Harm Reduction Australia

2024 National AOD Data Report

Annual Overview of Drug Issues in Australia

January 2025

ACKNOWLEDGMENTS

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HRA wishes to acknowledge that the data presented in this report has been collated and/or taken directly from the routine alcohol and other drugs (AOD) data sets produced by the Australian Institute of Health and Welfare (AIHW), National Drug and Alcohol Research Centre (NDARC), UNSW and the Kirby Institute, UNSW.

This is an unfunded report produced by HRA for the benefit of those working in the harm reduction and wider AOD sectors. No government funding has been used in the production of this report.

About HRA

Harm Reduction Australia is a national advocacy organisation committed to reducing the health, social and economic harms potentially associated with drug use and drug policies and laws. HRA has a diverse membership including those working in the Alcohol & Other Drugs (AOD) sector, parliamentarians, government employees, people who use drugs, interested family members, young people and other individuals wanting to advocate for the continuation and expansion of harm reduction and drug policy reform in Australia. The Board and members of HRA are people who understand the complexities of drug use and are advocating for the safest, most effective ways to protect the wellbeing of individuals, families and communities. As an organisation, we aim to ensure that drug policies in Australia first and foremost do no harm and provide real benefit to Australian society through evidence-based and humane responses to drug use. HRA takes a non-judgmental approach to drug use within society and is dedicated to ensuring that Australia has drug policies and laws that are just, effective and humane.

Suggested citation: Harm Reduction Australia. (2025). *2024 National AOD Data Report: Annual overview of drug issues in Australia*. HRA.

FOREWORD

For many years Harm Reduction Australia (HRA) has been concerned at the lack of a comprehensive annual national report on drug use issues affecting the community.

To date, the only annual report available is produced by the Australian Criminal Intelligence Commission Illicit Drug Data Report with a heavy focus on law enforcement data and interpretations. While some health-based data is included in this report it is limited and given less prominence than law enforcement data.

It is also worth noting that Australia has a strong network of national research centres focused on alcohol and other drug use and related issues. These centres provide a plentiful source of regular and one-off reports covering a range of factors and indicators, yet there is no co-ordinated annual report produced from these data sets and reports.

HRA believes that this current situation whereby the only annual report on drug issues is produced by a law enforcement authority, with a strong focus on arrests and interdiction, signals the issue as primarily being a criminal rather than a health matter for Australians.

Despite our limited resources, which is entirely self-inflicted given our avoidance of government funding in order to advocate without fear or favour, the HRA team have taken on the task of collating some existing data and information to provide the start of an annual process to report on drug use issues from a health, harm reduction and human rights perspective.

Our goal is to develop the HRA National AOD Data Report into more than a valuable central source of information and data by increasing the level of trend analysis and commentary for wider public consumption in future years.

Your feedback is welcome, especially on how we may improve the report in years to come.

Our thanks go to Dr Annie Madden AO, HRA Executive Director and Erica Franklin, HRA and Pill Testing Australia Project Officer for their incredible efforts in producing this first report.

Gino Vumbaca OAM
President
Harm Reduction Australia

INTRODUCTION

This report provides a comprehensive overview of the key national data sources on alcohol & other drugs (AOD) and harm reduction in 2024. Australia is in the fortunate position of having a collection of routine national data sets, early-warning systems and trend-based reports for monitoring drug use and related harms in the Australian community including the National Drug Strategy Household Survey and the Australian Drug Trends National Reports, to name just two. These data sources not only inform public health policies and programs but provide critical insights into the evolving landscape of drug use and harm reduction in Australia.

- National Drug Strategy Household Survey.
- National Drug-Induced Deaths/Overdose Data.
- National Opioid Pharmacotherapy Statistics Annual Data.
- Ecstasy and Related Drugs Reporting System.
- Illicit Drug Reporting System.
- Australian Needle and Syringe Program Survey.
- Needle and Syringe Program National Minimum Data Collection.

In the pages that follow you will find overview summaries of each data set, with a specific focus on illicit drug use, drug-related harms and harm reduction initiatives.

the report aims to empower those working in harm reduction and the wider AOD sector with the knowledge needed to support their work

As valuable as these data sources are, currently there is an absence of a centralised national report that collates key information from each of these data sources in one place. Currently, those with an interest in this data are forced to visit multiple websites and read often lengthy reports to gain the key information they need to inform their advocacy work and program development.

HRA has therefore designed this report so that those working in and around harm reduction can find the information they are seeking quickly, easily, and in one place. This report covers key findings from:

Each summary includes: who the report is produced by, when reporting commenced, the number of reports, the purpose of the report, the data collection method and it's limitation, and a summary of the key findings of the most recent report.

By presenting this information in a convenient and accessible format, the report aims to empower those working in harm reduction and the wider AOD sector with the knowledge needed to support their work. While this report aims to consolidate the most relevant national data sources, it acknowledges that there is a wider body of research and reporting on harm reduction that is not covered here.

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DATA SOURCES SUMMARY

AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE

National Drug Strategy Household Survey

Purpose	To monitor national estimates on patterns in legal and illegal drug use, attitudes, and perceptions related to drugs among the Australian population. This survey provides a broad view of population-level trends in drug use and public attitudes.
Methodology	The NDSHS is a structured survey conducted every three years that collects self-reported data from a sample of individuals aged 14 years and older living in private dwellings across Australia. Participants self-report answers to questions about their use of legal and illegal substances, perceptions of drug-related issues and attitudes towards drug-related policies.
Limitations	It excludes specific groups (e.g., homeless individuals, institutionalized populations), it does not capture the full scope of drug use among marginalized groups.

Alcohol, Tobacco and Other Drugs – Health Impacts

Purpose	To identify and track national trends in drug-induced deaths (from both acute toxicity and chronic use), hospitalisation and ambulance attendances. This data aims to identify at-risk populations and support health care planning.
Methodology	The AIHW annually compiles reports and data from multiple sources. This report covers AIHW reporting drug related ambulance attendance, hospitalisations, and drug induced deaths. Ambulance Attendance data is collected by the National Ambulance Surveillance System (NASS), which reviews clinical records from ambulance services in multiple jurisdictions. Hospitalization data derived from the National Hospital Morbidity Database (NHMD), which records episode-level details of admitted patient care

	across Australia's private and public hospitals. Drug-induced deaths data is collected from the National Mortality Database and the National Coronial Information System (deaths certified by a coroner).
Limitations	The AIHW's reporting on drug-related health impacts is limited by the inherent constraints of its data sources, including time lags, scope restrictions, and variability in data collection methods. Delays in drug-induced death data due to certification and coronial processes can lead to incomplete reporting of recent trends. Similarly, hospitalization and ambulance attendance data focus on acute incidents and admitted care, missing broader chronic harms and less severe cases.

National Opioid Pharmacotherapy Statistics Annual Data

Purpose	NOPSAD monitors Australia's opioid pharmacotherapy treatment landscape to identify changes in treatment delivery, patterns of opioid dependence, and client demographics.
Methodology	NOPSAD collects data annually on the number of clients receiving pharmacotherapy for the treatment of opioid dependence, the number of health professionals prescribing opioid pharmacotherapy drugs, dosing points that clients attend to receive their medication, and client demographics.
Limitations	The snapshot methodology does not capture the full scope of treatment activity throughout the year. Clients who do not present on the snapshot day (e.g. takeaway clients) may not be counted. It also does not capture information on individuals who seek alternative treatments outside the pharmacotherapy system. Additionally, the differences in jurisdictional data collection methods impact the data reported and comparability by jurisdiction and year.

NATIONAL DRUG AND ALCOHOL RESEARCH CENTRE

Ecstasy and Related Drugs Reporting System

Purpose	This national monitoring systems intends to provide an early-warning system that identifies emerging trends in party drug markets, including changes in drug use patterns, drug markets and drug-related harms and risks.
Methodology	The EDRS annually gathers data from structured surveys with regular users of ecstasy and other stimulants in urban settings and analyses this data with information contributed by law enforcement and health professionals.
Limitations	It focuses on a small sample size of regular users in urban areas, so does not capture patterns among occasional users, those in rural or regional settings, or people who regularly use drugs other than ecstasy and related stimulants.

Illicit Drug Reporting System

Purpose	This national monitoring systems intends to provide an early-warning system that identifies emerging trends among people who inject drugs, including changes in drug use patterns, drug markets and drug-related harms and risks.
Methodology	The IDRS annually conducts structured surveys with people who regularly inject drugs at harm reduction services in urban settings and analyses this data with information contributed by law enforcement and health professionals.
Limitations	It focuses on a small sample size of regular injectors in urban areas, so does not capture patterns among occasional users, those in rural or regional settings, or people who do not inject drugs.

KIRBY INSTITUTE

Australian Needle and Syringe Program Survey

Purpose	The ANSPS is intended as early-warning system to monitor trends in injecting practices and sexual behaviour, and the prevalence of BBVs like HIV and hepatitis C, among people who inject drugs (PWID).
Methodology	Conducted annually over a two-week period by the Kirby Institute, the ANSPS is a structured survey of people who inject drugs attending participating NSPs across Australia. The voluntary collects data on demographics, injecting behaviours, and blood-borne virus prevalence.
Limitations	The survey only captures client data from participating NSP located in predominantly metropolitan areas, which may impact the generalisability of results as rural and remote areas are underrepresented, and it excludes PWID who obtain syringes from alternative sources. NSP client participation in the survey is voluntary and the ANSPS has a low response rate, ranged from 34% to 45% (2019-2023).

Needle Syringe Program National Minimum Data Collection

Purpose	It provides a national and jurisdictional overview of NSP service delivery including outlet type, syringe distribution, and client demographics to monitoring service coverage for PWID across Australia.
Methodology	This report annually collects data from state and territory health departments on NSP sites (primary and secondary NSPs, pharmacies, and syringe dispensing machines) nationwide, tracking outlet type, syringe distribution. It also examines client-level data collected through NSPs routine data collection at primary and secondary NSPs on a designated snapshot day.
Limitations	NSP NMDC does not include all pharmacy-based NSP services and may underestimate service use in certain areas as NSP participation is voluntary and differences in reporting practices across NSP types.

ACRONYMS

1,4-BD	1,4-Butanediol
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ANSPS	Australian Needle and Syringe Program Survey
AOD	Alcohol and Other Drugs
ATOD	Alcohol, Tobacco and Other Drugs
ATSI	Aboriginal and Torres Strait Islander
BBV	Blood Bourne Virus
EDRS	Ecstasy and related Drugs Reporting System
GBL	Gamma Butyrolactone
GHB	Gamma Hydroxybutyrate
HCV	Hepatitis C Virus
HCV RNA	Hepatitis C Virus Ribonucleic Acid
HIV	Human Immunodeficiency Virus
HRA	Harm Reduction Australia
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Australian Modification
IDRS	Illicit Drug Reporting System
LAI	Long Acting Injectable
MDMA	Methylenedioxymethamphetamine
NASS	National Ambulance Surveillance System
NCIS	National Coronial Information System
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NHMD	National Hospital Mortality Database
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NSP	Needle & Syringe Program
NSP NMDC	Needle Syringe Program National Minimum Data Collection
NSW	New South Wales
NT	Northern Territory
OAT	Opioid Agonist Therapy
OOS	Occasions of Service
OPT	Opioid Pharmacotherapy Treatment
PEIDS	Performance and Image Enhancing Drugs
PWID	People who Inject Drugs
QLD	Queensland
UNSW	University of New South Wales
SA	South Australia
SDM	Syringe Dispensing Machines
TAS	Tasmania
VIC	Victoria
WA	Western Australia

NATIONAL DRUG STRATEGY HOUSEHOLD SURVEY

Produced by: Australian Institute of Health and Welfare (since 1998)

Reporting Commenced: 1985 **Number of Reports to Date:** 13
Most Recent Report: 2023

Purpose

To monitor national estimates on patterns in legal and illegal drug use, attitudes, and perceptions related to drugs among the Australian population. This survey provides a broad view of population-level trends in drug use and public attitudes and helps to inform policies, programs, and harm reduction initiatives.

Data reported on

- Demographic data such as age, gender, ATSI, sexual orientation, gender experience, and geographic area.
- Patterns of drug use (legal and illegal substances) both recently (past 12 months) and across the participants lifetime.
- Perceptions and attitudes towards drug-related issues and policies.

Data collection method

This structured survey is conducted every three years over a five-to-six-month period. The sample is comprised of people living in private dwellings using a stratified, multistage random sampling. Stratifying the sample size by region is done to produce reliable estimates of states and territories with smaller populations. In each dwelling, the person aged 14 and over who had the most recent birthday is invited to self-complete the survey via a paper form, online or with an interviewer over the telephone.

Limitations

- **Exclusion of Marginalized Populations**: This survey excludes people who are homeless, people living in non-private dwellings (hotels, motels, boarding houses, etc.), institutional and clinical settings (hospitals, rehabs, prisons, universities etc.), and does not provide data on people who are homeless, and the territories of Jervis Bay, Christmas Islands and Cocos Island. As such the results do not accurately reflect data on the most marginalised populations.

- **Small Sample for Indigenous Populations:** Estimates for Aboriginal and Torres Strait Islander people are not reliable due to the small sample size.
- **Self-Reported Data**: The survey relies on self-reported data and cannot be verified for accuracy. Participants report drug use based on their belief of what they consumed, which may not reflect actual substances taken. Respondents may underestimate actual consumption levels, be unwilling to provide information about behaviour regarding illegal activities, incorrectly complete the survey, or mis-remember information.
- **Selection and Non-Response Bias**: As participation is discretionary the sample may be skewed by those with strong opinions, and drug users may under-participate due to stigma.
- **Methodological Changes**: There have been multiple changes in how the survey is conducted over the years, including adjustments to questions and survey methods, making it difficult to compare results across different survey periods.

MOST RECENT NDSHS REPORT: 2022-2023

Suggested Citation: Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2022-2023: Detailed findings. Drug Statistic Series, AIHW Canberra; 2024, https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey/contents/about
Link: https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey/contents/about

Key Findings

Please note, this summary provides a snapshot and overview of the key findings related to illicit drug use and harm reduction. For additional information, please refer to the full report

Data Collection Period: Collected in two stages, the first 20 July to 18 December 2022 and the second from 20 March to 31 May 2023.

Sample Size: 21,663 completed questionnaires out of 49,389 households contacted.

Illicit Drug Use

- 1/2 people (47%) have used an illicit drug in their lifetime.
- 1/5 people (17.9%) have used an illicit drug in the previous 12 months. This equates to 3.9 million people (an increase from 3.4 million in 2019).

	Lifetime Use (aged 14+)		Recent Use (aged 14+)	
	%	Estimated pop.	%	Estimated pop.
Cannabis	41%*	8.8 million *	12%**	2.5 million**
Cocaine	14%	2.9 million	5%	1 million
Ecstasy	14%*	2.9 million*	2%	400,00
Hallucinogens	12%	2.6 million	2%	500,000
Meth/amphetamine	8%	1.6 million	1%	200,000
Inhalants	6%	1.2 million	1%	300,000
Ketamine	4%	900,000	1%	300,000
Synthetic Cannabinoids	3%	600,000	(0.1%)~	20,000
GHB, GBL, 1-4-BD	1%	300,000	(0.2%)	40,000
Heroin	1%	300,000	(0.1%)~	30,00
New and Emerging Psychoactive Substances	1%	200,000	(0.1%)~	<10,000

^ Used within last 12 months
* Includes prescribed and non-prescribed use
** Non-medical/non-prescribed/illegal use
*** No questions regarding prescribed use
~ Estimate has a relative standard error between 25% and 50% and should be interpreted with caution

Cannabis
Cannabis remained the most commonly used illicit drug in 2022-2023 with 2.5 million people having used it recently.

Hallucinogens
Hallucinogen use increased from 300,000 people in 2019 having used in the previous 12 months to 500,000 people in 2022-2023.

Ecstasy
Use of ecstasy has declined since 2019 although it showed signs of rebounding in 2023.

Meth/amphetamine
People who used methamphetamine and amphetamine in 2022-2023 had mainly used ice (43%).

Opioids
Non-medical use of pain-relievers and opioids continued to decline since 2016, from 3.6% to 2.2% in 2022-2023.

Ketamine
Recent ketamine use increased from 0.9% in 2019 to 1.4% in 2022-2023.

Perceptions

Drug Problem

Participants were asked to choose what was the first drug that came to mind when hearing the term ‘a drug problem’.

			
42% **Meth/amphetamine**	**12.9%** **Cannabis**	**12.3%** **Cocaine**	**11.4%** **Heroin**

		14-17 yrs	60-69 yrs
The first drug people associated with ‘a drug problem’ varies with age.	**Cocaine**	26%	8.4%
	Cannabis	28%	12.4%
	Meth/amphetamine	17%	46%
	Heroin	5%	13.2%

Drug Policy

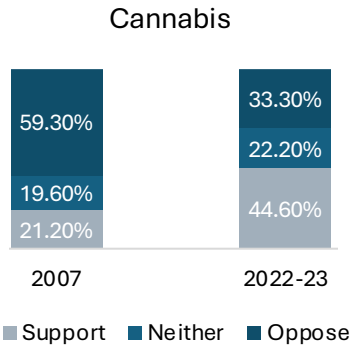
Support for harm reduction policies increased between 2019 and 2022-2023.

Harm Reduction Interventions

	2019	2022-2023
Drug Checking/ Pill Testing	57%	64% ↑
Supervised drug consumption rooms	47%	53% ↑
Take home naloxone	56%	61% ↑

Legalisation of Personal Use

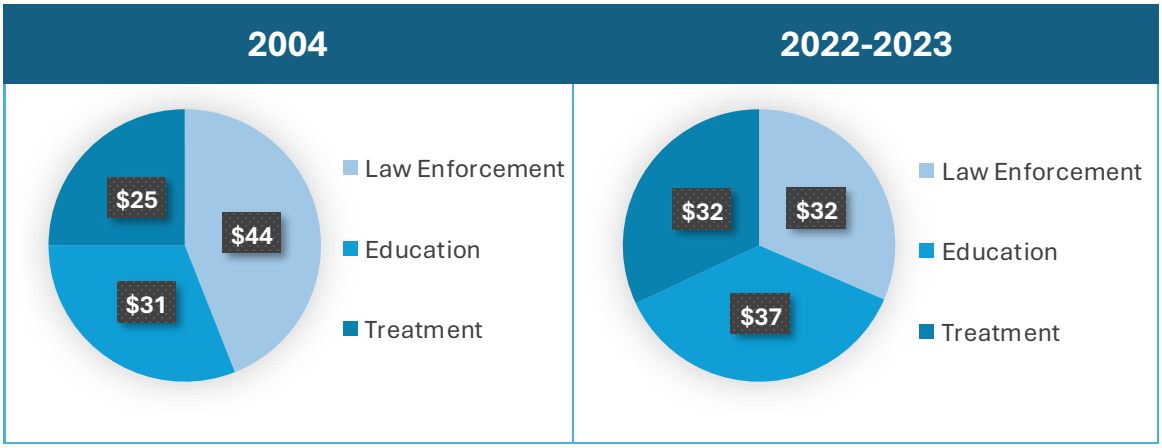
The majority of people opposed legalising illicit drugs, except for marijuana/cannabis.



	Heroin	Meth	Cocaine	Ecstasy
Support	6.6%	6.1%	10.3%	12%
Neither	6%	7.3%	11.5%	12.1%
Oppose	85.6%	86.6%	78.2%	75.8%

However, overall there has been a decrease in opposition to all illicit drugs being made legal between 2019 and 2022–2023.

Allocating $100 to Reduce Illicit Drug Use



ALCOHOL, TOBACCO AND OTHER DRUGS – HEALTH IMPACTS

Produced by: Australian Institute of Health and Welfare

Reporting Commenced: 1997 **Number of Reports to Date:** N/A*

Most Recent Update: 29.05.24

** This report is released in a web format. Numerous reports have been published since its inception as it is regularly updated from a range of sources with different frequencies in publication.*

Purpose

To identify and track national trends in drug related ambulance attendance, hospitalisation and drug-induced deaths related to both acute toxicity (drug overdose) and chronic use (determined by toxicology and pathology reports), to identify at-risk populations. It aims to aid governments, researchers, and the alcohol and drug sector in understanding the scope of drug-related harm, inform policy development, harm reduction strategies, and healthcare planning.

Data reported on

- Ambulance attendance: Characteristics of patients attended by ambulance services for AOD-related incidents, characterized by demographic factors, geography, the nature of incident (e.g. overdose, multiple drugs, police attendance), and whether the patient is transported to hospital.
- Hospitalisation: Episodes of care linked to drug overdose and drug-related health issues, including patient demographics, drug type, length of stay, and jurisdiction.
- Drug-Induced Deaths: Trends in mortality rates related to drug use, characterised by drug type, age, gender, and geography.

Data collection method

Multiple nationally representative data sources are used to regularly update this web report and analyse recent trends.

Ambulance attendance data is sourced by the AIHW from the National Ambulance Surveillance System (NASS). Electronic clinical records from ambulance services across most jurisdictions in Australia are submitted monthly. These records are reviewed by trained coders who identify AOD involvement-based paramedic observations, patient self-reporting, third-party accounts, and scene evidence (e.g., paraphernalia). Additional analysis is conducted annually by the AIHW, Monash University and Turning Point.

Hospitalization data is sourced from the National Hospitality Morbidity Database (NHMD), which annually collects data from state and territory health departments on episode-level records detailing patient care across Australia's private and public

hospitals. Data collected is coded to the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM).

Drug-induced death data is sourced from the AIHW National Mortality Database, which compiles information from the Registrar of Births, Deaths and Marriages in each state and territory and the National Coronial Information System (NCIS) for deaths certified by a coroner. This data is then coded and released by the Australian Bureau of Statistics (ABS). The ABS updates data for the previous year within 10 months post the year's end (e.g. 2022 data was released in September 2023). The AIHW, NDARC, and the Pennington Institute then conduct additional analysis and report on the data in the following year.

Limitations

- **Limited context:** Reported data on ambulance attendance, hospitalisations, and drug-induced deaths does not provide detailed contextual information that explores the complex nature of drug-related harms which are often-multifactorial.

Ambulance Attendance:

- **Jurisdictional Representation:** Not all Australian states and territories participate, leading to gaps in national data coverage. Currently data is not available for South Australia and Western Australia due to system constraints. Additionally, some data for Tasmania, the Australian Capital Territory and the Northern Territory is not included due to small numbers.
- **Subjectivity in Reporting:** The data relies on paramedic observations, patient self-reports, and evidence at the scene. The accuracy of substance identification depends on the paramedic's judgment and the availability of reliable information.
- **Data Collection Variability:** The level of detail in paramedic case narratives and reporting practices varies across jurisdictions, potentially affecting consistency and comparability.
- **Exclusion of Non-Reported Cases:** Cases where AOD involvement is not identified or reported may be excluded, underestimating the true scale of drug-related ambulance attendances.
- **Focus on Emergency and Acute Events:** The data only captures incidents severe enough to warrant ambulance attendance, excluding cases where people do not seek emergency assistance or access other health services. Additionally, it only captures acute AOD harms where an ambulance is called and attends. Chronic harms related to long-term substance use are not included in the dataset.
- **Secondary Contribution of AOD**: While AOD consumption must contribute to the ambulance attendance, it may not be the primary reason for the call-out. This complexity can make it challenging to attribute incidents directly to substance use.
- **Geographic Barriers:** Although ambulance services are considered universal in Australia, geographic barriers in remote areas and financial costs may restrict access. This could lead to underrepresentation of certain populations, particularly in very remote regions.

Hospitalisations:

- **Coding Practices**: Data is coded using the ICD-10-AM classification system, which may vary slightly in application across jurisdictions. Differences in coding practices across jurisdictions can lead to inconsistencies in reporting specific drug-related conditions or comorbidities.
- **Multiple Admissions**: A single individual may have multiple admissions for the same condition within a reporting period, potentially inflating the figures for certain diagnoses.
- **Exclusion of Patients Without Explicit Drug Related Diagnosis**: Only cases with an explicitly coded drug-related diagnosis are included. Instances where substance use contributed indirectly to hospitalization may be overlooked. This approach can underrepresent the broader health impacts of substance use, including cases where drugs exacerbate existing conditions or contribute to non-specific injuries.

the number of deaths for each drug type may be more than the total number of deaths

Drug Related Deaths:

- **Time Lag:** There is often a significant time lag between data collection and reporting due to the nature of death certification and coronial processes. As such, additional data analysis and revision of results occurs annually, and results vary between the AIHW, NDARC and the Pennington Institute based on their reporting schedule. The delay also means that the most recent released data is likely to be under-reported.
- **Death Registration Year:** Deaths recorded in the National Mortality Database are counted according to the year the deaths were registered, and not necessarily the year the death occurred. This means a number of deaths reported for a specific year may not have occurred during that year.
- **Data Source Variability:** Data is compiled from multiple sources to provide a detailed picture of current and emerging trends. However, each data source has variations in methodology which complicate interpretation and affect comparability across datasets.
- **Geographic Recording:** The geographic location of the deaths is recorded as the person's usual residence at the time of death, and not where the death occurred.
- **Multiple Drugs Involved:** Drug-induced deaths may have more than one drug type reported as associated with the cause of death. Consequently, the number of deaths for each drug type may be more than the total number of deaths.

LATEST UPDATE TO ATOD – HEALTH IMPACTS WEB REPORT: 2024

Suggested Citation: Australian Institute of Health and Welfare (AIHW), 2023, *Alcohol Tobacco, and Other Drugs in Australia: Drug Inducted Death Data,* AIHW, 2024.
https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/health-impacts#drug-induced-deaths
Link: https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/health-impacts#drug-induced-deaths

Key Findings

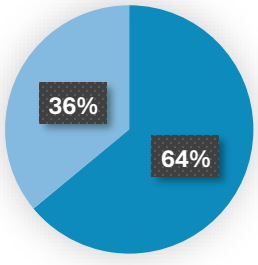
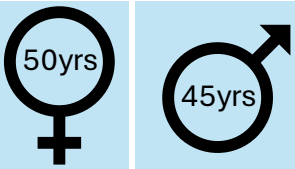
Please note, this summary provides a snapshot and overview of the key findings on illicit drug. For additional information, please refer to the full report

Data Collection Period: 2022
Sample Size: 1,693 drug induced deaths. 159,862 ambulance attendances. 135,179 drug related hospitalisations.

Drug Related Deaths

- 1,693 drug induced deaths. *This number is expected to rise following standard data revision process*.
- 78% of deaths occurred at home.
- The majority of deaths were considered accidental (69%) compared to intentional (24%). *Intentional drug-related deaths include assault and suicide.*
- Nearly ¾ of deaths (97%) were due to acute toxicity effects (overdose). Only 3.1% were related to the chronic effects of drugs.

Socio-demographic characteristics

Gender	Age	Socio-Economic
	**Median age**  The **highest rate of drug-induced deaths was for people aged 45–54.** The age range has increased from the early 2000s when it was highest among people aged 25-34.	**Almost** **1/3** among people living in the **most socio-economic disadvantaged** areas (32%).

Deaths by Drug Class and Type

More than one drug can be associated with a cause of death, as such multiple drugs may be reported on a single death record.

Drug associated deaths 2022

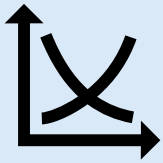
All opioids	1,022	60%
Heroin	455	27%
Natural and semi-synthetic opioids (e.g. Oxycodone, Codiene, Morphine)	373	22%
Synthetic opioids (e.g. Fentanyl, Tramadol, Pethidine)	208	12%
Benzodiazepines	703	42%
All Psychostimulants (excl. cocaine)	459	27%
Cocaine	63	4%
Cannabinoids	57	3%

Drug associated deaths 1997-2022

Benzodiazepines & Opiates largest contributor to drug induced deaths for past:

20 Yrs

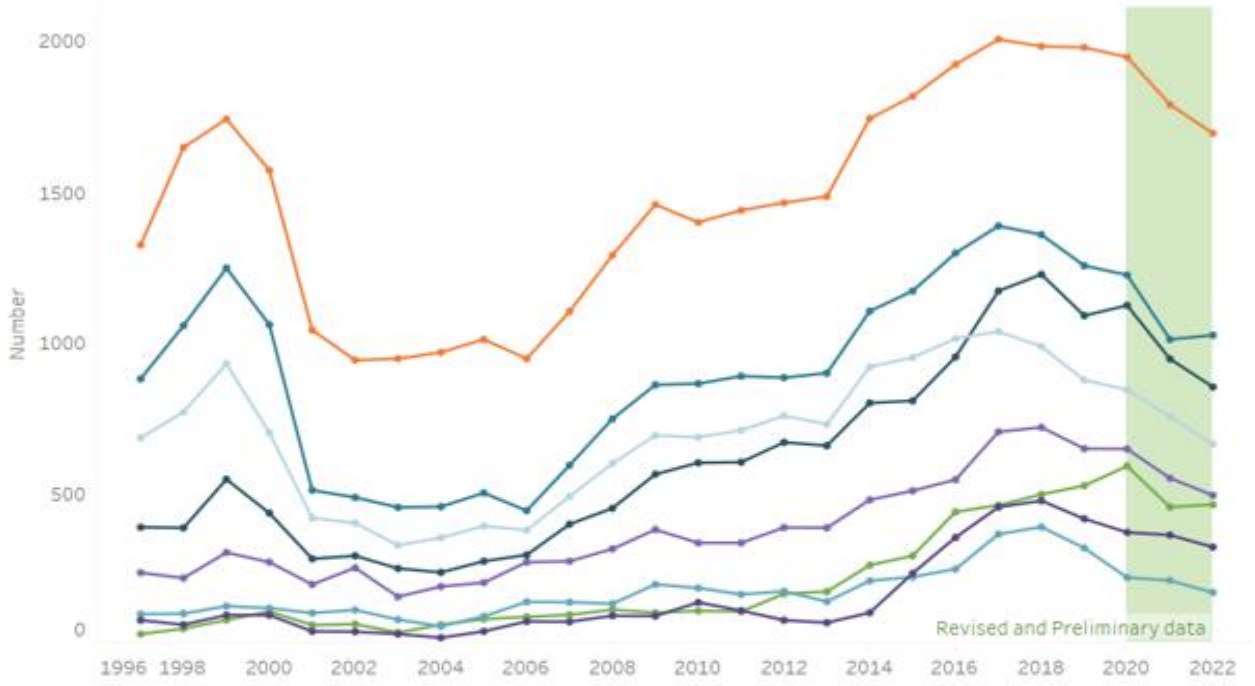
Benzodiazepine related deaths decreased since 2018.



Natural & semi-synthetic opioids related deaths have **declined** between 2017 and 2022.

Conversely, **heroin** induced deaths have **increased** between 2012 and 2022.

Number of drug-induced deaths[a] by drug class 1997-2022

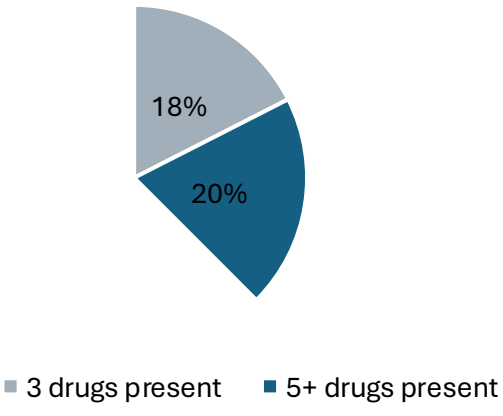


The trend of sum of Estimate for Year1 broken down by Measure1. Colour shows details about Drug type1. The marks are labelled by sum of Estimate. Details are shown for Figure number (Figure notes (Data for figures)), Title (Figure notes (Data for figures)) and Measure1. The data is filtered on Category1 and Figure code (Figure notes (Data for figures)). The Category1 filter keeps Drug class. The Figure code (Figure notes (Data for figures)) filter keeps IMPACT2. The view is filtered on Measure1, which keeps Number.

Drug type or drug class

- All drug-induced deaths[a]
- All opioids
- All opioids excluding heroin
- All antipsychotics
- All non-opioid analgesics
- All depressants[b]

Poly Drug Use



Five+ drugs present

♀ **26.1%**

♂ **16.4%**

Drug Related Ambulance Attendance

Data is available for NSW, VIC, QLD, TAS, ACT and the NT.

In 2022, 24% of all AOD ambulance attendances were responding to 'illicit drugs'.

	Total		Multiple Drugs involved		Transported to hospital		Police Attendance	
		% (of all AOD Attendances)	Number	%	Number	%	Number	%
All AOD attendances	159,862		30792	19%	128520	80%	48,958	37%
Any Amphetamines	12316	8%	5094	41%	10146	82%	5,204	42%
Cannabis	15777	10%	7045	45%	12589	80%	4,311	27%
Cocaine	2778	2%	2014	72%	2234	80%	701	25%
Ecstasy	1357	0.8%	1049	77%	1112	81%	309	23%
Heroin	4292	3%	1584	37%	2619	61%	1,202	28%
Benzodiazepines	10388	7%	7437	72%	9270	89%	3,244	31%
All opioid analgesics	4722	3%	3583	76%	4150	88%	1,044	22%

* 'All AOD attendances' includes attendances for alcohol intoxication, illicit drugs and pharmaceutical drugs. An attendance may involve more than one drug.
**'Any Amphetamines' includes amphetamines and methamphetamines (powder, base crystal)
***'Benzodiazepines' includes alprazolam, bromazepam, clobazam, clonazepam, diazepam, flunitrazepam, lorazepam, midazolam, nitrazepam, oxazepam, temazepam, triazolam, zolpidem, zopiclone, benzodiazepine (other).
****'All opioid analgesics' includes oxycodone, codeine and other opioid analgesics (dextropropoxyphene, fentanyl, hydromorphone, morphine, pethidine, tramadol and others).

! Caution should be used when interpreting this table as the following state and territory data was unavailable:

TAS:

- Benzodiazepines: multiple drugs involved, transportations to hospital, police attendance.

NT:

- Heroin: ambulance attendance, multiple drugs involved, transportations to hospital, police attendance.
- Opioid analgesics: transportations to hospital.
- Cocaine & ecstasy: multiple drugs involved, transportations to hospital, police attendance.

Drug Related Hospitalisations

Hospitalization Definition: *"A hospitalisation is an episode of admitted patient care ending with discharge, transfer or death, or a portion of a hospital stay beginning or ending in a change of type of care." (AIHW 2022)*

Drug-related Hospitalization definition: *"Drug-related hospitalisations are hospitalisations where the principal diagnosis relates to a substance use disorder or direct harm due to selected substances." (AIHW 2018)*

Principal Diagnosis: *"The principal diagnosis is considered to be responsible for an episode of admitted patient care to hospital." (AIHW 2018)*

In 2021-22 there were **135,179 hospitalisations** (public and private) with a **drug-related principal diagnosis, accounting for 1.3% of Australia's total hospitalisations.**

48% of all drug-related hospitalisations were due to **drug poisoning/toxicity.**

In 2021-2022 among all drug related hospitalisations:

	Number	Percent
Alcohol	80,259	59%
Amphetamines and other stimulants*	12,214	9%
Methamphetamine	10,069	7%
Opioids	5,836	4%
Cannabinoids	6,854	5%
Benzodiazepines	3,799	3%
Cocaine	1,256	1%
Hallucinogens	314	0.2%

* Includes 'Methamphetamine' and 'Other amphetamines and stimulants'. Excludes cocaine.

NATIONAL OPIOID PHARMACOTHERAPY STATISTICS ANNUAL DATA

Produced by: Australian Institute of Health and Welfare

Reporting Commenced: 2006 **Number of Reports to Date:** 17
Most recent Report:2023

Purpose

NOPSAD monitors Australia's opioid pharmacotherapy treatment landscape to identify trends in treatment delivery, patterns of opioid dependence, and client demographics. It serves as a key resource for policymakers, healthcare providers, and researchers to inform service planning and resource allocation.

Data reported on

- Client demographic data including age, sex, ATSI, and geographic area.
- National data on the number of clients receiving opioid pharmacotherapy treatment.
- Information on pharmacotherapy drugs prescribed, such as methadone, buprenorphine, and long-acting buprenorphine.
- Pharmacotherapy prescribers.
- Dosing points/dispensing sites.

Data collection method

Data is gathered from state and territory health departments across Australia on clients receiving opioid pharmacotherapy treatment, prescribers, and dosing points. Each jurisdiction collects data on a specific snapshot day in or around June each year, though this exact day may vary by location. However, because each jurisdiction has its own data collection practices shaped by local laws, technology, and resources, there are some variations in how data is recorded and reported.

Limitations

- **Missing Data for Some Regions:** In 2023, no data was available for Western Australia, and in 2021, data for Queensland was missing. This makes it hard to compare and analyse trends over time.

- **Data Collection Variability:** States and territories have different guidelines for collecting and reporting pharmacotherapy data. For instance, New South Wales only started separating different buprenorphine formulations in 2023. Before that, different types were grouped together, making the data less comparable across years.
- **Snapshot Day Limitations:** Data is collected on a single day and does not account for clients who may not attend a dosing point on that specific day, such as those receiving takeaway methadone, or those who enter or exit treatment before or after the snapshot day. This data does not capture the full scope of treatment activity throughout the year.
- **Inconsistent Prescriber Data:** In some regions (New South Wales, Western Australia, and South Australia), prescribers are only included if they had at least one active client on the snapshot day. This means the report does not fully capture all prescribers, and in some cases, prescribers who work in multiple locations may be counted more than once. This affects the accuracy of the client-to-prescriber ratios.
- **Incomplete Client Data**: In 2023, data on individual client characteristics (like age and gender) were missing from Victoria, Queensland, and Western Australia. This makes it difficult to assess the full demographic picture of pharmacotherapy clients.
- **Unclear Opioid Drug of Dependence:** In data for opioid drug of dependence, a significant portion of clients (42% in 2023) have their opioid drug of dependence listed as "Not stated/not reported." This means that in many cases, we do not know which opioid the client originally depended on. Also, some clients may have their current treatment drug reported instead of the opioid that led to them seeking treatment.

MOST RECENT NOPSAD REPORT: 2023

Suggested Citation: Australian Institute of Health and Welfare (AIHW). (2023). *National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) 2023*. AIHW. Available from: https://www.aihw.gov.au
Link: https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/contents/summary

Key Findings

Please note, this summary provides a snapshot and overview of the key findings. For additional information, please refer to the full report.

Disclaimer:

- *Data for Western Australia for 2023 NOPSAD collection were not available at the time of publication, as such results should be interpreted with caution.*
- *Additionally, data collection is not based on a nationally agreed data standard. HRA has endeavoured to include information on how this has impacted reported findings. Please refer to the AIHW website for further information.*

Data Collection Period: June 2023.
Sample Size: 53,272 Clients. 3,082 Dosing Points. 3,123 Prescribers.

	NSW	VIC	QLD	WA*	SA	TAS	ACT	NT
Clients	24,475	15,106	7,961	2,968*	3,528	666	922	185
Dosing Points	1,164	790	761	236*	234	69	42	22
Prescribers	1,222	1,204	367	116*	219	36	63	12

* This infographic and table produced by HRA contains Western Australian data reported in 2022, as it was not available for NOPSAD 2023. All other Australian states and territories are 2023 data.

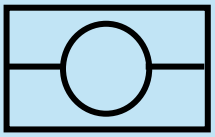
Client Data

53,272 clients received pharmacotherapy on snapshot day

Clients who did not attend a dosing point on snapshot day were not included.

67% Male

Median Age



12% ATSI

- 54% were continuing pharmacotherapy.
- 28% were new to treatment in 2023.
- 18% were re-entering treatment.

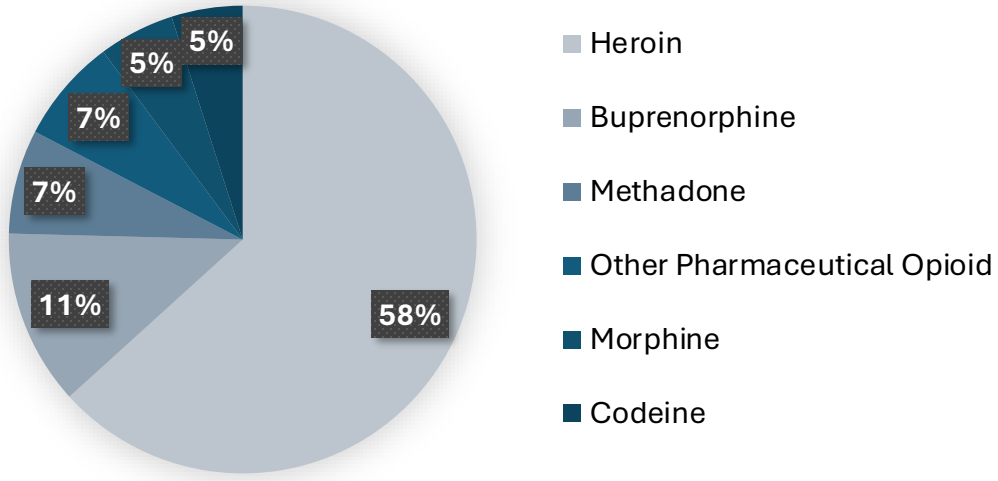
In 2023, data on individual client characteristics (like age and gender) were missing from Victoria, Queensland, and Western Australia. This makes it difficult to assess the full demographic picture of pharmacotherapy clients.

Drug of Dependence Clients Received OPT

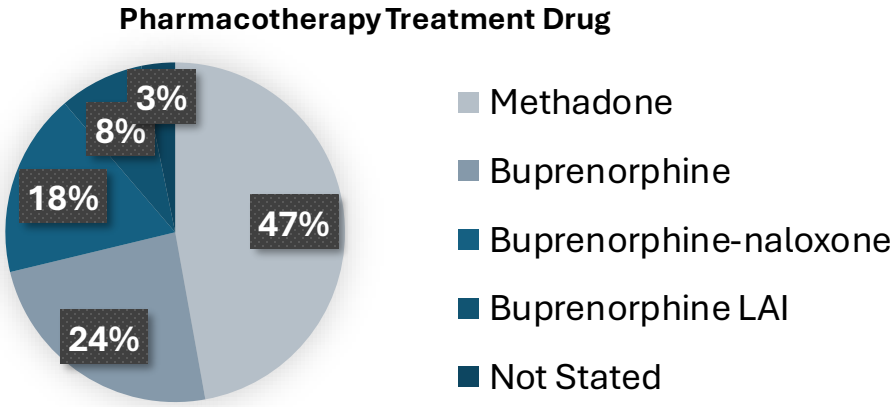
In data for opioid drug of dependence, a significant portion of clients (42% in 2023) have their opioid drug of dependence listed as "Not stated/not reported."

	Number	% all clients	% of clients with drug reported
Not Stated/Reported	22,150	41.6%	-
Heroin	18,030	34%	58%
Buprenorphine	3,451	6.5%	11%
Oxycodone	2,665	5%	9%
Methadone	2,058	3.9%	7%
Other pharmaceutical opioid	2,039	3.8%	7%
Morphine	1,486	2.8%	5%
Codeine	1,396	2.6%	5%

Clients with a drug of dependence reported:



Pharmacotherapy Treatment Drug



In 2023, for the first time since NOPSAD reporting commenced, buprenorphine formulations were received by more clients than methadone.

Pharmacotherapy Treatment by Age

Pharmacotherapy treatment varies by age

	30-39 yrs	40+ yrs
Buprenorphine formulation	63%	43%
Methadone	33%	55%

Dosing Sites

3,082 dosing sites were recorded on snapshot day.

- The majoirty (84.3%) of OTP dosing sites were located in pharmacies.
- On snapshot day, 59% of clients received treatment at a pharmacy.

	No.	%
Public Clinic	103	3.3%
Private Clinic	88	2.9%
Pharmacy	2,597	84.3%
Correctional Facility	46	1.5%
Other (e.g. hospitals, mobile sites, community health clinics, non-government organisations, doctor's surgeries)	246	8.0%

Dosing Site by Pharmacotherapy Type

Pharmacies were the most common dosing site for all pharmacotherapy drugs except for buprenorphine LAI.

Methadone	**Buprenorphine**	**Buprenorphine-naloxone**	**Buprenorphine LAI**
73% dose at pharmacies. 9.7% at private clinics. 9.3% at public clinics.	36% dose at pharmacies. 29% public clinics.	81% dose at pharmacies.	42% dose at correctional facilities 29% public clinics.

Dosing Site by Location

Data on dosing point location was not available for QLD and WA

	Number	%
Major Cities	1,467	63%
Inner regional areas	583	25%
Outer Regional areas	229	9.9%

Number of Clients Per Dosing Site

On snapshot day, nationally the average clients dosed was 17 clients. However, this number varies between sites.

Private clinics**	68 per site.
Pharmacies	12 per site.
Correctional facilities***	124 per site.

** Only includes data for NSW, QLD, SA.

*** This number is inflated as NSW does not count individual correctional dosing point sites. Correctional facilities are counted as 'single' site so all correctional clients across the state are counted to be dosed at this one site.

Client Characteristics by Dosing Site

The data below is based on all states and territories except Victoria, Queensland and Western Australia.

Client characteristics differ depending on the dosing site.

Age

Public Clinics	Private Clinics	Pharmacies	Hospitals	Correctional facilities
40s Over 2 in 3 clients were in their 40s (63% or 4,237 clients).	**40s** Over 3 in 4 clients were in their 40s (78% or 1,766 clients).	**50yrs+** Half of the clients were aged 50 and over (49% or 5,895 clients) compared to 1 in 8 in correctional facilities (12% or 371).	**30yrs - 40yrs** Over 2 in 3 clients were aged in their 30s and 40 (66% or 290 clients).	**30yrs and under** Almost 2 in 3 clients were aged in their 30s and under (62% or 1,983).

Sex

- All dosing points sites treated more males than females.
- Male clients were almost 5x more likely than female clients to dose in correctional facilities (14% male, 3% female).

- Female clients were more likely to dose at pharmacies compared to males (49% female, 36% male).

Prescribers

This data includes all registered or authorized prescribers except in New South Wales, Western Australia, and South Australia, where only those actively prescribing to at least one client on the snapshot day are counted. Additionally, prescribers in these three jurisdictions who work across multiple locations are counted more than once. This approach may inflate the prescriber count and affects the accuracy of prescriber-to-client ratios, potentially skewing data on prescriber availability and service reach in these areas.

Snapshot Day 2023

3,123 authorised opioid prescribers recorded on snapshot day

62% 	Almost two in three (1,949 prescribers) were authorised to prescribe more than one type of drug.
81% **Private prescribers**	More than four out of five prescribers (81% or 2,518 prescribers) operated in the private sector (excluding WA). The remaining prescribers were in the public sector (14% or 435 prescribers) or worked within correctional facilities (4.1% or 129 prescribers).
17 Average clients	Prescribers nationwide (excluding WA) treated an average of 17 clients each. QLD had the highest average, with 23 clients per prescriber, while VIC had the lowest at 13 clients, followed by the NT and ACT with 15 clients per prescriber.
2X Clients Public Sector	Public sector prescribers had about twice as many clients (30 clients) as prescribers in the private sector (13 clients).
Methadone	Methadone was the most commonly prescribed pharmacotherapy treatment across all prescriber types. Clients of private prescribers were most likely to receive methadone (53% or 17,983 clients), while correctional facility clients were most likely to be treated with buprenorphine LAI (24% or 1,388 clients).

ECSTASY AND RELATED DRUG REPORTING SYSTEM

Produced by: National Drug and Alcohol Research Centre

Reporting Commenced: 2003 **Number of Reports to Date:** 23
Most Recent Report: 2024

Purpose

The Ecstasy and Related Drugs Reporting System (EDRS) is a national monitoring system for ecstasy and related drugs that is intended to identify emerging trends of local and national interest in the markets for these drugs. Data is not considered representative of all people who use drugs.

Data reported on

- Demographics such as age, gender, employment status, student status, and location.
- Patterns of ecstasy and other related drug use.
- Market characteristics, including availability, purity, and price of ecstasy and other party drugs.
- Drug-related harms, risks and harm reduction practices.
- Other behaviours (mental health, drug checking, stigma).

Methodology

The EDRS is an annual structured survey conducted by interviewers either in person, over the phone or via teleconferencing with people across all Australian capital cities. Recruitment occurs via social media, print advertisements, interviewer contacts, and word-of-mouth. Participants are eligible to participate if they:

i) are at least 17 years of age (16 years in Perth)

ii) have used ecstasy and/or other illicit stimulants (including: MDA, methamphetamine, cocaine, non-prescribed stimulants, mephedrone or other simulant NPS) on at least 6 days in the past 6 month, and

iii) are a resident of a capital city the interview is taking place for ten of the past 12 months.

Limitations

- **Focus on Major Cities:** Data is collected from participants living in urban areas, so the findings do not represent regional or remote drug use patterns.

- **Self-Reported Data**: The survey relies on self-reported data and cannot be verified for accuracy. Participants report drug use based on their belief of what they consumed, which may not reflect actual substances taken. Respondents may underestimate actual consumption levels, be unwilling to provide information about behaviour regarding illegal activities, incorrectly complete the survey, or mis-remember information.
- **Focus on Stimulant Use**: Participants are only eligible if they use ecstasy and/or other illicit stimulants, therefore is not representative of communities who regularly use psychedelics, dissociatives, cannabis etc..
- **Exclusion of Occasional Users**: The sample only includes regular ecstasy and stimulant users, omitting those who may use infrequently.
- **Selection and Non-Response Bias**: As participation is discretionary the sample may be skewed by those with strong opinions, and participation rates may vary based on the stimulant drug of choice due to stigma.
- **Non Representative Sample**: The survey recruits a small sample of people who are regular ecstasy and stimulant users, participation is voluntary and therefore cannot provide information on the prevalence or patterns of drug use in the general population levels.
- **Methodological Changes**: There have been changes in how the survey is conducted over the years, including adjustments to questions, interview process (shift from face-to-face interviews to phone/teleconference during the pandemic), and eligibility (in 2013 eligibility criteria changed to include not only regular ecstasy users but also regular users of other illicit stimulant). These changes make it difficult to compare results across different survey periods.

MOST RECENT EDRS REPORT: 2024

Suggested Citation: Sutherland R, Chandrasena U, Karlsson A, Uporova J, Tayeb H, Price O, Salom C, Bruno R, Dietze P, Lenton S, Daly C, Thomas N, Radke S, Lloyd Z, Grigg J, Haywood S, Degenhardt L, Farrell M, & Peacock A. Australian Drug Trends 2024: Key Findings from the National Ecstasy and Related Drugs Reporting System (EDRS) Interviews. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney; 2024. Available from: https://doi.org/10.26190/unsworks/30462
Link: https://www.unsw.edu.au/research/ndarc/resources/australian-drug-trends-2024-key-findings-from-the-edrs

Key Findings

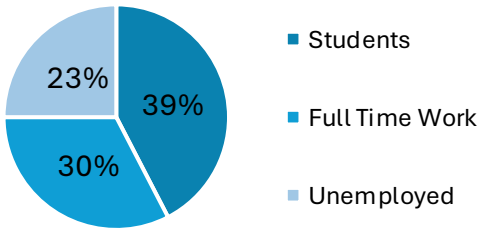
Please note, this summary provides a snapshot and overview of the key findings related to illicit drug use. For additional information, please refer to the full report.
The formatting of this section has been replicated from the EDRS executive summary (see above citation).

Data Collection Period: April-July 2024.
Sample Size: 740 participants.

Sample Characteristics

Median age 23 years

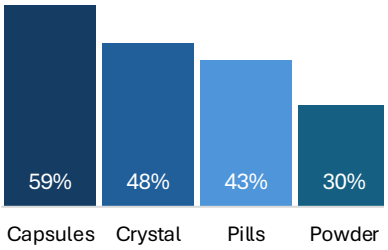
55% male



Drug Use

Ecstasy

Past 6 months reported use



17% used it weekly or more frequently.

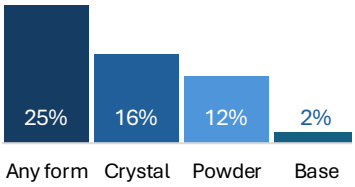
2 pills
2 capsules
0.30g crystal
0.30g powder

The median amount of ecstasy consumed in a typical session.

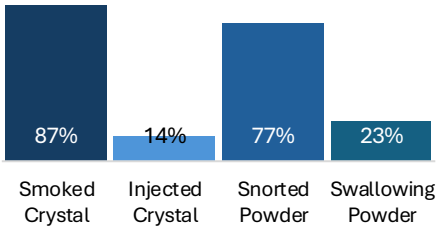
More participants in 2024 perceived the availability of all forms of ecstasy as 'easy' or 'very easy' compared to 2023.

Methamphetamine

Past 6 months reported use



42% used it weekly or more frequently.

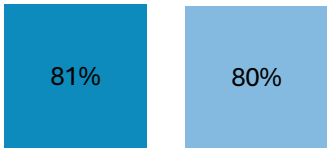


Participants were more likely to smoke crystal and snort powder.

93%

perceived crystal methamphetamine to be 'easy' or 'very easy' to obtain.

Cocaine



Past 6 months use of any cocaine remained stable between 2023 and 2024

Of the participants who had consumed cocaine recently, 12% reported weekly or more frequent use.

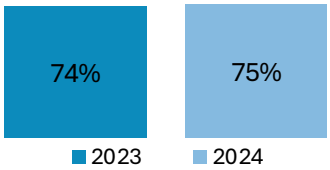
$350

median price of a gram of cocaine.

81%

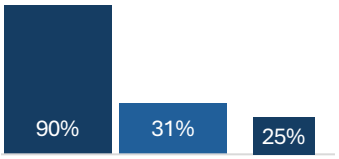
Perceived cocaine to be 'easy' or 'very easy' to obtain.

Cannabis and/or Cannabinoid-related products



Past 6 months use remained stable between 2023 and 2024

Of those who had consumed non-prescribed cannabis recently 62% reported weekly or more frequent use.



Participants were more likely to smoke cannabis.

97% Hydro

91% Bush

Perceived to be 'easy' or 'very easy' to obtain.

Past 6 months use of other illicit drugs

53% Ketamine

36% LSD

45% Mushrooms

12% GHB/GBL/1,4-BD

39% Nitrous Oxide

Drug Related Harms

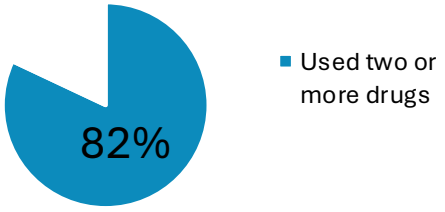
Overdoses in past year

28%
Reported a non-fatal **depressant** overdose.

19%
Reported a non-fatal **stimulant** overdose.

Poly-substance use

On last occasion of ecstasy or related drug use



Of 82% who reported using two or more drugs on the last occasion of ecstasy or related drug use:

- 29% used stimulants and depressants.
- 14% used stimulants, depressants, and cannabis.

Other Behaviours

Drug Checking

27%

reported that they or someone else had tested the contents and/or purity of their illicit drugs in Australia in the past year.

Stigma

28%

reported experiencing stigma because of their illicit drug use in the past 6 months preceding the interview, most commonly from police or a GP.

ILLICIT DRUGS REPORTING SYSTEM

Produced by: National Drug and Alcohol Research Centre

Reporting Commenced: 1997 **Number of Reports to Date:** 27
Most Recent Report: 2024

Purpose

The Illicit Drug Reporting System (IDRS) is a national monitoring system intended to identify emerging trends of local and national concern in illicit drug use and markets among people who regularly inject drugs. Its goal is to identify emerging trends and inform public health responses, harm reduction strategies, and law enforcement actions.

Data reported on

- Demographics such as age, gender, employment status, student status, and location.
- Patterns of drug use, including injecting drug use.
- Market characteristics, including availability, purity, and price of ecstasy and other party drugs.
- Drug-related harms, risks and harm reduction practices.
- Other behaviours (mental health, drug checking, stigma).

Methodology

The IDRS is an annual structured survey conducted by interviewers with people who inject drugs across all Australian capital cities. Recruitment is via advertisements at harm reduction services, drug user organisations, and word-of-mouth of participants. Participants are eligible to participate if they:

i) are at least 18 years of age

ii) have injected illicit/non-prescribed on at least 6 days in the past 6 month, and

iii) are a resident of a capital city the interview is taking place for ten of the past 12 months. Interviews are primarily conducted in person at needle and syringe programs, with a small number (10% in 2024) conducted over the phone (primarily in Hobart, Tasmania, and Perth).

Limitations

- **Focus on Major Cities:** Data is collected from participants living in urban areas, so the findings do not represent regional or remote drug use patterns.
- **Self-Reported Data**: The survey relies on self-reported data and cannot be verified for accuracy. Participants report drug use based on their belief of what they consumed, which may not reflect actual substances taken. Respondents may underestimate actual consumption levels, be unwilling to provide information about behaviour regarding illegal activities, incorrectly complete the survey, or mis-remember information.
- **Exclusion of Occasional Users**: The sample only includes regular injecting drug users, omitting those who may use infrequently.
- **Recruitment Bias:** Participants are often recruited through harm reduction services, which may attract those more engaged with health services and not capture the experiences of more hidden or less engaged populations. Additionally, some potential participants may be unwilling to engage due to fear of legal repercussions, stigma, or mistrust, leading to an underrepresentation of certain high-risk groups.
- **Non Representative Sample**: The survey recruits people who are regular injecting drug users attending harm reduction services, and participation is voluntary, therefore the data cannot provide information on the prevalence or patterns of drug use in the general population level.
- **Methodological Changes**: There have been changes in how the interview process has been conducted. Particularly the shift from face-to-face to phone or video interviews during the pandemic may have introduced new biases or inconsistencies in the data collection process, impacting the ability to compare data over time.

MOST RECENT IDRS REPORT: 2024

Suggested Citation: Sutherland R, Karlsson A, Uporova J, Chandrasena U, Tayeb H, Price O, Bruno R, Dietze P, Lenton S, Salom C, Radke S, Vella-Horne D, Haywood S, Daly C, Thomas N, Degenhardt L, Farrell M, & Peacock A. Australian Drug Trends 2024: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney; 2024. Available from: https://doi.org/10.26190/unsworks/30464
Link: https://www.unsw.edu.au/research/ndarc/resources/australian-drug-trends-2024-key-findings-from-the-idrs

Key Findings

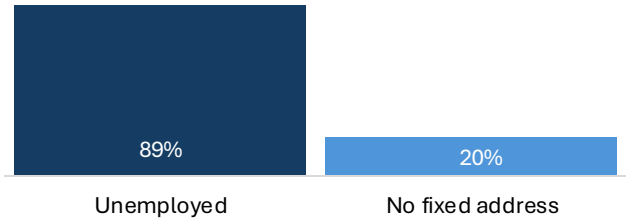
Please note, this summary provides a snapshot and overview of the key findings. For additional information, please refer to the full report (see above citation).

Data Collection Period: June-July 2024.
Sample Size: 884 participants.

Sample Characteristics

Median age 47 years

69% male



Drug Use

Heroin

51% had used heroin in the past 6 months.

75% used it weekly or more frequently.

$80

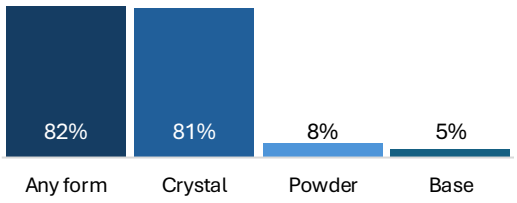
The median price of a point of heroin.

91%

Perceived to be 'easy' or 'very easy' to obtain.

Methamphetamine

Past 6 months reported use



78% had used any form weekly or more frequently.

$50

The median price of a point of crystal methamphetamine.

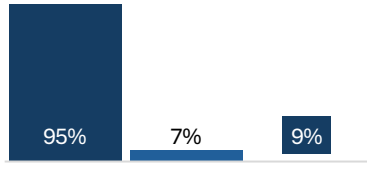
95%

Perceived to be 'easy' or 'very easy' to obtain.

Cannabis and/or Cannabinoid-Related Products

69% had used cannabis and/or cannabis-related products in the past 6 months.

Of those who had consumed non-prescribed cannabis recently **55% reported daily use.**



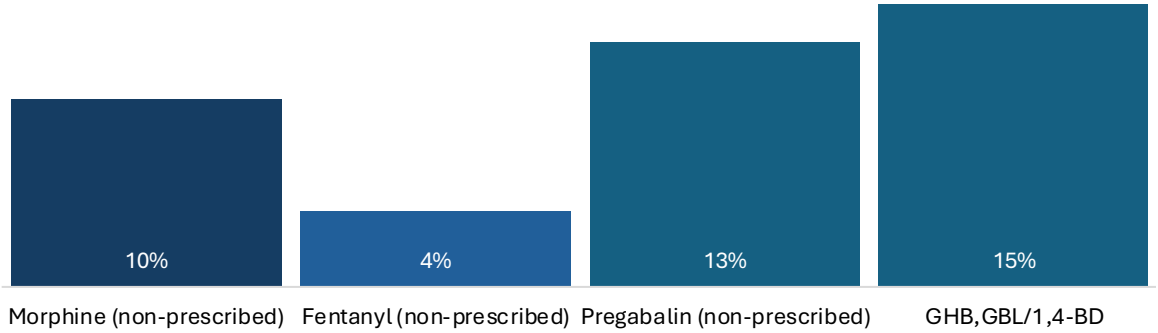
The majority of participants smoked cannabis.

89% Hydro

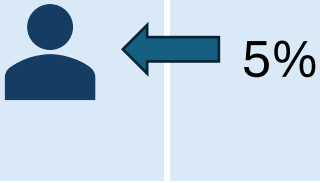
79% Bush

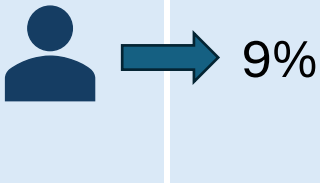
Perceived to be 'easy' or 'very easy' to obtain.

Past 6-Month use of Other Drugs



Injecting Related Harms and Risks





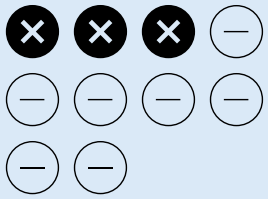
5% reported receptive sharing in the past 6 months, and 9% reported distributive sharing.

35%

Reported **re-using their own needles** in the past month.

34%

Reported they had **injected someone else after injecting themselves** in the past month.



29% reported having an injection-related health issue in the past month.

Drug Related Harms & Help Seeking

Overdose

21%

Reported non-fatal overdose

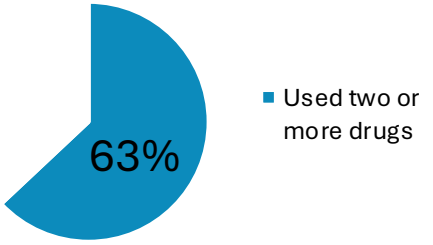
Drug Treatment

37%

Reported being currently in drug treatment

Poly-substance use

On day preceding the interview



Of 63% who reported using two or more drugs on the day preceding the interview:

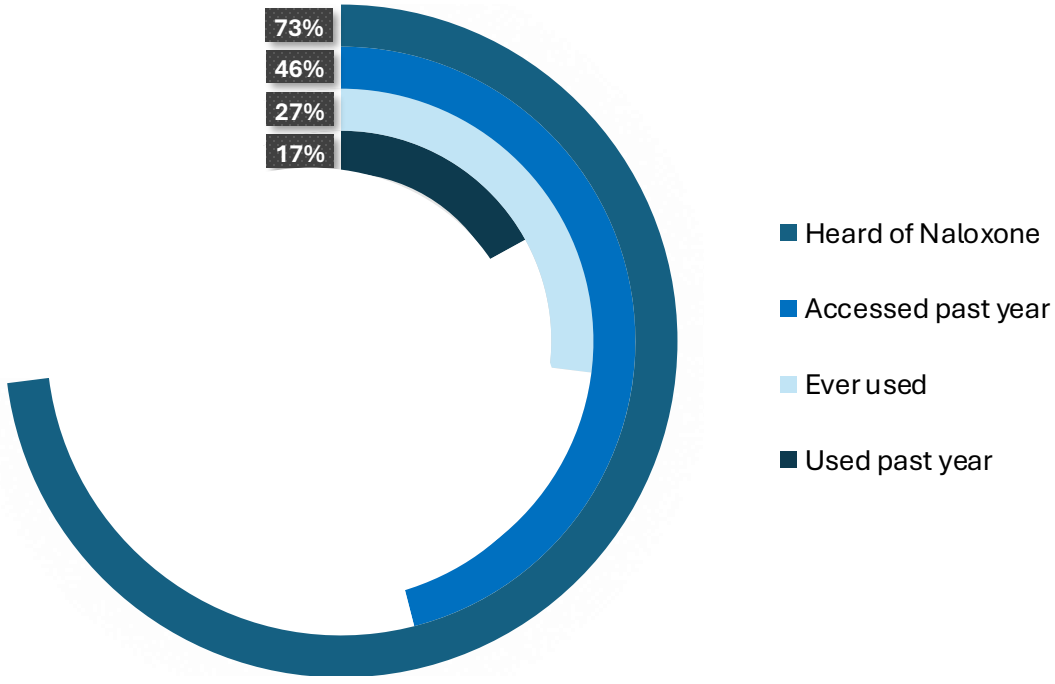
- 19% used stimulants and cannabis
- 9% used opioids and cannabis

Harm Reduction Strategies

Drug Checking

11% reported that they or someone else had tested the contents and/or purity of their illicit drugs in Australia in the past year.

Naloxone



AUSTRALIAN NEEDLE AND SYRINGE PROGRAM SURVEY

Produced by: Kirby Institute

Reporting Commenced: 1995
Most Recent Report: 2023

Number of Reports to Date: 28 (18 online)

Purpose

The Australian NSP Survey (ANSPS) functions as a strategic early-warning system designed to monitor trends in injecting practices, sexual behaviour and prevalence of blood borne viral infections (HIV and HCV) among people who inject drugs (PWID). It aims to inform national health strategies by monitoring prevalence of BBVs, inform service planning, and support advocacy and policy development.

Data reported on

- Demographic data including age, gender, sexual identity, country of birth, language spoken, ATSI status, incarceration and engagement in sex work.
- Injecting drug use patterns and risk behaviours.
- Engagement in drug treatment.
- Prevalence of HIV antibodies, HCV antibodies, HCV RNA prevalence.
- HCV treatment uptake.

Data collection method

The ANSPS is conducted annually over a one-two week period in October at participating NSPs across all Australian Jurisdictions. All clients who attend participating NSPs are invited by NSP staff to complete a voluntary anonymous self-administered or assisted questionnaire and to provide a finger prick capillary dried blood sample for HIV and HCV testing. The staff record the age and gender of participants and refusals, and whether the person is a new or repeat client. This is used to calculate the ANSPS response rate.

The selection criteria for NSP participation in 1995 was based on the number of occasions of client service, willingness to participate, and representation across all Australian jurisdictions. The ANSPS has subsequently expanded to recruit additional NSPs who are invited to participate each year and maintains a national network of ~50 sentinel NSP services. NSP service participation is voluntary, as such the number of services and which services participate varies between years. Ten services have participated every year since 1995, 25 have participated in twenty or more surveys, and 51 have participated in a total of 10 or more.

Number of participating services by jurisdiction and year

	Establishment	Last 5 years				
	1995	2019	2020	2021	2022	2023
ACT	1	1	1	1	1	1
NSW	4	18	12	3	18	19
NT	2	3	3	3	3	3
QLD	4	10	7	11	10	10
SA	2	8	7	8	8	8
TAS	1	4	4	4	4	4
VIC	5	6	0	3	5	6
WA	1	4	4	4	4	4

Limitations

- **Service Participation & Sampling Bias**: Not every NSP in Australia participates in the survey, and service participation is voluntary, leading to gaps in geographical coverage and potentially missing trends from certain regions. The survey only captures data from individuals who access the participating primary NSP services, meaning it may not reflect the experiences of those who access their equipment from secondary NSPs, SDMs, pharmacies, postal services of their peers. If this population is large, then the generalisability of the findings is limited.
- **Self-Reported Data**: The survey relies on self-reported data and cannot be verified for accuracy. Participants report drug use based on their belief of what they consumed, which may not reflect actual substances taken. Respondents may underestimate actual consumption levels, be unwilling to provide information about behaviour regarding illegal activities, incorrectly complete the survey, or mis-remember information.
- **Regional Representation**: The data is collected from selected NSP sites in primarily metropolitan areas, which might not represent drug use patterns and harm reduction access in regional, rural, or remote regions.
- **Snapshot Limitations:** Data is collected over a two-week period, missing clients who do not attend over this period. There is the potential to under-represent people who primarily or solely inject performance and image enhancing drugs (PIEDS) or methamphetamine who may inject less than daily or pick up equipment in larger quantities less frequently. This can potentially decrease the chances they will be recruited to the ANSPS.

- **Low Response Rate & Non-Response Bias**: Participation is voluntary, and without financial reimbursement, individuals in a hurry, involved in illegal activities, or are fearful of stigma or criminalisation from participation may be less likely to participate. The response rate for 2023 was 37% and ranged from 34% to 45% over the past five years (2019 -2023). While the ANSPS is not designed to produce a representative sample, the lower response rate could still influence the diversity of perspectives captured in the results.
- **Methodological Changes**: Changes in survey methodology over time, service participation, and the introduction of COVID-19-related questions affect the comparability of results across years.
- **Testing Platform Transition**: In 2023, there was a switch to a more sensitive HIV and HCV testing platform, that required a 12mm dried spot compared to 6mm. The change increased the number of insufficient samples (1.45% in 2022 increasing to 16.34% in 2023) but increased the detected HCV antibody prevalence (32% in 2022 to 45% in 2023), making comparisons to previous years difficult.
- **Limited Longitudinal Comparability:** Changes in the survey's methodology over time, and shifts in participating services may affect the comparability of results across years, making it difficult to assess long-term trends.

Methamphetamine was the most commonly reported in all years between 2019 & 2023

MOST RECENT ANSPS REPORT: 2019 -2023

Suggested Citation: Heard, S & Maher, L. (2024). Australian Needle Syringe Program Survey National Data Report 2019-2023: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees. Sydney: Kirby Institute, UNSW Sydney.
Link: https://www.kirby.unsw.edu.au/research/reports/australian-nsp-survey-national-data-report-2019-2023

Key Findings

Please note, this summary provides a snapshot and overview of the key findings related to illicit drug use and harm reduction. For additional information, please refer to the full report (see above citation)

Data Collection Period: The survey is administered in one-two week period in October.

Sample Size: 55 NSPs participated, 1,991 attendees completed the survey (response rate 37%).

Sample Characteristics

45 yrs median age	**66% male**	**ATSI 29%**
Decline in proportion of young injectors (<25years) from 4% in 2019 to 2% in 2023	Median time since first injection was stable at 24 years	Proportion of new initiates was stable (injecting less than 3 years) at 6%.
11 % incarcerated previous 12 months	6% participated in sex work in the month prior	70% used a condom at last paid sex (sex work)

Injecting Behaviour

51%

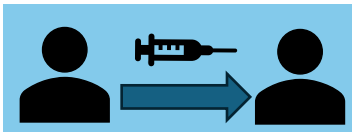
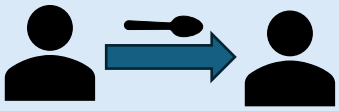
reported daily or more frequent injecting the month prior

Drug last injected

The proportion of respondents reporting methamphetamine as the last drug injected increased from 49% in 2019 to 53% in 2023.
Methamphetamine was the most commonly reported in all years between 2019 & 2023.
Heroin remained stable between 2019 and 2023 (range 20% to 27%).
Pharmaceutical opioid injecting declined from 6% in 2019 to 3% in 2023.

Receptive Sharing

Receptive Sharing Definition: The use of needles, syringes, or other drug preparation equipment (such as spoons, filters, or water) that have already been used by another person.

	Receptive sharing of syringes increased from 16% in 2019 to19% in 2023.
	Receptive sharing of drug preparation equipment (range 25-32%).
	Re-using of one's own syringe (23% to 26%) remained stable over the past 5 years.

Overdose

Non-fatal overdose self-reports declined from 16% in 2019 to 13% in 2023

Drug Treatment

Ever engaged in drug treatment	67%
Currently engaged in OAT	32%
Engagement in OAT by people who reported last injection was opioids	55%

Blood Bourne Viruses (BBV)

BBV Prevalence

	2023	2019-2023	Trends	
HIV antibody prevalence	1.8%	1.5 – 2.5%	Low and stable 2019 -2023	In all years 2019 to 2023 HIV antibody prevalence was **higher among homosexual men**, compared to bisexual or heterosexual men, and compared to women.
HCV antibody prevalence	44.8%	32% - 45.5%	Declined from 2019	**Seventh consecutive year that less than half of respondents had this marker indicating exposure to HCV**, following two decades of HCV antibody prevalence ≥50% (all years 1999 to 2016). Across all survey years 2019 to 2023, prevalence of HCV antibody was **higher among older** than younger respondents and higher among those with **longer injection histories**.
HCV RNA prevalence	12%	18%-12%	Declined from 2019	HCV RNA prevalence **declined among both males** (19% in 2019 to 13% in 2023) and **females** (16% in 2019 to 10% in 2023).

HCV Treatment Uptake

		2019	2023
Lifetime history of HCV treatment	↑	64%	75%
HCV treatment in last 12 months	↓	44%	38%
HCV diagnostic test last 12 months	↓	54%	47%

NEEDLE SYRINGE PROGRAM NATIONAL MINIMUM DATA COLLECTION

Produced/Published by: Kirby Institute, University of New South Wales (UNSW)

Reporting Commenced: 2016 **Number of Reports to Date:** 8
Most Recent Report: 2023

Purpose

The NSP NMDC provides a national and jurisdictional overview of NSP service delivery, including service/outlet type, syringe distribution, client demographics and health interventions. This data enables reporting against key NSP indicators outlined in the National Surveillance and Monitoring Plan for Australia's National Hepatitis C and National HIV Strategies.

Data reported on

- Data on services that provide sterile injecting equipment to PWID, including:
  - NSP service type: **primary NSP's** (services dedicate to PWID), **secondary NSPs** (services that operate within an existing health or community service but are not solely dedicate to PWID), community retail **pharmacy NSP,** and **syringe dispensing machines (SDMs)** (provide equipment via vending machines or dispensing chutes).
  - Method of service delivery: **fixed sites**, **outreach/mobile services,** formal **peer distribution**, and **postal distribution**.
  - Service location.
- Client level data including:
  - Demographic and behavioural data of NSP attendees, including age, gender, indigenous status, and frequency of drugs injected.
  - Health education interventions and referrals provided to clients.
- National distribution of needles and syringes through the public and pharmacy sector.

Data collection method

This report annually collects data each year from every state and territory health department on all NSPs outlet types and locations operating as of 30th June each year. Each jurisdiction also provides quarterly needle and syringe distribution report from the public and pharmacy sector. In addition, states and territories

provide client-level data on occasion of service (OOS) from public primary and secondary NSPs on a designated snapshot day during the last week of February. OOS data is collected by NSPs staff as part of their normal service operations anytime they provide equipment to a client, as such clients do not provide direct consent to participate in this study.

Limitations

- **Incomplete Pharmacy Coverage:** The NSP NMDC does not collect data from community pharmacies that are not associated with a state/territory NSP scheme as it cannot be determined whether equipment was distributed for PWID or for other medical conditions. Consequently, the number of pharmacies and the amount of equipment distributed by pharmacies to PWID is under-estimated.
- **Limited Reporting on Service Provision:** The NSP NMDC does not report on the full range of services and activities that NSP provide to PWID, such as nursing clinics, mental health support, or housing assistance. Thereby not fully representing the broader harm reduction activities and impact NSPs offer.
- **Counting Method for NSP Sites:** The NSP NMDC counts NSP sites by combining the total primary + secondary + pharmacy + SDMs. If an SDM is connected to a NSP outlet, it is counted as a separate service, potentially inflating the total NSP outlet count.
- **Underestimated Client Level and OOS Data:** There is no system in place to record pharmacy OOS, some secondary NSP outlets do not have the capacity to collect OOS data, and not all NSPs participate in the snapshot data collection, as such the number of OSS is under-estimated.
- **Non-Random Sampling and Self-Selection Bias:** Snapshot data on OOS is collected from a non-random sample of NPS. Participation is voluntary and some NSPs do not participate, which can impact the representativeness of client-level data.
- **Inconsistent Drug Reporting:** NSP NMDC data on injected drugs does not consistently specify if the drug reported was the one previously injected or intended for the next injection. Reporting standards vary across jurisdictions, leading to inconsistencies in drug use data.
- **Indigenous Status Data Collection**: Data on Indigenous status is collected inconsistently between jurisdictions. One jurisdiction did not collect any Indigenous status data between 2019 - 2022 and another missed this data in 2019. While five jurisdictions followed the ABS standard for collecting Indigenous status, one jurisdiction used a simplified yes/no format, limiting the depth and consistency of demographic information on Indigenous clients. This inconsistency impacts the comparability of Indigenous data across regions, potentially underrepresenting Indigenous clients.

- **Snapshot Limitations:** Data is collected on a single snapshot day missing any clients who do not attend. There is the potential to under-represent people who primarily or solely inject performance and image enhancing drugs (PIEDS) or methamphetamine who may inject less than daily or pick up equipment in larger quantities less frequently.

MOST RECENT NSP NMDC REPORT: 2023

Suggested Citation: Heard S, Zolala F, Kwon JA and Maher L. Needle Syringe Program National Minimum Data Collection: National Data Report 2023. Sydney: Kirby Institute, UNSW Sydney; 2023.
Link: https://www.kirby.unsw.edu.au/research/reports/needle-syringe-program-national-minimum-data-collection-2023-national-data-report

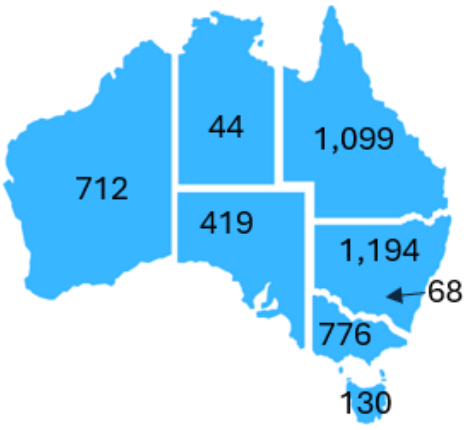
Key Findings

Please note, this summary provides a snapshot and overview of the key findings. For additional information, please refer to the full report (see citation above).

Data Collection Period: February snapshot day.
Sample Size: 4442 NSPs, 1769 clients.

Australia's NSP Network
4,442 services

109 Primary
833 Secondary
3,067 Pharmacy
433 Syringe Dispensing Machines (SDM)



	Primary	Secondary	Pharmacy	SDMs
ACT	2	14	42	10
NSW	31	240	636	287
NT	3	12	21	8
QLD	20	117	892	70
SA	8	77	315	19
TAS	7	21	97	5
VIC	18	243	488	27
WA	20	109	576	7

Syringe Distribution

In 2022/2023:

50.8 million needle and syringes distributed to an estimated population of 72,886 people who inject drugs (excluding people who inject occasionally)

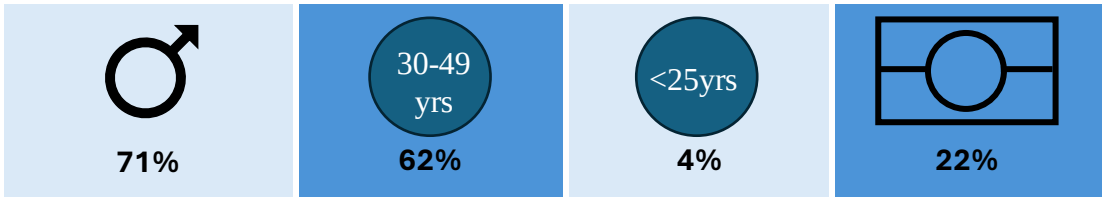
This equates to 698 needles/syringes each per annum, exceeding the UNAIDS definition of high syringe coverage by more than three-fold. Syringe coverage (syringes per injection) remained high at 114% in 2022/23.

Occasions of Service

Snapshot Day

- 1,800 NSP occasions of service (OOS) were recorded at primary and secondary NSPs.
- 1/3 OOS also involved health education or intervention.
- 1/10 involved a referral.

Client Demographics



Reported Drug

47%

Stimulants and hallucinogens (predominantly methamphetamine)

32%

Analgesics (heroin, other opioids and opioid substitution therapies)

14%

Anabolic agents and selected hormones (predominantly **anabolic steroids**)

DATA SET COMMENTARY

The national routine data sets presented in this report provide important insights into drug use, drug-related harms, NSPs and opioid treatment in Australia. Each data set brings unique strengths to understanding the scope and patterns of substance use, yet as with all studies, there can be methodology-related and other limitations that can affect the comprehensiveness and/or applicability of the data for various communities and regions including:

Population Coverage and Inclusion

While the data sets covered in this report collect detailed data on drug use trends, methodology limitations may miss some highly marginalised populations, such as the NDSHS exclusion of people who are homeless, living in institutional settings, and the IDRS and the ANSPS collecting data from people already engaged with NSPs. These exclusion/limitations can obscure the full spectrum of drug use and associated risks among people, who may have distinct needs and face unique challenges in accessing harm reduction services.

Urban vs. Regional Representation

The focus of many data sets, including EDRS, IDRS, ANSPS is primarily populations in urban/major regional centres. Consequently, these data sets may not adequately reflect patterns in smaller regional, rural and remote areas, where access to services and the types of drugs used may differ. Expanding geographic reach would enhance the understanding of regional/rural needs and provide more comprehensive support for harm reduction initiatives in these often-underserved areas.

Scope of Harm Reduction Initiatives

Existing data sets are primarily focused on illicit drug use and injecting behaviours (often reflecting the historical development of these monitoring systems within the context of blood borne virus prevention, diagnosis and treatment). While ongoing monitoring of these issues remains critical, further work is needed to ensure broader harm reduction initiatives such as naloxone distribution, drug checking services, drug consumption rooms, festival harm reduction initiatives, and peer-based harm reduction programs are also included in our key monitoring systems moving forward. Harm reduction encompasses diverse practices and initiatives, future data collection could include these emerging areas to provide a more comprehensive view of harm reduction's impact and scope across Australia.

National Minimum Data Collection Standards

NSP NMDC's inconsistencies in Indigenous status reporting highlights the need for standardisation. Inconsistencies in other data sets included in this report (including differences in prescriber data reporting in NOPSAD), underscore the need for a set of nationally aligned data standards to improve data collection, cross-state comparisons and help establish a unified framework for harm reduction policy and programmatic assessment.

Focus on Harm and Risk

Most data sets concentrate on the harms, risks, and negative health outcomes associated with drug use, often overlooking the broader experiences and motivations of people who use drugs. This emphasis can perpetuate a view of all drug use as inherently risky, reinforcing stigma and limiting a balanced understanding of diverse drug use patterns. Incorporating a broader range of experiences could contribute to a public discourse and service provision that is more nuanced and has less stigmatised view of drug use.