participants reported that they were able to comment on the price, purity and/or availability of cocaine in 2013, which is consistent with the 29% that could comment in 2012. The remainder did not feel confident to answer any questions on the cocaine market, and this is likely to reflect a proportion of users who do not use, or come into contact with users or dealers of, cocaine regularly enough to be able to comment.

### 5.3.1 Price

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

**Table 14: Price of most recent cocaine purchases by PWID participants, 2012–2013**

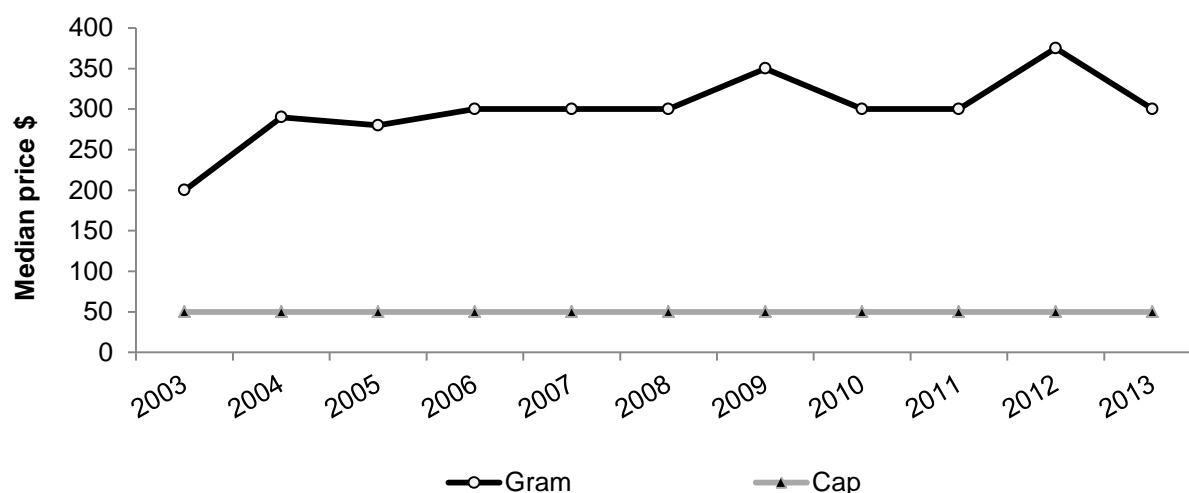
Amount	Median price* \$	Range \$	Number of purchasers*
Cap	50 (50)	\$50–\$100	32 (23)
Quarter gram	150 (100)	\$120–\$200	3 (3 <sup>^</sup> )
'Half weight' (0.5 grams)	200 (150)	\$100–\$600	16 (5 <sup>^</sup> )
Gram	300 (375)	\$160–\$600	14 (6)

Source: IDRS PWID interviews

\*2012 data are presented in brackets

<sup>^</sup> $n \leq 10$  results should be interpreted with caution

**Figure 42: Median price of a gram and cap of cocaine estimated from PWID participant purchases, 2003–2013**



Source: IDRS PWID interviews

The majority of participants (71%; 19% of entire sample) that could comment on cocaine reported that the price had remained 'stable' in the preceding six months. Twenty-two percent (6% of entire sample) of those commenting reported that the price of cocaine had 'increased', 7% (2% of entire sample) reported it had 'decreased' and no participants reported any 'fluctuations' over the past 6 months.

### 5.3.2 Availability

Forty-two percent (12% of entire sample) of participants commenting on cocaine market characteristics (price, purity and/or availability) thought that it was 'easy' and 28% (8% of entire sample) thought it was 'very easy' to obtain cocaine (Table 15). One-quarter (26%; 7% of entire sample) thought it was 'difficult' and only two participants reported that it was 'very difficult' to obtain (Table 15).

Sixty percent of participants (17% of entire sample) commenting on cocaine reported that availability had remained 'stable' (Table 15). Thirty-one percent (9% of the entire sample) reported that it had become 'more difficult' to obtain over the last six months, and 10% (3% of the entire sample) thought it had become 'easier' (Table 15). There were no reports on the availability of cocaine fluctuating.

Figure 43 shows the availability of cocaine over time since 2003.

**Table 15: Participants' reports of cocaine availability in the past six months, 2009–2013**

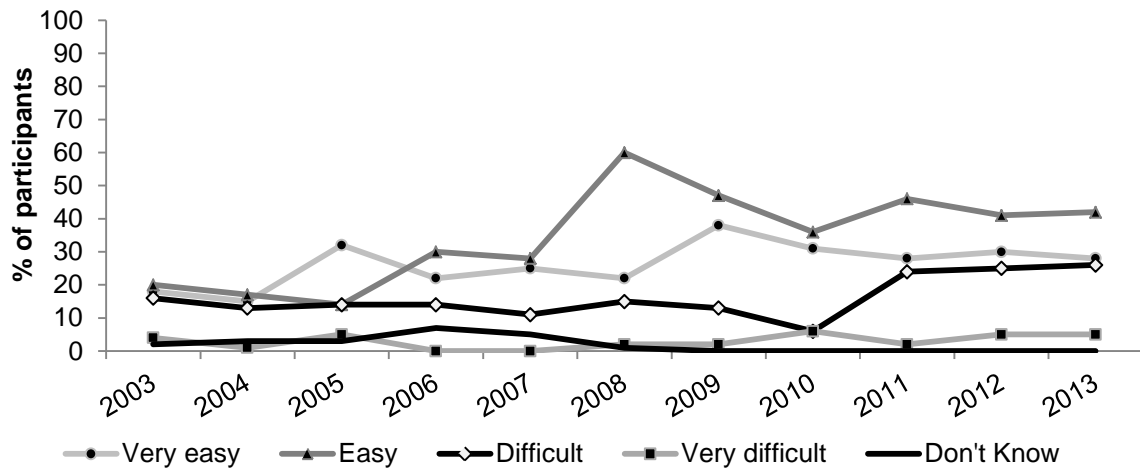
	2009 (N=152)	2010 (N=154)	2011 (N=150)	2012 (N=151)	2013 (N=151)
<b>Current availability</b>					
Did not respond* (%)	44	47	63	71	<b>72</b>
Did respond (%)	56	53	37	29	<b>28</b>
<b>Of those who responded:</b>					
Very easy (%)	38	31	27	30	<b>28</b>
Easy (%)	47	36	45	41	<b>42</b>
Difficult (%)	13	27	23	25	<b>26</b>
Very difficult (%)	2	6	2	5	<b>5</b>
Don't know^ (%)	0	0	4	0	<b>0</b>
<b>Availability change</b>					
Did not respond* (%)	44	49	63	72	<b>72</b>
Did respond (%)	56	51	37	28	<b>28</b>
<b>Of those who responded:</b>					
More difficult (%)	16	23	27	19	<b>31</b>
Stable (%)	62	67	55	65	<b>60</b>
Easier (%)	17	6	11	12	<b>10</b>
Fluctuates (%)	2	4	2	5	<b>0</b>
Don't know^ (%)	4	0	5	0	<b>0</b>

Source: IDRS PWID interviews

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

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

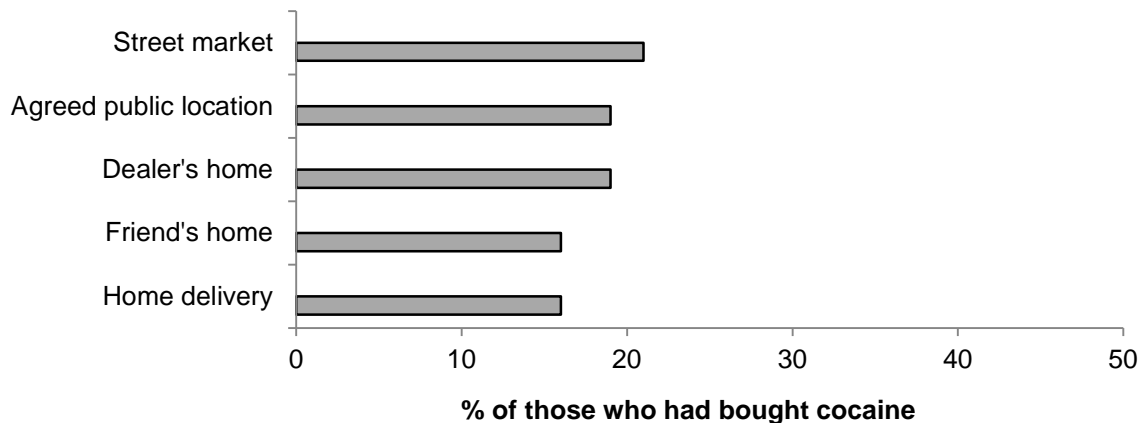
**Figure 43: Participant reports of current cocaine availability, 2003–2013**



Source: IDRS PWID interviews

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

**Figure 44: Locations where cocaine was scored in the preceding six months, 2013**



Source: IDRS PWID interviews

NB: More than one response could be selected

### 5.3.3 Purity

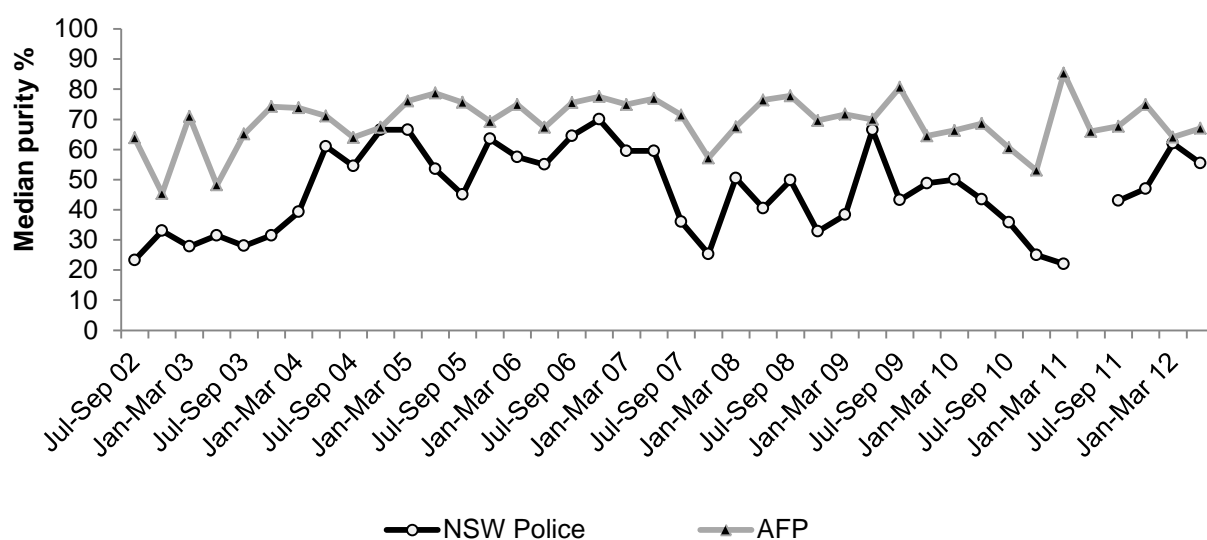
Since recording commenced, the total median purity of cocaine seizures analysed by the NSW Police has fluctuated and appears to have increased in the 12 months to March 2012, before decreasing in the final quarter to June.

The overall total seizures analysed by the AFP remained relatively stable over the same period (Figure 45). The total median purity of cocaine analysed by the AFP, however, was comparable with 2010/11 values (66%) at 66.7% (Figure 45).

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

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

**Figure 45: Purity of cocaine seizures analysed in NSW, by quarter, 2002/03–2011/12**



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

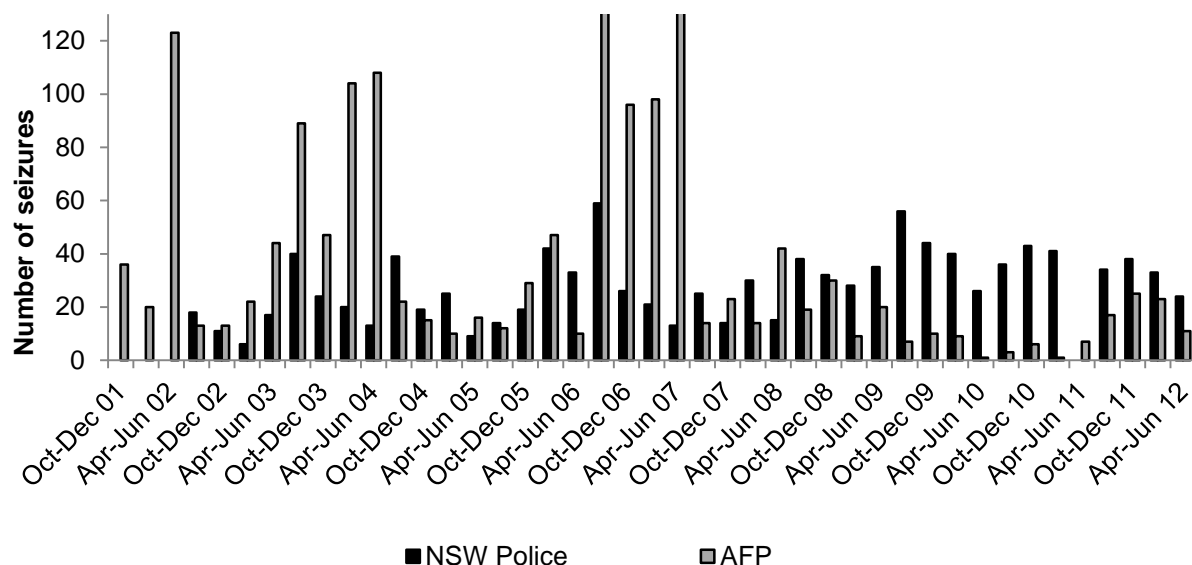
NB: NSW Police data for the financial year 2001/02 were unavailable. Data for 2011/12 were unavailable at time of publication

Figure 46 shows the number of seizures analysed in NSW between 1999/00 and 2011/12.

The number of seizures analysed by NSW Police remained stable in the 12 month period until June 2012 (129 cases in 2011/12 versus 120 cases in 2010/11).

The number of cases analysed by the AFP increased sharply from 17 cases in 2010/11 to 76 cases in 2011/12 (Figure 46).

**Figure 46: Number of cocaine seizures analysed in NSW, by quarter, 2001/02–2011/12**



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

NB: NSW Police data for the financial year 2001/02 were unavailable.



Twenty-eight percent of all participants could comment on current purity of cocaine. Of these, 40% (11% of the entire sample) reported cocaine to be 'medium' purity. Thirty-three percent (9% of entire sample) reported cocaine to currently be 'low' purity. Twenty-one percent of those who could comment (6% of entire sample) reported purity to be currently 'high' and 7% (2% of entire sample) reported that the purity of cocaine 'fluctuates' (Table 16). Comments on purity changes in the 6 months prior to interview were mixed. One-third (34% or 9% of entire sample) believed it was 'stable' while 44% (12% of entire sample) commented it had 'decreased'.

**Table 16: Participants' perceptions of cocaine purity in the past six months, 2009–2013**

	2009 (N=152)	2010 (N=154)	2011 (N=150)	2012 (N=151)	2013 (N=151)
<b>Current purity</b>					
Did not respond* (%)	44	50	64	72	<b>72</b>
Did respond (%)	56	50	36	28	<b>28</b>
<b>Of those who responded</b>					
High (%)	28	25	11	14	<b>21</b>
Medium (%)	39	36	30	48	<b>40</b>
Low (%)	18	26	38	26	<b>33</b>
Fluctuates (%)	12	13	18	12	<b>7</b>
Don't know^ (%)	4	0	4	0	<b>0</b>
<b>Purity change</b>					
Did not respond* (%)	44	47	64	74	<b>73</b>
Did respond (%)	56	53	36	26	<b>27</b>
<b>Of those who responded</b>					
Increasing (%)	19	12	13	8	<b>7</b>
Stable (%)	28	44	29	40	<b>34</b>
Decreasing (%)	18	23	32	30	<b>44</b>
Fluctuating (%)	24	21	20	23	<b>15</b>
Don't know^ (%)	12	0	7	0	<b>0</b>

Source: IDRS PWID interviews

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

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

### 5.3.4 Trends in cocaine use

In response to general, open-ended questions on changes in drug use, there were very few participants able to comment on cocaine.

### 5.3.5 Key expert comments

- The common theme among KE was that cocaine is viewed as expensive by PWID and the price has remained stable from the previous year.
- Of the few KE who could comment on cocaine in detail, it was generally reported that cocaine use among PWID was quite low and infrequent.
- There were mixed reports on the availability of cocaine. Law KE reported availability was dependent on an individual's sources and their connections to them.
- The KE that could comment reported that cocaine injection was more common amongst the sex-working population, though it was rare amongst PWID in general.

## 5.4 Cannabis

Participants were asked if they were able to comment on the price, potency and/or availability of hydroponic ('hydro') and/or outdoor-grown ('bush') cannabis, and in 2013, 65% of the sample felt confident to answer at least some of the survey items on hydro. By contrast, only 22% of participants were able to report on bush price, purity and/or availability, supporting previous years' findings that indicated hydro tends to dominate the Sydney market.

### 5.4.1 Price

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

#### 5.4.1.1 Hydroponic cannabis

Participants were surveyed concerning the price paid the last time they had bought hydro. The median price paid for a gram of hydro was \$20, the same as in previous years (Figure 17). In 2013, the median price of a quarter ounce of hydroponic cannabis decreased by \$5 to \$90, while the price of an ounce decreased by \$20 to \$300. The median price for half an ounce was \$180 (Table 17). As in previous years, and comparable with other drugs surveyed (e.g. heroin, cocaine, methamphetamine), the most popular purchase amount of hydro was the smallest generally available, i.e. grams (n=75), followed by quarter ounces (n=39).

Participants were also asked whether they thought that prices had changed over the six months preceding interview. The majority of PWID participants who commented (83%) reported that the price was 'stable', with smaller proportions stating that it had 'increased' (10%), or 'fluctuated' (6%). One participant reported a decrease in prices.

#### 5.4.1.2 Bush cannabis

In 2013, the median price for a gram of bush cannabis (\$20) remained stable (Table 17). The number of reported purchases for all other amounts was low (<10) so results should be interpreted with caution (Table 17).

The most popular purchase amount for bush remained at a gram (n=18), consistent with previous years, excluding 2006 when an ounce was reported as the most purchased amount. There was a tendency for larger quantities of bush to be slightly cheaper than for hydro, continuing a consistent pattern since 2003.

The majority of participants who commented (77%; 15% of the entire sample) thought prices of bush cannabis had remained 'stable', 10% reported it had 'decreased', 7% believed it had 'increased' and 7% of participants also reported that it had 'fluctuated'.

Again in 2013, price ranges for larger quantities of hydroponic and bush cannabis were wide. This is likely to be a reflection of potency/availability within that particular person's network and various other circumstances which may influence the cost of a particular purchase.

**Table 17: Price of most recent cannabis purchases by PWID participants, 2012–2013**

Amount	Median price* \$	Range \$	Number of purchases*
Hydro			
Gram	20 (20)	10–50	75 (51)
Quarter ounce	90 (95)	50–240	39 (24)
Half ounce	180 (120)	140–250	29 (11)
Ounce	300 (320)	250–360	34 (20)
Bush			
Gram	20 (20)	10–25	18 (14)
Quarter ounce	70 (80)	60–120	13 (6 <sup>^</sup> )
Half ounce	140 (120)	100–180	8 (2 <sup>^</sup> )
Ounce	240 (280)	180–350	13 (5 <sup>^</sup> )

Source: IDRS PWID interviews

\*2012, median prices are in brackets

<sup>^</sup>n ≤ 10 results should be interpreted with caution

### 5.4.1.3 Hash and hash oil

Four participants reported buying hash in the six months preceding interview. No one reported purchasing hash oil in the last 6 months. This indicated that the use of these forms of cannabis remained sporadic.

## 5.4.2 Availability

### 5.4.2.1 Hydroponic cannabis

The majority of participants commenting on hydro availability thought it was ‘very easy’ (60%; 38% of all participants) or ‘easy’ (37%; 24% of all participants) to obtain (Table 18). The majority (90%; 58% of all participants) reported availability as ‘stable’ over the preceding six months. Note that prior to 2004 no distinction was drawn between hydro and bush availability, with participants instead being surveyed about cannabis availability generally. From 2000 until 2004, approximately half of all respondents reported that cannabis was ‘very easy’ to obtain.

### 5.4.2.2 Bush cannabis

The majority of participants reported bush cannabis to be ‘easy’ (63%; 13% of entire sample) to obtain. However, a considerable proportion of the sample who responded reported that bush cannabis availability was ‘difficult’ (28%; 6% of the sample). Only three participants (9% of those who responded; 2% of the entire sample) reported that bush cannabis was ‘very easy’ to obtain (Table 18). There were varying reports about the availability of bush cannabis in the six months preceding interview. Just over one half (52% of those who responded) reported availability had remained ‘stable’. Twenty-six percent found it ‘more difficult’, 16% found it ‘easier’, and 7% of participants reported recent availability as ‘fluctuating’.

Figure 47 presents the availability of hydro and bush cannabis over time from 2004 onwards.

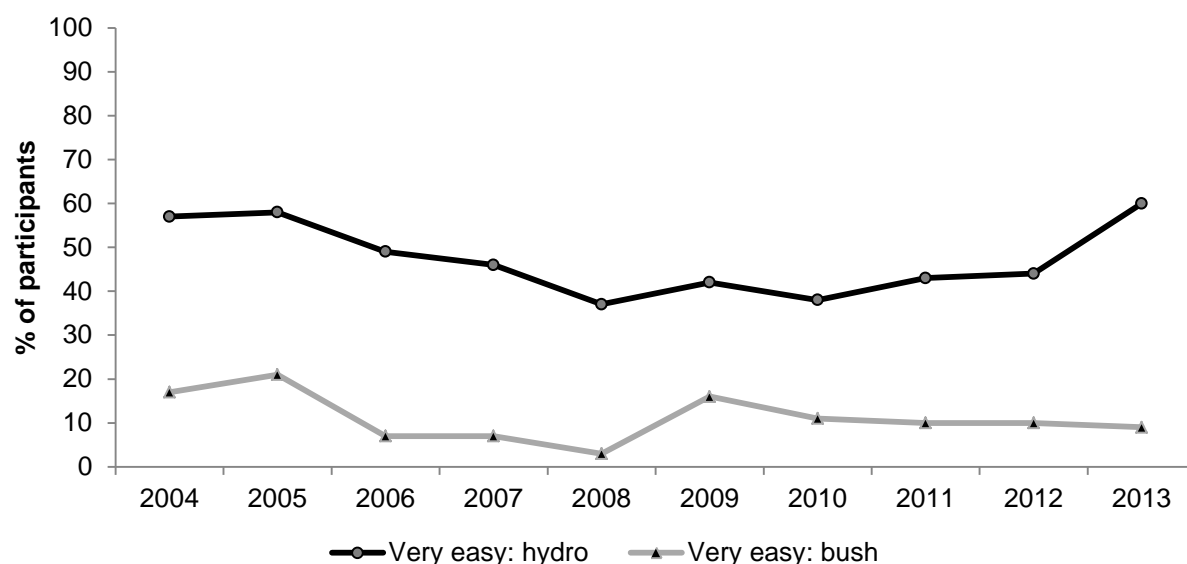
**Table 18: Participants' reports of cannabis availability in the past six months, 2012–2013**

	Hydro		Bush	
	2012 (N=151)	2013 (N=151)	2012 (N=151)	2013 (N=151)
<b>Current availability</b>				
Did not respond* (%)	38	<b>36</b>	79	<b>79</b>
Did respond (%)	62	<b>64</b>	21	<b>21</b>
<b>Of those who responded:</b>				
Very easy (%)	44	<b>60</b>	10	<b>9</b>
Easy (%)	43	<b>37</b>	55	<b>63</b>
Difficult (%)	13	<b>3</b>	19	<b>28</b>
Very difficult (%)	0	<b>0</b>	16	<b>0</b>
<b>Availability change</b>				
Did not respond* (%)	38	<b>36</b>	80	<b>79</b>
Did respond (%)	62	<b>64</b>	20	<b>21</b>
<b>Of those who responded:</b>				
More difficult (%)	9	<b>4</b>	7	<b>26</b>
Stable (%)	86	<b>90</b>	80	<b>52</b>
Easier (%)	4	<b>4</b>	10	<b>16</b>
Fluctuates (%)	1	<b>2</b>	3	<b>7</b>

Source: IDRS PWID interviews

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

**Figure 47: Participant reports of current cannabis availability, 2004–2013**

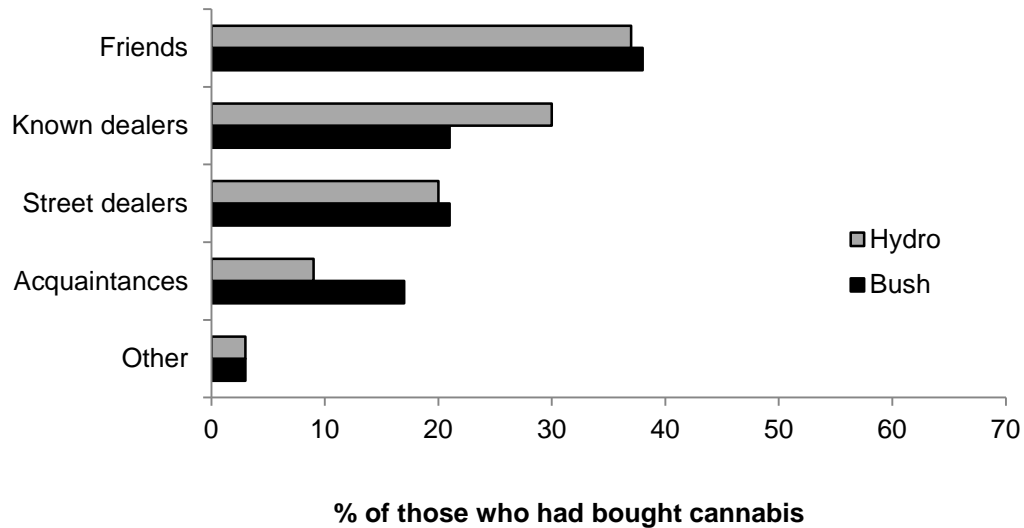


Source: IDRS PWID interviews

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

Sixty-five percent of all participants had purchased hydro in the preceding six months and 22% of participants had purchased bush. Patterns of purchase of hydro and bush were fairly similar, with those who had purchased in the last six months predominantly obtaining it through friends, from known dealers and/or from street dealers (Figure 48). Locations where cannabis was scored were varied, including public and private locations (Figure 49).

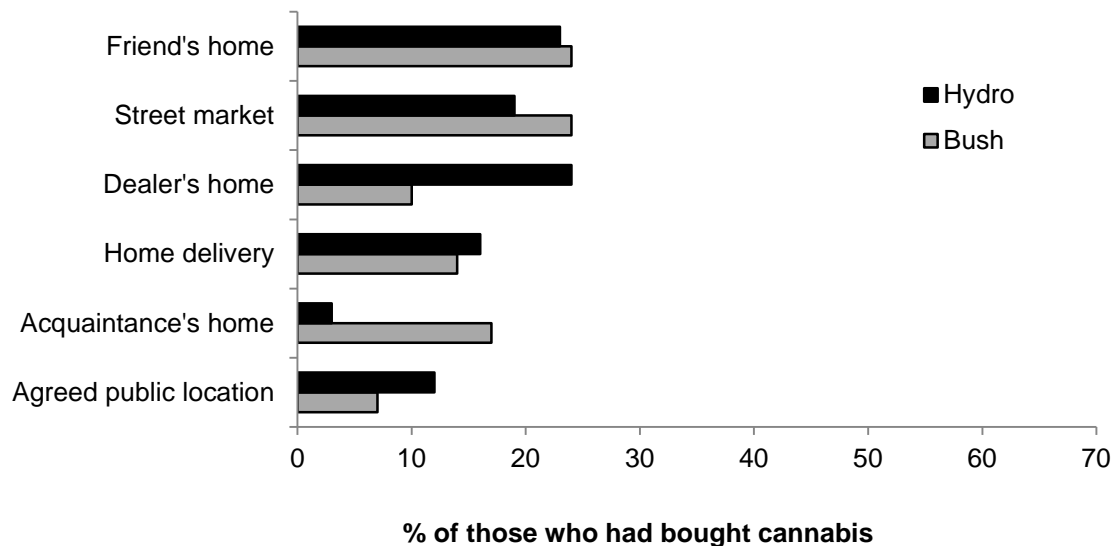
**Figure 48: People from whom cannabis was purchased in the preceding six months, 2013**



Source: IDRS PWID interviews

NB: More than one response could be selected

**Figure 49: Locations where cannabis was purchased in the preceding six months, 2013**



Source: IDRS PWID interviews

NB: More than one response could be selected

### 5.4.3 Potency

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

#### 5.4.3.1 Hydroponic cannabis

The majority of participants commenting on hydro reported it as currently being of 'high' potency (58%; 37% of the entire sample), followed by 30% (19% of the entire sample) who rated it as being of 'medium' potency. Only 3% (2% of the entire sample) thought that it was of 'low' potency, and 9% (6% of the entire sample) believed that it had 'fluctuated'. The majority (70% of those commenting; 44% of the entire sample) believed that potency had remained 'stable' in the preceding six months, with smaller proportions reporting that it had 'increased' (14%; 9% of the entire sample), 'fluctuated' (12%; 7% of the entire sample) or 'decreased' (5%; 3% of the entire sample). Despite some fluctuations, these figures followed a similar pattern to 2012.

#### 5.4.3.2 Bush cannabis

Among those who commented, 55% (12% of entire sample) thought bush was of 'medium' potency, 21% reported 'high' (5% of the sample), 15% (3% of entire sample) thought it was of 'low' potency, and 9% (2% of the sample) thought the potency 'fluctuates'. When asked about whether potency had changed over the last six months, 52% of the respondents that commented (10% of all participants) reported that potency had remained 'stable'. Equal proportions commented that it had 'decreased' or 'fluctuated' (17%; 5% of all participants), and 14% (3% of the entire sample) reported that it had 'increased'.

Overall, these findings indicated that, according to PWID perceptions, hydroponic cannabis appeared to dominate the market, and was generally seen as being higher in potency than outdoor-grown 'bush' cannabis. Potency of both forms was generally perceived to have remained stable in 2013.

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

### 5.4.4 Cannabis trends

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

#### 5.4.5 Key expert comments

- There was consensus among health KE that the prevalence of use remained high for this group, although it was not primarily the drug of concern.
- Availability was high and the price remained stable with the previous year.
- Most clients are focused on the purchase price, not the measurement in weight.
- Cannabis remained the most detected drug (use/possession and trafficking) in NSW according to law enforcement KE.

## 5.5 Methadone

As with other drug types, all participants were asked about the price, purity and availability of non-prescribed methadone. Thirty-four percent of the sample (31% in 2012) were able to comment on the price, purity and/or availability of illicit methadone. Among participants who had used any form of methadone in the preceding six months, the median price for methadone liquid was reported to be 55 cents per ml, which is stable with the data from previous years.

Only two participants were able to comment on the price of Physeptone tablets, with a median price of \$5 for 5mg tablet and \$10 for a 10mg tablet.

In response to the question 'Has the price of illicit methadone changed in the past six months?', the majority of those commenting (47%; 15% of the entire sample) reported that the price had remained 'stable' during this time. However, this was a statistically significant decrease ( $p < 0.05$ ) from the 70% (20% of the sample) that reported 'stable' in 2012. Thirty-eight percent (12% of the entire sample) reported prices had 'increased'. Smaller proportions of people stated that the price had 'fluctuated' (11%; representing 3% of the entire sample) and only two participants reported it had 'decreased'.

With regard to the current availability of non-prescribed methadone, there was a statistically significant ( $p < 0.05$ ) increase in those reporting it 'very easy' (39%; 17% in 2012) to obtain. Thirty-nine percent of participants also reported illicit methadone 'easy' (39%) to obtain and a further 16% (5% of the entire sample) thought it was 'difficult' to obtain. Three participants found it was 'very difficult' to obtain.

When asked whether availability had changed over the preceding six months, the majority of those commenting (80%; 26% of the entire sample) reported that it had remained 'stable'. Ten percent (3% of all participants) reported that it had become 'easier' to obtain in the preceding six months. The remainder of participants reported that it had become 'more difficult' (8%) to obtain illicit methadone, and only one participant reported its availability had 'fluctuated'.

Overall, the findings suggest that the illicit methadone market has remained relatively stable in terms of price and availability over the past few years. Of those that had obtained methadone, it was most commonly acquired from 'friends' (61%), 'street dealers' (19%), and 'acquaintances' (13%), with smaller amounts purchased from 'known dealers' (7%). The most commonly reported locations of purchase were 'agreed public location' (39%), 'friend's home' (23%), or 'street market' (23%), or 'home delivery' (10%), with smaller numbers obtaining from an 'acquaintance's home' (3%).

## 5.6 Buprenorphine

Eight percent of participants (11% in 2012) commented on the price and/or availability of non-prescribed buprenorphine, suggesting that while they may not have personally used it during this time, they were aware of some market characteristics. Buprenorphine (Subutex) is available in 0.4mg, 2mg and 8mg tablets (MIMS, 2007).

There were few reports ( $n=12$ ) of people commenting on all forms of Subutex tablets. Two-thirds (67%; 5% of entire sample) of those who commented reported current availability was 'very easy' (33%), or 'easy' (33%) while equal proportions of the remaining participants reported it was either 'difficult' (17%) or 'very difficult' (17%).

Half of the participants who commented (50%; 4% of entire sample) reported that availability of buprenorphine had remained 'stable' over the preceding 6 months, while 33% believed it had become 'more difficult'. Smaller numbers of participants (8%) reported the change in availability as 'easier', while the remaining 8% suggested it 'fluctuates'. Overall, these findings suggested

that while there was a market for non-prescribed buprenorphine, it was less available than non-prescribed methadone in NSW.

A question was added in 2007 that asked participants about the last occasion on which they used buprenorphine that wasn't prescribed to them, and what their main reasons for doing so were. In 2013, the main responses were for self-treatment (33%) and as a substitute for heroin (33%).

## 5.7 Morphine

Twenty-one percent of participants felt confident enough to respond to survey items concerning price and/or availability of illicit morphine, (21% in 2012). MS Contin continued to remain the most common brand of morphine used.

The median price for 100mg MS Contin tablets ('grey nurses') remained stable in 2013 at \$40 per tablet (\$40 in 2012; range \$25–\$80). Twelve participants commented on 60mg MS Contin (median price \$20) with less than 10 participants commenting on 10mg (median price \$10) and 5mg tablets (median price \$4). Additionally, only one participant only could comment on the price of 100mg Kapanol (median price \$20); therefore, results should be interpreted with caution. No participants commented on the price of Anamorph.

Sixty-three percent (13% of entire sample) of those commenting on the market for non-prescribed morphine reported that the price had remained 'stable' over the preceding six months (48% in 2012). Thirty-seven percent (7% of entire sample) of these participants believed that it had 'increased' (46% in 2012), and one participant each believed it had 'fluctuated' or 'decreased'. Overall, these figures are comparable to 2011.

The majority (61% or 13% of entire sample; 74% in 2012) commented that non-prescribed morphine was 'very easy' or 'easy' (23% and 39% respectively) to obtain. Thirty-nine percent (8% of the entire sample) believed it to be 'difficult' (19% in 2012), with no participants reporting morphine 'very difficult' to obtain. Sixty-seven percent (60% in 2012) of those commenting stated that availability had remained 'stable' over the preceding six months, while 30% reported the change in availability of morphine as 'more difficult'.

In 2013, morphine was most commonly purchased from 'friends' (43% of those commenting), 'street dealers' (33%), and 'acquaintances' (10%). These figures remained comparable with participant reports from 2012. The most commonly reported locations of purchase were from a 'street market' (40%), an 'agreed public location' (33%) or 'home delivery' (17%).

## 5.8 Oxycodone

In 2013, 39% of all participants were confident enough to complete survey items concerning the market for non-prescribed oxycodone, which remains stable with the 41% of participants from 2012. As per previous years, the most commonly purchased amounts were 80mg tablets (OxyContin, n=48), bought for a median of \$40 each (range \$20–\$100). The second most commonly purchased amount, 40mg OxyContin, had a median price of \$20 (range \$10–\$50). Twenty percent of participants (8% of the sample) purchased 20mg Oxycontin at a median of \$10 (range \$10–\$30). Fewer participants (n=7) purchased 10mg OxyContin at a median price of \$5. There were no participants who commented on prices of Endone.

The overall price for oxycodone was reported as having been 'stable' over the past six months (55% of those commenting), with 36% stating that it had 'increased', and 6% reporting that it had 'decreased'. Smaller numbers reported the price 'fluctuating' (4%). Availability was reported by the majority of those commenting to have remained 'stable' (67%) over the preceding six months, while 24% reported it had become 'more difficult'. Seven percent reported it had



become 'easier' and 2% of participants believed it 'fluctuates'. Overall, reports on the change in availability of oxycodone are consistent with 2012. Just under one-half (45% of those who could comment) thought that current availability of oxycodone was 'easy' and 38% thought it 'very easy'. Sixteen percent (25% in 2012) thought it 'difficult' and only one participant commented that it is currently 'very difficult'.

Oxycodone remained most commonly purchased from 'street dealers' (44%), 'friends' (40%) and 'acquaintances' (11%), with smaller proportions reporting 'known' and 'unknown' dealers (4% and 2% respectively). The most commonly cited locations for purchase were the 'street market' (49%), an 'agreed public location' (30%), or a 'friend's home' (12%). The remaining participants obtained Oxycodone through 'home delivery' (7%) or an 'acquaintance's house' (2%).

### 5.8.1 Key expert comments

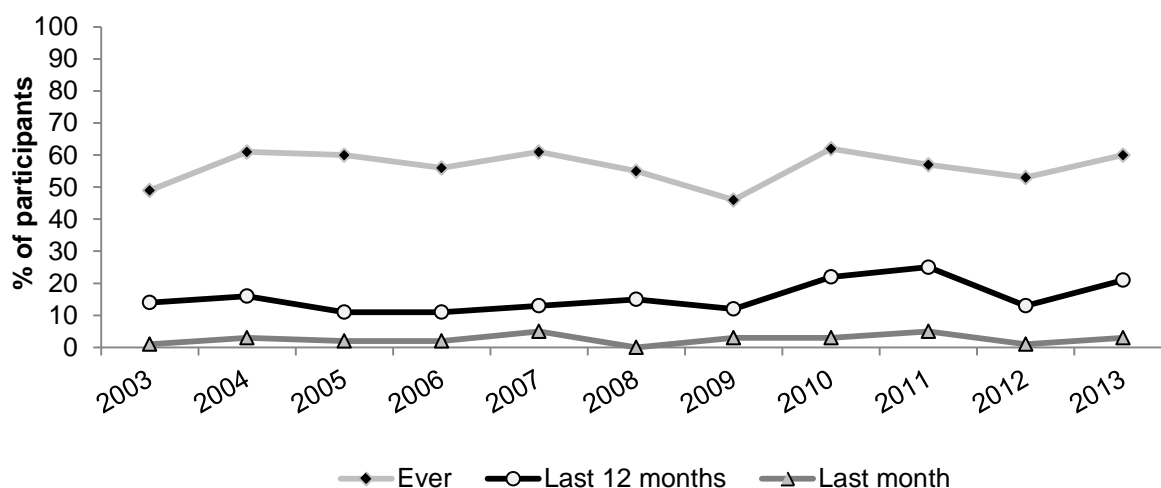
- The majority of health KE were able to comment on pharmaceutical opioids.
- Oxycodone remained the most frequently used pharmaceutical, followed by morphine according to health KE. However, it was repeatedly noted that heroin remained the first drug of choice for these users.
- Following comments on the previous year's poor quality heroin, known dosage and price (cheaper than a cap of heroin) were all identified as reasons for the popularity of pharmaceutical opioids (PO) among PWID.
- Health KE noted a high level of misinformation among clients about the safest way to prepare pharmaceutical opioid tablets for injection.
- A recurring theme among health KE was the prohibitive costs to their service of purchasing pill filters.

## 6 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

### 6.1 Overdose and drug-related fatalities

Sixty percent of participants reported having overdosed on heroin in their lifetime and 21% had done so the 12 months preceding the interview (13% in 2012). There were three reports of heroin overdose in the month prior to interview (one in 2012) (Figure 50).

**Figure 50: Proportion of PWID participants who had ever overdosed, overdosed in the past 12 months, and the past month, on heroin 2003–2013**

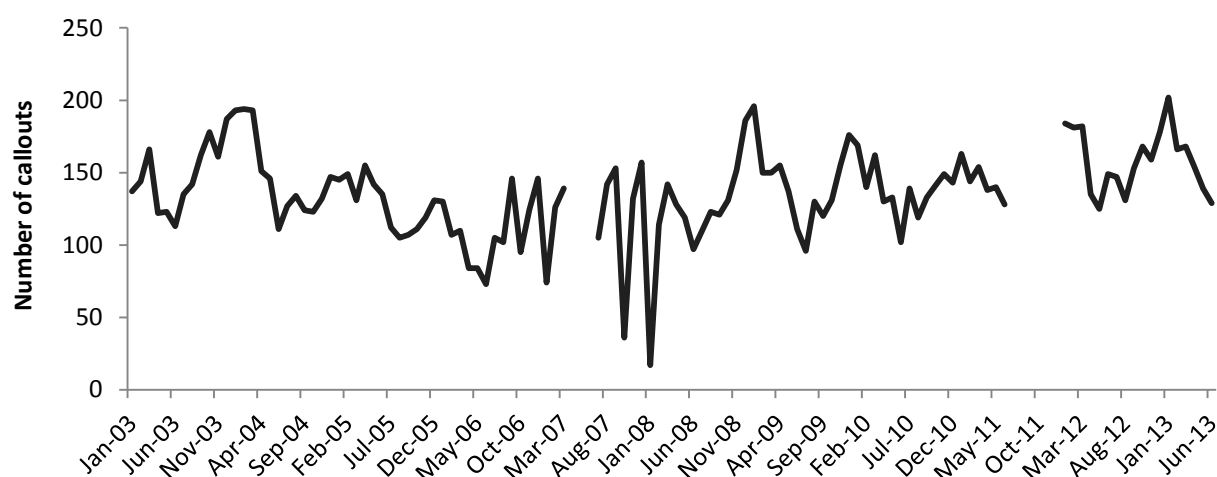


Source: IDRS PWID interviews

Twenty-three percent of participants (20% in 2012) reported that they had accidentally overdosed on other drugs excluding heroin and morphine on a median of one time only. Twenty-nine percent (6% in 2012) reported they had accidentally overdosed on other drugs excluding heroin and morphine in the 12 months prior to interview and two participants reported accidental overdose on other drugs in the past month.

The number of callouts to overdoses in NSW decreased dramatically in late 2000, and has not returned to levels recorded prior to 2000 (Figure 51). NSW ambulance callouts have remained relatively stable at a lower rate over the past 12 months to June 2013. For further information on ambulance callouts to overdoses in Inner Sydney, see National Centre in HIV Epidemiology and Clinical Research (2007).

**Figure 51: Number of ambulance callouts to overdoses January 2003–June 2013**

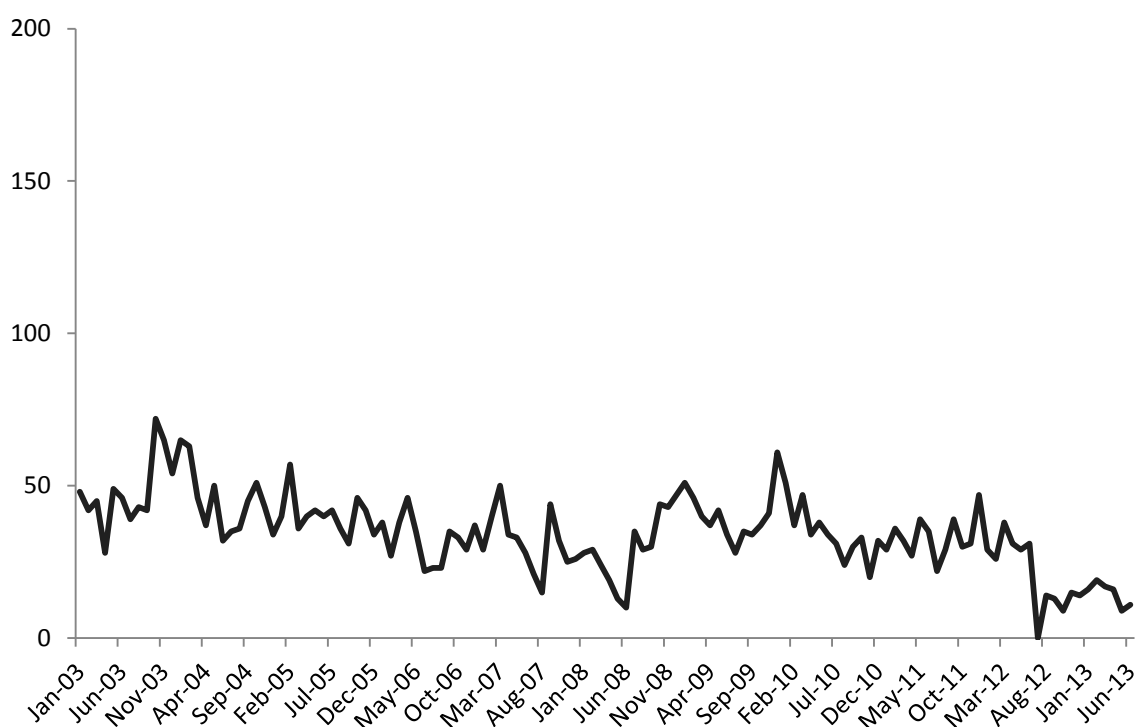


Source: Ambulance Service of NSW case sheet database

### 6.1.1 Heroin

Heroin overdose presentations to NSW emergency departments have remained relatively stable at less than 50 presentations per month since 2010. Figures have dropped off to less than 20 presentations per month during the period 2012–2013; however, it's unclear whether this may be related to a change in the use of SNOMED codes (Figure 52).

**Figure 52: Heroin overdose presentations to NSW emergency departments, January 2003–June 2013**



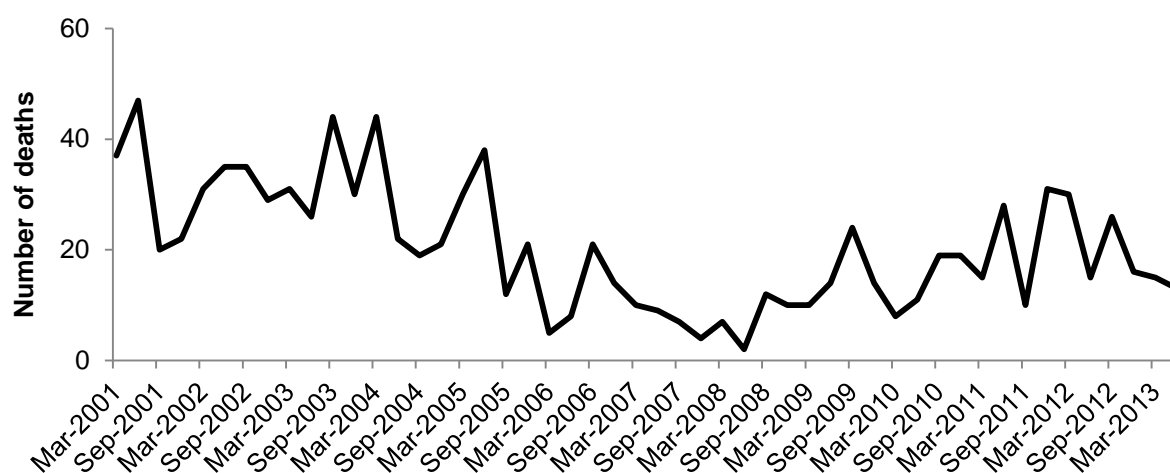
Source: Emergency Department Information System, NSW Ministry of Health

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

### 6.1.1.1 Fatal overdose

During the period 2012/13, there were relatively few deaths of people suspected of drug use (as determined by police or pathologists) in which morphine was detected (Figure 53). There was, however, a spike in fatalities in the three month periods leading up to December 2011 and March 2012 with 31 and 30 deaths reported, respectively, the highest numbers since mid-2005, in which 38 deaths were reported. Figures reached a peak in the late 1990s and have gradually decreased since 2000/01. As noted by other data sources, morphine-related deaths decreased dramatically in early 2001.

**Figure 53: Number of suspected drug-related deaths in which morphine was detected post-mortem, by quarter, 2001–2013**



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

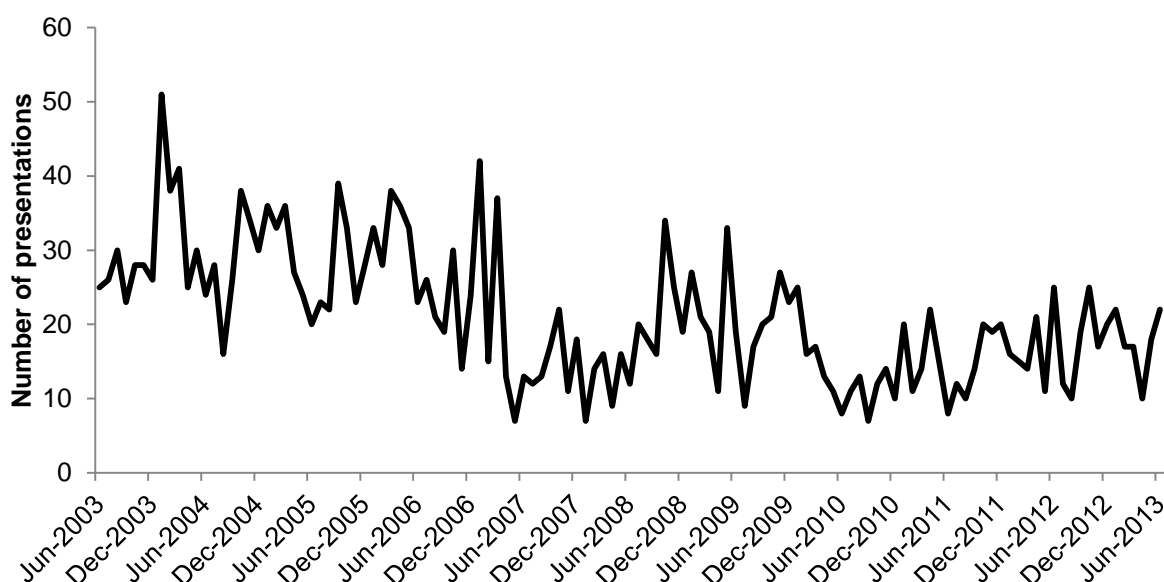
NB: These numbers relate to deaths in which morphine (a metabolite of heroin) was detected; however, there may have also been other drugs present

## 6.1.2 Methamphetamine

### 6.1.2.1 Non-fatal overdose

The number of amphetamine overdose presentations to NSW emergency departments fluctuated again in 2012/13, ranging between 10 and 25 presentations per month (Figure 54).

**Figure 54: Amphetamine overdose presentations to NSW emergency departments, June 2003–June 2013**



Source: Emergency Department Information System, NSW Ministry of Health

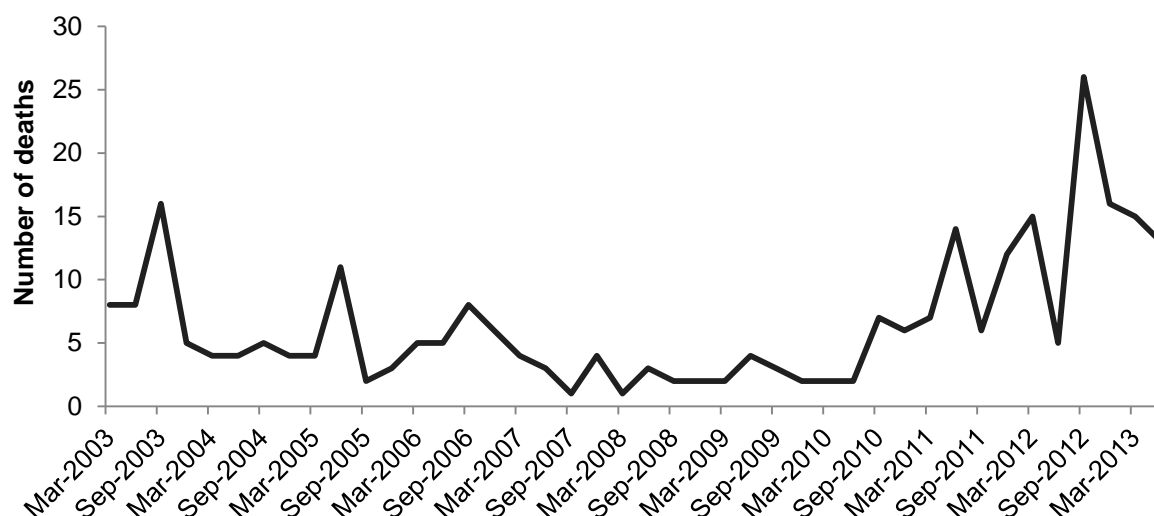
NB: Figures refer to overdose only and do not include presentations for use disorders

### 6.1.2.2 Fatal overdose

The number of deaths of individuals suspected of drug use where amphetamines were detected post mortem in NSW has increased in 2012/13, peaking in the September 2012 quarter at 26 deaths, the highest number recorded in one quarter over the 18 year period. These figures appear to be returning to the peaks seen between 1999 and 2003 (Figure 55).

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

**Figure 55: Number of deaths of individuals suspected of drug use, in which illicit amphetamines were detected post-mortem, NSW, by quarter, 2003–2013**



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

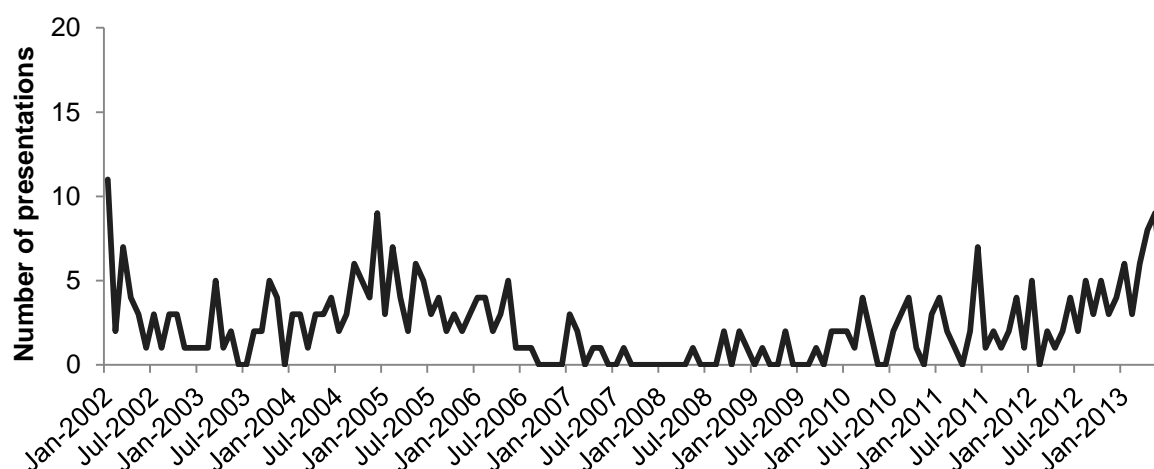
NB: These numbers relate to deaths in which amphetamines, including methamphetamine, were detected; however, there may have also been other drugs present

### 6.1.3 Cocaine

#### 6.1.3.1 Non-fatal overdose

The number of cocaine overdose presentations to NSW emergency departments has remained lower than ten per month since February 2002; however, they have increased compared to previous years (Figure 56). In the 12 months to June 2013, there were a total of 58 recorded presentations (compared to 25 in 2011/12 and 29 in 2010/11).

**Figure 56: Cocaine overdose presentations to NSW emergency departments, January 2002–June 2013**



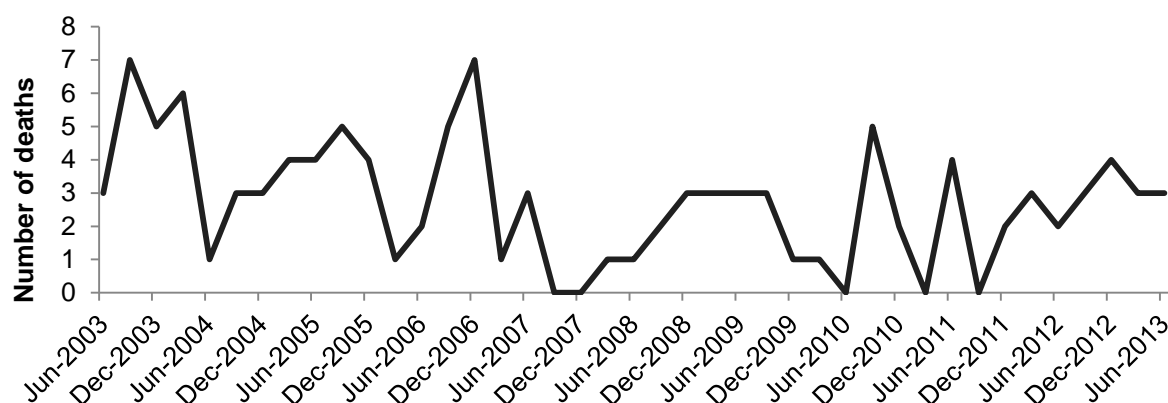
Source: Emergency Department Information System, NSW Ministry of Health

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

### 6.1.3.2 Fatal overdose

The number of drug-related deaths in which cocaine was detected post-mortem has remained low over the last 12 months to June 2013 (Figure 57), following a peak in the late 1990s. These deaths have not exceeded 20 in any given quarter over the past 12 years and have remained at five or less per quarter since 2007.

**Figure 57: Number of deaths of individuals suspected of drug use, in which cocaine was detected post-mortem, NSW, by quarter, 2003–2013**



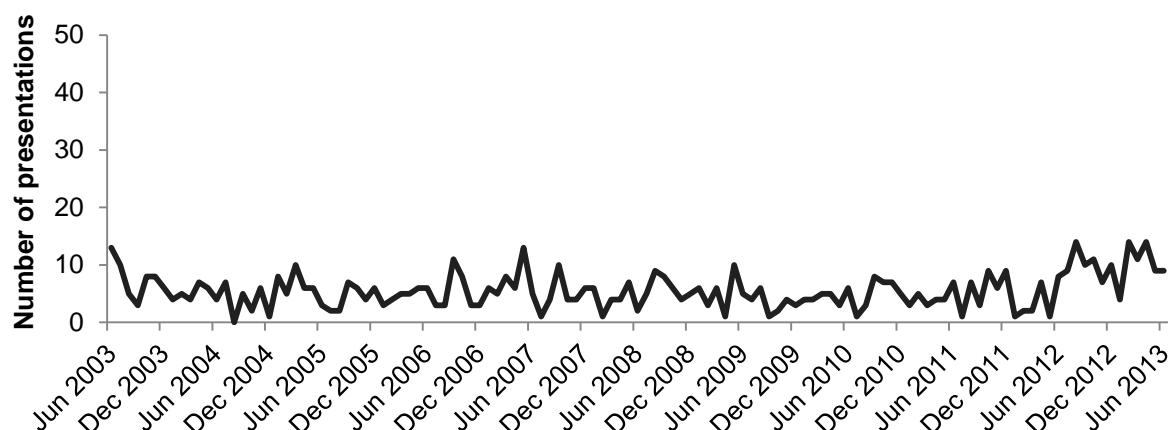
Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories, NSW Ministry of Health

NB: These numbers relate to deaths in which cocaine was detected; however, there may have also been other drugs present

### 6.1.4 Cannabis

The number of cannabis toxicity presentations to emergency departments has remained at less than 20 per month since 1997. The past 12 months to 2013 has seen an increasing trend in these presentations (Figure 58).

**Figure 58: Cannabis toxicity presentations to NSW emergency departments, June 2003–June 2013**



Source: Emergency Department Information System, NSW Ministry of Health

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

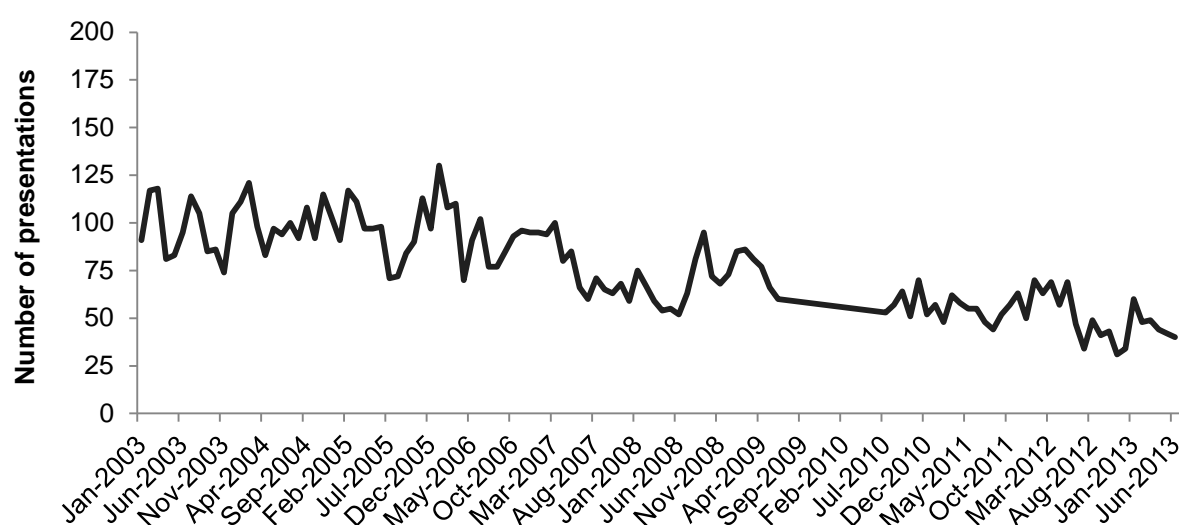
## 6.1.5 Benzodiazepines

### 6.1.5.1 Non-fatal overdose

The number of benzodiazepine overdose presentations to NSW emergency departments has fluctuated over the past 12 months to June 2013 (between 31 and 60 presentations per month; Figure 59) and continues to decline over time. There appears to be a continuing decline in these presentations; however, this may also reflect that coding practices have changed.

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

**Figure 59: Benzodiazepine overdose presentations to NSW emergency departments, January 2003–June 2013**



Source: Emergency Department Information System, NSW Ministry of Health

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

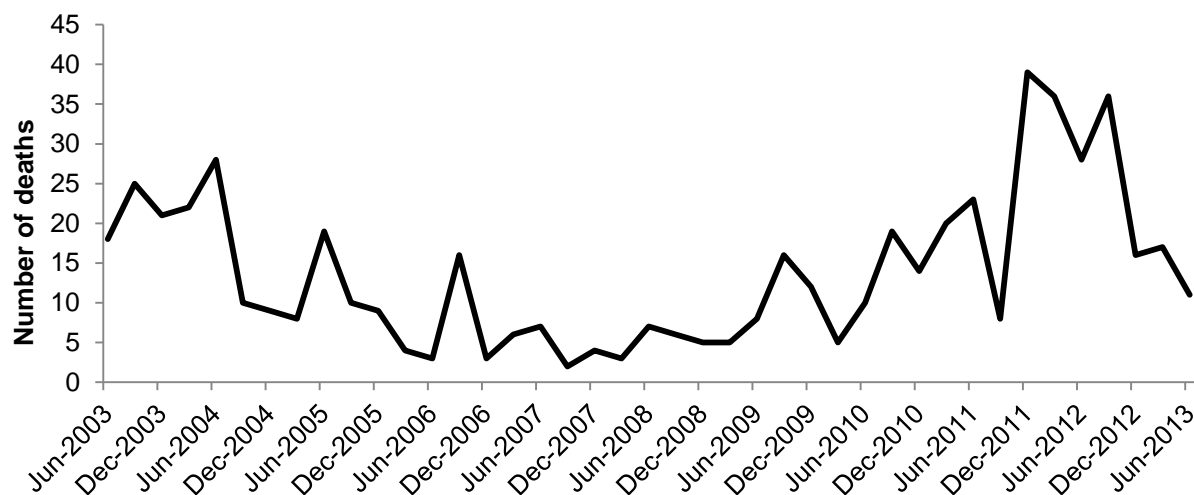


### 6.1.5.2 Fatal overdose

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

During 2012/13, figures increased again to levels not seen since early 2000 with a peak of 39 deaths recorded in the December 2012 quarter.

**Figure 60: Number of deaths of individuals suspected of drug use, in which benzodiazepines were detected post-mortem, NSW, by quarter, 2003–2013**



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

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

## 6.2 Calls to telephone helplines

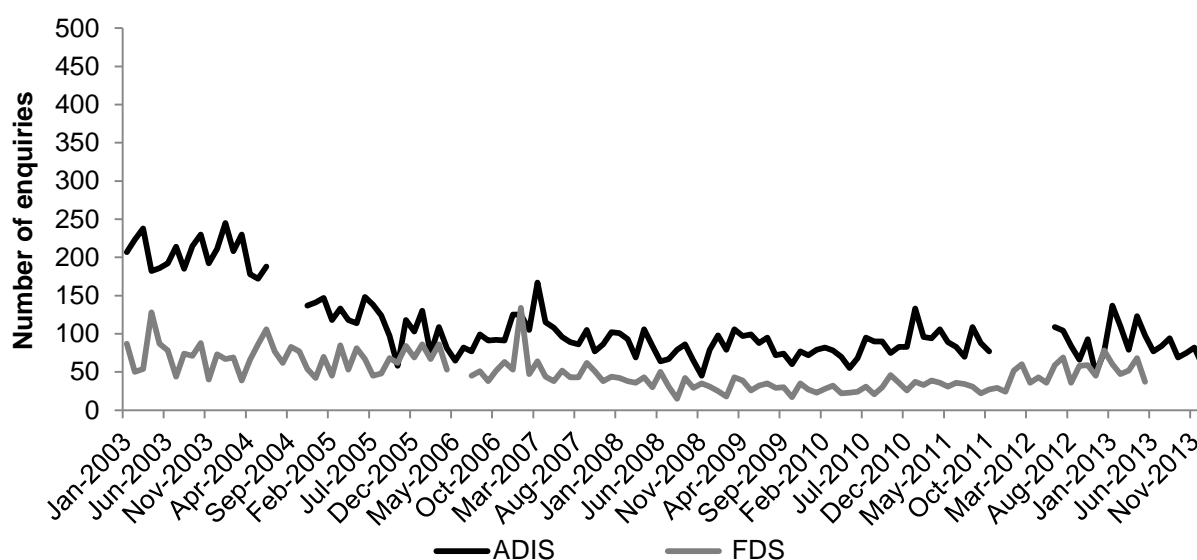
### 6.2.1 Heroin

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

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

The number of calls to both services regarding heroin has remained stable, ranging between 48–137 calls a month for ADIS and 36–78 calls a month to FDS.

**Figure 61: Number of enquiries to ADIS and FDS regarding heroin, January 2003–November 2013**



Source: NSW ADIS and FDS

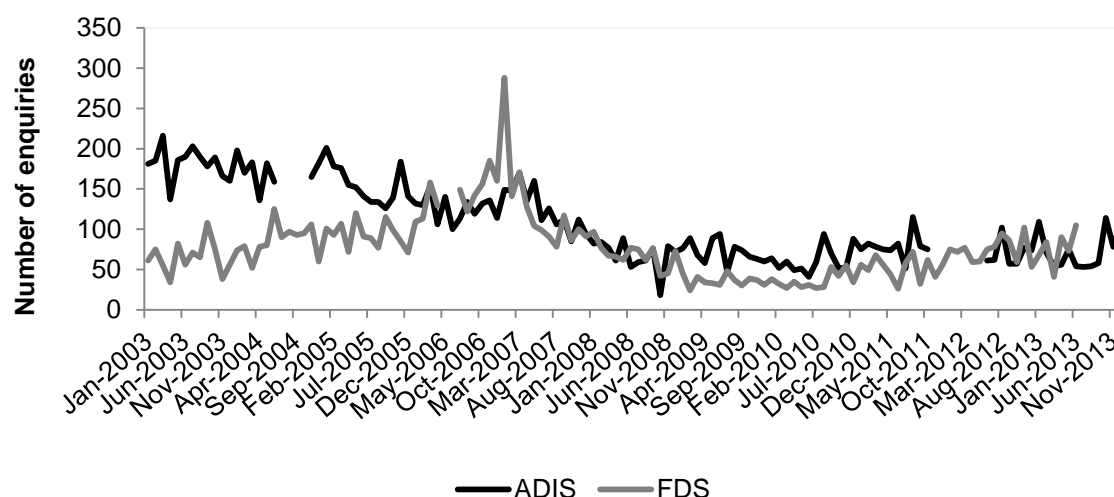
NB: FDS data were only available on a monthly basis and refer to calls where any mention of heroin was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where heroin was mentioned as any drug of concern. ADIS data were unavailable for the period July–November 2004 and November–June 2012. FDS data were unavailable for the period May–June 2006.

## 6.2.2 Methamphetamine

Figure 62 shows the number of calls to the ADIS and FDS lines regarding methamphetamines.

The numbers of enquiries to both ADIS and FDS has remained low over the past few years and have fluctuated in the last 12 months (ADIS range: 53–114; FDS range: 41–105).

**Figure 62: Number of enquiries to ADIS and FDS regarding methamphetamines including 'crystal/ice', January 2003–November 2013**

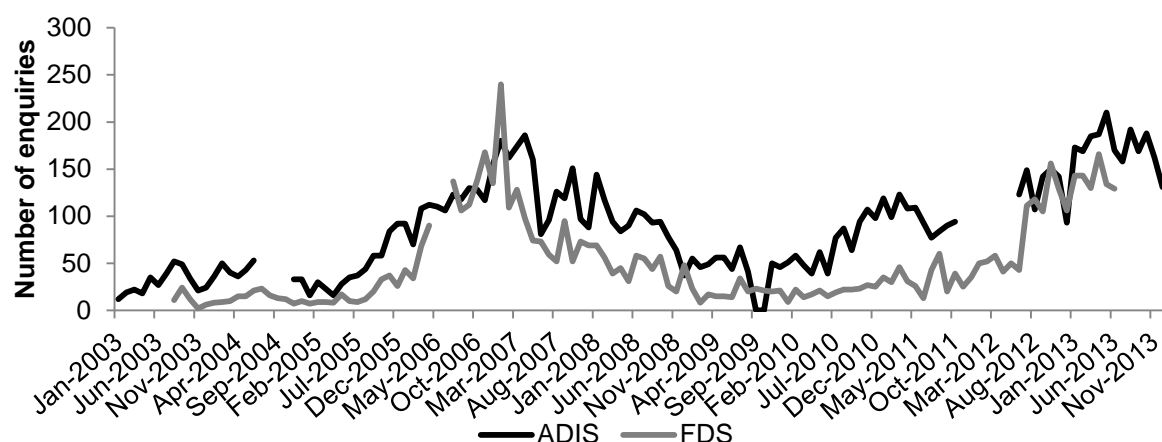


Source: NSW ADIS and FDS

NB: FDS data refer to calls where any mention of amphetamines was made. ADIS data refer to the number of calls where amphetamines were mentioned as any drug of concern. ADIS data were unavailable for the period July–November 2004 and November–June 2012. FDS data were unavailable for the period May–July 2006.

Figure 63 shows the number of calls to the ADIS and FDS lines regarding ice/crystal methamphetamine. Calls to both services have been increasing over the past two years.

**Figure 63: Number of enquiries to ADIS and FDS regarding ice/crystal methamphetamine, January 2003–November 2013**



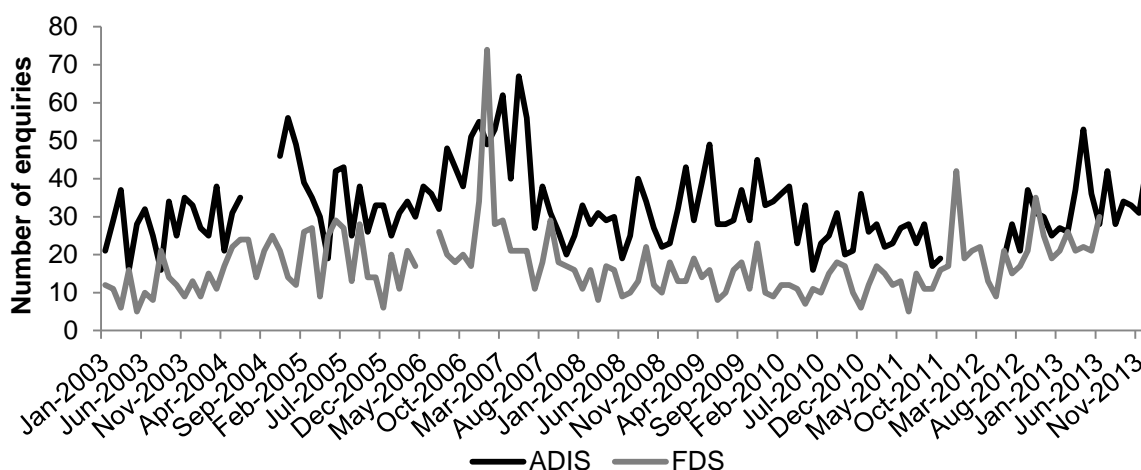
Source: NSW ADIS and FDS

NB: FDS data were only available on a monthly basis and refer to calls where any mention of ice/crystal methamphetamine was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where ice was mentioned as any drug of concern. ADIS data were unavailable for the period July–November 2004 and November–June 2012. FDS data were unavailable for the period May–July 2006.

### 6.2.3 Cocaine

Figure 64 shows the number of calls to the ADIS and FDS lines regarding cocaine. Despite fluctuations, the number of calls per month to both ADIS and FDS have remained relatively stable (ADIS range: 19–53; FDS range: 15–35) over the 12 months to December 2013.

**Figure 64: Number of enquiries to ADIS and FDS regarding cocaine, January 2003–November 2013**



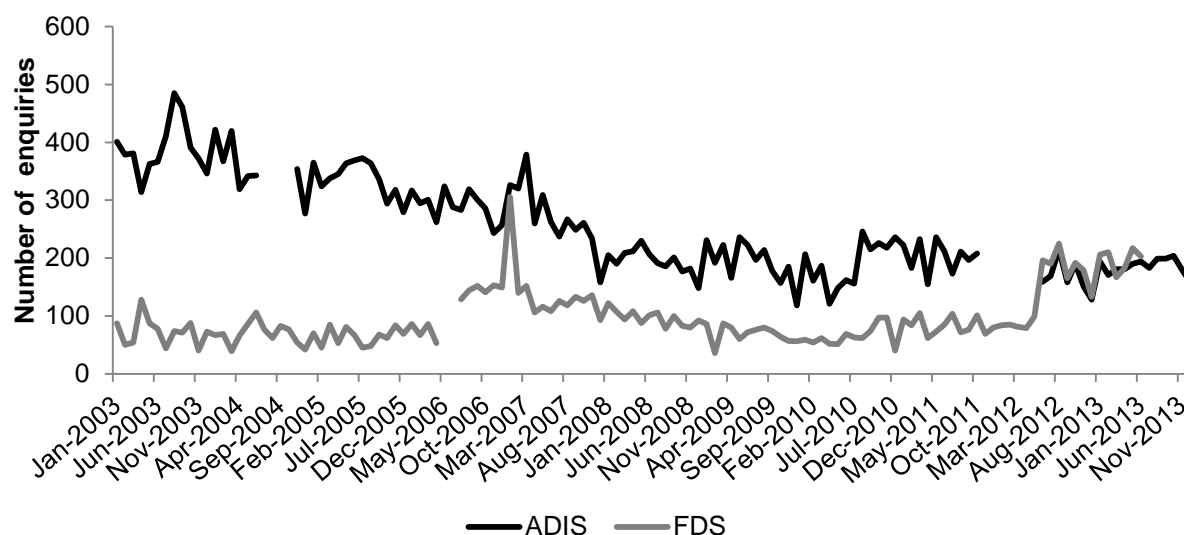
Source: NSW ADIS and FDS

NB: FDS data were only available on a monthly basis and refer to calls where any mention of cannabis was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where cocaine was mentioned as any drug of concern. ADIS data were unavailable July–November 2004 and November–June 2012. FDS data were unavailable for the period May–July 2006.

## 6.2.4 Cannabis

The number of calls to ADIS and FDS regarding cannabis has remained relatively stable in the 12 months to December 2013 (Figure 65).

**Figure 65: Number of enquiries to ADIS and FDS regarding cannabis, January 2003–November 2013**



Source: ADIS and FDS

NB: FDS data were only available on a monthly basis and refer to calls where any mention of cannabis was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where cannabis was mentioned as any drug of concern. ADIS data were unavailable July–November 2004 and November–June 2012. FDS data were unavailable for the period May–June 2006.

## 6.3 Drug treatment

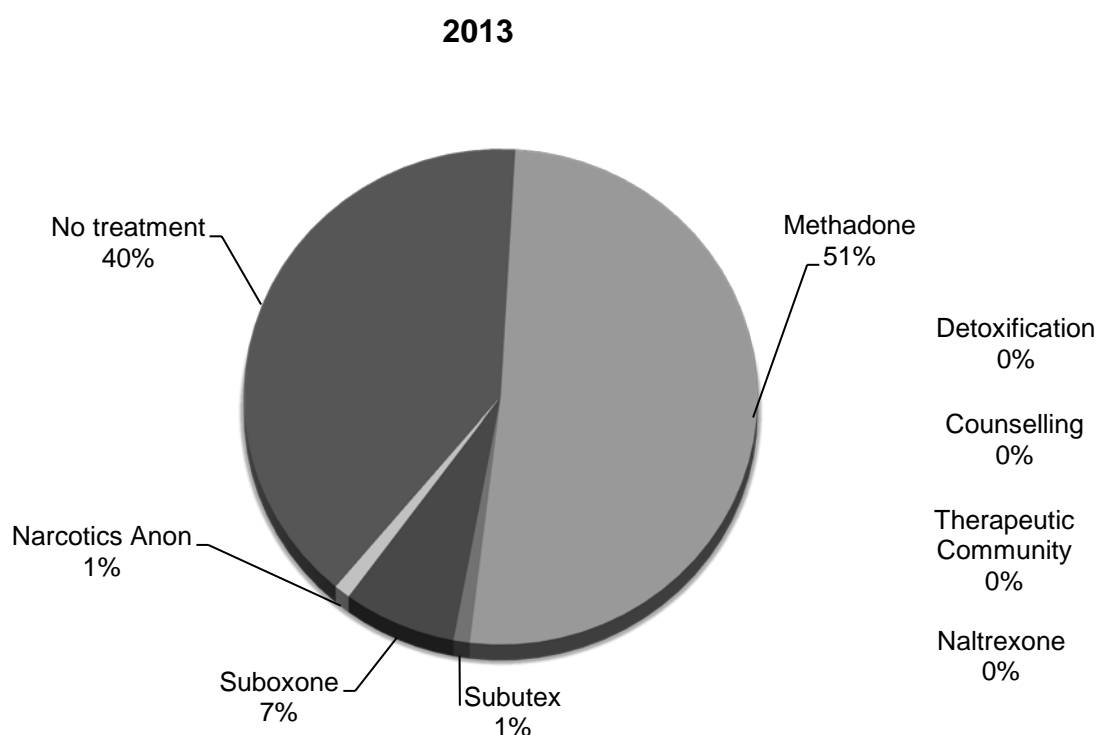
### 6.3.1 Forms of treatment

The majority (61%) of all PWID participants were in some form of treatment at the time of interview, which is stable with the 60% who were in some form of treatment in 2012.

Of those currently in drug treatment, 92% reported being currently in a form of OST, with the majority (86%) of those currently on OST receiving methadone and smaller amounts receiving buprenorphine-naloxone (Suboxone) (11%) or buprenorphine (2%). Those currently in treatment had been in that treatment for a median of 36 months (i.e. three years).

Fifty-nine percent of all participants had been in some form of treatment in the past six months. Of these, 79% (48% of the entire sample) had been on methadone maintenance treatment (MMT), 13% (8% of the entire sample) had been on buprenorphine-naloxone (Suboxone) treatment, and 9% (5% of the entire sample) reported drug counselling. Other treatments accessed over the past six months by participants were buprenorphine (Subutex) (7%; 4% of the sample), detoxification (4%; 3% of the sample) and 'other' treatments (5%; 3% of entire sample). Three percent of participants reported Narcotics Anonymous and only one participant reported treatment at therapeutic communities in the six months prior to interview (Figure 66).

**Figure 66: Proportion of participants reporting any form of drug treatment in last 6 months, 2013**



Source: IDRS PWID interviews

NB: More than one form of treatment could be nominated

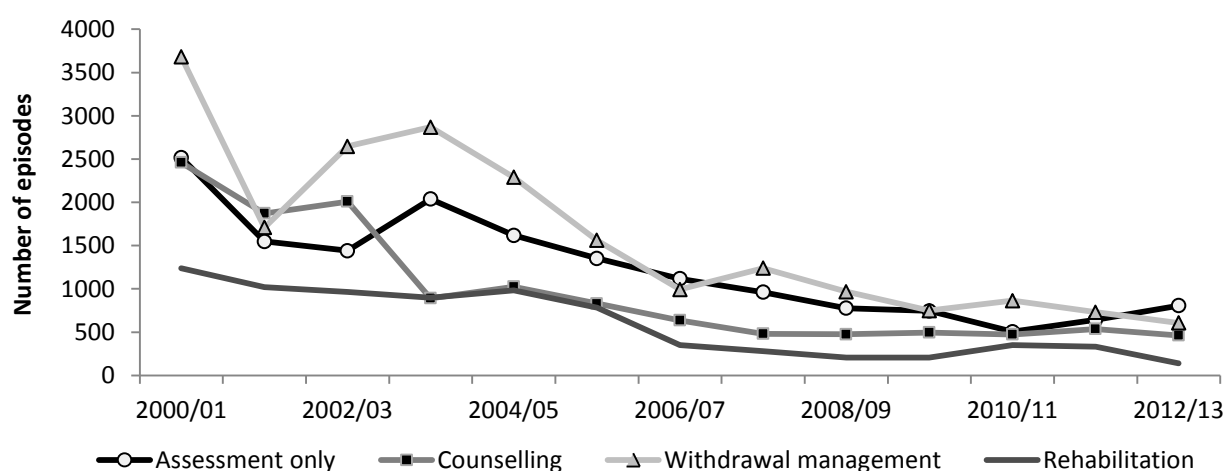
### 6.3.2 Heroin treatment

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

Numbers entering for 'assessment only' have fluctuated over the past few years, with a decrease during 2000/2001–2001/2002, a subsequent increase in 2003/04 and a low but steady decrease over the last nine years. Numbers entering residential rehabilitation have also gradually declined from 1,237 in 2000/2001 to 141 in 2012/2013. Numbers entering counselling continued to decline, and have remained stable over the past seven years than previously.

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

**Figure 67: Number of heroin treatment episodes by treatment type, NSW 2000/01–2012/13**



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

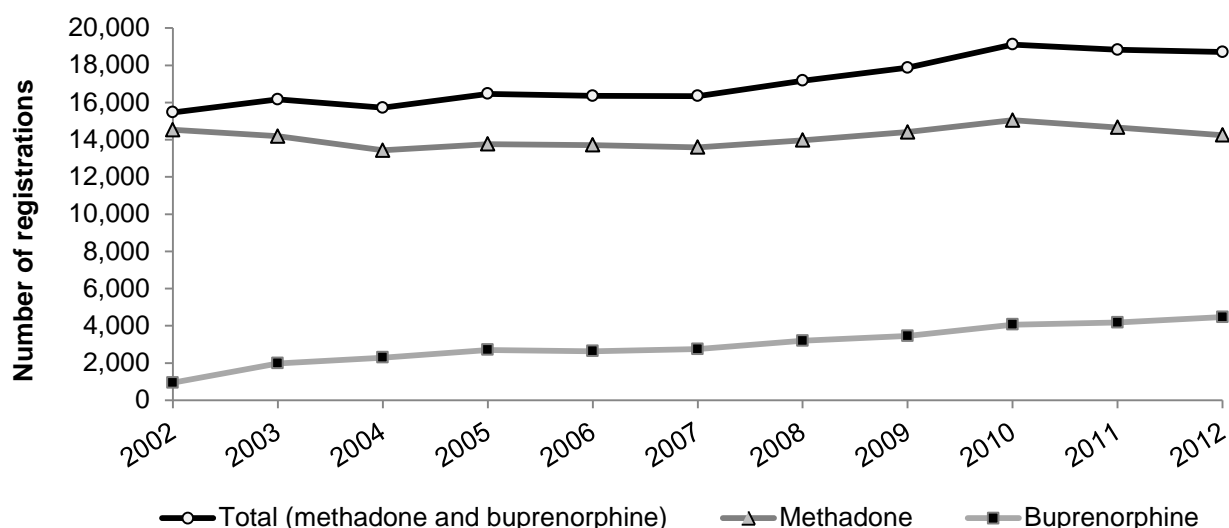
NB: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement.

Figure 68 shows that the number of people receiving all forms of opioid substitution treatment in NSW increased from 11,365 on the 30<sup>th</sup> June 1997 to 18,715 on the 30<sup>th</sup> June 2012. Overall, in 12 months to the end of June 2012 there was a slight decrease in the numbers seen in 2011 (18,831).

The vast majority of opioid pharmacotherapy clients received methadone. The number of people receiving buprenorphine has generally increased since its introduction in 2000. As of June 2012, 34% of Australia's 2,226 pharmacotherapy sites were located in NSW and were dosing 18,715 clients. The vast majority of sites (640) were pharmacies, with smaller amounts of hospitals (70), public clinics (36), private clinics (12) or correctional settings (1). The same data for 2013 was not available at the time of publication.

Fifty-eight percent of opioid pharmacotherapy clients obtained their treatment through a private provider, 33% received it through a public prescriber, 8% were in correctional facilities and 1% obtained their treatment through a public/private prescriber (i.e. a prescriber in a private clinic which receives some public funding (Australian Institute of Health and Welfare, 2013).

**Figure 68: Number of registrations for opioid substitution treatment on the 30<sup>th</sup> June each year, NSW, 2003–2012**



Source: (Australian Institute of Health and Welfare, 2013)

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

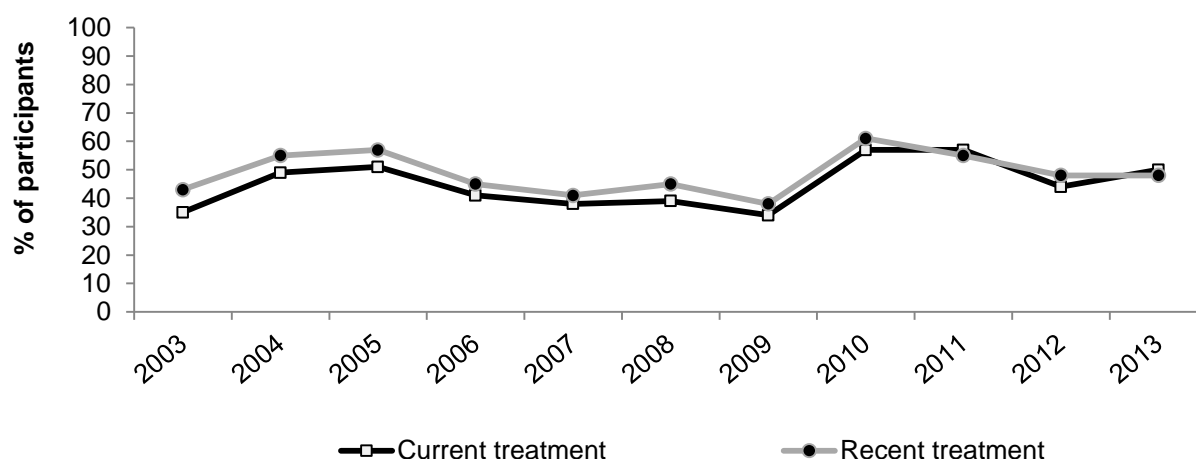


### 6.3.3 Methadone treatment

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

Fifty-six percent of participants had used methadone that had been prescribed for them in the preceding six months (48% in 2012) and 13% reported injecting prescribed methadone during this time. Only 2% of participants reported recent use of prescribed Physeptone tablets. Overall, there has been a steady increase in the proportion of PWID participants reporting current engagement in a methadone maintenance treatment (MMT) (Figure 69). Forty-eight percent of PWID reported receiving methadone treatment at some point in the preceding six months (recent treatment) (48% in 2012). As in previous years, methadone syrup was the predominant form of OST used.

**Figure 69: Proportion of participants reporting methadone treatment, 2003–2013**



Source: IDRS PWID interviews

Amongst those who had been on a methadone program in the six months preceding interview, the median number of days of use in the preceding six months was 180 days, i.e. daily use (the same as 2012). Seventy-eight percent of methadone users reported daily use (65% in 2012).

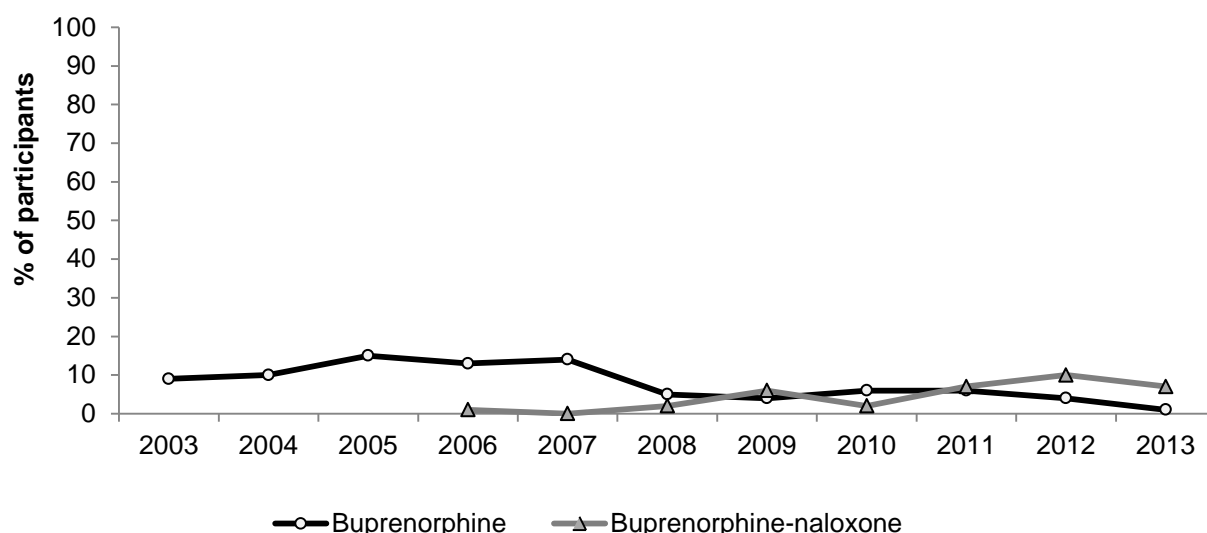
It should be noted that the IDRS deliberately recruits a 'sentinel' population of people who inject drugs and are current and active participants in illicit drug markets. As a consequence, those in the PWID samples who report being in treatment may not be representative of treatment populations more generally, particularly those who withdraw from injecting drug use and/or illicit drug market activity once engaged in treatment. Similarly, as regular injecting drug use is a requirement for participation in the IDRS survey, participants who are also engaged in methadone treatment – of whom there is a substantial proportion in the 2013 IDRS – may not be representative of methadone clients generally.

### 6.3.4 Buprenorphine treatment (including buprenorphine-naloxone)

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

Approximately two-fifths (42%) of the sample reported ever having been prescribed buprenorphine (Subutex). Five percent of participants reported using it in the preceding six months which is stable with the 8% reported in 2012. One percent stated they were currently participating in buprenorphine treatment (4% in 2012) (Figure 70). Among those who used prescribed buprenorphine, the median number of days of use in the last six months was 90 days, (median 93 days in 2012). When used as a maintenance treatment, buprenorphine can be dosed daily or every two days. The median days in treatment increased to 90 days (i.e. around every second day; range 7–180 days; 102 in 2012). Please note that buprenorphine may also be prescribed during opioid detoxification.

**Figure 70: Proportion of participants reporting current buprenorphine treatment, 2003–2013**



Source: IDRS PWID interviews

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

In the last six months, 3% of participants has used prescribed buprenorphine-naloxone tablets and 11% prescribed buprenorphine-naloxone sublingual film. The median number of days of use in the last six months for buprenorphine-naloxone tablets was 4 days (7 days licit; 3 days illicit) and the median days for buprenorphine-naloxone film was 33 days (72 days licit; 3 days illicit). The median number of days enrolled in treatment for buprenorphine-naloxone tablets and film was 150 and 90 days, respectively. Note: small numbers commenting so interrupt with caution. Two participants reported recent injection of prescribed buprenorphine-naloxone in its tablet form and five participants reported recent injection of buprenorphine-naloxone in its film form.

### 6.3.5 Methamphetamine treatment

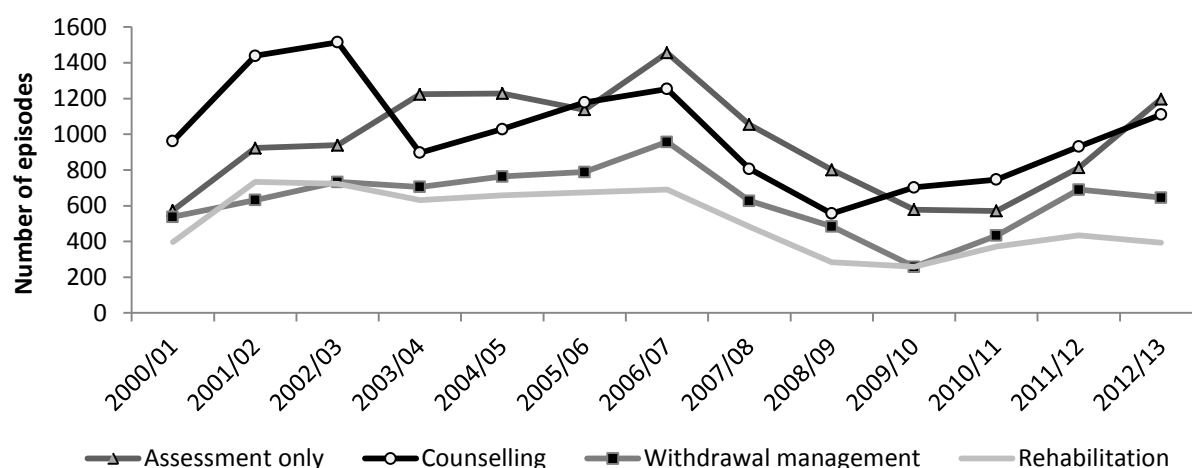
Over the past 12 months for all main forms of treatment, there were mixed results in the number of closed treatment episodes, based on the date of commencement where the principal drug of concern was amphetamines (Figure 71).

It does appear, however, that instances of withdrawal management and assessment treatment episodes are on the rise, though they are still lower than the highs seen in 2006/07.

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

The number of 'counselling' episodes is the highest recorded since the 2006/07 period. As noted above, these changes should be interpreted with caution.

**Figure 71: Number of amphetamine treatment episodes by treatment type, NSW, 2000/01–2012/13**



Source: NSW MDS AODTS, NSW Department of Health.

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

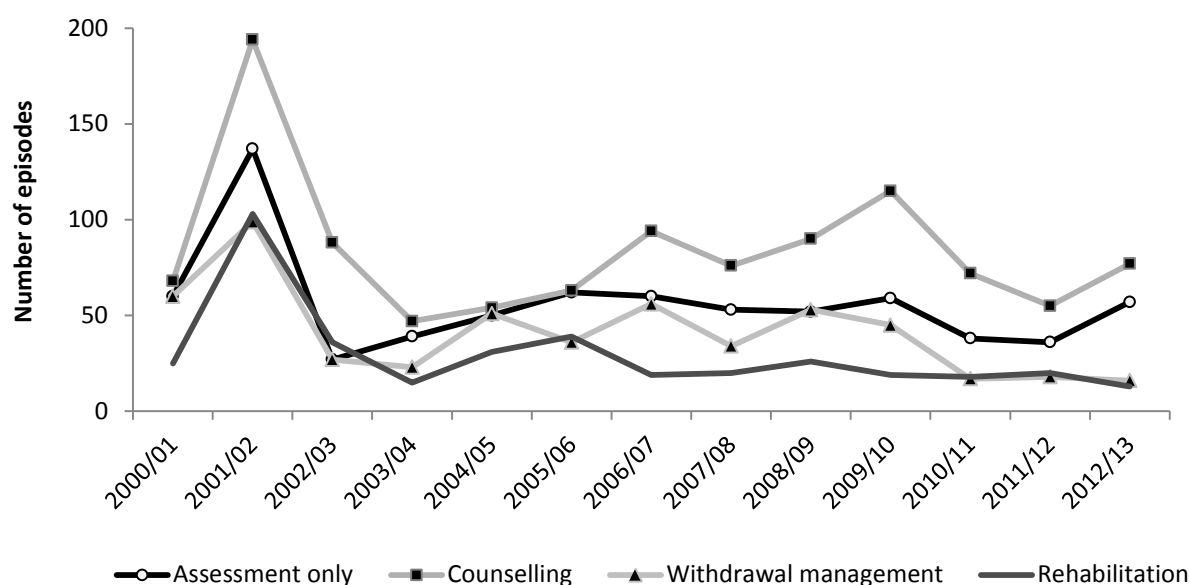
### 6.3.6 Cocaine treatment

Apart from a spike in 'counselling' in 2009/10 where the principal drug of concern was cocaine, the number of closed treatment episodes based on the date of commencement has remained at less than 100 per treatment type since 2002/03.

In 2012/13, 'withdrawal management' and 'residential rehabilitation' remained stable, while there was a slight increase in 'assessment only' and 'counselling' episodes (Figure 72).

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

**Figure 72: Number of cocaine treatment episodes by treatment type, NSW, 2000/01–2012/13**



Source: NSW MDS AODTS, NSW Department of Health.

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

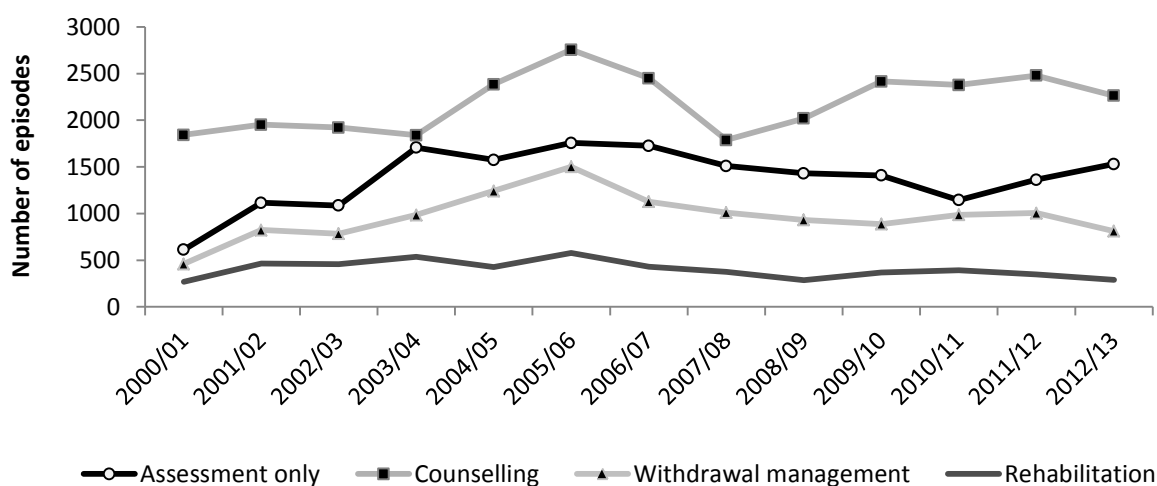
### 6.3.7 Cannabis treatment

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

Numbers entering for 'assessment only' has increased gradually over the past few years. Those entering 'withdrawal management' peaked in 2005/06 with 1,502 episodes, but the number of episodes reported has been declining gradually since this period. 'Residential rehabilitation' episodes have remained relatively stable since 2001/02 (270 treatment episodes), peaking in 2005/06 (577 treatment episodes), gradually declining since to stabilise over the last three years. Additionally, the number of 'counselling' episodes has remained stable over the past four years.

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

**Figure 73: Number of cannabis treatment episodes by treatment type, NSW, 2000/01–2012/13**



Source: NSW MDS AODTS, NSW Department of Health.

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

## 6.4 Hospital admissions

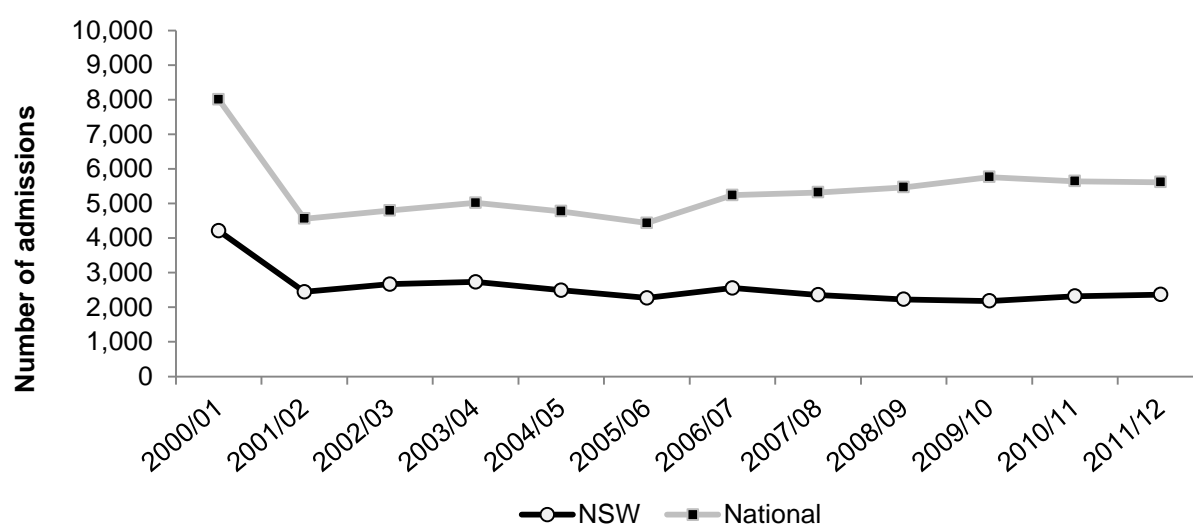
### 6.4.1 Heroin

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

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

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

**Figure 74: Number of principal opioid-related hospital admissions among people aged 15–54, NSW and Australia, 2000/01–2011/12**



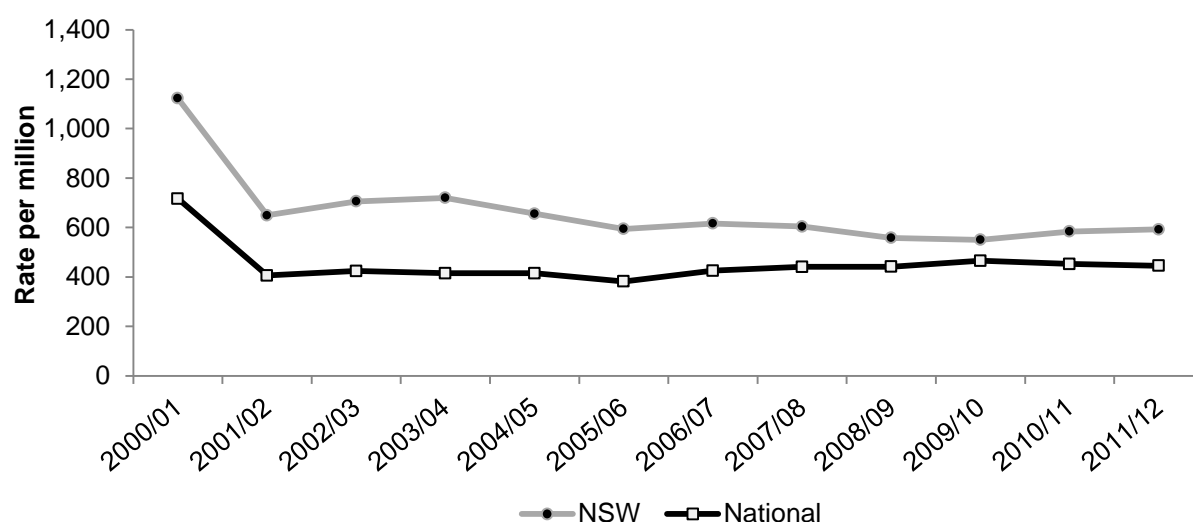
Source: Roxburgh and Burns (in press)

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

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

The number of admissions per million persons in both NSW and nationally remain substantially lower than in previous years and NSW continues to account for just under half (42%) of all opioid-related hospital admissions in Australia.

**Figure 75: Number per million persons of principal opioid-related hospital admissions among people aged 15–54 years, NSW and nationally, 2000/01–2011/12**

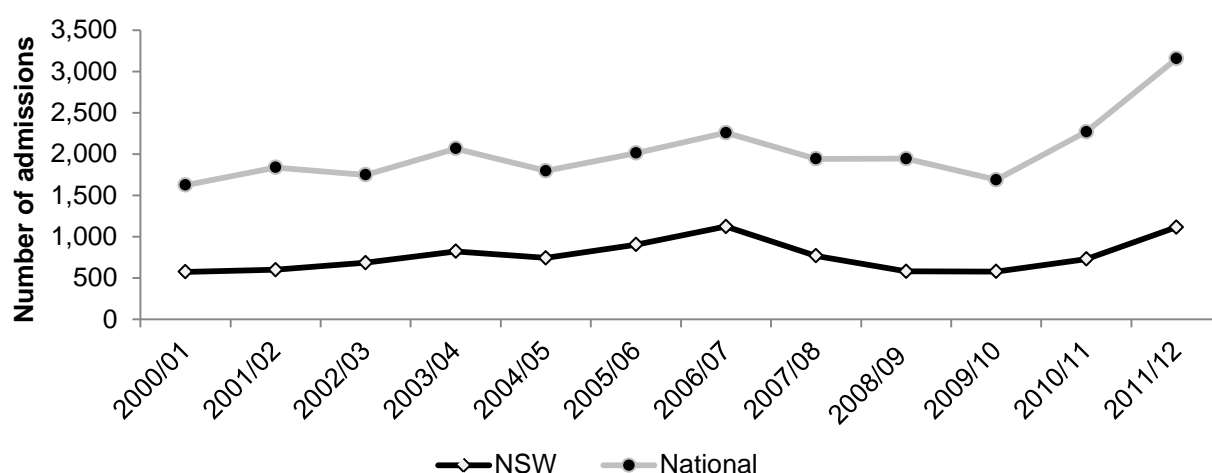


Source: Roxburgh and Burns (in press)

## 6.4.2 Methamphetamine

The number of inpatient hospital admissions among persons aged 15–54 years in which the principal diagnosis was amphetamine-related is shown in Figure 76. In 2011/12, admissions in NSW were the highest since the 2006/07 period (1,115). Overall this trend has remained stable and consistently lower than the national figures.

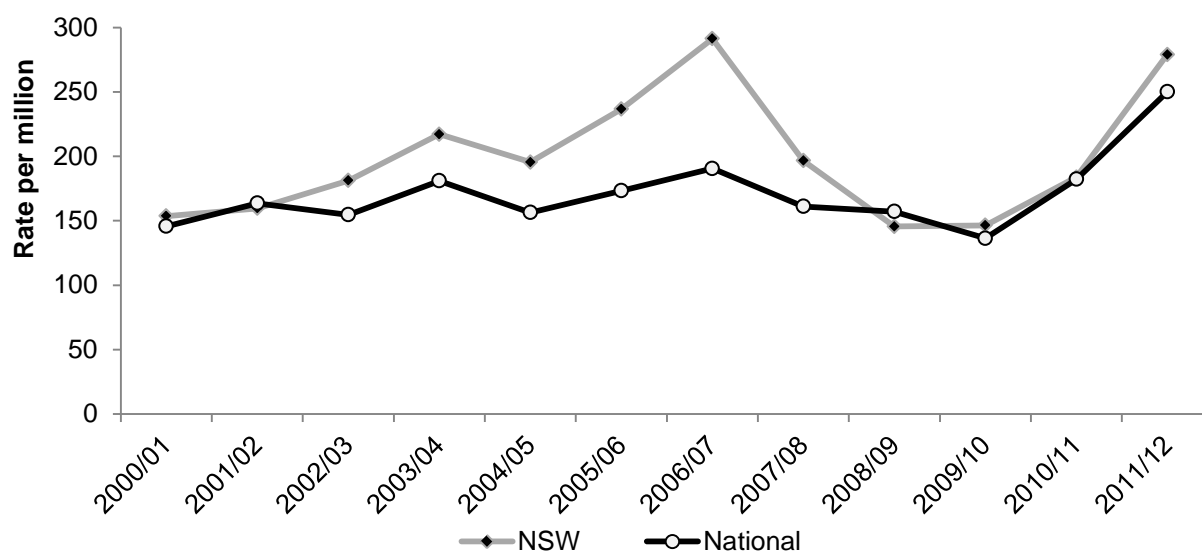
**Figure 76: Number of principal amphetamine-related hospital admissions among persons aged 15–54, NSW and nationally, 2000/01–2011/12**



Source: Roxburgh and Burns (in press)

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

**Figure 77: Number per million persons of principal amphetamine-related hospital admissions among people aged 15–54 years, NSW and nationally, 2000/01–2011/12**



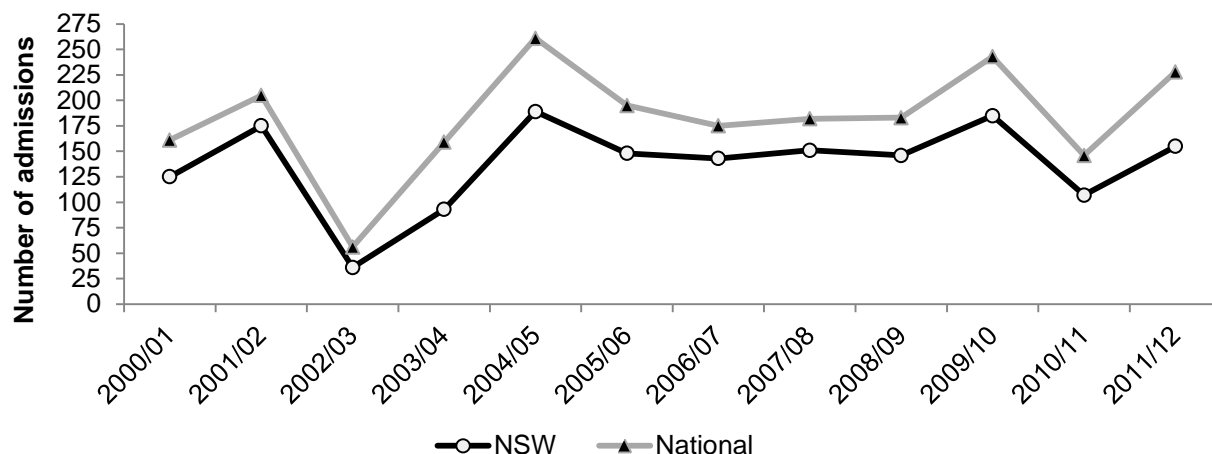
Source: Roxburgh and Burns (in press)



### 6.4.3 Cocaine

The numbers of inpatient hospital separations in which the principal diagnosis was cocaine-related are shown in Figure 78. Figures have fluctuated, with peaks occurring in 2004/05, 2009/10 and 2011/12.

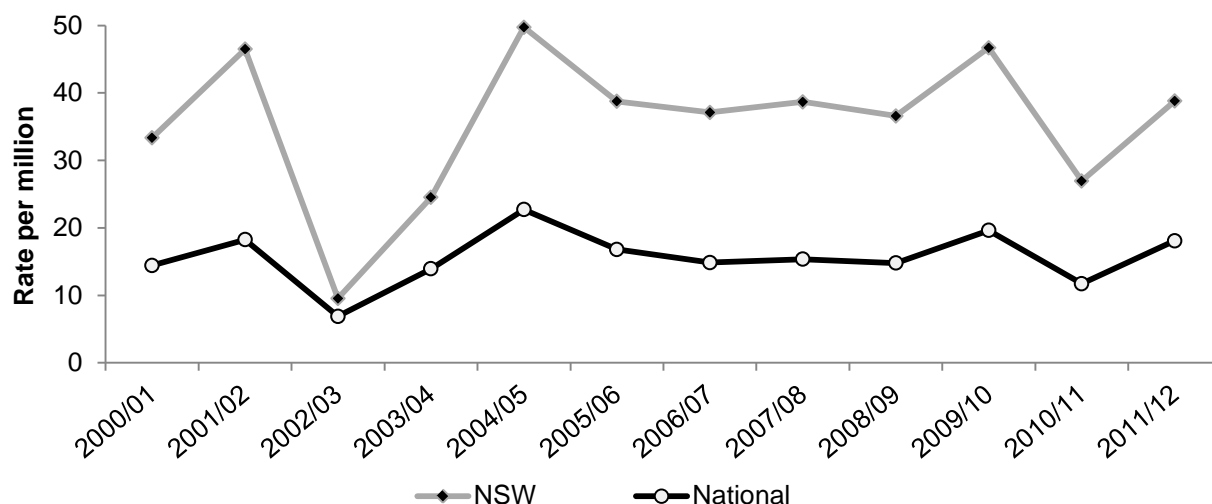
**Figure 78: Number of principal cocaine-related hospital admissions among persons aged 15–54, NSW and nationally, 2000/01–2011/12**



Source: Roxburgh and Burns (in press)

The number per million persons of cocaine-related hospital admissions are shown in Figure 79. Numbers in NSW have fluctuated across time; a sharp decrease was observed in 2002/03 followed by an increase in 2004/05 in which national and NSW both figures recorded their highest levels. Cocaine-related hospital admissions in NSW continue to account for the majority (68%) of these admissions nationally.

**Figure 79: Number per million persons of principal cocaine-related hospital admissions among people aged 15–54 years, NSW and nationally, 2000/01–2011/12**

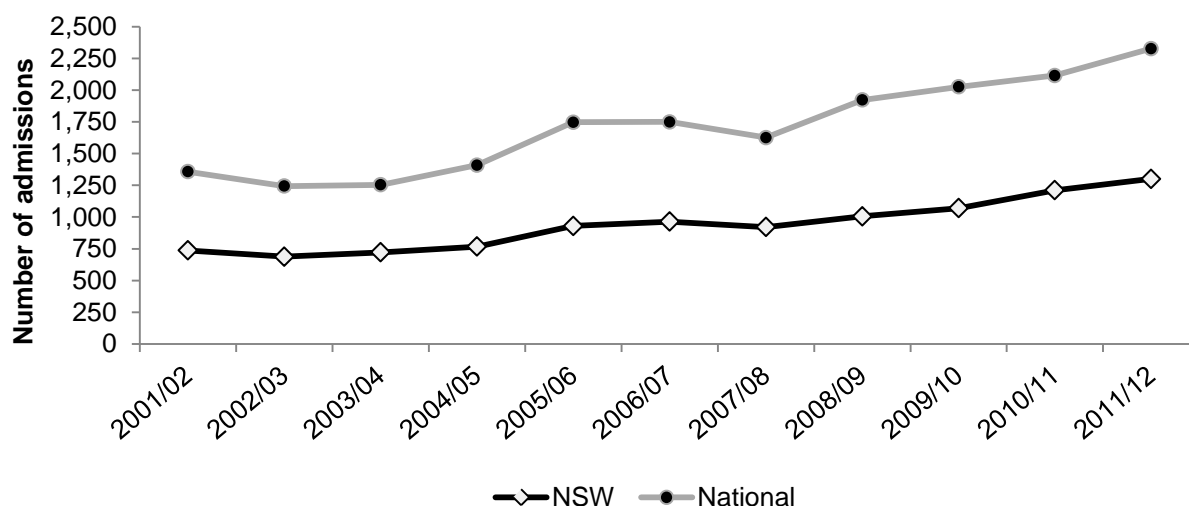


Source: Roxburgh and Burns (in press)

#### 6.4.4 Cannabis

The number of hospital admissions in which the principal diagnosis was cannabis-related is shown in Figure 80. Across time and continuing to 2011/12, figures have gradually increased both in NSW and nationally.

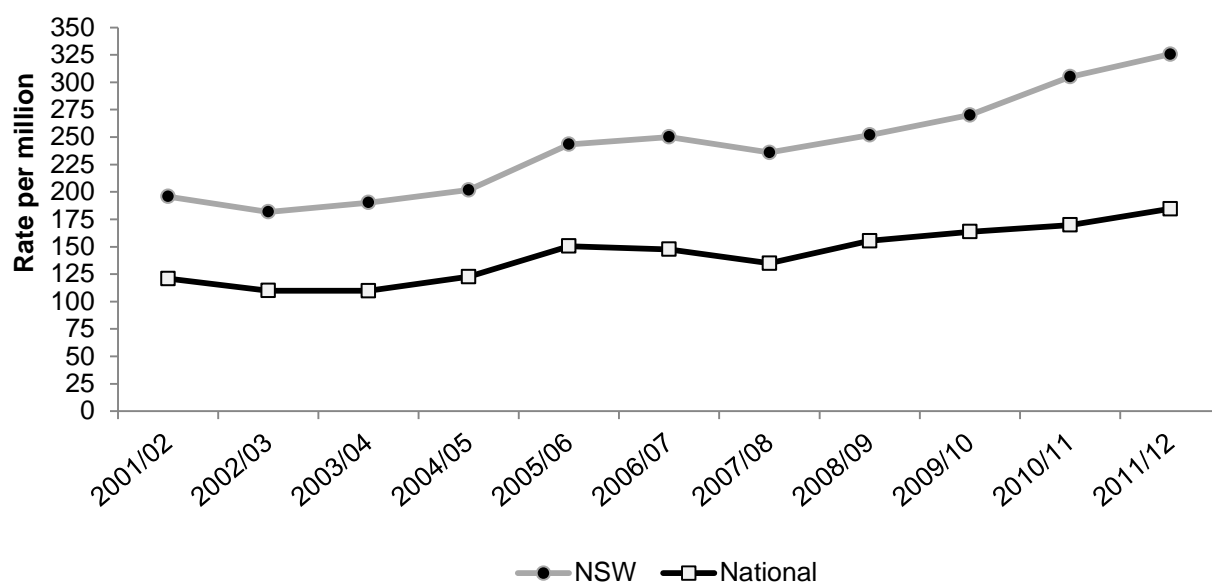
**Figure 80: Number of principal cannabis-related hospital admissions among persons aged 15–54, NSW and nationally, 2001/02–2011/12**



Source: Roxburgh and Burns (in press)

Figure 81 shows the number per million persons of cannabis-related hospital admissions among people aged 15–54 years. Both nationally and in NSW, numbers have increased steadily over time.

**Figure 81: Number per million persons of principal cannabis-related hospital admissions among people aged 15–54 years, 2001/02–2011/12**



Source: Roxburgh and Burns (in press)

## 6.5 Injecting risk behaviours

### 6.5.1 Sharing of injecting equipment by PWID participants

#### 6.5.1.1 Needle and Syringe Programs

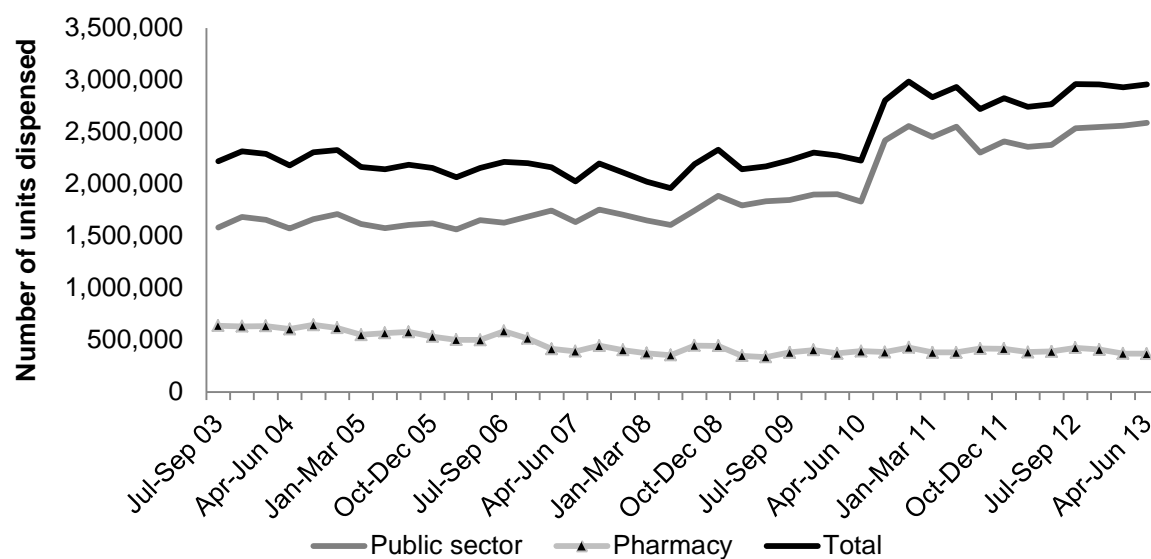
There are 33 primary NSP outlets across the state, which typically provide PWID with a range of injecting equipment including needles and syringes, advice on safer injecting, and referral to other services such as drug treatment programs. Primary outlets also undertake a range of other activities such as community liaison and education.

There are also over 300 secondary outlets, e.g. in hospital emergency departments and community health centres, which also provide injecting equipment and educational material. Primary and secondary outlets also provide condoms on request. Equipment obtained through secondary outlets is typically in the form of a Fitpack<sup>®</sup> containing needles/syringes, swabs, sterile water, spoon, information on safer injecting and referral. The Fitpack<sup>®</sup> also functions as a safe disposal container. There are approximately 160 NSP-maintained Fitpack<sup>®</sup> automatic dispensing machines across New South Wales which provide greater availability (typically 24-hour access) to a broad range of people across a range of locations.

A large number of pharmacies (approximately 375) are also involved in providing NSP services, further expanding availability across a broader range of people and locations. Pharmacies currently distribute less than 13% of equipment across the state, down from a peak of 35% in 2000/01. The number of needles and syringes dispensed in New South Wales by NSP has remained relatively stable over the past year (Figure 82). The number of needles and syringes dispensed by pharmacies over the same period has remained relatively stable and most of the equipment provided through the NSW NSP is dispensed from public NSP (HIV/AIDS and Infectious Diseases Branch; NSW Department of Health, 2012).

In 2013, participants in the IDRS were asked from what sources they obtained their needle and syringes over the last 6 months. Results showed the vast majority of participants (87%) obtained needles and/or syringes from the NSP (public sector). It is important to note that this number may also be high due to the method of IDRS recruitment via advertisements at NSP sites. Just over one quarter, of all participants reported they obtained needles and/or syringes from an NSP vending machine (25%). The third most popular source was chemist/pharmacy (21%), followed by friends (15%). Other sources reported included hospital (16%), partner (7%), dealer (also 7%), or outreach/peer worker (7%).

**Figure 82: Number of units dispensed from public NSP and pharmacies, NSW, July 2003–June 2013**

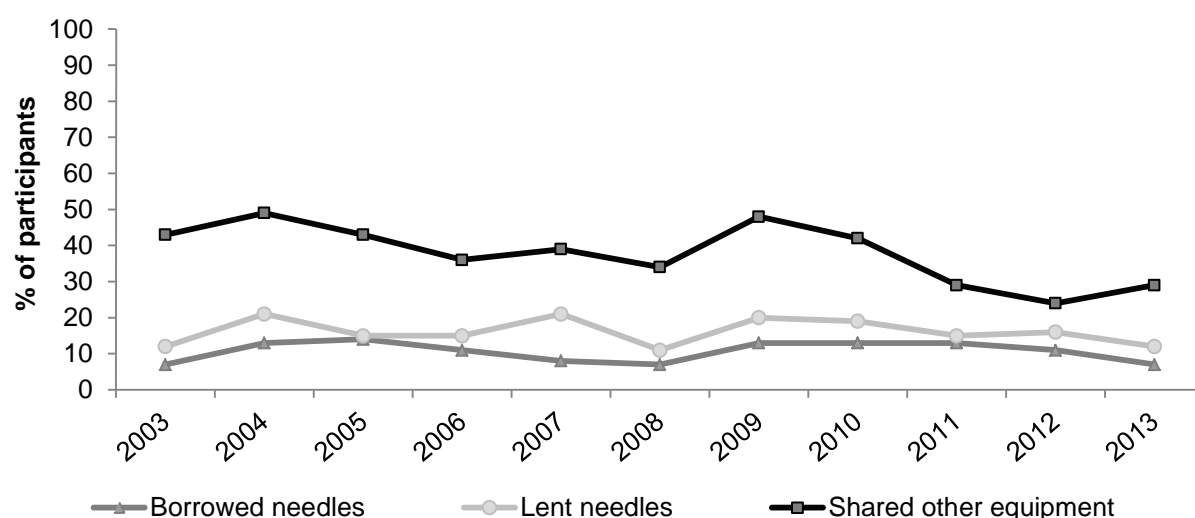


Source: NSW Ministry of Health; HIV/AIDS and Infectious Diseases Branch

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

Seven percent of these participants reported using a needle that had already been used by someone else ('borrowed needle'). This remained stable with 11% of participants who reported this in 2012 and 13% in 2011 (Figure 83). Twelve percent of those who had injected in the last month reported passing needles on to other PWID ('lent needle') in 2013, which remained stable with the 13% reported in 2012.

**Figure 83: Proportion of PWID reporting sharing injecting equipment in the month preceding interview, 2003–2013**



Source: IDRS PWID interviews

NB: Survey items on other injecting equipment (including spoons, water, filters and tourniquets) were first included in 1999. Figure excludes participants who had not injected in the last month (in 2003 n=1; 2004 n=1; 2005 n=4; 2006 n=1; 2007 n=2; 2008 n=2; 2012 n=1; 2013 n=2). In 2009 (n=152), 2010 (n=154) and 2011 (n=150) all participants reported injection in month prior to interview

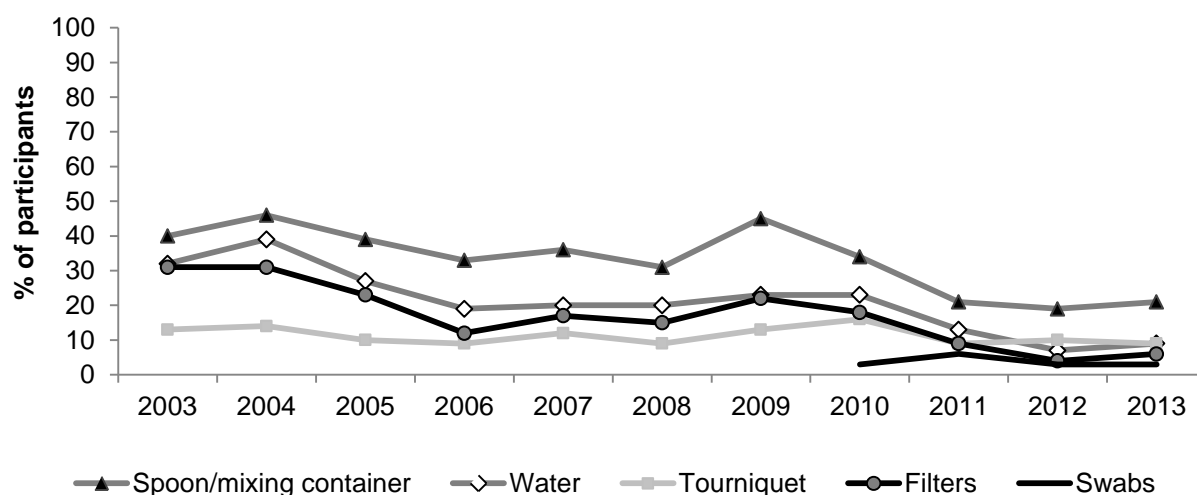
As in previous years, sharing of injecting equipment was more common than sharing of needles and syringes.

Twenty-nine percent reported sharing a filter, spoon, water, tourniquet and/or other item of injecting paraphernalia in the month preceding interview which is stable with the 24% reporting sharing equipment in 2012.

Figure 84 shows a breakdown of the types of injecting equipment PWID participants reported sharing. Among those reporting any sharing in the past month, 'spoons/mixing containers' remained the most commonly shared item (74%; 21% of entire sample), followed by both 'water' and 'tourniquets' (30%; 9% of entire sample), filters (21%; 6% of entire sample), and swabs (3%; 1% of entire sample).

Overall these figures are consistent with 2012.

**Figure 84: Proportion of PWID participants reporting sharing other injecting equipment by type, 2003–2013**



Source: IDRS PWID interviews

NB: Survey items on other injecting equipment (including spoons, water, filters and tourniquets) were first included in 1999 and swabs in 2010. Figure excludes participants who had not injected in the last month (in 2003 n=1; 2004 n=1; 2005 n=4; 2006 n=1; 2007 n=2; 2008 n=2; 2012 n=1; 2013 n=1). In 2009 (n=152), 2010 (n=154) and 2011 (n=150) all participants reported injection in month prior to interview

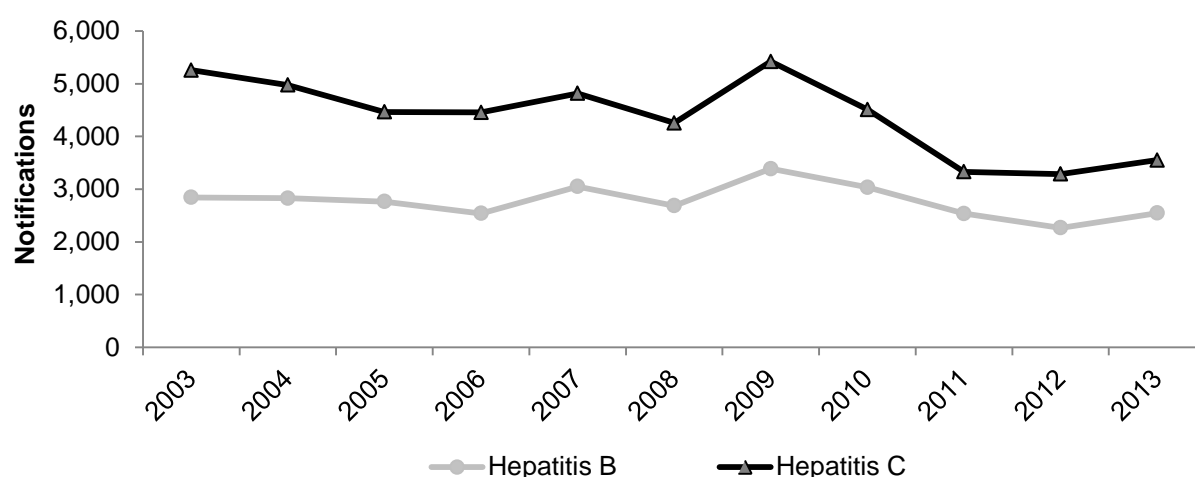
### 6.5.2 Blood-borne viral infections

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

Figure 85 shows the total number of notifications for HBV and HCV in NSW.

Incident (newly acquired) infections and unspecified infections (i.e. notifications where the timing of the disease acquisition is unknown) are presented. HCV continued to be more commonly notified than HBV, with the number of notifications increasing slightly in the 12 months to 2013 (3,551 notifications versus 3,287 notifications in 2012). HBV notifications have remained relatively stable since 2003 (2,844 notifications versus 2,547 in 2013). Notifications for both HCV and HBV still remained lower than levels reported in 2009.

**Figure 85: Total notifications for (unspecified and incident) HBV and HCV infections, NSW, 2003–2013**



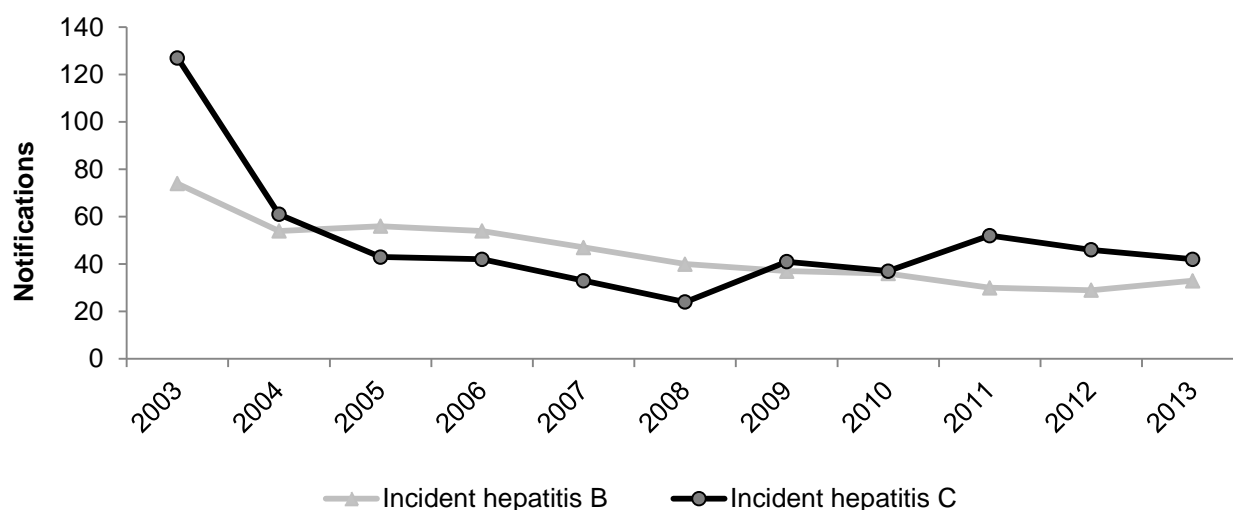
Source: Communicable Diseases Network – Australia – National Notifiable Diseases Surveillance System (NNDSS)<sup>9</sup>

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

Trends in the number of incident notifications for HBV and HCV in NSW are shown in Figure 86.

HBV incident reporting had remained stable and low in 2013 (33%; 29% in 2012 and 30% in 2011). A steady decline had been observed in the number of HCV incident notifications, from 127 in 2003 to 24 in 2008; however, it increased to 52 incident notifications in 2011 before declining in the previous two years.

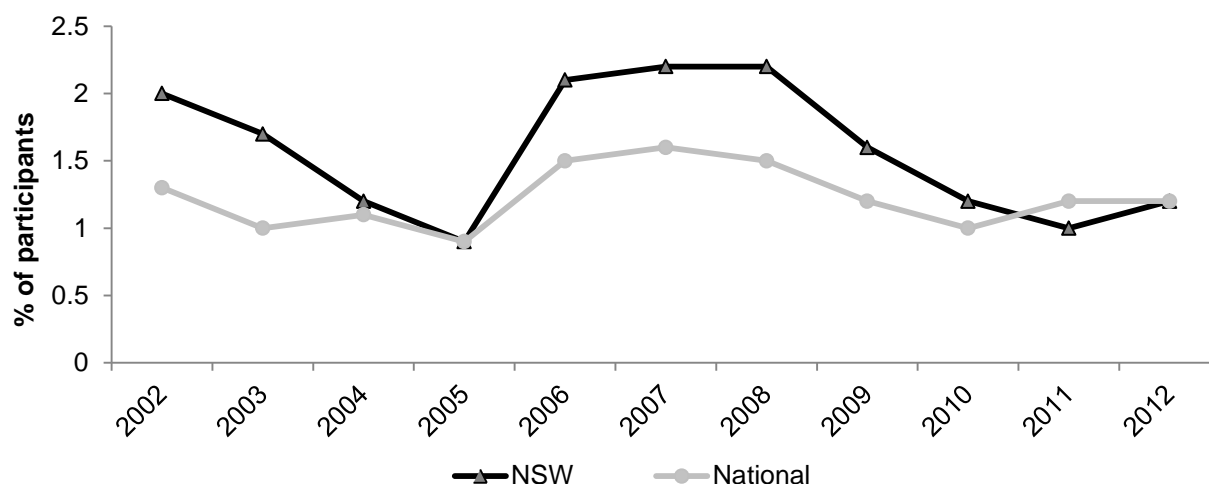
**Figure 86: Total notifications for incident HBV and HCV infection, 2003–2013**



Source: Communicable Diseases Network – Australia – NNDSS<sup>11</sup>

HIV antibody prevalence among NSP participants remained low and stable both in NSW (1.2%) and at a national level (1.2%). The NSW figure recorded a small increase in the last 12 months while the national figure remained stable. Overall, figures for the prevalence of HIV antibody in NSW and nationally remain low and stable (Figure 87).

**Figure 87: Prevalence of HIV antibody among NSP survey participants, 2002–2012**



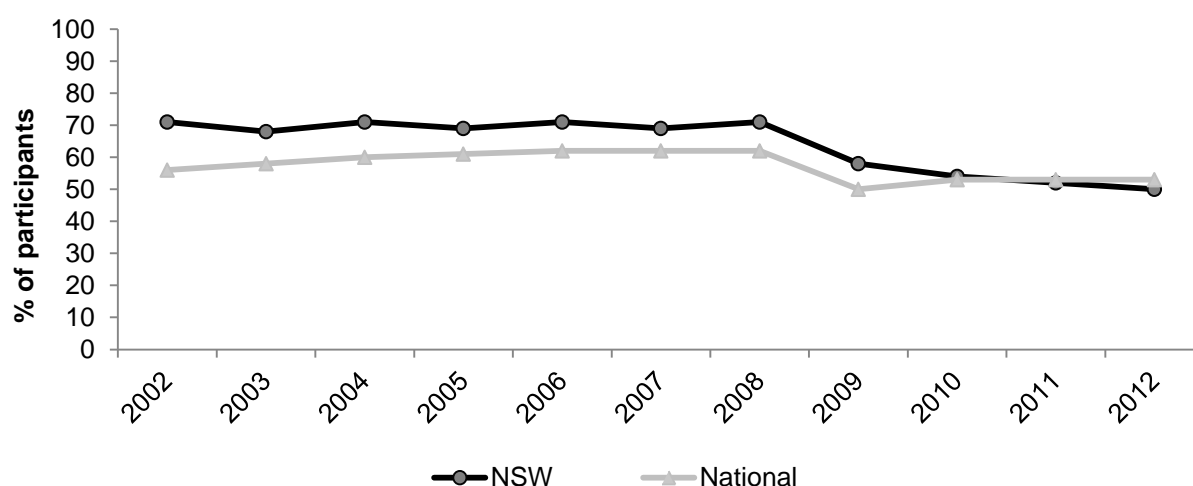
Source: The Kirby Institute

NB: Data for 2013 were unavailable at the time of publication



Detection of hepatitis C (HCV) antibody in capillary blood tests (finger-prick samples) conducted on NSW participants continued to remain high in 2012. In 2012, the NSW prevalence (50%) is comparable with the national figure (53%), and both of these figures are consistent with 2010 values (54% and 53%, respectively; Figure 88).

**Figure 88: Prevalence of HCV antibody among NSP survey participants, 2002–2012**



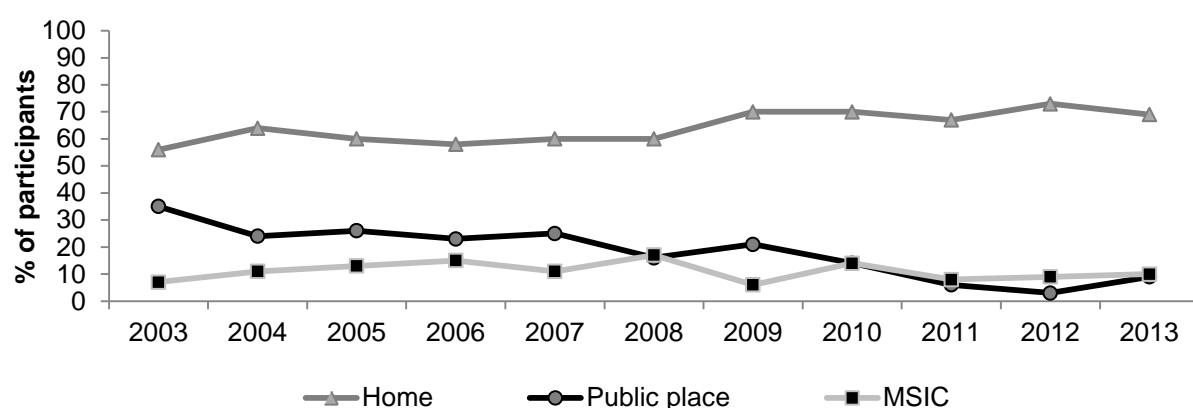
Source: The Kirby Institute

NB: Data for 2013 were unavailable at the time of publication

### 6.5.3 Location of injections

The most commonly reported location for last injection remained at a private home (69%; 73% in 2012). Ten percent reported Sydney MSIC (9% in 2012) and 9% reported public place (3% in 2012) as the locations of their most recent injection (Figure 89).

**Figure 89: Last location for injection, 2003–2013**



Source: IDRS PWID interviews

NB: Excludes those who had not injected in the last month (in 2003 n=1; 2004 n=1; 2005 n=4; 2006 n=1; 2007 n=2; 2008 n=2; 2012 n=1; 2013 n=1). In 2009 (n=152), 2010 (n=154) and 2011 (n=150) all participants reported injection in month prior to interview

### 6.5.4 Injection sites

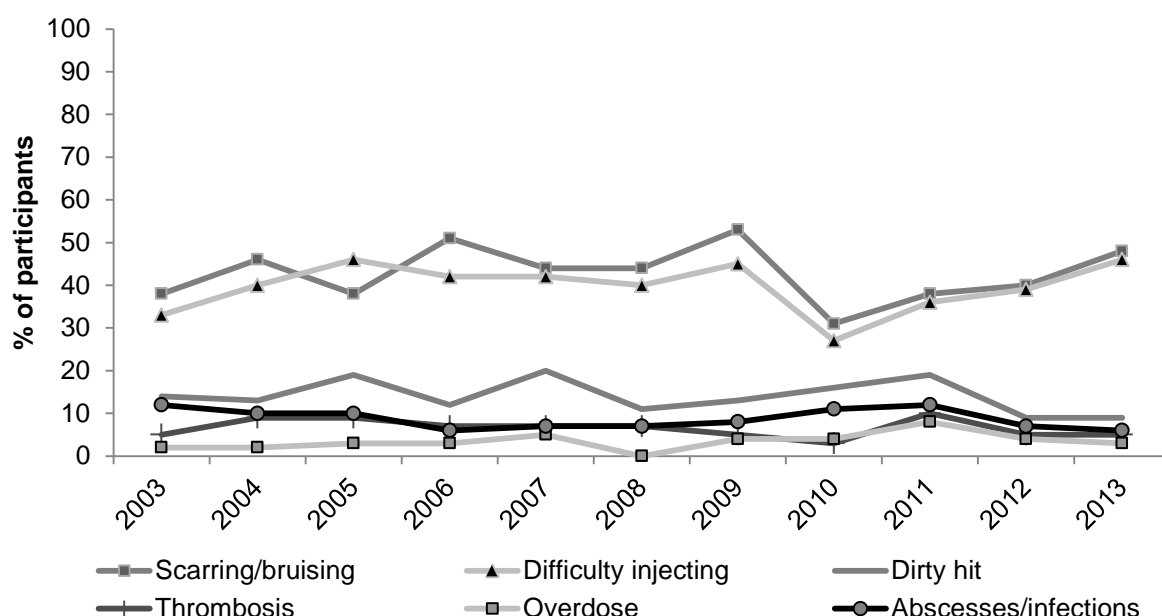
Again in 2013 participants were also asked questions about the site on their body where they had last injected. Seventy percent of participants reported that they last injected in their 'arm'. Sixteen percent of participants reported last injecting in their 'hand or wrist', 5% reported last injecting in their 'leg', 3% each reported their 'neck' or 'groin' and 1% reported their foot. This remained stable with 2012.

### 6.5.5 Injection-related health problems

Participants were asked whether they had experienced any of the following injection-related problems in the month before interview: overdose; a dirty hit; prominent scarring and/or bruising; thrombosis/blood clots; difficulty injecting; and/or abscesses or infections. Sixty-nine percent of all PWID participants who had injected in the last month reported at least one injection-related problem during this time (59% in 2012). As in previous years, the most commonly reported problems were prominent scarring/bruising of injection sites (48%) and difficulty injecting (46%). Nine percent reported experiencing a 'dirty hit' that made them feel sick, smaller proportions, in line with previous years, reported problems of abscesses or infections associated with injecting (6%), thrombosis (5%) and overdose (3%).

Figure 90 shows that while the proportion reporting prominent 'scarring or bruising' has remained the most commonly reported injection-related problem since 1997 (with the exception of 2005), since 2007 the issue of having 'difficulty injecting' has risen to almost equal levels in proportion of prevalence reported. Reports of thrombosis and abscesses/infections have continued to remain low and relatively stable. For the past 11 years overdose has remained the least commonly reported injection-related problem and this continued in 2013. For further information on overdose, see also section 6.1 'Overdose and drug-related fatalities'.

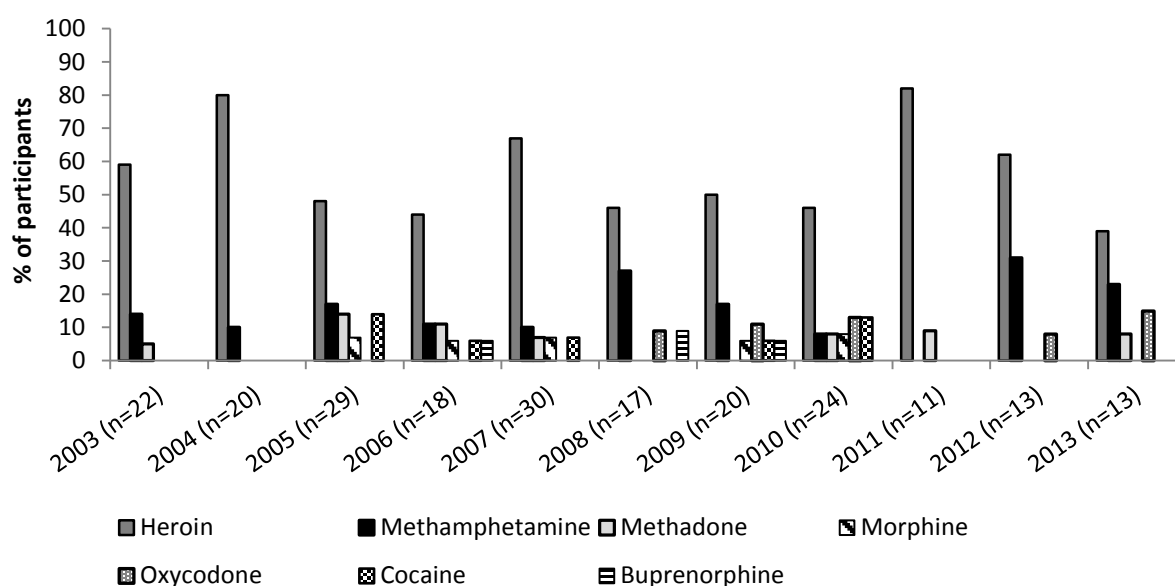
**Figure 90: Proportion of PWID reporting injection-related problems in past month, by problem type, 2003–2013**



Source: IDRS PWID interviews

NB: Includes all participants

**Figure 91: Main drug causing dirty hit in last month, 2003–2013**



Source: IDRS PWID interviews

As with overdose, participants who had experienced a ‘dirty hit’ in the last month were asked what they considered to have been the main drug they would attribute it to, and whether they had been using any other drugs at the time (polydrug use). The majority of participants who had experienced a dirty hit (n=13) continued to attribute it to heroin (39%; representing 3% of the entire sample; Figure 91).

## 6.6 Blood-borne viral infections

In 2013, IDRS participants were asked questions about BBVI testing and vaccinations (please refer to section 8.5)

## 6.7 Mental and physical health problems and psychological distress

Just under one-half (46%) of all participants reported experiencing a mental health problem other than drug dependence in the preceding six months (45% in 2012). As in previous years, the most commonly reported problem was depression (66%; 30% of all participants). Of those reporting a mental health problem, 46% (21% of all participants) reported anxiety, 13% (6% of all participants) reported schizophrenia, 11% (5% of all participants) reported post-traumatic stress disorder, and 6% (3% of all participants) reported paranoia. There were few reports (n<10) of panic, bipolar, personality disorders, obsessive compulsive disorder and drug induced psychosis; however, due to the small numbers, these results should be interpreted with caution.

Sixty-three percent of the sample had attended a health professional for a mental health problem during this time. Of those that reported a mental health problem in the six months prior to interview, 47% (13% of all participants) reported receiving prescribed antidepressant medication for treatment of that condition.

Among the most commonly prescribed antidepressant medications for treatment were Avanza (mirtazapine), followed by Lexapro (escitalopram) and Luvox (fluvoxamine). Smaller numbers reported being prescribed Prozac (fluoxetine), Zoloft (sertraline), Lovan (fluoxetine), Deptran (doxepin), and Cipramil (citalopram). Forty-four percent (12% of all participants) reported receiving prescribed antipsychotic medications for treatment of their mental health issue (47% or 12% of all participants in 2012). The most commonly reported antipsychotic medications for

treatment were Seroquel (quetiapine), Zyprexa (olanzapine) and Risperdone (generic). Twenty-nine percent (8% of entire sample) reported being prescribed benzodiazepines for mental health issues in the six months prior to interview. For more information on use of benzodiazepines, see section 4.9.

### 6.7.1 Psychological distress measure

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

Of those that answered this section (n=148), the mean score was 24.12 (median 24; SD 8.56; range 8–49). As is evident below, IDRS participant scores vastly differed from those reported among the Australian general population, with a larger proportion reporting 'high' and 'very high' distress (Table 19). However, it should be noted that these categories were developed from studies of the general population and the extent to which they would apply to the IDRS sample has not been established.

**Table 19: Kessler 10 scores in the 2010 National Drug Strategy Household Survey and NSW PWID participant sample 2009–2013**

K10 category	National Drug Strategy Household Survey 2010	IDRS 2009 N=149	IDRS 2010 N=154	IDRS 2011 N=148	IDRS 2012 N=149	IDRS 2013 N= 146
% reporting no or low distress	70	13	15	16	13	<b>16</b>
% reporting moderate distress	21	22	24	19	21	<b>24</b>
% reporting high distress	7	32	29	28	28	<b>34</b>
% reporting very high distress	2	34	32	37	38	<b>23</b>

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

## 6.8 Driving risk behaviour

Since 2005, participants have been surveyed on drug driving risk and additional questions were added on driving under the influence (i.e. over the limit) of alcohol in 2006. In 2007, further questions were added relating to the last occasion in which drug driving occurred, specifically, the drug that was taken, along with the waiting time before driving, as well as perceived driving ability while under the influence of illicit drugs. A question was also added in 2007, in light of legislation in NSW that allows NSW Police to conduct random roadside tests for driving under the influence of illicit drugs.

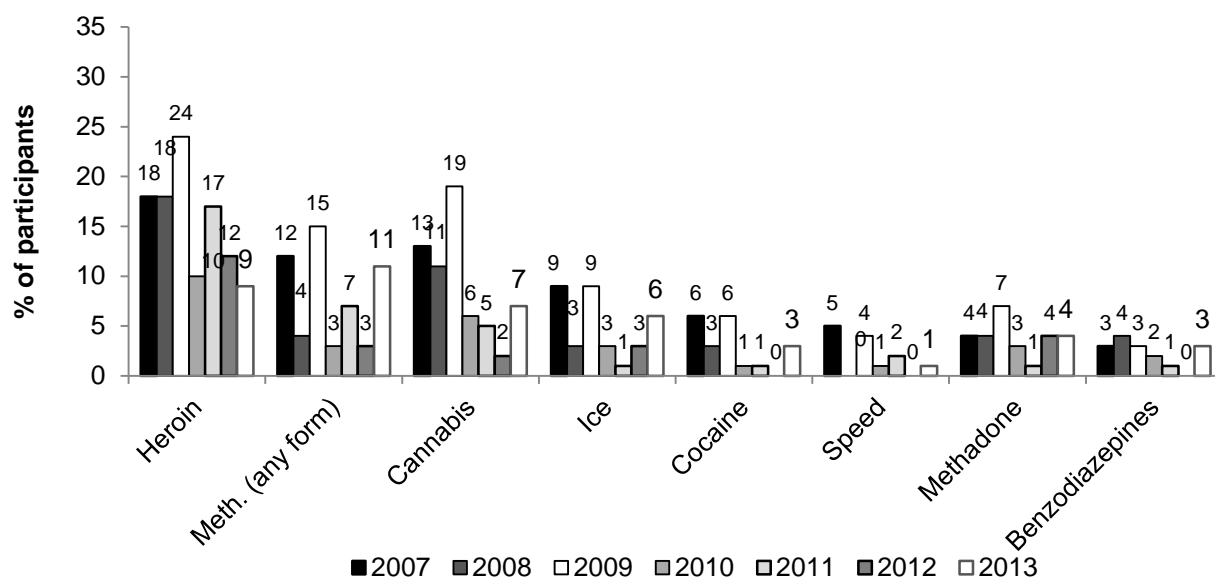
## 6.8.1 Driving and alcohol

Forty-three percent of the sample (n=47) had driven a motor vehicle in the six months preceding interview and, of these, 11% (3% of the entire sample) had driven under the influence of *any* alcohol. Of those reporting driving under the influence, two participants reported that they believed they had driven while they were over the legal limit<sup>10</sup> of alcohol on a median of 15 occasions.

## 6.8.2 Driving and illicit drugs

Of those who had driven a car in the past six months, 62% (19% of the entire sample) had driven 'soon' after taking (an) illicit drug(s) on a median of 10 occasions. As shown in Figure 92, heroin remained the drug nominated most by participants (9% of the entire sample; 48% of those who had driven under the influence of drugs); followed by cannabis (7% of the entire sample; 35% of those who had driven under the influence of drugs) and ice/crystal (6% of the entire sample; 31% of those who had driven under the influence of drugs).

**Figure 92: Driving under the influence among the entire PWID sample, by drug type, 2007–2013**



Source: IDRS PWID interviews

Again in 2013, participants that reported driving while under the influence of drugs other than alcohol were also asked about the last occasion on which that occurred, what specific drug had they taken, and on average how much time they left between taking the drug(s) and driving.

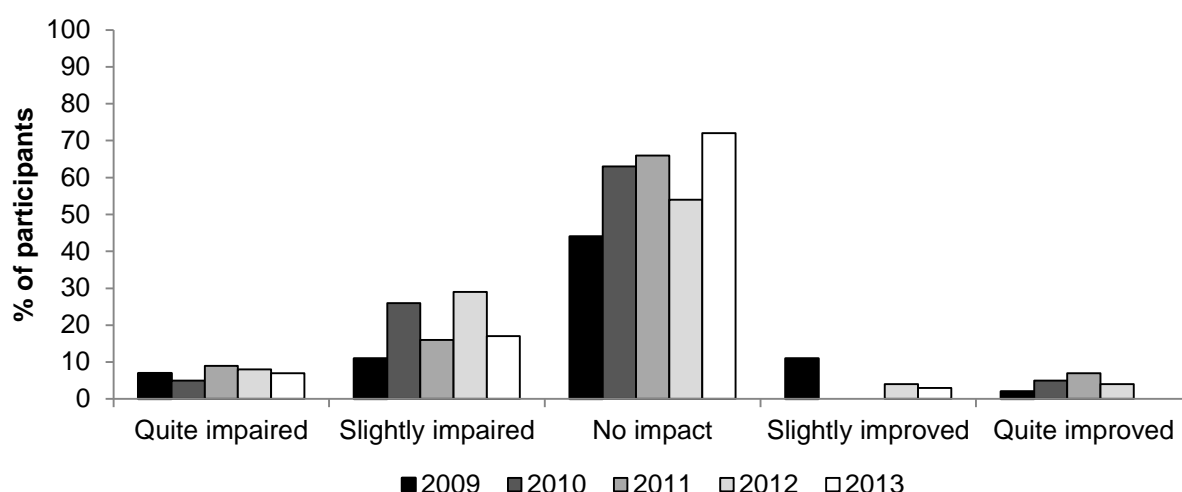
Results of the 'last drug taken' closely resembled trends observed in Figure 92, heroin was the drug reported by the majority of participants (35%; 7% of entire sample) who had driven under the influence of illicit drug(s) in the six months prior to interview. Heroin was followed by

<sup>10</sup> Note that these figures are based on self-report, and should be interpreted with caution.

cannabis (24%; 5% of entire sample), methadone (21%; 4% of entire sample), ice/crystal (17%; 3% of entire sample), then oxycodone (7%; 1% of entire sample). Participants waited an average of 112 minutes (1hr 52 minutes) after taking drug(s) and then driving (66 minutes in 2012). Twenty-one percent (4% of the entire sample) of participants responded that they usually waited 5 minutes or less after taking illicit drug(s) and driving a motor vehicle.

Perceived driving ability (i.e. level of impairment) was asked about on the last occasion in which driving under the influence of illicit drug(s) had occurred. The majority of participants reported that they perceived there was no impact from the drug(s) on their driving (72% of those who drove under the influence of illicit drugs; 14% of all participants); 17% percent (3% of all participants) reported that they believed their driving was 'slightly impaired', 7% (1% of entire sample) commented that their driving was 'quite impaired' and one participant each commented that driving ability was 'slightly improved' (Figure 93).

**Figure 93: Perceived driving ability (i.e. level of impairment) of PWID participants under the influence, 2009–2013**



Source: IDRS PWID interviews

December 2006 saw the introduction of legislation that allowed NSW Police the power to conduct roadside drug (driving) testing (RDT). The drugs that can be detected by the saliva sample include delta-9-tetrahydro-cannabinol (THC), the active component of cannabis; methamphetamine ('ice', 'speed', 'base' etc.); and methylene-dioxymethylamphetamine (MDMA or 'ecstasy'). It is also considered an offence to drive with the presence of cocaine or morphine (heroin) in blood or urine (unless prescribed). Penalties for positive results of driving under the influence of these illicit drugs include jail sentences of up to nine months, unlimited licence suspensions and fines of \$2,200.

Participants were asked if they had been roadside drug tested and the result. Twenty-four percent of those who commented (5% of the sample) reported being subject to a roadside drug test on at least one occasion. Of those ever subject to a test, one-quarter (25%; 2% of the entire sample) reported a positive result and, for 17% of participants, the result was inconclusive.

## 6.9 Key expert comments

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

- Mental health issues continue to be a major problem for PWID and there was ongoing issues with engaging and referring clients into mental health (MH) services.
- Dental health, stable housing and personal hygiene remained ongoing areas of health concern for this population.
- Increased levels of chronic pain may be associated in part to ageing population of PWID.
- Poor vein care, in part due to increased injection of pharmaceutical opioids designed for oral consumption, is leading to increased difficulty in finding veins, as well as increased rates of infection.
- The access and availability of prescription drugs such as Oxycodone and Xanax and the regulation of the authorities who dispense them.
- Although the use of pill filters is increasing, it is still quite low, and this leads to many associated problems such as emphysema and abscesses.
- Polydrug use, particularly the use of benzodiazepines with opioids and/or alcohol was a recurring comment in the management of overdoses.
- Non-fatal overdoses remained low and stable.

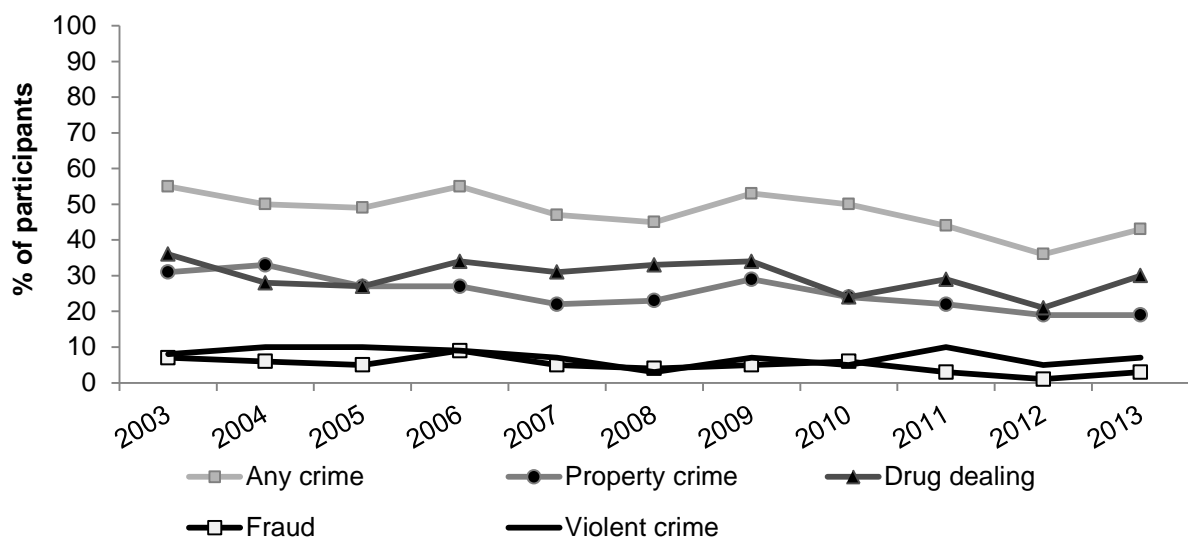
## 7 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

### 7.1 Reports of criminal activity among PWID

Forty-three percent of participants reported engaging in any form of crime in the month prior to interview (36% in 2012). Despite the slight increase, the proportion of the sample reporting any crime in the month prior to interview appears to be trending downwards from the 45–50% reported each year for the past decade (Figure 94).

The two most commonly reported crimes were, as in previous years, drug dealing and property crime (30% and 19% of the entire sample respectively). Seven percent of PWID participants reported engaging in violent crime (5% in 2012) and 3% reported fraud (1% in 2012).

**Figure 94: Proportion of participants reporting engagement in criminal activity in the last month by offence type, 2003–2013**



Source: IDRS PWID interviews



The percentage of PWID participants that reported being arrested in the previous 12 months remained relatively stable at 42% of the entire sample (36% in 2012) (**Table 20**). The most commonly cited reasons for arrest in the last 12 months were property crime (14%; 13% in 2012) and possession/use of a prohibited drug (13%; 11% in 2012).

Reported arrests for reasons pertaining to violent crime (includes assault, violence in a robbery, armed robbery, sexual assault) remain stable (9%; 5% in 2012). Small proportions reported having been arrested for driving offences (5%), drug dealing/trafficking (3%), or use/possession of weapons (3%).

**Table 20: Criminal activity as reported by PWID participants, 2006–2013**

	2006 N=152	2007 N=153	2008 N=151	2009 N=152	2010 N=154	2011 N=150	2012 N=151	<b>2013 N=151</b>
<b>Criminal activity in last month</b>								
Dealing (%)	34	31	33	34	24	29	21	<b>30</b>
Property crime (%)	27	22	23	29	24	22	19	<b>19</b>
Fraud (%)	9	5	4	5	6	3	1	<b>3</b>
Violent crime (%)	9	7	3	7	5	10	5	<b>7</b>
Any crime (%)	55	46	45	53	50	50	36	<b>43</b>
Arrested in last 12 months (%)	39	41	36	42	44	37	36	<b>42</b>

Source: IDRS PWID interviews

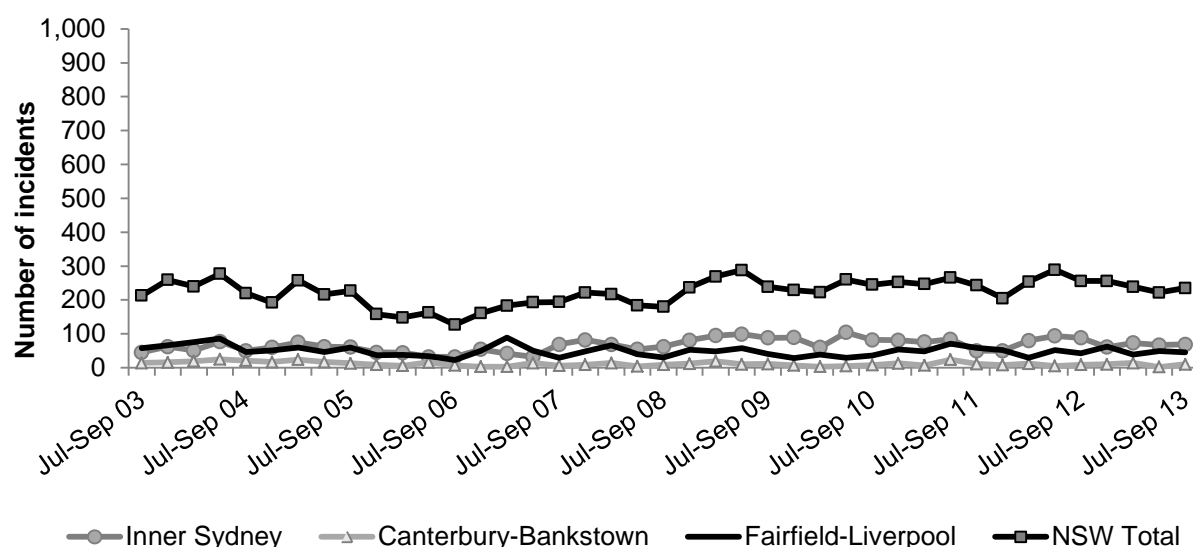
## 7.2 Arrests

### 7.2.1 Heroin

Figure 95 illustrates the number of police recorded criminal incidents for narcotics (heroin, methadone and opium) possession/use by quarter in the Inner Sydney area, the Fairfield-Liverpool area, the Canterbury-Bankstown area, and NSW as a whole from July 2003 to September 2013.<sup>11</sup>

As can be seen below, the numbers of incidents declined throughout 2001 and have remained relatively stable at lower levels since that time. Since the April-June quarter 2010, the number of incidents across all areas has remained relatively stable (Figure 95).

**Figure 95: Recorded incidents of narcotic possession/use by geographic area per quarter, July 2003–September 2013**



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 20th January 2014)

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

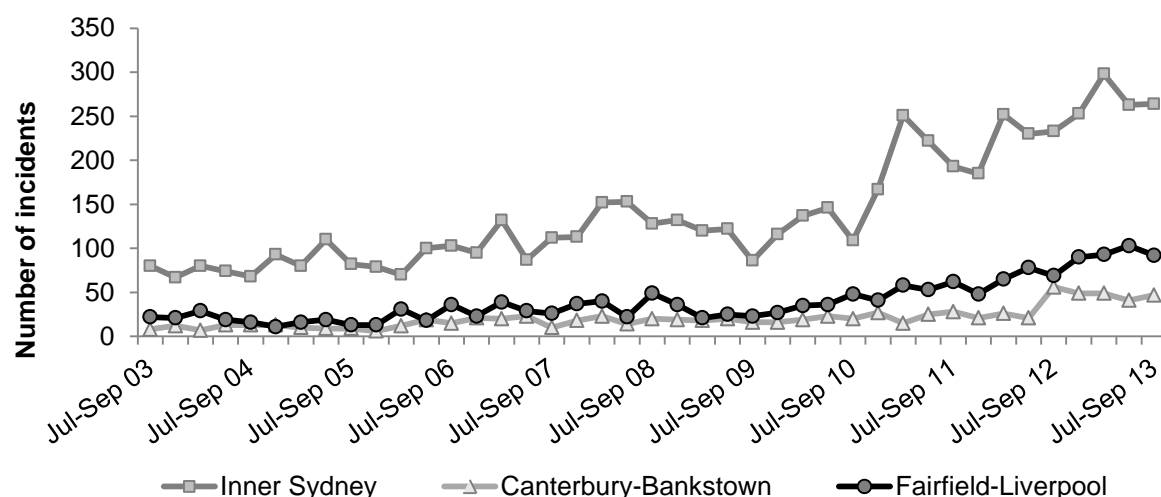
<sup>11</sup> The regions Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown refer to ABS Statistical Subdivisions.

## 7.2.2 Methamphetamine

Figure 96 shows the number of criminal incidents per quarter for amphetamine possession/use across Sydney.

Recorded incidents in Inner Sydney, Canterbury-Bankstown and the Fairfield-Liverpool area continued to remain relatively stable overall.

**Figure 96: Recorded incidents of amphetamine possession/use by geographic area per quarter, July 2003–September 2013**



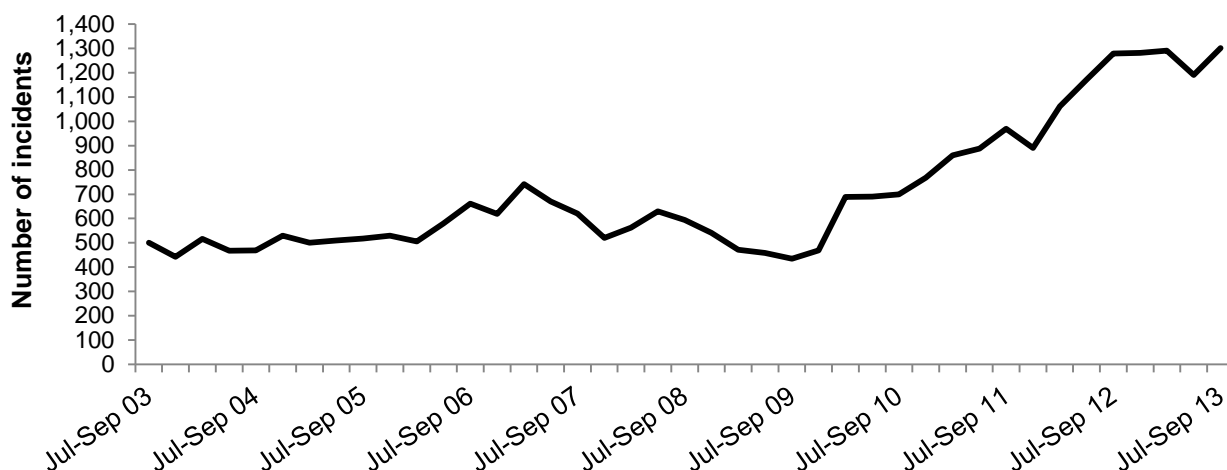
Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at <http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init> accessed 20th January 2014)

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

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

This trend has continued in the 12 months to September 2013 recording the highest number of incidents (1,301 incidents in July-September 2013) since recording began in 1996 (Figure 97).

**Figure 97: Recorded incidents of amphetamine possession/use (whole of NSW) per quarter, July 2003–September 2013**

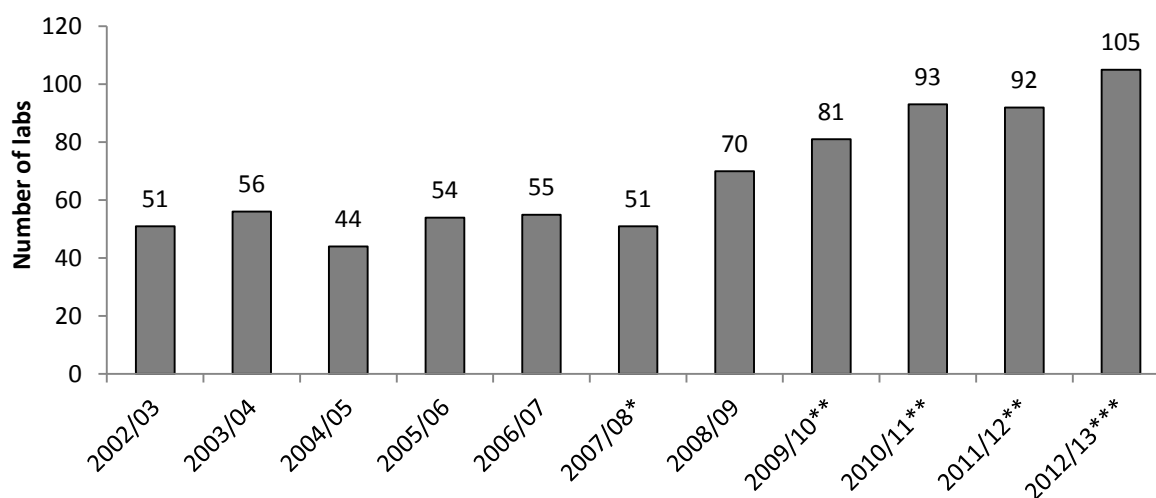


Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at <http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init> accessed 20th January 2014)

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

In 2012/13, there were 105 detections of clandestine laboratories detected in NSW, (Figure 98).

**Figure 98: Number of clandestine methamphetamine and MDMA laboratories detected by NSW Police, 2002/03–2012/13**



Source: NSW Police

\* Includes 2 para-methoxyamphetamine (PMA) laboratories

\*\*Includes 1 PMA laboratories

\*\*\*Includes two 2-CB labs

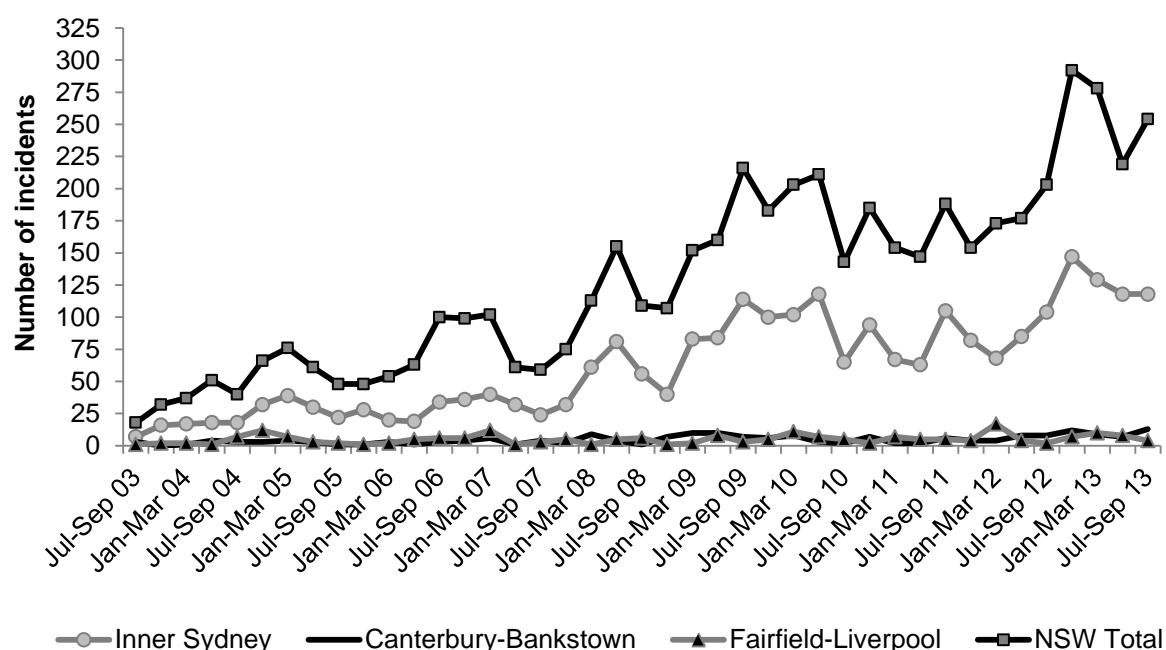
NB: data may include active, non-active and historical laboratories as well as storage sites

## 7.2.3 Cocaine

Figure 99 shows the number of police recorded criminal incidents for cocaine possession/use in Inner Sydney, Fairfield-Liverpool, Canterbury-Bankstown and NSW as a whole.

Levels have remained higher in Inner Sydney than in the South-West areas of Fairfield-Liverpool and Canterbury-Bankstown since data collection commenced in 1996/97. The October-December quarter of 2012 had the highest number of incidents recorded in Inner Sydney and trends have remained relatively stable over the 12 months to September 2013.

**Figure 99: Recorded incidents of cocaine possession/use by geographic area per quarter, July 2003–September 2013**



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 20th January 2014)

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

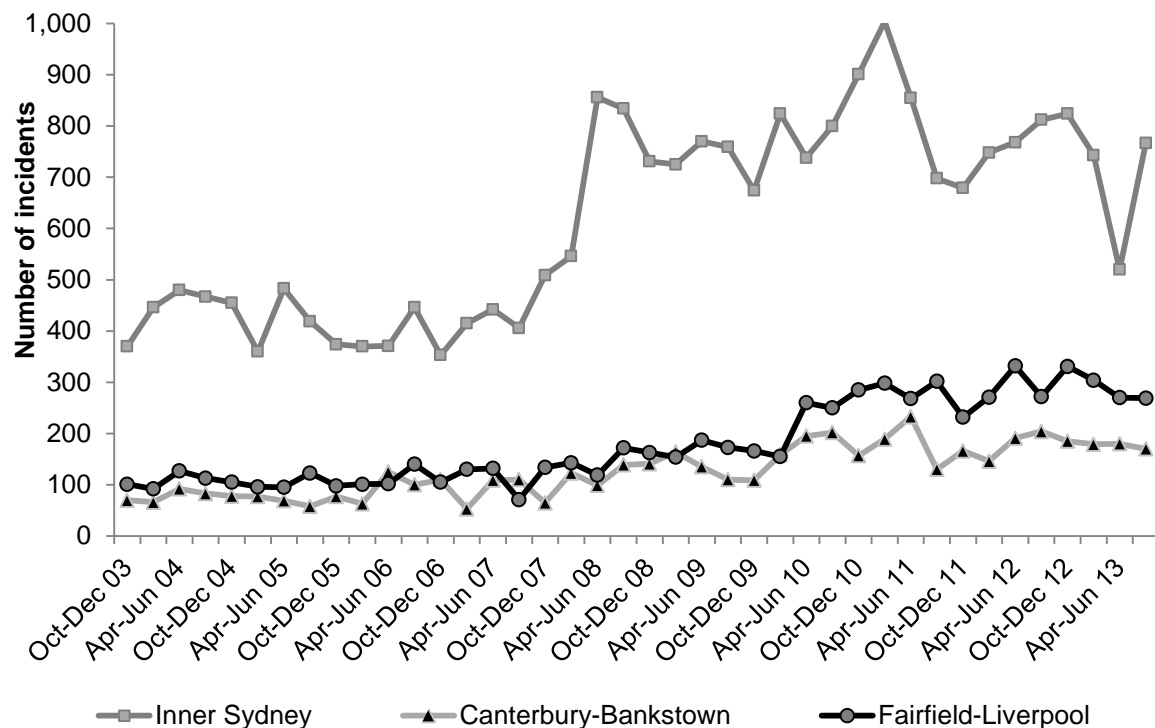
## 7.2.4 Cannabis

Figure 100 shows the number of police recorded criminal incidents of cannabis possession/use per quarter in the Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown areas.

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

The number of incidents recorded in the Fairfield-Liverpool and Canterbury-Bankstown areas has remained stable for the past two years and proportionally lower than inner city figures. The number of incidents recorded in Fairfield-Liverpool in April-June 2012 (332) was the highest seen for this area since data were first collected in July-September 1996.

**Figure 100: Recorded incidents of cannabis possession/use by geographic area per quarter, October 2003–September 2013**

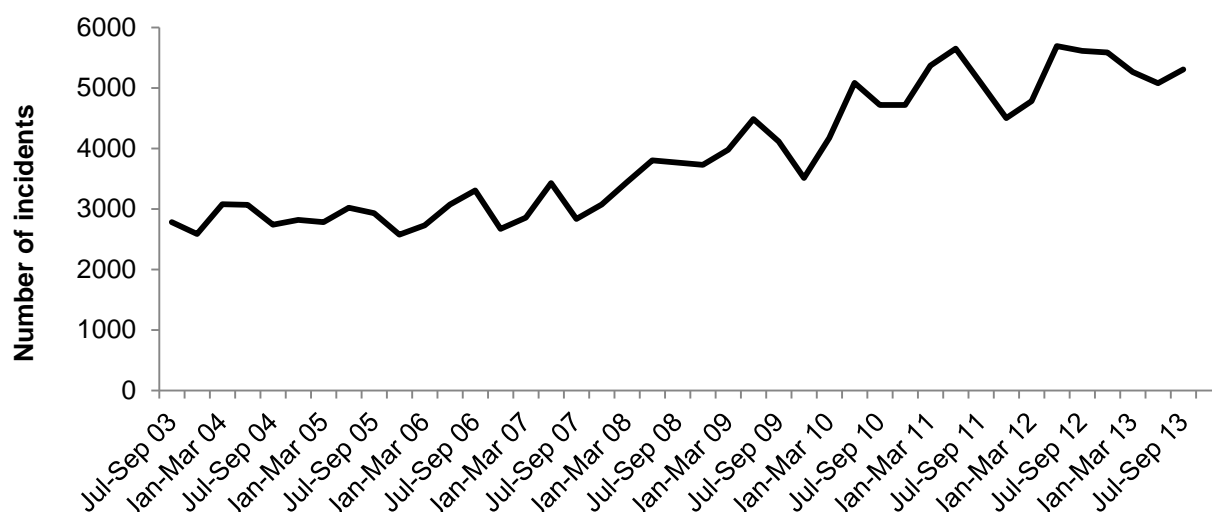


Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at <http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init> accessed 20th January 2014)

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

In the 12 months to September 2013, there has been a gradual increase in the number of recorded incidents of cannabis possession/use per quarter across NSW (Figure 101). Cannabis possessions per quarter have gradually increased over the past 10 year period and for the 12 months to September 2013, include the highest recorded number of incidents (5,693 April-June 2012).

**Figure 101: Recorded incidents of cannabis possession/use (whole of NSW) per quarter, July 2003–September 2013**



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 20th January 2014)

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

### 7.3 Expenditure on illicit drugs

Sixty-eight percent of participants reported purchasing drugs on the day prior to interview (72% in 2012), spending a median of \$85 (range \$7–\$1,000). Among participants who had bought drugs on the day before interview, 20% had spent between \$100–\$199, 17% had spent between \$50 and \$99, 15% between \$20–\$49, 9% between \$200–\$399 and 3% spent less than \$20. The same number of participants (3%) reported spending \$400 or more on drug purchases on the day prior to interview. One-third (32%) of those that reported obtaining drugs on the day prior to interview reported spending nothing (\$0).

### 7.4 Key expert comments

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

- An increase in clandestine laboratory detections reflects a coordinated response in detection intelligence from law enforcement rather than reflecting an actual increase in laboratories.
- There were few reports from law KE regarding speed and base. The reported availability of speed and base appears to be decreasing whereas the availability of ice/crystal was reportedly increasing.
- Purity reports from law KE were mixed.
- The number of police detainees using ice had increased in the year preceding the interview.

## 8 SPECIAL TOPICS OF INTEREST

### 8.1 Pharmaceutical opioids

Since the heroin shortage (2001), the Illicit Drugs Reporting System (IDRS) has noted an increase in the use and injection of morphine and oxycodone. Over the same period the age of people who inject drugs (PWID) has also increased. We know from a number of Australian and international studies that PWID experience excess morbidity and mortality when compared to those in the general population (English et al., 1995; Hulse, English, Milne, & Holman, 1999; Randall et al., 2011; Vlahov et al., 2004) and that prescribers are often reluctant to prescribe opioid analgesics to people with a history of injecting drug use (Baldacchino, Gilchrist, Fleming, & Bannister, 2010; Merrill & Rhodes, 2002). This section aims to examine the complex interplay among PWID, pain management and the extra-medical use of pharmaceutical opioids (PO).

In 2013, participants in the IDRS were asked questions about the use of PO and pain. Pharmaceutical opioids included methadone, buprenorphine, buprenorphine-naloxone, morphine, oxycodone, and other PO such as fentanyl, pethidine and tramadol. Of those who commented (n=150), around two-thirds (62%) reported the use of PO in the last 12 months (Table 21). Among those who had recently used PO and commented (N=563), 40% reported using PO as a substitute for heroin, while 22% reported using PO for pain relief.

Among those who recently used PO for pain relief (n=21), the majority (62%) obtained the PO from their own script while 24% reported purchasing them from somebody else. Small numbers reported trading or receiving them as a gift.

Of those who used their own prescription for pharmaceutical opioids (n=13), 92% reported the prescription origin as a Pharmaceutical Benefits Scheme (PBS) prescription from a regular doctor, and 8% obtained from a PBS prescription from another doctor.

Those participants who had recently used PO for pain relief were asked if they had been refused PO in the past six months (n=20). The majority (80%) commented 'no', while 10% were deemed 'not clinically appropriate'. No participants reported being refused due to their injecting history (Table 21). Among those who commented, 24% reported selling, trading or giving away their prescribed PO.



**Table 21: Pharmaceutical opioids use among people who inject drugs, 2013**

	<b>NSW n=150</b>
Used pharmaceutical opioids in the last 12 months (%)	62
<b>Reason for using pharmaceutical opioids in the last 12 months*</b>	n=94
Pain relief (%)	22
As a substitute for heroin (%)	40
To prevent withdrawal (%)	19
To experience an opioid effect (%)	6
To top up heroin (%)	3
Other reason (%)	9
<b>Method of obtaining pharmaceutical opioids for pain relief in the last 12 months<sup>##</sup></b>	n=21
On own prescription (%)	62
Purchased (%)	24
Trading with others (%)	10
Gift from others (%)	5
Other (%)	0
<b>Refused pharmaceutical opioids medications for pain relief last 6 months<sup>##</sup></b>	n=20
No (%)	80
Yes, not clinically appropriate (%)	10
Yes, injecting history (%)	0
Other (%)	10

Source: IDRS participant interviews

\* Among those who recently used pharmaceutical opioids

<sup>##</sup> Among those who used pharmaceutical opioids for pain relief

^ Small numbers commenting n<10; interrupt with caution

## 8.2 Brief Pain Inventory

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

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

In Table 22, seven percent of the sample experienced pain (other than everyday pain) in the last seven days. Of those who experienced pain, the majority (73%) reported the pain as chronic non-cancer pain (continuous pain which lasts for more than three months), while 27% reported acute pain. The mean 'pain severity score' was 4.4 (SD 1.3; range 2.3–6.3), with two-fifths (40%) scoring 5 or more. There were no reports of participants scoring 10 or more. The mean 'pain interference score' was 5.6 (SD 1.4; range 4.1–8.6), with three-fifths (60%) scoring 5 or more. There were no reports of any participants scoring 10 or more. A score of 10 means the pain 'completely interferes' with daily activities.

Participants were also asked on a scale of 0 to 10 (0=no relief, 10=complete relief) how much relief they experienced from any treatments/medications they received. Of those who received treatment/medication for pain (n=7), a mean score of 7.7 (SD 1.9; range 5–10) was reported. Just under three-quarters (70%) scored 5 or more and just under one-third (29%) scored 10.

Of those who experienced pain (other than everyday pain) the last seven days, 73% reported the pain due to an accident/injury or assault and 18% due to an illness/disease. Sixty-four percent reported that they were in pain at the time of the interview. The majority (91%) reported pain for more than three months.

**Table 22: Brief Pain Inventory (BPI) among PWID who commented, 2013**

	NSW
<b>Experienced pain (other than everyday pain) last 7 days** (%)</b>	n=11
Acute/short term pain	27
Chronic non-cancer pain	73
Chronic cancer	0
Other	0
<b>Mean 'Pain Severity' score</b>	4.4
<b>Mean relief experience from treatment/medications*</b>	7.7^
<b>Mean 'Pain Interference' score</b>	5.6

Source: IDRS injecting drug user interviews

\* Among those who received treatment/medication for pain and commented (n=65)

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

^ Small numbers commenting n<10; interrupt with caution

### 8.3 Opioid and stimulant dependence

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

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

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

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

Of those who had recently used a stimulant and commented (n=114), the median SDS score was 3 (mean 3.8; range 0–15), with 47% of those who could comment scoring 4 or above. Females reported a significantly higher mean stimulant SDS score than males (4.2 versus 3.5;  $p<0.05$ ). No significant difference was found between gender and those scoring 4 or above. Of those who scored 5 or above (n=44), 60% reported specifically attributing responses to methamphetamines and 36% cocaine. No participants who scored 5 or more attributed their stimulant dependence to pharmaceutical stimulants.

Of those who had recently used an opioid and commented (n=119), the median SDS score was 8 (mean 7.9, range 0–15), with 82% scoring 5 or above. There were no significant differences regarding gender and mean opioid SDS score; however, males were significantly more likely to score 5 or more compared to females (87% versus 57%;  $p<0.05$ ). Of those who scored 5 or above (n=119), 63% reported specifically attributing responses to heroin, 26% methadone, 13% oxycodone, 5% buprenorphine, and 3% morphine.

### 8.4 Opioid substitution treatment medication injection

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

Of the entire sample, 31% of participants reported recently injecting methadone which is a significant increase ( $p<0.05$ ) on the previous year (20% in 2012). Seven percent reported recently injecting buprenorphine, 4% buprenorphine-naloxone ‘film’ and 1% buprenorphine-naloxone ‘tablet’.

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

### 8.5 Hepatitis C virus testing and treatment

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

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

The majority of the sample (96%) had been tested for HCV in their lifetime with 79% reporting a positive result for HCV antibodies. Of those with a positive result for HCV antibodies, 50% reported this result more than 12 months ago and 50% within the last 12 months. Fifty-three percent reported undergoing further testing for HCV, i.e. to determine whether an active virus is present and which genotype. The main reasons for no further testing among those who commented (n=54) were 'wasn't a priority' (33%) and 'provider didn't mention the need for further tests' (28%) (Table 23).

Among those who received further tests (n=59), 58% reported a polymerase chain reaction (PCR) test (to see if the virus is active) and 63% a PCR viral genotype test. Over half (57%) of those who received a PCR test (n=20) reported that the test showed an active virus. Genotype 1 was the most common genotype reported among those who received a PCR viral genotype test. The community GP (38%) was the most common location of the last HCV test.

Of those who received a PCR test and commented (n=20), 25% reported that they had received HCV medical/antiviral treatment. Of those who had received treatment (n=5), three participants reported that the treatment was successful, one participant reported that it was not successful and one participant dropped out of treatment. Treatment is considered successful if the patient clears the virus as proved by a negative PCR result six months or more after treatment finishes. This is referred to as a 'sustained virological result' and is effectively a 'cure'.

Fifty percent of those who reported an active HCV result and commented (n=20) were aware of the new HCV treatment. Of those aware of the treatment (n=10), seven participants reported that they would consider the new HCV treatment. Of those who commented (n=43), the main setting they would consider convenient for treatment was a HCV clinic (86%), followed by the GP (29%) or OST provider (29%).

The main reasons among those who would not consider the new HCV treatment (n=2) were that they were 'not confident it will be successful', and that they 'did not know enough about it'.

**Table 23: Hepatitis C testing and treatment, by jurisdiction, 2013**

	<b>NSW N=151</b>
Ever tested for HCV (%)	96
<b>Positive HCV test (%)</b>	n=114
Within last 12 months	50
More than 12 months	50
Further testing for HCV antibody	53
<b>Reasons for no further testing (%)</b>	n=54
Provider didn't mention the need for further tests	28
Wasn't a priority	33
Blood tests are difficult for me	4
Don't feel sick	11
Concerned about confidentiality	0
Other reason	24
<b>Further tests for HCV (%)</b>	n=59
PCR test (see if virus is active)	59
PCR viral genotype test	64
Other	9
<b>Location last tested for HCV (%)</b>	n=59
Community GP	34
OST clinic	19
Specialist clinic	19
Prison	10
Other	19

Source: IDRS injecting drug user interviews

## 8.6 Naloxone program and distribution

Naloxone is a short-acting opioid antagonist that has been used for over 40 years to reverse the effects of opioids. It is the frontline medication for the reversal of heroin and other opioid overdose in particular. In Australia, naloxone has largely only been available for use by medical doctors (or those auspiced by medical doctors such as nurses and paramedics) for the reversal of opioid effects. In 2012 a take-home naloxone program commenced in the ACT through which naloxone was made available to peers and family members of people who inject drugs for the reversal of opioid overdose as part of a comprehensive overdose response package. Shortly after, a similar program started in NSW and some other states have followed suit (for more information refer to <http://www.cahma.org.au/naloxone.html> and/or <http://www.naloxoneinfo.org>).

In 2013, the IDRS included a series of questions about take-home naloxone and naloxone more broadly. Ninety-six percent of all participants had previously heard of naloxone. Three-fifths (62%) of those who had heard of naloxone (n=143), reported that naloxone was used to 'reverse heroin', while 32% reported the use of naloxone was to 're-establish consciousness'. Six per cent said naloxone was used to 'help start breathing' and 22% gave 'other' reasons (Table 24).

Participants were then asked if they had heard about take-home naloxone programs. Of those who commented (n=150), 40% reported that they had heard of the take-home naloxone program, while 59% had not. When asked if they would support the expansion of the take-home naloxone program, the majority reported that they would 'strongly support' an expansion (65%), 28% reported that they would 'support' an expansion, while 2% reported that they would 'strongly oppose' an expansion. Four percent of those who could comment neither supported or opposed an expansion (Table 24).

Of those who commented (n=149), 3% reported that they had completed training in naloxone administration along with a prescription for naloxone. Of those who had completed the course (n=4), 50% had used the naloxone to resuscitate someone who had overdosed (range 2–3 people).

Participants who had not completed training in naloxone administration were asked what they would do if they witnessed someone having an overdose or found someone they had suspected had overdosed. The majority (95%) of those who commented (n=145) reported that they would 'call 000', 36% reported that they 'stay with the victim', and a further 35% would perform mouth-to-mouth cardiopulmonary resuscitation (CPR) (Table 24).

Participants who had not completed training in naloxone administration and commented (n=145) were also asked if naloxone was available would they a) carry naloxone if trained in its use, b) administer naloxone after witnessing someone overdose, c) want peers to give them naloxone if they overdosed, and d) stay with someone after giving them naloxone. Ninety-eight per cent reported that they would stay with someone after giving them naloxone, 95% reported that they would administer naloxone after witnessing someone overdose, 92% would want their peers to give them naloxone if they overdosed and 77% reported that they would carry naloxone on them (Table 24).

**Table 24: Take-home naloxone program and distribution, 2013**

	<b>NSW N=151</b>
Heard of naloxone (%)	96
<b>Naloxone description (%)</b>	n=143
Reverses heroin	62
Help start breathing	6
Re-establish consciousness	32
Other	22
<b>Heard of the take-home naloxone program (%)</b>	n=150
Yes	40
No	59
<b>Expand naloxone program (%)</b>	n=150
Strongly support	65
Support	28
Neutral	4
Oppose	0
Strongly oppose	2
Don't know enough to say	1
<b>Witness overdose (%)</b>	n=145
Turn victim on side	29
Mouth-to-mouth CPR	35
Call 000	95
Stay with victim	36
Other remedies	18
<b>If naloxone was available would you: (%)</b>	n=145
Carry naloxone if trained	77
Administer naloxone after overdose	95
Want peers give you naloxone	92
Stay after giving naloxone	98

Source: IDRS injecting drug user interviews

## 8.7 Oral Health Impact Profile

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

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

For this report the OHIP-14 was divided into the seven dimensions of impact, and percentages calculated for those who responded 'occasionally', 'fairly often' and 'very often'. Psychological disability had the higher impact with 60% of those who commented (n=146) reporting either 'occasionally', 'fairly often' and 'very often'. This was followed by physical pain (58%) and psychological discomfort (56%) (Table 25).

A mean scale score of the 14 items was computed, with higher scores indicating poorer oral health-related quality of life. Participants can have an overall OHIP-14 total score ranging from zero to 56. Using the 'additive' method, the mean OHIP-14 total score for those that could comment was 14.3 (SD 13.5, range 0–56). Eighteen percent of those scored 'zero' (Table 25).

**Table 25: Oral health impact profile 14 short form (OHIP-14) score, 2013**

<b>Last three months:</b>	<b>NSW</b>
<b>Dimensions of impact (%)</b>	n=146
Functional limitation	43
Physical pain	58
Psychological discomfort	56
Physical disability	45
Psychological disability	60
Social disability	33
Handicap	37
<b>Mean total scores (range)</b>	14.3 (0–56)
Score of 'zero' (%)	18

Source: IDRS Injecting drug user interviews



## 8.8 Discrimination

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

Eighty-six percent of all participants were able to comment on the discrimination section. Of those who responded (n=130), 48% reported discrimination within the last 12 months, 15% over 12 months ago and 23% reported no discrimination. Those who had experienced discrimination in the last 12 months (n=72), reported the main source of the discrimination was by police (25%), a hospital (21%) and/or a doctor/prescriber (14%). The majority (79%) reported the main reason (perceived) for the discrimination was 'because I'm an injecting drug user (or people think I am)'. Twenty-one percent reported that they had experienced violence or abuse as a result of the discrimination, while a further 14% were refused service. The majority (89%) did not try to resolve the discrimination (Table 26).

**Table 26: Discrimination among people who inject drugs, 2013**

	NSW
<b>Ever discriminated against (%)</b>	n=130
Yes, within the last 12 months	55
Yes, but no in the last 12 months	18
No	27
<b>Location of discrimination (%)</b>	n=72
Doctor/prescriber	14
Pharmacy	7
Dentist	1
Health services	4
Government service, e.g. housing or Centrelink	8
Police	25
Hospital	21
Needle and Syringe Program	1
Drug and alcohol service	1
Prison	4
Other	57
<b>Reason for the discrimination (%)</b>	n=72
Person who injects drugs	79
On OST medication	13
HCV positive	7
HIV positive	1
Other	15
<b>Result of discrimination (%)</b>	n=72
Refused service	14
Taken off/reduced OST medication	0
'Outed' as a person who uses drugs	6
Experienced violence/abuse	21
Lost job	6
Other	32
<b>Tried to resolve discrimination (%)</b>	n=72
No didn't try to resolve	89
Australian Human Rights Commission	1
Health Care Complaint commission	0
Directly to service provider/organisation	6
Other	3

Source: IDRS Injecting drug user interviews

## REFERENCES

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