new south
wales

B. Phillips and L. Burns

NSW DRUG TRENDS 2010
Findings from the
Illicit Drug Reporting System (IDRS)

Australian Drug Trends Series No. 56

NEW SOUTH WALES DRUG TRENDS 2010

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
AODTS	Alcohol & other Drug Treatment Services
AUDIT-C	Alcohol Use Disorders Identification Test - Consumption
BBVI	Blood-borne viral infections
BMI	Body Mass Index
BNX	Buprenorphine-naloxone (Suboxone)
BOCSAR	NSW Bureau of Crime Statistics and Research
BPAQ-SF	Buss-Perry Aggression Questionnaire – Short Form
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 (formerly called the Party Drugs Initiative or PDI)
FDS	Family Drug Support
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
IDRS	Illicit Drug Reporting System
IDU	Injecting Drug Use
K10	10-item Kessler Psychological Distress Scale
KE	Key Expert(s)
MDMA	3,4-methylenedioxymethamphetamine
MERIT	Magistrates Early Referral Into Treatment
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	New South Wales Minimum Data Set for Drug and Alcohol Treatment Services
OP	Outpatient
OST	Opioid Substitution Treatment
OTC	Over the counter
PBS	Pharmaceutical Benefits Scheme
PDI	Party Drugs Initiative (now called the Ecstasy and Related Drugs Reporting System, or EDRS)

PGSI	Problem Gambling Severity Index
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
SNRI	Serotonin-norepinephrine reuptake inhibitor
SSRI	Selective serotonin reuptake inhibitor
STI	Sexually Transmitted Infection
STP	Stimulant Treatment Program
THC	delta-9 tetrahydro-cannabinol

GLOSSARY OF TERMS

Cap	Small amount, typically enough for one injection
Cook up	The use of heat to dissolve in the preparation for injection
Central Sydney	In the PWID survey data refers to participants recruited in Kings Cross and Redfern; in the KE survey data refers to participants referring to these and/or surrounding suburbs in the inner city, e.g. Surry Hills, Darlinghurst
Days of use/injection	180 days: daily use/injection over preceding 6 months 90 days: use/injection every 2nd day over preceding 6 months 24 days: weekly use/injection over preceding 6 months 12 days: fortnightly use/injection over preceding 6 months
Diverted/Diversion	The selling, trading, giving or sharing of one's medication to another person, including through voluntary, involuntary and accidental means.
Eightball	3.5 grams
Extra-medical use	Use of a prescribed medication without prescription, or not 'as directed' by a doctor but not excluding the possibility that use may be driven by medical reasons
Fit	Slang derived from 'outfit' referring to a needle-syringe
Fitpack	A small package of needle syringes and related injecting equipment dispensed by Needle Syringe Programs, vending machines, pharmacy or via Outreach
Halfweight	0.5 gram
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 gram, although may also be used as a term referring to an amount for one injection (similar to a 'cap'; see above)
Recent injection	Injection (typically intravenous) on at least one occasion in the last six months
Recent use	Use in the last six months via one or more of the following routes of administration: injecting; smoking; snorting; and/or swallowing
South-West Sydney	In the PWID survey data refers to participants recruited in Liverpool and Canterbury; in the KE survey data refers to participants referring to these and/or surrounding suburbs, e.g. Fairfield, Cabramatta.
Use	Use via one or more of the following routes of administration: injecting; smoking; snorting; and/or swallowing
Score	To purchase or obtain drugs
Sentinel surveillance	In the context of the IDRS, systematic, ongoing collection and analysis of data from sub-populations (PWID) considered to have the potential to provide an early indication of emerging trends in illicit drug use and associated harms

EXECUTIVE SUMMARY

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

Demographic characteristics of people who inject drugs (PWID)

In 2010, one hundred and fifty-four people participated in the IDRS survey. Sixty-one percent were male, eighty-eight percent reported they were not currently working or were currently receiving income support (such as disability or sickness benefits or the New Start jobseeker's allowance) at the time of interview. The average age of respondents was 39 years (range 19-58 years). Twenty-one percent of the sample identified as Aboriginal and/or Torres Strait Islanders[1]. Eighty-one percent of the sample reported being born in Australia, with 98% identifying English as the main language spoken at home. Fifty-nine percent of the sample had completed year 10, and 17% had completed year 12 at high school. Thirty-six percent had obtained a trade or technical qualification and 9% had completed a university or college qualification such as a degree. Fifty-five percent had not completed any further education after leaving school. The majority (69%) of participants reported previous prison history and the average age of first injection was 19 years (range 11-43).

Patterns of drug use among the PWID sample

Heroin

Following the trends of previous years, heroin was still the preferred drug of choice (71%), in 2010 and this remained stable with reports from last year (72% in 2009). Heroin was the drug most often injected in the month prior to interview (65%; 70% in 2009) and the drug people had injected most recently (62%; 64% in 2009). Ninety-two percent of participants reported use on one or more occasions in the six months preceding interview (94% in 2009). The median days of recent heroin use also remained stable at 96 days i.e. every 2nd day (also 96 days in 2009). The proportion of participants reporting daily use also remained stable (32% versus 34% in 2009).

The median price for a gram ($345) increased slightly in 2010 but the price for a cap of heroin ($50) continued to remain stable. Prices remained higher than those reported prior to the heroin shortage in 2001. Heroin remained accessible in 2010, with 83% (92% in 2009) of those who commented reporting that it was either 'easy' or 'very easy' to obtain. The largest percentage of participants that commented (70%; 77% in 2009) on ease of availability reported it had remained stable.

Participant reports (among those who commented) on heroin purity were again mixed this year. Forty-three percent of the participants that commented reported current purity as low, which

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

remained stable, approximately one-third (31%; 42% in 2009) reported it as medium. Forty-one percent (33% in 2009) of those commenting considered purity levels to have remained stable over the preceding six months, while approximately one-third (36%) commented it had decreased.

Methamphetamine

Although the proportion reporting any recent methamphetamine use (speed powder, base, ice or liquid[2,3]) remained stable in 2010 (57%; also 57% in 2009) there was a decrease in recent use of speed powder and the recent injection of both speed and base. The most common form used once again was ice/crystal (48%; 46% in 2009), followed equally by base and speed (both 29%; 36% and 33% in 2009 respectively. Prevalence of liquid methamphetamine remained stable and low (3%; 5% in 2009). Frequency of methamphetamine use (any form) also decreased again in 2010 to 14 days (approximately fortnightly use) from a median of 24 days (approximately weekly use) in 2009. Eighteen percent of the sample reported daily use of any type of methamphetamine, an increase from the 4% in 2009.

A 'point' (0.1 of a gram) was 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. In 2010, there were insufficient numbers of purchases of any form of methamphetamine to comment on price changes in amounts larger than points.

Speed and base forms of methamphetamine were typically reported by the majority of users as 'very easy' or 'easy' to obtain, as was ice/crystal. Availability for all forms was typically reported to have remained stable over the six months preceding interview, however, there was a noted decrease in the portion (12%; 32% in 2009) reporting that the availability of ice/crystal had become more difficult. As in previous years, users' reports indicated that ice/crystal was higher in purity than base and speed powder.

Cocaine

Stability was observed in levels of recent cocaine use among PWID with 57% of the sample reporting recent use in 2010 (61% reporting use in 2009). The median days of use among users, however, increased to 12 days (approximately fortnightly use) from the 20 days reported in 2009. Daily cocaine use remained stable with 8% of users reporting daily use (5% in 2009). Reports of crack cocaine were once again almost non-existent among the PWID sample, a finding reflected in KE reports. While the majority (67%) reported cocaine availability to be 'easy' or 'very easy' (85% in 2009) there was an increase in the number reporting it as difficult in 2010. Both availability and price was commonly perceived to have remained stable over the preceding six months.

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

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

The median price per gram of cocaine decreased in 2010 ($300; $350 in 2009). While a cap of cocaine remained stable at $50. Low numbers of participants reported purchases of other amounts.

Thirty-six percent of PWID reported cocaine purity as 'medium', which remained stable with reports from last year (39% in 2009). There was an increase in the proportion reporting current purity as 'low' (26% versus 18% in 2009). Purity was most often rated as having been 'stable' over the six months preceding interview and there was an increase in the number reporting this in 2010 (44%; 28% in 2009).

Cannabis

The cannabis market continued to remain relatively unchanged since the commencement of the NSW IDRS in 1996. The majority of participants (72%; 79% in 2009) in the 2010 participant sample reported having used cannabis in the six months prior to interview. The median frequency of use among PWID remained at 180 days (daily use), which has been stable for the past 8 years.

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 the majority of recent users (92%; 95% in 2009) reported that it was readily available, i.e. 'easy' or 'very easy' to obtain. 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 as reported 'medium'.

Use of pharmaceuticals

The IDRS monitors the extra medical (non-prescribed; illicit) 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).

Illicit methadone

Over one-quarter (27%) of participants reported use of illicitly obtained methadone syrup in the six months preceding interview, a decrease from 2009 (36%), use, however, remained stable and relatively infrequent (approximately monthly). One-fifth (20%) of participants reported injecting illicit methadone syrup in the preceding six months (23% in 2009), the frequency (median days) of injection also remained stable. The majority that could comment on the availability of illicit methadone reported that it was 'very easy' or 'easy'. The median price of 50 cents per ml remained stable.

Recent use and injection of illicitly obtained Physeptone continued to remain uncommon.

Illicit buprenorphine and buprenorphine-naloxone

The recent use and injection of illicit buprenorphine in the preceding six month remained stable in 2010. The frequency of injection of illicit buprenorphine over this period continued to remain low and stable.

Buprenorphine-naloxone (Suboxone) has been investigated by the IDRS since its listing on the Pharmaceutical Benefits Scheme in April 2006. Three percent of the sample reported illicit buprenorphine-naloxone use in 2010 and similarly only 3% also reported recent injection.

Morphine

An increase in prevalence of any recent morphine use among the NSW IDRS PWID sample had been observed since 2001; however, in 2010 it continued to stabilise and was comparable with last year (35% versus 31% in 2009). Recent use of illicit morphine also remained stable (31% versus 28% in 2009), as did recent injection (28% versus 27% in 2009). The median days illicit morphine was injected in 2010 also remained comparable with 2009 (4 days versus 6 days in 2009).

MS Contin remained the most common brand of morphine used, with 82% of recent illicit morphine use being MS Contin tablets. The median price for 100mg MS Contin tablets ('grey nurses') remained stable in 2010 at a median of $30 per tablet (range: $20-35). 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 licit and illicit oxycodone and other opioids in an effort to monitor the illicit use of, and problems associated with, the diversion of oxycodone. Until 2005, oxycodone was included under 'other opioids'.

Thirty-six percent of participants reported use of any (prescribed or illicitly sourced) oxycodone in the six months preceding interview (28% in 2009) on a median of 6 days (i.e. monthly), the same frequency of use as 2009 (also 6 days). Thirty-one of the sample reported injecting it in this time on a median of seven days, which remained stable compared with 2009.

One-third (33%) of the sample felt confident to comment on the price and/or availability of illicit oxycodone in 2010. The most common purchase amounts were 80mg OxyContin tablets, bought for a median price of $30 each, which was stable with 2009. The majority (64%; also 64% in 2009) of participants commenting reported that availability was considered 'easy' or 'very easy', with availability generally considered to have remained stable.

Other opioids and over the counter codeine

Reported use of other opioids not specified elsewhere (whether licitly or illicitly obtained) remained stable with only 5% (4% in 2009) reporting recent use. Since 2009 survey specific questions were asked about over the counter (OTC) codeine use and it was subsequently removed from the 'other opioids' classification. Again in 2010, half (51%) of the sample reported recent use of OTC codeine, on a median of 8 days, only 1% of participants reported recent injection. Recent injection of other opioids also remained low (1%).

Benzodiazepines

Since 2007, a distinction has been made between licit and illicit benzodiazepines due to concerns about problems associated with diversion.

Prevalence of benzodiazepine use remained relatively stable with 70% (66% in 2009) reporting use in the six months preceding interview, the frequency of use decreased from a median of 57 days in 2009 to 37 days in 2010. The injection of benzodiazepines remained low with only 6% (3% in 2009) reporting any injection in the past six months. In general, injection of benzodiazepines had remained substantially lower since the removal of benzodiazepine gelatine capsules (e.g. Normison, Euhypnos) from the market in 2004. Frequency of use patterns between licitly and illicitly obtained benzodiazepines were comparable in 2010 with the frequency of use of prescribed being only marginally higher than if they were obtained illicitly (49 days versus 43 days). Half (49%) of all participants reported use of illicitly obtained benzodiazepines in the last six months, which remained stable compared with 2009. Diazepam (Valium, Antenex and generic) remained the most common form used.

Other drugs

Hallucinogens, ecstasy and inhalant use were relatively low within this sample. Hallucinogen use in the six months preceding interview was reported by only 2% of the sample on a median of one day (also 1 day in 2009), similarly there were no reports of recent injection.

Although approximately one-half (47%) of the sample had tried ecstasy, recent use was reported by only 9% of the sample on a median of 3 days. Only two percent reported injecting it in the preceding six months on a median of three days. Prevalence of recent inhalant use (e.g. nitrous oxide, amyl nitrite) remained low at 1%.

Alcohol and tobacco

Fifty-eight percent of participants had consumed alcohol in the preceding six months (65% in 2009) on a median of 24 days, i.e. approximately once per week. While there was a decrease in the proportion reporting recent use, the frequency of use remained stable. One-fifth (22%) of participants reported daily alcohol use, which was consistent with figures over the past 3 years.

Tobacco remained the most commonly used substance investigated by the IDRS, with virtually all participants (96%) 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.

Health-related trends associated with drug use

Reported non-fatal heroin overdose in the year prior to interview (22%; 12% in 2009) increased in 2010. There were three reports of overdose in the last month (also 3 in 2009). There was an increase in those that reported having ever overdosed on heroin, however, 2009 was the lowest recorded lifetime heroin overdose since the IDRS began.

Participant reports of borrowing and lending of needles and syringes remained stable in 2010. There was a slight decrease in the proportion of participants reporting having shared other injecting equipment.

The most commonly reported location for last injection remained a private home, this remained stable with 2009.

Again in 2010, participants were asked the site on their body for their last injection. The majority (74%) reported their arm and only small proportions reported neck, groin, leg or foot.

Half (50%) of PWID participants who had injected in the last month reported at least one injection-related problem during this time (30% in 2009). As per 2009, the most commonly reported problems were prominent scarring/bruising of injection sites (31%; 53% in 2009) and difficulty injecting (27%; 45% in 2009).

Forty-four percent of the sample reported experiencing a mental health problem, other than drug dependence, in the preceding six months (39% in 2009) and 32% (24% in 2009) of this group reported seeking advice from a mental health professional during this time. Depression continued to be the most commonly reported mental health problem (29%; 30% in 2009).

Again in 2010, 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 were found to be in the 'very high distress' level of psychological distress category, at a proportion higher than the Australian normative value.

Only two percent of the entire sample had driven under the influence of any alcohol in 2010. Both the percentage of the sample recently driving and driving under the influence of any alcohol have decreased from 2009. Twelve percent of the entire sample had driven 'soon' after taking (an) illicit drug(s), a decrease from 2009.

More than half of the sample (56%) reported experiencing some form of pain in the month prior to interview. Of those experiencing some form of pain one-quarter (24%; 14% of entire sample) reported severe pain and 7% (4% of entire sample) reported experiencing very severe pain and one-fifth (22%) of the sample reported recent use of pharmaceutical opioids for pain.

The mean height and weight of participants was 1.72 metres and 73.2 kilograms respectively. Six percent had a BMI which was considered 'underweight' (BMI<18.5).

Eighty-five percent of participants reported visiting a GP in the last 12 months for a physical or mental health problem, on a median of 6 occasions during that time. Among those who reported visiting a GP in the last 12 months, approximately one-third (31%) of participants reported visiting a GP in a hospital outpatient (OP) or emergency department (ED).

In 2010, questions regarding sexual health were added to the survey. Sixty-nine percent of all participants reported that they had been tested for an STI over the past 2 years. Of these, two-fifths (39%) reported their GP as the place they were last tested. Female participants were asked about resent pap smear tests. Of those tested in the past 2 years the majority reported that the reason for the test was that they were due. The majority (44%) of women who had a recent test reported the receiving it from their GP.

Law enforcement-related trends associated with drug use

The proportion of PWID participants that reported being arrested in the previous 12 months remained stable at 44% of the entire sample (42% in 2009). While, the proportion of reporting involvement in any criminal activity in the month preceding interview decreased in 2010 (42%; 51% in 2009). Trends continued to follow those reported in previous years with the two most commonly reported crimes being drug dealing (24%; 34% in 2009) and property crime (also 24%; 29% in 2009). The daily expenditure on illicit drugs and alcohol (excluding tobacco) increased to a median of $100 per participant ($85 in 2009).

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 2010. 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 et al. 2006; Stafford, Degenhardt 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 2010 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 manufacture; 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 2010 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 2010 NSW IDRS, the PWID survey consisted of face-to-face interviews with 154 PWID, conducted in Sydney during June 2010. Slightly over half (52%) 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. Again in 2010, measures were taken to limit the proportion of participants engaged in pharmacotherapy treatment; nonetheless, 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 twelve 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 risk-taking behaviour, driving risk behaviour, experiences with drug detection dogs, 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 40 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 PASW Statistics (formerly SPSS) for Windows, Release 18.0 (IBM 2009).

2.2 Survey of key experts (KE)

Twenty-eight KE who had regular contact with, and/or specialist knowledge of, people using illicit drugs[4], drug dealers or drug manufacturers, were interviewed in October 2010. 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 2010 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. Notes were taken during the interview and content analysis conducted to identify recurring themes and patterns in the data.

2.3 Other indicators

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

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

Data sources that have been included in this report are:

Other indicators informing the NSW IDRS

- Alcohol and Drug Information Service – calls received regarding problematic drug use;
- Family Drug Support – telephone support service for family members affected by problematic drug use, and for people who use drugs themselves;
- Australian Bureau of Statistics – overdose data;
- Australian Crime Commission – purity data from police seizures;
- Australian Government Department of Health 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 154 PWID participants who took part in the interview in 2010 are presented below (Table 1). The mean age of the sample was 39 years (range 19-58), 61% were male and 22% identified themselves as Aboriginal and/or Torres Strait Islander[5]. The vast majority identified as heterosexual (84%) and the vast majority (98%) reported that English was the main language they spoke at home. The educational status of the sample varied from the completion of year 6 (3%) through to completion of year 12 (17%). More than half (59%) had completed year 10 or higher. Just over one-third (36%) had obtained a trade or technical qualification and 9% had completed a university or college qualification such as a degree. Fifty-five percent had not completed any further education after leaving school. The majority of the sample (88%) reported that they were currently not employed or receiving a government pension. Eighty-four percent of the sample reported that their main source of income over the preceding month had been a pension or government benefit, while 3% reported a wage or salary, 8% nominated criminal activity and 3% reported sex work. The majority (53%) of participants reported being single, while one-quarter (26%) reported being married or de facto and one-sixth (16%) had a current partner. Smaller proportions reported being separated or divorced (3%) or widowed/widower (2%).

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

Table 1: Demographic characteristics of PWID participants, 2007-2010

Characteristic	2007 N=153	2008 N=151	2009 N=152	**2010 N=154**
Age (mean years, range)	36.9 (18-60)	37.1 (19-57)	38.2 (19-52)	**39.3 (19-58)**
Sex (% male)	71	63	65	**61**
Employment (%):				
Not employed/on a pension	81	79	86	**88**
Full time	5	6	2	**1**
Part-time/casual	9	7	9	**9**
Home duties	3	5	3	**1**
Student	1	1	0	**1**
Aboriginal and/or Torres Strait Islander* (%)	24	19	20	**22**
Heterosexual (%)	84	86	88	**84**
Bisexual (%)	9	9	8	**7**
Gay or lesbian (%)	4	3	3	**6**
Other (%)	2	2	1	**3**
School education (mean no. years, range)	9.8 (0-12 years)	10 (1-12 years)	10 (5-12)	**9.7 (3-12)**
Tertiary education (%):				
None	61	48	57	**55**
Trade/technical	33	47	36	**36**
University/college	5	5	7	**9**
Currently in drug treatment^ (%)	53	50	47	**67**
Prison history (%)	63	62	65	**69**
Current relationship status (%):				
Married/de facto		37	21	**26**
Regular partner		19	16	**16**
Single		39	52	**53**
Separated/divorced		4	9	**3**
Widowed/widower		1	1	**2**

Source: IDRS PWID interviews

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

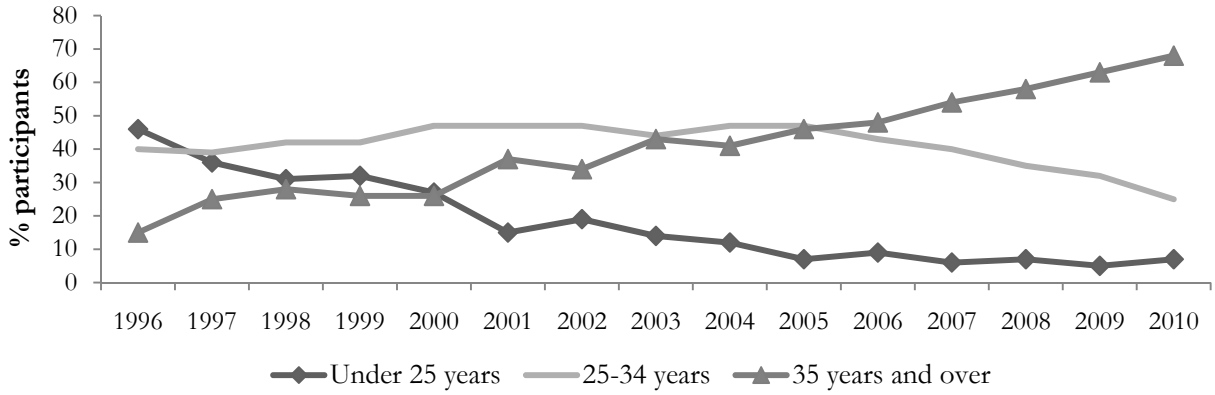
* Aboriginal and/or Torres Strait Islander proportion of sample is not indicative of numbers of Indigenous persons who regularly inject drugs

3.1.1 Age of the PWID sample over time

The mean age (39.3 years) of the sample has increased overtime. The 35 years and over age group, representing the majority (68%) 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) and in the last 5 years had plateaued. There are several reasons that could contribute to this. First, it may be that fewer younger users are accessing NSPs (where recruitment is conducted) in recent years, or are less willing to take part in research conducted at NSPs. Second, in recent years, younger PWID are more likely to be using methamphetamine than their older counterparts (Deganhardt, Kinner et al. 2008), and some research has shown that methamphetamine users may be less likely to access health services such as NSP (Kelly, McKetin et al. 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 et al. 2005). Further research is required to investigate these possibilities in greater detail.

Figure 1: Age distribution of PWID in the NSW (Sydney) IDRS samples, 1996-2010



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 1A. Only a small minority (3%) reported having been interviewed for the Ecstasy and related drugs reporting system (EDRS) previously. Just under one-third of participants in 2010 reported having taken part in the IDRS survey previously (between 1996 and 2009). The majority of participants had been recruited by way of advertisements placed in NSPs, followed by word of mouth (Table 1A).

Table 1A: Previous participation in the IDRS and EDRS and source of participant recruitment, 2008-2010

	2008 N=151	2009 N=152	**2010 N=154**
Participated in IDRS in previous years (%)	12	22	**30**
Where found out about IDRS survey recruitment (%)			
Needle and Syringe Program (NSP)	62	60	**53**
Treatment provider	8	7	**4**
Advert in street press	1	1	**0**
Word of mouth	29	33	**43**
Participated in EDRS in previous years (%)	1	1	**3**

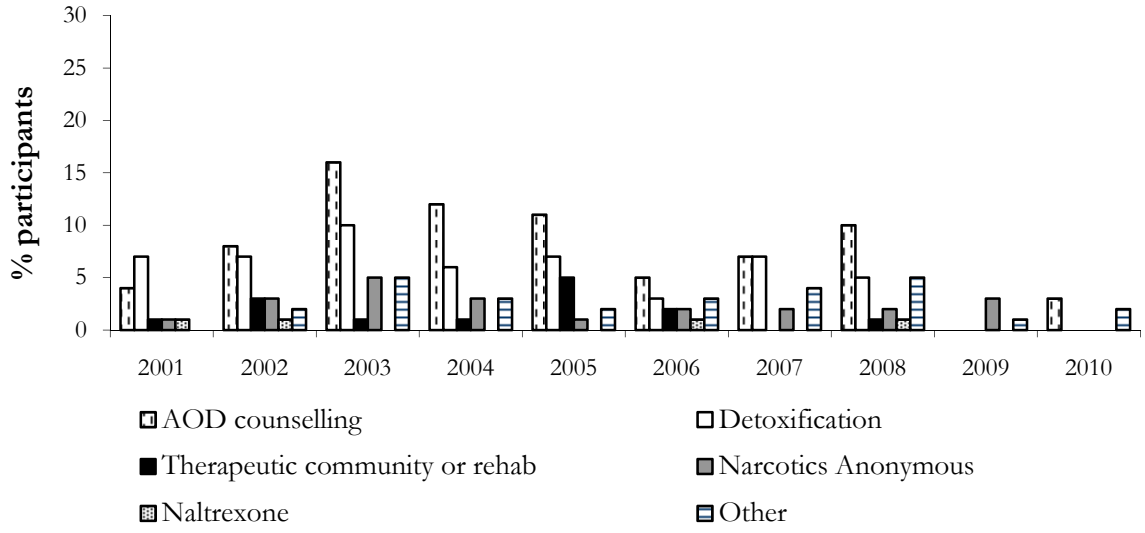
Source: IDRS PWID interviews

3.1.3 Current and previous drug treatment

Sixty-seven percent of participants reported that they were currently in drug treatment. Of those participants currently engaged in treatment, 84% (57% of the entire sample) reported methadone/biodone as their main form of treatment, and nine participants (6% of the sample) reported buprenorphine and three participants (2% of entire sample) reported they were on buprenorphine-naloxone (Suboxone). Four participants reported drug counselling (3% of entire sample) and there were no reports of Narcotics Anonymous, naltrexone treatment, therapeutic community or detoxification (Figure 2). 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; three-quarters (75%) 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 past six months, 2001-2010



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 18.7 years (SD 5.6, range 11-43) (Table 2). Similar to previous years, heroin was the first drug injected by the majority of participants (61%), followed by methamphetamine (33%) and cocaine (3%). Heroin remained the most commonly reported drug of choice (71%), remaining stable from 2009 (72%). In 2010, methamphetamines (all forms) and cocaine were nominated as drug of choice, drug most recently injected and drug most often injected and this remained comparable with 2009 (Table 2).

Table 2: Injection history, drug preferences and polydrug use of PWID participants, 2006-2010

Variable	2007 N=153	2008 N=151	2009 N=152	**2010 N=154**
Age first injection (mean years)	19.6	19.9	18.8	**18.7**
First drug injected (%)				
Heroin	61	54	58	**61**
Methamphetamines	33	37	34	**33**
Cocaine	5	5	5	**3**
Morphine	1	1	0	**1**
Drug of choice (%)				
Heroin	67	50	72	**71**
Cocaine	11	10	10	**11**
Methamphetamine (any form)	17	30	13	**10**
Speed	*5*	*5*	*5*	***3***
Base	*3*	*1*	*1*	***0***
Crystal methamphetamine (ice)	*10*	*24*	*7*	***7***
Benzodiazepines	1	1	1	**0**
Cannabis	2	3	3	**3**
Drug injected most often in last month (%)				
Not injected in last month	*1*	*1*	*0*	***1***
Heroin	57	46	70	**65**
Cocaine	16	11	11	**12**
Methamphetamine (any form)	19	33	15	**11**
Speed	*4*	*6*	*5*	***3***
Base	*3*	*1*	*1*	***1***
Crystal methamphetamine (ice)	*12*	*26*	*9*	***7***
Benzodiazepines	1	0	0	**1**
Morphine	4	3	3	**5**
Most recent drug injected (%)				
Heroin	56	49	64	**62**
Cocaine	15	13	13	**11**
Methamphetamine (any form)	22	30	14	**11**
Speed	*3*	*6*	*5*	***3***
Base	*4*	*1*	*3*	***3***
Crystal (ice)	*15*	*23*	*6*	***5***
Benzodiazepines	0	0	1	**2**
Morphine	3	1	4	**5**
Frequency of injecting in last month (%)				
Not injected in last month	*1*	*1*	*0*	***1***
Weekly or less	10	13	15	**15**
More than weekly, but less than daily	29	34	33	**30**
Once per day	24	21	17	**18**
2-3 times a day	26	25	24	**26**
>3 times a day	9	7	11	**10**

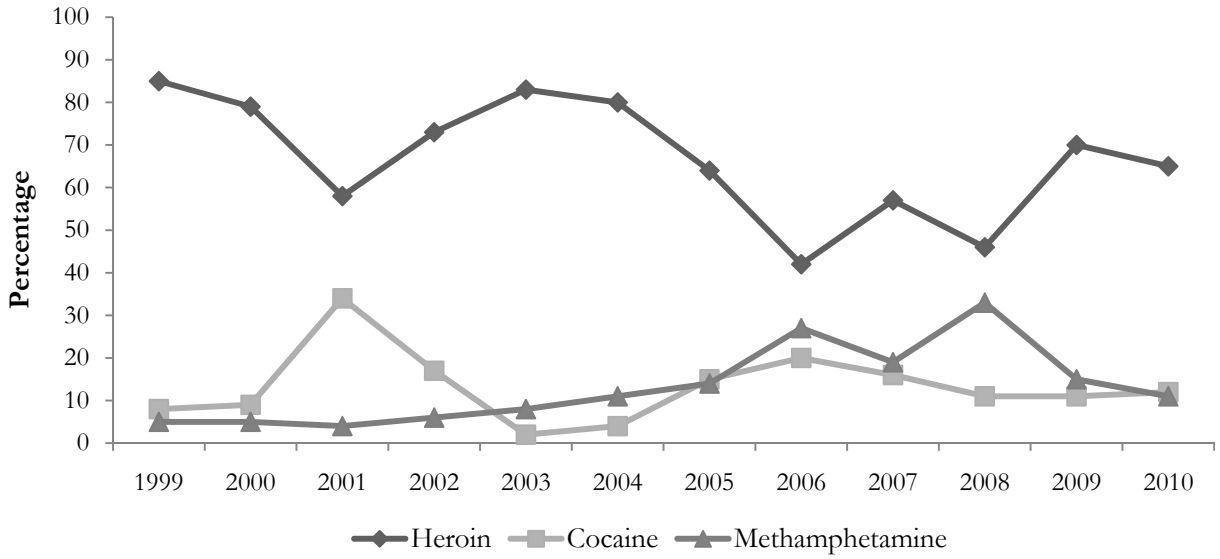
Source: IDRS PWID interviews

NB: Percentages do not equate to 100 as more than one response may have been selected

As in previous years, heroin remained the most commonly injected drug over the month preceding interview (65%), this is comparable with what was reported last year (70%; see Figure 3). Similarly, the proportion of respondents reporting methamphetamine as the most commonly injected drug was also comparable with 15% in 2009 versus 11% in 2010. The percentage of people reporting cocaine as the most recent drug injected (11%) and drug injected most in last

month (12%) remained stable from 2009. Overall, proportions nominating drugs other than heroin as the most commonly injected remained low and generally stable.

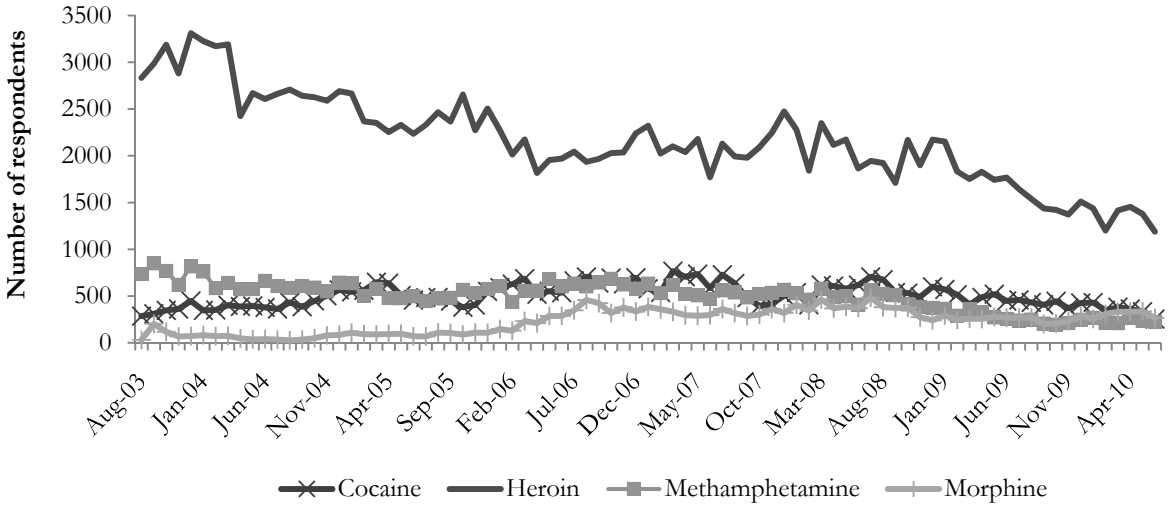
Figure 3: Drug injected most last month, 1999-2010



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

Figure 4 illustrates the most recent drug injected as reported by respondents attending three inner city NSPs. Heroin continued to be reported as the last drug injected consistently by the majority of respondents. Despite occasional fluctuations, there has been an overall decline, in the numbers reporting heroin throughout the reporting period. This decline had continued in 2010, with two of lowest levels recorded since 2003 reported in the past 12 months (February 2010: 1,200 and June 2010: 1,188 respondents nominating heroin as the last drug injected). The numbers reporting methamphetamine (all forms) over the past 12 months have also decreased, with the lowest levels also recorded since 2003 (194 respondents in October 2009). The number of people nominating cocaine in the 12 months to June 2010 also declined to the lowest since 2003 (254 respondents in June 2010). The number of respondents nominating morphine had 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. The last 12 months saw morphine injections decline to the lowest (203 respondents in September 2009) seen since early 2006.

Figure 4: Number of respondents attending three inner city NSPs reporting heroin, methamphetamine, cocaine and morphine as last drug injected, August 2003-October 2010



Source: Three inner city NSPs

The polydrug use histories of PWID participants, including routes of administration, are presented in Table 3. Recent use of the four main drugs monitored by the IDRS remained common: heroin (92%), cannabis (72%), cocaine (57%) and methamphetamine (any form; 57%). Further discussion of the use of these drugs may be found under the relevant section headings elsewhere in the report.

Table 3: Polydrug use history of the PWID sample, 2010

Drug Class	Ever used %	Ever injected %	Injected last 6 mths %	Median days injected in last 6 months*	Ever smoked %	Smoked last 6 mths %	Ever snorted %	Snorted last 6 mths %	Ever swallowed %	Swallowed last 6 mths+ %	Used^ last 6 mths %	Median days in treatment* last 6 mths	Median days used^ in last 6 mths*
Heroin	99	99	92	96	53	8	22	1	24	8	92		96
Homebake heroin	28	26	5	2	1	0	1	0	3	0	5		2
Any heroin (inc. homebake)	*99*	*99*	*92*	*96*	*54*	*8*	*23*	*1*	*25*	*8*	*92*		*96*
Methadone (prescribed)	80	41	12	48					76	60	61	180	180
Methadone (not prescribed)	46	35	20	7					28	14	27		6
Physeptone (prescribed)	11	6	0	0	0	0	0	0	10	0	0	0	0
Physeptone (not prescribed)	15	10	1	7	0	0	0	0	9	1	1		7
Any methadone (inc. Physeptone)	*87*	*59*	*25*	*15*					*81*	*66*	*70*		*180*
Buprenorphine 'Subutex' (prescribed)	28	11	5	90	2	1	0	0	24	9	11	180	96
Buprenorphine 'Subutex' (not prescribed)	25	20	10	5	2	0	1	0	10	6	13		5
Any buprenorphine (exc. buprenorphine-naloxone)	*42*	*27*	*14*	*7*	*4*	*1*	*0*	*0*	*29*	*12*	*18*		*32*
Buprenorphine-naloxone 'Suboxone' (prescribed)	10	1	1	1	0	0			9	5	5	64	64
Buprenorphine-naloxone 'Suboxone' (not prescribed)	9	6	3	2	1	0			5	2	3		1
Any buprenorphine-naloxone	*16*	*6*	*3*	*2*	*1*	*0*			*12*	*7*	*8*		*14*
Morphine (prescribed)	23	16	6	4	1	0	1	0	13	5	8		9
Morphine (not prescribed)	52	48	28	4	0	0	0	0	20	8	31		4
Any morphine	*60*	*54*	*32*	*4*	*1*	*0*	*1*	*0*	*29*	*12*	*35*		*5*
Oxycodone (prescribed)	15	8	4	54	0	0	0	0	10	6	10		21
Oxycodone (not prescribed)	53	47	29	6	2	1	0	0	19	12	33		6
Any oxycodone	*60*	*50*	*31*	*10*	*2*	*2*	*0*	*0*	*26*	*16*	*36*		*6*

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 3: Polydrug use history of the PWID sample, 2010 (continued)

Drug Class	Ever used %	Ever injected %	Injected last 6 mths %	Days injected in last 6 mths*	Ever smoked %	Smoked last 6 mths %	Ever snorted %	Snorted last 6 mths %	Ever swallowed %	Swallowed last 6 mths+ %	Used^ last 6 mths %	Days in treatment* last 6 mths	Days used^ in last 6 mths*
Other opioids (not elsewhere classified)	12	4	1	180	5	1	1	0	6	4	5		10
OTC Codeine	66	7	1	6	0	0	1	0	65	51	51		8
Speed powder	80	74	27	6	11	3	33	1	30	6	29		6
Base/point/wax	56	53	28	5	5	2	5	0	13	5	29		5
Ice/shabu/crystal	73	66	43	7	36	19	3	1	9	4	48		11
Amphetamine liquid	32	26	3	6					11	1	3		6
Any form methamphetamine#	*88*	*83*	*53*	*13*	*44*	*20*	*35*	*2*	*40*	*10*	*57*		*14*
Pharmaceutical stimulants (prescribed)	3	0	0		0	0	0	0	3	0	0		0
Pharmaceutical stimulants (not prescribed)	9	3	0		1	1	0	0	6	1	1		4
Any form pharmaceutical stimulants	*11*	*3*	*0*	*0*	*1*	*1*	*0*	*0*	*9*	*1*	*1*		*4*
Cocaine	87	83	56	12	15	4	37	9	11	3	57		12
Hallucinogens	47	6	0	0		0	0	0	45	2	2		1
Ecstasy	47	17	2	3	1	0	1	0	44	7	9		3
Benzodiazepines (prescribed)	55	5	1	1	1	0	1	0	53	42	43		90
Benzodiazepines (not prescribed)	60	11	5	17	2	0	1	0	58	47	49		15
Any form benzodiazepine	*78*	*13*	*6*	*3*	*2*	*0*	*1*	*0*	*77*	*68*	*70*		*37*
Alcohol	90	3	0	0					89	57	58		24
Cannabis	94										72		180
Inhalants	16										1		9
Tobacco	97										96		180

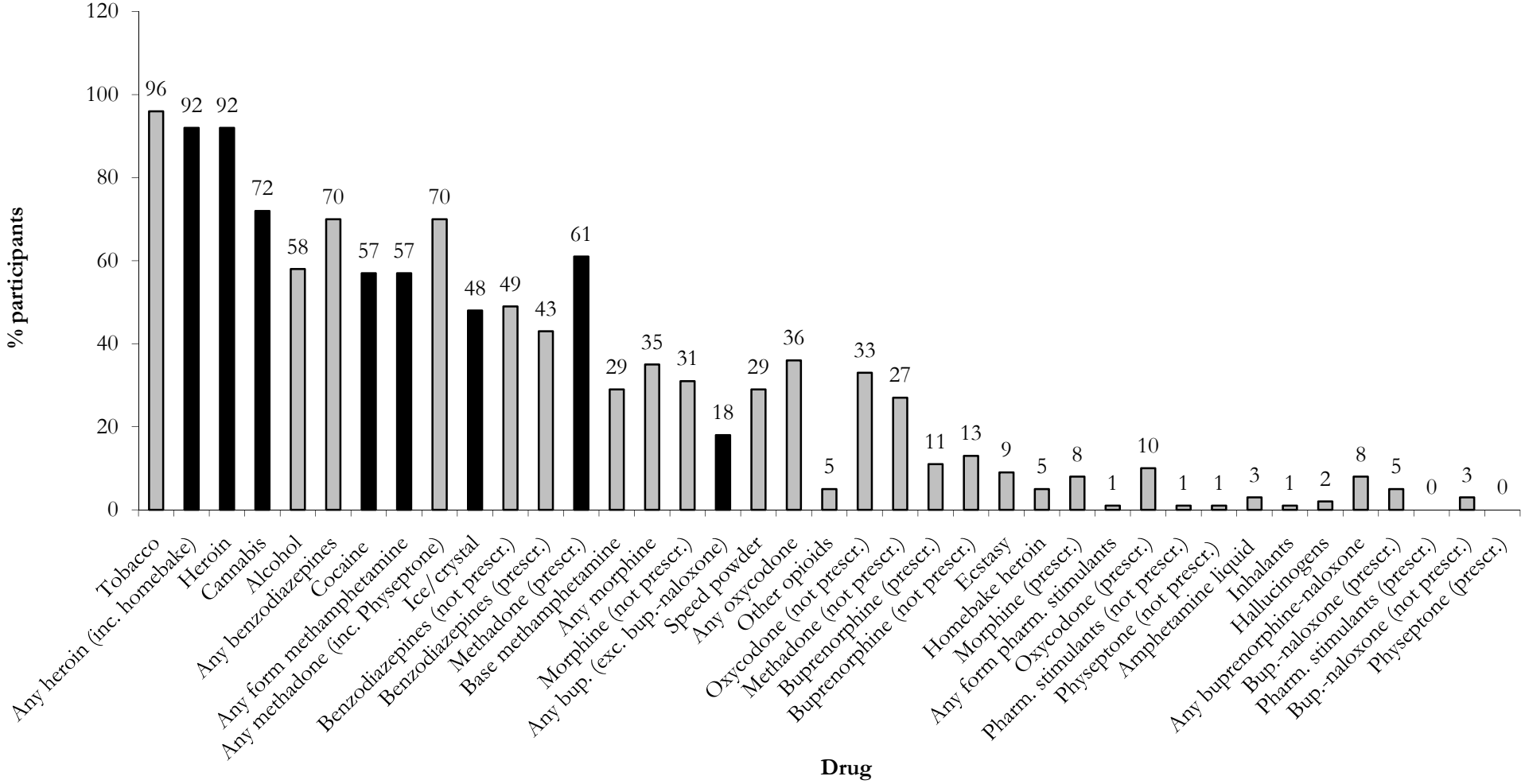
Source: IDRS PWID interviews

^ 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 2010*



Source: IDRS PWID interviews

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

NB: 'Any heroin' includes heroin and homebake heroin. 'Any form methamphetamine' includes speed powder, base, ice/crystal and liquid amphetamine. 'Any methadone' includes licit (prescr.) and illicit (not prescr.) methadone syrup and Physeptone. 'Any morphine', 'any buprenorphine', 'any oxycodone', 'any form pharmaceutical stimulants' and 'any form bup.-naloxone' include licit and illicit forms of the drug in any formulation unless otherwise specified. 'Other opioids' refers to opioids not elsewhere classified. 'Use' refers to any form of administration and does not necessarily imply injection - for further information on routes of administration, please refer to Table 3

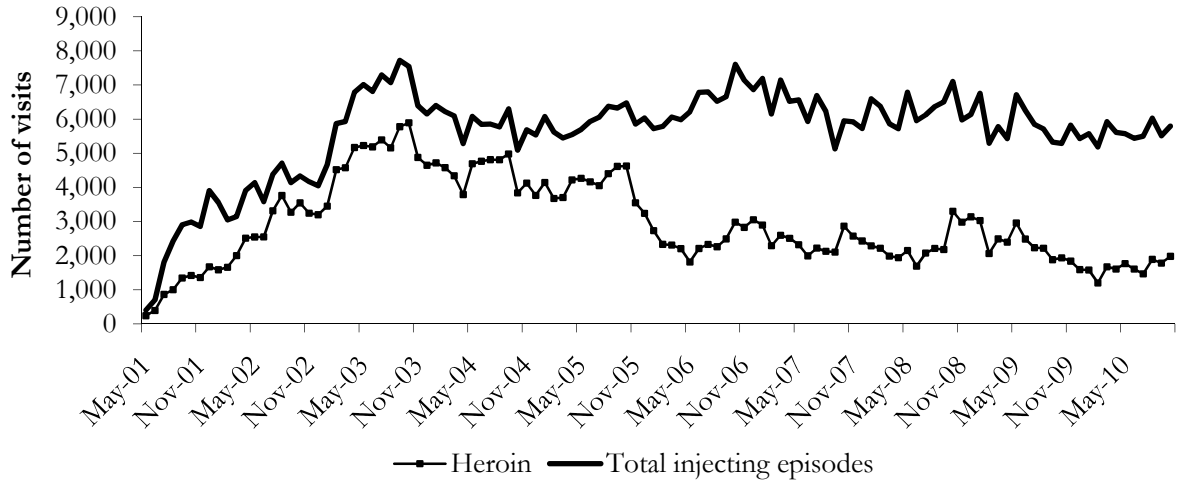
4.2 Heroin

4.2.1 Heroin use among PWID participants

The majority of participants (92%) had used heroin in the six months preceding interview, this remained stable with the 94% reported in 2009. Heroin remained the drug of choice for over two-thirds (74%) of the sample (Table 2) also remaining stable with the 72% reporting it in 2009. Heroin also remained the most commonly nominated for 'drug injected last' (62%), stable with the 64% reporting it in 2009. Similarly, heroin continued to be the 'drug injected most often in the last month' (65%), comparable with the 70% that reported it in 2009.

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 2010. 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 twelve 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 Section 8). While heroin has accounted for approximately 30-40% of all visits to Sydney MSIC since February 2006 there has been pronounced spikes in attendances since then. In the 12 months to October 2010 the median proportion of attendances for heroin injection of total attendances' to MSIC was 30% (range: 23-34%), a decrease from the 12 months to October 2009 (42%; range 35-51%).

Figure 6: Number of attendances to Sydney MSIC where heroin was injected and total number of visits, May 2001-October 2010



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

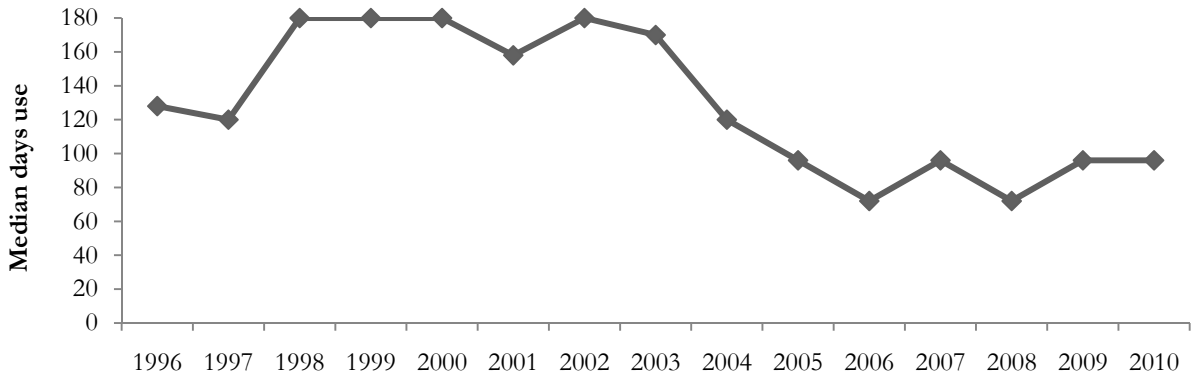
4.1.1.1 Homebake

Homebake use remained uncommon among the PWID sample of the NSW IDRS. Only five percent of the sample reported use in the last six months (Table 3), which is a decrease from the 15% reported in 2009. Five percent also reported injection in the preceding six months, a decrease from the figures reported in 2009 and 2008 figures (15%, 12% respectively).

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 2010 at 96, approximately every 2nd day. In comparison seven years earlier (2003) the median days use was almost daily (170 days) (Figure7). Similarly the prevalence of recent heroin use reported in 2010 has also remained stable (92% versus 94% in 2009).

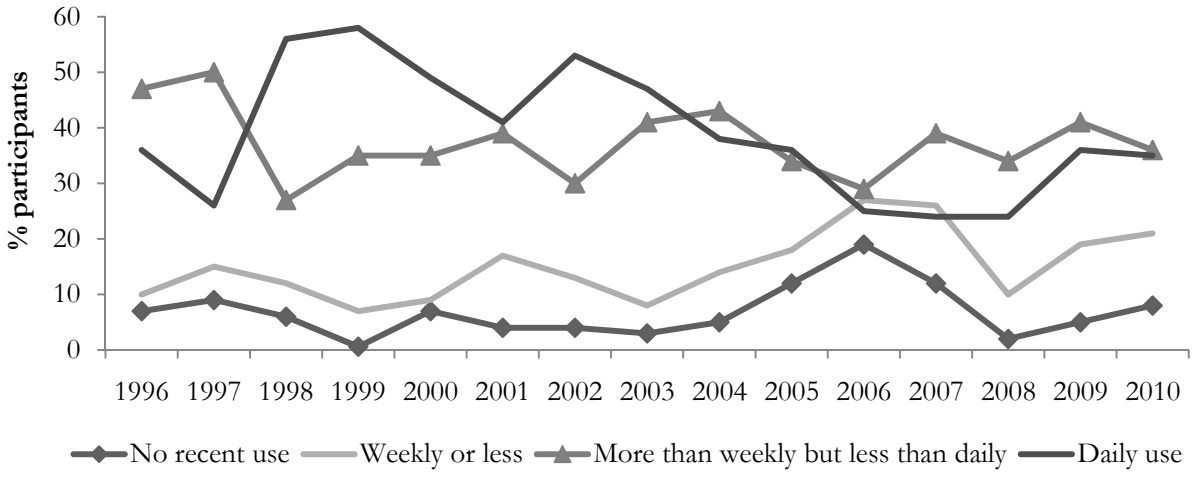
Figure 7: Median days of heroin use in the past six months, 1996-2010



Source: IDRS PWID interviews

The proportion of daily heroin users among the sample remained stable in 2010 at 35% of all participants (Figure 8). Similarly the proportion of participants who reported heroin use on the day prior to interview remained stable with 2009 with more than half (53%) reporting use in on the day prior. Proportions that have used heroin weekly or less, have also remained stable in 2010.

Figure 8: Patterns of heroin use, 1996-2010



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. Eight-seven percent of participants had reported recent use of heroin they described as white/off-white 'powder' or 'rock' and 72% reported recent use of heroin described as brown/beige 'powder' or 'rock'. The form most used (over the preceding six months) was evidently white/off-white 'powder' (35% of those commenting) with more than one-quarter (28% of those commenting) nominating beige/brown 'powder', followed closely by white/off-white 'rock' (24% of those commenting). Only 12% of those commenting had used beige/brown 'rock' most often in the preceding 6 months. Only one participant reported homebake as the form most often used.

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, 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 et al. 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 2010, 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. Fifty-six percent reported using heat on the last occasion, while only 6% 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 use had been used in preparation. Of those who reported using heat or acid on the last occasion the majority (69%) of respondents described the colour of heroin as brown/beige and more than one-quarter (28%) described it as white/off-white in colour.

4.2.1.1 Homebake

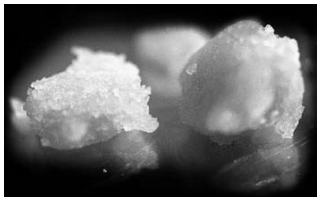
The median number of days of homebake use in the preceding six months was 2 (i.e. use approximately once every 3 months, range 1-180 days) this is a decrease from the seven days reported in 2009. The median number of days on which it had been injected by users in this time also decreased from 7 days last year to 2 days (range 1-180 days) this year.

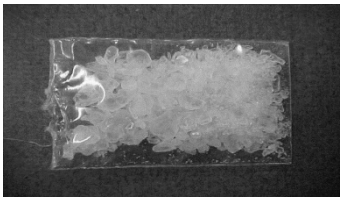
4.3 Methamphetamine

In response to the increasing diversification of the methamphetamine markets in Australia identified by the 2001 IDRS (Topp, Degenhardt et al. 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, Degenhardt et al. 2004; Roxburgh, Breen et al. 2004), and clarification was made with participants that they and the interviewer were referring to the same forms of methamphetamine.

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

Speed powder *Base* *Ice*





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

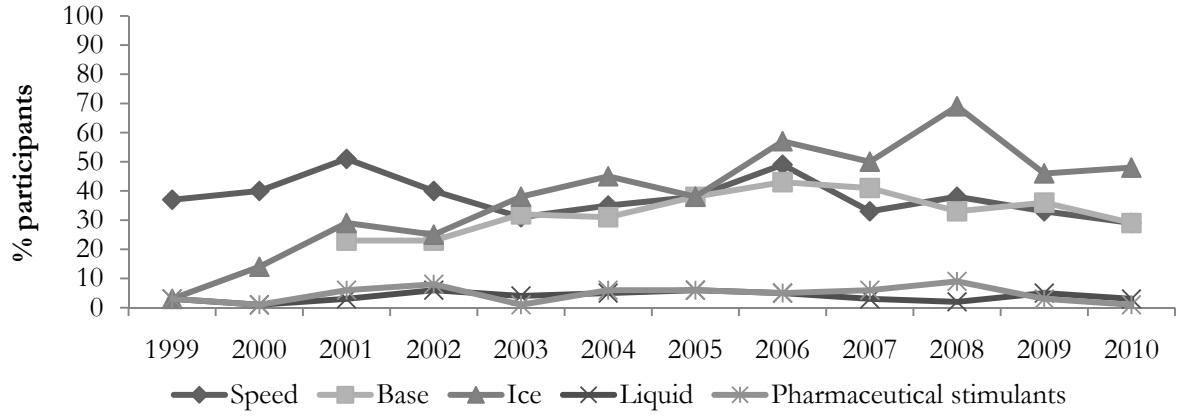
4.3.1 Methamphetamine use among PWID participants

The proportion (57%) reporting the use of any form of methamphetamine (speed, base, ice/crystal or liquid) remained stable in the six months preceding interview (also 57% in 2009). Considered separately, the most commonly used form was ice/crystal (48%; 46% in 2009), followed equally by base (29%; 36% in 2009) and speed (29%; 33% in 2009). Liquid amphetamine (also known as 'oxblood') remained considerably less common, with only 3% of participants reporting use in the last six months (Figure 9). These figures indicate that recent crystal/ice use remained stable in 2010 after a significant (Confidence Interval: [CI] 0.33, 0.12)

decrease in 2009. There was a slight decrease in the proportion reporting recent base use (29%; 36% in 2009), while recent us of speed and liquid remain relatively stable.

Again in 2010, a distinction was made between the licit versus illicit use of pharmaceutical stimulants (including prescription amphetamines). No participants reported use of licitly obtained pharmaceutical stimulants in the six months preceding interview; while the use of illicitly obtained pharmaceutical stimulants in this time continued to remain low, with only 1% (2% in 2009) of participants reporting 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, 1999-2010

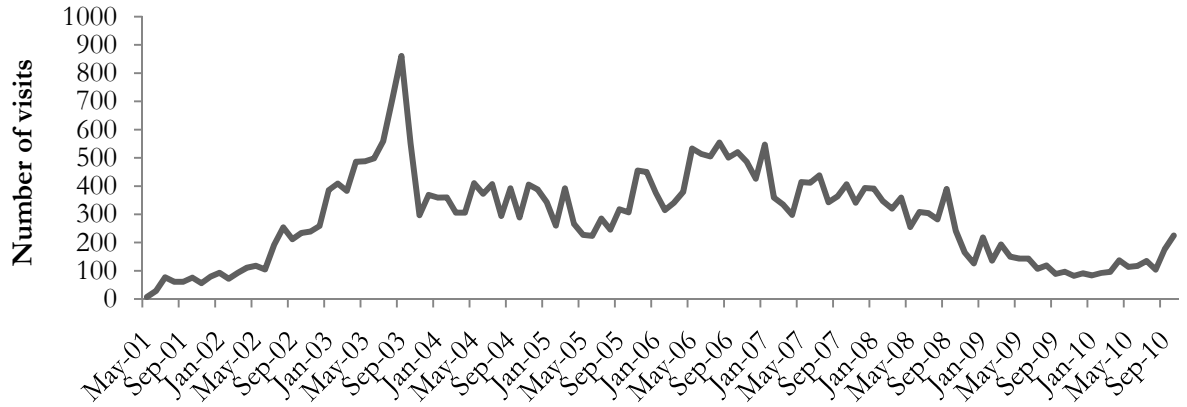


Source: IDRS PWID interviews
NB: Pharmaceutical stimulants include licit use of prescription amphetamines

Figure 10 shows the number of attendances to the Sydney Medically Supervised Injecting Centre (MSIC) where methamphetamine was the drug injected[6]. Numbers reporting methamphetamine increased gradually since 2001, reaching a peak in September 2003 (861 visits that month and accounting for 11% of all visits), followed by a steep decline in subsequent months (Figure 10). Figures remained relatively stable between December 2003 and June 2007, accounting for between 5-7% of visits, increasing slightly in April 2006 to January 2007. In the 12 months to October 2010 there was a further decrease in the number of methamphetamine injections at MSIC, with a low of 82 attendances to inject methamphetamines (1% of all injections) in November 2009, the lowest recorded since early 2002, this was followed by a steady upward trend to 225 attendances to inject methamphetamines (4% of all injections) in the month of October 2010 (Figure 10). Overall, attendances at MSIC for methamphetamine injection have remained under 5% of all attendances since October 2008.

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

Figure 10: Number of attendances to Sydney MSIC where methamphetamine was injected, May 2001-October 2010



Source: Sydney MSIC, Kings Cross

4.3.2 Current patterns of methamphetamine use

The proportion (57%; in both 2010 and 2009) of participants reporting any recent methamphetamine use (speed, base, ice/crystal, base) remained stable in 2010, however, there has been an overall decrease in median days of use of all forms of methamphetamine. Among those reporting any recent use (speed, base, ice, liquid) the median number of days of use was 14 days (approximately fortnightly use); a decrease from 24 days (weekly use) in 2009. 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 4 and Figure 11). Overall, this represents little change from 2009, however, closer examination of various types of methamphetamine showed a decrease in recent base use (29% versus 36% in 2009; Table 4). It should be noted that the proportion of people reporting daily use over the past four years remained low relative to the proportion of daily heroin users (see Section 4.2.2 Current patterns of heroin use).

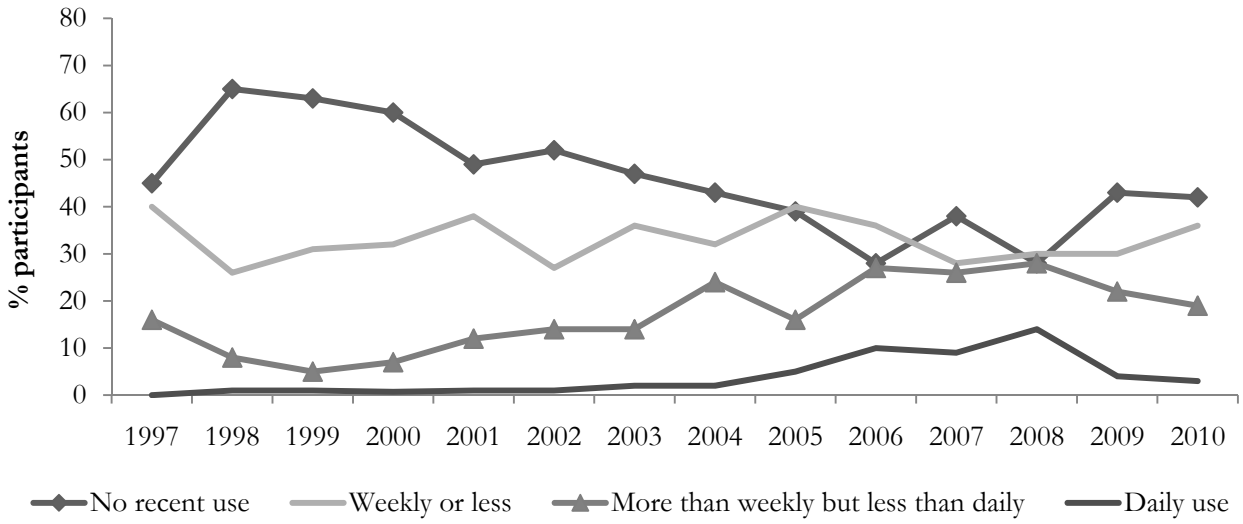
The median days of pharmaceutical stimulant use (whether licitly or illicitly obtained) was comparable with 2009. In 2010, the median days of any recent pharmaceutical stimulant use was 4 days (approximately every 6 weeks; 6 days in 2009). Illicitly obtained pharmaceutical stimulants were used on a median of 4 days use in the past 6 months (1 day in 2009). There were no reports of recent use of licitly obtained pharmaceutical stimulants, a decrease from weekly use (24 days) in 2009.

Table 4: Patterns of methamphetamine use in the last six months, by type, 2010

Form used	Among the entire sample		Among those who had used		
	% who had not used in the last 6 months	% who had used	% used weekly or less^	% used more than weekly, but less than daily	% used daily
Speed powder	71 [67]	29 [33]	79 [66] *(22% of entire sample)*	16 [26] *(5% of entire sample)*	5 [8] *(1% of entire sample)*
Base	71 [64]	29 [36]	93 [76] *(26% of entire sample)*	7 [24] *(2% of entire sample)*	0 [4] *(0% of entire sample)*
Ice/crystal	52 [54]	48 [46]	64 [71] *(31% of entire sample)*	36 [24] *(16% of entire sample)*	1 [4] *(1% of entire sample)*
Any form of methamphetamine*	43 [43]	57 [57]	62 [53] *(35% of entire sample)*	32 [39] *(18% of entire sample)*	6 [7] *(3% of entire sample)*

Source: IDRS PWID interviews
* Also includes liquid methamphetamine
^ Excludes those who had not used
[ ] Indicates % used in previous year
NB: Prior to 2006, 'any form methamphetamine' also included pharmaceutical stimulants (excluded from 2006)

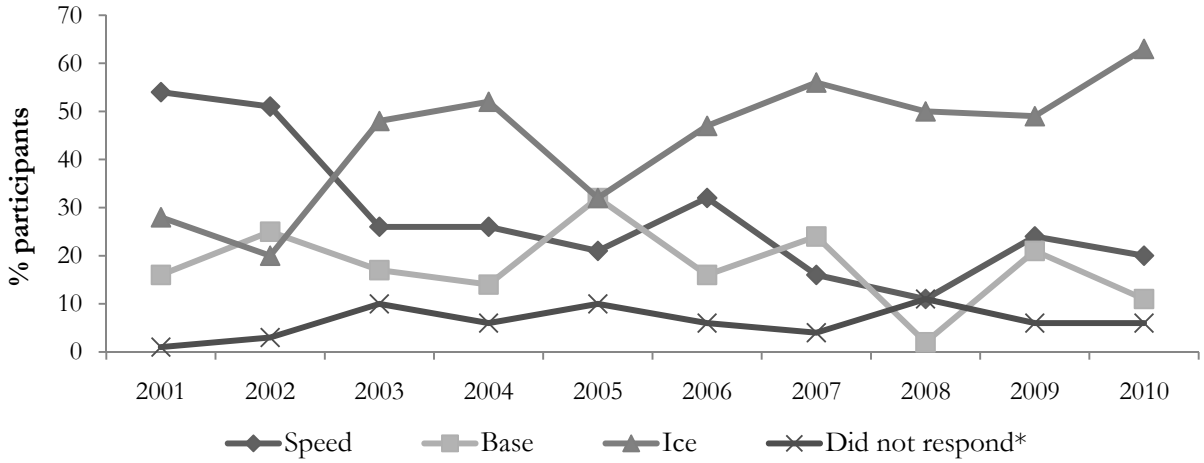
Figure 11: Patterns of methamphetamine use (any form) by PWID participants, 1997-2010



Source: IDRS PWID interviews
NB: 1996 data were unavailable

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. Sixty-three percent of recent users nominated ice/crystal, an increase from 49% in 2009, twenty percent nominated speed powder (24% in 2009) and 11% nominated base (this figure was 21% in 2009). This represented some change from 2009, with an increase in people nominating ice/crystal, and a decrease in people nominating base as the form most used (Figure 12).

Figure 12: Methamphetamine form most used in the preceding six months, among recent methamphetamine users, 2001-2010



Source: IDRS PWID interviews

* 'Did not respond' typically indicates respondents who were unable to nominate one form as the one most used, i.e. they used two or more forms equally as often

NB: Data collection on the form most used commenced in 2001. Pharmaceutical stimulants included in figures between 2001 and 2005; excluded in data from 2006-2010

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, Johnston et al. 2005; Shearer, Johnston et al. 2007)

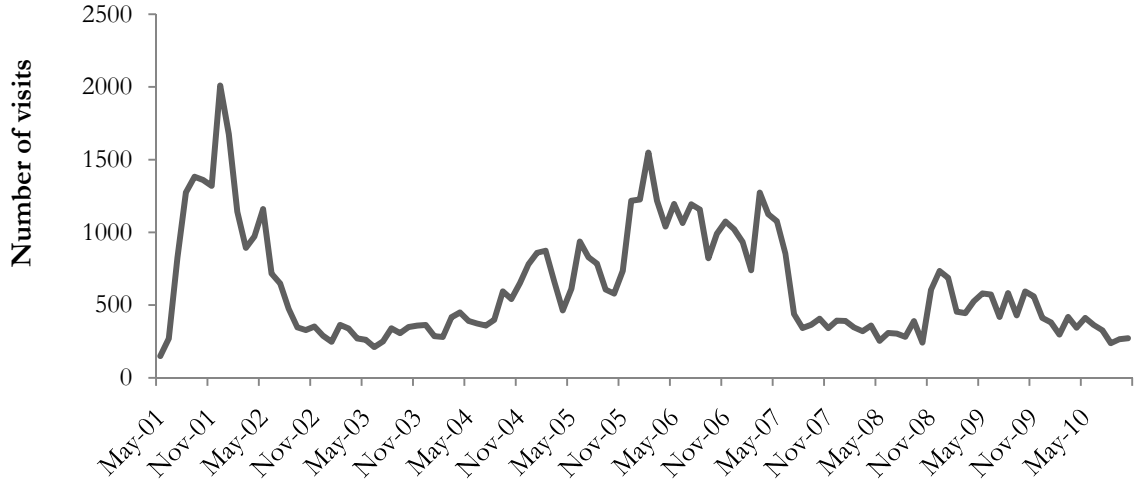
4.4.1 Cocaine use among PWID participants

Fifty-seven percent of PWID participants in 2010 reported cocaine use in the preceding six months, remaining stable with reports from 2009 (61%). Only eight percent (15% in 2009) of the sample reported use of cocaine on the day prior to interview.

Figure 13 shows the number of attendances to the Sydney MSIC where cocaine was the drug injected[7]. Following a peak in use in December 2001 (2,010 visits), and a subsequent decline to less than 450 visits per month to inject cocaine, numbers reporting cocaine use remained relatively stable until the third quarter of 2004. From this time, numbers fluctuated, varying between 464 visits in April 2005 and 937 visits in June 2005 to inject cocaine, reaching a peak of 1,549 in February 2006. The 12 months to October 2010 saw a decrease in attendances from the previous year. Overall, the total monthly attendances for cocaine injection ranged from a low of 4% (August 2010) to a high of 10% (November 2009) of total attendances for injecting in the 12 months to October 2010.

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

Figure 13: Number of attendances to Sydney MSIC where cocaine was injected, May 2001-October 2010

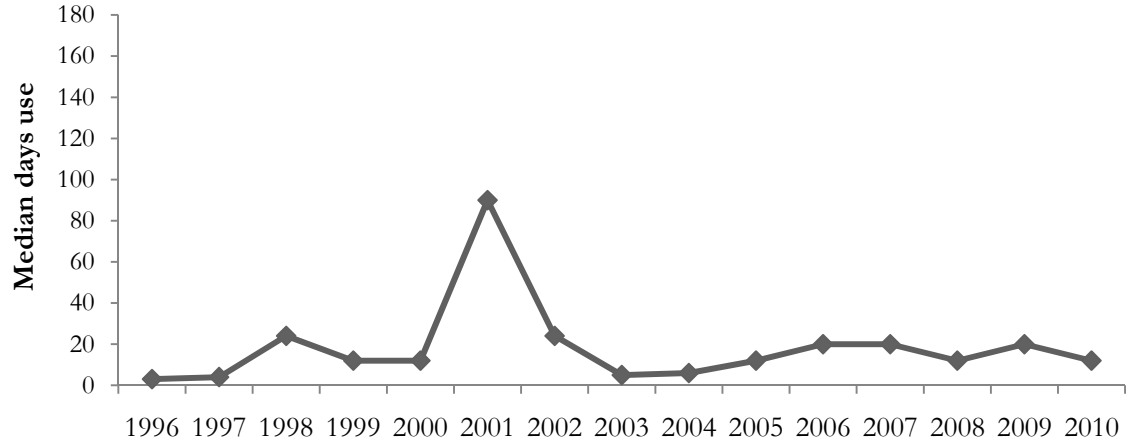


Source: Sydney MSIC, Kings Cross

4.4.2 Current patterns of cocaine use

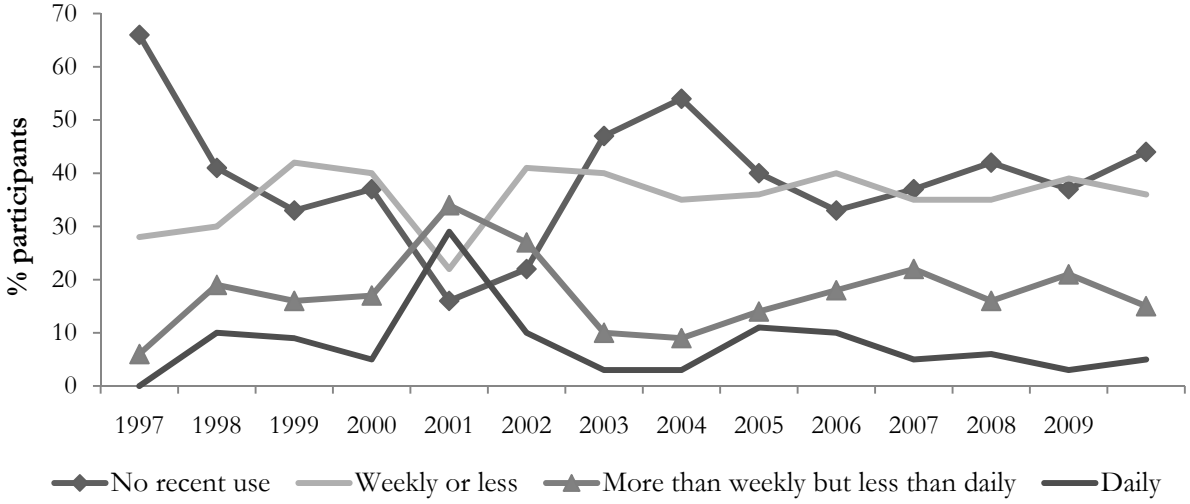
Frequency of cocaine use among the majority of PWID participants in the last six months had decreased to 12 days (fortnightly use) in 2010 from 20 days (i.e. just under weekly use) in 2009 (Figures 14 and 15). This increase was comparable with the frequency of use reported in 2008 and 2005. Daily cocaine use remained stable with 8% of users (5% of all participants) reporting daily use.

Figure 14: Median days of cocaine use in the past six months, 1996-2010



Source: IDRS PWID interviews

Figure 15: Patterns of cocaine use, 1997-2010



Source: IDRS PWID interviews

Participants were also asked which form of cocaine they had used most often over the last six months. Eighty-six percent of participants who had recently used cocaine reported that powder was the form they had used most often in the last 6 months, which is stable from 2009 (90%). Fourteen percent of recent users reported rock cocaine as the form most used, and there was no participants reporting using crack cocaine as the form most used. Only 4% of recent users 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

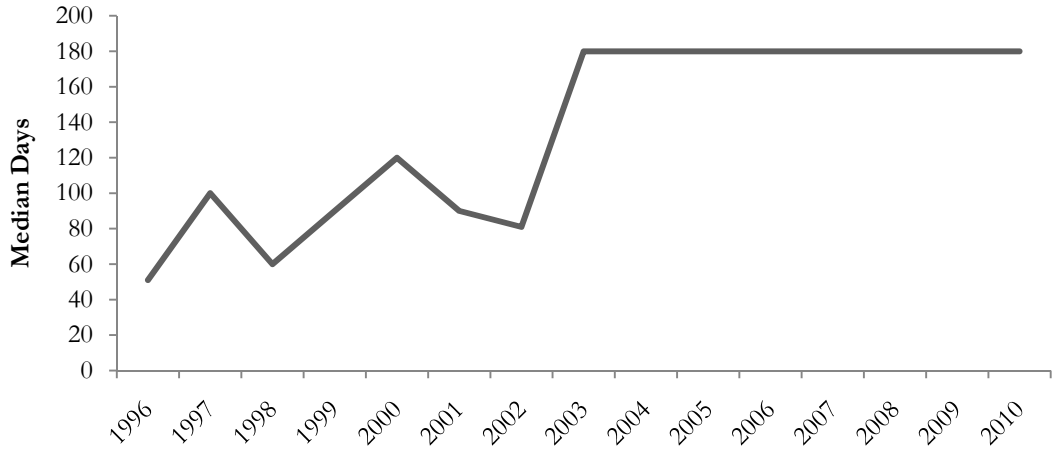
There was a decrease in cannabis use among participants in 2010. Seventy-two percent had used cannabis in the preceding six months (79% in 2009), and there was a decrease in the proportion reporting use on the day prior to interview (34%; 45% in 2009).

4.5.2 Current patterns of cannabis use

The median number of days of cannabis use, among those who used, was 180 in the preceding six months (i.e. daily). This had remained stable for the past eight years, with levels remaining substantially higher than pre-2002 inclusive (Figure 16). The proportion of recent consumers of cannabis reporting daily use of cannabis remained stable in 2010 (57%; 41% of entire sample).

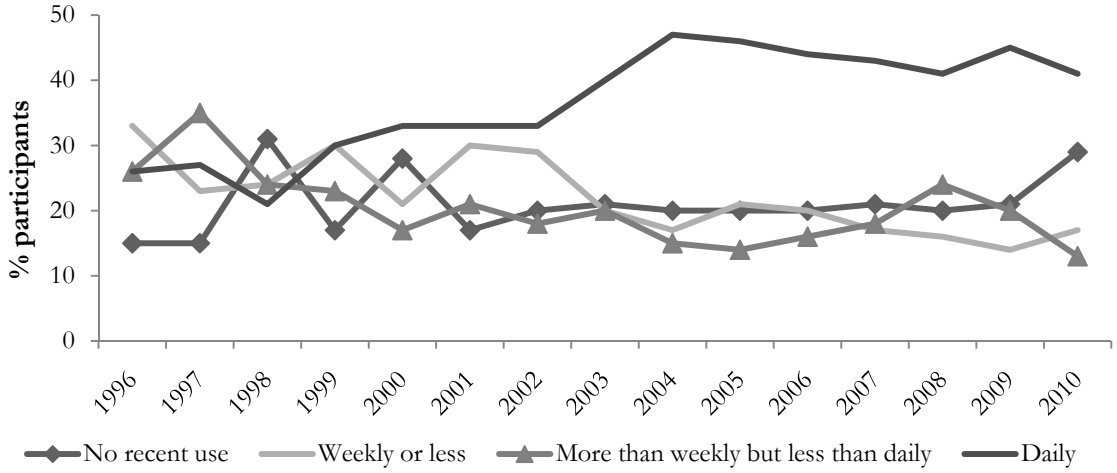
Participants who had smoked cannabis in the last six months were asked about the quantity used and methods of cannabis use on the last occasion. The majority (87%) had smoked cones, rather than joints (10%) on the last occasion of use, which remained consistent with previous years. A median of 4 cones (range 0.5-180) and a median of one joint (range 0.5-5) were reported. This remained consistent with 2009.

Figure 16: Median number of days of cannabis use among those who had used cannabis in the past six months, 1996-2010



Source: IDRS PWID interviews

Figure 17: Patterns of cannabis use, 1996-2010



Source: IDRS PWID interviews

Ninety-five percent of respondents, who had used cannabis, reported using hydro in the preceding six months, and 57% of cannabis users reported using bush during this time. These figures were 98% and 60% in 2009, respectively. Only three percent of recent cannabis users reported use of hashish (5% in 2009) and only one participants (<1%) had used hash oil, which is consistent with 2009. When asked which form of cannabis they had 'used most often' in the last six months, the vast majority (93%) of recent users reported hydro, and 7% reported bush. No participants reported hash oil as the form most frequently used. These changes remain stable with 2009.

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 et al. 2006). With regard to OST, it is imperative to consider that screening of participants ensured that those sampled had all been active in the illicit drug markets of the area, and thus that they were able to provide meaningful data on market indicators.

While a large proportion (61%) of those sampled in 2010 were engaged in OST at the time of interview, responses presented are not representative of all clients engaged in drug treatment services.

Table 5: Definitions used when discussing opioid use

Pharmaceutical Opioids (including OST)
Use of these substances is broadly split into the following categories (Black, Roxburgh et al. 2008). 1. Use of licitly obtained opioids, i.e. use of opioids obtained by a prescription in the user's name, through any route of administration. 2. Use of illicitly obtained opioids, i.e. those obtained from a prescription in someone else's name, through any route of administration ('illicit use'). 3. Use of any opioids, i.e. does not distinguish between licit and illicit methods of obtainment. **Injection** 4. Injection of licitly obtained opioids. 5. Injection of illicitly obtained opioids. 6. Injection of any opioids.

NB: See Glossary for further details of terms. For information on data covering the use of licitly obtained methadone, buprenorphine and buprenorphine-naloxone, data on OST, please see also 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 2010 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 Drug Treatment.

Approximately one-quarter (27%) of all participants reported using illicit methadone syrup in the six months preceding interview, a decrease from 36% in 2009. The frequency of use among recent users was a median of six days (5 days in 2009). In response to the question 'what were the main reasons you used illicit methadone in the last 6 months' 39% of participants reported self treatment, 27% reported substitution for heroin or other opioids, 24% reported intoxication and smaller amounts (5%) reported being away from home.

Twenty-five percent of participants reported injecting illicitly obtained methadone syrup in the preceding six months on a median of 7 days (i.e. approximately once a month), which remained stable compared to 2009 (24% of participants on a median of 6 days). Twenty-four percent of all participants reported injection of any form of methadone (i.e. syrup or Physeptone tablets; regardless of whether it was licitly or illicitly obtained) on a median of 15 days (approximately fortnightly use). While the proportion of participants reported injection of any form of methadone remained stable in 2010 (28% in 2009) there was an increase in the frequency of use (5 days in 2009).

Fourteen percent of participants (38% in 2009) reporting recent methadone or physeptone use reported illicit methadone syrup as the form most often used in the preceding six months. While the number of participants reporting illicit methadone as the form most used in 2010 (14% versus 38% in 2009), it is important to note that compared with 2009 there was an increased proportion of participants receiving OST at the time of interview in 2010 (61% versus 44% in 2009). Illicit Physeptone use remained uncommon, with only 1% of participants reporting use in the preceding six months (also 1% in 2009) on a median of 7 days (8 days in 2009). Only 1% reported injecting Physeptone in the 6 months prior to interview.

One-quarter (25%) of participants reported injecting methadone or Physeptone (whether licitly or illicitly obtained), on a median of 15 days (approximately fortnightly) in the six months preceding interview.

4.6.2 Buprenorphine

Twelve percent of participants were confident enough to answer questions on illicit buprenorphine (Subutex). Thirteen percent of all participants (18% in 2009) reported the use of illicit buprenorphine in the preceding six months. The frequency of use in 2010 remained stable with use occurring on a median of five days (four in 2009). Ten percent of participants reported injecting illicit buprenorphine on a median of five days, which remained consistent compared to 2009 (13%, on a median of four days).

Fourteen percent of participants reported injecting any form of buprenorphine in the preceding six months (17% in 2009) on a median of 7 days (approximately monthly use; 3 days in 2009). No participants reported an injection-related problem ('dirty hit') or overdose associated with

buprenorphine. The prevalence of buprenorphine injection remained comparable with 2009; however, the frequency of use increased slightly.

4.6.3 Buprenorphine-naloxone (Suboxone)

Questions on buprenorphine-naloxone (Suboxone) have also been included in the PWID survey since 2006 when it was first listed on the Pharmaceutical Benefits Scheme. In 2010, five percent (7% in 2009) of people interviewed reported being on Suboxone treatment at some stage in the last 6 months. As per 2009, the injection of Suboxone was extremely low. Only three percent reported injecting Suboxone that wasn't prescribed to them in the last 6 months (median 2 days), and only two percent had reported other routes of administration of Suboxone that wasn't directly prescribed to them on a median of 2 days (i.e. once every three months).

4.6.4 Morphine

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

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

4.6.5 Use patterns

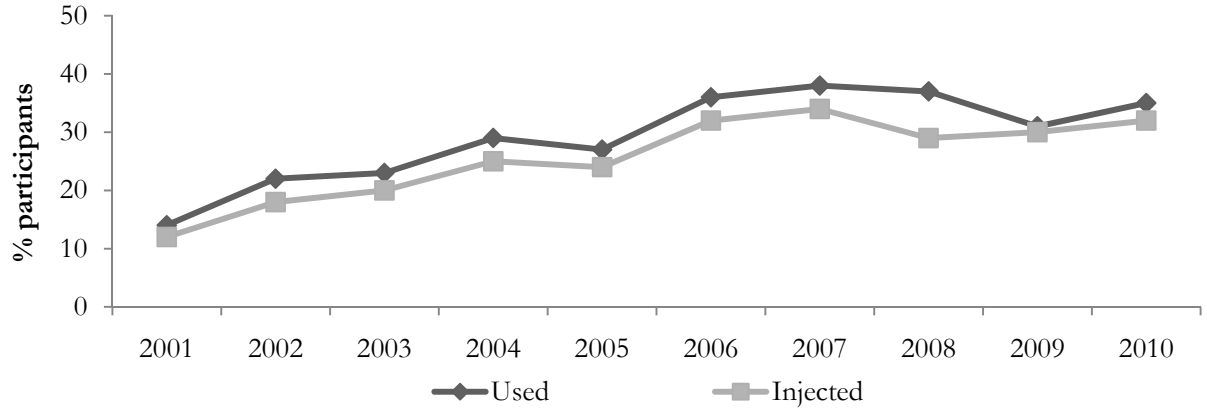
Since 2006, a distinction has been drawn between use of licitly obtained (prescribed) and illicitly obtained morphine (Table 3). Thirty-one percent (27% in 2009) reported use of illicit morphine on a median of four days (7 days in 2009), i.e. less than monthly, in the past six months, with 32% (29% in 2009) having injected (licit or illicit) morphine on a median of four days (6 days in 2009) in this time. While the prevalence of morphine use and injection had remained stable since 2008 the frequency of injection had decreased from fortnightly use in 2008 to monthly use in 2009 and less than monthly use in 2010. In response to the question 'what were your main motivations for illicit morphine use' the majority (55%) of recent users reported substitution for heroin and/or other opioids, 37% reported self treatment and 18% reported intoxication.

Use of licitly obtained morphine was noticeably less prevalent (8% had recently used it; 6% had injected it in the same period) which remained comparable with 2009 (6% recently used; 4% recently injected). Frequency of use had also remained stable at a median of 9 days (also 9 days in 2009), though there was a decrease in frequency of injection which occurred on a median of 4 days (7 days; i.e. monthly use in 2009) in the six months proceeding interview.

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

To enable comparison with previous years, the following information refers to 'any' form of morphine, i.e. no distinction has been made between licitly and illicitly sourced morphine. In 2010, approximately one-third (35%; 31% in 2009) of participants reported using any morphine in the preceding six months on a median of five days (6 days in 2009). In terms of injection, 32% of participants reported recent injecting any morphine (again, comparable with 30% in 2009) on a median of four days (6 days in 2009). The prevalence of morphine use and injection has gradually increased from 2001, however in 2010, the frequency of use had increased slightly while injection remained stable (Figure 18).

Figure 18: Proportion of PWID reporting morphine use and injection in the past six months 2001-2010

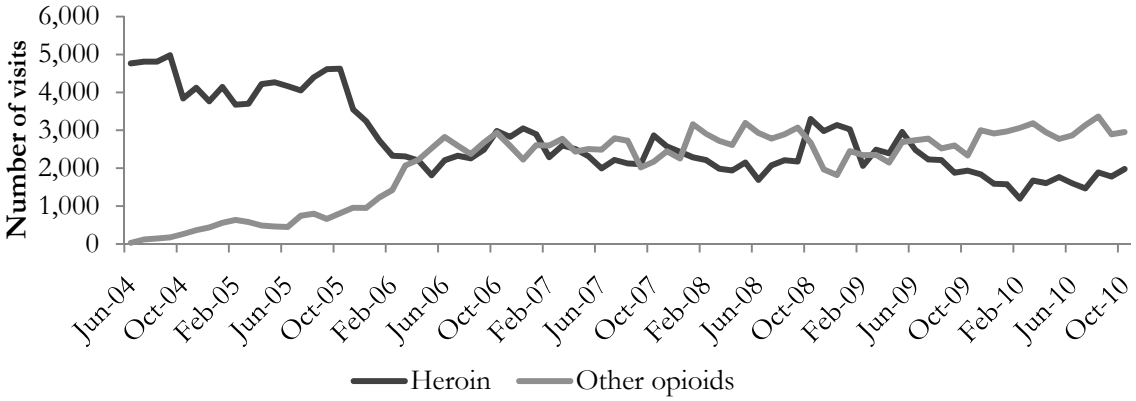


Source: IDRS PWID interviews
NB: Prior to 2001, morphine was included under 'other opioids'

Three percent of recent users (2% of entire sample) reported daily morphine use, although the majority (94%; 29% of entire sample) reported using weekly or less often. Three participants (2% of entire sample) reported experiencing problems that they attributed to morphine injection in the past month. Two reported a 'dirty hit' and the other reported an overdose attributed to morphine.

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. From October 2006 to January 2007, heroin returned to accounting for the greater proportions of injections over other opioids. Figures then became relatively equal before other opioids again, accounted for the greater proportion of injections from May 2007 to September 2008 and again in the 17 months from May 2009 to October 2010. Heroin accounted for a median of 1641 injections per month across the 12 months to October 2010.

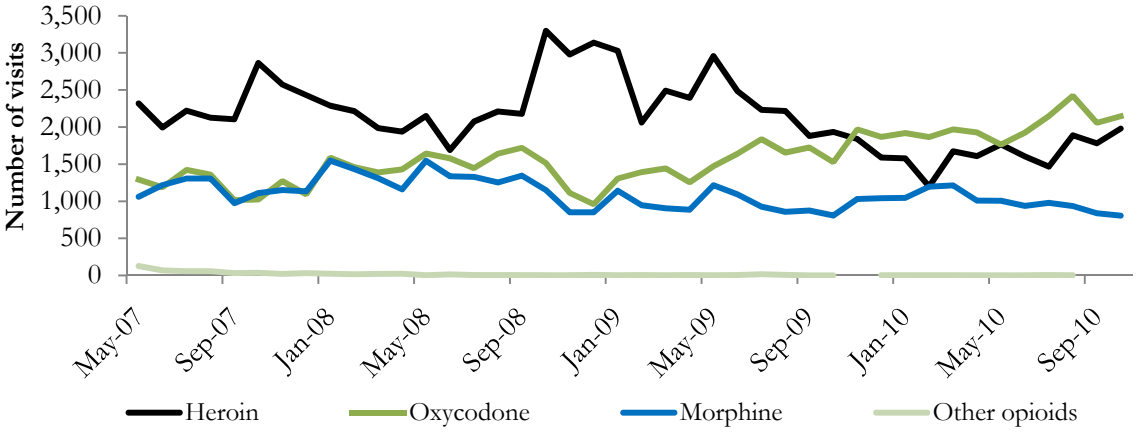
Figure 19: Number of attendances to Sydney MSIC where other opioids (including morphine)* and heroin were injected, June 2004-October 2010



Source: Sydney MSIC, Kings Cross
* Excludes heroin and methadone, and includes morphine, oxycodone, Palfium and pethidine

Since January 2008 oxycodone has been the most prevalent pharmaceutical opioid injected in attendances to the Sydney MSIC. In the 12 months to October 2010 attendances for oxycodone injection at the Sydney MSIC increased to overtake heroin, in all but one month (May 2010), as the most common drug injected with a median of 1948 injections per month across the 12 months to October 2010. There has been a mild decline in attendances for morphine at MSIC over the same period (Figure 20).

Figure 20: Number of attendances to Sydney MSIC where morphine, oxycodone and other opioids were injected, May 2007-October 2010



4.6.6 Oxycodone

For information on changes to oxycodone prescribing legislation that became effective from January 2006, please see Section 4.6.4 Morphine.

4.6.7 Use patterns

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

More than half (60%) of all participants reported having used oxycodone (whether licitly or illicitly obtained) at some stage in their lifetime, and 50% reported having ever injected it (Table 3). Thirty-six percent of participants reported using either licit or illicit oxycodone in the six months preceding interview on a median of six days (i.e. monthly use). Compared to 2009 there had been an increase in participants reporting recent use of oxycodone (36% versus 28% in 2009), however, the frequency of use remained the same as in 2009. The prevalence of recent oxycodone injection in 2010 (31%) remained comparable with 2009.

With regard to illicit oxycodone use, one-third (33%; 27% in 2009) of participants reported use in the preceding six months, on a median of six days (5 days, in 2009). Fourteen percent (5% of entire sample) of participants reporting recent illicit use were daily users (180 days), of which all were injectors. The majority (69%; 22% of entire sample) of people, however, reporting use in the last 6 months were using weekly or less often. Injection in the last six months was reported by 29% of the sample on a median of 6 days (once per month) (26% on a median of 5 days in 2009). Overall, these figures suggested that prevalence of recent illicit oxycodone use is comparable with 2009, although patterns of use were typically sporadic.

In response to the question 'what were your main motivations for illicit oxycodone use?' 44% of recent users reported substitution for heroin and/or other opioids, 29% reported intoxication and 25% reported self treatment.

With regard to licit oxycodone, 10% of participants reported use in the preceding six months, on a median of 7 days (3%; 21 days in 2009). Injection in the last six months was reported by 4% of the sample on a median of 54 days (3%; 20 days in 2009). These reports suggested that use of prescribed oxycodone had increased, while the frequency of use had declined, but the frequency of injection had increased.

Of those reporting recent oxycodone use, the vast majority (82%; 33% of entire sample) used illicit oxycodone rather than prescribed oxycodone. The most common brand used was OxyContin (87%; 29% of entire sample). There were only small numbers reporting Endone (8%; 3% of entire sample) as the brand most commonly used.

4.7 Over the counter codeine

Again in 2010, the IDRS survey included questions on the use of over the counter (OTC) codeine. Two-thirds (66%) of participants reported that they had ever used OTC codeine. Half (51%) of all participants reported that they had used OTC codeine in the six months prior to interview on a median of 8 days (approximately monthly use) and had taken a median of 2 tablets on the last occasion of use. All recent OTC codeine users had swallowed it and one participant

reported that they had recently injected it. The brands most commonly reported as being used were Nurofen Plus (61%) and Panadeine (18%) of recent users..

4.8 Other opioids

Twelve percent of participants reported that they had ever used opioids other than those listed above at least once in their lifetime, and 4% had ever injected them. In the six months prior to interview, 5% of participants reported the use of other opioids on a median of 10 days. Comparisons with data prior to 2009 should be interpreted with caution as OTC codeine wasn't included in its own section (See section 4.7) until 2009 rather under the category of other opioids. It should be also noted that 'other opioids' does not include homebake.

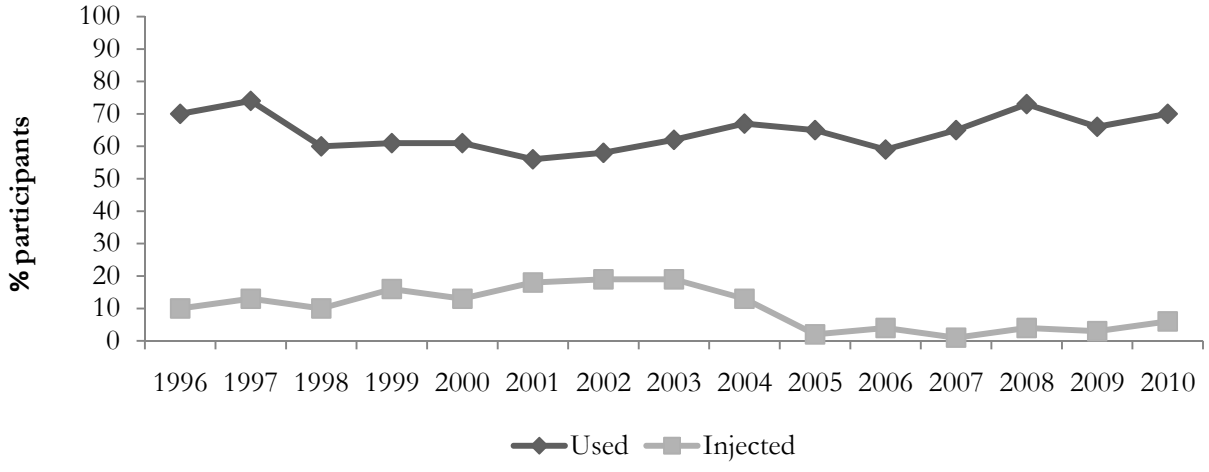
4.9 Other Drugs

4.9.1 Benzodiazepines

Three-quarters (78%) of the sample (66% in 2009) reported use of benzodiazepines in the six months preceding interview on a median of 37 days (50 days in 2009), i.e. approximately weekly use (Table 3; Figures 21 and 22).

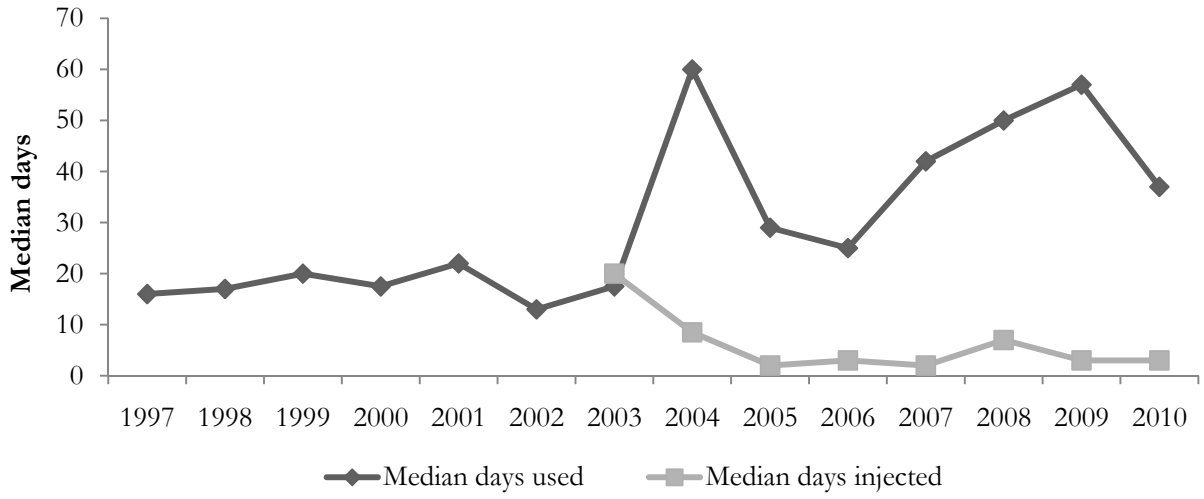
In 2010, the proportion reporting daily use was approximately one third (31%) of all recent users (37% in 2009). The proportion reporting recent licit use (43%) remained stable (also 43% in 2009) as did the proportion reporting recent illicit use (49% versus 51% in 2009). The frequency of use of illicit benzodiazepines was 15 days (20 days in 2009) and the median days of use for licit use increased from 60 days in 2009 to 90 days in 2010.

Figure 21: Proportion of PWID participants reporting (licit and illicit) benzodiazepine use and injection in the preceding six months, 1996-2010



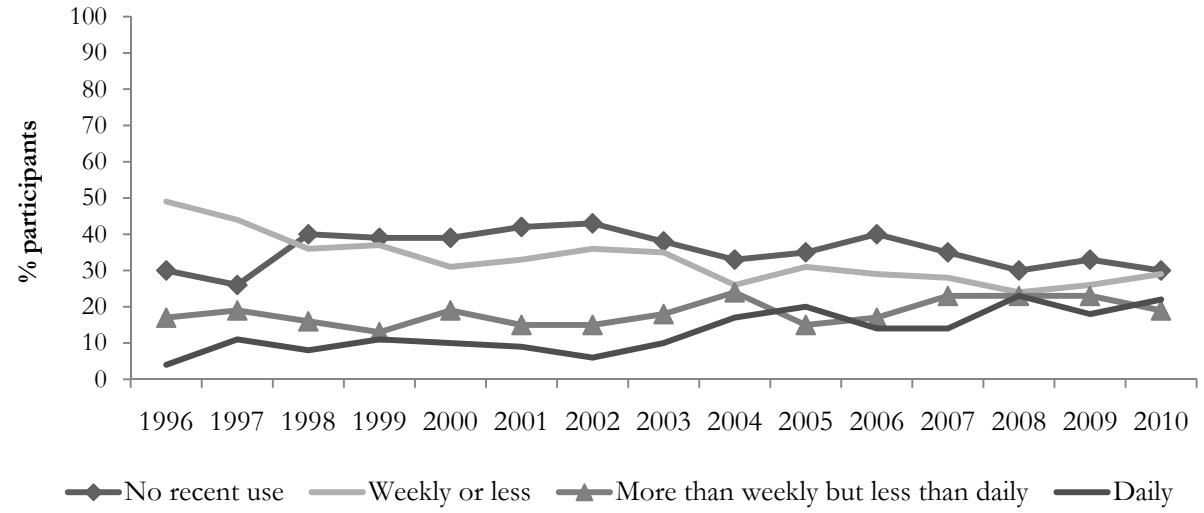
Source: IDRS PWID interviews

Figure 22: Median days use and injection of (licit and illicit) benzodiazepines in the past six months, 1997-2010



Source: IDRS PWID interviews
NB: Collection of data on the number of days injected commenced in 2003

Figure 23: Patterns of (licit and illicit) benzodiazepine use, 1996-2010



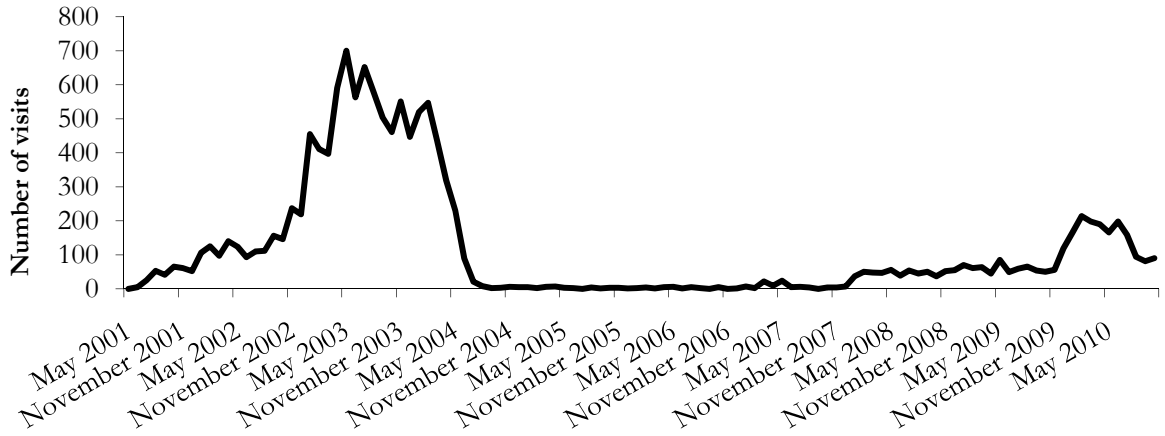
Source: IDRS PWID interviews

In 2010, the proportion of participants reporting recent use of prescribed (licit) benzodiazepines (43%) was less than those using illicitly obtained benzodiazepines (49%; Table 3). However, when asked the form 'most used' the difference was less pronounced, with 52% reporting illicit and 48% reporting licit use (also 52% and 48% respectively in 2009). The most commonly used brand of benzodiazepine remained diazepam (including generic diazepam, Valium, Antenex), which was specified by 60% of users, followed by 27% reporting alprazolam (Xanax) and only 5% specifying oxazepam (Serepax). No participants reported temazepam as the main form used, consistent with the restriction and withdrawal of this medication over the past five years. Twenty-one percent of participants reported benzodiazepine use on the day prior to interview (18% in 2009).

Six percent (3% in 2009) of people reported the injection of any form of benzodiazepines in the last 6 months on a median of 3 days (once every 2 months). This remained comparable with 2009. 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 2010, the prevalence of benzodiazepine injection is comparable with recent years (6% in 2010, 3% in 2009, 4% in 2008). Overall, the prevalence of benzodiazepine injection and the frequency of injection has remained stable over the past few years.

Data from the Sydney MSIC show that the number of clients who injected benzodiazepines had increased from 1% of all attendances to 3% of all attendances in 2010. The median number of benzodiazepine injections for the 12 month period to October 2009 was 163 (range: 56-198; 3% of all injections), or 1% of all injections. This increased from the median of 57 (range: 45-85) for the same period in 2009. However, recent levels were still less than those reported from 2003 until the withdrawal of temazepam gelatine caps from the market at the end of March 2004. The most commonly injected benzodiazepines at MSIC were temazepam gelatine capsules, and the withdrawal of these from the Australian pharmaceutical market at the end of March 2004 resulted in the dramatic decline observed[9].

Figure 24: Number of attendances to Sydney MSIC where benzodiazepines were injected, May 2001-October 2010



Source: Sydney MSIC, Kings Cross

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

4.9.2 Hallucinogens

Just under half (47%) of PWID participants reported having used hallucinogens at some stage in their lifetime but recent use remained minimal, with only 2% reporting use in the six months preceding interview (Table 3). Both the percentage reporting recent use (2%) and the median

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

days of use (1 day) remained stable in 2010 (also 1 day in 2009; 13 days in 2008; 30 days in 2007). LSD was reported as the form most used, and in 2009 there were no recent reports of mushrooms. Six percent of the sample had injected hallucinogens at some stage in the past and no participants reported having injected them in the last six months. These figures, overall, represented stability in the use of hallucinogens when compared with 2009.

4.9.3 Ecstasy

Ecstasy use within this sample of participants in NSW remained at relatively low levels. Fourty-seven percent of participants reported use of ecstasy in their lifetime, and 9% reported having used it within the six months prior to interview. Seventeen percent of participants had reported ever injecting ecstasy, 2% reported having injected ecstasy in the six months preceding interview on a median of 3 days (see Table 3).

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').

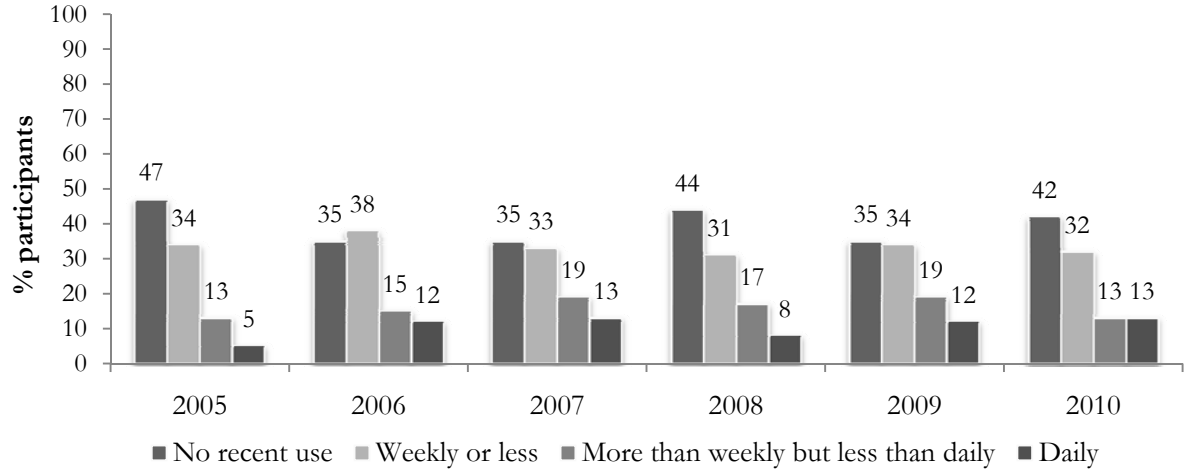
4.9.4 Inhalants

Sixteen percent of participants (21% in 2009) reported ever having inhaled volatile substances such amyl nitrite, petrol, glue and/or lighter fluid (butane) (Table 3). Recent use (1%) remained low and stable but there was an increase in the frequency of use from 3 days in 2009 to 9 days in 2010. The only two forms of inhalant reported being recently used by participants were amyl nitrite and nitrous oxide. There were no KE reports regarding use of inhalants.

4.9.5 Alcohol and tobacco

More than one-half (58%) 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). While the proportion of recent users had decreased (65% in 2009) the frequency of use remained the same compared with 2009. Twenty-two percent (13% of the entire sample) reported daily use of alcohol. These figures were generally consistent with levels reported over the last 3 years. The majority (55%; or 32% of all participants) drank weekly or less often (Figure 25). Rates of daily use (13%) were comparable with the general population aged 14 and over (9%), while rates of drinking weekly were lower than the general population (41%; Australian Institute of Health and Welfare 2005, p. 25).

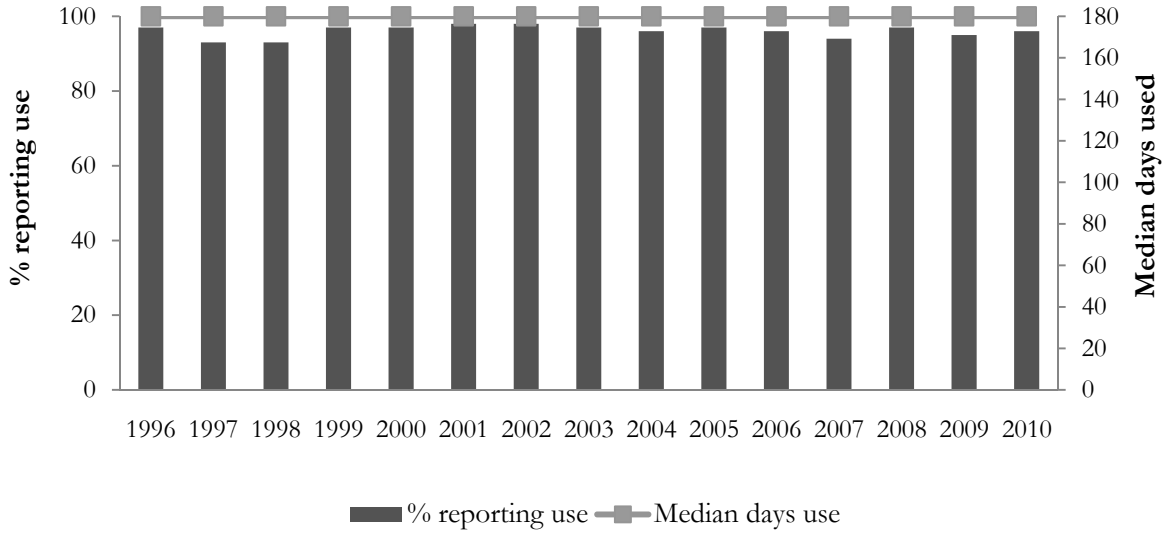
Figure 25: Patterns of alcohol use, 2005-2010



Source: IDRS PWID interviews

Tobacco remained the most commonly used substance investigated by the IDRS. The vast majority of participants (96%) reported smoking tobacco in the last six months on a median of 180 days (Table 3), i.e. daily use (range 48-180). Ninety-two percent of the sample 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 26). This figure continues to be substantially higher than among the general Australian population, 17% of whom are daily smokers (Australian Institute of Health and Welfare 2005, p.19).

Figure 26: Participant reports of tobacco use in the last six months, 1996-2010



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, 92% of the PWID sample felt confident to answer at least some of these survey items. The remaining 8% 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 who 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 6. Again in 2010, the median price reported for a cap of heroin remained unchanged at $50 and has remained unchanged since 2002. A gram of heroin, however, increased again in 2010 to $345 (Table 6). 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 27).

A decrease was observed in the number of participants reporting purchases of all quantities of heroin, except for halfweights, over the six months prior to interview compared with 2009 (Table 6). The most common purchase amounts were $50 deals (a cap or a point) at a time. Ten participants 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, defined by a set price, rather than a description of the actual weight.

As shown in Table 6, price ranges were extremely wide. This may reflect purity/availability within that particular person's network and the numbers reporting.

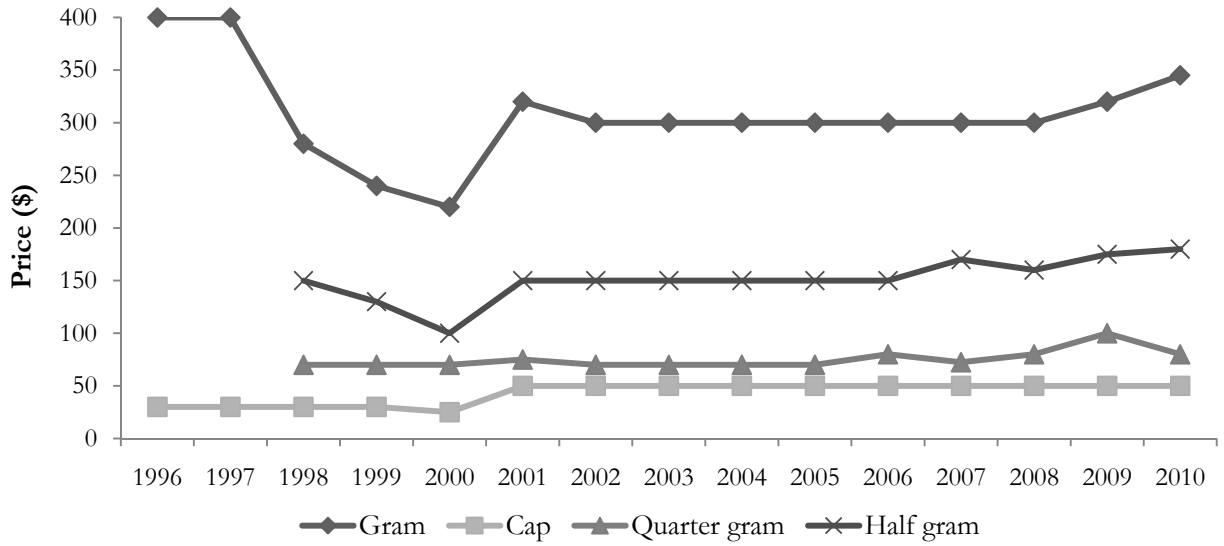
Table 6: Price of most recent heroin purchases by PWID participants, 2009-2010

Amount	Median price* $	Range $	Number of purchasers*
Cap	50 (50)	20-100	92 (111)
Quarter gram	80 (100)	50-180	30 (36)
Half gram ('halfweight')	180 (175)	120-600	49 (49)
Gram	345 (320)	200-400	24 (33)

Source: IDRS PWID interviews
* 2009 data are presented in brackets

Heroin prices have remained relatively stable since 2002, with the exception of single gram amounts which have increased in the last two years (Figure 27). 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 27: Median prices of heroin estimated from PWID purchases, 1996-2010



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'). More than three-quarters of participants that commented (76%) reported price stability over the preceding six months. Twenty percent of those who commented thought that price had increased over the preceding six months (comparable with 15% in 2009), with smaller proportions nominating 'fluctuating' (3%) or 'decreasing' (1%).

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 2010, the majority of participants reported that heroin was 'very easy' (57%) or 'easy' (26%) to obtain (Table 7; Figure 28). Fourteen percent (reported that heroin was difficult to obtain (8% in 2009) and only 4% of participants claimed that heroin was 'very difficult' to obtain.

Over ninety percent (92%) of the sample were able to comment on heroin availability in the last 6 months, 70% 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' (20%) or 'easier' (9%) to obtain (Table 7).

Table 7: Participants' reports of heroin availability in the past six months, 2007-2010

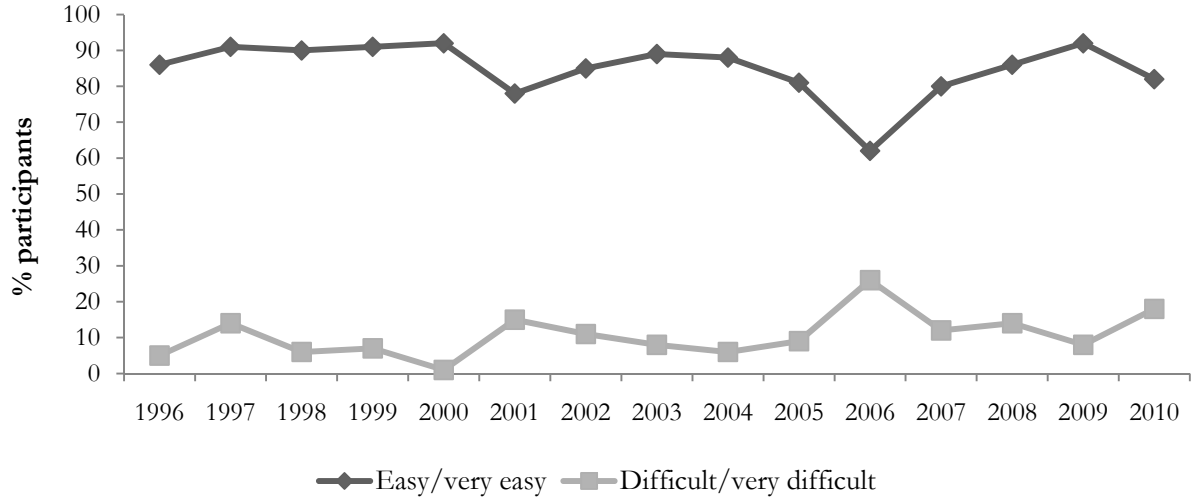
	2007 N=153	2008 N=151	2009 N=152	**2010 N=154**
Current availability				
Did not respond* (%)	6	17	6	**8**
Did respond (%)	94	83	94	**92**
Of those who responded:				
Very easy (%)	43 *(41% of entire sample)*	39 *(32% of entire sample)*	59 *(56% of entire sample)*	**57 *(52% of entire sample)***
Easy (%)	42 *(39% of entire sample)*	46 *(38% of entire sample)*	33 *(31% of entire sample)*	**26 *(23% of entire sample)***
Difficult (%)	13 *(12% of entire sample)*	13 *(11% of entire sample)*	8 *(7% of entire sample)*	**14 *(12% of entire sample)***
Very difficult (%)	0 *(0% of entire sample)*	1 *(1% of entire sample)*	0 *(0% of entire sample)*	**4 *(4% of entire sample)***
Don't know^ (%)	2 *(2% of entire sample)*	1 *(1% of entire sample)*	0 *(0% of entire sample)*	**0 *(0% of entire sample)***
Availability change over the last six months				
Did not respond* (%)	6	17	6	**8**
Did respond (%)	94	83	94	**92**
Of those who responded:				
More difficult (%)	15 *(14% of entire sample)*	17 *(14% of entire sample)*	14 *(13% of entire sample)*	**20** *(18% of entire sample)*
Stable (%)	67 *(63% of entire sample)*	67 *(56% of entire sample)*	72 *(68% of entire sample)*	**70** *(64% of entire sample)*
Easier (%)	8 *(8% of entire sample)*	10 *(9% of entire sample)*	11 *(11% of entire sample)*	**9** *(8% of entire sample)*
Fluctuates (%)	6 *(5% of entire sample)*	2 *(2% of entire sample)*	3 *(3% of entire sample)*	**1** *(1% of entire sample)*
Don't know^ (%)	4 *(5% of entire sample)*	3 *(3% of entire sample)*	2 *(2% of entire sample)*	**0** *(0% of entire sample)*

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

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

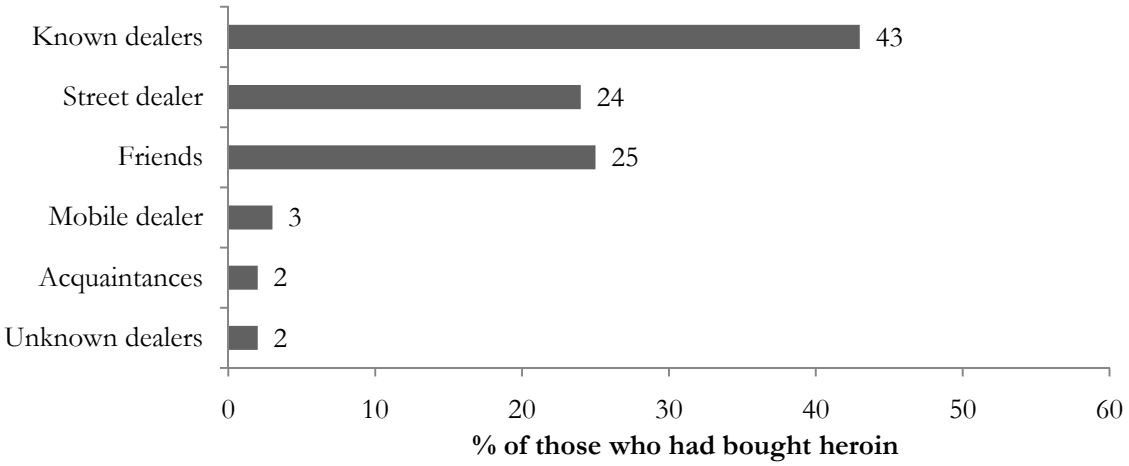
Figure 28: Participant reports of current heroin availability, 1996-2010



Source: IDRS PWID interviews

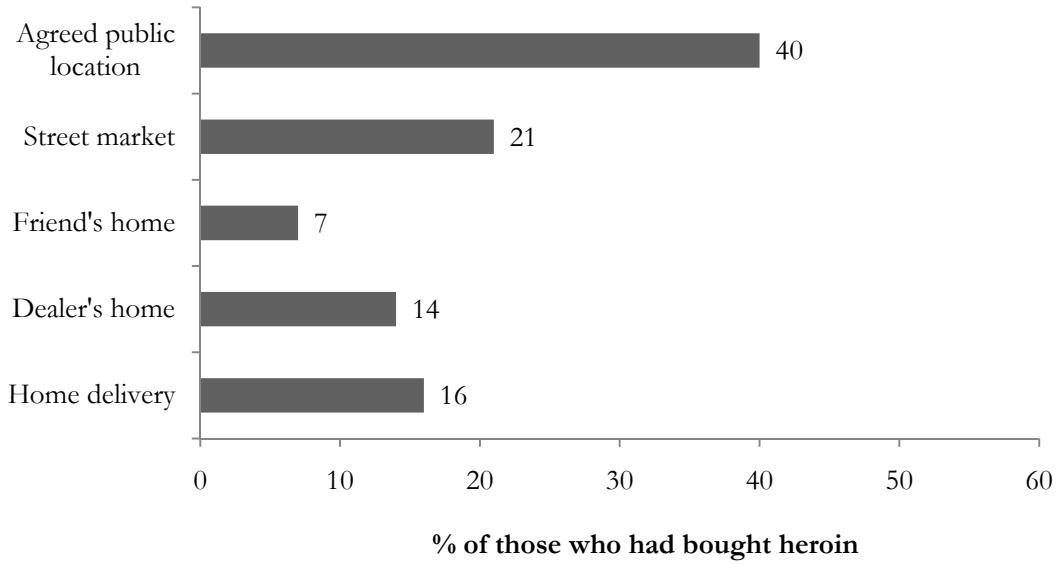
Of those participants that had purchased heroin in the last six months (89%), the most common sources of heroin on the last occasion of purchase were known dealers (43%), friends (25%) and street dealers (24%) (Figure 29). Participants reported scoring from a range of locations, both public (e.g. street market, agreed public location) and private (e.g. dealer's home, home delivery) (Figure 30).

Figure 29: People from whom heroin was purchased on the last occasion, 2010



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

Figure 30: Locations where heroin was purchased on the last occasion, 2010

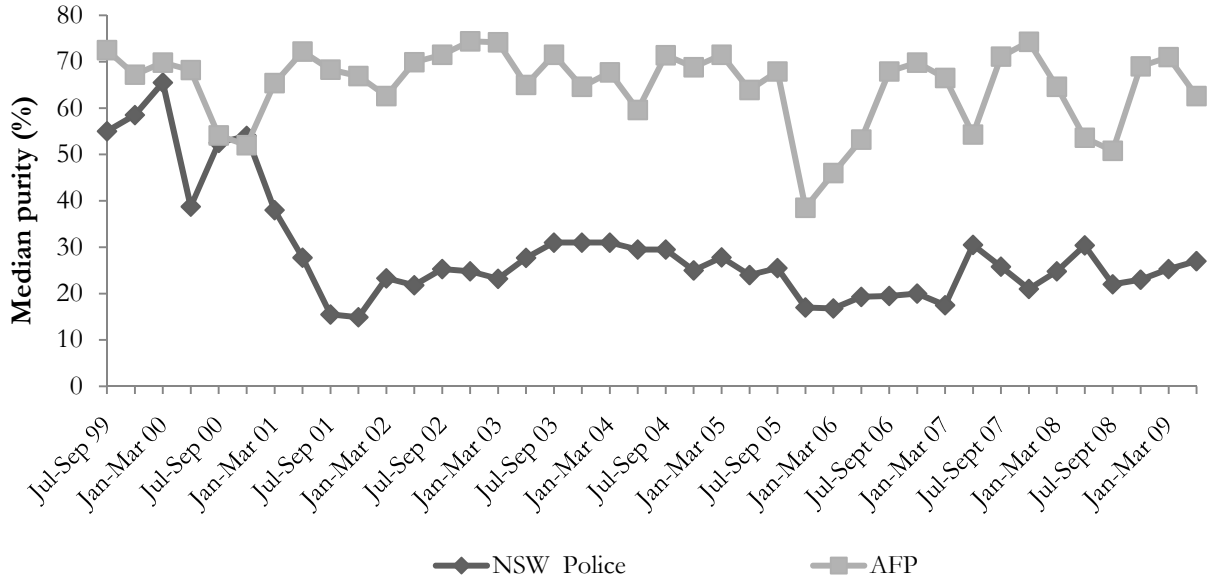


Source: IDRS PWID interviews
NB: More than one response could be selected

5.1.3 Purity

Figure 31 shows the analysed median purity of NSW Police heroin seizures during the 1999/00 to 2008/09 period. The overall median purity (23.5%; range: 22-27%) reported by NSW Police remained comparable with the 2007/08 reporting period (25% in 2007/08). Overall, the purity of Australian Federal Police (AFP) heroin seizures that were analysed during 2007/08 remained stable median of 63.7% in the 12 months to June 2009 (66.2% in 2008), despite fluctuations (range: 50.8-71.0%) across the period.

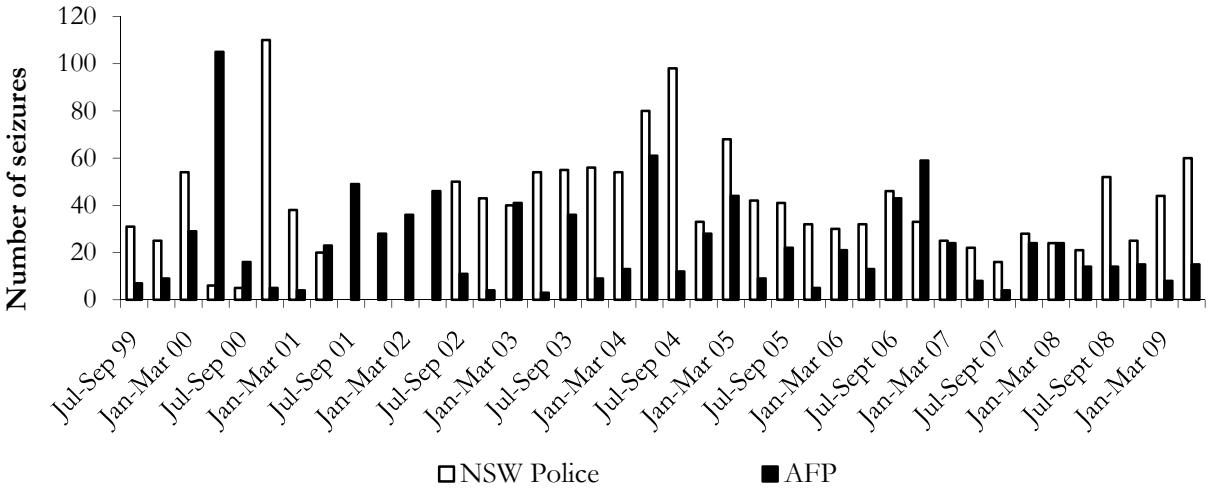
Figure 31: Purity of heroin seizures analysed in NSW, by quarter, 1999/00-2008/09



Source: Australian Bureau of Criminal Intelligence 2001, 2002; Australian Crime Commission, 2003, 2004, 2005, 2006, 2007, 2008, 2009
NB: Data were unavailable for 2009/10 at time of publication

Figure 32 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 increased from 89 cases in 2007/08 to 181 in the 12 months to June 2009. Conversely there was a small decrease in the total number of heroin seizures analysed by the AFP down from 66 to 52 cases in the same period (Figure 32).

Figure 32: Number of heroin seizures analysed in NSW, by quarter, 1999/00-2008/09



Source: Australian Bureau of Criminal Intelligence 2001, 2002; Australian Crime Commission, 2003, 2004, 2005, 2006, 2007, 2008, 2009
NB: NSW Police data for numbers of seizures for 2001/02 were unavailable. Data were unavailable for 2009/10 at time of publication

Participants were also asked to comment on their perception of the current purity of heroin. Forty-three percent reported to be low purity, 31% reported it to be medium approximately one-fifth (18%) of those who could comment believed it had fluctuated (Table 8). 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 33). 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, 41% reported that it had remained stable (33% in 2009) while over one-third (36%) reported it had decreased (30% in 2009). There was a decrease to 7% (16% in 2009), of those reporting increases in purity in the 6 months prior to interview (Table 8).

Table 8: Participants' perceptions of heroin purity in the past six months, 2007-2010

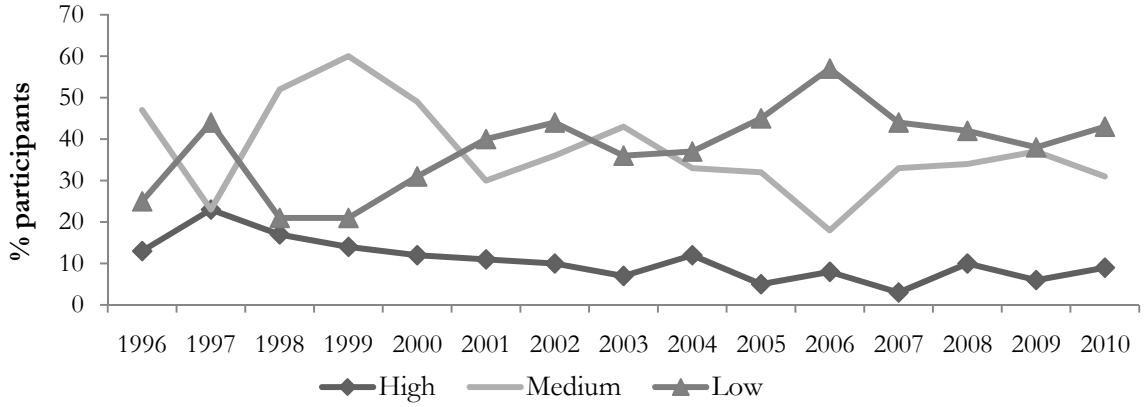
	2007 N=153	2008 N=151	2009 N=152	**2010 N=154**
Current purity				
Did not respond* (%)	6	17	6	**11**
Did respond (%)	94	83	94	**89**
Of those who responded:				
High (%)	4 *(3% of entire sample)*	10 *(8% of entire sample)*	6 *(6% of entire sample)*	**9** *(8% of entire sample)*
Medium (%)	35 *(33% of entire sample)*	34 *(28% of entire sample)*	39 *(37% of entire sample)*	**31** *(27% of entire sample)*
Low (%)	47 *(44% of entire sample)*	42 *(34% of entire sample)*	40 *(34% of entire sample)*	**43** *(38% of entire sample)*
Fluctuates (%)	11 *(11% of entire sample)*	8 *(7% of entire sample)*	13 *(12% of entire sample)*	**18** *(16% of entire sample)*
Don't know^ (%)	4 *(3% of entire sample)*	7 *(6% of entire sample)*	2 *(2% of entire sample)*	**0** *(0% of entire sample)*
Purity change over the last six months				
Did not respond* (%)	5	17	6	**13**
Did respond (%)	96	83	94	**87**
Of those who responded:				
Increasing (%)	13 *(12% of entire sample)*	18 *(15% of entire sample)*	16 *(15% of entire sample)*	**7** *(6% of entire sample)*
Stable (%)	38 *(35% of entire sample)*	27 *(23% of entire sample)*	33 *(31% of entire sample)*	**41** *(36% of entire sample)*
Decreasing (%)	22 *(20% of entire sample)*	37 *(31% of entire sample)*	30 *(28% of entire sample)*	**36** *(31% of entire sample)*
Fluctuating (%)	19 *(18% of entire sample)*	10 *(9% of entire sample)*	18 *(16% of entire sample)*	**17** *(14% of entire sample)*
Don't know^ (%)	9 *(9% of entire sample)*	8 *(7% of entire sample)*	4 *(3% of entire sample)*	**0** *(0% of entire sample)*

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

^ 'Don't know' refers to participants who were able to respond to survey items on price and/or availability of heroin, but had not had enough contact with users/dealers, or had not used a sufficient number of times to feel confident responding to items concerning purity

Figure 33: Proportion of PWID participants reporting current heroin purity as high, medium or low, 1996-2010



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 there was an increasing number of younger people using heroin (this may be influenced, at least in part, by the participants themselves growing older), and that there was also an increase in the number of people regularly using.

5.1.5 Key expert comments

- The majority of KE that commented believed the current purity of heroin fluctuated and this had been the case over the past 6 months.
- KE comments on patterns reflected findings in the PWID survey that heroin remained the drug of choice amongst this group, despite increased use of pharmaceutical opioids.
- The price of a cap of heroin was reported to be stable at $50.
- Again in 2010 KE commented that brown, alkaline 'brown' heroin remained uncommon in Sydney but there had been very occasional reports of it, and requests for citric acid at NSPs.

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 2010, twenty-eight percent of the PWID sample felt confident to answer at least some of the survey items regarding speed powder. Twenty-three percent commented on base price, purity and/or availability, and 44% commented on ice/crystal. 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, the smaller priced $50 amounts of speed were the most popular (in this case, points) and prices have continued to remain stable. In 2010, there was a decrease in the number of people reporting purchases of all weights (points, grams, eightballs and halfweights). Due to this shift, comparisons with 2009 for halfweights, grams and eightballs should be interpreted with caution due to the low number (n=<10) reporting. As shown in Table 9, 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 9: Price of most recent methamphetamine purchases by PWID participants, 2009-2010

Amount	Median price* $	Range $	Number of purchasers*
Speed powder			
Point (0.1 gram)	50 (50)	20-50	17 (32)
'Halfweight' (0.5 grams)	50 (113)	50-120	3^ (2^)
Gram	175 (120)	50-300	6^ (9^)
'Eightball' (3.5 grams)	150 (525)	150	1^ (4^)
Base			
Point (0.1 gram)	50 (50)	25-60	19 (23)
'Halfweight' (0.5 grams)	175 (150)	150-200	2^ (11)
Gram	100 (150)	50-300	5^ (2^)
'Eightball' (3.5 grams)	225 (825)	50-100	2^ (6^)
Ice/crystal meth			
Point (0.1 gram)	50 (50)	50-100	46 (51)
'Halfweight' (0.5 grams)	200 (200)	170-300	8^ (12)
Gram	400 (350)	350-450	3^ (6^)
'Eightball' (3.5 grams)	1150 (1100)	200-1800	5^ (3^)

Source: IDRS PWID interviews

* 2009 data are presented in brackets

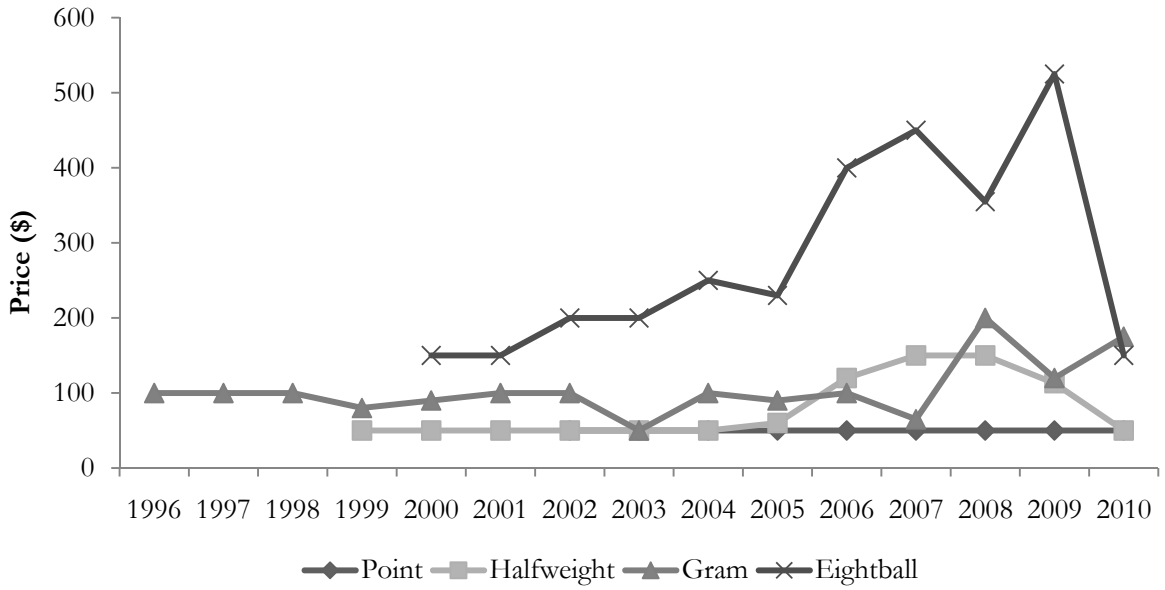
^ n=<10 results should be interpreted with caution

The median price per point of speed has remained the same since data were first collected on this purchase amount in 2002 ($50). It is important to note, however, that comparisons with the 2009

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 73% of those who commented (20% of all participants) reported price stability over the last six months. This remained consistent with comments from 2009. Similarly the proportion of participants reporting an increase (17%; 5% of all participants) remained stable from 2009 (15%; 5% of all participants). The number of people reporting a decrease also remained comparable with 2009 (5%; 1% of all participants in 2010 versus 2%; 1% of all participants in 2009). Overall, this suggested prices had remained relatively stable over the period, however, for some amounts (such as eightballs; Figure 34) trends in prices should be interpreted with caution due to small number of people reporting amounts larger than a point.

Figure 34: Median prices of speed powder estimated from PWID purchases, 1996-2010



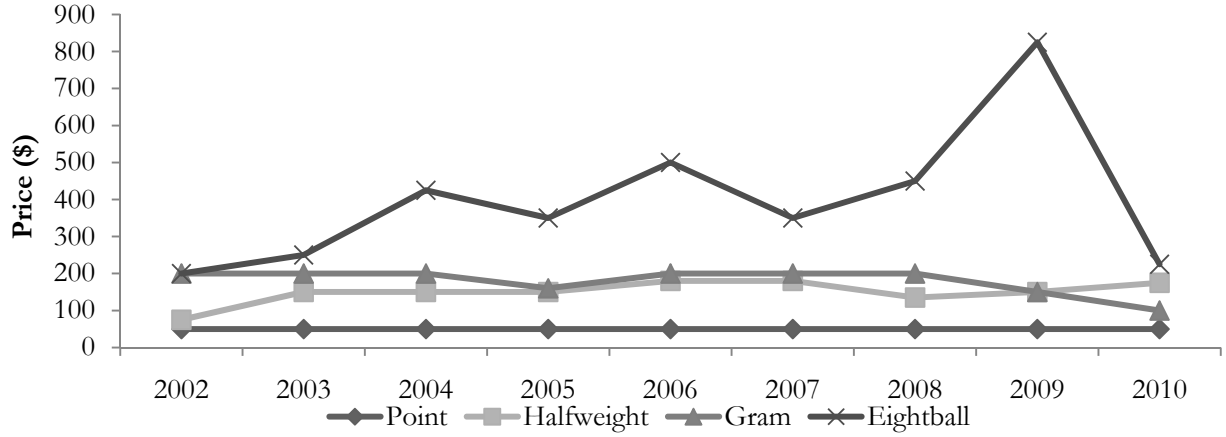
Source: IDRS PWID interviews

5.2.1.2 Base

The most popular purchase amount for base, as with all other forms of methamphetamine, continued to be $50 (a point), the smallest reported amount (Table 9). This has been a consistent finding over the preceding years of the IDRS in NSW. Twelve percent of all participants reported buying base in points in the preceding six months, making it the most popular purchase amount. Fewer participants (n=<10 for each amount) reported buying larger, more expensive amounts such as grams and eightballs.

The median price per point of base remained stable, while the median price for other amounts were based on small numbers (ten 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 the uncommon amount of an eightball (Figure 34).

Figure 35: Median prices of base estimated from PWID purchases, 2002-2010



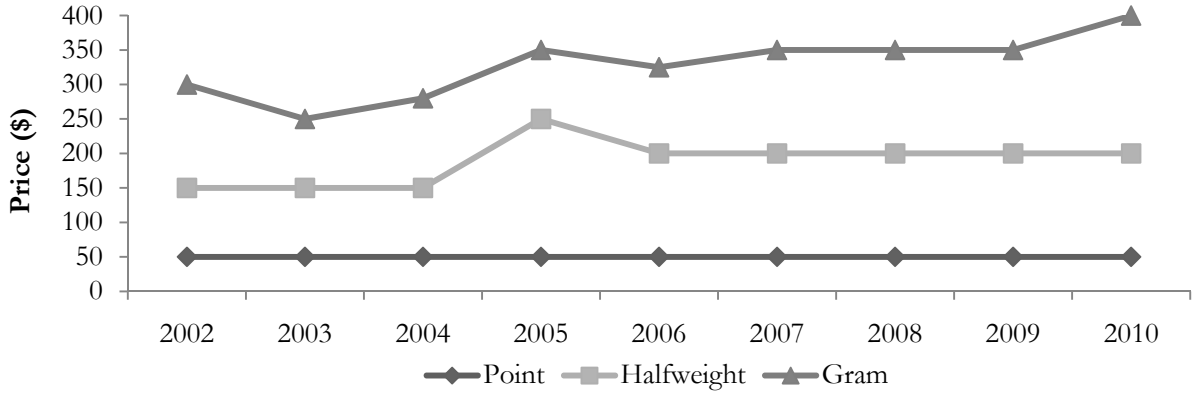
Source: IDRS PWID interviews

The majority of participants that commented on base generally thought that the price had remained stable over the preceding six months (78%; 16% of all participants). Thirteen percent reported that it had increased (3% of entire sample) and 9% (2% of entire sample) reported it had fluctuated. No participants reported a decrease. Base prices, overall, remained stable from 2009.

5.2.1.3 Ice/crystal

Again, as with speed and base, the most commonly purchased amounts of ice were $50 (a point), (30% of participants reporting at least one purchase in the last 6 months). For all other amounts (halfweights, gram, eightballs) only a small number of participants (n=>10) reported purchasing each type (Table 9). In 2010, overall prices for ice/crystal appeared to have remained stable. There was an increase reported in the price of an eightball (Table 9), however, as only small numbers reported buying eightball amounts in the last 4 years, results should be interpreted with caution.

Figure 36: Median prices of ice/crystal estimated from PWID purchases, 2002-2010



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

The majority of participants who commented on ice/crystal generally thought that the price had remained stable over the preceding six months (52%; representing 21% of the entire sample). Thirty-five percent stated that it had increased (representing 14% of the entire sample), and 13% each (both 5% of the entire sample) reported it had fluctuated in price. No participants had

reported a decrease in price. Overall in 2010, there was a rise in the number of people reporting an increase in price, however, comparisons with median prices for ice/crystal (see Table 9 and Figure 36) remained the same for all amounts except halfweights and grams which were relatively uncommon (n=<10).

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'. Availability was reported as 'very easy' (38%), 'easy' (41%) or 'difficult' (19%) to obtain (Table 10). Compared to 2009 (Table 10) its availability remained relatively stable.

The majority of the sample that commented reported availability in the preceding six months was stable (83%), as has been the case since 1996. In 2010, there was an increase in the number of participants who could comment on speed availability reporting stability (70% in 2009), while a smaller proportion than in 2009 reported the availability of speed powder as being 'easier' (2% in 2010; 13% in 2009).

One-quarter (25%) of participants reported purchasing speed powder in the six months preceding interview, of those purchasing it was most commonly from friends (41%), street dealers (31%) and known dealers (18%), with only a small proportion report obtaining it from other sources. The locations at which participants had usually scored were equally friend's home, street market or agreed public locations (all 26%)(Figure 38).

5.2.2.2 Base

Base was also generally reported to be 'easy' (41%) to obtain. In 2010, there was an increase in the number of people who could comment on availability as 'difficult' (Table 9). Forty-one percent of those that could comment reported it as 'easy', while 29% reported it as 'difficult'. Sixty-two percent (62%; or 14% of all participants) reported that availability over the past six months was 'stable' (Table 9). Although 'stable' had been the most commonly selected response option (excluding 'don't know' responses) since 2002, a decrease in the number reporting 'more difficult' in the 6 months prior to interview indicates that base availability may have decreased in 2010.

Over a quarter of the entire sample (29%, 28% in 2009) reported purchasing base in the six months preceding interview, of those that reported a purchase, it was most commonly from friends and street dealers (both 33%) and known dealers (27%). Locations that base had most commonly been purchased from included dealer's home (27%), home delivered (23%) street market or friend's home (both 20%) and an agreed public location (10%) (Figure 38).

Table 10: Participants' reports of methamphetamine availability in the past six months, 2009-2010

	Powder		Base		Ice/Crystal	
	2009 (N=152)	**2010 (N=154)**	2009 (N=152)	**2010 (N=154)**	2009 (N=152)	**2010 (N=154)**
Current availability						
Did not respond* (%)	68	**72**	71	**77**	57	**56**
Did respond (%)	32	**28**	29	**23**	43	**44**
Of those who responded:						
Very easy (%)	44 *(14% of entire sample)*	38 *(10% of entire sample)*	34 *(10% of entire sample)*	27 *(6% of entire sample)*	39 *(16% of entire sample)*	44 *(19% of entire sample)*
Easy (%)	42 *(13% of entire sample)*	41 *(11% of entire sample)*	41 *(12% of entire sample)*	41 *(9% of entire sample)*	20 *(9% of entire sample)*	33 *(14% of entire sample)*
Difficult (%)	13 *(4% of entire sample)*	19 *(5% of entire sample)*	16 *(5% of entire sample)*	29 *(7% of entire sample)*	31 *(13% of entire sample)*	15 *(7% of entire sample)*
Very difficult (%)	2 *(1% of entire sample)*	2 *(1% of entire sample)*	7 *(2% of entire sample)*	3 *(1% of entire sample)*	6 *(3% of entire sample)*	8 *(3% of entire sample)*
Don't know^ (%)	0 *(0% of entire sample)*	0 *(0% of entire sample)*	2 *(1% of entire sample)*	0 *(0% of entire sample)*	5 *(2% of entire sample)*	0 *(0% of entire sample)*
Availability change over the last six months						
Did not respond* (%)	68	**72**	71	**77**	57	**56**
Did respond (%)	32	**28**	29	**23**	43	**44**
Of those who responded:						
More difficult (%)	17 *(8% of entire sample)*	14 *(4% of entire sample)*	14 *(4% of entire sample)*	38 *(8% of entire sample)*	32 *(14% of entire sample)*	12 *(19% of entire sample)*
Stable (%)	70 *(22% of entire sample)*	83 *(23% of entire sample)*	68 *(20% of entire sample)*	62 *(14% of entire sample)*	43 *(18% of entire sample)*	71 *(14% of entire sample)*
Easier (%)	13 *(4% of entire sample)*	2 *(1% of entire sample)*	14 *(4% of entire sample)*	0 *(0% of entire sample)*	12 *(5% of entire sample)*	14 *(7% of entire sample)*
Fluctuates (%)	0 *(0% of entire sample)*	0 *(0% of entire sample)*	2 *(1% of entire sample)*	0 *(0% of entire sample)*	3 *(1% of entire sample)*	3 *(3% of entire sample)*
Don't know^ (%)	2 *(1% of entire sample)*	0 *(0% of entire sample)*	2 *(1% of entire sample)*	0 *(0% of entire sample)*	9 *(4% of entire sample)*	0 *(0% of entire sample)*

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

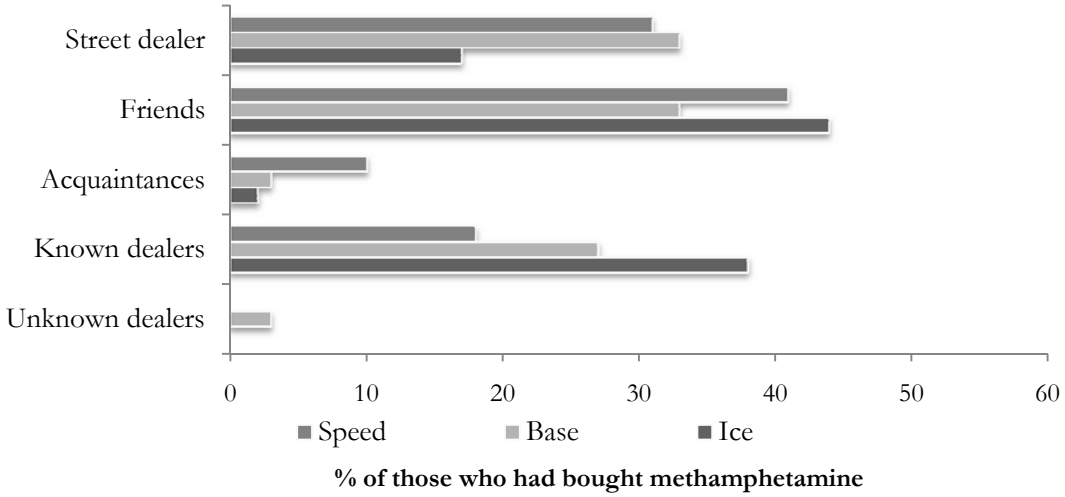
5.2.2.3 Ice/crystal

Forty-four percent of participants commenting on ice/crystal stated that it was 'very easy' (representing 19% of all participants) or 'easy' (44% or 19% of all participants) to obtain. This is an increase from 2009 (Table 10). There was a corresponding decrease in the proportion reporting it as 'difficult' (15% in 2010; 31% in 2009) to obtain. Overall, the current availability of ice/crystal appears to have increased since 2009.

The majority of participants (71%, or 30% of entire sample) reported that availability over the last six months had remained stable, while 14% (6% of the entire sample) reported it had become easier and only 12% (5% of entire sample) reported it had become more difficult (Table 10). Only three percent (1% of entire sample) of those who provided information about market indicators for ice/crystal (i.e. price, purity and/or availability) reported that availability had fluctuated in 2010. Overall, the majority of participants each year had reported availability as stable, with the exception of 2003 where it was most commonly reported as 'easier' to obtain and 2010 where it was seen as 'more difficult' to obtain.

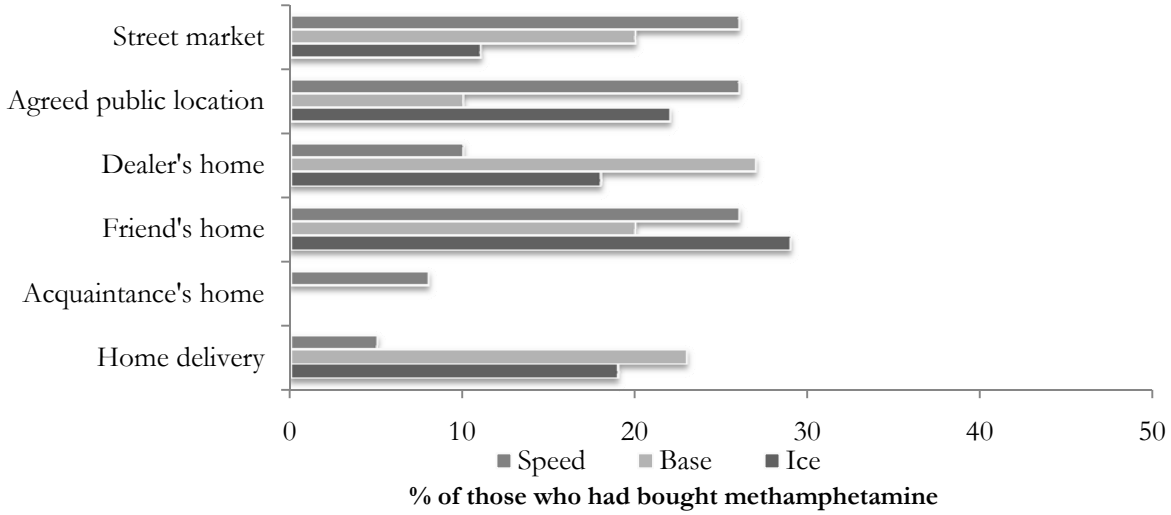
Forty-two percent of all participants had purchased ice in the six months preceding interview. Among these, the most commonly reported sources were friends (44%), known dealers (38%), and street dealers (17%) (Figure 37). The most commonly reported locations of purchase were a friend's home (29%), an agreed public location (22%) and a dealer's home (18%) (Figure 38).

Figure 37: People from whom methamphetamine was purchased in the preceding six months, 2010



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

Figure 38: Locations where methamphetamine was scored in the preceding six months, 2010

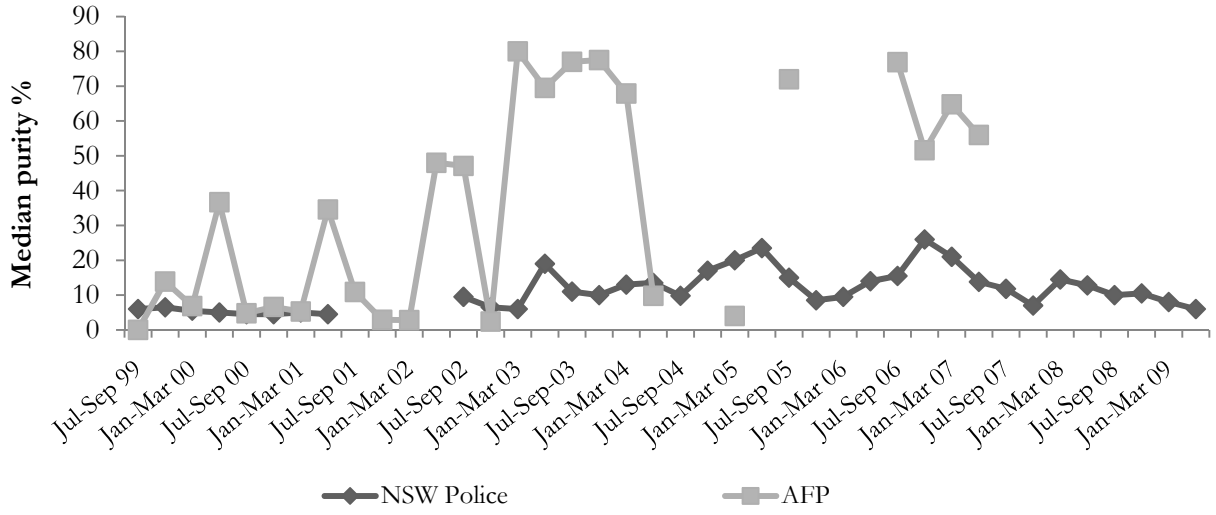


Source: IDRS PWID interviews
NB: More than one response could be selected

5.2.3 Purity

Figure 39 shows the median purity of methylamphetamine seizures analysed in NSW for the period 1999/00 to 2008/09. Again in 2008/09 there were no seizures analysed by AFP in the 12 month period. 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 remained stable in 2008/09 at 9% (range; 6-10.5%) with the 10% reported in the 2007/08. 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.

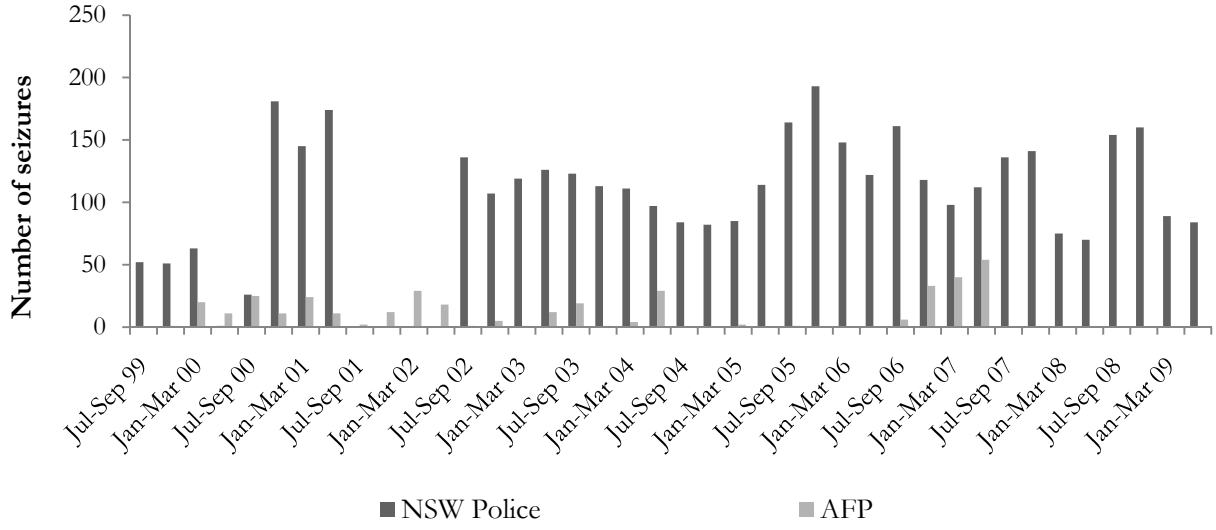
Figure 39: Purity of methylamphetamine seizures analysed in NSW, by quarter, 1999/00-2008/09



Source: Australian Bureau of Criminal Intelligence 2001, 2002; Australian Crime Commission, 2003, 2004, 2005, 2006, 2007, 2008, 2009
NB: NSW Police data for the financial year 2001/02 were unavailable. Data for 2009/10 were unavailable at time of publication

Figure 40 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 2 years to June 2009, meaningful interpretation is difficult. The number of seizures analysed by NSW Police has remained stable in the 12 months to June 2009 (487 in 2008/09 versus 489 in 2007/8).

Figure 40: Number of methylamphetamine seizures analysed in NSW, by quarter, 1999/00-2008/09



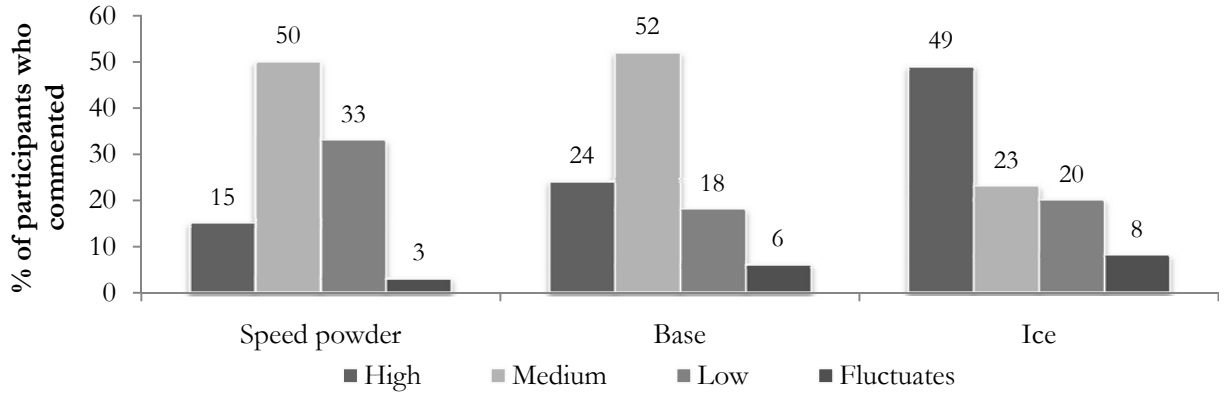
Source: Australian Bureau of Criminal Intelligence 2001, 2002; Australian Crime Commission, 2003, 2004, 2005, 2006, 2007, 2008, 2009
NB: NSW Police data for the financial year 2001/02 were unavailable. Data for 2009/10 were unavailable at time of publication

5.2.3.1 Speed powder

Twenty-six percent of the sample commented on the perceived current purity of speed powder. Of these one-half (50%) thought that it was of 'medium' purity (13% of entire sample) followed by 'low' purity (33%; 8% of entire sample). Fifteen percent (4% of all participants) thought it was 'high' and only 3% (1% of all participants) thought that it had fluctuated (Figure 41). Despite a slight increase in those reporting 'medium' the overall data suggested that reported purity had been generally stable since 2007.

When asked about changes in purity the majority of participants thought that speed purity had remained stable (48%; 12% of entire sample) over the preceding six months. One-quarter (25%; 6% of entire sample) reported it had decreased and 10% (3% of entire sample) thought that it had increased, and 18% (5% of entire sample) thought it had 'fluctuated'. Overall, the number reporting 'stable' in purity increased in 2010 (48% in 2010 versus 33% in 2009), this could be indicative of purity being generally stable over the six months prior to interview in 2010.

Figure 41: Participant perceptions of methamphetamine purity (speed powder, base and ice), among those who commented, 2010



Source: IDRS PWID interviews

5.2.3.2 Base

One-half of recent users (52%; 11% of entire sample) commented that base was currently 'medium' purity. One-quarter (24%; 5% of entire sample) of participants that commented on base thought that it was currently 'high', while 18% reported it as currently 'low' purity and only 6% (1% of all participants) thought it 'fluctuated' (Figure 41).

In reporting on changes in purity it was generally reported to have remained 'stable' (53%; 11% of entire sample), with lesser amounts reporting it had 'decreased' (25%; 5% of entire sample) or had 'fluctuated' (16%; 3% of the entire sample) over the six months preceding interview. Only 6% (1% of the entire sample) believed purity had 'increased'. These changes may indicate that base purity remained stable in 2010.

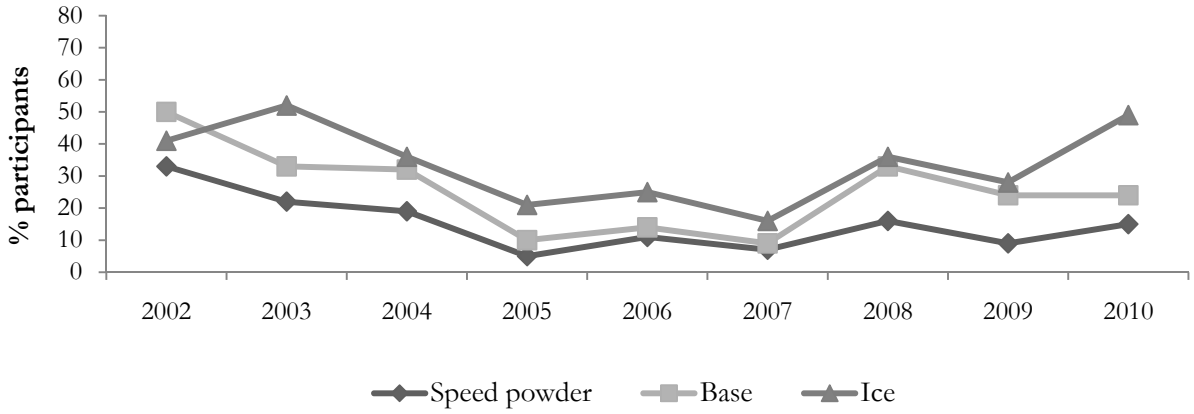
5.2.3.3 Ice/crystal

One-half (49%; 21% of entire sample) of recent users reported the purity of ice/crystal was reported as 'high'. Twenty-three percent reported it 'medium', while 20% reported 'low' purity (10% and 8% of entire sample, respectively). In 2010, there was an increase in the number reporting 'high' purity ice (27% in 2009). Only 8% percent of people reporting recent ice/crystal use commented it had fluctuated (Figure 41).

When asked about whether purity had changed over the last six months, forty-one percent of those responding (17% of all participants) believed that it remained 'stable'. One-quarter (24%; 10% of entire sample) thought it had 'fluctuated' and one-fifth (21%; 8% of all participants) commented it had 'decreased'. These changes may indicate that the purity of ice/crystal had remained stable in 2010.

Figure 42 shows the proportion of PWID participants reporting the purity of each form of methamphetamine as 'high'. Greater proportions of the PWID sample reported ice/crystal and base as being 'high' in purity compared with speed and ratings of perceived purity of ice/crystal and speed as 'high' have increased, while base has remained stable since 2009.

Figure 42: Proportion of participants reporting speed powder, base and ice/crystal purity as 'high', 2002-2010



Source: IDRS PWID interviews
NB: Data on all three forms commenced in 2002

5.2.4 Key Expert comments

- Reports from KE on recent methamphetamine use were mixed. One-half of those that could comment believed that crystal/ice use remained stable while the remaining half believed recent use had decreased.
- The price per point of crystal/ice remained stable according to KE.
- Law enforcement KE noted a decrease in detections for use/possession of methamphetamine.

5.2.5 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 consistent theme was that more people were using ice/crystal use, and this was particularly evident among younger users.

5.3 Cocaine

Fifty-three percent of participants reported that they were able to comment on the price, purity and/or availability of cocaine in 2010, which remained stable from 2009 (56% in 2009). 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

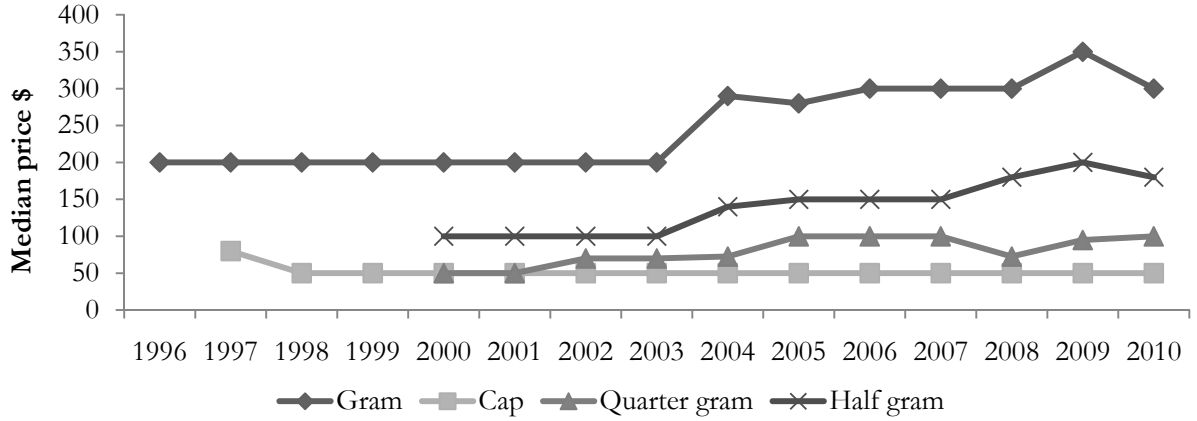
Prices paid for cocaine by PWID participants on the last occasion of purchase are presented in Table 10. The most common purchase amounts were the $50 deals (a cap). While the median price for caps, the most popular purchase amount, remained stable the prices for larger amounts had decreased. A decrease was observed in the numbers of participants, who had recently purchased all amounts; caps, quarter grams, halfweights and grams. Quarter gram purchases continued to remain comparatively uncommon. The median price for a gram of cocaine decreased by $50 in 2010, from the highest price ever recorded ($350 per gram in 2009), while there was insufficient number of participants (n=<10) to comment on price changes on quarter and halfweights (Table 11).

Table 11: Price of most recent cocaine purchases by PWID participants, 2009-2010

Amount	Median price*$	Range ($)	Number of purchasers*
Cap	50 (50)	40-100	33 (51)
Quarter gram	100 (95)	100	2^ (8^)
'Half weight'(0.5 grams)	180 (200)	150-200	9^ (23)
Gram	300 (350)	200-350	12 (18)

Source: IDRS PWID interviews
*2009 data are presented in brackets
^n=<10 results should be interpreted with caution

Figure 43: Median price of a gram and cap of cocaine estimated from PWID participant purchases, 1996-2010



Source: IDRS PWID interviews

Price ranges for caps and grams were wide (Table 11), and this is likely in most cases 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. It has been noted anecdotally that, with drugs such as cocaine and heroin, it is sometimes possible to buy a $50 cap or a $100 cap, with the price determined by the amount (i.e. a $100 cap contains more of the drug) and/or purity.

The majority of participants (83%; 38% of entire sample) that could comment on cocaine reported that the price had remained 'stable' in the preceding six months. Fourteen percent (7% of entire sample) of those commenting reported that cocaine prices had 'increased', three percent (1% of entire sample) reported it had 'fluctuated' in price and no participants reported it had 'decreased' over the past 6 months.

5.3.2 Availability

Thirty-one percent (16% of entire sample) of participants commenting on cocaine market characteristics (price, purity and/or availability) thought that it was 'very easy' to obtain cocaine, representing a decrease from 38% in 2009 (Table 12). Approximately one-third (36%) of participants commenting rated it as *easy* (a decrease from 47% in 2009). One-quarter (27%; 14% of entire sample) thought it was 'difficult' and 6% of participants reported that it was 'very difficult' to obtain (Table 12), which was an increase from 2009.

Sixty-seven percent of participants (34% of entire sample) commenting on cocaine reported that availability had remained *stable*, comparable to 62% (34% of the entire sample) in 2009 (Table 12). Twenty-three percent (12% of the entire sample) reported that it had become more *difficult* to obtain over the last six months, and only 6% (3% of the entire sample) thought it had become *easier*. Four percent (2% of the entire sample) thought that availability had *fluctuated* over this time period. Overall, there was an increase in the percentage reporting cocaine availability as *more difficult* (16% in 2009) and a decrease the number reporting it as easier (17% in 2009) (Table 12).

Table 12: Participants' reports of cocaine availability in the past six months, 2007-2010

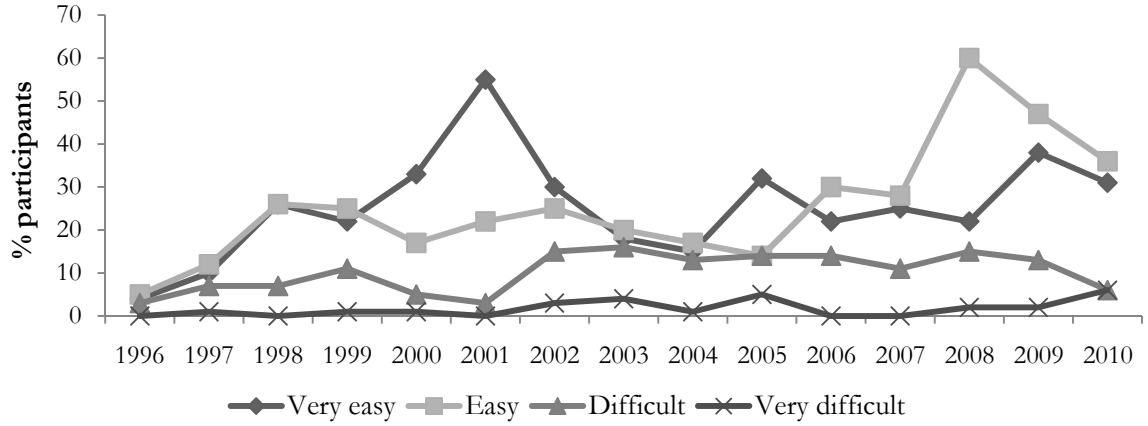
	2007 (N=153)	2008 (N=151)	2009 (N=152)	**2010 (N=154)**
Current availability				
Did not respond* (%)	30	56	44	**47**
Did respond (%)	70	44	56	**53**
Of those who responded:				
Very easy (%)	36 *(25% of entire sample)*	22 *(10% of entire sample)*	38 *(21% of entire sample)*	**31** *(16% of entire sample)*
Easy (%)	41 *(28% of entire sample)*	60 *(27% of entire sample)*	47 *(26% of entire sample)*	**36** *(19% of entire sample)*
Difficult (%)	17 *(11% of entire sample)*	15 *(7% of entire sample)*	13 *(7% of entire sample)*	**27** *(14% of entire sample)*
Very difficult (%)	0 *(0% of entire sample)*	2 *(1% of entire sample)*	2 *(1% of entire sample)*	**6** *(3% of entire sample)*
Don't know^ (%)	7 *(5% of entire sample)*	1 *(1% of entire sample)*	0 *(0% of entire sample)*	**0** *(0% of entire sample)*
Availability change over the last six months				
Did not respond* (%)	30	56	44	**49**
Did respond (%)	70	44	56	**51**
Of those who responded:				
More difficult (%)	13 *(9% of entire sample)*	17*(9% of entire sample)*	16 *(9% of entire sample)*	**23** *(12% of entire sample)*
Stable (%)	68 *(47% of entire sample)*	64 *(29% of entire sample)*	62 *(34% of entire sample)*	**67** *(34% of entire sample)*
Easier (%)	5 *(3% of entire sample)*	15 *(7% of entire sample)*	17 *(9% of entire sample)*	**6** *(3% of entire sample)*
Fluctuates (%)	6 *(4 % of entire sample)*	3 *(1 % of entire sample)*	2 *(1% of entire sample)*	**4** *(2% of entire sample)*
Don't know^ (%)	9 *(6% of entire sample)*	2 *(1% of entire sample)*	4 *(2% of entire sample)*	**0** *(0% of entire sample)*

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 44: Participant reports of current cocaine availability, 1996-2010



Source: IDRS PWID interviews

The most common sources of purchasing cocaine over the preceding six months were equally street dealers and known dealers (both 32%) and friends (26%). Locations where these purchases were most commonly made were varied, with the most common venues being an agreed public location (39%), street market (33%), equally home delivery and dealer's home (both 10%) and friend's home (8%) (Figure 45).

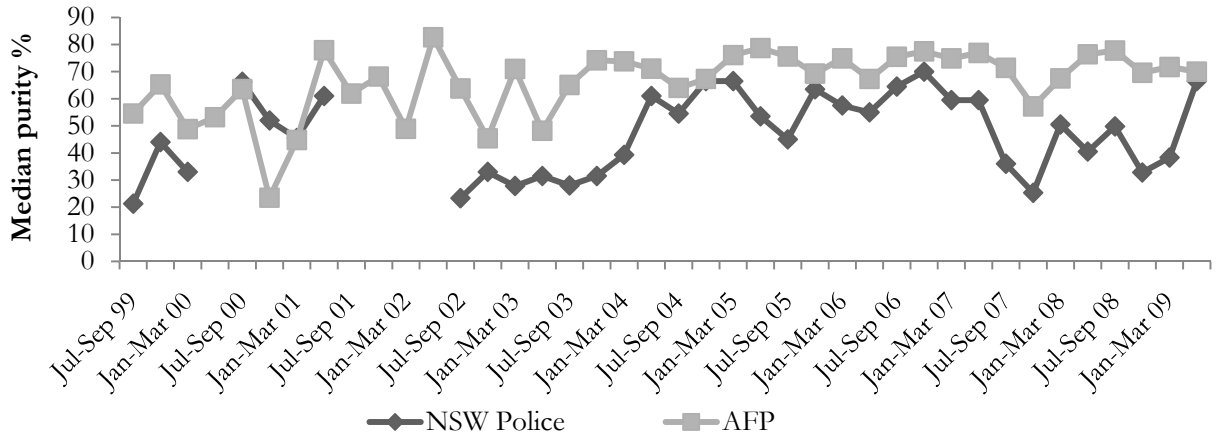
Figure 45: Locations where cocaine was scored in the preceding six months, 2010

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

5.3.3 Purity

Overall, the median total purity of cocaine seizures analysed by the NSW Police had remained stable 42%) in the 12 months to June 2009 compared with a 38.3% in 2007/08 despite a spike in purity in the second quarter of 2009. Similarly, the overall total seizures analysed by the AFP remained relatively stable over the same period (Figure 46). The total median purity of cocaine analysed by the AFP was 70.3% (72% in 2007/08) (Figure 46). Purity figures, however, should be interpreted with caution, particularly where they are based on small numbers of seizures (refer to Figure 47). 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.

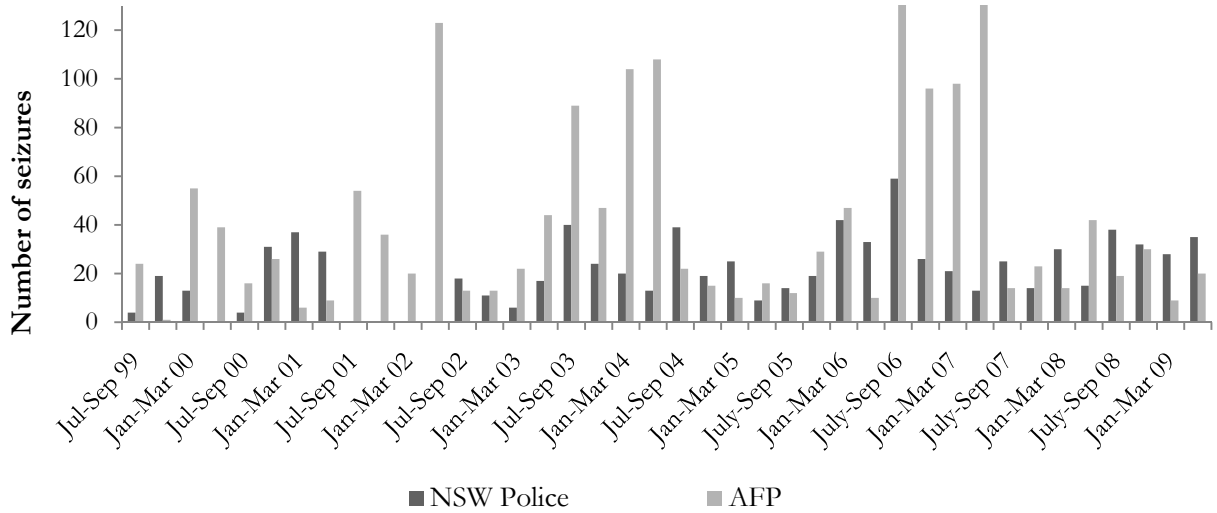
Figure 46: Purity of cocaine seizures analysed in NSW, by quarter, 1999/00-2008/09



Source: Australian Bureau of Criminal Intelligence 2001, 2002; Australian Crime Commission, 2003, 2004, 2005, 2006, 2007, 2008, 2009
NB: NSW Police data for the financial year 2001/02 were unavailable. Data for 2009/10 were unavailable at time of publication

Figure 47 shows the number of seizures analysed in NSW between 1999/00 and 2008/09. The number of seizures analysed by NSW Police increased in the 12 month period until June 2009 (133 cases in 2008/09 versus 84 cases in 2007/08). The number of cases analysed by AFP declined again in same period from 93 cases in 2007/08 to 78 cases in 2008/09 (491 cases in 2006/07) (Figure 47). Data for 2009/10 were unavailable at the time of publication.

Figure 47: Number of cocaine seizures analysed in NSW, by quarter, 1999/00-2008/09



Source: Australian Bureau of Criminal Intelligence 2001, 2002; Australian Crime Commission, 2003, 2004, 2005, 2006, 2007, 2008, 2009
NB: NSW Police data for the financial year 2001/02 were unavailable. Data for 2009/10 were unavailable at time of publication

One-half (50%) of all participants could comment on current purity of cocaine. Of these, over one-third (36%) reported cocaine to be currently be 'medium' purity (18% of entire sample), which remained consistent with 2009. One-quarter of participants reported purity to be currently 'low' (26%; 13% of entire sample) or 'high' (25%; 12% of entire sample) (Table 13).

Thirteen percent commented that purity had 'fluctuated' (12% in 2009). Overall, current cocaine purity appears to have remained generally consistent with reports from 2009.

Similar to previous years the majority (44%; 21% of the entire sample) of those commenting on cocaine purity thought that it had remained 'stable' in the preceding six months. Approximately one-quarter (23%; 11% of entire sample) believed purity had 'decreased', one fifth (21%; 10% of entire sample) reported it had 'fluctuated' and 12% (6% of entire sample) believed it had 'increased'. Although the reported percentage figures were generally comparable with 2009 data the total number of people reporting purity as 'stable' increased (28% in 2009) and there was a corresponding decrease in the number reporting it had 'increased' (19% in 2009) (Table 13).

Table 13: Participants' perceptions of cocaine purity in the past six months, 2007-2010

	2007 (N=153)	2008 (N=151)	2009 (N=152)	**2010 (N=154)**
Current purity				
Did not respond* (%)	30	56	44	**50**
Did respond (%)	70	44	56	**50**
Of those who responded:				
High (%)	22 *(15% of entire sample)*	30 *(13% of entire sample)*	28 *(16% of entire sample)*	**25** *(12% of entire sample)*
Medium (%)	40 *(28% of entire sample)*	24 *(11% of entire sample)*	39 *(22% of entire sample)*	**36** *(18% of entire sample)*
Low (%)	21 *(14% of entire sample)*	36 *(16% of entire sample)*	18 *(10% of entire sample)*	**26** *(13% of entire sample)*
Fluctuates (%)	8 *(5% of entire sample)*	6 *(3% of entire sample)*	12 *(7% of entire sample)*	**13** *(7% of entire sample)*
Don't know^ (%)	9 *(6% of entire sample)*	5 *(2% of entire sample)*	4 *(2% of entire sample)*	**0** *(0% of entire sample)*
Purity change over the last six months				
Did not respond* (%)	30	56	44	**47**
Did respond (%)	70	44	56	**53**
Of those who responded:				
Increasing (%)	13 *(9% of entire sample)*	18 *(8% of entire sample)*	19 *(11% of entire sample)*	**12** *(6% of entire sample)*
Stable (%)	37 *(25% of entire sample)*	34 *(15% of entire sample)*	28 *(16% of entire sample)*	**44** *(21% of entire sample)*
Decreasing (%)	21 *(14% of entire sample)*	30 *(13% of entire sample)*	18 *(10% of entire sample)*	**23** *(11% of entire sample)*
Fluctuating (%)	14 *(10% of entire sample)*	12 *(5% of entire sample)*	24 *(13% of entire sample)*	**21** *(10% of entire sample)*
Don't know^ (%)	14 *(10% of entire sample)*	6 *(3% of entire sample)*	12 *(7% of entire sample)*	**0** *(0% of entire sample)*

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 commenting on cocaine. The few that were able to comment suggested that there was an increase in cocaine use, particularly among younger users.

5.3.4 Key expert comments

- Again in 2010 both law enforcement and health KE were in agreement that there had been an increase in cocaine availability over the past 6 months.
- Law enforcement KE noted an increase in cocaine trafficking detections and an increase in arrests for use/possession in areas outside the inner city Sydney.
- Health KE noted an increase in availability of cocaine over the past 6 months but emphasized that it was not the primary drug of choice for the vast majority of the clients they were coming into contact with regularly.
- The final reoccurring theme from KE able to comment was that both price per cap and recent use of cocaine remained stable.

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 2010, fifty-eight percent of the sample felt confident to answer at least some of the survey items on hydro. By contrast, only 29% 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 Table 14. 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 (Table 13). In 2010, the median price of a quarter ounce of hydroponic cannabis decreased by $10 to $90 and an ounce of hydro decreased by $30 to $290 in 2010. Insufficient numbers of people reported on half ounces to comment on price (Table 14).

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=36), followed by quarter ounces (n=27).

Participants were also asked whether they thought that prices had changed over the six months preceding interview. Though there was a decrease in the median price of hydro for amounts larger than a gram, the majority of PWID participants who commented (80%; 46% of entire sample) reported that the price was 'stable', with smaller proportions stating that it had 'increased' (14%; 8% of entire sample), 'fluctuated' (5%; 3% of the entire sample) or 'decreasing' (2%; 1% of the entire sample). While the number reporting an increase declined slightly, and there was a corresponding increase in the numbers reporting a decrease, the remaining figures were stable compared to those presented in 2009.

5.4.1.2 Bush Cannabis

In 2010, the median prices for bush cannabis remained stable (grams and quarter ounces) among those amounts with sufficient number of people commenting (≥10) (Table 14). The number of reported purchases for all other amounts was low (<10) so results should be interpreted with caution (Table 14).

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

The majority of participants who commented (81%; 20% of the entire sample) thought prices of bush cannabis had remained 'stable', 11% believed it had 'increased', while 8% believed it had 'decreased'. No participants commented it had 'fluctuated'.

Again in 2010, price ranges for hydroponic and larger quantities of bush cannabis were wide (Table 14). 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 14: Price of most recent cannabis purchases by PWID participants, 2009-2010

Amount	Median price* $	Range	Number of purchasers*
Hydro			
Gram	20 (20)	10-25	36 (55)
Quarter ounce	90 (100)	60-100	27 (48)
Half ounce	155 (155)	130-180	4^ (20)
Ounce	290 (320)	150-400	10 (27)
Bush			
Gram	20 (20)	10-20	19 (25)
Quarter ounce	80 (80)	50-100	15 (12)
Half ounce	160 (130)	140-200	3^ (4^)
Ounce	250 (229)	200-280	6^ (9^)

Source: IDRS PWID interviews
*2009 median prices are in brackets
^n=<10 results should be interpreted with caution

5.4.1.3 Hash and Hash Oil

Only seven participants reported buying hash in the six months preceding interview for a median price of $20 a gram (range: $20-60). No one reported purchasing hash oil in 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' (66%; 38% of all participants) or 'easy' (26%; 15% of all participants) to obtain (Table 14). The majority (79%; 46% 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 'very easy' (39%; 11% of entire sample) or 'easy' (32%; 9% of entire sample) to obtain. While approximately one-quarter (27%; 8% of entire sample) reported it to be 'difficult' to obtain (Table 15). Three-quarters (74%; 21% of entire sample) reported that availability had remained 'stable' in the six months preceding interview. It appeared that the availability of bush cannabis has remained stable for the compared with 2009 (Table 15; Figure 48).

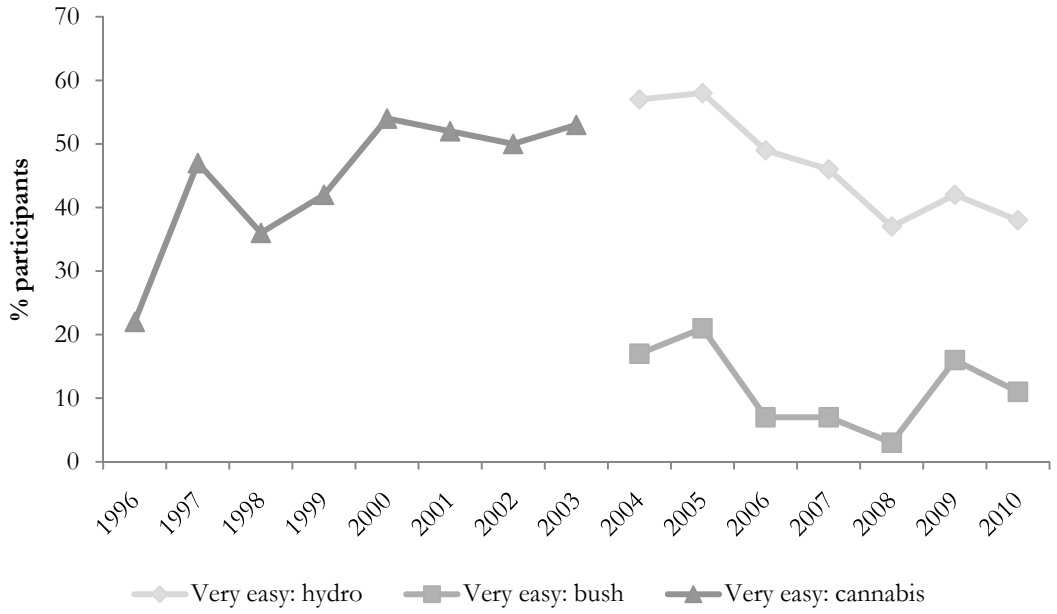
Table 15: Participants' reports of cannabis availability in the past six months, 2009-2010

	Hydro		Bush	
	2009 (N=152)	**2010 (N=154)**	2009 (N=152)	**2010 (N=154)**
Current availability				
Did not respond* (%)	28	**42**	63	**71**
Did respond (%)	72	**58**	37	**29**
Of those who responded:				
Very easy (%)	58 *(42% of entire sample)*	**66** *(38% of entire sample)*	43 *(16% of entire sample)*	**39** *(11% of entire sample)*
Easy (%)	37 *(27% of entire sample)*	**26** *(15% of entire sample)*	32 *(12% of entire sample)*	**32** *(9% of entire sample)*
Difficult (%)	5 *(3% of entire sample)*	**8** *(5% of entire sample)*	20 *(7% of entire sample)*	**27** *(8% of entire sample)*
Very difficult (%)	---	**1** *(1% of entire sample)*	5 *(2% of entire sample)*	**2** *(1% of entire sample)*
Availability change over the last six months				
Did not respond* (%)	28	**42**	63	**72**
Did respond (%)	72	**58**	37	**28**
Of those who responded:				
More difficult (%)	9 *(7% of entire sample)*	**8** *(5% of entire sample)*	11 *(4% of entire sample)*	**14** *(4% of entire sample)*
Stable (%)	81 *(58% of entire sample)*	**79** *(46% of entire sample)*	79 *(30% of entire sample)*	**74** *(21% of entire sample)*
Easier (%)	6 *(4% of entire sample)*	**9** *(5% of entire sample)*	5 *(2% of entire sample)*	**7** *(2% of entire sample)*
Fluctuates (%)	5 *(3% of entire sample)*	**4** *(3% of entire sample)*	5 *(2% of entire sample)*	**5** *(1% of entire sample)*

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

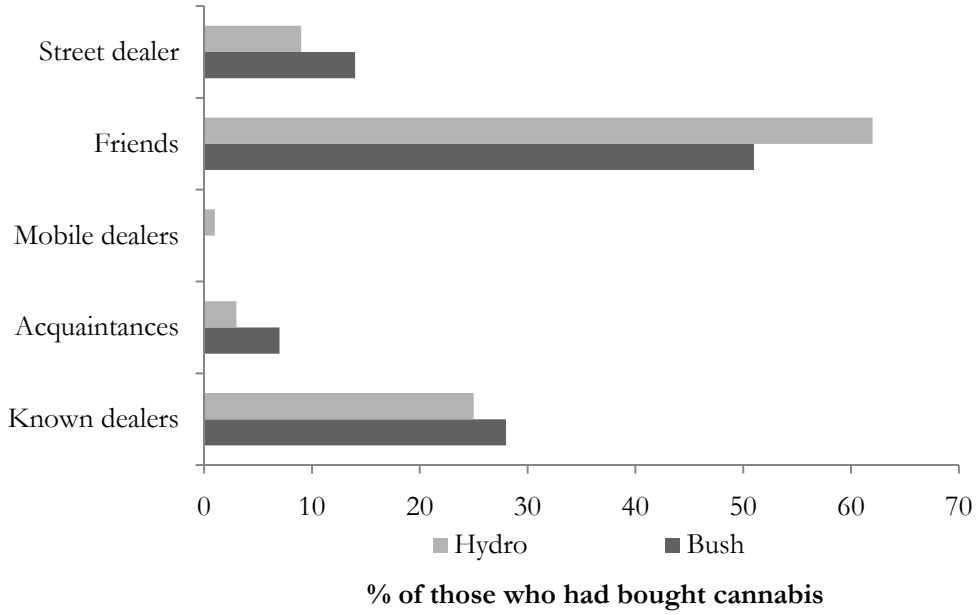
Figure 48: Participant reports of current cannabis availability, 1996-2010



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

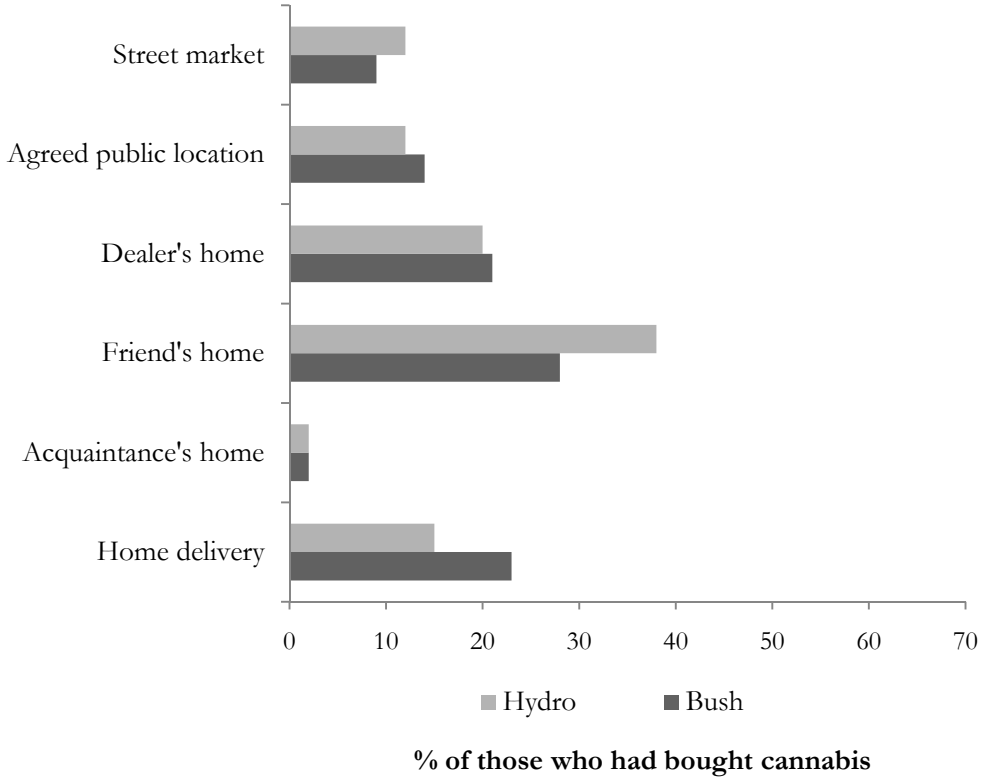
Sixty percent of all participants had purchased hydro in the preceding six months and 32% of participants had purchased bush. Patterns of purchase of hydro and bush were similar, with those who had purchased in the last six months predominantly obtaining it through friends, from known dealers and/or from street dealers (Figure 49). Locations where cannabis was scored were varied, including public and private locations (Figure 50).

Figure 49: People from whom cannabis was purchased in the preceding six months, 2010



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

Figure 50: Locations where cannabis was purchased in the preceding six months, 2010



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

5.4.2 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').

5.4.2.1 Hydroponic Cannabis

The majority of participants commenting on hydro reported it as currently being of 'high' potency (54%; 32% of the entire sample), followed by 39% (23% of the entire sample) who rated it as being of 'medium' potency. Only 6% (3% of the entire sample) thought that it was of 'low' potency, and 1% (<1% of the entire sample) believed that it had 'fluctuated'. The majority (65% of those commenting; 37% of the entire sample) believed that potency had remained 'stable' in the preceding six months, with smaller proportions reporting that it had 'increased' (12%; 7% of the entire sample) or 'fluctuated' (12%; 7% of the entire sample) or 'decreased' (10%; 6% of the entire sample). Overall, these figures followed a similar pattern to 2009.

5.4.2.2 Bush Cannabis

Among those who commented, 61% (16% of entire sample) thought bush was of 'medium' potency, 22% (6% of entire sample) thought it was of 'high' potency, and 15% (4% of all participants) thought it was of 'low' potency. Only 2% (1% of all participants) thought it fluctuated. When asked about whether potency had changed over the last six months, seventy-one percent of the respondents that commented (19% of all participants) reported that potency had remained 'stable'. Small proportions equally comment that it had 'increased', 'decreased' or 'fluctuated' (all 9%; 3 % of all participants).

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, despite an increasing number of participants reporting bush as 'high' purity (22% versus 14% in 2009) and a corresponding decrease in the proportion reporting purity as 'low' (15% versus 26% in 2009).

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

5.4.3 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.

5.4.4 Key expert comments

- Again in 2010, very few KE were able to comment on cannabis.
- 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.
- Cannabis remained the most detected drug (use/possession and trafficking) in NSW according law enforcement KE.
- The price per gram of both bush and hydroponic cannabis was seen to have remained stable.

5.5 Methadone

As with other drug types, all participants were asked about the illicit methadone market. Thirty-three percent of the sample (36% in 2009), were able to comment on the price, purity and/or availability of illicit methadone. Among participants who had used any form of methadone in the preceding six months, the median price for methadone liquid was reported to be 50 cents per ml, which is stable with the data from previous years.

No participants were able to comment on the price of Physeptone tablets.

In response to the question 'has the price of illicit methadone changed in the past six months?' the majority of those commenting (71%; 21% of the entire sample) reported that the price had remained 'stable' during this time. Eighteen percent (5% 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 no participants reported it had 'decreased'. Overall, this remained consistent with 2009.

With regard to the current availability of street methadone, among those who commented 86% it was 'very-easy' (42%) to 'easy' (44%) to obtain. Thirteen percent (4% of the entire sample) thought it was 'difficult' to obtain with only 2% (<1% of entire sample) reported it was 'very difficult' to obtain. Overall, there has been an increase of those reporting very-easy or easy availability (86% versus 65% in 2009) in 2010.

When asked whether availability had changed over the preceding six months, the majority of those commenting (83%; 25% of the entire sample) reported that it had remained *'stable'*. Eleven percent (3% of all participants) reported that it had become more *difficult* to obtain in the preceding six months and four percent (1% of entire sample) of participants reported that access to illicit methadone had become *easier*. Only one participant reported that it had become easier.

Overall, the findings suggest that the illicit methadone market has remained relatively stable in terms of price and availability over the past few years. Approximately one-quarter (27%; 36% in 2009, 24% in 2008, and 18% in 2007) of participants reported buying illicit methadone in the past six months. Of those that had bought methadone it was most commonly purchased from friends (60%), street dealers (23%), with smaller amounts purchasing from acquaintances (9%) or known dealers (6%). The most commonly reported locations of purchase were an agreed public location (35%), a friend's home (24%), a street market (21%), home delivery (12%) or at an acquaintance's home (6%).

5.6 Buprenorphine

Fifteen percent of participants (16% in 2009) commented on the price and/or availability of illicit (or 'street') 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).

Illicit buprenorphine was reportedly sold for a median price of $20 per 8mg tablet (also $20 in 2009) (range $10-50). There were insufficient numbers (n=<10) of people commenting on 2mg tablets. More than half (58%; 7% of entire sample) of those commented reported current availability was 'very-easy' or 'easy', however, 42% (5% of entire sample) claimed it was 'difficult'. The majority (67%; 8% of entire sample) commented that availability of buprenorphine had remained 'stable' over the preceding 6 months, while one-quarter (28%; 3% of entire sample) believed it had become 'easier'. Overall, these findings suggested that while there was a market for illicit buprenorphine, it was less available than illicit methadone in NSW.

A question was added in 2007 that asked participants about the last occasion on which they used illicit buprenorphine, and what their main reasons for doing so were. In 2010, the main responses were to substitute for heroin/other opioids (60%) and for self treatment (31%).

5.7 Morphine

Twenty-six percent of participants felt confident enough to respond to survey items concerning price and/or availability of illicit morphine, (25% in 2009). MS Contin continued to remain the most common brand of morphine used, with 82% of recent illicit morphine use being MS Contin tablets.

The median price for 100mg MS Contin tablets ('grey nurses') remained stable in in 2010 at a median of $30 per tablet (range: $20-35). However, while the price remained stable as only two percent of all participants commented on the price of 100mg MS Contin tablets, a decrease from 2009 where 20% of the entire sample commented on the price of MS Contin, the price should be interpreted with caution. Nine participants commented on 60mg MS Contin (median $20) and only five participants each were able to comment on 30mg MS Contin (median $15) and 100mg Kapanol prices (median $30) and less than five people each for all other sizes (Kapanol 50mg, MS Contin 10mg), therefore, results should be interpreted with caution.

The majority (65%; 16% of entire sample) of those commenting on the illicit morphine market reported that the price had remained 'stable' over the preceding six months (53% in 2009). Approximately one-third (30%; 7% of entire sample) of these participants believed that it had 'increased' (30% in 2009), and 3% equally reported that it had either 'decreased' or 'fluctuated' (both 1% of entire sample). Overall, these figures represented an increase in the participants reporting price stability compared to 2009.

The majority (68%; 73% in 2009) commented that illicit morphine was 'very-easy' or 'easy' (both 34%; 8% of entire sample) to obtain. One-quarter (26%; 7% of the entire sample) believed it to be 'difficult' (21% in 2009) and 5% that reported it as 'very difficult' remained stable with 2009. More than half (53%; comparable with 57% in 2009) of those commenting stated that availability had remained 'stable' over the preceding six months.

Again in 2010 morphine was most commonly purchased from friends (36% of those commenting), street dealers (25%) or known dealers and acquaintances (both 17%). These figures remained comparable with reports from 2009. The most commonly reported locations of purchase were from a street market (36%), an agreed public location (28%), a friend's home (22%), home delivery or an acquaintance's home (both 6%).

5.8 Oxycodone

In 2010, one-third (33%) of participants were confident enough to complete survey items concerning the market for illicit oxycodone. As per previous years the most commonly purchased amounts were 80mg tablets (OxyContin), bought for a median of $30 each (range $10-50) which was stable compared with 2009. Again in 2010, there were insufficient purchases of Endone to report on prices. The overall price for oxycodone was reported as having been 'stable' over the past six months (64% of those commenting), with 27% stating that it had 'increased', and a further 9% reporting that it had 'fluctuated'. This represented a 10% decrease in those reporting price stability and a corresponding 10% increase in those reporting an increase in price compared with 2009.

Reports of current Oxycodone availability varied among the participants that commented. Thirty-five percent thought that availability was currently *easy* and 29% thought it *very easy*, while approximately one-quarter (27%) thought it *difficult* and while 8% reported it was *very difficult*. Availability was reported by the majority of those commenting (59%) to have remained *stable* over the preceding six months, while 30% reported it had become *more difficult*. Nine-percent reported it had *fluctuated* and only two percent believed it had become *easier*.

Oxycodone remained most commonly purchased from street dealers (47%) and friends (33%), with small proportions reporting known dealers (12%) and acquaintances (7%). The most commonly cited locations for purchase were the street market (49%) an agreed public location (26%) or a friend's home (14%).

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 drug of choice for these users.
- Again in 2010 poor quality heroin, regular 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
- Health KE typically commented on the prohibitive costs to their service of purchasing pill filters.

5.9 Other Drugs

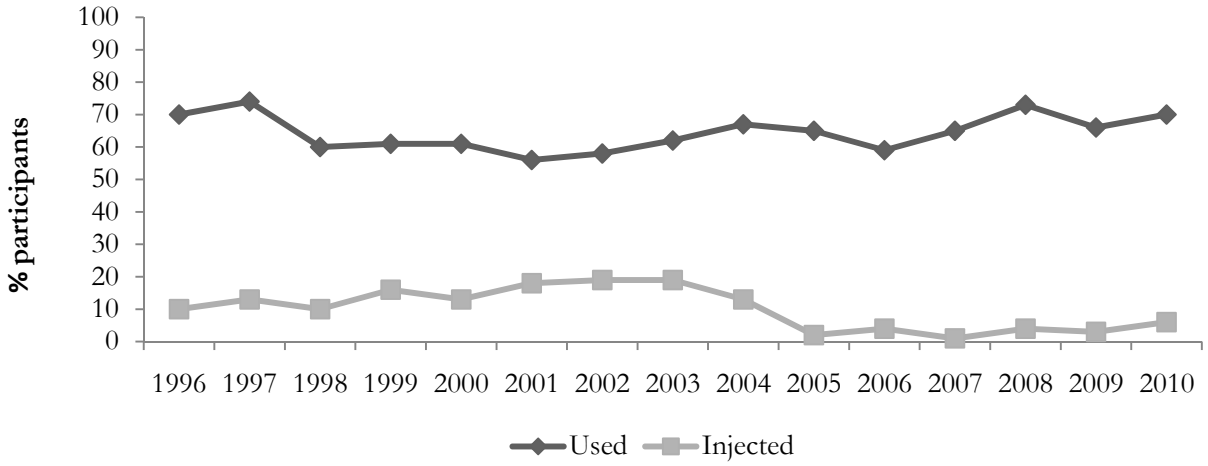
5.9.1 Benzodiazepines

Three-quarters (78%) of the sample (66% in 2009) reported use of benzodiazepines in the six months preceding interview on a median of 37 days (50 days in 2009), i.e. approximately weekly use (Table 3; Figures 51 and 52).

In 2010, the proportion reporting daily use was approximately one third (31%) of all recent users (37% in 2009). The proportion reporting recent licit use (43%) remained stable (also 43% in 2009) as did the proportion reporting recent illicit use (49% versus 51% in 2009). The

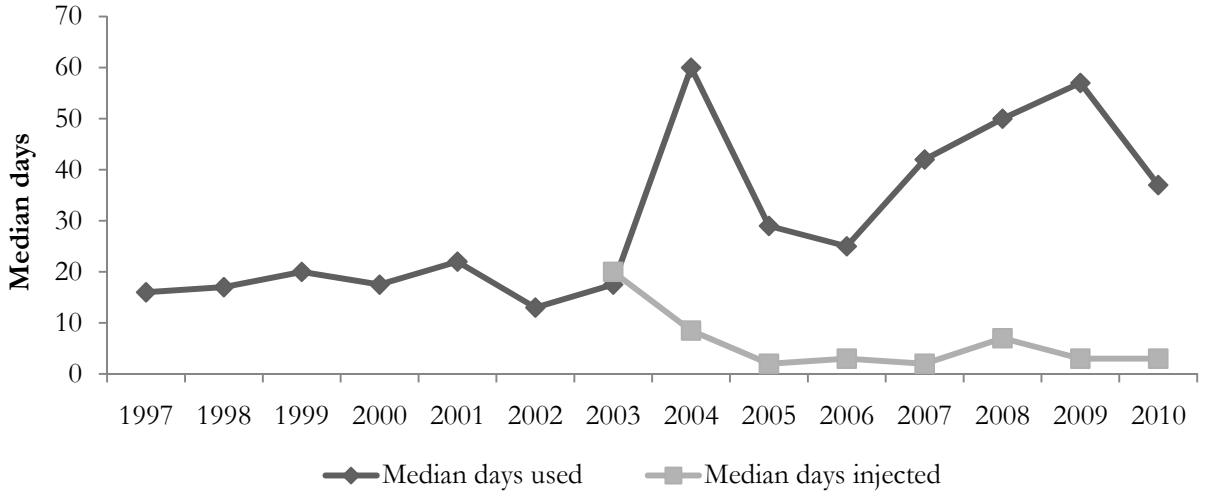
frequency of use of illicit benzodiazepines was 15 days (20 days in 2009) and the median days of use for licit use increased from 60 days to 90 days in 2010.

Figure 51: Proportion of PWID participants reporting (licit and illicit) benzodiazepine use and injection in the preceding six months, 1996-2010



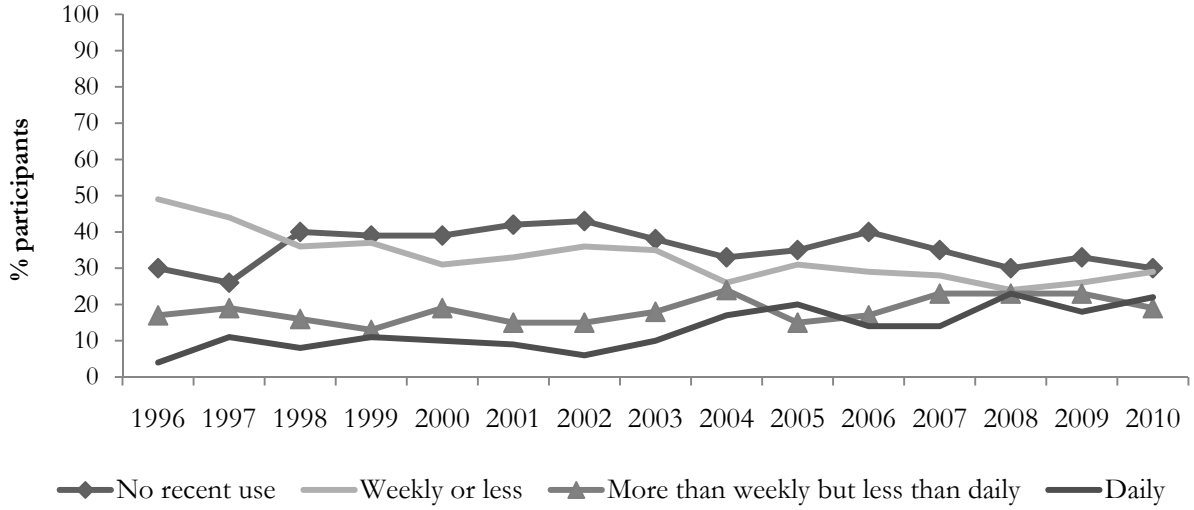
Source: IDRS PWID interviews

Figure 52: Median days use and injection of (licit and illicit) benzodiazepines in the past six months, 1997-2010



Source: IDRS PWID interviews
NB: Collection of data on the number of days injected commenced in 2003

Figure 53: Patterns of (licit and illicit) benzodiazepine use, 1996-2010



Source: IDRS PWID interviews

In 2010, the proportion of participants reporting recent use of prescribed (licit) benzodiazepines (43%) was less than those using illicitly obtained benzodiazepines (49%) (Table 3). However, when asked the form 'most used' the difference was less pronounced, with 52% reporting illicit and 48% reporting licit use (also 52% and 48% respectively in 2009). The most commonly used brand of benzodiazepine remained diazepam (including generic diazepam, Valium, Antenex), which was specified by 60% of users, followed by 27% reporting alprazolam (Xanax) and only 5% specifying oxazepam (Serepax). No participants reported temazepam as the main form used, consistent with the restriction and withdrawal of this medication over the past five years. Twenty-one percent of participants reported benzodiazepine use on the day prior to interview (18% in 2009).

5.9.1.1 Benzodiazepine injection

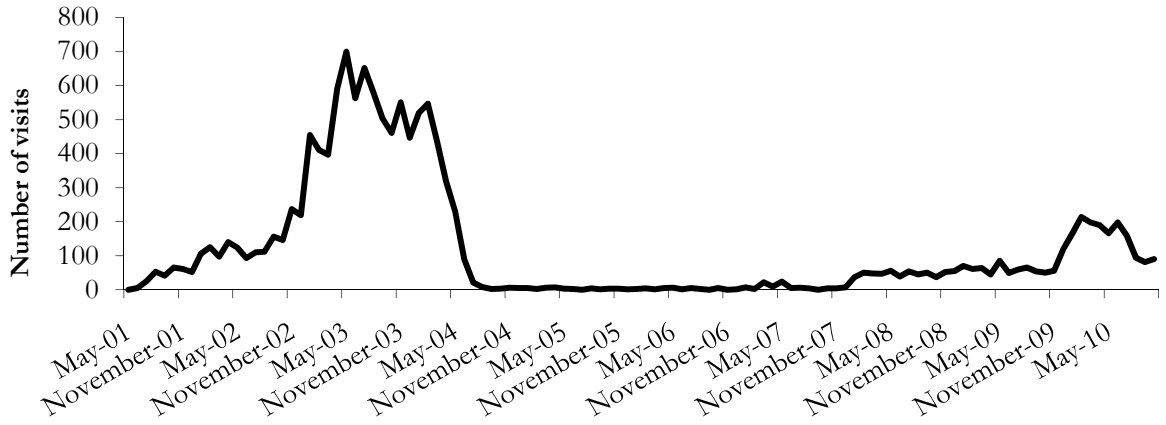
Six percent (3% in 2009) of people reported the injection of any form of benzodiazepines in the last 6 months on a median of 3 days (once every 2 months). This remained comparable with 2009 (Figure 52).

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 gelatine capsules ('gel caps') formulations were restricted on 1 May 2002, and subsequently removed completely from the pharmaceutical market at the end of March 2004. In 2010, the prevalence of benzodiazepine injection was comparable with recent years (6% in 2010, 3% in 2009, and 4% in 2008). Overall, the prevalence of benzodiazepine injection and the frequency of injection had remained stable over the past few years.

Data from the Sydney MSIC showed that the number of clients who injected benzodiazepines had increased from 1% of all attendances to 3% of all attendances in 2010. The median number of benzodiazepine injections for the 12 month period to October 2009 was 163 (range: 56-198; 3% of all injections), or 1% of all injections. This increased from the median of 57 (range: 45-85) for the same period in 2009. However, recent levels were still less than those reported from 2003 until the withdrawal of temazepam gelatine caps from the market at the end of March 2004. The most commonly injected benzodiazepines at MSIC were temazepam gelatine

capsules, and the withdrawal of these from the Australian pharmaceutical market at the end of March 2004 resulted in the dramatic decline observed[10].

Figure 54: Number of attendances to Sydney MSIC where benzodiazepines were injected, May 2001-October 2010



Source: Sydney MSIC, Kings Cross

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

5.9.2 Hallucinogens

Just under half (47%) of PWID participants reported having used hallucinogens at some stage in their lifetime but recent use remained minimal, with only 2% reporting use in the six months preceding interview (Table 3). Both the percentage reporting recent use (2%) and the median days of use (1 day) remained stable in 2010 (also 1 day in 2009; 13 days in 2008; 30 days in 2007). LSD was reported as the form most used, and in 2009 there were no recent reports of mushrooms. Six percent of the sample had injected hallucinogens at some stage in the past and no participants reported having injected them in the last six months. These figures, overall, represent stability in the use of hallucinogens when compared with 2009.

5.9.3 Ecstasy

Ecstasy use within this sample of participants in NSW remained at relatively low levels. Fourty-seven percent of participants reported use of ecstasy in their lifetime, and 9% reported having used it within the six months prior to interview. Seventeen percent of participants had reported ever injecting ecstasy, 2% reported having injected ecstasy in the six months preceding interview on a median of 3 days (see Table 3).

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

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

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').

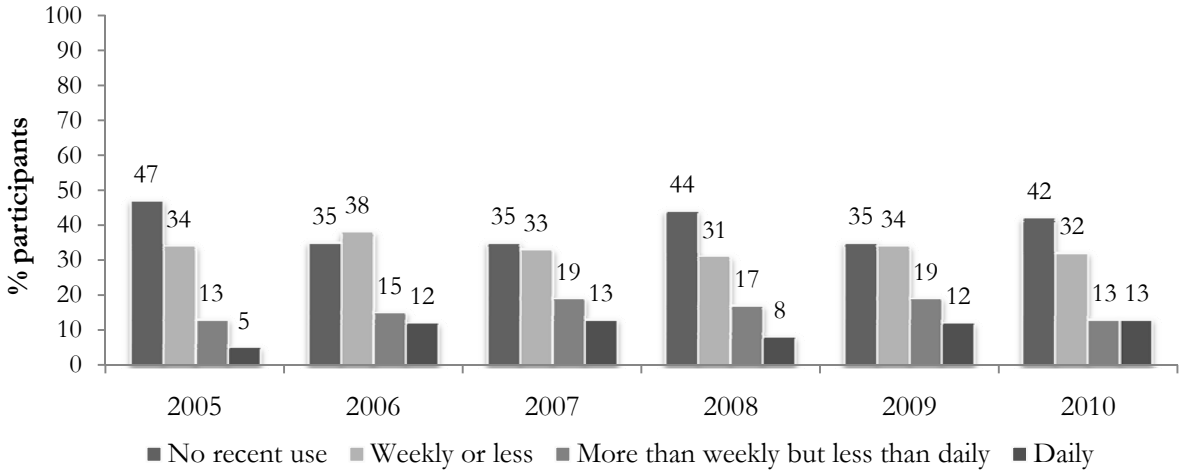
5.9.4 Inhalants

Sixteen percent of participants (21% in 2009) reported ever having inhaled volatile substances such amyl nitrite, petrol, glue and/or lighter fluid (butane) (Table 3). Recent use (1%) remained low and stable but there was an increase in the frequency of use from 3 days in 2009 to 9 days in 2010. The only two forms of inhalant reported being recently used by participants were amyl nitrite and nitrous oxide. There were no KE reports regarding use of inhalants.

5.9.5 Alcohol and tobacco

More than one-half (58%) 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). While the proportion of recent users had decreased (65% in 2009) the frequency of use remained the same compared with 2009. Twenty-two percent (13% of the entire sample) reported daily use of alcohol. These figures were generally consistent with levels reported over the last 3 years. The majority (55%; or 32% of all participants) drank weekly or less often (Figure 55). Rates of daily use (13%) were comparable with the general population aged 14 and over (9%), while rates of drinking weekly were lower than the general population (41%; Australian Institute of Health and Welfare 2005, p. 25).

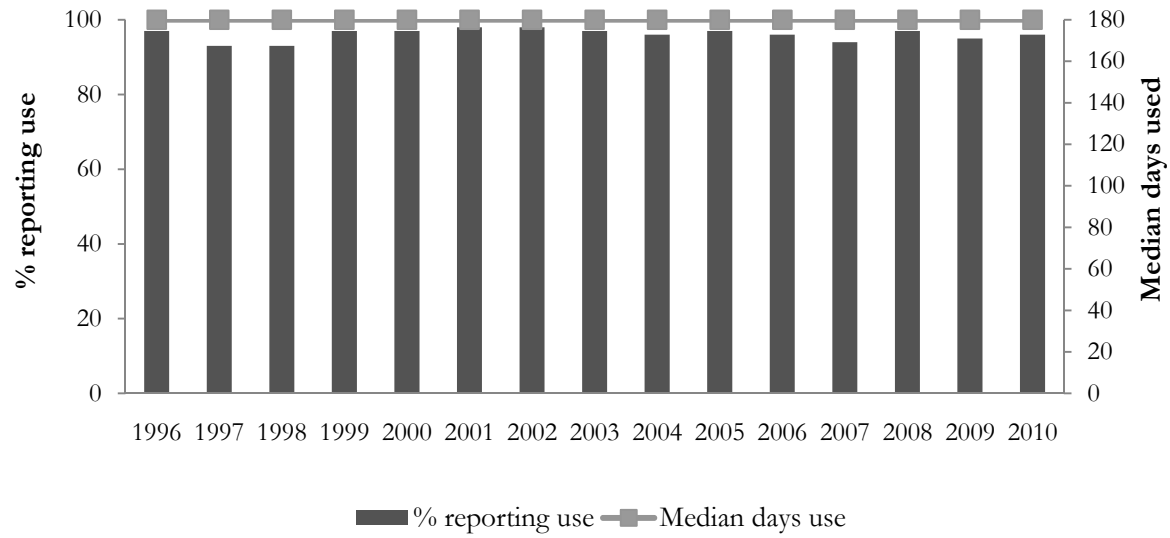
Figure 55: Patterns of alcohol use, 2005-2010



Source: IDRS PWID interviews

Tobacco remained the most commonly used substance investigated by the IDRS. The vast majority of participants (96%) reported smoking tobacco in the last six months on a median of 180 days (Table 3), i.e. daily use (range 48-180). Ninety-two percent of the sample 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 56). This figure continued to be substantially higher than among the general Australian population, 17% of whom are daily smokers (Australian Institute of Health and Welfare 2005, p.19).

Figure 56: Participant reports of tobacco use in the last six months, 1996-2010



Source: IDRS PWID interviews

5.9.6 Key expert comments

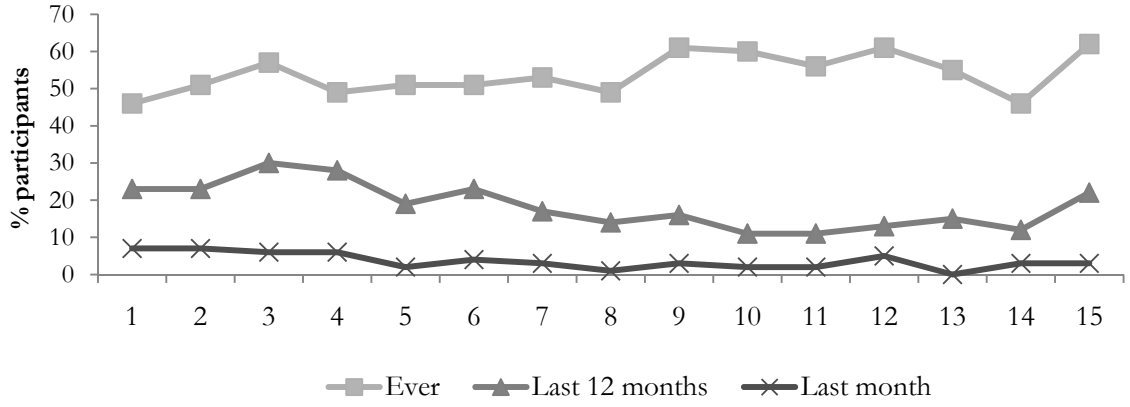
- Reflecting findings from the PWID survey KE comments suggested the use of benzodiazepines continued to be a major concern. Though injection was relatively uncommon, there continued to be a high prevalence of oral use and frequency of use continued to remain high. The associated harms of polydrug use with heroin/other opioids and benzodiazepines were noted by several KE.

6 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

6.1 Overdose and drug-related fatalities

Approximately one-fifth (22%) of participants reported overdosing on heroin in the last twelve months, and there were three reports of overdose in the last month (also 3 in 2009). There was an increase in those that reported having ever overdosed on heroin (Figure 57).

Figure 57: Proportion of PWID participants who had ever overdosed, overdosed in the past 12 months, and the past month, on heroin 1996-2010

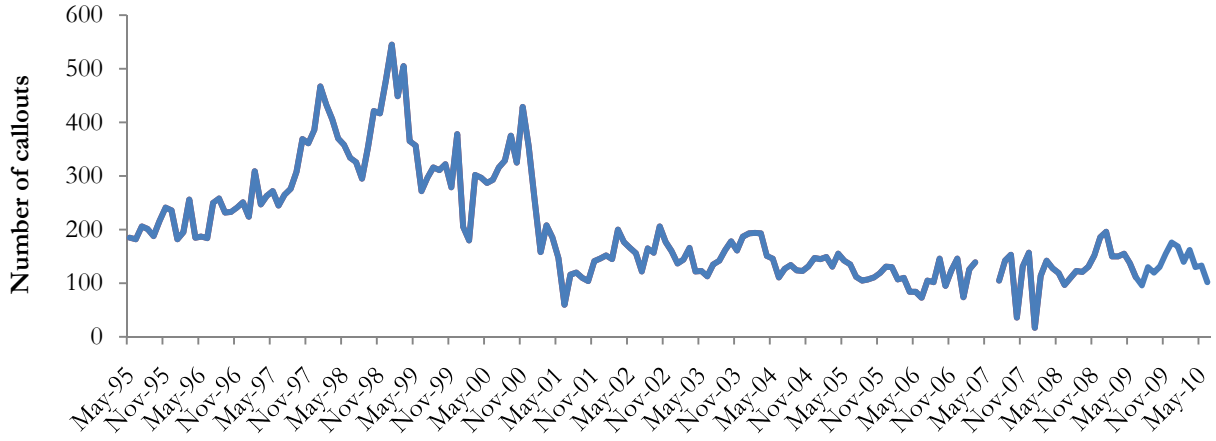


Source: IDRS PWID interviews

Sixteen percent of participants (18% in 2009) reported that they had accidentally overdosed on other drugs excluding heroin and morphine an average of once in their lifetime. Only 4% reported they had accidentally overdosed on other drugs excluding heroin and morphine in the 12 months prior to interview and no participants reported accidental overdose on other drugs in the past month.

NSW ambulance callouts to overdoses had remained stable in the 12 months to June 2010. Seasonal trends in the months of December and January continued to record the highest number of calls (176 and 169 respectively) in the period. The number of calls decreased dramatically in late 2000, and had not returned to levels recorded prior to 2000 (Figure 53). For further information on ambulance callouts to overdoses in Inner Sydney see: (National Centre in HIV Epidemiology and Clinical Research 2007)

Figure 58: Number of ambulance callouts to overdoses May 1995-June 2010

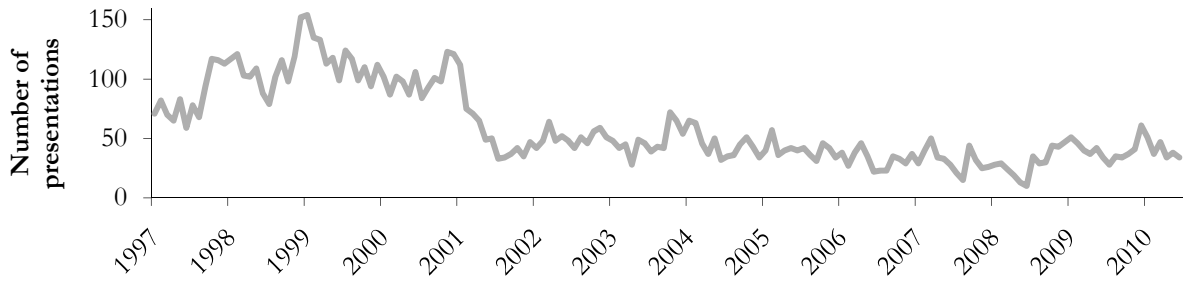


Source: Ambulance Service of NSW case sheet database

6.1.1 Heroin

Apart from a spike in December 2009 (61 presentations) heroin overdose presentations to NSW emergency departments were recorded at 50 per month or under since March 2005. Figures have remained low following a decrease in heroin overdose presentations in 2001 (Figure 59).

Figure 59: Heroin overdose presentations to NSW emergency departments, January 1997-June 2010



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

6.1.1.1 Fatal Overdose

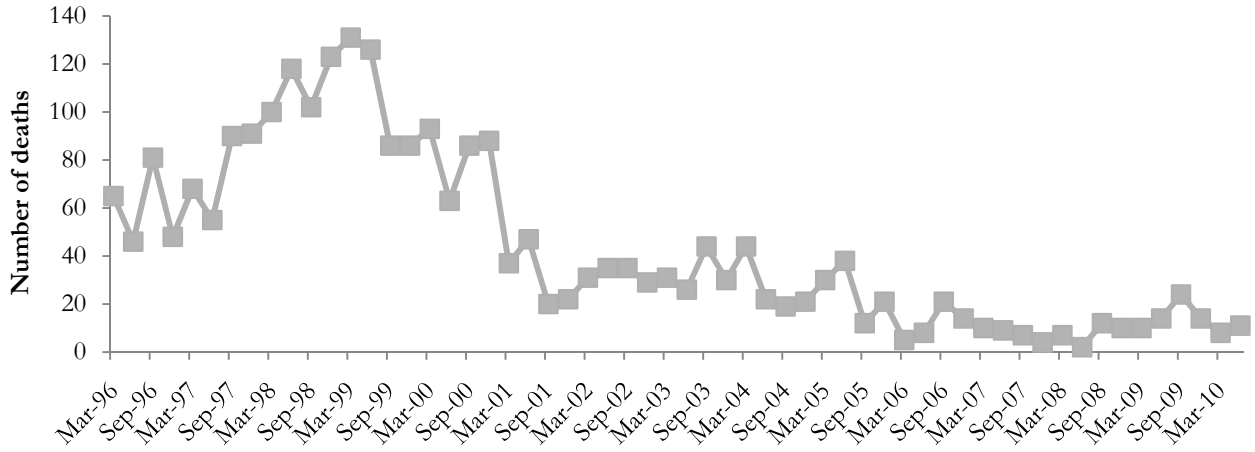
The Australian Bureau of Statistics (ABS) has changed the way it collates deaths data, making comparisons to earlier overdose bulletins published by the National Drug and Alcohol Research Centre (Degenhardt and Roxburgh 2007; Degenhardt and Roxburgh 2007) difficult. Since 2003, the ABS has progressively ceased visiting jurisdictional coronial offices to manually update causes of death that had not been loaded onto the computerised National Coronial Information System (NCIS). It was in 2006, that the ABS began to rely solely on data contained on NCIS at the time of closing the deaths data file. In addition, a number of jurisdictions, notably NSW and QLD, reported backlogs in cases that had been finalised by the coroner (i.e. cases where the coroner had determined the cause of death), but not yet loaded onto NCIS. This is likely to have an impact on the number of opioid-related deaths recorded at a national level in 2006, given that NSW and QLD recorded the highest number of opioid-related deaths in Australia during the period 2000 to 2005[11]. Accordingly, drug-related deaths have not been reported here. The following findings relate to numbers of drug-related deaths recorded **at the time of closure** of

[11] Excerpt taken from**:** Roxburgh, A. and L. Burns (in press). Drug-related hospital stays in Australia, 1993-2008. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.

the 2007 ABS deaths data file. These figures **may not be complete** due to changes in methodology**.**

During the period 2009/10, there were relatively few deaths of people suspected of drug use (as determined by police or pathologists) in which morphine was detected (Figure 60). There was, however, a spike in fatalities in September 2009 with 24 deaths reported, the highest number since mid-2005. 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 60: Number of suspected drug-related deaths in which morphine was detected post-mortem, by quarter, 1996-2010



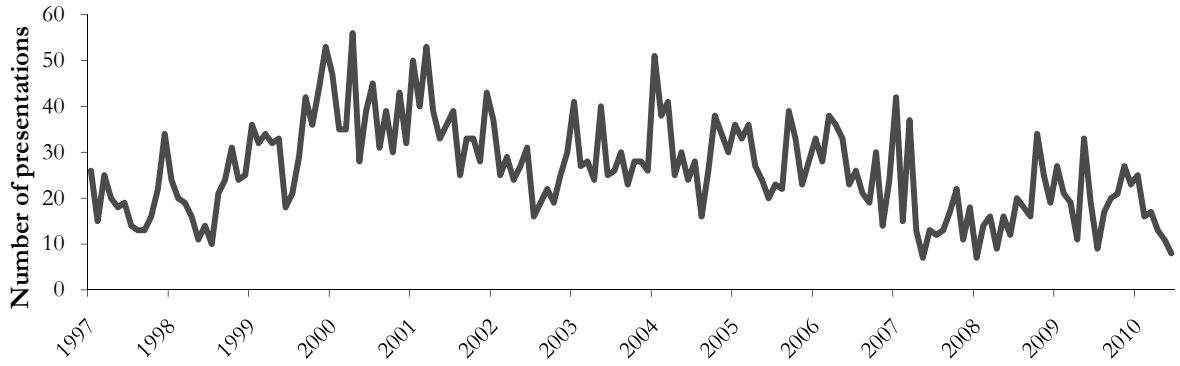
Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories
NB: These numbers relate to deaths in which morphine (a metabolite of heroin) was detected; however, there may have also been other drugs present

6.1.2 Methamphetamine

6.1.2.1 Non-fatal Overdose

The total number of amphetamine overdose presentations to NSW emergency departments fluctuated again in 2010, accounting for between 27 (November 2009) and 8 (June 2010) presentations in each month (Figure 61). The low recorded in June 2010 was comparable with the 7 presentations recorded in May 2007 the lowest recorded number of overdose amphetamine presentations in NSW since 1997.

Figure 61: Amphetamine overdose presentations to NSW emergency departments, January 1997-June 2010

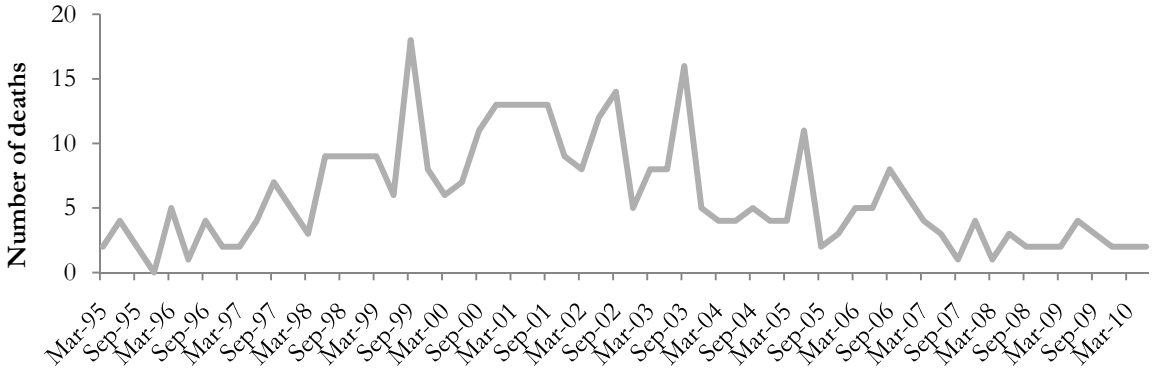


Source: Emergency Department Information System, NSW Department of Health.
NB: Figures refer to overdose only and do not include presentations for use disorders

6.1.2.2 Fatal Overdose

The number of deaths of individuals suspected of drug use where amphetamines were detected post mortem in NSW remained stable in 2009/10 but had generally declined over time (Figure 62). It is important to note that these figures do not include methylenedioxymethamphetamine, methylenedioxyamphetamine, or p-methoxyamphetamine. Pseudoephedrine and ephedrine are also excluded as only deaths related to illicit amphetamines are presented.

Figure 62: Number of deaths of individuals suspected of drug use, in which illicit amphetamines were detected post-mortem, NSW, by quarter, 1995-2010



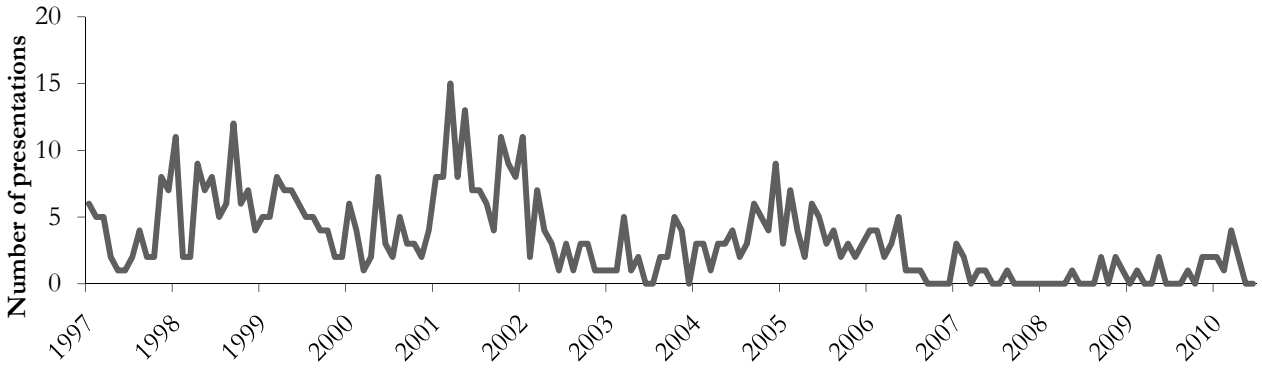
Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories
NB: These numbers relate to deaths in which amphetamines, including methamphetamine, were detected; however, there may have also been other drugs present

6.1.3 Cocaine

6.1.3.1 Non-fatal Overdose

The number of cocaine overdose presentations to NSW emergency departments has remained at less than ten per month since February 2002 (Figure 63). In the 12 months to June 2010 there were 14 recorded presentations (7 in 2009).

Figure 63: Cocaine overdose presentations to NSW emergency departments, January 1997-June 2010

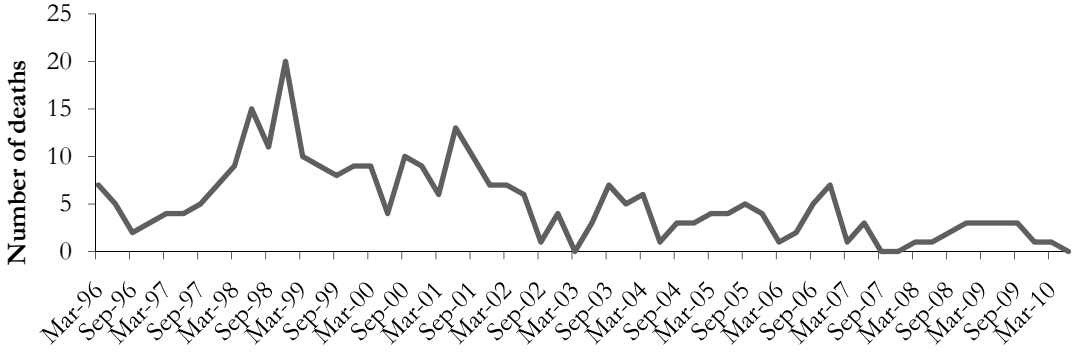


Source: Emergency Department Information System, NSW Department of Health
NB: Figures refer to overdose only and do not include presentations for use disorders

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 twelve months (Figure 64), following a peak in the late 1990s. These deaths have not exceeded 20 in any given quarter over the past 11 years and have remained less than five per quarter since 2007.

Figure 64: Number of deaths of individuals suspected of drug use, in which cocaine was detected post-mortem, NSW, by quarter, 1996-2010

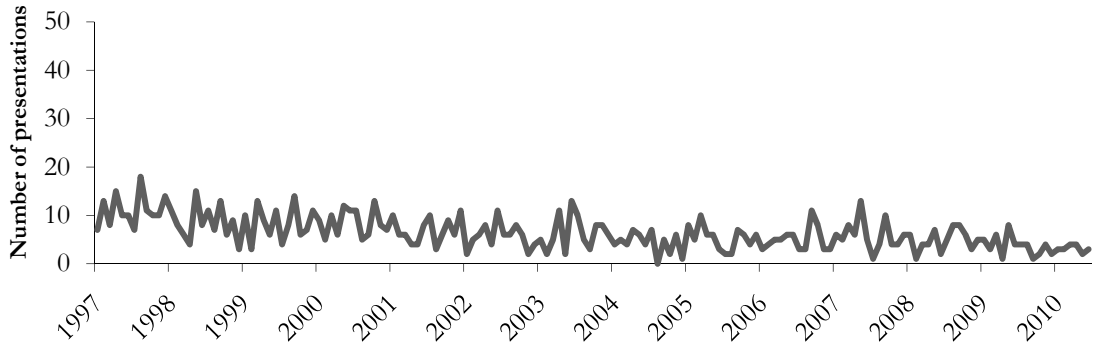


Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories
NB: These numbers relate to deaths in which cocaine was detected; however, there may have also been other drugs present

6.1.4 Cannabis

The number of cannabis toxicity presentations to emergency departments has remained at less than twenty per month since 1997 and this remained stable in 2010 (Figure 65).

Figure 65: Cannabis toxicity presentations to NSW emergency departments, January 1997-June 2010



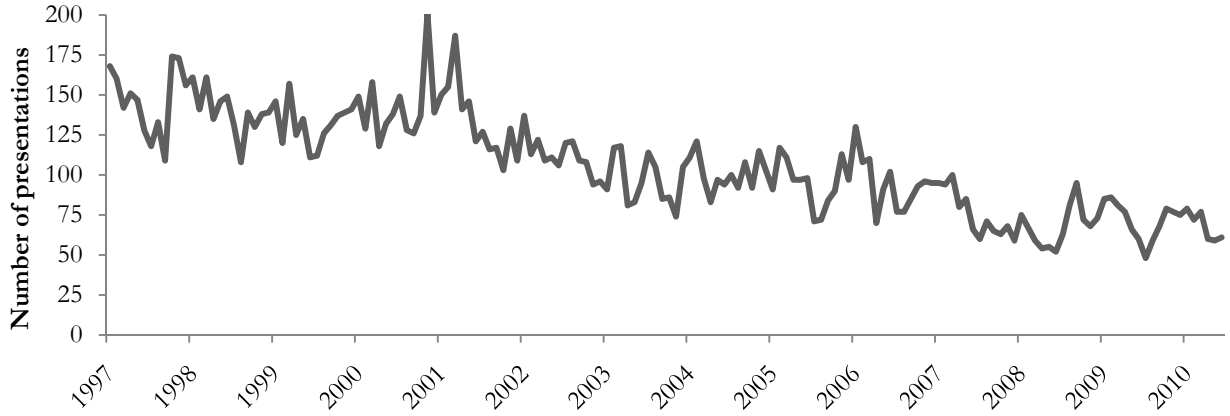
Source: Emergency Department Information System, NSW Department of Health
NB: Figures refer to overdose only and do not include presentations for use disorders

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 twelve months (range: 48 in July 2009 – 79 presentations in October 2009 (Figure 66). It is important to note, however, that the majority of overdose presentations occurred among older women and people who may have intentionally overdosed; it is likely that people who use/inject drugs form only a minority of suspected overdoses at emergency departments.

Figure 66: Benzodiazepine overdose presentations to NSW emergency departments, January 1997-June 2010

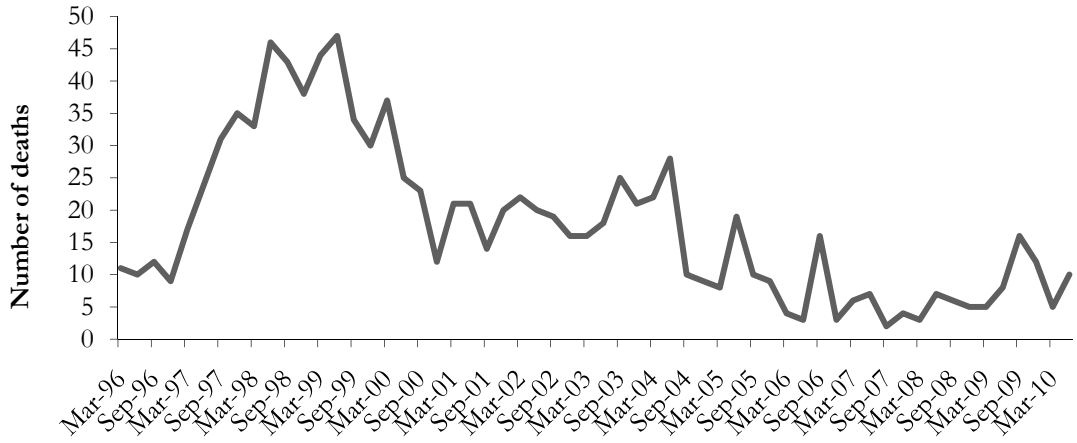


Source: Emergency Department Information System, NSW Department of Health
NB: Figures refer to overdose only and do not include presentations for use disorders

6.1.5.2 Fatal Overdose

The number of deaths of suspected people who use drugs in which benzodiazepines were detected post-mortem had fluctuated over the last 12 years (Figure 67); however, there had been a decline in numbers since early 2000. During 2009/10, figures peaked at 16 in the September 2009 quarter.

Figure 67: Number of deaths of individuals suspected of drug use, in which benzodiazepines were detected post-mortem, NSW, by quarter, 1996-2010



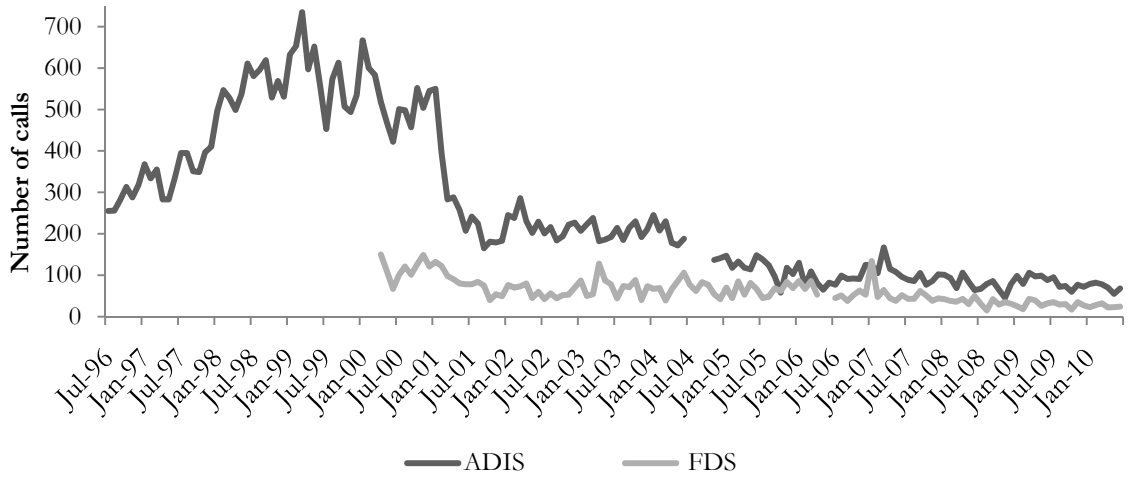
Source: Forensic Toxicology Laboratory database, Division of Analytical Laboratories
NB: These numbers relate to deaths in which benzodiazepines were detected; however, there may have also been other drugs present

6.2 Calls to telephone helplines

6.2.1 Heroin

Figure 68 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 until recently, reflecting the different sizes and target groups of these services. The number of calls to both services regarding heroin in 12 months to June 2010 remained comparable with 2009, ranging between 55-95 calls a month for ADIS and 17-35 calls a month to FDS.

Figure 68: Number of enquiries to ADIS and FDS regarding heroin, July 1996-June 2010

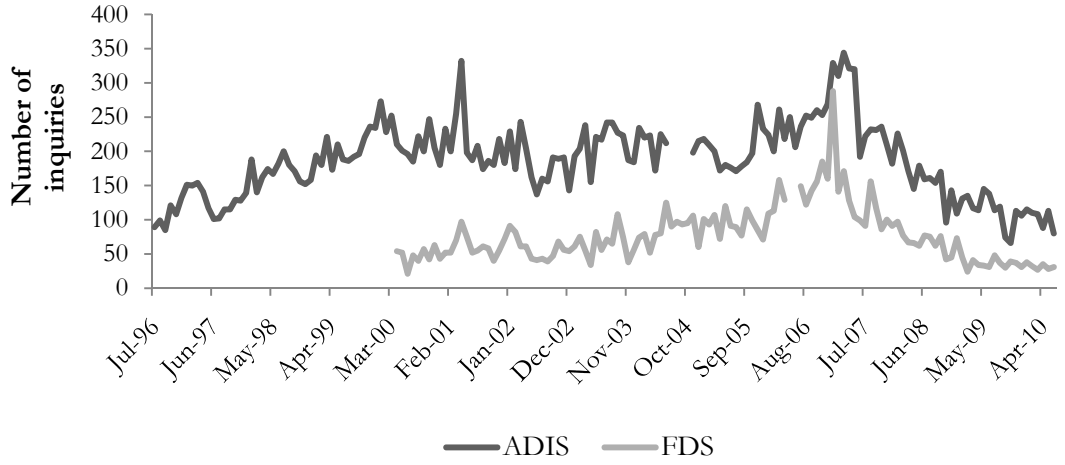


Source: ADIS and FDS
NB: FDS data were only available on a monthly basis from April 2000 and refer to calls where any mention of heroin was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where heroin was mentioned as any drug of concern. ADIS data were unavailable for the period July-October 2004 and FDS data were unavailable for the period May-June 2006

6.2.2 Methamphetamine

Figure 68 shows the number of calls to the ADIS and FDS lines regarding methamphetamines. The number of enquiries to FDS regarding amphetamines was much lower than numbers received at ADIS during the period 2000 to 2006. Calls to both services regarding methamphetamines had decreased over the past 12 months with ADIS calls dropping to a low of 66 in October 2009, the lowest number of monthly calls recorded since July 1996. A decrease was also noted in calls to FDS for amphetamines with a low of 27 calls in March 2010, the second lowest number since June 2000 (24 calls in February 2009).

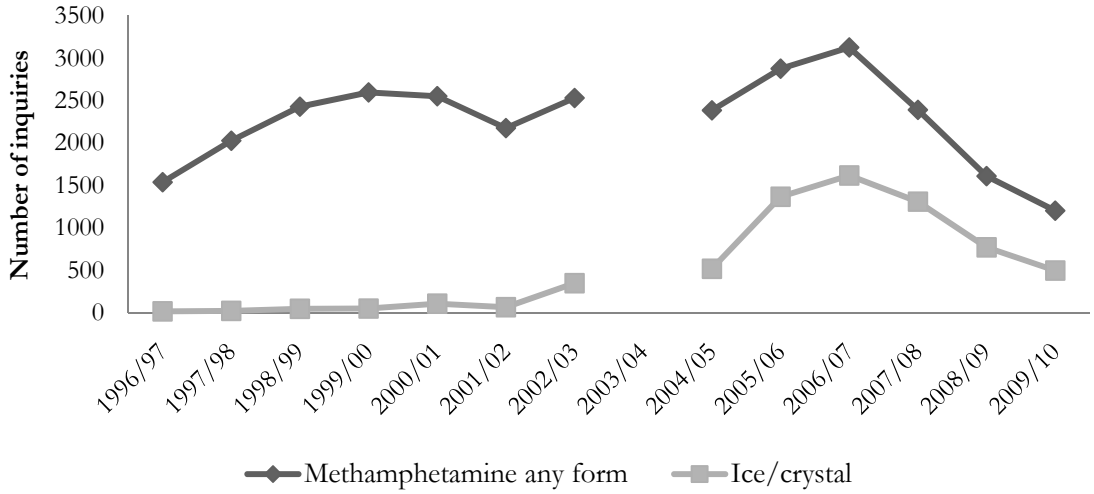
Figure 69: Number of inquiries to ADIS and FDS regarding methamphetamines including 'crystal/ice', July 1996-June 2010



Source: NSW ADIS and FDS
NB: Family Drug Support data were only available from April 2000 and 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-October 2004 and FDS data were unavailable for the period May-June 2006

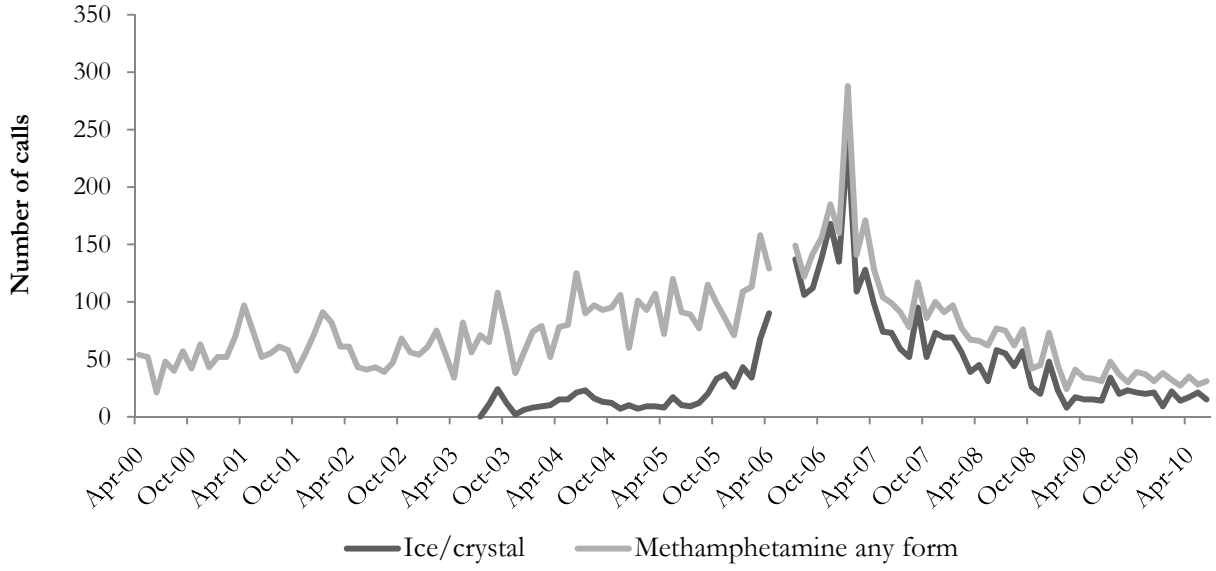
Figure 70 shows the number of calls to the ADIS lines regarding amphetamines for the period 1996/97 to 2009/10. In the 12 months to June 2010 there had been a decrease in both the number of calls regarding methamphetamines and ice/crystal. Comparatively the number of enquiries to FDS (Figure 71) regarding methamphetamines had also decreased over the past few years, with occasional fluctuations.

Figure 70: Number of enquiries to ADIS regarding methamphetamines, including 'ice/crystal', 1996/97-2008/09



Source: ADIS
NB: ADIS data refer to the number of calls where amphetamines (including ice/crystal) were mentioned as any drug of concern. Data are not shown for 2003/04 as data were unavailable for the full calendar year

Figure 71: Number of enquiries to FDS regarding amphetamines, including 'ice/crystal', April 2000-June 2010

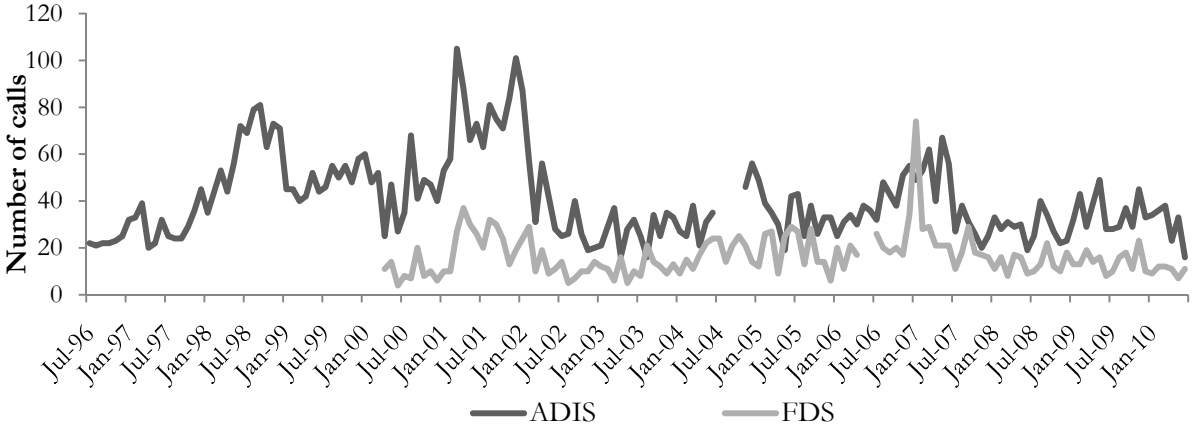


Source: FDS
NB: Data were unavailable for the period May-June 2006

6.2.3 Cocaine

Figure 72 shows the number of calls to the ADIS and FDS lines regarding cocaine. The number of calls per month to both ADIS and FDS had decreased (ADIS range: 16-45; FDS range: 7-23) over the 12 months to June 2010.

Figure 72: Number of enquiries to ADIS and FDS regarding cocaine, July 1996-June 2010



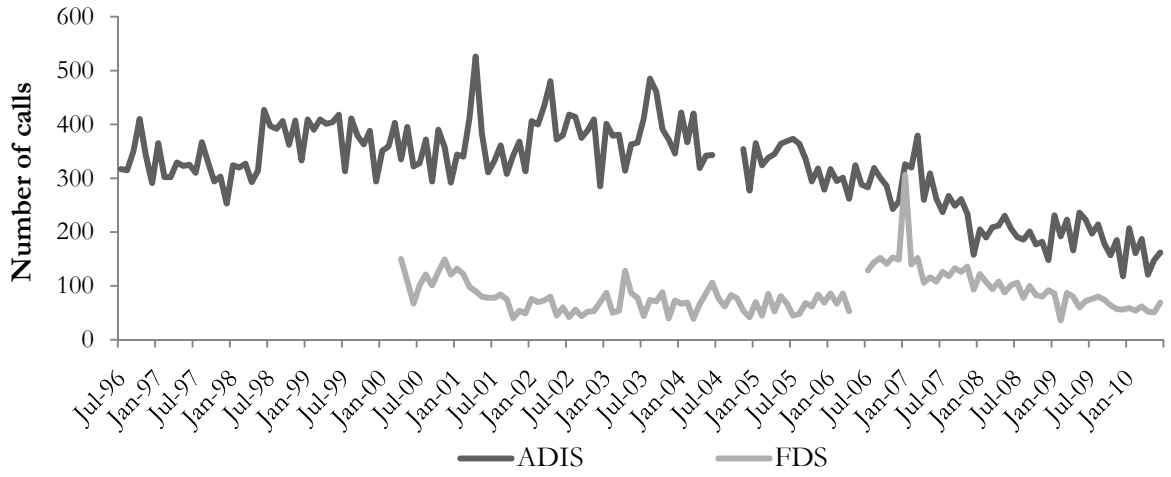
Source: NSW ADIS and FDS

NB: FDS data were only available on a monthly basis from April 2000 and refer to calls where any mention of cocaine was made. FDS is based in NSW but data may include some calls from interstate. ADIS data include calls made in NSW and the Australian Capital Territory (ACT) and refer to the number of calls where cocaine was mentioned as any drug of concern. ADIS data were unavailable for the period July to October 2004 and FDS data were unavailable for the period May-June 2006

6.2.4 Cannabis

The number of calls to ADIS regarding cannabis decreased again in 2009/10, with a range between 118-214 calls per month and a median number of 170 for the 12 month period (2008/09: range 166-236, median 191). The number of calls to FDS relating to cannabis appeared to have also decreased in the past year ranging between 51-80 calls per month for the 12 months to June 2010 (Figure 73).

Figure 73: Number of enquiries to ADIS and FDS regarding cannabis, July 1996-June 2010



Source: ADIS and FDS

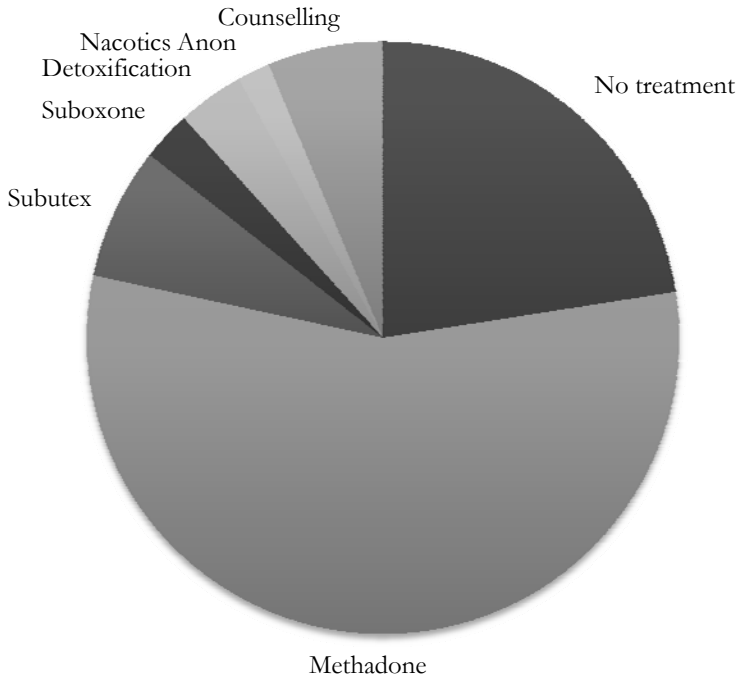
NB: FDS data were only available on a monthly basis from April 2000 and refer to calls where any mention of cannabis was made. FDS is based in NSW but data may include some calls from interstate. ADIS data refer to the number of calls where cannabis was mentioned as any drug of concern. ADIS data were unavailable for the period July-October 2004, July 2009-June 2010 and FDS data were unavailable for the period May-June 2006.

6.3 Drug Treatment

6.3.1 Forms of treatment

The majority (68%) of all PWID participants were in some form of treatment at the time of interview. Of those currently in drug treatment 67% reported being currently in a form of OST, with the majority (85%, 57% of all participants) of those currently on OST receiving methadone and smaller amounts receiving buprenorphine (9%; 6% of entire sample) or buprenorphine-naloxone (Suboxone) (3%; 2% of entire sample). Three-quarters (75%) of all participants had been in some form of treatment in the past six months Of these, 82% (62% on entire sample) had been on MMT, with a further 11% (8% of entire sample) on buprenorphine, 9% (7% of entire sample) receiving counselling. Other treatments accessed over the past 6 months by participants were detoxification treatment (5%; 4% of entire sample), buprenorphine-naloxone (4%; 3% of entire sample) and NA (3%; 2% of entire sample). There were no recent reports of treatment at therapeutic communities or with naltrexone (Figure 74).

Figure 74: Proportion of participants reporting any form of drug treatment in last 6 months, 2010

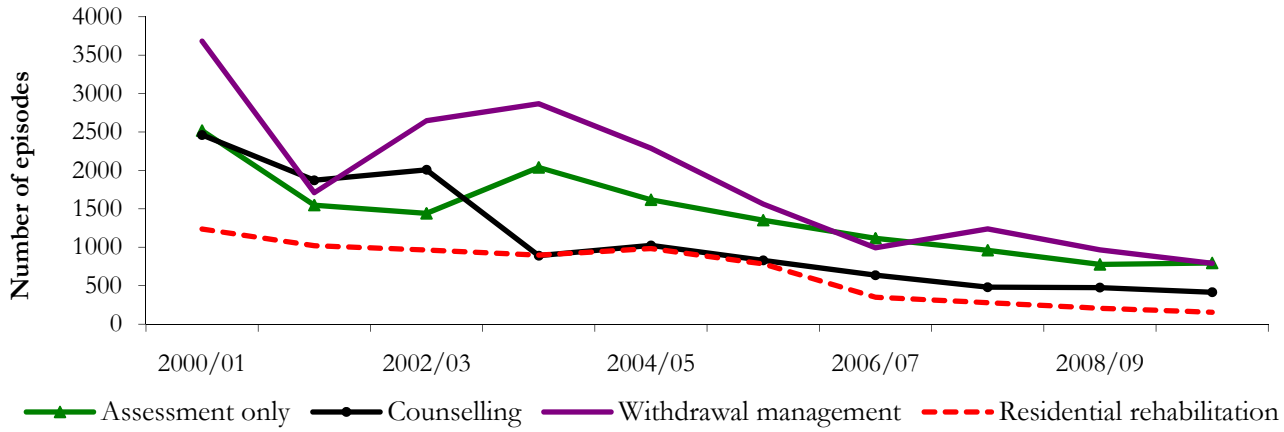


Source: IDRS PWID interviews
NB: More than one form of treatment could be nominated

6.3.2 Heroin treatment

Figure 75 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 six years. Numbers entering residential rehabilitation have also gradually declined from 1,237 in 2000/2001 to 155 in 2009/2010. Numbers entering counselling continued to decline, and have remained lower over the past five years than previously. It is important to interpret this data with caution as this is based on closed episodes and episodes maybe excluded if not completed in the period.

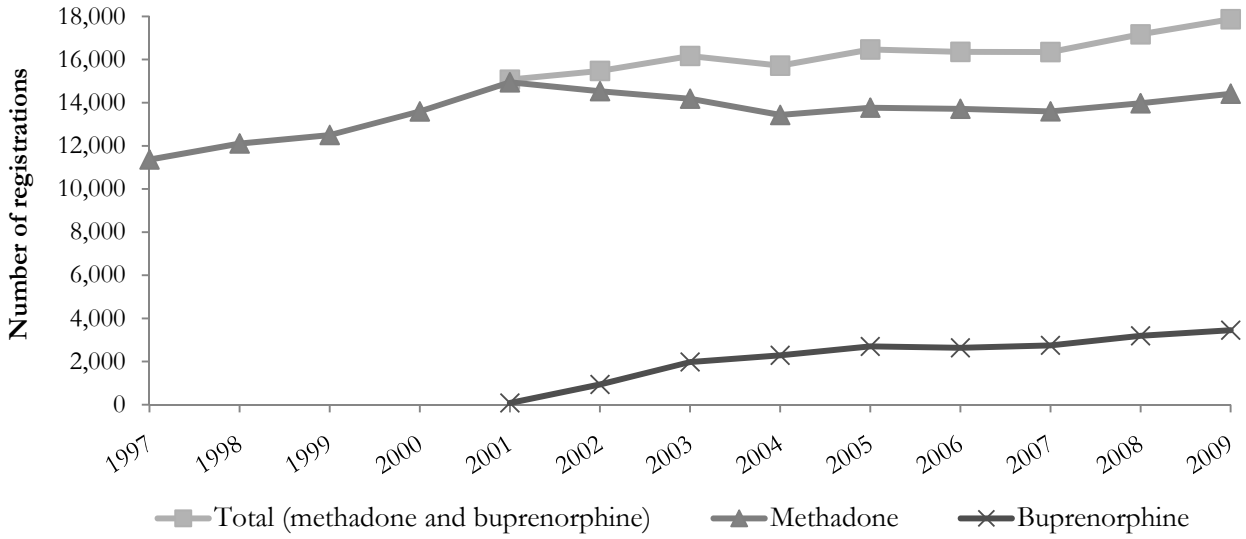
Figure 75: Number of heroin treatment episodes by treatment type, NSW 2000/01-2009/10



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 76 shows that the number of people receiving all forms opioid substitution treatment in NSW increased from 11,365 on the 30th June 1997 to 17,868 on the 30th June 2009. Overall, in 12 months to the end of June 2009 there was a slight increase in the total numbers registered. 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 2009 thirty-three percent of Australia's 2,157 pharmacotherapy sites were located in NSW and were dosing 17,768 clients. The vast majority of sites (572) were pharmacies, with smaller amounts of public clinics (37), private clinics (12) or correctional settings (1). Fifty-five percent of opioid pharmacotherapy clients obtained their treatment through a private provider, 31% received it through a public prescriber, 11% were in correctional facilities and 3% obtained their treatment through a public/private prescriber (i.e. a prescriber in a private clinic which receives some public funding). Data for 2010 was not available at the time of publication (Australian Institute of Health and Welfare 2010)

Figure 76: Number of registrations for opioid substitution treatment on the 30th June each year, NSW, 1997-2009



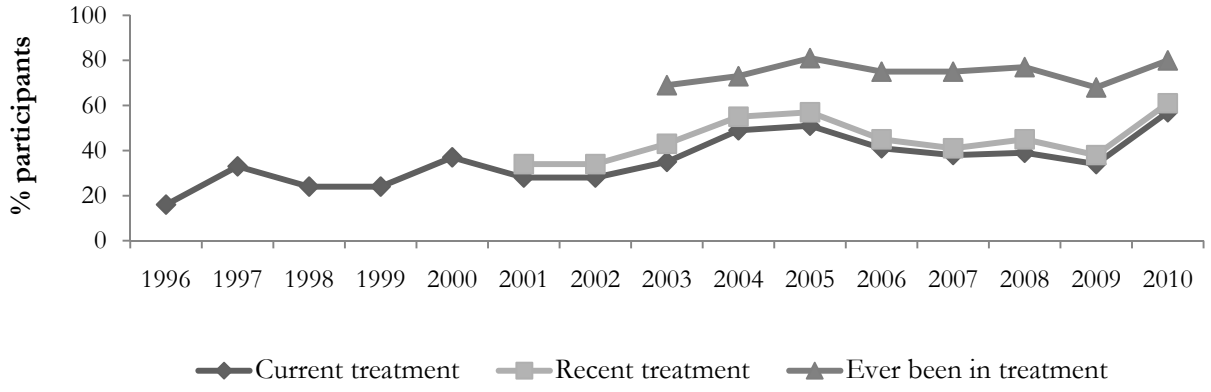
Source: (Australian Institute of Health and Welfare 2010)
NB: Buprenorphine pharmacotherapy was introduced in NSW in 2000. Data for 2010 were unavailable at the time of publication. In NSW, unlike all other jurisdictions, clients prescribed buprenorphine/naloxone (Suboxone) are counted under buprenorphine.

6.3.3 Methadone treatment

A distinction was made between the use of prescribed (licit; where the prescription was in the participant's name) and non-prescribed (illicit; 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.

Sixty-one percent of participants had used methadone that had been prescribed for them in the preceding six months (38% reported any use of licit methadone during this period in 2009), and 12% reported injecting prescribed methadone during this time. No 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 program, from 16% in 1996 to 51% in 2005, decreasing in 2009 and increasing again in 2010. This may be partially attributable to efforts made to recruit fewer clients in OST in the most recent years of the IDRS (Figure 77). The majority (61%) of PWID reported receiving methadone treatment at some point in the preceding six months (compared to 38% in 2009). As in previous years, methadone syrup was the predominant form used (as opposed to Physeptone).

Figure 77: Proportion of participants reporting methadone treatment, 1996-2010



Source: IDRS PWID interviews

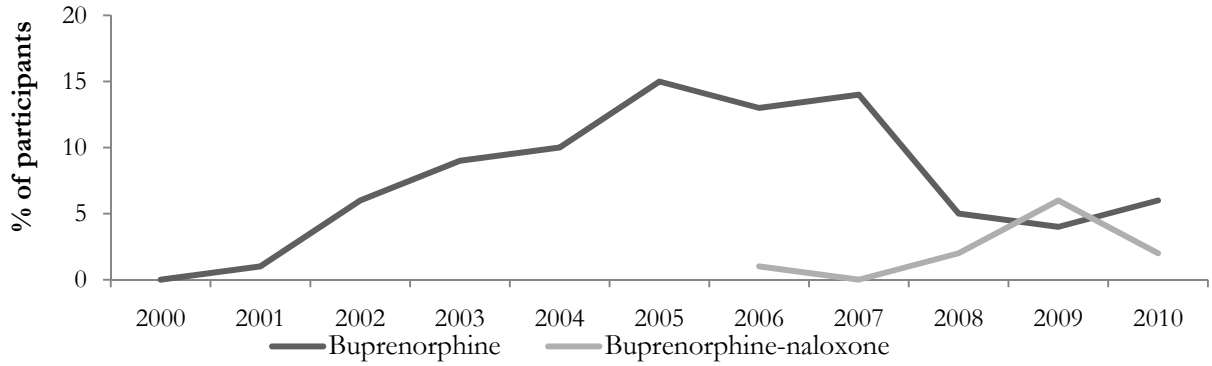
Amongst those who had been on a methadone program in the six months preceding interview, the median number of days of use in the preceding six months was 180 days, i.e. daily use (the same as 2009). Fifty-seven percent of methadone users reported daily use, a slight decrease compared to 2009 (68%). It 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 2009 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.

Approximately one-quarter (28%) percent of the sample reported ever having been prescribed buprenorphine (Subutex) which is a decrease from the 36% reported in 2009. Eleven percent of participants reported using it in the preceding six months which is stable with the 9% reported in 2009. Six percent stated they were currently participating in buprenorphine treatment (4% in 2009) (Figure 78). Among those who used licit buprenorphine, the median number of days of use in the last six months was 96 days (i.e. approximately every 2nd day), representing an increase from the 30 days reported in 2009. Among those who had used it, only one participant reported that they had used daily. When used as a maintenance treatment, buprenorphine can be dosed daily or every two days. The median days in treatment increased to 64 days (i.e. approximately thrice weekly in 2009 (52 in 2008). Please note that buprenorphine may also be prescribed during opioid detoxification.

Figure 78: Proportion of participants reporting current buprenorphine treatment, 2000-2010



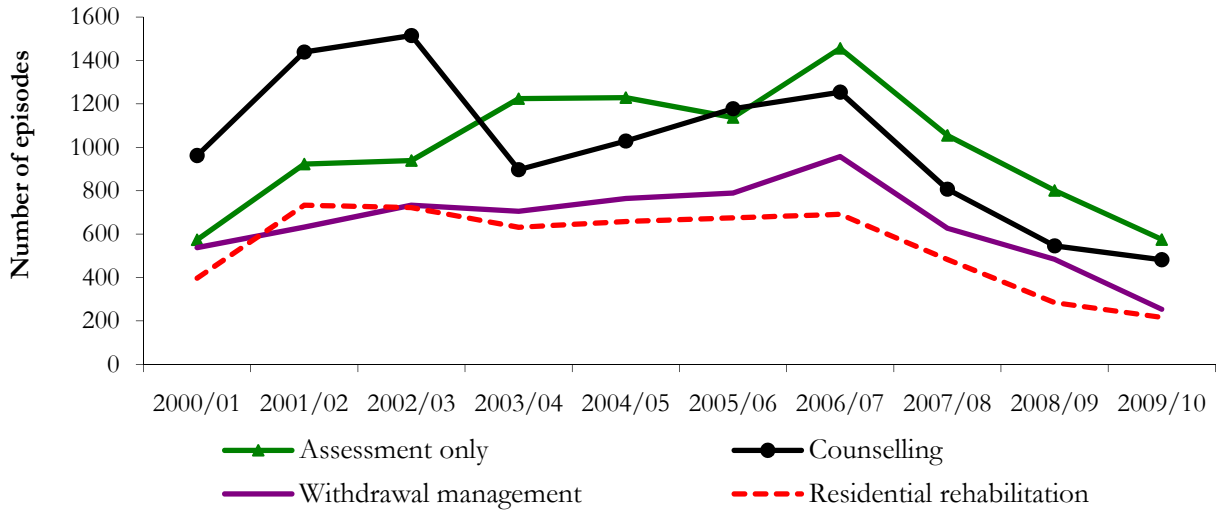
Source: IDRS PWID interviews
NB: Buprenorphine-naloxone (Suboxone) item first included in 2006

Ten percent of participants reported ever being prescribed buprenorphine-naloxone (Suboxone) with 5% reporting a prescription in the last 6 months. Two percent of participants had a prescription at the time of interview. The median number of days of use in the last six months was 64 (i.e. thrice weekly) (90 days in 2009) while the median number of days in treatment were 64 (approximately thrice weekly). Only one participant reported injecting prescribed Suboxone, in the preceding six months on a median of 1 day.

6.3.5 Methamphetamine treatment

The number of closed treatment episodes, based on the date of commencement where the principal drug of concern was amphetamines, decreased slightly over the past twelve months for all four of the main forms of treatment (Figure 79). It is important to interpret this data with caution as this is based on closed episodes and episodes maybe excluded if not completed in the period. Prior to 2006/07, there was a steady increase in numbers receiving 'assessment only' and 'withdrawal management'. There was a steady increase in 'counselling', after a marked decline in 2003/2004. The numbers engaged in 'residential rehabilitation' have remained relatively stable since 2002/2003 until a slight decline was recorded in the last 3 years, as noted above this decline should be interpreted with caution.

Figure 79: Number of amphetamine treatment episodes by treatment type, NSW 2000/01-2009/10

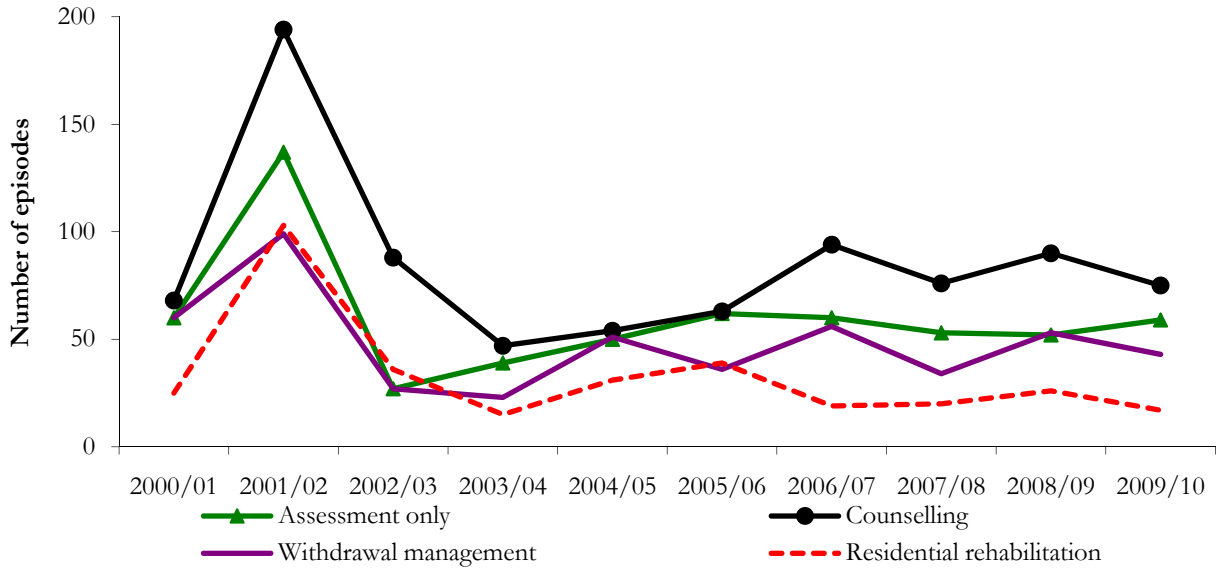


Source: NSW MDS AODTS, NSW Department of Health
NB: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement.

6.3.6 Cocaine treatment

The number of closed treatment episodes based on the date of commencement where the principal drug of concern was cocaine has remained at less than 100 per treatment type since 2002/03. A peak in treatment episodes occurred across all four main treatment types: assessment only; counselling; withdrawal management; and residential rehabilitation in 2001/02 (Figure 80).

Figure 80: Number of cocaine treatment episodes by treatment type, NSW, 2000/01-2009/10

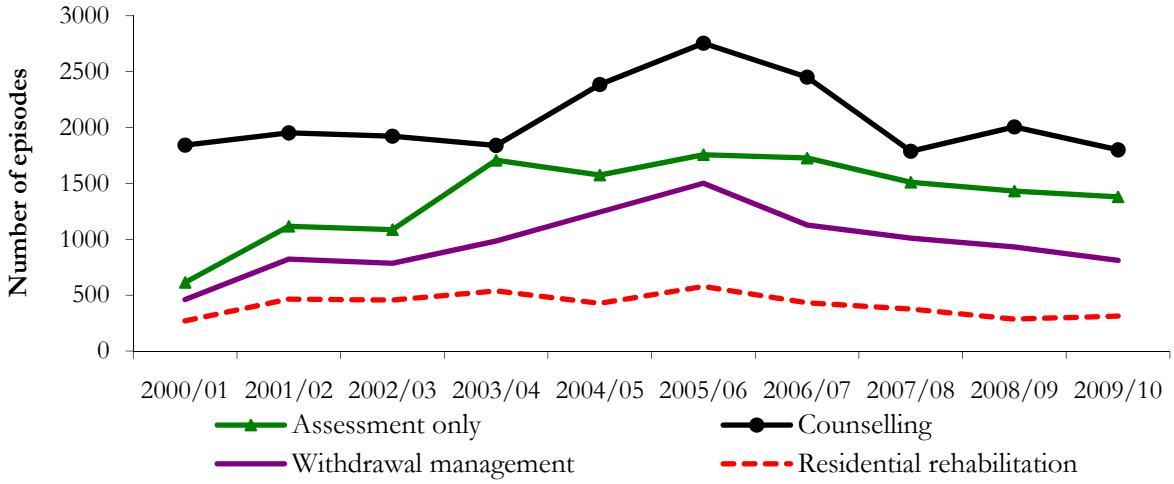


Source: NSW MDS AODTS, NSW Department of Health
NB: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement

6.3.7 Cannabis treatment

Figure 81 shows the number of closed treatment episodes based on the date of commencement where the principal drug of concern was cannabis, by treatment type. Numbers entering for 'assessment only' have declined gradually over the past few years. A decrease in the numbers entering 'counselling' has been noted since the peak in 2005/2006 (2,755 episodes). Similarly, numbers entering 'withdrawal management' have increased since 2000/2001, peaking in 2005/2006 (1,502 episodes) and subsequently decreased slightly in the past 4 years. As noted above it is important to interpret this data with caution as this is based on closed episodes and episodes may be excluded if not completed in the period. Numbers commencing 'residential rehabilitation' have remained relatively stable since 2001/2002 at 400 or more per year (this figure was 270 in 2000/2001), peaking in 2005/06, gradually declining since to stabilise again in 2009/10 (Figure 81).

Figure 81: Number of cannabis treatment episodes by treatment type, NSW, 2000/01-2009/10



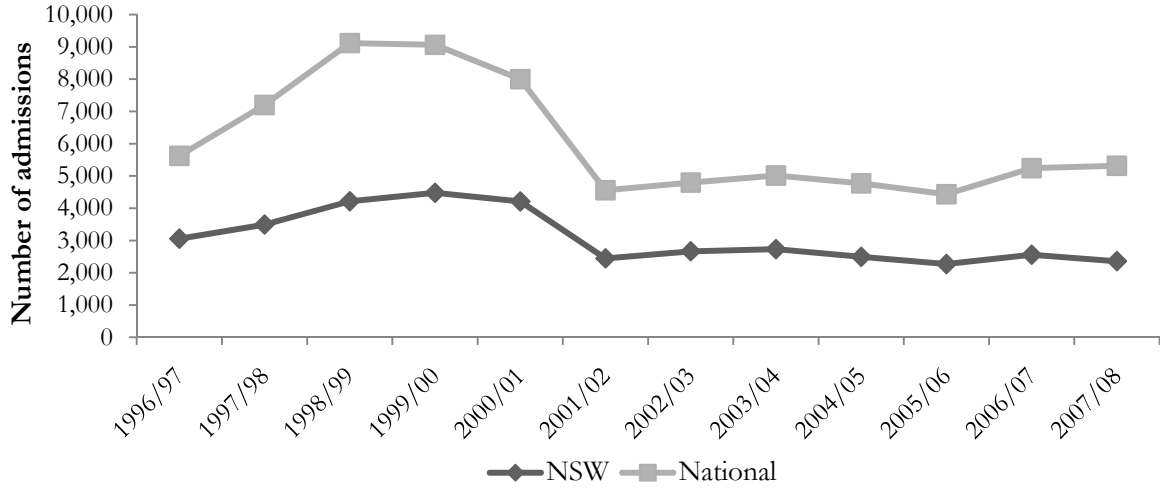
Source: NSW MDS AODTS, NSW Department of Health
NB: The NSW MDS is based on closed treatment episodes and so some episodes may be excluded if they did not finish in the given period. Numbers are based on the date of commencement.

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 82. 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 low and relatively stable.

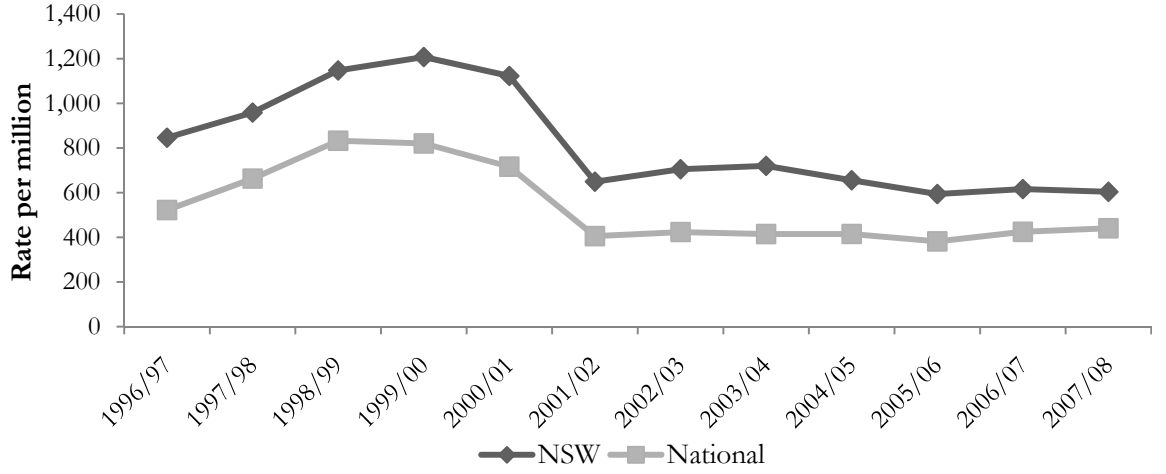
Figure 82: Number of principal opioid-related hospital admissions among people aged 15-54, NSW and Australia, 1996/97-2007/08



Source: National hospital morbidity database (NHMD), AIHW, ACT, TAS, NT, QLD, SA, NSW, VIC, and WA Health Departments and (Roxburgh and Burns in press)

Figure 83 shows the number per million persons aged 15-54 years of opioid-related hospital admissions**.** Numbers have remained relatively stable over the past twelve months, following a slight increase between 2001/02 and 2003/04 in NSW. New South Wales 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 continued to account for approximately half of all opioid-related hospital admissions in Australia.

Figure 83: Number per million persons of principal opioid-related hospital admissions among people aged 15-54 years, NSW and nationally, 1996/97-2007/08



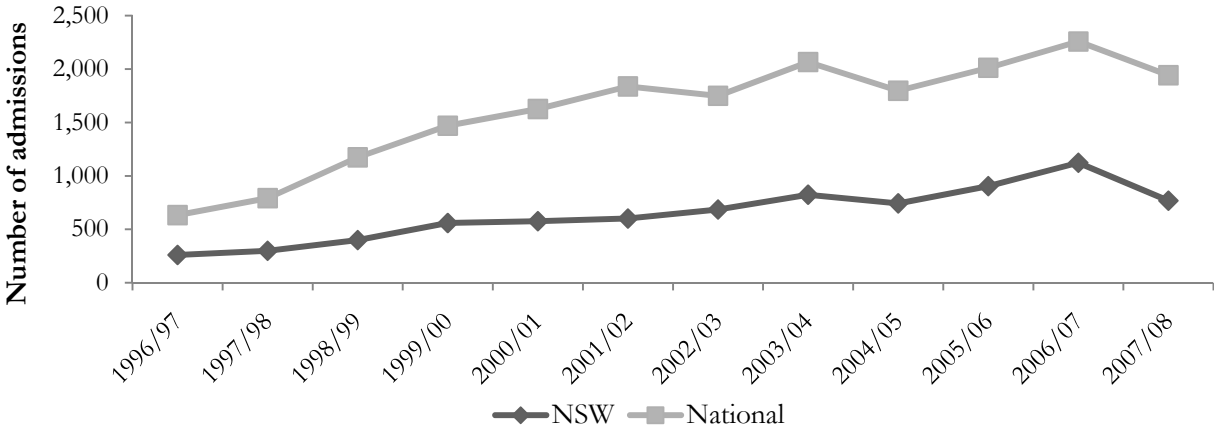
Source: NHMD, AIHW, ACT, TAS, NT, QLD, SA, NSW, VIC and WA Health Departments and (Roxburgh and Burns in press)

6.4.2 Methamphetamine

6.4.2.1 Hospital admissions

The number of inpatient hospital admissions among persons aged 15-54 years in which the principal diagnosis was amphetamine-related is shown in Figure 84. Despite minor fluctuations figures have steadily increased across time, both in NSW and nationally. In 2007/08, the most recent data available at the time of publication, the NSW (768) and the national figures (1,943) both decreased.

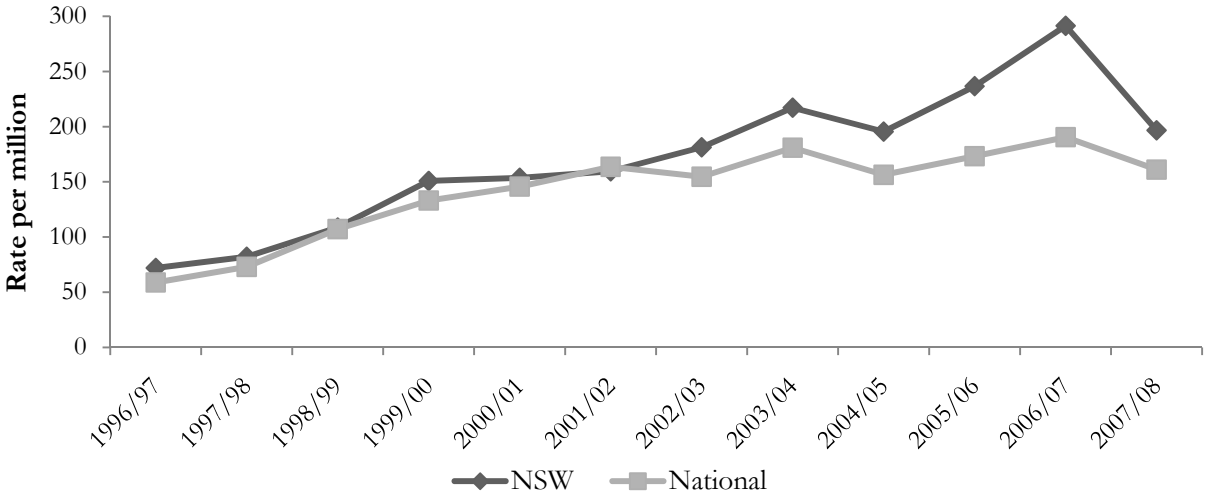
Figure 84: Number of principal amphetamine-related hospital admissions among persons aged 15-54, NSW and nationally, 1996/97-2007/08



Source: NHMD, AIHW, ACT, TAS, NT, QLD, SA, NSW, VIC and WA Health Departments and (Roxburgh and Burns in press)

Figure 85 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 time; however, in 2007/08 there was a decrease in both NSW and National admissions. Both NSW and National figures in 2007/08 dropped from record highs in 2006/07 to admissions comparable with 2004/05.

Figure 85: Number per million persons of principal amphetamine-related hospital admissions among people aged 15-54 years, NSW and nationally, 1996/97-2007/08

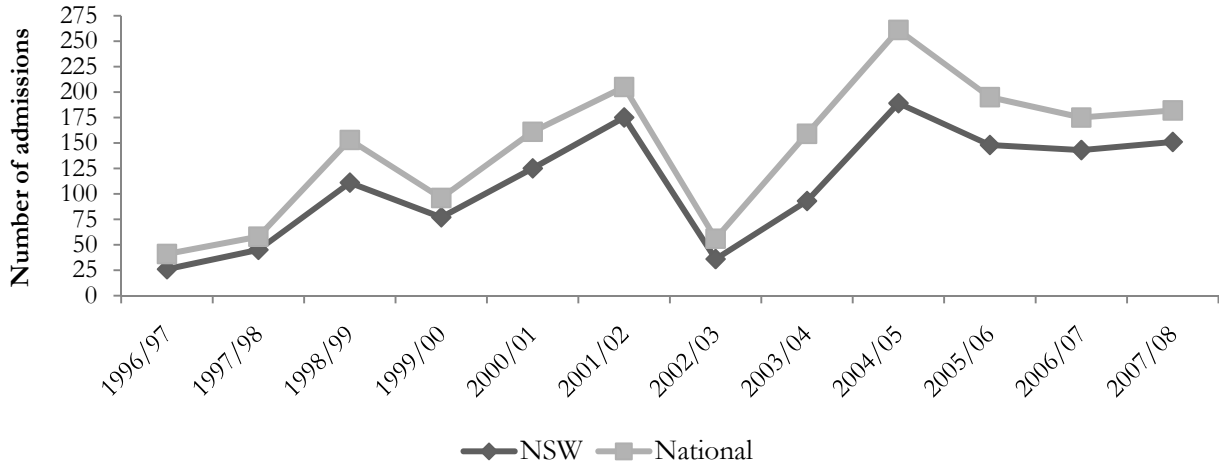


Source: NHMD, AIHW, ACT, TAS, NT, QLD, SA, NSW, VIC and WA Health Departments and (Roxburgh and Burns in press)

6.4.3 Cocaine

The numbers of inpatient hospital separations in which the principal diagnosis was cocaine-related are shown in Figure 86. Figures increased both in NSW and nationally from 2002/2003 to 2004/2005; however, these figures have decreased from 2004/2005 to 2006/07 and for the last year (2007/08) they have remained stable.

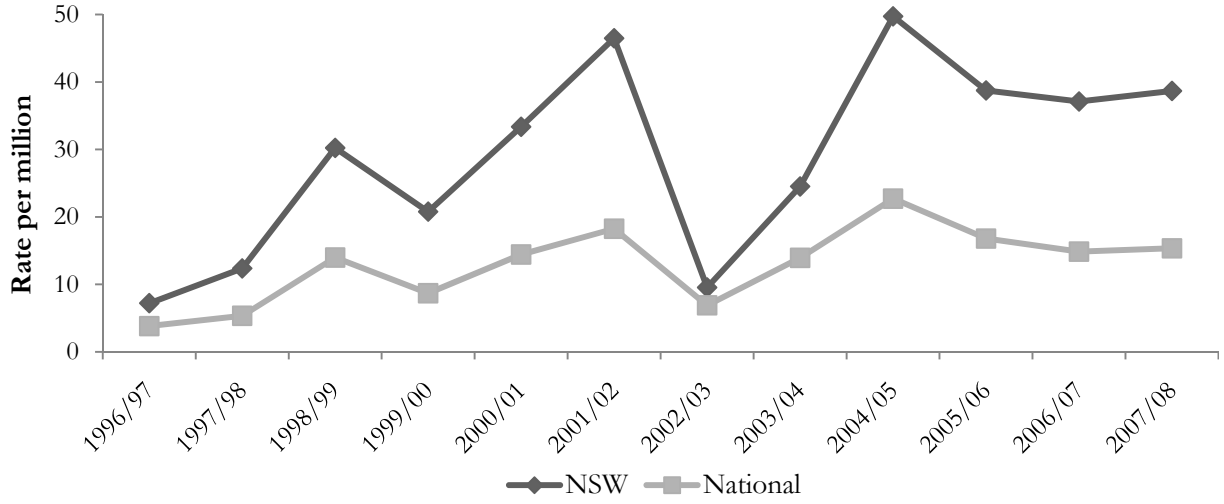
Figure 86: Number of principal cocaine-related hospital admissions among persons aged 15-54, NSW and nationally, 1996/97-2007/08



Source: NHMD, AIHW, ACT, TAS, NT, QLD, SA, NSW, VIC and WA Health Departments and (Roxburgh and Burns in press)

The number per million persons of cocaine-related hospital admissions are shown in Figure 87. Numbers in NSW have fluctuated across time; numbers peaked in 2001/02, decreased quite markedly between 2001/02 and 2002/03, and increased again to the highest recorded within the study period in 2004/05 (49.73 in NSW and 22.71 nationally). A decrease was observed in 2005/06 and figures have remained relatively stable in the 2 years to 2007/08, both nationally and in NSW.

Figure 87: Number per million persons of principal cocaine-related hospital admissions among people aged 15-54 years, NSW and nationally, 1996/97-2007/08

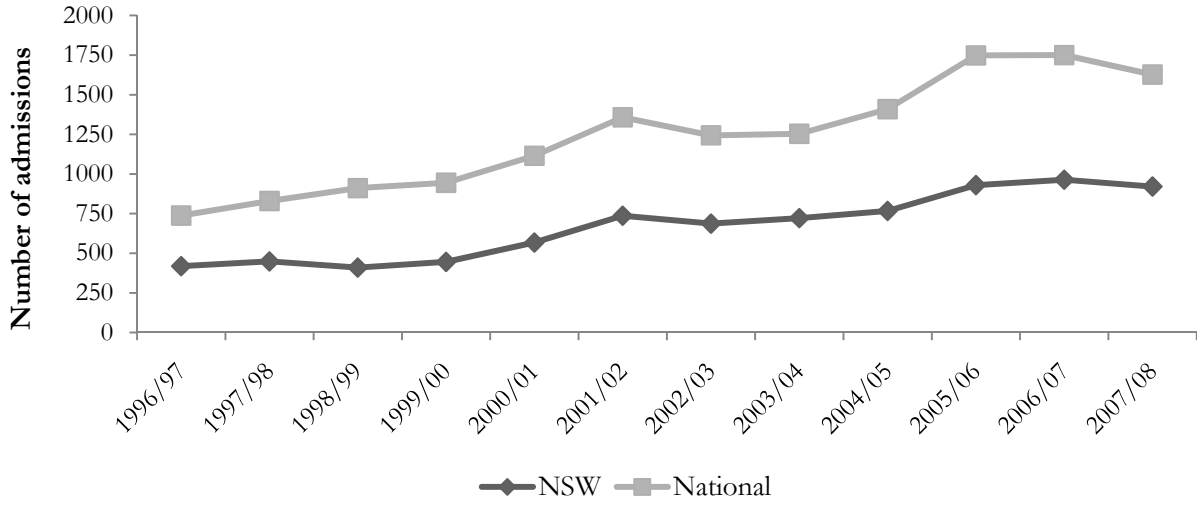


Source: NHMD, AIHW, ACT, TAS, NT, QLD, SA, NSW, VIC and WA Health Departments and (Roxburgh and Burns in press)

6.4.4 Cannabis

The number of hospital admissions in which the principal diagnosis was cannabis-related is shown in Figure 88. Across time, figures have gradually increased both in NSW and nationally. Figures observed in NSW in 2007/08 remained relatively stable, with national figures, dropping slightly from those recorded in 2006/07, the highest observed in the study period.

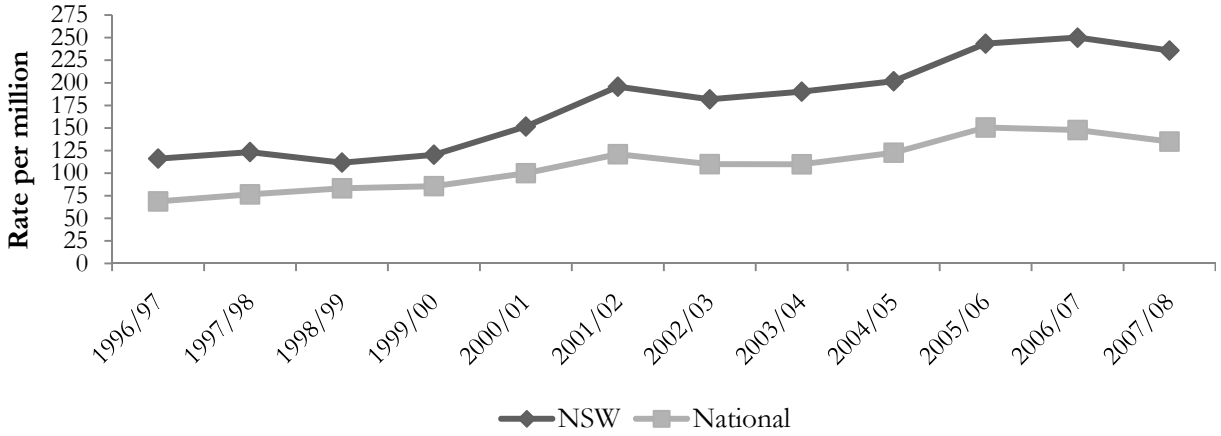
Figure 88: Number of principal cannabis-related hospital admissions among persons aged 15-54, NSW and nationally, 1996/97-2007/08



Source: NHMD, AIHW, ACT, TAS, NT, QLD, SA, NSW, VIC and WA Health Departments and (Roxburgh and Burns in press)

Figure 89 shows the number per million persons of cannabis-related hospital admissions among people aged 15-54 years. Both nationally and in NSW, numbers increased during 1996/97 and 2001/02, and remained relatively stable during 2001/02 and 2002/03. Since this time, numbers have increased. In the twelve months of 2007/08, admissions decreased slightly in both NSW and nationally from the highs observed over the two years prior (2005/06-2006/07).

Figure 89: Number per million persons of principal cannabis-related hospital admissions among people aged 15-54 years, 1996/97-2007/08



Source: NHMD, AIHW, ACT, TAS, NT, QLD, SA, NSW, VIC and WA Health Departments and (Roxburgh and Burns in press)

6.5 Injecting risk behaviours

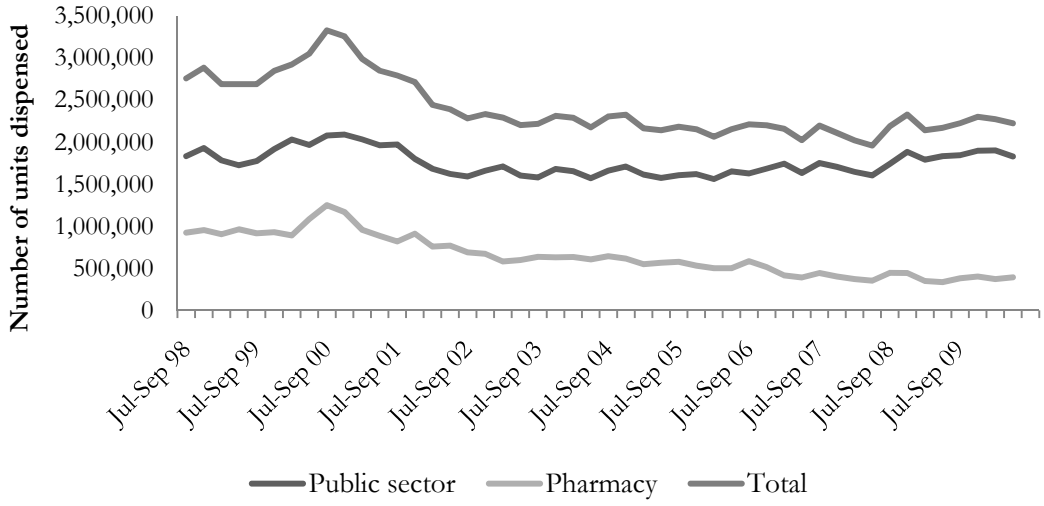
6.5.1 Sharing of injecting equipment by PWID participants

6.5.1.1 Needle syringe programs

There are 29 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 containing needles/syringes, swabs, sterile water, spoon, information on safer injecting and referral. The Fitpack also functions as a safe disposal container. There are 159 NSP-maintained Fitpack vending 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 350) are also involved in providing NSP services, further expanding availability across a broader range of people and locations. Pharmacies currently distribute less than 15% 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 NSPs has remained relatively stable over the past seven years, following a peak in distribution in 2000 (Figure 90). The number of needles and syringes dispensed by pharmacies over the same period has decreased 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 2011).

In 2010, 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 (91%) obtained needles and/or syringes from the NSP (public sector). It is important to note that this number may also be high due to the method of recruitment involved in advertisements at NSP sites. Approximately one-quarter of all participants reported they obtained needles and/or syringes from a chemist/pharmacy (28%). The third most popular source was NSP vending machines (23%). Other sources reported were friends (11%), hospital (9%), outreach/peer worker (5%), and dealer's (both 4%).

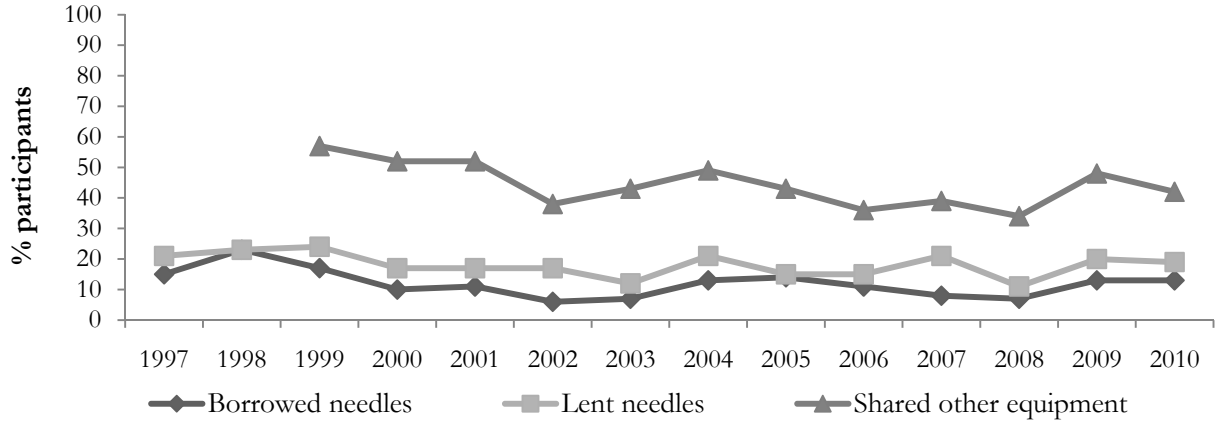
Figure 90: Number of units dispensed from public NSPs and pharmacies, NSW, July 1998-June 2010



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

In line with previous data, 100% of participants reported that they had injected on at least one occasion in the month preceding interview. Thirteen percent of these participants reported using a needle that had already been used by someone else ('borrowed needle'). This remained stable with the 13% also reported in 2009 (Figure 91). Five percent had borrowed a needle on one occasion, 7% reported borrowing a needle on between two and five occasions, and 1% reported borrowing a needle on more than 10 occasions. Among those who reported borrowing a needle, sharing had taken place with regular sex partner (8% of the entire sample), a close friend (3% of entire sample) or people other than friends or acquaintances (1%). One-fifth (19%) of those who had injected in the last month reported passing needles on to other PWID ('lent needle') in 2010, which remained stable with the 20% reported in 2009.

Figure 91: Proportion of PWID reporting sharing injecting equipment in the month preceding interview, 1997-2010

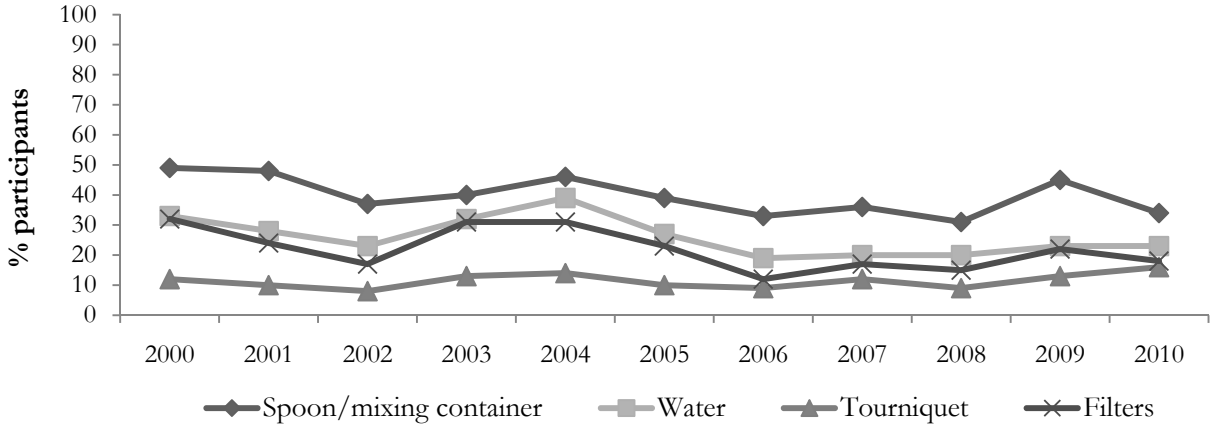


Source: IDRS PWID interviews

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) were excluded. In 2009 (n=152) and 2010 (n=154) all participates reported injection in month prior to interview

As in previous years, sharing of injecting equipment was more common than sharing of needles and syringes, with 42% reporting sharing a filter, spoon, water, tourniquet and/or other item of injecting paraphernalia in the month preceding interview. Figure 91 shows that participant reports of borrowing and lending of needles and syringes had remained stable in 2010 . There was a slight decrease in the proportion of participants reporting having shared other injecting equipment. Figure 92 shows a breakdown of the types of injecting equipment PWID participants reported sharing. Among those reporting sharing in the past month, spoons/mixing containers remained the most commonly shared item (81%; 34% of entire sample), followed by water (56%; 23% of entire sample), filters (42%; 18% of entire sample) tourniquets (39%; 16% of entire sample), and swabs (6%; 3% of entire sample).

Figure 92: Proportion of PWID participants reporting sharing other injecting equipment by type, 2000-2010



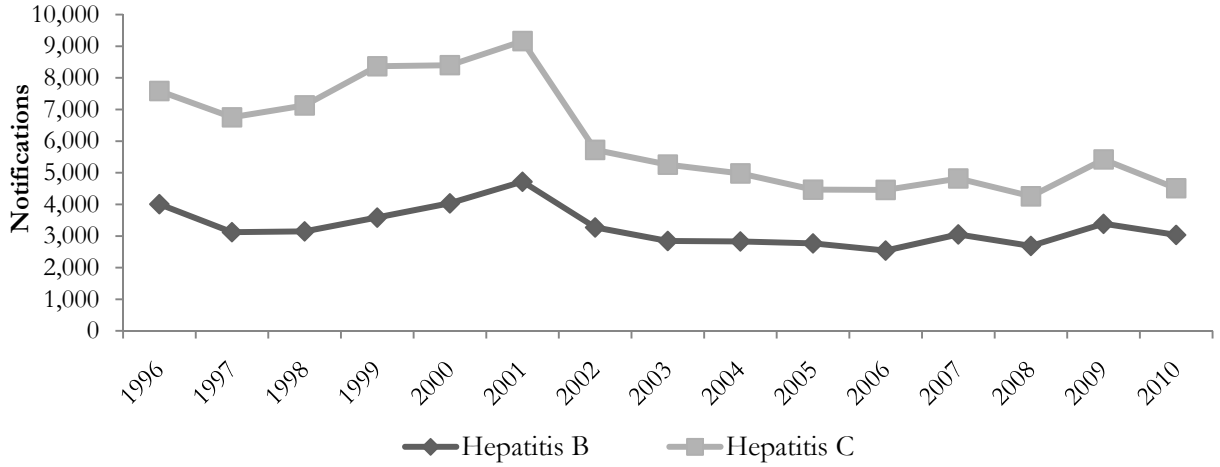
Source: IDRS PWID interviews
NB: Figure excludes participants who had not injected in the last month (in 2003 n=1; 2004 n=1; 2005 n=4; 2006 n=1; 2007 n=2; 2008 n=2) were excluded. In 2009 (n=152) and 2010 (n=154) all participates reported injection in month prior to interview

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 (National Centre in HIV Epidemiology and Clinical Research 2010).

Figure 93 shows the total number of notifications for HBV and HCV in NSW. Incident (newly acquired) infections and unspecified infections (i.e. notifications where the timing of the disease acquisition is unknown) are presented. HCV continued to be more commonly notified than HBV, with the number of notifications remaining relatively stable with a slight downward trend from 2002 (5,723 notifications). There was a decrease observed in the 12 months to 2010 (4,510 notifications). HBV notifications have remained relatively stable since 2003 (2,844 notifications) with a small decrease noted in 2010 (3,035 notifications). Notifications for both HCV and HBV still remained lower than levels reported in 2001.

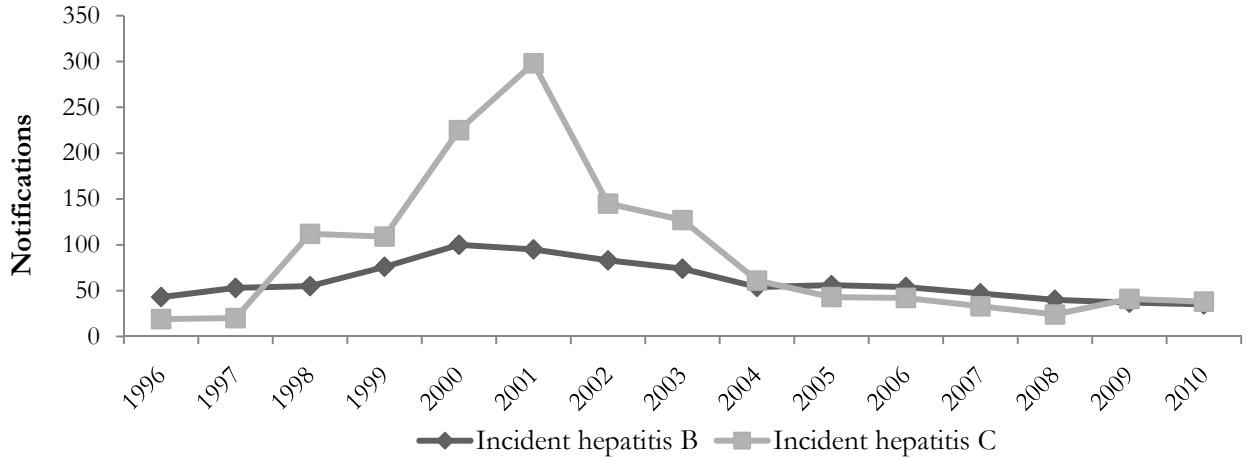
Figure 93: Total notifications for (unspecified and incident) HBV and HCV infections, NSW, 1996-2010



Source: Communicable Diseases Network – Australia – National Notifiable Diseases Surveillance System (NNDSS)[12]

Trends in the number of incident notifications for HBV and HCV in NSW are shown in Figure 94. HBV incident reporting had remained stable and low; recorded as 37 in 2009 and 35 in 2010. A steady decline had been observed in the number of HCV incident notifications, from 298 in 2001 to 24 in 2008, however, in the 12 months to 2010 it remained stable at 38 notifications (41 in 2009).

Figure 94: Total notifications for incident HBV and HCV infection, 1996-2010



Source: Communicable Diseases Network – Australia – NNDSS[12]

In 2009, both NSW (1.6%) and national level (1.2%) HIV antibody prevalence among NSP participants decreased. Both these figures are the lowest recorded since 2005 (both 0.9%) (Figure 95).

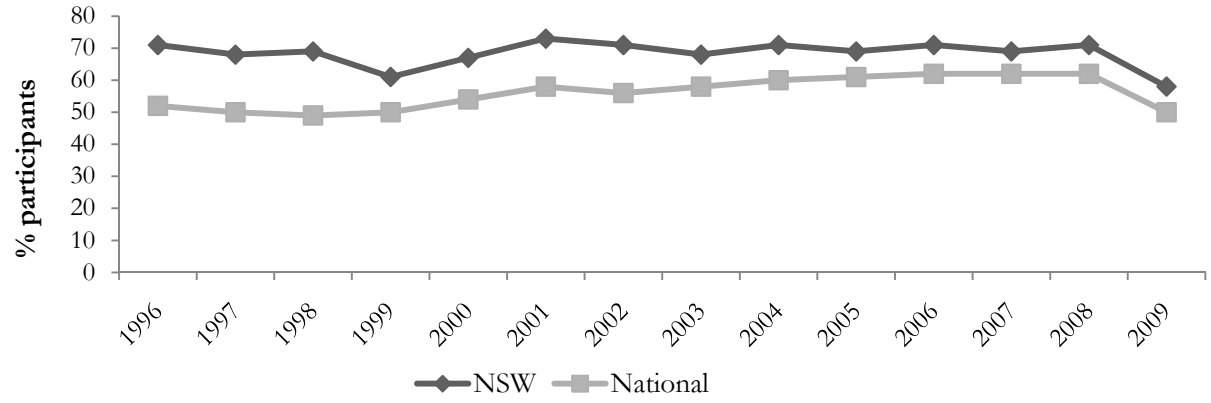
[12] There are several caveats to the NNDSS data that need to be considered. As no personal identifiers are collected, duplication in reporting may occur if patients move from one jurisdiction to another and are notified in both. In addition, notified cases are likely to represent only a proportion of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

Figure 95: Prevalence of HIV antibody among NSP survey participants, 1996-2009

Source: NCHECR
NB: Data for 2010 was unavailable at the time of publication

Detection of Hepatitis C (HCV) antibody in capillary blood tests (finger-prick samples) conducted on NSW participants remained high, but has decreased to 58% in 2009 (71% in 2008), and continues to remain higher than the national figure (50%; 62% in 2008) (Figure 96).

Figure 96: Prevalence of HCV antibody among NSP survey participants, 1996-2009

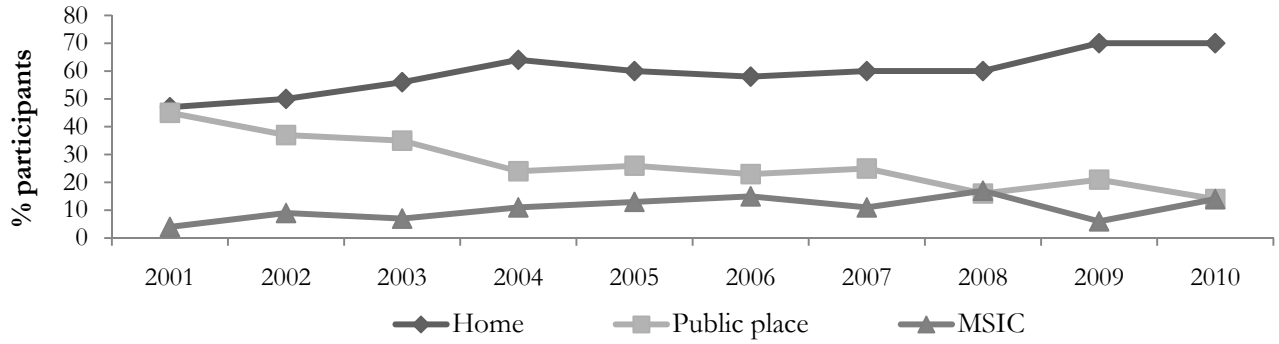


Source: NCHECR
NB: Data for 2010 were unavailable at the time of publication

6.5.3 Location of injections

The most commonly reported location for last injection remained at a private home (70%; also 70% in 2009). Fourteen percent equally reported Sydney MSIC (6% in 2009) or a public place (21% in 2009) were the locations of their most recent injection. In 2009, there was an increase in those reporting a Sydney MSIC as the location of their last injection and a decrease in those reporting a public place (Figure 97).

Figure 97: Last location for injection, 2001-2010



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; and 2008 n=2) were excluded. In 2009 (n=152) and 2010 (n=154) all participates reported injection in month prior to interview

6.5.4 Injection sites

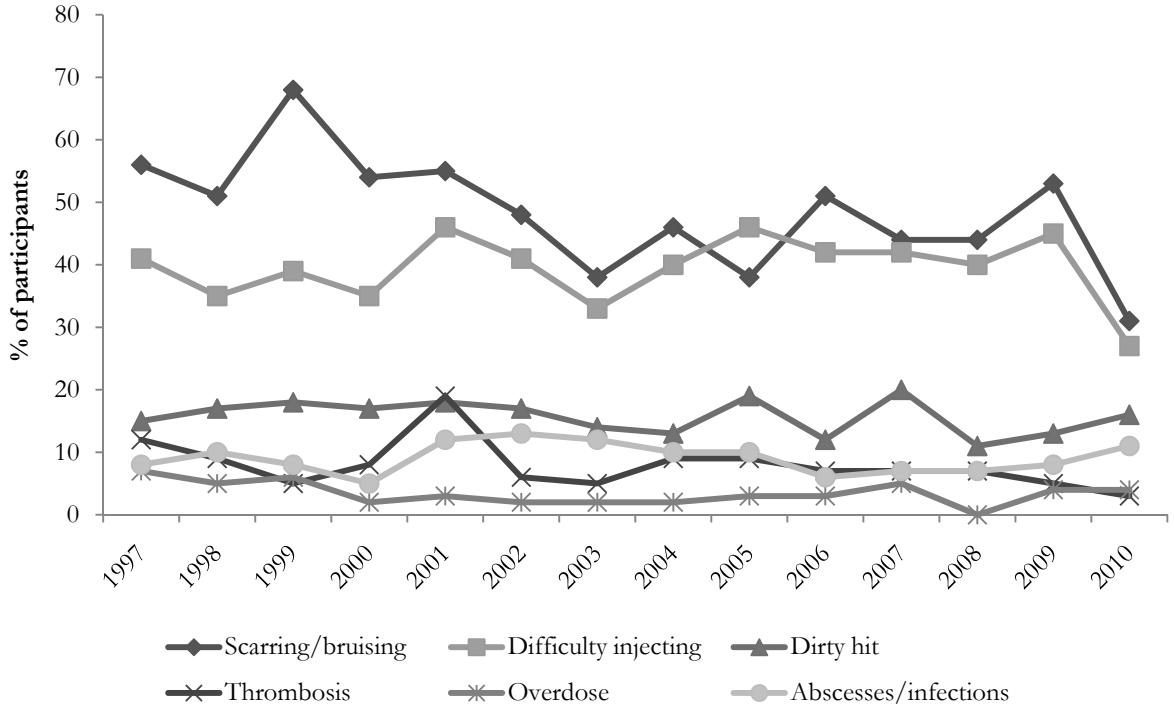
Again in 2010 participants were also asked questions about the site on their body where they had last injected. Three-quarters (74%) of participants reported that they last injected in their arm. Twelve percent of participants reported last injecting in their hand or wrist, 6% reported their neck, 4% reported their leg and equal amounts reported last injecting in their groin or foot (both 2%). This remained stable with 2009.

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. Half (50%) of PWID participants who had injected in the last month reported at least one injection-related problem during this time (30% in 2009). As in previous years, the most commonly reported problems were prominent scarring/bruising of injection sites (31%) and difficulty injecting (27%). Sixteen 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 (11%), overdose (4%) and thrombosis (3%).

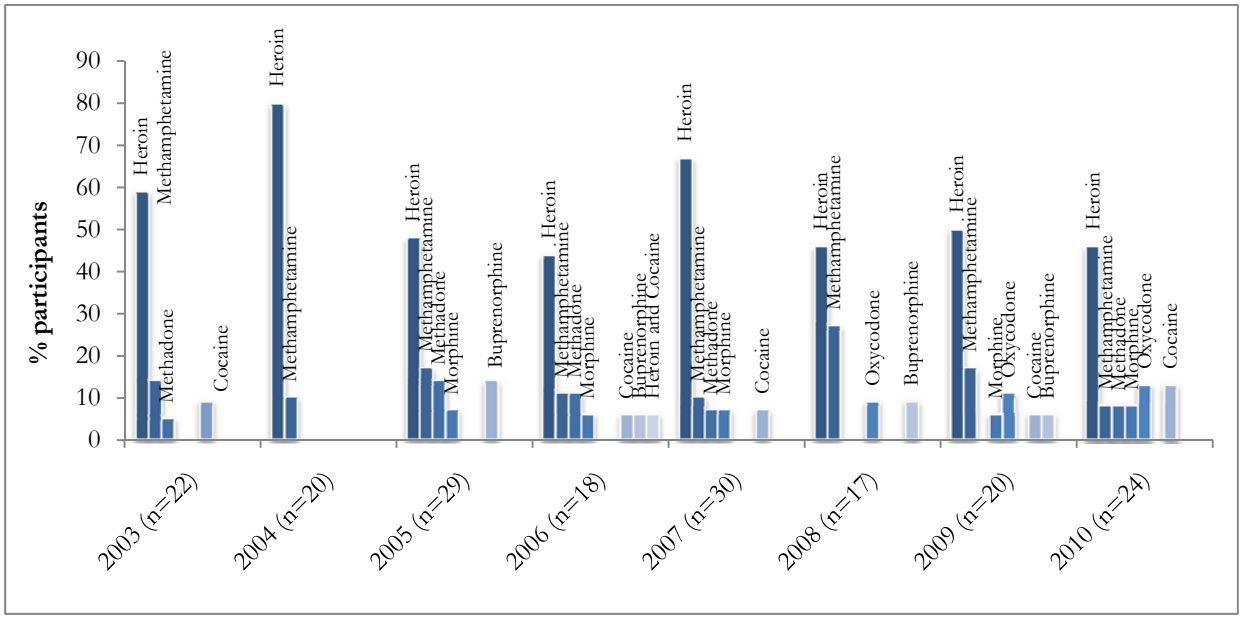
Figure 98 shows that while the proportion reporting prominent 'scarring or bruising' has remained the most commonly reported injection-related problem since 1997 (with the exception of 2005), since 2007 the issue of having 'difficulty injecting' has risen to almost equal levels in proportion of prevalence reported. In 2010 both prominent 'scarring or bruising' and 'difficulty injecting' decreased to the lowest reported levels since 1997 (31% and 27%, respectively). The injection-related issue of a 'dirty hit' remained comparable with 2009, which was the second lowest level to date. Reports of thrombosis and abscesses/infections have continued to remain relatively stable. For the past 10 years overdose has remained the least commonly reported injection-related problem and this continues in 201. For further information on overdose, see also Section 6.1 Overdose and drug-related fatalities.

Figure 98: Proportion of PWID reporting injection-related problems in past month, by problem type, 1997-2010



Source: IDRS PWID interviews
NB: Includes all participants

Figure 99: Main drug causing dirty hit in last month, 2003-2010



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=24) continued to attribute it to heroin (46%; representing 7% of the entire sample). The number of participants that reported experiencing a 'dirty hit' in the past month had remained relatively stable (n=24 versus n=20 in 2009) as has the proportion reporting heroin (46% versus 50% in 2009) as the drug attributed to the dirty hit. Again in 2010

there was a decrease, in the proportion that attributed methamphetamine (all types) to a dirty hit (8% versus 17% in 2009). The proportion that attributed cocaine to a dirty hit increased in 2010 to 13% (6% in 2009) the highest proportion since 2005. The remaining drugs, apart from Oxycodone (13%) asked for the first time in 2008, remained stable at less than 10% each.

6.6 Mental and physical health problems and psychological distress

Forty-four percent of all participants reported experiencing a mental health problem other than drug dependence in the preceding six months (39% in 2009). As in previous years, the most commonly reported problem was depression (65%; 29% of all participants). Of those reporting a mental health problem 28% (12% of all participants) reported manic-depression/bipolar disorder, one-quarter (25%; 11% of entire sample) reported anxiety, 15% (7% of entire sample) reported schizophrenia, 9% (4% of entire sample) reported paranoia and equal amounts reported panic and drug induced psychosis (6%; 3% of entire sample).

Thirty-two percent of the sample had attended a health professional for a mental health problem during this time, which increased from the 24% reported in 2009. This represented 72% of those reporting a mental health problem in the preceding six months, a decrease compared to 2009 (63%). Of those that reported a mental health problem in the six months prior to interview, 58% (16% of all participants) reported receiving prescribed antidepressant medication for treatment of that condition. Among the most commonly prescribed antidepressant medication for treatment were Avanza (mirtazapine), followed by Lexapro (escitalopram), Celapram (citalopram), and then equal reports of Endep (amitriptyline), Deptran (doxepin), Prozac (fluoxetine), Zoloft (setraline), Efexor (venlafaxine), Mirtazon (mirtazapine) and Zoloft (sertraline). Fifty percent (13% of all participants) reported receiving prescribed antipsychotic medications for treatment of their mental health issue (44% or 7% of all participants in 2009). The most commonly reported antipsychotic medications for treatment were Seroquel (quetiapine), Zyprexa (olanzapine), lithium (generic) and equal amounts of Clozaril (clozapine), Risperdal (risperidone), risperidone (generic), flupenthixol (generic) and ziprasidone (generic).

6.6.1 Psychological Distress measure

The 10-item Kessler Psychological Distress Scale (K10) (Kessler, Andrews 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 2007 National Drug Strategy Household Survey (Australian Institute of Health and Welfare 2008). K10 scores were classified in accordance with the following 10 to 15 '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=153), the mean score was 25.16 (median 23; SD 9.22; range 10-50). 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 16). 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 16: Kessler 10 scores in the 2007 National Drug Strategy Household Survey and NSW PWID participant sample 2008-2010

K10 category	National Drug Strategy Household Survey 2007	IDRS 2008 N = 149	IDRS 2009 N=149	IDRS 2010 N=154
% reporting no or low distress	69	13	13	15
% reporting moderate distress	21	26	22	24
% reporting high distress	8	27	32	29
% reporting very high distress	2	34	34	32

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

6.7 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.

6.7.1 Driving and Alcohol

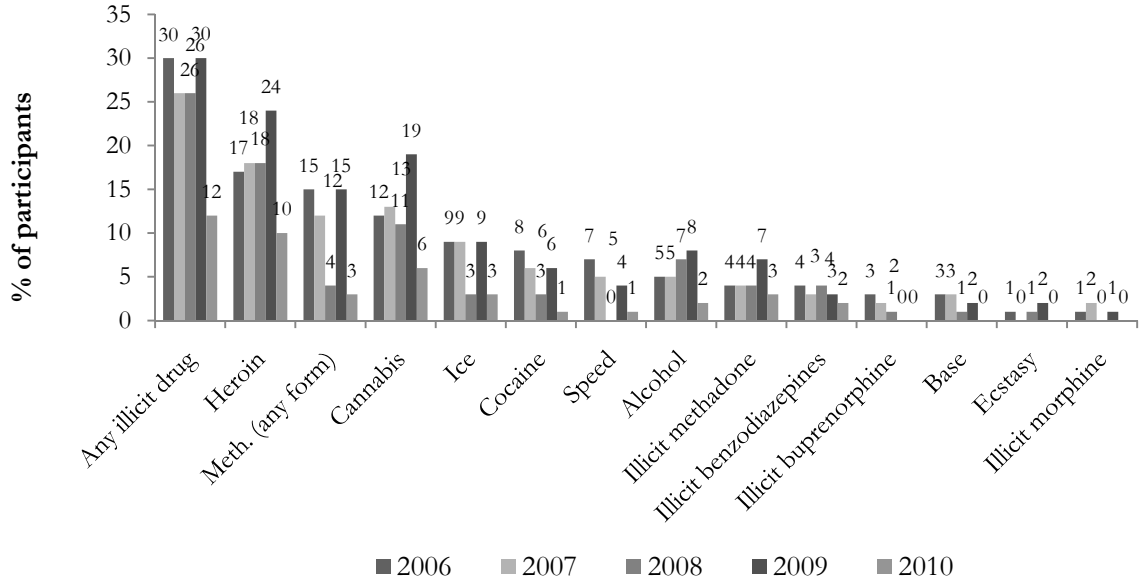
Twenty percent of the sample (n=30) had driven a motor vehicle in the six months preceding interview, and, of these, 10% (2% of the entire sample, n=3) had driven under the influence of any alcohol. Both the percentage of the sample recently driving and driving under the influence of any alcohol have decreased from 2009. Of those reporting driving under the influence 67% (1% of entire sample) reported that they believed they had driven while they were over the legal limit[13] of alcohol on a median of two occasions (range 1-3 times).

6.7.2 Driving and illicit drugs

Of those who had driven a car in the past six months, 63% (n =19, 12% of the entire sample) had driven 'soon' after taking (an) illicit drug(s). As shown in Figure 100, figures have decreased from 2009. Heroin remained the drug nominated most by participants (84% of those who had driven under the influence of illicit drugs, 10% of the entire sample); followed by cannabis (53%, 6% of entire sample), and equal amounts reported methadone or ice/crystal (21%, or 3% of the entire sample).

[13] Note that these figures are based on self-report, and should be interpreted with caution.

Figure 100: Driving under the influence by PWID participants, by drug type, 2006-2010

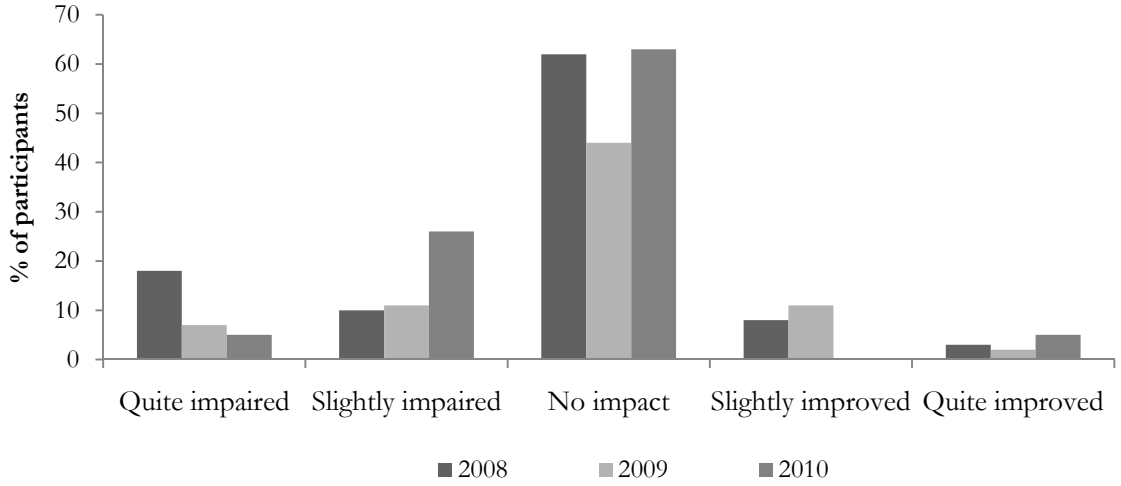


Source: IDRS PWID interviews

Again in 2010, participants that reported driving while under the influence of illicit drugs, 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 100, heroin was the drug reported by the majority of participants (84%; 10% of all participants) who had driven under the influence of illicit drug(s) in the six months prior to interview. Heroin was followed by cannabis (37%; 5% of all participants), methadone (26%; 3% of all participants) and equally benzodiazepines and any form of methamphetamines (11%; 2% of all participants). Participants waited an average of 15 minutes after taking drug(s) and then driving, this was a decrease compared with 2009 (30 minutes). One-third (35%; 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 (63% of those who drove under the influence of illicit drugs, 8% of all participants); 26% percent (6% of all participants) reported that they believed their driving was 'slightly impaired', and equal amounts (5%; 1% of entire sample) commented that their driving was either 'quite improved' or 'quite impaired' see (Figure 101).

Figure 101: Perceived driving ability (i.e. level of impairment) of PWID participants under the influence, 2008-2010



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 gaol sentences of up to nine months, unlimited licence suspensions and fines of $2,200.

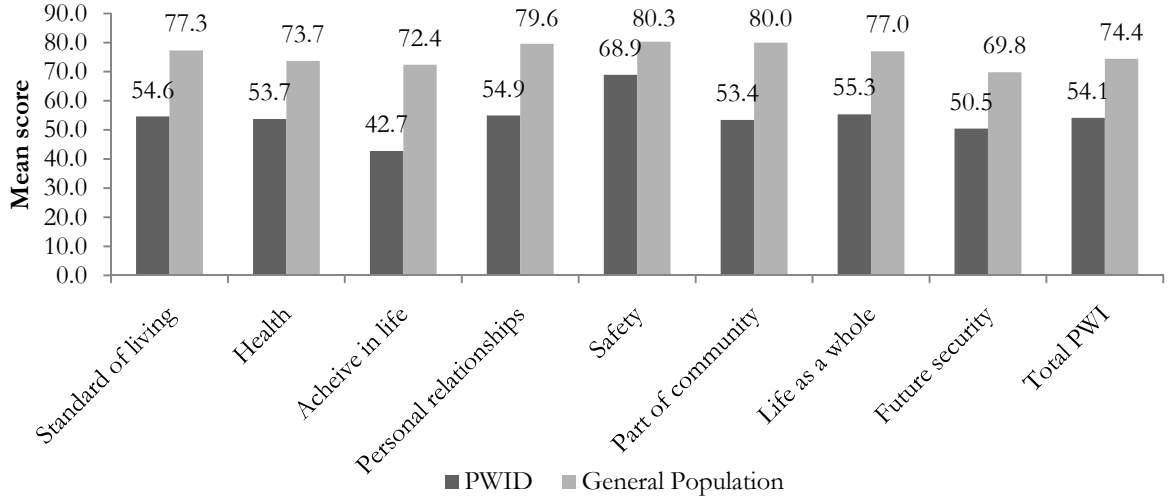
Participants were asked if they had been roadside drug tested, and of the result. Twelve percent of the sample reported driving under the influence of illicit drugs (n=19) in the past 6 months. Fourteen percent (3% of entire sample) reported being tested in random roadside tests (saliva sample test), of which one participant reported being tested on more than one occasion. Only one participant claimed the result was positive.

6.8 Personal Wellbeing Index (PWI)

Again in 2010 the PWI was entered into the IDRS survey. Questions asked how satisfied participants were with various aspects of their life. These included standard of living, health, personal achievement, personal relationships, and personal safety, feeling a part of the community, future security and life as a whole. PWID were asked to respond on a scale of 0-10 where 0 was 'very unsatisfied' and 10 was 'very satisfied'. Figure 102 shows the mean PWID scores compared to the Australian general population (Cummins, Woerner et al. 2007).

PWID scored lower than the general population on each factor of personal wellbeing. However, for all measures other than 'achievement in life', participants were within the expected range of wellbeing scores. Cummins, Woerner et al. (2007) reported that at normal levels of wellbeing (average scores lie between 70-80 points) people often feel good about themselves, are motivated to conduct their lives and have a strong sense of optimism. In comparison individuals with scores below 50 points are at a higher risk of depression. The PWID scores are low and show that general wellbeing of PWID may contribute to this group experiencing a higher risk of depression.

Figure 102: Mean PWID and Australian general population scores on the Personal Wellbeing Index

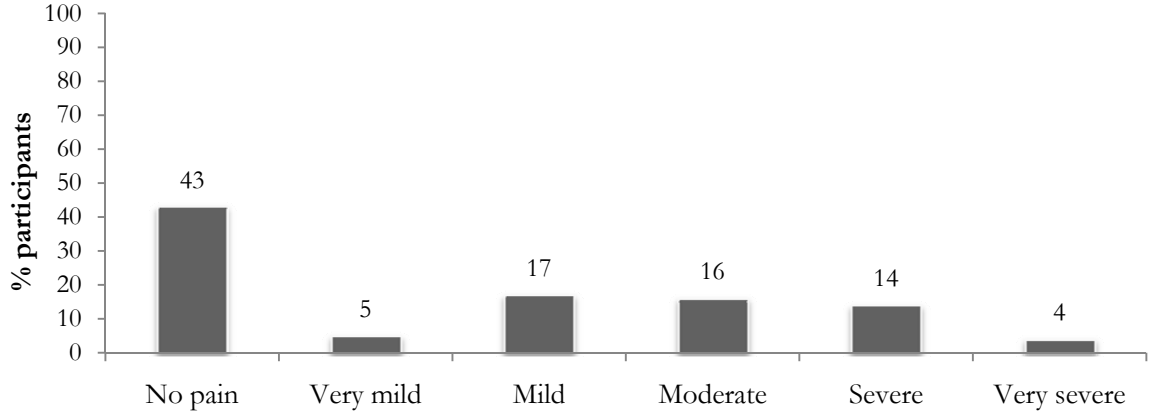


Source: IDRS PWID surveys 2010; Cummins et al., 2007

6.9 Pain Management

Again in 2010, the NSW IDRS included questions enquiring about any associated health problems, and pharmaceutical opioid use. More than half of the sample (56%) reported experiencing some form of pain in the month prior to interview. Of those experiencing some form of pain one-quarter (24%; 14% of entire sample) reported severe pain and 7% (4% of entire sample) reported experiencing severe pain (Figure 103).

Figure 103: Level of pain experienced in last 4 weeks

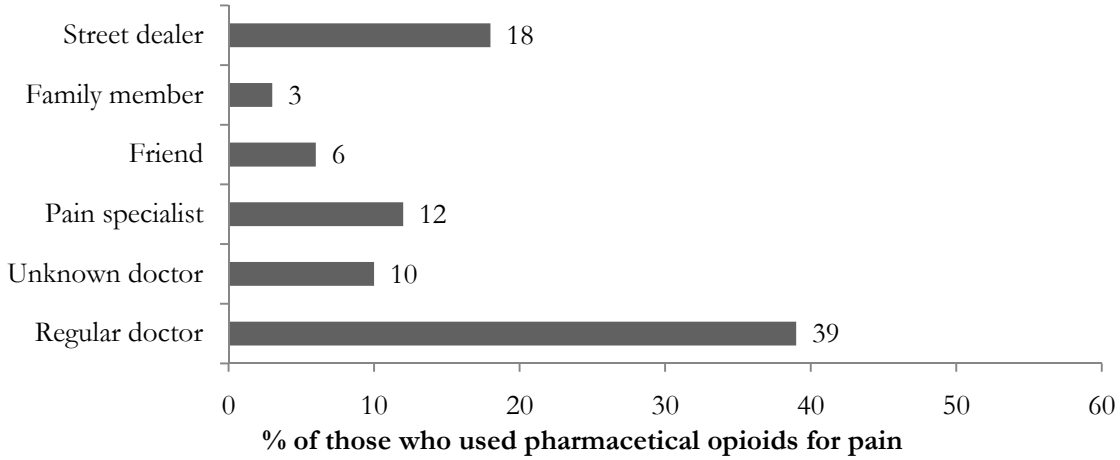


Source: IDRS PWID interviews

One-fifth (22%) of the sample reported recent use of pharmaceutical opioids for pain, of which the majority (58%; 12% of the entire sample) was for acute pain. One-quarter (27%; 6% of the entire sample) reported recent use of pharmaceutical opioids for chronic non-malignant pain and 15% (3% of the entire sample) reported use for chronic malignant pain. The main source of pharmaceutical opioids for pain management was a regular doctor (39%; 8% of entire sample), street dealer (18%; 4% of entire sample), or pain specialist (12%; 3% of entire sample) (Figure

104). On the last occasion 48% (9% of the entire sample) reported trouble obtaining pharmaceutical opioids from a doctor for pain.

Figure 104: Last source of pharmaceutical opioids for pain management



Source: IDRS PWID interviews

6.10 Sexual Health

Population studies have shown that younger age groups had engaged in sexual relationships with more partners in their lifetime than older age groups (Johnson, Mercer et al. 2001). Amongst the regular ecstasy user sample, participants of a younger age have been found to be more likely to engage in risky behaviours (Cogger and Kinner 2008). Furthermore, studies have shown that younger individuals who frequent night clubs are likely to report multiple sexual partners and incidents of Sexually Transmitted Infections (STI) (Wells, Kelly et al. 2010).

In Australia, approximately ten percent of young women and three percent of young men (aged under 30 years) report having been tested for Chlamydia (Kong, Hocking et al. in press). The issues surrounding sexual health prompted questions to be developed for the IDRS survey to investigate reasons why or why not participants choose to have STI screening. The responses to these questions were formulated by considering results of previous research (Dixon-Woods, Stokes et al. 2001; Tilson, Sanchez et al. 2004; Balfe and Brugha 2009).

Participants in the IDRS were firstly asked if they had been tested for a sexually transmitted infection (STI) in the last two years. Among the those who commented, the majority (69%) reported that they had been tested in the last two years for an STI by means of a blood test, urine sample or swab, of these, two-fifths (39%) reported their GP as the place they were last tested.

Seventy-two percent of female participants reported a pap smear test in the last two years. The main reason for having a pap smear test was 'due for a test'. The majority (44%) of women who had a recent test reported receiving it from their GP.

Table 17: STI and Pap smear testing

	NSW n=154
Tested for a sexually transmitted infection (STI) last two years? (%)	
No, don't think about it	18
No, I didn't want to be tested	3
No, another reason	11
Yes, I was tested by means of a blood test, urine sample or swab	69
Reason for test* (%)	n=105
Clear of infection after relationship	13
Clear of infection before starting relationship	10
Unprotected sex	11
Symptoms of infection	7
Health provider suggested	14
Friend suggested	1
Partner suggested	5
Partner had symptoms	3
Ex-partner told me to get tested	0
Clinic access was easy	14
Other@	51
Place last tested for STI* (%)	n=104
Sexual Health Clinic	20
GP	39
Hospital	12
Other	29
Had a pap smear test last two years (%)**	n=57 72
Reasons for no pap smear test# (%)	n=16
Wasn't sexually active	19
No symptoms	6
Don't like them	19
Didn't think of it	6
Embarrassed/uncomfortable	13
Financial cost	0
Other†	50
Reasons for having a pap smear test## (%)	n=41
Symptoms	5
Reminder letters	17
Health provider suggested	12
Friend suggested	0
Due for a test	42
Family history of cervical cancer	2
Other@	29
Place last tested for pap smear## (%)	n=41
Sexual Health Clinic	22
GP	44
Hospital	2
Other	32

Source: IDRS participant interviews

*Among those who were tested for a sexually transmitted infections in the last 2 years

**Among females only

#Among those who had not had a pap smear test in the last 2 years

##Among those who had a pap smear test in the last 2 years

@ 'Other' – most reported for a 'general check-up'

† 'Other' – most reported for 'did not want to have the procedure', 'forgot', 'hysterectomy' and 'pregnant'

6.11 Height, weight and body mass index

Eating disorders and drug use disorders are significant public health problems. However, epidemiologic research examining their associations yields ambiguous results. Evidence on a relationship between obesity and alcohol use is found in some studies (Wannamethee, Shaper et al. 2005). As to the relationships between overweight/obesity and nicotine dependence, some studies have found overweight and obese men, but not women, were more likely to be former daily smokers than non-smokers (Zimlichman, Kochba et al. 2005; John, Meyer et al. 2006). In a nationally representative sample, overweight, obesity and extreme obesity were associated with lower risk for past-year nicotine dependence in men but not in women (Pickering, Grant et al. 2007).

The relationship between body mass index (BMI) and drug use is unclear. For instance, cannabis can stimulate appetite, whereas cocaine is a stimulant and appetite suppressant, but one study found similar prevalence of overweight in individuals with illicit drug use disorders as that found in the general population (Rajs, Petersson et al. 2004) and another study found both positive and negative associations of BMI with various substance use disorders, and significant gender differences in those relationships (Barry and Petry 2009). Finally, BMI and drug use are both associated with mental health problems (Kemp, Gao et al. 2009).

For the first time in 2010, participants in the IDRS were asked their height and weight. With this information BMI was calculated among the national sample to determine the relationship between BMI, drug use and the risk of disease. BMI is calculated from height and weight information, using the formula weight (kg) divided by the square of height (m). BMI is divided into 4 groups (1) 'underweight' – less than 18.5, (2) 'normal weight' – 18.5 to less than 25.0, (3) 'overweight' – 25.0 to less than 30.0 or (4) 'obesity' – 30.0 and greater, in adults to measure prevalence. BMI values are grouped according to the groups reported by the World Health Organization (WHO, http://apps.who.int/bmi/index.jsp?introPage=intro_3.html).

Among those who commented the mean height was 1.72 metres and weight 73.2 kilograms. Of those who commented, 6% had a BMI which was considered 'underweight' (BMI<18.5), this compares to 2.6% of the general population aged 18-64 years (Australian Bureau of Statistics 2009) (Table 18).

Table 18: Self-reported height, weight and Body Mass Index, 2010

	National Health Survey 2007-2008	NSW 2010
Mean Height (metres)	-	n=144 1.72
Mean Weight (Kilograms)	-	n=140 73.4
Mean Body Mass Index (BMI)	-	n=132 25.1
BMI - Males (%)		n=83
Underweight	1.4	6.0
Normal range	35.8	56.6
Overweight	40.2	24.1
Obese	22.6	13.3
BMI - Females (%)		n=47
Underweight	3.7	12.8
Normal range	49.1	40.4
Overweight	27.2	25.5
Obese	20.0	21.3
BMI - All (%)		n=132
Underweight	2.6	8.3
Normal range	42.2	50.8
Overweight	33.9	25.0
Obese	21.3	15.9

Source: IDRS participant interviews, (Australian Bureau of Statistics 2009)

6.12 Alcohol Use Disorders Identification Test-Consumption

Recently a lot of media attention has focused on young people and alcohol. However, there has been less focus on alcohol use amongst people who inject drugs regularly. People who inject drugs are particularly at risk for alcohol related harms due to a high prevalence of the hepatitis C virus (HCV). Half of the participants interviewed in the Australian NSP Survey 2009 (n=2,697) were found to have HCV antibodies (National Centre in HIV Epidemiology and Clinical Research 2010). Given that the consumption of alcohol has been found to exacerbate HCV infection and to increase the risk of both non-fatal and fatal opioid overdose and depressant overdose (Darke, Ross et al. 1996; Schiff and Ozden 2004; Coffin, Tracy et al. 2007; Darke, Duflou et al. 2007) it is important to monitor risky drinking among PWID.

The information on alcohol consumption currently available in the IDRS includes the prevalence of lifetime and recent use, number of days of use over the preceding six months. In 2010, participants in the IDRS were asked the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) as a valid measure of identifying heavy drinking (Bush, Kivlahan et al. 1998). The AUDIT-C is a three item measure, derived from the first three consumption questions in the AUDIT. (Dawson, Grant et al. 2005) reported on the validity of the AUDIT-C finding that it was a good indicator of alcohol dependence, alcohol use disorder and risk drinking.

Among participants who commented, the overall mean score on the AUDIT-C was 3.2 (range 0-12). According to (Dawson, Grant et al. 2005) and (Haber, Lintzeris et al. 2009) *Guidelines for the Treatment of Alcohol Problems* a cut-off score of five or more indicated that further assessment was required. Approximately one-third (31%) of all participants scored 5 or over and 31% of males and 33% females scored 5 or more indicating the need for further assessment (Table 19).

Table 19: AUDIT-C among people who inject drugs, 2010

	NSW 2010
Mean AUDIT-C score; SD (range)	3.2; 3.5 (0-12)
Score of 5 or more (%)	31
Males (%)	31
Females (%)	33

Source: IDRS participant interviews

6.13 Stimulant and opioid dependence

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

In 2010, 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, and preoccupation with, and anxiety about, use. The SDS appears to be a reliable measure of the dependence construct. It has demonstrated good psychometric properties with heroin, cocaine, amphetamine, and methadone maintenance patients across five samples in Sydney and London (Dawe, Loxton et al. 2002).

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

Of those who had recently used an opioid, the median SDS score was 9 (mean=8.4, range=0-15), with 80% scoring five or above. Of those who scored five or above, 83% reported specifically attributing responses to heroin, 23% methadone, equal amounts reported morphine and oxycodone (6% each) and 4% attributed it to buprenorphine.

Of those who had recently used a stimulant, the median SDS score was 4 (range=0-15), with 58% scoring four or above. Of those who scored four or above, 52% specifically attributed responses to cocaine and 48% methamphetamines.

6.14 General medical practitioner service use

Literature has shown that the regular PWID population is a group that experiences a variety of physical and mental health problems. However, due to the marginalised status and concealed nature of this group, it can be difficult to ensure that it obtains the public health care access it requires and that targeted health care strategies reach it. This group also experiences barriers to treatment due to a lack of knowledge regarding available services, long wait times and limited operating hours (Neale, Sheard et al. 2007). Also due to the nature of the addiction, the time spent obtaining and consuming drugs may cause delays in seeking treatment (McCoy, Metsch et al. 2001) (Drumm, McBride et al. 2005) which often leads to over dependence on acute crisis and emergency interventions (Kerr, Wood et al. 2004).

The IDRS sought to investigate this issue of access to services further and identify the services which PWID have utilised most often to offer a resource for treatment providers and policy initiatives. This section focuses on general medical practitioner (GP or doctor) and not their opiate prescriber.

Eighty-six percent of participants reported visiting a GP in the last 12 months for a physical or mental health problem, on a median of 6 occasions in the last 12 months. Among those who reported visiting a GP in the last 12 months, approximately one-third (31%) of participants reported visiting a GP in a hospital outpatient (OP) or emergency department (ED) while only 5% reported a home visit from the GP (Table 20).

Of those who reported a GP visit in the past year, one-third (32%) reported visiting for problems with their mental health (MH) on an average of four occasions. This compares to 25% of the general population who visited a GP for a lifetime mental disorder with 12-month symptoms (Australian Bureau of Statistics 2007). Of those who commented, three-quarters (74%) reported visiting the 'same' GP for a problem with their MH (Table 18).

Table 20: General medical practitioner visits by PWID participants, 2010

	NSW 2010
Visited a GP last 12 months (%)	86
Median no. of GP's visits last 12 months*	n=133 6
Home visit from GP* (%)	5
GP visits in hospital OP or ED* (%)	31
GP visit for MH problem* (%)	32
Visited the same GP for mental health** (%)	n=42 74
Referred to GP from another GP for MH problem** (%)	28
Mean age first visited GP for MH problem** (%)	n=40 23

Source: IDRS participant interviews
*Among those who had visited a GP in the last 12 months
**Among those who visited a GP for mental health

6.15 Social networks

Interaction with other people is vital to human development. Social relationships and networks can act as protective factors against the onset or reoccurrence of mental illness and enhance recovery of mental disorders (World Health Organization 2003; World Health Organisation 2005). For example marital status has been shown to be related to a person's physical and mental health, with results indicating married people experience less negative effects associated with these areas. Regular drug users, particularly regular injectors, are a group that tend to be marginalised by society and experience many hardships including homelessness, social and financial disadvantage and physical health problems all of which may contribute to a mental health condition therefore implying social networks would be a vital area of support for this group.

Results from the 2007 National Survey of Mental Health and Well-being (Australian Bureau of Statistics 2007) demonstrated that the prevalence of a 12-month mental health disorder was very similar for people who did and did not have contact with family members, however, results differed for those who had contact and who did not have contact with friends. Of the 15.9

million people who had contact with their family and/or friends one in five (20%) had a 12-month mental disorder. However, of those who had no contact with family or no family, 23% had a 12months mental disorder compared to 38% of those who had no contact with friends or no friends (Australian Bureau of Statistics 2007).

In 2010, the IDRS asked participants questions in relation to social networks. Thirty-five percent of participants reported contact with a family member nearly every day, while one-fifth (20%) reported no contact or family. The majority (71%) were able to rely on one or two family members (Table 21).

Over half (58%) reported contact with friends nearly every day. The majority (71%) were able to rely on one or two friends. One-third (34%) reported that they could rely on their partner/spouse 'a lot'. Over half (53%) of the sample were single (Table 20).

Table 21: Social networks among PWID participants, 2010

	NSW n=154
How often are you in contact with any family member?	
Nearly every day (%)	35
3-4 days a week (%)	7
1-2 days a week (%)	14
1-3 days a month (%)	12
< once a month (%)	12
Never (%)	19
No family (%)	1
How many family members can you rely on*?	n=93
1-2 family members (%)	46
3-4 family members (%)	26
5 or more family members (%)	28
How often are you in contact with any of your friends?	
Nearly every day (%)	58
3-4 days a week (%)	12
1-2 days a week (%)	9
1-3 days a month (%)	5
< once a month (%)	2
Never (%)	3
No friends (%)	10
How many friends can you rely on?**	n=99
1-2 friends (%)	71
3-4 friends (%)	20
5 or more friends (%)	9
How much can you rely of your spouse/partner for help (for a serious problem)?	
A lot (%)	34
Some (%)	9
A little (%)	2
Not at all (%)	3
Don't know (%)	0
Currently single (%)	53

Source: IDRS participant interviews

*Among those in contact with a family member

**Among those in contact with friends

6.15.1 Key expert comments

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

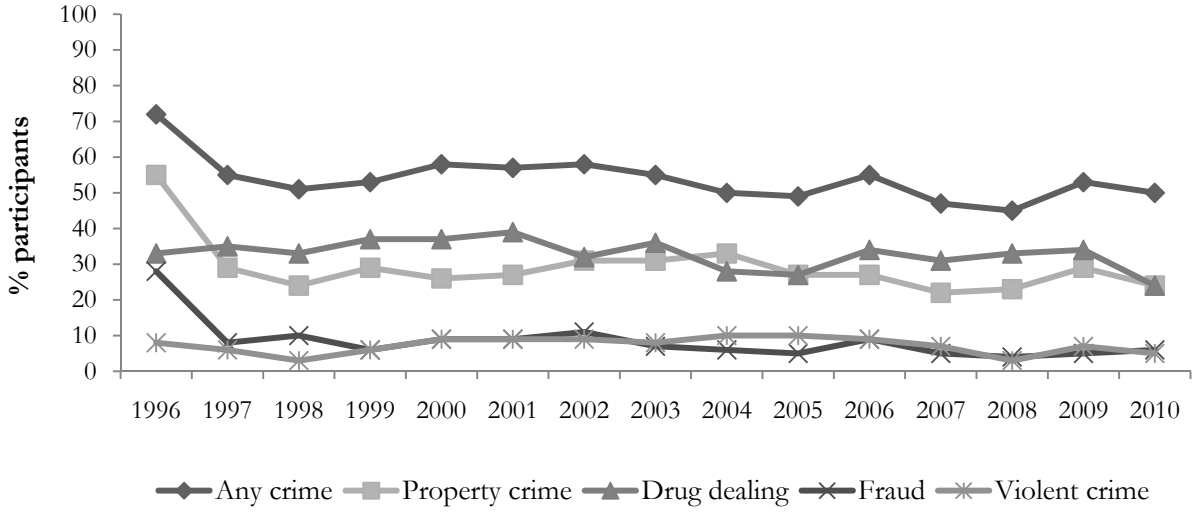
- Both dental health and stable housing remained an ongoing area of health concern for this population;
- polydrug use, particularly the use of benzodiazepines with opioids, was a reoccurring issue the management of overdoses;
- non-fatal overdoses remained low and stable; and
- mental health issues continue to be a major problem for PWID and there was ongoing issues engaging and referring clients into MH services.

7 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

7.1 Reports of criminal activity among PWID

Forty-two percent of participants reported engaging in any form of crime in the month prior to interview. The proportion reporting any crime in the month prior to interview has remained between 45-50% since 2003 (Figure 105). Trends continued to follow those reported in previous years with the two most commonly reported crimes being drug dealing and property crime (both 24%). Five percent of PWID participants reported engaging in violent crime (7% in 2009) and 6% reported fraud (5% in 2008).

Figure 105: Proportion of participants reporting engagement in criminal activity in the last month by offence type, 1996-2010



Source: IDRS PWID interviews

The percentage of PWID participants that reported being arrested in the previous twelve months remained relatively stable at 44% of the entire sample (42% in 2009) (Table 22). The most commonly cited reasons for arrest in the last 12 months were possession/use of a prohibited drug (16%; 37% in 2009), property crime (13%; also 15% in 2009). Reported arrests for reasons pertaining to violent crime (includes assault, violence in a robbery, armed robbery, sexual assault) remain stable (7%; 6% in 2009). Small proportions reported having been arrested for drug dealing/trafficking (7%), a driving offence or use/possession of weapons (both 1%).

Table 22: Criminal activity as reported by PWID participants, 2005-2010

Criminal and police activity	2005 N=154	2006 N=152	2007 N=153	2008 N=151	**2009 N=152**	**2010 N=154**
Criminal activity in last month (%):						
Dealing	27	34	31	33	34	**24**
Property crime	27	27	22	23	29	**24**
Fraud	5	9	5	4	5	**6**
Violent crime	10	9	7	3	7	**5**
Any crime	**49**	**55**	**46**	**45**	**53**	**50**
Arrested in last 12 months (%)	44	39	41	36	42	**44**

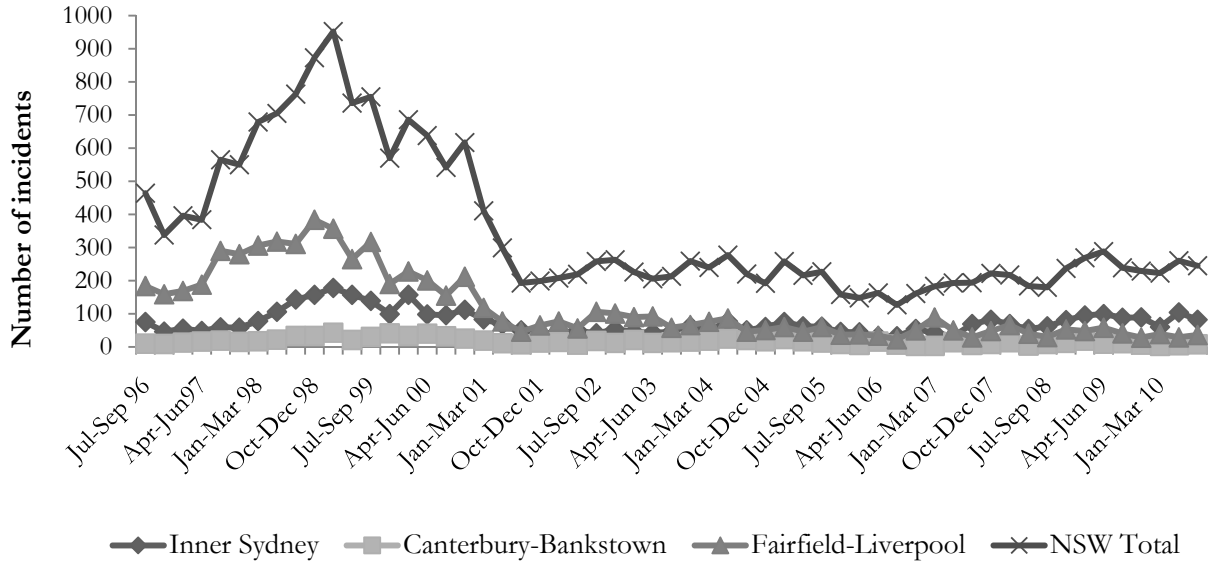
Source: IDRS PWID interviews

7.2 Arrests

7.2.1 Heroin

Figure 106 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 1996-September 2010[14]. 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 2009, the number of incidents has remained stable across the three local areas and NSW as a whole.

Figure 106: Recorded incidents of narcotic possession/use by geographic area per quarter, July 1996-September 2010



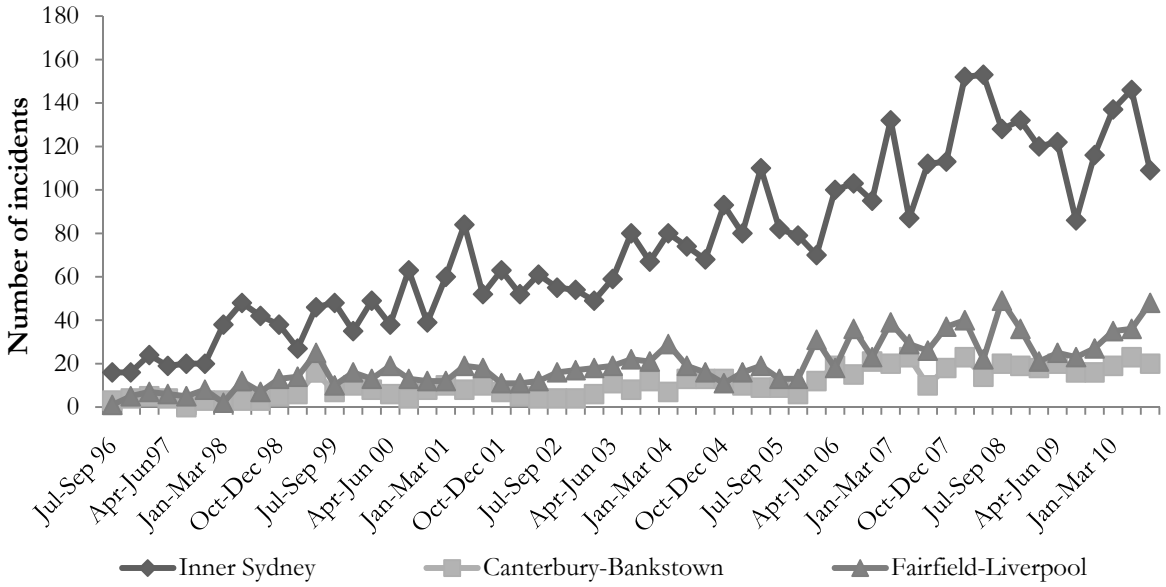
Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init January 2011) accessed 21st February 2011
NB: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both

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

7.2.2 Methamphetamine

Figure 107 shows the number of criminal incidents per quarter for amphetamine possession/use across Sydney. Recorded incidents in the Canterbury-Bankstown area remained relatively stable overall, while in the Inner Sydney area they fluctuated in the 12 months to September 2010; however, over the same period there was a notable decrease in incidents in Fairfield-Liverpool.

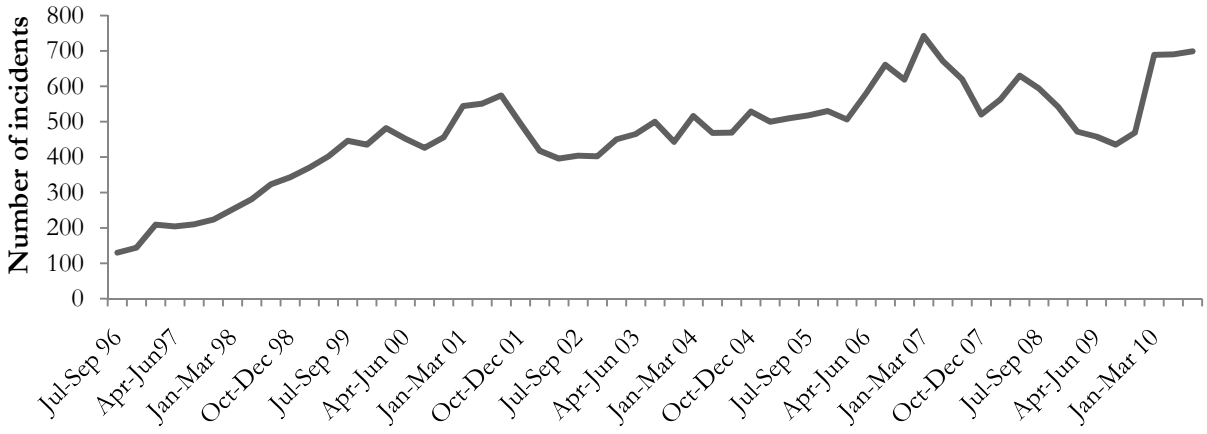
Figure 107: Recorded incidents of amphetamine possession/use by geographic area per quarter, July 1996-September 2010



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 January 2011) accessed 21st February 2011
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 gradual increase in incidents since 1996 with peaks in third quarter of 2006/07 and fourth quarter of 2007/08 for amphetamine possession/use, both surpassing the highest level reported to date, post-heroin shortage in 2001 (Figure 108). However, since April-June 2008 the number of incidents per quarter has declined to the lowest level recorded since January-March 2006 and in the 12 months to September 2010 there has been an increase in the number of incidents (Figure 108).

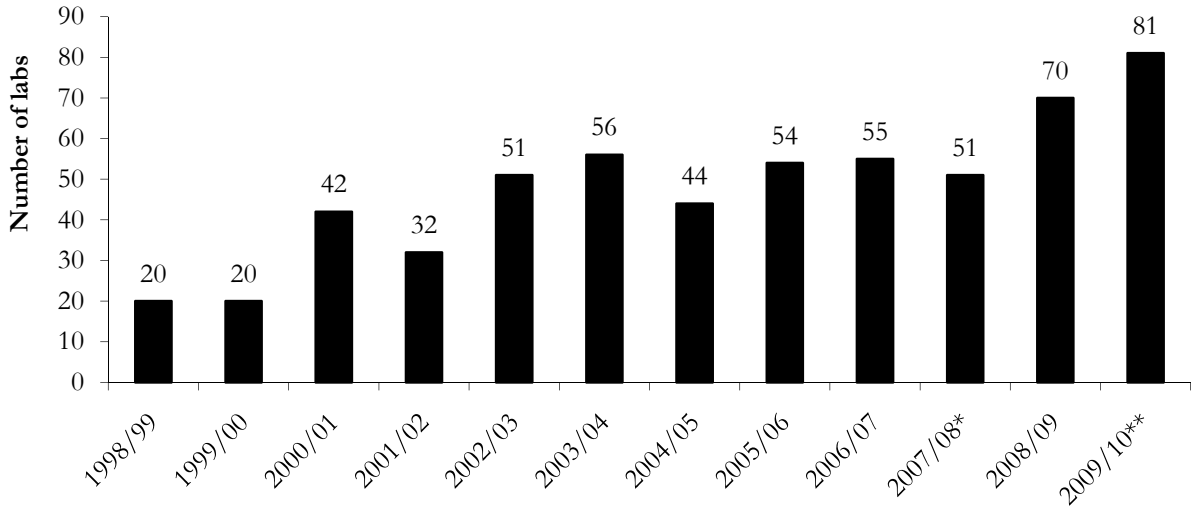
Figure 108: Recorded incidents of amphetamine possession/use (whole of NSW) per quarter, July 1996-September 2010



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 January 2011) accessed 21st February 2011
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.

The number of clandestine laboratories detected in NSW increased again in 2009/10. In 2009/10, there were 81 detections, of which approximately three-quarters were storage sites, one-quarter where inactive and the remainder were a combination of active or historical storage sites (Figure 109).

Figure 109: Number of clandestine methamphetamine and MDMA laboratories detected by NSW Police 1998/99-2009/10

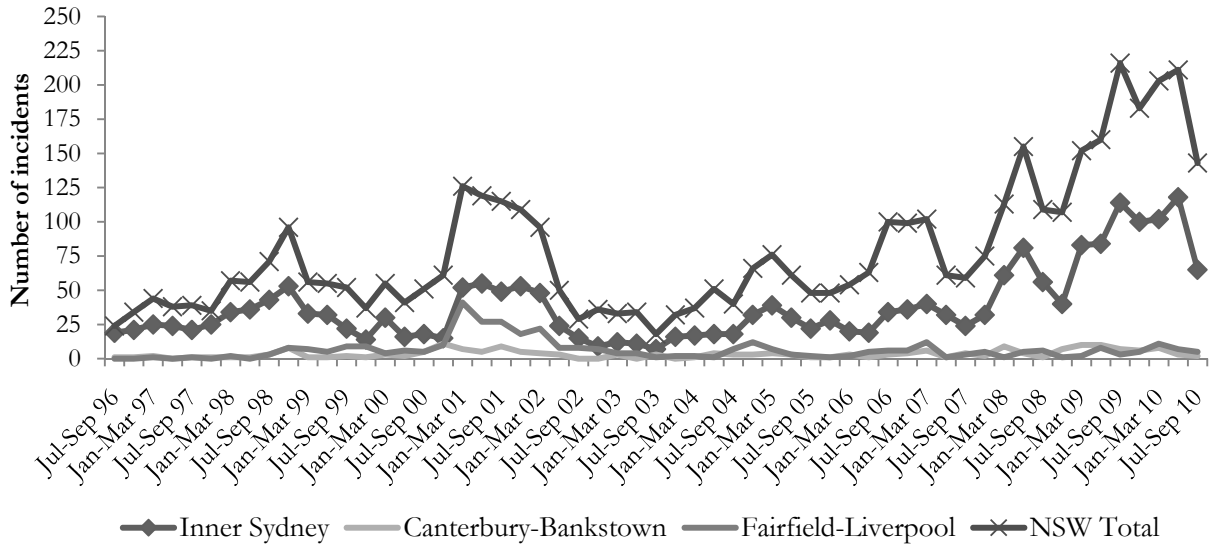


Source: NSW Police
NB: data may include active, non-active and historical laboratories as well as storage sites
* includes 2 PMA laboratories
**includes 1 PMA laboratories

7.2.3 Cocaine

Figure 110 shows the number of police recorded criminal incidents for cocaine possession/use in Inner Sydney, Fairfield-Liverpool, Canterbury-Bankstown and NSW as a whole. Incidents of cocaine possession/use recorded in the Inner Sydney area peaked in 1998, 2001 and 2010. Levels have remained higher in Inner Sydney than in the South-West areas of Fairfield-Liverpool and Canterbury-Bankstown. The April-June quarter of 2010 had the highest number of incidents recorded in Inner Sydney since data started being collected in 1996/97.

Figure 110: Recorded incidents of cocaine possession/use by geographic area per quarter, July 1996-September 2010

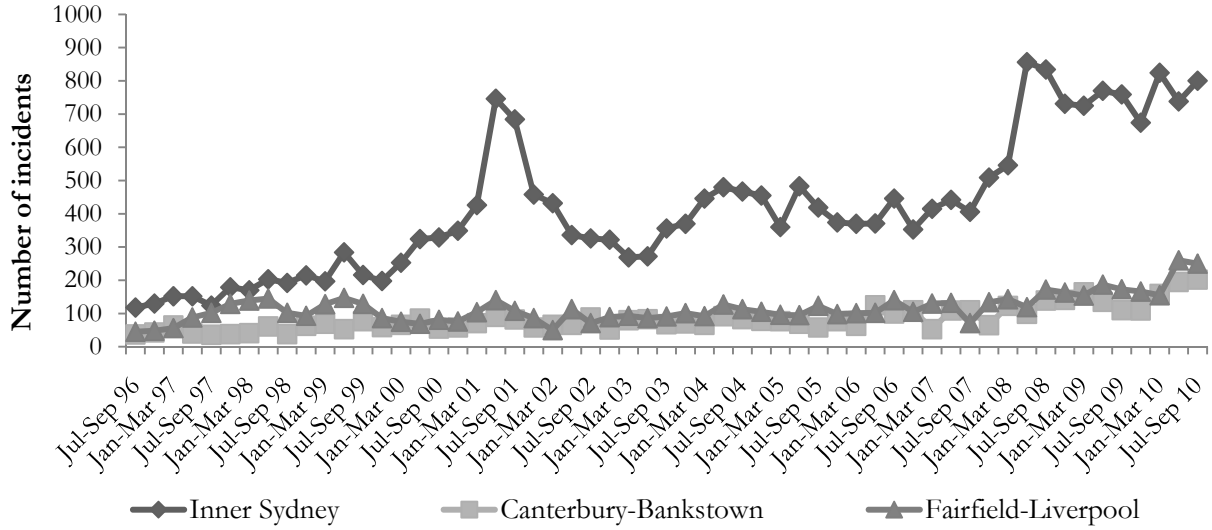


Source: NSW Bureau of Crime Statistics and Research (unpublished data accessed through the Crime Trends Tool at http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/Init January 2011) accessed 21st February 2011
NB: Changes in the number of recorded incidents may be indicative of changes in police activity, or an increase in possession/use, or a reflection of both.

7.2.4 Cannabis

Figure 111 shows the number of police recorded criminal incidents of cannabis possession/use per quarter in the Inner Sydney, Fairfield-Liverpool and Canterbury-Bankstown areas. There had been upward trends across Inner Sydney, Fairfield-Liverpool Canterbury-Bankstown areas and NSW as a whole over the 12 months to September 2010. The numbers of incidents recorded in the Fairfield-Liverpool and Canterbury-Bankstown areas are lower than inner city figures, yet similar to Inner Sydney, there has been an upward trend in the number of incidents; in 2010 both areas recording the highest number of incidents (250 and 202 incidents, respectively) since 1996.

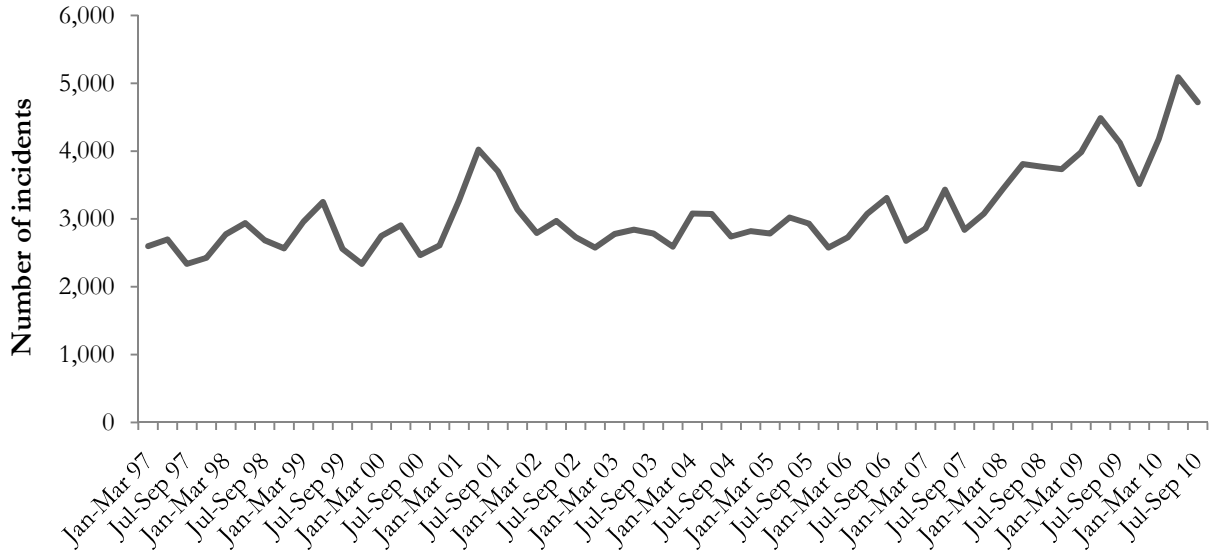
Figure 111: Recorded incidents of cannabis possession/use by geographic area per quarter, July 1996-September 2010



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 January 2011) accessed 21st February 2011
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 2010 there has been an increase in the number of recorded incidents of cannabis possession/use per quarter across NSW (Figure 112). A peak occurred in the second quarter of 2001 (April-June; 4,110 incidents) and from the 12 months to September 2010 incidents had increased to record number of incidents (5,088 April-June 2010).

Figure 112: Recorded incidents of cannabis possession/use (whole of NSW) per quarter, January 1997-September 2010



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 January 2011) accessed 21st February 2011
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

Almost all (99%) of participants reported purchasing drugs on the day prior to interview, spending a median of $100 (range $1-1000). This is an increase from 2009 when a median of $85 was reported by 74% of participants. Among participants who had bought drugs on the day before interview, over half (59%) had spent $150 or less (63% in 2009), with a further 15% having spent between $150-300. As per 2009 only three percent (n=4) of participants reported spending more than $300 on drug purchases on the day prior to interview.

7.3.1 Key expert comments

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

- an increase in clandestine laboratory detections, this, however, reflected a coordinated response in detection intelligence from law enforcement rather than reflecting an actual increase in laboratories;
- the average purity of methamphetamine detections had increased over the past 12 months;
- trafficking concealment methods remained consistent. Methamphetamine was being imported using a scattergun approach through the postal service: smaller amounts in larger packages;
- an increase was noted in use of Argentina as a point of embarkation for cocaine importation, while Brazil is no longer noted as point of embarkation.
- A decrease recent detections of ice/crystal was noted; and
- methamphetamine (all types) remained the second most common drug detected (after cannabis) in NSW by NSW police, and continued to be associated with large and complex organised criminal syndicates both domestically and internationally.

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