Queensland

Fairlie McIlwraith, Sophie Hickey and Rosa Alati

Queensland DRUG TRENDS 2012
Findings from the
Illicit Drug Reporting System (IDRS)

Australian Drug Trends Series No. 99

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Please note that as with all statistical reports there is the potential for minor revisions to data in this report over its life. Please refer to the online version at www.ndarc.med.unsw.edu.au

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ACS	Australian Customs Service
AGDH&A	Australian Government Department of Health and Ageing
ADIS	Alcohol and Drug Information Service
AFP	Australian Federal Police
AIHW	Australian Institute of Health and Welfare
ANSP	Australian Needle and Syringe Program
AOD	Alcohol and other drug(s)
ATODS	Alcohol Tobacco and Other Drug Services
ATS	Amphetamine-type stimulant
AUDIT-C	Alcohol Use Disorders Identification Test-Consumption
BPI	Brief Pain Inventory
CPR	Cardio pulmonary resuscitation
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders IV
DUMA	Drug Use Monitoring in Australia
EDRS	Ecstasy and Related Drugs Reporting System
FTND	Fagerstrom Test for Nicotine Dependence
GP	General practitioner
HCV	Hepatitis C virus
IDRS	Illicit Drug Reporting System
IRID	injection related injuries and diseases
KE	Key expert(s)
K10	Kessler Psychological Distress Scale
LSD	Lysergic acid diethylamide
MCS	Mental Component Score
MDMA	3,4-methylenedioxymethylamphetamine (‘ecstasy’)
NCIS	National Coronial Information System
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NSP	Needle and Syringe Program(s)
OST	Opioid Substitution Treatment
OTC	Over the counter
PCS	Physical Component Score
QAS	Queensland Ambulance Service

QNSP	Queensland Needle and Syringe Program
QPS	Queensland Police Service
QuIHN	Queensland Injectors' Health Network
SCID	Structural Clinical Interview for DSM disorders
SDS	Severity of Dependence Scale
SF-12®	Short-Form 12-Item Health Survey
SPSS	Statistical Package for the Social Sciences
TBI	traumatic brain injury

GLOSSARY OF TERMS

Bush	Outdoor-cultivated cannabis
Cap	Small amount, typically enough for one injection
Frequency	Number of occurrences within a given time period
Halfweight	0.5 gram
Hydro	Hydroponically grown cannabis
Illicit	In the context of this report, refers to Illegal drugs and 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
Indicator data	Sources of secondary data used in the IDRS (see Method section for further details
Key expert	A person participating in the key expert survey component of the IDRS (see Method section for further details)
Licit	In the context of this report, refers to pharmaceuticals (e.g. methadone, buprenorphine, morphine, ocycodone, 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 swallowing
Mean	The average
Median	The middle value of an ordered set of values
Participant	In the context of this report, refers to a person who participated in the injecting drug user survey (does not refer to key expert participants unless stated otherwise)
Point	0.1 gram; although may also be used as a term referring to an amount for one injection (similar to a 'cap' which is explained above)
Recent injection	Injected at least once in the previous six months
Recent use	Used at least once in the previous six months
Sentinel group	A surveillance group with the potential to point towards trends and harms
Use	Use via one or more of the following routes of administration: injecting, smoking, snorting, and swallowing

Guide to days of use/injection in preceding six months

180 days	daily
90 days	every second day
24 days	weekly

EXECUTIVE SUMMARY

The Illicit Drug Reporting System (IDRS) is a monitoring system designed to identify emerging trends of local and national concern in illicit drug markets. The reporting system comprises data collected each year from three sources: interviews with a sentinel group of people who regularly inject drugs (participants); interviews with key experts; and analysis of pre-existing data related to illicit drugs.

Demographic characteristics of participants

One hundred people who regularly inject drugs participated in the 2012 IDRS survey in South East Queensland. The mean age of participants was 38 years, 76% were male, 82% were unemployed, 47% had a trade/technical qualification, 8% had a university/college qualification, 37% were currently involved in some sort of drug treatment, and 59% had a prison history.

Consumption pattern results

Current drug use

The mean age of first drug injection was 20 years, with 58% first injecting methamphetamines and 29% first injecting heroin.

Heroin was nominated as drug of choice by 55% of participants, and methamphetamines by 20%. Heroin and methamphetamines were the drugs most commonly injected in the previous month, and they were also the most common drugs last injected.

Heroin

Heroin use was stable, with 65% of participants using heroin in the preceding six months. Amongst those who recently used heroin, median use was 72 days, with about one in five using daily. Almost half of participants (47%) reported heroin as the drug most often injected. Use of homebake remained low.

Methamphetamine

Use of methamphetamines in the previous six months decreased from 71% in 2011 to 53% in 2012 ($p<0.05$). The proportion of participants using each of the four forms of methamphetamine in the previous six months was crystal 44%, speed 30%, base 21%, and liquid 5%. Methamphetamine was the drug of choice for 20% of participants, and 26% reported that it was the drug most often injected in the past month.

Cocaine

Cocaine use continued to be uncommon, with the proportion reporting use in the previous six months dropping from 13% in 2011 to 4% in 2012 ($p<0.05$). Frequency of use was low.

Cannabis

As in previous years, the majority of participants (70%) had used cannabis in the preceding six months, with 40% using it daily. Hydro continued to be used more often than bush; cones more often than joints.

Other opioids

Methadone and buprenorphine-naloxone (Suboxone®) were the two most commonly used forms of prescribed substitution pharmacotherapy, but buprenorphine (Subutex®) was the most commonly used form of substitution pharmacotherapy used illicitly. The majority of participants who used illicit substitution pharmacotherapy injected it.

Recent use of illicit morphine (non-prescribed) remained stable at 34%, with most participants injecting it. Recent use of licit oxycodone was uncommon (7%), but 29% of participants reported recently using illicit oxycodone with most injecting. Lifetime use of non-medicinal use of over-the-counter codeine (predominantly Nurofen Plus®) was reported by 17% and 7%reported recent use.

Nearly one in five of participants had recently used other opiates such as pethidine, Panadeine Forte®, opium.

Other drugs

Recent use of ecstasy decreased from 23% in 2011 to 7% in 2012 ($p<0.05$). Hallucinogens use was rare, with 4% reporting use in the previous six months, with none injecting.

About three in five participants (62%) had used benzodiazepines (licit or illicit) in the preceding six months. Illicit use of Alprazolam was reported by 35%, and one in five reported illicit use of other benzodiazepines.

Illicit use of pharmaceutical stimulants (e.g. dexamphetamine and methylphenidate) in the previous six months was rare (3%), as was use of inhalants (2%).

Three in five participants reported alcohol use in the preceding six months. Almost all participants used tobacco (98%), and 89% used it daily.

Drug market: Price, purity, availability and purchasing patterns

Heroin

Price of heroin was consistent with previous years at $400 per gram and $50 per cap. Purity was generally reported as low or medium, with mixed ratings on whether purity had recently changed. Heroin was rated as readily available by most, but 25% rated availability as difficult. Two-thirds of participants last purchased from a known dealer, and half had made their last purchase at an agreed public location.

Methamphetamine

Price of speed was $100 per point, base $75 per point, and crystal/ice $100 per point. Price was commonly considered to be stable or increasing for all forms. Purity of speed was mainly considered to be medium. Rating of the purity of base and crystal/ice was more varied, although for both forms about half considered it to be high. All forms of methamphetamine were considered to be readily available.

Cocaine

Only two participants commented on the cocaine market, and both considered the market to be stable.

Cannabis

The potency of cannabis continued to be rated as high, particularly hydro. Price for both hydro and bush was stable, and both were readily available. The most recent purchase of both hydro and bush was generally from a friend or known dealer, with a friend's home being the most common place of purchase.

Methadone

Most of the participants who commented on the methadone market considered price to be stable, with a median price of one millilitre being $1. There was no consistency about availability, although most did not consider there had been recent changes in availability. Methadone was most likely to be purchased from a friend, and the place of purchase to be a public location.

Buprenorphine

Price and availability of buprenorphine was generally considered stable, with the median price of 2 mg reported as $10 and 8 mg as $35.

Buprenorphine-naloxone

Price and availability of buprenorphine-naloxone was generally considered stable by the small number of participants who commented.

Morphine

The median price for 100 milligrams of morphine was $70 for MS Contin© and $60 for Kapanol©, with price changes generally rated as stable or increasing. MS Contin® was the most common brand of morphine used, followed by Kapanol®. Morphine was mostly rated as readily available and was obtained from a variety of source people at various locations.

Oxycodone

The median price of 80 milligrams of oxycodone was $50, with most participants considering price to be stable. About half (52%) rated availability as difficult, with the remainder rating it as easy or very easy. Illicit oxycodone was most commonly sourced from a friend (58%).

Health-related trends associated with drug use

Overdose and drug-related fatalities

Nearly half of participants (46%) had accidently overdosed on heroin in their lifetime, and of these 29% had overdosed in the preceding year. Additionally, 18% had accidently overdosed on a depressant drug other than heroin in their lifetime.

Alcohol was overwhelmingly the most common drug implicated in overdose cases attended by Queensland Ambulance Service, followed by antidepressants, benzodiazepines, and then heroin.

Drug treatment

About a third of participants (35%) were currently in drug treatment which was predominantly opioid substitution pharmacotherapy.

Injecting risk behaviours

All participants had sourced needles from a needle and syringe program, and 23% had also sourced from a chemist.

Recent borrowing of used needles decreased from 20% in 2011 to 7% in 2012 ($p<0.05$); and 19% lent used needles compared with 28% in 2011. The proportion sharing other equipment (predominantly spoons/mixing containers) was stable at 36%. Forty-four per cent of participants re-used one of their own needles at least once in the previous month.

Mental health problems, psychological distress and general health

Over half of participants (56%) self-reported a mental health problem, with the most common problems being depression and anxiety. Compared with the general Australian population, IDRS participants were much more likely to score in the high distress or very high distress categories of the Kessler Psychological Distress Scale (K10) (59% compared with 2%).

Participants' scores on the SF-12 health survey indicated they had poorer mental and physical health than the population average. Nearly a third of participants (32%) had accessed a health professional in the previous four weeks.

Driving risk behavior

Of the 54% of participants who had driven in the past six months, 11% reported driving under the influence of alcohol, and 83% reported driving soon after taking an illicit drug. Most of these participants considered that the drug/s taken prior to driving had no impact on their driving ability.

Trends in law enforcement associated with drug use

Reports of criminal activity

Two in five participants reported criminal involvement in the previous month. Dealing was the most often reported criminal activity followed by property crime.

Arrests

Just under half (46%) of participants reported being arrested in the preceding 12 months with the most common reasons being property crime followed by use/possession of drugs.

Expenditure on illicit drugs

The median reported expenditure on illicit drugs the previous day was $70.

Special topics of interest

Fagerstrom Test for Nicotine Dependence

A third of daily smokers had scores on the Fagerstrom Test for Nicotine Dependence indicating high nicotine dependence; and 16% had scores indicating very high dependence.

Pharmaceutical opioids

Seven in ten participants reported using pharmaceutical opioids in the previous six months. The most common reason for use was to treat self-dependence followed by seeking an opioid effect and pain relief.

Brief Pain Inventory

A quarter of participants had experienced pain on the day of interview, predominantly non-cancer pain.

Opioid and stimulant dependence

Seventy-seven per cent of recent opioid users obtained a score on the Severity of Dependence Scale indicating possible opioid dependence; and 41% of recent stimulant users obtained a score indicating stimulant dependence.

Opioid substitution medication injection

Buprenorphine (Subutex®) was the most commonly injected opioid substitution medication, with one in five participants recently injecting it. The proportion recently injecting buprenorphine-naloxone (Suboxone®) was similar, with 16% injecting the tablet form and 3% the film.

Injection-related injuries and diseases

The most common problem near injection site amongst all participants was temporary redness, followed equally by temporary swelling and hives.

Neurological history

About half of participants (53%) had experienced a traumatic brain injury, with a median of two incidences over a lifetime.

Possession laws

Many participants appeared to be unaware of drug trafficking thresholds.

1 INTRODUCTION

The Illicit Drug Reporting System (IDRS) is an ongoing research project that serves as a strategic early-warning system for emerging trends and patterns in illicit drug use and associated harms. The IDRS has been conducted annually in every state and territory of Australia since 2000, and is supported by funding from the Australian Government under the Substance Misuse Prevention and Service Improvement Grants Fund. The IDRS focuses primarily on four main illicit drugs: heroin, amphetamines, cocaine, and cannabis but also monitors trends in other drug use and in drug-related harms.

An important aim of the IDRS is to disseminate its findings in a timely fashion, highlighting current issues that require further attention rather than providing a more protracted, in-depth analysis of available data. Each year, key findings are presented at the National Drug Trends Conference in October, and the final report is published by the National Drug and Alcohol Research Centre (NDARC) early the following year. In addition, NDARC produces an annual national report and, in collaboration with jurisdictional researchers, quarterly Drug Trends Bulletins highlighting issues of particular relevance. Selected findings from the IDRS are also published in peer-reviewed journals. Reports and other publications are available at www.ndarc.med.unsw.edu.au.

Data for the IDRS come from three complementary sources: (a) a survey of people who regularly inject drugs (participants) who are considered a 'sentinel' group in the community; (b) structured interviews with key experts within the drug and alcohol sector; and (c) pre-existing data sets related to illicit drugs. By triangulating information from these three sources, the IDRS aims to increase confidence in the reliability and validity of its findings.

The participant survey component of the IDRS has been conducted in Queensland since 2000, and with each passing year the value of the data set grows. Apparent trends from one year to the next can increasingly be interpreted within a broader historical context, and long-term trends in drug use and associated harms can be identified. Along with other complementary monitoring systems such as the national Ecstasy and related Drug Reporting System (EDRS), the Australian Needle and Syringe Program (ANSP) survey, and the crime-focused Drug Use Monitoring in Australia (DUMA) study, the IDRS helps to paint a contextualised picture of drug use and drug-related issues in Australia.

1.1 Study aims

As in previous years, the aims of the 2012 Queensland IDRS were to:

- document the price, purity, and availability of heroin, amphetamines, cocaine, cannabis and other drugs in Queensland
- identify, assess, and report on emerging trends in illicit drug use and associated harms.

2 METHOD

The IDRS maximises the reliability of its findings by presenting information from three complementary sources:

- structured interviews with people who inject drugs (participants)
- semi-structured interviews with key experts who are working in a professional capacity in the drug field
- recent indicator data collected from a variety of sources.

Participants gave informed consent prior to interview, and the information they provided has been de-identified.

Comparability across years and jurisdictions is maintained by the continued use of the same survey instruments and data sets nationwide, with minor adjustments made to the study methodology each year in accordance with developments and trends in illicit drug markets.

2.1 Survey of people who regularly inject drugs

During June 2012, 100 IDRS participants were individually interviewed face-to-face. Participants were people aged 17 years or older who inject drugs, had injected an illicit drug at least monthly in the previous six months, and had lived in South East Queensland for 12 months. Participants were recruited and interviewed at five Needle and Syringe Program (NSP) sites located in the Brisbane-Gold Coast area.

Participants provide a sentinel group of people who regularly inject drugs rather than a representative sample of all those who regularly inject drugs.

The interview schedule was administered by trained research staff in a private room at the NSP sites. The interviews took approximately one hour to complete and participants were reimbursed $40 for their time and travel expenses. The 2012 IDRS survey included sections on:

1. participant socio-demographic characteristics
2. drug use history
3. the price, purity, availability, and purchasing patterns of illicit drugs
4. criminal involvement
5. risk-taking behaviour
6. physical and psychological health
7. general trends.

Ethical approval was obtained from the Human Research Ethics Committee at the University of New South Wales; The University of Queensland; Metro North and Metro South, Queensland Health.

2.2 Survey of key experts

In September and October 2012, 12 professionals or professional groups working in the alcohol and other drugs (AOD) sector were interviewed as key experts for the Queensland IDRS. Key experts are individuals working in the health or law enforcement sectors who are equipped to provide information on trends and patterns in illicit drug use and associated harms. This is because they have regular contact with people who inject illicit drugs or considerable knowledge of manufacture, importation, supply, and seizure of illicit drugs.

In 2012, eight of the key experts were from the health sector and four were from law enforcement. They included NSP workers, nurses, staff of drug treatment agencies, researchers, outreach workers, youth workers, forensic chemists, and law enforcement and intelligence officers.

Key expert interviews were conducted face-to-face or over the telephone. Interviews took approximately 45 minutes to complete and included a range of open-ended and closed-ended questions. Questions were about the main problematic drugs, the resulting issues (health and legal), price/purity/availability of problematic drugs, and any subsequent recommendations. Responses to interview questions were analysed thematically according to recurring issues and type of drugs.

2.3 Other indicators

Secondary data was also collected to corroborate data from those who regularly inject drugs and from key experts. Suggested entry criteria for indicator data were to:

- be available at least annually
- include 50 or more cases
- provide details of illicit drug use
- be collected in Queensland
- include details on the four main illicit drugs under investigation (i.e. heroin, methamphetamines, cocaine, and cannabis).

The following indicator data sources largely fitted these criteria and are used in the report:

- Alcohol and Drug Information Service (ADIS): telephone counselling statistics
- Australian Bureau of Statistics (ABS): National Health Survey data
- Australian Crime Commission (ACC): median purity of drugs seized by Queensland Police Service (QPS) and the Australian Federal Police (AFP) in Queensland
- Australian Customs Service (ACS): total weight and number of drugs seized in Queensland by QPS and the AFP
- Australian Institute of Health and Welfare (AIHW): Queensland pharmacotherapy client registrations
- Queensland Ambulance Service (QAS): overdose and poisoning data
- Queensland Needle and Syringe Program (QNSP): needles and syringes dispensed to NSP in Queensland
- QPS: clandestine laboratory detections and drug-related arrests.

2.4 Data analysis

Participant survey results were analysed using IBM SPSS Statistics®, Version 21. Standard frequencies were calculated and tests for significant differences between 2011 and 2012 data were conducted for drug of choice, last drug injected, drug injected most often in the past month, and use of the major drug types. Test differences in proportions were calculated using excel (spreadsheet available at http://www.cebm.net/index.aspx?o=1023 (Tandberg)). Only test results that were statistically significant at $p<0.05$ have been reported.

3 DEMOGRAPHICS

KEY POINTS

- The mean age of participants was 38 years, with 61% aged 35 years and over.
- Demographic characteristics remain similar to previous years: participants were likely to be unemployed, male, with prison and drug treatment histories.

3.1 Overview of the IDRS participant sample

The demographic characteristics of the 2012 sample of 100 participants from South East Queensland were largely similar to those in 2011; however, there were significantly less participants who were married/de facto and significantly more who had completed a trade/technical course ($p<0.05$) (see Table 1). Participants were typically male, in their late thirties, single, and unemployed.

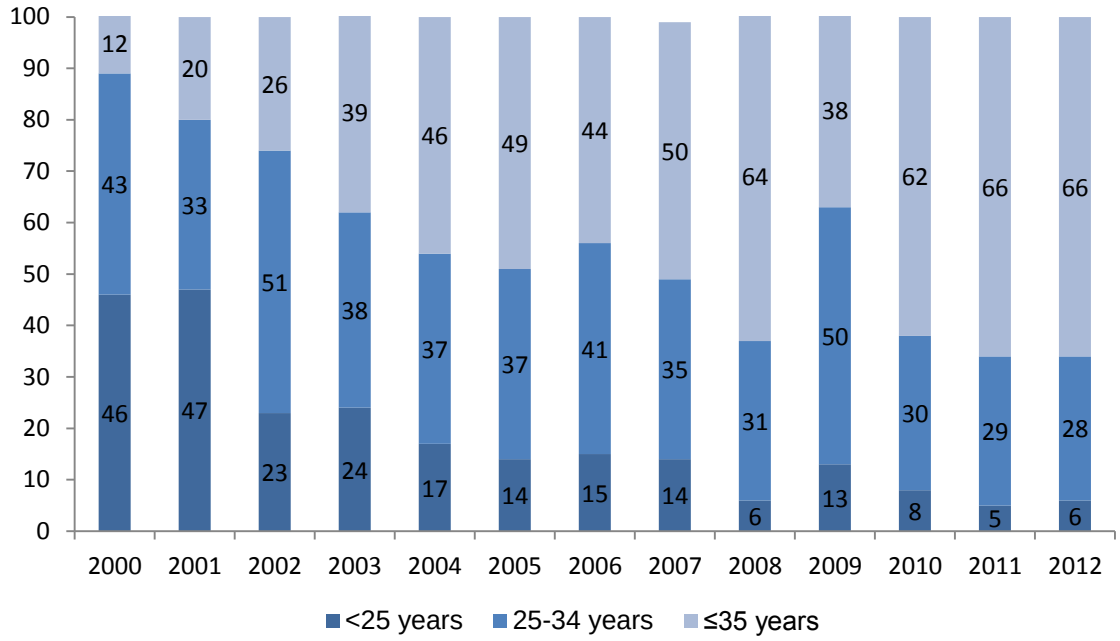
Table 1: Demographic characteristics, 2011 and 2012

	2011 N = 102	2012 N = 100
Age (mean, range)	38 (18–60)	**38 (17–71)**
Gender (% male)	79	**76**
Aboriginal and/or Torres Strait Islander (%)	19	**16**
Sexual identity (%)		
Heterosexual	85	**92**
Gay male	5	**3**
Lesbian	1	**0**
Bisexual	9	**5**
Other	0	**0**
Relationship status (%)		
Married/de facto	24	**11↓**
Partner	11	**15**
Single	62	**71**
Separated	1	**3**
Divorced	2	**0**
Widowed	1	**0**
Highest school grade completed (mean)	10	**10**
Course completed post-school (%)		
None	60	**51**
Trade/technical	32	**47↑**
University/college	8	**3**
Unemployed	82	**82**
Mean income/week ($)	360	**328**
Prison history	66	**59**
Currently in drug treatment[a]	47	**35**

[a] Refers to any form of drug treatment (e.g. pharmacotherapy, counselling, detoxification)
Note: arrow symbol signifies a significant difference $p<0.05$
Source: Queensland IDRS injecting drug user interviews

As seen in Figure 1, the percentage of participants aged 35 years and over has substantially increased since 2000, and now two-thirds of participants are in this age group.

Figure 1: Percentage of participants in each age group, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

4 CONSUMPTION PATTERNS

KEY POINTS

- Methamphetamine was the drug most likely to have been first injected by participants.
- Over half of participants nominated heroin as their drug of choice.
- Heroin was the drug most commonly injected in the preceding month.
- The most recent injection was most likely to be heroin, followed by methamphetamine and morphine.
- 43% of participants injected at least once per day.

4.1 Current drug use

Drug use patterns for 2012 are similar to those of 2011 (Table 2) with no statistically significant differences. Methamphetamines are most commonly the drugs first injected; heroin is most commonly the drug of choice, the drug most injected, and the last drug injected. Nearly four in five participants inject more than weekly.

Table 2: Drug use patterns, 2011 and 2012

	2011 N = 102	**2012 N = 100**
Age first injection (mean years, range)	20 (12-49)	**20 (12-70)**
First drug injected (%)		
Heroin	35	**29**
Methamphetamine (any form)	61	**58**
Cocaine	1	**3**
Morphine	2	**5**
Other	1	**5**
Drug of choice (%)		
Heroin	51	**55**
Cocaine	1	**2**
Methamphetamine (any form)	*(17)*	***(20)***
Speed powder	10	**13**
Base methamphetamine	2	**4**
Crystal methamphetamine	5	**3**
Cannabis	16	**13**
Morphine	6	**7**
Other	9	**3**
Drug injected most often in past month (%)		
Heroin	40	**49**
Cocaine	0	**1**
Methamphetamine (any form)	*(34)*	***(26)***
Speed powder	18	**14**
Base methamphetamine	7	**3**

	2011 N = 102	**2012 N = 100**
Crystal methamphetamine	10	**9**
Morphine	13	**14**
Other/have not injected in past month	13	**10**
Last drug injected (%)		
Heroin	39	**47**
Cocaine	0	**1**
Methamphetamine (any form)	*(28)*	***(25)***
Speed powder	19	**16**
Base methamphetamine	5	**1**
Crystal methamphetamine	5	**8**
Morphine	12	**17**
Buprenorphine/buprenorphine-naloxone	9	**5**
Other drug	12	**5**
Frequency of injecting in past month (%)		
Not in last month	0	**1**
Weekly or less	25	**21**
More than weekly, but less than daily	38	**35**
Once per day	12	**21**
2-3 times a day	22	**19**
>3 times a day	4	**3**

Source: Queensland IDRS injecting drug user interviews

4.1.1. Drug of choice

Heroin continued to be by far the most common drug of choice, nominated by 55% in 2012 (Table 2).

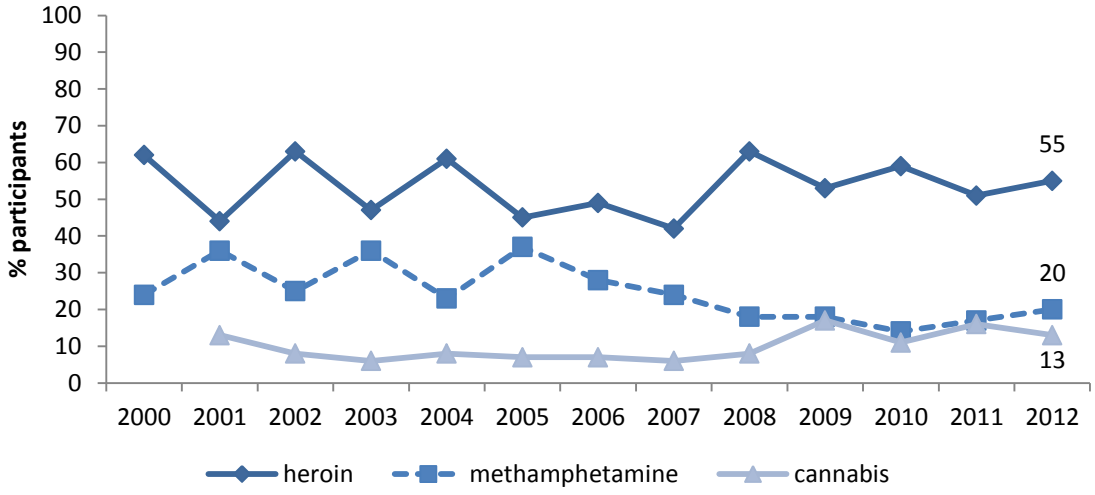
4.1.2. Drug last injected and injected most often in the past month

There was no significant difference in drug use patterns between 2011 and 2012; heroin continued to be the drug most often injected in the past month and the most recent drug injected (Table 2).

4.1.3 Trends over time

Since 2000, the three most common drugs of choice have continued to be heroin, methamphetamine, and cannabis (Figure 2). The proportions have been relatively stable in recent years.

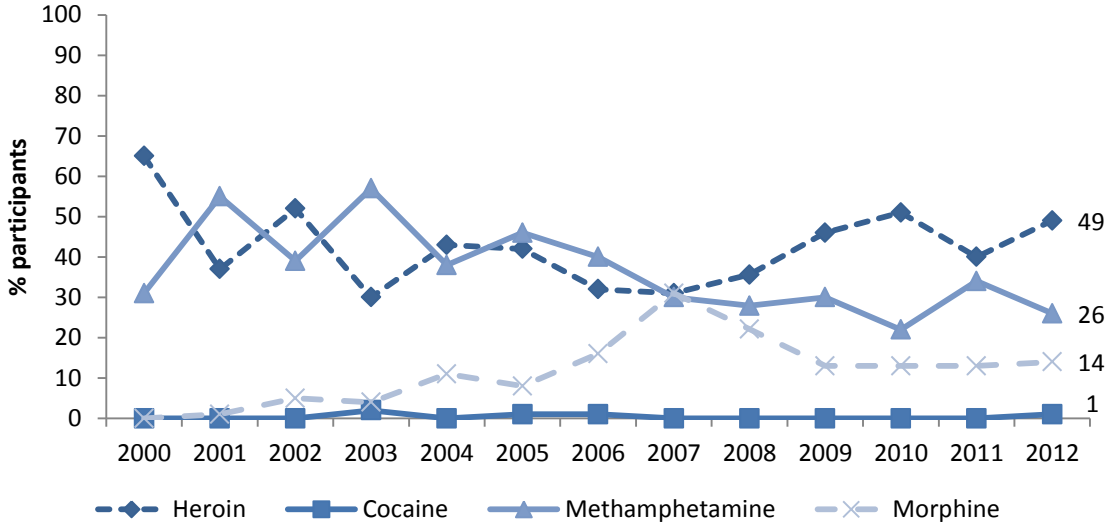
Figure 2: Drug of choice, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

As seen in Figure 3, heroin and methamphetamines have consistently been the drugs injected most often in the previous month, with morphine peaking in 2007 but since levelling off and cocaine very rarely nominated. In 2012 the drugs injected most frequently were heroin, methamphetamines, and morphine (in this order).

Figure 3: Drug injected most often in previous month, 2000 to 2012

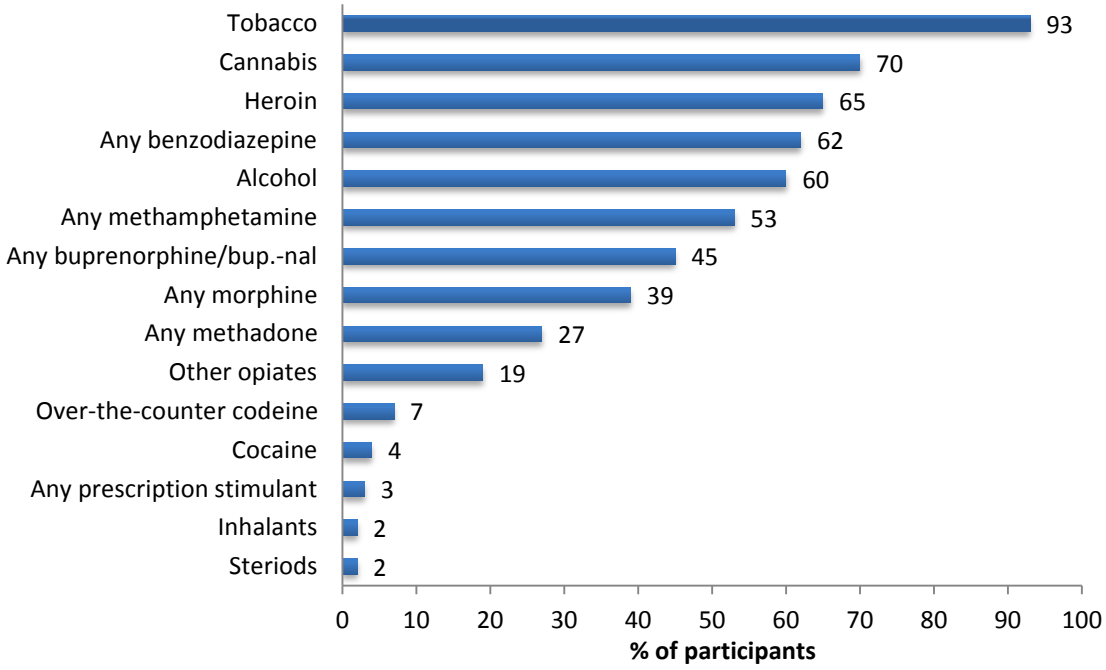


Source: Queensland IDRS injecting drug user interviews

4.1.4 Polydrug use

As in previous years, participants reported polydrug use. Figure 4 shows the main types of drugs used by participants in the preceding six months. The most commonly used drug was by far tobacco, followed by cannabis, heroin and benzodiazepines.

Figure 4: Main types of drugs used in preceding six months, 2012



Note: 'Any' refers to both licit and illicit. 'Use' refers to any form of administration and does not necessarily imply injection.
Source: Queensland IDRS injecting drug use interviews

4.1.5 Forms of drugs used in preceding six months

Participants were asked about their use of the main drug types (ever, previous six months), the sub-types used, and the mode of administration; and this information is presented in Table 3.

Table 3: Drug history, 2012

	Used			Route of administration								
				Injected			Smoked		Snorted		Swallowed	
	Ever %	Recent[a] %	Days[b]	Ever %	Recent[a] %	Days[b]	Ever %	Recent[a] %	Ever %	Recent[b] %	Ever %	Recent[a] %
Heroin	80	65	72	89	65	70	34	4	14	3	17	7
Homebake	43	7	10	38	7	10	1	0	0	0	2	0
Any heroin	89	65	72	89	65	70	34	4	14	3	17	7
Methadone *licit*	50	18	170	24	7	48					48	18
Methadone *illicit*	43	11	2	30	6	3					28	6
Physeptone *licit*	18	1	2	7	0	0	0	0	0	0	13	1
Physeptone *illicit*	22	1	2	14	1	2	0	0	0	0	12	0
Any methadone	72	27	150	46	12	5	0	0	0	0	63	23
Buprenorphine *licit*	41	10	120	19	3	24	3	0	1	0	36	10
Buprenorphine *illicit*	55	22	9	46	19	12	1	0	0	0	20	4
Bup-naloxone tablets *licit*	39	14	32	19	7	24	1	0	0	0	35	12
Bup-naloxone film *licit*	9	6	11	1	1	1	0	0	0	0	9	6
Bup-naloxone tablets *illicit*	32	14	6	23	10	8	0	0	0	0	18	7
Bup-naloxone film *illicit*	4	4	2	2	2	2	0	0	0	0	2	2
Any bup-naloxone	77	45	28	55	29	14	**5**	**0**	**1**	**0**	59	29
Morphine *licit*	30	8	180	18	3	180	0	0	0	0	19	5
Morphine *illicit*	64	34	11	58	32	12	0	0	0	0	17	4
Any morphine	72	39	18	63	33	12	0	0	0	0	29	8
Oxycodone *licit*	20	7	14	10	2	72	0	0	0	0	14	5
Oxycodone *illicit*	56	29	3	44	22	4	1	0	1	1	22	10
Any oxycodone	64	35	4	47	24	4	1	0	1	1	34	
Over-counter codeine (non-medicinal)	17	7	29	0	0	-	0	0	0	0	16	7
Other opiates	52	19	11	3	0	-	0	0	0	0	51	19
Speed powder	88	30	6	85	29	6	16	3	28	3	27	2

	Used			Route of administration								
				Injected			Smoked		Snorted		Swallowed	
	Ever %	Recent[a] %	Days[b]	Ever %	Recent[a] %	Days[b]	Ever %	Recent[a] %	Ever %	Recent[b] %	Ever %	Recent[a] %
Amphetamine liquid	21	5	5	20	5	5					5	2
Base/point/wax	51	21	20	44	19	24	9	3	1	0	13	3
Ice/crystal/shabu	75	44	17	74	43	12	30	13	5	1	11	2
Any methamphetamine	92	53	20	92	51	22	37	15	30	4	35	4
Prescrip. stimulants *licit*	12	0	0	2	0	-	0	0	0	0	12	0
Prescrip. stimulants *illicit*	28	3	2	13	3	2	0	0	2	0	20	0
Any prescrip. stimulants	36	3	2	14	3	2	0	0	2	0	29	0
Cocaine	61	4	4	38	3	5	9	0	30	2	7	0
Hallucinogens	65	4	2	8	0	-	0	0	0	0	64	4
Ecstasy	58	7	2	16	1	5	1	0	5	1	57	6
Alprazolam *licit*	25	12	80	5	1	6	0	1	0	0	25	12
Alprazolam *illicit*	54	35	5	6	1	2	1	1	0	0	52	34
Any Alprazolam	62	42	10	9	2	4	1	1	0	0	61	41
Other benzo. *licit*	66	40	150	2	0	-	0	0	0	0	65	40
Other benzo. *illicit*	46	20	6	2	0	-	0	0	0	0	44	20
Any other benzo.	78	48	90	4	0	-	0	0	0	0	75	48
Any benzodiazepine	85	62	96	11	2	4	1	1	0	0	82	61
Seroquel *licit*	27	12	180	0	0	-					27	11
Seroquel *illicit*	36	11	4	2	0	-					36	11
Any Seroquel	55	22	30	2	0	-					55	21
Alcohol	96	60	12	1	0	-					96	60
Cannabis	98	70	90				97	69			47	11
Inhalants	19	2	41									
Tobacco	98	93	180									
Steroids	7	1	21	7	1	21	0	0	0	0	1	0

[a] in the preceding six months; [b] Median days in the preceding six months (180 days) Source: Queensland IDRS injecting drug user interviews

4.2 Heroin

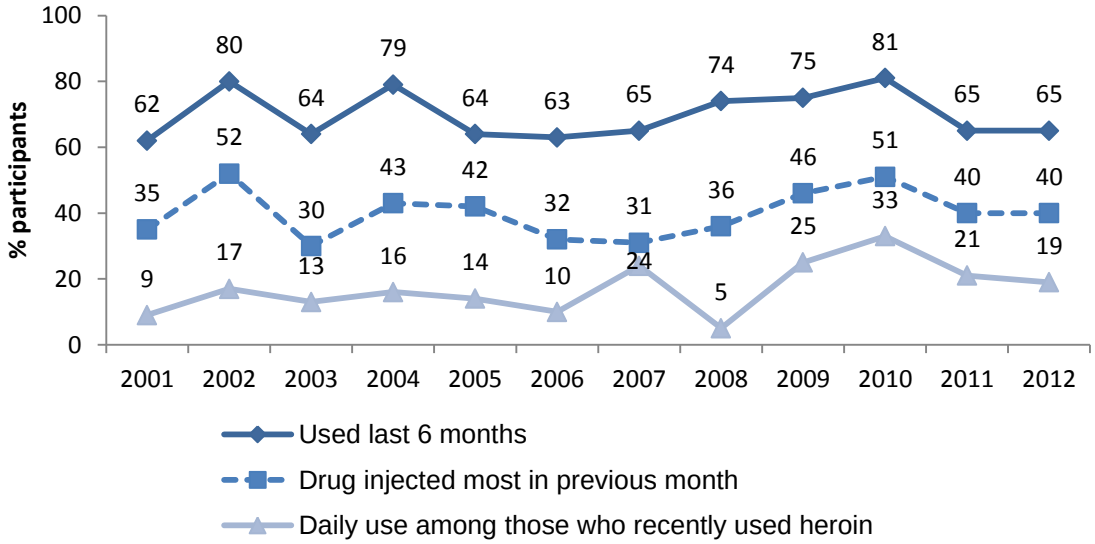
KEY POINTS

- 65% used heroin in the preceding six months.
- Amongst those who used heroin, median use was 72 days, with 19% using daily.
- Use of homebake remained low.

4.2.1 Use of heroin

Use of heroin has fluctuated since 2001, but the pattern of use in 2012 was almost identical to that of 2011 (Figure 5). Amongst those who used heroin, nearly one in five (19%) used daily (i.e. 12% of all participants).

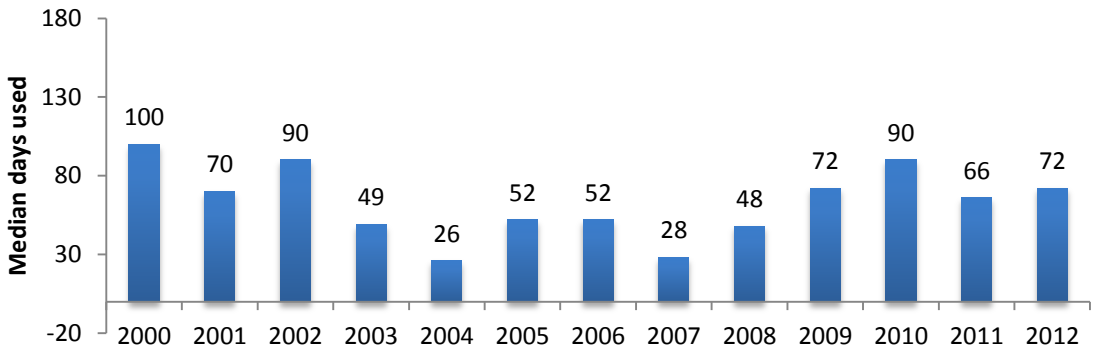
Figure 5: Prevalence and frequency of heroin use, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

The median days of reported heroin use in the previous six months (180 days) has ranged from 26 to 100 over the 13-year period (2000–12), with the median days of use reported as 72 in 2012 (Figure 6).

Figure 6: Median days of heroin use in preceding six months, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

4.2.2 Homebake

Homebake is a form of heroin made from pharmaceutical products and involves the extraction of diamorphine from pharmaceutical opioids such as codeine and morphine. Questions about homebake were first included in 2002 and since then reports of recent use have remained low. In 2012, 7% of participants had used homebake in the preceding six months, with use occurring on a median of 10 days (range = 1-80 days).

4.2.3 Heroin forms used

Most of those who had recently used heroin (92%), reported using white/off-white heroin and 60% reported having used brown heroin. The form most commonly used in the previous six months was white/off-white heroin rock (Table 4).

Table 4: Heroin forms most used, 2012 (n = 64)

	Heroin powder			Heroin rock		
	White/ off-white	Brown	Other colour	White/ off-white	Brown	Other colour
% most used in past six months	28	8	0	55	9	0

[a] more than one form could be reported
Source: Queensland IDRS injecting drug user interviews

4.2.4 Heroin preparation

When preparing their last heroin injection, about one-third used heat (34% compared with 57% in 2011), and the colour of the heroin was most likely to be white (Table 5).

Table 5: Use of heat and acid in the preparation of most recent heroin injection, 2011 and 2012

	2011 n = 63 %	2012 n = 64 %
Heated in the last injection	57	**34**
Acid in the last injection	2	**0**
Main colour[a]	n = 33	**n = 22**
White	64	**77**
Brown	36	**23**

[a] among those who reported either heating or using acid to prepare their last injection
Source: Queensland IDRS injecting drug user interviews

Key expert comments

Key experts reported that heroin is typically injected by older people who are well entrenched in the heroin-using lifestyle. Several key experts noted that the small minority of young people who inject heroin, do so frequently: as one key expert observed: '*young people who inject heroin, inject heavily'*. Another key expert observed that the stigma surrounding injecting meant that young people were often more inclined to smoke heroin than to inject it. Young people were reported as beginning opioid injecting with pharmaceutical opioids rather than with heroin. Use of pharmaceutical opioids alongside heroin was also reported as common. One key expert reported that more people were using heroin and amphetamines together.

4.3 Methamphetamines

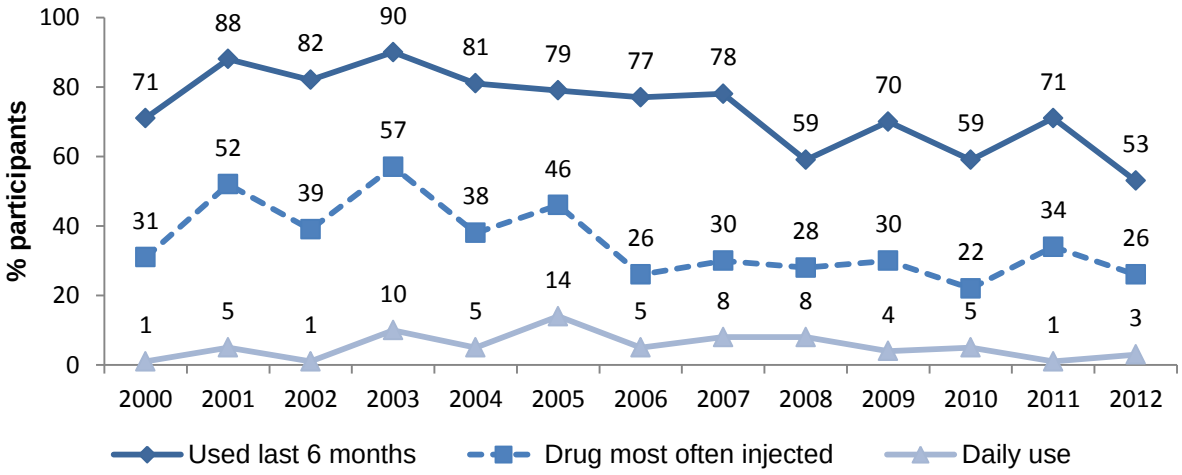
KEY POINTS

- 53% of participants had used methamphetamines in the previous six months.
- Methamphetamine was the drug most often injected by 26% of participants.
- 44% of participants had recently used crystal/ice.

4.3.1 Use of methamphetamines

In recent years, methamphetamine (includes speed, base, crystal, and liquid) use has fluctuated; and in 2012, use of a methamphetamine in the previous six months decreased from 71% in 2011 to 53% in 2012 ($p < .05$; Figure 7). Just over a quarter reported that methamphetamine was the drug most often injected in the past month. The percentage of all participants using a form of methamphetamine daily has generally been low (3% in 2012).

Figure 7: Use of methamphetamine (in any form) in preceding 6 months, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

4.3.2 Methamphetamine form most used

As in previous years, data was collected about four different forms of methamphetamines: methamphetamine powder (speed), base methamphetamine (base), crystal methamphetamine (crystal/ice), and methamphetamine liquid.

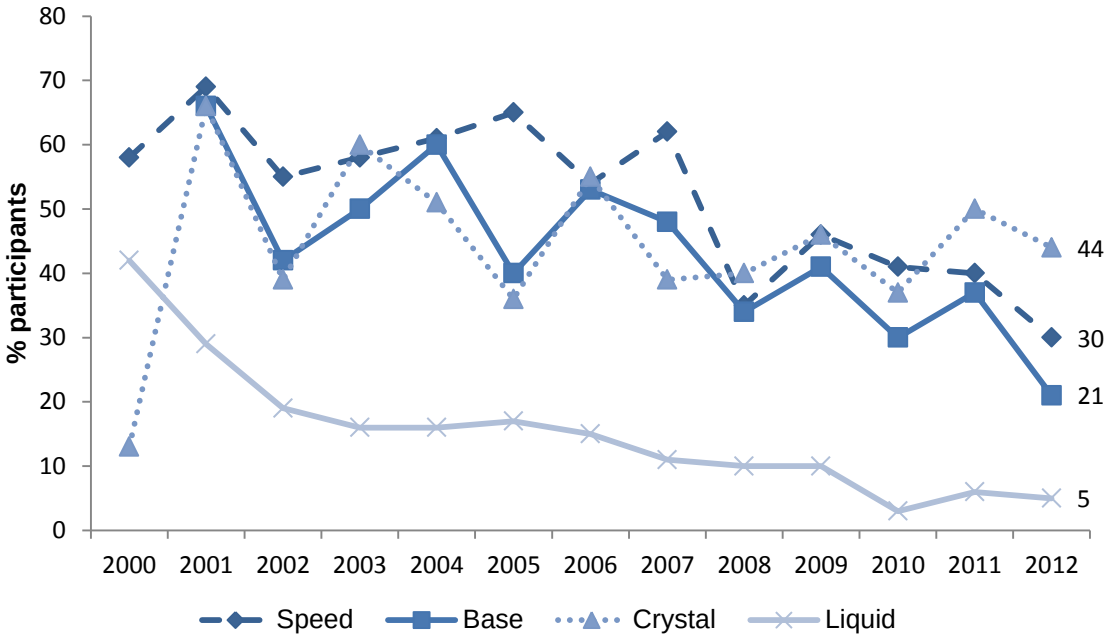
Speed

Base

Crystal/ice

Over the years there has been fluctuation in the recent use of the various forms of methamphetamine (Figure 8). The use of liquid has been low for some time and the ordering of the other three forms has been mixed. In 2012, 44% of the study sample had recently used crystal, 30% speed, 21% base and 5% liquid. Due to the low use of liquid methamphetamine in 2012, no further data will be presented.

Figure 8: Forms of methamphetamine used in preceding six months, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

4.3.3 Methamphetamine frequency of use

The median number of days of methamphetamine use for individual forms varies from 2011, with crystal being used on a median of 17 days compared with 6 in 2011 (Table 6).

Table 6: Median days of methamphetamine use in preceding six months, 2011 and 2012

	Median days	
	2011	**2012**
Speed	10	**6**
Base	12	**20**
Ice/crystal	6	**17**
Any form[a]	23	**20**

[a] includes speed powder, base, ice/crystal and liquid forms
Note: Maximum number of days (i.e. daily use) = 180
Source: Queensland IDRS injecting drug user interviews

Key expert comments

Key experts reported that specific forms of methamphetamines were not always differentiated; and that the street name 'fast' encompassed all forms. However there was agreement that crystal was becoming the preferred form: it was noted that it was marketed as a superior or premium product. There were mixed reports as to whether use of speed powder and base had declined. As one key expert explained '*People have favourites* [forms] *but will use whatever they can get*'.

4.4 Cocaine

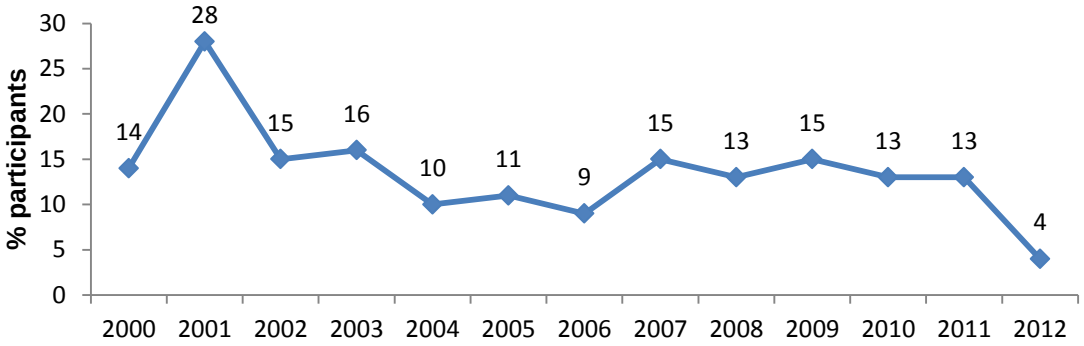
KEY POINTS

- Cocaine use continues to be uncommon among people who regularly inject drugs.
- Participants who used cocaine tended to use it infrequently.

4.4.1 Use of cocaine

In recent years, the proportion of participants reporting recent cocaine use has remained relatively constant but in 2012 there was a significant decrease from 13% in 2011 to 4% in 2012 ($p<0.05$) (see Figure 9). Of the four participants who had recently used cocaine, three had injected it, and two had snorted it during the past six months. Use tended to be occasional, with a median of four days use (range = 1–13) in the preceding six months (180 days).

Figure 9: Cocaine use in preceding six months, 2000 to 2012



Source: Queensland IDRS participant interviews

Key expert comments

KE reported that cocaine use was rare amongst people who regularly inject drugs, that there might be some occasional, opportunistic use and that overall it was atypical for someone who injects to regularly use cocaine.

4.5 Cannabis

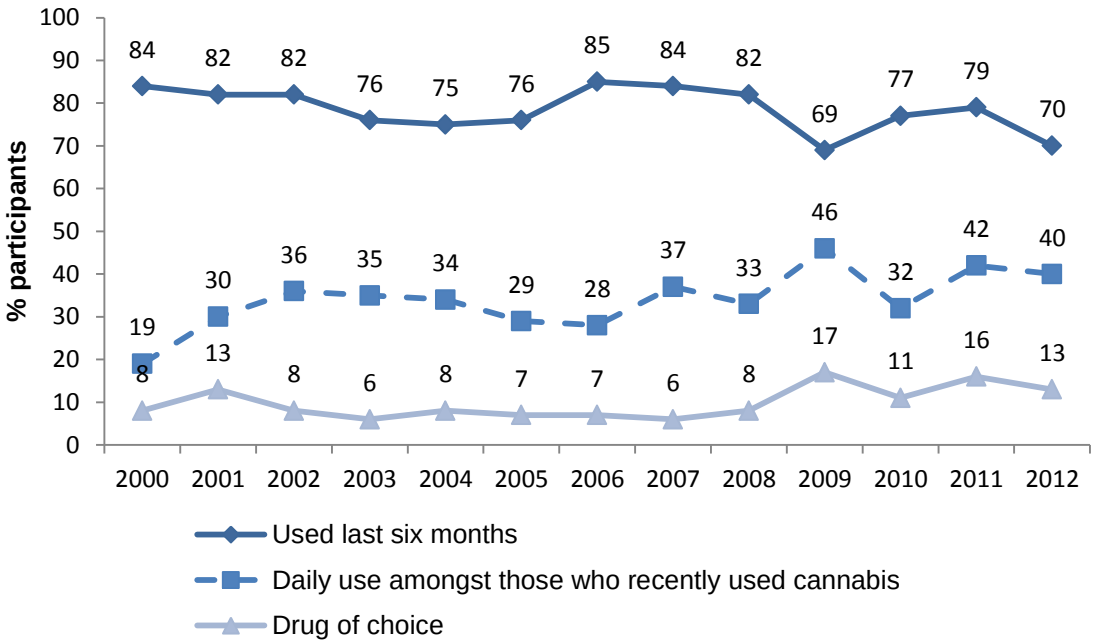
KEY POINTS

- Cannabis use continued to be common, with 70% reporting recent use.
- Two in five of those who recently used cannabis used it every day.
- Hydro rather than bush was mainly used; and cones rather than joints were used.

4.5.1 Use of cannabis

In 2012, almost all participants (98%) reported using cannabis at least once in their lifetime. Patterns of use are relatively stable from year to year, but the change that has occurred between 2000 and 2012 is that fewer participants reported recent use and more reported daily use (Figure 10). Cannabis was the drug of choice for 13% of participants in 2012.

Figure 10: Prevalence and frequency of cannabis use, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

4.5.2 Cannabis forms used

Of those who had used cannabis in the previous six months, 90% mostly used hydro (hydroponically grown); and most (78%) had used cones the last time they used cannabis. Use of hash and hash oil was rare.

Key expert comments

Cannabis use was reported as relatively stable amongst people who inject drugs, with use quite normalised. Bongs and buckets have become the most common way of using, and hydroponic cannabis continues to be used more often than bush; although older people often preferred bush. Key experts noted there was some use of synthetic cannabis, and this was sometimes combined with authentic cannabis. Cannabis was reported as being used for a variety of reasons including as a relaxant, to help cope, to assist with sleep, for pain relief, and to come down from using methamphetamines.

4.6 Other opioids

KEY POINTS

- 18% of participants reported prescription use of methadone in the previous six months.
- Buprenorphine (Subutex®) was the most commonly used illicit (i.e. not prescribed) substitution pharmacotherapy.
- Amongst those prescribed a substitution pharmacotherapy, injection of at least one prescribed dose was most common for those prescribed buprenorphine-naloxone (Suboxone®) tablets and methadone.
- The majority of participants who used illicit substitution pharmacotherapy injected it.
- Recent use of illicit morphine was consistent with previous years, with use by 34% and injecting by 32%.
- 29% had used illicit oxycodone in the previous six months.
- Lifetime non-medicinal use of over-the-counter codeine (predominantly Nurofen Plus®) was reported by 17%; 7% reported using in the preceding six months.
- Nearly one in five had recently used other opiates (e.g. pethidine, Panadeine Forte®, opium).

.6.1 Substitution pharmacotherapy

Methadone is prescribed as a substitute drug for opioids, and is usually prescribed as a liquid preparation and commonly dosed under supervision. 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 methadone is not tolerated.

More recently buprenorphine was introduced as an alternative to methadone, and since 2005 buprenorphine-naloxone is widely prescribed because of its agonist/anti-agonist properties. Both buprenorphine and buprenorphine-naloxone were dispensed in tablet form to be dissolved under the tongue but since late 2011, they have been dispensed as sublingual film strips. In 2012, 77% of participants had ever used a form of buprenorphine or buprenorphine-naloxone (licit or illicit) and 45% in the previous six months.

Participants' pattern of use of all four substitution drugs is presented in Table 7. Most participants who illicitly used substitution pharmacotherapy also injected the drug. Buprenorphine was most commonly used and injected illicitly.

Table 7: Use of licit and illicit substitute drugs in preceding six months, 2012

	Licit (prescribed)		**Illicit** (not prescribed)	
	Used %	**Injected** %	**Used** %	**Injected** %
Methadone *liquid*	18	7	11	6
Physeptone *tablets*	1	0	1	1
Buprenorphine *tablets*	10	3	22	19
Buprenorphine-naloxone *tablets*	14	7	14	10
Buprenorphine-naloxone *film*	6	1	4	2

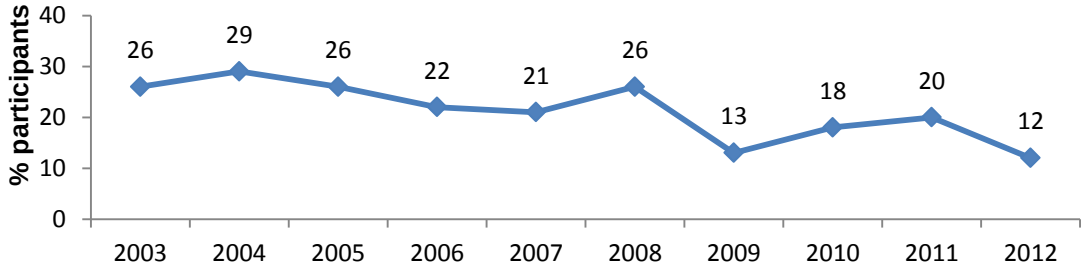
Source: Queensland IDRS injecting drug user interviews

Use of methadone

In 2012, 50% of participants reported having been prescribed methadone at least once in their lifetime (i.e. licit use), and 43% reported illicit use at least once in their lifetime.

Amongst all participants, 46% reported ever having injected methadone (prescribed or not prescribed) and 12% reported injecting it in the previous six months (Figure 11). Participants on prescribed methadone (daily use) injected their prescribed dose on a median of 48 out of 180 days (equivalent to twice weekly). The 6% of participants who reported injecting illicit methadone in the preceding six months injected it on a median of three days.

Figure 11: Injected methadone (prescribed or not prescribed) in preceding six months, 2003 to 2012



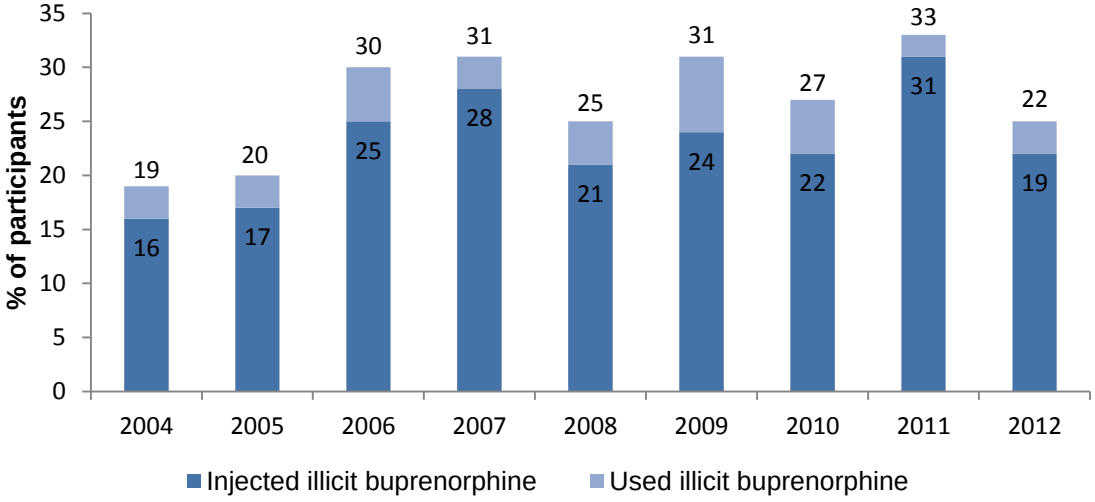
Source: Queensland IDRS drug user interviews

The most common reason given for use of illicit methadone was to treat self-dependence.

Use of buprenorphine (Subutex®)

Twenty-nine per cent of participants had used buprenorphine (licit and/or illicit) in the previous six months, with 10% reporting licit use (i.e. prescribed) and 22% reporting illicit use. Figure 12 shows the proportion of participants using and injecting illicit buprenorphine has varied, but in all years illicit buprenorphine was primarily injected. Median days of injecting over the previous six months was 12. The most common reasons for using illicit buprenorphine on the last occasion of use were that it was cheaper than heroin (36%) and self-treatment (29%).

Figure 12: Use and injection of illicit buprenorphine in preceding six months, 2004 to 2012

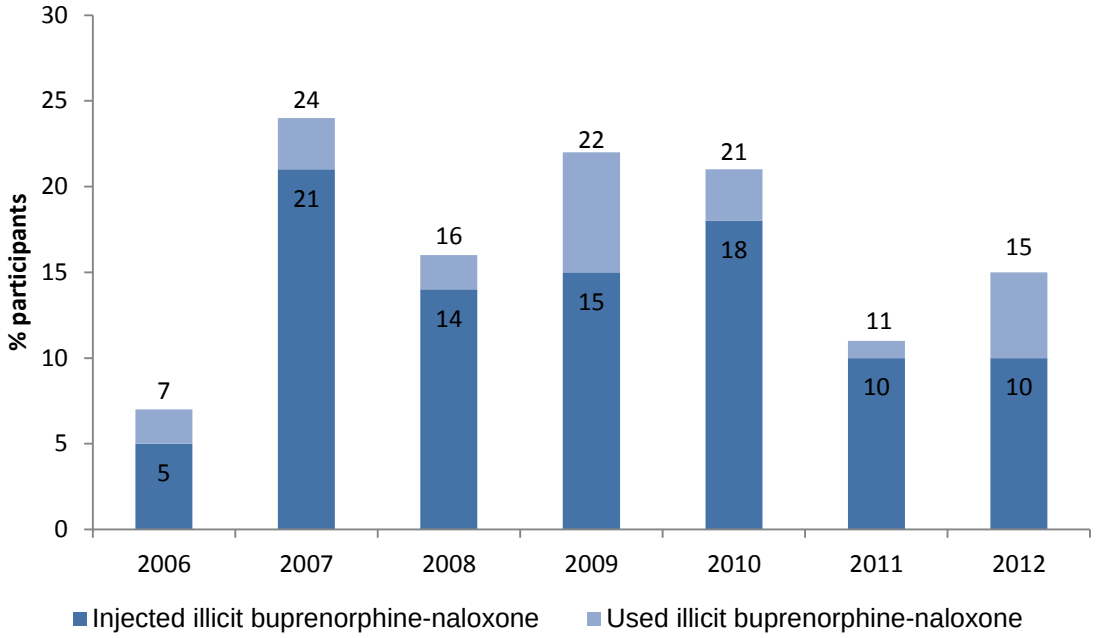


Source: Queensland IDRS injecting drug user interviews

Use of buprenorphine-naloxone (Suboxone®)

Thirty per cent of all participants had used buprenorphine-naloxone (licit and/or illicit) in the previous six months, and this included both tablet and film form. Fifteen per cent of participants reported illicit use whether in tablet or film form, and 10% injected it. The most frequent reason given for using illicit buprenorphine-naloxone was self-treatment.

Figure 13: Use and injection of illicit buprenorphine-naloxone (tablets or film) in preceding six months, 2006 to 2012



Note: Prescribing of film commenced in late 2011
Source: Queensland IDRS injecting drug user interviews

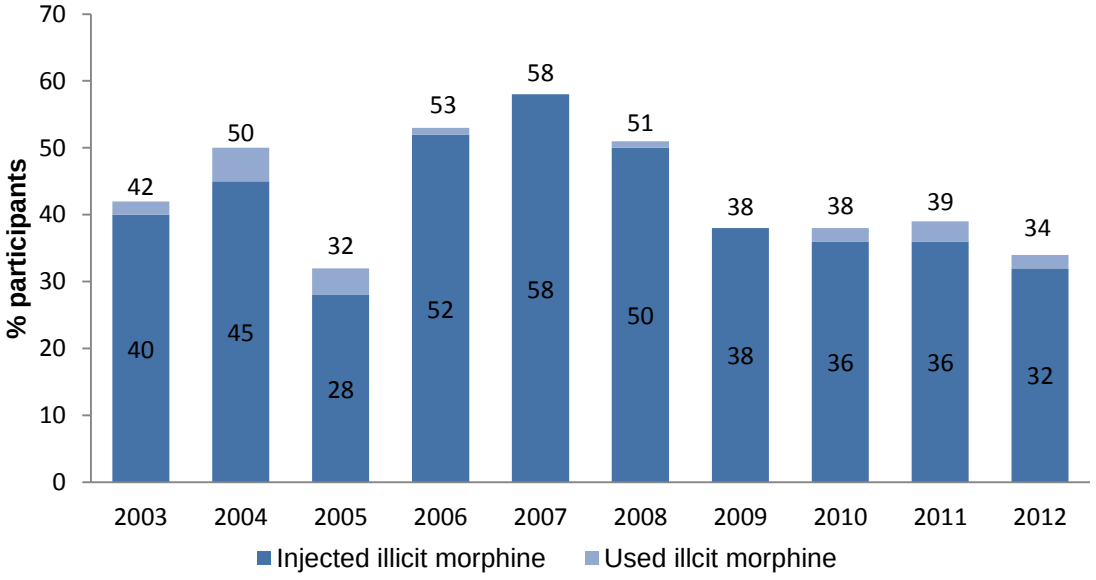
4.6.2 Use of morphine

Morphine (licit or illicit) was used by 39% of participants in the previous six months. MS Contin® was nearly always nominated as the main brand used.

Licit morphine was used by 8% of participants in the preceding six months, with 3% injecting it.

Illicit morphine use in the previous six months was similar to previous years (Figure 14), with most reporting injecting it. Illicit morphine was used on a median of 11 days in the preceding six months. The most common reason given for using illicit morphine was self-treatment followed by intoxication.

Figure 14: Use and injection of illicit morphine in preceding six months, 2003 to 2012



Source: Queensland IDRS injecting drug user interviews

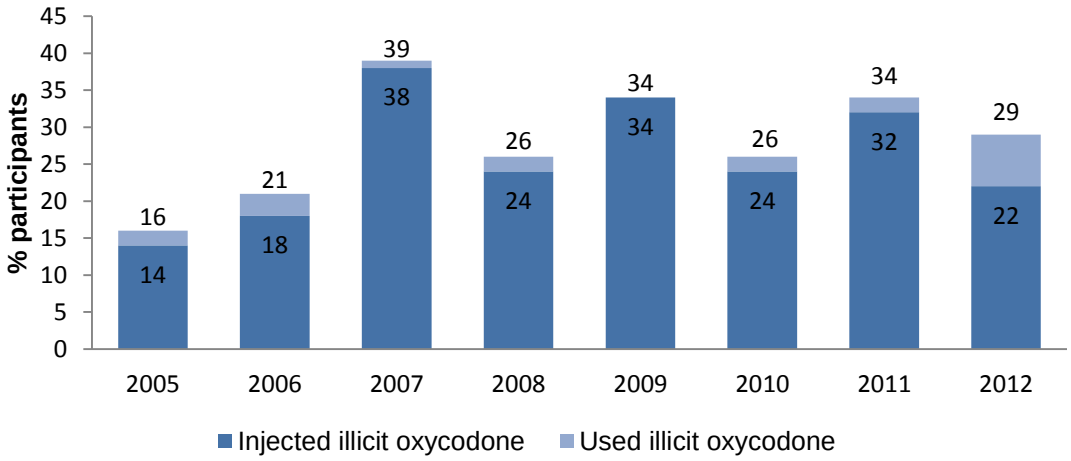
4.6.3 Use of oxycodone

Data has been gathered on licit and illicit forms of oxycodone (e.g. OxyContin®, Endone®) since 2005. Six per cent of participants reported using licit oxycodone in the previous six months, and 4% reported having injected it.

Illicit oxycodone

In 2012, 29% of participants had used illicit oxycodone in the previous six months (Figure 15), with 22% injecting it. Median days of use within the previous six months was three. By far the most frequent reason for using illicit oxycodone was self-treatment.

Figure 15: Use and injection of illicit oxycodone in preceding six months, 2005 to 2012



Source: Queensland IDRS injecting drug user interviews

4.6.4 Use of over-the-counter codeine, non-medicinal purposes only

In 2012, 17% of participants reported having ever used over-the-counter codeine for non-medicinal purposes, with 7% reporting use in the previous six months. Comparisons cannot be made with previous years because the question was narrowed down to 'non-medicinal use only'. The brand most commonly nominated as the most used was Mersyndol®.

4.6.5 Use of other opiates

In 2012, 52% of participants had used another type of opiate (e.g. pethidine, Panadeine Forte®, opium) in their lifetime, with 19% having used in the previous six months. Both these proportions were significantly lower than in 2011 when 68% reported lifetime use and 33% reported use in previous six months($p < .05$).

Key expert comments

Key experts reported that there is widespread use of pharmaceutical opioids, particularly Oxycontin® (oxycodone, a semi-synthetic opioid) and MS Contin® (morphine). Use was increasing and was often becoming more common than heroin. Although pharmaceutical opioids were reported as being used alongside heroin, some people with chronic pain injected Oxycontin® exclusively. Key experts pointed out that injecting non-prescribed pharmaceuticals sometimes stemmed from being initially prescribed them.

There was also a reported increase in problematic use of buprenorphine and buprenorphine-naloxone. One key expert noted that people who inject buprenorphine were: '*usually quite young and new to drug use*; as another key expert explained: '*mainly younger people; older folk stick to heroin'.*

4.7 Other drugs

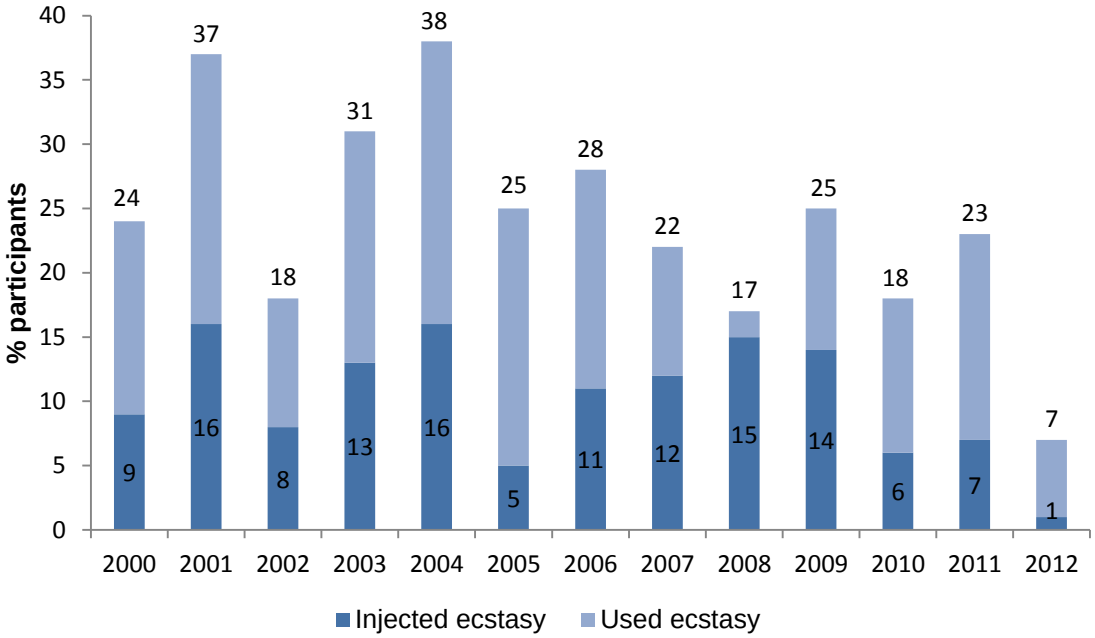
KEY POINTS

- Recent use of ecstasy decreased from 23% in 2011 to 7% in 2012 ($p<0.05$).
- Only 4% reported using hallucinogens in the previous six months, with none injecting.
- 62% had used benzodiazepines (licit or illicit) in the preceding six months.
- 35% reported recent illicit use of Alprazolam and 20% reported illicit use of other benzodiazepines.
- Recent use of pharmaceutical stimulants (e.g. dexamphetamine and methylphenidate) was rare (3% illicit use).
- About one in five of participants (19%) had used inhalants in their lifetime, but only 2% had used them in the past six months.
- Three in five participants reported alcohol use in the preceding six months.
- Almost all participants used tobacco (98%).

4.7.1 Ecstasy and related drugs

The pattern of recent ecstasy use has fluctuated somewhat since 2000 (Figure 16), although the proportion injecting ecstasy has generally been relatively low. In 2012 only 7% reported recent use, a decrease from 23% in 2011 ($p<0.05$).

Figure 16: Use and injection of ecstasy in preceding six months, 2000 to 2012



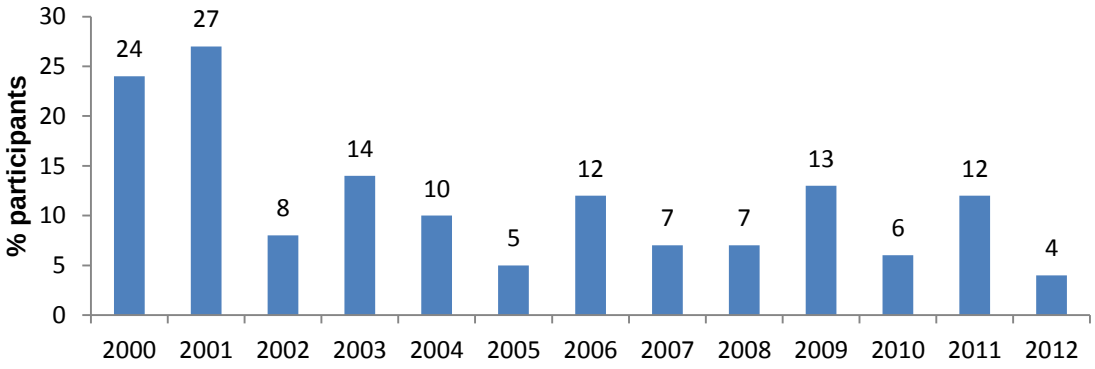
Source: Queensland IDRS injecting drug user interviews

4.7.2 Hallucinogens

Figure 17 shows that hallucinogens were used by a higher proportion of participants when interviewing first began in 2000 and 2001 than in subsequent years (4% in 2012). Median days used

has been low over the years and was two in 2012. Although 8% of participants reported having injected a hallucinogen in their lifetime, none had done so in the preceding six months.

Figure 17: Hallucinogen use in preceding six months, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

4.7.3 Benzodiazepines

In 2012, 85% of participants had used a benzodiazepine in their lifetime whether licit or illicit; and 62% had done so recently. In regard to alprazolam (e.g. Xanax®, Kalma®), 62% had used it in their lifetime (licit or illicit), and 42% recently. Table 8 shows the breakdown of licit and illicit use for alprazolam and other benzodiazepines. Median days use of alprazolam was 5 for illicit and 80 for licit: for other benzodiazepines median days use was 6 for illicit and 150 for licit. Injection of benzodiazepines was rare.

Table 8: Use of licit and illicit benzodiazepines in preceding six months, 2011 and 2012

	Licit (prescribed)		**Illicit** (not prescribed)	
	2011 %	**2012 %**	2011 %	**2012 %**
Alprazolam	17	**12**	40	**35**
Other benzodiazepines	46	**40**	33	**20**

Source: Queensland IDRS injecting drug user interviews

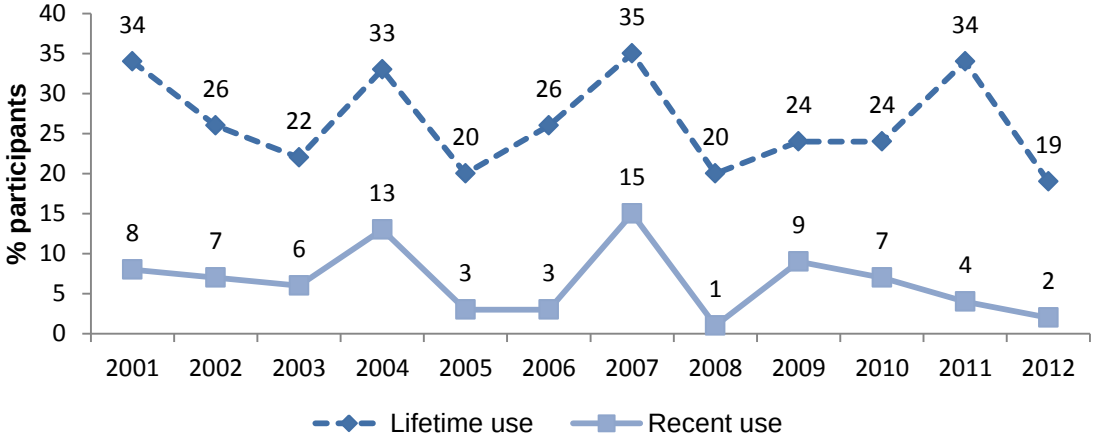
4.7.4 Pharmaceutical stimulants

Similar to previous years, recent use of pharmaceutical stimulants (e.g. dexamphetamine and methylphenidate) was uncommon (3%), and in 2012 was exclusively illicit and was injected.

4.7.5 Inhalants

The prevalence of inhalant use has peaked and troughed since 2001, and in 2012 lifetime use had significantly decreased from 2011 ($p<0.05$), while recent use remained low (Figure 18).

Figure 18: Prevalence of inhalant use, 2001 to 2012



Source: Queensland IDRS injecting drug user interviews

4.7.6 Alcohol and tobacco

Alcohol use

Similar to previous years, the majority of respondents (96%) reported having used alcohol in their lifetime, with 60% reporting recent use. Only one participant had injected alcohol in their lifetime and had not done so in the preceding six months. The median frequency of alcohol use was fortnightly.

Recently a lot of media attention has focused on young people and alcohol. However, there has been less focus on alcohol use amongst people who regularly inject drugs. People who regularly inject drugs are particularly at risk for alcohol-related harms due to a high prevalence of the hepatitis C virus (HCV). Half of the participants interviewed in the Australian NSP Survey 2011 (n = 2,395) were found to have HCV antibodies (Kirby Institute, May 2011). Given that the consumption of alcohol has been found to exacerbate HCV infection and to increase the risk of both non-fatal and fatal opioid overdose and depressant overdose (Coffin et al., 2007; Darke, Duflou, & Kaye, 2007; Darke, Ross, & Hall, 1996; Schiff & Ozden, 2004), it is important to monitor risky drinking among people who inject drugs.

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

Among study participants who drank alcohol in the past year, the overall mean score on the AUDIT-C was 4.9 (median = 5, range = 1–11) (Table 9). There was no significant gender difference: mean score was 5.6 for females (n = 14) and 4.7 for males (n = 50). According to Dawson and colleagues (2005) and Haber and colleagues' (2009) *Guidelines for the Treatment of Alcohol Problem's*, a cut-off score of five or more indicates that further assessment is required.

Just over half of the participants who drank in the past year scored ≥5 on the AUDIT-C, indicating the need for further assessment (Table 9). The gender break down was 57% of females and 50% of males.

Table 9: AUDIT-C amongst participants who drank alcohol in the past year, 2011 and 2012

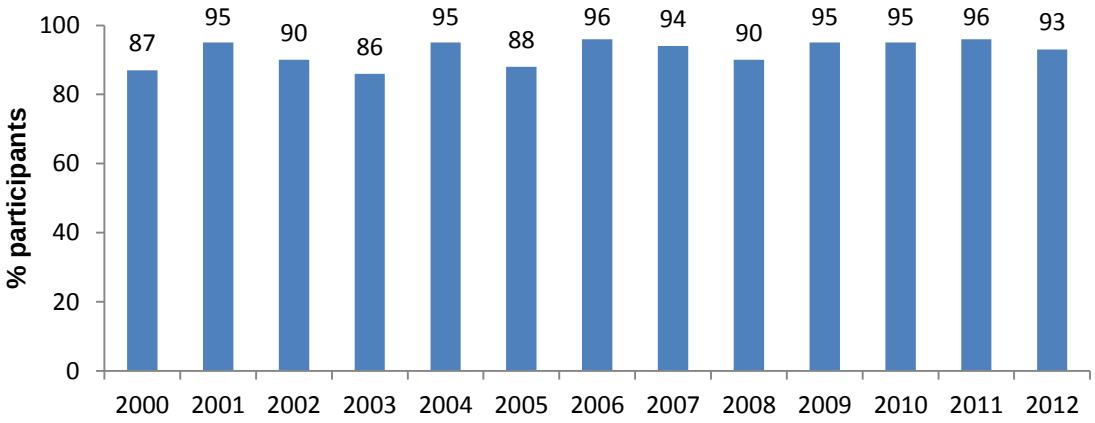
	2011 n = 75	**2012 n = 64**
Mean AUDIT-C score	5.8	**4.9**
SD	3.5	**3.6**
(range)	(1–12)	**(1–11)**
Score of 5 or more	61%	**52%**

Source: Queensland IDRS injecting drug user interviews

Tobacco use

As in previous years, nearly all participants reported recent tobacco use (Figure 19), with 89% reporting daily use (i.e. 96% of those who smoked in the previous six months).

Figure 19: Tobacco use in preceding six months, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

Key expert comments

Key experts reported that it was rare for people who inject drugs to use ecstasy, hallucinogens such as lysergic acid diethylamide (LSD), and inhalants. However, benzodiazepine use was still considered to be widespread, with Valium© reported as particularly easy to access whether licit or illicit. There were mixed reports about the use of Xanax©, with one key expert reporting it was harder to obtain while others noted that its use was continuing to be problematic. The benzodiazepine-opiates mix was still considered to be popular amongst people who inject drugs.

Key experts reported that many people who inject drugs, do not use alcohol at all; however those who do use alcohol tend to be heavy drinkers. Key experts spoke about the problems arising from combing alcohol with other substances. They pointed out that intoxication often resulted in less acute decision making about safer dosing and injecting practices.

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

This section is about the market characteristics (i.e. price, perceived purity, availability, and purchasing patterns) of the main drugs of interest. Participants were asked to provide information about a drug only if they were confident that they knew about that particular market. Consequently, the number of participants providing market information about each drug varies considerably. Due to limited response to some questions, meaningful interpretation of these responses was not possible.

5.1 Heroin market

KEY POINTS

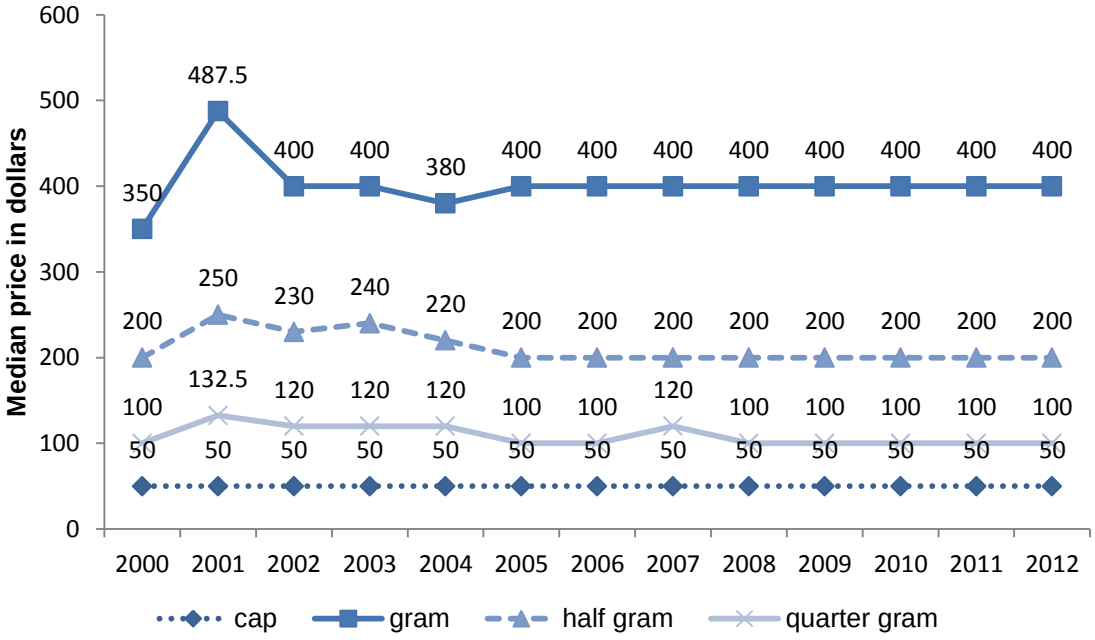
- Heroin price stable at $400 per gram ($50 cap).
- Purity was generally reported as low or medium, with mixed ratings on whether purity had recently changed.
- Heroin was readily available for most, but 25% rated availability as difficult.
- Two-thirds of participants last purchased from a known dealer, and half had made their last purchase at an agreed public location.

Of the entire sample (N = 100), 58 participants answered questions about the heroin market, and analysis is based on this sub-sample.

5.1.1 Heroin price

In recent years heroin prices have remained stable with a median price of $50 a cap, $400 per gram, $200 per half gram, and $100 per quarter gram (Figure 20).

Figure 20: Median cost of most recent heroin purchases, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

Consistent with the stability of pricing in recent years, most participants reporting on the heroin market (n = 53, 81%) rated heroin prices as stable. However, the Australian Crime Commission (2012)

reported that prices for a gram of heroin in Queensland had risen from $400 for the financial year 2009–10 to $700 in 2010–2011.

Participants were asked questions about their buying habits in the previous six months. When asked whether they usually buy heroin by weight or by dollar amount, 57% responded by dollar amount, 36% by weight, and 7% both (n = 56). Half a gram was the most common amount amongst those who generally bought by weight, and $100 was the most common amount amongst those who generally bought by price (Table 10).

Table 10: Weight or dollar amount of heroin generally bought in the previous month, 2012

Weight		Dollar amount	
	n = 19 %		n = 39 %
Point or cap	11	$50	13
1/8 gram	5	$100	64
¼ gram	21	$150	8
Half weight (1/2 gram)	42	$200	10
1/7 gram (1/16 ounce)	5	$400	3
1 gram	16	Other amount: $65	3

Source: Queensland IDRS injecting drug user interviews

Participants were then asked to nominate the reasons they usually buy this particular weight or dollar value from a list of responses (Table 11). The most common response was '*It is all I want, enough for me'* followed by *'It is all I can afford'*.

Table 11: Reasons for usually buying particular weight or dollar value, 2012

	n = 56 %
It is all I want, enough for me	46
It is all I can afford	30
To control my use	14
How the dealer sells it	4
Lower price when buy higher quantity	9
To share with friends/partner	9
Other	9

Note: Multiple responses allowed
Source: Queensland IDRS injecting drug user interviews

5.1.2 Heroin form and purity

Most respondents who answered questions about the heroin market rated the current purity of heroin as low or medium (Table 12). Compared with 2011, significantly more participants rated purity as increasing ($p<.05$).

Table 12: Perceptions of heroin purity in preceding six months, 2011 and 2012

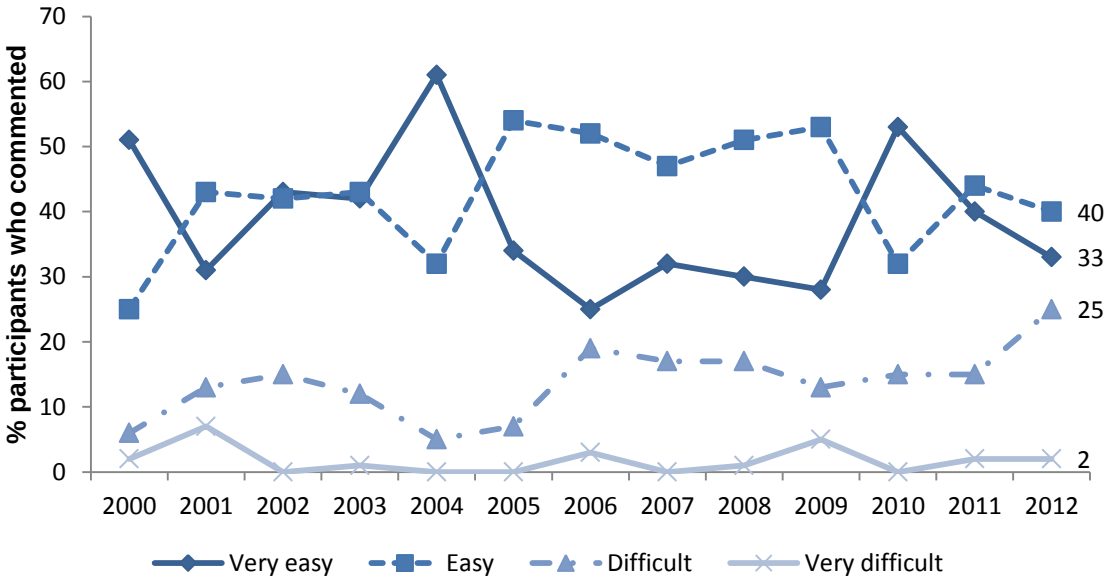
	2011 %	2012 %
Current purity	n = 64	**n = 56**
High	8	**9**
Medium	34	**32**
Low	38	**50**
Fluctuates	20	**9**
Purity change over the past six months	n = 61	**n = 53**
Increasing	3	**13↑**
Stable	39	**45**
Decreasing	28	**21**
Fluctuating	30	**21**

Note: Those choosing 'don't know' were excluded from analysis.
Arrow symbol signifies a significant difference p<0.05.
Source: Queensland IDRS injecting drug user interviews

5.1.3 Heroin availability

Rating of heroin availability was consistent with ratings in previous years, with most rating availability as very easy or easy; however just over a quarter (n = 57) rated availability as difficult or very difficult (Figure 21).

Figure 21: Current heroin availability, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

Participants were also asked about changes in heroin availability in the preceding six months. The majority of participants who commented considered it to be stable (Table 13).

Table 13: Changes in heroin availability in preceding six months, 2011 and 2012

	2011 (n = 62) %	**2012 (n = 56) %**
More difficult	13	**18**
Stable	76	**63**
Easier	5	**14**
Fluctuates	6	**5**

Note: Those choosing 'don't know' were excluded from analysis.
Source: Queensland IDRS injecting drug user interviews

5.1.5 Purchasing patterns of heroin

As shown in Table 14, two-thirds of those who commented on the heroin market made their last purchase from a known dealer and this was a significant increase from 2011 ($p<0.05$). Purchases were most often made at agreed public locations or the dealer's home.

Table 14: Purchasing patterns of heroin, 2011 and 2012

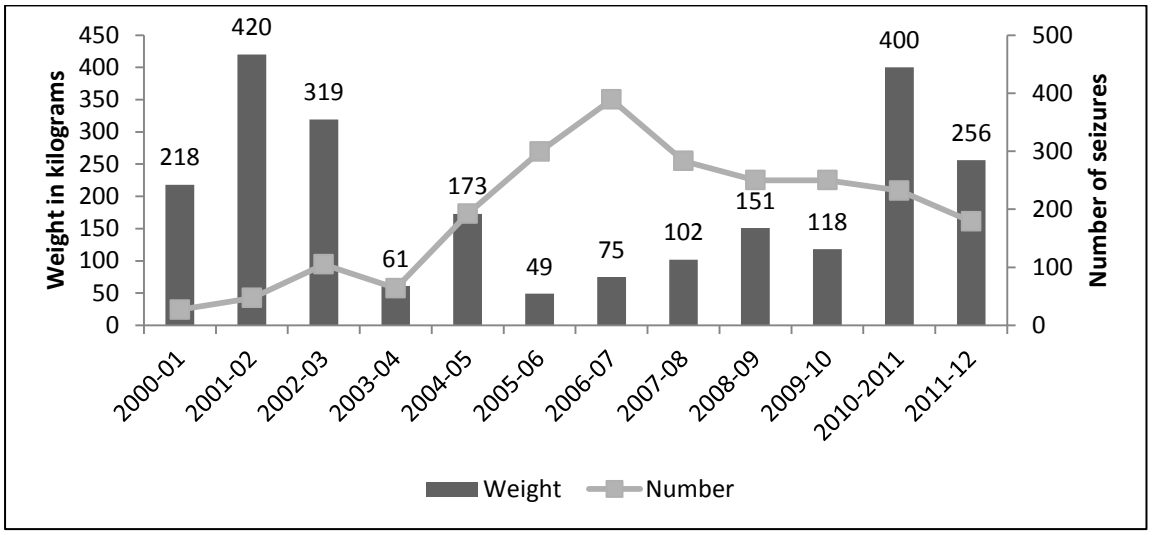
	2011 %	**2012 %**
Last purchased from	n = 59	**n = 56**
Street dealer	14	**5**
Friends	27	**16**
Known dealer	39	**66↑**
Work mates	2	**-**
Acquaintance	7	**7**
Unknown dealer	3	**5**
Mobile dealer	7	**-**
Other	2	**-**
Place of most recent purchase	n = 59	**n = 56**
Home delivery	12	**13**
Dealer's home	12	**20**
Friend's home	7	**14**
Acquaintance's house	3	**-**
Street market	2	**4**
Agreed public location	63	**50**
Other	2	**-**

Note: Arrow symbol signifies a significant difference $p<0.05$.
Source: Queensland IDRS injecting drug user interviews

5.1.6 Heroin detected at the Australian border

Figure 22 shows the total weight and number of heroin seizures at the border by the Australian Customs Service (ACS) from financial years 2000–2001 to 2011–2012. In 2010–11 there was a sharp increase in weight of seizure to 400 kilograms. This dropped to 256 kilograms in 2011–12 which was still considerable higher than it had been in the years leading up to 2010–11. The number of seizures, however, has remained relatively stable.

Figure 22: Weight and number of heroin border seizures by the Australian Customs Service, 2000–2001 to 2011–2012



Source: ACS

Key expert comments

Quality was reported as being inconsistent: one key expert reported that there was some high quality heroin currently available: '*potent heroin floating around'*. Another key expert related that clients described recent heroin quality as very poor. There was general consensus that heroin was readily available. Consistent with findings from the survey, the price of a shot of heroin was reported as $50.

5.2 Methamphetamine market

KEY POINTS

- Price of speed was $100 per point, base $75 per point, and crystal/ice $100 per point. Price was commonly considered to be stable or increasing for all forms.
- Purity of speed was mainly considered to be medium. Rating of the purity of base and crystal/ice was more varied, although for both forms about half considered it to be high.
- All forms of methamphetamine were considered to be readily available.

Of the entire sample (N = 100), 16% answered questions about the speed market, 14% about base, and 26% about crystal/ice, and analysis is based on these sub-samples.

5.2.1 Methamphetamine price

The median prices of participants' most recent purchase of each form of methamphetamine were:

Speed

Point (0.1g)	$100 (range = $50–$100, n = 8)
Halfweight (0.5g)	$150 (range = $100–$300, n = 3)
Gram (1g)	$775 (range = $700–$850, n = 2)

Base

Point (0.1g)	$75 (range = $50–$200, n = 4)
Halfweight (0.5g)	$375 (range = $250–$850, n = 4)
Gram (1g)	$550 (range = $200–$750, n = 6)

Crystal/ice

Point (0.1g)	$100 (range = $50–$100, n = 19)
Halfweight (0.5g)	$325 (range = $250–$400, n = 8)
Gram (1g)	$725 (range = $500–$850, n = 4)

Some price ranges were quite large reflecting the many factors that influence purchase price, including wholesale buying. When asked about recent changes to price, most participants considered price to be stable or increasing for all three forms; although nearly two in five (19%) considered the price of speed powder to be fluctuating (Table 15).

Table 15: Methamphetamine price changes in preceding six months, 2011 and 2012

Price	Speed powder		Base		Crystal/ice	
	2011 n = 32 %	**2012 n = 16 %**	2011 n = 24 %	**2012 n = 14 %**	2011 n = 27 %	**2012 n = 26 %**
Increasing	28	**25**	33	**36**	56	**31**
Stable	59	**56**	63	**57**	41	**58**
Decreasing	3	**0**	4	**0**	4	**4**
Fluctuating	9	**19**	0	**7**	0	**8**

Note: Those choosing 'don't know' were excluded from analysis.
Source: Queensland IDRS injecting drug user interviews

Participants reported that they usually buy speed by dollar amount, base by weight, and crystal/ice slightly more by dollar amount than weight (Table 16).

Table 16: Usual way of buying speed, base, and crystal/ice, 2012

	Speed n = 16 %	Base n = 12 %	Crystal/Ice n = 25 %
Dollar amount	63	25	52
By weight	31	75	44
Both	6	0	4

Source: Queensland IDRS injecting drug user interviews

The six participants who usually purchased speed by weight bought it in a variety of amounts. Of the 10 participants usually buying speed by dollar amount, six generally bought a $100 amount and the amounts varied for the remainder.

Small numbers commenting on the usual weight or dollar amount of base purchased prevented meaningful analysis.

The most common way of usually buying crystal/ice by weight was a point/cap; and the most common dollar amount was $100.

The most common response for buying a particular weight or dollar value was most often '*It is all I want, enough for me'* for speed and base, but reasons were more varied for crystal/ice (Table 17).

Table 17: Reasons for usually buying particular weight or dollar value, 2012

	Speed n = 16 %	Base n = 13 %	Crystal/ice n = 25 %
It is all I want, enough for me	63	46	64
It is all I can afford	25	0	24
To control my use	0	8	8
How the dealer sells it	6	31	20
Lower price when buy higher quantity	0	8	0
To share with friends/partner	0	15	4
Other	13	23	4

Note: Multiple responses allowed.
Source: Queensland IDRS injecting drug user interviews

5.2.2 Methamphetamine purity

The purity of speed was commonly rated as medium, with changes to purity rated as mostly decreasing or stable (Table 18). There were differences in the assessments on the purity of base, although three in five considered purity to be stable. The majority of participants commenting on the ice market rated purity as high or medium.

Table 18: Perceptions of methamphetamine purity in preceding six months, 2011 and 2012

	Speed powder		Base		Crystal/ice	
	2011 %	**2012 %**	2011 %	**2012 %**	2011 %	**2012 %**
Current purity/strength	n = 32	**n = 17**	n = 24	**n = 15**	n = 30	**n = 27**
High	31	**0**	46	**47**	43	**52**
Medium	28	**71**	38	**13**	37	**26**
Low	25	**24**	8	**33**	13	**19**
Fluctuates	16	**6**	8	**7**	7	**4**
Changes to purity/strength	n = 32	**n = 16**	n = 23	**n = 15**	n = 29	**n = 26**
Increasing	16	**6**	7	**20**	10	**27**
Stable	31	**44**	61	**60**	62	**42**
Decreasing	31	**50**	22	**13**	14	**15**
Fluctuating	22	**0**	9	**7**	14	**15**

Note: Those choosing 'don't know' were excluded from analysis.
Source: Queensland IDRS injecting drug user interviews

5.2.3 Methamphetamine availability

In 2012 most participants who commented rated all forms of methamphetamines to be very easy or very easy to obtain, with availability stable in the previous six months for speed. There was less consensus about changes for base and crystal (Table 19).

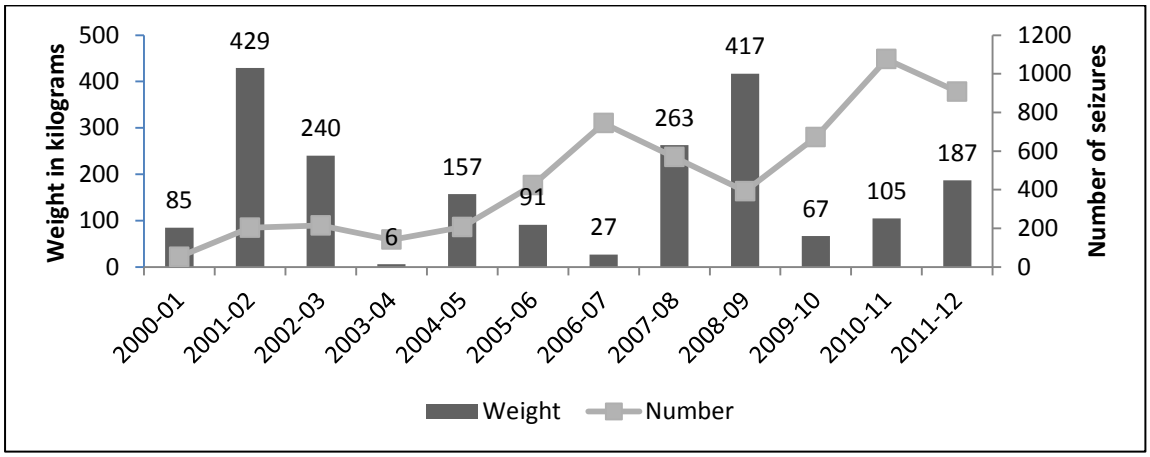
Table 19: Methamphetamine availability in preceding six months, 2011 and 2012

	Speed powder		Base		Crystal/ice	
	2011 %	**2012 %**	2011 %	**2012 %**	2011 %	**2012 %**
Current availability	n = 32	**n = 18**	n = 24	**n = 14**	n = 31	**n = 28**
Very easy	34	**44**	25	**36**	36	**61**
Easy	41	**44**	42	**36**	45	**29**
Difficult	22	**11**	33	**14**	19	**11**
Very difficult	3	**0**	0	**14**	0	**0**
Changes to availability	n = 31	**n = 17**	n = 24	**n = 14**	n = 30	**n = 27**
More difficult	13	**6**	17	**29**	3	**11**
Stable	81	**88**	71	**50**	83	**67**
Easier	6	**0**	0	**14**	7	**15**
Fluctuates	0	**6**	13	**7**	7	**7**

Note: Those choosing 'don't know' were excluded from analysis.
Source: Queensland IDRS injecting drug user interviews

Figure 23 shows that the total weight (in kilograms) and number of amphetamine-type stimulants (ATS) seizures at the border by the ACS from the financial years 2000–01 to 2009–10 vary considerably from year to year, and that weight is not always correlated with the number of seizures. This is exemplified in 2011–12 when there were less seizures than in the previous year but the weight of seizures increased.

Figure 23: Weight and number of amphetamine-type stimulants* detections by the Australian Customs Service, financial years 2000–01 to 2011–12



* includes amphetamine, methamphetamine and crystal methamphetamine detections, but excludes MDMA
Source: ACS

5.2.4 Purchasing patterns of methamphetamines

The most likely source for the most recent purchase of all forms of methamphetamines was a friend or known dealer (Table 20). The place of most recent purchase varied for all three forms of methamphetamines.

Table 20: Purchasing patterns of methamphetamine, 2011 and 2012

	Speed powder		Base		Crystal/ice	
	2011 %	**2012 %**	2011 %	**2012 %**	2011 %	**2012 %**
Last purchased from	n = 29	**n = 18**	n = 24	**n = 14**	n = 30	**n = 28**
Street dealer	14	**6**	21	**0**	10	**14**
Friend	45	**39**	38	**50**	43	**32**
Known dealer	17	**39**	29	**36**	37	**43**
Acquaintance	10	**6**	4	**0**	3	**4**
Unknown dealer	3	**6**	4	**0**	0	**0**
Mobile dealer	3	**6**	4	**0**	3	**4**
Other	7	**0**	0	**14**	3	**4**
Place of most recent purchase	n = 29	**n = 17**	n = 24	**n = 12**	n = 30	**n = 27**
Home delivery	21	**18**	17	**25**	27	**19**
Dealer's home	14	**6**	25	**8**	20	**19**
Friend's home	31	**18**	13	**42**	20	**22**
Acquaintance's house	3	**0**	0	**0**	0	**0**
Street market	7	**6**	13	**0**	13	**11**
Agreed public location	24	**47**	33	**25**	20	**30**
Other	0	**6**	0	**0**	0	**0**

Source: Queensland IDRS injecting drug user interviews

Key expert comments

There were no reports of changes in the speed and base markets. Crystal was, however, considered to be more readily available. The demand for crystal was reported to have increased and this was thought to be a consequence of marketing as well as the high purity levels. The Illicit Drug Group (Forensic Chemistry, Queensland Health) explained that there was more crystal being tested from seizures that was in the 60–100% purity band: more high purity, less low purity. Some key experts reported that the increase in purity had enabled dealers to ask for a higher price, but one key expert considered that the wider availability of crystal had resulted in lower prices.

5.3 Cocaine market

KEY POINTS

- Only two participants commented on the cocaine market, and both considered the market to be stable.

Only two participants answered questions about the cocaine market.

5.3.1. Cocaine price

No prices were given and only one participant commented on usual buying habits.

5.3.2 Cocaine purity

Both participants considered purity stable but one rated it high, the other low.

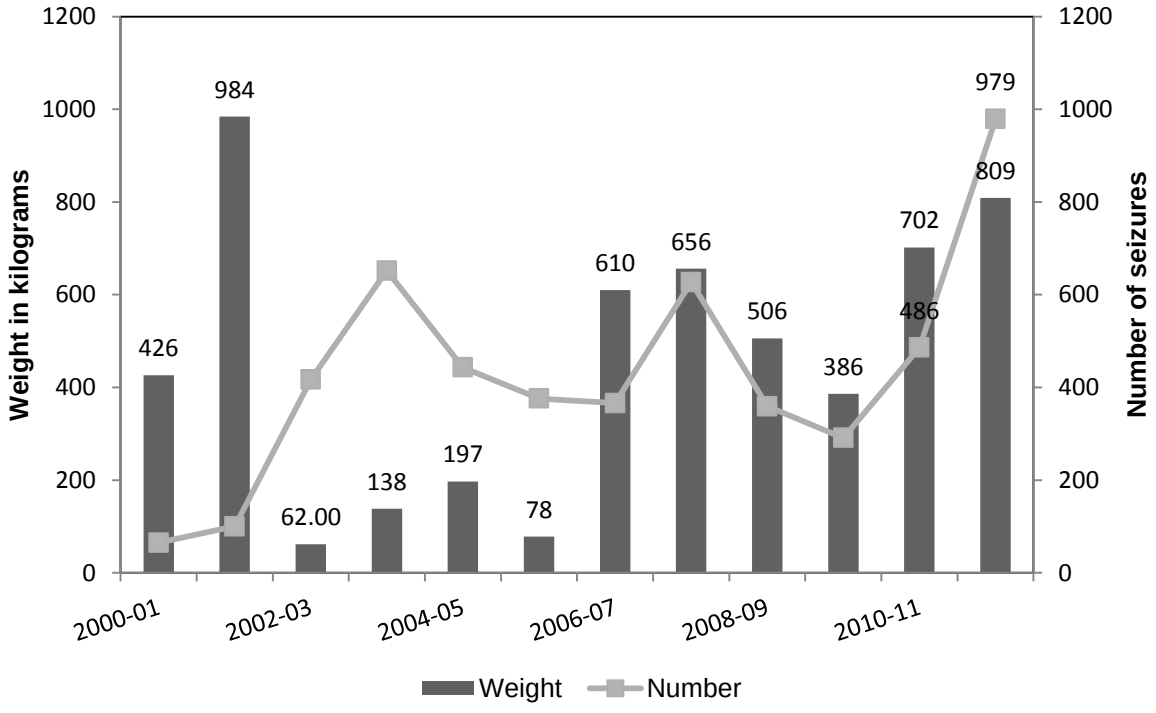
5.3.3 Cocaine availability

Both participants rated availability as stable and easy.

5.3.5 Cocaine detected at the Australian border

The total weight (in kilograms) and number of cocaine detections at the border by the Australian Customs Service (ACS) from the financial years 2000–01 to 2011–12 are presented in Figure 24. Both the number of seizures and weight of cocaine seized increased in 2011–12, particularly number of seizures from 486 in 2010–11 to 979 in 2011–12.

Figure 24: Weight and number of cocaine border seizures by the Australian Customs Service, 2000–01 to 2011–12



Source: ACS

Key experts reported that availability of cocaine tended to be ad hoc and not always reliable. Price was considered to be a barrier for many regular injecting drug users. For example one key expert reported that clients say it is too expensive and poor quality when they do use it. Purity was reported to be low and this was in keeping with the results from testing cocaine seizures (Illicit Drug Group, Forensic Chemistry, Queensland Health), though spikes in purity levels of seized cocaine were also identified.

5.4 Cannabis market

KEY POINTS

- Potency of cannabis continued to be high, particularly for hydro.
- Price for both hydro and bush was stable.
- Both hydro and bush were readily available.
- The most recent purchase of both hydro and bush was generally from a friend or known dealer, with a friend's home being the most common place of purchase.

Of the entire sample (N = 100), 64% agreed they were able to distinguish between hydroponically cultivated cannabis (hydro) and outdoor-cultivated cannabis (bush). Sixty-three per cent answered questions about the hydro market and 15% about the bush market.

5.4.1. Cannabis price

The median price of hydro and bush was:

Hydro

Stick	$25 (n = 13)
Gram	$25 (range = $20–$25, n = 11)
Quarter ounce	$100 (range = $75–$300, n = 20)
Ounce	$300 (range = $280–$450, n = 6)

Bush

Gram	$25 (n = 1)
Quarter ounce	$50 (range = $50–$100, n = 3)
Ounce	$60 (n = 1)

The majority (76%) of those who commented on the price of hydro (n = 45) rated the price as stable, with 18% considering it to have increased, and 7% to have fluctuated. Similarly with those who commented on the price of bush (n = 12), 75% rated the price as stable, with 17% considering it to have decreased, and 8% to have fluctuated.

There was little difference in the proportion usually buying hydro by a dollar amount or weight, but with bush nearly all usually bought by weight (Table 21).

Table 21: Usual way of buying cannabis, 2012

	Hydro n = 17 %	Bush n = 10 %
Dollar amount	40	0
By weight	54	90
Both	7	10

Source: Queensland IDRS injecting drug user interviews

For hydro, the usual purchase weight was commonly a quarter ounce, and the dollar amount most commonly $20 or $25. Numbers were too small to meaningfully report on bush.

Reasons for usually buying a particular weight or dollar value varied for both hydro and bush but for both, half reported that '*It is all I want, enough for me*' (Table 22).

Table 22: Reasons for usually buying a particular weight or dollar value, 2012

	Hydro n = 39 %	Bush n = 10 %
It is all I want, enough for me	49	50
It is all I can afford	26	10
To control my use	8	0
How the dealer sells it	3	10
Lower price when buy higher quantity	21	20
To share with friends/partner	5	0
Other	10	20

Note: Multiple responses allowed.
Source: Queensland IDRS injecting drug user interviews

5.4.2 Cannabis purity

The majority of participants who commented on hydro rated potency as high, and just over half considered that potency had remained stable in the previous six months (Table 23). The potency of bush was generally perceived as medium or high, with most participants considering that potency had remained stable.

Table 23: Perceived cannabis potency in preceding six months, 2011 and 2012

	Hydro		Bush	
	2011 %	**2012 %**	2011 %	**2012 %**
Current potency	n = 62	**n = 47**	n = 20	**n = 13**
High	55	**62**	20	**31**
Medium	36	**21**	55	**54**
Low	2	**4**	20	**15**
Fluctuates	8	**13**	5	**0**
Changes to potency	n = 62	**n = 47**	n = 20	**n = 13**
Increasing	13	**15**	15	**0**
Stable	61	**53**	70	**77**
Decreasing	5	**17**	15	**23**
Fluctuates	21	**15**	0	**0**

Source: Queensland IDRS participant interviews

5.4.3 Cannabis availability

Hydro was generally rated easy or very easy to access, with the majority rating availability as stable over the preceding six months. Most found bush easy or very easy to access; about one-third (29%) of the sample found it difficult. Recent availability of bush was commonly rated as stable, but others rated it as more difficult or fluctuating (Table 24).

Table 24: Cannabis availability in preceding six months, 2011 and 2012

	Hydro		Bush	
	2011 %	**2012 %**	2011 %	**2012 %**
Current availability	n = 61	**n = 48**	n = 20	**n = 14**
Very easy	54	**35**	30	**29**
Easy	39	**46**	50	**43**
Difficult	7	**19**	10	**29**
Very Difficult	0	**0**	10	**0**
Changes to availability	n = 61	**n = 47**	n = 20	**n = 13**
More difficult	5	**11**	10	**23**
Stable	80	**77**	75	**62**
Easier	5	**4**	10	**0**
Fluctuates	10	**9**	5	**15**

Note: Those choosing 'don't know' were excluded from analysis.
Source: Queensland IDRS injecting drug user interviews

5.4.4 Purchasing patterns of cannabis

The most recent purchase of both hydro and bush was generally from a friend or known dealer, with a friend's home being the most common place of purchase (Table 25).

Table 25: Purchasing patterns of cannabis, 2011 and 2012

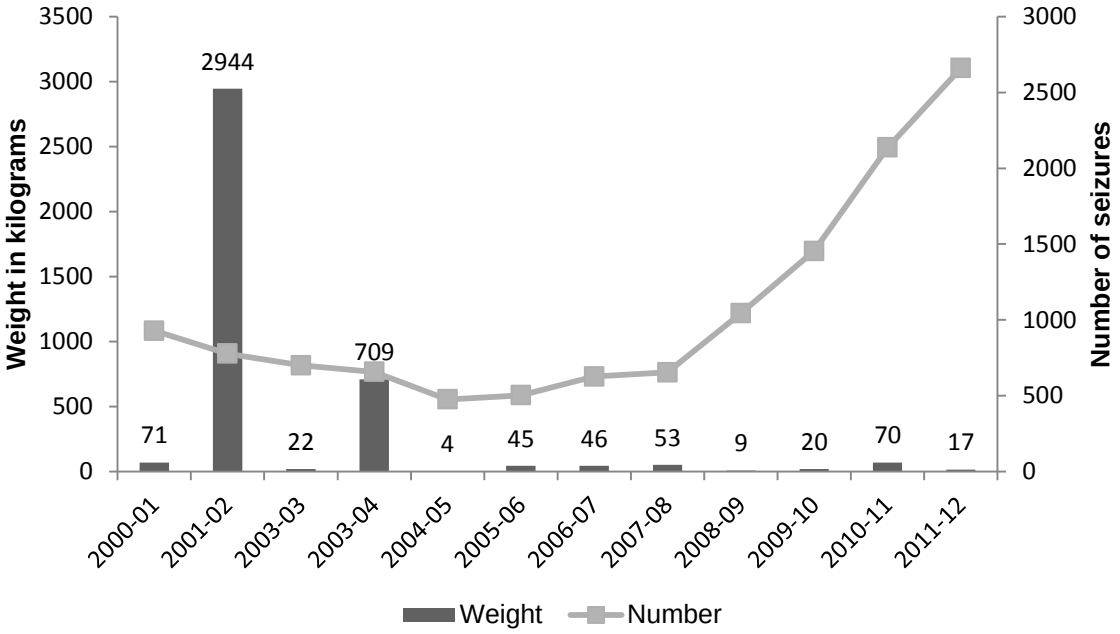
	Hydro		Bush	
	2011 %	**2012 %**	2011 %	**2012 %**
Last purchased from	n = 61	**n = 47**	n = 20	**n = 11**
Friend	68	**64**	70	**46**
Known dealer	21	**15**	20	**27**
Street dealer	0	**2**	5	**9**
Acquaintance	7	**9**	0	**9**
Workmate	2	**0**	0	**0**
Unknown dealer	0	**4**	0	**0**
Mobile dealer	0	**2**	0	**0**
Other	3	**4**	5	**9**
Place of purchase	n = 62	**n = 47**	n = 19	**n = 11**
Friend's home	47	**45**	37	**36**
Dealer's home	15	**6**	16	**18**
Home delivery	18	**15**	11	**9**
Agreed public location	16	**21**	32	**18**
Street market	0	**4**	0	**18**
Acquaintance's house	0	**4**	0	**0**
Work	2	**2**	0	**0**
Other	3	**2**	5	**0**

Source: Queensland IDRS injecting drug user interviews

5.4.5 Cannabis detections at the Australian border

The total weight (in kilograms) and number of cannabis detections at the border by the Australian Customs Service (ACS) from the financial year 2000–01 to 2011–12 is shown in Figure 25. These detections include cannabis, cannabis leaf, oil, seed, and resin. The number of seizures has been increasing (2,660 in 2012) but the weight of seizures remains modest.

Figure 25: Weight and number of cannabis border seizures by Australian Customs Service, financial years 2000–01 to 2011–12



Source: ACS

Key expert comments

Hydro and synthetic cannabis were reported as being widely available, and hydro was considered to often be particularly potent.

5.5 Methadone market

KEY POINTS

- Most of the participants who commented on the methadone market considered price to be stable, with median price of one millilitre being $1.
- There was no consistency about availability, although most did not consider there had been recent changes in availability.
- Methadone was most likely to have been purchased from a friend, and the purchase place to have been a public location.

Fourteen per cent of participants answered questions about the methadone market.

5.5.1 Methadone price

Of the nine participants who commented on the price of methadone, two-thirds rated the price as stable. The median price paid for one millilitre of methadone syrup was $1.

5.5.2 Methadone availability

There was no consistency amongst the seven participants who reported on current availability of illicit methadone. Most rated availability as stable.

5.5.3 Purchasing patterns of illicit methadone

Of the seven participants who reported on the source of their illicit methadone, five had obtained it from friends and two from acquaintances. Place of purchase was commonly a friend's home or an agreed public location.

5.6 Buprenorphine (Subutex®) market

KEY POINTS

- Price and availability of buprenorphine was generally considered stable, with the median price of 2 mg being $10 and 8 mg $35.

Fifteen per cent of participants answered questions about the buprenorphine market.

5.6.1 Buprenorphine price

The median price of buprenorphine was:

2 mg $10 (range = $5–$10, n = 4)

8 mg $35 (range = $10–$50, n = 4)

Most of the participants who reported on price changes (n = 14) rated prices as stable (79%), with 14% rating prices as increasing, and 7% as fluctuating.

5.6.2 Buprenorphine availability

Most participants regarded the recent availability of buprenorphine as easy or very easy, and availability as stable (Table 26).

Table 26: Availability of buprenorphine in preceding six months, 2012

Ease of access	% (n = 16)	Changes to ease of access in last 6 months	% (n = 15)
Very easy	25	Stable	93
Easy	56	Fluctuates	7
Difficult	19		

Note: Those choosing 'don't know' were excluded from analysis.
Source: Queensland IDRS injecting drug user interviews

5.6.3 Purchasing patterns of illicit buprenorphine

Of those who purchased illicit buprenorphine in the previous six months (n = 13), 62% purchased from friends, 23% from a known dealer, 8% from a street dealer, and 8% from an acquaintance. The location of the most recent purchase varied, but the most common location was a friend's home (43%).

5.7 Buprenorphine-naloxone (Suboxone®) market

KEY POINTS

- Price and availability of buprenorphine-naloxone was generally considered stable by the small number of participants who commented.

Seven per cent of participants answered questions about the buprenorphine-naloxone market.

5.7.1 Buprenorphine-naloxone price

The median price of buprenorphine-naloxone was:

Tablets

2 mg	$10 (no range, n = 3)
8 mg	$35 (range = $20–$40, n = 8)

Film

2 mg	no price given
8 mg	$10 (n = 1)

For tablets, the six participants who reported on price changes all rated prices as stable.

5.7.2 Buprenorphine-naloxone availability

Availability of buprenorphine-naloxone tablets was considered easy or very easy (n = 7), with all seven respondents regarding recent availability as stable.

Only two participants commented on the availability of film. Both rated it as easy to obtain and availability as stable.

5.7.3 Purchasing patterns of buprenorphine-naloxone

Of the five participants who commented about purchasing illicit buprenorphine-naloxone tablets, three had made their last purchase from friends, and four had made the purchase at a friend's house.

There were no comments about purchasing patterns of film.

5.8 Morphine market

KEY POINTS

- The median price for 100 milligrams of morphine was $70 for MS Contin© and $60 for Kapanol©, with price changes generally rated as stable or increasing.
- MS Contin® was the most common brand of morphine used, followed by Kapanol®.
- Morphine was reported as easy or very easy to obtain.
- Morphine was obtained from a variety of source people and locations.

Twenty-eight per cent of participants answered questions about the morphine market.

5.8.1 Morphine price

Participants were asked about the price of the specific brands of morphine (i.e. MS Contin® and Kapanol®) that they last purchased. The median prices were:

MS Contin®	60 mg	$40 (range = $30–$60, n = 6)
	100 mg	$70 (range = $50–$100, n = 19)
Kapanol®	5 0mg	$25 (n = 1)
	100 mg	$60 (range = $50–$70, n = 3)

Of those who reported on the price of morphine (n = 22), 41% considered price to have been stable in the previous six months, with 36% considering it to be increasing, 18% fluctuating, and 5% decreasing.

5.8.2 Morphine availability

Most participants who commented on the morphine market considered morphine to be readily available, and 55% considered availability to be stable (Table 27).

Table 27: Availability of morphine in preceding six months, 2012

Ease of access	% (n = 21)	Changes to ease of access in last 6 months	% (n = 21)
Easy	52	Stable	61
Very easy	19	More difficult	17
Difficult	19	Easier	17
Very difficult	10	Fluctuates	6

Source: Queensland IDRS injecting drug user interviews

5.8.3 Purchasing patterns of morphine

Respondents (n = 18) last purchased morphine from known friends (39%), known dealers (28%), street dealers (11%), acquaintances (11%), or unknown dealers (11%).

Venues for the most recent purchase of morphine were (n = 18): agreed public location (39%), street market (33%), a friend's home (17%), a dealer's home (6%), or an acquaintance's home (6%).

5.9 Oxycodone market

KEY POINTS

- The median price of 80 milligrams of oxycodone was $50, with most participants considering price to be stable.
- 52% rated availability of oxycodone as difficult, with the remainder rating it as easy or very easy.
- Illicit oxycodone was most commonly sourced from a friend (58%).

Twelve per cent of participants answered questions about the oxycodone market.

5.9.1 Illicit oxycodone price

Participants were asked about the price of the specific brands of illicit oxycodone that they had purchased, but reports were only received for Oxycontin®. Median price of the most recent purchase was:

Oxycontin®	20 mg	$15 (only one price report)
	40 mg	$25 (range = $20–$30, n = 4)
	80 mg	$50 (range = $40–$100, n = 11)

Of the 11 participants who commented on price, 73% considered it to be stable, 18% to be increasing, and 9% to be decreasing.

5.9.2 Illicit oxycodone availability

Just over half of those who commented regarded availability as difficulty with the remainder regarding it as easy or very easy (Table 28). Availability was most commonly reported as stable.

Table 28: Availability of oxycodone in preceding six months, 2012

Ease of access	% (n = 12)	Change to ease of access in last 6 months	% (n = 12)
Easy	58	Stable	67
Very easy	25	More difficult	17
Difficult	17	Easier	8
		Fluctuates	8

Note: Those choosing 'don't know' were excluded from analysis.
Source: Queensland IDRS injecting drug user interviews

5.9.3 Purchasing patterns of illicit oxycodone

Of the participants who commented on their most recent purchase of oxycodone (n = 12), 42% reported their source person was a friend, 25% known dealer, 17% street dealer, 8% unknown dealer, 8% acquaintance. The purchase was most likely to be made at an agreed public location (42%), street market (42%), or home delivered (17%).

6 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

KEY POINTS

- 46% of participants had accidently overdosed on heroin in their lifetime. Of these, 29% had overdosed in the preceding year.
- 18% had accidently overdosed on a depressant drug other than heroin in their lifetime.
- Alcohol was overwhelmingly the most common drug implicated in overdose cases attended by Queensland Ambulance Service, followed by antidepressants, benzodiazepines, and then heroin.
- 35% of participants were currently in drug treatment, predominantly opioid substitution pharmacotherapy.
- Calls to the Queensland Alcohol and Drug Information Services were most commonly about alcohol followed by cannabis
- All participants had sourced needles from a Needle and Syringe Program (NSP), and 23% had also sourced them from a chemist.
- Recent borrowing of used needles decreased from 20% in 2011 to 7% in 2012 ($p<0.05$), and 19% lent used needles compared with 28% in 2011. The proportion sharing other equipment (predominantly spoons/mixing containers) was stable at 36%.
- 44% of participants re-used one of their own needles at least once in the previous month.
- 56% of participants self-reported a mental health problem, with the most common problems being depression and anxiety.
- Compared with the general Australian population, IDRS participants were more likely to score in the high distress or very high distress categories of the Kessler Psychological Distress Scale (K10) (59% compared with 2%)
- Participants' scores on the SF-12 health survey indicated they had poorer mental and physical health than the Australian population average.
- 32% of participants had accessed a health professional in the previous four weeks.
- Of participants who had driven in the past six months, 11% reported driving under the influence of alcohol and 83% reported driving soon after taking an illicit drug.

6.1 Overdose and drug-related fatalities

6.1.1 Heroin and other opioid overdose

In 2012, 46% of participants reported accidently overdosing on heroin in their lifetime. Participants had overdosed a median of two times (range = 1–10). Twenty-nine per cent of those who had overdosed had done so in the previous 12 months. These 13 participants were asked to report the immediate treatment they received after their last overdose. Multiple responses were allowed (Table 29).

Table 29: Immediate treatment after most recent accidental heroin overdose, 2012

	% n = 13
Ambulance attendance	54
Hospital emergency department	31
Got Narcan	31
CPR from friend/partner/peer	23
CPR from health professional	23
Got oxygen	15
CPR from another person	8
GP	8
Did not receive treatment	23

Note: Multiple responses were allowed. Overdose occurred in past 12 months.
Source: Queensland IDRS injecting drug user interviews

The 13 participants who had accidently overdosed in the previous 12 months were asked if they sought out treatment/information as a result of the overdose. Twelve participants reported not seeking out treatment/information, and the other participant responded ‘don’t know/can’t remember’.

6.1.2 Other drugs overdose

Eighteen per cent of all participants reported an accidental overdose on a depressant drug other than heroin in their lifetime. The median number of other overdoses was 1.5 (range = 1–4). Eight participants had overdosed in the previous 12 months on a variety of drugs, with five participants reporting benzodiazepines were one of the drugs taken. None reported receiving treatment or information.

6.1.3 Queensland Ambulance Service data

Table 30 presents the number of attendances during the financial years 2010/11 and 2011/12 by the Queensland Ambulance Service to people who were coded as having a drug overdose and the primary drug was recorded. There were very similar patterns in both years, with alcohol being by far the most common primary drug followed by antidepressants, benzodiazepines and heroin in fourth place.

Table 30: Overdose cases attended by Queensland Ambulance Service where primary substance was recorded, 2010–11 to 2011–12

Primary drug	2010–11	2011–12
Alcohol	3,813	3,950
Antidepressants	661	641
Benzodiazepines	490	554
Heroin	285	281
Amphetamines	149	265
Cannabis	198	227
Antipsychotics	208	221
Ecstasy	107	137
Inhalants	80	136
GHB	32	53
Methadone	34	32
Cocaine	28	26
Buprenorphine	2	3

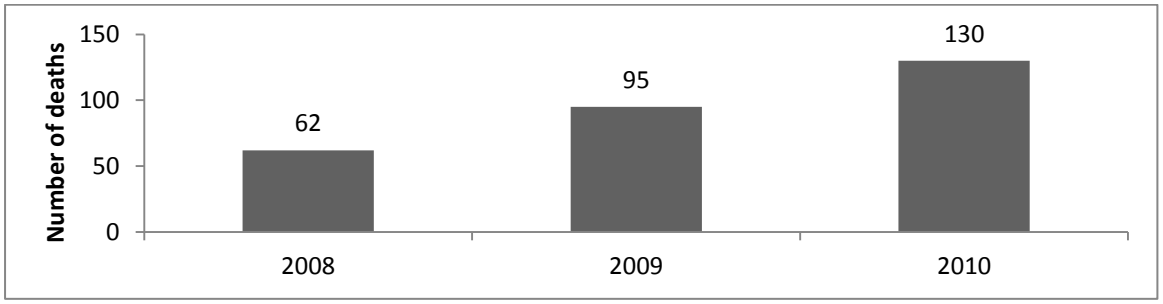
Source: Queensland Ambulance Service

These data are conservative and cannot be considered a definitive record of the number of overdoses attended by the service in the specified time period[1].

6.1.4 Fatal overdose

The Australian Bureau of Statistics (ABS) collates and manages the national causes of death database, utilising information from the National Coronial Information System (NCIS). Data for accidental opioid deaths in Queensland trend upwards from 2008 to 2010 (Figure 26).

Figure 26: Accidental opioid deaths in Queensland, 2008 to 2010



Note: 2008 data are the final figures after two revisions; 2009 data are the first revision figures; and 2010 data are the preliminary figures.
Source: Australian Bureau of Statistics (Roxburgh and Burns, in press)

[1] Queensland Ambulance Service data do not include formal diagnoses, as these are not made until the patient has received treatment at a hospital emergency department. Also the ambulance service may have attended people who had overdosed without an overdose code being assigned, thus excluding them from the data shown.

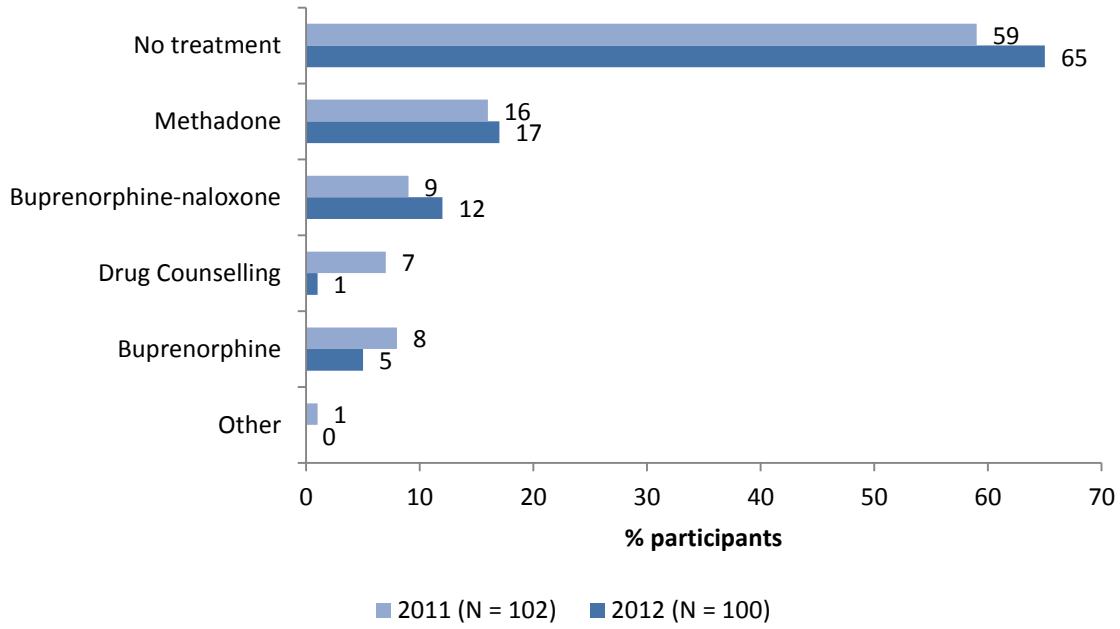
Moreover, the 'drug type' field is optional as it is not always possible for paramedics to establish the drug type involved. Only the primary drug is recorded so the data does not capture the range of different illicit drugs that may be involved in each overdose case. Finally, these data relate only to cases where the primary case nature was coded as overdose. Any overdose cases where the overdose was coded as secondary to the primary problem are not included (e.g. cardiac arrest due to drug overdose, trauma, and/or psychiatric cases).

6.2 Drug treatment

6.2.1 Current drug treatment

In 2012, drug treatment status was similar to 2011 with 35% of participants in treatment which was predominantly opioid substitution pharmacotherapy (Figure 27). The median time in treatment was two years (range = 1–24 years).

Figure 27: Current treatment status, 2011 and 2012



Source: Queensland IDRS injecting drug user interviews

6.2.2 Estimated number of pharmacotherapy clients

The estimated number of pharmacotherapy clients in Queensland was stable with 5,702 clients receiving pharmacotherapy treatment on a 'snapshot'/specified day in 2011 (AIHW, 2012). Of these, 52% were receiving methadone, 15% were receiving buprenorphine (Subutex®), and 32% were receiving buprenorphine-naloxone (Suboxone®). These were similar proportions to 2010 data.

In 2011, there were 435 dosing point sites in Queensland, most commonly pharmacies (82%) with the remainder located in public clinics (3%); correctional facilities (1%); and other locations (1%). The number of prescribers registered to prescribe pharmacotherapy drugs remained at 105.

6.2.3 Calls to telephone help lines

The following data was obtained from the Queensland Alcohol and Drug Information Service (ADIS) which is a 24-hour information and counselling service provided by Queensland Health. In the last financial year 2011–12, the majority of calls related to alcohol (Table 31).

Table 31: Number of calls to ADIS according to drug type, 2010–11 to 2011–12

Drug type	Calls	
	2010–11	2011–12
Alcohol	5,871 (48%)	5,975 (42%)
Cannabis	2,363 (19%)	2,456 (17%)
Amphetamines	1,543 (13%)	1,913 (13%)
Licit opioids	1,487 (12%)	1,752 (12%)
Illicit opioids	849 (7%)	1,069 (7.5%)
Benzodiazepines	845 (7%)	1,008 (7%)
Cocaine	99 (1%)	80 (1%)
Ecstasy	126 (1%)	120 (1%)
Hallucinogens	48 (<1%)	44 (<1%)
Other	2,831 (23%)	3,090 (22%)

Note: This represents the number and percentage of calls about each drug where there was a person with a drug history and information is known (as opposed to a call for information for assignments, etc.). More than one drug may be mentioned on each call.
Source: ADIS

People who called ADIS about drugs, other than alcohol, were most likely to be in the 25 to 34 year age group (Table 32).

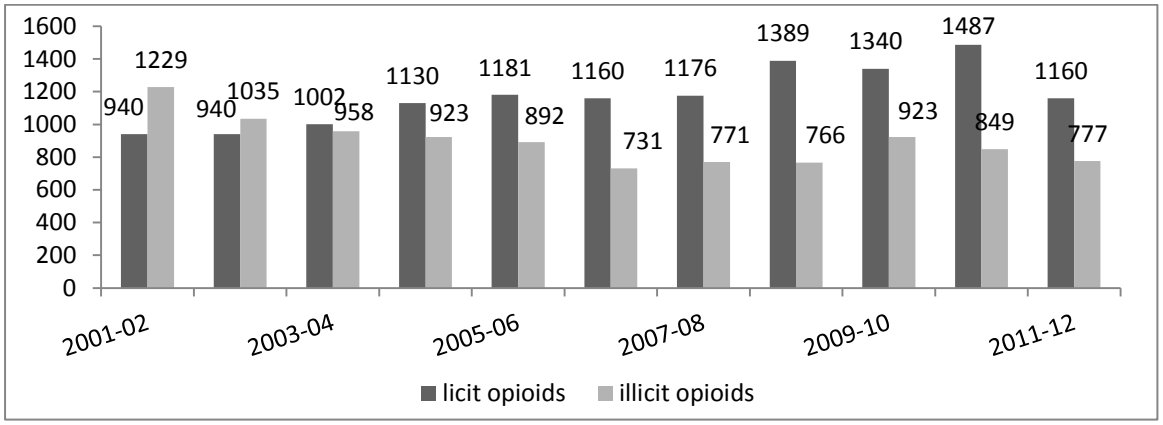
Table 32: Number of calls to Alcohol and Drug Information Service (ADIS) by drug type and age, Queensland 2011–12

	0–17	18–24	25–34	35–44	45–54	55>	Total
Alcohol	137	425	1272	1701	995	577	5107
Cannabis	328	564	738	444	129	31	2234
Amphetamine	67	442	748	380	54	16	1705
Opioids illicit	4	88	355	260	66	4	777
Opioids licit	6	81	450	395	132	96	1160
Benzodiazepine	5	71	227	192	120	284	899
Cocaine	4	20	23	9	2	0	67
Ecstasy	11	59	31	4	1	0	106
Hallucinogens	5	19	9	3	1	0	37
Other	149	341	540	400	223	449	2855

Source: ADIS

In the financial year 2011–12 there were 1160 calls about licit opioids compared with 1487 in the previous year, and 777 calls about illicit opioids compared with 849 in the previous year (Figure 28).

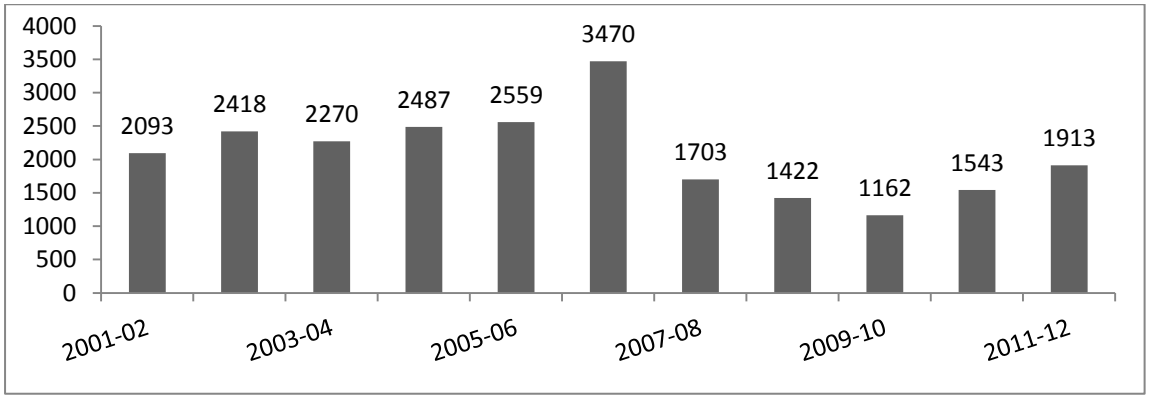
Figure 28: Number of enquiries to ADIS regarding licit and illicit opioids, 2001–02 to 2011–12



Source: ADIS

In the financial year 2011/12 there were 1913 calls about amphetamines compared with 1543 in the previous year. This remains much lower than the spike in 2006/07 of 3470 calls (Figure 29).

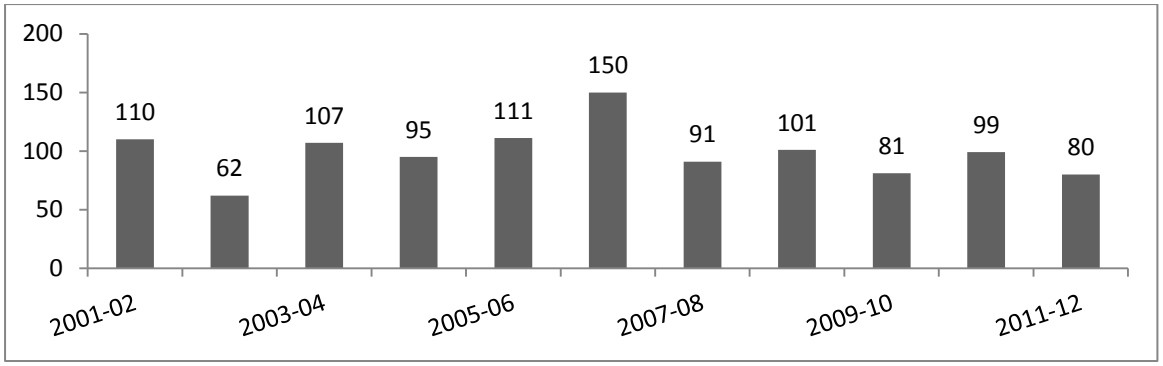
Figure 29: Number of enquiries to ADIS regarding amphetamines, including methamphetamines, 2001–02 to 2009–10



Source: ADIS

There has been a consistently low number of calls to ADIS about cocaine, with 80 calls in 2011/12, comprising 1% of all calls (Figure 30).

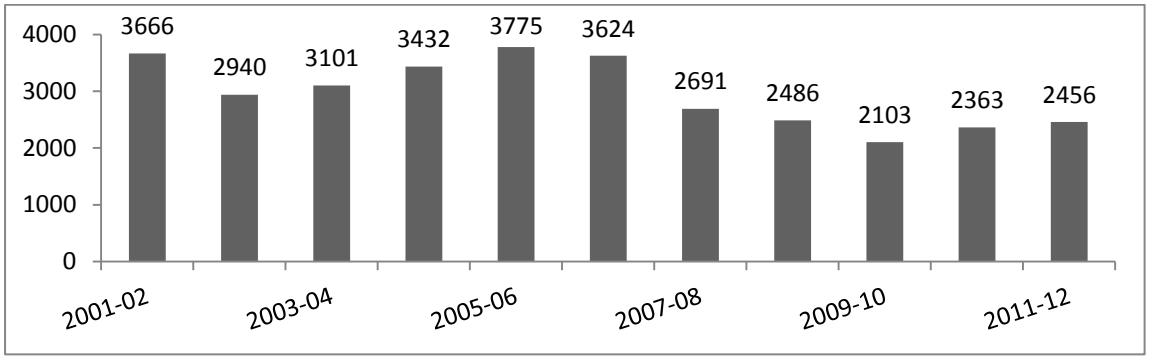
Figure 30: Number of enquiries to ADIS regarding cocaine, 2001–02 to 2011–12



Source: ADIS

As Figure 31 shows, the number of enquiries to ADIS about cannabis has been relatively consistent in the past few years after a peak in 2005–06.

Figure 31: Number of enquiries to ADIS regarding cannabis, 2001–02 to 2011–12



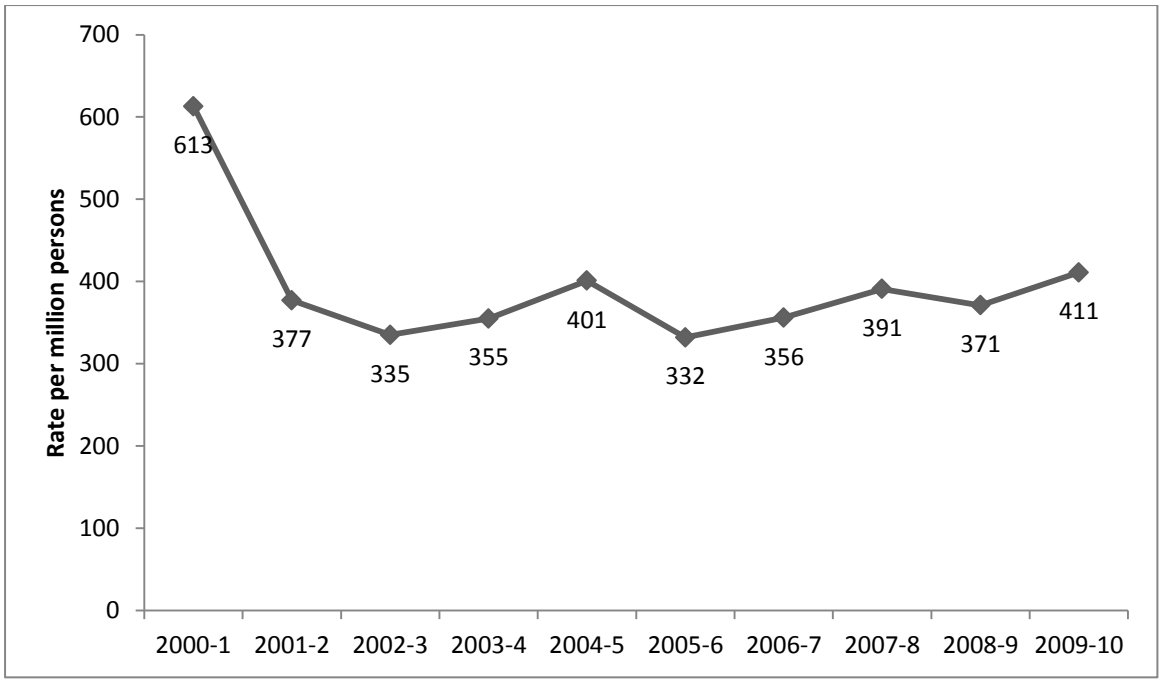
Source: ADIS

6.3 Hospital admissions

6.3.1 Heroin including other opioids

The number per million persons of inpatient hospital admissions among persons aged 15-54 years, with a principal diagnosis relating to opioids, is shown in Figure 32. In 2009/10, the number of opioid related hospital admission per million persons in Queensland was 411 admissions among persons aged 15-54 years. Data for 2010–11 was unavailable at the time of publishing.

Figure 32: Number of principal opioid-related hospital admissions per million persons aged 15–54 years, Queensland, 2000–01 to 2009–10

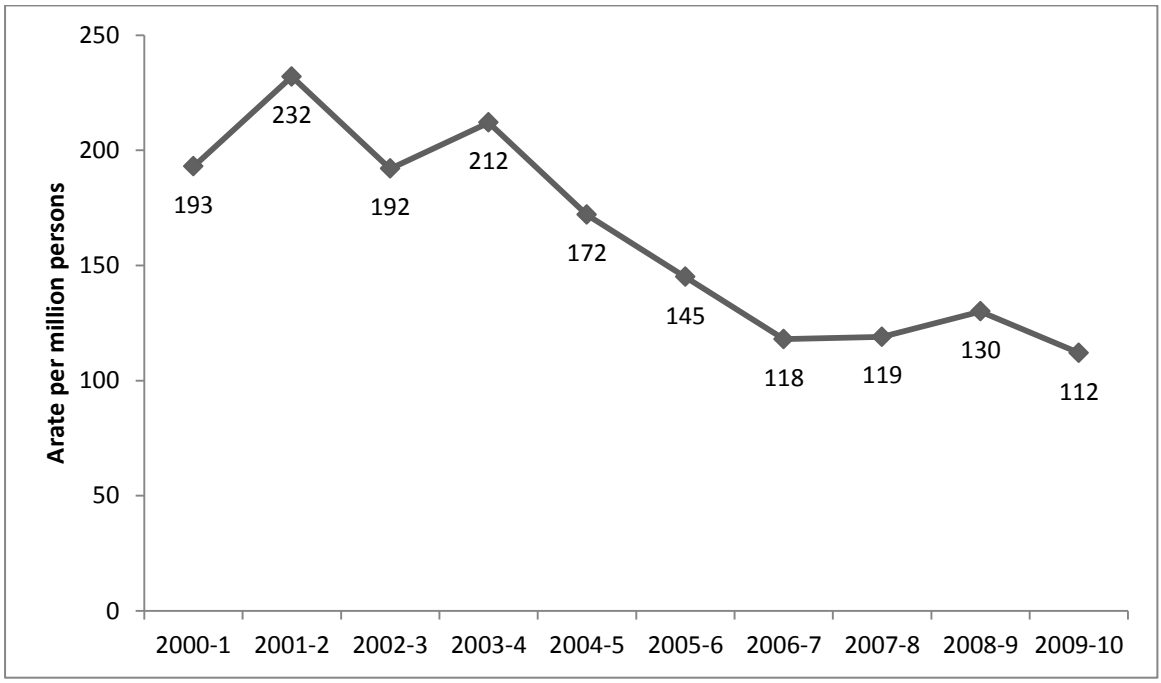


Source: Queensland Health (Roxburgh and Burns, in press)

6.3.2 Methamphetamine

Figure 33 shows the number of inpatient hospital admissions per million persons, since 2000–01, with a principal diagnosis relating to amphetamines among persons aged 15–54 years. Data for 2010–11 was unavailable at the time of publishing.

Figure 33: Number of principal amphetamine-related hospital admissions per million persons among people aged 15–54 years, Queensland, 2000–01 to 2009–10

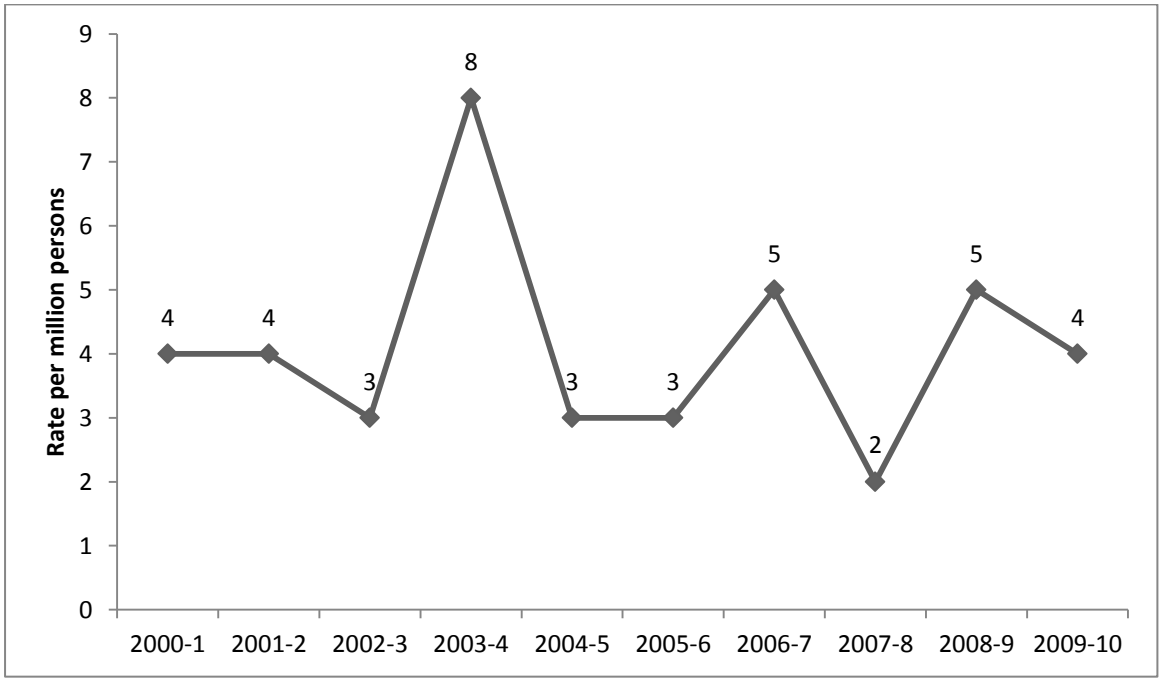


Source: Queensland Health (Roxburgh and Burns, in press)

6.3.3 Cocaine

Figure 34 shows the number of inpatient hospital admissions per million persons with a principal diagnosis relating to cocaine. The number of admissions has remained consistently low from 2001–01 to 2009–10. Data for 2010–11 was unavailable at time of publishing.

Figure 34: Number of principal cocaine-related hospital admissions per million persons among people aged 15–54 years, Queensland, 2000–01 to 2009–10

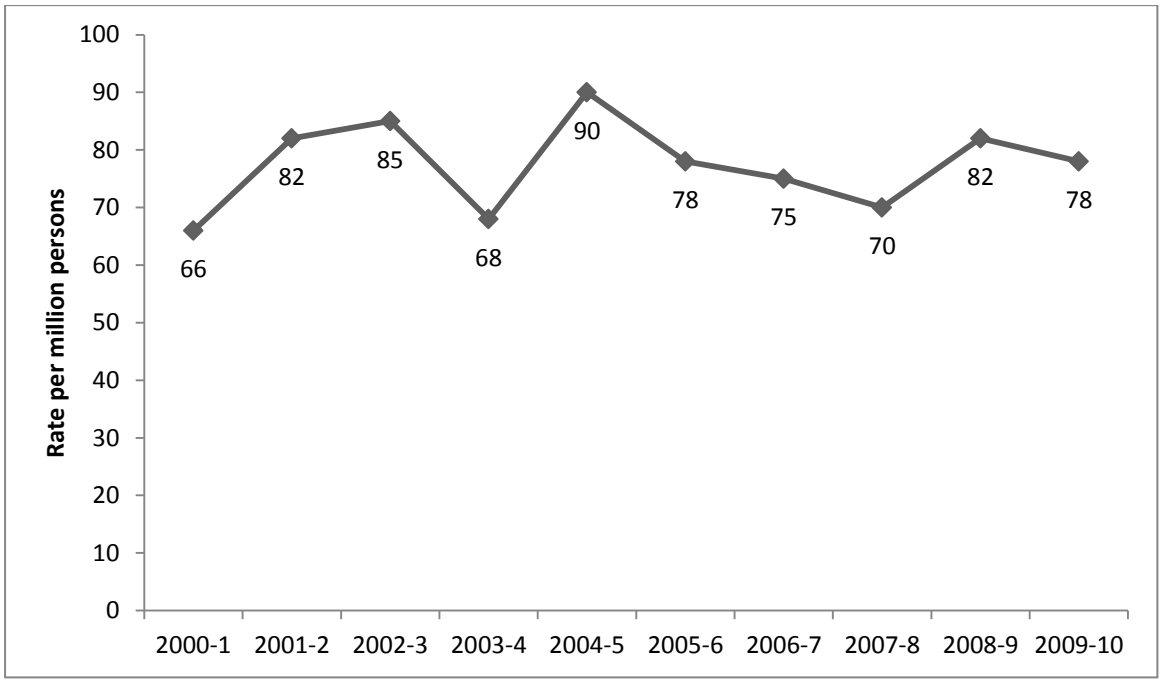


Source: Queensland Health (Roxburgh and Burns, in press)

6.3.4 Cannabis

Figure 35 shows the number of inpatient hospital admissions per million persons (among those aged 15–54 years) with a principal diagnosis related to cannabis. Data for 2010–11 was unavailable at time of publishing.

Figure 35: Number of principal cannabis-related hospital admissions per million persons among people aged 15–54 years, 2000–01 to 2009–10



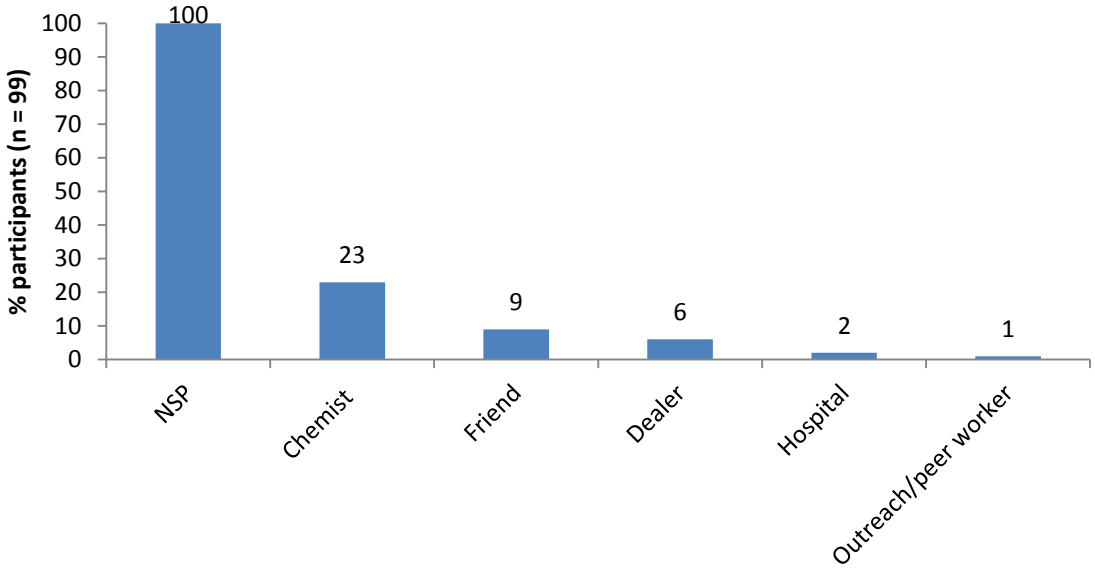
Source: Queensland Health (Roxburgh and Burns, in press)

6.4 Injecting risk behaviour

6.4.1 Access to needles and syringes

All participants sourced needles and syringes from needle and syringe programs (NSPs) in the previous month (Figure 36). Nearly a quarter also sourced needles and syringes from a chemist.

Figure 36: Source of needles and syringes in preceding month, 2012



Note: Multiple responses allowed.
Source: Queensland IDRS injecting drug user interviews

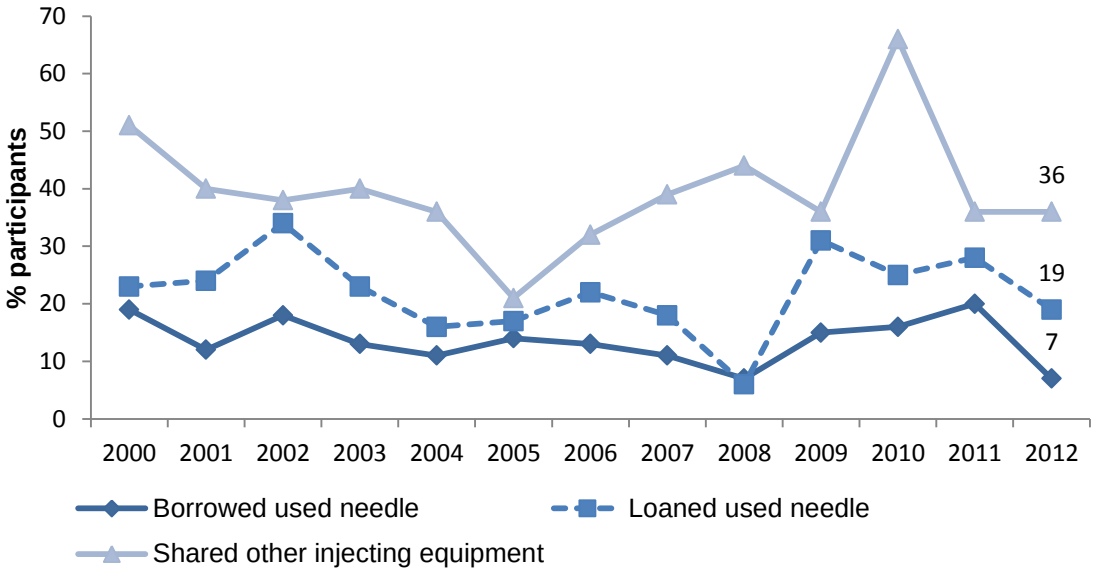
Participants were asked if they had trouble getting needles and syringes when they needed them in the last month: 10% responded '*yes*'.

Queensland needle and syringe programs (NSPs) dispensed a total of 7,924,015 needles in the 2011–12 financial year compared with 7,374,360 in the previous year.

6.4.2 Sharing of injecting equipment

In 2012, the proportion of participants reporting borrowing of used needles in the previous month decreased from 20% in 2011 to 7% ($p<0.05$); 19% of participants compared with 28% in 2011 had lent a used needle in the previous month. The proportion who had shared other equipment (e.g. spoons or mixing containers, filters, tourniquets, water, swabs) remained at 36% (Table 37).

Figure 37: Borrowing and loaning of needles and other equipment in the previous month, 2000 to 2012



Source: Queensland IDRS injecting drug user interviews

Forty-four per cent of participants re-used one of their own needles at least once in the previous month (51% in 2011). The proportions re-using other equipment were similar to 2011 whether it was re-use of own equipment or use after someone else (Table 33). Spoons/mixing containers were the items most commonly re-used.

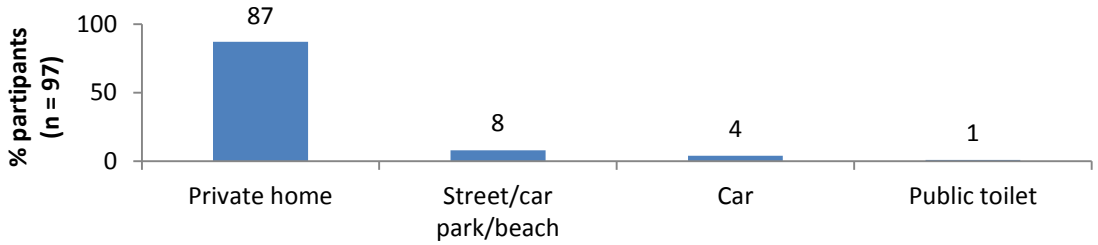
Table 33: Other equipment re-used in the previous month, 2011 and 2012

Other equipment	Other equipment re-used			
	Own		After someone else	
	2011 (n = 69) %	**2012 (n = 62) %**	2011 (n = 37) %	**2012 (n = 36) %**
Spoons/mixing containers	90	**90**	87	**86**
Filters	7	**3**	24	**0**
Tourniquets	41	**32**	24	**17**
Water	16	**10**	32	**8**
Swabs	3	**3**	8	**3**
Other	0	**5**	0	**0**

Note: Multiple responses allowed.
Source: Queensland IDRS injecting drug user interviews

As in previous years, the most common site of participants' last injection was the arm (81%), followed by hand (10%). Other sites were leg, groin, foot, and neck. Just over three-quarters of participants had their most recent injection in a private home (Figure 38).

Figure 38: Location where participant last injected, 2012



Source: Queensland IDRS injecting drug user interviews

The most common piece of injecting equipment was a 1 ml needle and syringe and the proportion increased from 2011 as did the proportion using wheel filters ($p<0.05$). No one used a 5 ml syringe (7% in 2011, $p<0.05$) (Table 34). The pattern of re-use was very similar to the previous year.

Table 34: Use and re-use of injecting equipment in previous month, 2011 and 2012

	Used in last month		Re-used in last month	
	2011 n = 101 %	**2012 n = 99 %**	2011 n = 100	**2012 n = 97 %**
1 ml needle and syringe	80	**93↑**	40	**38**
3 ml syringe (barrel)	26	**26**	11	**7**
5 ml syringe (barrel)	7	**0↓**	2	**1**
10 ml syringe (barrel)	5	**3**	5	**2**
20 ml syringe (barrel)	6	**9**	3	**3**
50 ml syringe (barrel)	0	**0**	0	**0**
Detachable needle (tip)	23	**21**	8	**3**
Winged vein infusion set (butterfly)	15	**10**	5	**2**
Wheel filter	10	**24↑**	2	**1**

Note: Multiple responses allowed.
Arrow signifies significant change at $p<0.05$.
Source: Queensland IDRS injecting drug user interviews

Table 35 shows information about obtaining needle and syringes in the previous month. Participants generally obtained needle and syringes about once a week and were likely to obtain more than they used. The median number of syringes given away or sold was five.

Table 35: Injecting and obtaining needles and syringes in the previous month, 2012

	Mean	Median	Range
Approximate times injected	30	27	0–120
Times got needles and syringes	5	3	1–40
Total number of new syringes obtained	86	50	5–500
Syringes given away or sold	33	5	0–750

Source: Queensland IDRS injecting drug user interviews

6.4.3 Injection-related issues

Three in five participants reported some type of injection-related issues in the past month. Amongst these participants, scarring/bruising followed by difficulty injecting were the two most reported issues (2012, n = 60) (see Table 36).

Table 36: Injection-related issues experienced in the preceding month[a], 2002 to 2012

	2002 %	2003 %	2004 %	2005 %	2006 %	2007 %	2008 %	2009 %	2010 %	2011 %	**2012 %**
Overdose	6	7	3	3	4	4	3	1	2	0	**2**
Dirty hit	18	19	16	14	25	31	20	31	11	13	**23**
Abscess/infection	14	16	11	5	8	6	8	15	8	13	**12**
Scarring/bruising	51	37	48	37	55	57	46	64	41	80	**60**
Difficulty injecting	43	35	40	31	38	41	38	38	30	49	**53**
Thrombosis	11	7	8	7	9	<1	4	9	4	2	**14**

[a] Amongst those who experienced an injection-related issue
Note: Multiple responses allowed.
Source: Queensland IDRS injecting drug user interviews

6.5 Mental health problems, psychological distress, and general health

The pattern of mental health problems was similar to 2011, with depression and anxiety being the two most common problems (Table 37). Fifty-eight per cent of participants with a self-reported mental health problem had attended a health professional for their mental health problem in the previous six months. The three most common health professionals attended by these 32 participants were a general practitioner (GP) (63%), a psychiatrist (34%), and a psychologist (16%). Three-quarters of those who visited a health professional for a mental health problem were prescribed medications, and the two drugs most commonly prescribed were Valium® and Seroquel®.

Table 37: Mental health in preceding six months, 2009 to 2012

	2009 N = 80 %	2010 N = 100 %	2011 n = 101 %	**2012 n = 99 %**
Self-reported mental health problem	41	43	63	**56**
Problems reported	(n = 33)	(n = 42)	(n = 64)	**(n = 52)**
Depression	64	50	66	**69**
Anxiety	46	41	41	**48**
Schizophrenia	9	19	16	**12**
Manic-depression/bipolar	18	10	16	**8**
Paranoia	12	5	3	**8**
Panic	6	24	8	**6**
Personality disorder	-	-	3	**2**
Phobias	-	-	8	**-**
Mania	-	-	5	**-**
Drug induced psychosis	12	2	3	**-**
Addiction	-	-	2	**-**
Amnesia	-	-	2	**-**
Dissociative disorder	-	-	2	**-**
Other	-	-	-	**14**
Attended mental health professional	58	71	64	**58**

Source: Queensland IDRS injecting drug user interviews

The Kessler Scale of Psychological Distress (K10)

The Kessler Scale of Psychological Distress (K10) was administered using a 10-item standardised measure that has been found to have good psychometric properties and to identify clinical levels of psychological distress as measured by the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) and the Structured Clinical Interview for DSM disorders (SCID) (Andrews & Slade, 2001; Kessler et al., 2002).

K10 scores reflecting 'risk' are often categorised as follows: 'low'—the person is likely to be well (scores 10–15); 'moderate'—the person may have a mild mental disorder (scores 16–20); 'high'— the person is likely to have a moderate mental disorder (scores 22–29); and 'very high'—the person is likely to have a severe mental disorder (scores 30–50). The 2010 National Drug Strategy Household Survey (NDSHS) (AIHW, 2010) provided the most recent Australian population norms for the K10.

As shown in Table 38, participants in both 2011 and 2012 were vastly more likely to score high distress or very high distress than the general population (18 years and over) in the NDSHS.

Table 38: K10 scores, 2011 and 2012

K10 score	Level of psychological distress	2011 N = 96 %	**2012 n = 89 %**	2010 NDSHS %
10–15	No/low distress	12	**19**	70
16–21	Moderate distress	22	**21**	21
22–29	High distress	28	**29**	7
30–50	Very high distress	39	**30**	2

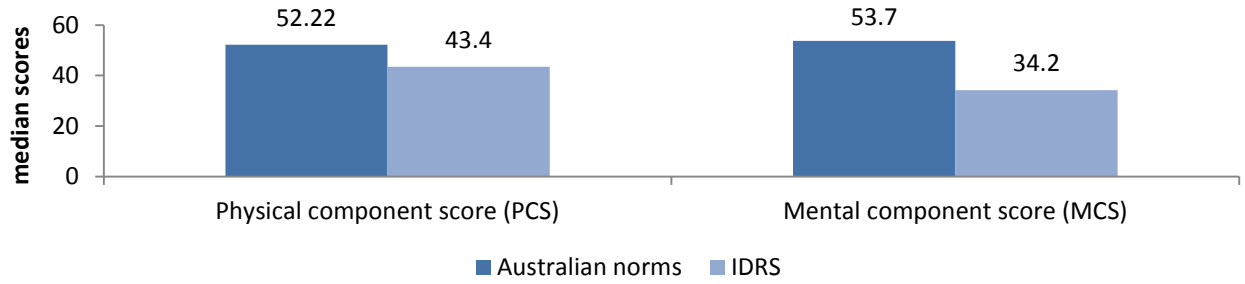
Source: Queensland IDRS injecting drug user interviews

The short form 12-item Health Survey (SF-12®)

The short form 12-item Health Survey (SF-12®) is a questionnaire designed to provide information on general health and wellbeing and includes 12 questions from the SF-36®. The SF-12 measures health status across eight dimensions concerning physical functioning, role limitations due to physical health problems, bodily pain, general health, energy/fatigue, social functioning, role limitations due to emotional problems, and psychological distress and wellbeing. The scores generated by these eight components are combined to generate two composite scores, the physical component score (PCS) and the mental component score (MCS) (Ware, Kosinski, & Keller, 1995, 1996). A higher score indicates better health.

The SF-12 scoring system was developed to yield a mean of 50 and a standard deviation of 10. IDRS participants scored a mean of 34.2 (SD = 10) for the mental component score and a mean of 43.4 (SD = 11.1) for the physical component score (Figure 39). Both these scores were significantly lower ($p<0.05$) than the Australian norms (Australian Bureau of Statistics, 1995), indicating that IDRS participants in Queensland had poorer mental and physical health than the Australian population average.

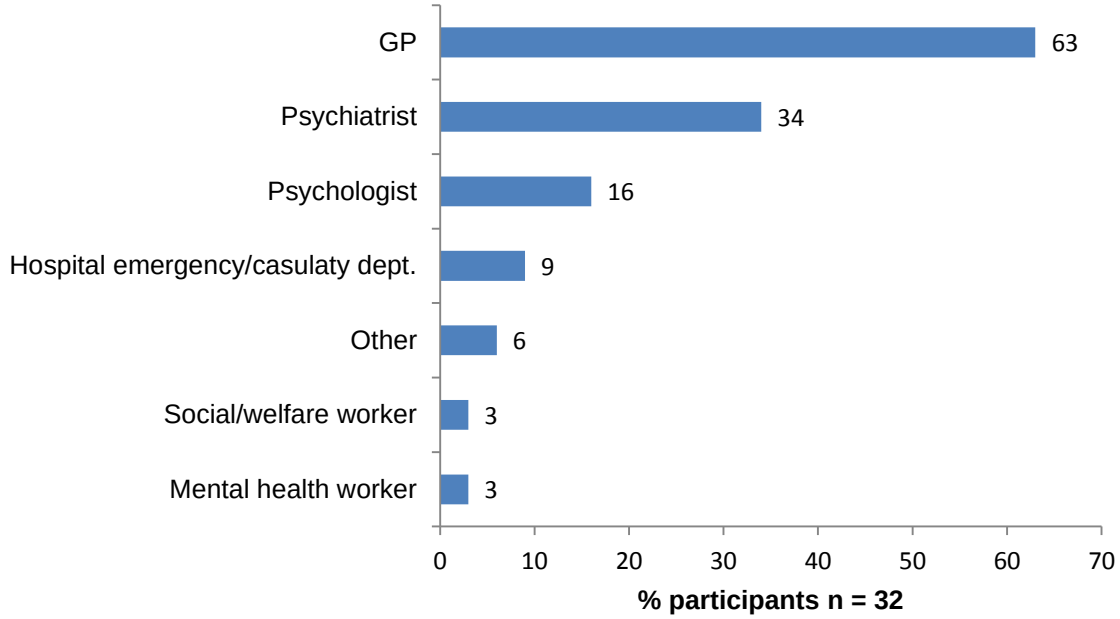
Figure 39: SF-12 scores for IDRS participants in 2012 compared with the general Australian population (ABS)



Source: Queensland IDRS injecting drug user interviews; ABS, 1995

In the previous four weeks, 32% of all participants had accessed a health service. Of these about two-thirds had visited a GP and one-third a psychiatrist (Figure 40).

Figure 40: Services accessed in previous four weeks, 2012



Note: Multiple responses allowed.
Source: Queensland IDRS injecting drug user interviews

6.6 Driving risk behaviour

Just over half of participants reported having driven in the past six months, with 11% having driven under the influence of alcohol and 83% having driven soon after taking an illicit drug (Table 39). Of the six participants who reported having driven under the influence of alcohol, three had driven over the legal limit. The median times participants reported driving soon after taking an illicit drug was 30 (range = 2–180). On the most recent occasion, 74% had driven within 30 minutes of consumption. Heroin was the drug most likely to have been consumed. Most considered that their illicit drug taking had no impact on their driving.

Table 39: Driving after licit and illicit drug use in preceding six months, 2007 to 2012

	2007 %	2008 %	2009 %	2010 %	2011 %	**2012 %**
	N = 119	N = 104	N = 80	N = 100	N = 102	N = 100
Driven in the past 6 months	47	57	65	57	45	53
	n = 56	n = 59	n = 52	n = 56	n = 46	n = 53
Driven under the influence of alcohol	28	20	20	13	20	11
Driven soon after taking an illicit drug	87	90	89	88	78	83
Drugs taken past time participant drug drove	n = 49	n = 53	n = 46	n = 49	n = 36	n = 43
Heroin	47	42	59	61	42	47
Cannabis	43	30	48	51	33	26
Methadone	7	9	7	4	8	14
Base methamphetamine	9	4	30	18	6	7
Speed powder	21	8	30	22	3	7
Crystal methamphetamine	6	8	22	12	6	5
Morphine	15	11	33	14	3	5
Buprenorphine-naloxone	4	6	7	8	3	5
Buprenorphine	2	4	11	10	3	2
Oxycodone	0	2	11	11	3	0
Benzodiazepines	9	4	20	8	14	0
Cocaine	2	2	4	4	0	0
Ecstasy	0	0	4	2	0	0
Other opiates	0	2	0	0	0	0
Impact of illicit drug on driving ability	n = 49	n = 53	n = 46	n = 48	n = 35	n = 42
Quite impaired	6	2	13	2	9	5
Slightly impaired	21	32	13	25	9	14
No impact	57	66	57	67	69	69
Slightly improved	13	0	9	4	9	5
Quite improved	2	0	7	2	6	7
Tested positive on police roadside drug-driving test in past 6 months	n = 4	n = 0	n = 3	n = 1	n = 2	n = 2

Source: Queensland IDRS injecting drug user interviews

7 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

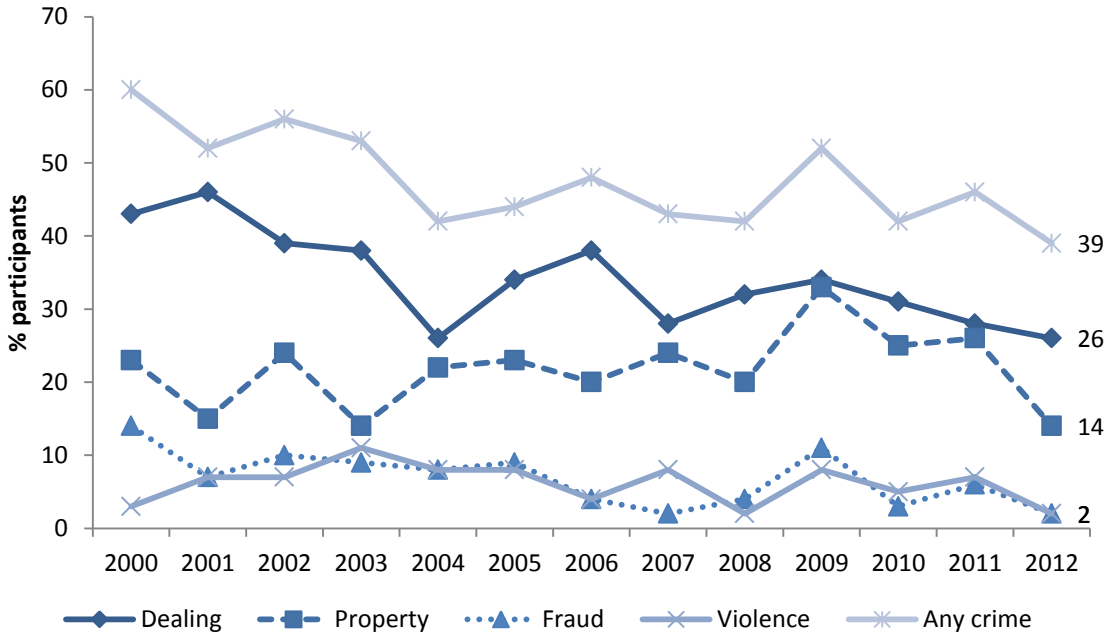
KEY POINTS

- 39% of participants reported criminal involvement in the previous month. Dealing was the most often reported criminal activity followed by property crime.
- 46% of participants reported being arrested in the preceding 12 months with the most common reason being property crime followed by use/possession of drugs.
- The median reported expenditure on illicit drugs the previous day was $70.

7.1 Reports of criminal activity

Self-reported criminal activity in the preceding month followed a similar pattern to previous years, with dealing most commonly reported followed by property crime, and only a small proportion of participants reporting fraud and violence (Figure 41).

Figure 41: Prevalence of criminal involvement in previous month, 2000 to 2012

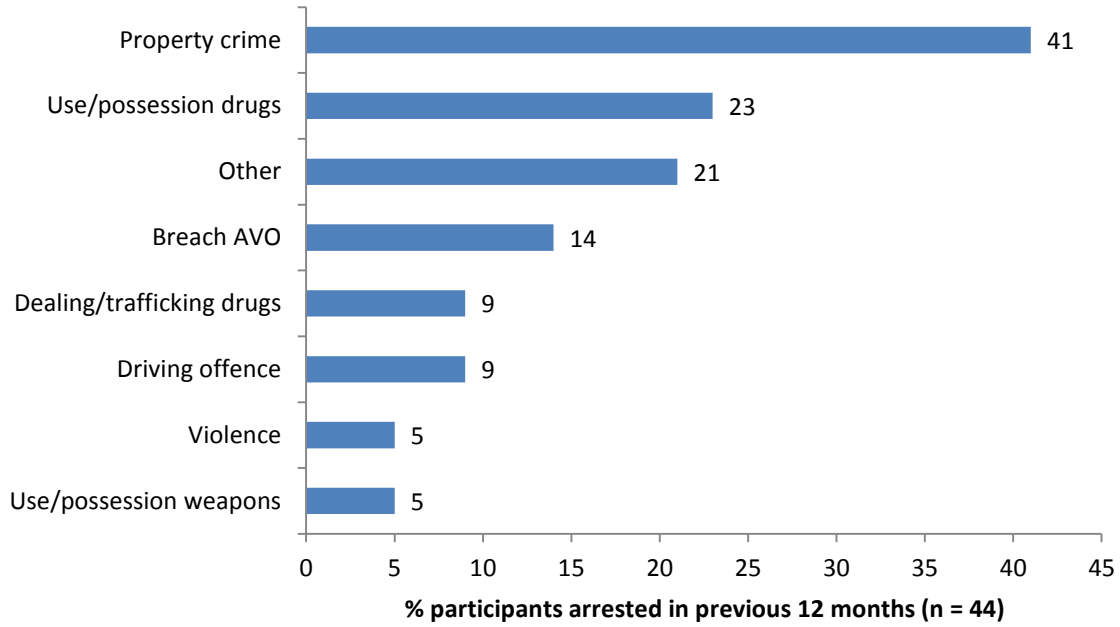


Note: Multiple responses allowed.
Source: Queensland IDRS injecting drug user interviews

7.2 Arrests

In 2012, 46% of participants reported being arrested in the preceding 12 months (56% in 2011). Among those who were arrested, the most common reason for arrest was property crime followed by use/possession of drugs (Figure 42).

Figure 42: Main reasons for arrest in preceding 12 months, 2012



Note: Multiple responses allowed
Source: Queensland IDRS injecting drug user interviews

The most recent available data for drug-related arrests made by the Queensland Police Service is for the 2010/11 financial year (Table 40). A total of 23,562 arrests were made, with 61% representing cannabis consumer charges.

Table 40: Drug-related arrests by Queensland Police Service by drug type, 2010–11

	Consumer	Provider	Total
Cannabis	14,397	1,880	16,277
Amphetamine type stimulants	2,213	898	3,111
Other and unknown	2,468	698	3,166
Heroin and other opioids	228	50	278
Steroids	185	46	231
Cocaine	120	25	145
Hallucinogens	116	29	145
Total	**20,375**	**3,187**	**23,562**

Note: consumer = use, possession or administering for own use; provider = importation, trafficking, selling, cultivation and manufacture.
Source: Australian Crime Commission

Table 41 shows that cannabis continues to be by far the most seized drug.

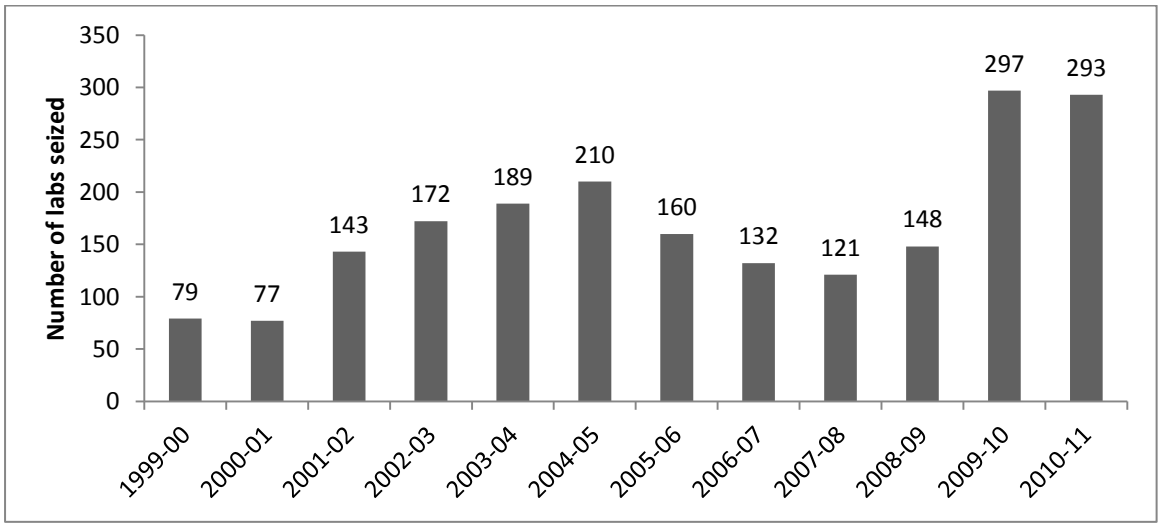
Table 41: Seizures made by Queensland Police Service by drug type, 2010–11

	Police Force	No of seizures	Weight (grams)
Cannabis	QPS	17,072	608,564
	AFP	6	10,173
Amphetamine type stimulant	QPS	2,577	22,731
	AFP	19	8,797
Heroin	QPS	189	1,971
	AFP	4	1,906
Other opioids	QPS	2	1
	AFP	1	10
Cocaine	QPS	155	734
	AFP	39	401,251
Steroids	QPS	15	523
	AFP	1	960
Hallucinogens	QPS	7	3,032
	AFP	-	-
Other and unknown drugs	QPS	607	68,791
	AFP	23	11,931

Note: QPS = Queensland Police Service; AFP = Australian Federal Police
Includes only those seizures for which a drug weight was recorded. No adjustment has been made for double counting data from joint operations between the AFP and QPS.
Source: Australian Crime Commission

In the 2010–11 financial year, a total of 293 clandestine labs were detected by the Queensland Police Service (Figure 43). Data for 2011–12 was unavailable at the time of publication.

Figure 43: Clandestine labs seized in Queensland from 1990–00 to 2010–11



Source: Queensland Police Service

7.3 Expenditure on illicit drugs

The median expenditure on illicit drugs the previous day was $70 compared with $100 in previous years (Table 42).

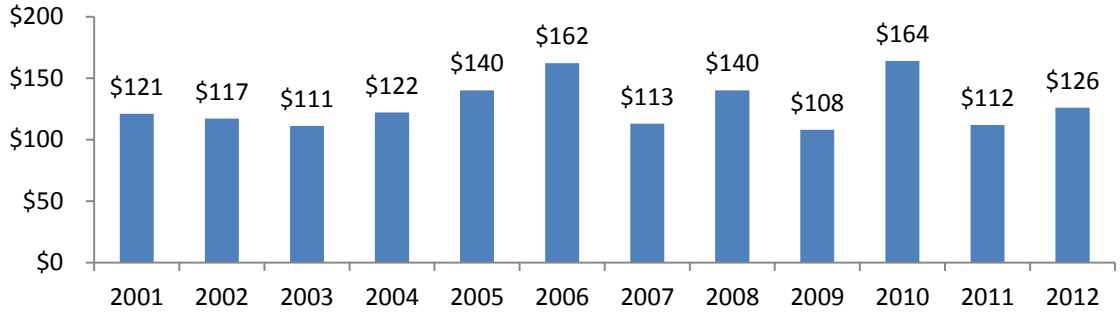
Table 42: Expenditure on illicit drugs on previous day, 2009 to 2012

Expenditure	2009 n = 70 %	2010 n = 99 %	2011 N = 102 %	**2012 N = 94 %**
Nothing	26	44	46	**46**
Less than $20	7	0	2	**3**
$20 to $49	14	8	11	**10**
$50 to $99	13	14	13	**18**
$100 to $199	20	16	20	**10**
$200 to $399	17	10	6	**11**
$400 or more	0	7	2	**3**
Median expenditure	$100	$100	$100	**$70**

Source: Queensland IDRS injecting drug user interviews

Moreover, the mean amount of money spent on illicit drugs on the day preceding interview has been relatively constant over the past decade (Figure 44). In 2012, the mean amount spent was $126 (range = $10–$600, n = 51).

Figure 44: Mean amount of money spent on illicit drugs on previous day[a], 2001 to 2012



[a] by those who reported spending money on drugs the day preceding interview
Source: Queensland IDRS injecting drug user interviews

8 SPECIAL TOPICS OF INTEREST

KEY POINTS

- 33% of daily smokers had scores on the Fagerstrom Test for Nicotine Dependence indicating high nicotine dependence, and 16% had scores indicating very high dependence.
- 70% of participants reported using pharmaceutical opioids in the previous six months. The most common reason for use was to treat self-dependence followed by seeking an opioid effect and pain relief.
- A quarter of participants had experienced pain on the day of interview, predominantly non-cancer pain.
- 77% of recent opioid users obtained a score on the Severity of Dependence Scale indicating possible opioid dependence.
- 41% of recent stimulant users obtained a score on the Severity of Dependence Scale indicating stimulant dependence.
- Buprenorphine (Subutex®) was the most commonly injected opioid substitution medication, with one in five participants reporting recently injecting it. A similar proportion recently injected buprenorphine-naloxone (Suboxone®), with 16% injecting the tablet form and 3% the film.
- The most common problem near injection site amongst all participants was temporary redness, followed equally by temporary swelling and hives.
- About half of participants (53%) had experienced a traumatic brain injury, with a median of two incidences over a lifetime.
- Many participants did not appear to know the quantity for drug trafficking thresholds in Queensland.

8.1 Fagerstrom Test for Nicotine Dependence

In 2012, participants who smoked daily were asked the Fagerstrom Test for Nicotine Dependence (FTND). These questions included 'How soon after walking do you smoke your first cigarette?' and 'How many cigarettes a day do you smoke?'. The responses for these questions were scored on a four category scheme (0,1,2,3) for both time to the first cigarette of the day (≤5, 6–50, 31–60, >60 minutes) and average daily consumption of cigarettes (1–10, 11–20, 21–30, 31+ cigarettes). The remaining questions were scored either 0 or 1. The sum of these scores was computed and a cut-off score between 6 and 8 was used to indicate high nicotine dependency, with a score of 8 or more indicating very high dependence (Heatherton, Kozlowski, Frecher, Rickert, & Robinson, 1989; Heatherton, Kozlowski, Frecker, & Fagerstrom, 1991 http://www0.health.nsw.gov.au/factsheets/general/nicotinedependence.html

As seen in Table 43, about half of participants who smoked daily reported smoking their first cigarette within five minutes of waking. Most did not smoke more than 20 cigarettes a day, with 28% smoking 10 or less. The mean Fagerstrom test score was 5.0 (SD = 2.5). Thirty-three per cent of daily smokers scored between 6 and 8 on the FTND indicating high nicotine dependence, and 16% scored 8 or more indicating very high dependence.

Table 43: Fagerstrom Test for Nicotine Dependence (FTND), 2012

	%
Time till first cigarette	n = 88
Within 5 minutes	51
5-30 minutes	32
31-60 minutes	8
60+ minutes	9
Number of cigarettes smoked a day	n = 88
10 or less	28
11-20	47
21-30	19
31 or more	6
Smoking behaviour	n ≈ 88
Experienced difficulty refraining from smoking in forbidden places	38
Would hate to give up first cigarette in the morning	72
Smoke when sick in bed	39
Smoke more often in the morning	44
Dependence (scored 6 or above)	n = 83
High	33
Very high	16
Mean score	5.0

Source: Queensland IDRS injecting drug user interviews

8.2 Pharmaceutical opioids

Since the heroin shortage (2001) an increase in the use and injection of morphine and oxycodone has been noted in the Illicit Drugs Reporting System (IDRS). Over the same period the age of people who inject drugs has also increased. Similar findings over the same period were noted in The Australian Needle Syringe Program (NSP) survey report (Kirby Institute, July 2012). We know from a number of Australian and international studies that people who inject drugs experience excess morbidity and mortality when compared to those in the general population ((English, Holman, Milne et al., 1995; Hulse, English, Milne et al., 1999; Randall, Degenhardtand al., 2001; Vlahov, Wang, Galai et al., 2004) and that prescribers are often reluctant to prescribe opioid analgesics to people with a history of injecting drug use (Merrill & Rhodes, 2002; Baldacchino, Gilchrist, Fleming et al., 2010). This section aimed to examine the complex interplay among people who inject drugs, pain management and the extra-medical use of pharmaceutical opioids.

In 2012, participants in the IDRS were asked questions about the use of pharmaceutical opioids and pain. Pharmaceutical opioids included methadone, buprenorphine, buprenorphine-naloxone, morphine, oxycodone, and other opioids such as fentanyl, pethidine and tramadol. As seen in Table 44, 70% of participants reported using pharmaceutical opioids in the previous six months. The most common reason for use was to treat self-dependence followed by seeking an opioid effect and pain relief. Preference for a particular pharmaceutical opioid was varied, with the most common choice being MS Contin®.

Participants were asked if they were refused pharmaceutical opioid medications for pain due to injecting history. Of those who commented (n = 65), 26% reported ‘yes’, with 31% not having sought pain relief.

Among those who sought pain relief (n = 45), two in five reported being prescribed pharmaceutical opioids for their pain. Participants were then asked to rate on a scale of zero (not taken pharmaceutical last week) to 10 (complete relief) how much pain relief the pharmaceutical opioids had provided in the last week. Of those who commented (n = 20), the median score was 6 (mean = 6.4,

SD = 3.6, range = 0-10). Ten per cent reported not taking any pharmaceutical opioids and 40% complete relief.

Nearly one in five participants (19%, n = 58) reported they had sold, traded or given away pharmaceutical opioids in the last six months. Morphine and buprenorphine-naloxone were the most common drugs sold, traded or given away.

Among participants who commented about obtaining information regarding filtering (n = 54), nearly half reported obtaining information from NSP, peer-run user group, or friends.

Table 44: Pharmaceutical opioids use, 2012

	% N = 96
Used pharmaceutical opioids in the last 6 months	70
Reason for using pharmaceutical opioids[a]	n = 66
Treat self-dependence	53
Seek an opioid effect	32
Pain relief	30
Know what dose to expect	8
Cheaper than heroin	15
Current heroin purity	3
Couldn't score heroin	3
Safer than heroin	8
Pharmaceutical opioid of choice	n = 65
MS Contin®	31
Suboxone® (Buprenorphine-Naloxone)	15
Subutex® (Buprenorphine)	12
Methadone®	12
Oxycontin®	12
Kapanol®	3
Ordine®	2
Endone®	2
Other	10
Refused pharmaceutical opioids medications for pain	n = 65
Haven't sought pain relief	31
Yes	26
No	40
No, because concealed injecting history	3
Prescribed pharmaceutical opioids for pain last six months[b]	n = 45
Yes	40
Sourced information about filtering[c]	n = 54
Haven't obtained any information	54
NSP	26
Peer-run user group	17
Friends	4

a Among those who recently used. Multiple responses were allowed.
b Among those who sought pain relief
c Among those who recently injected a pharmaceutical opioid
Source: Queensland IDRS injecting drug user interviews

8.3 Brief Pain Inventory

In 2012, the Brief Pain Inventory (BPI) was included to examine the association between injecting drug use and pain management. Comparisons been people who inject drugs and the general population, both in Australia and internationally, have consistently shown excess mortality and morbidity (English, Holman, Milne et al., 1995; Hulse, English, Milne et al., 1999; Vlahov, Wang, Galai et al., 2004) yet there is no current evidence in Australia on the characteristics or the extent to which people who inject drugs obtain licit or illicit pharmaceutical opioids for the management of chronic non-malignant pain. Furthermore, there is growing evidence that prescribers are often reluctant to prescribe pharmaceutical opioids to people with a history of injecting drug use (Baldacchino, Gilchrist, Fleming et al., 2010). Responses to questions on these issues are shown in Table 45.

One-quarter of participants experienced pain (other than everyday pain) on the day of interview. Of those who experienced pain, the majority (84%) reported the pain as chronic non-cancer pain (continuous pain which lasts for more than three months), with the remaining 16% reporting acute pain. The mean 'pain severity score' was 4.5 (SD = 2.0). The mean 'pain interference score' was 4.4 (SD = 2.3).

Participants were also asked on a scale of 0 to 10 (0 = no relief, 10 = complete relief) how much relief they experienced from any treatments/medications they received. Of those who received treatment/medication for pain (n = 20), a mean score of 4.0 (SD = 3.8) was reported.

Participants were then asked if they had any trouble obtaining sufficient pain relief from a doctor or specialist in the last six months. Of those who experienced pain, around three in five reported trouble obtaining pain relief. Participants were also asked if they informed the doctor or specialist about their drug use when requesting pain relief. The majority of those who commented reported they did not.

Table 45: Brief Pain Inventory, 2012

	N = 100
Experienced pain today (other than everyday pain) (%)	25
Nature of pain (%)	n = 25
Acute/short term	16
Chronic non-cancer pain	84
Chronic cancer/malignant pain	0
Other	0
Mean 'Pain Severity' score	4.5
Mean relief experience from treatment/medications[a]	4.0
Mean 'Pain Interference' score	4.4
Trouble obtaining pain relief from doctor last 6 months (%)	n = 23
Yes	61
Told doctor about drug use when requested pain relief (%)	n = 18
No	44
Yes	22
Yes, but not all use	11
Doctor already knew	22

[a] among those who received treatment/medication for pain and commented
Source: Queensland IDRS injecting drug user interviews

8.4 Opioid and stimulant dependence

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

In 2012, the participants 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, Hides et al., 2002).

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

Of those who had recently used an opioid and commented (n = 82), the median SDS score was 8.0 (mean = 8.0, range = 0–15), with 77% scoring five or above. There were no significant differences regarding gender. Of those who scored five or above (n = 57), 63% reported specifically attributing responses to heroin, 19% morphine, 11% buprenorphine, 9% methadone, and 2% other.

Of those who had recently used a stimulant and commented (n = 49), the median SDS score was 3.0 (mean = 4.1, range = 0–12), with 41% scoring four or above. There were no significant differences regarding gender and mean stimulant SDS score, or regarding gender and those who scored four or above. Of those who scored four or above (n = 20), all reported specifically attributing their responses about stimulants to methamphetamines.

8.5 Opioid substitution therapy injection

Due to the introduction of buprenorphine-naloxone film in 2011, questions were included in the 2012 IDRS survey asking about the recent injection of opioid substitution treatment (OST) medications (methadone, buprenorphine and buprenorphine-naloxone). Nine per cent of all participants reported recently injecting methadone, 20% reported recently injecting buprenorphine, 16% buprenorphine-naloxone 'tablet' and 3% buprenorphine-naloxone 'film'. Please refer to Larance and colleagues for further information on OST medication injection (Larance, Sims, White et al., in preparation).

8.6 Injection-related injuries and disease

People who inject drugs are exposed to a broad range of potential harms including (but not limited to) bacterial infections, soft tissue damage and vascular injury. Research conducted with injecting drug users has identified high levels of experience of such injuries (Dwyer, Power, Topp et al., 2007).

Previous IDRS surveys have asked a limited set of questions regarding harms experienced from injecting. The aim of these questions is to gather greater detail of experience of these harms and identify individual risk factors significant for injection-related injuries and diseases (IRID). Results can be compared with findings from the IRID project (Dwyer, Power, Topp et al., 2007).

In 2012, participants were asked if they had ever and recently (last six month) experienced any injection-related injuries or diseases from the list used in the IRID project. Table 47 below lists the IRID ever and recently experienced in the last six months by participants in the Queensland IDRS survey and also those from the IRID project. Note: recent use in the IRID project is in the last 12 months. For example, of those who commented in the IDRS project (N ≈ 94), half (50%) reported in their lifetime and 34% reported recently experiencing redness near the injection site. This compared to 42.2 (ever) and 28.3% (recently) in the IRID project. While most of the ever results were similar, some differences were noted (Table 46).

Table 46: Self-reported injecting-related injuries and diseases, ever and recently[a], 2012

Problem experienced	The IRID project % (N = 393)		National IDRS % (N ≈ 94)	
	Ever	Last 12 months*	Ever	Last 6 months*
Non-serious				
Redness near injection site	42.2	28.3	50	34
Swelling near injecting site	45.0	30.9	44	31
Raised red area (hives)	56.0	41.3	44	31
Dirty hit	67.9	35.4	59	18
Hit an artery when injecting	21.9	9.4	19	10
Numbness/pins and needles	19.3	12.4	26	18
Collapsed/blocked veins	47.8	27.0	39	23
Potentially serious				
Pus-filled lump (skin abscess)	16.5	7.0	13	6
Internal/inside body abscess	3.0	1.0	4	2
Red, hot, swollen, tender skin (cellulitis)	14.2	7.0	22	15
Inflamed veins (thrombophlebitis)	14.2	6.6	22	17
Swelling leaves a dent (pitting oedema)	7.4	4.4	17	11
Puffy Hands Syndrome (lymph oedema)	7.1	3.9	9	5
Fistula (permanent hole)	n.a.	n.a.	5	4
Injecting sinus	4.8	2.8	n.a.	n.a.
Serious				
Heart infection (Endocarditis)	3.0	1.0	1	0
Septicaemia	4.3	1.3	n.a.	n.a.
Septic arthritis	1.0	0.2	n.a.	n.a.
Osteomyelitis	0.5	0.2	n.a.	n.a.
Serious infection (unspecified)	2.3	0.5	n.a.	n.a.
Other serious infection needing stay in hospital and intravenous antibiotics (septic arthritis, osteomyelitis, septicaemia)	n.a.	n.a.	10	3
Deep vein thrombosis (blood clot)	3.3	1.3	3	0
Gangrene	0.8	0.3	1	0
Amputation	0.8	0.3	1	0
Venous ulcer	1.5	0.8	1	1
Other problem	n.a.	n.a.	2	0

[a]recently = last six months for the IDRS and the last 12 months for the IRID project
Note: N for the IDRS varied between 93 and 95.
Source: Queensland IDRS injecting drug user interviews; IRID Project (Dwyer, Power, Topp et al., 2007)

8.7 Neurological history

People with a neurological illness or injury may be at greater risk of experiencing adverse effects associated with drug use. Existing research indicates that there is an association between traumatic brain injury and drug use (Corrigan, Bogner, & Holloman, 2012). This may be due to greater exposure to violence, mental illness, poor nutrition and poor sleep among other factors. Traumatic brain injury is a major cause of morbidity and mortality in developed countries (Bruns & Hauser, 2003) and can result in long-term physical and cognitive impairments, as well as negatively impact upon psychological wellbeing, social and occupational outcomes (Tait, Anstey & Butterworth, 2010). The cognitive, emotional and functional impairments associated with drug use could potentially compound those associated with traumatic brain injury (Kelly, Johnson, Knoller et al., 1997). In 2012, questions about the prevalence of selected neurological illnesses and traumatic brain injury were included. Results are shown in Tables 47 and 48.

Table 47: Incidence of selected neurological conditions, 2012

	N = 95
Epilepsy[2] (%)	7
Stroke (%)	2
Hypoxia (%)	2
Traumatic Brain Injury[3] (%)	53

Source: Queensland IDRS injecting drug user interviews

The lifetime prevalence of epilepsy was higher in this group (7%) than the Australian population estimate (0.7%) obtained in the 2007/08 National Health Survey (ABS, 2010). Data from the same survey estimates the Australian prevalence of cerebrovascular disease (including stroke) as approximately 1.2%, lower than the proportion reported in the current sample (2%). It is difficult to estimate the prevalence of hypoxic brain injury because it can result from a range of different situations (including drowning, carbon monoxide poisoning, heart attack etc.). Nonetheless, the prevalence in this group is reasonably low.

In contrast, just over half of our sample (53%) reported a lifetime history of traumatic brain injury[4]. In a recent study, Perkes et al. (2011) estimated the lifetime prevalence of traumatic brain injury with loss of consciousness as 35% among a community sample of males in Australia. Similarly, a cohort study conducted in Christchurch, New Zealand demonstrated that approximately 32% of the community sample had experienced at least a mild-traumatic brain injury by 25 years of age. Both of these prevalence estimates are lower than that recorded in our sample. However, caution should be used when directly comparing these figures due to differences in sampling techniques and data collection.

Multiple traumatic brain injuries were the norm (Table 48). The vast majority of participants who had experienced a traumatic brain injury reported that the loss of consciousness on the most severe occasion lasted only a few minutes (consistent with a mild injury). Most were aged in their mid-twenties at the time. Twenty-eight per cent were under the influence of alcohol at the time of the injury and 26% were under the influence of at least one drug.

[2] National prevalence approximately 6.4 per 1000 people (i.e. 0.6%) in 2001 Australian Bureau of Statistics (2001) Long-term Health Conditions—A Guide To Time Series Comparability From The National Health Survey. *Occasional Paper.* Canberra, ABS.

[3] Population prevalence rates usually between approximately 0.1 and 0.4% Bruns, J. & Hauser, W.A. (2003) The epidemiology of traumatic brain injury: a review. *Epilepsia,* 44 Suppl 10**,** 2–10..

[4] TBI was measured as a knock on the head resulting in loss of consciousness.

Table 48: Traumatic brain injury, 2012

	n = 49
Median number of traumatic brain injuries (range)	2 (1–50)
Median loss of consciousness (minutes)	2
Median age of most severe loss of consciousness (range)	25 (5–58)
For most severe traumatic brain injury (%)	n = 46
Under influence of alcohol	28
Under influence of drugs	26
Main drug attributed to most severe traumatic brain injury (%)	n = 12
Heroin	25
Ice/crystal	25
Speed	17
Benzodiazepines	8
Morphine	8
Other	17

Source: Queensland IDRS injecting drug user interviews

Some people experience neuropsychological sequelae (symptoms such as cognitive, motor and behavioural changes) following a traumatic brain injury, which can complicate recovery. About two-thirds reported experiencing neurological sequelae immediately following the injury (Table 49). The most common complaints were poor coordination/balance (64%), concentration (57%), and memory loss (56%). Ongoing effects were experienced by a quarter of those that had a traumatic brain injury, with memory loss, problems finding the right words when speaking, and poor co-ordination the most common complaints.

Table 49: Effects of traumatic brain injury, 2012

	% n = 44
Experienced any effects[a] following the injury	64
Experienced at the time	n = 28
Poor coordination/ balance	64
Poor concentration	57
Memory loss	56
Word finding problems	46
Mood changes/anxiety issues	30
Personality change	26
Functional weakness	23

[a] Neurological, cognitive, behavioural or psychiatric
Source: Queensland IDRS injecting drug user interviews

8.8 Possession laws

Drug trafficking thresholds are used throughout every state and territory in Australia and often reverse the onus of proof onto users who exceed the nominated threshold quantity to prove they do not possess drugs for the purpose of trafficking. For the first time in 2012, participants in the IDRS were asked a number of questions relating to drug trafficking thresholds/possession laws. The aim of these questions was to find out whether regular users were aware of the existence of drug trafficking thresholds. Drug trafficking thresholds in Queensland are two grams for heroin, methamphetamines, MDMA, and cocaine; and 500 grams for cannabis.

Participants were firstly asked about a hypothetical scenario: '*Imagine you are caught by police and have drugs on you, do you think the quantity of drugs will affect the type of charge you will get*?'. Those participants who responded 'yes' were then asked '*what quantity would you need to possess to be charged with sell or supply (as opposed to possession for personal use)*', for the following drugs: heroin, methamphetamine (all forms), MDMA, cocaine, cannabis.

About four in five (81%) believed the quantity of drugs would affect the type of charge received. Median amounts provided were:

Heroin	0.1 point (n = 1) 2 grams (range = 0.1–28, n = 20)
Methamphetamine	0.5 points (0.1-10, n = 3) 2 grams (range = 0.1–7, n = 19)
MDMA	20 pills (range = 0.1–50, n = 4) 1 gram (range = 0.1–2, n = 3)
Cocaine	2.8 grams (0.1–28, n = 6)
Cannabis	3.3 grams (0.1–456, n = 6) 1 ounce (0.1–16, n = 14)

Note: Responses of 0.1 represented statements such as '*any amount however small*'.

From the small number of responses and range of responses regarding drug trafficking threshold amounts, it appears that many participants did not know the threshold amounts. Conversely, there were a small minority whose responses were accurate.

9 CONCLUSION

Demographic characteristics remained stable. Heroin and methamphetamine remained the most commonly used drugs. However, there was a significant decrease in methamphetamine use overall; although use of crystalline methamphetamine (ice) was stable. Use of pharmaceutical drugs remained common.

Price, purity, availability, and purchasing patterns of the drugs investigated generally remained stable. The majority of participants purchased drugs from either friends or known dealers.

As in previous years, participants had high levels of psychological distress and mental health problems, and their physical health was rated poorer than the general Australian public. Responses to questions about pharmaceutical opioid use and pain experiences highlighted the self-treatment aspect of regular injecting drug use.

Reports of crime and arrests were highest in areas associated with regular drug use, namely property crime and use/possession of drugs. Injecting risk behaviours had lessened with a significant decrease in participants using needles after someone else had used them.

These areas all have implications for policy-making and implementation of policies.

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