Queensland

Fairlie McIlwraith, Caroline Salom and Rosa Alati

QUEENSLAND DRUG TRENDS 2015

Findings from the

Illicit Drug Reporting System (IDRS)

Australian Drug Trends Series No. 153

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Fairlie McIlwraith, Caroline Salom and Rosa Alati

Queensland Alcohol and Drug Research and Education Centre

Australian Drug Trends Series No. 153

ISBN 978-0-7334-3626-0

Suggested citation: McIlwraith F, Salom C and Alati R (2016). Queensland Drug Trends 2015. *Findings from the Illicit Drug Reporting System (IDRS)*. Australian Drug Trend Series No.153. Sydney National Drug and Alcohol Research Centre, UNSW Australia.

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

TABLE OF CONTENTS

List of Tables

List of Figures

ACKNOWLEDGEMENTS

The 2015 Illicit Drug Reporting System (IDRS) was supported by funding from the Australian Government Department of Health under the Substance Misuse Prevention and Service Improvement Grants Fund. Thank you to the Australian Government Department of Health for their continued assistance and support throughout the year.

The IDRS is co-ordinated by the National Drug and Alcohol Research Centre (NDARC), University of New South Wales, and sincere thanks go to our colleagues at NDARC for their continued support, professionalism and collegiality:

- Associate Professor Lucy Burns, Chief Investigator
- Dr Courtney Breen, Acting Manager of Drug Trends
- Natasha Sindicich, National Coordinator
- Jennifer Stafford, Assistant National Coordinator
- Amanda Roxburgh, Senior Research Officer, for her help with access and analysis of indicator data.

The Queensland component of the IDRS is conducted by the Queensland Alcohol and Drug Research Centre (QADREC), The University of Queensland. The success of the Queensland IDRS depends upon the continuing support and co-operation of a large number of stakeholders. In particular, thank you to:

- survey participants for sharing your experiences and perceptions with us
- Needle and Syringe Programs (NSPs) in Queensland whose assistance, co-operation, and generosity over the years has continued to make data collection for the project possible:
    - Brisbane Harm Reduction Centre at Biala
    - Inala Alcohol and Drug Service NSP
    - Queensland Injector's Health Network (QuIHN)—Burleigh Heads NSP, Bowen Hills NSP, and Sunshine Coast NSP
- interviewers Melanie Gamble and Camila Couto e Cruz; and Nam Tran for technical support and data entry
- individuals from the health and law enforcement sectors for freely giving your time and knowledge as key experts
- health and law enforcement agencies for kindly providing indicator data.

ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ACBPS	Australian Customs and Border Protection Service
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
CPR	Cardio pulmonary resuscitation
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders IV
EDRS	Ecstasy and related Drugs Reporting System
GP	General practitioner
HCV	Hepatitis C virus
IDRS	Illicit Drug Reporting System
K10	Kessler Psychological Distress Scale
LSD	Lysergic acid diethylamide
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)
PWID	People who inject drugs
OST	Opioid substitution treatment
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
SD	Standard deviation
SDS	Severity of Dependence Scale
SPSS	Statistical Package for the Social Sciences

GLOSSARY OF TERMS

Base	a paste form of methamphetamine
Bush	Outdoor-cultivated cannabis
Cap	Small amount, typically enough for one injection
Halfweight	0.5 gram
Hydro	Hydroponically grown cannabis
Ice	Crystalline methamphetamine
Illicit	Illegal drugs as well as pharmaceuticals obtained from a prescription in someone else's name (e.g. by 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	Pharmaceuticals (e.g. methadone, buprenorphine, morphine, oxycodone, benzodiazepines, antidepressants) obtained by a prescription in the user's name. This definition does not take account of 'doctor shopping' practices; however, it differentiates between prescriptions for self as opposed to pharmaceuticals bought on the street or those prescribed to a friend or partner
Lifetime injection	Injection (typically intravenous) on at least one occasion in the participant's lifetime
Lifetime use	Use on at least one occasion in the participant's lifetime via one or more of the following routes of administration: injecting, smoking, snorting, or swallowing
Mean	The average
Median	The middle value of an ordered set of values
Participant	Refers to a person who participated in the Queensland IDRS survey of PWID (does not refer to key expert participants unless stated otherwise)
PWID	People who inject drugs
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
Speed	Powder methamphetamine
Use	Consuming a drug via one or more of the following routes of administration: injecting, smoking, snorting, or swallowing

Guide to days of use/injection in preceding six months

180 days	Daily
90 days	Every second day
24 days	Weekly
12 days	Fortnightly
6 days	Monthly

EXECUTIVE SUMMARY

The Illicit Drug Reporting System (IDRS) is a monitoring system designed to identify emerging trends in illicit drug markets which are of local and national concern. 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

In 2015, 98 people who injected drugs (PWID) participated in the IDRS survey in South-East Queensland. Participants were typically 41 years old, male, single, unemployed, with a long injecting history. Just over half the sample had a prison history, and two-in-five participants reported being currently in drug treatment.

Consumption pattern results

Current drug use

Although heroin remained the most common drug of choice (52%), methamphetamine—mostly crystalline (ice)—was the drug injected the most in the past month, and the most likely drug used in the most recent injection. The most frequent reason given for the disparity between drug of choice and drug use was availability.

Heroin

Only half the sample had used heroin in the previous six months, which was a significant drop from 66% in 2014. About a third (32%) reported heroin was the drug injected most in the previous month. Median use was 48 days in the past six months (180 days). The most common amount used in a typical session was a quarter of a gram.

Methamphetamine

Two-thirds of participants (67%) reported using methamphetamines in the previous six months. Four-in-five reported that ice was the most used form of methamphetamine, and one-in-five reported it was speed. Base was used infrequently and liquid even more infrequently. A third of the sample (33%) reported methamphetamine was the drug injected most in the previous month.

Median days use of methamphetamines was 24 of 180.

Cocaine

Recent cocaine use continued to be rare (8%) and occasional (median of two days).

Cannabis

Nearly all participants had used cannabis in their lifetime, with 60% reporting recent use. About a third of these participants used daily. Use of synthetic cannabis remained rare, with 2% of participants reporting recent use.

Other opioids

The most commonly used opioid substitution treatment (OST) drugs in the past six months were buprenorphine-naloxone (Suboxone®)—36%, followed by methadone—28%, and then Buprenorphine (Subutex®)—26%.

Recent illicitly used (non-prescribed) OSTs were buprenorphine-naloxone (27%), buprenorphine (17%), methadone liquid (13%) and methadone tablets (2%).

One third (33%) reported recent morphine use (29% illicit), and 26% reported recent oxycodone use (24% illicit).

Recent fentanyl use was reported by 14% after spiking at 25% in 2014. Recent non-medicinal use of over-the-counter codeine was reported by 22%, and other opiates (e.g. Panadeine Forte®) by 14%.

Other drugs

Recent use of ecstasy, hallucinogens, and inhalants remained low—all at 5%. Pharmaceutical stimulant use (e.g. dexamphetamine and methylphenidate) also continued to be rare, with 4% licit and 4% illicit.

Most participants (87%) had recently used benzodiazepines (licit or illicit). Recent illicit use of alprazolam was reported by 23% and other benzodiazepines by 59%.

Drug market: Price, purity, availability and purchasing patterns

Heroin

There has been little movement on heroin prices since reporting began in 2000. A cap has been constant at a median price of $50 and the most common purchase weight—a quarter gram— has cost a median of $100 since 2008. Three in five respondents reported purity as low. The availability of heroin was most commonly reported as easy to obtain (In 2014, 57% of respondents had reported it as very easy compared with 26% in 2015).

Methamphetamine

The median price of a point of ice and speed was $100 and $70 for base. Purity was most commonly reported as high for ice (35%), and medium for base (46%) and speed (38%). Nearly all respondents reported ice as readily available (92%). Most reported speed as readily available; a quarter reported it was difficult to obtain. Reports on the availability of base were split between easy and difficult.

Cocaine

The one report on the cocaine market was that it was difficult to access, the purity was medium, and the cost was $450 per gram.

Cannabis

Price was mostly reported as stable for both hydro and bush: median price of a quarter ounce of hydro was $90 and bush was $60. Potency was generally rated as medium or high for both hydro and bush. Hydro was readily available but bush was less so with 44% reporting it as difficult.

Methadone

Purchase quantity varied and numbers were too small for meaningful analysis. However, the five reports indicated that methadone was readily available and most likely to have been obtained from an acquaintance or friend for self-treatment.

Buprenorphine (Subutex®)

Buprenorphine was most commonly purchased at a median price of $40 for 8 mg. Three-quarters of respondents reported it was readily available and a quarter difficult or very difficult. The source person was generally a friend or acquaintance and the source venue mostly a friend's home or an agreed public location.

Buprenorphine-naloxone (Suboxone®)

Reports about the illicit buprenorphine-naloxone market were mainly about film (rather than tablets). The median price of 8 mg film was $20. Both tablets and film were reported as readily available.

Morphine

Price of morphine was mostly considered to be stable with the median price for 100 mg MS Contin® being $55. Morphine was generally reported as readily available and was sourced from a variety of people. The most common reason for purchasing illicit morphine was self-treatment.

Oxycodone

OxyContin® (reformulated) was the most common brand of oxycodone purchased: $20 for 40 mg and $40 for 80 mg. Availability was mostly rated as easy or very easy. Just over half (54%) reported their source person was a friend and the most common purchase venue was an agreed public location.

Benzodiazepine

No clear indication of the market was obtained due to only four respondents and little consensus.

Other drugs

No clear indication of the fentanyl or LSD market was obtained due to the small number of respondents and little consensus.

Health-related trends associated with drug use

Overdose and drug-related fatalities

Among participants who had used heroin (n = 81), 51% had accidently overdosed on it at some time. Of these, 15% (six participants) had overdosed in the preceding year. Very small numbers of participants reported ever overdosing on morphine, methadone, or oxycodone.

One-in-five participants had accidently overdosed on a drug other than heroin in their lifetime.

Drug treatment

Two-in-five participants (39%) were currently in drug treatment, mainly opioid substitution therapy (OST).

Injecting risk behaviours

A small proportion of participants reported sharing needles: 7% had recently borrowed a used needle and 10% had recently lent a used needle. Sharing of other equipment (mainly spoons/mixing containers) was more common (22%).

Two-in-five re-used one of their own needles at least once in the previous month.

Opioid and stimulant dependence

Of those who had recently used opioids, 72% had a score on the Severity of Dependence Scale (SDS) indicative of dependence.

Of those who had recently used stimulants, 41% had a score on the SDS indicative of dependence.

Psychological distress

Nearly half of the participants (45%) self-reported a mental health problem, with the most common problems being depression and anxiety.

Naloxone program and distribution

Three-quarters of participants (74%) had heard of naloxone, and 57% had heard of the take-home program. However, only one participant was participating in the program.

Self-reported general health status

One-in-five participants considered their general health to be very good or excellent, with the most common rating being good.

Trends in law enforcement associated with drug use

Reports of criminal activity

A third of participants (33%) reported criminal involvement in the previous month. As in previous years, dealing was the most often reported crime followed by property crime.

Arrests

Thirty-eight per cent of participants reported having been arrested in the previous 12 months. The most common reason was use/possession of drugs.

Expenditure on illicit drugs

Just over half of the sample (56%) reported spending money on illicit drugs the day before—a median of $100.

Special topics of interest

Hepatitis C testing

Most participants (90%) reported having been tested for Hepatitis C, and 60% reported a positive result. Of these (n = 49), 57% were screened or tested for RNA (PCR test).

Most participants revealed a moderately good understanding of HCV.

Blood donations

Of those who commented (n = 74), 18% reported having ever having given blood and 25% had commenced injecting drug use before donating.

Oxycodone use

Of those who commented (n = 88), 43% reported ever using any form of oxycodone (58% in 2014). Oxycodone used in the previous six months was most commonly reformulated Oxycontin® followed by original Oxycontin®.

1 INTRODUCTION

The Illicit Drug Reporting System (IDRS) 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 Department of Health. The IDRS focuses primarily on four illicit drugs: heroin, amphetamines, cocaine, and cannabis but also monitors trends in other drug use and 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 from the states and territories are presented at the National Drug Trends Conference in October, and the final jurisdictional reports are published by the National Drug and Alcohol Research Centre (NDARC) early the following year. Additionally, 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 inject drugs (PWID); (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 Drugs Reporting System (EDRS), and the Australian Needle and Syringe Program (ANSP) survey, 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 2015 Queensland IDRS were to:

- document the price, purity, and availability of heroin, methamphetamines, 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 PWID (participants)
- semi-structured interviews with key experts who are involved with the illicit drug sector
- 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 and July 2015, 98 IDRS participants were individually interviewed face-to-face. Participants were PWID aged 17 years or older who had injected an illicit drug at least monthly in the previous six months, and had lived in South-East Queensland for the previous 12 months. Participants were recruited and interviewed at five Needle and Syringe Program (NSP) sites located in the Brisbane, Gold Coast and Sunshine 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 2015 IDRS questionnaire contained 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. psychological and physical 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

During August through to October 2015, 19 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 due to being in regular contact with PWID or having considerable knowledge of manufacture, importation, supply, and seizure of illicit drugs.

In 2015, 12 of the key experts were from the health sector and 7 were from law enforcement. Key experts included NSP workers, AOD 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. The following indicator data sources were used in the report:

- Australian Bureau of Statistics (ABS): National Health Survey data
- Australian Crime Commission (ACC): total weight and number of drugs seized in Queensland by Queensland Police Service (QPS) and the Australian Federal Police (AFP); QPS clandestine laboratory detections and drug-related arrests
- Australian Customs & Border Protection Service (ACBPS): total weight and number of drugs seized at the Australian border
- Australian Institute of Health and Welfare (AIHW): Queensland pharmacotherapy client registrations
- Queensland Needle and Syringe Program (QNSP): syringes provided by QNSP to NSP sites and chemists in Queensland.

2.4 Data analysis

Participant survey results were analysed using IBM SPSS Statistics, Version 22. Standard frequencies were calculated and tests for significant differences between 2014 and 2015 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. Column percentages may not add up to 100% due to rounding. Test differences in proportions were calculated using the Newcombe-Wilson Hybrid Score for differences between two proportions (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

- **Mean age:** 41 years (range 17–65)
- **Median injecting history:** 19 years (range 1–45)
- Other characteristics of participants were similar to previous years: likely to be unemployed, male, and single; half with a prison history, and two-in-five currently in treatment.

3.1 Overview of the IDRS participant sample

The demographic characteristics of the sample of 98 PWID from South-East Queensland were similar to those in 2014 (Table 1). Participants were typically 41 years old, male, single, and unemployed.

Table 1: Demographic characteristics, 2014 and 2015

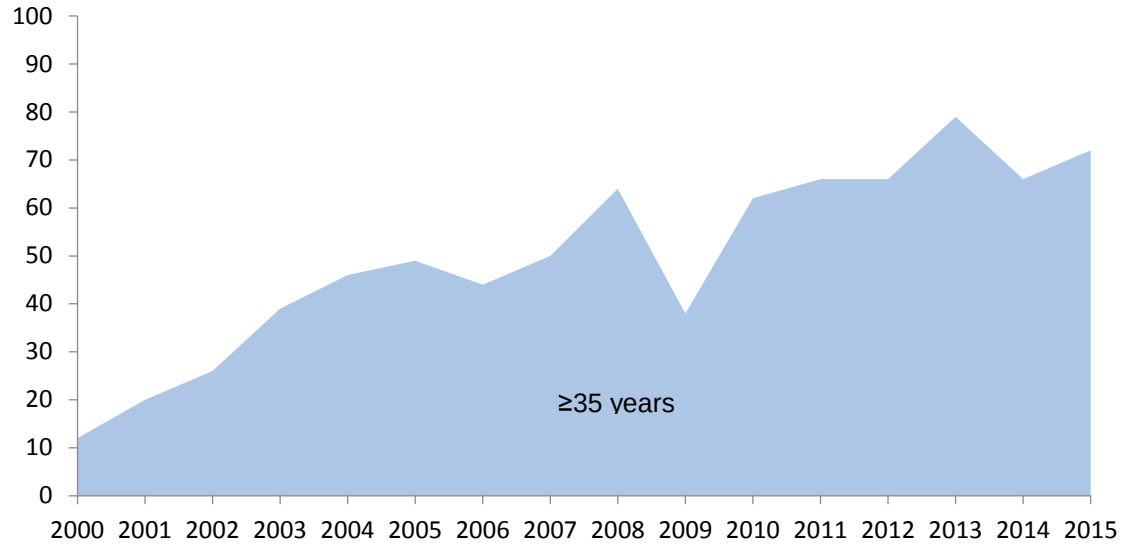
	2014 N = 100	**2015** **(N = 98)**
Age (mean, range)	40 (20–65)	**41 (17–65)**
Sex (% male)	65	**67**
Aboriginal and/or Torres Strait Islander (%)	15	**7**
Sexual identity (%)		
Heterosexual	88	**93**
Gay male	2	**1**
Lesbian	1	**2**
Bisexual	9	**3**
Other	0	**1**
Relationship status (%)		
Married / de facto	9	**18**
Partner	26	**14**
Single	57	**61**
Separated	4	**2**
Divorced	2	**2**
Widowed	1	**1**
Other	1	**1**
Highest school grade completed (mean)	10	**10**
Course completed post-school (%)		
None	50	**43**
Trade/technical	44	**51**

	2014 N = 100	**2015** **(N = 98)**
University/college	6	**6**
Accommodation (%)		
Own home (including renting)	66	**72**
Parents'/family home	7	**7**
Boarding house/hostel	11	**8**
Shelter/refuge	1	**1**
No fixed address	13	**7**
Other	2	**4**
Unemployed (%)	82	**78**
Main income from government pension, allowance or benefit (%)	87	**85**
Mean income per week ($)	(n = 98) 386	**(n = 96)** **403**
Prison history	51	**54**
Currently in drug treatment[a]	53	**39**

[a] Refers to any form of drug treatment (e.g. pharmacotherapy, counselling, detoxification)
Source: Queensland IDRS PWID interviews

Figure 1 highlights the increase in age of participants. In 2000, 12% were aged 35 years or older; in 2015, 72% were aged 35 years or older.

Figure 1: Percentage of participants 35 years and over, 2000 to 2015



Source: Queensland IDRS PWID interviews

On a population level, findings from the National Drug Strategy Household Survey show that the mean age of people who inject drugs (PWID) rose from 26 years in 2001 to 36 years in 2013 (AIHW 2014).

3.1.1 Injecting history

A corollary of the increasing age of participants is that many have long injecting drug histories. The median injecting history (i.e. period since first injection) was 19 years (range 1–45), which was the same number of years as in 2014.

3.1.2 Queensland Minimum Data Set for Needle and Syringe Programs (QMDS-NSP)

The 2014 QMDS-NSP (Department of Health Queensland 2015) showed that NSP clients in Queensland had a mean age of 37 years (SD = 10.5). Of the 183,204 service occasions, 75% were male clients and 25% were female clients. Ten per cent of clients identified as an Aboriginal and/or Torres Strait Islander person; though it was noted this may be an under-representation due to missing data.

4 CONSUMPTION PATTERNS

KEY POINTS

- **Most common first drug injected:** methamphetamine (58%) and heroin (28%)
- **Most common drug of choice:** heroin (52%) and methamphetamine (25%)
- **Most common drug injected the most in the preceding month:** methamphetamine—mostly ice (33%) and heroin (32%)
- **Most common drug last drug injected:** methamphetamine (38%) and heroin (31%)
- **Injected at least once per day:** 37%

4.1 Current drug use

Overall, the pattern of drug use in 2015 was similar to 2014 (Table 2). Although heroin remained the most common drug of choice, methamphetamine was the most common first drug injected, drug injected most often in the past month, and the last drug injected. The most common form of methamphetamine used was crystalline (ice).

Table 2: Drug use patterns, 2014 and 2015

	2014 N = 100	**2015** **N = 98**
Age first injection (mean years, range)	19 (11–37)	**21 (11–42)**
First drug injected (%)		
Methamphetamine (any form)	59	**58**
Powder (speed)	*(41)*	***(46)***
Base	*(11)*	***(4)***
Ice	*(7)*	***(8)***
Heroin	36	**28**
Morphine	1	**6**
Cocaine	1	**3**
Opioid substitution therapy (OST) drug[a]	1	**2**
Other	2	**3**
Drug of choice (%)		
Heroin	56	**52**
Methamphetamine (any form)	24	**25**
Speed	*(9)*	***(11)***
Base	*(5)*	***(2)***
Ice	*(10)*	***(12)***

	2014 N = 100	**2015** **N = 98**
Cannabis	8	**8**
Morphine	4	**7**
Oxycodone	3	**0**
Cocaine	1	**1**
Buprenorphine	1	**2**
Buprenorphine-naloxone	1	**0**
Methadone	0	**0**
Other	2	**5**
Drug injected most often in past month (%)		
Heroin	44	**32**
Methamphetamine (any form)	29	**33**
Speed	*(7)*	***(4)***
Base	*(0)*	***(1)***
Ice	*(22)*	***(28)***
Morphine	11	**16**
Opioid substitution therapy (OST) drug[a]	8	**16**
Oxycodone	3	**1**
Cocaine	0	**0**
Other/have not injected in past month	5	**2**
Last drug injected (%)		
Heroin	42	**31**
Methamphetamine (any form)	27	**38**
Speed	*(6)*	***(11)***
Base	*(0)*	***(2)***
Ice	*(21)*	***(25)***
Morphine	12	**14**
Opioid substitution therapy (OST) drug[a]	12	**12**
Oxycodone	3	**3**
Cocaine	1	**0**
Other drug	3	**2**
Frequency of injecting in past month (%)		
Not in last month	4	**3**
Weekly or less	21	**27**
More than weekly, but less than daily	38	**33**

	2014 N = 100	**2015** **N = 98**
Once per day	17	**15**
2–3 times a day	13	**17**
>3 times a day	7	**5**

[a]methadone, buprenorphine, buprenorphine-naloxone
Arrow symbol signifies a significant difference p <0.05.
Source: Queensland IDRS PWID interviews

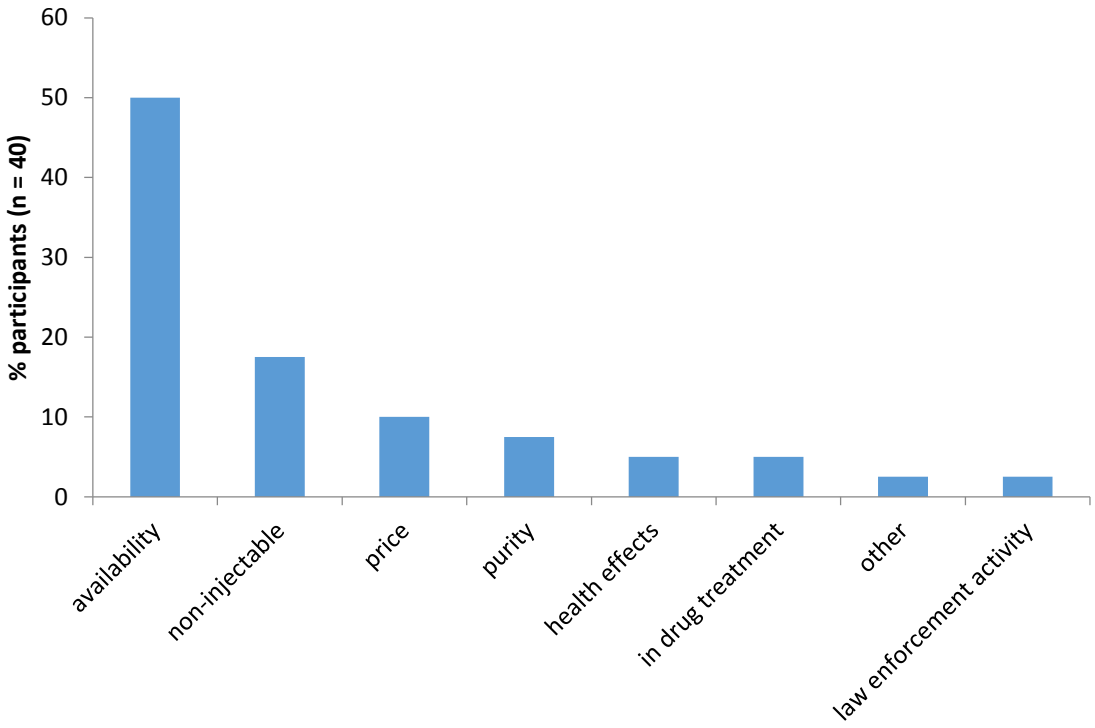
4.1.1. Drug of choice

Drug of choice followed a similar pattern to previous years (Table 2), with just over half of participants nominating heroin, and a quarter nominating a methamphetamine: ice (12%), speed (11%), and base (2%).

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

Methamphetamine has now taken heroin's place as the drug most likely to have been last injected and to have been most often injected in the past month (Table 2). Ice is the most common form of methamphetamine used with 28% reporting ice as the drug most often injected in the last month, and 25% reporting ice as the drug last injected. The main reason given for there being a difference between drug of choice and drug used was availability (Figure 2).

Figure 2: The reason for disparity between drug of choice and drug used most often, 2015

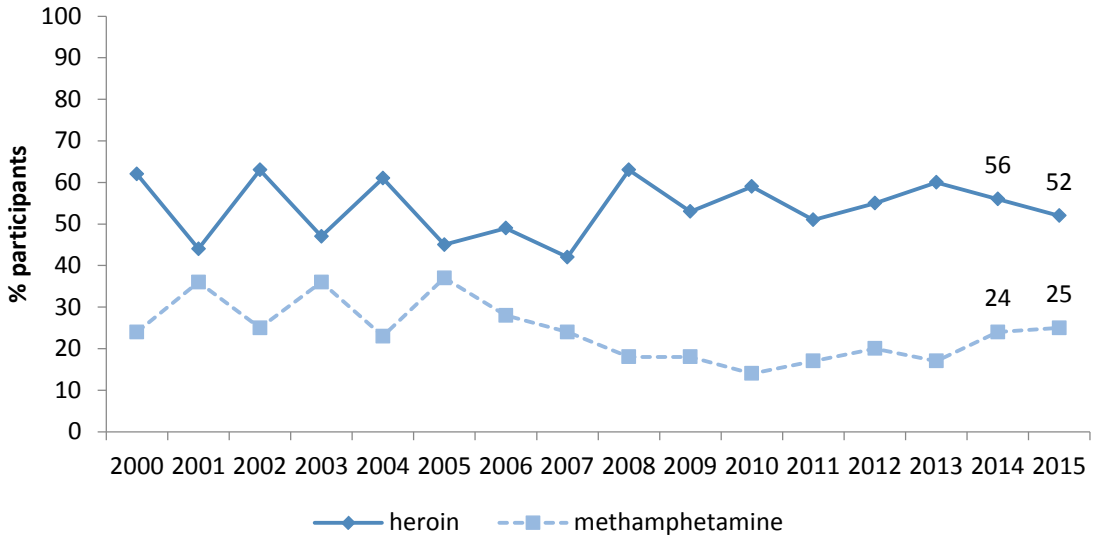


Source: Queensland IDRS PWID interviews

4.1.3 Trends over time

Heroin has remained the top drug of choice, followed by methamphetamines (Figure 3).

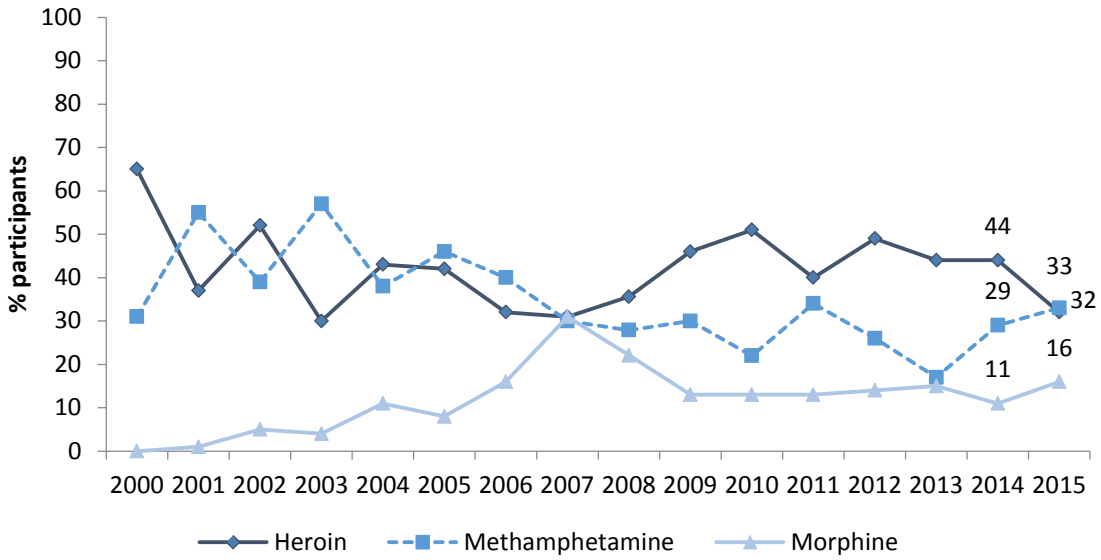
Figure 3: Top two drugs of choice, 2000 to 2015



Source: Queensland IDRS PWID interviews

In recent years, heroin was consistently the drug injected most often in the previous month (Figure 4); however, in 2015 methamphetamine was the drug most often injected (33%). The form of methamphetamine was mainly ice (28%), with only one participant injecting base the most often.

Figure 4: Drug injected most often in previous month, 2000 to 2015

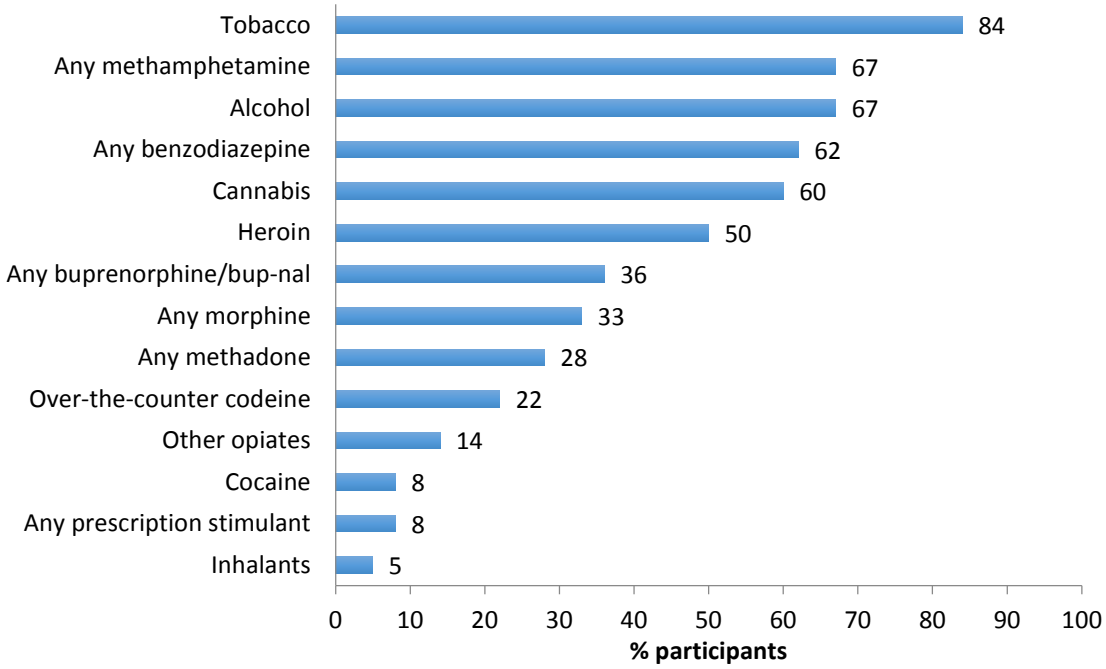


Source: Queensland IDRS PWID interviews

4.1.4 Polydrug use

Polydrug use continued to be nearly universal, with most participants using tobacco and high percentages using methamphetamines, cannabis, heroin, benzodiazepines, and alcohol (Figure 5).

Figure 5: Drugs used in preceding six months, 2015



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

4.1.5 Forms of drugs used in preceding six months

Table 3 presents information about use of the main drug types: when they were used (ever, previous six months), the sub-types used, the mode of administration, and the frequency.

Table 3: Drug use history, 2015

	Used			Injected			Other routes of administration used in the last 6 months		
							Smoked	Snorted	Swallowed
N = 98	Ever %	6 months %	Days (180)	Ever %	6 months %	Days (180)	%	%	%
Heroin	85	50	48	85	50	39	2	0	0
Homebake	46	6	4	45	6	7	0	0	0
Any heroin	85	50	48	85	50	39	2	0	0
Methadone *licit*	55	16	180	35	5	180			15
Methadone *illicit*	56	13	6	42	9	4			6
Physeptone *licit*	16	1	180	13	1	50	0	0	1
Physeptone *illicit*	27	2	6.5	26	2	6.5	0	0	0
Any methadone	74	28	180	59	13	12	0	0	21
BPN (Subutex®) *licit*	40	12	120	29	9	24	0	0	11
illicit	49	17	24	48	15	48	0	0	4
Any BPN	64	26	90	53	20	24	0	0	14
BPNX (Suboxone®) tablets *licit*	25	2	165	16	2	18	0	0	2
film *licit*	25	12	164.5	15	7	6	1	0	9
tablets *illicit*	30	11	7	27	9	7	1	0	4
film *illicit*	41	24	11	34	19	12	0	0	8
Any BPN	60	36	30	48	26	12	2	0	18
Any BPN or BPNX	74	41	90	61	30	24	2	0	26
Morphine *licit*	33	10	52	26	9	80	0	0	3
Morphine *illicit*	66	29	27	61	29	27	0	0	4

	Used			Injected			Other routes of administration used in the last 6 months		
							Smoked	Snorted	Swallowed
N = 98	Ever %	6 months %	Days (180)	Ever %	6 months %	Days (180)	%	%	%
Any morphine	75	33	39	70	32	54	0	0	7
Oxycodone *licit*	34	5	48	24	3	48	0	0	4
Oxycodone *illicit*	68	24	20	63	19	24	0	0	7
Any oxycodone	74	26	24	65	20	33	0	0	10
Fentanyl	41	14	4.5	38	14	4.5	0	0	0
Over-counter codeine (non-medicinal)	39	22	30.5	2	0	-	0	0	22
Other opiates	59	14	14	9	1	72	0	0	17
Speed powder	81	27	20	78	26	24	1	2	1
Amphetamine liquid	37	3	5	37	3	5			0
Base amphetamine	64	20	4	62	20	4	1	1	0
Crystal/ice	81	62	18	78	60	16	16	1	2
Any methamphetamine	92	67	24	90	66	24	18	3	2
Prescription stimulants *licit*	2	4	120	3	1	72	0	0	3
Prescription stimulants *illicit*	40	4	2	17	0	-	0	0	4
Any prescription stimulants	46	8	37	18	1	72	0	0	7
Cocaine	66	8	2	44	5	1	0	3	1
Hallucinogens	68	5	3	15	0	-	0	0	7
Ecstasy	71	5	2	34	0	-	0	0	5
Alprazolam *licit*	26	4	114	9	0	-	0	0	4
Alprazolam *illicit*	55	20	4	11	3	30	1	0	17
Any alprazolam	64	23	5	15	3	30	1	0	20

	Used			Injected			Other routes of administration used in the last 6 months		
							Smoked	Snorted	Swallowed
N = 98	Ever %	6 months %	Days (180)	Ever %	6 months %	Days (180)	%	%	%
Other benzo. *licit*	63	39	180	13	1	12	0	0	38
Other benzo. *illicit*	54	34	6	5	0	-	0	0	34
Any other benzodiazepine	80	59	48	14	1	12	0	0	58
Any benzodiazepine	87	62	48	28	4	21	1	0	61
Seroquel *licit*	25	12	180	4	2	1.5			12
Seroquel *illicit*	39	12	2.5	1	0	-			12
Any Seroquel	51	21	4	4	2	1.5			21
Alcohol	96	67	12	7	0	-			67
Tobacco	94	84	180						
E-cigarette	24	11	6						
Cannabis	94	60	90				60		1
Synthetic cannabis	10	2	11				2		0
Inhalants	36	5	45						
Steroids	5	1	2	4	1	2	0	0	0
New psychoactive substances (NPS)	4	1	2	1	0	-	0	0	1

Source: Queensland IDRS PWID interviews

4.2 Heroin

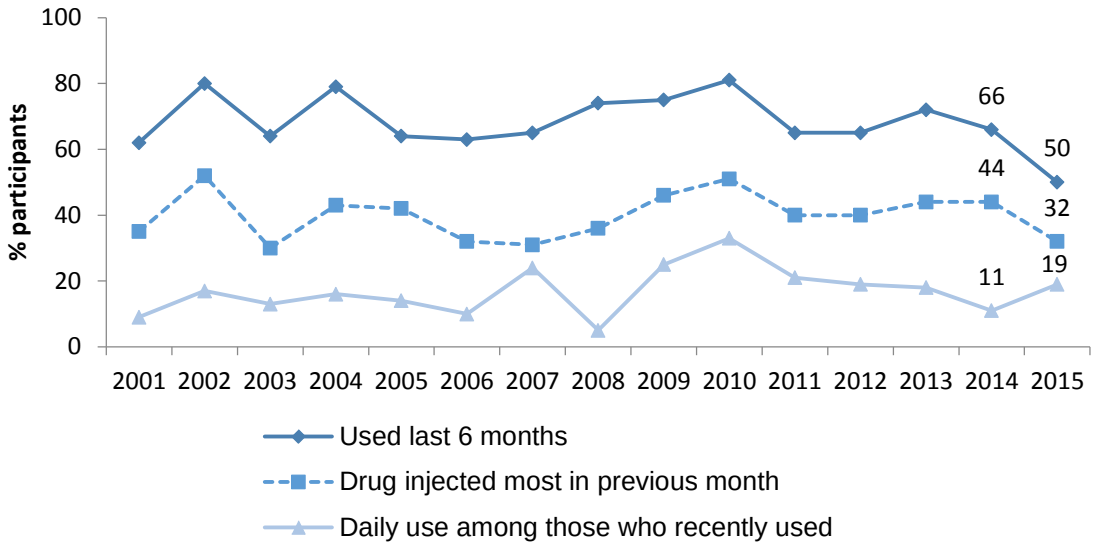
KEY POINTS

- **Recent heroin use:** 50% (66% in 2014)
- **Daily use:** 19% of those who used heroin
- **Injected heroin the most in the previous month:** 32%
- **Homebake:** use continued to be rare.

4.2.1 Use of heroin

The majority of participants (85%) had used heroin in their lifetime. As Figure 6 shows, however, recent use fell from 66% in 2014 to 50% in 2015 ($p < 0.05$): the lowest in the reporting period. All those who had recently used heroin reported injecting it, and 2% also reported smoking it. A third of all participants nominated heroin as the drug injected the most (44% in 2014). Of those who had used heroin in the last six months, one-in-five used it daily.

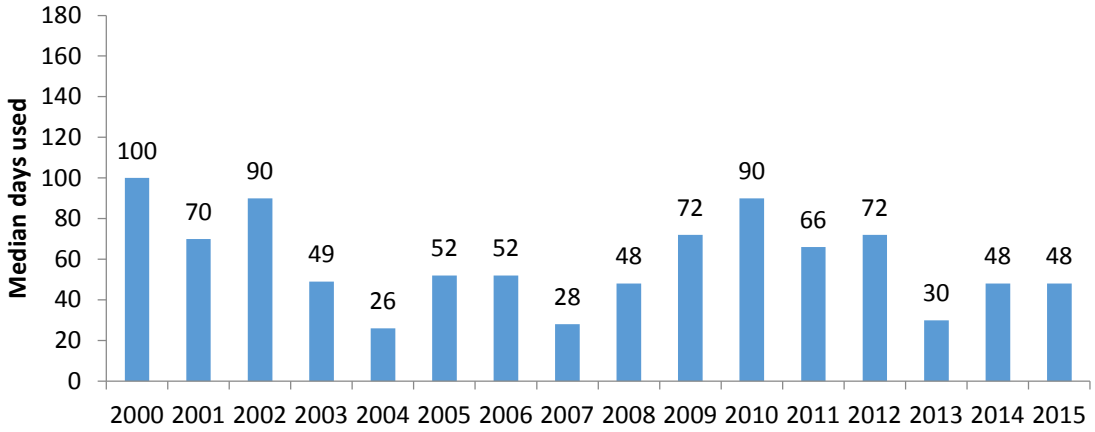
Figure 6: Prevalence and frequency of heroin use, 2001 to 2015



Source: Queensland IDRS PWID interviews

The median days of recent heroin use in the previous six months (n = 49, median 48 days, range 1–180) was consistent with 2014 data (Figure 7).

Figure 7: Median days of heroin use in preceding six months (180 days), 2000 to 2015



Source: Queensland IDRS PWID interviews

The amount of heroin used in a typical session was most commonly a quarter of a gram; the next most common was two points (0.2 gram).

4.2.2 Use of heroin in the general population

The National Drug Strategy Household Survey is undertaken approximately every three years, with the most recent survey in 2013. Survey results over the last 20 years show the recent decline in the use of heroin in the general population (Table 4).

Table 4: Heroin use among the Australian population aged 14 years and over, 1993 to 2013

	1993	1995	1998	2001	2004	2007	2010	**2013**
Last 12 months	0.2	0.4	0.8	0.2	0.2	0.2	0.2	**0.1**
Ever	1.7	1.4	2.2	1.6	1.4	1.6	1.4	**1.2**

Source: National Drug Strategy Household Survey 2013 (AIHW 2014)

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 been low. In 2015, 6% of participants used (injected) homebake in the preceding six months on a median of 4 days (range 3–180 days).

4.2.3 Heroin forms used

Among recent heroin users (n = 49), 71% reported having used white/off-white heroin in the previous six months and 55% reported having used brown/beige heroin.

Table 5 presents the most commonly used form in the previous six months. As in 2014, white/off-white rock or powder was most commonly used; however, 17% mostly used brown/beige powder compared with 2% in 2014.

Table 5: Heroin forms most used, 2015

n = 48	Heroin powder			Heroin rock		Homebake
	White/ off-white %	Brown/ Beige %	Other colour %	White/ off-white %	Brown/ Beige %	%
Most used in past six months	31	17	2	42	6	2

Source: Queensland IDRS PWID interviews

4.2.4 Heroin preparation

When preparing their most recent heroin injection (n = 48), 42% used heat. Of those who commented on the colour of heroin heated (n = 20), 50% heated heroin that was white/off-white, 45% brown/beige, and 5% another colour.

This is the first time for a number of years that respondents (n = 48) have reported using acid when preparing their most recent heroin injection: 9% (four participants).

Key experts report on heroin use

Heroin use continues to decrease, and those PWID who use heroin are generally older. There is an increasing preference for pharmaceutical opioids rather than heroin.

The divide between those who use opioids and those who use stimulants continues to fade. Some PWID use heroin (as well as cannabis and Valium®) to come down from ice and other stimulants; others shift between heroin and ice. As one key expert explained: '*some clients have a few weeks on heroin then have a shot of ice, or use ice for a bit and then back to heroin*'.

4.3 Methamphetamines

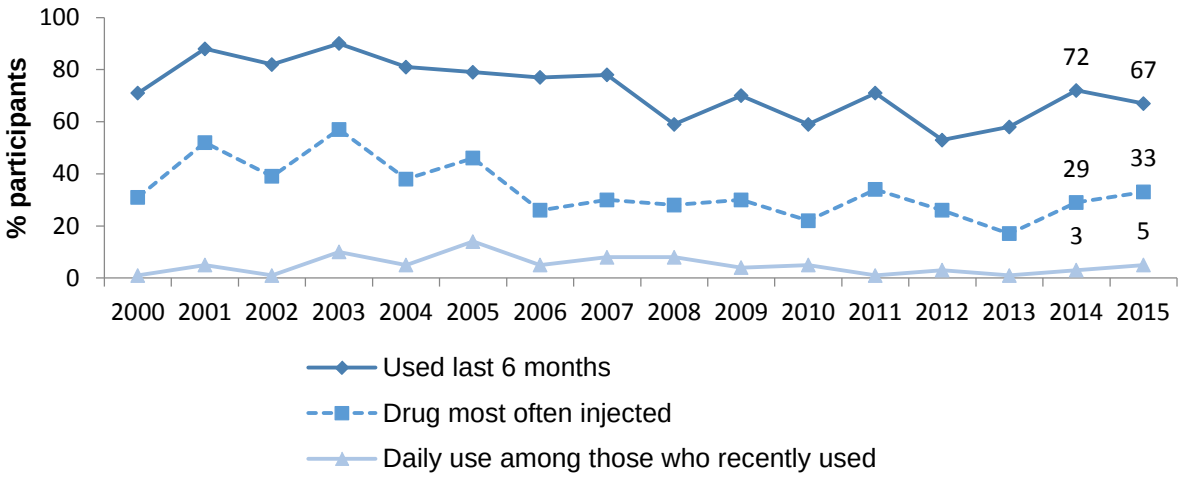
KEY POINTS

- **Recent methamphetamine use:** 67%
  - **ice:** 62%
  - **speed:** 27%
  - **base:** 20%
  - **liquid:** 3%
- **Injected methamphetamines the most:** 33%
- **Median days used methamphetamines:** 24 (n = 65, range 1–180)

4.3.1 Use of methamphetamines

Recent use of methamphetamines (includes speed, base, ice, and liquid) was stable (Figure 8). A third of the sample reported that methamphetamine was the drug most often injected; among those who had used methamphetamines in the last six months, 5% reported daily use.

Figure 8: Use of methamphetamine (in any form) in preceding six months, 2000 to 2015



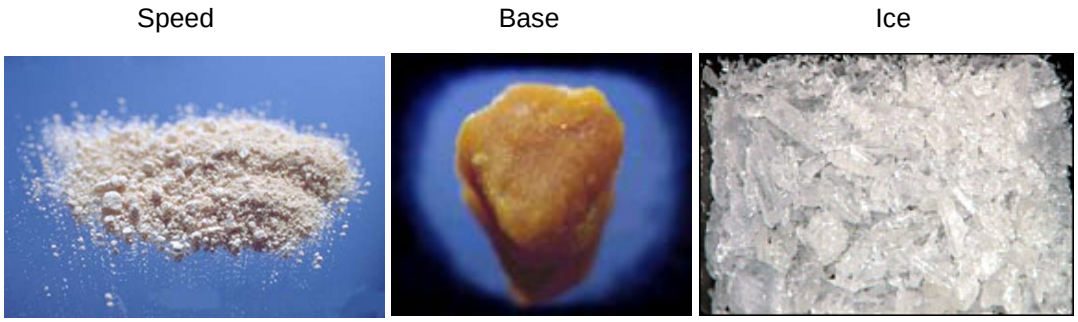
Source: Queensland IDRS PWID interviews

4.3.2 National population data

According to the 2013 National Drug Strategy Household Survey report (AIHW 2014), 7% of Australians had used methamphetamines in their lifetime with 2.1% having used methamphetamines in the previous 12 months.

4.3.3 Methamphetamine form most used

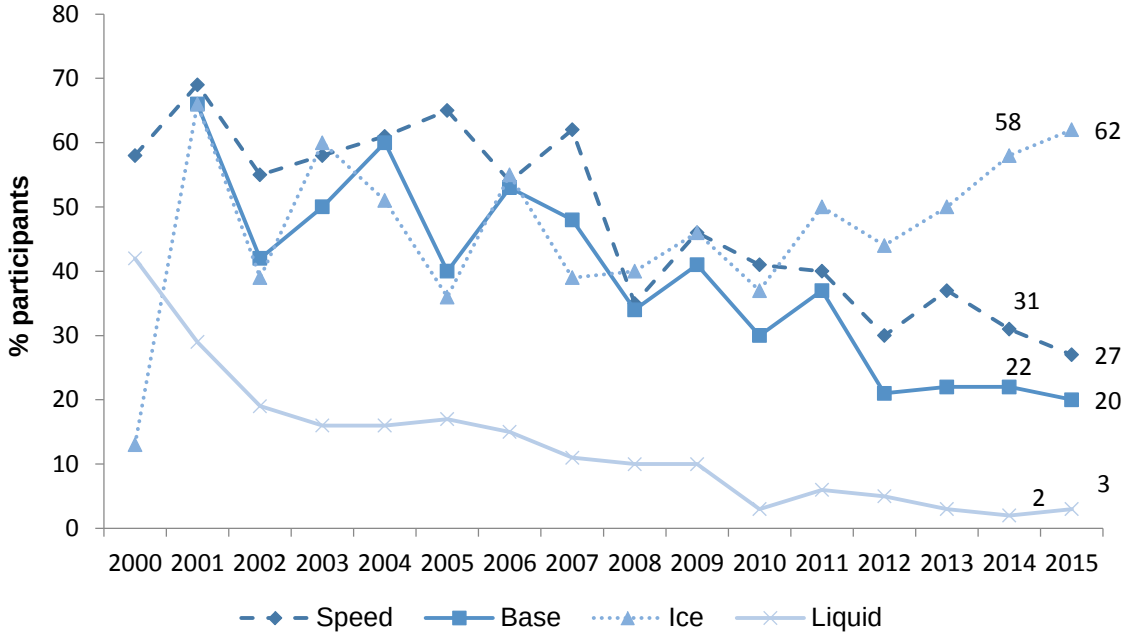
As in previous years, data were collected about four different forms of methamphetamines: speed (powder), base, ice (crystalline), and liquid.



Source: Methamphetamine Forms compiled by Adam Churchill, Australian Customs Service, and Libby Topp, National Drug and Alcohol Research Centre

A breakdown of the various forms of methamphetamines used by survey participants since 2000 (Figure 9) shows the dominance of ice from 2011 onwards.

Figure 9: Forms of methamphetamine used in preceding six months, 2000 to 2015



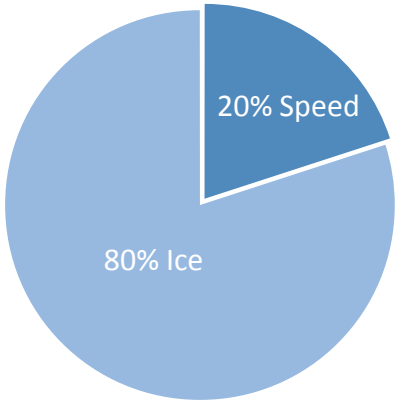
Source: Queensland IDRS PWID interviews

Due to the continuing low use of liquid methamphetamine in 2015, data specifically about liquid will not be presented.

4.3.4 Methamphetamine frequency of use

Among those who had recently used methamphetamines, four-in-five mostly used ice and one-in-five mostly used speed (Figure 10).

Figure 10: Form of methamphetamine most used in preceding six months, 2015



n = 64

Source: Queensland IDRS PWID interviews

In 2015, the median days methamphetamines were used increased ($p < 0.05$) for speed, and overall (Table 6). Unlike the data from 2014, median days of speed use (20, range 1–180) was similar to median days of ice use (18, range 1–180).

Table 6: Median days of methamphetamine use in preceding six months, 2014 and 2015

	Median days	
	2014	**2015**
Speed	6	**20↑**
Base	4	**4**
Ice	11	**18**
Any form[a]	11	**24↑**

[a] includes speed powder, base, ice/crystal and liquid forms

Note: Maximum number of days (i.e. daily use) = 180. Arrow symbol signifies a significant difference $p < 0.05$.

Source: Queensland IDRS PWID interviews

The amount of methamphetamine used in a typical session was most commonly a point for speed and ice, and one to two points for base.

Key experts report on methamphetamine use

Methamphetamine use is primarily ice. As one key expert commented, '*Ice makes you feel good, so easy and you get that big rush*'. The key expert also pointed out that, '*A big attraction of ice is hot sex with your partner—enhances the whole sex thing.*'

Key experts said that some PWID prefer speed or base but it is less easy to obtain, and that use of base in particular has become quite rare. Key experts from AOD services report that clients are increasingly nominating ice as the primary drug of concern. PWID are engaging in intensive patterns of use (bingeing), and when ice is mixed with alcohol the negative impact on health and wellbeing is quite profound. It was noted that there was '*a shorter period than with other drugs between first use and disaster*'.

4.4 Cocaine

KEY POINTS

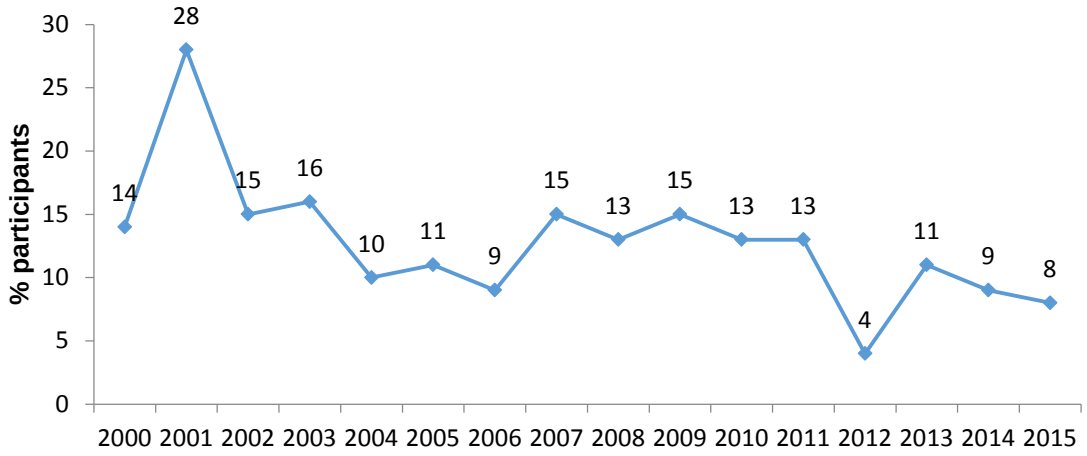
- **Recent cocaine use:** 8%
- **Lifetime use:** 66%
- **Frequency of recent use:** occasional

4.4.1 Use of cocaine

Two-thirds (66%) of the sample had used cocaine in their lifetime, but only 8% reported recent use. This low level of use in the previous six months has been relatively consistent over time, except for a peak in 2001 (Figure 11).

The eight participants used either powder (six) or rock (two). None used crack cocaine. Injecting was the most common route of administration (five of the eight), with three reporting snorting and one swallowing. Use was occasional (median of two days, n = 8, range 1–8) in the preceding six months (180 days).

Figure 11: Cocaine use in preceding six months, 2000 to 2015



Source: Queensland IDRS PWID interviews

4.4.2 National population data

The 2013 National Drug Strategy Household Survey report (AIHW 2014) shows that 8.1% of Australians reported using cocaine in their lifetime, and 2.1% in the previous 12 months.

Key experts report on cocaine use

Cocaine has not been associated with injecting drug use. Those PWID who use cocaine generally do so because they have been given it, and they tend to snort lines rather than inject it.

4.5 Cannabis

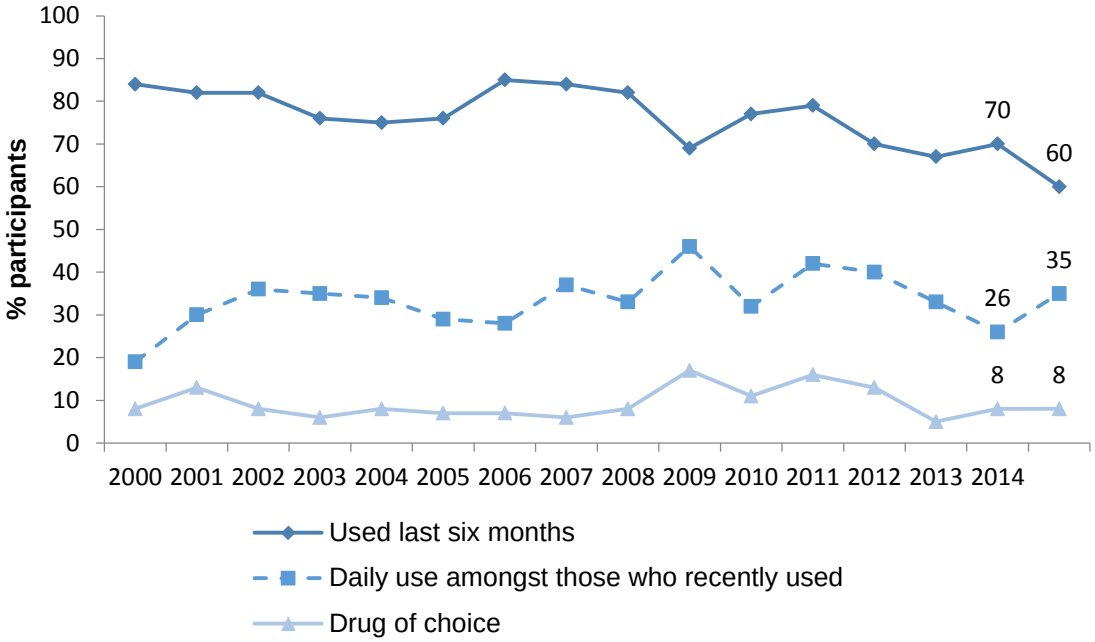
KEY POINTS

- **Recent cannabis use:** 60%
- **Lifetime use:** 94%
- **Daily use:** 35% of cannabis users
- **Recent synthetic cannabis use:** 2%

4.5.1 Use of cannabis

As in previous years, nearly all participants (94%) had used cannabis in their lifetime. Three-in-five participants reported recent use (Figure 12), and about a third of these participants used cannabis daily. Consistent with previous years, a small proportion of participants (8%) nominated cannabis as their drug of choice.

Figure 12: Prevalence and frequency of cannabis use, 2000 to 2015



Source: Queensland IDRS PWID interviews

4.5.2 National population data

According to the 2013 National Drug Strategy Household Survey report (AIHW 2014), cannabis was the most commonly used illicit drug in Australia, with 35% reporting use in their lifetime and 10.2% in the previous 12 months.

4.5.3 Cannabis forms used

Of those who reported recent cannabis use (n = 58), 97% had used hydroponic cannabis, and 43% had used bush (outdoor grown).

When asked whether they mostly used hydroponic or bush cannabis, 88% said they mostly used hydroponic and 12% said they mostly used bush.

Only one participant reported having used hashish and none reported use of hashish oil.

Cones continued to be more common than joints, with the median amount used in a session being four cones (range 1–100) or one joint (range 0.5–4).

4.5.4 Synthetic cannabis

Synthetic cannabis had been used by 10% of participants; however, only two participants had used it in the previous six months. Both participants smoked it: one occasionally (two days) and the other more regularly (20 days).

Key experts report on cannabis use

Younger PWID tend to use cannabis more than older PWID. Older PWID who use cannabis generally prefer bush rather than hydro.

Cannabis is also used with ice for the effect it produces which can cause problems.

Use of synthetic cannabis has reduced and is now rare among PWID. Key experts have been told by PWID of bad experiences when using synthetic cannabis. Key experts also said that many PWID don't use synthetic cannabis because they don't like the effect it has on them.

4.6 Other opioids

KEY POINTS

- **Methadone:** 28% recent use—16% licit and 13% illicit (non-prescribed).
- **Buprenorphine** (Subutex®)**:** 26% recent use—12% licit and17% illicit.
- **Buprenorphine-naloxone** (Suboxone®)**:** 36% recent use—licit tablets 2% and licit film 12%; illicit tablets 11% and illicit film 24%.
- **Morphine:** 33% recent use—10% licit and 29% illicit.
- **Oxycodone:** 24% recent use (38% in 2014)—5% licit and 24% illicit.
- **Fentanyl:** 14% recent use: all participants reported injection and no use as a transdermal patch.
- **Over-the-counter codeine for non-medicinal purposes:** 22% recent use.
- **Other opiates** (e.g. pethidine, Panadeine Forte®)**:** 14% recent use.

4.6.1 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. Two-thirds of participants (65%) had ever used liquid methadone or physeptone tablets (licit or illicit), and 35% in the previous six months.

More recently buprenorphine (Subutex®) was introduced as an alternative to methadone, and since 2005 buprenorphine-naloxone (Suboxone®) 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; however, since late 2011, they have been dispensed as sublingual film strips. In 2015, 74% of participants had used a form of buprenorphine or buprenorphine-naloxone (licit and/or illicit) in their lifetime and 41% in the previous six months.

The pattern of use of all four substitution drugs is shown in Table 7. Methadone liquid was the most common licit form and buprenorphine tablets were the most common illicit form.

Table 7: Use of licit and illicit substitute drugs in preceding six months, 2015

	LICT (prescribed)		ILLICIT (not prescribed)	
	Used	Injected	Used	Injected
N = 98	%	%	%	%
Methadone *liquid*	16	5	13	9
Physeptone *tablets*	1	1	2	2
Buprenorphine *film*	12	9	17	15
Buprenorphine-naloxone *tablets*	2	2	11	9
Buprenorphine-naloxone *film*	12	7	24	19

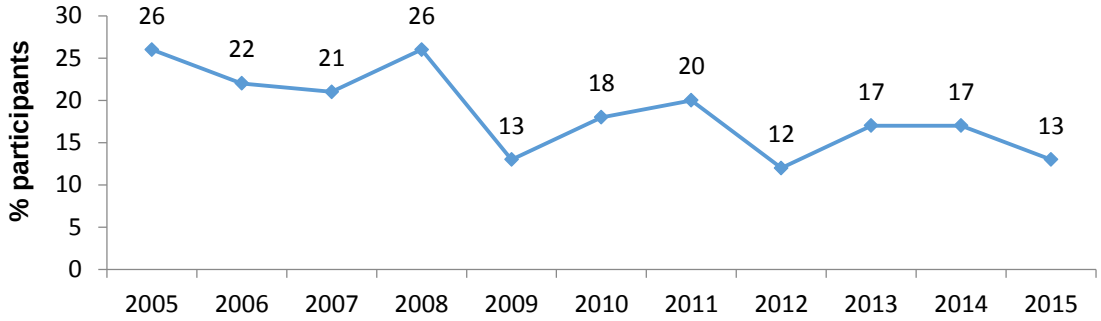
Source: Queensland IDRS PWID interviews

Use of methadone

Just over half (55%) of participants reported having been prescribed methadone at least once in their lifetime (i.e. licit use), and 56% reported illicit use at least once in their lifetime.

Fifty-nine per cent of participants reported injecting methadone (licit or illicit) in their lifetime, and 13% reported injecting it in the previous six months (Figure 13). The median days participants recently injected methadone were 12 (range 1–180).

Figure 13: Injected methadone (prescribed or not prescribed) in preceding six months, 2005 to 2015



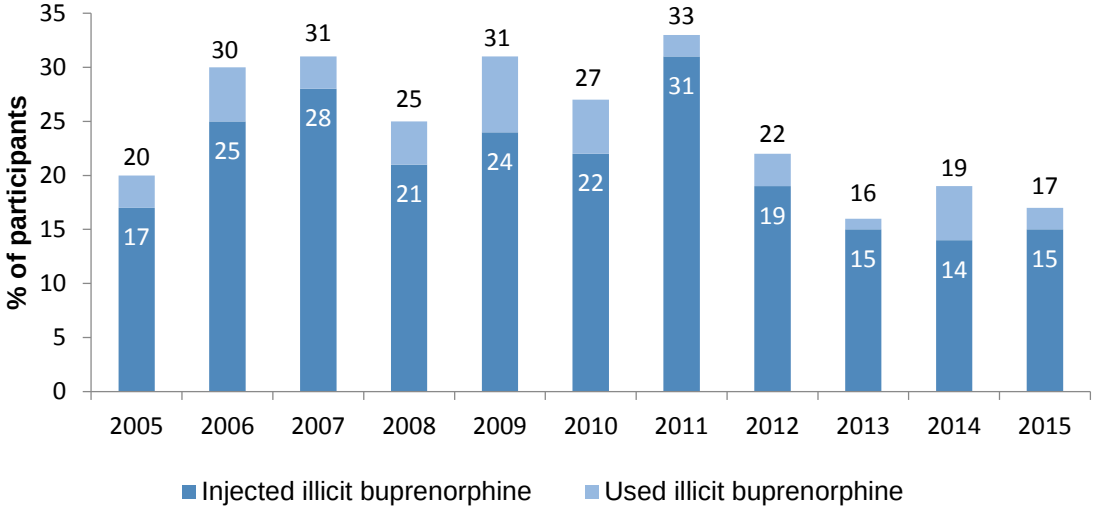
Source: Queensland IDRS PWID interviews

The most common reason for using illicit methadone was self-treatment.

Use of buprenorphine (Subutex®)

Nearly two-thirds (64%) of participants had used buprenorphine (licit or illicit) in their lifetime, with 26% having used it in the previous six months. Licit (i.e. prescribed) use was reported by 12% and illicit use by 17%. Of the 12 participants on a prescribed dose, nine reported injecting their dose (two occasionally, the others more regularly). As in previous years, illicit buprenorphine was generally injected (Figure 14). Median days injected in the previous six months was 48 (range 1–180). The main reasons given for using illicit buprenorphine were self-treatment, intoxication, or substitution for heroin/other opiates.

Figure 14: Use and injection of illicit buprenorphine in preceding six months, 2005 to 2015



Source: Queensland IDRS PWID interviews

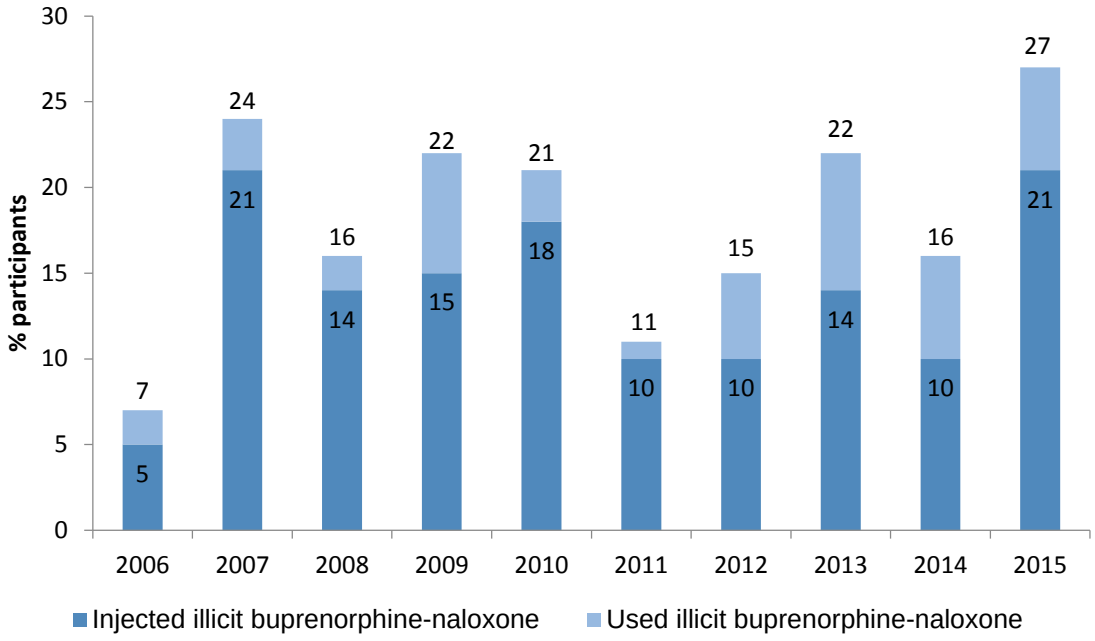
Use of buprenorphine-naloxone (Suboxone®)

Three-in-five participants (60%) had ever used buprenorphine-naloxone (licit or illicit), and 36% had used it in the previous six months.

Film was more likely to be used than tablets for both licit and illicit use (Table 3). The most frequent reason given for using illicit buprenorphine-naloxone was self-treatment followed by intoxication.

Over a quarter of participants reported recently using illicit buprenorphine-naloxone (tablet or film), with most of these injecting it (Figure 15).

Figure 15: Use and injection of illicit buprenorphine-naloxone (tablet or film) in preceding six months, 2006 to 2015



Note: Prescribing of film commenced in late 2011
Source: Queensland IDRS PWID interviews

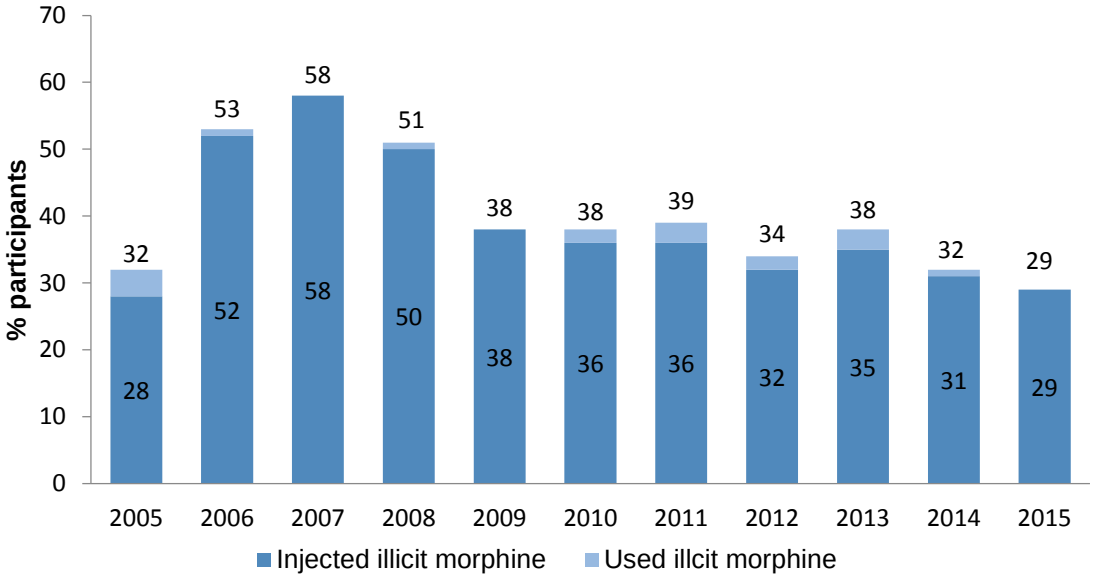
4.6.2 Use of morphine

Three-quarters (75%) of participants had used morphine (licit or illicit) in their lifetime, with a third (33%) reporting morphine use (licit or illicit) in the previous six months. As in previous years, the most common brand of morphine was MS Contin®.

Licit morphine was used by 10% with 9% reporting injection (5% used and 3% injected in 2014). Median days of use was 52 (n = 10, range 1–180).

Illicit morphine use peaked at 58% in 2007 and was 29% in 2015, with all injecting—though 4% also swallowed (Figure 16). Illicit morphine was used on a median of 27 days in the preceding six months (n = 28, range 1–180). The most common reasons given for using illicit morphine were self-treatment and substitution for heroin.

Figure 16: Use and injection of illicit morphine in preceding six months, 2005 to 2015



Source: Queensland IDRS PWID interviews

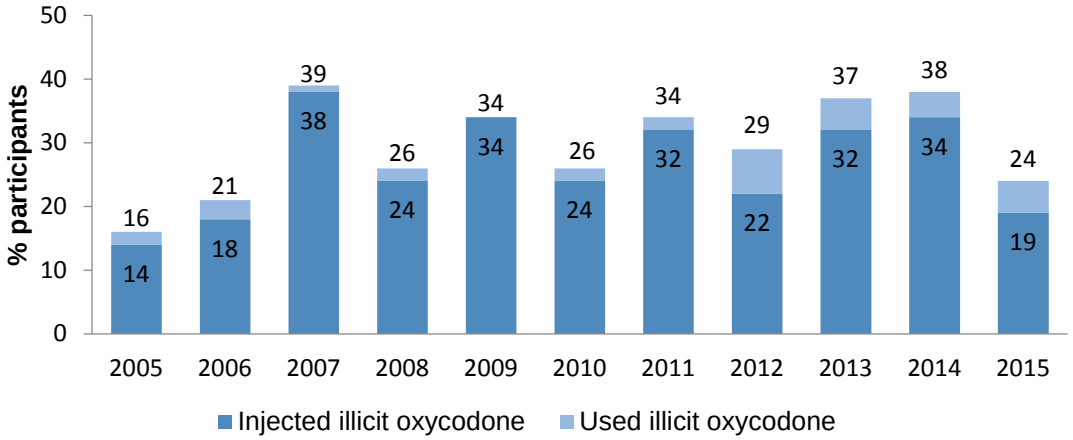
4.6.3 Use of oxycodone

Data have been gathered on licit and illicit forms of oxycodone (e.g. OxyContin®, Endone®) since 2005 with OxyContin® consistently being the most commonly used brand. In April 2014, OxyContin® was reformulated with the intention of making it harder to crush for injecting. This may have contributed to the decrease in recent use overall (licit and illicit) from 40% in 2014 to 26% in 2015 ($p < 0.05$).

Licit oxycodone was used by 34% of participants in their lifetime, and by 5% in the previous six months, with 3% reporting injection.

Illicit oxycodone was used by 68% of participants in their lifetime, and by 24% in the previous six months, with 5% reporting injection (Figure 17). Median days of use in the previous six months was 20 (n = 23, range 1–180), and self-treatment and substitution for heroin were the most common reason given for using illicit oxycodone.

Figure 17: Use and injection of illicit oxycodone in preceding six months, 2005 to 2015

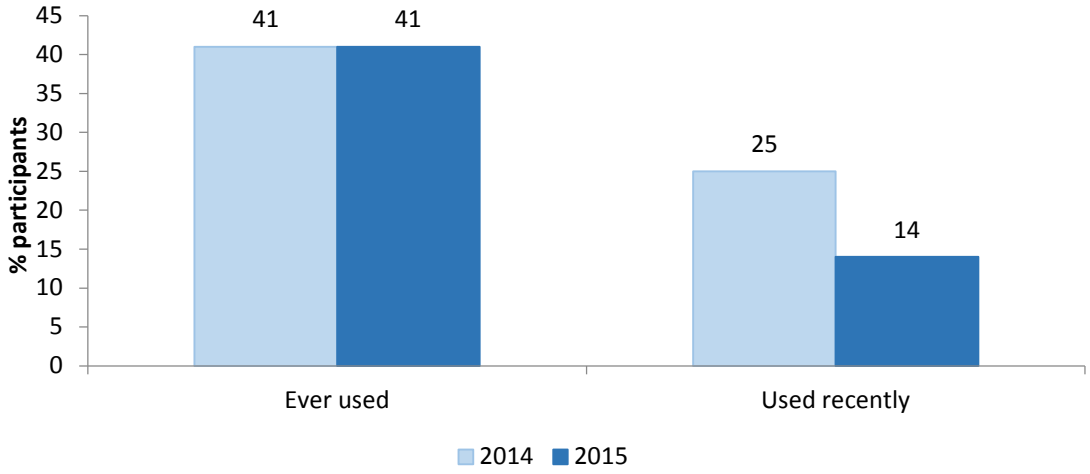


Source: Queensland IDRS PWID interviews

4.6.4 Use of fentanyl

Recent use of fentanyl was reported by14% (Figure 18). It had increased to 25% in 2014 from 12% in 2013.The proportion who had ever used fentanyl did not vary between 2014 and 2015 (two-in-five participants).

Figure 18: Use of fentanyl, 2014 and 2015



Source: Queensland IDRS PWID interviews

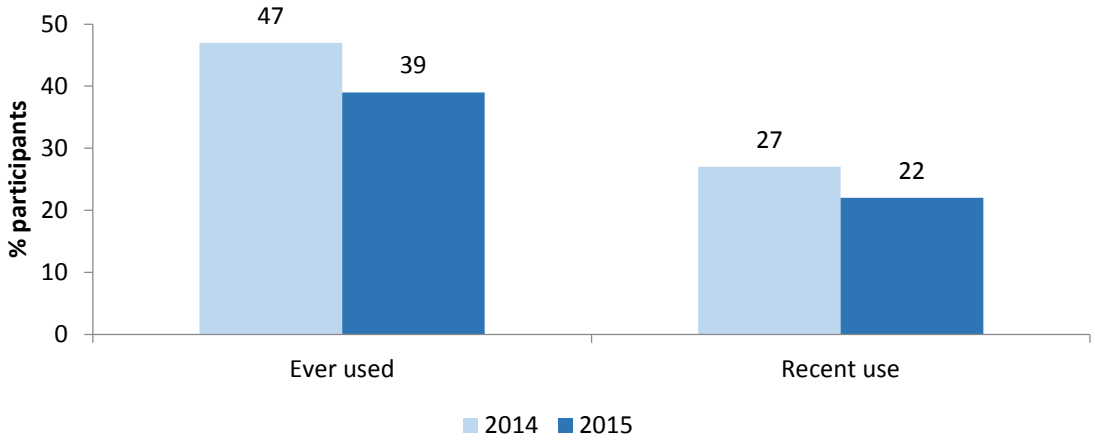
Of the 14% of participants who had recently used fentanyl, only one reported using prescribed fentanyl. All injected. Most reported heating, and the respondents generally used a cigarette filter although two reported using cotton wool on the last occasion they injected.

The median days of injection in the past six months was 4.5 (n = 14, range 1–180 days).

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

In 2015, 22% of participants had used over-the-counter codeine for non-medicinal purposes in the previous six months (27% in 2014; Figure 19). The most common brand was Chemists' Own® pain capsules or tablets. Use over lifetime was 39% compared with 47% in 2014.

Figure 19: Use of over-the-counter codeine, non-medicinal purposes only, 2014 and 2015

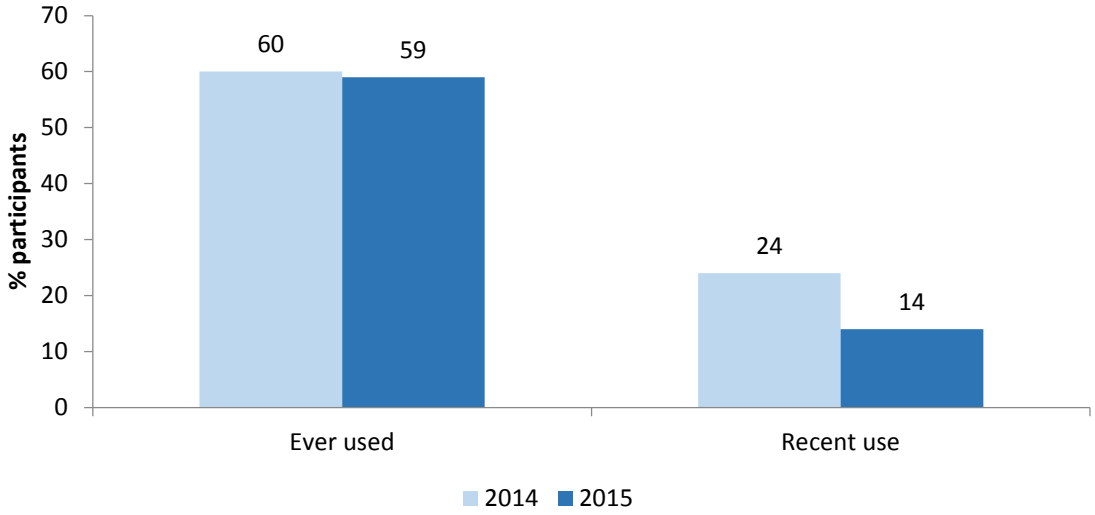


Source: Queensland IDRS PWID interviews

4.6.6 Use of other opiates

Lifetime use of opiates such as pethidine, Panadeine Forte®, and opium was stable at about three-in-five participants (Figure 20). Recent use (14%) was predominantly licit and Panadeine Forte® was the form most commonly used. Days of use varied widely (median 14, range 2–180).

Figure 20: Use of other opiates, 2014 and 2015



Source: Queensland IDRS PWID interviews

Key experts report on other opioid use:

Overall use of pharmaceutical opioids was considered to be stable. One key expert said that there was a stigma around using pharmaceutical opioids, noting that PWID '*prefer to say they are using heroin but, by the needles they ask for, they are using pills*'.

Other key experts said that '*OST clients report more opiate use than heroin—mainly MS Contin® and Endone®, as well as over-use of Panadeine Forte® and Nurofen Plus® which could be a box [50 tablets] at a time*'.

Key expert also report that '*there are "good doctors" known locally for easy access to pharmaceuticals*'.

Opioid Substitution Treatment (OST)

There appears to be an increase in use of Suboxone® (buprenorphine-naloxone). This is probably linked to it becoming the default OST prescribed, which increases its availability.

Key experts report seeing people whose addiction is Suboxone®. They are generally younger people in their twenties or thirties who haven't tried heroin: '*if they don't use other opiates, they get an opioid effect. The antagonist in Suboxone® only kicks in if the PWID has an opioid (e.g. heroin) already in their system. PWID using both Suboxone® and heroin avoid the antagonist effect by taking their Suboxone® dose and then later in the day they have some heroin'*

Morphine and oxycodone

Morphine use remains common. The most common brand continues to be MS Contin® but there has been an increase in Kapanol® and Endone® use. One key expert said that there had been considerable talk about hydromorphone. Key experts reported a drop in oxycodone use: '*don't hear much about oxys anymore—they're out*'. The reformulated Oxycontin® was '*only used by a few*'. The generic version was more commonly used.

It was also reported that PWID were using larger quantities of morphine in a session, '*crushing up to five or six tablets*'.

Fentanyl

Fentanyl use was regarded as rare; although it continued to be used by '*long-term intravenous users'* and *'was quite easy to obtain and easy to divert*'.

Over-the-counter codeine and other opiates

Key experts reported that over-the-counter codeine and other opiates like Panadeine Forte® were generally swallowed and rarely injected. Taking a packet of 50 tablets all at once or over two or three days was not unusual. Some PWID also took a mix of codeine tablets and benzodiazepine tablets at the same time.

4.7 Other drugs

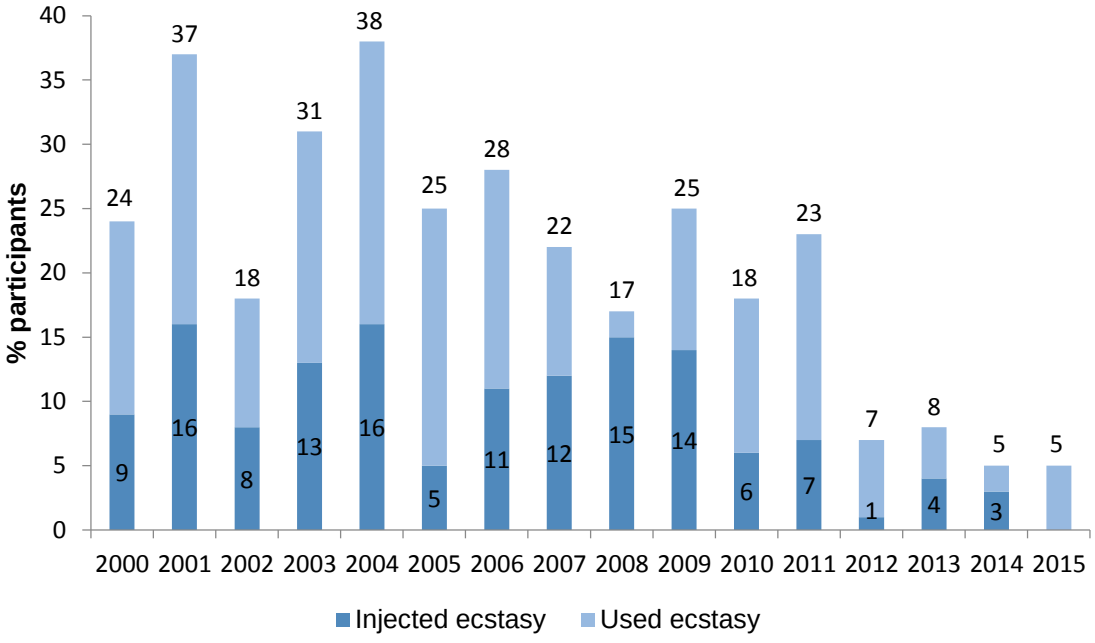
KEY POINTS

- **Ecstasy:** 5% recent use; 71% lifetime use
- **Hallucinogens:** 5% recent use; 68% lifetime use
- **Benzodiazepines:** 87% had used licit and/or illicit forms in the preceding six months. Recent illicit use was alprazolam 23% and other benzodiazepines 59%.
- **Pharmaceutical stimulants** (e.g. dexamphetamine and methylphenidate)**:** recent use continued to be rare (4% licit and 4% illicit).
- **Inhalants:** use remained low, with 5% reporting recent use.
- **Alcohol:** one-third (33%) reported abstinence from alcohol in the previous six months. Of those who drank, 49% scored ≥5 on the AUDIT-C, indicating the need for further assessment.
- **Tobacco:** 84% recently used tobacco, with 96% of these smoking daily.

4.7.1 Ecstasy and related drugs

Although 71% reported use of ecstasy (MDMA) in their lifetime, in recent years, use of ecstasy has become rare among survey participantswith only 5% reporting use in the previous 6 months (Figure 21). All five participants reported swallowing ecstasy and none reported injecting it.

Figure 21: Use and injection of ecstasy in preceding six months, 2000 to 2015

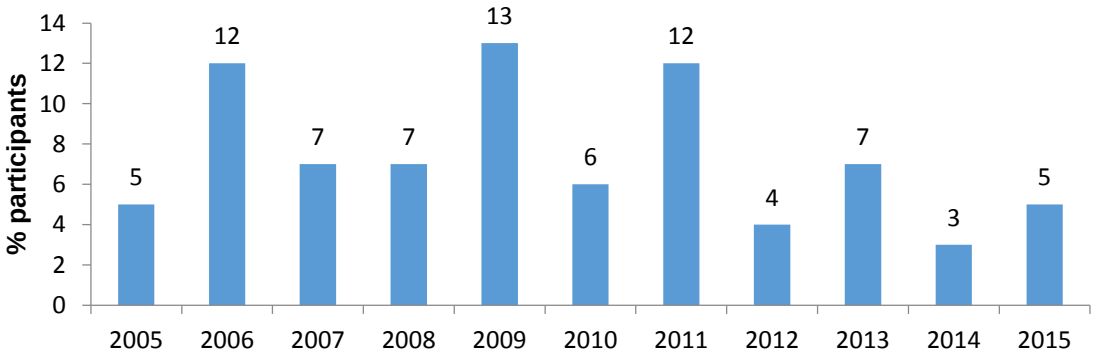


Source: Queensland IDRS PWID interviews

4.7.2 Hallucinogens

Recent hallucinogen use (LSD, mushrooms, etc.) remained low (5%); although 68% had used them in their lifetime (Figure 22).

Figure 22: Hallucinogen use in preceding six months, 2005 to 2015



Source: Queensland IDRS PWID interviews

4.7.3 Benzodiazepines

Most participants (87%) had used a form of benzodiazepine in their lifetime whether licit or illicit, and 62% had done so recently. Table 8 shows recent use of benzodiazepines such as diazepam (Valium®, Antenex®) and oxazepam (Serapax®) and recent use of alprazolam (Xanax®, Kalma®); the pattern of licit and illicit use is consistent with previous years.

Lifetime use of licit or illicit alprazolam was reported by 64%, with 23% reporting recent use. (Alprazolam was rescheduled as a controlled drug, Schedule 8, in February 2014).

Lifetime use of other licit or illicit benzodiazepines was reported by 80% of participants, with 59% reporting recent use. Injection of any form of benzodiazepine was rare.

Among those using any form of benzodiazepine (n = 60), 35% used daily. Median days use of alprazolam was 4 for illicit (n = 20, range 1–96) and 14 for licit (n = 4, range 14–180). For other benzodiazepines, median days of use was 6 for illicit (n = 30, range 1–180) and 180 for licit (n = 38, range 2–180).

Table 8: Use of licit and illicit benzodiazepines in preceding six months, 2014 and 2015

	Licit (prescribed)		**Illicit** (not prescribed)	
	2014 N = 100 %	**2015** **N = 98** **%**	2014 N = 100 %	**2015** **N = 98** **%**
Alprazolam	10	**4**	25	**20**
Other benzodiazepines	45	**39**	28	**34**

Source: Queensland IDRS PWID interviews

Key experts report on benzodiazepine use

There were reports of quite high use of benzodiazepine—frequently as a substitute for other substances. Benzodiazepines were also used when coming down from other drugs: '*when extended ice use over a number of days, then the come-down period often includes benzo use*'. Binge-use of licit benzodiazepines by females and couples—where the female obtains the prescription—was also observed.

Use of Xanax was reported as '*easing off*'.

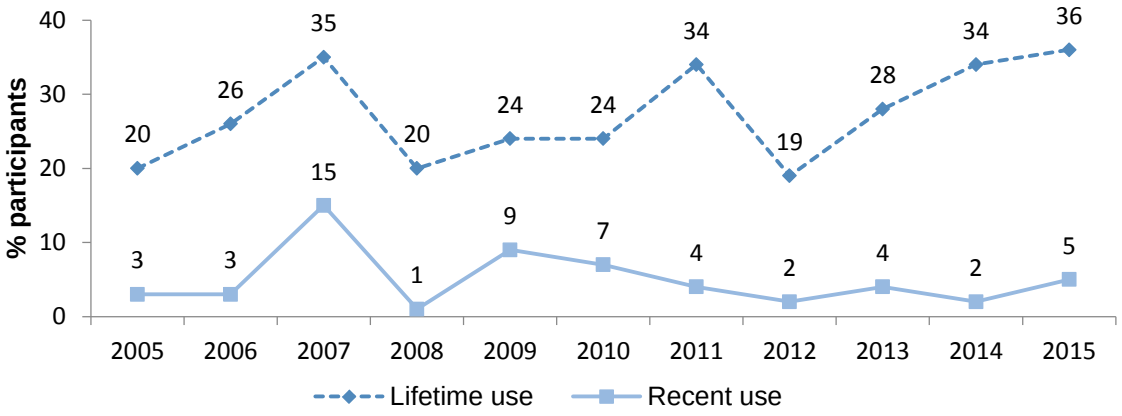
4.7.4 Pharmaceutical stimulants

As in previous years, recent use of pharmaceutical stimulants (e.g. dexamphetamine and methylphenidate) was rare with 4% of participants reporting licit use and 4% of participants reporting illicit use.

4.7.5 Inhalants

Consistent with previous years, only a few participants (5%) reported use of inhalants in the preceding six months (Figure 23).

Figure 23: Prevalence of inhalant use, 2005 to 2015



Source: Queensland IDRS PWID interviews

4.7.6 Alcohol

Nearly all participants (96%) reported lifetime use of alcohol, with 67% reporting recent use (i.e. 33% reporting abstinence from alcohol). Although 7% reported having injected alcohol in their lifetime, none reported doing so in the previous six months. The median frequency of alcohol use was 12 days (range 1–180).

There tends to be a focus on young people and alcohol in the media, with little attention given to alcohol use among PWID. PWID are particularly at risk for alcohol-related harms due to high prevalence of the hepatitis C virus (HCV). Half of the participants interviewed in the Australian NSP Survey 2013 (n = 2,407) reported having HCV antibodies (Iverson, Chow, & Maher, 2014). 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.

In recent years, participants have been asked to complete the Alcohol Use Disorders Identification Test–Consumption (AUDIT-C) as a validated measure of heavy drinking (Bush, Kivlahan, McDonell,

Fihn, & Bradley, 1998). The AUDIT-C is a three-item measure, using 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 risky drinking.

Among study participants who drank alcohol in the past year, the overall mean score on the AUDIT-C was 4.9 (median 4, range 1–12) (Table 9). Unlike previous years, there was a significant ($p < 0.05$) sex difference: mean score was 3.3 for females (n = 22) and 5.7 for males (n = 48). According to Dawson and colleagues (2005) and Haber and colleagues' (2009) *Guidelines for the Treatment of Alcohol Problems*, a cut-off score of 5 or more indicates that further assessment is required.

Nearly half (49%) of participants who drank in the past year scored ≥5 on the AUDIT-C, indicating the need for further assessment (Table 9). Males were more likely to score ≥5 than females (58% of males who drank compared with 27% of females).

Table 9: AUDIT-C amongst participants who drank alcohol in the past year, 2014 and 2015

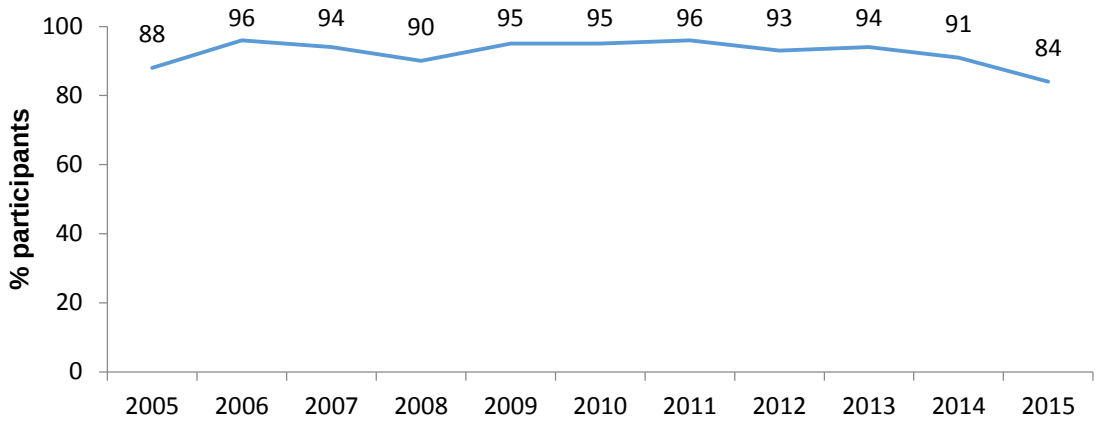
	2014 n = 66	**2015** **n = 70**
Mean AUDIT-C score	5.8	**4.9**
SD (range 1–12)	3.4	**3.3**
Score of 5 or more	57%	**49%**

Source: Queensland IDRS PWID interviews

4.7.7. Tobacco use

Consistent with previous years, most participants (84%) reported recent tobacco use (Figure 24) with 96% of these respondents reporting daily use (i.e. 76% of all participants smoked daily).

Figure 24: Tobacco use in preceding six months, 2000 to 2015



Source: Queensland IDRS PWID interviews

About a quarter (24%) reported lifetime use of e-cigarettes, with only 11% reporting recent use. Median days used was six (n = 11, range 1–90).

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

This section is about the market characteristics (i.e. price, perceived purity/strength, availability, and purchasing patterns) for 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. Limited responses to some questions restricted meaningful interpretation.

5.1 Heroin market

KEY POINTS

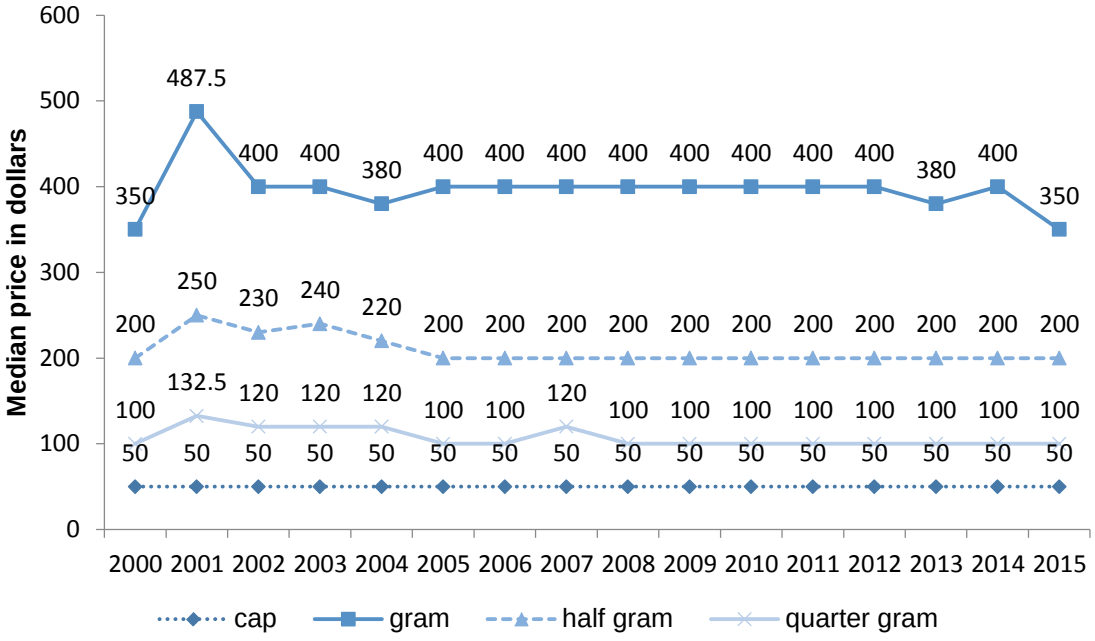
- **Median price:** remained constant (e.g. $100 per quarter gram)
- **Purity:** three-in-five reported it as low, with most reporting it as stable or decreasing.
- **Availability:** half reported it as easy to obtain, a quarter as very easy, and a quarter as difficult. Purchases were most commonly made from a known dealer or acquaintance at an agreed public location or dealer's home.

Of the entire sample (N = 98), 46 participants answered questions about the heroin market, and analysis is based on this sub-sample.

5.1.1 Heroin price

Heroin prices have remained constant with only occasional slight variance in the last decade (Figure 25). A quarter gram continued to be the most common purchase weight (n = 27, $100, range $40–$200).

Figure 25: Median cost of most recent heroin purchases, 2000 to 2015



Source: Queensland IDRS PWID interviews

In keeping with the consistency of pricing in recent years, most respondents (n = 45, 84%) rated heroin prices as stable. Pricing was in keeping with Queensland prices reported by the Australian Crime Commission (2015).

5.1.2 Heroin form and purity

Three-in-five rated the current purity of heroin as low, with no respondents rating it as high (Table 10). Just under half (44%) considered that purity had not changed in the past six months, but a third (33%) considered it to be decreasing.

Table 10: Perceptions of heroin purity in preceding six months, 2014 and 2015

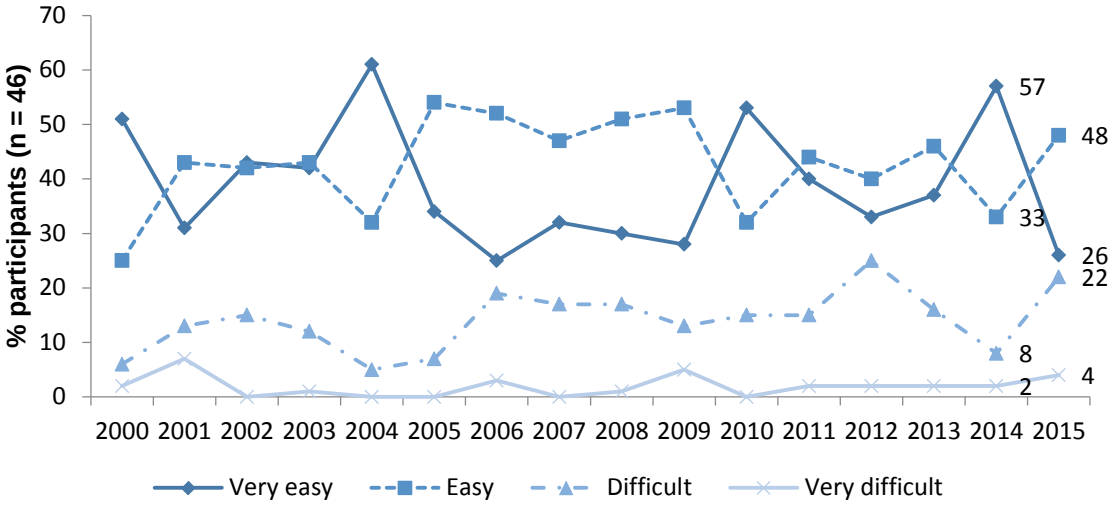
	2014	2015
	%	%
Current purity	n = 58	**n = 45**
High	7	**0**
Medium	29	**18**
Low	52	**60**
Fluctuates	12	**22**
Purity change over the past six months	n = 55	**n = 43**
Increasing	6	**5**
Stable	53	**44**
Decreasing	22	**33**
Fluctuating	20	**19**

Note: Those choosing 'don't know' were excluded from analysis. Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.1.3 Heroin availability

Heroin was most commonly reported to be easy to obtain (48%, n = 46) with similar proportions rating it as either very easy (26%) or difficult (22%). This is in contrast to 2014, when 57% of respondents reported it was very easy to obtain, and only 8% that it was difficult. (Figure 26)

Figure 26: Current heroin availability, 2000 to 2015



Source: Queensland IDRS PWID interviews

Participants were also asked about changes in heroin availability in the preceding six months. Two thirds (67%) considered it to be stable (Table 11).

Table 11: Changes in heroin availability in preceding six months, 2014 and 2015

	2014 (n = 60) %	**2015 (n = 45) %**
More difficult	7	**11**
Stable	81	**67**
Easier	10	**7**
Fluctuates	2	**16**

Note: Those choosing 'don't know' were excluded from analysis. Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.1.5 Purchasing patterns of heroin

A known dealer was the most common person from whom the most recent purchase of heroin was made (Table 12). The next most common person was an acquaintance (36%). This is in contrast to 2014, when only 9% had made their most recent purchase from an acquaintance. Place of purchase was similar to 2014, with the most likely purchase place being an agreed public location, followed by dealer's home.

Table 12: Purchasing patterns of heroin, 2014 and 2015

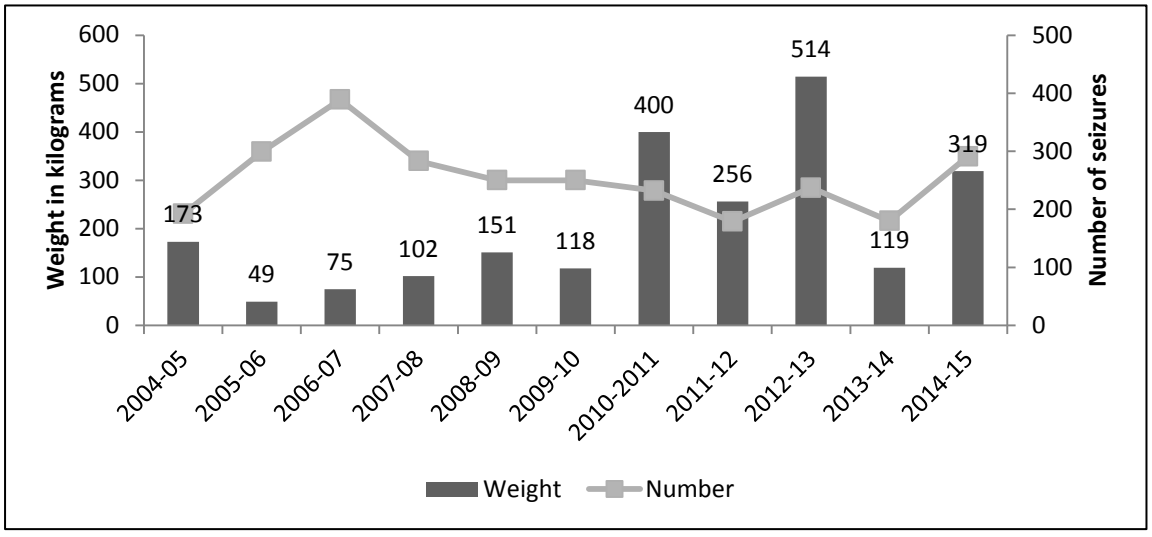
	2014	2015
	%	%
Last purchased from	n = 59	**n = 45**
Known dealer	54	**42**
Acquaintance	9	**36**
Friend	27	**18**
Unknown dealer	5	**4**
Street dealer	3	**0**
Mobile dealer	0	**0**
Place of most recent purchase	n = 59	**n = 45**
Agreed public location	49	**47**
Dealer's home	25	**27**
Friend's home	14	**13**
Home delivery	12	**7**
Street market	0	**0**
Acquaintance's home	0	**7**

Note: Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.1.6 Heroin detected at the Australian border

The number of heroin seizures at the border by the Australian Customs and Border Protection Service (ACBPS) in 2013–14 was 180 compared with 237 in 2012–13; the total weight also fell, from 514 kilograms in 2012–13 to 119 kilograms in 2013–14 (Figure 27).

Figure 27: Weight and number of heroin border seizures by the Australian Customs and Border Protection Service, 2004–05 to 2014–15



Source: ACBPS, 2015

Key experts report on heroin market

Key experts report that heroin has become less easy to obtain. It is frequently sold as a dollar amount (e.g. $200 which is a common amount used in a day). Most heroin is of low purity; although, a small number of PWID are able to obtain higher purity heroin.

5.2 Methamphetamine market

KEY POINTS

- **Median price**: a point of powder/speed was $100, base was $70, and crystal/ice was $100.
- **Purity:** crystal/ice reported as high by two-in-five. Speed was most commonly rated as medium, and base ratings were mixed.
- **Availability:** all forms of methamphetamine were reported to be readily available.

Of the entire sample (N = 98), 21 participants answered questions about the powder/speed market, 13 about base, and 54 about crystal/ice. 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 (0.1 g)	$100 (range $30–$100, n = 16)
Halfweight (0.5 g)	$200 (range $150–$400, n = 5)
Gram (1 g)	$500 (n = 1)
Eightball (3.5 g)	$1050 (range $800–$1300, n = 2)

Base

Point (0.1 g)	$70 (range $50–$100, n = 9)
Halfweight (0.5 g)	$200 (range $150–$250, n = 4)
Gram (1 g)	$425 (range $350–$500, n = 2)

Crystal/ice

Point (0.1 g)	$100 (range $50–$150, n = 42)
Halfweight (0.5 g)	$300 (range $200–$325, n = 14)
Gram (1 g)	$500 (range $350–$550, n = 5)
Eightball (3.5 g)	$1000 (range $780–1300, n = 3)

The price of all forms of methamphetamine was generally considered to be stable; although, 31% of respondents considered the price of crystal/ice to be decreasing (Table 13).

Table 13: Methamphetamine price changes in preceding six months, 2014 and 2015

Price	Speed powder		Base		Crystal/ice	
	2014 n = 14 %	**2015 n = 21 %**	2014 n = 10 %	**2015 n = 13 %**	2014 n = 38 %	**2015 n = 52 %**
Increasing	14	**0**	20	**0**	16	**4**
Stable	71	**76**	80	**85**	79	**62**
Decreasing	0	**14**	0	**8**	3	**31**
Fluctuating	14	**10**	0	**8**	3	**4**

Note: Those choosing 'don't know' were excluded from analysis. Percentage total may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.2.2 Methamphetamine purity

The most common purity rating was medium for powder/speed (38%) and base (46%), but high for crystal/ice (35%) (Table14). A stable rating was given to powder/speed purity by 67%, base by 39%, and crystal/ice by 39%.

Table 14: Perceptions of methamphetamine purity in preceding six months, 2013 and 2014

	Powder/speed		Base		Crystal/ice	
	2014 %	**2015 %**	**2014 %**	**2015 %**	**2014 %**	**2015 %**
Current purity/strength	n = 14	**n = 21**	n = 10	**n = 13**	n = 38	**n = 49**
High	14	**24**	30	**23**	40	**35**
Medium	43	**38**	30	**46**	26	**27**
Low	29	**10**	10	**15**	5	**12**
Fluctuates	14	**29**	30	**15**	29	**27**
Changes to purity/strength	n = 13	**n = 21**	n = 10	**n = 13**	n = 37	**n = 49**
Increasing	8	**0**	10	**15**	8	**8**
Stable	31	**67**	60	**39**	46	**39**
Decreasing	31	**5**	10	**23**	5	**20**
Fluctuating	31	**29**	20	**23**	41	**33**

Note: Those choosing 'don't know' were excluded from analysis. Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.2.3 Methamphetamine availability

The pattern of current availability was similar to 2014; although, small numbers for base make comparison difficult (Table 15). Over half the respondents reported crystal/ice was very easy to obtain, with only a few respondents rating it as difficult. The availability of powder/speed and crystal/ice was mainly considered to be stable.

Table 15: Methamphetamine availability in preceding six months, 2014 and 2015

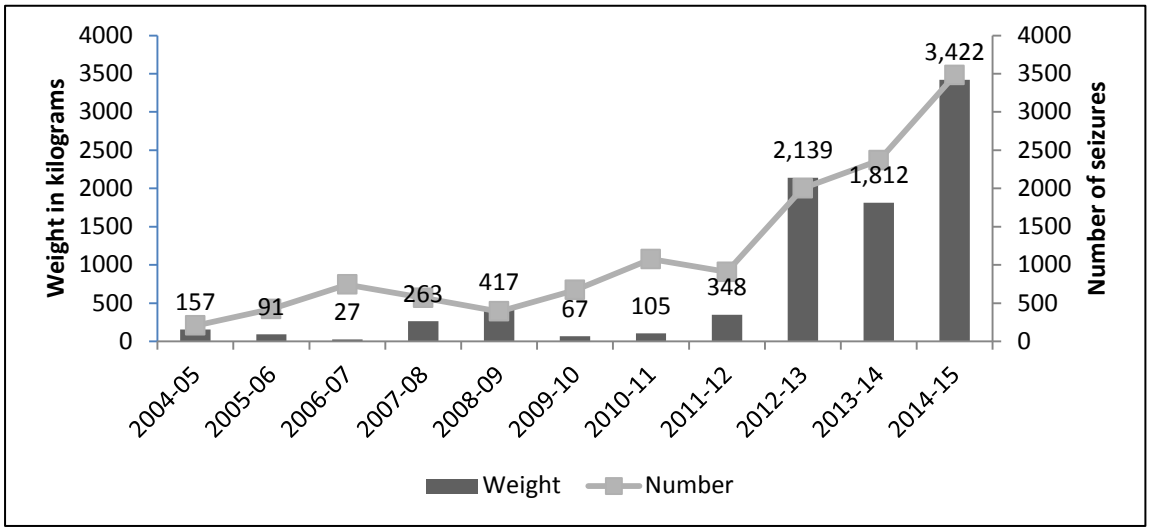
	Powder/speed		Base		Crystal/ice	
	2014 %	**2015 %**	2014 %	**2015 %**	2014 %	**2015 %**
Current availability	n = 14	**n = 21**	n = 10	**n = 13**	n = 39	**n = 54**
Very easy	36	**33**	40	**8**	64	**56**
Easy	43	**43**	40	**46**	28	**37**
Difficult	14	**24**	20	**46**	8	**7**
Very difficult	7	**0**	0	**0**	0	**0**
Changes to availability	n = 14	**n = 21**	n = 10	**n = 13**	n = 38	**n = 52**
More difficult	29	**29**	10	**46**	3	**8**
Stable	64	**62**	90	**39**	87	**60**
Easier	0	**10**	0	**8**	5	**27**
Fluctuates	7	**0**	0	**8**	5	**6**

Note: Those choosing 'don't know' were excluded from analysis. Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.2.4 Amphetamine-type stimulants detected at the Australian border

The number and weight of detections of amphetamine-type stimulants (ATS) by the Australian Customs and Border Protection Service (ACBPS) rose in 2014–15, with 3479 seizures weighing a total of 3422 kilograms (Figure 28).

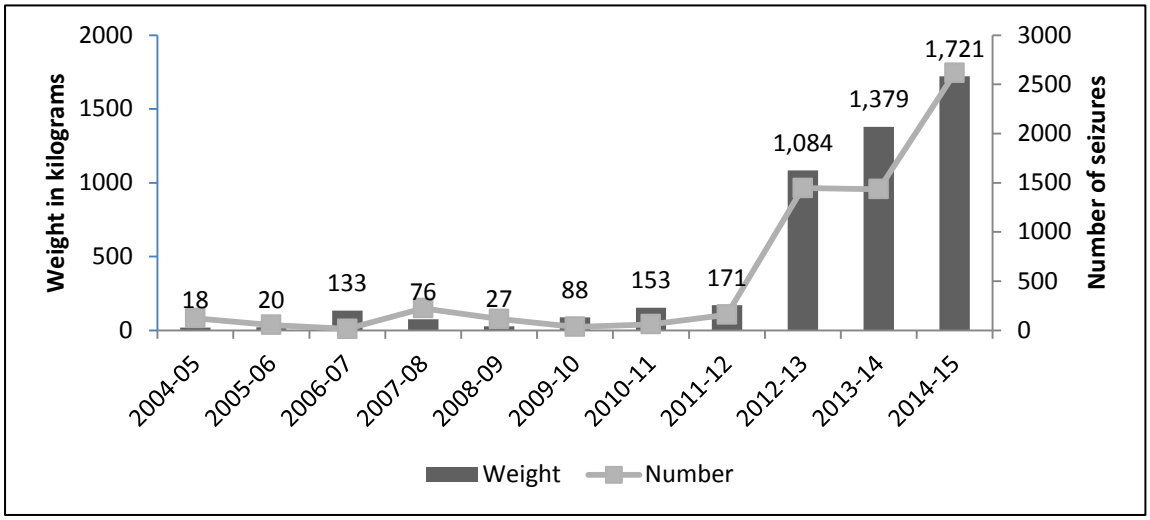
Figure 28: Weight and number of amphetamine-type stimulants* detections by the Australian Customs and Border Protection Service, financial years 2004–05 to 2014–15



* includes amphetamine, methamphetamine and crystal methamphetamine detections, but excludes MDMA
Source: ACBPS, 2014

Of the 3,479 detections in 2014–15, 2,615 were ice; and of the total weight of 3,422 kilograms, 1,721 kilograms were ice (ACBPS, 2014). Figure 29 shows the steep rise in ice detections and weight of seizures in 2012–13 and the upward trend since then.

Figure 29: Weight and number of crystalline methamphetamine (ice) detections by the Australian Customs and Border Protection Service, financial years 2004–05 to 2014–15



Source: ACBPS, 2014

5.2.5 Purchasing patterns of methamphetamines

A known dealer or a friend continued to be the most likely source for the most recent purchase of all forms of methamphetamines (Table 16). The place of most recent purchase varied for all three forms of methamphetamines, but an agreed public location was the most common.

Table 16: Purchasing patterns of methamphetamine, 2014 and 2015

	Powder/speed		Base		Crystal/ice	
	2014 %	2015 %	2014 %	2015 %	2014 %	2015 %
Last purchased from	n = 13	**n = 21**	n = 10	**n = 13**	n = 36	**n = 54**
Street dealer	0	**0**	0	**0**	0	**0**
Friend	23	**43**	30	**23**	25	**37**
Known dealer	46	**24**	20	**54**	47	**35**
Acquaintance	15	**24**	20	**15**	19	**19**
Unknown dealer	8	**5**	10	**0**	6	**6**
Mobile dealer	0	**5**	0	**0**	0	**0**
Relative	0	**0**	20	**0**	3	**4**
Other*	8	**0**	0	**8**	0	**0**
Place of most recent purchase	n = 13	**n = 21**	n = 10	**n = 13**	n = 36	**n = 54**
Home delivery	15	**14**	0	**8**	11	**24**
Dealer's home	15	**5**	10	**23**	11	**15**
Friend's home	31	**29**	30	**15**	22	**28**
Acquaintance's home	0	**5**	0	**8**	0	**4**
Street market	0	**0**	0	**0**	0	**0**
Agreed public location	39	**48**	40	**39**	53	**30**
Other	0	**0**	20	**8**	3	**0**

Source: Queensland IDRS PWID interviews

Key experts report on methamphetamine market:

Ice has become the principal form of methamphetamine because of its availability. As one key expert put it, '*Ice is so readily available. It is in your face'.* Ice was generally considered to have a high level of purity but those buying small quantities irregularly may be purchasing less potent ice.

Price was reported as $100 per point but cheaper if bought in larger quantities.

5.3 Cocaine market

KEY POINTS

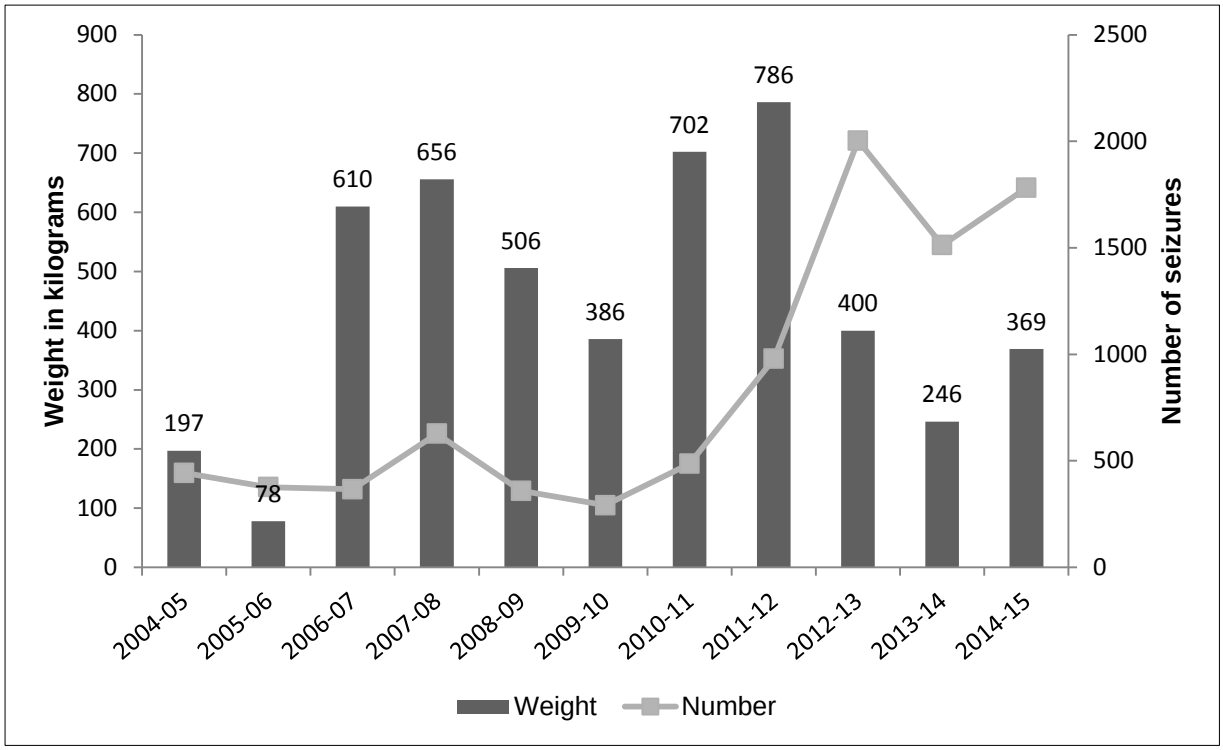
- The one report on the cocaine market was that it was difficult to access, the purity was medium, and the cost was $450 gram.

Only one participant answered questions about the cocaine market. They reported that cocaine was difficult to access, with no recent change in availability; the price was stable at $450 gram and the purity was stable at medium.

5.3.1 Cocaine detected at the Australian border

Figure 30 shows the number and weight of cocaine detections at the border by the Australian Customs and Border Protection Service (ACBPS) in 2014–15: 1781 seizures weighing a total of 369 kilograms.

Figure 30: Weight and number of cocaine border seizures by the Australian Customs and Border Protection Service, 2004–05 to 2014–15



Source: ACBPS 2014

Key experts report on cocaine market

Most cocaine was of low purity with a small percentage being quite high purity. Cocaine remains an expensive drug at around $350 per gram because '*the effect doesn't last so need to top up during the night*'. Overall, the cocaine market was considered stable.

5.4 Cannabis market

KEY POINTS

- **Median price:** mostly reported as stable for both hydro and bush: a quarter ounce of hydro cost $90 and bush cost $60.
- **Potency:** generally rated as medium or high for both hydro and bush.
- **Availability:** hydro was readily available but bush was less so with 44% reporting it as difficult.

Thirty-nine per cent of the sample agreed they were able to distinguish between hydroponically cultivated cannabis (hydro) and outdoor-cultivated cannabis (bush). Thirty-one participants answered questions about the hydro market and 16 about the bush market.

5.4.1. Cannabis price

The median price of hydro and bush was:

Hydro

Gram	$22.50 (range $20–$25, n = 6)
Quarter ounce	$90 (range $80–$100, n = 12)
Ounce	$280 (range $250–$300, n = 3)

Nearly all respondents (93%, n = 30) rated the price of hydro as stable.

Bush

Gram	$25 (n = 1)
Quarter ounce	$60 (range $50–$100, n = 7)
Ounce	$180 (range $100–$250, n = 3)

The price of bush was generally rated as stable (75%, n = 16), with the remainder giving a mix of ratings.

5.4.2 Cannabis purity

The potency of both hydro and bush was generally considered to be high or medium, with the majority reporting that potency had remained stable in the previous six months (Table 17).

Table 17: Perceived cannabis potency in preceding six months, 2014 and 2015

	Hydro		Bush	
	2014	**2015**	2014	**2014**
	%	**%**	%	**%**
Current potency	n = 35	**n = 29**	n = 10	**n = 15**
High	37	**38**	30	**33**
Medium	49	**38**	60	**47**
Low	3	**3**	0	**13**
Fluctuates	11	**21**	10	**7**
Changes to potency	n = 35	**n = 29**	n = 10	**n = 16**
Increasing	9	**3**	10	**19**
Stable	63	**79**	70	**56**
Decreasing	9	**0**	0	**13**
Fluctuates	20	**17**	20	**13**

Note: Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.4.3 Cannabis availability

Table 18 shows that the current availability of hydro was mostly rated as very easy or easy, with two-thirds considering availability to be stable. There was no clear consensus about the availability of bush. About half (56%) considered the market to be stable.

Table 18: Cannabis availability in preceding six months, 2014 and 2015

	Hydro		Bush	
	2014	**2015**	2014	**2015**
	%	**%**	%	**%**
Current availability	n = 36	**n = 31**	n = 11	**n = 16**
Very easy	56	**45**	27	**19**
Easy	28	**39**	36	**38**
Difficult	17	**16**	27	**44**
Very difficult	0	**0**	9	**0**
Changes to availability	n = 35	**n = 30**	n = 10	**n = 16**
More difficult	23	**17**	30	**6**
Stable	66	**67**	70	**56**
Easier	3	**0**	0	**19**
Fluctuates	9	**17**	0	**19**

Note: Those choosing ‘don’t know’ were excluded from analysis. Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.4.4 Purchasing patterns of cannabis

As in previous years, a friend or known dealer was the most likely source person for obtaining both hydro and bush (Table 19). Place of purchase varied.

Table 19: Purchasing patterns of cannabis, 2014 and 2015

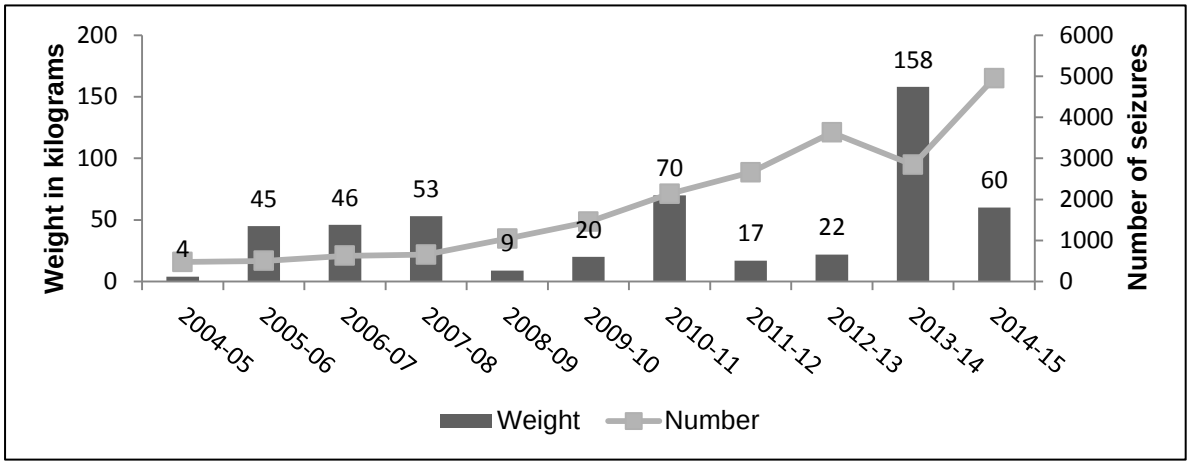
	Hydro		Bush	
	2014 %	2015 %	2014 %	2015 %
Last purchased from	n = 36	**n = 30**	n = 11	**n = 16**
Friend	42	**53**	64	**56**
Known dealer	42	**33**	36	**25**
Acquaintance	3	**13**	0	**13**
Relative	3	**0**	0	**6**
Workmate	3	**0**	0	**0**
Unknown dealer	3	**0**	0	**0**
Street dealer	6	**0**	0	**0**
Place of purchase	n = 36	**n = 30**	n = 11	**n = 16**
Friend's home	28	**33**	27	**38**
Agreed public location	31	**30**	27	**25**
Home delivery	8	**23**	27	**0**
Dealer's home	25	**7**	18	**25**
Street market	3	**0**	0	**0**
Acquaintance's home	0	**7**	0	**6**
Work	0	**0**	0	**0**
Other	0	**0**	0	**6**

Note: Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.4.5 Cannabis detections at the Australian border

The number of cannabis (includes cannabis leaf, oil, seed, and resin) detections at the border by the Australian Customs and Border Protection Service (ACBPS) sharply increased in 2014–15, but the total weight of seizures decreased from 158 kilograms in 2013–14 to 60 kilograms in 2014–15 (Figure 31).

Figure 31: Weight and number of cannabis border seizures by Australian Customs and Border Protection Service, financial years 2004–05 to 2014–15



Source: ACBPS 2015

Key experts report on cannabis market

Although the cannabis market was considered to be stable, some key experts reported that availability was not as easy as previously due to dealers preferring to sell ice.

5.5 Methadone market

KEY POINTS

- **Median price:** purchase quantity varied and numbers were too small for analysis
- **Availability:** readily available
- **Purchasing pattern:** most likely to have been obtained from an acquaintance or friend for self-treatment.

Five participants answered questions about the methadone market.

5.5.1 Methadone price

Three of the five respondents reported purchasing methadone, and purchases varied in quantity. The one respondent who reported on the price of one millilitre of methadone syrup paid $0.90 (The median for the previous few years has been $1 per millilitre).

5.5.2 Methadone availability

Four of the five respondents reported that methadone was easy to obtain and availability was stable.

5.5.3 Purchasing patterns of illicit methadone

Illicit methadone was sourced from an acquaintance or friend, and the purchase place varied. The main reason given for use was self-treatment. Of the four who provided further information, two reported it was someone else's take-away dose; the other two 'didn't know'.

5.6 Buprenorphine (Subutex®) market

KEY POINTS

- **Median price:** $40 for 8 mg tablet
- **Availability:** easy or very easy

Twelve participants answered questions about the buprenorphine market.

5.6.1 Buprenorphine price

The median price of buprenorphine was:

2 mg $10 (n = 3)

8 mg $40 (range $20–$50, n = 9)

Two-thirds of respondents reported that prices were stable (64%, n = 11).

5.6.2 Buprenorphine availability

Current availability of buprenorphine (n = 12) was reported as easy (67%), difficult (17%), very easy (8%) or very difficult (8%). Two-thirds (67%) reported that availability was stable, 25% fluctuating, and 8% more difficult.

5.6.3 Purchasing patterns of Buprenorphine

The source person for the most recent purchase (n = 12) was most commonly a friend (42%) or acquaintance (33%), and the source venue was a friend or acquaintance's home (58%) or an agreed public location (42%). Illicit buprenorphine was either bought (75%) or given for free (25%).

The original source was someone else's take-away dose (75%), not known (17%) or prescription fraud (8%).

The main reason given for using illicit buprenorphine was self-treatment (42%), intoxication (33%), or substitution for heroin/other opioids (25%).

5.7 Buprenorphine-naloxone (Suboxone®) market

KEY POINTS

- **Median price:** $20 for 8 mg film
- **Availability:** readily available
- **Purchasing patterns:** mainly purchased from a friend at a friend's home

Questions about the buprenorphine-naloxone market were answered by nine participants for tablets and 16 for film.

5.7.1 Buprenorphine-naloxone price

The median price of buprenorphine-naloxone was:

Tablets

2 mg $10^ (range $5–$10, n = 3)

8 mg $40^ (range $20–$40, n = 6)

Of the nine respondents, seven reported the price of tablets was stable, one reported it was increasing, the other fluctuating.

Film

2 mg $10^ (range $5–$10, n = 6)

8 mg $20 (range $10–$40, n = 11)

Nearly all of the 15 respondents (87%) reported the price of film was stable; 13% reported it was fluctuating.

5.7.2 Buprenorphine-naloxone availability

Tablets

Most of the nine respondents (7) reported that tablets were readily available; the other two respondents reported they were difficult or very difficult to access. The market was generally considered to be stable.

Film

Availability was similar to 2014 with most respondents reporting that Suboxone® film was readily available and that availability was stable (Table 20).

Table 20: Availability of buprenorphine-naloxone film in previous six months, 2014 and 2015

Ease of access	2014 % (n = 10)	**2015 % (n = 16)**	Changes to ease of access in last 6 months	2014 % (n = 8^)	**2015 % (n = 15)**
Very easy	20	**19**	More difficult	0	**13**
Easy	70	**63**	Stable	88	**80**
Difficult	10	**13**	Easier	13	**0**
Very difficult	0	**6**	Fluctuates	0	**7**

^ Small numbers reported; interpret with caution (n <10)
Note: Those choosing 'don't know' were excluded from analysis. Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.7.3 Purchasing patterns of buprenorphine-naloxone

Tablet

Five of the eight respondents made their most recent purchase of Suboxone® tablets from a friend, two purchased from their partner, and one from a known dealer.

Film

Most (73%) of the 15 respondents made their most recent purchase of Suboxone® film from a friend at their friend's home; the others purchased from their partner (20%) or an acquaintance (7%).

5.7.4 Original source of buprenorphine-naloxone

Respondents (n = 15) reported that the original source of their most recent purchase of Suboxone® film was someone else's take-away dose (73%), someone else's daily dose (7%), or unknown (20%).

5.7.5 Main reason for using illicit buprenorphine-naloxone

Respondents (n = 15) reported that the main reason for using Suboxone® film was self- treatment (40%), substitution for heroin/other opioids (33%), or intoxication (27%).

5.8 Morphine market

KEY POINTS

- **Median price:** 100 milligrams of MS Contin® (the most common purchase) was $55. Morphine prices were generally rated as stable.

  MS Contin® was the most commonly purchased brand, followed by Kapanol®.
- **Availability:** most reported it as easy or very easy.
- **Purchasing pattern:** obtained from a variety of source people and locations.

Seventeen 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 $25–$40, n =3)
	100 mg	$55^ (range $40–$60, n = 6)
Kapanol	50 mg	$22.50^ ($15 and $30, n = 2)
	100 mg	$30^ (n = 1)

Respondents (n = 16) generally considered price to be stable (69%); 25% considered it to be fluctuating, and 6% decreasing.

5.8.2 Morphine availability

Similar to 2014, participants who commented on the morphine market in 2015 generally considered morphine to be readily available. About two-thirds reported access was stable but about a quarter reported it was more difficult (Table 21).

Table 21: Availability of illicit morphine in preceding six months, 2014 and 2015

Ease of access	2014 % (n = 23)	**2015 % (n = 17)**	Changes to ease of access in last 6 months	2014 % (n = 23)	**2015 % (n = 17)**
Very easy	30	**12**	More difficult	17	**24**
Easy	57	**71**	Stable	83	**65**
Difficult	13	**18**	Easier	0	**12**
Very difficult	0	**0**	Fluctuates	0	**0**

Note: Those choosing 'don't know' were excluded from analysis. Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.8.3 Purchasing patterns of illicit morphine

Respondents (n = 16) last purchased morphine from a friend (44%), known dealer (25%), acquaintance (25%), or unknown dealer (6%).

Venues for the most recent purchase of morphine (n = 16) were: agreed public location (44%), a friend's home (25%), dealer's home (19%), home delivered (6%) or acquaintance's home (6%).

5.8.4 Main reason for purchasing illicit morphine

The main reason for using illicit morphine has remained stable, with about half of the responses reporting self-treatment (Table 22).

Table 22: Main reason for purchasing illicit morphine, 2014 and 2015

	2014	2015
	%	%
	n = 25	**n = 17**
Self- treatment	48	**47**
Substitute for heroin/other opioids	28	**35**
Intoxication	16	**12**
Other	12	**6**

Source: Queensland IDRS PWID interviews

5.9 Oxycodone market

KEY POINTS

- **Median price:** OxyContin® (reformulated) was the most common purchase: $20 for 40 mg and $40 for 80 mg.
- **Availability:** most (72%) rated it as readily available.
- **Purchasing pattern:** 54% reported their source person was a friend. The most common purchase venue was an agreed public location.

Fourteen participants answered questions about the oxycodone market.

5.9.1 Illicit oxycodone price

OxyContin® was the most commonly used brand of oxycodone. With the intention of reducing its diversion, on 1 April 2014 OxyContin® tablets were reformulated with physicochemical properties designed to make them harder to crush for injecting. Median prices were reported as:

OxyContin® reformulated	40 mg	$20^ ($10–$25, n = 8)
	80 mg	$40^ ($20–$50, n = 8)

Additionally, there were single reports of: 5 mg Endone® for $2, and generic controlled-release oxycodone—40 mg for $25 and 80 mg for $40.

Of the 13 participants who commented on price changes, 46% considered it to be stable, 23% increasing, 15% decreasing, and 15% fluctuating.

5.9.2 Illicit oxycodone availability

Oxycodone was generally regarded as readily available; although 28% found it difficult or very difficult to obtain (Table 23). Availability during the previous six months was most commonly reported as stable (71%) but 21% reported it was more difficult.

Table 23: Availability of illicit oxycodone in preceding six months, 2014 and 2015

Ease of access	2014 % (n = 23)	**2015 % (n = 14)**	Changes to ease of access in last 6 months	2014 % (n = 26)	**2015 % (n = 14)**
Very easy	30	**36**	More difficult	31	**21**
Easy	44	**36**	Stable	58	**71**
Difficult	13	**21**	Fluctuates	8	**7**
Very difficult	13	**7**	Easier	4	**0**

Note: Those choosing 'don't know' were excluded from analysis. The percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

5.9.3 Purchasing patterns of illicit oxycodone

Of the participants who commented on their most recent purchase of oxycodone (n = 13), 54% reported their source person was a friend, 23% an acquaintance, 15% known dealer, and 8% a street dealer. The purchase was most likely to have been made at an agreed public location (54%): other venues were a friend's home (15%), home delivery (15%), dealer's home (8%), and an acquaintance's home (8%).

5.9.4 Main reason

The two most common reasons given for using illicit oxycodone were self-treatment and substitution for heroin or other opiates.

5.10 Benzodiazepine market

KEY POINTS

Reports on the benzodiazepine market should be treated with caution due to small numbers and little consensus.

Four participants answered questions about the benzodiazepine market.

5.10.1 Illicit benzodiazepine price

There was only a single report on price: $1 for an alprazolam tablet.

5.10.2 Illicit benzodiazepine availability

Of the three participants who commented on availability, two considered it to be readily available and one difficult. Two of the three respondents rated changes in accessibility as stable, and one as easier.

5.10.3 Purchasing patterns of illicit benzodiazepine

There was no consensus among the respondents about who they obtained illicit benzodiazepine from and where. Three of the four respondents had purchased the benzodiazepine and one had been given it. Of the four respondents, two reported the original source was someone else's prescription, one theft from a pharmacy, and the other didn't know.

5.11 Other drugs market

KEY POINTS

Reports on other drug (fentanyl and LSD) markets should be treated with caution due to small numbers.

5.11.1 Fentanyl market

Five participants reported on the fentanyl market.

It was difficult to obtain reliable data on pricing of patches or intranasal doses. One respondent reported purchasing one tenth of a 100 mg patch for $30. Three of the five participants who commented on the fentanyl market reported that price was increasing and two reported it was stable.

Four of the five respondents reported that availability was very easy or easy and one reported it was difficult. There was no consensus on stability of the market. All five respondents reported purchasing (rather than being given) their most recent illicit fentanyl dose. The source person varied as did venue. Two of the five respondents reported it was someone else's prescription, the other three didn't know the original source.

5.11.2 LSD market

Only one participant reported on the LSD market. The respondent purchased a tab for $25 from a friend who home delivered. The respondent reported that pricing was stable; purity fluctuated; availability was very difficult and had become more difficult in the previous six months.

6 HEALTH-RELATED TRENDS ASSOCIATED WITH DRUG USE

KEY POINTS

- **Overdose:** among participants who had ever used heroin (n = 81), 51% had accidently overdosed on it. Of these, 15% (six participants) had overdosed in the preceding year. Very small numbers reported ever overdosing on morphine, methadone, or oxycodone.

  21% of participants had accidently overdosed on a drug other than heroin in their lifetime.

- **Treatment:** 39% of participants were currently in drug treatment, mainly opioid substitution therapy (OST).

- **Injecting risk:** nearly all participants had sourced needles from a Needle and Syringe Program (NSP) in the previous month.

  7% of participants had recently borrowed a used needle, and 10% had recently lent a used needle, with 22% reporting that they shared other equipment (predominantly spoons/mixing containers).

  Two-in-five had re-used one of their own needles at least once in the previous month.

- **Mental health:** 45% of participants self-reported a mental health problem, with the most common problems being depression and anxiety.

  Half of the participants scored in the high distress or very high distress categories of the Kessler Psychological Distress Scale (K10).

- **Opioid dependence:** 72% of those who had recently used opioids had a score indicative of dependence.

- **Stimulant dependence:** 41% of those who had recently used stimulants had a score indicative of dependence.

- **Naloxone:** three-quarters of participants had heard of naloxone, and 57% had heard of the take-home program; however, only one participant was participating in the program.

- **Self-reported general health status**: one in five participants considered their general health to be very good or excellent, with the most common rating being good.

6.1 Overdose and drug-related fatalities

6.1.1 Heroin overdose

Among participants who had used heroin and commented (n = 81), 51% reported accidently overdosing on heroin in their lifetime. The median number of overdoses was two (range 1–21).

Of those who had overdosed (n = 41), 15% (six participants) had done so in the previous 12 months. Three of the six respondents reported receiving CPR from a friend, partner or peer; none reported receiving Narcan; one reported receiving oxygen; two reported being attended to by ambulance officers; and two reported being admitted to an emergency department. Only one respondent reported later seeking out treatment/information as a result of the overdose.

6.1.2 Morphine overdose

Of those who had ever used morphine and commented (n = 67), four participants reported overdosing on it. The median number of times was three (range 1–6, n = 4). Two of these respondents reported overdosing on morphine in the previous 12 months but none reported overdosing on morphine in the previous month.

6.1.3 Methadone overdose

Of those who had ever used methadone and commented (n = 61), two participants reported overdosing on it. Both respondents had overdosed once, but not in the previous 12 months.

6.1.4 Oxycodone overdose

Of those who had ever used oxycodone and commented (n = 58), three participants reported overdosing (once only). One had overdosed on oxycodone in the previous 12 months but not in the last month.

6.1.7 Other drugs overdose

Of the entire sample, 21% reported an accidental overdose on any other drug. The median number of other overdoses was two (n = 21, range 1–100). . Five of the 21 respondents had overdosed in the previous 12 months, and one of these in the previous month. Among these five respondents, there was no common overdose substance: fentanyl, benzodiazepine, ice, LSD, unspecified other drug.

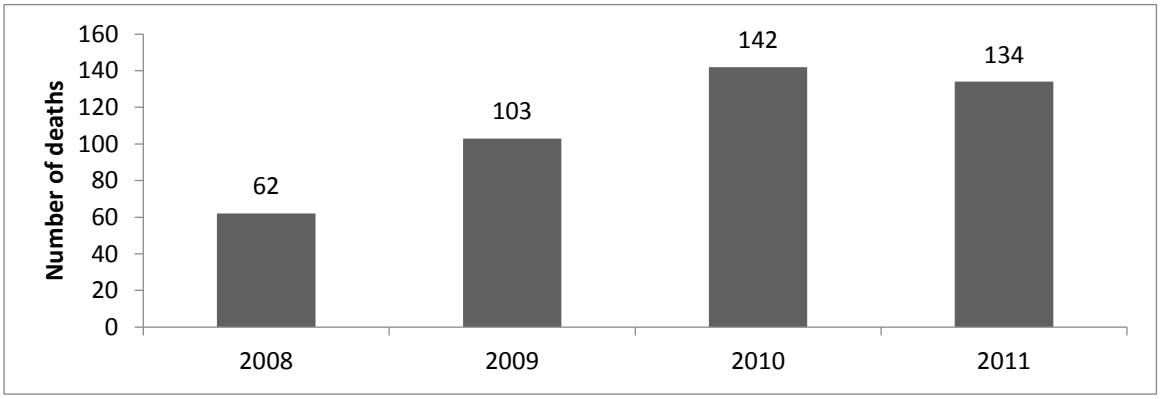
6.1.3 Queensland Ambulance Service data

Queensland Ambulance Service data were not available for 2014–15 due to changes being made to overdose reporting methodology.

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 decreased from 142 in 2010 to 134 in 2011 (Figure 32).

Figure 32: Accidental opioid deaths in Queensland among those aged 15–54 years, 2008 to 2011



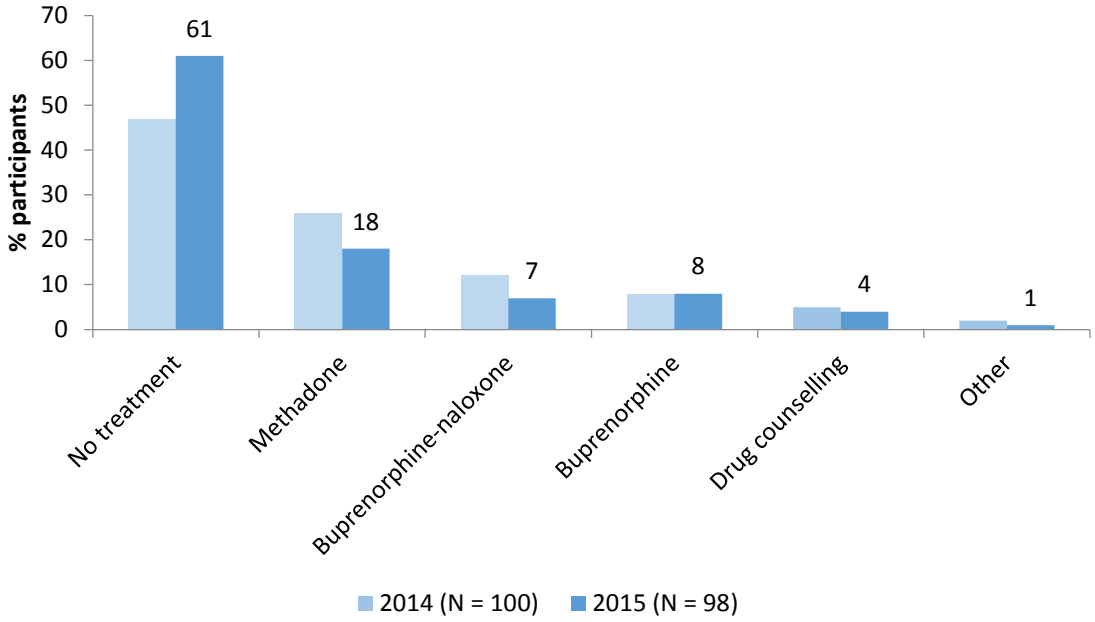
Source: Australian Bureau of Statistics (Roxburgh and Burns, 2015)

6.2 Drug treatment

6.2.1 Current drug treatment

Two-in-five (39%) of the sample reported being in treatment, with methadone being the most common form of treatment (Figure 33). The median time in current treatment was 15 months (n = 38, range 1 month–15 years).

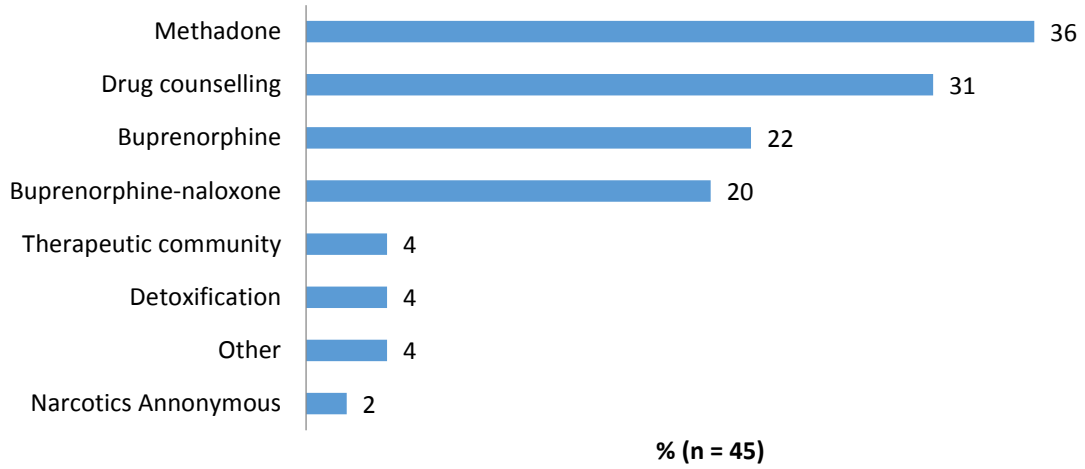
Figure 33: Current treatment status, 2014 and 2015



Source: Queensland IDRS PWID interviews

Figure 34 shows the forms of treatment that participants had been in over the preceding six months.

Figure 34: Forms of treatment received in previous six months, 2015



Note: Multiple responses allowed
Source: Queensland IDRS PWID interviews

Fifteen per cent of participants reported they had tried to access treatment in the last six months but were unable to. These treatment services were: detoxification (33%), ATOD worker (27%), opioid substitution program (20%), opioid substitution doctor (20%), counsellor (13%), psychologist (13%), therapeutic community, GP (7%), psychiatrist (7%), and unspecified other (7%). Two-in-five respondents reported that inability to access was because of a waiting list and the others gave a variety of reasons.

Thirteen participants were currently trying to get into treatment. Table 24 shows participants' perception of how easy it is to get drug treatment. Most commonly it was reported as difficult (43%).

Table 24: Perception of current access to drug treatment, 2014 and 2015

	2014 % n = 69	**2015** **%** **n = 80**
Very easy	5	**9**
Easy	47	**34**
Difficult	28	**43**
Very difficult	20	**15**

Note: 'don't know' responses were excluded from this analysis. Percentage totals may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

Participants (n = 63) reported that access to drug treatment services in the previous six months had become: more difficult 32%, was stable 56%, easier 6%, and fluctuates 6%.

6.2.2 Estimated number of pharmacotherapy clients in 2014

In Queensland, the estimated number of pharmacotherapy clients in was stable with 6,433 clients receiving pharmacotherapy treatment on a 'snapshot'/specified day in June 2014 (AIHW, 2015). Of these, 49% were receiving methadone, 12% were receiving buprenorphine (Subutex®), and 39% were receiving buprenorphine-naloxone (Suboxone®). The proportions were similar to those in 2013.

Three-in-five clients were male. The median age was 40 years, with the median age for methadone being 42 years, buprenorphine 39 years, and buprenorphine-naloxone 38 years.

There were 537 dosing sites in Queensland in 2014 (511 in 2013), and these were most commonly pharmacies (81%). The number of prescribers registered to prescribe pharmacotherapy drugs in 2014 was 221 (183 in 2013).

6.2.3 Calls to telephone help lines

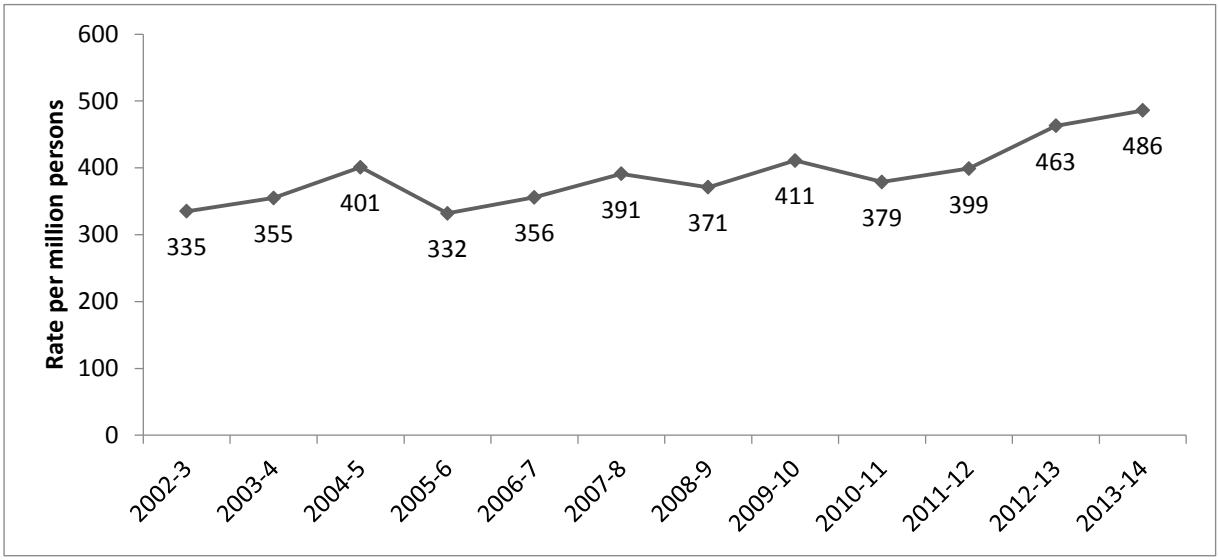
Data from the Queensland Alcohol and Drug Information Service (ADIS), which is a 24-hour information and counselling service provided by Queensland Health, were not available for 2014–15.

6.3 Hospital admissions

6.3.1 Heroin including other opioids

In 2013–14, the number of opioid-related inpatient hospital admissions in Queensland was 1,260 for persons aged 15–54 years. This equates to 486 admissions per million persons which is the highest rate over the last decade (Figure 35).

Figure 35: Number of principal opioid-related hospital admissions per million persons aged 15–54 years, Queensland, 2002–03 to 2013–14

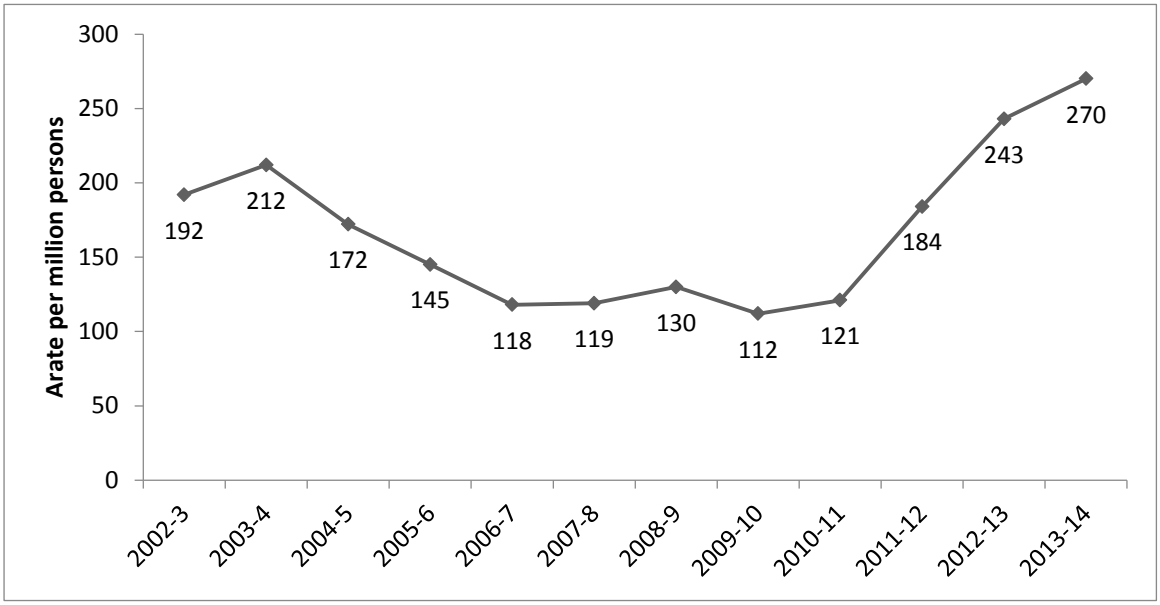


Source: Roxburgh and Breen, in press

6.3.2 Methamphetamine

In 2013–14, the number of inpatient hospital admissions in Queensland where the principal diagnosis related to amphetamines was 701 for persons aged 15–54 years (i.e. 270 per million persons). As Figure 36 shows, the number of inpatient hospital admissions per million persons has been trending upwards in recent years, and is now the highest in the reporting period.

Figure 36: Number of principal amphetamine-related hospital admissions per million persons among people aged 15–54 years, Queensland, 2002–03 to 2013–14

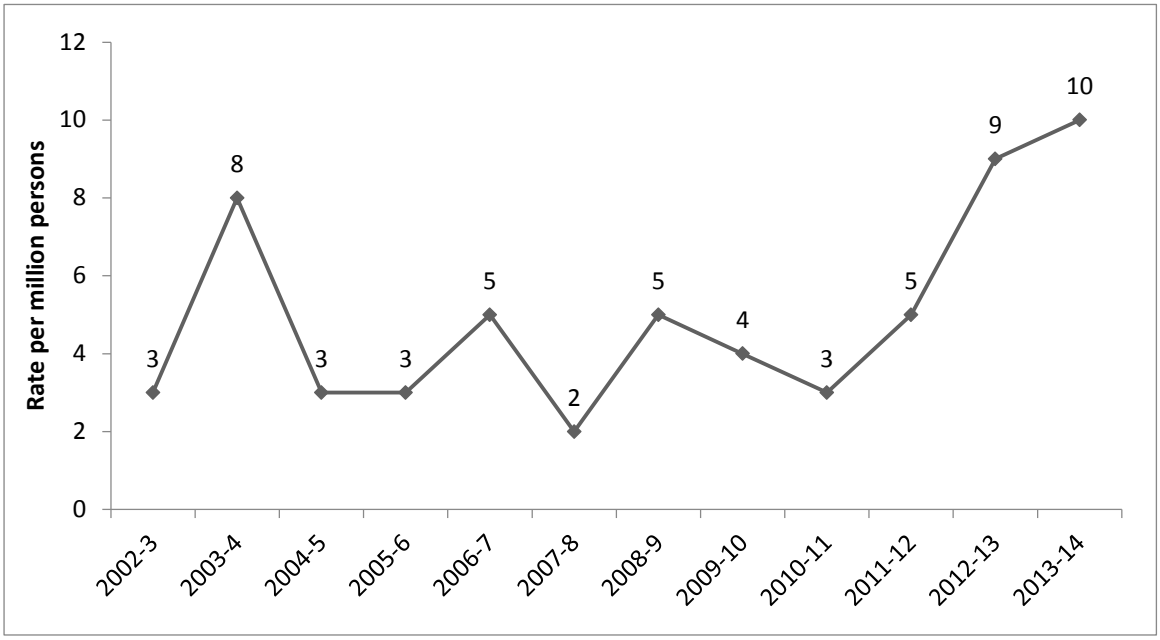


Source: Roxburgh and Breen, in press

6.3.3 Cocaine

Figure 37 shows the number of inpatient hospital admissions per million persons with a principal diagnosis relating to cocaine over the last decade. The ten admissions per million persons is much lower than the national rate of 34, and equates to 25 admissions.

Figure 37: Number of principal cocaine-related hospital admissions per million persons among people aged 15–54 years, Queensland, 2002–03 to 2013–14

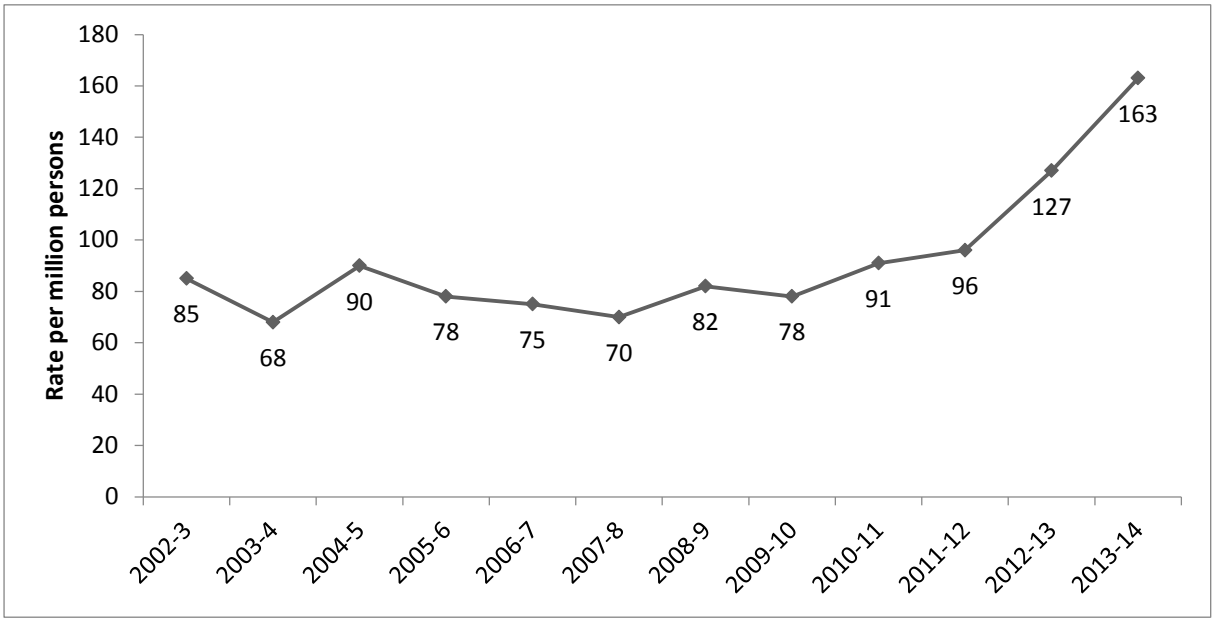


Source: Roxburgh and Breen, in press

6.3.4 Cannabis

In 2012–13, there were 424 inpatient hospital admissions in Queensland for those aged 15–54 years where the principal diagnosis related to cannabis. This equates to 163 inpatient hospital admissions per million persons (Figure 38). Although the admission numbers continue to trend upwards, they are lower than the the national rate of 221 per million persons.

Figure 38: Number of principal cannabis-related hospital admissions per million persons among people aged 15–54 years, 2002–03 to 2013–14



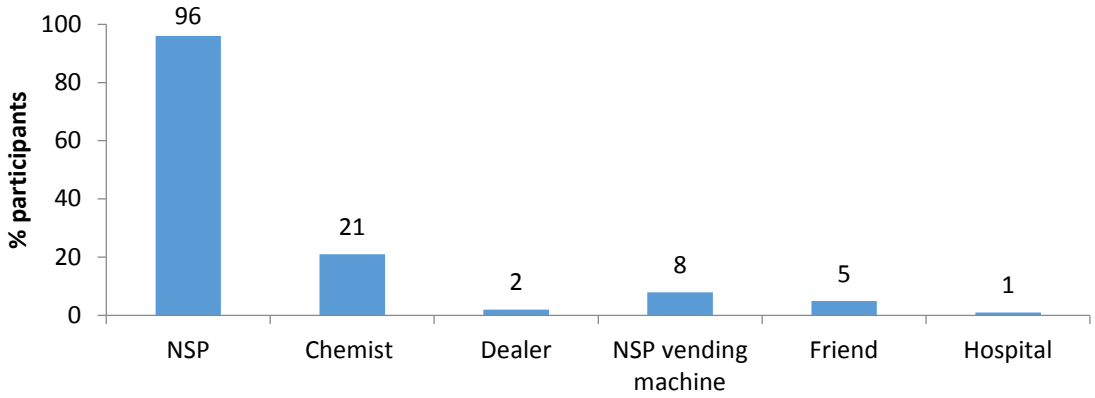
Source: Roxburgh and Breen, in press

6.4 Injecting risk behaviour

6.4.1 Access to needles and syringes

As in previous years, needle and syringe programs (NSP) were overwhelmingly the most common venue for acquiring needles and syringes (Figure 39). However, it must be remembered that our sample was largely recruited from NSP sites.

Figure 39: Source of needles and syringes in preceding month, 2015



Note: Multiple responses allowed.
Source: Queensland IDRS PWID interviews

Very few participants (7%) reported that they had trouble getting needles and syringes when they needed them in the last month.

In the financial year 2014–15, the Queensland Health NSP reported supplying a total of 9,755,085 syringes/sharps: 8,208,475 to their NSP programs, 1,445,970 to pharmacy NSPs, and 100,640 to private financial pharmacies.

Participants were asked the average number of needles they had needed to successfully inject each 'hit' during the last month. Most (77%) only needed one, but 23% had needed two or more.

Information about injecting and obtaining needles and syringes is provided in Table 25. More needles and syringes were obtained than needed for personal use.

Table 25: Injecting and obtaining needles and syringes in the previous month, 2015

n = 95	Mean	Median	Range
Approximate times injected	38	20	0–300
Times got needles and syringes	4	2	0–15
Total number of new needle and syringes obtained	76	50	0–750
Needles and syringes obtained for self	39	20	0–300
Syringes given away or sold	18	5	0–150
Syringes stored away	18	6	0–300

Source: Queensland IDRS PWID interviews

6.4.2 Access to filters

Participants were asked if they were able to access filters from the places where they had got needles in the last month. Of those who knew about availability of filters (n = 92), all reported being able to

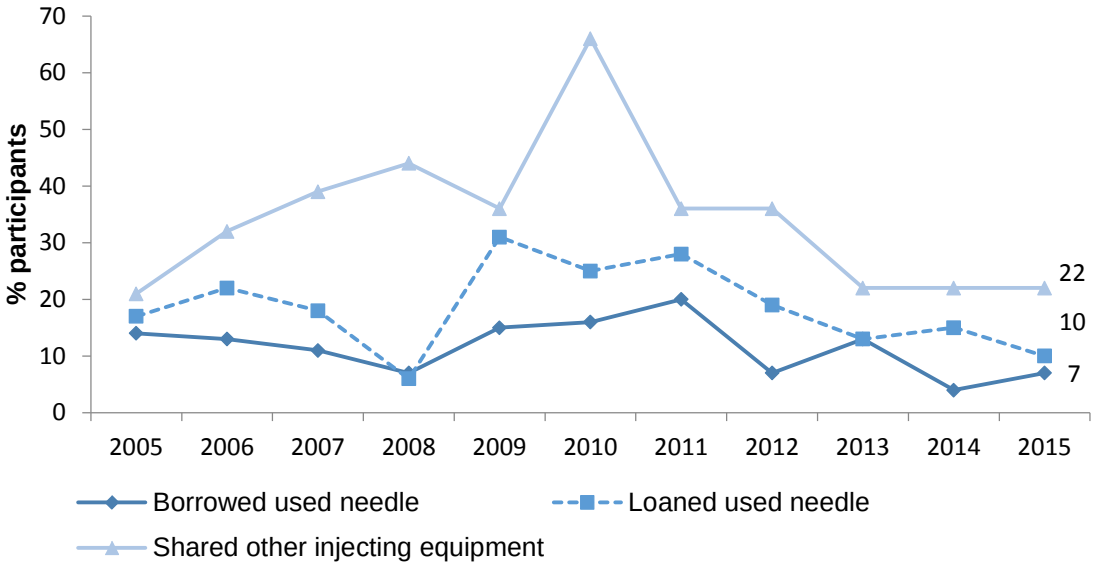
access them. Filters reported as being available were cigarette filters (76%), wheel filters (48%), and cotton filters (14%).

6.4.3 Sharing of injecting equipment

As Figure 40 shows, the numbers sharing injecting equipment have been relatively low and stable in recent years: 7% of participants reported borrowing a used needle in the past month; 10% reported lending a used needle in the past month; and 22% reported sharing other equipment (e.g. spoons or mixing containers, filters, tourniquets, water, swabs).

Among the seven participants who had borrowed a used needle in the past month, two reported they borrowed from their regular sex partner, and five from a close friend. Two of the seven reported borrowing once, two twice, and three three-to-five times. Six reported that one person had used a needle before them and one reported that two people had.

Figure 40: Borrowing and loaning of needles and other equipment in the previous month, 2005 to 2015



Source: Queensland IDRS PWID interviews

As in recent years, two in five participants (41%) re-used one of their own needles at least once in the previous month. The median number of times was three-to-five (range 1–>10, n = 39).

In regard to re-use of other equipment, spoons/mixing containers remained the items most commonly re-used, whether they were participants' own or someone else's (Table 26).

Table 26: Other equipment re-used in the previous month, 2014 and 2015

Other equipment	Other equipment re-used			
	Own		After someone else	
	2014 (n = 55) %	**2015 (n = 47) %**	2014 (n = 22) %	**2015 (n = 22) %**
Spoons/mixing containers	82	**70**	77	**64**
Filters	7	**11**	9	**23**
Tourniquets	35	**43**	14	**36**
Water	13	**11**	14	**27**
Swabs	0	**2**	0	**0**
Wheel filter	6	**9**	0	**5**
Other	2	**4**	0	**0**

Note: Multiple responses allowed.
Source: Queensland IDRS PWID interviews

In 2015, the use and re-use of injecting equipment followed a similar pattern to 2014, with the 1 ml needle and syringe continuing to be the most common piece of injecting equipment, and the piece of equipment most commonly re-used (Table 26).

Table 26: Use and re-use of injecting equipment in previous month, 2014 and 2015

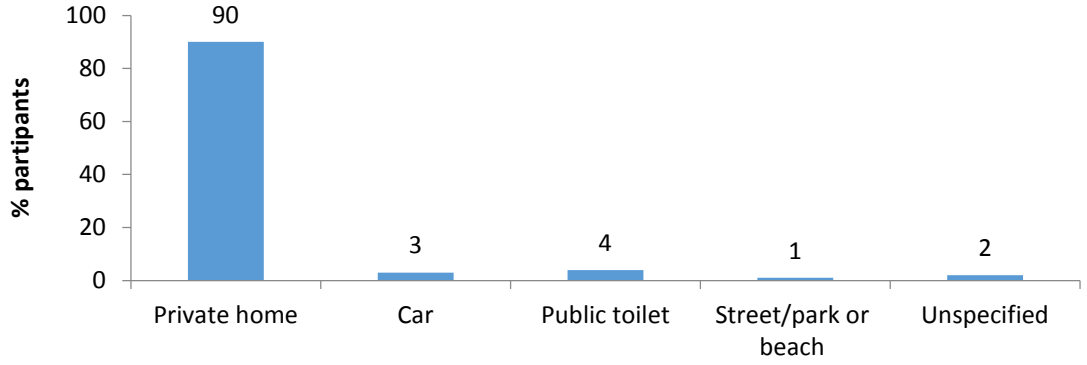
	Used in last month		Re-used in last month	
	2014 n = 94 %	**2015 n = 97 %**	2014 n = 94 %	**2015 n = 96 %**
0.5 ml needle and syringe	0	**2**	1	**1**
1 ml needle and syringe	85	**86**	36	**31**
3 ml syringe (barrel)	28	**23**	9	**10**
5 ml syringe (barrel)	6	**5**	0	**0**
10 ml syringe (barrel)	7	**8**	0	**1**
20 ml syringe (barrel)	7	**6**	1	**1**
Detachable needle (tip)	18	**4**	3	**1**
Winged vein infusion set (butterfly)	12	**14**	1	**3**
Wheel filter	13	**11**	2	**0**
Commercial cotton filter	43	**17**	0	**0**

Note: Multiple responses allowed.
Source: Queensland IDRS PWID interviews

6.4.4 Injection site, and location

The most likely site of participants' most recent injection was the arm (71%), followed by hand/wrist (20%), leg (4%), neck (3%), and groin (2%). Most participants had their most recent injection in a private home (Figure 41).

Figure 41: Location where participant last injected, 2015



Source: Queensland IDRS PWID interviews

6.4.5 Injection-related issues

Four in five of those who had experienced an injection-related problem (n = 58) reported difficulty injecting (Table 27). This is a problem that has increased over time (31% reported difficulty injecting in 2005).

Of those who reported a dirty hit, one-third specified an amphetamine with the remainder specifying an opioid as the main drug involved.

Table 27: Injection-related issues experienced in the preceding month[a], 2005 to 2015

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	%	%	%	%	%	%	%	%	%	%	%
Difficulty injecting	31	38	41	38	38	30	49	53	68	63	**81**
Scarring/bruising	37	55	57	46	64	41	80	60	60	57	**69**
Dirty hit	14	25	31	20	31	11	13	23	21	24	**12**
Abscess/infection	5	8	6	8	15	8	13	12	15	2	**9**
Thrombosis	7	9	<1	4	9	4	2	14	8	8	**9**
Overdose	3	4	4	3	1	2	0	2	2	8	**2**

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

6.5 Opioid and stimulant dependence

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

In 2014, 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 value 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.

Opioids

Of those who had recently used an opioid and commented (n = 85), the median SDS score was seven (mean = 7, range 0–15), with 72% scoring five or above. There were no significant differences regarding gender. Of those who scored five or above (n = 50), 12% did not specify a specific opioid, 44% specified heroin, 20% morphine, 14% buprenorphine, 4% oxycodone, 4% fentanyl, and 2% methadone.

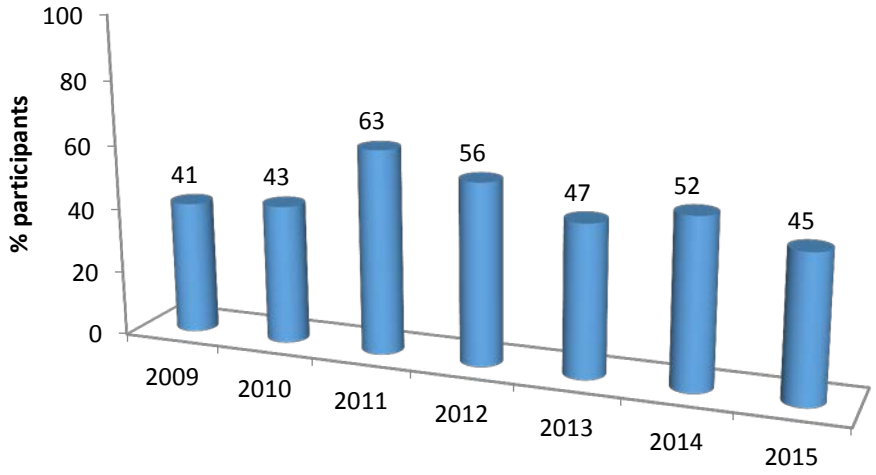
Stimulants

Of those who had recently used a stimulant and commented (n = 64), the median SDS score was two (mean = 3.12, range 0–12), with 41% scoring four or above. Males had a significantly higher ($p < 0.05$) mean stimulant SDS score than females (3.67 compared with 1.95), and there was a sex difference ($p < 0.05$) among those who scored four or above: 19% of females compared with 81% of males. Of those who scored four or above (n = 26), all but one specified that their responses were about methamphetamines.

6.6 Mental health problems, psychological distress, and general health

Just under half of participants reported a mental health problem (Figure 42), with depression and anxiety continuing to be the two most common problems (Table 28).

Figure 42: Percentage of participants with self-reported mental health problem, 2009–15



Source: Queensland IDRS PWID interviews

Table 28: Mental health in preceding six months, 2014 and 2015

	2014 N = 100 %	**2015** **N = 98** **%**
Self-reported mental health problem	52	**45**
Problems reported	(n = 52)	**(n = 44)**
Depression	64	**73**
Anxiety	65	**59**
Post-traumatic stress disorder	14	**0**
Schizophrenia	12	**9**
Manic-depression/bipolar	12	**7**
Panic	8	**0**
Drug induced psychosis	6	**5**
Mania	6	**0**
Obsessive-compulsive disorder	6	**0**
Other psychosis	4	**0**
Paranoia	4	**6**
Any personality disorder	4	**0**
Other	4	**0**
Attended mental health professional	64	**66**

Note: Multiple responses allowed
Source: Queensland IDRS PWID interviews

Two-thirds of participants with a self-reported mental health problem (n = 44) had attended a health professional for their mental health problem in the previous six months (Table 28). The mental health professional who participants (n = 29) had most likely attended in the previous month was a GP (76%), a psychologist (35%), a psychiatrist (24%), or a counsellor (17%). Those who did not attend a mental health professional (n = 15) gave a variety of reasons, with the most common being 'self-treated', 'previous bad experience/s with mental health services', and 'didn't think it was serious enough'.

Two-thirds of those who attended a mental health professional were prescribed one or more of the following medications: benzodiazepines (e.g. Valium®), followed by anti-psychotics (e.g. Seroquel®) and anti-depressants (e.g. Avanza®).

The Kessler Scale of Psychological Distress (K10)

The Kessler Scale of Psychological Distress (K10) was administered. This is 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 2013 National Drug Strategy Household Survey (NDSHS) (AIHW, 2014) provided the most recent Australian population norms for the K10.

As shown in Table 29, levels of psychological distress in 2015 were similar to 2014, and both were vastly more likely to score high distress or very high distress than the general population (18 years and over) in the NDSHS.

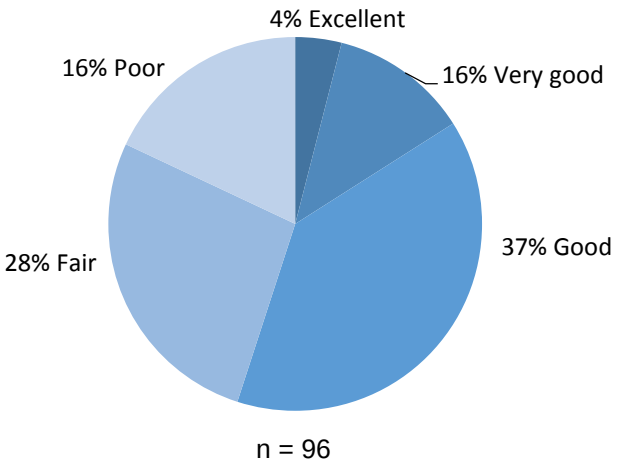
Table 29: K10 scores, 2014 and 2015

K10 score	Level of psychological distress	2014 n = 96 %	**2015 n = 97 %**	**2013 NDSHS %**
10–15	No/low distress	25	**26**	69
16–21	Moderate distress	25	**22**	21
22–29	High distress	25	**31**	7
30–50	Very high distress	25	**22**	3

Note: the extent to which cut-offs derived from population samples can be applied to the IDRS population is yet to be established and, therefore, these findings should be taken as a guide only.
Source: Queensland IDRS PWID interviews; AIHW 2014

Self-rating of health showed that one-in-five participants considered their general health to be very good or excellent, with the most common rating being good (Figure 43).

Figure 43: Self-reported general health status, 2015



Note: The percentage total may not equal 100 due to rounding.
Source: Queensland IDRS PWID interviews

Key experts report on health

Key experts reported a number of health issues:

PWID are an ageing population, mostly with long injecting histories and they are susceptible to injecting-related problems. Use of pharmaceutical drugs without adequate filtering was a cause of vein damage. One key expert said that PWID '*might have been using heroin for years but then have trouble when they switch to injecting Suboxone*.'

Ice use in particular had negative health effects because users were not hydrating or getting adequate rest. As one key expert pointed out, '*the constant nature of use means they are often run-down and therefore susceptible to rashes, sores, and infections*'. Sleep deprivation from binging on ice was seen as a causal factor for anxiety and depression, and key experts commented on the flat, depressed affect that made engaging clients therapeutically very difficult. Also '*intensive patterns of use of ice—binging—lead to psychotic episodes'*.

Social anxiety was common among PWID, particularly those who had been in jail: '*They face barriers to social interactions—struggling to talk with people who haven't been incarcerated or in jail'.*

Cannabis was reported as causing gastric problems (vomiting and diarrhoea) even among PWID who were long-term cannabis users.

Key experts reported an increase in clients with HIV and Hep C, together with an increased interest in treatment.

6.7 Naloxone program and distribution

Naloxone is a short-acting opioid antagonist that has been used for over 40 years to block the effects of opioids. It is the frontline medication for the reversal of heroin and other opioid overdoses. In Australia, use of naloxone for the reversal of opioid effects has been limited to medical doctors (or those authorised by medical doctors such as nurses and paramedics). In 2012, a take-home naloxone program commenced in the Australian Capital Territory as part of a comprehensive overdose-response package. The program made naloxone available to peers and family members of PWID. Shortly after, a similar program started in New South Wales, and Queensland and other states have since followed suit (for more information, refer to http://www.cahma.org.au/Naloxone.html and http://www.naloxoneinfo.org/).

Since 2013, a series of questions have been asked about take-home naloxone and naloxone more broadly. Three-quarters of those who commented had heard of naloxone; among these respondents, four-in-five reported that naloxone was used to 'reverse heroin' (Table 29).

Participants who had not completed training in naloxone administration were asked what they would do if they witnessed someone overdose or found someone whom they suspected had overdosed. Ninety-five per cent reported that they would call 000, while 61% reported that they would perform mouth-to-mouth cardiopulmonary resuscitation (CPR) (Table 29).

Nearly all participants reported that they would be willing to administer naloxone after an overdose, and nearly all would want peers to give them naloxone if they themselves had overdosed (Table 29).

Table 29: Take-home naloxone program and distribution, 2014 and 2015

	2014 n = 83 %	2015 n = 66 %
Heard of naloxone	82	**74**
Naloxone description	n = 61	**n = 44**
Reverses heroin	72	**80**
Helps start breathing	10	**18**
Re-establishes consciousness	33	**27**
Other	13	**16**
Heard of the take-home naloxone program	n = 83	**n = 65**
Yes	35	**57**
No	61	**43**
Unsure	1	**0**
Actions if witness an overdose	n = 81	**n = 62**
Turn victim on side	37	**36**
Mouth-to-mouth CPR	47	**61**
Call 000	95	**95**
Stay with victim	59	**53**
Other remedies	20	**16**
If naloxone was available in this way, would you:	n = 79	**n = 44**
Carry naloxone if trained	81	**88**
Administer naloxone if someone overdosed	98	**96**
Want peers to give you naloxone if you overdosed	96	**93**
Stay with person after giving them naloxone	100	**98**

Note: Multiple responses allowed.
Source: Queensland IDRS PWID interviews

In 2015, only one participant reported having completed a course and received a prescription for Narcan / naloxone. The person had not yet used the Narcan / naloxone to resuscitate someone who had overdosed.

6.8 Driving risk behaviour

Driving behaviour was last assessed in 2013. Of those who had driven in the past six months in 2015, two-thirds reported driving soon after having taken an illicit drug (81% in 2013; Table 30). Heroin was the drug most commonly taken prior to drug driving in both 2015 and 2013; however, in 2015, 31% reported having used ice before driving compared with 8% in 2013.

The median number of times participants reported driving soon after taking an illicit drug was 24 (range 1–180). On the most recent occasion, 45% had driven within 30 minutes of consumption.

Table 30: Driving after licit and illicit drug use in preceding six months, 2013 and 2015

	2013	**2015**
	%	**%**
	n = 78	**n = 87**
Driven in the past 6 months	60	**67**
	n = 47	**n = 58**
Driven under the influence of alcohol	11	**12**
Driven soon after taking an illicit drug	81	**67**
Drugs taken last time participant drug drove[a]	n = 38	**n = 39**
Heroin	40	**44**
Ice	8	**31**
Cannabis	26	**10**
Morphine	18	**8**
Benzodiazepines	8	**8**
Speed	3	**5**
Buprenorphine-naloxone (illicit)	0	**5**
Methadone (illicit)	13	**5**
Oxycodone	3	**3**
Base	0	**3**
Other	0	**3**
Buprenorphine	5	**0**
Tested positive on police roadside drug-driving test in past 6 months	n = 2	**n = 5**

[a] Multiple responses allowed.

Source: Queensland IDRS PWID interviews

7 LAW ENFORCEMENT-RELATED TRENDS ASSOCIATED WITH DRUG USE

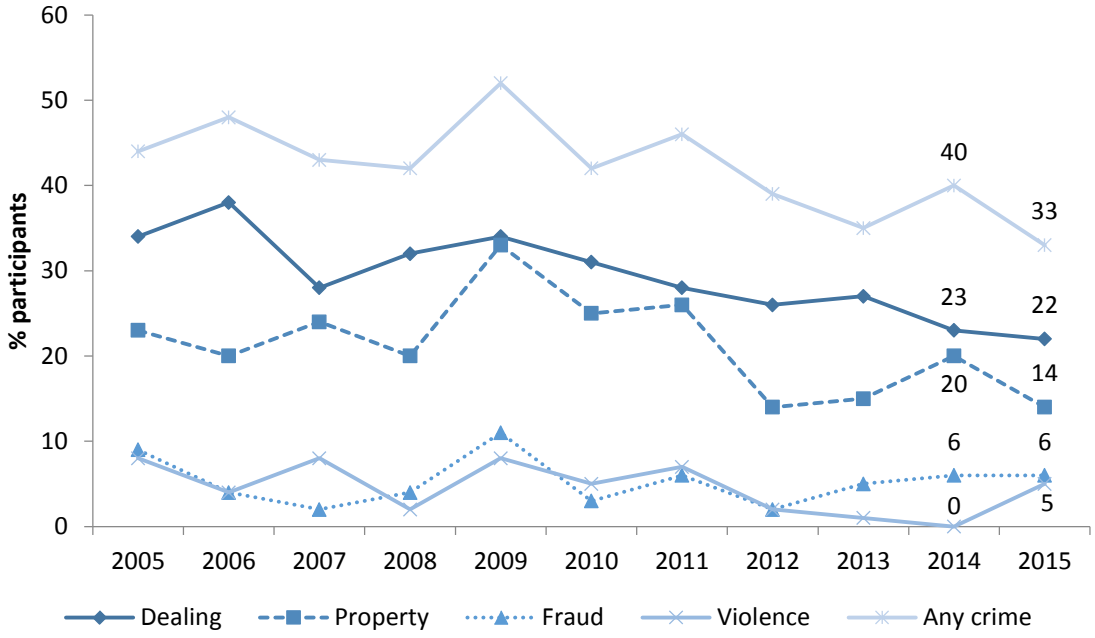
KEY POINTS

- **Criminal involvement reported in the previous month:** 33%. As in previous years, dealing was the most often reported criminal activity followed by property crime.
- **Arrested in the previous 12 months:** 38%. The most common reason was use/possession of drugs.
- **Money spent on illicit drugs:** just over half of the sample (56%) reported spending money on illicit drugs the day before, spending a median of $100.

7.1 Reports of criminal activity

The pattern of self-reported criminal activity has been relatively stable over the last decade, with dealing being the crime most commonly reported, followed by property crime (Figure 44). In 2015, a third of participants (n = 96) reported recent criminal activity.

Figure 44: Prevalence of criminal involvement in previous month, 2005 to 2015



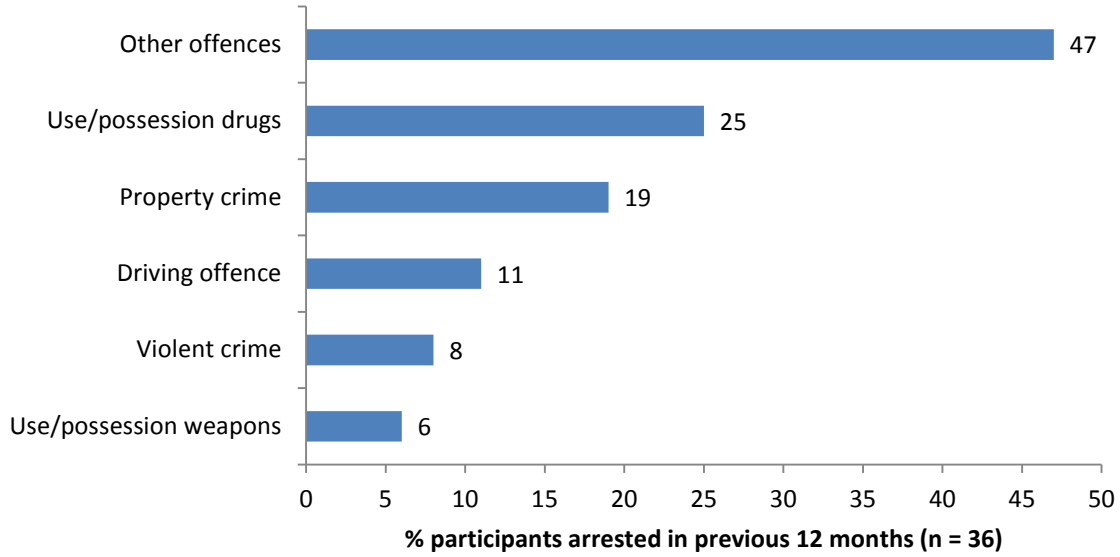
Note: Multiple responses allowed.
Source: Queensland IDRS PWID interviews

Eleven per cent of all participants reported that they had been a victim of a crime involving violence in the previous month. On the last occasion that this had happened in the previous month, four of the eleven participants thought the perpetrator was under the influence of alcohol, three drugs, and three both alcohol and drugs; the other participant didn't know.

7.2 Arrests

Thirty-eight per cent of all participants reported being arrested in the preceding 12 months (40% in 2014). A quarter of those arrested (25%) reported being arrested for use/possession of drugs (Figure 45).

Figure 45: Main reasons for arrest in preceding 12 months, 2015



Note: Multiple responses allowed
Source: Queensland IDRS PWID interviews

Table 31 presents the most recent available data for drug-related arrests made by the Queensland Police Service. In 2013–14 there was a similar pattern of arrests to 2012–13, with the majority of arrests related to cannabis (62%), followed by amphetamine-type stimulants (17%). There were a total of 32,391 arrests compared with 28,350 in 2012–13. Data for 2014–15 were unavailable at the time of publication.

Table 31: Drug-related arrests by Queensland Police Service by drug type, 2013–14

	Consumer	Provider	Total
Cannabis	17,835	2384	20,219
Amphetamine-type stimulants[a]	5958	814	6772
Other and unknown	3458	610	4068
Steroids	462	79	541
Heroin and other opioids	290	28	318
Hallucinogens	195	47	242
Cocaine	191	40	231
Total	**28,389**	**4002**	**32,391**

[a] includes amphetamine, methylamphetamine, and phenethylamines
Note: consumer = use, possession or administering for own use; provider = importation, trafficking, selling, cultivation and manufacture.
Source: Australian Crime Commission, 2015

Table 32 shows the number of seizures by the Queensland Police Service and the Australian Federal Police for each drug type along with their weight. Data for 2014–15 were unavailable at the time of publication.

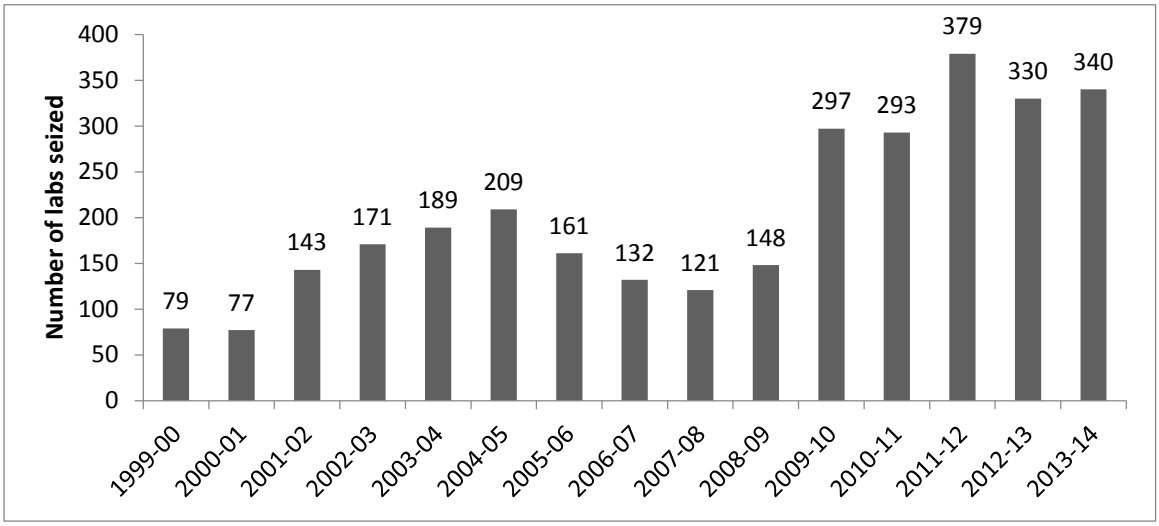
Table 32: Queensland drug seizures by police service and drug type, 2013–14

	Police force	No of seizures	Weight (grams)
Cannabis	QPS	15,712	913,911
	AFP	103	761
Amphetamine-type stimulant	QPS	4806	26,263
	AFP	271	283,457
Heroin	QPS	191	1986
	AFP	6	4232
Other opioids	QPS	3	0
	AFP	5	218
Cocaine	QPS	155	2809
	AFP	81	10,992
Steroids	QPS	101	1881
	AFP	1	2
Hallucinogens	QPS	29	2024
	AFP	9	39
Other and unknown drugs	QPS	836	59,983
	AFP	90	2,233,158

Note: 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 Australian Federal Police and Queensland Police Service.
Source: Australian Crime Commission, 2015

Nationally, a total of 744 clandestine labs were detected in the 2013–14 financial year (757 in 2012–13). In Queensland there were 340 detections, with 79% being an amphetamine-type stimulant (ATS; excluding MDMA) labs (Figure 46). Most of the detections in Queensland continued to be addict-based labs. Data for 2014–15 were unavailable at the time of publication.

Figure 46: Clandestine labs seized in Queensland from 1999–2000 to 2013–14



Source: Australian Crime Commission, 2015

7.3 Expenditure on illicit drugs

Just over half of the sample (56%) reported spending money on illicit drugs the previous day. The median amount spent was $100 (range $15–$600). A break-down of expenditure is shown in Table 33, with the most common range being $100 to $199.

Table 33: Expenditure on illicit drugs on previous day, 2009 to 2015

Expenditure	2009 N = 70 %	2010 N = 99 %	2011 N = 102 %	2012 N = 94 %	2013 N = 99 %	2014 N = 100 %	**2015** **N = 98** **%**
Nothing	26	44	46	46	48	57	**44**
Less than $20	7	0	2	3	4	1	**1**
$20 to $49	14	8	11	10	11	4	**5**
$50 to $99	13	14	13	18	14	7	**11**
$100 to $199	20	16	20	10	15	18	**20**
$200 to $399	17	10	6	11	6	7	**11**
$400 or more	0	7	2	3	2	5	**7**
Median expenditure	$100	$100	$100	$70	$77.5	127.50	**100**

Source: Queensland IDRS PWID interviews

8 SPECIAL TOPICS OF INTEREST

KEY POINTS

- **Hepatitis C testing:** 90% were tested with 60% reporting a positive result. Of these (n = 49), 57% were screened or tested for RNA (PCR test).

  Most participants revealed a moderately good understanding of HCV.

- **Blood donations:** of those who commented (n = 74), 18% reported giving blood in their lifetime and 25% had commenced injecting drug use before donating.

- **Oxycodone use:** of those who commented (n = 88), 43% (58% in 2014) reported ever using any form of oxycodone. Use of oxycodone in the previous six months was most commonly Reformulated OxyContin followed by Original Oxycontin.

8.1 Hepatitis C testing

Hepatitis C (HCV) is a major public health problem in Australia. Recent reports estimate 230,000 people living in Australia have chronic HCV, with up to 95% of newly diagnosed HCV infections occurring due to injecting risk behaviour (The Kirby Institute, 2015). Treatment options for HCV are currently experiencing rapid developments; however, despite efforts to improve access to anti-viral therapy for HCV infection—and hence treatment outcomes—uptake of chronic HCV infection treatments remains low among people with HCV who inject drugs (Iversen and Maher, 2015).

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

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

The aims of this module were to a) determine rates of, and referrals to, PCR testing; and b) determine the extent of knowledge possessed by PWID regarding HCV transmission.

Most (90%) of our Queensland sample had been tested for HCV antibodies (anti-HCV) in their lifetime with 60% reporting a positive result (Table 34). The median number of reported anti-HCV tests was four (range 1–60). The majority of participants reported the test had been ordered by their regular GP (49%), followed by an OST prescribing doctor (14%), a liver specialist (10%) and an OST clinic (4%).

Of those who commented (n = 49), 57% reported a PCR test to determine if the virus was active, with the median number of PCR tests being 2.5 (range 1–10). The majority of participants reported the PCR test had been ordered by their regular GP (36%), followed by an OST prescribing doctor (14%), a liver specialist (7%), and an OST clinic (4%).

All participants who had screened positive to an antibody test or a PCR test were asked what they remember discussing with the health professional at the time of diagnosis. While 22% couldn't remember what they were told, 24% remembered discussing the long-term effects of HCV, 12% the different strains of HCV (genotypes), 10% the types of tests needed, 10% the available treatments for HCV, 10% the impact of dietary choices on HCV, and 5% the benefit of limiting alcohol intake.

Table 34: Hepatitis C testing, 2015

	n = 92
% Ever tested for HCV	90
% Antibody positive result	(n = 82)
Yes	60
No	39
Unsure	1
% Ordered the antibody test	(n = 49)
Regular GP	49
OST clinic	4
OST doctor	14
Liver specialist	10
Other	16
Unsure	6
Median number of times tested for antibodies ever (range)[a]	4 (1–60)
% Screened or tested for RNA (PCR test)	(n = 49)
Yes	57
No	33
Unsure	10
% Ordered the PCR test	(n = 28)
Regular GP	36
OST clinic	4
OST doctor	14
Liver specialist	7
Other	18
Unsure	21
Median number of times tested for RNA ever (range)[b]	2.5 (1–10)
% Discussed by a health professional when told HCV antibody or RNA positive	(n = 41)
Long-term effects of HCV	24
Genotypes	12
Different tests	10
Available treatments	10
Alcohol intake	5
Dietary choices	10
Other	2
Don't know/ can't remember	22

[a] Among those who were ever HCV tested and commented
[b] Among those who were ever PCR tested and commented
Source: Queensland IDRS PWID interviews

Participants were also asked to endorse a list of statements related to their perceptions of HCV as either true or false (Table 35). The majority of participants believed the statements to be false, indicating most participants had a moderately good understanding of the virus.

Table 35: Perceptions of HCV, 2015

	n = 93 %
Don't feel sick I must have cleared HCV	
True	5
False	80
Unsure	15
Don't have symptoms I can't pass on HCV	
True	4
False	84
Unsure	12
Treatment for HCV works only for a few people	
True	28
False	54
Unsure	18
I have HCV, I can't get it again	
True	24
False	65
Unsure	12
If I wait, HCV will clear up on its own	
True	13
False	76
Unsure	11
I can wait until I feel real sick before seeking treatment	
True	13
False	79
Unsure	9
I can't get HCV treatment if still injecting drugs	
True	19
False	62
Unsure	18

Source: Queensland IDRS PWID interviews

8.2 Blood donations

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

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

Of those who commented (n = 74), 18% reported that they had given blood in their lifetime. A quarter (25%) of those that had given blood reported that they had commenced injecting drug use before donating blood (Table 36).

Table 36: Blood donations, 2015

	n = 74 %
Ever donated blood	18
Injected before blood donation*	25

* Among those who had ever donated blood
Source: Queensland IDRS PWID interviews

8.3 Oxycodone use

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

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

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

Post-marketing surveillance of the Reformulated OxyContin® and generic oxycodone formulations is underway in Australia (Degenhardt, Larance, Bruno et al., 2015). Early findings indicate that, among a prospective cohort of people who tamper with pharmaceutical opioids, there has been a decline in national pharmacy sales of 80 mg OxyContin® (the dose most commonly used and injected among people who inject drugs), as well as a reduction in prevalence of overall use and injection, street price, and attractiveness for misuse via tampering (Degenhardt, Bruno, Lintzeris et al., 2015; Larance, Lintzeris, Bruno et al., 2015; Peacock, Degenhardt, Hordern et al., 2015; Peacock, Degenhardt, Larance et al., 2015).

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

As shown in Table 37, in 2015, 43% of those who commented (n = 88) reported ever using any form of oxycodone (licit or illicit). Of those who reported using oxycodone in the previous six months (n = 38), 38% reported using the Reformulated OxyContin® brand tablets (licit or illicit) and 37% reported using the original (non-tamper resistant) OxyContin® brand tablets.

Table 37: Lifetime and recent use of oxycodone (any form), 2014 and 2015

	2014 n = 83 %	**2015** **n = 88** **%**
Ever used oxycodone (any form)	58	**43**
Recent use of oxycodone (any form)[a]	n = 46	**n = 38**
Reformulated OxyContin®	24	**38**
Original OxyContin®	57	**37**
Generic controlled-release oxycodone	n.a.	**14**
Endone®	9	**11**
Targin®	4	**5**
OxyNorm® tabs	4	**3**
OxyNorm® liquid	0	**0**
OxyNorm® Solution	0	**0**
Proladone®	0	**0**

[a]Among those who reported ever using oxycodone. Note: Multiple responses allowed
Source: Queensland IDRS PWID interviews

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