Drug and Alcohol Use in South Australia

Drivers, Community Impacts and Policy Responses

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Key informants

We sincerely thank the key experts and informants who shared their views with us to form sections of this report. These sections represent a summary of key themes from interviews with experts and does not necessarily reflect individual views. Other key informants were interviewed but asked not to be named.

Key informant	Affiliation *(listed alphabetically)*
Associate Professor Robert Ali	Adelaide Medical School, University of Adelaide
Sally Underdown	Alcohol and Drug Foundation
Professor Peter Miller	Centre for Drug Use, Addictive and Antisocial Behaviour Research, Deakin University
Dr Claire Wilkinson	Drug Policy Modelling Program, UNSW Sydney
Luke Hutchins	Foundation for Alcohol Research and Education
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Professor Ann Roche	National Centre for Education and Training on Addiction, Flinders University
Professor Michael Farrell	National Drug and Alcohol Research Centre, UNSW Sydney
Professor Simon Lenton Associate Professor Michael Livingston	National Drug Research Institute, Curtin University
Professor Kate Conigrave Associate Professor Kylie Lee	NHMRC Centre of Research Excellence in Indigenous Health and Alcohol, The University of Sydney
Professor James Ward	Poche Centre for Indigenous Health, University of Queensland
Dr Anne Rathjen	Serious and Organised Crime Branch, South Australia Police
Michael White	South Australian Network of Drug and Alcohol Services

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Executive summary

The use of alcohol and other drugs (AOD) places a significant burden on the health of South Australians, their families, the community and the health system. The social and economic ramifications of AOD are far reaching and profound, undermining family and community safety, and threatening the efficiency and capacity of health systems.

This report provides a critical analysis of the current state of alcohol and drug use in South Australia (SA) based on available data and input from 24 key informants working across the AOD sector or in AOD research in SA and across Australia. The report provides a snapshot of AOD trends in SA for the general community and for Aboriginal and Torres Strait Islander people, associated harms, critical analysis and identification of policy response gaps and strategies moving forward to reduce harms.[1]

General findings

- Nearly all respondents stated that AOD use tends to be framed as a criminal issue, which can serve as a barrier for people seeking treatment for AOD use and contribute to further harms. Framing needs to change to treat AOD use disorders as heath issues with underlying factors including trauma, mental health issues, social determinants of health, racism and family history of experiencing addiction.
- The social determinants of health (e.g. education, employment, housing) all underpin AOD use 'upstream', and successful strategies addressing these will have positive flow-on effects. Central upstream factors include work/employment, decreasing poverty and increasing liveable wages, access to health care/services, increased life opportunities, support for mental health, decreasing discrimination (e.g. racial, gender, sexuality), and workplace environments.
- SA has an older population structure than elsewhere in Australia, with a median age of 40 (compared to 38 nationally) and a greater proportion of residents aged over 50 years than the national average [1]. Therefore, increasing rates of AOD use among older people may be of particular concern for SA.
- This report presents alcohol and drugs separately, but many people use multiple drugs ('polydrug use'[2]), which can further increase the harms associated with drug use. Alcohol is the most common substance involved in polydrug use, with data showing more than 80% of people who had recently used cannabis, cocaine, ecstasy or meth/amphetamine reported also using alcohol at the same time [2].
- Informants identified that more policy action is required to address the harms of alcohol and drug use in SA, particularly to prevent harms from alcohol in the first place and reduce the burden on the health system. Informants also noted that the approach needs to be multifaceted, incorporating a range of interventions, much like the approach to tobacco control.
- The key overarching strategy to reduce AOD use in SA is the South Australian Alcohol and Other Drug Strategy 2017-2021, which outlines evidence-based steps for SA Government. While some of the policy recommendations listed in Tables 1 and 2 below may be listed in the strategy, the majority extend beyond current practice in SA and should be considered in the consultation process for the next strategy due to occur in late 2021.

[1] Note that tobacco is not covered in this report as it was out of scope, and there is already good evidence-based practice underway in SA.
[2] Polydrug use refers to a person using more than one type of drug, either at the same time or different times.

Alcohol

Alcohol is identified in the literature and overwhelmingly by experts as SA's primary drug of concern, particularly for the general community, but also for Aboriginal and Torres Strait Islander people.

Trends

- Four out of five South Australians (79%) report drinking alcohol in the past 12 months. In spite of a steady decline in South Australians who drink in excess of alcohol guidelines[3], likely due to reduced drinking in young people, one-quarter of South Australians still exceed the NHMRC guideline for short-term risk at least monthly and 18% exceed the guideline for long-term risk on average.
- Older South Australians (aged over 50 years) are more likely to drink at risky levels than other older Australians.
- Aboriginal and Torres Strait Islander people are more likely to abstain from alcohol consumption than the general community, but there are more harms from drinking at risky levels than the general community.

Drivers, according to key informants

- The decline in overall drinking is likely due to young people drinking less (teenagers and young adults under 30), which is a global trend that researchers are currently working to understand. Fewer parents supplying alcohol to children may be part of the reason (although parents are still the main suppliers) and the fact that social media is acting as surveillance (fear of being caught or embarrassment among peers).
- Key drivers affecting continued consumption are supply (alcohol is currently more widely available and less expensive, relative to previous years), industry promotion of products, limited community awareness of the harms of drinking, social norms, limited brief intervention when people are developing problem drinking, cumulative trauma, racism, and the social determinants of health.

Harms

- Despite the reduced rates of consumption among teenagers, alcohol is the leading cause of death and disability in young adults, and emergency room presentations are increasing.
- Harms range from harms to the individual (injury, chronic disease, suicide) through to harms to others (assault, domestic violence, transport accidents[4] [3]).
- A study has revealed that Aboriginal and Torres Strait Islander people died from conditions related to alcohol approximately five times more frequently than non-Indigenous people.

Policy responses

- Table 1 below shows key evidence-based policy responses recommended by informants and the literature. All strategies together will provide a comprehensive approach. Strategies include establishing minimum unit pricing, supporting a national volumetric tax, restricting alcohol advertising, reducing accessibility of alcohol, funding education campaigns, improving availability of early and brief interventions, ensuring responsible service of alcohol, creating meaningful activities, increase access to treatment services, reinstating wholesales data, and addressing data quality.

Meth/amphetamine

Amphetamine, and its derivative methamphetamine, are stimulant drugs used by a small proportion of South Australians: 1% report recent use. However, SA has had one of the highest rates of consumption nationally, and informants identified meth/amphetamine as the second highest drug of concern because of its harms to the individual and community.

[3] The alcohol guidelines established by NHMRC in 2009, and that were in place until 2020, have been used in this report as the newly released guidelines were not available to inform data trend analyses for SA.
[4] SA Police data indicates that 19% of driver and motor vehicle fatalities had an illegal blood alcohol level [3].

Trends

- Recent use of methamphetamine has been declining since 2001, in particular among younger age groups. However, use has been increasing or remaining stable among older age groups (40+).
- Methamphetamine consumption is higher in regional SA compared to Adelaide.[5]
- Aboriginal people have higher use than non-Indigenous Australians with recent data suggesting that 3.4% of Aboriginal adults had recently used meth/amphetamine.
- Wastewater data from metropolitan Adelaide show that use is consistent across the week, suggesting dependency issues, rather than casual use.

Drivers, according to key informants

- Recent declines in use may be due to a reduction in casual users, influenced by media coverage and stigma around use.
- The higher use in SA compared to other states may be due to availability (including local manufacture). Meth/amphetamine also has a functional use for some, enabling them to stay awake for long periods.
- Drivers particularly affecting consumption for Aboriginal and Torres Strait Islander people include cumulative trauma, boredom, lack of opportunity, and availability of the drug.

Harms

- Harms remain a significant concern, spanning short- and long-term health and social problems (e.g. anxiety and mood disorders, suicide and violent behaviours, and pressure on mental health and emergency services), as well as death due to overdose.
- Family and community impacts in Aboriginal communities were emphasised by informants including families becoming separated and children being taken from their parents' custody.
- Stimulants (i.e. meth/amphetamine, cocaine) accounted for 30.9% of unintentional drug-induced deaths recorded for Aboriginal people between 2014-2018.

Pharmaceuticals

Recent data indicates that in SA, non-medical use of pharmaceuticals is the second most common form of illicit drug use, after cannabis. Pharmaceutical drugs include painkillers and opioids, tranquilisers/sleeping pills, and steroids. Prescription opioids are of particular concern.

Trends

- 4.2% of South Australians reported recent non-medical use of pharmaceuticals (2.9% relating to painkillers and prescription opioids, and 1.3% relating to tranquilisers/sleeping pills).
- Use of prescription opioids has significantly reduced in SA since 2016 (according to both survey and metropolitan Adelaide wastewater data).
- Average fentanyl consumption is markedly higher in regional SA than in Adelaide and in other parts of Australia.[6]
- Users of prescription opioids are more likely to be older than for other drugs, and to be female.
- Nationally, Aboriginal and Torres Strait Islander people's recent use (7.7%) is higher than non-Indigenous Australians' use (4.1%).

Drivers, according to key informants

- Shifting codeine from an 'over the counter' medicine to 'prescription only' has reduced its use for non-medical purposes.

[5] This finding is based on national wastewater data, as well as published data from self-report surveys.
[6] This finding is based on national wastewater monitoring data.

- There is potential for individuals to have multiple prescriptions, from different providers ('doctor shopping'). Further, some prescription practices can increase risks.
- Treatment of complex pain associated with chronic illness can lead to pharmaceutical misuse and experiencing addiction.
- Alternative pain treatment options are often lacking for people in low socio-economic or regional areas.

Harms

- Nearly two-thirds of all drug-induced deaths have been associated with opioids (including heroin and pharmaceutical opioids).
- Opioids are the largest drug category identified in unintentional drug-induced deaths among Aboriginal and Torres Strait Islander people (51.6%).

Cannabis

Cannabis is the most frequently used illicit drug in Australia, by both Aboriginal and non-Indigenous people. Informants raised many concerns with patterns of use in Aboriginal communities, highlighting that it is often normalised and 'forgotten' in discussions around drug use.

Trends

- In SA, 10.6% of people aged 14+ have reported recent use of cannabis, with rates increasing during 2020 but reducing again in 2021.
- Cannabis use is more common among males than females, those living in remote or very remote areas, and those aged 20-29. Wastewater data from metropolitan Adelaide show that use is stable across the week, suggesting dependency issues for users.
- Nationally, 24.1% of Aboriginal people reported recent cannabis use, and this level has increased over time.

Drivers, according to key informants

- Partial decriminalisation of cannabis in SA has influenced use, as have drug diversion reforms, such as the Police Drug Diversion Initiative, which have offered benefits (e.g. in health assessments) [4]. Legislative changes also now allow for medical cannabis use.
- Cannabis use is normalised in Aboriginal and Torres Strait Islander communities, and influenced by broader social determinants (e.g. insufficient employment, lack of social infrastructure).

Harms

- Informants indicated that cannabis use is perceived in the community as relatively harmless, especially with occasional use.
- Daily and/or heavy use has been associated with poor educational outcomes, and increased anxiety, depression, and psychosis, including in Aboriginal and Torres Strait Islander communities.

Fantasy/GHB

Gamma-hydroxybutyrate (GHB, commonly 'fantasy') is a central nervous system depressant with relatively uncommon use. It has however been highlighted as an emerging concern, due to recent deaths associated with its use in SA.

Trends

- Use of GHB is low, with 0.1% of Australians estimated to have used recently.
- The use of GHB has been associated with specific communities, such as gay and bisexual men (nearly 20% had a history of GHB use and 2.7% used it at least monthly), and within prison populations.

- There are limited data on GHB use by Aboriginal people in Australia; where reported, use has been estimated to be relatively low (approximately 2% of young people, fewer than most other drugs), but was still noted as an emerging issue in Aboriginal communities.

Drivers, according to key informants

- Key informants suggested that GHB is often used alongside, or instead of, meth/amphetamine, and that it is relatively easy to manufacture.
- Use of GHB may have increased with COVID-19 border closures making other drugs (such as meth/amphetamine) difficult to source.

Harms

- Overdose is common, given the small difference in quantity required for intoxication and overdose; half of users in an Australian study reported having overdosed and losing consciousness.
- Recent deaths in SA associated with GHB use were noted by key informants.

Heroin

Heroin is a depressant opioid drug, and consumption is relatively low compared with other drugs.

Trends

- Heroin use has been in decline over a number of years; recent use is reported to be <0.1% in Australia.
- Wastewater data from metropolitan Adelaide showed a rise in use in 2020 in SA, but rates dropped again at the start of 2021. Use is most common in capital cities, and is stable across the week.
- Aboriginal and Torres Strait Islander people are more than six times as likely to receive heroin-related treatment services compared to non-Indigenous Australians, and this rate has increased over time.

Drivers, according to key informants

- Supply and ease of access are key drivers of heroin use, including availability of other drugs, such as prescription opioids.

Harms

- Heroin is associated with a range of social and health harms, of which the most serious being risk of death due to overdose.
- Death by overdose has been trending upwards nationally and accounts for a substantial proportion of drug-induced deaths (25%).

Ecstasy/MDMA

Ecstasy is a psychoactive stimulant drug, used by around 1.2% of the SA population, which is lower than national rates.

Trends

- Ecstasy use has been declining in SA based on surveys and wastewater data, but there was an increase in use in 2020 (based on Adelaide wastewater data). This seems to be dropping again in 2021.
- Use is most common amongst males, people in higher socioeconomic areas, and young people.
- Data on Aboriginal and Torres Strait Islander people's use is comparable with the non-Indigenous population.

Drivers, according to key informants

- Supply of ecstasy is a key driver of use.
- Ecstasy is seen as a 'party' drug, a view supported by wastewater data showing its use is most common on weekends in metropolitan Adelaide; use is driven by pleasure-seeking and risk-taking.

Harms

- Key harms are deaths related to drug toxicity and, although relatively low in number, are of concern in the community.
- Risk of drug toxicity increases with consumption via capsules (rather than pills), which are becoming more common.

Cocaine

Cocaine is a stimulant drug, with recent consumption of cocaine reported for 4.2% of the SA population, lower than the national average.

Trends

- Consumption of cocaine has been increasing steadily in SA (according to survey and metropolitan wastewater data).
- Wastewater data show that cocaine use increases in metropolitan Adelaide on weekends, and, according to survey data, it is more common amongst young people and those living in cities.
- Aboriginal and Torres Strait Islander people's use is comparable with the non-Indigenous population.

Drivers, according to key informants

- Cocaine is relatively expensive, potentially reducing the number of users.
- Border closures in 2020 may have increased use, by reducing access to other drugs.

Harms

- Cocaine use is associated with a range of short- and long-term health issues, including mental health issues and cardiovascular problems, and users can experience addiction.

Policy responses for other drugs

- Table 2 below shows some key evidence-based policy responses recommended by experts and the literature. As with alcohol responses, all strategies together will provide a comprehensive approach to preventing and addressing the harms of illicit drug use.

Table 1. Prevention strategies recommended to reduce harms from **alcohol** by key informants and the literature

Policy response	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
Primary prevention strategies to avoid the use of alcohol or delay the use				
Establish minimum unit price (MUP) in SA	Low – legislative change plus prior framing research (approx. $150,000) education campaign (approx. $250,000)	Strong support for all by informants	Over the past two decades alcohol has become more affordable in Australia relative to household income [5]. MUP has been successfully introduced and reduced harms in NT Australia [6] and other countries including Scotland, Russia, Ukraine and Canada [7, 8], and will come into effect in Ireland in 2022. *"Pricing levers we know are incredibly evidence-based and successful in changing population levels of consumption."*[7]	• Australian Hotels Association may oppose in principle, but data shows that losses in volume of sales at lower end of market are offset by the tax applied and reduced staff required for volume. • Cask wine industry are likely to oppose. • Community are likely to support, if communicated to clearly in advance. • Communication strategy important to gain support by community and politicians.
Restricting advertising/marketing including: • Restricting in sport (including via sponsorship) • Restricting in public places • Avoid politician promotion of alcohol products in the media (e.g. avoiding photo opportunities with alcohol products in hands)	Low – will need to offset unhealthy advertising with other forms of advertising on government property	Strong support for all by informants	Alcohol advertising normalises alcohol consumption. Removal of advertising would reduce cues to drinking in those with dependency issues who are attempting to reduce/abstain. *"Young men are the group at the highest risk from harms from alcohol and they're the one that sport advertising of alcohol appeals to. If you look at the WHO data on burden*	• Aim to phase out advertising on SA Government property. • Advocate for restrictions on advertising in sport to occur at the Commonwealth level. • Work with Commonwealth Government to replace the current Alcohol Beverages Advertising Code governed by alcohol industry and establish a mandatory code of practice.

[7] Quotes presented in blue italics are direct quotes from key informant interviews and are reproduced with consent.

Policy response	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
			of disease, alcohol is the lead contributor to years lost from death and disability in people aged 15 to 49 and that's the group we're advertising alcohol to when we advertise it in sport."	• Influence state sport sector through incentives and encourage Good Sports Program via Alcohol and Drug Foundation. • Research community to focus on social media promotions and consider ways to regulate this.
Reduce accessibility/availability of alcohol through regulating online and home delivery of alcohol products	Low – legislative change	Strong support for all by informants	A large number of informants expressed concern that there is currently a growth in the number of outlets selling alcohol online and it is largely unregulated, so minors are able to purchase alcohol easily as are intoxicated people. *"There's serious risk at the moment across Australia that people buying alcohol online and getting it delivered it's just not regulated to the same standard that we expect, that we have for traditional bricks and mortar venues."* At the time of writing this report, SA Government had just released the 'Liquor Licensing (Miscellaneous) Amendment Bill 2021' for consultation with submissions due by 18th June 2021. NSW has brought regulations into effect; Victoria are currently under review.	Ensure that the SA Liquor Licensing (Miscellaneous) Amendment Bill 2021 has provisions for: • ID checking at point of sale and at the door for delivery. • Time of sales/delivery to be limited to 10am-10pm). • Responsible service of alcohol (not delivering to already intoxicated people, and not leaving by a door). • 'Mystery buyer' check on responsible service.
Fund community education campaigns to:	To be costed but estimated at $1.5M per annum ongoing	Strong support for all by informants	Guidelines by NHMRC are new, awareness is low, awareness of the link between alcohol and cancer is low. Increased awareness is likely to	Review national plans for community education, develop campaign strategy to support this and implement strategy.

Policy response	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
• Raise awareness of the link between alcohol and cancer • Increase awareness of alcohol guidelines in community and among health professionals • Reduce parental supply to teenagers			reduce consumption. Campaigns such as this will also influence cultural norms. Informants highlighted that parents are the main supplier of alcohol to teenagers and messaging is needed for both the general community and Aboriginal and Torres Strait Islander Communities.	• Source creatives from other states including Victoria and WA.
Call for volumetric tax to be applied nationally	Low	Strong support for all by informants	There is clear evidence that increased price is associated with reduced consumption. *"…there's abundant evidence, including from economists, that a volumetric tax based on the price of alcohol would be a very good thing for reducing harms from alcohol."*	Advocacy required at the national level.
Secondary prevention strategies to identify risk factors for harms among people who drink				
Improve availability of early and brief interventions (e.g. motivational interviewing) – more support for GPs and other primary health care providers • Push for Medicare number related item to address alcohol for general community	Low – costs to be borne by Commonwealth Government	General	Informants identified that more could be done to address behaviours before they develop into problem drinking. *"There's substantially more that can be done in terms of early and brief intervention, that we're still really tardy at taking the opportunity to give supportive advice to people where patterns may start to become problematic before we're down to the very sharp end of a continuum."*	Advocacy required at the national level for Medicare item. Work with Primary Health Care networks in SA to support brief intervention and risk assessment (via AUDIT-C, ASSIST or Grog App).

Policy response	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
Licensed venues and responsible service of alcohol • Making licensed venues switch sales from full to mid-strength alcohol being served in venues after midnight • Using current/existing laws around harassment of female staff or other staff and patrons in licensed venues	Low – legislative change	Predominantly general	Licensed venues are associated with violence, violence against women, and intoxication is also associated with domestic violence. *"We never did a nightlife study in South Australia, but every place we've done and tested responsible service of alcohol, it has overwhelmingly failed. Over 86% of the people who we went in and observed in venues who were showing three signs or more of intoxication… this is slurring their words, spilling their drinks… subsequently went and got service alcohol."*	Undertake full review of licensed premises legislation, increase compliance checking in premises to ensure that venues are held accountable for violence and harassment.
Creating meaningful community activities (especially in regional areas) that don't involve alcohol and better mental health support	Review to be undertaken and costed	Aboriginal and Torres Strait Islander People in particular	Informants identified that boredom is associated with increased alcohol consumption and substance abuse. *"…in a metropolitan setting, like they've got, you've got venues and parties, you've got events that occur as well, whereas in your community, and especially your remote communities, there's not much going on, so it's sort of kind of a boredom type thing."*	Undertake review of evidence and review of community activities in place, discontinue programs that are not showing benefit and continue or expand programs that are based on evidence and are promising or that have demonstrated success. Identify and fill gaps.
Tertiary prevention strategies to treat alcohol misuse and prevent its reoccurrence				
Maintain and increase treatment services for people in regional areas, expand treatment to	To be determined	Support for all by informants	Informants identified that some regions do not have adequate treatment services (e.g. Yorke Peninsula, Riverland).	Undertake audit of treatment services and unmet needs by interviewing regional health centres.

Policy response	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
include additional follow-up treatment			*"Expanding access to treatment availability is certainly one and I particularly think that's relevant for regional areas and I think it's relevant for people who come from an Aboriginal and Torres Strait Islander background."*	Audit existing practice among treatment services and expand to include additional follow-up treatment if aligned with evidence base.
Implement sobriety tags for 24/7 monitoring among offenders who have committed alcohol-driven crimes	To be determined	All, but was listed in the context of reducing harms in the general context	An informant with expertise in reducing alcohol fuelled violence highlighted roll out in 30 states in the US, and also across England following a successful roll out in Wales. This strategy has been used in Victoria in civil cases to relieve pressure on a range of prison/remand/bail schemes. It was originally implemented in South Dakota, and the strategy has effectively reduced domestic violence by 9% across the county [9]. *"This is a really important intervention in terms of alternatives and sentencing that involve alcohol and/or other drugs and has for many people around the world led to their first periods of sobriety."*	Review of evidence from South Dakota, the UK and Victoria. This intervention is likely to have broader impacts including reduced road fatalities, reduced violence, and reduced domestic violence.
Consider the use of managed alcohol programs (also known as wet shelters)	To be determined	To be determined	A number of informants indicated that wet shelters were worthy of consideration to reduce alcohol harms and costs to SA Police. Wet shelters are in operation in Canada and the UK. A study of 23 individuals tracked over time found that this group totalled 1074 incidents	This model means that problem drinkers can drink at the wet shelter, protecting themselves, their families and the community. An evidence review would need to be conducted prior, and cost/benefit analysis undertaken.

Policy response	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
			involving police, costing about $122,000 prior to admission and this dropped to 53 incidents (costing $6,000 after admission) [10]. Evidence also found that another program in Canada resulted in a 47% decrease in emergency service use and a 41% decrease in interaction with police [11, 12]. *"It's important to consider the model. I think the medical model of managed alcohol is probably way too expensive… whereas the wet shelter model is closer to a safer injecting facility and is much more easily managed and far cheaper."*	
Other important priorities				
Reinstate access to wholesales data	Low	General	SA previously collected this, but has not done so for a long period of time. SA and NSW are the only states that don't have these data. Access to this data will allow Government to determine where sales are occurring, helping to triangulate and overcome limitations of self-report survey data [13]. This will also help to understand sales in regional areas. It will also assist in evaluating the effects of policies implemented and has been used routinely for this in QLD and NT.	Coordinator role required to collect and collate data. Regulations also need to factor in the interstate market e.g. Vinomofo and Jimmy Brings.

Policy response	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
Address data quality for Aboriginal and Torres Strait Islander Communities	To be costed	Aboriginal and Torres Strait Islander	Currently, National Drug Strategy Household Survey data is likely to underestimate population consumption generally, and particularly as Aboriginal and Torres Strait Islander respondents are more likely to be excluded by design (e.g. homeless) and experience barriers to completion (e.g. low cultural acceptability). The Grog App is not only a data collection tool but a primary care intervention, and remote NT communities have also expressed interest in its use.	Government to work with A/Prof Scott Wilson and team of researchers to cost out full implementation of the Grog App as a data collection tool and as an intervention tool. The review should draw on existing trials of the Grog App in SA and QLD.
Government to release annual survey results in unpaid media	Low	General population	Respondents suggested that framing in the media could thank people for reducing alcohol consumption to promote that drinking is no longer a social norm among young people.	SA Government currently release their data on risky drinking annually via their website. It is recommended that SA Government release results annually, and if drinking rates continue to decline in young people, this should be highlighted to change social norms.

Table 2. Prevention strategies recommended to reduce harms from other drugs by key informants and the literature

Policy response	Relevant drugs	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
Primary prevention strategies to avoid the use of other drugs or delay the use					
Fund evidence-based community education campaigns to: • Target risk perceptions and community norms around illicit drug use • Address stigma around drug use, reframing it as a health issue • Raise awareness of help seeking options, for individuals, families and community members	All	To be costed	Applicable to all; would need to be tailored for different communities	Increasing awareness and shifting community views around drug use will help reduce stigma, and increase help seeking and community support for users.	Review national plans for community education, develop campaign strategy to support this and implement strategy. Community education campaigns need to be based on evidence (an evidence review to be undertaken prior to development), and need to be supplemented by appropriate formative research, and evaluation to reduce risk of unintended consequences.
Supporting programs and policies that work 'upstream' to **address social determinants of drug use**: • Creating meaningful community/leisure activities (especially in regional areas), providing alternatives to drug use • Working with existing community strengths to build	All	Review to be undertaken and costed	All, but Aboriginal and Torres Strait Islander People in particular	Informants identified that social determinants of health (further information outlined on page 31) are associated with increased drug use and dependency, including coping with trauma, boredom, lack of opportunities, and lack of alternative leisure activities.	Undertake review of evidence to identify what works and undertake review of community activities to determine gaps.

Policy response	Relevant drugs	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
community cohesion and provide social support • Providing education and employment opportunities					
Continue to provide support to **Aboriginal Community Controlled Health Organisations** (ACCHOs)	All	Low	Aboriginal and Torres Strait Islander	ACCHOs are key to providing culturally appropriate, community-engaged services [14]. For example, they are *"really quite careful and tight around their prescribing of things like opioids and benzos. And that's meaning a good quality of care."*	Support and resourcing should be continued as a minimum, if not increased.
Secondary prevention strategies to address risk factors for harms among people who use other drugs					
Providing **affordable access to appropriate treatments** for physical and psychological pain and trauma • E.g. greater availability and accessibility of multidisciplinary, Medicare-funded, chronic pain services integrating substance use treatment services into pain management programs and reducing stigma • Training and support for GPs to manage co-morbidities, find alternative treatments, monitor pharmaceutical therapies	All	To be costed	All, and especially rural/regional and lower socio-economic communities	Informants indicated that self-medicating for physical and psychological pain/trauma are key drivers of drug use. Providing access to alternative options would reduce drug use, especially non-medical pharmaceutical use: *"There are very huge gaps in availability of treatment. So, for example, for opiate substitution treatment away from the big cities, it can be very hard to get. And yet we know, in rural areas, sometimes there can be higher rates of overdose on prescription drugs, prescription opiates. But it can be hard to find a prescriber for opiate substitution treatment or a*	Requires sufficient numbers of trained health professionals and available health services – state investment needed. Requires advocacy at a national level around Medicare support. Review of existing services and treatments to identify gaps would be beneficial.

Policy response	Relevant drugs	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
				dispensing point. You'll get pharmacies refusing to dispense."	
Education and support for health professionals to provide screening and early interventions for illicit drug use	All	To be costed	All	Health professionals, especially GPs, need further education and support to identify and treat risky use of illicit drugs: *"Most GPs would happily ask a question about tobacco consumption. A sizable proportion would ask about alcohol consumption but virtually none of them will ask about drug consumption and the principal reason they don't is because having asked the question, they don't know how to deal with the answer."*	Advocacy required at the national level for Medicare item – currently no item number for screening for substance use. Work with Primary Health Care networks in SA to support brief intervention and risk assessment, and further education of GPs. Additional substance use curricula content for tertiary medicine and health professional training (including nursing, social work, and psychology).
Develop **peer education and support** programs	All	To be costed	All	For community groups at risk of harms, informants suggested that peer education and support can be significant and more persuasive than other health messaging. Examples include: • Young people • LGBTIQ+ community • Aboriginal and Torres Strait Islander peoples	Undertake review of any existing programs and identify gaps where peer support would be beneficial.
Providing more **support and resources for families** of users	All, especially methamp-hetamine	To be costed	All	Informants noted that family members often do not know how to manage illicit drug use; this was especially noted in the case of methamphetamine use:	Consider the review recently completed by the Alcohol and Drug Foundation and undertake further review of any existing resources, identifying remaining needs.

Policy response	Relevant drugs	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
				"I think they're calling out for advice. What do you do if someone's running amok? How on earth do you link them with care? How do you keep yourself safe?"	
Support **Real Time Prescription Monitoring**	Pharmace-utical drugs	Low – already commenced	All	This program (ScriptCheckSA) was cited and recommended by informants; it monitors prescription and dispensation of opioids and benzodiazepines, and has commenced in SA recently.	Monitor current roll-out of Real Time Prescription Monitoring in SA.
Reviewing **available prescription medications** • Medication pack size for post-surgical pain could be reduced • Consider banning forms of drugs with high potential for pharmaceutical misuse (e.g. 2mg Xanax/alprazolam)	Pharmace-utical drugs	Low	All	Informants indicated that there are some currently available prescription medications that potentially contribute to dependency and could be amended to reduce harms to users.	Undertake review of available prescription medications.
Support **pill testing** at music festivals and other events	Ecstasy	Low	All	Informants referred to evidence in favour of pill-testing from the UK, where there was a reported 95% decrease in drug-related hospital admissions after introducing pill-testing at a music festival [15]. Recent research also shows that the vast majority of people engaging with testing already use drugs, and that testing does not encourage drug initiation [16].	Aim to trial pill-testing at SA events, with good evaluation mechanisms in place.

Policy response	Relevant drugs	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
Tertiary prevention strategies to treat other drug use and prevent its reoccurrence					
Consider **partial decriminalisation of drugs**	All but cannabis (already partially decriminalised)	Low – legislative change May ultimately save costs	All	Partial decriminalisation would shift focus on drug use from a criminal to a health issue. Evidence from the successful Portuguese diversion model (refer to Appendix C) was widely cited by informants and supports this policy response.	Undertake full review of international and national evidence around decriminalisation models, with a view to scoping potential reforms in SA. Informants advised that the model chosen is critical for success as some models have had unintended consequences. Cannabis is already partially decriminalised in SA, which informants typically described as appropriate. Some felt that further legalising is warranted, but others highlighted concerns about the potential for commercialisation if cannabis were to be fully legal, deregulated and market-driven, potentially leading to lower prices [17], higher potency, and increased harms. Ensuring there is no advertising to children is also crucial.
Maintain and **increase treatment and rehabilitation services**, especially for people in regional areas	All	To be determined	All	Informants identified that some regions do not have adequate treatment services (e.g. Yorke Peninsula, Riverland). *"Expanding access to treatment availability is certainly one and I particularly think that's relevant for regional areas and I think it's relevant for people who come from an Aboriginal and Torres Strait Islander background."*	Undertake audit of treatment services and unmet needs by interviewing regional health centres.
Reviewing/reducing the **costs associated with ambulance callouts**	All	To be determined	All	Informants identified costs associated with ambulances as a	Other barriers identified included: • Concerns around triggering police intervention.

Policy response	Relevant drugs	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
				barrier to individuals calling for help in the case of an overdose.	• Concerns around social welfare interventions (e.g. the removal of children from the care of the user). Further responses would be required to address these barriers.
Amending the current Controlled Substances (Youth Treatment Orders) Act and current treatment model for youth with substance use issues, to provide further resources and improved access to treatments	All	To be determined – review/ amendment of act is low cost, but revised treatment model may require funding	All	According to informants, the existing Controlled Substances (Youth Treatment Orders) Act and related treatment model is not best practice for addressing youth substance use issues. Youth service models in Victoria were recommended instead: they are family-based where appropriate and integrate allied services with AOD treatment, including mental health and health, education, housing, and family services [18].	Review Victorian service model to develop amendments for the Act in SA.
Continued support for **needle and syringe programs**, to reduce risks of blood-borne infections	Drugs administer-ed via injecting	Low – program already exists	All	Needle and syringe programs are an important component of a harm reduction approach to injecting drug use, e.g. for methamphetamine and heroin use.	This program already exists in SA and resourcing should be continued. However, it was noted that in SA, the program is called the Clean Needle Program, a name which should be changed to reduce stigma.
Undertake **a review to determine whether safe injecting spaces** would be appropriate for the SA context	Drugs administer-ed via injecting	To be costed	All	Three Medically Supervised Injecting Centres (MSICs) currently exist in NSW and Victoria; informants indicated that these spaces reduce harms associated with injecting drug use and could be considered in SA. Consideration needs to be given to the fact that the prevalence of	Undertake review of the benefits for the SA context.

Policy response	Relevant drugs	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
				injecting drug use may be lower in SA compared to the eastern states.	
Continue to make opioid antagonists (e.g. naloxone) available over the counter and on the PBS	Opioids (prescript-ion, heroin)	Low	All	Informants identified this as a harm reduction approach, ensuring easily available treatments for use in the case of an overdose. Using this rationale, naloxone nasal spray is listed on the PBS already.	Advocacy required at a national level in relation to the PBS. SA is currently participating in a pilot program, where naloxone nasal spray is available free with a voucher; this is currently funded to 30 June 2022 [19].
Other important priorities					
Strengthening existing and forming new **multi-sectoral collaborations** to review issues related to illicit drug use • Bringing together relevant stakeholders, including SA Police, SA Health, government ministers, key experts, community agencies, and users themselves	All	Low	All	Informants noted the need to have a more integrated approach to illicit drug use in SA. Examples include the SA Drug Early Warning System [20], the WA Overdose Strategy Group, and the Emerging Drugs Network of Australia. Similar groups exist in NSW and nationally. *"I think we need to… have health, drug and alcohol agencies like DASSA, ED departments, police, College of GPs, drug user organisations and others all sitting around the same table to tackle a lot of these issues. We've had that in WA for 30 years, called the Overdose Strategy Group, and it's been fantastic. We've been able to do some things that lots of other*	Review existing groups. Advocacy and leadership needed at state level to revise or form new groups.

Policy response	Relevant drugs	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
				jurisdictions haven't been able to do … I think that's a model which has some real utility, and other jurisdictions could be picking up."	
Address data quality for Aboriginal and Torres Strait Islander Communities	All	To be costed	Aboriginal and Torres Strait Islander	Currently, National Drug Strategy Household Survey data is likely to underestimate population consumption generally, and particularly as Aboriginal and Torres Strait Islander respondents are more likely to be excluded by design (e.g. homeless) and experience barriers to completion (e.g. low cultural acceptability). Studies have demonstrated that the Grog App is a more reliable tool [21] and NHMRC are funding a trial of the use of this tool for collection of data on other drugs. The Grog App is not only a data collection tool but a primary care intervention.	Government to work with A/Prof Scott Wilson and team of researchers to cost out full implementation of the Grog App as a data collection tool and as an intervention tool.
Continued **resourcing of the SA Police**, especially the Serious and Organised Crime Branch, to monitor and intervene to prevent the supply of illicit drugs	All	Low – supporting existing service	All	Informants identified supply factors to be key drivers of use for many illicit substances.	SA Police are already engaged in this work but should be supported to continue.
Resourcing ongoing evaluation, research, and monitoring **to identify new patterns in drug use in SA,** including emerging drugs of concern	All	Low – primarily supporting existing services [20]	All	Ongoing resourcing is required to identify new trends in drug use, including emerging drugs of concern, as well as evaluating the effectiveness of interventions. Includes:	DASSA are already engaged in this work, but should be supported to continue. Additional support/funding may be required for new datasets or integration of datasets,

Policy response	Relevant drugs	Cost to Govt	General population/ Aboriginal and Torres Strait Islander/ All	Rationale	Factors to consider and steps required
				• Wastewater analysis • SAPOL monitoring • Hospital admission data audits • Research funding • Integrating findings across datasets and sectors	especially in relation to emerging drugs of concern.

Introduction

Use of alcohol and other drugs (AOD) places significant burdens on the physical and mental health of users, and their families and communities. In this review we synthesise Australian evidence, supplemented by key informant interviews, to characterise patterns of use, trends, harms and drivers. We also present policy options to reduce harms in South Australia (SA).

Methodology

1. A literature review and synthesis of key data on drug and alcohol use and impacts in SA was undertaken to answer the following questions:

1. What are the current AOD trends in the SA, how do these compare to national trends, and how has this use changed over the past 20 years (if data permits)?
2. What are the harms of AOD use to users?
3. What potential policies could be introduced to influence change in the harms arising from AOD use in SA?

The principal data sources considered for this report include survey data (self-report) collected by the National Drug Strategy Household Survey (NDSHS), the National Aboriginal and Torres Strait Islander Social Survey, and the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS).[8] We also refer to wastewater data from the National Wastewater Drug Monitoring Program, as well as South Australian wastewater monitoring. Each data source has its strengths and weaknesses, which are taken into account here [22]. Some of the estimated proportions from these data sources should be interpreted with caution; relative standard errors of 25-50%[9] are indicated in this report with asterisks (*).

Recent critiques in Australia [23, 24] and overseas [25] highlight the declining response rates and design limitations of general population surveys, such that AOD use among key higher-risk groups (e.g. homeless or incarcerated people, who are often excluded from household data collection) cannot be estimated. In addition, and despite large overall survey samples, concern has also been raised about higher-risk demographic populations (e.g. older people, Aboriginal and Torres Strait Islander people, and people from lower socioeconomic backgrounds) being represented by relatively small numbers of survey respondents. Data quality issues remain even for those who do participate in general population surveys; respondents typically drink less alcohol than non-respondents, which also underestimates population trends in consumption [13]. Stigmatised behaviours more generally may also be under-reported, which is particularly relevant to estimates of risky drinking [24] and illicit drug use [23, 25].

2. Interviews were undertaken with key experts (informants) working in the SA and national AOD sector (n=18 from the general population and n=6 representing Aboriginal and Torres Strait Islander populations).

Lead investigators conducted interviews to assess likely drivers of change in AOD use in SA, harms to community, and policy responses. All interviews were semi-structured, with a topic guide based on initial findings from the literature review, as well as the scope to pursue additional topics raised by the informants. Interviewees included researchers, clinicians, policy makers, advocates and professionals in the AOD sector, with representation from academic, government, non-government, and community services organisations.

[8] Other data sources referred to in this report include the South Australian Population Health Survey Module System, which generally reflect similar AOD trends and were used to illustrate the consistency of findings.
[9] This indicates that an estimate from the sample of survey respondents has a higher degree of uncertainty, reflecting chance variation from the full population (i.e. compared to if all eligible members of the population completed a survey). However, relative standard errors of this size are still considered by the NDSHS data custodian to be suitable for most uses.

Table 3. Overview of key informants

Total number of key informants interviewed	24 (cooperation rate[10] = 75%)
Key informant area of expertise (n=24)	
Both alcohol and other drug use	16
Allied settings related to AOD use (e.g. homelessness services and the justice sector)	5
Alcohol use only	2
Other drug use	1
Key population expertise	
Aboriginal and Torres Strait Islander communities	6

Current strategies in place to reduce harms from AOD use

For context, it is important to note that there are a number of key strategies in place to address harms from AOD use at the population level. At the national level, two main strategies exist including the National Alcohol Strategy 2019-2028 [26] and the National Drug Strategy 2017-2026 [27]. Within SA, the key overarching strategy is the 'South Australian Alcohol and other Drug Strategy 2017-2021' [28]. This strategy ('the SA Strategy') includes key actions to address harms from alcohol and drug use in SA. The SA Strategy guides SA Government responses and was developed by SA Government in consultation with law enforcement, education, the non-government sector, the research community, and peak bodies.

In 2019, a mid-term review of the SA Strategy highlighted that, of the 90 actions, 37% were complete and 56% were in progress [29]. A final review has yet to be released. The SA Strategy is in its final year, with consultation set to take place at the end of 2021 for the next SA Strategy. While it is outside the scope of this report to review progress, steps taken and priorities of the SA Strategy, the results from this report should be considered in the consultation process for the next iteration as many of the policy recommendations extend beyond current practice in SA.

[10] Cooperation rate indicates the completed interviews with key informants as a percentage of all invited informants.

Findings

Trends in AOD use in South Australia (general population)

In 2019, approximately one in five (18.3%) South Australians consumed alcohol at levels that could put them at increased risk of long-term harms (e.g. chronic disease including cancer), and one-quarter (26.0%) at increased risk of short-term harms (i.e. injury) [2]. Other than alcohol, cannabis is the most frequently used drug with 10.6% of South Australians reporting recent[11] use in 2019, followed by the non-medical use of pharmaceuticals (4.2%). However, even for drug types with relatively low prevalence of use (e.g. 1.0% of South Australians reported recent methamphetamine use in 2019), the harms associated with use are substantial; subsequent sections of this report will outline these harms and groups at particular risk (Figure 1). It is also important to note that most people tend to be polydrug users (i.e. use multiple drugs[12]), which can further increase the harms associated with drug use. Alcohol is the most common substance involved in polydrug use.

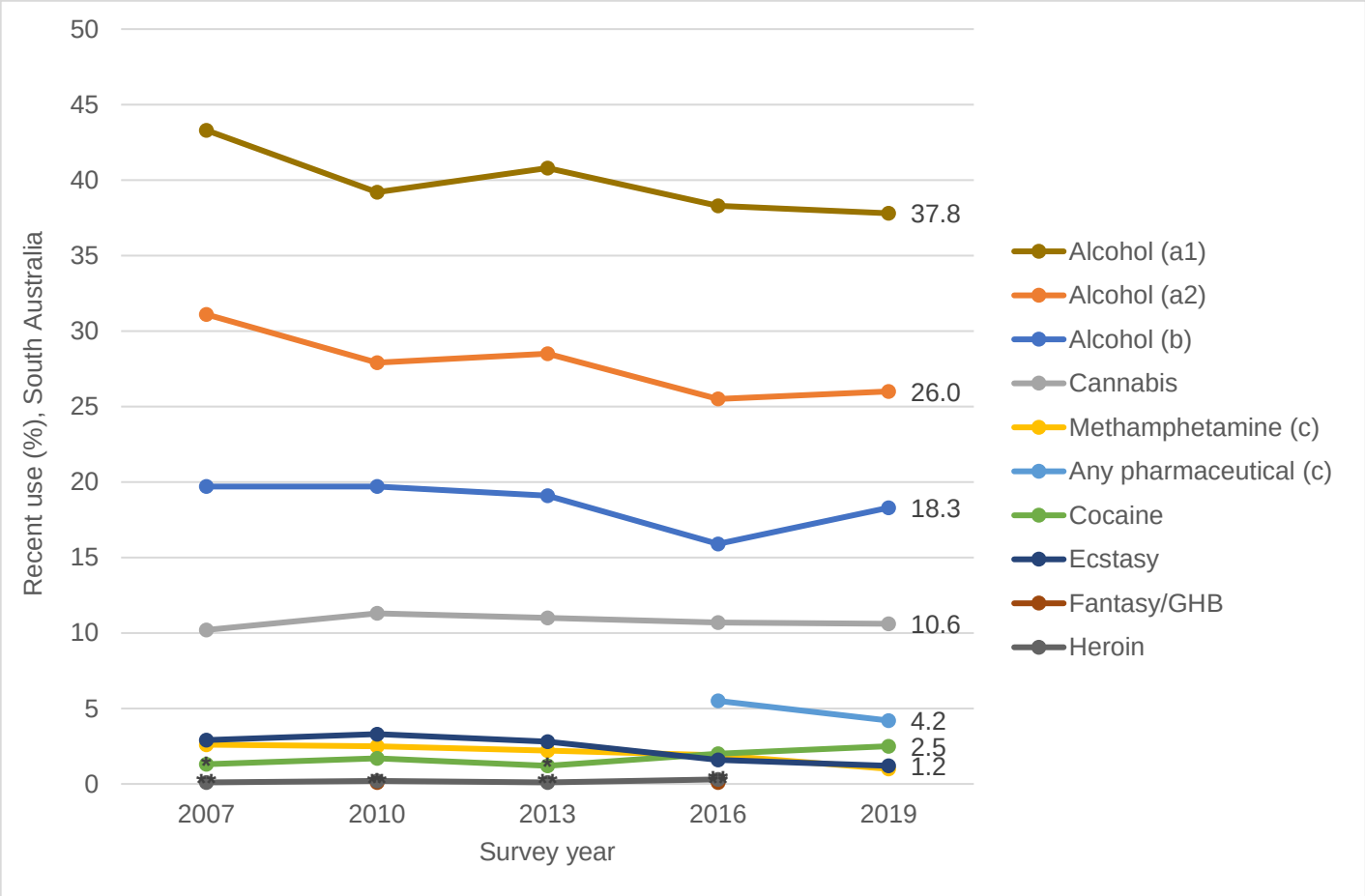


Figure 1. Summary of recent other drug use and risky alcohol use among South Australians aged 14 and over, 2007-2019 [2]

(a1) Exceeds 2009 NHMRC guideline 2 ('short-term risk'): Had more than 4 standard drinks on a single occasion in the previous 12 months (at least yearly).
(a2) Exceeds 2009 NHMRC guideline 2 ('short-term risk'): Had more than 4 standard drinks on a single occasion, at least monthly, in the previous 12 months.
(b) Exceeds 2009 NHMRC guideline 1 ('long-term risk'): On average, respondents had more than 2 standard drinks per day.
(c) For non-medical purposes. Due to differences in survey methodology, frequency of any pharmaceutical use is not available in survey years 2007-2013.

[11] For other drugs, recent use is defined as any reported use of the specified drug in the previous 12 months.
[12] Polydrug use refers to a person using more than one type of drug, either at the same time or different times.

AOD use among Aboriginal and Torres Strait Islander People

Figure 2 below shows most recent data for use by Aboriginal and Torres Strait Islander people in SA. Overall, 16% exceeded the long-term risk guidelines for alcohol vs 18.3% in the general population (previous figure).

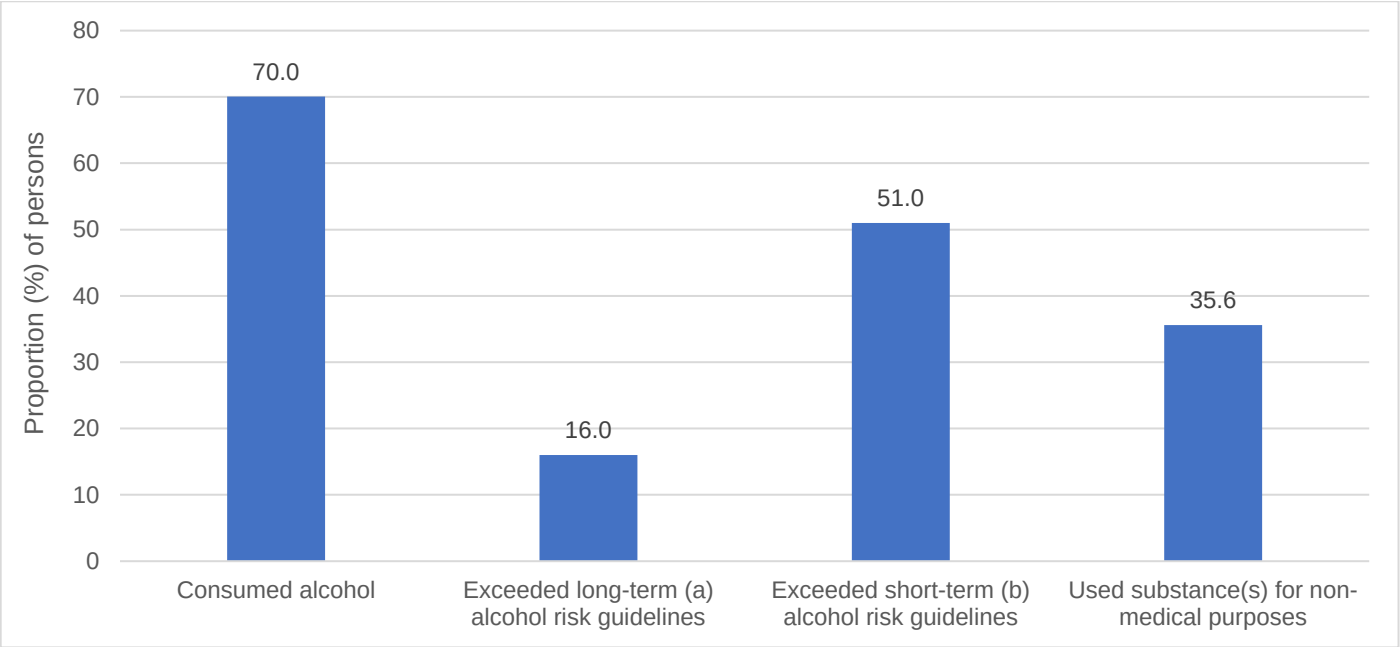


Figure 2. Alcohol consumption and substance use in the last 12 months among Aboriginal and Torres Strait Islander persons aged 18 years and over, South Australia, 2018-19 [30]

(a) Exceeds 2009 NHMRC guideline 1 ('long-term risk'): On average, respondents had more than 2 standard drinks per day.
(b) Exceeds 2009 NHMRC guideline 2 ('short-term risk'): Had more than 4 standard drinks on a single occasion in the previous 12 months.
Proportions are based on data reporting use of alcohol and substance in the last 12 months by ABS.

For other drug types, data for Australia as a whole is given, since the size of the SA subsample is too small for accurate data on uncommon behaviours. Figure 3 shows substance use among Aboriginal and Torres Strait Islander people for Australia, by drug type. Overall, alcohol is the most widely used substance followed by cannabis (including hashish and resin forms). Use of meth/amphetamines is at 3.4%, which is 2.4 times higher than non-Indigenous Australians.

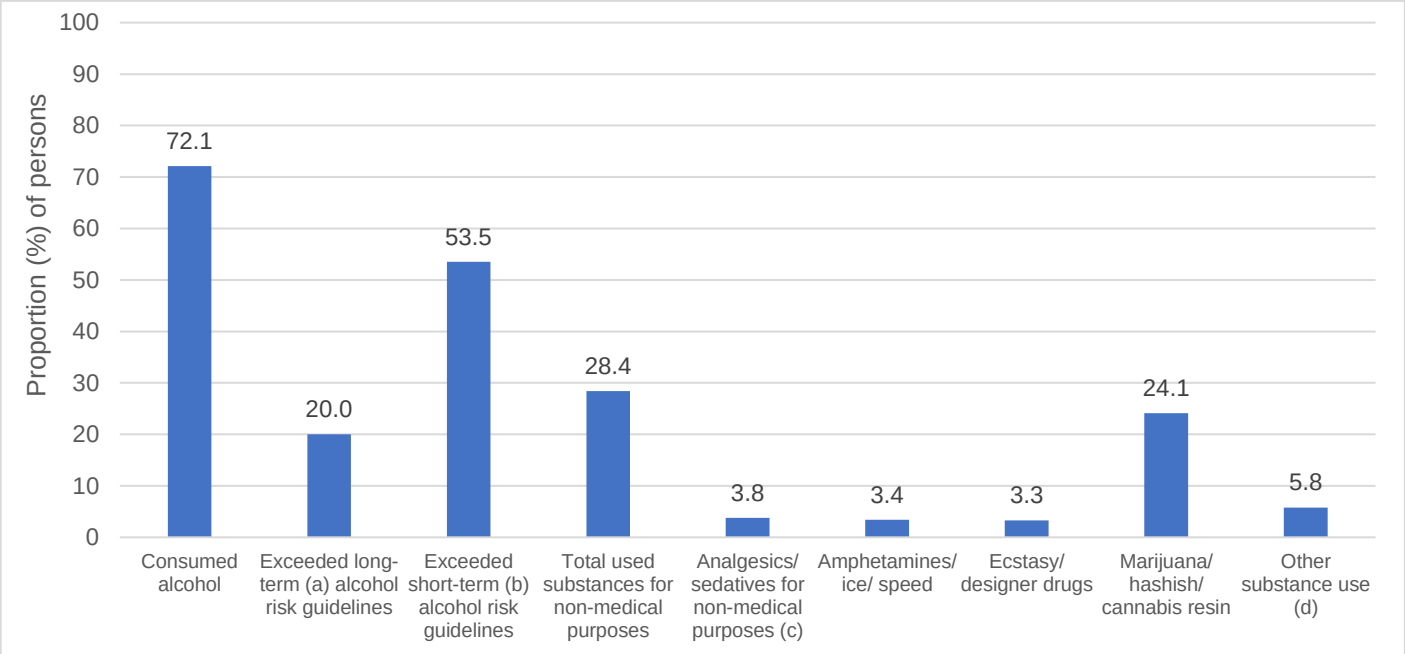


Figure 3. Alcohol consumption and other drug use in the last 12 months among Aboriginal and Torres Strait Islander persons aged 18 years and over, Australia, 2018-19 [31]

(a) Exceeds 2009 NHMRC guideline 1 ('long-term risk'): On average, respondents had more than 2 standard drinks per day.
(b) Exceeds 2009 NHMRC guideline 2 ('short-term risk'): Had more than 4 standard drinks on a single occasion in the previous 12 months.
(c) Analgesics/ sedatives for non-medical purposes include painkillers, tranquilisers, and sleeping pills.
(d) Other substances include heroin, cocaine, petrol, LSD/ synthetic hallucinogens and naturally occurring hallucinogens, kava, methadone, and other inhalants.
Proportions are based on use of alcohol and substance in the last 12 months in non-age standardised data reported by ABS.

Shared drivers across AOD

There are some key shared drivers that underpin substance abuse. These are the social determinants of health across the general population, which are further exacerbated by historical factors and racism among Aboriginal and Torres Strait Islander People. Relatedly, there are shared priorities needed to address AOD use and related harms.

Social determinants of health

It is well known that heath follows a social gradient, where increased socio-economic position relates to better health [32]. Substance dependence and use disorders are commonly associated with low socioeconomic status (SES). Further, Australian data reveal that for all drugs, except cocaine, the number of drug-induced deaths is markedly higher for the most disadvantaged than the most advantaged [33]. Alcohol use has a somewhat different pattern where studies tend to find that higher SES tends to be associated with drinking more frequently, whereas low SES tends to be associated with drinking being more concentrated in heavier-drinking occasions [e.g. 34]. However, more disadvantaged social groups experience more harm from alcohol even at the same levels of consumption, reflecting social determinants and broader health inequalities (e.g. increased psychosocial stress, or reduced resilience to alcohol-related illness) [35].

These societal inequalities in health can be explained by using a social determinants of health framework. Figure 4 shows an application of such a framework to alcohol-attributable harm specifically, although it can similarly be applied to the context of other drugs. This framework maps the relationship between people's individual factors, social and environmental factors, and health. Individual alcohol consumption and subsequent health and socio-economic outcomes are shaped by various layers of influences. It highlights that cultural, economic, living, working, and more general socio-economic conditions are integral to health.

Informants identified that strategies to decrease poverty and increase liveable wages, increase access to health care services, increase life opportunities, support for mental health, and decrease discrimination (e.g. racial, gender, sexuality) will reduce AOD misuse. Further data shows significantly different patterns of AOD use by industry and occupational groupings, and transitioning into work is also a key pivot point in the uptake of AOD.

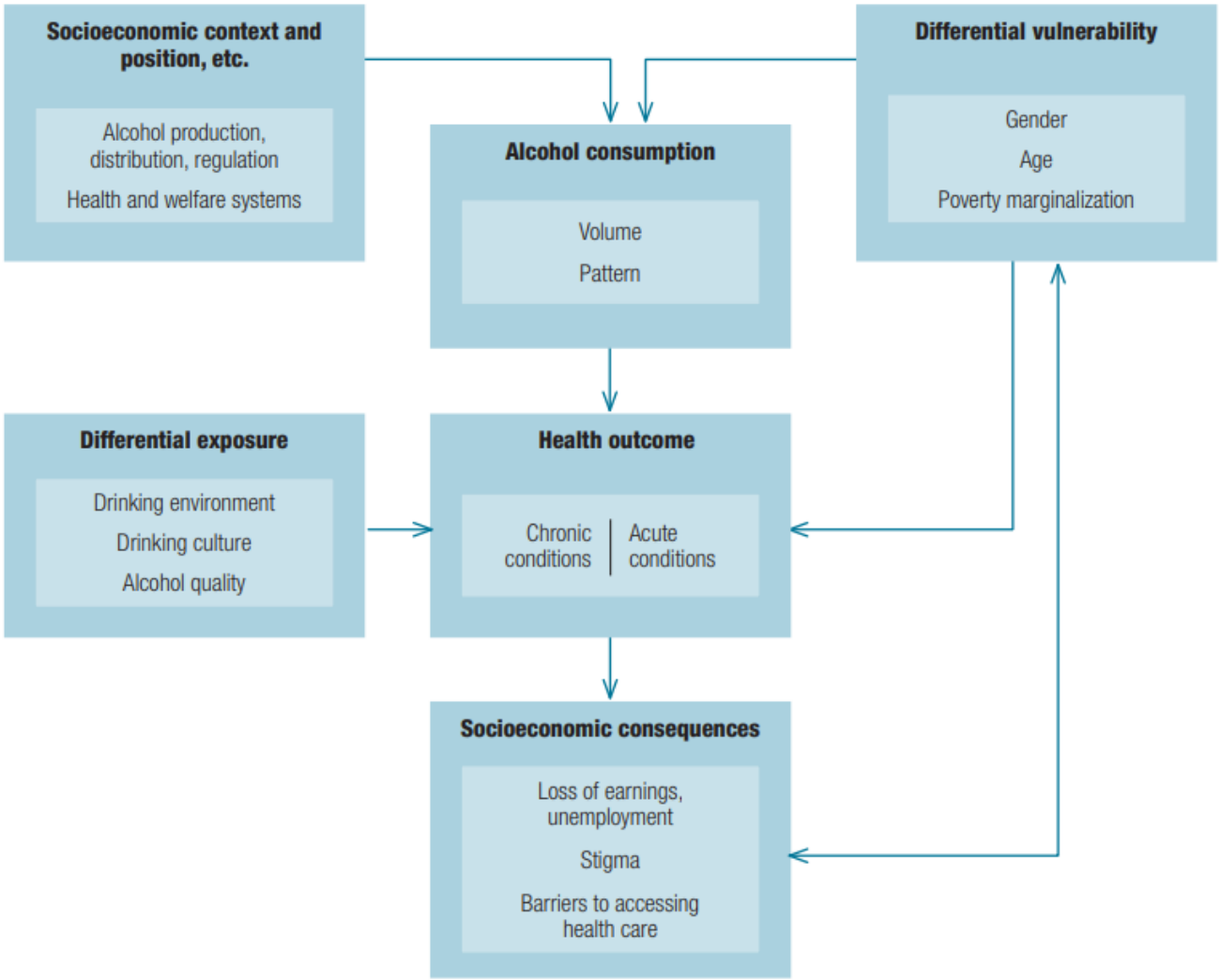


Figure 4. Priority public health conditions analytical framework as applied to alcohol attributable harm

Source: Schmidt LA, Mäkelä P, Rehm J, Room R. Alcohol: equity and social determinants. In: Blas E, Sivasankara Kurup A, World Health Organization, editors. Equity, social determinants and public health programmes. Geneva: World Health Organization; 2010 [36].

Context of Aboriginal and Torres Strait Islander AOD use

Alcohol (and other drug use) needs to be understood within the social and historical context of colonisation, dispossession of land and culture, the Stolen Generation, and economic exclusion [37].

Aboriginal and Torres Strait Islander people experience a burden of disease that is 2.3 times the rate of non-Indigenous Australians [15]. This differential disease burden is due to underlying factors [38] including:

- social exclusion
- marginalization
- discrimination and racism
- cumulative trauma [39, 40]
- poverty, and

- lack of adequate access to culturally appropriate services [41].

For context, the vast majority of Aboriginal and Torres Strait islander people live in major cities or regional areas (approx. 81%) [42]. However, 19% live in remote or very remote areas (where access to primary health care and specialist services remain poorer than in more populated areas), compared to just 1.5% of non-Indigenous Australians [43]. Further, as shown by Figure 5, and in part because of all the above-mentioned disparities, Aboriginal and Torres Strait Islander people have a much younger age structure, compared to non-Indigenous Australians. For instance, in 2016, the median age was 23.0 years, compared with 37.8 years for non-Indigenous Australians [42]. This difference in age structure also contributes to higher rates of AOD use among Aboriginal and Torres Strait Islander people (as it is more common in younger age groups).

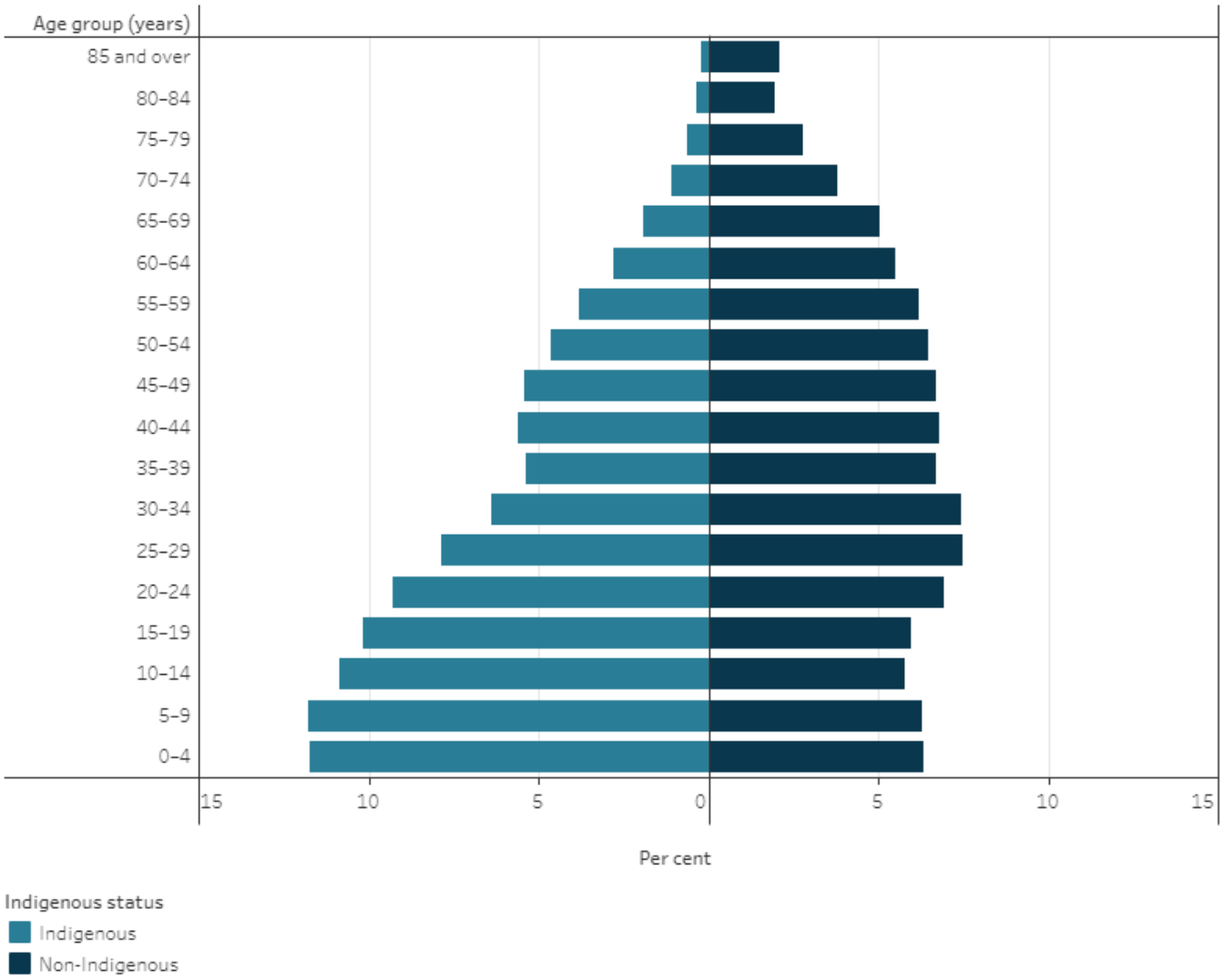


Figure 5. Age structure of the Australian population, by Indigenous status (2016)
Source: Australian Institute of Health and Welfare [42]

Key informants outlined the complexities underlying AOD use and abuse among Aboriginal and Torres Strait Islander communities, including:

- **Racism/discrimination -** conscious and unconscious bias – including micro-aggression on a daily basis, which can lead to depression and self-medication.

- **Cumulative trauma** – i.e. from the Stolen Generation, and its effects are still being seen today.
- **Poverty and associated disadvantage** – including hopelessness and exclusion from mainstream economy.

Some key areas critical for change listed by informants were:

- **Education** – including good role models (that extend beyond football players).
- **Quality housing**
- Community consultation is key and should be integral, and internal needs should be driven with the community *"we need to be honouring and prioritising the voices of what community leaders, as well as community members".* It was acknowledged that this takes time and ongoing funding is important *"if they could have just had some regular ongoing funding, then you might be able to design longer, more rigorous studies to see what the changes have had."*
- Because of the lower life-expectancy among Aboriginal people (Figure 5) there are not as many adults for children, meaning less supervision of the younger generations, which has a flow-on effect for the whole community: *"you've only got a certain number of grandparents, a certain number of parents, and you've got a lot more kids"* and *"our cultural processes of handling and managing children, caring for children, are really under strain by that population pyramid."*

Priority responses needed across AOD: Key informant interview responses

Many of the priorities for addressing AOD use and related harms are shared across substances. In particular, we note here the pillars of harm reduction and key informant responses about priorities.

Pillars of harm reduction

Reducing harms due to AOD in the context of the multifaceted, shared drivers of use requires a coordinated, and balanced effort across the three main pillars of harm minimisation. These pillars are outlined in Figure 6:

Figure 6. Three pillars of harm minimisation

Image source: Australia's National Drug Strategy, 2017-2026, page 1 [41].

Key informant interview responses: General population priority needs

Key informants were asked at the commencement of the interview: 'What are the most pressing needs in relation to alcohol and other drugs…?'. For the general population, responses included:

- AOD use tends to be framed by the media, politicians and police as a criminal issue. Currently, individuals with substance abuse issues are often characterised as *"deviants, self-centred, made a bad choice and should be locked up".* Informants highlighted that such framing neglects the underlying complexities, such as complex trauma and social determinants of health and serves as a barrier for people to seek help and treatment. Some informants commented that this is particularly the case in Aboriginal and Torres Strait Islander people who are worried that if they seek treatment, they may lose custody of their children. The following quote from one informant captures the view of the majority:

  "A lot of people have published [that] the war on drugs has failed. Using punishment to deter drug use is a very flawed approach and there's lack of evidence that that's an effective way to reduce harms from drug use. And using punishment as a way of stopping it is associated with a wide variety of harms, including mental health harms, family disruption, loss of ability to work because you've got a criminal record. All these things are likely to make it less likely you can engage in a productive life, not more likely. So, we need to move away from a punitive approach to substance use, or indeed to crimes related to substance use and move to a therapeutic approach."

  "Substance use is fun, drinking is nice, being stoned is nice. But nobody does it because they want to end up in the ED, but we do need to have systems and we do not have enough treatment for people who overstep the mark. What they should have is treatment, not conviction."

- As AOD use is related to complex social issues, there is a need to address the social determinants of health including education, employment, poverty, adequate housing and social infrastructure, homelessness, safe community spaces and activities, policies that affect low SES, and better supports for offenders.

- The funding for drugs and alcohol is in disparate places, which needs to be pulled together under a cohesive intersectoral framework. We need a *"mechanism for cooperation"* and integrated approaches across sectors/depts for welfare, employment, drug & alcohol, acute care, law enforcement, and school-based education – such a committee, namely, the Principal Committee for Drug & Alcohol, used to exist.

- A federal commission and ways to integrate the services and research in this area are needed to most effectively identify evidence-based approaches to prevention and treatment.

- Better integration is needed across State and Federal governance of treatment, funding and administration of services and policies relating to AOD. This area has typically been the *"poor sibling of mental health".*

- Many informants highlighted that industry tends to persuade governments to avoid regulation. For example: *"We have a problem of business and pleasure being very profitable and actually that's the challenge for us"* and *"…we know that the alcohol industry is very nimble and deft at getting around advertising restrictions, and we know that those are things which should be railed in".* However, governments of all political perspectives have been able to make successful policy changes in SA to reduce harms from AOD despite industry pressure, and previous examples of these have often been considered bold. Although it is *"sometimes easier to manage things in a crisis"*. Informants commented that there is a need to make sure we are making evidence-based policy change to influence positive trends even when there is no immediate crisis.

- There was also a sense that if the community understood the motivation from government, they would be supportive: *"the government shouldn't underestimate its ability to bring the people with them if they're actually working on evidence and working for the good of the people"*.

Key informant responses: Aboriginal and Torres Strait Islander priority needs

Responses relating to Aboriginal and Torres Strait Islander communities included:

- It is important to work meaningfully and effectively with people in communities.
- We need to honour voices in communities and work on the ground with communities, not pay lip service to it.
- We need strong Aboriginal leadership and focus on the workforce (e.g. leaders such as A/Prof Scott Wilson who are training many PhD students).
- Many programs are brought in and then defunded. However, programs take time and relationships need to be developed with communities first.

Alcohol

Alcohol is the most widely used drug in Australia and its use is culturally normative [44]. Despite this, alcohol is a psychoactive, toxic, and dependence building substance, and it is one of the leading risk factors for public health [45]. It is a nervous system depressant and alcohol is classified as the most harmful drug, because of its harm to individuals (i.e. increased risk of injury and chronic disease) and to others (e.g. domestic violence and assault) [46].

Trends: use and impacts

General population patterns of use

Australia ranks relatively high in the world on per capita alcohol consumption. In 2016, those aged 15 years and older consumed an average of 10.6 litres of pure alcohol per person compared to the global average of 6.4 litres [45]. In SA, the most recent population survey data from 2019 shows that the proportion of South Australians aged 14+ who drank alcohol in the past 12 months has decreased from 84% in 2007, to 79% in 2019. Moreover, both daily and weekly drinking have decreased significantly, from 8.0% to 5.8% and from 42% to 37% since 2007, respectively [47]. These levels are consistent with data from the South Australian Population Health Survey Module System 2019, which indicated that 77% of South Australians aged 15+ had consumed alcohol in the past 12 months, and that daily and weekly drinking were reported by 7% and 36% of South Australians, respectively [48]. The declining trends in overall consumption are also mirrored in wastewater data (Figure 7), which show lower average consumption in 2020 and 2021 than the years since sampling began.

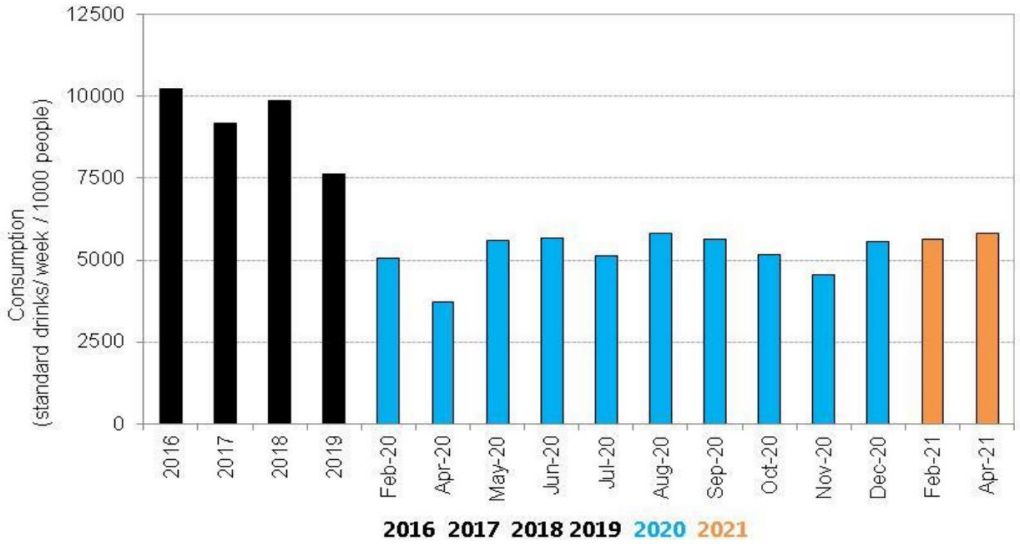


Figure 7. Alcohol consumption (standard drinks/week/1000 people)[13] [49]

[13] Average consumption (standard drinks/week/1000 people) from 2018-2019 (excludes February). Weekly consumption (standard drinks/week/1000 people) monthly from April to December 2020, and bi-monthly from February 2020 to April 2020 and from December 2020 onwards. Ethanol excretion=0.012% of ethanol consumption, 10g ethanol per standard drink.

In SA, drinking rates are higher among males, with 8.1% of males and 3.5% of females reported drinking daily (compared to 6.9% and 3.9% of males and females in Australia, respectively) in 2019 [47]. Risky alcohol consumption is more common among those living in remote or very remote areas.

Furthermore, 26.0% of South Australians aged 14+ drank at levels that put themselves at increased short-term risk of harms (e.g. injury) by drinking more than 4 standard drinks on one occasion at least once a month.[14] Overall, 18.3% drank at levels that increased their lifetime risk of harm (e.g. from chronic diseases) by drinking more than 2 standard drinks per day, while 21.0% abstained. These trends generally mirrored national trends (Figure 8). Nonetheless, one study informant indicated that Adelaide residents were found to have higher risky consumption, compared to other Australian cities. It also found that South Australians aged 50 years and over were more likely to drink at risky levels than the national population of people aged 50 years and over (informed by Prof Ann Roche). More fine-grained data are available on request.

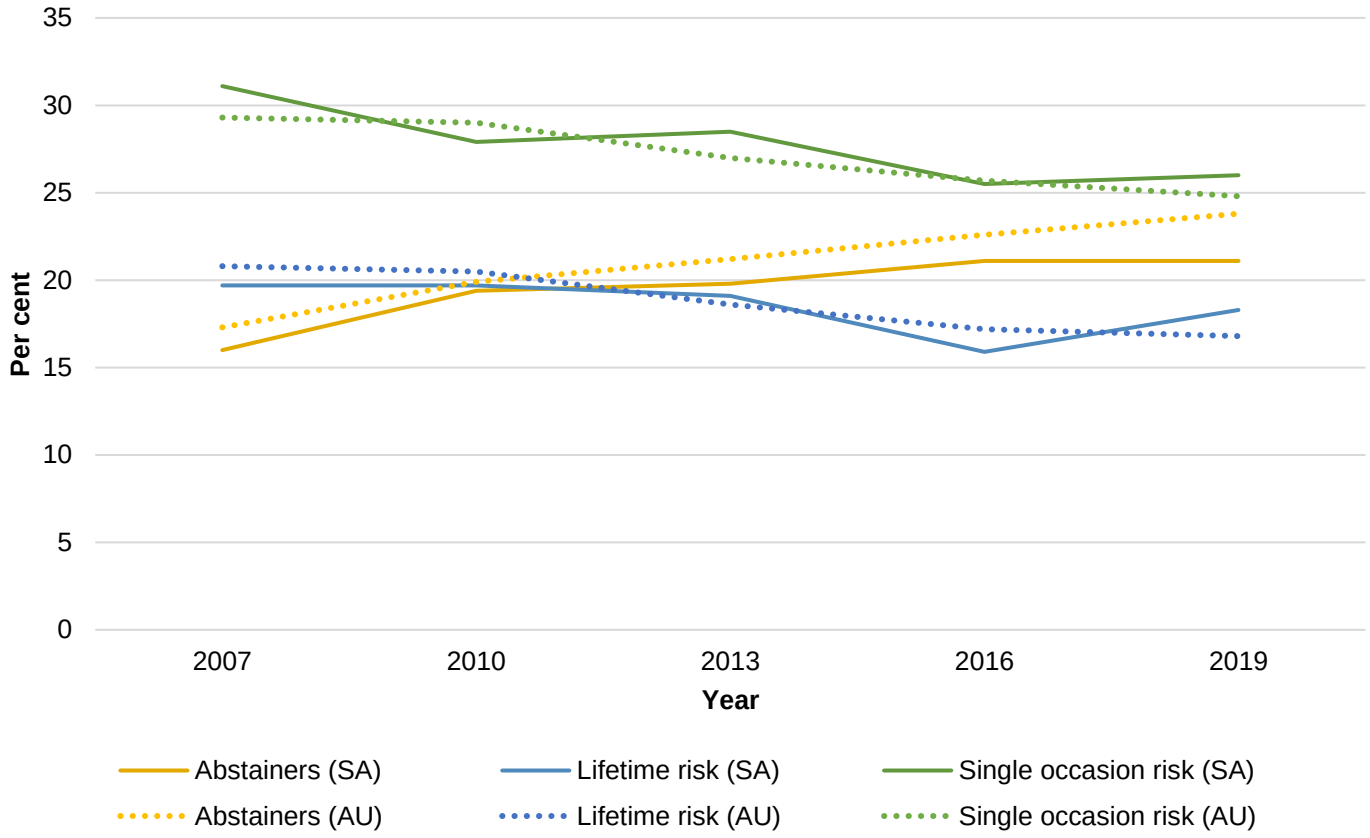


Figure 8. Alcohol risk type, people aged 14+ in Australia versus South Australia, 2007 to 2019 (%) [50]

Across the whole Australian population, there has been an increase in abstaining from alcohol among adults aged 18 years and over. However, this trend is largely attributable to drinking patterns among younger adults. For example, across the whole Australian population, the proportion of those aged 25-29 abstaining from alcohol more than doubled from 2001-2019 (from 9% to 24%). At the same time, rates of abstention have declined for those aged over 70 (from 32% to 28%). In 2019, drinking above long-term risk levels was most common among those aged 40-49 and 50-59 (each 21%). While rates have decreased over time for many younger groups, they have increased for older groups. However, younger age groups remain generally more likely to drink at short-term risky levels, compared to older age groups (e.g. 41% of those aged 18-24 and 36% of those aged 25-29 in

[14] The alcohol guidelines established by NHMRC in 2009 and that were in place until 2020 have been used in this report as the newly released guidelines were not available to inform data trend analyses for SA.

2019, compared to 9% of those 70+). Further, younger age groups typically drink more on weekend days compared to weekdays, and daily drinking is most common among those aged over 70 (at 13%) [2].

Aboriginal and Torres Strait Islander community patterns of use

Aboriginal and Torres Strait Islander Australians, compared to non-Indigenous Australians, are more likely to abstain from alcohol [2]. However, those that do consume alcohol are more likely to drink at risky levels [37], and rates of alcohol-related death are approximately five times higher among Indigenous Australians compared to non-Indigenous (23.8 vs. 4.7 per 100,000 population, respectively) [51]. Further, approximately half of Aboriginal and Torres Strait Islander people exceed the single occasion risky drinking guidelines (Figures 2 and 3), and this proportion has increased over time [52]. A recent marked decline in the rates of very high consumption (consuming 11 or more drinks at least once a month) has also been reported, from 18.8% in 2016 to 10.6% in 2019 [53].

Alcohol consumption by Aboriginal and Torres Strait Islander Australians differs considerably between and within communities [54], which highlights that estimates may not represent individual or local community patterns. Particularly, as consumption is often a group-based activity for Aboriginal people, typical population survey methods may have low acceptability and accuracy in this population. Key informants highlighted the recently developed 'Grog App' as a more culturally acceptable way to collect data on alcohol use among Indigenous people. The App includes interactive options to describe different beverage and container types and group or individual drinking [55, 56]. Based on App data, informants noted that the proportion of Aboriginal people meeting criteria for alcohol use disorder was relatively low [57].

General harms from alcohol use

The individual and social harms related to the misuse[15] of alcohol are numerous and include premature death, ill-health, noncommunicable diseases, poor mental health and wellbeing, and violence [45].

- Each year an estimated 3 million lives are lost globally, and consumption is linked to over 200 health issues [45], including harm to the individual (i.e. including liver disease, cancers, road accidents) and harm to others (e.g. child neglect and abuse, and domestic violence).
- Alcohol is associated with over 5,750 deaths per year in Australia and it is responsible for 4.5% of Australia's total disease burden [58].
- The social cost of alcohol consumption is estimated to be between $15 billion [59][16] and $36 billion annually[17] (in the form of lost productivity, costs to others around the drinker, and costs to the criminal justice system, health system and traffic accidents).
- From 2014-15 to 2018-19, alcohol was the drug with the highest principal diagnosis of hospital separations [60].
- In Australia, alcohol is rated by experts as the drug causing the *greatest harm to users and others combined*, and notably, scored highest on measures of 'family adversity', 'injury', 'economic costs', 'drug related morbidity', and 'drug specific mortality' [61].

While the proportion of adolescent drinkers has decreased in recent years, alcohol remains the leading cause of death and disability in those aged 15-24 globally [62], and hospital emergency presentations are increasing in this age group in Australia [63].Comments from informants regarding harms include:

- There was an overwhelming response from all participants that after tobacco, alcohol is the substance that causes the most harms in Australia.

[15] At either risky levels as prescribed by the NHMRC, or use in inappropriate contexts, including while driving.
[16] Most recent data on the social and economic costs of alcohol consumption to Australia were released in 2008. Updated data is scheduled for release in September 2021.
[17] This estimate combines Collins D, Lapsley H 2008. The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004–2005. Canberra: Commonwealth of Australia; and Laslett A-M et al. 2010. The range and magnitude of alcohol's harm to others. Melbourne: AER Centre for Alcohol Policy Research and Turning Point Alcohol and Drug Centre, Eastern Health. Note however, that it may involve a small element of double counting.

"Certainly without doubt, alcohol remains the most commonly misused drug in the community and creates the most significant harm, obviously with the exception of tobacco in regards to mortality."

- It is also associated with social harms – e.g. family and gendered violence, noise and community disturbances, and harassment (including sexual harassment/assault in licensed venues).
- Relatively little attention has been paid to the risks of acquired brain injuries resulting from falls associated with intoxication.
- Health professionals are not clear on understanding what the guidelines are, which makes identifying risky drinking difficult: *"one thing that has been a complete failure is communicating what low risk drinking actually means".*
- Informants also acknowledged that alcoholism contributes to a chaotic lifestyle: *"taken advantage of, a lot of, gets assaulted a lot, loses their stuff, gets things stolen a lot, gets his house taken over".*

Drivers of trends

General population drivers

Alcohol is firmly embedded in many dimensions of Australian life [64], and consumption is influenced by many factors, ranging from individual factors such as age and gender through to community norms and finally macro-factors related to the alcohol industry promoting their products for profit (Figure 9).

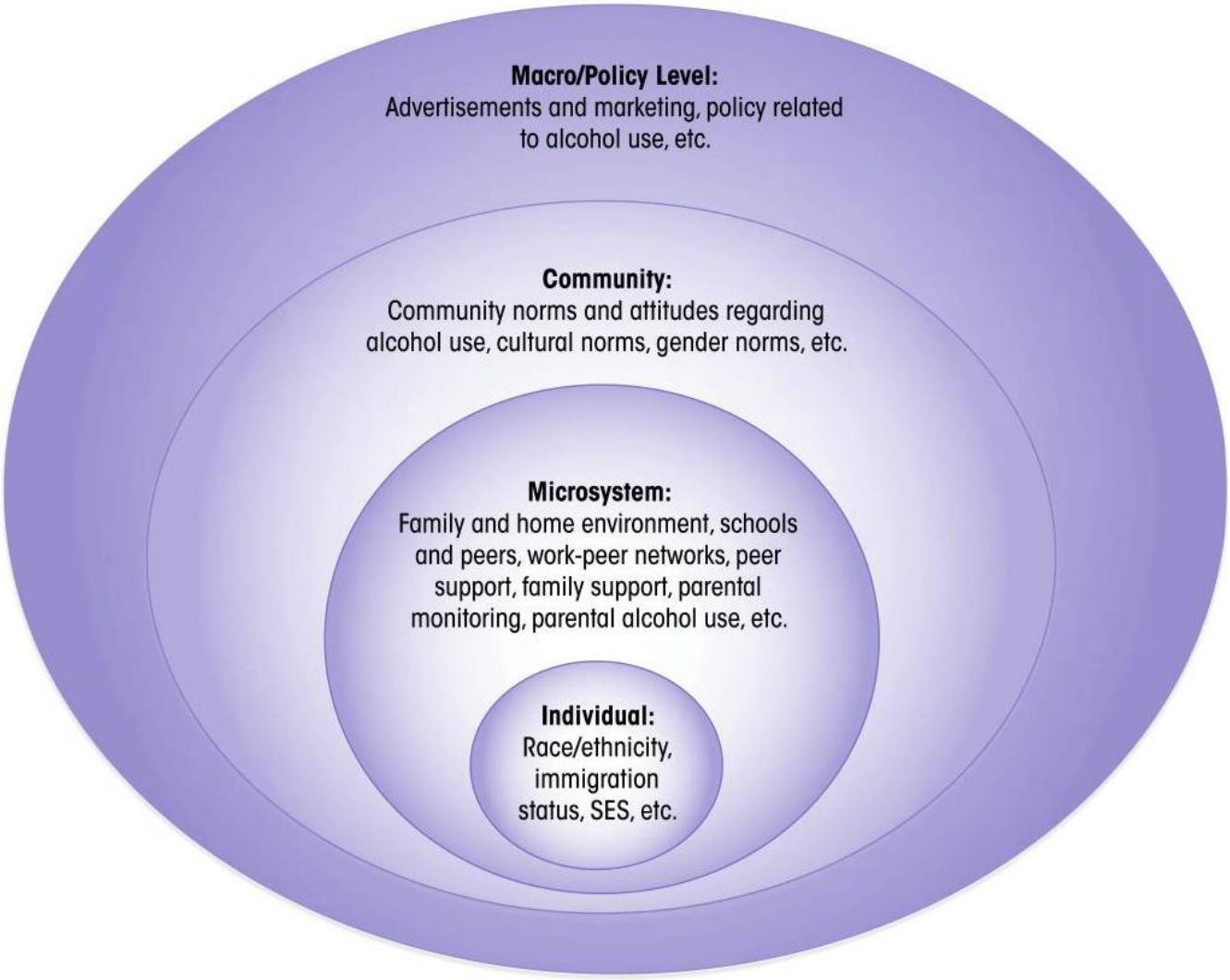


Figure 9. Influences of drinking from a social-ecological framework [65]

Comments from informants regarding drivers of trends

General community:

- The vast majority of informants reported the main reason for the overall decline in drinking rates was due to declining drinking rates in young people. There are studies underway to understand this further, but informants hypothesize the following:
    - There seems to be a clear trend in the changing socialisation processes that are more dependent on virtual socialising (in contrast to socialising in licensed venues). Further, social media both encourage and discourage consumption in others depending on circumstances (e.g. it can be used to name and shame people) and there is also the potential for parental monitoring of teenage activity on social media [66, 67].
    - Better awareness amongst young people and their caregivers around the acute risks of alcohol consumption and the need to delay age of onset.
    - Generational changes in parenting styles.
    - Increased cultural focus on healthy living amongst younger generations, as well as more conservatism in younger people.
    - There is also evidence that the reduced drinking in this younger group is continuing as they age [68].

- Comments related to ongoing drinking in SA
  Drivers of demand
    - Drinking is influenced by culture and context – policies can help shift the context of drinking, but future research should pay attention to culture, pleasure, and understanding why (or why not) people use substances.
    - Alcohol is connected to community cohesion, especially in regional communities.
    - There has been a shift over time from drinking primarily in licensed venues to drinking in home environments (especially exacerbated during COVID-19).

  Supply drivers
    - Alcohol industry have strong influence on policy makers and social norms through advertising and sports sponsorship.
    - Current challenge that may influence drinking in Australia: because of the China market dropping out, local industries will potentially look to drop prices and increase aggressive marketing, e.g. telemarketing (perhaps especially in SA, given we represent 80% of premium wine production and 60% of the wine export market in Australia).

Aboriginal and Torres Strait Islander communities:

- Many people just like it, a lot of people share – social experience, some people do it because they want to belong, lonely, bored, or drown sorrows – high prevalence of trauma – self-medication: *"in a sense, it's possibly helpful to think of this as one of the major symptoms of what's wrong, rather than the cause"*.

- It's become part of family gatherings: *"it's sort of become a culture in terms of pretty much every sort of family gathering that goes on, whether it's funerals, birthdays, camping trips, fishing, sport, you know it kind of goes hand in hand with that connection with family"*.

- Using it as a band-aid (e.g. for socialising and for a sense of belonging), with communities and families not as resilient as they were.

- The social determinants of health including education, housing and employment.

- One thing that is specific is the flow over from remote Anangu Pitjantjatjara Yankunytjatjara (APY) lands to SA – SA and NT are very linked.

- Large swathes of state that are remote – people bring alcohol into a dry area.

Potential policy responses

General population

The World Health Organisation has identified a list of key, evidence-based strategies to reduce the harms due to alcohol [69]:

- Effective interventions that will cost less than $100 per disability adjusted life year (DALY) are:
  - Increasing excise taxes on alcoholic beverages.
  - Enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media).
  - Enacting and enforcing restrictions on the physical availability of retailed alcohol (via reduced hours of sale).
- Effective interventions that will cost more than $100 per DALY are:
  - Enact and enforce drink-driving laws and blood alcohol concentration limits via sobriety checkpoints.
  - Provide brief psychosocial intervention for persons with hazardous and harmful alcohol use.

Key informants listed the following policies that have been considered successes in reducing the harms from alcohol from an evidence-based perspective:

- Drink driving policies.

- Minimum unit pricing (MUP).

  "Research on initiatives (price) are absolutely conclusive. Minimum unit pricing, absolutely does work, makes a big difference – that is how it should be. Alcohol is meant to be a recreational thing, why does it have to be so cheap? Alcohol has gotten cheaper". (informant discussing the benefit to Aboriginal and Torres Strait Islander people)

  "Pricing levers we know are incredibly evidence-based and successful in changing population levels of consumption".

  MUP has now been demonstrated to be effective in the Northern Territory, where the cost of cask and other boxed wine was increased if sold at under $1.30 per standard drink. In the NT, MUP reduced alcohol-related harms (e.g. assault offences, ambulance attendances, and emergency presentations) and total alcohol supply per capita, particularly for high-risk products (e.g. cask wine) [6, 70]. MUP has also been successfully introduced and reduced harms in countries including Scotland, Russia, Ukraine and Canada [7, 8], and will come into effect in Ireland in 2022. After the first year of Scotland's MUP, reductions in controlled off-trade alcohol sales (3.5% per adult) were observed; in the same period, per adult sales increased in England and Wales, where MUP has not been introduced [71].

- Reducing operating hours of licensed premises has been a key policy approach to managing alcohol-related harms in Australia (e.g. in Newcastle and Kings Cross, Sydney). A systematic review has demonstrated that reducing the hours on which on-premise alcohol outlets is associated with reduced violence [72].

- Alcohol interlock devices, which restrict the use of a car when blood alcohol content (BAC) is too high, combined with treatment for people with multiple offences or very high BAC. This system is currently in place in SA [73].

- Regional areas: police have proposed that drivers of all vehicles can be breath-tested.

- A range of Alcohol Management Plans (AMP's) have been operating in Aboriginal Communities in Australia to reduce alcohol-related harms and have been effective in some cases. AMPs vary in design across Australia but include strategies to reduce supply, demand and harm reduction measures and tend to be implemented where drinking rates and harms are excessively high [74].

- Related to the above, the pub in the town of Renmark, SA is cooperatively owned by the community (through an elected board whose members are required to be local residents) with the aim to allow the community to eat and drink in comfortable surroundings. It has been argued as an effective approach and the underlying logic was based on a Scandinavian system to decrease harms by eliminating the profit motive from alcohol sales. The proceeds of the pub were then used to benefit the community [75].

Key policy initatives to reduce the harms from alcohol

Key informants listed key policy initiatives recommended for action by SA Government as primary prevention strategies to reduce the harms from alcohol. Table 1 (page 11) lists them in order of key priorities from the majority.

It is important to note that nearly every informant listed that steps to address the social determinants of health (e.g. access to housing, education, reducing rates of poverty etc.) would have a positive impact on risky drinking at the population level, particularly among Aboriginal and Torres Strait Islander people, in addition to tackling the issue of racism and boredom in regional/remote communities.

Informants also noted that a multifaceted strategy is important: *"it's very much like learning from the tobacco area… in and of themselves, one intervention and one strategy is not going to be that effective. It's got to be a range of strategies that we can put in place."* Informants also emphasised the need to *target* both on-premises consumption and drinking in the home: *"for the acute injury where we see street violence, road trauma, it tends to be on-premise consumption that we start to see that because it's the movement of people. In regard to family violence, domestic violence and child protection, it's off-premise consumption and what people are doing in the home."*

"I think making sure that restrictions around advertising are kind of paired with consumer information, so you get better bang for buck."

There was also a general consensus across all applicants that there has not been enough of a focus on policy interventions in SA.

"…I know both political parties get a lot of pressure on them from the alcohol industry, a lot of pressure, especially in South Australia. But it shouldn't be at the expense of people's lives and health as well, is the thing."

Refer to Table 1 for the full list of policy options to reduce harms from alcohol.

Other drugs

For the purposes of this report, we define ‘other drugs’ as illicit drugs (e.g. meth/amphetamine, cannabis, fantasy/GHB, heroin, ecstasy/MDMA, cocaine) that are produced, sold, misused, or consumed contrary to Australian law (see Appendix A). This definition includes prescription drugs that are used in a way that is not compliant with a prescription.

A summary of the forms, modes of use, and effects for the other drug types included in this report is presented in Appendix B.

Trends: use and impacts of other drugs

General population patterns of use in Australia and South Australia

Recent data indicate that nearly half of Australians aged 14+ are reported to have used an illicit drug at some point in their lives, and 16% have used one recently [2]. The data for SA are similar, with more than 1 in 7 (15.4%) of South Australians reported to have used an illicit drug recently [50].

Trends for use of illicit drugs over time are noted earlier, in Figure 1, but notably use of methamphetamine, ecstasy and pharmaceuticals (e.g. painkillers and opioids) dropped in SA between 2016-2019, while cocaine use increased. Cannabis use remained stable. Figure 10 outlines the frequency with which commonly used illicit drugs are consumed nationally.

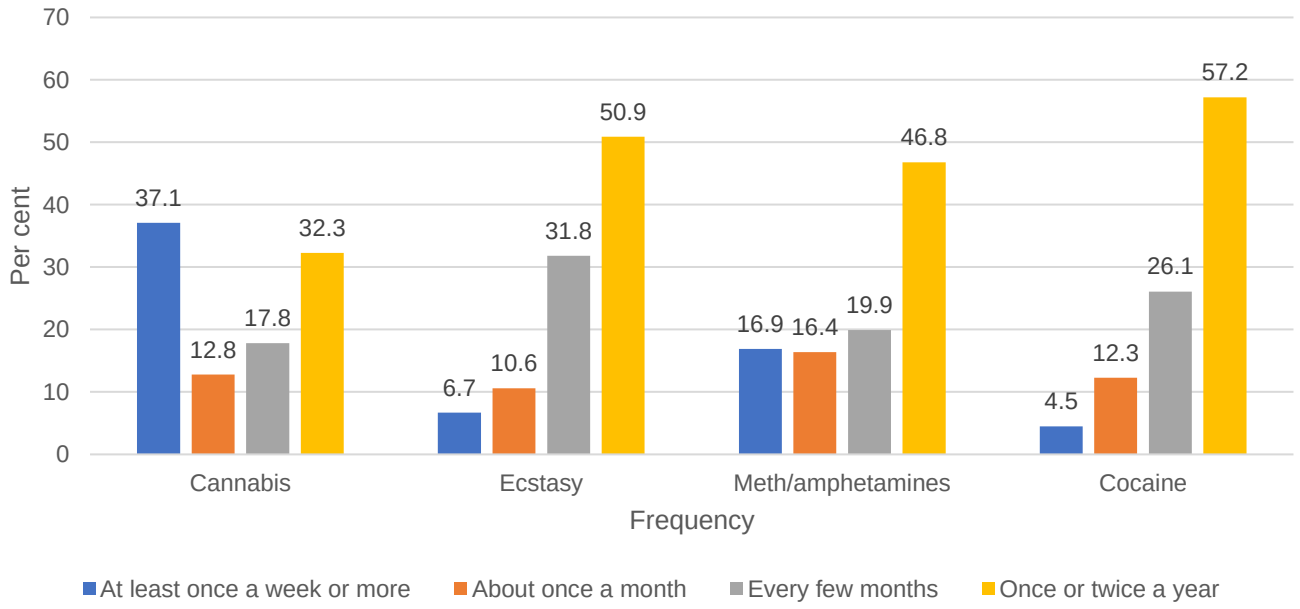


Figure 10. Frequency of illicit drug use, by specific illicit drug, people aged 14+, Australia 2019 (per cent)

Aboriginal and Torres Strait Islander community patterns of use in South Australia

Most recent data indicate that one-third (35.6%) of Aboriginal and Torres Strait Islander people in SA reported using at least one substance in the previous 12 months [30], higher than the national rate (28.4%) [31] (see Figure 2).

Cannabis is the most commonly used illicit drug amongst this population, reported by 24.1% of respondents nationally, and more common than pharmaceutical drugs (at 3.8%), meth/amphetamines (3.4%), or ecstasy/designer drugs (3.3%).

Drivers of trends

Drivers of drug use and of changing trends in drug use can be understood to be associated with demand and supply issues (see Figure 6).

Demand 'drivers' include:

- Pleasure-seeking and risk-taking behaviours.
- Levels of psychological and physical harm, for which people self-medicate with alcohol and illicit substances.
- Social determinants – there is increased demand when there is inadequate employment, education, 'healthy' leisure activities, social support, and increased trauma, poverty, boredom, mental health issues, fragmented families and communities.
- Community norms – e.g. culturally entrenched/normalised practices, including in Aboriginal communities; levels of understanding/concern about risks and harms.

Supply 'drivers' include:

- Availability of illicit drugs – e.g. key informants highlighted the rise of the 'dark net' being a significant problem, enabling easy access to drugs [76], including in Aboriginal and Torres Strait Islander communities. Informants reported that this changing landscape of supply of illicit drugs is a significant driver of trends in use, with users being able to order online and have substances delivered quickly (rather than having to meet a dealer).
- Border closures during COVID-19 have shifted the use of some drugs.

It is also important to note barriers to harm reduction, which can affect trends in the social and health impacts of other drug use:

- Stigma around drug use.
- Criminality associated with drug use, preventing help-seeking behaviour.
- Concerns about triggering social welfare consequences (e.g. removal of children).
- Costs of help-seeking (perceived and real).
- Inadequate resources for treatment and rehabilitation.
- Health professionals not always being trained to identify issues and support treatment.
- Potency or toxicity changes in drugs, which can increase harms.

Available policy responses to reduce illicit drug use and harm

Many of the informants highlighted current barriers to reducing use and harms from illicit drugs in Australia. In particular, the current framing of illicit drug use as a largely criminal issue was perceived as problematic, creating stigma around use and barriers to help-seeking for users. Informants highlighted the need to reprioritise drug use as a health issue to help address these barriers, drawing on examples of how this is being done elsewhere. It

should be noted that SA was considered world-leading within Australia and internationally with partial cannabis decriminalisation in 1987 [77, 78]. However, more recent legislative change in the ACT had been highlighted as an exemplar of drug policy reform.

Table 2 (page 18) presents a summary of policy responses relevant to other drug use and recommended by informants for consideration in SA. Although some policy recommendations are specific to particular drug types, it should be noted that many apply for all drugs.

Meth/amphetamine

Trends: use and impacts

General population patterns of use

SA has had one of the highest meth/amphetamine consumption rates in the country [49, 79, 80], and an estimated 1.0%* of males and 1.0%* of females reported recent use in 2019 [50]. However, reported rates of recent use have been declining since 2001 (from 2.5% to 1.0% in SA and 2.3% to 1.3% in Australia), in particular among younger age groups. However, use has been increasing or remaining stable among older age groups (40+) [2]. Use is also higher in regional SA than in Adelaide [80], as is the case in other areas of Australia [81].

Overall, wastewater data from Adelaide show consumption levels in 2020 at their lowest since 2014, although they have increased somewhat since October 2020 (see Figure 11). The fall in 2020 may have been related to COVID-19 border closures impacting on the importation of the drug into SA [82].

Wastewater data also show that methamphetamine use in Adelaide increases slightly on weekends [49], but is relatively stable when compared with alcohol and 'party drugs' such as cocaine and ecstasy. Stable use across the week suggests dependency issues for users, rather than casual use.

Aboriginal and Torres Strait Islander community patterns of use

Recent data suggest that 3.4% of Aboriginal adults recently used (in the last 12 months) meth/amphetamines (reported as 'amphetamines, ice or speed'; see Figure 3 [52]). Compared to earlier data [83], this finding indicates an increasing trend of use, and much higher use than amongst non-Indigenous Australians. Furthermore, stimulants (i.e. meth/amphetamine, cocaine) accounted for 30.9% of unintentional drug-induced deaths recorded between 2014-2018 for Aboriginal people [2].

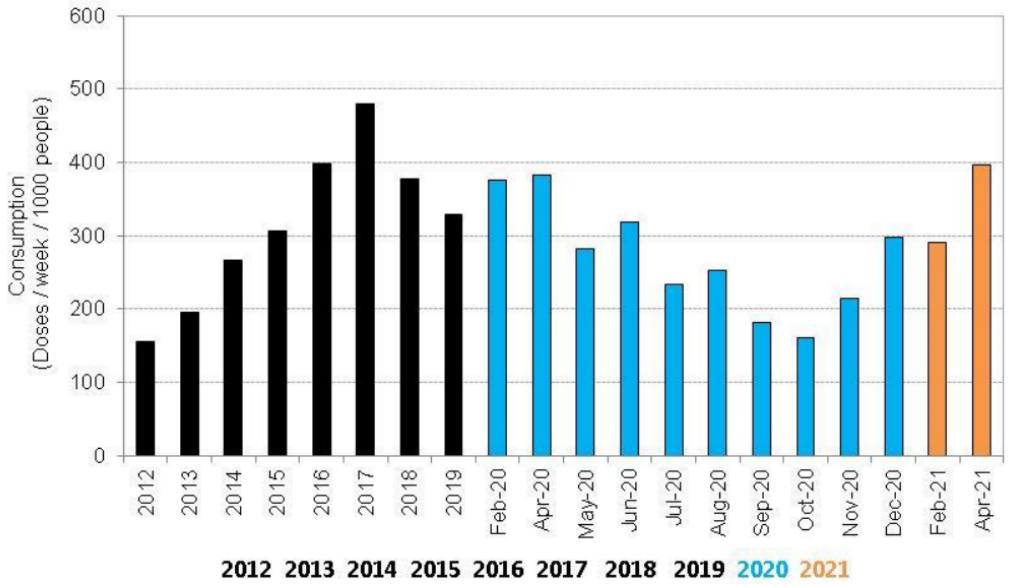


Figure 11. Methamphetamine consumption (dose/week/1000 people)[18] [49]

[18] Average consumption (dose/week/1000 people) of methamphetamine in metropolitan Adelaide for 2012-2019. Weekly consumption (dose/week/1000 people) monthly from April to December 2020, and bi-monthly from February 2020 to April 2020 and from December 2020 onwards. Dose=30mg.

Harms

Informants overwhelmingly reported that, despite a low and decreasing prevalence of use, harms from meth/amphetamine use remain significant and widespread, spanning short- and long-term health and social problems:

- Deaths are mostly due to accidental drug toxicity (i.e. overdose) [61]; polydrug use involving meth/amphetamine is most likely to increase the risk of accidental drug toxicity [84].
- Deaths due to meth/amphetamine and other stimulants in Australia increased significantly between 1999 and 2018 [51, 53].
- Associated with a significant burden of psychopathology, including anxiety and mood disorders, suicide and violent behaviours [84], and increased risk of developing schizophreniform paranoid psychosis [85].
- Also associated with an increased incidence and earlier onset of Parkinson's disease [86].
- Pressure on mental health services, emergency departments, and emergency services: estimated to account for between 28,400 and 80,900 additional admissions to psychiatric hospitals and between 29,700 and 151,800 additional emergency department presentations in 2013 [87].
- Places burdens on multiple components of the health system, especially 'front line' emergency responders, including ambulance, psychiatric and emergency department workers [88].
- Risks of blood-borne viruses for people who are injecting without safe injecting equipment.
- Violent offences: *"…personal violence I think is pretty prevalent with methamphetamine. People lose it and get crazy."*
- Harms to families and communities: *"I think breakdown of family and community, the way it affects everyone in the community", "so many communities in South Australia that they just don't know how to deal with it and they're not feeling supported with it."*

  These harms were particularly emphasised in Aboriginal and Torres Strait Islander communities:

  "We've had families separated when people using ice [crystal methamphetamine], and then those children are being taken away as well. But not only that, then you add in like the induced psychosis that comes on board, and people start to fear their family, and then they get, like they just want their family taken away and fixed. I mean if you ask the people who are looking after the children, the other family members that are picking up all the pieces, the family members that are under stress financially because of this drug, this family member that hasn't, and I think they'd say it's a pretty big problem, and it needs to stop."

  Informants also raised concerns about the role of *"Aboriginal people within that methamphetamine economy as well":*

  "Aboriginal people are not just the consumers, they are also people who are selling as well, and selling to support their use. But there are people above them of course, whoever they may be, who really are the ones who are making money out of it all."

Drivers of trends

General population drivers

Informants reported the following factors influencing trends in methamphetamine use:

- Decreasing prevalence of people consuming casually, potentially influenced by media coverage and stigma around use.
- Increased potency of the drug (i.e. crystal methamphetamine) compounding harms for continuing users.
- Functional use for some users (e.g. some occupational groups), as it can keep people awake for long periods.

- Higher use in SA than other states may be related to availability, including local manufacture.
- No medical substitution treatment (unlike other drugs), so difficult to treat dependent users.

Aboriginal and Torres Strait Islander communities

For Aboriginal and Torres Strait Islander people, informants emphasised the importance of mental health and broader social factors:

> *"…in that group, trauma would be the biggest driver of everything… But then add to that boredom. Lack of opportunity. And people are using it for energy to give them a lift because they haven't got anything else in their life giving them a lift."*

Access and availability are also significant drivers: *"you can get your meth faster than you can get your… takeaway pizza."*

Pharmaceuticals

Trends: use and impacts

General population patterns of use

Recent data indicate that, in SA, non-medical use of pharmaceuticals is the second most common form of illicit drug use, after cannabis. In 2019, 4.2% of South Australians reported recent use; 2.9% relating to painkillers and prescription opioids, and 1.3% relating to tranquilisers/sleeping pills. More women than men reported recent use of any pharmaceutical (4.7% vs. 3.7% in 2019 in SA). However, Figure 12 indicates that use of prescription opioids has significantly reduced since 2016 [49, 50].

Despite these decreases in use, national wastewater data show that the consumption of fentanyl in regional SA is markedly higher than that in Adelaide[19], and the average use of fentanyl in SA is higher than that in other parts of Australia. The consumption of oxycodone is also higher in Adelaide that in other Australian cities [80].

National data suggest that the average age of people using prescription opioids for non-medical purposes (41.9 years) is higher than for other drugs (30.7 years) [2]. A greater proportion of people over 65, living in low income households in less populated Statistical Local Areas (SLAs), and those with manual occupations, were associated with greater fentanyl utilisation [89].

Aboriginal and Torres Strait Islander community patterns of use

Nationally, it has been reported that 7.7% of Aboriginal people had recently used pharmaceuticals for non-medical purposes, compared to 4.1% of non-Indigenous Australians[20] [90].

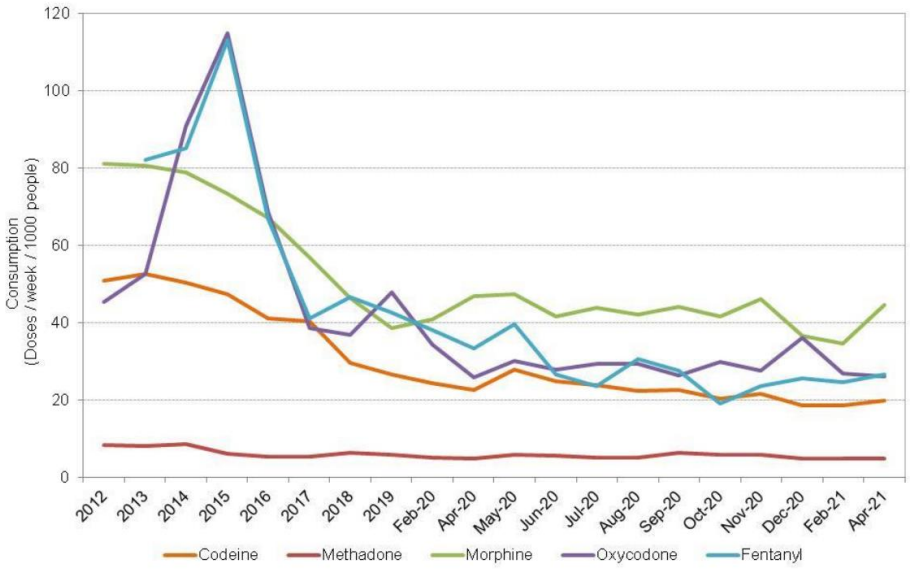


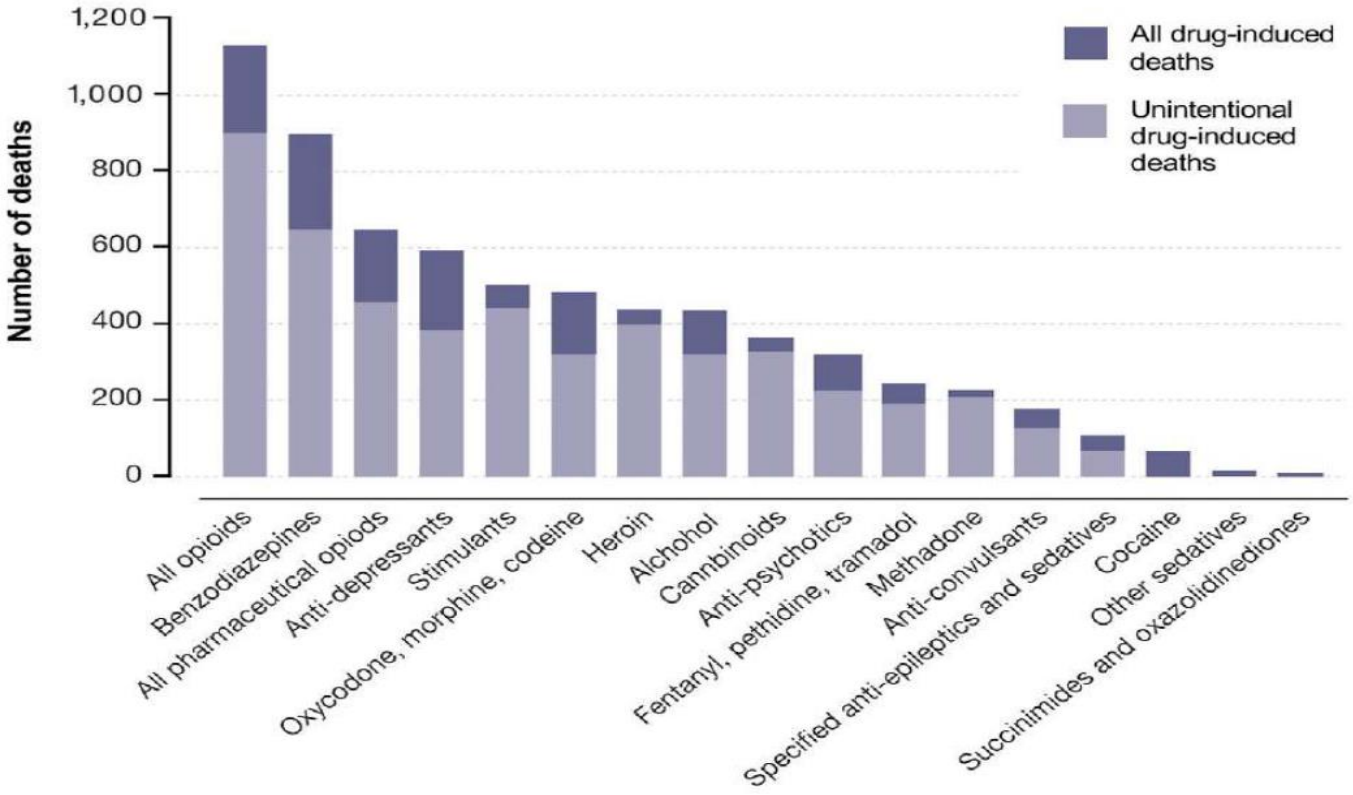
Figure 12. Pharmaceutical consumption (dose/week/1000 people)[21] [49]

[19] Wastewater measurement is less frequent in regional areas than in capitals.
[20] These data are age-standardised and may not match non age-standardised estimates presented for the general population.
[21] Average consumption (dose/week/1000 people) for 2012-2019, in metropolitan Adelaide. Weekly consumption (dose/week/1000 people) monthly from April to December 2020, and bi-monthly from February 2020 to April 2020 and from December 2020 onwards. Codeine (200mg dose), morphine (30mg dose), methadone (100mg dose), oxycodone (10mg dose) and fentanyl (0.2mg dose).

Harms

In 2018, data found that nearly two-thirds (64.5% or 1,123 deaths) of all drug-induced deaths involved opioids, including heroin and pharmaceutical opioids (Figure 13) [91]. The proportion of unintentional drug-induced deaths per 100,000 people in SA were lower than all other jurisdictions [33], yet the rate of unintentional drug-induced deaths was higher in rural and regional SA than in greater Adelaide. Most unintentional drug deaths occurred in a poly-drug context involving opioids, benzodiazepines, and other pharmaceuticals [33].

Opioids are the largest drug category identified in unintentional drug-induced deaths among Aboriginal and Torres Strait Islander people (51.6%), and heroin in particular. The next most common drugs involved in unintentional drug-induced deaths were stimulants, accounting for 30.9% of deaths, followed by benzodiazepines, another pharmaceutical drug group (24.3%).



Note: All opioids includes opium, heroin, methadone, oxycodone, morphine, codeine, fentanyl, pethidine, tramadol, buprenorphine, hydromorphone. All pharmaceutical opioids includes the groups oxycodone / morphine / codeine and fentanyl / pethidine / tramadol. Opium is not shown on the graph as a single bar as there were zero deaths involving opium.

Figure 13. Number of drug-induced deaths in 2018 by drug type: all death and unintentional deaths [33]

Drivers of trends

Factors reported to be associated with patterns in non-medical pharmaceutical drug use and harms include:

- Significant concerns surrounding the potential for individuals to have multiple prescriptions, from different providers (‘doctor shopping’).

- The ‘up-scheduling’ of codeine in 2018 from an ‘over the counter’ medicine to ‘prescription only’ [2]. The proportion of Australians using codeine for non-medical purposes halved from 3.0% in 2016, to 1.5% in 2018.
- Significant risk in the medical use of opioids in Australia over the last 20 years for non-cancer chronic pain management, which has been accompanied by an increase in the misuse of these drugs [89, 92-95].
- Pharmaceutical drug use often starts with genuine medical need (e.g. relating to pain management), and users often have complex co-morbidities, including physical and mental health issues; these issues will increase with an ageing population, and with a growing need for pain management associated with chronic illness.
- Prescription practices can be risky.
- Low SES areas are associated with higher numbers of scripts, and with more alternative options available to people with physical or psychological pain living in higher SES areas.

Cannabis

Trends: use and impacts

General population patterns of use

Cannabis is the illicit drug most frequently used in Australia [2], with the proportion of people ever using the drug increasing. In SA, 10.6% of people aged 14+ reported recent use of cannabis in 2019, compared to 11.6% in Australia [2]. Data suggest that cannabis use in SA increased during the pandemic in 2020 to the highest rates on record since 2012; the rates dropped again in early 2021 [49] (Figure 14).

Cannabis use is more common among males than females (12.9% versus 8.5% in SA, 2019), those living in remote or very remote areas, and those aged 20-29. Wastewater data show that use of cannabis is relatively stable across the week [49]. Cannabis use also frequently occurs in a polydrug use context [96], and is more frequently used by those who also smoke tobacco [97, 98].

Aboriginal and Torres Strait Islander community patterns of use

In 2019 national data, cannabis was the most commonly reported illicit drug used by Aboriginal people in the last 12 months, at 24.1%. This was an increase compared to previous 2013 data, where recent cannabis use was reported by 19% of Aboriginal people aged over 15 years [52].

Informants raised many concerns with patterns of cannabis use in Aboriginal communities, highlighting that it is often normalised and *'forgotten'* in discussions around drug use. They highlighted the need to take the risks and harms of cannabis use in Aboriginal communities seriously.

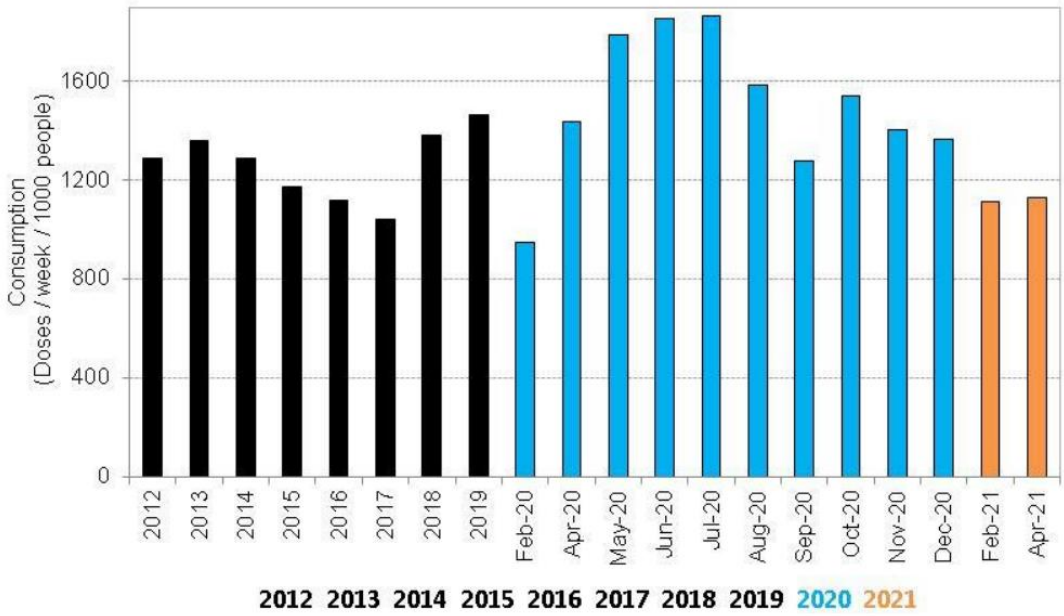


Figure 14. Cannabis consumption (dose/week/1000 people)[22] [49]

[22] Average consumption in metropolitan Adelaide (dose/week/1000 people) of THC for 2012-2019. Weekly consumption (dose/week/1000 people) monthly from April to December 2020, and bi-monthly from February 2020 to April 2020 and from December 2020 onwards. Dose=125mg.

Harms

Given the progressive laws around cannabis in SA, cannabis use is perceived as relatively harmless. However, key informants highlighted the need to distinguish between daily and occasional use.

While the latter was associated with few harms, daily use in young people has been associated with poor educational outcomes. Key informants noted that the harms of heavy cannabis use in Aboriginal communities include increased anxiety, depression, and psychosis. Further, some informants reported that the profits from cannabis sales support more major crimes, including in relation to other drugs.

Drivers of trends

General population drivers

SA was a pioneer and leader in Australian decriminalisation policies, with cannabis partially decriminalised in SA in 1987; some informants described this as facilitating and normalising use in the community. Drug diversion reforms, such as the Police Drug Diversion Initiative, were reported by some informants to have offered benefits, in terms of cannabis use and harms, by diverting users away from the criminal justice system, into a health assessment [4].

Legislative changes in 2016 have allowed for medical cannabis use, enabling more widespread use in the state. The use of medical cannabis may be influencing the form of cannabis used more broadly, with people moving towards using cannabis oils (e.g. rather than smoking cannabis).

Aboriginal and Torres Strait Islander communities

Informants described the following factors as influencing cannabis use in Aboriginal and Torres Strait Islander communities:

- Use is normalised, with cannabis seen as a 'better' drug: *"sometimes grandmothers have said 'I'd much rather they smoke ganja than drink alcohol. I'm much rather they smoke ganja than sniff petrol or use meth.' So, there's a bit of discordance there. It's seen as the better drug to use."*
- Broader social determinants, such as insufficient employment, not enough social/community infrastructure enabling alternative leisure activities, and ongoing systemic racism and trauma, influences use: *"Amongst my clients, boredom would be one of the key drivers. Boredom and trauma."*
- People will use it if they can't access alcohol; both can be forms of self-medication for pain and trauma, and there is evidence linking stressful life events with cannabis dependence [99].

Fantasy/GHB

Trends: use and impacts

General population patterns of use

Use of GHB is relatively uncommon in Australia, with only 0.1%* of Australians reporting recent use in 2019 [2]. However, in a survey of regional service providers in SA during 2020, 13% of agencies reported seeing increased uptake of GHB use [100], and our informants highlighted this drug as an emerging concern, particularly given recent deaths associated with use in SA.

Given its use as a 'party drug', use seems to be associated with specific communities. For example, GHB has been associated with 'chemsex' (along with methamphetamine) among same-sex attracted men [101], with one Australian study finding nearly 20% of gay and bisexual men surveyed had a history of using GHB, and 2.7% used it frequently (at least monthly) [102]. Key informants also indicated that use of GHB is an emerging problem within prison populations.

Aboriginal and Torres Strait Islander community patterns of use

There are limited data on GHB use by Aboriginal people in Australia; where reported, use has been estimated to be relatively low (approximately 2% of young people, fewer than most other drugs) [103]. Key informants noted that use and associated harms have been observed in Aboriginal and Torres Strait Islander communities, and are of concern.

Harms

GHB has a steep dose-response curve, and the difference in the quantity of GHB required for intoxication and for overdose is small [104]. As such, overdose commonly results [105]. Half of those using GHB in a study of Australian users reported having overdosed and losing consciousness [106]. Almost all (99%) reported experiencing one or more significant negative side effects, including vomiting, profuse sweating, fits, or seizures [106].

Drivers of trends

Key informants suggested that GHB is often used alongside, or instead of, meth/amphetamine, and that it is relatively easy to manufacture. Use of GHB may have increased with COVID-19 border closures making other drugs (such as meth/amphetamine) difficult to source.

Heroin

Trends: use and impacts

General population patterns of use

Heroin consumption is relatively low compared with other drugs [53]. In 2019, recent use of heroin was <0.1* in Australia [2]. Most use is concentrated in capital cities [107].

Analysis of wastewater data in Adelaide (Figure 15) reflects fluctuating heroin consumption since 2013, with a slight rise in use during 2020. Use is also noted to be stable across the week, suggesting dependency issues for users.

Given the relatively low use of heroin, this drug was not typically a focus in our discussions with key informants. Where discussed, informants supported the view that there is a downward trend in consumption and that levels of use are low. Harms remain high for users though, and harm reduction approaches are important.

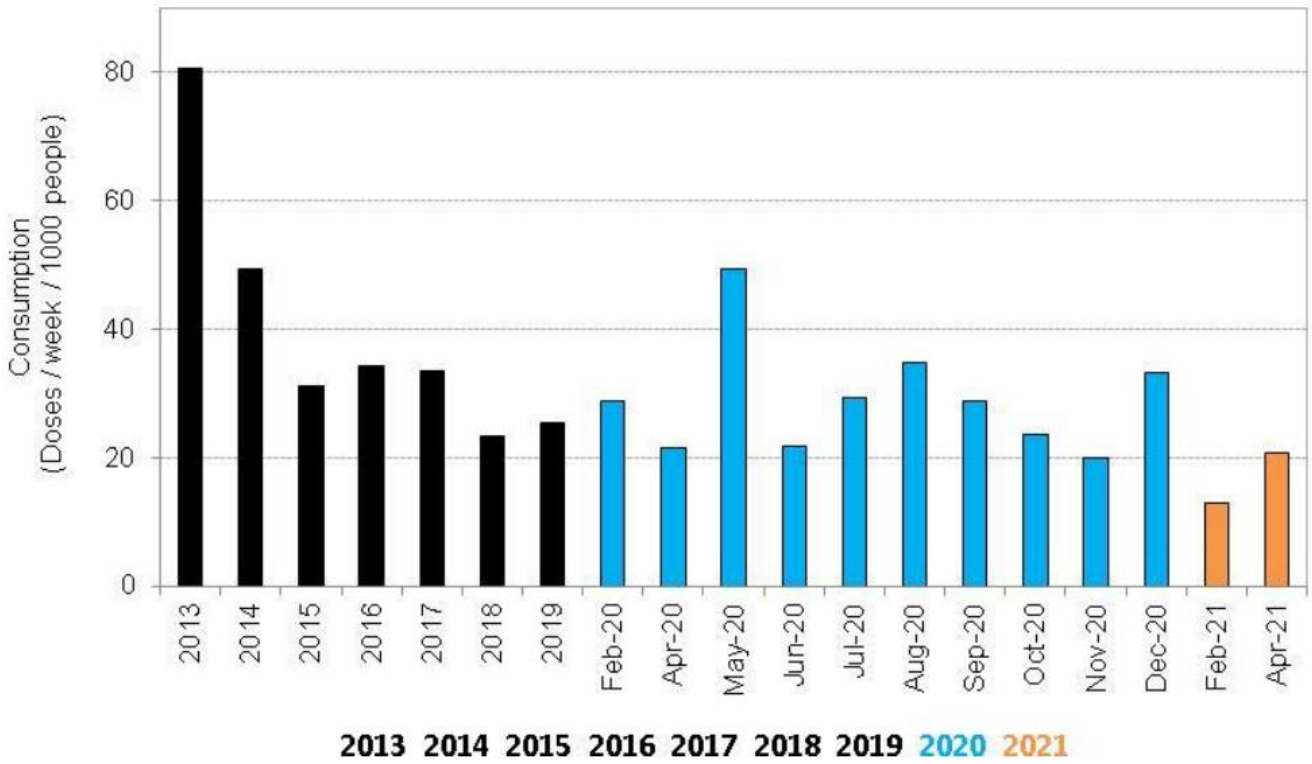


Figure 15. Heroin consumption (dose/week/1000 people)[23] [49]

Aboriginal and Torres Strait Islander community patterns of use

Heroin use by Aboriginal people in Australia has been estimated as relatively low (approximately 2% of young people, fewer than most other drugs) [103], but use is reported by around one-third of young Aboriginal people

[23] Average consumption (dose/week/1000 people) of heroin for 2012-2019 in metropolitan Adelaide. Weekly consumption (dose/week/1000 people) monthly from April to December 2020, and bi-monthly from February 2020 to April 2020 and from December 2020 onwards. Dose for calculation=20mg.

who have recently injected any drug [103, 108]. In a Queensland-based study, Indigenous respondents experiencing opioid use disorder reported injecting heroin more than twice as frequently as their non-Indigenous counterparts [109].

Indigenous Australians are over-represented in heroin-related treatment services, comprising 16% of all clients in 2018-2019. Compared to non-Indigenous Australians, Indigenous Australians were more than six times as likely to receive AOD treatment for heroin as the principal drug of concern (26 vs. 172 per 100,000 population), and this rate has increased over time [110].

Harms

Nationally, the risk of overdose from heroin has been increasing [51]: in 2019, 25% of all drug[24]-induced deaths were due to heroin. Rates of drug-related deaths from heroin have been higher in each year from 2017 to 2019 than in any other year since 2000 [53]. Drug-induced deaths related to heroin use are more common among males, and in metropolitan areas; the median age of death is also lower for than for pharmaceutical opioids [53].

Injecting heroin is associated with additional harms compared to other methods of use, including exposure to blood-borne viruses (e.g. HIV, Hepatitis C). These and other health impacts of long-term substance use further increase users' vulnerability [53].

Drivers of trends

Use of heroin appears to be related to ease of access to the drug [111]. Trends in use are also affected by availability of other illicit drugs, including prescription opioids [112, 113]. Harms can be reduced by acknowledging the stigma of use and barriers to help-seeking, as well as practical measures such as safe injecting rooms, needle and syringe programs, and medical substitution treatments (e.g. methadone).

[24] Deaths attributable only to alcohol and tobacco are not included in total drug-induced deaths reported by the ABS.

Ecstasy/MDMA

Trends: use and impacts

General population patterns of use

In SA, reported rates of use have declined since 2007 (from 2.9% to 1.2% in 2019), and are lower than national rates [50, 107, 114]. However, wastewater data from Adelaide indicated that use increased during 2020 (see Figure 16); it has lowered again since November 2020.

Figure 17 shows that ecstasy use spikes on weekends, suggesting casual or recreational use is most common. National data show that use is most common among males, people living in higher socioeconomic areas, and people aged 20-29 [2, 53].

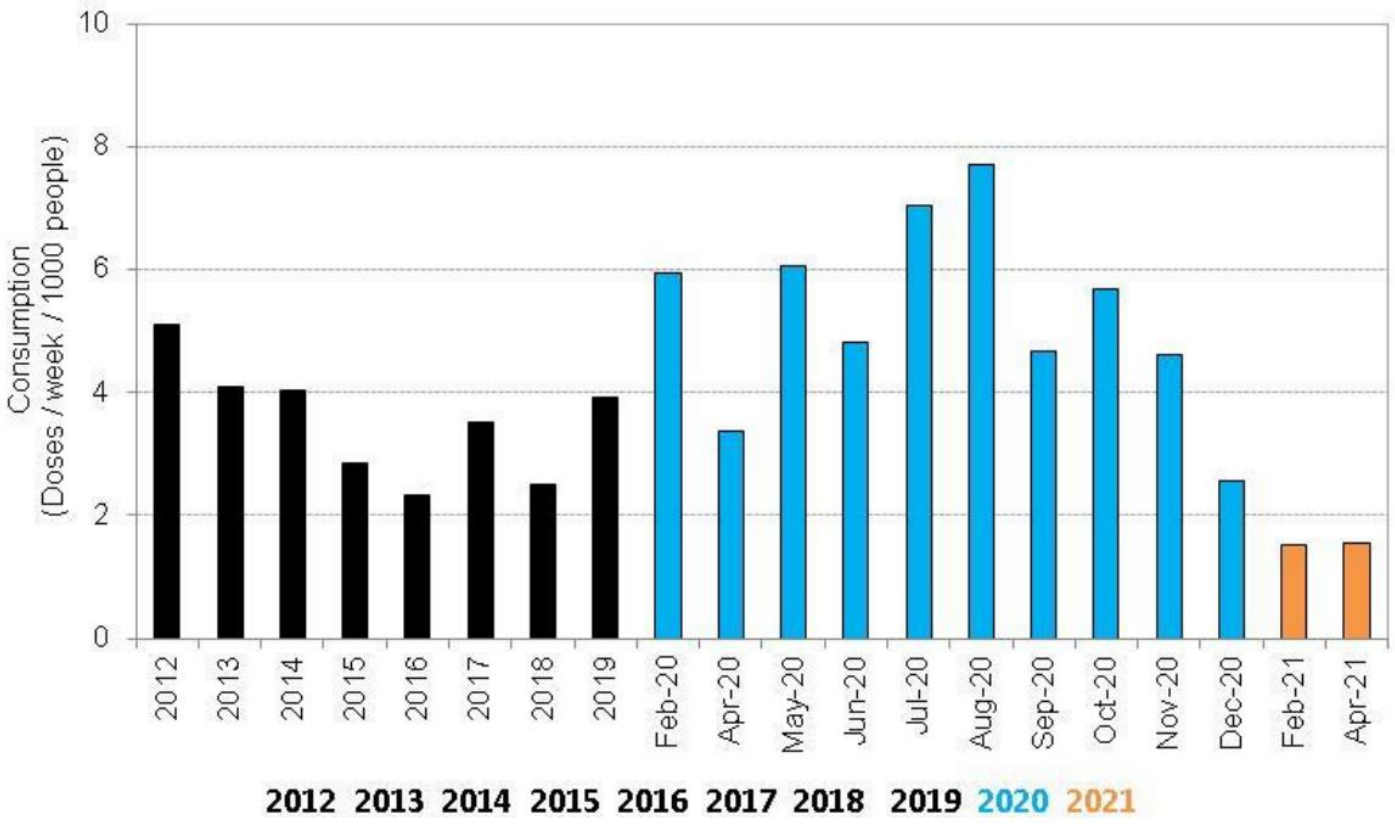


Figure 16. MDMA consumption (dose/week/1000 people)[25] [49]

[25] Average consumption (dose/week/1000 people) of MDMA for 2012-2019 in metropolitan Adelaide. Weekly consumption (dose/week/1000 people) monthly from April to December 2020, and bi-monthly from February 2020 to April 2020 and from December 2020 onwards. Dose=100mg.

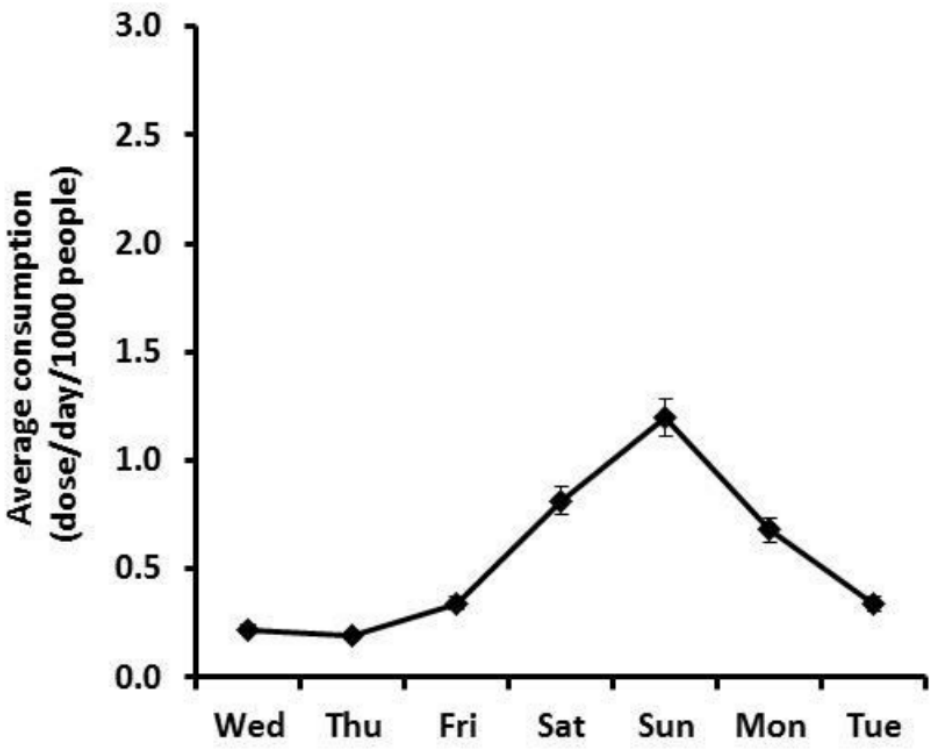


Figure 17. MDMA consumption (dose/day/1000 people) over the week[26] [49]

Aboriginal and Torres Strait Islander community patterns of use

Recent data sources estimate that between 3.0-3.3% of Aboriginal people had recently used ecstasy, which is comparable to rates among non-Indigenous Australians [31, 90].

Harms

There were 392 deaths related to ecstasy/MDMA use reported nationally between 2000-2018, occurring most commonly amongst young men, with 62% related to drug toxicity [115]. This number of deaths is relatively low, compared with other drugs, and other causes, but often receives media coverage and is not acceptable within the community. Despite media reporting, “only 7% of drug toxicity deaths… occurred at music festivals or dance parties” [115].

Key informants highlighted that with the recent trend for consumption to via capsules (rather than pills), the risk of toxicity is increased.

Drivers of trends

Key informants indicated that use of ecstasy declined around 2010, given a shortage of supply, then remained low. However, consumption rose in 2020, potentially related to availability during COVID.

[26] Average daily consumption (dose/day/1000 people) of MDMA over the week in Adelaide, February 2012 to February 2021. Dose = 100mg.

Cocaine

Trends: use and impacts

General population patterns of use

Data indicate that the popularity of cocaine has been rising in Australia since 2001 [2]. In SA, rates of recent use have increased since 2007 (from 1.3%* to 2.5% in 2019), but remain lower than national rates (4.2% in 2019) (Figure 18).

Cocaine use is more common among those aged 20-29, higher in cities than in regional areas, and similar for males and females in recent SA data [114]. Use is markedly higher on weekends (Figure 19).

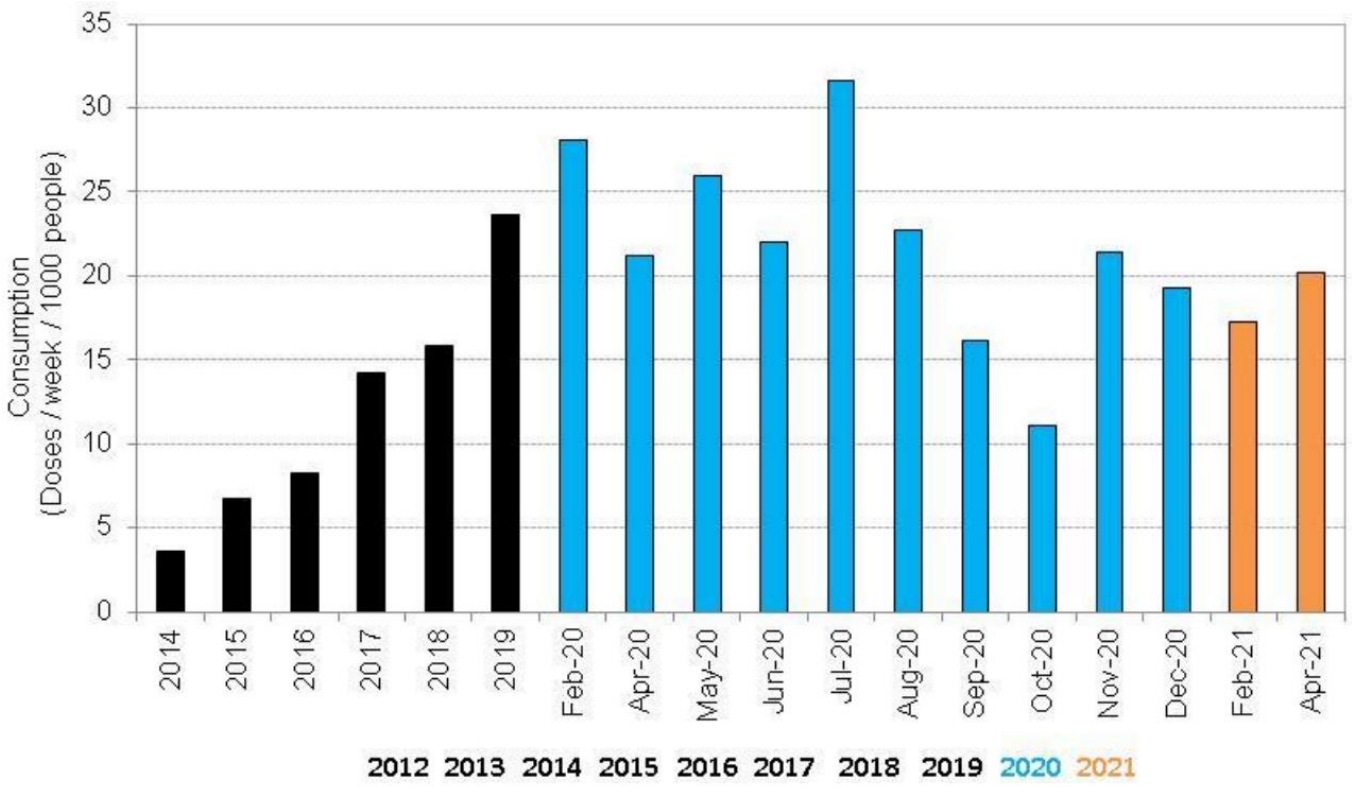


Figure 18. Cocaine consumption (dose/week/1000 people)[27] [49]

[27] Average consumption (dose/week/1000 people) of cocaine for 2012-2019, metropolitan Adelaide. Weekly consumption (dose/week/1000 people) monthly from April to December 2020, and bi-monthly from February 2020 to April 2020 and from December 2020 onwards. Dose=100mg.

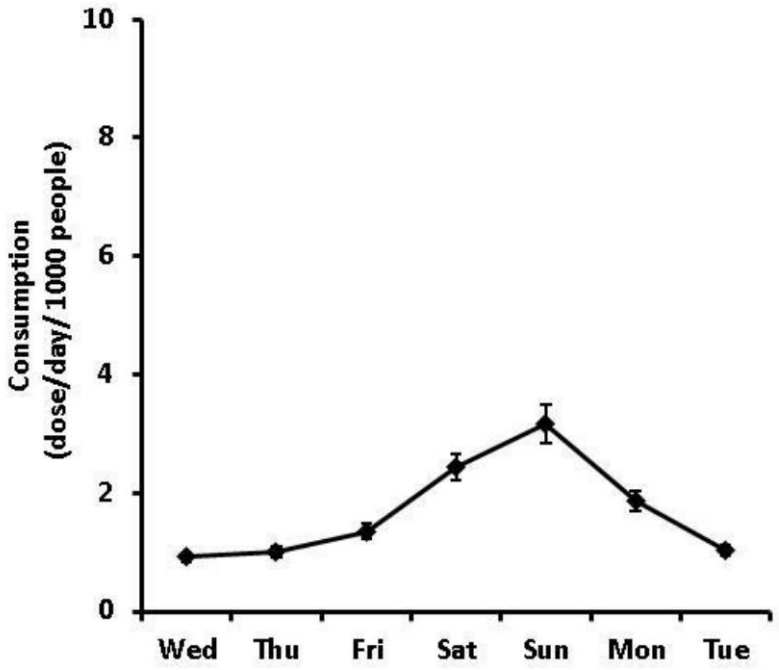


Figure 19. Cocaine consumption (dose/week/1000 people) over the week[28] [49]

Aboriginal and Torres Strait Islander community patterns of use

Nationally, 4.2% of Aboriginal people had recently used cocaine in 2019, which is comparable to the age standardised rates among non-Indigenous Australians (4.4%). Use appears to have increased from 2013 (1.8%) and 2016 data (1.9%*) [90].

Harms

Cocaine use is associated with a range of short- and long-term health issues, including mental health issues and cardiovascular problems, and users can experience addiction. However, most informants did not describe it as a significant current public health issue, relative to other drugs.

Drivers of trends

Cocaine is relatively expensive to use, affecting which population groups access it. The rise in use in mid-2020 may have been related to difficulties in sourcing methamphetamine due to COVID-19 border closures [82].

It was also suggested by informants that global cocaine markets may have shifted, with more focus now in Australia. A recent (September 2020) cocaine interception by the Australian Federal Police in Adelaide worth 20 million dollars may indicate that demand for the drug is high [116].

[28] Average daily consumption (dose/day/1000 people) of cocaine over the week, metropolitan Adelaide, February 2012 to April 2021. Dose=100mg.

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Appendix A

Current drug laws in South Australia

In SA, the use or simple possession of most illicit drugs (e.g. amphetamines other than those prescribed, heroin, and ecstasy) generally attracts maximum penalties of $2,000 and/or two years imprisonment [117]. Larger penalties apply for possessing commercial quantities, manufacturing, or selling.

Cannabis is one exception. SA was a pioneer and leader in Australian decriminalisation policies, and the personal use and possession of cannabis is currently penalised in SA with an expiation notice, rather than being subject to a criminal conviction. However, the large-scale cultivation, sale, or trafficking of cannabis remains a criminal offence. Medical cannabis is also now legally available to South Australians since legislative changes in 2016 came into effect.

Appendix B

Summary of other drug types

Meth/amphetamine

Amphetamine and its more potent derivative, methamphetamine (e.g. speed, base, and crystal), are synthetic stimulant drugs that speed up the brain's functioning inducing euphoria, a sense of wellbeing, increased energy, increased attention, nervousness, anxiety, and paranoia.

The main form of meth/amphetamine consumed by users in Australia is crystal methamphetamine ('ice'). Methods of administration include smoking, oral injection, injection, or intranasal (sniffing).

Pharmaceuticals

The non-medical use of pharmaceutical drugs includes use of painkillers and opioids (e.g. oxycodone, codeine, morphine and fentanyl), tranquilisers and sleeping pills (e.g. benzodiazepines), and steroids.

Opioids suppress the central nervous system and interact with opioid receptors in the brain, slowing breathing and eliciting sensations of relaxation, euphoria, a reduction in pain, and feelings of anxiety.

Cannabis

Cannabis is a psychoactive drug, with well-established acute and chronic effects, including impaired cognitive and psychomotor impairment, cannabis dependence, airway injury, chronic bronchitis, and risk of exacerbating or triggering schizophrenia in effected individuals [118].

Recently, research has demonstrated that cannabis can have therapeutic efficacy. Cannabis-based medicines[29] are being approved for a range of medical conditions, including pain management, nausea, cancer, and weight loss [118].

Fantasy/GHB

Gamma-hydroxybutyrate (GHB, commonly 'fantasy') is a central nervous system depressant. It is usually swallowed as a colourless and odourless liquid, or less frequently used in the form of a white powder or pill. Recreational use is associated with nightclub and party scenes. Short-term effects can include lowered inhibition and heightened sexual experience, and feelings of euphoria. Other effects include drowsiness, nausea, and impaired breathing, particularly when taken with alcohol or other drugs. GHB has received media attention as a drug implicated in cases of drink spiking and drug-facilitated sexual assault, although reports show that GHB use in these circumstances is relatively rare (i.e. lower than that of alcohol and some other drugs) [119, 120].

Heroin

Heroin is a depressant opioid drug, most commonly in white powder or rock form. In Australia, heroin is usually injected, but may also be heated and its fumes inhaled. By suppressing pain-signalling nerves (as well as areas of the brain responsible for coughing and breathing), it has strong painkilling effects. Short-term effects of use include a near-immediate high, followed by drowsiness, and slowed heart and breath function. Heroin use carries a very high risk of overdose and death, usually from impaired breathing, particularly when used alongside other drugs or alcohol.

Ecstasy/MDMA

Ecstasy is the common name for the psychoactive drug methylenedioxymethamphetamine (MDMA). Ecstasy is usually taken orally in pill or capsule form (which may also contain other substances), but can also come in crystal form, or powder, which can be smoked or snorted. MDMA can produce feelings of empathy, euphoria, closeness to others, happiness, and excitement.

[29] Delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) are the main chemicals used in medicinal use.

Cocaine

Cocaine is a stimulant drug that produces psychoactive effects. It functions by increasing the neurochemical dopamine in the brain, providing feelings of euphoria and driving a desire to take the drug again [121]. Cocaine can be snorted, injected or smoked, giving an immediate effect to the user.

Appendix C

Evidence from the successful Portuguese diversion model

The Portuguese diversion model of drug decriminalisation was a widely-cited example [122]. This model puts emphasis on drug use as a health and social (rather than criminal) issue, using an evidence-based drug strategy with efforts in prevention, harm reduction and social integration. Under the model, the personal use and possession of all illicit drugs is decriminalised. Trafficking (i.e. amounts greater than the equivalent of 10 days of personal supply) and selling remain criminal offences. People experiencing drug dependence are referred to treatment or education programmes when found to be using or possessing drugs; penalties for those not experiencing dependence include education, service, and fines. The model was not associated with major increases in drug use; evidence also suggests reduced problematic use and reduced drug-related harms [123].